PACIO-eLTSS Use Case for the September 2020 HL7 Connectathon

PATIENT PERSONA

Patient Background:

- 68-year-old retired white female widow
- Retired
- Moved from Maryland to Texas
- Depends of social security as primary source of income
- Lives alone, but has two children, with the son living close by and designated as assisting with healthcare decision-making.

Past Medical History

- Hypertension
- Depression
- Hyperlipidemia
- Cataracts
- Stage III chronic kidney disease
- Osteoarthritis
- Ischemic heart disease
- Type II Diabetes

Home Medications

- Lisinopril 40mg twice a day
- Atorvastatin 40mg nightly
- Calcium 500mg daily
- Sertraline 25mg nightly
- Metformin 500mg daily
- Vitamin D 800IU daily
- Tylenol 650mg every 6 hours or as needed
- Furosemide 20mg daily
- Ferrous Sulfate 325mg three times a day prior to meals

ACRONYMS

CM	Case Management
DEL	Data Element Library
eCQM	Electronic clinical quality measure
EHR	Electronic Health Record
eLTSS	Electronic Long Term Services and Support
HCBS	Home and Community Based Services
HHA	Home Health Agency
IG	Implementation Guide
iQIES	Internet Quality Improvement and Evaluation System
L MCA	Left middle cerebral artery
LTSS	Long term services and support
MD	Doctor of Medicine
MDS	Minimum Data Set
MMSE	Mini Mental State Exam
MoCA	Montreal Cognitive Assessment
Multi-D	Multi-Disciplinary
OT	Occupational Therapist
PAC	Post acute care
PT	Physical Therapist
SLP	Speech Language Pathologist
SNF	Skilled Nursing Facility
SW	Social Worker

KEY

Use case information flow:

Data flow in Scene 1:

Data flow in Scene 2:

Data flow in Scene 3:

Potential data flow in Scene 3:

Data flow in Scene 4:

Data flow in Scene 5:

IG used in Scene:

IG

PATIENT STORY

SCENE 1: Home with LTSS

Day 1 (7/6/20): Betsy is at home receiving LTSS. SW assesses her and documents Care Plan, Goals into in the CM EHR on 7/6/2020 at 1300. Betsy is functionally independent without the use of assistive devices.

Day 2 (7/7/20): Betsy experiences an acute onset of right sided weakness (with drift), facial palsy (partial paralysis of lower face), blurry vision with mild aphasia and dysarthria. She calls 911 for help and an ambulance transports her to the hospital.

SCENE 2: Hospital

Day 2 (7/7/20)**:** Hospital admits Betsy at 1500. Upon assessment by the Neurologist, Betsy is found to have an occlusion of the L MCA. MD documents ischemic stroke and a list of current medications on 7/7/20 at 1532. The care team decides to follow conservative management, since too much time has elapsed to effectively administer TPA.

Day 3 (7/8/20): PAC assessments are pulled from Pseudo DEL for PT and OT to complete (1) functional assessments at 1600 and (2) SLP to complete MMSE and MoCA 1732.

Day 4 (7/9/20): Betsy's condition significantly worsens resulting in complete right sided paralysis, worsening dysarthria and dysphagia. The care team decides to perform a mechanical thrombectomy. Betsy's condition improves after the thrombectomy with right sided weakness improving as well as the dysarthria and dysphagia.

Day 6 (7/10/20): PAC assessments are pulled from Pseudo DEL for (1) SLP to complete MoCA and MMSE at 1216 and (2) functional assessments at 1434. PT, OT and SLP recommend rehab in a SNF.

Day 7 (7/11/20): MD updates medication list on day of discharge at 7/11/20 0542 by MD. Hospital discharges Betsy to SNF soon after.

SCENE 3: SNF

Day 7 (7/11/20): SNF admits Betsy to the SNF at 1130. PT/SLP complete a medication review and assessments (Nursing Comprehensive on the MDS) by 1632.

Day 8 (7/12/20):OT completes assessments (Nursing Comprehensive on the MDS) at 1115

Day 9-26 (7/13/20 -7/30/20): During the SNF admission, Betsy's condition continues to improve.

Day 27 (8/1/20): PT/SLP complete the MDS discharge assessment, which shows improvement in function and cognition. However, Betsy requires home health services and a continuation of her home and community based services as she returns to her baseline function/cognition. SNF discharges Betsy to home.

SCENE 4: Home with HHA

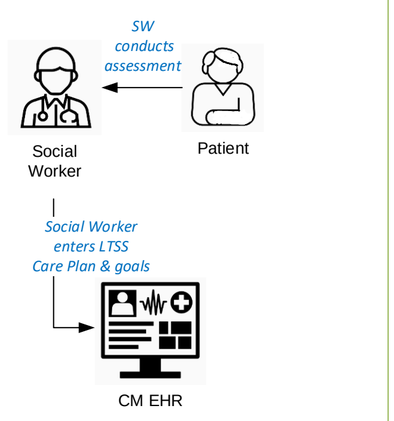
Day 27 (8/1/20): Betsy is now at home receiving both HHA and HCBS. The HHA admission nurse is able to view the patients transition summary to inform patients care and set therapy goals.

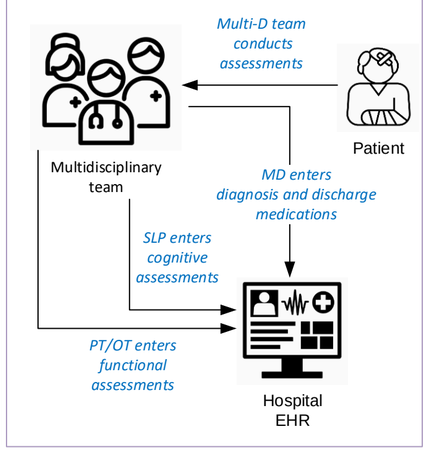
Day 28 (8/2/20)**:** PT assesses Betsy and completes the admission OASIS assessment (includes FASI information).

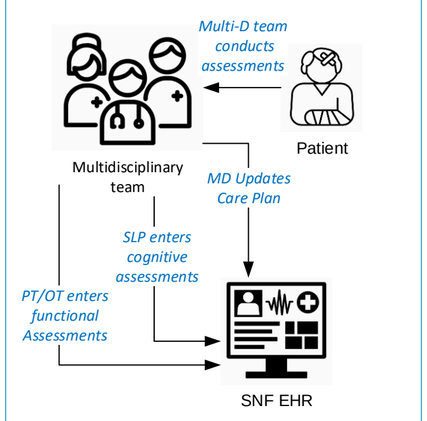
SCENE 5: Patient and Family Access

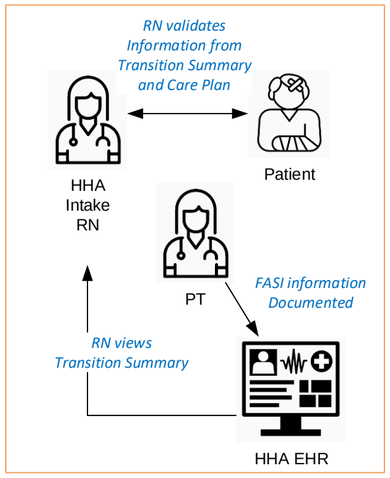
Day 1-28: Betsy shares her medical record with her adult son and daughter who are able to view her information at any point. Additionally Betsy is able to use the mobile app to inform her daily activities.

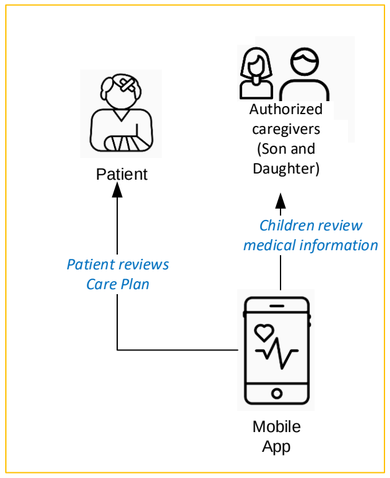
USE CASE



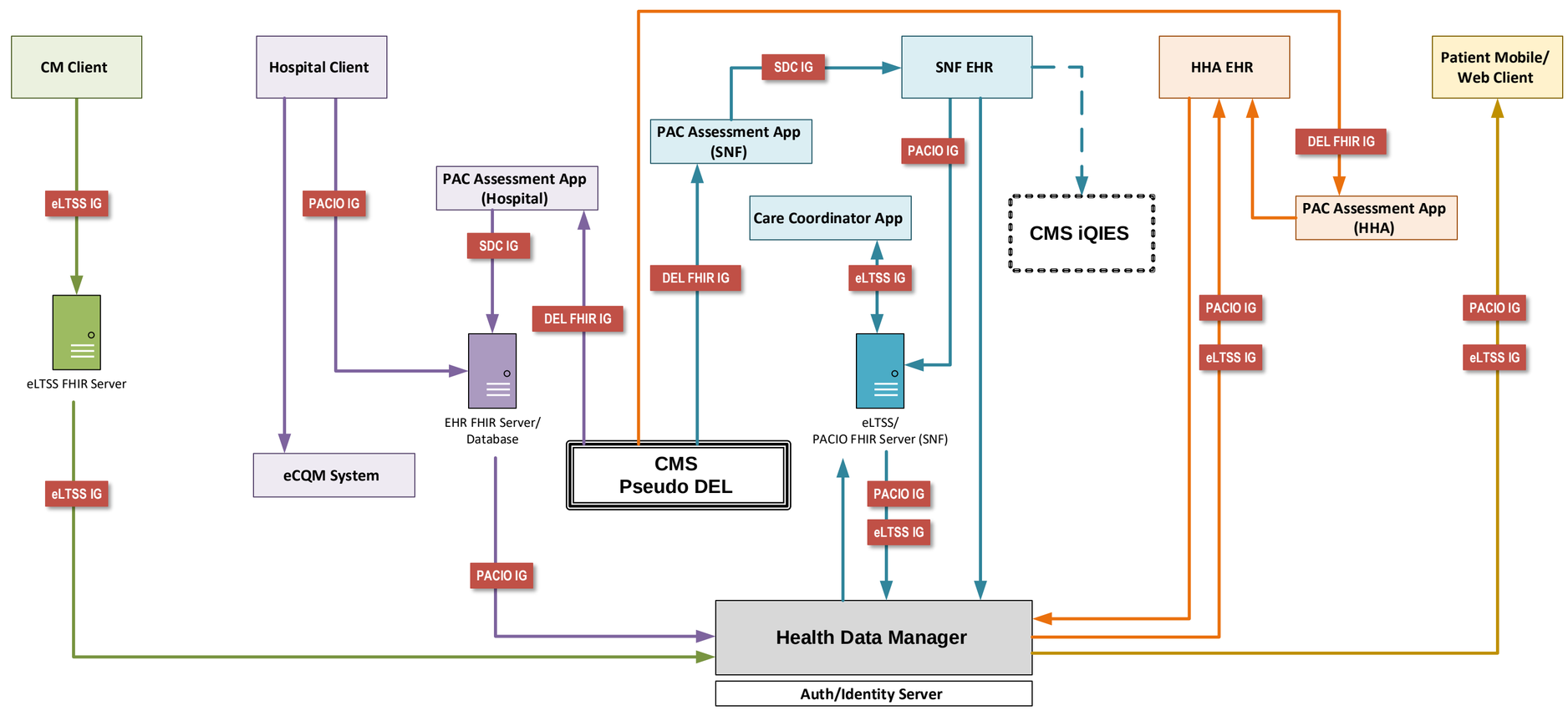








SYSTEMS



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Last updated 8/25/20