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.
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**.
This gives you the opportunity to indicate several noteworthy alerts about the patient. For demonstration purposes we'll click Legally blind.

Additional comments can be typed as well.

Click **Save & Close** when you're done.
The **Alerts** button turns red when there is an entry.

When you remove entries the **Sticky Note & Alerts** return to their baseline appearance, as below.
You can select a **Historian** from the picklist that appears if you click in that box; you can also type in an entry. This is most pertinent if the patient is a child or adult unable to care for himself.
Note the PCP.

If this needs to be changed, click Patient, which opens the Patient_demographics template.
Since Dr. Delp has graduated, we’ll change the PCP by clicking in the PCP field.

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

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

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 collapse the Information Bar down to a narrower strip if desired; that is particularly helpful on the small-screened laptops. Click this button.

The nurse will probably next enter Vital Signs. It would be more convenient if that section were at the top of this template. So if it’s not there already, let’s move it there. Click on the Vital Signs heading bar, & drag it up over Reason for Visit. (It can be a little touchy to make the drag work right, you’ll eventually get it.)
The Info Bar is collapsed, & Vital Signs are at the top.

To enter Vital Signs, click Add.
Enter Vital Signs. (Details are reviewed in another demo.)

Data used in this example:

Ht 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.

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

Type a few brief details as pertinent or volunteered by the patient. When done click **Save & Close**.
Moving down the **Intake Tab**, we come to **Medications**. Since this is the first encounter documented in NextGen, we need to add the patient’s meds. Click the **Add/Update** button.

If there were no meds, you’d click the **No medications** box.
A detailed discussion of the Medication Module is included in another lesson.

In this example, our patient is taking:
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.
Next, review allergies. If there are no allergies, just click the **No known allergies** box.

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

Now let’s move to the **Histories Tab**.
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.**

To enter pregnancy history, click **Details.**
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.
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.
To add diagnoses, click Add.
The **Problems Module** opens, focused on the **Problem List Tab**.

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

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

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

All of the other History Review links lead to the same popup. Click one of them.
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.
That's all we'll add, so click Save & Close.
Now we'll use the collapsible panels to move down to the **Family History**.

<table>
<thead>
<tr>
<th>Problem Description</th>
<th>Side</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergic rhinitis</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Disease/Disorder</th>
<th>Side</th>
<th>Onset Date</th>
<th>Management</th>
<th>Side</th>
<th>Date</th>
<th>Encounter Type</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pelvic inflammatory disease</td>
<td></td>
<td>2010</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

This history now displays.
**Click Add.**

### Family History

<table>
<thead>
<tr>
<th>Relationship</th>
<th>Family Member Name</th>
<th>Deceased</th>
<th>Age at Death</th>
<th>Condition</th>
<th>Onset Age</th>
<th>Cause of Death</th>
<th>Comments</th>
</tr>
</thead>
</table>

All History Review details are to be reviewed and included in visit note unless user indicates otherwise.
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.
Now move down to Social History & click the Add button.

These additions display in the grid.
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**.
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).
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**.
All Risk Indicators are now configured.

Now click **Intake Note**. (There's a similar button on the bottom of the Intake Tab as well.)
The Intake Note is created, summarizing all of the data you’ve just entered.

Close this & return to the Histories Tab.
The patient is ready for the provider. On the re-expanded Info Bar & click the Tracking icon.
Click in the **Room** box & select a room; alternately, you can just type a room number in the box.
Next, click in the **Status** box & select **waiting for provider**.
When done click **Save & Close**.
The provider then opens the chart from the appointment list & performs the 4-point check.
The provider generally starts on the Home Tab. It's good to begin by looking for Sticky Notes & Alerts; there are none on this patient. Also take note of the Risk Indicators.
You can select any of the headings on the left to view various aspects of the chart. In particular, this is a good place to look at Office Lab results or review previous vital signs.

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

Likewise, you can review & update everything else that appears on the Histories Tab from here. Select the category of history desired on the left.
Allergies, meds, vital signs, office labs—everything that can be found on the **Intake & Histories Tabs** can be reviewed & if necessary updated from this tab.
You can also just review the intake_note to see a summary as well. Regardless of the method chosen, the provider is responsible for reviewing & confirming this information, & updating it as necessary.

When you’re done reviewing the chart, move to the SOAP tab.
We’ll start entering the HPI. First note that you can keep or edit this introductory line—or delete it all together.

If you didn’t previously note them, you can review the nurse’s Intake Comments.

Next, you have some options as to how to proceed. You can click on one of the Reasons for Visit to open the HPI Popup. We’ll click annual exam.
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**.

**Reason for Visit**

**Introduction:**

This 26 year old female presents for annual exam.

**History of Present Illness**

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.
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.
There is an alternative many providers will find more comfortable than using the HPI popups. Click the **Comments** button.
Here you have essentially unlimited space to type the story. Sketch it out with a few words & phrases in real time while interviewing the patient; flesh it out later if desired. You can jump from one complaint to another, just like patients do when telling their story. And you have access to My Phrases—a robust way to save & reuse text that you say repeatedly throughout the day. (Setup & use of My Phrases is covered in the User Personalization demonstration.)

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

Introduction:
This 26 year old female presents for annual exam.

Reason for Visit
annual exam (comments) 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.

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.
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**.
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.
You'll next move down to the Physical Exam section.

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

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

While you may well complete the physical exam documentation later after you’re done working with the patient, for the ease of discussion I’ll go ahead & do it now, illustrating the value of using saved preset exams.
I’m going to click the Open Preset icon & double-click on 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.
Moving to the bottom of the SOAP tab, you might next perform any of several activities: Document assessments & plans, prescribe meds, order labs, plan X-rays, or request referrals.

For this exercise, let’s address Assessment/Plan. Begin by clicking the **Add/Update** button.
A group of tabbed popups appears; let’s call this the **Assessment-Plan Suite**. Here you have multiple ways to select diagnoses. The easiest involve picking something from the patient’s previous **Diagnoses History**, the **Problems** list, or your **My Favorites** list.
Clicking the **Add Common Assessment** button will give you a superbill-like short list of common diagnoses.
Click Routine GYN & pick ROUTINE GYN EXAMINATION V72.31 from the ensuing popup.
Given her BMI, we’ll also click Dietary & add OBESITY NOS.

When done click 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.
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**.
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.)
If we wanted to order X-rays or Referrals, we could do so using the Diagnostics or Referrals Tabs above. (We don't use the Labs Tab at present, since we have another way to place lab orders.) Those are covered in other lessons, so we won't do that on this encounter.

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

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Gyn Exam, Annual Exam W/Wo Pap (V72.31).</td>
<td>Refilled birth control pills. Continue to use condoms to provide some protection against sexually transmitted diseases. Otherwise, continue yearly checkups.</td>
</tr>
<tr>
<td>2. Obesity (278.00).</td>
<td>Attention to wt; minimize high-calorie/fatty foods &amp; salt. Exercise daily. Given 1500 calorie meal plan. If successful with 1500 cal, we could drop to 1200 cal if she’d like a little faster wt loss.</td>
</tr>
</tbody>
</table>

Let’s complete her prescriptions. Click **Meds**.
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.
The patient needs a work excuse, which might be generated by you or your nurse. Open the Document Library.
You have several options for generating a work excuse.

**Letters**
- Work/School Excuse Note
- Work/School Excuse Note-FM
- Work/School Excuse Note-Peds
- Work/School Status, Brief
- Work/School Status, Detailed
One of the Meaningful Use criteria requires patients to receive a summary of the visit. Click Patient Plan.
The Patient Plan generates. Click the Printer icon to print it, then return to the SOAP Tab.

It can be challenging from a time management standpoint to generate a Patient Plan before the patient leaves. This will become easier when we have expanded ways to electronically communicate with patients. In the meantime a strategy is to complete a very bare-bones assessment & plan, prescribe meds, then generate the Patient Plan. Print this for the patient, then flesh out the details later.
Now generate today’s visit note. One way to do this would be to click Visit Document.
Your visit note displays. You can review & edit it if desired. You can also click the Check Mark to sign it off; this is the same as signing the document in your PAQ.
But it can take 30-60 seconds to generate the document in real time, which can be annoying when you’re trying to move on to the next patient. As an alternative, you can generate the note offline. To do this, hover the mouse over Navigation to get the Navigation Bar to slide out. When the Navigation Bar displays, click Offline.
Now move to the **Finalize Tab**. You can do this by navigating back to the top & clicking the **Finalize Tab**, but if you’re at the bottom of the **SOAP Tab**, there is a shortcut to get there directly. Click **EM Coding**.
E&M coding 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.
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.
Residents will need to click Submit to supervising physician for review.
Select your attending & click **Add User(s)**.

Then click **OK**.
A resident also needs to view encounter properties to set the Supervising Physician for billing purposes. Right-click on the encounter folder & select **Properties** in the popup.
The resident doctor clicks the Supervisor dropdown arrow & selects the attending.

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.

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