Adult Patient Visit Workflow

1. Check and record vital signs (see appendix A)
   This includes temperature, pulse, respiration, and weight on all visits. Verbally notify nurse or provider for critical action abnormals as indicated in the table below:

   CRITICAL ACTION ABNORMAL VITAL SIGNS AND SYMPTOMS: MAs MUST VERBALLY NOTIFY NURSE OR PROVIDER FOR:

<table>
<thead>
<tr>
<th>VITAL SIGNS</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Pressure</td>
<td>Systolic &gt; 180</td>
</tr>
<tr>
<td></td>
<td>Systolic &lt; 90</td>
</tr>
<tr>
<td></td>
<td>Diastolic &gt; 110</td>
</tr>
<tr>
<td>Pulse</td>
<td>Pulse &gt; 110</td>
</tr>
<tr>
<td></td>
<td>Pulse &lt; 50</td>
</tr>
<tr>
<td></td>
<td>Irregular Pulse</td>
</tr>
<tr>
<td>Respiration</td>
<td>Respiration &gt; 20</td>
</tr>
<tr>
<td></td>
<td>Wheezing</td>
</tr>
<tr>
<td></td>
<td>Difficult or unusual breathing</td>
</tr>
<tr>
<td>Temperature</td>
<td>&gt; 101°F</td>
</tr>
<tr>
<td></td>
<td>&lt; 96°F</td>
</tr>
</tbody>
</table>

   RAPID TESTS

   | Fingerstick Glucose | > 400, or HI |
   |                    | < 60         |
   | Pulse Ox           | < 90%        |

   OTHER

   | Cardio-Respiratory | Chest pain |
   |                    | Short of breath |

   Appearance
   If you think the patient looks ill; has signs of abuse; or have other concerns

   | Productive Cough | Give the patient a mask |

2. Perform tests and services as indicate based on the following guidelines:

   • (Depression Screen) PHQ-9: Any depressed patient coming in for follow-up should complete this while waiting for the provider.
   • EKG: Patients over 50 with chest pain; (notify provider before EKG)
   • Glucose Fingerstick: ALL patients with diabetes. Unless patient had fingerstick within previous 2 hours. Staff should record the time that the patient last ate.
   • Hemoglobin A1c: Diabetic patients every 3 months if last A1c was > 7.0; once every six months if last A1c < 7.0
   • Pulse Ox: Patients with rapid respirations, wheezing or complaints of shortness-of-breath
   • Peak Flow: ALL patients with asthma or COPD.
   • Rapid Strep: Patients complaining of sore throat
• **Rapid Flu A+B**: Patients with flu exposure; headache, fever, myalgia during flu season

• **Spirometry**: Annually for ALL patients with asthma or COPD. (DO NOT DO THIS IF PATIENT IS HAVING TROUBLE BREATHING)

• **Urine Pregnancy Test**: Female patients with GYN complaints (unless the patient is past menopause or has a history of hysterectomy); or if LMP > 6 weeks; or for those who might require an xray; at request of patient; or for Depo-provera.

• **Urine Dipstick**: First save clean catch for possible culture. To be done prior to clinician visits for urinary symptoms such as dysuria, frequency, urgency, polyuria, flank/abd pain, etc. Document if patient is currently menstruating.

  EXCEPTION: Males 11 and older should collect a first void urine (first 10-60 ml’s of voided urine). Also done for Test of Cure visit – notify provider if leukocytes or nitrates are positive and send for culture.

• **Vision and Hearing screening** for patients complaining of vision or hearing problems

• **Vaccines**: Flu, pneumonia, HPV, hepatitis B after screening

3. Verbally notify provider for positive HCG; any abnormal UA (incl. heme or protein); any positive strep, flu, or RSV.

4. Update preventive care screen in the EMR. See Appendix A, #5.

5. Update the disease management tool in the EMR. See Appendix A, #6.

6. Update the past medical, surgical, family, and social history in the EMR based on the Adult Health Questionnaire. See Appendix A, # 7, 8

7. Review the medication list with the patient and notify the provider of discrepancies.

8. Ask the patient if they have any allergies. Update allergy screen in EMR. See Appendix A, #13.

9. Ask the patient if they have had any visits to a specialist, urgent care center, ER, or hospitalization since their last visit. If hospitalized outside of network facilities, fill out a medical release form, have patient sign, and request records. Document that records were requested.

10. Gown patient appropriately:
   a. Female patients should be undressed & gowned from waist down for:
      - Pelvic exams
      - C/O vaginal discharge
      - C/O pelvic or low abdominal pain
      - Other GYN complaints
   b. Patients should be undressed & gowned from waist up for:
      - Breast problem
      - Axillary problems
      - Shoulder injuries or pain
      - Respiratory complaints
      - Chest pain
   c. Patients should be gowned or dressed to expose the affected body part for:
Rash
Local abscess or injury
Pain in foot, ankle, hip, knees, etc.

**Diabetic patients should have feet uncovered at all exams**

11. Notify the provider that patient is ready to be seen. Check EMR desktop frequently for orders, referrals, etc so that all preparation for checkout is completed and all required documents are printed out when patient arrives to check out.

12. Discharge patient- See Appendix B
   a. Verify that an order has been written for all tests, supplies, treatments and medications and mark each as completed.
   b. Print out referrals, prescriptions, lab requisitions, patient education materials, and the **chart summary**- review each with patient.
   c. Reinforce follow-up dates or laboratory/radiology visit and verify telephone numbers.
   d. Offer specimen collection option at the practice, as applicable.

13. Disinfect table, change paper, tidy room, wash hands and prepare for the next patient.

**APPENDIX A**

**BEGINNING THE PATIENT VISIT- use the below as a workflow guide for using the EMR**

1. Log into the EMR and bring up the patient

2. Review the **Summary** page
   a. Look at the **Problem list** and see if the patient has diabetes, COPD, asthma, or depression
   b. Review the **Care Alerts** to see if there are specific patient needs
3. Click the 'Update' button, and open the 'Adult Preventive Care' and 'Adult-Problem Focused/Follow up' or 'Pre-op' template.

- Change the Provider name to the responsible provider for the visit
- Add in the reason for visit in the Summary line
- Click OK
4. The **Vital Signs** Template will automatically open

**a.** Weigh the patient and enter the **weight** for today.

**b.** Review the patient **height** with them and check ‘**Ht- Reviewed unchanged**’ or enter in the new height
   - **Note:** *this is important to calculate the patient’s BMI*

**c.** Take the patient’s pulse rate, temperature, and respirations

**d.** Take the patient’s **O2 Sat** (pulse ox) as indicated and record

**e.** Record the LMP (last menstrual period) for female. Take note if greater than 6 weeks.

**f.** Document Vital signs measure by **me**.

**g.** Take the patient’s **blood pressure** and record. Document taken by **me**.

**h.** Document the **chief complaint** (reason for visit).

**i.** Click **Next Form**.
5. Review the Preventive Care Tool

a. Review each vaccine & test to see if there is a last result, declined, or exclusion (N/A)

b. If blank, ask the patient if they have had the test or vaccine
   i. Any items that are provided by the patient, need to be validated with results from the rendering provider.

c. If patient declined the vaccine or test in the past or if it is indicated as due for today, ask if they would like it today.

d. Order any services the patient will be getting today per standing order protocol that your practice has adopted
   i. Flu – annually
   ii. Pneumovax – given once age 65 and older
   iii. HPV #2 and #3 – refer to standing order policy
   iv. Mammogram – refer to standing order policy

e. Document declined as “y” if the patient declines today.

f. Review the BMI and assure it is populated for today. If not, go back to the vitals screen and update accordingly.

g. Review Smoking status- determine if documented in the past year
   i. If not, go to the OV Risk form and document current smoking status as current, previous, or never
      *Also document alcohol use on the next tab

6. Review the Disease Management Form
If patient is diabetic
  o Order a HgBA1C POC Test if done more than 3 months ago if >7. If less than 7, order if date of test is greater than 6 months ago.
  o Ask patient if they have been to the eye doctor or podiatrist in the past year if last result greater than 1 year old
    ▪ If yes, attempt to obtain results
If patient has CAD (coronary artery disease)
  o Ensure Blood Pressure taken today is populated
If patient is Asthmatic
  o Review the severity level
    ▪ If greater than a year ago, go to the ‘Asthma/Reactive Airway Disease’ template
    ▪ Complete all 11 questions on the Asthma Severity ACCI
    ▪ Go back to the disease management tool and assure severity level is there for today
  o order Spirometry if last done over a year ago
If patient has COPD
  o Order Spirometry if last done over a year ago
If patient has depression
  o Go to the PHQ9 and complete all 9 questions
All patients
  o Review when the PHQ9 was done last
  o If greater than a year, go to the PHQ-9 and complete questions 1 & 2
7. Use the Adult Health Questionnaire or interview the patient to update the Past Medical and Surgical History

![Past Medical History]

8. Use the Adult Health Questionnaire or interview the patient to update the Family and Social History

![Family History]

9. Enter in remaining orders per protocol and the standing order policy your practice has adopted

![Orders]
10. After completing the appropriate **POC tests**, document on the POC Tests Template

11. **Immunizations**
   a. Complete the appropriate vaccine screening
b. Document Immunizations given today using the Adult Immunizations-CCC template

12. Review the Medication List with the Patient. Notify discrepancies to the provider.

13. Review/Complete the ALLERGY SECTION as follows:
   - Click on update ‘Allergies’ button
• If this section has not been completed, ask the patient if they have any Allergies, and enter these. If there are NO KNOWN ALLERGIES, click the “this patient has no known allergies or adverse reactions” check box.
• If the section is complete, check the “Allergy and adverse reaction list reviewed during this update”.
• Click the “OK” button to close the ALLERGIES screen.

14. End and **hold** the update for the provider

**APPENDIX B**