

ADULT PT WORK FLOW

*Pre-Appointment/Check-in
REVIEW and DOCUMENT
Front Desk*

*Select Patient on schedule
Open Pt Summary*

*REVIEW AND DOCUMENT-
Nurse and Physician*

Allergies
Current meds
Problem list
Recent labs
D/M flow sheets
PMH, Proc, Hosp, FH, SH

SET AGENDA

*Copy & Review Prior Note
Identify Today's Problems
Review Alerts*

Insert Additional Templates

PROVIDE CARE

HPI, ROS, SH, FH, PE
*Edit Prior Note IF Appropriate
Order and Document*
Office Testing and Office Tx

ASSESSMENT

*Document Today's Visit Issues
Use ICD codes only
Add Visit codes to Chr Dx list*

MEDS

*Update and order Medications
Refill, modify, or d/c Old meds
Add New meds
Send and/or Print Rxs*

ORDERS (Check Alerts)

Update and enter Orders
Labs, Xrays, other tests
today and future
Durable equipment
Exercise and diet
Referrals
Consultations

WRAP-UP

*Append Pt Educ Materials
Clarify Pt Action Steps
Provide Printed Rxs
Enter Next Office Visit*

BILLING

*Review, improve, verify E&M
Add Special Codes (PQRS, etc)
Add Procedure codes (CPT)*

CHART COMPLETION

SCHEDULED TASKS

MEANINGFUL USE OBJECTIVES AND QUALITY MEASURES

- Incoming labs and diagnostic test results are received and automatically populate EHR or data is entered manually as structured (Menu #2). Send results to physician for review. Send to patient portal within 4 days (Menu #5)
- Record demographics including race and ethnicity, preferred language, other (Core #4)
- Ask patient if access to Portal (Menu #5) is desired. Record email, indicate patient is a "portal" patient, and provide information on how to use portal.
- Record patient preferences on how to receive reminders (Menu #4)
- Nurse records Vitals for patients age 2+ (Core #8, Core CQM #1 and Core CQM #2)
- If BMI outside parameters, document follow-up plan or make note to physician (Core CQM #1)
- Nurse sends request for clinical information to other providers if not already in EHR (Core #14)
- Nurse records smoking status for patients age 13+ (Core #9 and Core CQM #3). If smoker, nurse either alerts physician (Core CQM #3) or provides cessation counseling and documents.
- Nurse reviews allergies and documents as structured data or "NKA" (Core #7)
- Nurse reviews medications and documents as structured data or "NKM" (Core #6)
- Nurse performs medication reconciliation if transferred from another facility/provider (Menu #7) and documents
- Nurse checks alerts, performs standing orders/order sets (e.g. vaccines, preps, etc.) (Menu CQMs)
- Review problem list and document as structured data or "NKP" (Core #5)
- Review recent labs and Vitals. If hypertension, add to problem list (Core CQM #2)
- Review alerts related to current problems (Core #10)
- Use templates and narrative text to record notes
- Order office testing and treatments using CPOE (Future Stage Core #1). Lab tech records in-house results as structured data (Menu #2)
- Add new diagnoses and problems to problems list (Core #5) using ICD-9 codes or drop-down lists. Update chronic problems.
- Order new medications using CPOE (Core #1): Check drug-to-drug and drug-to-allergy (Core #2)
- Check formulary (Menu #1)
- Transmit electronically (Core #3) and/or print
- Use CPOE to order labs, x-rays, other diagnostic tests if possible (Future Stage Core #1)
- Counsel on smoking cessation and document (Core CQM #3) unless nurse completed.
- If BMI outside parameters, provide weight, exercise, diet counseling and document unless nurse completed (Core CQM #1)
- Order consultation and referrals using CPOE (Future Stage Core #1). Team initiates referral process.
- Check alerts for preventive care, follow-up care and other quality measures that apply to patient (Core #10 and #11 and Menu CQMs). Order procedures using CPOE (Future Stage Core #1).
- Send reminder to portal. (Menu #4).
- Provide educational materials for patients and document (Menu #6)
- Print Clinical Summary (Core #13) and give to patient or send to portal
- If patient requests a copy of medical record, send message to staff. Staff logs request, prepares electronic copy and sends to portal, CD, or Flash drive (Core #12).
- Referral and consultation scheduling is completed prior to patient leaving and Summary of Care record is generated for specialist (Core #14). Summary of Care record/CCD is sent electronically (Menu #8).
- Review procedure codes and E & M codes that have been automatically populated
- Add PQRS codes if reporting through Claims/Registry—not necessary if reporting through EHR
- Nightly: Set task to transmit immunization (Menu #9) and syndromic surveillance data (Menu #10)
- Monthly: Run CQM and PQRS reports (Core #11); Generate patient lists (Menu #3). Identify root cause. Send Reminders (Menu #4) and schedule follow-up care.
- Monthly: Discuss quality reports at staff meetings and test strategies for improvement. Assign responsibilities to all team members.
- Annually or when EHR changes are made, conduct Risk Assessment (#15). Train.