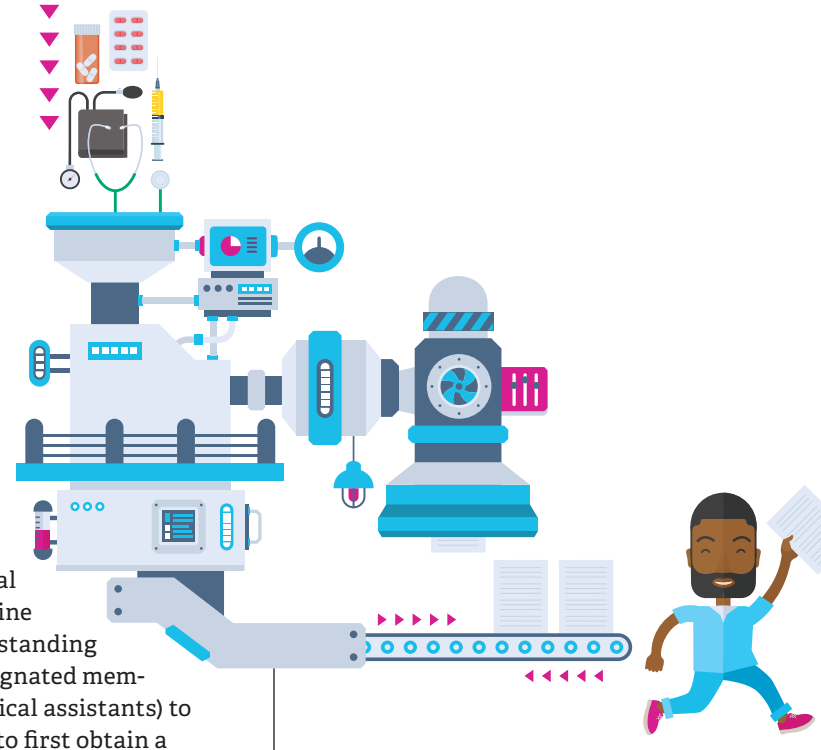
JASON LEUBNER, MD, AND SUSANNE WILD, MD

CME

Developing Standing Orders to Help Your Team Work to the Highest Level

Use this seven-step plan to create protocols that improve efficiency and reduce physician workloads.



Studies estimate that it would take 21.7 hours per day for a physician to provide all recommended acute, preventive, and chronic care for a panel of 2,500 patients.[1] Add to this the ever-growing requirements for quality reporting, and it's no wonder physicians are burned out.

Using standing orders is one way to redistribute the physician workload across the primary care team, allowing the physician to focus on acute care and more complex medical decision making while ensuring that more routine patient needs are met by others. Simply stated, standing orders are written protocols that authorize designated members of the health care team (e.g., nurses or medical assistants) to complete certain clinical tasks without having to first obtain a physician order. Several studies have demonstrated that standing orders can increase the delivery of routine preventive care services including immunizations, leading the Centers for Disease Control and Prevention's Community Preventive Services Task Force to strongly recommend their use.[2]

Our practice — an urban family medicine residency with 14 faculty clinicians and 24 residents — uses standing orders not only to improve efficiency but also to contend with some additional challenges inherent in a residency practice. These include limited patient-physician continuity, care delivered by learners at varying stages of their professional growth, and a need for residents to learn the team-based approach to patient care, which is so important to being successful and effective in health care today. Of course, because standing orders allow for patient care without the direct involvement of a physician, they should be carefully designed, supervised, and revised as needed to limit the potential for errors.[3] Here is the process we used to successfully develop and implement standing orders in our practice. ➤

ABOUT THE AUTHORS

Dr. Leubner is associate program director for clinical affairs and medical director at the Banner University Medical Center Family Medicine Residency in Phoenix. He is also a clinical assistant professor in the Department of Family and Community Medicine at the University of Arizona College of Medicine. Dr. Wild is the associate program director for academic affairs for the Banner University Medical Center Family Medicine Residency. She is also a clinical assistant professor in the Department of Family and Community Medicine at the University of Arizona College of Medicine. Author disclosures: no relevant financial affiliations disclosed.

POTENTIAL STANDING ORDERS

Immunizations	Influenza, pneumococcal, human papilloma virus
Screening tests	Mammograms, fecal occult stool cards, bone density scans
Routine labs for chronic disease monitoring	Diabetes, hypertension, hypothyroidism
Point of care testing	Rapid strep test, urine dip, urine pregnancy
Routine refills for chronic disease medications	Hypertension, cholesterol, hypothyroidism, contraceptives (if patient is up-to-date on pertinent labs and visits)
Referrals	Routine colonoscopy and diabetic eye exams

1. GARNER SUPPORT

For standing orders to be successful, the clinic's medical director, practice manager, physicians, and staff should all support them. The medical director is responsible for approving standing orders and supervising their use, but all clinicians should agree with them to avoid confusion, mistakes, and care lapses. Focus on developing standing orders for areas where there is broad agreement on the standard and process of care. Be sure to involve nurse leaders early in the development process, because nurses most likely will be implementing the majority of the standing orders.[4]

To increase buy-in, be sure to explain why you are establishing the standing order. Some individuals may only need simple education on why a given intervention is important. Others may require evidence. Collecting and reporting on the practice's current performance data can foster a desire for change among team members who may otherwise overestimate how well the practice's existing processes are working. You could also estimate reductions in the number of phone calls, physician tasks, patient delays, or similar metrics that could result from implementing standing orders.

2. SELECT STANDING ORDERS

Your initial list of standing orders should be limited to ones that have little potential for patient harm if incorrectly implemented (e.g., urine pregnancy test for women presenting with amenorrhea). See "Potential standing orders." Once clinic staff has effectively used the initial order set, you can always add new ones. Standing orders should always reflect current evidence-based guidelines. However, they should not supplant medical decision making by the clinician, as this will increase the potential for error and patient harm.

You should also be sure to consider how standing orders will affect existing clinic workflows and responsibilities. Avoid burdening one group of staff members with excessive duties, which could slow down the clinic flow. For example, if medical assistants are required to follow several new standing orders focused on preventive health measures, it may take them longer to room patients. Additionally, keep in mind any limitations of your office's physical space that could create problems or bottlenecks in patient flow. You may also have to consider adding prompts in the electronic health record (EHR), addressing staffing issues, or other operational strategies to fully distribute the workload. Finally, be aware of any state laws that may prevent certain staff members from performing certain tasks.

Our standing order for medication refills is available on page 15.

3. CULTIVATE OWNERSHIP

Identifying someone to champion a specific standing order set can make the initial implementation and eventual maintenance much easier. In addition to answering staff questions during the orders' roll out, the champion can help identify team members who are struggling with the new workflow and intervene to ensure the standing order process works correctly. The champion should understand not only the evidence for the standing order but also how it works. Physicians, nurses, nurse practitioners,

KEY POINTS

- Standing orders provide written authorization for nurses, medical assistants, and other members of the health care team to complete certain clinical tasks without first obtaining a physician order.
- Practices can use standing orders to relieve physicians of some clinical tasks so they can focus on acute care and more complex decision making.
- Standing orders should be carefully designed and supervised and regularly revised to reduce the chances for errors.

STANDING ORDER FOR MEDICATION REFILLS

Overview

This standing order allows nurses (LPNs and RNs) to fulfill routine requests for refills and physician orders without having to wait for a physician's approval. This allows the clinic to address patients' needs quickly but still ensure that patients are up-to-date on their recommended care and monitoring.

General expectations

- Before completing any standing order for refill requests, review the last clinic note for the patient to ensure that he or she is not overdue for follow-up. If a patient is overdue, schedule an appointment in the next 30 days in addition to providing the refill.
- Refill only the medications listed below. If you are unfamiliar with a medication, consult the primary care physician (PCP). Do not refill any medication not listed on this protocol.
- Refills only apply to medications that our office has previously prescribed.
- *No controlled substance prescriptions may be sent by LPNs or RNs.*

General prescriptions

If a prescription was written within the last two weeks but there was an error with the pharmacy receiving the prescription, nurses may resend the prescription.

Diabetic supplies

It is OK to refill all supplies, including syringes, needles, lancets, and glucometers, as long as the patient has been seen in the office within the prior year. It is OK to change the brand of supplies if required by insurance. Keep the testing frequency indicated for the previous supplies. Refill supplies for only up to one year following the patient's last office visit.

Thyroid medications

(levothyroxine and armour thyroid)

Ensure that the patient has had both a thyroid-stimulating hormone (TSH) test and an office visit within the previous 12 months.

- If the TSH was normal (0.45-4.5) and the patient was seen in the previous 12 months, then refill the medication up until the patient is due for the next annual visit.
- If the TSH was abnormal (lower than 0.45 or higher than 4.5), then send the request to the PCP.

If the patient was not seen within the previous 12 months:

- Schedule an appointment within 30 days.
- Notify the PCP that labs will be needed at the next visit.
- Send a 30-day refill with NO additional refills only after scheduling the appointment.

Cholesterol medications

(atorvastatin, pravastatin, other statins, gemfibrozil, and ezetimibe)

Ensure that the patient has had an office visit within the previous 12 months.

- If the patient has had an appointment, then refill until the patient's next annual visit.
- If the patient has not had an appointment in the previous 12 months, then schedule an appointment within 30 days. Send a 30-day refill with NO additional refills only after scheduling the appointment.

Oral contraceptives

(progestins: drospirenone, levonorgestrel, norethindrone acetate, desogestrel, ethynodiol diacetate, norgestimate, cyproterone, and dienogest; and estrogens: ethinyl estradiol, estradiol valerate, and mestranol)

Ensure that the patient has had an office visit within the previous 12 months.

- If the patient has had an appointment within 12 months AND has not missed more than one dose, then refill until the patient's next annual visit. If the patient has missed one dose, advise the patient to take two pills today and then one pill daily. If the patient has missed two or more doses, notify the PCP, who will determine whether to refill the medication.
- If it has been more than 12 months since the last visit AND the patient has not missed more than one dose, then schedule an appointment within 30 days. Send a 30-day refill with NO additional refills only after scheduling the appointment.

Note: State laws vary on which health care professionals are allowed to prescribe various types of medication. Always check your state's restrictions before implementing a standing order for medication refills.

AAFP FPM

***FPM* Toolbox** To find more practice resources, visit https://www.aafp.org/fpm/toolbox.

 Related article: https://www.aafp.org/fpm/2018/0500/p13.html. Updated: April 2018.

physician assistants, or pharmacists may be effective champions. Although not essential, possessing a strong clinical interest in the proposed intervention can create a palpable enthusiasm that may motivate others.[2]

4. WRITE STANDING ORDERS

Developing a new standing order can take time, so it may be worthwhile to determine if a comparable standing order is already available. If your practice is part of a larger health system, colleagues at other clinics may have already developed effective standing orders for the same tasks. Additionally, some organizations, such as the Immunization Action Coalition (http://www.immunize.org), provide samples that can serve as starting points.[4] If a new standing order must be written from scratch, we recommend using a standard format for all standing orders across a practice. Be sure to address these issues:

- Explain clearly who is responsible for each task,
- Include the date the standing order was written or when it was last reviewed,
- Describe the patient group to whom the order applies, including any contraindications,
- Provide the generic name of any medication or vaccine included in a standing order, the exact dosage, and the route of administration. Follow the Institute for Safe Medication Practices guidelines to avoid error-prone abbreviations, symbols, and dose designations (http://www.ismp.org/Tools/errorproneabbreviations.pdf).

> To increase buy-in, be sure to explain why you are establishing the standing order.

5. IMPLEMENT STANDING ORDERS

Before putting the new standing orders into place, meet with all of the involved staff to review them and answer questions. Allow time to identify potential negative consequences and consider changes before the go-live date. In the first few days after implementing more complex standing orders, the clinic champion and leaders should be readily available to answer staff questions and troubleshoot unforeseen challenges. Make sure staff members know where to find the new standing orders. Ours are formally documented in our clinic's digital policy manual and built into our EHR, which includes custom ordering sections for our medical assistants.

6. REASSESS STANDING ORDERS

Once a standing order is in place, be sure to periodically reassess its effectiveness. You should develop objective measurements of success for each protocol, such as a specified magnitude of improvement from baseline or a percentage of patients meeting a commonly accepted benchmark. Your clinic's EHR may be able to generate automated reports or tools that can allow frequent, real-time reassessment without requiring much data collection or manipulation by staff. Initially, you should reassess standing orders biweekly or monthly to allow rapid fine-tuning and determine staff adherence to and comfort with the new process. You can reduce the frequency as the standing order proves effective and becomes more ingrained in the clinic.

7. MAINTAIN STANDING ORDERS

Practice leaders should periodically review standing orders to make sure they comply with the latest care recommendations and state regulations. You may also need to redesign or eliminate certain standing orders to accommodate changes in the demands, structure, or size of the clinical team. Depending on the type and number of standing orders, reassess at least every two years. Clearly communicate any updates or adjustments to all affected staff.

MAKING IT WORK

By following this systematic approach, we have successfully implemented standing orders in our clinic. This in turn has helped us improve patient care and clinical efficiency. We have improved performance for every quality metric tied to a standing order. For example, colon cancer screenings improved from 50.5 percent of eligible patients to 64.5 percent one year following implementation of a standing order. Pneumococcal vaccination rates improved from 58.6 percent to 81.3 percent over a similar time frame.

Using a step-by-step approach can help avoid some common challenges of implementing standing orders. Once firmly established in the clinic workflow, standing orders can increase not only the quality of care but also clinical efficiency. FPM

1. Yarnall KS, Østbye T, Krause KM, Pollak KI, Gradison M, Michener JL. Family physicians as team leaders: "time" to share the care. *Prev Chronic Dis*. 2009;6(2):A59.

2. Centers for Disease Control and Prevention. Vaccine-preventable diseases: improving vaccination coverage in children, adolescents, and adults. A report on recommendations of the Task Force on Community Preventive Services. *Morb Mortal Wkly Rep*. 1999;48:1-15.

3. Institute for Safe Medication Practices. Guidelines for standard order sets. http://bit.ly/2FVwEQh. January 12, 2010. Accessed March 15, 2018.

4. Immunization Action Coalition. 10 steps to implementing standing orders for immunization in your practice setting. https://bit.ly/1S5qFTe.

Send comments to **fpmedit@aafp.org,** or add your comments to the article online.