**Standard Clinical Workflow – June 7, 2017**

**Before getting the Patient from the Waiting Room: in INTAKE**

1. Review the **reason for visit** and review the **appointment type**: The Appointment Type will be listed at the top of the page on the right side. Any appointment notes will be found in the Notes field under the Reason for Visit.
2. Review the **Problem List**: This is found on the left side of the intake page. For Medical Management and Wellness Visits this will help you to identify what encounter plans you will need to open.
3. Review the Social History for **smoking status**: Also located on the left side of the Intake page - click on it to determine if the patient is a smoker.
4. Load appropriate **encounter plan(s)**: Click on the “Reason for visit” tab on left side of page. Choose the + sign and find the appropriate encounter plan. If there is no encounter plan click, choose the appropriate Reason or type it into the Notes field. If the patient is a smoker or recently quit (within 3 months) load the tobacco encounter plan.
5. Load **HPI**: Found on the left side of the intake page, click on the tab. For Medical Management, Wellness Visits and Follow Up visits), find the previous HPI template and load it. For sick visits, open the one most nearly matching the Reason for visit.
6. Review **Quality Management tab**: Located on the left side of the intake page- click on tab to determine any needed services. Queue up orders for chlamydia testing, pap smears, Hep C screen, colonoscopy, mammograms, and immunizations (pediatric and pneumonia vaccines require nursing review).
7. **Prepare room** for any procedure set-up required: Paps, IUD insertion, skin biopsy, etc. Get CO monitor if needed.

**Enter the updated Patient Status and a room number at the top center of the intake page.**

**Call the Patient from the Waiting Room**

1. Verify patient’s **date of birth** using “positive id”
2. Review and update **Patient Preferences** including: pharmacy (primary and secondary), lab, usual provider and any specialists the patient see. Be sure and include Ob/Gyn and Eye Care if appropriate.
3. For **Vitals,** obtain patient’s weight (and height for wellness and pediatric visits).
4. Confirm/clarify **reason for visit**.
5. Review patient **allergies**: Click on allergies tab on left side of page for list of allergies
6. Perform **Medication Reconciliation**: For Wellness Visits queue up all current meds for one year (as per the medication reconciliation policy and procedure). For any other visit type: queue any needed medications.
7. **Social history**: For all visits: confirm alcohol and tobacco use. For Wellness Visits: review entire Social History (through HC proxy question)
8. Enter **screening** data: (Wellness Visits only)

Aged 0-5: SWYC (in Procedures, score only)

Aged 6-12: PSC-Youth (in Procedures, score only)

Aged 12-17: PSC (in Procedures, score only)

Aged 18 +: PHQ 9 (in Screening, enter data)

1. **History of Present Illness**: Sick visits- Begin documentation
2. **Medicare Wellness Visits**: complete functional status section, mark falls risk assessment completed in QM tab
3. **Complete Vital Signs**: BP (as per policy) and pulse. Temperature, respirations, CO Measurement, peak flows, O2 sat measured as appropriate. For pediatric visits, head circumference, vision and hearing tests as appropriate.
4. Administer any **vaccines** needed (refer to insurance grid)
5. Click on “Done With Intake” (upper right side of page). Bill for any services (CO monitoring, immunizations, POC testing you perform

**The Patient is ready for the Provider**