Good Samaritan Health & Wellness Center

Policies and Procedures

Subject: Hospital and ED Transition Policy	Policy #: 5.33
Prepared by:	Revision #:
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5.33 Hospital and ED Transition Policy

Purpose: The purpose of this policy is to define the procedures for exchanging clinical information and providing follow up care to patients when transitioning from one health care setting to another.

Responsibility: The patient's primary care medical team is responsible for managing transitions of care.

Procedure: In the event that a Good Samaritan Health & Wellness Center patient has been transferred to another facility for emergent, elective, or adjunct care, it is the responsibility of the Transferring Provider and her/his care team to send an up-to-date:

a. Medication list
b. Problem list
c. Allergy list
d. Medical/family/social histories list
e. Advanced directives list
f. Reason for transfer
g. Any other pertinent clinical information

…to that facility. The Transferring Provider and her/his care team are also responsible for documenting this transfer of care and information in the patient's chart in the Center's eClinicalWorks (EMR).

1) <u>Emergency Department Visits</u>
   a) ED Visits with clinical referral:
      i) In the case of a patient being referred to the ED by Good Samaritan Health & Wellness Center staff, the patient will be directed to the Piedmont Mountainside Hospital (PMH) ED, or their nearest ED if necessary.

ii) The Transferring Provider shall submit an electronic Emergency Department Call-In via the ECW homepage for Piedmont Mountainside Hospital ED visits and (_Northside_____) – Emergency Department Call-In.
iii) The up to date clinical information (items a-g above) will be sent to the ED.

b) ED Visits without clinical referral:
   i) Providers receive notification by e-mail from the PMH ED of the patient visit.
   ii) The team RN is notified of the visit by the provider and is responsible for importing the PMH ED note into the EMR and contacting the patient for follow-up management within a target of 48 hours.
   iii) The team RN is responsible for completing the ER/Hospital Discharge document and forwarding it to the primary provider for their review and co-signature.

c) ED visits outside of PMH
   i) The transferring provider will either call in, fax, or hand deliver (with EMS) an information handoff for the patient.

2) Hospitalization
   a) Elective Admissions:
      i) In the case of a transfer to a hospital (within PMH or outside) for non-emergency room care (elective hospital admission, specialist consultation, etc.), the Transferring Provider and \her/his care team are responsible for sending the pertinent clinical information, prior to the transfer of care, by fax, e-mail, snail mail, or via the patient.
   b) Non-elective Admissions Notification:
      i) The clinical team is informed of patient admissions through the following modes:
         (1) PMH Admission Report: Includes all admissions, any hospital, for _all___, ___GSHWC___ patients assigned to Piedmont.
         (2) _Admissions____ Report: a daily report that includes all Piedmont patients admitted to PMH.
         (3) Fax, e-mail or phone call notification from the admitting facility.
   c) Process for exchanging clinical information during hospitalization:
      i) At PMH: A Piedmont hospitalist will write notes and leave the pertinent Piedmont EMR clinical documentation in the patient's chart
      ii) Non-PMH hospitalization: the patient's Piedmont care team is responsible for reaching out to the inpatient care team and relaying any pertinent Piedmont EMR clinical documentation and other information; this communication will be documented in the Piedmont EMR.
   d) Discharge Notification:
      i) The clinical team is informed of patient discharges through the following modes:
         (1) _Discharge___ Report: daily report that includes all Piedmont patients discharged form PMH in the last 7 days.
         (2) Faxed discharged summaries from the facility. These summaries are distributed to the team RN by medical assistants to facilitate patient follow up
         (3) The original document from PMH will also be forwarded to the provider for review and then sent to scanning to be included in the EMR.
         (4) Discharges from outside facilities (outside PMH) will be handled the same way as PMH discharges with completion of the ER and hospital discharge template and forwarding to the PCP.

3) Post-Discharge Follow-Up

a) Patients will be contacted within a target of 48 hours after discharge by a member of their primary care team.
b) The team RN will review the document, contact the patient within a target of 48 hours, complete the ER and Hospital discharge form in the EMR. The completed not will be routed to the primary provider for review and co-signature.
c) The goal of the follow up call is to identify the following:
    i) Reason for the hospitalization/ED visit
    ii) Factors contributing to ED visit
    iii) Medication changes/adherence
    iv) Newly identified patient needs
    v) Pain assessment
    vi) Identify and/or coordinate follow up care
    vii) Identify and make updates to patient's care plan, as appropriate.