

# PHOENIXCARE ADMISSION PROTOCOL

## Assumptions:

- “Admission period” is time-limited (4 weeks of intervention)
- Interventions focus on: assessment of needs and goal-directed education  
management of presenting symptoms
- Intensity of service: RN CM visits twice per week x 2wks  
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*in addition to visits,*  
RN phone contacts twice per week for first month

## Goals:

What should be completed / in place by the end of the Admission Period:

1. Review of medical management by RN CM and Medical Director with suggestions to Attending Physician for pharmacological changes, further diagnostic studies, etc.
2. Establishment of patient-specific emergency response plan.
3. Completion of Advance Care Planning decisions regarding emergency care delivery.
4. Establishment of patient-specific self-monitoring program.
5. Identification of lifestyle education needs and initial educational materials provided.
6. Identification of psychosocial/emotional/spiritual counseling needs and referrals. provided.
7. Identification of community resource referral needs and access initiated.
8. Establish frequency/method/format of regular communication with Attending Physician and MCO representative.

## Tools Required

- Admission Assessment - Phone Intervention – Visit Intervention form
- Checklist for review of medical management/diagnostic data
- Medical Protocol (including pharmacological management) per disease category
- Patient-specific plan of care including:
  - emergency management plan / orders
  - lifestyle self-monitoring forms
  - educational goals
- Advance Care Planning documents
- Referral protocol and forms for psychosocial/emotional/spiritual issues
- Communication (physician, MCO) forms

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## ADMISSION PERIOD

<b>Admit Visit</b>	<b>Week 1 &amp; 2 (Visit 2,3&amp;4)</b>	<b>Week 3 &amp; 4 (Visit 5&amp;6)</b>
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### DISEASE AND SYMPTOM MANAGEMENT

Medical Management (including pharmacological interventions)	<ul style="list-style-type: none"> <li>Assess health status</li> <li>Obtain history/diagnostic data</li> <li>Identify immediate symptom management needs</li> </ul>	<ul style="list-style-type: none"> <li>Provide medication information sheets and review medication safety</li> <li>Assess need for medication delivery system (i.e. medi-set)</li> <li>Review medical condition/treatment history/pharmacology with Team and Medical Director</li> </ul>	<ul style="list-style-type: none"> <li>Re-evaluate physical status and effective symptom management</li> <li>Establish plan for on-going communication with MCO contact and Attending Physician</li> </ul>
Emergency Response Plan	<ul style="list-style-type: none"> <li>Review past management of emergencies</li> <li>Initiate discussion re home management</li> </ul>	<ul style="list-style-type: none"> <li>Implement written Emergency Response Plan</li> <li>Obtain physician PRN orders and notify Attending physician of emergency plan</li> <li>Obtain emergency meds / O2 as needed</li> </ul>	<ul style="list-style-type: none"> <li>“Rehearse” emergency situations with patient <u>and</u> surrogate</li> </ul>

### EDUCATIONAL SERVICES

Advance Care Planning	<ul style="list-style-type: none"> <li>Review Advance Directives previously completed by pt.</li> <li>Provide educational materials on Advance Care Planning and initiate discussion of preferences</li> </ul>	<ul style="list-style-type: none"> <li>Include patient and family members in discussions of Advance Care Planning</li> <li>Facilitate Advance Care Planning decisions by pt.</li> <li>Encourage patient to discuss Advance Care Planning with physician</li> </ul>	<ul style="list-style-type: none"> <li>Complete Advance Care Planning</li> <li>Post documents in home</li> <li>Communicate decisions to MCO contact and Attending Physician</li> </ul>
Disease / Health Promotion education	<ul style="list-style-type: none"> <li>Assess patient/family understanding of disease</li> <li>Assess patient/family learning level</li> <li>Identify home safety concerns via assessment</li> </ul>	<ul style="list-style-type: none"> <li>Provide disease or symptom specific educational materials appropriate to patient/family learning level</li> <li>Provide information re community educational resources available</li> <li>Resolve identified home safety concerns</li> <li>Provide education re home medical equipment</li> </ul>	<ul style="list-style-type: none"> <li>Review educational materials and community resource referrals</li> </ul>
Self-monitoring programs	<ul style="list-style-type: none"> <li>Introduce concept of self-management to improve health</li> <li>Identify priorities for self-monitoring via assessment</li> </ul>	<ul style="list-style-type: none"> <li>Establish specific self-monitoring program(s)</li> <li>Facilitate patient goal-setting</li> <li>Communicate with Attending Physician re self-monitoring program and goals</li> </ul>	<ul style="list-style-type: none"> <li>“Practice” self-monitoring / reporting of results to RN via phone</li> <li>Reinforce self-monitoring program goals</li> </ul>

## SUPPORT SERVICES

<p>Psychological/Spiritual / Emotional support and counseling</p>	<ul style="list-style-type: none"> <li>• Assess psychological/spiritual/emotional health per initial assessment</li> <li>• Identify immediate priority issues for referral</li> </ul>	<ul style="list-style-type: none"> <li>• Complete referral for counseling if indicated</li> <li>• Facilitate review of emotional or spiritual concerns as Advance Care Planning discussions proceed</li> <li>• Consult with Team (including Counselor) re identification of patient/family needs</li> </ul>	<ul style="list-style-type: none"> <li>• Complete referral for counseling (to Team Counselor or community resources)</li> <li>• Provide continued support to patient/family</li> </ul>
<p>Community resource referrals</p>	<ul style="list-style-type: none"> <li>• Assess patient/family ability to participate in / benefit from community resource referrals</li> <li>• Identify financial needs related to patient's disease (ie. costs of care)</li> <li>• Identify custodial care needs (current or anticipated)</li> <li>• Assess for other unmet needs (i.e. transportation, home-delivered meals, house cleaning/home repair)</li> </ul>	<ul style="list-style-type: none"> <li>• Provide information on community resources to assist with financial / custodial care issues.</li> <li>• Assist with referral(s) as needed.</li> </ul>	<ul style="list-style-type: none"> <li>• Evaluate patient/family follow-through on referrals</li> </ul>