Saint Joseph Health System

Based upon Hospitalist and Community Provider Service Agreement Policy

AGREEMENT FOR THE COORDINATION OF PATIENT CARE

In the interest of improving communication between the Primary Care Physicians of our community and the Hospitalist Inpatient Care Team at Saint Joseph Health System, an agreement between Saint Joseph Health System and it's contracted hospitalist physician group (hereafter referred to as HCT) and Dr._____ (hereafter referred to as PCP) do jointly enter into this Care Coordination Agreement with the intention of defining the roles of each party to maximize communication and coordination of Patient Care.

Article 1: Communication Procedures

Communication between parties shall occur in full compliance with relevant hospital policies and applicable state and federal laws regarding patient privacy and confidentiality. Communication methodology which may be utilized includes direct phone contact, Doc Halo (a secure HIPPA compliant text messaging system) Secured Email or Fax. The primary general contact number for contacting the HCT is 574-_____. The Medical Staff Office maintains and publishes a list of contact information for each member of the HCT and of each primary care physician which includes preferred and alternate methods of contact as appropriate. It is expected that at a minimum, communication about a patient visit will occur at the time of admission, at the time of discharge and at any point during the course of hospitalization where decisions are being made that will have significant impact beyond the hospital visit.

Article 2: Responsibilities of the Parties at the Time of Admission

It is recognized that multiple pathways exist for patients to be admitted into the hospital and therefore recognized that each situation may be unique. In general, patients will either be admitted directly from the PCP or via the emergency room after appropriate workup by the ER medical staff. In the case of direct admission by the PCP, the PCP will:

- Discuss the case with the Hospital Care Team (HCT) member on duty in preparation for admission.
- Provide demographics:
  - Patient name, DOB, and contact information
  - Contact person if not the patient e.g. healthcare proxy or guardian
  - Any special considerations, such as vision/hearing impairment, cognitive deficits, language/cultural preferences
  - PCP contact information
- Provide the reason for hospitalization:
  - Primary complaint /medical issue/assessment and diagnosis
  - Key physical findings and/or test results and a summary of recent changes in status
  - Any co-morbid conditions that will need addressed during hospitalization
- Prepare patient/family/caregiver:
  - Ensure understanding of reason and agreement with planned hospitalization
  - Ensure safe transfer to the appropriate facility in manner that takes into account

patient preferences
- Provide hospital contact information and expected time frame for hospital length of stay

In the case of patients being admitted to the hospital via the ED that are under the care of the PCP, the HCT will:

- Notify the PCP of admission.
- Communicate with the patient/family/caregiver the purpose/expectations and goals of the hospital stay and ensure understanding.
- Establish communication with the PCP that addresses transfer of pertinent patient clinical information at admission, during hospitalization and at discharge.
- Validate a means of contact for routine and urgent situations which may occur during the course of the admission.
- Obtain and review pertinent medical information from the PCP.

In the case of patients being admitted to the hospital via the ED, upon being notified by the HCT of the admission, the PCP will:

- Provide appropriate and adequate information to the HCT in a timely manner. If known, this information should include:
  - Problem list
  - Current list of medications
  - Current list of allergies/contraindications
  - Relevant medical and surgical history
  - Any Advanced directives
  - Any additional information specifically requested by a member of the hospital care team.
  - PCP contact information during routine and urgent situations.

Article 3: Responsibilities of the Parties During the Hospital Stay

During the hospital stay, the PCP will:

- Respond to all incoming calls or other communications from HCT in a timely manner.
- Engage with HCT around significant clinical issues arising in the hospital that will extend beyond the hospital stay.

During the hospital stay, the HCT will:

- Keep the PCP notified of major clinical developments.
- Involve the PCP as needed in significant patient care decisions that will have a significant impact post discharge, i.e. care transitions.
- Assure that the patient and or caregiver/proxy is kept fully informed regarding diagnosis, test results, and treatment options as appropriate.

Article 4: Responsibilities of the parties at discharge

When the patient is ready for discharge, the HCT will:

- Inform the patient/family/caregiver of diagnosis, prognosis and follow-up recommendations and ensure understanding.
- Inform the PCP of the pending discharge from acute care.
- Provide educational materials and resources to patient as appropriate.
- Provide a reconciled medication list and any scheduled appointments.
- Advise patient/family/caregiver of any outstanding tests that will require follow-up by their PCP.
- Work to ensure that patient/family/caregiver are in agreement with discharge plans.
- Provide information on how to manage symptoms and how to identify those requiring immediate medical attention and the contact information for appropriate providers.
- Transmit a discharge notification to the PCP which will include a concise discharge summary:
    - Reason for hospitalization
    - Summary of results of all testing/procedures
    - Discharge diagnosis
    - Current medication list
    - Pending studies
    - Patient instructions
- Make follow-up appointments with PCP if appropriate and necessary.
- Receive calls from PCP as needed for additional information or clarification.

Upon discharge, the PCP will:

- Engage in collaborative care management:
    - Around transitional care planning
    - Ensure receipt of discharge notification
    - Resume care of patient
        - Review patient Information upon discharge from hospital setting.
        - Agree to make contact with the patient within <u>two</u> business days of discharge.
        - Arrange clinically appropriate patient-centered appointment time.
        - Assume responsibility for follow up of pending results and/or scheduling recommended testing for diagnosis and/or medication monitoring.
        - Reach out to HCT if issues arise post-discharge that require input from that team.

Signed _____ Date _____
Referring Provider

Signed_____ Date _____
Hospitalist Representative