DAY 1 - PATIENT HISTORY & INITIAL ENCOUNTER WITH CARDIOLOGIST

SOCIAL HISTORY

- Ms. Smith is a 68 year old white female widow who retired 3 years ago and moved from Maryland to Texas.
- Prior to her retirement, she worked as a receptionist in a hotel lobby. She depends on her social security check as her primary source on income.
- Patient lives alone, but has remained independent in her Activities of Daily Living (ADLs) and is functionally independent with a cane. Patient uses her own car to get to medical appointments, although she has become more reliant on friends to take her, due to intermittent dyspnea and blurry vision in her right eye.
- She has two children, a son and a daughter who still reside in Maryland. The daughter works as an accountant, is married and has children. The son lives alone and works as a lawyer. Communication has been poor between the family members and Ms. Smith rarely discusses her healthcare with them.

PAST MEDICAL HISTORY

Patient leads a sedentary lifestyle and follows a poor diet with little exercise. Patient has also started to experience frequent falls due to the osteoarthritis of the right hip. Patient was diagnosed with the following while she was in Maryland:

- **Hypertension**
- **Hyperlipidemia**
- **Stage 3 chronic kidney disease**
- **Ischemic heart disease**
- **Depression**
- **Cataracts**
- **Osteoarthritis**
- **Type II diabetes**

CURRENT MEDICATIONS

Patient has an extensive med list, which contributes to poor adherence.

- **Lisinopril 40mg twice a day**
- **Calcium 500mg daily**
- **Furosemide 20mg daily**
- **Insulin 3 units with each meal**
- **Ferrous Sulfate 325mg three times a day prior to meals**
- **Atorvastatin 40mg nightly**
- **Vitamin D 800IU daily**
- **Glargine 24 units SQ nightly**
- **Sertraline 25mg nightly**

TYPICAL HEALTHCARE FOLLOW UP

Patient does follow up with the primary care physician and nephrologist regularly, but other specialist follow up is often sporadic.

- **Primary Care Physician**
- **Endocrinologist**
- **Psychiatrist**
- **Pharmacy**
- **Cardiologist**
- **Nephrologist**
- **Ophthalmologist**
- **Lab Services**

RECENT ENCOUNTERS

1. Patient visits the cardiologist to discuss her intermittent shortness of breath and the swelling in her feet. Vital signs are stable at this time.
2. The assessment is entered into the EHR and the cardiologist recommends increasing her furosemide dose to 40mg. The cardiologist also recommends a set of labs (CMP, CBC, Coags).
3. The new e-script is sent to the pharmacy.
4. Patient also requests that the information about the dose increase and her visit summary be sent to her PCP. The information is faxed from the cardiology office but is not received by the PCP.
- Patient picks up her new prescription but due to poor medication adherence, she does not take it as prescribed.
5. The patient schedules and attends an appointment the next day for a lab draw. The lab uses the e-requisition sent from the cardiologist to confirm patients labs

DAY 15 – EMS CALLED

6. 2 weeks after the encounter with the cardiologist patient experiences shortness of breath and is febrile. She calls an ambulance. The ambulance dispatcher fills out a triage sheet which is then handed to the EMT.
7. Once the ambulance arrives, the EMT attempts to complete an H&P but patient is unable to provide details due to her increasing dyspnea and fatigue. 4L oxygen via nasal cannula is placed on the patient.
8. The transport H&P is entered into the EMT/ Medic specific software

DAY 15 – 36 INPATIENT ADMISSION

9. A verbal report of the transport and H&P is provided to ED triage. The ambulance provides a paper copy of the H&P, which is handed to the ED nurse who then hands it to the front desk. Admitting places the H&P in the paper chart and scans a copy into the EHR
10. The admitting department, triage nurse and ED doctors take turns obtaining patients registration information, H&P and current symptom history, which is entered into the hospital EHR. This is the patient's first time entering Hospital A and no previous documentation is available in the EHR. In addition, patient is unable to recall the majority of her PMH and medications. PCP information is not available at this time (not on Medicare card and patient is still dyspneic). Ultimately, an incomplete PMH is entered into the EHR.
- Patient becomes increasingly lethargic. A CMP, CBC, Coags, Urine culture, HCT, CXR are ordered. As results start rolling in clinicians suspect that the patient most likely has pneumonia. During a VS check, patients BP drops to 70's systolic and patient shows signs of sepsis. Patient is pan cultured and STAT Vancomycin and Zosyn are ordered and administered. Patient is also given a fluid bolus.
- Because the PMH was incomplete, the medical team were unware of her diabetes history and the patient's glucose control suffered due to a missed dose of Lantus. Patient was placed on a sliding scale using short acting insulin only. In addition, the ABX were not renally dosed which caused further damage to the kidneys and the fluid bolus worsened the fluid overload. This sent patient into flash pulmonary edema.
11. On day 3, patient shows improvement, she is able to provide the medical team with her PCPs phone number. She has the pharmacy information in her bag along with her insulin vials. The intern then proceeds to call the pharmacy and the PCP to fill gaps in the PMH and records it in the EHR. The dose of furosemide that the patient states and the dose that the PCP states are different, which prompts the intern to call the pharmacy and investigate recently filled prescriptions.
- After 3 weeks in the hospital with the correct ABX doses and diuresis, patient is ready to be discharged from the hospital. During this time, she is seen by the hospital cardiologist, nephrologist, infectious disease doctor, internal medicine doctor, nurse practitioner, nurse, clinical technician, clinical pharmacist, dietician, social worker, case management, physical therapist and occupational therapist. during her stay.
- Due to her extended hospital stay and limited mobility, she experiences muscular deconditioning while in the hospital. PT and OT recommend HHA services and a walker. The resident places an order for home PT, OT, SN & HH Aide in addition to a walker.
12. Unfortunately the face to face remains electronically unsigned by the attending till 3 days after discharge. This leads to a 7 day delay in patient in patient starting home care services.
13. Patient is seen by case management who places a referral via fax. The fax machine is broken and it takes several attempts to send the referral. The case manager also shows the patient the signed Important Message from Medicare. Patient agrees with the discharge plan
14. The nurse prints off a discharge summary for the patient.
15. Doctors e-prescribe her medications to her home pharmacy. A walker is provided before discharge. Patient then calls her friend to transport her home.

KNOWN MEDICATIONS ON ADMISSION

- Lisinopril (dose unknown)

RECONCILED MEDICATION LIST ON DISCHARGE

- Lisinopril 40mg twice a day
- Calcium 500mg daily
- Furosemide 40mg daily
- Insulin 3 units with each meal
- Ferrous Sulfate 325mg three times a day prior to meals
- Atorvastatin 40mg nightly
- Vitamin D 800IU daily
- Glargine 24 units SQ nightly
- Sertraline 25mg nightly

DAY 36 to 46 - DISCHARGE HOME WITH HHA

- Once patient is home, she realizes that she has left her discharge instructions in the hospital room.
16. She calls the pharmacy to ask about the medications that were prescribed and then requests that refills are mailed to her home.
17. 10 days after discharge a HHA comes to her house to perform the intake interview. She is set up with SN, PT, OT and then is asked about her goals. The HHA completes a H&P and completes information through the OASIS.
18. The HHA asks about her hospital stay but the patient can't recall all of the details and does not have the discharge instructions on hand. The HHA nurse calls the hospital and locates the hospital CM. The CM faxes the discharge paperwork with follow up instructions, with the patient's permission.
19. The patient attempts to communicate all of her hospital interventions at her follow up appointments with the specialists using her printed discharge summary.
- HHA submits clinical information to CMS using the OASIS assessment instrument

DAY 47 – EMS CALLED

- The day after patient is seen by the HHA nurse, but before PT has had an opportunity to assess patient, she falls and is in excruciating pain.
20. EMS is called. An ambulance dispatcher fills out a triage sheet which is then handed to the EMT. The EMT is routed to a different hospital due an accident blocking the main highway.
21. Once the ambulance arrives, the EMT completes an H&P. The transport H&P is entered into the EMT/ Medic specific software

DAY 47 to 54 – SECOND INPATIENT ADMISSION

22. Once EMT arrives they print a paper copy of the H&P from their software to provide to ED triage. A verbal report of the transport and H&P is provided to ED triage. The ambulance does not provide a paper copy of the H&P, but the admitting provider writes the information and types it into her own H&P.
23. The admitting department, triage nurse and ED doctors take turns obtaining patients registration information, H&P, medications and current symptom history, which is entered into the hospital EHR. Patient is given oxycodone for her pain and is ordered a CMP, CBC and coags.
- This is patient's first time entering Hospital B and no previous documentation is available in the EHR. The patient communicates that she was recently admitted to Hospital A and that she was discharged with home health.
- Patient receives a phone call from the HHA PT explaining that he is at her home, but no one is answering. She explains that she is at the hospital and does not know how long she will be there. HHA faxes patients PMH and medication history Patient is discharged from HHA.
- Results begin to roll in and she is informed that she has a right broken hip and will need a hip replacement. Patient calls her children to let them know of her current medical condition and location. Patient is then consented and taken to the OR.
- Patients mobility is impaired significantly and she is unable to bear weight as she once did. PT assesses her and recommends a skilled nursing facility to help her return to her baseline (walking with a cane).
24. The social worker meets with the patient to assess her ability to look after herself at home. Patient reports that she was independent and expects a full recovery soon.
25. The social worker provides options for skilled nursing facilities and places referrals via NaviHealth. Medical information is uploaded to the NaviHealth site. Once a SNF accepts the patient, the SNF liaison will communicate this information with the SW. The discharge paperwork is completed before patient leaves the hospital and is placed in a manila envelope on the patient.
26. Non urgent ambulance transport is set up to transfer the patient to the SNF. A verbal report of information is given to the transport team and they check to see if the manila envelope with transport details is ready. The patient is then taken by the transport team
- Patient was given an extra dose of oxycodone before discharge to the SNF to help with transport pain. Oxycodone is also on her list of discharge medications

KNOWN MEDICATIONS ON ADMISSION

- Lisinopril 40mg twice a day
- Calcium 500mg daily
- Furosemide 40mg daily
- Sertraline 25mg nightly
- Ferrous Sulfate 325mg three times a day prior to meals
- Glargine 24 units SQ nightly
- Insulin 3 units with each meal
- Atorvastatin 40mg nightly
- Vitamin D 800IU daily

RECONCILED MEDICATIONS ON DISCHARGE

- Lisinopril 40mg twice a day
- Calcium 500mg daily
- Furosemide 40mg daily
- Sertraline 25mg nightly
- Ferrous Sulfate 325mg three times a day prior to meals
- Glargine 24 units SQ nightly
- Insulin 3 units with each meal
- 5-10mg oxycodone every 4 to 6 hours as needed for pain
- Acetaminophen 650 every 5 hours or as needed for pain
- Atorvastatin 40mg nightly
- Vitamin D 800IU daily

Day 54 – SNF ADMISSION

- The patient arrives at the SNF and the patient is "settled" in. The new CNA takes the paperwork and files it away in the wrong place.
- The patient is asked about her functional status and she reports that she is able to weight bear and want to get out of bed to stretch. The new CNA assists patient in getting out of bed, but patient immediately falls. Patient is in excruciating pain and readmitted to the hospital