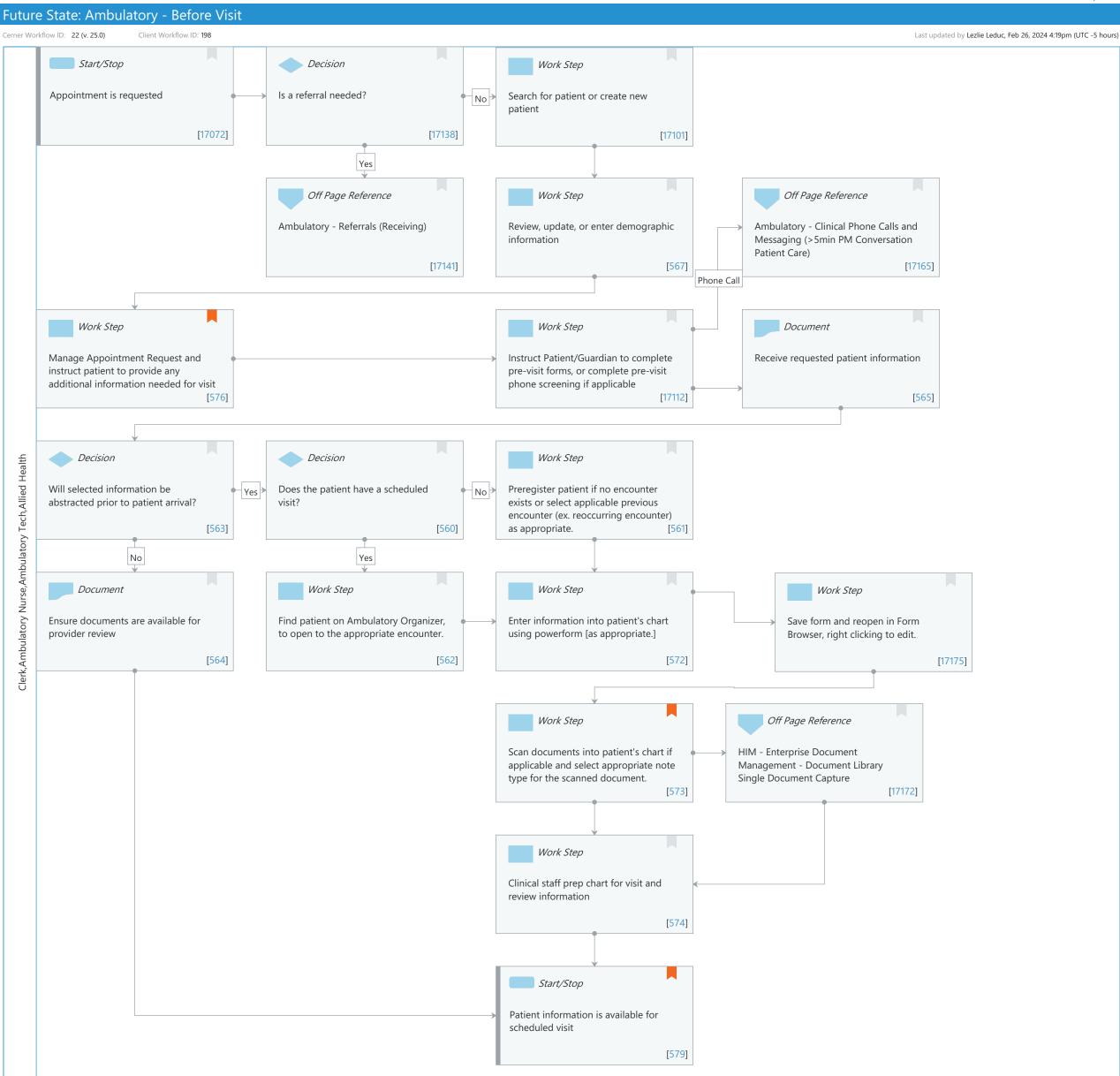
Niagara Health System



Future State: Ambulatory - Before Visit

Cerner Workflow ID: 22 (v. 25.0) Client Workflow ID: 198

Workflow Details:

Workflow Name: Ambulatory - Before Visit Workflow State: Future State Workstream: Pre-Admission/Pre-Visit Venue: Ambulatory Client Owner: Cerner Owner: Standard: Yes Related Workflow(s): Tags:

Workflow Summary:

Service Line: Related Solution(s): HealtheRegistries Cerner Millennium EMR - Ambulatory Cerner Oncology Project Name: Niagara Health System:OPT-0297674:NIAG_CD Niagara HIS RFP TestBuilder Script(s): Cerner Workflow ID: 22 (v. 25.0) Client Workflow ID: 198 Workflow Notes: Patients secure appointments from multiple sources:

New Patients: Referral from PCP or Inpatient discharge, or by Self Referral.

Established Patients: As a follow-up visit or recurring appointments

Appointments can be scheduled via Phone Call from patient, family or health care provider, via person to office staff or via Patient Portal.

The office can be responsible for calling the patient to obtain preliminary intake information prior to the visit.

Introduced By: WS 7 Validated By: WS 8

Swim Lane:

Role(s): Clerk

Ambulatory Nurse Ambulatory Tech [Custom]



Last updated by Lezlie Leduc, Feb 26, 2024 4:19pm (UTC -5 hours)

Cerner Workflow ID: 22 (v. 25.0) Client Workflow ID: 198

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Allied Health [Custom]

Department(s): Security Position(s):

Start/Stop [17072]

Description: Appointment is requested

Decision [17138]

Description: Is a referral needed?

Work Step [17101]

Description: Search for patient or create new patient

Off Page Reference [17141]

Workflow Link: Ambulatory - Referrals (Receiving)

Work Step [567]

Description: Review, update, or enter demographic information

Off Page Reference [17165]

Workflow Link: Ambulatory - Clinical Phone Calls and Messaging (>5min PM Conversation Patient Care)

Work Step [576]

- Description: Manage Appointment Request and instruct patient to provide any additional information needed for visit
- Comments: Appointment may be made at this time or entered on appointment request queue until approval for appointment is obtained.

Work Step [17112]

Description: Instruct Patient/Guardian to complete pre-visit forms, or complete pre-visit phone screening if applicable

Document [565]

Description: Receive requested patient information



Future State: Ambulatory - Before Visit

Cerner Workflow ID: 22 (v. 25.0) Client Workflow ID: 198

Decision [563]

Description: Will selected information be abstracted prior to patient arrival?

Decision [560]

Description: Does the patient have a scheduled visit?

Work Step [561]

Description: Preregister patient if no encounter exists or select applicable previous encounter (ex. reoccurring encounter) as appropriate.

Document [564]

Description: Ensure documents are available for provider review

Work Step [562]

Description: Find patient on Ambulatory Organizer, to open to the appropriate encounter.

Work Step [572]

Description: Enter information into patient's chart using powerform [as appropriate.]

Work Step [17175]

Description: Save form and reopen in Form Browser, right clicking to edit.

Work Step [573]

- Description: Scan documents into patient's chart if applicable and select appropriate note type for the scanned document.
- Comments: Scanning can be done via work queue management, clinical staff scanning, registration scanning, etc.

Off Page Reference [17172]

Workflow Link: HIM - Enterprise Document Management - Document Library Single Document Capture

Work Step [574]

Description: Clinical staff prep chart for visit and review information

Start/Stop [579]

Description: Patient information is available for scheduled visit



Comments: If the patient cancels or no shows after visit related documentation has been completed, the encounter cannot be deleted. The type of documentation that may be completed prior to the visit (e.g. Pre-Visit Planning, Huddle documentation) is still appropriate to be in the patient's chart. The provider prep work, completed in the Workflow mPage, stores in system use tables and will not be released in Clinical Reporting or health record requests. Any documentation within the Workflow mPage will remain there indefinitely but is only viewable by the user.

> In the case of a reschedule, the encounter and any associated documentation will follow to the new appointment.

