



Emergency Room and Urgent Care Strategies

DID YOU KNOW?

- People with IDD tend to use the ER for conditions that are different from the general population, such as seizures, urinary tract infections, and aspiration.
- Providers surveyed in 2013 by DDS indicated that bringing accurate and up-to-date health care information and history (86%) and having familiar staff accompany the person (76%) were the two most important factors in ensuring a successful ER visit.
- Physical injuries, seizures, and respiratory infections were the top 3 reasons people who receive services from DDS used the ER in 2014 and 2015.

Emergency Rooms (ER) can be an important source of care for people of all ages, but they can also be a risky place, especially for people with Intellectual or Developmental Disabilities (IDD). ER's can be chaotic, and fast-paced. ER doctors will likely be unfamiliar with the person's support needs. There is often a lack of privacy, and many people experience long wait times. Individuals may feel uncertain, fearful, or resistant to care in this type of environment. Clinicians may not know the person well or may be unfamiliar with how to treat or communicate best with people who have IDD.

Many conditions can, and should be, treated first in a primary care or urgent care setting. An analysis of recent ER visits for people receiving services from DDS looked at the top reasons for ER visits. Many of the top reasons are preventable or manageable conditions such as urinary tract infections, skin infections, or dehydration that may well have been treated early in a primary care setting before they rose to the level of a medical emergency.

Staff have some influence over the outcome of ER visits. Staff can be well-prepared for visits by bringing all relevant information and by being good health advocates.

Staff should complete an Incident Report for EVERY visit to the ER or Urgent Care

ER Visits: If the visit is for a suicide attempt, report as **Suicide Attempt**.

If the person is admitted to the hospital from the ER, report as an **Unexpected Hospital Visit/Medical Hospitalization**.

If the person is not admitted, report it as **Unexpected Hospital Visit/E. R. Visit**.

Urgent Care visits: Report as a **Medical or Psychiatric Intervention Not Requiring Hospital Visit**.

Risk Assessment

Determining where to go - Providers may wish to develop specific policies to guide staff on when to call 911 for emergency response, when to use the ER, and when to use Urgent Care clinics. Specific individuals may also have written, signed protocols that would dictate when they should be treated in the ER for ongoing medical conditions.

- When considering visiting an Urgent Care clinic, staff should call the PCP first and talk with office or after-hour staff to help determine if the condition can be treated in the urgent care as opposed to the ER.
- Consider having dedicated clinical support or managers to assist staff in the moment to guide their decision-making.

When is the ER most appropriate? In general, ER usage is most often based on the type and severity of the incident as well as individual characteristics. Ask yourself:

- Does the person require an immediate lifesaving intervention?
- Is the person in severe pain or distress?
- Is there a high likelihood of an injury? For example, a person experiences a fall and there is a high likelihood that they experienced a head injury.
- Is the person experiencing medical symptoms that are not typical for them? For example, someone has a seizure who normally does not.

Who to Call?

Primary Care Physician or Urgent Care

- The Primary Care Physician (PCP) is the best source for treatment of **minor illnesses** or minor bites, burns, or injuries; treatment of symptoms that are usual or familiar for the individual; and prescription medication for ongoing issues.
- If **unexpected or uncomfortable** conditions develop such as pink eye, rashes, dizziness, ear infections, cold, cough, flu or non-life threatening allergic reactions, the PCP is the best person to call because they are familiar with the person.
- If the PCP is unavailable, consider using an Urgent Care clinic.

Emergency Room

- **Emergent** (sudden) Conditions
- Severe burns, headaches, allergic reactions or asthma attacks
- Severe pain/bleeding that doesn't stop after 10 min.
- Choking (The person must be evaluated after the object was cleared).
- Unwitnessed falls

When to Call 911

- Is the condition life threatening such as choking, unconsciousness, or seizures lasting over 5 minutes?
- Could it get worse and become life threatening on the way to the hospital?
- Will you get delayed in traffic?
- If you try to move the person, will it lead to more harm?

Support Strategies

What to bring to the ER/UC

- Medical Record or other health history book
- Copy of the Health Care Record
- Emergency Fact Sheet & ID Form
- Current Medication List
- HCP Encounter Form(s)
- HCP Order Sheets
- Incident Report
- Health Insurance Card and/or Hospital Card

Who should go?

- Staff who are familiar with the person and their health history and medications and whom the person feels comfortable.
- If no such staff are available at the time of the incident, a familiar staff member should meet the person at the ER or UC as soon as possible.

Healthcare Advocacy

- Speak with the person, not for the person.
- Do not talk to hospital staff as if the person is not there.
- Help the person accurately report their symptoms and pain.
- Prompt with questions or provide additional info as needed.
- Remain with the person for tests and blood work.
- Review Health Care Provider's instructions with the person in terms that they can understand.
- Write down the answers to any questions anyone has about follow-up instructions.

If you call 911

- Call 911 first **and then** call your supervisor.
- Speak slowly, calmly and clearly.
- Give the person's name, address and phone number. If you're on the road, note the street and direction you're traveling.
- Briefly describe what's going on and when the problem started.
- Don't hang up until the dispatcher tells you to.

Be prepared

- Ensure residential locations are clearly marked with the house number.
- Don't let staff park in the driveway or directly in front of the house to allow a clear pathway for emergency vehicles.
- Assign one staff to stand outside to direct emergency personnel.
- Ensure house phones function properly and staff know how to call 911 and what to say.
- Practice emergency drills and emphasize the importance of remaining calm!

Post-ER Follow-up

Staff can best support people when leaving the ER or Urgent Care by:

- Following discharge instructions and asking clarification questions if any parts of the instructions are unclear. Document answers to questions.
- Understanding what signs and symptoms of illness to watch for.
- Knowing who to call with questions.

Staff should also follow up with their agency nursing supports and call the individual's PCP when any additional questions or concerns. Contacting the guardian or family to inform them of the event may also be necessary.

Hospital and Emergency Room Data

DDS analyzed unexpected hospital visits reported in HCSIS between October 2014 and September 2015. A total of 11,937 unexpected hospital visits were reported during this time, involving a total of 5,478 individuals served by DDS. The adult DDS service population had a 13% increase in the number of people with one or more unexpected hospital visits in 2014-2015, and a 15% increase in the number of unexpected hospital visits (11,393 in 2014-2015) compared to 2011-2012. The increase was largely due to incidents involving illness rather than injuries.

In 2014-15, 2,593 consumers had more than one Unexpected Hospital Visit, ranging from 1 to 43 visits. There was a 20% increase in the number of people with multiple incidents across this time period (compared to 2011-2012), almost entirely driven by an increase in the number of people with multiple ER visits.

Emergency Room Visits

Emergency Room (ER) usage data collected during this same time period identified the top causes of ER visits (see table below). The top three reasons for ER visits remained the same in 2014 – 2015 when compared to analyses done in 2011-12. Increased ER use was observed for gastrointestinal conditions including constipation, systemic infections and psychiatric conditions; a decrease was seen in G/J-tube related visits. Dehydrations, choking/aspiration, and diabetes-related incidents ranked in the top 15.

ER Visits Top 5 Diagnoses

Rank	<u>Diagnosis</u>	Oct 2014-Sept 2015	
		# Incidents	% of diagnoses
1.	Physical injuries (non-burn)	2,352	29%
2.	Seizures	448	5.4%
3.	Respiratory infections	400	4.8%
4.	Gastrointestinal conditions, incl. constipation	380	4.6%
5.	UTI	353	4.3%

Physical Injuries

Falls were the top cause of injury resulting in ER visits in the past 3 reporting cycles (2006–2007, 2011-2012, and 2014-2015). Falls accounted for 45% of injuries resulting in ER visits in 2014-15, down slightly from 49% reported in 2011-2012. The top remaining causes of injury for ER visits in 2014-2015 in were self-inflicted injury (13%), Seizure (4%), Environmental (4%) and peer-inflicted (3%).

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