**Trigger 1: PCP visit followed by admission (n=35)**

**Inclusion criteria**

|  |  |  |
| --- | --- | --- |
| **Criteria** | **Description** | **Comments** |
|  | | |
| 1. Type of Index visit |  |  |
| Primary care unscheduled visit (n=8) | Include |  |
| Primary care note(CBOC, LOPC, initial evaluation, follow up) (n=8) | Include |  |
| Nursing clinic visit note(n=4) | Include |  |
| Inpatient nursing assessment note(n=8) | Exclude |  |
| Telephone call note(n=3) | Exclude |  |
| Preventive medicine note(n=3) | Exclude may be | 1- No diagnostic activity  1-Care escalation. Advised to go to outside ER |
| CBOC Anticoagulation visit(n=1) | Exclude | No diagnostic activity |
| 1. Charlson Comorbidity Index |  | Need to refine. |
| 1. Hospitalization |  |  |
| ER(n=29) | Include |  |
| Other (n=6) | Exclude | Planned hospitalization for planned surgery. Direct admission in respective department. No admission through PCP or ER. |

**Exclusion criteria**

|  |  |  |
| --- | --- | --- |
| **Criteria** | **Yes/No** | **Comment** |
| 1. Terminal Illness | No=34  Yes=1 | Pt had metastatic lung cancer |
| 1. Hospice | No=35 |  |
| 1. Palliative medicine | No=35 |  |
| 1. SNF | No=35 |  |
| 1. LTACH | No=35 |  |
| 1. Prior hospitalization (>3) | No=35 |  |
| 1. Admission and Discharge on same date | No=35 |  |
| 1. Planned surgery | No=30  Yes=5 | All hospitalization through “other”. No ER  Elective cholecystectomy, Cyclophotocoagulation,  Diagnostic angiography with possible endovascular revascularization,  Planned laminectomy,  CT Angioplasty |
| 1. Mental health admission | No=34  Yes=1 | Admission to Mental Health |
| 1. External cause admission | No=35 |  |
| 1. Acute Diagnosis at Index visit | No=35 |  |

**Trigger 2 PCP visit followed by death**

* No notes after index visit note. Difficult to determine cause of death
* Hospice/Palliative medicine consultation after Index PCP visit
* Terminal illness not captured through ICD codes
* Telephone call note on index visit
* Social work notes on index visit.

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1. **Preventive Visit Note Example 1**

RN Triage: Patient presented to the clinic today as unscheduled visit with chief c/o numbness, tingliness, and weakness to right side of his body especially right hand and right foot. Onset x3 days. Patient states that he was in a MVA 2 weeks ago and did not seek emergency treatment. Patient also stated that he went to OSH Baptist ER yesterday and left without seeing a Physician since he did not want to wait for 6 hours.

RN assessment performed. Patient AAOX3, ambulatory, vss, afebrile, in no s/s distress, respirations even and unlabored.

Plan of care: Spoke with Nursing Supervisor re: above information.

Informed patient to report to local ER at own expense, or MEDVAMC ER for further evaluation and other tests prn.

1. **Preventive Visit Note Example 2**

--- Original Document ---

PREVENTIVE MEDICINE NOTE:

Patient Race: XXX

Patient Ethnicity: XXX

Patient's Preferred Language for discussing healthcare is English –

Patient's Decision for ORGAN DONOR is YES

Allergies: -Patient has answered NKA

Evaluation of outpatient pain screen: Pain of;

SITE of Pain: right hand, low back and Left knee

Last Evaluation: No Exam

The current pain level is unacceptable to the patient. Patient's

MOVE! weight management program:

MOVE SCREENING Patient's Current BMI is: 43\* Patient has elevated BMI and may have elevated health risk. The patient was counseled on the benefits of weight control and the risks of being overweight or obese. The patient could benefit from participation in a "Weight Management Program". Patient received the "MOVE! 101 Flyer" that explains the importance of weight control and tells the Veteran how to self-enroll into the VA-MOVE clinic to participate in the VA's Weight Management Program: "MOVE!". But at

this time the Veteran is not interested in weight management. colon ca screen:

The patient was given a FIT 1 VIAL KIT for fecal occult blood at this encounter

PATIENT EDUCATION: Fecal Occult Blood FIT KIT PROCEDURES

The patient was assessed for readiness to learn and presence of barriers to communication. Teaching was adjusted to meet the specific patient's needs.

The following has been discussed with the patient and the patient verbalizes understanding:

1. For the purpose of Colon Cancer Preventive Screening, the patient was given instructions on collection of stool samples to test for blood.

2. The purpose of the test and correct collection procedures were reviewed with the patient and written instructions were supplied.

3. The patient was given a FIT kit with one swab and a pre-addressed stamped envelope and was instructed to return the card by mail in only this special envelope immediately after finishing the test.

4. The patient was told to page the nurse 2 weeks after mailing the

card to receive the results.

TOBACCO USE SCREEN W/SC:

Patient quit all use of tobacco more than a year ago. Patient reports not using any tobacco product in:

years = 32

TUBERCULOSIS SCREENING:

Patient does not screen positive for tuberculosis Alcohol Use Screen AUDIT-C):

ALCOHOL SCREEN:

SCREEN FOR ALCOHOL (AUDIT-C)

An alcohol screening test (AUDIT-C) was negative (score=1).

An alcohol screening test (AUDIT-C) was negative (score=1).

1. How often did you have a drink containing alcohol in the past year? Monthly or less

2. How many drinks containing alcohol did you have on a typical day when you were drinking in the past year? 1 or 2

3. How often did you have six or more drinks on one occasion in the past year? Never

PTSD SCREEN NATL MOD: PC PTSD

A PTSD screening test (PC-PTSD) was negative (score=0).

1. Have had any nightmares about it or thought about it when you did not want to? No

2. Tried hard not to think about it or went out of your way to avoid situations that remind you of it? No

3. Were constantly on guard, watchful, or easily startled? No

4. Felt numb or detached from others, activities, or your surroundings?

No

DEPRESSION SCREENING NATL MOD:

PH5-2 A PHQ-2 screen was performed. The score was 1 which is a negative

screen for depression.

1. Little interest or pleasure in doing things Not at all

2. Feeling down, depressed, or hopeless Several days

====MHV Unauthenticated Pt ===

Does the patient own or have access to a web cam? No Does the patient own or have access to a computer? No Patient is NOT interested in being enrolled and/or authenticated for

My HealtheVet at this time. patient learning survey pe:

READINESS TO LEARN - SURVEY Patient's Readiness to Learn

Your patient's learning abilities, barriers to learning and learning preferences must be determined when there is a change of patient condition and/or at the beginning of any inpatient admission or outpatient clinic visit as appropriate.

Expresses willingness to learn LEARNER ABILITIES Can the patient read?

Patient is able to read. Is patient able to comprehend verbal and written communication?

Patient has no difficulty comprehending medical information. LEARNER LIMITATIONS/BARRIERS No identified limitations/barriers LEARNER PREFERENCE

Learner Preference: Printed Material, One-on-One opt learning needs:

LEARNER ASSESSMENT COMPLETED: XXXX

The last Patient Learning Assessment/Survey found the following positive items (no items indicate that no limitations were identified): \*\*\*\*\*\*\*\*\*

EDUCATION GIVEN Safe and effective use of medication(s) Other:

Comment: Tdap One-to-one verbal discussion

Topic: Pt. instructed on the benefits and precaution of Tdap. PATIENT OUTCOME Able to verbalize understanding

TDAP IMMUNIZATION:

The patient received Tetanus/Diphtheria/Pertussis (Tdap) 0.5ml IM today in Left Deltoid. Manufacturer: Glaxo Lot # and Expiration Date: 3044X exp XX/XX/XXXX Administered by protocol/policy Complications: None The Tetanus, Diphtheria/Pertussis Vaccine (Tdap) Immunization Sheet (VIS) was given to the patient today.

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LOCAL TITLE: Addendum

STANDARD TITLE: ADDENDUM

DATE OF NOTE: XXXX

AUTHOR: XXXXX EXP COSIGNER:

INSTITUTION: HOUSTON VAMC

DIVISION: VAMC HOUSTON URGENCY:

STATUS: COMPLETED

Evaluation of

influenza immunization XXXX-XXXX: Patient reports getting a Flu Shot from a NON-VA source for the XXXX-XXXX flu season.

on XX/XX/XXXX at El Paso VA Hes Information from Remote access

Pt. instructed to schedule RTC with Dr. XXXXX. Here today requesting for consult due to right hand carpal tunnel, chronic low back pain and left knee Pain. X-rays ordered. Pt. is back in Houston. Was managed in El Paso VA for 3 months.

XXX SN, RNC Signed: XX/XX/XXXX

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