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.
The nurse begins by double-clicking on the patient from her provider's appointment list.
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 Pulmonary Medicine.

Then click select a visit type & pick from the list; select Office Visit 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 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.)
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 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.

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)**.
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**.
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. 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.
Next, review allergies. Our patient states this list is correct & complete, so click the **Reviewed, no change** box.

Now let's move to the **Histories Tab**.
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 notes that the Risk Indicators have been configured, displaying her tobacco abuse.

OBGYN Detail can be reviewed as desired/pertinent.
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.**
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 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.

<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>
<tr>
<td>Benign essential hypertension</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic obstructive lung disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mixed hyperlipidemia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Osteoarthritis of knee</td>
<td></td>
<td>Bilateral This is a 2nd note about OA knee added on 2/21/14.</td>
</tr>
<tr>
<td>Postmenopausal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rheumatoid arthritis</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Medical/Surgical/Interim

<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>Carpal tunnel syndrome</td>
<td>right</td>
<td></td>
<td>Carpal tunnel release</td>
<td>right</td>
<td>2001</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appendicitis</td>
<td></td>
<td>1970</td>
<td>Appendectomy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

All History Review details are to be reviewed and included in visit note unless user indicates otherwise.
Now move to the Family History. We have nothing to add.

Then move to Social History. We can review some details by selecting the left side navigation.

To review further details or to make additions click the Add button.
Review & update as necessary. Here we have nothing to add, so we’ll click the **Reviewed** checkbox, then **Save & Close**.
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.

Click Submit to Superbill, then Place Order.

When done click Close.
Now click **Generate Intake Note** using the button at the bottom of the Intake or Histories Tab.
The Intake Note is created, summarizing all of the data you’ve just entered. Close this, returning you to the Intake Tab.
The patient is ready for the provider. 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 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.

Note also you can use the collapsible panels or scroll down to see a lot more information.
Likewise, you can review & update everything else that appears on the Histories Tab from here. Select the category of history desired on the left.

The Problem List is viewable & editable here.
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.

You could also review the **Master_Im (visit note)** from the last visit with the PCP.
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.

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.

If you didn't previously note them, you can review the nurse's Intake Comments.
You can use picklists, checkboxes, & bullets to document elements of the HPI. You can type a little more info in the Comments box.

And you can save & reuse presets.

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

<table>
<thead>
<tr>
<th>Reason for Visit</th>
<th>History of Present Illness</th>
</tr>
</thead>
<tbody>
<tr>
<td>COPD (consult)</td>
<td>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, hemoptyis, nausea and pleuritic pain.</td>
</tr>
<tr>
<td>sleep apnea (consult)</td>
<td>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.</td>
</tr>
</tbody>
</table>
Comments about HPI Popups:

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

• But many users find the “pick & click” nature of using HPI popups tedious, slow, & frustrating—and distracting when trying to perform documentation in real time in the exam room.

• The Comments boxes on the HPI popups provide only a limited amount of space to type, which can vary from one to another, so that you never know when you’re going to run out of space.

• And when entries from a series of “picks & clicks” are condensed into something resembling English, the result is often awkwardly-worded, not really reflecting any uniqueness of the story or the story-teller. Your eyes glaze over when you read it; sometimes 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.”
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.

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.
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.

You’ll next move down to the Physical Exam.

First notice the Office Diagnostics button. Click that.
This gives you a chance to review any office tests the nurse did via clinic standing orders, if you didn’t note them earlier 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.
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 baseline exam displays. Let’s change a few pertinent items. Click on One Page Exam.
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.
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. (Details are covered in another lesson.)
For this example, I’ll select several of the established diagnoses from the **Clinical Problems** list…

...then click **Diagnosis Code Lookup** to add another diagnosis.
Diagnosis search is covered more thoroughly in another lesson. For this example, I've searched for & selected **Sleep disturbance**.
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.)
Now go to the **Diagnostics Tab** to order a chest X-ray.
Select COPD, then click X-ray Body.

Select your film from the ensuing popup.
We have no other details to add, so click **Place Order**.

Dismiss the tasking popup that may appear & click **Save & Close**.
Your assessments & plans display. (We’ll show you how you or your staff can print that X-ray requisition in a minute.)

Let’s complete her prescriptions. Click **Meds**.
Medication Module details are reviewed in another lesson.

We've refilled her Advair & albuterol. We'll ERx those, then return to the SOAP Tab.
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. Also, you actually have 3 business days to generate this, so patients could just be informed that it will be available then.
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**.

<table>
<thead>
<tr>
<th>Assessment</th>
<th>COPD (496).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Plan</td>
<td>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.</td>
</tr>
<tr>
<td>Provider Plan</td>
<td>I don’t see a chest X-ray in the system, so we’ll order one today.</td>
</tr>
<tr>
<td>Plan Orders</td>
<td>Further diagnostic evaluations ordered today include X-ray, chest, two views, frontal/lateral to be performed.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Tobacco abuse (305.1).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Plan</td>
<td>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 &amp; nicotine patches are available at <a href="http://www.alabamacuteinnow.com">www.alabamacuteinnow.com</a> or 800-784-8669. A wealth of information &amp; assistance is also available at the American Lung Association, <a href="http://www.lung.org/stop-smoking">www.lung.org/stop-smoking</a>, or 800-586-4872.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Sleep disturbance (780.50).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Impression</td>
<td>Suspect sleep apnea, compounded by COPD, smoking.</td>
</tr>
<tr>
<td>Patient Plan</td>
<td>Some aspects of your picture DO fit sleep apnea. We’ll schedule a sleep study, w/ further plans pending that result.</td>
</tr>
</tbody>
</table>
E&M coding is reviewed in another lesson. For this exercise, click Moderate complexity for Medical decision making, then Calculate Code.
If the calculated code is acceptable to you, click **Submit Code**.
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.

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College of Medicine
Department of Family Medicine