Hospital Based Tools

There is no area of practice which has benefited more from SETMA's quest for electronic patient management than has our hospital practice. From the moment a patient arrives in the emergency department until the time of discharge the patient is treated with the tools built for electronic patient management.

Eight years ago, SETMA developed a "hospital-service team" which consisted of SETMA staff, either CFNPs or RNs, who are resident in the hospital twenty-four hours a day, seven days a week. Initially, we began completing history and physical examinations in the EMR and shortly added discharge summaries. We have the ability to do daily progress notes in the EMR and have found it to be a vastly superior way to document daily patient encounters and to treat patients. Once we have appropriate interfaces built for sharing of information between the hospital and our EMR, the daily progress note will not be so tedious and will be adopted by all providers.

The information we want to interface is:

1. 13 daily patient status data points: Weight, BP, Pulse, Pulse Oximetry, Percent Oxygen, Respiratory Rate, Temperature, Maximum Temperature over past 24 hours, Bowel Movement or not, Diet, Appetite and Percentage of Food Eating, Activity Level.
2. Laboratory
3. Current medications
4. Procedures and non-laboratory tests
5. Consultation Reports - conclusions and recommendations only

We hope to have this complete within the next year.

Discharge Summary

SETMA believes that the most important document in the hospital care is the discharge summary. It is not only the fail-safe point at which any untreated or incompletely treated conditions is documented and a plan of care determined, but it is the point where the "care transition" is either made excellently or poorly. The quality of documentation of the discharge

summary and its availability will generally determine the quality of follow-up care a patient will receive.

It is here that SETMA's program is at it best. Not only is the discharge summary completed at the time of discharge 96% of the time but co-incident with the discharge being completed and the discharge summary is immediately available in the EMR in the clinic, the following are done:

1. A Plan of Care and Follow-up Instruction are given to the patient and family.
2. All follow-up appointments are made
3. Medication reconciliations is completed.
4. The Care Transitions measures defined by the Physician Consortium for Performance Improvement are completed.
5. A Follow-up Call order with specific reasons for the care is initiated so that ALL patients discharged from the hospital or the emergency department receive a call the follow day from a SETMA nurse.
6. Any patient discharged to another facility, particular a nursing home, is sent with a copy of all hospital documents and with a specific, personalized plan of care which is typed for legibility and which gives precise instructions for follow-up care in the Nursing Home.

The hospital, electronic-patient management tools displayed in this section include:

1. Discharge SummaryT
2. Admission OrdersT
3. Daily Progress NotesT
4. Care Transition Data Set from Physician Consortium for Performance Improvement T
5. Telephone Calls Follow-up of hospital stay T
6. Insulin Infusion - no tutorial
7. IMRC (Impatient Medical Record Census) - no tutorial
8. Respiratory FailureT

Managing a large volume of inpatients

Several years ago, SETMA realized that five different departments were monitoring inpatient admissions and discharges and keeping paper records of these. At that point, we designed the IMRC - the inpatient medical record census. Upon admission a patient's name is place in the IMRC. At the time the H&P is completed, the date is documented in the IMRC. When the patient is discharged from the hospital, the date is recorded and when the discharge summary is completed the date is documented.

In addition, if the CBO (Central Business Office) has a billing question about a hospital patient, they post the question to the IMRC. The hospital service team picks up the question, researches it and posts the answer. With this method, records and billing queries are always current and we are able to audit the same for efficiency and timeliness.