Clinical Staff Standard Work ~ 2025 Q1

For Wellness Visit

Before you get the patient

1. Go to the Exam Room – is it clean and ready?
2. Check the patient chart
    a. Review Appointment Note – any other issues?
    b. Check smoking status
    c. Go to Reason for Visit and load Health Maintenance or Medicare Wellness ep
    d. Go to HPI and load last Wellness HPI if appropriate (same provider and age range), and Tobacco ep if appropriate. KEEP OLD INFORMATION – MA WILL ONLY ASK RISK/SAFETY, COGNITIVE, AND GET UP AND GO QUESTIONS.
    e. Review QM and queue up any needed preventive care and vaccine orders.
    f. If Pap needed, prepare room (check last pap – QM not always the best indicator)
    g. People with cervix 13-24 get urine cup and label for GC/CT

Get the patient from the Waiting Room

3. Update Patient Status and Exam Room Location
4. If the visit is an Initial Medicare of Welcome to Medicare, patient must also have an Eye Exam during the visit
5. Review Reason for Visit with patient
    a. Add any additional relevant notes
    b. If Virtual Visit, add Virtual Visit ep
    c. If Medicare patient, add Medicare Care Plan ep
6. Offer the patient a chaperone for the visit
7. Go to Patient Preferences
    a. Review/update Care Team
    b. Review/update Pharmacies (add local, mail-away, etc.)
8. Go to Vitals and enter height and weight (ok for pt to opt out except CHF visit). Please enter LMP in the Notes field of the Vitals section
9. Review allergies
10. Review med list
    a. Perform Medication Reconciliation as per P&P
11. Go to the Social History
    a. Review Social History including illicit substance question
    b. Print Healthcare Proxy if not in chart
    c. Provide MOLST form if patient does not have one and is 65+
    d. Ask if patient is a smoker, go to Reason for Visit and open Tobacco/vaping ep (if not already done in Step 2d above)
    e. Complete smoking pack-years for smokers and former smokers add years since last cig if former smoker. Add dx to problem list (former smoker/smoker/nicotine dependence)
12. Go to Screening Questions
    a. Record PHQ-9 (transcribe patients answers into Screening section)

    b. Record AUDIT-C (can use patient answers from Social History to enter into Screening section)
    c. Ask the question about other illicit substances in social history.
13. Review QM tab
    a. Add relevant QM Order Sets to the A/P (leave orders in A/P even if patient declines)
    b. Look for any missing documents send request (DM eye exams, mammograms, etc.)
    c. Ask patient to remove shoes if due for DM foot exam.
    d. Ask patient to give urine if due for albumin or GC/CT
14. Review HPI
    a. Complete Get Up and Go Safety Questions for Medicare members
15. Go to Vitals section
    a. Record BP (if BP high, re-check after another 5 minutes or communicate to provider)
    b. Record Heart Rate
16. Administer any Vaccines
    a. If patient declines a vaccine, use the Vaccine Refused Order Set and document WHICH vaccines were refused.
    b. Pedi patients discuss needed vaccines with parents and notify RN
17. Complete billing for Vaccines and Screeners
    a. Add billing codes (either before the provider goes into the room or after the provider completes their visit).
    b. If patient declines other services (pap, mammo, etc.) leave Diagnosis in the Assessment/Plan and add “Patient Declined macro” in the notes field. Remove the order.
18. Ask patients to complete forms while they wait: SWYC, SOGI/REaL, CCM, HCP, CRAFFT (teens)
19. If sensitive exam, ask if patient wants chaperone
20. If a provider works with a student, ask permission for student and add macro.
21. Provide the patient with a gown to change into for exam.

Choose DONE WITH INTAKE

Provider Standard Work:

- Review Social History, Risk assessment, PHQ-9 (need/no need), Audit-C, illicit Substances, SOGI/REaL (initial), MassHealth ACO SDOH (need/no need), maternal depression, CRAFFT, SWYC review/score, consider adding Safety and Social Determinates EP
- Discuss GC/CT testing for 13-24 yo patients with cervix
- Create plans for patients with positive Depression screens.
- Use A/P Encounter plan to create a “health plan” for Medicare patients-tell patients
- Review Medications and update list per MA review-take out meds patient is not taking.
- Review Athena RAF/HCC problems not addressed. Discuss with patient.
- If discussing medical conditions (not wellness) inform patient that you are addressing their non-wellness concerns/conditions.

- After visit use Check out slip to book labs and upcoming visits. Select appropriate wellness f/u interval.

For Disease Management or Follow-up Visit
Does not include DM specific work such as EKGs, A1C, etc.

Before you get the patient

1. Go to the Exam Room – is it clean and ready?
2. Check the patient chart
    a. Review Appointment Note – confirm Disease Management or Follow-up
    b. Review Social History for Tobacco Use and (if appropriate load Tobacco use ep)
    c. Review the QM for any preventive care needs – load orders

Get the patient

3. Get the patient from the Waiting Room
    a. Review Reason for Visit with the patient
    b. Add relevant notes
        a. If Virtual Visit, add Virtual Visit ep
        b. If Medicare patient, add Medicare Care Plan ep
    c. Offer the patient a chaperone for the visit
4. Go to Patient Preferences
    a. Review/update Care Team
    b. Review/update Pharmacies (add local, mail-away, etc.)
5. Go to Vitals and enter height and weight. If the patient has a GYN complaint, please enter LMP in the Notes field of the Vitals section
6. Review allergies
7. Review med list
    a. Perform Medication Reconciliation as per P&P
    b. Queue up needed refills-ADD 4 RF
8. Go to Social History - review alcohol and tobacco use update PYH and if former smoker years since last cigarette.
9. Review QM
    a. Add appropriate QM Order Sets (even if patient declines, leave orders for provider to discuss)
    b. Look for any missing documents (paps, mammos, DM eye exams, etc.)/request
    c. Get urine if due for microalbumin or GC/CT (12-24) on QM
10. Go to Vitals section
    a. Record BP (if elevated, re-take again in 5 minutes and leave the heart on the door for the provider)
    b. Record Heart Rate
    c. Add LMP for any abdominal pain, urinary, pelvic complaint
    d. Provide patient with a gown if they will need an exam. If sensitive exam ask if they would like a chaperone.
11. Administer any Vaccines
    a. If patient declines a vaccine, use the Vaccine Refused Order Set and document WHICH vaccines were refused.
12. Complete billing for Vaccines and Screeners

a. Add billing codes (either before the provider goes into the room or after the provider completes their visit).
b. If patient declines other services (pap, mammo, etc.) leave Diagnosis in the Assessment/Plan and add “Patient Declined at this time” in the notes field. Remove the order.

Choose DONE WITH INTAKE

Same Day Visit

Before you get the patient

1. Go to the Exam Room – is it clean and ready?
2. Check the patient chart
    a. Review Appointment Note – check reason for visit
    b. Go to Reason for Visit and add Reason or load acute ep (if appropriate)
    c. Review QM for any preventive care needs and load relevant orders

Get the Patient

3. Get the patient from the Waiting Room – request urine specimen if appropriate
    d. Review Reason for Visit. Open “Acute EP” if appropriate.
    e. Add relevant notes
        a. If Virtual Visit, add Virtual Visit ep
        b. If Medicare patient, add Medicare Care Plan ep
    f. Offer the patient a chaperone for the visit
4. Go to Patient Preferences
    a. Review/update Care Team
    b. Review/update Pharmacies (add local, mail-away, etc.)
5. Go to Vitals and enter height and weight and LMP for urinary/abdominal complaints
6. Review allergies
7. Review med list
    a. Perform Medication Reconciliation as per P&P
    b. Order needed refills
8. Go to Social History - review alcohol and tobacco use
9. Review QM
    a. Add relevant QM Order Sets (even if patient declines, leave QM order sets for provider to discuss)
    b. Look for any missing documents and request if patient states they have done.
10. Go to Vitals section
    a. Record BP(if elevated, re-take in 5 minutes or notify provider elevated.)
    b. Record Heart Rate
    c. If the patient has a GYN complaint, please enter LMP in the Notes field of the Vitals section and obtain urine for pregnancy test
    d. Provide gown if needed for exam and offer chaperone.
11. Administer any Vaccines
    a. If patient declines a vaccine, use the Vaccine Refused Order Set and document WHICH vaccines were refused.

12. Complete billing for Vaccines and Screeners
    a. Add billing codes (either before the provider goes into the room or after the provider completes their visit).
    b. If patient declines other services (pap, mammo, etc.) leave Diagnosis in the Assessment/Plan and add “Patient Declined at this time” in the notes field. Remove the order.

Run POC test
Choose DONE WITH INTAKE

Telehealth Visit (VV)

When it’s time for the appointment (if there is no Clinical Staff participating, this should be completed by the Provider). If this is completed via video, staff should be in a private space.

1. Go to the patient appointment and complete the Check-in process
2. Once in the encounter
    a. Review Appointment Notes – check reason for visit
    a. Add Virtual Visit ep
    b. If Medicare patient, add Medicare Care Plan ep
    b. If performing via video, Choose Open Online Visit (if the patient is not Online, call the patient to see if they need the Telehealth link sent again). If performing via telephone, be sure and check the link before completing the intake.

Greet the Patient

3. Review Reason for Visit with the patient and open “Acute EP” if appropriate
4. Add relevant notes
5. Go to Patient Preferences
    a. Review/update Care Team
    b. Review/update Pharmacies (add local, mail-away, etc.)
6. Go to Vitals and enter height and weight and LMP for urinary/abdominal complaints
7. Review allergies
8. Review med list
    a. Perform Medication Reconciliation as per P&P
    b. Order needed refills
9. Go to Social History - review alcohol and tobacco use
10. Review QM
    a. Add relevant QM Order Sets (even if patient declines, leave QM order sets for provider to discuss)
    b. Look for any missing documents and request if patient states they have done.
11. Complete billing for any Screeners
    a. Add billing codes (either before the provider goes into the room or after the provider completes their visit).

Choose DONE WITH INTAKE