

Hospital Care Summary and Post Hospital Plan of Care and Treatment Plan Tutorial

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Patient Engagement and Activation Documents

With all documents created in the care of a patient whether:

1. Ambulatory disease management plan of care or treatment plan
<http://www.jameslhollymd.com/epm-tools/Medical-Home-Plan-of-Care-and-Treatment-Plan>
2. Automated Team Patient Engagement and Activation Document
[Patient Engagement and Activation](#)
[Patient Engagement and Activation Document](#)
3. Ambulatory care summary of care document
4. Hospital Admission Plan of Care and Treatment Plan [Hospital Admission Plan of Care](#)
5. Hospital Care Summary and Post Hospital Plan of Care and Treatment Plan [Example of SETMA's Hospital Care Summary and Post Hospital Plan of Care and Treatment Plan. \(De-identified\)](#)

the key is to engage and activate the patient in their own care.

Nomenclature Can Confuse Function

While the traditional “discharge summary” should have been the most important document created during a patient’s hospital stay, it historically came to be nothing but a document created for an administrative and billing function for the hospital and attending physician. It has long ceased to being a dynamic document for the improvement of patient management. The “discharge summary” rarely provided continuity of care value, or transitions of care information, such as diagnoses, reconciled medication list, or follow-up instructions. In reality, the “discharge summary” was often completed days or weeks after the discharge and was a perfunctory task which was only completed when hospital staff privileges were threatened or payment was delayed.

The “discharge summary” should have always been a transition-of-care document which not only summarized the patient’s care during the hospitalization but guided the patient’s post-hospital care with a plan of care and treatment plan. In this way, the document would have been a vehicle for patient engagement and activation.

Changing the Name to Clarify the Function

In September, 2010, SETMA representatives as an invited participant attended a National Quality Forum conference on Transitions of Care. (<http://www.jameslhollymd.com/Letters/nqf-summary-of-dr-hollys-comments-sept-2-2010>) During that conference, SETMA realized that the name “discharge summary” needed to be changed. It was thought that a name change would clarify and focus the intent of this critical document. The name was changed to “Hospital Care Summary and Post Hospital Plan of Care and Treatment Plan.” The purpose and content of the new document was defined as:

1. **Follow-up instructions and plans** – appointments with all healthcare providers who participated in the patient’s inpatient care. These appointments should be made before the patient leaves the hospital and the following information given to the patient and/or family or other principle care giver: time and date of appointment, name, address and telephone number of the provider or providers involved and the reason for the appointment.

2. **Referrals** – appointments with new healthcare providers who have not been involved in the patient’s care but who will participate in care post-hospital. An example might be an oncologist who will treat the patient’s newly diagnosed prostate cancer but who did not see the patient in the hospital encounter. The same information as in the “follow-up” should be given to the patient in writing.
3. **Procedures** – any testing or examinations which are to be done after the hospital should be scheduled before the patient leaves the hospital and all contact information included in the “Post Hospital Plan of Care and Treatment Plan.”
4. **Testing which is not resulted at discharge** – a definite plan must be established prior to discharge for the reporting to and discussing with the patient any test results which have not complete at the time of discharge.
5. **Reconciled Medication List** – the most common cause for preventive readmissions is medication errors. An accurately reconciled medication lists which is clearly communicated to the patient with assurance that the patient can and has obtained their medication is a critical part of a transition of care document.
6. **Hospital Care Coaching Call** – This call, which lasts 12-30 minutes, is scheduled the day following discharge from the hospital. It provides a valuable bridge between inpatient and ambulatory care. In January, 2013, CMS published Transitions of Care Management Codes with which to pay primary care providers for the tasks they perform in transition care. One element required for billing one of these codes is the provider having made a telephone contact with the patient within forty-eight hours of the patient’s discharge from the hospital. The following link explains the *Transition of Care Management Code* requirement: <http://www.jameslhollymd.com/epm-tools/transition-of-care-management-code-tutorial>

The Hospital Care Summary and Post Hospital Plan of Care and Treatment Plan should acknowledgment that a follow-up telephone call has been scheduled for the day following discharge which call will include at least the addressing of the following information:

- a. An internal review and audit of the Hospital Consumer Assessment of Healthcare Provider and Systems.
- b. Review of reconciled medication list.
- c. Review of follow-up care and referrals.
- d. Patient’s care and understanding of that care.
- e. Patient’s engagement and activation in their care.

Discharge Summary Versus Hospital Care Summary – Post Hospital Plan of Care and Treatment Plan

The significant differences between these two documents are:

1. The Hospital Care Summary **MUST BE** completed at the time the patient is discharged from the hospital because it is not an administrative tool or simply a means where by a charge can be made. It is THE critical transition of care and continuity of care document linking the inpatient care with the ambulatory care.

From 2008 – 2013, SETMA has discharged over 20,000 patients from the hospital. 98.7% of the time the Hospital Care Summary and Post Hospital Plan of Care and Treatment Plan has been completed at the time the patient leaves the hospital. Prior to 2003, before SETMA recognized the critical value of this transition of care document, we were routinely thirty days behind in the completion of the discharge summary.

When SETMA's CEO, took over responsibility for leading SETMA's inpatient work, he asked the question, "How far behind are you with discharge summaries?" When the answer was 30 days, he asked, "Are you ever more than 30-days behind, or are you ever less than 30-days behind?" The answer to both was, "No." The staff was then asked, "If you are never more than 30-days behind and if you are never less than 30-days behind, what does that tell you?" When no answer was given, the CEO asked, "If you once get caught up, where would you stay?" The staff realized that if they got caught up, as they had stayed 30-days behind, always; they would stay caught up, always.

2. Because the Hospital Care Summary is being completed at the time of the patient's discharge, the document serves as a patient engagement and activation tool. It allows the patient to know what they need to do, when and where they are to do it and why they needed to do it. Because this document is completed at the time the patient leaves the hospital, the Summary contributes to active, reconciled medication lists.
3. Because the document is completed in the ambulatory EMR which is also used in the clinic, it meant that the provider seeing the patient in the clinic would have a complete explanation of what was done to and for the patient in the hospital. The reconciled medication list done on admission to the hospital, on discharge from the hospital, at the time of the care coaching call and at the follow-up visit in the clinic is the same in all four.
4. In order to manage transitions of care and to audit the process, SETMA created the **Inpatient Medical Record Census (IMRC)**. This is an electronic documentation of when and where a patient is admitted, when the history and physician is completed, when the Hospital Care Summary and Post Hospital Plan of Care is completed and questions posted by SETMA's Central Business Office about hospital charges.

Hospital Care Summary And Post Hospital Plan of Care and Treatment Plan Tutorial

As the Hospital Care Summary is first accessed, a pop up will display to allow you to select a hospital location where the care was given. See below outline in Green.

The screenshot shows the 'Hospital Care Summary' form. At the top, there are fields for 'Admission Date', 'Discharge Date', 'Facility' (set to 'Christus St. Elizabeth'), and 'Type' (set to 'Discharge Summary'). A 'Scheduled Admission' section has 'Yes' and 'No' radio buttons. A 'What Location?' pop-up window is overlaid on the form, listing several locations: 'Altus In-Patient Hospice, Baptist', 'Altus In-Patient Hospice, St. Elizabeth', 'Altus In-Patient Hospice, TMC', 'Baptist Hospital', 'Baptist Rehab', 'Christus St. Elizabeth', 'Dubuis', and 'SET Medical Center'. The pop-up has a 'Close' button. The form itself is divided into several sections: 'Admitting Diagnosis' and 'Discharge Diagnosis' (each with a list of conditions and a 'Status' column), 'Additional Admitting Dx', 'Admitting Chronic Conditions', and 'Discharge Chronic Conditions' (each with a list of conditions). On the right side, there are various assessment and follow-up sections, including 'Fall Risk Assessment', 'Functional Assessment', 'Pain Assessment', 'Karnofsky/Lansky Scale', 'Palliative Perf Scale', 'Last Hospital Discharge', 'Medication Reconciliation', 'Hospital Follow-Up Call', and 'Surgeries This Stay'. A sidebar on the far right contains links to 'Home', 'Histories', 'Health', 'System Review', 'Physical Exam', 'Procedures', 'Radiology', 'EKG', 'Laboratory', 'Hydration', 'Nutrition', 'Hospital Course', 'Discharge Home', 'Follow-up Instr', 'Follow-up Loc', 'Document', and 'Follow-Up Doc'.

You will notice that the Hospital Care Summary Master Template shows the admission diagnoses and the discharge diagnoses. The order and the content of the discharge diagnoses can be changed. See below the button entitled “re-order” which is outlined in “green.”

Hospital Care Summary		Admission Date		Facility		Home	
		/ /		Christus St. Elizabeth			
		/ /		Discharge Summary			
Scheduled Admission <input type="radio"/> Yes <input type="radio"/> No		Attending					
				Re-order			
Admitting Diagnosis		Discharge Diagnosis		Discharging To			
Hypertension		Hypertension					
Dizziness		Dizziness					
Fever		Fever					
Abnormal heart rate		Abnormal heart rate					
Diastolic CHF, chronic		Diastolic CHF, chronic					
Additional Admitting Dx		Additional Discharge Dx		Discharge Condition			
				Prognosis			
				Readmission Risk			
				Low			
				Discharge Time			
				<input type="radio"/> 1 - 31 minutes			
				<input type="radio"/> > 31 minutes			
				Prison Inmate			
				<input type="radio"/> Yes <input type="radio"/> No			
				Days in ICU			
				Days on IV Antibiotics			
				Days on Ventilator			
				Fall Risk Assessment		08/21/2013	
				Functional Assessment		05/21/2013	
				Pain Assessment		10/31/2012	
				Karnofsky/Lansky Scale		/ /	
				Palliative Perf Scale		/ /	
				Last Hospital Discharge Medication Reconciliation		/ /	
				Hospital Follow-Up Call			
				Surgeries This Stay			
						/ /	
						/ /	
						/ /	

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

You can change the Discharge Diagnoses and/or their status, but the admission diagnoses cannot be changed. However, if you do not go through the steps described below (see Page 40), this functionality will not work properly.

To change the discharges diagnoses, you click in the boxes under Discharge Diagnosis. When that is done, the list of ICD-9 Codes in the IMO software package will appear. You can then select new diagnoses which were discovered during the hospitalization.

The screenshot shows a 'Hospital Care Summary' form. At the top, there are fields for 'Admission Date', 'Discharge Date', 'Facility', and 'Type'. Below these are 'Scheduled Admission' (Yes/No) and 'Attending' fields. A 'Discharge Summary' button is visible. The 'Discharge Diagnosis' field is highlighted with a green box. Below the form, the 'IMO Search Plus' window is open, showing a 'Diagnosis Search' interface with a search bar and a 'Search IMO' button. The search bar contains the text 'chi'.

When an abbreviation or the first several letter of a diagnosis' name is typed in the box next to "Search IMO" above, the list of relevant ICD-9 codes will appear. The box to the left of the desired diagnosis is checked and then the button entitled "select" is depressed.

The screenshot shows the 'Diagnosis Search' window with the search bar containing 'chi'. A list of relevant ICD-9 codes is displayed, each preceded by a radio button. The codes are as follows:

- ☐ CHF (congestive heart failure) (4280) .368
- ☐ CHF (congestive heart failure), NYHA class I (4280) .368
- ☐ CHF (congestive heart failure), NYHA class II (4280) .368
- ☐ CHF (congestive heart failure), NYHA class III (4280) .368
- ☐ CHF (congestive heart failure), NYHA class IV (4280) .368
- ☐ CHF (NYHA class I, ACC/AHA stage B) (4280) .368
- ☐ CHF (NYHA class II, ACC/AHA stage C) (4280) .368
- ☐ CHF (NYHA class III, ACC/AHA stage C) (4280) .368
- ☐ CHF (NYHA class IV, ACC/AHA stage D) (4280) .368
- ☐ CHF due to valvular disease (4280) (specify) .368
- ☐ CHF exacerbation (4280) .368
- ☐ CHF NYHA class I (4280) .368
- ☐ CHF NYHA class I (no symptoms from ordinary activities) (4280) .368
- ☐ CHF NYHA class II (4280) .368
- ☐ CHF NYHA class II (symptoms with moderately strenuous activities) (4280) .368
- ☐ CHF NYHA class III (4280) .368
- ☐ CHF NYHA class III (symptoms with mildly strenuous activities) (4280) .368
- ☐ CHF NYHA class IV (4280) .368
- ☐ CHF NYHA class IV (symptoms with any physical activity and at rest) (4280) .368
- ☐ CHF with cardiomyopathy (4280) (specify) .368
- ☐ CHF with left ventricular diastolic dysfunction, NYHA class 1 (42830) (specify) .368

At the bottom of the window, there are 'Select' and 'Cancel' buttons.

Re-Ordering the Discharge Diagnostic List

Because the admission diagnoses will often be different from the discharge diagnoses and because the principle diagnosis which resulted in the hospitalization should be listed first, and because the co-morbidities which resulted in the hospital admission should be listed next, there is a “re-order” button which allows the provider to easily changed the order in which the diagnoses are listed. The following is a link to the full explanation of how to “re-order” a diagnoses list: [The ability to re-order the Chronic Problem List with the most important diagnoses at the top.](#)

The screenshot shows the 'Hospital Care Summary' form. At the top, there are fields for Admission Date, Discharge Date, Facility (Christus St. Elizabeth), Type (Discharge Summary), and a 'Re-order' button highlighted with a green box. Below this, there are sections for 'Admitting Diagnosis' and 'Discharge Diagnosis', each with a 'Status' column and a 'Re-order' button. The 'Discharge Diagnosis' section has a 'Re-order' button highlighted in green. To the right of these sections are various assessment and follow-up fields, including 'Discharge Condition', 'Prognosis', 'Readmission Risk', 'Discharge Time', 'Prison Inmate', 'Days in ICU', 'Days on IV Antibiotics', 'Days on Ventilator', 'Fall Risk Assessment', 'Functional Assessment', 'Pain Assessment', 'Karnofsky/Lansky Scale', 'Palliative Perf Scale', 'Last Hospital Discharge Medication Reconciliation', 'Hospital Follow-Up Call', and 'Surgeries This Stay'.

When you click the “re-order” button, the following template will appear.

The screenshot shows the 'Reorder Discharge Assessments' template. It has a title 'Reorder Discharge Assessments' and a brief instruction: 'Click the items in the "Current Order" in the sequence that you would like to reorder them. Clinically significant conditions are highlighted in red so that you may quickly select them first for the new order. You cannot click OK until you have moved ALL of the items from the "Current Order" column to the "New Order" column.' Below this, there are two columns: 'Current Order' and 'New Order'. The 'Current Order' column has 15 numbered items, with 'Hypertension' and 'Diastolic CHF, chronic' highlighted in red. The 'New Order' column has 15 empty numbered boxes for reordering.

By clicking each of the diagnoses in the new order in which you wish for them to appear, they will appear in the right hand column as they will appear on the Hospital Care Summary Discharge Assessment.

Reorder Discharge Assessments

Click the items in the "Current Order" in the sequence that you would like to reorder them.
Clinically significant conditions are highlighted in red so that you may quickly select them first for the new order.
You cannot click OK until you have moved ALL of the items from the "Current Order" column to the "New Order" column.

Current Order	New Order
1. <input type="text"/>	1. Diastolic CHF, chronic
2. <input type="text"/>	2. Abnormal heart rate
3. <input type="text"/>	3. Fever
4. <input type="text"/>	4. Dizziness
5. <input type="text"/>	5. Hypertension
6. <input type="text"/>	6. <input type="text"/>
7. <input type="text"/>	7. <input type="text"/>
8. <input type="text"/>	8. <input type="text"/>
9. <input type="text"/>	9. <input type="text"/>
10. <input type="text"/>	10. <input type="text"/>
11. <input type="text"/>	11. <input type="text"/>
12. <input type="text"/>	12. <input type="text"/>
13. <input type="text"/>	13. <input type="text"/>
14. <input type="text"/>	14. <input type="text"/>
15. <input type="text"/>	15. <input type="text"/>

When the "OK" button is clicked, the re-ordered Acute Discharge list will appear as below.

Hospital Care Summary

Admission Date: / / Facility:
 Discharge Date: / / Type:
 Scheduled Admission: ☐ Yes ☒ No Attending:

Admitting Diagnosis	Status	Discharge Diagnosis	Status	Re-order
Hypertension	<input type="text"/>	Diastolic CHF, chronic	<input type="text"/>	
Dizziness	<input type="text"/>	Abnormal heart rate	<input type="text"/>	
Fever	<input type="text"/>	Fever	<input type="text"/>	
Abnormal heart rate	<input type="text"/>	Dizziness	<input type="text"/>	
Diastolic CHF, chronic	<input type="text"/>	Hypertension	<input type="text"/>	
	<input type="text"/>		<input type="text"/>	
	<input type="text"/>		<input type="text"/>	

[Additional Admitting Dx](#) [Additional Discharge Dx](#)

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

Discharging To

Discharge Condition

Prognosis

Readmission Risk

Discharge Time
☐ 1 - 31 minutes
☐ > 31 minutes

Prison Inmate
☐ Yes ☒ No

Days in ICU

Days on IV Antibiotics

Days on Ventilator

Fail Risk Assessment 08/21/2013

Functional Assessment 05/21/2013

Pain Assessment 10/31/2012

Karnofsky/Lansky Scale

Palliative Perf Scale

Last Hospital Discharge Medication Reconciliation

Hospital Follow-Up Call

Surgeries This Stay

<input type="text"/>	<input type="text" value=""/>
<input type="text"/>	<input type="text" value=""/>
<input type="text"/>	<input type="text" value=""/>

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

The Hospital Care Summary Template has the following functions:

- **Admission Date** -- this date must be manually entered into the template. It is imperative that the dates be correct on the hospital care summary.
- **Discharge Date** – this date must be manually entered into the template. It is imperative that the dates be correct on the hospital care summary.

The screenshot shows the 'Hospital Care Summary' form. A calendar pop-up for 'August, 2013' is open, showing dates from 28 to 7. The date '26' is selected. The calendar is highlighted with a green rectangular box. The form includes fields for 'Admission Date', 'Discharge Date', 'Facility Type', 'Discharge Summary', 'Discharging To', 'Discharge Condition', 'Prognosis', 'Readmission Risk', 'Discharge Time', 'Prison Inmate', 'Days in ICU', 'Days on IV Antibiotics', 'Days on Ventilator', 'Additional Admitting Dx', 'Additional Discharge Dx', 'Admitting Chronic Conditions', and 'Discharge Chronic Conditions'. A sidebar on the right contains links to 'Home', 'Histories', 'Health', 'System Review', 'Physical Exam', 'Procedures', 'Radiology', 'EKG', 'Laboratory', 'Hydration', 'Nutrition', 'Hospital Course', 'Nursing Home', 'Follow-up Instr', 'Follow-up Loc', 'Document', and 'Follow-Up Doc'.

Down the left hand column (see the green outlined box) are listed the **Admitting Diagnoses** and the patient's chronic conditions. These cannot be changed on the discharge summary.

The screenshot shows the 'Hospital Care Summary' form with the 'Admitting Diagnosis' and 'Admitting Chronic Conditions' sections highlighted by a green rectangular box. The form includes fields for 'Admission Date', 'Discharge Date', 'Facility Type', 'Discharge Summary', 'Discharging To', 'Discharge Condition', 'Prognosis', 'Readmission Risk', 'Discharge Time', 'Prison Inmate', 'Days in ICU', 'Days on IV Antibiotics', 'Days on Ventilator', 'Additional Admitting Dx', 'Additional Discharge Dx', 'Admitting Chronic Conditions', and 'Discharge Chronic Conditions'. A sidebar on the right contains links to 'Home', 'Histories', 'Health', 'System Review', 'Physical Exam', 'Procedures', 'Radiology', 'EKG', 'Laboratory', 'Hydration', 'Nutrition', 'Hospital Course', 'Nursing Home', 'Follow-up Instr', 'Follow-up Loc', 'Document', and 'Follow-Up Doc'. The bottom section includes 'Fall Risk Assessment', 'Functional Assessment', 'Pain Assessment', 'Karnofsky/Lansky Scale', 'Palliative Perf Scale', 'Last Hospital Discharge', 'Medication Reconciliation', 'Hospital Follow-Up Call', and 'Surgeries This Stay'.

Next to this are the **Discharge Diagnoses** and the patient's chronic conditions. These can be changed. In this way, the admission diagnoses will reflect the clinician's impression on admission and the discharge diagnoses will reflect the clinician's conclusions after the patient's hospital evaluation and treatment are completed.

The screenshot shows a 'Hospital Care Summary' form. At the top, there are fields for Admission Date, Discharge Date, Facility Type, and Discharge Summary. Below these are sections for 'Admitting Diagnosis', 'Discharge Diagnosis', and 'Discharge Chronic Conditions'. The 'Discharge Diagnosis' section is highlighted with a green box. To the right of the 'Discharge Diagnosis' section are several clinical assessment tools: 'Discharge Time' (1-31 minutes or >31 minutes), 'Prison Inmate' (Yes/No), 'Days in ICU', 'Days on IV Antibiotics', 'Days on Ventilator', 'Fall Risk Assessment', 'Functional Assessment', 'Pain Assessment', 'Karnofsky/Lansky Scale', 'Palliative Perf Scale', 'Last Hospital Discharge', 'Medication Reconciliation', 'Hospital Follow-Up Call', and 'Surgeries This Stay'. A sidebar on the right contains a 'Home' button and a list of 'Histories' including Health, System Review, Physical Exam, Procedures, Radiology, EKG, Laboratory, Hydration, Nutrition, Hospital Course, Nursing Home, Follow-up Instr, Follow-up Loc, Document, and Follow-Up Doc.

The Column next to the discharge diagnose has the following parts:

- **Discharge to** – there is a pop-up with the options: deceased or stable. At the following link, it is shown that there are eight different places to where the patient can be discharged.
<http://www.jameslhollymd.com/your-life-your-health/patient-centered-medical-home- and-care-transitions-part-i>
- **Discharge Condition** -- there is a pop-up with the options: Good, Poor, and Terminal.
- **Prognosis**
- **Readmission Risk** – this is the assessment of the risk of the patient being readmitted. Currently, the formulae SETMA uses to calculate readmission probability is:
 1. Admitted 2 or more times in the last year = high risk
 2. Admitted 1 times in the last year = medium risk
 3. Admitted 0 times in the last year = low risk
- **Discharge Time** – 1-31 minutes -- >31 minutes
- **Prison Inmate** – yes or no
- **Days in ICU**
- **Days on IV Antibiotics**
- **Days on Ventilator**

Hospital Care Summary				Admission Date	Discharge Date	Scheduled Admission	Facility	Type	Attending	Home	
				/ /	/ /	<input type="radio"/> Yes <input type="radio"/> No		Discharge Summary		Histories	
										Health	
Admitting Diagnosis		Status	Discharge Diagnosis		Status	Re-order		Discharging To			System Review
											Physical Exam
								Discharge Condition			Procedures
								Prognosis			Radiology
								Readmission Risk			EKG
								Low			Laboratory
								Discharge Time			Hydration
								<input type="radio"/> 1 - 31 minutes			Nutrition
								<input type="radio"/> > 31 minutes			Hospital Course
								Prison Inmate			Nursing Home
								<input type="radio"/> Yes <input type="radio"/> No			Follow-up Instr
								Days in ICU			Follow-up Loc
								Days on IV Antibiotics			Document
								Days on Ventilator			Follow-Up Doc
								Fall Risk Assessment			08/11/2011
								Functional Assessment			08/11/2011
								Pain Assessment			08/11/2011
								Karnofsky/Lansky Scale			/ /
								Palliative Perf Scale			/ /
								Last Hospital Discharge			/ /
								Medication Reconciliation			/ /
								Hospital Follow-Up Call			/ /
								Surgeries This Stay			/ /
											/ /
											/ /

The next assessment which is critical in this transition of care document is the **Fall Risk Assessment**. Because patients leaving the hospital are often in a weakened or frail condition, they have an increased susceptibility to falls. The complete of the fall risk assessment is critical to patient safety and to the reduction of preventable readmissions.

When depressed the Fall Risk Assessment button deploys the following template:

When complete the assessment will identify the potential for falls and will allow the provider to give a proactive plan to decrease fall risk.

13

Global Assessment of Functioning

Last Updated/Reviewed 05/21/2013

<input type="radio"/> 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.
<input type="radio"/> 90 - 81	Absent or minimal symptoms, good functioning in all areas, interested and involved in a wide range or activities, socially effective, generally satisfied with life, no more than everyday
<input checked="" type="radio"/> 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.
<input type="radio"/> 70 - 61	Some mild symptoms OR some difficulty in social, occupational, or school functioning, but generally functioning pretty well, has some meaningful interpersonal relationships.
<input type="radio"/> 60 - 51	Moderate symptoms OR any moderate difficulty in social, occupational, or school functioning.
<input type="radio"/> 50 - 41	Serious symptoms OR any serious impairment in social, occupational, or school functioning.
<input type="radio"/> 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.
<input type="radio"/> 30 - 21	Behavior is considered influenced by delusions or hallucinations OR serious impairment in communications or judgment OR inability to function in all areas.
<input type="radio"/> 20 - 11	Some danger of hurting self or others OR occasionally fails to maintain minimal personal hygiene OR gross impairment in communication.
<input type="radio"/> 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

Most recent reconciliation is documented for the audit. This link is to an article which address medication reconciliation: <http://www.jameslhollymd.com/Your-Life-Your-Health/Medical-Home-Series-Two-Part-XIV-Medication-Reconciliation>

Hospital Care Summary		Admission Date	Discharge Date	Scheduled Admission	Facility	Type	Attending
		/ /	/ /	<input type="radio"/> Yes <input type="radio"/> No	Christus St. Elizabeth	Discharge Summary	

Admitting Diagnosis	Status	Discharge Diagnosis	Status
Hypertension		Diastolic CHF, chronic	
Dizziness		Abnormal heart rate	
Fever		Fever	
Abnormal heart rate		Dizziness	
Diastolic CHF, chronic		Hypertension	

Additional Admitting Dx: [Additional Discharge Dx](#)

Discharge into Chronic List

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

Additional Discharge Dx: [Re-order](#)

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: 10/31/2012

Karnofsky/Lansky Scale: / /

Ballistic Perf Scale: / /

Last Hospital Discharge Medication Reconciliation: 08/14/2013

Hospital Follow-Up Call:

Surgeries This Stay:

The next documentation is the Post Hospital Care Coaching Follow-up call. When the button outlined in green below is depressed the follow-up call template is opened so that the call can be scheduled. The following link is to an article about hospital and clinic follow-up calls: <http://www.jameslhollymd.com/epm-tools/Tutorial-Hospital-Follow-up-Call>

Hospital Care Summary		Admission Date	Discharge Date	Facility	Home
		Admission Date	Discharge Date	Christus St. Elizabeth	Home
		Scheduled Admission	Discharge Summary	Type	Discharge Summary
		Attending			
		Status		Re-order	
Admitting Diagnosis		Discharge Diagnosis		Discharging To	
Hypertension		Diastolic CHF, chronic			
Dizziness		Abnormal heart rate			
Fever		Fever			
Abnormal heart rate		Dizziness			
Diastolic CHF, chronic		Hypertension			
Additional Admitting Dx		Additional Discharge Dx		Discharge Time	
		Discharge into Chronic List		<input type="radio"/> 1 - 31 minutes <input type="radio"/> > 31 minutes	
Admitting Chronic Conditions		Discharge Chronic Conditions		Prison Inmate	
DM (diabetes mellitus) type II c		DM (diabetes mellitus) type II controlled		<input type="radio"/> Yes <input type="radio"/> No	
Diastolic CHF, chronic		Diastolic CHF, chronic		Days in ICU	
Chronic renal disease, stage I		Chronic renal disease, stage II		Days on IV Antibiotics	
Hypertension		Hypertension		Days on Ventilator	
Hypertensive retinopathy of b		Hypertensive retinopathy of both eyes			
Metabolic syndrome		Metabolic syndrome		Fall Risk Assessment	
Myocardial infarct, old		Myocardial infarct, old		08/21/2013	
Coronary artery disease		Coronary artery disease		Functional Assessment	
Elevated homocysteine		Elevated homocysteine		05/21/2013	
Elevated C-reactive protein		Elevated C-reactive protein		Pain Assessment	
Meniscus, lateral, derangement		Meniscus, lateral, derangement		10/31/2012	
Elevated blood uric acid level		Elevated blood uric acid level		Karnofsky/Lansky Scale	
Obesity, morbid		Obesity, morbid		/ /	
Elevated sed rate		Elevated sed rate		Palliative Perf Scale	
BPH without urinary obstructi		BPH without urinary obstruction		/ /	
Gout		Gout		Last Hospital Discharge	
				08/14/2013	
				Hospital Follow-Up Call	
				/ /	
				/ /	
				/ /	

When this button is depressed, the following template is opened.

Hospital Discharge Follow-Up Call		Return
Number to Call <input type="checkbox"/> Home Phone (409)833-9797 <input type="checkbox"/> Day Phone () - <input type="checkbox"/> Other () -		
Send Delayed-Delivery Email to Follow-Up Nurse		
Admit Date / / Discharge Date / / Setting <input type="radio"/> ER <input type="radio"/> In Patient Hospice Home Health		
Discharge Diagnoses Diastolic CHF, chronic Abnormal heart rate Fever Dizziness Hypertension		
Questions to Ask		
General <input checked="" type="checkbox"/> How are you feeling? <input checked="" type="checkbox"/> Are you having new symptoms since hospital stay? <input checked="" type="checkbox"/> Have you obtained all DME that you were prescribed? Other		
Medications <input checked="" type="checkbox"/> Were you able to get all of your medications filled? <input checked="" type="checkbox"/> Are you taking all of your prescribed medications? <input checked="" type="checkbox"/> Are you having any problems/side effects from your medications?		
Appointments Have you kept or are you aware of your appointment(s) with...? on / / on / / on / /		
Patient Responses How does the patient feel? Is the patient having new symptoms? Has the patient obtained all prescribed DME? Was the patient able to fill all of their medications? Is the patient taking all of their medications? Is the patient having any problems/side effects? Has the patient kept and/or aware of all scheduled appointments or referrals?		
Additional Comments Click to Document Completion Click to Send Response Follow-Up Call Completed By At / / Spoke with the patient? <input type="radio"/> Yes <input type="radio"/> No If no, list person spoken with. HCAHPS Patient Audit		
Actions Taken <input type="checkbox"/> Advised Patient To Come In - Made Same-Day Appointment <input type="checkbox"/> Advised Patient To Call If Improvement Discontinues <input type="checkbox"/> Advised Patient To Continue Medications Other		
Follow-Up Details From Hospital Staff <input type="checkbox"/> Patient Ok To Follow-Up > 6 Days <input type="checkbox"/> Patient To Follow-Up With Non-SETMA Provider		
Patient Education Discussed <input type="checkbox"/> Disease Process <input type="checkbox"/> Medications <input type="checkbox"/> Symptom Self Care Other		
Call Attempts <input type="checkbox"/> 1 / / <input type="checkbox"/> 2 / / <input type="checkbox"/> 3 / / <input type="checkbox"/> Unable to Call, Letter Sent / /		

Finally, the last element in this column is a listing of the surgeries done in this admission.

[illegible]

Care Transitions Audit

The Care Transition Audit is SETMA's adaptation of the Physician Consortium for Performance Improvement Data Set for Transitions of Care. SETMA has been auditing this data set since it was first published in June, 2009. The following is a link to a tutorial on this material:

<http://www.jameslhollymd.com/epm-tools/Tutorial-Care-Transition>. SETMA has publicly reported by provider name on SETMA's performance on this data set since 2009. The following is a link to the 2013 results of this audit. <http://www.jameslhollymd.com/public-reporting/reports/2013/SETMA.com-2013-Care-Transition-Audit.pdf> The following is a link to a series of articles on Care Transitions:

<http://www.jameslhollymd.com/your-life-your-health/care-transitions>.

The button outlined in green below deploys the Care Transition audit on each patient discharged from the hospital.

The screenshot shows a web-based form titled "Hospital Care Summary". The form is divided into several sections. At the top, there are fields for "Admission Date", "Discharge Date", "Facility", "Type", and "Discharge Summary". Below these are sections for "Admitting Diagnosis", "Discharge Diagnosis", "Discharge Condition", "Prognosis", "Readmission Risk", "Discharge Time", "Prison Inmate", "Days in ICU", "Days on IV Antibiotics", "Days on Ventilator", "Fall Risk Assessment", "Functional Assessment", "Pain Assessment", "Karnofsky/Lansky Scale", "Palliative Perf Scale", "Last Hospital Discharge", "Medication Reconciliation", "Hospital Follow-Up Call", and "Surgeries This Stay". On the right side, there is a vertical menu with links to "Home", "Histories", "Health", "System Review", "Physical Exam", "Procedures", "Radiology", "EKG", "Laboratory", "Hydration", "Nutrition", "Hospital Course", "Nursing Home", "Follow-up Instr", "Follow-up Loc", "Document", and "Follow-Up Doc". At the bottom left, there is a button labeled "Care Transition Audit" which is outlined in green. Below this button are checkboxes for "Follow-Up Exceptions": "Patient To Follow-Up With Non-SETMA Provider" and "Patient Ok To Follow-Up > 6 Days".

The following is what is deployed with the Care Transitions button is depressed:

Care Transition Audit		OK	Cancel				
Has the reason for hospitalization been documented?	No	Click to Update/Review					
Have discharge diagnoses been entered?	No	Click to Update/Review					
Have the patient's medications been updated/reconciled?	No	Click to Update/Review					
Have the patient's allergies been updated? Also document allergies/reactions to medications.	No	Click to Update/Review					
Has the patient's cognitive status been documented?	No	Click to Update/Review					
Have pending results or tests been documented?	No	Click to Update/Review					
Have major procedures been documented?	No	Click to Update/Review					
Has a follow-up care plan been completed?	No	Click to Update/Review					
Has the patient's progress to goals/treatment been documented?	No	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?	No	Click to Update/Review					
Has the reason for discharge been documented?	No	Click to Update/Review					
Has the patient's physical status been documented?	No	Click to Update/Review					
Has the patient's psychosocial status been documented?	No	Click to Update/Review					
Has a list of available community resources been documented?	No	Click to Update/Review					
--OR--							
Has a list of coordinated referrals been documented?	No	Click to Update/Review					
Has a follow-up call been scheduled?	No	Click to Update/Review					
<hr/>							
Has the current/reconciled medication list been discussed with the patient/family/caregiver?	<input type="radio"/> Yes <input type="radio"/> No	<table border="1"> <tr><td colspan="2"></td></tr> <tr><td>//</td><td></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"> <tr><td colspan="2"></td></tr> <tr><td>//</td><td></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"> <tr><td colspan="2"></td></tr> <tr><td>//</td><td></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"> <tr><td colspan="2"></td></tr> <tr><td>//</td><td></td></tr> </table>				//	
//							

When the Hospital Care Summary and Post Hospital Plan of Care and Treatment Plan has been completed, any incomplete elements of the audit will be in red. Any element in red can be completed by depressing the button “click to update/review.” Depressing the button will take the provider to the place in the chart where that element should be completed.

Hospital Consumer Assessment of Healthcare Provider and System (HCAHPS)

This is an assessment of patient satisfaction with the care they received in the hospital. There are elements which relate to healthcare providers and elements which related to the hospital. In order for SETMA providers to improve their performance on these measures, they have been deployed in the EMR. In the Care Coaching Call after being discharged from the hospital, these questions are included. Further more a COGNOS audit has been created. In January, 2014, SETMA is going to begin publicly reporting these results by provider name.

The following is a link to a complete tutorial on HCAHPS:

[http://www.jameslhollymd.com/epm- tools/SETMA-Internal-HCAHPS-Survey-Tutorial](http://www.jameslhollymd.com/epm-tools/SETMA-Internal-HCAHPS-Survey-Tutorial).

When the button entitled “Post Hospital Patient Audit” outlined in green below is deployed, the HCAHPS template appears.

Hospital Care Summary

Admission Date: / / Discharge Date: / / Facility: Type: Discharge Summary: Scheduled Admission: Yes No Attending: 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: 08/11/2011 Functional Assessment: 08/11/2011 Pain Assessment: 08/11/2011 Karnofsky/Lansky Scale: / / Palliative Perf Scale: / / Last Hospital Discharge: / / Medication Reconciliation: Hospital Follow-Up Call: Surgeries This Stay: / /

Admitting Diagnosis Status **Discharge Diagnosis** Status **Discharge Condition** **Prognosis** **Readmission Risk** **Discharge Time** **Prison Inmate** **Days in ICU** **Days on IV Antibiotics** **Days on Ventilator** **Fall Risk Assessment** **Functional Assessment** **Pain Assessment** **Karnofsky/Lansky Scale** **Palliative Perf Scale** **Last Hospital Discharge** **Medication Reconciliation** **Hospital Follow-Up Call** **Surgeries This Stay**

Additional Admitting Dx **Additional Discharge Dx** **Discharge into Chronic List** **Re-order**

Admitting Chronic Conditions **Discharge Chronic Conditions** **Re-order**

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

Post-Hospital Patient Audit

The following are the questions which are asked by SETMA Department of Care Coordination during the Care Coaching call the day after discharge from the hospital.

HCAHPS Patient Audit

(Hospital Consumer Assessment of Healthcare Providers and Systems)

Return

Send Results

Did your physician and his/her team explain your care plan to you? ☐ Yes ☐ No

Did your physician and his/her team answer all of your questions? ☐ Yes ☐ No

Did your physician and his/her team listen to your questions or comments without interrupting you? ☐ Yes ☐ No

Did anyone (doctors, nurses or other hospital staff) ask if you have the help you will need at home once you leave the hospital? ☐ Yes ☐ No

Did your physician give you in writing the symptoms which would make you need to return to the hospital or get immediate help? ☐ Yes ☐ No

Did they explain this in a way you understood? ☐ Yes ☐ No

During this hospital stay, how often did SETMA's doctors treat you with courtesy and respect? ☐ Always ☐ Sometimes ☐ Not At All

Patient Comments

Unable to Complete

☐ Prison Inmate
 ☐ Patient Refused
 ☐ Nursing Home/Rehab
 ☐ No Contact/Incorrect Information
 ☐ Not Discharged/Still Inpatient

Once a month, SETMA completes the HCAHPS Internal Survey audit and distributes the following report to all SETMA Providers. In January, 2014, this audit will be displayed publicly on SETMA's website.



HCAHPS Internal Audit

Discharge Date(s): 08/01/2013 through 08/23/2013

Hospital	Attending	Explain Care		Answer Questions		Listen W/O Interruption		Ask If Help Needed		Symptoms In Writing		Understood		Courtesy And Respect			Encounters
		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Always	Sometimes	Not At All	
Baptist Hospital	Anwar, Syed	67%	0%	67%	0%	67%	0%	67%	0%	67%	0%	67%	0%	67%	0%	0%	3
	Deiparine, Caesar	80%	20%	100%	0%	100%	0%	60%	40%	60%	40%	60%	40%	100%	0%	0%	5
	Holly, James	100%	0%	100%	0%	95%	5%	84%	16%	84%	16%	84%	16%	95%	0%	5%	19
	Le, Phuc	100%	0%	100%	0%	100%	0%	100%	0%	100%	0%	100%	0%	100%	0%	0%	5
	Leifeste, Alan	83%	17%	100%	0%	100%	0%	83%	17%	83%	17%	83%	17%	100%	0%	0%	6
	Qureshi, Absar	80%	20%	100%	0%	100%	0%	100%	0%	80%	20%	80%	20%	100%	0%	0%	5
	Unknown	100%	0%	100%	0%	100%	0%	100%	0%	0%	100%	0%	100%	100%	0%	0%	1
Totals		91%	7%	98%	0%	95%	2%	84%	14%	80%	18%	80%	18%	95%	0%	2%	44
Baptist Rehab	Deiparine, Caesar	0%	100%	0%	100%	0%	100%	0%	100%	100%	0%	100%	0%	0%	0%	100%	1
	Unknown	100%	0%	100%	0%	100%	0%	100%	0%	0%	100%	0%	100%	0%	100%	0%	1
	Totals	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	0%	50%	50%	2
Christus St. Elizabeth	Aziz, Muhammad	33%	67%	100%	0%	100%	0%	67%	33%	33%	67%	33%	67%	100%	0%	0%	3
	Halbert, Dean	100%	0%	100%	0%	100%	0%	100%	0%	100%	0%	100%	0%	100%	0%	0%	1
	Totals	50%	50%	100%	0%	100%	0%	75%	25%	50%	50%	50%	50%	100%	0%	0%	4
SET Medical Center	Shepherd, James	100%	0%	100%	0%	100%	0%	83%	17%	83%	17%	83%	17%	100%	0%	0%	6
	Thomas, Michael	100%	0%	100%	0%	100%	0%	100%	0%	100%	0%	100%	0%	100%	0%	0%	5
	Unknown	83%	17%	100%	0%	100%	0%	100%	0%	83%	17%	83%	17%	100%	0%	0%	6
Totals		94%	6%	100%	0%	100%	0%	94%	6%	88%	12%	88%	12%	100%	0%	0%	17

Encounters Not Completed

Prison Inmate	Patient Refused	Nursing Home/Rehab	Unable To Contact	Not Discharged/Inpatient
0	6	29	28	9

08/26/2013 7:20:51 AM

1 of 1

On the “Follow-up” page in this tutorial (page number _____), one of the most difficult of the HCAHPS’ survey is addressed. Below outlined in green are eight sets of “Reasons to Contact Provider.” This is given to the patient, in the Hospital Care Summary and Post Hospital Plan of Care document. It tells the patient in simple terms what symptoms should cause them to seek immediate attention either from their healthcare provider or by returning to the hospital.

When this document is being completed, the “General” symptoms is automatically completed for all patients and the specific condition such as pneumonia, CHF, etc., are completed for patients who have those conditions.

On the right hand side of the Master Hospital Care Summary and Post Hospital Plan of Care and Treatment Plan Template, there are 15 navigation buttons on the Hospital Care Summary Template.

The screenshot displays the 'Hospital Care Summary' form. At the top, there are fields for 'Admission Date', 'Discharge Date', 'Facility', and 'Type'. Below these are 'Scheduled Admission' (Yes/No) and 'Attending' fields. The main body of the form is divided into sections for 'Admitting Diagnosis', 'Discharge Diagnosis', 'Discharge Condition', 'Prognosis', 'Readmission Risk', 'Discharge Time', 'Prison Inmate', 'Days in ICU', 'Days on IV Antibiotics', 'Days on Ventilator', 'Fall Risk Assessment', 'Functional Assessment', 'Pain Assessment', 'Karnofsky/Lansky Scale', 'Palliative Perf Scale', 'Last Hospital Discharge', 'Medication Reconciliation', 'Hospital Follow-Up Call', and 'Surgeries This Stay'. On the right side, there is a vertical sidebar with 15 navigation buttons: Home, Histories, Health, System Review, Physical Exam, Procedures, Radiology, EKG, Laboratory, Hydration, Nutrition, Hospital Course, Nursing Home, Follow-up Instr, Follow-up Loc, Document, and Follow-Up Doc. The first seven buttons (Home through EKG) are highlighted with a green border.

Six of the first seven buttons launched templates which are identical to templates on the Master GP Templates, they are:

- Histories
- Health
- System Review
- Physical Exam
- Radiology
- EKG

The fifth button entitled **Procedures** launches a template which enables the documentation of the procedures and studies done in the hospital.

Special Procedures

Echocardiogram

☒

EKG

☒

Additional Procedures

Procedure	Results
<div><div></div><div>Date</div><div>//</div></div>	
<div><div></div><div>Date</div><div>//</div></div>	
<div><div></div><div>Date</div><div>//</div></div>	
<div><div></div><div>Date</div><div>//</div></div>	
<div><div></div><div>Date</div><div>//</div></div>	
<div><div></div><div>Date</div><div>//</div></div>	
<div><div></div><div>Date</div><div>//</div></div>	
<div><div></div><div>Date</div><div>//</div></div>	

By clicking in the box entitled Procedure, you will see the pop-up as below.

Special Procedures

Echocardiogram
☒

EKG
☒

Additional Procedures

Procedure	Results
<input type="text"/>	<input type="text"/>
Date <input type="text" value="//"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
Date <input type="text" value="//"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
Date <input type="text" value="//"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
Date <input type="text" value="//"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
Date <input type="text" value="//"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
Date <input type="text" value="//"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
Date <input type="text" value="//"/>	<input type="text"/>

Procedure
Results

Date

Date

Date

Date

Hospital Procedures
X

Bronchoscopy
CABG
Cardiac
Cardiac Cath
Colonoscopy
CT
Cysto
Doppler
EGD
MRA
MRI
Surgery
Ultrasound

At the top of this template which is entitled **Special Procedures** are two buttons, which launch pop-ups with which to document special studies:

Echocardiogram

Test Date:

Reading Physician:

Indication

☐ CHF
 ☐ Atrial
 ☐ Cardiology
 ☐ Atrial Fibrillation
 ☐ Valvular Abnormalities
 ☐ Murmurs
 ☐ Other

Interpretation

Ejection Fraction %

Impaired Relaxation ☐ No ☐ Yes

Decreased Compliance ☐ No ☐ Yes

Ventricular Dysfunction

Cardiomegaly ☐ No ☐ Yes

Hypertrophy ☐ No ☐ Yes

☐ Left Ventricular
☐ Right Ventricular
☐ Global
☐ Atrial

Dilation ☐ No ☐ Yes

☐ Left Ventricular
☐ Right Ventricular
☐ Global
☐ Atrial

Valvular Abnormalities

Aortic

☐ Normal
☐ Abnormal

☐ Stenosis
☐ Insufficiency/Regurgitation

☐ Mild
☐ Moderate
☐ Severe

Vegetation ☐ No ☐ Yes

Mitral

☐ Normal
☐ Abnormal

☐ Stenosis
☐ Insufficiency/Regurgitation

☐ Mild
☐ Moderate
☐ Severe

Vegetation ☐ No ☐ Yes

Tricuspid

☐ Normal
☐ Abnormal

☐ Stenosis
☐ Insufficiency/Regurgitation

☐ Mild
☐ Moderate
☐ Severe

Vegetation ☐ No ☐ Yes

Pulmonic

☐ Normal
☐ Abnormal

☐ Stenosis
☐ Insufficiency/Regurgitation

☐ Mild
☐ Moderate
☐ Severe

Vegetation ☐ No ☐ Yes

Motion

Kinesis

☐ Normal
☐ Abnormal

☐ Akinesis
☐ Hypokinesis
☐ Apical
☐ Inferior
☐ Lateral
☐ Anterior

Defects

☐ Atrial Spatial Defects
☐ Ventricular Spatial Defects

Pericardial Effusion

☐ No ☐ Yes

☐ Mild
☐ Moderate
☐ Severe (Tamponade)

Blood Clot

☐ No ☐ Yes

☐ Atrial
☐ Ventricular

Pulmonary Artery Pressure

Comments

EKG Report

Base Measurements

Rate bpm Rhythm

PR ms (N 120 - 200) QRS ms (N < 100) QT ms (N < 475)

R Axis

Return

☐ Normal Tracing

☐ Abnormal Tracing

Document

Ecctopy

☐ No Ecctopy Noted

PAC	PJC	PVC

Atrioventricular Blocks

☐ First Degree

☐ Prolonged QT

☐ Left Axis Deviation

☐ Left Atrial Abnormality

☐ Right Ventricular Hypertrophy

☐ Left Ventricular Hypertrophy

☐ Second Degree - Mobitz I

☐ Low Voltage

☐ Right Axis Deviation

☐ Right Atrial Abnormality

☐ ST-T changes

☐ ST-T changes

☐ Third Degree - Complete

☐ Second Degree - Mobitz II

☐ By Voltage

Electrical Conduction

Intraventricular Conduction Defect

☐ Left

☐ Anterior

☐ Hemiblock

☐ Right Bundle Branch Block

☐ Left Bundle Branch Block

☐ Posterior

☐ Complete

☐ Incomplete

Comments:

Scroll for More.

Clinical Impressions

☐ Myocardial Infarction

☐ Anterior

☐ Inferior

☐ Anteroseptal

☐ Posterior

☐ Lateral

☐ Septal

☐ No Variant

ST Segment Changes

☐ ST Depression

☐ Anterior

☐ T Wave Inversion

☐ Inferior

☐ Lateral

☐ Generalized

☐ Septal

☐ Non-specific

Findings Suggestive Of

☐ Ischemia

☐ Digitalis Effect

☐ Hypokalemia

☐ No Variant

☐ ST Elevation

☐ Anterior

☐ Inferior

☐ Lateral

☐ Generalized

☐ Septal

☐ Non-specific

Findings Suggestive Of

☐ Pericarditis

☐ Injury

☐ Aneurysm

☐ No Variant

☐ T Wave Inversion

☐ Anterior

☐ Inferior

☐ Lateral

☐ Generalized

☐ Septal

☐ Non-specific

T Wave Changes

☐ T Wave Inversion

☐ Anterior

☐ Inferior

☐ Lateral

☐ Generalized

☐ Septal

☐ Non-specific

Clinical Interpretation

☐ Normal Tracing

☐ Tracing Unchanging from

☐ Clinical Change Evident

☐ Tracing Repeat

☐ Abnormal Tracing

Laboratory Documentation from the hospital which interacts with Ambulatory EMR

One of the significant advances in quality and cost of healthcare is our ability to document laboratory values done in the hospital. The following tool allows those values to be entered into our EMR such those lab values interact with all quality metrics. This prevents us from having to repeat the testing done in hospital.

Discharge Summary Lab Entry

Return

Admission Labs

Option 1 -- Select Existing Labs
Click to Select

Option 2 -- Enter New Labs
1. Create Order **2. Enter Results in Lab Module** **3. Edit Date**

Discharge Labs

Option 1 -- Select Existing Labs
Click to Select

Option 2 -- Enter New Labs
1. Create Order **2. Enter Results in Lab Module** **3. Edit Date**

Additional Labs

CKMB Set 1 1. Create Order 2. Enter Results in Lab Module 3. Enter Date/Time <input type="text" value="//"/> <input type="text"/>	CKMB Set 2 1. Create Order 2. Enter Results in Lab Module 3. Enter Date/Time <input type="text" value="//"/> <input type="text"/>	CKMB Set 3 1. Create Order 2. Enter Results in Lab Module 3. Enter Date/Time <input type="text" value="//"/> <input type="text"/>
---	---	---

** Times must be entered in military time. (e.g. 22:45) **
** You must enter the colon between the hours and minutes. **

This allows the documentation of:

Arterial Blood Gases
CMP
Cultures
UA
Lipids

CBC
CPK/Troponins
Drug Levels
PT/INR
Hemoglobin A1c

Just off to the right of the screen (scroll over) on the discharge summary, you will see a button named “New Lab Entry.” Click it and it will take you to this screen.

Discharge Summary Lab Entry

Return

Admission Labs

Option 1 -- Select Existing Labs

Click to Select

Option 2 -- Enter New Labs

1. Create Order 2. Enter Results in Lab Module 3. Edit Date

Discharge Labs

1. Create Order 2. Enter Results in Lab Module 3. Edit Date

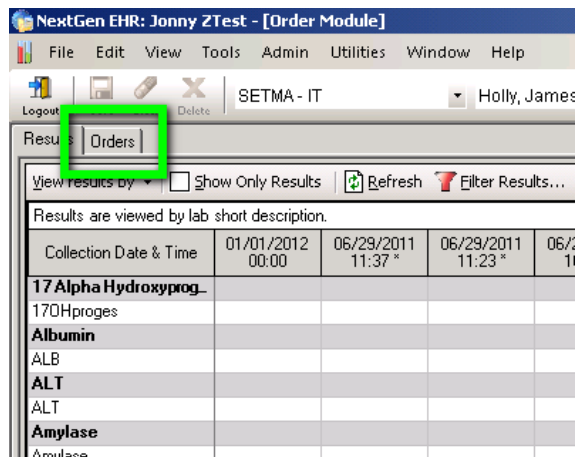
Additional Labs

CKMB

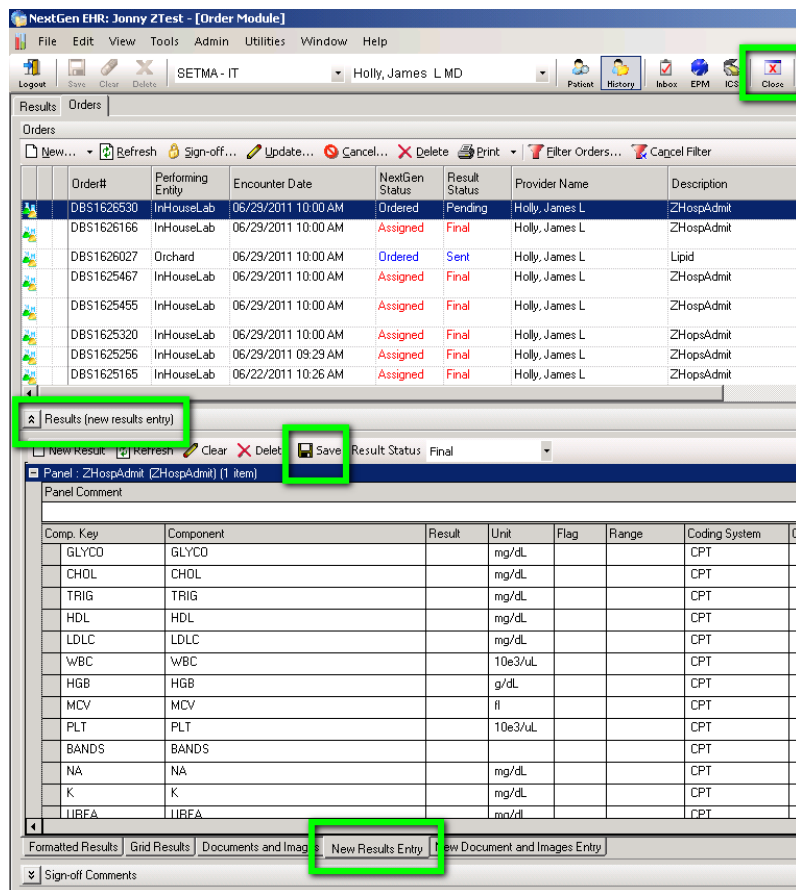
1. Create Order 2. Enter Results and Dates/Times in Lab Module

Under Admission Labs, Option 1 you can select labs that were previously entered using this method rather than re-entering the same set twice. For example, it would let you pick an old discharge set as the new admission set. However, since this only works with labs that have been entered this new way, you probably won’t be using it for a little while until we accumulate some of these.

Admission Labs, Option 2 and Discharge Labs work the same way. Click the Create Order button and it will take you to the lab module. When you get there, click Orders.



Next, find the order that you want to enter results for. If you are doing it for an admission, it will be “ZHospAdmit” and for a discharge it would be “ZHospDisch.” Select the correct order, the click the “Results (new results entry)” section and then the “New Results Entry” tab. Now, enter the results in the results column next to each descriptor. When you are done, click “Save” (there will be a few second freeze) and close the lab module.



This opens a template which allows for specific instructions to be given for a patient who is being transferred back to the nursing home.

Nursing Home Discharge Orders			
Diet	Activity Level		<div>Disch Master</div> <div>NH Master</div> <div>Guideline Summary</div> <div>Hydration</div> <div> <input type="checkbox"/> Podiatry Consult <input type="checkbox"/> Wound Care Team Consult </div>
SETMA Guidelines <div> <input type="checkbox"/> Diarrhea Guidelines <input type="checkbox"/> Insulin Sliding Scale Guidelines <input type="checkbox"/> Lethargy / Change in Mental Status Guidelines <input type="checkbox"/> Loss of Appetite / Weight Loss Guidelines <input type="checkbox"/> Physical Therapy Guidelines <input type="checkbox"/> Potassium Guidelines <input type="checkbox"/> Wound Care Guidelines </div> <div> <input type="checkbox"/> Fall Guidelines <input type="checkbox"/> Family Concerns Guidelines <input type="checkbox"/> Fever Guidelines <input type="checkbox"/> Hemorrhoid Guidelines <input type="checkbox"/> Hypertension Guidelines <input type="checkbox"/> Hypoglycemia Guidelines </div>			
Hospital Transfer <div> <input type="checkbox"/> Transfer to hospital <input type="checkbox"/> Reason for transfer </div>			
Future Orders <div> <input type="checkbox"/> B12 <input type="checkbox"/> Depakote <input type="checkbox"/> FBS <input type="checkbox"/> Liver Func <input type="checkbox"/> Se Ketones </div> <div> <input type="checkbox"/> BMP <input type="checkbox"/> Digoxin <input type="checkbox"/> GlycoHem <input type="checkbox"/> Micral Strip <input type="checkbox"/> Tegretol </div> <div> <input type="checkbox"/> CBC <input type="checkbox"/> Dilantin <input type="checkbox"/> HFP <input type="checkbox"/> Phenobarb <input type="checkbox"/> Theophylline </div> <div> <input type="checkbox"/> CMP <input type="checkbox"/> EKG <input type="checkbox"/> Lipid <input type="checkbox"/> Prealbumin <input type="checkbox"/> Thyroid profile </div> <div> <input type="checkbox"/> Chest PA/Lat <input type="checkbox"/> EP <input type="checkbox"/> Lithium <input type="checkbox"/> PT/INR <input type="checkbox"/> Urinalysis </div>			
Comments: <div></div>		Education/Instructions <div></div> <div></div> <div></div>	

Follow-up Instructions Template

<h3>Hospital Discharge Instructions</h3> <p><input type="checkbox"/> Consult Home Health agency</p> <p><input type="checkbox"/> Consult Altus Home Health</p> <p><input type="checkbox"/> Discussed condition, medications, and follow-up care with patient and/or family</p> <p><input type="checkbox"/> Discharge to Nursing Home <input type="text"/></p> <p><input type="checkbox"/> Give a copy of the Post Hospital Follow-up Document</p> <p><input type="checkbox"/> Home Rehab</p> <p><input type="checkbox"/> Home Speech Therapy</p> <p><input type="checkbox"/> Insure patient understands follow-up instructions</p> <p><input type="checkbox"/> Insure patient knows how to make follow-up appointment</p> <p><input type="checkbox"/> Review all follow-up instructions with patient</p> <p><input type="checkbox"/> Review medications with patient before discharge</p> <p><input type="checkbox"/> Send discharge summary, HP and consults to nursing home with patient</p> <p><input type="checkbox"/> Transport by Ambulance</p> <p><input type="checkbox"/> SETMA Follow-Up Appointment</p> <p><input type="text"/> / / <input type="text"/> (Use 24 Hour Time)</p> <p><input type="checkbox"/> Other Follow-Up Appointments</p> <p><input type="text"/> / / <input type="text"/> (Use 24 Hour Time)</p> <p><input type="text"/> / / <input type="text"/></p> <p><input type="text"/> / / <input type="text"/></p>	<h3>Post Hospital Follow-Up Instructions</h3> <p><input type="checkbox"/> BMP, CBC, UA in 10 days</p> <p><input type="checkbox"/> Bring ALL medications to next office appointment</p> <p><input type="checkbox"/> Code - Full</p> <p><input type="checkbox"/> Code - Meds</p> <p><input type="checkbox"/> Code - No</p> <p><input type="checkbox"/> Continue medications per Post Hospital Follow-up document</p> <p><input type="checkbox"/> Daily Weight - if patient gains more than 3lbs in one day call MD</p> <p>Diet <input type="text"/> <input type="button" value="Diet Help Desk"/></p> <p><input type="checkbox"/> Discontinue smoking</p> <p><input type="checkbox"/> Elevate Limb</p> <p><input type="checkbox"/> Fall Risk Assessment</p> <p><input type="checkbox"/> Follow SETMA Guidelines as per Instructions</p> <p><input type="checkbox"/> Hydration Alert</p> <p><input type="checkbox"/> Notify Family of Readmission</p> <p><input type="checkbox"/> Notify CFNP of Readmission</p> <p><input type="checkbox"/> Portable Chest x-ray in 10 days</p> <p><input type="checkbox"/> PT/INR in <input type="text"/></p> <p><input type="checkbox"/> Repeat labs in <input type="text"/></p> <p><input type="checkbox"/> Skin Care</p> <p><input type="checkbox"/> Stop antibiotics in <input type="text"/></p> <p><input type="checkbox"/> Sutures out in <input type="text"/></p> <p><input type="checkbox"/> Weight Loss Alert</p>
---	---

Reasons To Contact Provider

<input checked="" type="checkbox"/> General Instructions	<input type="checkbox"/> Asthma	<input type="checkbox"/> Myocardial Infarction	<input type="checkbox"/> Surgery
	<input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> Pneumonia	
	<input type="checkbox"/> GI Bleeding	<input type="checkbox"/> Stroke	

Comments

☐ Standard Nursing Home Discharge Orders
☐ Standard Home Discharge Orders

This is a list of instructions to the nursing home or family about follow-up. If the patient is going home the Standard Home Discharge Order buttons should be activated:

Hospital Follow-Up

Hospital Discharge Instructions

- ☐ Consult Home Health agency
- ☐ Consult Altus Home Health
- ☒ Discussed condition, medications, and follow-up care with patient and/or family
- ☐ Discharge to Nursing Home
- ☒ Give a copy of the Post Hospital Follow-up Document
- ☐ Home Rehab
- ☐ Home Speech Therapy
- ☒ Insure patient understands follow-up instructions
- ☐ Insure patient knows how to make follow-up appointment
- ☒ Review all follow-up instructions with patient
- ☒ Review medications with patient before discharge
- ☐ Send discharge summary, HP and consults to nursing home with patient
- ☐ Transport by Ambulance
- ☐ SETMA Follow-Up Appointment

____ / ____ / ____ (Use 24 Hour Time)

☐ Other Follow-Up Appointments

____ / ____ / ____ (Use 24 Hour Time)

____ / ____ / ____ (Use 24 Hour Time)

____ / ____ / ____ (Use 24 Hour Time)

Reasons To Contact Provider

☒ General Instructions

☐ Asthma

☐ Myocardial Infarction

☐ Surgery

☐ Congestive Heart Failure

☐ Pneumonia

☐ GI Bleeding

☐ Stroke

Comments

Post Hospital Follow-Up Instructions

- ☐ BMP, CBC, UA in 10 days
- ☒ Bring ALL medications to next office appointment
- ☐ Code - Full
- ☐ Code - Meds
- ☐ Code - No
- ☒ Continue medications per Post Hospital Follow-up document
- ☐ Daily Weight - if patient gains more than 3lbs in one day call MD
- ☐ Diet _____ [Diet Help Desk](#)
- ☐ Discontinue smoking
- ☐ Elevate Limb
- ☐ Fall Risk Assessment
- ☐ Follow SETMA Guidelines as per Instructions
- ☐ Hydration Alert
- ☐ Notify Family of Readmission
- ☐ Notify CFNP of Readmission
- ☐ Portable Chest x-ray in 10 days
- ☐ PT/INR in _____
- ☐ Repeat labs in _____
- ☐ Skin Care
- ☐ Stop antibiotics in _____
- ☐ Sutures out in _____
- ☐ Weight Loss Alert

☒ **Standard Home Discharge Orders**

OK

Cancel

If going to the NH, **Standard Nursing Home Discharge Orders** should be activated.

Hospital Follow-Up

Hospital Discharge Instructions

- ☐ Consult Home Health agency
- ☐ Consult Altus Home Health
- ☐ Discussed condition, medications, and follow-up care with patient and/or family
- ☒ Discharge to Nursing Home
- ☐ Give a copy of the Post Hospital Follow-up Document
- ☐ Home Rehab
- ☐ Home Speech Therapy
- ☐ Insure patient understands follow-up instructions
- ☐ Insure patient knows how to make follow-up appointment
- ☐ Review all follow-up instructions with patient
- ☐ Review medications with patient before discharge
- ☒ Send discharge summary, HP and consults to nursing home with patient
- ☒ Transport by Ambulance
- ☐ SETMA Follow-Up Appointment

____ / ____ / ____ (Use 24 Hour Time)

☒ Other Follow-Up Appointments

____ / ____ / ____ (Use 24 Hour Time)

____ / ____ / ____ (Use 24 Hour Time)

____ / ____ / ____ (Use 24 Hour Time)

Reasons To Contact Provider

☒ General Instructions

☐ Asthma

☐ Myocardial Infarction

☐ Surgery

☐ Congestive Heart Failure

☐ Pneumonia

☐ GI Bleeding

☐ Stroke

Comments

Post Hospital Follow-Up Instructions

- ☒ BMP, CBC, UA in 10 days
- ☒ Bring ALL medications to next office appointment
- ☐ Code - Full
- ☐ Code - Meds
- ☐ Code - No
- ☒ Continue medications per Post Hospital Follow-up document
- ☐ Daily Weight - if patient gains more than 3lbs in one day call MD
- ☐ Diet _____ [Diet Help Desk](#)
- ☐ Discontinue smoking
- ☐ Elevate Limb
- ☐ Fall Risk Assessment
- ☒ Follow SETMA Guidelines as per Instructions
- ☐ Hydration Alert
- ☒ Notify Family of Readmission
- ☒ Notify CFNP of Readmission
- ☒ Portable Chest x-ray in 10 days
- ☐ PT/INR in _____
- ☐ Repeat labs in _____
- ☒ Skin Care
- ☐ Stop antibiotics in _____
- ☐ Sutures out in _____
- ☒ Weight Loss Alert

☒ **Standard Nursing Home Discharge Orders**

OK

Cancel

In either case, once the default orders are reviewed, other pertinent issues like “when to stop antibiotics,” “when sutures are to be removed,” etc., should be activated.

Follow-up LOC Template

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

Return

Print Complete List

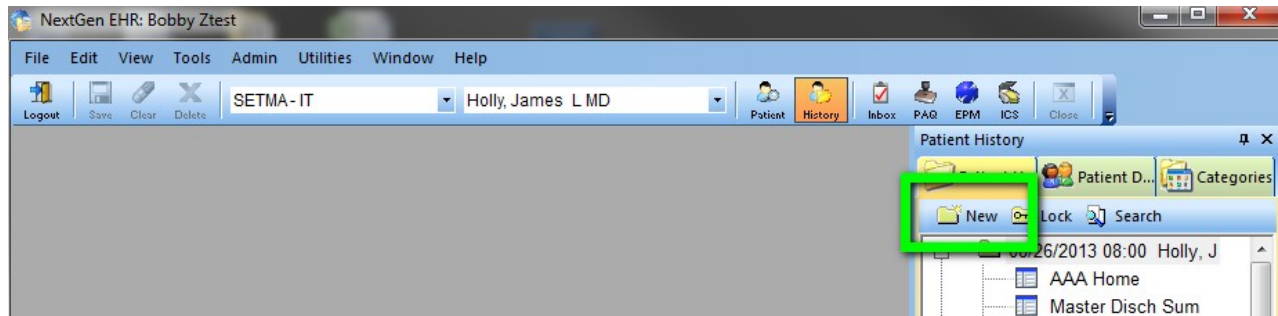
This launches a template with the names, addresses and telephone contact information for a number of clinics which are able to care for patients without insurance.

Document – this creates the Hospital Care Summary document for placing on the chart and for sending to the Nursing Home with the patient.

Back to the Start: Starting the Hospital Care Summary Process

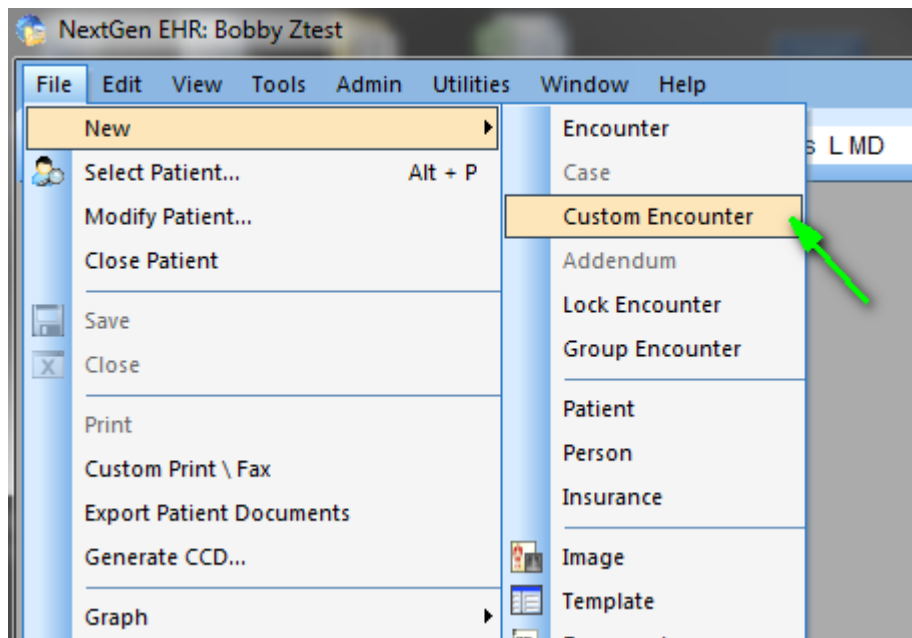
1. Open a visit for the date of discharge.

If you complete the hospital care summary discharge summary on the day you discharge the patient from the hospital, as you should, you do this simply by clicking on **NEW** on the Main Tool Bar.

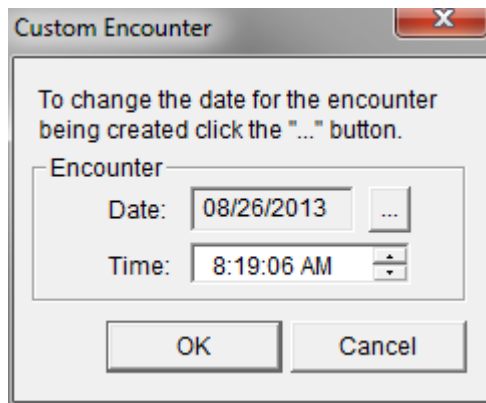


If you are completing a delinquent hospital care summary, you must create a **Custom Visit** so that the hospital care summary is filed on the date of discharge, even though it has been created on a different date, which date of document creation will be noted on the record.

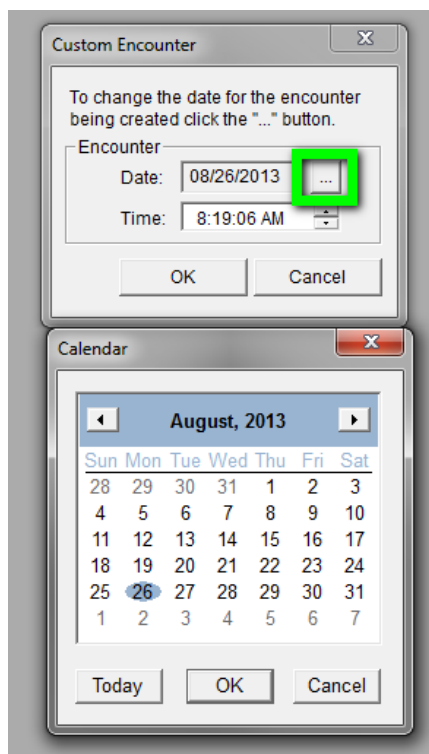
You do this by going to the Left Top of the screen and clicking on **FILE**. You then click on **NEW** and then on **CUSTOM VISIT**.



At this point, a Pop-Up entitled **Custom Visit** appears.



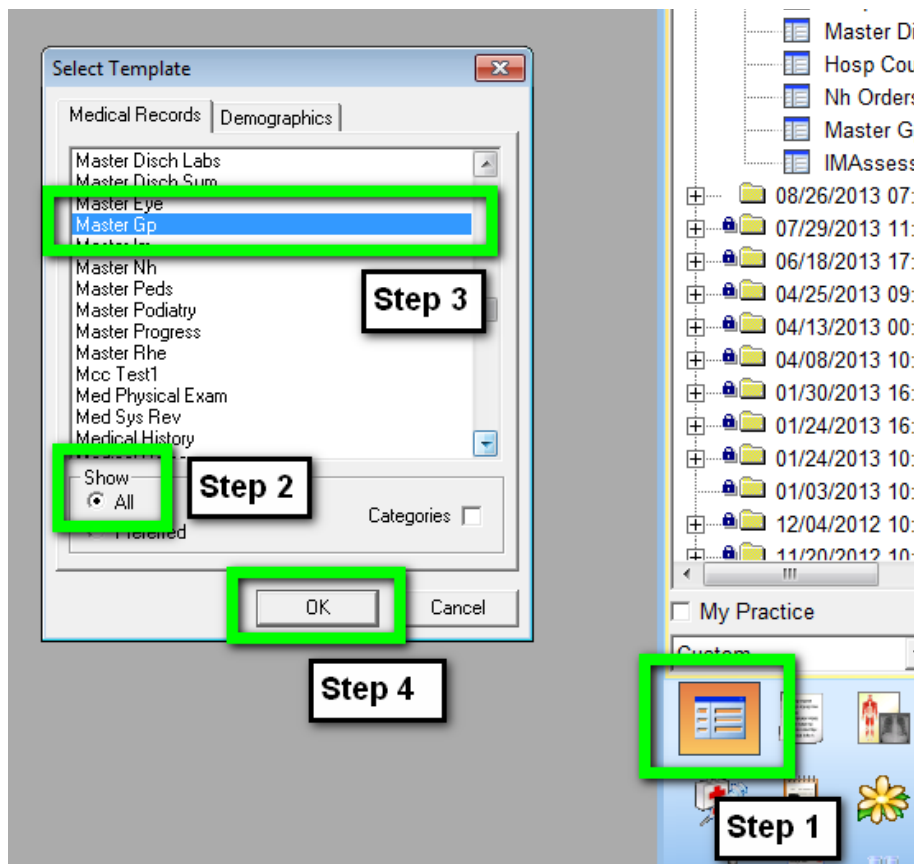
Beside the date on this Pop-up, there is a **Button** with three dots on it. If you click on that button, a calendar comes up which allows you to change the date to the date of the patient's actual discharge. Once the date is correct, you click the **OK** button to the right top of the Pop Up. This creates a visit with the correct date.



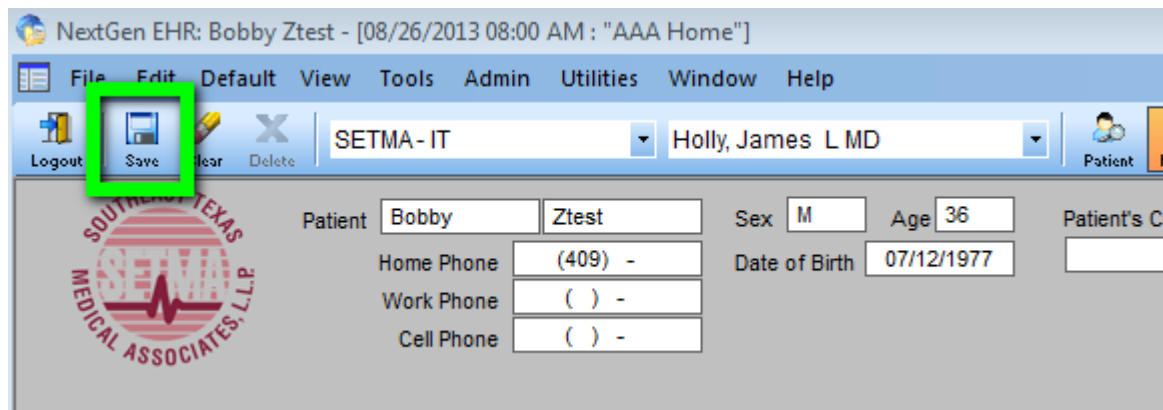
2. At this point, your New Visit has nothing in it. **In order to make the Hospital Care Summary work, you must follow these steps:**

At the bottom of the **Main Tool Bar**, you will click on the top left icon which is the **Template** Icon. You will then select **Master GP**.

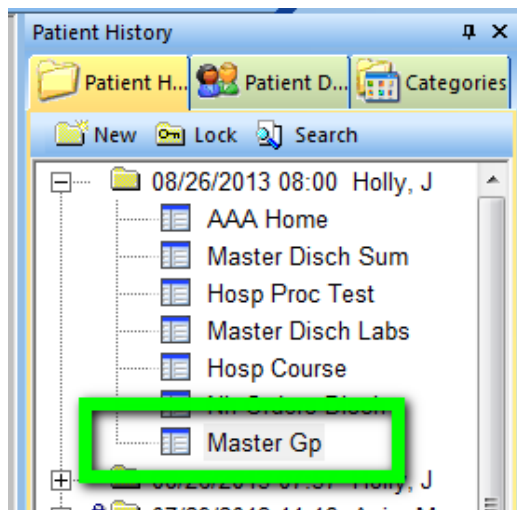
Double click on **Master GP**, or highlight it and the click on the **OK** button at the bottom of the Pop Up.



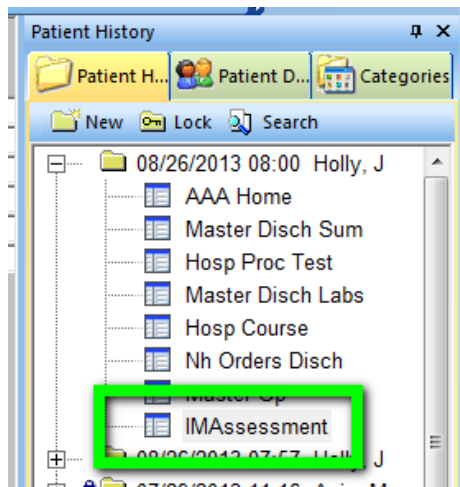
On the **Top Tool Bar**, the second icon is **SAVE**. You will click on this icon to save your change.



You will notice that **Master GP** now appears below the date of your custom visit, or your new visit at the right of your screen on the **Main Tool Bar**.

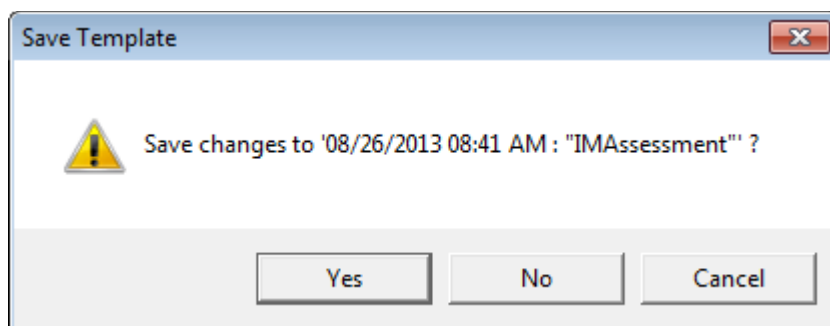
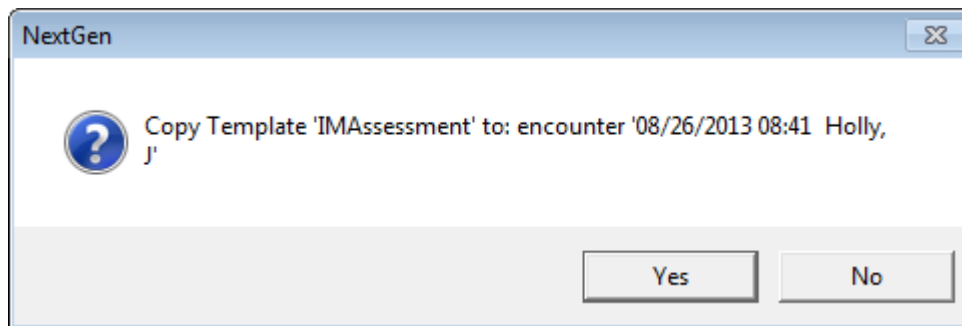


3. At this point, you will go back to the **patient's date of admission** and find the **Assessment** under the date of admission.

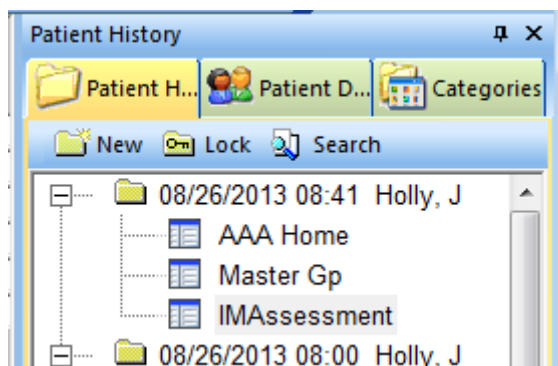


You will highlight **Assessment** by clicking on it. You will then hold the left mouse key down and DRAG the assessment up to your **current visit** – either a **new visit** if you are doing the discharge summary on time, or a **custom visit** if you are completing a delinquent hospital care summary.

Once you have successfully dropped this assessment on the date of the new visit or the custom visit, a pop up will appear which asks you if you want to **COPY** and **SAVE** the assessment to this visit. You click yes.



You will notice now that your new or custom visit has both the Master GP and the Assessment listed under it.



At this point, go back to the **Main Tool Bar** and click on the top left hand icon for **Templates**. You will select the **Master Hospital Care Summary** one of three ways: You can return to **AAA Home** and select it.

At this point two documents will be completed:

1. The Post Hospital Plan of Care and Treatment Plan: Patient Engagement and Activation Document The following is a link to an example of this document:
<http://www.jameslhollymd.com/Presentations/pdfs/Post-Hospital-Plan-of-Care-and-Treatment-Plan.pdf>
2. The Post Hospital Plan of Care and Treatment Plan. This is link to a sample document:
<http://www.jameslhollymd.com/Presentations/pdfs/Example-of-SETMAs-Hospital-Care-Summary-and-Post-Hospital-Plan-of-Care-and-Treatment-Plan.pdf>

Conclusion

To remind us of the constant need for change in healthcare transformation, we have archived a copy of the “old” version of our “discharge summary” tutorial. If you contrast the two, the progress we have made is remarkable, but more remarkable is the anticipation of the changes we will make over the next five years. The patient engagement and activation made possible by the functions detailed in this tutorial remind us of the constant change we will experience in the future. Sometimes the change is at lightening speed hardly leaving time for us to catch our breath. At other times the rate of change slows and allows us to incorporate all of the new ideas into our work flow. The key to the changes seen in this new tutorial is our clear understanding now of what it means for patients to be engaged, to be activated and to participate in shared decision making. Because this was the focus of our August, 2013 Provider training meeting, the following details the content of that session. We hope that it helps all who read this to incorporate these ideas into their practices and professional lives.

Today, August 20, 2013, we have our monthly provider training meeting. We close our offices for half a day. The subjects we will address today are:

1. HCAHPS - reviewed as a patient-centric approach in in-patient care. link to the develop process of this audit and project - began July 15th Completed July 30th --
<http://www.jameslhollymd.com/letters/>
2. CAHPS - we will review the questions which our CAHPS vendor will use.
3. “Have You Really Addressed Your Patient’s Concerns,” Carlos Roberto Jaen - a Patient-Centered Office Visit - How? The following is the link to the power point for this part of the meeting today: <http://www.jameslhollymd.com/Presentations/What-is-patient-centered-communication>
4. “Patient Engagement” Health Affairs, February 14, 2013 - How to promote patient engagement - <http://www.jameslhollymd.com/Presentations/SETMA-8-20-13-Provider-Training-Health-Affairs-2-14-13-Patient-Engagement>
5. Health Affairs, Health Gaps, August 15, 2013. - SETMA has eliminated ethnic disparities in hypertension and diabetes - this is a broader view
<http://www.jameslhollymd.com/Presentations/SETMA-8-20-13-Provider-Training-Health-Affairs-8-15-13-Health-Gap>.
6. SETMA’s Automated Team, the logical extension of Clinical Decision Support, Patient Engagement, Activation and Shared Decision Making. The following is the link to our

Automatic Team Tutorial: <http://www.jameslhollymd.com/epm-tools/Automated-Team-Tutorial-for-the-EMR-Automated-Team-Function>