AMA | STEPSforward™

Expanded Rooming and Discharge Protocols

Empower staff to make patient visits more meaningful and efficient.

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CME CREDITS: 0.5

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

1. Five ways to involve staff
2. Answers to questions about adopting protocols
3. Case vignettes describing practices using new protocols
4. Rooming and discharge checklist to help with implementation

Introduction

What are expanded rooming and discharge protocols?

Physicians alone cannot do all of the work needed for most office visits. With expanded rooming and discharge protocols, the nurse, medical assistant (MA) or other clinical support staff are able to fully use their skills to create a smooth visit for the patient and a satisfying clinic session for the entire team. Creating standard work routines enables staff to take on additional responsibilities that give physicians more time to spend on work for which they were uniquely trained.

How much time and money will implementing expanded rooming and discharge protocols save my practice?

This calculator allows you 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.

Your practice

$ 3 /min
Cost of physician's time

220 days/year
Clinic days per year

Estimate savings

						TIME		MONEY
20 /day	x	5 min/visit	=	1H 40M /DAY	=	$66,000		
Total visits per day		Physician time on standard tasks/visit*		Time saved		Annual savings with expanded rooming and discharge		

Source: AMA. Practice transformation series: expanded rooming and discharge protocols.. 2014.

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 patient 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.

> 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

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

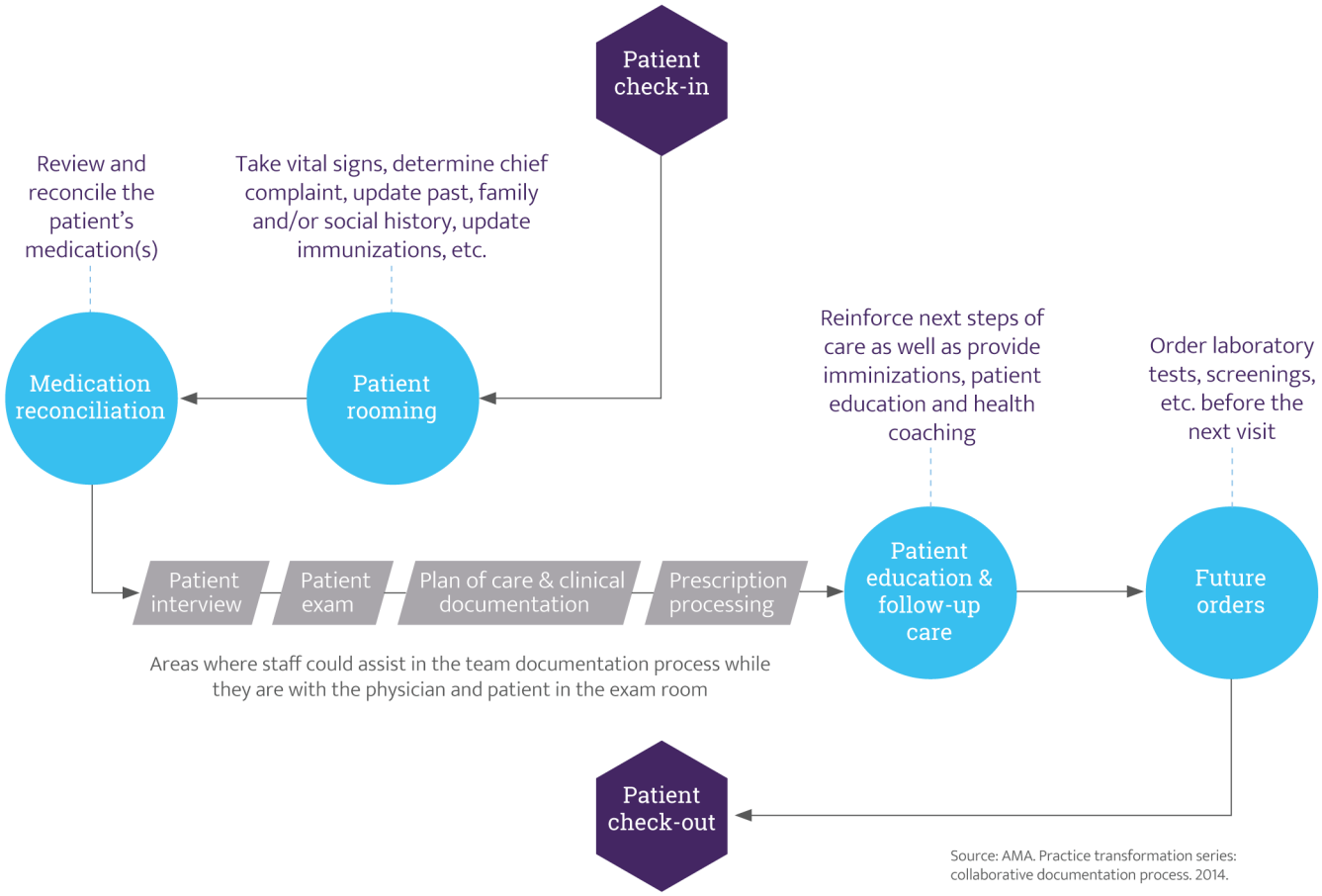
1 Identify current workflows

Write down the tasks that the nurse/MA currently completes during rooming, such as obtaining vital signs and documenting the reason for the visit as well as 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 physicians, staff and patients.

Sample rooming checklist
(MS-WORD, 37 KB)



Source: AMA. Practice transformation series: collaborative documentation process.. 2014.

Q&A

Our MAs don't have time to go back in 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 staff to reliably do these new tasks?

Investing in staff training will save time in the long run. Well-trained clinical staff 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. It hardly seems worth the time to invest in teaching them.

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 of 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 an RN document a patient's medication list in the EHR as part of medication reconciliation (MR) during an E/M visit?

Yes, where MR is part of the ROS or PFSH for the E/M service, under Medicare payment rules, the medication list may be recorded by any ancillary staff, and then signed by the physician.

MR is included in the Advancing Care Information performance category in the Merit-Based Incentive Payment System (MIPS) as well as the Meaningful Use (MU) program.

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

4 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.)

Patient discharge checklist
(MS-WORD, 34 KB)

5 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 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/MA workstation for ease of reference.

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/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/MA can help the patient 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.

"Empower staff to take on more responsibilities. #STEPSforward"

Conclusion

Expanded rooming and discharge protocols address inefficient workflows by organizing and standardizing common tasks that practice staff perform 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.

STEPS in practice

1 Rooming and Discharge Workflows in Boston, MA: A Case Study

In 2008, North Shore Physicians Group (NSPG)—a 365-provider, 20-site organization—began a system-wide change from a traditional physician-centric delivery model, where the physician is responsible for all elements

of care, to a team-based care delivery model, where the care is shared among a group of closely aligned professionals.

The model is based on an expanded role for 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. She 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 assure that all MAs in the system would have the same skill set, which aligned with their new responsibilities.

During the summer of 2009, NSPG trained 80 MAs in the new model of care. They were taught basic clinical skills, critical thinking, health coaching, patient self-management techniques and population management. Because improving work while doing the work is seen as an essential strategy going forward, MAs are also trained in process improvement.

The MA role was transformed from someone who generally answers phones, escorts patients and obtains vitals to a partner capable of team-based care. Each day, the MA, physician, scheduler and nurse start with a morning huddle to review the day's work and plan for a smooth workflow. What was previously a three-minute rooming process has been expanded to an eight-minute process, and now includes recording current medications and allergies, agenda setting, form completion and closing gaps in care (also known as "**in-reach**"). For example, the MAs review all health monitoring reminders, give immunizations and proactively book appointments for mammograms and bone density scans. The goal is to meet all of the 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 entering a greater portion of visit note data. As one NSPG leader reports, "a huge part of the change has been having the MA put extensive information into the EHR." The MA starts the note and performs most of the structured text data entry components of the visit. The provider will later edit these entries for accuracy and document the narrative portion of the note.

2 Rooming and Discharge Workflows in Rosemount, MN: A Case Study

At Fairview Health Services in Rosemount, MN, MAs are prompted by the EHR to obtain the relevant information or perform the appropriate condition-specific tasks for preventive care for adults, diabetes and 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 (it had been more than three years so the MA scheduled another bone density test), reviewed advance directives, colonoscopy, diabetic metrics, lipids and pneumococcal vaccine status. Because the patient's brief depression screen was positive during rooming, the MA administered a longer depression survey to more thoroughly assess the patient's status. The MA then uploaded all of the answers from the new survey into the EHR and communicated the results to the physician. This allowed the physician more time to address the depression uncovered by the MA while ensuring that all other acute and preventive measures were managed.

At the conclusion of the visit, the MA or physician used the exam room's printer and 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

CME Accreditation Information:
Increasing administrative responsibilities—due to regulatory pressures and evolving payment and care delivery models—reduces the amount of time physicians spend delivering care. By implementing expanded rooming and discharge protocols, physician practices can increase operational efficiency by leveraging the skills and training of staff to perform additional tasks and responsibilities associated with a patient visit. Such workflow adjustments will allow physicians to spend more time interacting with patients.

Release Date:
October 2014

End Date:
October 2018

Accreditation Statement:
The American Medical Association is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

Credit Designation Statement:
The American Medical Association designates this enduring material for a maximum of 0.5 *AMA PRA Category 1 Credit™*. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Target Audience:
This activity is designed to meet the educational needs of practicing physicians.

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 Professional Satisfaction, 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.

Glossary Terms

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.

Disclosure Statement

The project described was supported by Funding Opportunity Number CMS-1L1-15-002 from the U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services. The contents provided are solely the responsibility of the authors and do not necessarily represent the official views of HHS or any of its agencies.

The content of this activity does not relate to any product of a commercial interest as defined by the ACGME; therefore, neither the planners nor the faculty have relevant financial relationships to disclose.

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