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ORIGINAL RESEARCH

Geriatrics

Physical therapy consultation in the emergency department for older adults with falls: A qualitative study

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Abstract

Objectives: Little is known about current practices in consulting physical therapy (PT) in the emergency department (ED) for older adults with falls, a practice that can reduce fall-related ED revisits. This qualitative study aimed to understand perspectives of ED staff about ED PT consultation for older adults with falls and fall-related complaints, specifically regarding perceived value and associated challenges and strategies.

Methods: We performed focus groups and key informant interviews with emergency physicians, advanced practice clinicians, nurses, physical therapists, occupational therapists, and technicians who perform ED geriatric screenings. We used rapid

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qualitative analysis to identify common themes related to decisions to consult PT from the ED, perceived value of PT, and common challenges and strategies in ED PT consultation.

Results: Twenty-five participants in 4 focus groups and 3 interviews represented 22 distinct institutions with ED PT consultation available for older adults with falls. About two thirds of EDs represented relied on clinician gestalt to request PT consultation (n = 15, 68%), whereas one third used formal consultation pathways (n = 7, 32%). Participants valued physical therapists' expertise, time, and facilitation of hospital throughput by developing safe discharge plans and contact with patients to improve outpatient follow-up. Common challenges included limited ED PT staffing and space for PT evaluations; strategies to promote ED PT consultation included advocating for leadership buy-in and using ED observation units to monitor patients and avoid admission until PT consultation was available.

Conclusion: ED PT consultation for older adults with falls may benefit patients, ED staff, and hospital throughput. Uncertainty remains over whether geriatric screening-triggered consultation versus emergency clinician gestalt successfully identifies patients likeliest to benefit from ED PT evaluation. Leadership buy-in, designated consultation space, and formalized consultation pathways are strategies to address current challenges in ED PT consultation.

KEYWORDS
falls, geriatrics, injury, observation, older adults, physical therapy, screening

1 | INTRODUCTION

1.1 | Background

Falls are the most common cause of injury and injury-related death among adults age 65 years and older in the United States.[1,2] In 2018, falls and fall-related complaints accounted for 3 million emergency department (ED) visits.[3] Falls cause 12% of ED visits by older adults[4] and can lead to increased morbidity/mortality and loss of function/independence.[1,5]

1.2 | Importance

Although falls are highly prevalent, they are also preventable.[6,7] The ED plays a critical role in the medical care of older adults with falls and fall-related injuries, but the integration of secondary fall prevention initiatives into EDs has had limited uptake.[8] ED clinicians often focus on diagnosing fall-related injuries and any acute life-threatening events provoking the fall. A comprehensive fall risk assessment involves a multifaceted clinical approach, including gait and balance assessment, strength and balance exercises, and medication review for fall prevention.[5–7] Physical therapists have specialized training in assessing fall risk, optimizing gait/balance safety, and initiating interventions to reduce risk of future falls. ED-based physical therapy (PT) consultation for older adults with falls has been demonstrated by prior studies to decrease hospital admissions,[9] reduce fall-related ED revisits,[10,11] and generate revenue,[12] providing an evidence base as well as a financial argument to adopt the practice. EDs are increasingly using PT for musculoskeletal conditions, peripheral vertigo, gait assessment, delirium management, and disposition planning, as well.[13–15] Prior studies have shown both patient and emergency clinician receptivity to and satisfaction with ED PT consultations.[14,16,17]

The Geriatric Emergency Department Guidelines and other national guidelines recommend assessment by physical therapists for patients at risk for falls.[18,19] However, few EDs have PT programs. Among the EDs where PT consultations are available, there is great practice variation in how and when physical therapists are consulted. Little is known about decisions to consult PT in the ED and factors that contribute to improved patient outcomes from ED PT.

1.3 | Goals of this investigation

This qualitative study aimed to understand current practices regarding ED PT consultation for older adults presenting with falls and fall-related complaints. Such understanding can inform recommendations regarding which older adults in the ED are most likely to benefit from PT consultations and can inform design of future ED-based fall programs.

2 | METHODS

2.1 | Study design

We conducted focus groups (FGs) and semistructured interviews with emergency medicine and rehabilitation health care professionals. Focus groups are commonly used to understand areas of consensus and discordance in experiences among experts.[20] Key informant interviews elicit perspectives of stakeholders with experience directly relevant to the area of inquiry.[20] The study team developed a focus group guide (see Appendix) based on predetermined areas of interest: (1) reasons for consulting PT from the ED; (2) perceived value of ED PT consultation; and (3) challenges and strategies in obtaining ED PT consultation. We performed 1 focus group with study team members to refine questions and 1 interview with a study team member to adapt the guide for one-on-one interviews. We used a phenomenological approach in this research, which prioritizes participants' lived experiences and perspectives as individuals.

We follow the Consolidated Criteria for Reporting Qualitative Research (COREQ) in presenting our methods and results.[21] This study was approved by the Institutional Review Board of Baylor College of Medicine (H-51792).

2.2 | Setting and selection of participants

Participants for this study included health care professionals involved with their ED's process to consult doctorate-trained physical therapists for older adults presenting with falls. There is no comprehensive list of EDs that use PT consultation for older adults with falls. As such, we used convenience sampling. E-mail solicitations for participation were sent directly to health care professionals at EDs known to the study team to use ED PT consultation as well as to geriatric emergency medicine and PT list-servs in the United States and Canada. The study was also advertised through Twitter posts. Participants did not receive compensation for participating. Enrollment occurred from July to August 2022.

2.3 | Data collection and analysis

Four focus groups were performed by 2 facilitators with previous interviewing experience, who were trained and supervised by an experienced focus group facilitator with qualitative methods expertise (AC). The facilitators obtained verbal and written consent before focus groups. Individuals interested in participating but unavailable during scheduled focus group discussions were invited to interview separately. We collected basic demographic information from each participant. Sessions were audio-recorded and transcribed. We timed focus groups and interviews starting from participant introductions to the final response to the last question. Transcripts were not returned to participants for comment.

We conducted a rapid thematic content analysis to identify patterns in participants' responses.[22] Three researchers reviewed all transcripts for accuracy. We reduced data into a matrix organized by participant and interview topic. All members of the coding team subsequently reviewed summaries of responses to identify common themes through group discussions. We used an inductive approach, which synthesizes qualitative data emerging from iterative review of transcripts, rather than categorizing responses based on a priori hypotheses. The coding team then compared responses from participants to determine areas of consensus and discordance for each topic/question. We performed data collection and analysis simultaneously and ended recruitment when no new themes emerged, indicating thematic saturation. We used Microsoft Excel to organize and facilitate data analysis, maintain an audit trail of coding decisions from group discussions, and select illustrative quotations for the identified themes. Participant quotes are reported by interview format (focus group vs interview) and identification number to maintain anonymity.

The Bottom Line

Physical therapy (PT) consults, once a rare emergency department (ED) resource, have grown in availability across EDs and as a care tool for back pain, vertigo, delirium, and falls. ED PT consults can reduce avoidable hospitalizations and are cost effective. This qualitative study offers key stakeholder insights to help EDs build or improve this service.

3 | RESULTS

Twenty-five individuals participated in focus groups and 3 individuals in key informant interviews. Participants included doctorate-trained physical therapists, occupational therapists, nurses, advanced practice clinicians, physicians, and/or technicians who perform geriatric screenings in the ED. Participants represented 22 distinct institutions, the majority of which were academic, urban, and not accredited by the American College of Emergency Physicians as geriatric EDs (Table 1). Focus groups lasted an average of 55 minutes each (range 49–59 minutes). Mean interview duration was 19 minutes (range 15–22 minutes).

Themes are described in detail regarding decisions to consult PT, perceived value of PT, and challenges and strategies in ED PT consultation. Descriptions refer to consultation of doctorate-trained physical therapists. Illustrative quotations are provided in Table 2.

3.1 | Decisions to consult PT

The most common reason for ED PT consultation for older adults with falls was determining appropriate disposition, as reported by participants across all focus groups and key informant interviews. Rather than consulting PT for all older adults with falls, participants reported

TABLE 1 Characteristics of interviewees and represented emergency departments.

Characteristic	N (%)
Interviewee's professional role	
Physician	7 (25%)
Nurse	4 (14%)
Advanced practice clinician	3 (11%)
Physical therapist	11 (39%)
Occupational therapist	2 (7%)
Technician	1 (3%)
Sex	
Female	22 (79%)
Male	6 (21%)
Race	
White	25 (89%)
Asian	3 (11%)
Location	
United States	21 (96%)
West	3 (14%)
Midwest	8 (38%)
South	3 (14%)
Northeast	7 (33%)
Canada	1 (4%)
Teaching institution	
Yes	19 (86%)
No	3 (14%)
Geographic setting	
Urban	18 (82%)
Suburban	2 (9%)
Rural	2 (9%)
ED geriatric accreditation status	
Accredited	5 (23%)
Non-accredited	17 (77%)
Has ED observation unit	
Yes	14 (64%)
No	8 (36%)

The first 3 rows detail identities of N = 28 interviewees who represent 22 EDs. All subsequent rows detail attributes of N = 22 EDs. Abbreviation: ED, emergency department.

prioritizing patients who had concerning mobility or functional status and would be returning to the community setting if discharged. Other consultation questions, outlined in Table 3, pertained to optimizing physical function and mobility and prevent falls after discharge. We observed concordance within and across focus group discussions about common reasons for ED PT consultation, which were also endorsed in key informant interviews.

Participants' EDs made decisions to consult PT in 1 of 2 ways: (1) clinician discretion regarding disposition assessment and (2) structured geriatrics screening. The majority of sites had no formal protocol or algorithm for consulting PT from the ED, but rather relied on a care team's clinical discretion (n = 15, 68%). In these institutions, emergency nurses and clinicians could consult PT about whether patients could be safely discharged or needed a higher level of care (eg, inpatient rehabilitation, skilled nursing facility).

Two PTs noted that at their institutions, they additionally reviewed the census of ED patients for patients who might benefit from PT consult based on their age, chief complaint of fall, and workup. About one third of institutions used geriatric screening tools to assess for fall risk, with positive screens triggering a PT consultation (n = 7, 32%). Screening tools included Identifying Seniors at Risk (ISAR)[13,23] and the Timed Up and Go Test (TUG).[24] One site had developed a formal algorithm that included tiered mobility screening, orthostatic vital signs, and a functional screen. As one participant described:

> "So for our patients who are over the age of 65, we have dedicated nurse practitioners who do screens for those patients… based on [ISAR and TUG] scores is how our nurse practitioner recommends [consultation]."
>
> -FG 2, Participant 9 (occupational therapist)

3.2 | The value of ED PT consultation

Participants identified 4 major areas of value added in emergency care through PT consultations, which emerged in all focus groups and were endorsed in key informant interviews: (1) physical therapist expertise, (2) time, (3) facilitation of ED throughput, and (4) facilitation of continuity of care.

3.2.1 | Expertise

Participants perceived that as specialists, physical therapists use objective, systematic assessments to inform discharge planning in contrast to emergency clinicians who relied on gestalt. Emergency staff also have variable ideas about what constitutes independent and safe ambulation, whereas participants felt physical therapists used standard criteria to assess gait. Clinician participants felt a physical therapist's recommendation to discharge a patient home provided reassurance and confidence about disposition safety.

3.2.2 | Time

Emergency nurses and clinicians have multiple competing demands and as such usually perform brief assessments of mobility and function, if at all. Systematically considering functional limitations from a fall-related injury or delving into home safety concerns required time that clinician participants felt they could not allocate given other clinical demands. Comprehensive PT evaluation of older adults with falls,

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TABLE 2 Illustrative quotations about common themes in ED PT consultation.

Theme	Quotation
Decisions to consult PT	
Clinician discretion	"When I need to figure out the disposition for older adults who fall often the deciding factor is how well they are in terms of their physical health, so that they won't fall again… I rely on physical therapy to try to make that decision." -Interview Participant 1 (physician)
	"We do not have a specific protocol for consulting physical therapy for older adults who fall. It's much more ad hoc. The majority of my colleagues do a modified Timed Up and Go and if you're an older adult and you can't walk across the room, and there's a concern that you're going to fall again if you are discharged–if it's during the day, PT will be asked to see the patient, but it's very ad hoc." -FG 4, Participant 6 (physician)
	"If we have someone who has a fall that either doesn't result in an injury or someone who has repeated falls, but we're probably going to be sending them home, oftentimes we're just trying to figure out if it's really safe to send them home." -FG 1, Participant 5 (advanced practice clinician)
Screening	"Every patient 75 and older is screened using the STEADI [Stopping Elderly Accidents, Deaths & Injuries] questions… If someone answers yes to any of those questions, then the [technician] will check orthostatic blood pressures and if negative they will do a functional screen." -FG 3, Participant 7 (physical therapist)
	"In our screening that we do for falls, we are also asking about activities of daily living and social support, their home setup." -FG 3, Participant 6 (technician)
Value of ED PT	
Expertise	"I think their expertise is invaluable. You know your patient's getting a safety assessment, a thorough evaluation. I think that they are trained to do functionality tests that we would not even know how to begin to complete." -FG1, Participant 4 (advanced practice clinician)
	"You have to dig in deeper to figure out everything that's going on. For instance, somebody could, you know, pass with a walker doing these activities, but they're also the primary caretaker of their significant other at home. So what do you do at that point? So those skills [to work in the ED] are really, really important." -FG 3, Participant 3 (physical therapist)
Time	"I think it's our goal is really to be able to spend the time that other providers might not be able to look at the patient as a whole." -FG 2, Participant 7 (physical therapist)
	"Sometimes just moving them can reveal something that them being stationary in the bed wouldn't tell you, or a different story. Just because we do have the luxury of … more time on them." -FG 4, Participant 4 (physical therapist)
	"I think physical therapy also can dig a little deeper with asking more about their specific home setup, what durable medical equipment they have, and I think they also can do spend a little bit more time assessing their cognitive wherewithal as well, which may lend to a decision on placement." -FG 3, Participant 5 (physical therapist)
Throughput	"The thought of being able to get a patient home that you otherwise wouldn't have felt confident about, I think is a huge value added in our system. And that's probably true for a lot of others, but our hospital primarily serves underserved and uninsured people. So I think it feels like a huge win any admission if you can avoid." -FG 1, Participant 5 (physician)
	"What goes along with the case management is like the throughput and trying to clear out beds to get the waiting room numbers down." -FG 2, Participant 8 (occupational therapist)
Continuity of care	"With PT coming down [to the ED], the patient compliance to the follow up to physical therapy–when we do follow up calls–is increased from what I can tell. When PT interacts with our patients versus just sending them home with a consultant saying, you know, somebody's gonna call you to schedule you a PT appointment. When our physical therapists have come down, the patients are actually making the follow up appointments or going to their next appointments or their video visits." -FG 3, Participant 6 (technician)

(Continues)

TABLE 2 (Continued)

Theme	Quotation
Challenges	
Resources	"Me personally embedding myself between the emergency department [and the floor]–I'm only there [in the ED] half the day, the other half seeing patients on the floor and managing all of that. Sometimes you'll get [consulted] to see somebody down there, but they're in a CT scan. So then you go up and see somebody else and just trying to figure all of that out is definitely difficult." -FG 3, Participant 3 (physical therapist)
	"The off hours, that's kind of our biggest challenge–on the weekends and off hours or when our physical therapist is not here." -FG 1, Participant 1 (nurse)
Ad hoc consultation	"Oftentimes if you have people with Parkinson's disease, they're just going to fall at home…and our provider [says], 'We can't really send them home because they'll fall.' And whereas the neurologist was like, well, we're really not going to solve that problem." -FG 1, Participant 1 (nurse)
	"I don't think over-consultation is a thing [I'm worried about]…Eventually, hopefully with time, it'll start becoming second nature and people will be able to see a patient [with a fall] and be like, 'Okay, we should consult a physical therapist so they can work out a long term plan for this patient and make sure that they're okay in the long run.'" -Interview Participant 2 (physical therapist)
	"A nurse doesn't need to wait for PT to trial and ambulation with somebody. So that's something that we're actively working on at the hospital as well for the ED." -FG 4, Participant 7 (physical therapist)
Strategies	
Leadership Buy-In	"So I think for the most part when you look at the big picture for health care systems, they want to facilitate this [ED PT consultations]. It's just a matter of how to and bringing the numbers to admin… I think is where we need more research so we can show numbers to admin and be like, this is where it's at." -FG 3, Participant 5 (physical therapist)
	"So I think what's worked for us is getting as busy as we can to prove to my supervisors that we deserve more time down there." -FG 3, Participant 3 (physical therapist)
ED Observation	"You know, we've we have the same space constraints as everybody else…We have an observation unit. Part of that workflow is that people can be in the observation pathway and see PT in the morning. So if that person needs a little more time to get things sorted out, that's been one of our solutions." -FG 4, Participant 5 (physician)
	"We definitely leverage our observation unit very heavily…Again, the whole idea is that reducing one single admission is thousands of dollars of savings." -FG 3, Participant 2 (physician)

Abbreviation: ED, emergency department; PT, physical therapy.

TABLE 3 Common emergency department physical therapy consult questions.

- Is it safe to discharge the patient home or does the patient need a higher level of care?
- Can this patient benefit from durable medical equipment? (eg, crutches, cane, walker)
- How can mobility and function be optimized at home after discharge? (ie, through gait training, exercise regimen, education, home modifications)
- Can rapid physical therapy follow-up be set up and ensured for the patient after discharge?
- What measures can be taken to prevent future falls?

in the face of staff time constraints, was highly valued. One participant described both time and expertise as follows:

> "A lot of things that we're doing is relieving some of the headaches [clinicians] have in decision-making to send patients home. Doing their quote unquote, road tests that they were doing before–getting these patients up and moving, which they don't really want to do, takes up time, and they're not really skilled at doing it."
>
> -FG 3, Participant 3 (physical therapist)

3.2.3 | Throughput

Participants universally appreciated that ED PT consultation facilitates ED throughput by preventing unnecessary hospital admissions. Many participants described crowding, boarding, and hallway care exacerbated by the COVID-19 pandemic. The ability to safely discharge any

patient was felt to benefit hospitals as a whole. Overall, participants felt that the benefit of saving an inpatient bed outweighed increased ED length of stay from waiting for PT consultation. As one participant related:

> "[Physical therapists] prevent unnecessary admissions at a dramatic level in terms of finding alternative dispositions."
>
> -FG 3, Speaker 2 (physician)

3.2.4 | Continuity of care

Participants felt meeting with a physical therapist in the ED allowed patients to understand the potential benefits of an exercise program, gait training, and other resources, which improved patient satisfaction. Furthermore, participants reported that ED PT consultation often led to patients being discharged with a scheduled follow-up appointment, which encouraged referral completion. One participant described:

> "I think one of the things that we have noticed in having physical therapist in these areas is that for patients who definitely need follow up–like outpatient therapy–we're able to get that initiated in the ED."
>
> -FG2, Participant 9 (nurse)

3.3 | Challenges and strategies

3.3.1 | Resource constraints

PT availability

Many participants reported physical therapists' availability was limited in their institutions. For example, participants could consult PT during weekday business hours but had limited or no evening, night, or weekend hours. Additionally, although some institutions had a physical therapist or PT team dedicated specifically to the ED or to patients with trauma, in others physical therapists covered consultations in the ED in addition to inpatient or outpatient duties.

3.3.2 | Strategy

Leadership buy-in

Consult volume could vary weekly or monthly, which complicated requests to hospital and ED administrators to fund extended hours or ED-specific positions for physical therapists. Overall, participants noted that tracking and relaying data about ED throughput, admissions avoided, and decreases in ED revisits to hospital leadership was crucial for advocating for increased hours or an ED-specific commitment for physical therapists. For example, 1 participant described an experience of their institution's ED PT program being canceled due to hospital leadership seeking to reduce costs and lacking information about the program's effect on hospital admissions and ED throughput. After sharing this information with the hospital manager, the participant related:

> "[The] program was restarted like the next day. They were seeking to get people in there full time."
>
> -FG 4, Participant 4 (physical therapist)

3.3.3 | Resource constraints

Space

Due to ED crowding and boarding, hallway care was common; clinicians and nurses felt it was harder to mobilize patients under these conditions and that teaching them to use durable medical equipment in the hallway was suboptimal. Participants also noted that patients were less likely to mobilize while in the ED due to the nursing shortage, as nurses play a large role in encouraging ambulation, time out of bed, and toileting. Nurses and clinicians worried that immobility during the ED stay made it harder for patients to participate in their PT evaluations. Notably, physical therapist participants reported willingness to adapt under these conditions.

3.3.4 | Strategy

Temporary rooming and ED observation

Some EDs designated a temporary consultation room. Others placed patients awaiting PT consult into ED observation units, which have layouts similar to inpatient units.

> "So space is a huge issue. We have the vertical treatment zone which is six recliners, and it has a little procedure area. So for example, a patient with vertigo who's in an armchair can be walked over to the procedure area which has a stretcher and people can be examined there."
>
> -FG 4, Participant 6 (physician)

Ad hoc approaches to consultation

In institutions that used clinician discretion to identify patients for PT consultation, participants expressed concerns that PT might be over- or underconsulted. Both clinicians and physical therapists offered that ED care teams sometimes consulted PT without first performing any type of mobility or functional assessment or for patients who already had outpatient PT services. One participant described:

> "You know, many times we wish the patient would have gotten up with the nurse and walked before they called

us. Because very clearly the patient is able to walk and why can't we just get them home with some home services versus you know, calling down the PT? So yeah, I would love some guidelines."

-FG 4, Participant 3 (physical therapist)

In contrast, some physical therapist participants felt that they were not always consulted for ED patients who might benefit from their services.

3.3.5 | Strategy

Consultation pathways

Some EDs had created formalized fall-related PT consultation pathways based on algorithms or screening tests such as ISAR or the TUG to ensure consistency and a systematic consultation process. Participants also endorsed multidisciplinary team-based approaches to consulting PT that involved case management as needed.

3.4 | Limitations

Participants in our study were primarily from teaching institutions in urban areas with limited representation from other practice settings. Focus groups were mixed in composition and different themes may have emerged had discussions been separated by professional groups. We did not include the patient perspective but hope to in future studies of development of ED PT programs.

4 | DISCUSSION

This qualitative study offers unique data about current ED PT consultation practices. These practices vary considerably, with some EDs using structured pathways and others relying on clinical gestalt. Participants experienced resource constraints but felt ED PT consultation benefitted patients, ED staff, and hospital systems. Structured PT assessment pathways may be a way to improve ED care and hospital throughput.

Although our sample of health care professionals valued ED PT consultation, they identified as a challenge limited PT availability for the ED—both in general and during non-business hours. Investment in PT availability for ED consultations is prudent for multiple reasons. First, there is an evidentiary basis for ED PT consultation for falls given its potential to reduce subsequent fall-related ED revisits.[11] Second, consulting PT in the ED for older adults with falls offers advantages over admitting a patient for a PT evaluation in the absence of acute clinical problems. Hospitalization is associated with multiple adverse events in older adults such as delirium,[25] polypharmacy,[26] and functional and cognitive decline.[27] It is also one of the most expensive types of health care use, with the average cost per hospital stay exceeding $10,000.[28] A prior observational study at an academic medical center found that fall-related ED PT consultation, in conjunction with case management, facilitated discharge or rehabilitation placement in 75% of cases—in lieu of the default practice of admission.[9] Third, consulting PT in the ED also offers advantages over discharging a falls patient with a PT referral or instructions to coordinate outpatient PT through their primary care office, as patients may lack primary care or be lost to follow-up.[29]

Sharing evidence with hospital leadership about the potential for ED PT consultation to prevent unnecessary admissions[9] and ED revisits[10,11] may promote investment in ED PT. Our participants recommended gathering local data about cost-effectiveness to share with hospital leadership. Such data include consult volume, admissions prevented, and the proportion of evaluations that result in intervention, thus generating revenue. In the United States, physical therapists can bill for ED patient evaluations using outpatient evaluation codes. One single-center study found that the full salary and benefits of a physical therapist seeing ED patients were reimbursed with an average of 5.7 outpatient consultations in per day. Their site averaged 12 PT consultations per day and 61% were billable, which offset the cost of a dedicated ED PT team.[12] It is worth noting that PT consultation is beneficial for several other acute conditions including peripheral vertigo, musculoskeletal injury, and delirium management.[13–15] Developing ED PT consultation programs that address falls as well as these complaints could improve revenue generation and make investment in ED PT more feasible.

Time and space constraints in the ED were also described. In 1 feasibility study for a randomized controlled trial of an ED PT-based fall evaluation, ED PT consultation did not increase patient length of stay, though this was within a research context with a protocolized approach to consultation.[30] Participants suggested ED observation units to address extended ED length of stay and monitoring when PT was not available until morning business hours. Negative impacts of crowding and boarding could be mitigated by using observation instead of admission. Observation units may also represent an ideal setting for community EDs and EDs without geriatric accreditation to implement a robust PT consultation pathway, as availability of resources and time to fund such initiatives varies significantly across ED practice settings.

Participants valued physical therapists' expertise, increased time at the patient's bedside, improved throughput, and improved continuity and transitions of care. These elements align with hospital goals for the ED—improving throughput and decreasing admissions—and with patient goals—increased time at the bedside, improved transitions of care, and decreased admissions. Studies in both ED and inpatient settings have demonstrated that the opportunity to work with physical therapists improves patient and caregiver satisfaction.[31–33] Our findings also echo prior studies showing that emergency clinicians are highly receptive to ED PT consultations.[14,16,17] For example, a survey of emergency physicians at a single trauma center found that clinicians highly valued physical therapists' assistance with disposition planning and optimizing patient safety.[17] Similarly, a qualitative study reported that emergency physicians valued the ability of physical therapists to provide services outside the scope of physician training and improve department flow.[29]

A final implication from our study was that ED programs struggle with identifying which older patients need or would benefit from a PT evaluation. Our participants' varied approaches to PT consultation and desires to streamline pathways for ED PT consultation reflect that not all older adults with falls necessarily benefit from PT. Prior studies have found that patients with dementia or multiple comorbidities are less likely to benefit from PT interventions for falls.[34,35] It is unclear if standardized evaluations, compared to emergency clinician gestalt, improve identification of older patients who would benefit from ED PT consultation. A systematic review and meta-analysis found that the ISAR, a tool used by some study participants to screen patients for PT consultation, was not associated with adverse outcomes in older adults.[36] Similarly, a systematic review found that mobility assessments commonly used in ED settings for older adults—including the TUG, used by some of our study participants—do not reliably predict adverse outcomes such as ED return visits or future falls.[37] However, using a risk stratification tool may represent a practical strategy to limit consultations to a manageable volume depending on site-specific resources.

In conclusion, our focus group study found that ED PT consultations occurred through either clinician discretion regarding disposition assessment or geriatric screening. Participants found value in ED-based PT consultation related to (1) physical therapist expertise, (2) time, (3) facilitation of ED throughput, and (4) facilitation of continuity of care. Resource constraints and ad hoc approaches to consultation were identified as the major challenges in ED PT consultation. A multidisciplinary team approach is needed for PT assessment in the ED for older adults presenting with falls in order to optimize a fall prevention strategy and implement effective management. Future research is needed on best evidence-based practice for standardizing ED PT consultation and assessment for older adults with falls.

AUTHOR CONTRIBUTIONS

Conceptualization: all authors; Data collection: Anita Chary, Elise Brickhouse, Beatrice Torres, Lauren T. Southerland, Shan Liu; Data analysis: Anita Chary, Elise Brickhouse, Beatrice Torres, Lauren T. Southerland, Shan Liu; Critical review and evaluation of results: all authors; Primary authorship: Anita Chary; Review and editing of the paper: all authors; Study supervision: Lauren T. Southerland, Shan Liu; Procurement of grant or other funding: Anita Chary, Lauren T. Southerland, Shan Liu, Maura Kennedy, Rachel Skains, Lauren Cameron-Comasco, Catherine C. Quatman-Yates, Sangil Lee.

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CONFLICT OF INTEREST STATEMENT

The authors declare no conflicts of interest.

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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