Good Samaritan Health & Wellness Center
Policies and Procedures

Subject: Clinic Operations when EMR is Unavailable	Policy #: 5.41
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5.41 Clinic Operations when EMR is Unavailable

Policy: *Every effort will be made to keep the office flow moving during times of computer unavailability.*

The following forms will be used when eClinicalWorks is down:

1. *Encounter Form*
2. *Progress Note – individualized for adult medical, pediatric & dental*

A copy of each of these forms approved for use is attached to this document.

Each position is responsible for updating eClinicalWorks with the information gathered during the time the system was down in a timely manner – within 24 hours if down less than 4 hours and within 48 hours if more than 4 hours.

Procedures:

WHILE THE SYSTEM IS DOWN:

I. The appointment call list (generated the day before to confirm appointments) will be used to aid in patient check-in, as well as to schedule same day appointments. Each added patient will be recorded on the appropriate provider schedule by name and date of birth. A separate list will be kept for labs and unassigned walk-ins.

II. Telephone Calls

A. A call-back list for appointments will be kept and when the system comes up the receptionist will return calls to schedule appointments.
B. A message will be taken for patient inquiries and distributed to the appropriate department/provider for call back.

III. The receptionist will follow the established protocols for checking in new patients and established patients.

IV. The receptionist will complete an encounter form and progress note for each patient as follows:

A. Encounter Form
   1. Patient Name
   2. Patient DOB
   3. Current Date
   4. Provider to see patient
   5. Pay Status (Insurance, Slide, or Full Pay)

B. Progress Note
   1. Patient Name
   2. Patient DOB

V. The collected co-pay amount will be documented on the encounter form and day sheet and the patient will be given a copy of the encounter form as their receipt.

VI. The following stapled packet will be given to the nurse:

A. Established Patient
   1. Encounter Form on top
   2. Progress Note

B. New Patient
   1. Encounter Form on top
   2. Progress Note
   3. Health History
   4. Patient Demographics

VII. The nurse will document vitals, update medications and allergies, and the patient's chief complaint on the progress note and put the paperwork packet in the door for the provider.

VIII. The Provider will:

A. Document HPI, ROS, Medical Examination, Assessment, Plan and Return to Clinic date on the progress note.
B. Hand-write prescriptions and diagnostic test orders & attach to the packet.
C. Complete the encounter form with visit level, special procedures, labs, injections, etc., as well as with a substantiating diagnosis.
D. Give the packet to the check-out person.

IX. Medical Receptionist at Check out Will:

A. Copy any prescriptions before giving them to the patient and staple to the back of the packet.
B. Get a contact telephone number from the patient and write it next to the RTC (Return to Clinic date) on the encounter form. The patient will be told that we will call them to schedule the return appointment when the computer system is available. DO NOT TELL THE PATIENT TO CALL US TO MAKE THEIR RETURN APPOINTMENT.

C. The patient packets will be kept at checkout with the day sheet until the system is available.

WHEN THE SYSTEM IS BACK UP:

Each department is responsible for updating eClinicalWorks with the patient information as follows.

I. Receptionist Will:
   A. Verify that all appointments are on the appropriate provider schedule.
      1. Using a COPY of the day sheet, the receptionist will compare the packets to the day sheet, then to the schedule in eClinicalWorks, and check them off of the day sheet to ensure all are accounted for.
      2. Unstapled a packet.
      3. Medical Records will be given the documents to scan. progress note, prescriptions and diagnostic test orders to the appropriate categories in patient documents.
      4. Reseal the packet
      5. Initial the encounter form.
      6. Once 10 packets have been completed, they will be passed to the nurse. This will be done until all patients/appointments have been accounted for.
   B. Call back all patients on her appointment list.

II. Nurses Will:
   A. Enter history (for new patients), vitals, chief complaint, current meds, last mammogram/pap date, immunizations, lab drawn, etc. for each patient.
   B. Ensure all structured (reportable) data is entered
   C. Initial the progress note once completed.
   D. Forward the packet to the appropriate provider.
   E. Return messages and document the telephone encounter, as appropriate.

III. Providers Will:
   A. Either enter the complete progress note OR enter "see scanned progress note" in HPI, ROS and Examination sections of the computerized note.
   B. Enter the following:
      1. Assessment
      2. Prescriptions
      3. Return to clinic
      4. DI and lab orders
      5. Any other structured (reportable) data
      6. Exam and procedure codes for billing.
   C. Initial the progress note once completed.
   D. Return the packets to check-out.

IV. Medical Receptionist Will:
   A. Verify that all patients on the day sheet have a corresponding packet of information and that the progress note has been initialed by a nurse and a provider.
   B. Call patients to schedule RTC appointments. Document return appointments on encounter form.
   C. Separate clinical information from the encounter form.

D. Attach encounter forms to day sheet.
Forward to billing once deposit process has been completed.