

Practice Policy & Guidelines

Policy: Continuity of Care/Exchange of Patient Information/Obtaining Discharge Summaries	Developed by:	Approved by:
Updated:	Signature:	Signature:

PURPOSE:

To ensure that all patients have continuity and coordination of care as they may require care at other facilities, care by multiple providers and/or require transfer/transition to other entities for care. To ensure that the practice consistently obtains patient discharge summaries from hospitals and other care facilities.

GOALS AND OBJECTIVES:

To provide/retrieve appropriate and timely medical information to achieve optimum health outcomes for our patients.

RESPONSIBILITY:

Entire staff

DETAILS:

Our practice understands the importance of access to clinically relevant information, including discharge summaries from hospitals and other care facilities. In addition, all patients have access to a patient portal account, which allows them 24/7 web access to important information such as current/chronic medications, immunization records, growth measurements and allergies.

Referring for care:

All patients who are sent to outside facilities/specialists for care will have relevant medical information provided to the outside facility/specialist. Whenever possible and appropriate, if a patient is referred to an outside emergency department (ED) for care, the physician or designee will notify the ED of the patient's anticipated arrival and relevant clinical information provided over the phone or via fax. This transfer of information will be noted in the patient's message record. When a patient is referred to a specialist, the physician or their designee will provide a copy of relevant portions of the patient's medical record to the patient or directly to the specialist via phone or fax.

In addition, our practice has fax server bi-directional information with three local hospitals and majority of specialist providers. Reports or diagnostic studies, emergency room visits and newborn records are sent and received directly via our main fax server preventing misdirection of "paper" reports. Reports

are transferred directly into the patient's electronic chart. Ongoing triaging of hospital lab and diagnostic studies are done by licensed pediatric nurses prior to transfer to chart with direction of critical results to another physician in the case of an ordering provider being out of the office that day.

Patient portal messages:

Assigned triage staff are directed to check the incoming patient portal messages and triage them appropriately to the primary care physician (PCP) or correct staff per the following:

- scheduling and record requests are forwarded to the scheduler on duty
- nursing questions are handled by triage and specific CDM patient requests are sent to the CDM nurse if he/she is working that day or are handled by the triage nurse
- lab result requests are forwarded to the clinical supervisor or the clinical nurse covering that position on that day
- PCP messages are directed to that pediatrician or their covering physician as deemed appropriate by the triage nurse

Portal messages are checked by the triage nurse via PC or laptop at (insert practice name) for information received over night and periodically during the workday.

Patients who receive outside care:

Currently the most commonly utilized emergency departments in the area automatically "auto-fax" a report to our office on any of our patients that are seen in the ED. Assigned staff who arrive in the office each morning are directed to check the reports on the fax server via their logon to the server through their PC or laptop at 7:30am, 11am, 4pm and 6pm for information received over night and periodically during the workday. All ED reports are sent directly to the physician and saved into the patient's electronic health record (EHR). Primary physician (or if not present, a covering practice physician) will review, extract pertinent information into the EHR and either follow up directly with the patient/family or instruct office staff do so. Office staff will proactively contact any patients seen in the ED to either arrange for appropriate follow up in the office or with a specialist, or to make certain the patient's problem has been resolved satisfactorily. Disposition will be documented in the message center of the EHR or documented on the ED report, which will then be scanned into the medical record.

The "rounding" physician is responsible for accessing the hospital electronic system to identify any admitted or newborn patients. That physician can also access the same system to look at the list of patients treated in the emergency room.

Patients who are admitted to outside institutions will be proactively contacted. Any verbal or written reports received by the office via our fax server from outside institutions, clinicians or patients and families, will be transferred (scanned if received via postal mail) into the EHR. All information and reports are sent via electronic health record to physicians for review and co-sign. Physicians or their designee will then proactively contact the patient/family to arrange for appropriate follow up care and assist in coordination of specialty care, if necessary.

Patients who receive care from specialists will be tracked within the EHR referral system if referred directly from our office. All specialist reports will be given to the physicians for review. Important data will be extracted from written reports and put in the EHR. Any necessary follow up on diagnostic tests, medication and/or treatment plan will be noted and physicians or staff will proactively contact patients

to ensure appropriate follow-through. Received reports from specialists will be scanned into the medical record.

Patients who transfer care:

Patients who transfer care out of our practice will be asked to sign a transfer of care authorization and indicate where they would like their care records to be transferred. A transfer of patient information packet which will include any medically relevant scanned documents in the patient record, as well as the EHR generated standard medical transfer summary, is prepared. In addition, where medically appropriate, a written transition plan will be developed in coordination with the patient and family and provided in advance of or at the time of transfer.

Our practice routinely cares for children from birth until graduation from high school. Special exceptions are made on an individual basis for children with special health care needs and may be extended until age 21. Routinely during the preventative care visit when a patient is in their senior year of high school, the physician will begin to open the dialogue with the patient regarding transfer of care to an adult-oriented PCP and provide them with the transfer of medical records request form. Patients will be offered suggestions of appropriate primary care providers in the fields of Internal Medicine and/or Family Practice depending on their geographic location and unique needs. Female patients will be given additional information regarding area Gynecologists. All patients will be informed about their network website for their insurance company and website resources for area hospitals. Patients who have not yet requested transfer of their medical records by August after their high school graduation will be sent a standard letter to request transfer to an adult-oriented PCP.

MONITORING:

The practice administrator monitors compliance to this policy by conducting a sample retrospective analysis of patient charts and documentation completion every 6 months. This data is shared with providers.

This policy shall be reviewed at least every 2 years.

Approved Date: ____/____/____

APPROVALS:

Physician Partner: _____

Date: ____/____/____

Administrative Partner: _____

Date: ____/____/____

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