Healthcare

INBRIEF®

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Continuity of Care: Smoother Information Flow Means Fewer Errors, Lower Risk

As the variety and complexity of therapies performed by ambulatory care providers increase, the amount of information generated in each episode of care expands concomitantly. If critical results of diagnostic tests and consultations are not reported and acted upon in a timely manner, the failure to do so may result in patient injury and potential lawsuits alleging delayed diagnosis or failure to diagnose. Therefore, every type of healthcare organization should establish administrative protocols to facilitate the accurate and timely retrieval and transmittal of patient care data.

Risk exposures may be significantly reduced by focusing attention on such essential operations as appointment scheduling, information transfer, referral management, and test and specimen tracking. This edition of *inBrief*® offers a self-assessment tool designed to assess compliance with basic continuity of care protocols and determine where improvement is needed. The goal is to create a system for compiling, storing, sharing and transmitting information that underscores key data, prompts appropriate follow up and minimizes the possibility of error.

Self-assessment Tool: Continuity of Care Protocols and Practices

Areas of Risk	Present? Yes/No	Comments
Patient data, access and communication		
1. Is there a user-friendly electronic healthcare record (EHR) system for entering and managing patient data, including current status of care, advance directives and health insurance coverage, which interfaces with other health IT systems?		
2. Do staff members routinely capture the following minimum clinical data in a centralized and accessible location within the medical record:		
• symptoms of chief complaint and history of onset?		
• aggravating/relieving factors?		
• allergies?		
• current medication use?		
• pregnancy status?		
• previous medical and surgical history?		
• recent injury, illness or infection?		
• psycho-social history?		

Areas of Risk	Present? Yes/No	Comments
Patient data, access and communication (continued)		
3. Are electronic patient data readily accessible to physicians and providers (hereafter "providers"), as well as patients, in all settings of care?		
4. Does the EHR system emphasize contraindications and risk factors associated with patient conditions?		
5. Is there a policy regarding the management of routine, urgent and same-day appointments?		
6. Does the policy require that requests of an urgent nature be promptly assessed by a qualified provider?		
7. Do telephone advice protocols establish parameters for when patients should receive a follow-up call by a provider?		
8. Are patients informed at discharge of potentially problematic symptoms that require a return call to the provider for follow-up care?		
9. Is an interactive health information website or patient portal available to both patients and providers for the purpose of enhancing communication?		
10. Are electronic communication tools – including e-mail, text, patient portals and social media platforms – utilized to contact existing patients, and if applicable, prospective patients?		
11. Are policies promulgated regarding electronic communication in order to ensure the appropriate provider responds to messages in a timely manner?		
12. Are follow-up phone calls placed to all patients within 24 hours following discharge after an invasive surgical/medical/diagnostic procedure, in order to check for signs of potential complications and intervene in a timely manner, if necessary?		
13. Are all follow-up phone calls documented in the patient healthcare information record?		
Accountability		
1. Are the core responsibilities of providers, including patient monitoring, follow-up care, and communicating with patients and other providers, delineated in written policy?		
2. Are patients assigned to one primary provider over the course or episode of care, until the time of referral or discharge?		
3. Are results of diagnostic and laboratory tests that are ordered by an independent practitioner jointly interpreted with a physician, unless ordering privileges are permitted?		
4. Do written safeguards regarding coverage arrangements require providers to select a physician or other provider from within the same clinical discipline?		
5. Do covering physicians have ready access to patient healthcare information records?		
6. Are providers required to complete any pending EHR entries and/or transcription, thereby affording covering providers with up-to-date and accurate patient healthcare information?		

Areas of Risk	Present? Yes/No	Comments
Accountability (continued)		
7. When patients are referred to another provider, is a staff member assigned to coordinate contact and appointment scheduling?		
8. Does this coordinator send necessary records to facilitate a smooth transfer of care, as well as receive confirmation when patients are transferred?		
9. Are nursing and ancillary staffing levels analyzed monthly and updated, as necessary, to maintain and enhance continuity of care?		
10. Does written policy govern patient handoff practices, emphasizing the need to confirm staff responsibility for patient care, provide critical change updates, enhance continuity of care, and communicate across disciplines and professional boundaries?		
11. Does a standard reporting format support the handoff process, such as the "**SBAR**" technique (i.e., **S**ituation, **B**ackground Information, **A**ssessment Findings, **R**ecommendations) or "**I PASS** the **BATON**" (i.e., **I**ntroduction, **P**atient **A**ssessment, **S**ituation, **S**afety, **B**ackground, **A**ctions, **T**iming, **O**wnership, **N**ext)?		
Information management		
1. Is patient information contained in a single patient healthcare information record to enhance clarity and continuity?		
2. Do computerized tools, such as personal digital assistant-based medication resources and chronic care flowsheets, provide real-time access to data, while enhancing service coordination, case management and interdisciplinary communication?		
3. Are patient histories and problem lists, as well as information about visits, tests, allergies, medications and preferences, available to all providers caring for each patient?		
4. Are patients encouraged to ask questions about their care?		
5. Do providers offer complete answers to patient inquiries in a language that is understood by the patient and through an accessible medium?		
6. Are various teaching tools and methods utilized to enhance the level of patient information retention, including educational signs and posters, as well as the "teach-back" method, whereby patients repeat self-care instructions in their own words to demonstrate their understanding?		
7. Are tested computer technologies, including order-entry systems, clinical decision-support software, and referral and appointment scheduling programs, utilized to enhance efficiency and reduce errors?		

Areas of Risk	Present? Yes/No	Comments
Care management		
1. Are evidence-based diagnosis and treatment guidelines used for high risk conditions?		
2. Do the guidelines answer imperative questions, such as:		
• What types of services are appropriate and justified?		
• How many appointments/treatments/stays are authorized?		
• In what sequence should indicated diagnostic tests and procedures be performed?		
• Where and how will the patient be discharged from care?		
3. Do clinical decision support tools help providers comply with important parameters of service, including medical necessity criteria, referral indications, and access requirements for elective procedures and specialty care?		
4. Does written policy clearly define the purpose and scope of the patient problem list in all healthcare settings, focusing on these critical functions, among others:		
• Facilitating continuity of care between patient visits?		
• Recording medical conditions for treatment and reporting purposes?		
• Coordinating communication during patient transitions between settings and care providers?		
5. Is a medication reconciliation process – including patient verification of current drugs from all pharmacies – conducted at each patient encounter?		
6. Do providers comply with the requirements of the state prescription drug monitoring program?		
7. Is the medication prescription process electronic?		
8. Does the electronic prescription software include re-assessment reminders and decision-support capabilities?		
9. Are care plans or current orders available to all providers involved in patient care?		
10. Are care plans or current orders discussed with patients, using educational materials when necessary, to reinforce key messages?		
11. Are self-management programs available to help empower patients living with chronic and debilitating conditions, thereby enhancing continuity of care and shared decision-making with providers?		
12. Does a patient portal system issue preventive service notices and other clinical reminders on an ongoing basis?		
13. Does the facility issue mail, electronic or telephone compliance reminders at least three days before upcoming appointments?		

Areas of Risk	Present? Yes/No	Comments
Patient noncompliance		
1. Do patients sign a statement agreeing to comply with care recommendations and follow-up appointments, and is this statement included in the patient healthcare information record?		
2. Are written protocols established and implemented for managing high risk patient encounters, including documentation requirements for the following critical issues:		
• Repeated and unauthorized prescription refill requests?		
• Pain management in patients exhibiting drug seeking tendencies?		
• Unacceptable behavior, such as belligerent voice messages, yelling or cursing at staff?		
• After-hours patient management?		
3. When patients miss appointments, does a staff member contact them by telephone or e-mail?		
4. Is the occurrence of missed appointments documented in the progress notation of the patient healthcare information record?		
5. When making follow-up calls to patients, do providers explain the benefits of the proposed treatment course and the risks of not adhering to it?		
6. Are all attempts at contacting the patient documented in the patient healthcare information record?		
7. When deemed necessary, are patients informed in writing of basic behavioral expectations, and is a copy of the letter retained in the patient healthcare information record?		
8. Do noncompliant patients sign a refusal-to-consent form acknowledging that they have discussed the proposed course of care with their provider, and understand that failure to follow medical recommendations may have serious or even life-threatening consequences?		
9. Does organizational policy delineate the circumstances for sending noncompliant patients a registered letter, requesting a response?		
10. Does the organization have clear, legally reviewed protocols governing the termination of patient relationships, in order to avoid allegations of abandonment?		

Quick Links

- CNA *AlertBulletin*® 2018-Issue 2, "Test Result Management: Towards a Systematic Reporting Process."
- CNA *inBrief*® 2020-Issue 2, "Discharge Readiness: Sound Policies Help Reduce Outpatient Risk."
- CNA *inBrief*® Republished 2020, "Patient Non-compliance: Better Communication Means Lower Risk."
- CNA *inBrief*® Republished 2019, "Ambulatory Surgery Centers: Enhancing Continuity of Care."
- CNA *inBrief*® 2017-Issue 2, "Treatment Follow-through: Improving Patient Access and Adherence."
- CNA *Vantage Point*® Republished 2019, "Nonphysician Providers: A Guide to Safer Delegation."

Areas of Risk	Present? Yes/No	Comments
Test result tracking		
1. Are specified diagnoses or conditions that require routine screening, e.g., breast/prostate/cervical cancer, pediatric immunizations, diabetes and hypertension, tracked electronically?		
2. Is there an established list of medications that require laboratory baseline values before prescription and periodic re-assessment, once prescribed?		
3. Is there a system in place to notify staff when serial laboratory tests are to be ordered?		
4. Is there an electronic or manual system for managing pending diagnostic tests and laboratory specimens?		
5. Are specified time frames instituted for reviewing test results?		
6. Does written policy clarify the responsibilities of ordering providers, especially with respect to conveying and following up on time-critical results?		
7. Are patient healthcare information records that are awaiting test results either flagged electronically or placed in a designated area?		
8. Is a staff member assigned to check flagged records and follow up on outstanding results?		
9. Are laboratory, radiology and other diagnostic procedures ordered electronically?		
10. Does the ordering system generate reminders of pending specimen/test/imaging results?		
11. Are test results reported to the ordering provider and documented in the patient healthcare information record, including the date, time, name of caller and receiver, and test value/result?		
12. Is there a protocol for responding to critical values/findings that requires documenting the provider's review?		
13. Is there an escalation procedure for urgent or high priority test results that are not acknowledged by ordering providers within a specified time period?		
14. Are patients notified face-to-face about abnormal results, in order to protect patient confidentiality?		
15. Are all patient notifications carefully documented in the patient healthcare information record?		
16. Can providers and staff communicate directly with the laboratory/imaging facility when ordering tests, viewing results and managing alerts?		

Areas of Risk	Present? Yes/No	Comments
Patient referral and consultation		
1. Is there a procedure for identifying patients who may benefit from extended care management?		
2. Are follow-up and/or referral appointments scheduled and entered in the computer system before patients leave the facility?		
3. In the alternative, are patients offered assistance in making the initial appointment with an outside specialist or diagnostic center?		
4. Is there a written protocol for tracking referrals to other providers or care settings, which outlines the parameters for transfer of care?		
5. Is there a tracking mechanism for consultation requests to outside specialists?		
6. Do providers communicate with one another regarding referrals and consultations, conveying the following essential information:		
• Diagnoses and recent changes in condition or treatment?		
• Historical perspective on medical conditions?		
• Potential warning or danger signs?		
• Pending laboratory or diagnostic results?		
7. Are patient healthcare information records flagged for referral/consultation status, including missed or canceled appointments?		
8. Do staff members verify receipt of information, including current diagnosis and a description of procedures or treatments to date, sent to outside providers upon referral?		
9. Are both patients and families involved in the referral management process and aware of their own role in ensuring follow-up?		
Patient education		
1. Are barriers to communication assessed and documented in the patient healthcare information record, including low health literacy, cognitive impairment, hearing deficit and/or limited English fluency?		
2. Are qualified and credentialed interpreters available, when necessary, in order to avoid reliance on family members?		
3. Do patient healthcare information records reflect patient education, including their disease process, care plan goals, compliance expectations regarding treatment and testing, and potential consequences of non-compliance?		
4. Are educational sessions supplemented by documented use of explanatory materials, including printed handouts, illustrations, models and other teaching aids?		
5. Are patients informed of the reasons for and importance of additional treatment recommendations?		
6. Are providers instructed to employ the teach-back method?		
7. Do providers ask patients at the time of discharge to repeat back critical instructions, with responses noted in the patient healthcare information record?		

Areas of Risk	Present? Yes/No	Comments
Performance improvement		
1. Is facility performance evaluated according to pertinent patient outcome criteria, such as functional and clinical status, reported errors and continuity of care?		
2. Are patients surveyed regarding their level of satisfaction?		
3. Are survey findings reviewed on a regular basis?		
4. Are outcome data reported to providers, and are individual practice goals established and modified based on these data?		
5. Are referral outcome data tracked electronically and reported to leadership on a regular basis?		
6. Are key clinical and operational indicators monitored as part of the organization's quality improvement program?		
7. Are quality measures for laboratory test reporting monitored, including but not limited to:		
• Test results with the lowest follow-up rate?		
• Percentage of test results that go unreviewed by ordering providers?		
• Frequency of lab reviews that are delayed by a week or longer?		

This resource serves as a reference for healthcare organizations seeking to evaluate risk exposures associated with continuity of patient care. The content is not intended to represent a comprehensive listing of all actions needed to address the subject matter, but rather is a means of initiating internal discussion and self-examination. Your organization and risks may be different from those addressed herein, and you may wish to modify the activities and questions noted herein to suit your individual organizational practice and patient needs. The information contained herein is not intended to establish any standard of care, or address the circumstances of any specific healthcare organization. It is not intended to serve as legal advice appropriate for any particular factual situations, or to provide an acknowledgment that any given factual situation is covered under any CNA insurance policy. The material presented is not intended to constitute a binding contract. These statements do not constitute a risk management directive from CNA. No organization or individual should act upon this information without appropriate professional advice, including advice of legal counsel, given after a thorough examination of the individual situation, encompassing a review of relevant facts, laws and regulations. CNA assumes no responsibility for the consequences of the use or nonuse of this information.

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