AMBULATORY CARE HANDBOOK
2011-2012

Summa Health System
Internal Medicine Residency
An EIP Program

55 Arch Street, Suite 1B
Akron, Ohio 44304
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INTRODUCTION

Background

Training in the care of ambulatory patients is an essential part of Summa’s Internal Medicine resident training program. Since 1974 the program has emphasized the importance of ambulatory care by training all of its residents in the provision of longitudinal, preventive, and comprehensive care of the ambulatory patient. The program includes a variety of experiences that assures that the trainee is exposed to the broad field of internal medicine, assumes the primary responsibility for the care of patients, and acquires the skills necessary to practice internal medicine at a high level of expertise.

Overview

Internal Medicine residents receive their ambulatory care education in the Internal Medicine Center (IMC) and in community-based private practices.

As a hospital-based continuity clinic, the IMC provides the backbone for ambulatory education. Residents serve as primary care physicians to their own group of patients and are responsible for their ongoing care. Direct supervision of the residents is available at all times by on-site teaching staff physicians.

The Community Based Teaching program (CBT) was instituted in 1995 to supplement the ambulatory care experience by providing exposure to successful outpatient practices. In CBT, each resident is assigned to work with an internist who is known for his/her teaching ability.

While participating in their ambulatory continuity experiences, the resident serves as the patient’s primary physician. As the primary physician, the resident assumes the responsibility for the ongoing evaluation of each patient’s health care, including medical, psychosocial, socioeconomic and preventive care factors. The resident is responsible for supervising any hospital care required for his or her continuity patient and also serves as the primary point of referral to other healthcare providers.

Goals for residents:

- Master techniques of interviewing and physical examination
- Develop procedural skills pertinent to ambulatory care (joint injections, skin biopsies, etc.)
- Learn the natural history of disease
- Learn to manage chronic disease and assess disability
- Learn to manage acute medical problems, both physical and psychological
- Understand the distinction between the biologic events of illness, the human events associated with the illness and the importance of care that gives attention to both
- Communicate health promotion and disease prevention
- Develop skills as an accessible counselor, coordinator, and patient advocate
- Develop competence in practice management including: scheduling, record-keeping including the use of electronic medical records, personnel management, space utilization, billing and collection, phone management, time management, and quality assurance
- Master outpatient consult skills including pre-operative assessments
- Master the “New Competencies for Internal Medicine:” patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and system-based practice.
Structure of Ambulatory Medicine Experience
Structure of Ambulatory Medicine Experience

- PGY-I residents see patients one-half day per week in the IMC.
- PGY-II residents see patients one-half day per week in the IMC and one-half day per week at a community-based teaching (CBT) site.
- PGY-III residents see patients two half-days in the IMC, or under special circumstances, one half-day per week in the IMC and one-half day per week at a community-based teaching (CBT) site.

Over the course of three years, residents establish their own panel of approximately 200 patients for whom they serve as primary care physician. Patient care in the IMC is linked to patient care on the general medicine inpatient service: new hospital patients continue their care in the IMC with the resident who managed their hospital care, and hospitalized IMC patients are followed by their resident physician. At the community-based teaching site, each resident is paired with an internist who serves as his/her preceptor.

Residents are exposed to an extensive mix of patients, diseases, clinical encounters, procedures, and services in the hospital and ambulatory settings.

Preceptor responsibilities:

Faculty physicians precept all patients with the residents while the patients are still in the examination room. They are also available to see any patient with the residents. During the resident’s first six months of training, the preceptor is present for the key part of the patient’s visit. All residents should document the name of the assisting preceptor in their progress notes.

The primary goal of the preceptor is to provide guidance and supervision to optimize patient care and resident learning. Residents present patients to preceptors and are encouraged to develop their own conclusions and management plans. Preceptors may examine and interview patients to verify or clarify findings, teach techniques, model communication skills, or assist in determining the best course of treatment. The preceptor may ask residents to prepare brief talks on clinical questions raised during a case discussion. Preceptors allow residents a degree of autonomy that benefits their education without compromising patient care.

Guidelines for supervision: (see Appendix B for further information)

- Interns present every case to a preceptor before the patient has left the exam room. During the first six months of internship year, the attending preceptor may see every patient with the intern before he or she has left the exam room.
- During the PGY II and PGY III years, all patients must be presented to a preceptor during the patient encounter.
- Chart reviews are conducted on each resident at least once a year.
- When problems/questions arise outside of regular clinic hours, residents will contact a faculty physician to discuss these issues.

Resident responsibilities:
In all continuity sites, the resident physician acts as the primary care physician for his/her patients. While responsibilities on the inpatient service may often seem more pressing, the experience gained in the outpatient setting provides the foundation for a career in primary care. Preceptors will provide the supervision and assistance required by each resident.

The following are basic expectations for residents in the outpatient setting. Residents will:

- Report to the office promptly for all sessions and be available by pager daily (7:30 am to 5:00 pm)
- Participate in IMC didactic sessions during their IMC rotation (Tuesdays and Thursdays, 8:00 am to 8:30 am)
- Complete notes and billing for each patient visit on the day of the visit
- Provide routine health maintenance and preventive care to their patients
- Evaluate and manage medical problems
- Provide acute care and assist in patient triage
- See patients of fellow residents when necessary
- Follow through on results of laboratory and other forms of testing, and communicate directly with patients as needed
- Provide case management and referrals, and coordinate care given by subspecialists and other providers
- Document clearly all clinical encounters, medication refills and telephone consultations in the electronic medical record (EMR)
- Provide inpatient care to their own patients with the assistance of the inpatient medical teams
- Check the EMR for messages and lab results daily, and cover for other residents
- **Change sessions only with the consent of the chief resident and an IMC manager.** [Clinics may be cancelled or moved due to call schedules, holidays, vacations, away electives, away conferences, in-service or board examinations, interviews, or personal emergencies. In the case of illness or personal emergencies, remaining residents will be responsible for seeing any scheduled patients.]
- Conclude their IMC experiences by completing all outstanding records and transitioning their complicated patients to new physicians

The resident responsibilities in IMC and CBT are designed to reflect the demands of a traditional office practice in a supervised setting; therefore, residents gain experience in professional behavior and cross-coverage under the guidance of more experienced physicians. As this is also a learning experience, residents will have the unique opportunity to actively participate in new models of patient care which can be applied to future practices.

RESIDENT GUIDEBOOK
The IMC Staff

The IMC staff includes a practice manager, a clinical manager, nurses (RNs and LPNs), medical assistants (MAs), medical office associates, and a social worker. The office is divided into two teams (A and B) to facilitate continuity of care. The residents are divided into 6 firms (Red, Orange, Yellow, Green, Blue, and Violet) in order to facilitate cross-coverage of each other.

The medical office associates work in the business office. Their duties include patient registration, appointment scheduling, answering telephones, chart maintenance, scanning, document preparation, filing and other office work. The practice manager (Paula Warner) directly supervises the business office staff and works directly with the director and the clinical manager. Paula is the resource for questions regarding insurance, coding, scheduling, and other office concerns.

The medical assistants work directly with the physicians. Their responsibilities include bringing patients into rooms, obtaining vital signs, scheduling tests and referrals, and assistance in simple diagnostic procedures (such as pelvic exams, EKGs, and spirometry). The nurses triage phone calls and are able to perform or assist in several procedures (such as IVs, irrigations, injections, and suture removal). The clinical manager (Dave Conrad) supervises the clinical staff and is responsible for the drug program. He should be consulted for any clinical problems that may arise.

Clinical providers other than residents include faculty physicians, nurse practitioners and a doctor of pharmacy. As well as staffing the residents, faculty physicians see their own patients in the IMC and cover for each other as they would in a typical office practice. The two nurse practitioners (Denise Boville and Diane Duff) see a large number of urgent visits and have an instrumental role in the care of diabetic patients. Their role in care teams continues to evolve as the practice continues to develop more effective ways of caring for difficult chronic medical problems. Unlike residents and faculty physicians, they do not have their own assigned panel of patients for continuity care.

The pharmacist (Michelle Cudnik) has a unique and flexible role in the IMC. Her primary responsibility is pharmacy education and some of her contributions include: seeing diabetic planned visits, medication reconciliation and education visits, performing and assisting in research, and one-on-one informal consultations with physicians and students.

The goal of the IMC is to provide a well-rounded education in primary care. Although the IMC is a hospital department, the practice is designed to be as close to a private medical office as possible. Constructive feedback from residents is both welcome and appreciated.

Patient Appointment Schedule

The office experience in the Internal Medicine Center is the unique part of the residency training program that introduces the concept of “longitudinal care”. This differs dramatically from the inpatient model where a complete database and investigative studies are obtained as soon as possible.

The office schedule encompasses approximately 50 separate physician schedules. Appointments are scheduled in 10-20 minute intervals, modified according to resident level. New patients are asked to arrive 30 minutes early to allow time to complete a patient assessment, consent forms and other registration data.
Each new patient is given a copy of the patient information brochure, which explains the policies and principles of the Internal Medicine Center.

Because of the volume of calls received, patient loads may be increased to accommodate the need to bring in sick patients. The faculty and staff attempt to evenly distribute the workload, and the nurse practitioners see many of the work-in patients. Residents should work closely with their team’s clinical and clerical staff during their clinic sessions to avoid miscommunications.

Residents have regularly scheduled weekly office hours. PGY I residents see patients one half day a week. PGY IIs and IIIs generally see patients two half days a week, one morning and one afternoon. CBT may substitute for one half day of clinic per week. At the beginning of the year, residents are assigned a basic schedule, but often sessions will be moved to another day due to schedule conflicts with rotations and calls. Residents will be notified approximately one month in advance of the next month’s schedule. **The schedules should be immediately reviewed by the residents for any potential conflicts.** Schedules are posted under schedules at [www.imsumma.org](http://www.imsumma.org). Any changes should be discussed with the chief resident and the practice manager as soon as possible.

All physicians are expected to be in the clinic and ready to see patients at the beginning of their clinic session. Normal office hours begin at 8:00 and patients are scheduled until approximately 11:30 for the morning session. The afternoon session begins at 1:00 with patients scheduled until 4:30. These times vary according to resident level. **Residents are expected to remain in the IMC during their entire clinic session.** Downtime can be used to answer calls, complete forms, update records, assist other residents, or read.

On Tuesdays and Thursdays, the first half hour of the morning session is devoted to didactic case discussion. All residents on the IMC month are required to attend, and all other residents are encouraged to attend if their schedule permits. Patients are not scheduled until 8:30 on those days. The didactic teaching cases and schedule can be found under the IMC learning center link at [www.imsumma.org](http://www.imsumma.org).

Appointment cards are used and given to patients to remind them of follow up visits in the IMC. Hospitalized patients who are to follow up in the IMC should be given a specific appointment time when they are discharged from the hospital. The discharging physician should call the team secretary to schedule a **post-hospital appointment**. If the clinic is closed, a message with the patient’s name, phone number, physician and an approximate time (2 weeks, 4 weeks, etc) should be left on the message line (53664). Many residents also have the privilege to use the electronic record to schedule their own patients, provided that they are able to follow scheduling guidelines. Residents should avoid overbooking themselves or their colleagues. Residents arranging the patient follow-up should put a brief summary note into the patient’s record to facilitate care.

**Assignments**

First year residents are scheduled for one half-day a week in the IMC. Interns see only 2 patients a session for the first few weeks, then build up to seeing 6 patients per half-day. The schedule is designed to help new residents become familiar with the routine in the clinic.

**All residents are expected to arrive on time and stay in the IMC until the clinic session is over.** Running over to the hospital between patients is not acceptable. Residents who are on call and scheduled to be in the clinic should sign out to another resident during clinic hours.
Appointment schedules can be viewed through the electronic medical record, and can be used to track arrivals, cancellations, no-shows and work-in appointments. The assigned MA maintains the schedule and will know of any adjustments. The MAs use the Expeditor light system to facilitate the flow of patients and physicians through the IMC.

Each team has a triage RN and a floor RN. The triage RN receives the sick patient calls and discusses the calls with physicians as needed. The floor RN handles IVs, injections, breathing treatments and helps obtain samples. The assigned MA is usually the first resource available to the residents and assists with simple diagnostic tests and procedures rather than treatments. The clinical manager and the attending staff are available for more complicated problems and assistance.

The residents should make every attempt to complete their charts on the same day they see the patient—ideally when they see each patient. Patient encounters are left “open” in the electronic record until they are “locked” by the staff-member who completes a separate acuity form. Changes to the record can only be made on an “open” encounter; therefore, once an encounter is “locked” it cannot be altered in any way. Written documentation of the physical exam is required for each patient at the time of each visit.

The Electronic Medical Record

Each resident will receive training in the use of the electronic medical record (EMR) prior to seeing patients in the IMC. The EMR used in the IMC is called eClinicalWorks (eCW), which is the system used predominantly throughout the Akron area.

The use of the record for patient charting is similar to the use of paper charts, with the exception of the handling of documents, telephone encounters and labs. Since EMR is frequently upgraded, the office processes are still evolving. Feedback to the EMR administrative committee is invited and welcomed, as the best feedback tends to come from the people who use it the most.

Documents (D) and Labs (L)

Each physician in the IMC has a document queue in the electronic record which contains any document faxed or mailed to that physician. The documents may include forms for different agencies or services, results of patient tests, letters from consultants, old records, prescription refills, or any number of items which are sent to the clinic. Most of the items in the document tab can be electronically reviewed and filed with a single click. Documents requiring more than review can be either printed, filled out, rescanned and sent or can be edited using the “ink edit” feature on the tablets and directly faxed. Prescription refill requests received in the document queue should be completed through the “patient hub” rather than “ink-edited” and faxed (because prescriptions when refilled through the document faxes cannot be tracked easily).

Each resident also has lab queue in the EMR. It primarily contains test results generated from Summa labs. It is not perfect as it is dependent on an interface, which is still a work in progress. Please alert Ron Jones, Stephanie Tan or Paula Warner to any problems with viewing the lab results (with patient name, date and result). We continue to work with IT to improve this.
If additional testing is required after reviewing test results, the patient can be called and the order can be faxed to the lab. Some of the testing may require discussion with the test scheduler. Test requests can also be “assigned” (electronically sent) to the test scheduler; however, this should only be done if the test is not urgent and the indications are clearly documented. Many tests require clear and specific documentation which is seldom provided through a simple “assignment” to the scheduler.

**Telephone Encounters (T)**

Telephone encounters include calls from any source and patient-specific messages generated within the IMC. All of the encounters are left “open” until they are “addressed.” The “addressed” button should only be used if the encounter is ready to be electronically filed. If it is to go to anyone else (“assigned to”), then it should be left open, or the encounter will be filed into the patient chart rather than redirected.

The document, lab and telephone encounter queues should be checked daily. Residents who are not able to check their documents, labs and telephone encounters daily will have a colleague from their firm assigned to cover for them. Those who are not pre-assigned coverage should inform the IMC of other arrangements for coverage. All results, documents, and encounters should be “time-stamped” when they are reviewed.

**The Electronic Transition**

As we transition to a primarily electronic office, we do not routinely pull paper charts unless they are requested. Occasionally, physicians find documents in the paper chart that they would like scanned. Those pages can be marked with a purple page marker and directed to the scan box in the secretarial area. If it is to be placed in a certain folder in the patient’s chart it is helpful to leave a note indicating which folder and how it should be labeled.

Occasionally providers will receive paper documents. The documents can be completed first before scanning, or scanned then “ink edited” depending on the preference of the person handling the document.

**Patient Preparation**

During a clinic session, each patient arriving for an appointment must first be registered at the front desk. New patients will be given a packet of information about the IMC and will be asked to sign a medical record release form to facilitate transfer of their records. Demographic information is updated at this part of the visit.

When an exam room is available, the patient is brought in and vitals are taken. The patient is given a gown and instructed to change if necessary. All other preparations are done according to need, i.e. temperature, preparation for a pap/pelvic, blood sugar, peak flows, UAs, EKGs, etc.

The MA will assign each physician two to three rooms. There are buttons outside the exam rooms used for communicating the location of staff and the communication of needs. The buttons indicate:

- White/no blink       = Patient is in the room
• White/rapid blink = Patient is next to be seen
• White/slow blink = Physician is in the room
• Green = MA is in the room
• Blue = Nurse required for treatments
• Yellow = Urgent or MA required

The physician goes first to the room with the rapidly blinking light and presses the button as he/she enters, The light then goes to a slow blink. Pressing the white button again upon leaving the room turns off the light so that the MA knows that the room is free for another patient.

Residents can look at their assigned room numbers on the light panel (or on their EMR schedule) to see which rooms have patients ready. While seeing patients, residents may use the intercom for urgent assistance by pressing the call button once and waiting for a reply. If there is no response after 30 seconds, the call button should be pushed again. Once a reply is made, the resident can communicate through the intercom without pressing the button again.

The bullpen is the work area where residents consult with preceptors, look up labs, check resources, make phone calls, and complete charts. A few physicians choose to work in the computer alcoves on each side; however they are still required to staff each patient with an attending physician who is stationed in the bullpen. Residents are encouraged to work in the bullpen for educational purposes.

Patient Discharge

Patients are usually discharged from their clinic visit by the last person seeing the patient, usually the physician or the test/referral scheduler.

The following are the types of discharges:

1. Provider Discharge:
   • The patient is given prescriptions, signed lab orders, and an updated medical summary.
   • The patient is given an appointment card and directed to the scheduling secretary.

2. Scheduler Discharge:
   • The patient is given prescriptions by the provider and an updated medical summary.
   • The provider enters the test/lab order into the EMR and escorts the patient to the scheduler. Any order that is stat must be stated in the documentation and on the orders. The provider may need to sign additional orders or referrals or provide ICD-9 codes depending on the specific test.
   • The scheduler gives the patient information regarding their testing, schedules the follow-up appointment and discharges the patient.

Regardless of type of discharge, all patients must receive an updated medical summary at each visit. As all clinical practices are evolving due to the use of the electronic record, we anticipate a change in the discharge process as well.

Referrals to Specialists
As a primary care provider, you will be the physician coordinating the care of your patients. Referrals can be arranged through the clinic with the assistance of the scheduler or by the patient. In either case, a consult letter or form should be completed and sent to the appropriate clinic or specialists. Request and include copies of appropriate tests to be sent with the consult. If an urgent appointment is needed it may be necessary to contact the consultant directly.

**Private Pay Referrals**: Some of the patients you will see have private insurance or Medicare. Those patients may be referred to a specialist of their choice or to a specialist mandated by their insurance company.

- Most managed care plans, i.e. SummaCare, Prudential, Kaiser require referrals made to physicians on their provider list. This means that an authorization is required prior to the patient’s appointment. Your team scheduler will make the necessary calls and/or prepare the necessary forms for your signature.
- If you are the “middle-man” making the arrangements for a referral, you must make your team scheduler aware of the referral in case an authorization is necessary.

**House Case Referrals**: Many of the patients you see in the Internal Medicine Center will be financially unable to afford the costs of specialists. Because Summa Health System is a teaching hospital most specialists have agreed to see those patients at no cost. Most specialists consider a patient a house case if they are uninsured or on Medicaid. Common house case referrals and their providers include:

- **Dental Clinic**: PCN third floor
- **Detox**: Ignatia Hall at St. Thomas Hospital
- **Functional capacity assessment (disability)**: Summa Health Center at Green, 330-899-5599
- **Geriatrics**: Center for Senior Health, PCN ground floor
- **OB/GYN**: Women’s Health Center, PCN basement
- **Orthopedics**: Orthopedic Clinic at St. Thomas Hospital. They are currently requiring a call to a resident to facilitate timely visits.
- **Ophthalmology**: Ophthalmology Clinic, PCN second floor.
- **Rheumatology**: Crystal Clinic physicians prefer a direct physician call for any new referral appointments
- **Surgery**: COMPAS (across from hospital on E. Market).
- **Urology**: Advanced Urology (Ste. 101 PCN)
- **Worker’s comp**: Center for Corporate Health, 330-379-5959
- Other subspecialty appointments are sent to private physician offices, according to the physician on service that month (indicated in the EMR as HC).
- Podiatry has no established house case providers.

***All referrals require a letter to the appropriate specialist along with pertinent information***

**Procedures**

During training in the IMC, residents are encouraged to perform simple procedures as necessary. Instruments are available for the following procedures.
• Skin biopsy, punch biopsy
• Small lesion removal
• Application of hyfrecator
• Suture repair or removal
• Injections, arthrocentesis
• Incision & drainage
• Peak flow, pulse oximetry
• Aerosol treatment
• Spirometry screening
• Visual acuity
• Indirect laryngoscopy
• Pap and pelvic
• EKG

Supplies for procedures are located in the supply room and the lab. Your MA, nurse, or attending physician will be able to assist you in obtaining supplies. Procedures should be documented and billed through the EMR (CPT code) and logged into New Innovations for residency requirements and future credentialing.

**Patient Education**

There is a variety of educational material available to our patients. The most convenient and useful patient information material is available through a link in ECW. To access it, go to the treatment pane, click on the “education” button, and select “patient education.” This will bring up the ADAM patient education system. While the system will default to whichever “assessment” is open at the time, it can be searched for other topics as well and any of these materials can be easily printed. In addition to the ADAM system, printed booklets and pamphlets are located in the hall behind the bullpen, and internet access in the bullpen provides links to other sources such as *Up-to-Date* and *MDConsult*.

The IMC nurses are available to educate patients on a one to one basis or in a group setting about smoking, asthma, CHF, and diabetes. Videos are also available for patient viewing. Dietary & diabetic education can be scheduled with an IMC nurse practitioner or through the dietician who sees patients in the clinic weekly. The pharmacist can provide warfarin and other medication education/management assistance.

**Managed Care Plans**

Many of the patients seen in the Internal Medicine Center are covered by a managed care plan. The percentage of managed care covered lives is rapidly growing. Managed care plans contract with physicians and facilities to get the best care at the lowest cost.

Each contract has requirements that must be met, such as seeing emergent and urgent patients the same day they call, seeing routine patient appointments within two weeks, having 24 hour coverage and so on. We are also required to maintain our medical records with precise documentation of past medical history, medication allergies, problem lists, treatment plans, diagnoses that are consistent with findings, and documentation that supports the medical necessity of tests ordered. We are subject to office and chart reviews every two years.
for each company we contract with. Our bottom line is we must work more efficiently and continue to give the quality of care you would want for yourself and your family.

Physicians are required by contract, to send the patient to a participating specialist and or a participating facility when referring a patient for a consultation and/or tests. Our patients should be aware of their insurance coverage and requirements, but in reality, most of them aren’t.

The IMC staff is trained to know the major requirements of most contracted insurance plans. It is impossible for anyone to know everything there is to know due to the daily changes in the industry. The medical assistant assigned to scheduling will be helpful in matters of referrals and pre-authorizations. The practice manager is also another resource for information or assistance.

**Call Coverage**

**Working hours** (7:30 am-5:00 pm)
Urgent calls from patients will first be triaged by the nursing staff who then notify the resident by pager. **Residents must be available by pager for calls from 7:30 am to 5:00 pm every weekday**, including days that they are not scheduled to be in the IMC (except when they are required to leave the hospital post-call). In any case of scheduled absence, coverage arrangements will be made for the residents. Unscheduled absences should be called to the chief resident and IMC secretary.

**After hours** (5:00 pm-7:30 am)
The on-call resident (AR2) will provide coverage of IMC patients after hours. No routine prescriptions or prescriptions for controlled substances will be provided after hours. Routine prescriptions should be referred to the IMC prescription line: **330-375-7941**. Messages for the chart can be entered directly into eCW as a telephone encounter or called to **5-3664**. IMC faculty physicians are available 24 hours a day as backup to the AR2.

**SPECIAL SERVICES**

**Behavioral Science**
There is a fulltime behavioral scientist, Linda Sims, Ph.D. in the Internal Medicine Center. Some of her many responsibilities in resident education include:
- precepting patients with psychosocial issues
- seeing residents’ IMC patients in consultation
- short term counseling of IMC patients
- assisting residents with patient referrals to community agencies
- psychological testing of patients when indicated
- crisis intervention with patients
- assisting in developing treatment plan/contracts with patients
- organizing therapy groups
- resident portfolio “guru”

Her office is on the A side of the clinic, and she is available during the regular clinic hours. If she is not in her office, or the door is closed, she may be reached by paging her or calling the private line (5-3418) if she
is needed immediately. Patients may be scheduled to see her by either discussing the patient with her or by completing a consultation request for the desired patient services.

**Indigent Drug Program**

Many patients of the IMC are unable to afford their medications. A system is in place to assist these patients. When encountering a patient who cannot afford their medications:

1. The patient is to be referred to the clinical manager or the team R.N.
2. A written or verbal referral is to be made to the IMC social worker.
3. Most medication samples are available for a first time need. Any samples given must have a label stating the medication, dosage, physician signature, lot# and expiration date. Samples given are limited to a one month supply (less if supplies in the IMC appear short).
4. If the patient has been assessed by the Social Worker and found eligible, and samples are not available, the IMC may pay for the medication through Ritzman Pharmacy located in the Center of Excellence (95 Arch St.). The prescription must be assessed for cost effectiveness, approved and initialed by Dr. Diana Stewart, Dr. Julie Radwany or by the clinical manager.
5. The team nurse should be notified so she/he may begin the process of getting the patient on a drug company program for long-term medications. **The IMC has a drug formulary of approved drug company assistance program medications. This formulary is in the bullpen, in a black binder. If a medication is needed, that is NOT on the approved formulary, we will NOT fill out the paperwork to get this medication for the patient. If a resident feels that a patient needs a medication that is not on the formulary, a review for approval can be completed by Michelle Cudnik, PharmD or Mike Rich, MD.**
6. The medication supply in the IMC should be checked before considering the Ritzman option. If the medication desired is not available in sample form, the precepting faculty member may suggest alternative medications.
7. Many area pharmacies (Giant Eagle, Target, Discount Drug Mart, Walmart, Kmart, Sam’s Club, Marc’s and ACME) offer selected generic medications for $4 per month. An updated, complete list of these medications is available in the bullpen in a black binder. Every effort should be made to prescribe medications which the patient can afford.
8. The hospital social worker should be contacted when discharging new hospital inpatients who are unable to afford their prescribed medication(s). This should be initiated by writing an order on the inpatient chart. The unit social worker will then be contacted to evaluate the patient. The social work department has a yearly budget to cover these instances. **The IMC drug program does not and will not cover medications in these circumstances. Sample-eligible established IMC patients are able to receive samples upon discharge.**

**Anticoagulation Clinic (Coag Clinic)**

The IMC has a system to facilitate the management of patients on warfarin. The system includes rapid INR testing, the use of protocols, specialized documentation, and patient contracts. Potential coag clinic patients will first be evaluated by a nurse who reviews the contract with them. Subsequent visits consist of a brief nursing assessment, INR testing, and dosage adjustment. Routine INR testing is done Monday-Friday mornings, but INRs are available anytime during clinic hours. Dose adjustments are always made under the guidance of a physician. Residents are encouraged to
participate in the management of their patients’ warfarin dosing, and during the IMC month, residents will be scheduled to work in the Coag Clinic. Additional information may be found under “Anticoagulation Clinic,” page 21.

**Diabetes Education**

The IMC has two full-time nurse practitioners and a pharmacist who specialize in diabetes care and teaching. Most diabetic patients are participating in the Chronic Care Collaborative which is a team approach to disease management. Residents are instructed in the care team approach to diabetes and are included in the decision-making for their patients and for the change teams.

**Outpatient Lab**

The outpatient lab has provided the IMC with an on-site phlebotomist (Ray) to draw labs for our patients. This service has greatly streamlined the process for most of our patients. Use of the phlebotomist is restricted to same day orders (i.e. patients cannot be brought in to the IMC just to get their labs done). The labs to be done by the phlebotomist are not considered “in-house” because he is operating as a branch of the lab, not as a part of the IMC.

**Clinic Resources:**

- Department website: [www.imsumma.org](http://www.imsumma.org)
  Link to IMC learning center for IMC didactic schedule and cases
- Department of Medicine Library
- IMC library and core textbooks
- Computer access to hospital records and labs
- Internet access and Up-to-Date available on all tablets and bullpen desktop computers
- CD-ROM library
ANSWERS TO COMMON QUESTIONS

I am going on vacation (or to conference, interviews, or taking boards). What do I do about clinic?

First make sure you have your schedule request in to the chief resident. He or she will review the schedule for conflicts then forward it to Cindy who sends it on the Denise Heischman in the IMC. Denise adjusts the schedule. Review your schedule when it appears in your lab box and let Denise know if it needs to be corrected.

I have an ER rotation coming up. Can I make sure I’m not in clinic at the same time?

This is different from the above question because they make their schedule out earlier and they don’t always have the same chief every month. Your best bet is to find out who is the chief for the month you’ll be on and contact him/her with your off-call requests. You should also talk to Denise and the medicine chief resident to be sure there are no conflicts.

What do I do about maternity leave?

You generally sign out to the residents doing IMC. If you have any patients with active work-ups or frequent problems, you should make sure the chart reflects it. It may be helpful to delegate a trusted colleague to take over the care of those patients while you are on leave. You should also contact MedEd to work out the details of taking time off and meeting ABIM and residency requirements.

Somebody asked me to cover next week. What do I do?

Check his/her telephone, lab, and document queues daily and be available for phone questions. You should address anything that can’t wait for him/her to get back, especially prescription refills. Time stamp everything you have reviewed and change the reason for the encounter to “FYI” if the encounter does not require further action but you want the resident to know about it. You do not have to fill out their disability forms or home health care orders unless you know the patient well.

If I’m not on the schedule on certain days during IMC month, do I have the day off?

You still have to be available by pager from 7:30 am to 5 pm, unless you are post-call. If you are planning to take a vacation day, you have to find someone to cover for you and let the nurses on your team and Denise know who is covering. It also counts against your vacation time.

I have a family emergency and I have clinic today. Who do I call?

Call the chief resident and the IMC. The chief can facilitate contacting other people and the IMC needs advance notice so they can reschedule or cancel your patients’ appointments ASAP. If the IMC can’t reach all the patients, your colleagues have to cover them for you.
POLICIES

PATIENT DISMISSAL POLICY

The mission of the Internal Medicine Center is to provide quality care to all patients, regardless of their ability to pay, their social situations, or other issues which might preclude their receiving care elsewhere. Many patients cared for in the Internal Medicine Center have physical, social, financial, or emotional limitations to receiving health care. For others, the Internal Medicine Center is the provider of last resort. Therefore, patients will be dismissed from the clinic only after every avenue to providing their care has been exhausted. The following procedure is to be followed:

1. A patient may be summarily dismissed from the practice if he/she exhibits violent or threatening behavior toward any staff or patient in the clinic.

2. Threatening words or foul language alone is not sufficient to summarily dismiss a patient from the practice. A contract should be made and discussed with the patient regarding any future use of threatening or foul language.

3. Missed appointments alone are not a sufficient reason to summarily dismiss a patient from the practice. Should a patient consistently miss scheduled appointments, it is important to assess possible reasons that the patient has not kept the appointments (transportation, financial, etc.) and assist the patient in resolving these issues. The social worker, psychologist, and nurses are available to assist the resident in this process. (See “Missed Appointments Policy”)

4. Non-compliance alone is not a sufficient reason to summarily dismiss a patient from the practice. The resident should assess possible reasons for non-compliance and discuss with the patient, developing a treatment plan to be followed by patient, doctor, and staff.

5. Nonetheless, a pattern of noncompliance, lying, abusive behavior, forged prescriptions, or abuse of prescription medications might suggest that the patient could be best cared for elsewhere. A termination procedure should be followed by sending a registered letter, providing care for at least 30 days, and helping to find a new physician if the patient has active medical problems.

6. Patients may request a new physician in the practice on two (2) occasions. A third request will result in referral elsewhere.

7. Patients discharged from the IMC may still receive care on inpatient medical teams but they WILL NOT receive follow-up care in the IMC.

Rev 5/2008
DIFFICULT PATIENT TREATMENT PLAN
POLICY

The mission of the Internal Medicine Center is to provide quality care to all patients, regardless of their ability to pay, their social situations, or other issues which might preclude their receiving care elsewhere. Many patients cared for in the Internal Medicine Center have physical, social, financial, or emotional limitations to receiving health care. For others, the Internal Medicine Center is the provider of last resort. Therefore, patients will be dismissed from the clinic only after every avenue to providing their care has been exhausted. The following procedure is to be followed:

1. A patient who is identified by the doctor or nurse as being a "difficult patient" due to non-compliance, excessive or unreasonable demands on the staff, or other issues is to have a treatment plan developed.

2. The treatment plan should be developed by the physician with input from the team nurse, psychologist and medical faculty.

3. A nurse-case manager should be assigned to the patient.

4. This treatment plan should list the patient's medical problems, past medical treatment, and proposed medical treatment, including recommended lab tests, referrals to specialists, and medications.

5. The physician should discuss the treatment plan with the patient, and both sign it.

6. Should the physician and patient not agree on the proposed treatment plan, they should discuss the reasons for the disagreement in an attempt to resolve it.

7. If agreement on the proposed treatment plan is not possible, the patient may choose to have his or her medical care provided elsewhere.
MISSED APPOINTMENTS
POLICY

The mission of the Internal Medicine Center is to provide quality care to all patients, regardless of their ability to pay, their social situations, or other issues which might preclude their receiving care elsewhere. Therefore, patients will be dismissed from the clinic only after every avenue in providing their care has been exhausted. The following procedure is to be followed:

Should a NEW patient miss the first scheduled appointment, a letter will be sent explaining the appointment policy of the IMC. If a new patient misses two scheduled appointments, the patient will be sent a letter informing him/her that he/she must seek care at another office.

Should an ESTABLISHED patient miss an appointment, the patient will receive a letter informing the patient of the policy. If the patient misses a second consecutive appointment, the patient will receive a letter reminding him/her of the policy and a warning that the next missed appointment may lead to dismissal from the practice. If the patient misses three consecutive scheduled appointments, the patient will receive a letter informing the patient of his/her dismissal from the practice.

Letters for each situation are available in ECW letters under “Missed Appointments” and letters sent to patients regarding missed appointments can be found via the patient hub under “Letter Logs.”
GUIDELINES FOR PRESCRIBING CONTROLLED MEDICATIONS

Initiating Chronic Opioid Therapy for Chronic Pain Management

**Rule out Addiction using an AUDIT (Alcohol Use Disorders Identification Test) and CAGE**
- Ask family or significant other the f-CAGE (CAGE questionnaire from family’s point of view)
- Perform one or more toxicology tests
- Inquire of prior physicians re: use of controlled prescriptions
- If history of current or prior addiction, ever abused opioids?
- Identify a clear diagnosis
- Document an adequate work-up
- Ensure that nonopioid therapy failed or is not appropriate (treatment rationale)
- Identify anticipated outcome
- Implement an opioid contract
- Consult a physician with expertise in the organ system involved
- Generate OARRS report to confirm patient’s medication history and pattern of use

**Continuing Chronic Opioids for Chronic Pain Management in a Patient New to Doctor**

**There must be a clear diagnosis of a medical condition for which chronic opioid therapy is indicated**
- There is documentation of a thorough medical work-up
- There is impairment of function
- Nonopioid multimodal therapy has been tried and failed e.g. physical therapy, blocks, counseling

**Contraindications to opioid therapy must be ruled out in any patient under consideration for chronic opioid use.**

CONTRAINDICATIONS TO OPIOID THERAPY

- Allergy to opioid medications
- Current addiction to opioids
- Past addiction to opioids
- Prior conviction for narcotic trafficking or deception to obtain medications
- *Never use opioids in patients with past or current addiction*

PRESCRIBING CHRONIC OPIOIDS

- Have a monitoring strategy e.g. monthly or bi-weekly visits
- Document functional improvement
- Titrate opioids to improved function
- Monitor medications (pill counts)
- Avoid nonplanned escalation
- Monitor for scams e.g. “lost or stolen prescription,” altered prescription, doctor-shopping (OARRS)
- Perform occasional toxicology tests (at least quarterly)
- Document all the above
DECISION MAKING STRATEGY

Chronic Intractable Pain with Impairment of Function

↓

Failure of Non-opioid Chronic Pain Management Therapy
(physical therapy, pain management program)

Addiction Ruled Out?

YES

↓

Begin multi modal chronic pain management
with chronic opioids and monitor for improved
function and evidence of addiction

If evidence of addiction, revert to
detoxification and non-opioid pain
management approach

NO

↓

Detoxify and restart an opioid-free
multi modal chronic pain
management program AND
an addiction recovery program

If this fails, refer to a methadone
maintenance program and
continue chronic pain management
ANTICOAGULATION CLINIC  
(COAG CLINIC)  

I. Warfarin Contract  
The Warfarin contract outlines the terms for continuing participation in the anticoagulation clinic. These terms include:
- compliance with appointments and dosage changes  
- access to transportation  
- availability by telephone  
- understanding of the potential risks of taking warfarin  

This will be filled out by the RN/LPN staff whenever the patient is established with the Coag Clinic.  

II. Dismissal from Coag Clinic  
This will be at the discretion of the resident involved in the patient’s care and the Coag Clinic staff. Dismissal from the Coag Clinic does not mean dismissal from the IMC. 

III. Protocol for New Warfarin Patients  
These are patients who do not have an established IMC physician at the time of hospital discharge. 

A. Call the IMC to make a SEPARATE appointment for the Coag Clinic preferably after the first post-hospital follow-up. If the patient needs to be seen for an INR prior to their first IMC visit, the resident must speak to one of the Coag Clinic staff to make this arrangement.  

B. Patients should never be told to just come to the IMC for an INR check without prior notification of the Coag staff.  

C. If a patient is discharged during off hours or from the emergency department, the resident should call the doctors’ message line (53664) and leave the following information on the answering machine:  
   - patient’s name and phone number  
   - resident physician assuming care  
   - reason for warfarin use  
   - current therapy (LMW Heparin, warfarin dosage, strength of pills given)  
   - INR at discharge  
   - when patient needs to be seen  

The Coag Clinic staff will notify the patient the next day to schedule an appointment. 

IV. Protocol for Established Patients  
Patients should be scheduled separately for a Coag visit to get their INR check and be seen by Coag Clinic staff. Residents do not need to see their patient when they come in for a coag clinic visit. Residents will be assigned twice to staff in the coag clinic, with the nurse, during their IMC rotation as part of the EIP requirement. INR checks can also be done when patients are being seen for their regular IMC visits.
INTERNAL MEDICINE CENTER

ADDICTIVE MEDICATION AGREEMENT

Addictive Pain Medication Informed Consent Agreement
I understand that I am being prescribed regularly scheduled addictive medication for chronic pain control. It is unlikely that the use of this prescribed medication will completely eliminate my pain, and will be given to me as long as it is medically appropriate, and I follow the terms of this agreement. I agree to have a photocopy of my driver’s license or government issued ID made as part of my chart.

Expected Benefits
- Better control of my pain
- Increased capacity for physical activity
- Improved sleep
- Decreased use of other treatment modalities, i.e., nerve blocks, acupuncture, bedrest, elective surgery, etc.

Possible Side Effects
Nausea, constipation, stomach cramps, difficulty with urination, itching, loss of appetite, confusion, dizziness, fatigue, flushing, sweating, depressed respirations, and/or sexual dysfunction are among the most troublesome side effects of addictive medication. At times, it may be necessary to prescribe additional medication to minimize the side effects. Sometimes, the addictive medication will need to be discontinued.

I understand that I may not be able to safely operate machinery or drive while on this medication, especially during initiation of the medication or adjustment of dosages. I will need to make honest, careful judgments about my alertness and/or physical coordination while taking this medication to minimize risk of injury to myself or others.

Possible Complications/Problems
I understand that the possible problems and/or complications associated with chronic addictive therapy include:

Physical dependence
It will develop and I will need medical supervision to safely come off the medication. I understand that if I run out of my medication too soon or stop it suddenly that I could experience withdrawal symptoms which can be uncomfortable.

Psychological Dependence
Some patients become “psychologically” dependent on this medication and begin to crave it, independently increase their dosages, seek additional supplies from other doctors, and/or misuse the drug to control stress, disappointment, anxiety, or depression. This is a reason to taper and discontinue treatment.

Addiction
Addiction implies the abuse of a drug, and is defined by certain behaviors, including energy and time focused on obtaining medication, along with a decline of normal family and work functions.

Terms of the Agreement
I understand that addictive medications are being used to improve my overall level of function. Because the medications are addictive, certain rules must be followed for my own protection, safety and health. I agree to follow these rules precisely. I understand that not adhering to these rules will result in termination of the medication or of my care under your supervision (given 30 days to find a new physician.)

Rules that help to prevent addiction
1. I agree that the Internal Medicine Center will be the only physician prescribing this medication for me. I am not permitted to get such addictive medication from any other doctor, clinic, or Emergency Room for my current condition.

2. If I develop a new injury or pain problem and I am prescribed addictive medication for this, the prescribing physician must confirm this with Internal Medicine Center by notifying his/her office.

3. Addictive pain medications are controlled substances, and, therefore lost or stolen prescriptions will not be automatically replaced.
4. Stolen prescriptions must be reported to the police before any replacements will be made.

5. I will fill my prescriptions immediately, store them in a safe place, and I will not give or sell them to others.

6. I understand that I must keep all scheduled appointments with my doctor and follow through with laboratory work that is ordered.

7. The use of this medication will be strictly monitored and will come from one pharmacy. I will inform my doctor’s office of the pharmacy I use, and will notify them if I change pharmacies.

**Pharmacy name:**
**Pharmacy phone #**

I understand that my doctor’s office may contact my pharmacy at any time to determine my compliance with this agreement and to inquire about my prescription file. They will only access information on the controlled substances I am being prescribed.

8. A urine and/or serum toxicology screen may be administered at any time as deemed necessary by my doctor. I will inform my doctor of any legal or illicit substances I have taken within the past 3 days. If drugs other than the ones prescribed are found, I agree to have the police notified.

9. I understand that my doctor will check the Ohio Pharmacy Board database, and if there is any suspicion of my using multiple doctors/pharmacies to obtain controlled medication, I understand that my doctor will notify the police.

10. If I run out of my medication early, I will have to wait until the next regularly ordered refill. Extra medication will not be given, and no refills for Addictive or other controlled medications will be prescribed by telephone.

11. Any altered or forged prescriptions, or any attempt to sell or give my medication to someone else will result in immediate termination of this agreement. If this happens, my medication will be tapered and then stopped, and I will be discharged from care, resulting in my having to establish care with another physician. The police will be notified.

12. The continuation of this agreement will be based not only upon my compliance to its terms regarding Addictive usage, but my compliance with other medical recommendations, i.e., physical therapy, psychological counseling, participation in a pain clinic, etc.

13. If this medication ceases to be effective, my doctor and I will take this as an indication that another treatment plan will need to be developed.

14. The dosage must remain exactly what was agreed upon at my visit or in my last telephone conversation with the office. The dosage must not be increased or decreased without first checking with the office. I understand that I will never take an “extra pill” for pain.

15. The benefit of the medication to me will be determined by my function in life, and not by my report of pain relief. This is for my own protection, as one of the first signs of addiction is loss of function.

I hereby authorize you to fax or send this information to my pharmacy.

I have read and agree to all of the rules outlined above, and give my consent to be prescribed pain medications.

______________________________________________________________
patient

______________________________________________________________
physician

**DIAGNOSIS/CONDITION FOR WHICH CONTROLLED MEDICATIONS ARE BEING PRESCRIBED:**

<table>
<thead>
<tr>
<th>Name of Medication:</th>
<th>Dosing interval:</th>
</tr>
</thead>
<tbody>
<tr>
<td>SPECIALISTS SEEN</td>
<td>DATE</td>
</tr>
</tbody>
</table>

Rev 2008/03/27
CAGE Questionnaire

Patient name_________________________________________________________Date________________________________________

Have you ever felt you should Cut down on your drinking?

Have people Annoyed you by criticizing your drinking?

Have you ever felt bad or Guilty about your drinking?

Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (Eye opener)?

A total score of 2 or more “yes” answers is considered clinically significant
Alcohol Use Disorders Identification Test (AUDIT)

Patient name__________________________________________________Date___________________________

Scoring: 0 1 2 3 4

1. How often do you have a drink containing alcohol?
   Never       Monthly or less  Two to four times a month  Two to three times a week  Four or more times a week

2. How many drinks containing alcohol do you have on a typical day when you are drinking?
   1 or 2 3 or 4 5 or 6 7 to 9 10 or more

3. How often do you have six or more drinks on one occasion?
   Never       Less than monthly  Monthly  Weekly  Daily or almost daily

4. How often during the last year have you found that you were not able to stop drinking once you had started?
   Never       Less than monthly  Monthly  Weekly  Daily or almost daily

5. How often during the last year have you failed to do what was normally expected from you because of drinking?
   Never       Less than monthly  Monthly  Weekly  Daily or almost daily

6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?
   Never       Less than monthly  Monthly  Weekly  Daily or almost daily

7. How often during the last year have you had a feeling of guilt or remorse after drinking?
   Never       Less than monthly  Monthly  Weekly  Daily or almost daily

8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?
   Never       Less than monthly  Monthly  Weekly  Daily or almost daily

9. Have you or someone else been injured as a result of your drinking?
   No  Yes, but not in the last year  Yes, during the last year

10. Has a relative or friend or a doctor or other health worker been concerned about your drinking or suggested you cut down?
    No  Yes, but not in the last year  Yes, during the last year

Cut-off point of 10/40 indicates problem drinking  TOTAL___________________
APPENDICES

IMC MISSION STATEMENT

The IMC is the supportive interaction of patient, physician and staff that fosters the delivery of comprehensive, high quality, cost-effective primary care as part of a medical teaching institution.
APPENDIX A-1

DOCUMENTATION REQUIREMENTS FOR E/M CODING
Office Visits: Established Patients

History:

<table>
<thead>
<tr>
<th>Level</th>
<th>HPI</th>
<th>F/S/Phx</th>
<th>ROS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1 (99211)</td>
<td>None required</td>
<td>None required</td>
<td>None</td>
</tr>
<tr>
<td>Level 2 (99212)</td>
<td>Very Brief / No clear guidelines but this is usually a 10min visit / should be less than that for level 3</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Level 3 (99213)</td>
<td>Problem focused Only 1-3 qualifiers needed / ie- chest pain: burning and in left chest / qualifiers are quality and location of pain</td>
<td>None</td>
<td>1 system that is pertinent to the main complaint / ie- cardiac ROS in the example of chest pain</td>
</tr>
<tr>
<td>Level 4 (99214)</td>
<td>Detailed / defined as history on one problem that includes 4 or more qualifiers Or: history describing the status and condition of 3 chronic problems</td>
<td>Documented questioning in one of the three areas: Social Family Hx Past Hx</td>
<td>At least 2 systems covered and documented within ROS (see list of systems below)</td>
</tr>
<tr>
<td>Level 5 (99215)</td>
<td>Comprehensive history on a complex problem including 4 qualifiers Or: complete history on 3 chronic problems</td>
<td>Documented questioning in two of the three areas: Social Family Hx Past Hx</td>
<td>At least 10 systems covered and documented within ROS</td>
</tr>
</tbody>
</table>

*All abnormal items in the ROS must be explained with further history / detail
*Previously document social / family Hx does NOT qualify for documentation for that F/U visit

Physical Exam:

<table>
<thead>
<tr>
<th>Level</th>
<th>Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1</td>
<td>No specific criteria</td>
</tr>
<tr>
<td>Level 2</td>
<td>1 exam point from any organ system</td>
</tr>
<tr>
<td>Level 3</td>
<td>6 exam points from any system</td>
</tr>
<tr>
<td>Level 4</td>
<td>12 exam points from at least 2 separate systems</td>
</tr>
<tr>
<td>Level 5</td>
<td>18 exam points from at least 9 systems</td>
</tr>
</tbody>
</table>

The IMC progress note has boxes for check marks. These boxes correspond with examination items that are recognized as qualifying for one point to meet the above point requirements. Three vital signs documented by the MA's qualifies as one point for the documentation criteria.
For example- 6 check marks on the progress note qualifies as adequate exam for a level three exam. The vital signs would give an extra or seventh point.

Medical Decision Making:

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Presenting Problem</th>
<th>Dx Testing / Procs</th>
<th>Mgmt Options</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No criteria</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Level 2</th>
<th>Presenting Problem</th>
<th>Dx Testing / Procs</th>
<th>Mgmt Options</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Self limited / minor problem (insect bite, cold)</td>
<td>Labs, CXR, EKG, KOH prep, UA</td>
<td>Rest, Gargle, Elastic Bandage, Superficial Dressing</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Level 3</th>
<th>Presenting Problem</th>
<th>Dx Testing / Procs</th>
<th>Mgmt Options</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>-2+ self limited minor problems -1 stable chronic problem -1 acute uncomplicated illness (sprain)</td>
<td>Non stress test -PFT, Non cardiac imaging w/ contrast, Superficial FNA, Skin BX, Lab requiring arterial puncture</td>
<td>OTC drugs, Minor surgery, PT / OT, IV fluids</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Level 4</th>
<th>Presenting Problem</th>
<th>Dx Testing / Procs</th>
<th>Mgmt Options</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>-1 Chronic illness w/ mild progression or problem <strong>-2+ stable chronic problems</strong> -Undiagnosed new problem w/ uncertain prognosis (ie-breast lump) -Acute illness w/ systemic symptoms</td>
<td>Stress test, Diag Endoscopy, Deep incisional BX, CV imaging, Obtaining fluid from body cavity</td>
<td>-Minor surgery w/ identified risks -Elective major surgery <strong>-Prescription Drug</strong> -Therapeutic nuclear med</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Level 5</th>
<th>Presenting Problem</th>
<th>Dx Testing / Procs</th>
<th>Mgmt Options</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>MORE</td>
<td>MORE</td>
<td>MORE than level 4</td>
</tr>
</tbody>
</table>

Decision Making is the most complex process in deciding how to code a chart. Common practice is to best understand what qualifies as a level 3 and level 4 visit. Then, when seeing the patient decide if the pt qualifies for level 3 or 4. Once the decision on the level is made then focus on making the documentation complete for that chosen level. Start at the end and work backwards. IE- if I am seeing a complicated patient with 2+ stable medical problems I will be sure to ask enough questions to meet a level 4 visit.
Primary Care Physician Documentation for E/M Coding.
Office Visits NEW Patients
3 out of 3 key components required

<table>
<thead>
<tr>
<th>E/M Code</th>
<th>History</th>
<th>Exam</th>
<th>Decision Making</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201 (10 minutes)</td>
<td>cc.c 1-3 HPI</td>
<td>Affected area</td>
<td>Straightforward</td>
</tr>
<tr>
<td>99202 (20 minutes)</td>
<td>c.c. 1-3 HPI 1 ROS</td>
<td>Affected area + 1 other</td>
<td>Straightforward</td>
</tr>
<tr>
<td>99203 (30 minutes)</td>
<td>c.c. 4+ HPI 2 ROS 1 PFS Hx</td>
<td>5 + areas</td>
<td>Low complexity</td>
</tr>
<tr>
<td>99204 (45 minutes)</td>
<td>c.c. 4+ HPI 10 ROS 3 PFS Hx</td>
<td>8 + areas or systems</td>
<td>Moderate complexity</td>
</tr>
<tr>
<td>99205 (60 minutes)</td>
<td>c.c. 4+ HPI 10 +ROS 3 PFS Hx</td>
<td>8 + areas or systems</td>
<td>High complexity</td>
</tr>
</tbody>
</table>

The criteria for a new patient are very similar. The same level of coding requires far more extensive documentation for the new visit. A new visit is defined as a patient that has not been seen by a physician within the same office for the past 3 years.

The following are lists that contain the recognized history qualifiers and the systems for ROS and physical exam. These lists were used to help formulate our current progress note.

<table>
<thead>
<tr>
<th>HPI</th>
<th>ROS</th>
<th>Past Medical, Family, Social HX</th>
<th>Body Areas</th>
<th>Organ Systems</th>
</tr>
</thead>
</table>
APPENDIX A-1

BILLING 101: SIMPLIFIED GUIDE TO BILLING

3 basic components to each note:
   --history (including ROS, PMH, FMH, social, etc)
   --physical
   --medical decision-making

4 basic degrees of complexity to each component (which corresponds with billing levels):

<table>
<thead>
<tr>
<th>Level</th>
<th>History</th>
<th>Physical</th>
<th>Medical Decision-making</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Problem-focused</td>
<td>Problem-focused</td>
<td>straightforward</td>
</tr>
<tr>
<td>3</td>
<td>Expanded problem-focused</td>
<td>Exp problem-focused</td>
<td>low complexity</td>
</tr>
<tr>
<td>4</td>
<td>Detailed</td>
<td>Detailed</td>
<td>moderate complexity</td>
</tr>
<tr>
<td>5</td>
<td>Comprehensive</td>
<td>Comprehensive</td>
<td>high complexity</td>
</tr>
</tbody>
</table>

New patients require all three components to meet a level of complexity to be billed at that level. For example, if the history and the physical are both comprehensive but the decision-making is low complexity, it can only be billed as a new level 3.

Established patients (patients who have been seen here in the past 3 years) require only 2 out of 3 components to meet the level of complexity billed. For example, if the history and the physical are both detailed and the decision-making is only low complexity, the patient can still be billed at established level 4.

Based on this, about 2/3 of your patients will be level 4 (most of the established patients follow-ups) and about 1/3 will be level 3 (mostly the work-ins).

What defines problem-focused?
You stick to the one chief complaint, limit the ROS to the problem and don’t update any of the other history. You only examine the location in question. Example: Suture removal, cerumen impaction, skin laceration.

What defines expanded problem-focused?
You consider the chief complaint and ask related review of systems and you examine other areas that may be relevant. Example: sore throat (fever, chills, cough, headache, myalgias, appetite), examination includes ear, nose, throat, neck for lymph nodes, and one other system such as abdomen for hepatosplenomegaly, skin for rash, lungs and heart.

What defines detailed?
In the sore throat patient above you would do all of the exam listed and ask questions pertaining to additional past history, family history, or social history. You might also address other medical problems, refills, or chronic issues. It is expanded problem-focused plus additional information (but not so much information that you could call it comprehensive).

What defines comprehensive?
Comprehensive is doing everything short of admitting the patient. You will seldom use this level unless you have a very sick patient who is refusing admission.
APPENDIX B

Scheduling Guidelines for Ambulatory Care

Residents are scheduled to see patients in the IMC as follows:

WEEK 1  During the first week of the orientation month of July, interns will see patients with second and third year residents.

WEEK 2-4  During the remaining 3 weeks of the orientation month of July, interns will see 2 patients on their scheduled day of the week. The first appointment is at 9:00 and the second at 10:10 am.

WEEKS 5-8  Beginning with the first week of August, interns will see 4 patients scheduled at 9:00, 9:40, 10:20 and 10:50 am.

SEPT-JUNE  In September their schedules will be increased to 6 patients. At that time they will begin seeing patients at 8:30.

PGY-II Residents see 6-8 patients per half day

PGY-III Residents see 7-10 patients per half day.

JUNE  PGY-III Residents will be expected to transition complicated patients to new physicians and update their patients’ charts.
APPENDIX C

Preceptor responsibilities:

Review of cases:
- Staff all intern cases before the patient has left the examination room
- Staff all resident cases either during the patient’s visit

Patient encounters:
- Be present for the key part of the visit with all patients during an intern’s first six months of training.
- At other times, see patients whenever deemed necessary for patient care or teaching purposes.

Documentation:
- The resident will document the preceptor with whom he or she staffed the patient in the medical record.

Teaching:
- Adults learn better in settings that are learner-centered. Challenge the residents to find answers on their own.
- Identify goals for knowledge and skills acquisition and work towards them together.
- Ask residents to prepare brief talks on clinical questions raised during case discussions.
- Sit in periodically on resident-patient encounters when you don’t have to. Often sitting in for part of a visit can be useful, i.e., observe a resident giving instructions, or observe a particular part of history taking. Tailor this to the goals articulated by the resident.
- Encourage the resident to be a “lifelong learner” by fostering the practice of evidence-based medicine and literature review.
- Listen to residents’ conclusions and management plans.
APPENDIX D

Oral Presentation Suggestions

Oral Presentation:
Your oral presentation should be an appropriately detailed rendition that is interesting, complete yet concise, and logical. Here are some guidelines you might use:

Introductory Sentence:
Include:
A brief description of the patient
A concise listing of active medical problems and their current status

Example: Ms. P is a 48 year old, with a history of well-controlled hypertension, poorly controlled type II diabetes, and recurrent UTIs, who presents today with a complaint of...

HPI:
Chronological description of chief complaint(s)
Pertinent positives and negatives as related to active medical problems

Medications:
List current medications
How long on current medications
Highlight recent changes in medications or doses

PE:
General appearance
Vitals (Highlight as appropriate)
Highlight pertinent positives and negatives

Data:
Highlight pertinent positives and negatives

Assessment and Plan:
List problems in order of importance OR by system

Based on your evolving understanding of the problem, name the problem at the highest level of certainty

For EACH problem, discuss:
  Assessment: RELEVANT differential
  PLAN: Delineate appropriate plan based on differential

Highlight any medication changes you are making
APPENDIX E

Year End Schedule for PGY-III

June 1st thru June 22nd, you will be scheduled in the IMC on your regular half-day session. You will no longer have regular scheduled patients but you may bring in any patients you need to see and finish your patient charts and sign offs. You must coordinate those appointments as usual with the front office or the nurse. You are still expected to follow thru with your hospital patients during this time.

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Monday in June</td>
<td>Post Grad Day</td>
</tr>
<tr>
<td>Last Friday in June</td>
<td>Roast/Graduation</td>
</tr>
<tr>
<td>Last Friday in June</td>
<td>Friday is the last day of your residency.</td>
</tr>
</tbody>
</table>

Congratulations and thanks for your cooperation with the year-end schedule. As usual, we as faculty and staff here approach this time period with ambivalent feelings. We’re glad that you have made it, that you will be graduating, and that you will be either assuming fellowship duties or entering practice. We are happy for each and every one of you. On the other hand, we truly are sad to see our day-to-day relationship come to an end.
APPENDIX F

IMC Telephone Numbers

Patient line 375-3315
FAX 375-7779
Patient appointment line 375-7960
Patient prescription line 375-7941

Private line (doctors only) 55317 for scheduling post-hospital visits
53317

Message line (doctors only) 53664 ER messages or messages for the chart

Paula Warner—Practice Manager 53874
Beep 0791

Dave Conrad—Clinical Manager 53638
Beep 4166

Tom Balchak—Social Worker 54658
Beep 4358

Michelle Cudnik—PharmD 53602
Beep 1295

Team A nurse 53454
Team B nurse 53632

Palliative Care Clinic 53039

IMC Faculty: (see Summa Phone Book)
  • Skip Radwany
  • Dave Sweet
  • Stephanie Tan
  • Mike Rich
  • Linda Ha
  • Troy Bishop
  • Diana Stewart
  • Julie Radwany
  • Ron Jones
  • Linda Sims
  • Dean Frate
  • Rex Wilford
  • Michelle Cudnik