## Contents

1. Background and Introduction ................................................................. 2

2. Methods .................................................................................................. 2

3. Findings ................................................................................................... 6

4. Discussion .............................................................................................. 8

5. Recommendations .................................................................................. 9
   - Standardize Risk Levels ........................................................................ 9
   - Standardized Risk Categories Based on Commonly Available Data .......... 9
   - Incorporate Caregiver Availability ....................................................... 10
   - Electronic Data .................................................................................... 10

6. References ............................................................................................ 12
1. **Background and Introduction**

There are approximately 7.6 million individuals who because of acute illness, long-term care conditions, permanent disability or terminal illness receive care in their home from 17,000 home care providers (U.S. Census Bureau, 2002). Technological advances have expanded the capabilities of home care providers so that many chronic conditions that would previously have been cared for in the hospital are being safely managed in the home. Intravenous 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 common devices that have allowed the expansion of home care (Lehoux, 2004, Leff and Burton, 2001).

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 by the disaster situation. For example, Greenwald et al., (2004) found that during the 2003 North American power blackout, 23 of 255 patients who required ED care presented with medical device failure; 13 of these patients were admitted to the hospital and accounted for 22 percent of all admissions during the blackout. Patients most affected by a disruption of services would be those with the most complex treatment/equipment needs that cannot be met by family or other informal caregivers.

Abt Associates along with our partners from the Brigham and Women’s Hospital and Massachusetts General Hospital in Boston, have been contracted by the Agency for Healthcare Research and Quality (AHRQ) to develop a “model” patient risk assessment rating tool or tool for community-based patients, rating their risk status should there be a disaster. The goal for such a tool would be for home health agencies and others to identify and count the number of individuals/patients who would be most at risk of ED/hospitalization if their home supports and services were disrupted during an emergency. All community-dwelling patients would be considered at risk during a MCE. This study, however, focuses on those whose needs are most complex; patients who could not safely be 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*

We first sought to determine whether any standard requirements or guidance exist, related to patient risk categorization tools, at either the 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. Home health agencies 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 (Laditka et al., 2008).
Several examples of patient risk categorization tools were obtained and reviewed. The first documented patient classification system was introduced in 2001 by Barbara Citarella (Citarella, 2009). The New York State Department of Health, in a 2005 letter to home care and hospice agencies, mandated that emergency plans be revised to incorporate a patient risk classification system (Dougherty, 2005). The sample classification system included as guidance in this New York letter is a three-level system structured as follows:

**Level I: High Priority.** Patients in this priority level need uninterrupted services. The patient must have care. 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 requiring life sustaining equipment or medication, those needing highly skilled wound care, and unstable patients with 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 resources to help them. The patient can safely miss a scheduled visit with basic care provided safely by family or other informal support or by the patient personally.

Another classification system, also developed by a State home care association in 2007 and based on B. Citarella’s earlier version, uses a very similar approach to the three-level system above, and offers examples of patient types for each category (Sienkiewicz et al., 2007).

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 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 oxygen, suctioning, nebulization, 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 needing uncomplicated routine wound care.

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

All of these categorization tools are intended for patients receiving 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 have the potential to destabilize rapidly during an
emergency and require medical care. Other service providers such as adult day care centers, medical equipment suppliers, or Meal on Wheels may have routine contact with such at-risk people. We found no patient classification tools that could be applicable to community-dwelling patients receiving care or services from other providers, with the exception of one triage tool that was used after Hurricane Katrina with vulnerable older adults in shelters (Dyer et al, 2008). This tool was used to “rate” elders with 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, it consists of 13 questions in three categories (medical/mental health, financial, and social) that placed an individual into one of three levels of ‘assistance required’. Level 1 indicates the need for immediate medical placement/care for elders with 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 were not quickly addressed. The triage tool placed people into Level 1 (Health/Mental Health Priority) based on their answers to questions about:

- Medical problems (diabetes, heart disease, high blood pressure, memory)
- Medication (does the individual take medication and do they have the medication with them)
- Assistance with ADLs (walking, eating, bathing, dressing, toileting, medication administration) and ambulation/transfer (cane, walker, wheelchair, bath bench)
- Orientation (does the individual know where they are and what year it is)
- Short-term memory (ability to recall the names of three items after several minutes)

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

We were unable to locate any research studies evaluating 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, we 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**

We solicited guidance from members of the Technical Expert Panel (TEP) regarding States that would 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 rural and urban areas, and 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 – the extremes of the continuum. The following six States: Florida, Illinois, Massachusetts, Oregon, New York, and Texas were selected. TEP panelists advised that the use of patient assessment tools is at the discretion of each HHA, and there could be very different tools used by different HHAs in the same State. To examine the range of patient categorization tools, we sought to obtain 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 we contacted these people; other State associations could not provide referrals. In these latter States, we used CMS’ Home Health Compare website to identify several HHAs in each State. We also contacted other community service providers (e.g., medical equipment suppliers, Meals on Wheels programs, adult day health 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 – and can you share a copy or screen shot?
- If using a patient classification system, how is it structured:
  - How many levels
  - Criteria/description of each level
  - When is the information collected, how often is it updated
  - Did the HHA or service provider create this system or adopt it from somewhere else? If 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 minor ones) where patient care was disrupted or challenged (e.g., snow/ice storm, power outage)?
  - Please describe the emergency – 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, and what type?

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

Twenty-one home health/hospice agencies were interviewed by telephone. Exhibit 1 summarizes the number of home health agencies contacted, by State.

<table>
<thead>
<tr>
<th>State</th>
<th>Number of Contacts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Illinois</td>
<td>3</td>
</tr>
<tr>
<td>Florida</td>
<td>2</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>9</td>
</tr>
<tr>
<td>New York</td>
<td>1</td>
</tr>
<tr>
<td>Oregon</td>
<td>1</td>
</tr>
<tr>
<td>Texas</td>
<td>5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>21</strong></td>
</tr>
</tbody>
</table>

Source: Abt Associates; 6/2009

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

Abt Associates Inc. Home Health Assessment Tools for Emergency Triage
3. Findings

A total of 25 organizations in six States were interviewed about their use of a patient risk assessment rating tool. Seventeen (two thirds) of the 25 described a two, three, four or five level categorization system used to rank patients, which was usually done as each patient was admitted to the HHA. 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 told us they do not use a patient classification system because they are very small and know all their patients’ needs; they can quickly identify those at risk (e.g., people on oxygen, continuous IVs) and see no need for a formal system with graded levels.

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

Use of Formal Patient Classification Systems

The formal systems our HHA contacts described, typically utilize 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). 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 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. Exhibit 2 summarizes the basis for the level characterization in the systems we reviewed.

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

<table>
<thead>
<tr>
<th>Type of System</th>
<th>Number</th>
<th>Basis</th>
</tr>
</thead>
<tbody>
<tr>
<td>2-level system</td>
<td>1</td>
<td>Time Frame (1)</td>
</tr>
<tr>
<td>3-level system</td>
<td>13</td>
<td>Time Frame (3)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Care Needs (6)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Combination of Care Needs and Support (3)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Combination of Care Needs and Time Frame (1)</td>
</tr>
<tr>
<td>4-level system</td>
<td>2</td>
<td>Combination of Care Needs and Time Frame (1)</td>
</tr>
<tr>
<td>5-level system</td>
<td>1</td>
<td>Combination of Care Needs, Support and Response to Disaster (1)</td>
</tr>
</tbody>
</table>

Source: Abt Associates, 2009
Process for collecting and updating patient information

Our contacts reported using a mix of paper and electronic systems. Larger HHAs are using electronic medical record systems with smaller HHAs using paper systems or none at all.

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 for emergency management planning purposes or communicating information on medical supply reserve (e.g., number of tanks of oxygen kept in house, 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 we contacted 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 considered highest priority. They 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 HHAs have more high priority patients than they can serve during disasters.

We asked HHAs to estimate the percentage of their patients who would be classified at highest risk should home care or other community-based services be interrupted by a disaster. Two HHAs estimated that one percent of their average daily census would fit into the highest risk category and require hospital care; two other HHAs estimated that 21-25 percent of their census would be in this highest risk category. They cautioned that census varies from one month to the next. In general, these highest risk patients were described as follows:

- Bedbound without a caregiver; unable to get food or fluids; immobilized or paralyzed
- Ventilator dependent
- Oxygen dependent
- IV infusion
- Using high tech equipment (e.g., wound vac, pleurovac)
- Dependent on a skilled service (e.g., respiratory therapy) that if not delivered put the patient at extreme risk
- Receiving injectable medication and unable or not yet trained on the procedure
- Dialysis patients
- Severe dementia or Alzheimer’s disease
- Severely mentally disturbed or retarded
- Daily wound care

When HHA nurses were asked to describe how they used their patient classification systems in preparation for storms where 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 “ad hoc” which patients could be seen early before the storm arrived, which could be checked on by a family member or neighbor, and which might need transport to a hospital by local fire/police. 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 contacted local fire departments that a
patient needed to be seen but the visiting nurse could not get to them. In these cases, ambulances were sent to bring the patients to hospitals.

None of the HHAs we spoke with 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; small HHAs are less likely to use such tools.

Although many tools appear to be similar (e.g. three levels of risk), they are used very differently in practice. For example, two HHAs located in the same State both use a 3-level patient risk categorization system but very different portions of their patient census are rated in the highest risk group: one reporting that only one percent of their clients was at highest risk, while the other reported that 21 percent of their clients were in the highest risk category. Either the tools are very different, or they are operationalized very differently, or both.

Some HHAs’ patient risk tools categorize so many patients at the highest risk level that they 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” and then are reduced to reviewing 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 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 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 infuse more uniformity in terms of the frequency of patient ratings.

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 centers, oxygen suppliers, Meals on Wheels programs, and the like. Some 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 we spoke with, a significant proportion of their caseloads are classified in the highest risk level, potentially making the system cumbersome to use especially during a mass casualty event with no advance warning. We suggest the following improvements:

- Standardize risk levels as high, medium and low rather than using numeric rankings that are not always consistent.
- Utilize standardized categories for ranking risk (i.e., care needs/clinical diagnoses, caregiver supports, and timeframe for visits).
- Base the risk categorization on common data available to every home health agency.
- Design systems that can print or transmit lists (given data privacy is protected) of high risk patients to emergency responders.

**Standardize Risk Levels**

The following is one suggestion, adapted from the 3-level system noted above (Dougherty, 2005) using only high, medium and low risk labels. By avoiding numeric labels, the potential confusion for which level is highest 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 require care should be provided on time or within a day. Most of these patients could be temporarily cared for in a special needs shelter, if one is available. They 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 is 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.

**Standardized Risk Categories Based on Commonly Available Data**

There is general agreement that standardized data describing community-patients’ service and equipment needs would be valuable for estimating the number of these patients who would require hospital/ER admission during a MCE. We considered using items from the Outcomes and Assessment Information Set (OASIS). OASIS is completed on admission/readmission (and every 60 days) for patients over the age of 18 (excluding maternity patients) receiving skilled services from a Medicare or Medicaid-certified home health agency. Although providing 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 not required to complete the OASIS. Our Expert Panel pointed out that these individuals’ needs are not necessarily any less complex than those whose care is captured in OASIS, but that these programs are run under different administrative guidelines. New York city, for example, has 64,000 individuals in their personal care program, for whom
OASIS data do not exist. In addition, OASIS captures patient data at intake to home care – when patients needs are most acute. OASIS is not a real time “snapshot” of current patient acuity and needs. We have therefore determined that OASIS would be insufficient for planning purposes because so many patients are not captured in this database, and because it might over-state 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 will be available in the latest version of OASIS, planned for implementation in January 2010. We based our caregiver ranking on item M2100 (Types and Sources of Assistance) that will be used in OASIS, which includes three categories of caregiver availability:

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

Exhibit 3 on page 11 is an example of a screening tool that could be used by any home care agency to rank each patient’s risk of hospitalization in the event of an MCE. The tool is designed to be completed 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 could be used in paper form, but ideally home care agencies would create a small database for storing this information about their patient population. Such a system could also have the capability to aggregate (roll up) the data, for planning purposes. Given that our primary focus in this project is on estimating the number of patients who would require hospital/ER admissions, an electronic database could focus on the services and equipment needs of patients requiring highly skilled medical management. This information could be made available to community and hospital disaster planners for advance planning. This in turn would give hospital personnel good estimates of the number of individuals requiring highly complex care who may seek hospital care during an MCE, and what their equipment and care needs may be when they arrive at the hospital. 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 to first responders (e.g. fire, police, EMS).
Exhibit 3

Community-Living Patient Screening Tool for Disaster Planning

This screening tool creates a record for identifying patient needs, and plans for meeting those needs, in the event of a MCE. Update every 3 months or whenever the patient’s status changes.

Step 1: Review the services/needs provided for the community-living patient. Check all that the agency is providing; do not check services/needs that the patient manages on his/her own. Use blank lines to enter additional services/needs. Indicate the availability of a caregiver.

<table>
<thead>
<tr>
<th>Medical Procedures/ Treatments</th>
<th>Medication Management</th>
<th>ADL/ Supervision/ Communication/ Transportation</th>
<th>Equipment Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respiratory</td>
<td>☐ Subcutaneous or IM injections</td>
<td>☐ ADL</td>
<td>☐ Oxygen</td>
</tr>
<tr>
<td>☐ Ventilator dependent</td>
<td></td>
<td>☐ Bedbound/paralyzed</td>
<td></td>
</tr>
<tr>
<td>☐ Oxygen</td>
<td>☐ Patient controlled analgesic pump</td>
<td>☐ Feed/Eating assist</td>
<td>☐ Ventilator</td>
</tr>
<tr>
<td>☐ Suctioning</td>
<td>☐ IV medication</td>
<td>☐ Wheelchair dependent</td>
<td>☐ Nebulizer</td>
</tr>
<tr>
<td>☐ Nebulizer treatment</td>
<td>☐ Oral meds</td>
<td>☐ Toileting assist</td>
<td>☐ Apnea monitor</td>
</tr>
<tr>
<td>☐ Tracheostomy care</td>
<td>☐ HIV/AIDS meds</td>
<td>☐ Oximeter</td>
<td></td>
</tr>
<tr>
<td>☐ Narcotics</td>
<td></td>
<td>☐ Suction machine</td>
<td></td>
</tr>
<tr>
<td>Nutrition</td>
<td></td>
<td>☐ CPM machine</td>
<td></td>
</tr>
<tr>
<td>☐ Enteral nutrition</td>
<td>☐ Supervision</td>
<td>☐ Ventricular Assist Device</td>
<td></td>
</tr>
<tr>
<td>☐ Parenteral nutrition</td>
<td>☐ Dementia/Alzheimer's</td>
<td>☐ IV supplies/pump</td>
<td></td>
</tr>
<tr>
<td>☐ MR/MI</td>
<td>☐ Feeding tube</td>
<td>☐ Wound Vac</td>
<td></td>
</tr>
<tr>
<td>☐ Ileostomy/colostomy</td>
<td>☐ Wheelchair</td>
<td>☐ Non-English speaking</td>
<td></td>
</tr>
<tr>
<td>☐ Urinary catheter indwelling/intermittent</td>
<td>Communication needs</td>
<td>☐ Hospital Vac</td>
<td></td>
</tr>
<tr>
<td>☐ Dialysis</td>
<td>☐ Aphasic</td>
<td>☐ Commode</td>
<td></td>
</tr>
<tr>
<td>☐ Contagious</td>
<td>☐ Deaf</td>
<td>☐ No car</td>
<td></td>
</tr>
<tr>
<td>☐ MRSA, VRE, C Diff</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skin</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Wound care</td>
<td>☐ Transportation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Clinical assessment for</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Step 2. Based on the services, equipment needs and caregiver availability listed in Step 1, what level of care would be most appropriate for this individual, if the usual services/equipment were not available?

☐ Highly skilled medical management - e.g., hospital
☐ Mid-level medical management - e.g., nursing home
☐ Special needs shelter (if available) – for those individuals with special medical needs due to physical impairment, mental impairment, cognitive impairment or sensory disabilities, who are not ill enough to require hospitalization. These shelters are supported by volunteer doctors and nurses and often have backup electric capability to support those with medical equipment reliant on electricity. [http://www.semp.us/publications/disaster_dictionary.php?letter=S]
☐ Alternate housing or general population shelter (public building providing food, water and bedding)

Step 3. Based on the needs listed in Step 1, how long would this person be safe in their home if the usual services/equipment were not available (consider the battery-life of any necessary equipment if power lost):

☐ Less than 24 hours (due to highly skilled nature of needs, no trained caregiver available and/or extensive equipment needs)
☐ 1 – 2 days (due to limited caregiver assistance/support and/or limited supplies/equipment)
☐ 3 days or longer (caregiver trained and available and/or no supplies/equipment needs)
6. References

Citarella, B. Email correspondence. August 24, 2009.


