Creating an 'Activated Patient' to Bolster Transitions of Care

By: James L. Holly, MD

In 2010, Southeast Texas Medical Associates LLP (SETMA) realized that the name “hospital discharge summary” had lost significance as a “transition of care” document; therefore, we changed the name to “Hospital Care Summary and Post Hospital Plan of Care and Treatment Plan.” Over the last three years, SETMA has discharged more than16,000 patients from the hospital. Nearly 99 percent of the time, the patient, hospital and caregiver received this document at the time the patient left the hospital.

This Hospital Care Summary allows for the responsibility for care to be transitioned to the patient or to the caregiver, as it is “passed off” at discharge. Containing a reconciled medical list, follow-up appointments, risk of readmission assessment, diagnoses, and a plan of care, the summary functions as a baton, a secure transition from one person to the next. But hospital-to-outpatient is only one of the transitions in patient care; as a result, SETMA prepares several “batons” in the course of every patient’s care, all with the same purpose.

Firmly in the provider’s hand, the baton – the care and treatment plan – must be confidently and securely grasped by the patient if change is to make a difference 8,760 hours a year.

The image seen in Figure 1 is in every SETMA treatment room and a framed copy is found in every public area in all of our clinics. It illustrates the emphasis on transitions of care, as well as several components, including:

1. That the healthcare-team relationship, which exists between the patient and the healthcare provider, is key to the success of the outcome of quality healthcare.

2. That the plan of care and treatment plan is the engine through which the knowledge and power of the healthcare team is transmitted and sustained.

3. That the means of transfer of the “baton” which has been developed by the healthcare team is a coordinated effort between the provider and the patient.

4. That the healthcare provider understands the patient’s healthcare plan of care and the treatment plan, but that without its transfer to the patient, the provider’s knowledge is useless to the patient.

5. That the imperative for the plan – the “baton” – is that it be transferred from the provider to the patient if change in the life of the patient is going to make a difference in the patient’s health.

6. That this transfer requires that the patient grasp the baton, i.e., that the patient accepts, receives,

understands and comprehends the plan, and that the patient is equipped and empowered to carry out the plan successfully.

7. That the patient knows that of the 8,760 hours in the year, he will be responsible for carrying the baton – longer than any other member of the healthcare team.

The promise of the patient-centered medical home (PCMH) is symbolized by the baton. Its display continually reminds the provider and patient that, to be successful, the patient's care must be coordinated, which must result in coordinated care. As clinics transform into PCMHs, coordination begins at all points of care transitions, and the work of the healthcare team is that together they evaluate, define and execute care.

Reviewing Elements of A Plan

The great value of a written plan of care and treatment plan is to provide the patient and the patient's family with a means of reviewing what they learned during a hospital stay, a visit to the clinic or to the emergency department. Without the written plan, which has the patient's name on every page and which has the patient's personal laboratory and procedure results, little will be accomplished. With a written plan of care to review, the probability of real learning taking place is greatly enhanced.

Furthermore, as healthcare providers, we are committed to lifetime learning; now we want our patients to become students as well. The more the patient learns, the more they participate effectively in their own care. Having had a dialogue with their healthcare provider and having received a printed copy of their plan of care and treatment plan, the patient is prepared to accept responsibility for their own care all year long.

Example of Feedback Loop

Few things are as new to healthcare providers as the concept of a feedback loop. Most physicians were trained to have a monologue with patients. But a didactic exchange without a dialogue often results in two simultaneous monologues without effective communication.

In 2010, I saw a patient for the first time whose father, mother, sister and two brothers had diabetes. I thought, "Aha, I wonder if she has diabetes?" Upon testing, diabetes was proved. The day following the clinic visit, I called the patient and reviewed the diagnosis, condition and plan of care and treatment plan with the patient, which included medications, further evaluation with ophthalmology, endocrinology, diabetes self-management education, medical nutrition therapy and follow-up visits. The plan of care was evidenced-based, coordinated and communicated.

The patient agreed to all of the plans, but as I hung up the telephone, I thought to myself, "This patient is not buying any of it." Using SETMA's Clinic Follow-up Call template, I scheduled a call from our care coordination department for three days later. The call was made and I received the report: the patient appreciated the visit and the call, but she is not going to do the education, take the medication, or have any of the other evaluations.

Unintentional Neglect

For several years, I remembered this patient as an example of excellent patient-centered care, until I realized how ineffective the transition of care had been due to my ignoring the patient's reason for seeing me. As I thought about this patient, I went back and read her record. Over and over, the words rang in my head, "I want to lose weight." I remembered that once I had completed the patient's history and settled on treating her diabetes, I unintentionally ignored the patient's desires. I was certain that the patient had diabetes, which she did. And I was determined to give the patient excellent care for diabetes, which I didn't.

Rather than explaining to the patient why I don't treat weight loss with Ionamin, thyroid and diuretics, I ignored her goal. Because I ignored the patient's goal, the patient ignored my plan. I realized that while I would have labeled the patient "noncompliant" using ICD-9 or ICD-10 codes and SNOMED nomenclature for that diagnoses, the real diagnosis should have been "provider failure to communicate," "nonpatient-centric care," "failure to activate the patient," and/or "failure to engage the patient."

The fault was not the patient's; the fault was mine. What if I had engaged the patient in a conversation about weight reduction? What if I had walked the patient through SETMA's adult weight management program? What if I had said, "While we are helping you lose weight, we can also help you control your diabetes?"

Recognizing a Mistake

Plutarch said, "To make no mistakes is not in the power of man; but from their errors and mistakes the wise and good learn wisdom for the future." My mistake can be forgiven if I learn from it. And how will I demonstrate learning? I think I shall never see a patient without asking the question, "What is your goal? What do you want

to achieve in this visit and in the care you will receive from this clinic?"

That question is partially answered when the patient-encounter-record documents the patient's "chief complaint." But to make it more explicit, we added a "comment box" which is labeled "patient goal." It will be expressed in the patient's words. While we want to use structured data fields, this may be one case where structured data fields obscure the issue. As we have more experience with shared-decision making, we will clarify this data field more precisely. But, we will never ignore a patient's personal goal again. And, if the patient's goal is inappropriate or unattainable, we will address that directly, rather than ignoring it.

Transitions of care require a tool such as a baton, but it also requires the activation of the patient by engaging them in a process of taking charge of their care, and that requires an effective dialogue with the patient. If the patient does not accept the plan of care and agree to make it their own, the transition of care will fail, no matter how good it is.

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