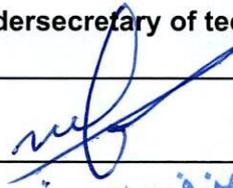


<b>Title: MOH standardized Outpatient Services policy</b>	
<b>Policy Owner: MOH committee on hospital clinical services and polices</b>	<b>Policy code: A-ADM-11</b>
<b>Section location: Administrative/ General</b>	<b>Effective date: 1/10/2023</b>
<b>Applies to: General and specialized health care facilities &amp; General, allied and specialized health care services</b>	<b>Revision dates: 1/10/2025</b>
<b>Approvals:</b>	<b>Signature/Date</b>
<b>Approved by: MOH committee on hospital clinical services and polices</b>	
<b>Approved by: Director of technical affairs</b>	
<b>Approved by: Assistant undersecretary of technical affairs</b>	
<b>Approved by:</b>	
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## 1.0 Introduction

1.1 The outpatient clinic is a facility, often associated with a healthcare facility, that is devoted to the diagnosis and care of outpatients who do not require an overnight stay in the facility. The outpatient setting encompasses many services and specialties and operates differently yet hand in hand with the rest of the health care facility and thus is usually governed by operational policies which ensure efficient and organized care is provided by all health care providers to all patients referred and in need.

## 2.0 Objective

2.1 It is aimed by this policy to guide health care providers about the operational policy of the outpatient clinics (including the rules, regulations and responsibilities).

## 3.0 Definitions

3.1 **Attending:** Any physician of the rank of specialist and above

3.2 **General Clinical Services:** Clinical services that provide General care within their scope of practice. (General surgery and General medicine)

3.3 **Subspecialty Clinical Services:** Clinical services of a practice, or field of study, that is part of a broader specialty that provide specialized care to their respective patient population (e.g., Neurology, Endocrinology, Urology)

3.4 **Index Hospital:** The hospital or health care facility the physician practices in, or patient resides or follows up in.

#### **4.0 Clinic/outpatient services leadership designation**

4.1 The health care facility will delegate the responsibility of clinic/outpatient services designation and organization to a respective service/unit established by approval of the Chief Medical Officer (CMO) and composed of:

4.1.1 Head of unit/ service (delegated to the head of the Utilization Committee of the respective facility ).

4.1.2 Representatives of the clinical departments (Internal Medicine, Pediatric, etc.)

4.1.3 Nurse(s)

4.1.4 Medical Records Department

4.1.5 Information Technology Department (IT)

#### **5.0 Clinic/outpatient services responsibilities**

5.1 To assess and monitor Clinic/Outpatient services technical and administrative requirements, standards and performance.

5.2 To evaluate Clinic/Outpatient services needs based on patient population and referrals.

5.3 To review and/or approve requests for clinic/OPD privileges for physicians based on hospital need, unit need, staff availability, patient traffic, and physical location.

5.4 To monitor and audit the Clinic/Outpatient services and appointment waiting times.

#### **6.0 Clinic appointments triage service**

6.1 Is a service by which referrals for patient clinic appointments are triaged based on the need to be evaluated.

6.2 The triage process is based on urgency of the diagnosis, referral indications, symptoms or clinical findings per disease process or specialty.

6.3 The criteria on which the triage is based, will be set by the respective clinical practice departments, units & respective specialties providing clinic/outpatient services.

6.4 A category system for triaging, incorporating the criteria on which the triage is based, will be set by the respective clinical departments, units and their respective specialties providing clinic/outpatient services (*e.g. similar to the CTAS* )

*\*\*Example; tumors = Category 1, appointments 1-2 weeks vs hernia =category 3, appointments 4-8 weeks*

6.5 An appointment waiting time for each triage category is to be set in accordance with the wait time limits set in this policy.

6.6 The triage category applies to new referrals and follow up cases.

6.7 Clinical departments, units and their respective specialties providing clinic/outpatient services will designate physicians (of the rank of senior registrars and above) to triage appointments and referrals based on the triage criteria set by them and in accordance with the specified limits of patient appointment waiting times.

6.8 The Clinic/Outpatient services unit will monitor the appointment waiting times as per triage category for each Clinical practice departments, units and their respective specialties.

6.9 The Clinic/Outpatient services unit will ensure the necessary resources and means are provided to assist the departments in adherence to the appointment waiting times per category.

6.10 The Clinic/Outpatient services will ensure the Clinical departments, units and their respective specialties providing clinic/outpatient services have a digital means of data storage and monitoring of referrals and triaging to assist in communication, and auditing (e.g., HIS system, clouds, google sheets etc.)

6.11 The triage service must ensure that patients are informed about their triage process and relative instructions (redirection/ reorientation/ rejection).

## **7.0 Clinic designation and allocation**

7.1 All physicians of the rank of senior registrar and above in all clinical departments (and their respective subspecialties) are expected to attend a minimum of 1 clinic and a maximum of 4 clinics per week and provide their services and expertise for their respective patients in accordance with Table 1. and Table 2. (including new referrals, follow ups and prescription renewals etc.).

7.2 Registrars and training board residents may, at times, be delegated to attend and cover clinics.

7.3 Registrars and training board residents delegated to attend and cover clinics, are to review cases with a clinic designated supervising attending or senior registrar prior to finalizing any decision or plan.

7.4 All clinical practice departments/units (and their respective specialties) are expected to ensure outpatient/clinic services are provided to their patient population (accepting referrals and follow ups) a minimum of 4 of the official 5 working days of the week for the general clinical departments and 3 of the official 5 working days of the week for the subspecialties units.

7.5 All clinical practice departments/units (and their respective specialties) are expected to ensure outpatient/clinic services are provided to their patient population (accepting referrals and follow ups) by a designated attending present every day for review of cases if needed.

7.5.1 In the absence of services/resources, the head of the departments should ensure the redirection of the referrals to MOH facilities with the required/ designated specialty.

7.5.2 All clinical practice departments/units (and their respective specialties) are expected to ensure outpatient/clinic services are provided to their patient population (accepting referrals and follow ups) in accordance with Table 1. And Table 2.

7.5.3 Clinical department/units and their respective specialties should be informed that the table set forth is a guide and subject to modification based on waiting lists, appointments and case flow (*i.e., slots empty for follow up can be filled with new if possible and waiting times exceed the set standards*).

## 8.0 Patient appointment allocation and clinic designation

### 8.1 Source of patient referral

8.1.1 Primary Health Care (PHC) facilities

8.1.2 Index health care facilities encompass any of the following:

8.1.2.1 MOH hospital inpatients after discharge

8.1.2.2 MOH hospital inpatients

8.1.2.3 MOH hospital clinic referrals

8.1.2.4 Emergency Department for non-urgent cases

8.1.2.5 Other MOH clinical institutions

### 8.2 Population of referred patients

8.2.1 Patients referred to the outpatient clinic are expected to fulfill criteria listed below:

8.2.1.1 Patients **not** requiring emergency medical care

8.2.1.2 Hemodynamically stable patients

8.2.1.3 Patients in need of medication reviews or prescription

8.2.1.4 Patients with known comorbidities in need of routine follow up

8.2.1.5 Patients with known comorbidities in need of expedited follow up

8.2.1.6 Patients with no known comorbidities with complaints in need of expedited expert specialized assessments

8.2.1.7 Patients who are mentally competent or with caretaker/ legal guardian.

### 8.3 Clinic booking

8.3.1 Referrals from the PHC (with/without prior file) are received by a designated senior registrar or above and triaged accordingly to the respective clinic as set by indications, available needed services and departmental policy.

8.3.2 Ward/inpatients referrals from within the index hospital are referred according to the follow up plan set in the ward prior to discharge.

8.3.2.1 All clinical and auxiliary/supportive services are expected to ensure appointments for outpatient based services have set dates and instructions prior to patient discharge when possible (clinic date time, elective radiology appointments, colonoscopy etc) to ensure efficient post discharge care plan.

8.3.3 Ward/inpatients referrals from **other** MOH hospitals are referred according to the follow up plan set in the ward prior to discharge.

8.3.4 Clinical practice departments, units and their respective specialties must ensure patient appointment waiting times should **NOT** exceed the following (according to triage criteria):

8.3.4.1 Urgent stable referrals: within 1-2 weeks

8.3.4.2 New non-urgent referrals, regardless of source: within 2-4 weeks

8.3.4.3 Patients with a preexisting medical file and follow up in index hospital: within 4-8 weeks.

8.3.4.4 Regular follow ups and prescription reassessment: within 12-24 weeks

*\*Routine follow up for certain specialties and patient populations (e.g., oncology, obstetrics, etc.) are subject to guidelines and international standards of care, set by the respective councils and submitted to the technical affairs office.*

*\*\*The above benchmark times are subject to modification if deemed necessary for earlier appointments accordingly by the respective physicians and by the department chairs based on audited appointment waiting times and patient case load and resources.*

### 8.3.5 Auditing and monitoring

8.3.5.1 The clinic/outpatient services unit, clinical practice departments, units and their respective specialties must ensure patient appointment waiting times should **NOT** exceed the above standards per clinic/ doctor.

8.3.5.2 Monitoring and auditing the Clinic/Outpatient services and appointment waiting times should be done every 3 months by the respective health care facility leadership involved (i.e.Utilization Committee of the quality assurance and CMO). Further feedback from referring health care facilities (e.g., PHC) is expected to be reviewed in these auditing and meetings.

8.3.5.3 If a clinic/physician appointment waiting times exceed the above set standards, it is the clinic/outpatient services unit responsibility to inform the clinical departments, units and their respective specialties to allocate the patients to appointments with other clinics/physician in accordance with the above set standards.

### 8.3.6 Referral triage

8.3.6.1 The respective clinical departments and units will establish the outpatient triage service, responsibilities and schedule.

8.3.6.2 The respective clinical councils, departments and units will establish a triage criteria for booking appointments based on urgency and presentation.

### 8.3.7 Rescheduling appointments

8.3.7.1 It is the rebooking of a patient appointment due to any of the following reasons:

8.3.7.1.1 missed appointment

8.3.7.1.2 late arrival

8.3.7.1.3 cancellation by the receiving physician

8.3.7.1.4 state/national holidays

8.3.7.1.5 physician leave

#### 8.3.7.2 Source of rescheduling

8.3.7.2.1 The process of rescheduling appointments maybe designated to any of the following personnel:

8.3.7.2.1.1 Clinic nurse

8.3.7.2.1.2 Front desk clerk

8.3.7.2.1.3 Treating Physician (or member of team)

8.3.7.2.2 If a nonphysician (clinic nurse, front desk/reception clerk) is approached by a patient for rescheduling, every attempt should be made to communicate with the treating physician regarding appointment allocation).

#### 8.3.7.3 Rescheduling time

8.3.7.3.1 If the patient is a new referral and missed the appointment due to late arrival, he/she is to be rescheduled with **any physician** of the respective clinical department or specialty within 10-14 working days.

8.3.7.3.2 If the patient is known with an existing file or is planned for a follow-up but missed the appointment due to late arrival, he/she is to be rescheduled with the **treating physician** within 10-14 working days.

8.3.7.3.3 If the visit of a new referral is canceled by the presiding physician, (due to leave of absence, emergency etc.) the patient should be referred to the clinic of any other member of the team **that same day**. If not possible, or none of the team is available , the next appointment is to be set with **any physician** of the respective clinical department or specialty within 5-10 working days.

8.3.7.3.4 If the visit of a known patient with a file (e.g., follow up) is canceled by the presiding physician, (due to leave of absence, emergency etc.) the patient is expected to be referred to the clinic of any other member of the team **the same day**. If not possible, or none is available , the next appointment is to be with the **treating physician (or designee from the same team)** of the respective clinical department or specialty within 5-10 working days.

8.3.7.3.5 If any of the above occurs due to national holidays, the next appointment for the patients is to be set within 10-14 working days.

8.3.7.3.6 If appointment rescheduling is due to the treating physician being or planning leaves exceeding 14 days, then it is the responsibility of the clinical department head of unit, to assign a physician to attend the

uncovered clinics and provide rescheduling of those patients not seen, to be seen in clinic within 14-21 days based on triaging if possible.

## **9.0 Acquiring clinic services privileges for Healthcare Practitioners (HCP)**

9.1 The process of acquiring outpatient clinic services starts with an official request by the applicant and submitted to the Clinic Services Unit.

9.2 The request will be reviewed by the Clinic Services Unit and the approval is subjected to many parameters including but not limited to hospital need, unit need, staff availability, patient population, and clinic space availability.

9.3 A written reply to the request/application is sent back with either approval or rejection with justification to the applicant via his/her clinical department office.

9.4 Approval or rejection is signed by the head of the Clinic Services Unit, the chairperson of the respective clinical department and CMO.

9.5 Orientation to the rules, regulations and responsibilities are to be provided by the respective clinical department chairperson to the health care practitioner upon approval of granting clinic services privileges.

9.6 The location of the approved clinic for the respective HCP will be decided by the chair of the department/unit and clinic services unit based on need and resources and may be within the index health care facility, surrounding attached facilities or satellite services (e.g., regional PHC facilities).

9.7 Allocation of clinic privileges for secondary/tertiary hospital health care practitioner, to other facilities is subject to the approval of the following:

### 9.7.1 For regional PHC:

9.7.1.1 Index hospital chair of respective clinical department

9.7.1.2 Index hospital CMO

9.7.1.3 Index hospital director

9.7.1.4 Director of the regional health governate

9.7.1.5 Primary Health care facility director

### 9.7.2 For other MOH facilities:

9.7.2.1 Index and recipient hospital chairs of respective clinical department

9.7.2.2 Index and recipient hospital CMOs (*in coordination with recipient Hospital Clinical Services Unit*)

9.7.2.3 Index and recipient hospital directors

9.7.2.4 Director of the regional health governate of both sites

9.8 Clinic appointment allocations should take into consideration above patient populations as well as Table 1 and Table 2, keeping in mind they are subject to modification based on patient appointment wait time by category, indications and audited appointment waiting times.

## **10.0 Clinic appointments and services during HCP leaves**

10.1 For leaves of absence duration of two weeks or less (e.g., sick leave), the clinic services of the respective physician are stopped, and the appointments of his/her patients are rescheduled, by the attending nurse or clinic services personnel, to clinic dates after resumption of duties, not exceeding 4 weeks waiting times; the physician's respective head of unit and or chair of department may at times elect to reschedule cases if deemed necessary for best patient care.

10.2 For leaves of absence duration of more than two weeks, it is the responsibility of the physician's respective head of unit and or chair of department to assign a senior doctor to attend the vacant respective clinic post and related duties accordingly.

10.3 For emergency leaves, it is the responsibility of the respective physician to assign a senior doctor to attend his/her clinic during his/her absence.

4. The following must be informed, by the respective physician, when any of the above-mentioned leaves are taken:
  - 4.1. The OPD services (clerk and nurse)
  - 4.2. The IT department must be informed about the date of absence and dates of resumption of clinic duties.
  - 4.3. The physician's respective head of unit & department chair
  - 4.4. The assigned replacement physician

## **11.0 Requests for changing HCP**

11.1 If the patient wishes to change his/her HCP for any reason, the following is to be ensured:

11.1.1 Submission of a formal request by the patient him/herself or legal representative to the chair of the respective clinical department.

11.1.2 Nomination of a new treating physician by the chair of the respective clinical department.

11.1.3 The approval of the submitted form is to be signed by the chair of the respective clinical department and designated head of the outpatient/clinic services.

11.1.4 All HCPs involved in the transfer of care are to be informed accordingly.

## **12.0 Redirection**

12.1 It is directing patients to the correct clinic/service after presenting to the wrong clinic/service.

12.2 Patients presenting to the wrong specialty clinic are to be redirected according to the following:

12.2.1 For first visits, the patient should be redirected to the respective specialty/ clinic on the same day if possible. If the service is not available, the earliest appointment is within 1-2 weeks.

12.2.2 For follow up visits, the patient should be redirected to the respective specialty clinic the same day if possible. If the service is not available, the earliest appointment is within 1-2 weeks.

12.3 For patients with medical history and available file, following another unit or specialty, who presents with new complaints on the clinic day of another unit or specialty, the patient **must** be evaluated by the attending doctor and either the patient is rescheduled for the next visit with the treating unit or redirected accordingly to the relevant service(s) based on clinical assessment (e.g., ER)

### **13.0 Reorientation**

13.1 For patients presenting to the ER in need of redirection/reorientation, the MOH Emergency Department Triage policy D-AE-001, article 6.0, is to be followed.

13.2 For patients reoriented from the ER triage, referral must be done by either manual or electronic referral to the respective department/ triage clinic services.

13.3 For patients reoriented from the ER bed after assessment, referral must be done by either manual or electronic referral to the respective department/ triage clinic services by the Most Responsible Physician (MRP).

### **14. Discharge from clinic services**

14.1 It is when patient care has been completed with no further need for follow up or management in the hospital clinic setting.

14.2 Patients, who completed their consultation in the OPD and planned for discharge, must have their discharge summary documented.

14.3 Copies of the discharge summary and necessary references will be provided to the patient as a reference for referrals if needed.

14.4 Clinical departments will set criteria for patient referral/ follow up in PHC's after discharge from the clinic services.

**Table 1**

Morning Shift (8:00 am – 1:00 pm)			
Time		Category	Appointment Type
08:00	AM	New	Referral from, PHC, OPD, Wards and ER (In-person)
08:20	AM	New	
09:40	AM	New	
09:00	AM	New From Ward/Urgent	
09:20	AM	Follow Up	From Ward or OPD (In-person & Tele)
09:40	AM	Follow Up	
10:00	AM	Follow Up	
10:20	AM	Medication Refill	Walk in only for the same doctor or same treating unit.
10:40	AM	Follow Up	From Ward or OPD (In-person & Tele)
11:00	AM	Follow Up	
11:20	AM	Follow Up	
11:40	AM	Follow Up	
12:00	PM	Follow Up	
12:20	PM	Special	Upon Doctor Request.
12:40	PM	Special	
01:00	PM	Special	

**Table 2**

Afternoon Shift 2:00 pm – 6:00 pm			
Time		Category	Appointment Type
02:00	PM	Follow Up	From Ward or OPD (In-person & Tele)
02:20	PM	Follow Up	
02:40	PM	Follow Up	
03:00	PM	Follow Up	
03:20	PM	New	Referral from, PHC, OPD, Wards, and ER (In-person)
03:40	PM	New	
04:00	PM	New	
04:20	PM	New from Ward/Urgent	
04:40	PM	Follow up	From Ward or OPD (In-person & Tele)
05:00	PM	Follow up	
05:20	PM	Follow up	
05:40 - 06:00	PM	Medication Refill	Walk in only for the same doctor or same treating unit.

*\*\* N.B: the above tables are suggested templates subject to modification based on patient appointment wait time by category, indications and audited appointment waiting times.*