

Physician Summary of the Patient Overview Process

This document provides an overview of the “Patient Overview Process” and the training that will occur.

The goals of the Patient Overview Process are:

- To provide the care team (the physician and his/her nurse/MA) with all of the information they need for the patient’s visit.
- To bring the care team’s attention to things they need to address during the visit.
- To improve patient care while reducing physician workload.

The Patient Overview Process has 3 Components

1. Pre-visit care coordination using the Patient Overview Document (attached).
Your nurse/MA will:
 - a. Review the patient record to understand the patient’s care needs and anything that has happened since the last visit,
 - b. Call the patient to complete the Patient Overview Document, and
 - c. Obtain additional information relevant to the patient visit that is not already available.
2. Care team huddle.
 - a. Your nurse/MA will review the completed Patient Overview Document with you on the day of the patient visit (beginning of the clinic session) and obtain any additional needed information.
3. Use of the Patient Overview Document during the patient visit.
 - a. You will have the Patient Overview Document and any additional information collected for use during and after the patient visit. The Patient Overview Document can be retained in the patient chart.

Training for the Patient Overview Process:

- Your nurse/MA will spend approximately 2 hours learning about the Patient Overview Process and how to use the Patient Overview Document. This includes a skill-building session with mock patients.
- You and your nurse/MA will attend a 1 hour session together on the Patient Overview Process and, specifically, the Huddle. During this session you will identify ways to fit the Huddle into your workflow.
- Your nurse/MA will talk with the WREN team once a week for the first two weeks of the study to review how the process is going.
- We have not scheduled specific time to meet with the physicians separately but we are happy to do so in person during the training, by phone at any time, or by email.

The Patient Overview Document (POD)

The POD was created to assist in collecting and having all of the information needed for an elderly patient visit available at the time of the visit, focusing on new information available since the patient’s last clinic visit. It was designed using a rigorous process: i) literature review, ii) observation of elderly patient primary care clinic visits, iii) interviews with physicians and patients about the information needed at visits, iv) primary care physician and nurse/MA input into the content of the form.

There is some flexibility in how the POD and huddle are used to share information between the care team members. See the starred areas of the discussion below.

There are 10 sections of the POD that will be filled out on the study patients:

1. **Reasons for Visit:** Lists the problems/issues the patient wants to discuss at the appointment. It can be used to help set the agenda for the visit and avoid hand-on-doorknob issues.
2. **Patient Questions:** Lists patient's questions or requests to be addressed during the visit.
3. **Ongoing/Chronic Problems:** Provides status updates from the patient on ongoing or chronic medical problems that may need ongoing care at this visit, even if they are not the primary reason for the patient's visit. *You may work with your nurse/MA to identify specific diseases to always address in this section, e.g. hypertension, diabetes, or heart disease.
4. **Follow-up items** (Doctor's Recommendations & Actions Taken by Patient): Identifies your previous recommendations to the patient and what and how the patient did with them.
5. **Lab/Test Results:** Indicates the labs and tests ordered and/or performed at or since the last visit and lets you know if the results are available. Nurse/MA will obtain outside documents for the visit. *You may work with your nurse/MA to record the results of certain labs/tests or have them print off the results for faster access.
6. **Visits with Clinicians:** (Clinician & Description of Visit): Lists patient visits with other clinicians, a description of the visit, and any tests that were done at outside facilities. Nurse/MA will obtain outside documents for the visit.
7. **Home Readings:** Records home blood pressure or blood glucose measurements if taken.
8. **Health Overview Changes/Problems:** Records aspects of a patient's well-being that can affect his/her health and may not be routinely discussed. Includes: diet, exercise, sleeping habits, mood/stressors, pain, alcohol and tobacco use, living arrangements and falls.
9. **Health Maintenance:** Records date of procedure for common health maintenance issues in the elderly. Includes: eye exam, lipid panel, colonoscopy, mammogram, bone density, and vaccinations. *You may work with your nurse/MA to have them record the results of the test or identify if the patient is due for the test/procedure and order it.
10. **Medication Changes / Problems:** Documents any changes, problems, or concerns with any medications since the last visit. Includes adherence, side effects and the cost of medications. This is NOT meant to be a medication reconciliation process. *You may work with your nurse/MA to have them review medication lists with the patient over the phone or refill medications before the visit.

The POD has three additional useful features:

- Attention Box: indicates information you should be aware of or take action for/during the visit.
- Information available: indicates information is available in the chart or attached to the POD.
- Notes column: for taking notes before/during or after the visit

How might you use the Patient Overview Process & the POD?

In addition to being a source of information about the patient for the visit, the Patient Overview Process and the POD may have many other potential uses.

Potential Care Team Uses before the visit (physician and/or nurse/MA before or during the huddle)

1. Identify and obtain additional information before the visit that you anticipate you will need.

2. Identify and obtain labs/tests before the visit that can be used to make decisions about patient care during the visit.
3. Identify and order labs/tests or medications before the visit, e.g., labs needed for visit, health maintenance, med refills.
4. Write notes on the POD or highlight text to remind yourself about something you'd like to address during the visit.

Potential Physician Uses of the POD during the visit

1. Set the agenda for the visit with the patient having identified what the patient wants to discuss and issues that you would like to address in the time available.
2. Write notes on the POD or highlight text as a reminder of issues discussed, actions taken, etc.

Potential Physician Uses of the POD after the visit

1. As billing and coding aide to recall the number and types of problems discussed during the visit.
2. A tool for recalling the visit details when dictating or entering the clinic note.
3. Partial documentation of the visit itself. The POD can be placed into the patient record once the nurse has made a copy of it for the study.

Note: The Patient Overview Process is **NOT** meant to replace the patient/doctor interaction during the visit or completely replace the medical record although you may use the Patient Overview Document to assist in documenting the patient visit. Its purpose is to help guide the patient/doctor interaction to make it easier for you to focus on the most important things and to assure that all needed information is readily available at the time of the visit.

Questions about the Study or the Patient Overview Process?

[provide contact information for person(s) who will be a resource.]