This example works through a sample adult rheumatology 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 Rheumatology.

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 is here to get established for rheumatoid arthritis, so click that.
If you don’t see the complaint you need, click Additional/Manage. Scroll through the list in the popup to make more selections.

If you still don’t see what you need, just type it in the next open box. In this example she is also complaining of hand pain & stiffness, so we’ll type that in.

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 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.

<table>
<thead>
<tr>
<th>Problem Description</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergic rhinitis</td>
<td></td>
</tr>
<tr>
<td>Benign essential hypertension</td>
<td></td>
</tr>
<tr>
<td>Chronic obstructive lung disease</td>
<td></td>
</tr>
<tr>
<td>Mixed hyperlipidemia</td>
<td></td>
</tr>
<tr>
<td>Osteoarthritis of knee</td>
<td></td>
</tr>
<tr>
<td>Postmenopausal</td>
<td></td>
</tr>
<tr>
<td>Rheumatoid arthritis</td>
<td></td>
</tr>
<tr>
<td>Bilateral 9 months since last steroid injection</td>
<td>2</td>
</tr>
</tbody>
</table>

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. She’s also had a left carpal tunnel release that isn’t listed, so click Add.
A full description of how to use these popups is included in the Histories lesson. Here we'll add a **Carpal tunnel release in 2002** on the left, then return to the Histories tab.
This additional history displays.

<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>9 months since last steroid injection.</td>
</tr>
<tr>
<td>Postmenopausal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rheumatoid arthritis</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Disease/Disorder</th>
<th>Side</th>
<th>Onset Date</th>
<th>Management</th>
<th>Side</th>
<th>Date</th>
<th>Encounter Type</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carpal tunnel syndrome</td>
<td>left</td>
<td>2002</td>
<td>Carpal tunnel release</td>
<td>left</td>
<td></td>
<td></td>
<td>successful</td>
</tr>
<tr>
<td>Carpal tunnel syndrome</td>
<td>right</td>
<td>2001</td>
<td>Carpal tunnel release</td>
<td>right</td>
<td></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>
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.
When the nurse is done entering data, she'll click the **Intake Note** 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.

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Temp F</th>
<th>BP</th>
<th>Pulse</th>
<th>Respiration</th>
<th>Ht In</th>
<th>Wt Lb</th>
<th>BMI</th>
<th>ESA</th>
<th>Pain Score</th>
<th>HAQ Score</th>
<th>Pulse</th>
</tr>
</thead>
<tbody>
<tr>
<td>02/26/2014</td>
<td>11:35 AM</td>
<td>99.2</td>
<td>138/84</td>
<td>86</td>
<td>16</td>
<td>65.00</td>
<td>170.00</td>
<td>28.29</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>02/25/2014</td>
<td>5:50 PM</td>
<td>99.2</td>
<td>138/84</td>
<td>86</td>
<td>16</td>
<td>65.00</td>
<td>170.00</td>
<td>28.29</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>02/14/2014</td>
<td>11:38 AM</td>
<td>98.8</td>
<td>142/84</td>
<td>84</td>
<td>20</td>
<td>65.00</td>
<td>162.00</td>
<td>30.29</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>02/14/2014</td>
<td>10:45 AM</td>
<td>96.8</td>
<td>162/90</td>
<td>102</td>
<td>22</td>
<td>65.00</td>
<td>156.00</td>
<td>25.96</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>02/04/2014</td>
<td>1:49 PM</td>
<td>99.4</td>
<td>134/78</td>
<td>78</td>
<td>16</td>
<td>65.00</td>
<td>160.00</td>
<td>26.63</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>02/26/2014</td>
<td>10:38 AM</td>
<td>99.2</td>
<td>144/88</td>
<td>88</td>
<td>11</td>
<td>65.00</td>
<td>162.00</td>
<td>24.99</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>02/21/2014</td>
<td>2:01 PM</td>
<td>98.9</td>
<td>132/82</td>
<td>88</td>
<td>11</td>
<td>65.00</td>
<td>162.00</td>
<td>24.99</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>01/29/2014</td>
<td>3:27 PM</td>
<td>99.7</td>
<td>140/90</td>
<td>100</td>
<td>20</td>
<td>65.00</td>
<td>150.20</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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 rheumatoid arthritis.

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.
Entries from the HPI popup displays on the SOAP Tab.
Comments about HPI Popups:

- HPI popups can present a rapid way to document key elements of the HPI if the user is very familiar with the popup.
- For some common complaints you may find yourself saying the same thing repeatedly throughout the day, & using presets may be of help there—though it takes some care not to inadvertantly 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.)
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.”

<table>
<thead>
<tr>
<th>Reason for Visit</th>
<th>History of Present Illness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rheumatoid arthritis</td>
<td>Onset was 20 years ago. Severity level is moderate. Location of the pain is bilateral hand. The patient describes the discomfort as pain with use. It occurs persistently. The problem is fluctuating. Symptom is aggravated by activity. Relieving factors include Rx medications. She is experiencing activity limitation, fatigue and joint swelling of right digit(s). Pertinent negatives include anorexia, eye symptoms, rash, weakness and weight loss.</td>
</tr>
<tr>
<td>Rheumatoid arthritis (comments)</td>
<td>Referred to get estab w/ rheumatologist after moving to area. She brought some records from her prev rheumatologist in Ipswich, including lab studies showing +ANA in speckled pattern, &amp; several elevated ESRs. CBC, basic chems nl. Was on Plaquenil until the move, when she ran out. PCP recently restarted at 200 mg BID while awaiting referral. Biggest c/o is hand pain, swelling. Deformity &amp; disability has been escalating over last yr even before running out of Plaquenil. She asks about new meds for RA she’s seen advertised; prev MD was considering this before she had to move to Mobile due to husband’s job.</td>
</tr>
<tr>
<td>hand pain &amp; stiffness</td>
<td></td>
</tr>
</tbody>
</table>
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 section.

First notice the Office Diagnostics button. Click that.
This gives you a chance to review any office tests the nurse did via clinic standing orders, if you didn’t note them earlier on the Home Tab. (Perhaps the results weren’t ready yet when you first entered the room.) There are none in this example. 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 PEFullINIFemale-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 findings display on the grid.

You can also use the menu on the left to pick systems to document. In particular, **ROM Exam & Connective Tissue Exam** give you some graphic methods to document your findings.
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.)
Here I've made a few selections from the Clinical Problems list.

Now let's document some plans. The My Plan tab has some potential, but we're still investigating how well that can be applied to our practice setting. So let's move on to A/P Details.
Record your plans. 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 some hand X-rays.
Select your film from the ensuing popup.

Select Rheumatoid Arthritis, then click X-ray Upper Extremity.
Next click in the Side box & choose Bilateral.

We have no other details to add, so click Place Order.

Dismiss the tasking popup that may appear & click Save & Close.
### Assessments and Plans Display

Let's complete her prescriptions. Click **Meds**.

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

---

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Plan Order</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Assessment Rheumatoid arthritis (714.0).</td>
<td>Since lab from previous MD is so recent &amp; complete, I don't really need to order anything else right now. I will get X-rays of both hands, however. I'll review those &amp; look more closely at the records from previous MD. Since hydroxychloroquine was just recently resumed, I want to observe her on that for 6 more weeks. Continue meloxicam as well, given handout on adjunctive topical/thermal therapy options to help pain. Plan recheck in 6 wks to see what sort of response she is having &amp; further discuss the use of DMARDs.</td>
</tr>
<tr>
<td>2. Assessment Osteoarthritis knees (715.36).</td>
<td>Plan Orders Further diagnostic evaluations ordered today include X-ray exam, hand, 3+ views Bilateral to be performed.</td>
</tr>
<tr>
<td>3. Assessment Benign essential hypertension (401.1).</td>
<td>Patient Plan Continue meds from PCP.</td>
</tr>
<tr>
<td>4. Assessment Chronic airway obstruction, not elsewhere classified (496).</td>
<td>Some 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.alabamaquitnow.com">www.alabamaquitnow.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>
<tr>
<td>5. Assessment Mixed hyperlipidemia (272.2).</td>
<td>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 &amp; nicotine patches are available at <a href="http://www.alabamaquitnow.com">www.alabamaquitnow.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>
Medication Module details are reviewed in another lesson.

We’ve refilled her hydroxychloroquine so she’ll have enough to last until the next visit. We’ll ERx that, 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.

PATIENT: Ashleigh Quagmire
DATE OF BIRTH: 01/02/1957
DATE: 03/26/2014 10:24 AM
VISIT TYPE: Office Visit

This 57 year old female presents for Rheumatoid arthritis and hand pain & stiffness.

History of Present Illness:
1. Rheumatoid arthritis
   Onset was 2 yrs ago. Has been slowly progressing since then. Her symptoms are getting more discomforting. She noted pain in hands, wrists, fingers, and knees. The problem is fluctuating. Symptom is aggravated by activity.
2. hand pain & stiffness

PROBLEM LIST:
But it can take 30-60 seconds to generate the document in real time, which can be annoying when you're trying to move on to the next patient. As an alternative, you can generate the note offline. To do this, hover the mouse over Navigation to get the Navigation Bar to slide out. When the Navigation Bar displays, click Offline.
Now move to the **Finalize Tab**. You can do this by navigating back to the top & clicking the **Finalize Tab**, but if you're at the bottom of the **SOAP Tab**, there is a shortcut to get there directly. Click **EM Coding**.
E&M coding is reviewed in another lesson. For this exercise, click Moderate complexity for Medical decision making, then Calculate Code.
If the calculated code is acceptable to you, click Submit Code.
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 Rheumatology Visit demonstration.

The trouble with life is there's no background music.

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University of South Alabama
College of Medicine
Department of Family Medicine