



# TEAM BASED CARE 3.0 STANDARD WORKFLOW GUIDE

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## Medical Assistant Standard Work

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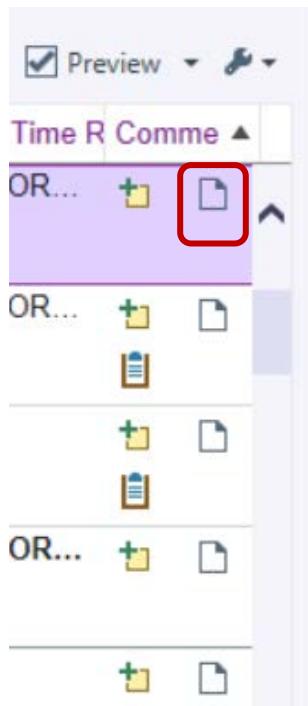
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## MA Pre-Visit Preparation

### 3 or more days prior to visit

- From the Schedule view
  - Select patient
  - Find the **Comments** section

Hover over the 'Specialty Comments' sticky note icon and **Double Click** to document or modify a comment



**Note:** Specialty comments are not part of the legal medical record. Comments made to the specialty sticky note can be viewed and edited in various places.

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- Use the **Huddle Snapshot** to review:
  - o Health Maintenance Summary
  - o Last Visit Progress Notes

The screenshot shows a software interface for managing patient visits. At the top, there is a header with the patient's name, 'BERGEN, CHRIS', and a 'Filter by Status' dropdown set to 'Total: 2'. Below this is a table of scheduled visits:

Time	Status	Patient	Notes / Visit Type	Visiting Provider	Orders	Room / Time
8:00 AM	Scheduled	Bassoboe, Evelyn 32 Y / F	new - establish care Return Patient Visit 15	Bergen, Chris, MD		HOOVER
8:30 AM	Scheduled	Bassoboe, George 65 Y / M	Return Return Patient Visit 15	Bergen, Chris, MD		

On the right side of the interface, there are two red boxes highlighting the 'Huddle Snapshot' button in the top right corner of the main window and the 'Huddle Snapshot' tab in the bottom right corner of the 'Health Maintenance Summary' panel.

- Open CareEverywhere
  - I. Click on '**Request Updates**'
  - II. Find labs and HM items within CareEverywhere.
    - o Abstract using Quick Abstraction

The screenshot shows the 'Care Everywhere Outside Records' interface. At the top, there is a red box around the 'Request Updates' button. Below it is a navigation bar with tabs: 'Home' (selected), 'Summary', 'Documents', 'Lab Results', and 'Other Results'. The main content area displays the following information:

Sutter Health Affiliates and Community Connect Practices      6/19/2018      6/19/2018

Available Information

Summary      Documents      Lab Results      Other Results

The 'Care Everywhere' logo is visible in the bottom right corner.



- Confirm that orders from previous office visits are complete and documented in Epic.
  - I. If results do not exist
    1. Contact patient to confirm they completed the tests
    2. Remind patient that any tests/labs must be completed at least 48 hours prior to visit
  - II. **New patients:** Recommend that they bring or send records from previous providers

**Chart Review**

**Labs**

Date/Time	Test	Doc Description	Status
01/10/2020 12:06	COMPREHENSIVE METABOLIC		
01/03/2020 10:30	COMPREHENSIVE METABOLIC		Final result
01/03/2020 10:30	ANTI-SMOOTH MUSCLE & MITOCHONDRIA		Final result

- Update HM activity
  - I. Search for HM Due items and data in the chart and abstract into quick abstraction tab. This makes it easier to identify outstanding care gaps in the chart
- Update patient's past Immunization History (children under 21 & new patients).
  - I. Select the correct Immunization template (Adult or Peds).

**Historical Admins**

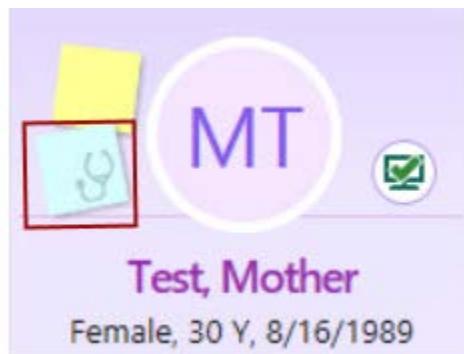
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**Historical Immunizations**

Template to use: **AMB ADULT IMMUNIZATIONS [21000000]**

	Immunization		
1	Flu vaccine - unspecific formulation [21500]	10/6/2017	

- Follow up on hospital/ER visits
  - I. Obtain records from facility
  - II. Once records are received, scan records
- Document in specialty comments:  
"Missing \*\*\*, etc.  
Date of last visit & reason  
PVP Done  
Initials + Date"



**Family Medicine Comments** Last updated: Today

HTN- BP stable HCT, no medication changes  
Labs missing called to remind  
LOV-1/1/2020 for f/u HTN  
PVP done VMR 4/14/2020



### **1 day prior to visit**

- Check 'Specialty Comments' sticky note
  - I. Check PVP status
  - II. Attempt to obtain missing items. Anything not completed will be notes in the **Specialty Comments' sticky note**
  - III. Complete new prep for newly added appointments

### **Day of visit**

- Review same day "Reason for Visit".
  - I. Attempt to obtain missing items
  - II. Do prep for newly added patients

## **Provider/MA Huddle**

Provider and MA should huddle 15 minutes prior to the first patient of each shift while reviewing the daily schedule.

- Review details of each appt (labs, HM, hospital docs, etc.)
- Discuss future/standing/pending orders to be released during the visit
- Identify double-booking opportunities
- Identify potential flow busters and countermeasures



## Patient Rooming

- Confirm patient has arrived in Epic
- Greet patient and introduce yourself
  - I. Use two patient identifiers (picture, last name, DOB)
- Measure height/weight (height at least once per year)
- Log into exam room computer
  - I. Open patient encounter from the schedule
- Launch standard MA Support note using .UHAMASUPPORTNOTE or .UHWELLNESSSUPPORTNOTE (for MAW/IPPE)

Visit Info	Vital Signs	Extended Vitals	Hearing/Vision	Support Note	Allergies	Med Reconciliation
------------	-------------	-----------------	----------------	--------------	-----------	--------------------

**Health Maintenance Due**

Topic	Date Due
• DIABETES FOOT SCREENING 1 YEAR	12/19/2019

Body mass index is 40.61 kg/m<sup>2</sup>.

Ht Readings from Last 1 Encounters:
06/19/19 5' 7.46 m (5' 8.75")

**Assessment: PHQ-2**

PHQ-2	2/21/2020	10/21/2019	6/19/2019	12/18/2018	10/31/2018
Little interest or pleasure in doing things	0-Not at all				
Feeling down, depressed, or hopeless	0-Not at all				

**Assessment: STEADI**

STEADI	10/21/2019
Did the patient fall anytime in the past year?	No
Does the patient feel unsteady when standing or walking?	No
Does the patient worry about falling?	No
Does patient have a medical reason for not completing falls screening? (e.g. non-ambulatory)	No

- Document patient's chief complaint/symptoms under reason for visit. DO NOT chart a diagnosis
  - I. Under comment section document severity, duration, treatment, causation etc.

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 Reason for Visit

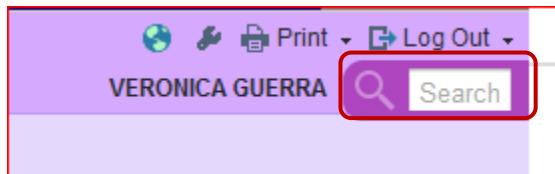
Chief Complaint			
Annual Wellness	Birth Control	CHP	Cough
Est. Care	F/U	Hospital Follow...	Immunization/Inj...
Medicare Welln...	Pain	Pre-op	Procedure
URI	UTI	X-ray f/u	
Chief Complaint	Comment		
Follow Up Visit	<input type="text"/> type 1 Diabetes		

### Confirm Health Maintenance (Address all yellow BPA Alerts).

- I. Make HM Due editable.
- II. Confirm with patient if service has been completed
- III. **New patients:** enter information from forms patient brought to visit using **Quick Abstraction/Historical Immunizations**
- IV. If HM activities have been done but Results have not been received, send the **UHA results letter** via Communication Management to the provider of service
- V. Complete **Request for External Medical Records** for each Care Gap item not reconciled via Care Everywhere or via letter through Communication Management
- VI. Confirm with patient if they would like to complete HM due today. If so, pend orders
- VII. Document next to the HM item the "Status" and "Action" "Plan"
- VIII. Results obtained from outside sources, update using **Quick Abstractor** and/or **Historical Immunizations**
- IX. Click '**Update Health Maintenance**' to refresh any HM updates completed in Epic

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X. For quicker search of missing items at the time of rooming, search using the search field. (Upper right had corner of screen).



**Health Maintenance**

Postpone Remove Postpone Override Remove Override Document Past Immunizations Edit Modifiers Report Update HM

Due Date	Topic	Frequency	Date Completed
09/27/2013	Zoster Vaccine (1 of 2)	Sequential	
01/01/2020	COLONOSCOPY	5 year(s)	1/1/2015 10/2/2014
03/24/2026	DTaP/Tdap/Td Immunizations (2 - Td)	Sequential	3/24/2016
Completed	INFLUENZA VACCINE	Sequential	12/20/2017 3/10/2016
Completed	HEPATITIS C SCREENING	Once	6/21/2018

**Health Maintenance Due**

Topic	Date Due
• HPV IMMUNIZATIONS (1 - Female 2-dose series)- Would like today, series order pending	01/01/2011
• DTaP/Tdap/Td Immunizations (1 - Tdap)- Declined, has upcoming volleyball game and can not be sore over the weekend, will plan for next ov.	01/01/2011
• CHLAMYDIAL INFECTION SCREENING - Declined, has never been sexually active	01/01/2012

- History (**new and established pts.**)
  - Collect tobacco history in Vitals section
  - Collect medical/surgical Hx
  - Family Hx
  - Substance and Social Hx
  - Tobacco Hx (smokeless tobacco and e-cigs)  
Document Counseling see Tobacco Counseling section.
  - Mark as '**Reviewed**'

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2/21/2020 visit with Mehta, Anand Yogesh, MD for ESTABLISHED PATIENT

Reason for Visit      Vital Signs      Extended Vital Signs      Med Reconciliation      Allergies      **History**

View Ques Answers      Goals      Time Ready/Rm#

**History**

Medical History (Click Here to Enter Additional Medical History)

**+ Add**      **+ Pertinent Negative**

Alcohol Problem      Yes      No      Emphysema

Anemia      Yes      No      ENDO: DM 1

- Confirm Allergies
  - I. Document reaction and any additional information in the Comments field as needed
  - II. 'Mark as Reviewed'
- Medication Reconciliation
  - I. Review current medication list with patient including over the counter and herbal supplements
  - II. Mark meds as: Taking, Taking Differently, Not Taking
  - III. If patient is asking to discontinue a medication; Mark as temporarily not taking, document in the

Reason for Visit      Vital Signs      Extended Vital Signs      **Med Reconciliation**      Allergies      History      Support Note      BestPractice      Rx Benefits      Outside Meds

View Ques Answers      Goals      Time Ready/Rm#

**Med Reconciliation**

**New medications from outside sources**

Medications need attention: [Go Reconcile](#)

Medication reconciliation is the process of identifying the most accurate list of all medications that the patient is taking by comparing the medical record to a list of medications obtained from a patient, hospital, or other provider. At a minimum, this is done at new patient encounters and when updated medication information is available such as through Care Everywhere. The provider is responsible to review the list and complete this process by clicking "Mark as Reviewed".

**Add Comment**

New home med: [+ Add](#)

Sort by: **Alphabetical** [▼](#)

pharmacy: Walgreens #04659 - HAYWARD, CA - 164 W JACKSON ST AT SEC JACKSON & CYPRESS

Alphabetical

atorvastatin (LIPITOR) 40 mg tablet

THIS IS A NEW PRESCRIPTION REQUEST. PLEASE PROVIDE DIRECTIONS, QUANTITY, AND REFILLS., Disp-90 Tab, R-0, E-Prescribe  
\*\*Patient requests 90 days supply\*\*

**Taking**      **Taking Differently**      **Not Taking**      **Taking** [Last Dose](#) [Taking?](#)

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support note using the **red hyperlink** (.REMOVEMEDS) and include the name of the medication for provider to discuss (**Do not remove medications**)

- IV. Add missing medications (from Outside Sources)
  - i. If unsure of dose, choose Rx name without further information. Mark as "taking"
  - ii. Ensure outside Sources med req. "banner" is no longer yellow
- V. MA completes medication reconciliation with patient and **marks Med List Status: Complete**. (**Only licensed staff should press the "Mark as Reviewed" button**)

Med List Status: **Complete** 

- VI. Ask patient if refills are needed
  - i. If yes, document in support note and pend order for 12-month supply for provider to approve. (Confirm patient's preferred pharmacy)



Select the patient's pharmacy CVS/pharmacy #9895 - Campbell, CA - 100 N San Tomas Aquino

Select Pharmacies for Prescriptions

Replace Pharmacy	CVS/pharmacy #9895 - Ca... 100 N San Tomas Aquino Campbell CA 95008 408-374-1337	ACCREDO HEALTH GRO... 1620 Century Center Parkway S... Memphis TN 38134 800-803-2523
atorvastatin (LIPITOR) 40 mg tablet 40 mg, Oral, DAILY Disp-90 Tab, R-1, Starting 6/28/2018		
<input checked="" type="checkbox"/> <input type="checkbox"/>		
<a href="#">+ Add Pharmacy</a>		

- Obtain vitals. \*\*\*See Appendix for video visit vitals
  - I. Gel or wash hands prior to taking vital signs
  - II. **Address all yellow BPA alerts**
  - III. Take BP following standard work

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- i. If the blood pressure is elevated use your department specific visual cue to alert the provider
- ii. BP is considered elevated if the top number (systolic) is 139 or higher and /or the bottom number (diastolic) is 89 or higher
- IV. MA or Provider to Recheck BP if  $\geq 139/89$
- V. Obtain temperature, pulse, height and weight
- VI. Document LMP, if applicable
- VII. Update tobacco use (smokeless tobacco and e-cigs)

**Vital Signs**

6/28/18 2:26 PM [New Set of Vitals](#)

Taken on: 6/28/2018 02:26 PM

BP:	<input type="text"/>	Weight:	<input type="text"/>
Site:	<input type="text"/>	Height:	<input type="text"/>
Position:	<input type="text"/>	Resp:	<input type="text"/>
Pulse:	<input type="text"/>	SpO2:	<input type="text"/>
Temp:	<input type="text"/>		
Source:	<input type="text"/>		

Tobacco Use

Former Smoker (Quit: 12/28/2017) (0.75 pack-years)      Smokeless: Never Used

Ready to quit?  Yes  No approx  
 Counseling given?  Yes  No

**Mark as Reviewed**      Last Reviewed by Sellmeyer, Deborah Elaine, MD on 6/5/2018 at 11:18 AM      [Edit Tobacco Use](#)

Tobacco Use (not e-cig, etc.)	Former Smoker	<input type="text"/>	Smokeless Tobacco Use (not e-cig, etc.)	Never Used	<input type="text"/>			
Start Date:	<input type="text"/>	Quit Date:	<input type="text"/>	Smokeless Tobacco Quit Date:	<input type="text"/>			
Packs/day:	0.25	<input type="text"/>	0.25	0.5	1	1.5	2	
Years:	3.00	<input type="text"/>	3	0.5	1	2	3	4
Pack Years:	0.75	<input type="text"/>	5	10	15			



GENERAL

Medical

Surgical

Family

SOCIAL

Substance & Sex...

E-Cigarette

ADL

Social Documenta...

Socioeconomic

SPECIALTY

Birth History

E-Cigarette

E-Cigarettes

E-Cigarette Use

Current Every Day User

Former User

Never Assessed

Never User

User - Current Status Unknown

Unknown If Ever Used

Quit Date

[Mark as Reviewed](#)
Last Reviewed by Mehta, Anand Yogesh, MD on 2/21/2020 at 9:15 AM

## Tobacco Counseling

Basic Tobacco Counseling is to be offered if the patient is identified as a tobacco/smokeless tobacco user. MAs may provide basic tobacco counseling during rooming. **MARK "YES" TO COUNSELING GIVEN IF PATIENT SAYS YES OR NO.**

A warm handoff to the provider is always required.



VIII. Extended vitals, PRN  
IX. Mark as 'Reviewed'

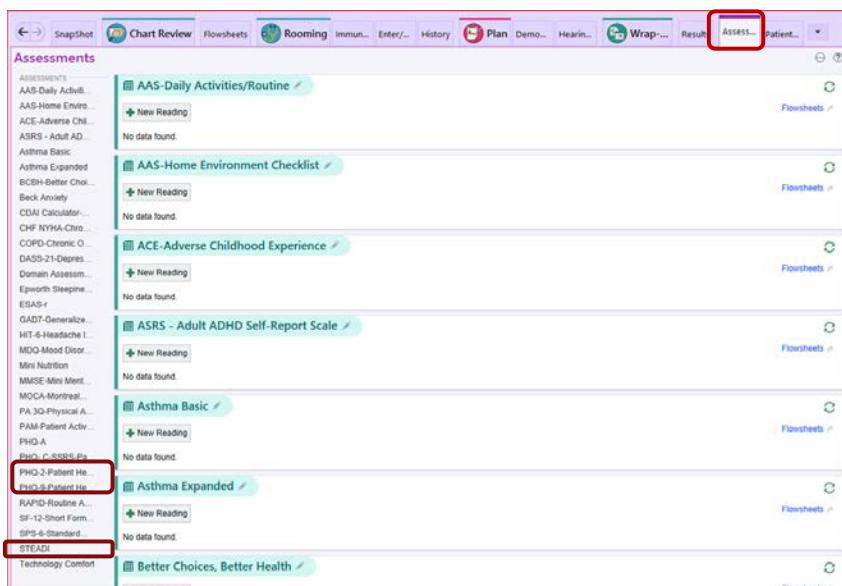
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- The Assessments tab in Epic provides pre-built health Screening templates and questionnaires to be completed during the visit
  - Navigate to the Assessments tab on the left side bar

*(can be found under the more tab if not already a favorite)*

Assessments	USE in clinical support notes/progress notes to populate results
PHQ-2	.PHQ2ASSESS
PHQ-9	.PHQ9ASSESS
Steadi (falls Risk Assessment).	.STEADIASSESS



- If patient is 65 or older perform Fall Risk assessment (STEADI).



**STEADI - STEADI**

**OTHER**

Did the patient fall anytime in the past year?  Yes  No  N/A

Does the patient feel unsteady when standing or walking?  Yes  No

Does the patient worry about falling?  Yes  No

Does patient have a medical reason for not completing falls screening? (e.g. non-ambulatory)  Yes (Document Reason)  No

- PHQ2:

**Patient Health Questionnaire - PHQ-2**

Over the past 2 weeks, how often have you been bothered by any of the following problems?

<input type="checkbox"/> Little interest or pleasure in doing things	<input type="checkbox"/> 0-Not at all	<input type="checkbox"/> 1-Several days	<input type="checkbox"/> 2-More than half the days	<input type="checkbox"/> 3-Nearly every day
<input type="checkbox"/> Feeling down, depressed, or hopeless	<input type="checkbox"/> 0-Not at all	<input type="checkbox"/> 1-Several days	<input type="checkbox"/> 2-More than half the days	<input type="checkbox"/> 3-Nearly every day

If PHQ2 is positive (3 or above) place PHQ9 on exam room keyboard and warm handoff to provider if possible.

- Offer to assist patient with MyHealth activation if not enrolled.
  - Click on Wrap up.
  - Click on MyHealth Sign-up.
  - From patient letter, type in MRN and activation code to start the process. Patient will complete the rest of the steps.

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- Input Time Ready/Room Number,
- Delete "**Specialty Comments sticky note**" that you documented for PVP. DO NOT delete anything you did not document.
- Exit room courteously using CICARE.
  - I. Gel or wash hands when exiting the exam room
  - II. Alert patient of any delays
  - III. Offer water, magazines, etc. if a delay occurs

\*\*\*See Appendix for video visit exiting and provider handoff



## MA to Provider Handoff

- MA completes rooming
- If in person, MA and provider huddle and communicate patient needs
  - I. Agenda setting: Patient's reason for visit, additional concerns, and prioritization of issues
  - II. Abnormal vitals
  - III. Exceptions to patient attitude/mood
  - IV. Pending test/records/forms/results/HM due or refused/other info requested
  - V. Flow status and countermeasure
    - a. Running behind and plans to get back on track
- If unable to handoff in person, MA should fill **out Handoff Checklist** (with the same items as above) and places it in agreed upon location

<b>Handoff Checklist</b>	
<input type="checkbox"/>	Priority issues: 1. _____ 2. _____ 3. _____
<input type="checkbox"/>	Other concerns: _____
<input type="checkbox"/>	Abnormal vitals: _____
<input type="checkbox"/>	Extraordinary attitude/mood: _____
<input type="checkbox"/>	Pending tests/records/forms/ results/ HM due or refused/ other info requested: _____
<input type="checkbox"/>	Time check & countermeasure (e.g. running behind and plans to get back on track): _____



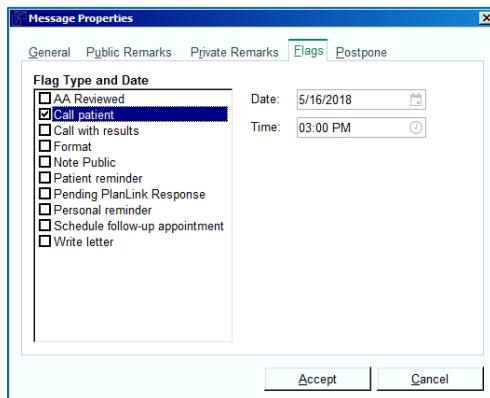
## Provider to MA Handoff

- Provider exits room
- If in person, provider and MA quickly communicate patient's needs.
  - I. Review orders (labs, referral etc.) placed and any follow up needed
  - II. Call out urgent items
  - III. Communicate follow up items
  - IV. Communicate in-box items needing attention or follow up
- If unable to handoff in person, Provider should fill **out Handoff Checklist**
- MA reviews chart for orders and follow up



## MA In-Basket & Offline Work Management

- MA to manage provider's:
  - Patient Calls
  - Refills
  - Results
  - IV. Myhealth messages
- Prioritize messages and use Red Flags.



Patient Call 72 unread, 73 total						Sgt & Filter ▾
A	Status	Pool	Patient	Reason for Call	Encounter	Open?
●	Pend	X	Chordophone, Ge...	Migraine	6/29/2018 8:5...	Closed
●	Sent By: Apple, Laura, RN				Provider: Apple, Laura, RN	
	Last Accessed:				Next Appt Date: None	
	Next Appt w Me: None				Refill:	Def...:
●	New	X	Harmonica, George	Migraine	6/29/2018 8:5...	Closed
●	Sent By: Apple, Laura, RN				Provider: Apple, Laura, RN	
	Last Accessed:				Next Appt Date: None	
	Next Appt w Me: None				Refill:	Def...:
●	New	X	Bassdrum, George	Migraine	6/29/2018 8:5...	Closed
●	Sent By: Apple, Laura, RN				Provider: Apple, Laura, RN	
	Last Accessed:				Next Appt Date: None	
	Next Appt w Me: None				Refill:	Def...:

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- Verbally communicate content of message to provider during handoff or use Flow Communication Board if unable to see provider between visits

### Flow Communication Board

MD:	MA:		Date:
MA Lunch:	MA Buddy & Ext:		

Comments:

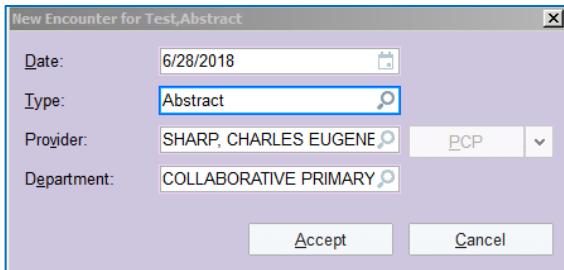
Patient Calls	Rx Request	Results	Printer

- Discuss plan to resolve message/charts



## Abstraction

1. Open Abstract Encounter.

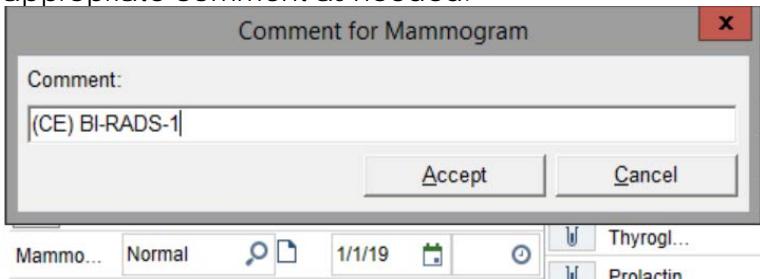


2. Type in Result Date (**Date of Collection**), Lab name and lab values in the correct fields.

Primary documentation (e.g. paper lab report or Care Everywhere data) must always be submitted or available in Epic

Common Procedures	Laboratory: Chemistry
Upper Endoscopy	Sodium 141 mmol/L 2/13/20
Colonoscopy	Potassium 4.7 mmol/L 2/13/20
Sigmoidoscopy	Creatinine, Serum 1.02 mg/dL 2/13/20
Fecal Occult Blood, Guaiac	BUN 15 mg/dL 2/13/20
iFOBT Immunochemical Fecal...	eGFR Non African American 75 mL/min/1.73 2/13/20
Fecal Occult Blood, Dna	eGFR African American 75 mL/min/1.73 2/13/20
DM Foot Exam/Monofilament	Glucose 94 mg/dL 2/13/20

3. Abstract lab and procedure results from CareEverywhere and add comment "CE" and appropriate comment as needed.



4. Sign and close encounter

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Use standard abstraction guide to ensure accurate data abstraction:

[https://shcconnect.stanfordmed.org/depts/uha/Documents/UHA%20HIMS%20Basic%20Abstraction%20Guide\\_FINAL%2011-5-19.pdf](https://shcconnect.stanfordmed.org/depts/uha/Documents/UHA%20HIMS%20Basic%20Abstraction%20Guide_FINAL%2011-5-19.pdf)

**UHA Basic Abstraction Guide**  
Inputting Outside Clinical Results into EPIC

*When laboratory and other test results are received from a source other than one of the sources which automatically feeds information into EPIC, the report is to be scanned and data entered as defined to ensure the information is easily accessible for continuity of care. Please ensure Result Date (Collection Date), and Lab values are entered as appropriate to the test.*

Test Type	Date Parameters - If there are no other labs available, abstract regardless of date.					
Blood Tests	Last Value (Past Result- 2 Years from Present)					
Pap Smears, HPV Results, Endoscopies, Bone Density (DXA)Tests	Last Result with the Scan of Actual Test (Past Result- 2 Years from Present)					
Colonoscopy	Last Result with Scan of Actual Procedure. (Results can go back 10 years)					
Value	Abbrev	Type of Test	Quick Abstraction documentation	Normal/Negative	Abnormal/Positive	Comments
LABORATORY VALUES						
White Blood Count	WBC	Complete Blood Count (CBC)	Enter Result			
Hemoglobin	HGB	Complete Blood	Enter Result			

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## APPENDIX

### Rooming for Video Visits:

Medical Assistants will continue to "room" patients even with virtual visits. This can be accomplished via a phone call prior to the video appointment (even a day prior) or by having the MA launch the video visit before to the provider.

**MA**s continue to do Prep and Rooming as described in this Team Based Care Booklet with the following exceptions:

- Starting the visit-see below
- Vitals: **Do Not** enter vitals as discreet data in the vitals section. If patient has taken some of their own vitals, all patient self-reported vitals can be documented in the support note.

**MA Medication Review Complete**

There is no height or weight on file to calculate BMI.

**Ht Readings from Last 1 Encounters:**

04/15/19	1.626 m (5' 4")
----------	-----------------

**Self reported vitals- 133/67**

- Closing the rooming process and handoff to the provider is described below.

#### For phone call rooming

MA contacts the patient via phone before the video visit, performs the usual MA rooming questions via phone, entering information in the Support note.

- Make sure patient is located in California and will have photo ID available during video visit

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- Have patient test system and prepare for visit (see preparation instructions below)
- Advantage: can be done ahead of time and is less technically challenging. Good when video visits are back to back

### For MA Video Launch Rooming

- MA logs into the Video visit once the patient has logged into the video visit. (up to 15 minutes before appointment)

\*\*\*If the patient is having difficulty connecting through MyHealth, the MA will call the patient to do rooming activities and document in support note. Once rooming is complete, the MA will then tell the patient that the provider will connect a different way and should expect a text from the provider. The MA informs provider of the video failure, and provider will initiate a Doximity video connection to complete the visit.\*\*\*

- If no connection problems, MA connects to video and makes sure that the patient is in California and has their photo ID.
- MA completes all standard rooming activities via video.
- MA tells patient that (s)he is going to disconnect from the video visit. The MA should inform the patient to not disconnect from video, as the Provider will be with them shortly, even though the screen will go blank and the sound will disconnect.
- MA then disconnects from the video visit and badges out of the visit. The easiest way to do it is to click the X in the upper right corner of the video window and then badge out after speaking with the patient. The MA MUST close the window, or the patient will continue to have viewing capabilities.

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- MA does a warm handoff with the provider. If provider is remote, Jabber or staff message the provider.
- Provider can then connect to the video visit. Providers will utilize the support note information as they would in a regular office visit.
- Advantage: All done contemporaneously during the visit after patient logs in. Does not require patient to be available earlier than their appointment.

### Video Visit Preparation Instructions

#### **Test your hardware ideally 1 day before your appointment.**

Smartphones are preferred over Desktop computers due to better connection.

Be sure your phone is well charged or connected to power.

A strong WiFi connection helps

Earphones or Ear buds help with the audio quality

If you have home Blood pressure cuff, have it with you (preferably on your arm) during the video visit.

#### ***Smartphone/Myhealth mobile app***

- Make sure to download and install the latest version of Stanford Health Care MyHealth app from Apple Store (IOS) or Google Play store (Android)
- Launch and log in to MyHealth
- Once you're logged in, tap on the "appointments" tile
- Next, scroll down and tap on your upcoming video visit
- Click "Test Video". If not successful, please call 1-866-367-0758

#### ***Windows desktop computer or Mac (WITH camera)***

- Log in to the Stanford Health Care MyHealth website
- Click on "Appointments" and select upcoming video visit from the list
- On appointment details page click "Test Hardware"
- If prompted, follow instructions to download and install Vidooweb plug-in

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- After running installer, close window and click "Test Hardware" again
- If not successful, please call 1-866-367-0758

### On the day of your appointment

Log in to MyHealth App up to 15 minutes before the appointment  
**Have some paper and a pen with you to write notes on, if necessary.**

### **Smartphones/Myhealth mobile app**

- Once you're logged in, tap on the "appointments" tile
- Next, scroll down and tap on your upcoming video visit. Tap on the visit.
- If you did not yet Check In, Tap "Check In" and complete the steps
- Then tap "**Begin Visit**" This alerts the office that you are ready to be seen. This is critical

### **Windows computer or MAC: (WITH camera)**

- Close all other applications. This will help with the audio and video quality of your visit.
- Log in to the Stanford Health Care MyHealth website
- Under the Appointments tab, select Upcoming Appointments and click on your appointment.
- Click "**Begin Visit**". You'll see a pop-up asking you to grant the program access to your camera and microphone. Click "Allow." This step is critical.

Please wait for your care team member to join.

If you are still unable to access your video visit, your care team member will call you to continue your visit by phone.



## Additional Notes: