Catholic Health

Care Transition Best Practices

Physicians engage with patients in different capacities when there is a transition between hospital and community living. Seamless, timely, and effective communication is essential for best patient care. The list characterizes the 4 most common roles of our physicians in Care Transitions between home and hospital, and the expectations associated with each of these positions.

1. **Emergency Room Physician**
   Best practices for physicians in the Department of Emergency Medicine are established by that department. However, since these relationships are collaborative and interdependent, idealized models generally accepted as best practiced for ER physicians are described herein.

   Timely and robust communication from the Emergency Department (ED) to the primary care physician (PCP) when a patient presents with an illness needing or possibly needing admission to the hospital is considered important in all such presentations.

   When referrals are needed to specific specialists or subspecialists, the ED physician should work with the PCP to identify when referrals are needed, and which network specialists are preferred.

   Secure text messaging - currently using Tiger Connect as the system STM program – should be used routinely whenever it is available for such contacts.

2. **Primary Care Physician – ED Patients**
   There should be direct communication from PCP to ED whenever a patient is referred to the ED by the PCP and /or their office, including relaying any information needed for appropriate evaluation of the patient.

   Make available to Emergency Department easy access to reach PCP such as private office lines, secure text messaging with Tiger Connect, mobile phone number or whichever preferred communication processes allow the ED contact PCP promptly and directly.

   PCP's should collaborate actively with the ED to identify patients who can be diverted and cared for in ways other than being hospitalized, often including close or prompt office follow up.

3. **Hospitalist Physicians**
   Definition – purposes of defining high quality Care Transition a hospitalist is considered a physician who is taking care of a hospitalized patient for whom the physician is not the primary care physician in the outpatient setting. Currently there are multiple models of who delivers care this way. Some hospitalist are full-time hospitalists who have not outpatient practice. Other hospitalists are physicians who practice in both settings and admit patients from practices other than their own or unreferred patients and thus are hospitalists for those patients. A third model is physicians who care for patients of other physicians in their group. They are also working as

Hospitalists for these patients. These scenarios reflect the diversity of situations we currently see in our Catholic Health hospitals.

All hospitalist must communicate with the PCP or designated representative at key stages – admission or potential admission to hospital, change in condition of patient, death or discharge – in timely fashion with relevant information conveyed. Also, there should be communication when there is patient/family conflict if there is likelihood that the PCP can assist in resolution or needs to be made aware.

When a patient is discharged to home, there needs to be a same-day delivery of an informative and well-written discharge summary, accurate medication list, key diagnoses, results of essential testing as well as treatment provided and response to treatment. There also needs to be a clear delineation of what outpatient follow-up, monitoring, or testing has been either scheduled or recommended.

All hospitalists need to provide easy and direct lines of communication for the PCP to know whom to contact and how to contact them such as mobile phone, secure text messaging, use of pagers, or other straightforward process. There must be a prompt and seamless availability of the appropriate hospitalist for the PCP to contact. All hospitalist should use secure text messaging and use that preferentially whenever the PCP also uses this program. It is advisable to recommend secure text messaging to PCP's they deal with who are not yet using STM.

On admission, each hospitalist should request information from PCP office that will allow for better understanding of the patient, diagnoses, medications and previous testing performed in a way to facilitate hospital care and evaluation.

4. **Primary Care Physician – Hospitalized Patient**

   All PCP's and their offices should encourage and facilitate timely discussion with hospitalists in all appropriate situations and provide and transmit any information known to the practice that will help the hospitalist in caring for the patient.

   PCP's should make readily available to all hospitalists easy access to reach them such as private lines to office, secure text messaging, mobile phone number or whichever capabilities allow the hospitalist to contact the PCP promptly. Preferred communication forms are secure text messaging with Tiger Connect, mobile phone call/message, or private direct office line (during business hours). These forms of contact are preferred, reliable, and always superior to more passive and non-interactive forms of communications such as document transmission without direct communication or leaving messages with staff or answering services.

5. **Consultants**

   Consultations occur during ER and hospital stays and the reports and recommendations are primarily directed toward the inpatient caregivers. There are several situations where the consultant would be expected to communicate directly with the PCP. These include important new diagnoses or medication changes significant enough that the PCP needs to know promptly and when there is important follow-up and testing that needs to be done after discharge, regardless of whether they have already scheduled follow-up such for the patient. The consultant should be in

indirect contact with the PCP (phone call or STM are the 2 preferred options) unless they are directly aware (and document) that the hospitalist has already communicated such directly with the PCP. It is not enough to note that it has been typed into a discharge summary report.

In addition, it is essential for the consultant to contact the PCP when there is or there may be information (testing, diagnoses, prior consultations, recent clinical course, allergies, prior medications tried, patient preferences or Advance Directives) that do exist or may exist in the PCP history but are not available to the consultant in any other format such as the EHR, HEALTHeLink, pharmacy records, etc.