MONROE COUNTY MEDICAL SOCIETY

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Monroe County Medical Society
Quality Collaborative

Community Philosophy for Physician Communication

Background: Problems with transitions of care are well known in the U.S. healthcare system. These problems are known to contribute to excessive use of resources, excessive readmissions, as well as medical errors related to communication problems. Medicare has recently implemented penalties for hospitals that have higher than expected readmission rates. Despite the demand by physicians, third party payers and the government for improved coordination and given the increased complexity of the health care system, caregiver fragmentation continues to be a major problem. Multiple specialists, hospitalists, community-based physicians, nurse practitioners and physician assistants all are involved in treating patients. These increased complexities coupled with demands for greater coordination of care require organized systems to overcome this "integration-fragmentation paradox."

Inefficiency in the quality of communication among this complicated team can add adverse consequences. The Joint Commission reporting on sentinel adverse events cites communication errors in more than half of all adverse events. Readmissions and failure in transitions of care are estimated to cost billions of dollars.

Because of these multiple problems, and in an effort to standardize these transitions, Monroe County Medical Society formed a Physician Communication Committee comprised of representation from independent community physicians, Accountable Health Partners, Greater Rochester Independent Practice Association, Monroe County Health Department, Rochester Business Alliance Health Care Initiative, Rochester Regional Health Information Organization, Rochester General Health System, Unity Health System, and UR Medicine.

"Transitions of care" can be defined as the movement of a patient from one care setting to another. These transitions take multiple forms including primary care to specialty care; intensive care unit to ward; hospital to post-acute care; or from hospital to hospice or between multiple providers.

The goal of this committee was to develop standards for optimal transitions, develop tools that will help achieve these standards, and attempt to measure outcomes across four transitional circumstances. The Committee focused on the following four transitions: (1) the transition from outpatient care to the Emergency Department/Inpatient care, (2) transition from the Emergency Department to outpatient care, (3) transition from inpatient care to outpatient care and (4) transition from the primary care office to specialty evaluation and/or care. The successful development of the transitions of care system will be dependent upon the development of a culture and philosophy supporting successful transitions. As part of this effort, importance should be placed on the active role of the receiver of information where the physician and other clinicians are available and establishes a patient-centered system to receive information. It is important that the receiving entity incorporates all relevant information about the ongoing care of the patient. This includes Emergency Departments ensuring that all relevant information follows the patient.

Standards for Optimal Transitions - Essential Elements of a Transition Record

I. Communication of information from the primary care physician to the Emergency Department; communication at time of admission from primary care physician to hospital

At the time a primary care physician becomes aware of one of their patients being evaluated in the Emergency Department for hospitalization/placement in observation status, the following information should be provided to the individual/team caring for the patient:

1. Current patient problem list;
2. Current medication list and health maintenance status (i.e. immunizations);
3. Brief clinical history of patient and current state of patient, relevant specialty consultations;
4. Any family or social issues that may be pertinent; if applicable, identify primary contact in family;
5. Relevant past medical history of hospital admission/observation stay/Emergency Department-related conditions;
6. MOLST information (if known) and health proxy information.

II. Communication of information from the Emergency Department to the primary care physician:

When a patient presents to the Emergency Department, preliminary notification should be sent to the primary care physician (PCP). If the patient is not hospitalized or placed in observation status, the discharge communication should be brief and clinically relevant, including:

1. Primary (and other significant major) diagnoses;
2. Brief summary of the Emergency Department stay;
3. MOLST information and health proxy information if developed or changed during Emergency Department stay;
4. Results of procedures and tests done during Emergency Department stay, specialty consultations;
5. Discharge medications and medication changes from preadmission medications;
6. Test results pending at time of discharge and who is responsible for following up on those tests. Important pending tests at time of discharge should be directly communicated and cleanly handed off with the PCP. A clean hand-off is a physician-to-physician direct communication where there is an acknowledgement that a physician has accepted responsibility or a predefined system of hand-off with a predefined acceptance of responsibility. The receiving PCP needs to be responsible for notifying the sender when information is received on a patient who does not belong to the PCP;
7. Follow-up specialty appointments that were scheduled;
8. Follow-up tests or specialty appointments that need to be scheduled by PCP. Important follow-up tests or specialty appointments that need to be made should be directly communicated and cleanly handed off with the PCP. A clean hand-off is a physician-to-physician direct communication where there is an acknowledgement that a physician has accepted responsibility or a predefined system of hand-off with a predefined acceptance of responsibility. The receiving PCP needs to be responsible for notifying the sender when information is received on a patient who does not belong to the PCP; and

9. The expected short-term course of the patient, post discharge, with unique red flags or warnings for PCP to watch for.

10. Patient/Caregiver: The patient should demonstrate an understanding of the most important symptoms and signs to look for which may indicate problems after discharge. Emphasis should be placed on evaluating the patient's understanding as well as including ONLY the most important items and not an exhaustive list of all possibilities. At discharge, the patient must be given an accurate medication list and instructions which are culturally appropriate and easy to understand. A follow-up appointment with the specialist/PCP providing follow-up care should already be made at the time of discharge.

11. The Emergency Department physician who discharges the patient will have responsibility for the accuracy of the discharge summary and ensuring the summary will be provided to the receiving physician in a timely fashion, i.e. within 24 hours of discharge. The receiving physician should agree to see the patient in a timely fashion, 7 days or less. Verbal communication should occur between both physicians, if possible, but most certainly if the patient requires continued close monitoring and/or prompt follow up. Medication reconciliation should be done at all levels at each transition of care.

III. Communication of transition information from the hospitalist/discharge physician to the primary care physician:

It is well known that there are problems with timely receipt of information from hospitalist to primary care physician (PCP). When a patient is first admitted, preliminary notification should be sent to the PCP that a patent is an inpatient or under observational stay. (Electronic health records are providing standardized information and novel medical communication tool such as HIPAA-compliant texting hope to enhance electronic means of communication.) In general, the discharge communication should be brief and clinically relevant, including:

1. Primary (and other significant major) diagnoses;

2. Brief summary of the hospitalization/observation stay;

3. MOLST information and health proxy information if developed or changed during hospitalization/observation stay;

4. Results of procedures and tests done during hospitalization/observation stay, specialty consultations, (including immunizations during hospital stay);

5. Discharge medications and medication changes from preadmission medications;

6. Test results pending at time of discharge and who is responsible for following up on those tests;

7. Follow-up specialty appointments that were scheduled;

8. Follow-up tests or specialty appointments that need to be scheduled by PCP. Important follow-up tests or specialty appointments that need to be made should be directly communicated and cleanly handed off with the PCP. A clean hand-off is a physician-to-physician direct communication where there is an acknowledgement that a physician has accepted responsibility or a predefined system of hand-off with a predefined acceptance of responsibility. The receiving PCP needs to be responsible for notifying the sender when information is received on a patient who does not belong to the PCP; and

9. The expected short-term course of the patient, post discharge, with unique red flags or warnings for PCP to watch for.

10. Patient/Caregiver: The patient should demonstrate an understanding of the most important symptoms and signs to look for which may indicate problems after discharge. Emphasis should be placed on evaluating the patient's understanding as well as including ONLY the most important items and not an exhaustive list of all possibilities. At discharge, the patient must be given an accurate medication list and instructions which are culturally appropriate and easy to understand. A follow-up appointment with the specialist/PCP providing follow-up care should already be made at the time of discharge.

11. The hospital physician who discharges the patient will have responsibility for the accuracy of the discharge summary and ensuring the summary will be provided to the receiving clinician in a timely fashion, i.e. within 24 hours of discharge. The receiving physician should agree to see the patient in a timely fashion, 7 days or less. Verbal communication should occur between both physicians, if possible, but most certainly if the patient requires continued close monitoring and/or prompt follow up. Medication reconciliation should be done at all levels at each transition of care.

IV. Communication among outpatient physicians and for referrals:

Referring physician

1. Referring physician name and best contact numbers should be maintained on an up-to-date database;

2. Reason for referral with associated relevant information;

3. Expectations by the referring physician for the consultation; i.e. necessity for an evaluation and/or procedure and/or continuing ongoing care;

4. Referring physician must forward the consulting physician a brief summary of the problem requiring the referral.

Consulting physician

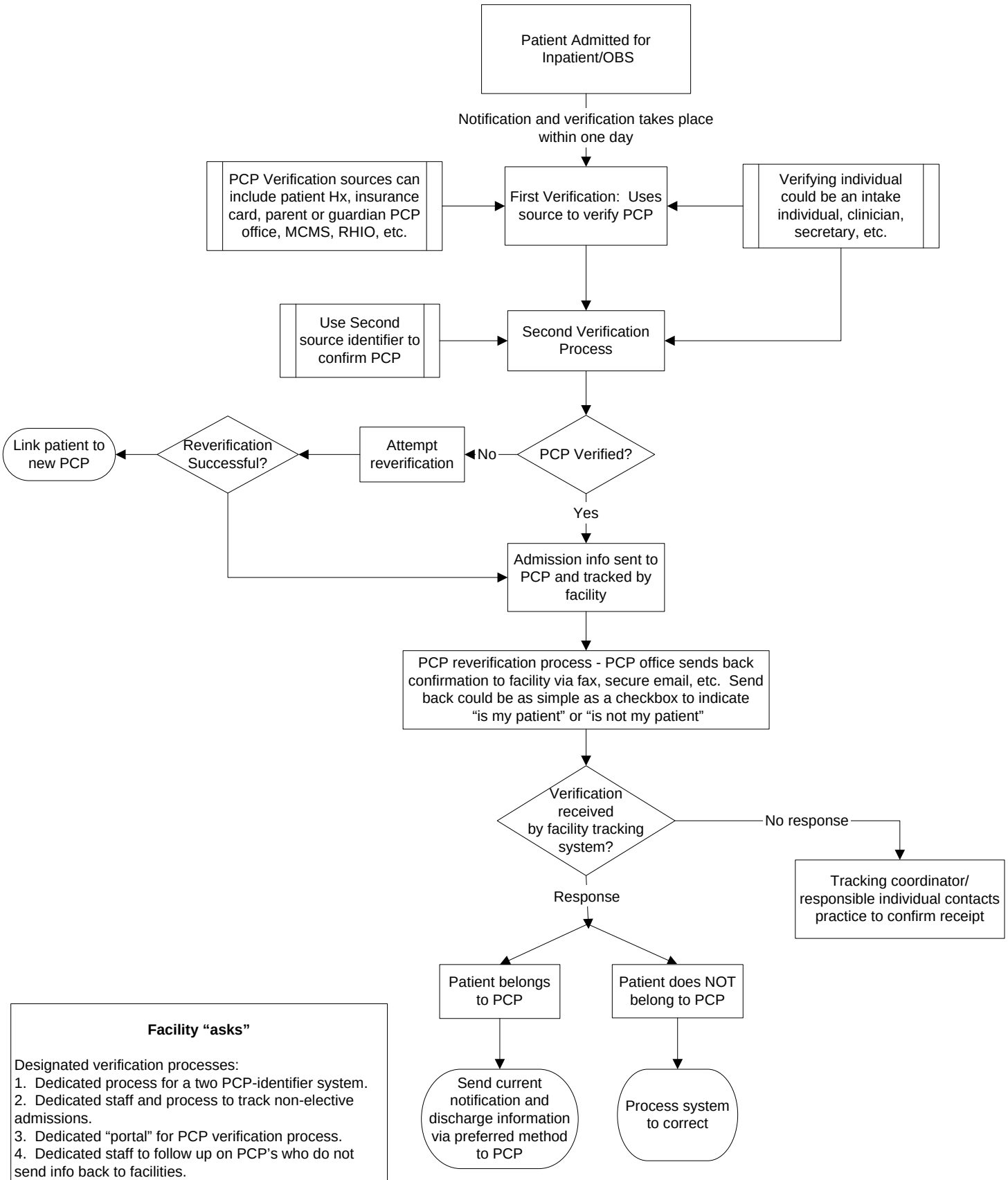
1. The receiving consultant physician should be available to see the patient within an appropriate time based on clinical reason for referral;

2. The consulting physician must report pertinent findings in a timely manner depending on outcome of evaluation and no later than 7 days.

Tools to Help Achieve Standards for Optimal Transitions - Verification of Primary Care Physician in Inpatient/Emergency Department and Outpatient Setting

Accurate identification of a patient's primary care physician (PCP) in the inpatient/emergency department and outpatient setting is an important component to good communication and achieving standards for optimal transitions. To aid in this process, workflows (on pages five and six) were created that outline workflows to identify and verify the PCP before information is released. It is a directive process and not prescriptive on how the verification occurs. The goal is that the PCP attribution process, if followed, will significantly increase the percentage of accurate attributions.

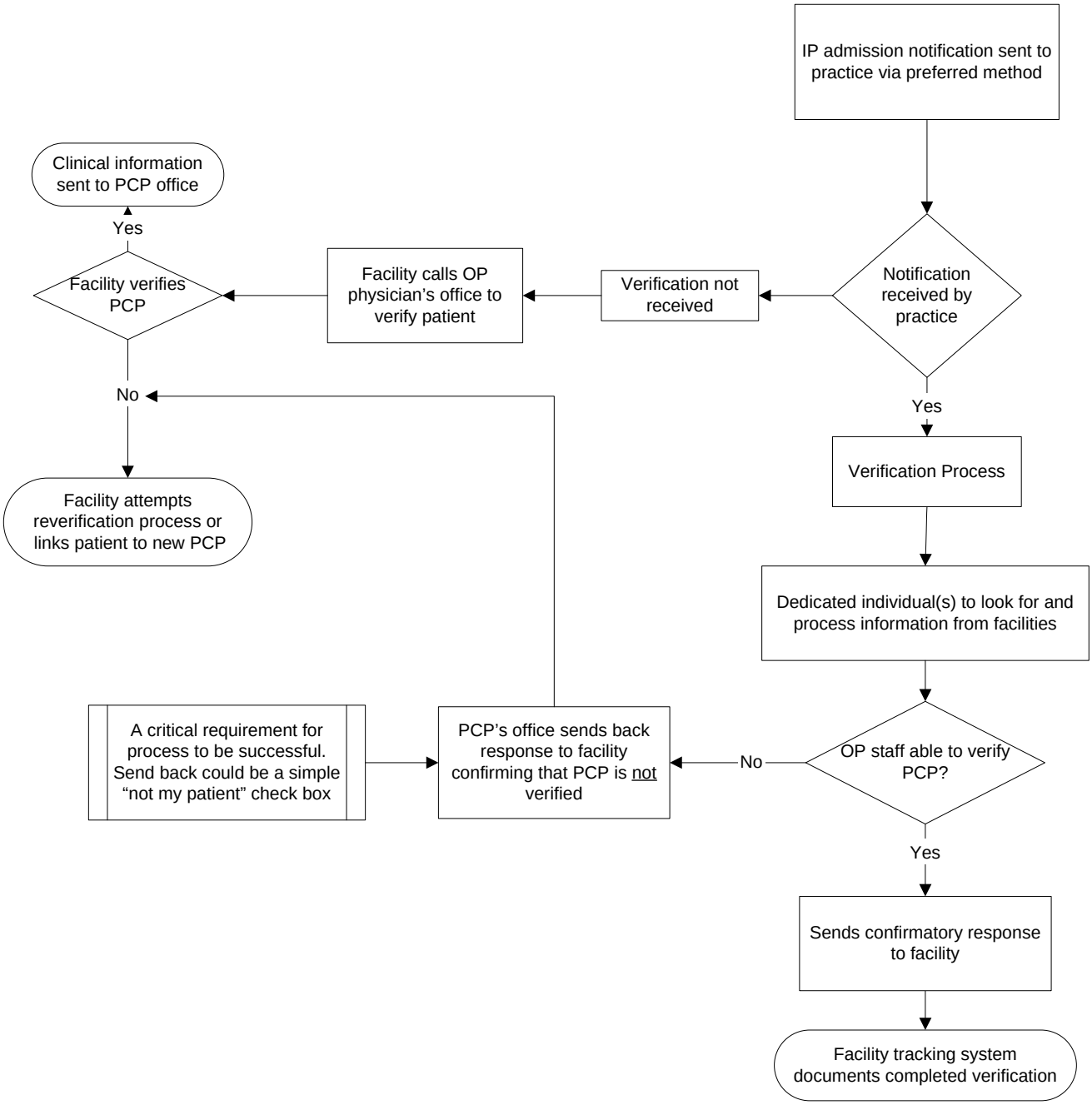
Inpatient Admission - Primary Care Physician Verification Workflow



Facility "asks"

Designated verification processes:
1. Dedicated process for a two PCP-identifier system.
2. Dedicated staff and process to track non-elective admissions.
3. Dedicated "portal" for PCP verification process.
4. Dedicated staff to follow up on PCP's who do not send info back to facilities.
5. Process to correct PCP information
6. Process for non-facility EMRs.

Outpatient - Primary Care Physician Verification Workflow



Outpatient "asks"

1. Identification of preferred method of notification.
2. Trained individual who understands how to manage information from facility (could be non-clinician).
3. An internal process to verify a patient.
4. Must have buy in from office to communicate with facility regardless if patient belongs to PCP.