CPCPracticeSpotlight45

Comprehensive Primary Care is an initiative of the Center for Medicare & Medicaid Innovation

PDSA Cycles Focused on Reducing Falls Risk Help Reduce ED Use

Family Medical Group Northeast, Portland, Oregon; independent; 5 physicians, 1 NP, 9,600 patients

May 8, 2015

These strategies stem from

CPC Change Driver 1: Comprehensive Primary Care Functions

- 1.2: Planned Care for Chronic Conditions and Preventive Care
- 1.4: Patient and Caregiver Engagement

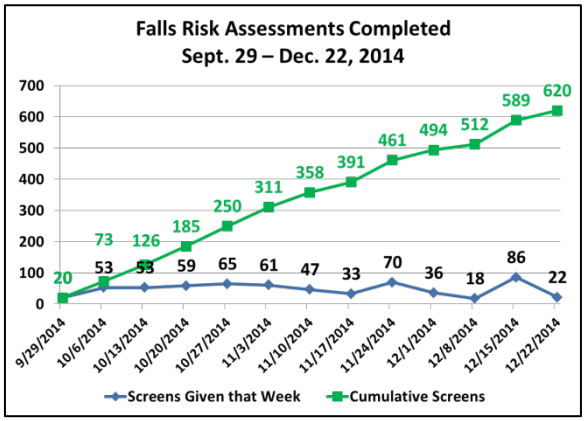
Change Driver 3: Continuous Improvement Driven by Data

- 3.1: Internal Measurement and Review

For more information about the CPC initiative, visit http://innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Initiative/.

Situation: At a spring 2014 Oregon learning session, the care management team at **Family Medical Group Northeast** (FMG) learned about falls risk assessment and saw it as an opportunity for their practice. However, the practice was in start-up mode on multiple other CPC-related activities, and falls risk was tabled for future consideration. In fall 2014, FMG was surprised to see that their internal tracking data showed nearly 31% of their patients' ED visits in Q2 were attributed to "falls, injury or laceration," which renewed their interest in pursuing falls risk assessments.

Strategy: Although FMG had deferred working on falls assessments, the care managers began the background work to launch an initiative, including developing potential workflows and processes for testing as described below.



When physicians saw the care managers had completed most of the prep work for implementing a new screening into workflows with the work spread across the team, they readily endorsed the plan and testing began. FMG's first quarter goal was to screen 80% of the practice's patients 65+, regardless of falls history (1,608 patients), and the practice would run data weekly to monitor progress.

FMG ran a series of PDSAs through fall 2014 to test multiple tactics. In September 2014, medical assistants began giving the screening to patients as they roomed them. Data showed rates lagged considerably behind expectations; one cause was lack of time. If the patient was running late or the staff needed to make up time in the schedule, other parts of the workflow such as depression screening took priority over the falls screening.

A second test was to screen patients during an October 2014 flu shot clinic, which would attract the same target group of patients and their families. The practice set up an information table during the clinic, and a staff person was available to answer questions and offer a same-day screening. Unfortunately, turnout for the clinic was unusually low. However, all eligible patients who came in for a flu shot (five) were also screened for fall risk.

Next the practice conducted a PDSA cycle with a direct mail outreach. In mid-November, FMG mailed 75 patients a packet containing a letter of explanation; the falls risk screener and a pre-addressed return envelope to facilitate the response rate. Only 10 patients put their names on the returned screeners. Because FMG provided its own envelopes in the mailing, the practice was unable to track the remaining responses. For the follow-up PDSA in early December, staff put patient names on the mailed screeners. The response rate increased to 83%, but staff and care managers noted that the follow-up for the positive screeners was more labor and resource intensive than the screeners administered at point of care. *A positive screener in the office could be immediately addressed with the patient, and additional interventions (Timed Up & Go test and education resources) could be completed at the visit. Positive screeners from the mailings required additional phone calls and office visits to complete the work. Although the rate of screeners administered was high, the rate of interventions on positive screeners was lower for the screens mailed.*

Also in November, FMG revisited how to deliver the screeners while eligible patients were seen in the office. For this PDSA cycle, the screener was delivered at check in, which resulted in 100% of eligible patients receiving the screener.

At the end of December 2014, the practice had screened 620 patients. While this was short of FMG's goal – which they admit may have been overly ambitious – several key learnings had emerged:

- Conducting the screeners at point of care allowed for more meaningful dialogue, education and interventions for at-risk patients.
- Direct mailings were resource intensive and resulted in a lower intervention rate for at-risk patients.
- At each ED follow-up call, care coordinators again remind patients about the after-hours call line.
- FMG found that trusted care coordinators can influence patients to call the practice before to heading to the ED.

Outcomes: FMG has found monitoring data over time will not only document improvements but reveal additional opportunities for the practice to apply their PDSA skills. For example, data for Q4 2014 showed falls, fractures and lacerations accounted for 21% of ED visits, with eight of the patients identified as seniors with falls in October 2014. Data for Q1 of 2015 shows a decrease in this ED visit category to 17.54%. An audit of those patients revealed a possible second target population: many of the injuries were sports-related in 47- to 65-year-old patients. Another positive data point as of March 2015 is that only one patient over 65 has been seen in the ED for a fall.

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