Policy: Patient Care Coordination Across the Continuum

ORGANIZATIONAL: Effects two or more departments.							
Folder	Organizational Choices: Nursing			**Sub-Folder** (If Applicable)	**Provision of Care/Care Coordination**		
Original Effective Date	12/21/2015	**Scope**	*What departments does this policy apply to? State "All" as is may apply to the entire organization.* *ED, Nursing, Case Mgmt/Social Services, Medical Staff*				
Approved (Approver/Date)	MDRC: 2/20/2020						
Last Reviewed/ Revised Date	2/20/2020	**OSHA Category** (If Applicable)	Not Applicable	**Standard** (If Applicable)	*LD.04.03.11 MS.03.01.03 PC.02.02.01 CoP 482.43*	**Number of pages**	7

PURPOSE:
To facilitate the communication and coordination of care for patients as they transition to acute hospitalization and from hospitalization to post-acute care.

GUIDELINES:
The organization will coordinate the patient's care to facilitate a smooth admission and a safe transition to post-acute care through discharge planning. This policy will serve as the agreement with medical staff, which provide post discharge follow up care. The completed Care Coordination Agreement Signature page (appendix A) will serve as the agreement with medical staff that provide post discharge follow up care.

PROCEDURE:

- Definition of Primary Care Provider (PCP)—reflects those settings dedicated to providing first contact, whole person, and longitudinal care to their patient panel.
- Definition of Health Care Team (HCT) - reflects the broad set of physicians and other health professionals involved with the care of the patient within the hospital setting. Professionals involved will vary by location but can include emergency room staff, admission staff, inpatient physicians, nurses, case managers, social workers, and members of various other hospital departments.

The Primary Care Provider (PCP) responsibilities and agreement:

1. If admission is directly initiated by PCP
   - Notify the hospital access center that will facilitate the communication between the on-call hospitalist and the primary care physician
   - Discuss the case with HCT member on duty in preparation for admission
   - Provide demographics

    - Patient name, DOB, and contact information
    - Contact person if not patient e.g. healthcare proxy or guardian
    - Any special considerations required such as vision/hearing impairment, cognitive deficits, language/cultural preferences
    - PCP designation, referring provider, contact information
- Provide reason for hospitalization
    - Primary complaint /medical issue/assessment and diagnosis
    - Relevant notes, key physical findings and/or test results as well as summary of recent changes in status
    - Any co-morbid conditions that will need attention during hospitalization
- Prepare patient/family/caregiver
    - Ensure there is understanding of reason and agreement with planned hospitalization
    - Ensure safe transfer to the appropriate facility in manner that takes into account patient preferences
    - Provide hospital contact information and expected time frame for hospital length of stay.

2. For any hospitalization of a patient under a PCP's care:
    - Upon notification of the patient's hospitalization, provide appropriate and adequate information to the HCT in a timely manner. When available, this information should include:
        - Problem list
        - Reconciled medication list
        - Allergy/contraindications list
        - Relevant medical and surgical history
        - Advanced directives
        - List of other relevant healthcare professional involved
        - Any additional information specifically requested by a member of the hospital care team.
    - Address communication issues
        - Establish a standard communication process with HCT that ensures secure, timely, and reliable transfer of information. This process should address the following situations:
            - Transfer of required patient clinical and other information at admission, during hospitalization and at discharge
            - Means of contact during routine and urgent situations.
        - Receives and responds to all incoming calls or other communications from HCT in timely manner in order to provide input on clinical and other issues
    - Engages with HCT around significant clinical issues arising in the hospital that will extend beyond the hospital stay
3. Engage in collaborative care management regarding discharge:

- Engage with HCT around transitional care planning
- Ensure receipt of discharge notification (i.e. has systems in place to receive such information, such as EMR, fax, etc.)
- Resume care of patient
    - Review patient Information upon discharge from hospital setting
    - Agree to make contact with the patient within two business days of discharge
    - Arrange clinically appropriate patient-centered appointment time
    - Incorporates care plan recommendations into overall care of the patient and provides revised care plan to other physicians and healthcare professionals involved with patient, as appropriate.
    - Assume responsibility for follow up of pending results and/or scheduling recommended testing for diagnosis and/or medication monitoring
    - Reach out to HCT if issues arise post-discharge that require input from that team

The Health Care Team (HCT) responsibilities and agreement:

1. At the beginning of the hospitalization:
    - Review patient Information available
    - Inform patient/family/caregiver of need/purpose, expectations and goals of hospitalization
    - Ensure patient's/healthcare proxy's understanding and agreement with hospitalization
2. Establish communication with PCP:
    - Establish a standard communication protocol with PCP that ensures secure, timely, and reliable transfer of information. This protocol should address the following situations:
        - Transfer of required patient clinical and other information at admission, during hospitalization and at discharge
        - Means of contact during routine and urgent situations
        - Identify and make contact with the PCP within 24 hours of admission with mode of communication based on clinical needs and acuity.
        - If not admitted directly by the PCP , ensures that PCP is aware of admission and reason for admission with appropriate patient permission
        - Provides PCP with information on how best to communicate with the HCT, including means for urgent contact
        - Obtains contact information from PCP as well as preferred method for urgent contact
        - Obtains and reviews pertinent medical information from PCP, and requests any additional pertinent information as needed)
3. Engage in collaborative care management during hospital stay:
    - Keep PCP abreast of major clinical developments

- Involve the PCP when needed in significant patient care decisions that significantly impact care beyond the hospitalization, e.g. regarding longitudinal medical issues, advanced care planning/goals of care determinations, and care transitions issues

4. Prepare patient for discharge:
    - Inform patient/family/caregiver of diagnosis, prognosis and follow-up recommendations
        - Assess understanding of these issues by patient/family/caregivers
    - Ensure patient/family/caregiver is in agreement with discharge plans
    - Provide educational material and resources to patient when appropriate
    - Provide patient/family/caregiver with written care plan including patient-centered reconciled medication list and any scheduled appointments and planned therapies
    - Advise patient/family/caregiver of any outstanding laboratory and/or other testing that will require follow up by the PCP
    - Provide patient/family/caregiver with a plan for the transition period including how to manage symptoms/signs and how to identify those requiring immediate medical attention and related contact information for appropriate provider
5. Provide appropriate and adequate information at discharge
    - Transmit a discharge notification to PCP within 24 hours of discharge. This should include the following:
        - Reason for inpatient admission
        - Major procedures and tests performed during inpatient stay and summary of results
        - Principal diagnosis at discharge
        - Current medication list
        - Studies pending at discharge (e.g., laboratory, radiological), AND
        - Patient instructions
    - Make follow up appointment for patient with PCP if clinically appropriate and necessary
    - Send a concise discharge summary to PCP within 48 hours of discharge
    - Reaffirm direct contact information to be used by PCP to contact HCT
    - Receive calls from PCP as needed for additional information or clarification

Other facility responsibilities:

1. When the patient is a direct admit the patient placement will be coordinated through the Access Center. See Policy “Room Bed Assignments: Admissions and Transfers.
2. The patient’s primary care provider will be automatically notified electronically of the admission. Information will include; the unit and room where the patient is located, the name of the admitting provider/hospitalist, the reason for admission, and the admission date and time.
3. A Readmission Risk Assessment will be completed by a case manager/social worker on all inpatient admissions and will be reviewed during daily multidisciplinary huddle. The risk assessment score is documented and found in the HER. Discharge planning interventions will be implemented based on the Risk Assessment Score.

4. There is an interdisciplinary approach to discharge planning through Patient Care Huddles. See “Interdisciplinary Approach to Patient Care: Patient Care Huddles Policy/Procedure”. Patients/patient representative will be involved in their discharge plan and the Primary care provider will be notified of the patient’s discharge plan within 24 hours of discharge utilizing the Transition of Care/Referral document. The final document will be sent to the primary care provider within 48 hours. Patients/families will receive in writing a reconciled medication discharge list upon discharge. See “Discharge Planning Policy” and “Nursing Discharge Procedure”.
5. The hospital discharging unit will attempt to set up follow up appointments based on the patient’s readmission risk score or as determined by the physician, whichever is the earliest. The post-acute appointment scheduling process will be audited by the Quality Department and reviewed by the necessary committees.
6. The following information will be shared in the Transition of Care/Referral document with the primary care provider to coordinate care: reason for the hospitalization, major procedures and tests performed and a summary of results, principle diagnosis at discharge, current medication list, studies pending at discharge and the planned follow up appointment.
7. If a patient is readmitted within 30 days a detailed readmission assessment will occur to identify discharge planning improvement opportunities.

REFERENCES:

Anthem, 2020. Post Hospital Care Follow Up Guidelines

Anthem, 2020. Care Coordination Guidelines

The Joint Commission, 2020. LD.04.03.11, MS.03.01.03, PC.02.02.01

AHC Media, New Discharge Planning Rules Focus on Preferences and Transitions, 2016, retrieved from https://www.ahcmedia.com/articles/137019-new-discharge-planning-rules-focus-on-preferences-transitions on May 26, 2017.

Centers for Medicare and Medicaid Services, Hospital Discharge Planning Worksheet, 2014. Retrieved from https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-15-12-Attachment-3.pdf on May 26, 2017.

AHA & HRET & US Department of Health and Human Services. 2014. Readmissions Change Package: Improving Care Transitions and Reducing Readmissions.

Osei-Anto A, Joshi M, Audet AM, Berman A, Jencks, Health Care Leader Action Guide to Reduce Avoidable Readmissions, Health Research and Educational Trust: Chicago IL, January 2010.

American College of Physicians and the Society of Hospital Medicine

Attachments: (Label as Appendix A, B, C, etc.)
Appendix A Care Coordination Agreement Signature Page

Appendix A Medical Staff Care Coordination Signature Page

Please sign and return this page only to Medical Staff Services.

I have read, understand and agree to the responsibilities in the **Patient Care Coordination across the Continuum Policy.**

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Signature of Medical Staff Date

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Printed name Title