Home Health Quality Improvement
National Campaign

Best Practice Intervention Package - Emergency Care Planning

HHQI
Home Health Quality Improvement

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Acknowledgements

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<table>
<thead>
<tr>
<th>Name</th>
<th>Organization</th>
</tr>
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<tbody>
<tr>
<td>Judy Lentz, RN, MSN, NHA</td>
<td>Executive Director Hospice and Palliative Nurses Association</td>
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<tr>
<td>Carol Siebert, MS, OTR/L, FAOTA</td>
<td>Representative American Occupational Therapy Association</td>
</tr>
<tr>
<td>Linda Krulish, PT, MHS, COS-C</td>
<td>Home Health Section Representative American Physical Therapy Association</td>
</tr>
<tr>
<td>Rebecca Skrine, CCC-SLP, CHCE, COS-C</td>
<td>Home Health Representative American Speech-Language-Hearing Association</td>
</tr>
<tr>
<td>Terri Lindsey, RNC, BSN</td>
<td>Project Manager Virginia Health Quality Center Virginia Quality Improvement Organization</td>
</tr>
<tr>
<td>Karin Schumacher, PT, MPH</td>
<td>Home Health Project Manager</td>
</tr>
<tr>
<td>Judy Fye, RN</td>
<td>Home Health Project Manager</td>
</tr>
<tr>
<td></td>
<td>Colorado Foundation for Medical Care</td>
</tr>
<tr>
<td>Karen Vance, OTR/L</td>
<td>Representative American Occupational Therapy Association</td>
</tr>
<tr>
<td>Jean Ellis, RN</td>
<td>Vice President Member Services &amp; Business Administration Visiting Nurses Association of America</td>
</tr>
<tr>
<td>Dr. Stephen Winbery, Ph.D, M.D.</td>
<td>Associate Medical Director, Q-Source Tennessee Quality Improvement Organization</td>
</tr>
<tr>
<td>Ben Peirce, RN, CWOCN</td>
<td>National Director, Clinical Practice Gentiva Health Services</td>
</tr>
<tr>
<td>Mary Ruth Price, RN</td>
<td>Administrator. All Care Home Care, Inc.</td>
</tr>
<tr>
<td>Bobbie Warner, RN, BSN</td>
<td>Performance Improvement Manager Home Health Care Management</td>
</tr>
<tr>
<td>Vickie Cunningham, BSN, RN, BC</td>
<td>Clinical Director Lehigh Valley Home Care</td>
</tr>
<tr>
<td>Tasha Mears, RN, BSN</td>
<td>Operation Analyst LHC Group</td>
</tr>
<tr>
<td>Kathleen Verdes, RN, BSN</td>
<td>Nursing Supervisor Fidelity Health Care</td>
</tr>
<tr>
<td>Maureen Matras, RN, BSN</td>
<td>Quality Improvement Director Fayette Home Care, Inc.</td>
</tr>
<tr>
<td>Julie Pazun, RN</td>
<td>Performance Improvement Team Leader Great Lakes Home Healthcare and Hospice</td>
</tr>
</tbody>
</table>
We also appreciate the time and expertise from the following home health agencies that facilitated a review of the “My Emergency Plan” with clinicians and patients:

All Care Home Care
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Dubois Regional Medical Center
Fayette Homecare, Inc.
Great Lakes Home Healthcare
Moses-Taylor Home Health
Personal-Touch Home Care of PA, Inc.

Editor
Misty Kevech, RN, MS, COS–C, Communications/Training Manager

Contributing Home Health QIOSC Staff
Marian Essey, RN, BSN, Director, Health Care Quality Improvement, HHQIOSC
Donna Anderson, RN, PhD, Subject Matter Expert
Christine Bernes, RN, Project Coordinator
Eve Esslinger, RN, MS, Project Manager
Bonnie Kerns, RN, BSN, Community of Practice Manager
Lee Krumenacker, RN, BS, Subject Matter Expert
David Wenner, DO, Medical Director

Communications Staff
Shanen Wright, Communication Manager
Laura Dugan, Communication Specialist
Russell Hartman, Communication Specialist
Bethany Knowles, Communication Specialist

Communication QIOSC Staff
Mary Guiden, Sr. Communications Specialist
Kam Valentine, Sr. Communications Specialist
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The Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services, in conjunction with the Home Health Quality Improvement Organization Support Center (HHQIOSC), has launched the Home Health Quality Improvement (HHQI) National Campaign.

The HHQI National Campaign seeks to unite the home care community under the shared vision of reducing avoidable hospitalizations to improve patient quality of care. Being hospitalized can unnecessarily create financial and emotional burdens for patients and their families, and can negatively impact the health care delivery system. Currently, more than one in four home health patient episodes will result in a hospitalization (according to the Home Health Compare national outcome rate of 28% - December 2006).

This campaign targets avoidable hospitalizations. Its goal is to reduce the acute care hospitalization (ACH) rate nationally. Home health agencies’ support for achieving this goal will be provided through the monthly distribution of tools, resources, practice guidelines, clinical information and best practice education, such as this Best Practice Intervention Package. This is an interdisciplinary campaign. All disciplines need to work collaboratively toward the goal of reducing avoidable hospitalizations.

The monthly intervention packages have been designed for ease of use by leadership and individual disciplines as they strive to reduce avoidable ACH. A monthly intervention package will be released the beginning of each month. Participants will work through the package within the four weeks, selecting the sections they want to utilize at their agency.

The packages were designed for use with the Medicare population (age 65 or older), but can be adapted by an individual agency to meet their specific patient needs. The best practice intervention packages can be used to supplement an agency’s quality improvement efforts or can be used to orient all agency new hires. The various approaches to the use of the information in these packages will promote ongoing quality improvement and assure that all staff are informed of current best practice interventions for reducing avoidable hospitalizations.
Introduction to the Best Practice Intervention Package

There will be a new “best practice” theme for each month of the 12-month campaign from March 2007 through February 2008.

The theme for this month is **Emergency Care Planning**.

This best practice intervention package was designed to educate and create an awareness of current strategies or “best practices interventions” to reduce avoidable hospitalizations and emergent care visits.

Home health agencies can be flexible in their use of these packages. **Agencies may choose to use all, some or none of the components of the monthly packages.** There is no requirement to utilize the entire package. Most agencies will utilize part of the packages.

The Best Practice Intervention Packages have **something for all home health agencies:**

- Agencies experienced with the best practice of the month or
- Agencies that have no experience with this best practice

**Package Contents**

Each package contains the following sections for agency personnel:

- Leadership (administration, managers, quality improvement leads)
- Care Providers (direct care provider staff)

**A Fast Track** is available on the Web site that includes a one page educational sheet with the principal tool for the month. This is ideal for agencies that do not have sufficient time during this month to utilize portions of the Best Practice Intervention Package.
How to Use the Best Practice Intervention Packages

1. **Begin each month with a review of the leadership section.** Minimally, this should include your agency lead for the campaign. May include review on leadership track as standing agenda items in leadership monthly or quality improvement meetings.

2. Since there will be 12 different intervention packages (one for each month of the campaign, March 2007-February 2008), you may want to **develop a small team to review all the sections of the package monthly** and determine what portions will be implemented.

   Team membership may include any of the following:
   a. Organizational Leadership (administration or management team member)
   b. QI lead or QI team member
   c. A representative from each of the Care Providers (nursing, therapy, home health aide, and medical social work)
   d. Staff who have a good understanding of implementing or modifying processes and interventions

3. **Schedule time each month to review and then discuss the Best Practice Intervention Package.** As the package will be available on the first business day of each month, this review and planning period should occur **within the first week of each month**.

4. **Optional:** Complete the voluntary Best Practice Intervention Package Survey to provide feedback and have the opportunity to be randomly selected as the HHQI Agency of the Month.

5. Plan on breaking down this package and **distributing portions of the package (“tracks”) to staff members within your agency monthly.** Example: Listen to audio in team meeting and provide additional track information as self-study.

6. **Encourage your staff to actively participate** by visiting the campaign Web site at [www.homehealthquality.org](http://www.homehealthquality.org) and becoming a **campaign supporter.**

7. **Share your monthly data reports with all staff.** Promote quality improvement and sharing data trending at staff meetings or post on HHQI bulletin board.

8. **Develop your vision for the “optimal home care experience” for all of your patients.** Move one step further toward achieving this vision with each passing month of the campaign.

   Good luck in transforming the quality of care in your agency!
Leadership

The Leadership section is for agency administration, managers, and those leading the campaign. Home health agencies vary in their knowledge and use of the best practice strategies, therefore each Best Practice Intervention Package will offer information to leadership in two formats: information that is geared toward the novice and information appropriate for the expert.

Leadership information will be made available through two distinctly different leadership tracks:

- The “Leadership Path” for the leader that has limited or no experience with this best practice of the month.

- The “Leadership Highway” for those leaders that have implemented this best practice and have a comfortable level of knowledge.

Throughout this campaign, it is expected that an agency leader will need to “alter the route” each month depending upon the agency’s level of knowledge and experience with the monthly best practice theme. While a leader may take the Leadership Path one month, the Leadership Highway may be more appropriate for the next month.

Leadership Track #1 – “Leadership Path”

Home health agency leaders that have no previous experience with the best practice intervention of the month should select this track. The “Leadership Path” will offer simple, easy to understand leadership strategies needed to succeed with this best practice. These agencies will be directed to use the content as an introduction to the best practice intervention(s) in the package.

Leadership Track #2 – “Leadership Highway”

Home health agency leaders that have experience with the best practice intervention of the month should select this track. The “Leadership Highway” will offer content to assess the current effectiveness of the intervention(s) and improve their agency’s performance by modifying its approach to the best practice.
The Care Providers section is for agency staff that care directly for patients. It is recommended that each of these tracks be distributed to the appropriate agency staff monthly. Further suggestions for use of the Best Practice Intervention Packages are available in the Leadership sections of each package.

There are four Care Provider Tracks:

- **Nursing Track**
- **Therapy Track**
- **Medical Social Worker Track**
- **Home Health Aide Track**
Best Practice: Emergency Care Planning

Leadership Section
Objectives
After completing the activities included in the Leadership Section of this Best Practice Intervention Package – Emergency Care Planning, the leader will be able to:

1. Define emergency care planning and how it can be implemented and/or used more effectively by a home health agency.
2. Define a patient emergency plan and how to implement one in a home health agency.
3. Evaluate the agency’s current emergency care planning system.
4. Describe two leadership applications for emergency care planning.

Section Contents and Instructions for Use

| Leadership Self-Assessment | Use this assessment to analyze current emergency care planning and explore opportunities to:  
|                           | o improve emergency care planning  
|                           | o evaluate need for emergency care planning tool(s) or  
|                           | o evaluate effectiveness of current emergency care planning tool(s) |
| Leadership Action Items   | Review the list of potential action items; select those applicable for improving and sustaining patient emergency planning standards and practices. |
| Leadership Action Plan    | Using the administration action items, develop your administrative action plan by selecting and prioritizing two to four of the action items to implement or modify related to emergency care planning. Document your action plan. |
| Implementation Tools      | Review the connection pages, posters and success story to identify additional interventions to reduce avoidable ACH. |
| Care Provider Tracks      | Review and determine what portions of this Best Practice Intervention Package – Emergency Care Planning you may want to use at your agency and how you choose to utilize them.  
|                           | Free CNEs for Registered Nurses  
|                           | Utilize the discipline sections for agency continuing education and/or for competencies. The home health aide section can be used for required monthly educational sessions. |
Emergency Care Planning: Role of Leadership

There are many different interventions that home care agencies may use as they strive to achieve the national goal for reducing avoidable acute care hospitalizations. Some of the interventions may stand alone, but the majority of them are more effective if integrated with other interventions. Emergency care planning is one of the interventions that complement the use of a hospitalization risk assessment. A hospitalization risk assessment provides the foundation for recognizing which patients are at risk and identifying specific risk factors. Awareness of the patient’s risk factors will assist a clinician in developing a more specific patient emergency plan.

In this package we will be talking about two similar, but different terms – emergency care planning and patient emergency plan.

**Emergency Care Planning**
Definition: The established agency process that includes all activities, tools and policies/procedures used to assist clinicians with educating patients on what actions to take if a medical problem or change in condition occurs. Emergency care planning assists the patient/caregiver in determining who, what, where, when, why and how to respond to changes in health status. Agencies can then utilize patient-centered interventions to try to keep the patient at home or recommend the most appropriate care setting for the patient.

**Patient Emergency Plan**
Definition: A home health patient’s emergency plan is a written plan that helps a patient to identify emergent health problems and to determine whom to call to obtain care for the problem, either home care agency or EMS. The patient emergency plan is a significant part of emergency care planning.

Simply, emergency care planning is the overall process and the patient emergency plan is a specific patient tool.

The patient emergency plan is the foundation of the emergency care planning process. To be successful, the agency must use a quality tool and be consistent with its use. The patient emergency plan must be written in the language and at a level the patient can understand. The instructions must be written with large, clear font and contain pertinent agency information with relevant guidelines that enable patients to determine how to respond to a change in health status. Leadership must establish or modify current policies and procedures to support emergency care planning. Leadership buy-in is significant to successfully implement this intervention.
Creating the quality tool is the easy part. There are samples to work from, including the sample “My Emergency Plan” that is included in this package. It is recommended that agencies utilize an interdisciplinary team and medical director in creating OR modifying the tool for patient emergency planning. The challenging component of the patient emergency plan is the implementation phase. The challenge lies beyond developing staff education and policies and procedures to support the emergency care planning process. The most difficult part of successfully implementing this intervention is obtaining clinician and patient buy-in. Your agency may have all the tools, policies and procedures in place, but if they are not being consistently implemented at the clinician/patient level, success will not be achieved.

Each time one patient calls the agency instead of going to the emergency department, the agency has an opportunity to possibly prevent an avoidable acute care hospitalization.

It is important that leadership demonstrates that emergency care planning is recognized as an essential patient-centered intervention for the agency. Random audits or routine calls to patients/caregivers are essential in determining if your processes are working. A structured evaluation will assist you in determining if the tools are being implemented, if patients know where the tools are located and understand how to use them. This phone call can also be used to reinforce the importance of the patient emergency plan to the patient/caregiver and offers an opportunity to reinforce education. Identification of specific staff who are consistently implementing the emergency care planning process versus staff who are not may also be revealed with the calls.

Recognizing and/or rewarding the individual staff or teams that do a good job with emergency care planning is the next step. By recognizing and rewarding those using the intervention, leadership is stating they value staff who are working hard at keeping their patients at home, where patients want to be.

- **Individual Recognition** and rewards can be as simple as a certificate presented at a staff meeting, names/pictures on a bulletin board, candy bars, a gas card or any other type of recognition.
- **Team Recognition** not only rewards the identified team, but can serve as an incentive for other teams. Sample ideas for team recognition can include highlighting the team of the month on a bulletin board with pictures (consider a picture of team members with patients who avoided a hospitalization), an article in the agency newsletter, snack for their team meeting or other ideas.

**What gets recognized gets repeated.**
Suggestions for Leadership Involvement

Home Health Administrators can:

- Actively support implementation of a quality patient-centered emergency plan tool.
- Establish a quality improvement review of emergency care planning processes to improve the effectiveness of the intervention in reducing avoidable ACH. Calling the patient/caregiver within the first week of care can an effective strategy to verify that patient/caregiver has and is learning how to use the patient emergency plan. The call also provides opportunity to reinforce emergency care planning.
- Leadership support of this best practice measure is essential for success.

Clinical Managers can:

- Determine staff documentation processes for patient emergency planning activities and outcomes, including patient/caregiver response.
- Recognition and reward staff for consistently implementing emergency care planning. Leadership support of this best practice is essential for success.
- Review internal processes with clinicians to ensure that patients/caregivers have necessary equipment and supplies to perform self-assessment activities (e.g. thermometers, blood glucose machines and supplies).

Quality Improvement Leads can:

- Monitor implementation with the patient emergency plan tool to support its effectiveness in reducing avoidable hospitalizations.
- Add random or systematic monitoring calls to your current quality improvement plan or plan of action to monitor implementation.
  - Utilize an office staff person (does not need to be a clinical person) or a QI person to call patients with a scripted screening tool to verify patients know where their patient emergency plan is located, how to use it and understand how to call the agency.
  - Reinforce emergency care planning education and evaluate patient’s understanding of the emergency plan.
**Emergency Care Planning**  
Leadership Self Assessment

Does your agency do **formal** emergency care planning?  
Choose one track below based upon your answer to this question:

| If NO  
<table>
<thead>
<tr>
<th>(Leadership Path)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you have <strong>any</strong> process in place to inform the patient/caregiver about calling the agency, including: Who, what, when, where and how? (e.g. verify that the patient has a phone, can access the phone and can successfully place a call to the agency or 911)</td>
</tr>
<tr>
<td>Is instruction provided to patient/caregiver about when it is appropriate to call the agency and when to seek emergent care?</td>
</tr>
<tr>
<td>Do you have a structured on-call program in place for after hours, weekend and holiday calls?</td>
</tr>
<tr>
<td>Does your agency provide regular education to the on-call staff related to interventions to help reduce ACH?</td>
</tr>
<tr>
<td>Does staff instruct on emergency care planning more than just on the SOC/ROC visit? (Is this documented?)</td>
</tr>
<tr>
<td>Are all disciplines responsible for the education of emergency care planning with the patient/caregiver?</td>
</tr>
<tr>
<td>Do patients have the necessary supplies/equipment (e.g. thermometer, blood glucose machine supplies) to self assess and report abnormal findings as instructed?</td>
</tr>
<tr>
<td>Have you compared your patient hospitalization list with your regular business hours and after hours documentation to determine if the patient called the agency before going to the hospital?</td>
</tr>
</tbody>
</table>

**Leadership engagement and active support is essential for successful implementation and ongoing application of this patient-centered clinical best practice intervention – Emergency Care Planning**
Does your agency do formal emergency care planning?

Choose one track below based upon your answer to this question:

<table>
<thead>
<tr>
<th>If YES (Leadership Highway)</th>
<th>Y</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does your emergency care planning process include who, what, when, where and how for patient/caregiver education? (e.g. verify that the patient has a phone, can access the phone and can successfully place a call to the agency to 911)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is instruction provided to patient/caregiver about when it is appropriate to call the agency and when to seek emergent care?</td>
<td></td>
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<td>Do you have a structured on-call program in place for after hours, weekend and holiday calls?</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Does staff instruct on emergency care planning more than just on the SOC/ROC visit? (Is this documented per agency standard?)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are all disciplines responsible for the education of emergency care planning with the patient/caregiver?</td>
<td></td>
<td></td>
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<tr>
<td>Do all patients have the necessary supplies/equipment (e.g. thermometer, blood glucose machine supplies) to self assess and report abnormal findings as instructed?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you compared your patient hospitalization list with your regular business hours and after hours documentation to determine if the patient called the agency before going to the hospital?</td>
<td></td>
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</tr>
<tr>
<td>Have you reviewed data to see if the patients are admitted to the hospital certain days of the week or on the weekends?</td>
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<tr>
<td>Do you perform random calls to patients to assess staff implementation and patient understanding of emergency care planning?</td>
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<tr>
<td>Have you followed up with a call to patients that experienced emergent care events or hospitalization to assess understanding of emergency care planning?</td>
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</table>

Leadership engagement and active support is essential for successful implementation and ongoing application of this patient-centered clinical best practice intervention – Emergency Care Planning
My Emergency Plan
Modification/Instruction Suggestions

My Emergency Plan was designed using a symptom model, as opposed to a medical model, to accommodate the patient perspective. The intent is to have a tool that is patient-centered and in patient-identifiable terms.

The sample My Emergency Plan included in the Best Practice Intervention Package is a four single-page document. This example was designed to be all-inclusive, but agencies may prefer to be selective and condense as desired. The tool is provided in Microsoft Word for ease of modification.

The tool was patient and clinician tested with numerous home health agencies. Overall, clinicians and patients found it very easy to use. The primary concern with the tool was the length. Content was developed from multiple resources including the National Guidelines Clearinghouse (see pages 22-24).

Leadership decisions:
1. Modify content to meet agency’s patient population needs
2. Revise or delete icons per agency preference
3. Determine printing options

Suggestions for modification:
- Increase font size (currently at 13 point)
- Change words or phrases to address agency’s patient population (currently at 6th grade level)
- Revise or delete icons
- Bold or highlight specific words for emphasis
- Re-prioritize the order of the symptoms
- Reduce the length to a 1 or 2 page tool by removing the least common symptoms demonstrated by agency patient population
- Remove, add or modify symptoms
- Remove, add or modify bullets from any of the boxes

Additional suggestions to optimize effectiveness:
- Print front and back
- Print in color, black and white or on colored paper
- Place sheets in plastic protectors
- Use agency magnets to secure to refrigerator
- Instruct clinicians to highlight or star specific symptoms to individualize patient education
- Instruct the patient on how to use the tool at each visit, or at a frequency specified in the agency’s guidelines
MY EMERGENCY PLAN

<table>
<thead>
<tr>
<th>WHAT TO DO?</th>
<th>CALL MY HOME HEALTH AGENCY WHEN:</th>
<th>CALL 911 WHEN:</th>
</tr>
</thead>
<tbody>
<tr>
<td>I hurt</td>
<td>• New pain OR pain is <strong>worse</strong> than usual&lt;br&gt;• Unusual bad headache&lt;br&gt;• Ears are ringing&lt;br&gt;• My blood pressure is above: <strong><strong>/</strong></strong>&lt;br&gt;• Unusual low back pain&lt;br&gt;• Chest pain or tightness of chest RELIEVED by rest or medication</td>
<td>• Severe or prolonged pain&lt;br&gt;• Pain/discomfort in neck, jaw, back, one or both arms, or stomach&lt;br&gt;• Chest discomfort with sweating/nausea&lt;br&gt;• Sudden severe unusual headache&lt;br&gt;• Sudden chest pain or pressure &amp; medications don’t help (e.g. Nitroglycerin as ordered by physician), OR&lt;br&gt;• Chest pain went away &amp; came back</td>
</tr>
<tr>
<td></td>
<td><strong>Severe or prolonged pain</strong></td>
<td><strong>Call 911 when:</strong></td>
</tr>
<tr>
<td></td>
<td><strong>I have trouble breathing</strong></td>
<td><strong>Severe or prolonged pain</strong></td>
</tr>
<tr>
<td></td>
<td>• Cough is worse&lt;br&gt;• Harder to breathe when I lie flat&lt;br&gt;• Chest tightness RELIEVED by rest or medication&lt;br&gt;• My inhalers don’t work&lt;br&gt;• Changed color, thickness, odor of sputum (spit)</td>
<td>• I can’t breathe!&lt;br&gt;• My skin is gray OR fingers/lips are blue&lt;br&gt;• Fainting&lt;br&gt;• Frothy sputum (spit)</td>
</tr>
<tr>
<td></td>
<td><strong>Severe or prolonged pain</strong></td>
<td><strong>Call 911 when:</strong></td>
</tr>
<tr>
<td></td>
<td><strong>I have fever or chills</strong></td>
<td><strong>Severe or prolonged pain</strong></td>
</tr>
<tr>
<td></td>
<td>• Fever is above _______ F&lt;br&gt;• Chills/can’t get warm</td>
<td>• Fever is above _______ F with chills, confusion or difficulty concentrating</td>
</tr>
<tr>
<td></td>
<td><strong>Severe or prolonged pain</strong></td>
<td><strong>Call 911 when:</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Trouble moving or fell</strong></td>
<td><strong>Fell and have severe pain</strong></td>
</tr>
<tr>
<td></td>
<td>• Dizziness or trouble with balance&lt;br&gt;• Fell and hurt myself&lt;br&gt;• Fell but didn’t hurt myself</td>
<td><strong>Fell and have severe pain</strong></td>
</tr>
</tbody>
</table>

This plan is a guide only and may not apply to all patients and/or situations. This plan is not intended to override patient/family decisions in seeking care.

Developed by Quality Insights of Pennsylvania in conjunction with Carol Siebert, MS, OTR/L, FAOTA, American Occupational Therapy Association and Karen Vance, OTR/L, BKD Healthcare Group and American Occupational Therapy Association. Based on MyEmergency Plan created by Delmarva in conjunction with OASIS Answers, Inc.
Patient Name _______________________

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<table>
<thead>
<tr>
<th>WHAT TO DO?</th>
<th>CALL MY HOME HEALTH AGENCY WHEN:</th>
<th>CALL 911 WHEN:</th>
</tr>
</thead>
<tbody>
<tr>
<td>😞 I see blood</td>
<td>• Bloody, cloudy, or change in urine color or foul odor</td>
<td>• Bleeding that won’t stop</td>
</tr>
<tr>
<td></td>
<td>• Gums, nose, mouth or surgical site bleeding</td>
<td>• Bleeding with confusion, weakness, dizziness and fainting</td>
</tr>
<tr>
<td></td>
<td>• Unusual bruising</td>
<td>• Throwing up bright red blood or it looks like coffee grounds</td>
</tr>
<tr>
<td>😔 Trouble thinking</td>
<td>• Confused</td>
<td>• Sudden difficulty speaking</td>
</tr>
<tr>
<td></td>
<td>• Restless, agitated</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Can’t concentrate</td>
<td></td>
</tr>
<tr>
<td>😞 My weight or appetite changed</td>
<td>• I don’t have an appetite</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Lost ____ lbs in ______ days</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Gained ____ lbs in 1 day OR ____ lbs in ____ days</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Feet/ankles/legs are swollen</td>
<td></td>
</tr>
<tr>
<td>😞 I don’t feel right</td>
<td>• Weaker than usual</td>
<td>• Sudden numbness or weakness of the face, arm or leg</td>
</tr>
<tr>
<td></td>
<td>• Dizzy, lightheaded, shaky</td>
<td>• Sudden difficulty speaking/slurred words</td>
</tr>
<tr>
<td></td>
<td>• Very tired</td>
<td>• Suddenly can’t keep my balance</td>
</tr>
<tr>
<td></td>
<td>• Heart fluttering, skipping or racing</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Blurred vision</td>
<td></td>
</tr>
<tr>
<td>😞 I feel sick to my stomach</td>
<td>• Throwing up</td>
<td>• Can’t stop throwing up</td>
</tr>
<tr>
<td></td>
<td>• New coughing at night</td>
<td>• Throwing up blood</td>
</tr>
</tbody>
</table>

This plan is a guide only and may not apply to all patients and/or situations. This plan is not intended to override patient/family decisions in seeking care.
**WHAT TO DO?** | **CALL MY HOME HEALTH AGENCY WHEN:** | **CALL 911 WHEN:** |
---|---|---|
**Bowel troubles** | • Diarrhea  
• Black/dark OR bloody bowel movement  
• No bowel movement in ____ days  
• No colostomy/ileostomy output in ______ hours/days |  

**Trouble urinating** | • Leaking catheter  
• No urine from catheter in _____ hours  
• Have not passed water in _____ hours  
• Urine is cloudy  
• Burning feeling while urinating  
• Belly feels swollen or bloated |  

**I am anxious or depressed** | • Always feeling anxious  
• Loss of appetite  
• Unable to concentrate  
• Trouble sleeping  
• Loss of hope  
• Constant sadness | • I have a plan of hurting myself or someone else |

**My wound changed** | • Change in drainage amount, color or odor  
• Increase in pain at wound site  
• Increase in redness/warmth at wound site  
• New skin problem  
• Fever is above ________F | • Fever is above ________ F with chills, confusion or difficulty concentrating  
• Bleeding that won’t stop |

This plan is a guide only and may not apply to all patients and/or situations. This plan is not intended to override patient/family decisions in seeking care.
**[Agency Name & Agency Phone Number]**

**Patient Name _______________________

<table>
<thead>
<tr>
<th>WHAT TO DO?</th>
<th>CALL MY HOME HEALTH AGENCY WHEN:</th>
<th>CALL 911 WHEN:</th>
</tr>
</thead>
</table>
| I have Diabetes and I’m . . . | • Thirsty or hungry more than usual  
• Urinating a lot  
• Vision is blurred  
• I’m feeling weak  
• My skin is dry and itchy  
• Repeated blood sugars greater than _______mg/dl | • Fruity breath  
• Nausea/throwing up  
• Difficulty breathing  
• Blood sugar greater than _______mg/dl |
| Other problems | • Shaky  
• Sweating  
• Extreme tiredness  
• Hungry  
• Have a headache  
• Confusion  
• Heart is beating fast  
• Trouble thinking, confused or irritable  
• Vision is different  
• Repeated blood sugars less than _______mg/dl | • Low blood sugar not responding to treatment  
• Unable to treat low blood sugar at home  
• Unconsciousness  
• Seizures |
| Take: 3 glucose tablets, OR  
½ glass of juice, OR  
5-6 pieces of hard candy, OR  
_______________________ | Wait: 15 minutes & re-check blood sugar  
IF your blood sugar is still low and symptoms do not go away: Eat a light snack:  
½ peanut butter OR  
meat sandwich, ½ glass milk  
Wait: 15 minutes & re-check blood sugar |

This plan is a guide only and may not apply to all patients and/or situations. This plan is not intended to override patient/family decisions in seeking care.
My Emergency Plan References

Adapted from the *Home Telehealth Reference 2006/2007* teletriage decision support tools available at www.medqic.org.

I hurt


I have trouble breathing


I have fever or chills


Trouble moving or fell

I see blood

Trouble thinking

My weight or appetite changed

I don’t feel right

I feel sick to my stomach

Bowel troubles
Trouble urinating

I am anxious or depressed

My wound changed

I have diabetes and I’m...
# Emergency Care Planning

**Leadership Action Items**

**Does your agency do formal emergency care planning?**

Choose one track based upon your answer. Check all the action items you **may** want to execute at your agency.

<table>
<thead>
<tr>
<th>If NO (Leadership Path)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review your emergency care planning process. Does it include the following:</td>
</tr>
<tr>
<td>- <strong>Who</strong> (e.g. your agency’s name, specific team)</td>
</tr>
<tr>
<td>- <strong>What</strong> (e.g. agency offers 24 hours/day and 7 day/week service to assist the patient with their health care needs)</td>
</tr>
<tr>
<td>- <strong>When</strong> (e.g. to report signs and symptoms, to call the office or to go to the ER)</td>
</tr>
<tr>
<td>- <strong>Where</strong> (e.g. phone number large, bold and obvious on your tools/documents such as phone stickers, refrigerator magnets, patient folders)</td>
</tr>
<tr>
<td>- <strong>How</strong> (e.g. assess patient’s physical &amp; cognitive ability to reach/use phone)</td>
</tr>
</tbody>
</table>

| Review and modify current on-call process, including: |
| - **Policy** (e.g. hours and days of week) |
| - **Guidelines for on-call staff** (check for frequent references to emergent care vs. implementing appropriate interventions) |
| - **Availability of qualified staff** |
| - **Staff orientation, continuing education and competency** |
| - **Sufficient compensation for responsibilities** |

Note: Additional resources are available in the Home Telehealth Reference 2006/2007 under Teletriage (see Resource section on Web site under For Home Health Agencies)

| Review your current process of educating the patient/caregiver/family of when to call the agency. Ensure that the directions to call are specific, clear and patient oriented. |
| Modify the sample “**My Emergency Plan**” and implement. |
| - Add or remove items to meet your agency needs |
| - Include paper-based patient emergency plan in SOC/ROC packages for accessibility for clinicians |

| Agencies with point of care documentation systems can include a reminder for creating and reviewing the patient emergency plan or if system permits, may develop form to be stored for use. |
| Educate **all disciplines** on your agency’s emergency care planning including: |
| - Purpose and significance of emergency care planning tools |
| - Interdisciplinary approach and responsibilities |
| - When the emergency care planning tools are to be reviewed by all disciplines (e.g. every visit or 1 – 2 times a week) |
| - Suggest possible location(s) for the patient to place their patient emergency plan, stickers, magnets, ‘call us first’ signs. Assess for visibility and easy patient accessibility. |

| Schedule random calls to patients/caregivers within first week of SOC/ROC to verify that patients received and understands their emergency plan – document findings per agency standard – remediate as necessary. |
Does your agency do formal emergency care planning?
Choose one track based upon your answer. Check all the action items you may want to execute at your agency.

### If YES (Leadership Highway)
- Review your current patient emergency plan tool using the following as a guide:
  - HHA name, team and phone number printed large and predominately on tool
  - Layman language
  - Medical model or signs/symptom model
  - Large clear font (13 - 14 point) for patients to read
  - Organized
  - Too much information
  - Not enough information
  - Areas to individualize for each patient
  - Space provided for agency or physician standing protocols

- Assess & modify your staff processes related to patient emergency plan:
  - Frequency of reviewing patient emergency plan with patient/caregivers, beyond at SOC/ROC (e.g. every visit or minimally 1 – 2 times a week)
  - All disciplines are reviewing patient emergency plan, moving beyond admitting clinician or just nursing (e.g. include home health aides)
  - Suggest possible location(s) for the patient to place the patient emergency plan
  - Process for updating the patient emergency plan beyond ROC/recert (e.g. each nursing or therapy visit if status changes, case conferences)

- Do you inform patients about:
  - Agency hours (e.g. 24 hours/day and 7 day/week)
  - Purpose of home care including assisting patients with their health care needs

- Review and modify current on-call process, including:
  - Policy (e.g. hours and days of week)
  - Guidelines for on-call staff (check for frequency of referrals to emergent care vs. adding appropriate interventions)
  - Availability of qualified staff
  - Staff orientation, continuing education and competency
  - Notification of patient/caregiver calls to team managers and clinicians
  - Support on-call staff with adequate resources and patient information
  - Sufficient compensation for responsibilities

Note: Additional resources are available in the Home Telehealth Reference 2006/2007 under Teletriage (see Resource section on Web site under For Home Health Agencies)

- Review the sample “My Emergency Plan”
  - Modify your current patient emergency plan OR
  - Modify the sample to meet your agency needs and implement
  - Include paper based patient emergency plan in SOC/ROC packages for accessibility for clinicians

- Agencies with point of care documentation systems can include a reminder for creating and reviewing the patient emergency plan or if system permits, may develop form to be stored for use
Utilize additional emergency care planning tools such as:
- Magnets
- “Call Me First” posters (see page 37 for 8 ½” x 10” sample and the Web site for two different size templates
- Flyer or poster printed on bright colored paper to post on refrigerator reminding patient/caregiver to call the agency & phone number (see sample in Tennessee success story and template on the Web site)

Educate **all disciplines** on your agency’s emergency care planning process including:
- Physical assessment to see if the patient can physically reach and use the phone and cognitively use the phone to call the agency or 911
- Purpose and significance of emergency care planning tools
- Interdisciplinary approach
- Expected frequency of review of emergency care planning tools
- Location for patient emergency plan, stickers, flyers/posters for easy access for patients
- Stress to all disciplines the need to educate the patient to call the agency early with health changes, rather than waiting until symptoms are severe
- Educate caregivers and family members on emergency care planning

Monitor implementation with creating and reviewing the patient emergency plan:
- Recognize and reward individual staff or team with high rates of compliance as determined by QI monitoring or random audits
- Include findings with staff performance appraisals
- Conduct random phone calls with patients to determine if the emergency plan was received and understood
- Conduct phone checks with all patients who received emergent care or a hospitalization to evaluate agency response and interventions

“When faced with a problem, people apply whatever skills they have, whether or not those skills are appropriate to the situation...”

- Marshall Becker, PhD, Professor of Health Education
  University of Michigan

Provide the patient/caregivers with appropriate tools!
Leadership Action Plan

Using the Leadership Action Items (previous three pages), request that your leadership team members select and prioritize two to four items that they want to implement or modify. Remember, you will have four weeks to review, plan and implement some key action items. Another important best practice intervention will be released at the beginning of the following month.

You may choose to add more action items after accomplishing your priority action items.

<table>
<thead>
<tr>
<th>Date</th>
<th>Action</th>
<th>By Whom</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Review nurse, therapy and supporting service sections to determine what portions of this Best Practice Package – Emergency Care Planning - you choose to use and how you want to utilize them.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Emergency Care Planning
Implementation Tools: How to Use

Patient & Family Connection
• Use educational page for leadership staff to begin cultural changes within the agency and with staff to empower patients with self-care management skills
• Share this document with leadership and utilize principles in process changes and staff education

Physician Connection
• Use education for collaborating with physicians
• Share this document with your agency’s medical director/physician liaison in developing strategies for improving physician relationships

Hospice & Palliative Connection
• To be use as an educational page for leadership staff
• Use the document to initiate a management brainstorming session to select possible solutions to improve your emergency care planning

Hospital Connection
• Utilize the content to improve patient care coordination with hospitals, including discharge planners and emergency departments
• Share this document with your physician liaisons, intake staff, managers, weekend managers and on-call staff

Managed Care Connection
• Use this document as an educational tool with managed care organizations to open dialogue related to interventions to reduce ACH, including emergency care planning
• Send the “7 Key Points for Reducing ACH related to Managed Care” to your managed care contacts - available at www.homehealthquality.org

Emergency Care Planning Poster
• Use poster around the office(s) as a visual reminder of the monthly best practice intervention topic
  o Available in the leadership track or on Web site with intervention postings
• Start a bulletin board of the monthly posters; highlight specific action items, post success stories and trending data reports

Call Me First Poster
• Use poster as a visual reminder or to support an internal awareness campaign for staff to remind patients to call the agency first
  o Available in two different sizes on the Web site

Success Stories
• Read at staff meetings, distribute in mail boxes, post on bulletin board
The patient and family connection is a critical factor in reducing acute care hospitalizations. This connection is the bridge from agencies managing patients’ health to patients managing their own health.

Developing an emergency plan is the first step. An emergency plan is a customized tool for the patient to recognize and respond to changes in his own health. Having an emergency plan helps the agency and the patient ensure that the type and intensity of care fits the problem and helps the patient to learn to manage his/her own care. Agencies effectively supporting patients’ emergency plans may require some internal system redesign.

The role of leadership is to guide the agency in this redesign. Leadership may need to provide changes in structure to support the processes that will achieve better outcomes, in this case, reduced hospitalizations. Leading a discussion in how the Emergency Plan may alter agency practice is a primary step. Such a discussion will begin to identify changes in structure and processes to improve quality and reduce avoidable hospitalizations.

Some questions for discussion:

- How do we tell patients to handle emergencies now?
- Why is it important to the agency for patients to have and use an emergency plan?
- Why is it important to the patient to have and use an emergency plan?
- What systems do we have/need to handle patient calls?
- What systems do we have/need to handle visits triggered by patients using their emergency plan?
Emergency Care Planning
Physician Connection

Improving physician relationships through awareness and education can improve care coordination for patients and assist in keeping patients in the best setting for their care. **Select one or two areas to improve physician relationships.**

**ADMINISTRATIVE**

- Home health medical directors & physician liaisons

- **Purpose** for home health includes:
  - Promote education to other physicians in promoting treatment in the right care setting
  - Provide expertise on medical coverage issues
  - Act as a physician liaison

- **Interventions** related to emergency care planning:
  - Involve medical director in development of agency’s patient emergency care plan including tool, policies and procedures
  - Marketing and education

**HOME HEALTH PHYSICIANS**

- Frequent referrals for home care

- **Purpose** for home health includes:
  - Making appropriate referrals
  - Understanding the agency’s patient emergency care plan

- **Interventions** related to emergency care planning:
  - Educate physicians in the patient emergency care plan
  - Communicate purpose of patient emergency care plan:
    - Keep patient in right setting
    - Educate patient to understand ‘who to call when’
    - Begin patient self-management education

**OTHER PRESCRIBING CLINICIANS**

- Physicians who infrequently order or consult home care, including physician assistants and nurse practitioners

- **Purpose** for home health includes:
  - Making appropriate referrals/consult
  - Understand agency’s patient emergency care planning

- **Interventions** related to emergency care planning:
  - Take advantage of opportunities with physicians or other clinicians who infrequently refer to or consult with home care for education focused on keeping patient in the right care setting
  - Share sample of agency’s patient emergency plan

Key Point: Medical directors will educate colleagues in the **value of the emergency care plan** to promote treatment in the **right care setting**

Key Point: **Effective emergency care planning** may reduce unnecessary **physician calls** and **emergent care**

Key Point: Demonstrate how the agency is **proactively** working with patients to **decrease unnecessary emergent care**
Emergency Care Planning
Hospice & Palliative Connection

Palliative care begins with defining patient/family goals for care and then communicating these goals to all members of the care team through the individualized plan of care.

All interdisciplinary staff educate the patient and family to contact the agency when problems arise. This is extremely important for ensuring that care is "appropriate and meets the goals of the patient and family" per Judy Lentz, Executive Director of Hospice and Palliative Nurses Foundation.

The patient and family must understand why calling the home care agency first is so important. A clearly defined patient emergency plan supports care decisions and outcomes that will meet specific goals defined by the patient/family. The home care nurse/therapist act as the patient’s gatekeeper to navigate the individualized plan of care.

Hospice and palliative care is proactive in being prepared to address changes or decline in health status. Physician orders and even medications are made available in advance. These emergency care planning concepts may be applied to non-hospice patients to achieve the goal of reducing avoidable hospitalizations.

“Hospice patients and their family members call hospice first because they trust that we will have pharmacological and non-pharmacological treatment solutions for the symptoms presenting. This assurance is what home health patients need when they call the home health agency. Home health patients, like hospice patients, need to have a plan of treatment that includes solutions for symptoms. If standing orders and emergency medications for pain and symptom management were available in the home, it would significantly decrease emergency department visits and hospitalizations.”

~ Susan Smith M.S.N., C.H.P.N, Director of Hospice Columbia Montour Home Hospice, Bloomsburg, PA

“At the time of admission, the primary nurse in hospice stresses the need to call us first. It is imperative to get a complete history of the patient from attending physician or discharge planner to understand all co-morbidities. Recognizing their needs helps the team to better understand caregiver abilities and limitations. This helps to develop a realistic plan of care. Services are individualized to meet patient/family needs. These are all strategies for helping the patients remain in their homes.”

~ Chris Constantine, Hospice Director Albert Gallatin Home Care & Hospice, Uniontown, PA
Effective emergency care planning supports reducing avoidable hospitalizations. Communicating this to hospitals, specifically hospital discharge planners and emergency departments, will facilitate better coordination of patient care.

**Hospital Discharge Planners:**
- Ask hospital discharge planner to review and offer suggestions to patient emergency plan
- Educate discharge planners in goal of reducing avoidable hospitalizations through emergency care planning
- Discuss collaborative approach to patients who are frequently hospitalized

**Emergency Departments (EDs):**
- Educate area EDs on home health services and goal of reducing avoidable hospitalizations through emergency care planning
- If emergent care is necessary:
  - Contact ED staff to give patient status report and offer potential HH interventions (e.g. telehealth)
  - Advise patients to take complete and accurate medication list and give to ED staff
  - Advise patient to take agency name and phone number (e.g. business card) and share with ED staff
**Emergency Care Planning**  
Managed Care Connection

Definition: A home health patient’s emergency plan is a written plan that helps a patient to identify emergent health problems and to determine whom to call to obtain care for the problem, either home care agency or EMS.

Calling the home health agency first allows the agency to determine if the problem can be handled at home rather than through a trip to the emergency department.

Benefits of home health emergency care planning to patient and managed care:
- Promotes patient care self-management
- Facilitates cost-effective quality outcomes
- Supports reduction of avoidable emergent care and hospitalizations

**Emergency Care Process**

1. **Patient Call to Home Health Agency**
2. **Teletriage**
   - **Emergent Care**
   - **Onsite Visit**
   - **Education**

Option only home health can provide!
Do your patients know when to call the home health agency and when it is appropriate to call 911?

Do all disciplines reinforce the patient’s emergency plan at every visit?

Do your patients know that calling you first may prevent a hospitalization?

**My Emergency Plan** outlines for the patient what to do in case of an emergency, including a range of signs and symptoms.

Examples include what to do when:

- “I have trouble breathing”
- “I have fever or chills”
- “My wound changed”
- “I see blood”
Every visit, every contact, remind your patients...

CALL ME FIRST!

We can help our patients avoid unplanned hospitalizations if we know they need our help.

Every time you see or speak with a patient, remember to say “CALL ME FIRST!”
Success Stories

Tennessee Agency’s Emergency Plan Helps Improve Patient Care

Sometimes it’s a simple thing that provides a solution to a tricky problem. Medical Center Homecare Services in Johnson City has instituted a number of new programs and processes in recent years to lower its acute care hospitalization (ACH) rate. To illustrate, the agency increased educational resources for patients aimed at reducing ACH and also focused on recruitment, retention and recognition of staff. Both of those efforts resulted in more informed patients and improved morale and productivity among staff.

Performance Improvement Coordinator, Julie Sharp, said what’s recently made a real difference in tackling ACH reduction is the placement of a simple sticker on the front of folders left in patients’ homes. The stickers state “call us first,” in capital letters and it includes the agency’s phone number,” said Sharp, who is also a registered nurse. Staff also stress to patients that if they are feeling worse, they should give the agency a call before heading to the emergency room (ER). “It seems really simple,” she said. But adding this intervention in combination with other agency efforts seems to be paying off.

The agency attends roundtable meetings sponsored by QSource, the state’s Medicare Quality Improvement Organization, which are a “huge benefit in networking and sharing ideas with other home health agencies,” Sharp said. “Staff is always there to help with resources that assist us with our ACH rate, and always there with an answer to my questions,” she added.

The idea for the emergency care plan sticker came from Johnson City’s medical director, a physician who was a member of a focus group formed by the agency to work on reducing ACH. As a doctor working with the agency, he told members of the focus group that some of the agency’s patients were calling his office or going directly to the ER, and the ER would then contact him about his patient. He quickly recognized that often the patient’s condition could have been treated and/or addressed through a visit by home health staff.

Sharp said examples of what may typically happen is that a patient may notice additional swelling in his or her feet, experience a two-pound weight gain in one day or even panic because he or she gets a little short of breath. Patients experiencing these symptoms end up in the ER, when home health intervention may have been the better option. “We could have prevented it, gone to the home, called the doctor, and made a medication change,” she said.

Typically the first person to educate the patient and explain the purpose of the sticker is a nurse or therapist, Sharp explained. This takes place when the staff person makes the initial visit, and is reinforced on subsequent visits. Home health staff—typically nurses, and occasionally home health aides—reiterate the importance of calling the agency first with health concerns. Patients find this approach reassuring. “They know that there’s a nurse available 24 hours a day,
seven days a week,” she said. “Even in the middle of the night, and on the weekends, [we tell them], ‘don’t hesitate to call because there is always somebody available.’”

On call coordinators have also played a significant role in helping to reduce ACH. The coordinators triage phone calls after hours and if the patient needs to be seen, the coordinators notify the nurses on call to see that patient, said Sharp. The coordinators make sure the on call nurses haven’t worked during the day so they are sharp and ready to go. In addition, because of the new focus on ACH reduction in recent years, coordinators are better educated about patients’ conditions and what “emergencies” may actually be treated in the home setting.

The agency’s ACH rate is currently at its lowest point in years, according to Sharp. December 2006 CASPER data shows an ACH rate of 25.68 percent (January 2006 to December 2006 reporting period); this compares with 31.6 percent in November 2005. (The eligible number of cases or patients that could potentially be hospitalized for the 2006 period was 2,485.)

In addition to the “call us first” campaign, Johnson City has also found success in recent years by utilizing a congestive heart failure (CHF) disease management program. Launched at the agency in 2003, the program provides CHF patients with telehealth monitoring equipment that transmits vital signs, such as weight and blood pressure readings to a call center in Atlanta, Georgia. If their weight has increased or their blood pressure has elevated, the patient is called, and registered nurses who work at the telehealth center in Atlanta follow orders written specifically for the patient. Sharp said the agency plans to implement a similar diabetes disease management program in the future.

“It’s truly a team effort, and the entire team finds pleasure in watching our ACH rate decline,” Sharp said.

_Data in this article was provided by Julie Sharp, Medical Center Homecare Services._

“We would rather have the patients call us first and allow a clinician to assess them before just going into the ER... and if we have to, we will send them to the ER. Many times we provide intervention at home and keep the patient at home.”

Jane Andrews, RN
Disease Management
Medical Center Homecare Services
Iowa Home Health Agency Thinks “Pink,” and Reduces Avoidable Hospitalizations with Improved Emergency Care Plans

Iowa’s Pocahontas Community Hospital – Home Health is working to create a health care system that ensures each person receives the right care at the right time by: increasing patient and caregiver satisfaction, improving health outcomes and reducing avoidable hospitalizations. The agency was recognized in 2006 as a home health “superstar” by the Iowa Foundation for Medical Care (IFMC), the state’s Medicare Quality Improvement Organization.

The national hospitalization rate for home health patients has been steadily rising over the past three years. The Centers for Medicare & Medicaid Services (CMS), in recent years, set a national target of reducing the home health acute care hospitalization (ACH) rate to 23 percent CASPER data. Pocahontas Community has not only achieved this goal, but has also already surpassed it with an ACH rate of 21 percent.

Pocahontas Community’s reduction in ACH shows a leadership and staff commitment to improving the quality of health care provided to patients. Based on various quality measures, the agency is providing more effective care and saving Medicare dollars, according to IFMC’s Medical Director, Tim Gutshall.

To reduce avoidable hospitalizations, physicians and home care agencies must continuously communicate and address patient problems and care needs both efficiently and effectively. “We have provided additional staff, patient and family education, and introduced new emergency care plans and call sheets to help reduce the number of hospitalizations,” said Judy Schmidt, Pocahontas Community’s project’s leader and case manager. “Our patients want to be at home and we are working hard to keep them there.”

More specifically, the agency in June 2006 began using a patient emergency care plan that is reviewed with all patients at start of care and resumption of care. The plan is left in the home for the patient to use. The plan includes the agency name and phone number, and lists problems or conditions; including diabetes, infection, heart/lung problems, etc. To illustrate, under “diabetic problems” signs and symptoms that are listed include: sudden weakness or dizziness, uncontrollable thirst or hunger, blurred vision, sweating spells and frequent headaches.

Home health nurses complete the emergency care plan with the patient and/or family during the initial evaluation. The clinicians discuss various problem areas with the patient, and provide examples of when the patient should call the agency or when it is more appropriate to go to the emergency room. The emergency care plan also includes information for patients to assist them in determining when they should call 911. Conditions listed in that category include a fall resulting in a broken bone or bleeding, chest pain that is not relieved by medication, and signs or symptoms of a stroke (including a sudden weakness on one side and difficulty with speech).
In addition to the emergency care plan forms, nurses also continue to leave emergency information sheets with patients. The 8.5 by 11 sheet—which is posted on the patient’s refrigerator—includes the agency name and phone numbers in large, bold font which also provides an area to write in the names of the nurse, physician and hospital. To make the emergency information sheet more noticeable for the patient, staff decided to print the form on hot pink paper (a sample emergency information sheet is available on the HHQI website for home health agencies to utilize).

Nurses review both the emergency care plan and emergency information sheet at the start of care, resumption of care, and at re-certification. Schmidt said the simple change from plain white paper to hot pink appears to be making a difference. Prior to changing to the brightly colored form, Schmidt said most clients would merely answer, “yes,” when asked if they knew how to get in touch with the agency. Now, patients or clients all refer to the “pink sheet.”

Agencies that want to reduce ACH and improve outcomes can include the use of the emergency care plan as an intervention. As part of the agency’s goals, Schmidt said that it is imperative to beef up the agency’s education. It is the continuing education component of the emergency care planning process that is perhaps even more important than new forms. “We’ve improved [because of] the education,” she said. “I always say, ‘educate, educate, educate’ the client on calling us.”

Hospital leaders express pride when asked about the success of the facility’s home health services. “We strive to provide the highest quality of care for our community, said CEO James Roetman, Pocahontas Community Hospital. “I am proud of the ongoing quality improvement efforts of our Home Care staff,” he concluded.

Data in this article was provided by Judy Schmidt, Pocahontas Community Hospital – Home Health.
Each track of the Best Practice Intervention Package has a post-test that providers may choose to complete after reviewing the track and completing the activities.

For the Emergency Care Planning package, the post-tests are found on the following pages:
Nurse Track – page 59
Therapy Track – page 78
Medical Social Work Track – page 96
Home Health Aide Track – page 108

Use the answer keys below to score the post-tests included with the Emergency Care Planning Best Practice Intervention Package.

**Nursing Post-Test Answers:**
1. B
2. C
3. D
4. A
5. E

**Therapy Post-Test Answers:**
1. B
2. C
3. D
4. A
5. D

**Medical Social Worker Post-Test Answers:**
1. B
2. C
3. D
4. A
5. D

**Home Health Aide Post-Test Answers:**
1. E
2. B
3. A
4. A
5. C
Best Practice:
Emergency Care Planning

Nurse Track
Nurse Track

This best practice intervention package is designed to introduce all nurses to emergency care planning to assist in reducing avoidable acute care hospitalizations.

Objectives

After completing the activities included in the Nurse Track of this Best Practice Intervention Package – Emergency Care Planning, the learner will be able to:

1. Define what emergency care planning is and how it can be used effectively by a home health agency.
2. Define what a patient emergency plan is and how to use the plan with patients.
3. Describe how emergency care planning may reduce avoidable acute care hospitalizations.
4. Describe two nursing actions or applications that support emergency care planning.

Complete the following activities:

<table>
<thead>
<tr>
<th>Activity</th>
<th>Location</th>
<th>Estimated Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Read the emergency care planning description and review the sample “My Emergency Plan”</td>
<td>Pages 45, 48</td>
<td>15 minutes</td>
</tr>
<tr>
<td>Listen to the audio recording: Emergency Care Planning for Clinicians</td>
<td>Page 47</td>
<td>15 minutes</td>
</tr>
<tr>
<td>Read the Nurse’s Guide to Practical Application</td>
<td>Page 52</td>
<td>5 minutes</td>
</tr>
<tr>
<td>Read the success stories</td>
<td>Page 55</td>
<td>15 minutes</td>
</tr>
<tr>
<td>Access and explore the supporting resources HHQI National Campaign – <a href="http://www.homehealthquality.org">www.homehealthquality.org</a></td>
<td>Page 59</td>
<td>15 minutes</td>
</tr>
</tbody>
</table>

- RNs: Complete the nursing evaluation and post-test on line for free CNEs [See link below] 10 minutes
- LPNs: Complete the nursing post-test Page 60 (10 minutes)

Total time for completion 75 minutes

FREE CNEs for Registered Nurses

RNs may apply for free 1.25 CNEs for completing all of the nursing track activities (see above table) from this Best Practice Intervention Package – Emergency Care Planning

Emergency Care Planning

There are many different interventions that home care agencies may use as they strive to achieve the national goal of reducing avoidable acute care hospitalizations. Some of the interventions may stand alone, but the majority of them are more effective if used with other interventions. Emergency care planning is one of the interventions that complement the use of a hospitalization risk assessment. A hospitalization risk assessment provides the foundation for recognizing which patients are at risk and identifies specific risk factors. Knowing the patient’s risk factors will assist a clinician in developing a more specific patient emergency plan.

In this package we will be talking about two similar, but different terms – emergency care planning and patient emergency plan.

**Emergency Care Planning**
Definition: The established agency process that includes all activities, tools and policies/procedures used to assist clinicians with educating patients on what actions to take if a medical problem or change in condition occurs. Emergency care planning assists the patient in determining who, what, where, when, why and how to respond to changes in health status. Agencies can then utilize patient-centered interventions to try to keep the patient at home or recommend the most appropriate care setting for the patient.

**Patient Emergency Plan**
Definition: A home health patient’s emergency plan is a written plan that helps a patient to identify emergent health problems and to determine whom to call to obtain care for the problem, either home care agency or EMS. The patient emergency plan is a significant part of emergency care planning. Simply, emergency care planning is the overall process and the patient emergency plan is a specific patient tool.

Components of emergency care planning can include:
- Patient emergency plan
- Magnets or stickers for the phone with HHA name and number
- Posters or flyers for the patient to serve as reminders to call the agency first before seeking emergent care, except in case of true emergencies
- Posters or flyers in the office as reminders to staff about emergency care planning
- Documentation reminders (paper based or electronic) to educate on the patient emergency plan and to document the education
- Processes for handling patient calls during regular hours and after hours (e.g. on-call system)
- Processes, procedures and guidelines to support emergency care planning
Education on the patient emergency plan is crucial to the success of this intervention. The education should be started by the admitting clinician, but should not stop there. Think about all the paperwork and instructions clinicians are required to give or ask patients on SOC visits – it is overwhelming to the clinicians, let alone the patient and caregivers. Therefore, teaching on the first visit will not be very fruitful. Start with the basics – agency hours and phone number. On subsequent visits, continue to educate and build upon the groundwork you laid during the first visit – working simple to complex!

Who is responsible for this education? The interdisciplinary team. Initially, the focus is on the basics—verifying that the patient can use the phone effectively, teaching the patient how to contact the agency, identifying risk areas specific to this patient and teaching the patient how to recognize signs and symptoms that indicate an emergency. Throughout the course of care, each discipline reinforces the emergency plan on each visit, and updates the plan when appropriate. The more the patient learns to monitor signs and symptoms and respond to emerging problems, the more the patient assumes responsibility for his or her own health.

The purpose of emergency care planning is more than just giving the patient a tool, documenting that it was completed and tucking it away in the patient folder. It can reduce the physical and psychological stress for the patient with frequent exacerbations of his/her medical conditions and reduce time away from home, if they use the tool timely. Emergency care planning is an intervention that can help reduce avoidable acute care hospitalizations, keeping patients at home, where they want to be.

“When faced with a problem, people apply whatever skills they have, whether or not those skills are appropriate to the situation...”

- Marshall Becker, PhD, Professor of Health Education
  University of Michigan

Provide the patient/caregivers with appropriate tools!
**Instructions:**
Listen to the audio recording to learn more about reducing avoidable acute care hospitalizations and the use of emergency care planning. A sample patient emergency plan is on the next page.

<table>
<thead>
<tr>
<th>Title</th>
<th>Description</th>
<th>Link</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Care Planning for Clinicians</td>
<td>A 15-minute audio recording that can be used by clinicians in staff/team meetings or while traveling in the car.</td>
<td>The audio link is located at <a href="http://www.homehealthquality.org/hh/hha/interventionpackages/ecp.aspx">www.homehealthquality.org/hh/hha/interventionpackages/ecp.aspx</a></td>
</tr>
</tbody>
</table>

There are several ways to listen to the audio recording:
- Visit the link above and listen directly through the Web site.
- Download the audio recording by right-clicking on the audio file and selecting “Save Target As...”. This will save the file to your hard drive. Once you have saved the file, you can listen to it on your computer or you can burn the audio file to a CD to listen to in your car or stereo.

“By providing patients with clear directions to follow prior to an unexpected event occurring, significant amounts of anxiety can be avoided. If a patient's need can be addressed through interventions in the home, the need can be potentially minimized to prevent a more serious condition and can save the patient from a lengthy ER visit and hospital stay.”

Linda K. Wankel, RN
Director of Nursing
McKean County VNA & Hospice
Patient Name _______________________

**MY EMERGENCY PLAN**

<table>
<thead>
<tr>
<th>WHAT TO DO?</th>
<th>CALL MY HOME HEALTH AGENCY WHEN:</th>
<th>CALL 911 WHEN:</th>
</tr>
</thead>
</table>
| **I hurt**             | • New pain OR pain is *worse* than usual  
• Unusual bad headache  
• Ears are ringing  
• My blood pressure is above: _____/_____  
• Unusual low back pain  
• Chest pain or tightness of chest RELIEVED by rest or medication | • Severe or prolonged pain  
• Pain/discomfort in neck, jaw, back, one or both arms, or stomach  
• Chest discomfort with sweating/nausea  
• Sudden severe unusual headache  
• Sudden chest pain or pressure & medications don’t help (e.g. Nitroglycerin as ordered by physician), OR  
• Chest pain went away & came back |
| **I have trouble breathing** | • Cough is worse  
• Harder to breathe when I lie flat  
• Chest tightness RELIEVED by rest or medication  
• My inhalers don’t work  
• Changed color, thickness, odor of sputum (spit) | • I can’t breathe!  
• My skin is gray OR fingers/lips are blue  
• Fainting  
• Frothy sputum (spit) |
| **I have fever or chills** | • Fever is above ________ F  
• Chills/can’t get warm | • Fever is above ________ F with chills, confusion or difficulty concentrating |
| **Trouble moving or fell** | • Dizziness or trouble with balance  
• Fell and hurt myself  
• Fell but didn’t hurt myself | • Fell and have severe pain |

This plan is a guide only and may not apply to all patients and/or situations. This plan is not intended to override patient/family decisions in seeking care.

Developed by Quality Insights of Pennsylvania in conjunction with Carol Siebert, MS, OTR/L, FAOTA, American Occupational Therapy Association and Karen Vance, OTR/L, BKD Healthcare Group and American Occupational Therapy Association. Based on MyEmergency Plan created by Delmarva in conjunction with OASIS Answers, Inc.
### WHAT TO DO?

#### CALL MY HOME HEALTH AGENCY WHEN:

| I see blood | Bloody, cloudy, or change in urine color or foul odor  
|            | Gums, nose, mouth or surgical site bleeding  
|            | Unusual bruising |

#### CALL 911 WHEN:

- Bleeding that won’t stop  
- Bleeding with confusion, weakness, dizziness and fainting  
- Throwing up bright red blood or it looks like coffee grounds

#### Trouble thinking

- Confused  
- Restless, agitated  
- Can’t concentrate

#### CALL 911 WHEN:

- Sudden difficulty speaking

#### My weight or appetite changed

- I don’t have an appetite  
- Lost ____ lbs in ______ days  
- Gained ____ lbs in 1 day OR ___ lbs in ___ days  
- Feet/ankles/legs are swollen

#### I don’t feel right

- Weaker than usual  
- Dizzy, lightheaded, shaky  
- Very tired  
- Heart fluttering, skipping or racing  
- Blurred vision

#### CALL 911 WHEN:

- Sudden numbness or weakness of the face, arm or leg  
- Sudden difficulty speaking/slurred words  
- Suddenly can’t keep my balance

#### I feel sick to my stomach

- Throwing up  
- New coughing at night

#### CALL 911 WHEN:

- Can’t stop throwing up  
- Throwing up blood

---

This plan is a guide only and may not apply to all patients and/or situations. This plan is not intended to override patient/family decisions in seeking care.
**WHAT TO DO?**

**CALL MY HOME HEALTH AGENCY WHEN:**

**CALL 911 WHEN:**

### Bowel troubles
- Diarrhea
- Black/dark OR bloody bowel movement
- No bowel movement in ____ days
- No colostomy/ileostomy output in ______ hours/days

### Trouble urinating
- Leaking catheter
- No urine from catheter in _____ hours
- Have not passed water in _____ hours
- Urine is cloudy
- Burning feeling while urinating
- Belly feels swollen or bloated

### I am anxious or depressed
- Always feeling anxious
- Loss of appetite
- Unable to concentrate
- Trouble sleeping
- Loss of hope
- Constant sadness
- I have a plan of hurting myself or someone else

### My wound changed
- Change in drainage amount, color or odor
- Increase in pain at wound site
- Increase in redness/warmth at wound site
- New skin problem
- Fever is above ________ F
- Fever is above ________ F with chills, confusion or difficulty concentrating
- Bleeding that won’t stop

This plan is a guide only and may not apply to all patients and/or situations. This plan is not intended to override patient/family decisions in seeking care.
<table>
<thead>
<tr>
<th>WHAT TO DO?</th>
<th>CALL MY HOME HEALTH AGENCY WHEN:</th>
<th>CALL 911 WHEN:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>I have Diabetes and I’m . . .</strong></td>
<td>• Thirsty or hungry more than usual • Urinating a lot • Vision is blurred • I’m feeling weak • My skin is dry and itchy • Repeated blood sugars greater than _______ mg/dl</td>
<td>• Fruity breath • Nausea/throwing up • Difficulty breathing • Blood sugar greater than ______mg/dl</td>
</tr>
<tr>
<td></td>
<td><strong>Take:</strong> 3 glucose tablets, OR ½ glass of juice, OR 5-6 pieces of hard candy, OR ____________________</td>
<td><strong>Wait:</strong> 15 minutes &amp; re-check blood sugar <strong>IF</strong> your blood sugar is still low and symptoms do not go away: Eat a light snack: ½ peanut butter OR meat sandwich, ½ glass milk <strong>Wait:</strong> 15 minutes &amp; re-check blood sugar</td>
</tr>
<tr>
<td><strong>Other problems</strong></td>
<td>• Feeding Tube clogged • Problems with my IV/site</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Shaky • Sweating • Extreme tiredness • Hungry • Have a headache • Confusion • Heart is beating fast • Trouble thinking, confused or irritable • Vision is different • Repeated blood sugars less than _______ mg/dl</td>
<td></td>
</tr>
</tbody>
</table>

This plan is a guide only and may not apply to all patients and/or situations. This plan is not intended to override patient/family decisions in seeking care.

This material was prepared by Quality Insights of Pennsylvania, the Medicare Quality Improvement Organization Support Center for Home Health, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. Publication number RSOW-PA-HHO07 397
Emergency Care Planning
Nurse’s Guide to Practical Application

Purpose: To assist the nurse with establishing and reinforcing emergency care planning with the patient and his/her family or caregiver

- Determine if patient has a phone
- Evaluate patient’s physical and cognitive ability to:
  - Access the phone
  - Successfully place a call to the agency and/or to 911
  - Effectively communicate with the other party
  - Consider programming the HHA phone number into patient’s phone if possible and with patient/caregiver permission
- Establish an emergency plan at start of care; Reinforce and document instruction at every visit
- Include the patient and family in completing the patient emergency plan, especially the “Other” section of the plan
- Incorporate signs and symptoms that may or may not be related to the primary reason for home health care into the patient emergency plan
- Customize the patient emergency plan for the patient with specific physician directed parameters, obtained throughout the entire episode of care
- Educate patient/family/caregiver that a patient emergency plan:
  - is the patient’s plan that outlines what to do in the event of new or exacerbated symptoms.
  - helps the patient identify changes in health status which should not be ignored.
  - assists the patient and/or family/caregiver with deciding when to call the home health agency and when to call 911.
  - allows the agency to determine if the problem can be handled at home rather than going to the emergency department.
- Include family members living outside of the home in the educational process (e.g. patient is very anxious and dyspneic and calls her daughter living in another city or state – the daughter could direct patient to the emergency plan and help the patient determine whom to call based upon the symptoms the patient is experiencing.)
- During each visit ask the patient to locate “My Emergency Plan”
Emphasize that the emergency plan is a tool to help the patient remain at home and avoid the emergency department or hospital unless this level of care is necessary

Utilize emergency care planning as the first step to promote patient self-care management

Stress that early identification of changes in condition may prevent a hospitalization

Incorporate a review of the patient emergency plan into part of every nursing visit (e.g. before you leave as a closing activity or with your patient education)

Reinforce specific patient emergency plan areas after any new diagnosis or medication/treatment change and after any emergent care events

Describe specific situations and ask the patient to identify what the appropriate course of action would be
  - Example: “What would you do if noticed blood in your urine?”

Establish interventions the agency can implement to attempt to manage the patient at home. Examples of interventions that an agency may offer includes:
  - PRN nursing visits
  - Medication management
  - Front-loading visits
  - Phone monitoring
  - Telemonitoring

  - Fall prevention
  - Immunization
  - Patient self-management
  - Disease/case management

When a patient must seek emergent care, coordinate care with the ER by providing pertinent medical information (include a medication list) and advise of home health services

Consistent and appropriate handling of after hours calls is key to success with emergency care planning

Remember that effective emergency care planning will help patients feel more confident in their ability to identify changes in their condition and to seek the most appropriate level of care
Clinicians can utilize many different adult learning principles for education. Several of Jane Vella’s (Learning to Listen Learning to Teach, 1994. San Francisco: Josey-Bass, Inc. Publication) are provided in the table below with an application to emergency care planning.

<table>
<thead>
<tr>
<th>Adult Learning Principle</th>
<th>Application</th>
</tr>
</thead>
</table>
| Reinforcement            | • Older adults need teaching reinforced more than two or three times  
                          | • Imperative to review the patient’s emergency plan and agency phone numbers more than just on SOC and ROC |
| Engagement               | • Include patient/caregiver/family in the development of the patient’s emergency plan  
                          | • Personalize the plan with physician ordered parameters and with completion of the “Other” section of the tool with patient/caregiver concerns |
| Sequencing               | • Start with simple information such as the agency’s phone number and hours of availability (avoid overwhelming patient/caregiver)  
                          | • Progress to details of the patient’s emergency plan on subsequent visits |
| Immediacy                | • Link the importance of the patient emergency plan with the patient’s recent hospitalization  
                          | • Review the patient’s admitting signs and symptoms and coach the patient selecting identify options on the patient emergency plan |
| Relevance                | • The emergency plan is a patient-centered tool to be used to help keep the patient at home  
                          | • Discuss with patient/caregiver their goals for home care at start of care and throughout the episode |
Tennessee Agency’s Emergency Plan Helps Improve Patient Care

Sometimes it’s a simple thing that provides a solution to a tricky problem. Medical Center Homecare Services in Johnson City has instituted a number of new programs and processes in recent years to lower its acute care hospitalization (ACH) rate. To illustrate, the agency increased educational resources for patients aimed at reducing ACH and also focused on recruitment, retention and recognition of staff. Both of those efforts resulted in more informed patients and improved morale and productivity among staff.

Performance Improvement Coordinator, Julie Sharp, said what’s recently made a real difference in tackling ACH reduction is the placement of a simple sticker on the front of folders left in patients’ homes. The stickers state “call us first,” in capital letters and it includes the agency’s phone number,” said Sharp, who is also a registered nurse. Staff also stress to patients that if they are feeling worse, they should give the agency a call before heading to the emergency room (ER). “It seems really simple,” she said. But adding this intervention in combination with other agency efforts seems to be paying off.

The agency attends roundtable meetings sponsored by QSource, the state’s Medicare Quality Improvement Organization, which are a “huge benefit in networking and sharing ideas with other home health agencies,” Sharp said. “Staff is always there to help with resources that assist us with our ACH rate, and always there with an answer to my questions,” she added.

The idea for the emergency care plan sticker came from Johnson City’s medical director, a physician who was a member of a focus group formed by the agency to work on reducing ACH. As a doctor working with the agency, he told members of the focus group that some of the agency’s patients were calling his office or going directly to the ER, and the ER would then contact him about his patient. He quickly recognized that often the patient’s condition could have been treated and/or addressed through a visit by home health staff.

Sharp said examples of what may typically happen is that a patient may notice additional swelling in his or her feet, experience a two-pound weight gain in one day or even panic because he or she gets a little short of breath. Patients experiencing these symptoms end up in the ER, when home health intervention may have been the better option. “We could have prevented it, gone to the home, called the doctor, and made a medication change,” she said.

Typically the first person to educate the patient and explain the purpose of the sticker is a nurse or therapist, Sharp explained. This takes place when the staff person makes the initial visit, and is reinforced on subsequent visits. Home health staff—typically nurses, and occasionally home health aides—reiterate the importance of calling the agency first with health concerns. Patients find this approach reassuring. “They know that there’s a nurse available 24 hours a day,
seven days a week,” she said. “Even in the middle of the night, and on the
weekends, [we tell them], ‘don’t hesitate to call because there is always somebody
available.’”

On call coordinators have also played a significant role in helping to reduce ACH.
The coordinators triage phone calls after hours and if the patient needs to be seen, the coordinators notify the nurses on call to see that patient, said Sharp.
The coordinators make sure the on call nurses haven’t worked during the day so they are sharp and ready to go. In addition, because of the new focus on ACH reduction in recent years, coordinators are better educated about patients’ conditions and what “emergencies” may actually be treated in the home setting.

The agency’s ACH rate is currently at its lowest point in years, according to Sharp. December 2006 CASPER data shows an ACH rate of 25.68 percent (January 2006 to December 2006 reporting period); this compares with 31.6 percent in November 2005. (The eligible number of cases or patients that could potentially be hospitalized for the 2006 period was 2,485.)

In addition to the “call us first” campaign, Johnson City has also found success in recent years by utilizing a congestive heart failure (CHF) disease management program. Launched at the agency in 2003, the program provides CHF patients with telehealth monitoring equipment that transmits vital signs, such as weight and blood pressure readings to a call center in Atlanta, Georgia. If their weight has increased or their blood pressure has elevated, the patient is called, and registered nurses who work at the telehealth center in Atlanta follow orders written specifically for the patient. Sharp said the agency plans to implement a similar diabetes disease management program in the future.

“It’s truly a team effort, and the entire team finds pleasure in watching our ACH rate decline,” Sharp said.

_Data in this article was provided by Julie Sharp, Medical Center Homecare Services._

“We would rather have the patients call us first and allow a clinician to assess them before just going into the ER... and if we have to, we will send them to the ER. Many times we provide intervention at home and keep the patient at home.”

Jane Andrews, RN
Disease Management
Medical Center Homecare Services
Iowa Home Health Agency Thinks “Pink,” and Reduces Avoidable Hospitalizations with Improved Emergency Care Plans

Iowa’s Pocahontas Community Hospital – Home Health is working to create a health care system that ensures each person receives the right care at the right time by: increasing patient and caregiver satisfaction, improving health outcomes and reducing avoidable hospitalizations. The agency was recognized in 2006 as a home health “superstar” by the Iowa Foundation for Medical Care (IFMC), the state’s Medicare Quality Improvement Organization.

The national hospitalization rate for home health patients has been steadily rising over the past three years. The Centers for Medicare & Medicaid Services (CMS), in recent years, set a national target of reducing the home health acute care hospitalization (ACH) rate to 23 percent CASPER data. Pocahontas Community has not only achieved this goal, but has also already surpassed it with an ACH rate of 21 percent.

Pocahontas Community’s reduction in ACH shows a leadership and staff commitment to improving the quality of health care provided to patients. Based on various quality measures, the agency is providing more effective care and saving Medicare dollars, according to IFMC’s Medical Director, Tim Gutshall.

To reduce avoidable hospitalizations, physicians and home care agencies must continuously communicate and address patient problems and care needs both efficiently and effectively. “We have provided additional staff, patient and family education, and introduced new emergency care plans and call sheets to help reduce the number of hospitalizations,” said Judy Schmidt, Pocahontas Community’s project’s leader and case manager. “Our patients want to be at home and we are working hard to keep them there.”

More specifically, the agency in June 2006 began using a patient emergency care plan that is reviewed with all patients at start of care and resumption of care. The plan is left in the home for the patient to use. The plan includes the agency name and phone number, and lists problems or conditions; including diabetes, infection, heart/lung problems, etc. To illustrate, under “diabetic problems” signs and symptoms that are listed include: sudden weakness or dizziness, uncontrollable thirst or hunger, blurred vision, sweating spells and frequent headaches.

Home health nurses complete the emergency care plan with the patient and/or family during the initial evaluation. The clinicians discuss various problem areas with the patient, and provide examples of when the patient should call the agency or when it is more appropriate to go to the emergency room. The emergency care plan also includes information for patients to assist them in determining when they should call 911. Conditions listed in that category include a fall resulting in a broken bone or bleeding, chest pain that is not relieved by medication, and signs or symptoms of a stroke (including a sudden weakness on one side and difficulty with speech).
In addition to the emergency care plan forms, nurses also continue to leave emergency information sheets with patients. The 8.5 by 11 sheet—which is posted on the patient’s refrigerator—includes the agency name and phone numbers in large, bold font which also provides an area to write in the names of the nurse, physician and hospital. To make the emergency information sheet more noticeable for the patient, staff decided to print the form on hot pink paper (a sample emergency information sheet is available on the HHQI website for home health agencies to utilize).

Nurses review both the emergency care plan and emergency information sheet at the start of care, resumption of care, and at re-certification. Schmidt said the simple change from plain white paper to hot pink appears to be making a difference. Prior to changing to the brightly colored form, Schmidt said most clients would merely answer, “yes,” when asked if they knew how to get in touch with the agency. Now, patients or clients all refer to the “pink sheet.”

Agencies that want to reduce ACH and improve outcomes can include the use of the emergency care plan as an intervention. As part of the agency’s goals, Schmidt said that it is imperative to beef up the agency’s education. It is the continuing education component of the emergency care planning process that is perhaps even more important than new forms. “We’ve improved [because of] the education,” she said. “I always say, ‘educate, educate, educate’ the client on calling us.”

Hospital leaders express pride when asked about the success of the facility’s home health services. “We strive to provide the highest quality of care for our community, said CEO James Roetman, Pocahontas Community Hospital. “I am proud of the ongoing quality improvement efforts of our Home Care staff,” he concluded.

Data in this article was provided by Judy Schmidt, Pocahontas Community Hospital – Home Health.
Investigating Resources

Information about the HHQI campaign, including the Best Practice Intervention Packages and additional resources, can be found on the HHQI Web site. This exercise provides an opportunity to explore this comprehensive site. To complete this investigation activity you will need access to a computer and the Internet.

**HHQI Web Site Investigation Activities**

<table>
<thead>
<tr>
<th>![magnifying_glass]</th>
<th>Go to the HHQI National Campaign <strong>home page</strong> at: <a href="http://www.homehealthquality.org">www.homehealthquality.org</a></th>
</tr>
</thead>
<tbody>
<tr>
<td>![magnifying_glass]</td>
<td>Find and record the approximate number of home health agencies that have registered to participate in the campaign as of today. _________________</td>
</tr>
<tr>
<td>![magnifying_glass]</td>
<td>What home health agency is the current agency of the month? _________________</td>
</tr>
<tr>
<td>![magnifying_glass]</td>
<td>On the home page, click on the <strong>Quick Link</strong> “Campaign Registration Report.” Find the percentage of home health agencies that are registered as participants in the HHQI National Campaign in your state. My state has ______ percentage of home health agencies participating.</td>
</tr>
<tr>
<td>![magnifying_glass]</td>
<td>Locate the page where the <strong>campaign goal</strong> is explained. Using the table on that page, answer the following question: If your agency’s baseline ACH rate is 25%, what would the 5% <strong>relative improvement</strong> goal be? _________________</td>
</tr>
<tr>
<td>![magnifying_glass]</td>
<td>Go to the <strong>For Home Health Agencies</strong> page, then the <strong>Intervention Package</strong> page. Find the schedule for the Best Practice Intervention Packages. The topic for June 2007 is _________________________. <em>(Hint: Scroll down)</em></td>
</tr>
<tr>
<td>![magnifying_glass]</td>
<td>Navigate to the <strong>Resources</strong> page. Find the “OASIS Accuracy Support Packet for ACH” created by the Oasis Competency and Certification Board (OCCB). Read pages 1 – 4 of the document. You may want to print and keep.</td>
</tr>
<tr>
<td>![magnifying_glass]</td>
<td>Using the left navigation bar, go to the <strong>HHQI Summit</strong> page. Locate one of the four patient vignettes. View one of the vignettes. <em>(You may want to watch all four of them!)</em></td>
</tr>
<tr>
<td>![magnifying_glass]</td>
<td>Go to the <strong>How to Get Involved</strong> page. Read about what a campaign supporter is and how to register. What will you receive if you sign up to be a campaign supporter? A monthly _________________. You are welcome to register as a campaign supporter at this time.</td>
</tr>
</tbody>
</table>
RNs – May apply for 1.25 FREE CNEs by following directions on page 44.

1. This is a written patient-centered plan that defines what the patient is to do in case of an emergency. The plan includes a range of signs and symptoms to report to the agency versus when it is more appropriate to call 911.
   a. Emergency Care Planning
   b. Patient Emergency Plan

2. Emergency Care Planning includes all of the following, except:
   a. Patient emergency plan
   b. Magnets and phone stickers
   c. Hospitalization Risk Assessment
   d. On-call policies and procedures

3. A patient emergency plan should ideally be reviewed at:
   a. Start of care and resumption of care only
   b. Recertification only
   c. Discharge only
   d. Every visit

4. Emergency care planning is an intervention that should be completed by all disciplines (interdisciplinary).
   a. True
   b. False

5. When creating the patient’s emergency plan, the following people should be involved:
   a. Nurse
   b. Patient
   c. Family/caregiver
   d. Physician
   e. All of the above
Best Practice: Emergency Care Planning

Therapy Track
Therapy Track

This best practice package is designed to introduce home care physical and occupational therapists as well as speech language pathologists to emergency care planning as an intervention to assist in reducing avoidable acute care hospitalizations.

Objectives
After completing the activities in the Therapy Track of this Best Practice Intervention Package – Emergency Care Planning, the therapist will be able to:

1. Define what emergency care planning is and how it can be used effectively by a home health agency.
2. Define what a patient emergency plan is and how to use the plan with patients.
3. Describe how emergency care planning may reduce avoidable acute care hospitalizations.
4. Describe two therapy action applications to support emergency care planning.

Complete the following activities:

<table>
<thead>
<tr>
<th>Activity</th>
<th>Location</th>
<th>Estimated Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>✔️ Read the emergency care planning description and review the sample &quot;My Emergency Plan&quot;</td>
<td>Pages 63, 66</td>
<td>15 minutes</td>
</tr>
<tr>
<td>✔️ Listen to the audio recording: Emergency Care Planning for Clinicians</td>
<td>Page 65</td>
<td>15 minutes</td>
</tr>
<tr>
<td>✔️ Read the Emergency Care Planning – Therapist’s Guide to Practical Application</td>
<td>Page 70</td>
<td>5 minutes</td>
</tr>
<tr>
<td>✔️ Read the therapy success stories</td>
<td>Page 74</td>
<td>15 minutes</td>
</tr>
<tr>
<td>✔️ Access and explore the supporting resources HHQI National Campaign – <a href="http://www.homehealthquality.org">www.homehealthquality.org</a></td>
<td>Page 78</td>
<td>15 minutes</td>
</tr>
<tr>
<td>✔️ Complete the therapy post-test</td>
<td>Page 79</td>
<td>10 minutes</td>
</tr>
<tr>
<td><strong>Total Time</strong></td>
<td></td>
<td><strong>75 minutes</strong></td>
</tr>
</tbody>
</table>
Emergency Care Planning

There are many different interventions that home care agencies may use as they strive to achieve the national goal for reducing avoidable acute care hospitalizations. Some of the interventions may stand alone, but the majority of them are more effective if used with other interventions. Emergency care planning is one of the interventions that complement the use of a hospitalization risk assessment. A hospitalization risk assessment provides the foundation for recognizing which patients are at risk and identify specific risk factors. Knowing the patient’s risk factors will assist a clinician in developing a more specific patient emergency plan.

In this package we will be talking about two similar, but different terms – emergency care planning and patient emergency plan.

Emergency Care Planning
Definition: The established agency process that includes all activities, tools and policies/procedures used to assist clinicians with educating patients on what actions to take if a medical problem or change in condition occurs. Emergency care planning assists the patient in determining who, what, where, when, why and how to respond to changes in health status. Agencies can then utilize patient-centered interventions to try to keep the patient at home or recommend the most appropriate care setting for the patient.

Patient Emergency Plan
Definition: A home health patient’s emergency plan is a written plan that helps a patient to identify emergent health problems and to determine whom to call to obtain care for the problem, either home care agency or EMS. The patient emergency plan is a significant part of emergency care planning.

Simply, emergency care planning is the overall process and the patient emergency plan is a specific patient tool.

Components of emergency care planning can include:
- Patient emergency plan
- Magnets or stickers for the phone with HHA name and number
- Posters or flyers for the patient to serve as reminders to call the agency first before seeking emergent care, except in case of true emergencies
- Posters or flyers in the office as reminders to staff about emergency care planning
- Documentation reminders (paper based or electronic) to educate on the patient emergency plan and to document the education
- Processes for handling patient calls during regular hours and after hours (e.g., on-call system)
- Processes, procedures and guidelines to support emergency care planning
Education on the patient emergency plan is crucial to the success of this intervention. The education should be started by the admitting clinician, but should not stop there. Think about all the paperwork and instructions clinicians are required to give or ask patients on SOC visits – it is overwhelming to the clinicians, let alone the patient and caregivers. Therefore, teaching on the first visit will not be very fruitful. Start with the basics – agency hours and phone number. On subsequent visits, continue to educate and build upon the groundwork you laid during the first visit – working simple to complex!

Who is responsible for this education? The interdisciplinary team. Initially, the focus is on the basics—verifying that the patient can use the phone effectively, teaching the patient how to contact the agency, identifying risk areas specific to this patient and teaching the patient how to recognize signs and symptoms that which indicate an emergency. Throughout the course of care, each discipline reinforces the emergency plan on each visit, and updates the plan when appropriate. The more the patient learns to monitor signs and symptoms and respond to emerging problems, the more the patient assumes responsibility for his or her own health.

The purpose of using emergency care planning is more than just giving the patient a tool, documenting that it was completed and tucking it away in the patient’s folder. It can reduce the physical and psychological stress for the patient with frequent exacerbations of their medical conditions and time away from home, if they use the tool timely. Emergency care planning is an intervention that can help reduce avoidable acute care hospitalizations, keeping patients at home, where they want to be.

“When faced with a problem, people apply whatever skills they have, whether or not those skills are appropriate to the situation…”

- Marshall Becker, PhD, Professor of Health Education
University of Michigan

Provide the patient/caregivers with appropriate tools!
Audio Recordings

Instructions:
Listen to the audio recording to learn more about reducing avoidable acute care hospitalizations and the use of emergency care planning. A sample patient emergency plan is on the next page.

<table>
<thead>
<tr>
<th>Title</th>
<th>Description</th>
<th>Link</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Care Planning for Clinicians</td>
<td>A 15-minute audio recording that can be used by clinicians in staff/team meetings or while traveling in the car.</td>
<td>The audio link is located at <a href="http://www.homehealthquality.org/hh/hha/interventionpackages/ecp.aspx">www.homehealthquality.org/hh/hha/interventionpackages/ecp.aspx</a></td>
</tr>
</tbody>
</table>

There are several ways to listen to the audio recording:
• Visit the link above and listen directly through the Web site.
• Download the audio recording by right-clicking on the audio file and selecting “Save Target As...”. This will save the file to your hard drive. Once you have saved the file, you can listen to it on your computer or you can burn the audio file to a CD to listen to in your car or stereo.

“By providing patients with clear directions to follow prior to an unexpected event occurring, significant amounts of anxiety can be avoided. If a patient’s need can be addressed through interventions in the home, the need can be potentially minimized to prevent a more serious condition and can save the patient from a lengthy ER visit and hospital stay.”

Linda K. Wankel, RN
Director of Nursing
McKean County VNA & Hospice
### MY EMERGENCY PLAN

<table>
<thead>
<tr>
<th>WHAT TO DO?</th>
<th>CALL MY HOME HEALTH AGENCY WHEN:</th>
<th>CALL 911 WHEN:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>I hurt</strong></td>
<td>• New pain OR pain is <strong>worse</strong> than usual&lt;br&gt;• Unusual bad headache&lt;br&gt;• Ears are ringing&lt;br&gt;• My blood pressure is above: <em><strong><strong>/</strong></strong></em>&lt;br&gt;• Unusual low back pain&lt;br&gt;• Chest pain or tightness of chest RELIEVED by rest or medication</td>
<td>• Severe or prolonged pain&lt;br&gt;• Pain/discomfort in neck, jaw, back, one or both arms, or stomach&lt;br&gt;• Chest discomfort with sweating/nausea&lt;br&gt;• Sudden severe unusual headache&lt;br&gt;• Sudden chest pain or pressure &amp; medications don’t help (e.g. Nitroglycerin as ordered by physician), OR&lt;br&gt;• Chest pain went away &amp; came back</td>
</tr>
<tr>
<td><strong>I have trouble breathing</strong></td>
<td>• Cough is worse&lt;br&gt;• Harder to breathe when I lie flat&lt;br&gt;• Chest tightness RELIEVED by rest or medication&lt;br&gt;• My inhalers don’t work&lt;br&gt;• Changed color, thickness, odor of sputum (spit)</td>
<td>• I can’t breathe!&lt;br&gt;• My skin is gray OR fingers/lips are blue&lt;br&gt;• Fainting&lt;br&gt;• Frothy sputum (spit)</td>
</tr>
<tr>
<td><strong>I have fever or chills</strong></td>
<td>• Fever is above ________ F&lt;br&gt;• Chills/can’t get warm</td>
<td>• Fever is above ________ F with chills, confusion or difficulty concentrating</td>
</tr>
<tr>
<td><strong>Trouble moving or fell</strong></td>
<td>• Dizziness or trouble with balance&lt;br&gt;• Fell and hurt myself&lt;br&gt;• Fell but didn’t hurt myself</td>
<td>• Fell and have severe pain</td>
</tr>
</tbody>
</table>

This plan is a guide only and may not apply to all patients and/or situations. This plan is not intended to override patient/family decisions in seeking care.
**[Agency Name & Agency Phone Number]**
**Patient Name __________________________**

<table>
<thead>
<tr>
<th>WHAT TO DO?</th>
<th>CALL MY HOME HEALTH AGENCY WHEN:</th>
<th>CALL 911 WHEN:</th>
</tr>
</thead>
<tbody>
<tr>
<td>I see blood</td>
<td>• Bloody, cloudy, or change in urine color or foul odor</td>
<td>• Bleeding that won’t stop</td>
</tr>
<tr>
<td></td>
<td>• Gums, nose, mouth or surgical site bleeding</td>
<td>• Bleeding with confusion, weakness, dizziness and fainting</td>
</tr>
<tr>
<td></td>
<td>• Unusual bruising</td>
<td>• Throwing up bright red blood or it looks like coffee grounds</td>
</tr>
<tr>
<td>Trouble thinking</td>
<td>• Confused</td>
<td>• Sudden difficulty speaking</td>
</tr>
<tr>
<td></td>
<td>• Restless, agitated</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Can’t concentrate</td>
<td></td>
</tr>
<tr>
<td>My weight or appetite changed</td>
<td>• I don’t have an appetite</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Lost ____ lbs in ______ days</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Gained ____ lbs in 1 day OR ___ lbs in ___ days</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Feet/ankles/legs are swollen</td>
<td></td>
</tr>
<tr>
<td>I don’t feel right</td>
<td>• Weaker than usual</td>
<td>• Sudden numbness or weakness of the face, arm or leg</td>
</tr>
<tr>
<td></td>
<td>• Dizzy, lightheaded, shaky</td>
<td>• Sudden difficulty speaking/slurred words</td>
</tr>
<tr>
<td></td>
<td>• Very tired</td>
<td>• Suddenly can’t keep my balance</td>
</tr>
<tr>
<td></td>
<td>• Heart fluttering, skipping or racing</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Blurred vision</td>
<td></td>
</tr>
<tr>
<td>I feel sick to my stomach</td>
<td>• Throwing up</td>
<td>• Can’t stop throwing up</td>
</tr>
<tr>
<td></td>
<td>• New coughing at night</td>
<td>• Throwing up blood</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>WHAT TO DO?</th>
<th>CALL MY HOME HEALTH AGENCY WHEN:</th>
<th>CALL 911 WHEN:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Bowel troubles</strong></td>
<td>• Diarrhea</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Black/dark OR bloody bowel movement</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• No bowel movement in ____ days</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• No colostomy/ileostomy output in _______hours/days</td>
<td></td>
</tr>
<tr>
<td><strong>Trouble urinating</strong></td>
<td>• Leaking catheter</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• No urine from catheter in _____ hours</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Have not passed water in _____ hours</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Urine is cloudy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Burning feeling while urinating</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Belly feels swollen or bloated</td>
<td></td>
</tr>
<tr>
<td><strong>I am anxious or depressed</strong></td>
<td>• Always feeling anxious</td>
<td>• I have a plan of hurting myself or someone else</td>
</tr>
<tr>
<td></td>
<td>• Loss of appetite</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Unable to concentrate</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Trouble sleeping</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Loss of hope</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Constant sadness</td>
<td></td>
</tr>
<tr>
<td><strong>My wound changed</strong></td>
<td>• Change in drainage amount, color or odor</td>
<td>• Fever is above _______ F with chills, confusion or difficulty concentrating</td>
</tr>
<tr>
<td></td>
<td>• Increase in pain at wound site</td>
<td>• Bleeding that won’t stop</td>
</tr>
<tr>
<td></td>
<td>• Increase in redness/warmth at wound site</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• New skin problem</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Fever is above _______F</td>
<td></td>
</tr>
</tbody>
</table>

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**[Agency Name & Agency Phone Number]**

**Patient Name _______________________

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<thead>
<tr>
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<th>CALL MY HOME HEALTH AGENCY WHEN:</th>
<th>CALL 911 WHEN:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Thirsty or hungry more than usual&lt;br&gt;• Urinating a lot&lt;br&gt;• Vision is blurred&lt;br&gt;• I’m feeling weak&lt;br&gt;• My skin is dry and itchy&lt;br&gt;• Repeated blood sugars greater than ________mg/dl</td>
<td>• Fruity breath&lt;br&gt;• Nausea/throwing up&lt;br&gt;• Difficulty breathing&lt;br&gt;• Blood sugar greater than ________mg/dl</td>
</tr>
<tr>
<td>I have Diabetes and I’m . . .</td>
<td>• Shaky&lt;br&gt;• Sweating&lt;br&gt;• Extreme tiredness&lt;br&gt;• Hungry&lt;br&gt;• Have a headache&lt;br&gt;• Confusion&lt;br&gt;• Heart is beating fast&lt;br&gt;• Trouble thinking, confused or irritable&lt;br&gt;• Vision is different&lt;br&gt;• Repeated blood sugars less than ________mg/dl</td>
<td>Take: 3 glucose tablets, OR ½ glass of juice, OR 5-6 pieces of hard candy, OR ____________________________&lt;br&gt;Wait: 15 minutes &amp; re-check blood sugar&lt;br&gt;IF your blood sugar is still low and symptoms do not go away: Eat a light snack: ½ peanut butter OR meat sandwich, ½ glass milk&lt;br&gt;Wait: 15 minutes &amp; re-check blood sugar</td>
</tr>
<tr>
<td>Other problems</td>
<td>• Feeding Tube clogged&lt;br&gt;• Problems with my IV/site</td>
<td></td>
</tr>
</tbody>
</table>

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This material was prepared by Quality Insights of Pennsylvania, the Medicare Quality Improvement Organization Support Center for Home Health, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. Publication number RSOW-PA-HHO07 397
Emergency Care Planning
Therapist’s Guide to Practical Application

Purpose: To assist the therapist with establishing (Therapy Only cases) and reinforcing emergency care planning with the patient and his/her family or caregiver.

- Determine if patient has a phone
- Evaluate patient’s physical and cognitive ability to:
  - Access the phone
  - Successfully place a call to the agency and/or to 911
  - Effectively communicate with the other party
  - Consider programming the HHA phone number into patient’s phone if possible and with patient/caregiver permission
- Reinforce and document patient emergency plan every visit for all disciplines for full benefit
- Include the patient and family in completing the patient emergency plan, especially the “Other” section of the plan
- Educate patient/family/caregiver that a patient emergency plan:
  - is the patient’s plan that outlines what to do in the event of new or exacerbated symptoms.
  - helps the patient identify changes in health status which should not be ignored.
  - assists the patient and/or family/caregiver with deciding when to call the home health agency and when to call 911.
  - allows the agency to determine if the problem can be handled at home rather than going to the emergency department.
- Include family members living outside of the home in the educational process (e.g. patient is concerned orthopedic incision is warm to touch and calls her daughter living in another state – the daughter could remind patient to look at the patient emergency plan in the home)
- During each visit ask the patient to locate “My Emergency Plan”
- Customize the patient emergency plan for the patient with specific physician directed parameters and communicate changes or concerns with other team members as needed
- Initiate a discussion with patient/caregiver regarding patient’s understanding of emergent situations versus when to call home health
- Assess for potential safety or environmental issues that could disrupt emergency care planning
Emphasize that the emergency plan is a tool to help the patient remain at home and avoid the emergency department or hospital unless this level of care is necessary.

Utilize emergency care planning as the first step to promote patient self care management.

Notify nursing if patient or family demonstrates need for complex self-care management guidance.

Stress that early identification of changes in condition can prevent a hospitalization.

Incorporate a review of the patient emergency plan into part of every therapy visit (e.g. before you leave as a closing activity or with your patient education).

Reinforce specific patient emergency plan areas after any new diagnosis or medication/treatment change and after any emergent care events.

Describe specific situations and ask the patient to describe what the appropriate course of action would be.
- Example: “What would you do if you fell and hurt yourself?”

Contribute in patient case conferences to discuss patient/caregiver’s participation with emergency care planning and offer expertise in supporting patient/caregiver participation.

When a patient must seek emergent care, coordinate care with the ER by providing pertinent medical information and advise of available home health services.

Remember that effective emergency care planning will help patients feel more confident in their ability to identify changes in their condition and to seek the most appropriate level of care.
Therapy Tips

Physical Therapy

Identify potential problems on Patient Emergency Plan such as:
• Difficulty in moving an extremity
• Loss of balance
• Complications with cast or orthotics
• Complications or problems with equipment
• Increased pain related to exercise program...

Address mobility so patient can access the phone(s)

Speech Therapy

Identify potential problems on Patient Emergency Plan such as:
• Difficulty swallowing liquids or solids
• Choking on foods or liquids
• Loss of liquids from mouth when drinking
• Increased difficulty with speech or trouble saying words
• Facial weakness, drooling, sudden onset of slurred or garbled speech
• Confusion disorientation
• Increased confusion with writing, reading ...

Identify alternative methods to place phone calls or communicate via phone for patients who cannot use conventional phone effectively

Occupational Therapy

Identify potential problems on Patient Emergency Plan such as:
• Problems with splints or casts
• Complications or problems with equipment
• Difficulty opening medications bottles

Identify alternatives for accessing phone and placing calls for patients unable to execute calls effectively
Clinicians can utilize many different adult learning principles for education. Several of Jane Vella’s (Learning to Listen Learning to Teach, 1994. San Francisco: Josey-Bass, Inc. Publication) are provided in the table below with an application to emergency care planning.

<table>
<thead>
<tr>
<th>Adult Learning Principle</th>
<th>Application</th>
</tr>
</thead>
</table>
| Reinforcement            | • Older adults need teaching reinforced more than two or three times  
                           • Imperative to review the patient’s emergency plan and agency phone numbers more than just on SOC and ROC |
| Engagement               | • Include patient/caregiver/family in the development of the patient’s emergency plan  
                           • Personalize the plan with physician ordered parameters and with completion of the “Other” section of the tool with patient/caregiver concerns |
| Sequencing               | • Start with simple information such as the agency’s phone number and hours of availability (avoid overwhelming patient/caregiver)  
                           • Progress to details of the patient’s emergency plan on subsequent visits |
| Immediacy                | • Link the importance of the patient emergency plan with the patient’s recent hospitalization  
                           • Review the patient’s admitting signs and symptoms and coach the patient selecting identify options on the patient emergency plan |
| Relevance                | • The emergency plan is a patient-centered tool to be used to help keep the patient at home  
                           • Discuss with patient/caregiver their goals for home care at start of care and throughout the episode |
**Success Stories**

**Tennessee Agency’s Emergency Plan Helps Improve Patient Care**

Sometimes it’s a simple thing that provides a solution to a tricky problem. Medical Center Homecare Services in Johnson City has instituted a number of new programs and processes in recent years to lower its acute care hospitalization (ACH) rate. To illustrate, the agency increased educational resources for patients aimed at reducing ACH and also focused on recruitment, retention and recognition of staff. Both of those efforts resulted in more informed patients and improved morale and productivity among staff.

Performance Improvement Coordinator, Julie Sharp, said what’s recently made a real difference in tackling ACH reduction is the placement of a simple sticker on the front of folders left in patients’ homes. The stickers state “call us first,’ in capital letters and it includes the agency’s phone number,” said Sharp, who is also a registered nurse. Staff also stress to patients that if they are feeling worse, they should give the agency a call before heading to the emergency room (ER). “It seems really simple,” she said. But adding this intervention in combination with other agency efforts seems to be paying off.

The agency attends roundtable meetings sponsored by QSource, the state’s Medicare Quality Improvement Organization, which are a “huge benefit in networking and sharing ideas with other home health agencies,” Sharp said. “Staff is always there to help with resources that assist us with our ACH rate, and always there with an answer to my questions,” she added.

The idea for the emergency care plan sticker came from Johnson City’s medical director, a physician who was a member of a focus group formed by the agency to work on reducing ACH. As a doctor working with the agency, he told members of the focus group that some of the agency’s patients were calling his office or going directly to the ER, and the ER would then contact him about his patient. He quickly recognized that often the patient’s condition could have been treated and/or addressed through a visit by home health staff.

Sharp said examples of what may typically happen is that a patient may notice additional swelling in his or her feet, experience a two-pound weight gain in one day or even panic because he or she gets a little short of breath. Patients experiencing these symptoms end up in the ER, when home health intervention may have been the better option. “We could have prevented it, gone to the home, called the doctor, and made a medication change,” she said.

Typically the first person to educate the patient and explain the purpose of the sticker is a nurse or therapist, Sharp explained. This takes place when the staff person makes the initial visit, and is reinforced on subsequent visits. Home health staff—typically nurses, and occasionally home health aides—reiterate the importance of calling the agency first with health concerns. Patients find this approach reassuring. “They know that there’s a nurse available 24 hours a day,
seven days a week,” she said. “Even in the middle of the night, and on the weekends, [we tell them], ‘don’t hesitate to call because there is always somebody available.’”

On call coordinators have also played a significant role in helping to reduce ACH. The coordinators triage phone calls after hours and if the patient needs to be seen, the coordinators notify the nurses on call to see that patient, said Sharp. The coordinators make sure the on call nurses haven’t worked during the day so they are sharp and ready to go. In addition, because of the new focus on ACH reduction in recent years, coordinators are better educated about patients’ conditions and what “emergencies” may actually be treated in the home setting.

The agency’s ACH rate is currently at its lowest point in years, according to Sharp. December 2006 CASPER data shows an ACH rate of 25.68 percent (January 2006 to December 2006 reporting period); this compares with 31.6 percent in November 2005. (The eligible number of cases or patients that could potentially be hospitalized for the 2006 period was 2,485.)

In addition to the “call us first” campaign, Johnson City has also found success in recent years by utilizing a congestive heart failure (CHF) disease management program. Launched at the agency in 2003, the program provides CHF patients with telehealth monitoring equipment that transmits vital signs, such as weight and blood pressure readings to a call center in Atlanta, Georgia. If their weight has increased or their blood pressure has elevated, the patient is called, and registered nurses who work at the telehealth center in Atlanta follow orders written specifically for the patient. Sharp said the agency plans to implement a similar diabetes disease management program in the future.

“It’s truly a team effort, and the entire team finds pleasure in watching our ACH rate decline,” Sharp said.

*Data in this article was provided by Julie Sharp, Medical Center Homecare Services.*

“We would rather have the patients call us first and allow a clinician to assess them before just going into the ER... and if we have to, we will send them to the ER. Many times we provide intervention at home and keep the patient at home.”

Jane Andrews, RN
Disease Management
Medical Center Homecare Services
Iowa Home Health Agency Thinks “Pink,” and Reduces Avoidable Hospitalizations with Improved Emergency Care Plans

Iowa’s Pocahontas Community Hospital – Home Health is working to create a health care system that ensures each person receives the right care at the right time by: increasing patient and caregiver satisfaction, improving health outcomes and reducing avoidable hospitalizations. The agency was recognized in 2006 as a home health “superstar” by the Iowa Foundation for Medical Care (IFMC), the state’s Medicare Quality Improvement Organization.

The national hospitalization rate for home health patients has been steadily rising over the past three years. The Centers for Medicare & Medicaid Services (CMS), in recent years, set a national target of reducing the home health acute care hospitalization (ACH) rate to 23 percent CASPER data. Pocahontas Community has not only achieved this goal, but has also already surpassed it with an ACH rate of 21 percent.

Pocahontas Community’s reduction in ACH shows a leadership and staff commitment to improving the quality of health care provided to patients. Based on various quality measures, the agency is providing more effective care and saving Medicare dollars, according to IFMC’s Medical Director, Tim Gutshall.

To reduce avoidable hospitalizations, physicians and home care agencies must continuously communicate and address patient problems and care needs both efficiently and effectively. “We have provided additional staff, patient and family education, and introduced new emergency care plans and call sheets to help reduce the number of hospitalizations,” said Judy Schmidt, Pocahontas Community’s project’s leader and case manager. “Our patients want to be at home and we are working hard to keep them there.”

More specifically, the agency in June 2006 began using a patient emergency care plan that is reviewed with all patients at start of care and resumption of care. The plan is left in the home for the patient to use. The plan includes the agency name and phone number, and lists problems or conditions; including diabetes, infection, heart/lung problems, etc. To illustrate, under “diabetic problems” signs and symptoms that are listed include: sudden weakness or dizziness, uncontrollable thirst or hunger, blurred vision, sweating spells and frequent headaches.

Home health nurses complete the emergency care plan with the patient and/or family during the initial evaluation. The clinicians discuss various problem areas with the patient, and provide examples of when the patient should call the agency or when it is more appropriate to go to the emergency room. The emergency care plan also includes information for patients to assist them in determining when they should call 911. Conditions listed in that category include a fall resulting in a broken bone or bleeding, chest pain that is not relieved by medication, and signs or symptoms of a stroke (including a sudden weakness on one side and difficulty with speech).
In addition to the emergency care plan forms, nurses also continue to leave emergency information sheets with patients. The 8.5 by 11 sheet—which is posted on the patient’s refrigerator—includes the agency name and phone numbers in large, bold font which also provides an area to write in the names of the nurse, physician and hospital. To make the emergency information sheet more noticeable for the patient, staff decided to print the form on hot pink paper (a sample emergency information sheet is available on the HHQI website for home health agencies to utilize).

Nurses review both the emergency care plan and emergency information sheet at the start of care, resumption of care, and at re-certification. Schmidt said the simple change from plain white paper to hot pink appears to be making a difference. Prior to changing to the brightly colored form, Schmidt said most clients would merely answer, “yes,” when asked if they knew how to get in touch with the agency. Now, patients or clients all refer to the “pink sheet.”

Agencies that want to reduce ACH and improve outcomes can include the use of the emergency care plan as an intervention. As part of the agency’s goals, Schmidt said that it is imperative to beef up the agency’s education. It is the continuing education component of the emergency care planning process that is perhaps even more important than new forms. “We’ve improved [because of] the education,” she said. “I always say, ‘educate, educate, educate’ the client on calling us.”

Hospital leaders express pride when asked about the success of the facility’s home health services. “We strive to provide the highest quality of care for our community, said CEO James Roetman, Pocahontas Community Hospital. “I am proud of the ongoing quality improvement efforts of our Home Care staff,” he concluded.

Data in this article was provided by Judy Schmidt, Pocahontas Community Hospital – Home Health.
**Investigating Resources**

Information about the HHQI campaign, including the Best Practice Intervention Packages and additional resources, can be found on the HHQI Web site. This exercise provides an opportunity to explore this comprehensive site. To complete this investigation activity you will need access to a computer and the Internet.

**HHQI Web Site Investigation Activities**

<table>
<thead>
<tr>
<th>Task</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Go to the HHQI National Campaign home page at:</td>
<td><a href="http://www.homehealthquality.org">www.homehealthquality.org</a></td>
</tr>
<tr>
<td>Find and record the approximate number of home health agencies that</td>
<td>have registered to participate in the campaign as of today. _________________</td>
</tr>
<tr>
<td>What home health agency is the current agency of the month?</td>
<td>_________________</td>
</tr>
<tr>
<td>On the home page, click on the Quick Link “Campaign Registration</td>
<td>Report.”</td>
</tr>
<tr>
<td>Find the percentage of home health agencies that are registered as</td>
<td>participants in the HHQI National Campaign in your state. My state has ______ percentage of home health agencies participating.</td>
</tr>
<tr>
<td>Locate the page where the campaign goal is explained. Using the</td>
<td>table on that page, answer the following question: If your agency’s baseline ACH rate is 25%, what would the 5% relative improvement goal be?</td>
</tr>
<tr>
<td>Go to the For Home Health Agencies page, then the Intervention</td>
<td>Packages. The topic for June 2007 is _________________. (Hint: Scroll down)</td>
</tr>
<tr>
<td>Navigate to the Resources page. Find the “OASIS Accuracy Support</td>
<td>Packet for ACH” created by the Oasis Competency and Certification Board (OCCB). Read pages 1 – 4 of the document. You may want to print and keep.</td>
</tr>
<tr>
<td>Using the left navigation bar, go to the HHQI Summit page. Locate</td>
<td>one of the four patient vignettes. View one of the vignettes. (You may want to watch all four of them!)</td>
</tr>
<tr>
<td>Go to the How to Get Involved page. Read about what a campaign</td>
<td>supporter is and how to register. What will you receive if you sign up to be a campaign supporter? A monthly ________________. You are welcome to register as a campaign supporter at this time.</td>
</tr>
</tbody>
</table>
1. This is a written patient-centered plan that defines what the patient is to do in case of an emergency. The plan includes a range of signs and symptoms to report to the agency versus when it is more appropriate to call 911.
   a. Emergency Care Planning
   b. Patient Emergency Plan

2. Emergency Care Planning includes all of the following, except:
   a. Patient emergency plan
   b. Magnets and phone stickers
   c. Hospitalization Risk Assessment
   d. On-call policies and procedures

3. A patient emergency plan should ideally be reviewed at:
   a. Start of care and resumption of care only
   b. Recertification only
   c. Discharge only
   d. Every visit

4. Emergency care planning is an intervention that should be completed by all disciplines (interdisciplinary).
   a. True
   b. False

5. Therapists can assist with emergency care planning by:
   a. Notifying nursing if patient or family demonstrates need for complex self-care management guidance
   b. Including family members/caregivers living outside of the home in development and educational process
   c. Describing specific situations and asking the patient to describe the appropriate course of action
   d. All of the above
Best Practice:
Emergency Care Planning

Medical Social Worker Track
Medical Social Worker Track

This best practice package is designed to introduce the home care medical social worker to emergency care planning to assist in reducing avoidable acute care hospitalizations.

Objectives

After completion of the activities in the Medical Social Worker track of this Best Practice Intervention Package – Emergency Care Planning, the learner will be able to:

1. Define what emergency care planning is and how it can be used effectively by a home health agency.
2. Define what a patient emergency plan is and how to use the plan with patients.
3. Describe how emergency care planning may reduce avoidable acute care hospitalizations.
4. Describe two medical social worker actions applications to support emergency care planning.

Complete the following activities:

<table>
<thead>
<tr>
<th>Activity</th>
<th>Location</th>
<th>Estimated Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Read the emergency care planning description and review the sample</td>
<td>Pages 82, 85</td>
<td>15 minutes</td>
</tr>
<tr>
<td>“My Emergency Plan”</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Listen to the audio recording:</td>
<td>Page 84</td>
<td>15 minutes</td>
</tr>
<tr>
<td>Emergency Care Planning for Clinicians</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Read the Emergency Care Planning – Medical Social Worker’s Guide to</td>
<td>Page 89</td>
<td>5 minutes</td>
</tr>
<tr>
<td>Practical Application</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Read the success stories</td>
<td>Page 92</td>
<td>15 minutes</td>
</tr>
<tr>
<td>Access and explore the supporting resources HHQI National Campaign –</td>
<td>Page 96</td>
<td>15 minutes</td>
</tr>
<tr>
<td><a href="http://www.homehealthquality.org">www.homehealthquality.org</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complete the medical social worker post-test and give to your manager</td>
<td>Page 97</td>
<td>10 minutes</td>
</tr>
<tr>
<td><strong>Total Time</strong></td>
<td></td>
<td><strong>75 minutes</strong></td>
</tr>
</tbody>
</table>
Emergency Care Planning

There are many different interventions that home care agencies may use as they strive to achieve the national goal for reducing avoidable acute care hospitalizations. Some of the interventions may stand alone, but the majority of them are more effective if used with other interventions. Emergency care planning is one of the interventions that complement the use of a hospitalization risk assessment. A hospitalization risk assessment provides the foundation for recognizing which patients are at risk and identify specific risk factors. Knowing the patient’s risk factors will assist a clinician in developing a more specific patient emergency plan.

In this package we will be talking about two similar, but different terms – emergency care planning and patient emergency plan.

**Emergency Care Planning**

Definition: The established agency process that includes all activities, tools and policies/procedures used to assist clinicians with educating patients on what actions to take if a medical problem or change in condition occurs. Emergency care planning assists the patient in determining who, what, where, when, why and how to respond to changes in health status. Agencies can then utilize patient-centered interventions to try to keep the patient at home or recommend the most appropriate care setting for the patient.

**Patient Emergency Plan**

Definition: A home health patient’s emergency plan is a written plan that helps a patient to identify emergent health problems and to determine whom to call to obtain care for the problem, either home care agency or EMS. The patient emergency plan is a significant part of emergency care planning.

Simply, emergency care planning is the overall process and the patient emergency plan is a specific patient tool.

Components of emergency care planning can include:

- Patient emergency plan
- Magnets or stickers for the phone with HHA name and number
- Posters or flyers for the patient that serve as reminders to call the agency first before seeking emergent care, except in case of true emergencies
- Posters or flyers in the office as reminders to staff about emergency care planning
- Documentation reminders (paper based or electronic) to educate on the patient emergency plan and to document the education
- Processes for handling patient calls during regular hours and after hours (e.g., on-call system)
- Processes, procedures and guidelines to support emergency care planning
Education on the patient emergency plan is crucial to the success of this intervention. The education should be started by the admitting clinician, but should not stop there. Think about all the paperwork and instructions clinicians are required to give or ask patients on SOC visits – it is overwhelming to the clinicians, let alone the patient and caregivers. Therefore, teaching on the first visit will not be very fruitful. Start with the basics – agency hours and phone number. On subsequent visits, continue to educate and build upon the groundwork you laid during the first visit – working simple to complex!

The medical social worker’s expertise and insight can add valuable information to the emergency care planning for the patient and family.

**Medical Social Worker**

<table>
<thead>
<tr>
<th>Identify potential problems on Patient Emergency Plan such as:</th>
<th>Sample areas of emergency care planning that medical social workers can address:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Trouble thinking</td>
<td>• Work with families/caregivers to determine differences related to patient’s confusion and forgetfulness</td>
</tr>
<tr>
<td>• Weight or appetite change</td>
<td>• Loss of appetite, especially if the underlying cause is psychosocial</td>
</tr>
<tr>
<td>• I am anxious or depressed</td>
<td>• More specific terms to this area of the patient emergency plan and plan specific interventions</td>
</tr>
</tbody>
</table>

The purpose of emergency care planning is more than just giving the patient a tool, documenting that it was completed and tucking it away in the patient’s folder. It can reduce the physical and psychological stress for the patient with frequent exacerbations of their medical conditions and time away from home, if they use the tool timely. Emergency care planning is an intervention that can help reduce avoidable acute care hospitalizations, keeping patients at home, where they want to be.

“When faced with a problem, people apply whatever skills they have, whether or not those skills are appropriate to the situation...”

- Marshall Becker, PhD, Professor of Health Education  
University of Michigan

**Provide the patient/caregivers with appropriate tools!**
**Audio Recordings**

**Instructions:**
Listen to the audio recording to learn more about reducing avoidable acute care hospitalizations and the use of emergency care planning. A sample patient emergency plan is on the next page.

<table>
<thead>
<tr>
<th>Title</th>
<th>Description</th>
<th>Link</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Care Planning for Clinicians</td>
<td>A 15-minute audio recording that can be used by clinicians in staff/team meetings or while traveling in the car.</td>
<td>The audio link is located at [<a href="http://www.homehealthquality.org">www.homehealthquality.org</a> hh/ha/interventionpackages/ecp.aspx](<a href="http://www.homehealthquality.org">http://www.homehealthquality.org</a> hh/ha/interventionpackages/ecp.aspx)</td>
</tr>
</tbody>
</table>

There are several ways to listen to the audio recording:
- Visit the link above and listen directly through the Web site.
- Download the audio recording by right-clicking on the audio file and selecting “Save Target As...”. This will save the file to your hard drive. Once you have saved the file, you can listen to it on your computer or you can burn the audio file to a CD to listen to in your car or stereo.

“By providing patients with clear directions to follow prior to an unexpected event occurring, significant amounts of anxiety can be avoided. If a patient's need can be addressed through interventions in the home, the need can be potentially minimized to prevent a more serious condition and can save the patient from a lengthy ER visit and hospital stay.”

Linda K. Wankel, RN
Director of Nursing
McKean County VNA & Hospice
**MY EMERGENCY PLAN**

<table>
<thead>
<tr>
<th>WHAT TO DO?</th>
<th>CALL MY HOME HEALTH AGENCY WHEN:</th>
<th>CALL 911 WHEN:</th>
</tr>
</thead>
</table>
| **I hurt**  | • New pain OR pain is *worse* than usual  
• Unusual bad headache  
• Ears are ringing  
• My blood pressure is above: _____/_____  
• Unusual low back pain  
• Chest pain or tightness of chest RELIEVED by rest or medication | • Severe or prolonged pain  
• Pain/discomfort in neck, jaw, back, one or both arms, or stomach  
• Chest discomfort with sweating/nausea  
• Sudden severe unusual headache  
• Sudden chest pain or pressure & medications don’t help (e.g. Nitroglycerin as ordered by physician), OR  
• Chest pain went away & came back |
| **I have trouble breathing** | • Cough is worse  
• Harder to breathe when I lie flat  
• Chest tightness RELIEVED by rest or medication  
• My inhalers don’t work  
• Changed color, thickness, odor of sputum (spit) | • I can’t breathe!  
• My skin is gray OR fingers/lips are blue  
• Fainting  
• Frothy sputum (spit) |
| **I have fever or chills** | • Fever is above ________ F  
• Chills/can’t get warm | • Fever is above ________ F with chills, confusion or difficulty concentrating |
| **Trouble moving or fell** | • Dizziness or trouble with balance  
• Fell and hurt myself  
• Fell but didn’t hurt myself | • Fell and have severe pain |

This plan is a guide only and may not apply to all patients and/or situations. This plan is not intended to override patient/family decisions in seeking care.

Developed by Quality Insights of Pennsylvania in conjunction with Carol Siebert, MS, OTR/L, FAOTA, American Occupational Therapy Association and Karen Vance, OTR/L, BKD Healthcare Group and American Occupational Therapy Association. Based on MyEmergency Plan created by Delmarva in conjunction with OASIS Answers, Inc.
Patient Name _______________________

<table>
<thead>
<tr>
<th>WHAT TO DO?</th>
<th>CALL MY HOME HEALTH AGENCY WHEN:</th>
<th>CALL 911 WHEN:</th>
</tr>
</thead>
<tbody>
<tr>
<td>I see blood</td>
<td>• Bloody, cloudy, or change in urine color or foul odor</td>
<td>• Bleeding that won’t stop</td>
</tr>
<tr>
<td></td>
<td>• Gums, nose, mouth or surgical site bleeding</td>
<td>• Bleeding with confusion, weakness, dizziness and fainting</td>
</tr>
<tr>
<td></td>
<td>• Unusual bruising</td>
<td>• Throwing up bright red blood or it looks like coffee grounds</td>
</tr>
<tr>
<td>Trouble thinking</td>
<td>• Confused</td>
<td>• Sudden difficulty speaking</td>
</tr>
<tr>
<td></td>
<td>• Restless, agitated</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Can’t concentrate</td>
<td></td>
</tr>
<tr>
<td>My weight or appetite changed</td>
<td>• I don’t have an appetite</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Lost ____ lbs in ______ days</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Gained ___ lbs in 1 day OR ___ lbs in ___ days</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Feet/ankles/legs are swollen</td>
<td></td>
</tr>
<tr>
<td>I don’t feel right</td>
<td>• Weaker than usual</td>
<td>• Sudden numbness or weakness of the face, arm or leg</td>
</tr>
<tr>
<td></td>
<td>• Dizzy, lightheaded, shaky</td>
<td>• Sudden difficulty speaking/slurred words</td>
</tr>
<tr>
<td></td>
<td>• Very tired</td>
<td>• Suddenly can’t keep my balance</td>
</tr>
<tr>
<td></td>
<td>• Heart fluttering, skipping or racing</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Blurred vision</td>
<td></td>
</tr>
<tr>
<td>I feel sick to my stomach</td>
<td>• Throwing up</td>
<td>• Can’t stop throwing up</td>
</tr>
<tr>
<td></td>
<td>• New coughing at night</td>
<td>• Throwing up blood</td>
</tr>
</tbody>
</table>
# WHAT TO DO?

<table>
<thead>
<tr>
<th>CALL MY HOME HEALTH AGENCY WHEN:</th>
<th>CALL 911 WHEN:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Bowel troubles</strong></td>
<td></td>
</tr>
<tr>
<td>• Diarrhea</td>
<td></td>
</tr>
<tr>
<td>• Black/dark OR bloody bowel movement</td>
<td></td>
</tr>
<tr>
<td>• No bowel movement in _____ days</td>
<td></td>
</tr>
<tr>
<td>• No colostomy/ileostomy output in _______hours/days</td>
<td></td>
</tr>
<tr>
<td><strong>Trouble urinating</strong></td>
<td></td>
</tr>
<tr>
<td>• Leaking catheter</td>
<td></td>
</tr>
<tr>
<td>• No urine from catheter in _____ hours</td>
<td></td>
</tr>
<tr>
<td>• Have not passed water in _____ hours</td>
<td></td>
</tr>
<tr>
<td>• Urine is cloudy</td>
<td></td>
</tr>
<tr>
<td>• Burning feeling while urinating</td>
<td></td>
</tr>
<tr>
<td>• Belly feels swollen or bloated</td>
<td></td>
</tr>
<tr>
<td><strong>I am anxious or depressed</strong></td>
<td>I have a plan of hurting myself or someone else</td>
</tr>
<tr>
<td>• Always feeling anxious</td>
<td></td>
</tr>
<tr>
<td>• Loss of appetite</td>
<td></td>
</tr>
<tr>
<td>• Unable to concentrate</td>
<td></td>
</tr>
<tr>
<td>• Trouble sleeping</td>
<td></td>
</tr>
<tr>
<td>• Loss of hope</td>
<td></td>
</tr>
<tr>
<td>• Constant sadness</td>
<td></td>
</tr>
<tr>
<td><strong>My wound changed</strong></td>
<td>Fever is above _______ F with chills, confusion or difficulty concentrating</td>
</tr>
<tr>
<td>• Change in drainage amount, color or odor</td>
<td></td>
</tr>
<tr>
<td>• Increase in pain at wound site</td>
<td>Bleeding that won’t stop</td>
</tr>
<tr>
<td>• Increase in redness/warmth at wound site</td>
<td></td>
</tr>
<tr>
<td>• New skin problem</td>
<td></td>
</tr>
<tr>
<td>• Fever is above _______F</td>
<td></td>
</tr>
</tbody>
</table>

[Agency Name & Agency Phone Number]

Patient Name _______________________

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<table>
<thead>
<tr>
<th>WHAT TO DO?</th>
<th>CALL MY HOME HEALTH AGENCY WHEN:</th>
<th>CALL 911 WHEN:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Thirsty or hungry more than usual</td>
<td>• Fruity breath</td>
</tr>
<tr>
<td></td>
<td>• Urinating a lot</td>
<td>• Nausea/throwing up</td>
</tr>
<tr>
<td></td>
<td>• Vision is blurred</td>
<td>• Difficulty breathing</td>
</tr>
<tr>
<td></td>
<td>• I'm feeling weak</td>
<td>• Blood sugar greater than ______mg/dl</td>
</tr>
<tr>
<td></td>
<td>• My skin is dry and itchy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Repeated blood sugars greater than ______mg/dl</td>
<td></td>
</tr>
<tr>
<td>I have Diabetes and I'm . . .</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Shaky</td>
<td>Take: 3 glucose tablets, OR ½ glass of juice, OR 5-6 pieces of hard candy, OR</td>
</tr>
<tr>
<td></td>
<td>• Sweating</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Extreme tiredness</td>
<td>Wait: 15 minutes &amp; re-check blood sugar</td>
</tr>
<tr>
<td></td>
<td>• Hungry</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Have a headache</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Confusion</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Heart is beating fast</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Trouble thinking, confused or irritable</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Vision is different</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Repeated blood sugars less than ______mg/dl</td>
<td></td>
</tr>
<tr>
<td>Other problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Feeding Tube clogged</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Problems with my IV/site</td>
<td></td>
</tr>
</tbody>
</table>

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Emergency Care Planning
Medical Social Worker’s Guide to Practical Application

Purpose: To assist the medical social workers with reinforcing emergency care planning with the patient and his/her family or caregiver.

- Determine if patient has a phone
- Evaluate patient’s physical and cognitive ability to:
  - Access the phone
  - Successfully place a call to the agency and/or to 911
  - Effectively communicate with the other party
  - Consider programming the HHA phone number into patient’s phone if possible and with patient/caregiver permission
- Assess patient and/or caregiver’s ability to understand the patient’s emergency plan
- Assess for factors that can impact the patient’s status that may interfere with emergency care planning (e.g. inability to perform ADLs or make meals)
- Assess support and caregiving situation based on potential emergency situations for patient, especially if patient lives alone
- Assess for potential safety or environmental issues that could disrupt emergency care planning
- Review and document patient’s emergency plan on each MSW visit and identify areas that need medical social worker intervention
- Educate additional family members not in the home on the patient emergency plan
- Initiate a discussion with patient/caregiver regarding patient’s understanding of emergent situations versus when to call the home health agency
- Assist patient/caregiver with additional support systems to provide for patient’s participation with emergency plan (e.g. Lifeline, daily or more frequent phone calls or visits from family/friend if patient is a live alone)
- Assist patient/caregiver with medication management, since a significant number of hospitalizations are related to medication issues
- Evaluate patient/caregiver cognitive status for potential issues that could impact their ability to remain at home safely
Contribute in patient case conferences to discuss patient/caregiver’s participation with emergency care planning and offer expertise in supporting patient/caregiver participation.

Communicate potential issues and possible solutions to staff, managers and physicians.

Participate in agency education programs, sharing expertise related to:
- patient adherence issues
- home safety evaluation
- identification of environmental hazards
- community resources
- cognitive assessments
- anxiety/depression
- stress reduction
- patient medication resources
Clinicians can utilize many different adult learning principles for education. Several of Jane Vella’s (Learning to Listen Learning to Teach, 1994. San Francisco: Josey-Bass, Inc. Publication) are provided in the table below with an application to emergency care planning.

<table>
<thead>
<tr>
<th>Adult Learning Principle</th>
<th>Application</th>
</tr>
</thead>
</table>
| **Reinforcement**        | • Older adults need teaching reinforced more than two or three times  
                          • Imperative to review the patient’s emergency plan and agency phone numbers more than just on SOC and ROC |
| **Engagement**           | • Include patient/caregiver/family in the development of the patient’s emergency plan  
                          • Personalize the plan with physician ordered parameters and with completion of the “Other” section of the tool with patient/caregiver concerns |
| **Sequencing**           | • Start with simple information such as the agency’s phone number and hours of availability (avoid overwhelming patient/caregiver)  
                          • Progress to details of the patient’s emergency plan on subsequent visits |
| **Immediacy**            | • Link the importance of the patient emergency plan with the patient’s recent hospitalization  
                          • Review the patient’s admitting signs and symptoms and coach the patient selecting identify options on the patient emergency plan |
| **Relevance**            | • The emergency plan is a patient-centered tool to be used to help keep the patient at home  
                          • Discuss with patient/caregiver their goals for home care at start of care and throughout the episode |
Tennessee Agency’s Emergency Plan Helps Improve Patient Care

Sometimes it’s a simple thing that provides a solution to a tricky problem. Medical Center Homecare Services in Johnson City has instituted a number of new programs and processes in recent years to lower its acute care hospitalization (ACH) rate. To illustrate, the agency increased educational resources for patients aimed at reducing ACH and also focused on recruitment, retention and recognition of staff. Both of those efforts resulted in more informed patients and improved morale and productivity among staff.

Performance Improvement Coordinator, Julie Sharp, said what’s recently made a real difference in tackling ACH reduction is the placement of a simple sticker on the front of folders left in patients’ homes. The stickers state “call us first,” in capital letters and it includes the agency’s phone number,” said Sharp, who is also a registered nurse. Staff also stress to patients that if they are feeling worse, they should give the agency a call before heading to the emergency room (ER). “It seems really simple,” she said. But adding this intervention in combination with other agency efforts seems to be paying off.

The agency attends roundtable meetings sponsored by QSource, the state’s Medicare Quality Improvement Organization, which are a “huge benefit in networking and sharing ideas with other home health agencies,” Sharp said. “Staff is always there to help with resources that assist us with our ACH rate, and always there with an answer to my questions,” she added.

The idea for the emergency care plan sticker came from Johnson City’s medical director, a physician who was a member of a focus group formed by the agency to work on reducing ACH. As a doctor working with the agency, he told members of the focus group that some of the agency’s patients were calling his office or going directly to the ER, and the ER would then contact him about his patient. He quickly recognized that often the patient’s condition could have been treated and/or addressed through a visit by home health staff.

Sharp said examples of what may typically happen is that a patient may notice additional swelling in his or her feet, experience a two-pound weight gain in one day or even panic because he or she gets a little short of breath. Patients experiencing these symptoms end up in the ER, when home health intervention may have been the better option. “We could have prevented it, gone to the home, called the doctor, and made a medication change,” she said.

Typically the first person to educate the patient and explain the purpose of the sticker is a nurse or therapist, Sharp explained. This takes place when the staff person makes the initial visit, and is reinforced on subsequent visits. Home health staff—typically nurses, and occasionally home health aides—reiterate the importance of calling the agency first with health concerns. Patients find this approach reassuring. “They know that there’s a nurse available 24 hours a day,
seven days a week,” she said. “Even in the middle of the night, and on the weekends, [we tell them], ‘don’t hesitate to call because there is always somebody available.’”

On call coordinators have also played a significant role in helping to reduce ACH. The coordinators triage phone calls after hours and if the patient needs to be seen, the coordinators notify the nurses on call to see that patient, said Sharp. The coordinators make sure the on call nurses haven’t worked during the day so they are sharp and ready to go. In addition, because of the new focus on ACH reduction in recent years, coordinators are better educated about patients’ conditions and what “emergencies” may actually be treated in the home setting.

The agency’s ACH rate is currently at its lowest point in years, according to Sharp. December 2006 CASPER data shows an ACH rate of 25.68 percent (January 2006 to December 2006 reporting period); this compares with 31.6 percent in November 2005. (The eligible number of cases or patients that could potentially be hospitalized for the 2006 period was 2,485.)

In addition to the “call us first” campaign, Johnson City has also found success in recent years by utilizing a congestive heart failure (CHF) disease management program. Launched at the agency in 2003, the program provides CHF patients with telehealth monitoring equipment that transmits vital signs, such as weight and blood pressure readings to a call center in Atlanta, Georgia. If their weight has increased or their blood pressure has elevated, the patient is called, and registered nurses who work at the telehealth center in Atlanta follow orders written specifically for the patient. Sharp said the agency plans to implement a similar diabetes disease management program in the future.

“It’s truly a team effort, and the entire team finds pleasure in watching our ACH rate decline,” Sharp said.

Data in this article was provided by Julie Sharp, Medical Center Homecare Services.

“We would rather have the patients call us first and allow a clinician to assess them before just going into the ER… and if we have to, we will send them to the ER. Many times we provide intervention at home and keep the patient at home.”

Jane Andrews, RN
Disease Management
Medical Center Homecare Services
Iowa Home Health Agency Thinks “Pink,” and Reduces Avoidable Hospitalizations with Improved Emergency Care Plans

Iowa’s Pocahontas Community Hospital – Home Health is working to create a health care system that ensures each person receives the right care at the right time by: increasing patient and caregiver satisfaction, improving health outcomes and reducing avoidable hospitalizations. The agency was recognized in 2006 as a home health “superstar” by the Iowa Foundation for Medical Care (IFMC), the state’s Medicare Quality Improvement Organization.

The national hospitalization rate for home health patients has been steadily rising over the past three years. The Centers for Medicare & Medicaid Services (CMS), in recent years, set a national target of reducing the home health acute care hospitalization (ACH) rate to 23 percent CASPER data. Pocahontas Community has not only achieved this goal, but has also already surpassed it with an ACH rate of 21 percent.

Pocahontas Community’s reduction in ACH shows a leadership and staff commitment to improving the quality of health care provided to patients. Based on various quality measures, the agency is providing more effective care and saving Medicare dollars, according to IFMC’s Medical Director, Tim Gutshall.

To reduce avoidable hospitalizations, physicians and home care agencies must continuously communicate and address patient problems and care needs both efficiently and effectively. “We have provided additional staff, patient and family education, and introduced new emergency care plans and call sheets to help reduce the number of hospitalizations,” said Judy Schmidt, Pocahontas Community’s project’s leader and case manager. “Our patients want to be at home and we are working hard to keep them there.”

More specifically, the agency in June 2006 began using a patient emergency care plan that is reviewed with all patients at start of care and resumption of care. The plan is left in the home for the patient to use. The plan includes the agency name and phone number, and lists problems or conditions; including diabetes, infection, heart/lung problems, etc. To illustrate, under “diabetic problems” signs and symptoms that are listed include: sudden weakness or dizziness, uncontrollable thirst or hunger, blurred vision, sweating spells and frequent headaches.

Home health nurses complete the emergency care plan with the patient and/or family during the initial evaluation. The clinicians discuss various problem areas with the patient, and provide examples of when the patient should call the agency or when it is more appropriate to go to the emergency room. The emergency care plan also includes information for patients to assist them in determining when they should call 911. Conditions listed in that category include a fall resulting in a broken bone or bleeding, chest pain that is not relieved by medication, and signs or symptoms of a stroke (including a sudden weakness on one side and difficulty with speech).
In addition to the emergency care plan forms, nurses also continue to leave emergency information sheets with patients. The 8.5 by 11 sheet—which is posted on the patient’s refrigerator—includes the agency name and phone numbers in large, bold font which also provides an area to write in the names of the nurse, physician and hospital. To make the emergency information sheet more noticeable for the patient, staff decided to print the form on hot pink paper (a sample emergency information sheet is available on the HHQI website for home health agencies to utilize).

Nurses review both the emergency care plan and emergency information sheet at the start of care, resumption of care, and at re-certification. Schmidt said the simple change from plain white paper to hot pink appears to be making a difference. Prior to changing to the brightly colored form, Schmidt said most clients would merely answer, “yes,” when asked if they knew how to get in touch with the agency. Now, patients or clients all refer to the “pink sheet.”

Agencies that want to reduce ACH and improve outcomes can include the use of the emergency care plan as an intervention. As part of the agency’s goals, Schmidt said that it is imperative to beef up the agency’s education. It is the continuing education component of the emergency care planning process that is perhaps even more important than new forms. “We’ve improved [because of] the education,” she said. “I always say, ‘educate, educate, educate’ the client on calling us.”

Hospital leaders express pride when asked about the success of the facility’s home health services. “We strive to provide the highest quality of care for our community, said CEO James Roetman, Pocahontas Community Hospital. “I am proud of the ongoing quality improvement efforts of our Home Care staff,” he concluded.

Data in this article was provided by Judy Schmidt, Pocahontas Community Hospital – Home Health.
Investigating Resources

Information about the HHQI campaign, including the Best Practice Intervention Packages and additional resources, can be found on the HHQI Web site. This exercise provides an opportunity to explore this comprehensive site. To complete this investigation activity you will need access to a computer and the Internet.

**HHQI Web Site Investigation Activities**

<table>
<thead>
<tr>
<th>Task</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Go to the HHQI National Campaign home page at:</td>
<td><a href="http://www.homehealthquality.org">www.homehealthquality.org</a></td>
</tr>
<tr>
<td>Find and record the approximate number of home health agencies that have registered to participate in the campaign as of today.</td>
<td>_________________</td>
</tr>
<tr>
<td>What home health agency is the current agency of the month?</td>
<td>_________________</td>
</tr>
<tr>
<td>On the home page, click on the Quick Link “Campaign Registration Report.” Find the percentage of home health agencies that are registered as participants in the HHQI National Campaign in your state. My state has ______ percentage of home health agencies participating.</td>
<td></td>
</tr>
<tr>
<td>Locate the page where the campaign goal is explained. Using the table on that page, answer the following question: If your agency’s baseline ACH rate is 25%, what would the 5% relative improvement goal be?</td>
<td>_________________</td>
</tr>
<tr>
<td>Go to the For Home Health Agencies page, then the Intervention Package page. Find the schedule for the Best Practice Intervention Packages. The topic for June 2007 is _______________________. (Hint: Scroll down)</td>
<td></td>
</tr>
<tr>
<td>Navigate to the Resources page. Find the “OASIS Accuracy Support Packet for ACH” created by the Oasis Competency and Certification Board (OCCB). Read pages 1 – 4 of the document. You may want to print and keep.</td>
<td></td>
</tr>
<tr>
<td>Using the left navigation bar, go to the HHQI Summit page. Locate one of the four patient vignettes. View one of the vignettes. (You may want to watch all four of them!)</td>
<td></td>
</tr>
<tr>
<td>Go to the How to Get Involved page. Read about what a campaign supporter is and how to register. What will you receive if you sign up to be a campaign supporter? A monthly _________________. You are welcome to register as a campaign supporter at this time.</td>
<td></td>
</tr>
</tbody>
</table>
1. This is a written patient-centered plan that defines what the patient is to do in case of an emergency. The plan includes a range of signs and symptoms to report to the agency versus when it is more appropriate to call 911:
   a. Emergency Care Planning
   b. Patient Emergency Plan

2. Emergency Care Planning includes all of the following, **except**:
   a. Patient emergency plan
   b. Magnets and phone stickers
   c. Hospitalization Risk Assessment
   d. On-call policies and procedures

3. A patient emergency plan should **ideally** be reviewed at:
   a. Start of care and resumption of care only
   b. Recertification only
   c. Discharge only
   d. Every visit

4. Emergency care planning is an intervention that should be completed by all disciplines (interdisciplinary).
   a. True
   b. False

5. A Medical Social Worker can assist with emergency care planning by:
   a. Educating additional family/caregivers not in the home on the patient emergency plan
   b. Assisting patient/caregiver to access additional support and resources to enhance patient’s participation with emergency plan
   c. Participating in agency education programs, sharing expertise related to: patient adherence issues, home safety evaluation, the identification of environmental hazards, community resources, cognitive assessments, anxiety/depression assessment, stress reduction and patient medication accessing support
   d. All of the above
Best Practice:
Emergency Care Planning

Home Health Aide
Track
Home Health Aide Track

This best practice package is designed to introduce the home health aide to emergency care planning to assist in reducing avoidable acute care hospitalizations.

Objectives

After completing the activities in the Home Health Aide track of this Best Practice Intervention Package – Emergency Care Planning, the learner will be able to:

1. Identify three basic components of emergency care planning.
2. Define what a patient emergency plan is and how to use the plan with patients.
3. Describe how home health aides can assist with emergency care planning.
4. Describe two home health aide action or applications to support emergency care planning.

Complete the following:

<table>
<thead>
<tr>
<th>Activity</th>
<th>Location</th>
<th>Estimated Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Read the emergency care planning description and review the sample “My Emergency Plan”</td>
<td>Pages 100, 101</td>
<td>15 minutes</td>
</tr>
<tr>
<td>☐ Listen to the audio recording: Emergency Care Planning for Home Health Aides and utilize the discussion points</td>
<td>Pages 105</td>
<td>15 minutes</td>
</tr>
<tr>
<td>☐ Read the Emergency Care Planning – Home Health Aide’s Guide to Practical Application</td>
<td>Page 106</td>
<td>10 minutes</td>
</tr>
<tr>
<td>☐ Read the success story</td>
<td>Page 107</td>
<td>5 minutes</td>
</tr>
<tr>
<td>☐ Complete the home health aide post-test and give it to your manager</td>
<td>Page 109</td>
<td>15 minutes</td>
</tr>
</tbody>
</table>

Total Time 60 minutes
Emergency Care Planning

There are numerous interventions that can be used to assist in reducing avoidable acute care hospitalizations. In the first Best Practice Intervention package we learned about using a hospitalization risk assessment to help recognize which patients are at risk and how to identify specific risk factors. The next intervention is emergency care planning.

Emergency care planning is the agency process for all activities, tools and policies/procedures to assist clinicians with educating patients on whom to call if a medical problem or change in condition occurs.

Components of emergency care planning can include the following:

- **A patient emergency plan**
  - Written plan with signs and symptoms or medical conditions and directions on whom should be called (e.g. the agency versus 911)
  - Personalized for each patient
  - Kept in the patient’s home where it is easy to locate
  - Reviewed often with patient
- Magnets and/or phone stickers with the home health agency’s name and phone number
- Posters or flyers to remind the patient/caregiver to call the agency first before going to the emergency department, unless it is a true emergency
- Posters or flyers in the agency’s office as reminders to staff about emergency care planning
- Documentation reminders to review the patient emergency plan with patient/caregiver and to document the education
- On-call process – after business hours, weekends and/or holidays
- Agency policies and processes to support emergency care planning

Reviewing and educating on the patient emergency plan is important to the success of this intervention. The education should be started by the admitting nurse or therapist, but should not stop there. The more members of the care team who participate in reinforcing emergency care planning – the better.

Every discipline should review the patient emergency plan with the patient and/or caregiver on every visit throughout the episode of care. This should help most of the patients and/or caregivers learn how to use the tool. Home health aides are very skilled at talking to patients at their own level, and can help in reinforcing the importance of the plan. The more the patient emergency plan is reviewed the greater the chance of keeping the patient at home and out of the hospital.

Look at the sample “**My Emergency Plan**” on the next page.
### MY EMERGENCY PLAN

<table>
<thead>
<tr>
<th>WHAT TO DO?</th>
<th>CALL MY HOME HEALTH AGENCY WHEN:</th>
<th>CALL 911 WHEN:</th>
</tr>
</thead>
</table>
| **I hurt**  | - New pain OR pain is *worse* than usual  
- Unusual bad headache  
- Ears are ringing  
- My blood pressure is above: _____/_____  
- Unusual low back pain  
- Chest pain or tightness of chest RELIEVED by rest or medication | - Severe or prolonged pain  
- Pain/discomfort in neck, jaw, back, one or both arms, or stomach  
- Chest discomfort with sweating/nausea  
- Sudden severe unusual headache  
- Sudden chest pain or pressure & medications don’t help (e.g. Nitroglycerin as ordered by physician), OR  
- Chest pain went away & came back |
| **I have trouble breathing** | - Cough is worse  
- Harder to breathe when I lie flat  
- Chest tightness RELIEVED by rest or medication  
- My inhalers don’t work  
- Changed color, thickness, odor of sputum (spit) | - I can’t breathe!  
- My skin is gray OR fingers/lips are blue  
- Fainting  
- Frothy sputum (spit) |
| **I have fever or chills** | - Fever is above _______ F  
- Chills/can’t get warm | - Fever is above _______ F with chills, confusion or difficulty concentrating |
| **Trouble moving or fell** | - Dizziness or trouble with balance  
- Fell and hurt myself  
- Fell but didn’t hurt myself | - Fell and have severe pain |

This plan is a guide only and may not apply to all patients and/or situations. This plan is not intended to override patient/family decisions in seeking care.

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Developed by Quality Insights of Pennsylvania in conjunction with Carol Siebert, MS, OTR/L, FAOTA, American Occupational Therapy Association and Karen Vance, OTR/L, BKD Healthcare Group and American Occupational Therapy Association. Based on MyEmergency Plan created by Delmarva in conjunction with OASIS Answers, Inc.
[Agency Name & Agency Phone Number]
Patient Name _______________________

<table>
<thead>
<tr>
<th>WHAT TO DO?</th>
<th>CALL MY HOME HEALTH AGENCY WHEN:</th>
<th>CALL 911 WHEN:</th>
</tr>
</thead>
<tbody>
<tr>
<td>I see blood</td>
<td>• Bloody, cloudy, or change in urine color or foul odor&lt;br&gt;• Gums, nose, mouth or surgical site bleeding&lt;br&gt;• Unusual bruising</td>
<td>• Bleeding that won’t stop&lt;br&gt;• Bleeding with confusion, weakness, dizziness and fainting&lt;br&gt;• Throwing up bright red blood or it looks like coffee grounds</td>
</tr>
<tr>
<td>Trouble thinking</td>
<td>• Confused&lt;br&gt;• Restless, agitated&lt;br&gt;• Can’t concentrate</td>
<td>• Sudden difficulty speaking</td>
</tr>
<tr>
<td>My weight or appetite changed</td>
<td>• I don’t have an appetite&lt;br&gt;• Lost ____ lbs in ______ days&lt;br&gt;• Gained ____ lbs in 1 day OR ____ lbs in ___ days&lt;br&gt;• Feet/ankles/legs are swollen</td>
<td></td>
</tr>
<tr>
<td>I don’t feel right</td>
<td>• Weaker than usual&lt;br&gt;• Dizzy, lightheaded, shaky&lt;br&gt;• Very tired&lt;br&gt;• Heart fluttering, skipping or racing&lt;br&gt;• Blurred vision</td>
<td>• Sudden numbness or weakness of the face, arm or leg&lt;br&gt;• Sudden difficulty speaking/slurred words&lt;br&gt;• Suddenly can’t keep my balance</td>
</tr>
<tr>
<td>I feel sick to my stomach</td>
<td>• Throwing up&lt;br&gt;• New coughing at night</td>
<td>• Can’t stop throwing up&lt;br&gt;• Throwing up blood</td>
</tr>
</tbody>
</table>

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### WHAT TO DO?

<table>
<thead>
<tr>
<th>CALL MY HOME HEALTH AGENCY WHEN:</th>
<th>CALL 911 WHEN:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Bowel troubles</strong></td>
<td></td>
</tr>
<tr>
<td>• Diarrhea</td>
<td></td>
</tr>
<tr>
<td>• Black/dark OR bloody bowel movement</td>
<td></td>
</tr>
<tr>
<td>• No bowel movement in _____ days</td>
<td></td>
</tr>
<tr>
<td>• No colostomy/ileostomy output in _______hours/days</td>
<td></td>
</tr>
<tr>
<td><strong>Trouble urinating</strong></td>
<td></td>
</tr>
<tr>
<td>• Leaking catheter</td>
<td></td>
</tr>
<tr>
<td>• No urine from catheter in _____ hours</td>
<td></td>
</tr>
<tr>
<td>• Have not passed water in _____ hours</td>
<td></td>
</tr>
<tr>
<td>• Urine is cloudy</td>
<td></td>
</tr>
<tr>
<td>• Burning feeling while urinating</td>
<td></td>
</tr>
<tr>
<td>• Belly feels swollen or bloated</td>
<td></td>
</tr>
<tr>
<td><strong>I am anxious or depressed</strong></td>
<td></td>
</tr>
<tr>
<td>• Always feeling anxious</td>
<td></td>
</tr>
<tr>
<td>• Loss of appetite</td>
<td>I have a plan of hurting myself or someone else</td>
</tr>
<tr>
<td>• Unable to concentrate</td>
<td></td>
</tr>
<tr>
<td>• Trouble sleeping</td>
<td></td>
</tr>
<tr>
<td>• Loss of hope</td>
<td></td>
</tr>
<tr>
<td>• Constant sadness</td>
<td></td>
</tr>
<tr>
<td><strong>My wound changed</strong></td>
<td></td>
</tr>
<tr>
<td>• Change in drainage amount, color or odor</td>
<td></td>
</tr>
<tr>
<td>• Increase in pain at wound site</td>
<td></td>
</tr>
<tr>
<td>• Increase in redness/warmth at wound site</td>
<td></td>
</tr>
<tr>
<td>• New skin problem</td>
<td>Fever is above _______ F with chills, confusion or difficulty concentrating</td>
</tr>
<tr>
<td>• Fever is above _______F</td>
<td>Bleeding that won’t stop</td>
</tr>
</tbody>
</table>

This plan is a guide only and may not apply to all patients and/or situations. This plan is not intended to override patient/family decisions in seeking care.
<table>
<thead>
<tr>
<th>WHAT TO DO?</th>
<th>CALL MY HOME HEALTH AGENCY WHEN:</th>
<th>CALL 911 WHEN:</th>
</tr>
</thead>
<tbody>
<tr>
<td>I have Diabetes and I’m . . .</td>
<td>Thirsty or hungry more than usual</td>
<td>Fruity breath</td>
</tr>
<tr>
<td></td>
<td>Thirsty or hungry more than usual</td>
<td>Nausea/throwing up</td>
</tr>
<tr>
<td></td>
<td>Urinating a lot</td>
<td>Difficulty breathing</td>
</tr>
<tr>
<td></td>
<td>Vision is blurred</td>
<td>Blood sugar greater than ( \text{________}_{\text{mg/dl}} )</td>
</tr>
<tr>
<td></td>
<td>I’m feeling weak</td>
<td></td>
</tr>
<tr>
<td></td>
<td>My skin is dry and itchy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Repeated blood sugars greater than ( \text{________}_{\text{mg/dl}} )</td>
<td></td>
</tr>
<tr>
<td>Other problems</td>
<td>Shaky</td>
<td>Low blood sugar not responding to treatment</td>
</tr>
<tr>
<td></td>
<td>Sweating</td>
<td>Unable to treat low blood sugar at home</td>
</tr>
<tr>
<td></td>
<td>Extreme tiredness</td>
<td>Unconsciousness</td>
</tr>
<tr>
<td></td>
<td>Hungry</td>
<td>Seizures</td>
</tr>
<tr>
<td></td>
<td>Have a headache</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Confusion</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Heart is beating fast</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Trouble thinking, confused or irritable</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Vision is different</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Repeated blood sugars less than ( \text{________}_{\text{mg/dl}} )</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Take: 3 glucose tablets, OR</td>
<td></td>
</tr>
<tr>
<td></td>
<td>( \frac{1}{2} ) glass of juice, OR</td>
<td></td>
</tr>
<tr>
<td></td>
<td>5-6 pieces of hard candy, OR</td>
<td></td>
</tr>
<tr>
<td></td>
<td>________________</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Wait: 15 minutes &amp; re-check blood sugar</td>
<td></td>
</tr>
<tr>
<td></td>
<td>IF your blood sugar is still low</td>
<td></td>
</tr>
<tr>
<td></td>
<td>and symptoms do not go away: Eat a light snack:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>( \frac{1}{2} ) peanut butter OR</td>
<td></td>
</tr>
<tr>
<td></td>
<td>meat sandwich, ( \frac{1}{2} ) glass milk</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Wait: 15 minutes &amp; re-check blood sugar</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Feeding Tube clogged</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Problems with my IV/site</td>
<td></td>
</tr>
</tbody>
</table>
Audio Recordings

Listen to the audio recording to learn more about reducing avoidable acute care hospitalizations and the use of emergency care planning. A sample patient emergency plan is on the next page.

<table>
<thead>
<tr>
<th>Title</th>
<th>Description</th>
<th>Link</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Care Planning for Home Health Aides</td>
<td>A 10-minute audio recording that can be used by home health aides in staff/team meetings or while traveling in the car. A few discussion points are included.</td>
<td>The audio link is located at <a href="http://www.homehealthquality.org/hh/hha/interventionpackages/ecp.aspx">www.homehealthquality.org/hh/hha/interventionpackages/ecp.aspx</a></td>
</tr>
</tbody>
</table>

There are several ways to listen to these audio recording:

- Visit the link above and listen directly through the Web site.
- Download the audio recording by right-clicking on the audio file and selecting “Save Target As...”. This will save the file to your hard drive. Once you have saved the file, you can listen to it on your computer or you can burn the audio file to a CD to listen to in your car or stereo.

Discussion Questions

You may complete these discussion questions together in a group setting (team meeting) or just think about them if you are doing this as a self-study.

- Does your agency use a patient emergency plan?
- Where do the patients place their patient emergency plan?
  - Refrigerator, phone, patient folder ...
- What are your agency’s policies and procedures related to home health aides reviewing or reminding patient/caregivers about emergency care planning?
- Does the patient emergency plan help you, as a home health aide to decide when to call the nurse/office?
- Does your agency use any other tools with emergency care planning?
  - Magnets, phone stickers ...
- Why is it important that the patient/caregiver is involved with emergency care planning?
- What are some ways that a home health aide can help improve the use of emergency care planning?
Emergency Care Planning

Home Health Aide’s Guide to Practical Application

Purpose: For the home health aide to:
1. Become more involved with reinforcing the patient’s emergency plan.
2. Learn actions that home health aides can take to assist in reducing avoidable hospitalizations.

☐ Successful emergency care planning occurs when it is interdisciplinary and if the emergency plan is reviewed on every visit by every discipline.
   - Ask your patient/caregiver locate the patient emergency plan(tool) during each visit
   - Talk with your patients/caregivers about the importance of their patient emergency plan
   - Explain to your patients/caregivers that the tool can help the patient remain at home and avoid the emergency department or hospital when appropriate
   - Stress that the earlier the patient/caregiver identifies changes in condition, the better chance of preventing a hospitalization
   - Discuss any additional resources (e.g. Emergency Information Sheets, phone stickers) to remind patient to call the agency first, except in the case of a life-threatening emergency
   - Document if patient/caregiver could locate the patient emergency plan

☐ Assist your care team in reducing avoidable hospitalizations
   - Assess your patient for safety issues with walking (e.g. not using their cane or walker), with transfers (e.g. difficulty getting in and out of the shower), and with balance (e.g. not steady on their feet, almost falling)
   - Refer to the patient emergency plan when patient is having any problems
     - This is a good opportunity to show the patient how to first look at the plan to help decide who to call with problems
   - Actively participate in case conferences or team meetings – patients/caregivers often tell the aide important personal information that they might not share with the nurse or therapist
Success Stories

Tennessee Agency’s Emergency Plan Helps Improve Patient Care

Sometimes it’s a simple thing that provides a solution to a tricky problem. Medical Center Homecare Services in Johnson City has instituted a number of new programs and processes in recent years to lower its acute care hospitalization (ACH) rate. To illustrate, the agency increased educational resources for patients aimed at reducing ACH and also focused on recruitment, retention and recognition of staff. Both of those efforts resulted in more informed patients and improved morale and productivity among staff.

Performance Improvement Coordinator, Julie Sharp, said what’s recently made a real difference in tackling ACH reduction is the placement of a simple sticker on the front of folders left in patients’ homes. The stickers state “call us first,’ in capital letters and it includes the agency’s phone number,” said Sharp, who is also a registered nurse. Staff also stress to patients that if they are feeling worse, they should give the agency a call before heading to the emergency room (ER). “It seems really simple,” she said. But adding this intervention in combination with other agency efforts seems to be paying off.

The agency attends roundtable meetings sponsored by QSource, the state’s Medicare Quality Improvement Organization, which are a “huge benefit in networking and sharing ideas with other home health agencies,” Sharp said. “Staff is always there to help with resources that assist us with our ACH rate, and always there with an answer to my questions,” she added.

The idea for the emergency care plan sticker came from Johnson City’s medical director, a physician who was a member of a focus group formed by the agency to work on reducing ACH. As a doctor working with the agency, he told members of the focus group that some of the agency’s patients were calling his office or going directly to the ER, and the ER would then contact him about his patient. He quickly recognized that often the patient’s condition could have been treated and/or addressed through a visit by home health staff.

Sharp said examples of what may typically happen is that a patient may notice additional swelling in his or her feet, experience a two-pound weight gain in one day or even panic because he or she gets a little short of breath. Patients experiencing these symptoms end up in the ER, when home health intervention may have been the better option. “We could have prevented it, gone to the home, called the doctor, and made a medication change,” she said.

Typically the first person to educate the patient and explain the purpose of the sticker is a nurse or therapist, Sharp explained. This takes place when the staff person makes the initial visit, and is reinforced on subsequent visits. Home health staff—typically nurses, and occasionally home health aides—reiterate the importance of calling the agency first with health concerns. Patients find this approach reassuring. “They know that there’s a nurse available 24 hours a day,
seven days a week,” she said. “Even in the middle of the night, and on the weekends, [we tell them], ‘don’t hesitate to call because there is always somebody available.’”

On call coordinators have also played a significant role in helping to reduce ACH. The coordinators triage phone calls after hours and if the patient needs to be seen, the coordinators notify the nurses on call to see that patient, said Sharp. The coordinators make sure the on call nurses haven’t worked during the day so they are sharp and ready to go. In addition, because of the new focus on ACH reduction in recent years, coordinators are better educated about patients’ conditions and what “emergencies” may actually be treated in the home setting.

The agency’s ACH rate is currently at its lowest point in years, according to Sharp. December 2006 CASPER data shows an ACH rate of 25.68 percent (January 2006 to December 2006 reporting period); this compares with 31.6 percent in November 2005. (The eligible number of cases or patients that could potentially be hospitalized for the 2006 period was 2,485.)

In addition to the “call us first” campaign, Johnson City has also found success in recent years by utilizing a congestive heart failure (CHF) disease management program. Launched at the agency in 2003, the program provides CHF patients with telehealth monitoring equipment that transmits vital signs, such as weight and blood pressure readings to a call center in Atlanta, Georgia. If their weight has increased or their blood pressure has elevated, the patient is called, and registered nurses who work at the telehealth center in Atlanta follow orders written specifically for the patient. Sharp said the agency plans to implement a similar diabetes disease management program in the future.

“It’s truly a team effort, and the entire team finds pleasure in watching our ACH rate decline,” Sharp said.

Data in this article was provided by Julie Sharp, Medical Center Homecare Services.
1. Components of emergency care planning include:
   a. Patient Emergency Plan
   b. Magnets and phone stickers
   c. Posters or flyers to remind staff
   d. Agency polices and procedures
   e. All of the above

2. Written plan with signs and symptoms or medical conditions and directions on who should be called (e.g. the agency versus 911):
   a. Hospitalization risk Assessment
   b. Patient Emergency Plan

3. A patient emergency plan should ideally be reviewed on every visit.
   a. True
   b. False

4. Emergency care planning is an intervention or action that ideally should be completed by all disciplines (staff).
   a. True
   b. False

5. Home health aides could (if agency policies and procedures allow) assist with emergency care planning by all of the following except:
   a. Remind patient/caregiver where the emergency plan is located
   b. Point out the agency phone number on phone sticker, magnet or patient’s emergency plan to the patient/caregiver
   c. Enter signs and symptoms on the patient emergency plan that the patient should report
   d. Notify the nurse/therapist if patient did not know where their patient emergency plan is located.