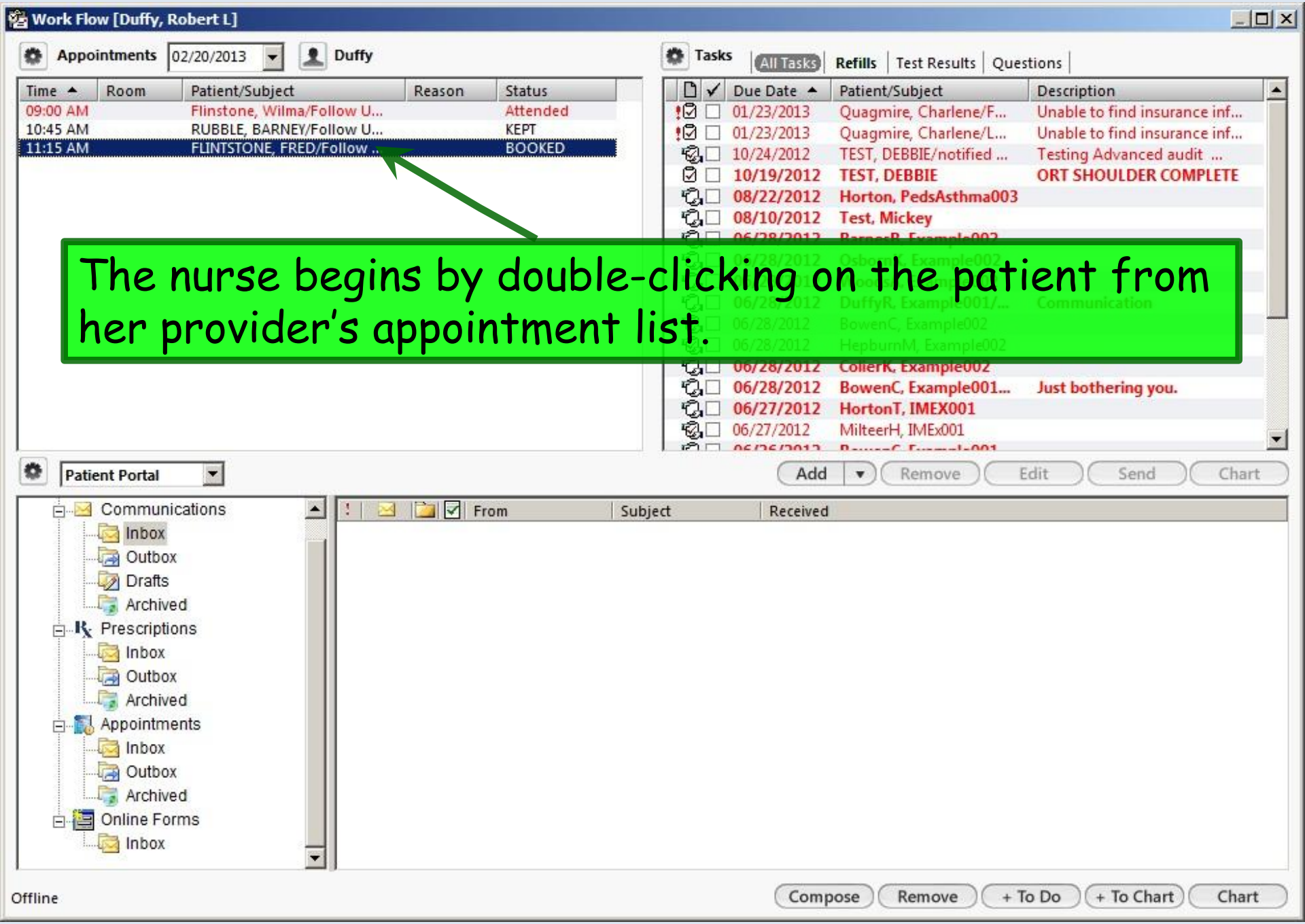
# NEXTGEN WORKFLOW DEMONSTRATION
## Adult Patient With Bronchitis, Hypertension, & Diabetes

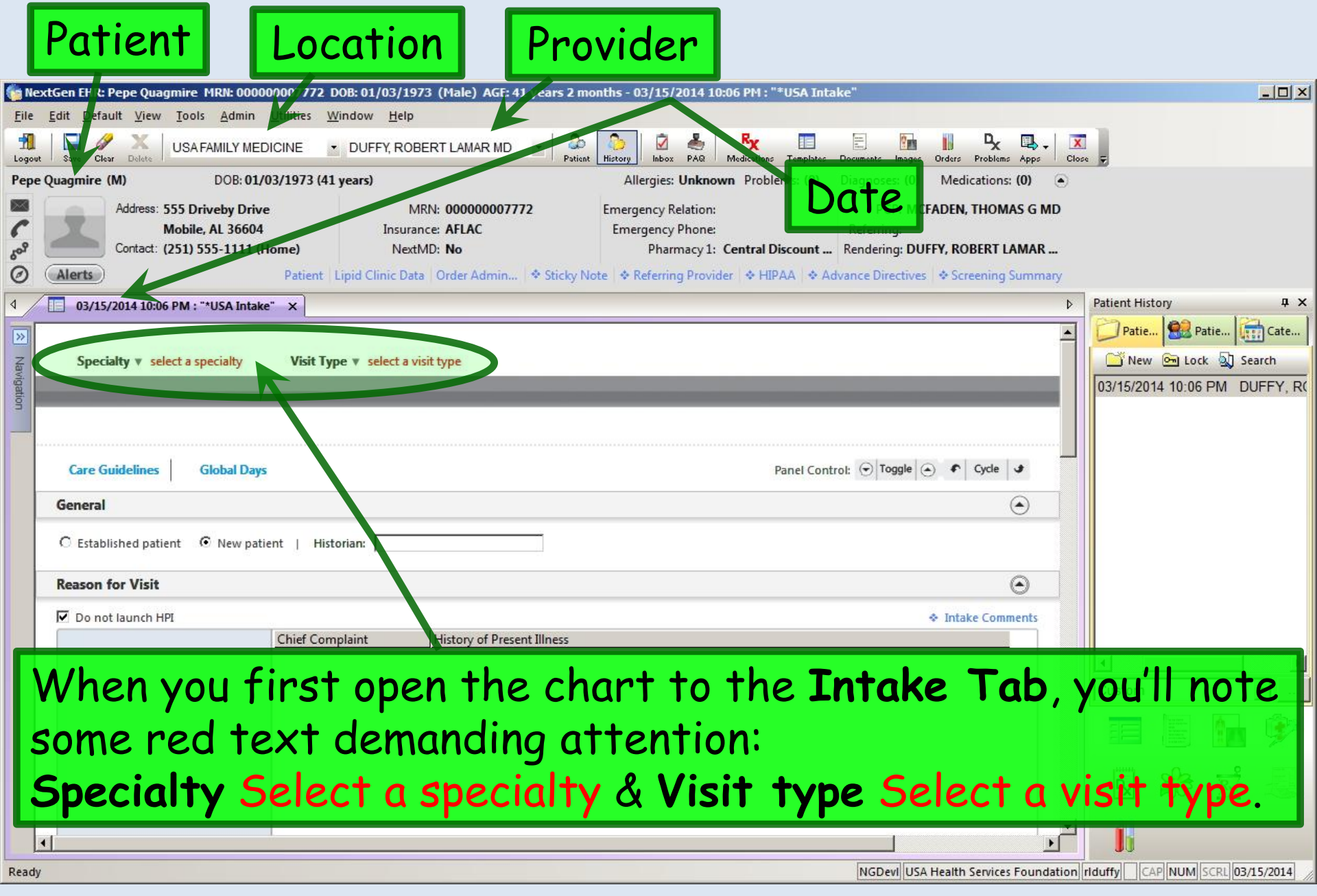
This example works through a sample adult encounter on a patient with a combination of acute complaints & chronic problems. For demonstration purposes, it will be presented as if we're entering most of the data for the first time, as would be done with a new patient, or an established patient being seen for the first time using the EHR. On subsequent encounters the workflow would be more streamlined.

This has been prepared for EHR 5.8 & KBM 8.3. Subsequent updates may display cosmetic & functional changes.

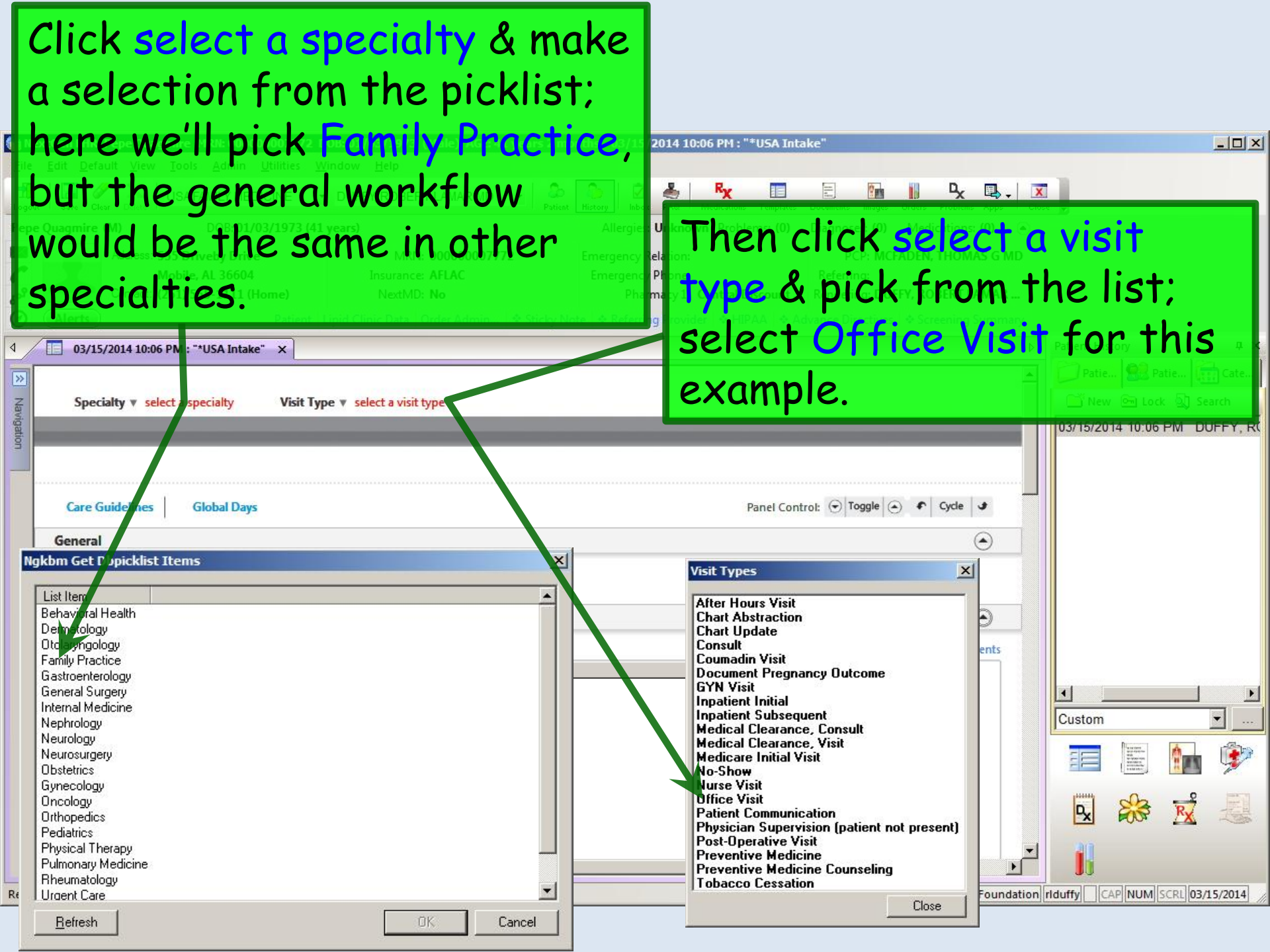
Use the keyboard or mouse to pause, review, & resume as necessary.


Work Flow [Duffy, Robert L]
Appointments
02/20/2013
Duffy
Time
Room
Patient/Subject
Reason
Status
09:00 AM
Flinstone, Wilma/Follow U...
Attended
10:45 AM
RUBBLE, BARNEY/Follow U...
KEPT
11:15 AM
FLINTSTONE, FRED/Follow ...
BOOKED
Tasks
All Tasks
Refills
Test Results
Questions
Due Date
Patient/Subject
Description
01/23/2013
Quagmire, Charlene/F...
Unable to find insurance inf...
01/23/2013
Quagmire, Charlene/L...
Unable to find insurance inf...
10/24/2012
TEST, DEBBIE/notified ...
Testing Advanced audit ...
10/19/2012
TEST, DEBBIE
ORT SHOULDER COMPLETE
08/22/2012
Horton, PedsAsthma003
08/10/2012
Test, Mickey
06/28/2012
BowenC, Example002
06/28/2012
HepburnM, Example002
06/28/2012
CollerK, Example002
06/28/2012
BowenC, Example001...
Just bothering you.
06/27/2012
HortonT, IMEX001
06/27/2012
MilteerH, IMEx001
The nurse begins by double-clicking on the patient from her provider's appointment list.
Patient Portal
Add
Remove
Edit
Send
Chart
Communications
Inbox
Outbox
Drafts
Archived
Prescriptions
Inbox
Outbox
Archived
Appointments
Inbox
Outbox
Archived
Online Forms
Inbox
From
Subject
Received
Offline
Compose
Remove
+ To Do
+ To Chart
Chart

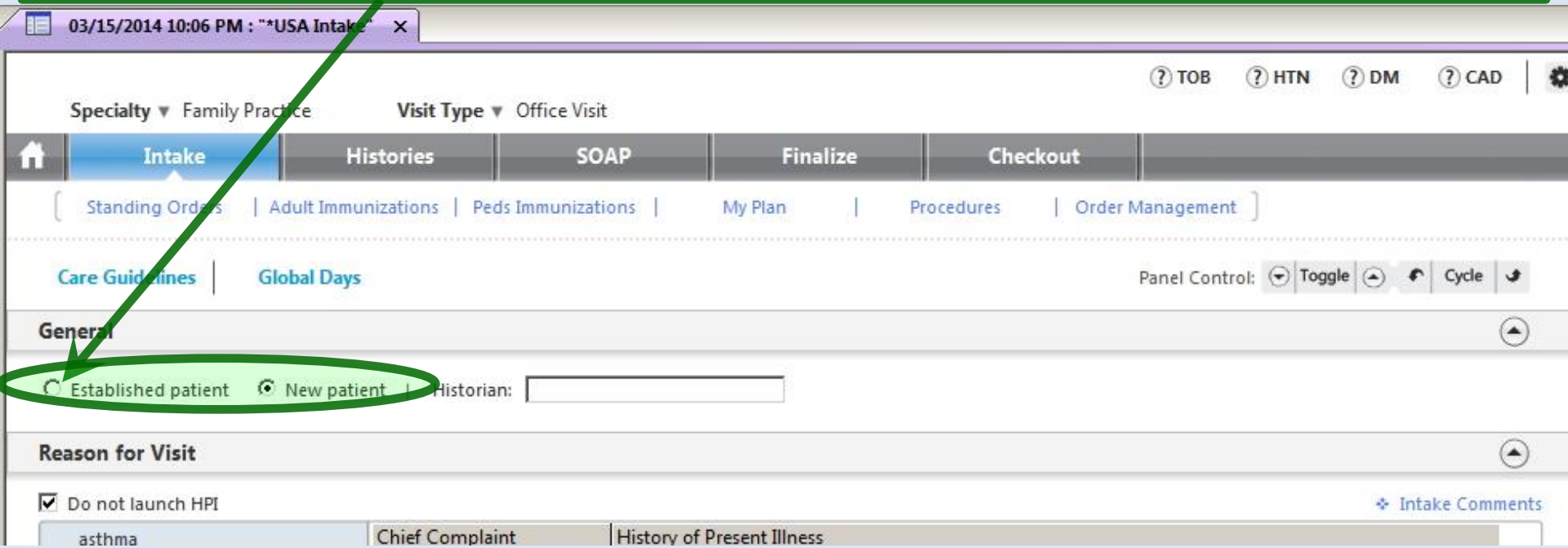
# Always begin by performing the 4-Point check.




When you first open the chart to the **Intake Tab**, you'll note some red text demanding attention:
**Specialty** Select a specialty & **Visit type** Select a visit type.


Click select a specialty & make a selection from the picklist; here we'll pick Family Practice, but the general workflow would be the same in other specialties.
Then click select a visit type & pick from the list; select Office Visit for this example.
03/15/2014 10:06 PM : "*USA Intake"
Specialty ▾ select a specialty
Visit Type ▾ select a visit type
Care Guidelines
Global Days
Panel Control: Toggle Cycle
General
Ngkbm Get Popicklist Items
List Item
Behavioral Health
Dermatology
Otolaryngology
Family Practice
Gastroenterology
General Surgery
Internal Medicine
Nephrology
Neurology
Neurosurgery
Obstetrics
Gynecology
Oncology
Orthopedics
Pediatrics
Physical Therapy
Pulmonary Medicine
Rheumatology
Urgent Care
Refresh
OK
Cancel
Visit Types
After Hours Visit
Chart Abstraction
Chart Update
Consult
Coumadin Visit
Document Pregnancy Outcome
GYN Visit
Inpatient Initial
Inpatient Subsequent
Medical Clearance, Consult
Medical Clearance, Visit
Medicare Initial Visit
No-Show
Nurse Visit
Office Visit
Patient Communication
Physician Supervision (patient not present)
Post-Operative Visit
Preventive Medicine
Preventive Medicine Counseling
Tobacco Cessation
Close
Custom
Foundation
rlduffy
CAP
NUM
SCRL
03/15/2014

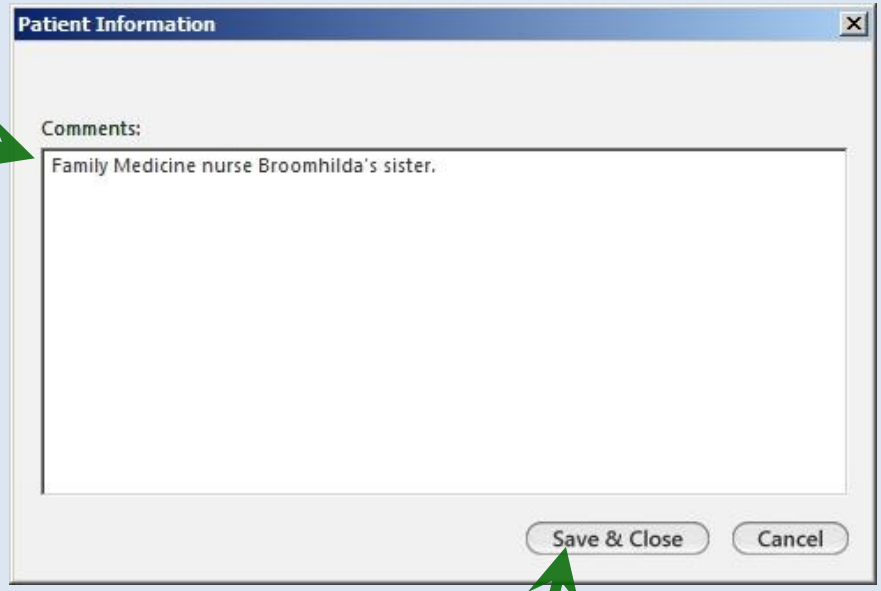
Note whether the patient is listed as **New** or **Established**, since this sometimes needs to be changed. A patient seen elsewhere in the USA system might initially appear as **Established**, but if it's the first time he's been to your office, that would need to be changed to **New**. Conversely, if you've seen the patient before you started using the EHR, but today is the first visit in NextGen, you may need to change the encounter from **New** to **Established**, so we'll click Established here.



It's always good to begin by noting whether there are any **Sticky Note** or **Alerts** entries.


We call tell by their appearances that there are no **Sticky Notes** or **Alerts**. But for demonstration purposes, we'll enter some. Click Sticky Note.

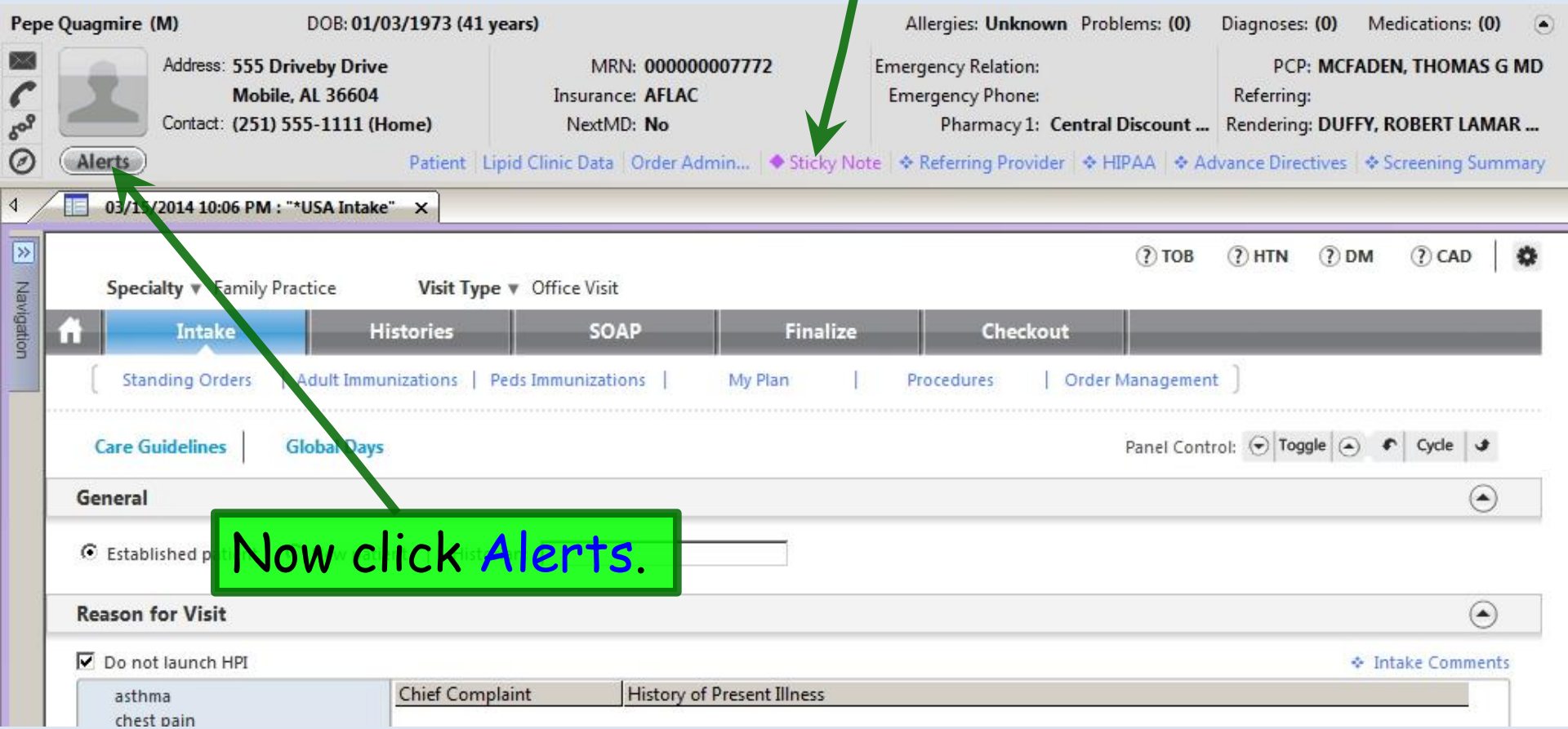
Like actual sticky notes, these are things that are nice to know, but aren't meant to be permanent chart records. We've entered here that this is one of our nurse's sister.



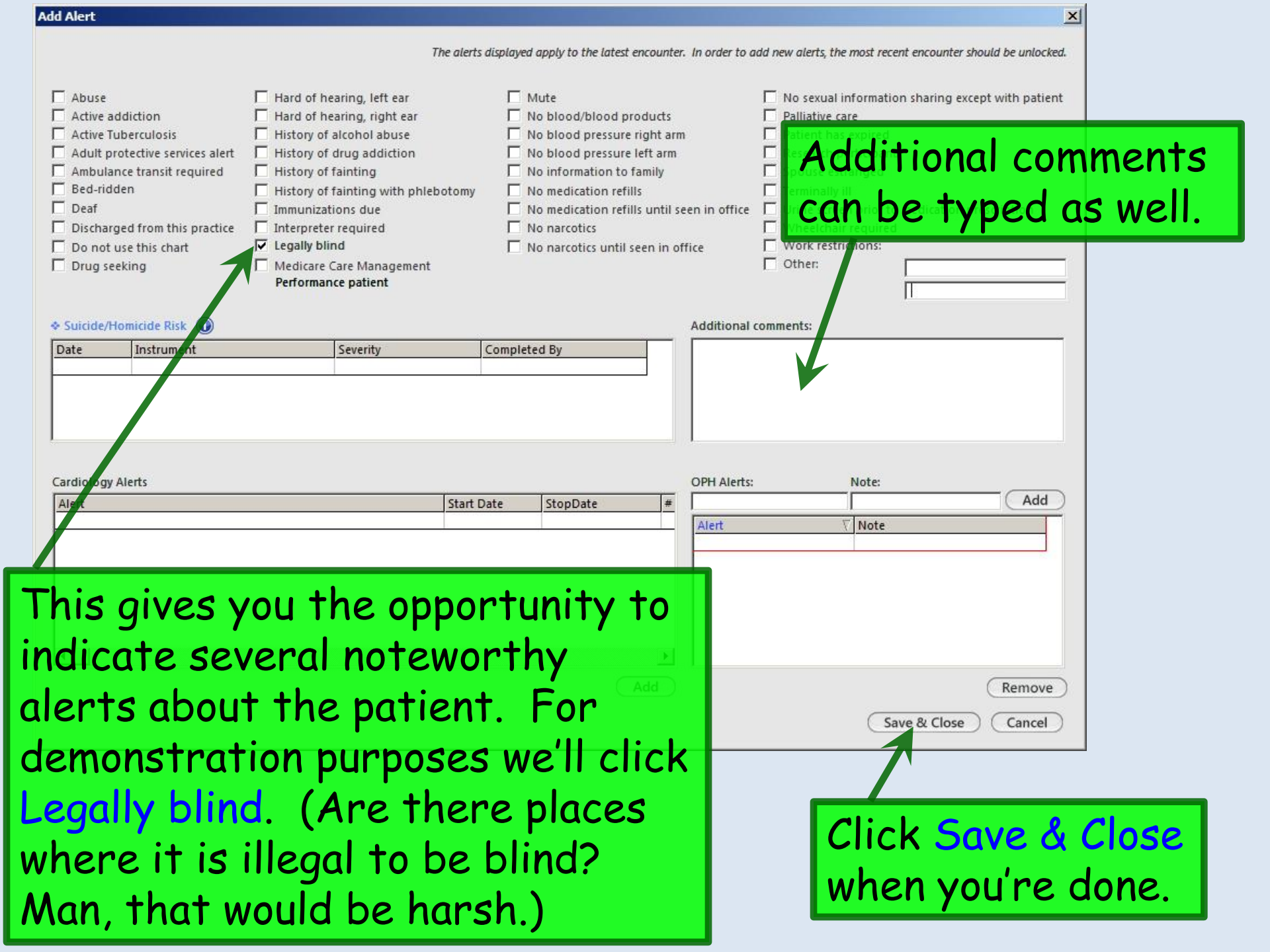

Other times a sticky note would be a temporary notice, like Ask about Tdap next visit. RL Duffy 2/13/14. It's good to put your name & date on such things; otherwise, you have no idea whether they're still pertinent when you see them in the future. And you should delete such sticky notes when they're no longer meaningful.

When done click Save & Close.

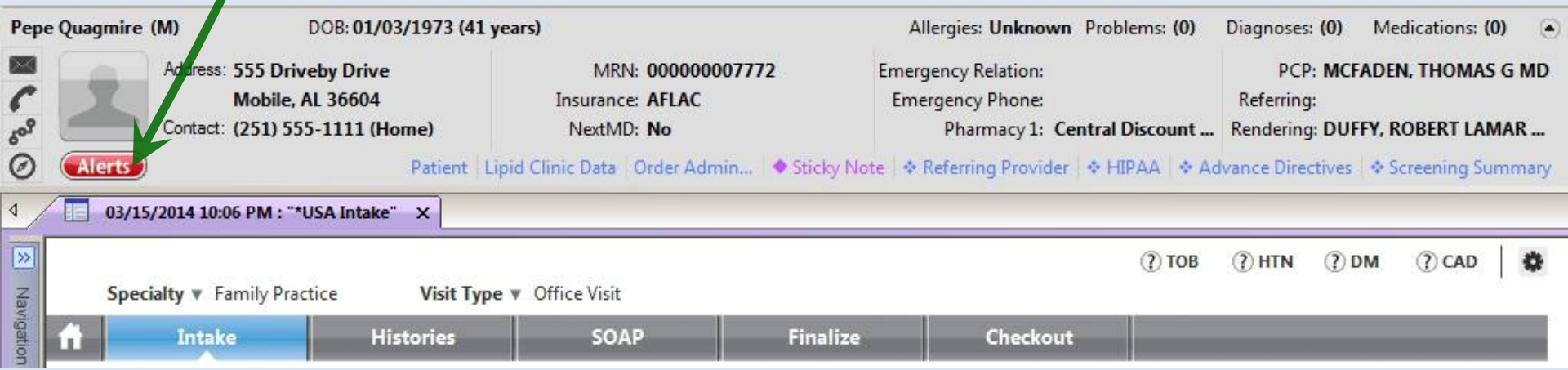
When a **Sticky Note** is present, the link will change to a magenta color with a solid diamond.



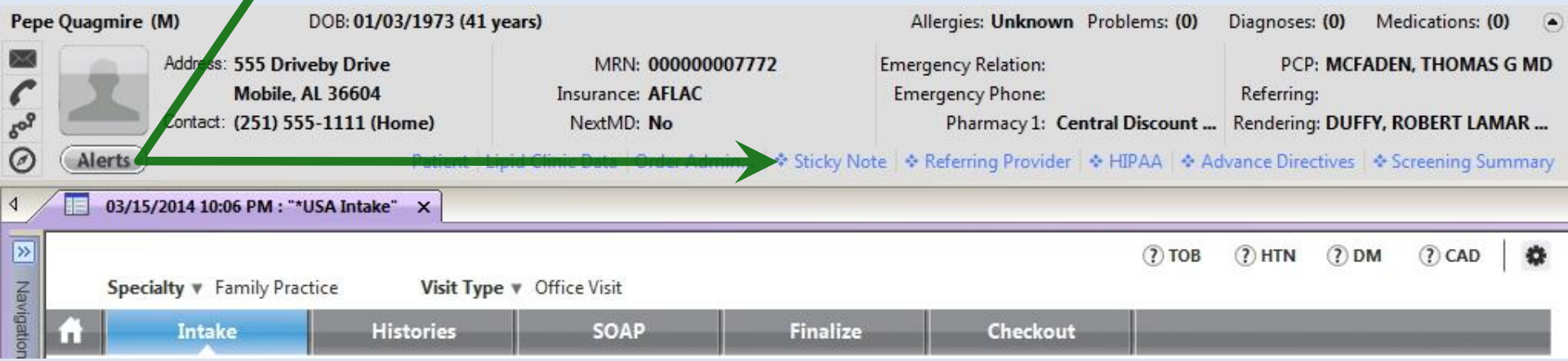

Now click Alerts.


Add Alert
The alerts displayed apply to the latest encounter. In order to add new alerts, the most recent encounter should be unlocked.
Abuse
Active addiction
Active Tuberculosis
Adult protective services alert
Ambulance transit required
Bed-ridden
Deaf
Discharged from this practice
Do not use this chart
Drug seeking
Hard of hearing, left ear
Hard of hearing, right ear
History of alcohol abuse
History of drug addiction
History of fainting
History of fainting with phlebotomy
Immunizations due
Interpreter required
Legally blind
Medicare Care Management
Performance patient
Mute
No blood/blood products
No blood pressure right arm
No blood pressure left arm
No information to family
No medication refills
No medication refills until seen in office
No narcotics
No narcotics until seen in office
No sexual information sharing except with patient
Palliative care
Other:
Suicide/Homicide Risk
Date
Instrument
Severity
Completed By
Additional comments:
Cardiology Alerts
Alert
Start Date
StopDate
#
OPH Alerts:
Note:
Add
Alert
Note
Remove
Save & Close
Cancel
Additional comments can be typed as well.
This gives you the opportunity to indicate several noteworthy alerts about the patient. For demonstration purposes we'll click Legally blind. (Are there places where it is illegal to be blind? Man, that would be harsh.)
Click Save & Close when you're done.

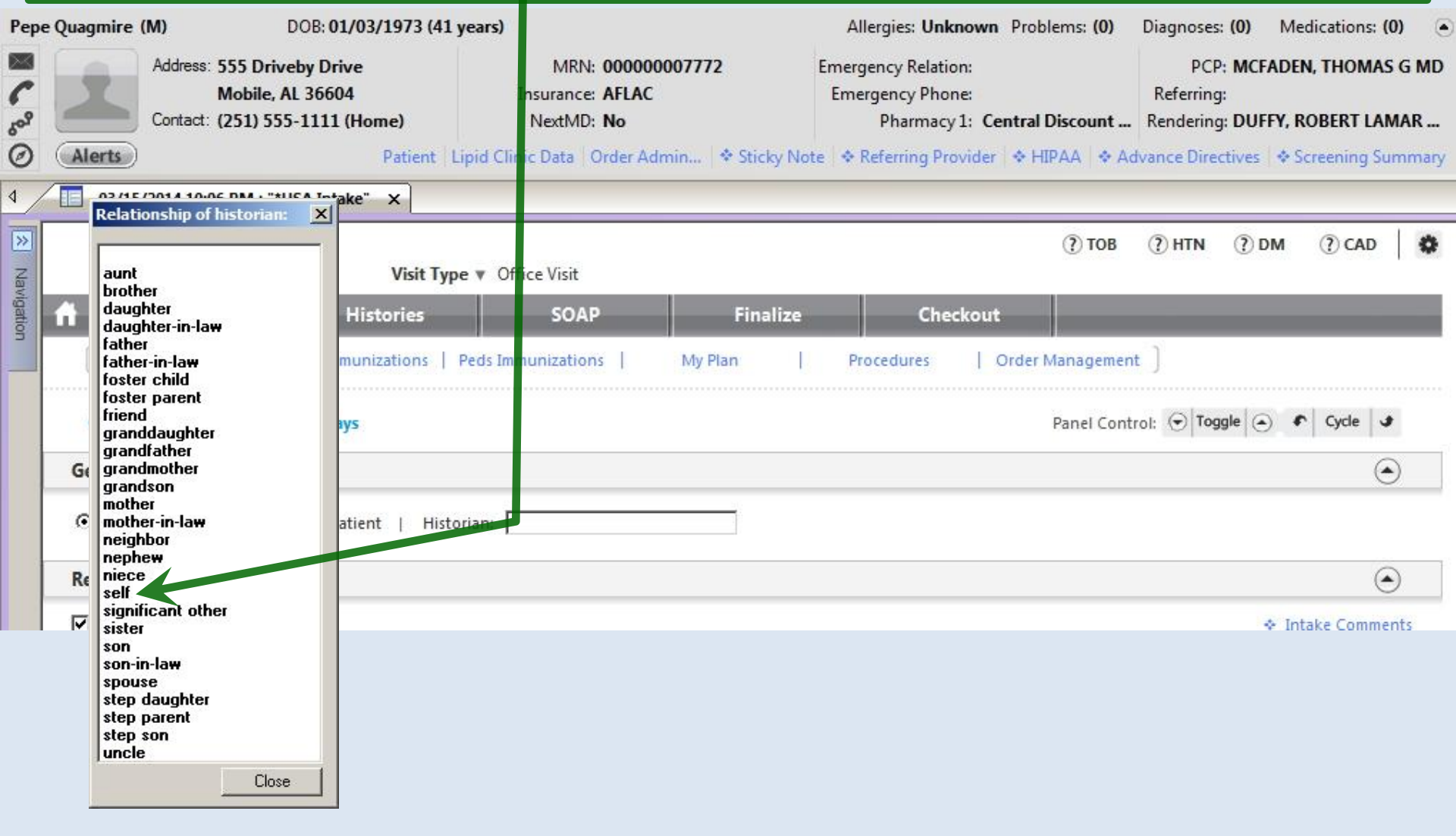
The Alerts button turns red when there is an entry.

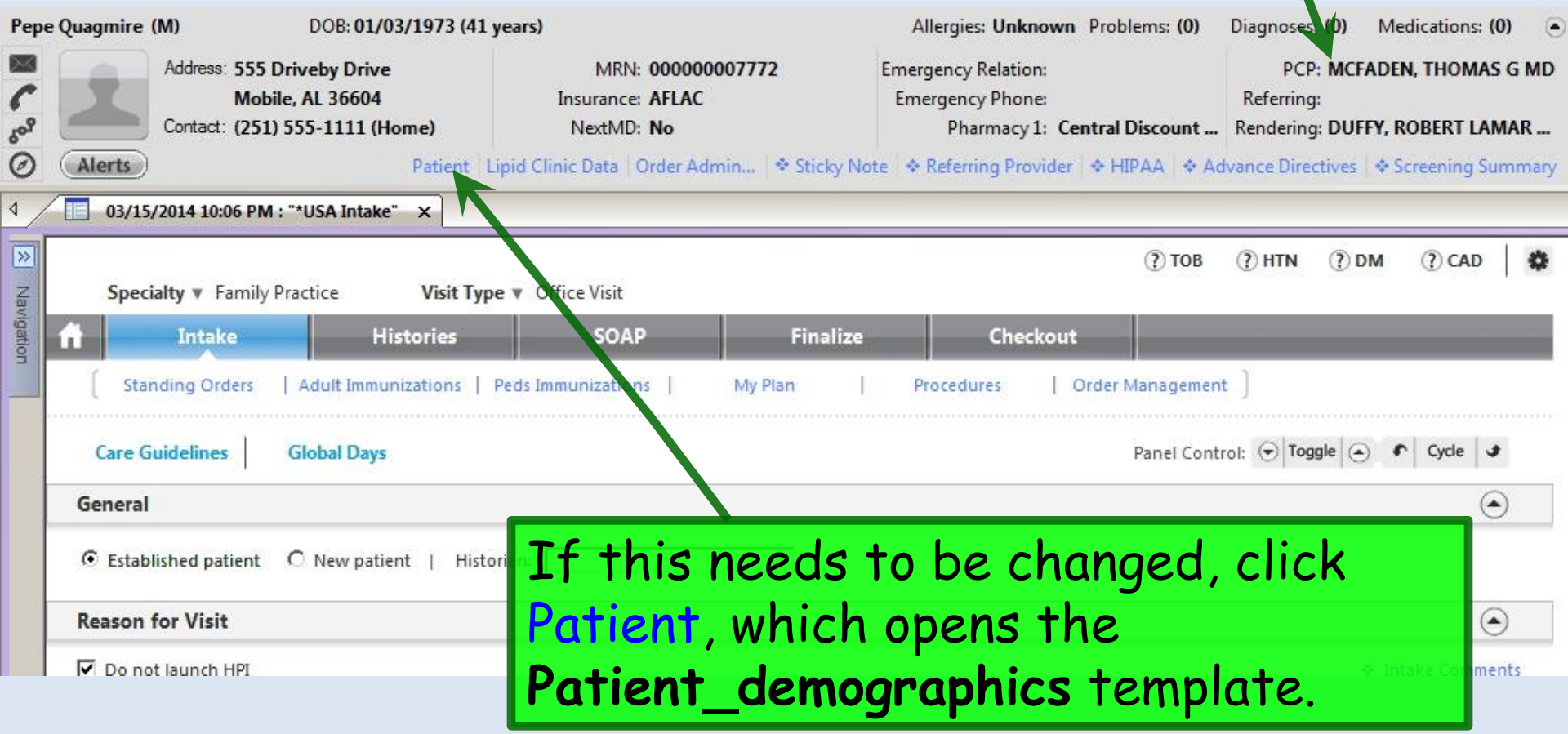


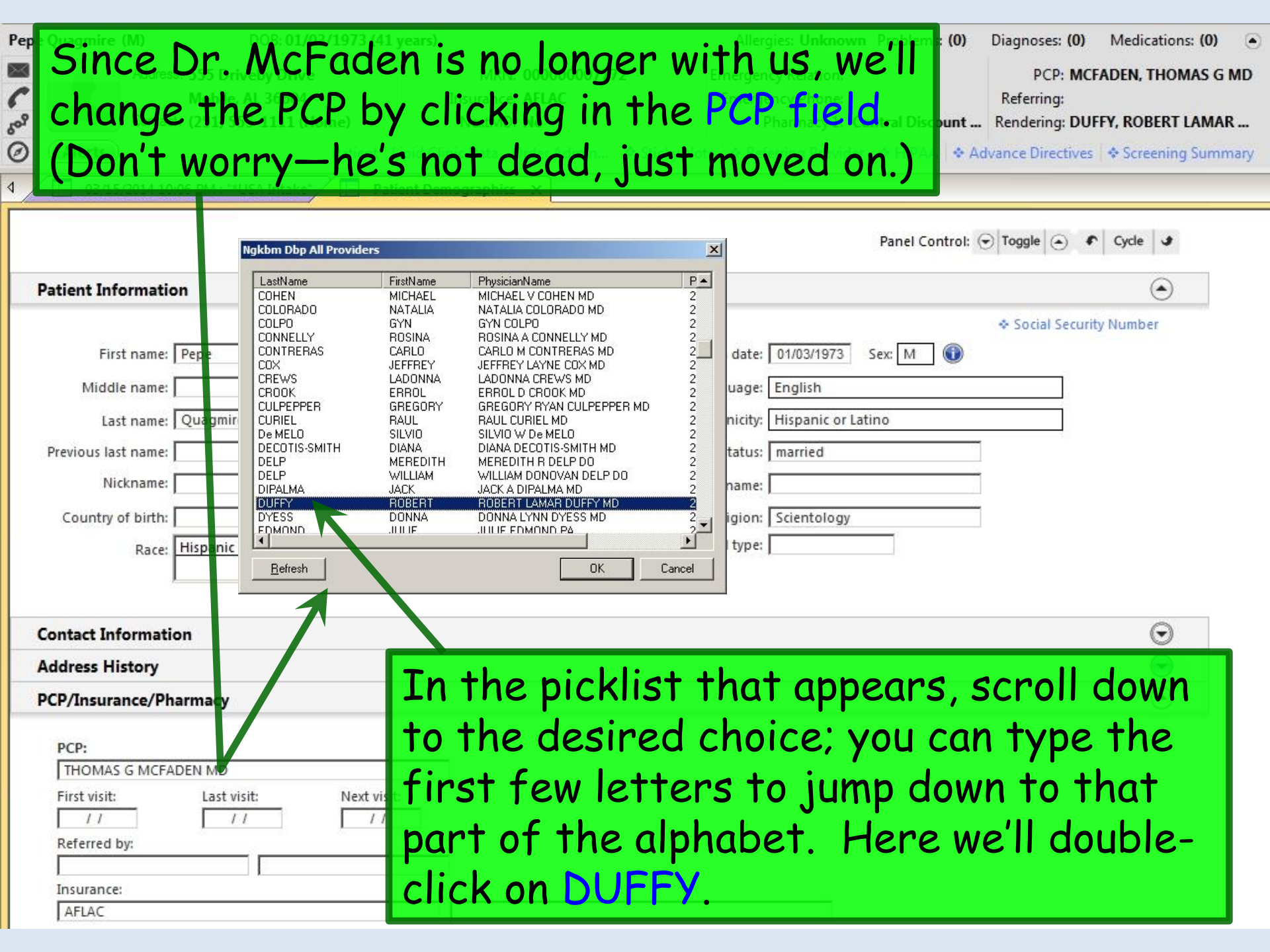

When you remove entries the Sticky Note & Alerts return to their baseline appearance, as below.

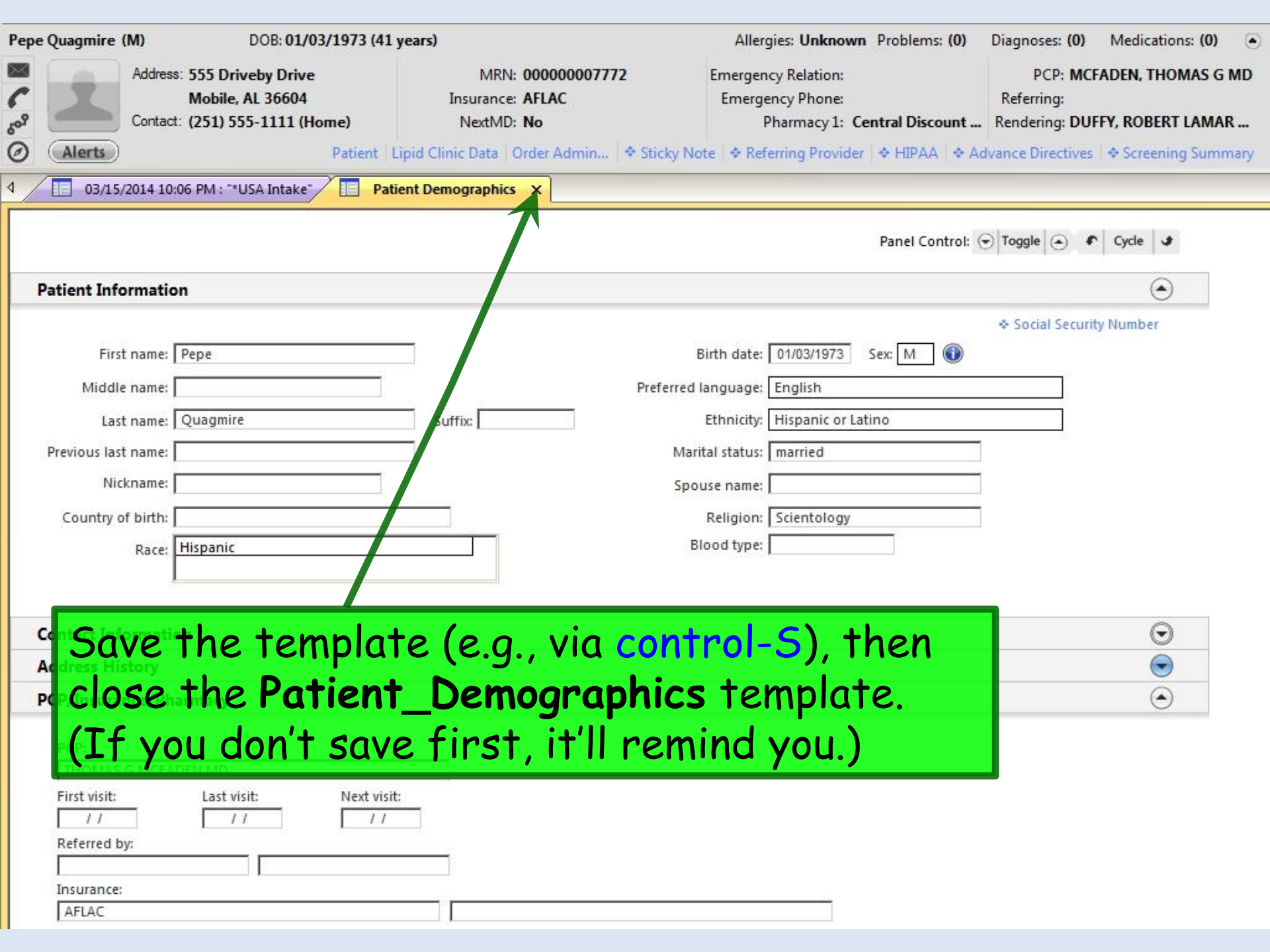


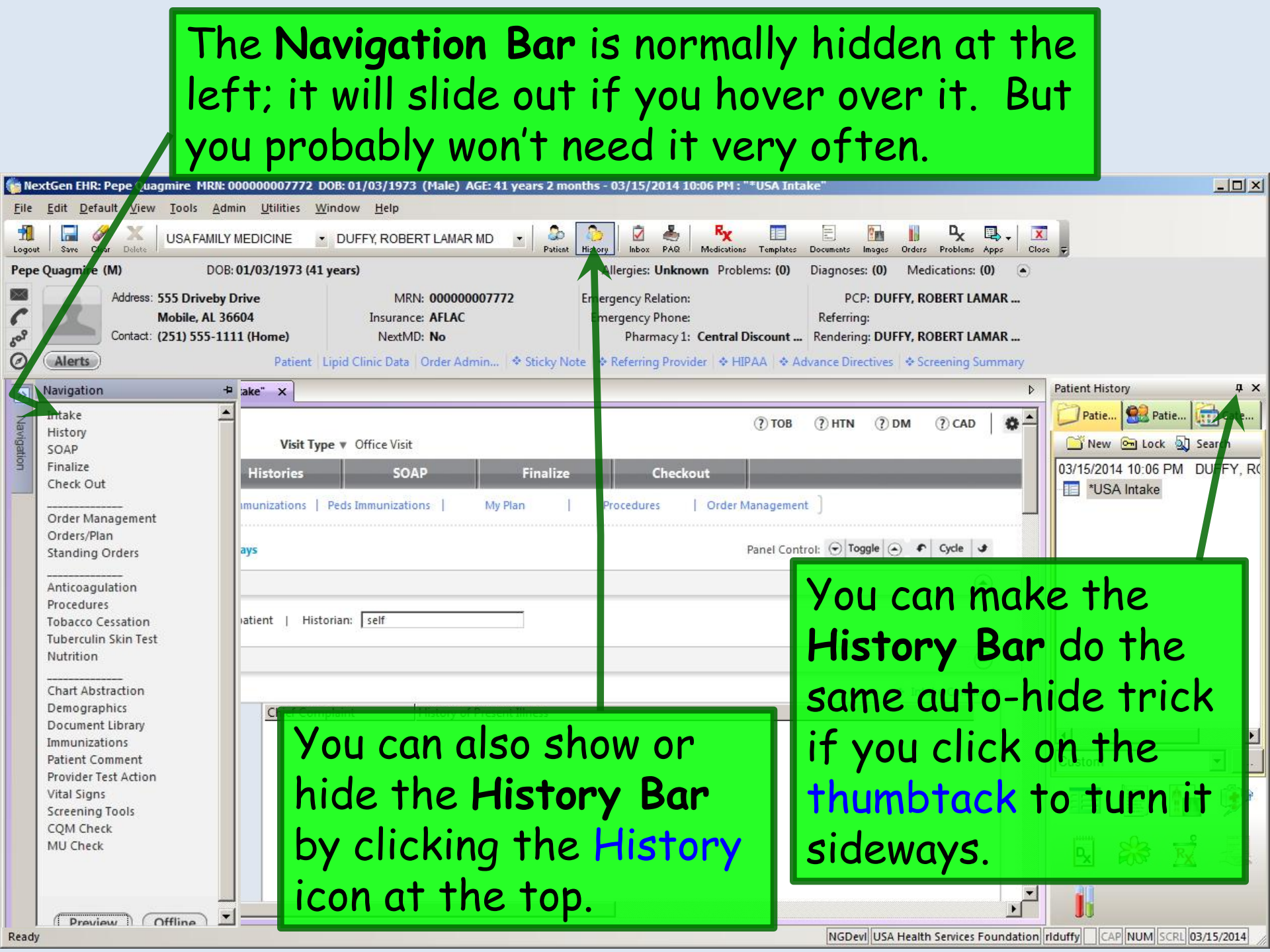
You can select a **Historian** from the picklist that appears if you click in that box; you can also type in an entry. This is most pertinent if the patient is a child or adult unable to care for himself.

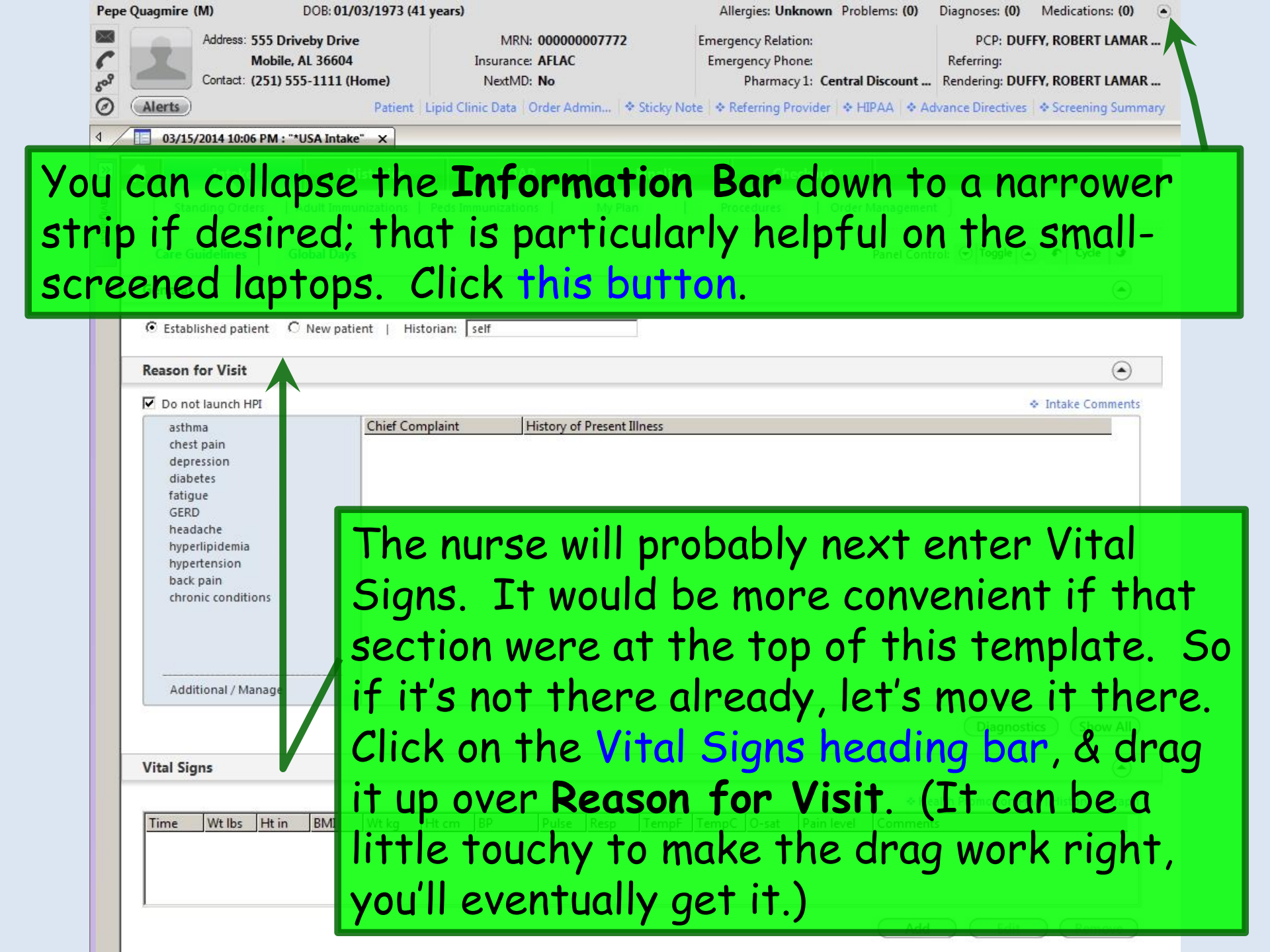



Note the PCP.
Pepe Quagmire (M)
DOB: 01/03/1973 (41 years)
Allergies: Unknown
Problems: (0)
Diagnoses: (0)
Medications: (0)
Address: 555 Driveby Drive
Mobile, AL 36604
Contact: (251) 555-1111 (Home)
MRN: 000000007772
Insurance: AFLAC
NextMD: No
Emergency Relation:
Emergency Phone:
Pharmacy 1: Central Discount ...
PCP: MCFADEN, THOMAS G MD
Referring:
Rendering: DUFFY, ROBERT LAMAR ...
Alerts
Patient
Lipid Clinic Data
Order Admin...
Sticky Note
Referring Provider
HIPAA
Advance Directives
Screening Summary
03/15/2014 10:06 PM : "*USA Intake"
Navigation
TOB
HTN
DM
CAD
Specialty ▼ Family Practice
Visit Type ▼ Office Visit
Intake
Histories
SOAP
Finalize
Checkout
Standing Orders
Adult Immunizations
Peds Immunizations
My Plan
Procedures
Order Management
Care Guidelines
Global Days
Panel Control:
Toggle
Cycle
General
Established patient
New patient
Reason for Visit
Do not launch HPI
If this needs to be changed, click Patient, which opens the Patient_demographics template.


Since Dr. McFaden is no longer with us, we'll change the PCP by clicking in the PCP field. (Don't worry—he's not dead, just moved on.)
Diagnoses: (0)
Medications: (0)
PCP: MCFADEN, THOMAS G MD
Referring:
Rendering: DUFFY, ROBERT LAMAR ...
Advance Directives
Screening Summary
Panel Control:
Toggle
Cycle
Ngkbm Dbp All Providers
LastName FirstName PhysicianName P
COHEN MICHAEL MICHAEL V COHEN MD 2
COLORADO NATALIA NATALIA COLORADO MD 2
COLPO GYN GYN COLPO 2
CONNELLY ROSINA ROSINA A CONNELLY MD 2
CONTRERAS CARLO CARLO M CONTRERAS MD 2
COX JEFFREY JEFFREY LAYNE COX MD 2
CREWS LADONNA LADONNA CREWS MD 2
CROOK ERROL ERROL D CROOK MD 2
CULPEPPER GREGORY GREGORY RYAN CULPEPPER MD 2
CURIEL RAUL RAUL CURIEL MD 2
De MELO SILVIO SILVIO W De MELO 2
DECOTIS-SMITH DIANA DIANA DECOTIS-SMITH MD 2
DELP MEREDITH MEREDITH R DELP DO 2
DELP WILLIAM WILLIAM DONOVAN DELP DO 2
DIPALMA JACK JACK A DIPALMA MD 2
DUFFY ROBERT ROBERT LAMAR DUFFY MD 2
DYESS DONNA DONNA LYNN DYESS MD 2
Refresh
OK
Cancel
Patient Information
Social Security Number
First name:
Middle name:
Last name:
Previous last name:
Nickname:
Country of birth:
Race:
date: 01/03/1973
Sex: M
uage: English
nicity: Hispanic or Latino
tatus: married
name:
igion: Scientology
type:
Contact Information
Address History
PCP/Insurance/Pharmacy
PCP:
THOMAS G MCFADEN MD
First visit:
Last visit:
Referred by:
Insurance:
AFLAC
In the picklist that appears, scroll down to the desired choice; you can type the first few letters to jump down to that part of the alphabet. Here we'll double-click on DUFFY.

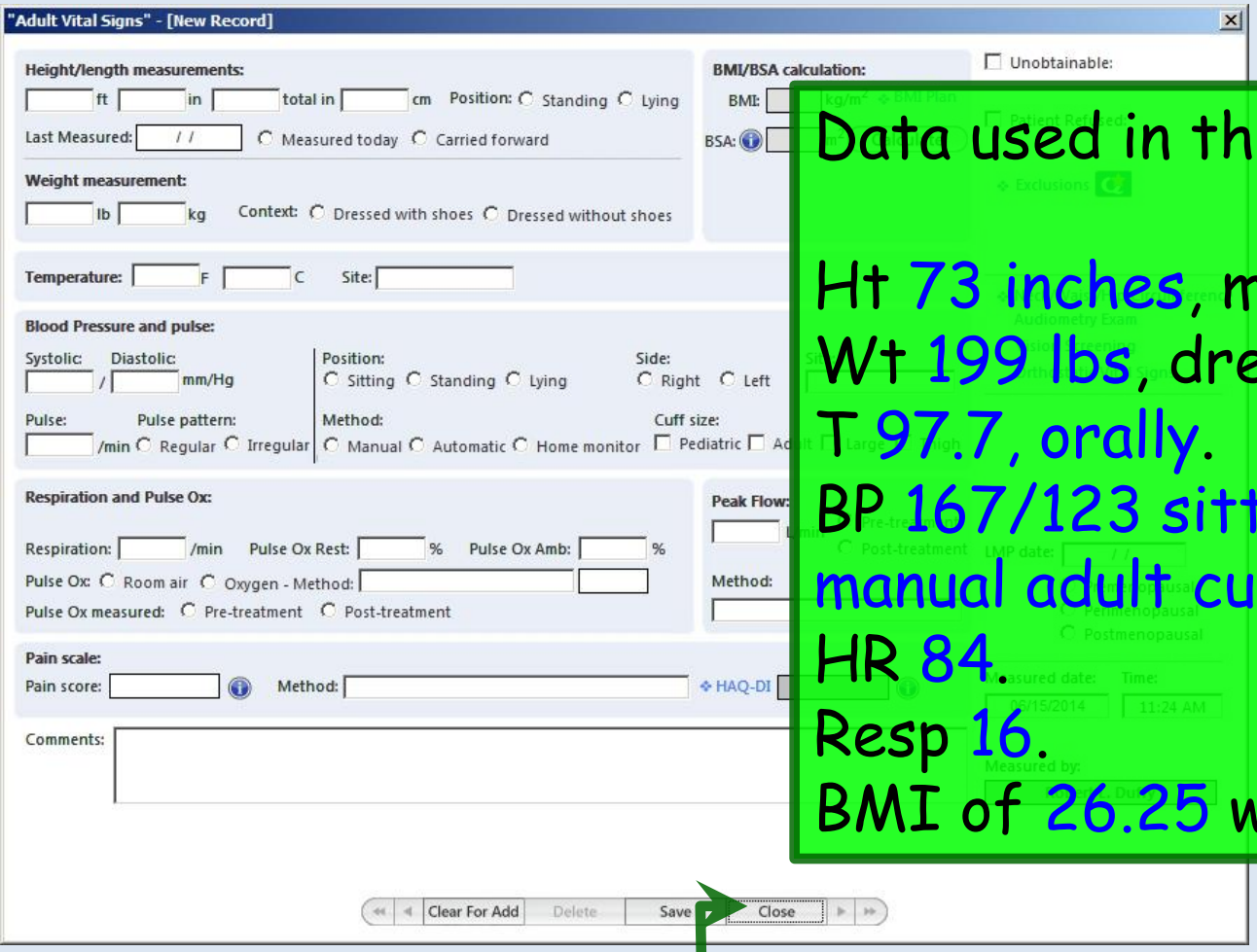

Pepe Quagmire (M)
DOB: 01/03/1973 (41 years)
Allergies: Unknown
Problems: (0)
Diagnoses: (0)
Medications: (0)
Address: 555 Driveby Drive
Mobile, AL 36604
Contact: (251) 555-1111 (Home)
MRN: 000000007772
Insurance: AFLAC
NextMD: No
Emergency Relation:
Emergency Phone:
Pharmacy 1: Central Discount ...
PCP: MCFADEN, THOMAS G MD
Referring:
Rendering: DUFFY, ROBERT LAMAR ...
Alerts
Patient
Lipid Clinic Data
Order Admin...
Sticky Note
Referring Provider
HIPAA
Advance Directives
Screening Summary
03/15/2014 10:06 PM : "*USA Intake"
Patient Demographics
Panel Control:
Toggle
Cycle
Patient Information
Social Security Number
First name: Pepe
Middle name:
Last name: Quagmire
Suffix:
Previous last name:
Nickname:
Country of birth:
Race: Hispanic
Birth date: 01/03/1973
Sex: M
Preferred language: English
Ethnicity: Hispanic or Latino
Marital status: married
Spouse name:
Religion: Scientology
Blood type:
Save the template (e.g., via control-S), then close the Patient_Demographics template. (If you don't save first, it'll remind you.)
First visit:
Last visit:
Next visit:
Referred by:
Insurance:
AFLAC


The Navigation Bar is normally hidden at the left; it will slide out if you hover over it. But you probably won't need it very often.
You can also show or hide the History Bar by clicking the History icon at the top.
You can make the History Bar do the same auto-hide trick if you click on the thumbtack to turn it sideways.
NextGen EHR: Pepe Quagmire MRN: 000000007772 DOB: 01/03/1973 (Male) AGE: 41 years 2 months - 03/15/2014 10:06 PM : "*USA Intake"
File Edit Default View Tools Admin Utilities Window Help
Logout Save Clear Delete USA FAMILY MEDICINE DUFFY, ROBERT LAMAR MD Patient History Inbox PAQ Medications Templates Documents Images Orders Problems Apps Close
Pepe Quagmire (M) DOB: 01/03/1973 (41 years)
Allergies: Unknown Problems: (0) Diagnoses: (0) Medications: (0)
Address: 555 Driveby Drive
Mobile, AL 36604
Contact: (251) 555-1111 (Home)
MRN: 000000007772
Insurance: AFLAC
NextMD: No
Emergency Relation:
Emergency Phone:
Pharmacy 1: Central Discount ...
PCP: DUFFY, ROBERT LAMAR ...
Referring:
Rendering: DUFFY, ROBERT LAMAR ...
Alerts
Patient Lipid Clinic Data Order Admin... Sticky Note Referring Provider HIPAA Advance Directives Screening Summary
Navigation
Intake
History
SOAP
Finalize
Check Out
Order Management
Orders/Plan
Standing Orders
Anticoagulation
Procedures
Tobacco Cessation
Tuberculin Skin Test
Nutrition
Chart Abstraction
Demographics
Document Library
Immunizations
Patient Comment
Provider Test Action
Vital Signs
Screening Tools
CQM Check
MU Check
Preview Offline
TOB HTN DM CAD
Visit Type Office Visit
Histories SOAP Finalize Checkout
Peds Immunizations My Plan Procedures Order Management
Panel Control: Toggle Cycle
Historian: self
Patient History
New Lock
03/15/2014 10:06 PM
*USA Intake
Ready
NGDevl USA Health Services Foundation rlduffy CAP NUM SCRL 03/15/2014


Pepe Quagmire (M) DOB: 01/03/1973 (41 years) Allergies: Unknown Problems: (0) Diagnoses: (0) Medications: (0)
Address: 555 Driveby Drive
Mobile, AL 36604
Contact: (251) 555-1111 (Home)
MRN: 000000007772
Insurance: AFLAC
NextMD: No
Emergency Relation:
Emergency Phone:
Pharmacy 1: Central Discount ...
PCP: DUFFY, ROBERT LAMAR ...
Referring:
Rendering: DUFFY, ROBERT LAMAR ...
Alerts
Patient | Lipid Clinic Data | Order Admin... | Sticky Note | Referring Provider | HIPAA | Advance Directives | Screening Summary
03/15/2014 10:06 PM : "*USA Intake"
You can collapse the Information Bar down to a narrower strip if desired; that is particularly helpful on the small-screened laptops. Click this button.
Established patient
New patient
Historian: self
Reason for Visit
Do not launch HPI
Intake Comments
asthma
chest pain
depression
diabetes
fatigue
GERD
headache
hyperlipidemia
hypertension
back pain
chronic conditions
Chief Complaint
History of Present Illness
Additional / Manage
The nurse will probably next enter Vital Signs. It would be more convenient if that section were at the top of this template. So if it's not there already, let's move it there. Click on the Vital Signs heading bar, & drag it up over Reason for Visit. (It can be a little touchy to make the drag work right, you'll eventually get it.)
Vital Signs
Time
Wt lbs
Ht in
BMI
Wt kg
Ht cm
BP
Pulse
Resp
TempF
TempC
O-sat
Pain level
Comments


The Info Bar is collapsed, & Vital Signs are at the top.
Pepe Quagmire (M)
DOB: 01/03/1973 (41 years)
Allergies: Unknown
Problems: (0)
Diagnoses: (0)
Medications: (0)
Alerts
Patient
Lipid Clinic Data
Order Admin...
Sticky Note
Referring Provider
HIPAA
Advance Directives
Screening Summary
03/15/2014 10:06 PM : "*USA Intake"
Intake
Histories
SOAP
Finalize
Checkout
Standing Orders
Adult Immunizations
Ped Immunizations
My Plan
Procedures
Order Management
Navigation
Care Guidelines
Global Days
Panel Control:
Toggle
Cycle
General
Established patient
New patient
Historian:
self
Vital Signs
Health Promotion Plan | History | Graph
Time
Wt lbs
Ht in
BMI
Wt kg
Ht cm
BP
Pulse
Resp
TempF
TempC
O-sat
Pain level
Comments
Add
Edit
Remove
Reason for Visit
Do not launch HPI
Intake Comments
asthma
chest pain
depression
To enter Vital Signs, click Add.

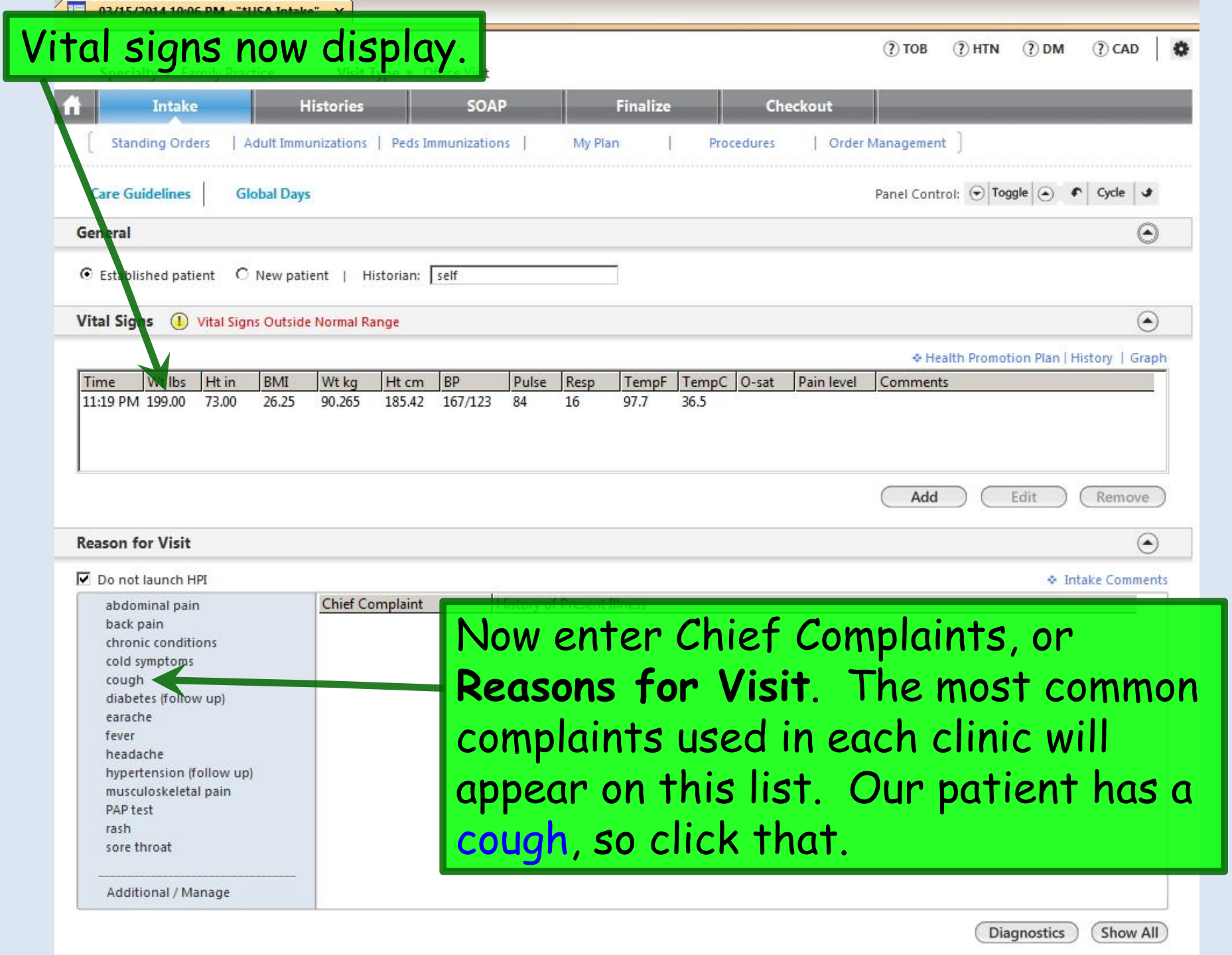
# Enter Vital Signs. (Details are reviewed in another demo.)



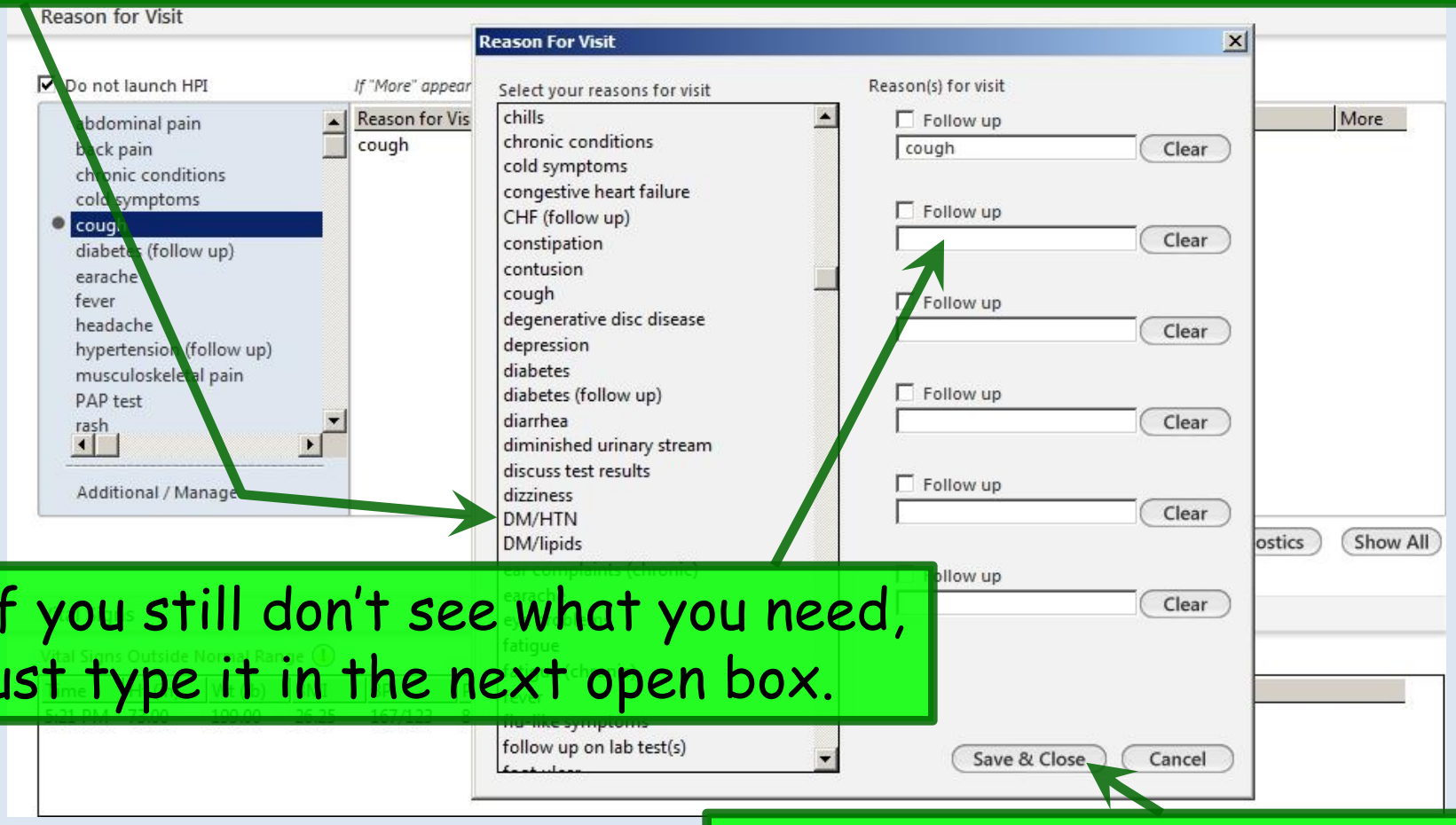

Data used in this example:

Ht 73 inches, measured today.
Wt 199 lbs, dressed without shoes.
T 97.7, orally.
BP 167/123 sitting, left arm, manual adult cuff.
HR 84.
Resp 16.
BMI of 26.25 will be calculated.

When done, click Save then Close.

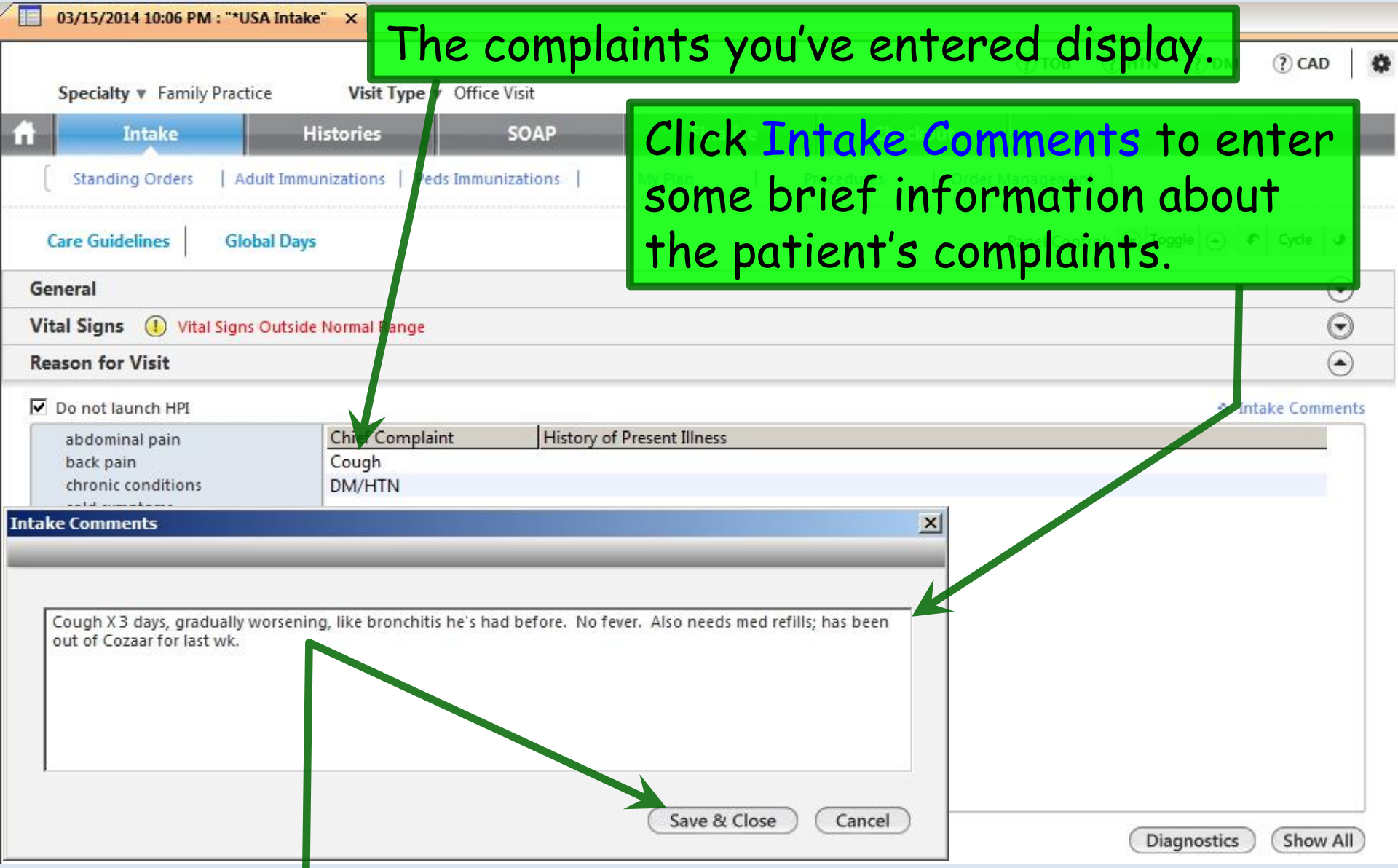

Vital signs now display.
TOB
HTN
DM
CAD
Intake
Histories
SOAP
Finalize
Checkout
Standing Orders
Adult Immunizations
Peds Immunizations
My Plan
Procedures
Order Management
Care Guidelines
Global Days
Panel Control:
Toggle
Cycle
General
Established patient
New patient
Historian:
self
Vital Signs
Vital Signs Outside Normal Range
Health Promotion Plan | History | Graph
Time
Wt lbs
Ht in
BMI
Wt kg
Ht cm
BP
Pulse
Resp
TempF
TempC
O-sat
Pain level
Comments
11:19 PM
199.00
73.00
26.25
90.265
185.42
167/123
84
16
97.7
36.5
Add
Edit
Remove
Reason for Visit
Do not launch HPI
Intake Comments
abdominal pain
back pain
chronic conditions
cold symptoms
cough
diabetes (follow up)
earache
fever
headache
hypertension (follow up)
musculoskeletal pain
PAP test
rash
sore throat
Additional / Manage
Chief Complaint
History of Present Illness
Now enter Chief Complaints, or Reasons for Visit. The most common complaints used in each clinic will appear on this list. Our patient has a cough, so click that.
Diagnostics
Show All

If you don't see the complaint you need, click Additional/Manage. Scroll through the list in the popup to make more selections. Our patient is also here to follow-up on diabetes & hypertension, which happens to be available as a combination, so we'll click DM/HTN.

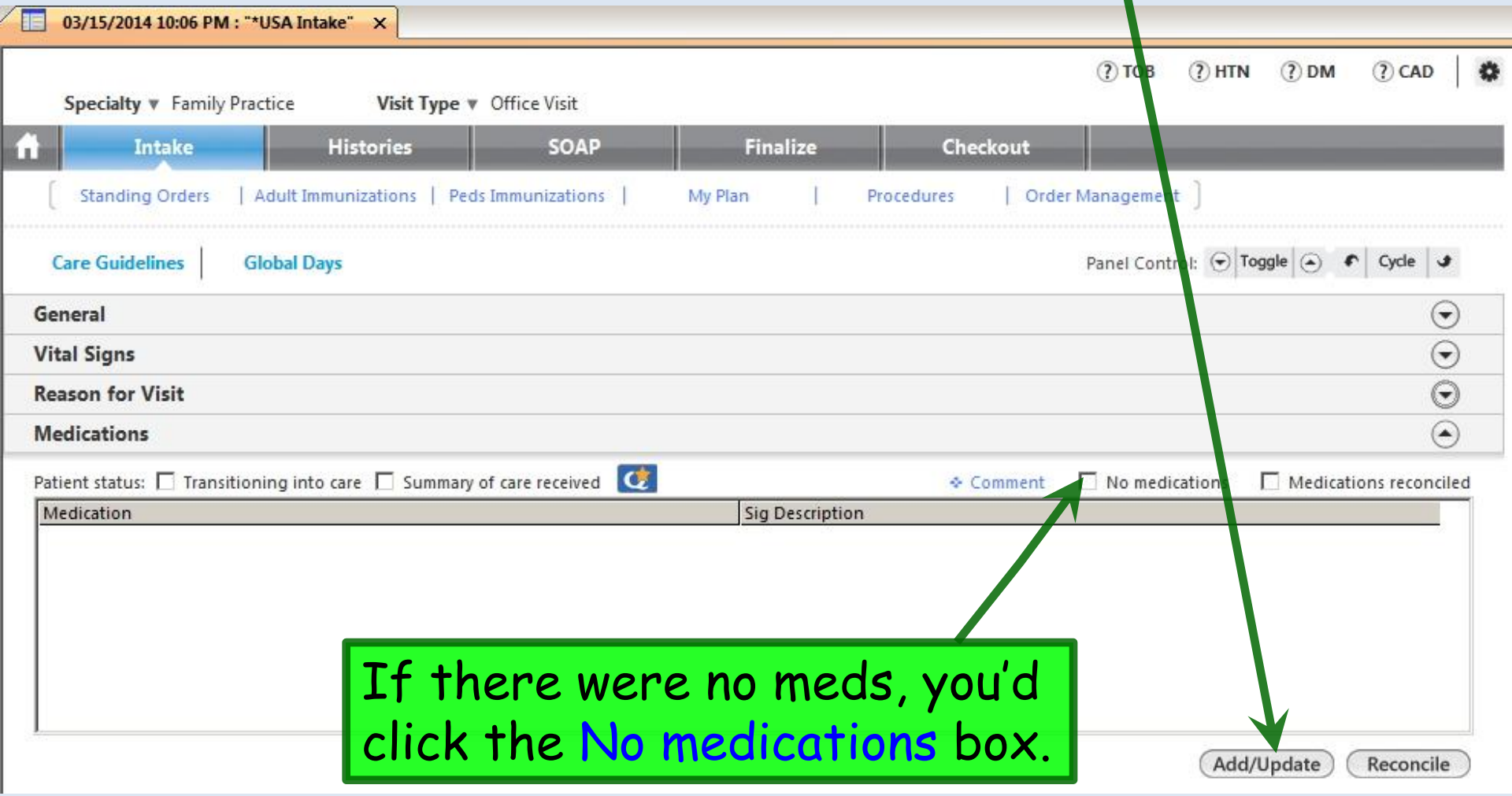



If you still don't see what you need, just type it in the next open box.

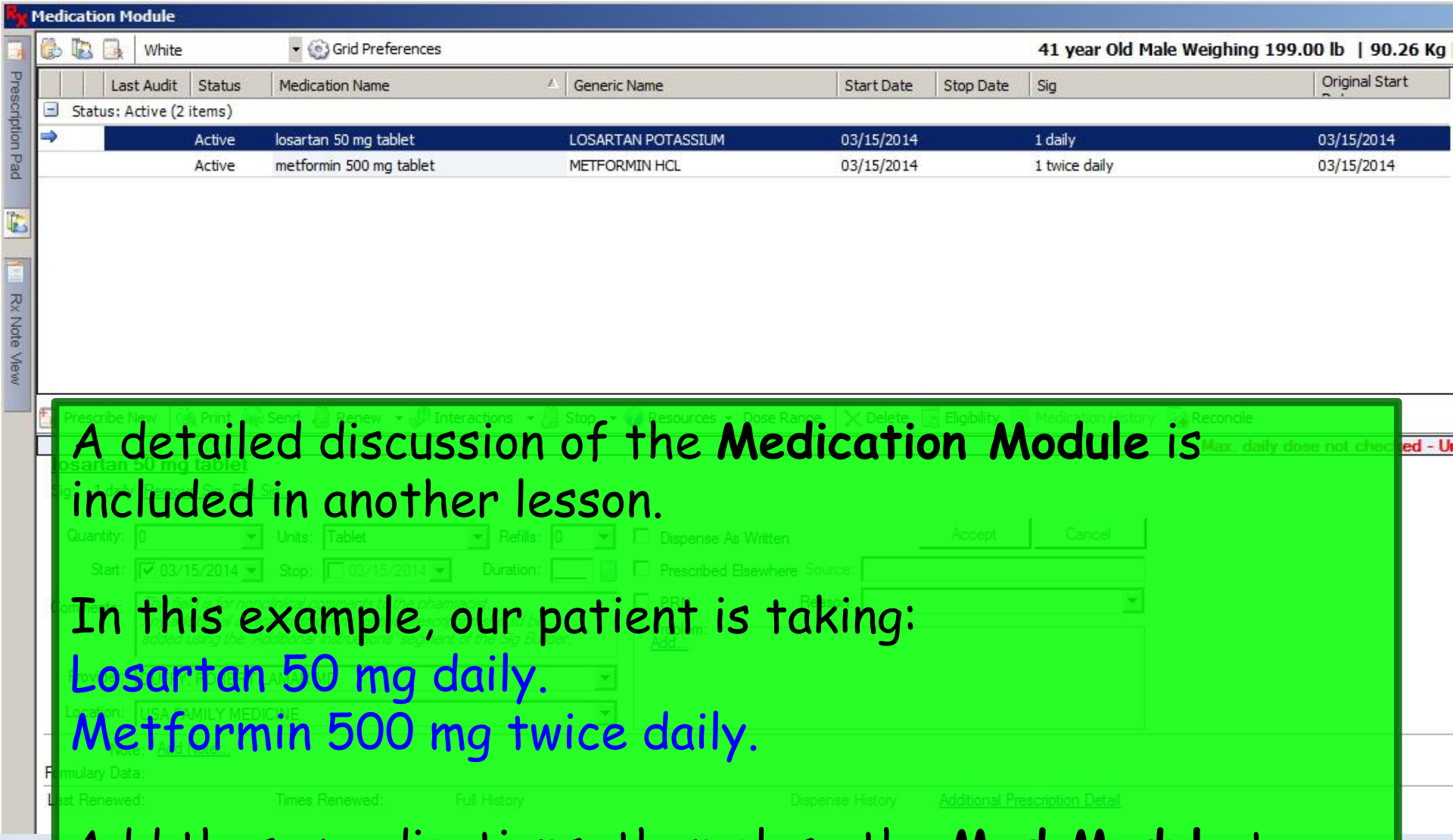
When done, click Save & Close.


03/15/2014 10:06 PM : "*USA Intake"
The complaints you've entered display.
Specialty ▼ Family Practice
Visit Type ▼ Office Visit
CAD
Intake
Histories
SOAP
Standing Orders
Adult Immunizations
Peds Immunizations
Click Intake Comments to enter some brief information about the patient's complaints.
Care Guidelines
Global Days
General
Vital Signs
Vital Signs Outside Normal Range
Reason for Visit
Do not launch HPI
Intake Comments
abdominal pain
back pain
chronic conditions
Chief Complaint
History of Present Illness
Cough
DM/HTN
Intake Comments
Cough X 3 days, gradually worsening, like bronchitis he's had before. No fever. Also needs med refills; has been out of Cozaar for last wk.
Save & Close
Cancel
Diagnostics
Show All
Type a few brief details as pertinent or volunteered by the patient. When done click Save & Close.

Moving down the **Intake Tab**, we come to **Medications**. Since this is the first encounter documented in NextGen, we need to add the patient's meds. Click the Add/Update button.




If there were no meds, you'd click the No medications box.



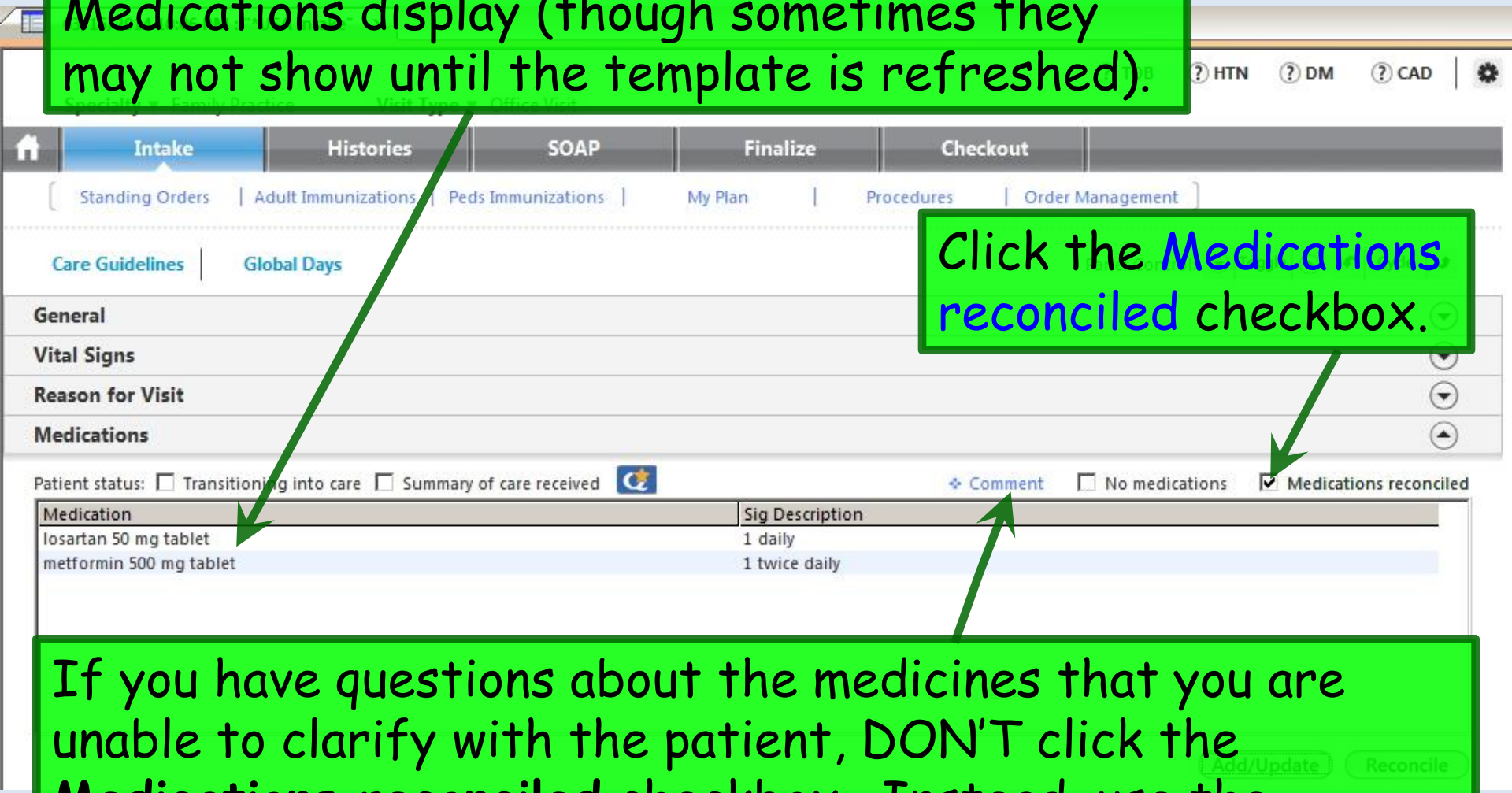

A detailed discussion of the **Medication Module** is included in another lesson.

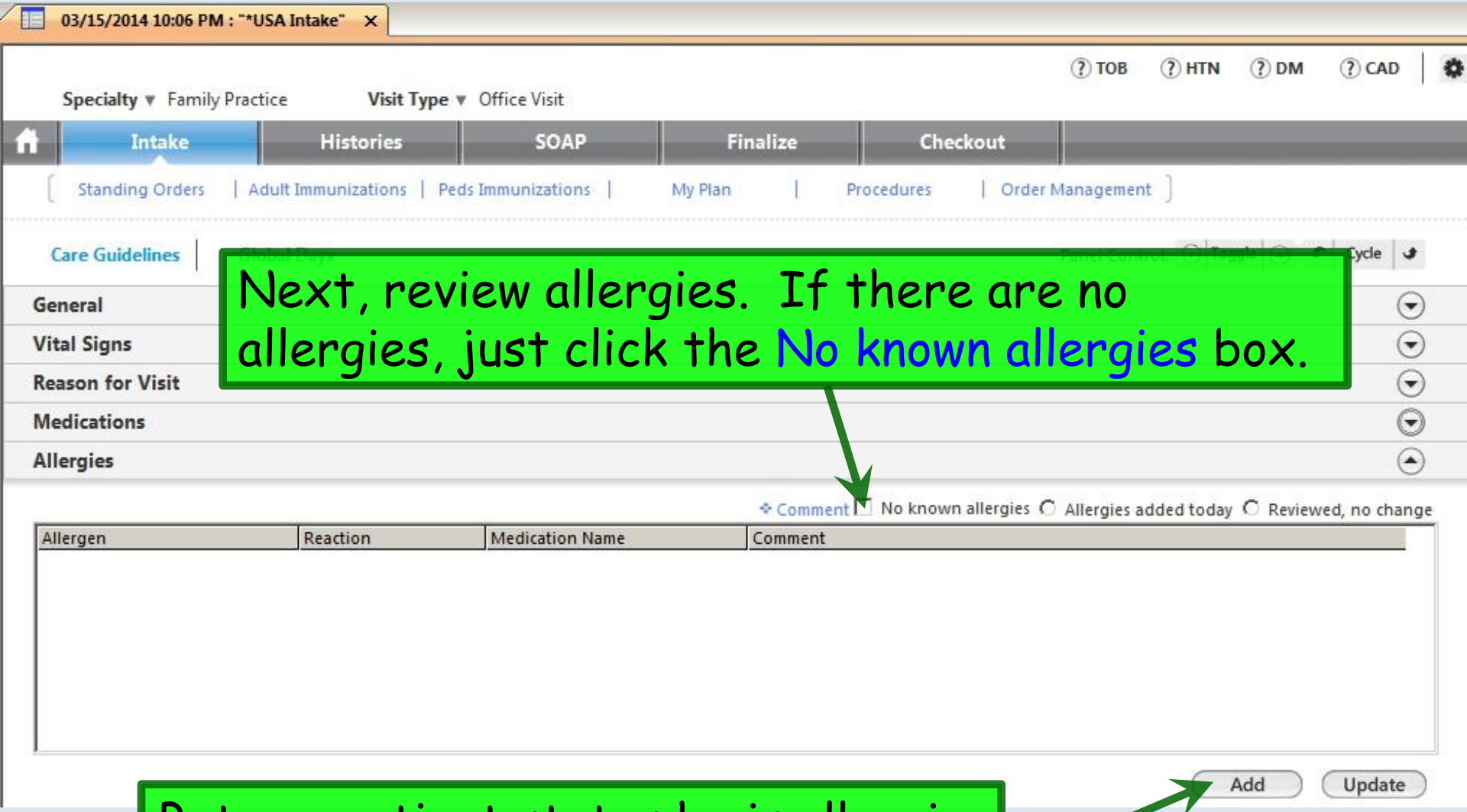
In this example, our patient is taking:

Losartan 50 mg daily.

Metformin 500 mg twice daily.

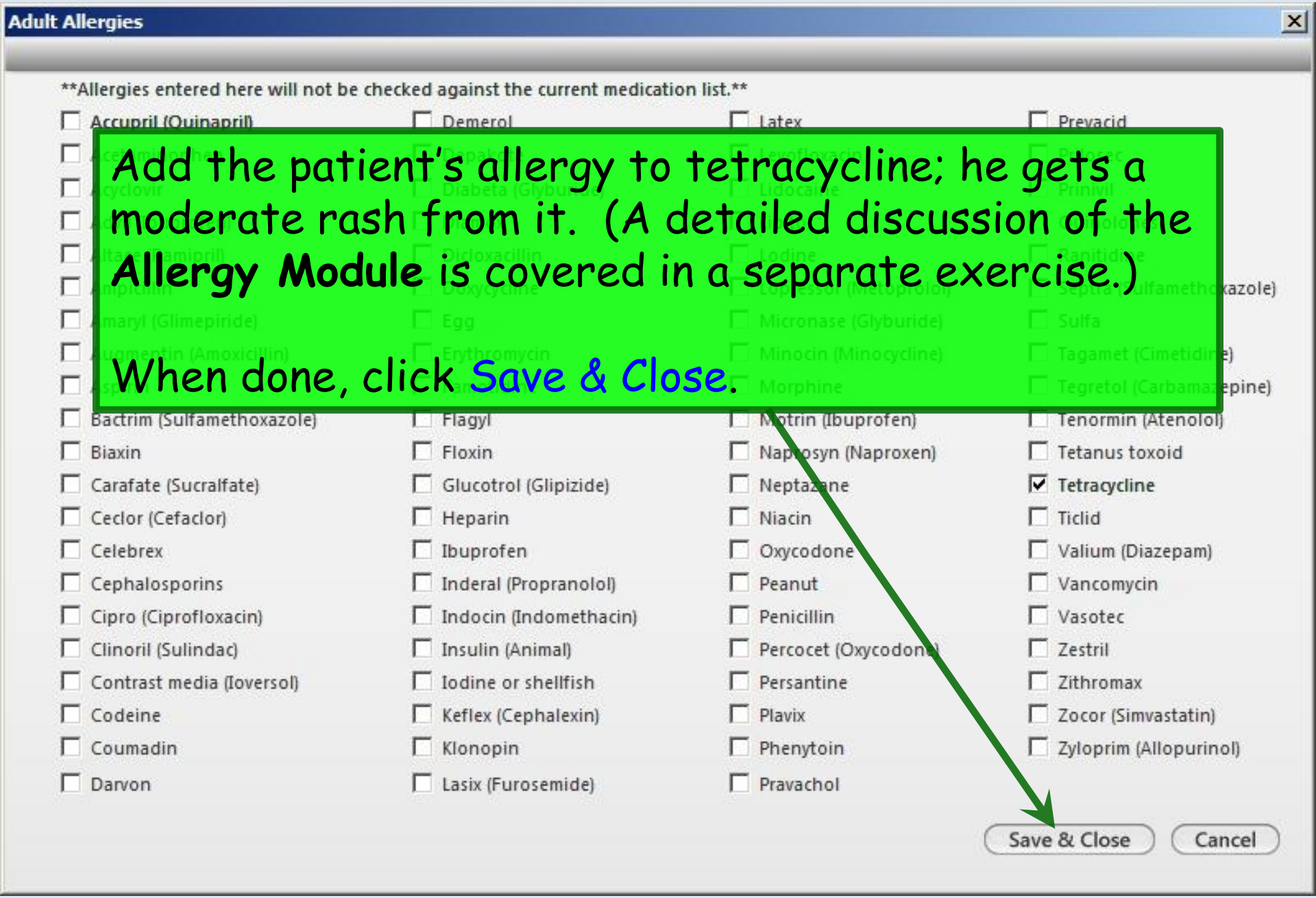
Add these medications, then close the **Med Module** to return to the **Intake Tab**.

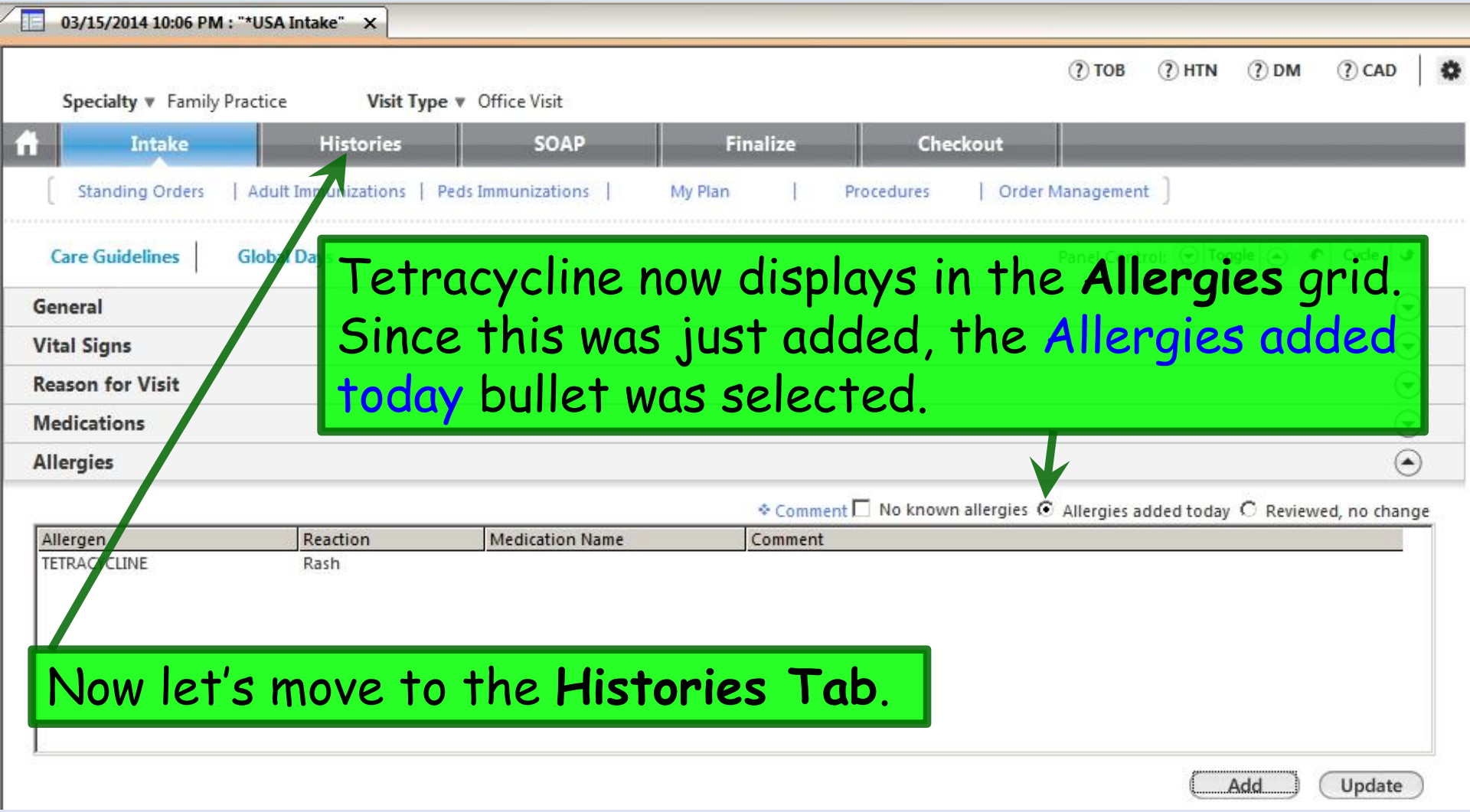

Medications display (though sometimes they may not show until the template is refreshed).
HTN
DM
CAD
Intake
Histories
SOAP
Finalize
Checkout
Standing Orders
Adult Immunizations
Peds Immunizations
My Plan
Procedures
Order Management
Care Guidelines
Global Days
Click the Medications reconciled checkbox.
General
Vital Signs
Reason for Visit
Medications
Patient status:
Transitioning into care
Summary of care received
Comment
No medications
Medications reconciled
Medication
Sig Description
losartan 50 mg tablet
1 daily
metformin 500 mg tablet
1 twice daily
If you have questions about the medicines that you are unable to clarify with the patient, DON'T click the Medications reconciled checkbox. Instead, use the Comment link (or perhaps better, the Intake Comments link you used under Reasons for Visit above), and/or verbally tell the provider.

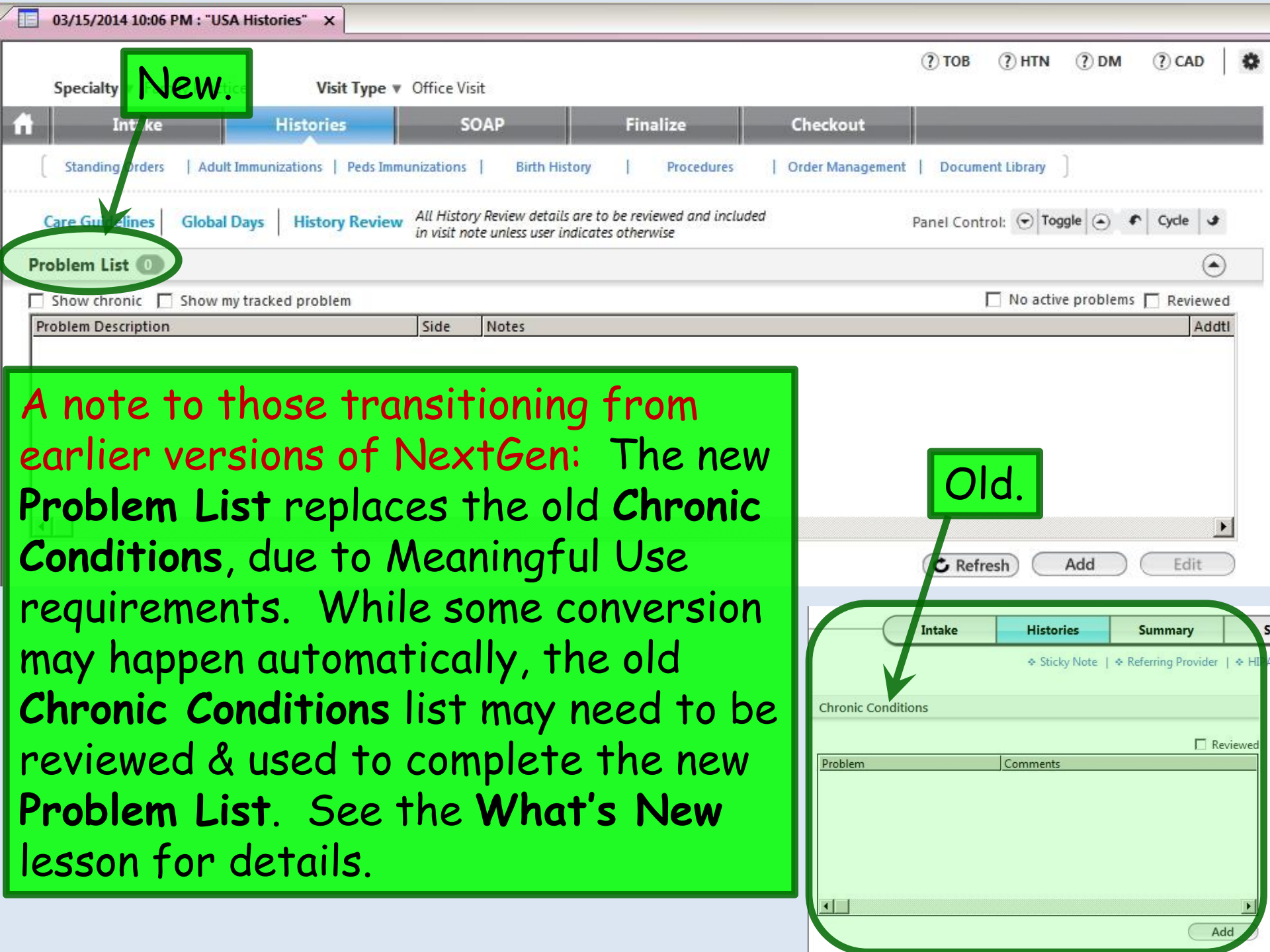


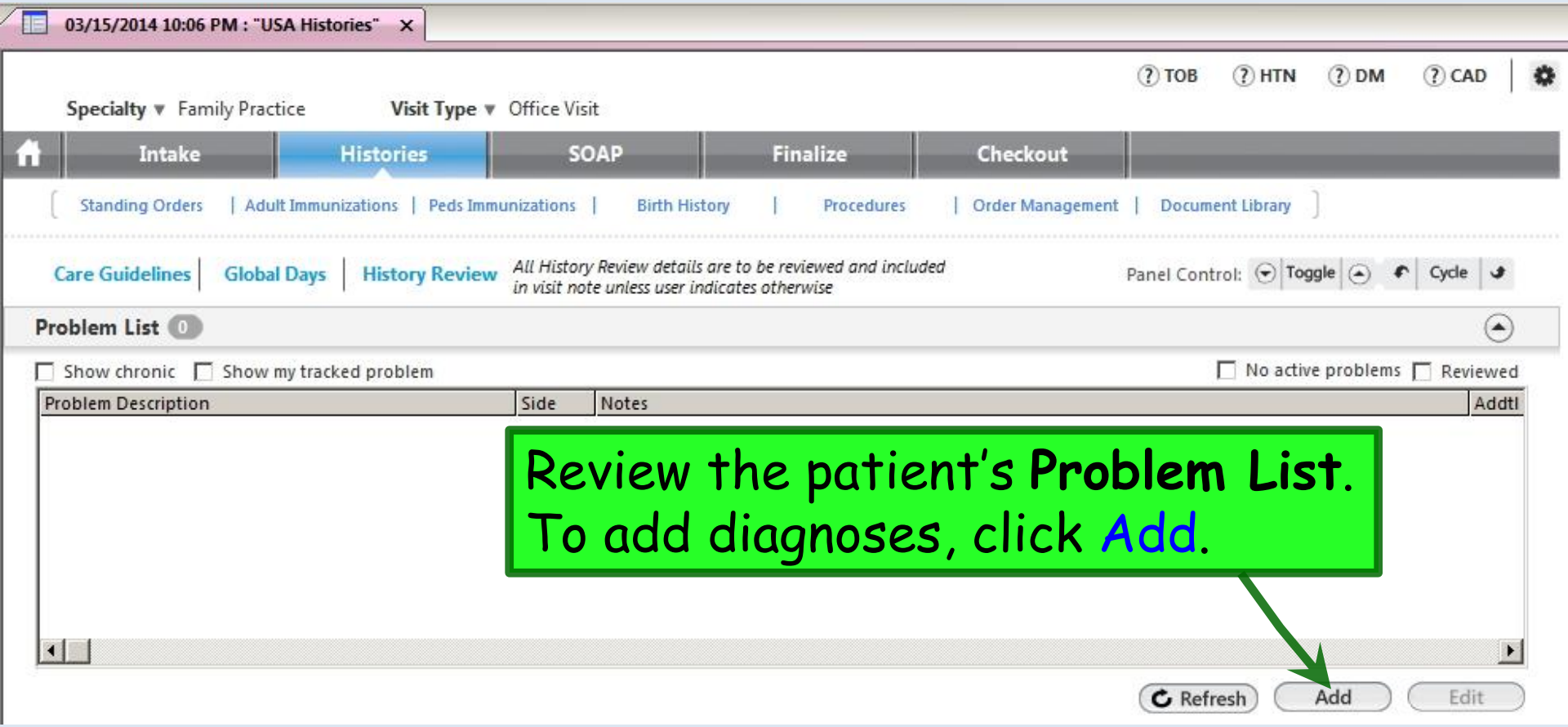

Next, review allergies. If there are no allergies, just click the No known allergies box.

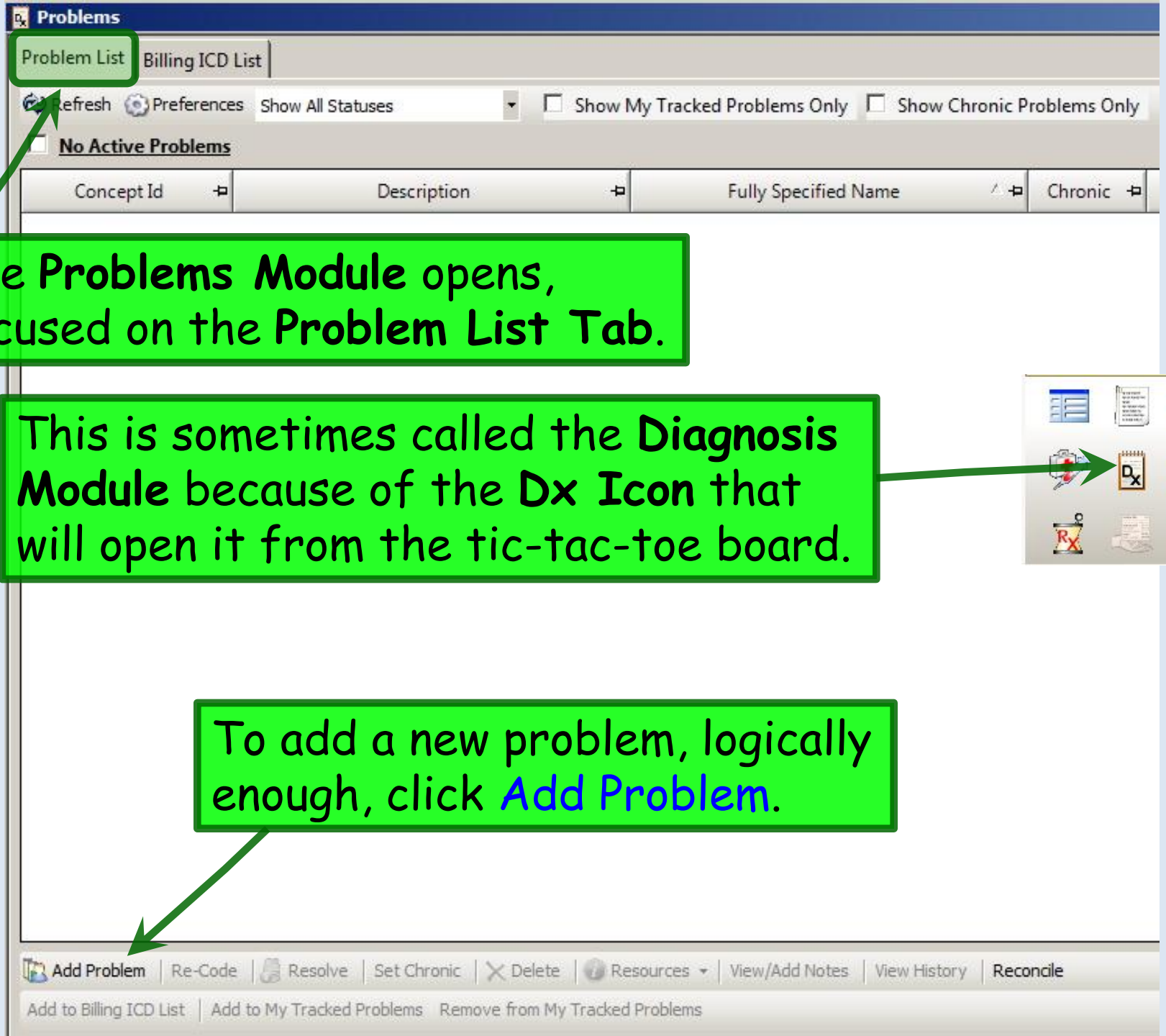
But our patient states he is allergic to tetracycline, so click Add.


Adult Allergies
**Allergies entered here will not be checked against the current medication list.**
Accupril (Quinapril)
Bactrim (Sulfamethoxazole)
Biaxin
Carafate (Sucralfate)
Ceclor (Cefaclor)
Celebrex
Cephalosporins
Cipro (Ciprofloxacin)
Clinoril (Sulindac)
Contrast media (Ioversol)
Codeine
Coumadin
Darvon
Demerol
Flagyl
Floxin
Glucotrol (Glipizide)
Heparin
Ibuprofen
Inderal (Propranolol)
Indocin (Indomethacin)
Insulin (Animal)
Iodine or shellfish
Keflex (Cephalexin)
Klonopin
Lasix (Furosemide)
Latex
Neptazane
Niacin
Oxycodone
Peanut
Penicillin
Persantine
Plavix
Phenytoin
Pravachol
Prevacid
Tetracycline
Ticlid
Valium (Diazepam)
Vancomycin
Vasotec
Zestril
Zithromax
Zocor (Simvastatin)
Zyloprim (Allopurinol)
Add the patient's allergy to tetracycline; he gets a moderate rash from it. (A detailed discussion of the Allergy Module is covered in a separate exercise.)
When done, click Save & Close.
Save & Close
Cancel


03/15/2014 10:06 PM : "*USA Intake"
TOB
HTN
DM
CAD
Specialty ▼ Family Practice
Visit Type ▼ Office Visit
Intake
Histories
SOAP
Finalize
Checkout
Standing Orders
Adult Immunizations
Peds Immunizations
My Plan
Procedures
Order Management
Care Guidelines
General
Vital Signs
Reason for Visit
Medications
Allergies
Tetracycline now displays in the Allergies grid. Since this was just added, the Allergies added today bullet was selected.
Comment
No known allergies
Allergies added today
Reviewed, no change
Allergen
Reaction
Medication Name
Comment
TETRACYCLINE
Rash
Add
Update
Now let's move to the Histories Tab.


03/15/2014 10:06 PM : "USA Histories"
New.
TOB
HTN
DM
CAD
Specialty
Visit Type ▾ Office Visit
Intake
Histories
SOAP
Finalize
Checkout
Standing Orders | Adult Immunizations | Peds Immunizations | Birth History | Procedures | Order Management | Document Library
Global Days
History Review
All History Review details are to be reviewed and included in visit note unless user indicates otherwise
Panel Control: Toggle Cycle
Problem List 0
Show chronic
Show my tracked problem
No active problems
Reviewed
Problem Description
Side
Notes
Addtl
A note to those transitioning from earlier versions of NextGen: The new Problem List replaces the old Chronic Conditions, due to Meaningful Use requirements. While some conversion may happen automatically, the old Chronic Conditions list may need to be reviewed & used to complete the new Problem List. See the What's New lesson for details.
Old.
Refresh
Add
Edit
Intake
Histories
Summary
Sticky Note | Referring Provider
Chronic Conditions
Reviewed
Problem
Comments
Add


03/15/2014 10:06 PM : "USA Histories"
TOB
HTN
DM
CAD
Specialty ▼ Family Practice
Visit Type ▼ Office Visit
Intake
Histories
SOAP
Finalize
Checkout
Standing Orders | Adult Immunizations | Peds Immunizations | Birth History | Procedures | Order Management | Document Library
Care Guidelines | Global Days | History Review
All History Review details are to be reviewed and included in visit note unless user indicates otherwise
Panel Control: Toggle Cycle
Problem List 0
Show chronic
Show my tracked problem
No active problems
Reviewed
Problem Description
Side
Notes
Addtl
Review the patient's Problem List.
To add diagnoses, click Add.
Refresh
Add
Edit

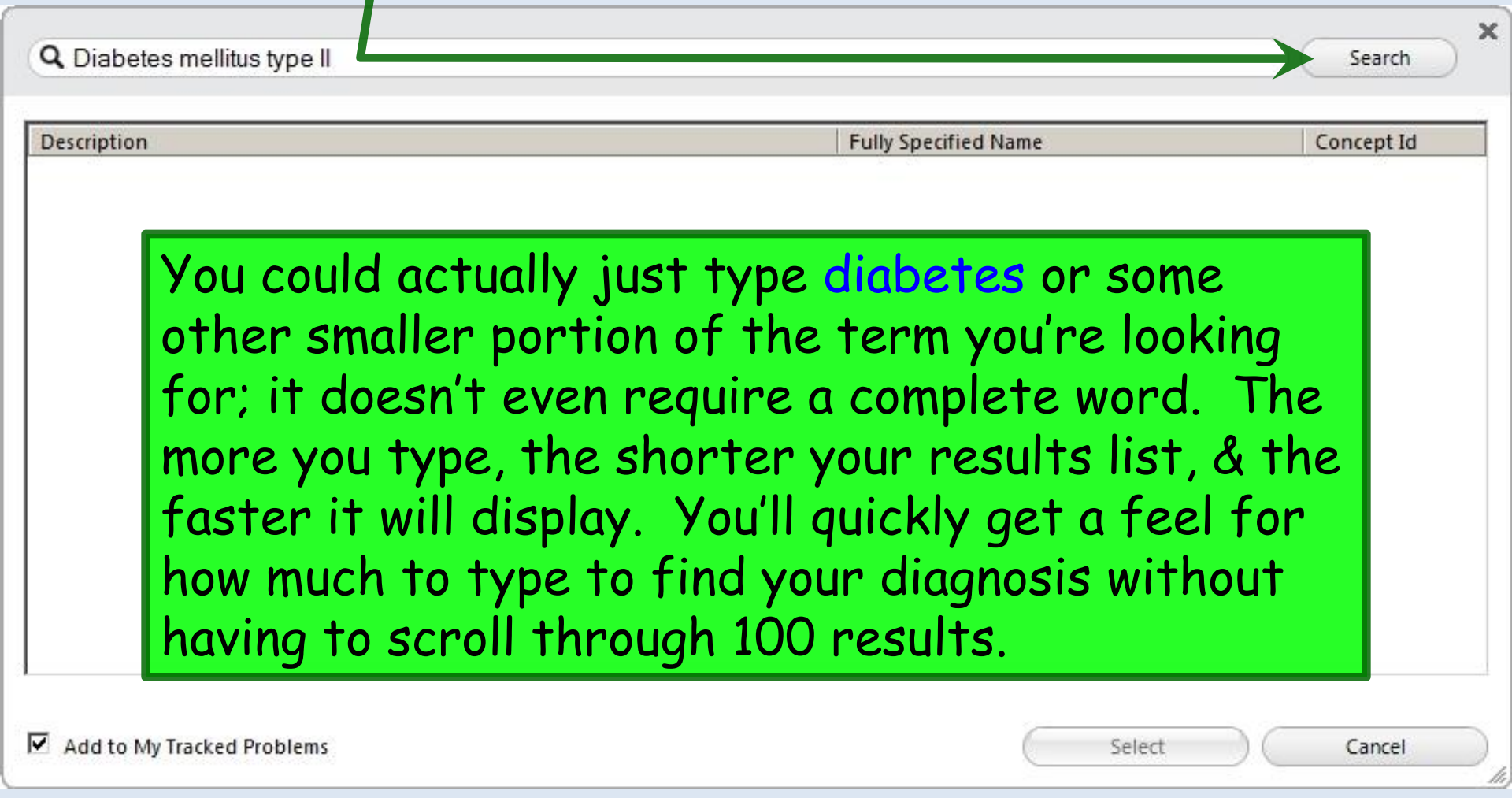



The **Problems Module** opens, focused on the **Problem List Tab**.

This is sometimes called the **Diagnosis Module** because of the **Dx Icon** that will open it from the tic-tac-toe board.

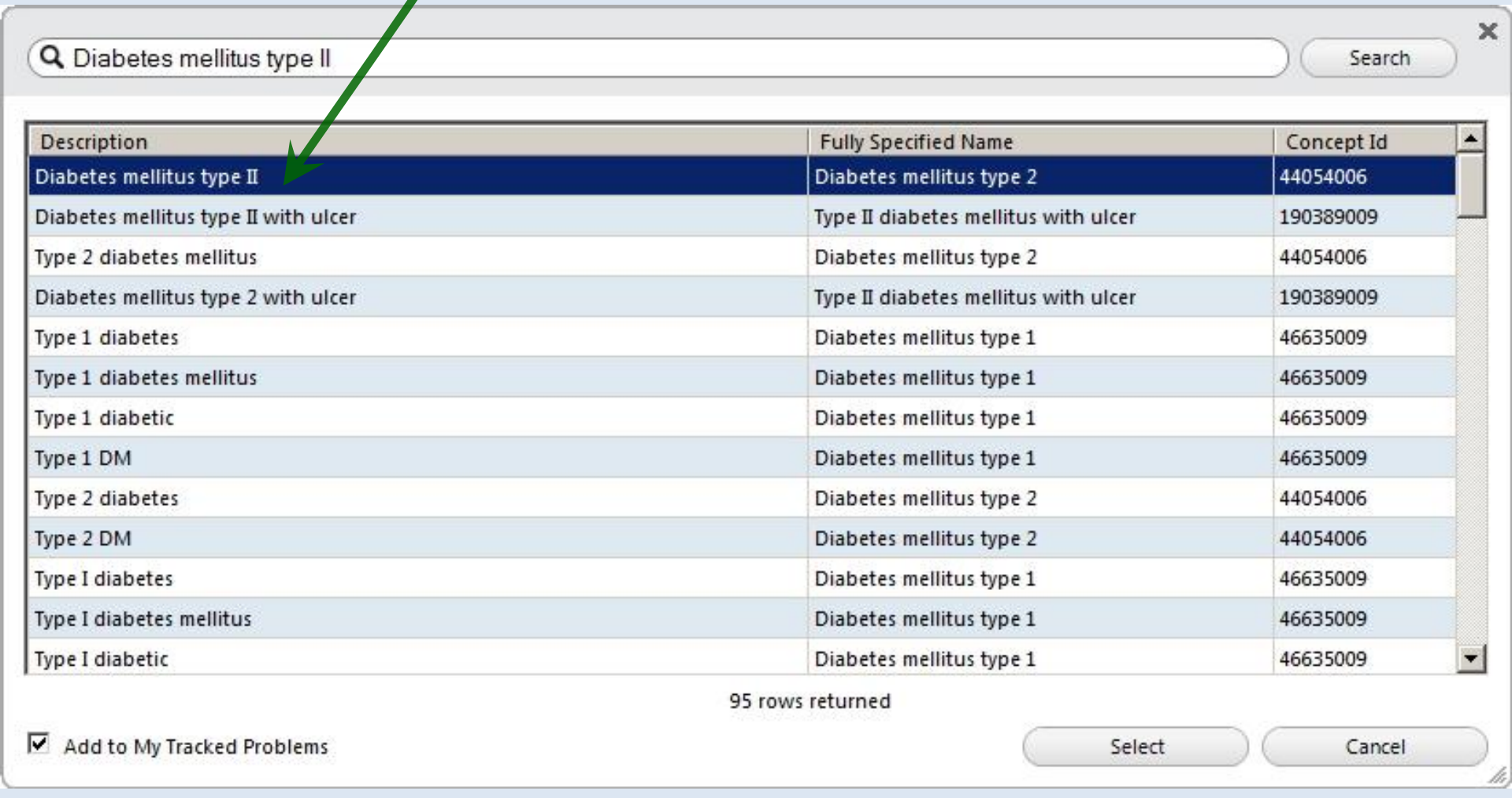
To add a new problem, logically enough, click Add Problem.

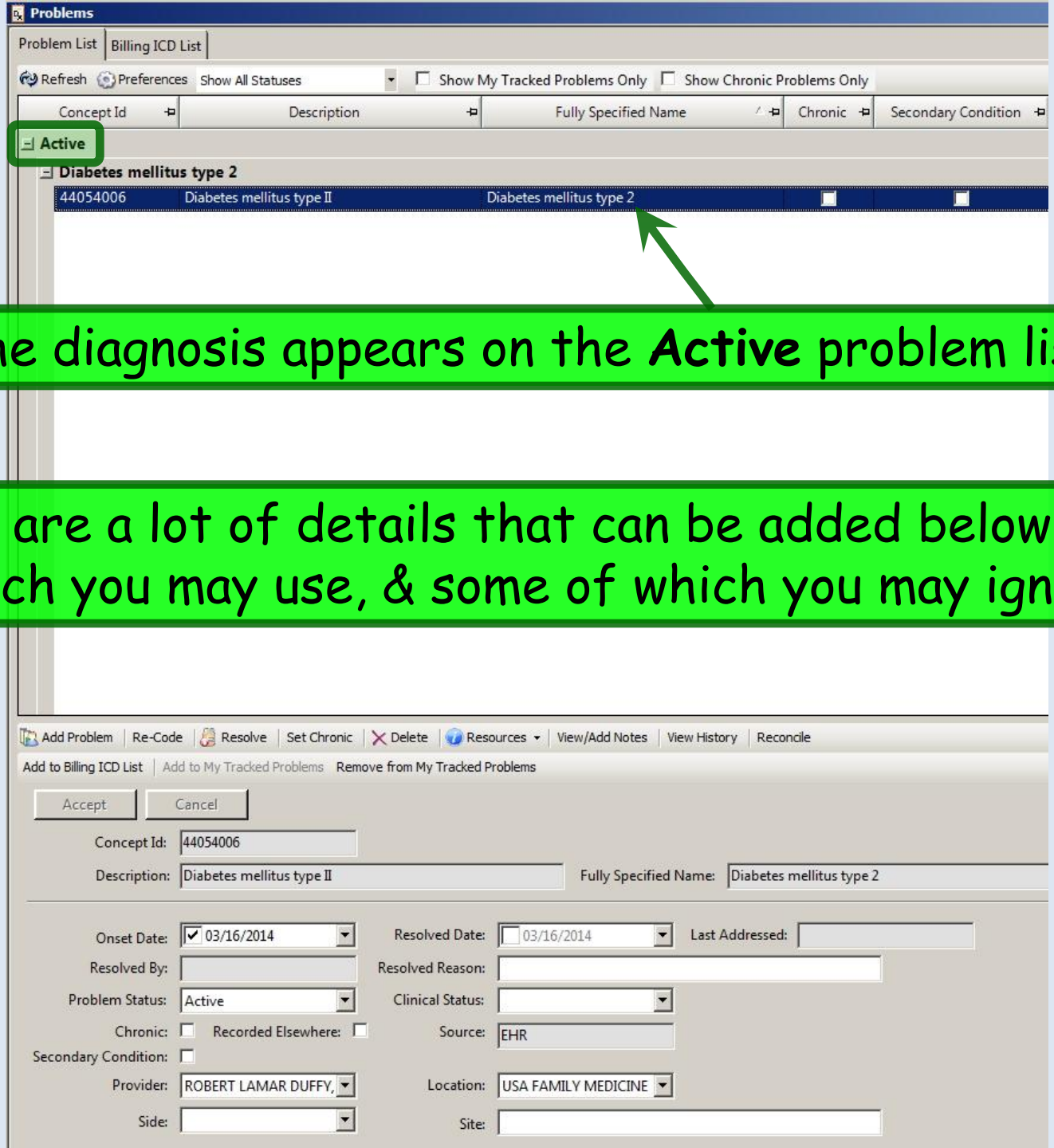
The diagnosis search popup appears. Let's find glaucoma. Click in the search field, type Diabetes mellitus type II, then click Search.

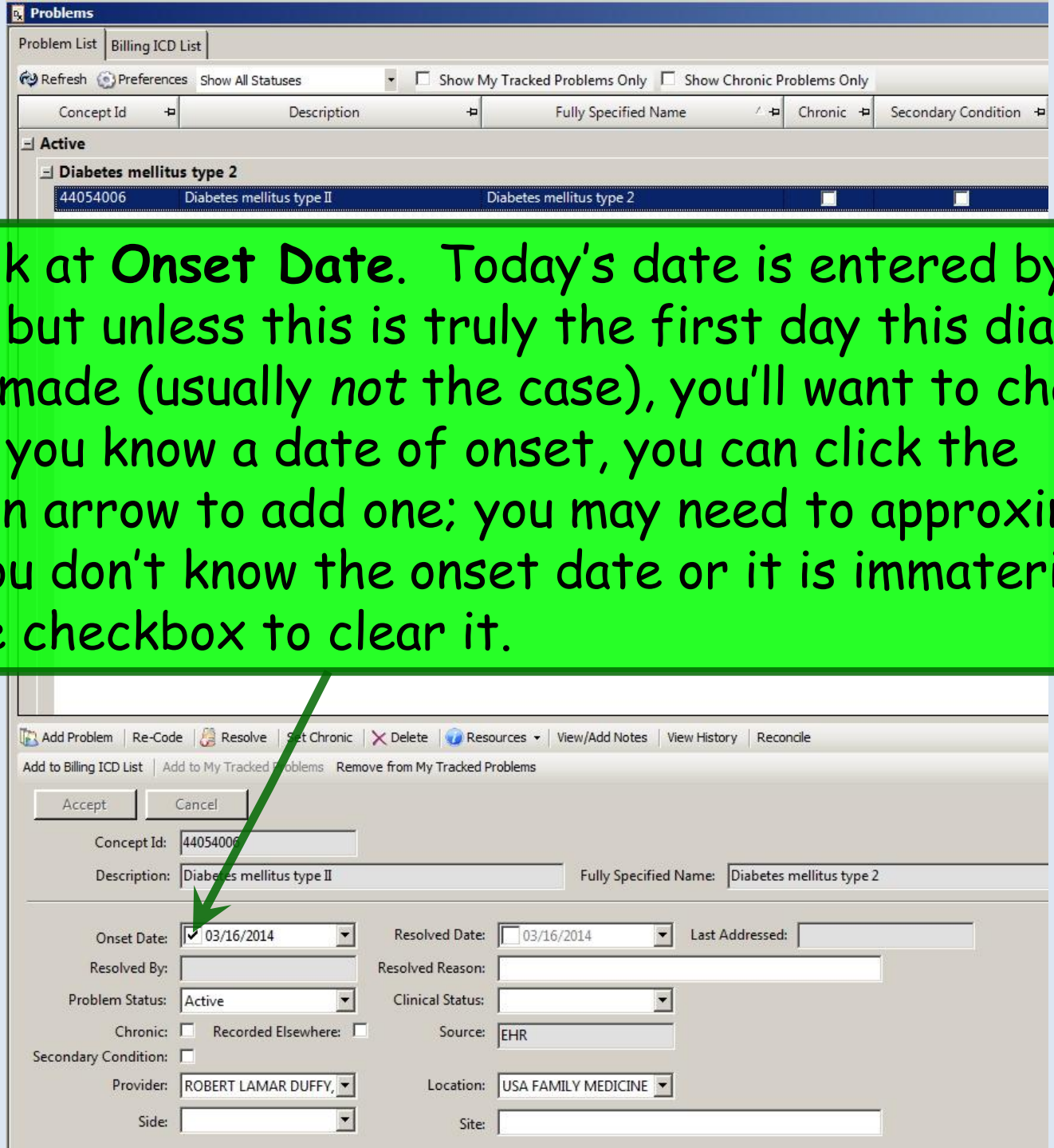



You could actually just type diabetes or some other smaller portion of the term you're looking for; it doesn't even require a complete word. The more you type, the shorter your results list, & the faster it will display. You'll quickly get a feel for how much to type to find your diagnosis without having to scroll through 100 results.

A list of results appears. We'll select Diabetes mellitus type II by double-clicking on it.



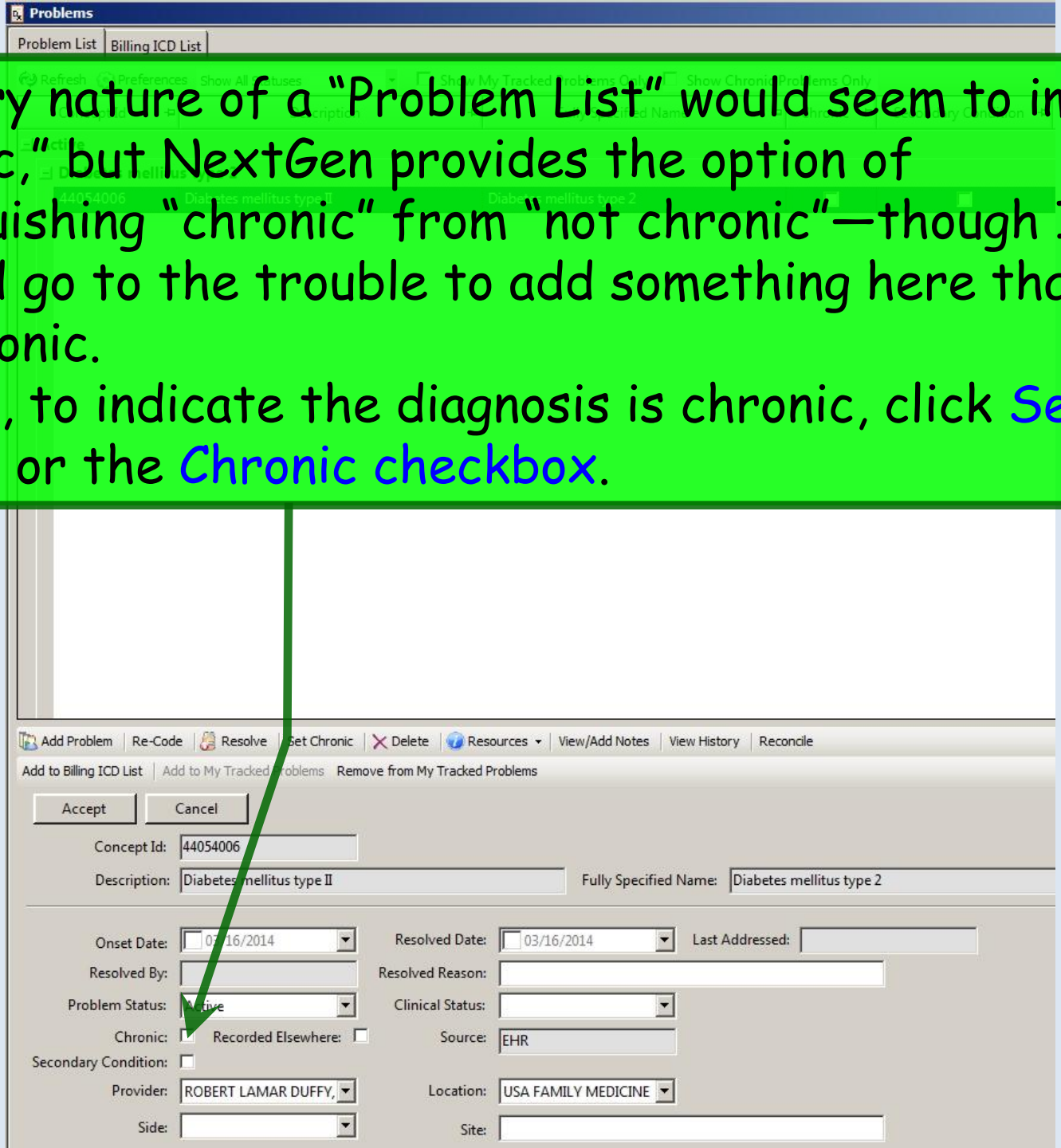

Problems
Problem List
Billing ICD List
Refresh
Preferences
Show All Statuses
Show My Tracked Problems Only
Show Chronic Problems Only
Concept Id
Description
Fully Specified Name
Chronic
Secondary Condition
Active
Diabetes mellitus type 2
44054006
Diabetes mellitus type II
Diabetes mellitus type 2
The diagnosis appears on the Active problem list.
There are a lot of details that can be added below, some of which you may use, & some of which you may ignore.
Add Problem
Re-Code
Resolve
Set Chronic
Delete
Resources
View/Add Notes
View History
Reconcile
Add to Billing ICD List
Add to My Tracked Problems
Remove from My Tracked Problems
Accept
Cancel
Concept Id:
44054006
Description:
Diabetes mellitus type II
Fully Specified Name:
Diabetes mellitus type 2
Onset Date:
03/16/2014
Resolved Date:
03/16/2014
Last Addressed:
Resolved By:
Resolved Reason:
Problem Status:
Active
Clinical Status:
Chronic:
Recorded Elsewhere:
Source:
EHR
Secondary Condition:
Provider:
ROBERT LAMAR DUFFY,
Location:
USA FAMILY MEDICINE
Side:
Site:

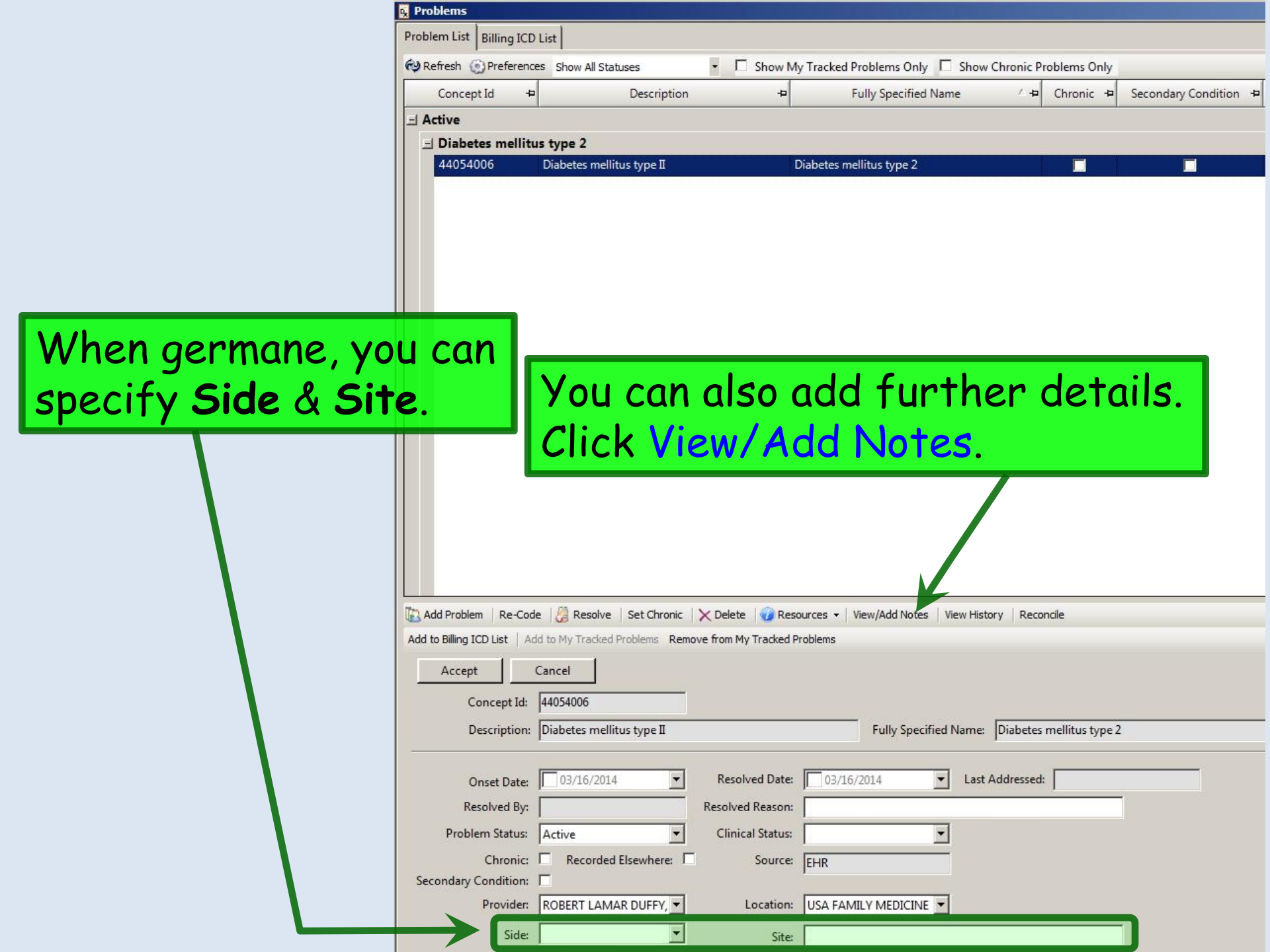


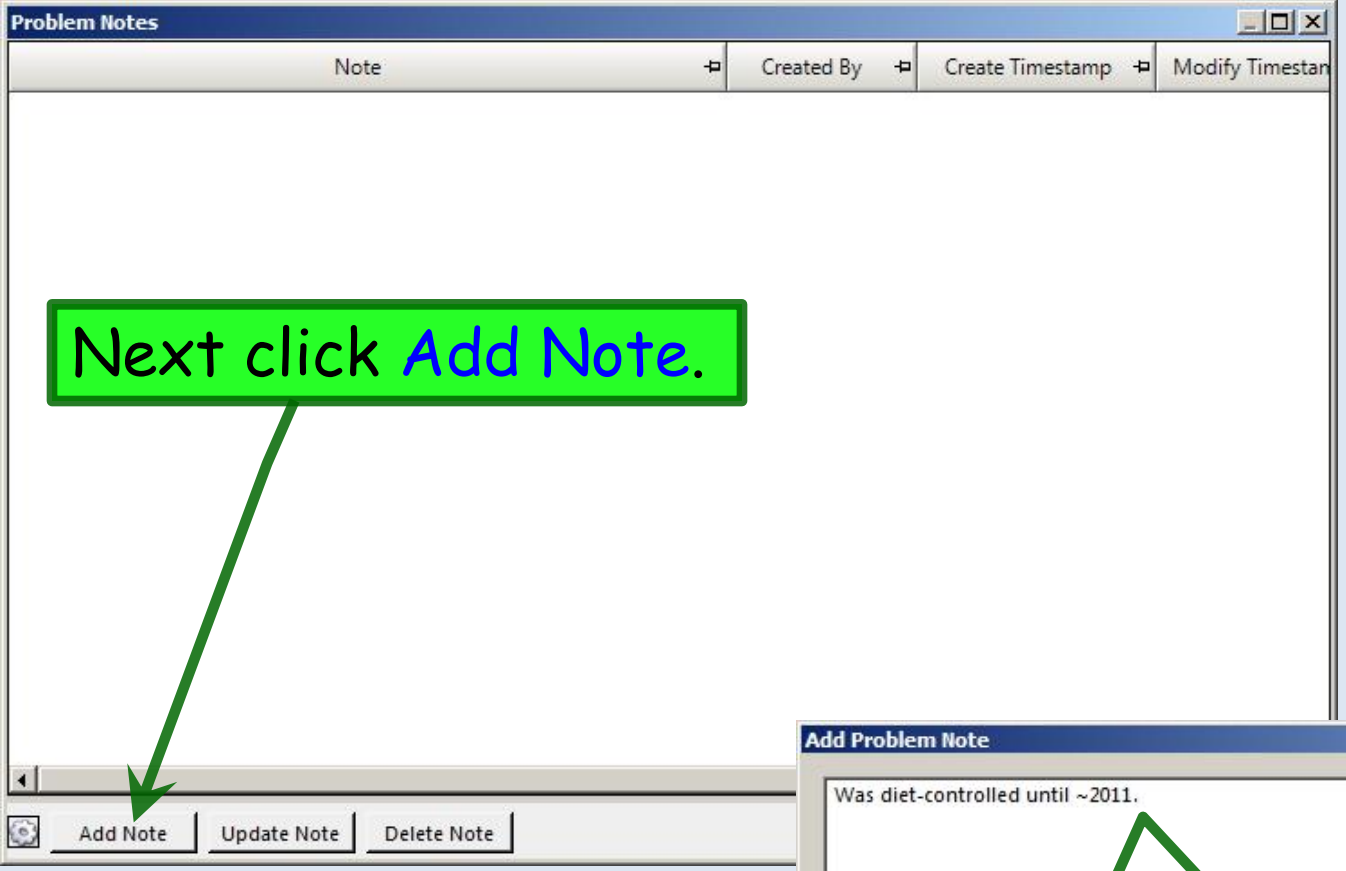

First look at **Onset Date**. Today's date is entered by default, but unless this is truly the first day this diagnosis is being made (usually *not* the case), you'll want to change this. If you know a date of onset, you can click the dropdown arrow to add one; you may need to approximate. But if you don't know the onset date or it is immaterial, just click the checkbox to clear it.

The very nature of a "Problem List" would seem to imply "chronic," but NextGen provides the option of distinguishing "chronic" from "not chronic"—though I'm not sure I'd go to the trouble to add something here that is not chronic.

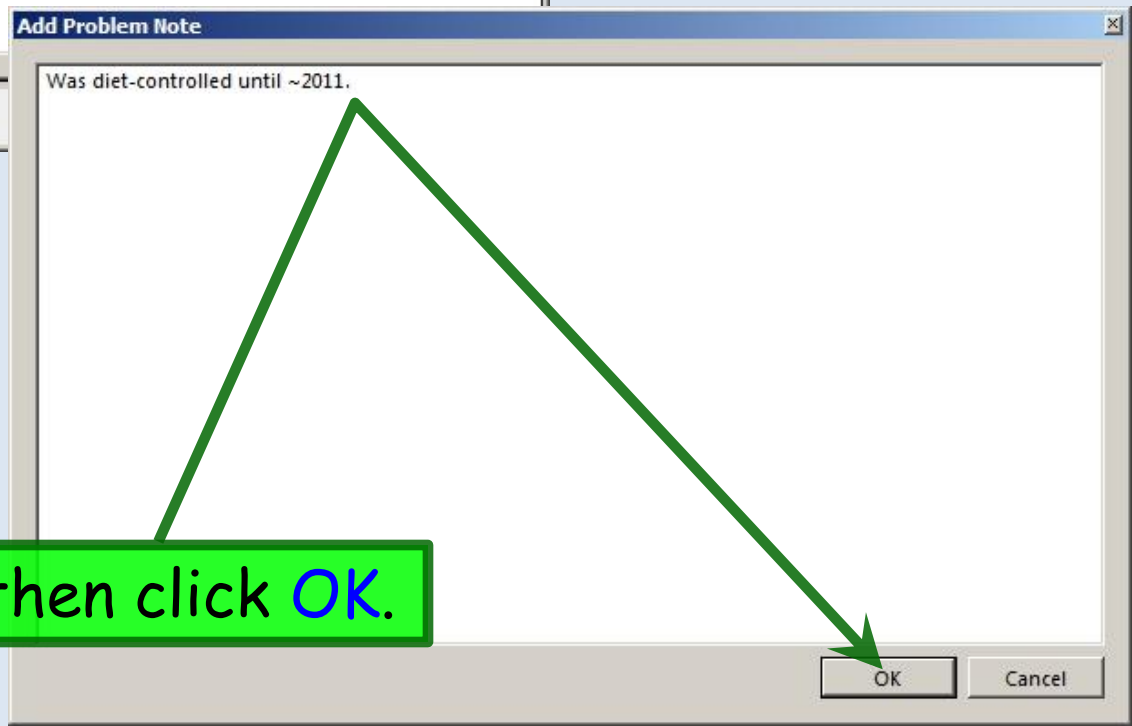
Anyway, to indicate the diagnosis is chronic, click Set Chronic or the Chronic checkbox.



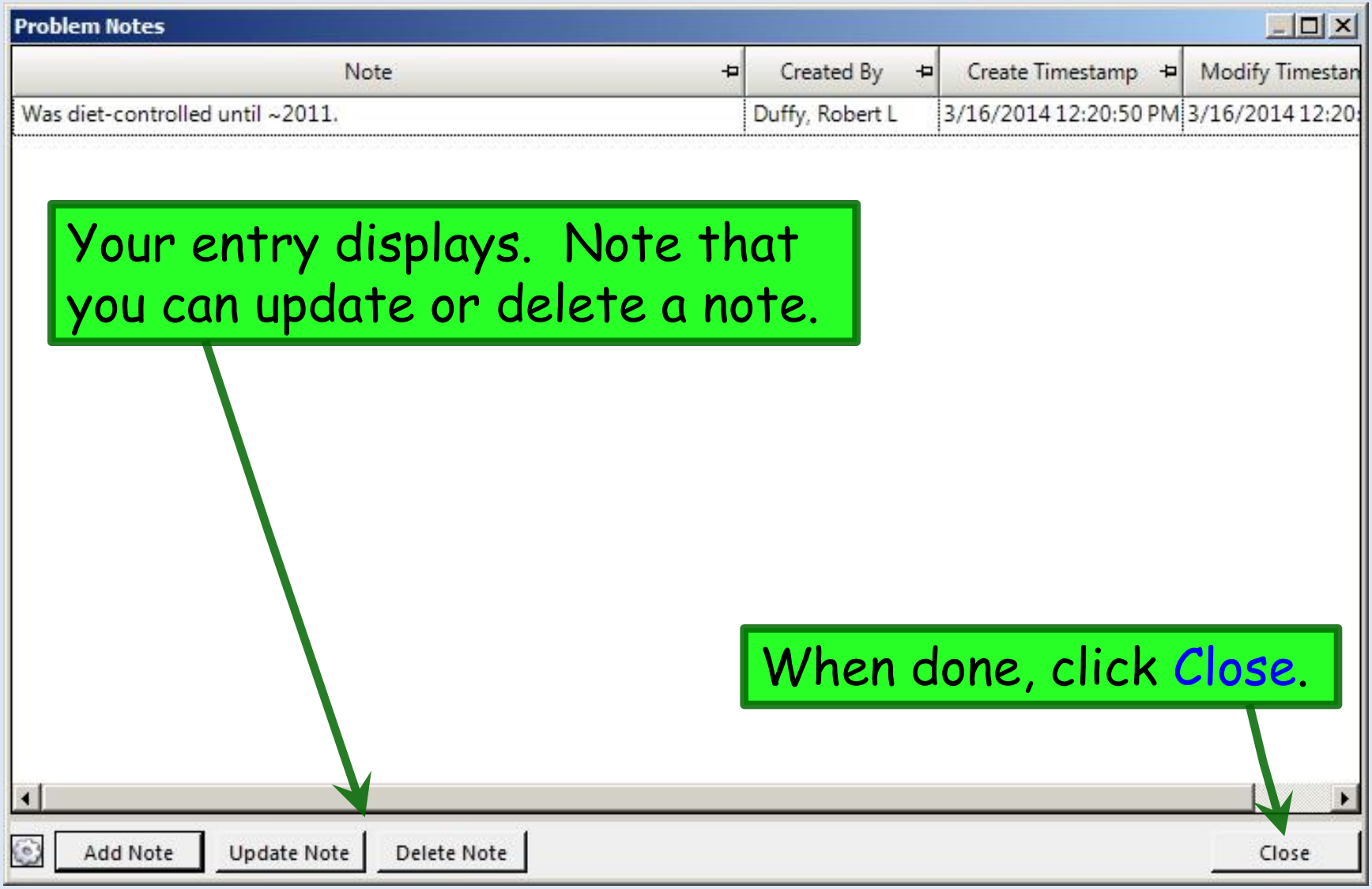

When germane, you can specify **Side** & **Site**.
You can also add further details. Click View/Add Notes.
Problems
Problem List
Billing ICD List
Refresh
Preferences
Show All Statuses
Show My Tracked Problems Only
Show Chronic Problems Only
Concept Id
Description
Fully Specified Name
Chronic
Secondary Condition
Active
Diabetes mellitus type 2
44054006
Diabetes mellitus type II
Diabetes mellitus type 2
Add Problem
Re-Code
Resolve
Set Chronic
Delete
Resources
View/Add Notes
View History
Reconcile
Add to Billing ICD List
Add to My Tracked Problems
Remove from My Tracked Problems
Accept
Cancel
Concept Id:
44054006
Description:
Diabetes mellitus type II
Fully Specified Name:
Diabetes mellitus type 2
Onset Date:
03/16/2014
Resolved Date:
03/16/2014
Last Addressed:
Resolved By:
Resolved Reason:
Problem Status:
Active
Clinical Status:
Chronic:
Recorded Elsewhere:
Source:
EHR
Secondary Condition:
Provider:
ROBERT LAMAR DUFFY,
Location:
USA FAMILY MEDICINE
Side:
Site:

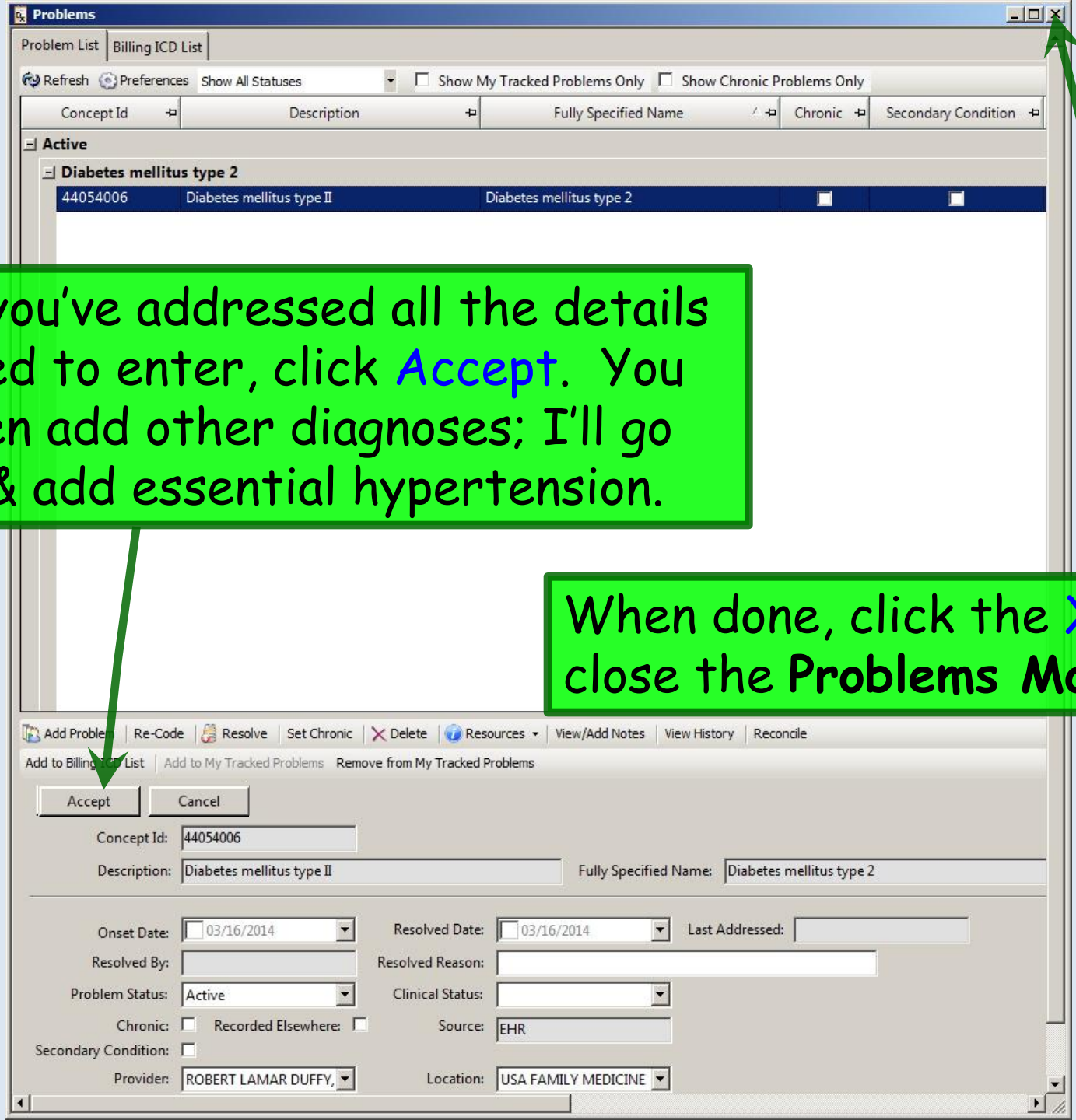



Next click Add Note.



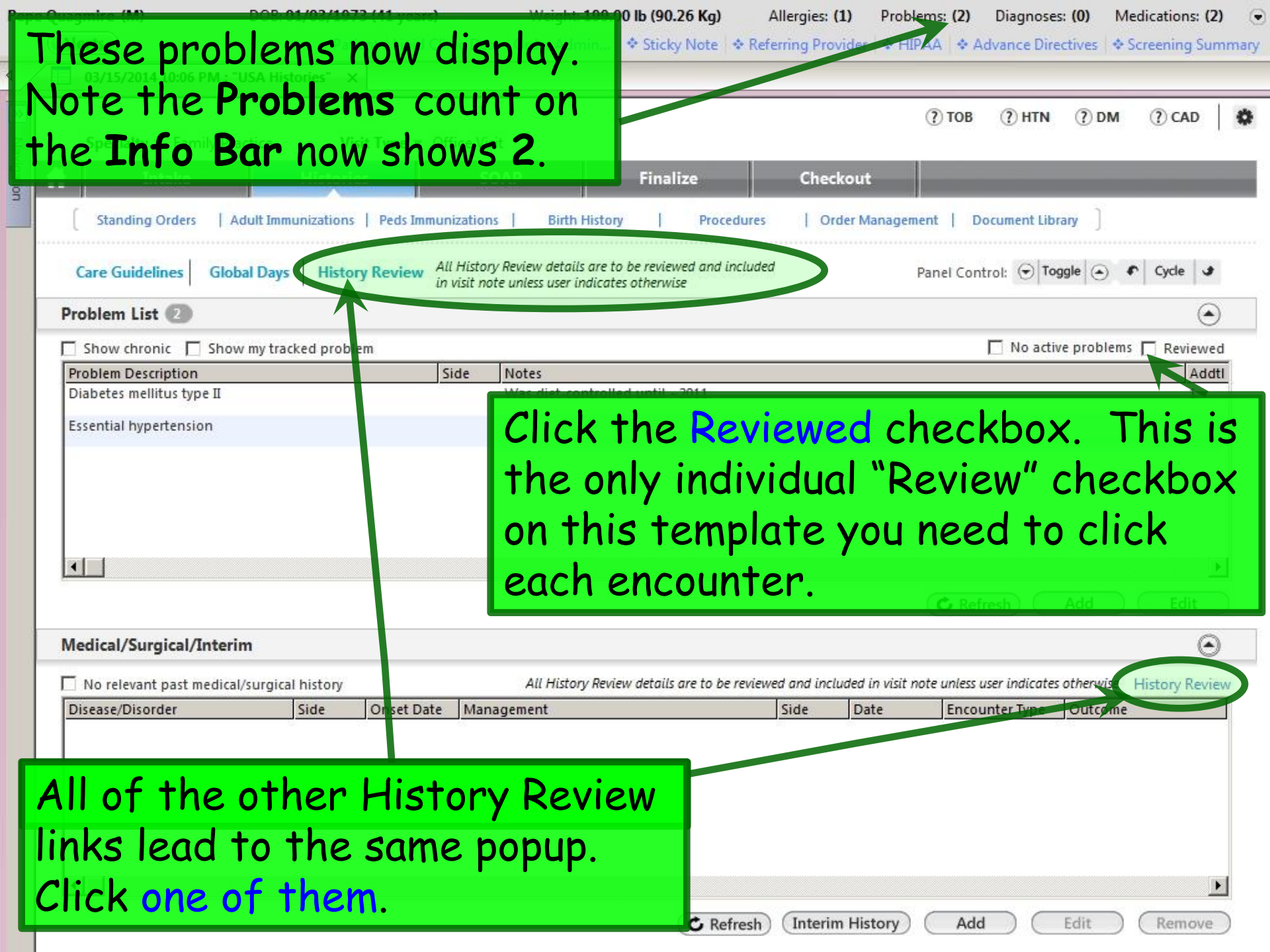

Type your entry, then click OK.

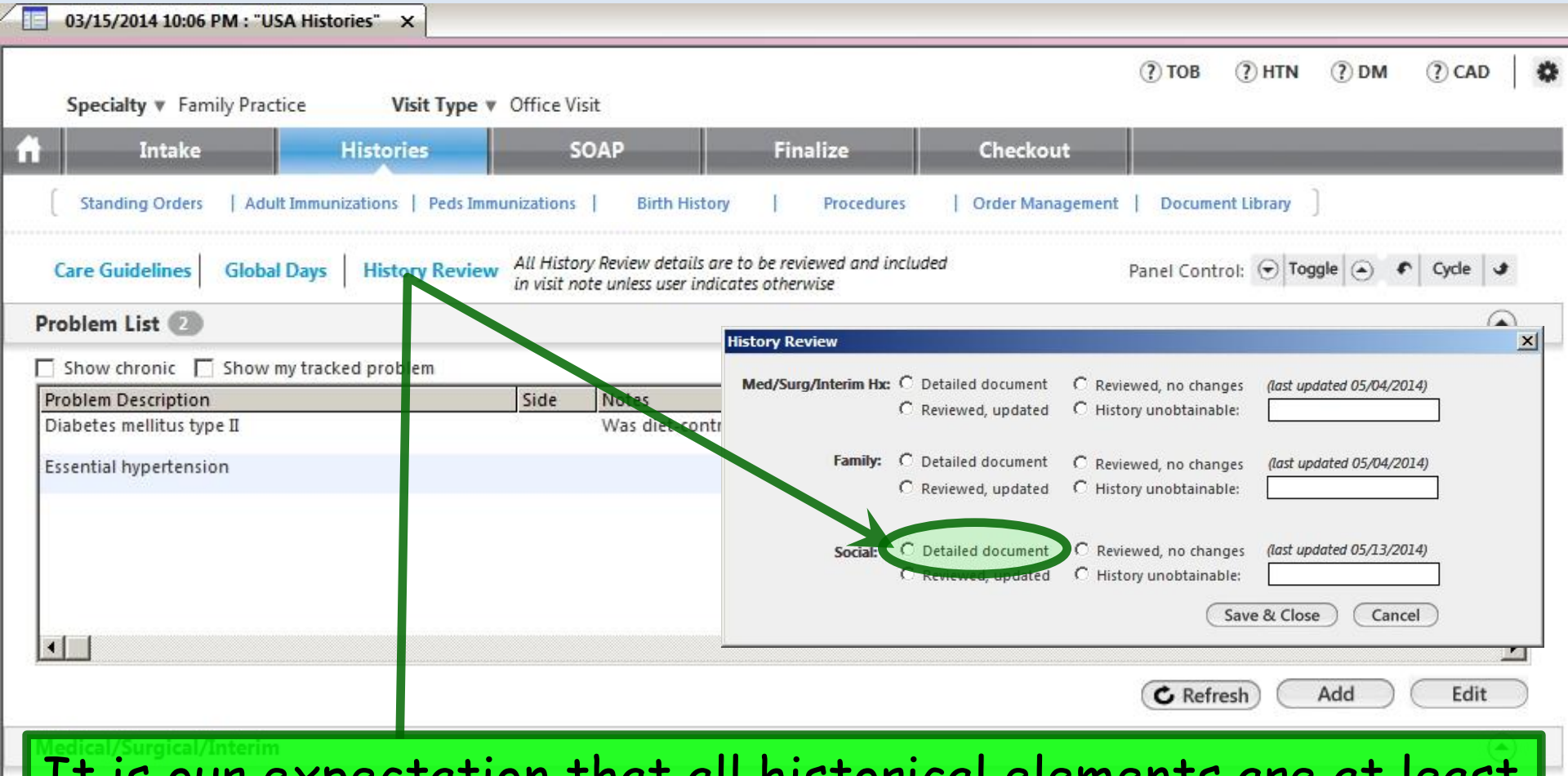

Problem Notes
Note
Created By
Create Timestamp
Modify Timestan
Was diet-controlled until ~2011.
Duffy, Robert L
3/16/2014 12:20:50 PM
3/16/2014 12:20
Your entry displays. Note that you can update or delete a note.
When done, click Close.
Add Note
Update Note
Delete Note
Close




When you've addressed all the details you need to enter, click Accept. You can then add other diagnoses; I'll go ahead & add essential hypertension.

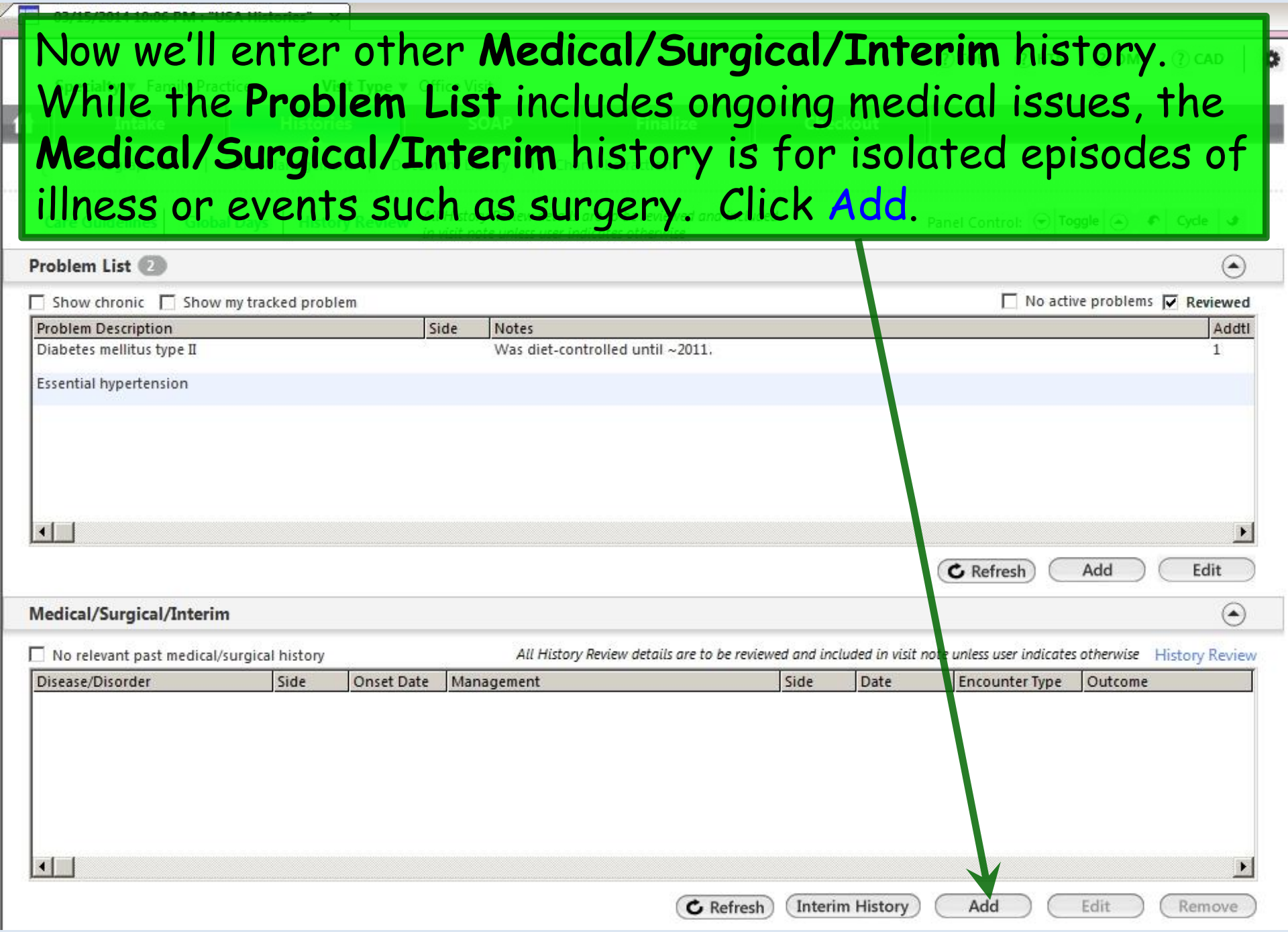
When done, click the X to close the **Problems Module**.

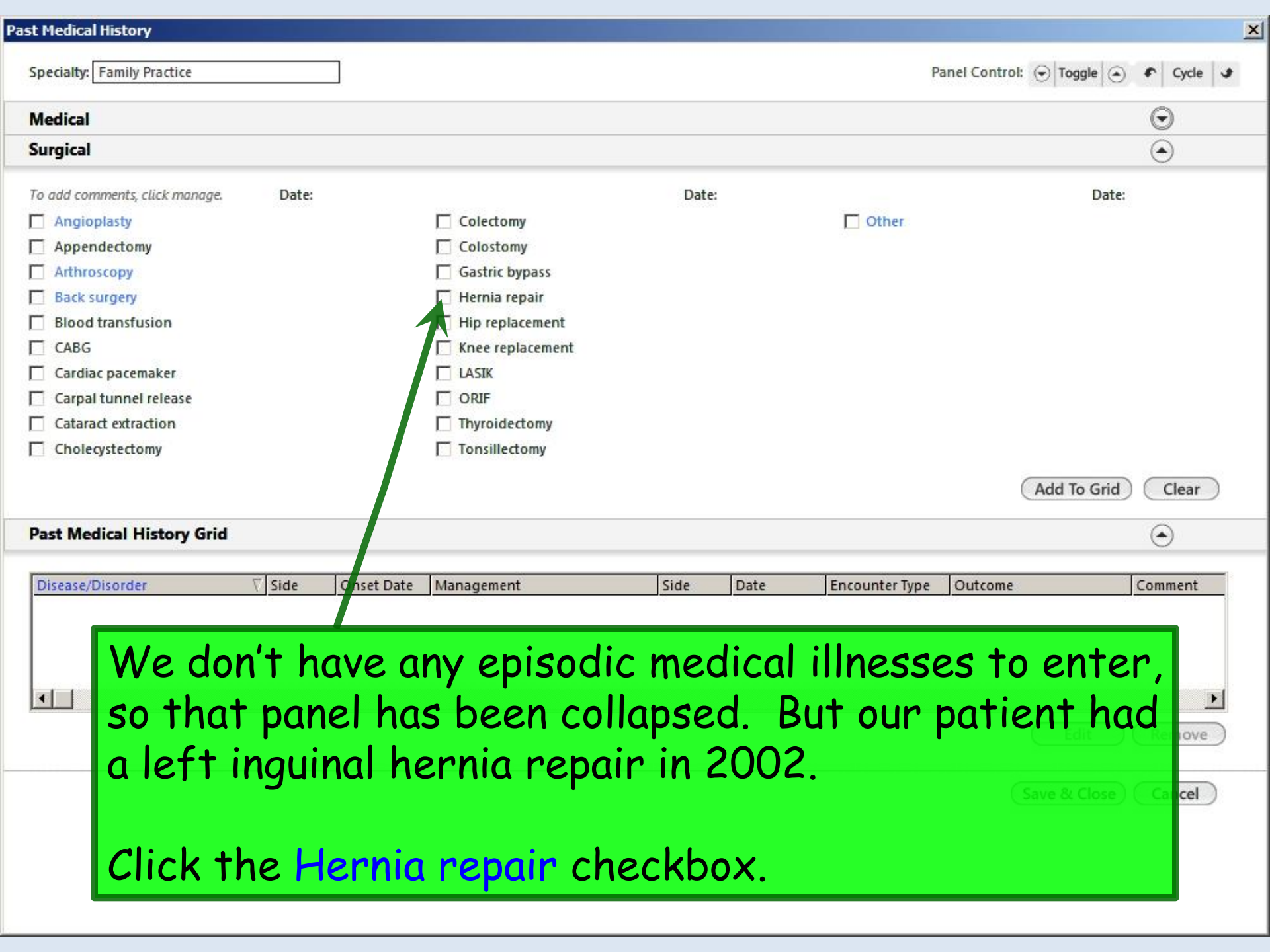

These problems now display. Note the Problems count on the Info Bar now shows 2.
Allergies: (1)
Problems: (2)
Diagnoses: (0)
Medications: (2)
Sticky Note
Referring Provider
HIPAA
Advance Directives
Screening Summary
TOB
HTN
DM
CAD
Finalize
Checkout
Standing Orders
Adult Immunizations
Peds Immunizations
Birth History
Procedures
Order Management
Document Library
Care Guidelines
Global Days
History Review
All History Review details are to be reviewed and included in visit note unless user indicates otherwise
Panel Control:
Toggle
Cycle
Problem List 2
Show chronic
Show my tracked problem
No active problems
Reviewed
Problem Description
Side
Notes
Addtl
Diabetes mellitus type II
Essential hypertension
Click the Reviewed checkbox. This is the only individual "Review" checkbox on this template you need to click each encounter.
Refresh
Add
Edit
Medical/Surgical/Interim
No relevant past medical/surgical history
All History Review details are to be reviewed and included in visit note unless user indicates otherwise
History Review
Disease/Disorder
Side
Onset Date
Management
Side
Date
Encounter Type
Outcome
All of the other History Review links lead to the same popup. Click one of them.
Refresh
Interim History
Add
Edit
Remove

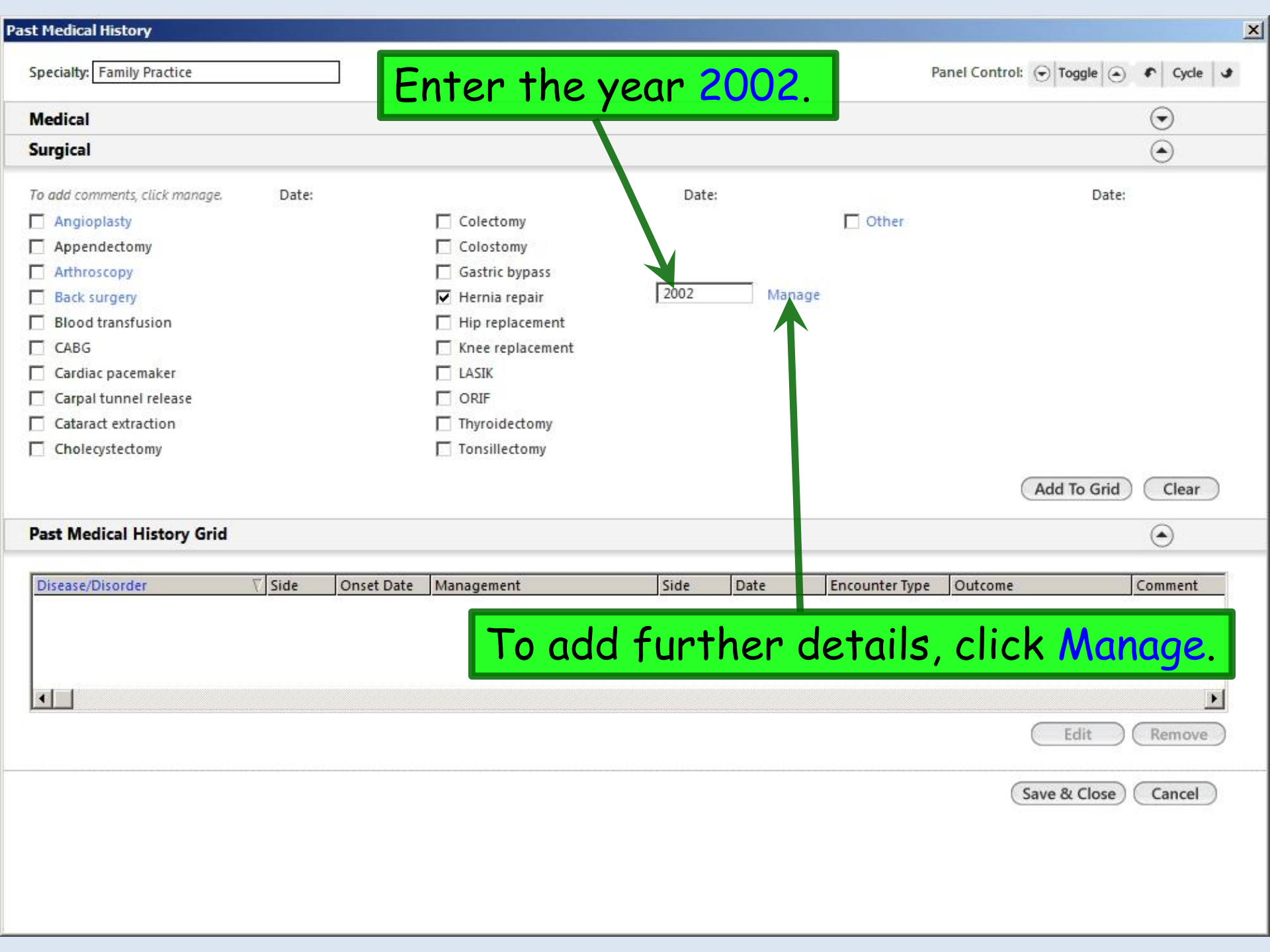


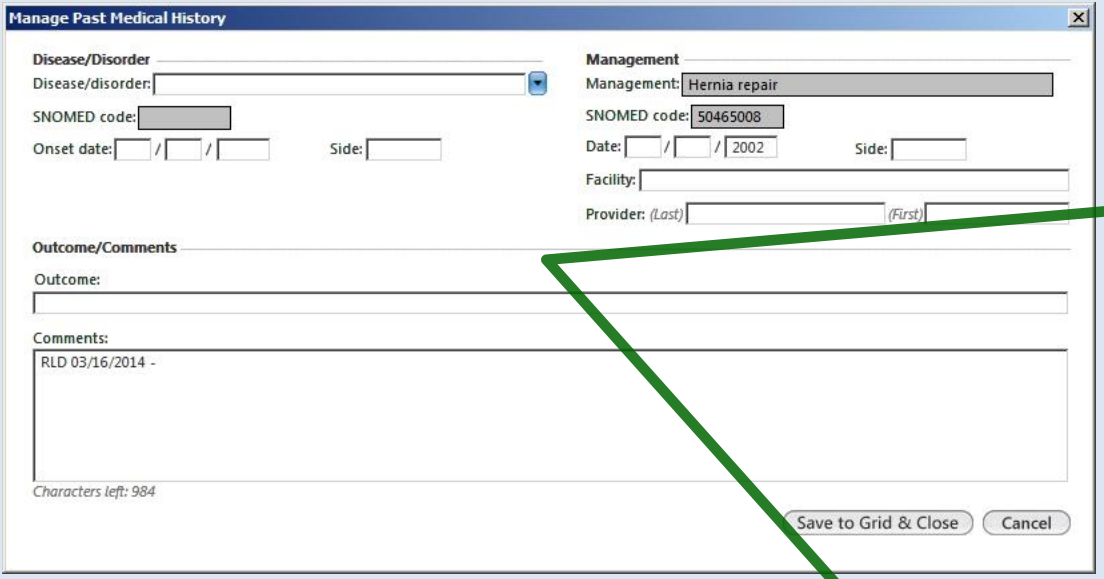

It is our expectation that all historical elements are at least briefly reviewed at every encounter, so most of these details appear in our notes by default anyway. However, only *basic* Social History details are defaulted into our notes, so if you've added a lot of other details, you need to specifically select Detailed document for Social History.

Now we'll enter other **Medical/Surgical/Interim** history. While the **Problem List** includes ongoing medical issues, the **Medical/Surgical/Interim** history is for isolated episodes of illness or events such as surgery. Click Add.

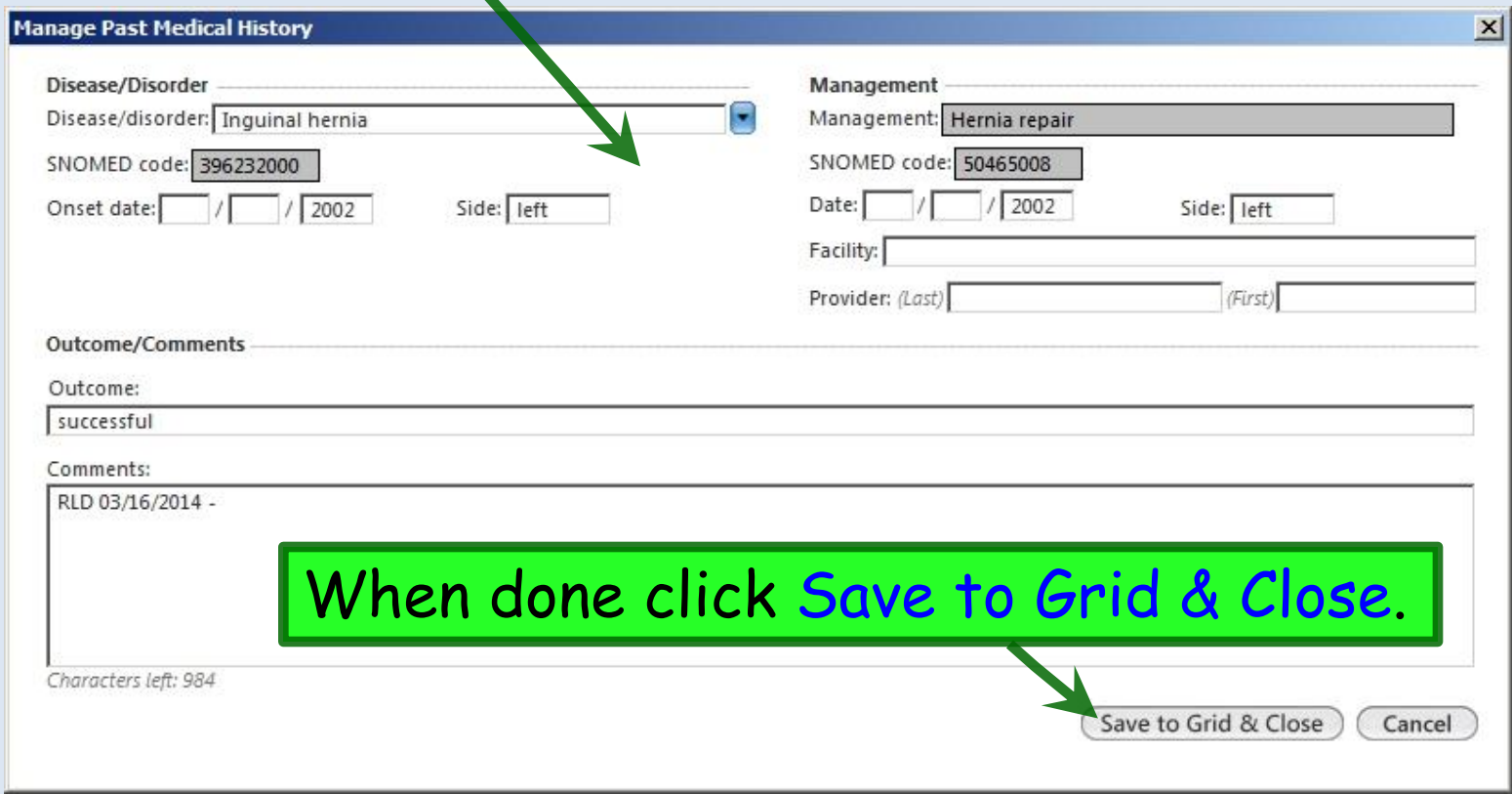



Past Medical History
Specialty: Family Practice
Panel Control: Toggle Cycle
Medical
Surgical
To add comments, click manage.
Date:
Date:
Date:
Angioplasty
Appendectomy
Arthroscopy
Back surgery
Blood transfusion
CABG
Cardiac pacemaker
Carpal tunnel release
Cataract extraction
Cholecystectomy
Colectomy
Colostomy
Gastric bypass
Hernia repair
Hip replacement
Knee replacement
LASIK
ORIF
Thyroidectomy
Tonsillectomy
Other
Add To Grid
Clear
Past Medical History Grid
Disease/Disorder
Side
Onset Date
Management
Side
Date
Encounter Type
Outcome
Comment
We don't have any episodic medical illnesses to enter, so that panel has been collapsed. But our patient had a left inguinal hernia repair in 2002.
Click the Hernia repair checkbox.

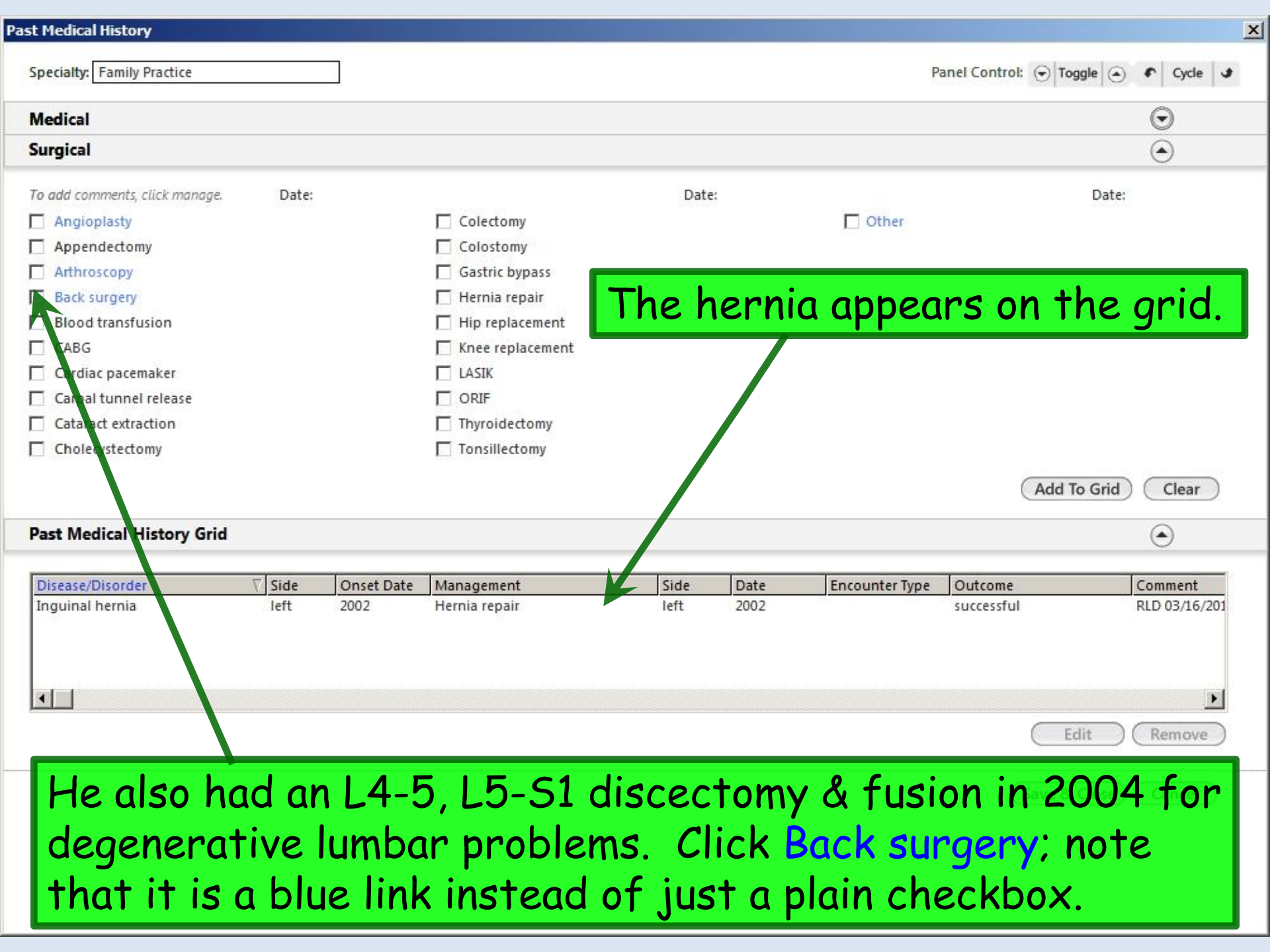

Past Medical History
Specialty: Family Practice
Enter the year 2002.
Panel Control: Toggle Cycle
Medical
Surgical
To add comments, click manage.
Date:
Date:
Date:
Angioplasty
Appendectomy
Arthroscopy
Back surgery
Blood transfusion
CABG
Cardiac pacemaker
Carpal tunnel release
Cataract extraction
Cholecystectomy
Colectomy
Colostomy
Gastric bypass
Hernia repair
Hip replacement
Knee replacement
LASIK
ORIF
Thyroidectomy
Tonsillectomy
Other
2002
Manage
Add To Grid
Clear
Past Medical History Grid
Disease/Disorder
Side
Onset Date
Management
Side
Date
Encounter Type
Outcome
Comment
To add further details, click Manage.
Edit
Remove
Save & Close
Cancel



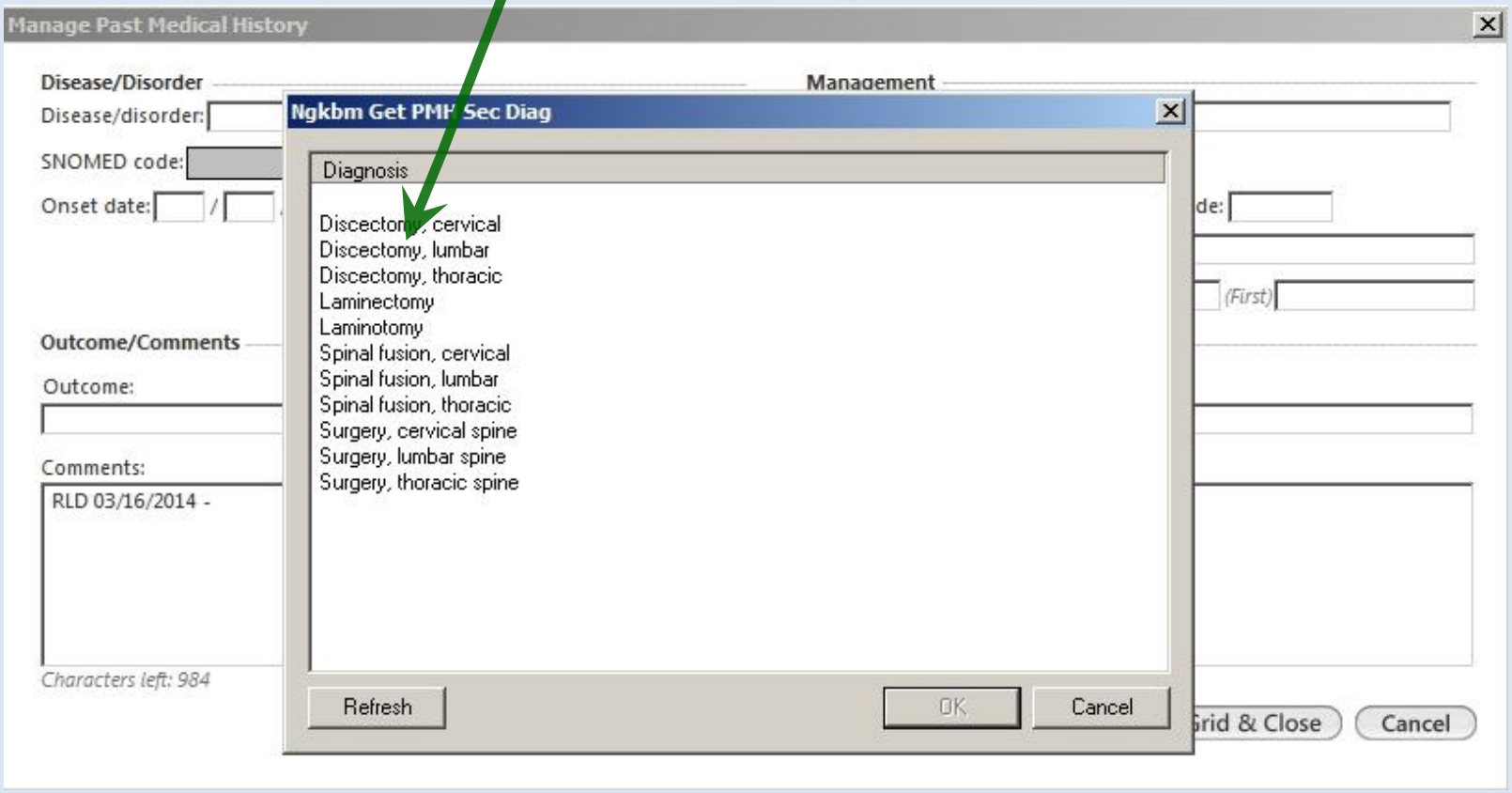

A popup appears that allows you to associate a disease/medical problem with the surgery, along with other details, as you see demonstrated.



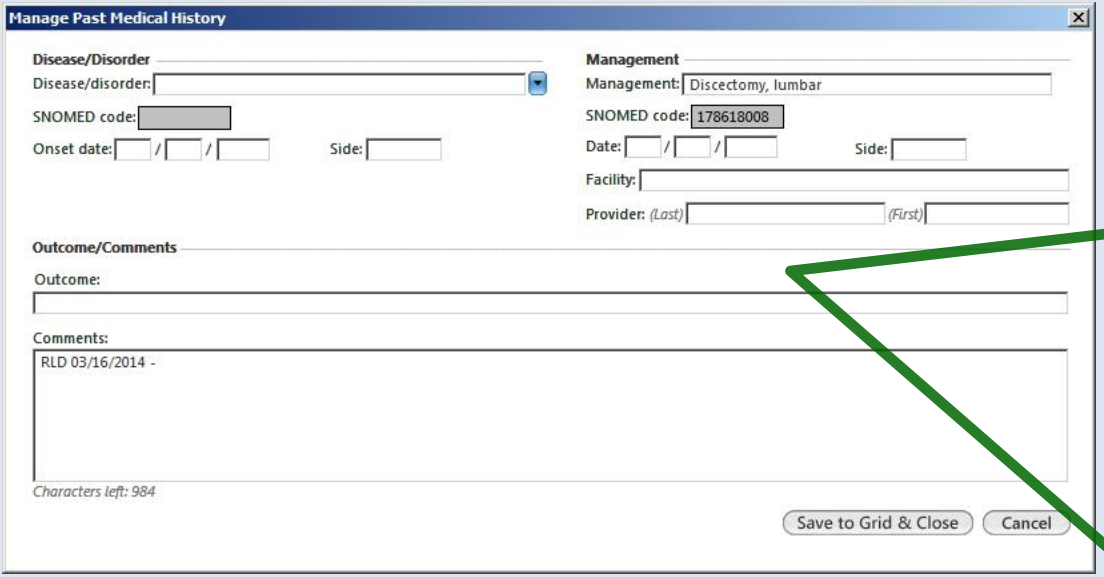

When done click Save to Grid & Close.


Past Medical History
Specialty: Family Practice
Panel Control: Toggle Cycle
Medical
Surgical
To add comments, click manage.
Date:
Date:
Date:
Angioplasty
Appendectomy
Arthroscopy
Back surgery
Blood transfusion
CABG
Cardiac pacemaker
Carpal tunnel release
Cataract extraction
Cholecystectomy
Colectomy
Colostomy
Gastric bypass
Hernia repair
Hip replacement
Knee replacement
LASIK
ORIF
Thyroidectomy
Tonsillectomy
Other
Add To Grid
Clear
Past Medical History Grid
Disease/Disorder
Side
Onset Date
Management
Side
Date
Encounter Type
Outcome
Comment
Inguinal hernia
left
2002
Hernia repair
left
2002
successful
RLD 03/16/201
Edit
Remove
The hernia appears on the grid.
He also had an L4-5, L5-S1 discectomy & fusion in 2004 for degenerative lumbar problems. Click Back surgery; note that it is a blue link instead of just a plain checkbox.

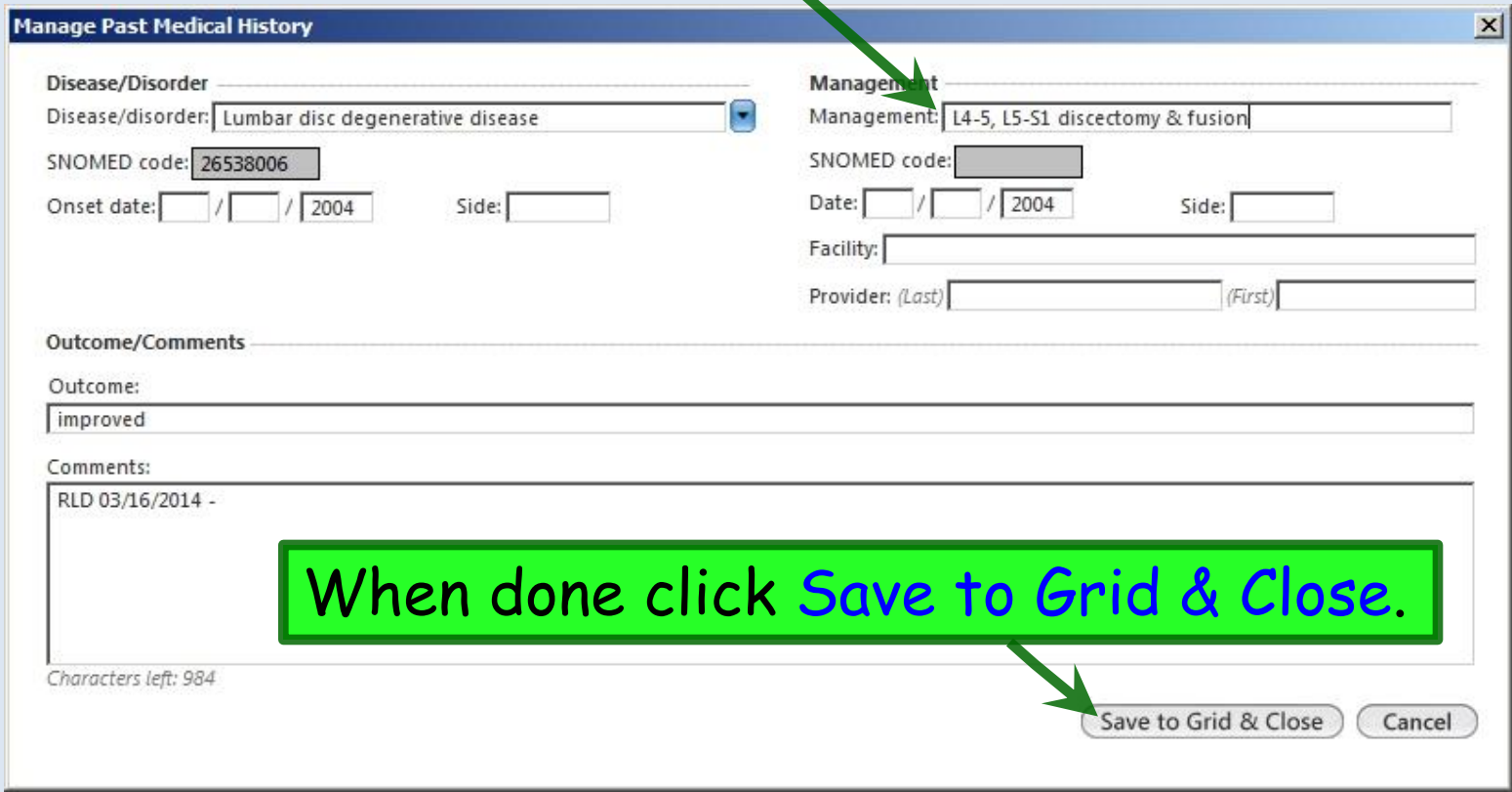
Here you see a short picklist of spinal procedures. More than one may be appropriate. Pick the best match; here we'll double-click Discectomy, lumbar.



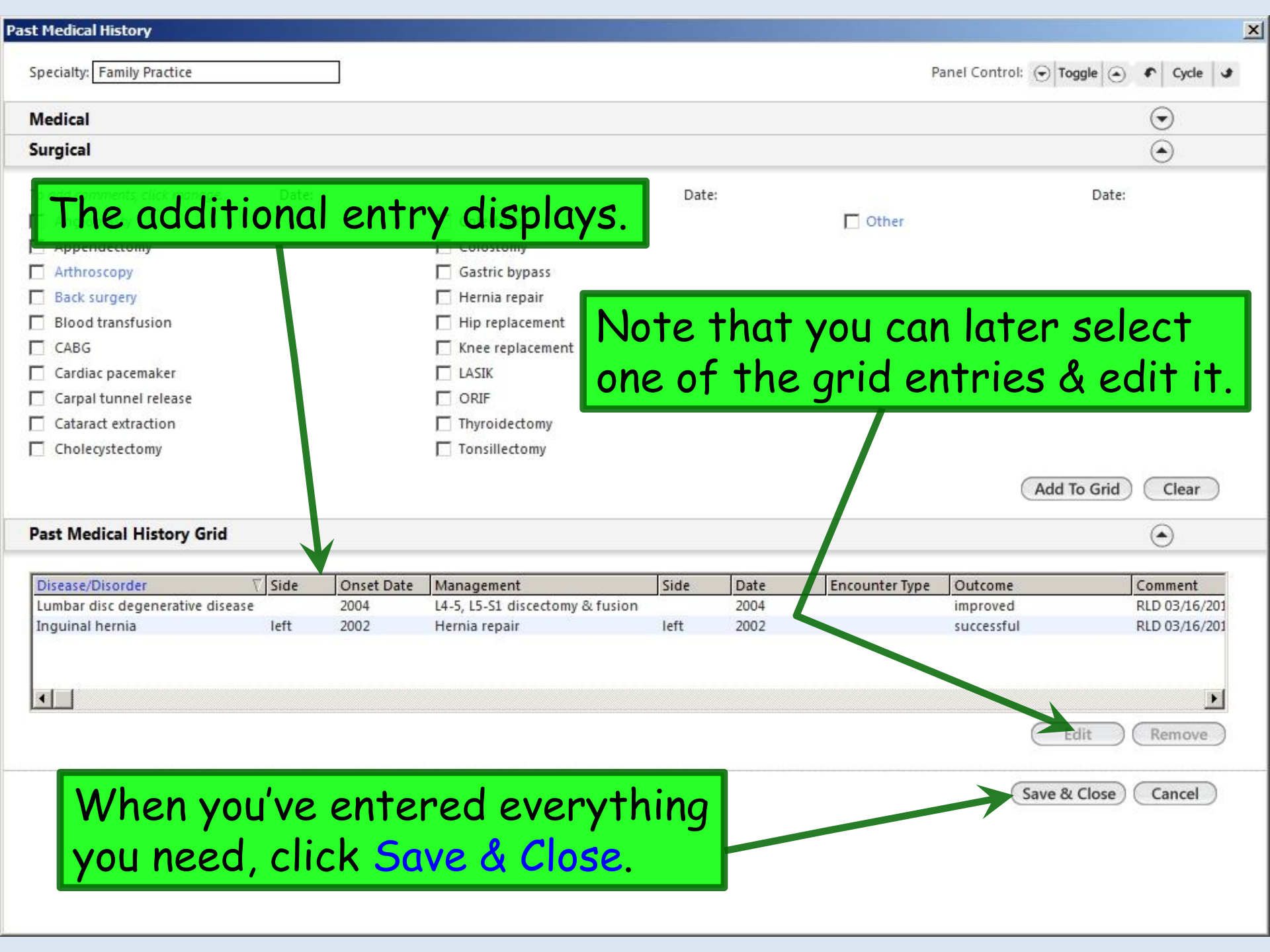

If there is just *nothing* here you can use, you can cancel out of this & type an entry.

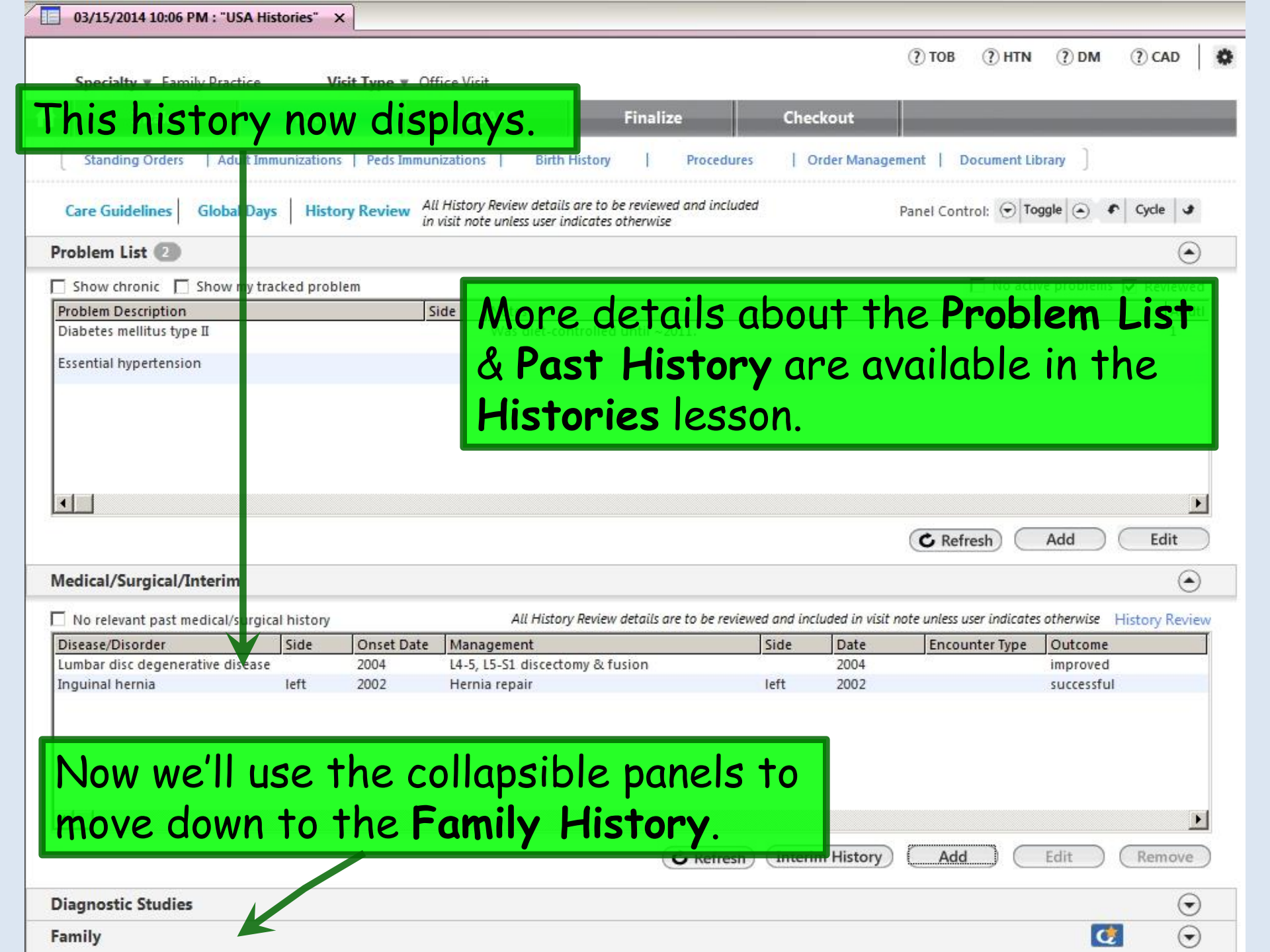


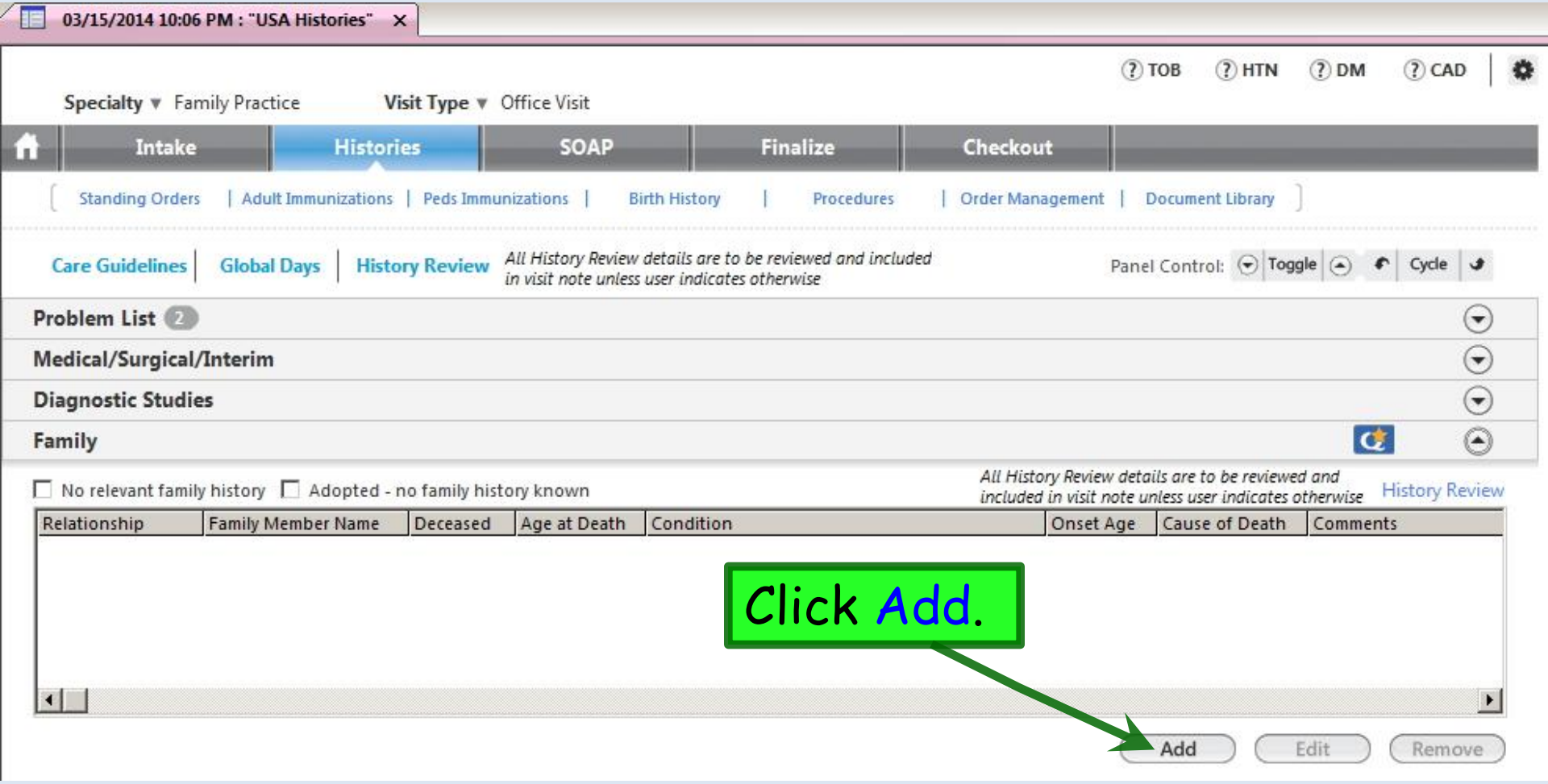

As before, a popup allows you to enter details; note that I've expanded upon the management details.

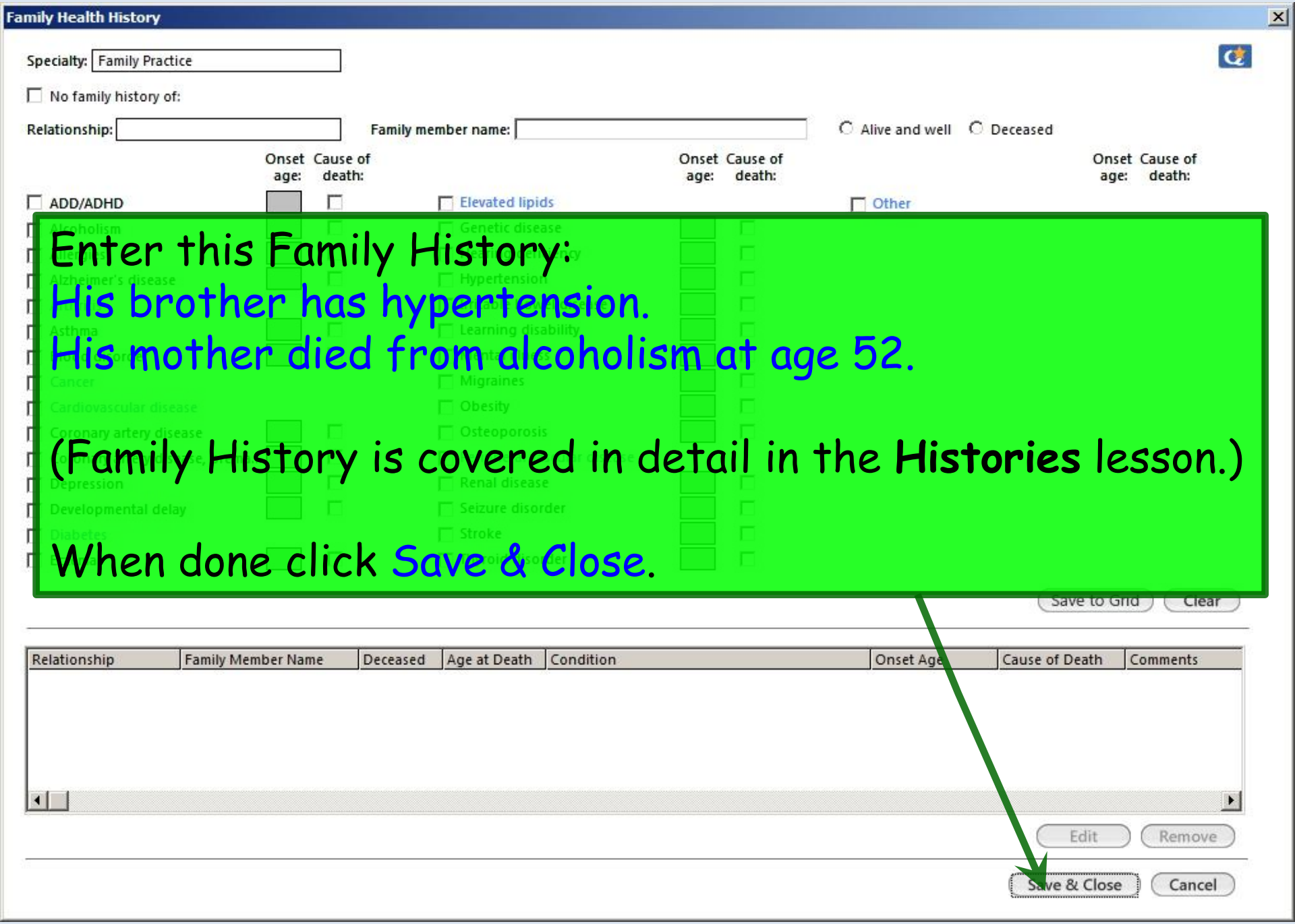


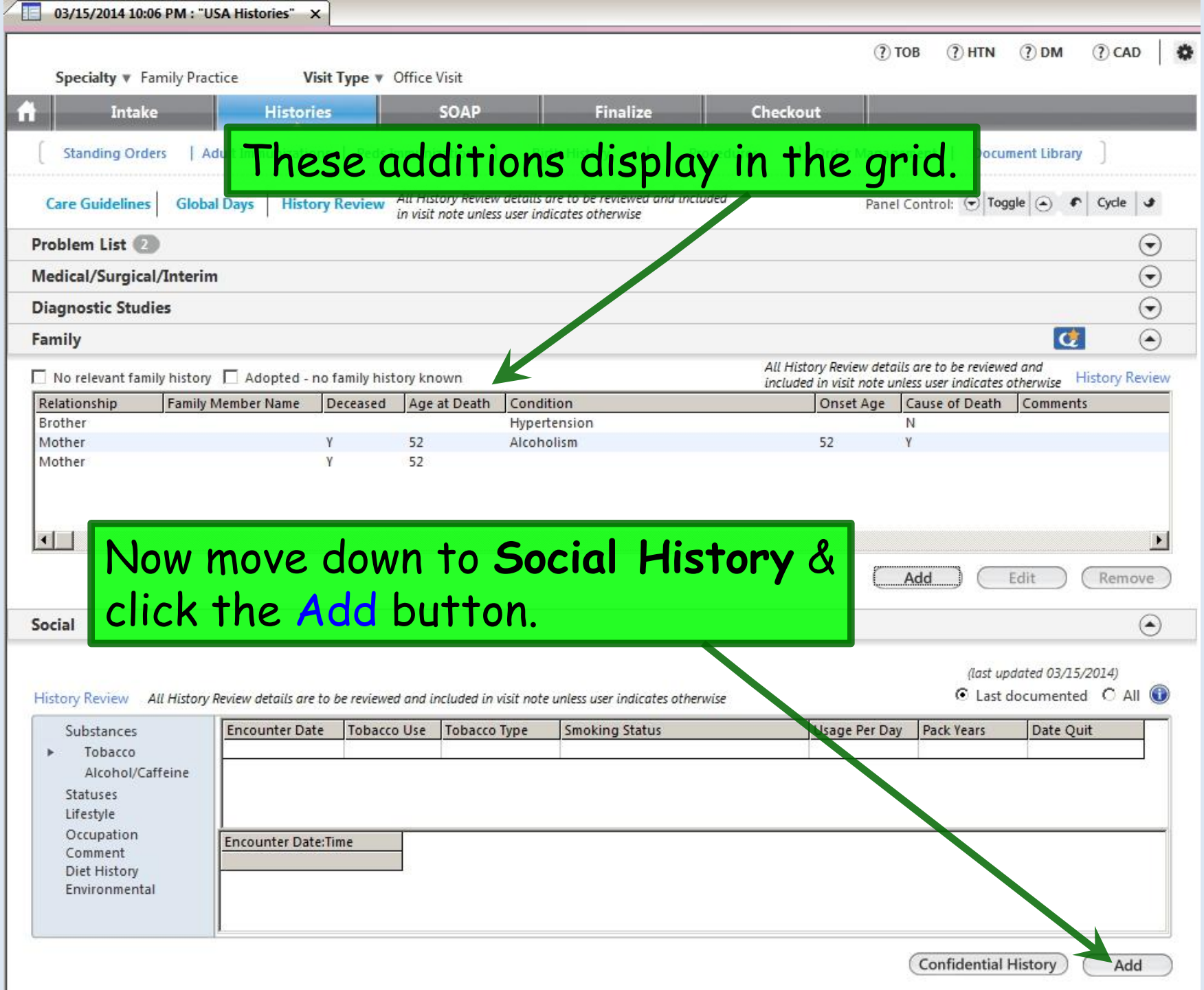

When done click Save to Grid & Close.

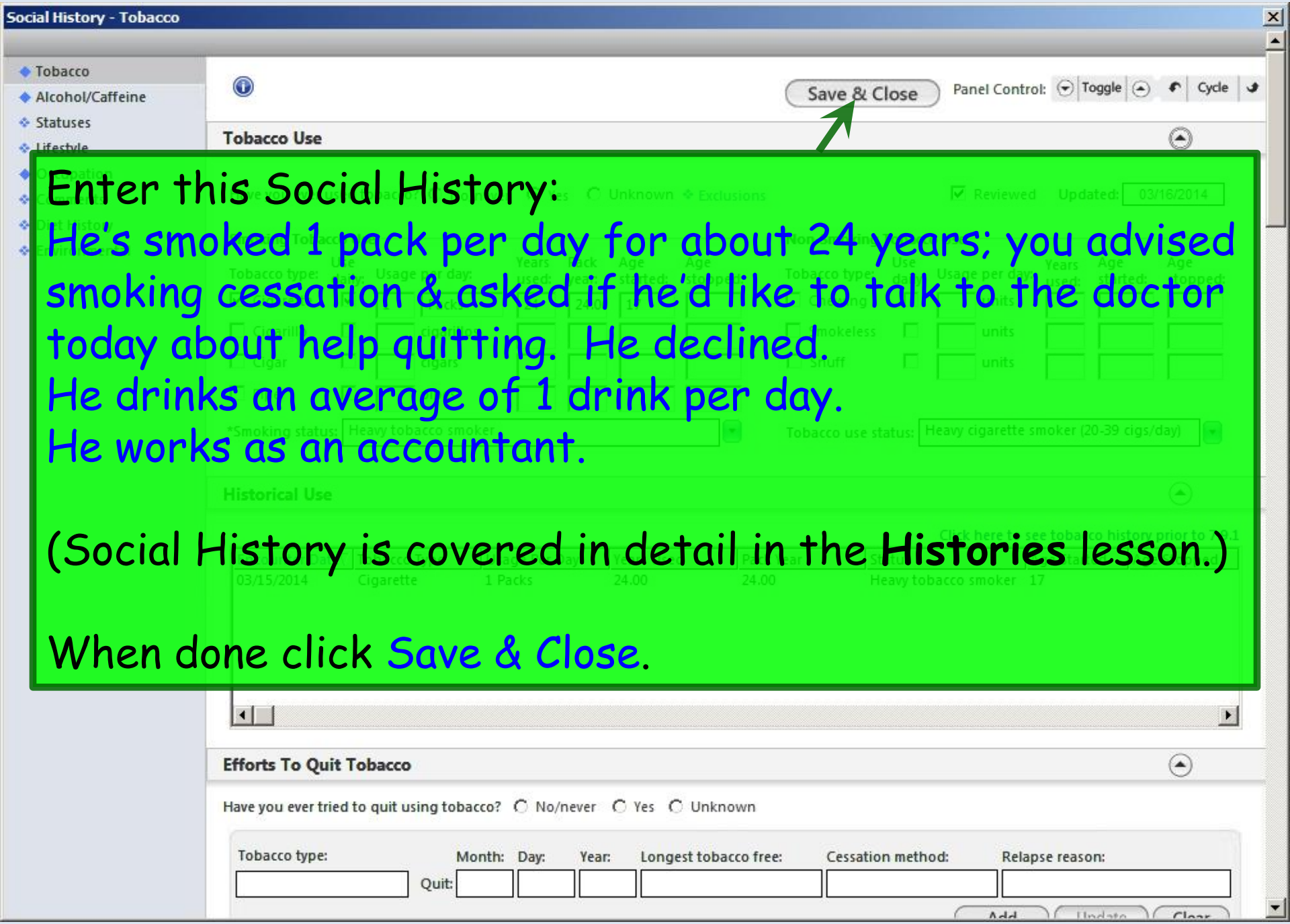

Past Medical History
Specialty: Family Practice
Panel Control: Toggle Cycle
Medical
Surgical
The additional entry displays.
Date:
Date:
Other
Arthroscopy
Back surgery
Blood transfusion
CABG
Cardiac pacemaker
Carpal tunnel release
Cataract extraction
Cholecystectomy
Gastric bypass
Hernia repair
Hip replacement
Knee replacement
LASIK
ORIF
Thyroidectomy
Tonsillectomy
Note that you can later select one of the grid entries & edit it.
Add To Grid
Clear
Past Medical History Grid
Disease/Disorder
Side
Onset Date
Management
Side
Date
Encounter Type
Outcome
Comment
Lumbar disc degenerative disease
2004
L4-5, L5-S1 discectomy & fusion
2004
improved
RLD 03/16/201
Inguinal hernia
left
2002
Hernia repair
left
2002
successful
RLD 03/16/201
Edit
Remove
When you've entered everything you need, click Save & Close.
Save & Close
Cancel


03/15/2014 10:06 PM : "USA Histories"
TOB
HTN
DM
CAD
Specialty Family Practice
Visit Type Office Visit
This history now displays.
Finalize
Checkout
Standing Orders
Adult Immunizations
Peds Immunizations
Birth History
Procedures
Order Management
Document Library
Care Guidelines
Global Days
History Review
All History Review details are to be reviewed and included in visit note unless user indicates otherwise
Panel Control:
Toggle
Cycle
Problem List 2
Show chronic
Show my tracked problem
Problem Description
Side
Diabetes mellitus type II
Essential hypertension
More details about the Problem List & Past History are available in the Histories lesson.
Refresh
Add
Edit
Medical/Surgical/Interim
No relevant past medical/surgical history
All History Review details are to be reviewed and included in visit note unless user indicates otherwise
History Review
Disease/Disorder
Side
Onset Date
Management
Side
Date
Encounter Type
Outcome
Lumbar disc degenerative disease
2004
L4-5, L5-S1 discectomy & fusion
2004
improved
Inguinal hernia
left
2002
Hernia repair
left
2002
successful
Now we'll use the collapsible panels to move down to the Family History.
Refresh
Interim History
Add
Edit
Remove
Diagnostic Studies
Family


03/15/2014 10:06 PM : "USA Histories"
TOB
HTN
DM
CAD
Specialty ▼ Family Practice
Visit Type ▼ Office Visit
Intake
Histories
SOAP
Finalize
Checkout
Standing Orders | Adult Immunizations | Peds Immunizations | Birth History | Procedures | Order Management | Document Library
Care Guidelines | Global Days | History Review
All History Review details are to be reviewed and included in visit note unless user indicates otherwise
Panel Control: Toggle Cycle
Problem List 2
Medical/Surgical/Interim
Diagnostic Studies
Family
No relevant family history
Adopted - no family history known
All History Review details are to be reviewed and included in visit note unless user indicates otherwise
History Review
Relationship
Family Member Name
Deceased
Age at Death
Condition
Onset Age
Cause of Death
Comments
Click Add.
Add
Edit
Remove


Family Health History
Specialty: Family Practice
No family history of:
Relationship:
Family member name:
Alive and well
Deceased
Onset age:
Cause of death:
ADD/ADHD
Alcoholism
Alzheimer's disease
Asthma
Cancer
Cardiovascular disease
Coronary artery disease
Depression
Developmental delay
Diabetes
Elevated lipids
Genetic disease
Hypertension
Learning disability
Migraines
Obesity
Osteoporosis
Renal disease
Seizure disorder
Stroke
Other
Enter this Family History:
His brother has hypertension.
His mother died from alcoholism at age 52.
(Family History is covered in detail in the Histories lesson.)
When done click Save & Close.
Save to Grid
Clear
Relationship
Family Member Name
Deceased
Age at Death
Condition
Onset Age
Cause of Death
Comments
Edit
Remove
Save & Close
Cancel


03/15/2014 10:06 PM : "USA Histories"
TOB
HTN
DM
CAD
Specialty ▼ Family Practice
Visit Type ▼ Office Visit
Intake
Histories
SOAP
Finalize
Checkout
These additions display in the grid.
Standing Orders
Document Library
Care Guidelines
Global Days
History Review
All History Review details are to be reviewed and included in visit note unless user indicates otherwise
Panel Control:
Toggle
Cycle
Problem List 2
Medical/Surgical/Interim
Diagnostic Studies
Family
No relevant family history
Adopted - no family history known
All History Review details are to be reviewed and included in visit note unless user indicates otherwise
History Review
Relationship
Family Member Name
Deceased
Age at Death
Condition
Onset Age
Cause of Death
Comments
Brother
Hypertension
N
Mother
Y
52
Alcoholism
52
Y
Mother
Y
52
Add
Edit
Remove
Now move down to Social History & click the Add button.
Social
(last updated 03/15/2014)
History Review
All History Review details are to be reviewed and included in visit note unless user indicates otherwise
Last documented
All
Substances
Tobacco
Alcohol/Caffeine
Statuses
Lifestyle
Occupation
Comment
Diet History
Environmental
Encounter Date
Tobacco Use
Tobacco Type
Smoking Status
Usage Per Day
Pack Years
Date Quit
Encounter Date:Time
Confidential History
Add




Enter this Social History:

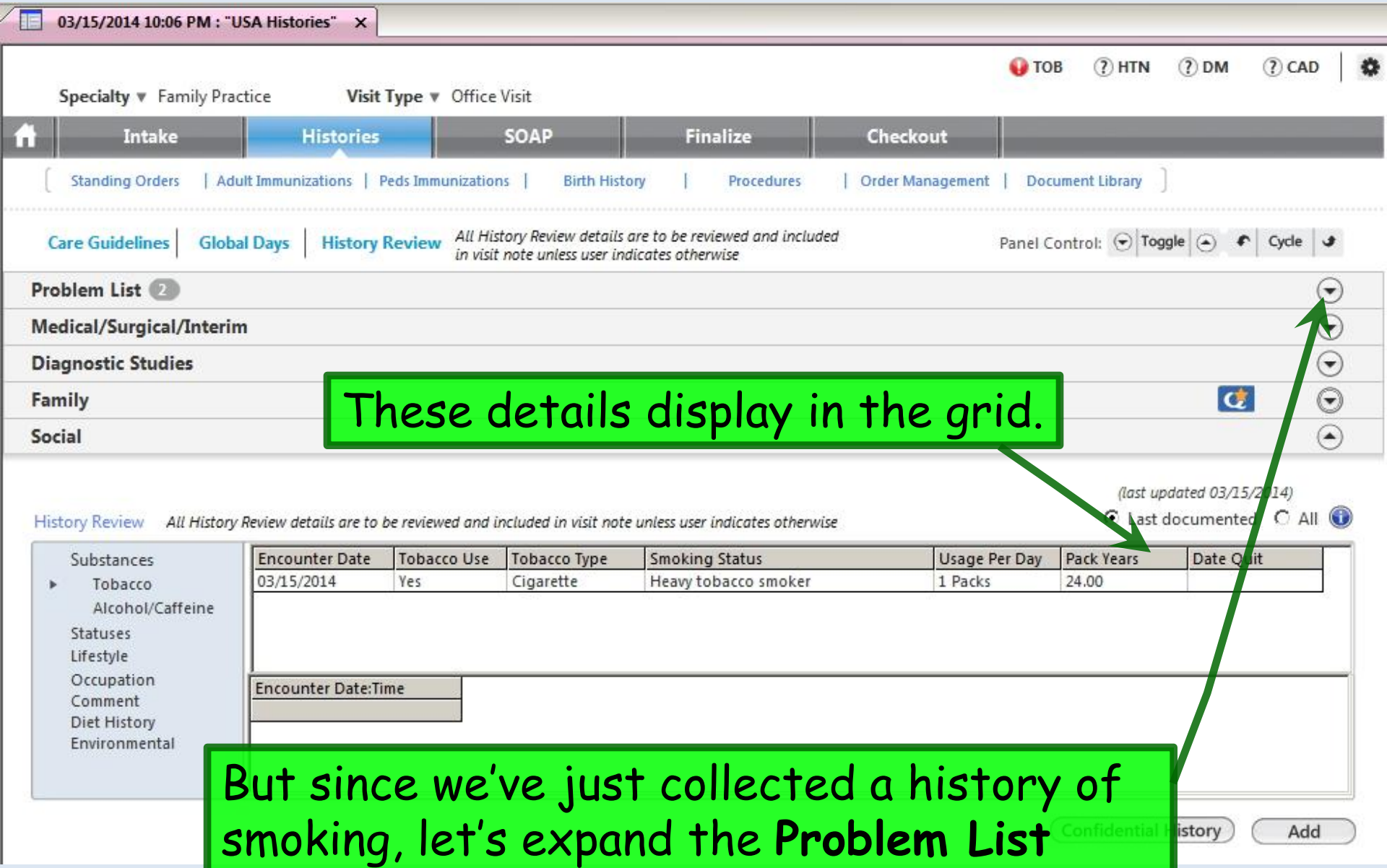
He's smoked 1 pack per day for about 24 years; you advised smoking cessation & asked if he'd like to talk to the doctor today about help quitting. He declined.

He drinks an average of 1 drink per day.

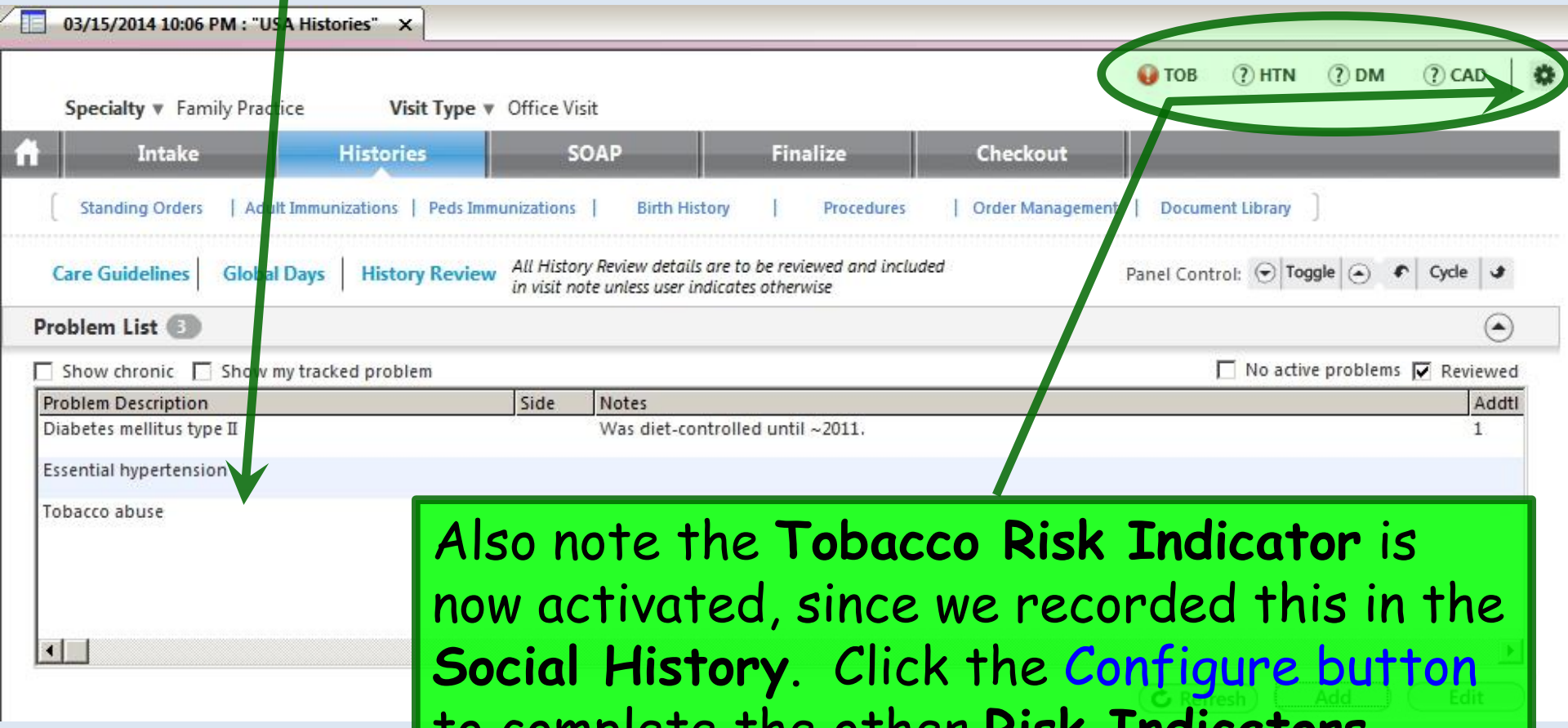
He works as an accountant.

(Social History is covered in detail in the **Histories** lesson.)

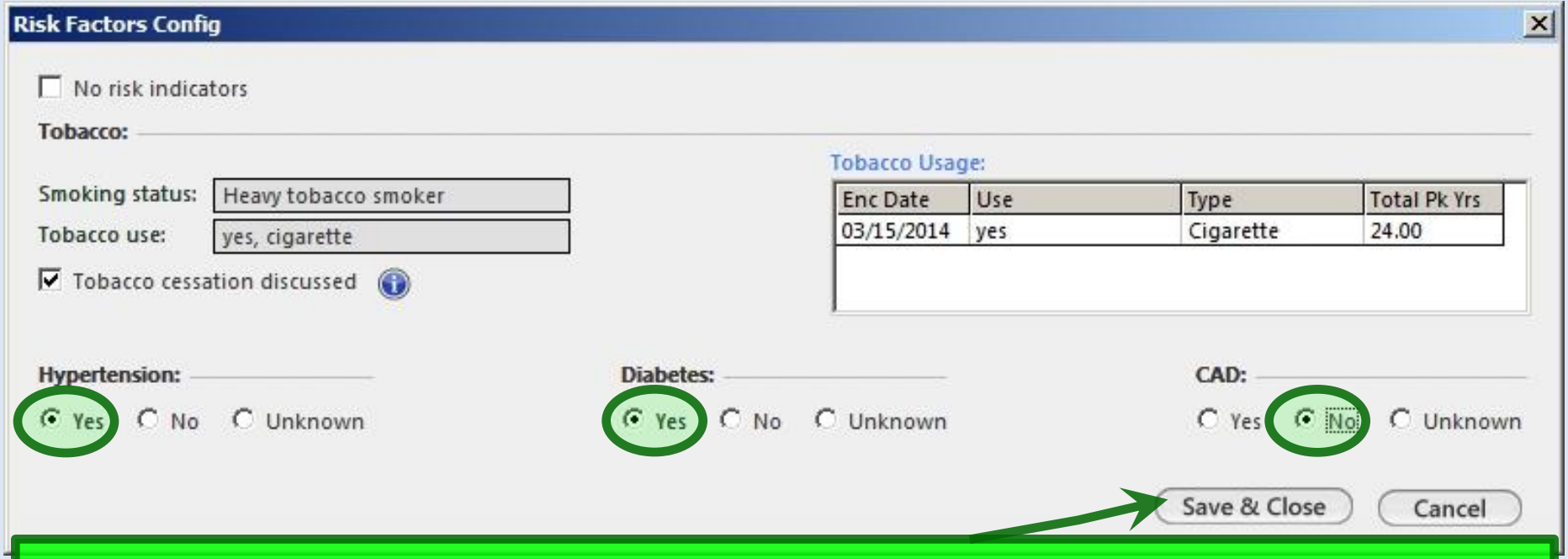
When done click Save & Close.


03/15/2014 10:06 PM : "USA Histories"
TOB
HTN
DM
CAD
Specialty ▼ Family Practice
Visit Type ▼ Office Visit
Intake
Histories
SOAP
Finalize
Checkout
Standing Orders | Adult Immunizations | Peds Immunizations | Birth History | Procedures | Order Management | Document Library
Care Guidelines | Global Days | History Review
All History Review details are to be reviewed and included in visit note unless user indicates otherwise
Panel Control: Toggle Cycle
Problem List 2
Medical/Surgical/Interim
Diagnostic Studies
Family
Social
These details display in the grid.
(last updated 03/15/2014)
History Review
All History Review details are to be reviewed and included in visit note unless user indicates otherwise
Last documented
All
Substances
Tobacco
Alcohol/Caffeine
Statuses
Lifestyle
Occupation
Comment
Diet History
Environmental
Encounter Date
Tobacco Use
Tobacco Type
Smoking Status
Usage Per Day
Pack Years
Date Quit
03/15/2014
Yes
Cigarette
Heavy tobacco smoker
1 Packs
24.00
Encounter Date:Time
But since we've just collected a history of smoking, let's expand the Problem List panel & add Tobacco Abuse.
Add

I've done that, using the methods demonstrated earlier.




Also note the **Tobacco Risk Indicator** is now activated, since we recorded this in the **Social History**. Click the Configure button to complete the other **Risk Indicators**.

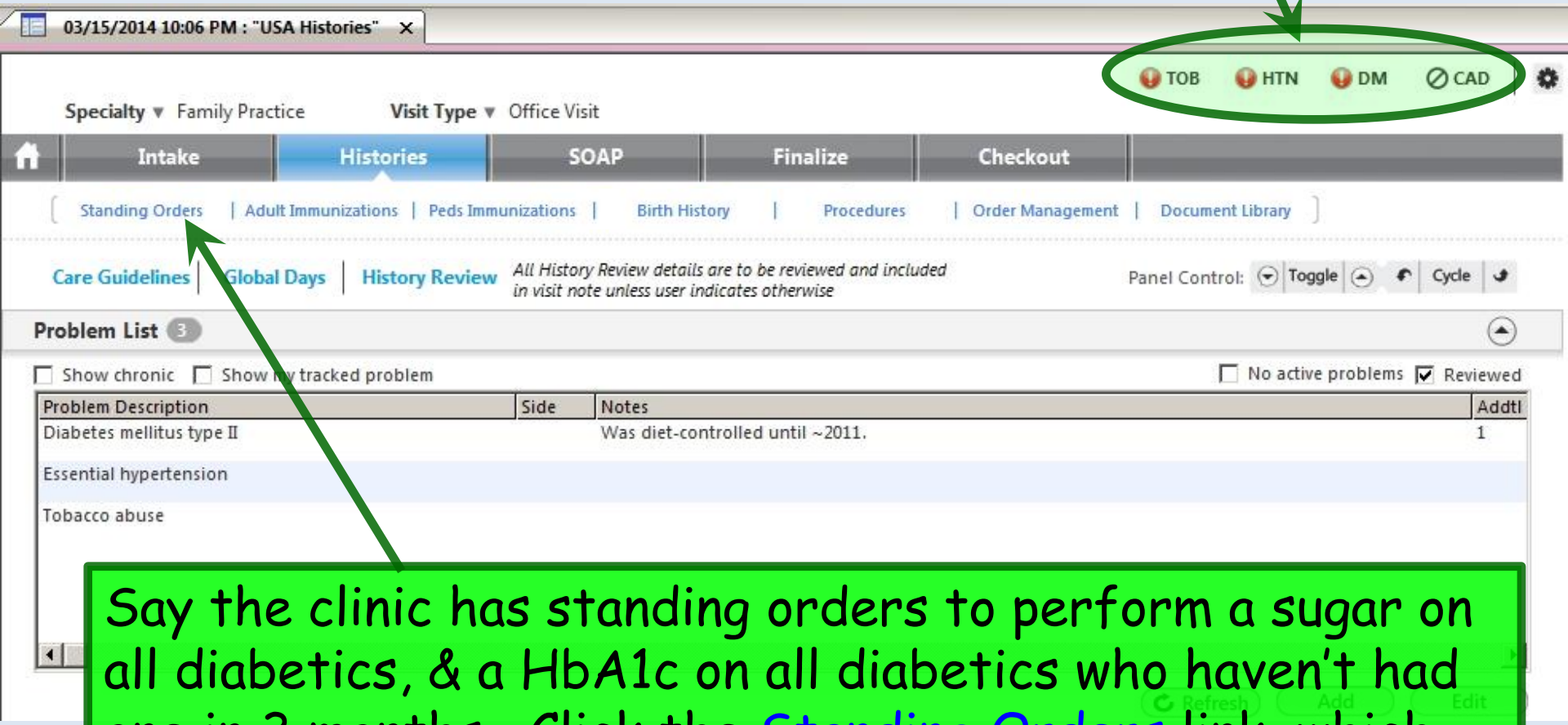



Tobacco has already been addressed. Sometimes the other risk indicators will also be answered "yes" automatically if those diagnoses are previously documented on the **Chronic Condition List** or earlier encounters, but this doesn't work predictably, & no entry will be pre-populated as "no." So this will require some manual configuration the first time & upon any subsequent change.

Click the bullets for Hypertension Yes, Diabetes Yes, & Coronary Artery Disease No.

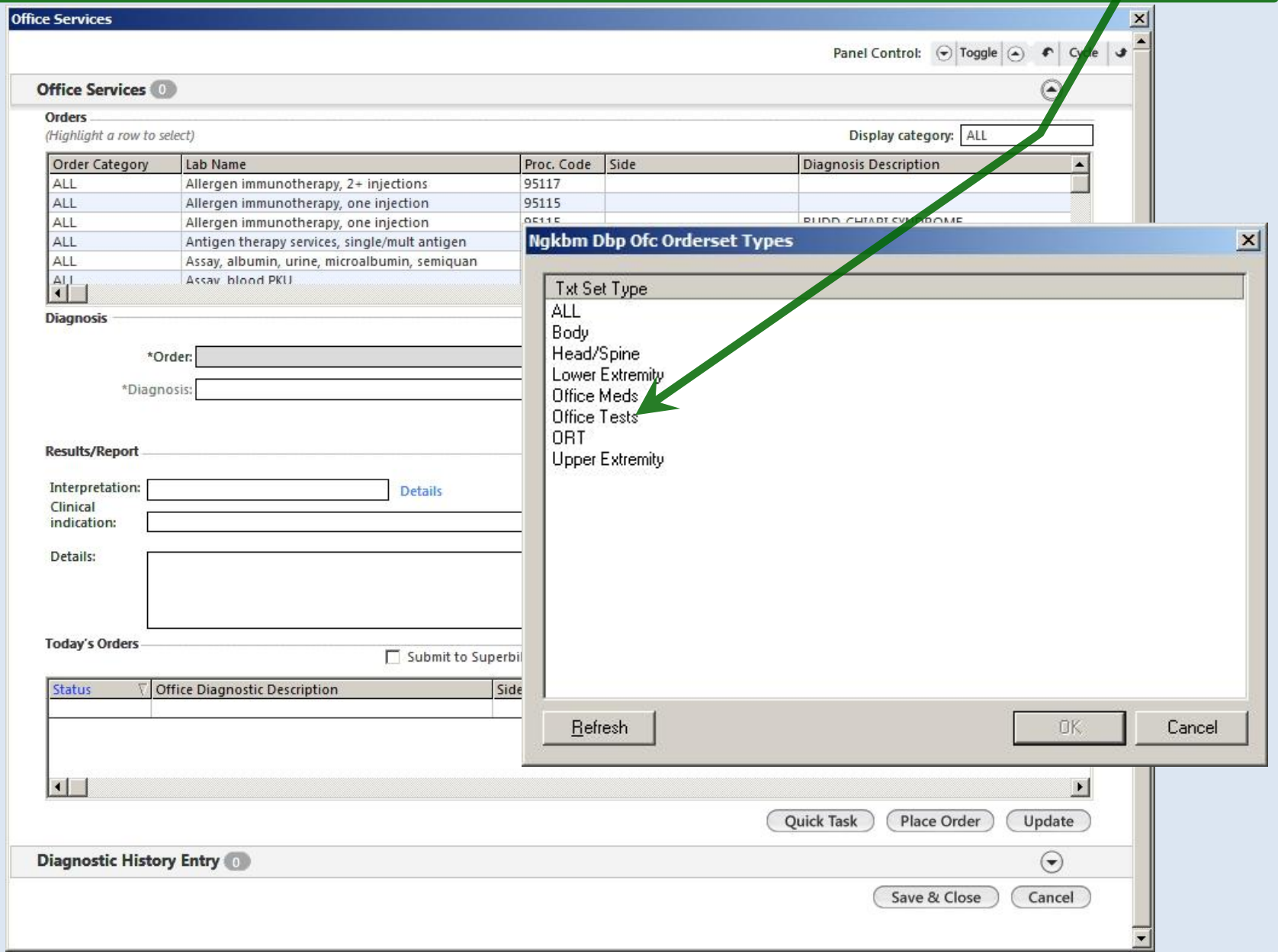
When done click Save & Close.

All **Risk Indicators** are now configured.

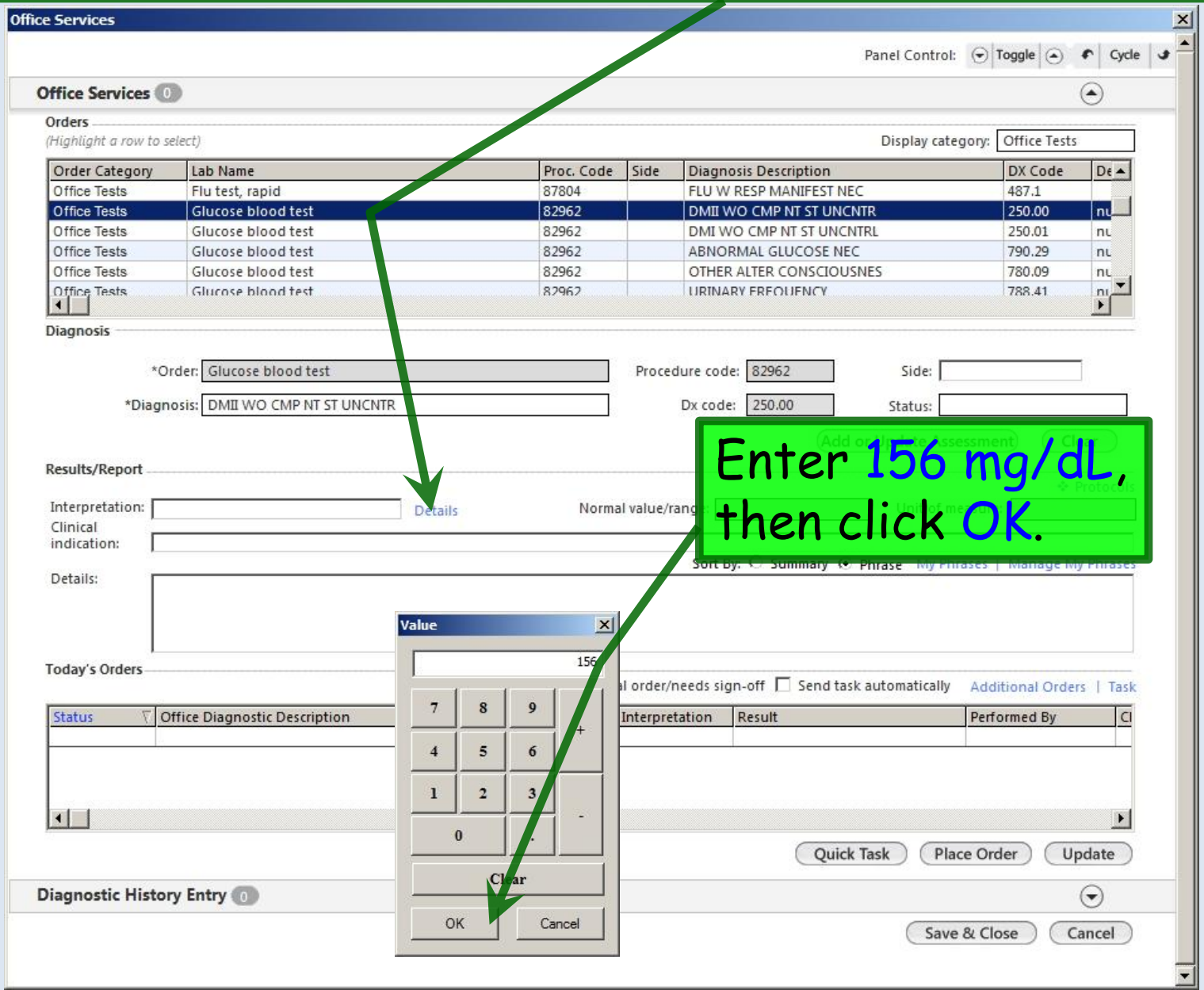



Say the clinic has standing orders to perform a sugar on all diabetics, & a HbA1c on all diabetics who haven't had one in 3 months. Click the Standing Orders link, which can be found in several locations.

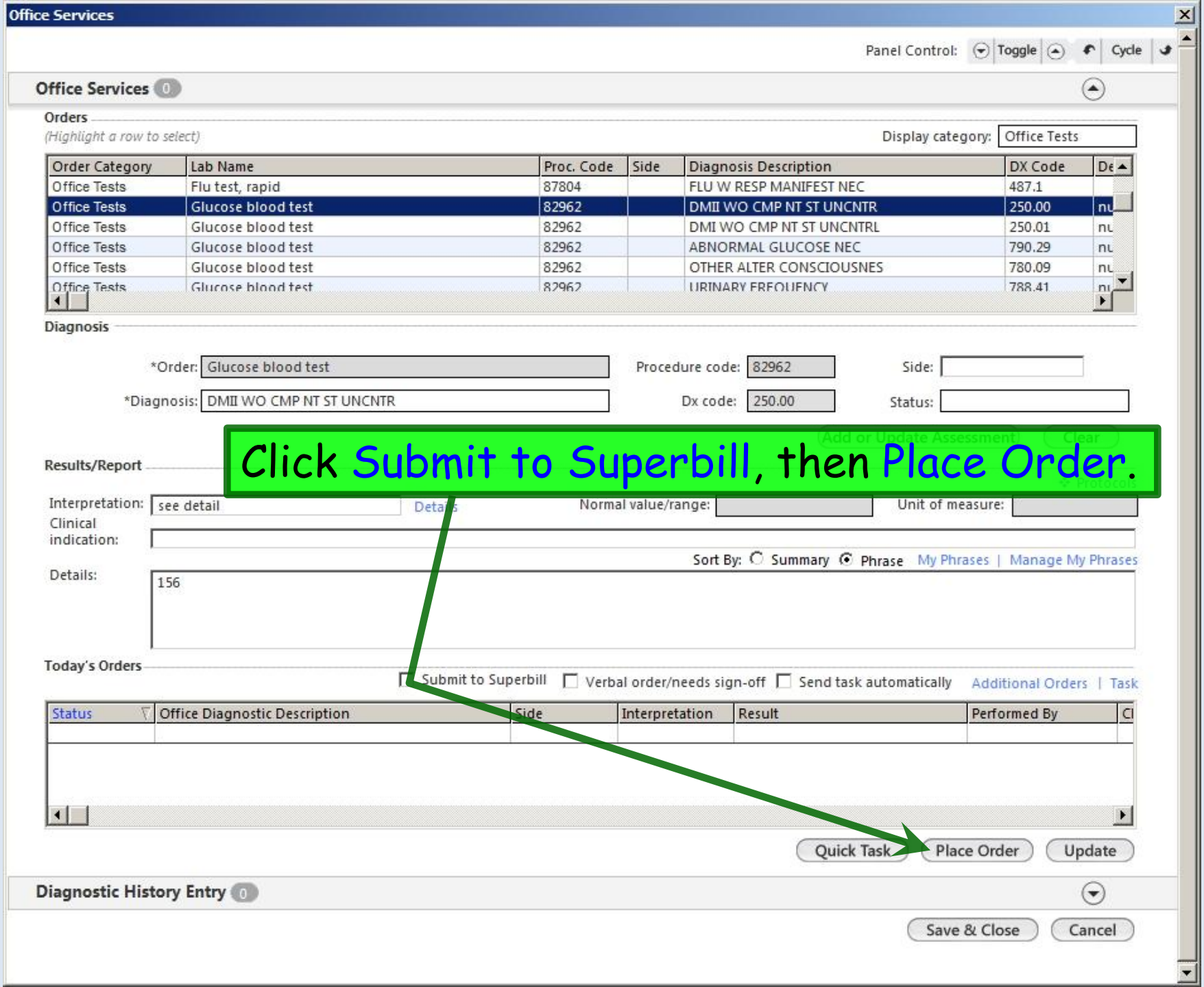
On the **Standing Orders** popup, click in the Display order set box. In the ensuing popup, double-click Office Tests.

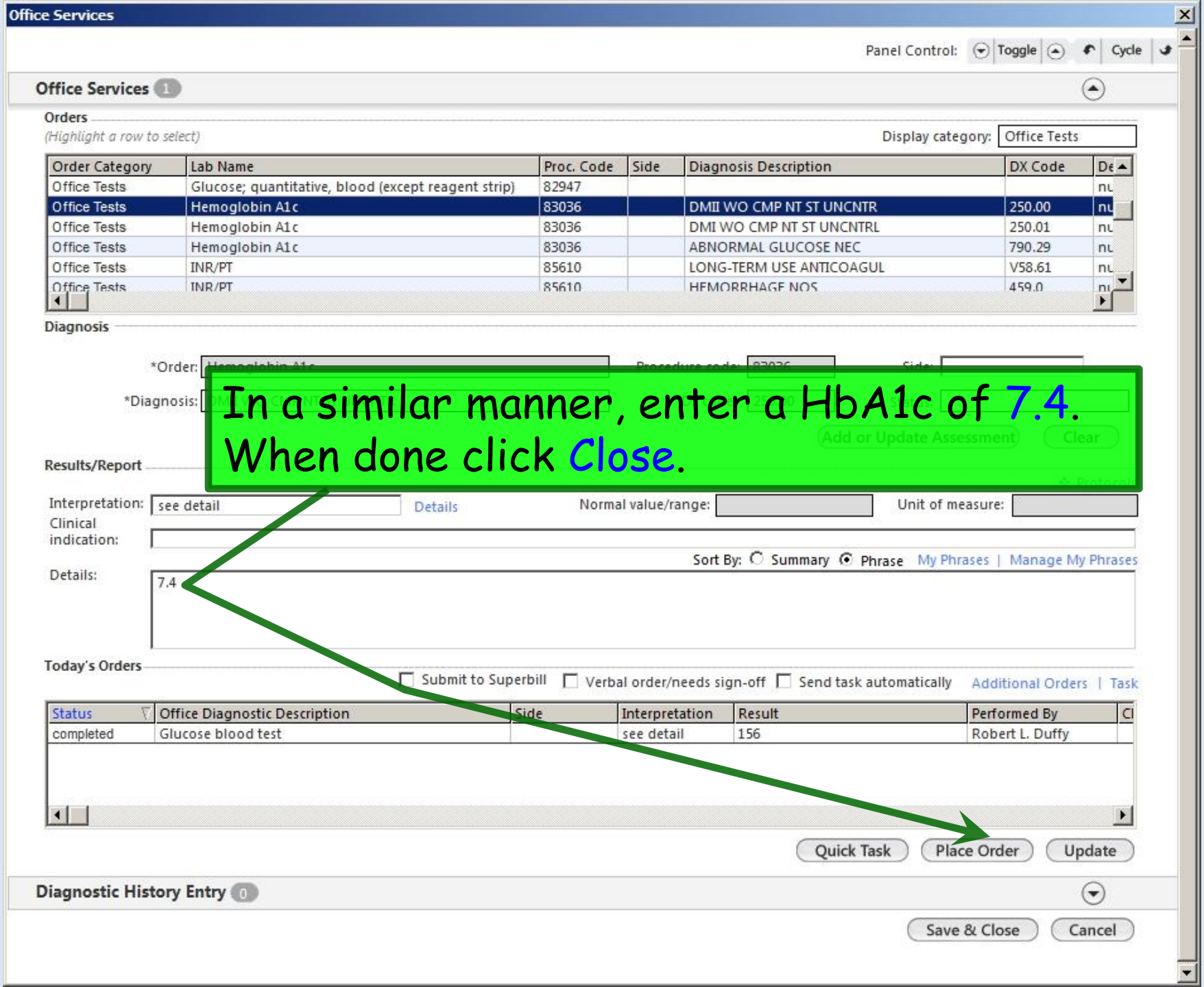


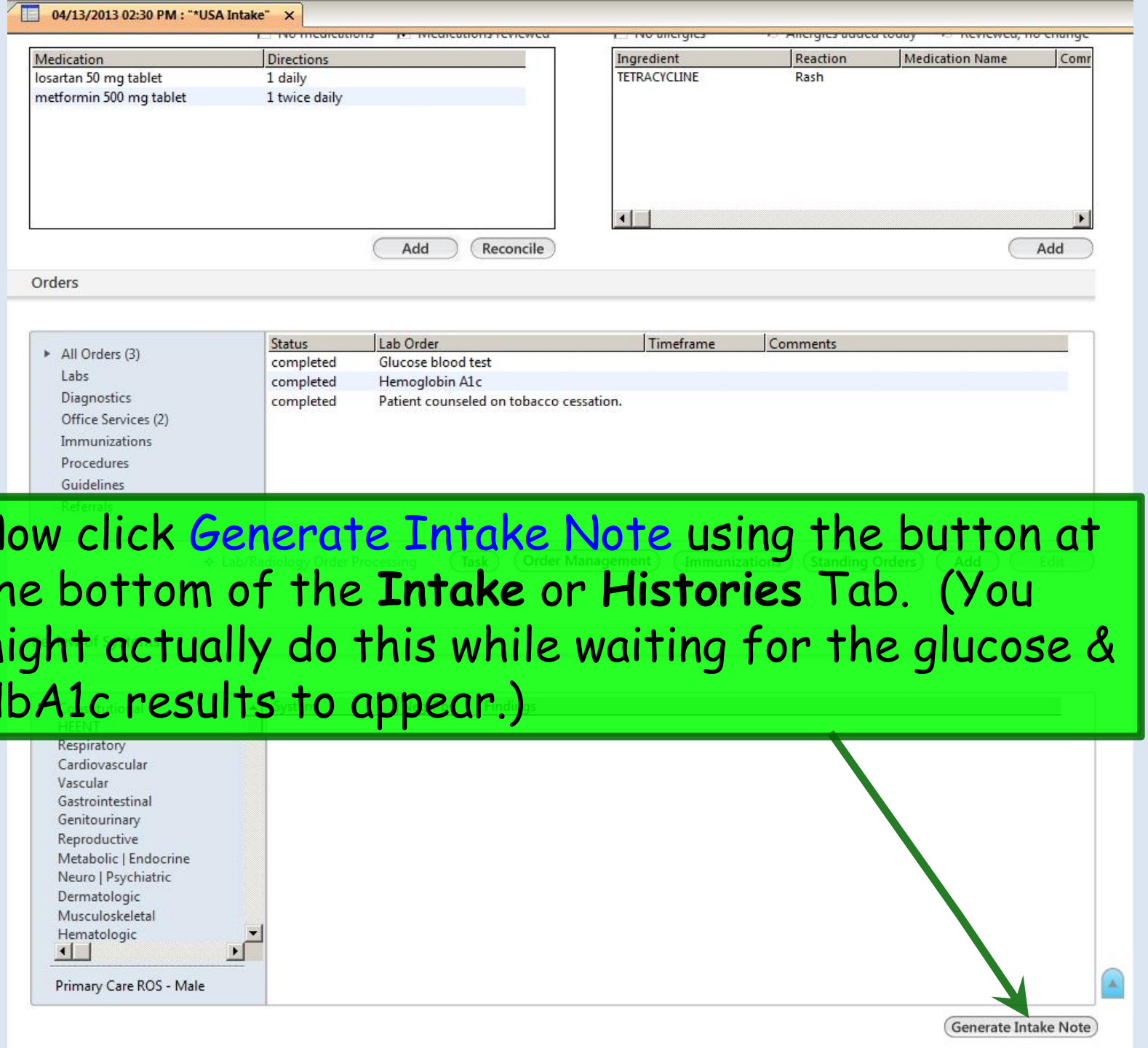
Scroll down & find Glucose blood test associated with Diabetes…250.00. Select that, then click the Details.



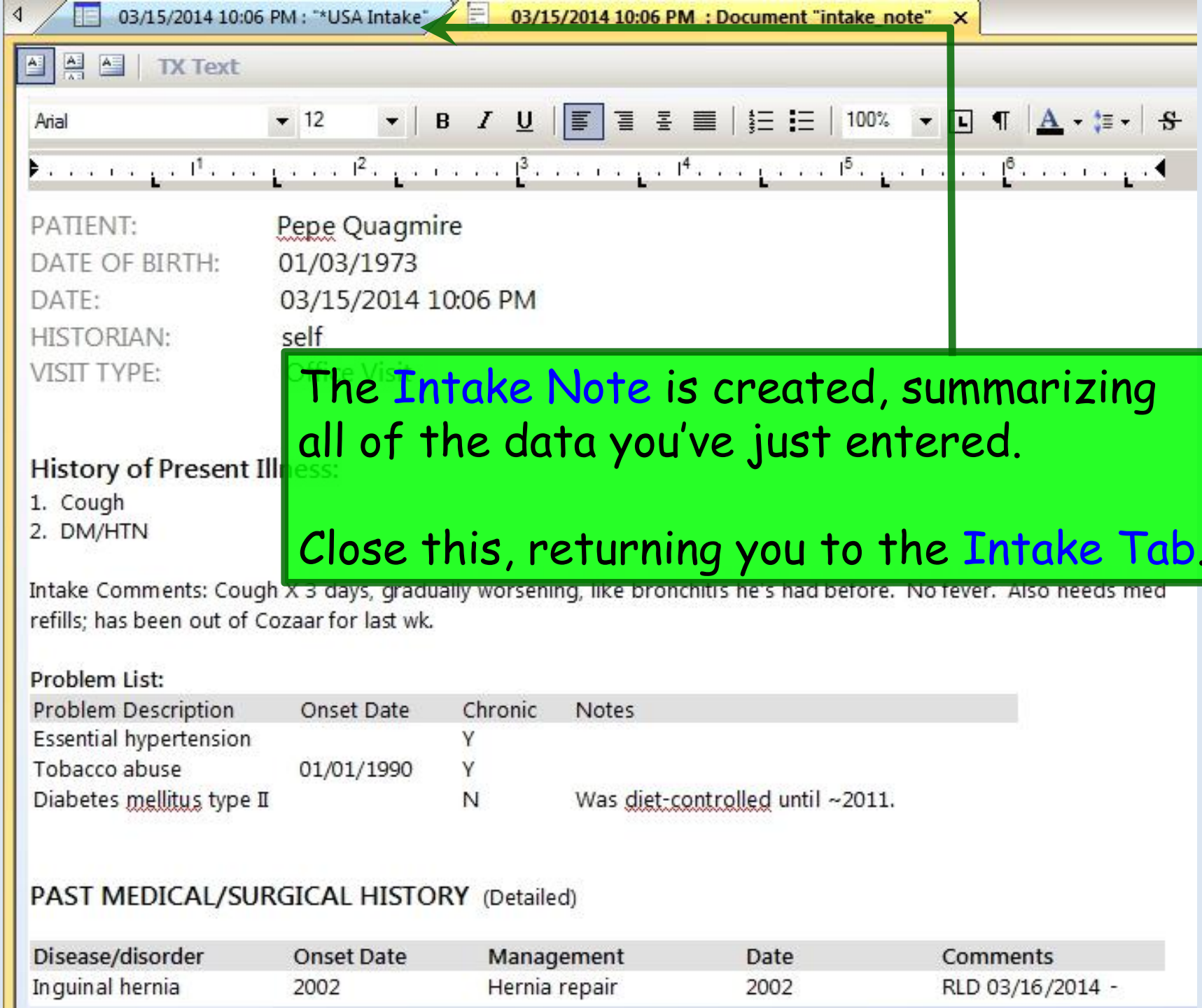

Enter 156 mg/dL, then click OK.

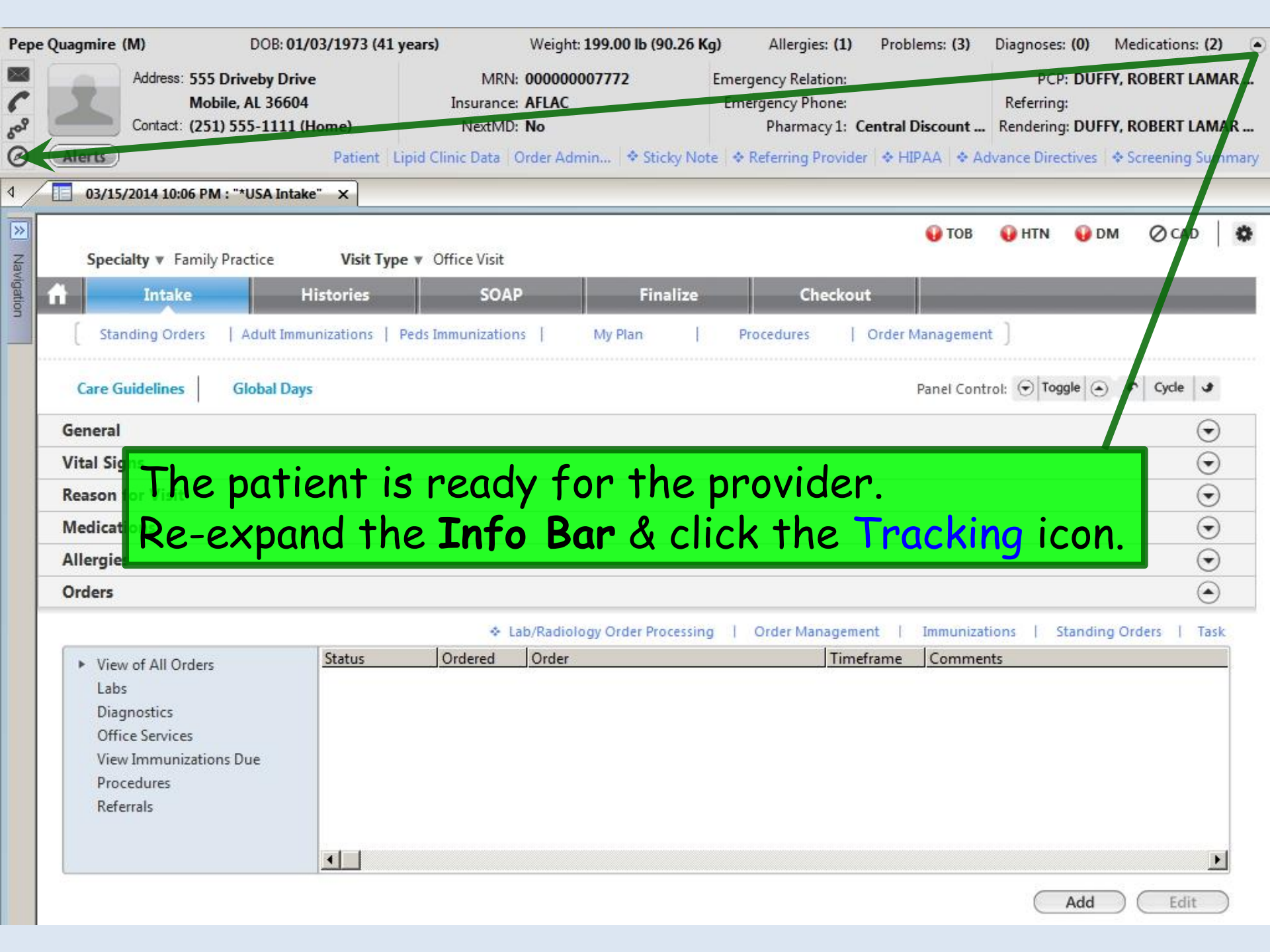

Office Services
Panel Control: Toggle Cycle
Office Services 0
Orders
(Highlight a row to select)
Display category: Office Tests
Order Category | Lab Name | Proc. Code | Side | Diagnosis Description | DX Code
Office Tests | Flu test, rapid | 87804 | | FLU W RESP MANIFEST NEC | 487.1
Office Tests | Glucose blood test | 82962 | | DMII WO CMP NT ST UNCNTR | 250.00
Office Tests | Glucose blood test | 82962 | | DMI WO CMP NT ST UNCNTRL | 250.01
Office Tests | Glucose blood test | 82962 | | ABNORMAL GLUCOSE NEC | 790.29
Office Tests | Glucose blood test | 82962 | | OTHER ALTER CONSCIOUSNES | 780.09
Office Tests | Glucose blood test | 82962 | | URINARY FREQUENCY | 788.41
Diagnosis
*Order: Glucose blood test
Procedure code: 82962
Side:
*Diagnosis: DMII WO CMP NT ST UNCNTR
Dx code: 250.00
Status:
Add or Update Assessment
Clear
Click Submit to Superbill, then Place Order.
Results/Report
Interpretation: see detail
Details
Normal value/range:
Unit of measure:
Clinical indication:
Sort By: Summary Phrase
My Phrases | Manage My Phrases
Details: 156
Today's Orders
Submit to Superbill
Verbal order/needs sign-off
Send task automatically
Additional Orders | Task
Status | Office Diagnostic Description | Side | Interpretation | Result | Performed By
Quick Task
Place Order
Update
Diagnostic History Entry 0
Save & Close
Cancel

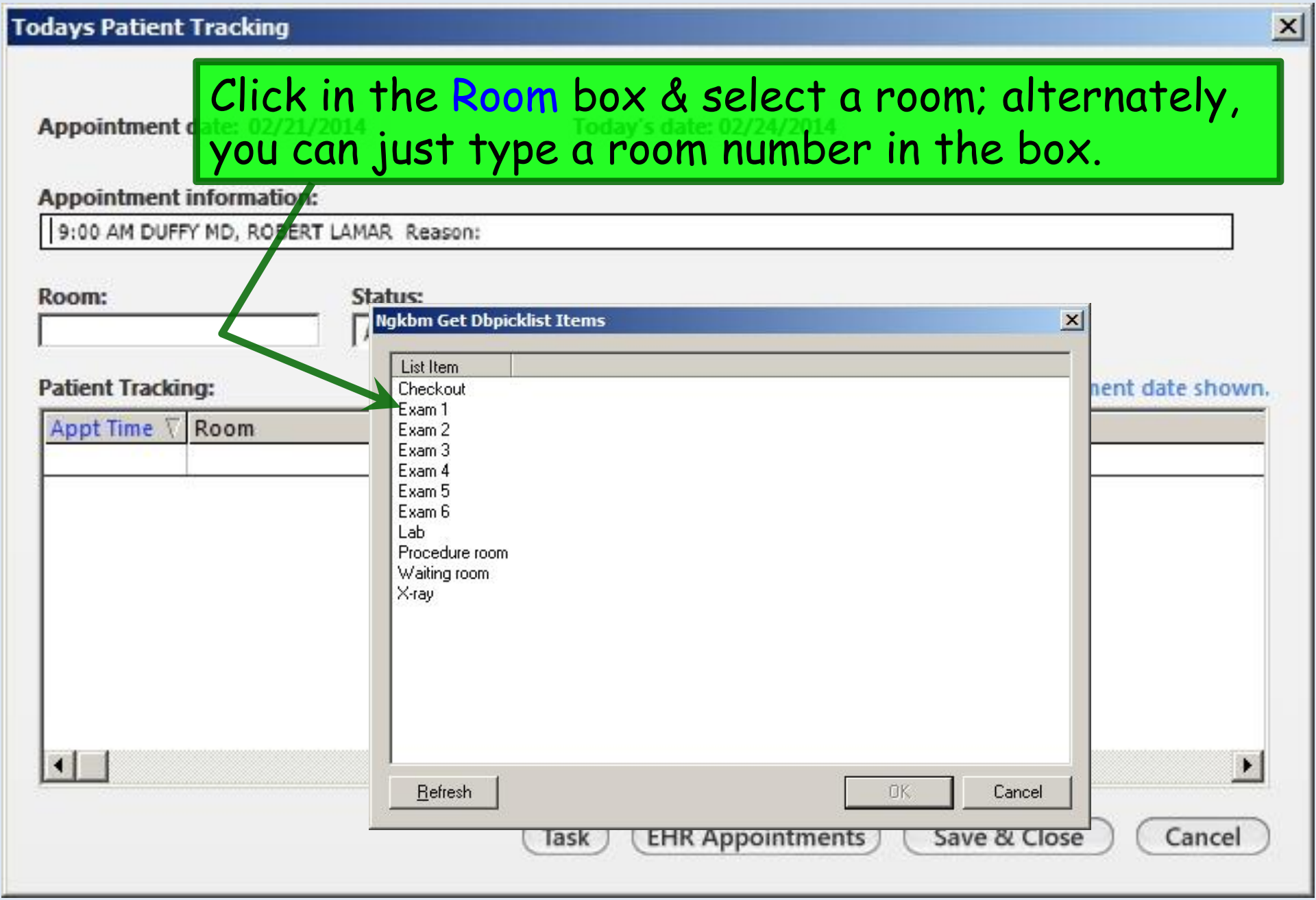

Office Services
Panel Control: Toggle Cycle
Office Services 1
Orders
(Highlight a row to select)
Display category: Office Tests
Order Category | Lab Name | Proc. Code | Side | Diagnosis Description | DX Code
Office Tests | Glucose; quantitative, blood (except reagent strip) | 82947
Office Tests | Hemoglobin A1c | 83036 | DMII WO CMP NT ST UNCNTR | 250.00
Office Tests | Hemoglobin A1c | 83036 | DMI WO CMP NT ST UNCNTRL | 250.01
Office Tests | Hemoglobin A1c | 83036 | ABNORMAL GLUCOSE NEC | 790.29
Office Tests | INR/PT | 85610 | LONG-TERM USE ANTICOAGUL | V58.61
Diagnosis
*Order:
*Diagnosis:
Add or Update Assessment
Clear
In a similar manner, enter a HbA1c of 7.4.
When done click Close.
Results/Report
Interpretation: see detail
Details
Normal value/range:
Unit of measure:
Clinical indication:
Sort By: Summary Phrase
My Phrases | Manage My Phrases
Details: 7.4
Today's Orders
Submit to Superbill
Verbal order/needs sign-off
Send task automatically
Additional Orders | Task
Status | Office Diagnostic Description | Side | Interpretation | Result | Performed By
completed | Glucose blood test | see detail | 156 | Robert L. Duffy
Quick Task
Place Order
Update
Diagnostic History Entry 0
Save & Close
Cancel

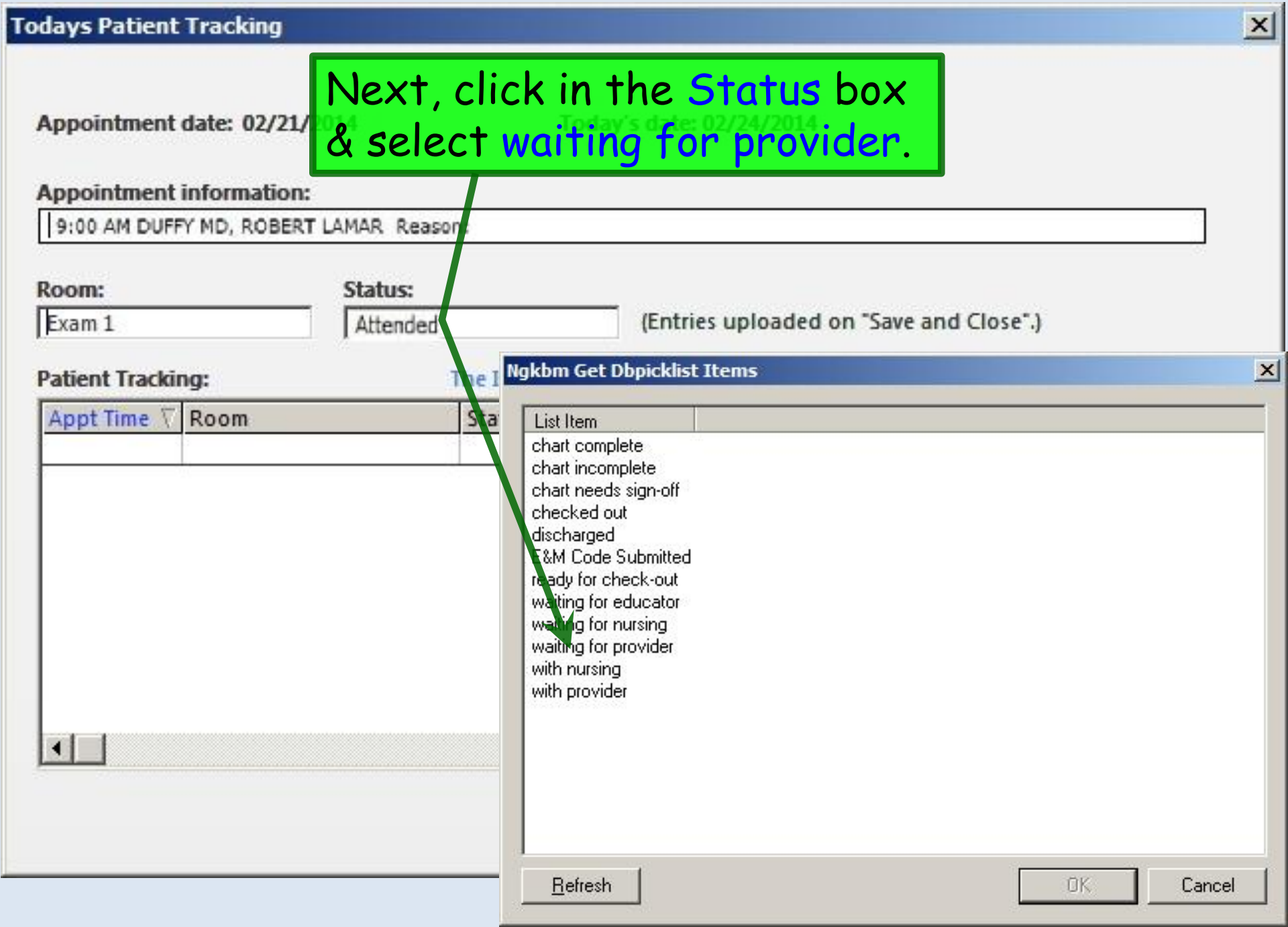


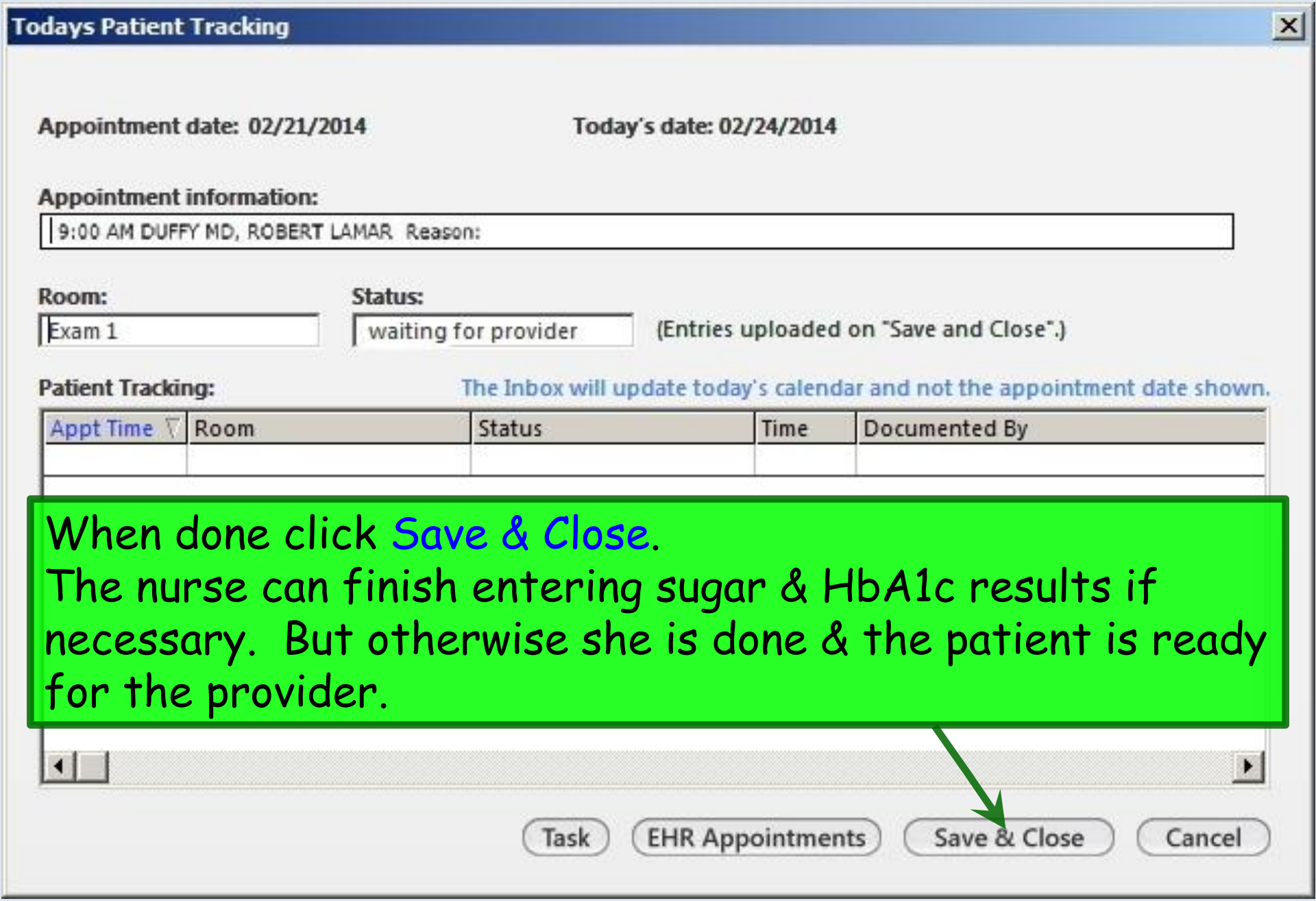

Now click Generate Intake Note using the button at the bottom of the **Intake** or **Histories** Tab. (You might actually do this while waiting for the glucose & HbA1c results to appear.)

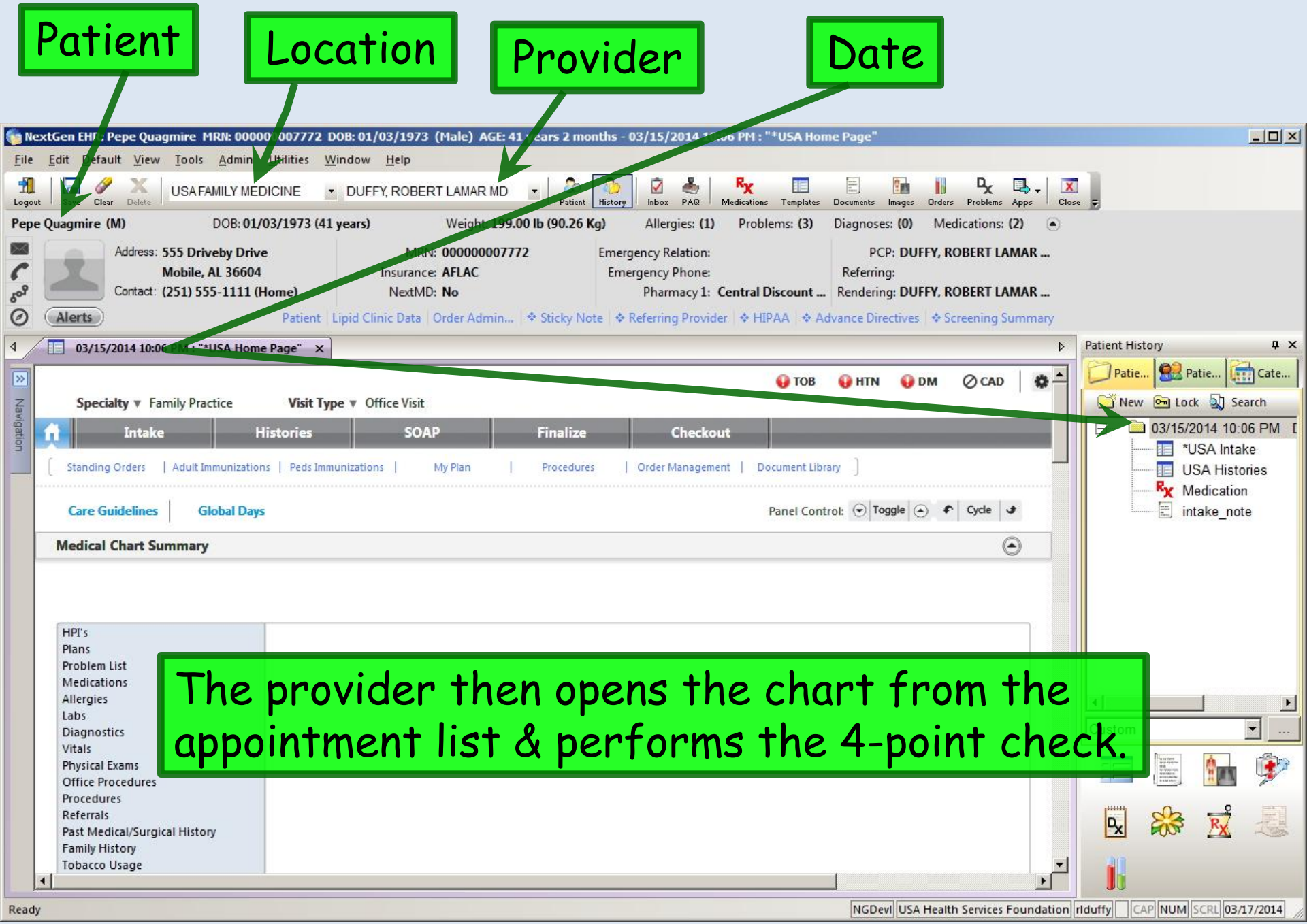

03/15/2014 10:06 PM : "*USA Intake"
03/15/2014 10:06 PM : Document "intake_note"
TX Text
Arial
12
100%
PATIENT: Pepe Quagmire
DATE OF BIRTH: 01/03/1973
DATE: 03/15/2014 10:06 PM
HISTORIAN: self
VISIT TYPE:
The Intake Note is created, summarizing all of the data you've just entered.
Close this, returning you to the Intake Tab.
History of Present Illness:
1. Cough
2. DM/HTN
Intake Comments: Cough X 3 days, gradually worsening, like bronchitis he's had before. No fever. Also needs med refills; has been out of Cozaar for last wk.
Problem List:
Problem Description | Onset Date | Chronic | Notes
Essential hypertension | | Y |
Tobacco abuse | 01/01/1990 | Y |
Diabetes mellitus type II | | N | Was diet-controlled until ~2011.
PAST MEDICAL/SURGICAL HISTORY (Detailed)
Disease/disorder | Onset Date | Management | Date | Comments
Inguinal hernia | 2002 | Hernia repair | 2002 | RLD 03/16/2014 -

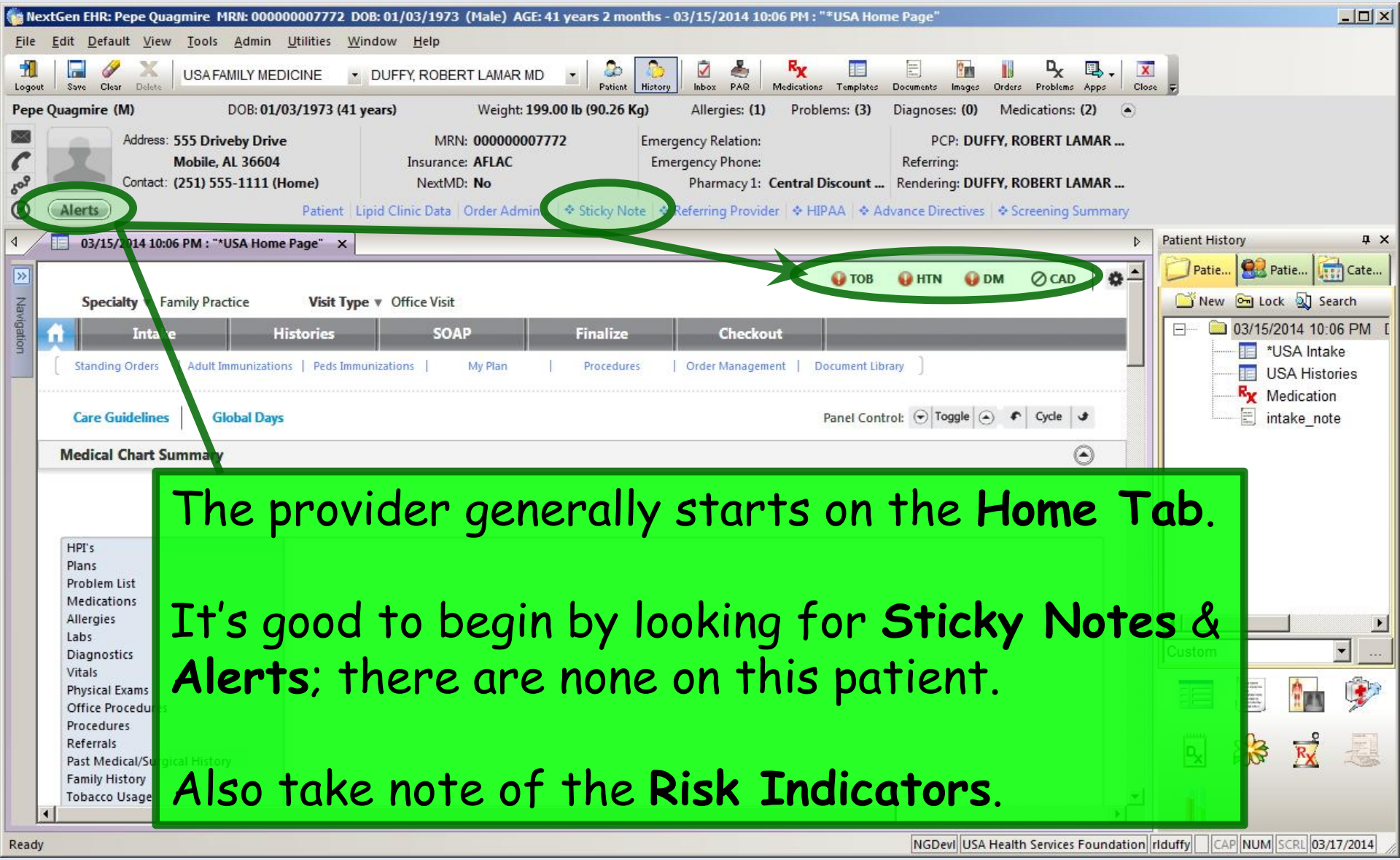

Pepe Quagmire (M)
DOB: 01/03/1973 (41 years)
Weight: 199.00 lb (90.26 Kg)
Allergies: (1)
Problems: (3)
Diagnoses: (0)
Medications: (2)
Address: 555 Driveby Drive
Mobile, AL 36604
Contact: (251) 555-1111 (Home)
MRN: 000000007772
Insurance: AFLAC
NextMD: No
Emergency Relation:
Emergency Phone:
Pharmacy 1: Central Discount ...
PCP: DUFFY, ROBERT LAMAR ...
Referring:
Rendering: DUFFY, ROBERT LAMAR ...
Alerts
Patient
Lipid Clinic Data
Order Admin...
Sticky Note
Referring Provider
HIPAA
Advance Directives
Screening Summary
03/15/2014 10:06 PM : "*USA Intake"
TOB
HTN
DM
CAD
Specialty ▼ Family Practice
Visit Type ▼ Office Visit
Intake
Histories
SOAP
Finalize
Checkout
Standing Orders
Adult Immunizations
Peds Immunizations
My Plan
Procedures
Order Management
Care Guidelines
Global Days
Panel Control:
Toggle
Cycle
General
Vital Signs
Reason for Visit
Medications
Allergies
Orders
The patient is ready for the provider.
Re-expand the Info Bar & click the Tracking icon.
Lab/Radiology Order Processing
Order Management
Immunizations
Standing Orders
Task
View of All Orders
Labs
Diagnostics
Office Services
View Immunizations Due
Procedures
Referrals
Status
Ordered
Order
Timeframe
Comments
Add
Edit


Todays Patient Tracking
Click in the Room box & select a room; alternately, you can just type a room number in the box.
Appointment information:
9:00 AM DUFFY MD, ROBERT LAMAR Reason:
Room:
Status:
Patient Tracking:
Appt Time
Room
Ngkbm Get Dbpicklist Items
List Item
Checkout
Exam 1
Exam 2
Exam 3
Exam 4
Exam 5
Exam 6
Lab
Procedure room
Waiting room
X-ray
Refresh
OK
Cancel
Task
EHR Appointments
Save & Close
Cancel


Todays Patient Tracking
Next, click in the Status box & select waiting for provider.
Appointment date: 02/21/
Appointment information:
9:00 AM DUFFY MD, ROBERT LAMAR Reason
Room:
Exam 1
Status:
Attended
(Entries uploaded on "Save and Close".)
Patient Tracking:
Appt Time
Room
Ngkbm Get Dbpicklist Items
List Item
chart complete
chart incomplete
chart needs sign-off
checked out
discharged
E&M Code Submitted
ready for check-out
waiting for educator
waiting for nursing
waiting for provider
with nursing
with provider
Refresh
OK
Cancel


Todays Patient Tracking
Appointment date: 02/21/2014
Today's date: 02/24/2014
Appointment information:
9:00 AM DUFFY MD, ROBERT LAMAR Reason:
Room:
Exam 1
Status:
waiting for provider
(Entries uploaded on "Save and Close".)
Patient Tracking:
The Inbox will update today's calendar and not the appointment date shown.
Appt Time
Room
Status
Time
Documented By
When done click Save & Close.
The nurse can finish entering sugar & HbA1c results if necessary. But otherwise she is done & the patient is ready for the provider.
Task
EHR Appointments
Save & Close
Cancel

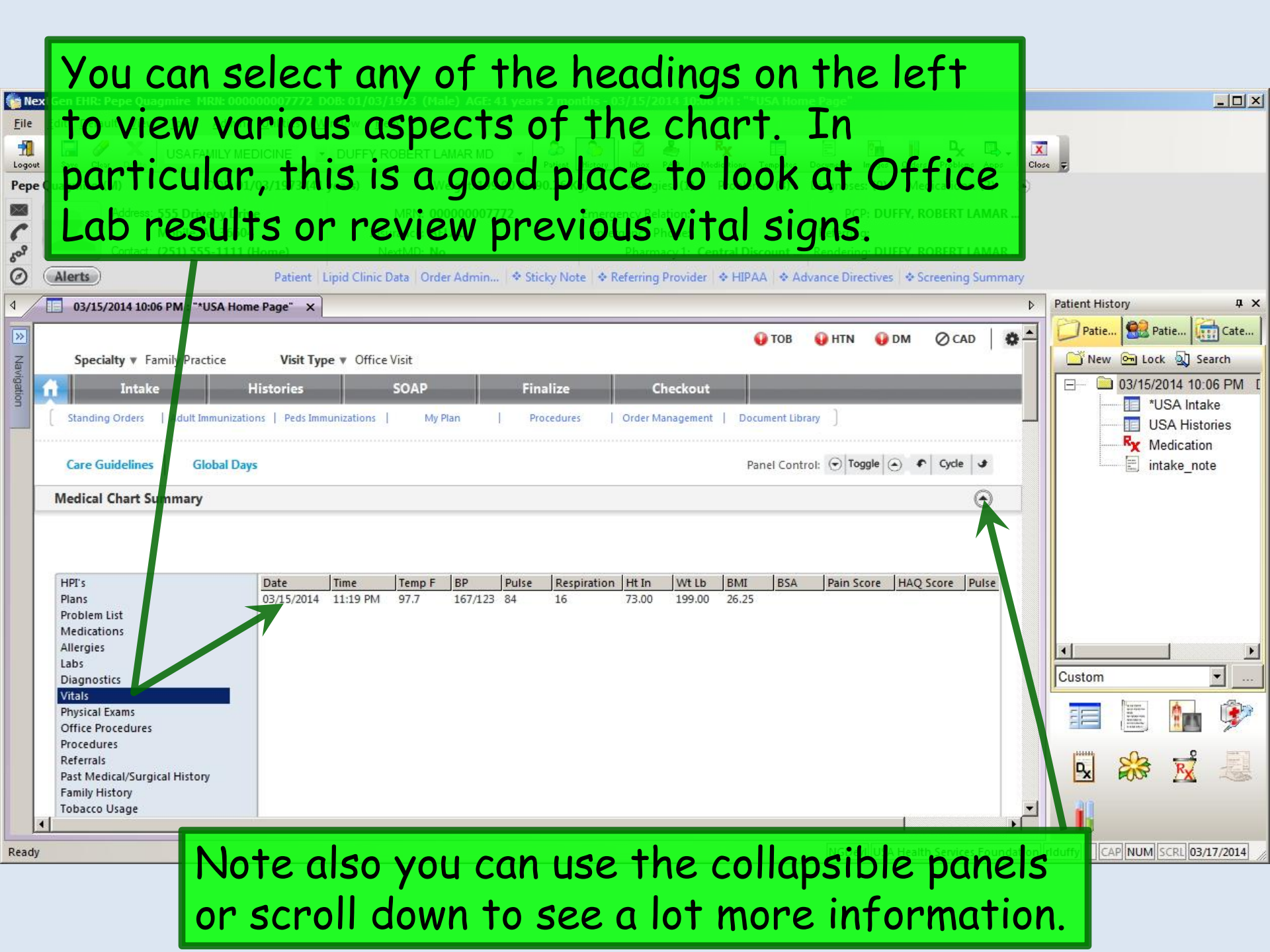

Patient
Location
Provider
Date
NextGen EHR: Pepe Quagmire MRN: 000000007772 DOB: 01/03/1973 (Male) AGE: 41 years 2 months - 03/15/2014 10:06 PM : "*USA Home Page"
File Edit Default View Tools Admin Utilities Window Help
Logout Clear Delete
USA FAMILY MEDICINE
DUFFY, ROBERT LAMAR MD
Patient History Inbox PAQ Medications Templates Documents Images Orders Problems Apps Close
Pepe Quagmire (M) DOB: 01/03/1973 (41 years) Weight: 199.00 lb (90.26 Kg) Allergies: (1) Problems: (3) Diagnoses: (0) Medications: (2)
Address: 555 Driveby Drive
Mobile, AL 36604
Contact: (251) 555-1111 (Home)
MRN: 000000007772
Insurance: AFLAC
NextMD: No
Emergency Relation:
Emergency Phone:
Pharmacy 1: Central Discount ...
PCP: DUFFY, ROBERT LAMAR ...
Referring:
Rendering: DUFFY, ROBERT LAMAR ...
Alerts
Patient Lipid Clinic Data Order Admin... Sticky Note Referring Provider HIPAA Advance Directives Screening Summary
03/15/2014 10:06 PM : "*USA Home Page"
TOB HTN DM CAD
Specialty Family Practice
Visit Type Office Visit
Intake Histories SOAP Finalize Checkout
Standing Orders | Adult Immunizations | Peds Immunizations | My Plan | Procedures | Order Management | Document Library
Care Guidelines | Global Days
Panel Control: Toggle Cycle
Medical Chart Summary
HPI's
Plans
Problem List
Medications
Allergies
Labs
Diagnostics
Vitals
Physical Exams
Office Procedures
Procedures
Referrals
Past Medical/Surgical History
Family History
Tobacco Usage
Patient History
New Lock Search
03/15/2014 10:06 PM
*USA Intake
USA Histories
Medication
intake_note
The provider then opens the chart from the appointment list & performs the 4-point check.
Ready
NGDevl USA Health Services Foundation rlduffy CAP NUM SCRL 03/17/2014

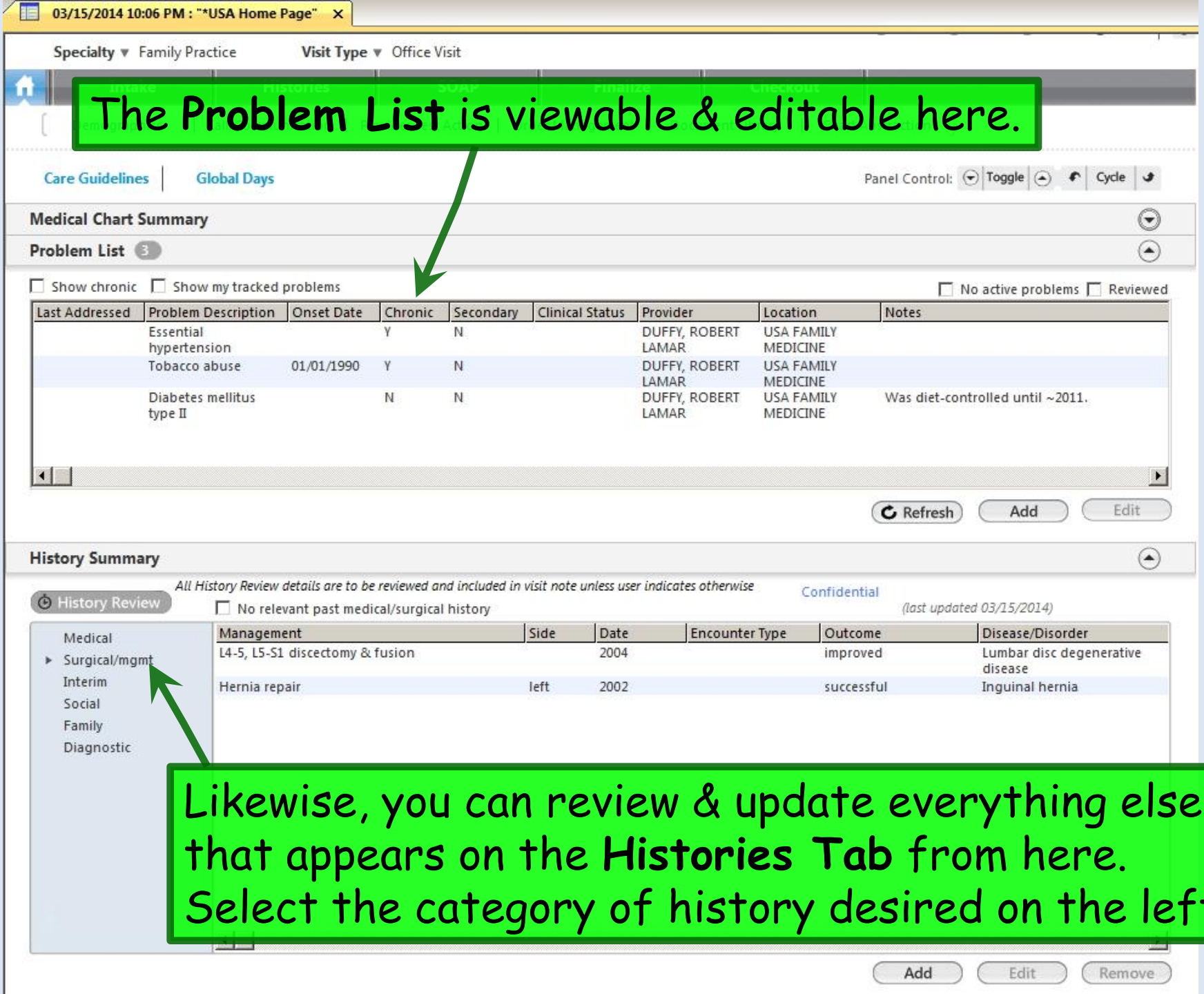


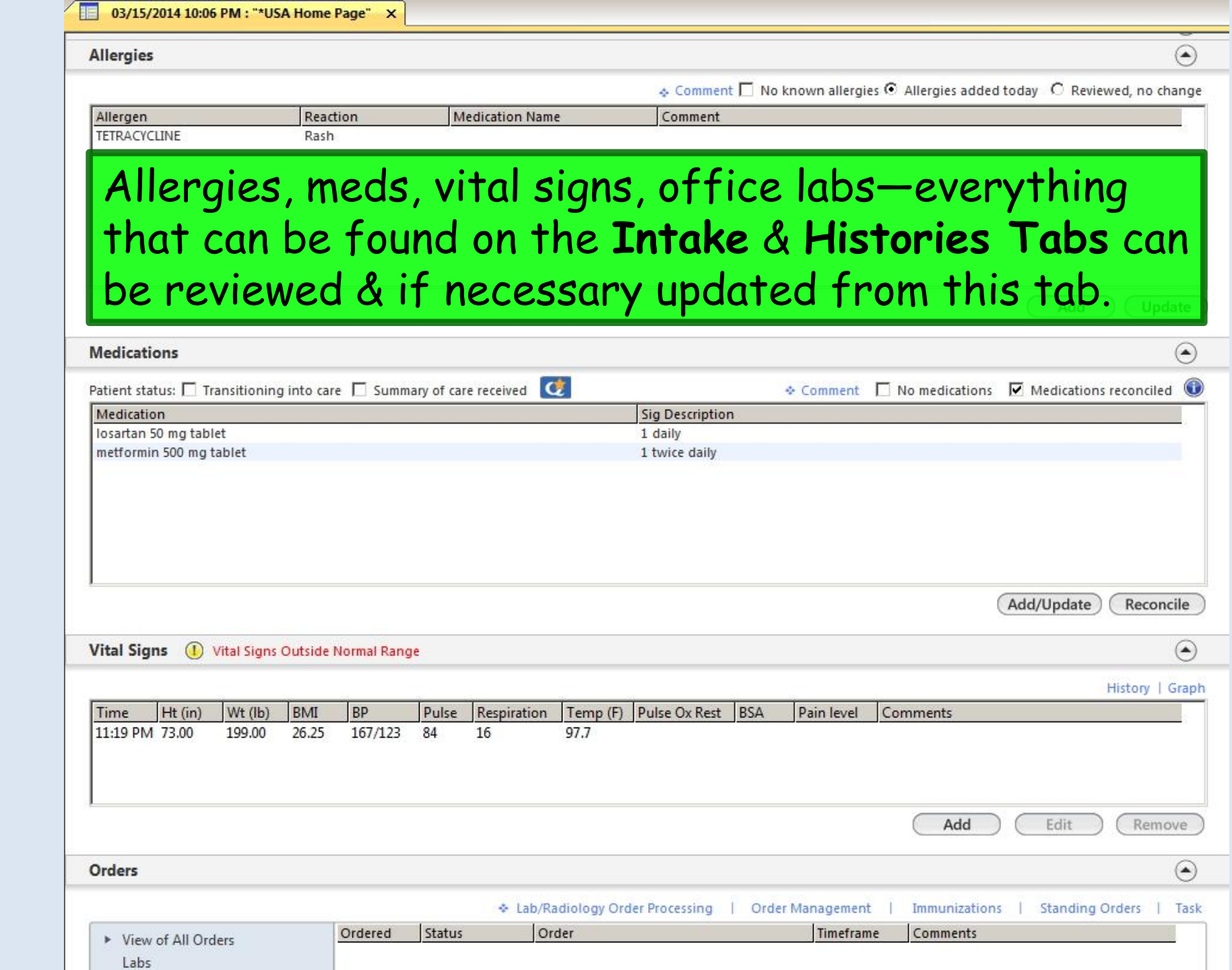

The provider generally starts on the **Home Tab**.

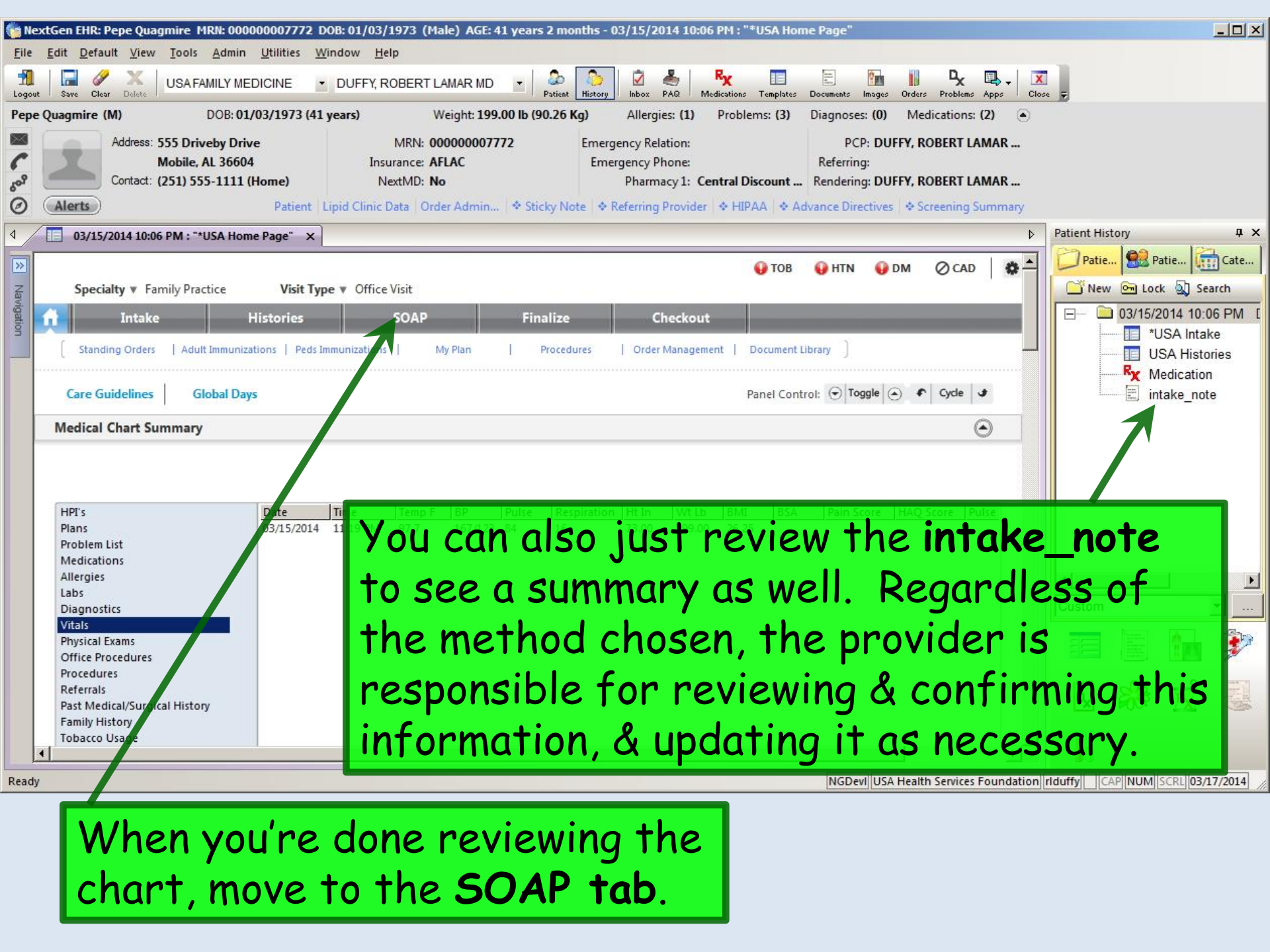
It's good to begin by looking for **Sticky Notes** & **Alerts**; there are none on this patient.

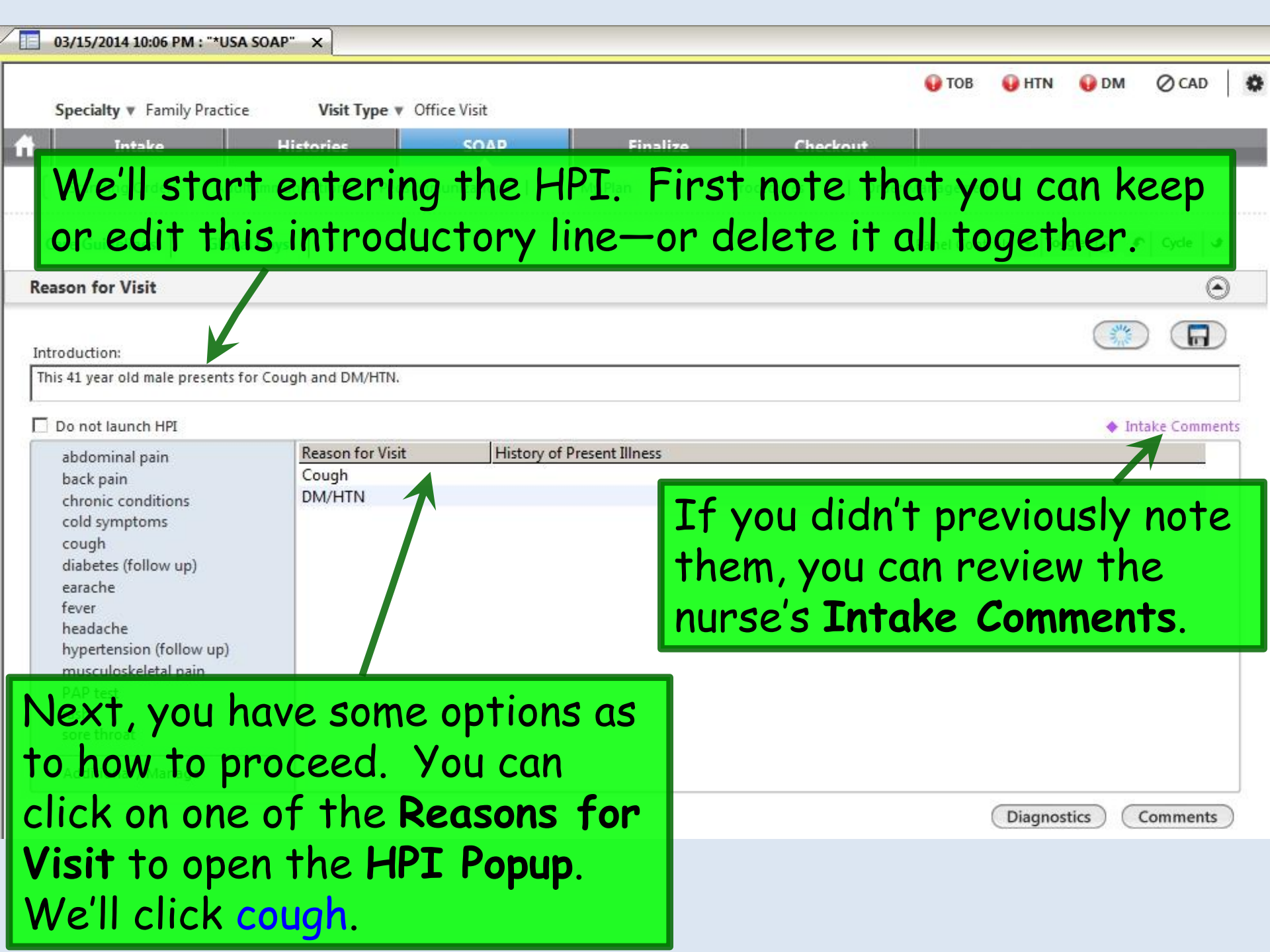
Also take note of the **Risk Indicators**.

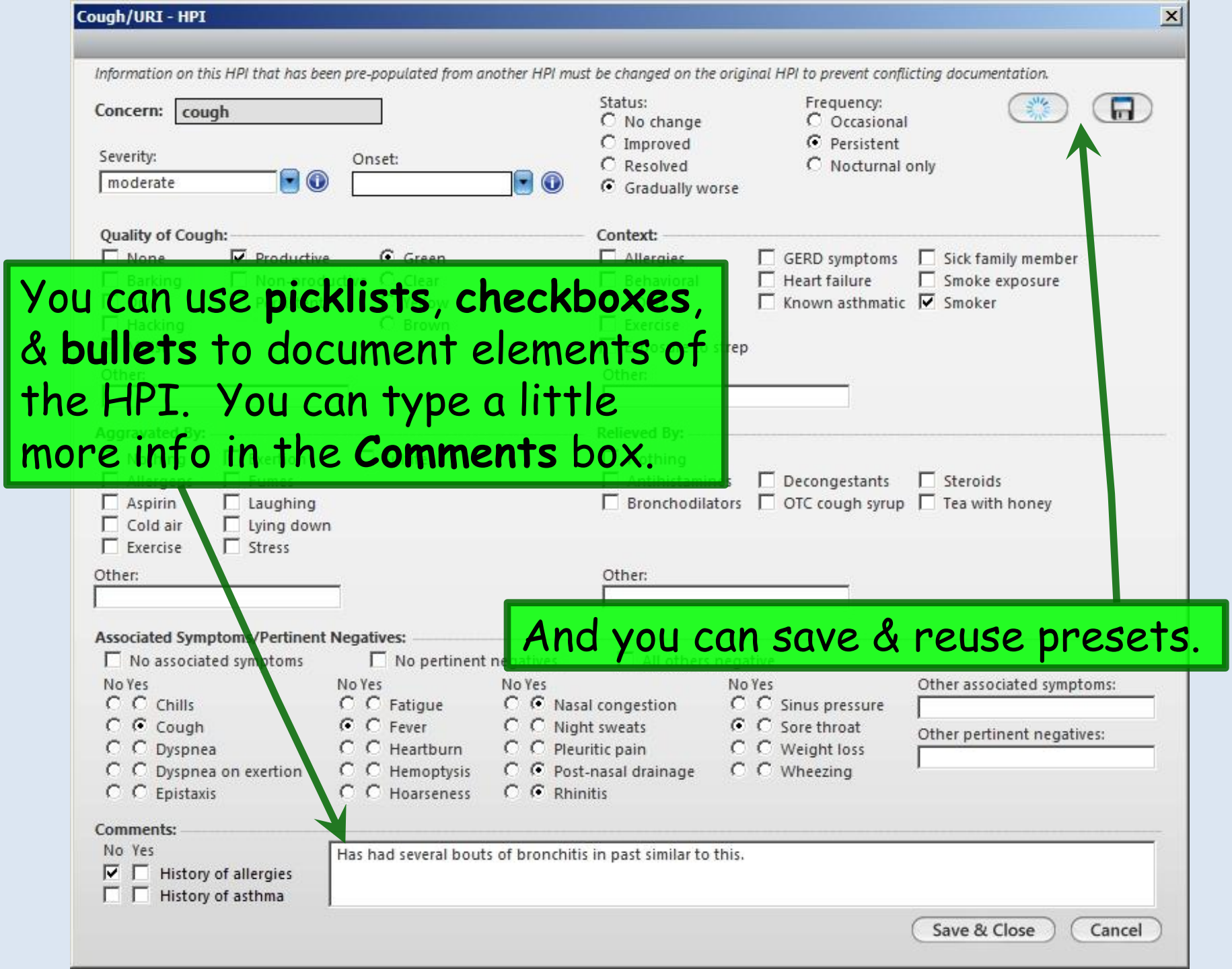

You can select any of the headings on the left to view various aspects of the chart. In particular, this is a good place to look at Office Lab results or review previous vital signs.
Alerts
Patient
Lipid Clinic Data
Order Admin...
Sticky Note
Referring Provider
HIPAA
Advance Directives
Screening Summary
03/15/2014 10:06 PM "*USA Home Page"
TOB
HTN
DM
CAD
Specialty ▼ Family Practice
Visit Type ▼ Office Visit
Intake
Histories
SOAP
Finalize
Checkout
Standing Orders
Adult Immunizations
Peds Immunizations
My Plan
Procedures
Order Management
Document Library
Care Guidelines
Global Days
Panel Control:
Toggle
Cycle
Medical Chart Summary
HPI's
Plans
Problem List
Medications
Allergies
Labs
Diagnostics
Vitals
Physical Exams
Office Procedures
Procedures
Referrals
Past Medical/Surgical History
Family History
Tobacco Usage
Date
Time
Temp F
BP
Pulse
Respiration
Ht In
Wt Lb
BMI
BSA
Pain Score
HAQ Score
Pulse
03/15/2014
11:19 PM
97.7
167/123
84
16
73.00
199.00
26.25
Patient History
New
Lock
Search
03/15/2014 10:06 PM
*USA Intake
USA Histories
Medication
intake_note
Custom
Note also you can use the collapsible panels or scroll down to see a lot more information.
Ready
CAP
NUM
SCRL
03/17/2014


03/15/2014 10:06 PM : "*USA Home Page"
Specialty ▼ Family Practice
Visit Type ▼ Office Visit
The Problem List is viewable & editable here.
Care Guidelines
Global Days
Panel Control: Toggle Cycle
Medical Chart Summary
Problem List 3
Show chronic
Show my tracked problems
No active problems
Reviewed
Last Addressed | Problem Description | Onset Date | Chronic | Secondary | Clinical Status | Provider | Location | Notes
Essential hypertension | Y | N | DUFFY, ROBERT LAMAR | USA FAMILY MEDICINE
Tobacco abuse | 01/01/1990 | Y | N | DUFFY, ROBERT LAMAR | USA FAMILY MEDICINE
Diabetes mellitus type II | N | N | DUFFY, ROBERT LAMAR | USA FAMILY MEDICINE | Was diet-controlled until ~2011.
Refresh
Add
Edit
History Summary
History Review
All History Review details are to be reviewed and included in visit note unless user indicates otherwise
Confidential
No relevant past medical/surgical history
(last updated 03/15/2014)
Medical
Surgical/mgmt
Interim
Social
Family
Diagnostic
Management | Side | Date | Encounter Type | Outcome | Disease/Disorder
L4-5, L5-S1 discectomy & fusion | 2004 | improved | Lumbar disc degenerative disease
Hernia repair | left | 2002 | successful | Inguinal hernia
Likewise, you can review & update everything else that appears on the Histories Tab from here. Select the category of history desired on the left.
Add
Edit
Remove


03/15/2014 10:06 PM : "*USA Home Page"
Allergies
Comment
No known allergies
Allergies added today
Reviewed, no change
Allergen
Reaction
Medication Name
Comment
TETRACYCLINE
Rash
Allergies, meds, vital signs, office labs—everything that can be found on the Intake & Histories Tabs can be reviewed & if necessary updated from this tab.
Update
Medications
Patient status:
Transitioning into care
Summary of care received
Comment
No medications
Medications reconciled
Medication
Sig Description
losartan 50 mg tablet
1 daily
metformin 500 mg tablet
1 twice daily
Add/Update
Reconcile
Vital Signs
Vital Signs Outside Normal Range
History | Graph
Time
Ht (in)
Wt (lb)
BMI
BP
Pulse
Respiration
Temp (F)
Pulse Ox Rest
BSA
Pain level
Comments
11:19 PM
73.00
199.00
26.25
167/123
84
16
97.7
Add
Edit
Remove
Orders
Lab/Radiology Order Processing | Order Management | Immunizations | Standing Orders | Task
View of All Orders
Labs
Ordered
Status
Order
Timeframe
Comments

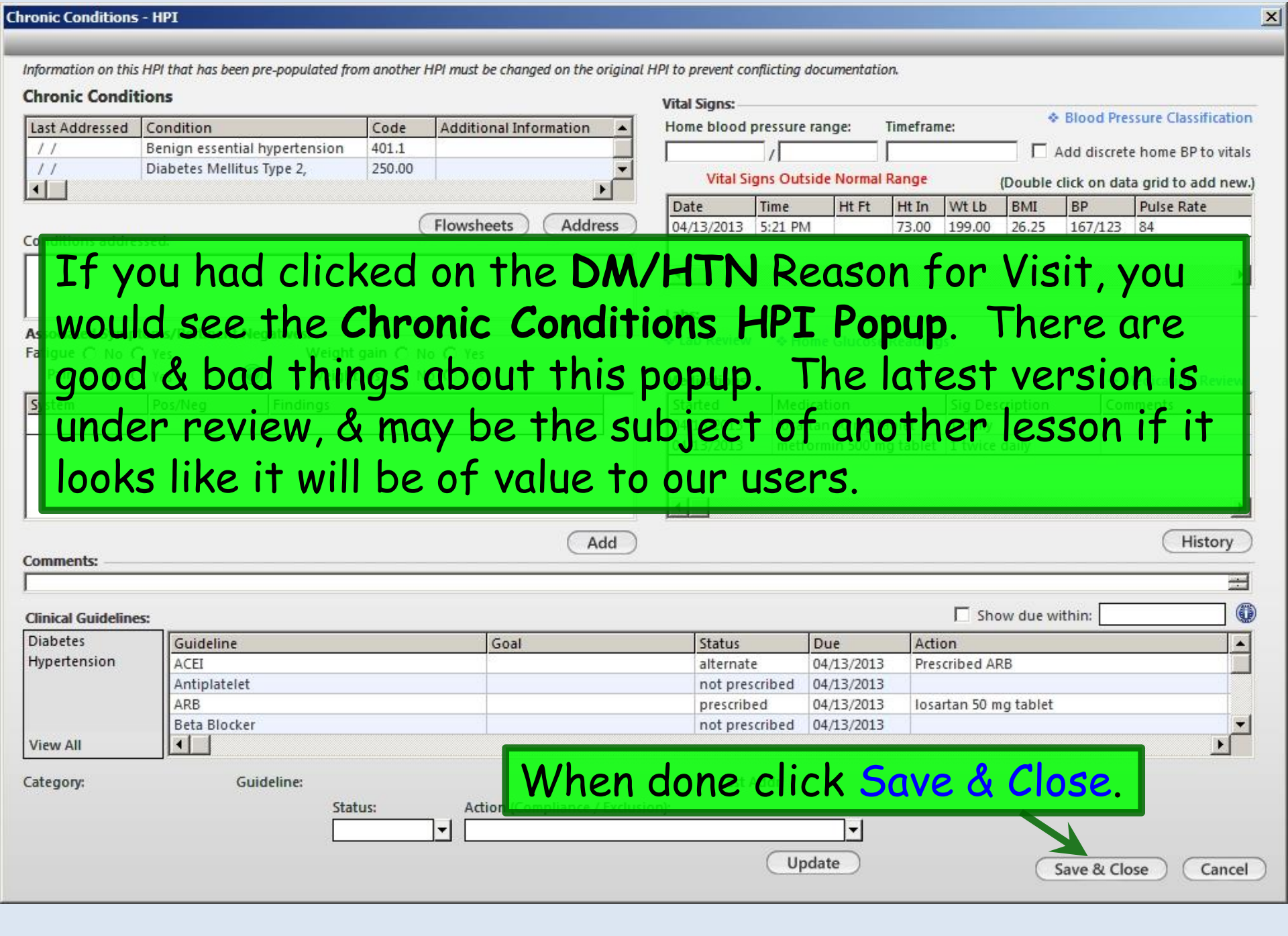

NextGen EHR: Pepe Quagmire MRN: 000000007772 DOB: 01/03/1973 (Male) AGE: 41 years 2 months - 03/15/2014 10:06 PM : "*USA Home Page"
File Edit Default View Tools Admin Utilities Window Help
Logout Save Clear Delete USA FAMILY MEDICINE DUFFY, ROBERT LAMAR MD Patient History Inbox PAQ Medications Templates Documents Images Orders Problems Apps Close
Pepe Quagmire (M) DOB: 01/03/1973 (41 years) Weight: 199.00 lb (90.26 Kg) Allergies: (1) Problems: (3) Diagnoses: (0) Medications: (2)
Address: 555 Driveby Drive
Mobile, AL 36604
Contact: (251) 555-1111 (Home)
MRN: 000000007772
Insurance: AFLAC
NextMD: No
Emergency Relation:
Emergency Phone:
Pharmacy 1: Central Discount ...
PCP: DUFFY, ROBERT LAMAR ...
Referring:
Rendering: DUFFY, ROBERT LAMAR ...
Alerts
Patient Lipid Clinic Data Order Admin... Sticky Note Referring Provider HIPAA Advance Directives Screening Summary
03/15/2014 10:06 PM : "*USA Home Page"
TOB HTN DM CAD
Specialty Family Practice Visit Type Office Visit
Intake Histories SOAP Finalize Checkout
Standing Orders Adult Immunizations Peds Immunizations My Plan Procedures Order Management Document Library
Care Guidelines Global Days
Panel Control: Toggle Cycle
Medical Chart Summary
HPI's
Plans
Problem List
Medications
Allergies
Labs
Diagnostics
Vitals
Physical Exams
Office Procedures
Procedures
Referrals
Past Medical/Surgical History
Family History
Tobacco Usage
Date
03/15/2014
Patient History
New Lock Search
03/15/2014 10:06 PM
*USA Intake
USA Histories
Medication
intake_note
You can also just review the intake_note to see a summary as well. Regardless of the method chosen, the provider is responsible for reviewing & confirming this information, & updating it as necessary.
When you're done reviewing the chart, move to the SOAP tab.
Ready
NGDevl USA Health Services Foundation rlduffy CAP NUM SCRL 03/17/2014


03/15/2014 10:06 PM : "*USA SOAP"
TOB
HTN
DM
CAD
Specialty ▾ Family Practice
Visit Type ▾ Office Visit
Intake
Histories
SOAP
Finalize
Checkout
We'll start entering the HPI. First note that you can keep or edit this introductory line—or delete it all together.
Reason for Visit
Introduction:
This 41 year old male presents for Cough and DM/HTN.
Do not launch HPI
Intake Comments
abdominal pain
back pain
chronic conditions
cold symptoms
cough
diabetes (follow up)
earache
fever
headache
hypertension (follow up)
musculoskeletal pain
PAP test
sore throat
Reason for Visit
History of Present Illness
Cough
DM/HTN
If you didn't previously note them, you can review the nurse's Intake Comments.
Next, you have some options as to how to proceed. You can click on one of the Reasons for Visit to open the HPI Popup. We'll click cough.
Diagnostics
Comments

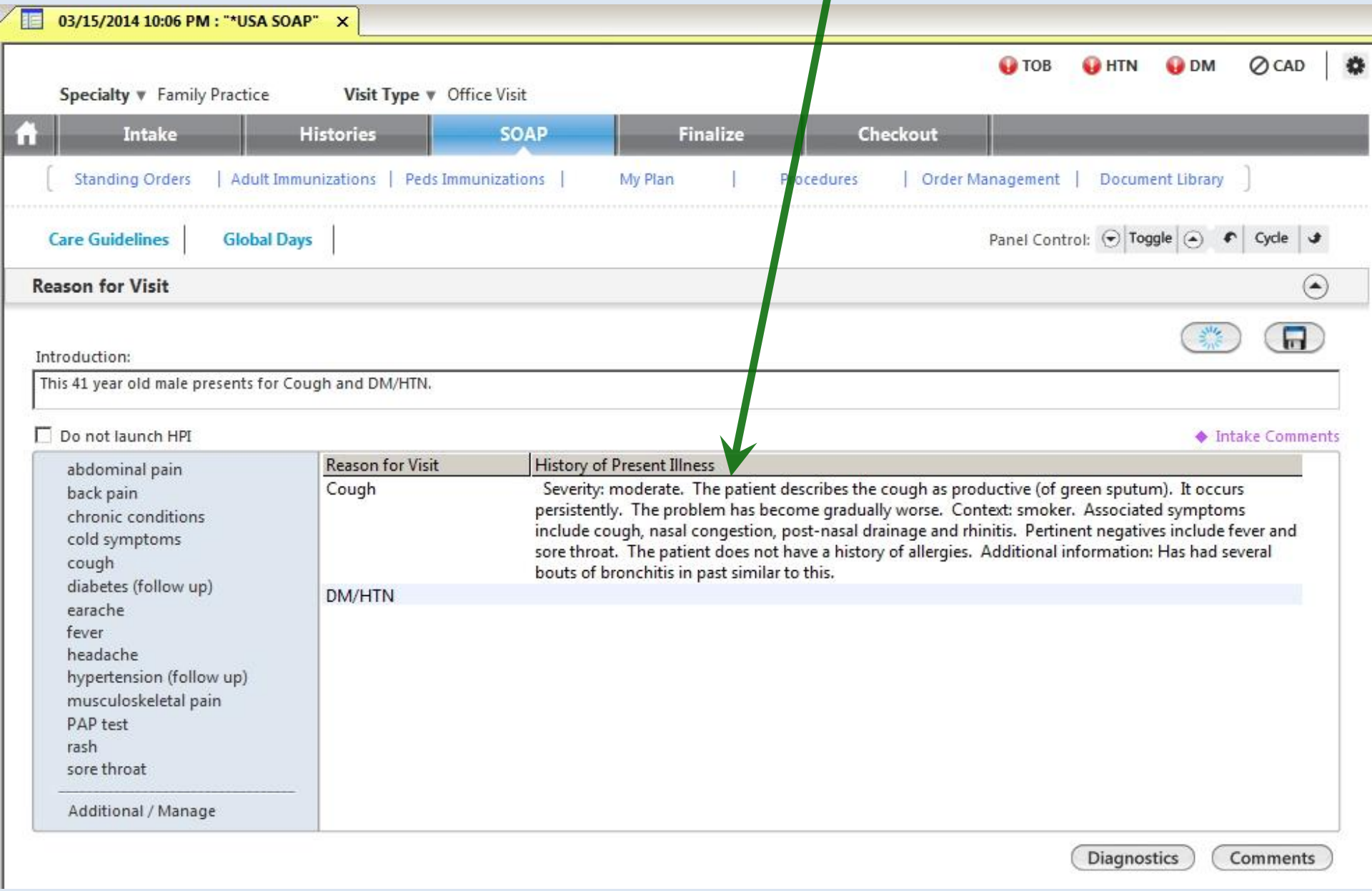


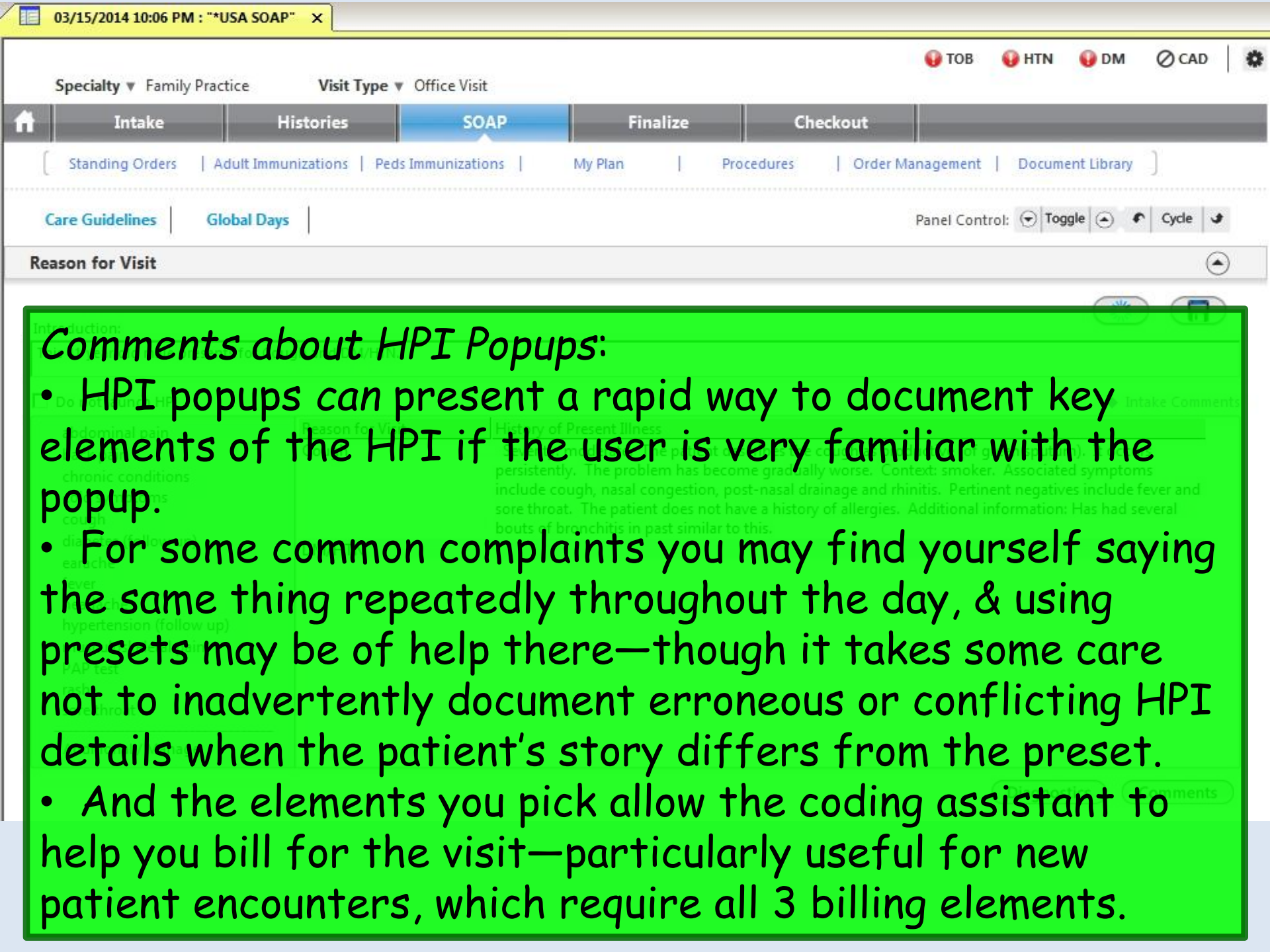

You can use **picklists**, **checkboxes**, & **bullets** to document elements of the HPI. You can type a little more info in the **Comments** box.

And you can save & reuse presets.


Chronic Conditions - HPI
Information on this HPI that has been pre-populated from another HPI must be changed on the original HPI to prevent conflicting documentation.
Chronic Conditions
Last Addressed
Condition
Code
Additional Information
/ /
Benign essential hypertension
401.1
/ /
Diabetes Mellitus Type 2,
250.00
Flowsheets
Address
Vital Signs:
Blood Pressure Classification
Home blood pressure range:
Timeframe:
Add discrete home BP to vitals
Vital Signs Outside Normal Range
(Double click on data grid to add new.)
Date
Time
Ht Ft
Ht In
Wt Lb
BMI
BP
Pulse Rate
04/13/2013
5:21 PM
73.00
199.00
26.25
167/123
84
If you had clicked on the DM/HTN Reason for Visit, you would see the Chronic Conditions HPI Popup. There are good & bad things about this popup. The latest version is under review, & may be the subject of another lesson if it looks like it will be of value to our users.
Add
History
Comments:
Clinical Guidelines:
Show due within:
Diabetes
Hypertension
View All
Guideline
Goal
Status
Due
Action
ACEI
alternate
04/13/2013
Prescribed ARB
Antiplatelet
not prescribed
04/13/2013
ARB
prescribed
04/13/2013
losartan 50 mg tablet
Beta Blocker
not prescribed
04/13/2013
Category:
Guideline:
Status:
When done click Save & Close.
Update
Save & Close
Cancel

# Entries from the HPI popups display on the **SOAP Tab.**



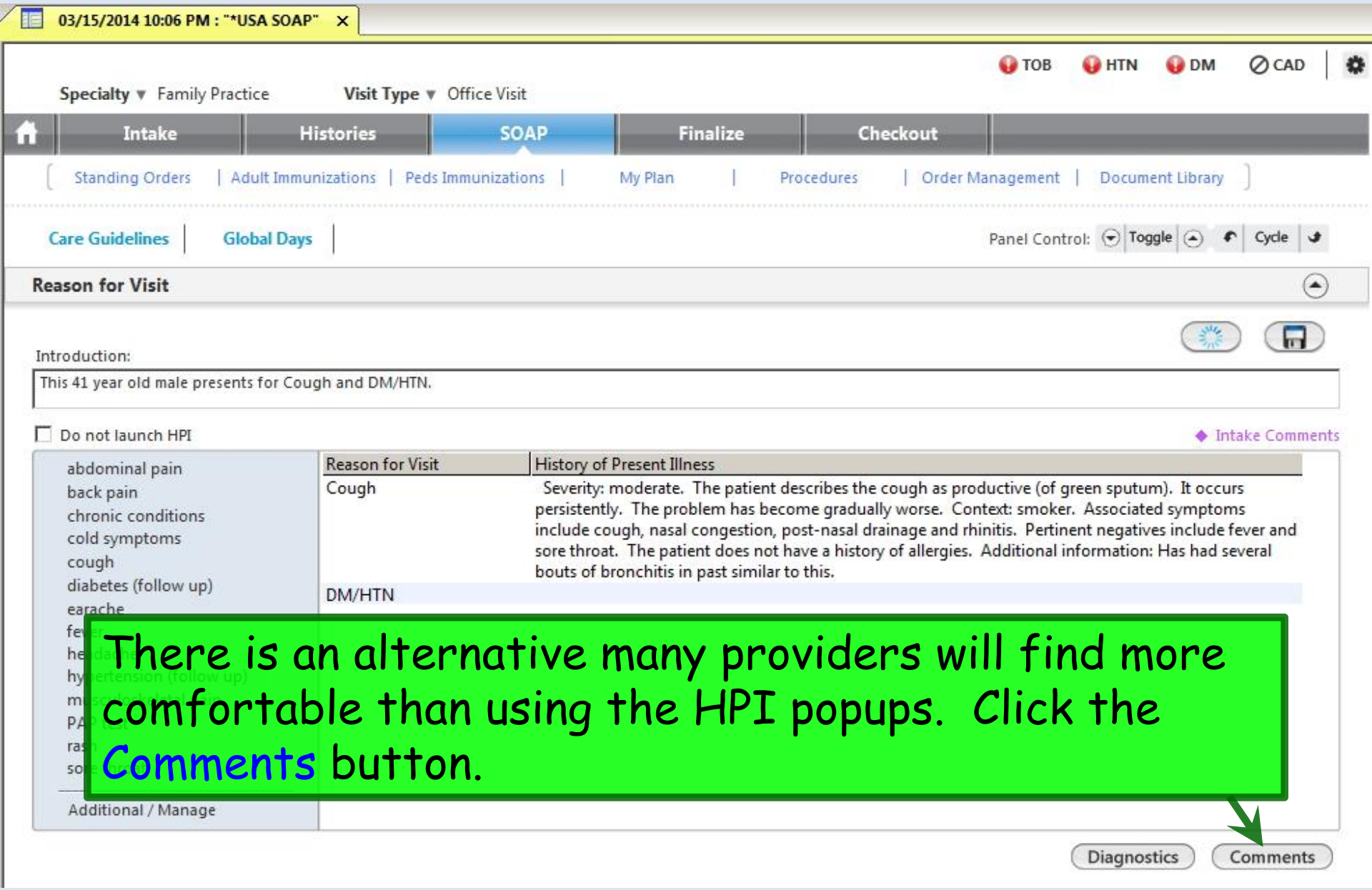


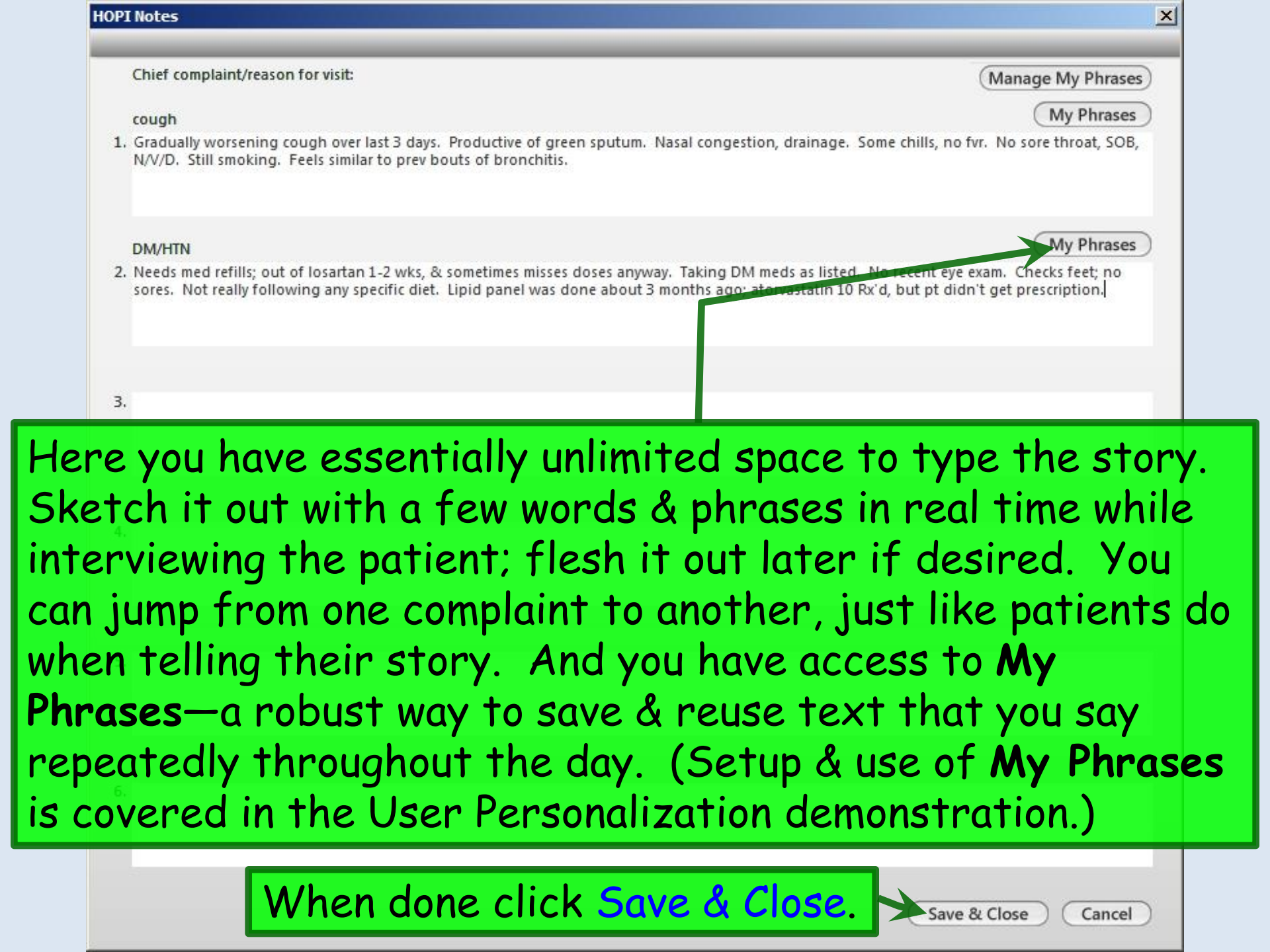

*Comments about HPI Popups*:

- HPI popups *can* present a rapid way to document key elements of the HPI if the user is very familiar with the popup.
- For some common complaints you may find yourself saying the same thing repeatedly throughout the day, & using presets may be of help there—though it takes some care not to inadvertently document erroneous or conflicting HPI details when the patient's story differs from the preset.
- And the elements you pick allow the coding assistant to help you bill for the visit—particularly useful for new patient encounters, which require all 3 billing elements.

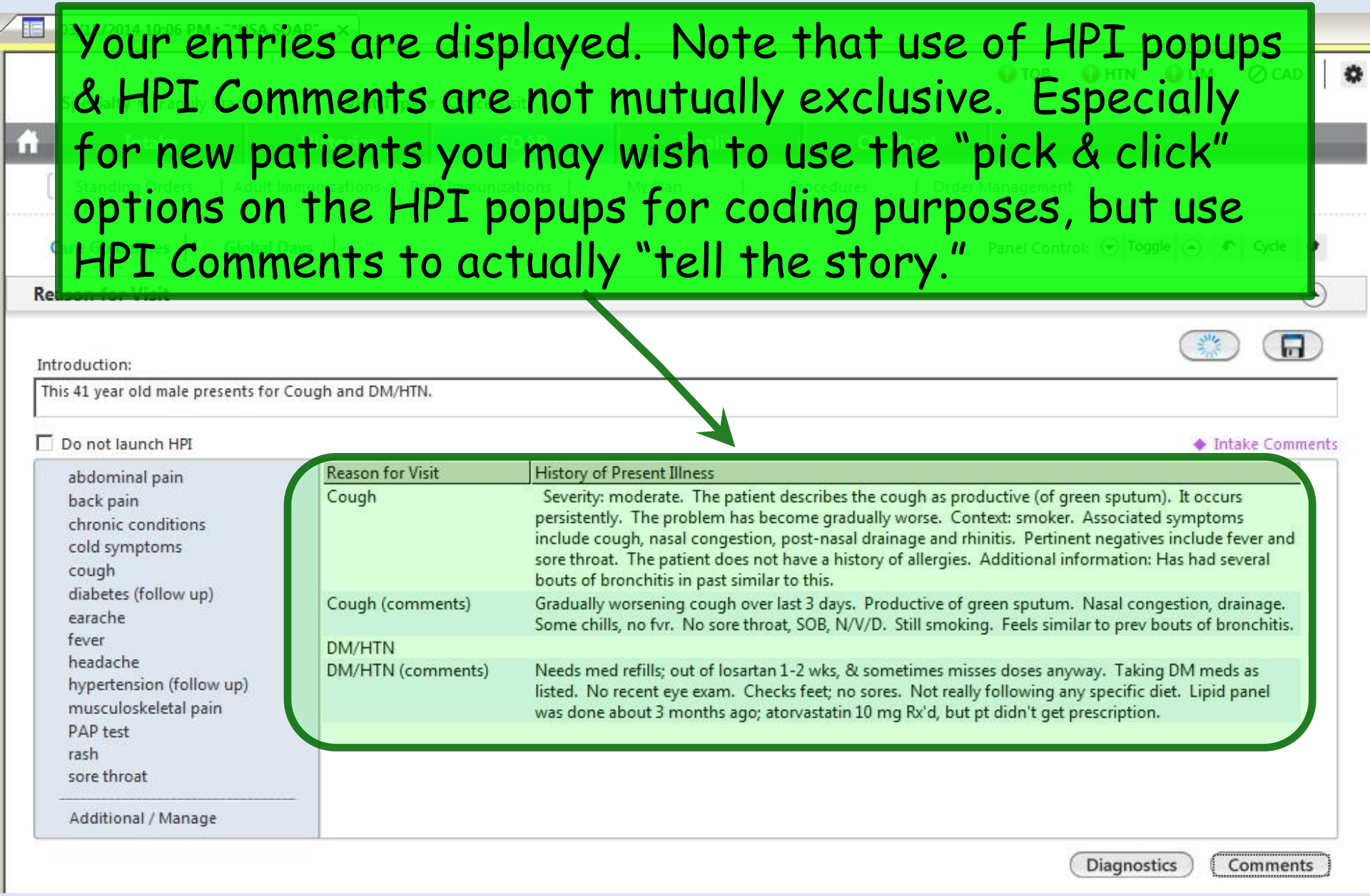
*Comments about HPI Popups*:

- But many users find the "pick & click" nature of using HPI popups tedious, slow, & frustrating—and distracting when trying to perform documentation in real time in the exam room.
- The Comments boxes on the HPI popups provide only a limited amount of space to type, which can vary from one to another, so that you never know when you're going to run out of space.
- And when entries from a series of "picks & clicks" are condensed into something resembling English, the result is often awkwardly-worded, not really reflecting any uniqueness of the story or the story-teller. Your eyes glaze over when you read it; often you can't even recognize whether you performed the visit or if it was done by one of your colleagues.

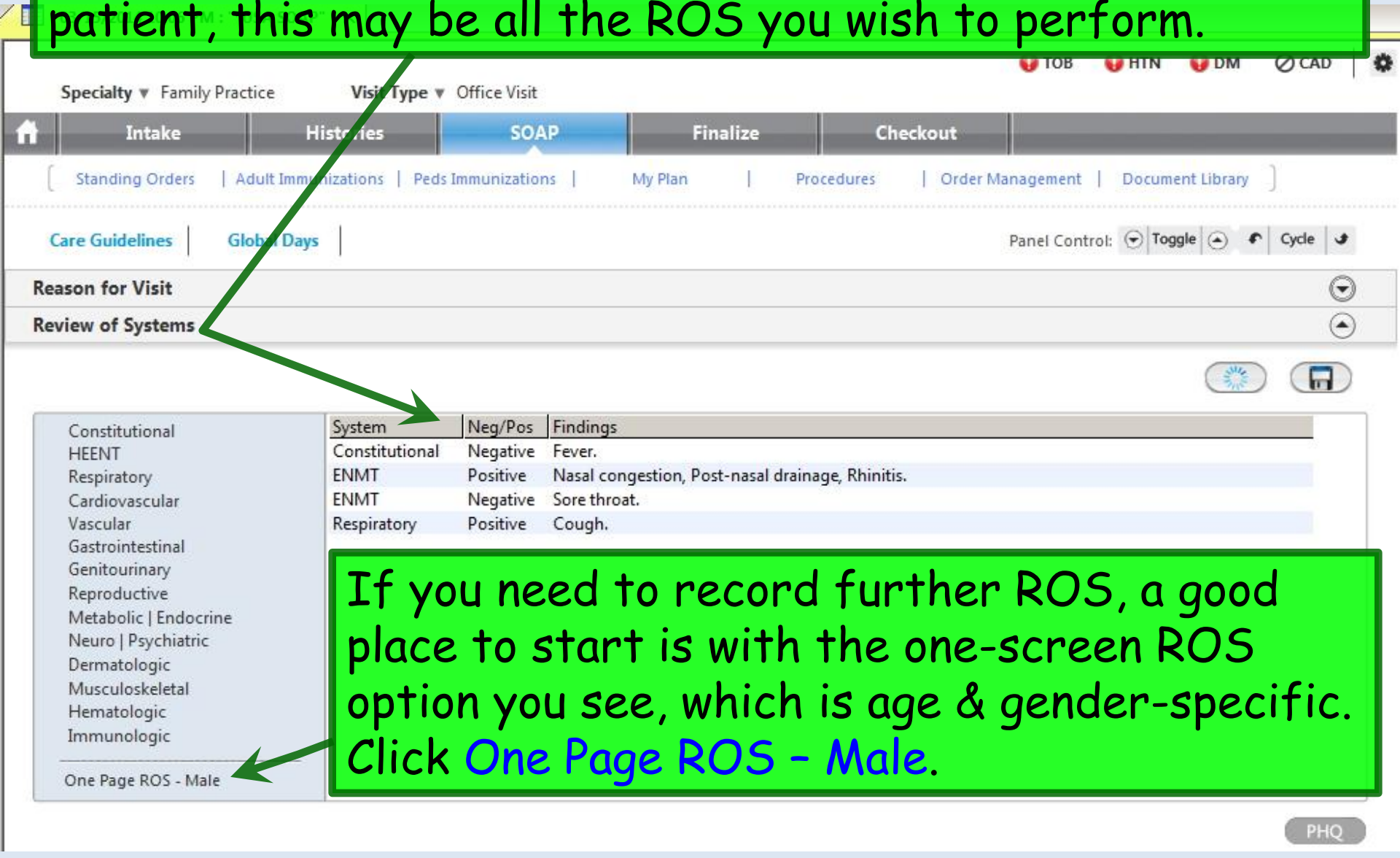

03/15/2014 10:06 PM : "*USA SOAP"
TOB
HTN
DM
CAD
Specialty ▼ Family Practice
Visit Type ▼ Office Visit
Intake
Histories
SOAP
Finalize
Checkout
Standing Orders | Adult Immunizations | Peds Immunizations | My Plan | Procedures | Order Management | Document Library
Care Guidelines
Global Days
Panel Control: Toggle Cycle
Reason for Visit
Introduction:
This 41 year old male presents for Cough and DM/HTN.
Do not launch HPI
Intake Comments
abdominal pain
back pain
chronic conditions
cold symptoms
cough
diabetes (follow up)
earache
Additional / Manage
Reason for Visit
History of Present Illness
Cough
Severity: moderate. The patient describes the cough as productive (of green sputum). It occurs persistently. The problem has become gradually worse. Context: smoker. Associated symptoms include cough, nasal congestion, post-nasal drainage and rhinitis. Pertinent negatives include fever and sore throat. The patient does not have a history of allergies. Additional information: Has had several bouts of bronchitis in past similar to this.
DM/HTN
There is an alternative many providers will find more comfortable than using the HPI popups. Click the Comments button.
Diagnostics
Comments


HOPI Notes
Chief complaint/reason for visit:
Manage My Phrases
cough
My Phrases
1. Gradually worsening cough over last 3 days. Productive of green sputum. Nasal congestion, drainage. Some chills, no fvr. No sore throat, SOB, N/V/D. Still smoking. Feels similar to prev bouts of bronchitis.
DM/HTN
My Phrases
2. Needs med refills; out of losartan 1-2 wks, & sometimes misses doses anyway. Taking DM meds as listed. No recent eye exam. Checks feet; no sores. Not really following any specific diet. Lipid panel was done about 3 months ago; atorvastatin 10 Rx'd, but pt didn't get prescription.
3.
Here you have essentially unlimited space to type the story. Sketch it out with a few words & phrases in real time while interviewing the patient; flesh it out later if desired. You can jump from one complaint to another, just like patients do when telling their story. And you have access to My Phrases—a robust way to save & reuse text that you say repeatedly throughout the day. (Setup & use of My Phrases is covered in the User Personalization demonstration.)
When done click Save & Close.
Save & Close
Cancel

Your entries are displayed. Note that use of HPI popups & HPI Comments are not mutually exclusive. Especially for new patients you may wish to use the "pick & click" options on the HPI popups for coding purposes, but use HPI Comments to actually "tell the story."

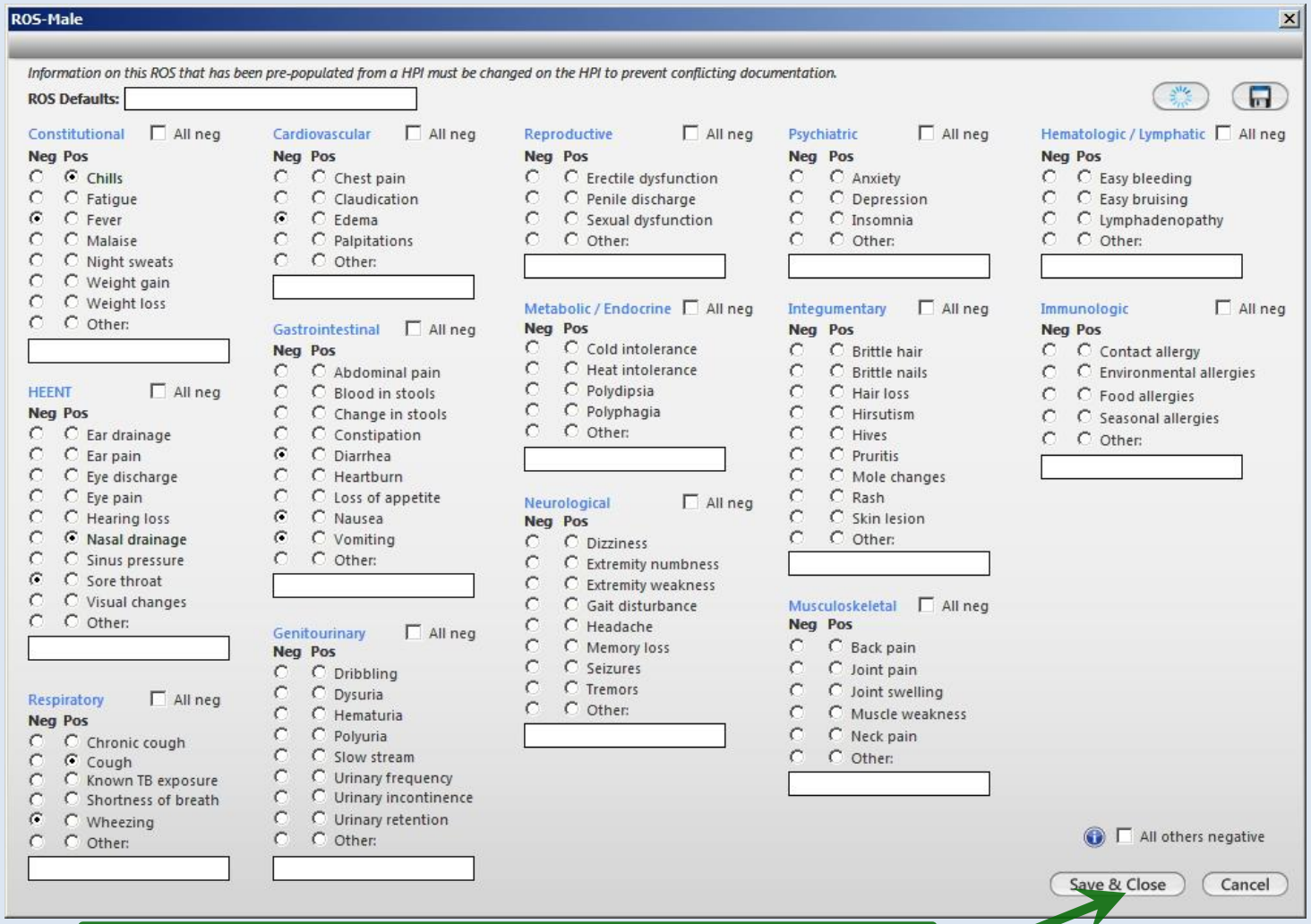


Working down the **SOAP tab**, you come to the **Review of Systems**. Note that some items that are shared with the HPI popups may already be documented. For an established patient, this may be all the ROS you wish to perform.

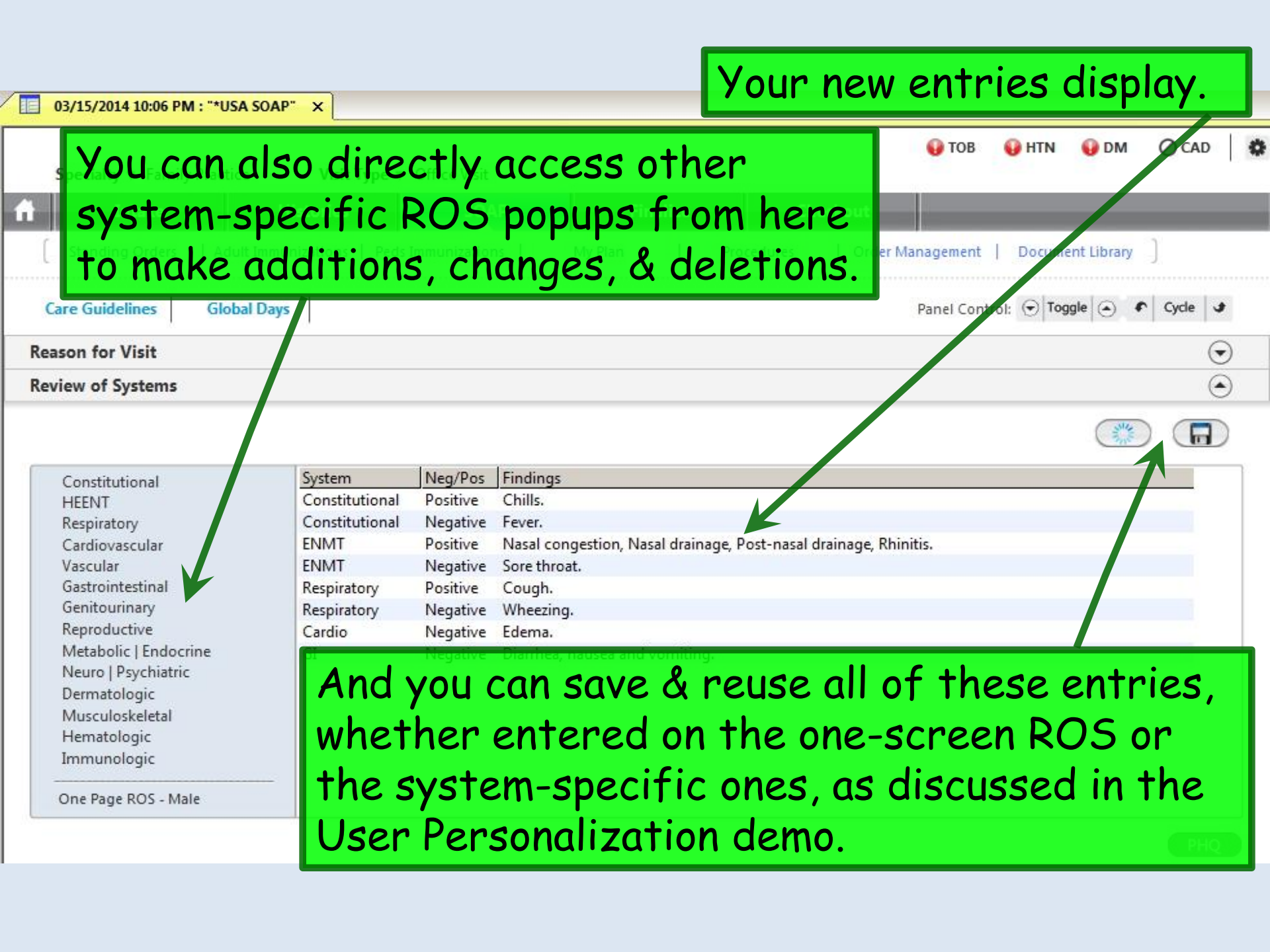



If you need to record further ROS, a good place to start is with the one-screen ROS option you see, which is age & gender-specific. Click One Page ROS - Male.

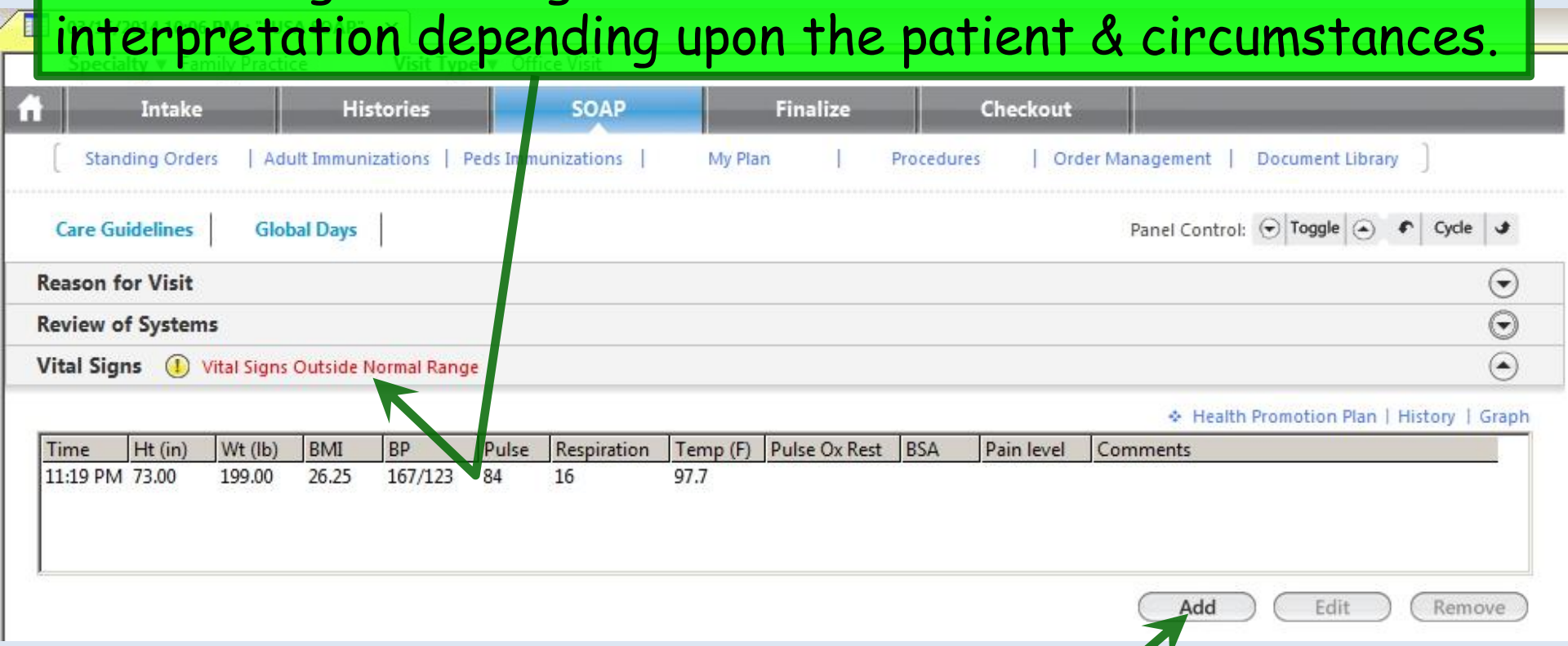
Make additional entries as necessary. You can click on any system heading to take you to a more detailed ROS for that system. And you can save & reuse presets.



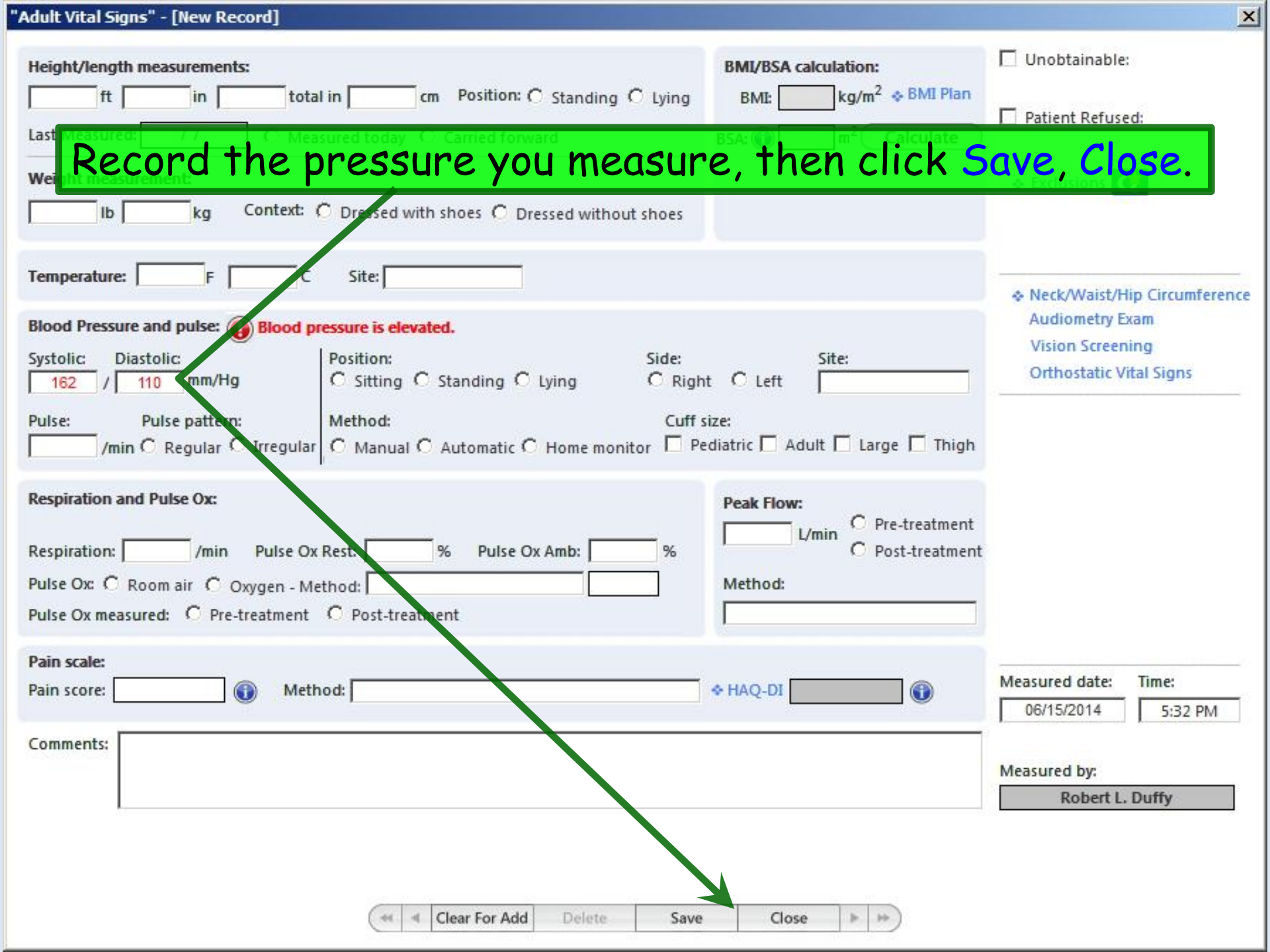

When done click Save & Close.


Your new entries display.
You can also directly access other system-specific ROS popups from here to make additions, changes, & deletions.
03/15/2014 10:06 PM : "*USA SOAP"
TOB
HTN
DM
CAD
Care Guidelines
Global Days
Panel Control:
Toggle
Cycle
Reason for Visit
Review of Systems
Constitutional
HEENT
Respiratory
Cardiovascular
Vascular
Gastrointestinal
Genitourinary
Reproductive
Metabolic | Endocrine
Neuro | Psychiatric
Dermatologic
Musculoskeletal
Hematologic
Immunologic
One Page ROS - Male
System
Neg/Pos
Findings
Constitutional
Positive
Chills.
Constitutional
Negative
Fever.
ENMT
Positive
Nasal congestion, Nasal drainage, Post-nasal drainage, Rhinitis.
ENMT
Negative
Sore throat.
Respiratory
Positive
Cough.
Respiratory
Negative
Wheezing.
Cardio
Negative
Edema.
And you can save & reuse all of these entries, whether entered on the one-screen ROS or the system-specific ones, as discussed in the User Personalization demo.

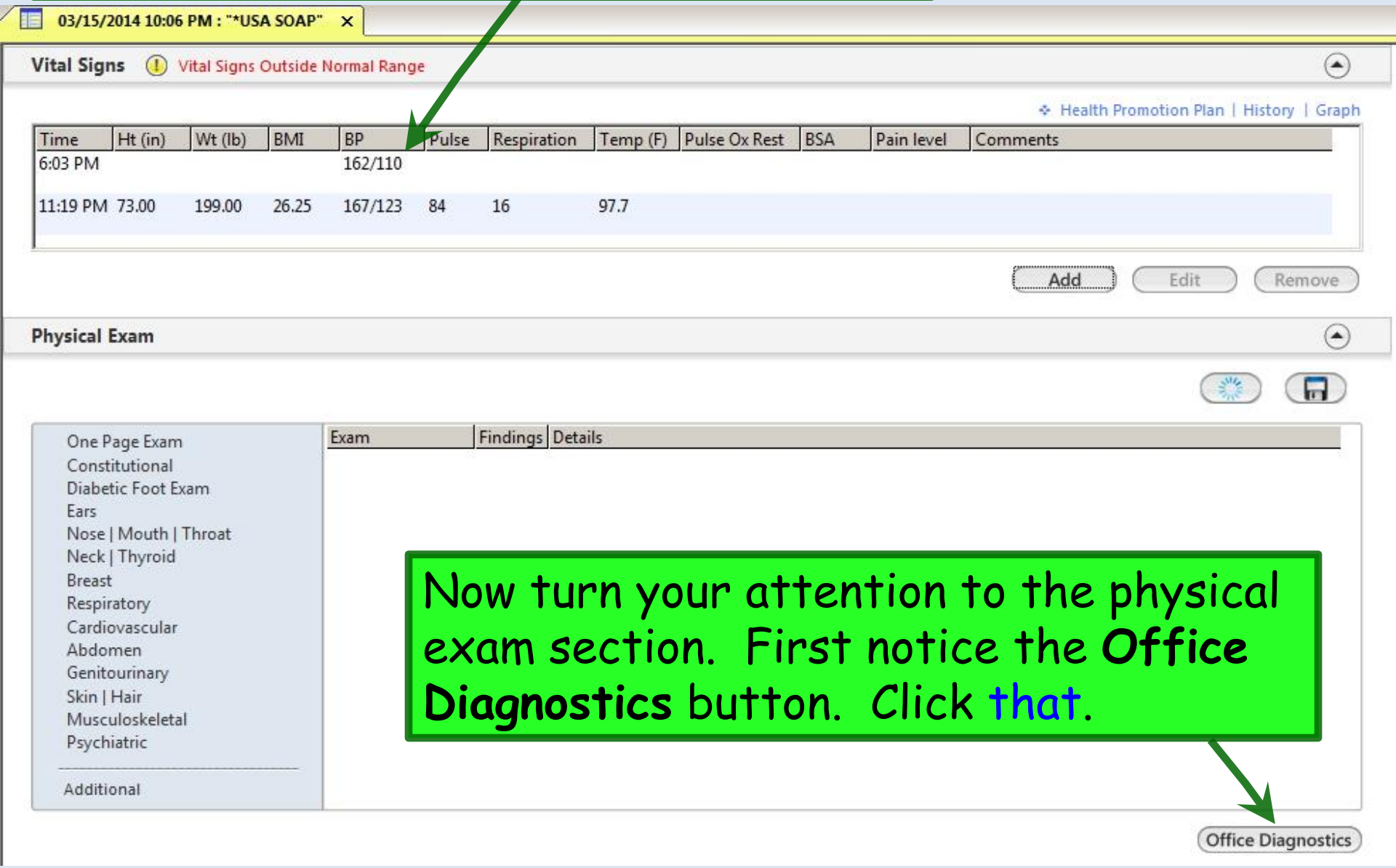
Continuing down the **SOAP tab**, you can review the **Vital Signs** again. You'll receive notices about VS that are out of normal ranges—though that is sometimes a matter of interpretation depending upon the patient & circumstances.



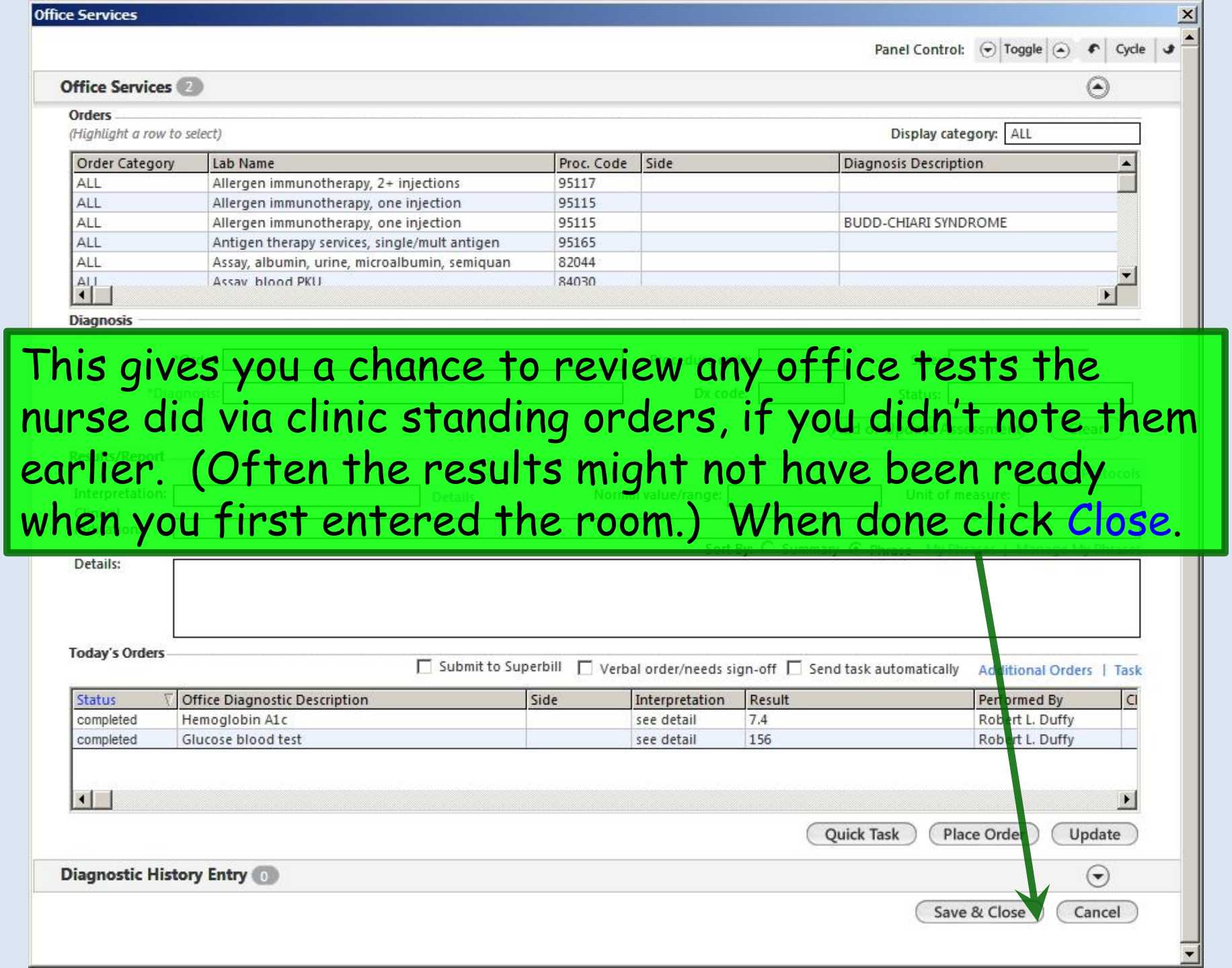

Let's say we'd like to recheck that elevated blood pressure. Click Add.


"Adult Vital Signs" - [New Record]
Height/length measurements:
ft in total in cm Position: Standing Lying
BMI/BSA calculation:
BMI: kg/m2 BMI Plan
Unobtainable:
Patient Refused:
Record the pressure you measure, then click Save, Close.
lb kg Context: Dressed with shoes Dressed without shoes
Temperature: F C Site:
Neck/Waist/Hip Circumference
Audiometry Exam
Vision Screening
Orthostatic Vital Signs
Blood Pressure and pulse: Blood pressure is elevated.
Systolic: 162 / Diastolic: 110 mm/Hg
Position: Sitting Standing Lying
Side: Right Left
Site:
Pulse: /min Pulse pattern: Regular Irregular
Method: Manual Automatic Home monitor
Cuff size: Pediatric Adult Large Thigh
Respiration and Pulse Ox:
Respiration: /min Pulse Ox Rest: % Pulse Ox Amb: %
Pulse Ox: Room air Oxygen - Method:
Pulse Ox measured: Pre-treatment Post-treatment
Peak Flow:
L/min Pre-treatment Post-treatment
Method:
Pain scale:
Pain score: Method: HAQ-DI
Measured date: 06/15/2014 Time: 5:32 PM
Comments:
Measured by: Robert L. Duffy
Clear For Add Delete Save Close

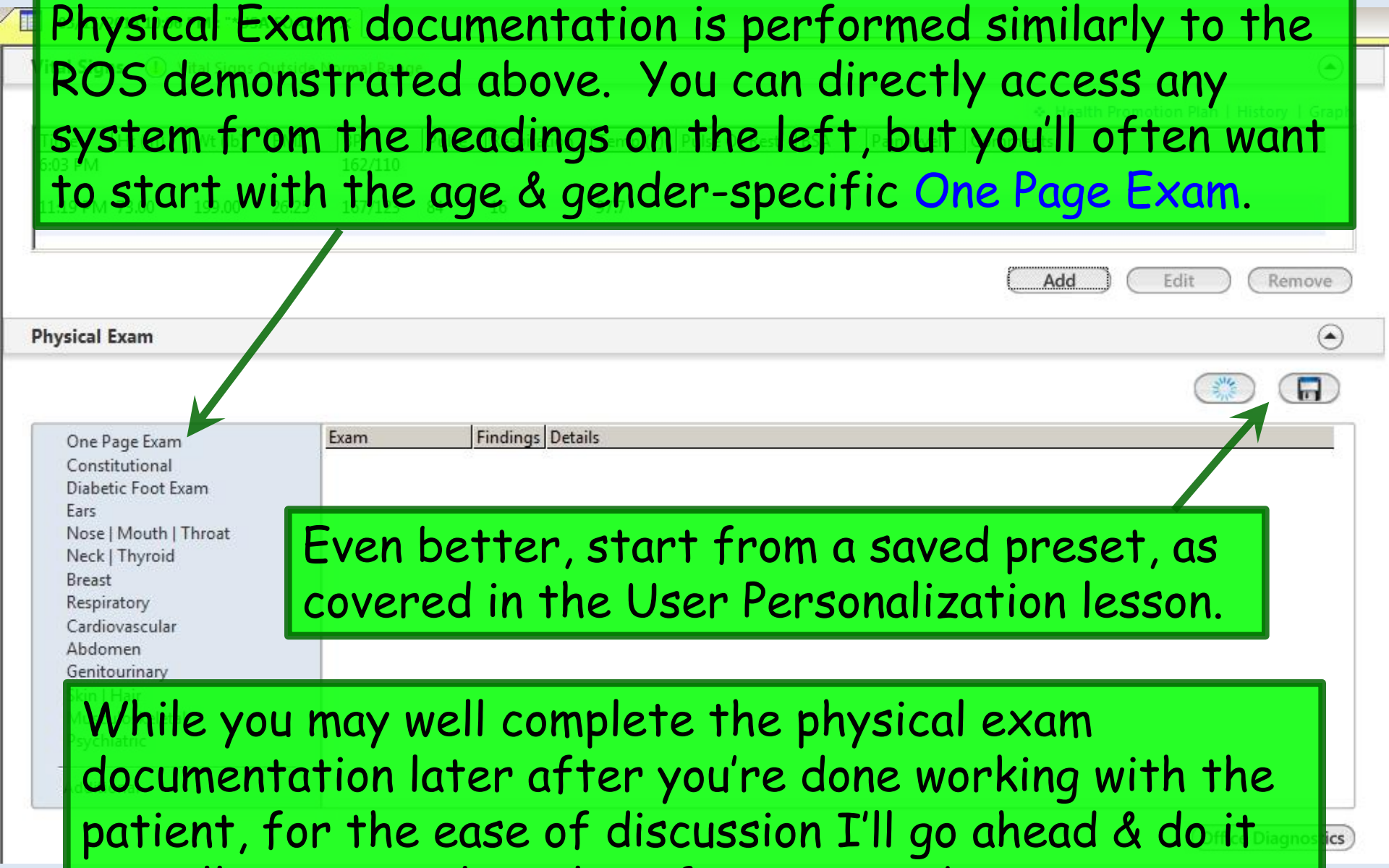
Your additional blood pressure displays.




Now turn your attention to the physical exam section. First notice the **Office Diagnostics** button. Click that.

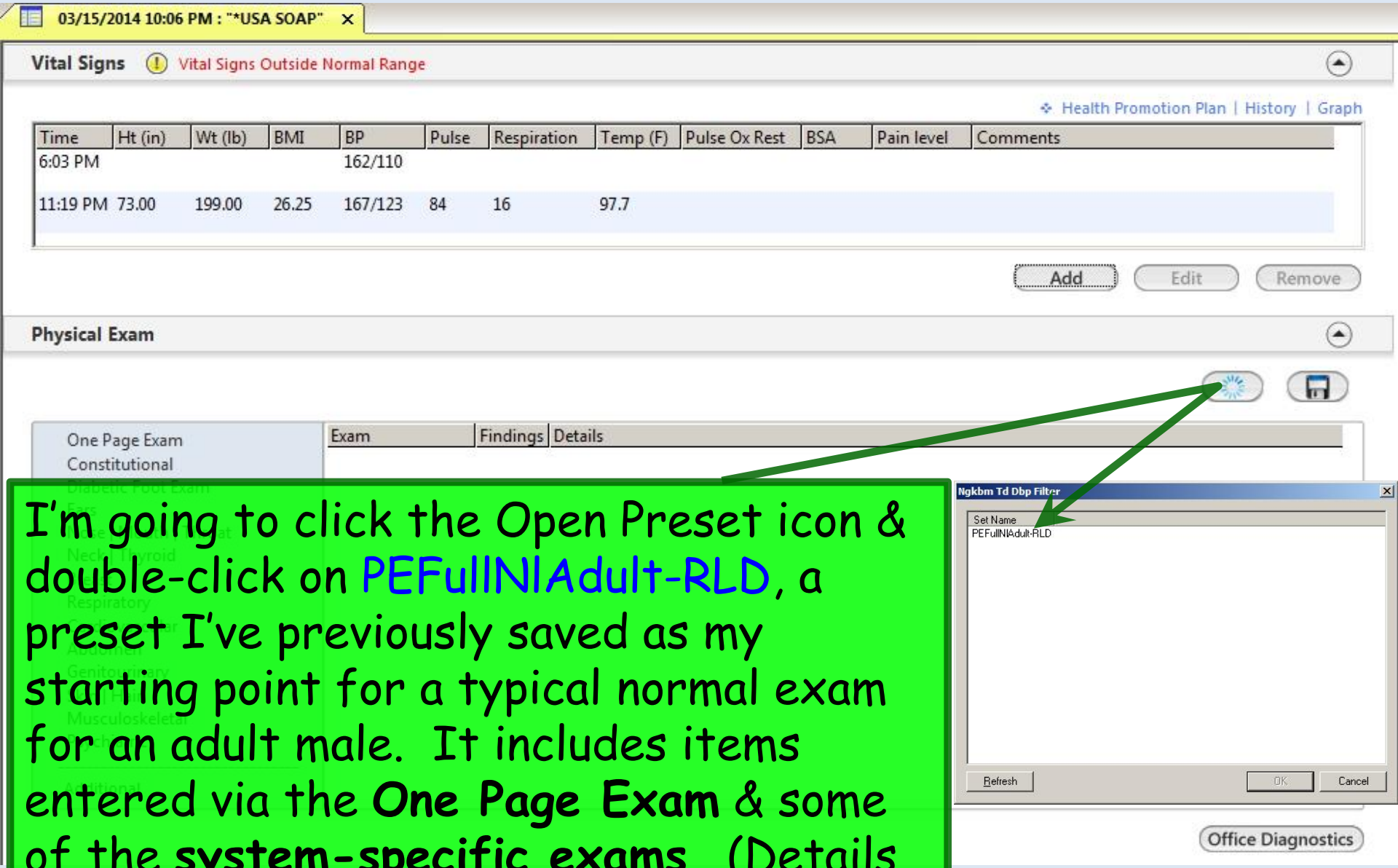

Office Services
Panel Control: Toggle Cycle
Office Services 2
Orders
(Highlight a row to select)
Display category: ALL
Order Category | Lab Name | Proc. Code | Side | Diagnosis Description
ALL | Allergen immunotherapy, 2+ injections | 95117
ALL | Allergen immunotherapy, one injection | 95115
ALL | Allergen immunotherapy, one injection | 95115 | BUDD-CHIARI SYNDROME
ALL | Antigen therapy services, single/mult antigen | 95165
ALL | Assay, albumin, urine, microalbumin, semiquan | 82044
ALL | Assay, blood PKU | 84030
Diagnosis
This gives you a chance to review any office tests the nurse did via clinic standing orders, if you didn't note them earlier. (Often the results might not have been ready when you first entered the room.) When done click Close.
Details:
Today's Orders
Submit to Superbill
Verbal order/needs sign-off
Send task automatically
Additional Orders | Task
Status | Office Diagnostic Description | Side | Interpretation | Result | Performed By
completed | Hemoglobin A1c | see detail | 7.4 | Robert L. Duffy
completed | Glucose blood test | see detail | 156 | Robert L. Duffy
Quick Task
Place Order
Update
Diagnostic History Entry 0
Save & Close
Cancel

Physical Exam documentation is performed similarly to the ROS demonstrated above. You can directly access any system from the headings on the left, but you'll often want to start with the age & gender-specific One Page Exam.



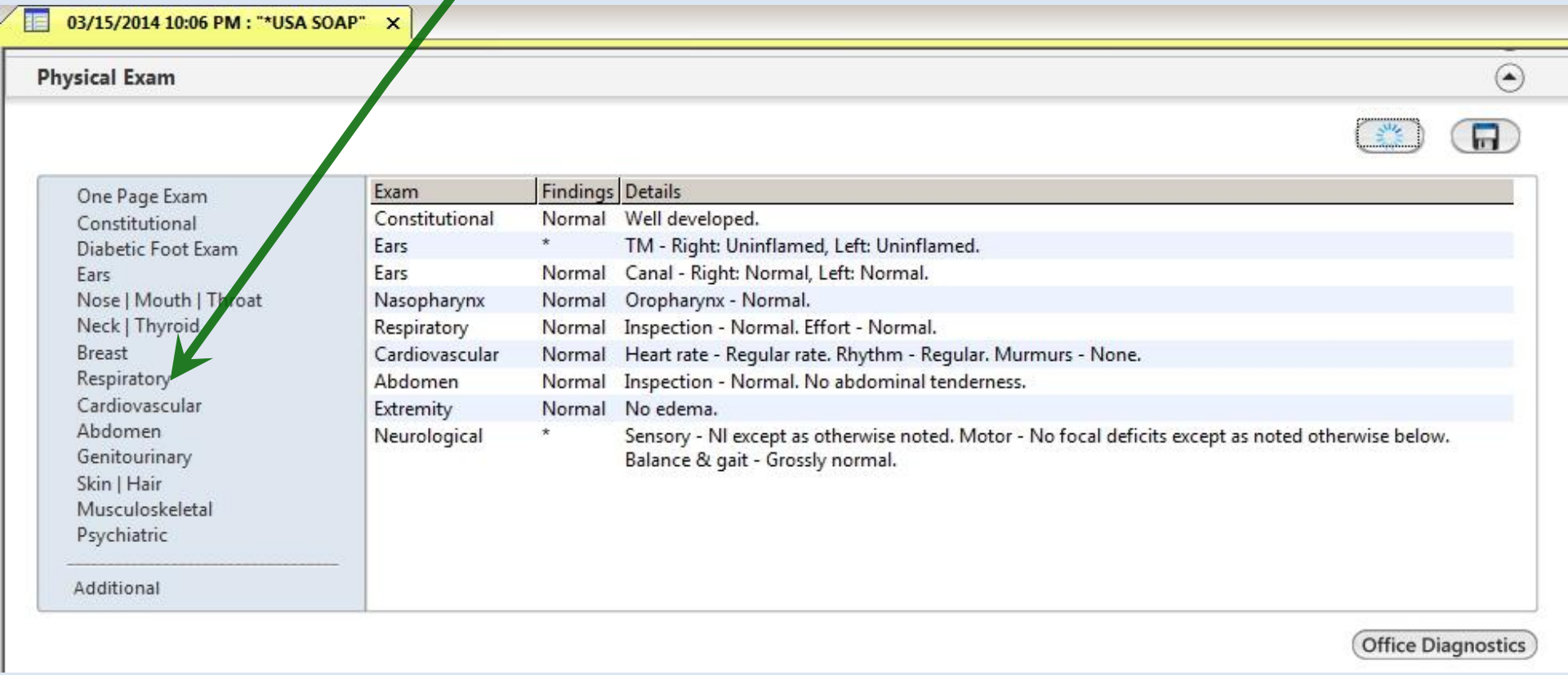

Even better, start from a saved preset, as covered in the User Personalization lesson.

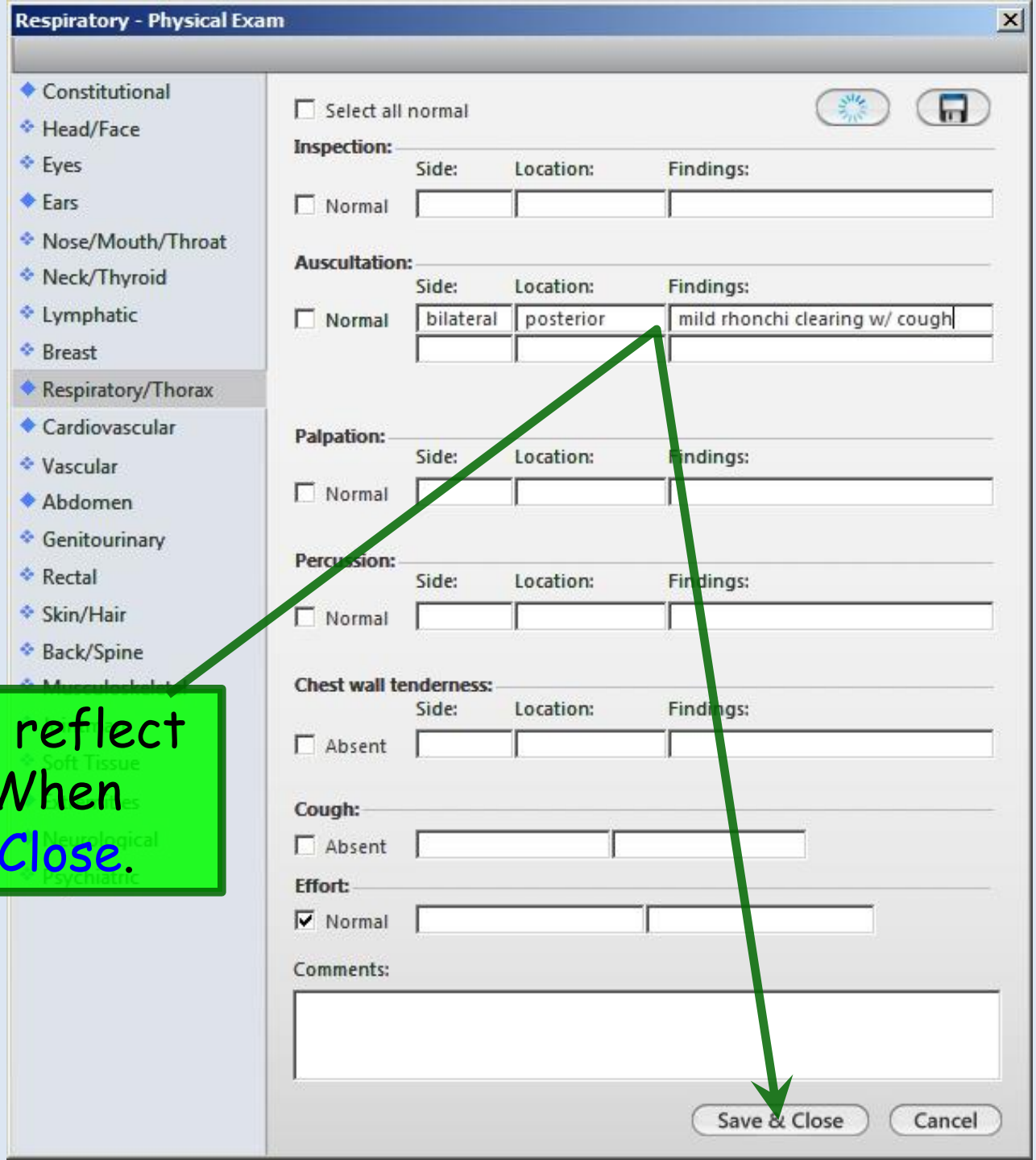
While you may well complete the physical exam documentation later after you're done working with the patient, for the ease of discussion I'll go ahead & do it now, illustrating the value of using saved preset exams.




I'm going to click the Open Preset icon & double-click on PEFullNlAdult-RLD, a preset I've previously saved as my starting point for a typical normal exam for an adult male. It includes items entered via the **One Page Exam** & some of the **system-specific exams**. (Details on setup of these presets are covered in the User Personalization demo.)

Your default normal exam displays. Now let's change the respiratory exam to mention some abnormalities found today. Click on Respiratory.

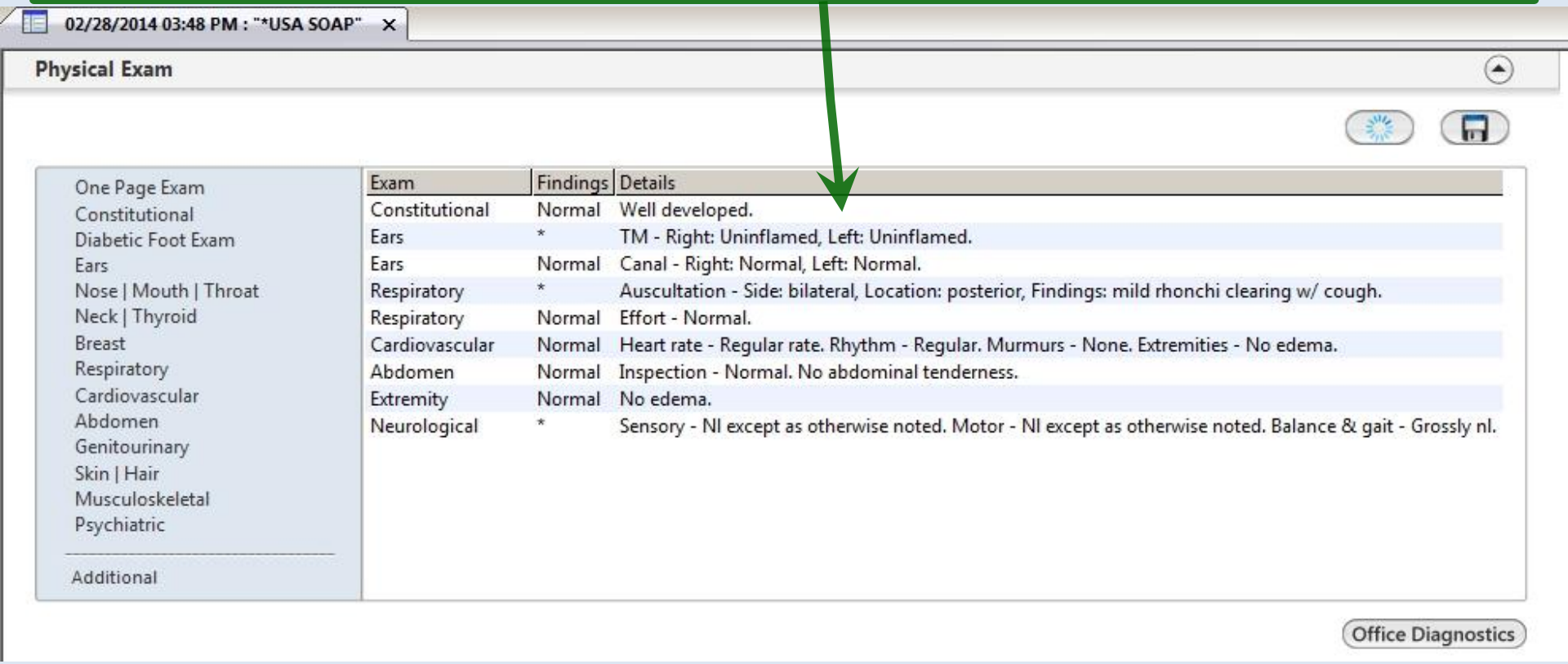


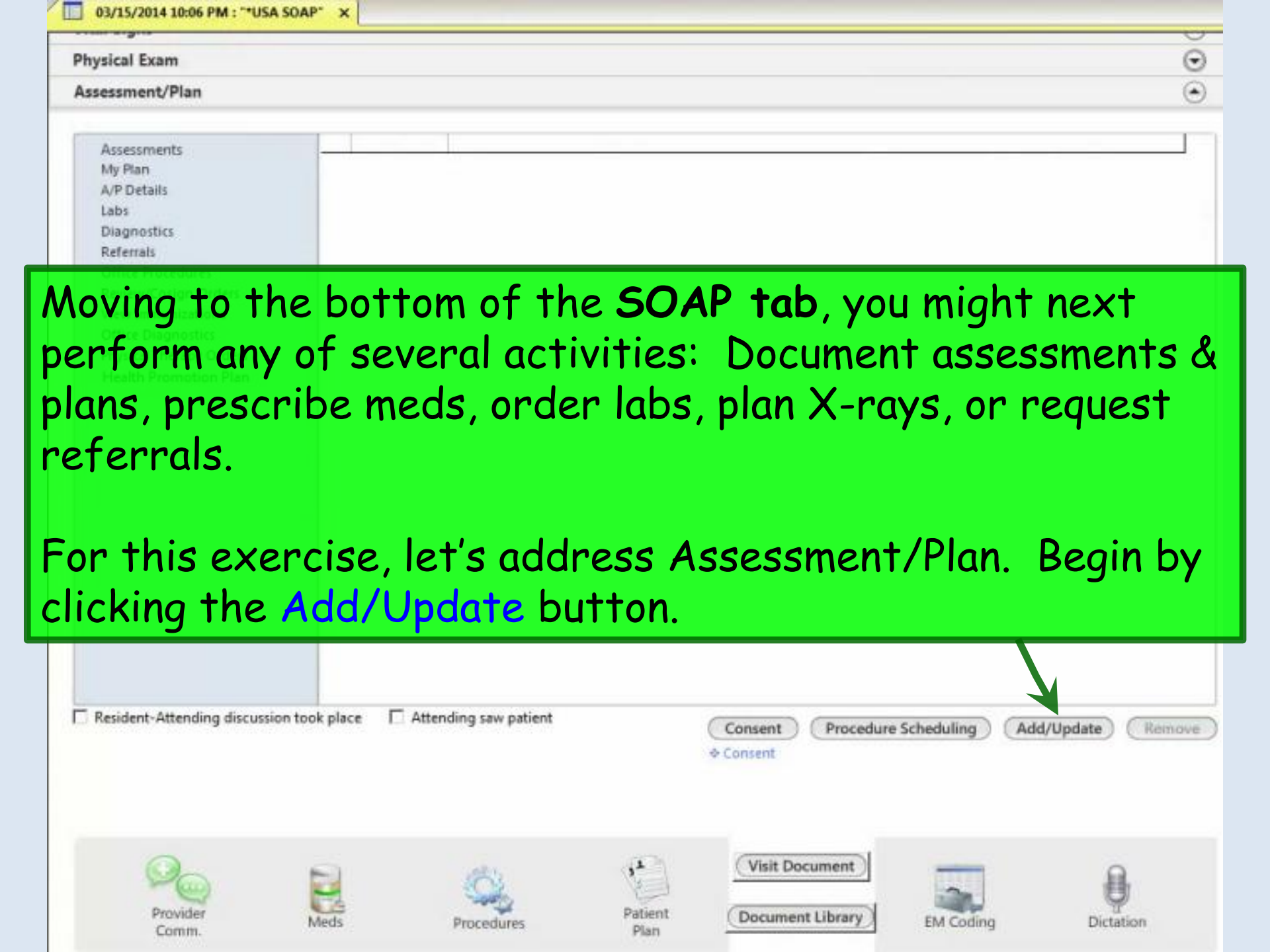


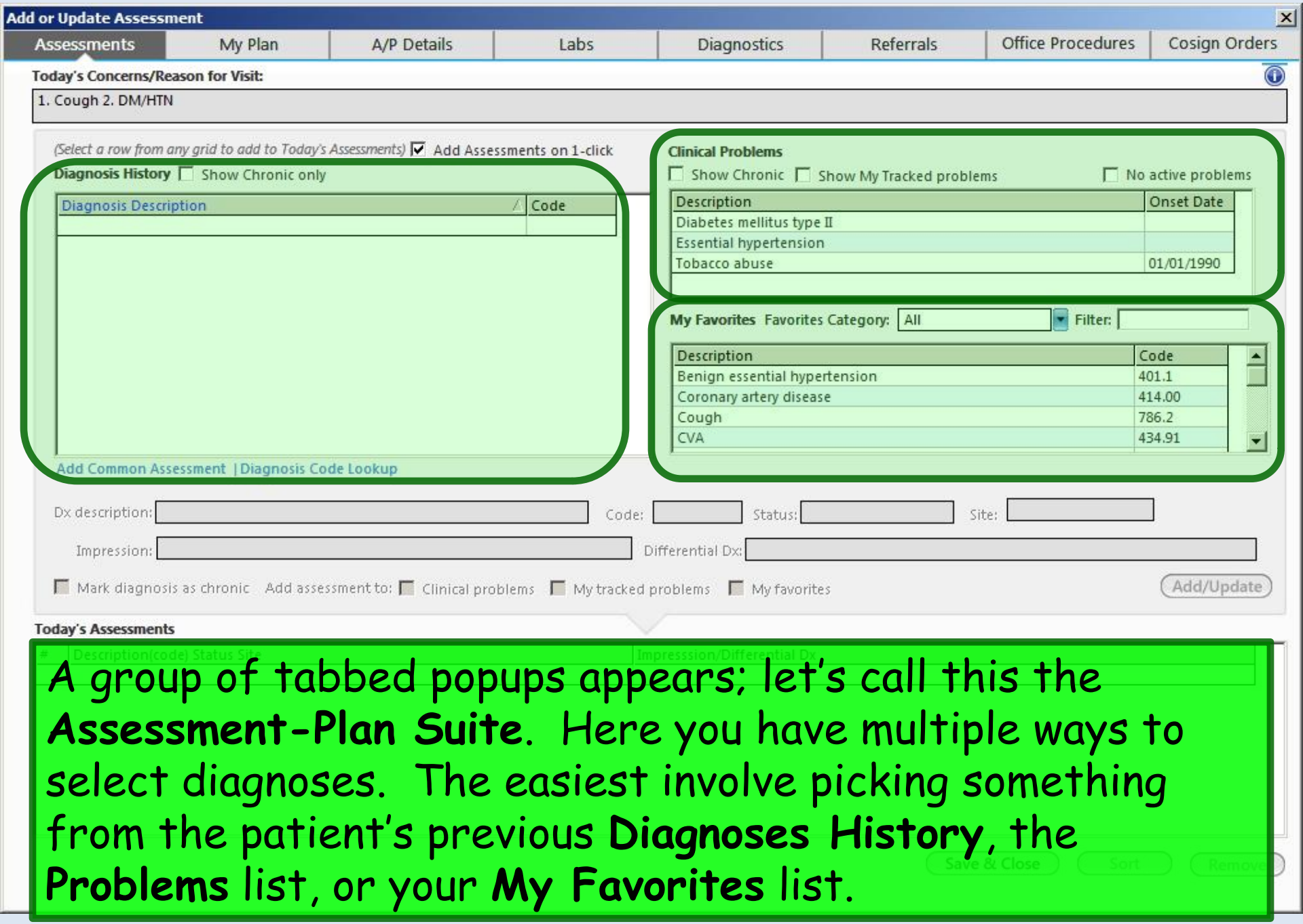

Edit your entry to reflect today's findings. When done click Save & Close.

Your completed exam displays on the **SOAP tab**.

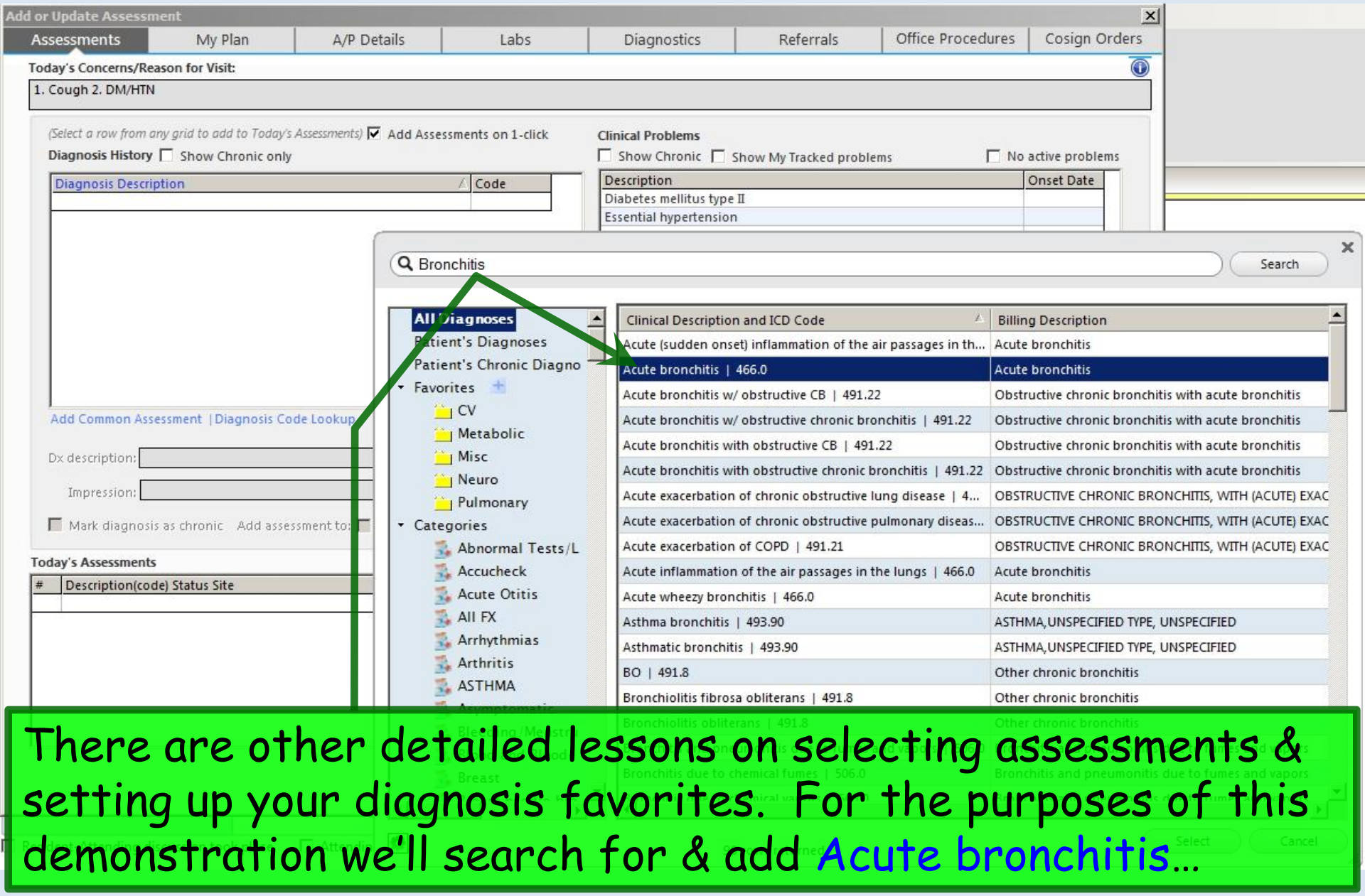
Using this combination of presets & editing of only specific pertinent findings, sometimes called **documentation by exception**, is a powerful & rapid way to record an accurate exam, customized to the way you want to say it.



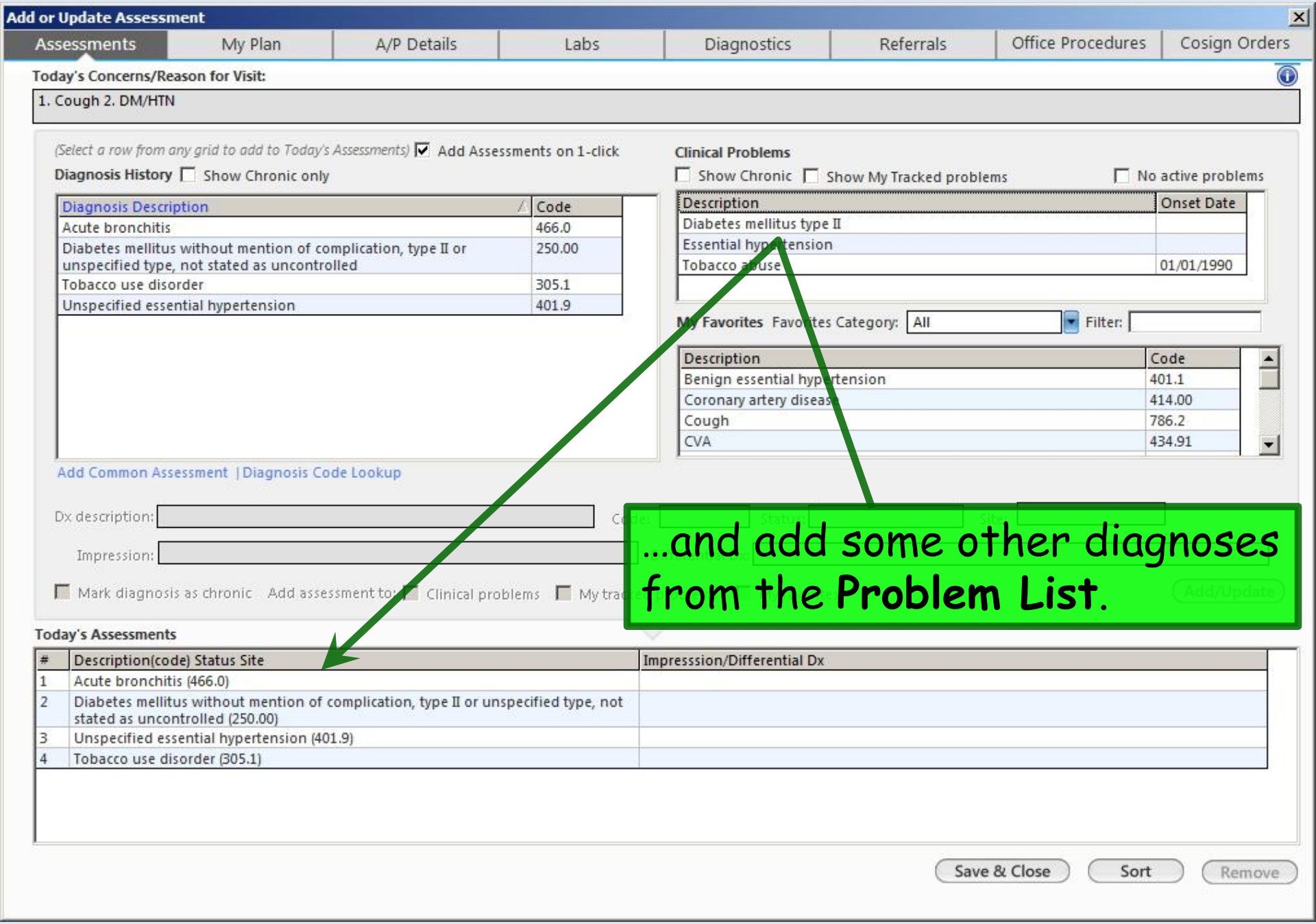

03/15/2014 10:06 PM : "USA SOAP"
Physical Exam
Assessment/Plan
Assessments
My Plan
A/P Details
Labs
Diagnostics
Referrals
Moving to the bottom of the SOAP tab, you might next perform any of several activities: Document assessments & plans, prescribe meds, order labs, plan X-rays, or request referrals.
For this exercise, let's address Assessment/Plan. Begin by clicking the Add/Update button.
Resident-Attending discussion took place
Attending saw patient
Consent
Procedure Scheduling
Add/Update
Remove
Consent
Provider Comm.
Meds
Procedures
Patient Plan
Visit Document
Document Library
EM Coding
Dictation

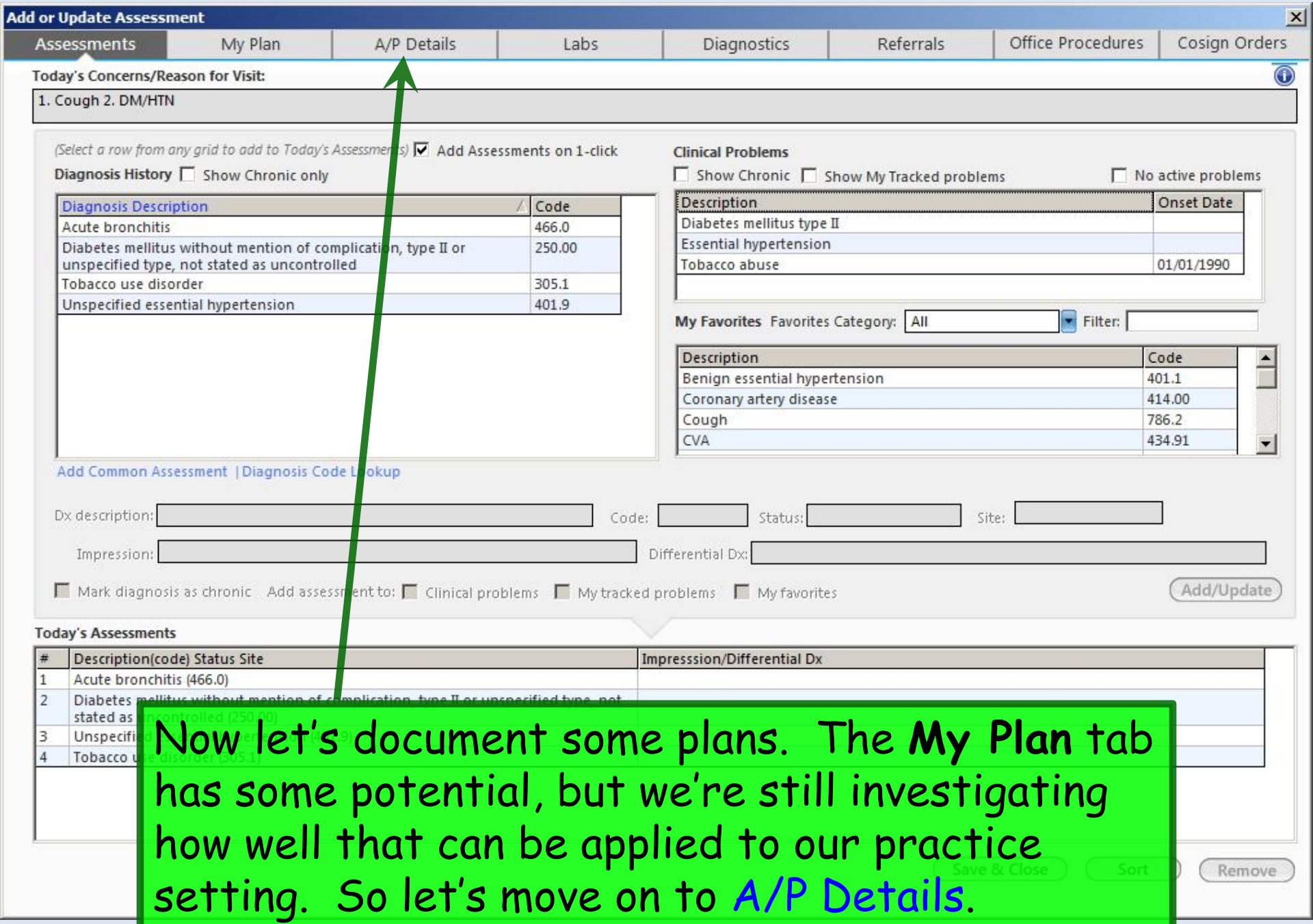



A group of tabbed popups appears; let's call this the **Assessment-Plan Suite**. Here you have multiple ways to select diagnoses. The easiest involve picking something from the patient's previous **Diagnoses History**, the **Problems** list, or your **My Favorites** list.

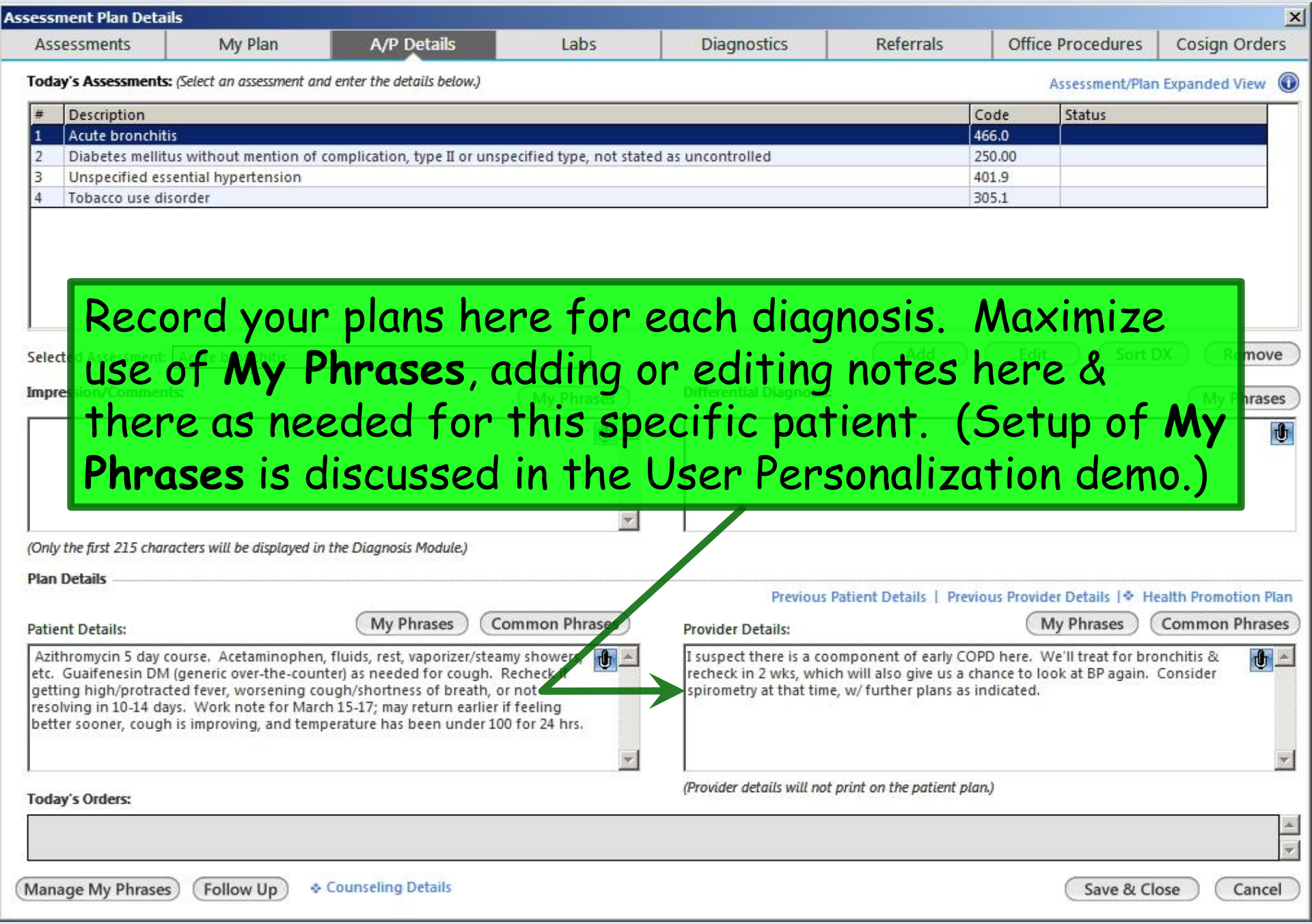


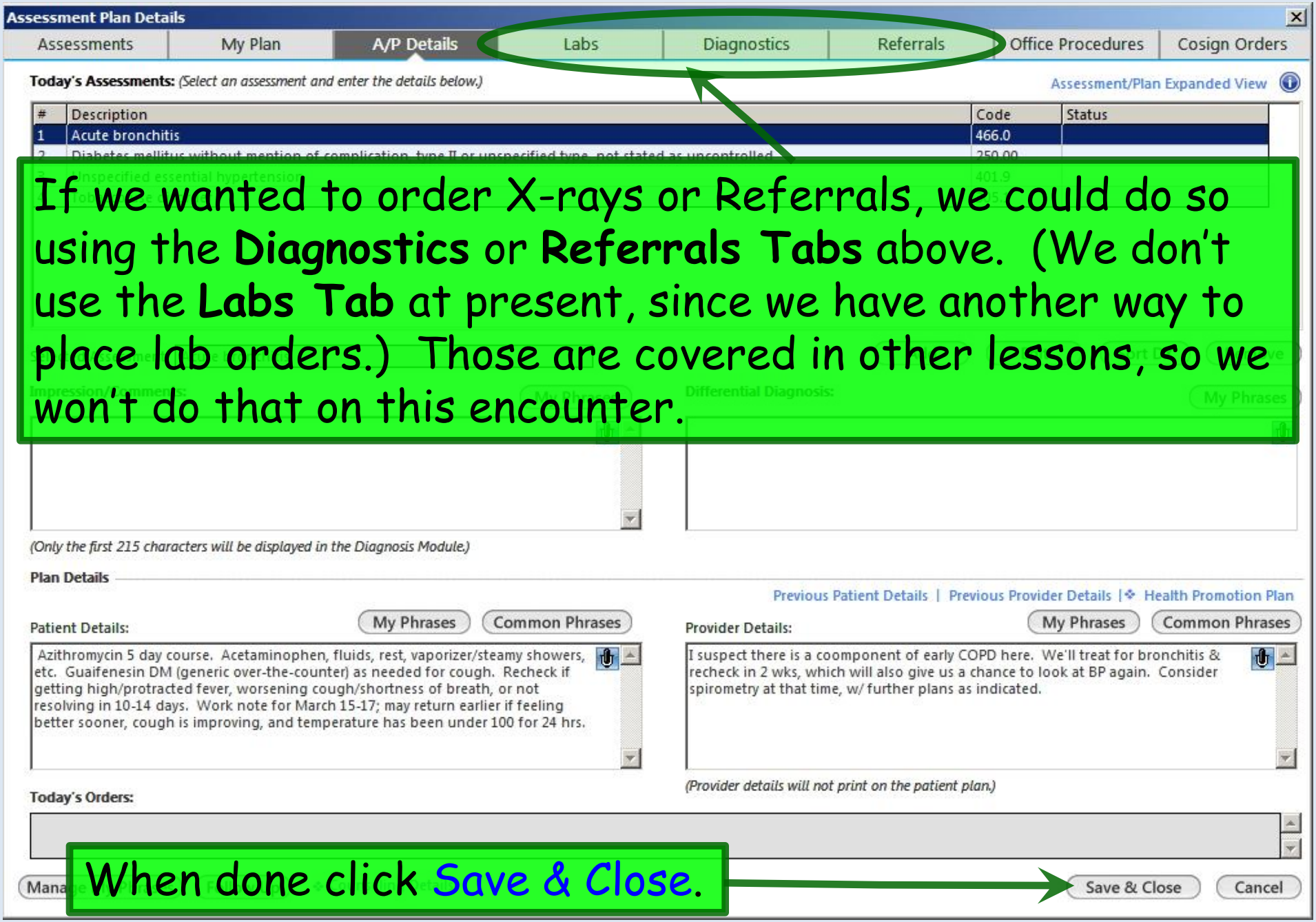

There are other detailed lessons on selecting assessments & setting up your diagnosis favorites. For the purposes of this demonstration we'll search for & add Acute bronchitis…

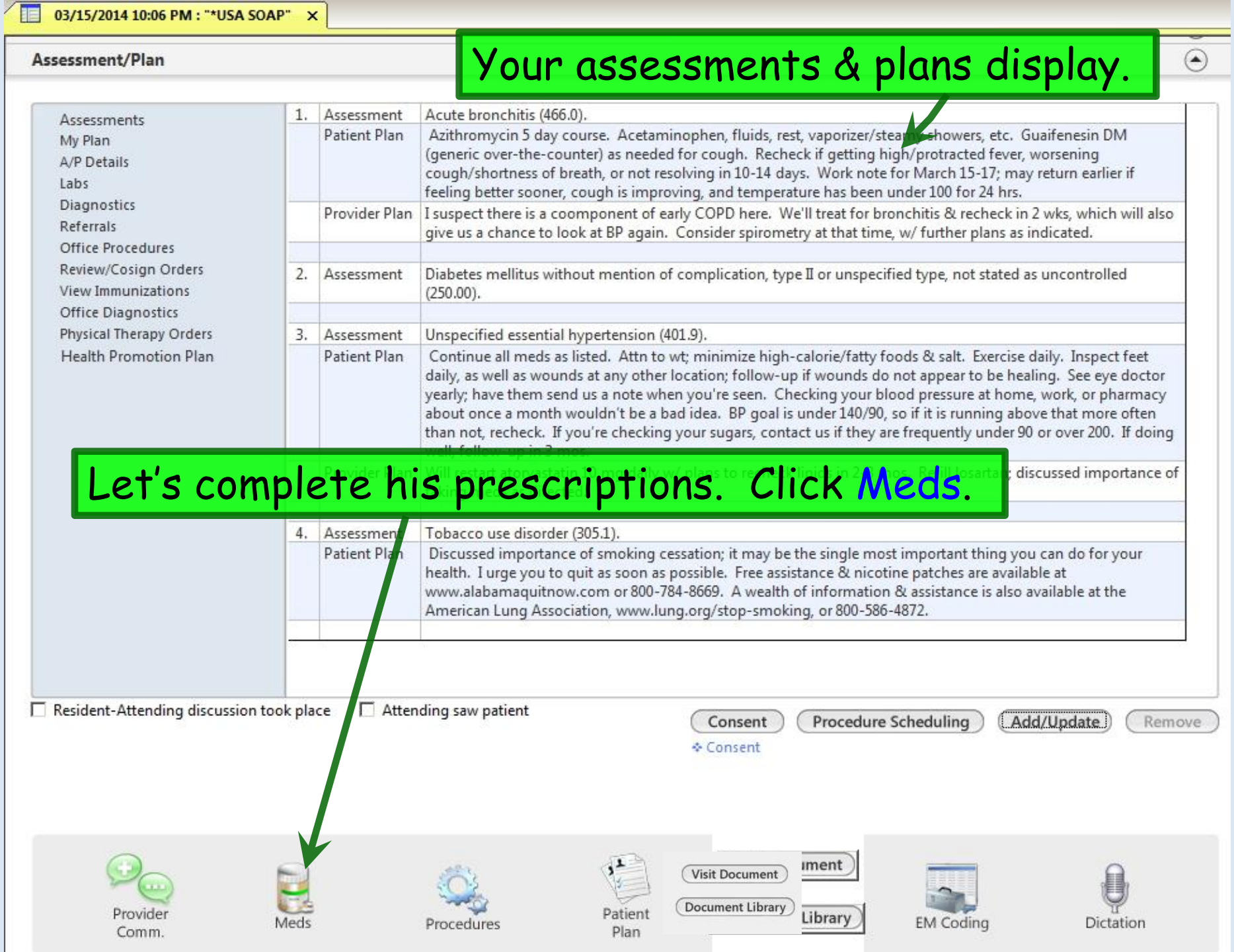

Add or Update Assessment
Assessments
My Plan
A/P Details
Labs
Diagnostics
Referrals
Office Procedures
Cosign Orders
Today's Concerns/Reason for Visit:
1. Cough 2. DM/HTN
(Select a row from any grid to add to Today's Assessments)
Add Assessments on 1-click
Diagnosis History
Show Chronic only
Diagnosis Description
Code
Acute bronchitis
466.0
Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled
250.00
Tobacco use disorder
305.1
Unspecified essential hypertension
401.9
Add Common Assessment
Diagnosis Code Lookup
Clinical Problems
Show Chronic
Show My Tracked problems
No active problems
Description
Onset Date
Diabetes mellitus type II
Essential hypertension
Tobacco abuse
01/01/1990
My Favorites
Favorites Category:
All
Filter:
Description
Code
Benign essential hypertension
401.1
Coronary artery disease
414.00
Cough
786.2
CVA
434.91
Dx description:
Impression:
Mark diagnosis as chronic
Add assessment to:
Clinical problems
...and add some other diagnoses from the Problem List.
Today's Assessments
#
Description(code) Status Site
Impresssion/Differential Dx
1
Acute bronchitis (466.0)
2
Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled (250.00)
3
Unspecified essential hypertension (401.9)
4
Tobacco use disorder (305.1)
Save & Close
Sort
Remove

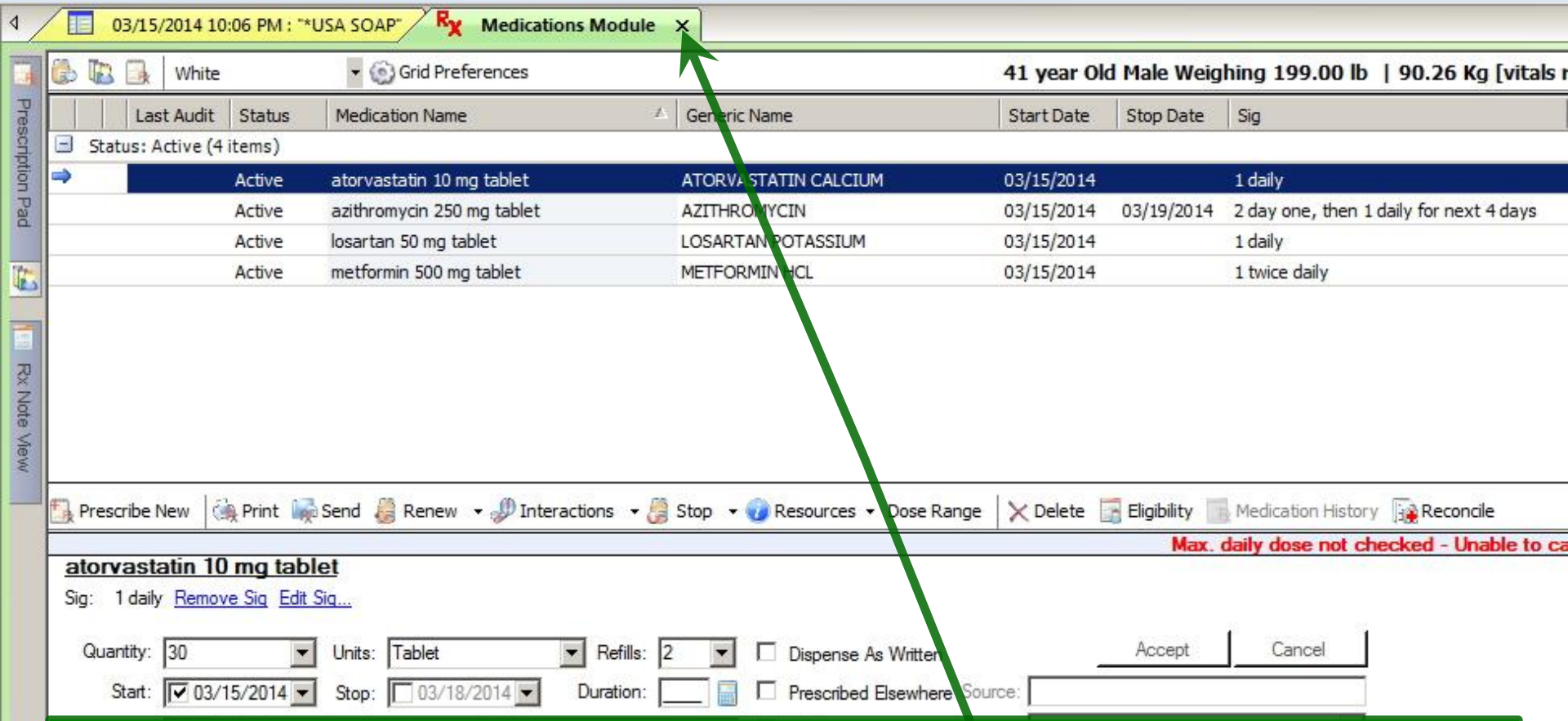



Now let's document some plans. The **My Plan** tab has some potential, but we're still investigating how well that can be applied to our practice setting. So let's move on to A/P Details.


Assessment Plan Details
Assessments
My Plan
A/P Details
Labs
Diagnostics
Referrals
Office Procedures
Cosign Orders
Today's Assessments: (Select an assessment and enter the details below.)
Assessment/Plan Expanded View
# Description Code Status
1 Acute bronchitis 466.0
2 Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled 250.00
3 Unspecified essential hypertension 401.9
4 Tobacco use disorder 305.1
Record your plans here for each diagnosis. Maximize use of My Phrases, adding or editing notes here & there as needed for this specific patient. (Setup of My Phrases is discussed in the User Personalization demo.)
(Only the first 215 characters will be displayed in the Diagnosis Module.)
Plan Details
Previous Patient Details | Previous Provider Details | Health Promotion Plan
Patient Details:
My Phrases
Common Phrases
Azithromycin 5 day course. Acetaminophen, fluids, rest, vaporizer/steamy shower etc. Guaifenesin DM (generic over-the-counter) as needed for cough. Recheck if getting high/protracted fever, worsening cough/shortness of breath, or not resolving in 10-14 days. Work note for March 15-17; may return earlier if feeling better sooner, cough is improving, and temperature has been under 100 for 24 hrs.
Provider Details:
My Phrases
Common Phrases
I suspect there is a coomponent of early COPD here. We'll treat for bronchitis & recheck in 2 wks, which will also give us a chance to look at BP again. Consider spirometry at that time, w/ further plans as indicated.
(Provider details will not print on the patient plan.)
Today's Orders:
Manage My Phrases
Follow Up
Counseling Details
Save & Close
Cancel

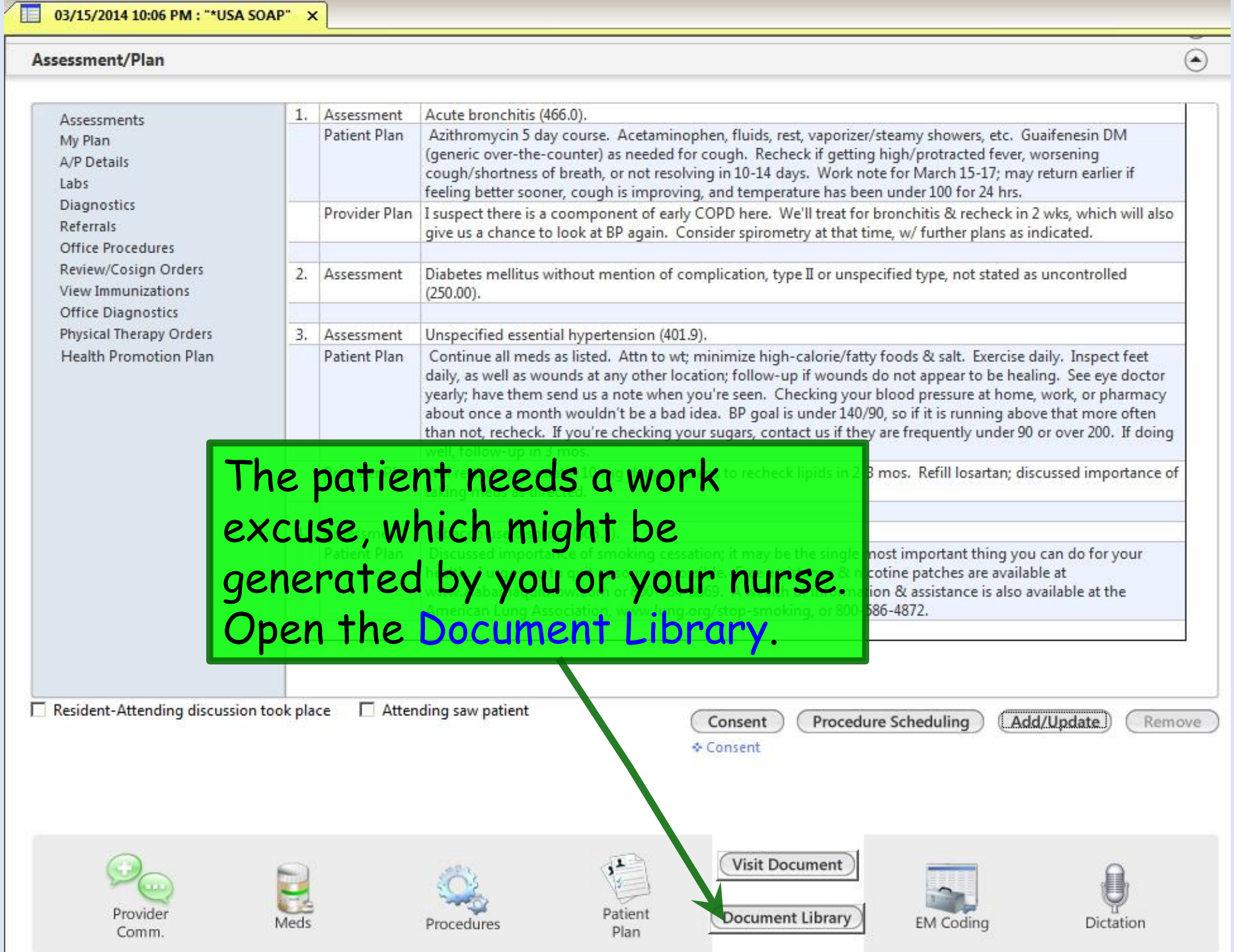

Assessment Plan Details
Assessments
My Plan
A/P Details
Labs
Diagnostics
Referrals
Office Procedures
Cosign Orders
Today's Assessments: (Select an assessment and enter the details below.)
Assessment/Plan Expanded View
# Description Code Status
1 Acute bronchitis 466.0
If we wanted to order X-rays or Referrals, we could do so using the Diagnostics or Referrals Tabs above. (We don't use the Labs Tab at present, since we have another way to place lab orders.) Those are covered in other lessons, so we won't do that on this encounter.
(Only the first 215 characters will be displayed in the Diagnosis Module.)
Plan Details
Previous Patient Details | Previous Provider Details | Health Promotion Plan
Patient Details:
My Phrases
Common Phrases
Azithromycin 5 day course. Acetaminophen, fluids, rest, vaporizer/steamy showers, etc. Guaifenesin DM (generic over-the-counter) as needed for cough. Recheck if getting high/protracted fever, worsening cough/shortness of breath, or not resolving in 10-14 days. Work note for March 15-17; may return earlier if feeling better sooner, cough is improving, and temperature has been under 100 for 24 hrs.
Provider Details:
My Phrases
Common Phrases
I suspect there is a coomponent of early COPD here. We'll treat for bronchitis & recheck in 2 wks, which will also give us a chance to look at BP again. Consider spirometry at that time, w/ further plans as indicated.
(Provider details will not print on the patient plan.)
Today's Orders:
When done click Save & Close.
Save & Close
Cancel


03/15/2014 10:06 PM : "*USA SOAP"
Assessment/Plan
Your assessments & plans display.
Assessments
My Plan
A/P Details
Labs
Diagnostics
Referrals
Office Procedures
Review/Cosign Orders
View Immunizations
Office Diagnostics
Physical Therapy Orders
Health Promotion Plan
1. Assessment Acute bronchitis (466.0).
Patient Plan Azithromycin 5 day course. Acetaminophen, fluids, rest, vaporizer/steam showers, etc. Guaifenesin DM (generic over-the-counter) as needed for cough. Recheck if getting high/protracted fever, worsening cough/shortness of breath, or not resolving in 10-14 days. Work note for March 15-17; may return earlier if feeling better sooner, cough is improving, and temperature has been under 100 for 24 hrs.
Provider Plan I suspect there is a coomponent of early COPD here. We'll treat for bronchitis & recheck in 2 wks, which will also give us a chance to look at BP again. Consider spirometry at that time, w/ further plans as indicated.
2. Assessment Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled (250.00).
3. Assessment Unspecified essential hypertension (401.9).
Patient Plan Continue all meds as listed. Attn to wt; minimize high-calorie/fatty foods & salt. Exercise daily. Inspect feet daily, as well as wounds at any other location; follow-up if wounds do not appear to be healing. See eye doctor yearly; have them send us a note when you're seen. Checking your blood pressure at home, work, or pharmacy about once a month wouldn't be a bad idea. BP goal is under 140/90, so if it is running above that more often than not, recheck. If you're checking your sugars, contact us if they are frequently under 90 or over 200. If doing
Let's complete his prescriptions. Click Meds.
discussed importance of
4. Assessment Tobacco use disorder (305.1).
Patient Plan Discussed importance of smoking cessation; it may be the single most important thing you can do for your health. I urge you to quit as soon as possible. Free assistance & nicotine patches are available at www.alabamaquitnow.com or 800-784-8669. A wealth of information & assistance is also available at the American Lung Association, www.lung.org/stop-smoking, or 800-586-4872.
Resident-Attending discussion took place
Attending saw patient
Consent
Procedure Scheduling
Add/Update
Remove
Consent
Provider Comm.
Meds
Procedures
Patient Plan
Visit Document
Document Library
EM Coding
Dictation



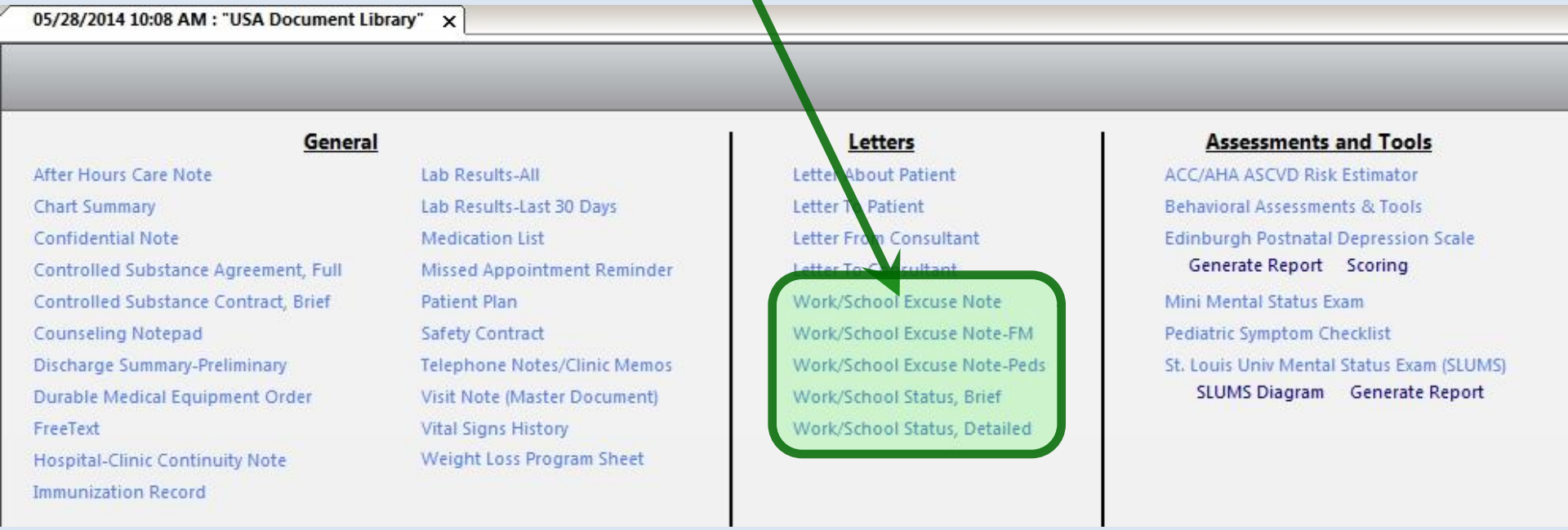

**Medication Module** details are reviewed in another lesson.

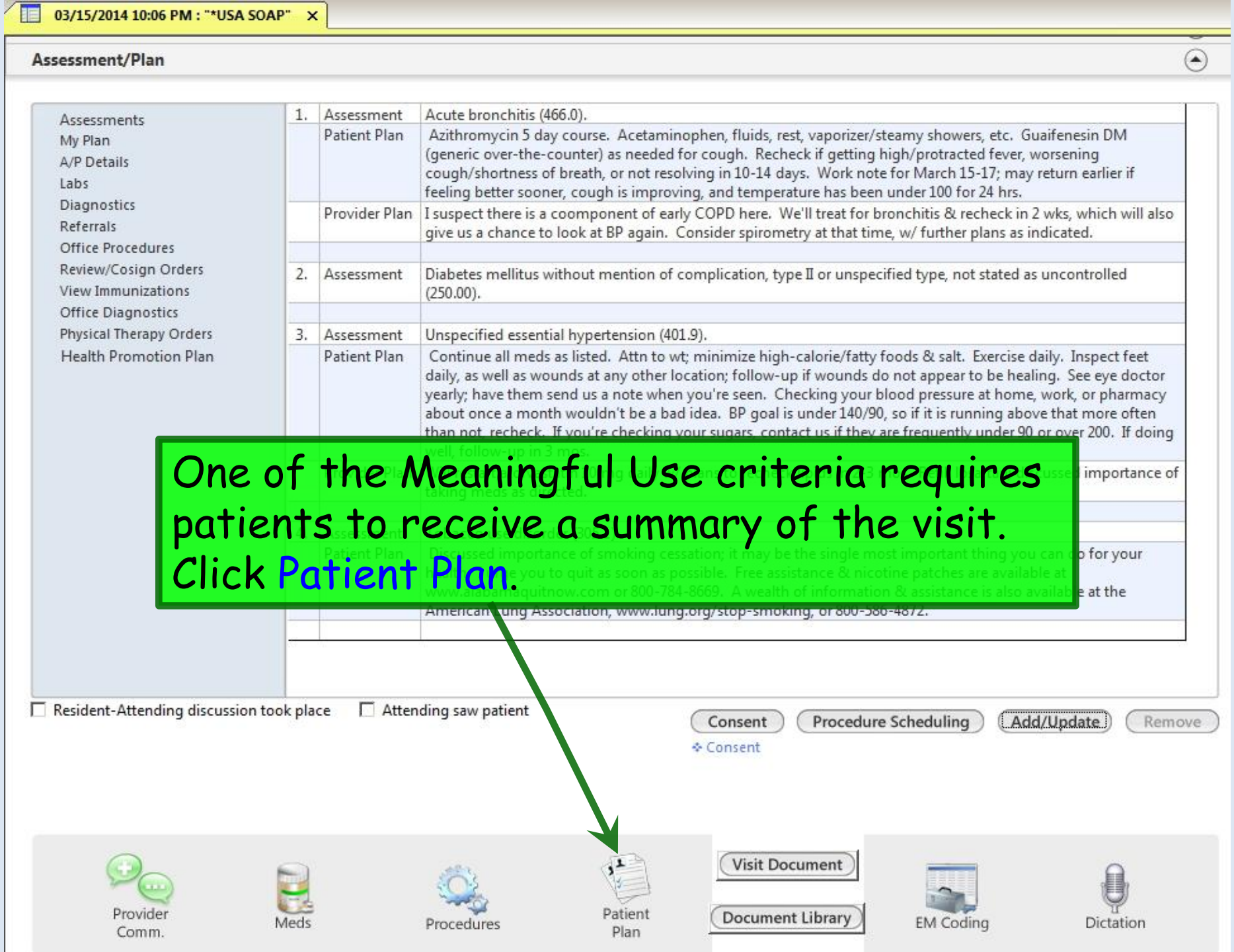
We've refilled his losartan & metformin, prescribed a 5 day course of azithromycin, & started atorvastatin, all as we mentioned in the plan. We'll ERx these, close the med module, & return to the **SOAP Tab**.

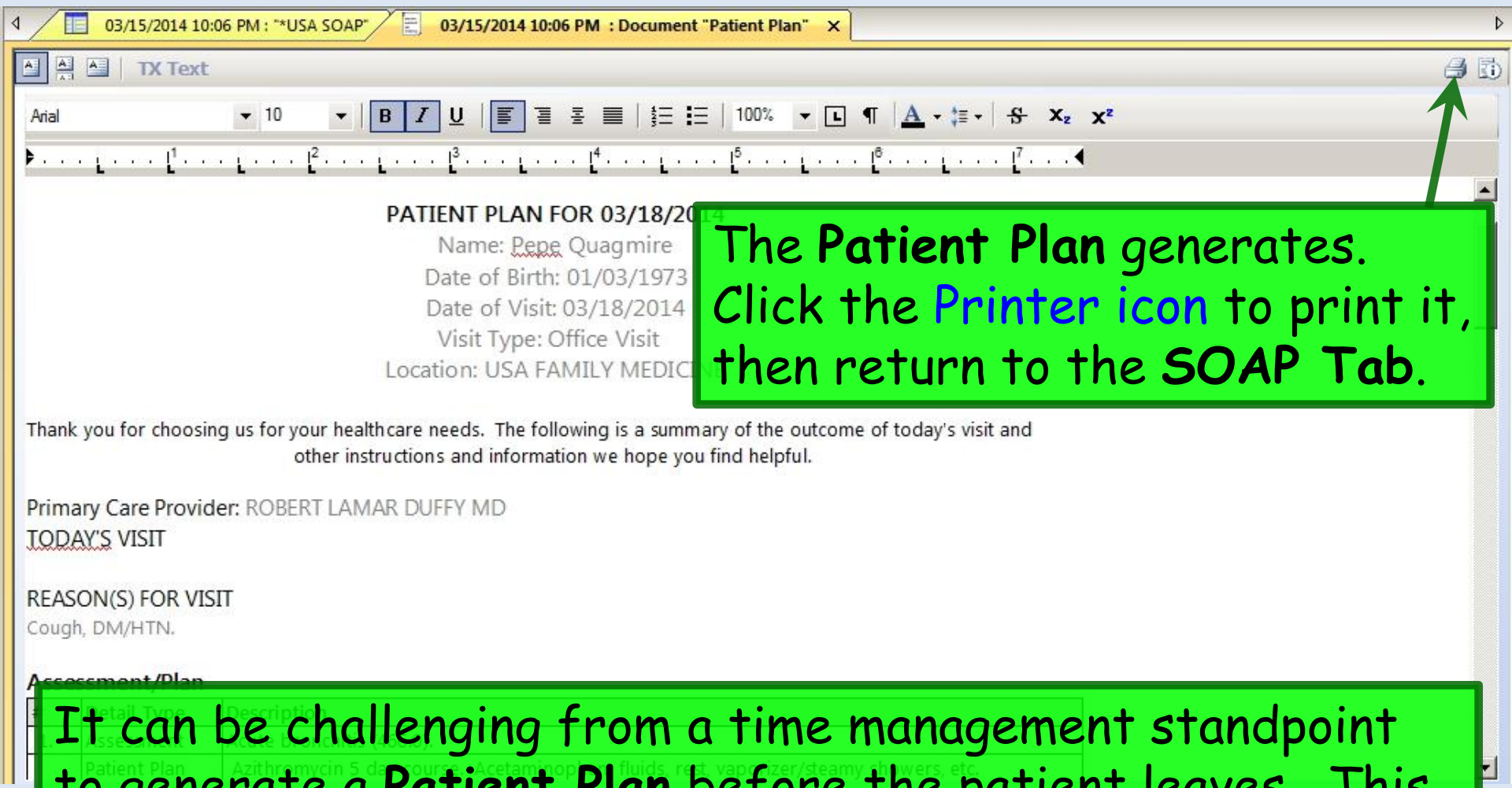



The patient needs a work excuse, which might be generated by you or your nurse. Open the Document Library.

You have several options for generating a work excuse.

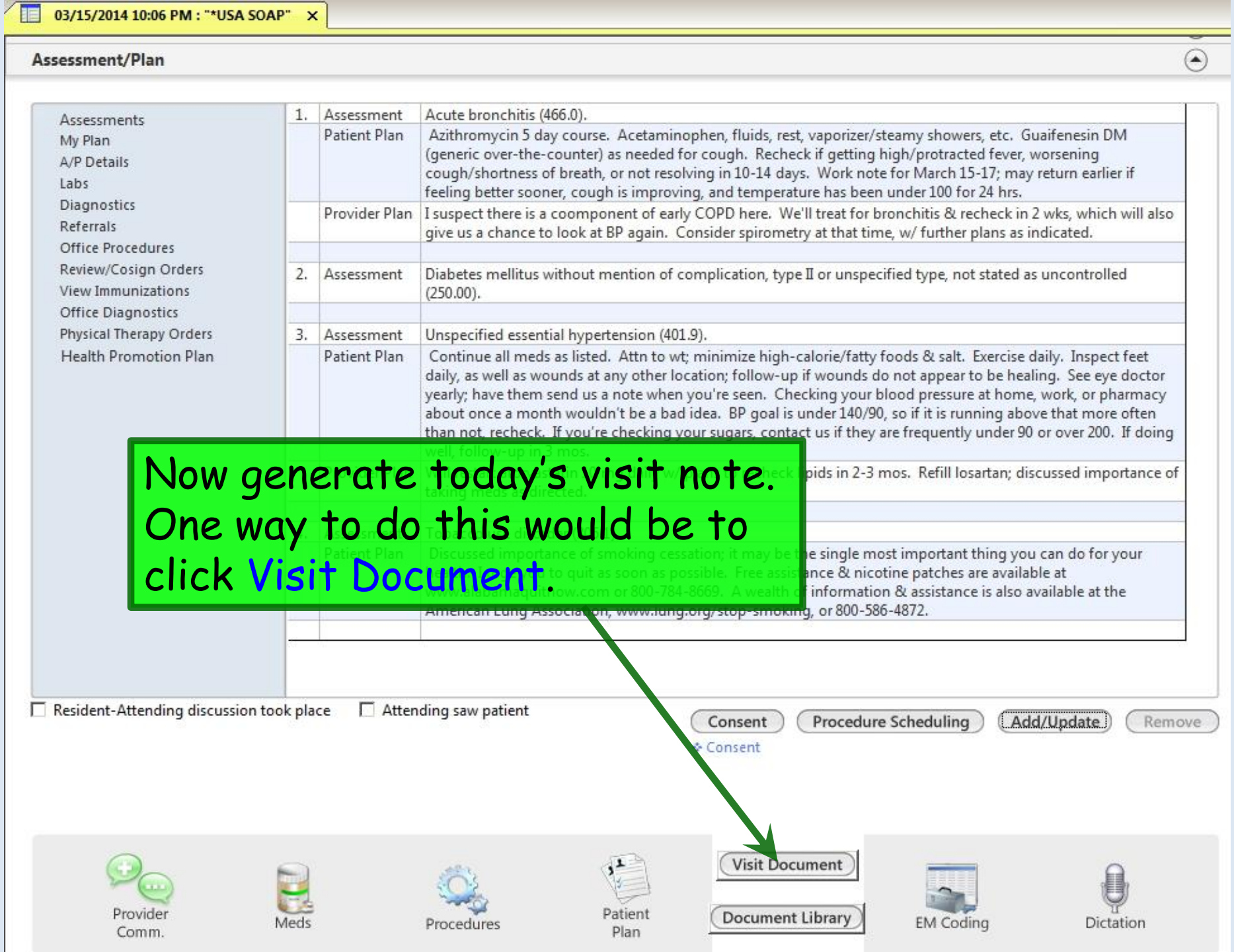


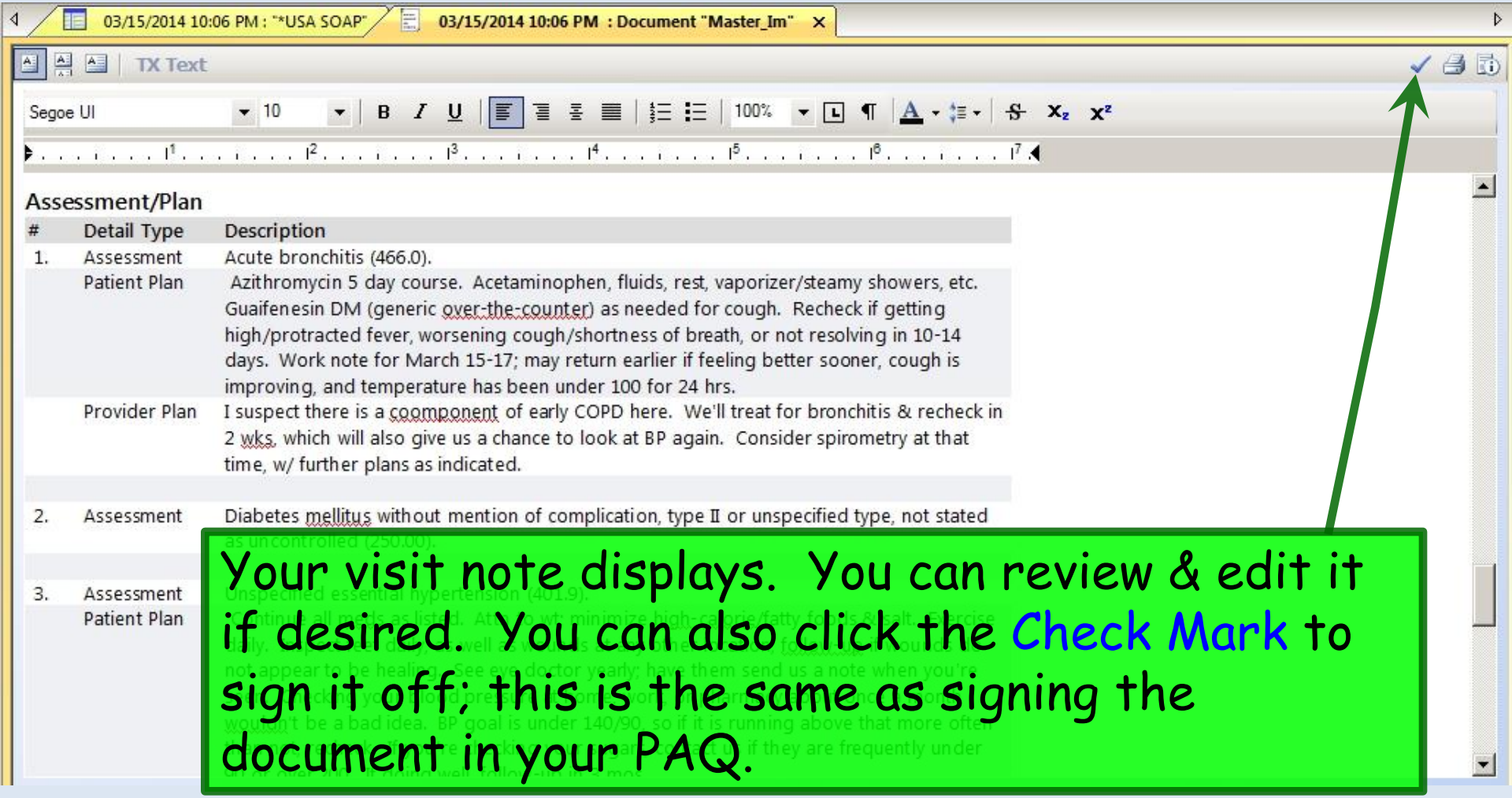

03/15/2014 10:06 PM : "*USA SOAP"
Assessment/Plan
Assessments
My Plan
A/P Details
Labs
Diagnostics
Referrals
Office Procedures
Review/Cosign Orders
View Immunizations
Office Diagnostics
Physical Therapy Orders
Health Promotion Plan
1. Assessment Acute bronchitis (466.0).
Patient Plan Azithromycin 5 day course. Acetaminophen, fluids, rest, vaporizer/steamy showers, etc. Guaifenesin DM (generic over-the-counter) as needed for cough. Recheck if getting high/protracted fever, worsening cough/shortness of breath, or not resolving in 10-14 days. Work note for March 15-17; may return earlier if feeling better sooner, cough is improving, and temperature has been under 100 for 24 hrs.
Provider Plan I suspect there is a coomponent of early COPD here. We'll treat for bronchitis & recheck in 2 wks, which will also give us a chance to look at BP again. Consider spirometry at that time, w/ further plans as indicated.
2. Assessment Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled (250.00).
3. Assessment Unspecified essential hypertension (401.9).
Patient Plan Continue all meds as listed. Attn to wt; minimize high-calorie/fatty foods & salt. Exercise daily. Inspect feet daily, as well as wounds at any other location; follow-up if wounds do not appear to be healing. See eye doctor yearly; have them send us a note when you're seen. Checking your blood pressure at home, work, or pharmacy about once a month wouldn't be a bad idea. BP goal is under 140/90, so if it is running above that more often than not, recheck. If you're checking your sugars, contact us if they are frequently under 90 or over 200. If doing well, follow-up in 3 mos.
One of the Meaningful Use criteria requires patients to receive a summary of the visit. Click Patient Plan.
Resident-Attending discussion took place
Attending saw patient
Consent
Procedure Scheduling
Add/Update
Remove
Consent
Provider Comm.
Meds
Procedures
Patient Plan
Visit Document
Document Library
EM Coding
Dictation

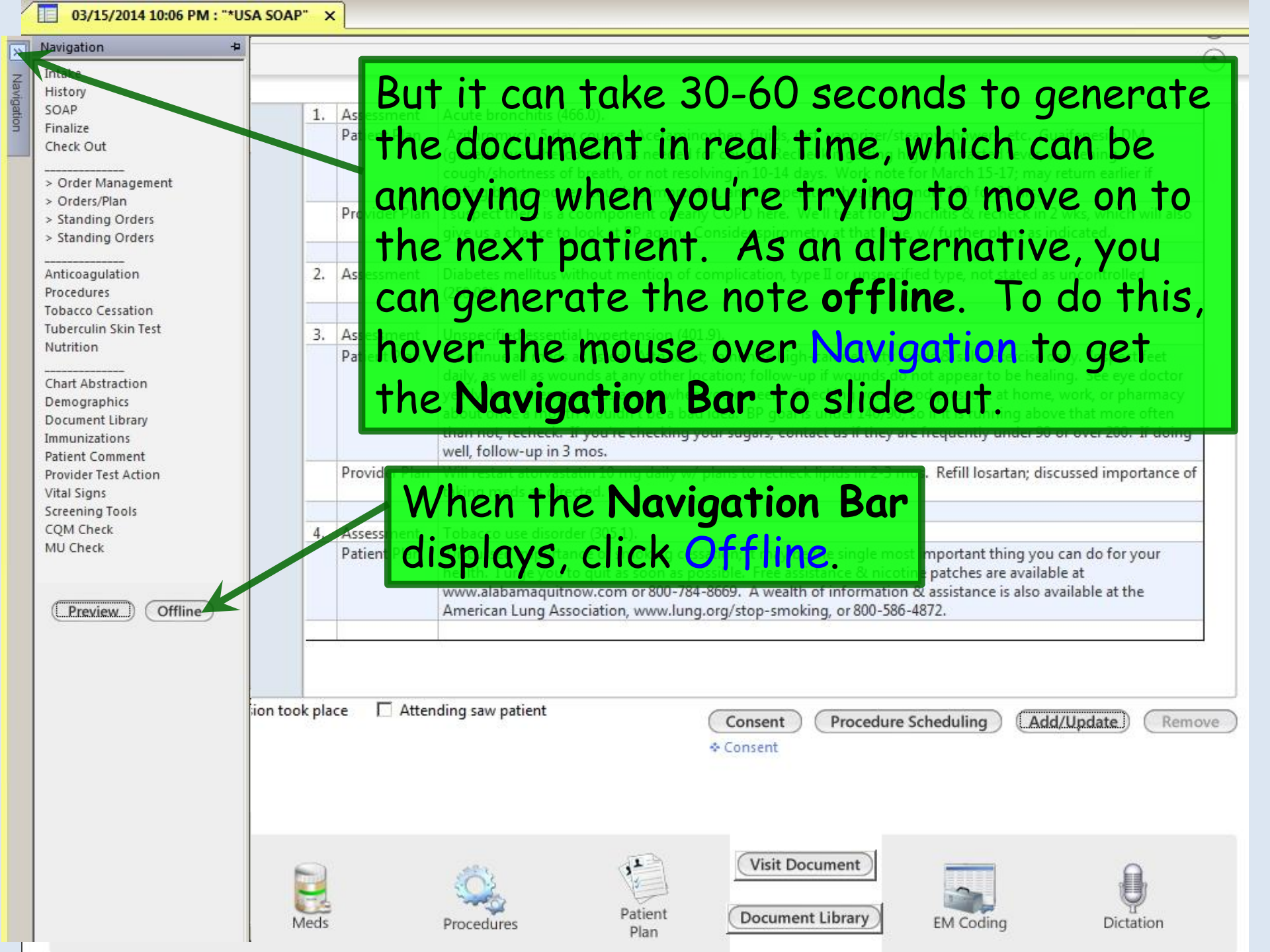


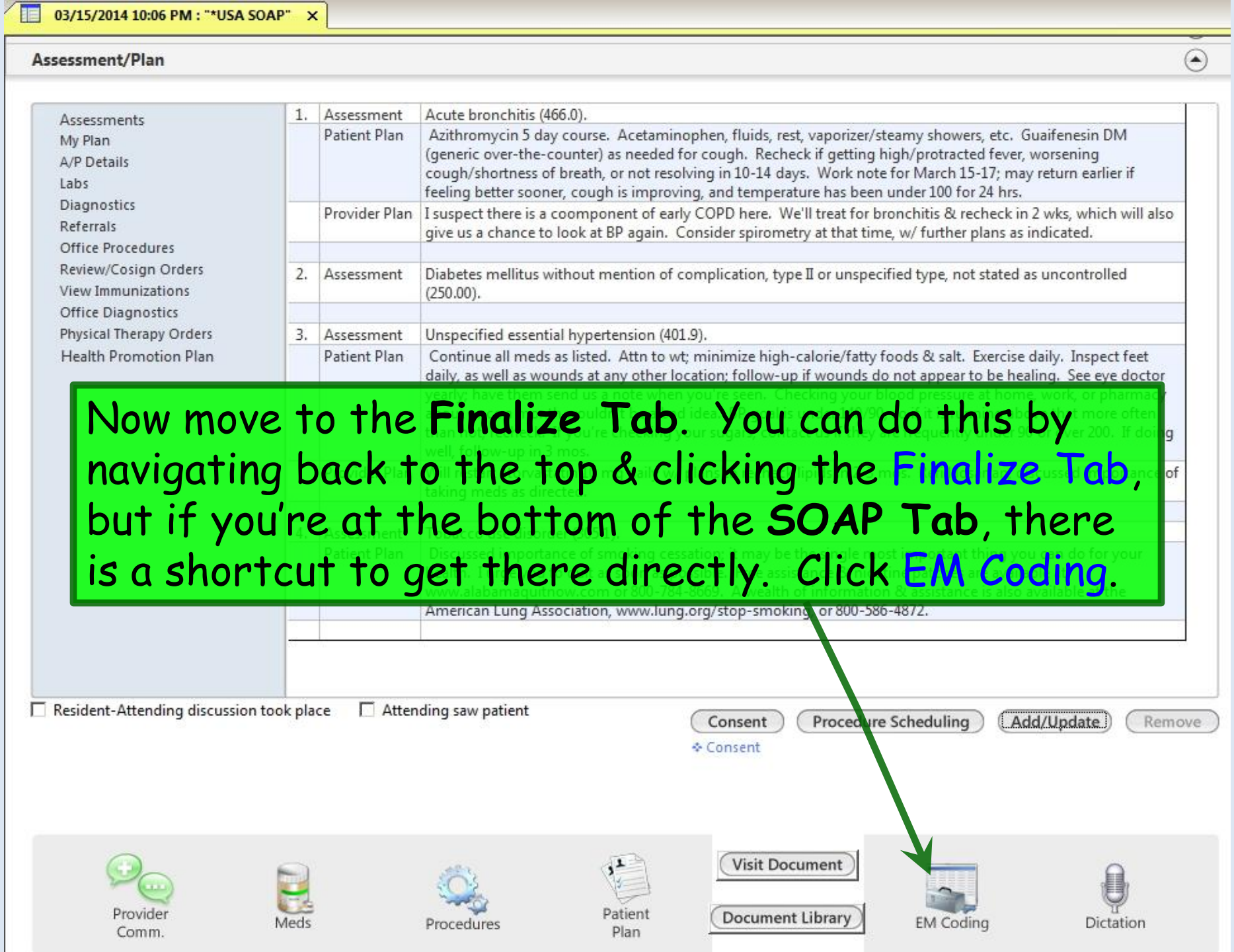

The **Patient Plan** generates. Click the Printer icon to print it, then return to the **SOAP Tab**.

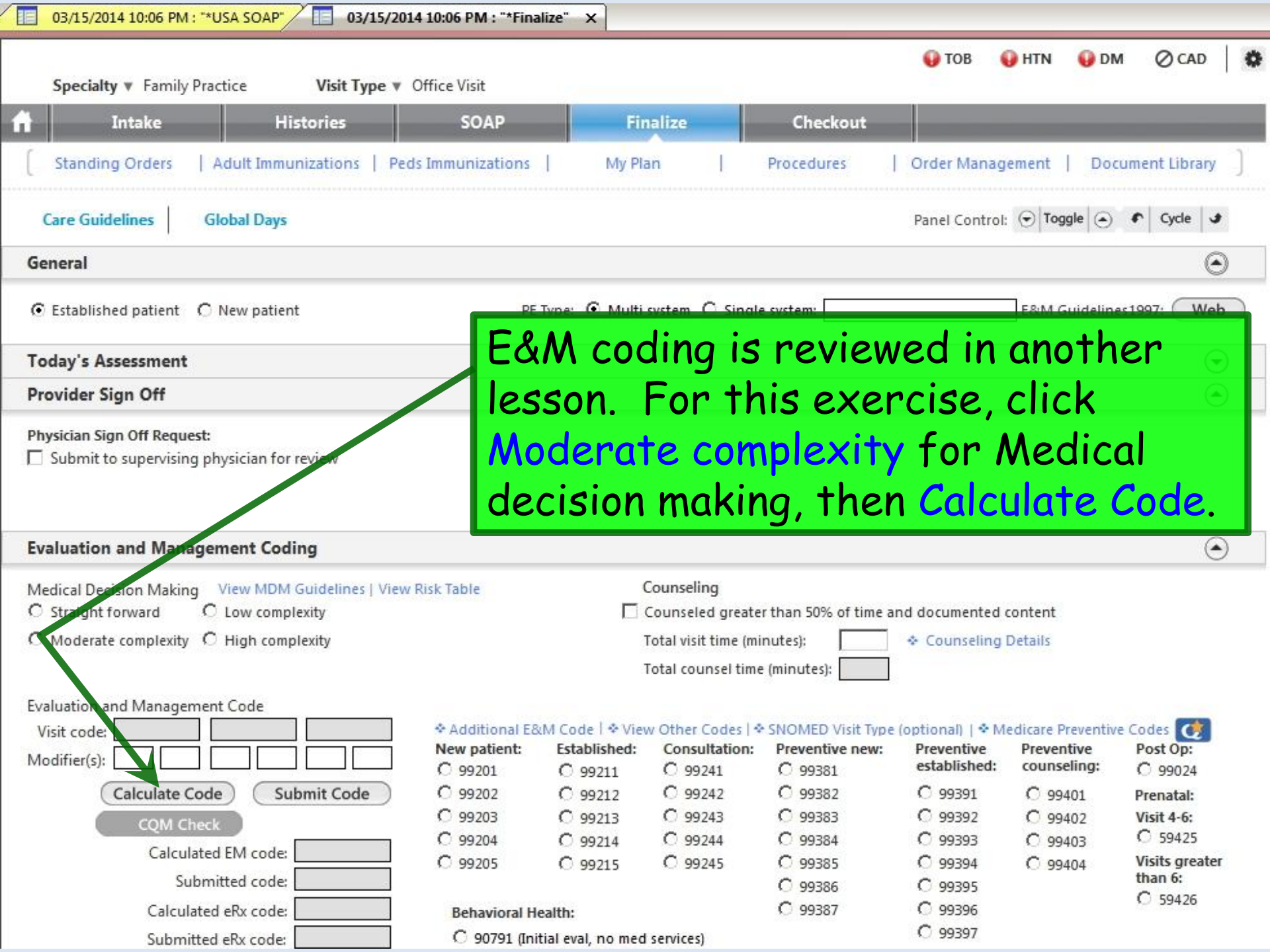
It can be challenging from a time management standpoint to generate a **Patient Plan** before the patient leaves. This will become easier when we have expanded ways to electronically communicate with patients. In the meantime a strategy is to complete a very bare-bones assessment & plan, prescribe meds, then generate the **Patient Plan**. Print this for the patient, then flesh out the details later.

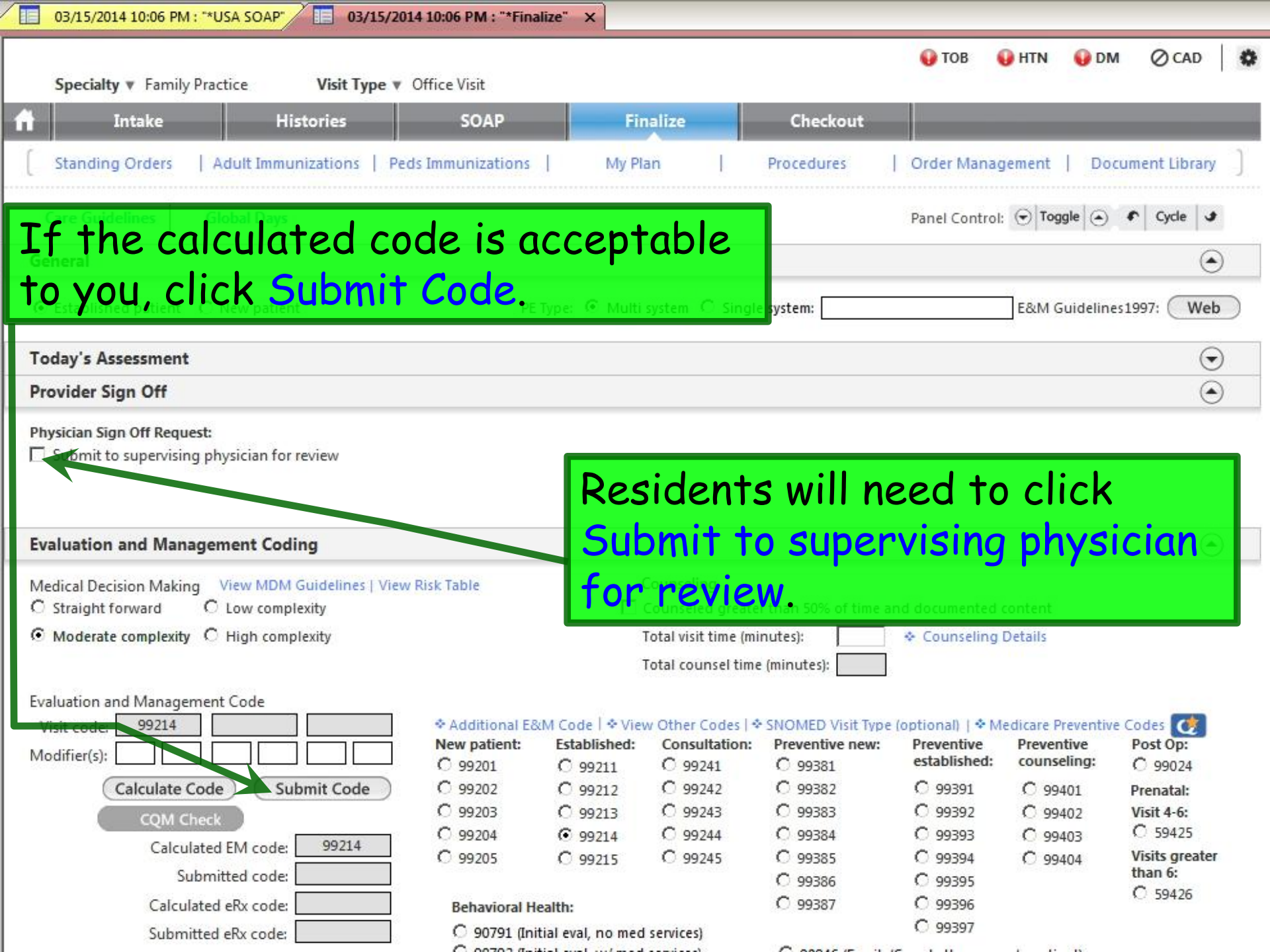

03/15/2014 10:06 PM : "*USA SOAP"
Assessment/Plan
Assessments
My Plan
A/P Details
Labs
Diagnostics
Referrals
Office Procedures
Review/Cosign Orders
View Immunizations
Office Diagnostics
Physical Therapy Orders
Health Promotion Plan
1. Assessment Acute bronchitis (466.0).
Patient Plan Azithromycin 5 day course. Acetaminophen, fluids, rest, vaporizer/steamy showers, etc. Guaifenesin DM (generic over-the-counter) as needed for cough. Recheck if getting high/protracted fever, worsening cough/shortness of breath, or not resolving in 10-14 days. Work note for March 15-17; may return earlier if feeling better sooner, cough is improving, and temperature has been under 100 for 24 hrs.
Provider Plan I suspect there is a coomponent of early COPD here. We'll treat for bronchitis & recheck in 2 wks, which will also give us a chance to look at BP again. Consider spirometry at that time, w/ further plans as indicated.
2. Assessment Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled (250.00).
3. Assessment Unspecified essential hypertension (401.9).
Patient Plan Continue all meds as listed. Attn to wt; minimize high-calorie/fatty foods & salt. Exercise daily. Inspect feet daily, as well as wounds at any other location; follow-up if wounds do not appear to be healing. See eye doctor yearly; have them send us a note when you're seen. Checking your blood pressure at home, work, or pharmacy about once a month wouldn't be a bad idea. BP goal is under 140/90, so if it is running above that more often than not, recheck. If you're checking your sugars, contact us if they are frequently under 90 or over 200. If doing well, follow-up in 3 mos.
Now generate today's visit note. One way to do this would be to click Visit Document.
Resident-Attending discussion took place
Attending saw patient
Consent
Procedure Scheduling
Add/Update
Remove
Consent
Provider Comm.
Meds
Procedures
Patient Plan
Visit Document
Document Library
EM Coding
Dictation


03/15/2014 10:06 PM : "*USA SOAP"
03/15/2014 10:06 PM : Document "Master_Im"
TX Text
Segoe UI
10
100%
Assessment/Plan
# Detail Type Description
1. Assessment Acute bronchitis (466.0).
Patient Plan Azithromycin 5 day course. Acetaminophen, fluids, rest, vaporizer/steamy showers, etc. Guaifenesin DM (generic over-the-counter) as needed for cough. Recheck if getting high/protracted fever, worsening cough/shortness of breath, or not resolving in 10-14 days. Work note for March 15-17; may return earlier if feeling better sooner, cough is improving, and temperature has been under 100 for 24 hrs.
Provider Plan I suspect there is a coomponent of early COPD here. We'll treat for bronchitis & recheck in 2 wks, which will also give us a chance to look at BP again. Consider spirometry at that time, w/ further plans as indicated.
2. Assessment Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled (250.00).
3. Assessment Unspecified essential hypertension (401.9).
Patient Plan
Your visit note displays. You can review & edit it if desired. You can also click the Check Mark to sign it off; this is the same as signing the document in your PAQ.


But it can take 30-60 seconds to generate the document in real time, which can be annoying when you're trying to move on to the next patient. As an alternative, you can generate the note **offline**. To do this, hover the mouse over Navigation to get the **Navigation Bar** to slide out.
When the **Navigation Bar** displays, click Offline.
03/15/2014 10:06 PM : "*USA SOAP"
Navigation
History
SOAP
Finalize
Check Out
> Order Management
> Orders/Plan
> Standing Orders
> Standing Orders
Anticoagulation
Procedures
Tobacco Cessation
Tuberculin Skin Test
Nutrition
Chart Abstraction
Demographics
Document Library
Immunizations
Patient Comment
Provider Test Action
Vital Signs
Screening Tools
CQM Check
MU Check
Preview
Offline
Acute bronchitis (466.0).
Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled
Unspecified essential hypertension (401.9)
well, follow-up in 3 mos.
Refill losartan; discussed importance of
Tobacco use disorder (305.1).
important thing you can do for your
patches are available at
www.alabamaquitnow.com or 800-784-8669. A wealth of information & assistance is also available at the
American Lung Association, www.lung.org/stop-smoking, or 800-586-4872.
Attending saw patient
Consent
Procedure Scheduling
Add/Update
Remove
Consent
Meds
Procedures
Patient Plan
Visit Document
Document Library
EM Coding
Dictation


03/15/2014 10:06 PM : "*USA SOAP"
Assessment/Plan
Assessments
My Plan
A/P Details
Labs
Diagnostics
Referrals
Office Procedures
Review/Cosign Orders
View Immunizations
Office Diagnostics
Physical Therapy Orders
Health Promotion Plan
1. Assessment Acute bronchitis (466.0).
Patient Plan Azithromycin 5 day course. Acetaminophen, fluids, rest, vaporizer/steamy showers, etc. Guaifenesin DM (generic over-the-counter) as needed for cough. Recheck if getting high/protracted fever, worsening cough/shortness of breath, or not resolving in 10-14 days. Work note for March 15-17; may return earlier if feeling better sooner, cough is improving, and temperature has been under 100 for 24 hrs.
Provider Plan I suspect there is a coomponent of early COPD here. We'll treat for bronchitis & recheck in 2 wks, which will also give us a chance to look at BP again. Consider spirometry at that time, w/ further plans as indicated.
2. Assessment Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled (250.00).
3. Assessment Unspecified essential hypertension (401.9).
Patient Plan Continue all meds as listed. Attn to wt; minimize high-calorie/fatty foods & salt. Exercise daily. Inspect feet daily, as well as wounds at any other location; follow-up if wounds do not appear to be healing. See eye doctor
Now move to the Finalize Tab. You can do this by navigating back to the top & clicking the Finalize Tab, but if you're at the bottom of the SOAP Tab, there is a shortcut to get there directly. Click EM Coding.
American Lung Association, www.lung.org/stop-smoking, or 800-586-4872.
Resident-Attending discussion took place
Attending saw patient
Consent
Procedure Scheduling
Add/Update
Remove
Consent
Provider Comm.
Meds
Procedures
Patient Plan
Visit Document
Document Library
EM Coding
Dictation


03/15/2014 10:06 PM : "*USA SOAP"
03/15/2014 10:06 PM : "*Finalize"
TOB
HTN
DM
CAD
Specialty ▼ Family Practice
Visit Type ▼ Office Visit
Intake
Histories
SOAP
Finalize
Checkout
Standing Orders | Adult Immunizations | Peds Immunizations | My Plan | Procedures | Order Management | Document Library
Care Guidelines | Global Days
Panel Control: Toggle Cycle
General
Established patient
New patient
Today's Assessment
Provider Sign Off
Physician Sign Off Request:
Submit to supervising physician for review
E&M coding is reviewed in another lesson. For this exercise, click Moderate complexity for Medical decision making, then Calculate Code.
Evaluation and Management Coding
Medical Decision Making
View MDM Guidelines | View Risk Table
Straight forward
Low complexity
Moderate complexity
High complexity
Counseling
Counseled greater than 50% of time and documented content
Total visit time (minutes):
Counseling Details
Total counsel time (minutes):
Evaluation and Management Code
Visit code:
Modifier(s):
Calculate Code
Submit Code
CQM Check
Calculated EM code:
Submitted code:
Calculated eRx code:
Submitted eRx code:
Additional E&M Code | View Other Codes | SNOMED Visit Type (optional) | Medicare Preventive Codes
New patient:
99201
99202
99203
99204
99205
Established:
99211
99212
99213
99214
99215
Consultation:
99241
99242
99243
99244
99245
Preventive new:
99381
99382
99383
99384
99385
99386
99387
Preventive established:
99391
99392
99393
99394
99395
99396
99397
Preventive counseling:
99401
99402
99403
99404
Post Op:
99024
Prenatal:
Visit 4-6:
59425
Visits greater than 6:
59426
Behavioral Health:
90791 (Initial eval, no med services)


03/15/2014 10:06 PM : "*USA SOAP"
03/15/2014 10:06 PM : "*Finalize"
TOB
HTN
DM
CAD
Specialty ▼ Family Practice
Visit Type ▼ Office Visit
Intake
Histories
SOAP
Finalize
Checkout
Standing Orders | Adult Immunizations | Peds Immunizations | My Plan | Procedures | Order Management | Document Library
Panel Control: Toggle Cycle
If the calculated code is acceptable to you, click Submit Code.
E&M Guidelines1997: Web
Today's Assessment
Provider Sign Off
Physician Sign Off Request:
Submit to supervising physician for review
Residents will need to click Submit to supervising physician for review.
Evaluation and Management Coding
Medical Decision Making
View MDM Guidelines | View Risk Table
Straight forward
Low complexity
Moderate complexity
High complexity
Total visit time (minutes):
Counseling Details
Total counsel time (minutes):
Evaluation and Management Code
Visit code:
99214
Modifier(s):
Calculate Code
Submit Code
CQM Check
Calculated EM code:
99214
Submitted code:
Calculated eRx code:
Submitted eRx code:
Additional E&M Code | View Other Codes | SNOMED Visit Type (optional) | Medicare Preventive Codes
New patient:
99201
99202
99203
99204
99205
Established:
99211
99212
99213
99214
99215
Consultation:
99241
99242
99243
99244
99245
Preventive new:
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99385
99386
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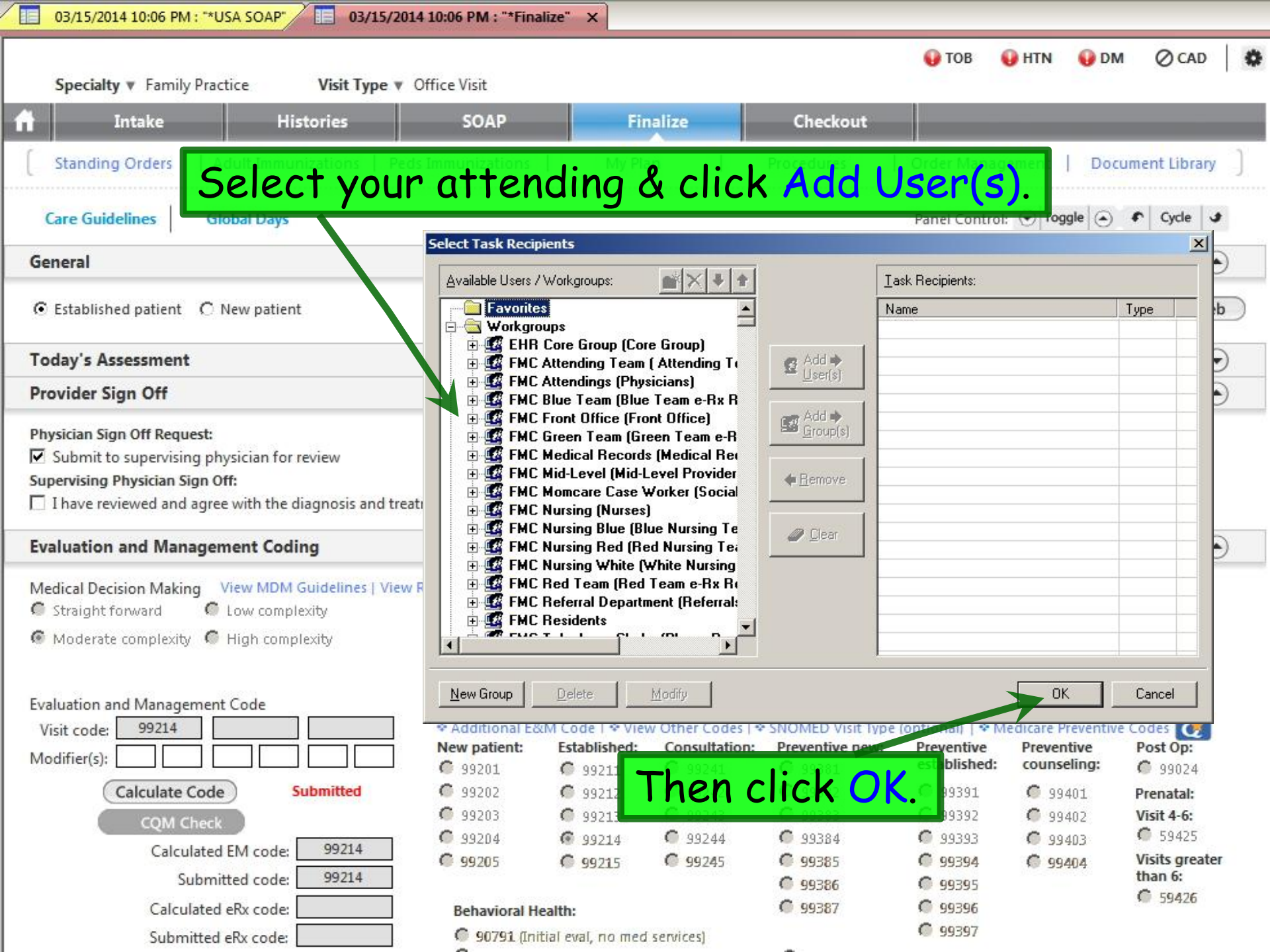
Preventive established:
99391
99392
99393
99394
99395
99396
99397
Preventive counseling:
99401
99402
99403
99404
Post Op:
99024
Prenatal:
Visit 4-6:
59425
Visits greater than 6:
59426
Behavioral Health:
90791 (Initial eval, no med services)


03/15/2014 10:06 PM : "*USA SOAP"
03/15/2014 10:06 PM : "*Finalize"
TOB
HTN
DM
CAD
Specialty ▼ Family Practice
Visit Type ▼ Office Visit
Intake
Histories
SOAP
Finalize
Checkout
Standing Orders
Document Library
Care Guidelines
Global Days
Panel Control:
Toggle
Cycle
Select your attending & click Add User(s).
General
Established patient
New patient
Today's Assessment
Provider Sign Off
Physician Sign Off Request:
Submit to supervising physician for review
Supervising Physician Sign Off:
I have reviewed and agree with the diagnosis and treat
Evaluation and Management Coding
Medical Decision Making
View MDM Guidelines | View R
Straight forward
Low complexity
Moderate complexity
High complexity
Evaluation and Management Code
Visit code:
99214
Modifier(s):
Calculate Code
Submitted
CQM Check
Calculated EM code:
99214
Submitted code:
99214
Calculated eRx code:
Submitted eRx code:
Select Task Recipients
Available Users / Workgroups:
Favorites
Workgroups
EHR Core Group (Core Group)
FMC Attending Team ( Attending T
FMC Attendings (Physicians)
FMC Blue Team (Blue Team e-Rx R
FMC Front Office (Front Office)
FMC Green Team (Green Team e-R
FMC Medical Records (Medical Rec
FMC Mid-Level (Mid-Level Provider
FMC Momcare Case Worker (Social
FMC Nursing (Nurses)
FMC Nursing Blue (Blue Nursing Te
FMC Nursing Red (Red Nursing Tea
FMC Nursing White (White Nursing
FMC Red Team (Red Team e-Rx Re
FMC Referral Department (Referrals
FMC Residents
Add User(s)
Add Group(s)
Remove
Clear
Task Recipients:
Name
Type
New Group
Delete
Modify
OK
Cancel
Additional E&M Code | View Other Codes | SNOMED Visit Type (optional) | Medicare Preventive Codes
New patient:
99201
99202
99203
99204
99205
Established:
99211
99212
99213
99214
99215
Consultation:
99244
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Preventive
99384
99385
99386
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Preventive
established:
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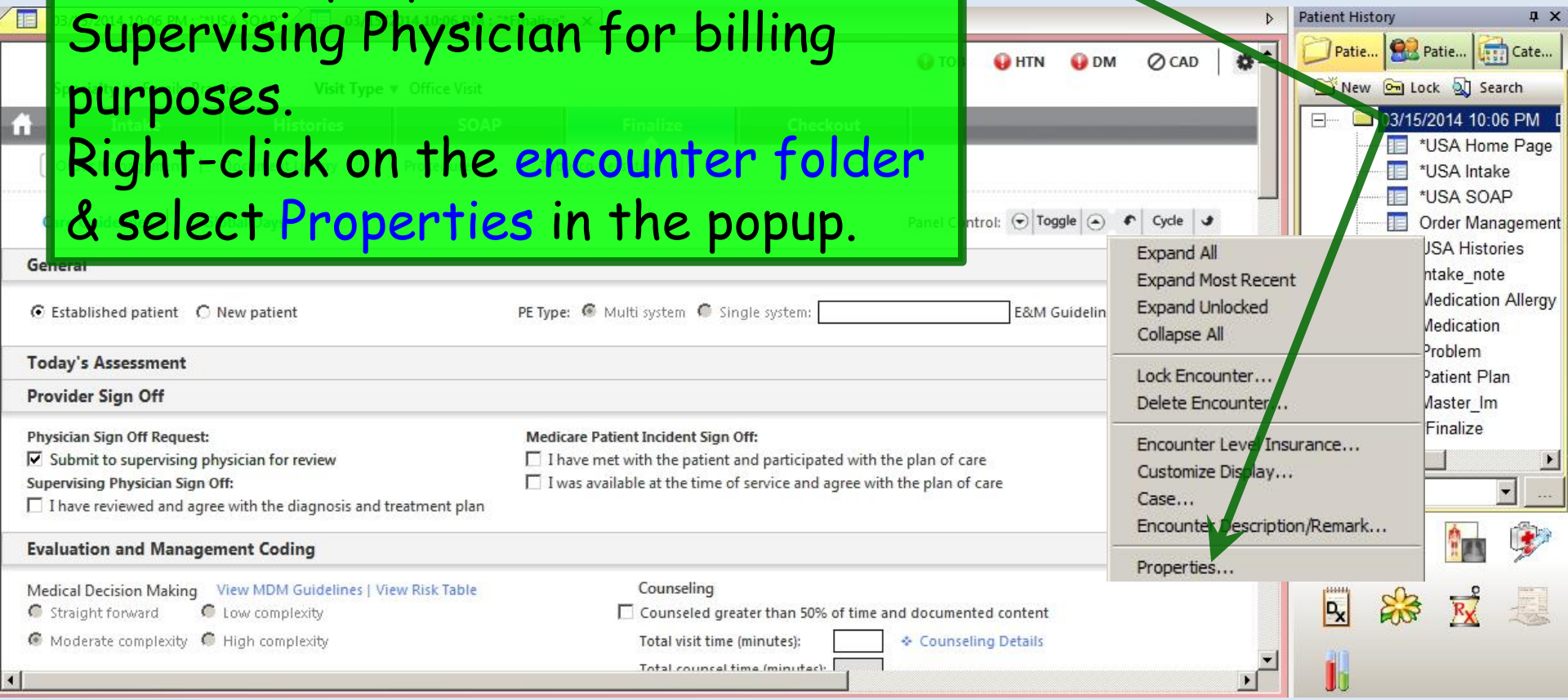
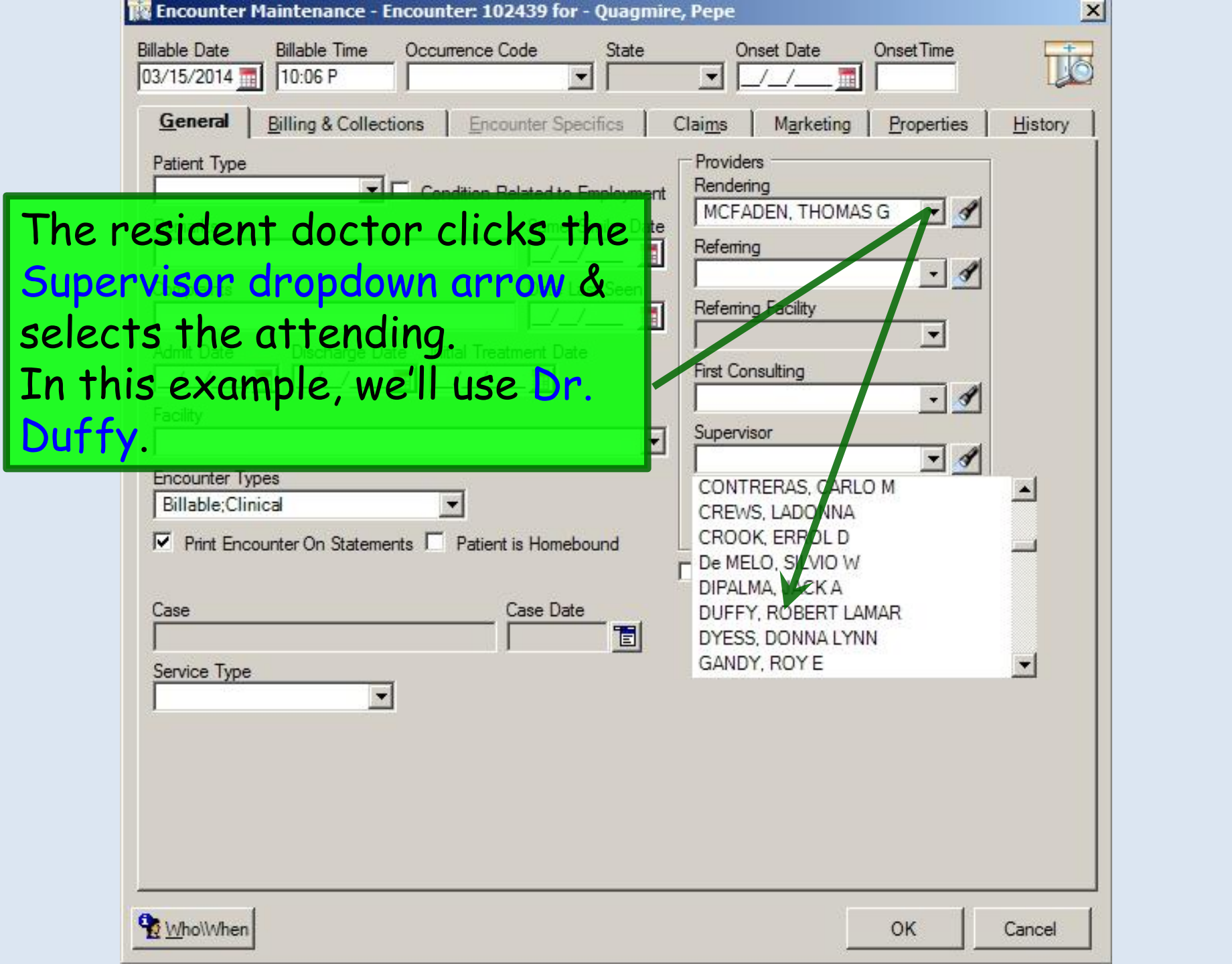
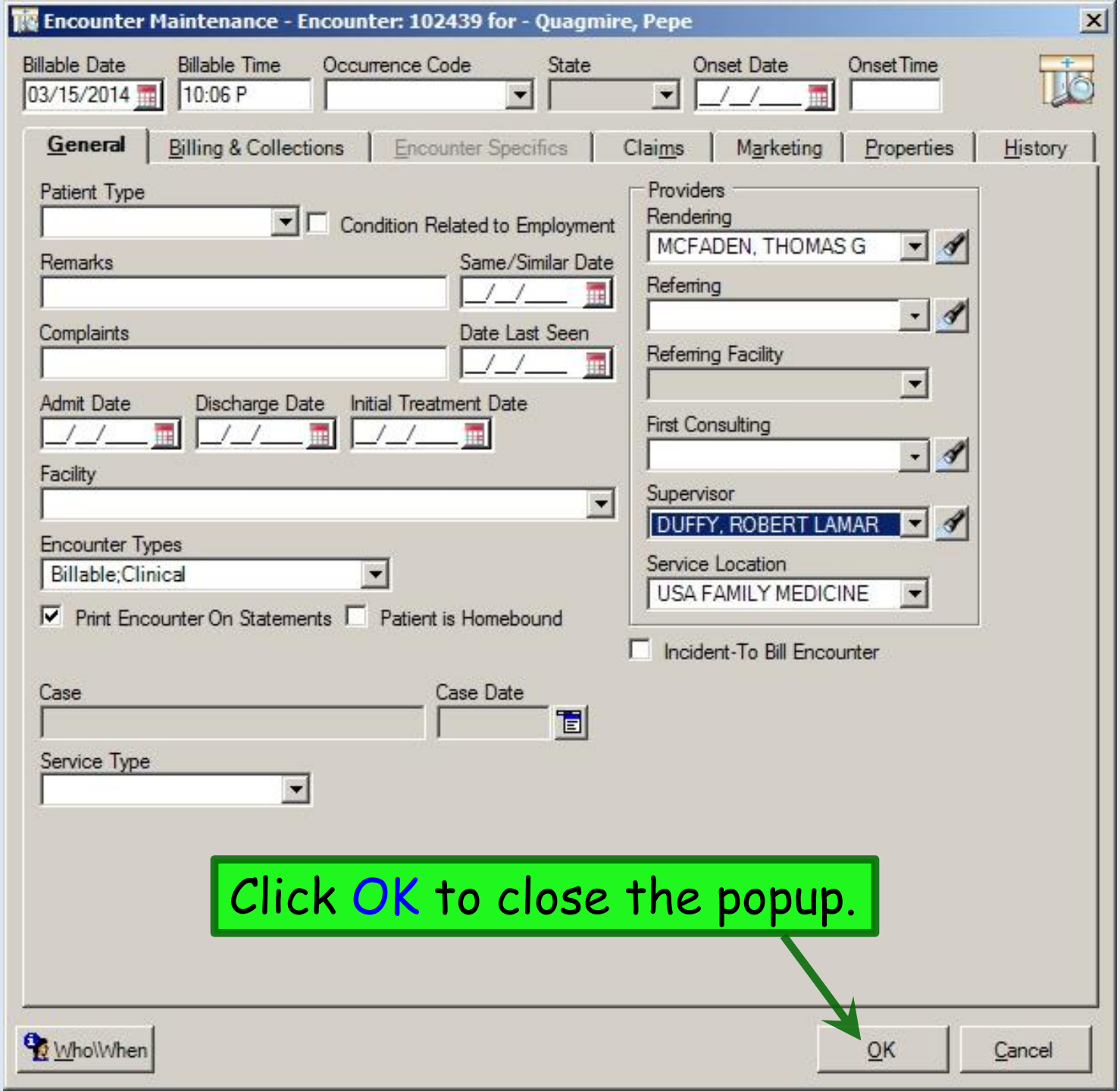
99392
99393
99394
99395
99396
99397
Preventive counseling:
99401
99402
99403
99404
Post Op:
99024
Prenatal:
Visit 4-6:
59425
Visits greater than 6:
59426
Behavioral Health:
90791 (Initial eval, no med services)
Then click OK.

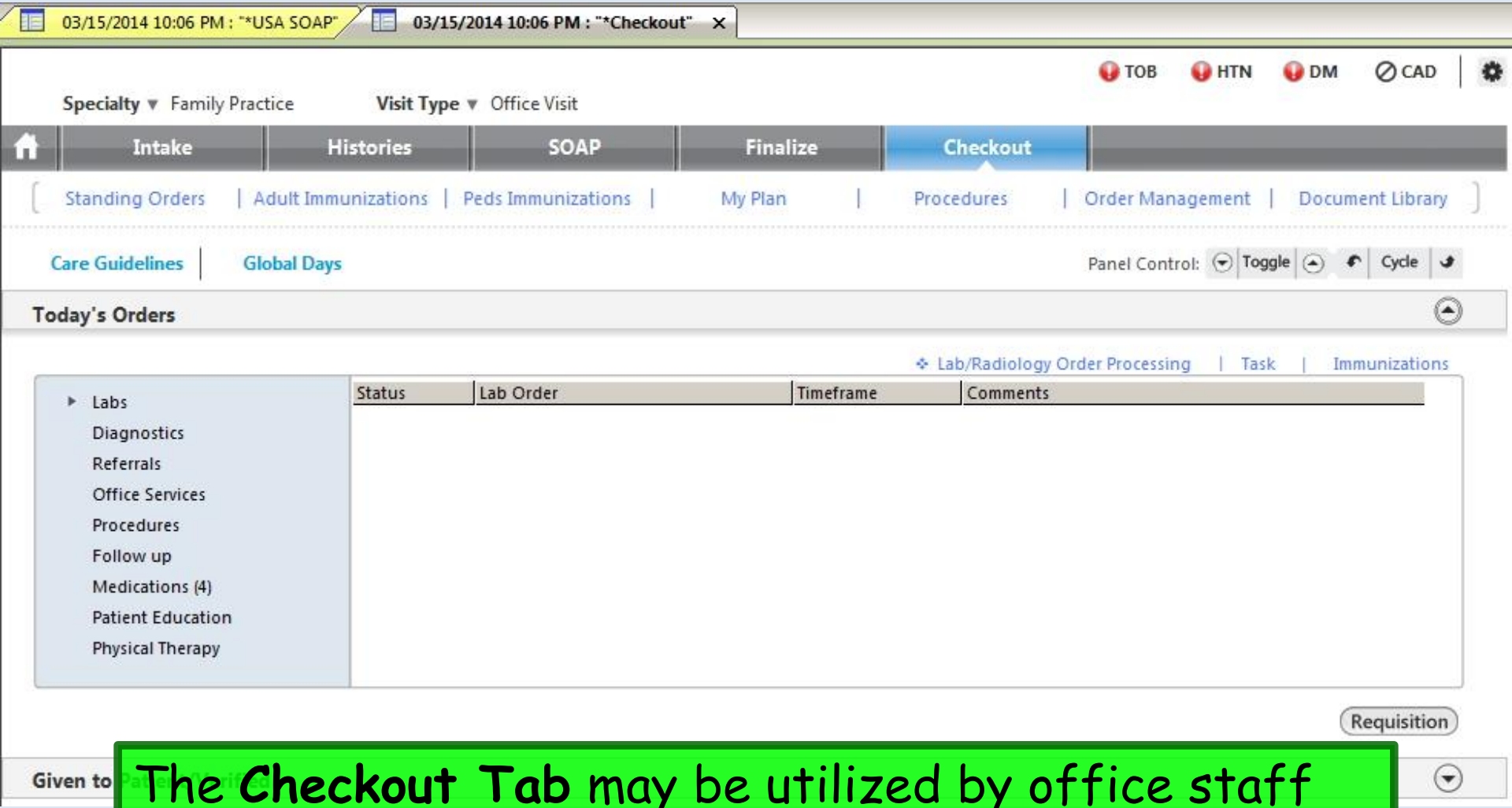
A resident also needs to view encounter properties to set the Supervising Physician for billing purposes.
Right-click on the encounter folder & select Properties in the popup.






The resident doctor clicks the Supervisor dropdown arrow & selects the attending.
In this example, we'll use Dr. Duffy.


Encounter Maintenance - Encounter: 102439 for - Quagmire, Pepe
Billable Date
03/15/2014
Billable Time
10:06 P
Occurrence Code
State
Onset Date
Onset Time
General
Billing & Collections
Encounter Specifics
Claims
Marketing
Properties
History
Patient Type
Condition Related to Employment
Remarks
Same/Similar Date
Complaints
Date Last Seen
Admit Date
Discharge Date
Initial Treatment Date
Facility
Encounter Types
Billable;Clinical
Print Encounter On Statements
Patient is Homebound
Providers
Rendering
MCFADEN, THOMAS G
Referring
Referring Facility
First Consulting
Supervisor
DUFFY, ROBERT LAMAR
Service Location
USA FAMILY MEDICINE
Incident-To Bill Encounter
Case
Case Date
Service Type
Click OK to close the popup.
Who\When
OK
Cancel




The **Checkout Tab** may be utilized by office staff to document completion of various orders, referrals, appointments, etc. The degree & manner of its use will be individualized to the workflow of each clinic.

# This concludes the NextGen Adult Visit demonstration.

Experience is something you often don't get until just after you need it.

R. Lamar Duffy, M.D.
Associate Professor
University of South Alabama
College of Medicine
Department of Family Medicine