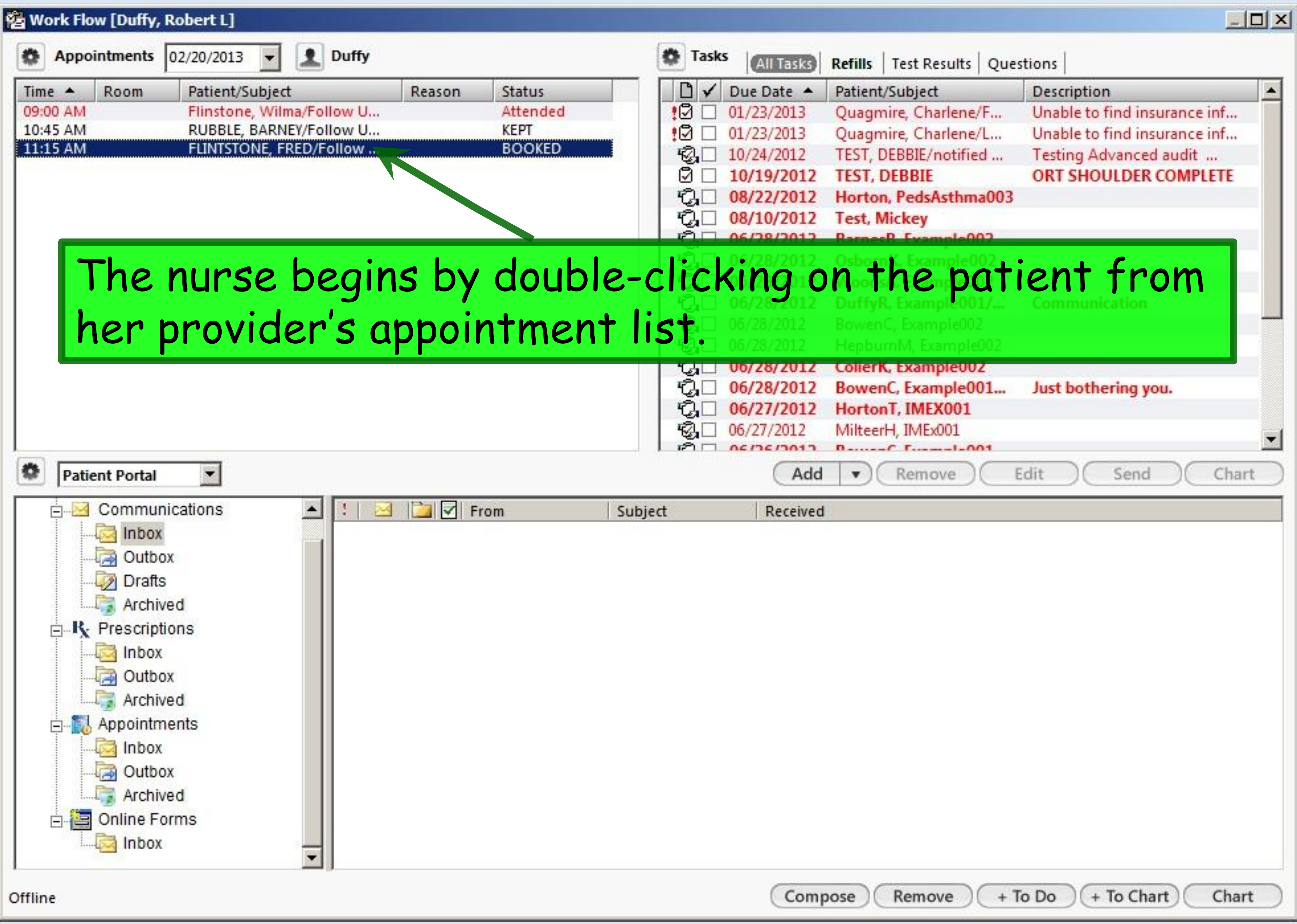
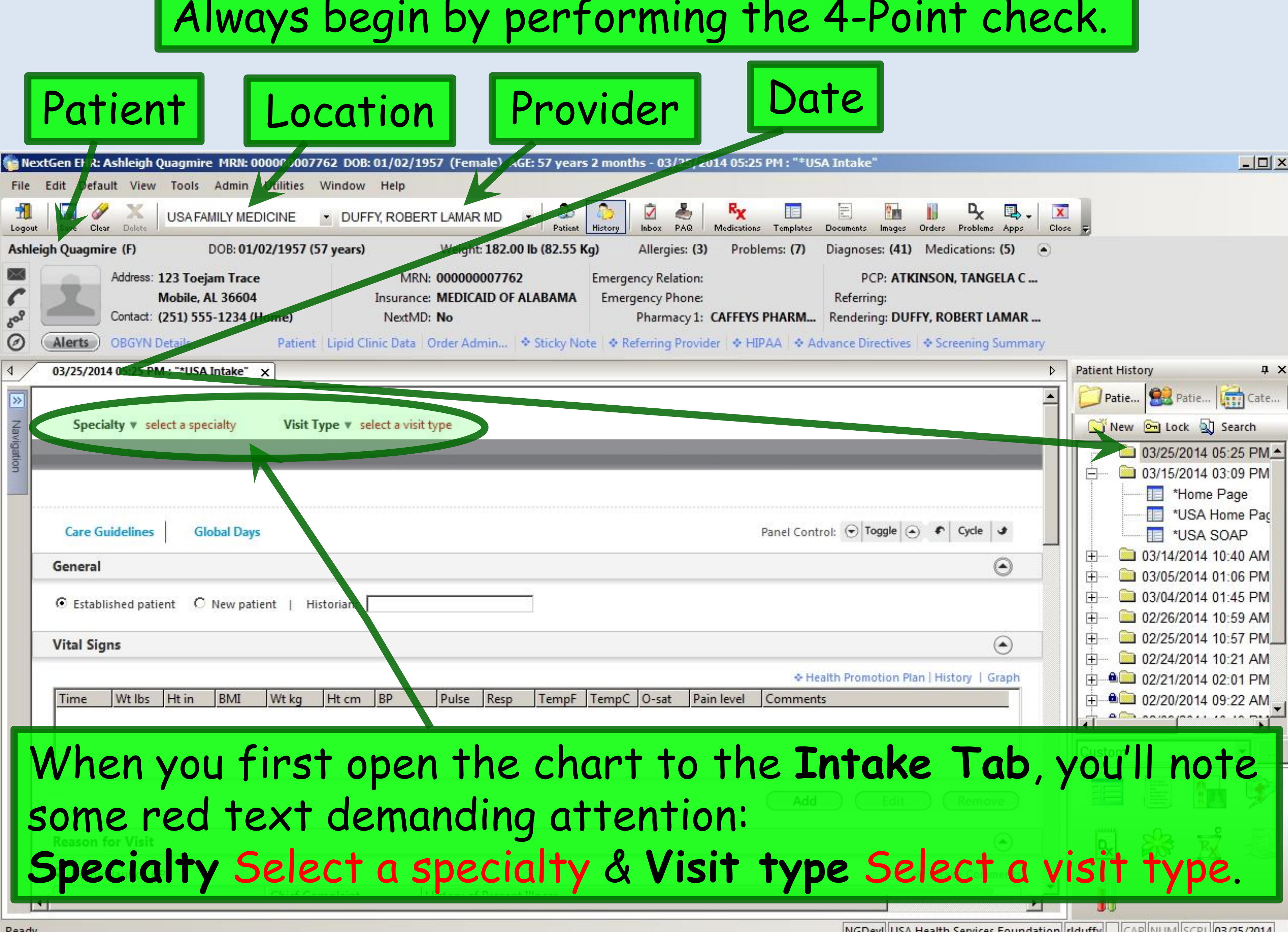
NEXTGEN PULMONOLOGY WORKFLOW DEMONSTRATION

This example works through a sample adult pulmonology encounter. In this demonstration, the patient has been seen by other USA HSF providers, so most basic history will already be entered into the chart, though we'll touch upon updating this information as well.

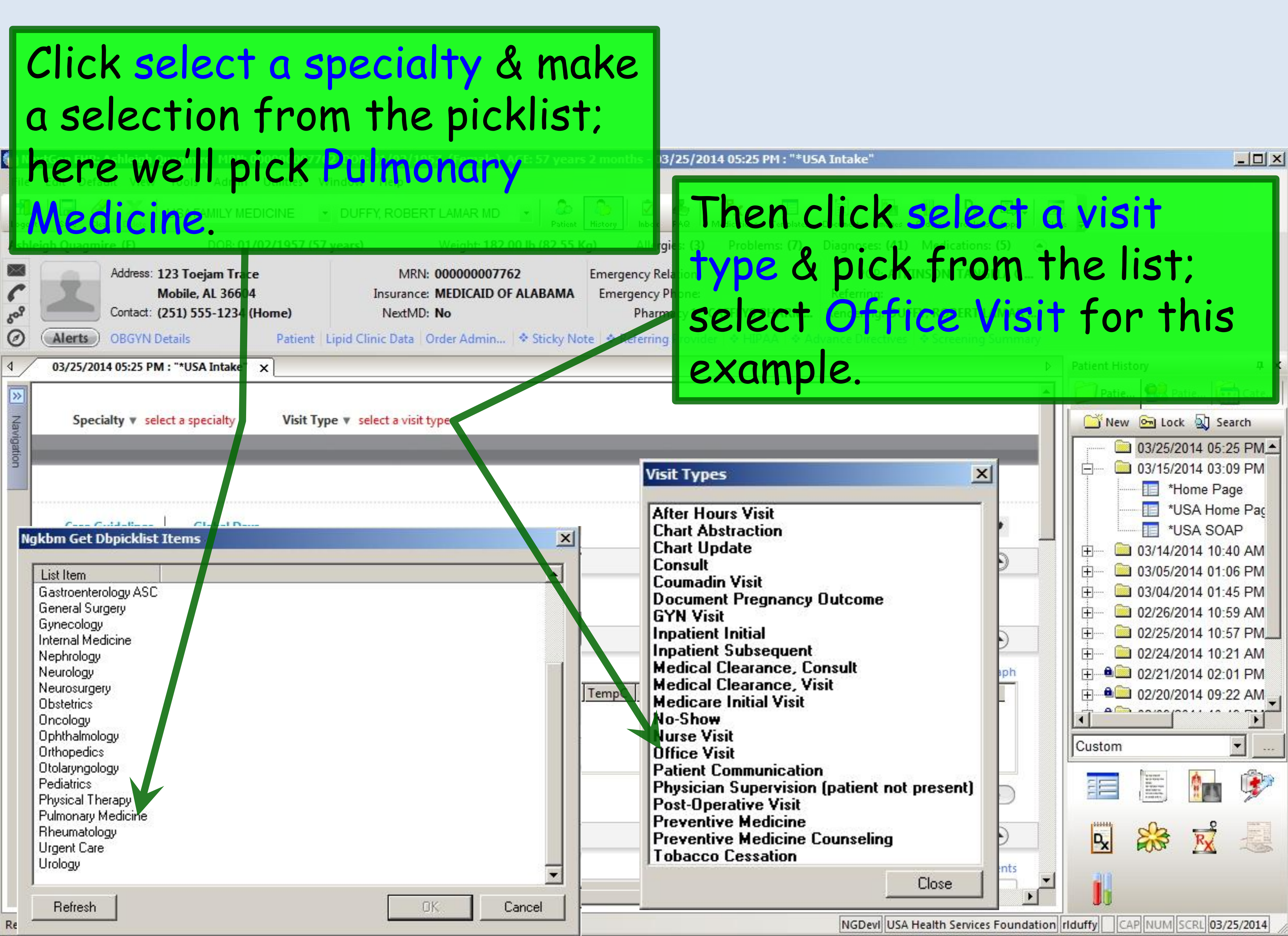
This has been prepared for EHR 5.8 & KBM 8.3. Subsequent updates may display cosmetic & functional changes.

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

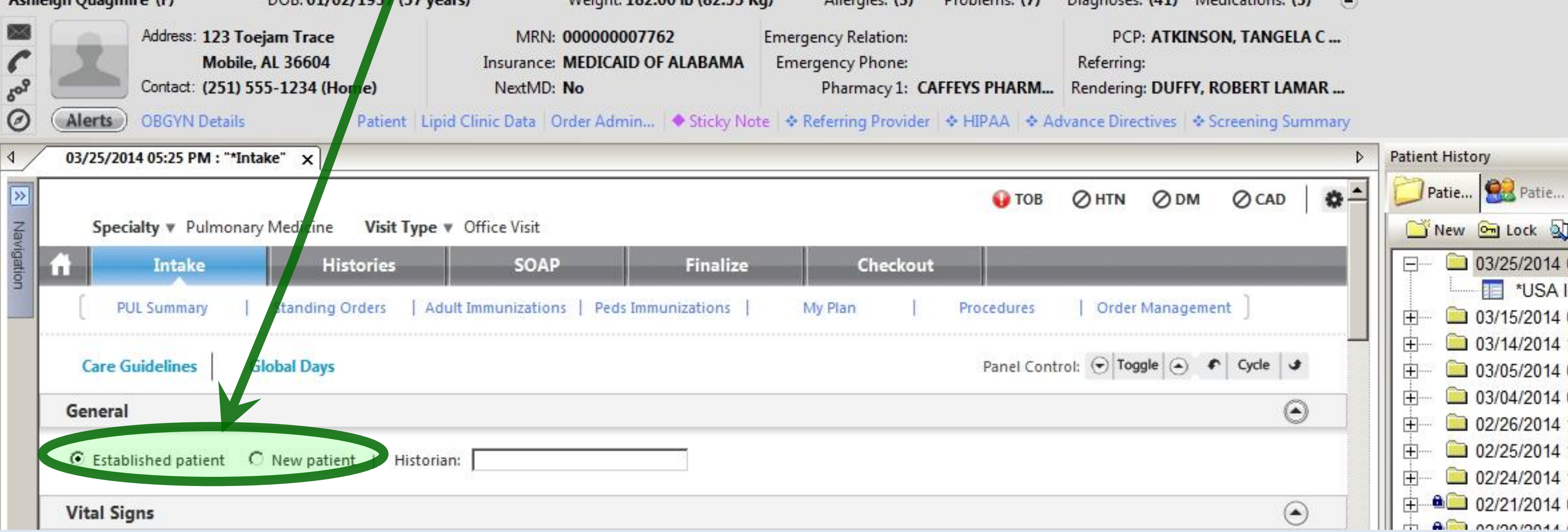

Work Flow [Duffy, Robert L]
Appointments
02/20/2013
Duffy
Time
Room
Patient/Subject
Reason
Status
09:00 AM
Flinstone, Wilma/Follow U...
Attended
10:45 AM
RUBBLE, BARNEY/Follow U...
KEPT
11:15 AM
FLINTSTONE, FRED/Follow ...
BOOKED
Tasks
All Tasks
Refills
Test Results
Questions
Due Date
Patient/Subject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



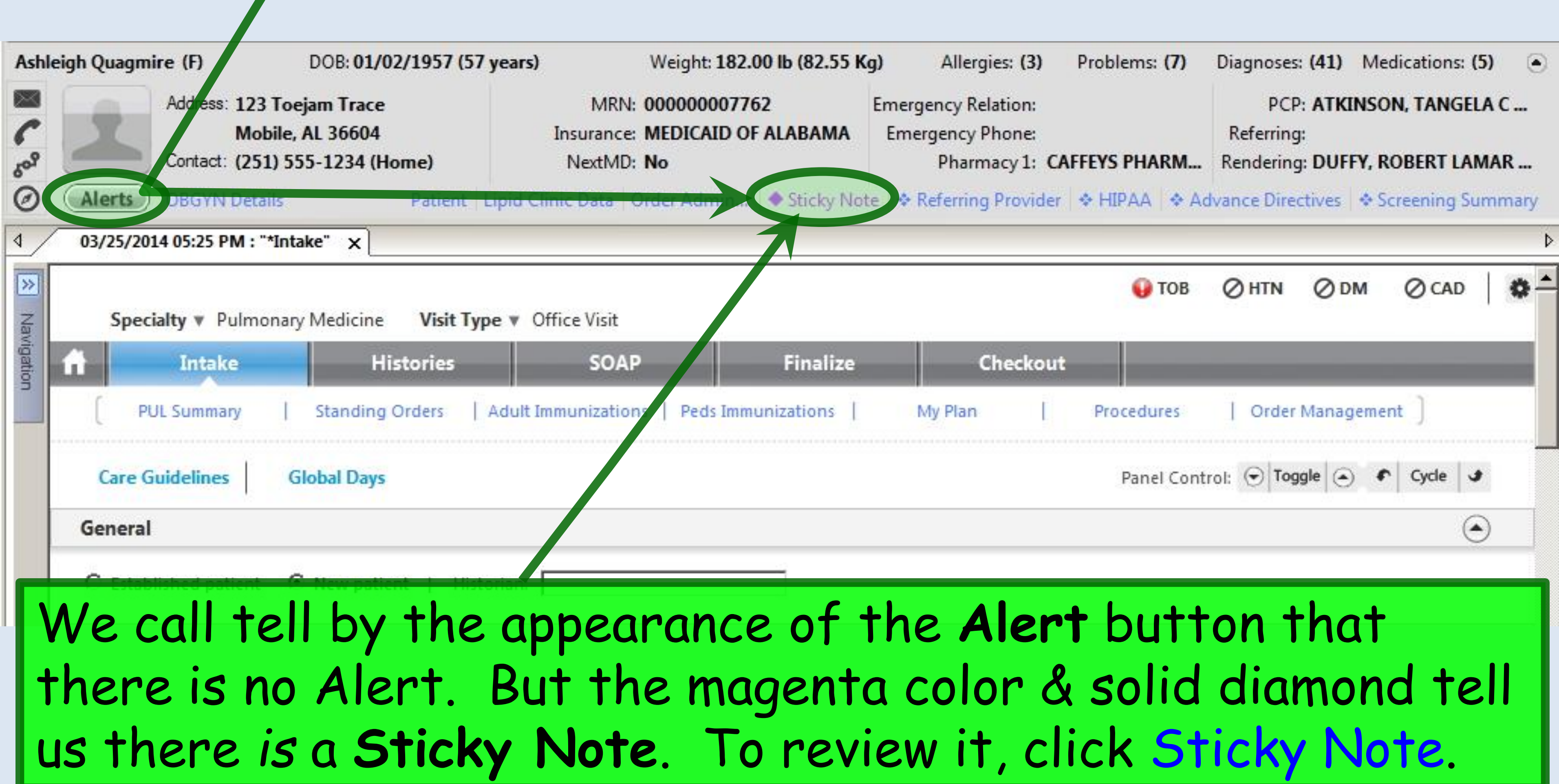
Always begin by performing the 4-Point check.
Patient
Location
Provider
Date
NextGen EHR: Ashleigh Quagmire MRN: 000000007762 DOB: 01/02/1957 (Female) AGE: 57 years 2 months - 03/25/2014 05:25 PM : "*USA Intake"
USA FAMILY MEDICINE
DUFFY, ROBERT LAMAR MD
Ashleigh Quagmire (F)
DOB: 01/02/1957 (57 years)
Weight: 182.00 lb (82.55 Kg)
Allergies: (3)
Problems: (7)
Diagnoses: (41)
Medications: (5)
Specialty select a specialty
Visit Type select a visit type
Patient History
03/25/2014 05:25 PM
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 Pulmonary Medicine.
Then click select a visit type & pick from the list; select Office Visit for this example.
03/25/2014 05:25 PM : "*USA Intake"
Address: 123 Toejam Trace
Mobile, AL 36604
Contact: (251) 555-1234 (Home)
MRN: 000000007762
Insurance: MEDICAID OF ALABAMA
NextMD: No
Alerts
OBGYN Details
Patient
Lipid Clinic Data
Order Admin...
Sticky Note
Specialty
select a specialty
Visit Type
select a visit type
Ngkbm Get Dbpicklist Items
List Item
Gastroenterology ASC
General Surgery
Gynecology
Internal Medicine
Nephrology
Neurology
Neurosurgery
Obstetrics
Oncology
Ophthalmology
Orthopedics
Otolaryngology
Pediatrics
Physical Therapy
Pulmonary Medicine
Rheumatology
Urgent Care
Urology
Refresh
OK
Cancel
Visit Types
After Hours Visit
Chart Abstraction
Chart Update
Consult
Coumadin Visit
Document Pregnancy Outcome
GYN Visit
Inpatient Initial
Inpatient Subsequent
Medical Clearance, Consult
Medical Clearance, Visit
Medicare Initial Visit
No-Show
Nurse Visit
Office Visit
Patient Communication
Physician Supervision (patient not present)
Post-Operative Visit
Preventive Medicine
Preventive Medicine Counseling
Tobacco Cessation
Close
New
Lock
Search
03/25/2014 05:25 PM
03/15/2014 03:09 PM
*Home Page
*USA Home Pag
*USA SOAP
03/14/2014 10:40 AM
03/05/2014 01:06 PM
03/04/2014 01:45 PM
02/26/2014 10:59 AM
02/25/2014 10:57 PM
02/24/2014 10:21 AM
02/21/2014 02:01 PM
02/20/2014 09:22 AM
Custom
NGDevl
USA Health Services Foundation
rlduffy
CAP
NUM
SCRL
03/25/2014

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 she'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**. This patient is new to us, so we'll make that change.

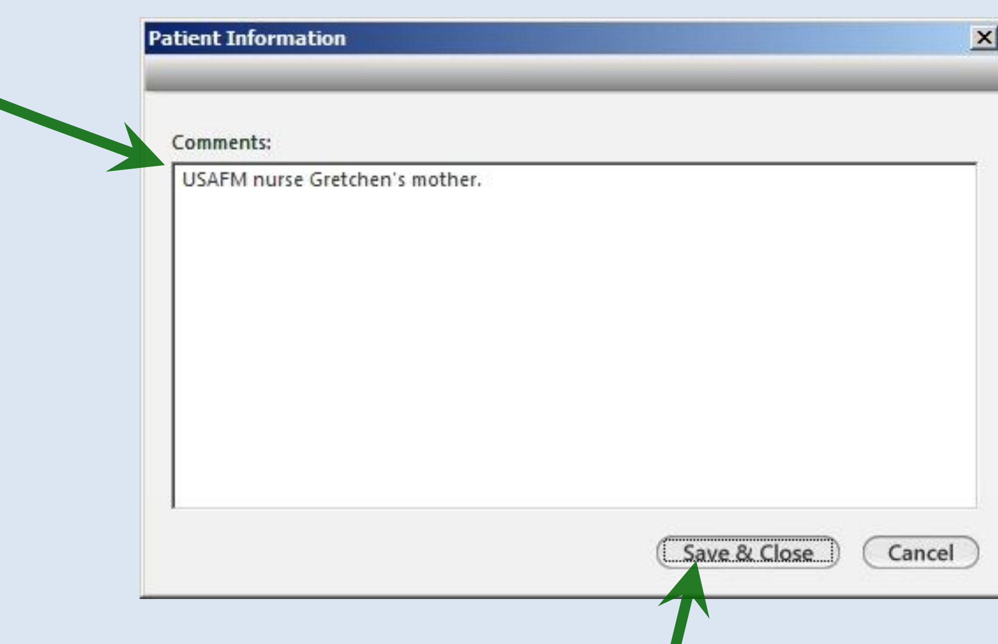


It's always good to begin by noting whether there are any **Sticky Note** or **Alerts** entries.



We call tell by the appearance of the **Alert** button that there is no Alert. But the magenta color & solid diamond tell us there *is* a **Sticky Note**. To review it, click Sticky Note.

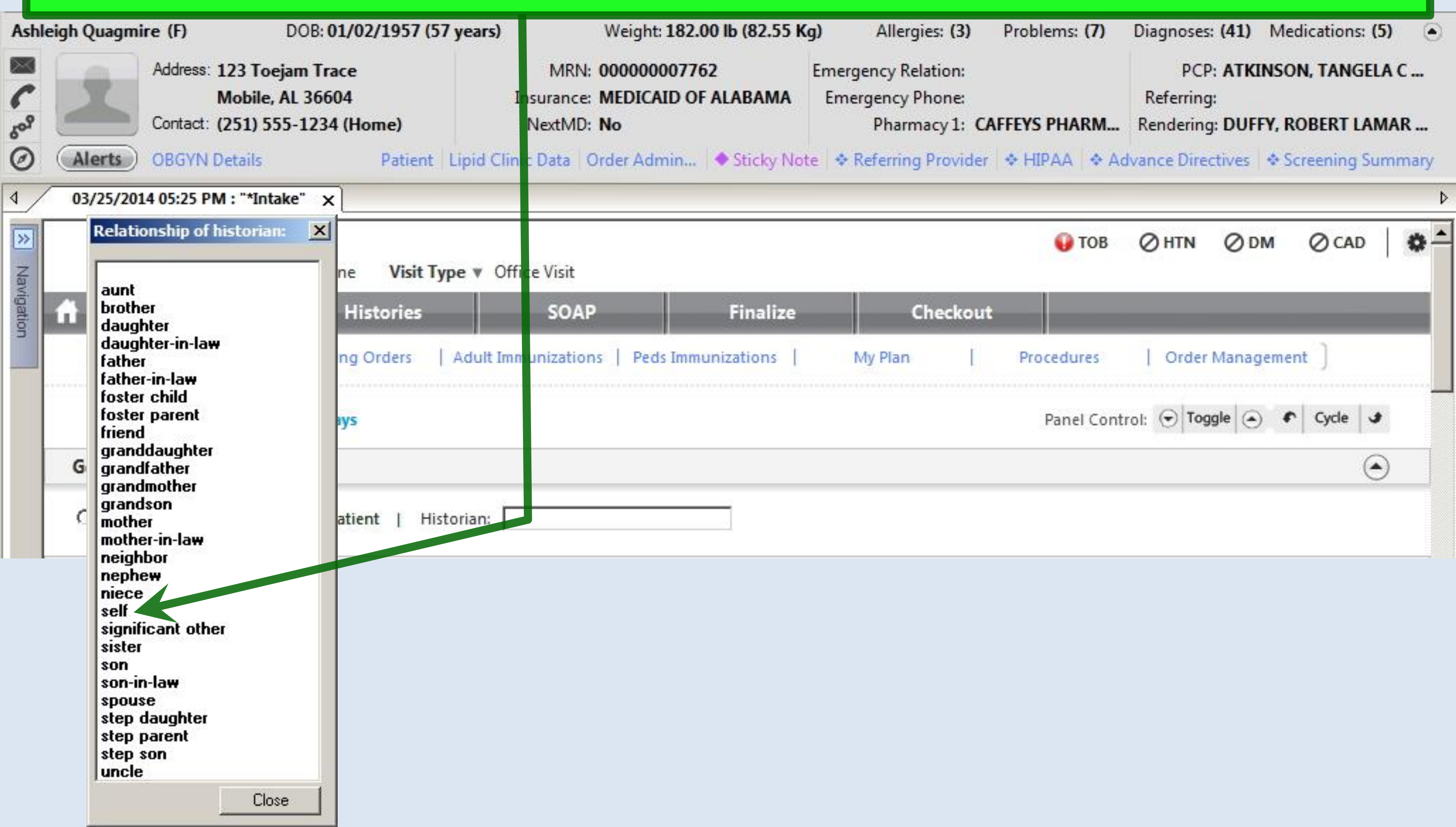
Like actual sticky notes, these are things that are nice to know, but aren't meant to be permanent chart records. We note that the patient is the mother of one of the Family Medicine nurses.



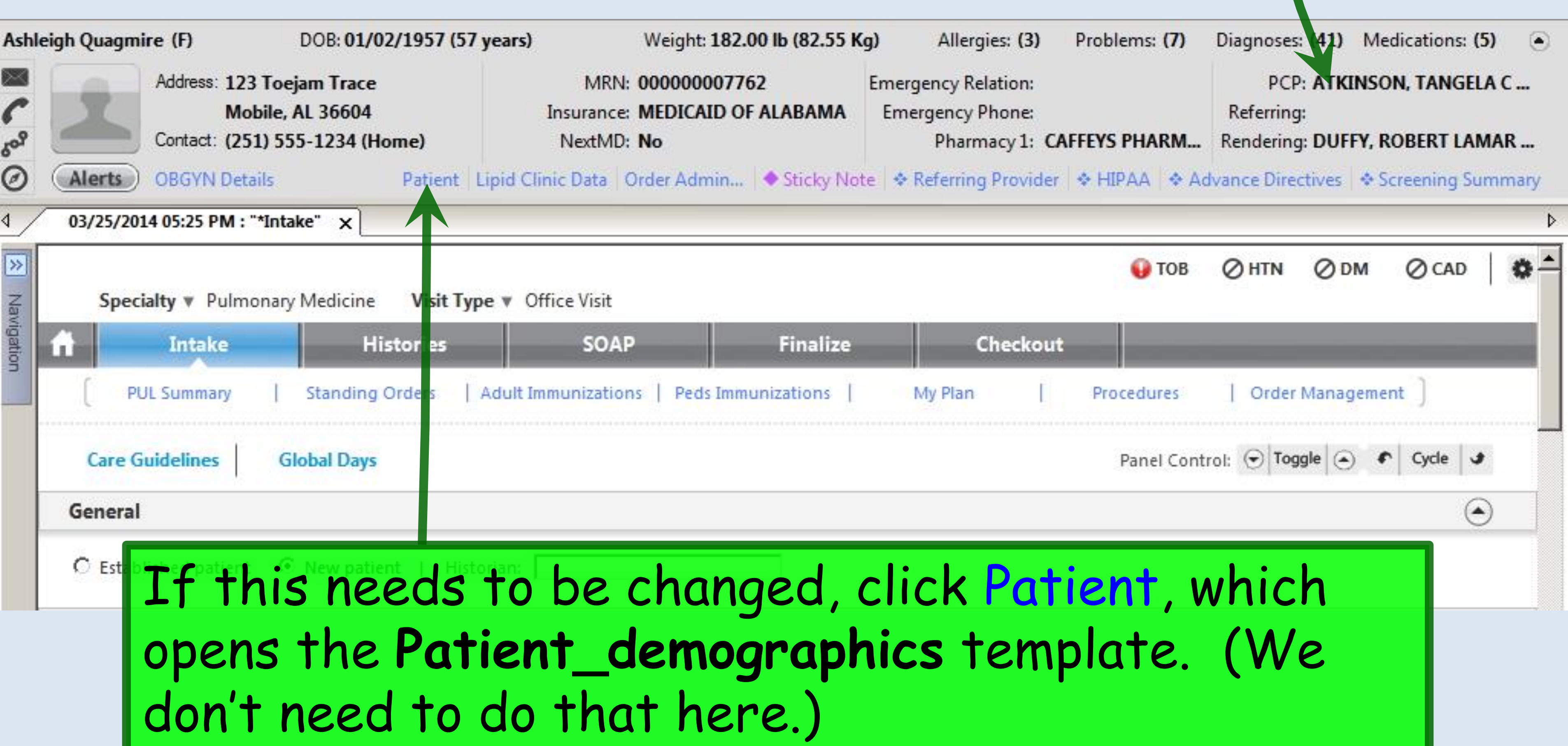
Other times a sticky note would be a temporary notice, like Ask about Tdap next visit. RL Duffy 4/13/13. It's good to put your name & date on such things; otherwise, you have no idea whether they're still pertinent when you see them in the future. And you should delete such sticky notes when they're no longer meaningful.

When done click Save & Close.

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 herself.

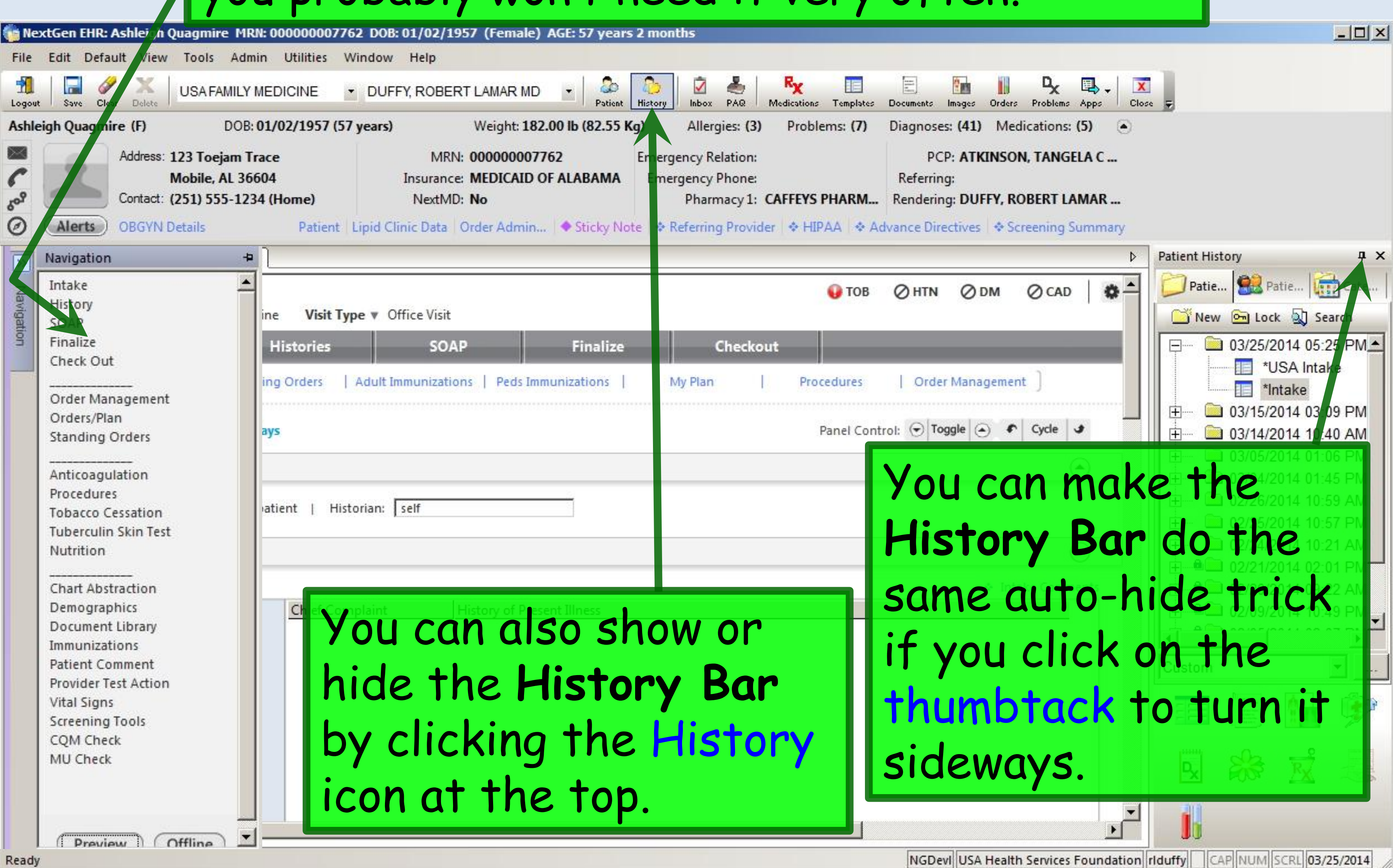


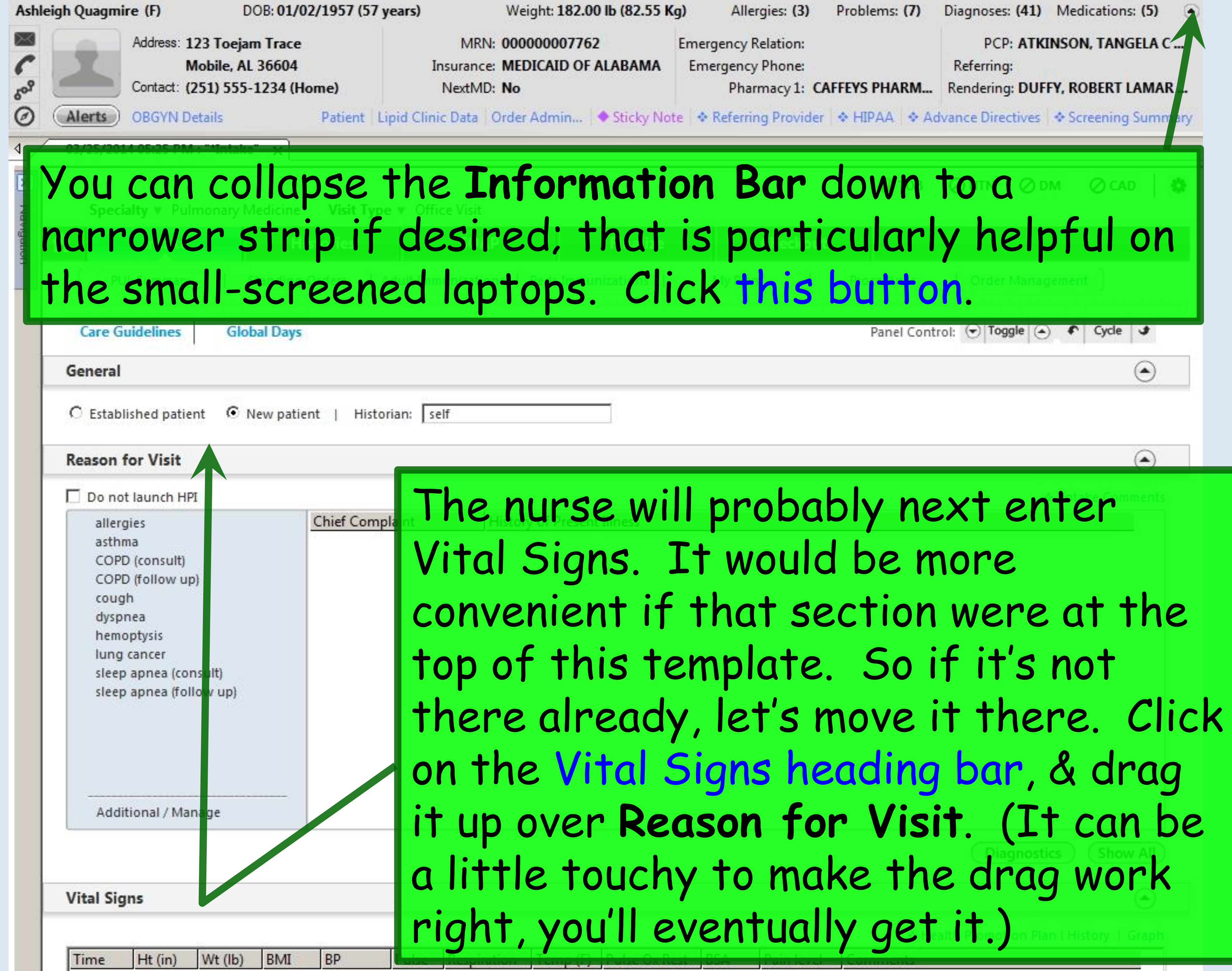
Note the **PCP**.



If this needs to be changed, click Patient, which opens the **Patient_demographics** template. (We don't need to do that here.)

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.





Ashleigh Quagmire (F)
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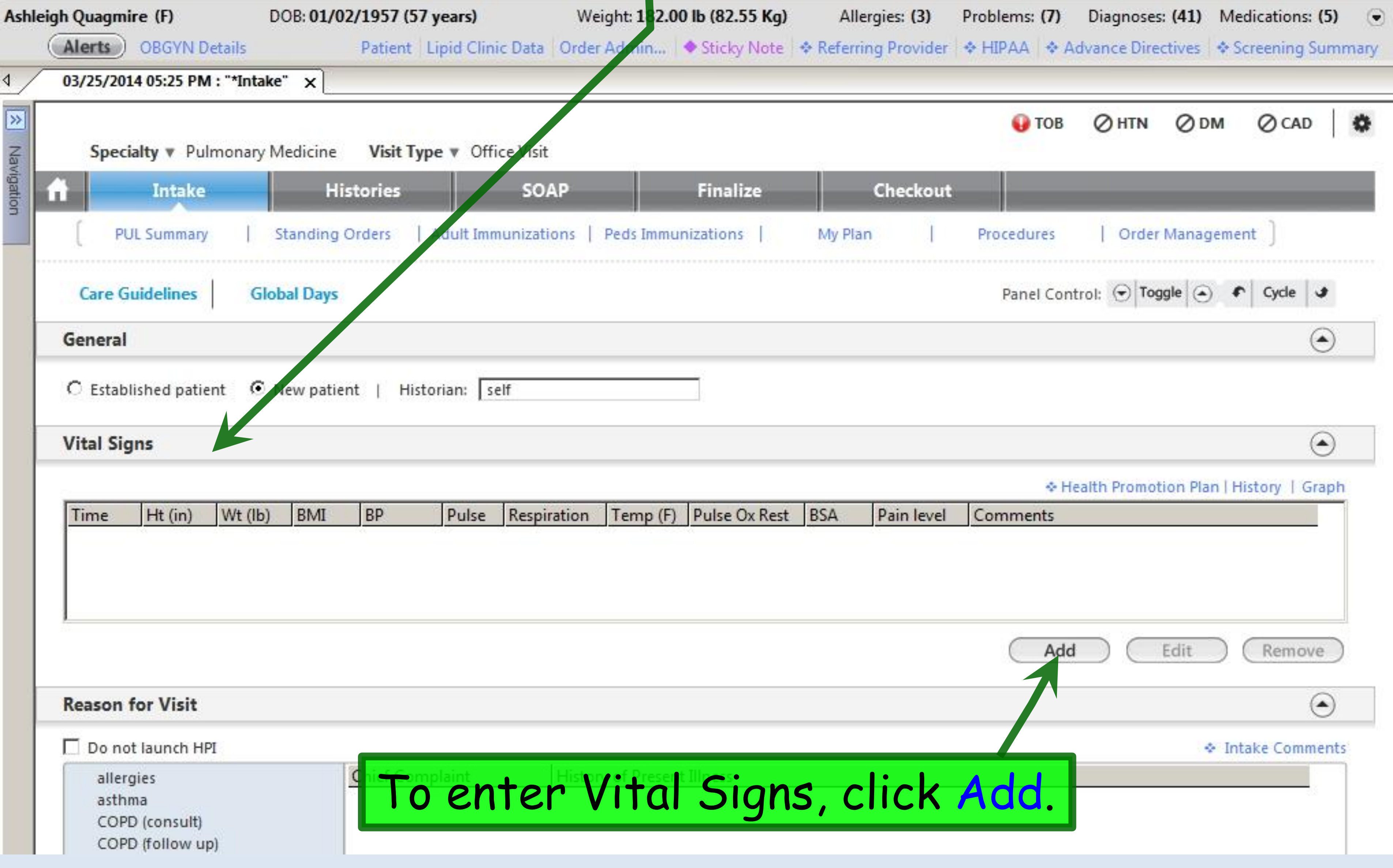
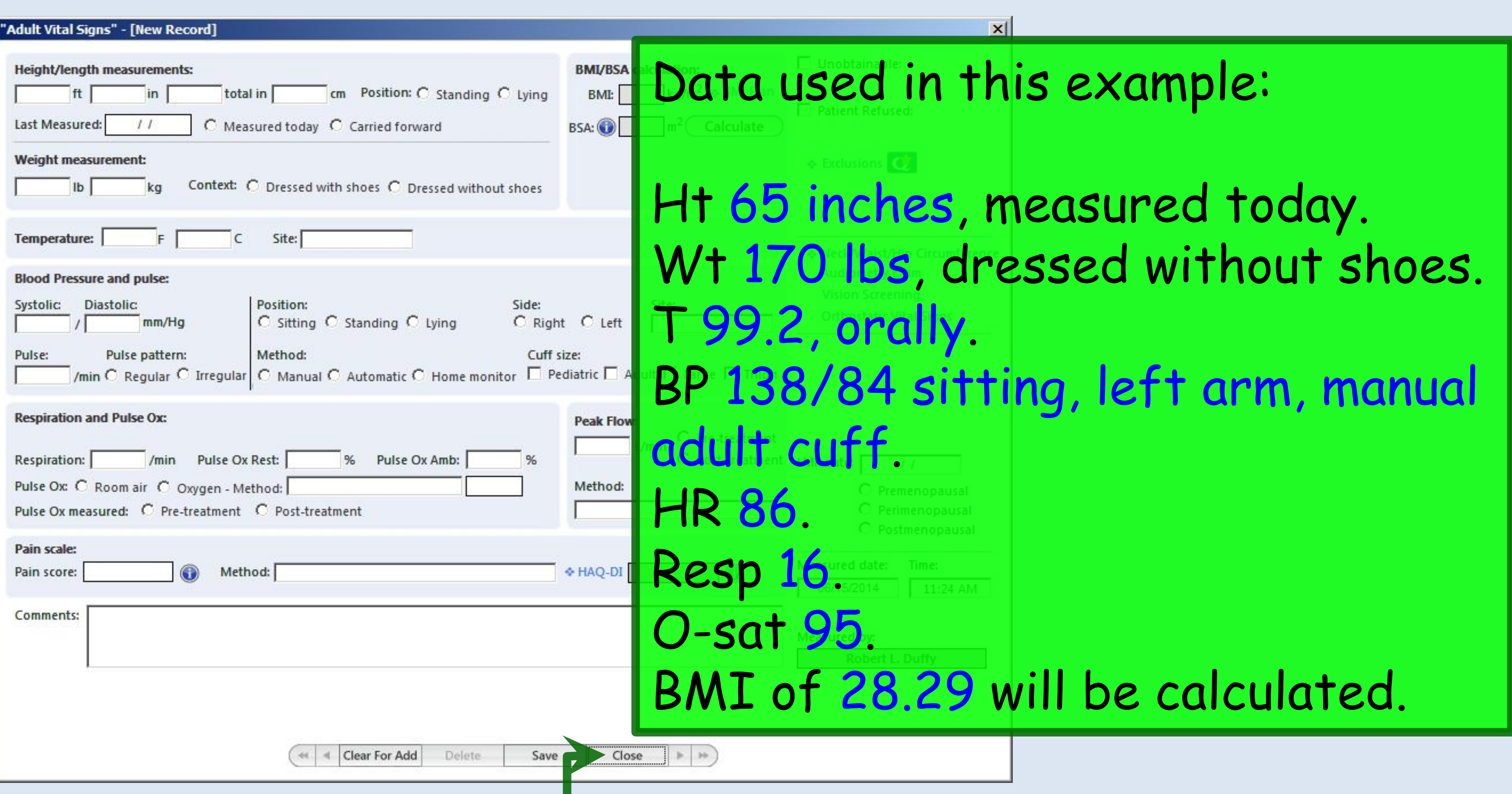
Address: 123 Toejam Trace
Mobile, AL 36604
Contact: (251) 555-1234 (Home)
MRN: 000000007762
Insurance: MEDICAID OF ALABAMA
NextMD: No
Emergency Relation:
Emergency Phone:
Pharmacy 1: CAFFEYS PHARM...
PCP: ATKINSON, TANGELA C...
Referring:
Rendering: DUFFY, ROBERT LAMAR...
Alerts
OBGYN Details
Patient
Lipid Clinic Data
Order Admin...
Sticky Note
Referring Provider
HIPAA
Advance Directives
Screening Summary
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.
Care Guidelines
Global Days
Panel Control:
Toggle
Cycle
General
Established patient
New patient
Historian:
self
Reason for Visit
Do not launch HPI
allergies
asthma
COPD (consult)
COPD (follow up)
cough
dyspnea
hemoptysis
lung cancer
sleep apnea (consult)
sleep apnea (follow up)
Additional / Manage
Chief Complaint
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)
BMI
BP

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



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



Data used in this example:

Ht 65 inches, measured today.
Wt 170 lbs, dressed without shoes.
T 99.2, orally.
BP 138/84 sitting, left arm, manual adult cuff.
HR 86.
Resp 16.
O-sat 95.
BMI of 28.29 will be calculated.

When done, click Save then Close.

Vital signs now display.

03/25/2014 05:25 PM : "*Intake" ×

General

Established patient   New patient | Historian: self

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
5:50 PM	65.00	170.00	28.29	138/84	86	16	99.2	95			

Remove

Reason for Visit

Do not launch HPI

Intake Comments

- allergies
- asthma
- COPD (consult)
- COPD (follow up)
- cough
- dyspnea
- hemoptysis
- lung cancer
- sleep apnea (consult)
- sleep apnea (follow up)

Additional / Manage

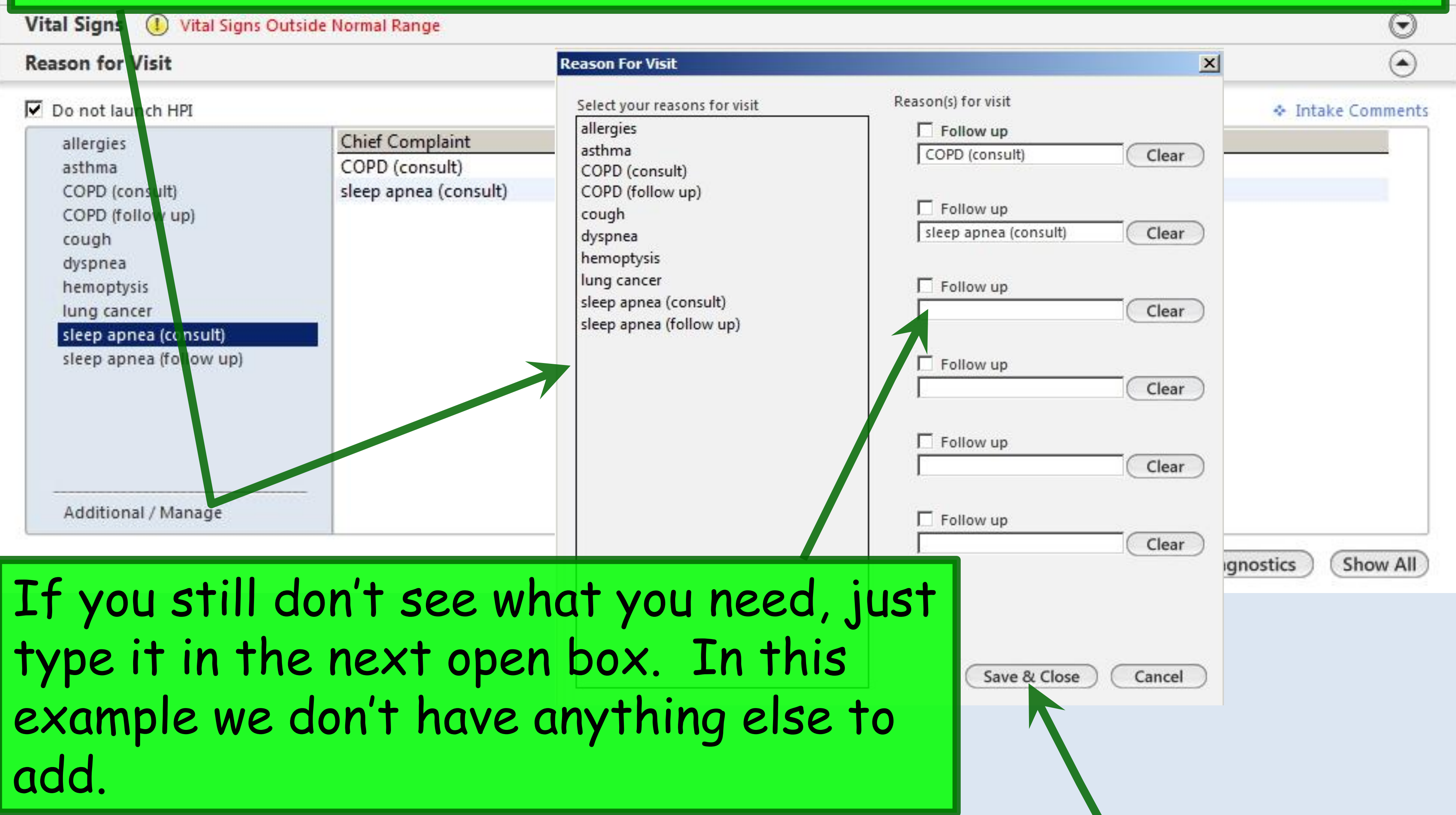
Chief Complaint | History of Present Illness

Now enter Chief Complaints, or **Reasons for Visit**. The most common complaints used in each clinic will appear on this list. Our patient was referred for COPD, so click COPD (consult).

She's also recently seen info about sleep apnea, & wonders if she has that, so also click sleep apnea (consult).

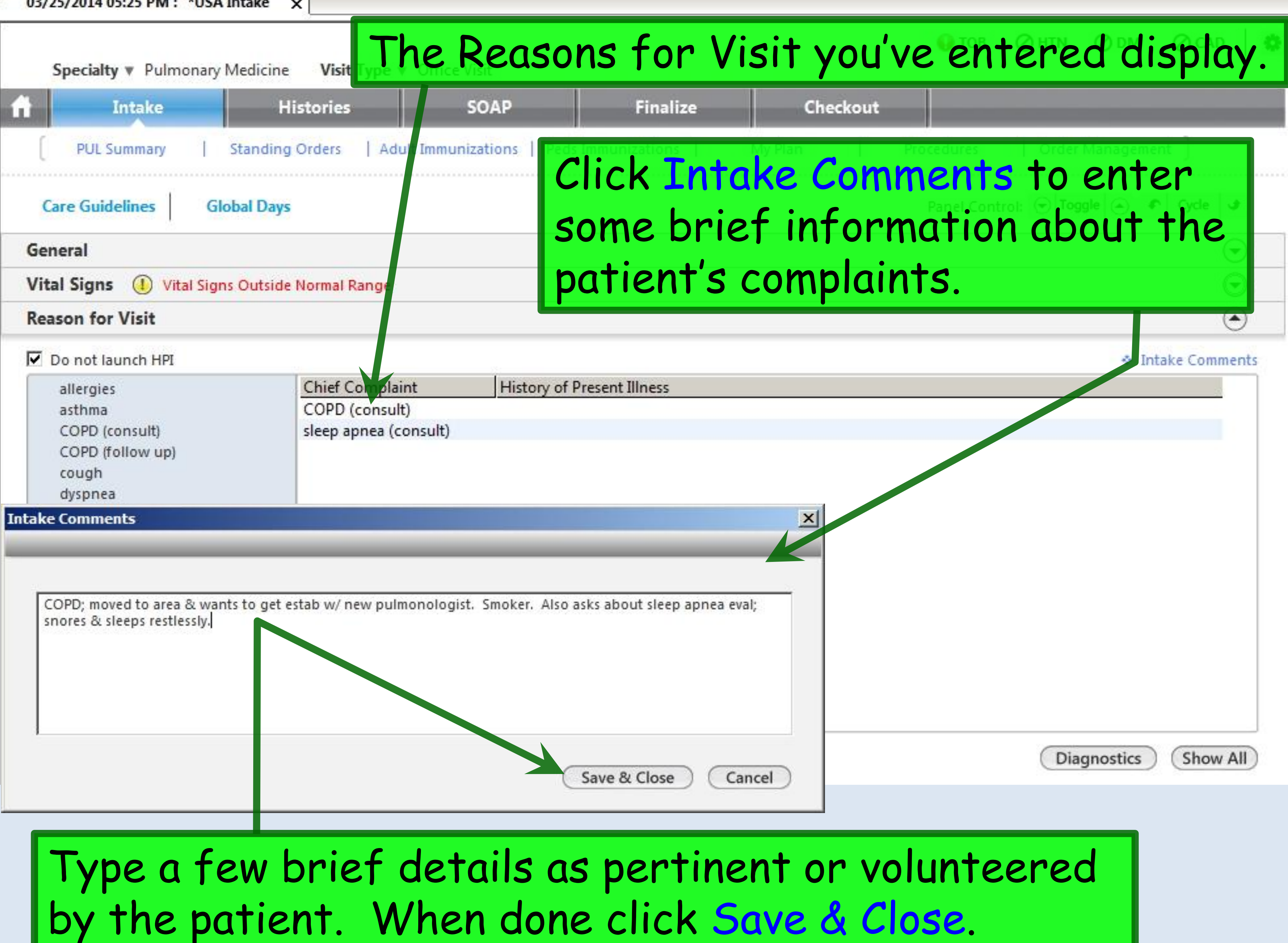
Diagnostics   Show All

If you don't see the complaint you need, click Additional/Manage. Scroll through the list in the popup to make more selections.

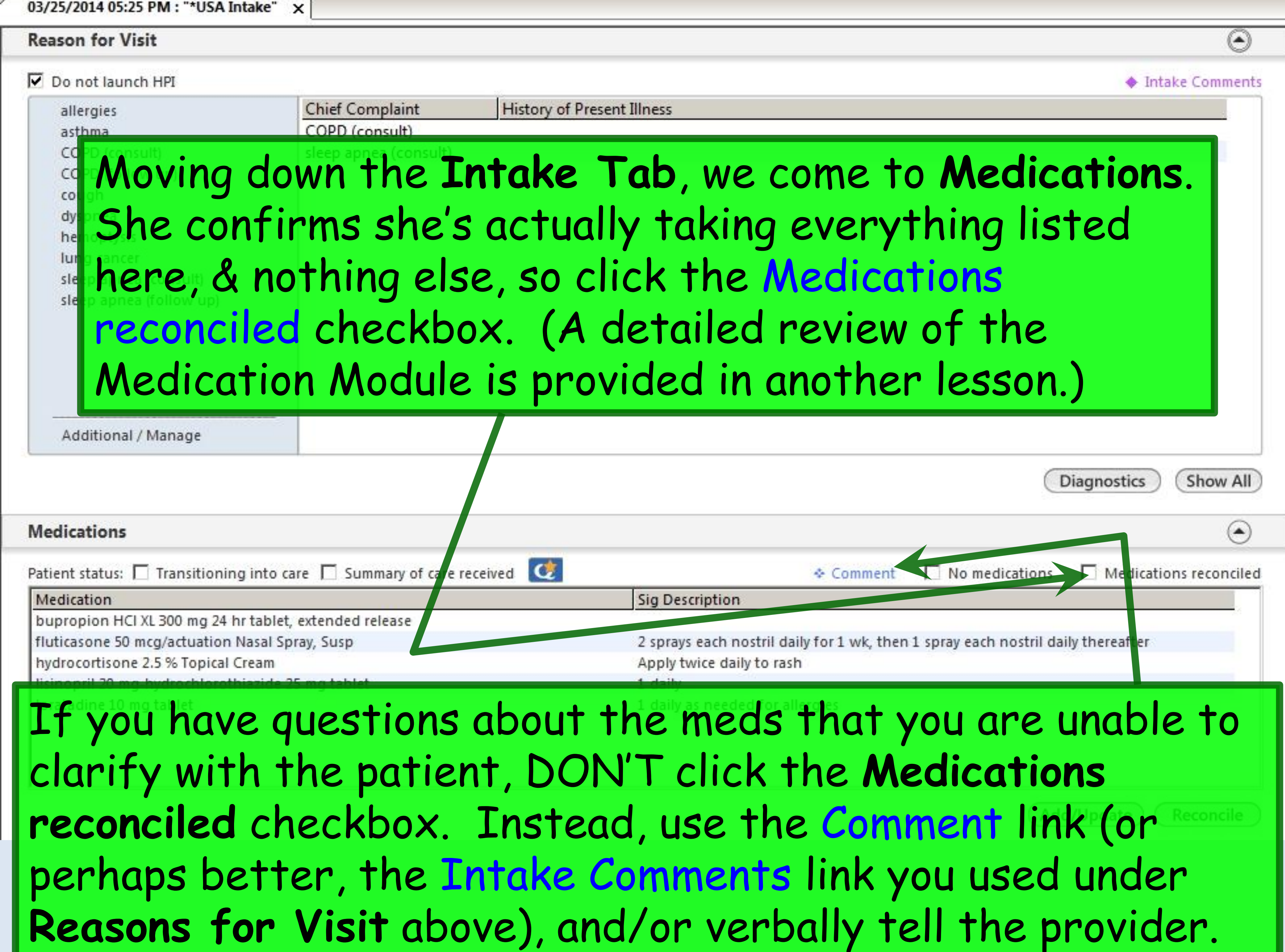


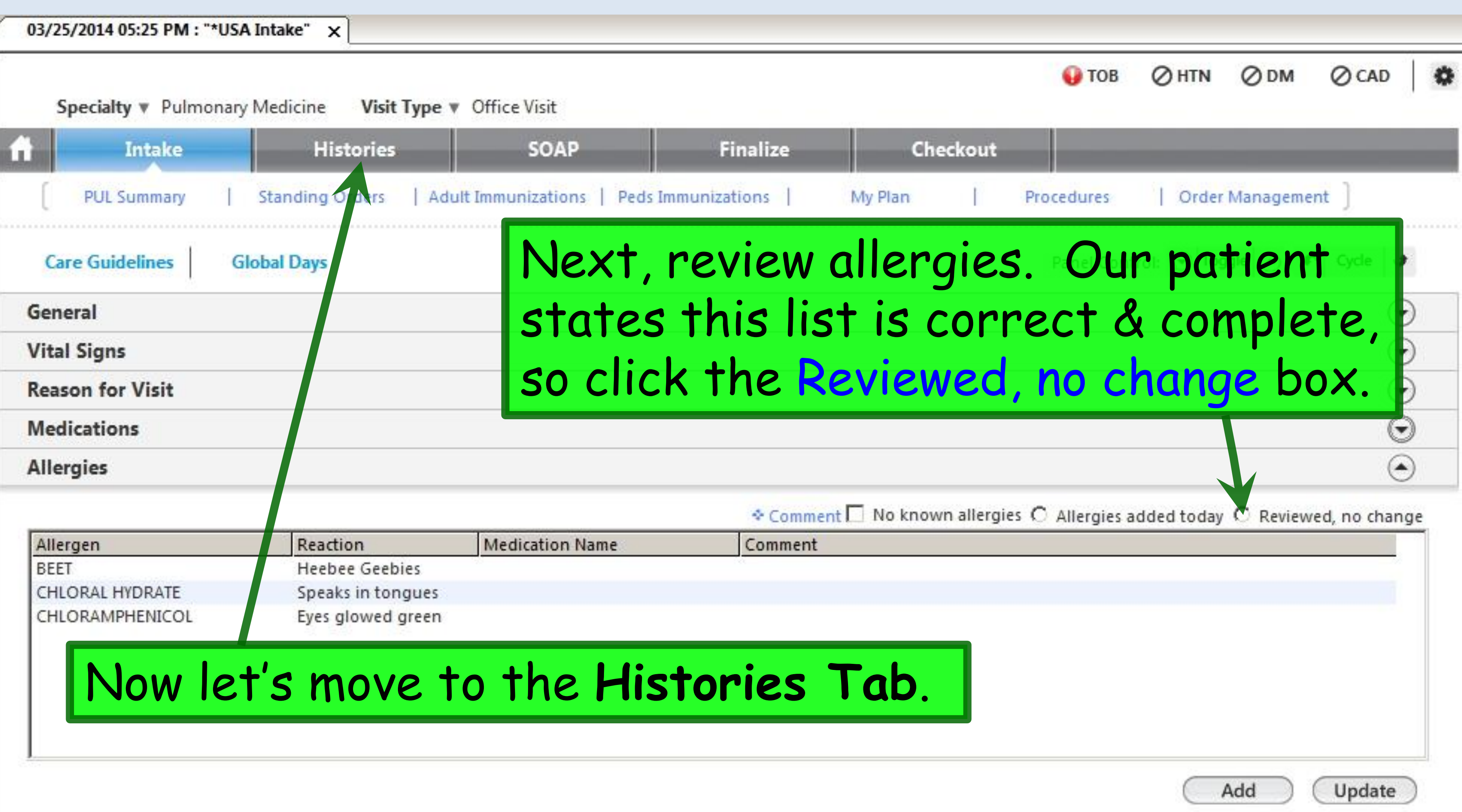
If you still don't see what you need, just type it in the next open box. In this example we don't have anything else to add.

When done, click Save & Close.

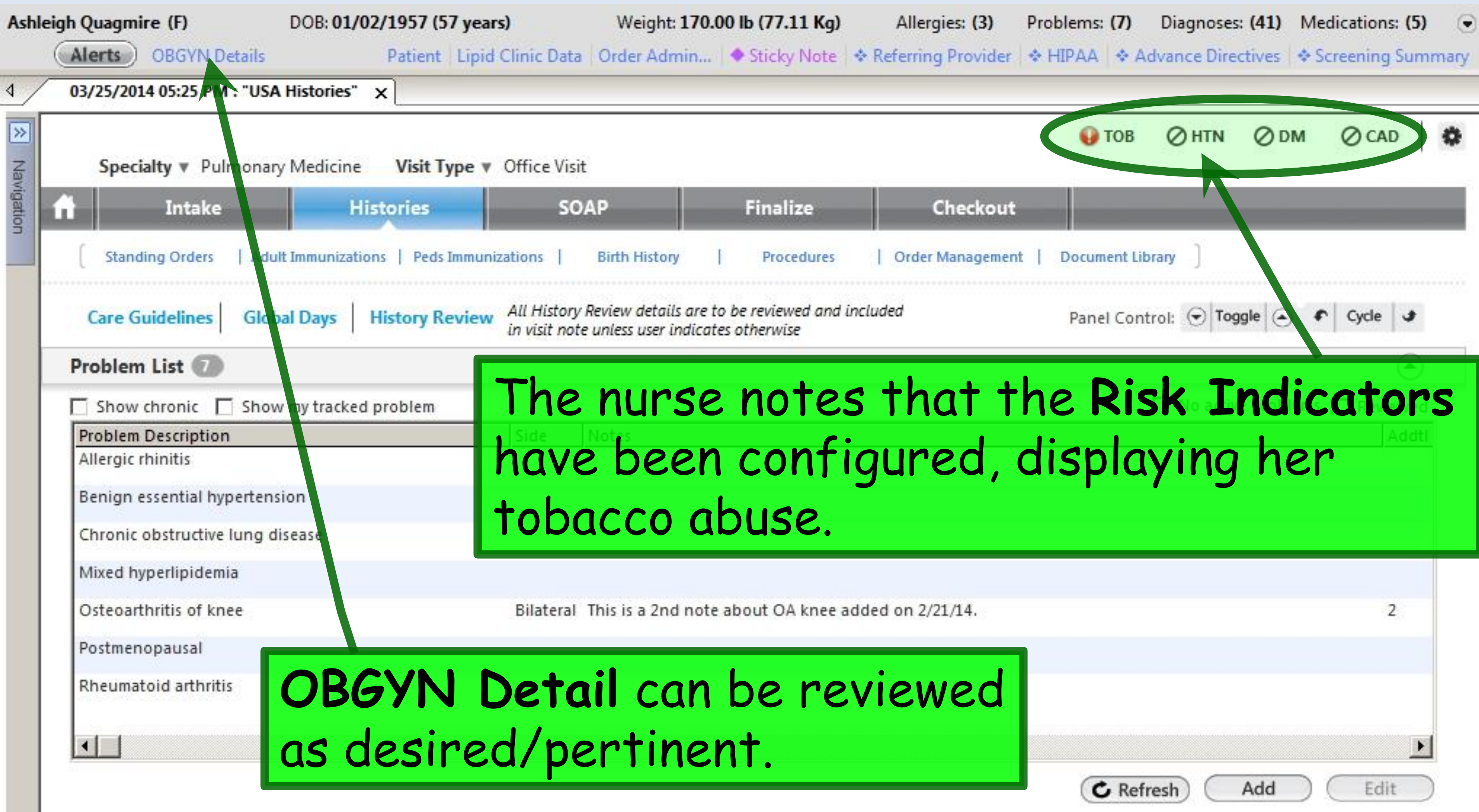


03/25/2014 05:25 PM : "*USA Intake"
The Reasons for Visit you've entered display.
Specialty Pulmonary Medicine
Visit
Intake
Histories
SOAP
Finalize
Checkout
PUL Summary
Standing Orders
Adult Immunizations
Click Intake Comments to enter some brief information about the patient's complaints.
Care Guidelines
Global Days
General
Vital Signs
Vital Signs Outside Normal Range
Reason for Visit
Do not launch HPI
Intake Comments
allergies
asthma
COPD (consult)
COPD (follow up)
cough
dyspnea
Chief Complaint
History of Present Illness
COPD (consult)
sleep apnea (consult)
Intake Comments
COPD; moved to area & wants to get estab w/ new pulmonologist. Smoker. Also asks about sleep apnea eval; snores & sleeps restlessly.
Save & Close
Cancel
Diagnostics
Show All
Type a few brief details as pertinent or volunteered by the patient. When done click Save & Close.

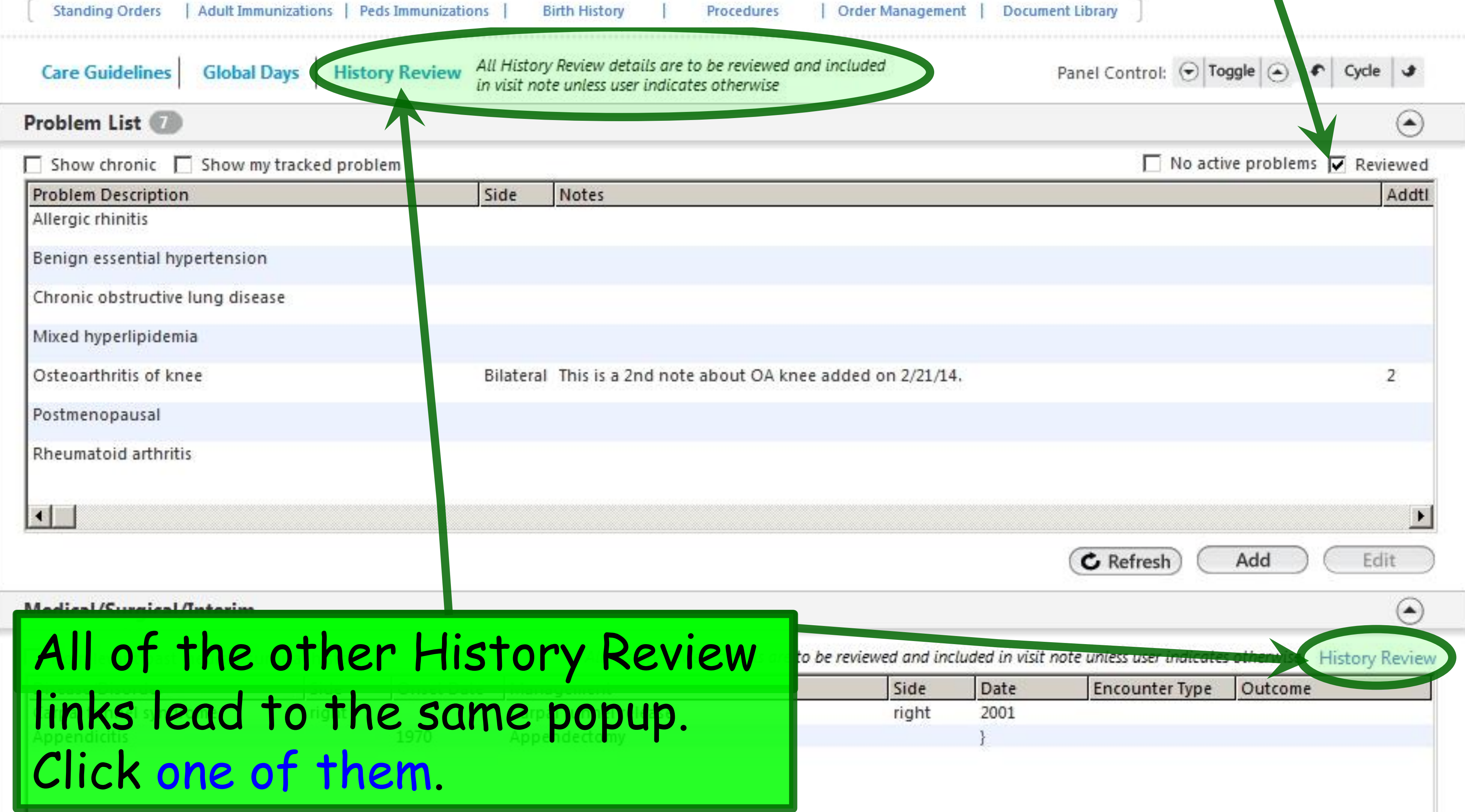

03/25/2014 05:25 PM : "*USA Intake"
Reason for Visit
Do not launch HPI
Intake Comments
allergies
asthma
Chief Complaint
History of Present Illness
COPD (consult)
Additional / Manage
Diagnostics
Show All
Medications
Patient status:
Transitioning into care
Summary of care received
Comment
No medications
Medications reconciled
Medication
Sig Description
bupropion HCl XL 300 mg 24 hr tablet, extended release
fluticasone 50 mcg/actuation Nasal Spray, Susp
2 sprays each nostril daily for 1 wk, then 1 spray each nostril daily thereafter
hydrocortisone 2.5 % Topical Cream
Apply twice daily to rash
Moving down the Intake Tab, we come to Medications. She confirms she's actually taking everything listed here, & nothing else, so click the Medications reconciled checkbox. (A detailed review of the Medication Module is provided in another lesson.)
If you have questions about the meds 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.


03/25/2014 05:25 PM : "*USA Intake"
TOB
HTN
DM
CAD
Specialty
Pulmonary Medicine
Visit Type
Office Visit
Intake
Histories
SOAP
Finalize
Checkout
PUL Summary
Standing Orders
Adult Immunizations
Peds Immunizations
My Plan
Procedures
Order Management
Care Guidelines
Global Days
Next, review allergies. Our patient states this list is correct & complete, so click the Reviewed, no change box.
General
Vital Signs
Reason for Visit
Medications
Allergies
Comment
No known allergies
Allergies added today
Reviewed, no change
Allergen
Reaction
Medication Name
Comment
BEET
Heebee Geebies
CHLORAL HYDRATE
Speaks in tongues
CHLORAMPHENICOL
Eyes glowed green
Now let's move to the Histories Tab.
Add
Update

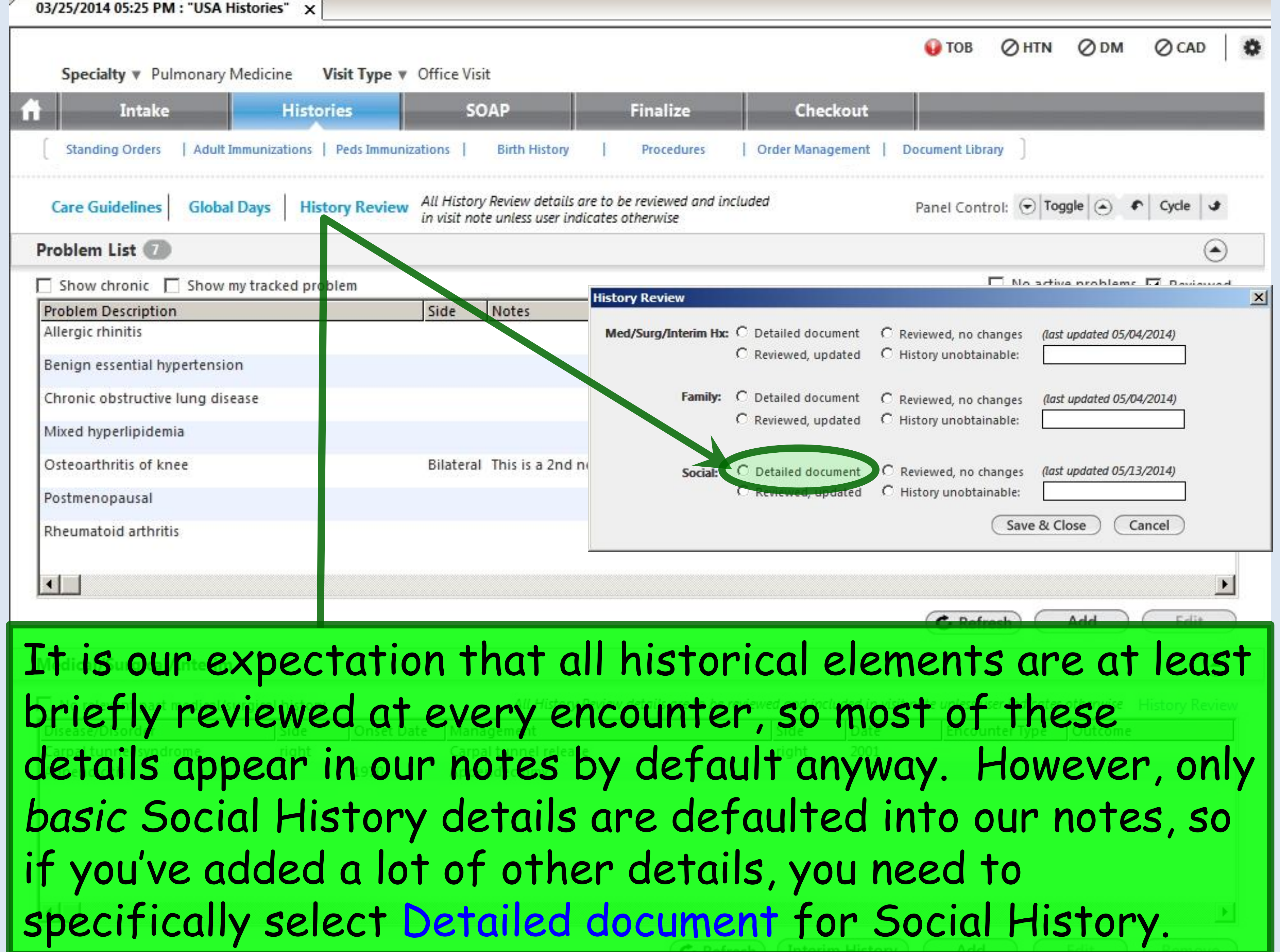
A detailed review of data entry on the **Histories Tab** is included in another lesson, so in this example we'll keep it simple.



The nurse reviews the **Chronic Conditions List**. There is nothing to add, so she'll 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.


03/25/2014 05:25 PM : "USA Histories"
TOB
HTN
DM
CAD
Specialty Pulmonary Medicine
Visit Type Office Visit
Intake
Histories
SOAP
Finalize
Checkout
Standing Orders
Adult Immunizations
Peds Immunizations
Birth History
Procedures
Order Management
Document Library
Care Guidelines
Global Days
History Review
All History Review details are to be reviewed and included in visit note unless user indicates otherwise
Panel Control:
Toggle
Cycle
Problem List 7
Show chronic
Show my tracked problem
Problem Description
Side
Notes
Allergic rhinitis
Benign essential hypertension
Chronic obstructive lung disease
Mixed hyperlipidemia
Osteoarthritis of knee
Bilateral
Postmenopausal
Rheumatoid arthritis
History Review
Med/Surg/Interim Hx:
Detailed document
Reviewed, no changes
(last updated 05/04/2014)
Reviewed, updated
History unobtainable:
Family:
Detailed document
Reviewed, no changes
(last updated 05/04/2014)
Reviewed, updated
History unobtainable:
Social:
Detailed document
Reviewed, no changes
(last updated 05/13/2014)
Reviewed, updated
History unobtainable:
Save & Close
Cancel
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.

03/25/2014 05:25 PM : "USA Histories"

Now review **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. There is nothing to add.

Show chronic | Show my tracked problem | No active problems | Reviewed

Problem Description	Side	Notes	Addtl
Allergic rhinitis			
Benign essential hypertension			
Chronic obstructive lung disease			
Mixed hyperlipidemia			
Osteoarthritis of knee	Bilateral	This is a 2nd note about OA knee added on 2/21/14.	2
Postmenopausal			
Rheumatoid arthritis			

Refresh | Add | Edit

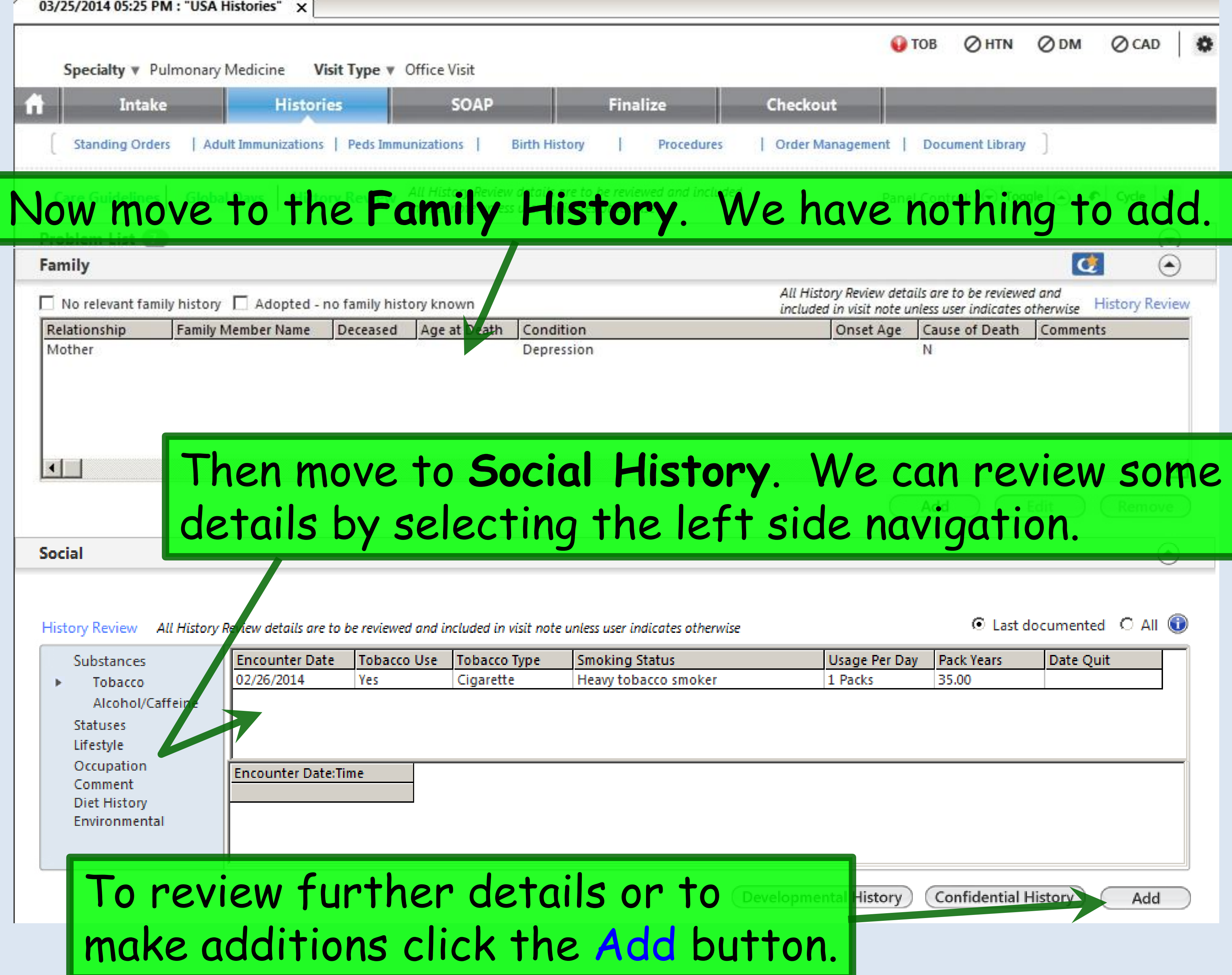
Medical/Surgical/Interim

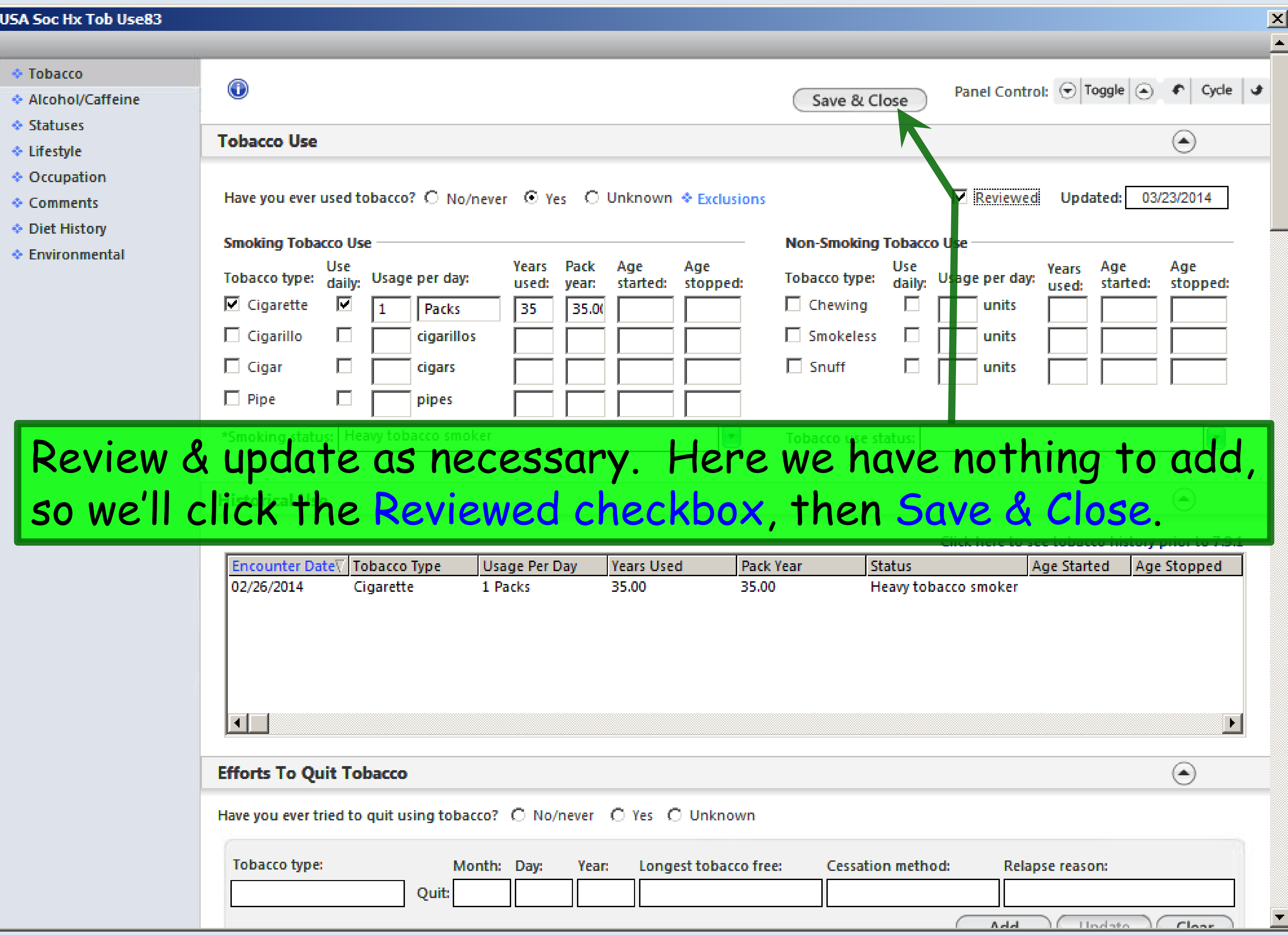
No relevant past medical/surgical history

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
Carpal tunnel syndrome	right		Carpal tunnel release	right	2001		
Appendicitis		1970	Appendectomy		}		

Refresh | Interim History | Add | Edit | Remove


03/25/2014 05:25 PM : "USA Histories"
TOB
HTN
DM
CAD
Specialty Pulmonary Medicine
Visit Type Office Visit
Intake
Histories
SOAP
Finalize
Checkout
Standing Orders | Adult Immunizations | Peds Immunizations | Birth History | Procedures | Order Management | Document Library
Now move to the Family History. We have nothing to add.
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
Mother | Depression | N
Then move to Social History. We can review some details by selecting the left side navigation.
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
02/26/2014 | Yes | Cigarette | Heavy tobacco smoker | 1 Packs | 35.00
Encounter Date:Time
To review further details or to make additions click the Add button.
History
Confidential History
Add


USA Soc Hx Tob Use83
Tobacco
Alcohol/Caffeine
Statuses
Lifestyle
Occupation
Comments
Diet History
Environmental
Save & Close
Panel Control:
Toggle
Cycle
Tobacco Use
Have you ever used tobacco? No/never Yes Unknown Exclusions
Reviewed
Updated: 03/23/2014
Smoking Tobacco Use
Tobacco type: Use daily: Usage per day: Years used: Pack year: Age started: Age stopped:
Cigarette 1 Packs 35 35.0
Cigarillo cigarillos
Cigar cigars
Pipe pipes
Non-Smoking Tobacco Use
Chewing units
Smokeless units
Snuff units
Review & update as necessary. Here we have nothing to add, so we'll click the Reviewed checkbox, then Save & Close.
Encounter Date Tobacco Type Usage Per Day Years Used Pack Year Status Age Started Age Stopped
02/26/2014 Cigarette 1 Packs 35.00 35.00 Heavy tobacco smoker
Efforts To Quit Tobacco
Have you ever tried to quit using tobacco? No/never Yes Unknown
Tobacco type:
Quit:
Month: Day: Year: Longest tobacco free: Cessation method: Relapse reason:

03/23/2014 04:27 PM : "USA Histories" ×

TOB HTN DM CAD

Specialty ▾ Nephrology Visit Type ▾ Office Visit

Intake | Histories | SOAP | Finalize | Checkout

Standing Orders | Adult Immunizations | Peds Immunizations | Birth History | Procedures | Order Management | Document Library

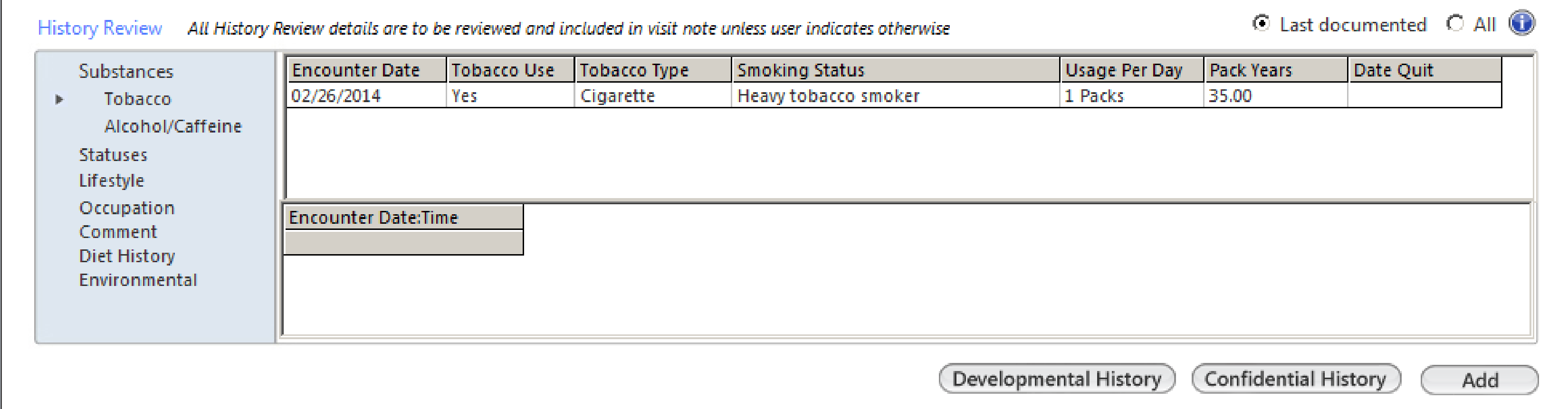
Care Guidelines | Global Days | History Review *All History Review details are to be reviewed and included in visit note unless user indicates otherwise* Panel Control: Toggle Cycle

Family

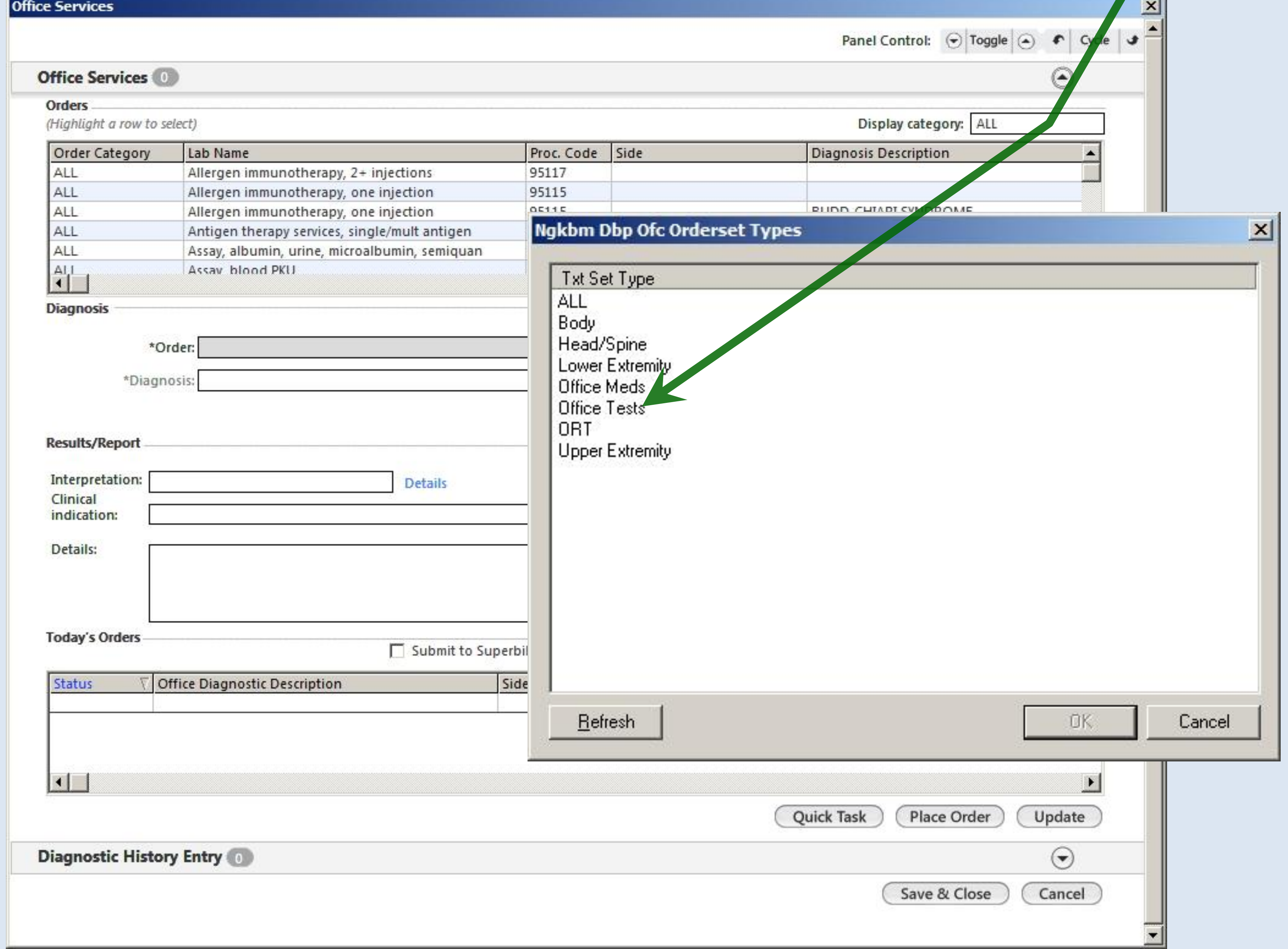
☐ No relevant family history ☐ Adopted - no family history known *All History Review details are to be reviewed and included in visit note unless user indicates otherwise* History Review

Relationship	Family Member Name	Deceased	Age at Death	Condition	Onset Age	Cause of Death	Comments
				No family history of Alcoholism		N	
				No family history of Diabetes mellitus		N	
Father		Y					
Father				Coronary artery disease		N	
Father				Hypertension		N	
Father		Y		Cancer, lung	65	Y	

Say the clinic has standing orders to perform spirometry on all asthma/COPD patients. Click the Standing Orders link, which can be found in several locations.



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



Scroll down & find Spirometry associated with Obstructive Chronic Bronchitis…. Select that, then type in the Detail Box. The exact preferred workflow may vary among clinics & providers, but a sample entry would be See scanned results & MD's interpretation.

Order Category	Lab Name	Proc. Code	Side	Diagnosis Description
Office Tests	Spirometry	94010		ASTHMA NOS
Office Tests	Spirometry	94010		OBST CHR BRONC W/O EXAC
Office Tests	Strep test, rapid	87880		ACUTE PHARYNGITIS
Office Tests	Strep test, rapid	87880		STREP SORE THROAT
Office Tests	TB skin test/PPD	86580		
Office Tests	TB skin test/PPD	86580		ROUTIN CHILD HEALTH EXAM

Diagnosis

*Order: Spirometry

*Diagnosis: OBST CHR BRONC W/O EXAC

Results/Report

Interpretation: see detail Details

Normal value/range:

Unit of measure:

Clinical indication:

Sort By: Summary Phrase My Phrases | Manage My Phrases

Details: See scanned results & MD's interpretation.

Today's Orders

Submit to Superbill   Verbal order/needs sign-off   Send task automatically   Additional Orders | Task

Status	Office Diagnostic Description	Side	Interpretation	Result	Performed By	Cl

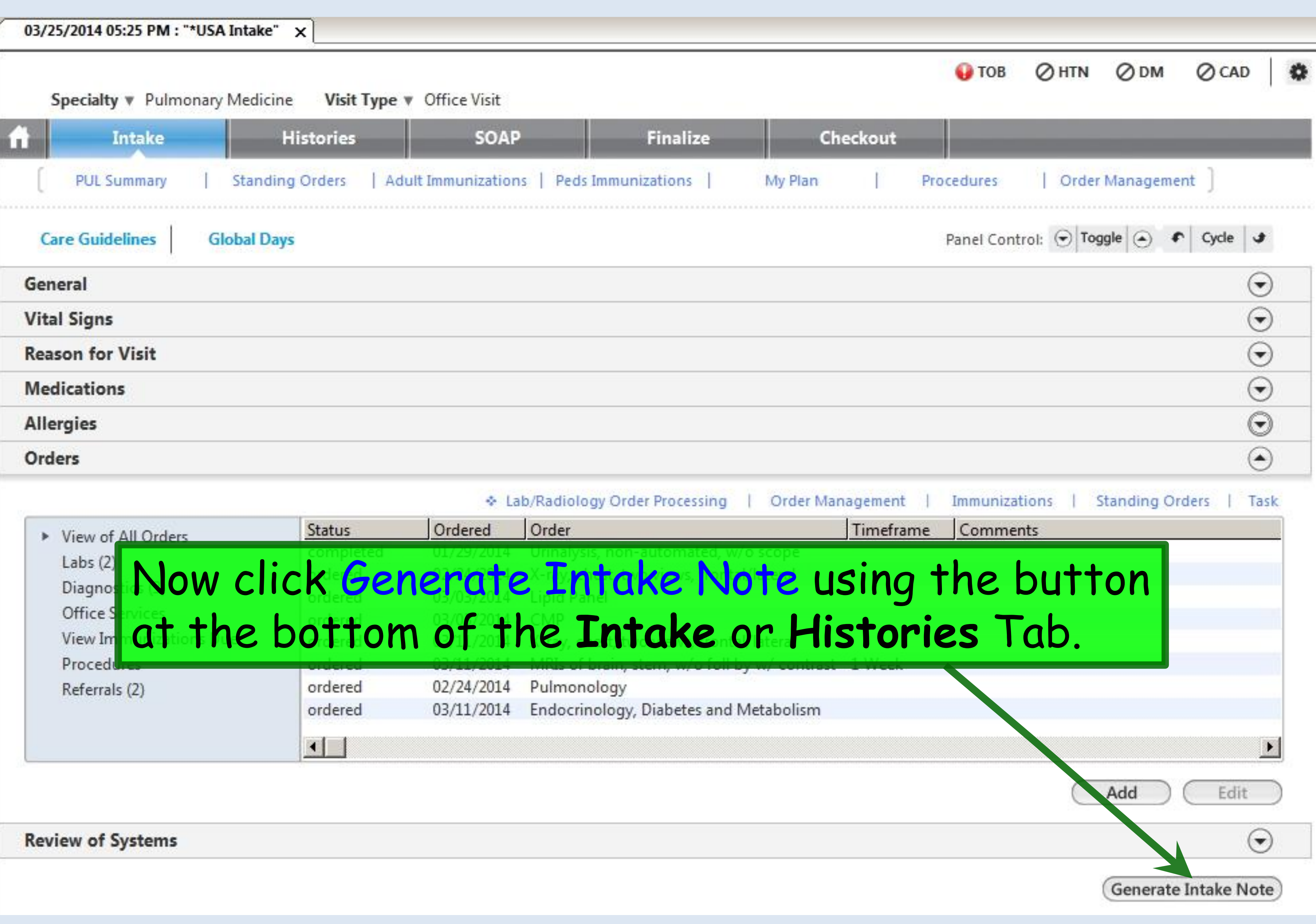
Quick Task   Place Order   Update

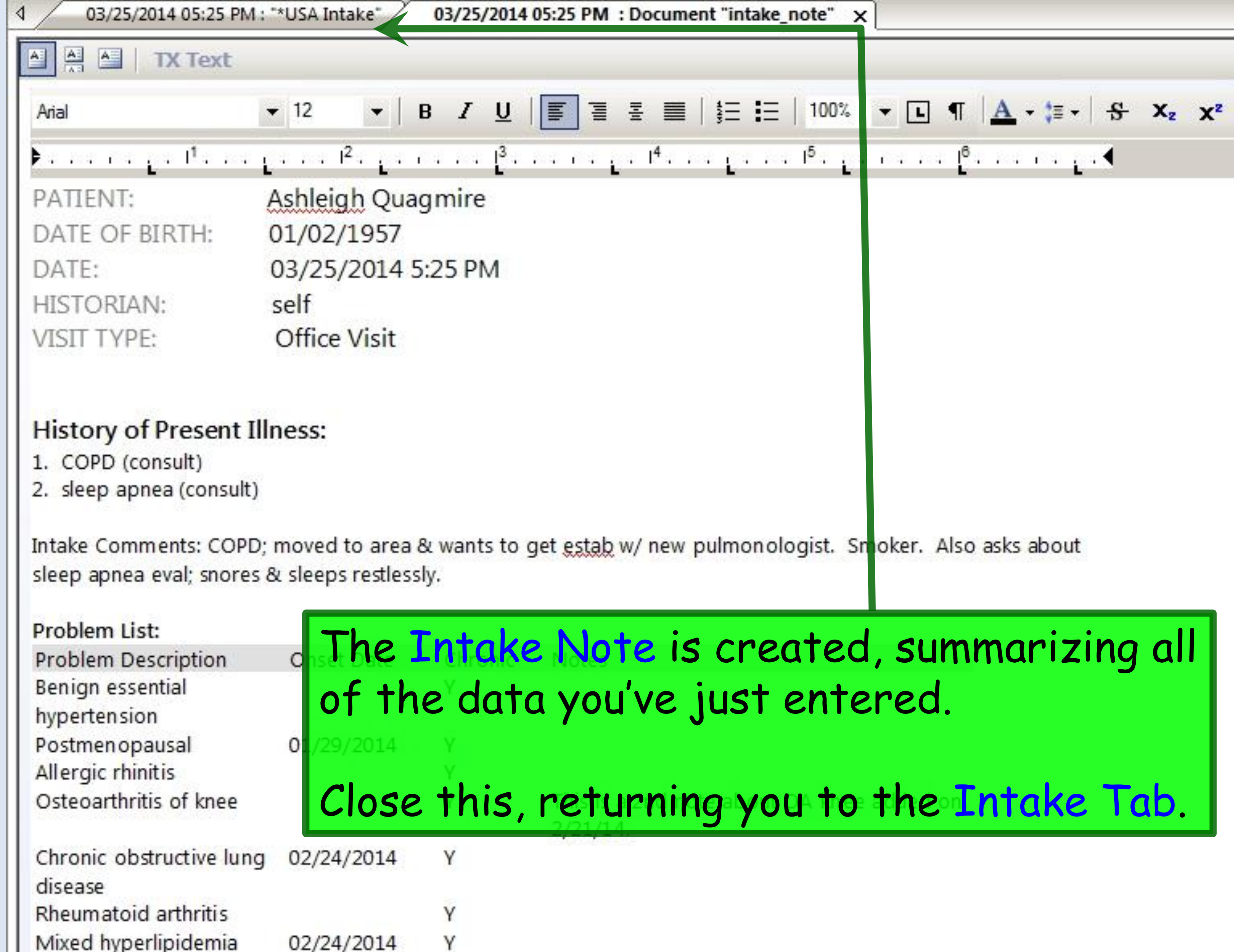
Diagnostic History Entry

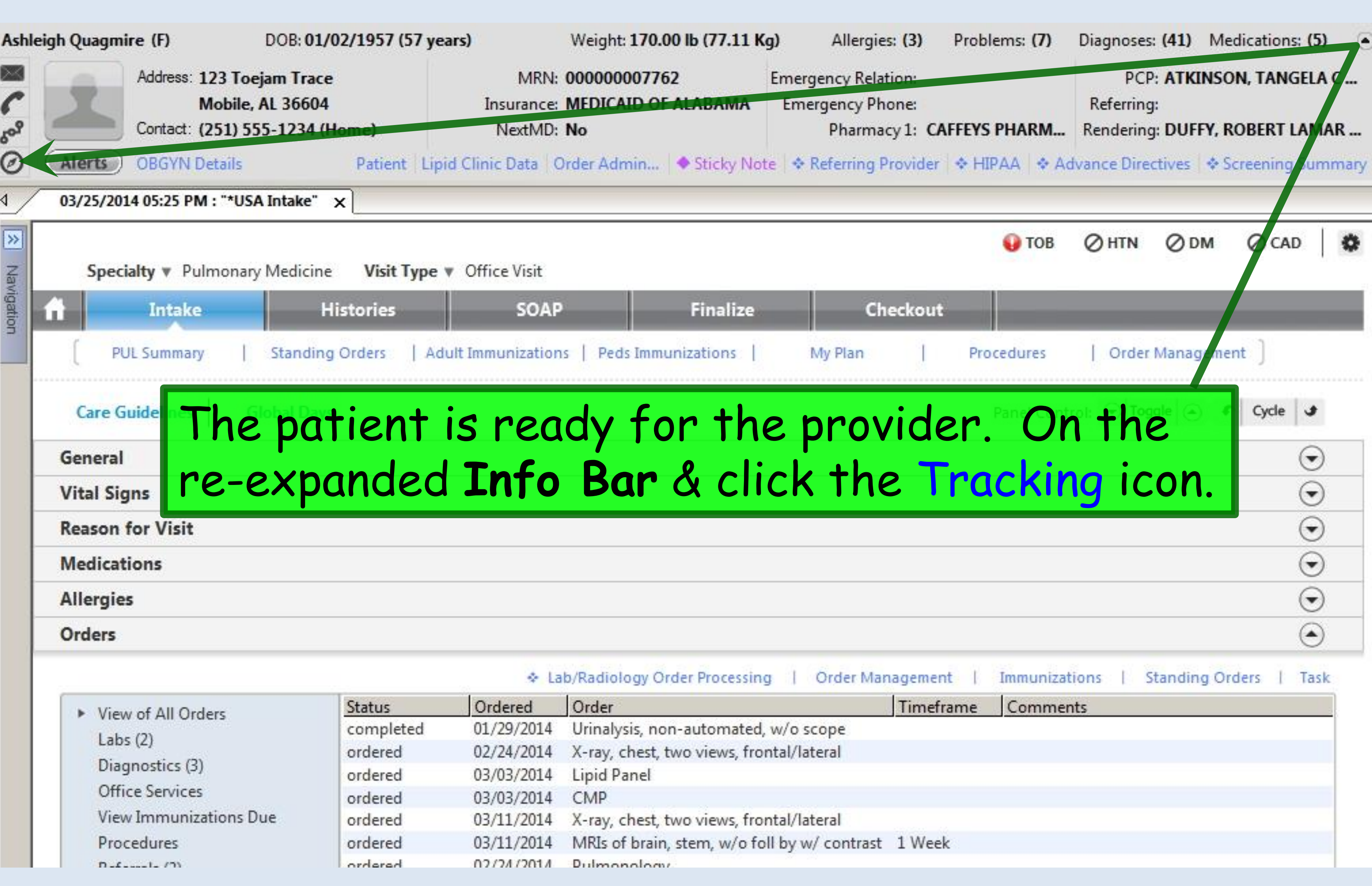
Save & Close   Cancel

Click Submit to Superbill, then Place Order.

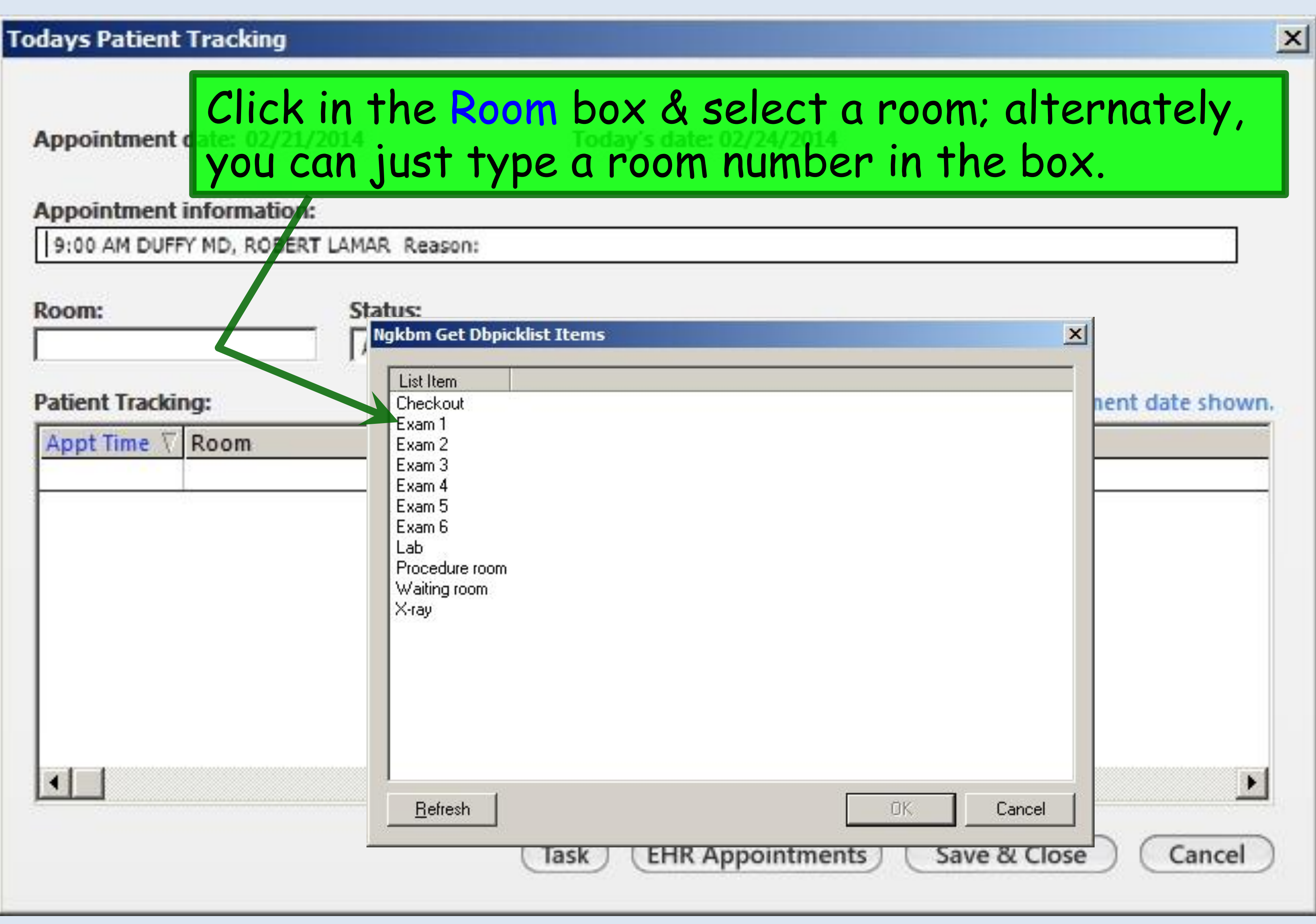
When done click Close.

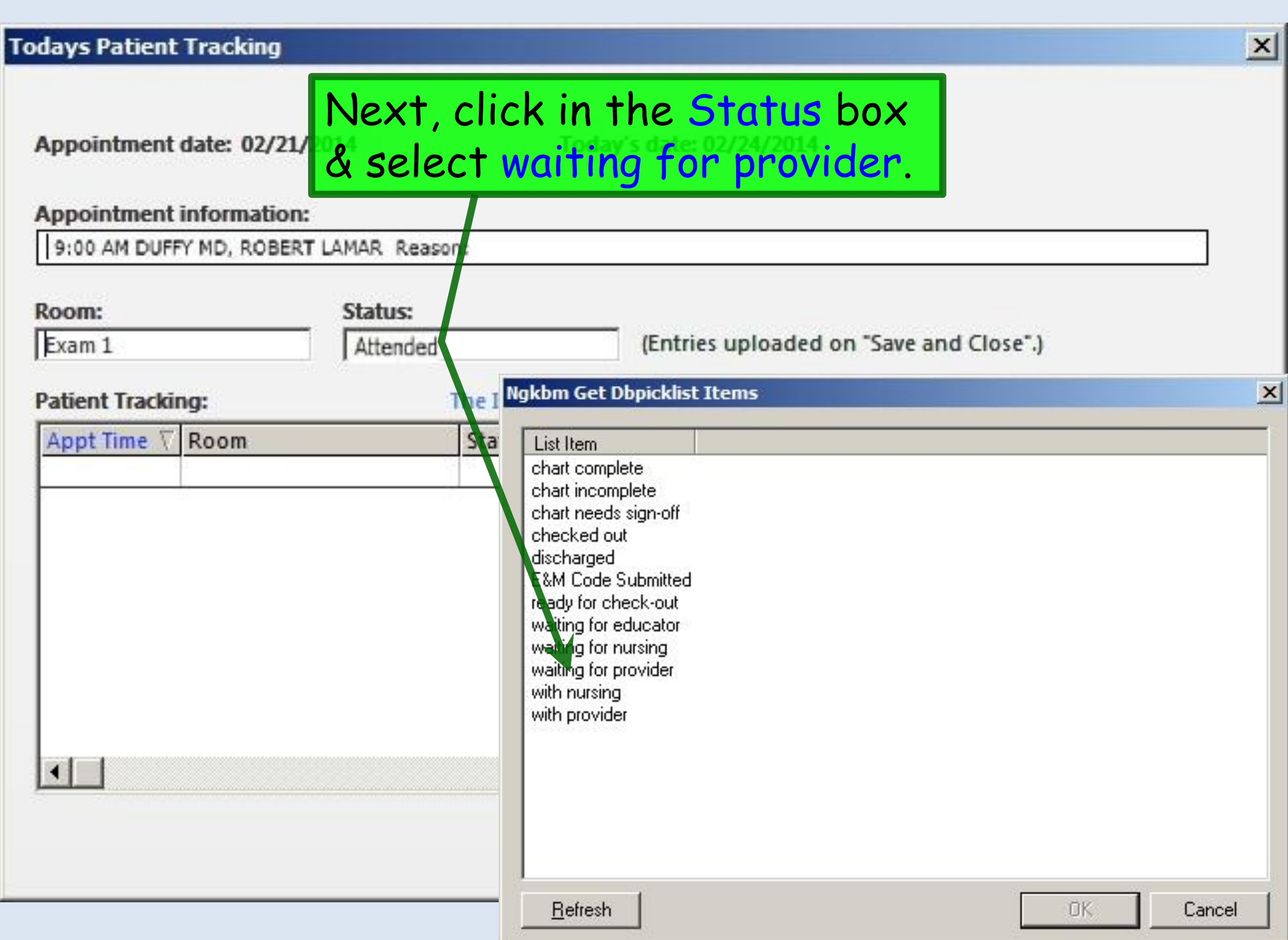

03/25/2014 05:25 PM : "*USA Intake"
TOB
HTN
DM
CAD
Specialty Pulmonary Medicine
Visit Type Office Visit
Intake
Histories
SOAP
Finalize
Checkout
PUL Summary | Standing Orders | Adult Immunizations | Peds Immunizations | My Plan | Procedures | Order Management
Care Guidelines
Global Days
Panel Control: Toggle Cycle
General
Vital Signs
Reason for Visit
Medications
Allergies
Orders
Lab/Radiology Order Processing | Order Management | Immunizations | Standing Orders | Task
View of All Orders
Labs (2)
Referrals (2)
Status
Ordered
Order
Timeframe
Comments
ordered 02/24/2014 Pulmonology
ordered 03/11/2014 Endocrinology, Diabetes and Metabolism
Now click Generate Intake Note using the button at the bottom of the Intake or Histories Tab.
Add
Edit
Review of Systems
Generate Intake Note

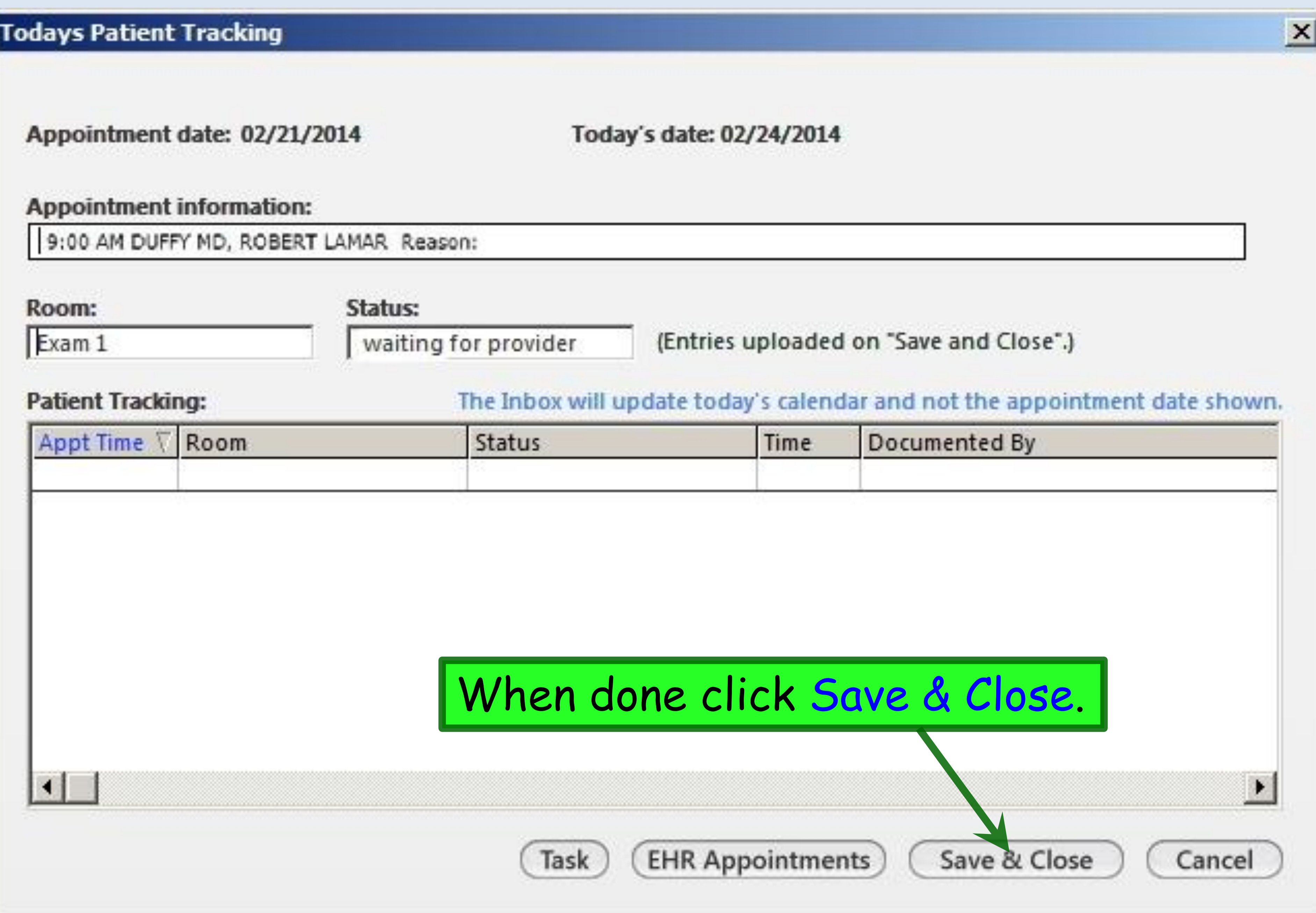

03/25/2014 05:25 PM : "*USA Intake"
03/25/2014 05:25 PM : Document "intake_note"
TX Text
Arial
12
100%
PATIENT: Ashleigh Quagmire
DATE OF BIRTH: 01/02/1957
DATE: 03/25/2014 5:25 PM
HISTORIAN: self
VISIT TYPE: Office Visit
History of Present Illness:
1. COPD (consult)
2. sleep apnea (consult)
Intake Comments: COPD; moved to area & wants to get estab w/ new pulmonologist. Smoker. Also asks about sleep apnea eval; snores & sleeps restlessly.
Problem List:
Problem Description
Benign essential hypertension
Postmenopausal
Allergic rhinitis
Osteoarthritis of knee
Chronic obstructive lung disease 02/24/2014 Y
Rheumatoid arthritis Y
Mixed hyperlipidemia 02/24/2014 Y
The Intake Note is created, summarizing all of the data you've just entered.
Close this, returning you to the Intake Tab.

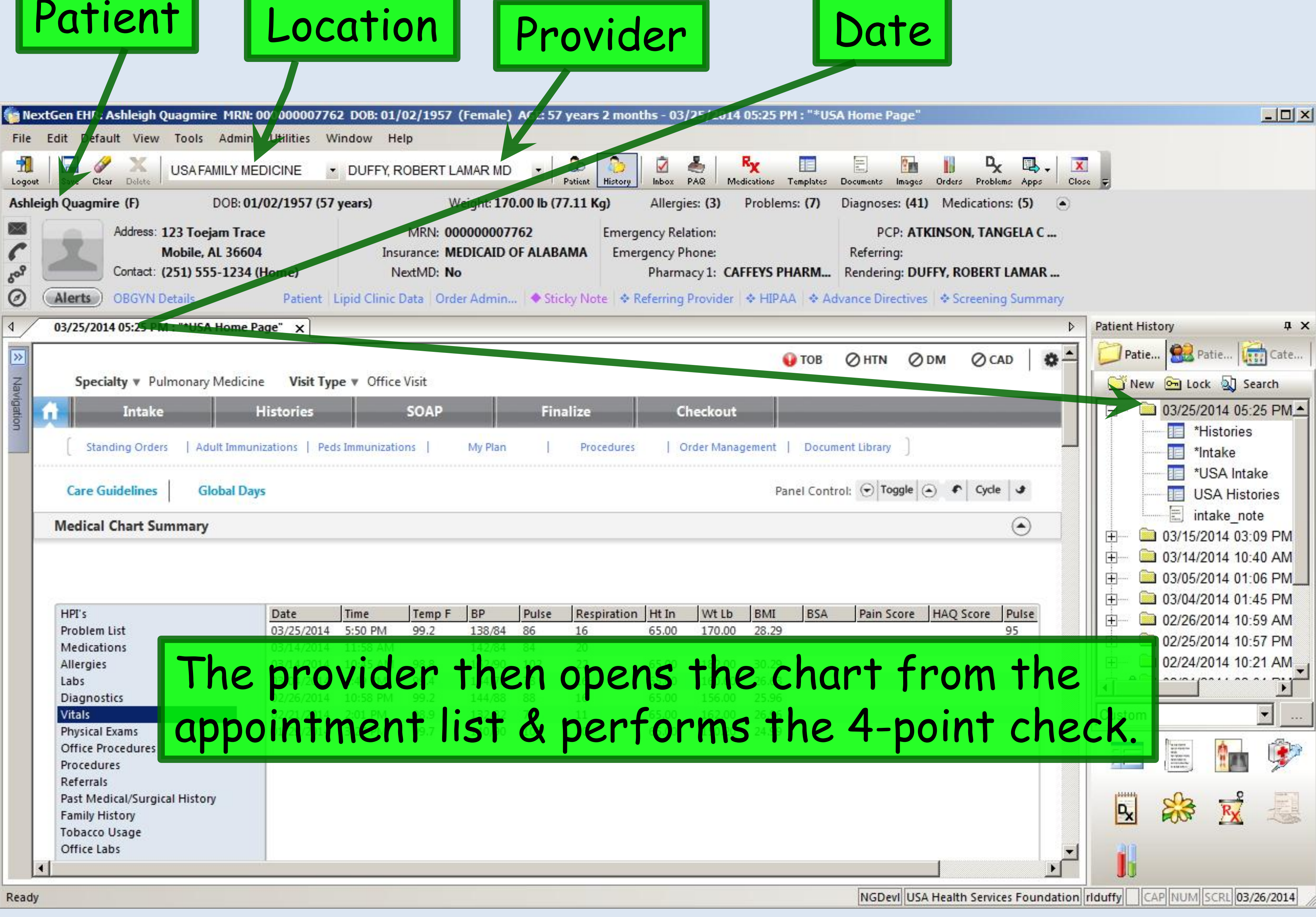


Ashleigh Quagmire (F)
DOB: 01/02/1957 (57 years)
Weight: 170.00 lb (77.11 Kg)
Allergies: (3)
Problems: (7)
Diagnoses: (41)
Medications: (5)
Address: 123 Toejam Trace
Mobile, AL 36604
Contact: (251) 555-1234 (Home)
MRN: 000000007762
Insurance: MEDICAID OF ALABAMA
NextMD: No
Emergency Relation:
Emergency Phone:
Pharmacy 1: CAFFEYS PHARM...
PCP: ATKINSON, TANGELA C...
Referring:
Rendering: DUFFY, ROBERT LAMAR ...
Alerts
OBGYN Details
Patient
Lipid Clinic Data
Order Admin...
Sticky Note
Referring Provider
HIPAA
Advance Directives
Screening Summary
03/25/2014 05:25 PM : "*USA Intake"
Navigation
TOB
HTN
DM
CAD
Specialty Pulmonary Medicine
Visit Type Office Visit
Intake
Histories
SOAP
Finalize
Checkout
PUL Summary
Standing Orders
Adult Immunizations
Peds Immunizations
My Plan
Procedures
Order Management
Care Guide
Cycle
General
Vital Signs
Reason for Visit
Medications
Allergies
Orders
Lab/Radiology Order Processing
Order Management
Immunizations
Standing Orders
Task
View of All Orders
Labs (2)
Diagnostics (3)
Office Services
View Immunizations Due
Procedures
Status | Ordered | Order | Timeframe | Comments
completed | 01/29/2014 | Urinalysis, non-automated, w/o scope
ordered | 02/24/2014 | X-ray, chest, two views, frontal/lateral
ordered | 03/03/2014 | Lipid Panel
ordered | 03/03/2014 | CMP
ordered | 03/11/2014 | X-ray, chest, two views, frontal/lateral
ordered | 03/11/2014 | MRIs of brain, stem, w/o foll by w/ contrast | 1 Week
The patient is ready for the provider. On the re-expanded **Info Bar** & click the Tracking icon.

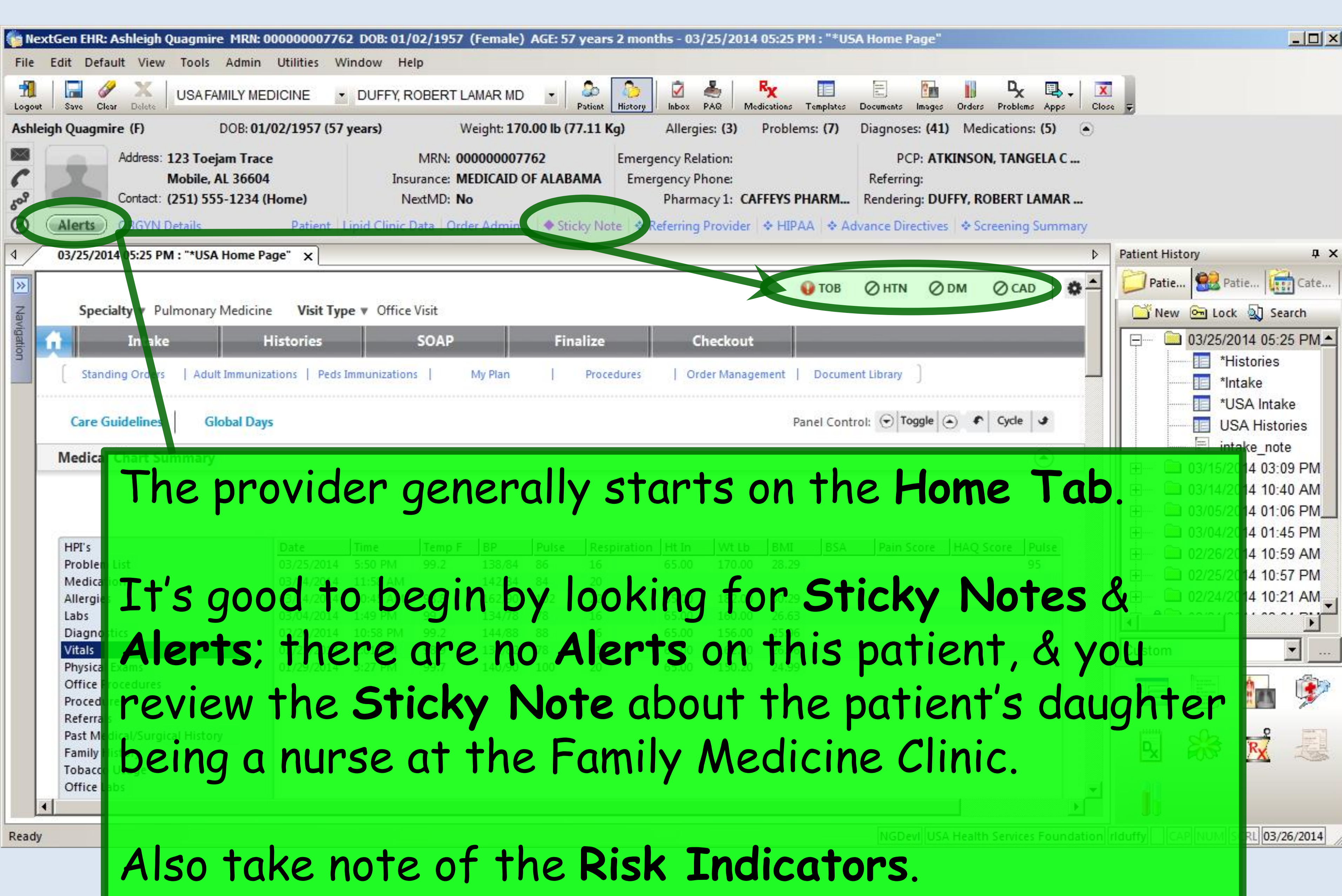

Todays Patient Tracking
Click in the Room box & select a room; alternately, you can just type a room number in the box.
Appointment date: 02/21/2014
Today's date: 02/24/2014
Appointment information:
9:00 AM DUFFY MD, ROBERT LAMAR Reason:
Room:
Status:
Patient Tracking:
Appt Time
Room
Ngkbm Get Dbpicklist 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

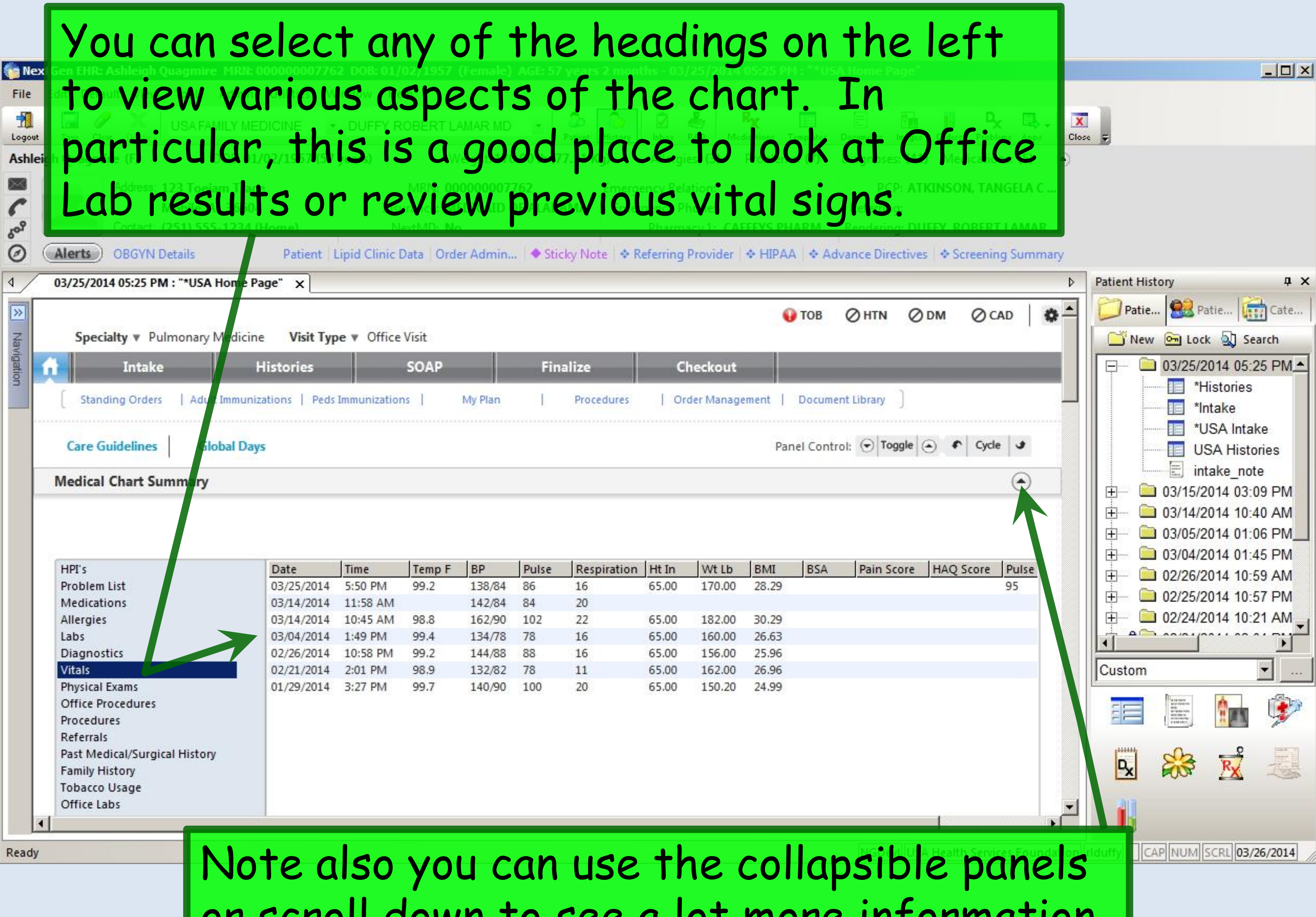

Todays Patient Tracking
Next, click in the Status box
& select waiting for provider.
Appointment date: 02/21/2014
Today's date: 02/24/2014
Appointment information:
9:00 AM DUFFY MD, ROBERT LAMAR Reason
Room:
Exam 1
Status:
Attended
(Entries uploaded on "Save and Close".)
Patient Tracking:
Appt Time
Room
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

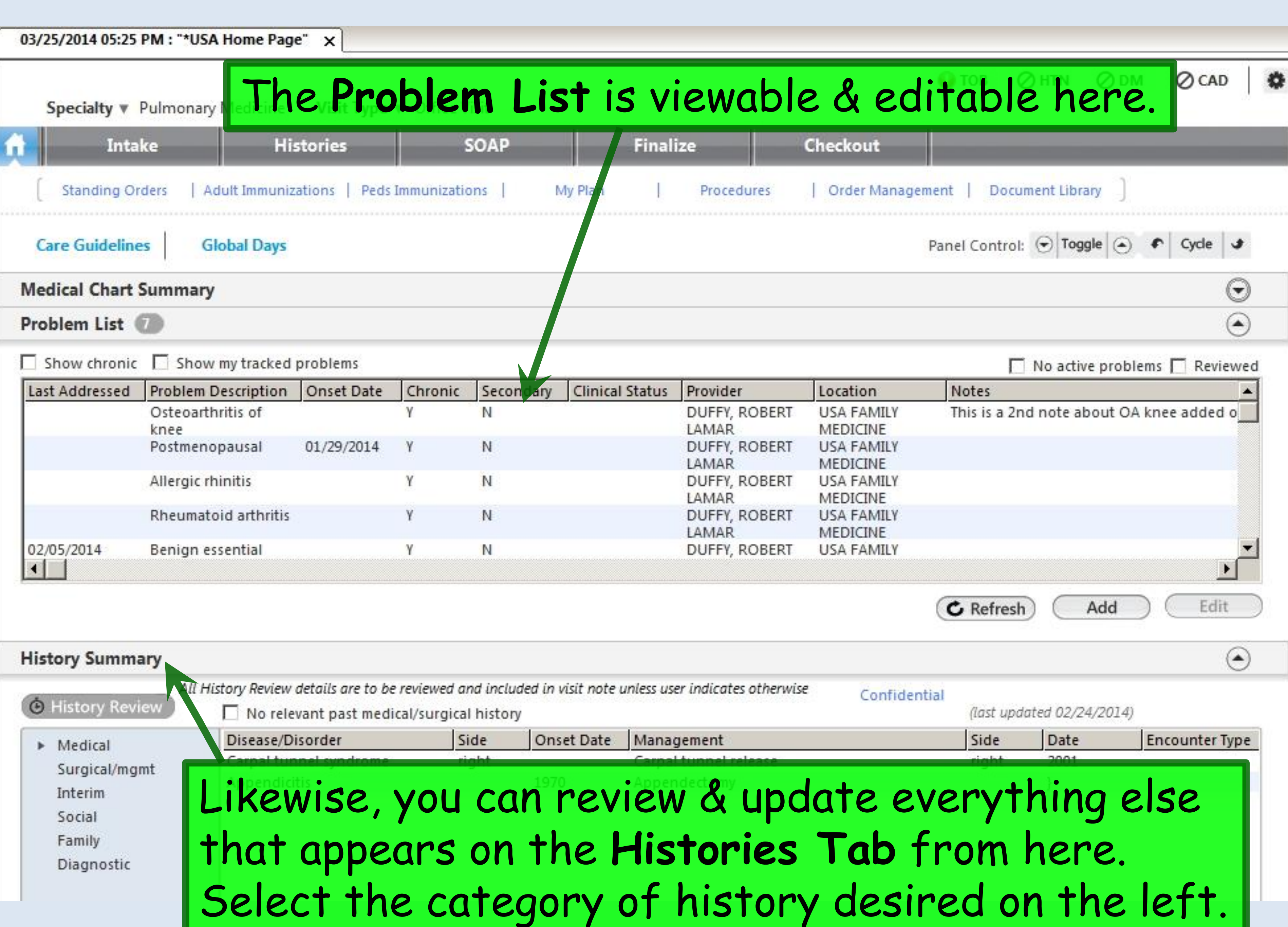

Todays Patient Tracking
Appointment date: 02/21/2014
Today's date: 02/24/2014
Appointment information:
9:00 AM DUFFY MD, ROBERT LAMAR Reason:
Room:
Exam 1
Status:
waiting for provider
(Entries uploaded on "Save and Close".)
Patient Tracking:
The Inbox will update today's calendar and not the appointment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

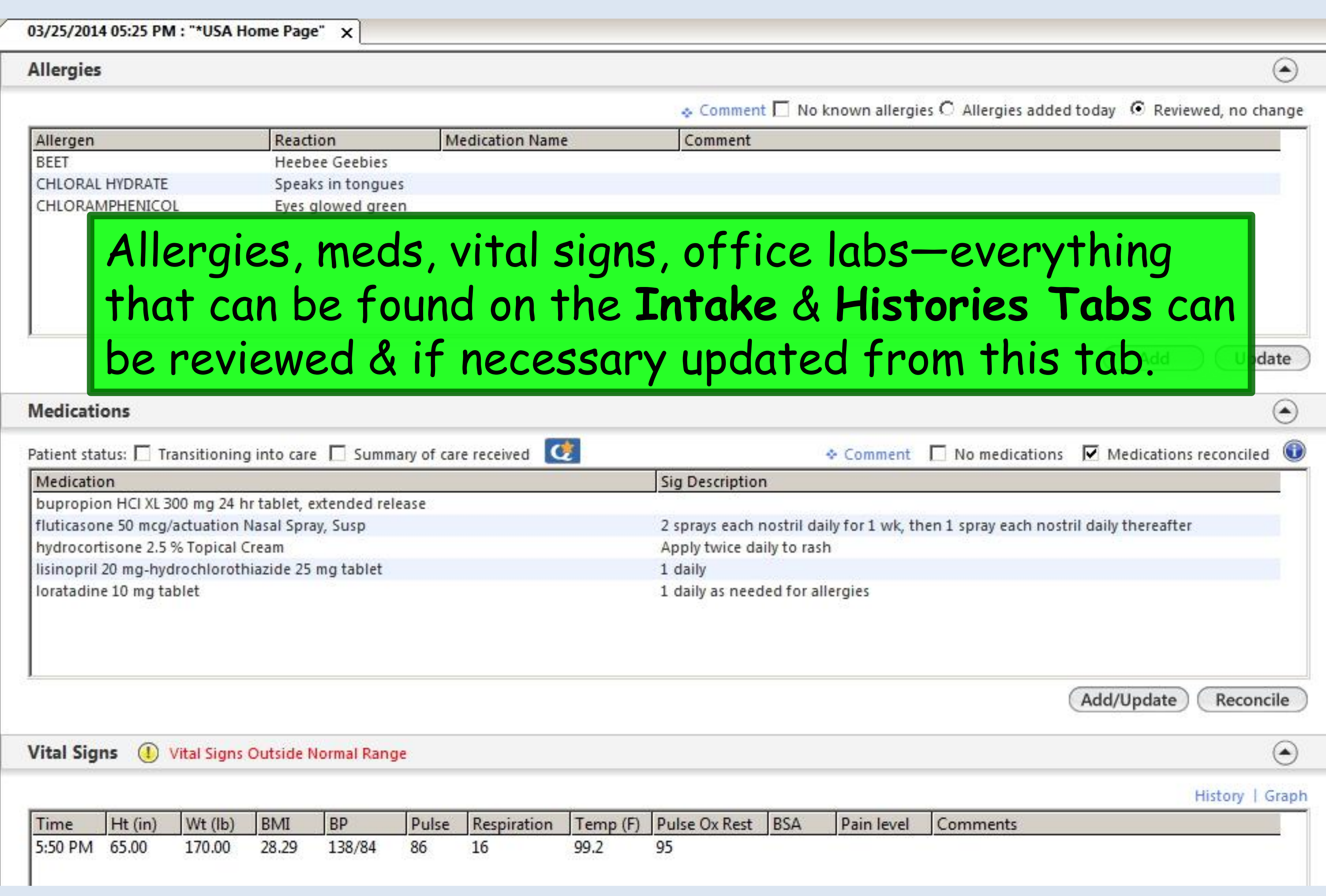


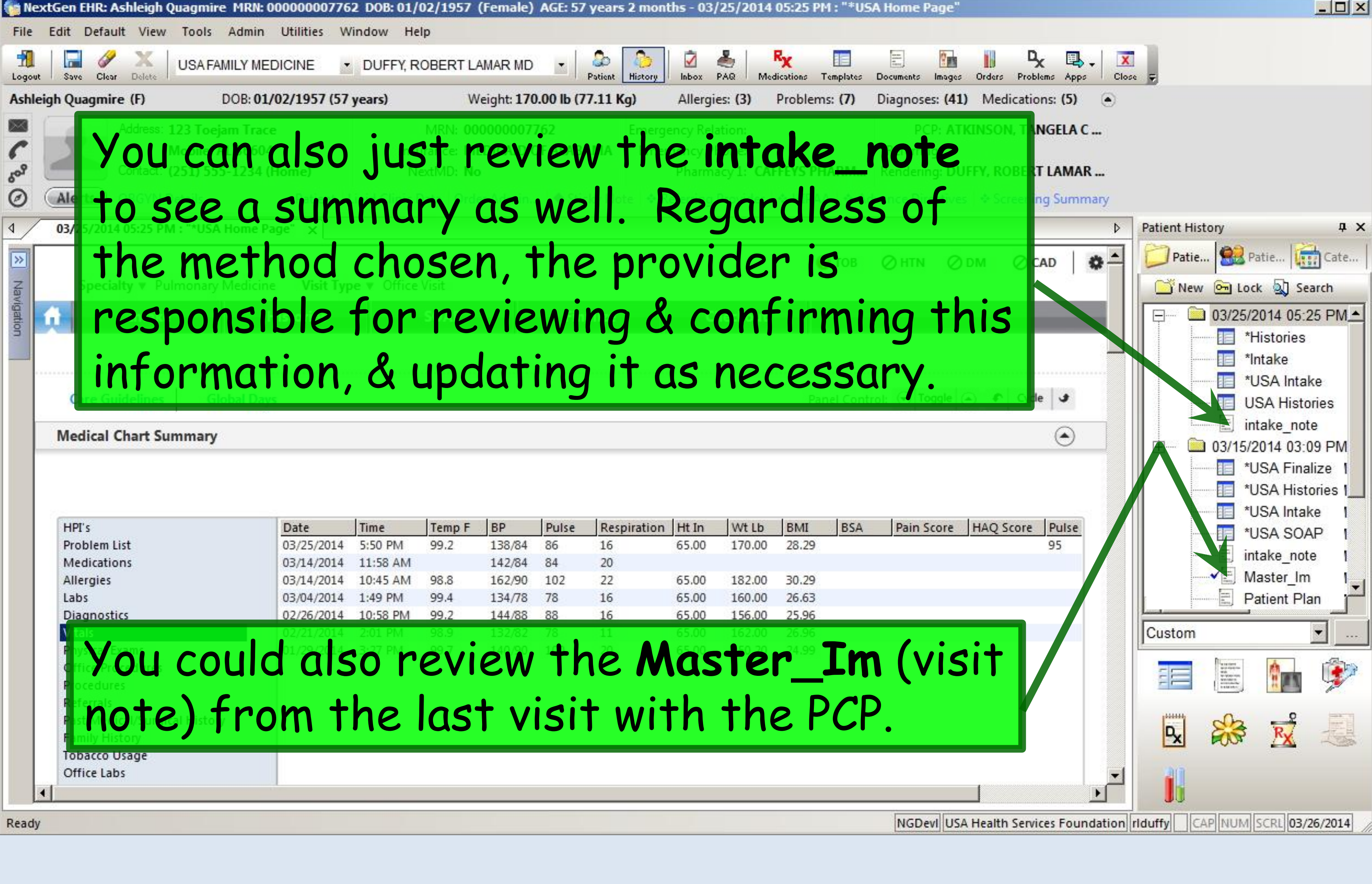
Patient
Location
Provider
Date
The provider then opens the chart from the appointment list & performs the 4-point check.

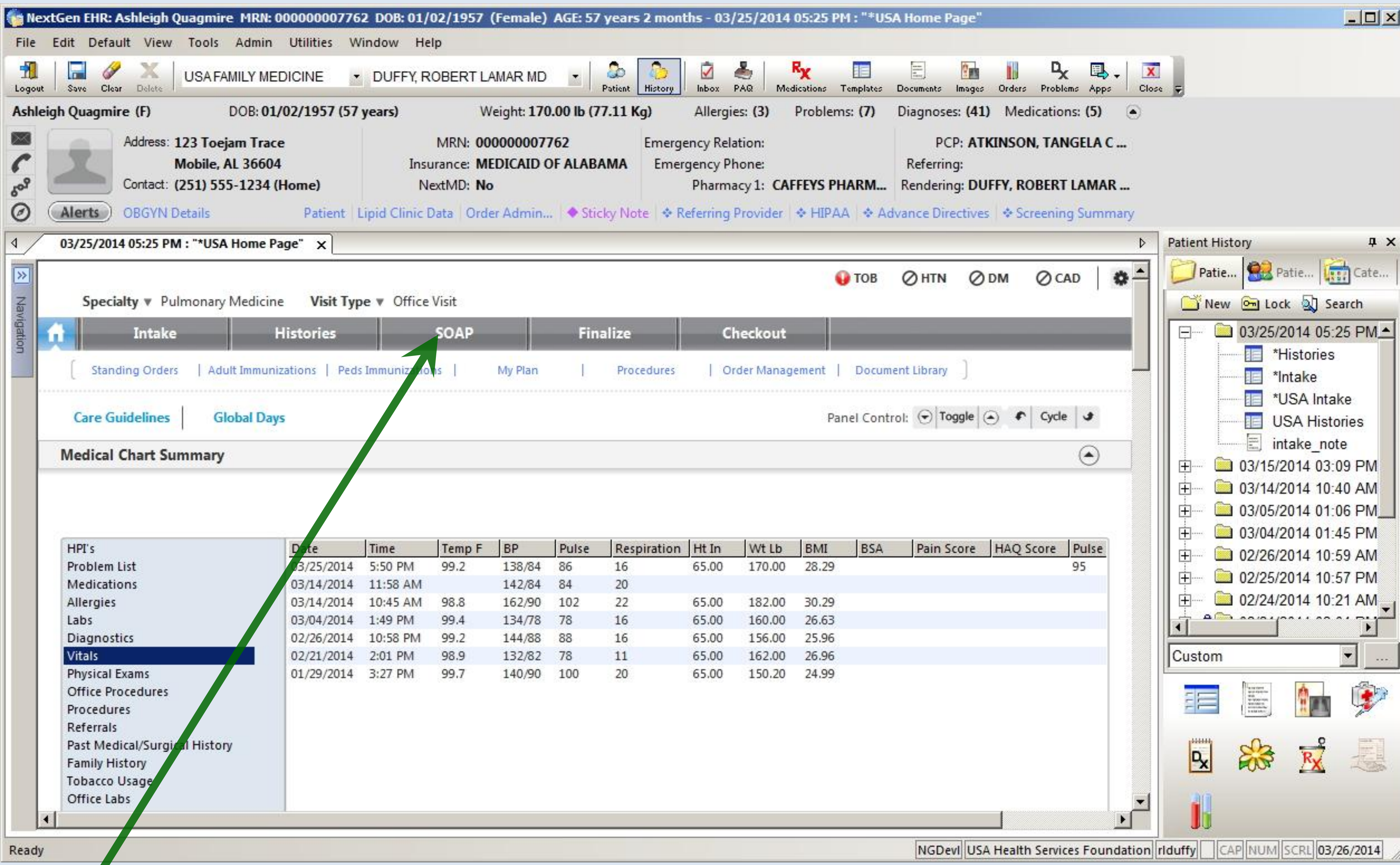

NextGen EHR: Ashleigh Quagmire MRN: 000000007762 DOB: 01/02/1957 (Female) AGE: 57 years 2 months - 03/25/2014 05:25 PM : "*USA Home Page"
File Edit Default View Tools Admin Utilities Window Help
Alerts
Sticky Note
TOB HTN DM CAD
Intake Histories SOAP Finalize Checkout
Patient History
The provider generally starts on the **Home Tab**.
It's good to begin by looking for **Sticky Notes** & **Alerts**; there are no **Alerts** on this patient, & you review the **Sticky Note** about the patient's daughter being a nurse at the Family Medicine Clinic.
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.
Medical Chart Summary
HPI's
Problem List
Medications
Allergies
Labs
Diagnostics
Vitals
Physical Exams
Office Procedures
Procedures
Referrals
Past Medical/Surgical History
Family History
Tobacco Usage
Office Labs
Date | Time | Temp F | BP | Pulse | Respiration | Ht In | Wt Lb | BMI | BSA | Pain Score | HAQ Score | Pulse
03/25/2014 5:50 PM 99.2 138/84 86 16 65.00 170.00 28.29 95
03/14/2014 11:58 AM 142/84 84 20
03/14/2014 10:45 AM 98.8 162/90 102 22 65.00 182.00 30.29
03/04/2014 1:49 PM 99.4 134/78 78 16 65.00 160.00 26.63
02/26/2014 10:58 PM 99.2 144/88 88 16 65.00 156.00 25.96
02/21/2014 2:01 PM 98.9 132/82 78 11 65.00 162.00 26.96
01/29/2014 3:27 PM 99.7 140/90 100 20 65.00 150.20 24.99
Note also you can use the collapsible panels or scroll down to see a lot more information.


03/25/2014 05:25 PM : "*USA Home Page"
The Problem List is viewable & editable here.
CAD
Specialty Pulmonary
Intake
Histories
SOAP
Finalize
Checkout
Standing Orders | Adult Immunizations | Peds Immunizations | My Plan | Procedures | Order Management | Document Library
Care Guidelines
Global Days
Panel Control: Toggle Cycle
Medical Chart Summary
Problem List 7
Show chronic
Show my tracked problems
No active problems
Reviewed
Last Addressed | Problem Description | Onset Date | Chronic | Secondary | Clinical Status | Provider | Location | Notes
Osteoarthritis of knee | Y | N | DUFFY, ROBERT LAMAR | USA FAMILY MEDICINE | This is a 2nd note about OA knee added o
Postmenopausal | 01/29/2014 | Y | N | DUFFY, ROBERT LAMAR | USA FAMILY MEDICINE
Allergic rhinitis | Y | N | DUFFY, ROBERT LAMAR | USA FAMILY MEDICINE
Rheumatoid arthritis | Y | N | DUFFY, ROBERT LAMAR | USA FAMILY MEDICINE
02/05/2014 | Benign essential | Y | N | DUFFY, ROBERT | USA FAMILY
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
(last updated 02/24/2014)
Medical
Surgical/mgmt
Interim
Social
Family
Diagnostic
Disease/Disorder | Side | Onset Date | Management | Side | Date | Encounter Type
Likewise, you can review & update everything else that appears on the Histories Tab from here. Select the category of history desired on the left.

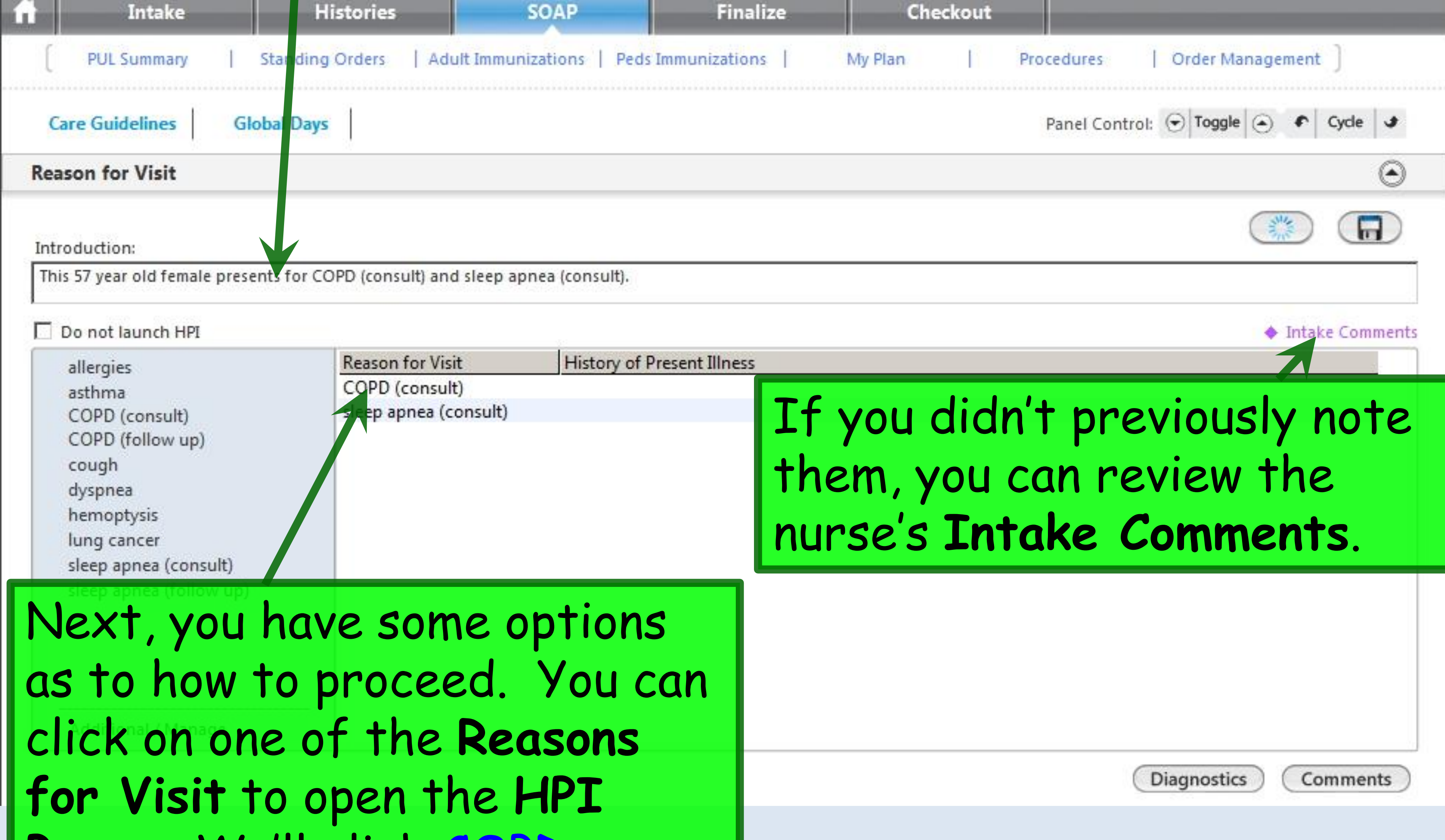

03/25/2014 05:25 PM : "*USA Home Page"
Allergies
Comment
No known allergies
Allergies added today
Reviewed, no change
Allergen
Reaction
Medication Name
Comment
BEET
Heebee Geebies
CHLORAL HYDRATE
Speaks in tongues
CHLORAMPHENICOL
Eyes glowed green
Allergies, meds, vital signs, office labs—everything that can be found on the Intake & Histories Tabs can be reviewed & if necessary updated from this tab.
Medications
Patient status:
Transitioning into care
Summary of care received
Comment
No medications
Medications reconciled
Medication
Sig Description
bupropion HCl XL 300 mg 24 hr tablet, extended release
fluticasone 50 mcg/actuation Nasal Spray, Susp
2 sprays each nostril daily for 1 wk, then 1 spray each nostril daily thereafter
hydrocortisone 2.5 % Topical Cream
Apply twice daily to rash
lisinopril 20 mg-hydrochlorothiazide 25 mg tablet
1 daily
loratadine 10 mg tablet
1 daily as needed for allergies
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
5:50 PM
65.00
170.00
28.29
138/84
86
16
99.2
95


NextGen EHR: Ashleigh Quagmire MRN: 000000007762 DOB: 01/02/1957 (Female) AGE: 57 years 2 months - 03/25/2014 05:25 PM : "*USA Home Page"
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.
You could also review the **Master_Im** (visit note) from the last visit with the PCP.
Patient History
03/25/2014 05:25 PM
*Histories
*Intake
*USA Intake
USA Histories
intake_note
03/15/2014 03:09 PM
*USA Finalize
*USA Histories
*USA Intake
*USA SOAP
intake_note
Master_Im
Patient Plan
Medical Chart Summary



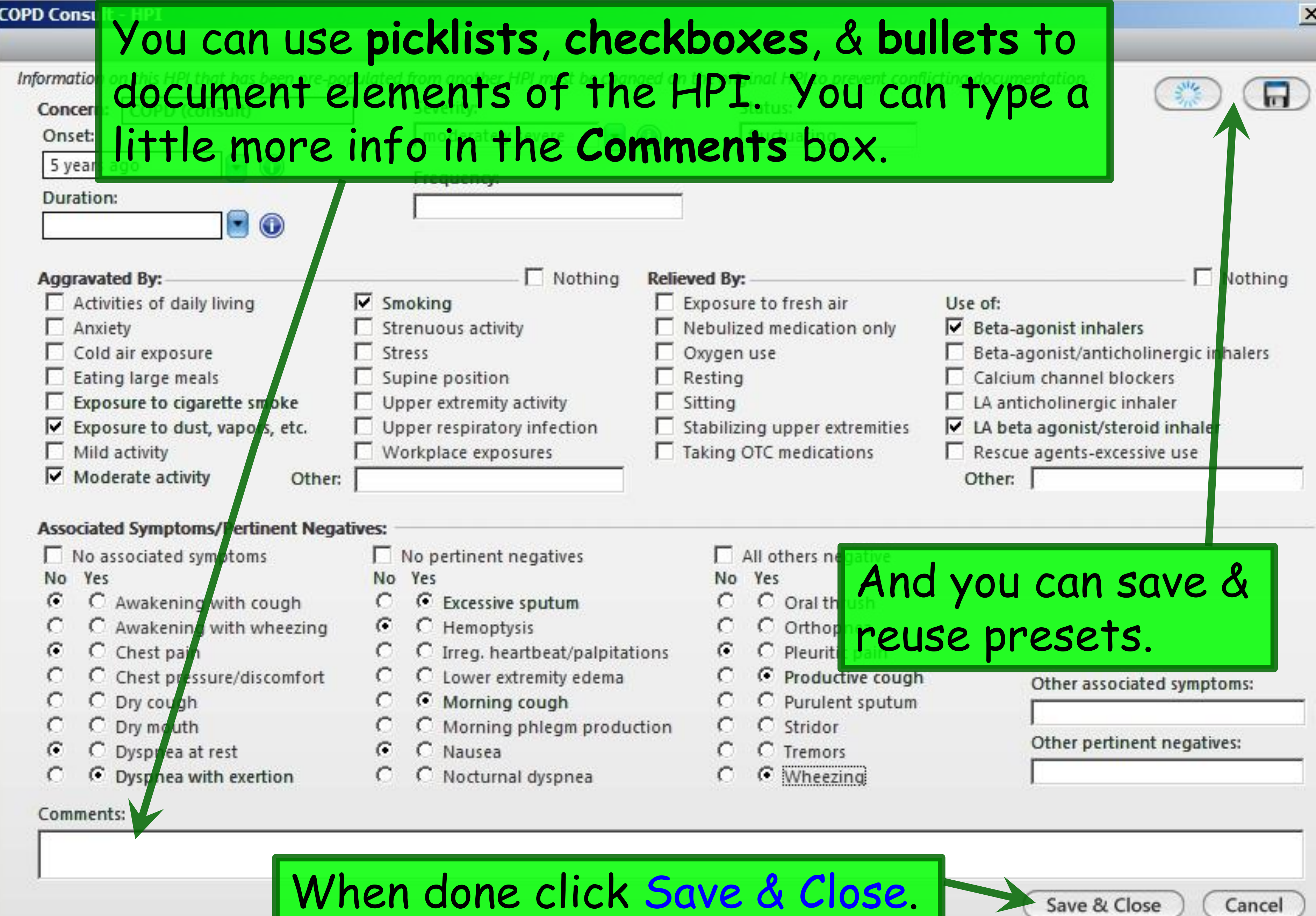
When you're done reviewing the chart, move to the **SOAP tab**.

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 COPD.



COPD Consult - HPI
You can use picklists, checkboxes, & bullets to document elements of the HPI. You can type a little more info in the Comments box.
Duration:
Frequency:
Aggravated By:
Nothing
Activities of daily living
Anxiety
Cold air exposure
Eating large meals
Exposure to cigarette smoke
Exposure to dust, vapors, etc.
Mild activity
Moderate activity
Smoking
Strenuous activity
Stress
Supine position
Upper extremity activity
Upper respiratory infection
Workplace exposures
Other:
Relieved By:
Nothing
Exposure to fresh air
Nebulized medication only
Oxygen use
Resting
Sitting
Stabilizing upper extremities
Taking OTC medications
Use of:
Beta-agonist inhalers
Beta-agonist/anticholinergic inhalers
Calcium channel blockers
LA anticholinergic inhaler
LA beta agonist/steroid inhaler
Rescue agents-excessive use
Other:
Associated Symptoms/Pertinent Negatives:
No associated symptoms
No Yes
Awakening with cough
Awakening with wheezing
Chest pain
Chest pressure/discomfort
Dry cough
Dry mouth
Dyspnea at rest
Dyspnea with exertion
No pertinent negatives
No Yes
Excessive sputum
Hemoptysis
Irreg. heartbeat/palpitations
Lower extremity edema
Morning cough
Morning phlegm production
Nausea
Nocturnal dyspnea
All others negative
No Yes
Productive cough
Purulent sputum
Stridor
Tremors
Wheezing
And you can save & reuse presets.
Other associated symptoms:
Other pertinent negatives:
Comments:
When done click Save & Close.
Save & Close
Cancel

We used a similar popup for the sleep apnea complaint, & now you see the entries from those HPI popups on the **SOAP Tab**.

03/25/

Specialty ▼ Pulmonary Medicine Visit Type ▼ Office Visit

TOB HTN DM CAD

Intake | Histories | SOAP | Finalize | Checkout

PUL Summary | Standing Orders | Adult Immunizations | Peds Immunizations | My Plan | Procedures | Order Management

Care Guidelines | Global Days

Panel Control: Toggle Cycle

Reason for Visit

Introduction:

This 57 year old female presents for COPD (consult) and sleep apnea (consult).

☐ Do not launch HPI

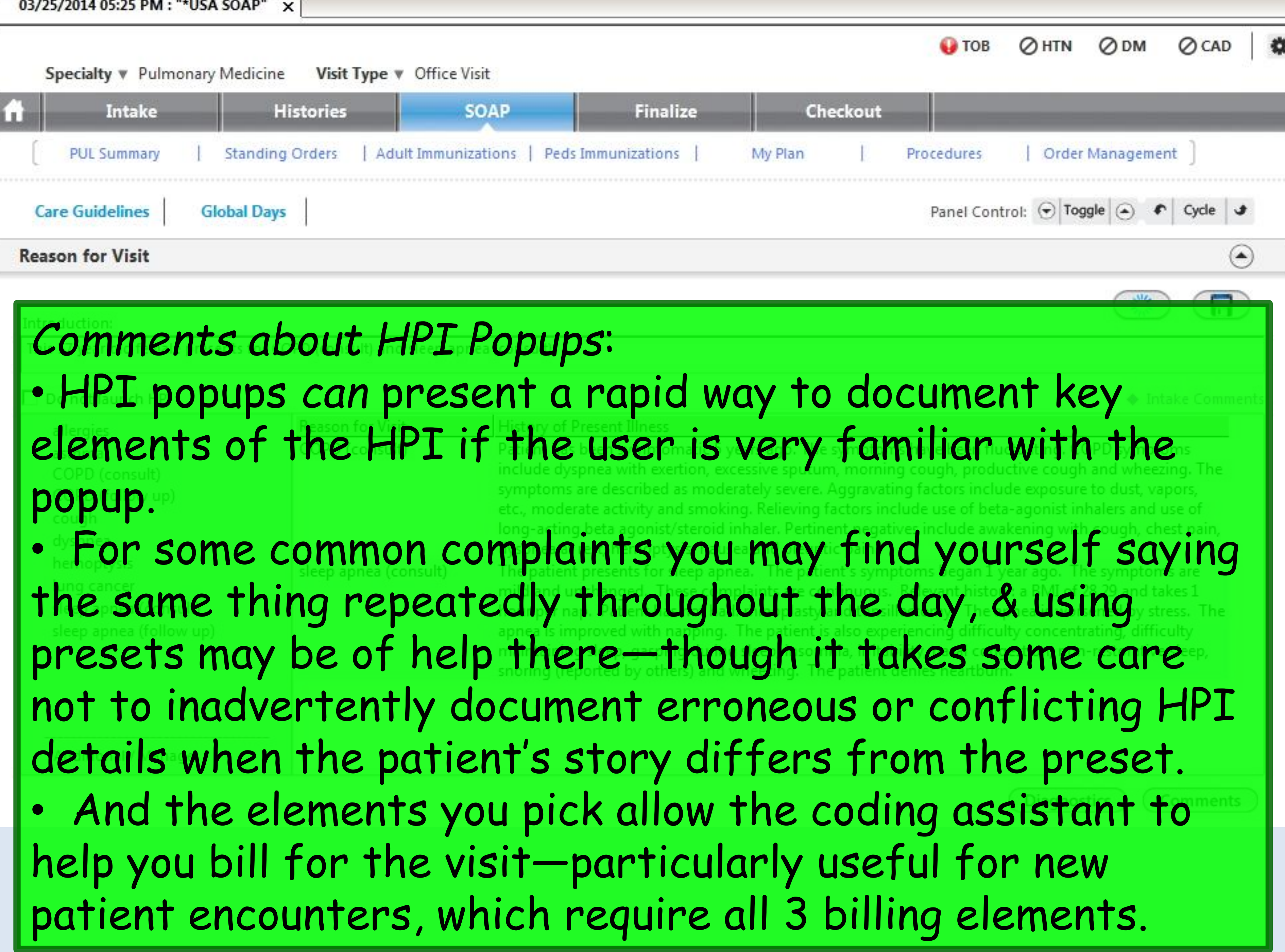
Intake Comments

- allergies
- asthma
- COPD (consult)
- COPD (follow up)
- cough
- dyspnea
- hemoptysis
- lung cancer
- sleep apnea (consult)
- sleep apnea (follow up)

Additional / Manage

Reason for Visit	History of Present Illness
COPD (consult)	Patient has been symptomatic 5 years ago. The symptoms have been fluctuating. COPD symptoms include dyspnea with exertion, excessive sputum, morning cough, productive cough and wheezing. The symptoms are described as moderately severe. Aggravating factors include exposure to dust, vapors, etc., moderate activity and smoking. Relieving factors include use of beta-agonist inhalers and use of long-acting beta agonist/steroid inhaler. Pertinent negatives include awakening with cough, chest pain, dyspnea at rest, hemoptysis, nausea and pleuritic pain.
sleep apnea (consult)	The patient presents for sleep apnea. The patient's symptoms began 1 year ago. The symptoms are mild and unchanged. These complaints are continuous. Relevant history: a BMI of 28.29 and takes 1 hour per nap. Patient has not had: rhinoplasty and tonsillectomy. The apnea is worsened by stress. The apnea is improved with napping. The patient is also experiencing difficulty concentrating, difficulty maintaining sleep, gasping during sleep, insomnia, irritability, nasal congestion, non-restorative sleep, snoring (reported by others) and wheezing. The patient denies heartburn.

Diagnostics | Comments


03/25/2014 05:25 PM : "*USA SOAP"
TOB
HTN
DM
CAD
Specialty Pulmonary Medicine
Visit Type Office Visit
Intake
Histories
SOAP
Finalize
Checkout
PUL Summary
Standing Orders
Adult Immunizations
Peds Immunizations
My Plan
Procedures
Order Management
Care Guidelines
Global Days
Panel Control:
Toggle
Cycle
Reason for Visit
Comments about HPI Popups:
• HPI popups *can* present a rapid way to document key elements of the HPI if the user is very familiar with the popup.
• For some common complaints you may find yourself saying the same thing repeatedly throughout the day, & using presets may be of help there—though it takes some care not to inadvertently document erroneous or conflicting HPI details when the patient's story differs from the preset.
• And the elements you pick allow the coding assistant to help you bill for the visit—particularly useful for new patient encounters, which require all 3 billing elements.

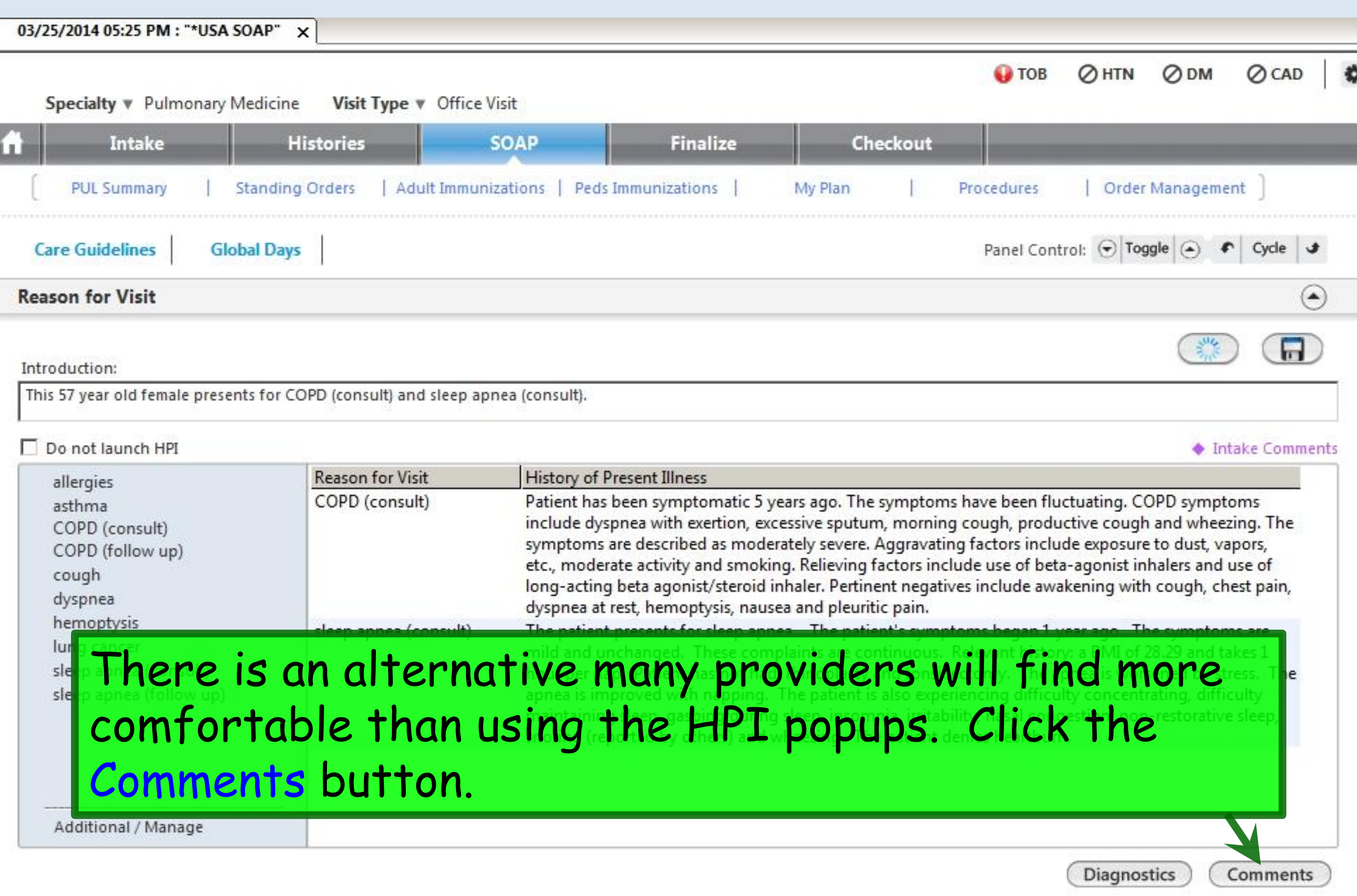
03/25/2014 05:25 PM : "*USA SOAP"

TOB HTN DM CAD

Specialty Pulmonary Medicine Visit Type Office Visit

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; sometimes you can't even recognize whether you performed the visit or if it was done by one of your colleagues.


03/25/2014 05:25 PM : "*USA SOAP"
TOB
HTN
DM
CAD
Specialty Pulmonary Medicine
Visit Type Office Visit
Intake
Histories
SOAP
Finalize
Checkout
PUL Summary | Standing Orders | Adult Immunizations | Peds Immunizations | My Plan | Procedures | Order Management
Care Guidelines
Global Days
Panel Control: Toggle Cycle
Reason for Visit
Introduction:
This 57 year old female presents for COPD (consult) and sleep apnea (consult).
Do not launch HPI
Intake Comments
allergies
asthma
COPD (consult)
COPD (follow up)
cough
dyspnea
hemoptysis
Reason for Visit
History of Present Illness
COPD (consult)
Patient has been symptomatic 5 years ago. The symptoms have been fluctuating. COPD symptoms include dyspnea with exertion, excessive sputum, morning cough, productive cough and wheezing. The symptoms are described as moderately severe. Aggravating factors include exposure to dust, vapors, etc., moderate activity and smoking. Relieving factors include use of beta-agonist inhalers and use of long-acting beta agonist/steroid inhaler. Pertinent negatives include awakening with cough, chest pain, dyspnea at rest, hemoptysis, nausea and pleuritic pain.
There is an alternative many providers will find more comfortable than using the HPI popups. Click the Comments button.
Additional / Manage
Diagnostics
Comments

HOPI Notes

Chief complaint/reason for visit:

Manage My Phrases

COPD (consult)

My Phrases

1. Followed by pulmonologist OOT for ~5 yrs for COPD, now on Advair 50/250 BID. Rarely needing albuterol except w/ mod'ly hard exertion or extreme heat. Since she's pretty sedentary, this hasn't limited ADLs much. Still smoking, & not interested in assistance stopping at this time. Just wanted to get estab w/ pulmonologist again after moving to Mobile.

sleep apnea (consult)

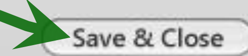
My Phrases

2. Husband says she snores & tosses/turns a lot. Wakes up not feeling rested, & often naps during the day. Saw ad about sleep apnea, & thinks this may actually be a bigger problem w/ her breathing than the smoking. Wants to be tested for OSA.

3.

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

When done click Save & Close.



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."

Reason for Visit

Introduction:

This 57 year old female presents for COPD (consult) and sleep apnea (consult).

Do not launch HPI

Intake Comments

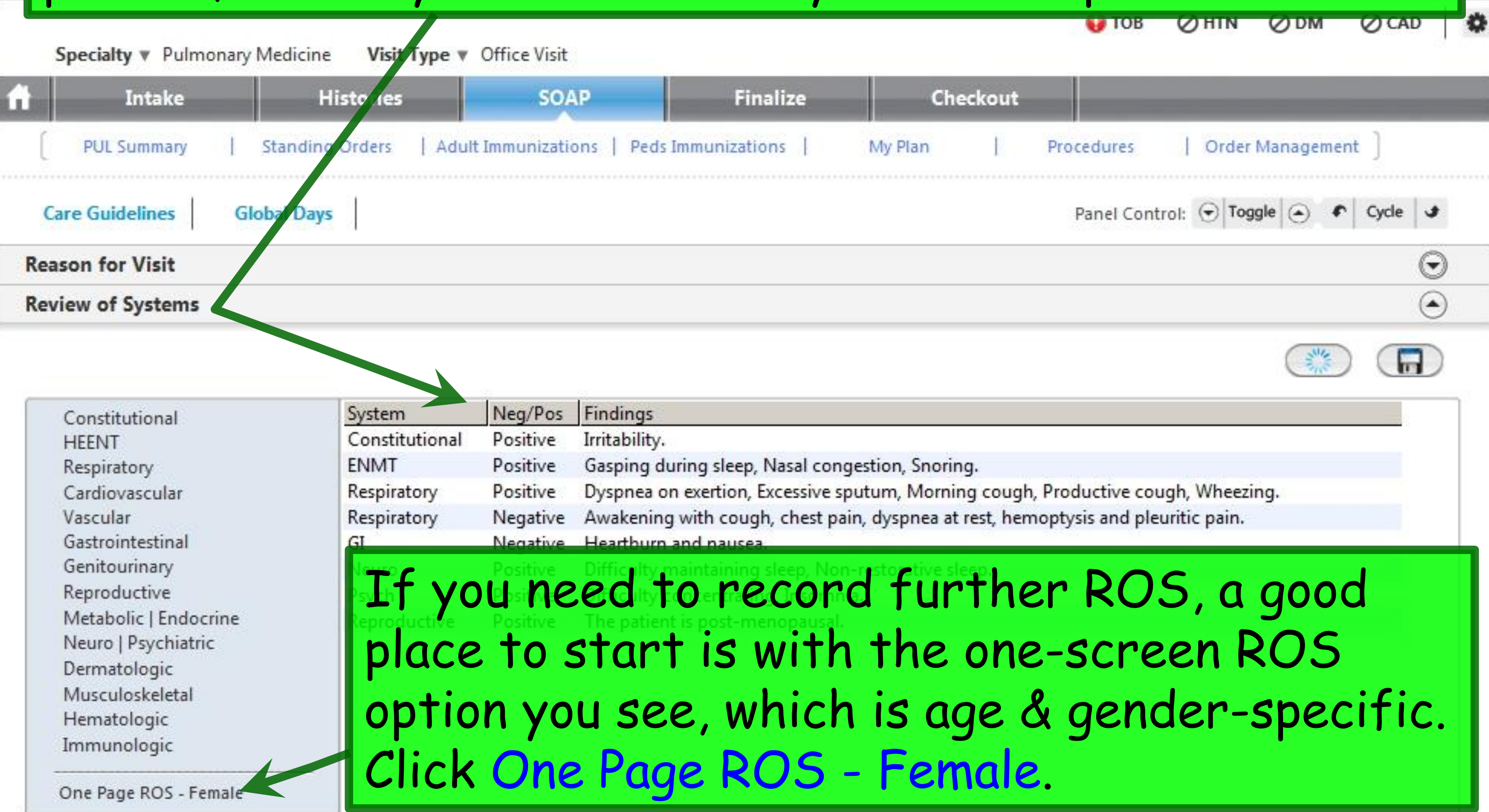
- allergies
- asthma
- COPD (consult)
- COPD (follow up)
- cough
- dyspnea
- hemoptysis
- lung cancer
- sleep apnea (consult)
- sleep apnea (follow up)

Additional / Manage

Reason for Visit	History of Present Illness
COPD (consult)	Patient has been symptomatic 5 years ago. The symptoms have been fluctuating. COPD symptoms include dyspnea with exertion, excessive sputum, morning cough, productive cough and wheezing. The symptoms are described as moderately severe. Aggravating factors include exposure to dust, vapors, etc., moderate activity and smoking. Relieving factors include use of beta-agonist inhalers and use of long-acting beta agonist/steroid inhaler. Pertinent negatives include awakening with cough, chest pain, dyspnea at rest, hemoptysis, nausea and pleuritic pain.
COPD (consult) (comments)	Followd by pulmonologist OOT for ~5 yrs for COPD, now on Advair 50/250 BID. Rarely needing albuterol except w/ mod'ly hard exertion or extreme heat. Since she's pretty sedentary, this hasn't limited ADLs much. Still smoking, & not interested in assistance stopping at this time. Just wanted to get estab w/ pulmonologist again after moving to Mobile.
sleep apnea (consult)	The patient presents for sleep apnea. The patient's symptoms began 1 year ago. The symptoms are mild and unchanged. These complaints are continuous. Relevant history: a BMI of 28.29 and takes 1 hour per nap. Patient has not had: rhinoplasty and tonsillectomy. The apnea is worsened by stress. The apnea is improved with napping. The patient is also experiencing difficulty concentrating, difficulty maintaining sleep, gasping during sleep, insomnia, irritability, nasal congestion, non-restorative sleep, snoring (reported by others) and wheezing. The patient denies heartburn.

Diagnostics | Comments

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



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

ROS-Female

Information on this ROS that has been pre-populated from a HPI must be changed on the HPI to prevent conflicting documentation.

ROS Defaults:

Constitutional — All neg
Neg Pos
- Chills
- Fatigue
- Fever
- Malaise
- Night sweats
- Weight gain
- Weight loss
- Other:

HEENT — All neg
Neg Pos
- Ear drainage
- Ear pain (Neg)
- Eye discharge
- Eye pain
- Hearing loss
- Nasal drainage (Pos)
- Sinus pressure (Neg)
- Sore throat (Neg)
- Visual changes
- Other:

Respiratory — All neg
Neg Pos
- Chronic cough (Pos)
- Cough
- Known TB exposure
- Shortness of breath
- Wheezing (Pos)
- Other:

Cardiovascular — All neg
Neg Pos
- Chest pain (Neg)
- Claudication
- Edema (Neg)
- Palpitations (Neg)
- Other:

Gastrointestinal — All neg
Neg Pos
- Abdominal pain
- Blood in stools
- Change in stools
- Constipation
- Diarrhea (Neg)
- Heartburn (Neg)
- Loss of appetite
- Nausea (Neg)
- Vomiting (Neg)
- Other:

Genitourinary — All neg
Neg Pos
- Dysuria
- Hematuria
- Polyuria
- Urinary frequency
- Urinary incontinence (Neg)
- Urinary retention
- Other:

Reproductive — All neg
Neg Pos
- Abnormal Pap
- Dysmenorrhea
- Dyspareunia
- Hot flashes
- Irregular menses
- Vaginal discharge
- Other:

Integumentary — All neg
Neg Pos
- Breast discharge
- Breast lump
- Brittle hair
- Brittle nails
- Hair loss
- Hirsutism
- Hives
- Pruritis
- Mole changes
- Rash (Neg)
- Skin lesion
- Other:

Neurological — All neg
Neg Pos
- Dizziness
- Extremity numbness (Neg)
- Extremity weakness (Neg)
- Gait disturbance
- Headache
- Memory loss
- Seizures
- Tremors
- Other:

Psychiatric — All neg
Neg Pos
- Anxiety
- Depression
- Insomnia (Pos)
- Other:

Metabolic / Endocrine — All neg
Neg Pos
- Cold intolerance
- Heat intolerance
- Polydipsia
- Polyphagia
- Other:

Musculoskeletal — All neg
Neg Pos
- Back pain
- Joint pain (Neg)
- Joint swelling
- Muscle weakness
- Neck pain
- Other:

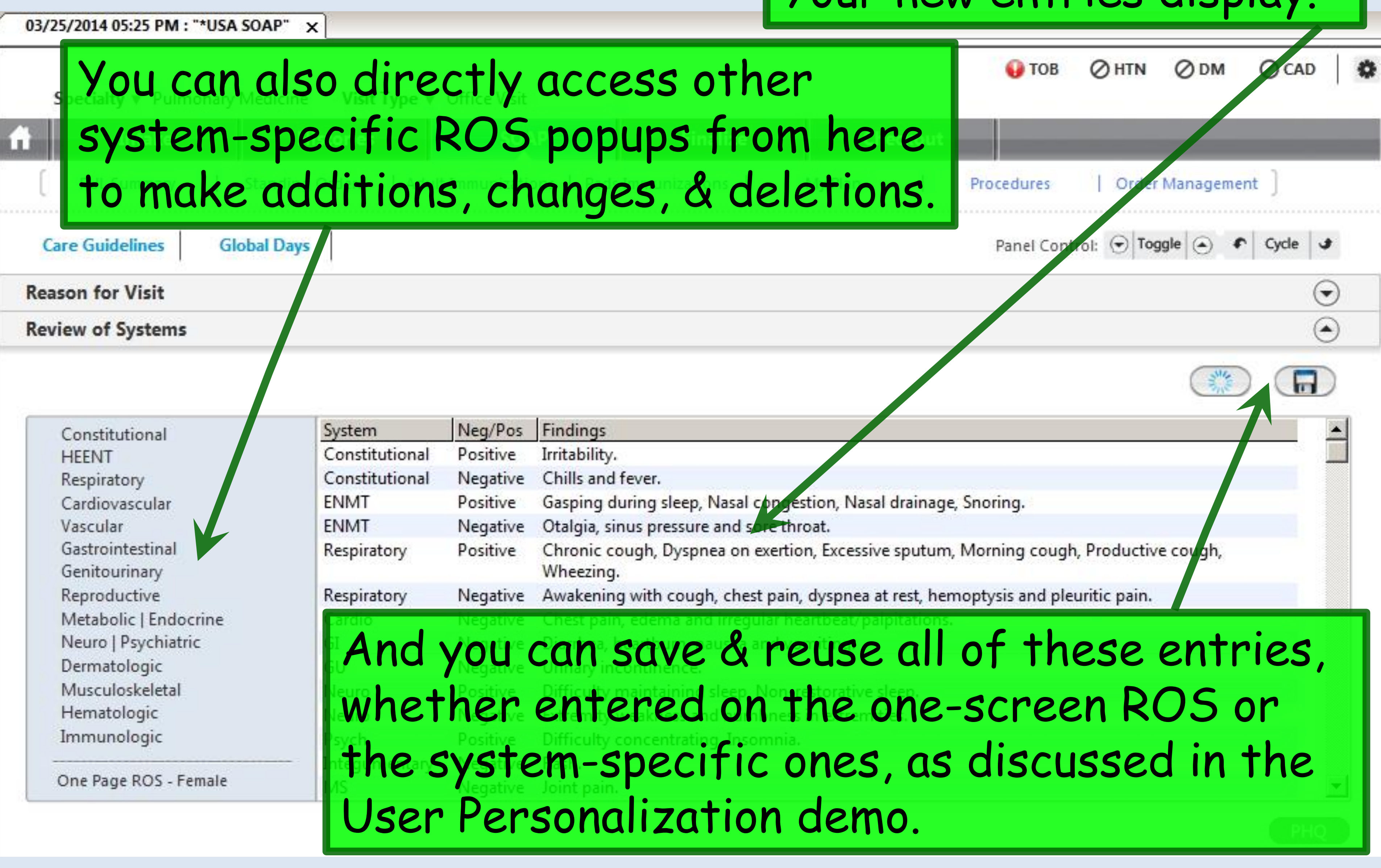
Hematologic / Lymphatic — All neg
Neg Pos
- Easy bleeding
- Easy bruising
- Lymphadenopathy
- Other:

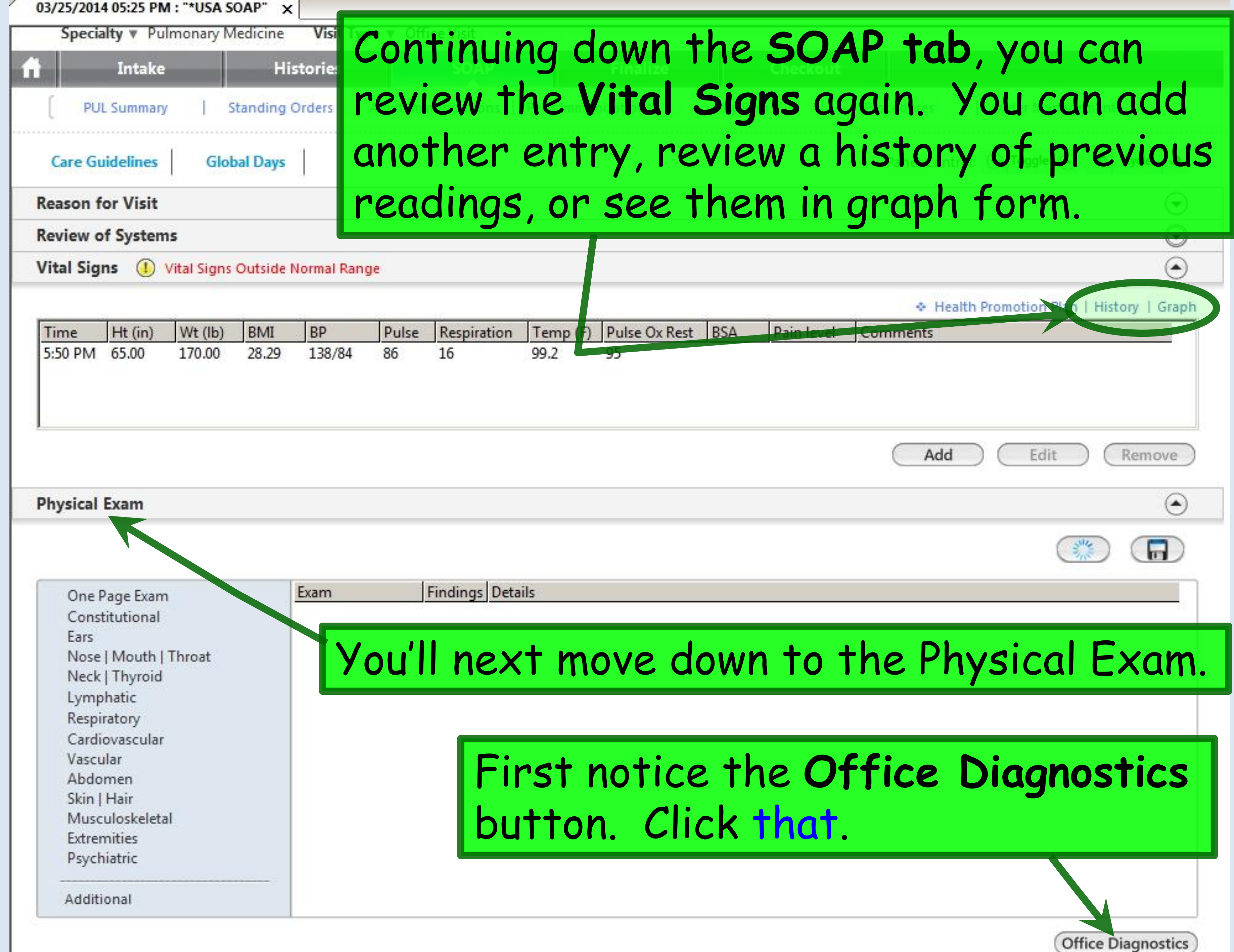
Immunologic — All neg
Neg Pos
- Contact allergy
- Environmental allergies
- Food allergies
- Seasonal allergies
- Other:

All others negative

Save & Close | Cancel

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.
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.
03/25/2014 05:25 PM : "*USA SOAP"
TOB
HTN
DM
CAD
Procedures
Order Management
Care Guidelines
Global Days
Panel Control:
Toggle
Cycle
Reason for Visit
Review of Systems
Constitutional
HEENT
Respiratory
Cardiovascular
Vascular
Gastrointestinal
Genitourinary
Reproductive
Metabolic | Endocrine
Neuro | Psychiatric
Dermatologic
Musculoskeletal
Hematologic
Immunologic
One Page ROS - Female
System
Neg/Pos
Findings
Constitutional Positive Irritability.
Constitutional Negative Chills and fever.
ENMT Positive Gasping during sleep, Nasal congestion, Nasal drainage, Snoring.
ENMT Negative Otalgia, sinus pressure and sore throat.
Respiratory Positive Chronic cough, Dyspnea on exertion, Excessive sputum, Morning cough, Productive cough, Wheezing.
Respiratory Negative Awakening with cough, chest pain, dyspnea at rest, hemoptysis and pleuritic pain.


03/25/2014 05:25 PM : "*USA SOAP"
Specialty Pulmonary Medicine
Intake
Histories
PUL Summary
Standing Orders
Care Guidelines
Global Days
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.
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
5:50 PM
65.00
170.00
28.29
138/84
86
16
99.2
95
Add
Edit
Remove
Physical Exam
One Page Exam
Constitutional
Ears
Nose | Mouth | Throat
Neck | Thyroid
Lymphatic
Respiratory
Cardiovascular
Vascular
Abdomen
Skin | Hair
Musculoskeletal
Extremities
Psychiatric
Additional
Exam
Findings
Details
You'll next move down to the Physical Exam.
First notice the Office Diagnostics button. Click that.
Office Diagnostics

Office Services

Panel Control: Toggle Cycle

This gives you a chance to review any office tests the nurse did via clinic standing orders, if you didn't note them earlier on the **Home Tab**. (Perhaps the results weren't ready yet when you first entered the room.) Here you just see that she's done a spirometry—which hopefully you already knew if she's given you the printout. When done click Save & Close.

Results/Report

Protocols

Interpretation: Details Normal value/range: Unit of measure:

Clinical indication:

Sort By: Summary Phrase My Phrases | Manage My Phrases

Details:

Today's Orders

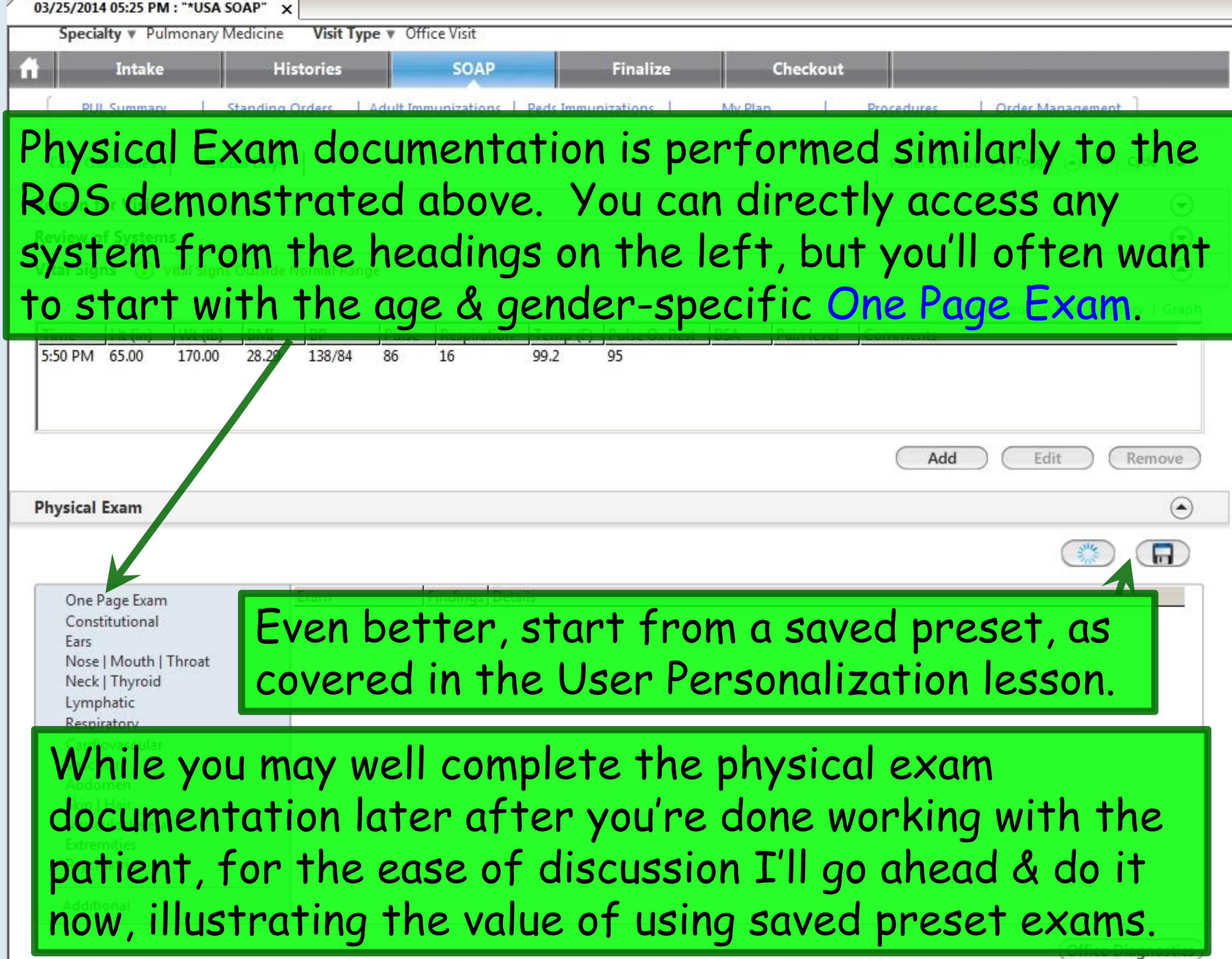
Submit to Superbill Verbal order/needs sign-off Send task automatically Additional Orders | Task

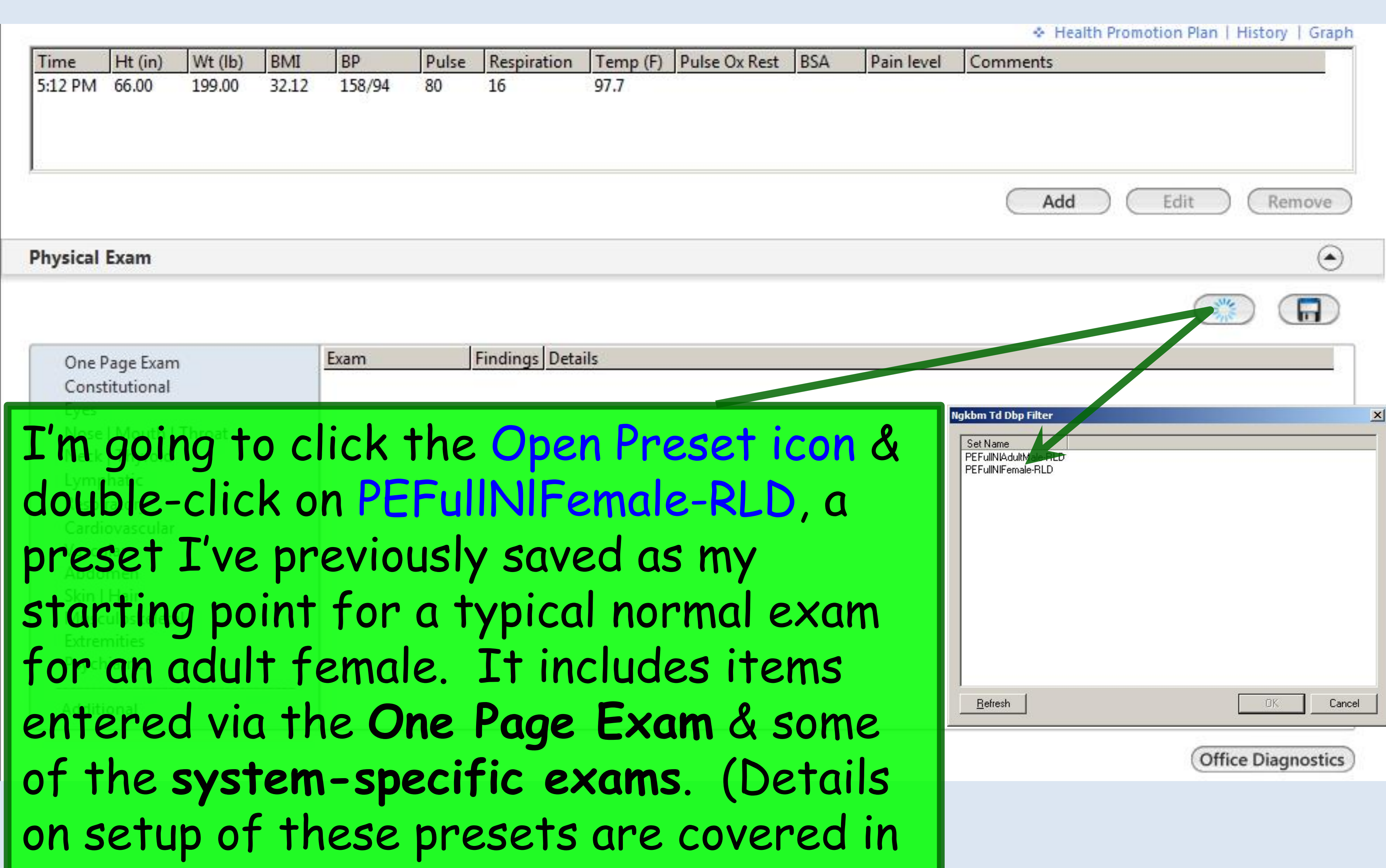
Status	Office Diagnostic Description	Side	Interpretation	Result	Performed By	Cl
completed	Spirometry		see detail	See scanned results & MD's interpretation.	Robert L. Duffy	

Quick Task Place Order Update

Diagnostic History Entry 0

Save & Close Cancel


03/25/2014 05:25 PM : "*USA SOAP"
Specialty Pulmonary Medicine
Visit Type Office Visit
Intake
Histories
SOAP
Finalize
Checkout
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.
5:50 PM 65.00 170.00 28.29 138/84 86 16 99.2 95
Add
Edit
Remove
Physical Exam
One Page Exam
Constitutional
Ears
Nose | Mouth | Throat
Neck | Thyroid
Lymphatic
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.


Health Promotion Plan | History | Graph
Time | Ht (in) | Wt (lb) | BMI | BP | Pulse | Respiration | Temp (F) | Pulse Ox Rest | BSA | Pain level | Comments
5:12 PM | 66.00 | 199.00 | 32.12 | 158/94 | 80 | 16 | 97.7
Add
Edit
Remove
Physical Exam
One Page Exam
Constitutional
Exam
Findings
Details
Ngkbm Td Dbp Filter
Set Name
PEFullNlAdultMale-RLD
PEFullNlFemale-RLD
Refresh
OK
Cancel
Office Diagnostics
I'm going to click the Open Preset icon & double-click on PEFullNlFemale-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 baseline exam displays. Let's change a few pertinent items. Click on One Page Exam.

PUL Summary | Standing Orders | Adult Immunizations | Peds Immunizations | My Plan | Procedures | Order Management

Care Guidelines | Global Days

Panel Control: Toggle Cycle

Reason for Visit

Review of Systems

Vital Signs

Physical Exam

One Page Exam
Constitutional
Ears
Nose | Mouth | Throat
Neck | Thyroid
Lymphatic
Respiratory
Cardiovascular
Vascular
Abdomen
Skin | Hair
Musculoskeletal
Extremities
Psychiatric

Additional

Exam	Findings	Details
Constitutional	*	Overall appearance - In no acute distress.
Ears	*	Canal - Right: No excess wax or inflammation, Left: No excess wax or inflammation. TM - Right: Benign, Left: Benign.
Nasopharynx	*	Oropharynx - No redness or drainage.
Neck Exam	Normal	Palpation - Normal. Thyroid gland - Normal.
Breast	Normal	Inspection - Bilateral: Normal. Palpation - Bilateral: Normal.
Respiratory	Normal	Auscultation - Normal. Effort - Normal.
Cardiovascular	Normal	Regular rhythm. No murmurs, gallops, or rubs.
Abdomen	Normal	No abdominal tenderness.
Genitourinary	Normal	No suprapubic tenderness.
Extremity	Normal	No edema.
Neurological	*	Sensory - Grossly normal. Motor - Grossly normal.

Office Diagnostics

Pe General Exam

Default:

Constitutional:
Overall appearance: Normal | In no acute distress | Overweight

Eyes: Vision Screening:
Conjunctiva: R Normal / L Normal
Pupil: R Normal / L Normal
Fundus: R Normal / L Normal

Ears Nose/Mouth/Throat:
External ear: R Normal / L Normal
Canal: R Normal | No excess wax or inflammatic / L Normal | No excess wax or inflammatic
TM: R Normal | Benign / L Normal | Benign
Hearing: R Normal / L Normal
External nose: Normal
Lips/teeth/gums: Normal
Oropharynx: Normal | No redness or drainage
Tonsils: Normal

Neck/Thyroid: Lymphatic:
Neck inspection: ☑ Normal — Thyroid gland: ☑ Normal
Neck palpation: Normal — Lymph nodes: Normal

Breast: Breast exam deferred
Breast inspection: Normal — Breast palpation: Normal

Respiratory:
Effort: ☑ Normal
Side: Location: Findings:
Inspection: Normal
Auscultation: Normal | Distant but clear bilat

Cardiovascular:
Auscultation: Normal

Vascular: Extremity
Pedal pulses: Normal — Capillary refill: Less than 2 seconds / Greater than 2 seconds
Edema: ◉ No ○ Yes

Abdomen:
Inspection: Normal | No masses
Auscultation: Normal

Genitourinary:
External genitalia: Normal
Urethra: Normal
Cervix: Normal
Uterus: Normal
Adnexa: Normal
Sphincter tone: Normal
Fecal occult blood test: ○ Negative ○ Positive ○ Not indicated — Submit to Superbill

Musculoskeletal:
Overview: Normal

Skin:
Inspection: Normal

Neurological:
Memory: Normal
Cranial nerves: II - XII grossly intact — I is grossly intact — Details
DTRs: Normal
Sensory: Normal | No focal deficits

Psych:
No Yes
Oriented to person, place, time _situation
Appropriate mood and affect
Poor judgement
Poor insight
Carry forward comments
Comments:

Save & Close — Cancel

Here I've amended my exam to comment on her weight & lung exam.

When done click Save & Close.

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

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

Vital Signs

Physical Exam

One Page Exam
Constitutional
Ears
Nose | Mouth | Throat
Neck | Thyroid
Lymphatic
Respiratory
Cardiovascular
Vascular
Abdomen
Skin | Hair
Musculoskeletal
Extremities
Psychiatric

Additional

Exam	Findings	Details
Constitutional	*	Overall appearance - In no acute distress, Overweight.
Ears	*	Canal - Right: No excess wax or inflammation, Left: No excess wax or inflammation. TM - Right: Benign, Left: Benign.
Nasopharynx	*	Oropharynx - No redness or drainage.
Neck Exam	Normal	Palpation - Normal. Thyroid gland - Normal.
Breast	Normal	Inspection - Bilateral: Normal. Palpation - Bilateral: Normal.
Respiratory	*	Auscultation - Findings: Distant but clear bilat.
Respiratory	Normal	Effort - Normal.
Cardiovascular	Normal	Regular rhythm. No murmurs, gallops, or rubs.
Abdomen	Normal	No abdominal tenderness.
Genitourinary	Normal	No suprapubic tenderness.
Neurological	*	Sensory - Grossly normal. Motor - Grossly normal.

Office Diagnostics

03/25/2014 05:25 PM : "*USA SOAP"

Vital Signs

Physical Exam

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.

Health Promotion Plan

Resident-Attending discussion took place

Attending saw patient

Consent | Procedure Scheduling | Add/Update | Remove

Consent

Provider Comm.

Meds

Procedures

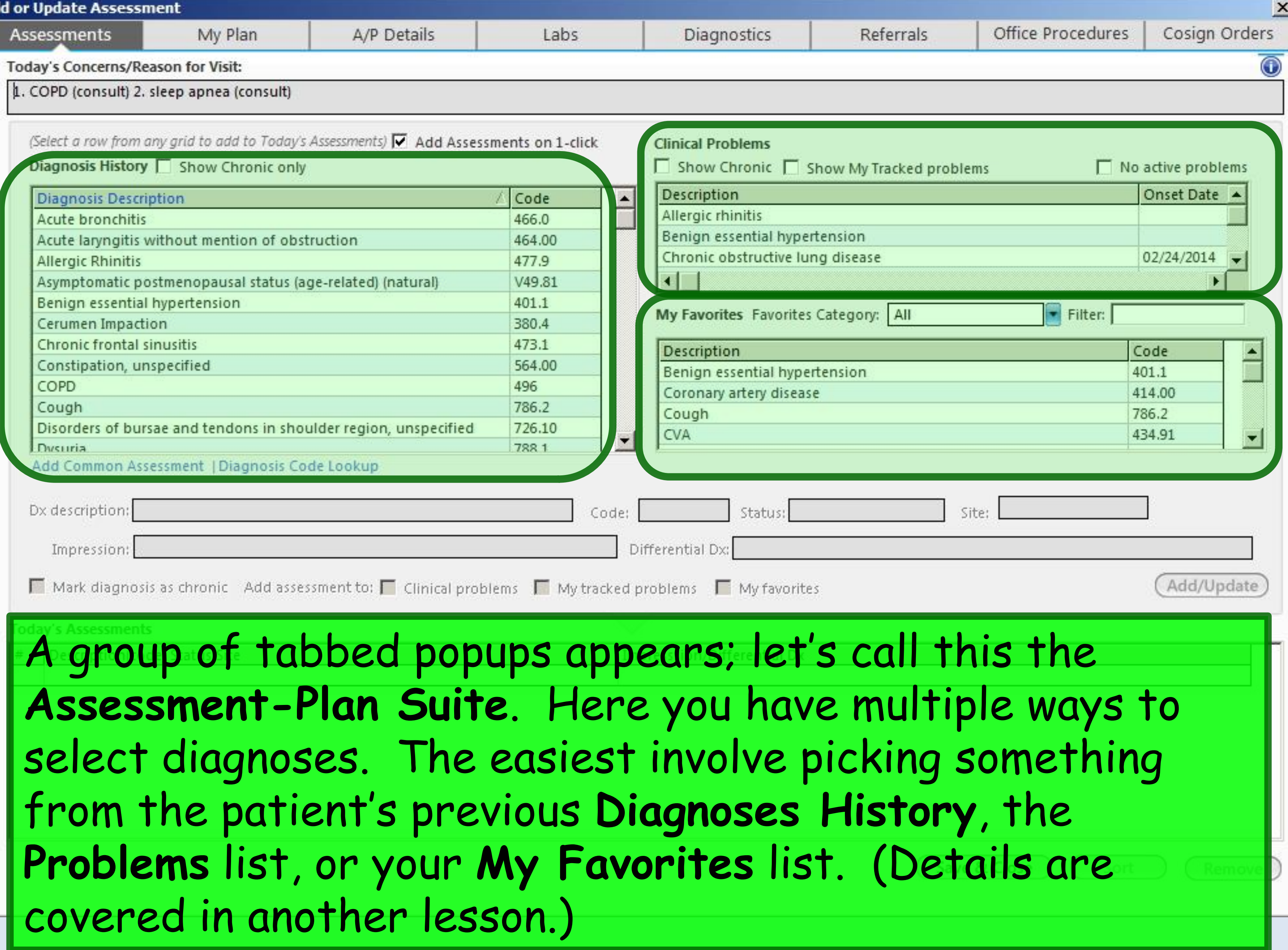
Patient Plan

Visit Document

Document Library

EM Coding

Dictation



Add or Update Assessment
Assessments
My Plan
A/P Details
Labs
Diagnostics
Referrals
Office Procedures
Cosign Orders
Today's Concerns/Reason for Visit:
1. COPD (consult) 2. sleep apnea (consult)
(Select a row from any grid to add to Today's Assessments)
Add Assessments on 1-click
Diagnosis History
Show Chronic only
Diagnosis Description
Code
Acute bronchitis 466.0
Acute laryngitis without mention of obstruction 464.00
Allergic Rhinitis 477.9
Asymptomatic postmenopausal status (age-related) (natural) V49.81
Benign essential hypertension 401.1
Cerumen Impaction 380.4
Chronic frontal sinusitis 473.1
Constipation, unspecified 564.00
COPD 496
Cough 786.2
Disorders of bursae and tendons in shoulder region, unspecified 726.10
Add Common Assessment
Diagnosis Code Lookup
Clinical Problems
Show Chronic
Show My Tracked problems
No active problems
Description
Onset Date
Allergic rhinitis
Benign essential hypertension
Chronic obstructive lung disease 02/24/2014
My Favorites
Favorites Category:
All
Filter:
Description
Code
Benign essential hypertension 401.1
Coronary artery disease 414.00
Cough 786.2
CVA 434.91
Dx description:
Code:
Status:
Site:
Impression:
Differential Dx:
Mark diagnosis as chronic
Add assessment to:
Clinical problems
My tracked problems
My favorites
Add/Update
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. (Details are covered in another lesson.)

For this example, I'll select several of the established diagnoses from the **Clinical Problems** list…

Add or Update Assessments

Assessments | My Plan | A/P Details | Labs | Diagnostics | Referrals | Office Procedures | Cosign Orders

Today's Assessments

1. COPD (consult) 2. sleep apnea (consult)

(Select a row from any grid to add to Today's Assessments) ☑ Add Assessments on 1-click

Diagnosis History ☐ Show Chronic only

Diagnosis Description	Code
Acute bronchitis	466.0
Acute laryngitis without mention of obstruction	464.00
Allergic Rhinitis	477.9
Asymptomatic postmenopausal status (age-related) (natural)	V49.81
Benign essential hypertension	401.1
Cerumen Impaction	380.4
Chronic frontal sinusitis	473.1
Constipation, unspecified	564.00
COPD	496
Cough	786.2
Disorders of bursae and tendons in shoulder region, unspecified	726.10
Dysuria	788.1

Add Common Assessment | Diagnosis Code Lookup

Clinical Problems

☐ Show Chronic ☐ Show My Tracked problems ☐ No active problems

Description	Onset Date
Allergic rhinitis	
Benign essential hypertension	
Chronic obstructive lung disease	02/24/2014

My Favorites Favorites Category: All Filter:

Description	Code
Benign essential hypertension	401.1
Coronary artery disease	414.00
Cough	786.2
CVA	434.91

Dx description: Code: Status: Site:

Impression: Differential Dx:

☐ Mark diagnosis as chronic Add assessment to ☐ Clinical problems ☐ My tracked problems ☐ My favorites Add/Update

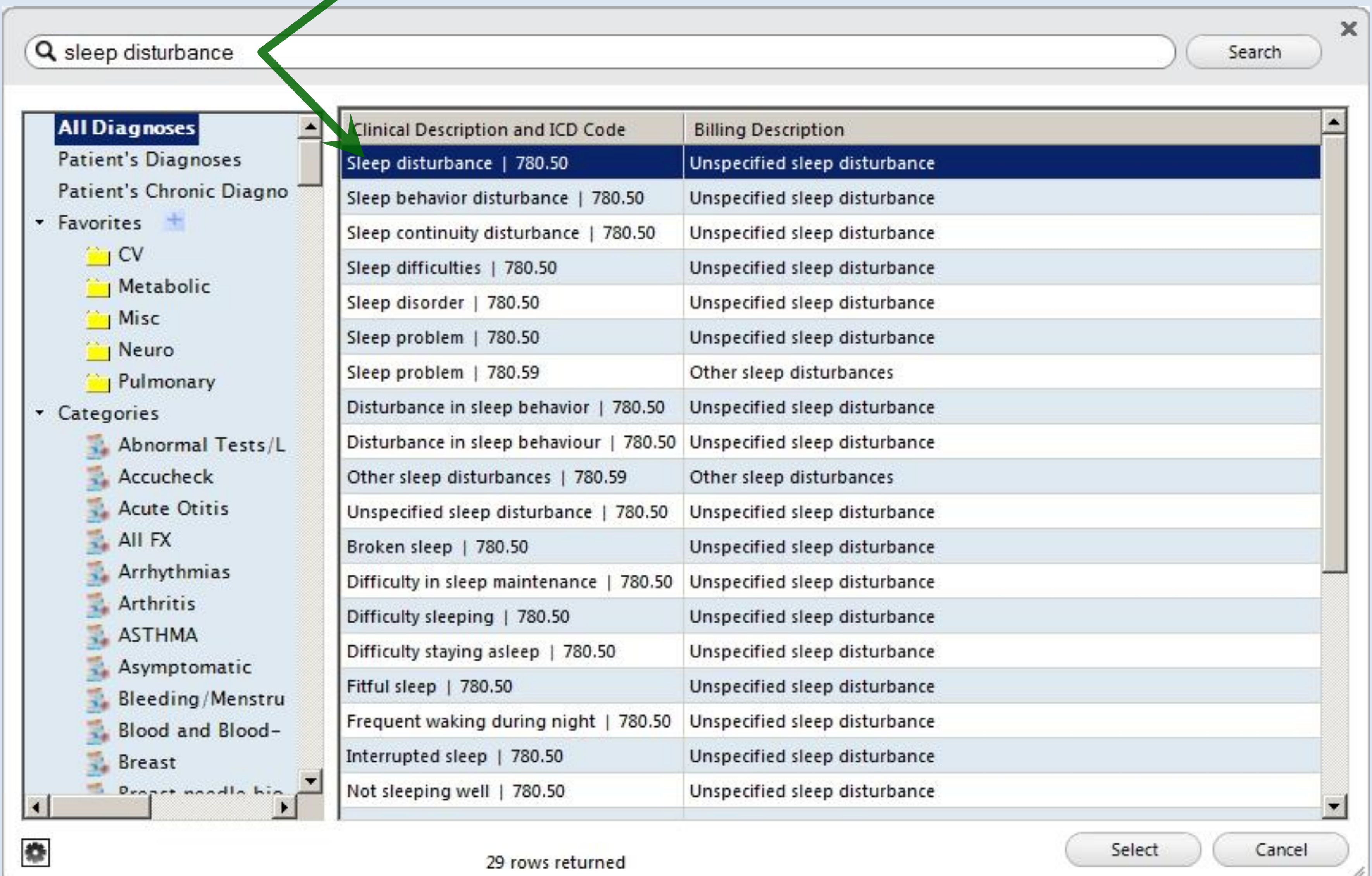
Today's Assessments

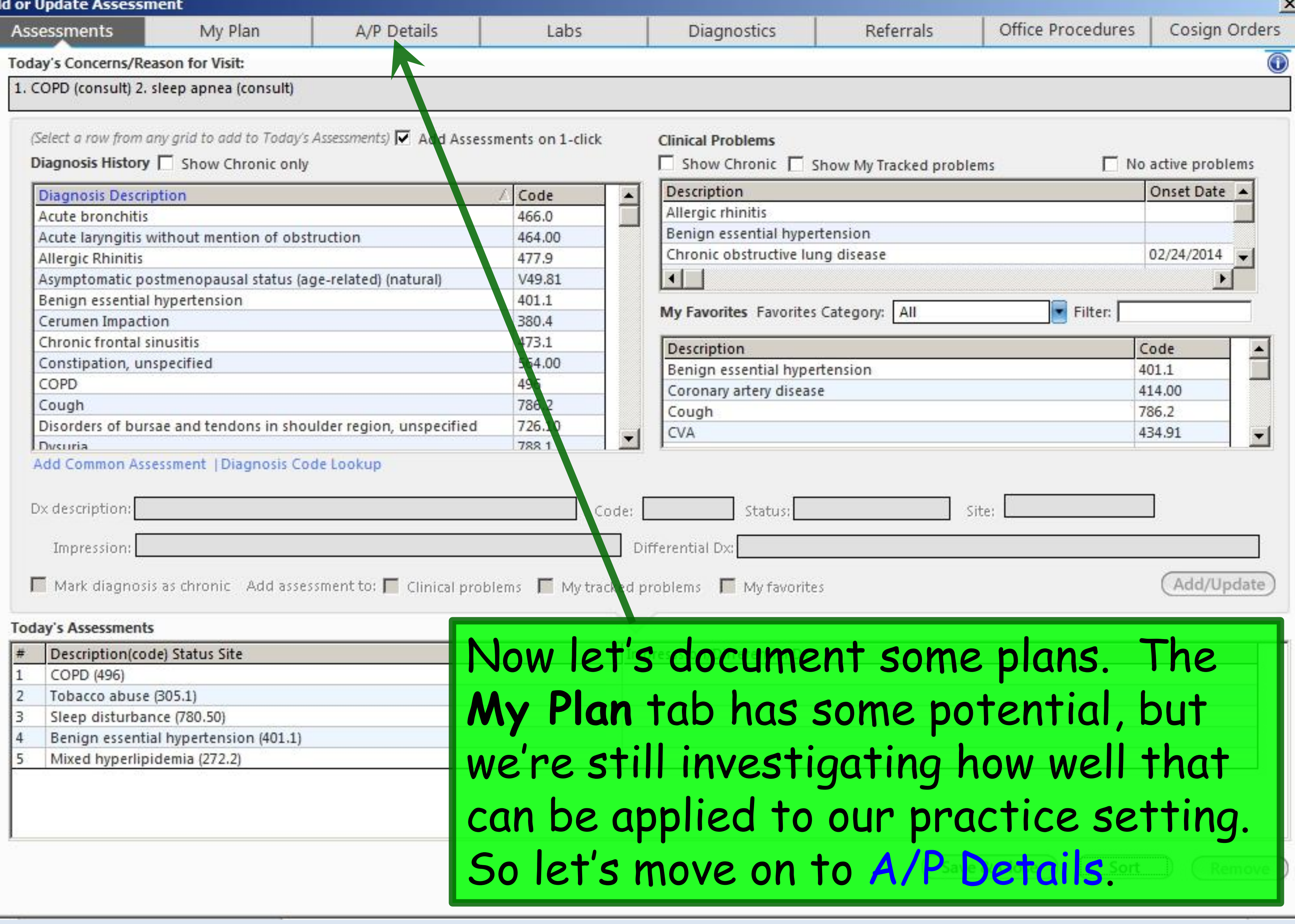
#	Description(code) Status Site	Impresssion/Differential Dx

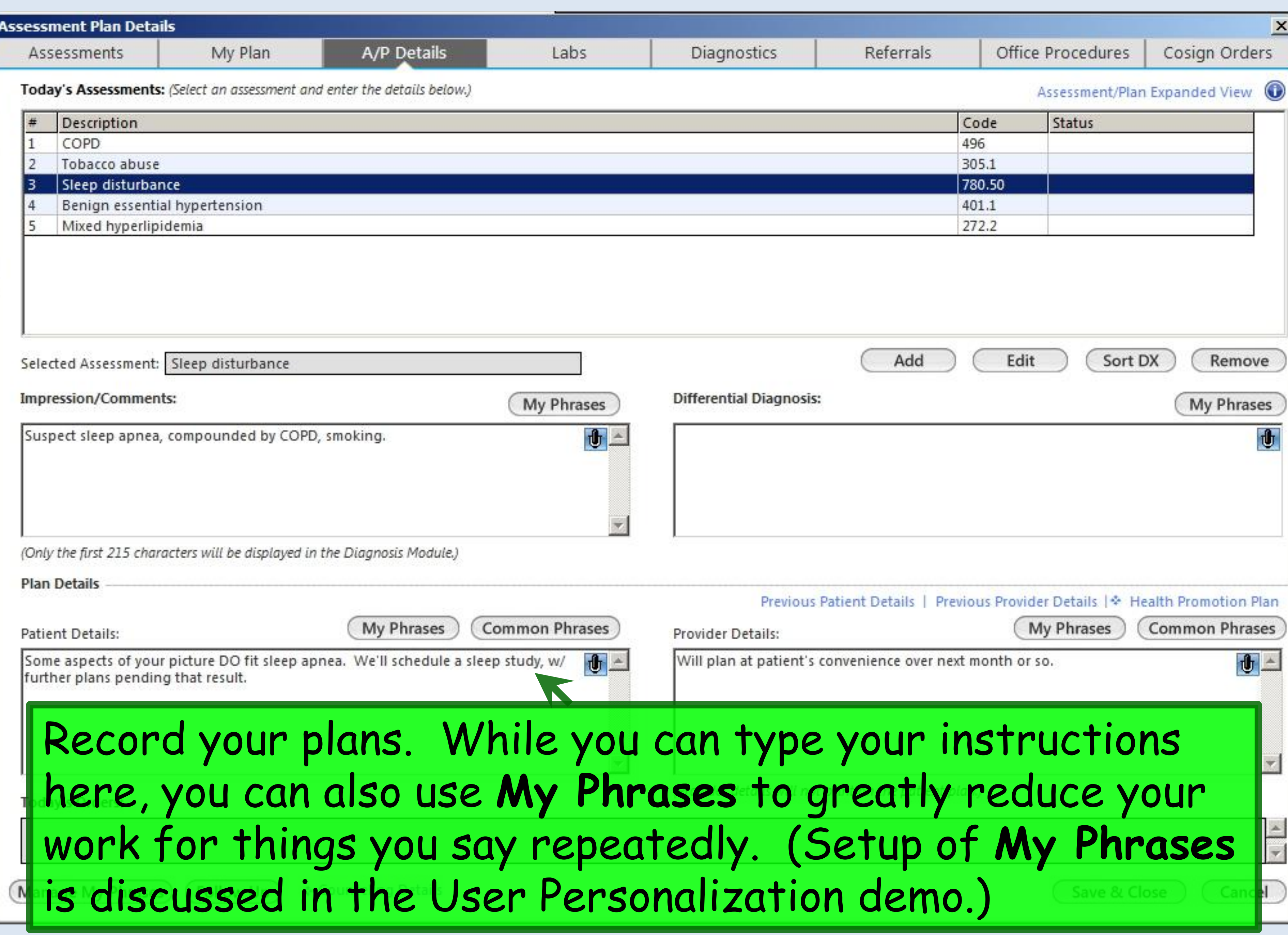
…then click Diagnosis Code Lookup to add another diagnosis.

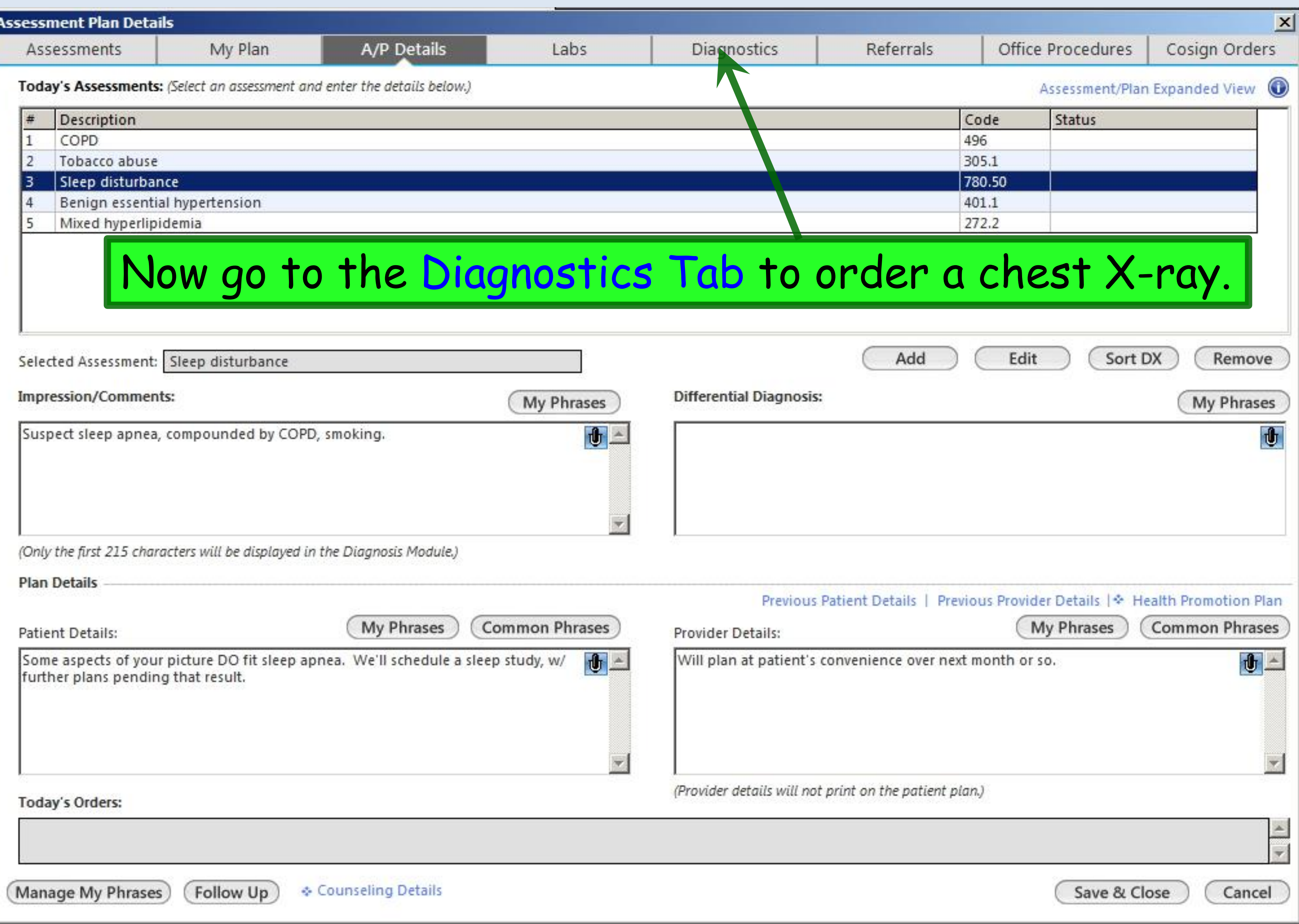
Save & Close Sort Remove

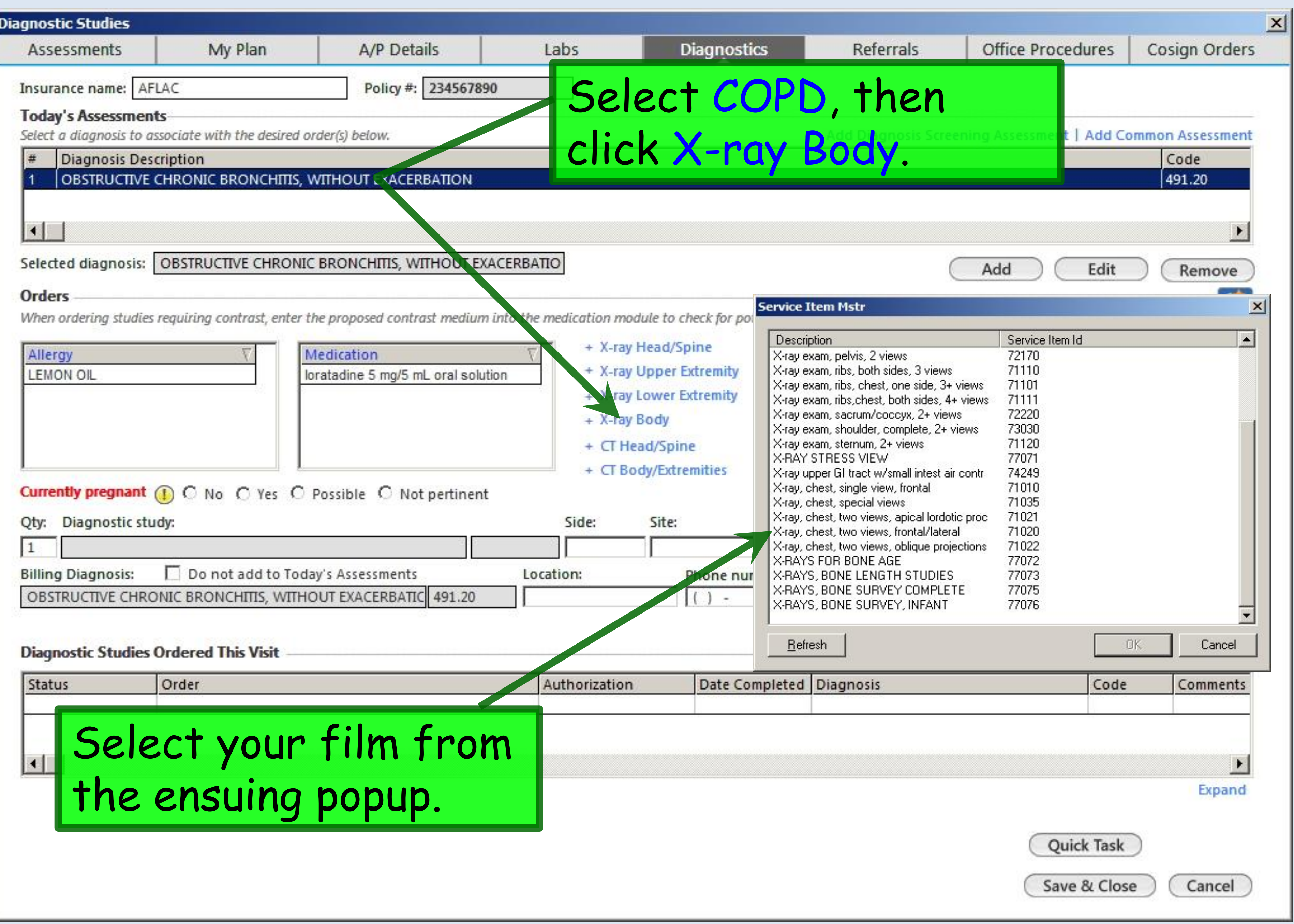
Diagnosis search is covered more thoroughly in another lesson. For this example, I've searched for & selected Sleep disturbance.

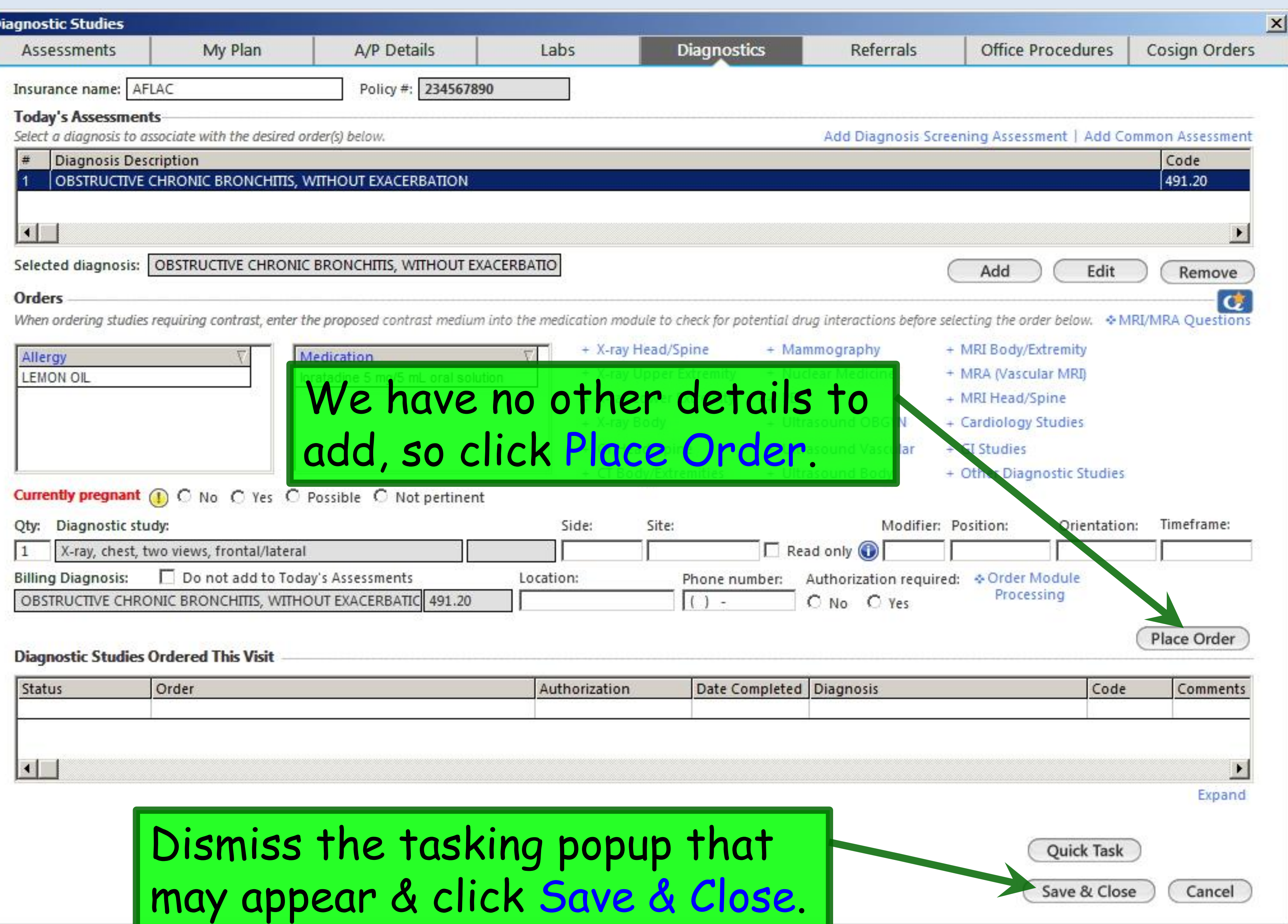



Add or Update Assessment
Assessments
My Plan
A/P Details
Labs
Diagnostics
Referrals
Office Procedures
Cosign Orders
Today's Concerns/Reason for Visit:
1. COPD (consult) 2. sleep apnea (consult)
(Select a row from any grid to add to Today's Assessments)
Add Assessments on 1-click
Diagnosis History
Show Chronic only
Diagnosis Description
Code
Acute bronchitis 466.0
Acute laryngitis without mention of obstruction 464.00
Allergic Rhinitis 477.9
Asymptomatic postmenopausal status (age-related) (natural) V49.81
Benign essential hypertension 401.1
Cerumen Impaction 380.4
Chronic frontal sinusitis
Constipation, unspecified
COPD
Cough
Disorders of bursae and tendons in shoulder region, unspecified
Add Common Assessment
Diagnosis Code Lookup
Clinical Problems
Show Chronic
Show My Tracked problems
No active problems
Description
Onset Date
Allergic rhinitis
Benign essential hypertension
Chronic obstructive lung disease 02/24/2014
My Favorites
Favorites Category:
All
Filter:
Description
Code
Benign essential hypertension 401.1
Coronary artery disease 414.00
Cough 786.2
CVA 434.91
Dx description:
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
1 COPD (496)
2 Tobacco abuse (305.1)
3 Sleep disturbance (780.50)
4 Benign essential hypertension (401.1)
5 Mixed hyperlipidemia (272.2)
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 COPD 496
2 Tobacco abuse 305.1
3 Sleep disturbance 780.50
4 Benign essential hypertension 401.1
5 Mixed hyperlipidemia 272.2
Selected Assessment: Sleep disturbance
Add
Edit
Sort DX
Remove
Impression/Comments:
My Phrases
Suspect sleep apnea, compounded by COPD, smoking.
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
Some aspects of your picture DO fit sleep apnea. We'll schedule a sleep study, w/ further plans pending that result.
Provider Details:
My Phrases
Common Phrases
Will plan at patient's convenience over next month or so.
Save & Close
Cancel
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 COPD 496
2 Tobacco abuse 305.1
3 Sleep disturbance 780.50
4 Benign essential hypertension 401.1
5 Mixed hyperlipidemia 272.2
Now go to the Diagnostics Tab to order a chest X-ray.
Selected Assessment: Sleep disturbance
Add
Edit
Sort DX
Remove
Impression/Comments:
My Phrases
Suspect sleep apnea, compounded by COPD, smoking.
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
Some aspects of your picture DO fit sleep apnea. We'll schedule a sleep study, w/ further plans pending that result.
Provider Details:
My Phrases
Common Phrases
Will plan at patient's convenience over next month or so.
(Provider details will not print on the patient plan.)
Today's Orders:
Manage My Phrases
Follow Up
Counseling Details
Save & Close
Cancel


Select COPD, then click X-ray Body.
Select your film from the ensuing popup.
Diagnostic Studies
Assessments
My Plan
A/P Details
Labs
Diagnostics
Referrals
Office Procedures
Cosign Orders
Insurance name: AFLAC
Policy #: 234567890
Today's Assessments
Select a diagnosis to associate with the desired order(s) below.
Add Common Assessment
Diagnosis Description
Code
OBSTRUCTIVE CHRONIC BRONCHITIS, WITHOUT EXACERBATION
491.20
Selected diagnosis: OBSTRUCTIVE CHRONIC BRONCHITIS, WITHOUT EXACERBATIO
Add
Edit
Remove
Orders
When ordering studies requiring contrast, enter the proposed contrast medium into the medication module to check for po
Allergy
LEMON OIL
Medication
loratadine 5 mg/5 mL oral solution
+ X-ray Head/Spine
+ X-ray Upper Extremity
+ X-ray Lower Extremity
+ X-ray Body
+ CT Head/Spine
+ CT Body/Extremities
Currently pregnant
No
Yes
Possible
Not pertinent
Qty:
Diagnostic study:
Side:
Site:
Billing Diagnosis:
Do not add to Today's Assessments
Location:
OBSTRUCTIVE CHRONIC BRONCHITIS, WITHOUT EXACERBATIC
491.20
Service Item Mstr
Description
Service Item Id
X-ray exam, pelvis, 2 views 72170
X-ray exam, ribs, both sides, 3 views 71110
X-ray exam, ribs, chest, one side, 3+ views 71101
X-ray exam, ribs,chest, both sides, 4+ views 71111
X-ray exam, sacrum/coccyx, 2+ views 72220
X-ray exam, shoulder, complete, 2+ views 73030
X-ray exam, sternum, 2+ views 71120
X-RAY STRESS VIEW 77071
X-ray upper GI tract w/small intest air contr 74249
X-ray, chest, single view, frontal 71010
X-ray, chest, special views 71035
X-ray, chest, two views, apical lordotic proc 71021
X-ray, chest, two views, frontal/lateral 71020
X-ray, chest, two views, oblique projections 71022
X-RAYS FOR BONE AGE 77072
X-RAYS, BONE LENGTH STUDIES 77073
X-RAYS, BONE SURVEY COMPLETE 77075
X-RAYS, BONE SURVEY, INFANT 77076
Refresh
OK
Cancel
Diagnostic Studies Ordered This Visit
Status
Order
Authorization
Date Completed
Diagnosis
Code
Comments
Expand
Quick Task
Save & Close
Cancel



Diagnostic Studies
Assessments
My Plan
A/P Details
Labs
Diagnostics
Referrals
Office Procedures
Cosign Orders
Insurance name: AFLAC
Policy #: 234567890
Today's Assessments
Select a diagnosis to associate with the desired order(s) below.
Add Diagnosis Screening Assessment | Add Common Assessment
Diagnosis Description Code
1 OBSTRUCTIVE CHRONIC BRONCHITIS, WITHOUT EXACERBATION 491.20
Selected diagnosis: OBSTRUCTIVE CHRONIC BRONCHITIS, WITHOUT EXACERBATIO
Add
Edit
Remove
Orders
When ordering studies requiring contrast, enter the proposed contrast medium into the medication module to check for potential drug interactions before selecting the order below.
MRI/MRA Questions
Allergy
LEMON OIL
Medication
+ X-ray Head/Spine
+ Mammography
+ MRI Body/Extremity
+ MRA (Vascular MRI)
+ MRI Head/Spine
+ Cardiology Studies
+ GI Studies
+ Other Diagnostic Studies
We have no other details to add, so click Place Order.
Currently pregnant
No
Yes
Possible
Not pertinent
Qty: 1
Diagnostic study: X-ray, chest, two views, frontal/lateral
Side:
Site:
Read only
Modifier:
Position:
Orientation:
Timeframe:
Billing Diagnosis:
Do not add to Today's Assessments
OBSTRUCTIVE CHRONIC BRONCHITIS, WITHOUT EXACERBATIC 491.20
Location:
Phone number:
Authorization required:
No
Yes
Order Module Processing
Place Order
Diagnostic Studies Ordered This Visit
Status
Order
Authorization
Date Completed
Diagnosis
Code
Comments
Expand
Quick Task
Dismiss the tasking popup that may appear & click Save & Close.
Save & Close
Cancel

03/25/2014 05:25 PM : "*USA SOAP" ×

Assessment/Plan

- Assessments
- My Plan
- A/P Details
- Labs
- Diagnostics
- Referrals
- Office Procedures
- Review/Cosign Orders
- View Immunizations
- Office Diagnostics
- Physical Therapy Orders
- Health Promotion Plan

1.	Assessment	COPD (496).
	Patient Plan	Urged to quit smoking. Continue Advair 250/50 1 puff twice daily. Albuterol as needed for shortness of breath; follow-up if having an escalating need for albuterol, or more severe/frequent shortness of breath.
	Provider Plan	I don't see a chest X-ray in the system, so we'll order one today.
	Plan Orders	Further diagnostic evaluations ordered today include X-ray, chest, two views, frontal/lateral to be performed.
2.	Assessment	Tobacco abuse (305.1).
	Patient Plan	Discussed importance of smoking cessation; it may be the single most important thing you can do for your health. I urge you to quit as soon as possible. Free assistance & nicotine patches are available at www.alabamaquitnow.com or 800-784-8669. A wealth of information & assistance is also available at the American Lung Association, www.lung.org/stop-smoking, or 800-586-4872.
3.	Assessment	Sleep disturbance (780.50).
	Impression	Suspect sleep apnea, compounded by COPD, smoking..
	Patient Plan	Some aspects of your picture DO fit sleep apnea. We'll schedule a sleep study, w/ further plans pending that result.
	Provider Plan	Will plan at patient's convenience over next month or so.
4.	Assessment	Benign essential hypertension (401.1).
	Patient Plan	Continue current meds & follow-up w/ PCP.

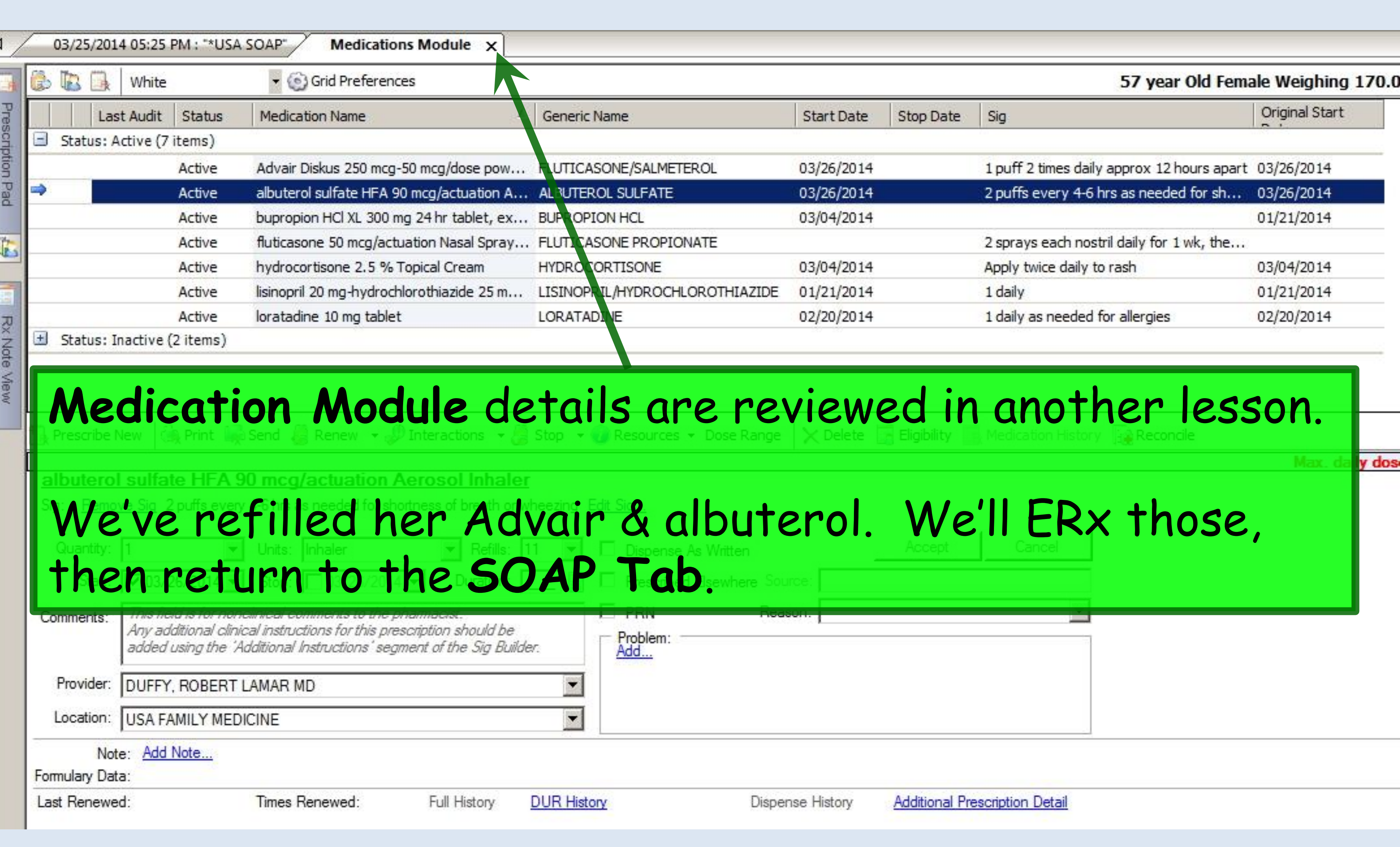
Your assessments & plans display. (We'll show you how you or your staff can print that X-ray requisition in a minute.)

☐ Resident-Attending discussion took place ☐ Attending saw patient

Consent | Procedure Scheduling | Add/Update | Remove

Let's complete her prescriptions. Click Meds.

Provider Comm. | Meds | Procedures | Patient Plan | Visit Document | Document Library | EM Coding | Dictation


03/25/2014 05:25 PM : "*USA SOAP"
Medications Module
White
Grid Preferences
57 year Old Female Weighing 170.0
Last Audit
Status
Medication Name
Generic Name
Start Date
Stop Date
Sig
Original Start
Status: Active (7 items)
Active Advair Diskus 250 mcg-50 mcg/dose pow… FLUTICASONE/SALMETEROL 03/26/2014 1 puff 2 times daily approx 12 hours apart 03/26/2014
Active albuterol sulfate HFA 90 mcg/actuation A… ALBUTEROL SULFATE 03/26/2014 2 puffs every 4-6 hrs as needed for sh… 03/26/2014
Active bupropion HCl XL 300 mg 24 hr tablet, ex… BUPROPION HCL 03/04/2014 01/21/2014
Active fluticasone 50 mcg/actuation Nasal Spray… FLUTICASONE PROPIONATE 2 sprays each nostril daily for 1 wk, the…
Active hydrocortisone 2.5 % Topical Cream HYDROCORTISONE 03/04/2014 Apply twice daily to rash 03/04/2014
Active lisinopril 20 mg-hydrochlorothiazide 25 m… LISINOPRIL/HYDROCHLOROTHIAZIDE 01/21/2014 1 daily 01/21/2014
Active loratadine 10 mg tablet LORATADINE 02/20/2014 1 daily as needed for allergies 02/20/2014
Status: Inactive (2 items)
Medication Module details are reviewed in another lesson.
We've refilled her Advair & albuterol. We'll ERx those, then return to the SOAP Tab.
Comments:
Any additional clinical instructions for this prescription should be added using the 'Additional Instructions' segment of the Sig Builder.
Problem:
Add...
Provider: DUFFY, ROBERT LAMAR MD
Location: USA FAMILY MEDICINE
Note: Add Note...
Formulary Data:
Last Renewed:
Times Renewed:
Full History
DUR History
Dispense History
Additional Prescription Detail

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Assessment/Plan

- Assessments
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	Provider Plan	I don't see a chest X-ray in the system, so we'll order one today.
	Plan Orders	Further diagnostic evaluations ordered today include X-ray, chest, two views, frontal/lateral to be performed.
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	Patient Plan	Some aspects of your picture DO fit sleep apnea. We'll schedule a sleep study, w/ further plans pending that result.
	Provider Plan	Will plan at patient's convenience over next month or so.
4.	Assessment	Benign essential hypertension (401.1).
	Patient Plan	Continue current meds & follow-up w/ PCP.
5.	Assessment	Mixed hyperlipidemia (272.2).

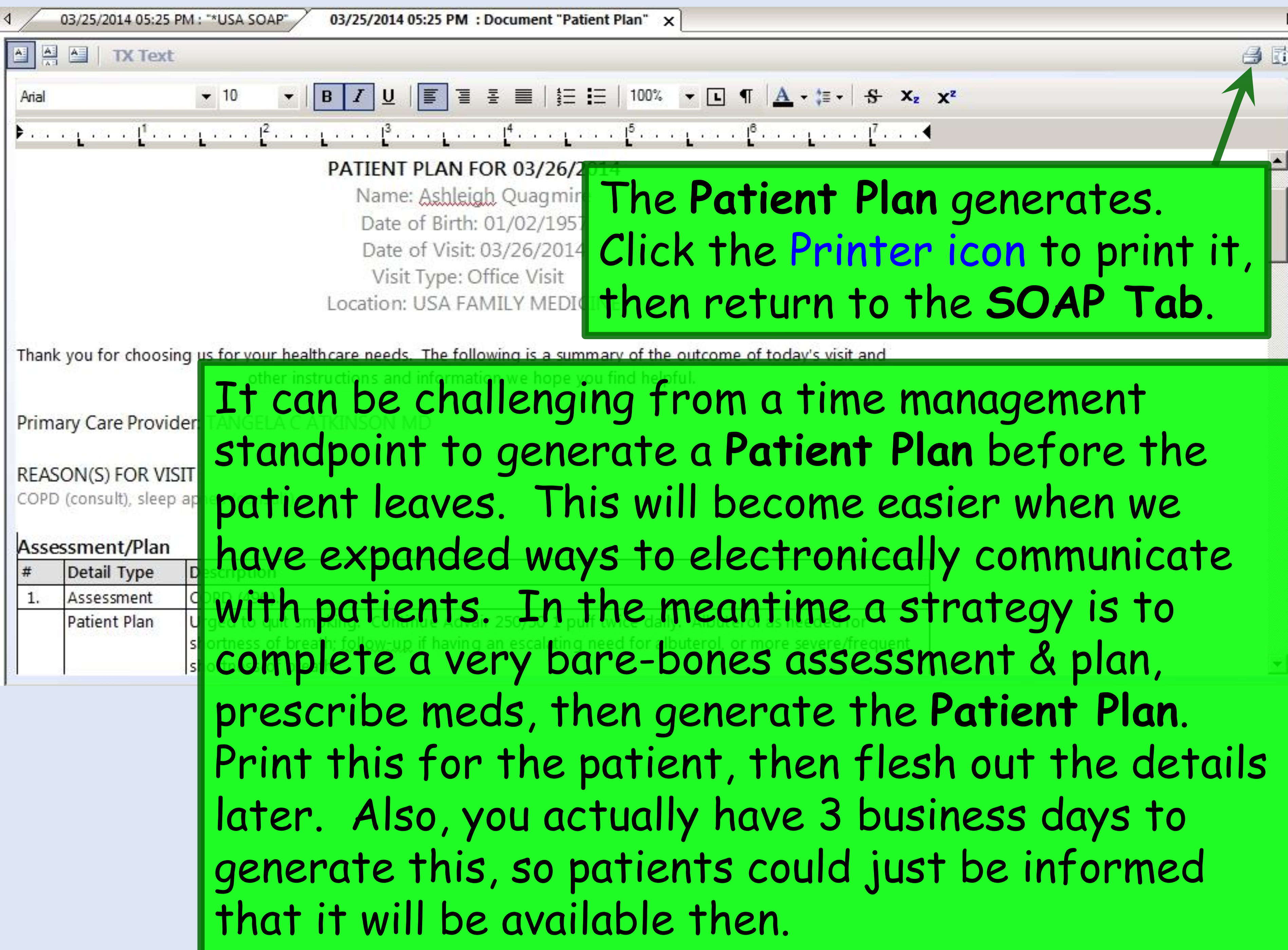
One of the Meaningful Use criteria requires patients to receive a summary of the visit. Click Patient Plan.

☐ 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


03/25/2014 05:25 PM : "*USA SOAP"
03/25/2014 05:25 PM : Document "Patient Plan"
TX Text
Arial
10
100%
PATIENT PLAN FOR 03/26/2014
Name: Ashleigh Quagmire
Date of Birth: 01/02/1957
Date of Visit: 03/26/2014
Visit Type: Office Visit
Location: USA FAMILY MEDICINE
The Patient Plan generates. Click the Printer icon to print it, then return to the SOAP Tab.
Thank you for choosing us for your healthcare needs. The following is a summary of the outcome of today's visit and
Primary Care Provider:
REASON(S) FOR VISIT
COPD (consult), sleep ap
Assessment/Plan
Detail Type
1. Assessment
Patient Plan
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. Also, you actually have 3 business days to generate this, so patients could just be informed that it will be available then.

03/25/2014 05:25 PM : "*USA SOAP"

Assessment/Plan

- Assessments
- My Plan
- A/P Details
- Labs
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- Office Procedures
- Review/Cosign Orders
- View Immunizations
- Office Diagnostics
- Physical Therapy Orders
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1.	Assessment	COPD (496).
	Patient Plan	Urged to quit smoking. Continue Advair 250/50 1 puff twice daily. Albuterol as needed for shortness of breath; follow-up if having an escalating need for albuterol, or more severe/frequent shortness of breath.
	Provider Plan	I don't see a chest X-ray in the system, so we'll order one today.
	Plan Orders	Further diagnostic evaluations ordered today include X-ray, chest, two views, frontal/lateral to be performed.
2.	Assessment	Tobacco abuse (305.1).
	Patient Plan	Discussed importance of smoking cessation; it may be the single most important thing you can do for your health. I urge you to quit as soon as possible. Free assistance & nicotine patches are available at www.alabamaquitnow.com or 800-784-8669. A wealth of information & assistance is also available at the American Lung Association, www.lung.org/stop-smoking, or 800-586-4872.
3.	Assessment	Sleep disturbance (780.50).
	Impression	Suspect sleep apnea, compounded by COPD, smoking..
	Patient Plan	Some aspects of your picture DO fit sleep apnea. We'll schedule a sleep study, w/ further plans pending that result.
	Provider Plan	Will plan at patient's convenience over next month or so.
4.	Assessment	Benign essential hypertension (401.1).
	Patient Plan	Continue current meds & follow-up w/ PCP.
5.	Assessment	Mixed hyperlipidemia (272.2).

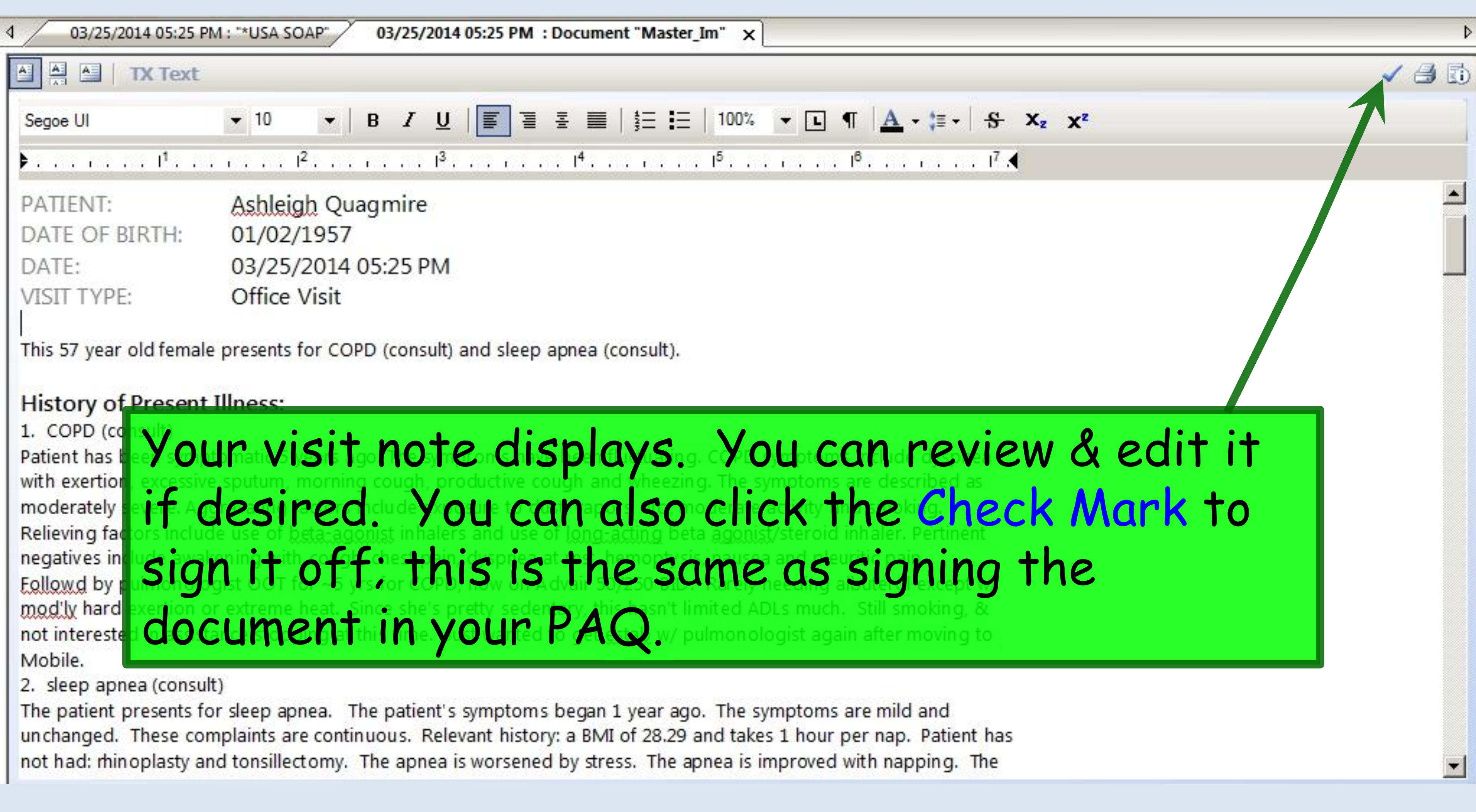
Now generate today's visit note. One way to do this would be to click Visit Document.

☐ Resident-Attending discussion took place ☐ Attending saw patient

Consent | Procedure Scheduling | Add/Update | Remove

Consent

Provider Comm. | Meds | Procedures | Patient Plan | Visit Document | Document Library | EM Coding | Dictation


03/25/2014 05:25 PM : "*USA SOAP"
03/25/2014 05:25 PM : Document "Master_Im"
TX Text
Segoe UI
10
100%
PATIENT: Ashleigh Quagmire
DATE OF BIRTH: 01/02/1957
DATE: 03/25/2014 05:25 PM
VISIT TYPE: Office Visit
This 57 year old female presents for COPD (consult) and sleep apnea (consult).
History of Present Illness:
1. COPD (co
Patient has
with exertion
moderately
Relieving factors include use of beta-agonist inhalers and use of long-acting beta agonist/steroid inhaler. Pertinent
negatives in
Followd by
mod'ly hard
not intereste
Mobile.
2. sleep apnea (consult)
The patient presents for sleep apnea. The patient's symptoms began 1 year ago. The symptoms are mild and
unchanged. These complaints are continuous. Relevant history: a BMI of 28.29 and takes 1 hour per nap. Patient has
not had: rhinoplasty and tonsillectomy. The apnea is worsened by stress. The apnea is improved with napping. The
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.

03/25/2014 05:25 PM : "*USA SOAP"

Navigation

Intake
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.

1.	Assessment	COPD (496).
	Patient Plan	Urged to quit smoking. Continue Advair 250/50 1 puff twice daily. Albuterol as needed for shortness of breath;
	Provider Plan	I don't see a chest X-ray in the system, so we'll order one today.
	Plan Orders	Further diagnostic evaluations ordered today include X-ray chest, two views frontal/lateral to be performed
2.	Assessment	Tobacco abuse (305.1).
	Patient Plan	health. I urge you to quit as soon as possible. Free assistance & nicotine patches are available at www.alabamaquitnow.com or 800-784-8669.
3.	Assessment	
	Impression	Suspect sleep apnea, compounded by COPD, smoking..
	Patient Plan	... further plans pending that result.
	Provider Plan	Will plan at patient's convenience over next month or so.
4.	Assessment	Benign essential hypertension (401.1).
	Patient Plan	Continue current meds & follow-up w/ PCP.
5.	Assessment	Mixed hyperlipidemia (272.2).

When the **Navigation Bar** displays, click Offline.

took place ☐ Attending saw patient

Consent | Procedure Scheduling | Add/Update | Remove

Consent

Meds | Procedures | Patient Plan | Visit Document | Document Library | EM Coding | Dictation

03/25/2014 05:25 PM : "*USA SOAP"

Assessment/Plan

- Assessments
- My Plan
- A/P Details
- Labs
- Diagnostics
- Referrals
- Office Procedures
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1.	Assessment	COPD (496).
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3.	Assessment	Sleep disturbance (780.50).
	Impression	Suspect sleep apnea, compounded by COPD, smoking..
	Patient Plan	Some aspects of your picture DO fit sleep apnea. We'll schedule a sleep study, w/ further plans pending that result.

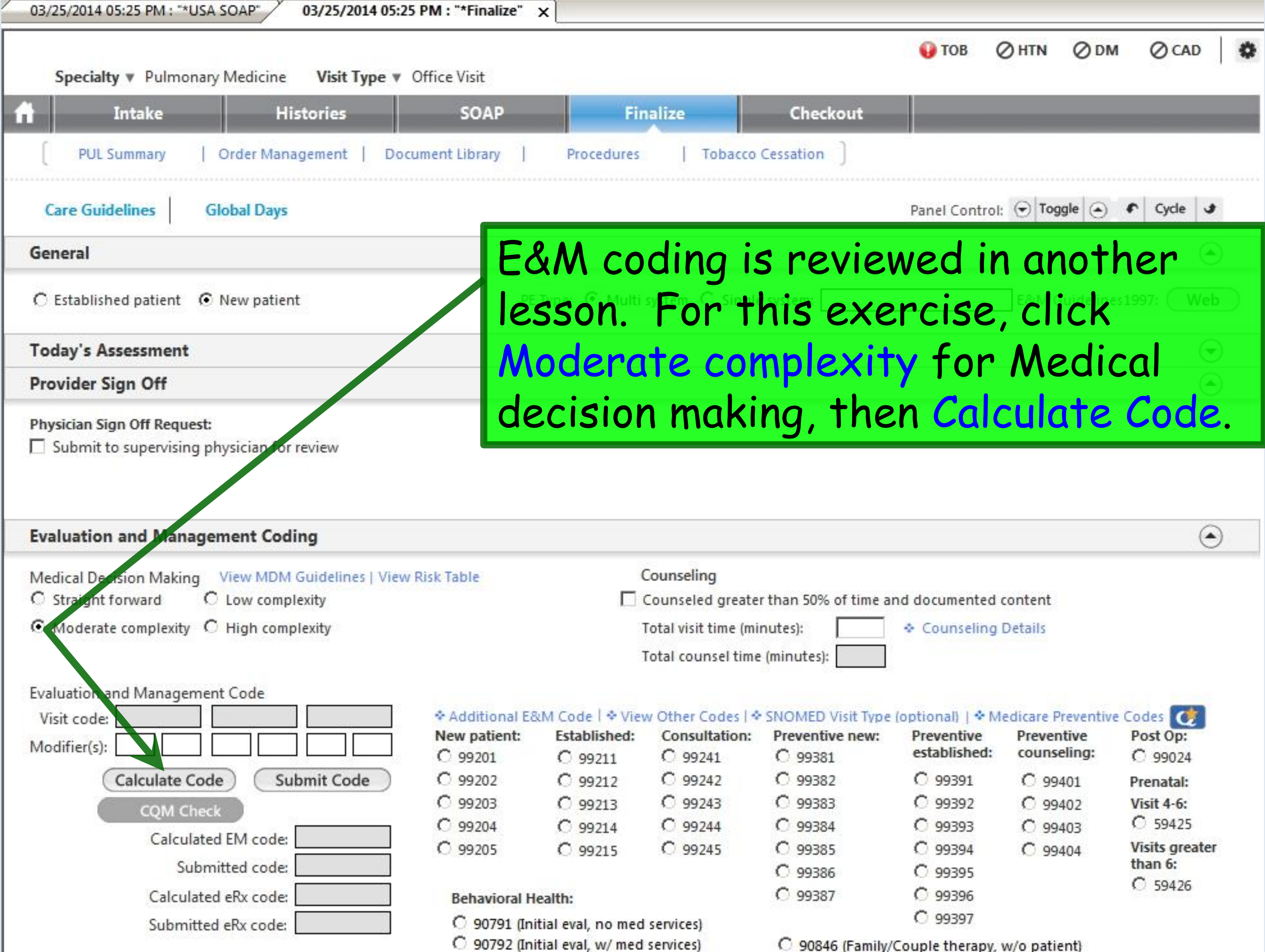
Now move to the **Finalize Tab**. You can do this by navigating back to the top & clicking the Finalize Tab, but if you're at the bottom of the **SOAP Tab**, there is a shortcut to get there directly. Click EM Coding.

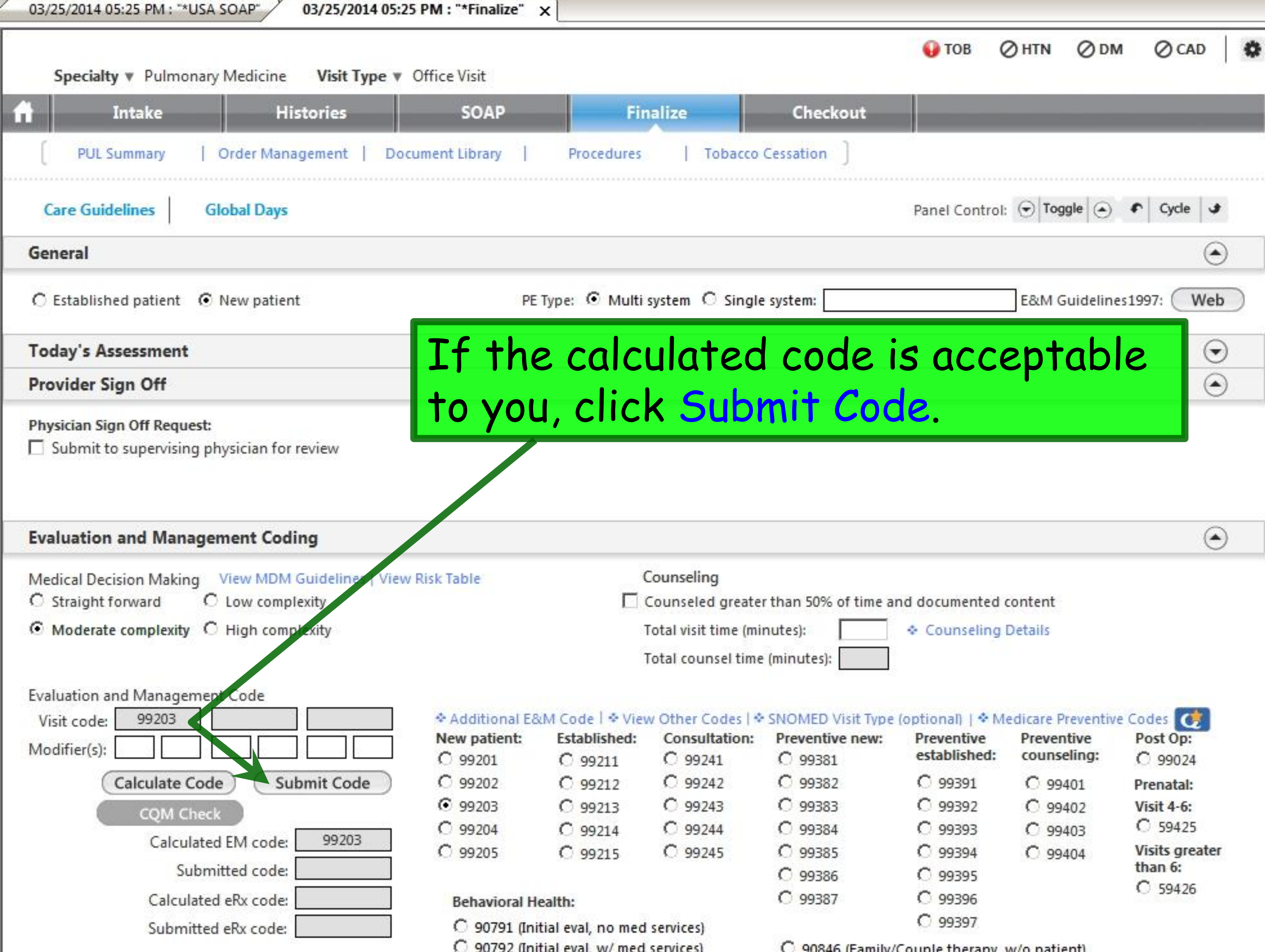
☐ Resident-Attending discussion took place ☐ Attending saw patient

Consent | Procedure Scheduling | Add/Update | Remove

Consent

Provider Comm. | Meds | Procedures | Patient Plan | Visit Document | Document Library | EM Coding | Dictation


03/25/2014 05:25 PM : "*USA SOAP"
03/25/2014 05:25 PM : "*Finalize"
TOB
HTN
DM
CAD
Specialty Pulmonary Medicine
Visit Type Office Visit
Intake
Histories
SOAP
Finalize
Checkout
PUL Summary
Order Management
Document Library
Procedures
Tobacco Cessation
Care Guidelines
Global Days
Panel Control:
Toggle
Cycle
General
Established patient
New patient
Today's Assessment
Provider Sign Off
Physician Sign Off Request:
Submit to supervising physician for review
E&M coding is reviewed in another lesson. For this exercise, click Moderate complexity for Medical decision making, then Calculate Code.
Evaluation and Management Coding
Medical Decision Making
View MDM Guidelines | View Risk Table
Straight forward
Low complexity
Moderate complexity
High complexity
Counseling
Counseled greater than 50% of time and documented content
Total visit time (minutes):
Counseling Details
Total counsel time (minutes):
Evaluation and Management Code
Visit code:
Modifier(s):
Calculate Code
Submit Code
CQM Check
Calculated EM code:
Submitted code:
Calculated eRx code:
Submitted eRx code:
Additional E&M Code | View Other Codes | SNOMED Visit Type (optional) | Medicare Preventive Codes
New patient:
99201
99202
99203
99204
99205
Established:
99211
99212
99213
99214
99215
Consultation:
99241
99242
99243
99244
99245
Preventive new:
99381
99382
99383
99384
99385
99386
99387
Preventive established:
99391
99392
99393
99394
99395
99396
99397
Preventive counseling:
99401
99402
99403
99404
Post Op:
99024
Prenatal:
Visit 4-6:
59425
Visits greater than 6:
59426
Behavioral Health:
90791 (Initial eval, no med services)
90792 (Initial eval, w/ med services)
90846 (Family/Couple therapy, w/o patient)



03/25/2014 05:25 PM : "*USA SOAP"
03/25/2014 05:25 PM : "*Finalize"
TOB
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Specialty Pulmonary Medicine
Visit Type Office Visit
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Panel Control:
Toggle
Cycle
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
If the calculated code is acceptable to you, click Submit Code.
Evaluation and Management Coding
Medical Decision Making
View MDM Guidelines | View Risk Table
Straight forward
Low complexity
Moderate complexity
High complexity
Counseling
Counseled greater than 50% of time and documented content
Total visit time (minutes):
Counseling Details
Total counsel time (minutes):
Evaluation and Management Code
Visit code: 99203
Modifier(s):
Calculate Code
Submit Code
CQM Check
Calculated EM code: 99203
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)
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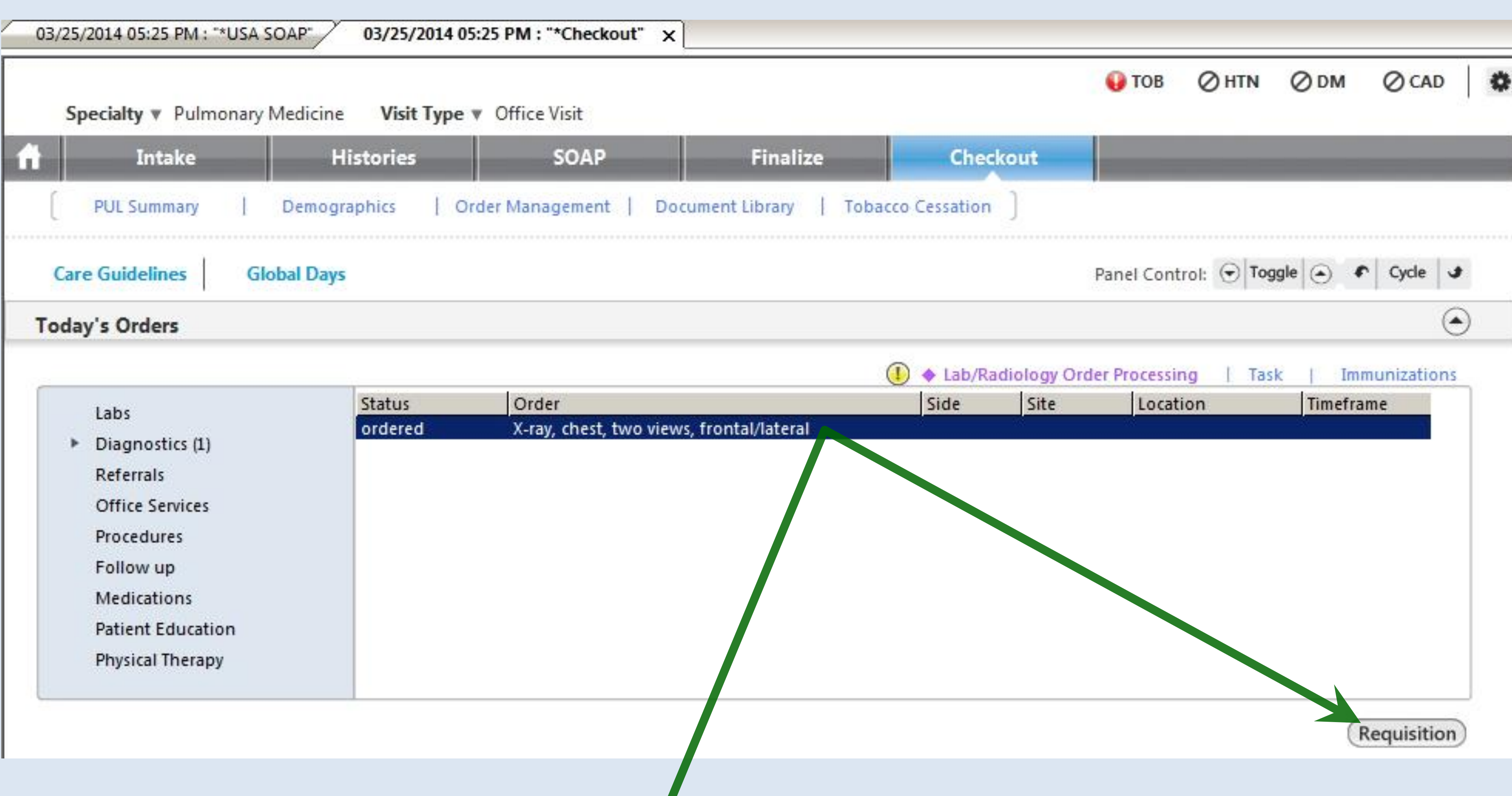

The **Checkout Tab** may be utilized by office staff to document completion of various orders, referrals, appointments, etc. For example, this is where the X-ray requisition can be printed.

This concludes the NextGen Adult Pulmonology Visit demonstration.

Save the whales. Collect the whole set.

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