HIM Department

Process for Coordinating Care Transitions

Site:	**Version: 1**
Approver(s): Medical Clinical Staff	**Date Revised:**
Implementation Date: 3/17/17	**Next Review Date:**
Standards: NCQA PCMH 5:	

> **All sections in our Coordinating Care Transitions process describe how we conduct "two-way" communication with our local hospitals/ER's. This process explains how we provide information they need and how we receive information from them.**

1. **IHS sends patient to hospital:** At times, patients seen at the _____ require emergent care that cannot be provided here. They are sent to either _____ or _____ ER's.

   > **Meets Standard CC15**

   a. The provider puts a consult in the EHR and verbally notifies the HIM staff.
   b. The HIM staff faxes the consult and supporting medical records to the ER. The medical records include but are not limited to: lab results, medication list, EKG's, imaging reports, progress notes and care plans.

2. **Request for IHS to send records to hospital:**

   > **Meets CC15**

   a. The Health Information Management (HIM) Department staff receives a telephone request for records from the hospital.
      i. The HIM Technician will ask and confirm the specific information that the hospital is requesting.
      ii. They will look up the patient in the Electronic Health Record (EHR) to confirm they are an active patient and that we have the information available.
      iii. They will then fax the information (including, but not limited to: lab results, medication list, EKG's, imaging reports, progress notes and care plans) immediately, or by close of business that day.
   b. The HIM staff receives a faxed request for records from the hospital.
      i. If the faxed request is not specific, the HIM Technician will call the hospital and ask for the specific information they are requesting.
      ii. The HIM Technician will look up the patient in the EHR to confirm they are an active patient and that we have the information available.
      iii. They will then fax the information (including, but not limited to: lab results, medication list, EKG's, imaging reports, progress notes and care plans) immediately, or by close of business that day.

3. **Obtain discharge summaries:** Emergency Room Reports and Admission Notices are received via fax in the Health Information Management (HIM) Department.

   > **We identify patients by receiving reports and admission notices from our ER's.**
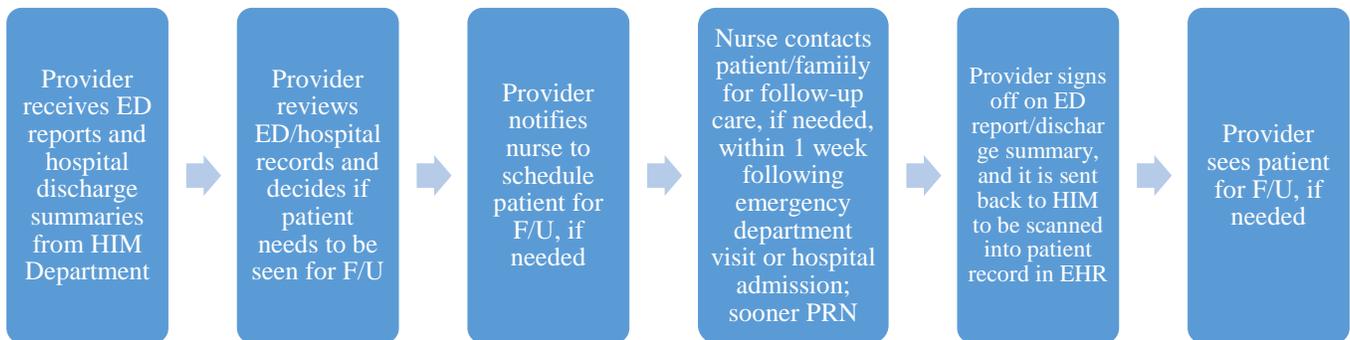   >
   > **Meets CC14**

   a. The HIM Technicians look up the patient in the EHR to determine who their Primary Care Provider (PCP) is, and then they put the received report in the appropriate provider's folder at the Medical desk.
   b. The providers review and sign off on the reports and send them back to the HIM Department.
   c. The HIM Technician scans the report into VistA Imaging.
   d. At the time of scanning, the HIM Technician will review the report.

4.   Conducts Follow-Up Care

| Provider receives ED reports and hospital discharge summaries from HIM Department | → | Provider reviews ED/hospital records and decides if patient needs to be seen for F/U | → | Provider notifies nurse to schedule patient for F/U, if needed | → | Nurse contacts patient/famiily for follow-up care, if needed, within 1 week following emergency department visit or hospital admission; sooner PRN | → | Provider signs off on ED report/discharge summary, and it is sent back to HIM to be scanned into patient record in EHR | → | Provider sees patient for F/U, if needed |

This process describes how we receive reports, discharge summaries from the Emergency Department and how our facility uses the information to **follow up with the patient within one week.**

Meets CC16

Date Implemented: March 21, 2017