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Blood Pressure Assessment in the Family Care Center (2019)

University of Iowa Health Care
Family Medicine Clinic

Subject: Blood pressure assessment in the Family Medicine Clinic

Purpose: To ensure blood pressures recorded during the Family Medicine Clinic visit accurately reflect the patient's blood pressure.

Staff Level to Perform: Physician and nursing staff

Equipment:

1. Appropriate size blood pressure cuff
2. Stethoscope if taking a manual blood pressure
3. Available automatic machine (or other available automatic device capable of taking programmed readings and averaging them)

Policy:

1. Patients with a blood pressure greater than 139mm Hg systolic and/or a blood pressure greater than 89mm Hg diastolic will have a second blood pressure reading taken prior to completion of the clinic visit on that date in the Family Care Center. Providers will communicate with medical assistants whether a second blood pressure reading is still needed. Both blood pressure measurements will be entered into Epic.

2. The first blood pressure measurement may be taken manually or automatically, and preferably following standard American Heart Association (AHA) procedure steps 1-4 outlined below.
   - ❖ For prenatal visits, the first blood pressure measurement **must** be taken following the standard procedure listed below.

3. If the initial blood pressure measurement is elevated, the second blood pressure measurement must be taken using an automatic blood pressure machine, following the standard AHA procedure below and including step 5.

Standard AHA Procedure:

1. Explain the procedure to patient and/or family
2. Have the patient sit quietly for 5 minutes with back supported and feet resting flat on the ground.
3. Choose the appropriate size cuff for the patient and seat patient with midpoint of upper arm at heart level.
4. Obtain the blood pressure reading and document in the EMR.
5. For measurement taken by automatic machine after an initial elevated reading, the machine should be set to countdown 5 minutes, then take 3 readings 1 minute apart and averaged.
   The patient is to be left alone in the room while these readings are taken.
6. If the mean systolic BP (SBP) ≥135 mm Hg or diastolic BP (DBP) ≥ 85 mm Hg DBP the patient should be identified as having a high blood pressure.

- **Related Information:** An analysis of blood pressures in a segment of our Family Medicine Clinic population indicates variation for the same patient's blood pressure over time in the Family Medicine Clinic. In an effort to ensure accurate blood pressures are recorded, blood pressure recordings will be rechecked on all patients whose blood pressure exceeds recommended guidelines.

References:

1. Clinical Nursing Skills and Techniques, 6th edition, 2006, Mosby, Inc.

2. Roerecke M1, Kaczorowski J2, Myers MG3. Comparing automated office blood pressure readings with other methods of blood pressure measurement for identifying patients with possible hypertension: a systematic review and meta-analysis. JAMA Intern Med. 2019 Feb 4, doi:10.1001/jamainternmed.2018.6551

Written: July 1998
Reviewed: April 2001, July 2004, June 2007, March 2009, December 2009, March 2019
Revised: May 2001, July 2004, March 2009, December 2009, March 2019 (Shen & Ernst)
Approved: December 2009, March 2019 (COT)

Communication Plan for Clinic Delays (2019)

University of Iowa Health Care
Family Medicine Clinic

Receptionist

- Inform patients at check in when there are known provider delays.
- Scan waiting room periodically.
    - If a patient is identified that has been waiting longer than 15 minutes, ask patient who they are scheduled to see.
    - Communicate with nursing personnel as to timeliness of that provider.
    - Inform patient of anticipated delay and ask if they are okay to wait or want to reschedule.

Nursing Personnel

- Huddle with provider at the beginning of each clinic session.
- Discuss anticipated delays.
- Proactively identify and plan for issues that may impede patient flow.
- Monitor the dashboard and communicate with receptionist when provider is >15 minutes behind schedule.
- Communicate directly with patients when delays extend > 15 minutes into their appointment time. Give them an option to wait or reschedule.

Provider

- Huddle with nursing personnel at the beginning of each clinic session.
- Communicate anticipated delays to nursing personnel.
- When patients present with multiple concerns or healthcare needs beyond those noted on the schedule, providers may inform the patient that they will manage their primary concern today and be happy to see them in a return visit for the other issues.

Consider service recovery process as needed

Written: January 2003-Houlahan
Reviewed: March 2019(COT)
Revised: March 2019(COT)
Approved: April 2019 (COT)

Family Medicine Clinic (FMC) Provider Leave Request, and Clinic Assignment Adjustment Policy (2019)

University of Iowa Health Care
Family Medicine Clinic

Subject: Family Medicine Clinic (FMC) Provider Leave Request, and Clinic Assignment Adjustment Policy

Purpose: To assure that licensed independent practitioners (LIPs) providing patient care in the FMC give appropriate notice for all planned absences/adjustments

To ensure adequate patient access to FMC services with advanced scheduling capability

Staff Level to Perform: Requesting LIP, Clinic Medical Director/Department Head or Residency Director

Equipment: None

Policy:

1. The LIP must have adequate vacation/CME time accrued for the request.

2. The LIP will submit leave requests at least 20 weeks prior to requested date(s). (This includes vacation, conferences and all other meetings. This does not include Family Medical Leave or Family Care Giving Leave.)

3. Absence requests submitted less than 20 weeks prior to the requested date(s) will not be automatically granted and will be reviewed on a case-by-case basis by Clinic Medical Director, Associate Head for Clinic Affairs and Department Head.

4. If the request is less than 20 weeks prior to the requested date(s), the LIP is responsible to find their own coverage for all affected staffing, ACC, and call sessions before leave request can be approved, and the plan for coverage is to be submitted with the leave request. (See staffing and call coverage policies)

5. If the rotation change request occurred less than 20 weeks prior to the requested date(s), the residents will be provided with clinic time depending on clinic space, nursing and staffing availability.

6. If resident makes elective rotation choices less than 20 weeks prior, the rotation will work around the published clinic schedule.

7. The LIP should not make any unchangeable travel plans (i.e., purchasing non-refundable plane tickets) until leave request has been approved.

8. Emergency requests will be handled on a case-by-case basis by discussion among Clinic Medical Director, Associate Head for Clinic Affairs and Department Head.

Procedure:

1. The LIP or designee (i.e., secretary) will submit absence request to the Family Medicine Clinic Master Scheduler at least 20 weeks but not greater than 52 weeks prior to date(s) being requested.

2. The Family Medicine Clinic Master Scheduler will seek approval from Residency Director+ (for resident physicians) or Clinic Medical Director* (for staff physicians) for all absence requests.

3. The Family Medicine Clinic Master Scheduler will seek final approval of rotation schedule from residency program 20 weeks prior to the scheduling block.

4. Resident elective rotation schedule will be made 5 months ahead.

5. The Residency Director+ or Clinic Medical Director* will approve the request within two weeks of the submission date with the exception of the requests for 2-weeks of Christmas and New Year's, and the week of Spring break , and in the order requests were received if the following criteria are met:

   a. The request is received 20 weeks prior to the leave days being requested.
   b. The clinic is sufficiently staffed to provide adequate patient access every day for the leave being requested.
   c. The requests for 2-weeks of Christmas and New Year's, and the week of Spring break will be reviewed and approved after the call schedule for those periods are completed.

6. If the request is denied, the LIP may appeal to the Residency Director+ or Clinic Medical Director* with a written explanation and a plan to provide adequate patient access. If the request is denied, the LIP may appeal to the Department Head with a written explanation and a plan to provide adequate patient access. The entire appeal process will be completed within 5 working days.

Special Considerations:
* If the Clinic Medical Director is unavailable, the Associate Director for Clinical Affairs and /or DEO will carry the responsibility.
+ If the Residency Director is unavailable, the Associate Residency Director will carry the responsibility.

Related Information: None

References: None

Written: 2/12/02 Beth Morden
Reviewed: 3/6/02 DFM Faculty mtg; 5/7/08 COT, 3/5/14 COT, 7/10/19 COT
Revised: 5/7/08; 9/2/10, 3/4/2014, 7/10/19 COT
Approved: 2/20/02 COT mtg; 5/7/08 COT, 3/5/14 COT, 7/10/19 COT

FAMILY MEDICINE ACUTE ABSENCE PROCESS (2021)

University of Iowa Health Care
Family Medicine Clinic

Subject: Family Medicine Acute Absence Process

Purpose: Establish procedure by which all necessary personnel are notified of provider's acute absence. Acute absence can be due to ILLNESS OR AN EMERGENCY.

IF YOU ARE ON CALL, YOU WILL MAKE 1 PHONE CALL AND SEND 1 EMAIL: one phone call to appropriate person for call coverage as listed below and the second, an email using instructions listed in #1 directly below.

<u>If provider is scheduled to be in clinic:</u>

1. As soon as possible and before 7:30 am on the day of the absence, provider must use absence line email to report an absence, expected length of absence and if possible, a suggested clinic make-up date, by emailing familymedicineabsenceline@healthcare.uiowa.edu.

The email system will provide messages to the following groups: Frontline Staff, Nursing Staff, and DFM Reception.

2. Residents are responsible for calling attending/supervising physician on their assigned rotation.
3. Nurse station will notify nursing personnel.
4. Frontline staff will send out an email broadcast, hold provider schedules and start re-scheduling patients as necessary.
5. The DFM reception desk will notify the following to report the absence: 1) appropriate faculty secretary, 2) if resident, the residency director or residency coordinator at 384-7507 or 384-7957, and 3) if resident, the chief resident if call coverage is required, 384-7956 or 384-7955.
6. The Area Medical Director or his/her designee, the Family Medicine Master Schedule Coordinator and Frontline designee will assist in finding a physician replacement for staffing when necessary. If there is a clinic back-up assigned for that day, they will be contacted to cover. If there is no clinic back-up assigned, the designated staff member will page/work with other providers to find coverage.
7. If the provider is scheduled to be in Acute Care, Frontline staff will put the clinic on hold and will check-in patients based on provider availability. Resident to staff ratio will be reviewed with every resident absence and faculty staffing assignments will be adjusted accordingly. If there is a clinic back-up assigned for that day, they will be contacted to cover. If there is no clinic back-up assigned, the designated staff member will page/work with other providers to find coverage.

<u>If faculty is scheduled for day/night call:</u>

The inpatient service director is to be contacted by either the Day Call or Night Call Day call faculty needing an acute absence. The director is responsible for arranging short- or long-term coverage. Until that arrangement is certified by the inpatient director the faculty requesting absence is still responsible for duty until relieved.

In the event the inpatient director is unavailable, the Day call Faculty needing an acute absence should notify the night call faculty for that night who is providing back-up. It is the duty of that night call faculty to find an appropriate replacement for day call coverage. The night call faculty will notify the absent faculty's secretary of the absence. For a prolonged faculty absence, the night call person or their designee is expected to cover the hospital service until other arrangements can be made.

Night call faculty acute absence if the inpatient director is unavailable: He/she must call the day call faculty who will assist the night call faculty in finding replacement following the above protocol.

If additional assistance in finding a replacement is needed, the department vice chair for clinic affairs or the office of the Department Head is to be contacted.

The absent faculty's secretary will notify the Family Medicine Schedule Coordinator, who will notify hospital operator, and Lead resident for inpatient team.

If provider is scheduled for OB Call:

The OB service director is to be contacted by either the Day Call or Night Call Day call faculty needing an acute absence. The director is responsible for arranging short- or long-term coverage. Until that arrangement is certified by the inpatient director the faculty requesting absence is still responsible for duty until relieved.

In the event the OB director is unavailable, the OB day call faculty needing an acute absence should notify the night call faculty. It is the duty of that OB night call faculty to assist his/her colleague in finding an appropriate replacement. The OB night call faculty will notify the absent faculty's secretary of the absence. For a prolonged faculty absence, the OB night call person is expected to cover the OB service until other arrangements can be made.

Night OB call faculty acute absence if the inpatient director is unavailable: He/she must call the OB day call faculty who will assist the night call faculty in finding replacement following the above protocol.

If additional assistance in finding a replacement is needed, the department vice chair for clinic affairs or the office of the Department Head is to be contacted.

The absent faculty's secretary will notify the Family Medicine Schedule Coordinator, who will notify the hospital operator, labor and delivery, and Lead resident for inpatient team.

Acute absence on weekends:

1. The on-call physician remains responsible for care until a replacement is found. The on-call physician and the director of the appropriate medical service or in their absence, the department vice chair for clinic affairs or the office of the Department Head, will be notified and assist in finding a replacement. When a replacement is determined, the hospital operator will be directly notified of the change. The Master Schedule Coordinator and the faculty's secretary should be notified of the change in call via e-mail.

If faculty is scheduled for office time/meetings/lectures/teaching:

1. Provider must call DFM Reception phone, 354- 7000, by 8:00 a.m. on day of absence. Leave a message to report absence, expected length of absence and any special instructions related to the day's calendar.
2. Reception desk will notify the appropriate secretary of absence.
3. The secretary will notify nurse triage of faculty absence.

Approved by: DFM Faculty July 2006
Revised: September 2006, September 2016
Revised by: September 2019 (COT), October 2019 (Drs. Dobyns, Fick, Wilbur and Shen), May 2021 (COT)

Department of Family Medicine Clinic Staffing Policy (2020)

University of Iowa Health Care
Family Medicine Clinic

Subject: The roles and responsibilities of attending physicians staffing residents in the Family Medicine Clinic (FMC).

Purpose: This policy has been developed and advanced in order to identify clearly the roles and expectations for the staffing physicians in the Family Medicine Clinic. The development of this policy is intended to comply with ACGME requirements, which in part state that "Family physician faculty…supervise and are immediately available on site to the residents in the (Family Medicine Clinic)…(and) must provide direct precepting of the residents."

Staff Level to Perform: Faculty

Equipment: None

Policy: During assigned sessions, the staffing physician will serve as a physician-leader for the FMC and a role model for residents in the clinic during that session. The staffing physician will have roles as outlined below under "Procedure." It is the staffing physician's prerogative and responsibility to prioritize these roles. The roles of the staffing physician will include patient care, education of residents, and assistance with clinic operations in the event that the area medical director is not immediately available.

Procedure:

1. Faculty identified as office preceptors are expected to supervise and teach the residents assigned to the outpatient clinic that half-day. Listed below are specific expectations for preceptors to follow.

   - Arrive on time (8:00 AM, 1:00 PM) and stay until the end of the half-day (12:00 PM., 5:00 PM); longer if needed until all the residents have seen their patients.
   - Ensure the residents provide quality and safe patient care. Listen carefully as the residents present their patients to you.
   - Faculty are expected to code an encounter based on the level of care provided. It is important that faculty are available to staff with residents as majority of patient visits are a 99214 complexity and should physically be seen by faculty.
   - Review resident documentation and provide feedback to improve the resident's documenting ability.
2. Staffing Ratios:
   - There is one faculty attending per 3.5 residents in clinic (1:3.5) with exception of 1:4 per faculty approval.
   - The procedure clinic is scheduled with one faculty attending and 1 resident (1:1)
   - PA residents within their first 6 months of training do count towards staffing ratio
   - Most APPs do not count towards staffing ratio
   - Any visiting resident (ex. psych, radiology) also counts towards ratio

- Psychiatry and Radiology residents always provide care in the acute care clinic, and are given a maximum patient load of 4-6 patients per session (psychiatry residents begin at 2 PM on Wednesday afternoons)

3. Clinic operations:
    - Collaborate with the charge nurse regarding problems with patient flow in the residents' clinics.
    - In the event of an acute absence when the area medical director is not available, assist the charge nurse in triaging patients who cannot be rescheduled.
    - Respond to nurse triage requests when the primary physician and his/her identified covering physician are not available and the issue is deemed urgent.
    - Respond to pharmacy renewal requests when the primary physician and his/her identified covering physician are not available and the issue is deemed urgent.
    - If a resident has downtime, remind him/her to check the schedules of fellow residents and offer to provide assistance if they are behind.
    - Faculty is encouraged to put their name on the dashboard after staffing the patients. This is to help facilitate billing.

Related Information: None

References:

Accreditation Council for Graduate Medical Education. Program requirements for residency education in family medicine. In: Graduate Medical Education Directory 2005-06. Chicago: American Medical Association, 2006: 83-88.

Lillich DW, et al. Active Precepting in the residency clinic: A pilot study of a new model. Fam Med 2005;37(3):205-10.

Written: July 5, 2006, by Jason Wilbur, MD
Reviewed: July 6, 2006, by Paul James, MD
Revised: October 4, 2006, by Jason Wilbur, MD
Approved: October 4, 2006 by vote of Family Medicine faculty at faculty meeting;
November 18, 2020 by COT

MANAGEMENT OF WALK-IN PATIENTS (TABLED ON 02/2021)

University of Iowa Health Care
Family Medicine Clinic

Subject:
Goal:

1. Patient presents with a perceived emergent situation (e.g. chest pain, difficulty breathing, feels like they are going to pass out,person falls or needs immediate assessment):
   a. Receptionist/scheduler will send a Voalte message to charge nurse. Receptionist/scheduler identifies patient need and location and requests a nurse's assessment now.
   b. Back up: 4-7555 or 4-7990 (nurses station phones).
2. Patient presents requesting non-emergent appointment:
   a. Patient will be instructed: "We strongly encourage that you pre-schedule appointments". At the meanwhile, the scheduler will look at the available same day access slots. If none is available, the patient will be offered a future appointment.
   b. The patient may also wait for a no-show or cancel and be informed by the charge nurse there will be a delay. (If the patient is asked to wait, they will be seen in that half-daysession.)
   c. The patient may be instructed by the charge nurse to schedule on a different day.
3. Patient presents for **test results:**
   a. The patient will be instructed as follows: "The nurse is busy with scheduled patients. They will assist you with your results when they can. There may be a wait. Would you like to have a seat in the waiting room or can the nurse call you?"
   b. Receptionist will look up the patient's last visit on the computer to determine the ordering physician.
   c. Receptionist will complete walk-in request form and deliver to the plastic holder at the west end of the nurse's station.
   d. The appropriate team leader will respond by managing the patient's request.

4. Patient presents to the front desk for **medication refills:**

a. The patient will be asked: "How much medication do you have left?"
b. If greater than a 24 hour supply, direct the patient to the pharmacy refill line, 4-7857.
c. If the patient is persistent in acquiring the refill now, instruct as follows: "The nurse is busy with scheduled patients. They will assist you with your refill request but there will be a wait. Can we call you at home when the prescription has been called in?" If the prescription is to be filled at the FCC pharmacy, the patient may wait in the waiting room. If being filled elsewhere, they should be strongly encouraged to return home and the tech will call them after they have called in the prescription.
d. The receptionist will provide the patient with the refill request form after filling in the patient's hospital number. They will be instructed to complete and return the form to the receptionist when finished.
e. When the form is returned, the receptionist will page the pharmacy technician {pager #2226) to pick up the form.
f. The pharmacy tech will review the refill request form, research the request and deliver the form to the corresponding charge nurse.
g. If the patient is completely out of medication, the charge nurse will be contacted at 4- 8825. Back-up: 4-7555 or 4-7990.

5. When a patient presents to the clinic and becomes angry or disruptive, the charge nurse will be notified at 4-8825, Back-up 4-7555 or 4-7990.

Please note: In the event the designated individual in any of these processes is unavailable due to an admission, procedure, or unable to break away from a patient encounter, the charge nurse will serve as the back-up and can be reached at 4-8825.

FCC-INTERNAL MEDICINE

Triage Process

1. Primary Triage RN is assigned to the triage position in medical records.

2. A back-up RN who is working in the clinic will be assigned to triage on a half day basis.

3. Back-up RN will check voice mail periodically and specifically at 1000 and 1500. RN will take off voice mail messages, manage calls per triage algorithm.

4. Primary triage RN will request assistance from back up RN to manage calls when she determines a need based on a back log of calls.

5. If the back-up RN is busy they will request assistance from another RN to help the triage RN manage back-log.

6. Back-up RN will copy the days telephone log at the end of the session and forward to triage.

7. Primary Triage RN will put phone on break mode for the lunch hour, recognizing there will be back-up assistance and coverage available upon her return.

WALK-IN REQUEST

Date:____________________ ☐ **Waiting**

Time:____________________ ☐ **Please Call**

Patient Name:___________________________ **Phone #(H)_____________**
(W)_____________

DOB:___________________________________

Patient Number:_________________________

Physician:______________________________

Last Visit:_____________________________

Patient request:

- ☐ **Lab results**
- ☐ **X-ray results**
- ☐ **Appointment**
- ☐ **General advice/question**
- ☐ **Other:_______________________**
  ____
  ____

WALK-IN REQUEST FOR REFILLS

Date:______________________ ☐ **Waiting**

Time:______________________ ☐ **Please Call**

Patient Name:______________________________ **Phone #(H)**_____________
(W)_____________

DOB:_______________________________________

Patient Number:___________________________

Physician:_________________________________

Last Visit:_________________________________

Pharmacy:___________________________________

Medication(s) requested (Please list each medicine separately with dosage if known)

1. ____

2. ____

3. ____

4. ____

5.____

6.____

7.____

8.____

9.____

Opioid Policy

University of Iowa Health Care
Family Medicine Clinic

Subject: Opioid Agreement

Purpose: To provide guidelines and a tool which providers can utilize to document discussion with patients regarding the risks, benefits, and rules related to the prescribing of opioid medication for chronic pain management.

Staff Level to Perform: MD, DO, Nurse Practitioner, and Physician Assistant

Equipment: None

Procedure: The opioid agreement document consists of the following four sections:

1. Opioid (Narcotics) Guidelines for chronic pain (attached page 2) – outlines the procedure providers should follow when prescribing opioid medication for the management of chronic pain.
2. Introduction to the Opioid Agreement (attached page 3) – summarizes the reasons and key processes to be followed when prescribing opioid medications.
3. Opioid Agreement (attached pages 4-5) – a two-page document outlining the responsibilities of patients and providers regarding opioid medications. After all the patient's questions are answered, the patient and the provider must sign the agreement.
4. Opioid Medication Prescription Record (attached page 6) - the final page is a tool that may be utilized to document the prescribing of opioid medication when the provider deems this documentation appropriate.

Special Considerations: N/A

Related Information: N/A

OPIOID (NARCOTIC) GUIDELINES FOR CHRONIC PAIN

University of Iowa Health Care
Family Medicine Clinic

Preface: All providers* with the authority to prescribe opioid medications must have a clear understanding of their obligations and responsibilities when using these agents. These agents shall be prescribed, dispensed, and administered in good faith for the accepted medical or therapeutic purpose. This opioid policy and the accompanying agreement have been developed for patients with chronic pain who require opioids to manage their pain.

Procedure:

A. History and Physical Examination
   1. The provider must conduct an appropriate history and physical exam of the patient prior to initiation of opioids.
   2. Document assessment and treatment, which reflects why the patient requires opioid treatment in the medical record.
   3. Must state if the patient has a history of substance abuse and treatment.
   4. Document current and prior medications for management of the pain condition.
   5. Document a treatment plan with types of medication(s) prescribed, reason(s) for selection, dose, schedule administered and quantity issued.

B. Documentation of the Opioid Agreement
   1. The opioid agreement must be reviewed with the patient by the pharmacist or provider.
   2. If the primary review is done by the pharmacist, the provider must insure patient's questions are answered about the agreement.
   3. Patient and provider sign the opioid agreement at the initial visit.

C. Periodic Review
   1. Periodic review and comparison of previous documentation with the current medical records should be done to determine if continued opioid treatment is necessary.
   2. Assess patient's pain at each visit.
   3. Medication side effects and compliance should be assessed at each visit.
   4. Unannounced urine/serum drug screens and indicated laboratory testing may be done when appropriate.
   5. The patient should be periodically re-evaluated to determine the cause of pain if a specific etiologic diagnosis has not been established.

* Provider refers to MD, DO, Nurse Practitioner, and Physician Assistant

PATIENTS ARRIVING LATE POLICY (2019)

University of Iowa Health Care
Family Medicine Clinic

There are many circumstances that may intervene and cause a patient to be delayed for their appointment in Family Medicine Clinic. All staff will be empathetic to our patients and attempt to accommodate them whenever possible.

Staff will follow this process for patients arriving 30 minutes or more after their scheduled appointment time. Exceptions: 15 minute late arrival policy will apply for patients with appointments times at 11:30 and 4:15 to ensure proper clinic session closure.

1. Receptionist will greet the patient and inform them their appointment was scheduled at X time and that they are X minutes late. The receptionist will listen for the reason for the delay.*
   a. *Any delays caused by weather, parking difficulties, patients getting lost, UIHC related problems the patients will be assured that all attempts will be made to have the patient seen. If patient does not offer any information, do **NOT** ask.

2. The receptionist will place a call to the nurse or MA working with the provider and inform them the patient has arrived.

3. The nurse/MA will review the schedule, consult with provider if necessary and determine if the patient can still be seen. All Acute Care Clinic patients who arrive late will be triaged by the charge nurse. If the patient cannot be seen the charge nurse will be consulted for additional options:
   a. Acute Care clinic
   b. See another provider
   c. Be seen later by the appointed provider

4. The MA/nurse will share options with the receptionist.

5. The receptionist will communicate options to patient including but not limited to:
   a. Be seen within 30 minutes by original provider
   b. Be seen by a different provider
   c. Be seen in the Acute Care Clinic
   d. Be seen by original provider later in the session
   e. Reschedule appointment at a time more convenient to the patient

6. Receptionist will communicate option selected by patient with MA/nurse.

Special Considerations:

- Providers will have a conversation with patients who are habitually late and inform them that we will not be able to accommodate them with same day appointments if they continue to arrive late.
- Patients arriving on time but needing to complete tasks (ie: financial counseling) that could make them late for their appointment- Front desk will alert MA/provider by calling or updating dashboard comments line. The expectation will be the patient will still be seen.
- Residents may not turn a patient away without approval from a staff provider.

Reviewed: 7/10/19 COT
Updated: 9/27/17, 7/10/19 COT
Approved: 7/10/19 COT

POLICY SUBMISSION/REVISION GUIDELINES

University of Iowa Health Care
Family Medicine Clinic

Subject: Policy Submission/Revision Guidelines for Family Practice Policy Shared Drive

Purpose: To ensure a standard format for clinic policies and their submission.

Staff Level to Perform: Individual policy writer.

Equipment: NA

Policy:

Submission:

1. Make sure the intended subject is not covered or is not contradictory to another policy on the shared drive.
2. Complete blank policy form located on shared drive.
3. Use the standard format as appropriate as possible.
4. Have the policy approved by the DFM Chair or other delegate.
5. Submit final/approved policies to Kim Hobbs via email.
6. Kim will place the policy on the shared drive with the appropriate cross-referencing as needed.

Revision:

1. If a revision of a current policy on the shared drive is needed let Kim know that you are resubmitting a policy in replacement of the current policy so that the outdated policy can be removed.

Procedure: N/A

Special Considerations: N/A

Related Information: N/A

References: N/A

Written: March 21, 2002 by S. Wolfswinkel
Reviewed: April 4, 2002 by S. Wolfe, MD
Revised: April 26, 2002 by S. Wolfswinkel
Approved: April 26, 2002 by S. Wolfe, MD

FAM Same day access (SDA) operation and philosophy (2020)

University of Iowa Health Care
Family Medicine Clinic

Subject: Same Day Access (SDA) Clinic Operation and Philosophy

Purpose: The purposes of the SDA Clinic are as follows:

- To allow patients same-day access to our clinic for acute and limited problems only (chronic care, routine follow up, physical exams, well-child checks, pre-operative physicals, hospitalization follow up, ED follow up and procedures should NOT be scheduled in the SDA except under rare circumstances.)

Staff Level to Perform: Providers and Nursing

Procedures:

1. ACC Clinic will only available when we have an outside rotation residents and/or designed midlevel provider (i. e. Carol Gorney)
2. All other providers in clinic (residents and faculties) will have one same day access slot built into the template
   a. The slots will be 9:15 AM or 2:15 PM. For R1s, it will be 8:45 AM or 1:45 PM.
   b. These slots will only open at the midnight of
   c. Providers will not be allowed to schedule into those slots for their own overbooking ahead of the time
   d. If provider has already overbooked his/her clinic ahead, **the Same Day Access Slot will still be used on the day of**.
3. APP will have their schedule arranged in a way that one of them will only have same access slots at a given half day. Their other clinic schedule will still be available for team short term follow up.
4. PA residents will have one same day access slot during the first 6 months, and 2 slots during the second 6 months of their training.
5. Patients calling the afternoon prior will be offered acute appointments for the next morning.
6. The slots are to be used ***only*** for **quick returns** when the patient's PCP is not available. Patients should then schedule a follow up with their PCP.
7. All appts are to be minimal 30 mins

Written: June 18, 2003 by Michael Maharry, M.D.
Reviewed: March 29, 2006, by Jason Wilbur and Clinic Operations Team
Revised: March 29 and May 3, 2006, by Jason Wilbur; December 2008 by Jason Wilbur
Approved: Nominally by Clinic Operations Team May 3, 2006; COT December 2008
Revised: November 2011 by Carmen Kealey
Written: September 2020 by Wendy Shen, MD
Approved: (COT)

EXTERNAL DOCUMENT SCANNING GUIDELINES

University of Iowa Health Care
Family Medicine Clinic

Providers: Below are external documents that are eligible for scanning if identified by the provider.

- All external past medical records that do not fall into the categories below should be reviewed by the provider and a summary of the records should be documented and entered into the patient's problem list or initial clinic documentation.
- Providers should identify that they have reviewed the records, specify which documents they would like scanned into Epic and give their initials or signature or the records will be returned to the provider for same.
- To minimize scanning of documents that are not medically necessary, as a rule, clinic notes and daily hospital notes from an external physician or hospital will not be scanned unless specifically requested.

External documents that are eligible for scanning:

Providers

- Legal (living wills, guardianship, etc.)
- Discharge Summaries/Consultation Reports, H&P (external only)
- Radiology reports (mammogram and chest x-ray, if normal, scan most recent only)
- Procedure/operative reports
- Specified forms completed/signed by Fam Med providers: FMLA paperwork, CPAP orders, Oxygen orders, DME (Dur Med Equip), Physical Exam forms, Medicaid Level of Care
- EKG Report (if normal, scan most recent only)
- Lab/Pathology results:
    a. Medical Assistant will selectively enter important lab values into Epic External Lab Result Section.
    b. Important lab result pages may be scanned (recommend 1-3 pages maximum for scanning) (pap; if normal, scan most recent only)
- Immunizations/TB/PPD: Nursing should continue to enter outside immunization information and TB/PPD results directly into Epic. This should not be scanned after it has been charted. Foreign country immunization documents can be scanned as a backup with approval of the Area Medical Director.
- Blood pressure and blood sugar records from patient or nursing facility.
- Plan of Treatment/Care forms from Physical Therapy centers or child occupational therapy centers (like Children's Center for Therapy)

Scanning Exclusions and Special Instructions

- Patient e-mails should be copied and pasted into EPIC telephone note.
- Outside orders (nursing home, VNA, Physical therapy) will not be scanned, may be kept in your personal files for 60 days and then discarded. *Exception: annual oxygen orders & CPAP orders will be scanned, see above.*
- Nursing home lab results and notes excluded from scanning *unless specifically indicated by provider.*
- When requesting outside records from another physician's office, provider should instruct the patient to only request specific pertinent information that will affect the patient's future medical care; Discharge Summaries, pertinent lab and diagnostic test results, operative reports. *Do not request all records to be sent unless pertinent to care.*

- Medication approvals from drug/pharmacies.
- Prior approval forms for medications will be kept in a file next to the pharmacy renewal assistant desk for one year and not scanned into Epic.
- *PHQ-9/Patient Health Questionnaire (has "Return to folder" in upper R hand corner) – file in Comebeh file.*

Internal Scanning Exclusions and Instructions

- Questionnaires & Screening forms (HHQ, FU HHQ, MCHAT, ASQ, Depression, Adolescent, Alcohol, Geriatric GAD-7 Anxiety survey) should be summarized in the patient's clinic documentation. The exception will be if a provider indicates on the form to scan and signs it.

Blue Hospital/Nurse Charge documents for coding go to Lori Quinn's office.

Revised: April 2010; May 2010; January 2013
Approved: February 6, 2013, Family Medicine COT Meeting
As of October 2019 per HIM
COT approved April 2021

SPECIAL PATIENT ACCOMMODATION

University of Iowa Health Care
Family Medicine Clinic

Subject: “Special” Patient Accommodation.

Purpose: To accommodate patients outside of a physician’s typical appointed clinic times

Staff Level to Perform: Requesting Physician, Nursing staff, Clinic Supervisor

Equipment: None

Policy: Because other duties require our faculty to be out of clinic, patients may need to have appointments outside of a physician’s usual clinic times. We usually call these “special patient visits.” This greater access to the Family Medicine Clinic (FMC) must be balanced with usual clinic operations.

Procedure:

1. Physician will identify a situation in which to see a special patient. Physician will send staff message to the **FMC Specials** Epic Pool, which goes to the lead MA and frontline scheduling supervisor. Special visits may originate from schedulers or nursing as well but must follow the same procedure.

2. Physician will provide the following information:
   - Name/number of patient to be seen as a “special.”
   - Date and time of the visit
   - Reason for visit (procedures may require other accommodations).

3. Designated Medical Assistants will determine or their designee will determine:
   - Available space
   - Amount of time required for patient visit.
   - Requirement for nursing assistance for visit (i.e., R.N. needed for IV rehydration, MA needed for vitals or procedural assistant, etc.).

4. Designated Medical Assistants will affirm or deny:
   - If affirmed, they will respond to staff message instructing to schedule and will add the provider to the daily breakdown sheet
   - If denied, they will work with physician and scheduling personnel to offer an alternate day or time.

5. Once approved the clinic supervisor or designated support staff will modify the provider’s schedule in Epic and schedule the appointment. All special appointments must be added under the provider’s schedule and can’t be scheduled into another provider or Acute Care Clinic.

6. Scheduler will contact the patient with the confirmed date and time of the appointment.

Special Considerations: Residents must have staff approval when seeking a special and this must be noted in the message request. Resident-staff ratios must be followed for all appointments and if the special would make the clinic exceed that ratio, the resident will be asked to seek another provider to staff that particular appointment. If within the ratio, the resident may use one of the staffers already scheduled that day. Clinic supervisor and/or designated scheduler will review staffing ratio before final approval and scheduling. The resident will be notified if they need to find another provider to staff.

Related Information: None.

References:

Written: 12/01
Reviewed:
Revised: 10/06, 11/06, 9/16, 4/21
Approved:

STANDARDIZATION OF COMMUNICATION TIMELINE FOR PATIENT REQUESTED DOCUMENTS (2021)

Subject: Standardization of communicating test results to patients

Purpose: To improve patient satisfaction and quality of care by standardizing the method of communication of lab results and expectant turnaround time.

Staff Level to Perform: Providers

Types of documents:

1. Letters: excuse letters, flex account reimbursement letters
2. School physical forms
3. FMLA paper
4. DOT forms
5. Disability forms: short-term, long term

Time Standards: Time refers to the duration between when the request from the patient is generated (either in person, by phone, or by MyChart) and when the patient is informed of completion.

a. Excuse letters
b. Other forms

Guideline

1. The document is expected to be ready for patient to pick up in 7-10 business days; exception is excuse letters which should be done within 2 business days.
   a. Simple work or school excuse letters can be done by nursing staff directly
   b. Extension letters will need to be completed by provider
2. Nursing will enter the time of receiving the forms in EPIC, providers will enter the time of completion, and then nursing will enter the time of informing the patient of completion
3. If the document is not completed in the expected time frame (often upon patient's inquiry), nursing will escalate to the clinic medical director and/or residency director.
4. Standard script to patients

   Please allow us 7-10 business days to complete the form. If you need it sooner, please note the date. We will do our best to meet your deadline, but there is no guarantee.
5. Our clinic does not fill out long-term disability forms

Written: October 2021 by Wendy Shen
Approved: November 2021 (COT)

Resident Check-Out Form

RESIDENT CHECK-OUT FORM

To provide optimum care for your patients during your absences, whether you are on an out-of-town rotation, on vacation, conference leave, or a brief absence, you must identify a colleague to cover your patients and provide a list to the Residency Director (or his designee). Please complete the form below and submit to the Residency Director's office at least three days prior to your planned absence.

Name: ____

Dates to be absent: ____

Reason: ____

I have made care arrangements for my patients and have discussed their cases with my colleague(s). In addition, my obstetrical patients have the name of the physician providing their care during my absence.

Dr. ______________________________ will review consult letters and/or lab reports and prescription refills.

Dr. ______________________________ is providing care to my obstetric patients.

Dr. ______________________________ is providing care to my Geriatric patients.

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DISTRIBUTION: The upper portion of this form is provided to L&D at UIHC. The entire page, including the patient listing below, is distributed to Family Practice Center Nurse Triage, Clinical Pharmacists, and Geriatrics Secretary to assist them in handling patient calls during your absence:

Obstetric Patients	Geriatric Patients

Other Instructions:

Revised 10/01

CHECK-OUT POLICY

One of the reasons you chose the field of Family Practice is the on-going relationship you have with your patients and their families -- "Continuity of Care". The Family Practice Center or model office is the arena in which you learn the skills of continuity of care by providing on-going care to your patients. This does not mean that you personally are available 24 hours a day, 365 days a year to your patients. However, continuity of care means working with your colleagues to provide care to your patients, whether in the model office or in other settings, day or night.

Our faculty, staff and the Hospital Operators are informed of planned absences (out-of-town rotations, vacation and other leaves) via the monthly office schedules. In addition to planned absences, there will be times you are free of service and call commitments and may wish to leave town for the weekend (i.e. visit family, an overnight camping trip, a night in Chicago, or to moonlight). These brief absences are not considered vacation if you are free of service and call commitments; however, arrangements must be made to provide continuing care to your patients.

Typically, the Family Practice Service and on-call physicians will cover any emergencies that occur; however, you will have patients you are closely following who may need medical care during your absence. For example, an obstetrical patient at term or obstetrical patient with complications, a nursing home patient with an unstable problem, or an acutely ill patient you have been following on a daily basis.

To provide optimum care for your patients during your absences, whether you are on an out-of-town rotation, on vacation, conference leave, or a brief absence, you must identify a colleague to cover the following patients and submit the Resident Check Out Form to the Residency Director (or his designee) at least three days prior to your planned absence.

- Make arrangements with a colleague to cover your obstetrical patients > 36 weeks or those with pregnancy related complications, and review the patient's medical status with the identified colleague before leaving town. Make sure your patients know who is covering for you so they know who to contact should they have questions, develop problems or begin labor.

- Make arrangements with a colleague to cover nursing home or geriatric patients with acute problems.

- Make arrangements with a colleague to cover any acutely ill patients from your patient panel in the Family Practice Center you have been following and review the patient's status before leaving town.

- Make arrangements with a colleague to review consult letters and/or lab reports during your absence (if more than one week).

- Check out forms are located in the residents room. These need to be filled out at least 3 days prior to departure and turned in to either Brenda or Linda. Copies are then sent to L&D and Nurse Triage.

The intent of this checkout policy is to provide the best care possible for your patients. Making arrangements for patient care during your absence is a skill needed for good patient care, both now and in the future.

Jeff Hunter October, 2001

FCC RESEARCH PROJECT

University of Iowa Health Care
Family Medicine Clinic

Subject: FCC Research Project Policy

Purpose: The FCC periodically receives requests to conduct research projects which involve patients encountered in the FCC or information collected and recorded in the FCC. This policy provides information and guidance relating to the process to be utilized in approving research projects requested to be conducted in the FCC.

Staff Level to Perform: Clinic Medical Director and FCC Leadership Team

Equipment:

Policy:

1. The proposed project must be discussed with the Medical Director of the Family Care Center or group of physicians. Ideally, a faculty physician will be chosen to collaborate so that eventual publication of work will include authors from the Department of Family Medicine.
2. The research project must be approved by the University of Iowa Institutional Review Board (IRB).
3. The design of the research project is appropriate to the clinical environment of the Family Care Center.
4. The Family Care Center must be compensated for the resources which are utilized by the research project. These resources include provider and staff time, patient care charges, and any materials consumed in the project for which the FCC is the cost center.
5. The design and duration of the project must insure it does not interfere with the primary mission of the FCC, which is the efficient delivery of primary medical services.

Procedure:

1. The individual requesting to conduct a research project in the Family Care Center should prepare a brief written request explaining the project. This request should be submitted at least 90 days prior to anticipated beginning date for project. This explanation must include a statement relating, at a minimum, to the above 5 major criteria which a project must meet to be approved in the FCC.

2. If FCC resources are to be consumed, a brief business plan must be included. This brief business plan must consist of the following: a) title of research project with brief description; b) duration of project; c) source of funding for the project; d) number of FCC patients to be enrolled in project; e) brief description of the services to be provided in the FCC, to include a description of the human resources, i.e. business office, nurse, physician time required to provide services; f) determination of the cost of resources required, this will be determined by working collaboratively with the FCC Administrative Office; g) estimated reimbursement by the research project for resources required; h) if reimbursement exceeds costs, how will

excess funds be distributed or used; i) description of the specific method of payment to the FCC for resources utilized.

3. The written request for project approval should be submitted to the Family Medicine Medical Director. The Clinic Medical Director will review the project based on the five major criteria. The project review will also assess whether the initiation of the requested research project will or would have a negative impact on any other current or proposed research projects to be done in the Family Care Center.

4. In the Family Practice Clinic, the Clinic Medical Director will request the Chair of the Family Medicine Research Committee and the Research Committee to review the research project utilizing the same criteria. The Family Medicine Research Committee will make a recommendation to the Family Practice Clinic Medical Director as to the appropriateness of the research project. The Family Practice Clinic Medical Director will include this information in the evaluation process.

5. The Clinic Medical Director may prioritize the approval of projects if more than one project is requested or if other projects are occurring in the Family Care Center. Each project, even though appropriate for the FCC, will be reviewed at the requested time and may not be recommended for implementation if the addition of this research project to already on-going projects would interfere with the primary mission of the FCC.

6. The Clinic Medical Director and FCC Leadership Team will discuss and review each research project and make a recommendation to approve or disapprove the project's implementation in the Family Care Center. Where necessary, the Clinic Medical Director will offer guidance to the requestor if minor modifications would result in the approval of the project's implementation in the FCC. The requestor of the research project will be notified by the Clinic Medical Director with recommendations for modification or with the decision to approve or disapprove the research project.

7. The Clinic Medical Director and the FCC Leadership Team will review the request with the Director of the Family Care Center if questions or concerns arise related to the implementation of a specific research project in the Family Care Center. The Director of the Family Care Center may utilize the resources of the Family Care Executive Committee if additional review or recommendations are needed to determine whether a research project is recommended for implementation in the Family Care Center.

Special Considerations: Persons requesting the distribution or posting of information concerning research projects being conducted outside The Family Care Center: The approval of the FCC Leadership Team and the appropriate Clinic Medical Director must be obtained prior to posting or distributing such information in The Family Care Center.

Related Information:

References:

Written: July 2004
Reviewed: August 2004
Revised: August 1, 2019 by Barcey Levy
Approved: FCC Area Medical Directors Committee, August 25, 2004

Medical Marijuana Prescription Implementation (2022)

University of Iowa Health Care
Family Medicine Clinic

Subject: Medical Marijuana Attestation Policy

Purpose: Define ordering and scheduling guidelines

Staff Level to Perform: Family Medicine Providers only

Policy:

1. Patients are not allowed to call in and make appointments on their own. The patient must have a current relationship with the provider.
2. The Scheduling Team and Nurse Triage will communicate to callers/patients that our providers in general do not provide this service and will be advised to consult their current PCP and get an appropriate consult. Scripting examples:
   a) *Most Family Medicine providers in our clinic do not provide Medical Marijuana Attestations. However, if you feel that you need to discuss this with your PCP, we encourage you to make an appointment with your PCP to discuss alternatives.*
   b) *If the patient does not or claims to not have a PCP, advice to patients that they will need to establish care with a provider before Medical Marijuana Attestation discussions will occur. This discussion will not occur at your first appointment and a relationship needs to be established first.*
3. This is a provider generated appointment for specific patients who would like to get the marijuana attestation. Providers will not, in general, transfer patient care to another provider for the sole purpose of obtaining a Medical Marijuana Attestation.
4. Follow Up order with specific instructions will be submitted by the provider for the marijuana attestation and details of the order need to be followed by the Scheduling team when the appointment is made.
5. The appointment will be made with the ordering provider only for a 30-minute visit to only discuss the marijuana attestation.
6. Residents- considerations to be reviewed and established at a later time.

Initial Discussion: COT May 11, 2021
Drafted: April 2022 by Wendy Shen, MD
Approved: COT May 5, 2022

PROCESS ON TRANSFERRING DISRUPTIVE PATIENTS FROM OFFSIDE CLINICS TO MAIN CAMPUS (2021)

Subject: Standardization of the transferring disruptive patients from Family Medicine offsite clinics to the clinic on main campus

Purpose: To ensure safety of clinic staff while providing necessary care to patients with disruptive behavior.

Staff Level to Perform: Providers, Nursing staff, Medical Directors, and frontline supporting staff

Patient selection:

Disruptive behavior is inappropriate behavior that interferes with the functioning and flow of the clinic. It includes but is not limited to

1. Repetitive Aggression toward staff/providers/other patients
2. Threats of violence
3. Any intentional inappropriate physical contact

Guidelines

1. The provider will alert their campus Medical Director they have a disruptive patient issue. Provider and the local medical director will work out a process to attempt to maintain the medical care at the local clinic
2. Offsite clinic will contact Disruptive Patient Program for evaluation and assistance. Call or email Lance Clemsen, Social Work Specialist II, at 319-356-2431 or lance-clemsen@uiowa.edu. Doug Vance, Director Safety & Security, at 319-356-0841 or douglas-vance@uiowa.edu. *(please see attachment below: Management of Patients and/or Visitors with Disruptive Behavior)*
3. When recommendation of a transfer is made, a warm hand off will occur among Medical Director leadership from both clinics, transferring provider and identified accepting provider at main clinic.
4. If the patient needs to be seen urgently for medical care
   a. The local clinic may call for local police for assistance, or send the patient to ER
   b. If time allows, the main campus may see the patient with Safety & Security available for patient's arrival.
5. Timeline of actions plans for disruptive patient will be made in the Specialty Comment tab in EPIC. The documentation in the patient's clinic note will guide providers to the Specialty Comment tab.

Management of Patients and_or Visi

Written: December 2021 by Family Medicine Disruptive Patient Taskforce

Approved: