

Transfer of Patient Health Information Across the Continuum (2003 update)

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Editor's Note: The following information supplants information contained in the June 2001 "Transfer of Patient Health Information Across the Continuum" practice brief.

Background

In order to assure continuity of patient care, healthcare providers disclose to subsequent healthcare providers the health information that is necessary to facilitate a smooth transition and efficient and effective care. Such disclosures occur verbally, when a referring physician telephones a consultant, or through the provision of documentation originated by the first provider and sent to the second.

As advances in technology provide for the automation of these information transfers, it is important that members of the health information management and information services team understand the data that must be transferred as identified in law, accreditation, or professional practice standards.

Legal and Regulatory Requirements

Federal

The Medicare Conditions of Participation for Hospitals state, "The hospital must transfer or refer patients, along with necessary medical information, to appropriate facilities, agencies or outpatient services, as needed, for follow-up or ancillary care." (42 CFR 482.43)

The Requirements for States and Long Term Care Facilities state:

- "The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution or record release is required by law." (42 CFR 483.10)
- "In cases of transfer of a resident with mental illness or mental retardation from a nursing facility to a hospital or to another nursing facility, the transferring nursing facility is responsible for ensuring that copies of the resident's most recent PASARR and resident assessment reports accompany the transferring resident." (42 CFR 483.106)

The Conditions of Participation for Home Health Agencies state:

- "All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care. The clinical record or minutes of case conferences establish that effective interchange, reporting, and coordination of patient care does occur. A written summary report for each patient is sent to the attending physician at least every 60 days." (42 CFR 484.14)
- "The home health agency must inform the attending physician of the availability of a discharge summary. The discharge summary must be sent to the attending physician upon request and must include the patient's medical and health status at discharge." (42 CFR 484.48)
- "If a patient is transferred to another health facility, a copy of the record or abstract is sent with the patient." (42 CFR 484.48)

The Conditions of Participation for Comprehensive Outpatient Rehabilitation Facilities state:

- "All patients must be referred to the facility by a physician who provides the following information to the facility before treatment is initiated:
 - the patient's significant medical history
 - current medical findings
 - diagnosis(es) and contraindications to any treatment modality
 - rehabilitation goals, if determined." (42 CFR 485.58)
- "...A physician must establish a plan of treatment before the facility initiates treatment..." (42 CFR 485.58)

The Conditions of Participation for Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services state:

- "The following are obtained by the organization before or at the time of initiation of treatment:
 - the patient's significant past history
 - current medical findings, if any
 - diagnosis(es), if established
 - physician's orders, if any
 - rehabilitation goals, if determined
 - contraindications, if any
 - the extent to which the patient is aware of the diagnosis(es) and prognosis

If appropriate, the summary of treatment furnished and results achieved during previous periods of rehabilitation services or institutionalization." (42 CFR, 485.711)

The federal government permits the disclosure of protected health information to another healthcare provider for treatment, payment, and certain healthcare operations in the privacy rule (Standards for Privacy of Individually Identifiable Health Information, [45 CFR164.506]).

State

Individual states may also have laws or regulations that require one healthcare provider to provide specific health information to another caring for a patient.

Accreditation Standards

Standard CC.5 in the Joint Commission's automated *Comprehensive Accreditation Manual for Hospitals* states, "Appropriate information related to the care and services provided is exchanged when a patient is accepted, referred, transferred, discontinued service, or discharged to receive further care or services.." The corresponding statement of intent says, "Information shared with other providers consists of relevant information, including: the reason for transfer, referral, discontinuation of services, or discharge; the patient's physical and psychosocial status; a summary of care provided and progress toward goals; and community resources or referrals provided to the patient."

The Joint Commission's automated *2002–2003 Comprehensive Accreditation Manual for Ambulatory Care*, standard CC.5, states: "Appropriate information related to the care and services provided is exchanged when a patient is accepted, referred, transferred, discontinued service, or discharged to receive further care or services." The corresponding statement of intent says: "Information shared with other providers consists of relevant information, including: the reason for transfer, referral, discontinuation of services, or discharge; the patient's physical and psychosocial status; a summary of care provided and progress toward goals; and community resources or referrals provided to the patient."

Standard CC.5 in the Joint Commission's *2002–2003 Comprehensive Accreditation Manual for Long Term Care* states, "Appropriate information related to the care and services provided is exchanged when residents are accepted, referred, transferred, discontinued service, or discharged to receive further care or services." Standard IM 7.5 states, "Discharge information is provided to the resident or to the receiving organization." The corresponding intent statement says, "The

organization provides relevant information to the resident, family, or another entity accepting the resident when the resident is transferred or discharged. The information includes:

- medical findings, diagnosis(es), and treatment orders
- a summary of the care and services provided and progress toward achieving goals
- diet orders and medication orders
- behavioral status, ambulation status, nutrition status, and rehabilitation potential
- the resident's physical and psychosocial status
- nursing information useful in resident care
- advance directives
- referrals provided to the resident
- the reason for transfer, discharge, or referral
- the physician's orders for the resident's immediate care
- instructions given to the resident before discharge
- the referring physician's name
- and the physician who has agreed to be responsible for the resident's medical care and treatment, if other than the referring physician"

In the Joint Commission's *2003 Comprehensive Accreditation Manual for Home Care*, standard CC.4.1 states, "As appropriate to the scope of care or services, the organization provides the responsible physician with information on the patient's condition, the outcome of current treatment, and the patient's response." In the corresponding intent statement, the manual also states, "There is ongoing communication between organization staff and the patient's physician as appropriate to the scope of care or services. The organization provides information on a timely basis and as required by law and regulation. The information includes the patient's current condition, changes in the patient's condition, the outcome of care and service, the patient's response to current treatment and medication, changes in caregiver support or the environment, or results of relevant laboratory tests when they become available."

In addition, standard CC.5.2 states, "Appropriate patient information is exchanged when the patient is referred, transferred or discharged." In the corresponding statement of intent, the manual states, "The organization communicates appropriate patient information to any health care organization or provider to which the patient is referred, transferred, or discharged. Relevant information includes (when appropriate):

- the reason for transfer, referral or discharge
- the patient's physical and psychosocial status at the time of transfer
- a summary of the care or services provided and progress toward goals
- continuing symptom management needs (for example, pain, nausea, dyspnea)
- instruction and referrals provided to the patient
- and the existence of any advance directives

The physician(s) who ordered care or service is notified if the patient is referred, transferred, or discharged. When required by law and regulation, written discharge summaries are provided to the patient's physician." The intent statement also says, "When a hospice patient is transferred from home care to inpatient service, or vice versa, the service transferring the patient provides a summary including: the care or services provided; specific medical, psychosocial, or other problems requiring intervention or follow-up; and any follow-up to be provided by an interdisciplinary team member from the service that is transferring the patient."

Standard CC.5 in the Joint Commission's *2003–2004 Comprehensive Accreditation Manual for Health Care Networks* states, "The network facilitates timely communication of information among components and practitioner sites to support continuity of care." The corresponding intent statement says, "Information necessary to provide continuity of care is given to any health care component or practitioner or other clinical care site to which the member is admitted, referred, or discharged." The intent statement also says, "The network provides the receiving component or practitioner site with relevant member information including: care requested; the reason for changing the site of care; a summary of care provided and progress toward achieving goals; and instructions or referrals provided to the member."

The Accreditation Association for Ambulatory Care's *Accreditation Handbook for Ambulatory Health Care 2003* states, "When necessary for ensuring continuity of care, summaries or records of a patient who was treated elsewhere (such as by another physician, hospital, ambulatory surgical service, nursing home, or consultant) are obtained. When necessary for ensuring continuity of care, summaries of the patient's records are transferred to the health care practitioner to whom the patient was transferred and, if appropriate to the organization where future care will be rendered."

Recommendations

In order to ensure continuity of care, healthcare providers should:

- identify existing federal and state requirements relative to the transfer of information between providers
- identify applicable accreditation requirements
- establish policies and procedures to facilitate appropriate provision of patient health information when referring, transferring or discharging patients
- educate staff as to policies and procedures for transferring information to other healthcare providers
- audit processes against established policies and procedures and implement corrective action when indicated

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