
TBIM had the "Pleasure" of being selected for a PCMH site visit

PCMH Processes

PCMH Education Process

(Domain 1)

Do Your Patients REALLY Know What PCMH Means?

Traverse Bay Internal Medicine is your

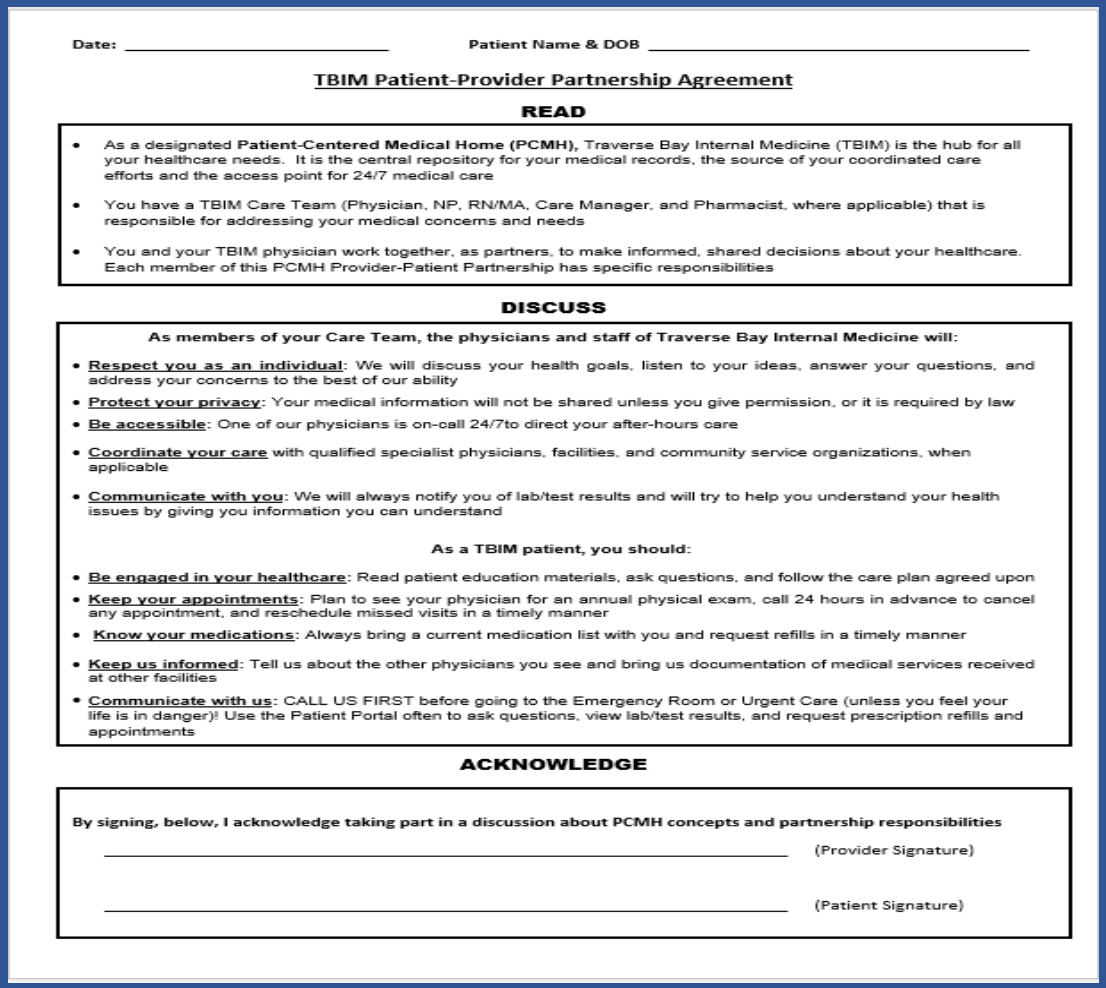
Patient-Centered Medical Home

What does this mean?

The **Patient-Centered Medical Home (PCMH)** is a model of care delivery in which:

- **YOU, the patient, and your Primary Care Physician (PCP) work together, as partners, to manage your healthcare**
  - Your PCP will always try to discuss your health issues, address your concerns, and answer your questions in a manner you can understand
  - Your PCP will always try to present treatment options that fit with your system of beliefs and level of comfort
- **Your PCP is the primary person responsible for delivering and coordinating your care**
  - Your PCP will take a proactive approach to managing your healthcare, to prevent the development, or progression, of chronic disease
  - Your PCP is the first person you should call when a medical issue arises! If an urgent situation arises after hours, call the TBIM physician on-call! He will give you medical instructions and/or direct you to the appropriate facility for care
  - Your PCP will collaborate and coordinate with other physicians (specialists and sub-specialists, including Behavioral Health specialists) to ensure that YOU receive the necessary care when and where you need it
- **Traverse Bay Internal Medicine is the central hub for all aspects of your healthcare**
  - Communication begins and ends with us; We need you to keep us in the loop, so be sure to tell us about other physicians you are seeing (even if out-of-state) and bring us records for medical services received at other locations
  - Your TBIM Care Team (PCP/NP, Nurse/MA, Pharmacist and Care Manager, if applicable) are here to address all of your medical needs and concerns. Use your portal to ask questions and send us messages
  - TBIM has a large Community Resource library! If you need assistance of any kind, talk to us; **WE CAN HELP**! (Also, see the brochures in the foyer and the binder in the waiting area)

PCMH Info Sheet



Date: _____ Patient Name & DOB _____

TBIM Patient-Provider Partnership Agreement

READ

- As a designated **Patient-Centered Medical Home (PCMH),** Traverse Bay Internal Medicine (TBIM) is the hub for all your healthcare needs. It is the central repository for your medical records, the source of your coordinated care efforts and the access point for 24/7 medical care
- You have a TBIM Care Team (Physician, NP, RN/MA, Care Manager, and Pharmacist, where applicable) that is responsible for addressing your medical concerns and needs
- You and your TBIM physician work together, as partners, to make informed, shared decisions about your healthcare. Each member of this PCMH Provider-Patient Partnership has specific responsibilities

DISCUSS

As members of your Care Team, the physicians and staff of Traverse Bay Internal Medicine will:

- **Respect you as an individual**: We will discuss your health goals, listen to your ideas, answer your questions, and address your concerns to the best of our ability
- **Protect your privacy**: Your medical information will not be shared unless you give permission, or it is required by law
- **Be accessible**: One of our physicians is on-call 24/7to direct your after-hours care
- **Coordinate your care** with qualified specialist physicians, facilities, and community service organizations, when applicable
- **Communicate with you**: We will always notify you of lab/test results and will try to help you understand your health issues by giving you information you can understand

As a TBIM patient, you should:

- **Be engaged in your healthcare**: Read patient education materials, ask questions, and follow the care plan agreed upon
- **Keep your appointments**: Plan to see your physician for an annual physical exam, call 24 hours in advance to cancel any appointment, and reschedule missed visits in a timely manner
- **Know your medications**: Always bring a current medication list with you and request refills in a timely manner
- **Keep us informed**: Tell us about the other physicians you see and bring us documentation of medical services received at other facilities
- **Communicate with us**: CALL US FIRST before going to the Emergency Room or Urgent Care (unless you feel your life is in danger)! Use the Patient Portal often to ask questions, view lab/test results, and request prescription refills and appointments

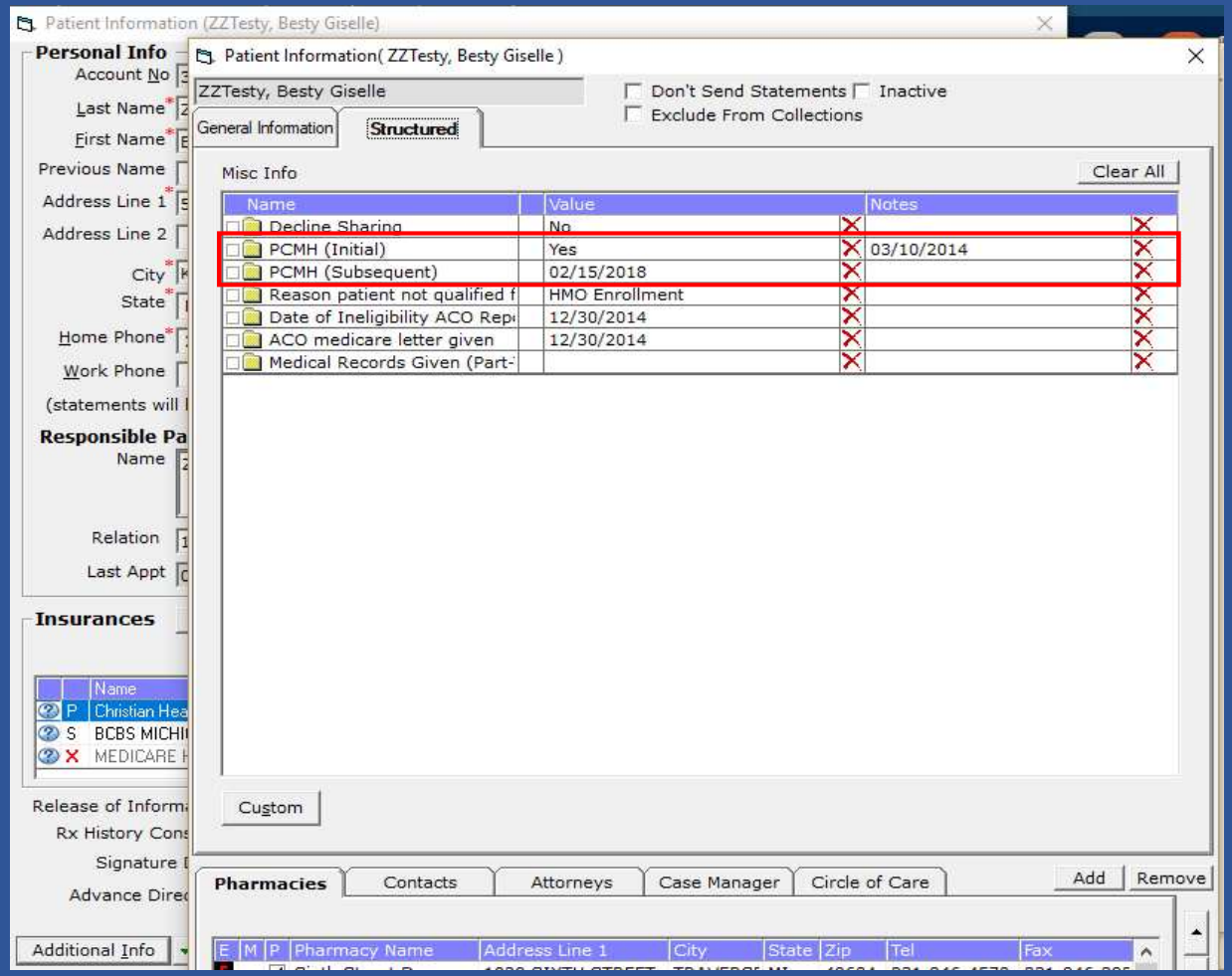
ACKNOWLEDGE

By signing, below, I acknowledge taking part in a discussion about PCMH concepts and partnership responsibilities

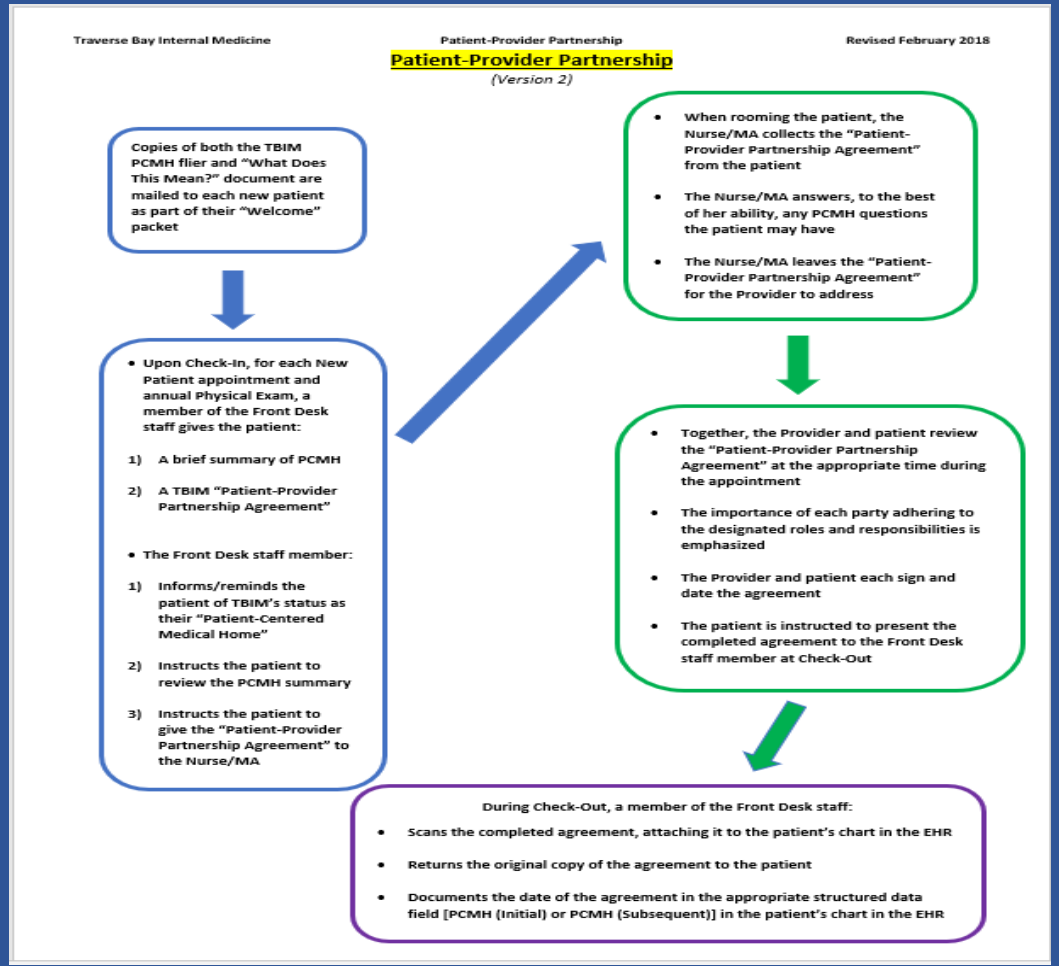
_____ (Provider Signature)

_____ (Patient Signature)

PCMH Contract



Contract date is entered into a structured data field for tracking purposes



Traverse Bay Internal Medicine | Patient-Provider Partnership | Revised February 2018

Patient-Provider Partnership

(Version 2)

Copies of both the TBIM PCMH flier and "What Does This Mean?" document are mailed to each new patient as part of their "Welcome" packet

- Upon Check-In, for each New Patient appointment and annual Physical Exam, a member of the Front Desk staff gives the patient:

1) A brief summary of PCMH
2) A TBIM "Patient-Provider Partnership Agreement"

- The Front Desk staff member:

1) Informs/reminds the patient of TBIM's status as their "Patient-Centered Medical Home"
2) Instructs the patient to review the PCMH summary
3) Instructs the patient to give the "Patient-Provider Partnership Agreement" to the Nurse/MA

- When rooming the patient, the Nurse/MA collects the "Patient-Provider Partnership Agreement" from the patient
- The Nurse/MA answers, to the best of her ability, any PCMH questions the patient may have
- The Nurse/MA leaves the "Patient-Provider Partnership Agreement" for the Provider to address

- Together, the Provider and patient review the "Patient-Provider Partnership Agreement" at the appropriate time during the appointment
- The importance of each party adhering to the designated roles and responsibilities is emphasized
- The Provider and patient each sign and date the agreement
- The patient is instructed to present the completed agreement to the Front Desk staff member at Check-Out

During Check-Out, a member of the Front Desk staff:

- Scans the completed agreement, attaching it to the patient's chart in the EHR
- Returns the original copy of the agreement to the patient
- Documents the date of the agreement in the appropriate structured data field [PCMH (Initial) or PCMH (Subsequent)] in the patient's chart in the EHR

PCMH Education Process

Planned Patient Visits

(Domain 4)

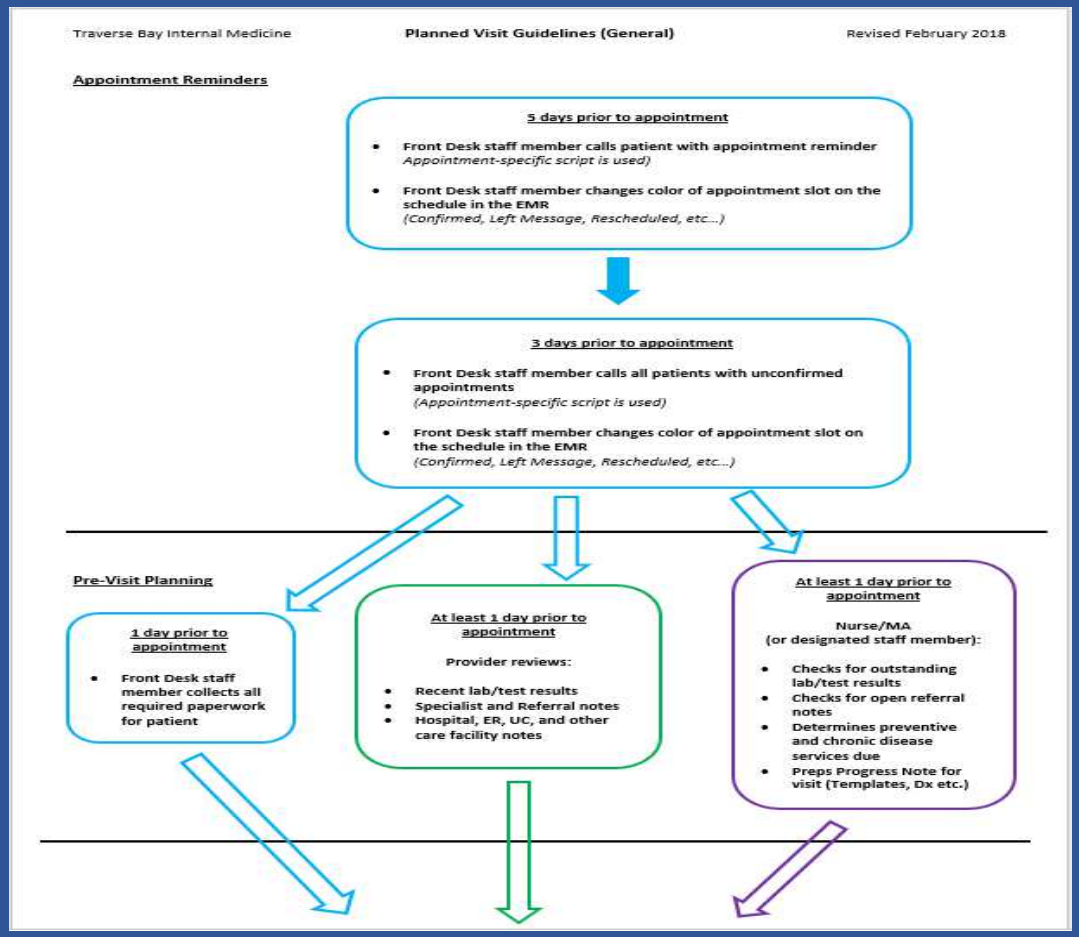
What do different visits look like?

FIRST

Designed a schematic of a generic patient visit

Stages of a Generic Office Visit

1. Appointment Reminder
2. Patient Check-In
3. Patient Appointment: Rooming and Interview
4. Patient Appointment: Provider Exam
5. Patient Check-Out
6. Post-Appointment



Traverse Bay Internal Medicine — Planned Visit Guidelines (General) — Revised February 2018

Appointment Reminders

5 days prior to appointment

- Front Desk staff member calls patient with appointment reminder
  Appointment-specific script is used)
- Front Desk staff member changes color of appointment slot on the schedule in the EMR
  (Confirmed, Left Message, Rescheduled, etc…)

3 days prior to appointment

- Front Desk staff member calls all patients with unconfirmed appointments
  (Appointment-specific script is used)
- Front Desk staff member changes color of appointment slot on the schedule in the EMR
  (Confirmed, Left Message, Rescheduled, etc…)

Pre-Visit Planning

1 day prior to appointment

- Front Desk staff member collects all required paperwork for patient

At least 1 day prior to appointment

Provider reviews:

- Recent lab/test results
- Specialist and Referral notes
- Hospital, ER, UC, and other care facility notes

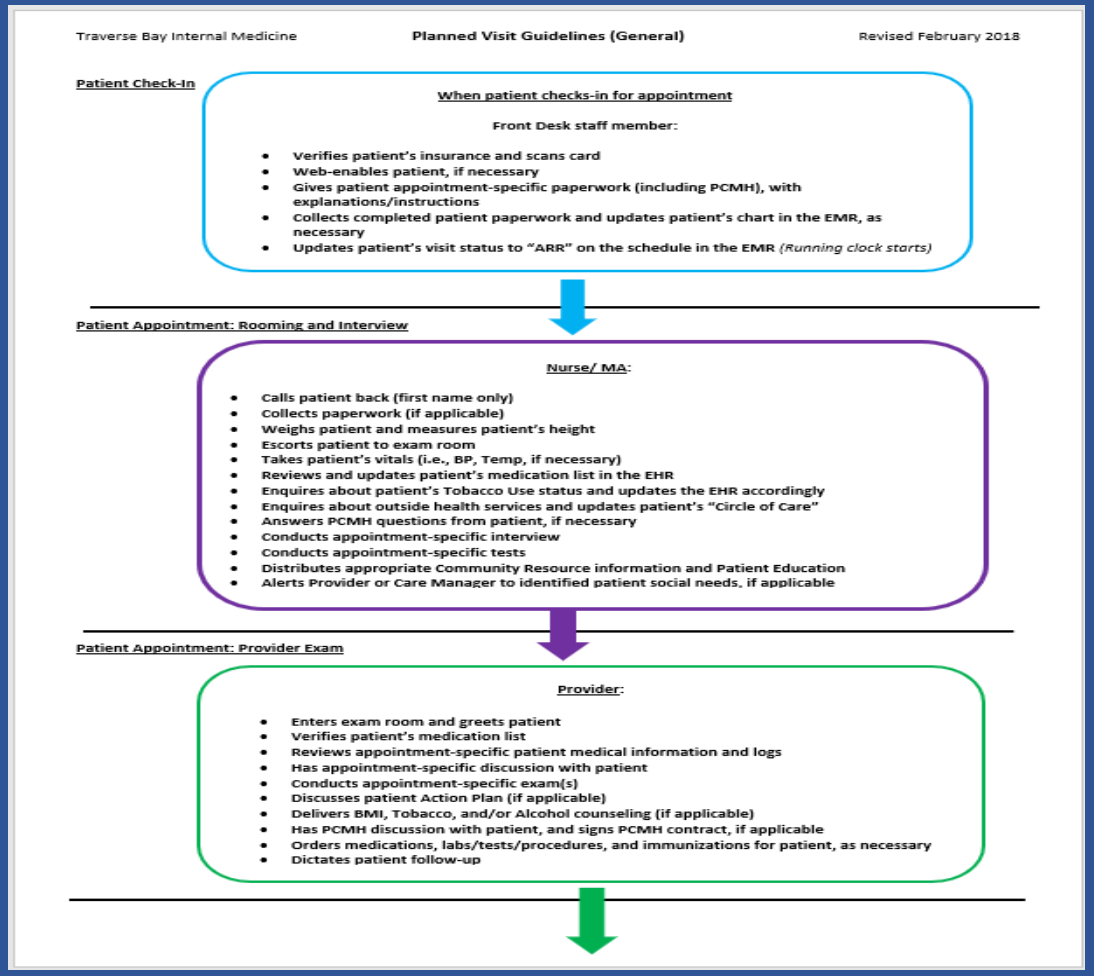
At least 1 day prior to appointment

Nurse/MA
(or designated staff member):

- Checks for outstanding lab/test results
- Checks for open referral notes
- Determines preventive and chronic disease services due
- Preps Progress Note for visit (Templates, Dx etc.)

General Schematic

(Page 1)



Traverse Bay Internal Medicine **Planned Visit Guidelines (General)** Revised February 2018

Patient Check-In

When patient checks-in for appointment

Front Desk staff member:

- Verifies patient's insurance and scans card
- Web-enables patient, if necessary
- Gives patient appointment-specific paperwork (including PCMH), with explanations/instructions
- Collects completed patient paperwork and updates patient's chart in the EMR, as necessary
- Updates patient's visit status to "ARR" on the schedule in the EMR *(Running clock starts)*

Patient Appointment: Rooming and Interview

Nurse/ MA:

- Calls patient back (first name only)
- Collects paperwork (if applicable)
- Weighs patient and measures patient's height
- Escorts patient to exam room
- Takes patient's vitals (i.e., BP, Temp, if necessary)
- Reviews and updates patient's medication list in the EHR
- Enquires about patient's Tobacco Use status and updates the EHR accordingly
- Enquires about outside health services and updates patient's "Circle of Care"
- Answers PCMH questions from patient, if necessary
- Conducts appointment-specific interview
- Conducts appointment-specific tests
- Distributes appropriate Community Resource information and Patient Education
- Alerts Provider or Care Manager to identified patient social needs, if applicable

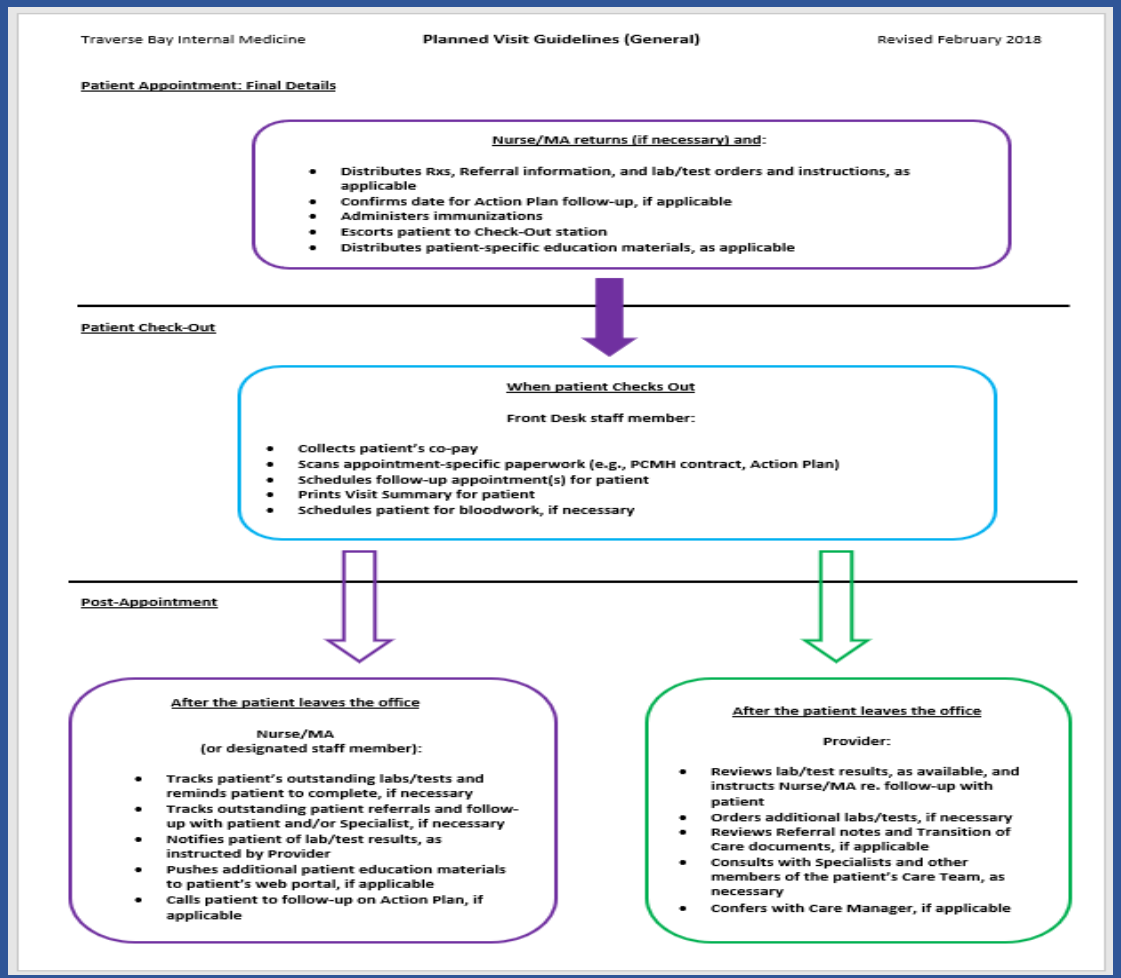
Patient Appointment: Provider Exam

Provider:

- Enters exam room and greets patient
- Verifies patient's medication list
- Reviews appointment-specific patient medical information and logs
- Has appointment-specific discussion with patient
- Conducts appointment-specific exam(s)
- Discusses patient Action Plan (if applicable)
- Delivers BMI, Tobacco, and/or Alcohol counseling (if applicable)
- Has PCMH discussion with patient, and signs PCMH contract, if applicable
- Orders medications, labs/tests/procedures, and immunizations for patient, as necessary
- Dictates patient follow-up

General Schematic

(Page 2)



Traverse Bay Internal Medicine | **Planned Visit Guidelines (General)** | Revised February 2018

Patient Appointment: Final Details

Nurse/MA returns (if necessary) and:

- Distributes Rxs, Referral information, and lab/test orders and instructions, as applicable
- Confirms date for Action Plan follow-up, if applicable
- Administers immunizations
- Escorts patient to Check-Out station
- Distributes patient-specific education materials, as applicable

Patient Check-Out

When patient Checks Out

Front Desk staff member:

- Collects patient's co-pay
- Scans appointment-specific paperwork (e.g., PCMH contract, Action Plan)
- Schedules follow-up appointment(s) for patient
- Prints Visit Summary for patient
- Schedules patient for bloodwork, if necessary

Post-Appointment

After the patient leaves the office

Nurse/MA
(or designated staff member):

- Tracks patient's outstanding labs/tests and reminds patient to complete, if necessary
- Tracks outstanding patient referrals and follow-up with patient and/or Specialist, if necessary
- Notifies patient of lab/test results, as instructed by Provider
- Pushes additional patient education materials to patient's web portal, if applicable
- Calls patient to follow-up on Action Plan, if applicable

After the patient leaves the office

Provider:

- Reviews lab/test results, as available, and instructs Nurse/MA re. follow-up with patient
- Orders additional labs/tests, if necessary
- Reviews Referral notes and Transition of Care documents, if applicable
- Consults with Specialists and other members of the patient's Care Team, as necessary
- Confers with Care Manager, if applicable

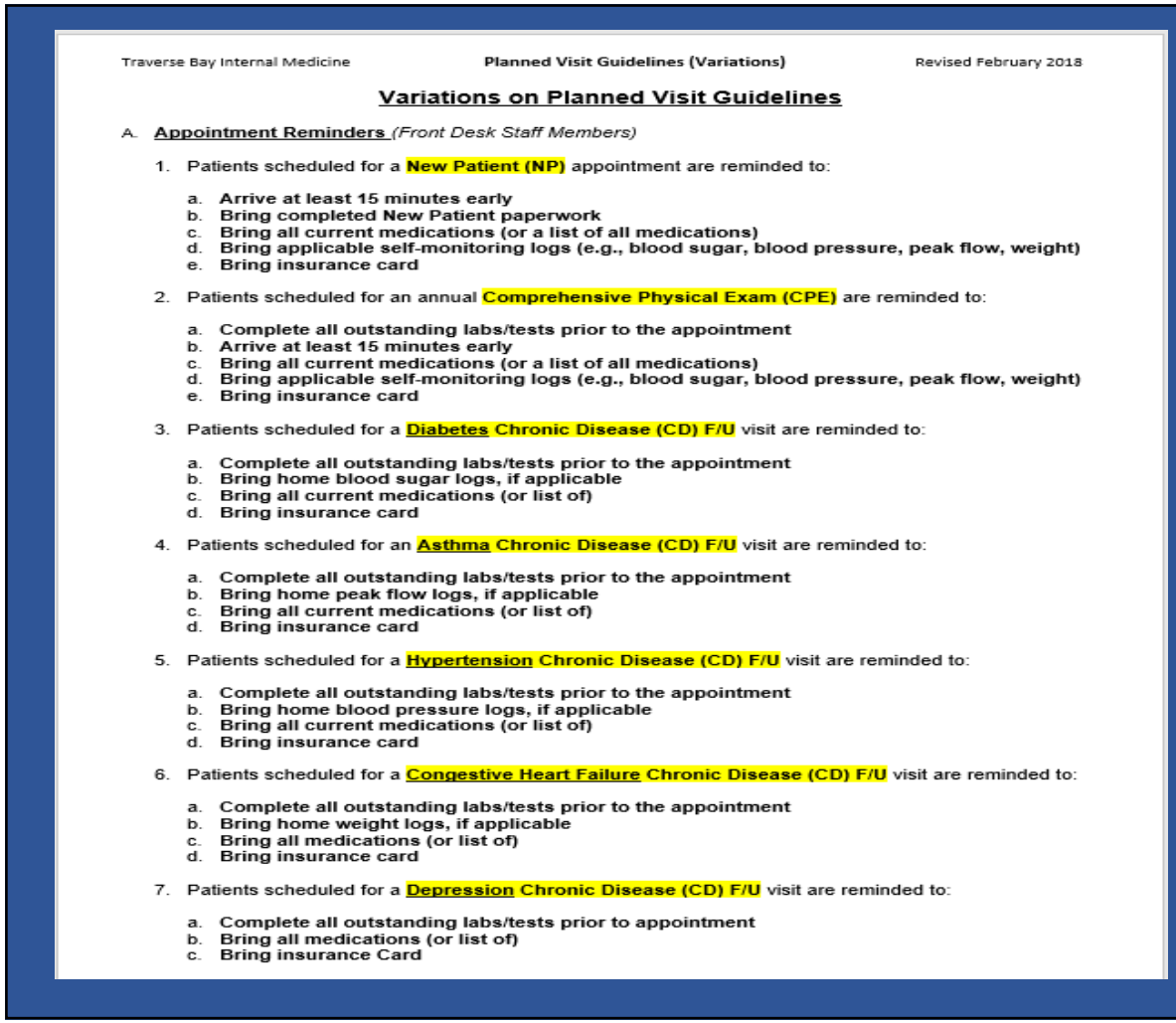
General Schematic

(Page 3)

SECOND

Generated a separate document listing stage-specific variations for each of the following appointment types:

1. New Patient (NP) Appointment
2. Comprehensive Physical Exam (CPE)
3. Diabetes Chronic Disease (CD) F/U
4. Asthma Chronic Disease (CD) F/U
5. Hypertension Chronic Disease (CD) F/U
6. Congestive Heart Failure Chronic Disease (CD) F/U
7. Depression Chronic Disease (CD) F/U
8. Annual Wellness Visit (AWV)
9. Care Management (CM) Appointment
10. Pharmacist Appointment
11. "Return to Area" Appointment
12. "Exit From Area" Appointment



Traverse Bay Internal Medicine | Planned Visit Guidelines (Variations) | Revised February 2018

Variations on Planned Visit Guidelines

A. **Appointment Reminders** *(Front Desk Staff Members)*

1. Patients scheduled for a **New Patient (NP)** appointment are reminded to:
   a. **Arrive at least 15 minutes early**
   b. **Bring completed New Patient paperwork**
   c. **Bring all current medications (or a list of all medications)**
   d. **Bring applicable self-monitoring logs (e.g., blood sugar, blood pressure, peak flow, weight)**
   e. **Bring insurance card**

2. Patients scheduled for an annual **Comprehensive Physical Exam (CPE)** are reminded to:
   a. **Complete all outstanding labs/tests prior to the appointment**
   b. **Arrive at least 15 minutes early**
   c. **Bring all current medications (or a list of all medications)**
   d. **Bring applicable self-monitoring logs (e.g., blood sugar, blood pressure, peak flow, weight)**
   e. **Bring insurance card**

3. Patients scheduled for a **Diabetes Chronic Disease (CD) F/U** visit are reminded to:
   a. **Complete all outstanding labs/tests prior to the appointment**
   b. **Bring home blood sugar logs, if applicable**
   c. **Bring all current medications (or list of)**
   d. **Bring insurance card**

4. Patients scheduled for an **Asthma Chronic Disease (CD) F/U** visit are reminded to:
   a. **Complete all outstanding labs/tests prior to the appointment**
   b. **Bring home peak flow logs, if applicable**
   c. **Bring all current medications (or list of)**
   d. **Bring insurance card**

5. Patients scheduled for a **Hypertension Chronic Disease (CD) F/U** visit are reminded to:
   a. **Complete all outstanding labs/tests prior to the appointment**
   b. **Bring home blood pressure logs, if applicable**
   c. **Bring all current medications (or list of)**
   d. **Bring insurance card**

6. Patients scheduled for a **Congestive Heart Failure Chronic Disease (CD) F/U** visit are reminded to:
   a. **Complete all outstanding labs/tests prior to the appointment**
   b. **Bring home weight logs, if applicable**
   c. **Bring all medications (or list of)**
   d. **Bring insurance card**

7. Patients scheduled for a **Depression Chronic Disease (CD) F/U** visit are reminded to:
   a. **Complete all outstanding labs/tests prior to appointment**
   b. **Bring all medications (or list of)**
   c. **Bring insurance Card**

Variations

C. Patient Appointment: Rooming and Interview

1. New Patient (NP) appointments

   a. Nurse/MA enters the following information, from the New Patient paperwork, into the patient's chart in the EHR
      1) Medical History (including Gynecologic and Surgical histories)
      2) Social History (including Alcohol and Tobacco use)
      3) Sexual History
      4) Family History
      5) Immunizations
      6) Allergies/Intolerances

   b. Nurse/MA scans the ROS bubble sheet into the Progress Note for the visit and alerts the Provider to any positive responses
   c. Nurse/MA collects any self-monitoring logs the patient has brought
   d. Nurse/MA answers the patient's PCMH questions (to the best of her ability)
   e. Nurse/MA administers a PHQ-9 Depression Screen

   f. If the patient is 65+ years of age, the Nurse/MA documents a Fall Risk Assessment
   g. The Nurse/MA scans the patient's Social Needs bubble sheet into the Progress Note for the visit

      1) If a need is indicated, the Nurse/MA alerts the Provider and Care Manager
      2) The Nurse/MA distributes Community Resource information to the patient, as applicable

   h. Nurse/MA discusses Action Plan with patient
   i. Nurse/MA initiates Advance Care Plan discussion with patient

2. Comprehensive Physical Exam (CPE)

   a. Nurse/MA updates the following information in the patient's chart in the EHR:

      1) Medical History (including Gynecologic and Surgical histories)
      2) Social History (including Alcohol and Tobacco use)
      3) Sexual History
      4) Family History
      5) Immunizations
      6) Allergies/Intolerances

   b. Nurse/MA scans the ROS bubble sheet into the patient's chart in the EHR and alerts the Provider to any positive responses

3. Diabetes Chronic Disease (CD) F/U

   a. Nurse/MA collects blood sugar logs from patient, if applicable
   b. Nurse/MA gives patient a Retinal Eye Exam reporting form, if necessary
   c. Nurse/MA offers, and assists with, patient Action Plan (if applicable) or follows-up on existing Action Plan

4. Asthma Chronic Disease (CD) F/U

   a. Nurse/MA collects peak flow logs from patient if applicable
   b. Nurse/MA administers an Asthma Control Test to the patient
   c. Nurse/MA offers, and assists with, patient Action Plan (if applicable) or follows-up on existing Action Plan
   d. Nurse readies Asthma Action Plan (Stoplight version) for Provider, if applicable

5. Hypertension Chronic Disease F/U

   a. Nurse/MA collects blood pressure logs from patient, if applicable
   b. If patient brought in a home blood pressure cuff, Nurse/MA calibrates cuff

   c. Nurse/MA offers, and assists with, patient Action Plan (if applicable) or follows-up on existing Action Plan

6. Congestive Heart Failure Chronic Disease F/U

   a. Nurse/MA collects weight logs, if applicable
   b. Nurse/MA offers, and assists with, patient Action Plan (if applicable) or follows-up on existing Action Plan

7. Depression Chronic Disease F/U

   a. Nurse/MA administers PHQ-9 Depression Screen
   b. If PHQ-9 score is > 9, Nurse/MA sets Action for herself for administration of a follow-up Depression screen (at 12 months +/- 30 days later)
   c. Nurse/MA offers, and assists with, patient Action Plan (if applicable) or follows-up on existing Action Plan

8. Annual Wellness Visit (AWV)

   a. Nurse (RN) collects AWV paperwork from patient
   b. Nurse (RN) scans Social Needs bubble sheet into Progress Note

D. **Patient Appointment: Provider Exam**

1. **New Patient (NP) appointments**

   a. Provider = MD, DO or NP
   b. Provider reviews patient's medical and family Hx, noting medical risk factors
   c. Provider conducts complete physical exam
   d. Provider has PCMH discussion with patient
   e. Provider and patient sign PCMH contract
   f. Provider reviews any self-monitoring logs the patient has brought
   g. If patient is a diabetic, Provider conducts diabetic foot exam
   h. If patient is an asthmatic, Provider discusses a plan of action with the patient
   i. If patient had a positive Depression screen, Provider may re-screen the patient
   j. Provider continues Advance Care Planning discussion with patient, if applicable

2. **Comprehensive Physical Exams (CPEs)**

   a. Provider = MD, DO or NP
   b. Provider conducts complete physical exam
   c. Provider has PCMH discussion with patient
   d. Provider and patient sign PCMH contract
   e. Provider reviews any self-monitoring logs the patient has brought
   f. If patient is a diabetic, Provider conducts a diabetic foot exam
   g. If patient is an asthmatic, Provider discusses a plan of action with the patient
   h. If patient had a positive Depression screen, Provider may re-screen the patient
   i. Provider continues Advance Care Planning discussion with patient, if applicable

3. **Diabetes Chronic Disease (CD) F/U**

   a. Provider = MD, DO or NP
   b. Provider reviews patient's blood sugar logs, if applicable
   c. Provider discusses diabetic lab results with patient

   d. Provider conducts limited physical exam, including a diabetic foot exam
   e. Provider reviews Retinal Eye Exam results with patient (or instructs patient to schedule eye exam)
   f. Provider tweaks patient's diabetic medication regimen, if necessary
   g. Provider and patient discuss options for diabetic diets, education, and self-management

4. **Asthma Chronic Disease (CD) F/U**

   a. Provider = MD, DO or NP
   b. Provider reviews patient's peak flow logs, if applicable

E. **Patient Check-Out**

1. **New Patient (NP) appointments**

   a. Front Desk staff member scans the signed PCMH contract and returns the original to the patient
   b. Front Desk staff member scans the patient's self-management Action Plan, if applicable, and returns the original to the patient
   c. Front Desk staff member web-enables patient, if necessary

2. **Comprehensive Physical Exams (CPEs)**

   a. Front Desk staff member scans the signed PCMH contract and returns the original to the patient
   b. Front Desk staff member scans the patient's self-management Action Plan, if applicable, and returns the original to the patient

3. **Diabetes Chronic Disease (CD) F/U**

   Front Desk staff member scans the patient's self-management Action Plan, if applicable, and returns the original to the patient

4. **Asthma Chronic Disease (CD) F/U**

   Front Desk staff member scans the patient's self-management Action Plan, if applicable, and returns the original to the patient

5. **Hypertension Chronic Disease (CD) F/U**

   Front Desk staff member scans the patient's self-management Action Plan, if applicable, and returns the original to the patient

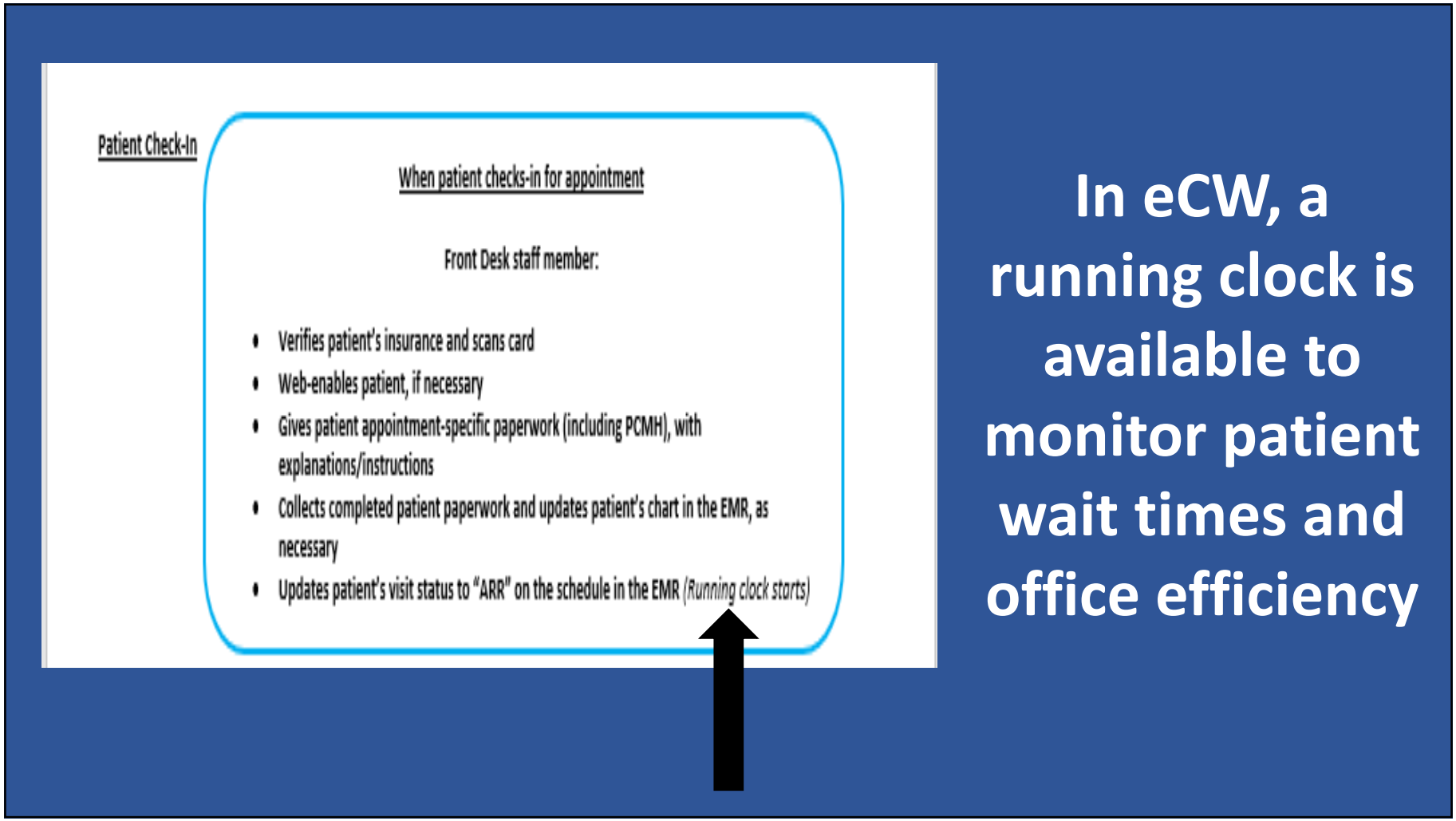
6. **Congestive Heart Failure Chronic Disease (CD) F/U**

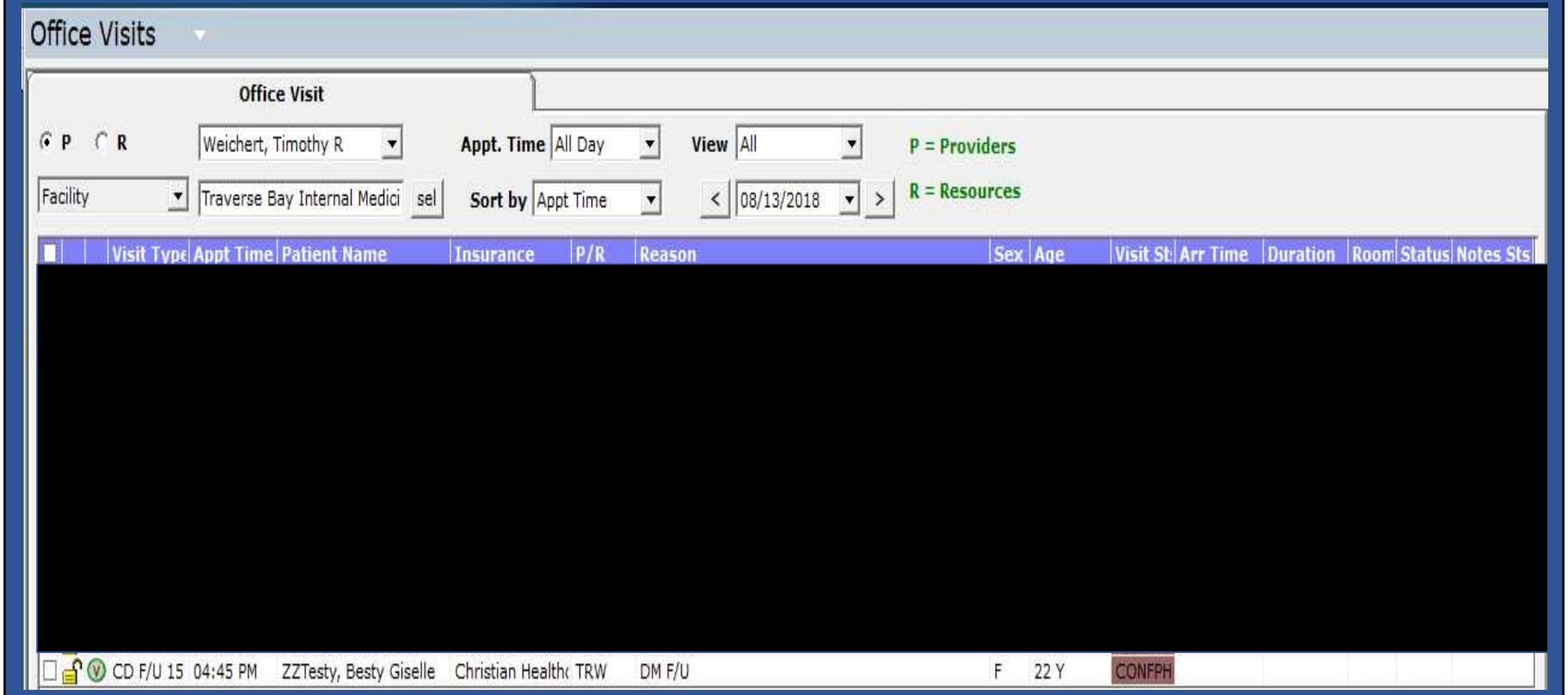
   Front Desk staff member scans the patient's self-management Action Plan, if applicable, and returns the original to the patient

7. **Depression Chronic Disease (CD) F/U**

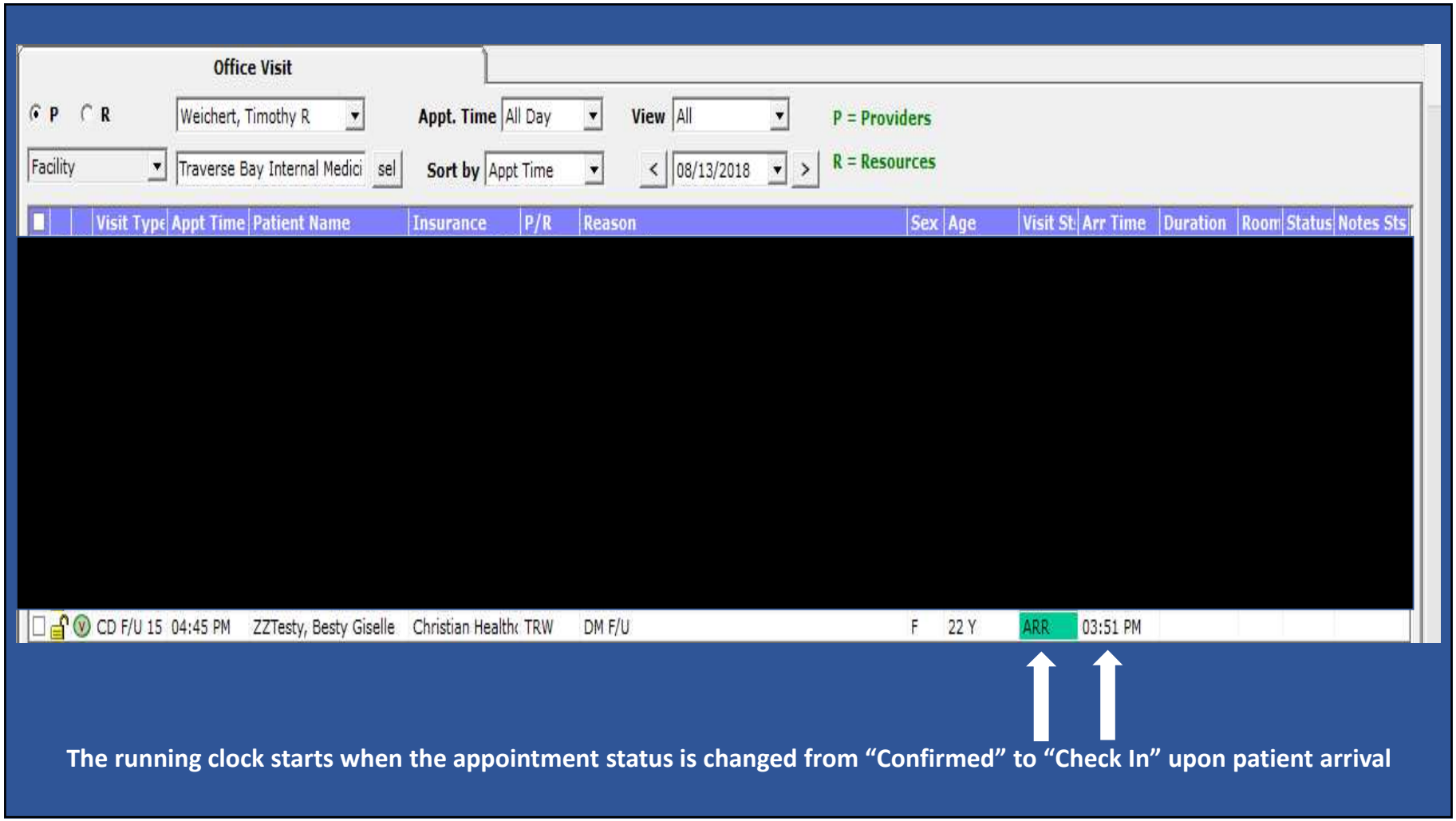
   Front Desk staff member scans the patient's self-management Action Plan, if applicable, and returns the original to the patient

The Running Clock

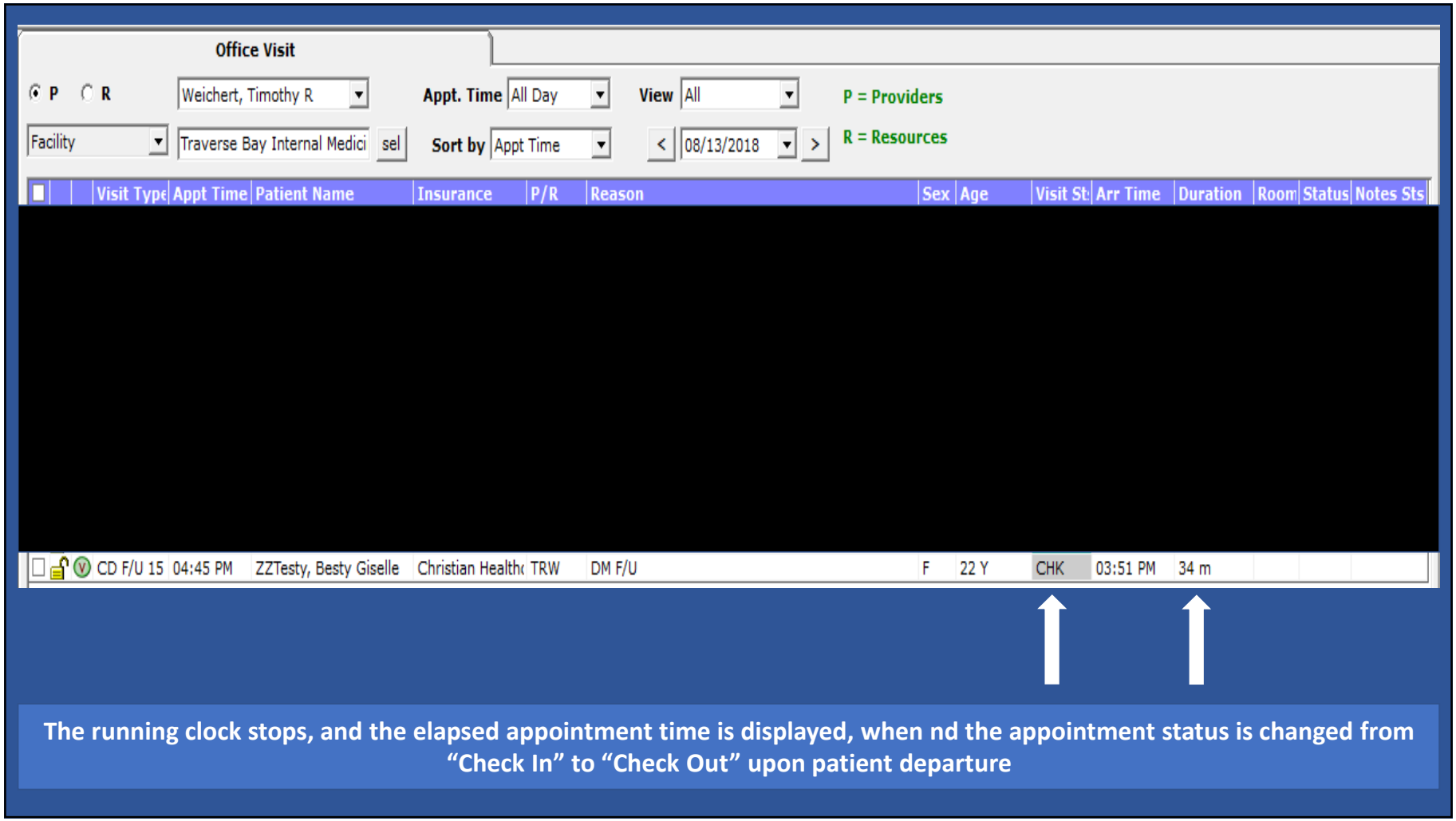

Patient Check-In
When patient checks-in for appointment
Front Desk staff member:
Verifies patient's insurance and scans card
Web-enables patient, if necessary
Gives patient appointment-specific paperwork (including PCMH), with explanations/instructions
Collects completed patient paperwork and updates patient's chart in the EMR, as necessary
Updates patient's visit status to "ARR" on the schedule in the EMR (Running clock starts)
In eCW, a running clock is available to monitor patient wait times and office efficiency



In eCW, click on the S Jellybean to get a list of patients scheduled for the day
Here, the patient has confirmed her appointment but has not yet arrived and checked in



The running clock starts when the appointment status is changed from "Confirmed" to "Check In" upon patient arrival



The running clock stops, and the elapsed appointment time is displayed, when nd the appointment status is changed from "Check In" to "Check Out" upon patient departure

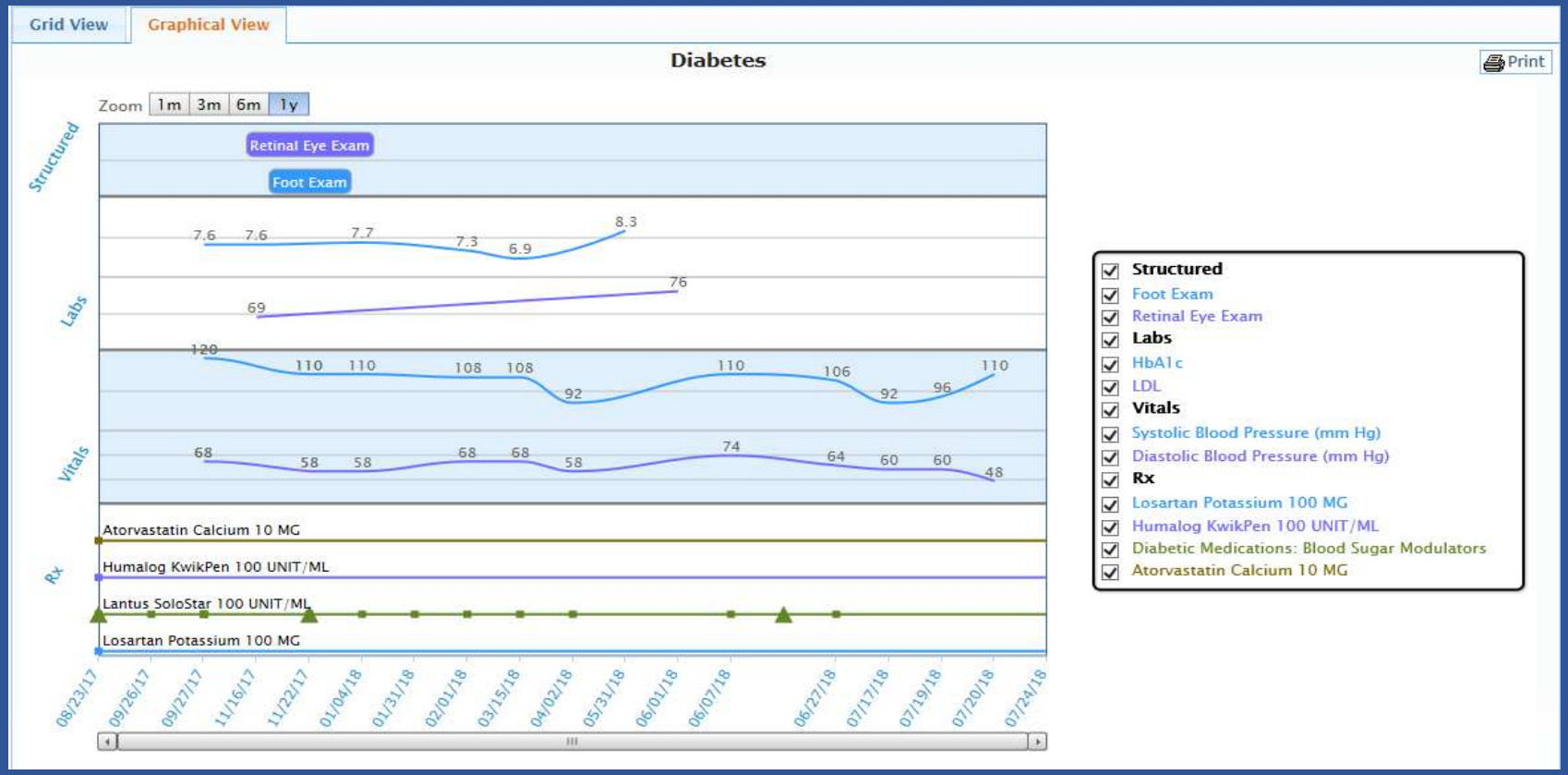
Evidence-Based Care and Gaps-in-Care at the Point of Care

(Domain 4)

How are Providers alerted to needed health services during a patient appointment?

The following data is available to, and used by, all members of a patient's Clinical Care Team at the point of care:

1. **Current MQIC Binder**
2. **Flow Sheets**
3. **Health Maintenance Data**
4. **CDSS Alerts**
5. **Patient-Specific Alerts**

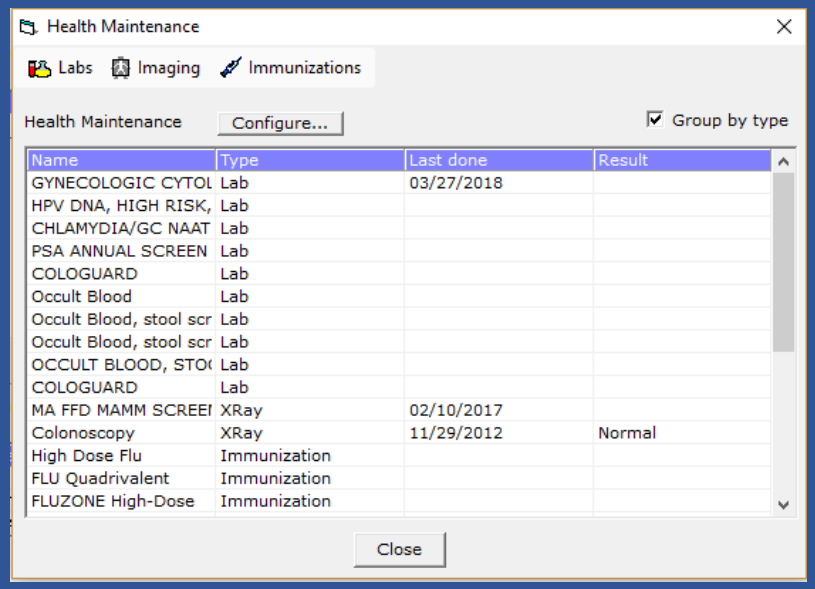


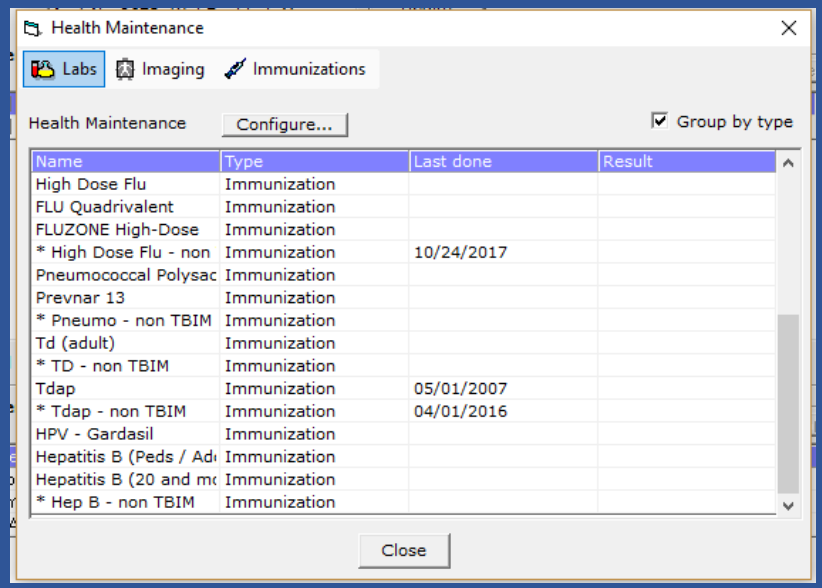
Diabetes Flow Sheet
(EMR > Flowsheet Manager)

Flowsheets have been configured for:

1. Asthma
2. CAD
3. Depression
4. Diabetes
5. Hypertension

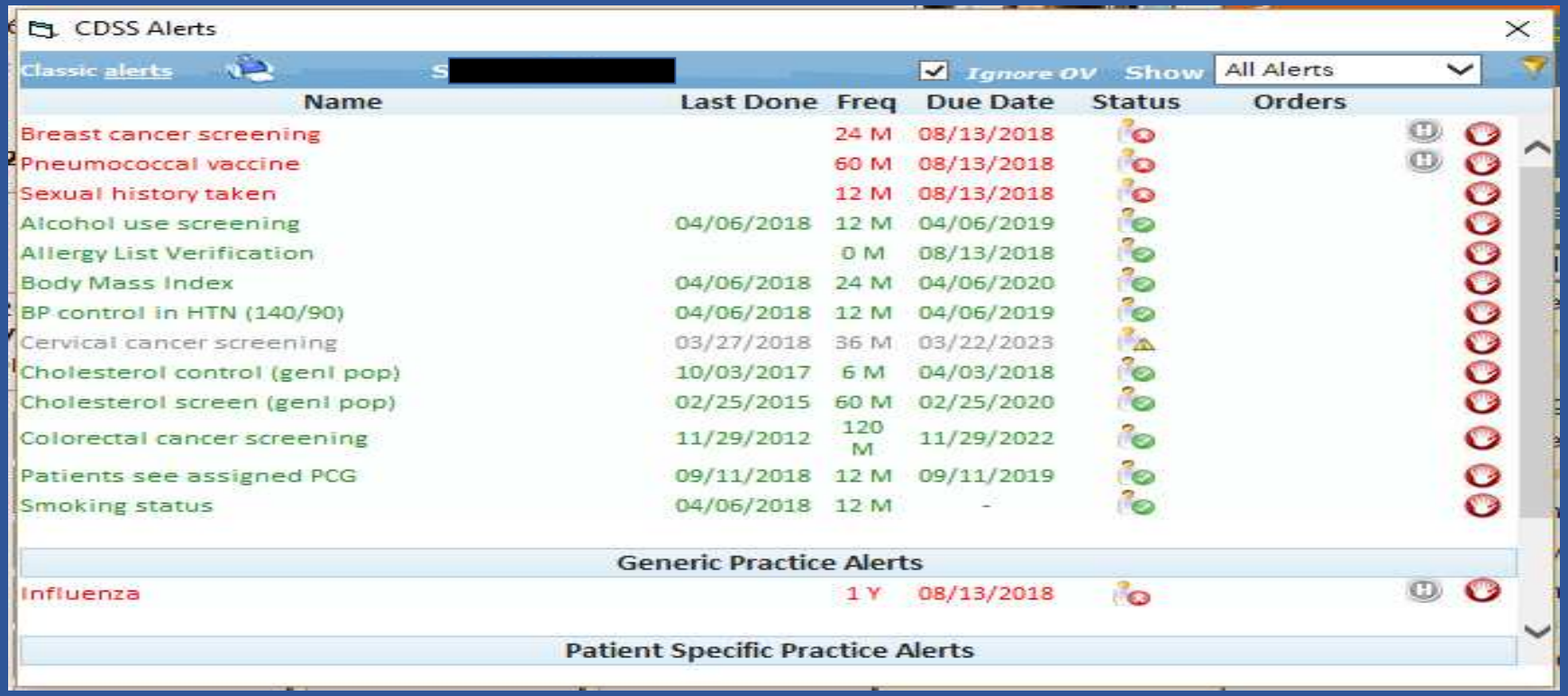
Health Maintenance Data





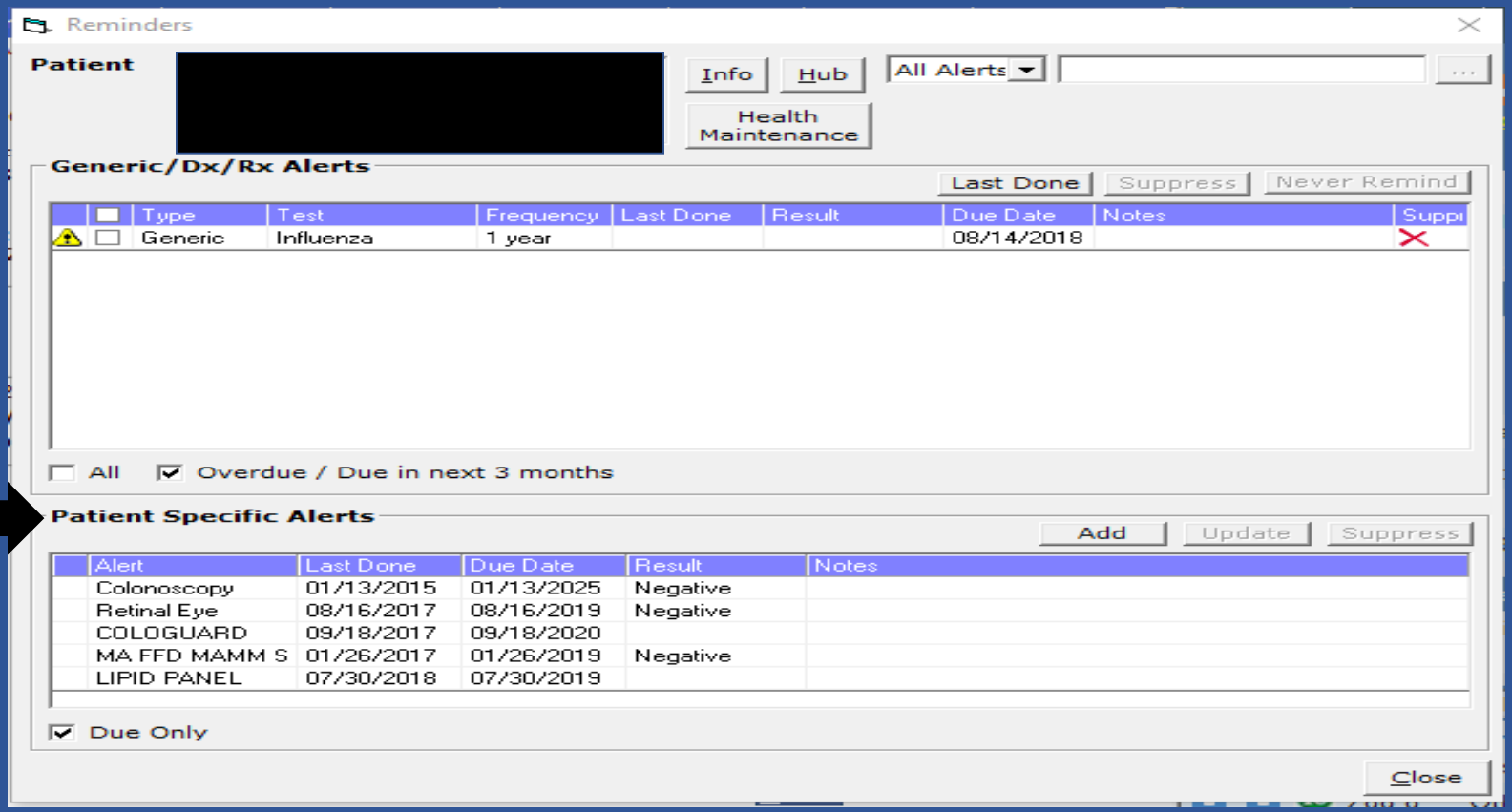
From within patient's chart:
Alerts > Health Maintenance

CDSS Alerts


CDSS Alerts
Classic alerts
Ignore OV
Show
All Alerts
Name
Last Done
Freq
Due Date
Status
Orders
Breast cancer screening 24 M 08/13/2018
Pneumococcal vaccine 60 M 08/13/2018
Sexual history taken 12 M 08/13/2018
Alcohol use screening 04/06/2018 12 M 04/06/2019
Allergy List Verification 0 M 08/13/2018
Body Mass Index 04/06/2018 24 M 04/06/2020
BP control in HTN (140/90) 04/06/2018 12 M 04/06/2019
Cervical cancer screening 03/27/2018 36 M 03/22/2023
Cholesterol control (genl pop) 10/03/2017 6 M 04/03/2018
Cholesterol screen (genl pop) 02/25/2015 60 M 02/25/2020
Colorectal cancer screening 11/29/2012 120 M 11/29/2022
Patients see assigned PCG 09/11/2018 12 M 09/11/2019
Smoking status 04/06/2018 12 M -
Generic Practice Alerts
Influenza 1 Y 08/13/2018
Patient Specific Practice Alerts

Patient-Specific Alerts

(Patient Hub > Alerts)



Patient-Specific Alerts are displayed in the right-hand chart panel (CDSS tab)

After-Hours Care

(Domain 5)

How do you direct patient care after hours?

After-Hours Business Card (Side 1)

Traverse Bay
Internal Medicine

After-Hours
Contact Information

After-Hours Business Card (Side 2)

If you feel your life is in danger:

Call 911 or go to the nearest Emergency Room

For all other medical questions and concerns:

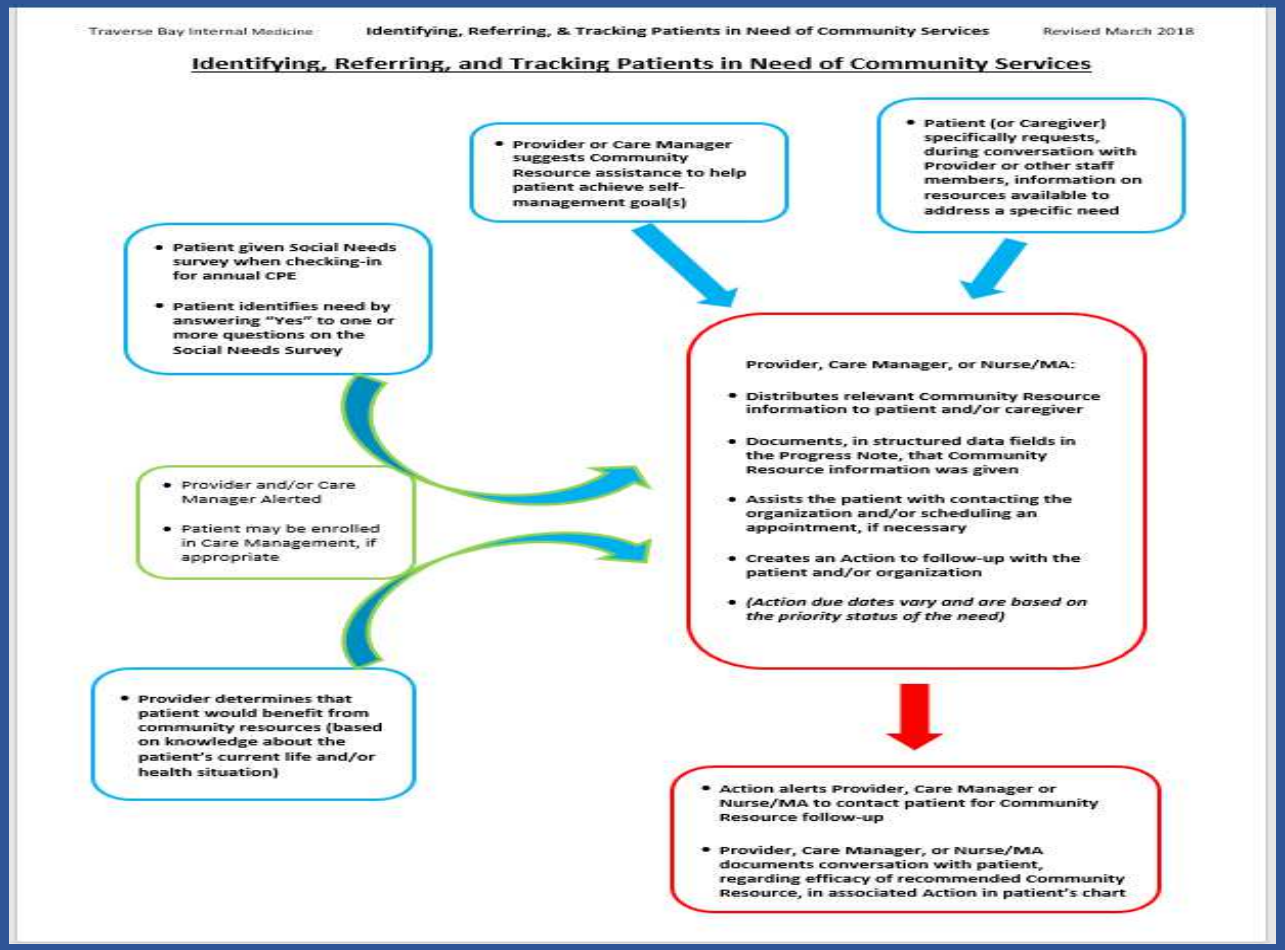
Dial (231)935-5000 and ask the operator to page the TBIM physician on call

Community Resource Use

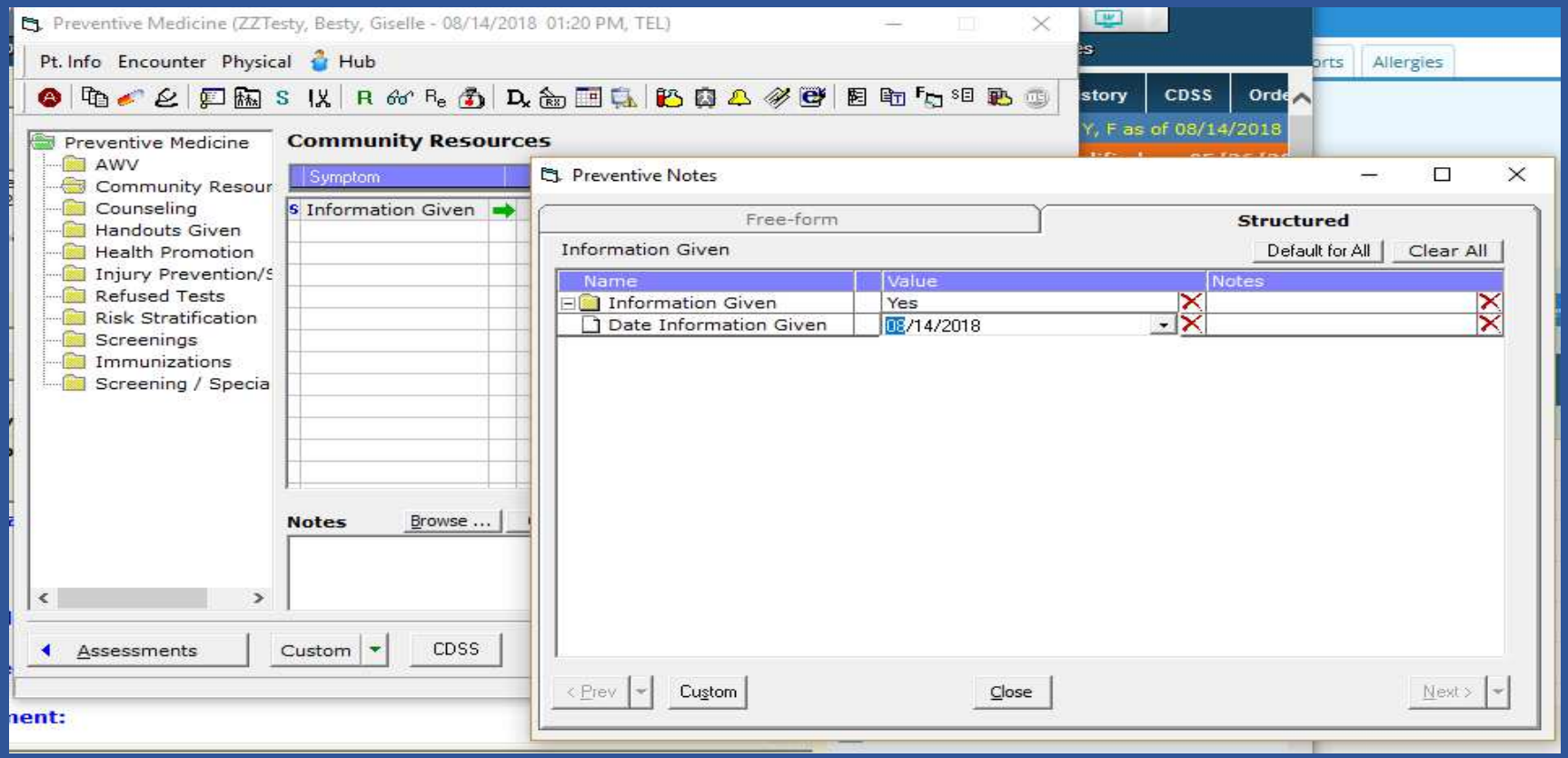
(Domain 10)

How do you follow-up on Community Resource referrals?

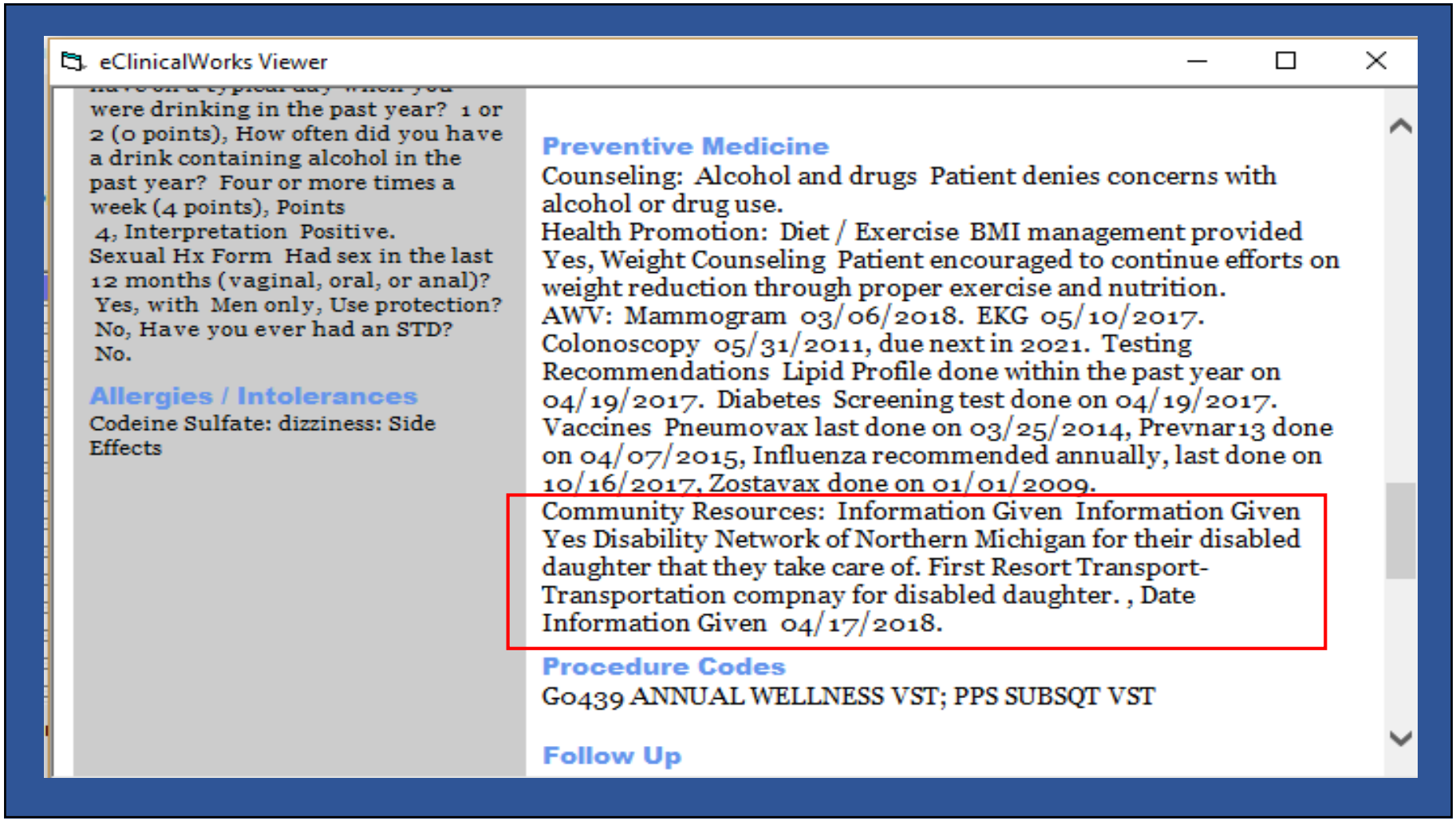
"Most dinosaurs were vegetarians and they never smoked tobacco or drank alcohol — and where are *they* now?!"

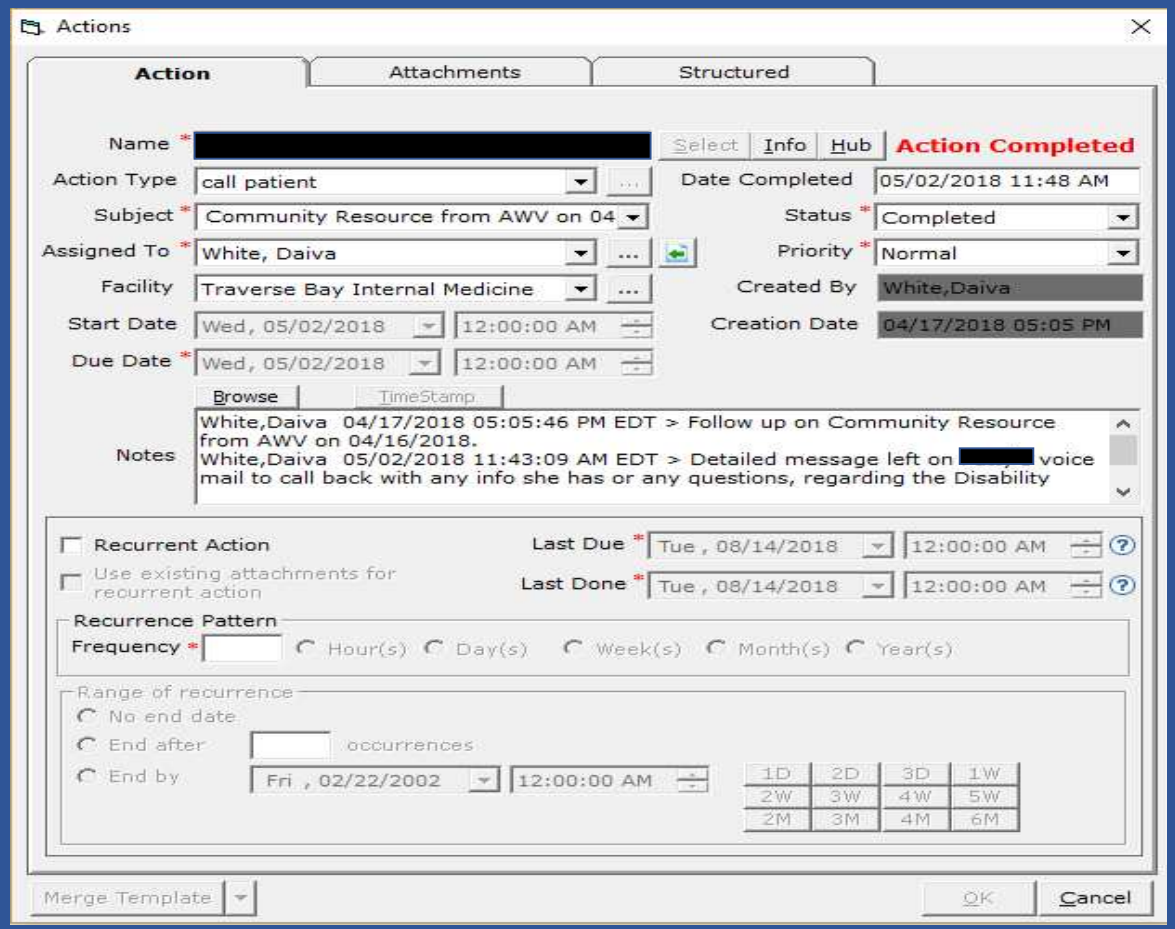


Community Resource Referral and Tracking Process



Structured data fields allow us to easily identify patients given Community Resource information


eClinicalWorks Viewer
were drinking in the past year? 1 or 2 (0 points), How often did you have a drink containing alcohol in the past year? Four or more times a week (4 points), Points 4, Interpretation Positive.
Sexual Hx Form Had sex in the last 12 months (vaginal, oral, or anal)? Yes, with Men only, Use protection? No, Have you ever had an STD? No.
Allergies / Intolerances
Codeine Sulfate: dizziness: Side Effects
Preventive Medicine
Counseling: Alcohol and drugs Patient denies concerns with alcohol or drug use.
Health Promotion: Diet / Exercise BMI management provided Yes, Weight Counseling Patient encouraged to continue efforts on weight reduction through proper exercise and nutrition.
AWV: Mammogram 03/06/2018. EKG 05/10/2017. Colonoscopy 05/31/2011, due next in 2021. Testing Recommendations Lipid Profile done within the past year on 04/19/2017. Diabetes Screening test done on 04/19/2017. Vaccines Pneumovax last done on 03/25/2014, Prevnar13 done on 04/07/2015, Influenza recommended annually, last done on 10/16/2017, Zostavax done on 01/01/2009.
Community Resources: Information Given Information Given Yes Disability Network of Northern Michigan for their disabled daughter that they take care of. First Resort Transport-Transportation compnay for disabled daughter. , Date Information Given 04/17/2018.
Procedure Codes
G0439 ANNUAL WELLNESS VST; PPS SUBSQT VST
Follow Up

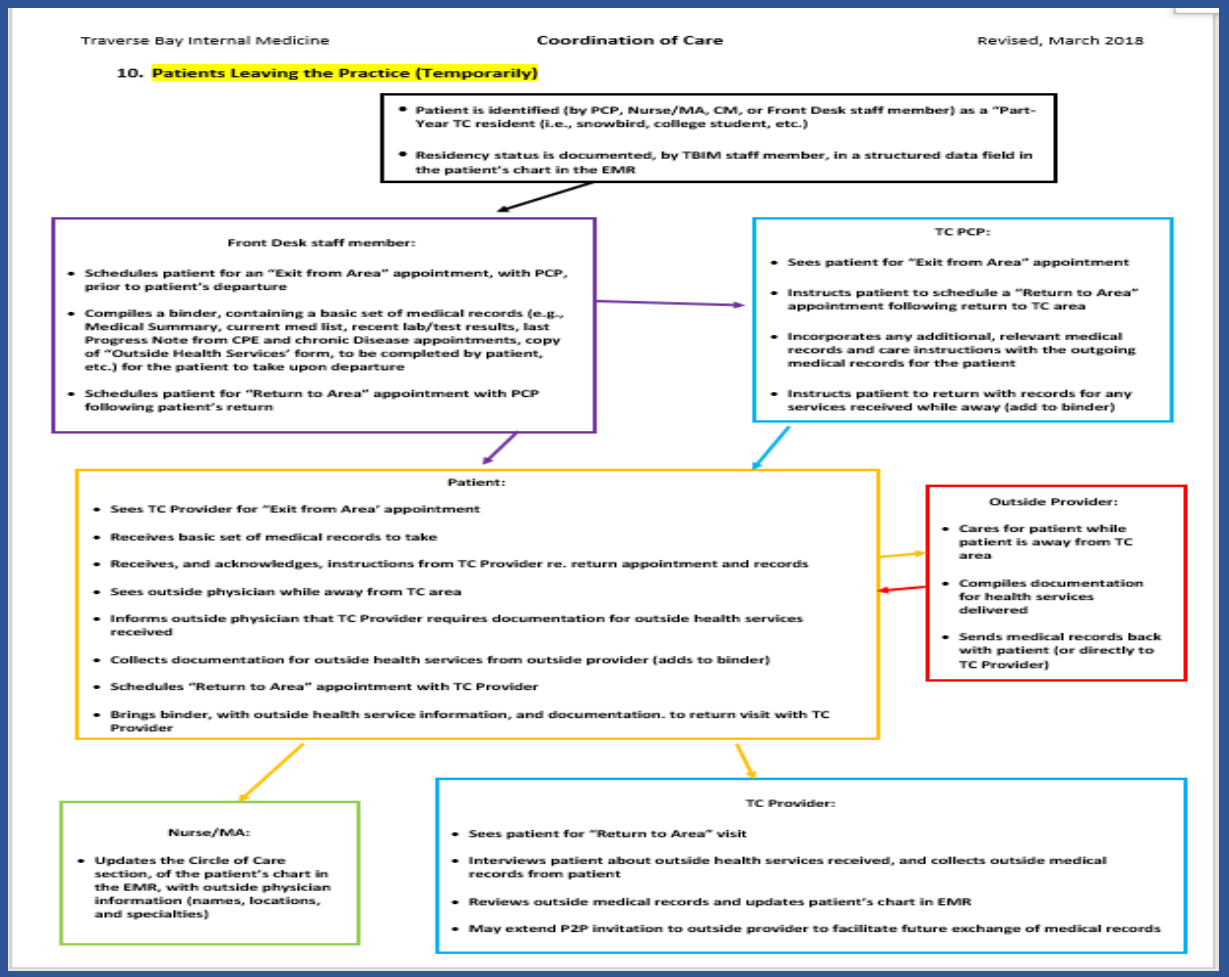


Actions are set for easy Community Resource referral follow-up and documentation

Transition of Care Plans

(Domain 13)

How do you coordinate care for your Snowbirds?



Traverse Bay Internal Medicine — Coordination of Care — Revised, March 2018

10. **Patients Leaving the Practice (Temporarily)**

- Patient is identified (by PCP, Nurse/MA, CM, or Front Desk staff member) as a "Part-Year TC resident (i.e., snowbird, college student, etc.)
- Residency status is documented, by TBIM staff member, in a structured data field in the patient's chart in the EMR

Front Desk staff member:

- Schedules patient for an "Exit from Area" appointment, with PCP, prior to patient's departure
- Compiles a binder, containing a basic set of medical records (e.g., Medical Summary, current med list, recent lab/test results, last Progress Note from CPE and chronic Disease appointments, copy of "Outside Health Services' form, to be completed by patient, etc.) for the patient to take upon departure
- Schedules patient for "Return to Area" appointment with PCP following patient's return

TC PCP:

- Sees patient for "Exit from Area" appointment
- Instructs patient to schedule a "Return to Area" appointment following return to TC area
- Incorporates any additional, relevant medical records and care instructions with the outgoing medical records for the patient
- Instructs patient to return with records for any services received while away (add to binder)

Patient:

- Sees TC Provider for "Exit from Area' appointment
- Receives basic set of medical records to take
- Receives, and acknowledges, instructions from TC Provider re. return appointment and records
- Sees outside physician while away from TC area
- Informs outside physician that TC Provider requires documentation for outside health services received
- Collects documentation for outside health services from outside provider (adds to binder)
- Schedules "Return to Area" appointment with TC Provider
- Brings binder, with outside health service information, and documentation. to return visit with TC Provider

Outside Provider:

- Cares for patient while patient is away from TC area
- Compiles documentation for health services delivered
- Sends medical records back with patient (or directly to TC Provider)

Nurse/MA:

- Updates the Circle of Care section, of the patient's chart in the EMR, with outside physician information (names, locations, and specialties)

TC Provider:

- Sees patient for "Return to Area" visit
- Interviews patient about outside health services received, and collects outside medical records from patient
- Reviews outside medical records and updates patient's chart in EMR
- May extend P2P invitation to outside provider to facilitate future exchange of medical records

Coordination of Care

Process for Part-Year Residents

Part-year residents receive a colorful Transition of Care binder, containing:

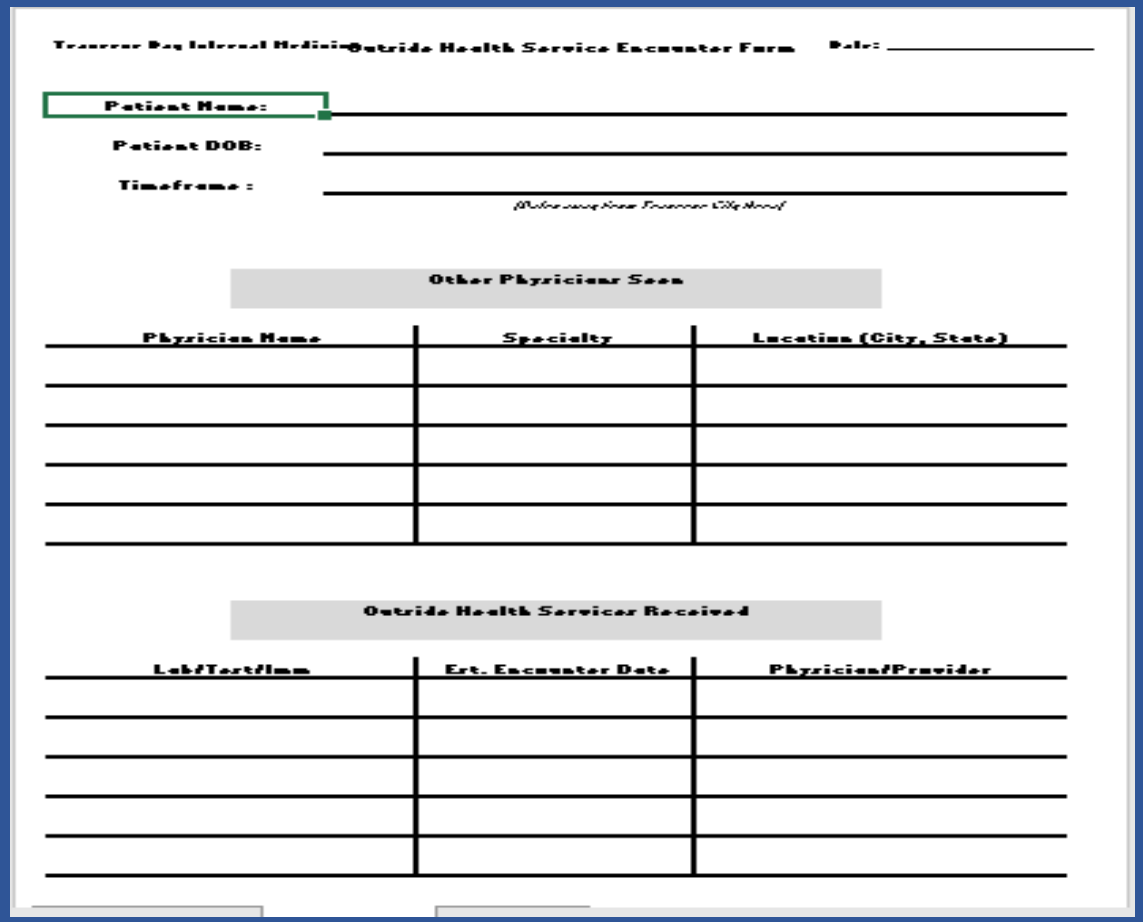
1. An Outside Health Service Encounter Form
2. Medical Summary
   a. Problem List
   b. Current Medication List
   c. Allergies
   d. Medical Hx (including Surgical and Gyn)
   e. Health Maintenance (Health Services due)
   f. Recent Encounters
   g. Recent Referrals
3. Progress Notes
   a. Last CPE
   b. Last OV
   c. Any other relevant visit (e.g., CD F/U)
4. Any other information the Provider deems relevant (e.g., EKG etc.)

Patients:

- Receive the binder prior to leaving the Traverse City area
- Record information (names, specialties and locations) of outside health providers seen, while away, in the binder
- Collect documentation of outside health services received, while away, in the binder
- Return the binder to TBIM upon return to the Traverse City area

Staff members:

- Enter information, for outside health providers seen, in the Circle of Care section of patients' charts
- Scan documentation, for outside health services received, into patients' charts
- Enter information, for outside health services received, in the appropriate fields/locations in patients' charts (e.g., Immunizations, Colonoscopies etc.)



Outside Health Service Encounter Form Date: _____

Patient Name: _____

Patient DOB: _____

Timeframe : _____

(Before using Your Insurance Policy Name)

Other Physicians Seen

Physician Name	Specialty	Location (City, State)

Outside Health Services Received

Lab/Test/Item	Ext. Encounter Date	Physician/Provider

Outside Health Services Encounter Form