# Wrench and hammertool logo Tool 13: ED Care Plan

### Purpose

The purpose of the emergency department (ED) care plan is to create institutional memory across numerous providers; make easily visible prior recurrent presentations and related testing; identify a patient’s existing clinical, behavioral, and social services; and recommend strategies to promote safe, high-quality care in the ED.

### Description

This tool provides an ED care plan template and examples of ED care plans. Hospitals can use this template, adapt the template, or draw inspiration from the examples to develop their own template to suit their specific needs and preferences.

### Instructions for Care Plan Development

Step 1. Identify desired care plan elements. Using a structured template helps. Keep ED care plan to 1 page only. Consider who the primary audience is and what the desired use of the document is.

Step 2. Identify an ED care plan champion. This person will either directly develop the ED care plan or will delegate that task to a specific person. The care plan champion will schedule meetings to review and finalize care plans.

Step 3. Identify who will be involved in developing, reviewing, and finalizing care plans versus who will receive communication about and a copy of a care plan.

Step 4. Identify which populations of patients would benefit from an ED care plan. This might be patients who are frequent users of the ED (for example, patients with 10 or more ED visits in the past year), or patients who are frequently hospitalized (for example, patients with 4 or more hospitalizations in the past year), or patients with a specific need for consistent high-quality care across providers (patients with chronic pain syndromes, behavioral or safety concerns, other rare management issues). Create care plans for patients after they have most recently presented (e.g., create care plans for the target population patients who presented this week).

Step 5. Schedule regular interdisciplinary meetings to discuss and finalize care plans. Aim to discuss and finalize a minimum of four care plans per hour meeting. The interdisciplinary care plan meetings might include representation from Emergency Department, Hospital Medicine, Social Work, Case Management, Behavioral Health, Palliative Care, Quality, Risk Management, and others.

Step 6. Identify location to store care plan (e.g., in electronic medical record, health information exchange, shared drive, or paper binder) and train providers on what to do when a patient has a care plan in his or her record.

### Staff

Champion of efforts to reduce frequent utilization.

### Time Required

Target 30 minutes per patient to develop a care plan (the first 10 patients may require significantly more time as you learn what information to incorporate). Recommend weekly or biweekly meetings to review and discuss care plans.

### Additional Resource

See Section 6 of the *Hospital Guide to Reducing Medicaid Readmissions*.

# ED CAre Plan Template

| **Patient Name** |  |
| --- | --- |
| **Patient MRN** |  |
| **DOB / Age / Gender** |  |
| **Care plan date** | Date care plan created: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date(s) modified: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Situation**  [Reason for care plan] | [Provide brief (1 line) summarizing history of repeated presentations and reason for this care plan] |
| **Background**  [Patterns of utilization and summary of relevant testing] | [Provide 2-3 sentences summarizing history of repeated presentations, including symptomatic complaints. List presentations in past (12) months, list or provide count of number of relevant tests (e.g., abdominal CT scans). Summarize what has been tried in the past.] |
| **Assessment**  [Drivers of repeated utilization, resource(s) in place] | [Provide interdisciplinary assessment of the drivers of utilization]  [Identify the clinical, behavioral, and social services in place, with contact names and numbers] |
| **Recommendations**  [Directed at ED clinical staff to promote safety, quality, consistency and otherwise advance care] | [Provide recommendations to promote safety, quality, consistency of care]  [Provide recommendations to minimize harm – such as avoiding certain medications or repeated tests without clear benefit]  [Provide specific name/team/service to call while patient is in ED] |
| **Whom to contact about care plan:** | Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone/Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

# ED Care Plan Example 1

High-Risk Patient Assessment

**Clinical Background**

* History of [list diagnoses] with [frequent ED visits] for [list symptoms here]
* Is connected to [list relevant resources here]

**Clinical Challenge**

* 17 inpatient admissions at this hospital in past year; numerous other admissions at other area hospitals
* Requests [e.g., IV opioids]; declines other alternatives
* Attempts to manage presenting symptoms often unsuccessful

**Name:**

**DOB:**

**Age:**

**Gender:**

**MRN:**

**Standards of Care:**

* [Enumerate professional society and evidence-based management principles]
* [Narcotics have a high potential for abuse]
* [Medical ethics do not require prescribing a medication when you judge the risks to be greater than the benefits, even if the patient demands the medication]
* [Consider non-narcotic medications such as xxx]
* [Check the State prescription drug monitoring program before prescribing controlled substances]
* [An oral or written agreement for chronic pain medication management may be useful]

**Recommended Intervention – Emergency Department**

* [Rule out any emergency medical condition or life-threatening condition]
* [Attempt to treat symptomatic pain without the use of narcotics]
* [For safety place a sitter in the room]
* [If you feel medication is indicated, use [medication, dose, route; medication, dose, route]. Do not use [medication route].]
* [Contact case management as early in presentation as possible]
* [If no need for ongoing hospital care is indicated, patient will be contacted within 48 hours for followup at XXX clinic]

**Recommended Intervention – Attending Physician**

* [If patient cannot be discharged from ED, consider observation status]
* [Avoid narcotics; if medication treatment is indicated, attempt regimen, above]
* [Contact case management, social work, and pain management on admission]
* [Patient has primary care provider, pain management contract, hospital case management]

**Recent Studies**

* 14 Abdominal and CXR films in 2015 without significant findings
* 4 KUB in 2015 without findings
* 3 Ab CT Jan 2015, Apr 2015, May 2015; no significant findings
* 2 Chest CT Jan, Feb 2015, unremarkable
* Stress Thallium Mar 2015, normal

**For Help With High-Risk Case Management, Call:**

**Dr. XXX**

**Administrator**

**Director of Case Management**

**Complex Care Manager 1**

**Complex Care Manager 2**

# ED Care Plan Example 2

This is an example of a “Complex Care Plan” (ED Care Plan) that is currently in use and highly regarded by staff at a hospital with an ED high-utilizer program. The use of this “complex care plan” is to inform management decisions in the ED, consistent with what the guide describes as the ED care plan: creates institutional memory across different providers; makes visible recurrent presentations; summarizes repeated testing to inform diagnostic decisionmaking; identifies the patient’s existing clinical, behavioral, and social services; and recommends management strategies that promotes safe, high-quality care in the ED.

Note that this plan has the following structural elements: date created and/or date last modified (this will help the new user know how current the resources and recommendations are); SBAR type format (S= reason for plan; B= brief history of recurrent presentations; A: summary of prior visits, tests, existing resources; R: recommendations); and consistent structure (each care plan has same format). The team uses this structured Word document.

As with all examples, feel free to modify this template to best suit your needs.

Patient:

Age/Sex:

MRN#:

DOB:

**[Acute or ED] Care Plan**

**Care Plan Date:**

* [date plan was created and/or last updated]

**Reason for Care Plan:**

* [short phrase to describe high risk/frequent use]

**Brief History:**

* [brief 2-3 sentences summarizing recurrent presentations]
* Identify the “driver of utilization”: why does the patient repeatedly return to acute care?

**Utilization Summary:**

* [summarize past 12 months of ED visits, hospitalizations, relevant diagnostic tests]
* ED visits past 12 months:
* Hospitalizations past 12 months:
* CXR past 12 months [location, findings]
* CT scans past 12 months: [location, findings]

**Clinical and Support Resources:**

* [list clinical, behavioral, and social services - including contact names]

**Key Contacts:**

* [list primary contacts from the above and/or person from “complex care team” at hospital to contact when patient is in the ED]

**Recommendations:**

* [list strategies to improve management in ED and involvement of relevant teams/providers/agencies]
* [list any next steps to take in ED to advance the plan to promote quality and reduce high-frequency use]