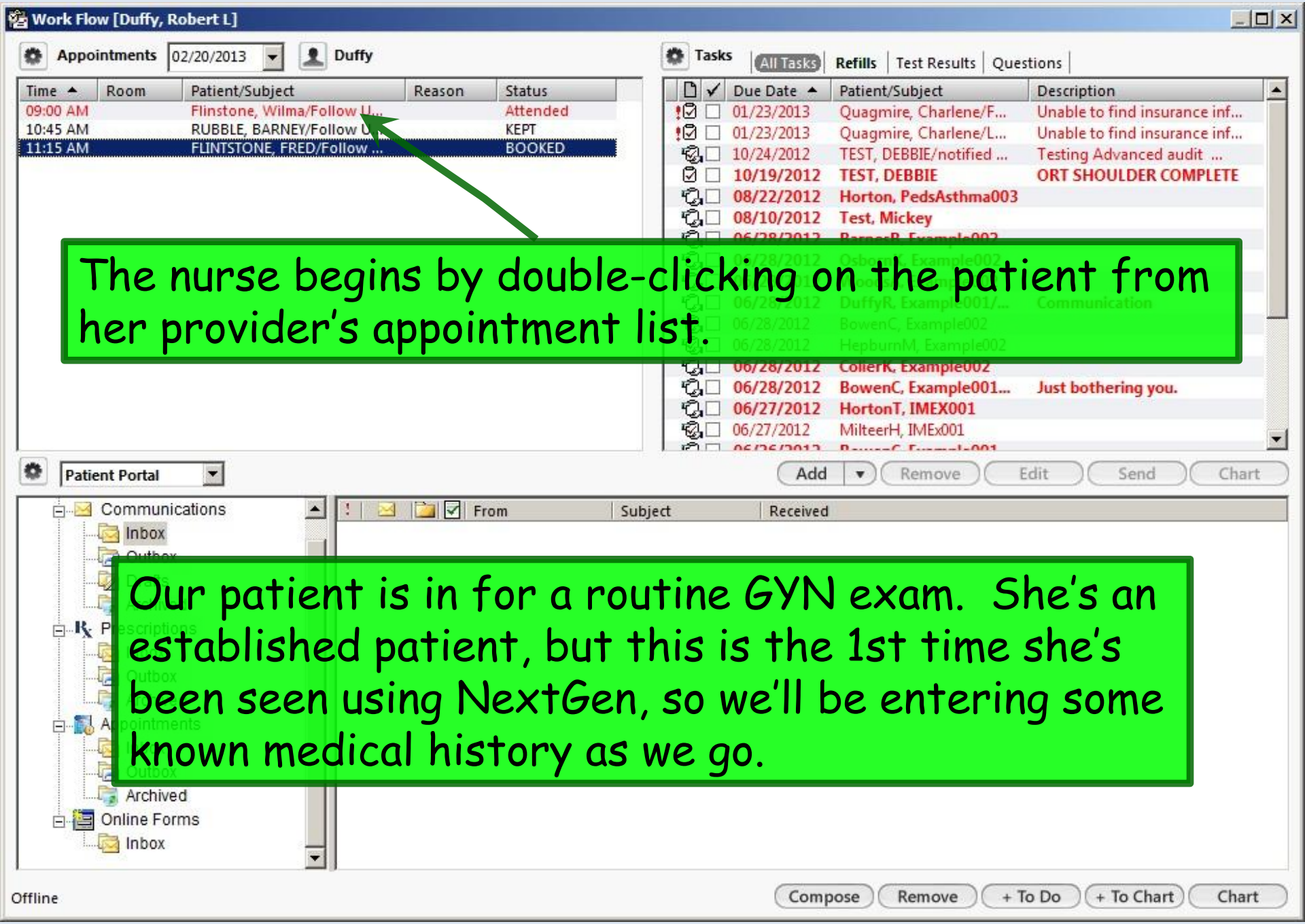
NEXTGEN
GYN ROUTINE ANNUAL VISIT DEMONSTRATION

This demonstration reviews a typical routine GYN "well woman" visit. Details of the workflow will likely vary somewhat, depending on practice policy & clinic layout, though this should give you a good idea of NextGen functionality.

This has been prepared for EHR 5.8 & KBM 8.3, though some screen shots of older versions may appear if they don't compromise the presentation. 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.

Our patient is in for a routine GYN exam. She's an established patient, but this is the 1st time she's been seen using NextGen, so we'll be entering some known medical history as we go.

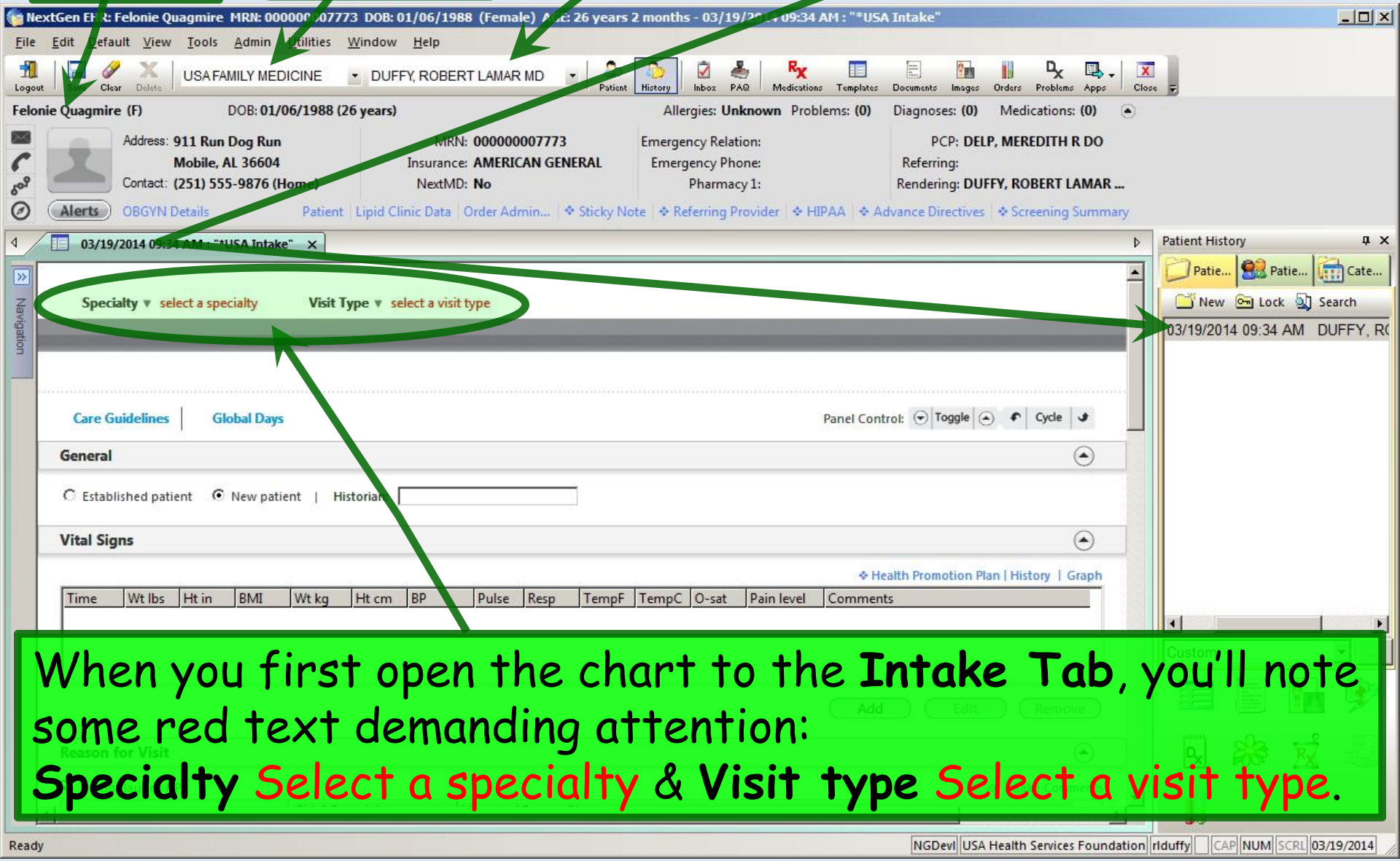
Always begin by performing the 4-Point check.

Patient

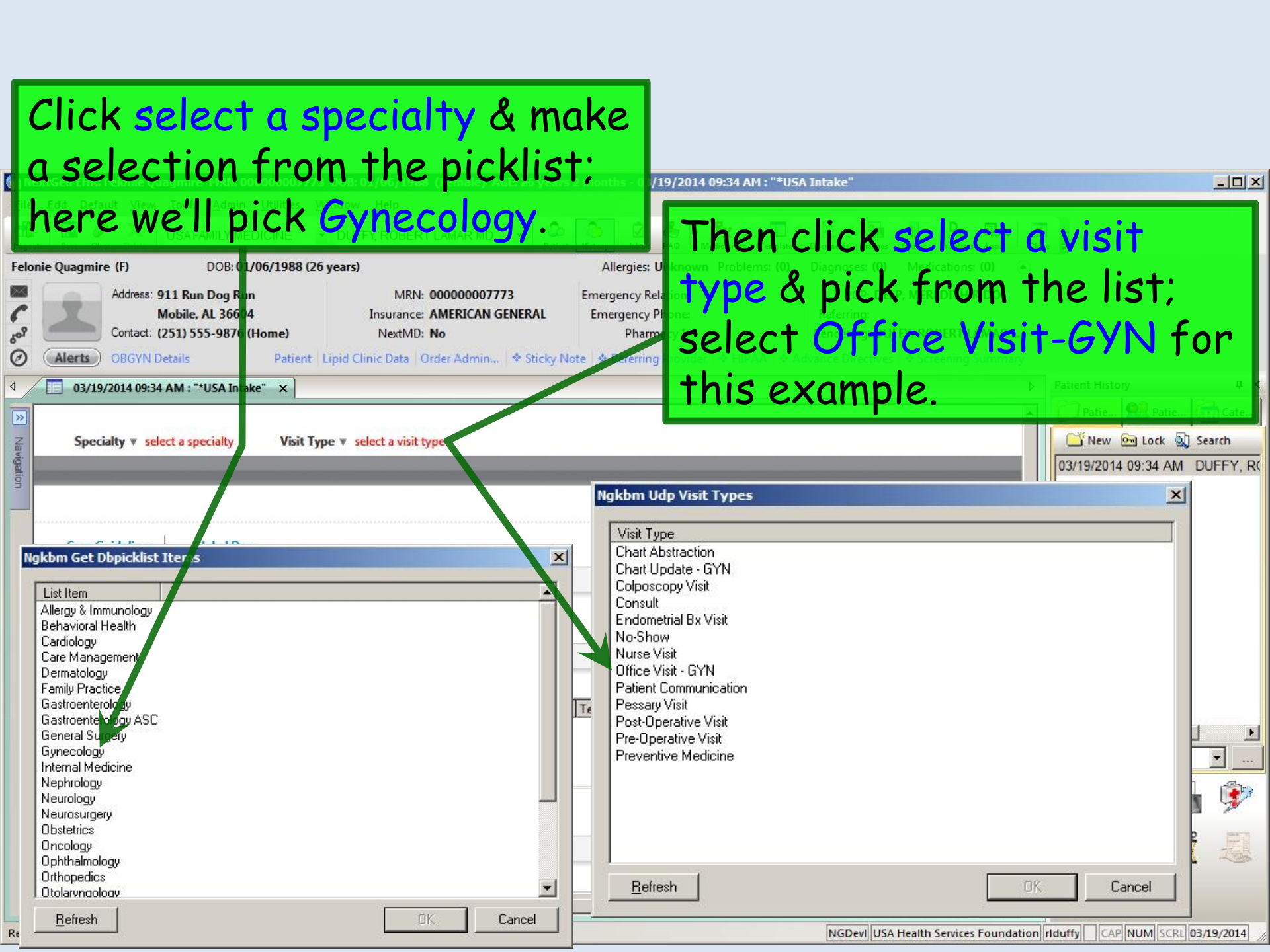
Location

Provider

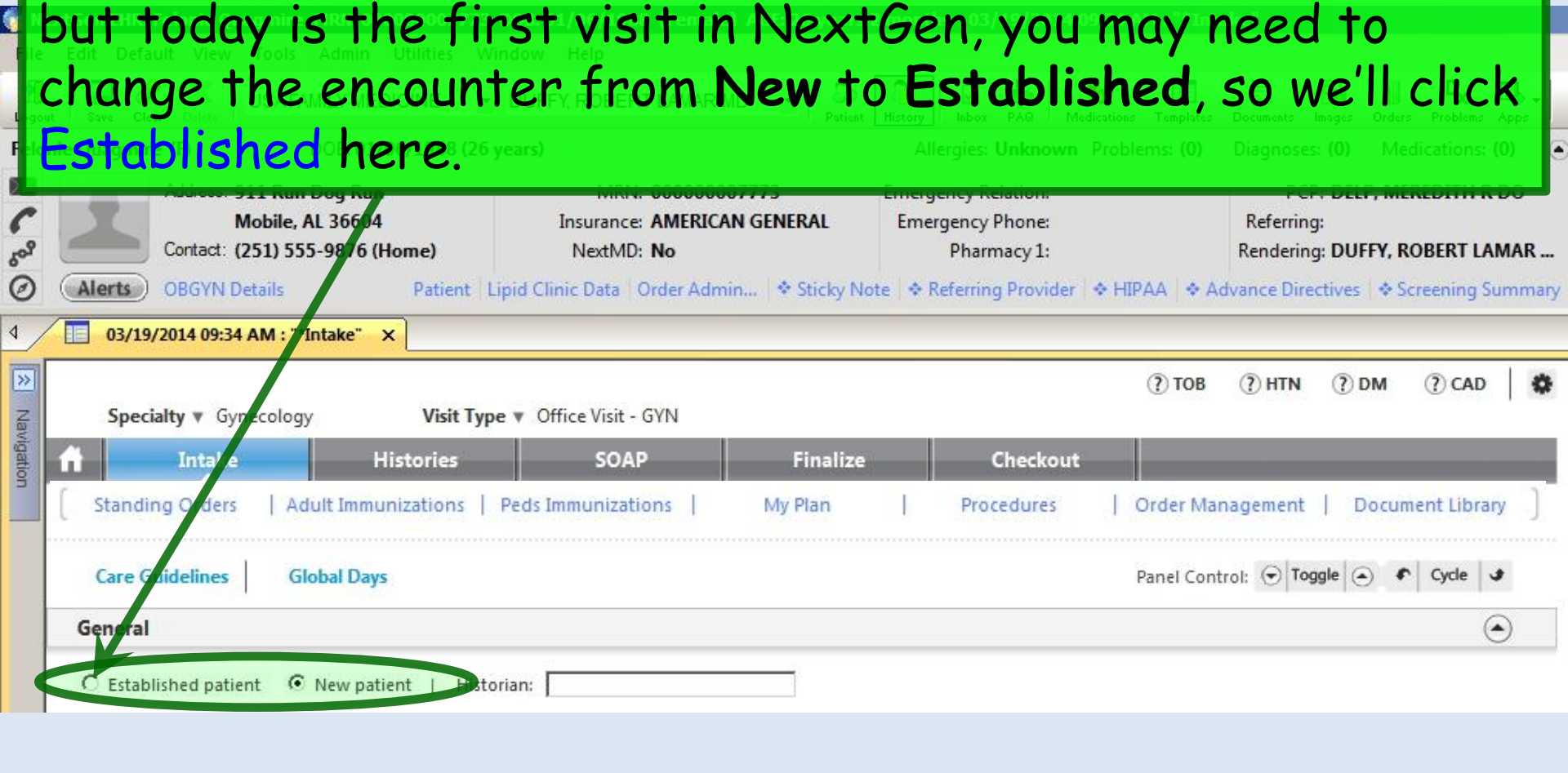
Date



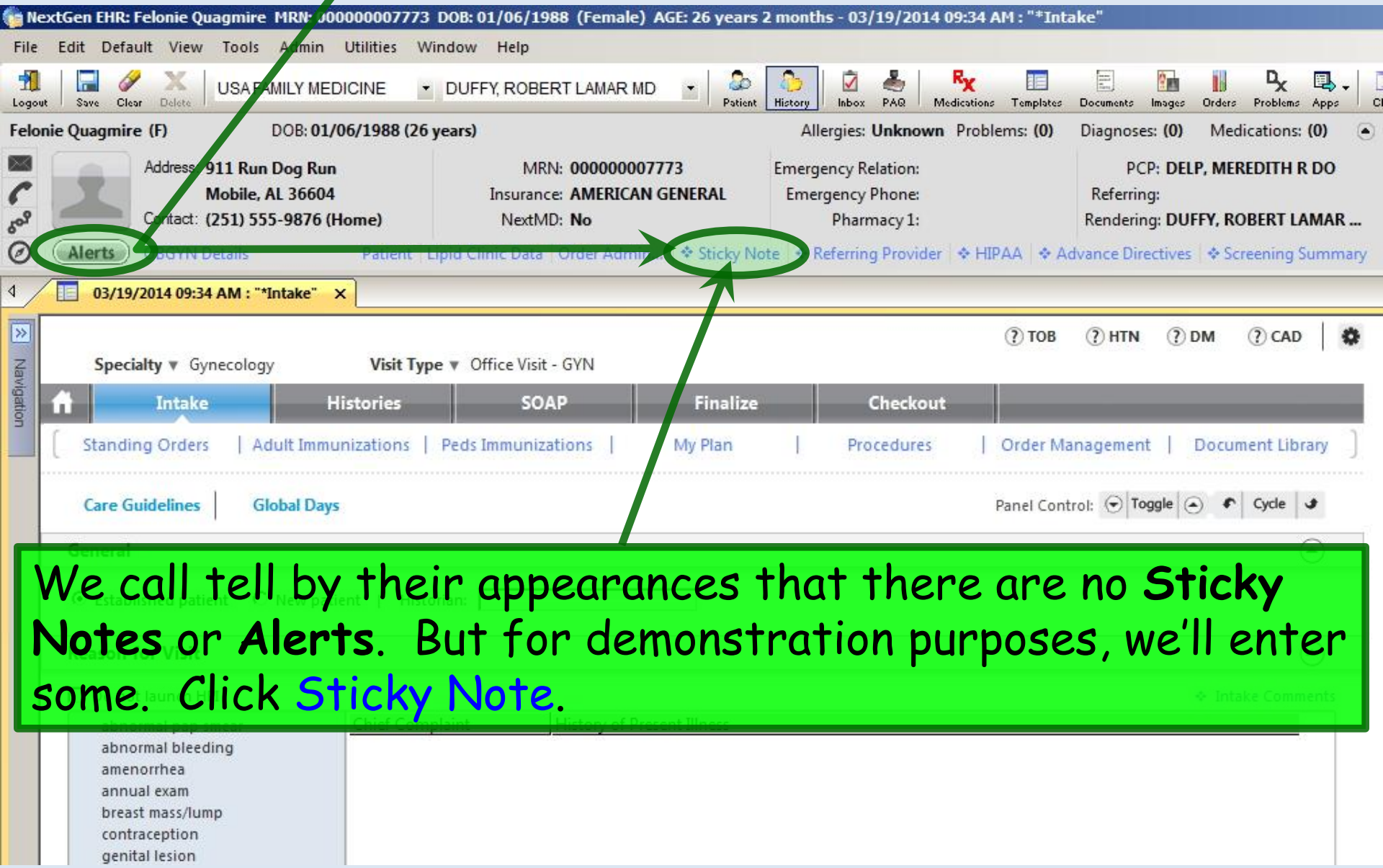
When you first open the chart to the **Intake Tab**, you'll note some red text demanding attention:
Specialty Select a specialty & **Visit type** Select a visit type.


Click select a specialty & make a selection from the picklist; here we'll pick Gynecology.
Then click select a visit type & pick from the list; select Office Visit-GYN for this example.
Felonie Quagmire (F)
DOB: 01/06/1988 (26 years)
Address: 911 Run Dog Run
Mobile, AL 36604
Contact: (251) 555-9870 (Home)
MRN: 000000007773
Insurance: AMERICAN GENERAL
NextMD: No
Alerts
OBGYN Details
Patient
Lipid Clinic Data
Order Admin...
Sticky Note
03/19/2014 09:34 AM : "*USA Intake"
Specialty
select a specialty
Visit Type
select a visit type
Ngkbm Get Dbpicklist Items
List Item
Allergy & Immunology
Behavioral Health
Cardiology
Care Management
Dermatology
Family Practice
Gastroenterology
Gastroenterology ASC
General Surgery
Gynecology
Internal Medicine
Nephrology
Neurology
Neurosurgery
Obstetrics
Oncology
Ophthalmology
Orthopedics
Otolaryngology
Refresh
OK
Cancel
Ngkbm Udp Visit Types
Visit Type
Chart Abstraction
Chart Update - GYN
Colposcopy Visit
Consult
Endometrial Bx Visit
No-Show
Nurse Visit
Office Visit - GYN
Patient Communication
Pessary Visit
Post-Operative Visit
Pre-Operative Visit
Preventive Medicine
Refresh
OK
Cancel
New
Lock
Search
03/19/2014 09:34 AM DUFFY, R
NGDevl
USA Health Services Foundation
rlduffy
CAP
NUM
SCRL
03/19/2014

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.

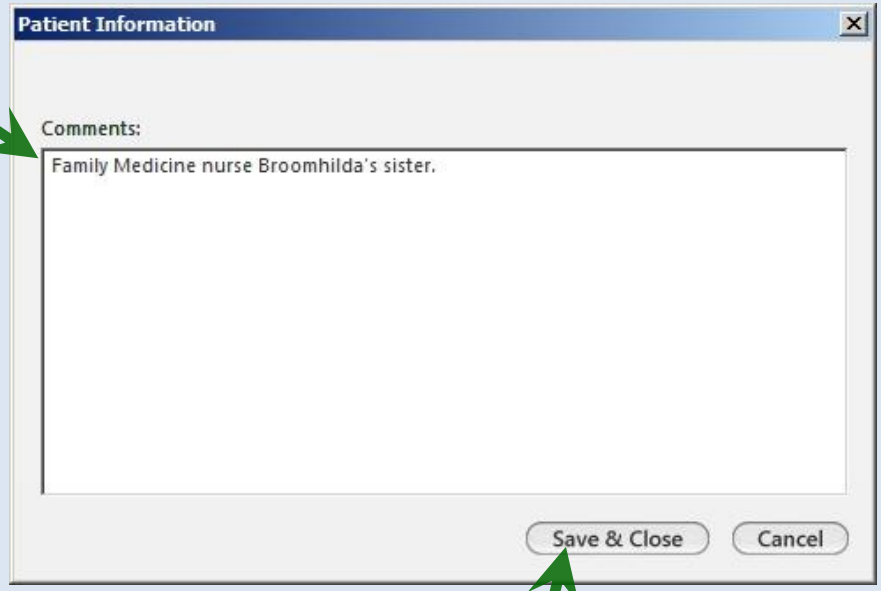


It's always good to begin by noting whether there are any **Sticky Note** or **Alerts** entries.



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.

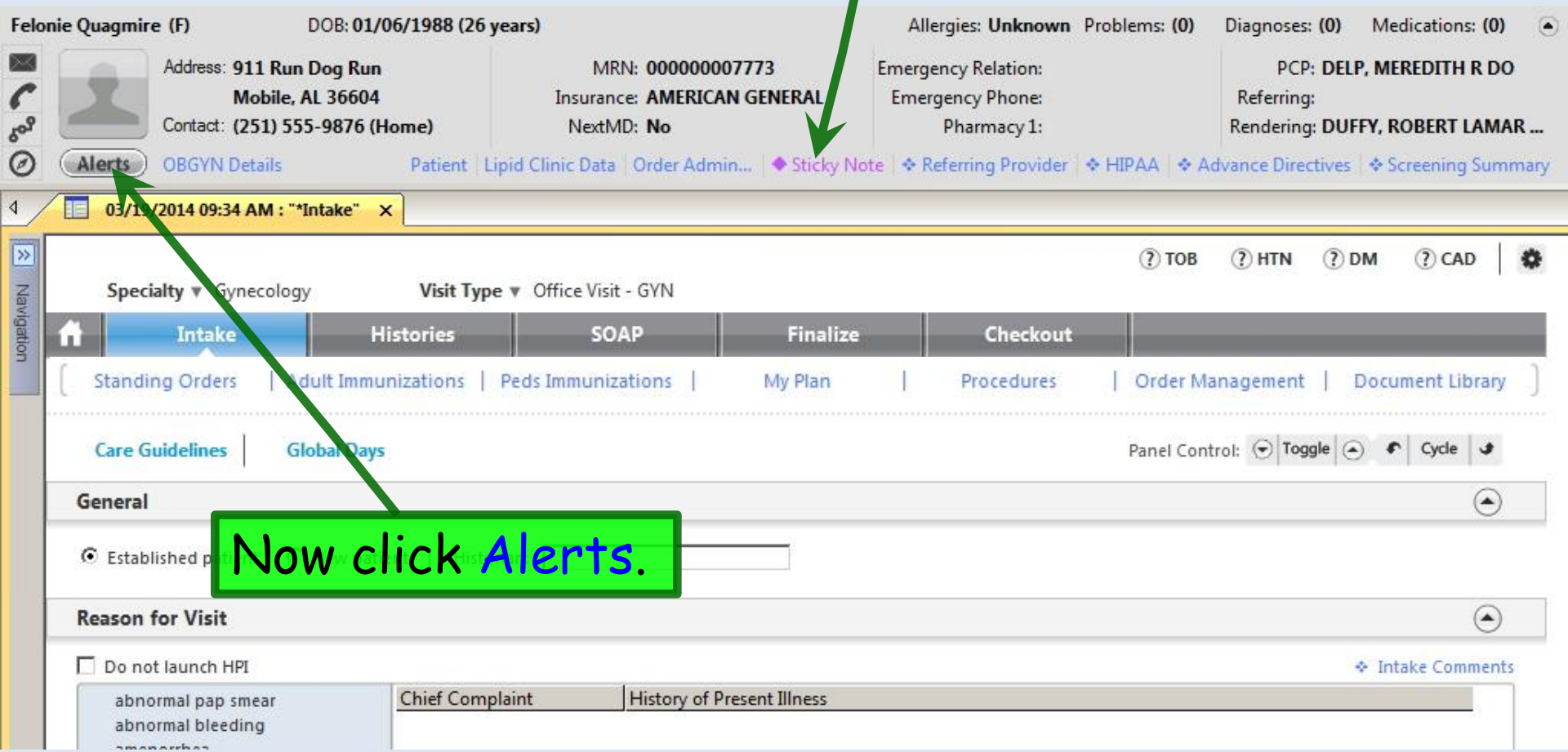
Like actual sticky notes, these are things that are nice to know, but aren't meant to be permanent chart records. We've entered here that her sister works in the Family Medicine clinic.



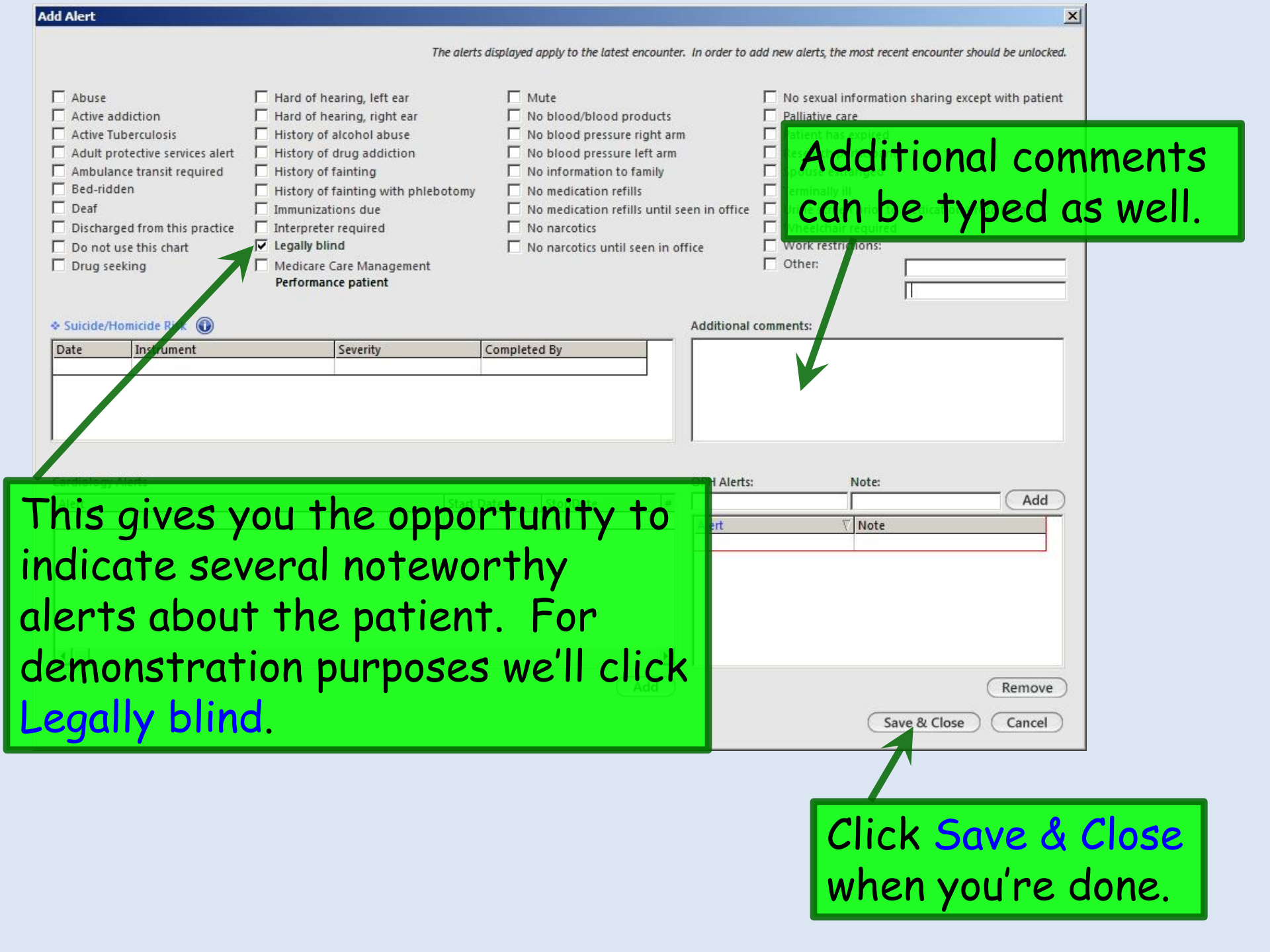
Other times a sticky note would be a temporary notice, like Ask about Tdap next visit. RL Duffy 2/13/14. It's good to put your name & date on such things; otherwise, you have no idea whether they're still pertinent when you see them in the future. And you should delete such sticky notes when they're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

When done click Save & Close.

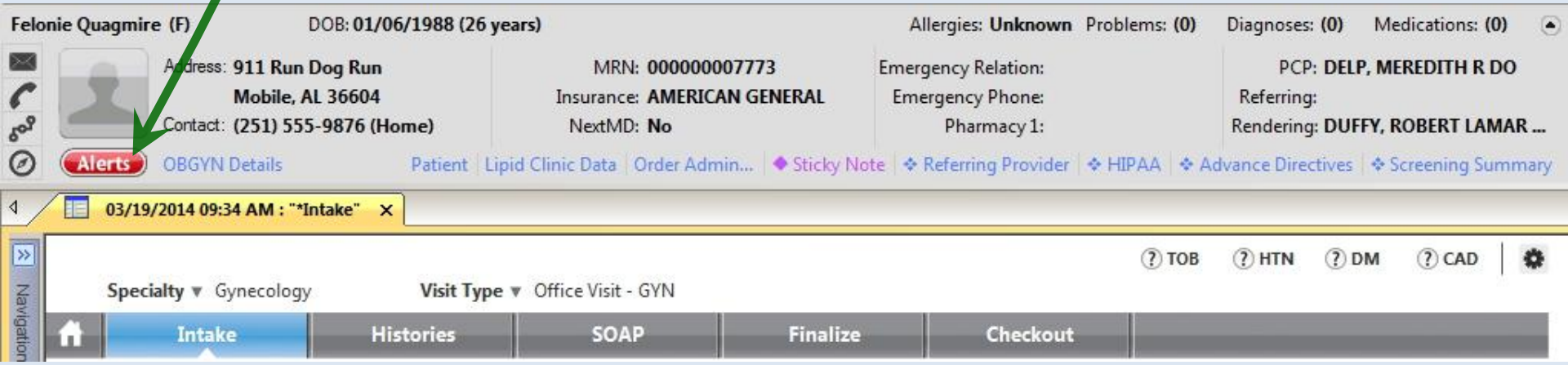
When a **Sticky Note** is present, the link will change to a magenta color with a solid diamond.



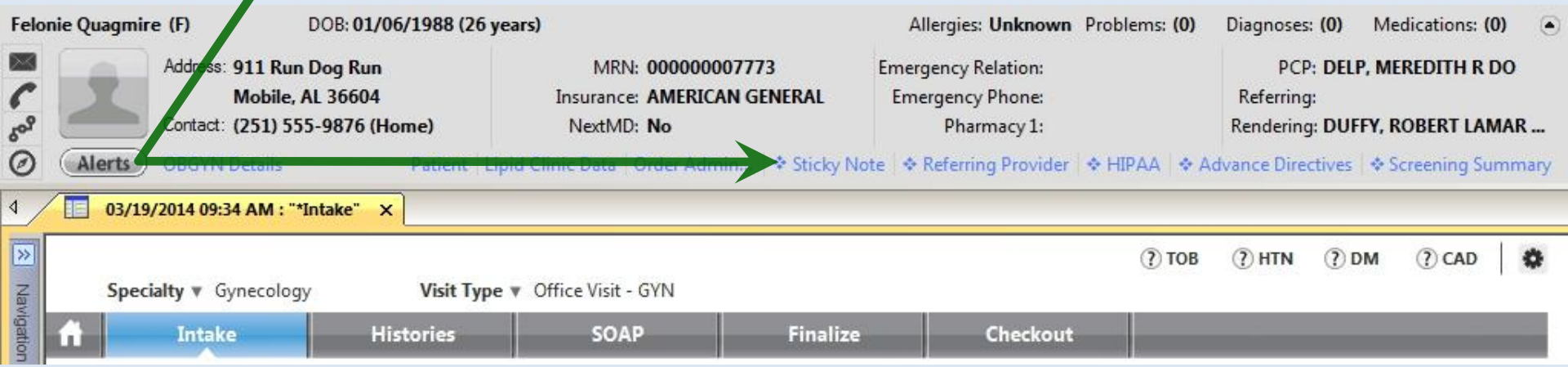
Now click *Alerts*.


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:
Note:
Add
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.
Click Save & Close when you're done.

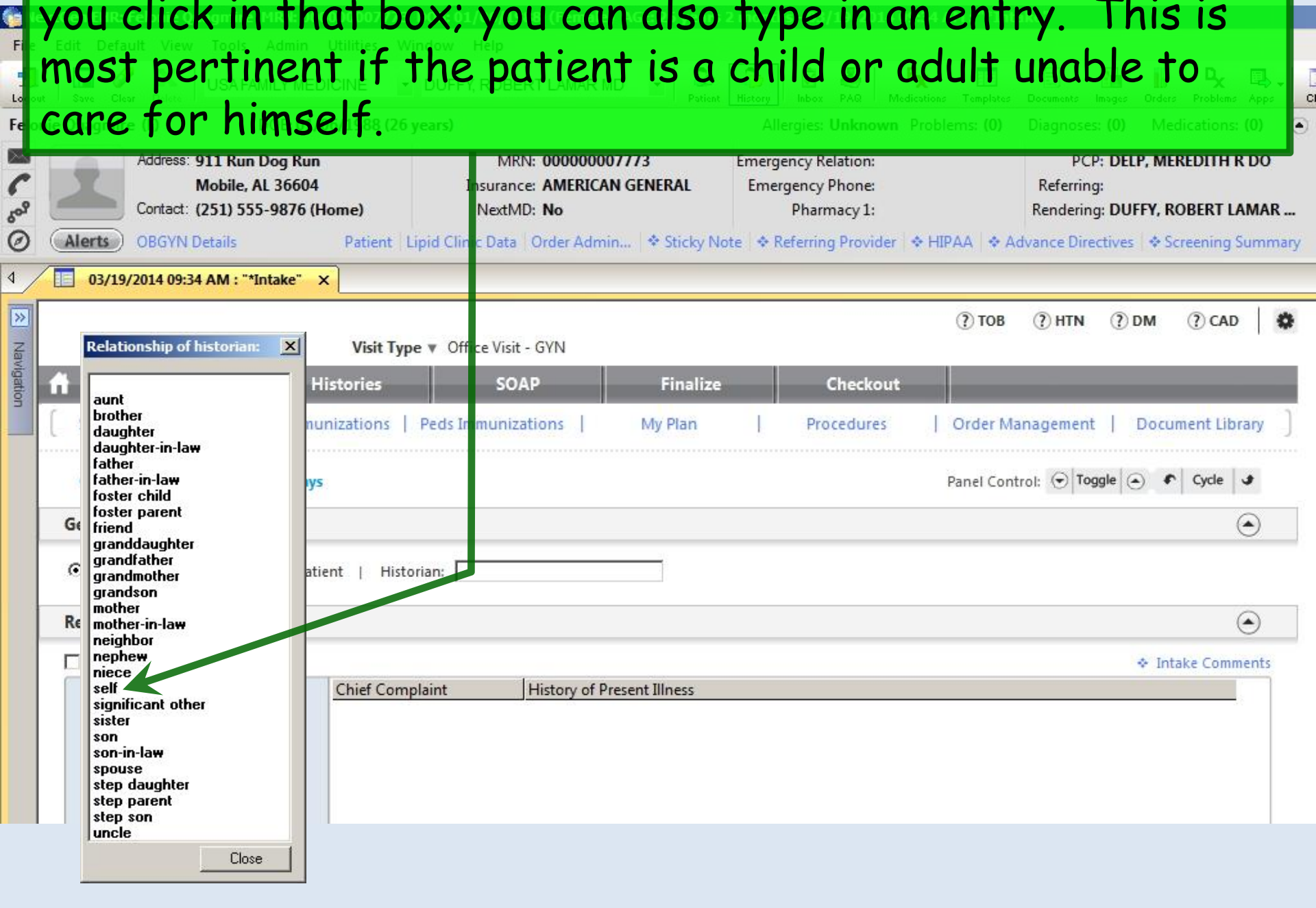
The Alerts button turns red when there is an entry.

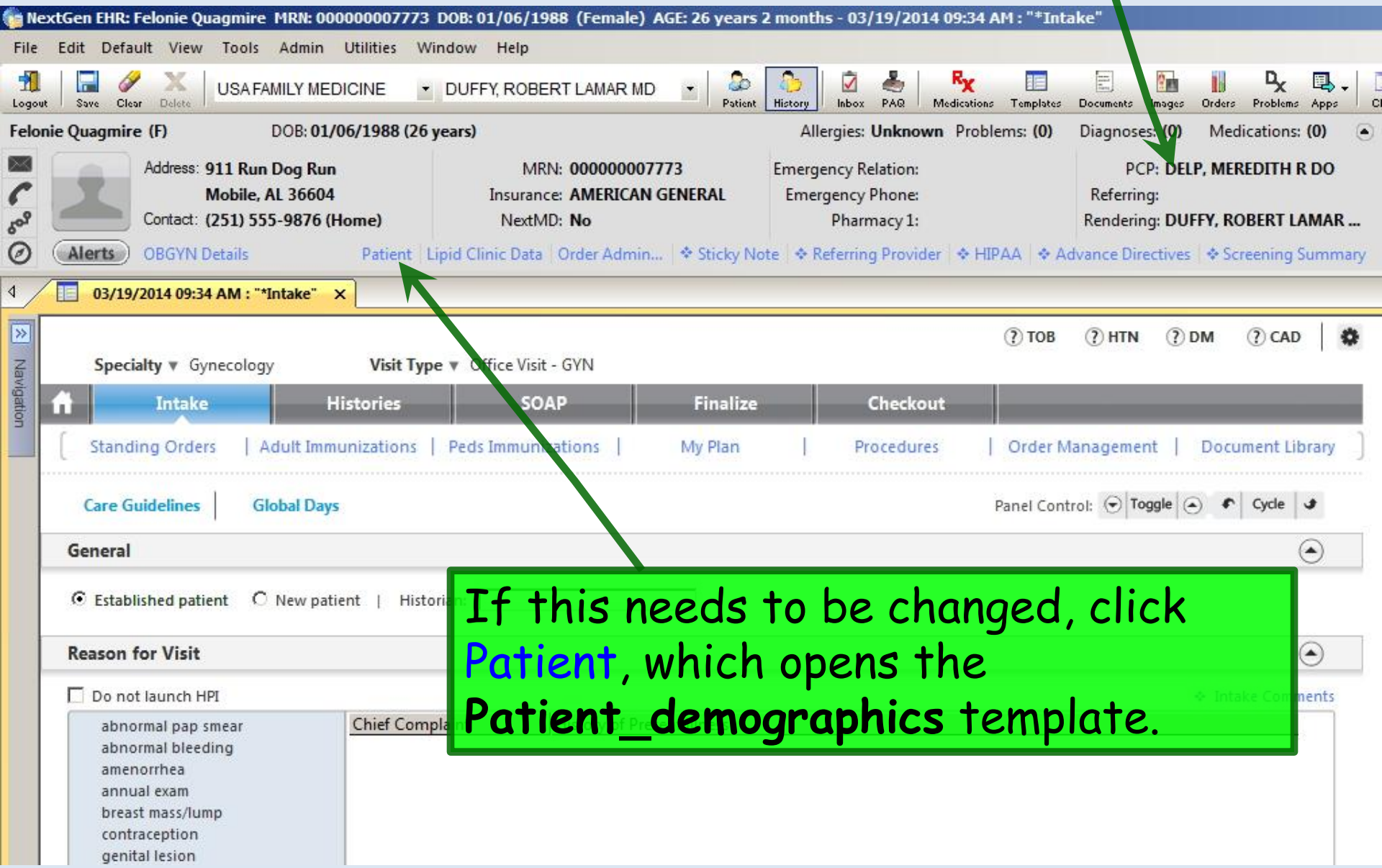


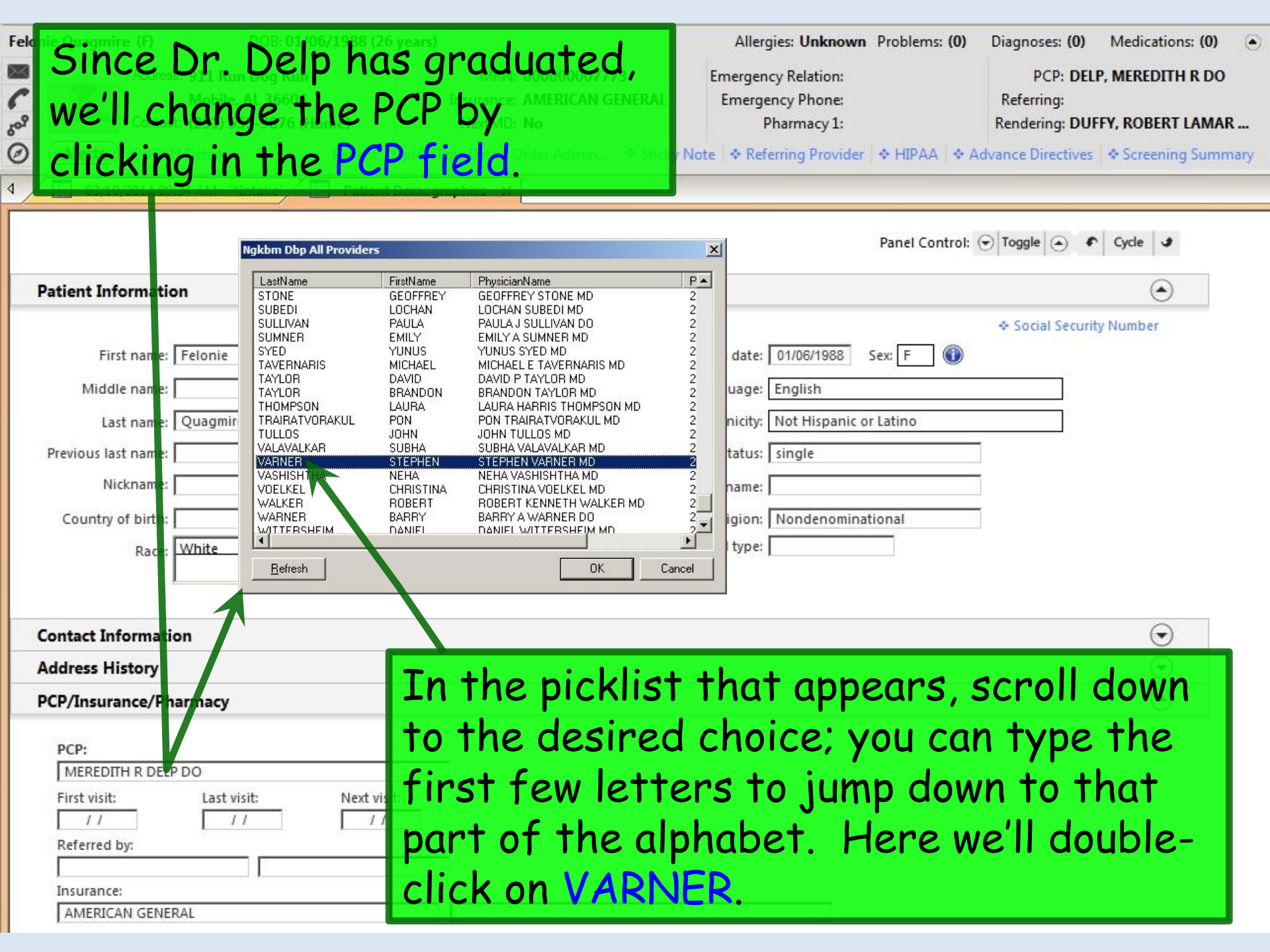
When you remove entries the Sticky Note & Alerts return to their baseline appearance, as below.

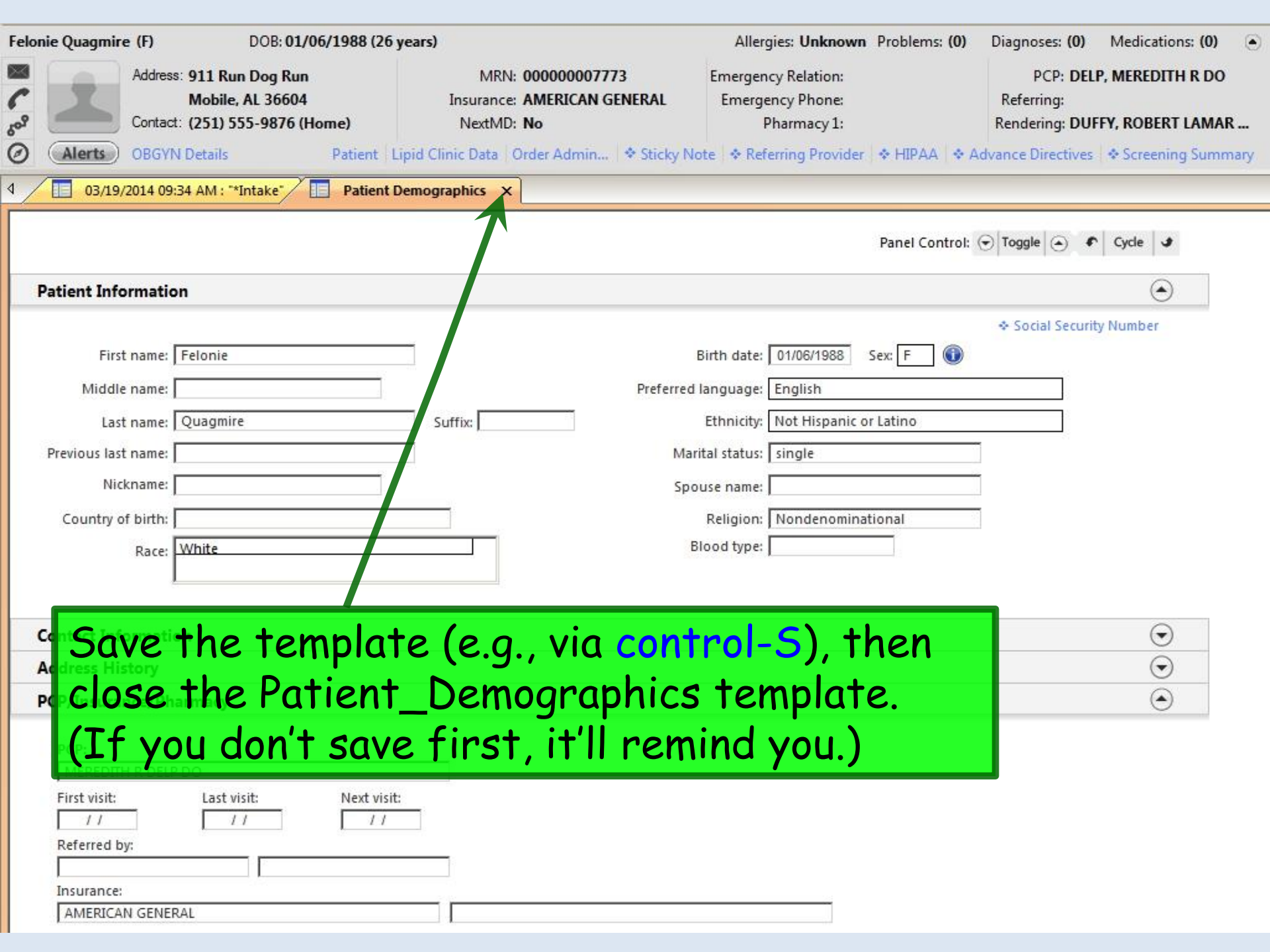


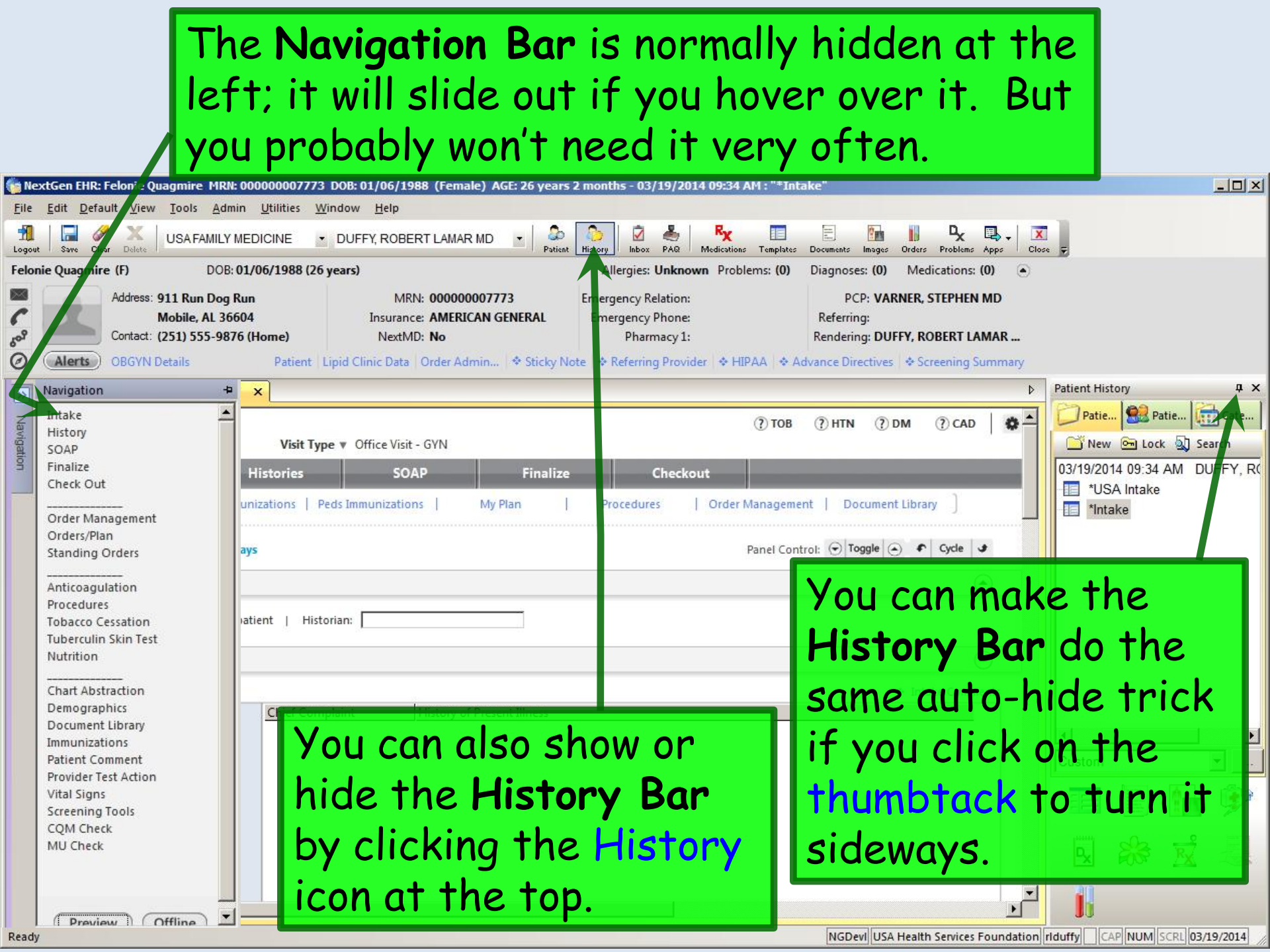
You can select a **Historian** from the picklist that appears if you click in that box; you can also type in an entry. This is most pertinent if the patient is a child or adult unable to care for himself.

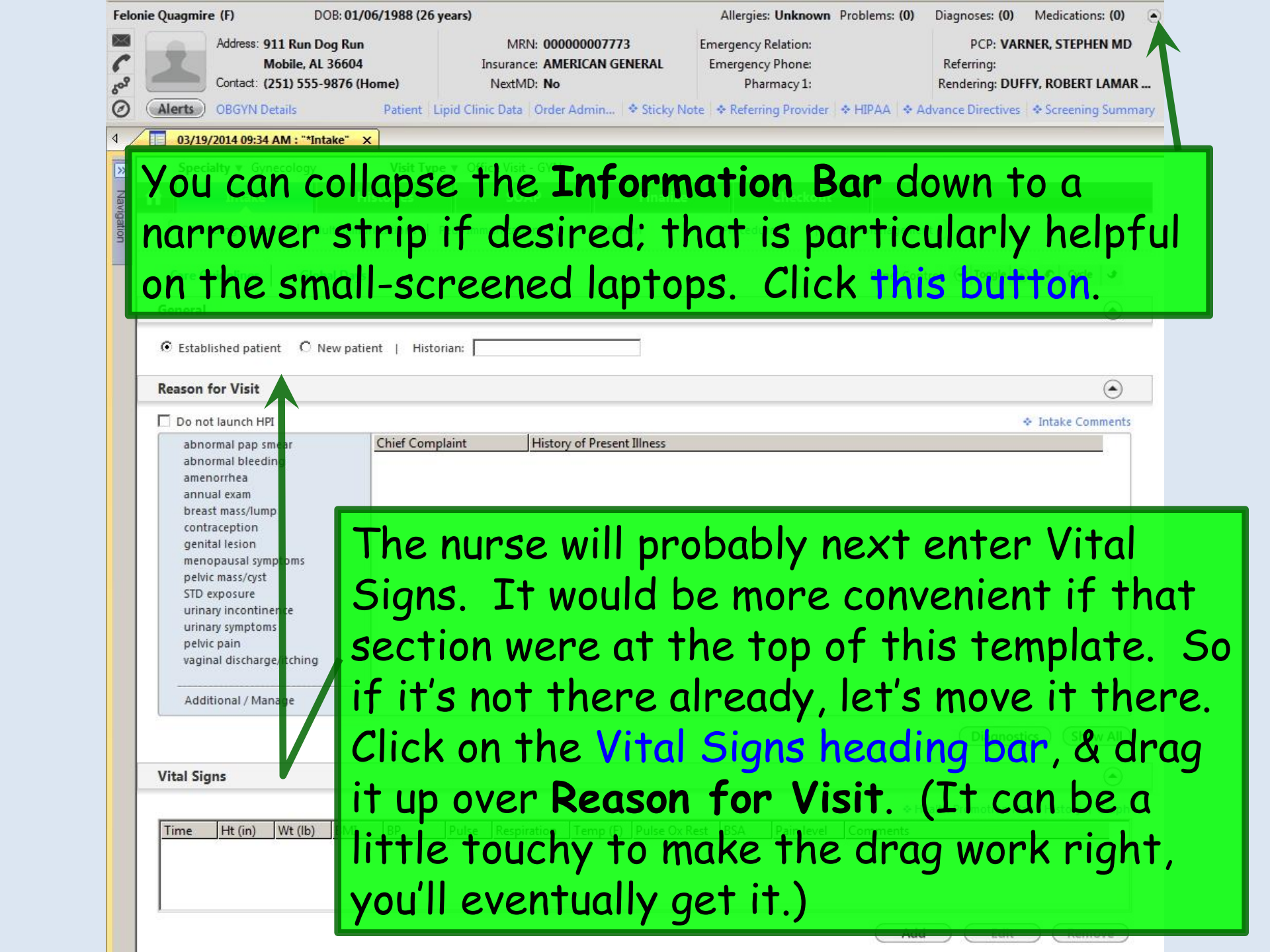



Note the PCP.
NextGen EHR: Felonie Quagmire MRN: 000000007773 DOB: 01/06/1988 (Female) AGE: 26 years 2 months - 03/19/2014 09:34 AM : "*Intake"
File Edit Default View Tools Admin Utilities Window Help
Logout Save Clear Delete USA FAMILY MEDICINE DUFFY, ROBERT LAMAR MD Patient History Inbox PAQ Medications Templates Documents Images Orders Problems Apps
Felonie Quagmire (F) DOB: 01/06/1988 (26 years) Allergies: Unknown Problems: (0) Diagnoses: (0) Medications: (0)
Address: 911 Run Dog Run
Mobile, AL 36604
Contact: (251) 555-9876 (Home)
MRN: 000000007773
Insurance: AMERICAN GENERAL
NextMD: No
Emergency Relation:
Emergency Phone:
Pharmacy 1:
PCP: DELP, MEREDITH R DO
Referring:
Rendering: DUFFY, ROBERT LAMAR ...
Alerts OBGYN Details Patient Lipid Clinic Data Order Admin... Sticky Note Referring Provider HIPAA Advance Directives Screening Summary
03/19/2014 09:34 AM : "*Intake"
Navigation
TOB HTN DM CAD
Specialty Gynecology Visit Type Office Visit - GYN
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 | Historian
Reason for Visit
Do not launch HPI
abnormal pap smear
abnormal bleeding
amenorrhea
annual exam
breast mass/lump
contraception
genital lesion
Chief Complaint
If this needs to be changed, click Patient, which opens the Patient_demographics template.


Since Dr. Delp has graduated, we'll change the PCP by clicking in the PCP field.
Allergies: Unknown Problems: (0) Diagnoses: (0) Medications: (0)
Emergency Relation:
Emergency Phone:
Pharmacy 1:
PCP: DELP, MEREDITH R DO
Referring:
Rendering: DUFFY, ROBERT LAMAR ...
Referring Provider
HIPAA
Advance Directives
Screening Summary
Panel Control:
Toggle
Cycle
Ngkbm Dbp All Providers
LastName FirstName PhysicianName
STONE GEOFFREY GEOFFREY STONE MD
SUBEDI LOCHAN LOCHAN SUBEDI MD
SULLIVAN PAULA PAULA J SULLIVAN DO
SUMNER EMILY EMILY A SUMNER MD
SYED YUNUS YUNUS SYED MD
TAVERNARIS MICHAEL MICHAEL E TAVERNARIS MD
TAYLOR DAVID DAVID P TAYLOR MD
TAYLOR BRANDON BRANDON TAYLOR MD
THOMPSON LAURA LAURA HARRIS THOMPSON MD
TRAIRATVORAKUL PON PON TRAIRATVORAKUL MD
TULLOS JOHN JOHN TULLOS MD
VALAVALKAR SUBHA SUBHA VALAVALKAR MD
VARNER STEPHEN STEPHEN VARNER MD
VASHISHTHA NEHA NEHA VASHISHTHA MD
VOELKEL CHRISTINA CHRISTINA VOELKEL MD
WALKER ROBERT ROBERT KENNETH WALKER MD
WARNER BARRY BARRY A WARNER DO
Refresh
OK
Cancel
Patient Information
Social Security Number
First name: Felonie
Middle name:
Last name: Quagmir
Previous last name:
Nickname:
Country of birth:
Race: White
date: 01/06/1988
Sex: F
uage: English
nicity: Not Hispanic or Latino
tatus: single
name:
igion: Nondenominational
type:
Contact Information
Address History
PCP/Insurance/Pharmacy
PCP:
MEREDITH R DELP DO
First visit:
Last visit:
Referred by:
Insurance:
AMERICAN GENERAL
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 VARNER.

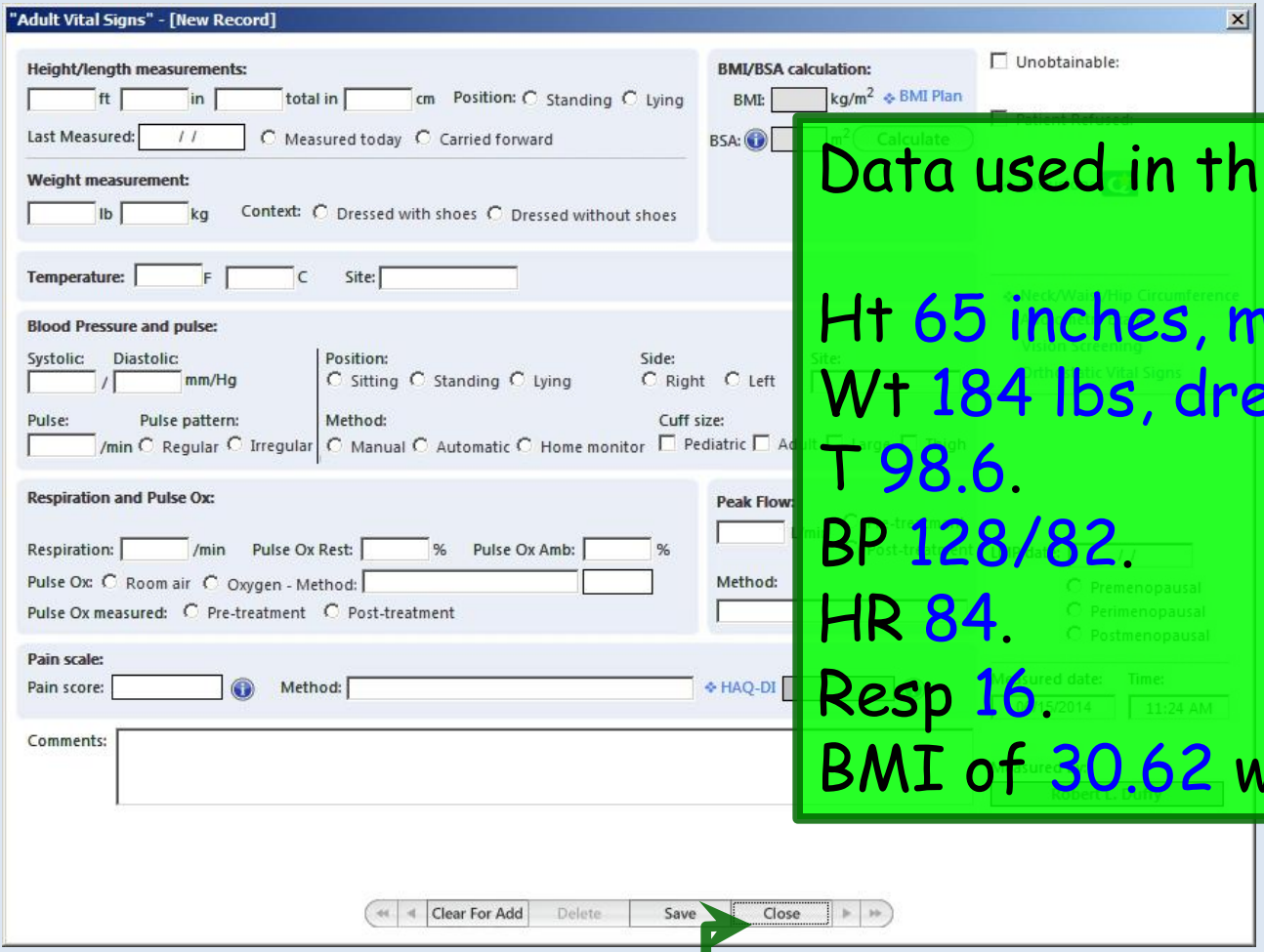

Felonie Quagmire (F)
DOB: 01/06/1988 (26 years)
Allergies: Unknown
Problems: (0)
Diagnoses: (0)
Medications: (0)
Address: 911 Run Dog Run
Mobile, AL 36604
Contact: (251) 555-9876 (Home)
MRN: 000000007773
Insurance: AMERICAN GENERAL
NextMD: No
Emergency Relation:
Emergency Phone:
Pharmacy 1:
PCP: DELP, MEREDITH R DO
Referring:
Rendering: DUFFY, ROBERT LAMAR ...
Alerts
OBGYN Details
Patient
Lipid Clinic Data
Order Admin...
Sticky Note
Referring Provider
HIPAA
Advance Directives
Screening Summary
03/19/2014 09:34 AM : "*Intake"
Patient Demographics
Panel Control:
Toggle
Cycle
Patient Information
Social Security Number
First name: Felonie
Middle name:
Last name: Quagmire
Suffix:
Previous last name:
Nickname:
Country of birth:
Race: White
Birth date: 01/06/1988
Sex: F
Preferred language: English
Ethnicity: Not Hispanic or Latino
Marital status: single
Spouse name:
Religion: Nondenominational
Blood type:
Address History
First visit:
Last visit:
Next visit:
Referred by:
Insurance:
AMERICAN GENERAL
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 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: Felonie Quagmire MRN: 000000007773 DOB: 01/06/1988 (Female) AGE: 26 years 2 months - 03/19/2014 09:34 AM : "*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
Felonie Quagmire (F) DOB: 01/06/1988 (26 years)
Allergies: Unknown Problems: (0) Diagnoses: (0) Medications: (0)
Address: 911 Run Dog Run
Mobile, AL 36604
Contact: (251) 555-9876 (Home)
MRN: 000000007773
Insurance: AMERICAN GENERAL
NextMD: No
Emergency Relation:
Emergency Phone:
Pharmacy 1:
PCP: VARNER, STEPHEN MD
Referring:
Rendering: DUFFY, ROBERT LAMAR ...
Alerts OBGYN Details 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 - GYN
Histories SOAP Finalize Checkout
Peds Immunizations My Plan Procedures Order Management Document Library
Panel Control: Toggle Cycle
Historian:
Patient History
New Lock
03/19/2014 09:34 AM
*USA Intake
*Intake
Ready
NGDevl USA Health Services Foundation rlduffy CAP NUM SCRL 03/19/2014


Felonie Quagmire (F) DOB: 01/06/1988 (26 years) Allergies: Unknown Problems: (0) Diagnoses: (0) Medications: (0)
Address: 911 Run Dog Run
Mobile, AL 36604
Contact: (251) 555-9876 (Home)
MRN: 000000007773
Insurance: AMERICAN GENERAL
NextMD: No
Emergency Relation:
Emergency Phone:
Pharmacy 1:
PCP: VARNER, STEPHEN MD
Referring:
Rendering: DUFFY, ROBERT LAMAR ...
Alerts
OBGYN Details
Patient
Lipid Clinic Data
Order Admin...
Sticky Note
Referring Provider
HIPAA
Advance Directives
Screening Summary
03/19/2014 09:34 AM : "*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:
Reason for Visit
Do not launch HPI
Intake Comments
abnormal pap smear
abnormal bleeding
amenorrhea
annual exam
breast mass/lump
contraception
genital lesion
menopausal symptoms
pelvic mass/cyst
STD exposure
urinary incontinence
urinary symptoms
pelvic pain
vaginal discharge/itching
Additional / Manage
Chief Complaint
History of Present Illness
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
Ht (in)
Wt (lb)


The Info Bar is collapsed, & Vital Signs are at the top.
Felonie Quagmire (F)
DOB: 01/06/1988 (26 years)
Allergies: Unknown
Problems: (0)
Diagnoses: (0)
Medications: (0)
Alerts
OBGYN Details
Patient
Lipid Clinic Data
Order Admin...
Sticky Note
Referring Provider
HIPAA
Advance Directives
Screening Summary
03/19/2014 09:34 AM : "*Intake"
Specialty ▾ Gynecology
Visit Type ▾ Office Visit - GYN
Intake
Histories
SOAP
Finalize
Checkout
Standing Orders
Adult Immunizations
Peds Immunizations
My Plan
Procedures
Order Management
Document Library
Navigation
Care Guidelines
Global Days
Panel Control:
Toggle
Cycle
General
Established patient
New patient
Historian:
Vital Signs
Health Promotion Plan | History | Graph
Time
Ht (in)
Wt (lb)
BMI
BP
Pulse
Respiration
Temp (F)
Pulse Ox Rest
BSA
Pain level
Comments
Add
Edit
Remove
Reason for Visit
Do not launch HPI
Intake Comments
abnormal pap smear
abnormal bleeding
amenorrhea
To enter Vital Signs, click Add.

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

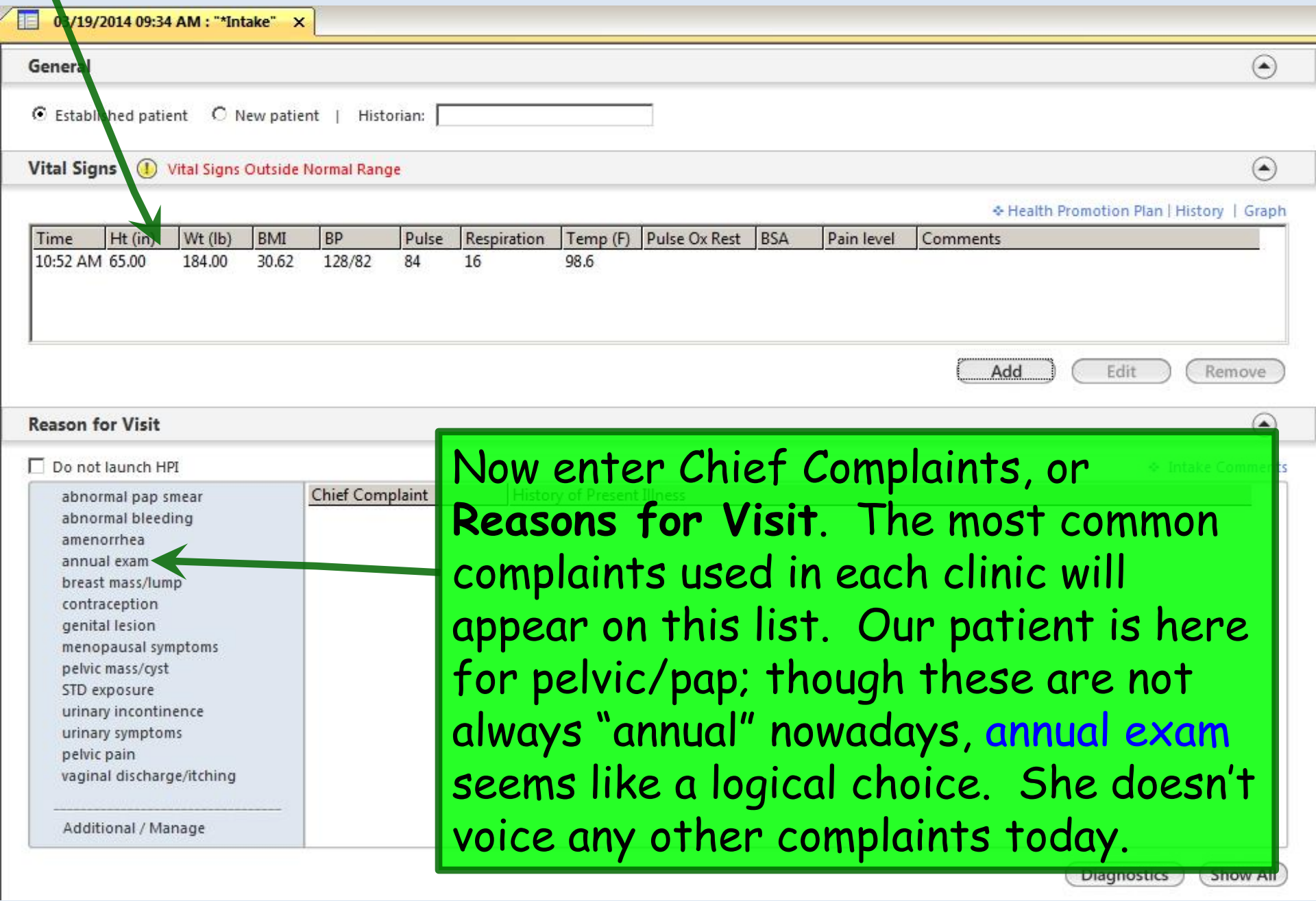


Data used in this example:

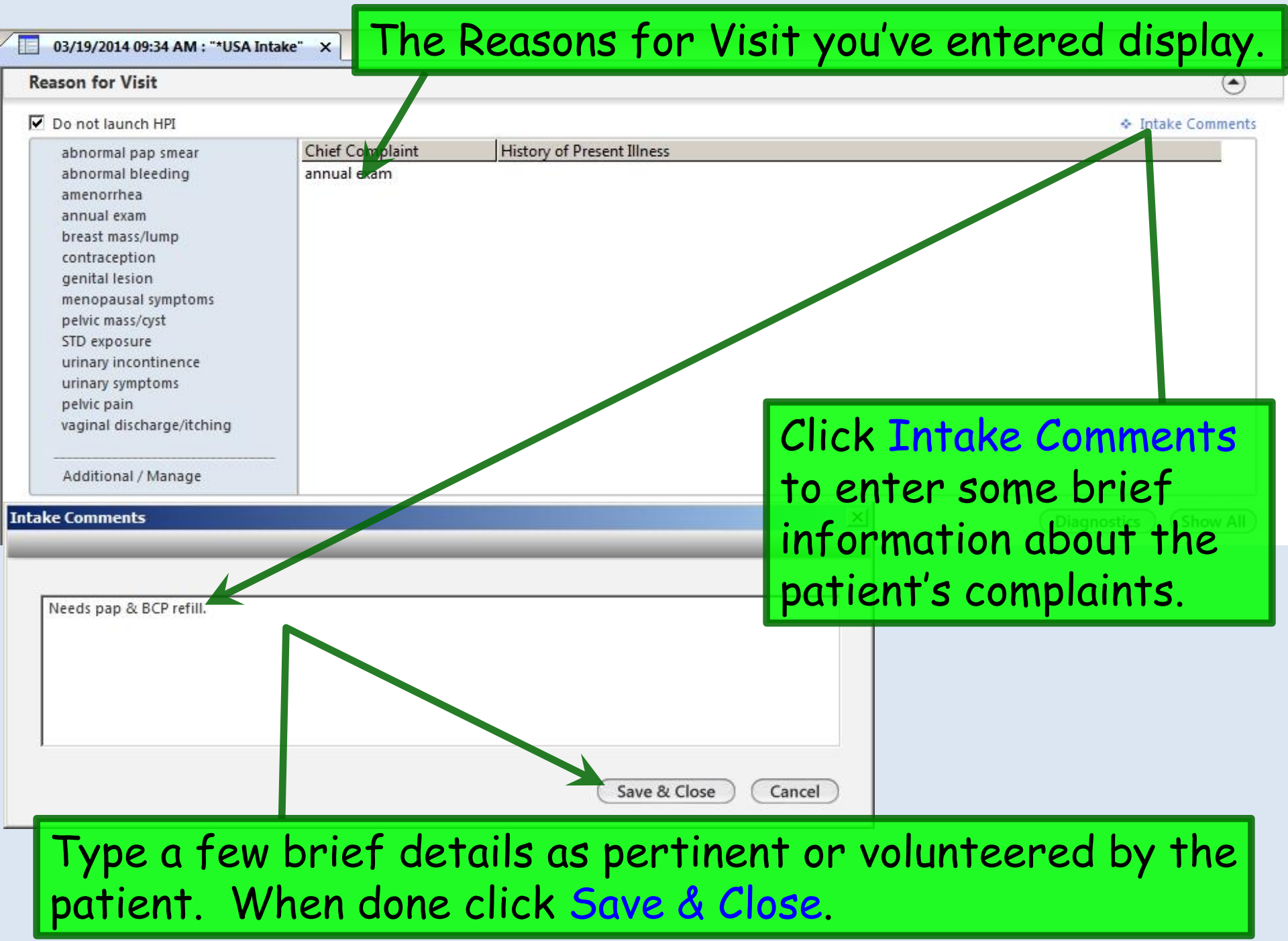
Ht 65 inches, measured today.
Wt 184 lbs, dressed without shoes.
T 98.6.
BP 128/82.
HR 84.
Resp 16.
BMI of 30.62 will be calculated.

When done click Save then Close.

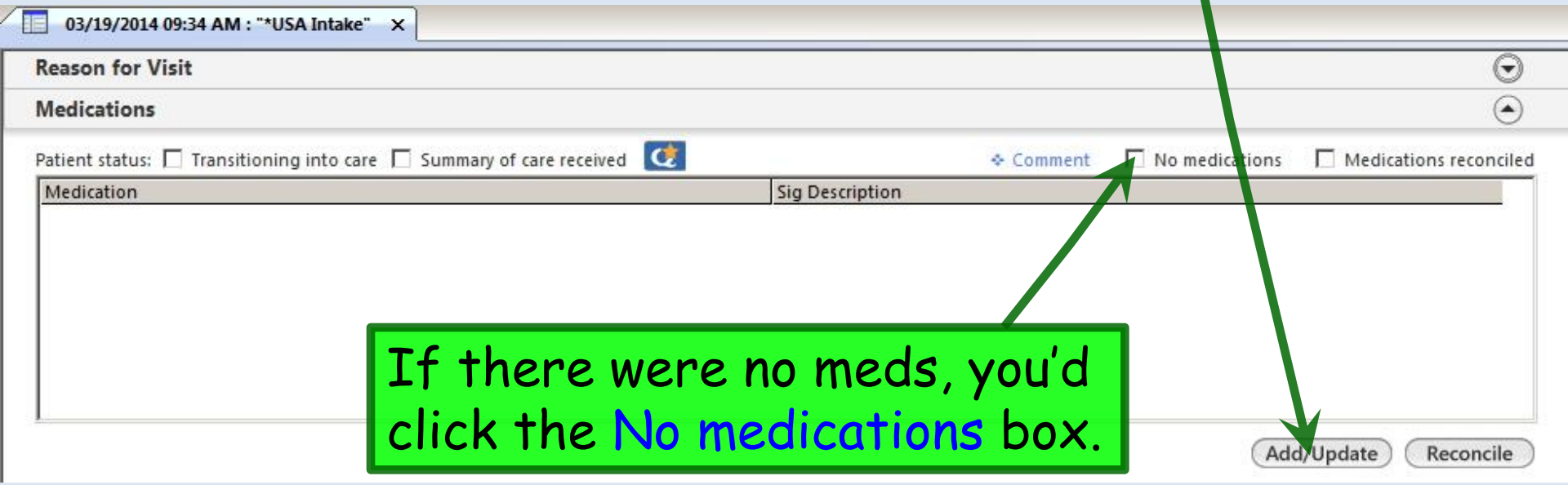
Vital signs now display.



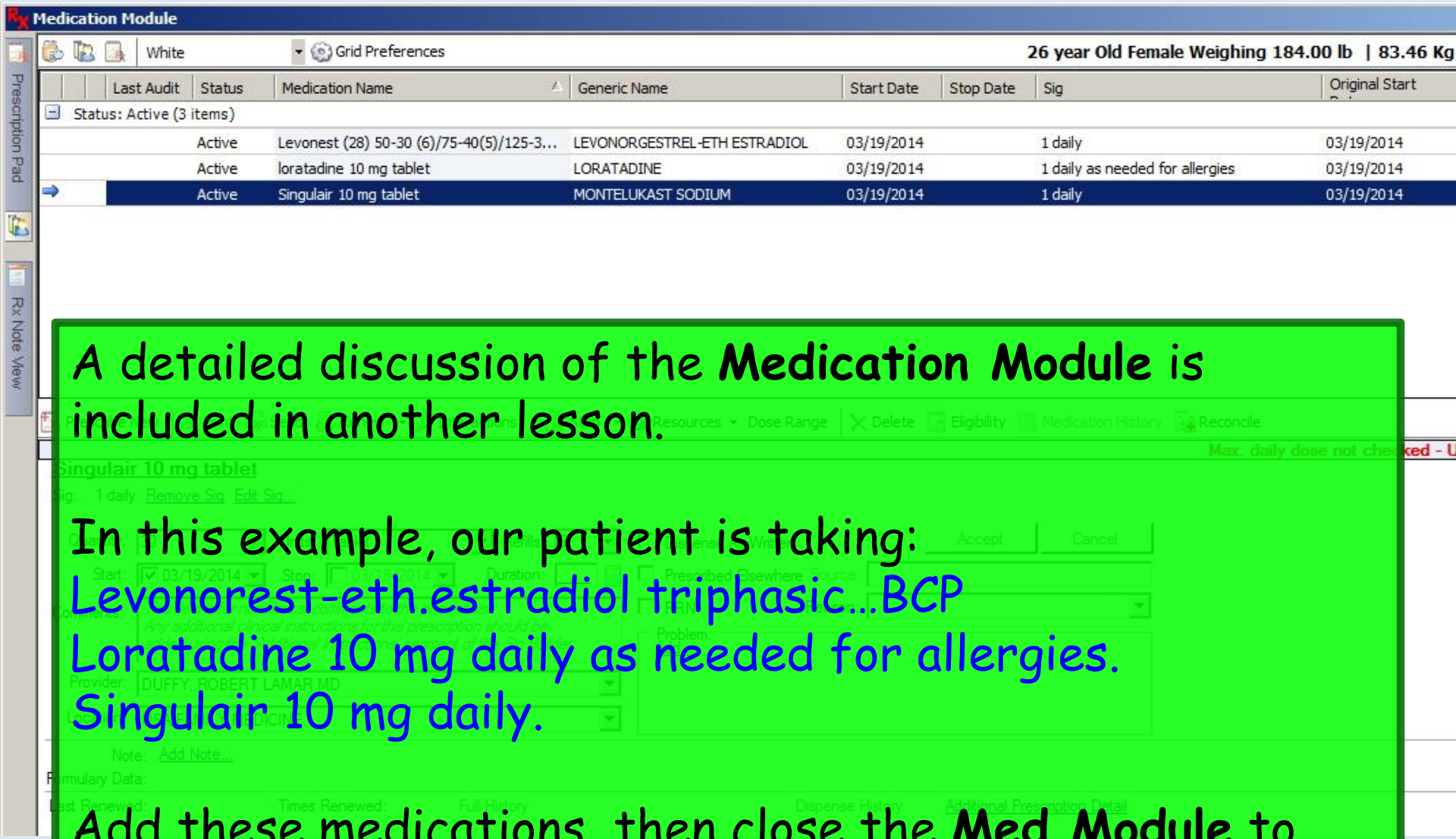
Now enter Chief Complaints, or **Reasons for Visit**. The most common complaints used in each clinic will appear on this list. Our patient is here for pelvic/pap; though these are not always "annual" nowadays, annual exam seems like a logical choice. She doesn't voice any other complaints today.


The Reasons for Visit you've entered display.
03/19/2014 09:34 AM : "*USA Intake"
Reason for Visit
Do not launch HPI
Intake Comments
abnormal pap smear
abnormal bleeding
amenorrhea
annual exam
breast mass/lump
contraception
genital lesion
menopausal symptoms
pelvic mass/cyst
STD exposure
urinary incontinence
urinary symptoms
pelvic pain
vaginal discharge/itching
Additional / Manage
Chief Complaint
History of Present Illness
annual exam
Click Intake Comments to enter some brief information about the patient's complaints.
Intake Comments
Needs pap & BCP refill.
Save & Close
Cancel
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.



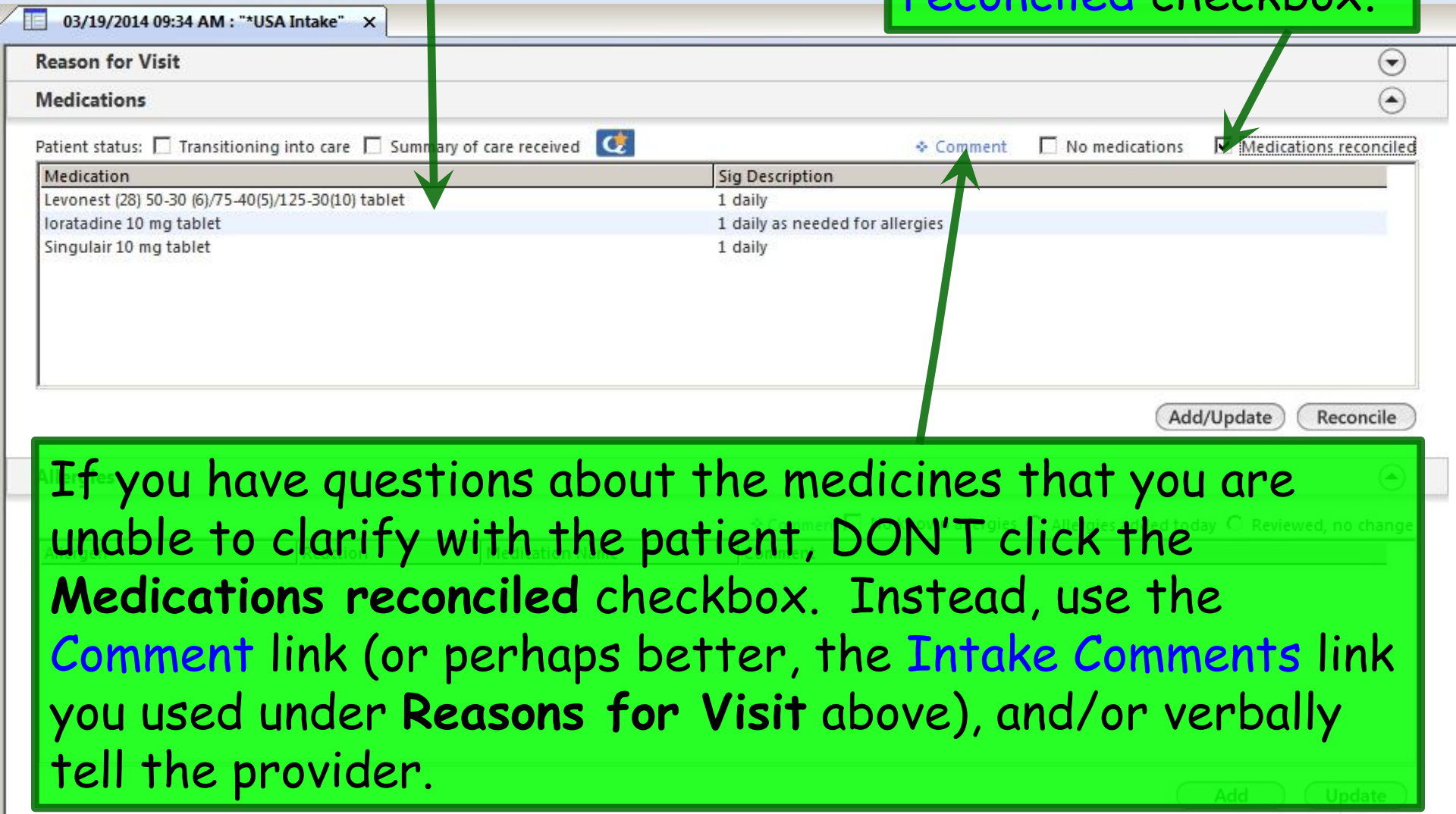
A detailed discussion of the **Medication Module** is included in another lesson.

In this example, our patient is taking:
Levonorest-eth.estradiol triphasic...BCP
Loratadine 10 mg daily as needed for allergies.
Singulair 10 mg daily.

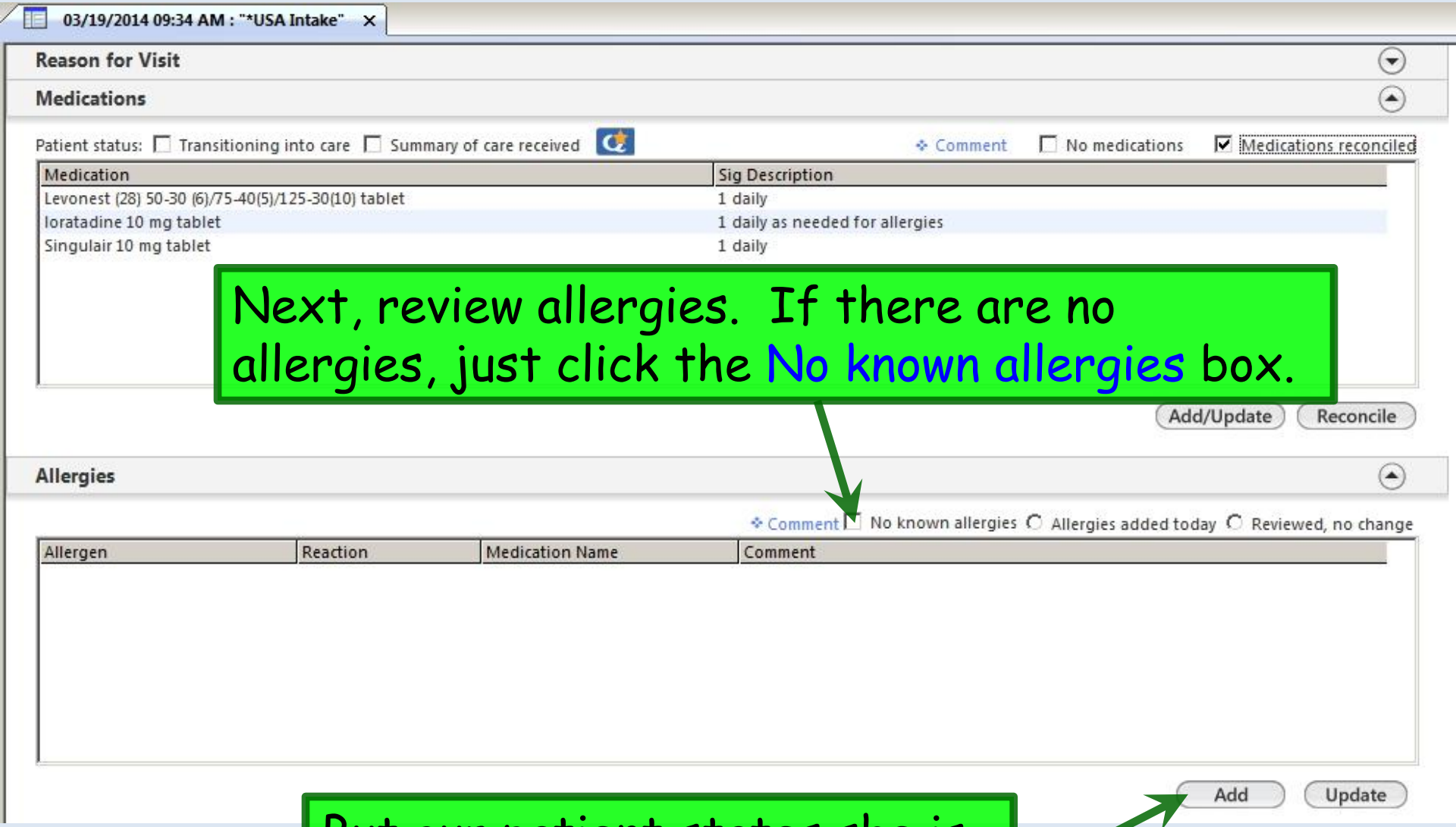
Add these medications, then close the **Med Module** to return to the **Intake Tab**.

Medications display (though sometimes they may not show until the template is refreshed).

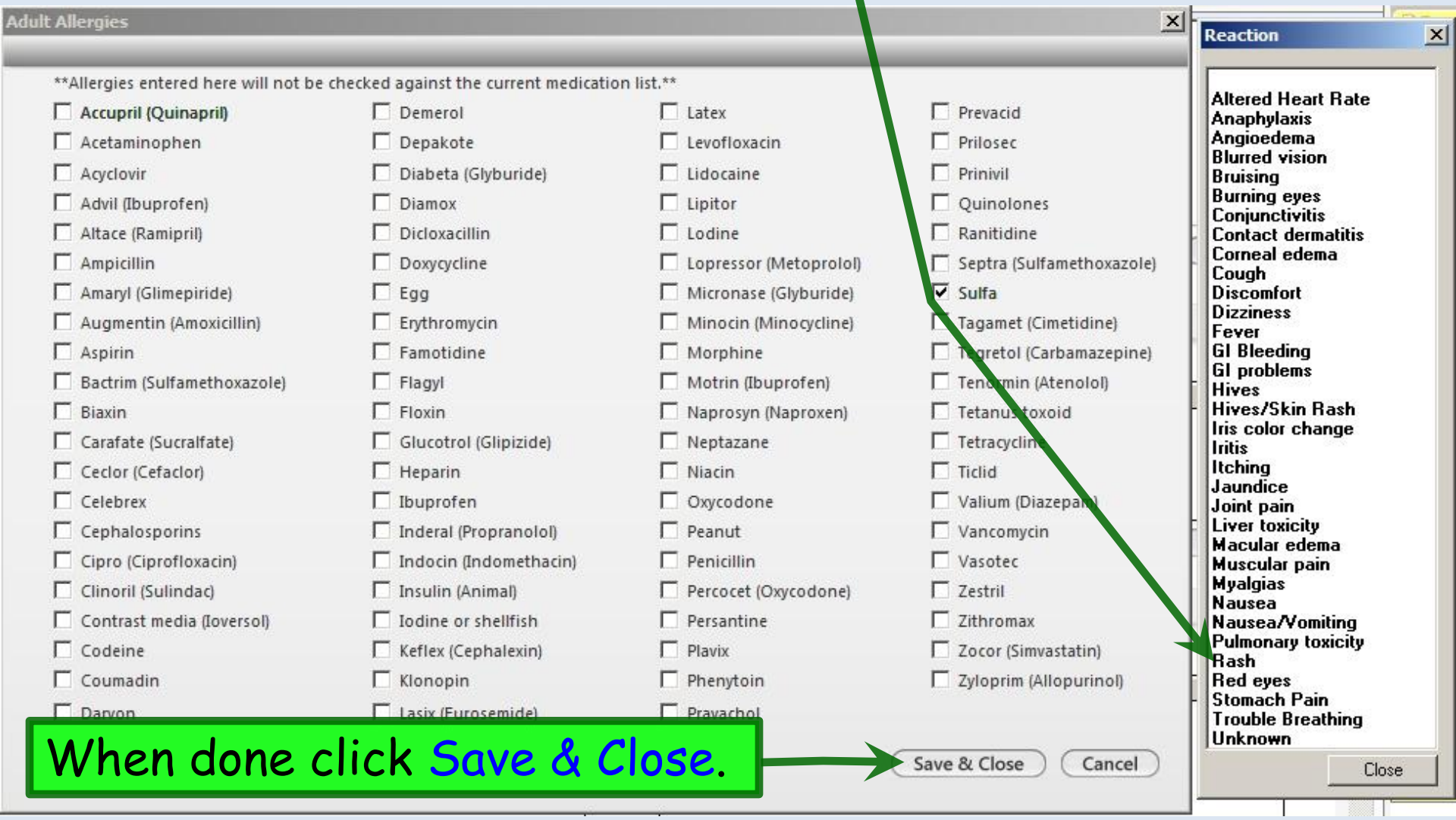
Click the Medications reconciled checkbox.



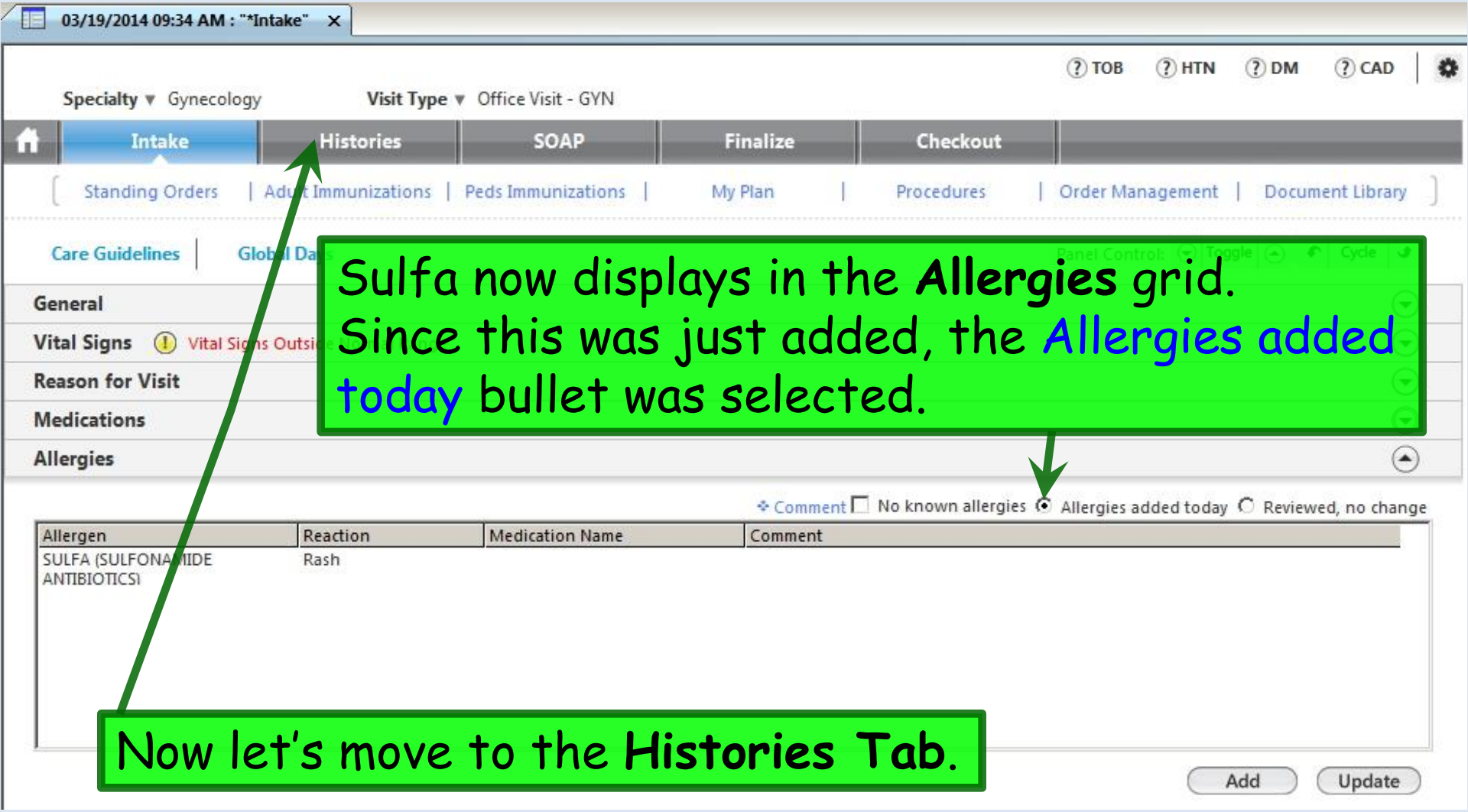
If you have questions about the medicines that you are unable to clarify with the patient, DON'T click the **Medications reconciled** checkbox. Instead, use the Comment link (or perhaps better, the Intake Comments link you used under **Reasons for Visit** above), and/or verbally tell the provider.


03/19/2014 09:34 AM : "*USA Intake"
Reason for Visit
Medications
Patient status: Transitioning into care Summary of care received
Comment No medications Medications reconciled
Medication
Sig Description
Levonest (28) 50-30 (6)/75-40(5)/125-30(10) tablet
1 daily
loratadine 10 mg tablet
1 daily as needed for allergies
Singulair 10 mg tablet
1 daily
Next, review allergies. If there are no allergies, just click the No known allergies box.
Add/Update
Reconcile
Allergies
Comment No known allergies Allergies added today Reviewed, no change
Allergen
Reaction
Medication Name
Comment
Add
Update
But our patient states she is allergic to sulfa, so click Add.

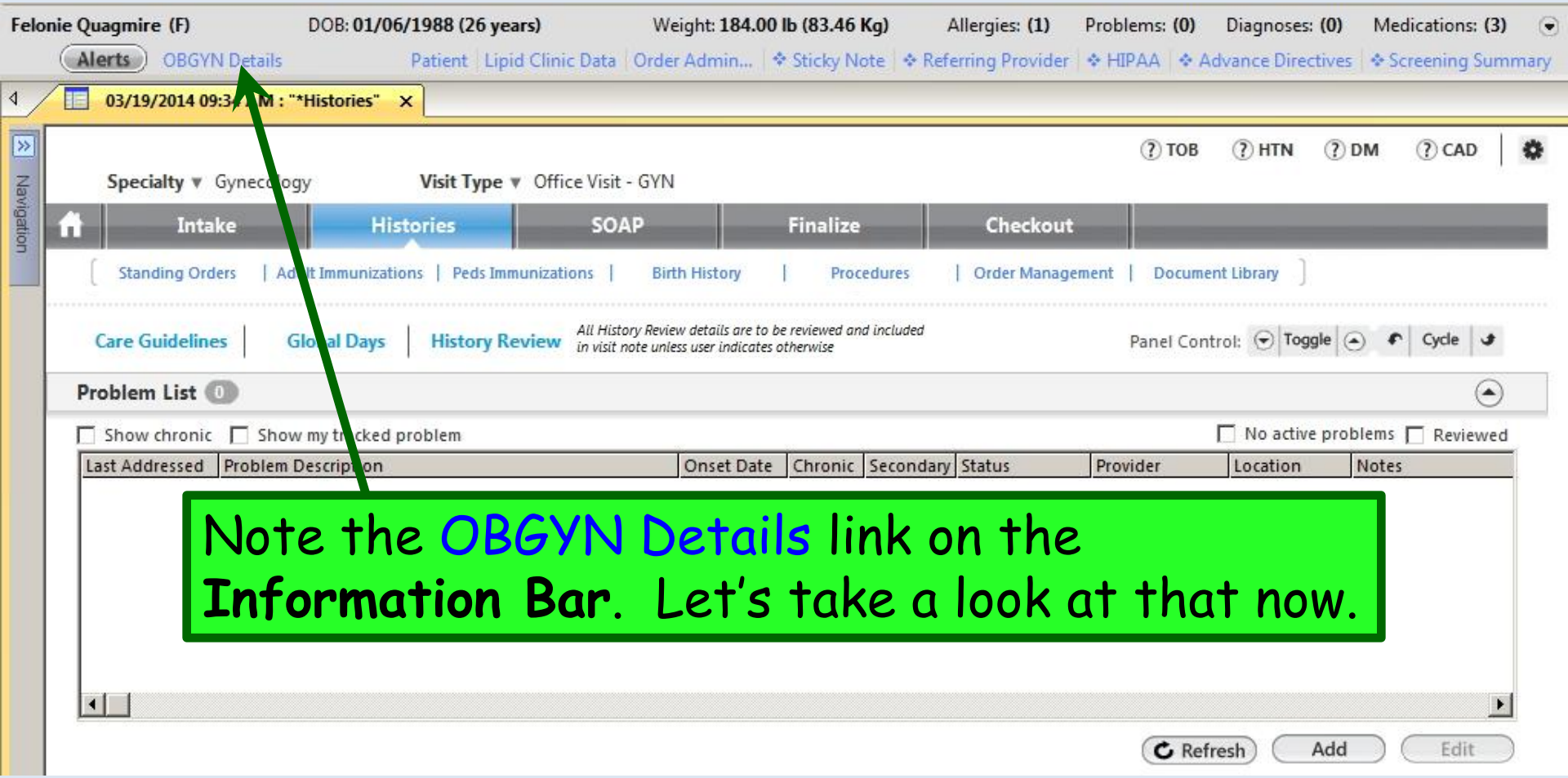
Add the patient's allergy to Sulfa; she gets a Rash from it. (A detailed discussion of the **Allergy Module** is covered in a separate exercise.)



When done click Save & Close.

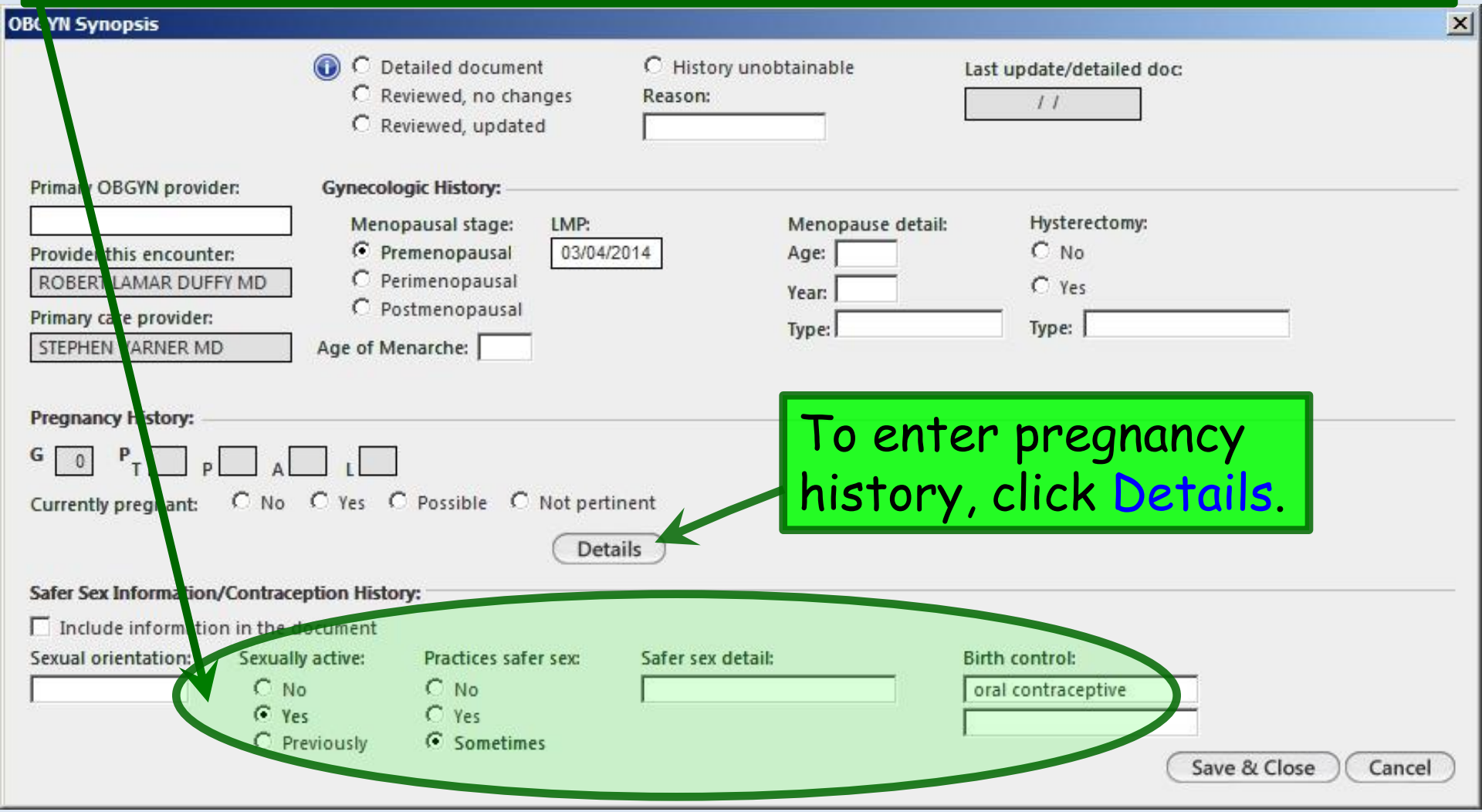

03/19/2014 09:34 AM : "*Intake"
TOB
HTN
DM
CAD
Specialty ▼ Gynecology
Visit Type ▼ Office Visit - GYN
Intake
Histories
SOAP
Finalize
Checkout
Standing Orders
Adult Immunizations
Peds Immunizations
My Plan
Procedures
Order Management
Document Library
Care Guidelines
General
Vital Signs
Reason for Visit
Medications
Allergies
Sulfa 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
SULFA (SULFONAMIDE ANTIBIOTICS)
Rash
Add
Update
Now let's move to the Histories Tab.

Instructions for entering most of the items on the **Histories Tab** are covered in the Histories lesson. We won't rehash them in detail here, but let's go through the general workflow.

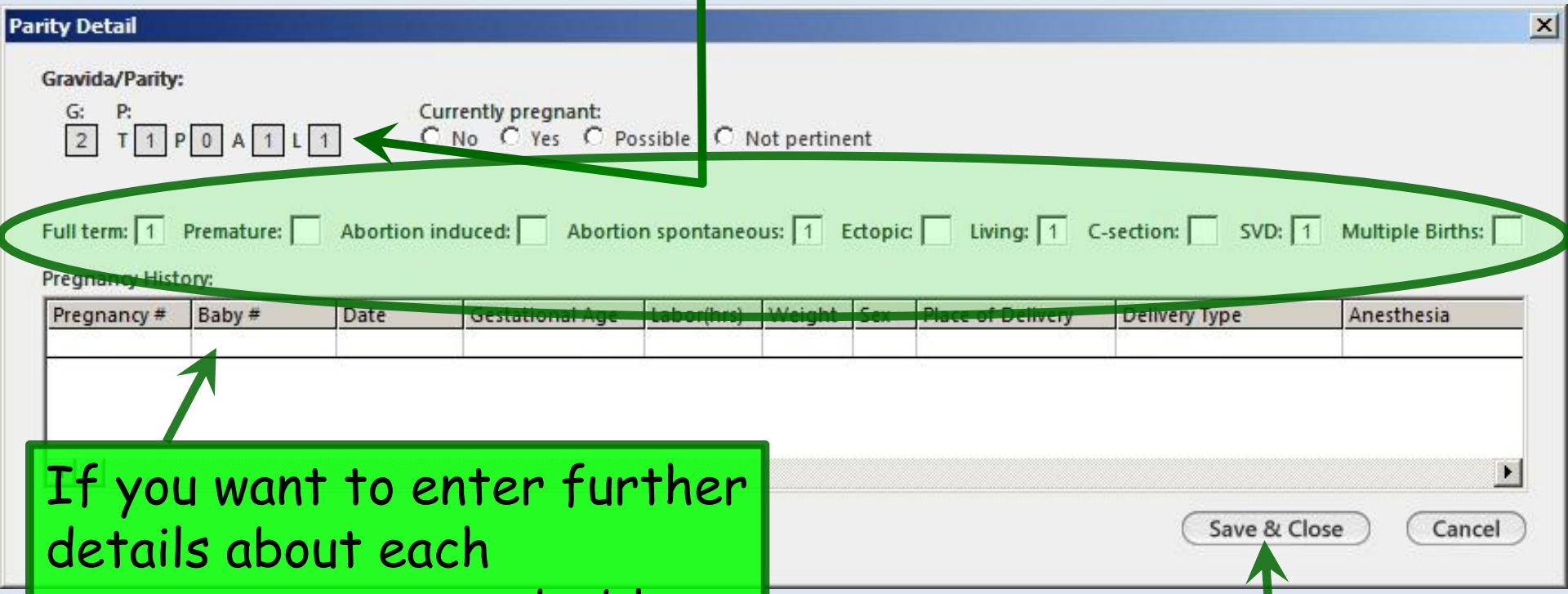


Note the OBGYN Details link on the **Information Bar**. Let's take a look at that now.

Some details can be entered directly here. We've added that she's sexually active, sometimes practicing safer sex, & using oral contraceptive.

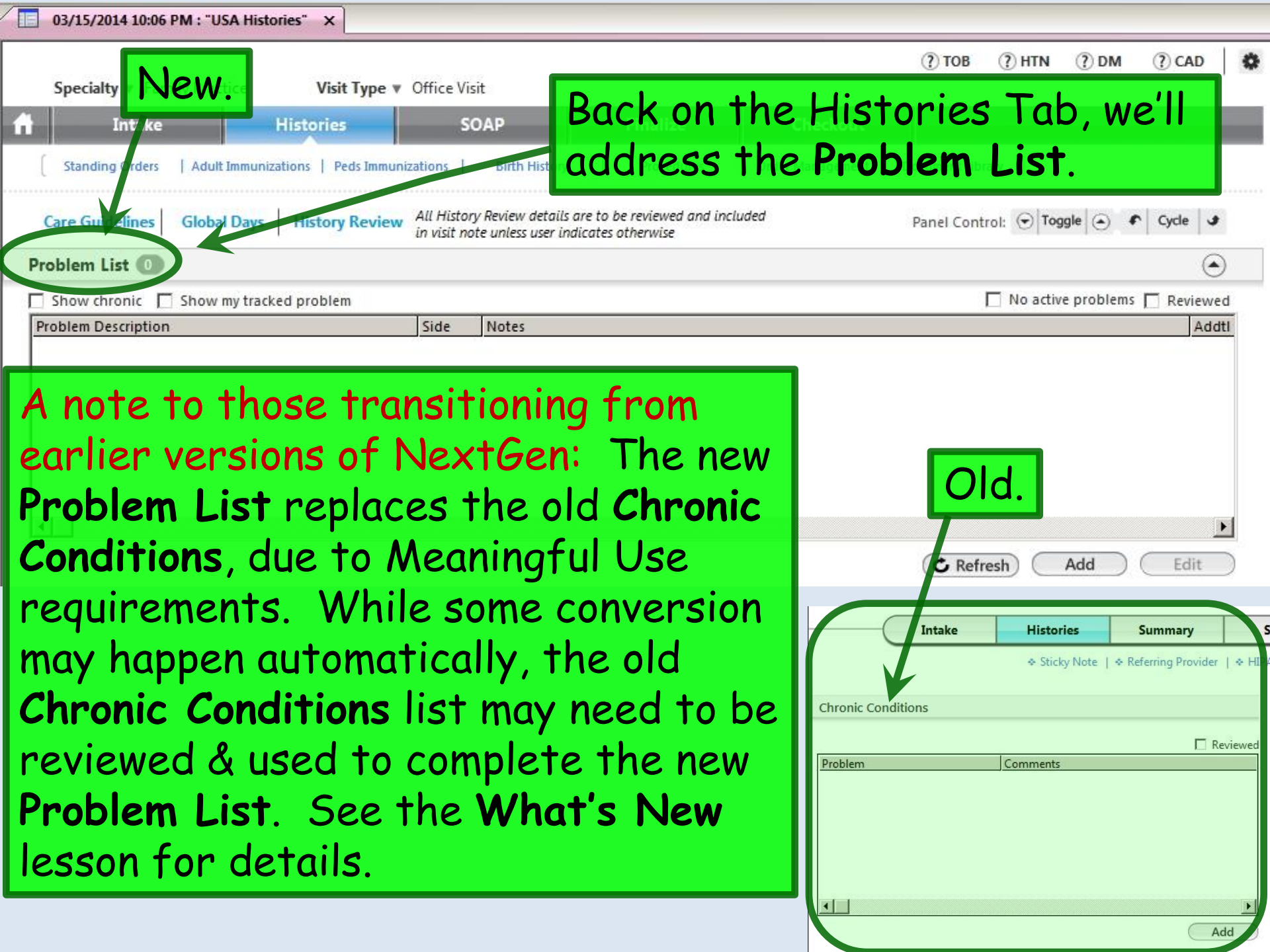


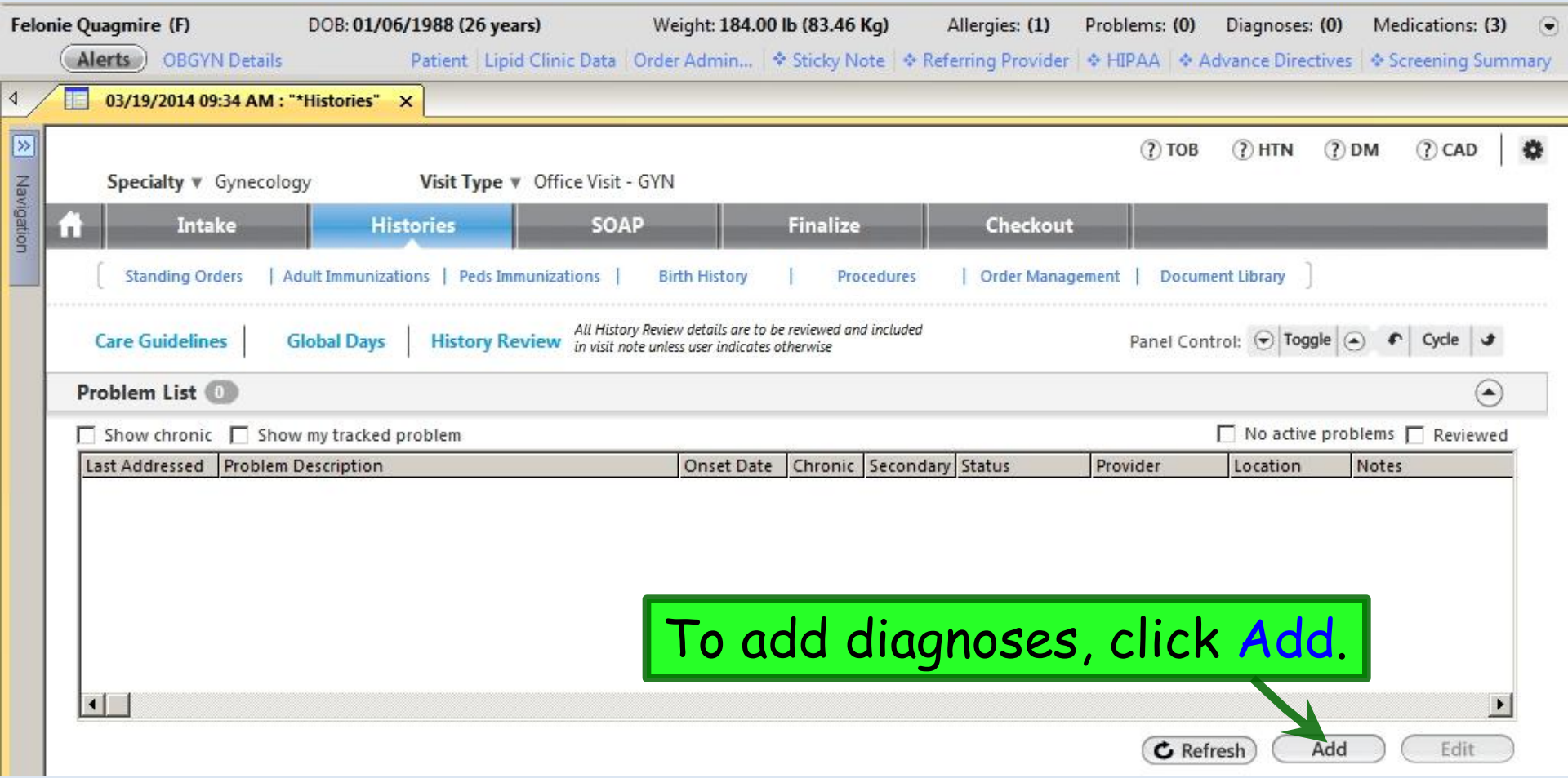
Enter data in the white boxes & they'll be summarized in the gray boxes above. She's had one term vaginal delivery & one miscarriage.

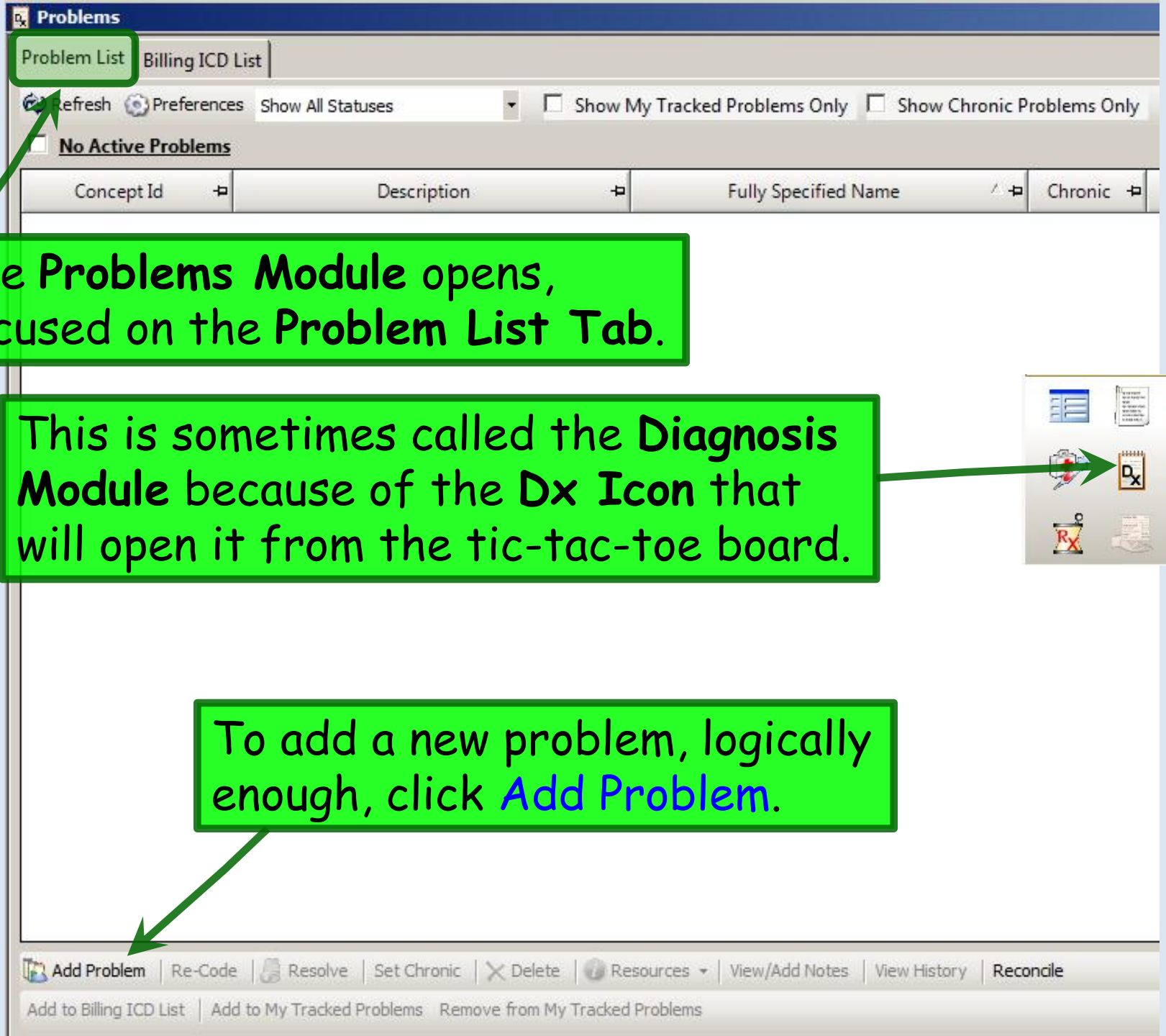


If you want to enter further details about each pregnancy, you can double-click on the grid to do so.

When done click Save & Close (twice) to close these popups.


03/15/2014 10:06 PM : "USA Histories"
TOB
HTN
DM
CAD
Specialty
Visit Type ▾ Office Visit
New.
Intake
Histories
SOAP
Back on the Histories Tab, we'll address the Problem List.
Standing Orders | Adult Immunizations | Peds Immunizations
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
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.
Refresh
Add
Edit
Old.
Intake
Histories
Summary
Sticky Note | Referring Provider
Chronic Conditions
Reviewed
Problem
Comments
Add

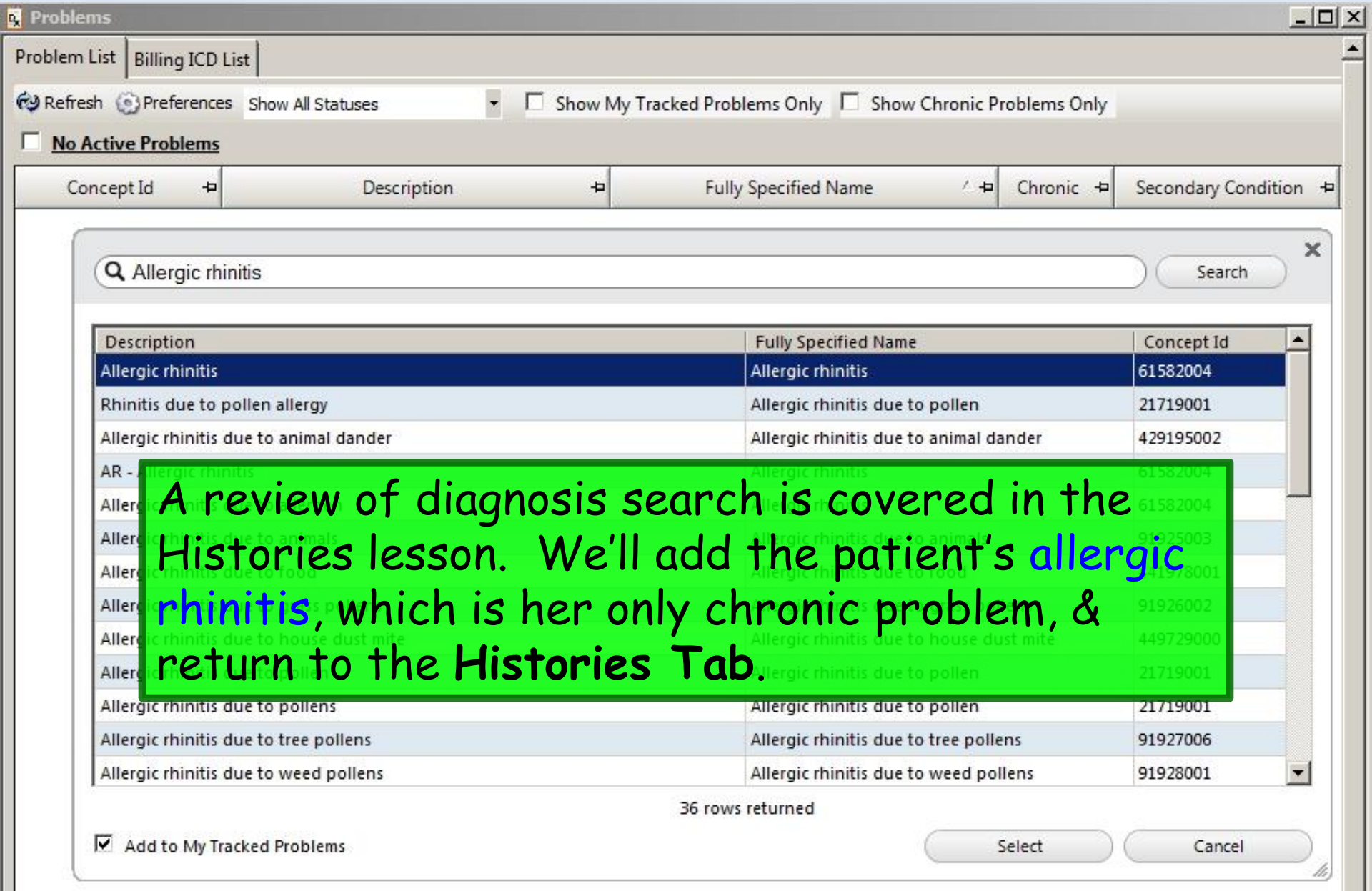

Felonie Quagmire (F)
DOB: 01/06/1988 (26 years)
Weight: 184.00 lb (83.46 Kg)
Allergies: (1)
Problems: (0)
Diagnoses: (0)
Medications: (3)
Alerts
OBGYN Details
Patient
Lipid Clinic Data
Order Admin...
Sticky Note
Referring Provider
HIPAA
Advance Directives
Screening Summary
03/19/2014 09:34 AM : "*Histories"
Navigation
TOB
HTN
DM
CAD
Specialty ▼ Gynecology
Visit Type ▼ Office Visit - GYN
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
Last Addressed
Problem Description
Onset Date
Chronic
Secondary
Status
Provider
Location
Notes
To add diagnoses, click Add.
Refresh
Add
Edit



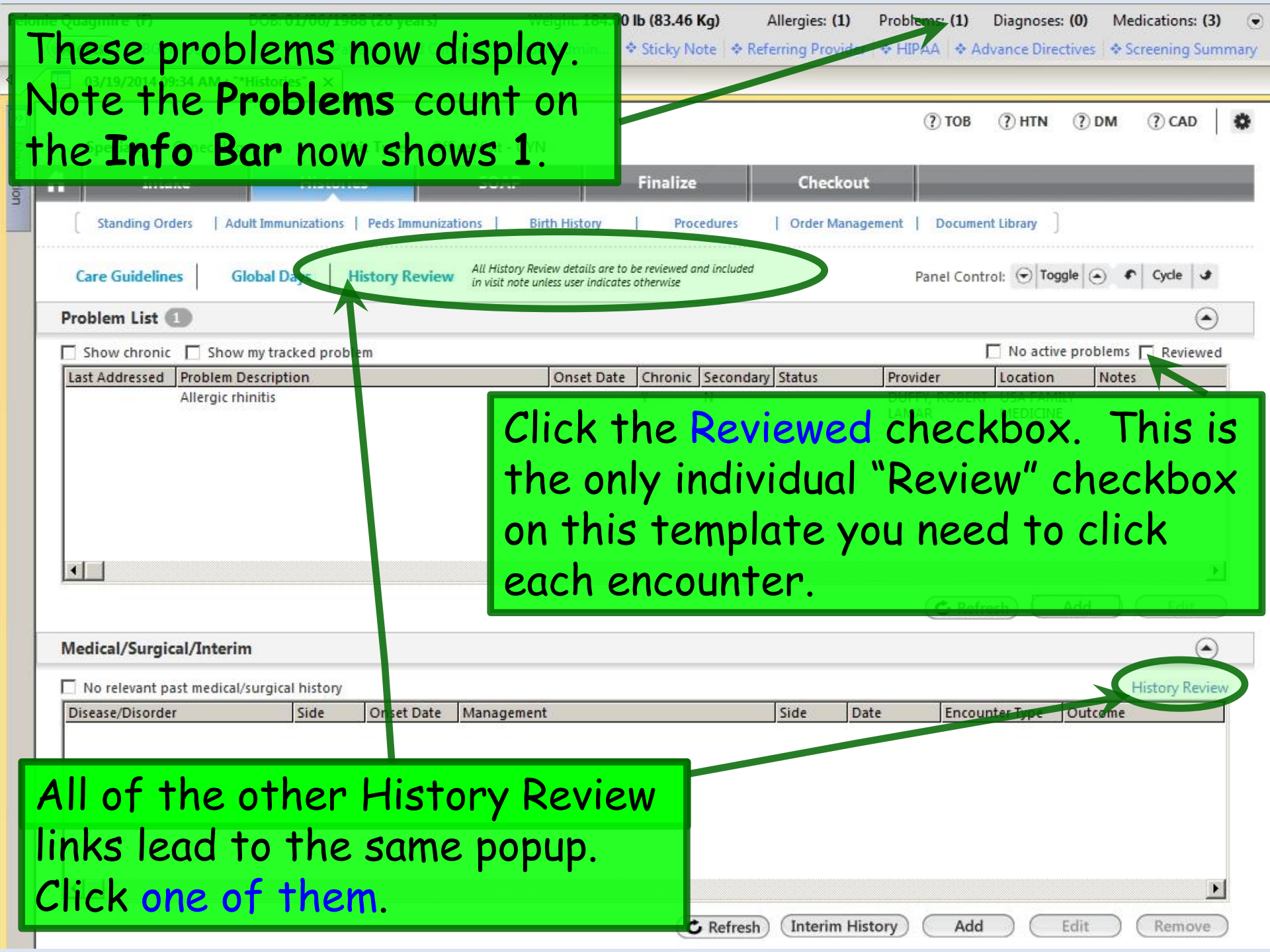
The **Problems Module** opens, focused on the **Problem List Tab**.

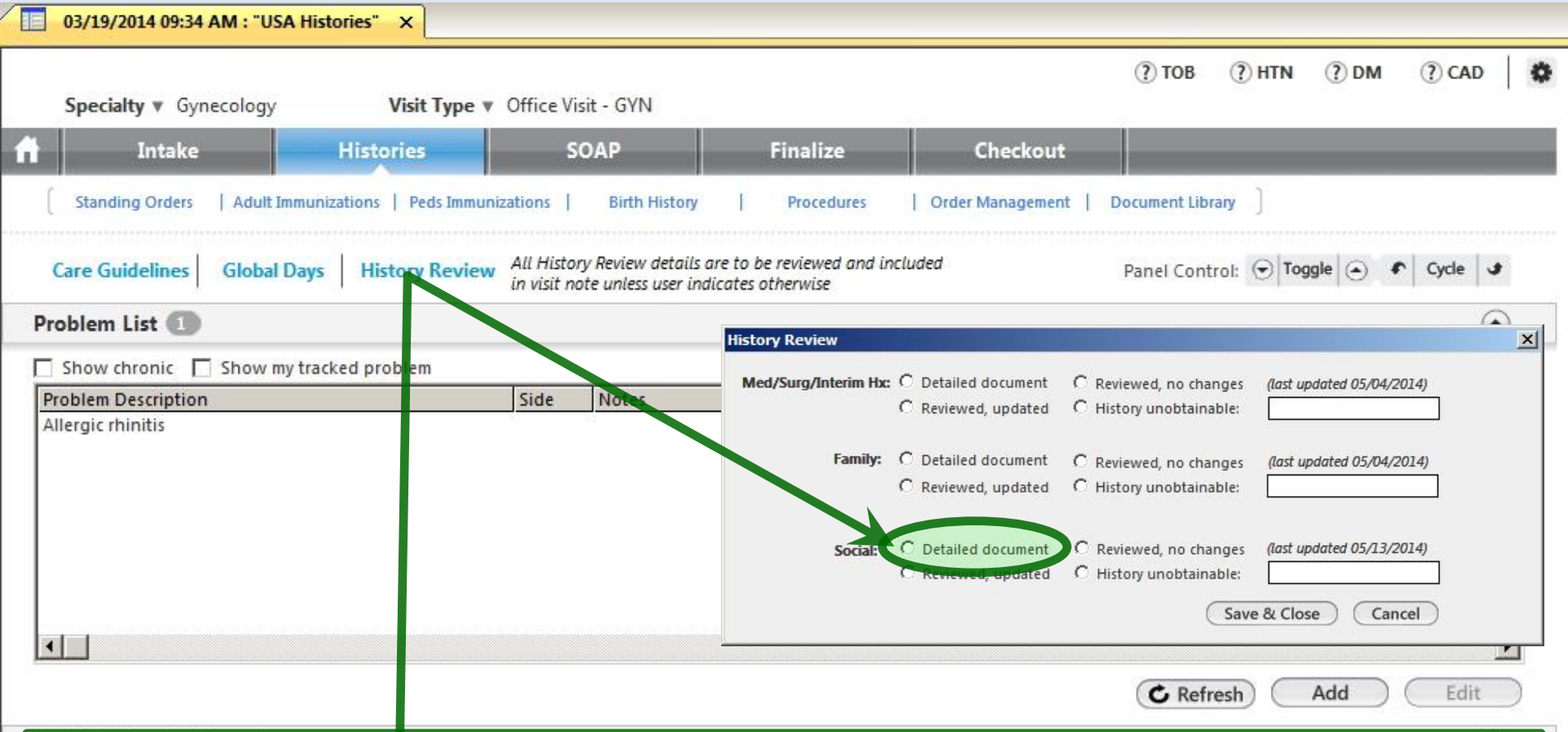
This is sometimes called the **Diagnosis Module** because of the **Dx Icon** that will open it from the tic-tac-toe board.

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



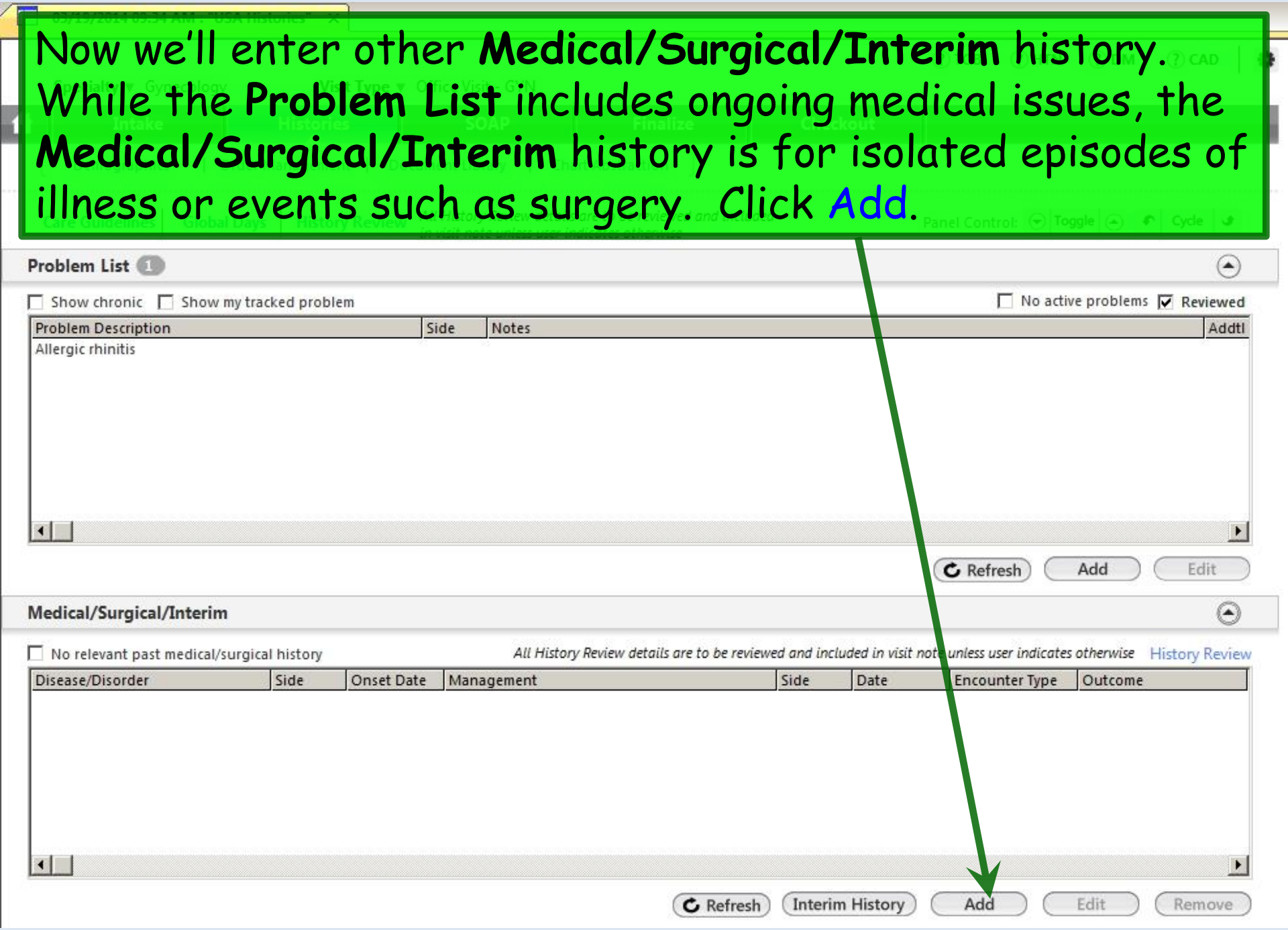
A review of diagnosis search is covered in the Histories lesson. We'll add the patient's allergic rhinitis, which is her only chronic problem, & return to the **Histories Tab**.


These problems now display. Note the Problems count on the Info Bar now shows 1.
Allergies: (1)
Problems: (1)
Diagnoses: (0)
Medications: (3)
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
Show chronic
Show my tracked problem
No active problems
Reviewed
Last Addressed
Problem Description
Onset Date
Chronic
Secondary
Status
Provider
Location
Notes
Allergic rhinitis
Click the Reviewed checkbox. This is the only individual "Review" checkbox on this template you need to click each encounter.
Medical/Surgical/Interim
No relevant past medical/surgical history
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

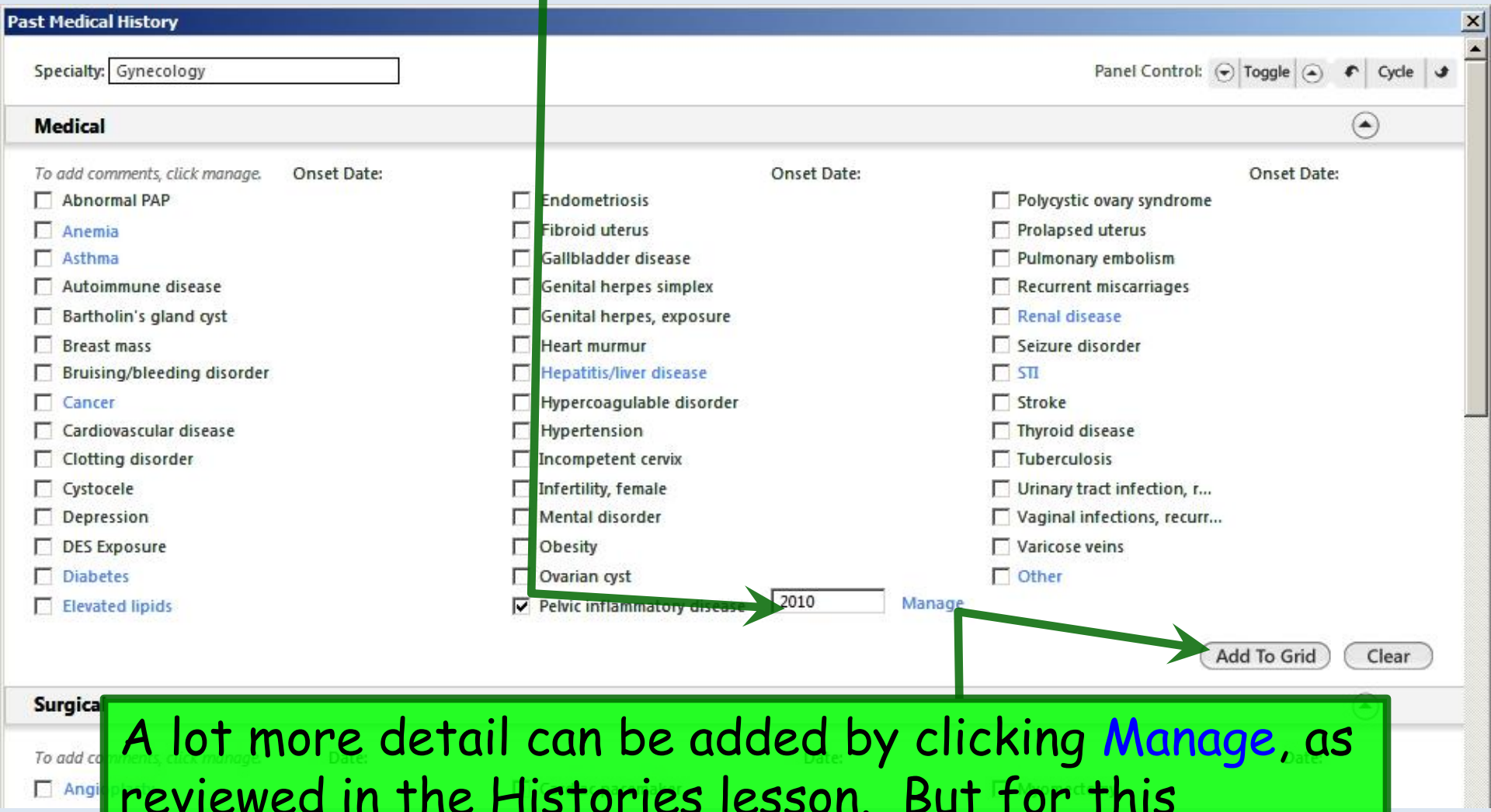


It is our expectation that all historical elements are at least briefly reviewed at every encounter, so most of these details appear in our notes by default anyway. However, only *basic* Social History details are defaulted into our notes, so if you've added a lot of other details, you need to specifically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



There is a list of items that can be quickly checked. In 2010 she had an episode of Pelvic inflammatory disease, so we'll check that.



A lot more detail can be added by clicking Manage, as reviewed in the Histories lesson. But for this example we'll just click Add To Grid.

Past Medical History

Clotting disorder | Incompetent cervix | Tuberculosis
Cystocele | Infertility, female | Urinary tract infection, r...
Depression | Mental disorder | Vaginal infections, recurr...
DES Exposure | Obesity | Varicose veins
Diabetes | Ovarian cyst | Other
Elevated lipids | Pelvic inflammatory disease

Add To Grid | Clear

Surgical

To add comments, click manage. Date: Date: Date:

Angioplasty | Cardiac pacemaker | Myomectomy
Appendectomy | Chemotherapy | Pelvic sling
Arthroscopy | Cholecystectomy | Radiation therapy procedure
Back surgery | D&C | Thyroidectomy
Bilateral oophorectomy | Gastric bypass | Other
Bilateral tubal ligation | Hernia repair
Blood transfusion | Hip replacement
Breast augmentation | Hysterectomy
Breast reduction | Knee replacement
CABG | Mastectomy

Add To Grid | Clear

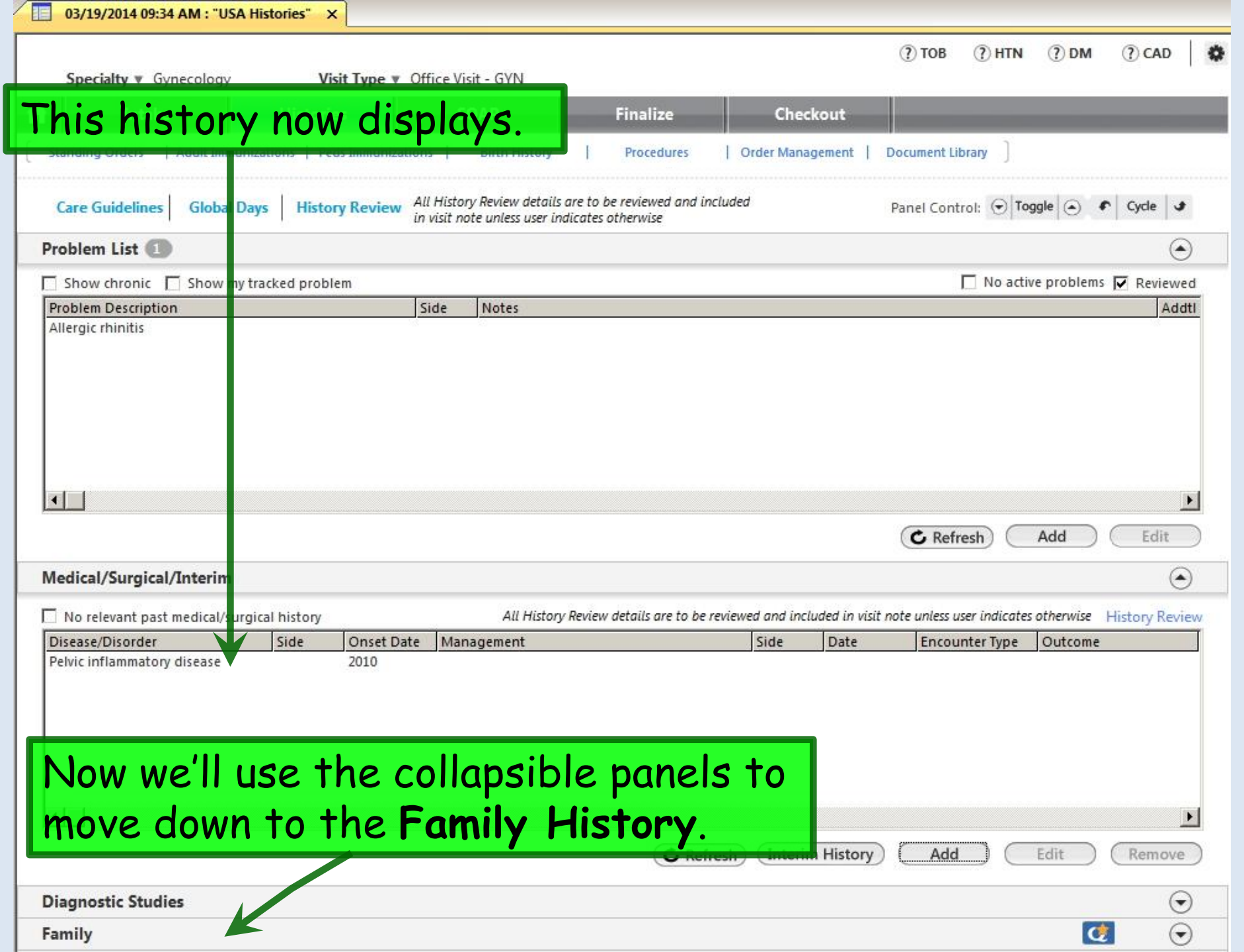
Past Medical History Grid

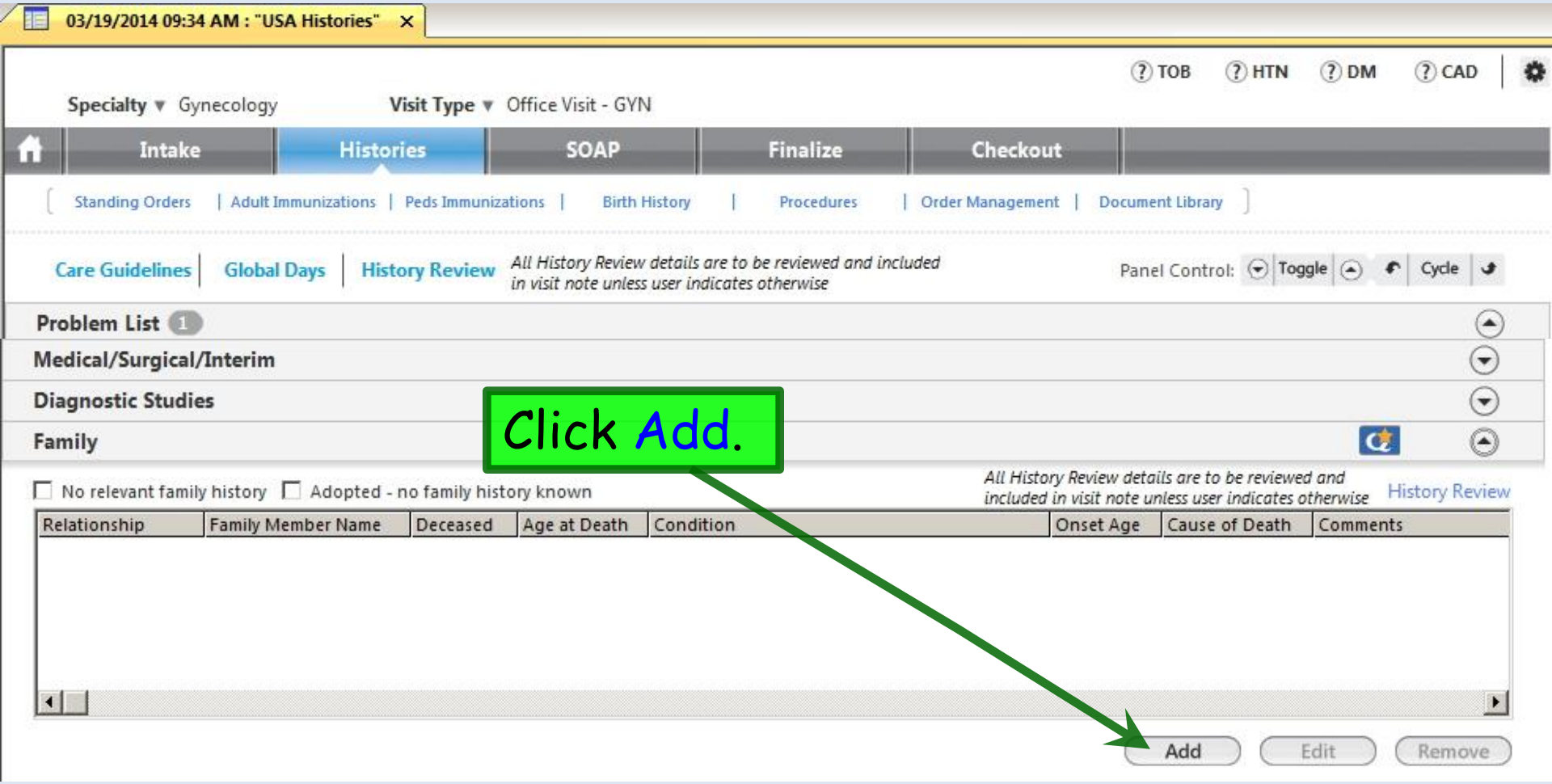
Disease/Disorder	Side	Onset Date	Management	Side	Date	Encounter Type	Outcome	Comment
Pelvic inflammatory disease		2010						

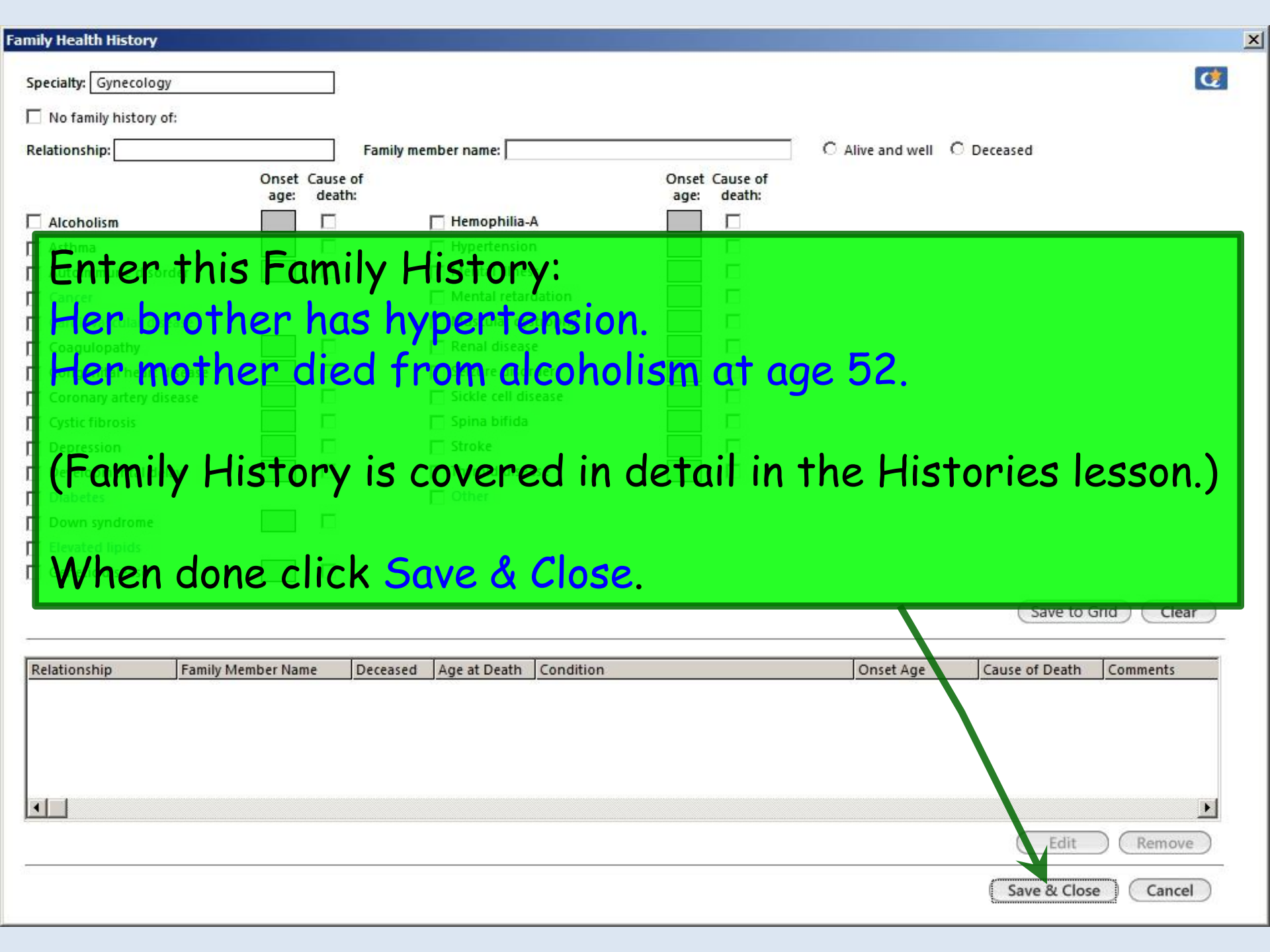
That's all we'll add, so click Save & Close.

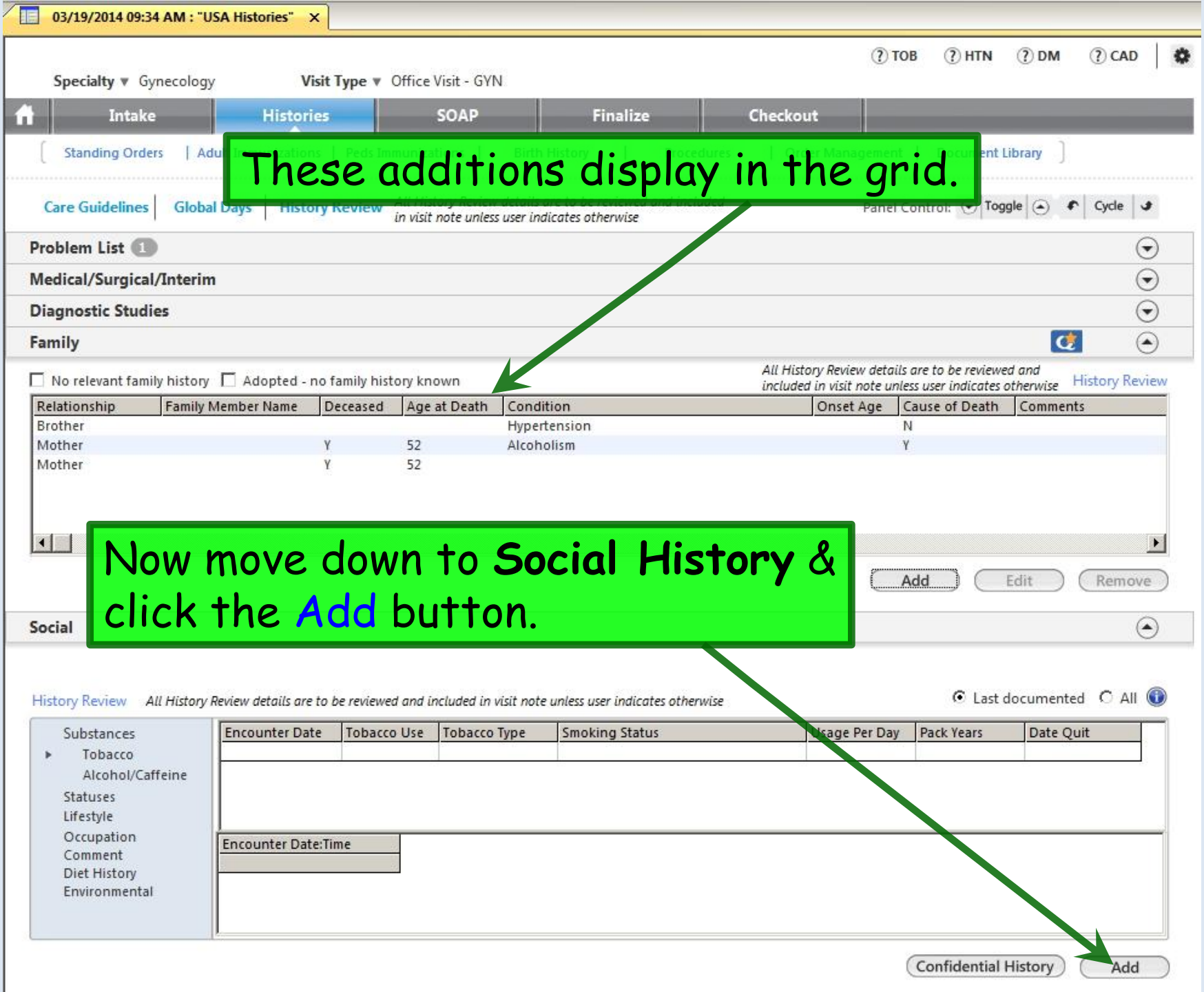
Edit | Remove

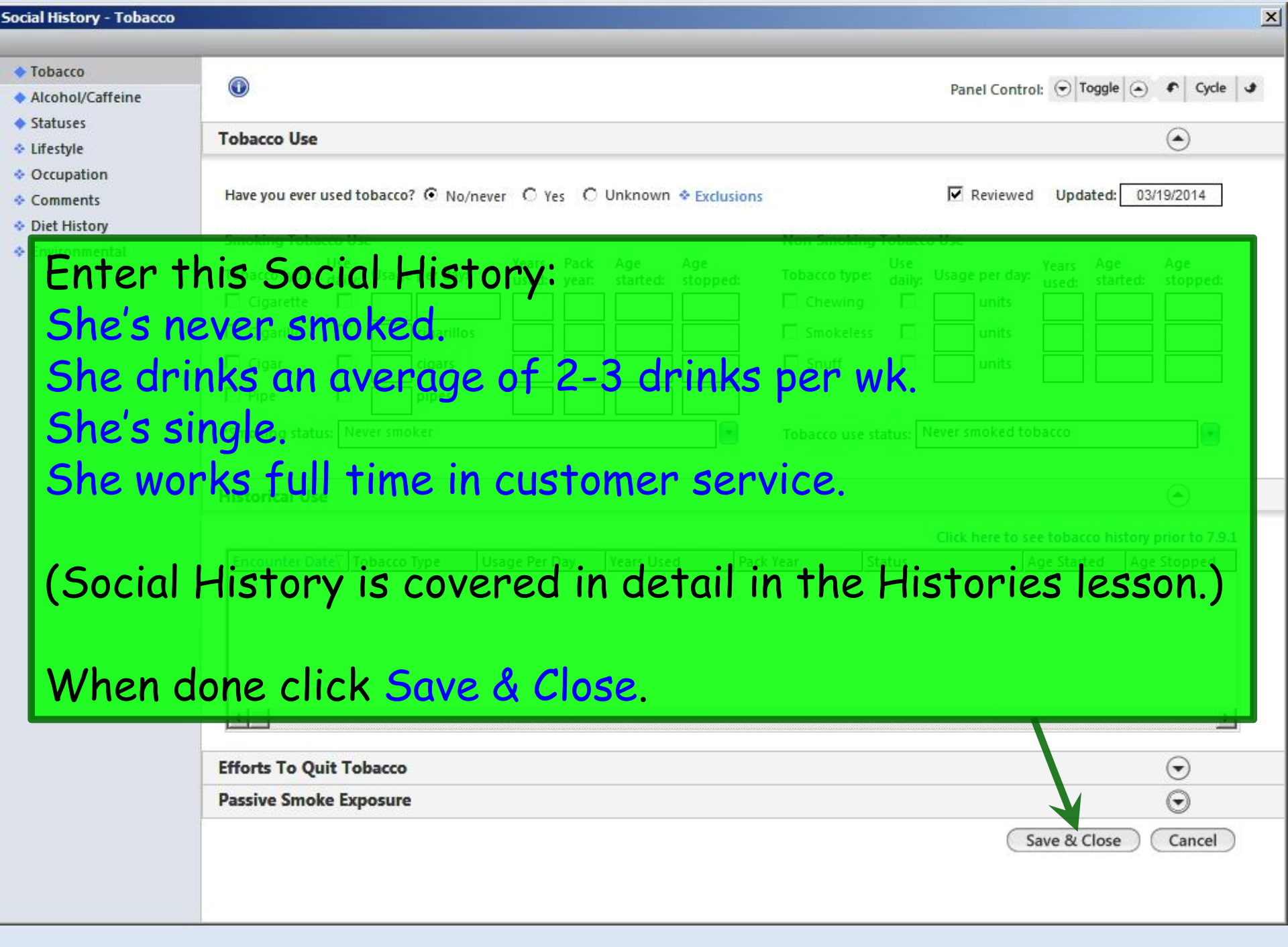
Save & Close | Cancel

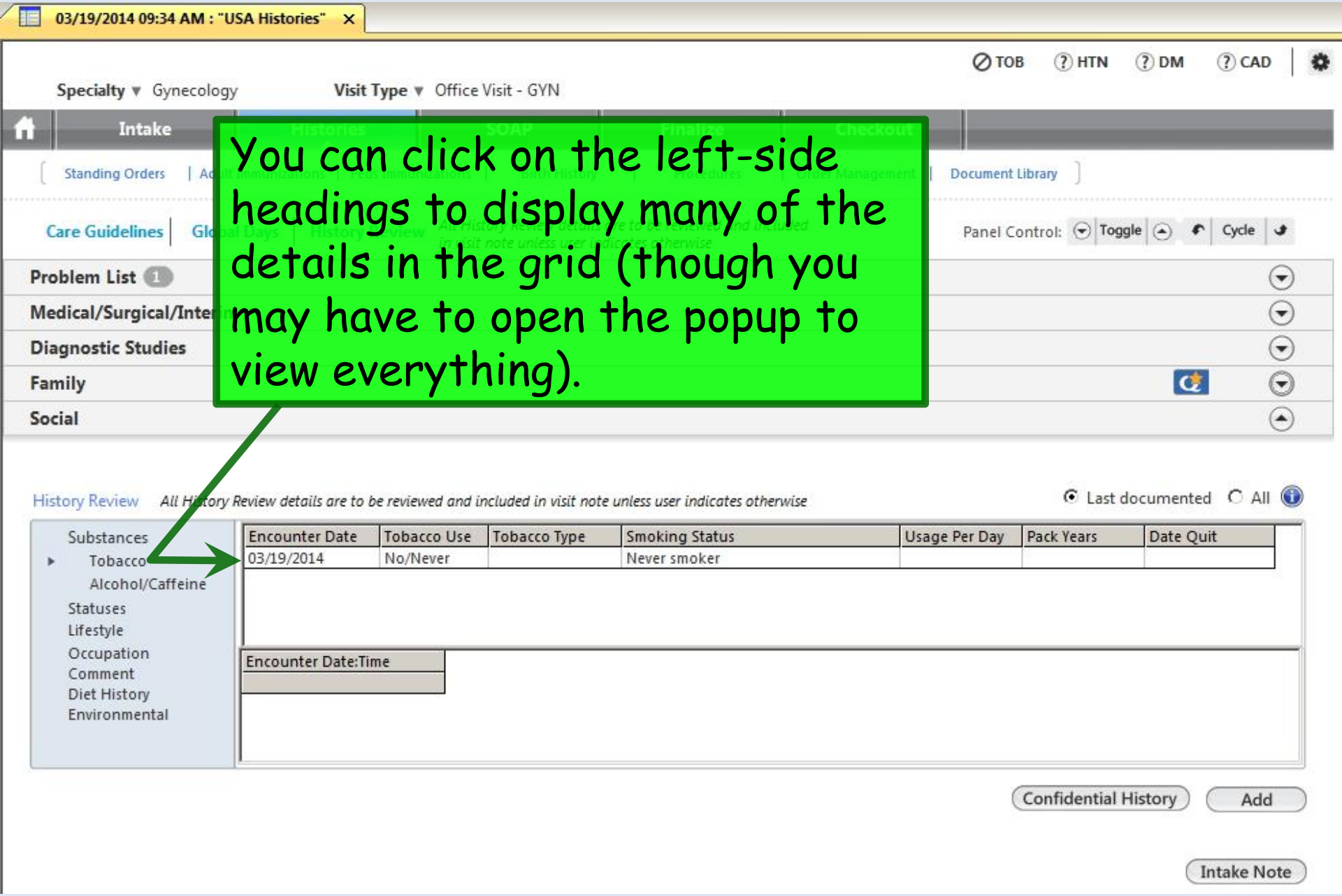

03/19/2014 09:34 AM : "USA Histories"
TOB
HTN
DM
CAD
Specialty ▼ Gynecology
Visit Type ▼ Office Visit - GYN
This history now displays.
Finalize
Checkout
Procedures
Order Management
Document Library
Care Guidelines
Global Days
History Review
All History Review details are to be reviewed and included in visit note unless user indicates otherwise
Panel Control:
Toggle
Cycle
Problem List 1
Show chronic
Show tracked problem
No active problems
Reviewed
Problem Description
Side
Notes
Addtl
Allergic rhinitis
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
Pelvic inflammatory disease
2010
History
Add
Edit
Remove
Now we'll use the collapsible panels to move down to the Family History.
Diagnostic Studies
Family

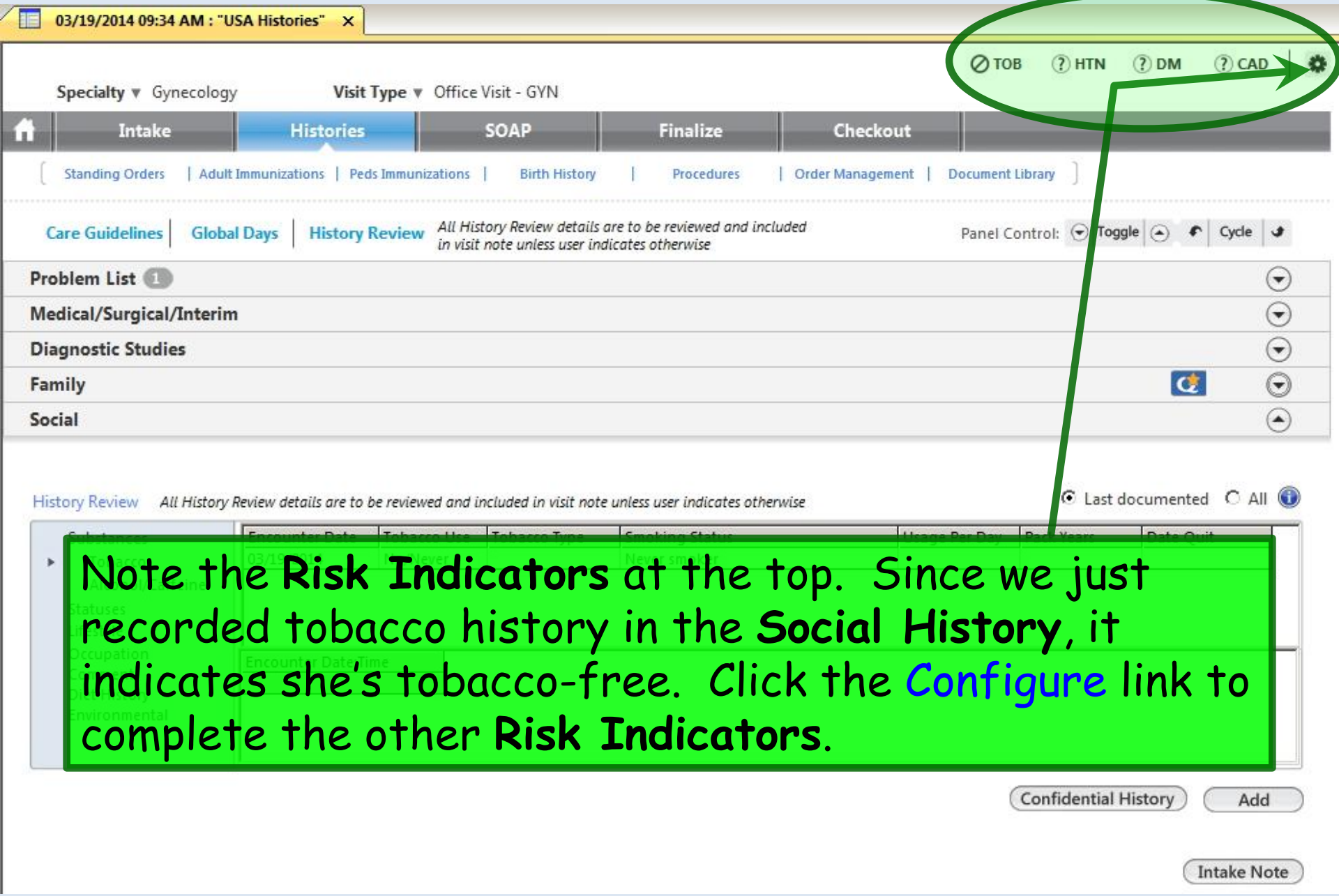

03/19/2014 09:34 AM : "USA Histories"
TOB
HTN
DM
CAD
Specialty ▼ Gynecology
Visit Type ▼ Office Visit - GYN
Intake
Histories
SOAP
Finalize
Checkout
Standing Orders | Adult Immunizations | Peds Immunizations | Birth History | Procedures | Order Management | Document Library
Care Guidelines | Global Days | 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 1
Medical/Surgical/Interim
Diagnostic Studies
Family
Click Add.
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
Add
Edit
Remove


Family Health History
Specialty: Gynecology
No family history of:
Relationship:
Family member name:
Alive and well
Deceased
Onset age:
Cause of death:
Alcoholism
Hemophilia-A
Hypertension
Mental retardation
Renal disease
Sickle cell disease
Spina bifida
Stroke
Other
Coagulopathy
Coronary artery disease
Cystic fibrosis
Depression
Diabetes
Down syndrome
Elevated lipids
Enter this Family History:
Her brother has hypertension.
Her 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

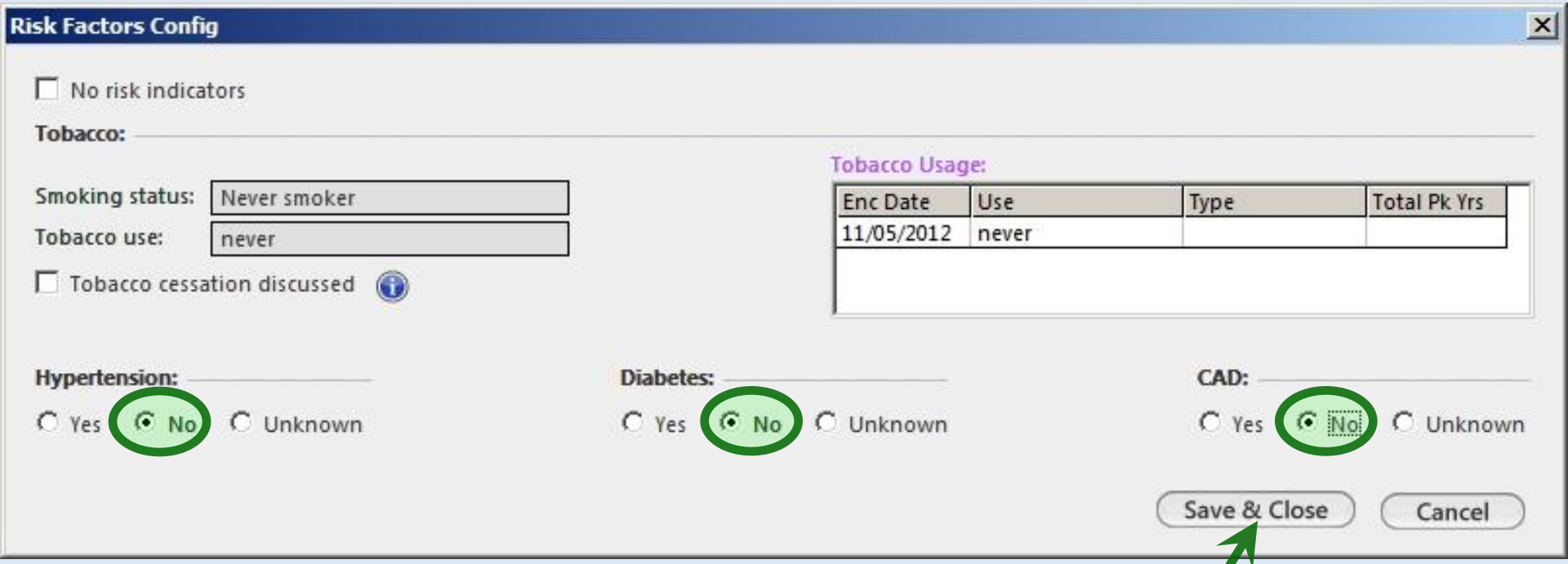

03/19/2014 09:34 AM : "USA Histories"
TOB
HTN
DM
CAD
Specialty ▼ Gynecology
Visit Type ▼ Office Visit - GYN
Intake
Histories
SOAP
Finalize
Checkout
Standing Orders
These additions display in the grid.
Care Guidelines
Global Days
History Review
in visit note unless user indicates otherwise
Panel Control:
Toggle
Cycle
Problem List 1
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
Y
Mother
Y
52
Now move down to Social History & click the Add button.
Add
Edit
Remove
Social
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


Social History - Tobacco
Tobacco
Alcohol/Caffeine
Statuses
Lifestyle
Occupation
Comments
Diet History
Panel Control:
Toggle
Cycle
Tobacco Use
Have you ever used tobacco?
No/never
Yes
Unknown
Exclusions
Reviewed
Updated:
03/19/2014
Enter this Social History:
She's never smoked.
She drinks an average of 2-3 drinks per wk.
She's single.
She works full time in customer service.
(Social History is covered in detail in the Histories lesson.)
When done click Save & Close.
Efforts To Quit Tobacco
Passive Smoke Exposure
Save & Close
Cancel

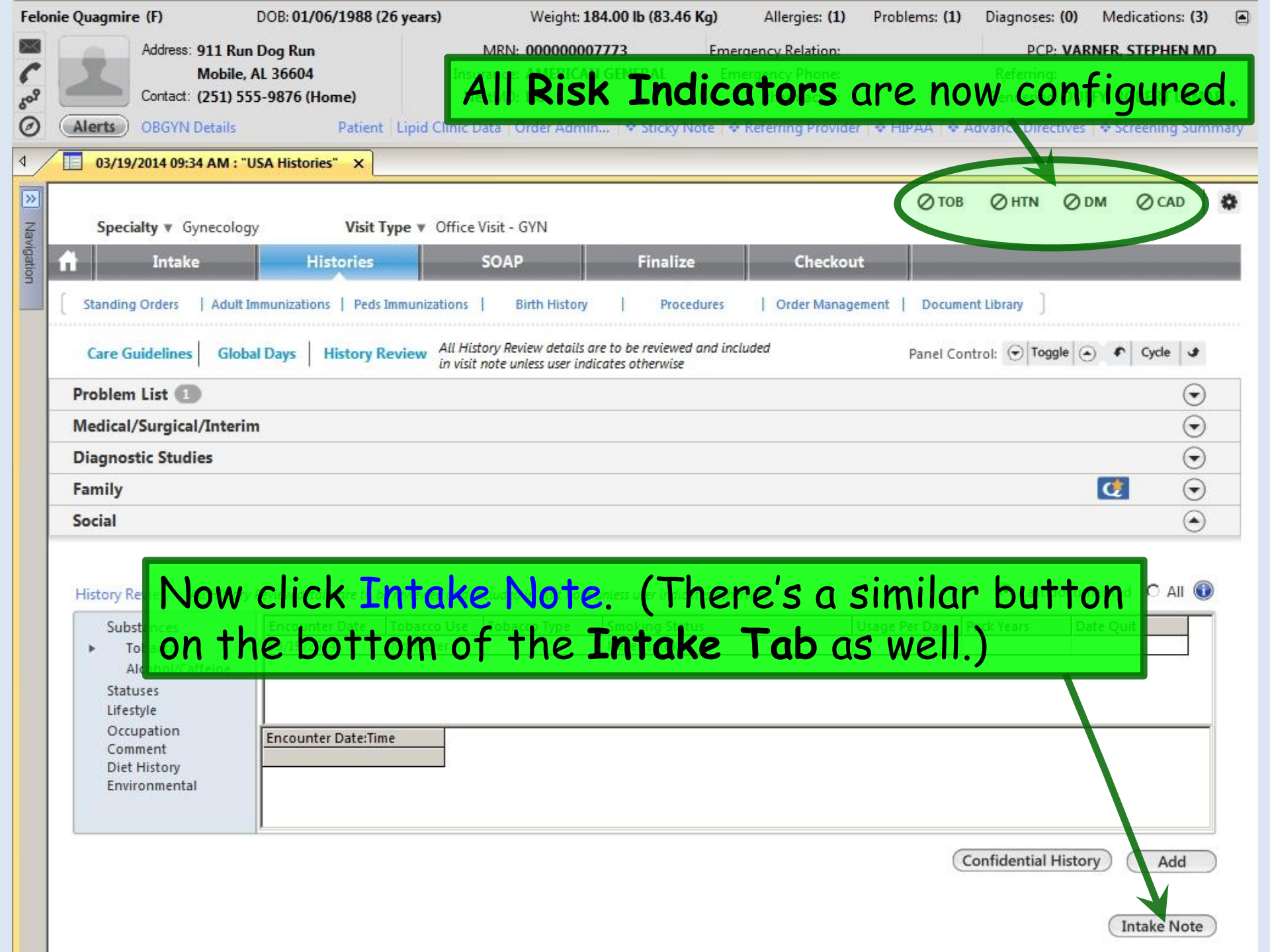

03/19/2014 09:34 AM : "USA Histories"
TOB
HTN
DM
CAD
Specialty ▾ Gynecology
Visit Type ▾ Office Visit - GYN
Intake
Standing Orders
Document Library
Care Guidelines
Panel Control:
Toggle
Cycle
Problem List 1
Medical/Surgical/Inte
Diagnostic Studies
Family
Social
You can click on the left-side headings to display many of the details in the grid (though you may have to open the popup to view everything).
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
03/19/2014
No/Never
Never smoker
Encounter Date:Time
Confidential History
Add
Intake Note

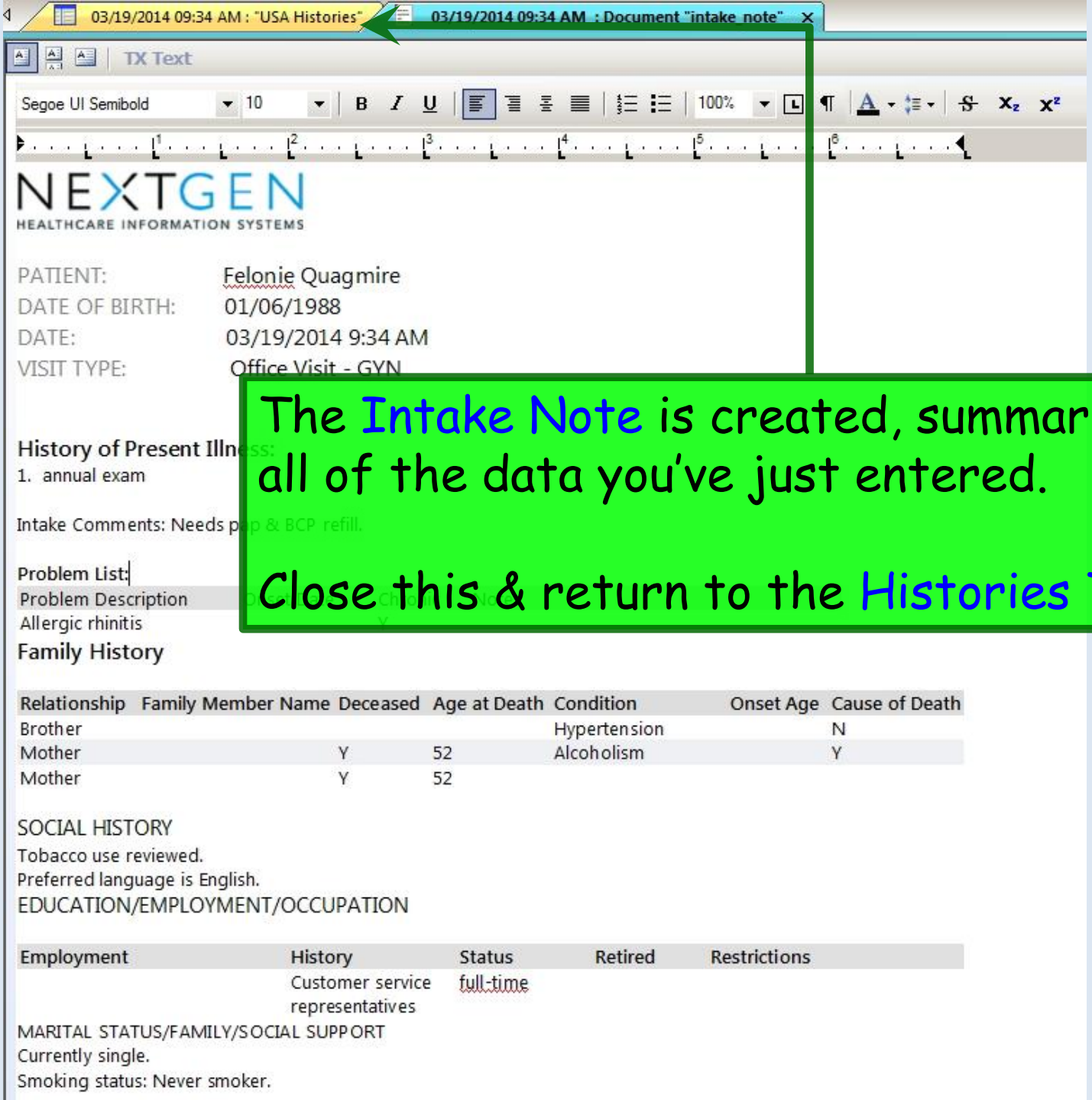


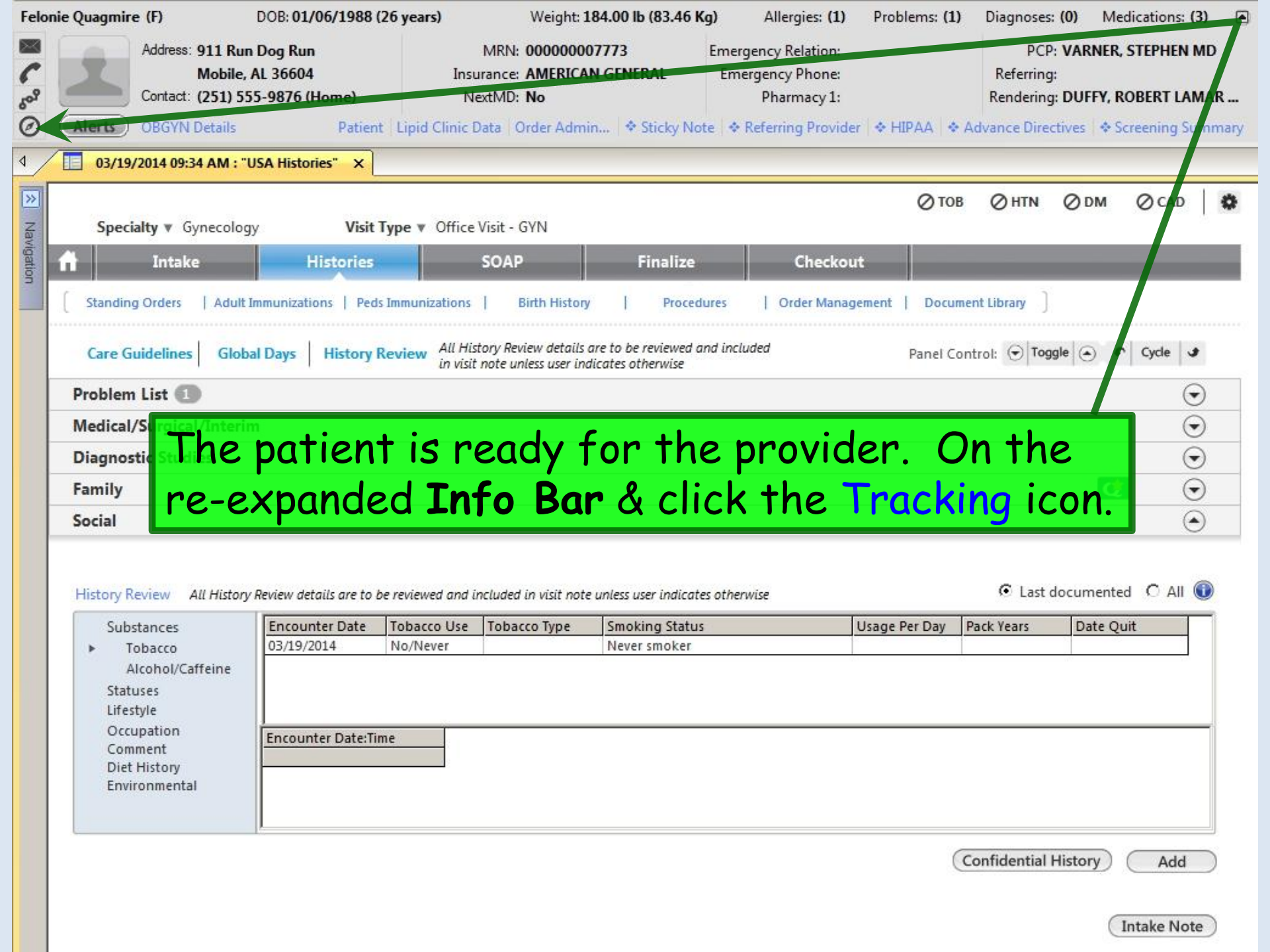
Note the **Risk Indicators** at the top. Since we just recorded tobacco history in the **Social History**, it indicates she's tobacco-free. Click the Configure link to complete the other **Risk Indicators**.

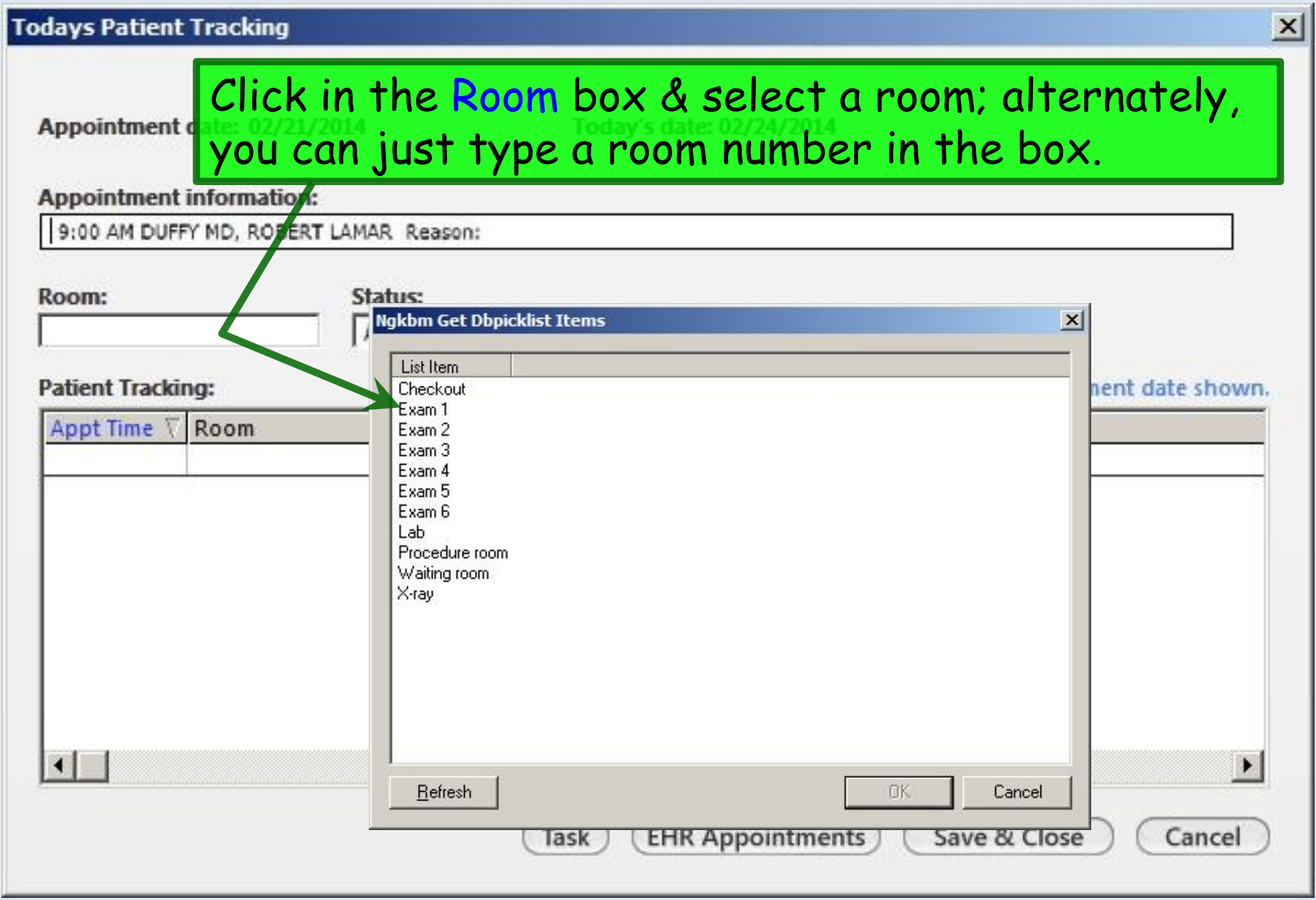


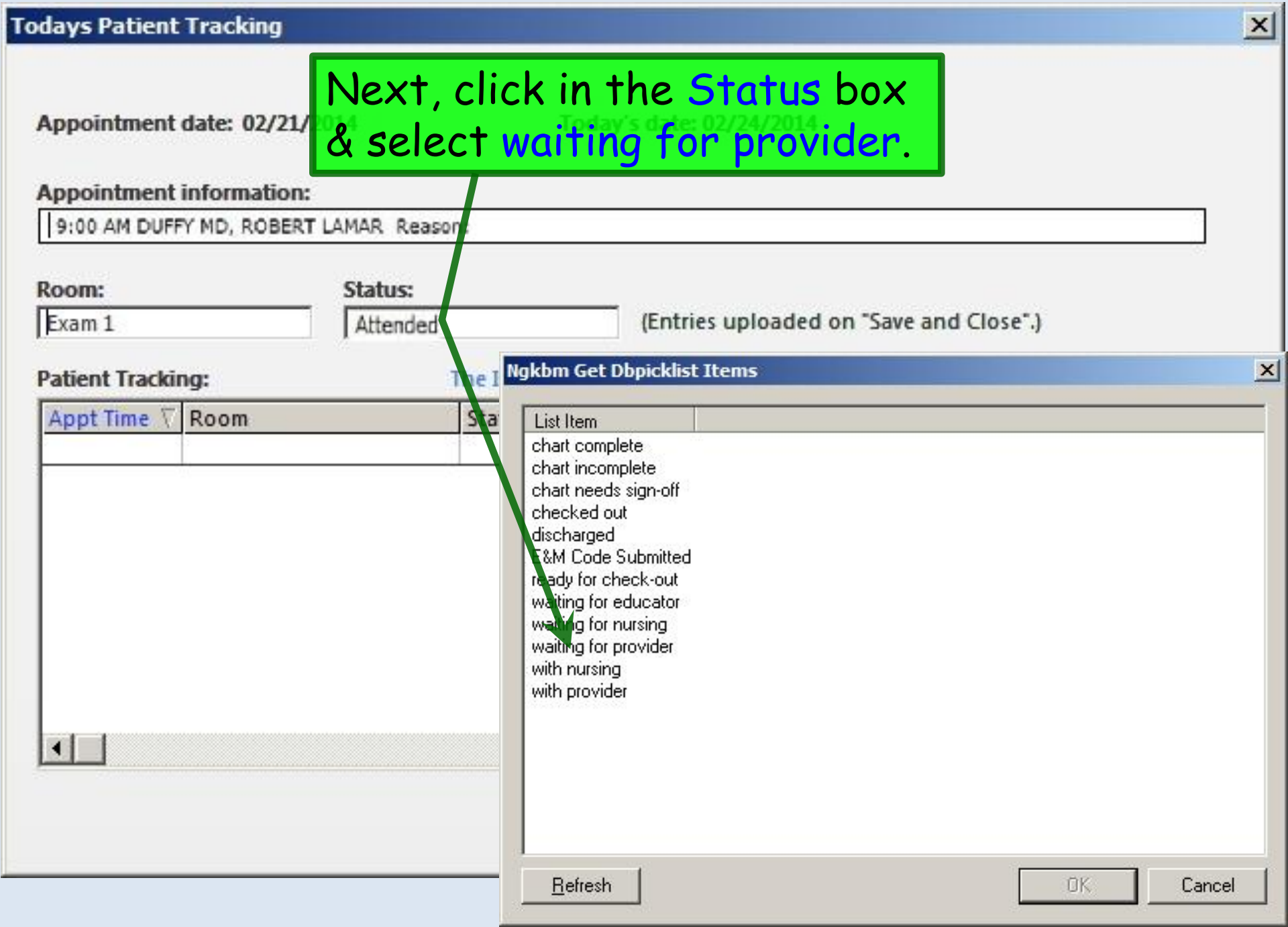
Tobacco has already been addressed.
Click the bullets for Hypertension No, Diabetes No, & Coronary Artery Disease No.
When done click Save & Close.

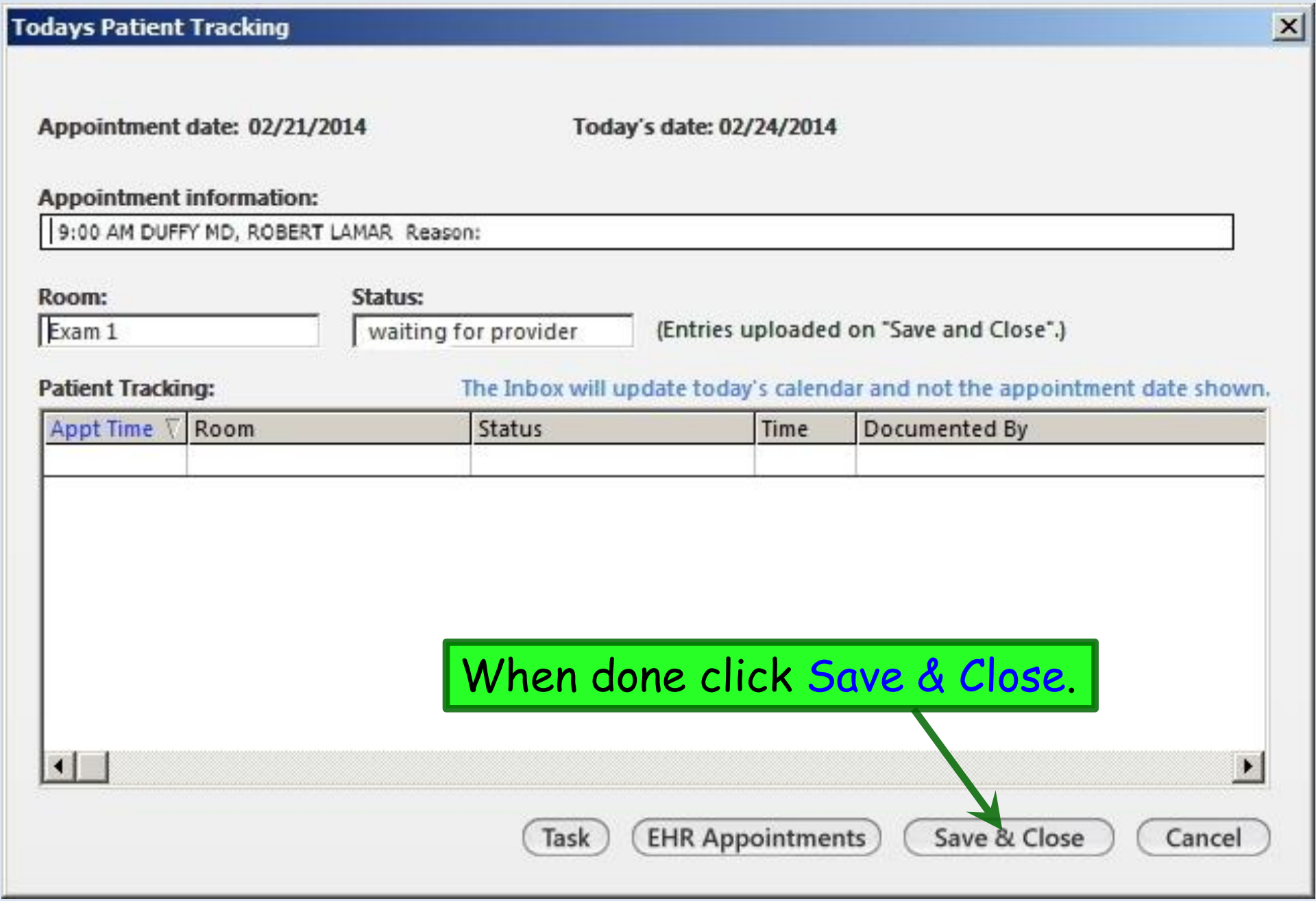

Felonie Quagmire (F) DOB: 01/06/1988 (26 years) Weight: 184.00 lb (83.46 Kg) Allergies: (1) Problems: (1) Diagnoses: (0) Medications: (3)
Address: 911 Run Dog Run
Mobile, AL 36604
Contact: (251) 555-9876 (Home)
MRN: 000000007773
Emergency Relation:
PCP: VARNER, STEPHEN MD
Alerts
OBGYN Details
Patient
Lipid Clinic Data
Order Admin...
Sticky Note
Referring Provider
HIPAA
Advance Directives
Screening Summary
All Risk Indicators are now configured.
03/19/2014 09:34 AM : "USA Histories"
TOB
HTN
DM
CAD
Specialty ▾ Gynecology
Visit Type ▾ Office Visit - GYN
Intake
Histories
SOAP
Finalize
Checkout
Navigation
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 1
Medical/Surgical/Interim
Diagnostic Studies
Family
Social
Now click Intake Note. (There's a similar button on the bottom of the Intake Tab as well.)
All
Substances
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
Intake Note

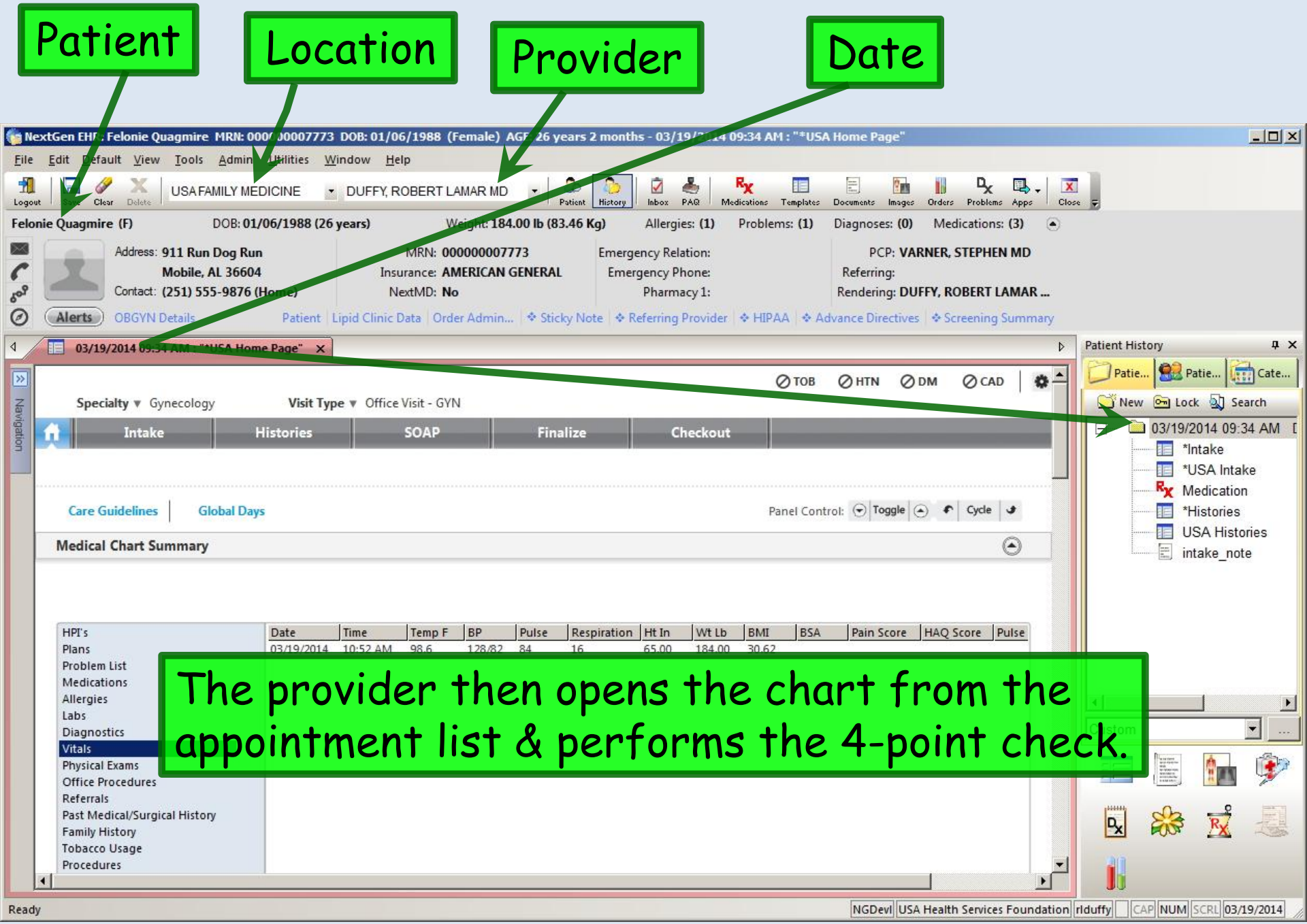

03/19/2014 09:34 AM : "USA Histories"
03/19/2014 09:34 AM : Document "intake_note"
TX Text
Segoe UI Semibold
10
100%
NEXTGEN
HEALTHCARE INFORMATION SYSTEMS
PATIENT: Felonie Quagmire
DATE OF BIRTH: 01/06/1988
DATE: 03/19/2014 9:34 AM
VISIT TYPE: Office Visit - GYN
History of Present Illness:
1. annual exam
Intake Comments: Needs pap & BCP refill.
Problem List:
Problem Description
Allergic rhinitis
Family History
Relationship | Family Member Name | Deceased | Age at Death | Condition | Onset Age | Cause of Death
Brother | | | | Hypertension | | N
Mother | | Y | 52 | Alcoholism | | Y
Mother | | Y | 52 |
SOCIAL HISTORY
Tobacco use reviewed.
Preferred language is English.
EDUCATION/EMPLOYMENT/OCCUPATION
Employment | History | Status | Retired | Restrictions
Customer service representatives | full-time
MARITAL STATUS/FAMILY/SOCIAL SUPPORT
Currently single.
Smoking status: Never smoker.
The Intake Note is created, summarizing all of the data you've just entered.
Close this & return to the Histories Tab.

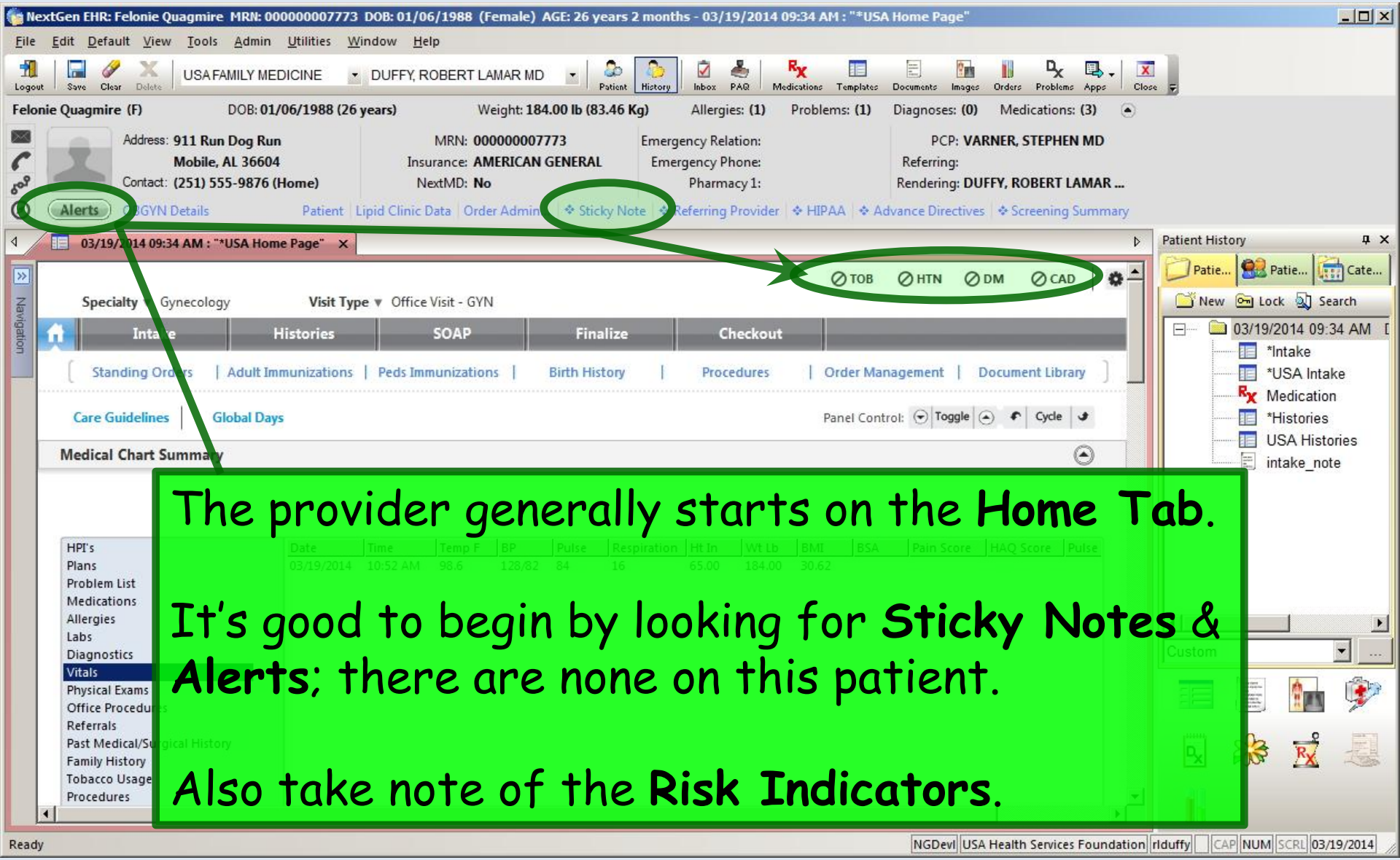

Felonie Quagmire (F) DOB: 01/06/1988 (26 years) Weight: 184.00 lb (83.46 Kg) Allergies: (1) Problems: (1) Diagnoses: (0) Medications: (3)
Address: 911 Run Dog Run
Mobile, AL 36604
Contact: (251) 555-9876 (Home)
MRN: 000000007773
Insurance: AMERICAN GENERAL
NextMD: No
Emergency Relation:
Emergency Phone:
Pharmacy 1:
PCP: VARNER, STEPHEN MD
Referring:
Rendering: DUFFY, ROBERT LAMAR ...
Alerts
OBGYN Details
Patient
Lipid Clinic Data
Order Admin...
Sticky Note
Referring Provider
HIPAA
Advance Directives
Screening Summary
03/19/2014 09:34 AM : "USA Histories"
TOB
HTN
DM
CVD
Specialty ▼ Gynecology
Visit Type ▼ Office Visit - GYN
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 1
Medical/Surgical/Interim
Diagnostic Studies
Family
Social
The patient is ready for the provider. On the re-expanded Info Bar & click the Tracking icon.
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
03/19/2014
No/Never
Never smoker
Encounter Date:Time
Confidential History
Add
Intake Note


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.
Task
EHR Appointments
Save & Close
Cancel


Patient
Location
Provider
Date
NextGen EHR: Felonie Quagmire MRN: 000000007773 DOB: 01/06/1988 (Female) AGE: 26 years 2 months - 03/19/2014 09:34 AM : "*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
Felonie Quagmire (F) DOB: 01/06/1988 (26 years) Weight: 184.00 lb (83.46 Kg) Allergies: (1) Problems: (1) Diagnoses: (0) Medications: (3)
Address: 911 Run Dog Run
Mobile, AL 36604
Contact: (251) 555-9876 (Home)
MRN: 000000007773
Insurance: AMERICAN GENERAL
NextMD: No
Emergency Relation:
Emergency Phone:
Pharmacy 1:
PCP: VARNER, STEPHEN MD
Referring:
Rendering: DUFFY, ROBERT LAMAR ...
Alerts OBGYN Details Patient Lipid Clinic Data Order Admin... Sticky Note Referring Provider HIPAA Advance Directives Screening Summary
03/19/2014 09:34 AM : "*USA Home Page"
TOB HTN DM CAD
Specialty Gynecology Visit Type Office Visit - GYN
Intake Histories SOAP Finalize Checkout
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
Referrals
Past Medical/Surgical History
Family History
Tobacco Usage
Procedures
Date Time Temp F BP Pulse Respiration Ht In Wt Lb BMI BSA Pain Score HAQ Score Pulse
03/19/2014 10:52 AM 98.6 128/82 84 16 65.00 184.00 30.62
Patient History
New Lock Search
03/19/2014 09:34 AM
*Intake
*USA Intake
Medication
*Histories
USA Histories
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 03/19/2014

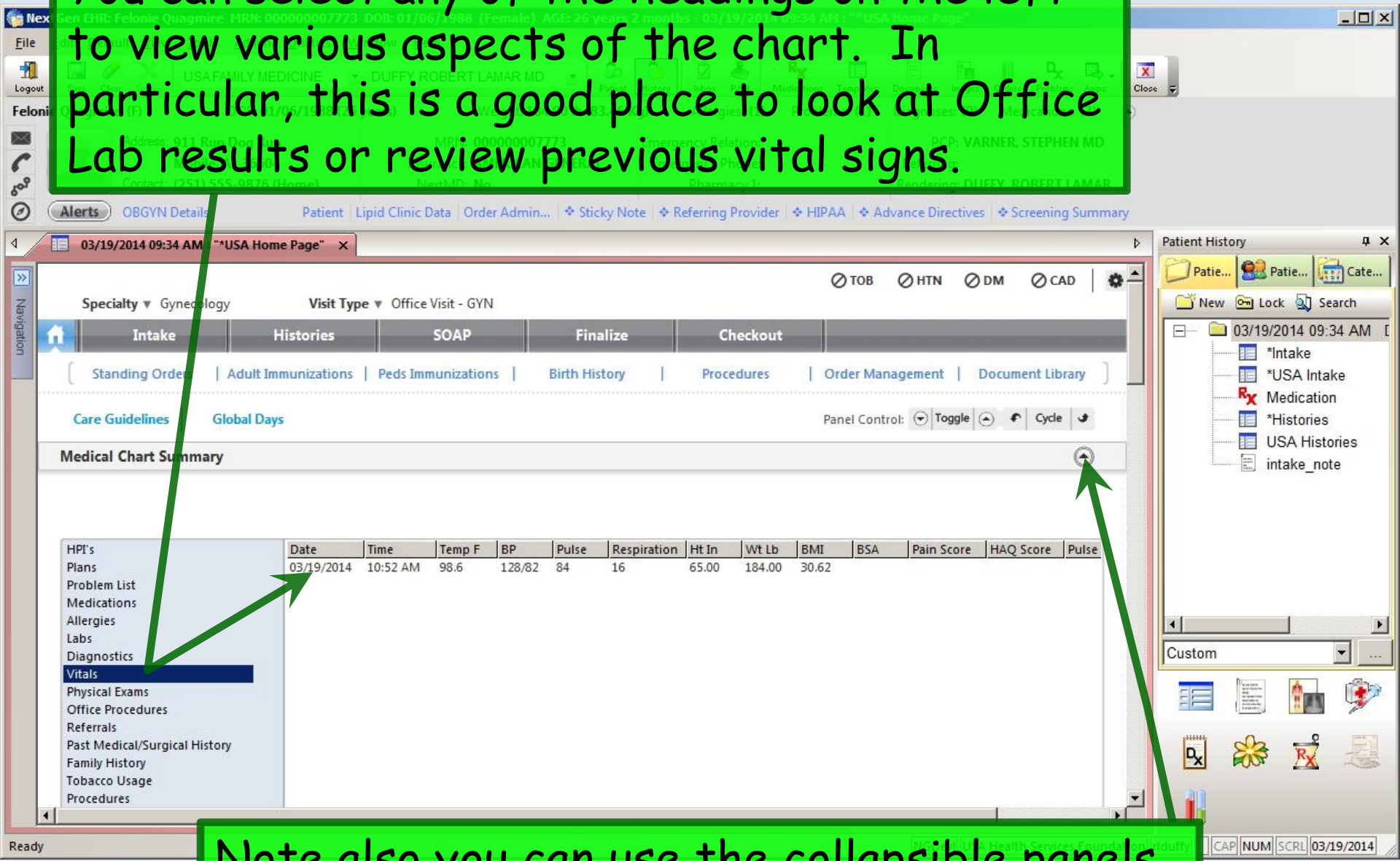


The provider generally starts on the **Home Tab**.

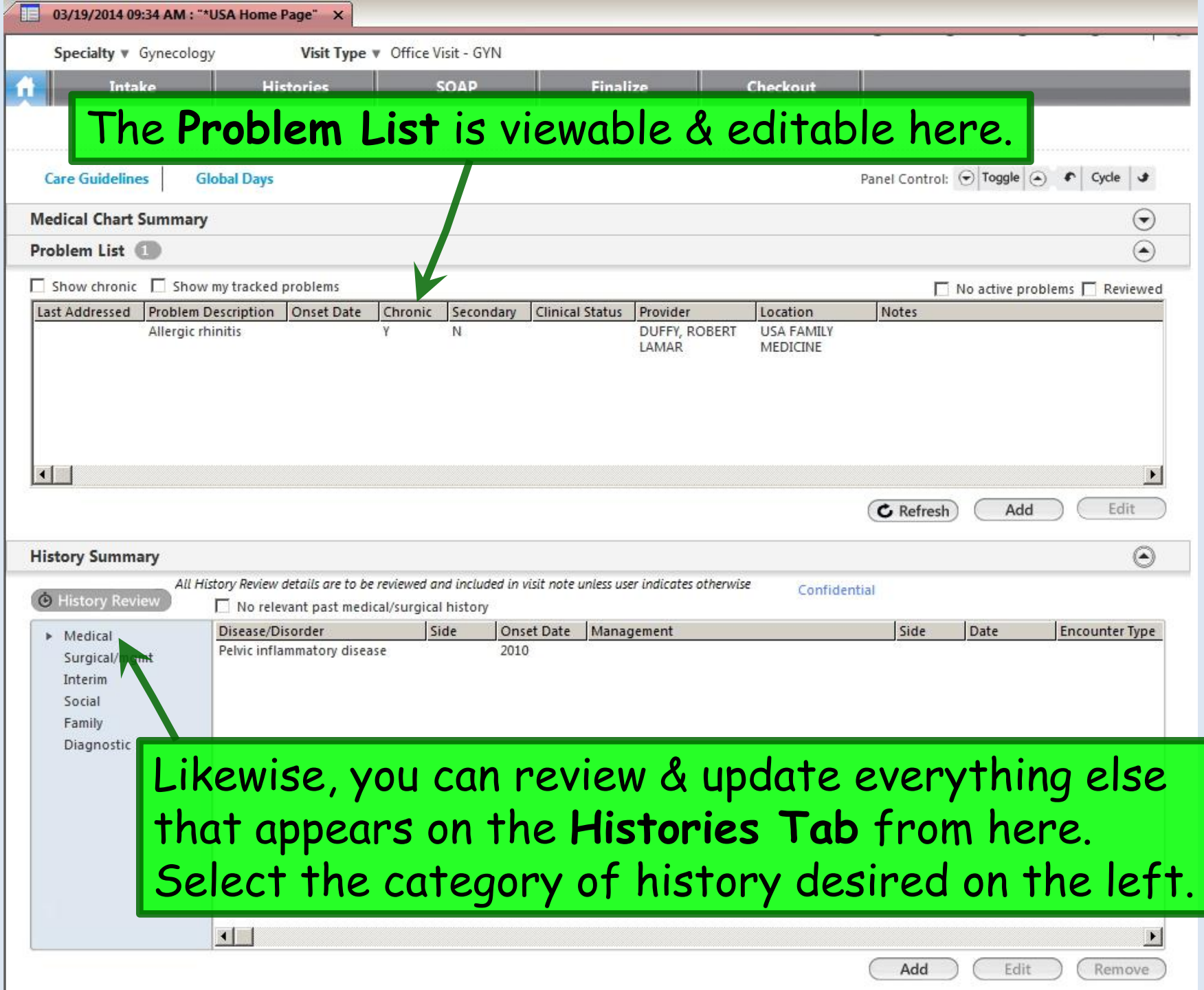
It's good to begin by looking for **Sticky Notes** & **Alerts**; there are none on this patient.

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.



Note also you can use the collapsible panels or scroll down to see a lot more information.


03/19/2014 09:34 AM : "*USA Home Page"
Specialty ▾ Gynecology
Visit Type ▾ Office Visit - GYN
Intake
Histories
SOAP
Finalize
Checkout
The Problem List is viewable & editable here.
Care Guidelines
Global Days
Panel Control:
Toggle
Cycle
Medical Chart Summary
Problem List 1
Show chronic
Show my tracked problems
No active problems
Reviewed
Last Addressed
Problem Description
Onset Date
Chronic
Secondary
Clinical Status
Provider
Location
Notes
Allergic rhinitis
Y
N
DUFFY, ROBERT LAMAR
USA FAMILY MEDICINE
Refresh
Add
Edit
History Summary
All History Review details are to be reviewed and included in visit note unless user indicates otherwise
Confidential
History Review
No relevant past medical/surgical history
Medical
Surgical/Trauma
Interim
Social
Family
Diagnostic
Disease/Disorder
Side
Onset Date
Management
Side
Date
Encounter Type
Pelvic inflammatory disease
2010
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

03/19/2014 09:34 AM : "*USA Home Page"

Allergies

Comment | No known allergies | Allergies added today | Reviewed, no change

Allergen	Reaction	Medication Name	Comment
SULFA (SULFONAMIDE ANTIBIOTICS)	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
Levonest (28) 50-30 (6)/75-40(5)/125-30(10) tablet	1 daily
loratadine 10 mg tablet	1 daily as needed for allergies
Singulair 10 mg tablet	1 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
10:52 AM	65.00	184.00	30.62	128/82	84	16	98.6				

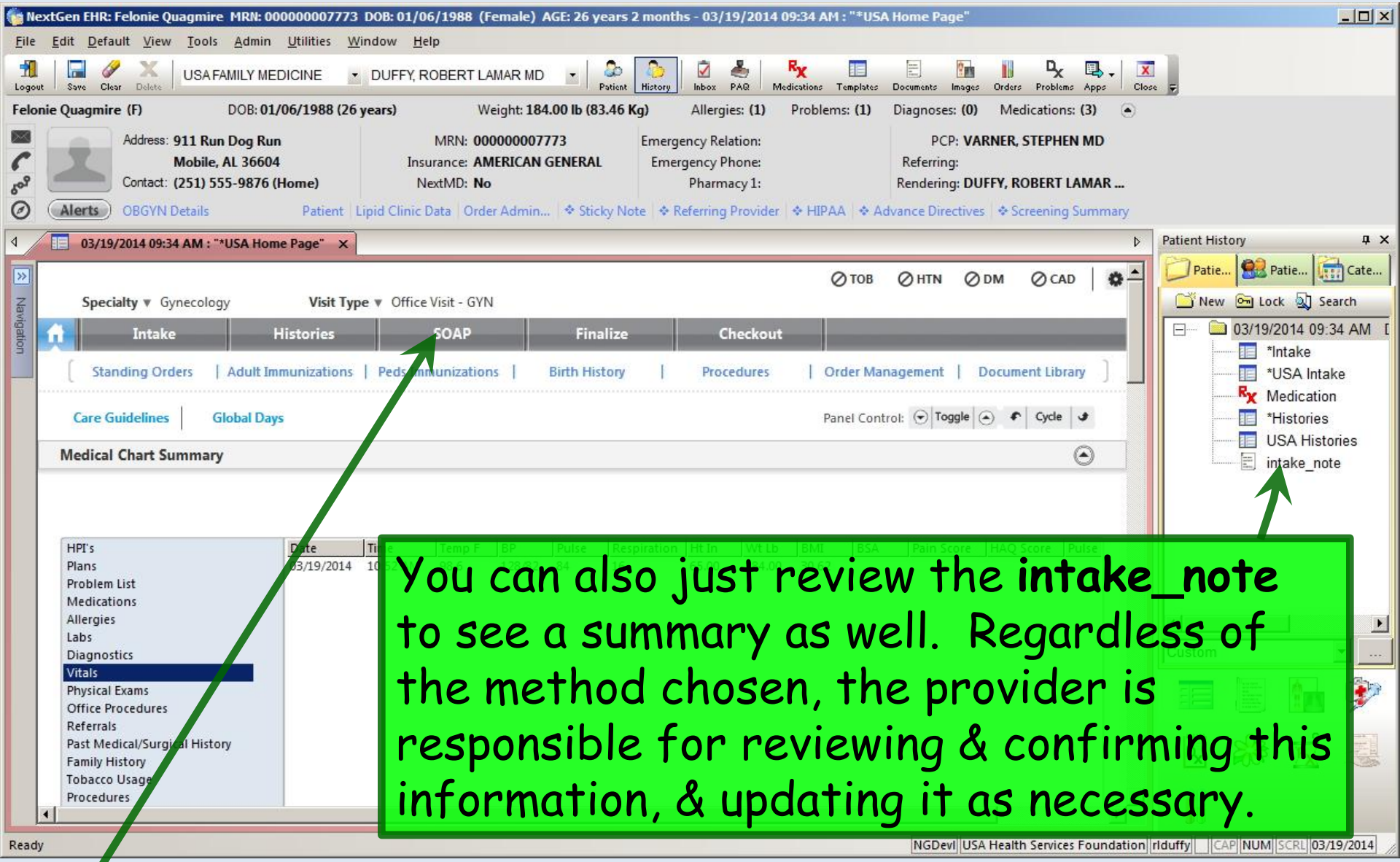
Add | Edit | Remove

Orders

Lab/Radiology Order Processing | Order Management | Immunizations | Standing Orders | Task

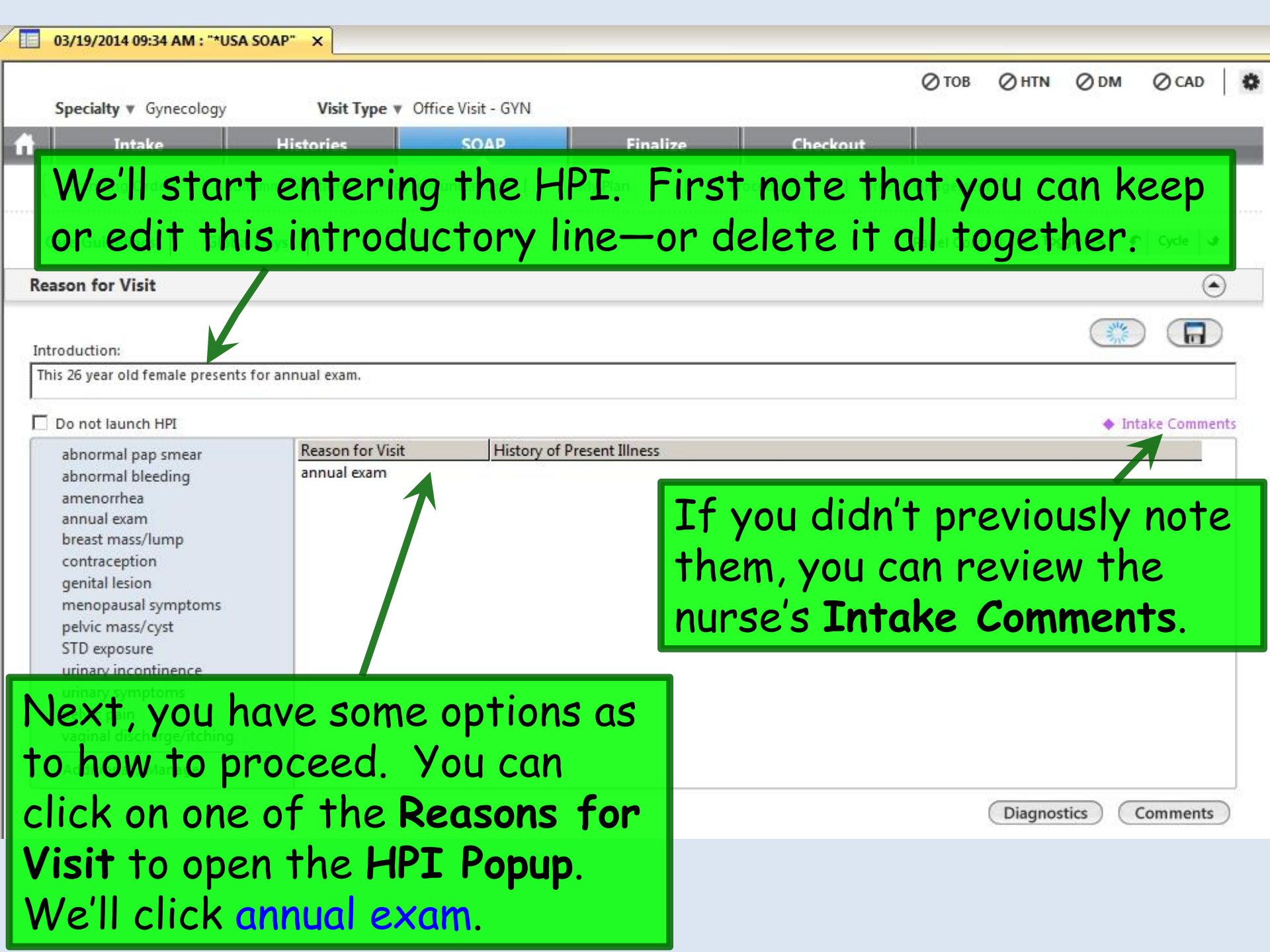
View of All Orders
Labs

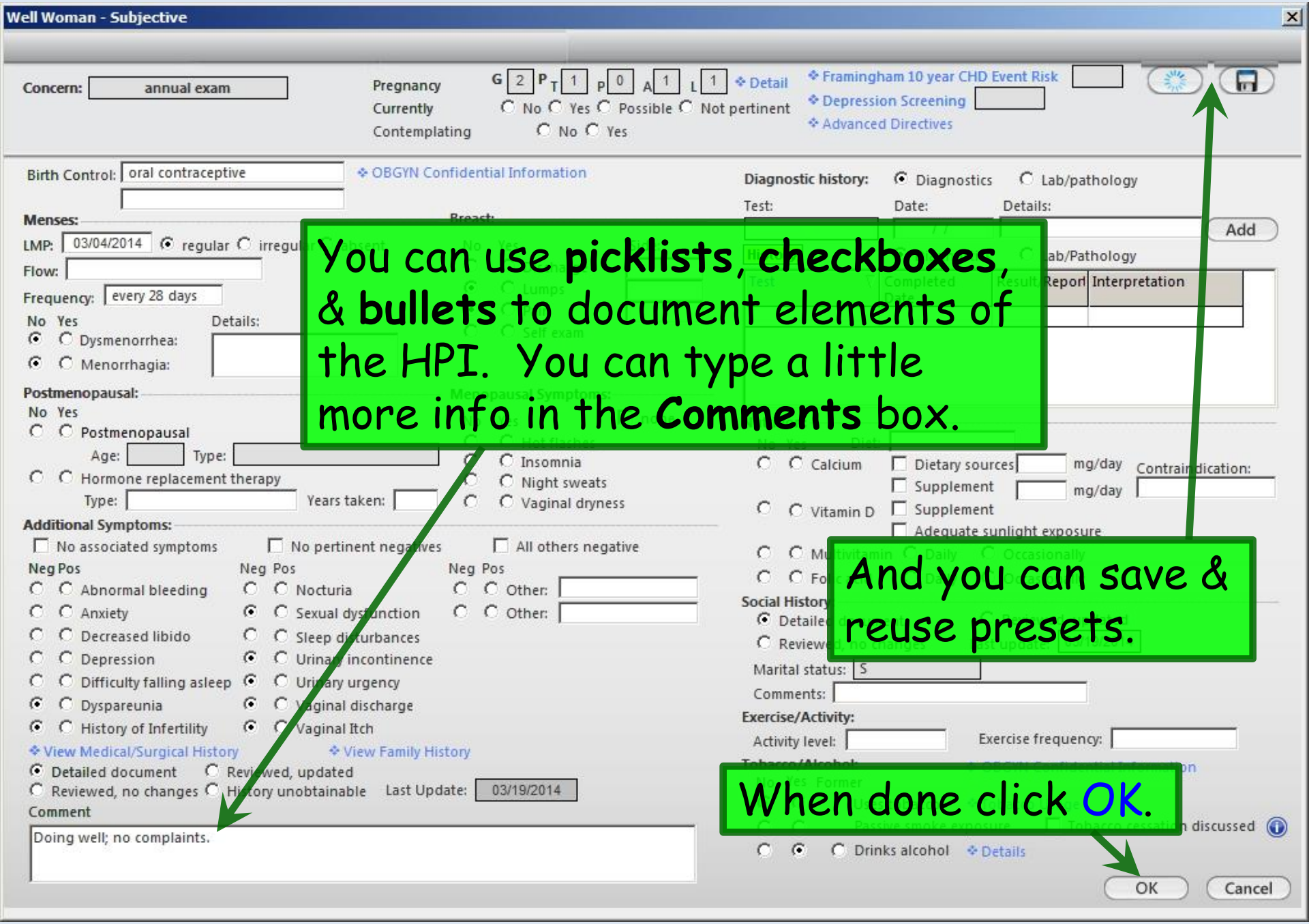
Ordered	Status	Order	Timeframe	Comments

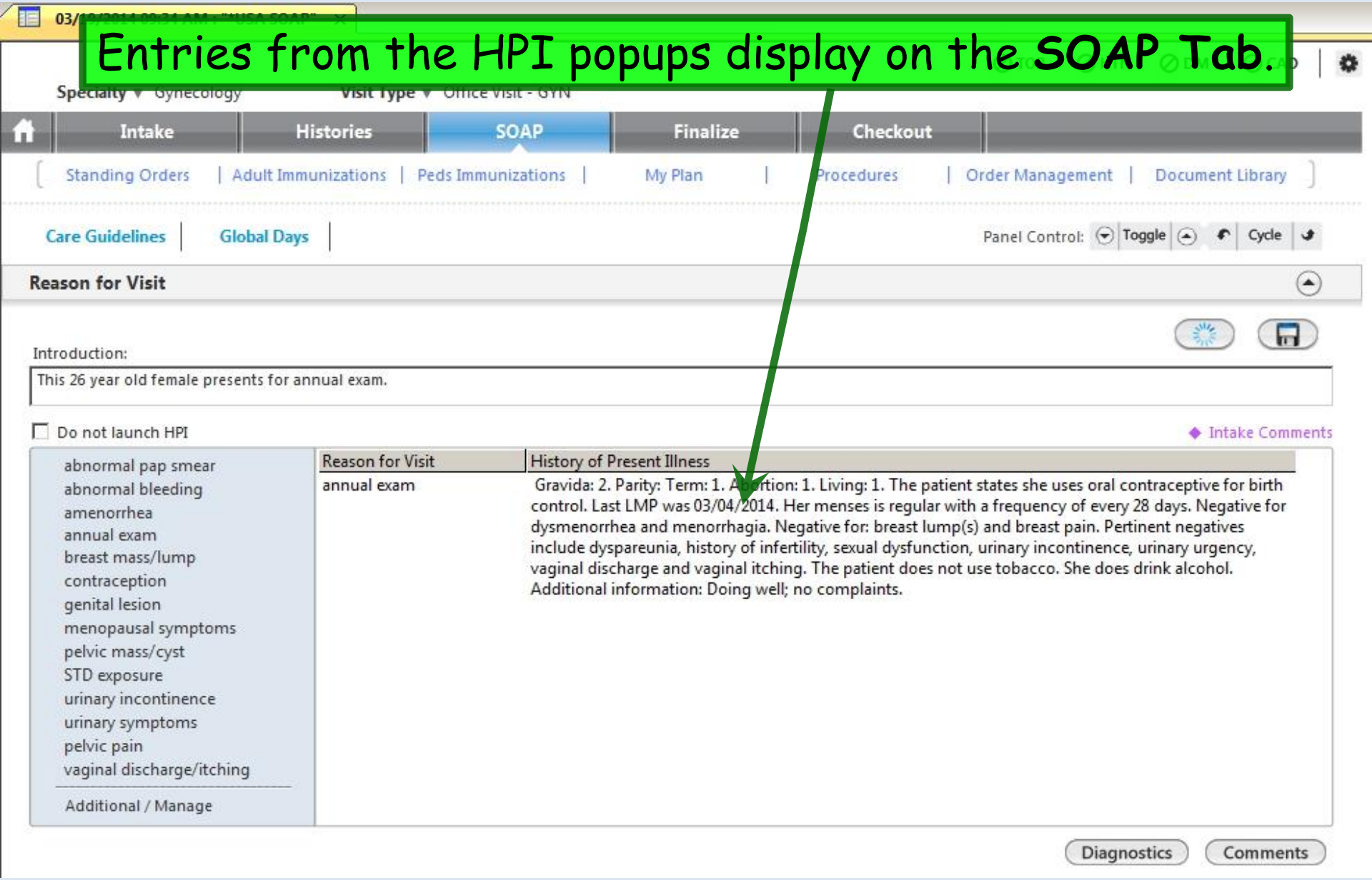


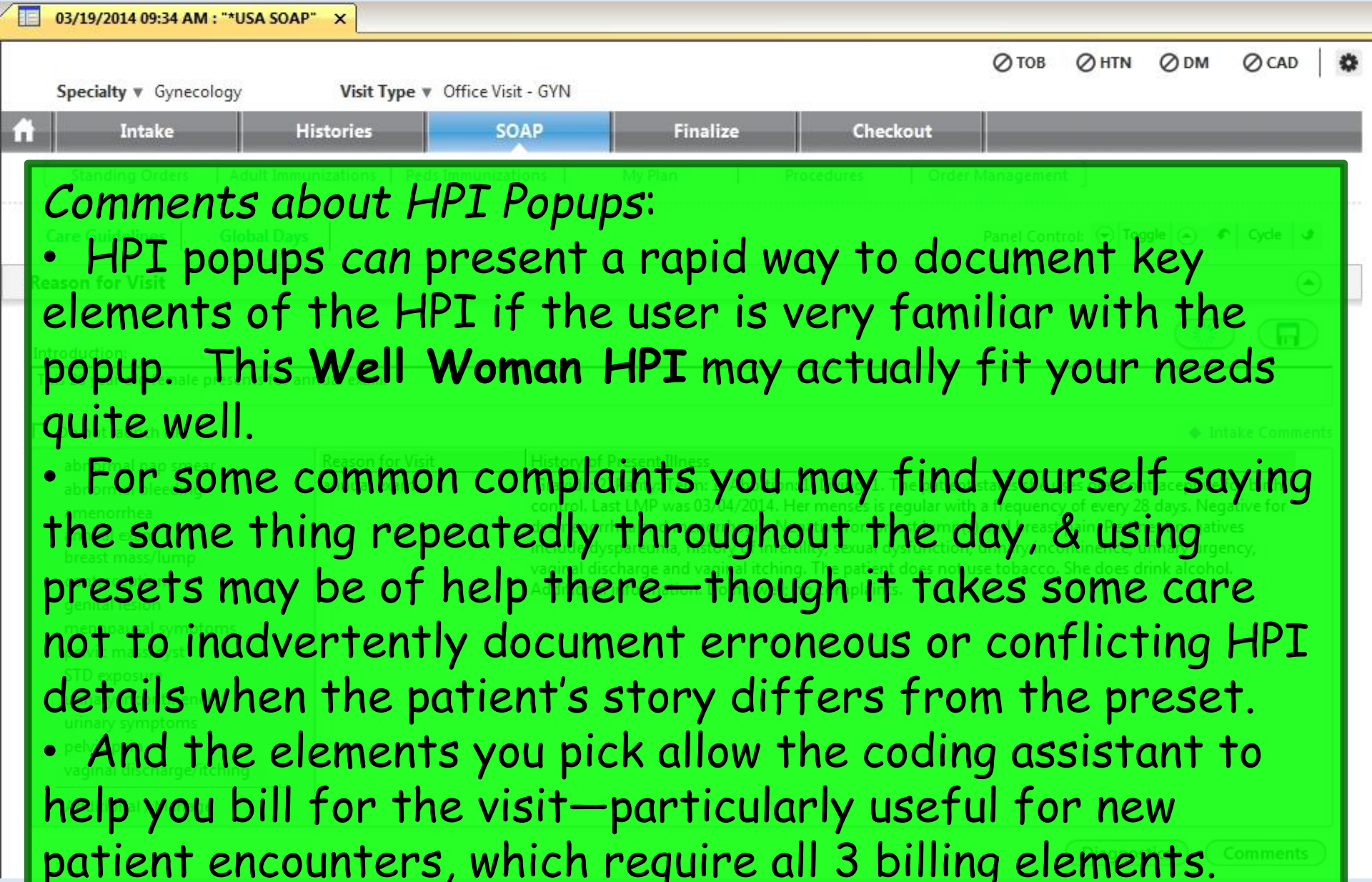
You can also just review the **intake_note** to see a summary as well. Regardless of the method chosen, the provider is responsible for reviewing & confirming this information, & updating it as necessary.

When you're done reviewing the chart, move to the **SOAP tab**.


03/19/2014 09:34 AM : "*USA SOAP"
TOB
HTN
DM
CAD
Specialty ▼ Gynecology
Visit Type ▼ Office Visit - GYN
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 26 year old female presents for annual exam.
Do not launch HPI
Intake Comments
abnormal pap smear
abnormal bleeding
amenorrhea
annual exam
breast mass/lump
contraception
genital lesion
menopausal symptoms
pelvic mass/cyst
STD exposure
urinary incontinence
urinary symptoms
vaginal discharge/itching
Reason for Visit
History of Present Illness
annual exam
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 annual exam.
Diagnostics
Comments

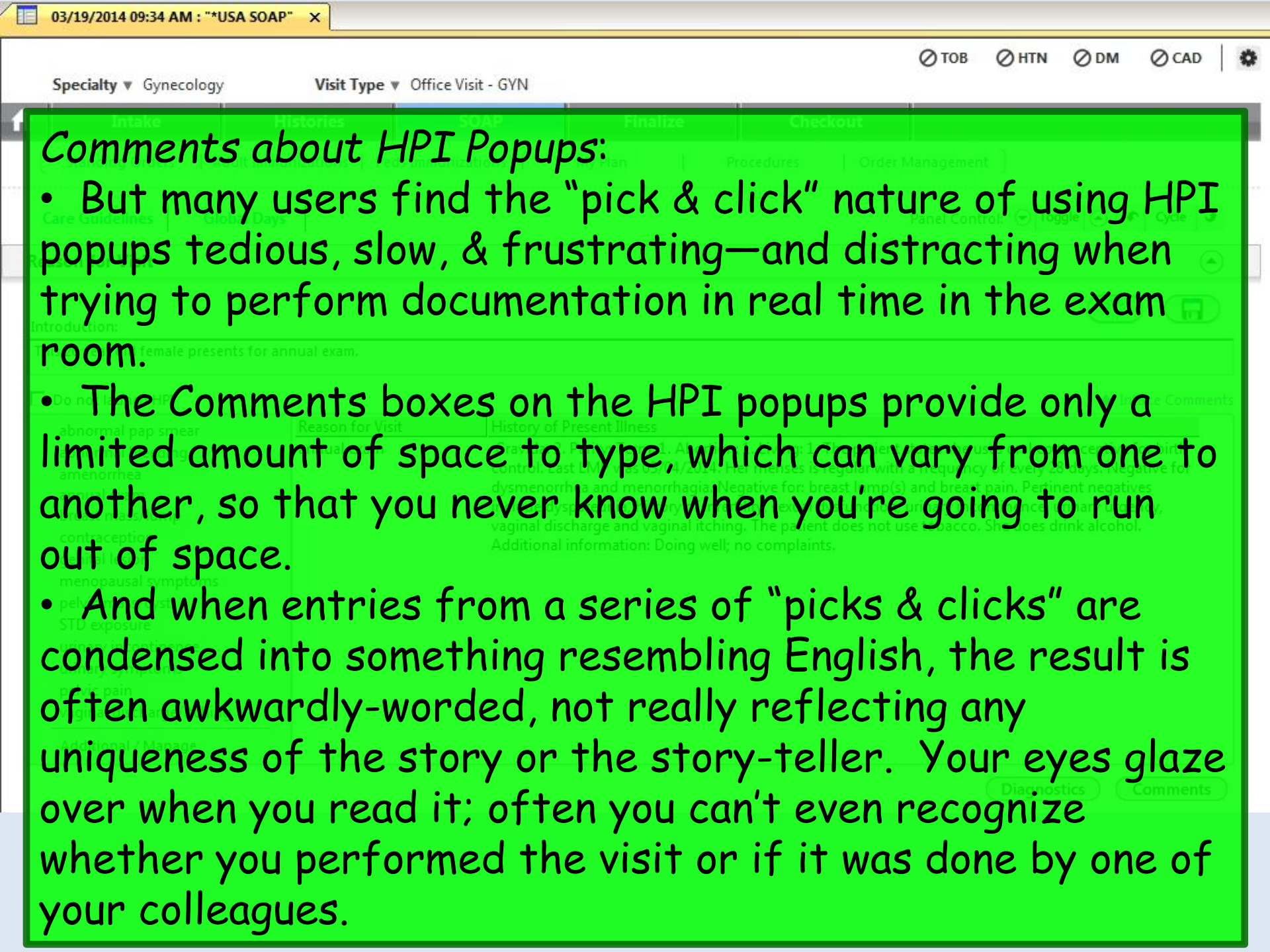

Well Woman - Subjective
Concern: annual exam
Pregnancy
Currently
Contemplating
G 2 P T 1 P 0 A 1 L 1
Detail
No Yes Possible Not pertinent
No Yes
Framingham 10 year CHD Event Risk
Depression Screening
Advanced Directives
Birth Control: oral contraceptive
OBGYN Confidential Information
Menses:
LMP: 03/04/2014 regular irregu
Flow:
Frequency: every 28 days
No Yes Details:
Dysmenorrhea:
Menorrhagia:
Postmenopausal:
No Yes
Postmenopausal
Age: Type:
Hormone replacement therapy
Type: Years taken:
Additional Symptoms:
No associated symptoms
No pertinent negatives
All others negative
Neg Pos
Abnormal bleeding
Anxiety
Decreased libido
Depression
Difficulty falling asleep
Dyspareunia
History of Infertility
Nocturia
Sexual dysfunction
Sleep disturbances
Urinary incontinence
Urinary urgency
Vaginal discharge
Vaginal Itch
Insomnia
Night sweats
Vaginal dryness
Other:
Other:
View Medical/Surgical History
View Family History
Detailed document
Reviewed, no changes
Reviewed, updated
History unobtainable
Last Update: 03/19/2014
Comment
Doing well; no complaints.
Diagnostic history:
Diagnostics
Lab/pathology
Test:
Date:
Details:
Add
Lab/Pathology
Result
Report
Interpretation
Calcium
Dietary sources
mg/day
Supplement
mg/day
Contraindication:
Vitamin D
Supplement
Adequate sunlight exposure
Social History
Marital status: S
Comments:
Exercise/Activity:
Activity level:
Exercise frequency:
Drinks alcohol
Details
discussed
OK
Cancel
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.
When done click OK.


Entries from the HPI popups display on the SOAP Tab.
Specialty Gynecology
Visit Type Office Visit - GYN
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 26 year old female presents for annual exam.
Do not launch HPI
Intake Comments
abnormal pap smear
abnormal bleeding
amenorrhea
annual exam
breast mass/lump
contraception
genital lesion
menopausal symptoms
pelvic mass/cyst
STD exposure
urinary incontinence
urinary symptoms
pelvic pain
vaginal discharge/itching
Additional / Manage
Reason for Visit
History of Present Illness
annual exam
Gravida: 2. Parity: Term: 1. Abortion: 1. Living: 1. The patient states she uses oral contraceptive for birth control. Last LMP was 03/04/2014. Her menses is regular with a frequency of every 28 days. Negative for dysmenorrhea and menorrhagia. Negative for: breast lump(s) and breast pain. Pertinent negatives include dyspareunia, history of infertility, sexual dysfunction, urinary incontinence, urinary urgency, vaginal discharge and vaginal itching. The patient does not use tobacco. She does drink alcohol. Additional information: Doing well; no complaints.
Diagnostics
Comments



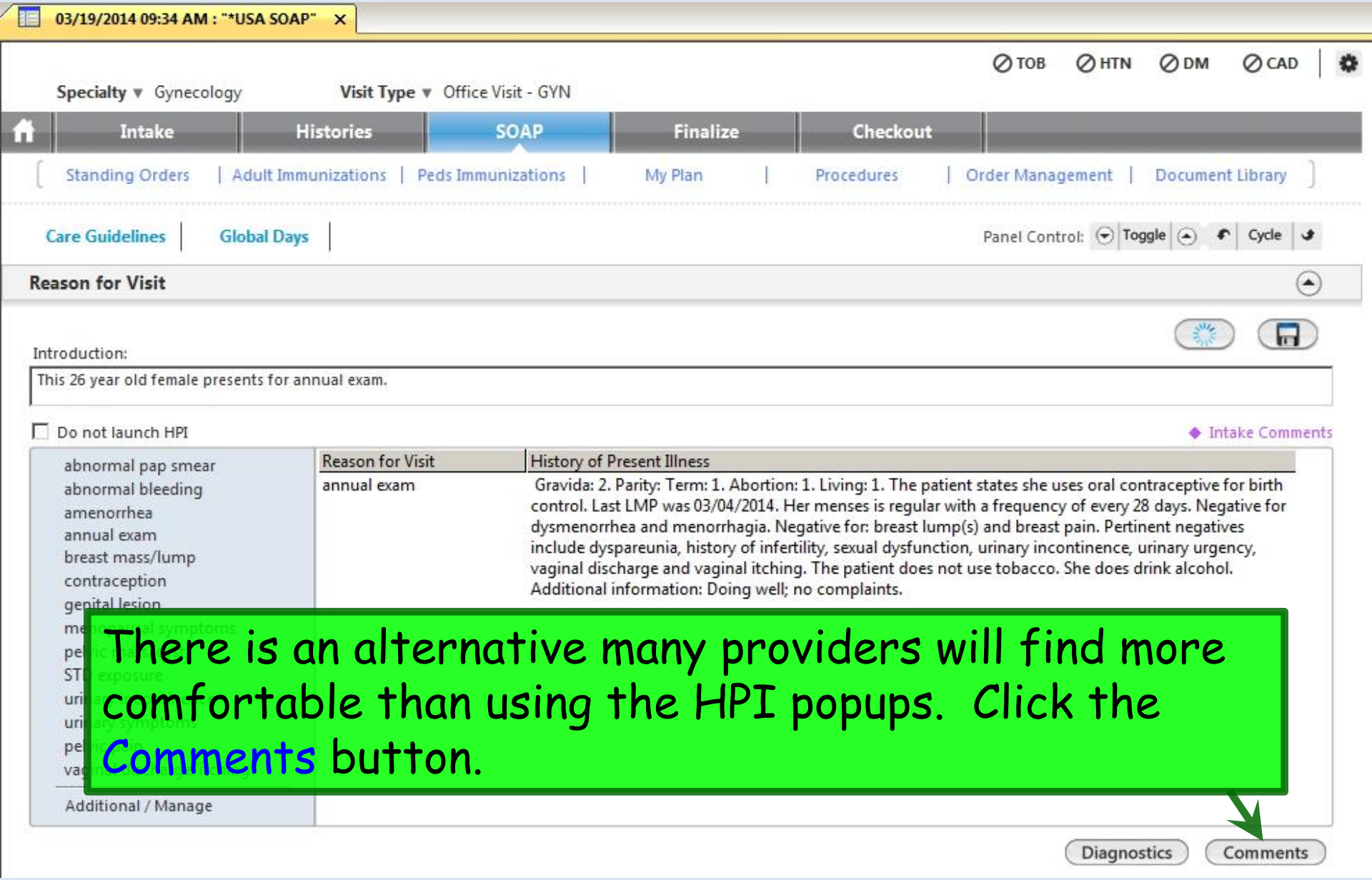
Comments about HPI Popups:

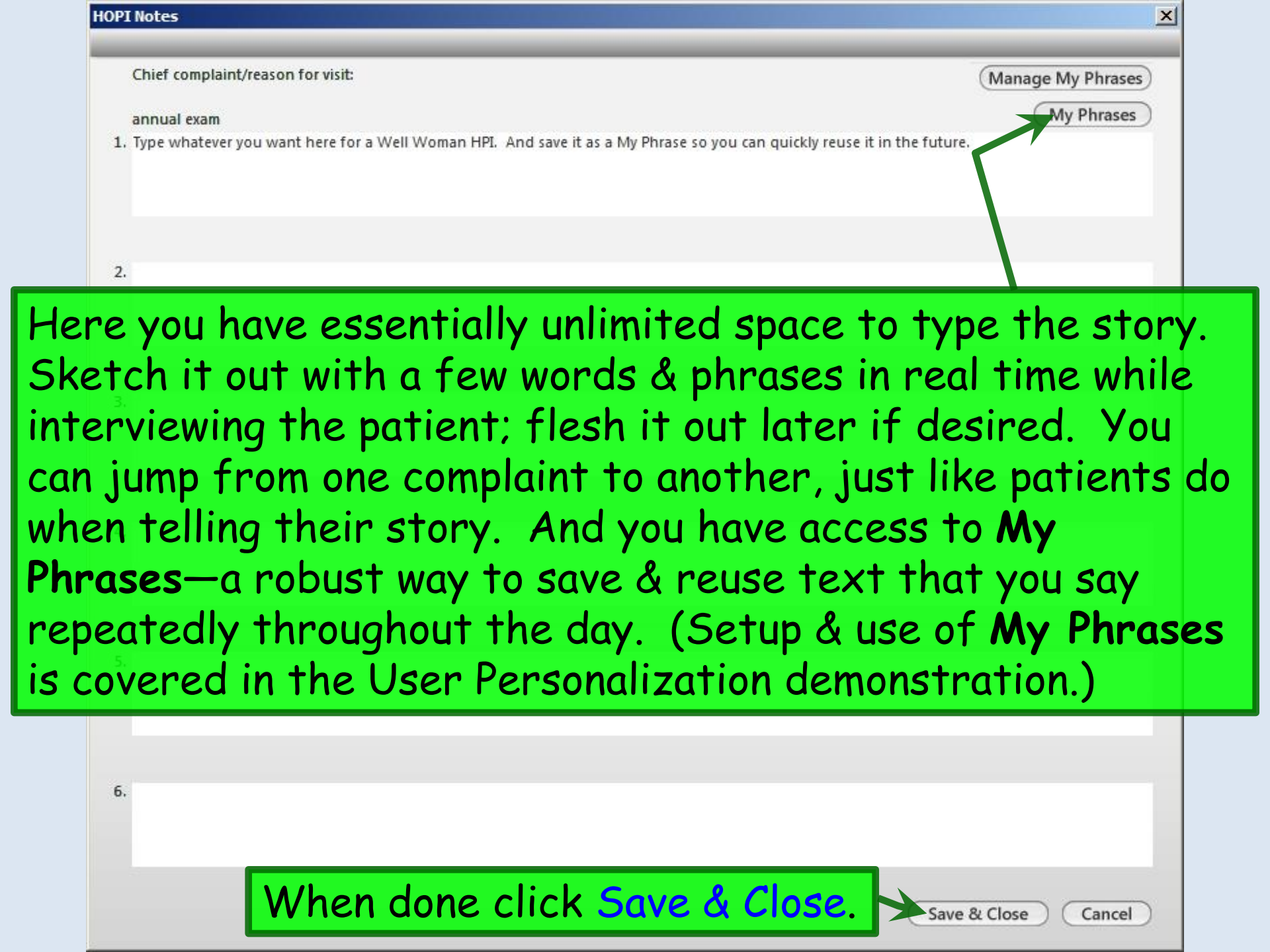
- HPI popups *can* present a rapid way to document key elements of the HPI if the user is very familiar with the popup. This **Well Woman HPI** may actually fit your needs quite well.
- For some common complaints you may find yourself saying the same thing repeatedly throughout the day, & using presets 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.



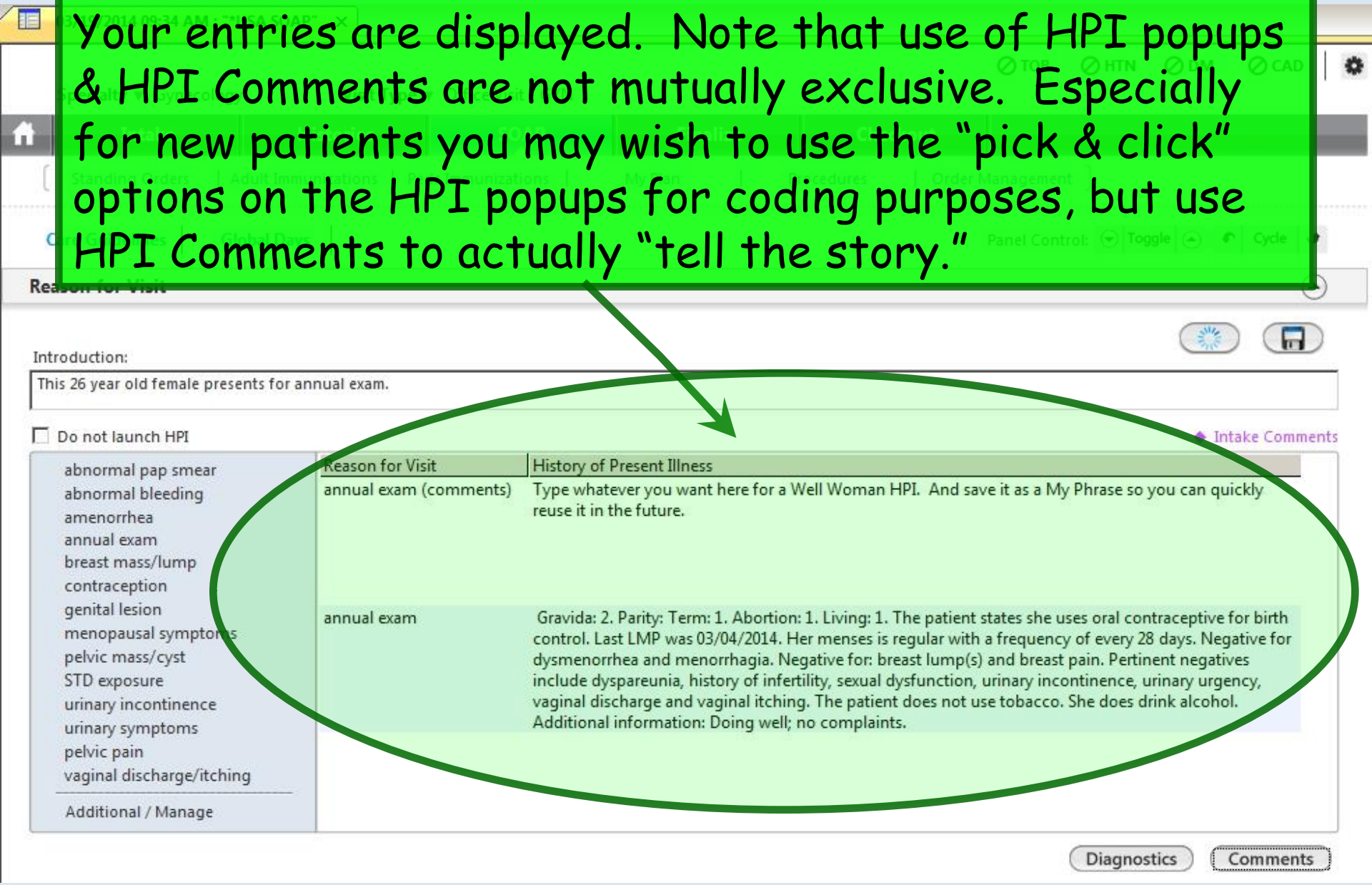
Comments about HPI Popups:

- 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.

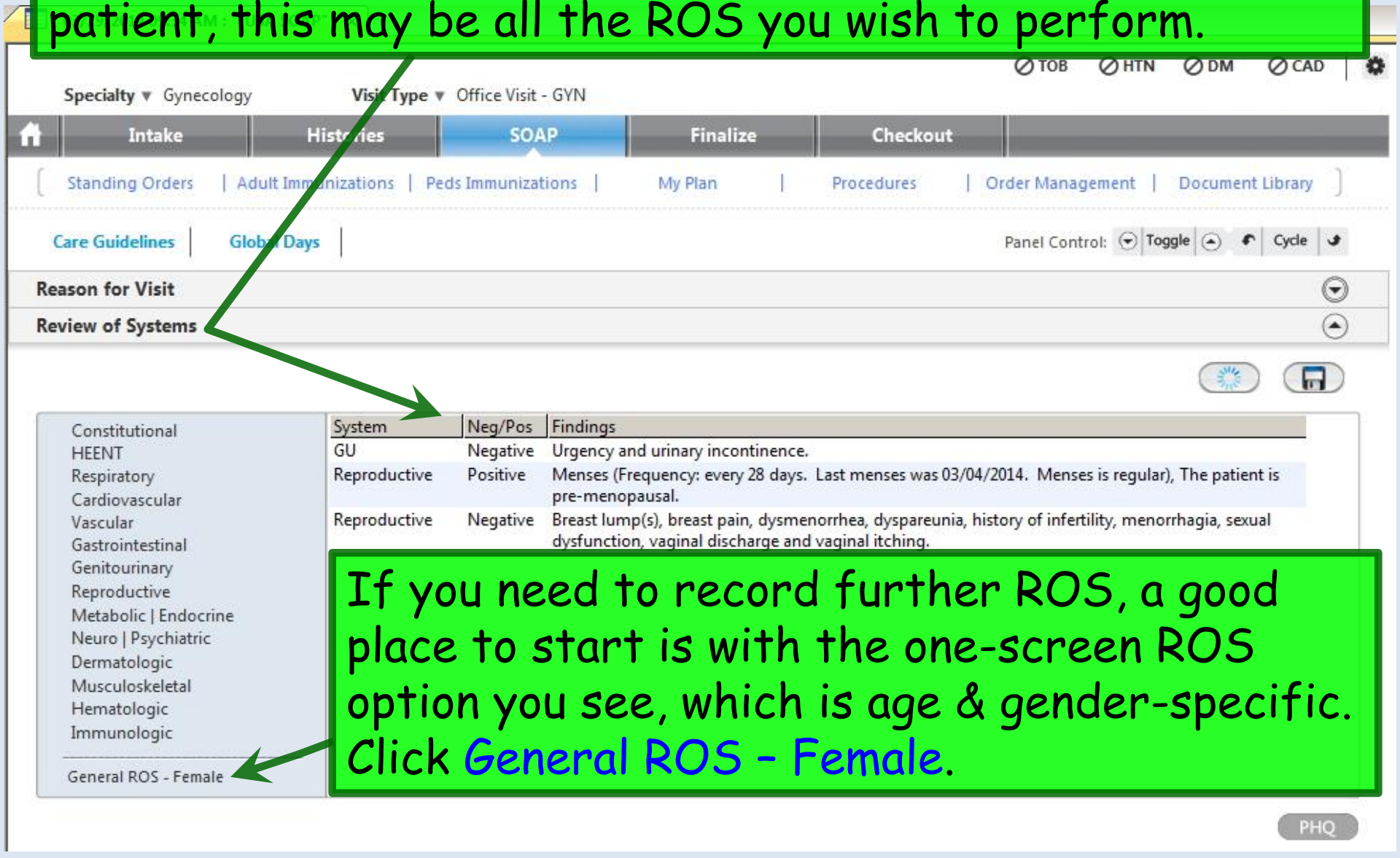

03/19/2014 09:34 AM : "*USA SOAP"
TOB
HTN
DM
CAD
Specialty ▼ Gynecology
Visit Type ▼ Office Visit - GYN
Intake
Histories
SOAP
Finalize
Checkout
Standing Orders | Adult Immunizations | Peds Immunizations | My Plan | Procedures | Order Management | Document Library
Care Guidelines | Global Days
Panel Control: Toggle Cycle
Reason for Visit
Introduction:
This 26 year old female presents for annual exam.
Do not launch HPI
Intake Comments
abnormal pap smear
abnormal bleeding
amenorrhea
annual exam
breast mass/lump
contraception
genital lesion
Additional / Manage
Reason for Visit
History of Present Illness
annual exam
Gravida: 2. Parity: Term: 1. Abortion: 1. Living: 1. The patient states she uses oral contraceptive for birth control. Last LMP was 03/04/2014. Her menses is regular with a frequency of every 28 days. Negative for dysmenorrhea and menorrhagia. Negative for: breast lump(s) and breast pain. Pertinent negatives include dyspareunia, history of infertility, sexual dysfunction, urinary incontinence, urinary urgency, vaginal discharge and vaginal itching. The patient does not use tobacco. She does drink alcohol. Additional information: Doing well; no complaints.
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
annual exam
My Phrases
1. Type whatever you want here for a Well Woman HPI. And save it as a My Phrase so you can quickly reuse it in the future.
2.
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.)
6.
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."

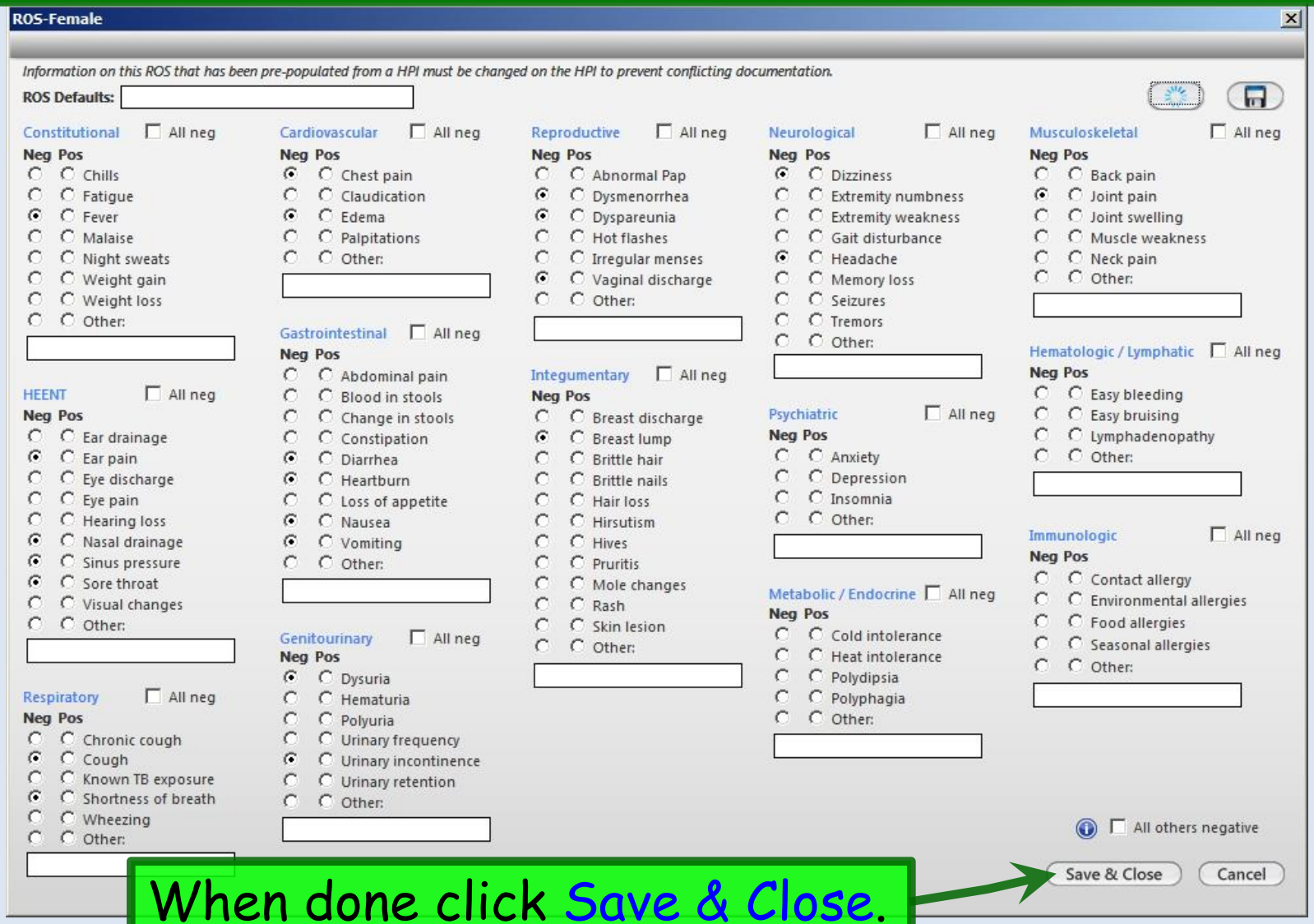


Working down the **SOAP tab**, you come to the **Review of Systems**. Note that some items that are shared with the HPI popups may already be documented. For an established patient, this may be all the ROS you wish to perform.

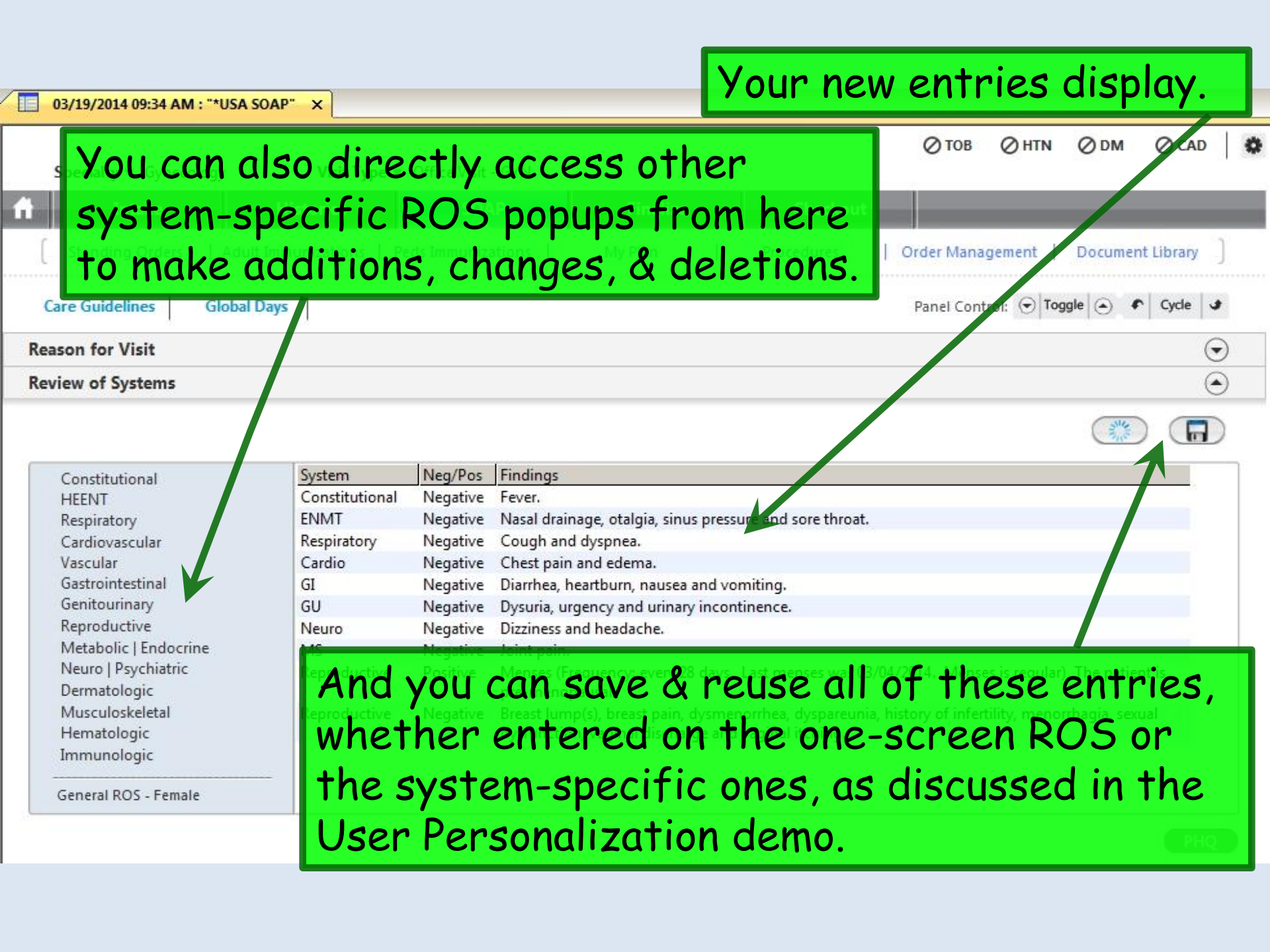


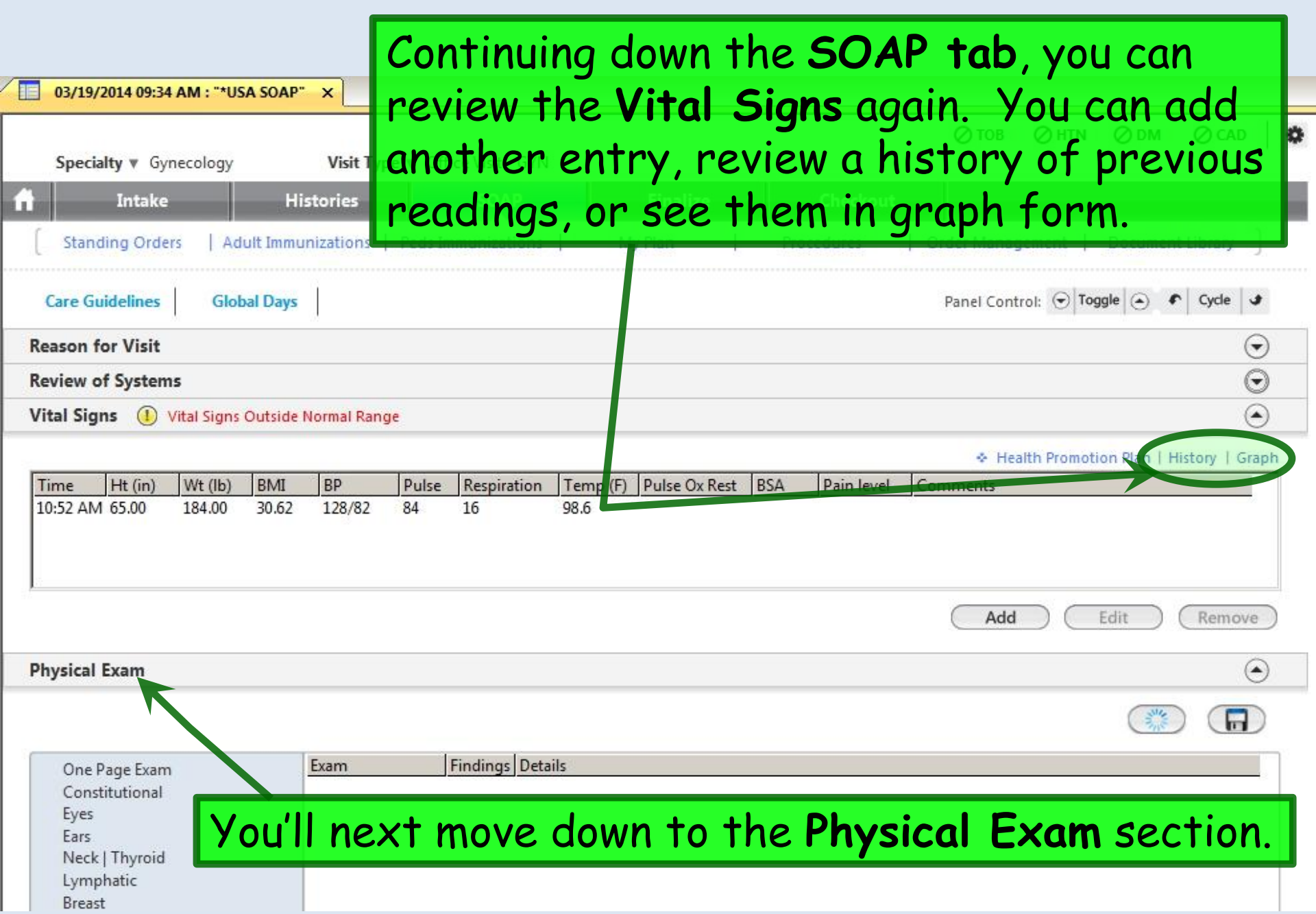
If you need to record further ROS, a good place to start is with the one-screen ROS option you see, which is age & gender-specific. Click General ROS - Female.

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.



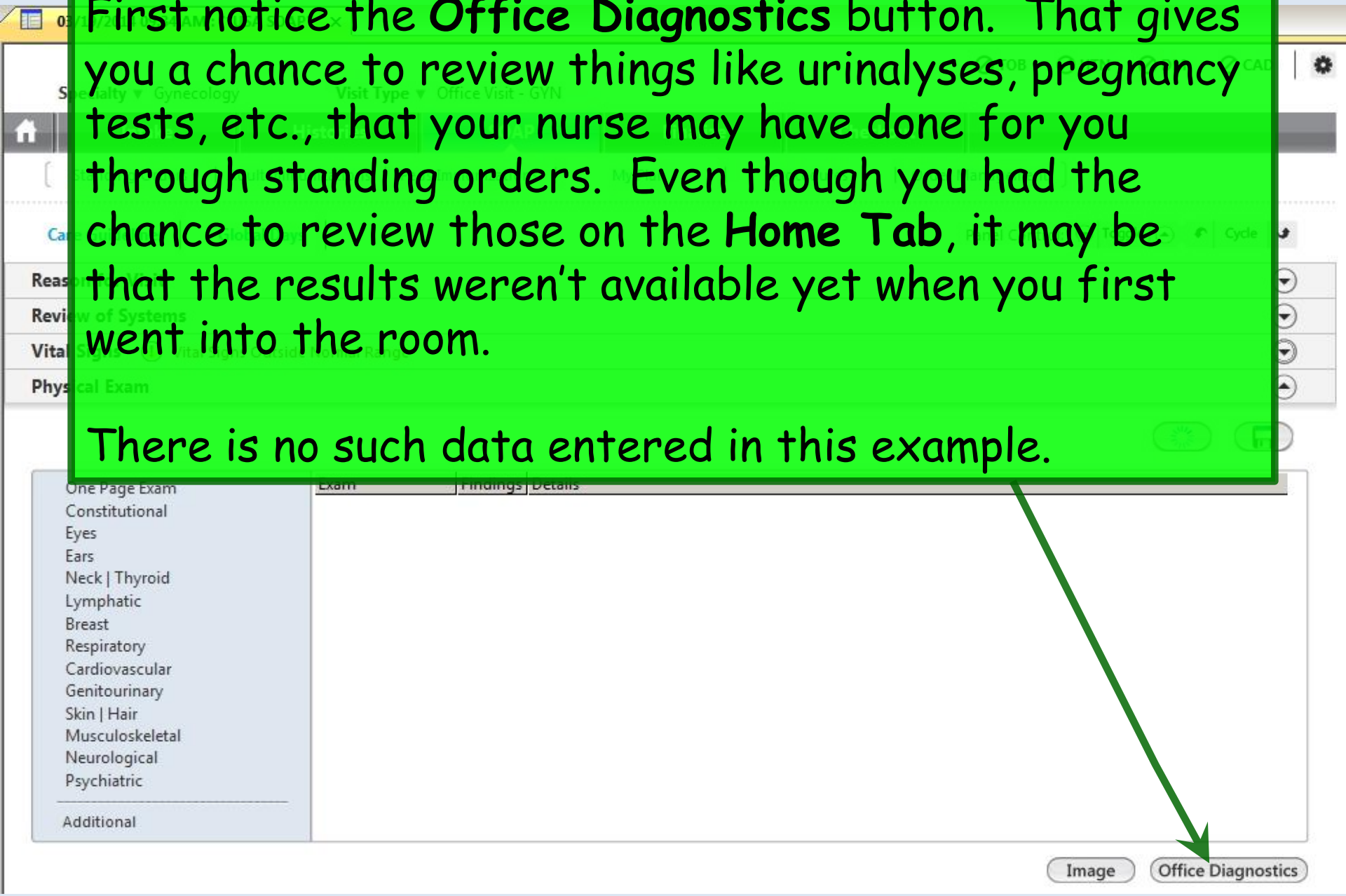
When done click Save & Close.

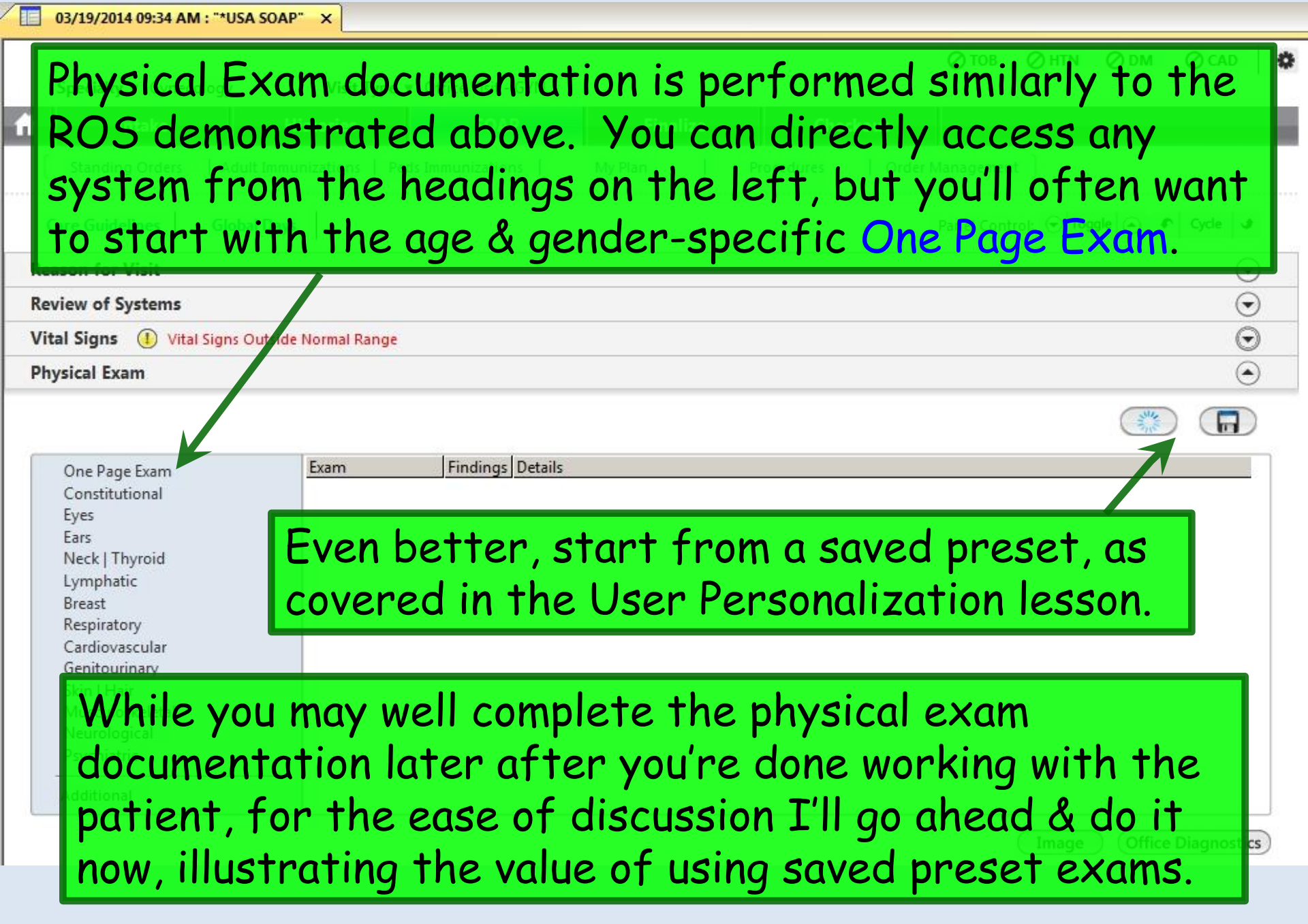

Your new entries display.
You can also directly access other system-specific ROS popups from here to make additions, changes, & deletions.
03/19/2014 09:34 AM : "*USA SOAP"
TOB
HTN
DM
CAD
Order Management
Document Library
Care Guidelines
Global Days
Panel Control:
Toggle
Cycle
Reason for Visit
Review of Systems
Constitutional
HEENT
Respiratory
Cardiovascular
Vascular
Gastrointestinal
Genitourinary
Reproductive
Metabolic | Endocrine
Neuro | Psychiatric
Dermatologic
Musculoskeletal
Hematologic
Immunologic
General ROS - Female
System
Neg/Pos
Findings
Constitutional
Negative
Fever.
ENMT
Negative
Nasal drainage, otalgia, sinus pressure and sore throat.
Respiratory
Negative
Cough and dyspnea.
Cardio
Negative
Chest pain and edema.
GI
Negative
Diarrhea, heartburn, nausea and vomiting.
GU
Negative
Dysuria, urgency and urinary incontinence.
Neuro
Negative
Dizziness and headache.
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.

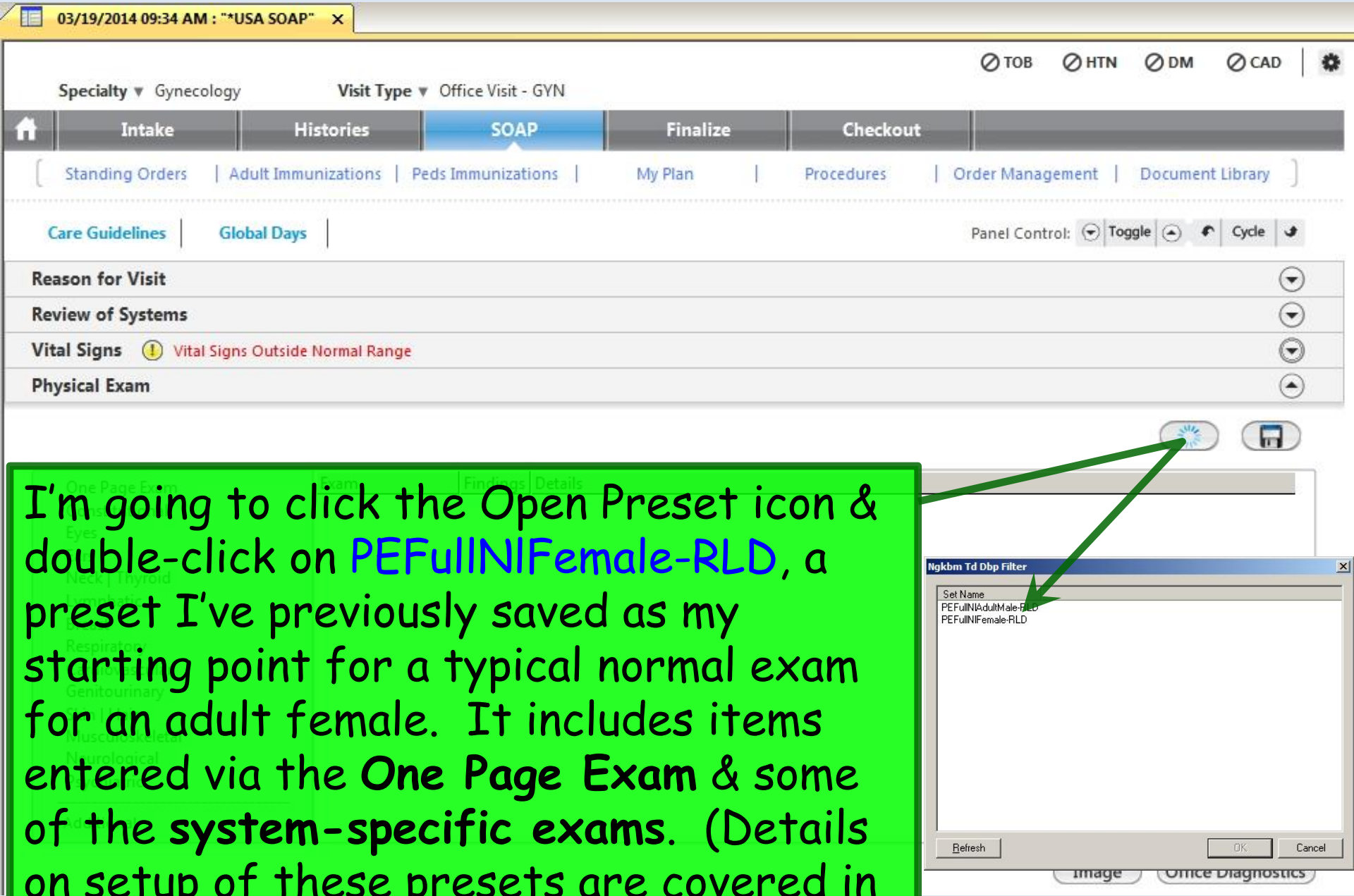

Continuing down the SOAP tab, you can review the Vital Signs again. You can add another entry, review a history of previous readings, or see them in graph form.
03/19/2014 09:34 AM : "*USA SOAP"
Specialty ▾ Gynecology
Intake
Histories
Standing Orders
Adult Immunizations
Care Guidelines
Global Days
Panel Control:
Toggle
Cycle
Reason for Visit
Review of Systems
Vital Signs
Vital Signs Outside Normal Range
Health Promotion Plan | History | Graph
Time | Ht (in) | Wt (lb) | BMI | BP | Pulse | Respiration | Temp (F) | Pulse Ox Rest | BSA | Pain level | Comments
10:52 AM | 65.00 | 184.00 | 30.62 | 128/82 | 84 | 16 | 98.6
Add
Edit
Remove
Physical Exam
One Page Exam
Constitutional
Eyes
Ears
Neck | Thyroid
Lymphatic
Breast
Exam
Findings
Details
You'll next move down to the Physical Exam section.

First notice the **Office Diagnostics** button. That gives you a chance to review things like urinalyses, pregnancy tests, etc., that your nurse may have done for you through standing orders. Even though you had the chance to review those on the **Home Tab**, it may be that the results weren't available yet when you first went into the room.

There is no such data entered in this example.

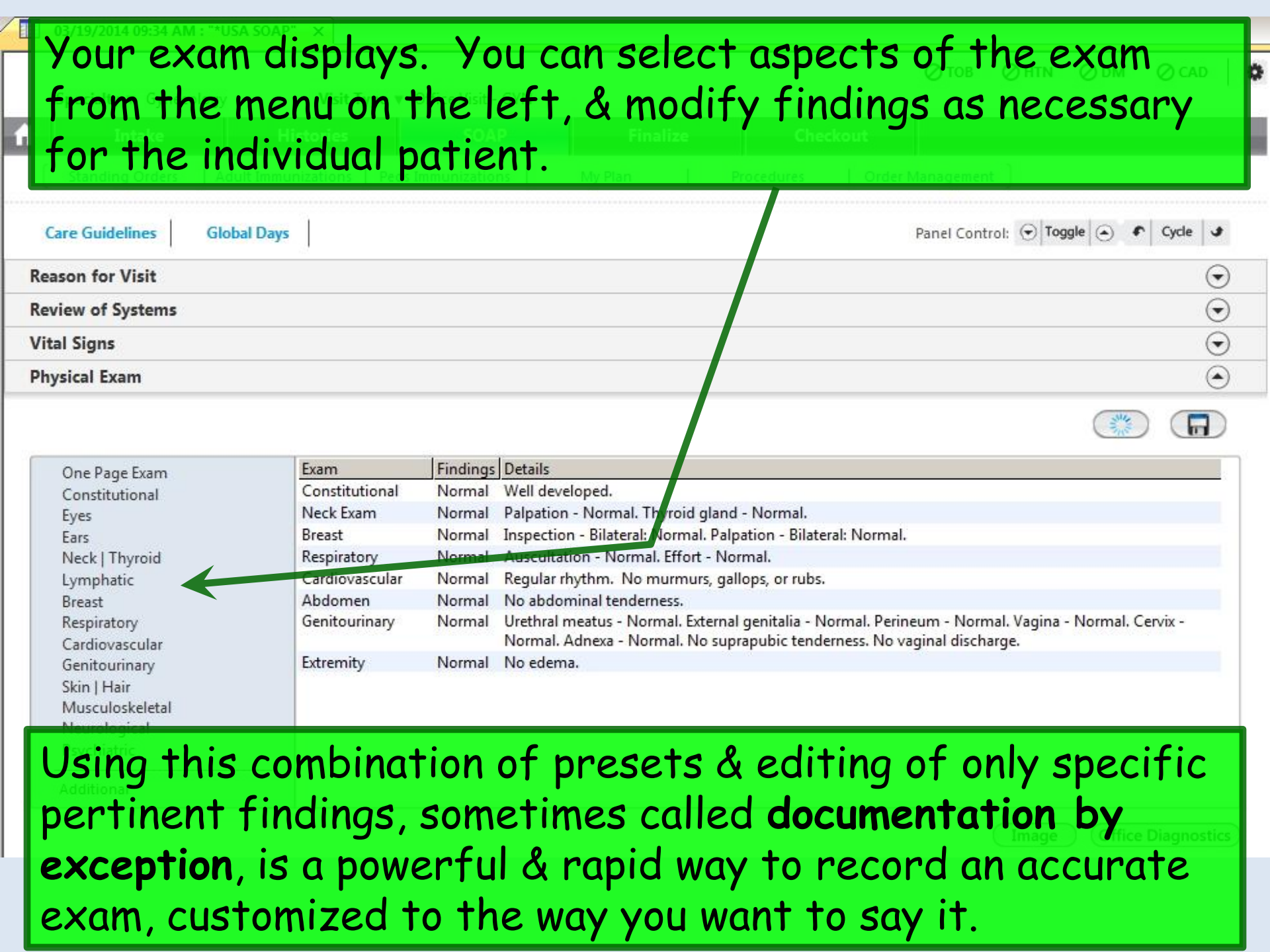



03/19/2014 09:34 AM : "*USA SOAP"
Physical Exam documentation is performed similarly to the ROS demonstrated above. You can directly access any system from the headings on the left, but you'll often want to start with the age & gender-specific One Page Exam.
Review of Systems
Vital Signs
Vital Signs Outside Normal Range
Physical Exam
One Page Exam
Constitutional
Eyes
Ears
Neck | Thyroid
Lymphatic
Breast
Respiratory
Cardiovascular
Genitourinary
Exam
Findings
Details
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.

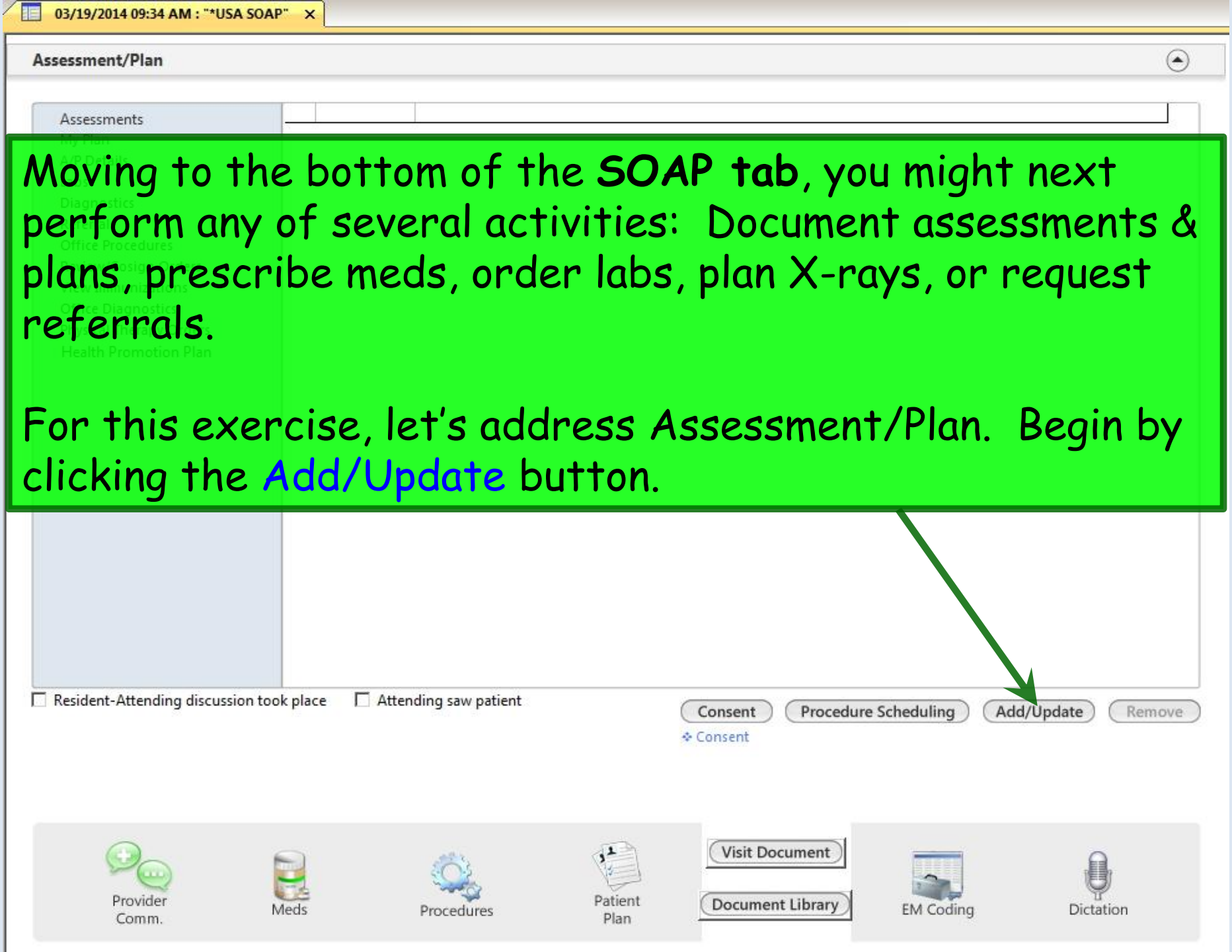


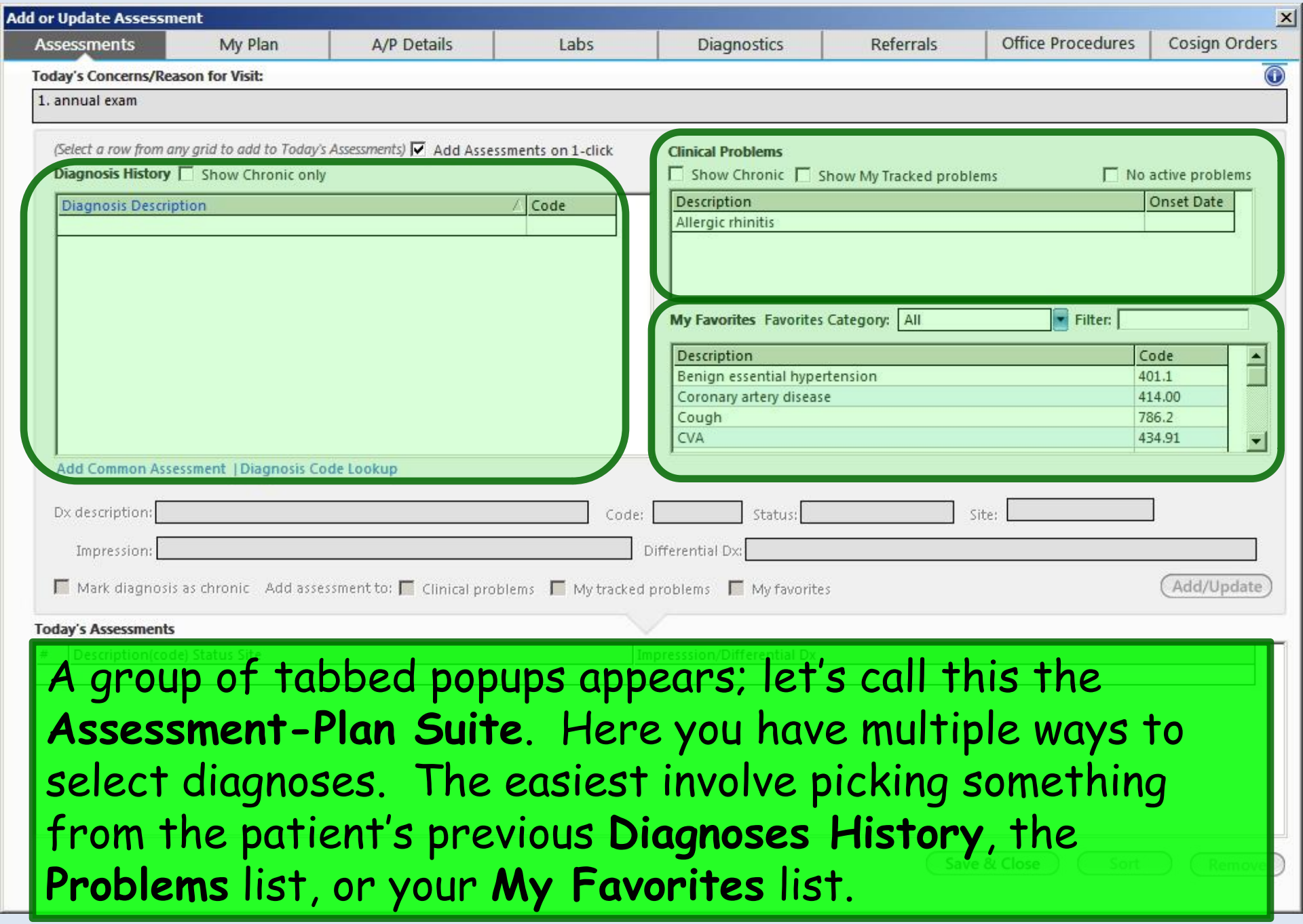
I'm going to click the Open Preset icon & double-click on PEFullNIFemale-RLD, a preset I've previously saved as my starting point for a typical normal exam for an adult female. It includes items entered via the **One Page Exam** & some of the **system-specific exams**. (Details on setup of these presets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

Your exam displays. You can select aspects of the exam from the menu on the left, & modify findings as necessary for the individual patient.

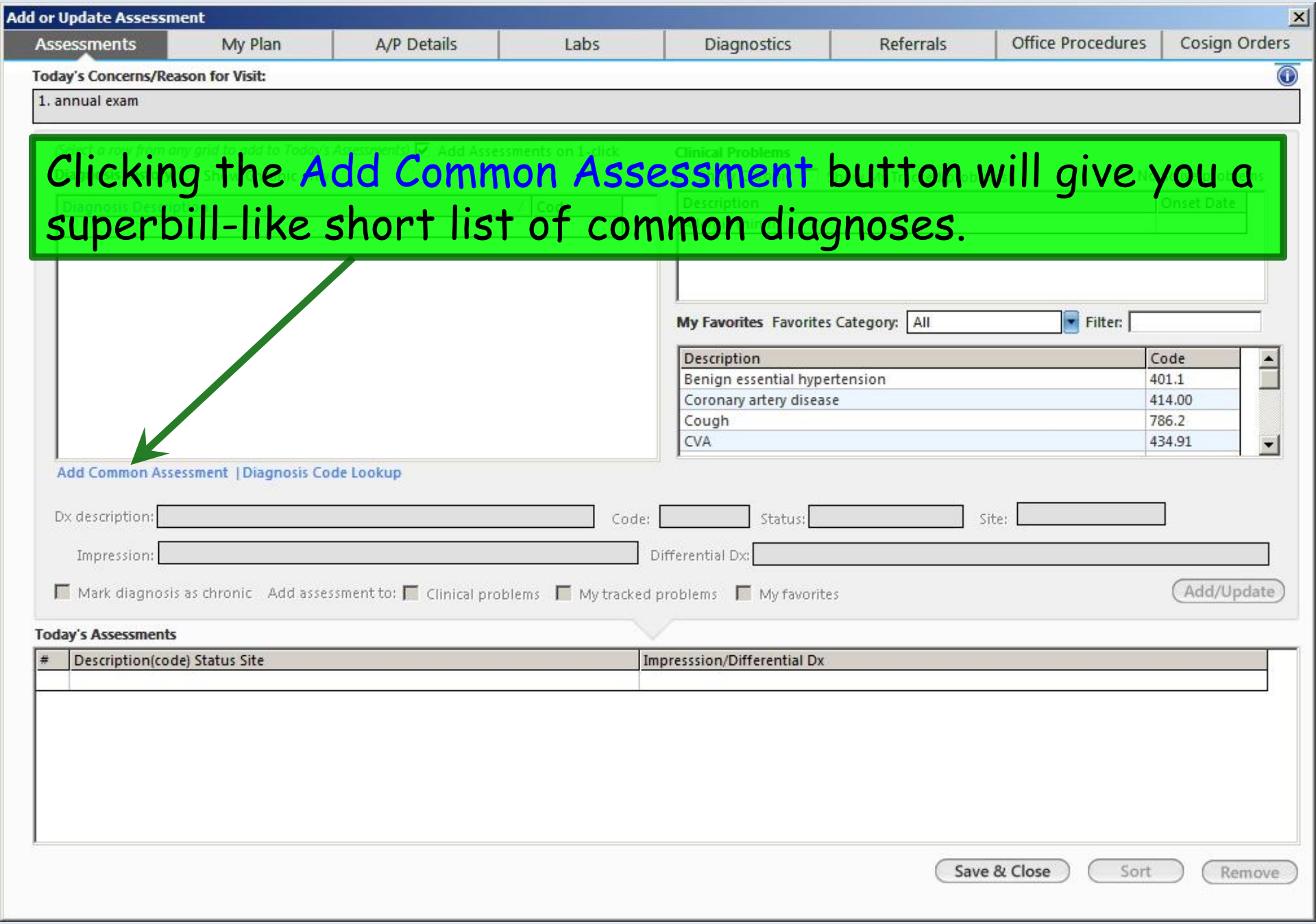


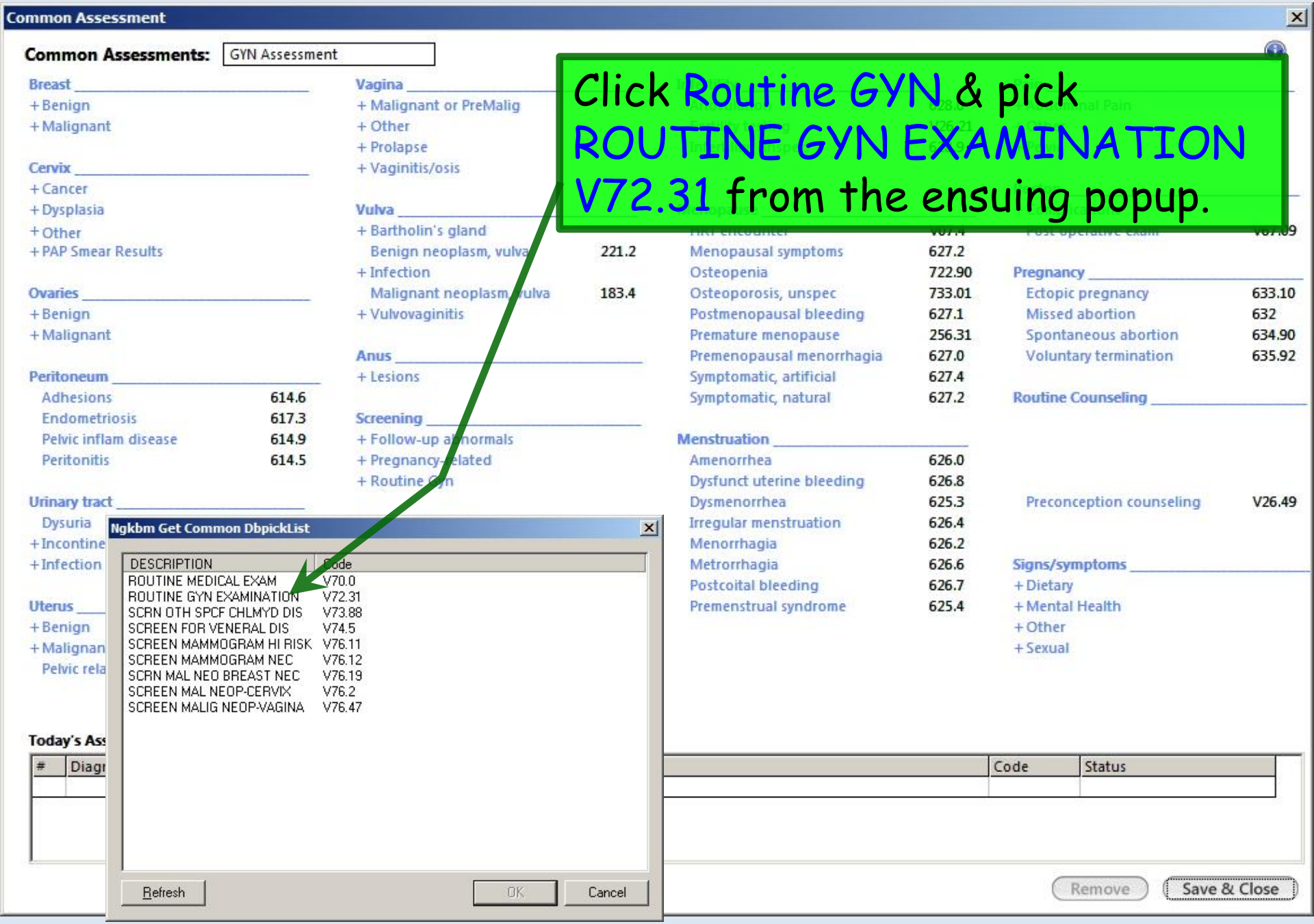
Using this combination of presets & editing of only specific pertinent findings, sometimes called **documentation by exception**, is a powerful & rapid way to record an accurate exam, customized to the way you want to say it.

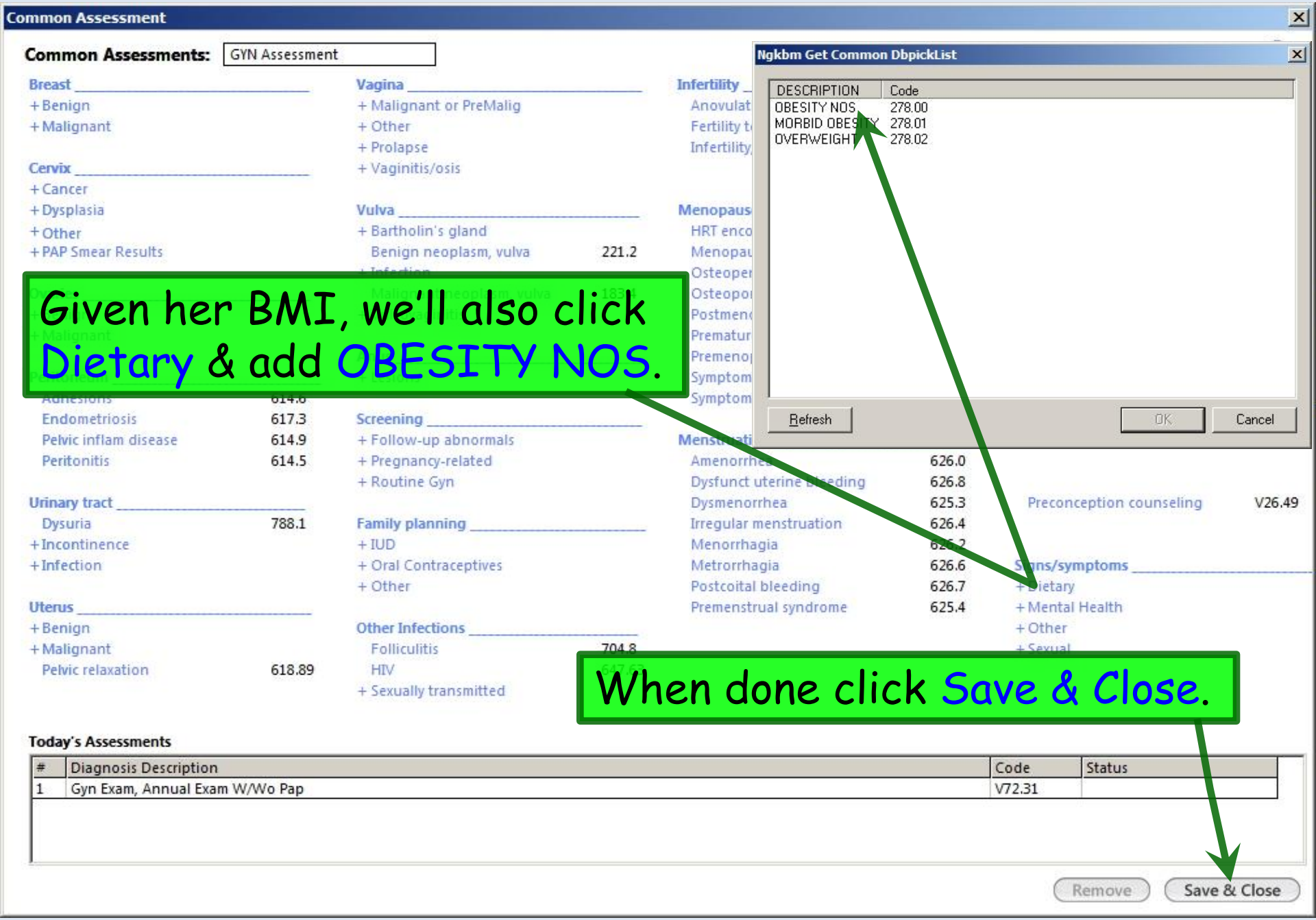

03/19/2014 09:34 AM : "*USA SOAP"
Assessment/Plan
Assessments
Moving to the bottom of the **SOAP tab**, you might next perform any of several activities: Document assessments & plans, prescribe meds, order labs, plan X-rays, or request referrals.
For this exercise, let's address Assessment/Plan. Begin 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

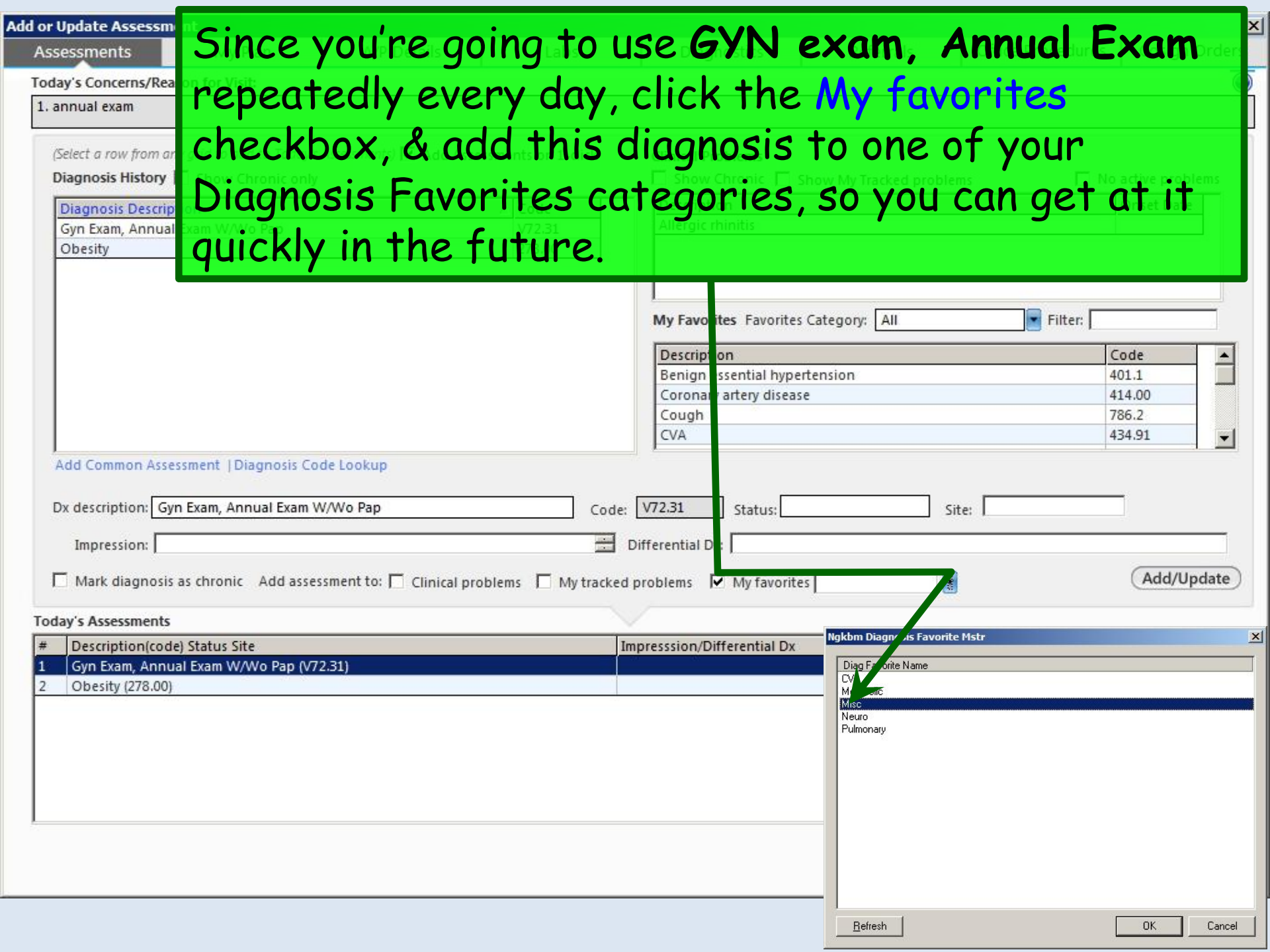


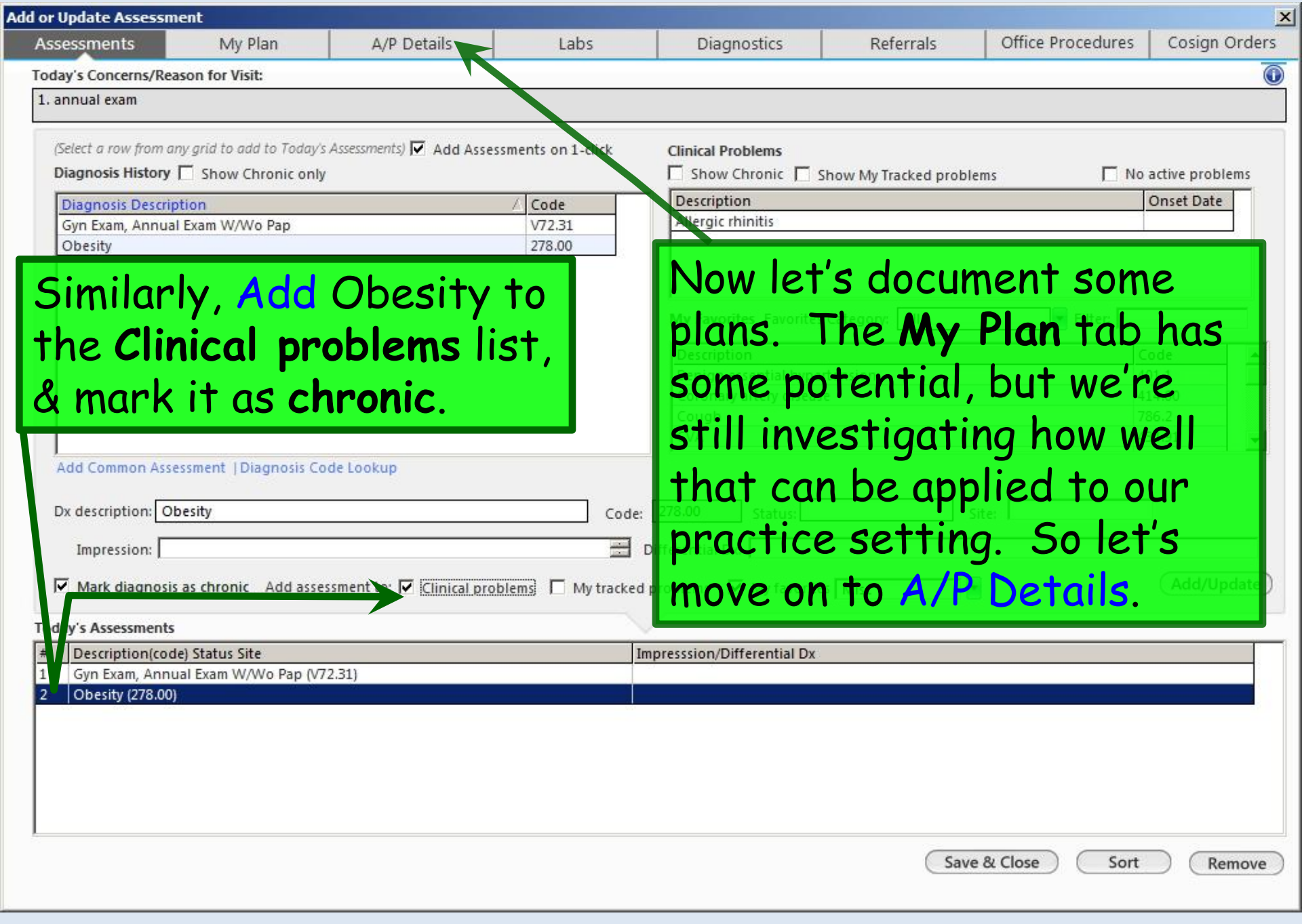
A group of tabbed popups appears; let's call this the **Assessment-Plan Suite**. Here you have multiple ways to select diagnoses. The easiest involve picking something from the patient's previous **Diagnoses History**, the **Problems** list, or your **My Favorites** list.

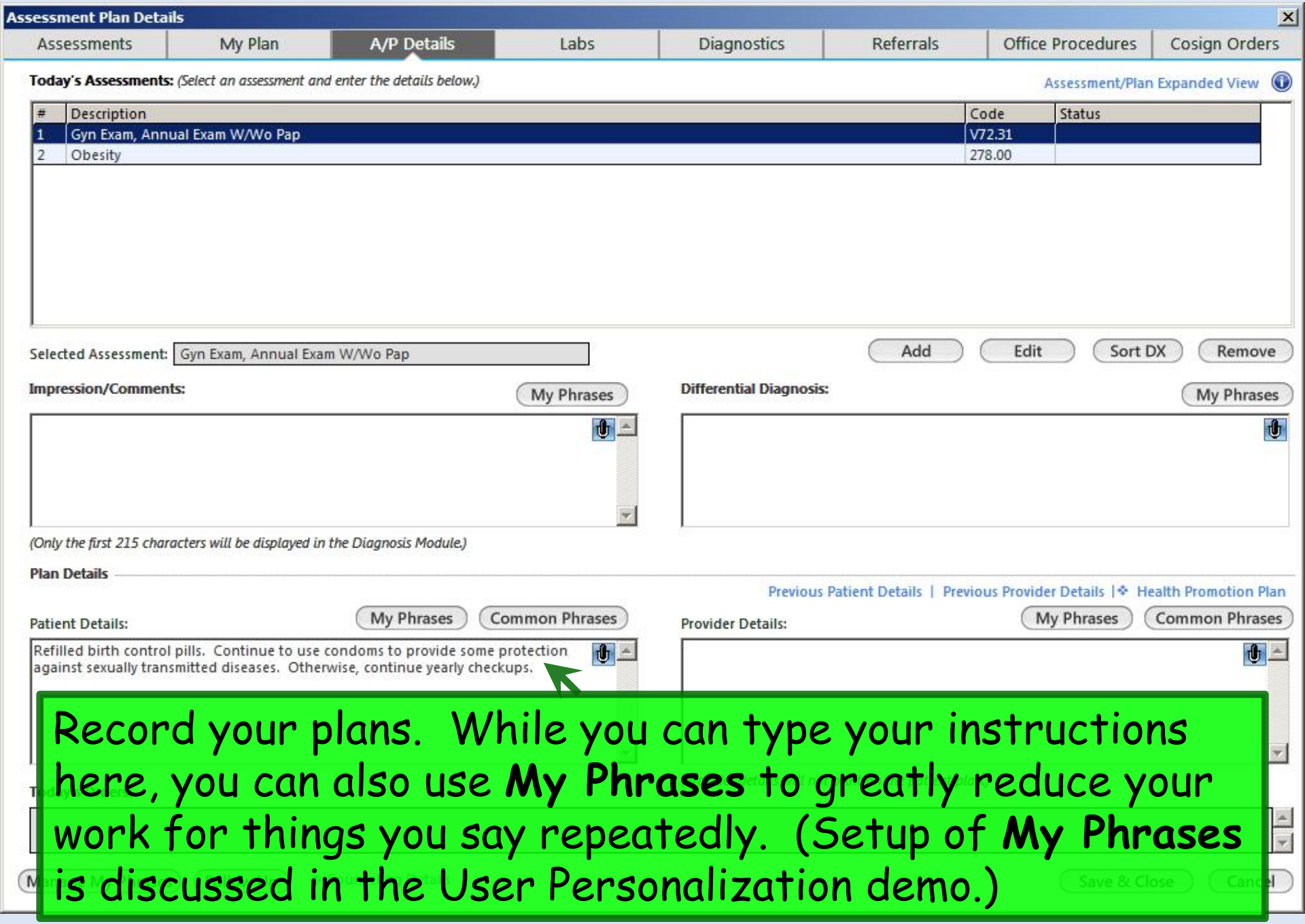

Add or Update Assessment
Assessments
My Plan
A/P Details
Labs
Diagnostics
Referrals
Office Procedures
Cosign Orders
Today's Concerns/Reason for Visit:
1. annual exam
Clicking the Add Common Assessment button will give you a superbill-like short list of common diagnoses.
Clinical Problems
Description
Onset Date
My Favorites
Favorites Category:
All
Filter:
Description
Code
Benign essential hypertension
401.1
Coronary artery disease
414.00
Cough
786.2
CVA
434.91
Add Common Assessment | Diagnosis Code Lookup
Dx description:
Code:
Status:
Site:
Impression:
Differential Dx:
Mark diagnosis as chronic
Add assessment to:
Clinical problems
My tracked problems
My favorites
Add/Update
Today's Assessments
#
Description(code) Status Site
Impresssion/Differential Dx
Save & Close
Sort
Remove

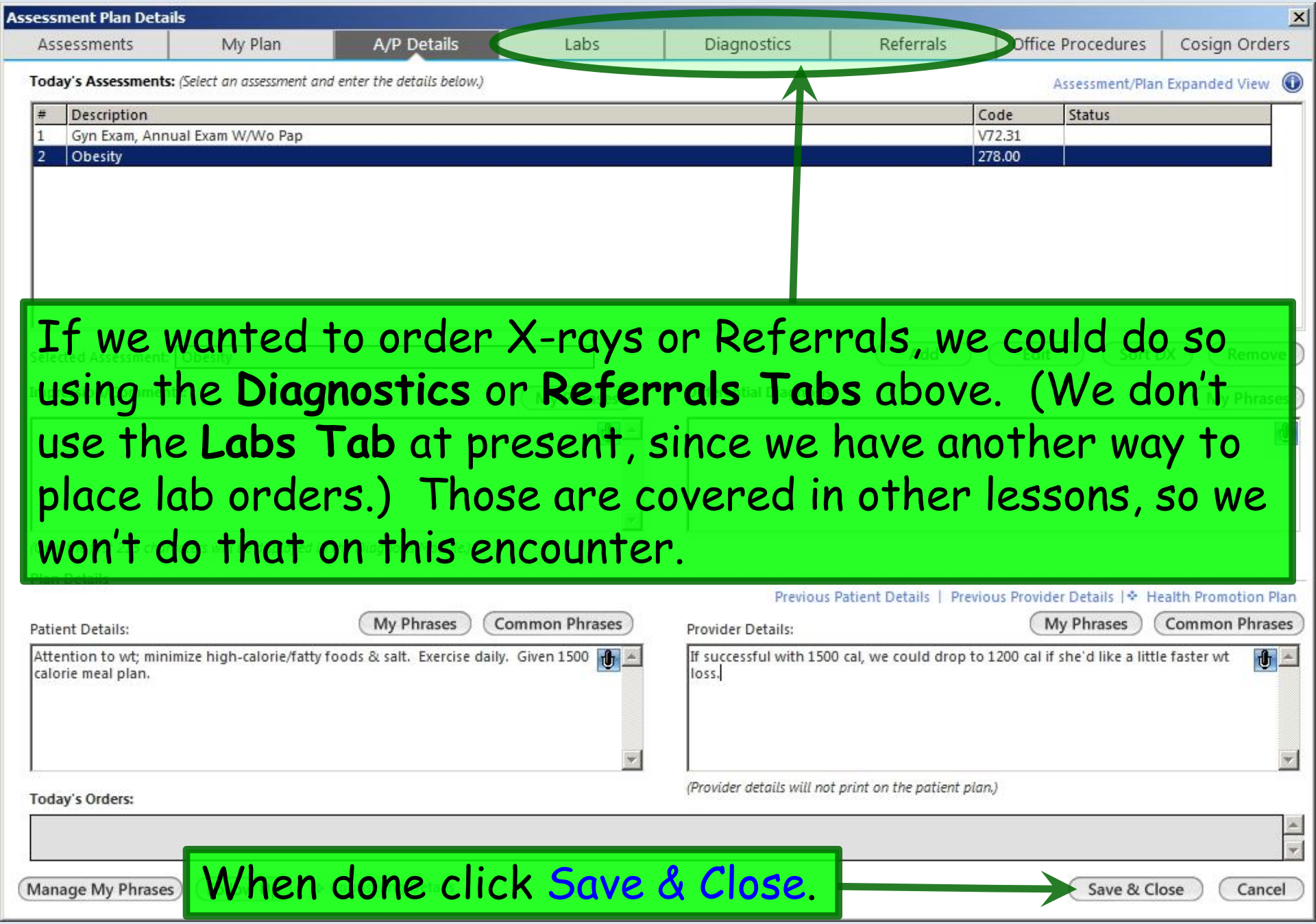

Common Assessment
Common Assessments: GYN Assessment
Breast
+ Benign
+ Malignant
Cervix
+ Cancer
+ Dysplasia
+ Other
+ PAP Smear Results
Ovaries
+ Benign
+ Malignant
Peritoneum
Adhesions 614.6
Endometriosis 617.3
Pelvic inflam disease 614.9
Peritonitis 614.5
Urinary tract
Dysuria
+ Incontine
+ Infection
Uterus
+ Benign
+ Malignan
Pelvic rela
Vagina
+ Malignant or PreMalig
+ Other
+ Prolapse
+ Vaginitis/osis
Vulva
+ Bartholin's gland
Benign neoplasm, vulva 221.2
+ Infection
Malignant neoplasm, vulva 183.4
+ Vulvovaginitis
Anus
+ Lesions
Screening
+ Follow-up abnormals
+ Pregnancy-related
+ Routine Gyn
Menopausal symptoms 627.2
Osteopenia 722.90
Osteoporosis, unspec 733.01
Postmenopausal bleeding 627.1
Premature menopause 256.31
Premenopausal menorrhagia 627.0
Symptomatic, artificial 627.4
Symptomatic, natural 627.2
Menstruation
Amenorrhea 626.0
Dysfunct uterine bleeding 626.8
Dysmenorrhea 625.3
Irregular menstruation 626.4
Menorrhagia 626.2
Metrorrhagia 626.6
Postcoital bleeding 626.7
Premenstrual syndrome 625.4
Pregnancy
Ectopic pregnancy 633.10
Missed abortion 632
Spontaneous abortion 634.90
Voluntary termination 635.92
Routine Counseling
Preconception counseling V26.49
Signs/symptoms
+ Dietary
+ Mental Health
+ Other
+ Sexual
Today's Ass
Diagr
Code
Status
Remove
Save & Close
Ngkbm Get Common DbpickList
DESCRIPTION Code
ROUTINE MEDICAL EXAM V70.0
ROUTINE GYN EXAMINATION V72.31
SCRN OTH SPCF CHLMYD DIS V73.88
SCREEN FOR VENERAL DIS V74.5
SCREEN MAMMOGRAM HI RISK V76.11
SCREEN MAMMOGRAM NEC V76.12
SCRN MAL NEO BREAST NEC V76.19
SCREEN MAL NEOP-CERVIX V76.2
SCREEN MALIG NEOP-VAGINA V76.47
Refresh
OK
Cancel
Click Routine GYN & pick ROUTINE GYN EXAMINATION V72.31 from the ensuing popup.

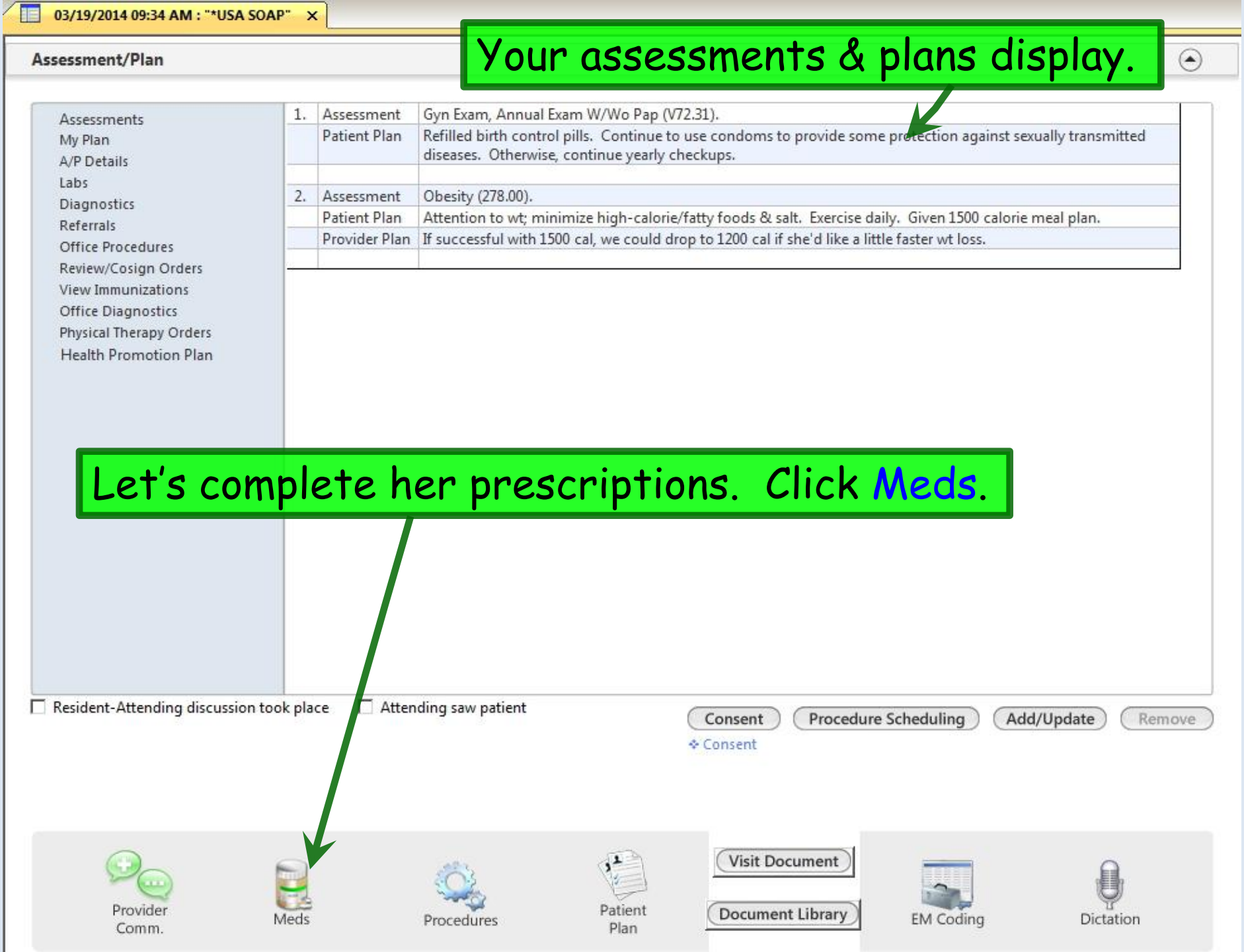

Common Assessment
Common Assessments: GYN Assessment
Breast
+ Benign
+ Malignant
Cervix
+ Cancer
+ Dysplasia
+ Other
+ PAP Smear Results
Vagina
+ Malignant or PreMalig
+ Other
+ Prolapse
+ Vaginitis/osis
Vulva
+ Bartholin's gland
Benign neoplasm, vulva 221.2
Infertility
Anovulat
Fertility t
Infertility
Menopaus
HRT enco
Menopau
Osteoper
Osteopor
Postmen
Prematur
Premenop
Symptom
Symptom
Endometriosis 617.3
Pelvic inflam disease 614.9
Peritonitis 614.5
Screening
+ Follow-up abnormals
+ Pregnancy-related
+ Routine Gyn
Urinary tract
Dysuria 788.1
+ Incontinence
+ Infection
Family planning
+ IUD
+ Oral Contraceptives
+ Other
Uterus
+ Benign
+ Malignant
Pelvic relaxation 618.89
Other Infections
Folliculitis 704.8
HIV
+ Sexually transmitted
Amenorrhea 626.0
Dysfunct uterine bleeding 626.8
Dysmenorrhea 625.3
Irregular menstruation 626.4
Menorrhagia
Metrorrhagia 626.6
Postcoital bleeding 626.7
Premenstrual syndrome 625.4
Preconception counseling V26.49
Signs/symptoms
+ Dietary
+ Mental Health
+ Other
+ Sexual
Ngkbm Get Common DbpickList
DESCRIPTION Code
OBESITY NOS 278.00
MORBID OBESITY 278.01
OVERWEIGHT 278.02
Refresh
OK
Cancel
Given her BMI, we'll also click Dietary & add OBESITY NOS.
When done click Save & Close.
Today's Assessments
Diagnosis Description Code Status
1 Gyn Exam, Annual Exam W/Wo Pap V72.31
Remove
Save & Close

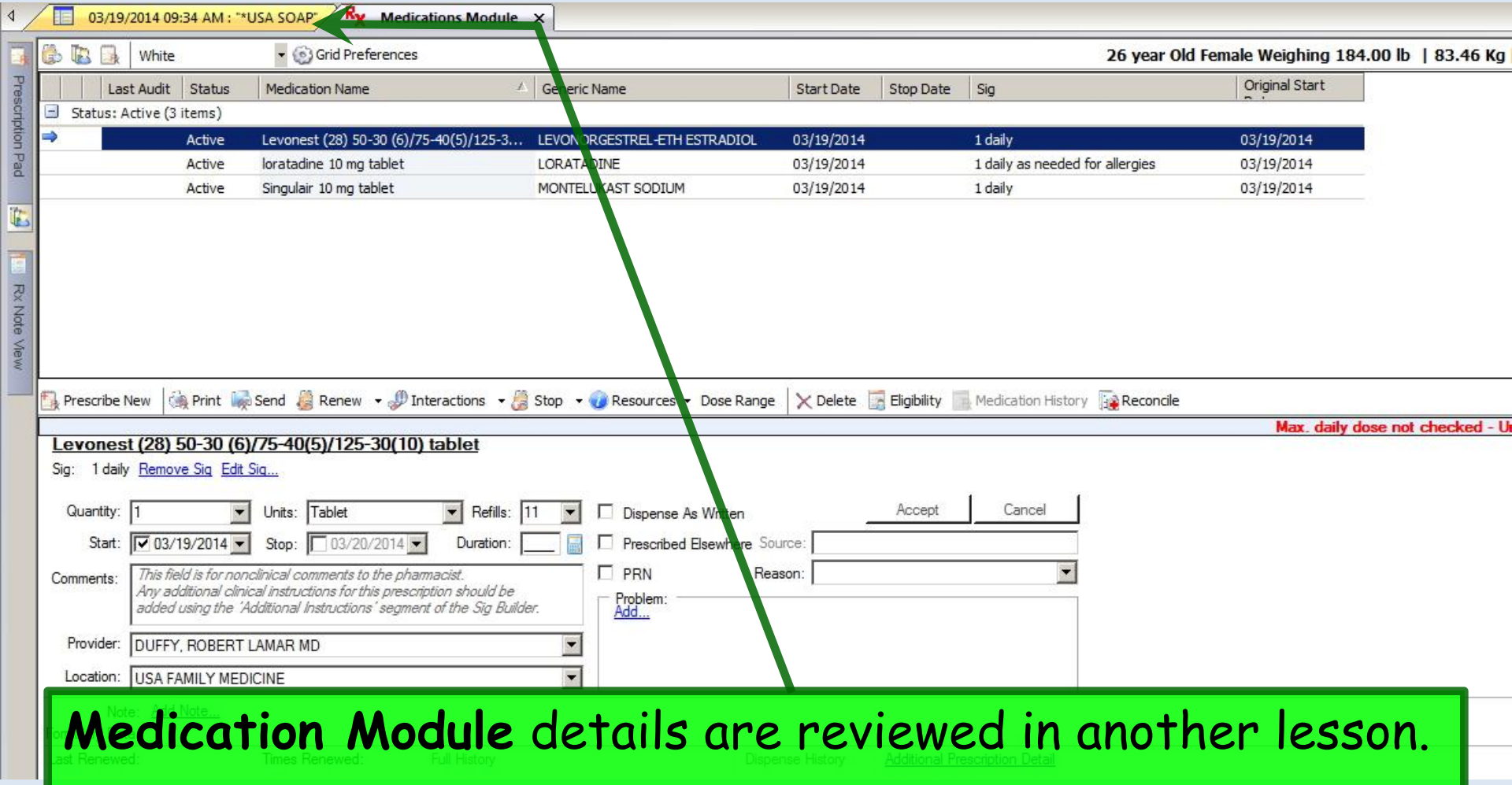

Since you're going to use GYN exam, Annual Exam repeatedly every day, click the My favorites checkbox, & add this diagnosis to one of your Diagnosis Favorites categories, so you can get at it quickly in the future.
Add or Update Assessm
Assessments
Today's Concerns/Rea
1. annual exam
Diagnosis History
Diagnosis Descrip
Gyn Exam, Annual
Obesity
My Favorites Favorites Category: All
Filter:
Description
Code
Benign essential hypertension
401.1
Coronary artery disease
414.00
Cough
786.2
CVA
434.91
Add Common Assessment | Diagnosis Code Lookup
Dx description: Gyn Exam, Annual Exam W/Wo Pap
Code: V72.31
Status:
Site:
Impression:
Differential Dx:
Mark diagnosis as chronic
Add assessment to:
Clinical problems
My tracked problems
My favorites
Add/Update
Today's Assessments
#
Description(code) Status Site
Impresssion/Differential Dx
1
Gyn Exam, Annual Exam W/Wo Pap (V72.31)
2
Obesity (278.00)
Ngkbm Diagnosis Favorite Mstr
Diag Favorite Name
CV
Misc
Neuro
Pulmonary
Refresh
OK
Cancel


Add or Update Assessment
Assessments
My Plan
A/P Details
Labs
Diagnostics
Referrals
Office Procedures
Cosign Orders
Today's Concerns/Reason for Visit:
1. annual exam
(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
Gyn Exam, Annual Exam W/Wo Pap
V72.31
Obesity
278.00
Clinical Problems
Show Chronic
Show My Tracked problems
No active problems
Description
Onset Date
Allergic rhinitis
Add Common Assessment
Diagnosis Code Lookup
Dx description:
Obesity
Code:
Impression:
Mark diagnosis as chronic
Add assessment to:
Clinical problems
My tracked
Today's Assessments
#
Description(code) Status Site
Impresssion/Differential Dx
1
Gyn Exam, Annual Exam W/Wo Pap (V72.31)
2
Obesity (278.00)
Save & Close
Sort
Remove
Similarly, Add Obesity to the Clinical problems list, & mark it as chronic.
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 Gyn Exam, Annual Exam W/Wo Pap V72.31
2 Obesity 278.00
Selected Assessment: Gyn Exam, Annual Exam W/Wo Pap
Add
Edit
Sort DX
Remove
Impression/Comments:
My Phrases
Differential Diagnosis:
My Phrases
(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
Refilled birth control pills. Continue to use condoms to provide some protection against sexually transmitted diseases. Otherwise, continue yearly checkups.
Provider Details:
My Phrases
Common Phrases
Record your plans. While you can type your instructions here, you can also use My Phrases to greatly reduce your work for things you say repeatedly. (Setup of My Phrases is discussed in the User Personalization demo.)

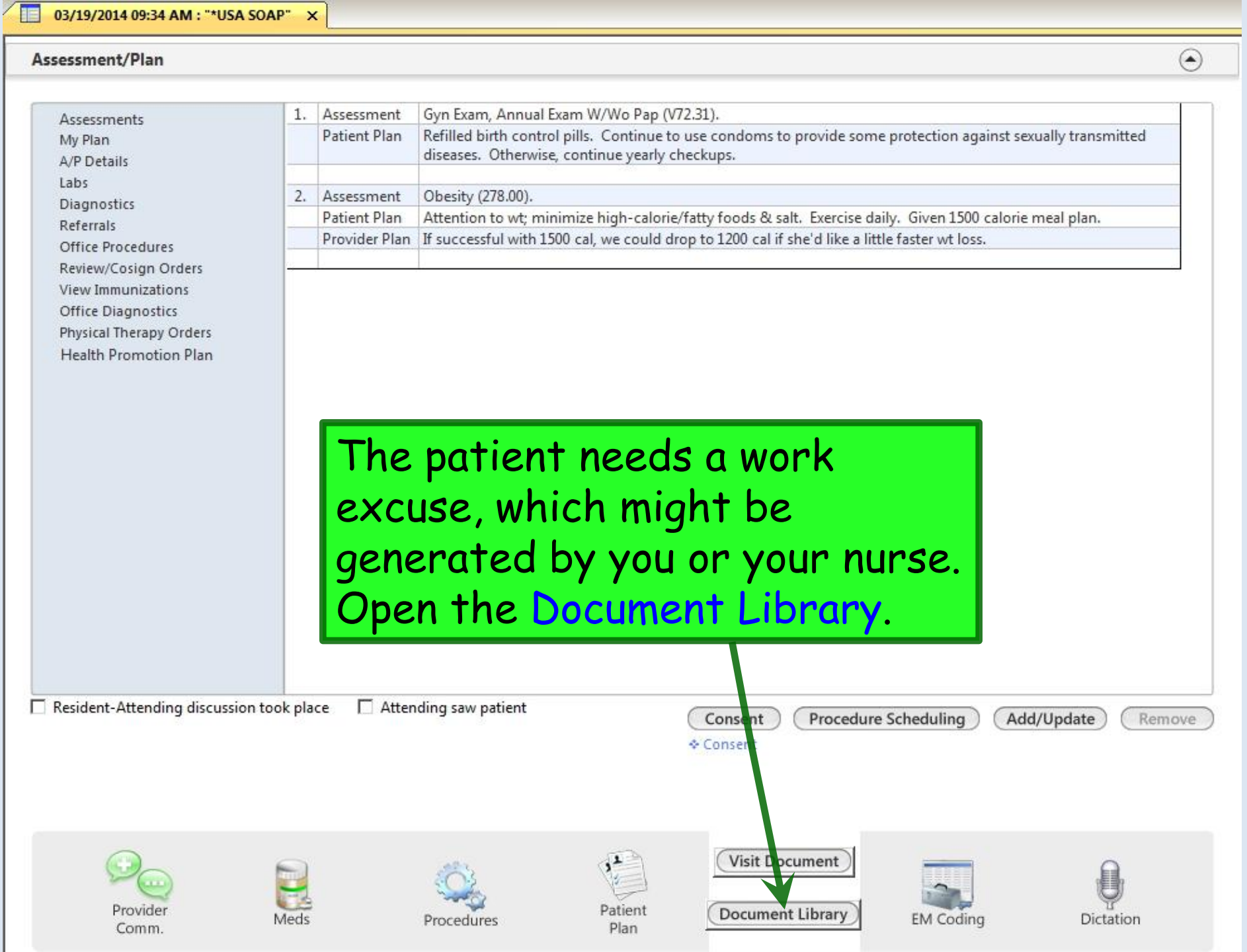

Assessment Plan Details
Assessments
My Plan
A/P Details
Labs
Diagnostics
Referrals
Office Procedures
Cosign Orders
Today's Assessments: (Select an assessment and enter the details below.)
Assessment/Plan Expanded View
Description Code Status
1 Gyn Exam, Annual Exam W/Wo Pap V72.31
2 Obesity 278.00
If 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.
Previous Patient Details | Previous Provider Details | Health Promotion Plan
Patient Details:
My Phrases
Common Phrases
Attention to wt; minimize high-calorie/fatty foods & salt. Exercise daily. Given 1500 calorie meal plan.
Provider Details:
My Phrases
Common Phrases
If successful with 1500 cal, we could drop to 1200 cal if she'd like a little faster wt loss.
(Provider details will not print on the patient plan.)
Today's Orders:
Manage My Phrases
When done click Save & Close.
Save & Close
Cancel


03/19/2014 09:34 AM : "*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 Gyn Exam, Annual Exam W/Wo Pap (V72.31).
Patient Plan Refilled birth control pills. Continue to use condoms to provide some protection against sexually transmitted diseases. Otherwise, continue yearly checkups.
2. Assessment Obesity (278.00).
Patient Plan Attention to wt; minimize high-calorie/fatty foods & salt. Exercise daily. Given 1500 calorie meal plan.
Provider Plan If successful with 1500 cal, we could drop to 1200 cal if she'd like a little faster wt loss.
Let's complete her prescriptions. Click Meds.
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

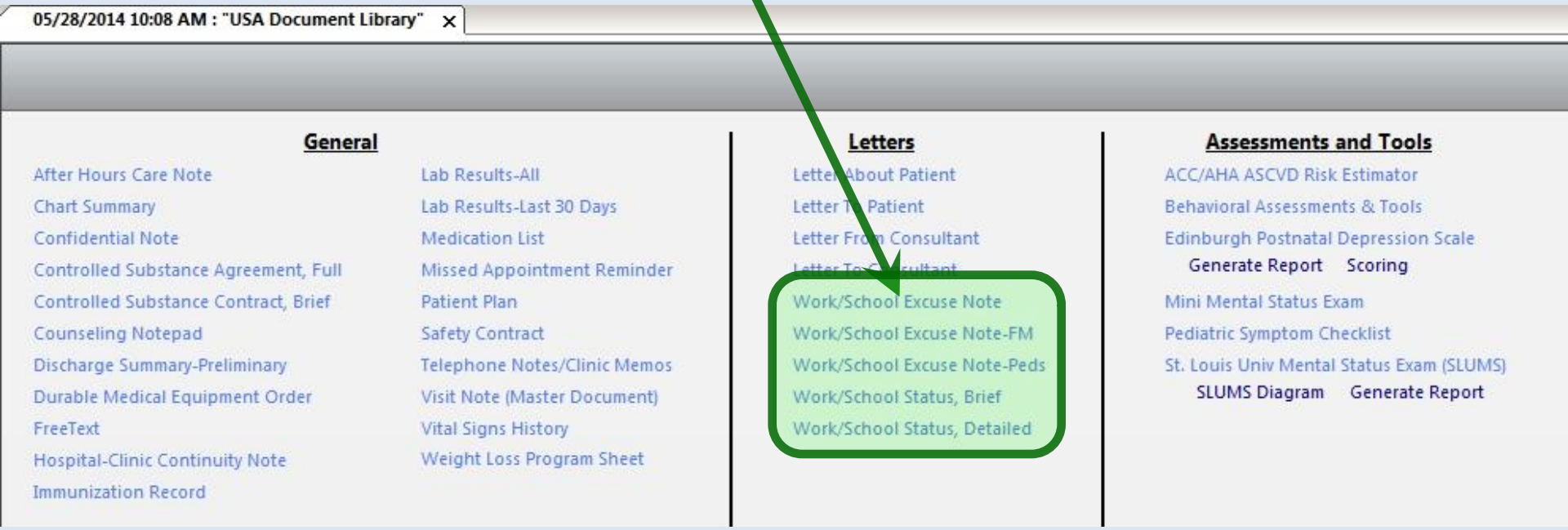


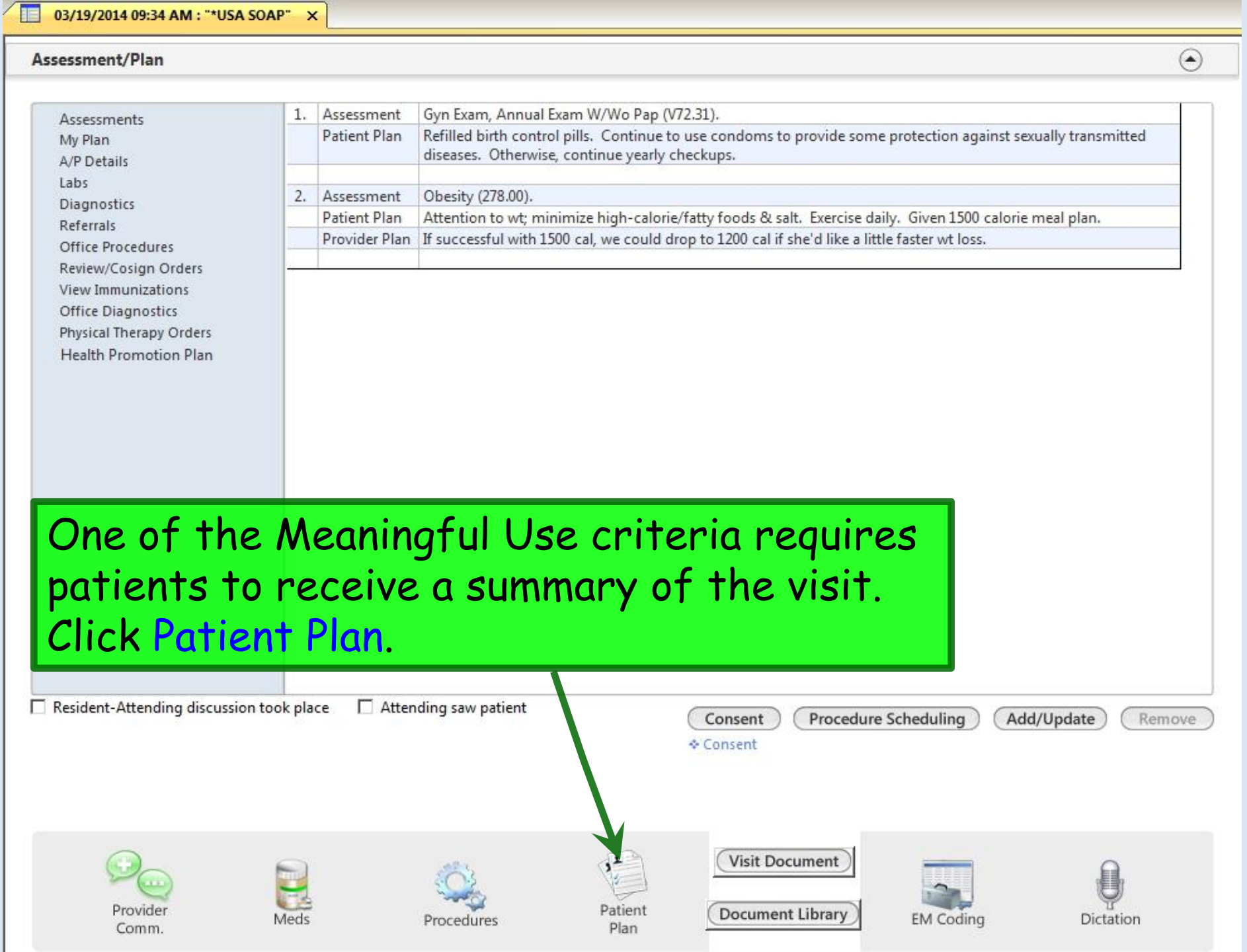
Medication Module details are reviewed in another lesson.

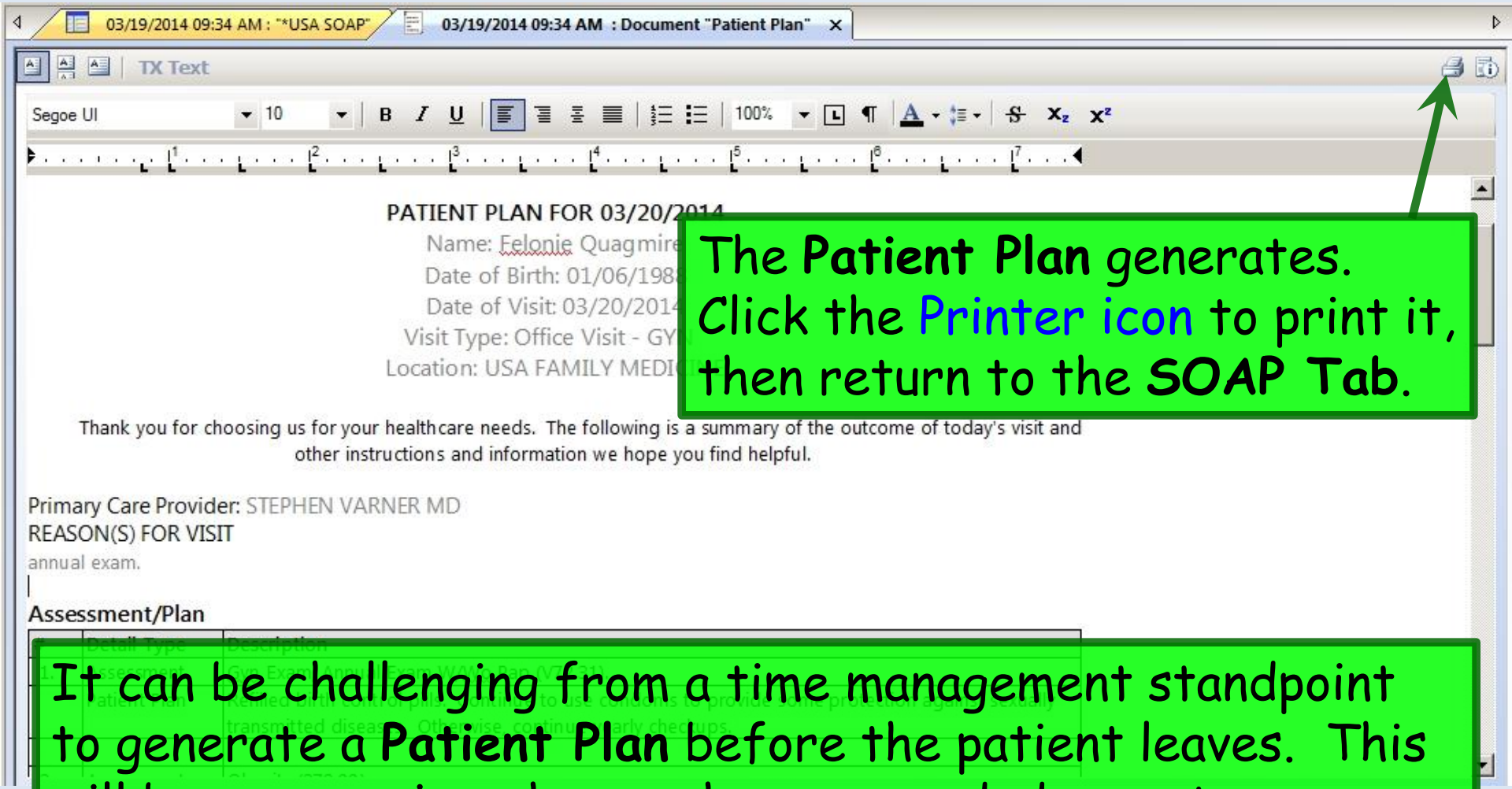
We've refilled & ERx'd her birth control pill; the other meds are prescribed by another doctor. Close the med module & return to the **SOAP Tab**.


03/19/2014 09:34 AM : "*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 Gyn Exam, Annual Exam W/Wo Pap (V72.31).
Patient Plan Refilled birth control pills. Continue to use condoms to provide some protection against sexually transmitted diseases. Otherwise, continue yearly checkups.
2. Assessment Obesity (278.00).
Patient Plan Attention to wt; minimize high-calorie/fatty foods & salt. Exercise daily. Given 1500 calorie meal plan.
Provider Plan If successful with 1500 cal, we could drop to 1200 cal if she'd like a little faster wt loss.
The patient needs a work excuse, which might be generated by you or your nurse. Open the Document Library.
Resident-Attending discussion took place
Attending saw patient
Consent
Procedure Scheduling
Add/Update
Remove
Provider Comm.
Meds
Procedures
Patient Plan
Visit Document
Document Library
EM Coding
Dictation

You have several options for generating a work excuse.

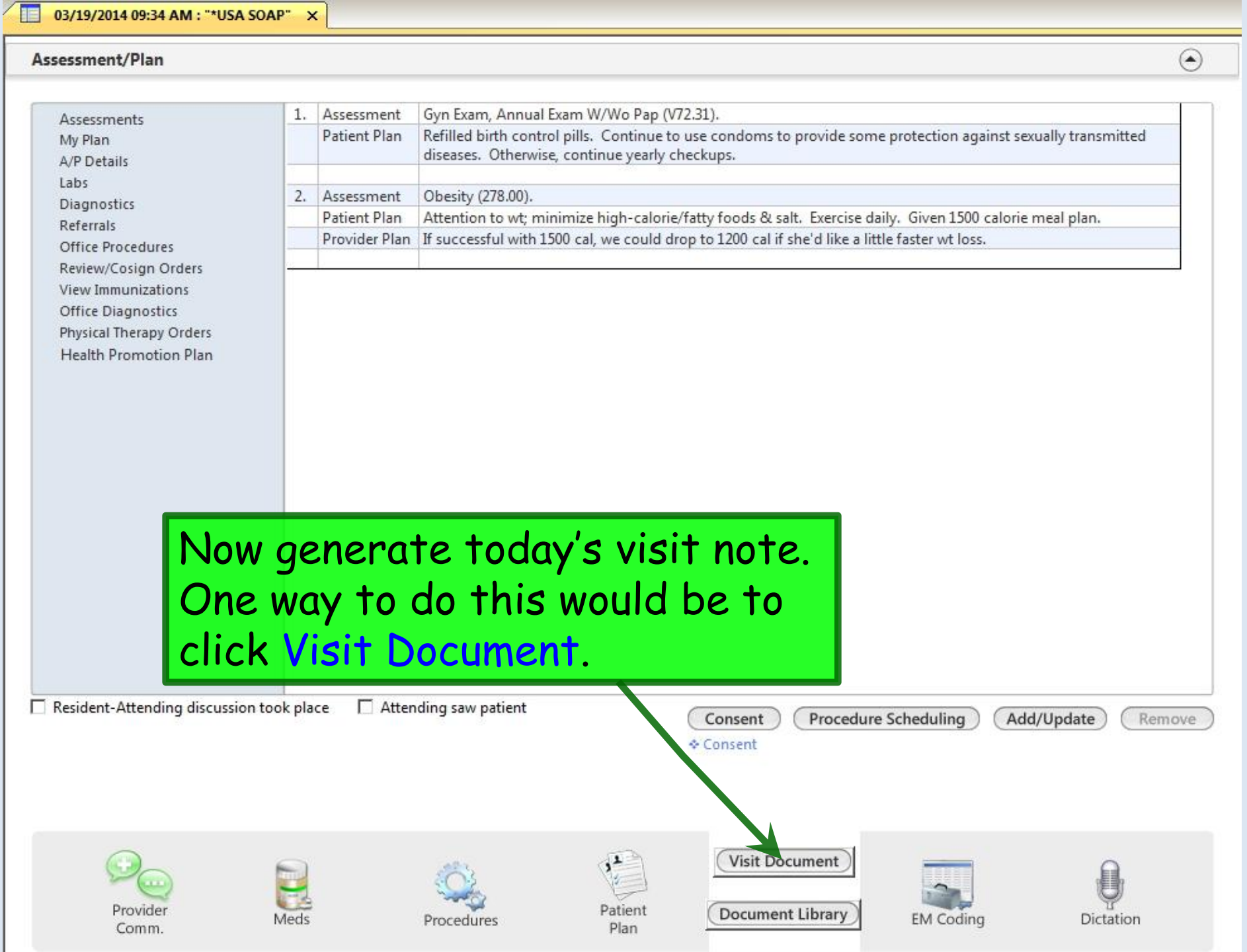


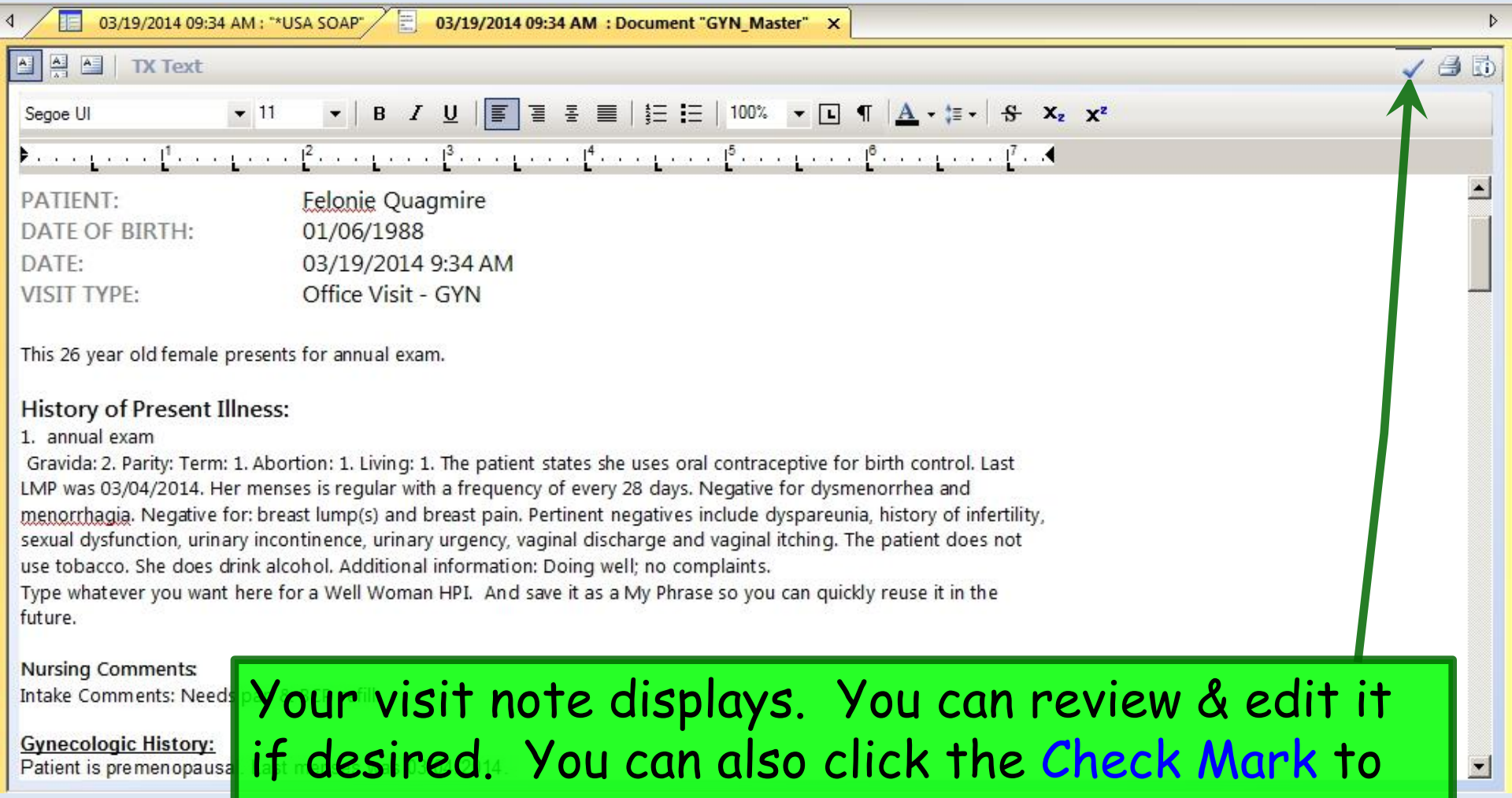

03/19/2014 09:34 AM : "*USA SOAP"
Assessment/Plan
Assessments
My Plan
A/P Details
Labs
Diagnostics
Referrals
Office Procedures
Review/Cosign Orders
View Immunizations
Office Diagnostics
Physical Therapy Orders
Health Promotion Plan
1. Assessment Gyn Exam, Annual Exam W/Wo Pap (V72.31).
Patient Plan Refilled birth control pills. Continue to use condoms to provide some protection against sexually transmitted diseases. Otherwise, continue yearly checkups.
2. Assessment Obesity (278.00).
Patient Plan Attention to wt; minimize high-calorie/fatty foods & salt. Exercise daily. Given 1500 calorie meal plan.
Provider Plan If successful with 1500 cal, we could drop to 1200 cal if she'd like a little faster wt loss.
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



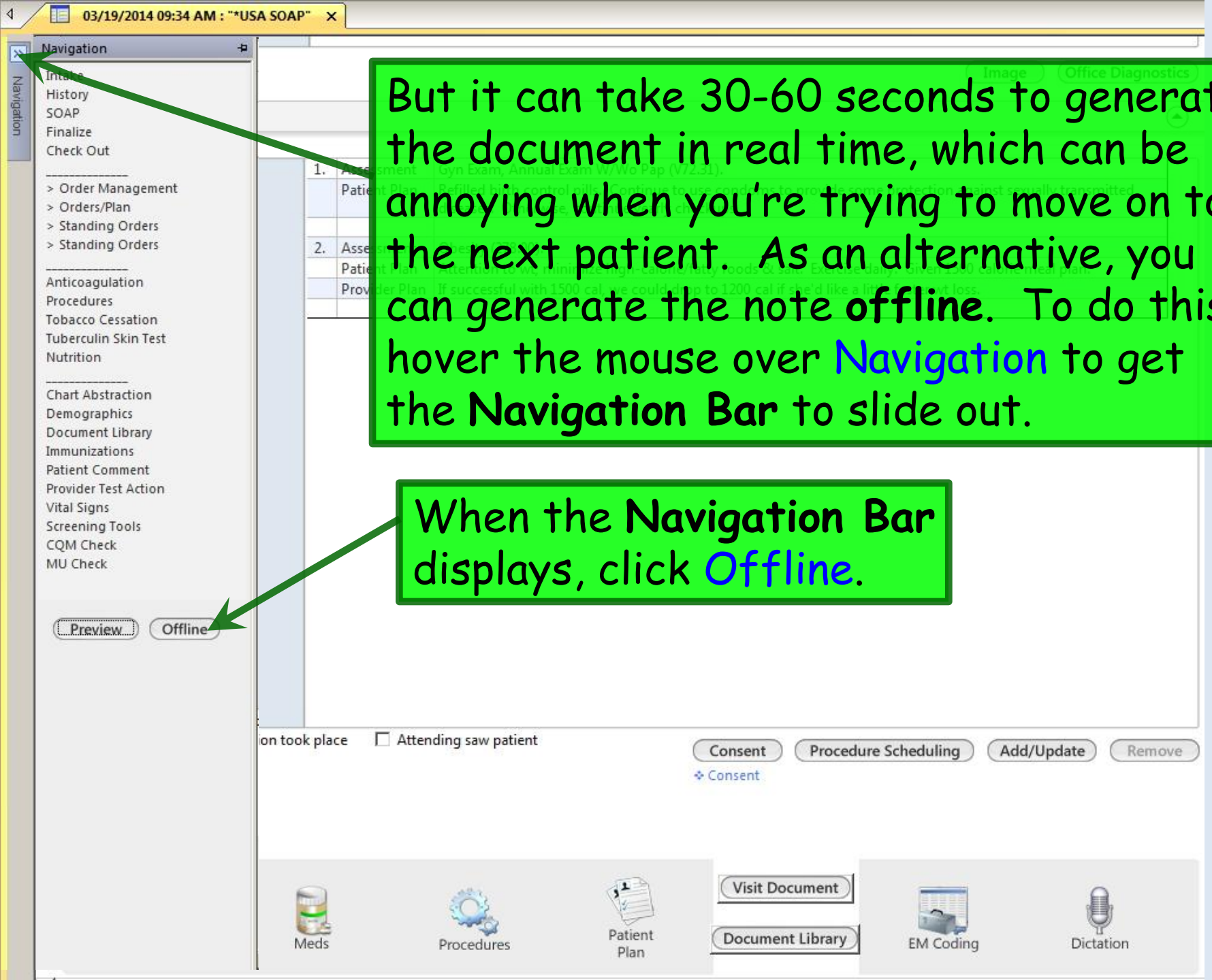
The **Patient Plan** generates. Click the Printer icon to print it, then return to the **SOAP Tab**.

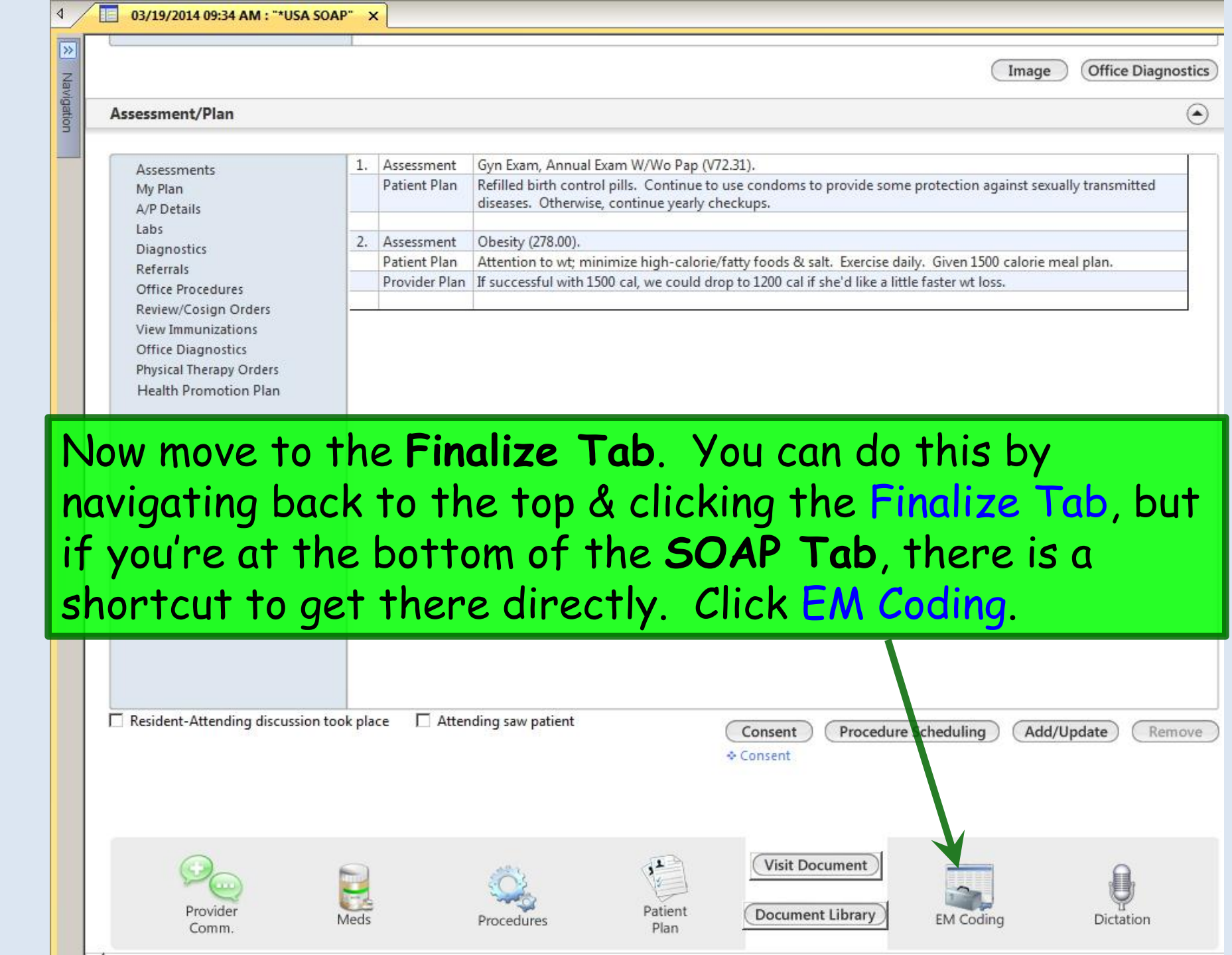
It can be challenging from a time management standpoint to generate a **Patient Plan** before the patient leaves. This will become easier when we have expanded ways to electronically communicate with patients. In the meantime a strategy is to complete a very bare-bones assessment & plan, prescribe meds,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

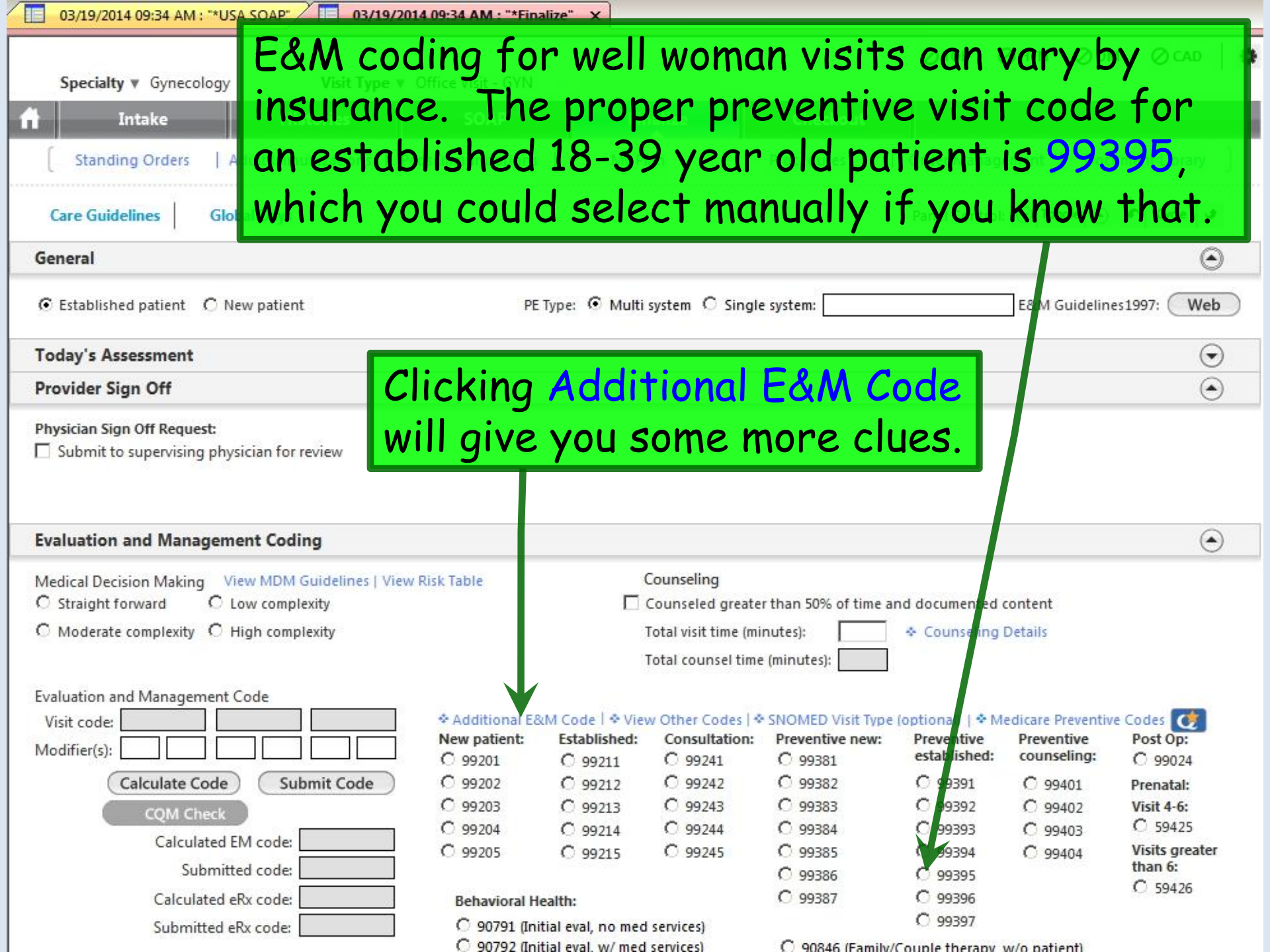

03/19/2014 09:34 AM : "*USA SOAP"
Assessment/Plan
Assessments
My Plan
A/P Details
Labs
Diagnostics
Referrals
Office Procedures
Review/Cosign Orders
View Immunizations
Office Diagnostics
Physical Therapy Orders
Health Promotion Plan
1. Assessment Gyn Exam, Annual Exam W/Wo Pap (V72.31).
Patient Plan Refilled birth control pills. Continue to use condoms to provide some protection against sexually transmitted diseases. Otherwise, continue yearly checkups.
2. Assessment Obesity (278.00).
Patient Plan Attention to wt; minimize high-calorie/fatty foods & salt. Exercise daily. Given 1500 calorie meal plan.
Provider Plan If successful with 1500 cal, we could drop to 1200 cal if she'd like a little faster wt loss.
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



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.

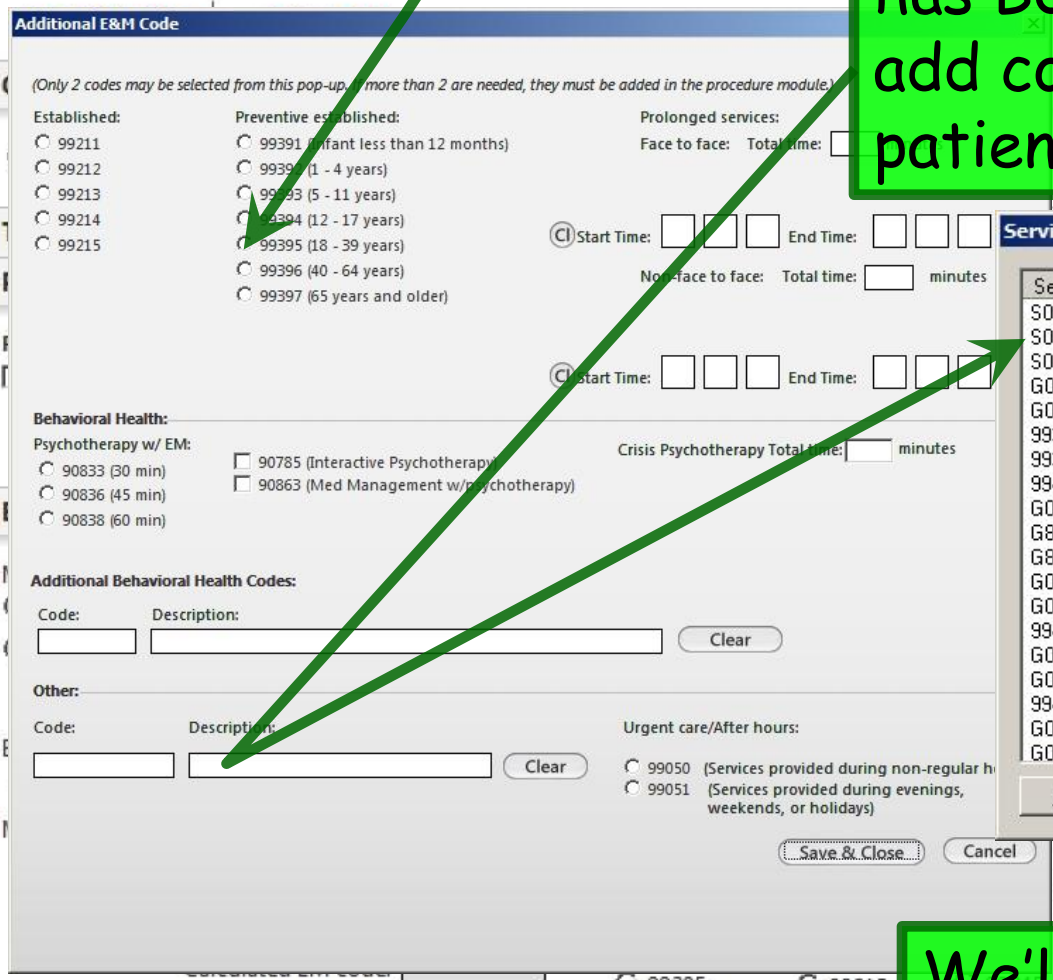

03/19/2014 09:34 AM : "*USA SOAP"
Navigation
History
SOAP
Finalize
Check Out
> Order Management
> Orders/Plan
> Standing Orders
> Standing Orders
Anticoagulation
Procedures
Tobacco Cessation
Tuberculin Skin Test
Nutrition
Chart Abstraction
Demographics
Document Library
Immunizations
Patient Comment
Provider Test Action
Vital Signs
Screening Tools
CQM Check
MU Check
Preview
Offline
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.
Attending saw patient
Consent
Procedure Scheduling
Add/Update
Remove
Meds
Procedures
Patient Plan
Visit Document
Document Library
EM Coding
Dictation

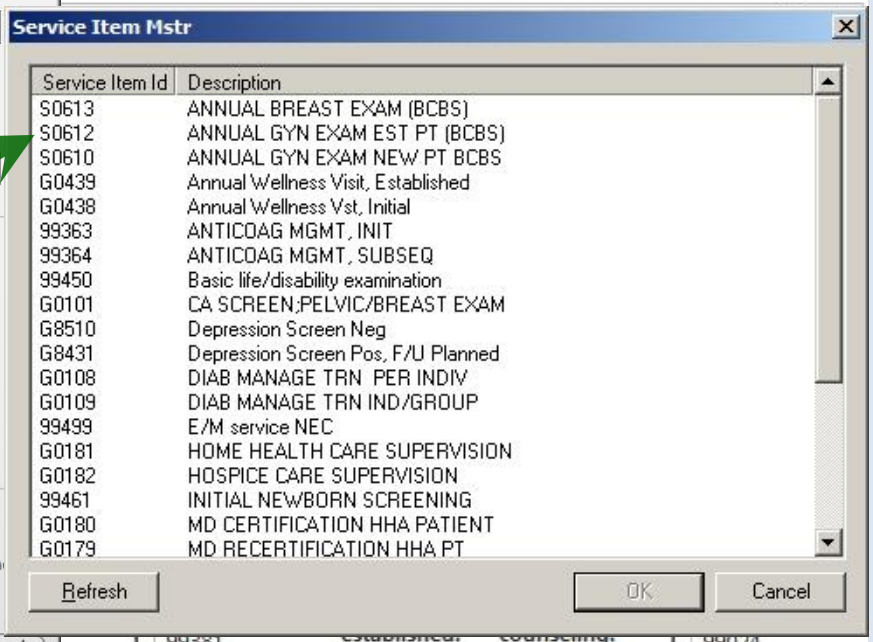

03/19/2014 09:34 AM : "*USA SOAP"
Navigation
Image
Office Diagnostics
Assessment/Plan
Assessments
My Plan
A/P Details
Labs
Diagnostics
Referrals
Office Procedures
Review/Cosign Orders
View Immunizations
Office Diagnostics
Physical Therapy Orders
Health Promotion Plan
1. Assessment Gyn Exam, Annual Exam W/Wo Pap (V72.31).
Patient Plan Refilled birth control pills. Continue to use condoms to provide some protection against sexually transmitted diseases. Otherwise, continue yearly checkups.
2. Assessment Obesity (278.00).
Patient Plan Attention to wt; minimize high-calorie/fatty foods & salt. Exercise daily. Given 1500 calorie meal plan.
Provider Plan If successful with 1500 cal, we could drop to 1200 cal if she'd like a little faster wt loss.
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.
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


E&M coding for well woman visits can vary by insurance. The proper preventive visit code for an established 18-39 year old patient is 99395, which you could select manually if you know that.
Clicking Additional E&M Code will give you some more clues.
03/19/2014 09:34 AM : "*USA SOAP"
03/19/2014 09:34 AM : "*Finalize"
Specialty ▼ Gynecology
Intake
Standing Orders
Care Guidelines
General
Established patient
New patient
PE Type:
Multi system
Single system:
E&M Guidelines1997:
Web
Today's Assessment
Provider Sign Off
Physician Sign Off Request:
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
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)
90792 (Initial eval, w/ med services)
90846 (Family/Couple therapy, w/o patient)

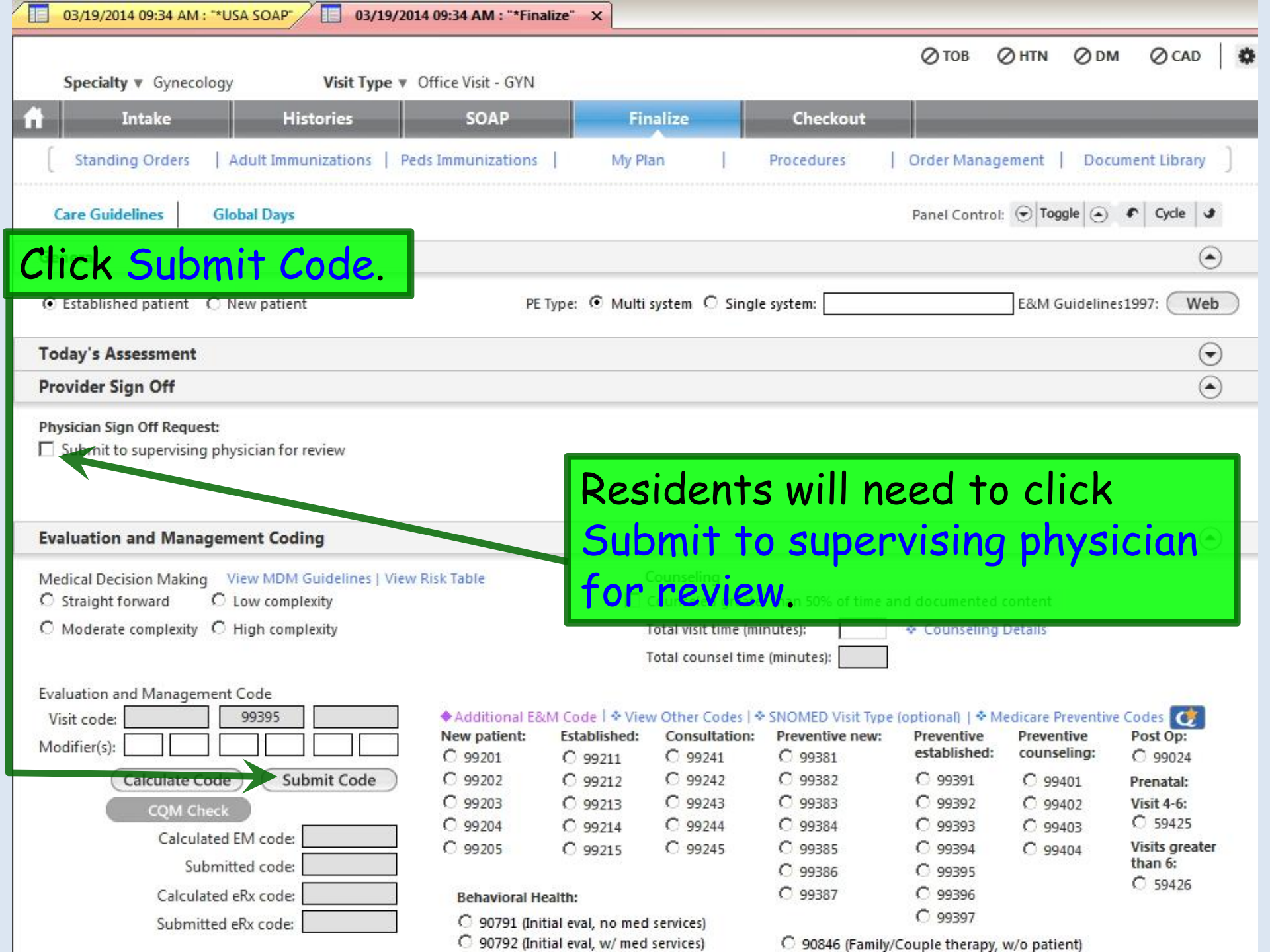
This popup points you toward the 99395 code.

Clicking in one of the Other boxes also provides another piece of info: if the patient has BCBS insurance, we would add code S0612 as well. (This patient doesn't have BCBS.)





We'll select 99395 then Save & Close out of these popups.


03/19/2014 09:34 AM : "*USA SOAP"
03/19/2014 09:34 AM : "*Finalize"
TOB
HTN
DM
CAD
Specialty ▼ Gynecology
Visit Type ▼ Office Visit - GYN
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
Click Submit Code.
Established patient
New patient
PE Type: Multi system Single system:
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
Counseling
Total visit time (minutes):
Counseling Details
Total counsel time (minutes):
Evaluation and Management Code
Visit code:
99395
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
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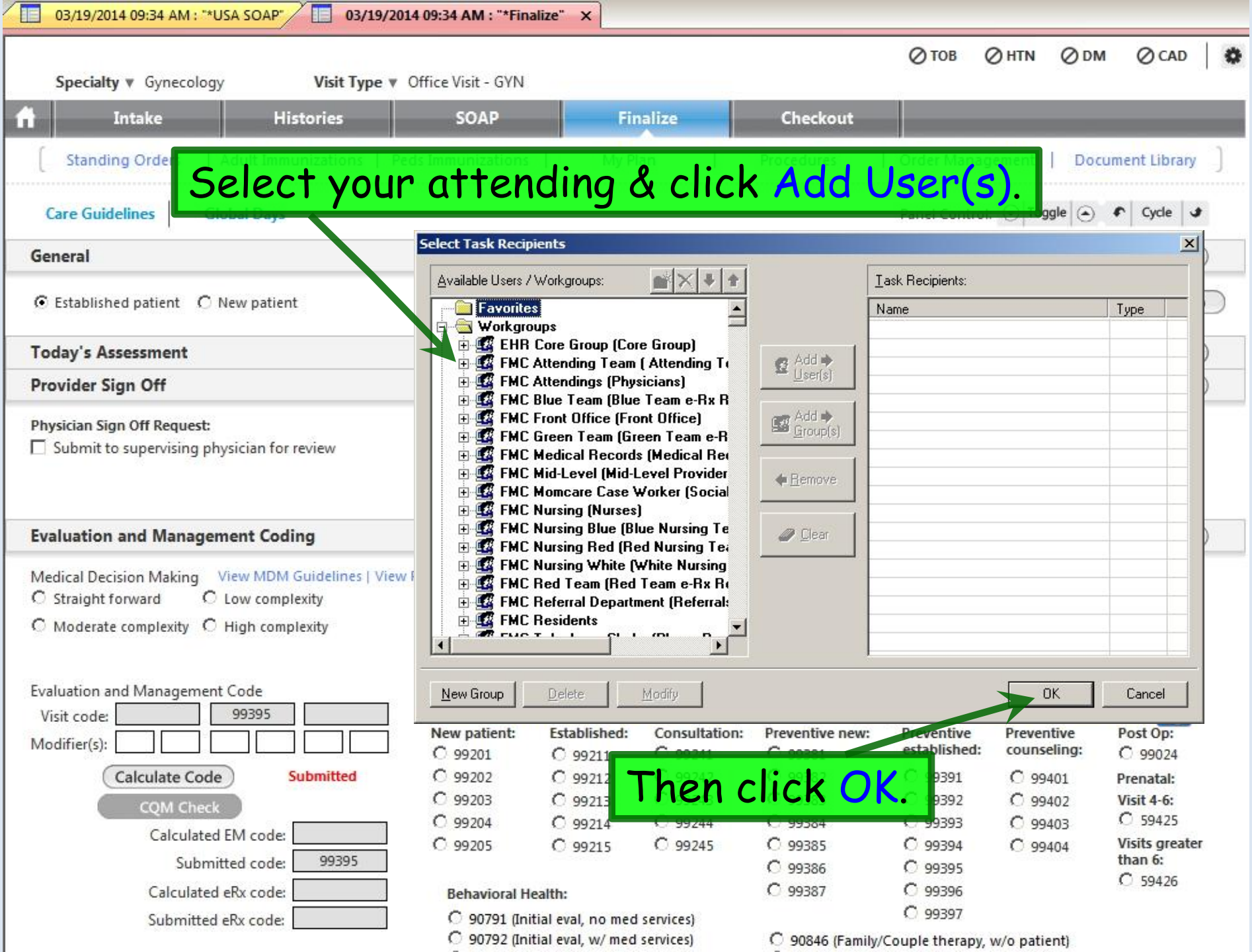
03/19/2014 09:34 AM : "*USA SOAP"
03/19/2014 09:34 AM : "*Finalize"
TOB
HTN
DM
CAD
Specialty ▼ Gynecology
Visit Type ▼ Office Visit - GYN
Intake
Histories
SOAP
Finalize
Checkout
Document Library
Care Guidelines
Cycle
Select your attending & click Add User(s).
Select Task Recipients
Available Users / 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
General
Established patient
New patient
Today's Assessment
Provider Sign Off
Physician Sign Off Request:
Submit to supervising physician for review
Evaluation and Management Coding
Medical Decision Making
View MDM Guidelines | View
Straight forward
Low complexity
Moderate complexity
High complexity
Evaluation and Management Code
Visit code:
99395
Modifier(s):
Calculate Code
Submitted
CQM Check
Calculated EM code:
Submitted code:
99395
Calculated eRx code:
Submitted eRx code:
New patient:
99201
99202
99203
99204
99205
Established:
99211
99212
99213
99214
99215
Consultation:
99245
Preventive new:
99385
99386
99387
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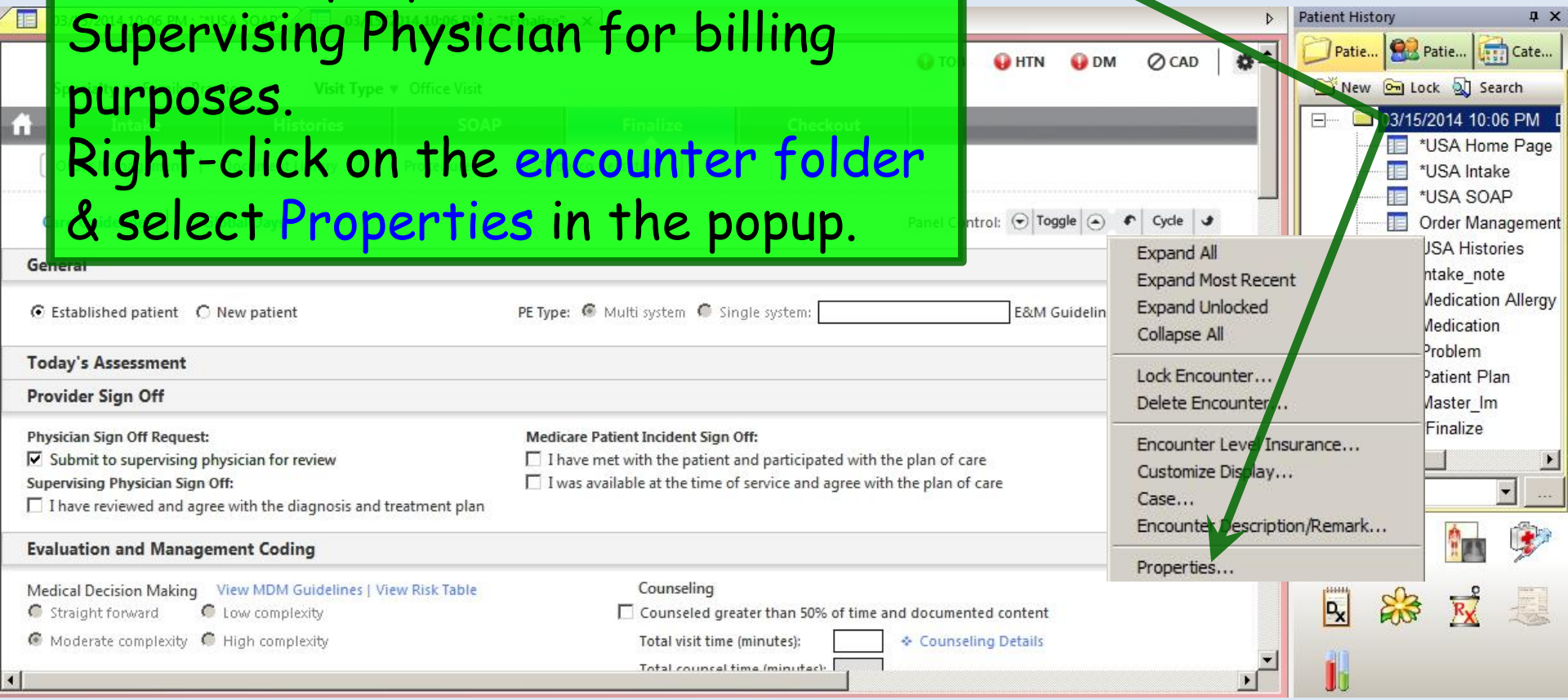
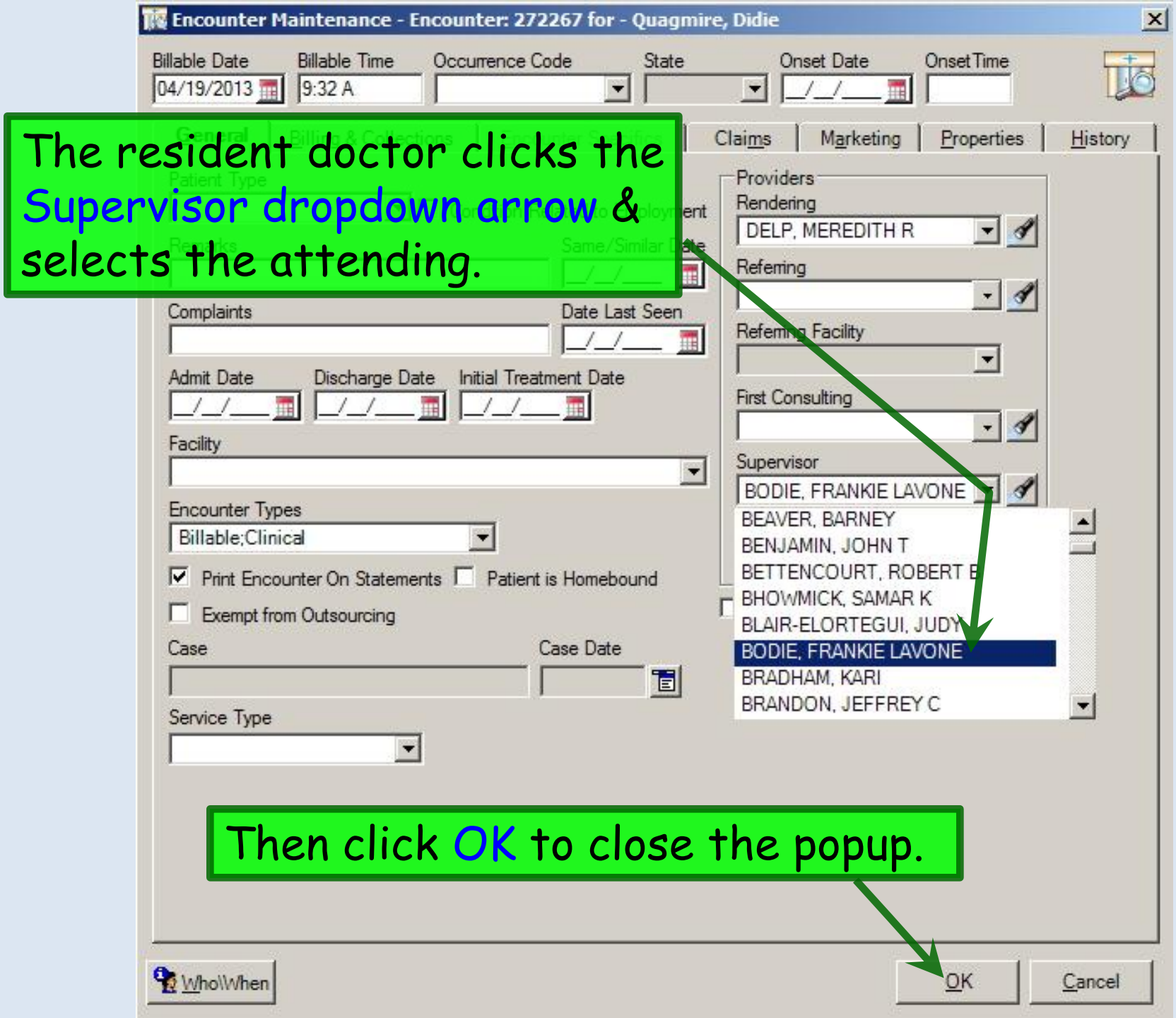
Then click OK.

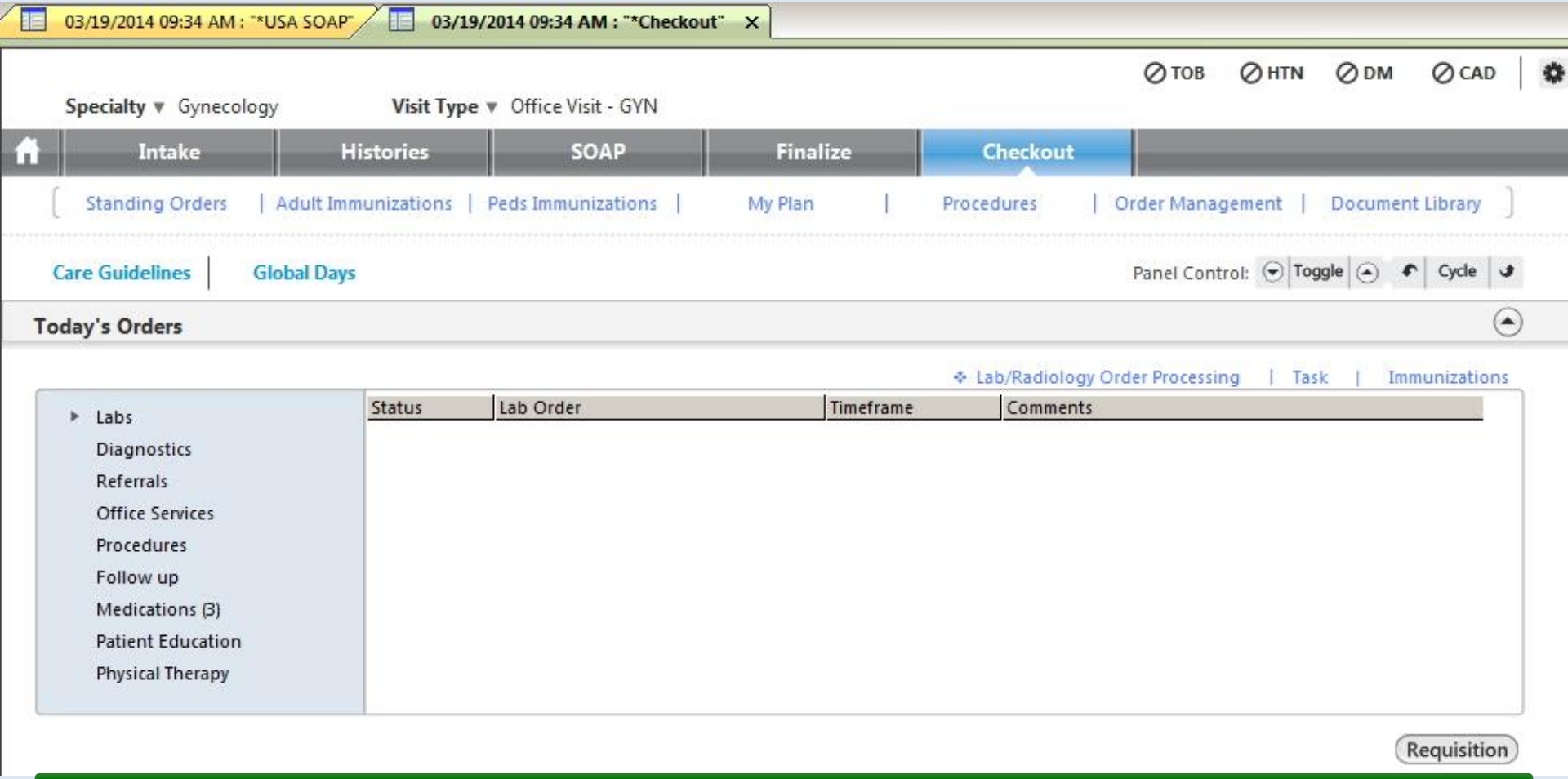
A resident also needs to view encounter properties to set the Supervising Physician for billing purposes.
Right-click on the encounter folder & select Properties in the popup.





The resident doctor clicks the Supervisor dropdown arrow & selects the attending.

Then 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 GYN Routine Annual Visit demonstration.

The colder the X-ray table, the more of your body is required to be on it.

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