

# Helping Hands



**Health & Wellness Center**

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## Clinic Workflow

*July 2018*

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## **WELCOME!**

Dear Volunteer:

We want to welcome you as a new volunteer of the Helping Hands Health and Wellness Center, Inc. The free clinic, counseling and social services is made possible through the generous support of our member churches, grants, donations and the gracious help of time and talent by volunteers like you. God has placed many blessings on this ministry and your help is fulfilling His command for us to witness His love and healing touch.

Nothing is more important to our success than God's guidance and the dedication and effort of our volunteers; therefore, this handbook has been prepared for you and will acquaint you with the philosophies, policies and procedures of Helping Hands.

To those who are newcomers, we welcome you and trust you will find your volunteer experience with Helping Hands rewarding. We hope you will all find the challenges of volunteering at a free clinic rewarding and part of your personal ministry to serve our Lord.

Thank you for your willingness to serve your God and to provide a valuable service for the under-served of Central Ohio. This is a great commission and a wonderful adventure, so welcome aboard!

If at any time you have questions, please contact Steve Thompson, Volunteer Coordinator, at (614) 262-5094.

## 1. Reception

- a. Patient walks in, takes a number card and is given a clipboard with registration forms (if they are a new patient) then takes a seat in waiting area
- b. Patient is then called up by number, ask for their ID, and verify they are over 18 and their reason for visit
  - NOTE: once done with the ID, hand over to the other volunteer working at the table so that they can write down their name, reason for visit, whether they have been here before, and photocopy ID if needed
- c. Registration searches for last name or DOB in the search bar at the top right
  - i. **if patient has been here before**, their name will populate, click *quickview*. If there has been a name change, update the information and save changes
    - NOTE: check to make sure we have an updated copy of their ID. Check this by clicking on Clinical > Chart > Find (marked by a magnifying glass) > Administration
  - ii. **if patient has never been here before** then register as a new patient (see steps below)
    - Scan the registration forms, and fill all YELLOW fields as these are mandatory (name, sex, email, home phone, and usual provider)
    - FOR EMAIL: check no to opt out
    - FOR HOME PHONE: if their paperwork is already filled out add their phone number they provided, otherwise, enter 000-000-0000 (do not ask patient to state number, for privacy reasons)
    - FOR USUAL PROVIDER: ask whether they are here for the following (clinic, lab, social work, or work physical)
    - Once done, scroll to the bottom and under privacy there is the option that says, "Consent to call." Ask the patient if it is okay if we were to call them and click response. Save responses
    - NOTE: if patient is new, have the other volunteer scan their ID
  - iii. Ask patient if an interpreter is needed. If they say yes, click the ( ! ) under their name, at the top left and "Martti- the language they speak"
    - Example: Martti- Spanish
  - iv. Once all information is inputted/updated, schedule the patient for appointment (see below).
    - Go to "Appointments" section at the very bottom and click *schedule*

- Click today's date on the calendar then the time corresponding to their place in line (usually the next available appointment)
- Then at the bottom put reason they are here (*Appointment Type*)
  - i. Indicate if patient is new, existing, work physical, social work, or labs
- v. If patient doesn't have their picture in their chart (top left, beside their name) use Athena Capture application on the iPad to take it
  - Click the picture icon beside their name
  - Ask the patient if it is okay to take the picture and if they consent, ask them to stand in front of the brick wall
  - Scan the QR code for the patient then proceed to take a picture of the patient and click upload photo
  - Ensure the picture uploads to AthenaNet and send patient back to waiting area with their number card (and if it applies, check the paperwork and copy of ID)
- d. Once all information in AthenaNet is completed, the patient's four-digit ID number will show up in the search box in the top right. Inform the other volunteer of the patient's ID number so they can write it down on the Registration Log

## 2. Registration/ Intake

- a. Patient called up in order by number of the number card
- b. Welcome the patient and click on patient name in schedule
- c. Go to Full Registration
- d. Complete the registration process
  - i. Fill in the fields patient lists on the registration form
  - ii. Decline Ethnicity and Decline Portal
  - iii. If existing patients, confirm that fields are current and up-to-date, i.e. address, preferred method of contact, DOB, etc.
- e. Try to garner an idea as to why the patient is coming to clinic today to ensure that we can help them before they sit in waiting area

NOTE: we do not provide Flu shots (only in the fall), STD testing or Pregnancy/Maternal check-ups (though we do urine pregnancy testing), further we have very limited mental health resources

  - i. When we have social worker in clinic, we can try to get the patient in to see him/her to see if we can connect to other resources in the area
  - ii. Further, we can give patients information on other free resources for STD/Pregnancy/Maternal check-ups at the Columbus Dept. of Public Health off Parsons Ave (downtown)
    - Materials for STD/pregnancy/maternal check-ups can be found on the information board or on the sign in desk
  - iii. Additionally, ensure that the patient is under 200% the poverty line – there will be a handout at the intake desk for your reference
    1. If patient is unemployed or a temporary visitor this can be assumed
    2. If the patient is employed but uninsured/underinsured this will have to be verified
- f. IF EXISTING PATIENT, ensure that we have an **Authorization Form** on file that is current – i.e. has been captured within a year-to-date (there will be a field in the registration window that lists last date of collection)
- g. IF NEW PATIENT, give and review an **Authorization** and **Notice of Privacy Practices** forms, have them sign and date appropriate fields and collect for later scanning and filing.
- h. Offer the patient the opportunity to talk to social worker and offer the form that details services offered.
- i. Prior to completing Registration, make sure you have collected the following forms:
  - i. Registration forms and number card

- ii. Scanned ID
- iii. Social Services
- iv. Authorization form \*if applicable
- v. Notice of Privacy Practice \*if applicable
- vi. Organize documents by patient, ensuring patient ID number on each to be filed at the end of the day
  - 1. Documents collected Thursday and Friday will be filed for scanning Friday, if possible
- vii. Update Patient Status to "Ready for Staff"
- j. Ensure the patient is made aware of the additional services offered at that clinic for the day including (but not exhaustive): tax help, OTC consult with pharmacy student, Chiropractor, etc.
- k. Lastly, ensure they know we are a FAITH-BASED clinic with opportunities for spiritual counsel, prayer, prayer circles and information on additional free resources then send back to waiting area for nurse to call them for Triage

### 3. Triage

- a. Identify the next patient listed as “Ready for Staff” and retrieve them from the waiting area.
- b. Prior to bringing into the patient room, collect height, weight and temperature reading.
  - i. It is best to have a scratch piece of paper to collect the readings then record them in the EHR after
- c. Confirm patient demographics in their medical record such as DOB, address, and telephone number to ensure it is the correct patient and with no errors in the EHR.
- d. Update the Patient Status and Patient Location to “with staff” and “Triage.”
- e. Document the reason for the patient’s visit.
- f. Review all of the patient’s allergies and immunizations and record in medical record.
- g. Gather a set of vitals on the patient including blood pressure, pulse, and respirations, and pain scale (when applicable).
- h. Identify the patient’s medical and social history including a family history of illnesses.
  - i. For patients with diabetes – collect a glucose reading either at the Glucose Screen in the waiting area, or via a POC finger stick when available.
- i. The Nursing Cheat Sheet is an up-to-date and fairly comprehensive tool that can help explain these steps in greater detail provided by the Director of Nursing and in the bins attached to the workstation on wheels.
- j. Update the patient’s location to “Waiting – Med History” and return them to waiting area



#### 4. Medication History

- a. Identify the next patient listed as “Waiting – Med History” and retrieve them from the waiting area.
- b. Confirm patient demographics in their medical record such as DOB, address, and telephone number to ensure it is the correct patient and with no errors in the EHR.
- c. Record preferred pharmacy. Note: If a pharmacy name is entered, AthenaNet auto-populates the pharmacy closest to their house. Some patients may have never frequented a pharmacy. In which case, use internet resources to help find a pharmacy close to where they live.
- d. Capture any allergies or vaccinations (when applicable).
- e. Review medications and enter as a structured sig when possible.
  - i. Ensure up-to-date and current. There is also a place to chart historic medications.
  - ii. Take notes where see fit, i.e. if patient experiencing side effects, or unsatisfied with current medications
- f. Ensure patient is clear on protocol and identify any barriers to adherence, i.e. financial, environmental, etc.
- g. Conduct PHQ-2 Screening.
- h. Review any additional questions the patient may have prior to updating their Patient Location to “Ready for Provider” and click on “Done with Intake.”

NOTE: When logging onto AthenaNet from the iPads, be sure to click “see full AthenaNet version” on the EHR homepage.

## 5. Provider

- a. Sign in to AthenaNet (see Director of Administration for sign-in information) and click Main Office, the day sheet with the list of patients will then appear
- b. Identify the next patient listed as “Ready For Provider”, change patient status to “With Provider” and retrieve them from the waiting area
- c. All provider encounters should have a scribe in the room (when available) as well as a pharmacy student (preferably the same pharmacy student that performed the medication history). This helps with continuity of care as the pharmacy students will be the ones that ultimately discharge the patients.
- d. The provider will review the medical history - History of Present Illness (HPI) and Review of Systems (ROS) – will then complete their examination, which will allow them to make medical or clinical decision to determine the Diagnoses and Orders (D&O)
- e. When evaluating the patient complaints and history, documents like previous lab results or current medications can be found in the left-hand column, their last visit notes can be found there as well (Labs are found through the “Find” tab)
- f. Diagnoses and Orders are entered. Orders (labs or medication prescriptions) have to be attached to a diagnosis and a diagnosis has to have an ICD code so that the chart can be signed. Any necessary information will highlight orange.
  - i. Medication prescriptions can be printed once the order is signed.
  - ii. If we have the medication in stock and the patient is leaving with an outgoing prescription, the pharmacy will give them their first month’s refill and send them home with a paper copy of the prescription to get their next refills at their preferred pharmacy.
  - iii. Lab Orders do not need to be printed. The lab orders can be viewed from the patient chart at the blood draw station.
- g. Discharge instructions and follow up information should be documented in the “Patient Instructions” cell. Discharge Summaries can be found at the bottom of the “Sign-Off” tab. Click “Search” > Discharge Summary to populate the document.
  - i. In order to print the Discharge Summary, you need to open up the document and “Approve Now” before it can be printed.
- h. All printed documents including prescriptions and discharge summaries are sent to the pharmacy station OR the pharmacy representative who is going to discharge the patient.
- i. After the provider is done with the patient, there are three steps before discharge. (1) Labs and (2) Pharmacy (3) Discharge Counseling with

pharmacist. Patient will then be sent to Labs, if applicable, or back to the waiting area for a pharmacy consult/discharge papers.

- i. If the labs station is already occupied by another patient, the patient will go back to the waiting area. The lab station should still be notified verbally and in-person that a patient needs labs and is waiting in the waiting area.

#### **HHHWC PHYSICIAN POLICY:**

- One paper prescription will be generated for each medication ordered by a prescriber for each patient on the day they visit HHHWC
- All prescriptions will be given to student pharmacist along with discharge instructions and taken to medication preparation area
- Medications listed on the HHHWC Formulary will be provided to the patient by the prescriber when available according to the following procedure:

#### **PROCEDURE:**

- Medication provided to patients from HHHWC medication cart if in stock
- A medication label will be generated and medication packaged for checking by the prescriber as follows:
  - o Prescriptions with no refills (i.e. antibiotics, topical, etc.) will be prepared as directed on the prescription. Prescriptions are kept in clinic and shredded
  - o Prescriptions for chronic therapy, that the patient will take with them for filling at community pharmacies, will be prepared as directed on the prescription for a 30-day or 90-day supply with appropriate refills determined by the provider
  - o Prescriptions for OTC medications will be prepared as directed on the prescription for a 14-day supply

## 6. Labs

- a. If a provider orders a urine specimen, scribe/student will often retrieve a sample container and collection dish, then instruct patient where the restroom is to fill the container with urine and bring back to the lab area for analysis.
  - i. Urine is collected for pregnancy test or urinalysis and can be resultated before the patient leaves.
  - ii. The patient goes back to the exam room and results are given to the provider.
- b. If a provider orders a blood draw, scribe/student will ensure the nurse is aware of the labs being ordered and bring patient to the lab area for blood draw.
  - i. If the lab volunteer is currently seeing another patient, it is suggested that they send the patient back to the waiting area. Other accommodations may be made.
  - ii. After blood draw is complete, patient will be instructed that the sample will be sent to an off-site lab for additional testing and will be made aware of the results of the tests the following week. Our policy is within 2 weeks.
    1. Ensure we have correct contact information and preferred method of contact for results review
- c. Once labs are complete, the lab volunteer can instruct patient to return to waiting area for pharmacy consult, medications and discharge summary.
- d. The blood specimens are labeled and placed in a biohazard bag along with the lab order slip.
  - i. Gold-top tubes are to be spun in the centrifuge, located in the medical supplied room, for 10 minutes.
- e. All biohazard collection bags are stored in a larger biohazard transportation unit to be taken to the off-site lab at the end of the evening.
- f. A Daily Clinic Lab Report is kept with the patient's name, DOB, ID number, and other information. Please make sure this is up-to-date.

Note: If the lab volunteer notices supplies are running low, they should tell the Director of Nursing.

## 7. Discharge

- a. Review the prescribed medications and instruct patient on those filled at the clinic on the prescribed dosage/protocol
  - i. For example, if taking a new BP medication, provider may want patient to record BP readings for two weeks and monitor symptoms to see how they are responding to new med/dosage
  - ii. Otherwise, may include what time of day and to take the meds w/ or w/o food
- b. Review the prescribed medications that need to be filled at an outside pharmacy and review prescribed dosage/protocol
  - i. May need to assist the patient in ensuring the nearest pharmacy or working with pharmacy students to see if any pharmacies have discounts or deals on generics prescribed during visit
- c. Review discharge instructions, particularly the Assessment and Plan for each complaint treated at the day's visit
- d. Address any additional questions or concerns about the visit that the patient might have
- e. Ensure the patient understands the plan and medication protocol with teach/repeat back and then provide them printed/signed medication scripts and discharge summary for their reference, as well as confirm their follow-up schedule prior to departure
- f. Close patient's MR record/check-out and ensure patient shows as complete in the schedule for the day (will need to be logged in as a provider to close out the chart completely).