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**Monroe County Medical Society
Quality Collaborative**

Optimal Community Principles 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, potentially preventable readmissions, as well as medical errors related to communication problems. Medicare has recently implemented financial 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.”

Problems with 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 can significantly increase the cost of health care. Because of these

multiple problems, and in an effort to optimize communications, the Monroe County Medical Society formed a Physician Communication Committee comprised of physician representation from independent community physicians, major ACOs and hospital systems. “Transitions of care” can be defined as the movement 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 set goals for optimal transitions, develop tools that will help achieve these goals, and attempt to improve across four transitional circumstances. The Committee focused on the communication around: (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, (4) transition from the primary care office to specialty evaluation and/or care, (5) transition from urgent care centers and retail clinics, and (6) transition of practitioner home-based services, telehealth and telemedicine services to the primary care office.

Guidelines 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 is being or will be evaluated in the Emergency

Department for hospitalization/placement in observation status, the following particularly relevant information should be provided to the individual/team caring for the patient:

1. Current pertinent patient problem list.
2. Current pertinent medication list and health maintenance status (i.e. immunizations).
3. Brief clinical history of patient and current state of patient, relevant specialty consultations or recent pertinent test/procedure results.
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.
7. The receiving Emergency Department should review any relevant EMR or Continuity of Care documents that are available to them.

II. 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 stays with the discharge summary easily found.
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 the patient was instructed to schedule or may have been 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

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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.

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

10. 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 within 24 hours of discharge. Verbal/texting/EMR communication should occur between both physicians and 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. It is the responsibility of the Emergency Department provider to ensure there is a clear follow up plan if clinically indicated.

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 patient is an inpatient or under observational stay. 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.

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 within 24 hours of discharge. The receiving physician within a medically reasonable time period, ideally 7 days or less if clinically warranted. Verbal/texting/EMR communication should occur between both physicians and 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 should 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 should report pertinent findings in an expeditious manner and no later than 7 days.
3. The primary care physician should be copied in on any communication between consulting physician(s).

V. Communication from Urgent Care Centers and Retail Clinics:

36.When a patient presents to an urgent care center or to a retail clinic, a copy of the visit record or summary of the visit and any laboratory/radiological study results should be sent to the primary care physician (PCP). The communication should be brief and clinically relevant, including:

1. Primary (and other significant pertinent) diagnoses.
2. Brief summary of the visit.
3. Results of procedures and tests performed.
4. Discharge medication and medication changes from pre-visit medications.
5. Test results pending at the time of discharge and who is responsible for following up on those tests.
6. Follow-up tests or specialty appointments (as applicable) that need to be scheduled by the PCP. These need to be directly communicated and cleanly handed off with the PCP. 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. The expected short-term course of the patient, post discharge, with any unique red flags or warnings for the PCP to watch.

8. Patient/Caregiver: The patient should demonstrate an understanding of the most important signs and symptoms to look for which may indicate problems after discharge.
9. The 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 within 24 hours of discharge. The receiving physician should agree to see the patient in 7 days or less if clinically warranted. Verbal/texting/EMR communication should occur between both physicians and 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.

VI. Communication from Telemedicine providers to other physicians

Telemedicine should be used as a tool for physicians to provide treatment to patients that may include treatment by a PCP for his/her own patients, by a specialist, or by a physician in a rapid response capacity akin to an Urgent Care center. As such treating physicians should review the communication principles for the appropriate transition of care described elsewhere in this document.

******ADDITION TO EXISTING DOCUMENT******

VII. Communication from Radiology to other physicians

Effective communication is a critical component of diagnostic imaging. Quality patient care can only be achieved when study results are conveyed in a timely fashion to those responsible for treatment decisions. An effective method of communication should 1) promote optimal patient care and support the referring physician/health care provider in this endeavor, 2) be tailored to satisfy the need for timeliness, and 3) minimize the risk of communication errors.

An official interpretation (final report) by the interpreting physician must be generated and archived following any examination, procedure, or officially requested consultation regardless of the site of performance (hospital, imaging center, physician office, mobile unit, etc). It is not appropriate for non-physicians to provide interpretations or generate diagnostic reports.

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Approved Aug. 2021. Next scheduled review by Aug. 2023. 6

Principles of Reporting; (Final Report)

1. The final report is the definitive documentation of the results of an imaging examination or procedure.
2. A copy of the final report should be archived by the imaging facility as part of the patient's medical record and be retrievable for future reference.

Communications Other Than the Final Report

1. Preliminary report. When needed, a preliminary report precedes the final report. It very likely will contain limited or incomplete information. It should not be expected to contain all the information subsequently found in the final report. Preliminary reports may be communicated in writing, electronically, or verbally, and the method of communication should be documented. These preliminary communications should be reproduced into a permanent format as soon as practical and appropriately labeled as a preliminary report, distinct from the final report, and archived because clinical decisions may have been based on the preliminary report. The archived preliminary report should contain the name of the person or office that received the report, if applicable and the date and time that the report was provided. As soon as possible, a significant variation in findings and/or conclusions between the preliminary and final interpretations should be reported in a manner that reasonably ensures receipt by the referring or treating physician/health care provider, particularly when such changes may impact patient care. Documentation of communication of any discrepancy should be incorporated into the final report.

2. Nonroutine communications

In an emergent or other non-routine clinical situation, the interpreting physician should expedite the delivery of a diagnostic imaging report (preliminary or final) in a manner that reasonably ensures timely receipt of the findings. This communication will usually be to the referring physician/health care provider or their designee. When the referring physician/health care provider cannot be contacted expeditiously, it may be appropriate to convey results directly to the patient, depending upon the nature of the imaging findings.

Situations that may warrant non routine communication include the following:

- i. Findings that suggest a need for immediate or urgent intervention.

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- ii. ii. Findings that are discrepant with a preceding interpretation of the same examination and where failure to act may adversely affect patient health.
- iii. Findings that the interpreting physician reasonably believes are significant and unexpected, may have a reasonable probability of impacting the patient's health, and may not require immediate attention but, if not acted on, may worsen over time and likely result in an adverse patient outcome.

Documentation of non-routine communications:

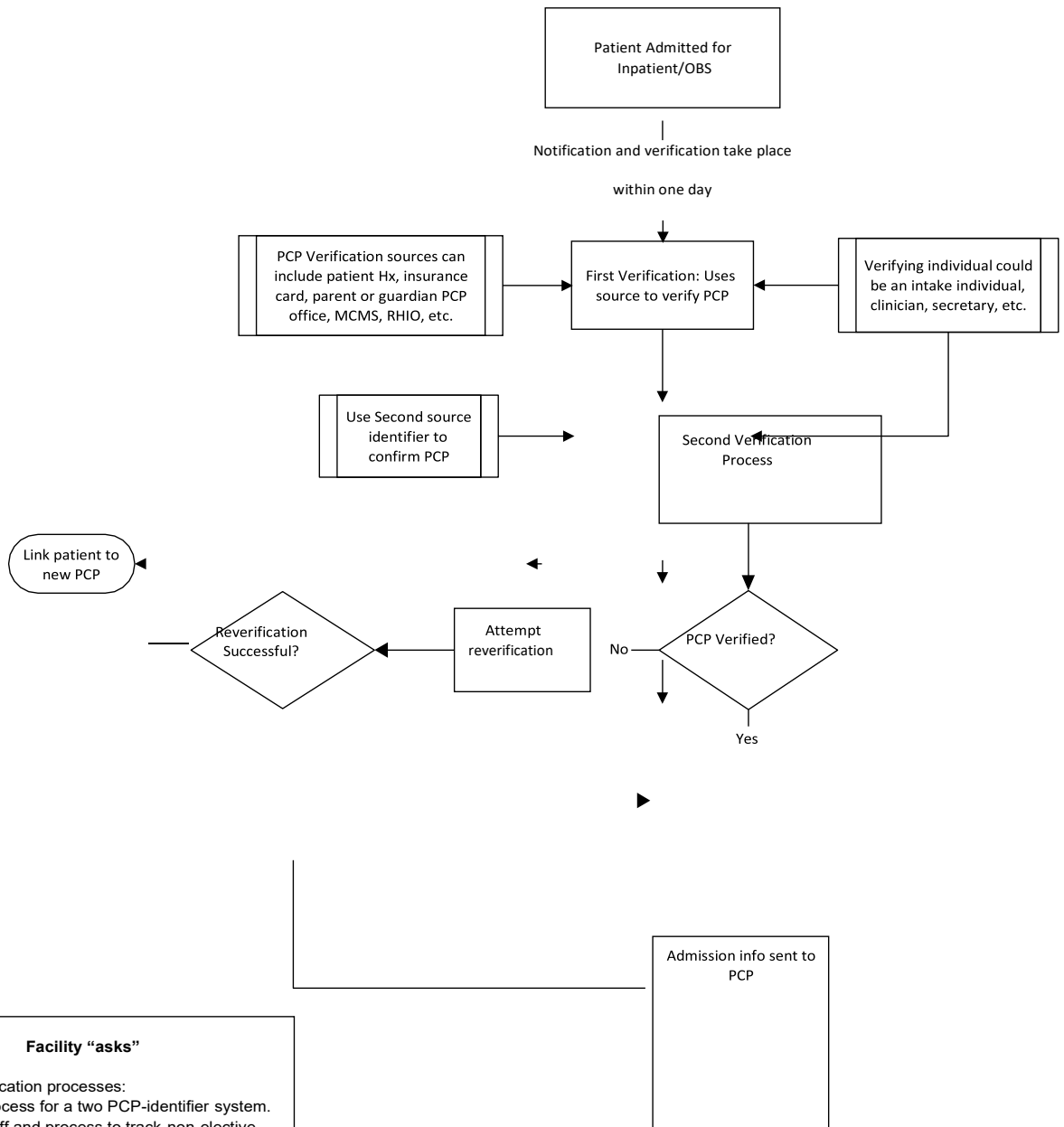
Interpreting physicians should document all non-routine communications. Documentation is best placed in the radiology report or the patient's medical record. Inclusion of the date and time, method of communication, and the name of the person to whom the communication was delivered is an example of such documentation.

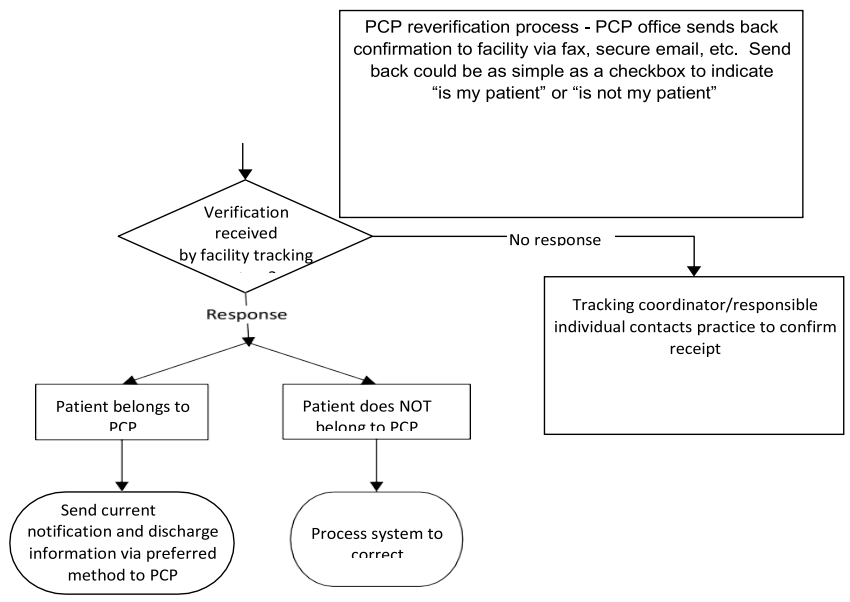
Ref. ACR Practice Parameter for Communication of Diagnostic Imaging Findings. Revised 2020

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

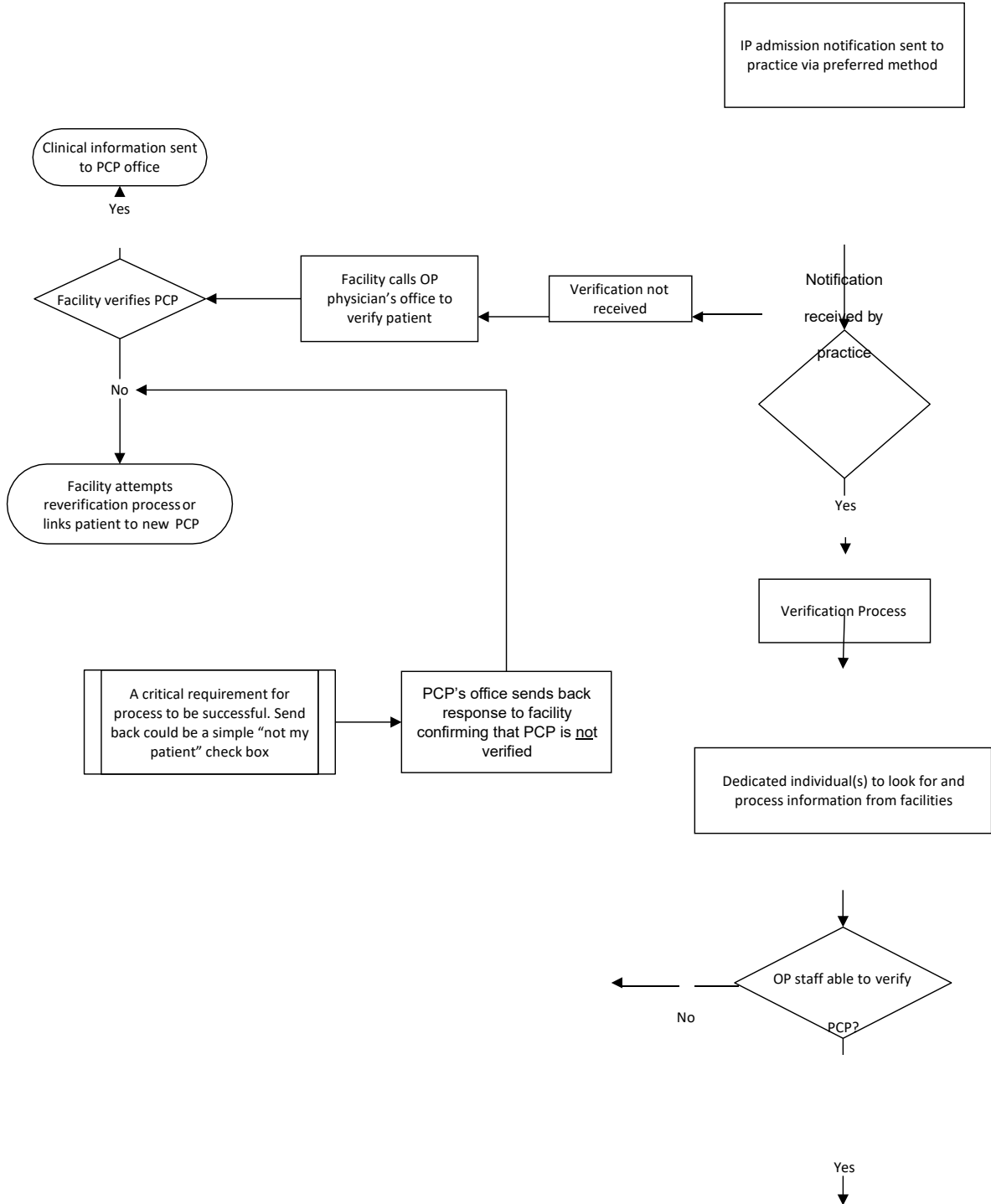
Accurate identification of a patient's primary care physician (PCP) in the inpatient/emergency department and outpatient setting is an important component to good communication and achieving standards for optimal transitions. To aid in this process, workflows were created that outline a process to identify 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





Outpatient - Primary Care Physician
Verification Workflow



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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.

Sends confirmatory response to facility



Facility tracking system documents completed verification