Major Hospital A Major Health Partner	Hospital Admissions MS-17
Does this policy meet a regulatory standard? Yes __X__ No ____	Formulated by: Medical Staff Office/Administration Approved by: Medical Executive Staff, Board of Directors Effective Date: 09/23/2013

PURPOSE: **To describe Practitioner requirements for the processes of patient admission to the hospital.**

GUIDELINE STATEMENTS:

1. General Hospital Admission Requirements

1.1. A patient may be admitted to the hospital only by a M.D. / D.O who has been granted admitting privileges.

1.1.1. A nurse practitioner or a physician assistant who has not been granted admitting privileges by the hospital's medical staff may act as a proxy for the ordering M.D. / D.O. which allows them to write inpatient admission orders on his or her behalf, if the ordering M.D. approves and accepts responsibility for the admission decision by countersigning the order prior to discharge.

1.1.2. Emergency department physicians, nurse practitioners and physician assistants who do not have admitting privileges are authorized to write temporary or "bridge" orders for inpatient admission on behalf of the ordering physician, if the ordering practitioner approves and accepts responsibility for the admission decision by countersigning the order prior to discharge.

1.2. Patients presenting for admission who have no attending physician shall be attended by members of the Active Staff in the service to which the needs of the patient indicate the assignment. The Service Chief shall have authority to call any members of the Medical Staff to attend a patient as is necessary.

1.3. All inpatients and MOB patients, excluding newborns born at Major Hospital, must have documented assessment and admission orders signed by a M.D. / D.O. either at the referring site or in a timely manner after arrival to the hospital.

2. Direct Patient Admissions

2.1. Practitioner to inform patient to report to the hospital within one (1) hour after the office visit.

2.2. Practitioner will notify hospital staff of the anticipated arrival time of the patient.

2.3. If the patient fails to show up at the designated time, hospital staff will notify the referring practitioner to allow the office to call the patient for further instructions.

2.4. If the patient admission occurs after the Hospitalists have left the hospital, the referring practitioner will contact the on-call Hospitalist for discussion regarding appropriate care and treatment.

3. Collaborative Care Agreement (As developed by the American College of Physicians and the Society of Hospital Medicine)

3.1. The Hospital Care Team agrees to

3.1.1. At the beginning of the hospitalization

3.1.1.1. Review patient information available

3.1.1.2. Inform patient/family/caregiver of need/purpose, expectations and goals of hospitalization

3.1.1.3. Ensure patient's/healthcare proxy's understanding and agreement with hospitalization

3.1.2. Establish communication with the Primary Care Practice (PCP)

3.1.2.1. Establish a standard communication protocol with PCP that ensures secure, timely, and reliable transfer of information to address the following situations

3.1.2.1.1. Transfer of required patient clinical and other information at admission, during hospitalization and at discharge

3.1.2.1.1.1. Required information is available within shared EHR

3.1.2.1.2. Means of contact during routine and urgent situations

3.1.2.1.1.2. Daytime contact through EHR workload message, Vocera, or phone call. After hours contact to on-call provider via Vocera or phone call

3.1.2.2. Identify the PCP within 24 hours of admission and contact as needed based on clinical needs and acuity

3.1.2.2.1. If not admitted directly by the PCP, ensures that PCP is aware of admission and reason for admission with appropriate patient permission, as needed

3.1.2.2.2. Provides PCP with information on how to best communicate with the Hospital Care Team (HCT), including a means of urgent contact

3.1.2.2.3. Obtains and reviews pertinent medical information from PCP, and requests any additional pertinent information as needed

3.1.2.3. Engage in collaborative care management during hospital stay

3.1.2.3.1. Keep PCP abreast of major clinical developments as needed

3.1.2.3.2. Involve the PCP when needed in significant patient care decisions that significantly impact care beyond the hospitalization, e.g. regarding longitudinal medical issues, advanced care planning/goals of care determinations, and care transitions issues

3.1.3. Prepare patient for discharge

3.1.3.1. Inform patient, family, caregiver of diagnosis, prognosis and follow-up recommendations

3.1.2.1.2. Assess understanding of these issues by patient, family, caregivers

3.1.3.2. Ensure patient, family, caregiver agrees with discharge plans

3.1.2.3. Provide educational material and resources to patient when appropriate

3.1.2.4. Provide patient, family, caregiver with written care plan including patient-centered reconciled medication list and any scheduled appointments and planned therapies

3.1.2.4.1. Ensures patient receives all discharge medications prior to leaving hospital or that all medications are available as ordered at patient's pharmacy of choice

3.1.2.5. Advise patient, family, caregiver of any outstanding laboratory and/or other testing that will require follow-up by the PCP

3.1.2.6. Provide patient, family, caregiver with a plan for the transition period including how to manage symptoms/signs and how to identify those requiring immediate attention and related contact information for appropriate provider

3.1.4. Provide appropriate and adequate information at discharge

3.1.4.1. Transmit a discharge notification to PCP within 24 hours of discharge. This should include the following:

3.1.4.1.1. Reason for admission

3.1.4.1.2. Major procedures and tests performed during inpatient stay and a summary of results

3.1.4.1.3. Principal diagnosis at discharge
3.1.4.1.4. Current medication list
3.1.4.1.5. Studies pending at discharge (e.g. lab, imaging)
3.1.4.1.6. Patient instructions
3.1.4.2. Prior to discharge, make follow-up appointment for patient with PCP if clinically appropriate and necessary
3.1.4.2.1. Scheduled by the HCT Admin Coordinator or the PCP TCM team with input from patient/family/caregiver
3.1.4.3. Send a concise discharge summary to PCP within 48-72 hours of discharge
3.1.4.4. Reaffirm direct contact information to be used by PCP to contact HCT
3.1.4.5. Receive calls from PCP as needed for additional information or clarification
3.2. The Primary Care Practice (PCP) agrees to
3.2.1. If admission directly initiated by PCP
3.2.1.1. Discuss the case with HCT member on duty in preparation for admission
3.2.1.2. Provide demographics
3.2.1.2.1. Patient name, DOB, and contact information
3.2.1.2.2. Contact person if not patient e.g. healthcare proxy or guardian
3.2.1.2.3. Any special considerations required such as vision/hearing Impairment, cognitive deficits, language/cultural preferences
3.2.1.2.4. PCP designation, referring provider, contact information
3.2.1.3. Provide reason for hospitalization
3.2.1.3.1. Primary complaint, medical issue, assessment and diagnosis
3.2.1.3.2. Relevant notes, key physical findings and/or test results as well as summary of recent changes in status
3.2.1.3.3. Any co-morbid conditions that will need attention during hospitalization
3.2.1.4. Prepare patient, family, caregiver
3.2.1.4.1. Ensure there is understanding of reason and agreement with planned hospitalization

3.2.1.4.2. Ensure safe transfer to the appropriate facility in a manner that considers patient preferences

3.2.1.4.3. Provide hospital contact information and expected hospital LOS

3.3. For any hospitalization of a patient under a PCP's care

3.3.1. Upon notification of the patient's hospitalization, provide timely, appropriate, and adequate information, when available, to the HCT

3.3.1.1. Problem list

3.3.1.2. Reconciled medication list

3.3.1.3. Allergy/contraindications list

3.3.1.4. Relevant medical and surgical history

3.3.1.5. Advanced directives

3.3.1.6. List of any other relevant healthcare professionals involved

3.3.1.7. Any additional information specifically requested by the HCT

3.3.2. Address communication issues

3.3.2.1. Establish a standard communication protocol with HCT that ensures secure, timely, and reliable transfer of information during the following situations

3.3.2.1.1. At admission, during hospitalization and at discharge

3.3.2.1.2. A means of contact during routine and urgent situations

3.3.2.2. Receives and responds to all incoming calls or other communications from HCT in a timely manner in order to provide input on clinical and other issues

3.3.2.3. Engages with HCT around significant clinical issues arising in the hospital that will extend beyond the hospital stay

3.4. Engage in collaborative care management regarding discharge

3.4.1. Engage with HCT around transitional care planning

3.4.2. Ensure receipt of discharge notification (i.e. has systems in place to receive such information such as EMR, fax, etc.)

3.4.3. Resume care of patient

3.4.3.1. Review patient information upon discharge from hospital setting

3.4.3.2. Agree to contact with the patient within two business days of discharge

3.4.3.3. Arrange clinically appropriate patient-centered appointment time

3.4.3.4. Incorporate care plan recommendations into overall care of the patient and provides revised care plans to other physicians and healthcare professionals involved with the patient, as appropriate

3.4.3.5. Assume responsibility for follow up of pending results and/or scheduling recommended testing for diagnosis and/or medication monitoring

3.4.3.6. Reach out to HCT if issues arise post-discharge that require input from that team

4. Reviewed & Revised

Reviewed	Revised
03.31.15	05.23.16
	12.11.19
	12.18.20

UPDATE WEBSITE WITH REVISIONS

Reference CMS, Center for Medicare, Hospital Inpatient Admission Requirement updated 2017 https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R234BP.pdf

Based on the High Value Care Coordination project from the American College of Physicians (https://hvc.acponline.org/physres_care_coordination.html)