PointClickCare®

Improve Transitions of Care with Timely Clinical Documents

In today's complex healthcare environment, hospitals, health systems, and providers are faced with the challenges of coordinating care across more diverse settings, while also under significant pressure to improve the transition experience and reduce costs in support of value-based reimbursement models.

The ability to receive and import complete and accurate patient clinical information quickly, without workflow disruption, makes the difference in health outcomes, patient satisfaction, and the cost of care.

The patient information contained in clinical documents helps to improve care transitions. Access to these documents also ensures that patients receive the appropriate and timely care they need to reduce the risk of duplicate or unnecessary services, gaps in care, and readmissions.

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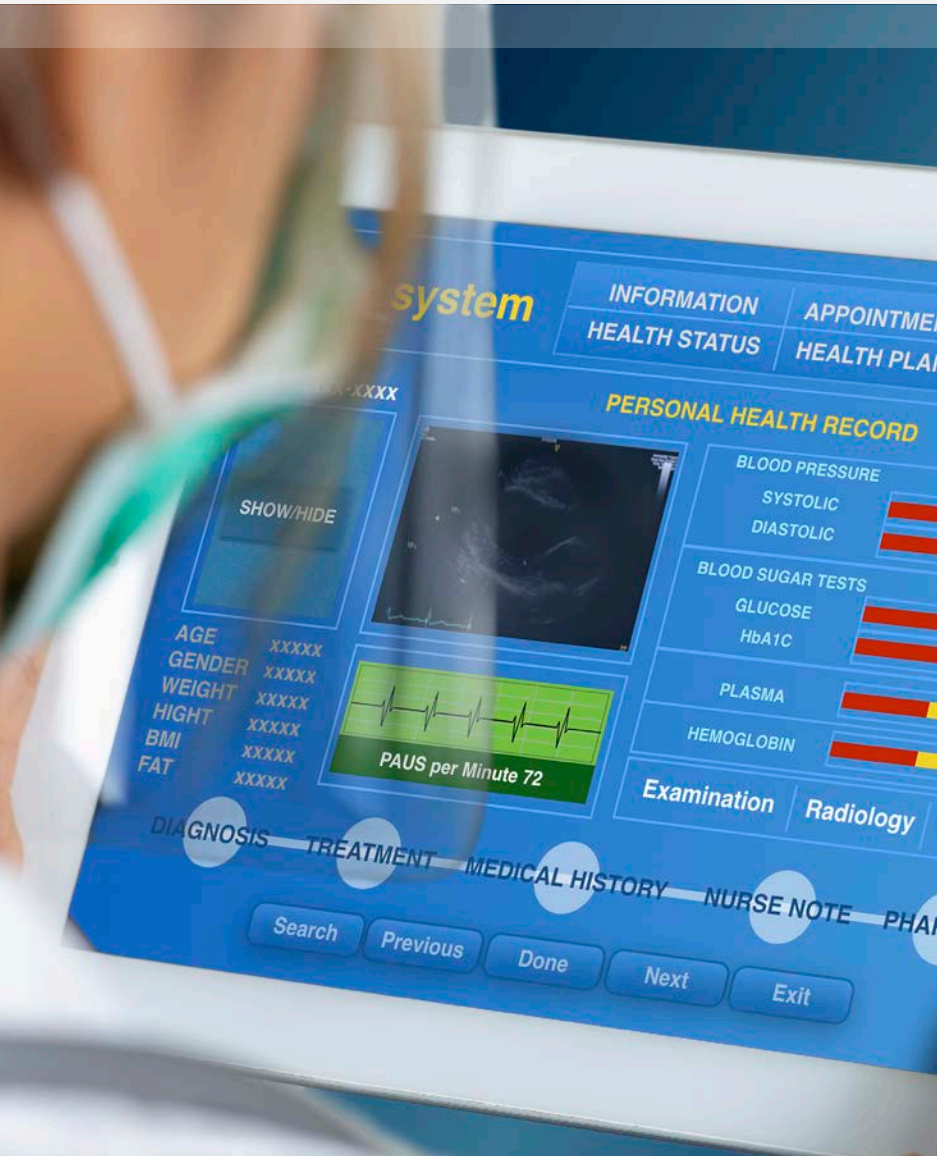
What is a Clinical Document?



Clinical documents are those documents created by certified electronic medical records (EMRs).

Clinical documents include Continuity of Care Documents (CCDs), Consolidated Clinical Document Architecture (C-CDA), discharge summaries, clinical summaries, emergency care summaries, hospital encounter summaries, and more. They contain detailed information collected during a patient's encounter or multiple encounters by a healthcare provider. The clinical document framework was created by a collaborative effort of the Health Level 7 (HL7) and ASTM E31 organizations, as a standards-based approach to securely share patient health data across care settings.

Information contained in clinical documents can include the following data elements:

Patient demographics	Active and chronic medical conditions		Patient history
Medications	Allergies	Procedures	Encounters
Problem lists	Diagnosis	Lab results	Imaging studies
Immunizations	Care team	Insurer	Functional status

Clinical documents are intended to share patient details and information about care plans and care received, along with information about a transfer to or discharge from a hospital or outside provider. By helping to improve communication among providers across care settings, these documents play a critical role in successful care transitions. They are created automatically from the content located in the patient record and are available in multiple formats. When updates are made to the patient record, the clinical documents are typically updated automatically by the source EMR.

The Challenges of Clinical Document Retrieval

It's safe to say healthcare providers choose their careers to care for patients and effect positive health outcomes, not because they're eager to spend time chasing down clinical documents, sometimes called "**chart chasing**." However, the current reality is that the process of clinical document retrieval is often time-consuming, burdensome, and too slow. Providers, payers, and care coordinators expend resources and time in calling, faxing, logging into various portals, querying data networks, and even using mail to access critical information in patient medical records.

Ensuring clinical documents make it to the other members of the patient's care team is crucial to preventing a readmission—whether the next step is to visit a primary care provider (PCP), stay in a skilled nursing facility (SNF), receive home care, or transition to an outpatient setting. When clinical documents don't reach other providers on the broader care team, it becomes difficult to conduct timely follow-up and can impact quality of care.

In fact, a review of nearly **88,000 hospital discharges** found that for every three days discharge summaries were delayed, there was a 9% higher risk of readmission. Another analysis concluded that the risk of readmission drops by 26% when patients have a follow-up visit with a caregiver who has access to the discharge summary.

HIGHER RISK
of readmission for every three days of delayed discharge summaries

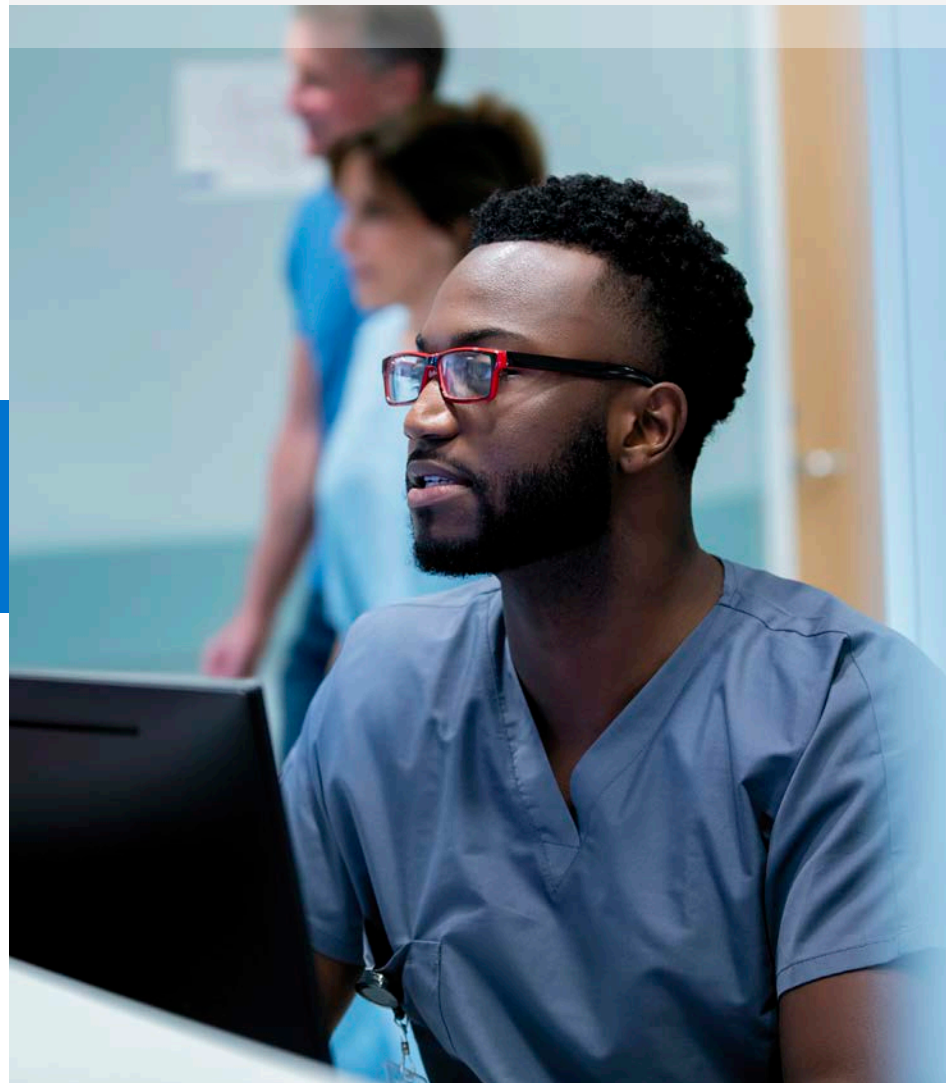
↑ 9%

READMISSION DROPS
when patients have a follow-up visit with a caregiver who has access to the discharge summary

↓ 26%

According to Healthcare Information and Management Systems Society (HIMSS), common reasons that care coordination documents do not reach providers include obstacles like

- **interoperability issues**
- **poor integration**
- **wrong or missing contact information**
- **lack of a set timeframe for sending documents**



Finding the Clinical Insights You Need When You Need Them

National networks for clinical data query and retrieval are a source of millions of clinical documents across the country.

For example, Carequality has compiled a nationwide registry of healthcare providers who share health data via the Carequality Interoperability Framework, enabling nationwide care coordination.

While these national networks are invaluable resources for healthcare providers, challenges remain. Access to the networks may solve one problem but create others. Providers still may need to sort through data to find what they need. Querying health care facilities and finding exactly the right document is another form of chart chasing. If it takes a nurse 5-10 minutes for each query in an organization responsible for 50,000 patients that may have as many as 90 discharges per day, you get an idea of how much time is lost on chart chasing that could be spent on patient care.

How Automated Data Exchange Impacts Transitional Care Management

The primary objective of transitional care management is to ensure successful transitions from one care setting to the next and, ultimately, to promote the best health outcomes possible for patients. Automated clinical document exchange reduces the time it takes for a care team to gather a patient's clinical information that does not currently exist in their own EMR/data systems and removes the dependency on manual follow up (i.e., chart chasing).

Automated access to these critical patient documents when and where care providers need them means that instead of calling, faxing, searching portals, querying data networks, or waiting for documents to arrive in the mail, the document is sent automatically to the requestor's EMR when a transition in care occurs, such as a hospital discharge. As a result, when the patient presents for follow-up care, there is contextual clinical document accessible in their healthcare system. Equipped with more timely information about a patient's status and recent encounters, staff can make better-informed decisions at the point of care. Additionally, timely and accurate clinical documents help to reduce unnecessary or duplicate testing, medical errors, adverse events, and potential rehospitalizations.

The patient experience is also improved with better discharge processes and improved transitions of care. During discharge or transfers, effective communication is needed to ensure medication adherence and continuity of care. Transfer of patient records, through admit, discharge, transfer (ADT) notifications or other methods, can enhance experiences by facilitating care coordination between primary care and specialist providers.

Additionally, access to automated clinical documents can help alleviate patient and family confusion of post-discharge instructions and subsequently reduce hospital readmissions. An **analysis** of studies of patients hospitalized for heart attack showed that patients with more positive reports about their care experiences had better health outcomes a year after discharge.

Benefits of Automated Clinical Document Technology

Automated clinical document capabilities place essential patient clinical information directly into the provider's workflow. **This helps to ensure**

successful
care transitions

higher quality
patient data
at the point of care

time and
cost savings

When providers can spend less time looking for information and more time caring for patients, health outcomes and provider and patient satisfaction improve.

About PointClickCare

PointClickCare is a leading healthcare technology platform enabling meaningful collaboration and access to real-time insights at every stage of the patient healthcare journey. More than 27,000 long-term and post-acute care providers, over 3,100 hospitals and health systems, 2,000 ambulatory clinics, every major U.S. health plan across the U.S, and over 70 state and government agencies use PointClickCare, enabling care collaboration and value-based care delivery for millions across North America.

Learn how PointClickCare's national care collaboration network supports providers with timely access to automated clinical documents as well as enhanced collaboration across the continuum through our Value Based Care for ACOs solution.

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