The implementation of an electronic health record (EHR) will introduce changes in the way providers record information about clinical and administrative activities associated with a patient encounter. Your office can also expect changes in patient flow when you move from paper to an electronic system. The goal of this document is to guide a practice in the transition of this workflow from a paper-based operation to one that includes the use of an electronic health record (EHR). It also highlights data elements integral in meaningful use (MU) attainment and patient centered medical home (PCMH).

Please document your current process for capturing information at the point of care.

Assigning an Exam Room

How is room assignment for a patient documented?

Who escorts the patient to the assigned room?

☐ Front Desk Staff  ☐ MA  ☐ MD  ☐ Nurse

Prior to the physician visit, is the chart reviewed for outstanding or follow-up items that should be addressed during this visit?  ☐ Yes  ☐ No

If ‘Yes,’ how is this information communicated to the physician?

Which information is collected and documented before the provider sees the patient?

☐ Vitals  ☐ Reason for Visit  ☐ Medications

☐ Allergies  ☐ Review of RHIO portal  ☐ Refills

☐ Other:

How does the provider know the patient is ready for the encounter?
The Rooming Process: Current State
This is an example of a potential rooming process for a physician’s office.

Workflow diagrams visually show how a task is handed from one person to another until it is completed. Each symbol represents a step in the workflow process:

- **Terminator symbol** represents the beginning or end of a process.
- **Process step** represents an independent step or task.
- **Decision step** represents a question or decision where there are multiple options.
Documenting the Provider Visit
Does the provider review information about the patient (e.g., the paper chart, hospital system) before entering the exam room? □ Yes □ No
If ‘Yes,’ what data is reviewed?

Where is this information located?

Are there special forms a provider uses to document the clinical note? □ Yes □ No
Describe the forms and critical information they capture:

Are patient education handouts given during the provider visit? □ Yes □ No

Patients may require follow-up as a result of the encounter, how does the provider communicate this to the office staff? How are follow-ups communicated to the patient (physical and verbal)? (E.g., scripts, referrals, super bill)

Services such as immunizations, allergy shots, etc., can be delivered by the physician or other clinical staff. If these are not done by the provider, how does the office staff know that the patient needs that service?

Where are charges for this visit captured?
Workflow Optimization
Point of Care

The Provider Visit: Current State
This is an example of a simple provider visit at a medical office.

Workflow diagrams visually show how a task is handed from one person to another until it is completed. Each symbol represents a step in the workflow process:

- **Terminator symbol** represents the beginning or end of a process.
- **Process step** represents an independent step or task.
- **Decision step** represents a question or decision where there are multiple options.
Documenting the Nursing Visit: Current State

Are there any specific check-in processes for a nursing visit that differ from the provider visit?

What information does the nurse review prior to the visit? What forms are used/reviewed?

Where are charges for this visit captured?

Which types of visits are conducted by a nurse in your practice?

- ☐ Injections/Immunizations
- ☐ Post-operative
- ☐ Wound management
- ☐ Counseling/Coaching/Education
- ☐ Allergy shot
- ☐ Other:
- ☐ Lab/DI Tests
- ☐ Blood pressure checks

<table>
<thead>
<tr>
<th>Visit Type</th>
<th>What information is documented during the visit?</th>
<th>How is the information documented? (example: flow sheet, vaccination card)</th>
<th>What is the provider involvement for the visit?</th>
<th>How is the provider notified of the visit?</th>
<th>Are there other reporting/documentation requirements? (example: School forms, RHIO, registries)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Injection/Immunization</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Counseling/Coaching</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Lab tests</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allergy shot</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
A Generic Nurse Visit: Current State

Patients may have basic services rendered by clinical staff other than their primary physician. Those visits can include immunizations, allergy shots and many other services. This is an example workflow of a nurse visit at a provider’s office.

Workflow diagrams visually show how a task is handed from one person to another until it is completed. Each symbol represents a step in the workflow process:

- **Terminator symbol** represents the beginning or end of a process.
- **Process step** represents an independent step or task.
- **Decision step** represents a question or decision where there are multiple options.
Documenting the Lab/Diagnostic Treatment Visit

How does your office schedule lab tests?

Does your office have a separate room for testing or lab draw?  □ Yes  □ No

If ‘no’ describe how these services are handled:

Who performs these tests in your office?

What types of tests are performed in the office? (e.g. CBC, EKG, urinalysis)

What information is documented in the patient chart?

Does the staff maintain any paper logs? (e.g. specimen handling logs)  □ Yes  □ No

If so, please identify all logs and describe the processes:

Does your office use specific equipment for your lab visits?

Does your office inquire about patient insurance as it relates to laboratory procedures?
The Lab Visit: Current State
This is an example a generic laboratory workflow process for a provider’s office.

Lab Draw

Patient checks in for lab work

Staff pulls paper chart to review lab orders
Staff labels vial and chart with patient name and DOB
Staff draws specimen and bandages patient
Staff records lab event in log
Chart is returned to front desk or medical records
Specimen is stored for delivery to lab

Note: Visit can be a standalone or completed after another visit at the practice

Lab Result

Picks up specimen from practice
Lab runs tests on specimen
Results are documented and returned to provider
Provider receives lab results
Provider signs off on lab results
Provider notifies patient, if needed
Results are sent to be filed in patient chart

Workflow diagrams visually show how a task is handed from one person to another until it is completed. Each symbol represents a step in the workflow process:
Documentation Responsibilities

Understanding the documentation culture of your practice will assist you in determining staff preferences and patterns. This analysis will help identify where devices should go and what types of devices should be used in different areas of the office.

In the table below, detail each role’s documentation responsibilities at your practice. (Note: patterns may differ by specific staff member. Please keep personal preferences in mind when using this information to identify staff needs.)

- Who documents patient information?
- Where in the office do they document?
- Which parts of the visit do they document?
- At what point of the visit do they complete their documentation?

<table>
<thead>
<tr>
<th>ROLE</th>
<th>WHAT</th>
<th>WHERE</th>
<th>WHEN</th>
<th>CHALLENGES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example: MD</td>
<td>Clinical Note, Assessments, plans, orders</td>
<td>In exam room, some notes finished in office some at home</td>
<td>During the visit and after the visit</td>
<td>Providers not familiar with health record, have been using PC for a couple of months</td>
</tr>
<tr>
<td>MD/NP (EPs with prescriptive priv.)</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RN</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MA</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Front Desk</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phlebotomist</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Records</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Additional grids are available at the end of this tool to document responsibilities of individual staff members (see Appendix 3)
Rules of Thumb

Clinical Best Practices

- Use the flow of the system screens to enhance/guide providers and staff through the new workflow.
- Work with your EHR software vendors to develop and configure templates that represent the most common visit types in your practice.
- A list of preferences can be used for fields commonly entered by staff such as: diagnosis, reason for visit, frequently orders labs and procedures.
- Validate medications and allergies at each visit.

Point of Care Documentation

Implement processes that enable support staff to review and enter information into the system before the providers visit. This activity can increase efficiency by reducing the need of the provider to search for information.

- It will take time getting used to having the computer with the EHR software in the room. To ease the transition there are several techniques a provider can implement to support the provider-patient connection during this transition period.
  - Review the summary record before entering the exam room.
  - Try to make eye contact with the patient when greeting them when you enter the exam room.
  - As you document on the computer, explain to the patient what you are doing.

- Invite the patient to sit where they can see the screen. Providers can use the EHR as a tool to encourage patient participation in their care which documenting during the encounter.
- Develop unique ways to document the visit efficiently without taking away from the provider-patient experience.
- Take time after the visit to complete your chart note (at first, it may be okay to use a note pad to guide your thoughts).
Appendix 1: Cross-Walk Meaningful Use and Patient Centered Medical Home (PCMH) at Point of Care (POC)

Many activities engaged in at point of care correspond to meaningful use and NCQA Patient Centered Medical Home metrics. Please review the crosswalk of activities and how they correlate to these two programs when documenting health information in the exam room. (This is not intended to be a complete mapping between the two programs.)

### PCMH STANDARD 1: ACCESS AND CONTINUITY

<table>
<thead>
<tr>
<th>PCMH Standard Element Factor</th>
<th>Meaningful Use Stage 1 Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Electronic Access</td>
<td>Provide patient electronic copy of health information</td>
</tr>
<tr>
<td></td>
<td>Clinical summary of visit</td>
</tr>
<tr>
<td>Continuity of care with clinician/ care team</td>
<td>Timely access to health information</td>
</tr>
</tbody>
</table>

### PCMH STANDARD 2: IDENTIFY AND MANAGE PATIENT POPULATIONS

<table>
<thead>
<tr>
<th>PCMH Standard Element Factor</th>
<th>Meaningful Use Stage 1 Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capture clinical information electronically</td>
<td>Maintain an up-to-date problem list</td>
</tr>
<tr>
<td>Information collected is used for population health</td>
<td>Maintain an active medication list</td>
</tr>
<tr>
<td></td>
<td>Maintain an active medication allergy list</td>
</tr>
<tr>
<td></td>
<td>Record changes in vital signs</td>
</tr>
<tr>
<td></td>
<td>Record smoking status</td>
</tr>
<tr>
<td></td>
<td>Generate lists of patients</td>
</tr>
<tr>
<td></td>
<td>Send patient reminders</td>
</tr>
</tbody>
</table>

Remember the requirements above as your office redesigns its workflow to optimize use of the electronic health record, qualify for federal incentive programs and achieve NCQA recognition in the year(s) to come. Think about how you can achieve each measure in your “To Be” workflow.
1: Cross-Walk Meaningful Use and Patient Centered Medical Home (PCMH) Appendix at Point of Care (POC)

Many activities engaged in at point of care correspond to meaningful use concepts and NCQA Patient Centered Medical Home metrics. Please review the crosswalk of activities and how they correlate to these two programs when documenting health information in the exam room. (This is not intended to be a complete mapping between the two programs.)

**PCMH STANDARD 3: PLAN AND MANAGE CARE**

<table>
<thead>
<tr>
<th>PCMH Standard Element Factor</th>
<th>Meaningful Use Stage 1 Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implement evidence-based guidelines</td>
<td>Implement clinical decision support</td>
</tr>
<tr>
<td>Identify High-risk patients</td>
<td>Generate list of patients</td>
</tr>
<tr>
<td>Medication management</td>
<td>Perform medication reconciliation</td>
</tr>
<tr>
<td>Electronic prescribing</td>
<td>Use CPOE for medication orders</td>
</tr>
<tr>
<td></td>
<td>Drug-drug interaction checking</td>
</tr>
<tr>
<td></td>
<td>Drug-allergy interaction checking</td>
</tr>
<tr>
<td></td>
<td>Transmit permissible prescriptions electronically</td>
</tr>
</tbody>
</table>

**PCMH STANDARD 4: PROVIDE SELF-CARE SUPPORT AND COMMUNITY RESOURCES**

<table>
<thead>
<tr>
<th>PCMH Standard Element Factor</th>
<th>Meaningful Use Stage 1 Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support the self-care process</td>
<td>Identify and provide patient specific resources to patient</td>
</tr>
<tr>
<td>Provide referral to Community</td>
<td></td>
</tr>
<tr>
<td>Resources</td>
<td></td>
</tr>
</tbody>
</table>

For information on a complete list of 2011 NCQA PCMH requirements, please go to http://www.ncqa.org/tabid/631/default.aspx

For information on all of the Meaningful Use Core and Menu set measures, please go to https://www.cms.gov/ehrincentiveprograms/30_Meaningful_Use.asp
Appendix 1: Cross-Walk Meaningful Use and Patient Centered Medical Home (PCMH) at Point of Care (POC)

Many activities engaged in at point of care correspond to meaningful use and NCQA Patient Centered Medical Home metrics. Please review the crosswalk of activities and how they correlate to these two programs when documenting health information in the exam room. (This is not intended to be a complete mapping between the two programs).

**PCMH STANDARD 5: TRACK AND COORDINATE CARE**

<table>
<thead>
<tr>
<th>PCMH Standard Element Factor</th>
<th>Meaningful Use Stage 1 Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Test tracking and follow-up</td>
<td>Incorporate lab tests into the EHR as structured data</td>
</tr>
<tr>
<td>Referral tracking and follow-up</td>
<td>Exchange clinical information among providers of care</td>
</tr>
<tr>
<td>Coordinate care transitions with facilities</td>
<td>Provider summary of care record to receiving provider for patients in care transitions</td>
</tr>
<tr>
<td></td>
<td>Exchange clinical information among providers of care</td>
</tr>
<tr>
<td></td>
<td>Provider summary of care record to receiving provider for patients in care transition</td>
</tr>
</tbody>
</table>

**PCMH STANDARD 6: MEASURE AND IMPROVE PERFORMANCE**

<table>
<thead>
<tr>
<th>PCMH Standard Element Factor</th>
<th>Meaningful Use Stage 1 Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report data externally</td>
<td>Report clinical quality measures</td>
</tr>
<tr>
<td></td>
<td>Submit data to immunization registry</td>
</tr>
<tr>
<td></td>
<td>Submit syndromic surveillance data to public health agencies</td>
</tr>
</tbody>
</table>

Remember the requirements above as your office redesign its workflow to optimize use of the electronic health record, qualify for federal incentive programs and achieve NCQA recognition in the year(s) to come. Think about how you can achieve each measure in your “To Be” workflow.
Appendix 2: List Meaningful Use and Patient Centered Medical Home (PCMH) at Point of Care (POC)

Many activities at point of care correspond to meaningful use and NCQA Patient Centered Medical Home metrics. Please review the list of activities and how they correlate to these two programs. (This is not intended to be a complete mapping between the two programs.)

**Documenting vitals**
- Core MU measure 8: record vital signs
- Supports PCMH element 2B: electronic system for clinical data
- Supports PCMH element 2C: use of electronic clinical data

**Patient specific education**
- Core MU measure 13: provide a clinical summary
- Menu MU measure 6: patient-specific education resource

**Medication/allergy/problems**
- Core MU measure 1: CPOE for medication orders
- Core MU measure 2: drug interaction check
- Core MU measure 3: maintain up-to-date problem list
- Core MU measure 4: e-Prescribing
- Core MU measure 5: maintain active medication lists
- Core MU measure 6: maintain medication allergy list
- Menu MU measure 7: medication reconciliation
- Menu MU measure 1: drug formulary check
- PCMH element 2B: electronic system for clinical data
- PCMH element 2C: Use of electronic clinical data
- PCMH element 2D: organizing clinical data
- PCMH element 2E: identifying important conditions
- PCMH element 3D: care management of important conditions
- PCMH element 5A: electronic prescription writing
- PCMH element 5B: prescribing decision support capabilities
- PCMH element 5C: prescribing decision support-efficiency

**Report to Registries**
- Menu MU measure 9: submit data to immunization registry

**Labs**
- Menu MU measure 2: incorporate clinical lab tests
- PCMH element 6A: test tracking and follow-up
- PCMH element 6B: electronic system for managing tests

Remember the requirements above as your office redesigns its workflow to optimize use of the electronic health record, qualify for federal incentive programs and achieve NCQA recognition in the year(s) to come. Think about how you can achieve each measure in your “To Be” workflow.

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For information on all of the Meaningful Use Core and Menu set measures, please go to https://www.cms.gov/ehrincentiveprograms/30_Meaningful_Use.asp
Appendix 3: Additional Table for Documentation Responsibilities

In the table below, detail documentation responsibilities at your practice. (Note: patterns may differ by specific staff member. Please keep personal preferences in mind when using this information to identify staff needs)

- Who documents patient information?
- What parts of the visit do they document?
- Where in the office do they document?
- At what point of the visit do they complete their documentation

<table>
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<th>WHEN</th>
<th>CHALLENGES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example: Dr. Jones MD</td>
<td>Clinical note, assessments, plans, orders</td>
<td>In exam room, some notes finished in office some at home</td>
<td>During the visit and after the visit</td>
<td>Providers not familiar with health record, have been using PC for a couple of months</td>
</tr>
</tbody>
</table>