BASIC SCENARIO – NURSING HOME (V 1.1)

A. PATIENT BACKGROUND

1. John Doe is a 67 year-old white male with a history of COPD, diabetes, and hypertension. Mr. Doe was hospitalized 20 days ago at High Plains Hospital for pneumonia related to respiratory distress, and was admitted 2 days ago to University Hospital in Helena for acute exacerbation of his COPD. The discharge planner has approached Mrs. Doe about the need for nursing home placement for Mr. Doe following this hospital stay.

2. University Hospital has electronically queried the skilled nursing facility (SNF) at the High Plains Medical Complex and received a response indicating the facility currently has no available skilled beds, and does not anticipate any within the next 72 hours. The system continues to query bed availability at SNFs within a 50 mile radius of the Doe’s home and returns 3 prospective facilities. The system retrieves information from the federal Nursing Home compare web site and reports staffing levels, survey results, and performance measures for the prospective facilities. The hospital discharge planner shares this information with Mrs. Doe, who identifies a clear preference for two of the three facilities. The SNF at the Big Sky Village continuing care retirement community is one of the preferred facilities.

B. FACILITY AND SYSTEMS BACKGROUND

3. Big Sky Village is a continuing care retirement community featuring 40 independent living “cottage” units, a 50 bed assisted living facility, and a 50 bed SNF. The community has implemented an EHRs for all residents of the community (SNF, assisted living, independent).

C. PRE-ADMISSION PROCESS

4. Once Mrs. Doe identifies Big Sky Village as a preferred SNF, the discharge planner at University Hospital transmits Mr. Doe’s continuum of care profile to the SNF. The SNF’s EHRs populates a pre-admission module and notifies Adam the Admissions Coordinator, Deb the Director of Nursing, and Bonnie the Business Office Manager, of the admission prospect. Deb reviews the diagnoses, medication orders, treatment orders, and nursing evaluation provided by the hospital to determine if the clinical needs of Mr. Doe can be met by the SNF, and identify any daily skilled nursing or rehab services that would qualify Mr. Doe for Medicare Part A SNF benefits. Deb needed additional clinical information so, based on security permissions from the hospital system, she queried the hospital EHR to review diagnostic testing and nursing assessments of cognition, ADL’s, behaviors and other care related issues. The SNF’s EHRs then used the hospital information provided and queried to estimate staffing acuity levels, cost per day, and the Medicare reimbursement rate used to populate revenue forecast models for the Community. Based on the composite of information on Mr. Doe, Deb approves the clinical appropriateness of Mr. Doe’s admission. The system notifies Adam that Mr. Doe is clinically appropriate for admission.

5. The SNF’s EHRs, upon receipt of the continuum of care profile from the hospital, launched queries which captured dates of inpatient service at the hospital, available days for SNF benefit from the Medicare Common Working File, and eligibility under Mr. Doe’s secondary private health insurance. This information was reviewed by Bonnie in the business office who, based on the results of these queries, updates the EHRs to indicate that Mr. Doe is an appropriate admission.
6. Mrs. Doe visits the SNF at Big Sky Village the day prior to Mr. Doe’s planned discharge from the hospital. Adam takes Mrs. Doe on a tour of the facility, showing her a bed the EHRs identified on the Sagebrush unit for her husband. Adam and Mrs. Doe then sit down to complete the admission process. They validate the correctness of demographic and contact information; identify providers to be used by Mr. Doe in the SNF (pharmacy, podiatrist, etc.); review admission documents, and secure her electronic signature as the health care proxy on the admission agreement, receipt of Notice of Privacy Practices, Consent to Treat, etc. With Mrs. Doe’s signature in place on the admission agreement, the SNF’s EHRs automatically queries supply and food inventories, verifying the availability of an oxygen concentrator and food items for Mr. Doe’s diabetic diet. The Sagebrush unit, along with clinical, support and administrative departments, are notified of the admission planned for the next day. Nurse staffing allocations are automatically adjusted to reflect the planned admission.

7. University Hospital has successfully stabilized Mr. Doe’s COPD and complicating clinical conditions. The continuum of care transfer is populated, and ambulance transport automatically scheduled and sent to the ambulance service, upon Dr. Tell’s entry of a Discharge Order. Dr. Tell reviews, modifies, and appends the orders, vitals, diagnoses, etc. that are populating the transfer and the SNFs admission order set. He authenticates the information. The hospital system transmits the continuum of care transfer information along with SNF admission order set, H&P, medication administration record (MAR), treatment record, lab reports, x-ray reports, preadmission screening (PASAAR) and Advance Directives to the SNF. The ambulance system sends notification to the SNF of the resident’s scheduled time of arrival.

8. The hospital continuum of care transfer information, admission orders, and ambulance service notice are received at the SNF, triggering the EHRs to notify clinical and support departments of Mr. Doe’s scheduled arrival; adjust staffing assignments to assure appropriate nursing personnel are available for the admission; and transmit the order set to the pharmacy.

D. INITIAL CARE

9. The ambulance arrives with Mr. and Mrs. Doe at the appointed time, and the couple is shown to his room. The EHRs is updated to show Mr. Doe’s admission. Assessments are initiated by nursing, including prompted completion and documentation in the EHR of the nursing admission assessment and focused assessments of skin status, falls potential, etc. An initial care plan and nursing assistant task list is developed based on disease and functional protocols triggered by assessment findings. Descriptive entries related to resident status are recorded in the EHR as necessary. Ordered medications are administered based on automated verification of right medication-right patient, and documented in the EHR. Nursing assistants electronically chart their delivery of care in accordance with the task lists compiled from the disease and functional protocols and individualized to Mr. Doe’s needs.

E. ONGOING CARE AND ADMINISTRATION

10. Further development of Mr. Doe’s EHR takes place as assessments are completed by the Dietitian, Social Worker, and Activities personnel. Interdisciplinary assessment information drives enhancement of the resident care plan and task lists, and populates the federally required minimum data set (MDS). Diagnosis codes assigned by the EHRs are reviewed and validated by the Health Information Management Coordinator. Scheduled MDS assessments are compiled from EHR data, reviewed, revised, and authenticated as appropriate, and transmitted as required by state and federal regulations.
11. On day 8 of Mr. Doe’s stay a lab was ordered. The EHRs automatically updated the lab schedule and communicated with the lab to have the specimen drawn. Nursing staff reviewed the lab schedule list and selected the applicable diagnosis to justify the lab from the EHRs listing of active diagnoses for Mr. Doe. Applicable demographic, financial, and diagnostic information was transmitted to the lab for their information and billing system. The lab technician arrived at the SNF to gather the specimen as scheduled.

12. The next day the lab report was transmitted automatically to the SNF and the attending physician’s office/clinic. Nursing staff at the SNF reviewed the lab report and noted abnormal results. An e-mail was sent to the Dr. Tell informing him of the abnormal results, reporting information about Mr. Doe’s condition as suggested by EHRs nursing prompts, and asking if action was necessary. Dr. Tell reviews the lab result, information from the nurse and then accessed the WEDOITALLFORYOU EHRs. The EHRs authenticates Dr. Tell as an approved user of the system. He has specific access rights to clinical information in the EHRs for his residents.

13. Dr. Tell reviews clinical flowsheet data in the EHRs regarding Mr. Doe’s respiratory status along with recent nursing notes, electronic MAR’s, and treatment records to understand the resident’s current condition. Based on the information, Dr. Tell enters a new physician order directly into the EHRS and authenticates the order. Dr. Tell would also like additional clinical monitoring on respiratory status every 4 hours for the next 48 hours. He selects the charting guidelines and schedules the frequency. The system updates the charting work list for the nursing staff to conduct respiratory assessments every 4 hours. He continues to monitor the patient each day reviewing the clinical monitoring documentation for Mr. Doe to be assured that his status is stable. The nursing staff work list automatically identifies the schedule of resident’s

14. Days later Mr. Doe was walking with his wife in the courtyard when he became dizzy, blacked out and fell. Nursing staff were called to Mr. Doe to assess his clinical status and evaluate for possible injury. She documents in the EHRs the results of the assessment and initiates the incident report and falls protocol. The quality indicator and quality measure statistics are immediately updated. The system prompts the nurse to assess certain criteria and consider certain guidelines to evaluate the reason for the fall and implement appropriate follow up documentation, monitoring and testing. The documentation related to the incident automatically is sent to Dr. Tell’s office for his review. Dr. Tell reviews the information and accesses the SNF’s EHRs to review additional charting. Dr. Tell contacts Mr. Doe’s nurse manager to further discuss the resident’s status. Dr. Tell documents a progress note directly into the SNF’s EHRS of his assessment of Mr. Doe’s condition and a plan to have further tests run. He enters a physician order for an x-ray and an MRI directly in the EHRS.

15. The Sagebrush Unit Coordinator receives a list of diagnostic tests to be scheduled at the local hospital through the EHRs. She enters the hospital outpatient scheduling system and schedules the x-ray and MRI. She electronically sends applicable demographic and financial information for the tests. Since Mr. Doe is a Medicare recipient, the system recognizes that the x-ray is to be billed to the nursing home under consolidated billing rules, but the MRI is billed by the hospital directly to Medicare. The hospital billing system is updated to bill the appropriate party. Once the tests are scheduled, the Unit Coordinator sends an e-mail to the transportation vendor (not an ambulance provider) and schedules transportation. On the day of the test, Mr.
Doe’s nurse manager completes the clinical referral documentation on the EHRS and transmits it to the hospital.

**F. TRANSFER IN CONTINUUM OF LONG TERM CARE**

16
Once Mr. Doe’s condition stabilized, discharge planning was initiated. The couple felt that they could no longer live in their own home due to John’s chronic conditions and his wife’s continued frailty. After looking at the options available at Big Sky Village, the couple decided to move into one of the assisted living unit with home care services. The social service coordinator queried the CCRC’s information system for availability of an assisted living unit. A unit was found, a discharge date was identified and the move scheduled into the assisted living unit. Discharge planning has been initiated by the care plan team; in anticipation of a doctors’ order. Preliminary results of the planning have been sent electronically to Nursing, Rehab for home safety evaluation, to Dietary for consult on diabetic management, and to social services.

17
Nursing assesses John and his wife for assisted living (mini-mental, ADL status), and this info is sent to the Assisted Living coordinator. The Assisted Living coordinator reviews the updated assessment and approves the move-in, pending the physician’s discharge order.

18
After reviewing the patient’s electronic chart, Dr. Tell gives instructions for John Doe to be discharged. John’s wife signs the discharge instructions, and the chart/records are transmitted to Assisted Living. Census entries are generated for the health center bed (discharge) and Assisted Living (admission). A bill is prepared for John Doe’s health center stay and submitted to insurance.

19
Discharge prescriptions include an order for Oxygen in the home, home health care visits, and all meds. The discharge order is sent to the health center, pharmacy, home health agency, and medical supplier, with a cc to the community administrator.