Practice Policy & Guidelines

Policy: Coordination of Care with an Emergency Room (ER) or Inpatient Setting	Developed by:	Approved by:
Updated:	Signature:	Signature:

PURPOSE:

To ensure that patients are receiving coordinated comprehensive care throughout care transitions, such as ER/Urgent Care/RBC visits and hospitalizations; and that the practice has clinical information summarizing outside care received and a plan for appropriate follow-up, if needed.

RESPONSIBILITY:

Care coordinator, nurses, providers

PROCEDURE:

(select or modify one based on which workflow type would work best for your practice)

Sample Workflow #1: The care coordinator/nurse logs in to the hospital system, downloads a report of inpatient admissions, and cross-references with the practice's patient panel every morning. The care coordinator/nurse shares the patient name and diagnosis of new admissions with the provider within 2 hours.

Sample Workflow #2: The care coordinator reviews the Admission, Discharge, Transfer (ADT) feeds from the area hospitals every morning. The care coordinator shares the patient name and diagnosis for new admissions with the provider within 2 hours.

Sample Workflow #3: The care coordinator reviews reports received from area hospitals and Urgent Care Centers/Retail-based Clinics that the practice has pre-arranged agreements with every morning. The care coordinator shares patient name and diagnosis of new admissions with the provider within 2 hours; and places other reports about care received for provider review and sign off by the end of the business day.

The care coordinator/nurse will obtain a copy of the patient's clinical summary from the outside facility (post-visit or post-discharge) and will forward to the provider for review and sign off by the end of the business day that the summary is received. If necessary, the provider will request that the care coordinator/nurse arrange for follow-up, along with the time frame that follow-up should take place.

In certain circumstances, the care coordinator will contact an outside facility to determine whether additional information from the patient's EHR might be beneficial for continuity of the patient's care; such as direct admissions from the practice to the hospital, referral to the ER for additional evaluation, or a patient that is being transferred to another hospital.

All pertinent information will be documented in the patient medical record. The practice will attempt to reach the patient for follow-up at least, but not limited to three times. Each attempt will be documented in the patient's medical record.

This policy shall be reviewed at least every 2 years.

Approved Date: _____/_____/_____

APPROVALS:

Physician Partner: _____ Date: _____/_____/_____

Administrative Partner: _____ Date: _____/_____/_____