NEXTGEN WORKFLOW DEMONSTRATION
Well Child Visit

This demonstration works through a sample well child visit, introducing the new user to the general workflow.

This has been prepared for EHR 5.8 & KBM 8.3, though some older templates may appear when they do not adversely affect the presentation. Subsequent updates may display cosmetic & functional changes.

Use the keyboard or mouse to pause, review, & resume as necessary.
The nurse begins by double-clicking on the patient from her provider's appointment list.
Always begin by performing the 4-Point check.

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.
Note to Family Medicine users:

You can now do a Well Child from the Family Practice specialty.

Click in the Specialty box & pick Pediatrics.

Then click in the Visit type box & pick from the list; select Well Child.
Note whether the patient is listed as **New** or **Established**, since this sometimes needs to be changed. A patient seen elsewhere in the USA system might initially appear as **Established**, but if it’s the first time he’s been to your office, that would need to be changed to **New**. Conversely, if you’ve seen the patient before you started using the EHR, but today is the first visit in NextGen, you may need to change the encounter from **New** to **Established**. In this case, we’ll leave it as **New patient**.
You can select a **Historian** from the picklist that appears if you click in that box. Here we’ll pick **mother**.

Also note the **PCP**. To add this, click **Patient**, which opens the **Patient_demographics** template.
Since Dr. McFaden is no longer with us, we'll change the PCP by clicking in the PCP field.

In the picklist that appears, scroll down to the desired choice; you can type the first few letters to jump down to that part of the alphabet. For the purposes of this example we'll double-click on DUFFY.
Save the template (e.g., via control-S), then close the Patient_Demographics template. (If you don’t save first, it’ll remind you.)
You can select a Historian from the picklist that appears if you click in that box. Here we'll pick mother.
It's always good to begin by noting whether there are any Sticky Note or Alerts entries.

We call tell by their appearances that there are no Sticky Notes or Alerts. But for demonstration purposes, we'll enter some. Click Sticky Note.
Like actual sticky notes, these are things that are nice to know, but aren't meant to be permanent chart records. We've entered here that the mother used to work here.

Other times a sticky note would be a temporary notice, like **At next visit confirm 15 mo Prevnar was given—don't see it listed. Duffy 3/20/14.** It’s good to put your name & date on such things; otherwise, you may not know if they’re still pertinent when you see them in the future. And you should delete such sticky notes when they’re no longer meaningful.

When done click Save & Close.
When a **Sticky Note** is present, the link will change to a magenta color with a solid diamond.

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

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

When you remove entries the **Sticky Note & Alerts** return to their baseline appearance, as below.
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 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.
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 a separate exercise.)

Data used in this example:

Ht 35 inches, measured today.
Wt 30.4 lbs, dressed with shoes.
T 98.9, ear.
BP 100/60 sitting, right arm, sitting.
HR 88.
Resp 16.

Click Save, then Growth Charts to display growth charts.
Click Close when you’re done viewing the graphs.
As an aside, note that growth charts are also accessible through the file menu. This may be preferable, since this will display the graphs in a larger, more easily viewable format.
When age-appropriate, the nurse would also perform **Audiometry & Vision Screening** through these links.
If you don’t plan to bill for the hearing test, clear this checkbox.

Enter results in whatever manner your machine gives them to you.

But if you do want to submit to superbill, you’ll need to pick a reason for the test.
For screening you probably want to pick routine child health examination or Other examination of ears and hearing.

A search list with some likely choices appears. For hearing loss, you'll see some likely options.

Unfortunately, you may get nagged about diagnosis & superbill submission even if you don't want to charge for the test & you clear the checkboxes. Sigh....
Data entry, diagnosis, & superbill considerations are analogous on the Vision Screening popup.

Note there is a link to display a color vision screen.
Note about failed hearing & vision screens: With all of the red vital sign alerts popping up everywhere, it is intuitive to believe that you’ll get an alert if the hearing or vision tests are abnormal. That is, unfortunately, not the case. Nurses need to include this fact in the Intake Comments or verbally communicate it to the provider to help keep this from being overlooked.

Providers, note that the hearing & vision results are posted to your physical exam, so you’ll get a chance to notice it there—just later than you might be expecting.
When done click **Save** then **Close**.

Note that other VS, such as head or waist circumference, can be entered when age-appropriate.
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. In addition to the WCC, his mother asks about his stuffy nose, so click congestion.
The Well Child Visit complaint is implied (& may actually display automatically), but to demonstrate adding another complaint you don’t see listed, click *Additional/Manage*. Congestion is added as a complaint.
Scroll through the list to look for other complaints. If you don’t see what you need, just click in the next open box & type it; here we’ll type **Well Child Check**.

When done click **Save & Close**.
The complaints you’ve entered display.

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

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

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

In this example, our patient is taking:
Loratadine 5 mg/5 mL, 1 tsp daily as needed for runny nose, drainage.

Add this medication, then close the Med Module to return to the Intake Tab.
Medications display (though sometimes they may not show until the template is refreshed).

Click the **Medications reconciled** checkbox.

If you have questions about the medicines that you are unable to clarify with the patient, DON'T click the **Medications reconciled** checkbox. Instead, use the **Comment** link (or perhaps better, the **Intake Comments** link you used under **Reasons for Visit** above), and/or verbally tell the provider.
Next, review allergies. He has no allergies, just click the **No allergies** box.

If there had been any allergies, you would click the **Add** button, as reviewed in the separate Allergies demonstration.
The nurse might next review vaccinations, which you could do by clicking **Immunizations**.
The Immunization – Pediatric template opens; it now interacts with the Order Module for managing vaccinations. We hope that at least some interaction with the Alabama ImmPRINT vaccination registry materializing soon. There will be other lessons demonstrating the vaccination workflow.

We'll close the Immunization – Pediatric template & move to the Histories Tab.
Notice that Birth History can be entered here. Click **Birth History**.
Enter Birth History as known/relevant. When done, save & close the template, returning to the Histories Tab.
A note to those transitioning from earlier versions of NextGen: The new Problem List replaces the old Chronic Conditions, due to Meaningful Use requirements. While some conversion may happen automatically, the old Chronic Conditions list may need to be reviewed & used to complete the new Problem List. See the What's New lesson for details.
Review the patient’s **Problem List**. To add diagnoses, click **Add**.
The Problems Module opens, focused on the Problem List Tab.

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

To add a new problem, logically enough, click Add Problem.
A review of diagnosis search is covered in the Histories lesson. As an example, we'll add **allergic rhinitis** & return to the Histories Tab.
These problems now display. Note the Problems count on the Info Bar now shows 1.

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

All of the other History Review links lead to the same popup. Click one of them.
It is our expectation that all historical elements are at least briefly reviewed at every encounter, so most of these details appear in our notes by default anyway. However, only basic Social History details are defaulted into our notes, so if you’ve added a lot of other details, you need to specifically select Detailed document for Social History.
Now we'll enter other Medical/Surgical/Interim history. While the Problem List includes ongoing medical issues, the Medical/Surgical/Interim history is for isolated episodes of illness or events such as surgery. Click Add.
We don't have any episodic medical illnesses to enter, so that panel has been collapsed. But our patient had an umbilical hernia repair in 2013.

Click the Hernia repair, umbilical checkbox.

The Histories lesson goes into more detail about adding items here, but for this example just click **Add To Grid**, then **Save & Close**.
Now we'll use the collapsible panels to move down to the **Family History**.
Click **Add**.
Enter this Family History:
- His mother is alive & well.
- His father has migraines.
- His sister has asthma.

(Family History is covered in detail in the Histories lesson.)

When done click **OK**.
Now move down to **Social History** & click the **Add** button.

These additions display in the grid.
The Social History popup appears. Note that there are several headings on the left, corresponding to the Social History pilltabs we just saw; we start out on the Relationships heading. We’ll enter the following information:

Daycare 5 days a week.
Lives with mother & father, who are married.
He’s the 2nd child, having 1 sibling.
There are no smokers at home.
Note the Adult Social History link. This gives you the chance to toggle to & from the adult version of the social history—particularly useful for adolescents. You can also directly access Tobacco history for adolescents.

(The Histories lesson gives a demonstration of entering adult-type social history.)

Now move to the Home Environment heading.
Now move to **Education**.

Enter details to the degree they're known or pertinent.

Data used in this example:
- **Municipal water**.
- **Car seat face rear**.
- Has smoke & CO detectors. **Hedgehogs at home**.
Now move to Nutrition/Elimination.

Enter details to the degree they’re known or pertinent.

Data used here:
Doesn’t take naps.
Doesn’t sleep with parents.
Sleeps through night.
Now move to Comments.

Again enter as much detail as desired.

Data used here:
Bladder & bowel training in progress, going well.
No dental concerns; had check 2/4/14.
This gives you a good place to free-type other social history notes.

When done click **Save & Close**.
You can click on the left-side headings to display many of the details in the grid (though you may have to open the popup to view everything).
Note there’s also a link to Developmental History here. Some clinics may have the nursing staff enter all or part of this, while providers also have an opportunity to review or update this on the SOAP Tab. We’ll go ahead & demonstrate entry here.

Click Developmental History.
If we've been seeing this child since birth, all of the developmental screens through the last visit will display. For this example click **Details** under **2 Years**.

Note that the results of other developmental screens can also be entered.
Inquire about each milestone & click the appropriate Pass/Fail box, adding comments as necessary. When done, click **Save & Close**.
If you select the **Child Development History** tab, you can review a history of all previous screens.

When done close the **Developmental templates** & return to the **Histories Tab**.
To generate a summary of the medical history & any notes entered by the nurse today, click **Intake Note**.
The Intake Note is created. Now close this & go back to the Histories Tab.
As an aside, note there are **Risk Indicators** visible at the top of each template, which can be configured as appropriate. This usually won’t be pertinent for young children, but with older children & adolescents it may be appropriate to configure these indicators, as described in the Histories lesson. We won’t go through that in this example.
The patient is ready for the provider. On the re-expanded Info Bar & click the Tracking icon.
Click in the Room box & select a room; alternately, you can just type a room number in the box.
Next, click in the **Status** box & select **waiting for provider**.
When done click **Save & Close**.
The provider then opens the chart from the appointment list & performs the 4-point check.
The provider generally starts on the Home Tab. It's good to begin by looking for Sticky Notes & Alerts; there are none on this patient. Also take note of the Risk Indicators (if used).
You can select any of the headings on the left to view various aspects of the chart. In particular, this is a good place to look at Office Lab results or review previous vital signs.

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

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

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

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

Next, you have some options as to how to proceed. You can click on one of the Reasons for Visit to open the HPI Popup. We’ll click congestion.
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.
If you had clicked on the **Well Child Check** Reason for Visit, you would see the **Generic Free Form HPI Popup**. This is a good place to review any little questions the parent has, especially when there are not other major complaints to discuss.

When done click **Save & Close**.
Entries from the HPI popups display 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 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 (though for a Well Child Check this is less of an issue).
Comments about HPI Popups:

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

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

- And when entries from a series of “picks & clicks” are condensed into something resembling English, the result is often awkwardly-worded, not really reflecting any uniqueness of the story or the story-teller. Your eyes glaze over when you read it; often you can’t even recognize whether you performed the visit or if it was done by one of your colleagues.
There is an alternative many providers will find more comfortable than using the HPI popups. Click the **Comments** button.
Here you have essentially unlimited space to type the story. Sketch it out with a few words & phrases in real time while interviewing the patient; flesh it out later if desired. You can jump from one complaint to another, just like patients do when telling their story. And you have access to My Phrases—a robust way to save & reuse text that you say repeatedly throughout the day. (Setup & use of My Phrases is covered in the User Personalization demonstration.)

When done click Save & Close.
Your entries are displayed. Note that use 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.” (Obviously, there is some redundant documentation here for the sake of illustration.)

<table>
<thead>
<tr>
<th>Reason for Visit</th>
<th>History of Present Illness</th>
</tr>
</thead>
<tbody>
<tr>
<td>congestion (comments)</td>
<td>Nasal congestion over the last 3 days, w/ runny nose, puffy eyes. No fvr, sore throat, cough, rash. Has had allergies in the past, so mom wasn’t sure if this was allergies or a cold.</td>
</tr>
<tr>
<td>congestion</td>
<td>Onset: 3 Days ago. The severity of the problem is moderate and has not changed. Symptoms are associated with history of allergies. Associated symptoms include nasal congestion, postnasal drainage and rhinitis. Pertinent negatives include cough, dyspnea, fever and rash.</td>
</tr>
<tr>
<td>Well Child Check</td>
<td>Potty training going well. Gets along w/ other kids in day care. Eats wide assortment of table foods.</td>
</tr>
<tr>
<td>Well Child Check (comments)</td>
<td>In for WCC. No concerns about diet. Day care 5 days a wk; gets along well w/ others. Potty training coming along well.</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 Pediatrics ROS.
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 HPI popups from here.

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.

Also note you can open up the Developmental History from here, to either review nurse’s entries or add further data.

You’ll next move down to the Physical Exam section.
First notice the **Office Diagnostics** button. That would give you a chance to review things like rapid strep, RSV, & flu tests that your nurse may have done for you. Even though you had the chance to review those on the **Home Tab**, it may be that the results weren’t available yet when you first went into the room.

There is no such data entered in this example.
Physical Exam documentation is performed similarly to the ROS demonstrated above. You can directly access any system from the headings on the left, but you’ll often want to start with the age & gender-specific One Page Exam.

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

While you may well complete the physical exam documentation later after you’re done working with the patient, for the ease of discussion I’ll go ahead & do it now, illustrating the value of using saved preset exams.
I’m going to click the Open Preset icon & double-click on `PEFullINIToddler-RLD`, a preset I’ve previously saved as my starting point for a typical normal exam for an adult female. It includes items entered via the One Page Exam & some of the system-specific exams. (Details on setup of these presets are covered in the User Personalization demo.)
Your exam displays. You can select aspects of the exam from the menu on the left, & modify findings as necessary for the individual patient. Here I’ll click on the **Nose | Mouth | Throat** exam to change my findings.
You can go directly to any other system to make further entries.

I’ll change these entries to discharge - clear.

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, we'll document assessments & plans. Since this is a well child check, Routine Child Health Exam has already been added as the 1st diagnosis.

To document plans/counseling regarding the WCC, click the **Well Visit** button.
There are numerous anticipatory guidance items listed. You may wish to check several off as you discuss them.

There is also room to add further comments at the bottom.

<table>
<thead>
<tr>
<th>Anticipatory guidance</th>
<th>Diet</th>
<th>Safety</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bedtime rituals</td>
<td>3 meals/day; 2-3 snacks/day</td>
<td>Car safety (use age appropriate seat in back seat facing forward)</td>
</tr>
<tr>
<td>Begin toilet training when child is ready</td>
<td>Allow toddler to decide how much to eat</td>
<td>Caution about hot liquids, cigarette ashes</td>
</tr>
<tr>
<td>Child care</td>
<td>Eat meals as a family</td>
<td>Choking (toys, food, small objects)</td>
</tr>
<tr>
<td>Consistent limit setting/discipline</td>
<td>Iron-fortified foods</td>
<td>Drowning (tubs, toilets, pools)</td>
</tr>
<tr>
<td>Dental care</td>
<td>No bottle</td>
<td>First aid knowledge</td>
</tr>
<tr>
<td>Encourage opportunities for physical activity</td>
<td>Nutritious snacks</td>
<td>Guns (unload/lock up)</td>
</tr>
<tr>
<td>Encourage self expression/express feelings</td>
<td>Self feeding</td>
<td>Home child proofing</td>
</tr>
<tr>
<td>Follow 1-2 step commands</td>
<td>Vitamin and fluoride supplements</td>
<td>Insect protection</td>
</tr>
<tr>
<td>Limit TV viewing to no more than 1-2 hours/day</td>
<td></td>
<td>Limit sun exposure/use of sunscreen</td>
</tr>
<tr>
<td>Listen and respond to child</td>
<td></td>
<td>Microwave-heated food</td>
</tr>
<tr>
<td>Model appropriate language</td>
<td></td>
<td>Peds/animals</td>
</tr>
<tr>
<td>Moving from crib to bed</td>
<td></td>
<td>Poison (Poison Control Center info)</td>
</tr>
<tr>
<td>Napping</td>
<td></td>
<td>Smoke detectors</td>
</tr>
<tr>
<td>Night terrors/wakening</td>
<td></td>
<td>Supervise play</td>
</tr>
<tr>
<td>Play and peer contacts</td>
<td></td>
<td>Teach hand washing</td>
</tr>
<tr>
<td>Praise good behavior/respect</td>
<td></td>
<td>Water temperature less than 120 degrees F</td>
</tr>
<tr>
<td>Representational play/hidden games</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-comforting behavior</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social interaction at meals</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Speech development/read to child daily</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comments: Handout given

2% milk is a good choice for a lower fat milk for the whole family.
His vaccines are up-to-date, & it’s not flu vaccine season, so we don’t need to order any immunizations. Click Save & Close.
To add further diagnoses, click 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.
Here I’ve added Allergic rhinitis by clicking on it on the Clinical Problems list.

Now let’s document some plans for allergic rhinitis. 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 here. You can type and/or use **My Phrases** for instructions you give repeatedly throughout the day. (Setup of **My Phrases** is discussed in the User Personalization demo.)
If we wanted to order X-rays or Referrals, we could do so using the **Diagnostics** or **Referrals** **Tabs** above. (We don’t use the **Labs** **Tab** at present, since we have another way to place lab orders.) Those are covered in other lessons, so we won’t do that on this encounter.

When done click **Save & Close**.
Your assessments & plans display. (Though you don’t see the output of the **Well Visit** plan popup here, everything you documented will be included in the visit note.)

To complete his prescriptions click **Meds**.
Medication Module details are reviewed in another lesson.

Here we would renew/prescribe meds as necessary & ERx them. He’ll just continue to use OTC loratadine, so we’ll close the med module & return to the SOAP Tab.
If the patient needs a school excuse, which might be generated by you or your nurse. Open the Document Library.
You have several options for generating a school excuse.

<table>
<thead>
<tr>
<th>General</th>
<th>Letters</th>
<th>Assessments and Tools</th>
</tr>
</thead>
<tbody>
<tr>
<td>After Hours Care Note</td>
<td>Letter About Patient</td>
<td>ACC/AHA ASCVD Risk Estimator</td>
</tr>
<tr>
<td>Chart Summary</td>
<td>Letter To Patient</td>
<td>Behavioral Assessments &amp; Tools</td>
</tr>
<tr>
<td>Confidential Note</td>
<td>Letter From Consultant</td>
<td>Edinburgh Postnatal Depression Scale</td>
</tr>
<tr>
<td>Controlled Substance Agreement, Full</td>
<td>Letter To Consultant</td>
<td>Generate Report</td>
</tr>
<tr>
<td>Controlled Substance Contract, Brief</td>
<td></td>
<td>Scoring</td>
</tr>
<tr>
<td>Counseling Notepad</td>
<td></td>
<td>Mini Mental Status Exam</td>
</tr>
<tr>
<td>Discharge Summary-Preliminary</td>
<td></td>
<td>Pediatric Symptom Checklist</td>
</tr>
<tr>
<td>Durable Medical Equipment Order</td>
<td>Work/School Excuse Note</td>
<td>St. Louis Univ Mental Status Exam (SLUMS)</td>
</tr>
<tr>
<td>FreeText</td>
<td>Work/School Excuse Note-FM</td>
<td>SLUMS Diagram</td>
</tr>
<tr>
<td>Hospital-Clinic Continuity Note</td>
<td>Work/School Excuse Note-Peds</td>
<td>Generate Report</td>
</tr>
<tr>
<td>Immunization Record</td>
<td>Work/School Status, Brief</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Work/School Status, Detailed</td>
<td></td>
</tr>
</tbody>
</table>
One of the Meaningful Use criteria requires patients to receive a summary of the visit. Click 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.
Now generate today’s visit note. One way to do this would be to click Visit Document.
Your visit note displays. You can review & edit it if desired. You can also click the Check Mark to sign it off; this is the same as signing the document in your PAQ.
But it can take 30-60 seconds to generate the document in real time, which can be annoying when you’re trying to move on to the next patient. As an alternative, you can generate the note offline. To do this, hover the mouse over Navigation to get the Navigation Bar to slide out.

When the Navigation Bar displays, click Offline.
Now move to the **Finalize Tab**. You can do this by navigating back to the top & clicking the **Finalize Tab**, but if you're at the bottom of the **SOAP Tab**, there is a shortcut to get there directly. **Click EM Coding.**
E&M coding is reviewed in another lesson. But for a well child check it’s simple. The program knows the patient’s age, & whether he’s new or established, so just click Calculate Code.
The calculated code is acceptable, so click Submit Code.

Residents will need to click Submit to supervising physician for review.
Select your attending & click Add User(s).

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

Then click **OK** to close the popup.
The **Checkout Tab** may be utilized by office staff to document completion of various orders, referrals, appointments, etc. The degree & manner of its use will be individualized to the workflow of each clinic.
This concludes the NextGen Well Child Visit demonstration.

Monday is an awful way to spend 1/7 of your week.

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