

# **James L. Holly, M. D.**

## **Physician Consortium for Performance Improvement Care Transition Data Set Tutorial for Using SETMA's Deployment**

### **2009 Introduction to SETMA's Care Transition Tutorial**

In June, 2009, the Physician Consortium for Performance Improvement, which in part includes the American Board of Internal Medicine Foundation, American College of Physicians, Society of Hospital Medicine and the AMA Physician Consortium, published Care Transitions: Performance Measurement Set entitled Phase I: Inpatient Discharges and Emergency Department Discharges.

Since 2003, SETMA has utilized NextGen EMR in the in-patient setting in order to complete Admission History and Physician examinations and Discharge Summaries (renamed Hospital Care Summary and Post Hospital Plan of Care and Treatment Plan in 2010) for the patients whose care we manage. SETMA has also designed and used a Daily Progress Note in our EMR. That project was suspended until we get an interface built between the hospital and NextGen so that daily vital signs and patient-condition data, laboratory values and medications can be automatically posted to our EM. We hope that will be accomplished with the deployment of our Health Information Exchange (HIE).

After reviewing the content of the Care Transitions Measurement Set, it was apparent that with a few modifications which have been made, SETMA performs all of the elements of this set. We believe that the auditing of this performance measure by the provider at the point of service will improve that quality of care given to patients transitioning from inpatient or ER to another place of care. The following links are discussions posted on SETMA's website about the complexities of care transitions.

[SETMA's Inpatient Team Based Process Analysis: The Interaction of SETMA's Hospital Care Team - Collegiality and "Electronic Huddles"](#)

[SETMA's Care Coordination and Transitions of Care: Part I](#)

[A Care System for Effecting Reductions in Preventable Readmission Rates](#)

[CMMI Care Innovation Summit, Washington, D.C. January 26, 2012: Observations of an Attendee](#)

[Medical Home Series Two: Part VI Care Transitions](#)

[Patient-Centered Medical Home and Care Transitions: Part II](#)

[Patient-Centered Medical Home and Care Transitions: Part I](#)

[Reducing Preventable Readmissions to the Hospital](#)

[Concierge Medicine and the Future of Healthcare](#)

[Patient-Centered Medical Home - Care Coordination and Coordinated Care](#)

[SETMA and the National Quality Forum](#)

[The Future of Healthcare - SETMA's View](#)

[Passing the Baton: Effective Transitions in Healthcare Delivery](#)

In addition, the method SETMA has developed to make the elements automatically interactive with the patient's care streamlines this process and makes it easy.

This Tutorial explains SETMA's deployment of this measurement set and how to use it. Currently, the Care Transition Data Set contains 18 elements. Fourteen or documentation elements and four are action elements. Please note that this is Phase I of the Care Transition Data Set; as this set evolves, SETMA will modify this deployment to reflect those upgrades.

The following are links to SETMA's first 4.5 years of auditing of our use of the Care Transitions Data Set.

- **Care Transition Audit**
  - [2013 Q-1,Q-2 - Care Transition Audit](#)
  - [2012 - Care Transition Audit](#)
  - [2011 - Care Transition Audit](#)
  - [2010 - Care Transition Audit](#)
  - [2009 - Care Transition Audit](#)

## How to use SETMA's Care Transition Audit

You will find the Care Transition Audit tool by opening the AAA Home template

**SOUTHEAST TEXAS MEDICAL ASSOCIATES, L.L.P.**

Patient:   Sex:  Age:  Patient's Code Status:

Home Phone:  Date of Birth:

Work Phone:  Cell Phone:

Patient has one or more alerts!

[Click Here to View Alerts](#)

[Pre-Vist/Preventive Screening](#)      [Bridges to Excellence View](#)      [Intensive Behavioral Therapy Transtheoretical Model](#)

Preventive Care	Template Suites	Disease Management	Last Updated	Special Functions
<a href="#">SETMA's LESS Initiative</a> <input type="text" value="I"/>	<a href="#">Master GP</a> <input type="text" value="I"/>	<a href="#">Diabetes</a> <input type="text" value="I"/>	<input type="text" value="09/28/2013"/>	<a href="#">Lab Present</a> <input type="text" value="I"/>
Last Updated: <input type="text" value="09/28/2013"/>	<a href="#">Pediatrics</a>	<a href="#">Hypertension</a> <input type="text" value="I"/>	<input type="text" value="05/21/2013"/>	<a href="#">Lab Future</a> <input type="text" value="I"/>
<a href="#">Preventing Diabetes</a> <input type="text" value="I"/>	<a href="#">Nursing Home</a> <input type="text" value="I"/>	<a href="#">Lipids</a> <input type="text" value="I"/>	<input type="text" value="03/08/2013"/>	<a href="#">Lab Results</a> <input type="text" value="I"/>
Last Updated: <input type="text" value="//"/>	<a href="#">Ophthalmology</a>	<a href="#">Acute Coronary Syn</a> <input type="text" value="I"/>	<input type="text" value="//"/>	<a href="#">Hydration</a> <input type="text" value="I"/>
<a href="#">Preventing Hypertension</a> <input type="text" value="I"/>	<a href="#">Physical Therapy</a>	<a href="#">Angina</a> <input type="text" value="I"/>	<input type="text" value="//"/>	<a href="#">Nutrition</a> <input type="text" value="I"/>
<a href="#">Smoking Cessation</a> <input type="text" value="I"/>	<a href="#">Podiatry</a>	<a href="#">Asthma</a>	<input type="text" value="//"/>	<a href="#">Guidelines</a> <input type="text" value="I"/>
<a href="#">Care Coordination Referral</a>	<a href="#">Rheumatology</a>	<a href="#">Cardiometabolic Risk Syn</a> <input type="text" value="I"/>	<input type="text" value="09/23/2013"/>	<a href="#">Pain Management</a>
<a href="#">PC-MH Coordination Review</a>	<b>Hospital Care</b>	<a href="#">CHF</a> <input type="text" value="I"/>	<input type="text" value="//"/>	<a href="#">Immunizations</a>
<a href="#">Needs Attention!!</a>	<a href="#">Hospital Care Summary</a> <input type="text" value="I"/>	<a href="#">Diabetes Education</a>	<input type="text" value="//"/>	<a href="#">Reportable Conditions</a>
<a href="#">HEDIS</a> <a href="#">NQF</a> <a href="#">PQRS</a> <a href="#">ACO</a>	<a href="#">Daily Progress Note</a>	<a href="#">Headaches</a>	<input type="text" value="//"/>	<b>Information</b>
<a href="#">Elderly Medication Summary</a>	<a href="#">Admission Orders</a> <input type="text" value="I"/>	<a href="#">Renal Failure</a>	<input type="text" value="//"/>	<a href="#">Charge Posting Tutorial</a>
<a href="#">STARS Program Measures</a>		<a href="#">Weight Management</a> <input type="text" value="I"/>	<input type="text" value="//"/>	<a href="#">Drug Interactions</a> <input type="text" value="I"/>
<b>Exercise</b>				<a href="#">E&amp;M Coding Recommendations</a>
<a href="#">Exercise</a> <input type="text" value="I"/>				<a href="#">Infusion Flowsheet</a>
<a href="#">CHF Exercise</a> <input type="text" value="I"/>				<a href="#">Insulin Infusion</a>
<a href="#">Diabetic Exercise</a> <input type="text" value="I"/>				

Patient's Pharmacy:

Phone:  Fax:

**Pending Referrals**

Status	Priority	Referral	Referring Provider
Completed	Routine	SETMA Diabetes Education	Holly
Completed	Routine	Abdominal U/S	Holly

In previous iterations of this tool, the transitions audit was triggered off the Discharge Summary template. Now, however, the Discharge Summary has been renamed to Hospital Care Summary and Post Hospital Plan of Care and Treatment Plan. The tutorial for that tool can be found at <http://www.jamesholllymd.com/epm-tools/hospital-care-summary-and-post-hospital-plan-of-care-and-treatment-plan-tutorial>. The Hospital Care Summary and Post Hospital Plan of Care and Treatment Plan is triggered off the button entitled Hospital Care Summary which is outlined in green below.

**SOUTHEAST TEXAS MEDICAL ASSOCIATES, L.L.P.**

Patient:   Sex:  Age:  Patient's Code Status:

Home Phone:  Date of Birth:

Work Phone:  Cell Phone:

**Patient has one or more alerts!**  
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**Preventive Care**  
[SETMA's LESS Initiative](#) | Last Updated: 09/28/2013  
[Preventing Diabetes](#) | Last Updated: //  
[Preventing Hypertension](#) |  
[Smoking Cessation](#) |  
[Care Coordination Referral](#)  
[PC-MH Coordination Review](#)  
*Needs Attention!!*  
[HEDIS](#) [NQF](#) [PQRS](#) [ACO](#)  
[Elderly Medication Summary](#)  
[STARS Program Measures](#)

**Template Suites**  
[Master GP](#) |  
[Pediatrics](#)  
[Nursing Home](#) |  
[Ophthalmology](#)  
[Physical Therapy](#)  
[Podiatry](#)  
[Rheumatology](#)

**Disease Management**  
[Diabetes](#) |  
[Hypertension](#) |  
[Lipids](#) |  
[Acute Coronary Syn](#) |  
[Angina](#) |  
[Asthma](#)  
[Cardiometabolic Risk Syn](#) |  
[CHF](#) |  
[Diabetes Education](#)  
[Headaches](#)  
[Renal Failure](#)  
[Weight Management](#) |

**Last Updated**

**Special Functions**  
[Lab Present](#) |  
[Lab Future](#) |  
[Lab Results](#) |  
[Hydration](#) |  
[Nutrition](#) |  
[Guidelines](#) |  
[Pain Management](#)  
[Immunizations](#)  
[Reportable Conditions](#)

**Exercise** [Exercise](#) |  
[CHF Exercise](#) |  
[Diabetic Exercise](#) |

**Hospital Care**  
[Hospital Care Summary](#) |  
[Daily Progress Note](#)  
[Admission Orders](#) |

**Pending Referrals** |

Status	Priority	Referral	Referring Provider
Completed	Routine	SETMA Diabetes Education	Holly
Completed	Routine	Abdominal U/S	Holly

**Chart Note - Now**  
**Chart Note - Offline**

**Patient's Pharmacy**  
  
 Phone:   
 Fax:





### Care Transition Audit

Has the reason for hospitalization been documented?	<input type="button" value="No"/>	<input type="button" value="Click to Update/Review"/>		
Have discharge diagnoses been entered?	<input type="button" value="No"/>	<input type="button" value="Click to Update/Review"/>		
Have the patient's medications been updated/reconciled?	<input type="button" value="No"/>	<input type="button" value="Click to Update/Review"/>		
Have the patient's allergies been updated? Also document allergies/reactions to medications.	<input type="button" value="No"/>	<input type="button" value="Click to Update/Review"/>		
Has the patient's cognitive status been documented?	<input type="button" value="No"/>	<input type="button" value="Click to Update/Review"/>		
Have pending results or tests been documented?	<input type="button" value="No"/>	<input type="button" value="Click to Update/Review"/>		
Have major procedures been documented?	<input type="button" value="No"/>	<input type="button" value="Click to Update/Review"/>		
Has a follow-up care plan been completed?	<input type="button" value="No"/>	<input type="button" value="Click to Update/Review"/>		
Has the patient's progress to goals/treatment been documented?	<input type="button" value="No"/>	<input type="button" value="Click to Update/Review"/>		
Have advanced directives been completed and a surrogate decision maker named or a reason given for not completing an advanced care plan?	<input type="button" value="No"/>	<input type="button" value="Click to Update/Review"/>		
Has the reason for discharge been documented?	<input type="button" value="No"/>	<input type="button" value="Click to Update/Review"/>		
Has the patient's physical status been documented?	<input type="button" value="No"/>	<input type="button" value="Click to Update/Review"/>		
Has the patient's psychosocial status been documented?	<input type="button" value="No"/>	<input type="button" value="Click to Update/Review"/>		
Has a list of available community resources been documented?	<input type="button" value="No"/>	<input type="button" value="Click to Update/Review"/>		
--OR--				
Has a list of coordinated referrals been documented?	<input type="button" value="No"/>	<input type="button" value="Click to Update/Review"/>		
Has the current/reconciled medication list been discussed with the patient/family/caregiver?	<input type="radio"/> Yes <input type="radio"/> No	<table border="1" style="width: 100px; height: 20px;"><tr><td style="text-align: center;">//</td><td style="width: 20px;"></td></tr></table>	//	
//				
Have the discharge orders been discussed with the patient/family/caregiver?	<input type="radio"/> Yes <input type="radio"/> No	<table border="1" style="width: 100px; height: 20px;"><tr><td style="text-align: center;">//</td><td style="width: 20px;"></td></tr></table>	//	
//				
Have the follow-up instructions been discussed with the patient/family/caregiver?	<input type="radio"/> Yes <input type="radio"/> No	<table border="1" style="width: 100px; height: 20px;"><tr><td style="text-align: center;">//</td><td style="width: 20px;"></td></tr></table>	//	
//				
Have the discharge materials been printed and given to the patient/family/caregiver?	<input type="radio"/> Yes <input type="radio"/> No	<table border="1" style="width: 100px; height: 20px;"><tr><td style="text-align: center;">//</td><td style="width: 20px;"></td></tr></table>	//	
//				
<input type="button" value="OK"/>	<input type="button" value="Cancel"/>			

There are eighteen data points in the Care Transition Data Set. Fourteen are elements of documentation and four are actions which are to be taken. Once the discharge summary has been completed,

If the element has been met in the patient's record, or if the action required **has been taken**, two things will appear:

1. The element will appear in black fonts
2. The box next to the element will contain a "Yes" which will be in black fonts.

If the documentation or action required for an element in the Care Transition **has not been completed**, two things will appear:

1. The element will appear in red fonts
2. The box next to the element will contain a "No" which will be in red fonts.

To the right of each of the first fourteen elements of the data set, there is a button entitled "Click to update/review." When this button is depressed, it will automatically take you to the part of the discharge record which will allow you to document what is required but missing. In that the last four elements require an action, the documentation is completed by marking the "yes" or "no" radial button next to the element.

### Care Transition Audit

Has the reason for hospitalization been documented?	<input type="radio"/> No	<input type="button" value="Click to Update/Review"/>
Have discharge diagnoses been entered?	<input type="radio"/> No	<input type="button" value="Click to Update/Review"/>
Have the patient's medications been updated/reconciled?	<input type="radio"/> No	<input type="button" value="Click to Update/Review"/>
Have the patient's allergies been updated? Also document allergies/reactions to medications.	<input type="radio"/> No	<input type="button" value="Click to Update/Review"/>
Has the patient's cognitive status been documented?	<input type="radio"/> No	<input type="button" value="Click to Update/Review"/>
Have pending results or tests been documented?	<input type="radio"/> No	<input type="button" value="Click to Update/Review"/>
Have major procedures been documented?	<input type="radio"/> No	<input type="button" value="Click to Update/Review"/>
Has a follow-up care plan been completed?	<input type="radio"/> No	<input type="button" value="Click to Update/Review"/>
Has the patient's progress to goals/treatment been documented?	<input type="radio"/> No	<input type="button" value="Click to Update/Review"/>
Have advanced directives been completed and a surrogate decision maker named or a reason given for not completing an advanced care plan?	<input type="radio"/> No	<input type="button" value="Click to Update/Review"/>
Has the reason for discharge been documented?	<input type="radio"/> No	<input type="button" value="Click to Update/Review"/>
Has the patient's physical status been documented?	<input type="radio"/> No	<input type="button" value="Click to Update/Review"/>
Has the patient's psychosocial status been documented?	<input type="radio"/> No	<input type="button" value="Click to Update/Review"/>
Has a list of available community resources been documented?	<input type="radio"/> No	<input type="button" value="Click to Update/Review"/>
--OR--		
Has a list of coordinated referrals been documented?	<input type="radio"/> No	<input type="button" value="Click to Update/Review"/>

---

Has the current/reconciled medication list been discussed with the patient/family/caregiver?	<input type="radio"/> Yes <input type="radio"/> No	<input type="text" value="//"/>
Have the discharge orders been discussed with the patient/family/caregiver?	<input type="radio"/> Yes <input type="radio"/> No	<input type="text" value="//"/>
Have the follow-up instructions been discussed with the patient/family/caregiver?	<input type="radio"/> Yes <input type="radio"/> No	<input type="text" value="//"/>
Have the discharge materials been printed and given to the patient/family/caregiver?	<input type="radio"/> Yes <input type="radio"/> No	<input type="text" value="//"/>

The eighteen elements are:

**1. Has the reason for hospitalization been documented?"**

If the box next to this element indicates that it has not been documented, in which case a red "No" appears, depressing the "update/review" button displays the following template reason for hospitalization can be entered.

**Hospital Course**

Admitted  Through the ER  
 From the office  
 By elective admission

Other Facility:

For Treatment Of:

Uninsured patient?  Yes  No  
 Unassigned patient?  Yes  No

Add Treatment Comments

Treated with IV Fluids

Fluids	Antimicrobial	Units	Type	Date
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

and

Received Blood Transfusion

Units	Type	Date
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

Patient Received

Breathing treatments of

Physical therapy  
 Speech therapy  
 Occupational therapy  
 Radiation therapy  
 Chemotherapy

Add Diagnostic Comments

**Diagnostics**

The following were obtained and reviewed  Cultures  
 Diagnostic Tests  
 Lab

Add Complication Comments

**Complications**

No complications experienced  
 Hospital course uneventful  
 Gradual improvement took place

Patient developed a complication of   
 Patient was transferred to ICU for

Add Response Comments

**Response to Treatment**

Patient responded to treatment  
 Patient did not respond to treatment

Abdominal tenderness has resolved  
 Blood pressure control has been reestablished.  
 Chest pain has resolved  
 Chest x-ray and physical exam of lungs improved

Fluid and electrolyte balance were re-established  
 Neuro status has returned to normal  
 Patient is afebrile

Add Discharge Comments

**Discharge Condition**

Has improved  
 Is ambulatory

Has deteriorated  
 Is up in chair

Stable but cont. to have problems  
 Is bedfast

Patient Deceased  
 Cause of Death:

**Reason for Discharge**

Recovered from acute condition  
 Transferred to higher level of care

Maximum benefit reached in hospital setting  
 Transferred to Hospice for end of life care

Patient is stable  
 Transferred to LTAC for continued care

Patient expired  
 Scheduled Readmission

The reason for hospitalization can then quickly be added to the record.

## 2. "Have Discharge Diagnoses been entered?"

If the box next to this element indicates that it has not been documented, in which case a red "No" appears, depressing the "update/review" button displays the following template where the discharge diagnoses can be entered.

**Hospital Care Summary**

Admission Date // Facility SET Medical Center  
 Discharge Date // Type Discharge Summary  
 Scheduled Admission  Yes  No Attending

Admitting Diagnosis	Status	Discharge Diagnosis	Status	Re-order

Additional Admitting Dx Additional Discharge Dx  
 Discharge into Chronic List

Admitting Chronic Conditions	Discharge Chronic Conditions	Re-order
DM (diabetes mellitus) type II c	DM (diabetes mellitus) type II controllec	
Chronic renal disease, stage I	Chronic renal disease, stage II	
Diastolic CHF, chronic	Diastolic CHF, chronic	
Malnutrition	Malnutrition	
Chronic renal disease, stage I	Chronic renal disease, stage II	
Metabolic syndrome	Metabolic syndrome	
Hypertension	Hypertension	
Gout	Gout	
Hypertensive retinopathy of b	Hypertensive retinopathy of both eyes	
Elevated blood uric acid level	Elevated blood uric acid level	
BPH without urinary obstructi	BPH without urinary obstruction	
Coronary artery disease	Coronary artery disease	
Obesity, morbid	Obesity, morbid	
Meniscus, lateral, derangeme	Meniscus, lateral, derangement	
Elevated C-reactive protein	Elevated C-reactive protein	
Myocardial infarct, old	Myocardial infarct, old	
Elevated sed rate	Elevated sed rate	

Care Transition Audit Post-Hospital Patient Audit

Follow-Up Exceptions  
 Patient To Follow-Up With Non-SETMA Provider  
 Patient Ok To Follow-Up > 6 Days

Discharging To  
 Discharge Condition  
 Prognosis  
 Readmission Risk Low  
 Discharge Time  1 - 31 minutes  > 31 minutes  
 Prison Inmate  Yes  No  
 Days in ICU  
 Days on IV Antibiotics  
 Days on Ventilator

Fall Risk Assessment 08/21/2013  
 Functional Assessment 05/21/2013  
 Pain Assessment 09/13/2013  
 Karnofsky/Lansky Scale //  
 Palliative Perf Scale //  
 Last Hospital Discharge Medication Reconciliation 08/14/2013  
 Hospital Follow-Up Call  
 Surgeries This Stay //  
 //  
 //

Home  
 Histories  
 Health  
 System Review  
 Physical Exam  
 Procedures  
 Radiology  
 EKG  
 Laboratory  
 Hydration  
 Nutrition  
 Hospital Course  
 Nursing Home  
 Follow-up Instr  
 Follow-up Loc  
 Document  
 Follow-Up Doc

### 3. “Have the patient’s medications been updated/reconciled?”

If the box next to this element indicates that it has not been documented, in which case a red “No” appears, depressing the “update/review” button displays the following template where the medications can be updated and/or reconciled.

During the hospitalization process, SETMA’s patients have four medication reconciliations:

- Upon admission
- Upon discharge
- Care Coaching Call from SETMA’s Care Coordination Department the day after discharge
- Follow-up visit in clinic: within two days for high risk readmission and within five days for other others.



hospitalization can be documented.

Formulary	Status	Medication Name	Generic Name	Original Start	Start Date
Status: Active (11 items)					
Active		Advil Cold & Sinus 30 mg-200 mg tablet	IBUPROFEN/PSEUDOEPHEDRINE HCL	03/12/2013	
Active		Ecotrin Low Strength 81 mg Tab	ASPIRIN	04/04/2008	
Active		Fenofibrate 160 mg Tab	FENOFIBRATE	02/04/2008	08/23/2013
Active		Nasonex 50 mcg/actuation Spray	MOMETASONE FUROATE	03/12/2013	08/23/2013
Active		Neurontin 100 mg capsule	GABAPENTIN	09/17/2013	09/17/2013
Active		Norvasc 10 mg tablet	AMLODIPINE BESYLATE	08/23/2012	08/23/2013
Active		Plavix 75 mg Tab	CLOPIDOGREL BISULFATE	06/26/2008	08/23/2013
Active		Prilosec OTC 20 mg Tab	OMEPRAZOLE MAGNESIUM	07/13/2011	08/23/2013
Active		Synthroid 100 mcg Tab	LEVOTHYROXINE SODIUM	01/23/2007	08/23/2013

Prescribe New | Print | Send | Renew - Edit Rx | Interactions | Stop | Education | Dose Range | Delete | Eligibility | Medication

**Advil Cold & Sinus 30 mg-200 mg tablet**

Sig: take 1 tablet by oral route every 4 - 6 hours as needed; do not exceed 6 tablets in 24hrs [Remove Sig](#)

Quantity:  Units:  Refills:   Dispense As Written

Start:  Stop:  Duration:   Prescribed Elsewhere Site:

Comments: *This field is for nonclinical comments to the pharmacist. Any additional clinical instructions for this prescription should be added using the 'Additional Instructions' segment of the Sig Builder.*  PRN Reason:

Problem:

**4. “Have the patient’s allergies been updated?” “Also, document allergies/reactions to medications.”**

If the box next to this element indicates that it has not been documented, in which case a red “No” appears, depressing the “update/review” button displays the following template where the allergies can be reviewed, updated and where any adverse reactions which took place during the

Date	Description	Onset/Sympt	Resolved	Type	Contr
01/10/2013 01:20 PM	NO KNOWN DRUG ALLERGIES	01/10/2013	00/00/0000	Specific Allergen Group	

Include Resolved Allergies  No Unresolved Allergies

Allergy:

Location:   Intolerance

Provider:  Severity:

Onset/Sym:  Reaction:

Resolved:  Allergy type:

Allergy Comments:

**5. “Has the patient’s cognitive status been documented?”**

If the box next to this element indicates that it has not been documented, in which case a red “No” appears, depressing the “update/review” button displays the Constitutional template of the

### Constitutional Exam

**Normal**

Level of Consciousness

Orientation

Level of Distress

Nourishment   BMI

Overall Appearance

**Comments**

**6. “Have pending results or test been documented?”**

If the box next to this element indicates that it has not been documented, in which case a red “No” appears, depressing the “update/review” button displays the Hospital Course template where any pending or unreported tests can be denoted.

### Hospital Course

Admitted  Through the ER  Other Facility  For Treatment Of

From the office  Uninsured patient?  Yes  No

By elective admission  Unassigned patient?  Yes  No

Treated with IV Fluids  Received Blood Transfusion  Patient Received

Fluids	Antimicrobial	Units	Type	Date	Breathing treatments of
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>

Received IV medications  Physical therapy

Speech therapy

Occupational therapy

Radiation therapy

Chemotherapy

**Diagnostics**

The following were obtained and reviewed  Cultures

Diagnostic Tests

Lab

**Complications**

No complications experienced  Patient developed a complication of

Hospital course uneventful  Patient was transferred to ICU for

Gradual improvement took place

**Response to Treatment**

Patient responded to treatment  Patient did not respond to treatment

Abdominal tenderness has resolved  Fluid and electrolyte balance were re-established

Blood pressure control has been reestablished  Neuro status has returned to normal

Chest pain has resolved  Patient is afebrile

Chest x-ray and physical exam of lungs improved

**Discharge Condition**

Has improved  Has deteriorated  Stable but cont. to have problems  Patient Deceased

Is ambulatory  Is in chair  Is bedfast

Cause of Death:

**Reason for Discharge**

Recovered from acute condition  Maximum benefit reached in hospital setting  Patient is stable  Patient expired  Scheduled Readmission

Transferred to higher level of care  Transferred to Hospice for end of life care  Transferred to LTAC for continued care

Last Name	First Name	Date	Reason
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

**Pending Tests/Results**

List any tests or results which are still pending.

Check here if none  List Contact to Obtain Results

( ) - (ext)

I have reviewed and agree with the consultant's documentation and plan.

Yes  No

**7. “Have major procedures been documented?”**

If the box next to this element indicates that it has not been documented, in which case a red

“No” appears, depressing the “update/review” button displays the Major Procedures template where the results can be entered.

The screenshot shows a web interface titled "Special Procedures". At the top, there are two buttons: "Echocardiogram" and "EKG". Below these is a section titled "Additional Procedures". This section contains a table with two columns: "Procedure" and "Results". The table has several rows, each with a text input field for the procedure name and a date input field (formatted as //). A dropdown menu is open over the first row, listing various medical procedures: Bronchoscopy, CABG, Cardiac, Cardiac Cath, Colonoscopy, CT, Cysto, Doppler, EGD, MRA, MRI, Surgery, and Ultrasound. A "Close" button is located at the bottom of the dropdown menu.

**8. “Has a follow-up care plan been completed?”**

If the box next to this element indicates that it has not been documented, in which case a red “No” appears, depressing the “update/review” button displays the Follow-up Plan template where the plan can be entered.





### Hospital Course

Admitted  Through the ER  From the office  By elective admission  Other Facility: \_\_\_\_\_ Par Treatment Of: \_\_\_\_\_

Unassigned patient?  Yes  No  
Unassigned patient?  Yes  No  Add Treatment Comments

**Treated with IV Fluids**  
 Fluids: \_\_\_\_\_ and \_\_\_\_\_  
 Antimicrobial: \_\_\_\_\_  
 Units: \_\_\_\_\_ Type: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Received Blood Transfusion**  
 Units: \_\_\_\_\_ Type: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Patient Received**  
 Breathing treatments of \_\_\_\_\_  
 Physical therapy  
 Speech therapy  
 Occupational therapy  
 Radiation therapy  
 Chemotherapy

**Received IV medications**  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Diagnosics**  Add Diagnostic Comments  
 The following were obtained and reviewed:  Cultures  Diagnostic Tests

**Complications**  Add Complication Comments  
 No complications experienced  Patient developed a complication of \_\_\_\_\_  
 Hospital course uneventful  Patient was transferred to ICU for \_\_\_\_\_  
 Gradual improvement took place

**Response to Treatment**  Add Response Comments  
 Patient responded to treatment  Patient did not respond to treatment  
 Abdominal tenderness has resolved  Fluid and electrolyte balance were re-established  
 Blood pressure control has been reestablished  Neuro status has returned to normal  
 Chest pain has resolved  Patient is afebrile  
 Chest x-ray and physical exam of lungs improved

**Discharge Condition**  Add Discharge Comments  
 Has improved  Has deteriorated  Stable but cont. to have problems  Patient Deceased  
 Is ambulatory  Is up in chair  Is bedfast Cause of Death: \_\_\_\_\_

**Reason for Discharge**  
 Recovered from acute condition  Maximum benefit reached in hospital setting  Patient is stable  Patient expired  Scheduled Readmission  
 Transferred to higher level of care  Transferred to Hospice for end of life care  Transferred to LTAC for continued care

**Consults**  

Last Name	First Name	Date	Reason

**Pending Tests/Results**  
 List any tests or results which are still pending.  
 Check here if none  List Contact to Obtain Results  
 \_\_\_\_\_  
 ( ) - ext \_\_\_\_\_

I have reviewed and agree with the consultants documentation and plan.  
 Yes  No

**10. “Have advanced directives been completed and a surrogate decision maker selected or a reason given for not completing an advanced care plan?”**

If the box next to this element indicates that it has not been documented, in which case a red “No” appears, depressing the “update/review” button displays the Advanced Directive Detail template.

### Advanced Directives Detailed Information

Advanced Directives Discussed?  Yes  No Date Discussed: \_\_\_\_/\_\_\_\_/\_\_\_\_

Advanced Directives Completed?  Yes  No Date Completed: \_\_\_\_/\_\_\_\_/\_\_\_\_

If no, specify reason: \_\_\_\_\_

If yes, specify surrogate decision maker. Name: \_\_\_\_\_  
 Phone: ( ) - \_\_\_\_\_

Comments/Details  
 \_\_\_\_\_

## 11. “Has the reason for discharge been documented?”

If the box next to this element indicates that it has not been documented, in which case a red “No” appears, depressing the “update/review” button displays the Hospital Course Template where the reason for discharge can be documented in the section provided.

**Hospital Course**

Admitted  Through the ER  From the office  By elective admission

Other Facility

For Treatment Of

Uninsured patient?  Yes  No

Unassigned patient?  Yes  No

Add Treatment Comments

Treated with IV Fluids

Fluids  and

Antimicrobial

Received Blood Transfusion

Units  Type  Date

Patient Received

Breathing treatments of

Physical therapy

Speech therapy

Occupational therapy

Radiation therapy

Chemotherapy

Received IV medications

**Diagnostics**  Add Diagnostic Comments

The following were obtained and reviewed  Cultures  Diagnostic Tests  Lab

**Complications**  Add Complication Comments

No complications experienced  Patient developed a complication of

Hospital course uneventful  Patient was transferred to ICU for

Gradual improvement took place

**Response to Treatment**  Add Response Comments

Patient responded to treatment  Patient did not respond to treatment

Abdominal tenderness has resolved  Fluid and electrolyte balance were re-established

Blood pressure control has been reestablished.  Neuro status has returned to normal

Chest pain has resolved  Patient is afebrile

Chest x-ray and physical exam of lungs improved

**Discharge Condition**  Add Discharge Comments

Has improved  Has deteriorated  Stable but cont. to have problems  Patient Deceased

Is ambulatory  Is up in chair  Is bedfast

Cause of Death

**Reason for Discharge**

Recovered from acute condition  Maximum benefit reached in hospital setting  Patient is stable  Patient expired  Scheduled Readmission

Transferred to higher level of care  Transferred to Hospice for end of life care  Transferred to LTAC for continued care

**Consults**

Last Name	First Name	Date	Reason
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

**Pending test results**

List any tests or results which are still pending.

Check here if none

List Contact to Obtain Results

( ) - ext

I have reviewed and agree with the consultants documentation and plan.

Yes  No

## 12. “Has the patient’s physical status been documented?”

If the box next to this element indicates that it has not been documented, in which case a red “No” appears, depressing the “update/review” button displays the Physical Examination section of the discharge summary.

<b>Chief Complaints</b>	<b>Chronic Conditions</b>	Positive
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	DM (diabetes mellitus) type II c Chronic renal disease, stage I Diastolic CHF, chronic Malnutrition Chronic renal disease, stage I Metabolic syndrome Hypertension Gout Hypertensive retinopathy of b Elevated blood uric acid level BPH without urinary obstructi Coronary artery disease Obesity, morbid Meniscus, lateral, derangeme Elevated C-reactive protein Myocardial infarct, old Elevated sed rate         	<input checked="" type="checkbox"/> Constitution <input type="checkbox"/> Head / Face <input type="checkbox"/> Eyes <input type="checkbox"/> Ears <input type="checkbox"/> Nasopharynx <input type="checkbox"/> Neck / Thyroid <input type="checkbox"/> Lymph Nodes <input type="checkbox"/> Respiratory/Thorax <input type="checkbox"/> Cardiovascular <input type="checkbox"/> Breast <input type="checkbox"/> Abdomen / GI <input type="checkbox"/> Genitourinary <input type="checkbox"/> Rectal <input type="checkbox"/> Back <input type="checkbox"/> Musculoskeletal <input type="checkbox"/> Neurological <input type="checkbox"/> Integumentary <input type="checkbox"/> Psychiatric <input type="checkbox"/> Foot
<input type="button" value="Vital Signs"/>		
<b>Source of Information</b>		
<input type="checkbox"/> Patient <input type="checkbox"/> Family member <input type="checkbox"/> Caregiver <input type="checkbox"/> Chart (Hospital Only)		

**13. “Has the patient’s psychosocial condition been documented?”**

If the box next to this element indicates that it has not been documented, in which case a red “No” appears, depressing the “update/review” button displays the Functional Assessment template where the patient’s psychosocial condition can be documented.

## Global Assessment of Functioning

Last Updated/Reviewed 05/21/2013

- 91 -100 Superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his or her many qualities. No symptoms.
- 90 - 81 Absent or minimal symptoms, good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday
- 80 - 71 If symptoms are present they are transient and expectable reactions to psychosocial stresses; no more than slight impairment in social, occupational, or school functioning.
- 70 - 61 Some mild symptoms OR some difficulty in social, occupational, or school functioning, but generally functioning pretty well, has some meaningful interpersonal relationships.
- 60 - 51 Moderate symptoms OR any moderate difficulty in social, occupational, or school functioning.
- 50 - 41 Serious symptoms OR any serious impairment in social, occupational, or school functioning.
- 40 - 31 Some impairment in reality testing or communication OR major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood.
- 30 - 21 Behavior is considered influenced by delusions or hallucinations OR serious impairment in communications or judgment OR inability to function in all areas.
- 20 - 11 Some danger or hurting self or others OR occasionally fails to maintain minimal personal hygiene OR gross impairment in communication.
- 10 - 1 Persistent danger of severely hurting self or others OR persistent inability to maintain minimum personal hygiene OR serious suicidal act with clear expectation of death.

OK

Cancel

### 14. “Has a list of available community resources and/or coordinated referrals been documented?”

If the box next to this element indicates that it has not been documented, in which case a red “No” appears, there are two options for fulfilling the element:

- A. For those patients not being followed-up in a SETMA clinic depressing the “update/review” button displays Local Available Services template which will allow you to refer them to a local clinic.
- B. For those patients who are being followed by SETMA, you would simply complete any referrals which need to be done by utilizing the referral template function which is displayed on the Discharge Master



## Local Available Services

### Gulf Coast Health Care Center, Inc.

- 2548 Memorial Blvd.  
Port Arthur, Texas 77640  
(409) 983-1161
- 601 Rev Dr Ransom Howard St  
Pt Arthur, Texas 77642  
(409) 983-1161
- 1301 West Park Ave Ste C  
Orange, Texas 77630  
(409) 886-4400
- 710 Hwy 327 East  
Silsbee, Texas 77656  
(409) 386-1222
- 103 West Gibson Ste 110  
Jasper, Texas 75951  
(409) 489-9103

### Jefferson County Public Health Department

- Health & Welfare Unit #1  
1295 Pearl  
Beaumont, Texas 77701  
(409) 835-8530
- Health & Welfare Unit #2  
246 Dallas  
Port Arthur, Texas 77640  
(409) 983-8380

### Ibn Sina Community Medical Center

- 8599 9th Ave  
Pt. Arthur, Texas 77642  
(409) 724-7462

### Legacy Community Health Services

- 4450 Highland  
Beaumont, Texas 77705  
(409) 242-2525

## Referrals Summary

Double-click to Add/Edit

Status	Priority	Referral	Referring Provider
Completed	Routine	Abdominal U/S	Holly
Completed	Routine	SETMA Diabetes Education	Holly

OK

Cancel

The last four elements are actions which need to be taken and simply requiring checking whether or not these four functions have taken place.

