HOME HEALTH VNA

VULNERABLE PATIENT CLINICAL PROTOCOL

A. Definition

A Vulnerable Patient (VP) is defined as a patient with very complex care needs resulting from any combination of serious medical condition, cognitive deficit, functional deficit, psycho-social instability, lack of reliable caregiving, and/or inadequate or dangerous home environment. Due to the presence of these factors, VPs are at a greatly elevated risk for serious injury or rapid disease progression up to and including death. Several defining characteristics of VPs have been identified. These characteristics are not all-inclusive, but the presence of any of these characteristics should prompt evaluation for identification of the patient as a VP by the assessing clinician.

Clinicians caring for patients identified as VP will be subject to required adherence to specific assessment, care delivery and documentation requirements that are designed to mitigate risk and ensure an optimal plan of care is ordered.

B. Defining Characteristics

Some or all of the characteristics below may be present. No single characteristic qualifies the patient as a VP; the clinician must do a thorough evaluation and use clinical judgment. Whenever a clinician assesses a patient as meeting the criteria for consideration as a VP, the clinician discusses this with his/her Team Manager and a decision is reached jointly. Alternatively a team discussion at IDT may result in the determination that a patient be designated a VP. (Please also see Criteria and Resource Grid, Attachment 1)

1. Clinical Domain:

- Repeated hospitalizations (>3 in 6 months)
- Uncontrolled or difficult to control pain
- Inability to manage medications reliably with no willing or able caregiver
- Discrete care needs (foley catheter, B12 injection) resulting in minimal VNA utilization/contact but patient receives extensive supportive services from other providers or from family
- Weight loss / Wasting syndrome
- Multiple chronic conditions with deteriorating condition
- Chronic pressure ulcers
- Incontinence

2. Functional Domain:

- Major functional limitation(s) – i.e. bedbound, total dependence for ADLs
- Significant fall history

3. Psychosocial Domain:

- Cognitive Deficits, Poor Insight/Judgment, Self-Neglect, Self Abuse
- Acute, severe psychiatric symptoms – delusions, depression
- Family/Caregiver dynamics are impacting negatively on plan of care
- Socially isolated, very dependent patient
- Suspected financial abuse
- Aggressive, intimidating caregiver

4. Safety Domain:

- Requires/Receives 24-hour care from formal or informal caregivers (family, neighbor, PCA) that does not appear to meet the patient's needs
- Inadequate or absent support system (unreliable, unwilling or absent caregiver)
- Unsafe environment (i.e. hoarding, aggressive animals, fire safety concern)
- Unable to leave home in an emergency without extensive assistance
- Criteria for filing protective services are present, whether or not the patient was ruled out or ineligible due to age

C. Action Steps

1. Identify patient as a VP – Responsibility – Assessing Clinician, Primary Clinician, Team Manager

2. Notify Clinical Team via HW email – Responsibility – Team Manager

3. Set HW Attribute – Vulnerable Patient – Responsibility – Team Manager

4. Initiate Vulnerable Patient Protocol (see section D, below) – Primary Clinician

5. Schedule patient for inclusion in next IDT and ensure follow up IDT every 60 days – Team Manager

D. Clinical Protocol

1. Utilize Criteria and Resource Grid (Attachment 1) to determine whether additional discipline(s) should be ordered to address patient-specific risk factors

2. Establish Vulnerable Patient Plan of Care (Attachment 2)

Requirements:

- IDT discussion upon VP identification and every 60 days; utilize Criteria and Resource Grid to guide discussion toward patient-specific risk factors; compare most recent OASIS with last OASIS to identify any areas of decline and address with new Plan of Care interventions

- Environmental Assessment in HW upon identification and with every recertification
- At a minimum, a SW eval visit ordered initially and every 120 days to assess psycho-social and safety domains
- At a minimum, a PT and/or OT eval visit ordered initially and every 6 months to evaluate safety of environment, equipment, and current mobility and/or self-care status
- All formal and informal caregivers involved in the patient's care must be identified utilizing the Vulnerable Patient POC
- Advanced Directives must be clearly documented according to policy. When the clinician encounters difficulty obtaining code status and/or other advanced directives, the Clinical Manager is notified and additional resources are employed (e.g. SW, Palliative NP for "goals of care" visit)
- Advanced Directives include code status, Healthcare Proxy, Power of Attorney, MOLST and are entered in the Advanced Directives POC (see Attachment 3)

Other Considerations:

- For patients receiving infrequent VNA services (B12 injections, catheter changes), the Primary Clinician and Team Manager will consider appropriateness of increasing visit frequency under a "Management and Evaluation of a Complex Plan of Care" visit reason. POC must reflect specifically why such a plan of care is required. Presence of a complex supportive-services care plan may justify increased visit frequency.
- Patients identified as VP may be hospice-eligible. IDT meeting discussion will include review of LCD's and whether patient/caregivers may be open to hospice informational visit.