**Policy:** Patient Care Coordination Across the Continuum

**ORGANIZATIONAL:** Effects two or more departments.

<table>
<thead>
<tr>
<th>Folder</th>
<th>Organizational Choices: Nursing</th>
<th>Sub-Folder (If Applicable)</th>
<th>Provision of Care/Care Coordination</th>
</tr>
</thead>
<tbody>
<tr>
<td>Original Effective Date</td>
<td>12/21/2015</td>
<td>Scope</td>
<td>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</td>
</tr>
<tr>
<td>Approved (Approver/Date)</td>
<td>READMISSION TEAM: 6/8/17; CARE COORDINATION TEAM:5/31/17 ; MEC: 8/22/17; MDRC: 7/21/17</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Last Reviewed/Revised Date</td>
<td>8/22/2017</td>
<td>OSHA Category (If Applicable)</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Standard (If Applicable)</td>
<td>LD.04.03.11 MS.03.01.03 PC.02.02.01 CoP 482.43</td>
<td>Number of pages</td>
<td>15</td>
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</tbody>
</table>

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

**SKILL LEVEL:**
Clinical care providers and clinical staff

**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 D) 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. (Anthem, 2015)
- 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. (Anthem, 2015)

**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
  o Patient name, DOB, and contact information
  o Contact person if not patient e.g. healthcare proxy or guardian
  o Any special considerations required such as vision/hearing impairment, cognitive
deficits, language/cultural preferences
  o PCP designation, referring provider, contact information
• Provide reason for hospitalization
  o Primary complaint /medical issue/assessment and diagnosis
  o Relevant notes, key physical findings and/or test results as well as summary of
recent changes in status
  o Any co-morbid conditions that will need attention during hospitalization
• Prepare patient/family/caregiver
  o Ensure there is understanding of reason and agreement with planned
hospitalization
  o Ensure safe transfer to the appropriate facility in manner that takes into account
patient preferences
  o 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:
  o Problem list
  o Reconciled medication list
  o Allergy/contraindications list
  o Relevant medical and surgical history
  o Advanced directives
  o List of other relevant healthcare professional involved
  o Any additional information specifically requested by a member of the hospital
care team.
• Address communication issues
  o 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.
  o 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
     o Review patient Information upon discharge from hospital setting
     o Agree to make contact with the patient within two business days of discharge
     o Arrange clinically appropriate patient-centered appointment time
     o 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.
     o Assume responsibility for follow up of pending results and/or scheduling recommended testing for diagnosis and/or medication monitoring
     o 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:
     o Transfer of required patient clinical and other information at admission, during hospitalization and at discharge
     o Means of contact during routine and urgent situations
     o Identify and make contact with the PCP within 24 hours of admission with mode of communication based on clinical needs and acuity.
     o If not admitted directly by the PCP, ensures that PCP is aware of admission and reason for admission with appropriate patient permission
     o Provides PCP with information on how best to communicate with the HCT, including means for urgent contact
     o Obtains contact information from PCP as well as preferred method for urgent contact
     o 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
  o 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:
  o Reason for inpatient admission
  o Major procedures and tests performed during inpatient stay and summary of results
  o Principal diagnosis at discharge
  o Current medication list
  o Studies pending at discharge (e.g., laboratory, radiological), AND
  o 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. The access center will document the patient demo graphics and reason for admission from information provided by the primary care physician. The patient placement will be coordinated through the Access Center. See Policy “Room Bed Assignments: Admissions and Transfers.
2. When the patient is admitted through the Emergency Department (ED), the Patient Registration staff in the ED will validate with the patient their primary care provider. The Patient Registration Staff will then print a copy of the face sheet with the Primary Care Provider and the Room number to the Access Center immediately after Transitioning the ED Patient to Inpatient or Observation Status.
3. The patient’s primary care provider will be notified of the admission by the Access Center staff. 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.

4. A Readmission Risk Assessment will be completed by a case manager/social worker and reviewed during daily multidisciplinary huddle. The risk assessment form will be located in the medical record and the score shared with the healthcare team. Discharge planning interventions will be implemented based on the Risk Assessment Score. See Appendix A & B.

5. 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 Preliminary Summary of Care 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”.

6. 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.

7. The following information will be shared on the “Summary of Care” 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.

8. If a patient is readmitted within 30 days a detailed readmission assessment will occur to identify discharge planning improvement opportunities. See Appendix C.

REFERENCES:

Anthem, 2017. Post Hospital Care Follow Up Guidelines

Anthem, 2015. Care Coordination Guidelines

The Joint Commission, 2017. LD.04.03.11, MS.03.01.03, PC.02.02.01


American College of Physicians and the Society of Hospital Medicine

**Attachments:** (Label as Appendix A, B, C, etc.)
- Appendix A Readmission Risk Assessment
- Appendix B Risk Assessment Scoring Interventions
- Appendix C Readmission Assessment
- Appendix D Care Coordination Agreement Signature Page
Appendix A Readmission Risk Assessment

Patient Readmission Interview

If this a planned readmission, you don't need to complete the assessment

Is this a Planned Readmission?
- Yes
- No

Admission Date

Reason for Seeking Health Care

Date of Patient Readmission Interview

Admitted From
- Acute Care
- ER
- Home
- ECF
- Other Hospital
- Cath Lab
- Clinic
- Digestive Health
- Dr. Office
- Intervention Radiology
- Radiology
- Rehab Unit
- Surgery

Why Unable to Assess
# Nutrition Questions

**Did Pt have malnutrition diagnosis on previous discharge?**
- Yes
- No

**Was the patient sent home on a nutrition plan?**
- Yes
- No

---

**If patient was sent home on a nutrition plan, please answer the following:**

**Did the patient follow nutrition plan?**
- Yes
- No

**Why didn't you follow your Nutrition Plan?**
- Financial
- Lack of family/caregiver
- Patient did not understand
- Other
## Discharge Questions

While you were in the hospital the last time, did someone talk to you about:

<table>
<thead>
<tr>
<th>What your illness was?</th>
<th>What symptoms you need to look for and what to do if you experienced them?</th>
</tr>
</thead>
<tbody>
<tr>
<td>○ Yes</td>
<td>○ Yes</td>
</tr>
<tr>
<td>○ No</td>
<td>○ No</td>
</tr>
<tr>
<td>○ Not sure</td>
<td>○ Not sure</td>
</tr>
</tbody>
</table>

Who to contact if you did experience any symptoms?

| ○ Yes                  | ○ Yes                  |
| ○ No                   | ○ No                   |
| ○ Not sure             | ○ Not sure             |

Do you have any questions about the discharge instructions you received?

| ○ Yes                  | ○ Yes                  |
| ○ No                   | ○ No                   |
| ○ Not sure             | ○ Not sure             |

If yes, explain:

Provider Questions

Do you have a regular provider who takes care of you for most things?

| ○ Yes                  | ○ Yes                  |
| ○ No                   | ○ No                   |
| ○ Not sure             | ○ Not sure             |

How long after being discharged did you have to wait for the appointment?

| ○ A few days           | ○ A few days           |
| ○ About a week         | ○ About a week         |
| ○ About 2 weeks        | ○ About 2 weeks        |
| ○ Longer than 2 weeks  | ○ Longer than 2 weeks  |

If not, why not?

After you left the hospital, did you have an appointment with your provider?

| ○ Yes                  | ○ Yes                  |
| ○ No                   | ○ No                   |
| ○ Not sure             | ○ Not sure             |

Did you go to your doctor/provider’s appointment?

| ○ Yes                  | ○ Yes                  |
| ○ No                   | ○ No                   |
| ○ Not sure             | ○ Not sure             |
Medication Questions

Before you left the hospital, did someone talk to you about which medications to take when you left and which ones to stop taking?

☐ Yes  ☐ No  ☐ Not sure

Were you prescribed any new medications?  Did you get them filled?

☐ Yes  ☐ No  ☐ Not sure

☐ Yes  ☐ No  ☐ Not sure

Did you take your medications as they were prescribed?  Reasons not taking meds

☐ Yes  ☐ No  ☐ Not sure

☐ Financial  ☐ Med not available at pharmacy  ☐ No transportation to pharmacy  ☐ Other

Other reason not taking meds
# Appendix B Risk Assessment Scoring Interventions

## Readmission Risk Scoring

<table>
<thead>
<tr>
<th>Age of Patient</th>
<th>Gender</th>
<th>Ethnicity</th>
<th>Acute Care Encounters</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elderly (65+)</td>
<td>Male</td>
<td>Hispanic</td>
<td>None</td>
</tr>
<tr>
<td>65-70 years</td>
<td>Female</td>
<td>African American</td>
<td>1 or more 30 days</td>
</tr>
<tr>
<td>71 and older</td>
<td></td>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ED/Outpatient During Previous 6 Months</th>
<th>Anticipated Length of Stay</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 Visits</td>
<td>1 Day</td>
</tr>
<tr>
<td>1 Visit</td>
<td>2-3 Days</td>
</tr>
<tr>
<td>2 Visits</td>
<td>14 or more days</td>
</tr>
<tr>
<td>3 Visits</td>
<td>46 days</td>
</tr>
</tbody>
</table>

### Conditions or Characteristics

- Diabetes: No/Yes (DM) complication: GI disorders including Peptic Ulcer Disease, Vascular Disease including cerebral, cardiac, peripheral
- No

- Malignant or Connective Tissue Disease
- No

- Moderate to Severe Liver Disease; HIV Infection
- No

- Mental Health Psychosocial Issues; Metastatic Cancer; Substance Abuse; Homelessness; Unhoused; No support
- No

### Additional Points

- Yes (right click to comment)
- No

### Level of Risk for Readmission

- Low
- Moderate
- High
- Complex

## Southeast Hospital
### Appendix C Readmission Assessment

<table>
<thead>
<tr>
<th>Readmission Risk Screening</th>
<th>Total</th>
<th>Moderate (9-10)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low (0-6)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Muddle Care coordination managed with daily huddle</td>
<td></td>
<td>Muddle Care coordination managed with daily huddle</td>
</tr>
<tr>
<td>- Coordinate w/ Post-Acute Services (Home Care Rehab, Therapy)</td>
<td></td>
<td>Coordinate w/ Post-Acute Services (Home Care Rehab, Therapy)</td>
</tr>
<tr>
<td>- Disease specific education &amp; medication use/side effects, Validate understanding w/reach back</td>
<td></td>
<td>Phone Call within 48 hours of discharge</td>
</tr>
<tr>
<td>- High (11-12)</td>
<td></td>
<td>Pharmacy consultation, ED visit, Call, ED visit, Call</td>
</tr>
<tr>
<td>- Muddle Care coordination managed with daily huddle</td>
<td></td>
<td>Muddle Care coordination managed with daily huddle</td>
</tr>
<tr>
<td>- Coordinate w/ Post-Acute Services (Home Care Rehab, Therapy)</td>
<td></td>
<td>Coordinate w/ Post-Acute Services (Home Care Rehab, Therapy)</td>
</tr>
<tr>
<td>- Disease specific education &amp; medication use/side effects, Validate understanding w/reach back</td>
<td></td>
<td>Phone Call within 48 hours of discharge</td>
</tr>
<tr>
<td>- Complex (13+)</td>
<td></td>
<td>Pharmacy consultation, ED visit, Call, ED visit, Call</td>
</tr>
<tr>
<td>- Muddle Care coordination managed with daily huddle</td>
<td></td>
<td>Muddle Care coordination managed with daily huddle</td>
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<td></td>
<td>Pharmacy consultation, ED visit, Call, ED visit, Call</td>
</tr>
<tr>
<td>- Link to community agencies as indicated</td>
<td></td>
<td>Link to community agencies as indicated</td>
</tr>
</tbody>
</table>

Southeast Hospital
Appendix D Medical Staff Care Coordination Signature Page

Southeast HEALTH

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.

_____________________________________
Signature of Medical Staff       Date

_____________________________________
Printed name       Title

Southeast Hospital