

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 be 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.jameshollymd.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 for a patient at Christus St. Elizabeth. A 'What Location?' dialog box is open, listing the following options:

- Altus In-Patient Hospice, Baptist
- Altus In-Patient Hospice, St. Elizabeth
- Altus In-Patient Hospice, TMC
- Baptist Hospital
- Baptist Rehab
- Christus St. Elizabeth
- Dubuis
- SET Medical Center

The background form includes sections for Admitting and Discharge Diagnoses, Chronic Conditions, and various assessment scales. The 'Discharge Diagnosis' section lists conditions such as Diastolic CHF, Abnormal heart rate, Fever, Dizziness, and Hypertension. The 'Discharge Chronic Conditions' section lists conditions like DM (diabetes mellitus) type II, Diastolic CHF, Chronic renal disease, Hypertension, Hypertensive retinopathy, Metabolic syndrome, Myocardial infarct, Coronary artery disease, Elevated homocysteine, Elevated C-reactive protein, Meniscus, lateral, derangement, Elevated blood uric acid level, Obesity, morbid, Elevated sed rate, BPH without urinary obstruction, and Gout.

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.”

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

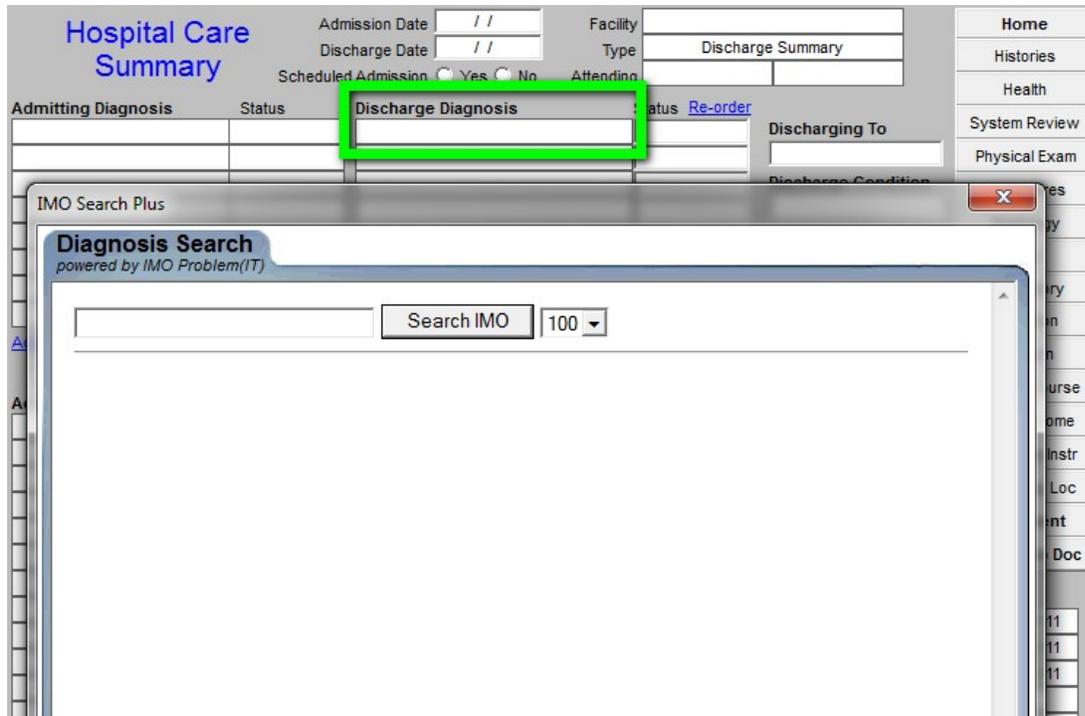
Admitting Chronic Conditions		Discharge Chronic Conditions	
DM (diabetes mellitus) type II c		DM (diabetes mellitus) type II controllec	
Diastolic CHF, chronic		Diastolic CHF, chronic	
Chronic renal disease, stage I		Chronic renal disease, stage II	
Hypertension		Hypertension	
Hypertensive retinopathy 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	

Discharge into Chronic List	Re-order
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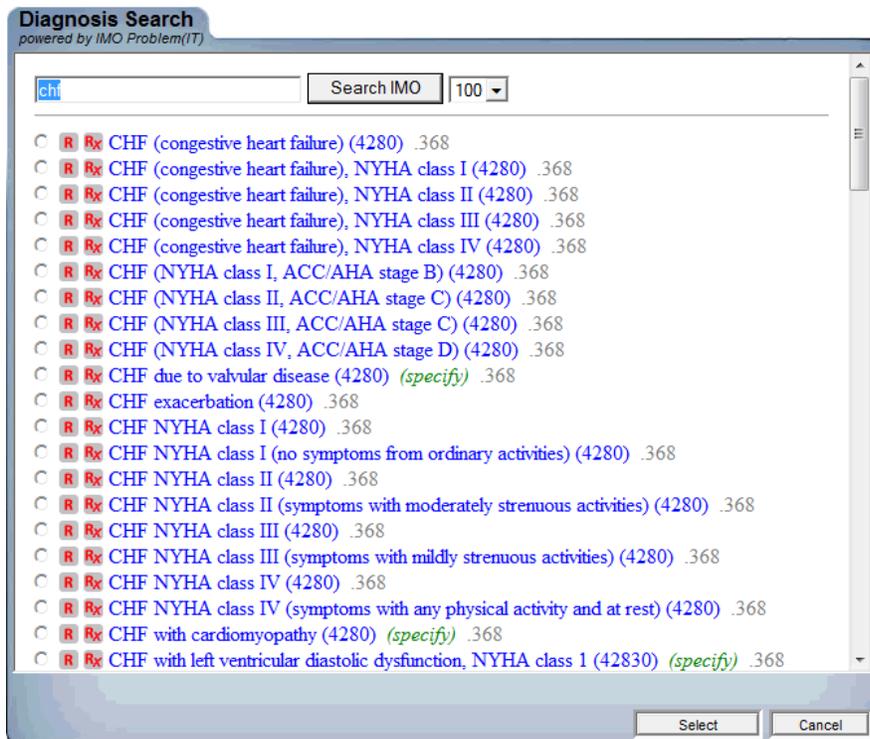
Discharge Condition	
Prognosis	
Readmission Risk	Low
Discharge Time	<input type="radio"/> 1 - 31 minutes <input type="radio"/> > 31 minutes
Prison Inmate	<input type="radio"/> Yes <input type="radio"/> No
Days in ICU	
Days on IV Antibiotics	
Days on Ventilator	
Fall Risk Assessment	08/21/2013
Functional 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	//
	//
	//

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.



When an abbreviation or the first several letters 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.



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), and Type (Discharge Summary). Below these are sections for Admitting Diagnosis and Discharge Diagnosis, each with a 'Status' column and a 'Re-order' button. The 'Re-order' button in the Discharge Diagnosis section is highlighted with a green box. To the right of the diagnosis lists are sections for 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 the instruction 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: // /
 Discharge Date: // /
 Facility: Christus St. Elizabeth
 Type: Discharge Summary
 Scheduled Admission: Yes No
 Attending:

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

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

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

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 obstructi	BPH without urinary obstruction	
Gout	Gout	

Discharging To	<input type="text"/>
Discharge Condition	<input type="text"/>
Prognosis	<input type="text"/>
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	<input type="text"/>
Days on IV Antibiotics	<input type="text"/>
Days on Ventilator	<input type="text"/>
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	<input type="text"/>
Surgeries This Stay	<input type="text"/>
	//
	//

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 window is open, displaying the month of August 2013. The date '26' is selected. The calendar is highlighted with a green border. The background 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', and 'Days on Ventilator'. There are also sections for 'Admitting Diagnosis', 'Additional Admitting Dx', 'Admitting Chronic Conditions', and 'Discharge Diagnosis'.

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 with a green border. 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', and 'Days on Ventilator'. There are also sections for 'Discharge Diagnosis', 'Discharge Chronic Conditions', '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 this is a table with columns for 'Admitting Diagnosis', 'Status', 'Discharge Diagnosis', and 'Status Re-order'. The 'Discharge Diagnosis' column is highlighted with a green box. To the right of the table are several sections: 'Discharging To', 'Discharge Condition', 'Prognosis', 'Readmission Risk', 'Discharge Time', 'Prison Inmate', 'Days in ICU', 'Days on IV Antibiotics', 'Days on Ventilator', and a list of assessment scales with dates. The assessment scales include Fall Risk Assessment, Functional Assessment, Pain Assessment, Karnofsky/Lansky Scale, and Palliative Perf Scale, all with dates of 08/11/2011. There are also fields for 'Last Hospital Discharge Medication Reconciliation' and 'Hospital Follow-Up Call'.

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.jamesholllymd.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**

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: // / Facility: Christus St. Elizabeth
 Discharge Date: // / Type: Discharge Summary
 Scheduled Admission: Yes No Attending: // /

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

Discharge into Chronic List

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 obstructi	BPH without urinary obstruction	
Gout	Gout	

Discharge Time: 1 - 31 minutes > 31 minutes
 Prison Inmate: Yes No
 Days in ICU: // /
 Days on IV Antibiotics: // /
 Days on Ventilator: // /

Discharge Time: 08/21/2013
 Functional Assessment: 05/21/2013
 Pain Assessment: 10/31/2012
 Karnofsky/Lansky Scale: // /
 Bellows 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: // Facility: Christus St. Elizabeth
 Discharge Date: // Discharge Type: Discharge Summary
 Scheduled Admission: Yes No Attending: //

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

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: //

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: 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: Home Phone (409)833-9797
 Day Phone () -
 Other () - [Send Delayed-Delivery Email to Follow-Up Nurse](#)

Admit Date: // Discharge Date: // Setting: ER In Patient
 Hospice: // Home Health: //

Discharge Diagnoses
 Diastolic CHF, chronic
 Abnormal heart rate
 Fever
 Dizziness
 Hypertension

Questions to Ask

General
 How are you feeling?
 Are you having new symptoms since hospital stay?
 Have you obtained all DME that you were prescribed?
 Other: //

Medications
 Were you able to get all of your medications filled?
 Are you taking all of your prescribed medications?
 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? Yes No
 If no, list person spoken with: //

Actions Taken
 Advised Patient to Come In - Made Same-Day Appointment
 Advised Patient to Call If Improvement Discontinues
 Advised Patient to Continue Medications
 Other: //

Follow-Up Details From Hospital Staff
 Patient Ok To Follow-Up > 6 Days
 Patient To Follow-Up With Non-SETMA Provider

Patient Education Discussed
 Disease Process
 Medications
 Symptom Self Care
 Other: //

Call Attempts
 1 // //
 2 // //
 3 // //
 Unable to Call, Letter Sent // //

HCAHPS Patient Audit

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

Hospital Care Summary

Admission Date
 Discharge Date
 Scheduled Admission Yes No
 Facility
 Type
 Attending

- [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](#)

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

Discharging To

Discharge Condition

Prognosis

Readmission Risk

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

Discharge Time
 1 - 31 minutes
 > 31 minutes
Prison Inmate
 Yes No
Days in ICU

Days on IV Antibiotics

Days on Ventilator

Admitting Chronic Conditions	Discharge Chronic Conditions
DM (diabetes mellitus) type II c	DM (diabetes mellitus) type II controllec
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

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	08/14/2013

Surgeries This Stay	
<input type="text"/>	//
<input type="text"/>	//
<input type="text"/>	//

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

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

The screenshot shows a web-based form titled "Hospital Care Summary". At the top, there are fields for Admission Date, Discharge Date, Facility, and Type. Below this are sections for Admitting Diagnosis, Discharge Diagnosis, and Discharge Condition. There are also sections for Admitting Chronic Conditions and Discharge Chronic Conditions. On the right side, there are various assessment tools and metrics, including Discharge Time, Prison Inmate status, 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. At the bottom left, a button labeled "Post-Hospital Patient Audit" is highlighted with a green border. At the bottom right, there are "Follow-Up Exceptions" checkboxes for "Patient To Follow-Up With Non-SETMA Provider" and "Patient OK To Follow-Up > 6 Days".

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)

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.

Hospital Follow-Up

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

Reasons To Contact Provider
 General Instructions
 Asthma
 Myocardial Infarction
 Surgery
 Congestive Heart Failure
 Pneumonia
 GI Bleeding
 Stroke

Comments
[]
 Standard Nursing Home Discharge Orders
 Standard Home Discharge Orders

The following are examples of what will appear on the Hospital Care Summary and Post Hospital Plan of Care and Treatment plan which will meet and exceed the questions in the HCAHPS survey.

Symptoms To Be Alert For

The day following your discharge from the hospital, you will receive a telephone call from SETMA's Care Coordination Department at which time all of your questions will be addressed and your medications will be reviewed. Within 2-5 days, you will have a follow-up appointment with your healthcare provider. The good news about this is that there will be very little time for you to develop a problem before you will have direct access to your healthcare provider.

If you have any of the following, you should call your healthcare provider no matter the time of day or night. Someone will always be available who has access to your medical record.

General Instructions

1. If you have a reaction to your medications
2. If you are unable to obtain or to take your medications
3. If you have nausea or vomiting which last longer than two hours
4. If you have any bleeding
5. If you have any loss of consciousness or significant change in your level of consciousness

Congestive Heart Failure

1. You have more than 4 pounds of weight gain in any one day
2. If you become suddenly and severely short of breath

Myocardial Infarction (Heart Attack)

1. Recurrent chest pain
2. Shortness of breath

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 shows the 'Hospital Care Summary' form. At the top, there are fields for Admission Date, Discharge Date, Facility, Type, and Discharge Summary. Below this are sections for Admitting and Discharge Diagnoses, Prognosis, Readmission Risk, Discharge Time, and Discharge Condition. A navigation menu on the right side is highlighted with a green border and contains the following items: 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 of the form includes various assessment scales like Fall Risk Assessment, Functional Assessment, Pain Assessment, Karnofsky/Lansky Scale, and Palliative Perf Scale, along with a section for Surgeries This Stay.

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.

The image shows a software interface for documenting medical procedures. At the top, the title "Special Procedures" is displayed in blue. Below the title are two checkboxes: "Echocardiogram" and "EKG", both of which are checked. Underneath these is another section titled "Additional Procedures" in blue. This section contains a table with two columns: "Procedure" and "Results". The "Procedure" column has eight rows, each with a text input field and a "Date" label followed by a date input field containing two slashes (//). The "Results" column has eight corresponding empty text input fields for recording the outcomes of the procedures.

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

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

Echocardiogram

Be sure to click "Return" when finished entering data

Click To Add New Test Previous Tests

Test Date: // / // Document

Reading Physician: // / //

Indication

CHF Angina Cardiomegaly Atrial Fibrillation Valvular Abnormalities Murmurs Other: _____

Interpretation

Ejection Fraction: % Cardiomegaly: No Yes Hypertrophy: No Yes Dilation: No Yes

Impaired Relaxation: No Yes Left Ventricular: Left Ventricular Right Ventricular Right Ventricular: Left Ventricular Right Ventricular

Decreased Compliance: No Yes Global: Global Atrial

Ventricular Dysfunction:

Valvular Abnormalities

Aortic <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal Stenosis: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe Insufficiency/Regurgitation: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe Vegetation: <input type="checkbox"/> No <input type="checkbox"/> Yes	Mitral <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal Stenosis: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe Insufficiency/Regurgitation: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe Vegetation: <input type="checkbox"/> No <input type="checkbox"/> Yes	Tricuspid <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal Stenosis: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe Insufficiency/Regurgitation: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe Vegetation: <input type="checkbox"/> No <input type="checkbox"/> Yes	Pulmonic <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal Stenosis: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe Insufficiency/Regurgitation: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe Vegetation: <input type="checkbox"/> No <input type="checkbox"/> Yes
--	--	---	--

Motion Normal Abnormal Kinesis: Apical Inferior Lateral Anterior

Defects Atrial Spatal Defects Ventricular Spatal Defects

Pericardial Effusion No Yes Moderate Severe (Tamponade)

Blood Clot No Yes Atrium Ventricular

Pulmonary Artery Pressure:

Comments: _____

Electrocardiogram

EKG Report

Rate: bpm Rhythm: Return

PR: ms (N 120 - 200) QRS: ms (N + 100) QT: ms (N +470) Normal Tracing Abnormal Tracing

R Axis: Document

ECG No Ectopy Noted

ECG PAC: PJC: PVC:

Atrioventricular Blocks First Degree Second Degree - Mobitz I Second Degree - Mobitz II Third Degree - Complete

Electrical Conduction

Prolonged QT Low Voltage By Voltage

Left Axis Deviation Right Axis Deviation

Left Atrial Abnormality Right Atrial Abnormality

Right Ventricular Hypertrophy ST-T changes

Left Ventricular Hypertrophy ST-T changes

Intraventricular Conduction Defect

Left Anterior Posterior

Hemiblock Complete Incomplete

Right Bundle Branch Block

Left Bundle Branch Block

Comments: _____

Clinical Impressions

Myocardial Infarction

Anterior Anteroseptal Lateral NI Variant

Inferior Septal

ST Segment Changes

ST Depression T Wave Inversion Lateral Generalized Septal Nonspecific

Anterior Inferior

Findings Suggestive Of

Ischemia Digitalis Effect Hypokalemia NI Variant

ST Elevation Anterior Inferior Lateral Generalized Septal Nonspecific

Findings Suggestive Of

Pericarditis Pkary Aneurysm NI Variant

T Wave Changes

T Wave Inversion Anterior Inferior Lateral Generalized Septal Nonspecific

Clinical Interpretation

Normal Tracing Abnormal Tracing

Tracing Unchanging from: // / //

Clinical Change Evident: _____

Tracing Repeat: // / //

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.

The screenshot shows a web application titled "Discharge Summary Lab Entry" with a "Return" button in the top right. The interface is organized into three main sections: "Admission Labs", "Discharge Labs", and "Additional Labs".

- Admission Labs:** Contains two options. Option 1, "Select Existing Labs", has a "Click to Select" button. Option 2, "Enter New Labs", includes a "1. Create Order" button, the text "2. Enter Results in Lab Module", a "3. Edit Date" button, and a date input field containing "//".
- Discharge Labs:** Mirrors the structure of Admission Labs with similar buttons and input fields.
- Additional Labs:** Features three columns labeled "CKMB Set 1", "CKMB Set 2", and "CKMB Set 3". Each column has a "1. Create Order" button, followed by the text "2. Enter Results in Lab Module" and "3. Enter Date/Time". Below the text are two input fields, one containing "//" and the other empty.

At the bottom of the form, there are two lines of instructional text: "** Times must be entered in military time. (e.g. 22:45) **" and "** 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 //

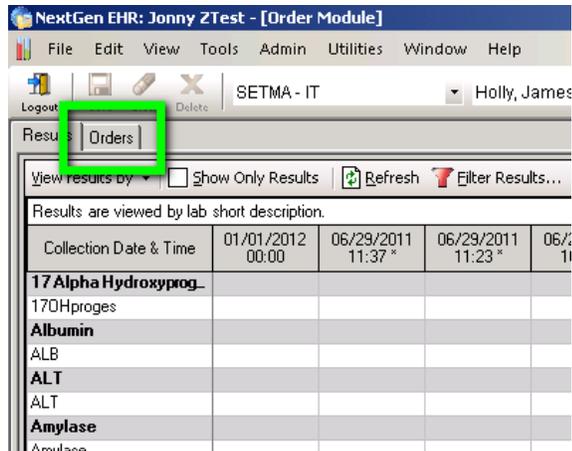
Additional Labs

CKMB

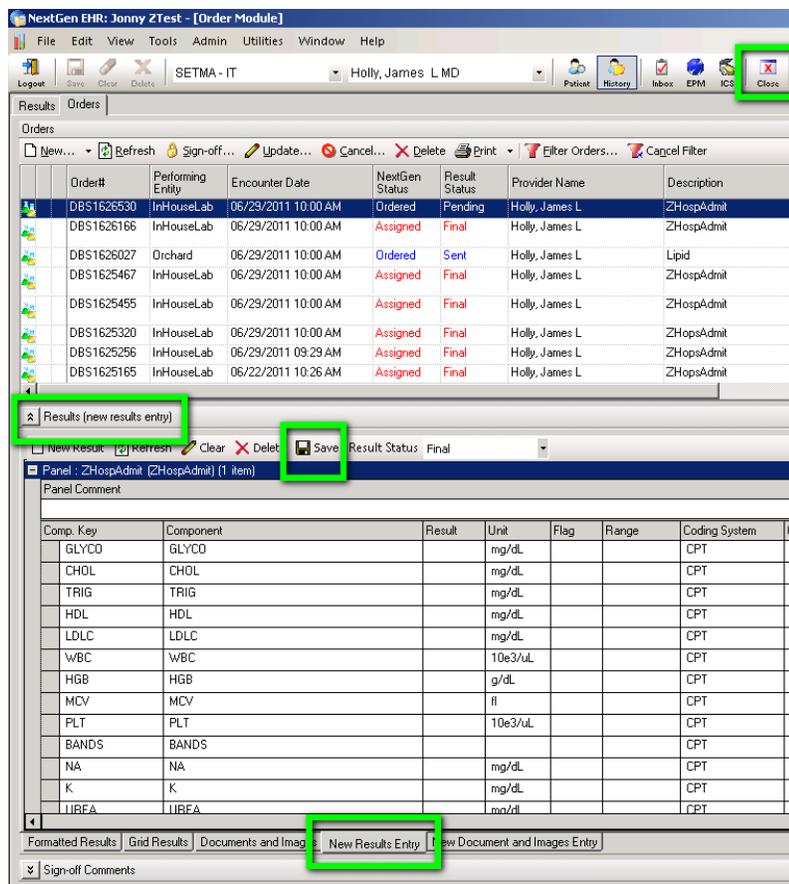
1. Create Order 2. Enter Results and Dates/Times in Lab Module

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.



You will then return to the previous screen. Click the “3. Edit Date” button. You will get a calendar and you should select the date you want each of the results you just entered to have. When you select the date and click ok, it will update all of them with the date you selected. The CKMB section operates the same way...except you have to enter the date/time manually when you enter the result. Just do everything else like you normally would.

The next two navigation buttons are:

- [Hydration](#) -- for instructions on using this template see this LINK
- [Nutrition](#) – for instructions on using this template see this LINK

The next Navigation button is **Hospital Course**

Normal **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 Received Blood Transfusion Patient Received

Fluids	Antimicrobial	Units	Type	Date
_____	_____	_____	_____	__/__/__
_____	_____	_____	_____	__/__/__
_____	_____	_____	_____	__/__/__
_____	_____	_____	_____	__/__/__

Received IV medications _____

Breathing treatments of _____

Physical therapy Speech therapy Occupational therapy Radiation therapy Chemotherapy

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
_____	_____	__/__/__	_____
_____	_____	__/__/__	_____
_____	_____	__/__/__	_____
_____	_____	__/__/__	_____
_____	_____	__/__/__	_____
_____	_____	__/__/__	_____

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

This allows for detail to be documented about the patient’s hospital course and condition on discharge.

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. <ul style="list-style-type: none"><input type="checkbox"/> 2548 Memorial Blvd. Port Arthur, Texas 77640 (409) 983-1161<input type="checkbox"/> 601 Rev Dr Ransom Howard St Pt Arthur, Texas 77642 (409) 983-1161<input type="checkbox"/> 1301 West Park Ave Ste C Orange, Texas 77630 (409) 886-4400<input type="checkbox"/> 710 Hwy 327 East Silsbee, Texas 77656 (409) 386-1222<input type="checkbox"/> 103 West Gibson Ste 110 Jasper, Texas 75951 (409) 489-9103	Jefferson County Public Health Department <ul style="list-style-type: none"><input type="checkbox"/> Health & Welfare Unit #1 1295 Pearl Beaumont, Texas 77701 (409) 835-8530<input type="checkbox"/> Health & Welfare Unit #2 246 Dallas Port Arthur, Texas 77640 (409) 983-8380 Ibn Sina Community Medical Center <ul style="list-style-type: none"><input type="checkbox"/> 8599 9th Ave Pt. Arthur, Texas 77642 (409) 724-7462 Legacy Community Health Services <ul style="list-style-type: none"><input type="checkbox"/> 4450 Highland Beaumont, Texas 77705 (409) 242-2525	<div style="border: 1px solid black; padding: 2px; text-align: center;">Return</div> <div style="border: 1px solid black; padding: 2px; text-align: center;">Print Complete List</div>
---	---	--

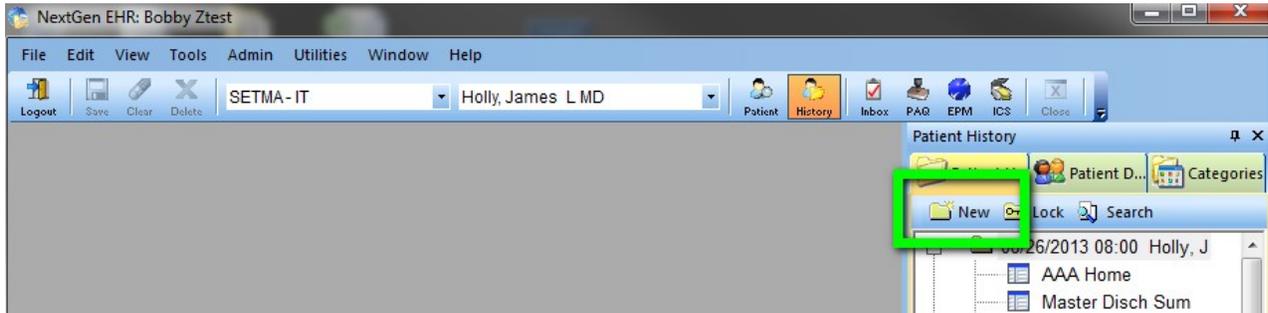
This launches a template with the names, addresses and telephone contact information for a number of clinics which are able to care for patients without insurance.

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

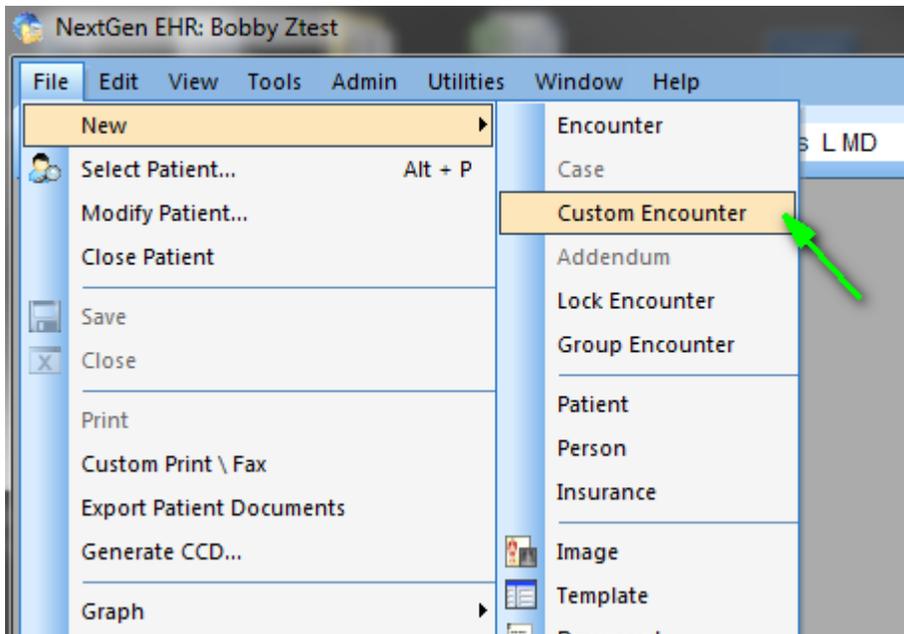
1. Open a visit for the date of discharge.

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.

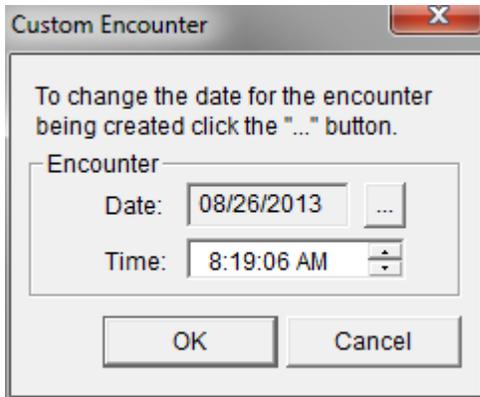


If you are completing a delinquent hospital care summary, you must create a **Custom Visit** so that the hospital care summary is filed on the date of discharge, even though it has been created on a different date, which date of document creation will be noted on the record.

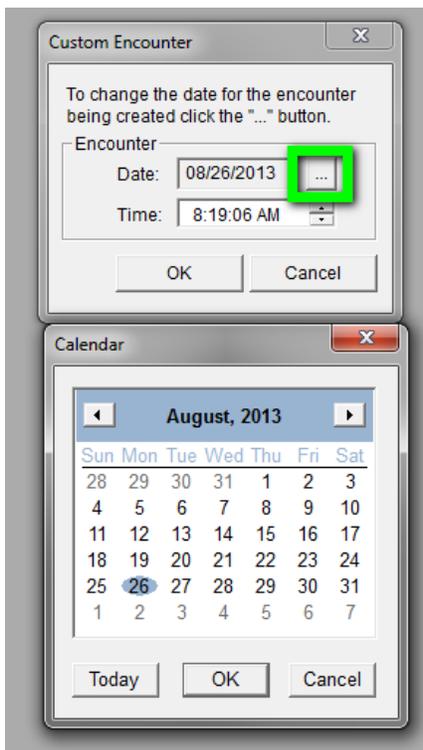
You do this by going to the Left Top of the screen and clicking on **FILE**. You then click on **NEW** and then on **CUSTOM VISIT**.



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



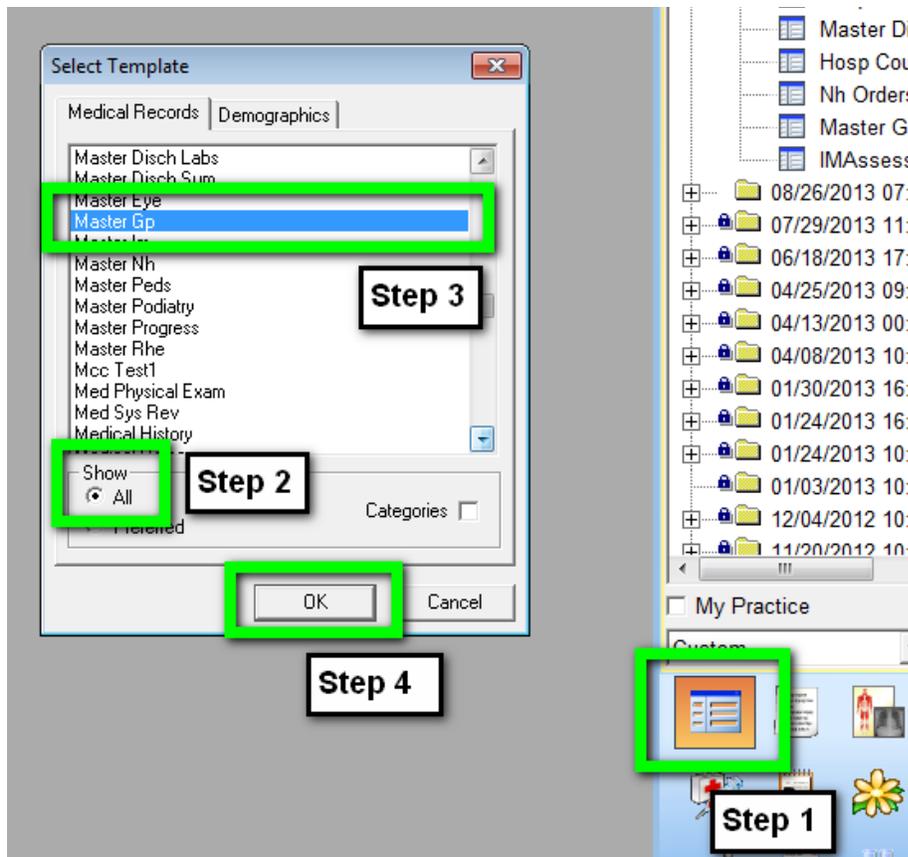
Beside the date on this Pop-up, there is a **Button** with three dots on it. If you click on that button, a calendar comes up which allows you to change the date to the date of the patient's actual discharge. Once the date is correct, you click the **OK** button to the right top of the Pop Up. This creates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



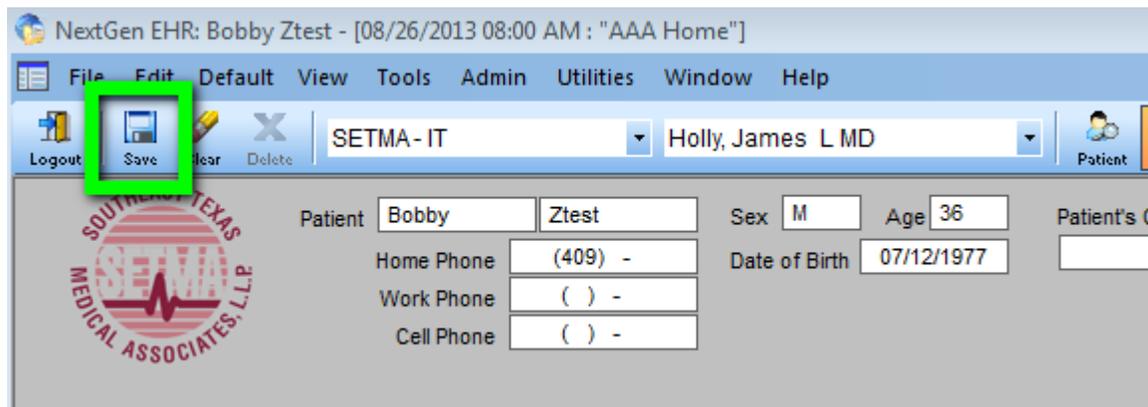
2. At this point, your New Visit has nothing in it. **In order to make the Hospital Care Summary work, you must follow these steps:**

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**.

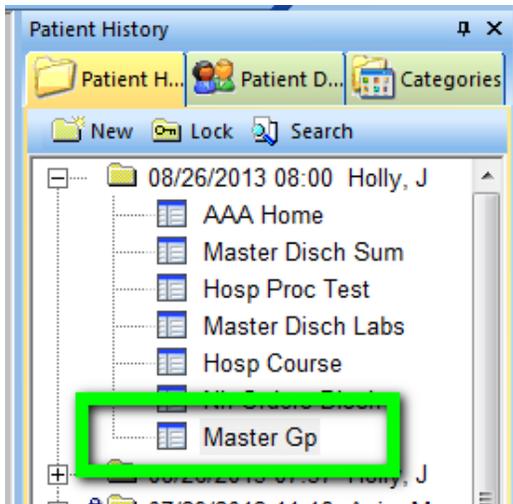
Double click on **Master GP**, or highlight it and the click on the **OK** button at the bottom of the Pop Up.



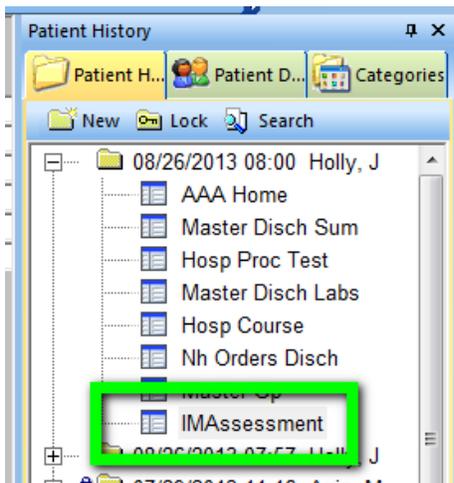
On the **Top Tool Bar**, the second icon is **SAVE**. You will click on this icon to save your change.



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**.

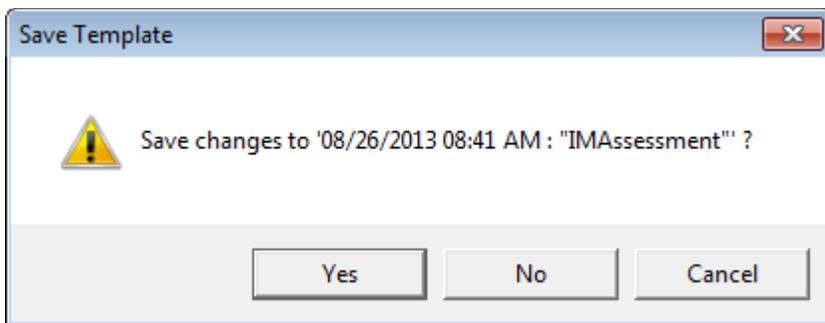
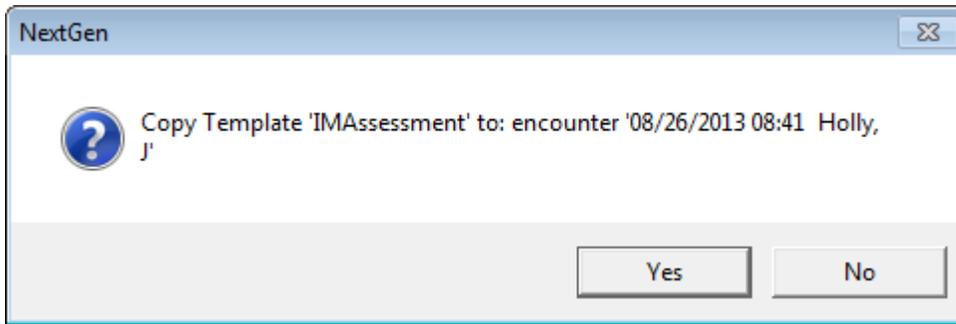


3. At this point, you will go back to the **patient's date of admission** and find the **Assessment** under the date of admission.

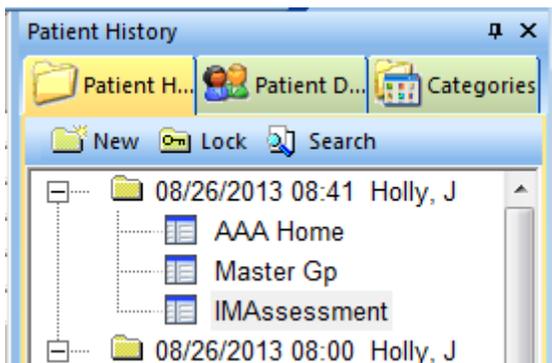


You will highlight **Assessment** by clicking on it. You will then hold the left mouse key down and **DRAG** the assessment up to your **current visit** – either a **new visit** if you are doing the discharge summary on time, or a **custom visit** if you are completing a delinquent hospital care summary.

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>