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A Proposal to Dramatically Enhance Continuity of Care through Interoperability

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At the time of discharge, after the discharging clinician has completed the discharge orders and reconciled the discharge medications and problem list, the acute care facility will push, via Direct, a C-CDA to the primary care physician (PCP) and also, if applicable, the clinician/facility that will next be primarily responsible for caring for the patient (e.g. skilled nursing facility (SNF), home health agency, etc.). This generally will be prior to the completion of the traditional discharge summary which, depending on variable state laws, may not be required to be completed for several weeks post discharge.

The receipt of the discharge C-CDA by the clinician(s) that will subsequently be caring for the patient allows for ongoing continuity of patient care and the ability to maintain an accurate care plan. They can reconcile the patient's record, specifically the medications and problem list, in the PCP office with the most up to date hospital discharge information. As the problem list, allergies, medications and immunizations that are in the C-CDA are all discrete data, this information can be reconciled in the PCP's EHR without the risk of transcription errors while decreasing provider burden of entering the data manually. Receipt and reconciliation of this information also allows the PCP practice to follow up with their high risk patients within 24 hours post discharge to provide appropriate post discharge follow up. Specifically, to confirm patient's understanding of their discharge medications and instructions. Timely patient follow up can prevent adverse events, particularly adverse drug events which have been shown to occur in ~ 20% of patients discharged from hospital. [1]

If the patient is being transferred to a SNF, having the most up to date and accurate patient information enables both the PCP and SNF to ensure that the patient receives optimal care. The discrete data in the C-CDA received from the hospital to the SNF or Home Health Agency (HHA) can be used to populate a new patient chart in the SNF reducing clinician burden and eliminating transcription errors and ensuring that the facility staff are best prepared to receive and care for the patient.

As noted above, this proposal promotes interoperability and health information exchange and continuity of care in a vulnerable patient population, those recently discharged from hospital. The proposal can eliminate faxed patient information as well as the need for staff to search acute facility EHRs and "pull" their patient information. The ability to incorporate the accurate discrete data received from the discharging hospital C-CDA in real time into the recipient EHR for reconciliation or to create a new patient chart decreases clinician documentation burden and eliminates medication transcription errors. Timely information to the patient's PCP allows for patient outreach and follow up for high risk patients and their caregivers within 24 hours post-discharge improving outcomes, enhancing patient satisfaction and reducing adverse events. Timely information to post-acute long term caregivers facilitates the preparedness for patient care at the time of transfer and the ability for proper post hospital continuity of care thereby reducing hospital readmissions.

1. https://psnet.ahrq.gov/primers/primer/11/Readmissions-and-Adverse-Events-After-Discharge