Transition of Care Process
Follows PCMH practices in 13.0

We use Allscripts Professional EHR

Goal: Patient transitions are well-managed and patient care is coordinated across health care settings through a process of active communication and collaboration among providers, patients and their caregivers

Bayside Family & Sports Medicine Tools:

ED & Hospital Admissions:
McLaren Northern Michigan / Hospice / Spectrum / UofM / Cheboygan / Mackinac Straits / Otsego Memorial / Sparrow

Front Office Team:

- Daily, receives eFax or ePHI Imports and updates from Health Systems as to who was admitted and their process of care.
  - Admitted to the hospital or ED
  - Discharged from the hospital or ED
- Alerts are indexed to the appropriate patient chart and sent to the Provider/Care Manager/Medical Assistant as designated by the preferences of the Leadership Team.
- ePHI will contain Medication Lists, Problem Lists and Dx, Immunizations, Allergies, Labs, etc

Care Manager - RN

- Indexed alerts from eFax are awaiting the Care Manager's inbox for processing.
- Discharge notifications are gleaned from on line services.
  - Access to McLaren
  - Access to Northern Physicians Organization - State Wide Registry
  - Access to Payers such as Priority Health and BCBS Portals with admission and discharge alerts in the system.
- Reviews all discharge summaries and forwards to the appropriate Provider.
- Outreach occurs within 48 hours of discharge.
- 10 Key Points are reviewed and documented with the patient over the phone.
  Template is built into the Care Manager's EMR program

Hospital Name	Hospital Service
Demographic Information	Admit and Discharge Date and Time
Diagnosis/Problem	Source of Information
Medication Reconciliation	Follow Up Appointment Scheduled

- Recorded in Patient Chart as a Patient Phone Encounter
- Reviews hospital notes, labs, and consultations as necessary and notifies/shares documentation with the appropriate Provider.
- Patient appointment scheduled within 1-3 days with the appropriate Provider.
  Tier 1 Response is follow up appt within 1-5 days of discharge.
  Tier 2 Response is follow up appt within 6-10 days of discharge.
  Mid-Level Providers have schedules open to achieve Tier 1 Response.
- Notification sent to appropriate Provider.

- Tracking sheet – Excel spread sheet allows CM to track an ER page, as well as, a Hospital Discharge page for quick reference. This is a daily work review at a glance.

Provider:

- Reviews Discharge Summaries, History & Physicals, Specialist Notes, Plans of Care, Labs, Pathology, Radiology, etc
- Provider may assign the MA/Care Manager action steps to obtain additional documentation prior to TOC visit.
- At the TOC visit, Provider codes TOC to alert the Billing team of the type of visit.

MA:

- If there is information pending, indicated by the discharge summary, for example lab tests, the lab tests will be obtained and the Provider updated with results prior to the TOC visit.

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Time-sensitive Health issues can receive highlighted status with an Urgent **(RED)** message or **(RED)** document in our EHR. Any staff members who receive the incoming alert can use this method of delivery in our EHR.