

Home Health Patient Assessment Tools: Preparing for Emergency Triage

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1. Background and Introduction

Approximately 7.6 million individuals receive care in their home from 17,000 home care providers because of acute illness, long-term care conditions, permanent disability, or terminal illness (1). Technological advances have expanded the capabilities of home care providers so that many chronic conditions that previously would have been cared for in the hospital are now being safely managed in the home. Intravenous (IV) infusion technology, parenteral nutrition, peritoneal dialysis, oxygen therapy, feeding pumps, ventilators, pulse oximeters, and hand-held blood analysis devices are just a few examples of the common devices that have allowed the expansion of home care (2, 3).

During a mass casualty event (MCE), these community-dwelling patients could experience disruption of needed support services. Depending on the level of their needs, a disruption of care/services could lead to patient decompensation and increased reliance on acute care services, including emergency medical systems and hospital emergency departments (EDs) already stretched thin by the disaster situation. For example, Greenwald et al. (4) found that during the August 2003 North American electrical blackout, 23 of 255 patients who required ED care presented with medical device failure; 13 of these patients were admitted to the hospital, accounting for 22 percent of all admissions during the blackout. The patients most affected by a disruption of services are those with the most complex treatment/equipment needs that cannot be met by family members or other informal caregivers.

Abt Associates, along with its partners from the Brigham and Women's Hospital and Massachusetts General Hospital in Boston, was contracted by the Agency for Healthcare Research and Quality to develop a model patient risk assessment tool that rates the risk status of community-based patients in the event of a disaster. The goal for such a tool is for home health agencies (HHAs) and others to be able to identify and count the number of individuals/patients who would be most at risk of hospitalization if their home supports and services were disrupted during an emergency. All community-dwelling patients would be considered at risk during an MCE. This study, however, focuses on those whose needs are most complex—those patients who could not be safely evacuated to a public shelter or even a special needs shelter during an MCE. With this information, emergency planners could begin to anticipate and prepare for this additional surge demand.

The objective of this study is not to design a home care triage tool for use in the midst of an MCE. Rather, the purpose is to develop a patient risk assessment tool that will allow home care agencies, hospitals, and emergency planners to anticipate the needs of all home care patients in a community, should an MCE occur.

2. Methods

Review of Existing Patient Categorization Tools

First, the investigators determined whether any standard requirements or guidance related to patient risk categorization tools exist at a State or national level. A review of the literature revealed some efforts on behalf of State and national associations for home care and hospice agencies to provide guidance on the development of emergency plans and use of an abbreviated patient assessment tool. HHAs participating in Medicare/Medicaid programs are subject to Federal and State regulations and must undertake disaster planning; however, those regulations do not specify the content of plans, and personal care agencies do not appear to have such plans in place (5).

Several examples of patient risk categorization tools were obtained and reviewed. The first documented patient classification system was introduced in 2001 by Barbara Citarella (e-mail correspondence, August 24, 2009.)

In a 2005 letter to home care and hospice agencies, the New York State Department of Health mandated that emergency plans be revised to incorporate a patient risk classification system (6). The sample classification system proposed in the letter is a three-level system, structured as follows:

- **Level I: High Priority.** Patients in this priority level need uninterrupted services. In the case of a disaster or emergency, every possible effort must be made to see this patient. The patient's condition is highly unstable and deterioration or inpatient admission is highly probable if the patient is not seen. Examples include patients who require life sustaining equipment or medication, those who need highly skilled wound care, and unstable patients who have no caregiver or informal support to provide care.
- **Level II: Moderate Priority.** Services for patients at this priority level may be postponed with telephone contact. A caregiver can provide basic care until the emergency situation improves. The patient's condition is somewhat unstable and requires care that should be provided that day but could be postponed without harm to the patient.
- **Level III: Low Priority.** The patient may be stable and has access to informal support to provide care. The patient can safely miss a scheduled visit if basic care is provided by family members, other informal support, or by the patient himself.

Another classification system, developed by a State home care association in 2007 and based on Citarella's earlier version, uses a similar approach to the three-level system described above, and offers examples of patient types for each category (7):

- Examples of patients classified as **Level 1 (High Priority):** A patient who is bed-bound or paralyzed, ventilator dependent, unable to meet physiologic and safety needs, or who

requires daily insulin injections for diabetes but is unable to self-administer the medication.

- Examples of patients classified as **Level 2 (Moderate Priority)**: A patient who uses equipment such as an oxygen tank, suction pump, nebulizer, or patient-controlled analgesia pump.
- Examples of patients classified as **Level 3 (Low Priority)**: A patient who is mobile and independent in functioning or a patient who needs uncomplicated routine wound care.

In 2008, a four-level system was suggested by the National Association for Home Care and Hospice (NAHC) in the report “Emergency Preparedness Packet for Home Health Agencies” (8). The first three levels are similar to those proposed by the New York State Department of Health; a fourth level suggested by NAHC, “Lowest Priority,” includes patients for whom visits may be postponed 72 hours or more with little or no adverse effects, patients who have a willing and able caregiver available, or patients who are independent in most activities of daily living (ADLs).

All of these categorization tools are intended for patients who receive care from home health and hospice agencies. The general community-dwelling population also includes many individuals who do not routinely receive services from those agencies but who have the potential to destabilize rapidly during an emergency and require medical care. Other service providers, such as adult day care programs, medical equipment suppliers, or Meals on Wheels programs, may have routine contact with such at-risk individuals. The investigators found no patient classification tools that could apply to community-dwelling patients who receive care or services from these other type of providers, with the exception of one triage tool that was used after Hurricane Katrina to assess vulnerable older adults residing in shelters (9). This tool was used to rate elderly individuals who had no accompanying family members in terms of their ability to access medical and social services at the shelter and from County government. Called SWiFT, for Seniors Without Families Team, the tool consists of 13 questions in three categories (medical/mental health, financial, and social) and places an individual into one of three levels of “assistance required.” “Level 1” indicates the need for immediate medical placement/care for older adults who have cognitive deficits and ADL deficits; “Level 2” indicates the need for help with housing and/or income support; and “Level 3” designates a need for assistance in locating family or friends, or other disaster-related problems. Individuals classified as “Level 1” might be at risk of hospitalization if their medical needs are not quickly addressed. The triage tool classifies individuals as “Level 1 (Health/Mental Health Priority)” based on their answers to questions about:

- Medical problems (diabetes, heart disease, high blood pressure, memory loss);
- Medication (does the individual take medication and is the medication with him/her);
- Assistance with ADLs (walking, eating, bathing, dressing, toileting, medication administration) and ambulation/transfer (cane, walker, wheelchair, bath bench);
- Orientation (does the individual know where he/she is and what year it is); and

- Short-term memory (ability to recall the names of three items after several minutes).

The developers of the triage tool noted that it could be useful in disaster preparations as a uniform description of level of need and as general guidelines for the type(s) of assistance needed.

The investigators were unable to locate any research studies that evaluated the usefulness or accuracy of patient assessment tools for emergency planning. Given the limited information available on the types and uses of patient classification tools, and their ability to identify those most at risk for hospitalization if community health services are interrupted, the investigators sought additional information from home care agencies and State home care associations about their plans for triaging patients during an MCE.

Discussions With Home Care Agencies

The investigators solicited guidance from members of the Technical Expert Panel (TEP) regarding those States that would most likely demonstrate a range of activities related to emergency planning, and perhaps development and implementation of standardized patient classification tools. TEP members suggested that States with both rural and urban areas that are prone to a variety of natural disasters be represented. TEP members also suggested including some specific States known to have either offered guidance to HHAs or to have been entirely silent on this issue to represent the extremes of the continuum. Based on this criteria, the following six States were selected: Florida, Illinois, Massachusetts, Oregon, New York, and Texas. TEP panelists advised that the use of patient assessment tools is at the discretion of each HHA, and different tools could be used by different HHAs within the same State. To examine the range of patient categorization tools, the investigators obtained examples from several HHAs in each of the six States.

Contact was first attempted with the State home care association, to request referral to HHAs that might be willing to share their patient categorization tools. Some of the State associations were able to suggest knowledgeable individuals at HHAs—usually nursing directors—and these individuals were contacted; other State associations could not provide referrals. For these latter States, the investigators used the Centers for Medicare and Medicaid Services’ “Home Health Compare” Web site to identify several HHAs in each State. The investigators also contacted other community service providers (e.g., medical equipment suppliers, Meals on Wheels programs, adult day care programs) in one Massachusetts community to understand whether these other types of providers might use a similar patient risk categorization tool for their clients.

Unstructured telephone interviews were conducted during May and June 2009 and included the following questions:

- Does your organization use a patient classification scheme or tool that assigns a numerical value to each patient to represent priority of need?

- If yes, is this tool electronic- or paper-based,, and can you share a copy or screen shot?
- If your organization uses a patient classification system, how is it structured?
 - How many levels are there?
 - What is the criteria/description of each level?
 - When is the information collected, and how often is it updated?
 - Did the HHA or service provider create this system or adopt it from somewhere else? If it was adopted from elsewhere, how was it selected?
 - Has the HHA or service provider communicated with local emergency planners to share the patient classification system (e.g., participated in a workgroup, informal discussion, local meetings/drills)?
- Has the HHA or service provider experienced an emergency situation (even a minor one) in which patient care was disrupted or challenged (e.g., snow/ice storm, power outage)?
 - Can you describe the emergency, and how many people (patients and staff) were affected?
 - Did some patients go to emergency departments? For what reasons?
 - Did the HHA have a patient classification system in place? If not, how did staff prioritize patient care?
 - If a patient classification system was used, how well did it work? Were there any problems? Did the HHA make revisions to the system afterwards? If so, what type of revisions were made?

Calls were placed to a total of 57 home health/hospice agencies in six States and 22 other types of service providers in Massachusetts.

Of the 57 home health/hospice agencies contacted, 21 were interviewed by telephone. Table 1 summarizes the number of HHAs contacted, by State.

Table 1. Number of Home Health and Hospice Providers Contacted, by State

State	Number of Contacts
Illinois	3
Florida	2
Massachusetts	9
New York	1
Oregon	1
Texas	5
Total	21

Source: *Abt Associates; 6/2009*

Contact with other providers (medical suppliers, oxygen companies, Meals on Wheels programs, adult day care programs, and substance abuse clinics) in Massachusetts was attempted, but yielded limited results, as few were willing to discuss this issue with investigators. One oxygen supplier, two substance abuse clinics, and one Meals on Wheels program were interviewed.

3. Findings

A total of 25 organizations in six States were interviewed about their use of a patient risk assessment rating tool. Of the 25 organizations interviewed, two thirds (17) described using a two-, three-, four-, or five-level categorization system to rank patients, usually at the time of admission. The 17 entities that reported using a formal system were all home health and/or hospice agencies. Four other home health and/or hospice agencies reported that they do not use a patient classification system because they are small and know all their patients' needs; staff at these agencies can quickly identify those who are at risk (e.g., patients who require oxygen or continuous IV infusion) and see no need for a formal system with graded levels.

None of the four other community service providers (non-home health/hospice agencies) use a formal risk assessment tool, although they could describe their clients who are at highest risk (e.g., patients who have little or no support in the home, require high flow use of oxygen, or have restricted mobility).

Use of Formal Patient Classification Systems

The formal classification systems described by the HHAs typically use a numeric or color coded ranking, with descriptions of the types of patients that fit in each level. These systems vary in terms of the number of levels, the basis for the level characterization, and the order ranking of risk (highest risk to lowest or vice versa). The majority of patient categorization systems have three levels.

The basis for the categorizations varies; some focus on the time frame in which each patient must be seen (e.g., patient needs to be seen in 24 hours, 48 hours), while some vary based on medical care needs, using examples of medical diagnoses or care conditions to determine risk level. Others are based on the amount of support an individual has available (e.g., caregiver in the home), and one is based in part on the individual's own ability to respond to a disaster situation. Several patient categorization tools are based on some combination of the above criteria. Table 2 summarizes the basis for each level characterization in the systems reviewed.

Table 2. Basis for Level Characterization in Patient Classification Systems Reviewed

Type of System	Number	Basis
2-level system	1	Time Frame (1)
3-level system	13	Time Frame (3) Care Needs (6) Combination of Care Needs and Support (3)
4-level system	2	Combination of Care Needs and Time Frame (1) Combination of Care Needs and Time Frame (1) No information available (1)
5-level system	1	Combination of Care Needs, Support, and Response to Disaster (1)

Source: *Abt Associates, 2009*

In most systems, the first or number “1” level represents the patients who are most at risk. One system was the reverse, with a higher numeric level (“Level 3”) indicating greater risk. Standardization in this regard—where “Level 1” indicates greatest risk—would reduce the potential for confusion.

Process for Collecting and Updating Patient Information

The HHAs reported using a mix of paper and electronic systems. Larger HHAs tended to use electronic medical record systems, while smaller HHAs tended to use paper systems or none at all.

The HHAs reported that their intake assessment protocols include questions about patient risk classification. The risk classification item is completed on admission to the HHA and updated at recertification (every 60 days) or when the patient’s medical condition worsens. Several reported updating seasonally and/or annually. A few HHAs reported faxing the medical risk information to the city government for emergency management planning purposes or communicating information on medical supply reserves (e.g., number of oxygen tanks kept on site, how long the generator will last in the event of a power failure) to the local fire department.

Experiences Using the Patient Classification System in an Emergency Situation

Several of the HHAs described their experiences using their patient classification system in anticipation of severe storms. Each used an electronic system and was able to print a list of patients who were considered highest priority. Many of the respondents explained that there were far too many patients on the high priority list to possibly visit them all quickly. This seems to indicate that either the categorization tool did not accomplish its goal of triaging patients effectively or that HHAs have more high-priority patients than they can serve during disasters.

The HHAs were asked to estimate the percentage of their patients who would be classified as highest risk should home care or other community-based services be interrupted by a disaster.

Two HHAs estimated that 1 percent of their average daily census would fit into the highest risk category and require hospital care; two other HHAs estimated that 21 to 25 percent of their census would be in this highest risk category. These HHAs cautioned that the census varies from one month to the next. In general, these highest risk patients were described as follows:

- Bed-bound and without a caregiver, unable to get food or fluids, or immobilized or paralyzed;
- Ventilator dependent;
- Oxygen dependent;
- IV infusion dependent;
- In need of highly technical equipment (e.g., wound vacuum-assisted closure device, chest tube drainage system);
- Dependent on a skilled service (e.g., respiratory therapy);
- Medication dependent and unable to self-administer;
- Dialysis dependent;
- Patients with severe dementia or Alzheimer's disease;
- Patients with severe mental illness; or
- In need of daily wound care.

When HHA nurses were asked to describe how they used their patient classification systems in preparation for storms in which services could be disrupted, they described taking their lists of at risk patients and reviewing cases individually to further identify the most critical patients. Based on information from medical records, nursing notes, or personal knowledge of the patients, they could then determine in an ad hoc manner which patients could be seen before the storm arrived, which could be checked on by a family member or neighbor, and which might need transport to a hospital by the local fire/police department. Patients who could not be visited in person during or immediately after the storm were contacted by telephone to determine whether they had enough medication/food/water/power and if there was a family member available to help. In the worst situations, the HHAs informed local fire departments that a patient needed to be seen but the visiting nurse could not reach them. In these cases, ambulances were sent to bring the patients to hospitals.

None of the HHAs had experienced an emergency that arrived without advance warning; their experiences were all storm-related, with sufficient lead time to sort through their patient lists and prioritize visits. In a sudden disaster (e.g., earthquake) none of this would be possible; moreover, the clinicians with personal knowledge of patient needs might not be available.

4. Discussion

Most larger HHAs that provided information use some sort of patient risk categorization tool; smaller HHAs are less likely to use such tools.

Although many tools appear to be similar (e.g., most have three levels of risk), they are used quite differently in practice. For example, two HHAs located in the same State both use a three-level patient risk categorization system, but the proportion of their patients who were placed in the highest risk category widely differed; one reported that only 1 percent of their clients were at highest risk, while the other reported that 21 percent of their clients were in the highest risk category. The two tools were either designed or implemented quite differently, or both.

Some HHAs' patient risk tools categorize so many patients at the highest risk level that the tools are impractical during an emergency—it is not possible to focus resources on so many patients at once. In an emergency, these HHAs use the list only as a “first sort”; they then must review each case individually to prioritize nurse time and to direct local emergency responders. This ad hoc review seems to work when there is advance warning of an emergency (e.g., approaching snow storm or hurricane), but in a situation without advance warning (e.g., earthquake), this approach would not suffice. Moreover, the clinicians who know the most about each patient's status may not be available during an emergency. The existing patient risk categorization tools may need additional tiers or subcategories to further distinguish those who are at highest risk.

In addition to these concerns, the frequency with which patient risk ratings are reviewed and revised is inconsistent, but important. A patient who is considered low risk one month could deteriorate to become high risk the next month; if the assessment is not repeated/revised, this patient would be incorrectly classified. In addition to greater consistency in terms of the rating categories, and more tiers that distinguish urgent from non-urgent needs, it would be helpful to have more uniformity in terms of the frequency of patient assessment.

In terms of other community service providers, there appears to be little or no use of risk categorization tools; this would be a new concept for adult day care programs, oxygen suppliers, Meals on Wheels programs, and the like. Some providers may have sufficient information about their clients to use such a system, and could supply information about highest risk patients to local emergency responders, but others may not.

5. Recommendations

Among the HHAs reviewed, a significant proportion of their caseloads are classified in the highest risk level, which could potentially make the system cumbersome to use, especially during an MCE with no advance warning. The investigators suggest the following improvements:

- Standardize risk levels as “high,” “medium,” and “low,” rather than using numeric rankings that are not always consistent.

- Standardize the categories for assessing risk (e.g., care needs/clinical diagnoses, caregiver supports, or timeframe for visits) and base risk categorization on common data that are available to every HHA.
- Design systems that can print or transmit lists of high risk patients to emergency responders (assuming that data privacy is protected).

Standardize Risk Levels

The following suggestion for a patient risk classification system was adapted from the New York State Department of Health three-level structure (6), which uses only “high,” “medium,” and “low” risk labels. By avoiding numeric labels, the potential for confusion about which level is the highest risk is eliminated.

- **High Risk or High Priority.** Patients in this category need uninterrupted services and/or are highly unstable; deterioration requiring hospital inpatient admission is likely if these patients are not seen for regularly scheduled visits or if there is failure (including power loss) of life-sustaining equipment.
- **Medium Risk or Medium Priority.** If services for patients at this priority level are interrupted, mid-level medical management (e.g., nursing home-level care) will be needed. These patients are somewhat medically unstable and required care should be provided on time or within 24 hours. Most of these patients could be temporarily cared for in a special needs shelter, if one is available. These patients do not use life-sustaining equipment or their equipment can be easily moved with them to a special needs shelter.
- **Low Risk or Low Priority.** The patient’s medical condition may be stable. If home and community services are interrupted, the patient can be cared for in alternate housing or a general population shelter. The patient can safely miss a scheduled visit(s) with basic care provided by self or an informal caregiver.

Standardize Risk Categories Using Commonly Available Data

There is general agreement that standardized data that describes the service and equipment needs of community-dwelling patients would be valuable for estimating the number of these patients who would require hospital/ED admission during an MCE. One such data source is the Outcomes and Assessment Information Set (OASIS). OASIS is completed upon admission/readmission (and every 60 days) for patients over the age of 18 (excluding maternity patients) who receive skilled services from a Medicare- or Medicaid-certified HHA. Although it provides standardized data, OASIS is not required for non-Medicare/Medicaid-certified agencies. Many patients pay for private nursing, personal care, or housekeeping services from agencies that are not Medicare/Medicaid-certified and thus are not required to complete the OASIS. TEP members pointed out that these individuals’ needs are not necessarily any less complex than those of the patients whose care is captured in OASIS, but that these programs are run according to different administrative guidelines. New York City, for example, has 64,000

individuals in its personal care program for whom OASIS data do not exist. In addition, OASIS captures patient data at the point of intake to home care—when patients’ needs are most acute. However, OASIS is not a real-time “snapshot” of current patient acuity and needs. Therefore, the investigators determined that OASIS would be insufficient for planning purposes, because so many patients are not captured in this database, and because it might overstate the acuity/needs of the patients that it does capture.

Incorporate Caregiver Availability

The need for hospitalization during an MCE may in part be related to caregiver availability. Although the presence of a caregiver will not have any impact on many patients’ risk of hospitalization during an MCE, there are patients who can safely remain in their homes for a longer time without professional care if a competent caregiver is available. The ability to rank patients in terms of the level of caregiver assistance/availability across various patient care needs is available in the latest version of OASIS. The following suggested caregiver rankings are based on item M2100 (Types and Sources of Assistance) from OASIS, which includes three categories of caregiver availability:

- **Low Risk.** No assistance is needed or a caregiver currently provides assistance.
- **Medium Risk.** A caregiver is available, but needs training or support, or caregiver availability is unclear.
- **High Risk.** Assistance is needed, but no caregiver is available or the caregiver is not likely to provide assistance.

Included with this report is an example of a screening tool that could be used by any home care agency to rate each patient’s risk of hospitalization in the event of an MCE. The tool is designed to be used by a health care professional. In three steps, it identifies the treatment/service/equipment needs of the patient (including caregiver availability); leads the clinician to identify the most appropriate locus or level of care if the previously noted treatments/services/equipment are interrupted by an MCE; and asks the clinician to estimate the length of time that the patient could safely remain at home if the usual services/equipment were interrupted by an MCE. This is not a triage tool to be used in the midst of an MCE, rather it is a tool for anticipating the needs of home care patients to aid in emergency planning.

Electronic Data

This tool can be used in paper form, but ideally it would be included as a module in OASIS or some other industry software so that home care agencies could create a small database for storing this information about their patient population. Such a system could also have the capability to aggregate data for planning purposes. Given that the primary focus of this study was to estimate the number of patients who would require hospital/ED admission, an electronic database could focus on the service and equipment needs of patients who require highly skilled medical management. This information could be made available to community and hospital disaster planners for advance planning. In turn, this would give hospital personnel a good estimate of the number of individuals who require highly complex care and who may seek hospital care during

an MCE, and what their equipment and care needs may be when they arrive. In the event of an actual MCE, the database information could be immediately forwarded to emergency management and local hospitals and shared with first responders. Information about electricity-dependent patients could also be forwarded to utility companies and first responders (e.g., fire and police departments, emergency medical services).

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7. The Community-Living Patient Assessment Tool for Disaster Planning (With Instructions)

The Community-Living Patient Assessment Tool for Disaster Planning creates a record for identifying patient needs and a plan for meeting those needs in the event of a mass casualty event (MCE). It should be completed for every patient/client upon admission or program entry and reviewed and updated as needed on a regular basis (at least every 60 days) or prior to an anticipated MCE. The tool should be completed by a health care professional or someone who knows the individual's physical and medical needs and the resources/support that are available in the community.

In three steps, this tool identifies the treatment/service/equipment needs of the patient (including caregiver availability), leads the user to identify the most appropriate locus or level of care if the previously noted treatments/services/equipment are interrupted by an MCE, and asks the user to estimate the length of time that the patient can safely remain at home if the usual services/equipment are interrupted by an MCE. This is not a triage tool to be used in the midst of an MCE, rather it is a tool for anticipating the needs of home care patients to aid in emergency planning.

Label the tool with a patient/client ID and enter zip code for patient/client's residence.

Step 1. Review the services/needs that are being provided for the community-living patient.

Medical Procedures/Treatments: Check all that the agency provides; **do not check services/needs that the patient manages on his/her own.** Use the blank lines to enter additional services/needs not listed. For each service, indicate if the need priority is "high" (column 1/red box), "medium" (column 2/yellow box), or "low" (column 3/green box) using the following criteria:

High Priority. Patients in this category need uninterrupted services and/or are highly unstable.

Medium Priority. These patients are somewhat medically unstable and care should be provided on time or within 24 hours. These patients do not use life-sustaining equipment or their equipment can be easily moved with them.

Low Priority. The patient's medical condition may be stable. The patient can safely miss a scheduled visit(s) if basic care is provided by self or an informal caregiver.

Activities of Daily Living (ADLs)/Supervision/Communication/Transportation: Check all that the agency provides; **do not check services/needs that the patient manages on his/her own.** Use the blank lines to enter additional services/needs not listed. For each service, indicate if

the need priority is “high” (column 1/red box), “medium” (column 2/yellow box), or “low” (column 3/green box) using the following criteria:

High Priority. Patients in this category need uninterrupted services and/or are highly unstable.

Medium Priority. These patients are somewhat medically unstable and care should be provided on time or within 24 hours. These patients do not use life-sustaining equipment or their equipment can be easily moved with them.

Low Priority. The patient’s medical condition may be stable. The patient can safely miss a scheduled visit(s) if basic care is provided by self or an informal caregiver.

Equipment Management: Check the equipment needs of the patient.

Medication Management: Check the types of medication(s) prescribed for the patient.

Caregiver Availability: Indicate the availability of a caregiver.

Step 2. Determine the most appropriate level of care if services/care are interrupted.

Review the information gathered in Step 1 and your overall assessment of the patient. Based on the services, equipment needs, and caregiver availability listed in Step 1, what level of care is most appropriate for this individual if the usual services/equipment are not available?

Step 3. Determine how long this patient will be safe in the home if services/care are interrupted.

Review the information gathered in Step 1 and your overall assessment of the patient. Based on the services, equipment needs, and caregiver availability listed in Step 1, how long will this patient be safe in the home if the usual services/equipment are not available (consider the battery-life of any necessary equipment if power lost)?

