Integration of Standing Orders into the Patient-Centered Medical Home Approach: A Community Health Center Provider Perspective

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Abstract
The PCMH (Patient Centered Medical Home) model is a team based model of care and standing orders are created by providers, executed by support personnel (such as nurses or medical assistants) and are intended to increase efficiency and improve patient care for preventative measures or conditions such as diabetes mellitus and hypertension. Use of standing orders in a non-profit community health center that seeks to attain Level 3 Patient Centered medical Home Certification will prove to be a useful resource that is believed to increase efficiency and reduce workload by streamlining workflow thus providing a higher quality of integrative and preventative healthcare, increasing patient compliance and reducing complications from chronic conditions such as hypertension and type 2 diabetes mellitus.

Keywords: patient-centered medical home (PCMH), standing orders, preventative medicine, hypertension guidelines, Community Health Center (CHC)

Introduction
A standing order in the healthcare system is a prescribed procedure that remains in place as guidance for administering healthcare until changed or canceled. These procedures are described as best practices guidelines that are established by physicians but can be implemented by support staff such as medical assistants (MAs) or nurses without direct approval by the
physician every time the practice is enforced (Nemeth et al, 2012). A great example of standing orders is that pertaining to vaccinations for children (Dexter et al, 2004). When a child reaches a certain age or after a given increment of time, they are administered a vaccine by a member of the support staff at their physician’s office. The physician does not give verbal or written authorization for that support staff member to administer the vaccine, but has a previously established understanding with the support staff that children will be administered vaccinations at the appropriate intervals. It is up to that MA or nurse to determine if children are due for vaccinations since the physicians typically do not administer them. This is a classic example of a standing order.

**Background**

The Patient Centered Medical Home (PCMH) model is one prominent form of healthcare delivery that was designed by primary care professionals to provide a high quality of healthcare at a lower overall cost and focuses on preventative measures and coordination of primary care that focuses on the patient (Rittenhouse, 2009).

The Joint Principles of the Patient-Centered Medical Home were released in 2007 and designed by four groups representing over 330,000 physicians belonging to the American Academy of Family Physicians (AAFP), the America Academy of Pediatrics (AAP), the American College of Physicians (ACP) and the American Osteopathic Association (AOA) (Peikes, 2007). The Joint Principles list the following tenants as key characteristics of the PCMH (See Appendix 1): (1) Personal physician (2) Physician directed medical practice (3) Whole person orientation (4) Care is coordinated and/or integrated across all elements of the complex health care. Recent guidelines have expanded to include more emphasis on team-based care, care management focus on high-need populations and further integration of behavioral health
into the PCMH (O’Kane presentation, 2014) (See Appendix 2 for more detail on the expansion of PCMH standards).

Standing orders have been found to improve performance in the areas of immunizations and diabetes (Nemeth et al, 2012). Extension of this practice into the PCMH team-based approach could potentially enhance integrative healthcare and improve patient compliance and decrease workload and increase efficiency. Use of such practices will be implemented into the new Adelante Healthcare Peoria site which will wholly incorporate the PCMH model as it is designed to be a comprehensive site that offers primary medical care for the whole family. The use of standing orders is thought to streamline the delivery of and improve the quality of healthcare at the primary level.

Recommendations of immunization practices for the prevention and control of influenza are commonplace (Fiore et al, 2007). These recommendations include strategies to increase the number of vaccinations with the expanded use of reminder/recall systems and the use of standing orders in the prevention and control of influenza.

Methodology

Standing Orders Research

The primary focus of my project was to develop standing orders for chronic conditions such as hypertension as well as preventative health measures for both adults and children (see Appendices 3-5). The purpose of this objective was to have a procedural template set in place with the upgraded software version of NextGen (Adelante Healthcare’s Electronic Health Records System) before the new site in Peoria opens in September.

Adelante Healthcare Peoria is an imitative of Adelante Healthcare (a community health center – CHC) in collaboration with Dignity Healthcare to provide primary care for the medically
underserved population of Peoria, AZ. The goal of this facility is to incorporate use of the PCMH model to all patients in all aspects of their healthcare with the understanding that PCMH is designed to improve the overall quality of healthcare, reduce costs for both the provider and the patient as well as provide a better experience of care for the patient.

Provider Survey

As a proponent of the community health care system, the tenants of PCMH and a future health care provider, I was curious to see how current healthcare providers felt about the use of standing orders in the PCMH model. So I surveyed the current healthcare providers at Adelante Healthcare (a CHC). The survey (see Appendix 6) was administered to healthcare providers from the varying fields of primary care, including family medicine, internal medicine, pediatrics and dentistry and the results of the survey are as follows:

Results

Standing Orders Research

Standing orders for hypertension and preventative measures for adults and children guidelines were developed, see Appendices 3-5 and submitted for approval from the Director of Clinical Programs at Adelante Healthcare. Pending her approval, the guidelines will be passed on to the Chief Medical Officer for approval.

Provider Survey

The 7-question provider survey (see appendix 6) was administered at an Adelante Healthcare Provider Meeting with the participation of 22 providers, 8 representing Family Medicine (FM), 7 from Obstetrics/Gynecology (Ob/Gyn), 3 from Internal Medicine (IM), 1 from Pediatrics (Peds) and 3 from Dentistry (D). Of the 22 surveyed, exactly half of those surveyed have been practicing for over 15 years while the other half have been practicing between 1-15
years, post residency. In the context of this survey, PCMH model was defined as a team based model of care and standing orders are created by providers, executed by support personnel (such as nurses or medical assistants) and are intended to increase efficiency and improve patient care for preventative measures or conditions such as hypertension.

The overwhelming majority across all specialties is the belief that standing orders in the PCMH model will increase patient compliance (95.45%) and improve the overall quality of patient healthcare (100%) in the PCMH model. Furthermore, if given the choice, 95.5% of the providers surveyed would choose to implement the use of standing orders in preventative health and chronic conditions such as hypertension. Of all the providers sampled, 86.4% of providers believe that standing orders will increase productivity while the remaining 13.6% believe standing orders will have no effect on productivity in the PCMH model (See Appendix 7, Chart A).

As a group, OB/Gyn has the most consistent view of standing orders in PCMH as compared to FM physicians with regard to the belief that standing orders will improve patient compliance, overall quality of healthcare and increase productivity with no regard to how long the physician has been in practice. 88% of OB/Gyn providers also believe that patient outcome would definitely benefit from the use of standing orders as compared to only 75% of FM physicians who believe patients would definitely benefit from the use of standing orders. The remaining 25% of FM physicians believe that standing orders might benefit patient outcome. (See Appendix 7, Chart B)

Only 60% of FM providers practicing over 15 years believe standing orders will definitely benefit patient healthcare, whereas 100% of FM providers practicing less than 15 years believe patients will definitely benefit from the implementation of standing orders in the PCMH.
model (See Appendix 7, Chart C). 27.3% of newer providers (practicing less than 15 years) believes that standing orders will have no effect on workload as compared to 90.1% of physicians practicing over 15 years who believe that standing orders will decrease workload. 54.5% of newer providers believe that standing orders will decrease workload as compared to 90.1% of older providers (See Appendix 7, Chart D.)

Discussion

The sample size for the survey is 22 providers, of which 19 are currently licensed physicians and 3 are licensed dentists. Despite the sample size, the results represent the majority of physicians and half of the dentists currently employed at Adelante Healthcare. The field of Pediatrics, however, was severely underrepresented with an n=1. Thus, most of the comparisons across specialties are limited to FM (n=8) and OB/Gyn (n=7). My research did not include standing orders with respect to dentistry or behavioral health but healthcare providers in the field of dentistry were included given their familiarity with the subject of standing orders. Although there were a couple of behaviorists in attendance during the time of the survey, they elected not to participate in the survey.

Recommendations

My recommendation would be to proceed as planned with the new Adelante Healthcare Peoria site by wholly utilizing the PCMH approach and implementing the use of standing orders as a means of improving the overall quality of healthcare. Given that the overwhelming majority of Adelante Healthcare providers agree that it may improve patient compliance, the use of best practices for standing orders should prove quite beneficial for patients and thus improve the quality of healthcare. It would be my recommendation to incorporate these practices into all the
Adelante Healthcare sites and other CHCs so that patient outcomes might be improved and the workflow processes can be streamlined so that patients can receive the best quality of care.

**Conclusion**

Comprehensive and quality healthcare should be what all physicians want for their patients. The implementation of standing orders in the PCMH model is another way to standardize healthcare and make it more accessible for all, despite their background or economic standing. The use of standing orders will not only reduce workload for physicians and perhaps increase productivity at their practice, it is designed to enhance patient compliance and improve the overall quality of healthcare.
References


Appendix
Appendix 1: Joint Principles of the Patient-Centered Medical Home

Joint Principles of the Patient-Centered Medical Home

Published on Patient Centered Primary Care Collaborative (http://www.pcpcc.net)

Joint Principles of the Patient-Centered Medical Home

American Academy of Family Physicians (AAFP)
American Academy of Pediatrics (AAP)
American College of Physicians (ACP)
American Osteopathic Association (AOA)

February 2007

Introduction

The Patient-Centered Medical Home (PCMH) is an approach to providing comprehensive primary care for children, youth and adults. The PCMH is a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient's family.

The AAP, AAFP, ACP, and AOA, representing approximately 333,000 physicians, have developed the following joint principles to describe the characteristics of the PCMH.

Principles

Personal physician - each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.

Physician directed medical practice – the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.

Whole person orientation – the personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care, chronic care, preventive services, and end of life care.

Care is coordinated and/or integrated across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange, and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

Quality and safety are hallmarks of the medical home:

- Practices advocate for their patients to support the attainment of optimal, patient-centered outcomes that are defined by a care planning process driven by a compassionate, robust partnership between physicians, patients, and the patient's family.
- Evidence-based medicine and clinical decision-support tools guide decision making.
- Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement.
- Patients actively participate in decision-making and feedback is sought to ensure patients' expectations are being met.
- Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication.
Joint Principles of the Patient-Centered Medical Home
Published on Patient Centered Primary Care Collaborative (http://www.pcpcc.net)

- Practices go through a voluntary recognition process by an appropriate non-governmental entity to demonstrate that they have the capabilities to provide patient centered services consistent with the medical home model.
- Patients and families participate in quality improvement activities at the practice level.

Enhanced access to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff.

Payment appropriately recognizes the added value provided to patients who have a patient-centered medical home. The payment structure should be based on the following framework:

- It should reflect the value of physician and non-physician staff patient-centered care management work that falls outside of the face-to-face visit.
- It should pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources.
- It should support adoption and use of health information technology for quality improvement.
- It should support provision of enhanced communication access such as secure e-mail and telephone consultation.
- It should recognize the value of physician work associated with remote monitoring of clinical data using technology.
- It should allow for separate fee-for-service payments for face-to-face visits. (Payments for care management services that fall outside of the face-to-face visit, as described above, should not result in a reduction in the payments for face-to-face visits).
- It should recognize case mix differences in the patient population being treated within the practice.
- It should allow physicians to share in savings from reduced hospitalizations associated with physician-guided care management in the office setting.
- It should allow for additional payments for achieving measurable and continuous quality improvements.

Background of the Medical Home Concept
The American Academy of Pediatrics (AAP) introduced the medical home concept in 1967, initially referring to a central location for archiving a child’s medical record. In its 2002 policy statement, the AAP expanded the medical home concept to include these operational characteristics: accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective care.

The American Academy of Family Physicians (AAFP) and the American College of Physicians (ACP) have since developed their own models for improving patient care called the "medical home" (AAFP, 2004) or “advanced medical home” (ACP, 2006).

For More Information:
American Academy of Family Physicians

American Academy of Pediatrics:

American College of Physicians:
http://www.acponline.org/advocacy/7hp [3]

American Osteopathic Association

Source URL: http://www.pcpcc.net/joint-principles
Joint Principles of the Patient-Centered Medical Home
Published on Patient Centered Primary Care Collaborative
(http://www.pcpcc.net)

Links:
### Appendix 2: PCMH 2014 Updated Standards

#### PCMH 2014

*6 standards/27 elements/100 points*

1. **Patient-Centered Access (10)**
   - A) *Patient-Centered Appointment Access*
   - B) 24/7 Access to Clinical Advice
   - C) Electronic Access

2. **Team-Based Care (12)**
   - A) Continuity
   - B) Medical Home Responsibilities
   - C) Culturally and Linguistically Appropriate Services
   - D) *The Practice Team*

3. **Population Health Management (20)**
   - A) Patient Information
   - B) Clinical Data
   - C) Comprehensive Health Assessment
   - D) Use Data for Population Management
   - E) Implement Evidence-Based Decision Support

   * Must-pass

4. **Care Management and Support (20)**
   - A) Identify Patients for Care Management
   - B) *Care Planning and Self-Care Support*
   - C) Medication Management
   - D) Use Electronic Prescribing
   - E) Support Self-Care & Shared Decision Making

5. **Care Coordination and Care Transitions (18)**
   - A) Test Tracking and Follow-Up
   - B) *Referral Tracking and Follow-Up*
   - C) Coordinate Care Transitions

6. **Performance Measurement and Quality Improvement (20)**
   - A) Measure Clinical Quality Performance
   - Measure Resource Use and Care Coordination
   - A) Measure Patient/Family Experience
   - B) *Implement Continuous Quality Improvement*
   - C) Demonstrate Continuous Quality Improvement
   - D) Report Performance
   - E) Use Certified EHR Technology
Appendix 3: Standing Orders for Hypertension

**Hypertension**

1. **Confirm diagnosis of hypertension**
   a. If first reading is elevated, repeat measurement and document both readings

2. **Assess patient for cardiovascular risks**
   a. Non-modifiable risks
      i. Genetic predisposition
      ii. Age
      iii. Gender
   b. Modifiable risks
      i. Smoking
      ii. Exercise
      iii. Sodium intake

3. **Target Blood pressures**
   - Low Risk: BP 140/90 mm Hg over 3 visits within 1 month
   - High Risk: BP 140/80 mm Hg over 3 visits within 1 month

4. **Hypertensive Patients BP Goals**
   - w/ DM or non-diabetic CKD *

<table>
<thead>
<tr>
<th>Age</th>
<th>Hypertensive Patients BP Goals*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age &gt;60</td>
<td>&gt;150/90</td>
</tr>
<tr>
<td>Age 30-59</td>
<td>&gt;140/90</td>
</tr>
<tr>
<td></td>
<td>Diastolic &lt;90</td>
</tr>
<tr>
<td>Age &lt;30</td>
<td>&gt;140/90</td>
</tr>
</tbody>
</table>

5. **Determine if any end organ damage has occurred**

<table>
<thead>
<tr>
<th>Test</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dipstick urine test:</td>
<td>Every year</td>
</tr>
<tr>
<td>Hematuria and proteinuria</td>
<td></td>
</tr>
<tr>
<td>ACR (albumin:creatinine)</td>
<td>Every year</td>
</tr>
<tr>
<td>CMP/CBC:</td>
<td>Every year</td>
</tr>
<tr>
<td>Measure eGFR, electrolytes,</td>
<td></td>
</tr>
<tr>
<td>HbA1c, lipid panel, urate</td>
<td>Every year</td>
</tr>
<tr>
<td>Ophthalmic exam</td>
<td>Every year</td>
</tr>
<tr>
<td>ECG</td>
<td>Every year</td>
</tr>
</tbody>
</table>

6. **Detect causes of secondary hypertension**
   a. Excessive alcohol intake
   b. Obstructive sleep apnea
   c. Medicines
      i. Ex: oral contraceptives, NSAIDs
   d. Drug abuse
      i. Ex: cocaine or methamphetamine
   e. Renal disease
   f. Renal artery stenosis
   g. Primary hyperaldosteronism
   h. Cushing’s syndrome
   i. Pheochromocytoma

* Guidelines taken from JNC 8: Evidenced Based Guideline for the Management of High Blood Pressure in Adults JAMA.
**Preventative Health – Adults**

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Age: 18-39</th>
<th>Age: 40-64</th>
<th>Age: 65+</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cholesterol Screen</strong></td>
<td>Every 5 years at age 35</td>
<td>Every 5 years</td>
<td>Every 5 years</td>
</tr>
<tr>
<td><strong>Blood Pressure</strong></td>
<td>Every visit</td>
<td>Every visit</td>
<td>Every visit</td>
</tr>
<tr>
<td><strong>Diabetes</strong></td>
<td>If at risk *</td>
<td>If at risk *</td>
<td>If at risk *</td>
</tr>
<tr>
<td><strong>Tetanus-diphtheria booster</strong></td>
<td>Every 10 years</td>
<td>Every 10 years</td>
<td>Every 10 years</td>
</tr>
<tr>
<td><strong>Influenza vaccine</strong></td>
<td>Every year</td>
<td>Every year</td>
<td>Every year</td>
</tr>
<tr>
<td><strong>Pneumococcal vaccine</strong></td>
<td>Once if at high risk</td>
<td>Once if at high risk</td>
<td>Once at age 65</td>
</tr>
<tr>
<td><strong>Clinical breast exam</strong></td>
<td>Women: Every 3 years beginning at age 20</td>
<td>Women: Every year</td>
<td>Women: Every year to age 75</td>
</tr>
<tr>
<td><strong>Cervical cancer (pap) screenings</strong></td>
<td>Women: Do not screen younger than age 21. Every 3 years with cytology or every 5 years with co-testing (cytology/HPV testing)</td>
<td><em>Women: Every 3 years with cytology or every 5 years with co-testing (cytology/HPV testing)</em></td>
<td>Women: Do not screen if patient has had adequate prior screening and are not at high risk</td>
</tr>
<tr>
<td><strong>Mammogram</strong></td>
<td>---</td>
<td>Women: Every 2 years</td>
<td>Women: Every 2 years to age 75</td>
</tr>
<tr>
<td><strong>Osteoporosis</strong></td>
<td>---</td>
<td>---</td>
<td>Women: Every 2 years</td>
</tr>
<tr>
<td><strong>Colon cancer screenings</strong></td>
<td>---</td>
<td>**Begin at age 50; see below **</td>
<td><strong>until age 85</strong></td>
</tr>
<tr>
<td><strong>Prostate exam</strong></td>
<td>---</td>
<td><strong>Men:</strong> Every year at age 50</td>
<td><strong>Men:</strong> Every year</td>
</tr>
</tbody>
</table>

* Asymptomatic adults with sustained blood pressure greater than 135/80mm Hg should be screened for type 2 diabetes mellitus

** Annual screenings with high-sensitivity fecal occult blood testing (FOBT)
Sigmoidoscopy every 5 years, with high sensitivity fecal occult blood testing every 3 years
Screening colonoscopy every 10 years

Appendix 4: Standing Orders for Preventative Health: Adults
## Appendix 5: Standing Orders for Preventative Health: Children

### Preventative health – Children

<table>
<thead>
<tr>
<th></th>
<th>Infancy (Newborn – 9mo)</th>
<th>Early Childhood (12mo – 4 yrs)</th>
<th>Middle Childhood (5 yrs – 10 yrs)</th>
<th>Adolescence (11 yrs-18yrs)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Length/Height &amp; Weight</strong></td>
<td>Every visit</td>
<td>Every visit</td>
<td>Every visit</td>
<td>Every visit</td>
</tr>
<tr>
<td><strong>Head Circumference</strong></td>
<td>Every visit</td>
<td>Every visit up to 24 mo</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td><strong>Weight for length</strong></td>
<td>Every visit</td>
<td>Every visit up to 18 mo</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td><strong>BMI</strong></td>
<td>--</td>
<td>Every visit at 24 mo</td>
<td>Every visit</td>
<td>Every visit</td>
</tr>
<tr>
<td><strong>Blood pressure</strong></td>
<td>--</td>
<td>Every visit at 3y</td>
<td>Every visit</td>
<td>Every visit</td>
</tr>
<tr>
<td><strong>Vision</strong></td>
<td>--</td>
<td>Every 2-3y at age 4</td>
<td>As needed</td>
<td>As needed</td>
</tr>
<tr>
<td><strong>Hearing</strong></td>
<td>At Newborn</td>
<td>Every 2-3y at age 4</td>
<td>Every 2-3 years</td>
<td>As needed</td>
</tr>
<tr>
<td><strong>Autism screening</strong></td>
<td>--</td>
<td>At age 18 mo</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td><strong>Developmental surveillance</strong></td>
<td>Every visit</td>
<td>Every visit</td>
<td>Every visit</td>
<td>Every visit</td>
</tr>
<tr>
<td><strong>Psychosocial/Behavioral Assessment</strong></td>
<td>Every visit</td>
<td>Every visit</td>
<td>Every visit</td>
<td>Every visit</td>
</tr>
<tr>
<td><strong>Alcohol and Drug Use</strong></td>
<td>--</td>
<td>--</td>
<td>Every visit</td>
<td>--</td>
</tr>
<tr>
<td><strong>Depression screening</strong></td>
<td>--</td>
<td>--</td>
<td>Every visit</td>
<td>--</td>
</tr>
<tr>
<td><strong>Newborn Blood screen</strong></td>
<td>Once</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td><strong>Critical Congenital Heart Defect screening</strong></td>
<td>At newborn</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td><strong>Hematocrit or Hemoglobin</strong></td>
<td>--</td>
<td>At 15 and 30 mo</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td><strong>Immunization</strong></td>
<td>Every visit</td>
<td>Every visit</td>
<td>Every visit</td>
<td>Every visit</td>
</tr>
<tr>
<td><strong>Dyslipidemia screening</strong></td>
<td>--</td>
<td>Around age 10</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td><strong>STI/HIV screening</strong></td>
<td>--</td>
<td>--</td>
<td>Between 16-18yrs</td>
<td></td>
</tr>
<tr>
<td><strong>Cervical dysplasia screening</strong></td>
<td>--</td>
<td>--</td>
<td>Age 21</td>
<td></td>
</tr>
<tr>
<td><strong>Oral Health</strong></td>
<td>--</td>
<td>Beginning at age 12 mo</td>
<td>--</td>
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</tbody>
</table>
Appendix 6: Standing Orders Survey: A Provider’s Perspective Questionnaire

Survey: The Use of Standing Orders in the PCMH model: A Physician’s Perspective

The PCMH (Patient Centered Medical Home) model is a team based model of care and standing orders are created by providers, executed by support personnel (such as nurses or medical assistants) and are intended to increase efficiency and improve patient care for preventative measures or conditions such as diabetes mellitus and hypertension.

1. What is your specialty?
   a. Family Medicine
   b. Internal Medicine
   c. Pediatrics
   d. Ob/Gyn
   e. Other: ________________________________

2. How long have you been practicing medicine (post-residency)?
   a. 1-5 years
   b. 6-10 years
   c. 10-15 years
   d. 15+ years

3. Do you believe the use of standing orders will improve patient compliance in the PCMH model?
   a. Yes
   b. No

4. Do you believe that standing orders will improve the overall quality of patient healthcare in the PCMH model?
   a. Yes
   b. No

5. How well do you think patient outcome would benefit from the use of standing orders?
   a. Patient would definitely benefit
   b. Patient might benefit
   c. Patient outcome would be the same
   d. Patient will not benefit at all – use of standing orders will be a detriment to patient outcome

6. If given the choice, would you choose to implement the use of standing orders in preventative health and chronic conditions such as hypertension?
   a. Yes
   b. No

7. As a healthcare provider, how would the use of standing orders affect your workload and productivity? (choose one option from each column)

<table>
<thead>
<tr>
<th>WORKLOAD</th>
<th>PRODUCTIVITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase Workload</td>
<td>Increase Productivity</td>
</tr>
<tr>
<td>Decrease Workload</td>
<td>Decrease Productivity</td>
</tr>
<tr>
<td>No effect on Workload</td>
<td>No effect on Productivity</td>
</tr>
</tbody>
</table>
Appendix 7: Standing Orders Survey: A provider’s Perspective Results

Chart A.

![Use of Standing Orders in PCMH](chart_a)

Chart B.

![Use of Standing Orders in PCMH](chart_b)
Chart C.

Family Medicine

- Improve Pt Compliance
- Pt Would Definitely Benefit

Chart D.

Effect of Standing Orders on Workload
Across All Specialties

- Decrease
- No Effect
- Increase