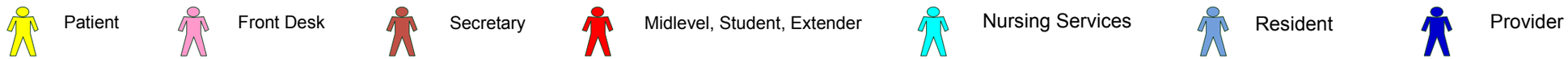
Best Practice Workflow: Routine Patient Visit



Pt Accesses System

- Appointments are made in centralized Registration desk: Reg/sched system interface to EHR ambulatory if system is not integrated
- **Record Patient Demographics (sex, race, ethnicity, date of birth, preferred language, and in the case of hospitals, date and preliminary cause of death in the event of mortality)**
- Appointment notes available in EHR schedule
- Need to know all appointment types used to enter in EHR Vendor definitions and have a conversion for encounter types

Scheduling Pre-Reg

- Pre-registration will continue with virtual registration
- Registration and insurance updates need to interface to EHR

Pre Visit

- Two days before the patient is to be seen clinic staff will check the reason for visit and determine if test results are in
- Staff can search open orders for unregulated tests
- Staff may need to contact patient to determine if testing was completed
- Staff will ensure that results are available in the EMR
- If consult reports are essential prior to a patient being seen, staff will contact referring provider/office for reports
- Make appt reminder calls,(automate if feasible) if patient has not responded contact by phone to determine if patient plans to keep appointment or wishes to reschedule

Pt Arrival

- Check in process
- Copies/scans of insurance card, photo ID made
- Patient may be given history forms to fill out
- "arrive the patient on the schedule "to track patient throughput
- Document referring provider and PCP (for f/u letters)
- If patient is 20 minutes late (unless they call) they will be required to reschedule unless the provider has an opening that day
- If provider is running behind, staff will explain this to the patient and give them the option to reschedule
- Develop no show policy, document No Show action in EHR

Rooming/Triage

- Rooming will be done by RN, LPN, MA, if providers room they need to consistently document all the standard rooming information
- PCP and referring doctor information will be collected /confirmed
- Refills needed will be noted
- Reason for visit or chief complaint will be descriptive, not just f/u
- **Record vital signs and chart changes (height, weight, blood pressure, body-mass index, growth charts for children)** **Baseline vitals will include: blood pressure, weight and pulse. New patients should get full set of vitals, BP, T, P, RR, Wt, Ht. **1**
- **Review Meds, each visit including vitamins, OTC, Herbal **2**
- **Review/ Document Allergies**
- History

  New Pt, PMH, PSH, Family, Social, **Substance (smoking history)**

  Return Pt, update
- Orders started per protocol
- Electronically Indicate pt is ready via schedule

Midlevel, Resident, Student

- Reviews pt information, electronic and paper
- History of present illness
- Review of systems
- Physical exam
- Clinical note
- Conference with Attending

Exam/Visit

- If relevant information not filed in chart define workflow for getting it (i.e. labs, imaging etc)
- Consent obtained for in-clinic procedures
- Nurse present for exam, close by, on to next patient, called as needed
- **Update problem list based on ICD-9/10 or SNOMED**
- **Maintain active Dx**
- **Where appropriate trigger one Clinical Decisions support rule**

Orders Written

- Residents, Mid level practitioners (PS, NP, PT,OT,SW, Dietician etc) can enter orders without cosign. Medical students can pend orders and will be released by precepting MD. Any verbal orders that the nurses enter must have written protocols in the clinic.
- Preference list will be created for ease in order entry
- **All Orders entered must have associated diagnosis; Conduct drug-drug/ drug- allergy checking**
- Complete consult orders in the system, including required information
- MAs, HCT, Secretaries cannot sign any medication orders. RN & LPN can enter with cosign from authorizing MD.
- **Medications will be done by E-prescribing, or for printed scripts, tamper resistant paper checking formulary.**
- Samples and meds dispensed at the clinic will documented in EHR

Visit Documentation

- Encounter documentation is done using charting tools or dictation within 24 hours of appointment
- Dictation needs to be one system for all providers
- Send consult or visit note automatically faxed of generate letter electronically, or communicate via secure messaging) within 24 hrs
- All transcription will be signed within 48 hours of receipt.
- **Interface to Immunization Registries or others as feasible**
- **Submit electronic syndromic surveillance data to public health agencies if appropriate**
- **Document selected clinical quality measures**

Visit Discharge

- **Print Summary of Care Record (including patient instructions and current medication list)**
- Review patient instructions, encounter orders,
- **Department educational handouts appropriate to patient and condition**
- Patient follow-up, consult and testing appointments will be made prior to the patient leaving ****3**
- Give prescriptions if hard copy

Check-Out

- Verify appointments are made
- Make appointments if duties of check out

HAYES MANAGEMENT CONSULTING

****1** Will need to consider how to accomplish this with high volume clinics
****2** MA's may need additional training to be able to do this task
****3** Evaluate potential for clinic staff to be able to book appointments directly in the department they are sending a patient to when possible to ensure care continuity
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