POLICY & PROCEDURE

TITLE: ED / Hospital Admission Care Transition, Tracking, and Follow Up				
Scope/Purpose: To provide a consistent, orderly process for the tracking of patients known to have been seen in an emergency department or with a hospital admission.				
Division/Department: All Clinics		**Policy/Procedure #:**		
Original Date: June 23, 2011		**___New _X_Replacement for: Same**		
Date Reviewed:	**Date Revised:**	**Implementation:**	**CPIC Approved:**	**Board Approved:**
	10/01/2015	10/22/2015	10/22/2015	
Responsible Party: Director of Nursing, Director of Compliance; Administrator of HealthPoint Initiatives				

DEFINITIONS:

Established patient:

A patient is considered an established patient if they have been seen by one or more clinical providers in a HealthPoint clinic within the last three (3) years.

Inactive patient:

Patient that has been seen in the past by a Healthpoint provider but not within the last three years.

New patient:

Patient that has not been seen by a HealthPoint facility within the last three years

a.) not an existing HealthPoint patient within eCW

b.) may have an account within eCW, but has not been seen by a medical provider (e.g. primary, pediatric, dental, obstetrics-gynecology, or acute)

ED Visit Level:

A Visit Level (1, 2, 3, 4, or 5) is assigned to each ED visit based on the acuity (severity) of the patient at the time of the visit. Level 1 & 2 visits are emergent and more likely to result in a hospital admission. Level 3 is considered urgent but less critical. Levels 4 & 5 are minor in acuity.

POLICY:

It is the policy of HealthPoint to provide continuity of care and appropriate follow up to HealthPoint patients incurring an emergency department visit or hospital admission.

PROCEDURE:

A. Admissions

1. HealthPoint adult patients admitted to the hospital are followed primarily by contracted hospitalist groups at the local hospitals. Pediatric patients admitted to the hospital are followed by contracted Pediatricians.
2. Patients also may be followed by their primary physician (employed or contracted with the agency) with admitting privileges at the local hospitals.
3. For elective and urgent care admissions, HealthPoint Providers shall contact the ED, on-call physician or the hospitalist group to discuss the patient's case.
4. Patients may present directly to the Emergency Department or be referred to ED by HealthPoint providers as necessary.

B. Notification of Admissions
   1. The Hospitalist service should notify the HealthPoint clinic via fax when a HealthPoint patient is admitted to their service. The notification is placed in patient documents and is forwarded to the staff tracking the admission. The admission information is documented in the tracking log. The faxed notification is reassigned to the provider and sent via their D jelly bean to make aware of the admission.
   2. HealthPoint or contract physicians should notify the care team or the clinic manager when they admit a HealthPoint patient to the hospital so the admission is tracked, discharge documents obtained and follow up appointments scheduled.

C. Sharing Clinical Information with Hospitals and Emergency Departments
   1. When HealthPoint sends a patient to the hospital/emergency room, HeathPoint staff shall take the following actions:
      a. When patient's condition allows, before the patient leaves the clinic, a release of information should be signed by the patient in order for the clinic to obtain appropriate medical records from the ED to which the patient was referred.
      b. The provider or designee should personally call the ED to which the patient has been referred to inform the ED physician/staff of the clinical circumstances of the referral.
      c. The patient's demographic information, clinical assessment, and other pertinent clinical information as well as a release of records for the patient's discharge paperwork is sent with the EMS or faxed to the receiving ED/hospital.
      d. The patient's information is added to a log for tracking patient's sent to the ED or message is sent via -telephone encounter to "Hospital Tracking" resource (depending on clinic specific system). This is to ensure that staff follow-up with the patient.
      e. A Variance Report is completed by the Clinic Manager and submitted to Compliance/QA for tracking and reporting purposes.
      f. Designated staff should request ED records and scan into the medical record within three business days of the original provider visit.
   2. Should the hospitalist request clinical information from the HealthPoint Provider, the requested information shall be transmitted to the admitting hospitalist physician.
   3. To the extent possible, HealthPoint providers shall obtain available information regarding the patient's clinical condition and treatment and communicate such information to the hospitalist managing the patient's hospital care.
   4. HealthPoint shall make every effort to instruct patients to identify themselves as patients of HealthPoint clinics whenever they receive care elsewhere to encourage ongoing communication between all care providers. When a patient is seen in the ED or admitted

to the hospital clinic staff should have the patient sign a release of medical records form at the next clinic visit in order to obtain those records.

D. Discharge Summaries/ER Report
   1. The Hospitalist Service shall send the discharge summary to the primary clinic/rendering provider of the patient. If a patient self-refers to the ED, records should be requested from the facility when the clinic becomes aware of the visit/admission if the reports have not already been received. Additionally, HealthPoint should receive admit records, discharge summaries, or emergency room records from the hospital on patients that have been admitted to the hospital or have had a visit to the emergency department. These summaries allow HealthPoint to identify the patients needing follow up, especially if the clinic was not notified immediately of the ED visit or admission.
   2. The report will be assigned to the patient's provider for review through the D Jelly Bean. (Refer to Section F for follow up tracking process)

E. Post Discharge Visit
   1. Patients discharged from the hospital or those seen in the ED with a higher visit level of 1 or 2, and high risk level 3 visits (COPD, Diabetes, CHF, Asthmatics, and Hypertension) should be contacted within 7 days of discharge if the patient has not already contacted the clinic for follow up visit.
   2. Follow up appointments should be scheduled within 14 days of discharge but no longer than 30 days. The provider may designate a shorter timeframe for the visit depending on the acuity of the patient and need for a more urgent follow up visit. Appointments for follow up of lower risk level 3, 4 and 5 visits will be scheduled per provider discretion.
   3. At the appointment, referrals to community resources or disease/case management will be given as well as self-management support programs if applicable.

F. Scheduling Appointment and Tracking Follow Up
   Two systems have been identified for tracking hospital admissions and ER visits follow up. Depending on the size of the clinic and resources available, tracking may be with a manual log at the specific clinic or through a centralized tracking process.

   Process One – Centralized Tracking Process Through Designated Tracker (This process is followed by BCS, Memorial, Centerville, Franklin, and Madisonville)
   1. Hospital discharge summaries and ED reports may be received directly at BCS Medical Records or at the specific clinics. If received at the non-BCS clinics, reports should be reassigned to the Hospital Tracking resource.
   2. Reports are sent to the designated tracker.
   3. Information is entered into a spreadsheet tracking tool to collect the following data obtained from the report(s) and the patient's hub:

      ER report
      - Account Number
      - Age

- Payor Source
- Date of last clinic appointment
- Appointment type
- Appointment provider
- Date of Emergency Department Follow Up, if scheduled
- Emergency Department Follow Up Appointment Type
- Emergency Department Follow Up provider
- ACO Member (Y/N)
- Patient Status (New/Established/Inactive)
- Emergency Department Visit Date / Time
- Chief Complaint
- Urgency level
- Location.

Hospital Admission:

- Account Number
- Age
- Payor Source
- Complaint
- Date of last clinic appointment
- Appointment type
- Appointment provider
- Follow Up date if scheduled
- Follow UP appointment type
- Follow Up provider
- ACO (Y/N)
- Patient Status(New/Established/Inactive)
- Admit date
- Discharge data
- Location.

4. If the report is received through the D jellybean, it is sent to the provider with a note stating whether the patient has a Follow Up appointment or not. If the patient is not established, it is designated in the note and marked as reviewed.
5. If the discharge summary or ED report is picked up from medical records, it is verified that it is in the patient's documents or it is scanned into the record and forwarded to the provider.
6. If patient requires a follow up appointment (refer to Section E) but has not scheduled an appointment or been contacted within three business days of discharge to do so, a telephone encounter, with a REASON of "Hospital/ER Follow-Up", is sent to the Call Center or patient's primary clinic designated person to contact the patient for an appointment.
7. Information from the tracking log is summarized and reported to the Compliance and Performance Improvement Committee (CPIC).

Process Two – Non-centralized/Individual Clinic Tracking

1. Hospital and ED discharge summaries are received through e-Fax or scanned to the patient docs.
2. Tracking information is entered into the Hospital or ED Tracking Log (electronic format) at the time the clinic is notified of the ED/Hospital visit. The same tracking tools will be utilized for the centralized and non-centralized processes. The tracking tool will be located in a shared computer folder maintained in compliance to HIPAA security requirements.
3. Discharge Summaries and ED Reports are sent to the providers for review via D Jelly Bean.
4. If the patient requires a follow up appointment (refer to Section E) but has not scheduled an appointment or been contacted within three business days of discharge to do so, , clinic staff will contact the patient to schedule a follow up visit. Follow up appointment information is documented on the tracking log.
5. The Tracking Logs are sent to BCS to the designated tracking staff at the end of each month for data to be incorporated into the overall HealthPoint report to the CPI Committee.

RELATED POLICY:

Urgent Assessment / Activation of 911
Release of Medical Records

REFERENCES:

PCMH Standard 5, Element C

REQUIRED BY:

PCMH Standards

ATTACHMENTS/ENCLOSURES

Hospital Admissions Tracking Log
ED Visit Tracking Log

POLICY/PROCEDURE TRACKING FORM

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Date of Revision	**Description of Changes**
October 2015	Enhancement of tracking and follow up process.