Cornerstone Care	**Procedure**
Title: Hospital Admission and Discharge Procedure	
Approval Date: 4/19/2022	**Review: Every 3 Years**
Policy Owner: Chief Medical Officer	
Effective Date: 2/2019	

Purpose: To decrease preventable readmissions to ensure safe and effective care transitions.

Leaving the hospital can be a dangerous time for patients. Changes in care settings, care providers and medications experienced after discharge can result in errors that lead to health care complications. Many people end up going back to the hospital because of these complications, or because they were not prepared to manage their own care. Unclear discharge instructions; Conflicting instructions from different providers; Medication errors, including dangerous drug interactions, duplications. It's also important for us to know our patients who went to the emergency room for continuity.

Definition: Care transitions refer to the movement of patients from one health care provider or setting to another.

Procedures: When a patient goes to the ER or has an unplanned admission, the hospital will call requesting information from the patient chart. We immediately fax that information straight from the record to the nursing floor of the hospital requesting the information. To help in the coordination of care, we have agreements with the admitting hospitals regarding exchange of patient information. In the event a patient is sent to the hospital at the direction of our provider, the provider or a designated staff member will contact the hospital to share pertinent info as well as send a copy of the patient's health record to the hospital via whatever means is most appropriate (NG share, fax, or paper copy with patient).

Designated staff are proactively identifying patients who were admitted to the hospital or ER, retrieving discharge information from The Washington Hospital (WHINN), Mon General and WVU (Cerner) when it is made available and making a transition of care

call to the discharged patient. Many of the hospitals also call us when a patient is being discharged to get them scheduled. We also receive CCDA's (continuity of care documents) directly into our EHR from Allegheny Health network and UPMC using Nextgen Share.

- Obtain discharge information from designated hospital software program, for all other hospitals, we receive a discharge summary directly scanned to us.
- These designated staff proactively working on discharged patients will call the patient to schedule their follow up appointment in the office. Appointments are scheduled within 7-14 days of discharge.
- Staff will review chart information regarding medications and compare with the discharge summary.
- Staff will call patient to:
  a. Be sure patient understands discharge instructions.
  b. Confirm patient is taking medications as ordered on discharge instructions.
  c. Check for orders from home health, Durable Medical Equipment or specialist appointment and ensure that the patient has been contacted or is set up as ordered.
  d. Make sure the patient has an appointment and remind the patient of the importance of keeping their hospital follow up appointment here in the office.
- Staff document the phone call in the chart, what was discussed & outcomes of call and add to the patient's interim history. Send to provider for review.

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Dr. Ed Foley Date