Expanded Rooming and Discharge Protocols

Streamline Your Patient Visit Workflow

AMA IN PARTNERSHIP WITH

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How will this module help me implement expanded rooming and discharge protocols?

1. Outlines five ways to expand staff responsibilities.
2. Provides answers to common questions about expanding rooming protocols.
3. Includes case reports describing how other practices implemented new rooming protocols.
4. Provides rooming and discharge checklists to help you with implementation.

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Introduction

What are expanded rooming and discharge protocols?
Expanded rooming and discharge protocols are standard work routines that enable staff to take on additional responsibilities. Physicians alone cannot do all the work needed for most office visits. With expanded rooming and discharge protocols, the nurse, medical assistant (MA) or other clinical support staff can use their skills to create a smooth visit for the patient and a satisfying clinic session for the entire team.

Interactive Calculator: Expanded Rooming and Discharge
To estimate the amount of time and money you can save by implementing expanded rooming and discharge protocols in your practice, enter the number of patient visits per day and physician time spent on rooming and discharge tasks per day.

Interactive
Time and cost savings calculator

As part of the expanded rooming protocol, the nurse or MA can complete the following tasks:

- Identify the reason for the visit and help the patient set the visit agenda.
- Perform medication reconciliation.
- Screen for conditions based on protocols.
- Update past medical, family, and social history.
- Provide immunizations based on standing orders.
- Arrange for preventive services based on standing orders.
- Assemble medical equipment, if needed, before the physician enters the exam room.

Conducting these activities during patient rooming will enable the physician to spend more time directly interacting with the patient and family, rather than focusing on these elements of the visit.

As part of the expanded discharge protocol, the nurse or MA can complete the following tasks:

- Print and review an updated medication list and visit summary.
- Reiterate to patients the medical instructions prescribed by the physician.
- Coordinate the next steps of care.

This augmented patient discharge process will ensure that patients understand and remember their discharge instructions, leading to improved treatment adherence.

Five steps for involving staff in rooming and discharge activities:

1. Identify current workflows.
2. Create a rooming checklist.
3. Refine the rooming checklist.

4. Create a discharge checklist.

5. Provide ongoing staff training.

1 Identify current workflows.

Write down the tasks that the nurse or MA currently completes during rooming, such as obtaining vital signs, documenting the reason for the visit, and tasks completed after the visit.

2 Create a rooming checklist.

Create a wish list of tasks that the clinical support staff could do before and after the physician component of the visit to improve care and reduce physician time on routine functions. Your list might include reconciling medications or identifying the patient’s agenda for the visit. Next, pick one or two of these tasks and try them out for a week. Then pick two more and continue to refine the list. Encourage feedback and suggestions during team meetings or morning huddles to ensure that the new process is working for patients, physicians, and team members.

Rooming checklist
(MS-WORD, 37 KB)
Figure 1. Collaborative Documentation Process
This sample workflow may help you to design your expanded rooming and discharge protocols.

Q&A

Our MAs don't have time to go back into the exam room after the physician is finished with their portion of the visit. Do we have to complete the patient discharge protocol?

You may incorporate either or both expanded protocols into your practice. We suggest you start with the expanded rooming protocol. After this becomes an established routine, you might add the patient discharge protocol for a subset of your patients, such as those with more complex care.

How can I trust my team to do these new tasks reliably?

Investing in training will save time in the long run. Well-trained clinical team members may do their work more effectively and with greater purpose if they understand the rationale behind the process and the benefits to the patient. A few hours of training will pay off with a more efficient practice and a happier work environment.

I work with a different MA each day. What is the best way to train everyone?

Having teams of people work together every day is ideal. Nonetheless, if that isn't possible in your setting, it is even more important to develop standard workflows across all the providers in your department.

Will the rooming checklist vary by specialty?

Yes. For example, in a primary care practice the staff may be trained to perform a diabetic foot exam as part of the rooming process for patients with diabetes. In a pulmonary practice, the staff may be trained to teach the proper inhalation technique using a handheld nebulizer. In a palliative care practice, the staff may be trained to complete a detailed pain assessment prior to the physician portion of the visit.
Under Medicare payment rules, can non-physician staff, such as a registered nurse (RN), licensed practical nurse (LPN), or medical assistant (MA), enter elements of an evaluation and management (E/M) visit?

In both the 2019 Fiscal Year Medicare Physician Fee Schedule and an FAQ dated Nov. 26, 2018, CMS expanded current documentation policy applicable to office/outpatient E/M visits. Starting Jan. 1, 2019, any part of the chief complaint (CC) or history that is recorded in the medical record by ancillary staff or the patient does not need to be re-documented by the billing practitioner.

Instead, when the information is already documented, billing practitioners can review the information, update or supplement it as necessary, and indicate in the medical record that they have done so. This is an optional approach for the billing practitioner and applies to the chief complaint (CC) and any other part of the history (HPI, Past Family Social History (PFSH), or Review of Systems (ROS)) for new and established office/outpatient E/M visits.

CMS notes that it has never addressed who can independently take/perform histories or what part(s) of history they can take, but rather addresses who can document information included in a history and what supplemental documentation should be provided by the billing practitioner if someone else has already recorded the information in the medical record.

The physician must still personally perform the physical exam and medical decision-making activities of the E/M service being billed.

For additional information, please visit AMA's Debunking Regulatory Myths site, which discusses this topic in depth.

3 Refine the rooming checklist.

Over a period of several weeks, refine the rooming checklist based on team feedback and post it close to where the work is done. For example, the checklist can be placed in workstations and exam rooms so that the care team can easily access and refer to it. Making the checklist easily accessible will help the team gain confidence and consistency in performing their new responsibilities.

"We developed a greater role for our medical assistants so the physicians don’t have to shoulder all of the work."

Beverly Loudin, MD, MPH, Medical Director, Patient Safety & Risk Management, Atrius Health, Boston, MA
Create a discharge checklist.

Similar to how the rooming checklist was developed, create, refine, and post a list of tasks that nurses or MAs will do after the physician leaves the exam room. **Note:** Not all patients or practices will need a discharge step. This step can be used as needed.

Discharge checklist
(MS-WORD, 34 KB)

Provide ongoing staff training.

Training often occurs on the spot. For example, the physician can explain a new task or provide feedback regarding the way the support team documents particular elements of the patient rooming or discharge process. Regular team meetings provide another opportunity for ongoing education. Some organizations may create skills assessments to formally sign off on an employee's acquisition of new skills, such as performing a diabetic foot exam. The more comfortable nurses and MAs become with their new responsibilities and enhanced roles, the greater the contribution they will make—and the more they will enjoy their work.

Q&A

Could expanded rooming work in a teaching practice?

Definitely. In fact, nurses and MAs can be an important source of cohesion in teaching practices where there are different physicians in session each day. Additionally, the standardized process of expanded rooming ensures that medical students or residents don't miss necessary elements of patient care, such as immunizations or diabetic foot exams.

Our printer is down the hall, so I make several trips per visit in and out of the exam room. Sometimes, I get distracted or interrupted and forget to finish a task for a patient. What can I do?

Many clinics have found that having a printer in every room increases efficiency. For example, staff can print the updated medication list while in the exam room with the patient. One clinic found that this saved 20 minutes of physician time every day. By reducing the need for multiple trips in and out of the room, a practice can decrease the likelihood that the MA, nurse, or physician will be interrupted while processing their thoughts on the patient. Minimizing distractions and disruptions enables practices to deliver safer care. If having a printer in each room is not possible in your practice, strategically place the printers in locations that are close to the exam rooms and other patient care areas.

Should the patient rooming and/or discharge process be standardized across all practices in our organization?

There is no right answer. Standard processes can add to reliability and efficiency, at the same time, standardization is best balanced with the ability to customize to the unique needs of an individual practice or specialty. Balancing this tension is essential to engaging staff and preventing burnout. An organization can develop a standard rooming and/or discharge template that individual practices can then use as a starting point in creating their own local protocols.
Our electronic health record (EHR) doesn't include pop-ups that remind the clinical team about a patient's preventive care needs. Can the staff still help bring patients up to date?

Some practices create a visit prep checklist and place it in each exam room and at the nurse or MA workstation for ease of reference.

“A lot of the work has already been done for me, so I can spend more time with the patient and less time looking at the computer.”

Mary Wild Crea, MD, Pediatrics, Fairview Health Services, Rosemount, MN

Conclusion

Expanded rooming and discharge protocols address inefficient workflows by organizing and standardizing common tasks that the practice team performs during patient visits. The strategies in this module will enable practices to create personalized patient rooming and discharge checklists to increase patient and staff satisfaction with the care being provided.

AMA Pearls

Dealing with the “list”.

Some patients come to their appointments with multiple issues on their minds, and the most important one may not surface until the time allotted for the appointment is nearly past. The nurse or MA can help avoid this problem by clarifying the patient's objectives for the visit (e.g., “How can we help you today?” or “What are you hoping to accomplish today?”). If the list is long, the nurse or MA can help patients prioritize their agenda by asking clarifying questions, such as, "What are
the three issues that are most important for you today?” A pre-appointment questionnaire given to the patient before the visit and reviewed by the staff during rooming is also useful.

**STEPS in practice**

### 1. Expanded Rooming and Discharge Case Report: North Shore Physicians Group

North Shore Physicians Group (NSPG), a 20-site organization with 365 employed providers, began a system-wide change to a team-based care delivery model in which the physician leads the care team of closely aligned professionals, each having a different role in the care of the patient.

The model is based on an expanded role for medical assistants (MAs), “so that the physicians wouldn't have to shoulder all of the work,” said Beverly Loudin, MD, MPH, former NSPG Director of Patient Safety and Quality, and director of the initiative. Dr. Loudin began by interviewing physicians regarding the skills and responsibilities they would want in a highly functional MA.

Once the role was designed, NSPG developed a week-long training program to ensure that all MAs in the system would have the same skillset aligned with their new responsibilities.

The following year, NSPG trained 80 MAs in the new model of care. They were taught additional clinical skills, health coaching, patient self-management techniques, and population management. MAs were also trained in process improvement methods.

The MA role transitioned to a care team partner within the practice. Each day, the physician, nurse, MA, and scheduler start with a morning huddle to review the coming day's schedule to plan for a smooth workflow. The rooming process previously took three minutes, but was expanded to an eight-minute process to include recording current medications and allergies, agenda-setting, form completion, and closing gaps in care (also known as “in-reach approach”). For example, the MAs review all health monitoring reminders, give immunizations, and proactively book appointments for preventive care. The goal is to identify patient needs while in the exam room, rather than leaving time-consuming loose ends to be addressed after the patient leaves.

The MA also assumes responsibility for documentation. As one NSPG leader reports, “a huge part of the change has been having the MA put extensive visit information into the electronic health record.” The MA starts the note and performs most of the structured text data entry components of the visit. The provider later edits these entries for accuracy and documents the narrative portion of the note.

### 2. Expanded Rooming and Discharge Case Report: Fairview Health Services

At Fairview Health Services in Rosemount, MN, medical assistants (MAs) are prompted by the electronic health record (EHR) to obtain the relevant information or perform the appropriate condition-specific tasks for preventive care for adults, including diabetes, cardiovascular disease, low back pain, asthma, and migraines, in addition to standard rooming tasks and medication reconciliation.

For example, during a visit, an elderly woman presented with a rash and blood pressure issues. During rooming, the MA checked the date of the last bone density scan, and noticed that it had been more than three years before the present visit. The MA scheduled another bone density test, performed a depression screening, and then reviewed her advance directive, as well as her colonoscopy results, diabetic metrics, lipids, and pneumococcal vaccine status.

Due to the fact that the patient’s initial depression screen was positive, the MA administered a longer depression survey to more thoroughly assess the patient’s mental health status. The MA then uploaded all of the answers.
from the depression screenings into the EHR and communicated the results to the physician. This allowed the physician more time to address the depression discovered by the MA while ensuring that all other acute and preventive measures were managed.

At the conclusion of the visit, the care team provided the patient with a printed summary of the visit, including instructions for behavioral change, medication adjustment, and next appointments.

**Learning Objectives:**
At the end of this activity, you will be able to:
1. Describe expanded rooming and discharge protocols;
2. Identify how to involve staff in expanded rooming and discharge activities;
3. Explain key steps to implement expanded rooming and discharge protocols in your practice.

**Article Information**

**AMA CME Accreditation Information**

**Credit Designation Statement:** The American Medical Association designates this enduring material activity for a maximum of .50 AMA PRA Category 1 Credit™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

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**Statement of Competency:** This activity is designed to address the following ABMS/ACGME competencies: practice-based learning and improvement, interpersonal and communications skills, professionalism, systems-based practice, interdisciplinary teamwork, quality improvement and informatics.

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About the AMA Professional Satisfaction and Practice Sustainability group: The AMA Professional Satisfaction and Practice Sustainability group has been tasked with developing and promoting innovative strategies that create sustainable practices. Leveraging findings from the 2013 AMA/RAND Health study, "Factors affecting physician professional satisfaction and their implications for patient care, health systems and health policy,” and other research sources, the group developed a series of practice transformation strategies. Each has the potential to reduce or eliminate inefficiency in broader office-based physician practices and improve health outcomes, increase operational productivity and reduce health care costs.

ABMS MOC: Through the American Board of Medical Specialties (“ABMS”) ongoing commitment to increase access to practice relevant Maintenance of Certification (“MOC”) Activities, this activity has met the requirements as an MOC Part II CME Activity. Please review the ABMS Continuing Certification Directory to see what ABMS Member Boards have accepted this activity.

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Glossary

Standing orders: A protocol-driven approach for providing care, such as established procedures for renewing prescriptions and ordering laboratory tests and health screenings. State laws and regulations may address to whom and what can be delegated by standing order.

In-reach approach: Planning in advance so that care gaps are closed at the time of each face-to-face visit.

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References