Scenario: Sequential Transitions of Care

This business scenario describes the transitioning of a patient’s care across several settings. At each transition, a text box describes how the living, shared care plan is affected by the transition. In this scenario it is important to keep in mind the distinction between care plans and lower-level plans as regards their “longevity of relevance”:

* *Plans of Care* and *Treatment Plans* are typically of operational importance only until they are done executing (unless exceptions occur). More will be said about this later in the document.
* *Care Plans* contain only information of *ongoing relevance* to future care - by definition. Any given care plan is routinely gaining and shedding lower-order plans as those are completed.

Even when a completed plan is excluded from the current plan tree, it is possible for a planning user to link supportive content for future reference during planning. The scenario now follows.

**Preconditions:**

* The primary care physician (PCP) has created a CCS care plan (care plan A) to track care for patient A. The dominant health concern was diabetes mellitus (DM) so PCP created the plan from a DM plan template and then individualized it for patient A’s minor conditions as well.
* All enterprises in this scenario have networking security and access controls in place to support secure sharing of care plans over http.
* The Hospital’s enterprise and jurisdictional policies require CCD documents to be created at various points, even though the care team prefers to collaborate online. Fortunately, the hospital’s CCS implementation product has a feature to generate CCD plan of care sections as an export format whenever they are needed (this is not a CCS standardized function).

**Patient Admitted to Inpatient Setting**

1. The PCP provides a secure Web-based reference to care plan A. An Assessment Process and a planning process are conducted.
2. *multiple* plans of care are installed under care plan A to deal with varying health concerns. Some plans of care are produced autonomously by specialists, while other planners conducted multidisciplinary CCS discussions to collaborate on items they have tagged. But all these plan contributors work in light of the unifying care plan and can see each other’s goals and planned action, etc. subject to access controls as they are confirmed. Instructions are also embedded in the plans of care.
	* 1. Treatment plan for high glucose levels.
		2. Treatment plan for abnormal lab results
		3. …
	1. Nursing plan of care may include getting the patient and family ready for the next level of care. Instructions are also embedded in the plans of care
	2. Social service’s plan of care includes assisting the patient and family in identifying resources for healthcare financial needs. Instructions are also embedded.
	3. Physical Therapy plan of care to evaluate and prevent complications related to immobility.

The various plans of care are implemented and goals are met. Patient A is ready to transition to the next level of care. A CDA discharge summary with plan and instructions for the next level of Care is generated and replicated for the recordkeeping, but ongoing collaboration will be “online.”

Transition Care Planning Activities

* Ordinarily, the discharge plan (that might be contained in a discharge summary) might deal with only those health concerns that the patient had at discharge, so that plan alone cannot constitute a unifying care plan. However, since “the” care plan is now shared among its contributors and participants, the broader-scoped original plan was never lost and the Hospital-based care team members are already on the same page (not even needing pages now)
* The hospital’s various plans of care are remain installed under the care plan even after they are marked as closed; but they no longer show as children under the current active care plan. They can still be viewed retrospectively on demand, subject to access controls.
* The goals and plans of continuing relevance at the care plan level might be collaboratively adjusted at this time.
* Any procedures or observations that remain particularly importance to future planning are electronically linked directly to the care plan as “supportive content.”

**Outpatient Setting (PCP)**

Assessment and planning Processes are conducted for the outpatient setting.

1. Ambulatory provider(s) create an action plan for patient A
2. Patient A Care plan will again contain multiple plans of care to deal with varying health concerns. Goals are identified in order to determine if the plans of care needs are met.
3. Patient A health concerns may include
	1. Medical diagnosis and severity = IDDM-new onset
	2. Nursing issues = difficulty coping; knowledge deficit - patient A is legally blind and may not be able to self-administer his insulin at home
	3. Financial Issue = patient A is uninsured and may not be able to afford his needed care
4. Ambulatory provider(s) create plans of care for each health concern
	1. New onset IDDM plan of care include the following. Instructions are also embedded in the plans of care.
		1. Treatment plan for high glucose levels.
		2. Treatment plan for abnormal lab results (plan for frequency of lab results and what should be done for abnormal results)
		3. …

PCP involves other care providers in the patient care because serum glucose is not being adequately controlled. A referral to an endocrinologist is made. Transient plan content is flagged to expire from display after a settable number of days.

The referral document might deal with only those health concerns that are the reason for the referral. However, since “the” care plan is shared among participants, the goals and plans of continuing relevance are adjusted and retained.

All the efficiencies of online collaboration previously described are still in effect. The closed plans of care associated with the recent episode are by default moved out of the forward-looking view of the care plan, but are still accessible.

**Outpatient Setting (Specialist - Endocrinologist)**

…

**Outpatient Setting (Homecare Services)**

**…**

(The process repeats for life)

In this manner the care plan itself continuously retains the correct “horizon” of goals and planned actions. It continues to inform plans of care; and those plans of care continue to post or promote items of lasting planning relevance up into the care plan.

The care plan stays concise and manageable for the life of the patient, and also serves as a very sund basis for outcomes analysis and retrospective analysis of coordination effectiveness. The very fact that the complete record of plans is captured - and that gaps and overlaps can be discovered from one electronic location - is a huge incentive itself toward continual improvement of care coordination.