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Learning objectives:

- Review community-based interventions to prevent falls in the elderly
- Recognize the barriers and challenges to care coordination between PCPs, specialists, hospital and home health providers
- Examine community resources to support independent living for older adults

Case synopsis:

Ms. Davis is an 80-year-old woman who presented to her primary care physician 4 days after a fall. She was in the laundry room of her apartment building when she felt "hot," so she hurried to her apartment using her rolling walker. She left her walker in the living room due to clutter in her apartment and rushed to her bedroom when she fell to the floor without hitting her head. She did not have loss of consciousness, lightheadedness, weakness, headache, blurry vision, palpitation, chest pain, nausea, vomiting, muscle or joint pain. She had a life alert button around her neck but refused to use it because she was embarrassed about the state of her apartment. She struggled for about 7 hours before she was able to get up again.

Her past medical history is significant for diabetes on metformin, hypertension on lisinopril and osteoarthritis in her knees and hips for which she takes acetaminophen. She was admitted one month ago for leg and back pain from a prior fall.

After the death of her mother 2 years ago, Ms. Davis moved from the neighborhood where she grew up to a second floor apartment in a nearby community. She was still teary at each visit when talking about her mom. She has a son who lives about 30 minutes away in the suburb. She speaks with her son on the phone once a week but she hates to trouble him with her issues because of his busy work schedule. He does come to visit her once a month. She has 2 grandchildren and 4 great-grandchildren whom she adores. She used to work at a convenience store but retired 20 years ago. She is covered by both Medicaid and Medicare. She currently has a case manager and a home nurse who visits her once a week. The PCP signed the required paperwork for home health but neither he nor clinic staff has spoken with the nurse or case manager. Ms. Davis admits that she has difficulty keeping up with her household chores, such as cleaning, cooking, and doing laundry. A shared-ride paratransit service's van takes her to grocery store and to church. Her ultimate priority is to live in her own home, and she refuses to live in a nursing home. She fears that entering a nursing home is a death sentence since she knew many people from her old neighborhood who died shortly after moving to a nursing home. Furthermore, her mother lived until she was 100 and she did not need to stay in a nursing home. Ms. Davis hopes to live until she is 100, just like her mother.

Physical exam is significant for BMI 38, BP 140/90, P 78. There is no bruising or joint deformity, but she does endorse muscle soreness on palpation of bilateral arms. Monofilament testing revealed reduced sensation of both feet. A1C is 7.8. Previous basic metabolic profile, full blood count, B12 level are within normal limits.

1. Construct a problem list for this patient

2. Conduct root-cause analysis for one problem

3. Describe positive/protective social determinants of health for this patient
4. Describe negative SDH factors
5. Propose patient-level solution with attention to facilitators and barriers
6. Imagine possible health system or institutional solutions
7. Discuss potential community/societal-level solutions

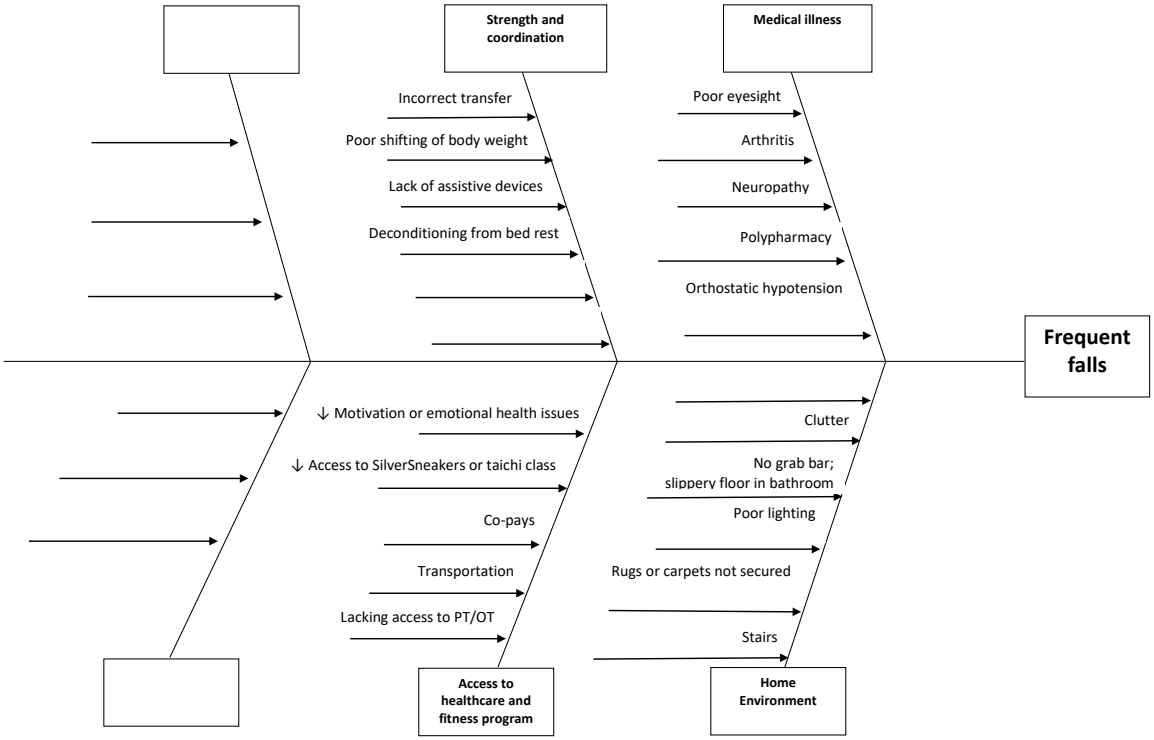
Facilitator's Guide:

1. **Construct a problem list for this patient**

A reasonable problem list might be: 1) Frequent falls 2) DM with neuropathy 3) HTN 4) obesity 5) arthritis 6) depression 7) Functional decline

2. **Conduct root-cause analysis for each problem**

Students may just focus on the first problem for this exercise. It might be helpful to use the fishbone or driver diagram for root-cause analysis. Immediate causes of frequent falls might be neuropathy, arthritis, obesity, ambulation with walker. More distal causes might be clutter, hoarding, inability to care for herself, fear of loss of independence and mistrust of long-term care institutions (which prevented her from getting help).



3. Describe positive/protective social determinants of health for this patient

She has supportive family members (although not living with them) and insurance coverage under Medicaid and Medicare. Community HealthChoices (CHC) is Pennsylvania's mandatory managed care program for individuals who are dually eligible for both Medical Assistance and Medicare, designed to improve the quality of in-home support services. Benefits to CHC members include personal care attendants to help with bathing, dressing, making meals, light housekeeping and service coordination to arrange for all the long-term services and supports. Indeed, she has home health—a nurse checking in with her once or twice a week and a service coordinator. She has door to door transportation for medical appointments and grocery shopping. She has support and comradery from attending religious services and social interaction with members of her congregation. Lastly, she has an alert button for emergency uses.

4. **Describe negative SDH factors**

She lives alone, on a fixed budget; she has mistrust/fear of skilled nursing/long-term care facilities. She is still grieving from the recent death of her mother. Because she moved recently, she is a bit far away from her usual friends and neighbors. She also has intense fear of being a burden to her family.

5. **Propose patient-level solution with attention to facilitators and barriers**

Encourage students to propose what is possible as well as innovative and/or unconventional solutions. Ms. Davis should be screened for depression and referred for therapy as needed. Physicians could order home or outpatient PT/OT and home safety evaluation. How could we help her clear the clutter in her apartment or install grab bar in her bathroom? She might also benefit from having more in-home support such as home aide (a personal care attendant who could help with cleaning and cooking) and the senior companion program. Her physician should also reach out to her son and any other relatives to encourage more frequents visits with the patient and to potentially help with cleaning her apartment. Other families have explored video monitoring (like nanny cam) for their frail elderly family members. How could primary care physicians take advantage of such technology?

Imagine potential health system or institutional solutions

Ask students to imagine being in the PCP's role or take the patient's perspective. What would make it easier to help this patient? Ask if students have ever tried to contact a home nurse? PCP or specialist in the community? What are some of the challenges in care transition (ED or inpatient to home and communication among all her providers)? This patient is receiving a lot of services but it appears that communication is poor among her care team. If the PCP/staff had communicated their concern about frequent falls with the case manager and the home health nurse (or vice versa), perhaps they could brainstorm solutions—getting home aide, physical therapy, new housing, talking to her son, mobile mental health service. She might be open to a program like Vintage (senior day care). Community Life might be a good option for her as well to keep her living independently in the community. Allow students to look up Community Life or similar programs that offer a wide range of services and care that are designed to keep seniors independent and in their homes. Should patients who receive home services have a conference call (an "e-visit" or telehealth) with all her care team members on a monthly basis? Or is there a secure online communication platform that could incorporate texting/messaging into her EMR and provide almost instantaneous real-time communication among her care providers? How is Medicare reimbursing for care coordination?

6. Discuss potential community/societal-level solutions

Encourage students to look up community services for the elderly. Most counties in the US have an Area Agency on Aging. Of note, we have a caregiver crisis with both a shortage as well as inadequate social infrastructure that will help families manage their caregiving responsibilities. Low pay, limited training and few advancement opportunities make home care a suboptimal career option. Social workers, case managers and patient care attendants are generally poorly paid. On the other hand, home aide/patient attendant services should be subsidized and easily accessible by more patients and families without regard to insurance coverage? She might be open to assisted

living facility but for some reason, assisted living facility is very expensive in this country (it is not covered by Medicare or other insurance plans). How could we develop/fund more programs like Community life? Students could also explore resources offered by the National Council on Aging, AARP, Programs of All-Inclusive Care for the Elderly (PACE) and mental wellness programs.

Key learning points:

- Good communication and care coordination between home health team and physicians are important to ensure seamless transition of care, patient satisfaction and improved health outcomes
- A multidisciplinary risk factor screening and intervention program including home hazard assessment, exercise program, patient/caregiver education, vision, podiatry and medication review have been shown to be effective to prevent falls
- There are several community resources for older adults to improve and preserve physical, social and mental wellness, independence and quality of life (of course we need more)

References

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