

Interoperability Scenarios

Care Theme: Clinical Decision Support

Act 24 - Care of the Stroke Patient in the Acute Care Setting

Scenario Primary Goal: To demonstrate practice interoperability and content interoperability using a common professional practice framework and clinical documentation model.

Key Points

- This scenario demonstrates how a professional practice framework and clinical documentation model can enhance clinical decision support.

Meaningful Use Relevance

MU Objective 1: Improving Quality, Safety, Efficiency and Reducing Health Disparities.

- This scenario demonstrates how clinical information is documented and displayed in a standardized way to support NQF-endorsed quality measures, patient care coordination, and information exchange in order to deliver quality outcomes.

MU Objective 2: Improving Care Coordination.

- This scenario demonstrates how clinical decision support at the point of care leverages interoperable systems using evidence-based clinical content to support chronic care delivery across the continuum of care.

Clinical Workflow:

A 64 year male patient with a history of Atrial Fibrillation is admitted to the intensive care unit (ICU) with right sided arm and leg weakness. He is diagnosed with an ischemic stroke. The nurse obtains baseline labs and vital signs, gathers history from the Patient Profile and performs a functional screening assessment. The nurse completes the baseline for the NIH Stroke Scale, initiates the interdisciplinary plan of care and adds the Stroke/Transient Ischemic Attack Clinical Practice Guideline. After 24 hours in the ICU the patient is stable and transferred to a medical unit. After receiving the patient on the medical unit the nurse performs a head toe assessment, completes a fall risk assessment, and updates the interdisciplinary plan of care by adding the Fall/Trauma/Injury Risk Clinical Practice Guideline. The nurse also updates the NIH Stroke Scale.

The Rehab Service dept receives a referral generated by the health information system based on functional screening assessment score of 2. Rehab Service performs an evaluation of the patient and adds the Functional Deficit Clinical Practice Guideline and patient specific goals to the interdisciplinary plan of care. The Social Service department receives a referral generated by the health information system based on needs identified on the Patient Profile, and completes an evaluation, documenting discharge needs and the follow-up plan.

Care Scenario Steps:	Care Setting From	Care Setting To	Standardized Guidelines	Source	Standardized Guidelines	Source
<p>24-1 Patient Admitted to ICU A 64 year male patient with a history of Atrial Fibrillation is admitted to the ICU with right sided arm and leg weakness. He is diagnosed with an ischemic stroke. The nurse gathers patient history from the Patient Profile and completes a functional screening assessment. The nurse completes the NIH Stroke Scale during the physical assessment. The nurses initiates the interdisciplinary plan of care and adds the Stroke/Transient Ischemic Attack Clinical Practice Guideline</p>	Home	Intensive care unit (ICU)	<p>Patient Profile</p> <p>Stroke/Transient Ischemic Attack Clinical Practice Guideline</p>	<p>Functional Screening Assessment</p> <p>Interdisciplinary Plan of Care</p>	NIH Stroke Scale	Physical Assessment
<p>24-2 Patient Transferred to Medical Unit After 24 hours in the ICU the patient is stable and transferred to a medical unit. The ICU nurse uses the Professional Exchange Report to transfer over care. After receiving the patient on the medical unit the nurse completes a head toe assessment, completes a fall risk assessment, and updates the interdisciplinary plan of care by adding the Fall/Trauma/Injury Risk Clinical Practice Guideline. The nurse also completes the NIH Stroke Scale 24 hrs post onset of symptoms.</p>	Intensive care unit	Medical Unit	<p>Professional Exchange Report</p> <p>Fall/Trauma/Injury Risk Clinical Practice Guideline</p>	<p>Transfer of Care</p> <p>Fall Risk Assessment</p>	NIH Stroke Scale	Physical Assessment

<p>24-3 Rehab Services Ordered The Rehab Service department receives a referral generated by the health information system based on functional screening assessment score of 2. Rehab Services performs an evaluation of the patient and adds the Functional Deficit Clinical Practice Guideline and patient specific goals to the interdisciplinary plan of care</p>	Medical Unit	Rehab Services Department	Auto-generated Consultation Referral	Patient Profile	Functional Deficit Clinical Practice Guideline	Interdisciplinary Plan of Care
<p>24-4 Social Services Ordered The Social Services department receives a referral generated by the health information system based on needs identified in the Patient Profile and completes an evaluation, documenting discharge needs and the follow-up plan.</p>	Medical Unit	Social Services	Auto-generated Consultation Referral	Patient Profile		

New Directions: Interoperability will be expanded to include other considerations for quality, standardized care that supports patients' values and preferences. This scenario demonstrates the following key elements needed to support and sustain comprehensive interoperability including:

- Intentionally designed automation (IDA) expedites interoperable systems by preparing and engaging clinicians, supporting an evidence-based practice framework and delivering quality outcomes.
- Practice interoperability supports utilizing a professional practice framework to exchange patient information and interdisciplinary professional services across all clinical settings.
- Content interoperability involves the use of consistent professional data that is exchanged accurately and effectively within the technological systems across the continuum of care.