EMSWORLD

Who's Taking the Fall?

BY JOHN ERICH (/CONTACT/10225397/JOHN-ERICH)
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Wake County is looking to treat and release simple-fall patients in assisted-living facilities

Mike Legeros

The protocol would utilize Wake's advanced-practice paramedics, who have extra training and operate solo.

Several times a day, EMS crews in Wake County, NC, are summoned to assisted-living facilities for patients who have fallen. Often these patients aren't seriously injured, and transporting them to emergency departments offers no real clinical benefit commensurate to its cost.

By way of evidence, system leaders looked at 150 such calls their crews responded to last year. They found 81% of those patients were discharged directly from the emergency department without requiring hospital admission. Yet Wake County EMS conducted 1,500 such transports, totaling around $2.5 million in healthcare expenses.

Is there an alternative? Maybe so: If it holds up against a retrospective review of the rest of those transports, Wake will trial a new protocol to treat and release some assisted-living patients with simple falls who aren't seriously injured.

"What we want to do is go back through the whole 1,500 cases and make sure the draft protocol we've put together would have captured all the patients who needed intervention," says Brent Myers, MD, MPH, FACEP, the system's director and medical director. "We don't have that data yet, but the 150 we looked at were randomly selected, so we have no reason to believe it'll be any different."

The protocol would have strict inclusion and exclusion criteria, one of the former being that the patient be a client of Doctors Making Housecalls, a local physician group that offers home visits with same- and next-day appointments. Around 80% of patients in Wake's assisted-living facilities are clients of the group. This will help ensure timely physician follow-up for those who might need it. Doctors Making Housecalls actually conceived the idea (they'd trialed it successfully with patients who had mild altered mental status), and will collect advance participation consent from its clients. Patients not affiliated with the group will be excluded from the protocol, as will anyone with any other emergency medical condition identified.

Under the protocol, transport won't be required for assisted-living facility patients who are found down with no complaint or external signs of trauma. Those with simple cuts or hip pain with full range of motion and no change in ambulatory status may also be treated and released. Those with uncontrolled hemorrhage, open or dislocated fractures, acute neck pain, altered mental status vs. baseline, lacerations requiring repair or abnormal vital signs will still be transported.

Some patients will require consultation with on-call DMH physicians: those on anticoagulants, with unclear spinal exams, who require pain control beyond existing orders, with abnormal lab values, with borderline vitals or with any other uncertainty. In all cases, patients will be seen by one of Wake's advanced-practice paramedics, who have real-time access to Doctors Making Housecalls' patient records and can follow up as they feel a case warrants.

Those advanced-practice medics represent one of the big advantages the Wake County system has in trialing a protocol like this. Specially trained paramedics who operate solo, they're used to supplement ambulance responses on critical calls, check on and help prevent crises in patients who can benefit from monitoring (e.g., diabetics, CHFers, fall risks, etc.), and redirect those with mental health or substance abuse crises but no other medical emergencies to help beyond emergency departments. They'll be dispatched for patients whose participation in the treat-and-release program is noted on their facility chart.

Doctors Making Housecalls is another key asset. Its 23 board-certified docs make more than 40,000 home visits a year throughout North Carolina's Triangle Region, specializing in older patients.

These are important safety measures without which it would be difficult to test the treat-and-release idea.

"I think there would be no way to safely validate this protocol without all the safety stopgaps we have," says Myers. "By this group consenting all their patients, we have a very tight group we can monitor. But if the protocol is actually validated, our plan is to roll it out to the broader community. So our hope is that we have a safe way to validate it. It's very objective; the only question would be if the patient received timely follow-up. And in the world of healthcare reform, it sure seems payers might be willing to pay for a 12- or 24-hour follow-up visit to an assisted-living facility rather than a patient's visit to an emergency department."

Little has been required in the way of groundwork. Doctors Making Housecalls met with facility representatives to explain the role and capabilities of advanced-

practice paramedics, and just prior to rollout, assuming the data holds up, medics will visit each facility to explain what staff should and shouldn't call for.

"Certainly, if a patient has an obvious injury or some other complaint, we want them to go through standard EMD," says Myers. "I'm anticipating it'll go very easily, because fall calls are basically already protocol-driven at these facilities. They're already asking, 'Does the patient have chest pain or shortness of breath?' If they do, they're already calling on those complaints. I'm thinking from a safety perspective it's going to be just fine."