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.
The nurse begins by double-clicking on the patient from her provider’s appointment list.
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.
Then click select a visit type & pick from the list; select Office Visit for this example.

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.
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**.
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.

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.)

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**.
Save the template (e.g., via control-S), then close the Patient_Demographics template. (If you don’t save first, it’ll remind you.)
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 make the **History Bar** do the same auto-hide trick if you click on the thumbtack to turn it sideways.

You can also show or hide the **History Bar** by clicking the **History icon** at the top.
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.

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.)
The **Info Bar** is collapsed, & **Vital Signs** are at the top.

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.

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.
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**.
The complaints you’ve entered display.

Click **Intake Comments** to enter some brief information about the patient’s complaints.

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).

Click the Medications reconciled checkbox.

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**.
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**.
Tetracycline now displays in the Allergies grid. Since this was just added, the Allergies added today bullet was selected.

Now let's move to the Histories Tab.
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.
Review the patient’s Problem List. To add diagnoses, click Add.
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.
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.
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**.
Next click **Add Note**.

Type your entry, then click **OK**.
Your entry displays. Note that you can update or delete a note.

When done, click 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.

All of the other History Review links lead to the same popup. Click one of them.

Click the **Reviewed** checkbox. This is the only individual “Review” checkbox on this template you need to click each encounter.
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.
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.
Enter the year **2002**.

To add further details, click **Manage**.
When done click **Save to Grid & Close**.

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

Note that you can later select one of the grid entries & edit it.

When you’ve entered everything you need, click **Save & Close**.
Now we’ll use the collapsible panels to move down to the Family History.

More details about the Problem List & Past History are available in the Histories lesson.

This history now displays.
Click **Add**.
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**.
These additions display in the grid.

Now move down to Social History & click the Add button.
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**.
These details display in the grid.

But since we've just collected a history of smoking, let's expand the **Problem List** panel & add **Tobacco Abuse**.
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**.
Click **Submit to Superbill**, then **Place Order**.
In a similar manner, enter a HbA1c of 7.4. When done click Close.
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.)
The Intake Note is created, summarizing all of the data you've just entered.

Close this, returning you to the Intake Tab.
The patient is ready for the provider. Re-expand the Info Bar & click the Tracking icon.
Click in the Room box & select a room; alternately, you can just type a room number in the box.
Next, click in the Status box & select waiting for provider.
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.
The provider then opens the chart from the appointment list & performs the 4-point check.
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.

Note also you can use the collapsible panels or scroll down to see a lot more information.
The Problem List is viewable & editable here.

<table>
<thead>
<tr>
<th>Last Addressed</th>
<th>Problem Description</th>
<th>Chronic</th>
<th>Secondary</th>
<th>Clinical Status</th>
<th>Provider</th>
<th>Location</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Essential hypertension</td>
<td>Y</td>
<td>N</td>
<td></td>
<td>Duffy, Robert</td>
<td>USA Family Medicine</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tobacco abuse</td>
<td></td>
<td>N</td>
<td></td>
<td>Duffy, Robert</td>
<td>USA Family Medicine</td>
<td></td>
</tr>
<tr>
<td>01/01/1990</td>
<td>Diabetes mellitus type II</td>
<td>N</td>
<td>N</td>
<td></td>
<td>Duffy, Robert</td>
<td>USA Family Medicine</td>
<td>Was diet-controlled until ~2011.</td>
</tr>
</tbody>
</table>

Likewise, you can review & update everything else that appears on the Histories Tab from here. Select the category of history desired on the left.
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.
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.
We'll start entering the HPI. First note that you can keep or edit this introductory line—or delete it all together.

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.
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.
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.

When done click **Save & Close**.
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.
There is an alternative many providers will find more comfortable than using the HPI popups. Click the **Comments** button.
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.
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.”

**Reason for Visit**

- **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.

- **Cough (comments)**
  - 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**
  - 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 mg Rx’d, but pt didn’t get prescription.
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.**
You can also directly access other system-specific ROS popups from here to make additions, changes, & deletions.

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

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.
Record the pressure you measure, then click **Save, Close**.
Your additional blood pressure displays.

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

<table>
<thead>
<tr>
<th>Exam</th>
<th>Findings</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constitutional</td>
<td>Normal</td>
<td>Well developed.</td>
</tr>
<tr>
<td>Ears</td>
<td>*</td>
<td>TM - Right: Uninflamed, Left: Uninflamed.</td>
</tr>
<tr>
<td>Ears</td>
<td>Normal</td>
<td>Canal - Right: Normal, Left: Normal.</td>
</tr>
<tr>
<td>Respiratory</td>
<td>Normal</td>
<td>Effort - Normal.</td>
</tr>
<tr>
<td>Abdomen</td>
<td>Normal</td>
<td>Inspection - Normal. No abdominal tenderness.</td>
</tr>
<tr>
<td>Extremity</td>
<td>Normal</td>
<td>No edema.</td>
</tr>
<tr>
<td>Neurological</td>
<td>*</td>
<td>Sensory - NI except as otherwise noted. Motor - NI except as otherwise noted. Balance &amp; gait - Grossly nl.</td>
</tr>
</tbody>
</table>
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.
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**...
...and add some other diagnoses from the Problem List.
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.
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.)
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.

When done click **Save & Close**.
Your assessments & plans display.

Let's complete his prescriptions. Click Meds.
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.
One of the Meaningful Use criteria requires patients to receive a summary of the visit. Click Patient Plan.
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.
Now generate today's visit note. One way to do this would be to click Visit Document.
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**.
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.**
E&M coding is reviewed in another lesson. For this exercise, click Moderate complexity for Medical decision making, then Calculate Code.
If the calculated code is acceptable to you, click **Submit Code**.

Residents will need to click **Submit to supervising physician for review**.
Select your attending & click **Add User(s)**.

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.
Click OK to close the popup.
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.

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