CAROLINA FAMILY HEALTH CENTERS, INC.
PROCEDURE

TITLE: CLN-200.03 Continuity of Care for Hospital Transitions

EFFECTIVE DATE: September 2012

SECTION: Clinical
REFERENCE POLICY: CLN-200 Care Coordination and Transitions

RESPONSIBLE CHIEF OF STAFF: Chief Medical Officer
RESPONSIBLE COMMITTEE: Medical CIT

REVIEWED: 12/13, 9/14, 4/16, 10/16, 4/17, 11/18, 2/25/2021, 2/6/2024, 03/04/2025

I. PURPOSE

The purpose of this procedure is to outline Carolina Family Health Centers, Inc.'s (CFHC, Inc.) process for tracking patient hospital admissions and emergency department (ED) evaluations, assuring the receipt of records from such visits and maintaining continuity of care through the provision of care management to individuals at risk for readmission.

II. PROCEDURE

CFHC, Inc. patients are admitted through hospitalist groups at Wilson Medical Center in Wilson, University of North Carolina (UNC) Nash Hospital in Rocky Mount, and East Carolina University (ECU) Health Edgecombe in Tarboro, depending on the patient's county of residence or the hospital of the patient's preference.

CFHC, Inc. participates in the North Carolina Health Information Exchange (HIE), which allows for two-way sharing of protected health information electronically. This allows for the sharing of patient information upon admission and discharge and allows hospital staff access to CFHC, Inc.'s patient information during and after hours. All three local hospitals participate in the HIE. Notifications regarding a patient's hospital admission or ED visits are sent electronically through the electronic health record and forwarded to the medical provider and the case manager's pool. Information received through the HIE contains patient information, date of admission or visit, date of the notification, reason for the visit, and the documentation received. Admission and discharge summaries are available through Care Everywhere. If additional records from the hospitalization are needed (i.e., labs, radiology, procedural reports, specialty consults, etc.) and are not attached to the discharge summary, medical record staff calls for these records, and the request is documented in the electronic health record (date included)

CFHC, Inc. telephone system provides a menu option for non-health center inpatient providers and other healthcare partners to use that directs the call to a designated staff person(s) that can page the provider to notify them of the incoming call.

It is the current practice of the service area hospitals to refer a patient back to his/her primary care provider (PCP) for follow-up. Language regarding this is provided within our

memorandum of agreement with our local hospitals. CFHC, Inc. has developed a relationship with each hospital's discharge planner. The discharge planners have been given a point of contact, the Population Health Manager at CFHC, Inc., who can help coordinate hospital follow-up appointments. Follow-up coordination efforts with the hospital or patient, and the date of such efforts, are documented in the electronic health record.

Each provider has hospital follow-up slots on their schedule to accommodate these visits. CFHC, Inc.'s goal is to follow up with patients within 48 hours of discharge from the hospital and provide them with a follow-up appointment within ten days of a hospital discharge. Case management staff attempt to contact all patients upon discharge. High-risk patients are provided transition care management services for the first 30 days after discharge in hopes of decreasing 30-day hospital readmission rates. Refer to *CLN 600.01 Care Management* for more information regarding transition care management.