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NQF - Summary of Dr. Holly's Comments - September 2nd, 2010

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Comments by James L. Holly, MD
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Principle: The Only way we can validly address re-admissions is to accurately establish admission diagnoses.

Common diagnoses which are charted in the emergency department which have to be modified or eliminated during the admission are:

- Sepsis – this diagnosis is often established because the patient has fever but without culture proved septicemia.
- CHF – there are precise diagnostic criteria but this diagnosis is often established on the basis of past medical history and imprecise symptoms of shortness of breath.
- Pneumonia -- this diagnosis is often established in the elderly due to cough and fever without clinical or radiographic support for the diagnosis of pneumonia as opposed to chronic bronchitis or acute bronchitis.
- Acute Coronary Syndrome – this diagnosis is often established on the basis of atypical chest pain and is not supported by clinical or laboratory evaluation.

Continuity of Care – this is often discussed in terms of the patient being seen by the same provider at each encounter. In the real world, that is not a realistic or obtainable standard:

  - **Provider Centric**
  - **Data Centric** – this is when each patient encounter is documented in the same data base, which data base is available to every provider who sees and contributes to the care of a patient regardless of the site of care.
    - Clinic

- Telephone
- Electronic
- Emergency Department
- Nursing Home
- Hospital
- Physical Therapy
- Home Health
- Hospice

The Data Centric continuity of care allows for the development of a "**Patient Portrait**," a granular, precise, in-depth, health picture of a patient rather than the "**Patient Silhouette**" of a patient which has been the result of medical records for the past 150 years. It allows for the growth and refinement of that "portrait" with each encounter, as each provider contributes new insights to the patients' health picture.

Systemic Solutions to Complex Problems

In his seminal work, *The Fifth Disciple*, MIT Professor, Dr. Peter Senge, said, "***The more complex a problem, the more systemic the solution must be."*** He was not talking about computer systems but all of the principles of his work apply to healthcare delivery.
Many of the complex problems of healthcare are solved by the Data Centric continuity of care, including:

- Medication Reconciliation
- Complete and current chronic problem list
- Collaborative fulfillment of Preventive health and Screening health quality metrics
- Assess to all prior laboratory and diagnostic testing and reports
- Others

When the same data base is used at the Nursing Home and medication reconciliations are done and audited at regular intervals, and the same data base is used in the hospital, and medication reconciliations are done at every transition of care, whether within the hospital or at the point of transition from the inpatient to the nursing home site of care, this complex and difficult problem can be solved.

Transforming healthcare

There are three methodologies which will contribute to the transformation of healthcare as opposed to the reforming of healthcare.

(**Transforming** comes from internal vision, passion, and generative energy; **reforming** comes from external pressure which squeezes an organization or activity into a pre-determine pattern with rules, regulations and restrictions. Reform makes no permanent, self-sustaining changes. Transforming is creative and self-sustaining.)

- **Content of care – evidenced based medicine**
- **Payment for care – Medicare Advantage**
- **Organization of care – Patient-Centered Medical Home.**

The complexity of the patient conditions which affects the care of patients and which should be included in the payment model for that care is solved by the **Hierarchical Condition Codes** (HCC and RxHCC, see SETMA's tutorial at www.jameslhollymd.com under "Electronic Patient Management Tools")

Plans of Care and Treatment Plans

A simple, systemic solution in SETMA which increased the consistency of patients receiving these critical documents was the placing of **laser printers** in each examination room.

Care Coordination and Coordinated Care

The distinction in these two concepts may be the most important thing I learned at this conference. **Care Coordination** is the **process** of the Transition of care and **Coordinated Care** is the **outcome** of the Transition of Care. Each can be described and evaluated by process and outcomes quality metrics with which the standard of care for each can be established and evaluated.

Nomenclature Can Confuse Function

Discharge Summary versus Hospital Care Summary – Post Hospital Plan of Care and Treatment Plan

As discussed at the conference, the "Discharge Summary" has historically fulfilled an administrative and billing function for the hospital without it being a dynamic document for the improvement of patient management. The "Discharge Summary" is the most important documented created during an inpatient stay, but it's real function is concealed by the name.

The "discharge summary" needs to be a transition-of-care document which not only summarizes the patient's care during the hospitalization but guides the patient's post-hospital care with a plan of care and treatment plan.

A name change would clarify and focus the intent of this critical document. We propose changing the name to: "**Hospital Care Summary. Post Hospital Plan of Care and Treatment Plan**." The following will become important parts of this new document:

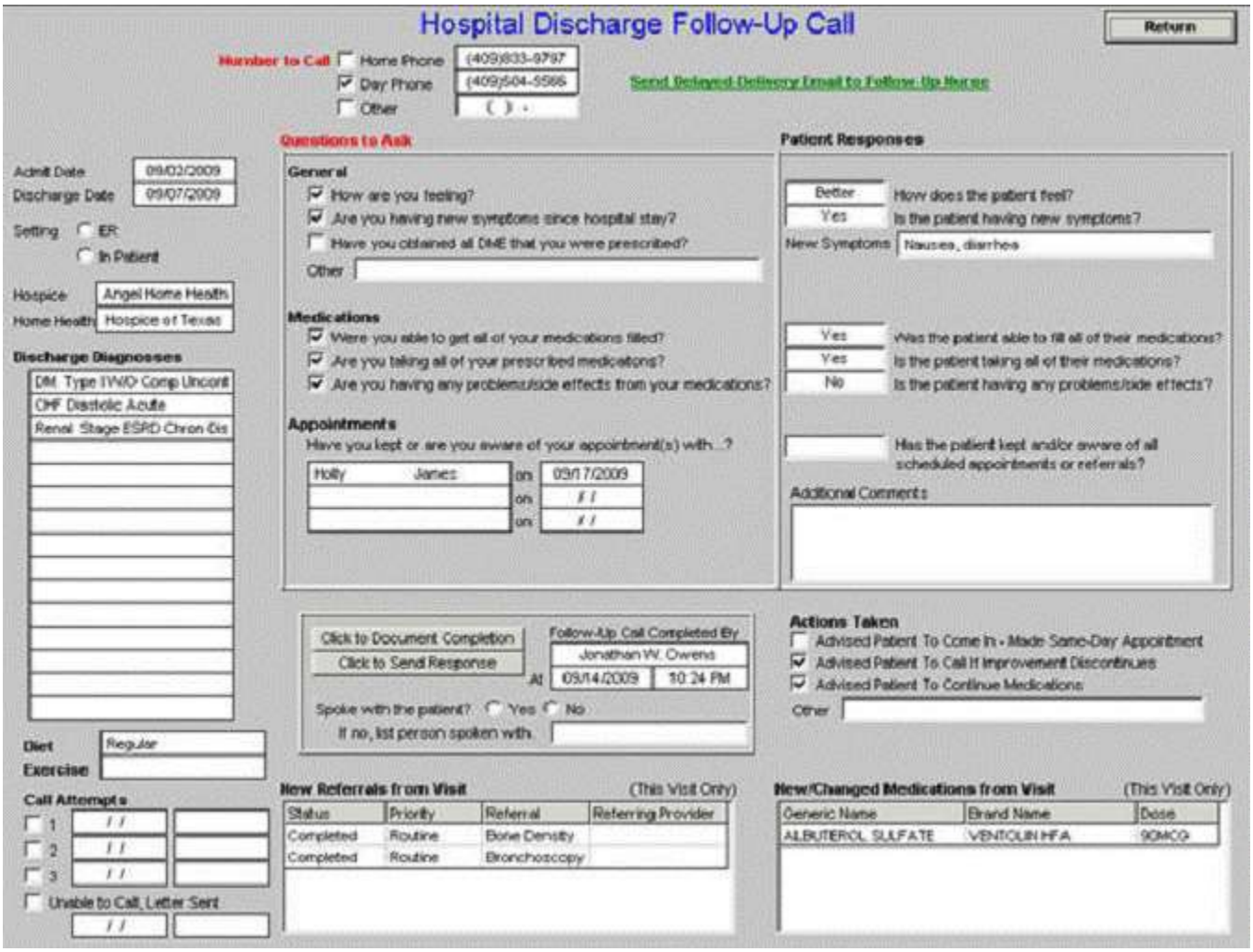
- **Follow-up** – appointments with all healthcare providers who participated in the patient's inpatient care. These appointments should be made before the patient leaves the hospital

and the following information given to the patient and/or family or other principle care giver: time and date of appointment, name, address and telephone number of the provider or providers involved and the reason for the appointment.

- **Referrals** – appointments with new healthcare providers who have not been involved in the patient's care but who will participate in care post-hospital. An example might be an oncologist who will treat the patient's newly diagnosed prostate cancer but who did not see the patient in the hospital encounter. The same information as in the "follow-up" should be given to the patient in writing.
- **Procedures** – any testing or examinations which are to be done after the hospital should be scheduled before the patient leaves the hospital and all contact information included in the "Post Hospital Plan of Care and Treatment Plan."
- **Testing which is un-resulted at the time of discharge** – a definite plan must be established prior to discharge for the reporting to and discussing with the patient any test results which have not complete at the time of discharge.

Caregivers – Post Hospital Plan of Care and Treatment Plan

- An acknowledgment that a follow-up telephone call has been scheduled for the day following discharge which will include at least the addressing of the following information:



- The name and contact information for the principle caregiver, if other than the patient must be included in the follow-up document.
- An acknowledgement that the patient's condition, diagnoses, medications and care needs have been discussed with the patient and/or caregivers.
- An acknowledgment that they understand the plan of care and treatment plan and that they accept the responsibility of the patient's care.
- An acknowledgement that the patient and/or caregiver has been given the contact information for the principle healthcare provider who is to follow-up the patient.
- An acknowledgement that any barriers to care – financial, physical, understanding, transportation, -- have been addressed and resolved.
- An acknowledgement of any ancillary care which has been arranged an why – home health, physical therapy, hospice, etc.
- An acknowledgement that a Plan of Care and Treatment Plan document has been given to the care giver.

Content of follow-up visit

The immediacy of the follow-up call and then the follow-up visit will significantly decrease unnecessary visits. The ability o the patient to get same-day appointments if they have anxiety or unanswered questions from the hospital will also decrease the use of the ED as a "safety net.

The willingness of the primary-care provider to receive "walk-in" visits will increase the patient's confidence that they have access to "their" doctor and will decrease ED visits and/or re-admissions which are unnecessary.

The Post-Hospital Visit should include at least the following:

- Medication Reconciliation with a review of whether the patient has the medications and is talking the medications.
- Answering of all questions about the hospitalization and the plan of care and treatment plan for avoiding re-admissions for the same or related problems.
- Evaluation of all primary reasons for admission and the significant co-morbidities with Review of Systems, Physical Examination and Assessment.
- Assessment of patient's risk for re-admission in the next 60 days and a plan for intervening.
- Review of all follow-up appointments referrals, procedures, etc.
- Request for the patient to address their:
    - Feelings about their care in the hospital
    - Sense of whether they feel that their care is well organized
    - Ability to fulfill their care responsibilities and their follow-up care
    - Barriers to care – financial, transportation, willingness to undertake care, understanding
    - Confidence in their care and in their immediate future.
- Clear instructions for follow-up care beyond the first visit.