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Healthcare Transformation: Dynamic and Documents
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As it becomes more and more apparent that real healthcare delivery transformation will not take place simply by a change in the payment methodology or the structure of care delivery; it become obvious that the dynamic of healthcare delivery will make the difference. Dynamic relates to how various member of the healthcare team interact with one another. Dynamic deals with how the members of the healthcare team relate to one another, i.e., how patients and healthcare providers related to one another.

In this two-part discussion, we will define terms such as:

1. Patient activation
2. Patient engagement
3. Shared decision making
4. Patient-centered conversation
5. Hospital Consumer Assessment of Healthcare Providers and Systems, and Consumer Assessment of Healthcare Providers and Systems.

The foundation of this transformation will be communication, coordination and collaboration. Communication will be done in person by conversation and with documents which summarize that conversation. To facilitate this process, a number of documents will be created. All of these documents have at their core the transition of care between one setting,, i.e., inpatient and another setting, i.e., outpatient, or between the clinic and the home, etc.

Some of these documents are new and others have been a part of healthcare for decades, but require change. One of those is the document which connects the inpatient care experience with the outpatient experience which follows a hospitalization. The term used to link these two is continuity or co-ordination of care. Continuity addresses the continuation of the healthcare and the benefit of that care from one setting to another. Coordination is the process of continuity.

In the case of all documents created in the care of a patient, whether:

1. Ambulatory disease management plan of care or treatment plan http://www.jameslhollymd.com/epm-tools/Medical-Home-Plan-of-Care-and-Treatment- Plan
2. Automated Team Patient Engagement and Activation Document Patient Engagement and Activation Patient Engagement and Activation Document

3. Ambulatory care summary of care document
4. Hospital Admission Plan of Care and Treatment Plan Hospital Admission Plan of Care
5. Hospital Care Summary and Post Hospital Plan of Care and Treatment Plan Example of SETMA's Hospital Care Summary and Post Hospital Plan of Care and Treatment Plan. (De- identified)

the key is to engage and activate the patient in their own care.

Nomenclature Can Confuse Function

While the traditional "discharge summary" should have been the most important document created during a patient's hospital stay, it historically came to be nothing but a document created for an administrative and billing function for the hospital and attending physician. It has long cease to being a dynamic document for the improvement of patient management. The "discharge summary" rarely provided continuity of care value, or transitions of care information, such as diagnoses, reconciled medication list, or follow-up instructions. In reality, the "discharge summary" was often completed days or weeks after the discharge and was a perfunctory task which was only completed when hospital staff privileges were threatened or payment was delayed.

The "discharge summary" should have always been a transition-of-care document which not only summarized the patient's care during the hospitalization but guided the patient's post-hospital care with a plan of care and treatment plan. In this way, the document would have been a vehicle for patient engagement and activation.

Changing the Name to Clarify the Function

In September, 2010, SETMA representatives as an invited participate attended a National Quality Forum conference on Transitions of Care. (http://www.jameslhollymd.com/Letters/nqf- summary-of-dr-hollys-comments-sept-2-2010) During that conference, SETMA realized that the name "discharge summary" needed to be changed. It was thought that a name change would clarify and focus the intent of this critical document. The name was changed to "Hospital Care Summary and Post Hospital Plan of Care and Treatment Plan."

The purpose and content of the new document was defined as:

1. **Follow-up instructions and plans** – 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.
2. **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.

3. **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."
4. **Testing which is not resulted at 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.
5. **Written symptoms** which would alert the patient that their health is at risk or that they are relapsing and should call their provider immediately to prevent their being readmitted to the hospital.
6. **Reconciled Medication List** – the most common cause for preventive readmissions is medication errors. An accurately reconciled medication lists which is clearly communicated to the patient with assurance that the patient can and has obtained their medication is a critical part of a transition of care document.
7. **Hospital Care Coaching Call** – This call, which lasts 12-30 minutes, is scheduled the day following discharge from the hospital. It provides a valuable bridge between inpatient and ambulatory care. In January, 2013, CMS published Transitions of Care Management Codes with which to pay primary care providers for the tasks they perform in transition care. One element required for billing one of these codes is the provider having made a telephone contact with the patient within forty-eight hours of the patient's discharge from the hospital. The following link explains the ***Transition of Care Management Code*** requirement: http://www.jameslhollymd.com/epm-tools/transition-of-care- management-code-tutorial

The Hospital Care Summary and Post Hospital Plan of Care and Treatment Plan should acknowledge that a follow-up telephone call has been scheduled for the day following discharge which call will include at least the addressing of the following information:

a. An internal review and audit of the Hospital Consumer Assessment of Healthcare Provider and Systems.
b. Review of reconciled medication list.
c. Review of follow-up care and referrals.
d. Patient's care and understanding of that care.
e. Patient's engagement and activation in their care.

As we continue to examine the terms mentioned above and as we continue to examine how those terms will impact the quality and cost of care, it will become clearer how the changes which are being recommended will positively affect the relationship between provider and patient.