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ABMT-GEN-012
POLICY FOR REFERRING PHYSICIANS FOR
PATIENT DISCHARGE AND FOLLOW-UP MANAGEMENT

1 PURPOSE

- 1.1 To describe the methods used to communicate with referring physicians and other health career professionals regarding patient discharge and follow-up.

2 INTRODUCTION

- 2.1 Transplant patients undergo a complex and risky procedure at the transplant center. At the time that they are discharged to home, they continue to have ongoing complex medical issues, need to continue to avoid exposure to opportunistic infections, continue to take medications for GvHD and infection prophylaxis which require monitoring and dose adjustments and require long-term follow-up for late effects. This procedure describes the methods of communication between the transplant center and the referring physician(s) to ensure they remain an integral part of the patient's care team and to ensure they are fully informed regarding the type of care the patient will require when they return home.

3 SCOPE AND RESPONSIBILITIES

- 3.1 Physicians and advanced practice providers are responsible for ensuring patients are ready for discharge and that the ABMT Program communicates discharge plan and ensures appropriate follow up is established upon their return to their referring physician.

4 DEFINITIONS/ACRONYMS

- 4.1 GvHD – Graft vs Host Disease
4.2 TPN – Total Parental Nutrition
4.3 IVIG – Intravenous Immunoglobulin

5 MATERIALS

- 5.1 NA

6 EQUIPMENT

- 6.1 NA

7 SAFETY

- 7.1 NA

8 PROCEDURE

- 8.1 All patients remain under the care of the transplant center until their acute medical problems have resolved, they are on a stable medication regimen, they are

transfusion independent or are on a stable schedule of regular transfusions, GvHD - if present, is controlled, their nutritional needs are met on a stable regimen of oral/enteral feeding and/or TPN, their families are comfortable returning home and their local caretakers can provide the care and support that is required.

- 8.1.1 The referring physician must be able to provide access to medical care 24/7 for the patient.
- 8.1.2 Irradiated, leukocyte-depleted blood products must be available to the patient on a routine and emergent basis.
- 8.1.3 Transplant-related medications/IVIG, GvHD medications must be available or the patient must be willing to return to the transplant center on a regular basis to receive these therapies.
- 8.1.4 Drug levels (e.g. cyclosporine/tacrolimus), routine chemistries, CBC, liver and renal function tests must be available in a timely fashion.
- 8.1.5 Any ancillary therapies ongoing on a regular basis must be available in or near the patient's local community
- 8.1.6 If home care is needed, the local homecare agency will be contacted by a member of the medical team. Documentation pertaining to transplant course will be communicated appropriately.
- 8.2 Routine, uncomplicated patients undergoing autologous transplantation typically return home to the care of their referring physician between 25-40 days post transplant.
- 8.3 Routine, uncomplicated patients undergoing allogeneic transplantation from an HLA-matched sibling, without active GvHD, typically return home to the care of their referring physician between 60-100 days post transplant.
- 8.4 Routine, uncomplicated patients undergoing allogeneic transplantation from an unrelated adult or umbilical cord blood donor, without active GvHD, typically return home to the care of their referring physician between 100-120 days post transplant.
- 8.5 Patients with complications, including but not limited to, GvHD, recurrent or ongoing active infections, organ dysfunction, feeding intolerance, remain near the transplant center under their care until these problems stabilize and the criteria outlined in section 1 are met.
- 8.6 The clinical program provides appropriate instructions to patient, caregiver or legally authorized representative prior to discharge.
- 8.7 A consult between the attending physician and/or advanced practice provider will occur with receiving health care facility if a patient is discharge directly.
- 8.8 Records Management for communications with referring physicians: A series of documents and letters are provided to the referring physician(s) on a regular basis. In addition, copies of daily notes are emailed, faxed or mailed to the referring MD on a weekly basis. Referring physicians are queried to determine their preferences for communication, e.g. phone, e-mail, fax, mail, and these

preferences are recorded and honored whenever possible. Specific scheduled written communications with the referring MD are detailed below.

- 8.8.1 A New Patient Evaluation or an Interval Note outlines the results of the patient's pre-transplant work up and upcoming plan of care is faxed to the referring MD.
- 8.8.2 Daily notes are sent to the referring MD on a weekly basis during the inpatient admission and outpatient recovery period.
- 8.8.3 The Daily Note including the discharge plan is sent to the referring MD when the patient is discharged home. The BMT MD or physician extender will also contact the referring MD by phone to discuss the transplant course and plan for follow up.
- 8.8.4 The patient is re-evaluated at Duke at quarterly intervals for the first year post transplant and a minimum of yearly thereafter. Interval Notes including studies performed and plans for treatment and follow-up until the next scheduled visit are provided in the note to the referring MD. At these visits, the patient's disease status, chimerism, organ function, GvHD status, and access to medical care and follow-up are evaluated.

9 RELATED DOCUMENTS/FORMS

9.1 NA

10 REFERENCES

10.1 NA

11 REVISION HISTORY

Revision No.	Author	Description of Change(s)
05	Jennifer Frith	8.6 Added The clinical program provides appropriate instructions to patient, caregiver or legally authorized representative prior to discharge. 8.7 A consult between the attending physician and/or advanced practice provider will occur with receiving health care facility if a patient is discharge directly.

Signature Manifest

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