

PHOENIXCARE STABLE PATIENT PROTOCOL

Assumptions:

“Stable Period” is ongoing from end of “Admission Period” to discharge

“Stable Period” may be interrupted by “Exacerbation Periods”

Intensity of service: RN CM visit once monthly
RN CM phone contact weekly

Goals:

What should be accomplished with each intervention:

1. Review of patient-specific Emergency Response plan.
2. Review of patient self-management diaries, logs.
3. Review of patient clinical condition (how is patient doing?).
4. Follow-up on Advance Care Planning issues (if issues unresolved).
5. Re-assess need for psychosocial/emotional/spiritual referral or support.
6. Follow-up on access to community resources.
7. Communication to physician / MCO per agreement (or monthly).

Tools Required:

- Phone Intervention & Visit Intervention form
- Patient-specific plan of care (with area for changes/updates)
- Physician / MCO communication form

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Phone Contacts (Weekly)

Visit (Monthly)

DISEASE AND SYMPTOM MANAGEMENT

Medical Management (including pharmacological interventions)	<ul style="list-style-type: none"> Assess health status (phone format) Identify new symptoms/ change in status Evaluate compliance with medication regime and understanding of instructions Update Attending Physician / MCO as patient condition requires 	<ul style="list-style-type: none"> Assess health status (visit format) Identify new symptoms/change in status Evaluate compliance with medication regime and understanding of instructions Update Attending Physician / MCO per established schedule
Emergency Response Plan	<ul style="list-style-type: none"> Review Emergency Plan with patient/family Reinforce availability of PhoenixCare team for Emergency Response; Verify contact number availability 	<ul style="list-style-type: none"> Verify placement of Emergency Plan and contact number in home “Rehearse” emergency responses with patient and surrogate

EDUCATIONAL SERVICES

Advance Care Planning	<ul style="list-style-type: none"> Discuss any Advance Care Planning issues unresolved from Admission Period Review decisions / issues and facilitate patient discussion 	<ul style="list-style-type: none"> Verify placement of Advance Care Planning documents in home Facilitate patient/surrogate review of decisions made and outstanding issues Encourage patient to review Advance Care Plan decisions with physician
Disease / Health Promotion education	<ul style="list-style-type: none"> Discuss any questions patient/family has regarding educational materials Offer additional materials as needed 	<ul style="list-style-type: none"> Discuss any questions patient/family have re educational materials Verify patient/family understanding of medical equipment management and home safety issues Offer additional materials as needed
Self-monitoring programs	<ul style="list-style-type: none"> Review self-monitoring diaries/logs and document information patient provides Reinforce value of health promotion/self-monitoring Reinforce patient’s goals 	<ul style="list-style-type: none"> Verify accuracy of self-monitoring diaries/logs and data reported by patient to nurse per phone Reinforce value of health promotion/self-Monitoring Reinforce patient’s goals

SUPPORT SERVICES

Psychological/Spiritual/Emotional support and counseling	<ul style="list-style-type: none"> Assess psychological/spiritual/emotional health Identify priority issues for referral Refer for counseling as indicated 	<ul style="list-style-type: none"> Assess psychological/spiritual/emotional health Provide support to patient/family Refer for counseling as indicated
Community resource referrals	<ul style="list-style-type: none"> Inquire re status of earlier referrals Inquire re outstanding issues (financial, custodial care, home maintenance, etc.) 	<ul style="list-style-type: none"> Facilitate community resource contacts if indicated Assess for unmet referral needs