NextGen – Clinical Workflow User Manual

NextGen 5.8 KBM 8.3

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Kootenai Health Information Services
December 31, 2014

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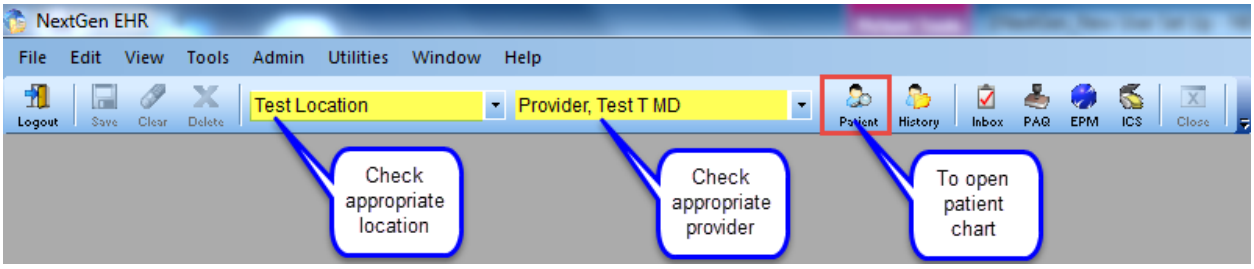
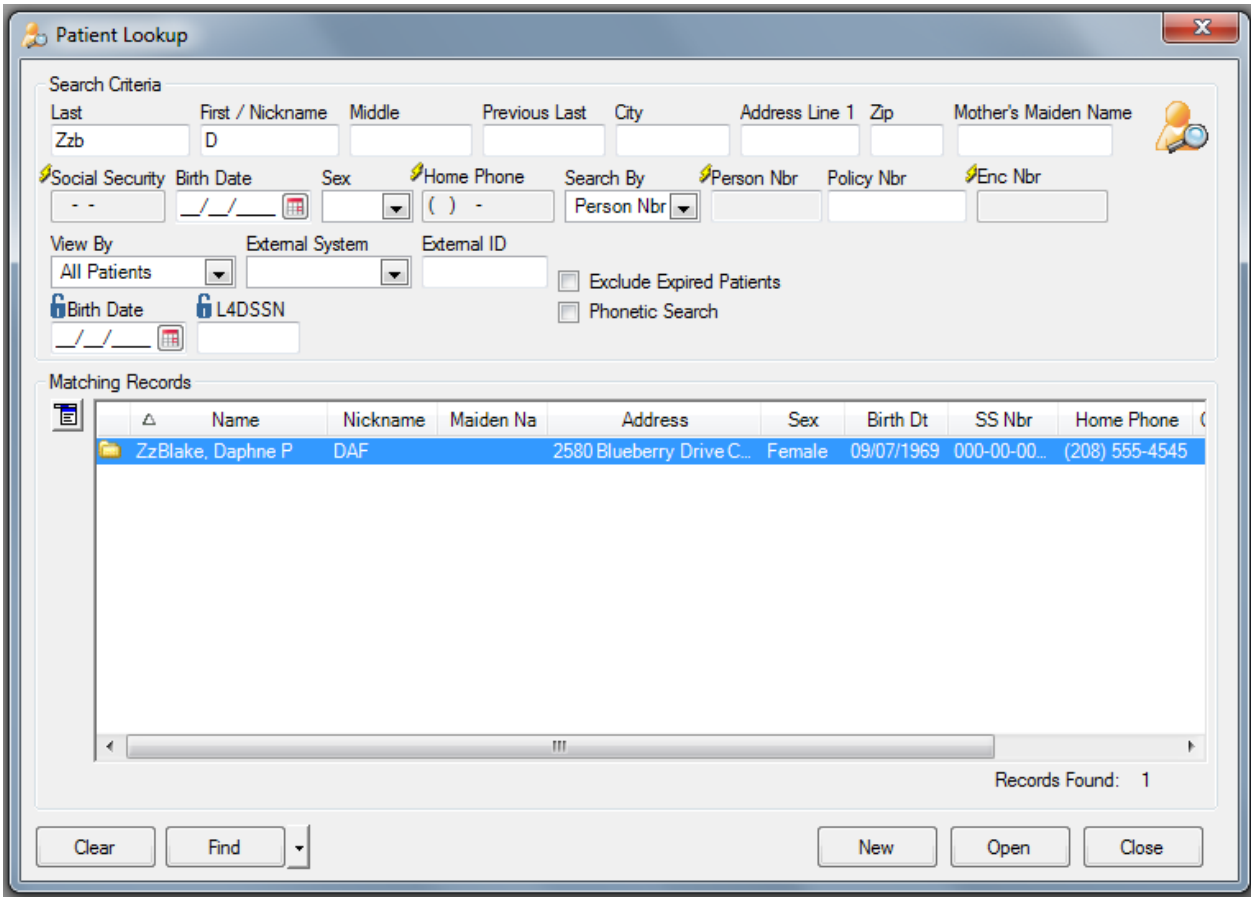
Basic Layout

Opening NextGen EHR

To find a patient, select the ***Patient*** icon indicated in red. The **Patient Lookup** window will display.

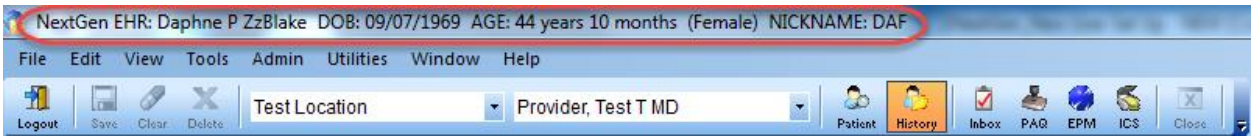


Fill in the first three letters of the last name and the first letter of the first name. Select the ***Find*** button or enter on your keyboard. Once your patient appears in the **Matching Records** window, double click the name or select ***Open.***



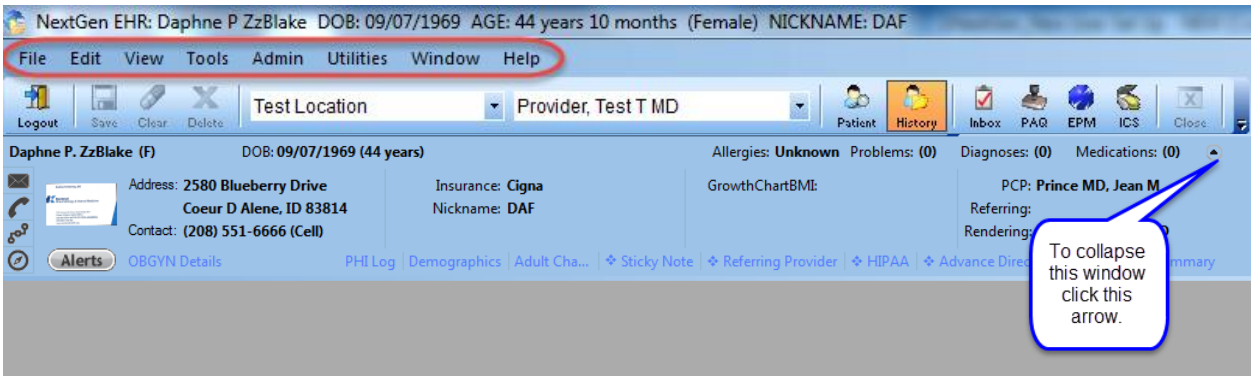
Title Bar

The **Title Bar** is located at the top of the NextGen EHR main window. The **Title Bar** displays the name of the application, selected patient's name, birthdate, age, gender and nickname. Located below the **Title Bar,** you can see the **Patient Information Bar (PIB)** outlined in red.



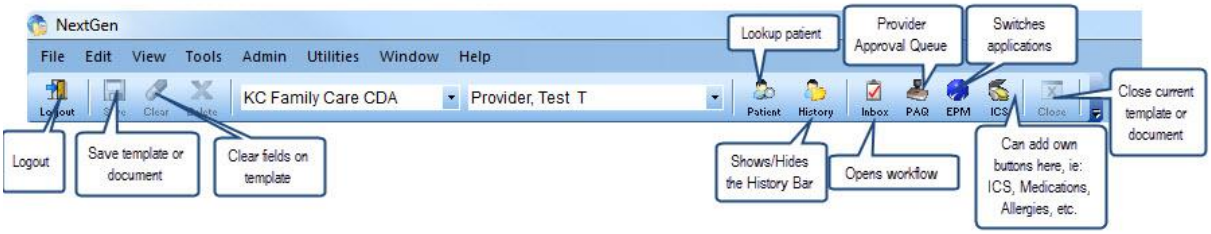
Main Menu Bar

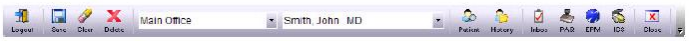
The **Main Tool Bar** is located just below the **Title Tool Bar**.



Top Toolbar

The **Top Toolbar** contain most of the icons that control the basic functions of the system.

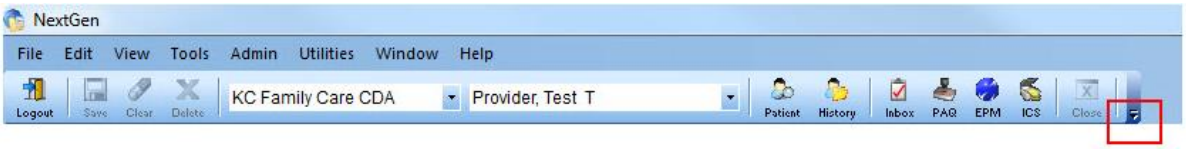




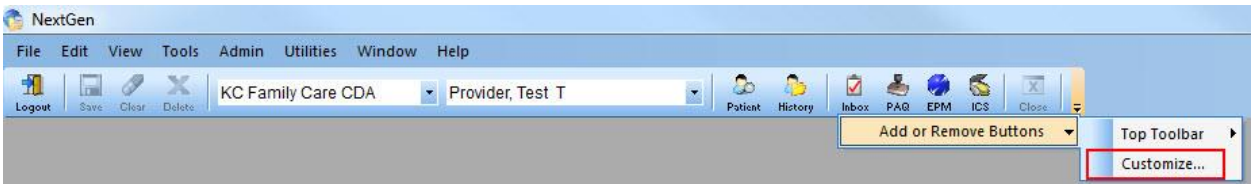
Icon	Name	Description
	Logout	Logs out from, but does **not** close, the application.
	Save	Saves the work in the active window.
	Clear	Clear the data you have entered in the active window.
	Delete	Deletes the data you have entered in the active window.
	Patient	Prompts the *Patient Lookup* dialog box.
	History	Toggles the History Toolbar on/off.
	Inbox	Toggles Workflow Module on/off.
	PAQ	Prompts the Provider Approval Queue (PAQ).
	EPM	Opens NextGen EPM directly from the NextGen EHR bypassing the *Logon* window, automatically selected the current patient.
	ICS	Opens NextGen ICS directly from the NextGen EHR bypassing the *Logon* window, automatically selected the current patient.
	Close	Closes the current open window.

Additional Tollbar Icons

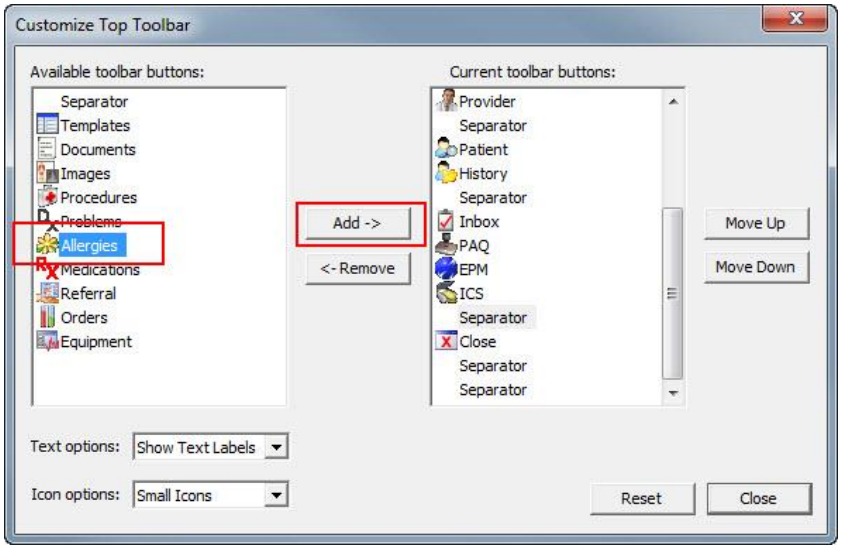
To add the **Allergies**, **Medications** and **Templates** icons to the **Top Toolbar**, select the drop-down arrow next to the **Close** button.



Select the ***Add or Remove*** buttons>***Customize*** buttons.



From the **Available** toolbar buttons, highlight ***Allergies*** and select ***Add***

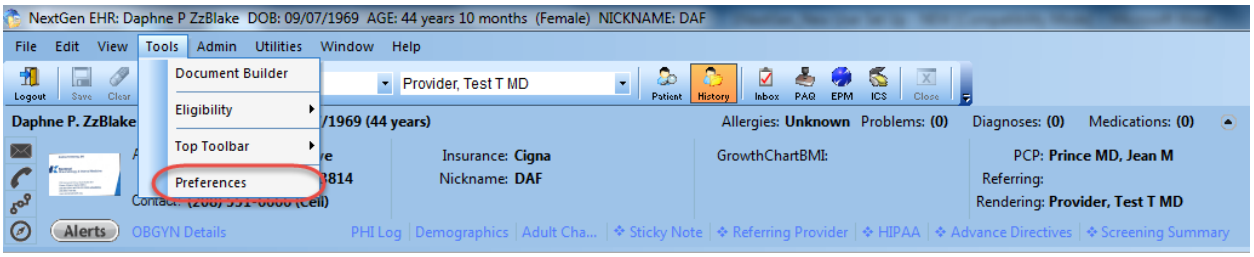


Repeat for **Medications**, **Templates**, and/or any other icons you want to be added to the **Top Toolbar.** When completed, select ***Close***.

NOTE: Use the **Move Up** and **Move Down** buttons to reorganize the icon order, if needed.

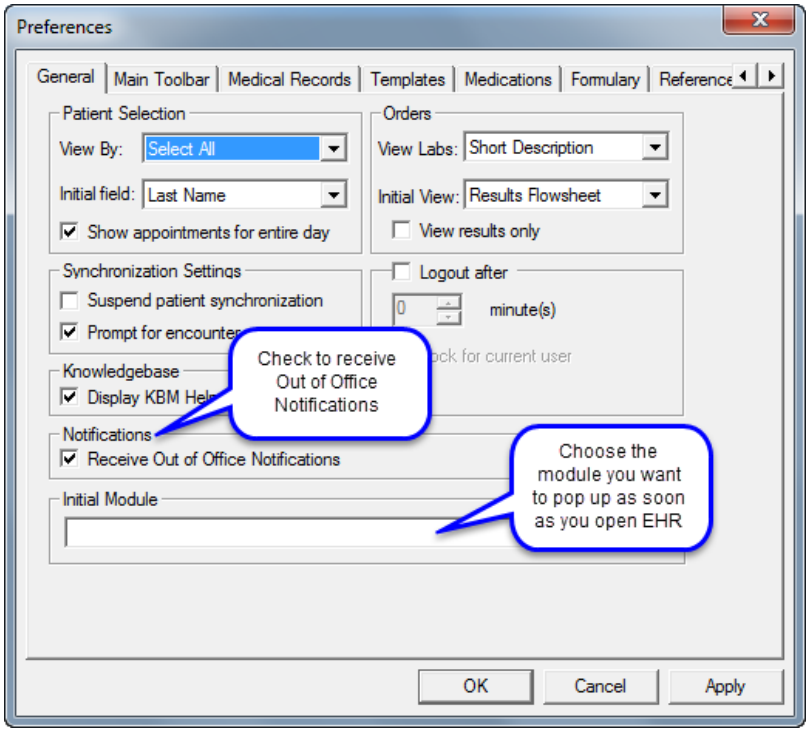
User Preferences

To change/update user preferences, select from the **Main Menu Bar**, ***Tools > Preferences***

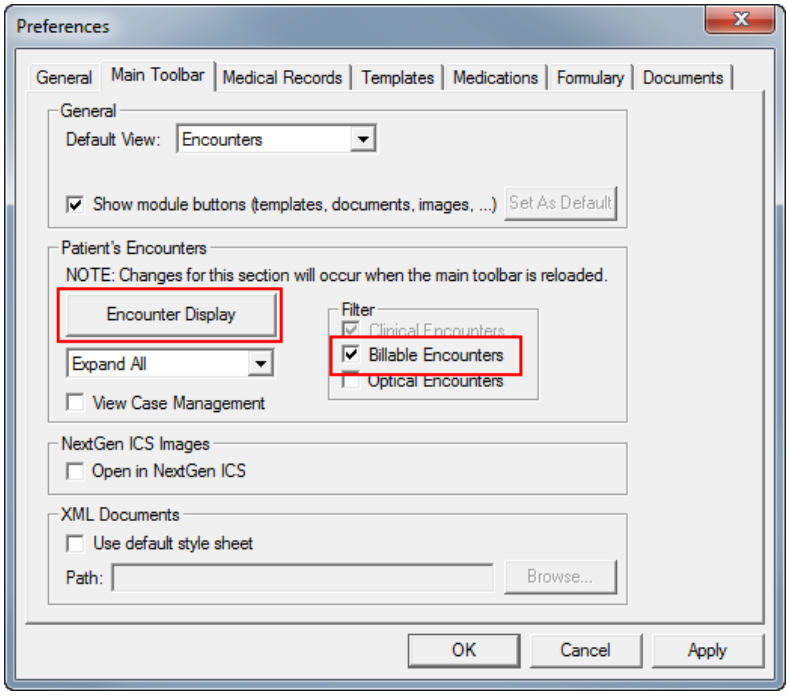


There are 8 tabs in **Preferences**

General:

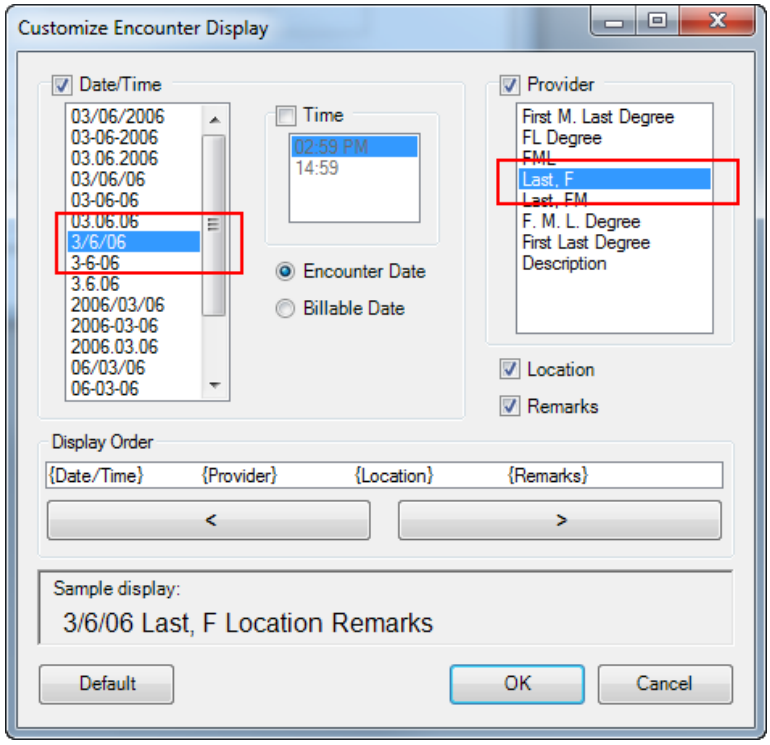


Main Toolbar:

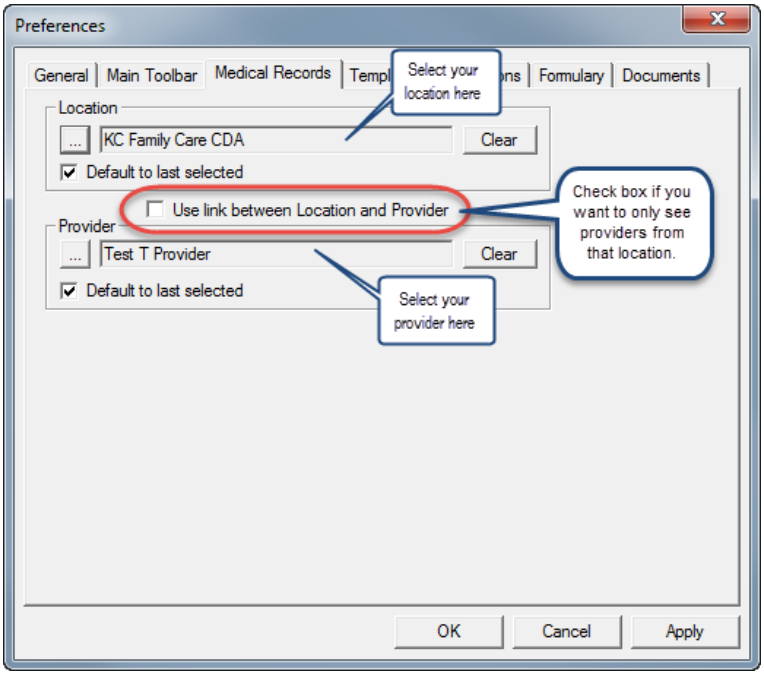


Customize the encounter display by selecting the ***Encounter Display*** button.

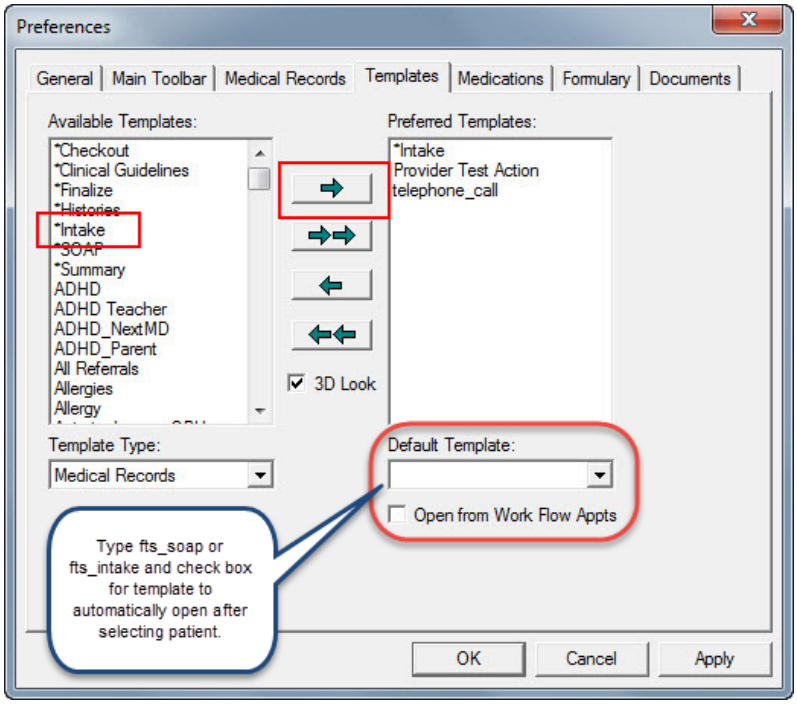
Customize Encounter Display:



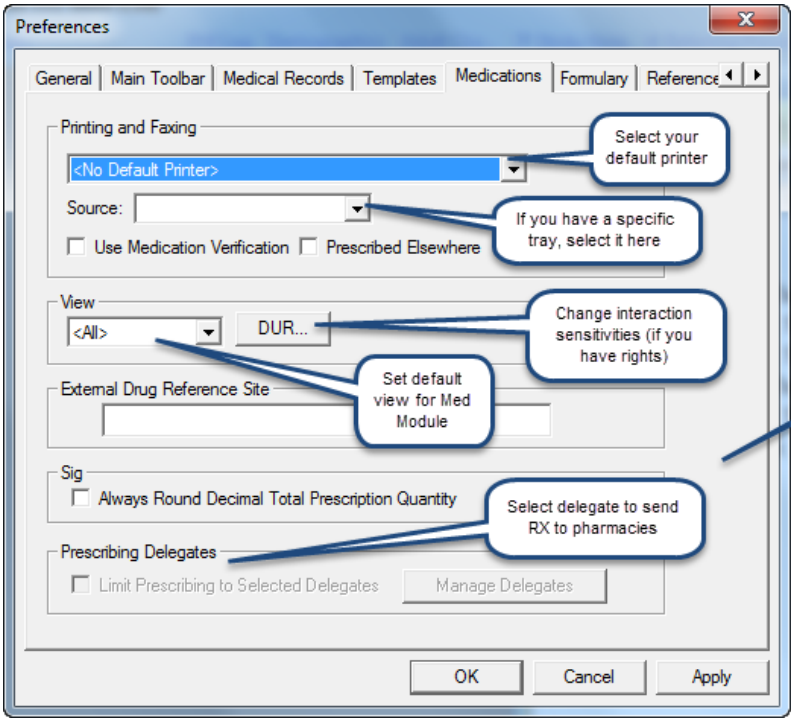
Medical Records:



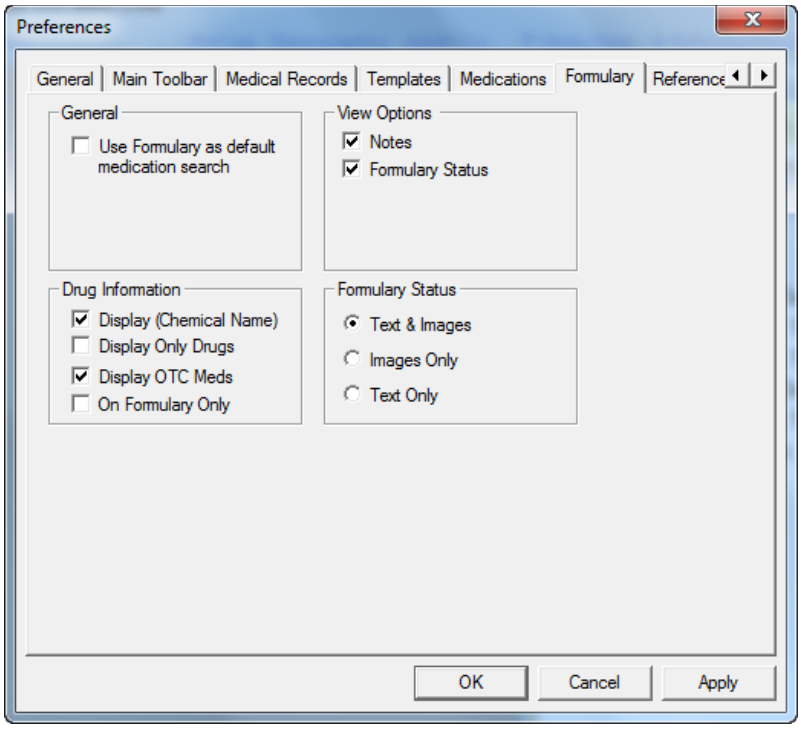
Templates:
Select ***Intake*** from your **Available Templates** and select the arrow to add ***Intake** to your **Preferred Templates**. Repeat for **Telephone Call Template** and any other templates you want added to your **Preferred Templates**.



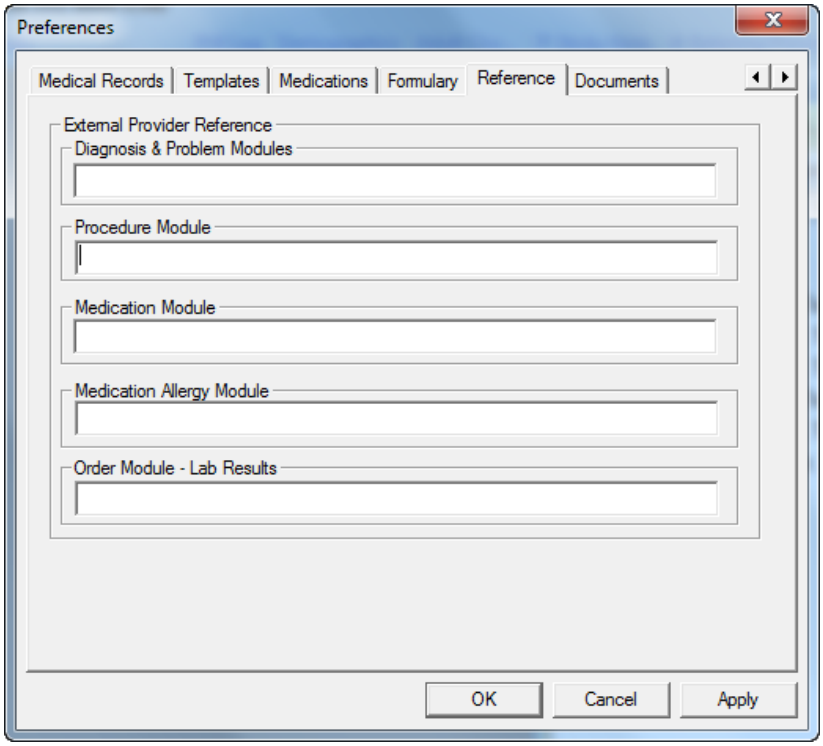
Medications:



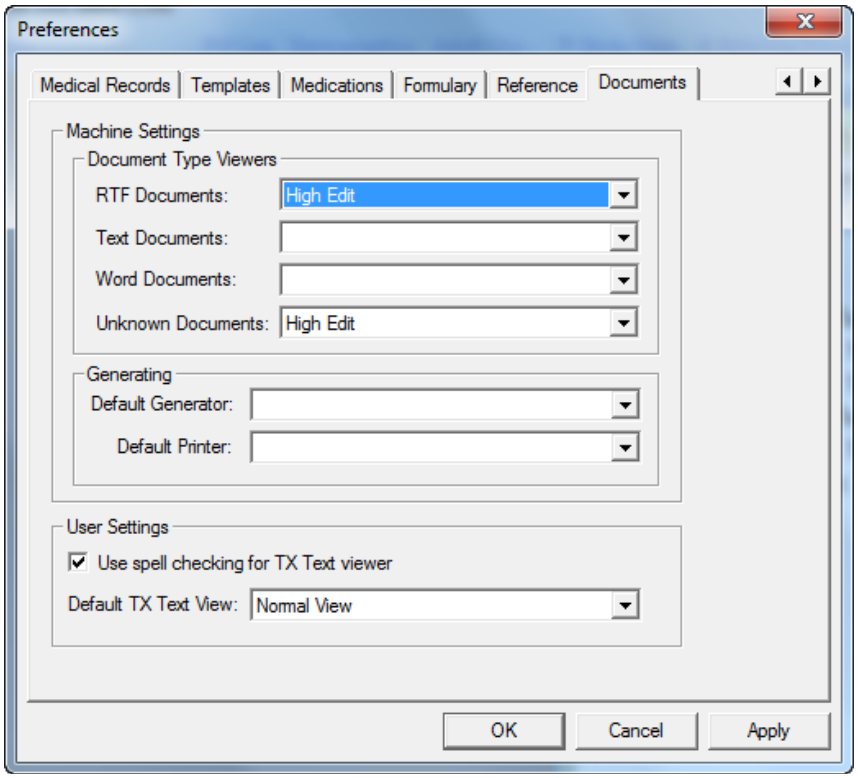
Formulary:



Reference:
Type commonly used web sites to be accessed in each one of these modules.



Documents

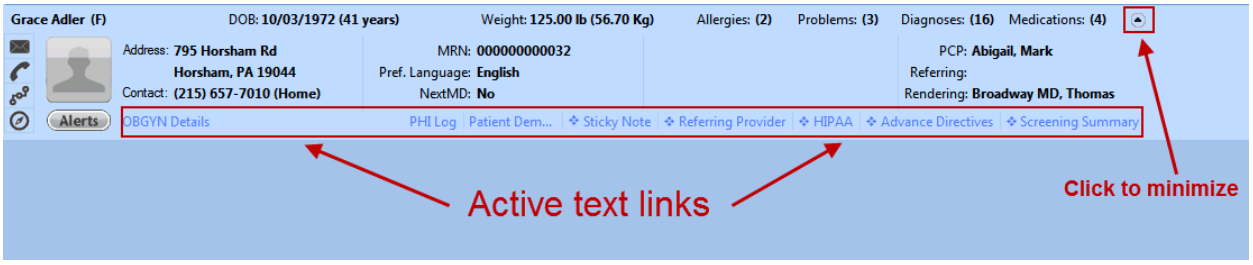


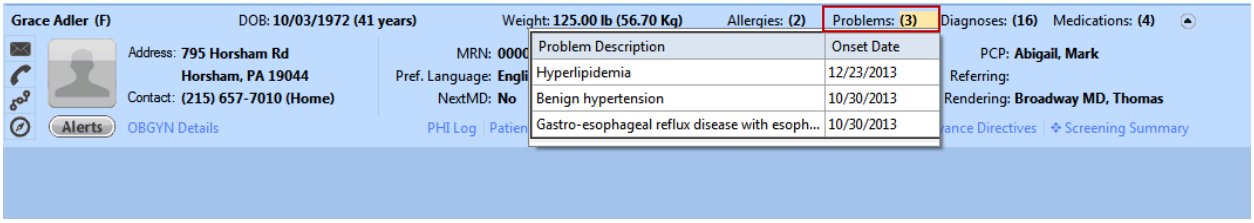
Patient Information Bar

Overall View

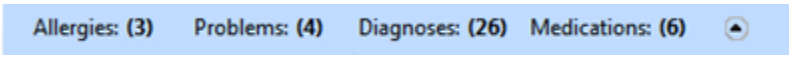
The **Patient Information Bar** is:

- A toolbar enabled by your practice
- Customized to present the most valuable information for your workflow
- Always present above the current template or module
- Minimized or maximized with one select (note the small arrow beside Medications)
- The **Patient Information Bar** displays when a patient's chart is open regardless of whether a template or module is open.
- Consists of static and configurable components.
- ***Patient Summary Medical Information*** section includes a list of the patient's allergies, problems, diagnoses and mediations.
- Hover over the ***number*** next to **Allergies, Problems, Diagnosis or Medication** to view the list.
- Select on the ***number*** next to **Allergies, Problems, Diagnosis or Medication** to open the selected module.



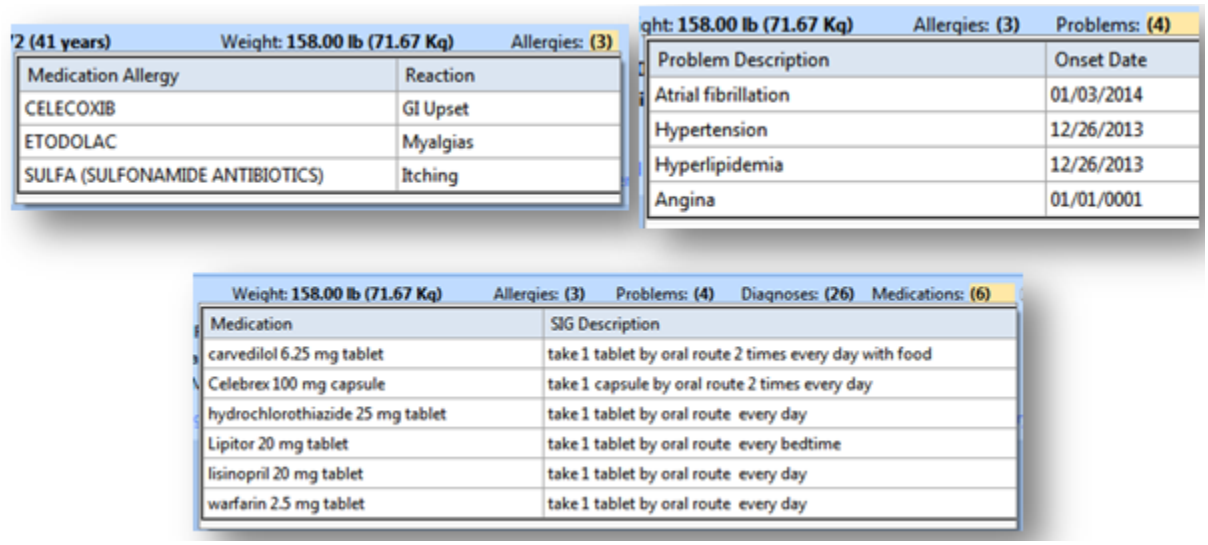


Patient Summary Medical Information displays a summary of the patient's data, even while minimized:



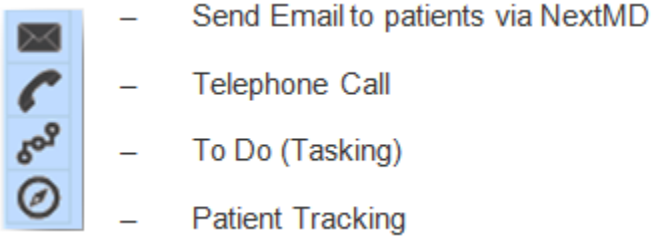
- Allergies
- Problems
- Diagnoses
- Medications
- Alerts

It provides easy access to view and change information.



General Information

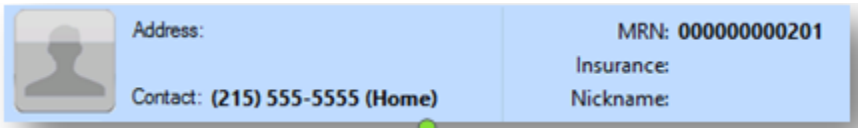
The **General Information** section provides tools to take action from a patient's chart.



Demographic Information

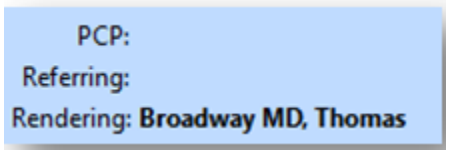
Patient demographic information allows the user to view additional contact details and identifiers for your patient at a glance.

- Insurance type
- Enterprise Chart Indicator
- Parent/Guardian
- Patient Portal Indicator



Encounter Based Information

The encounter-based information section includes visit-specific provider information for your patient, including:



- Primary Care Provider (PCP)
- Referring Provider
- Rendering Provider

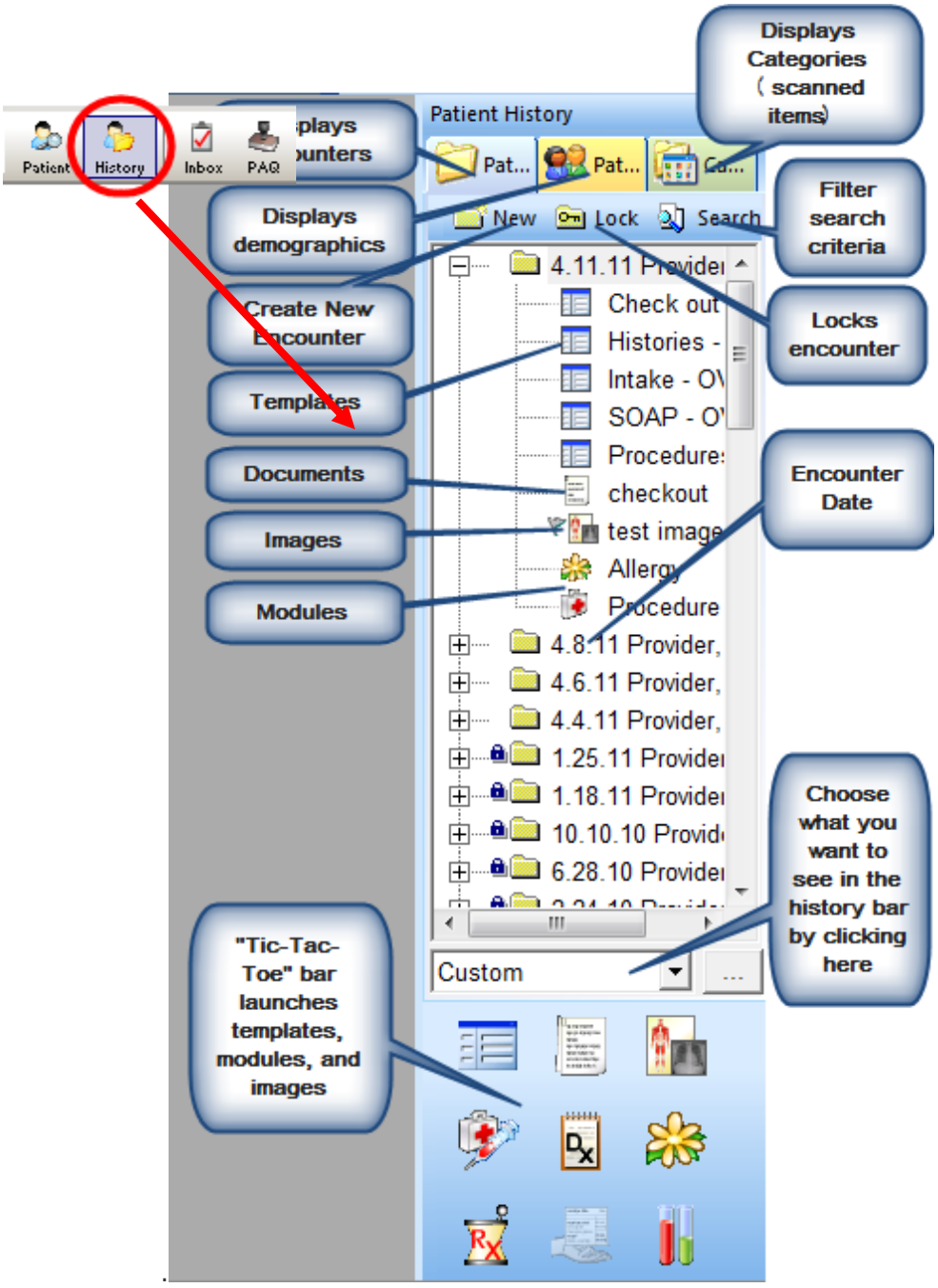
Template Shortcuts

The **Patient Information Bar** contains links to pop-up templates that you frequently need. Options include:

- Sticky Note
- Referring Provider
- HIPAA
- Advance Directives
- Screening Summary
- OBGYN Details (females over 12)

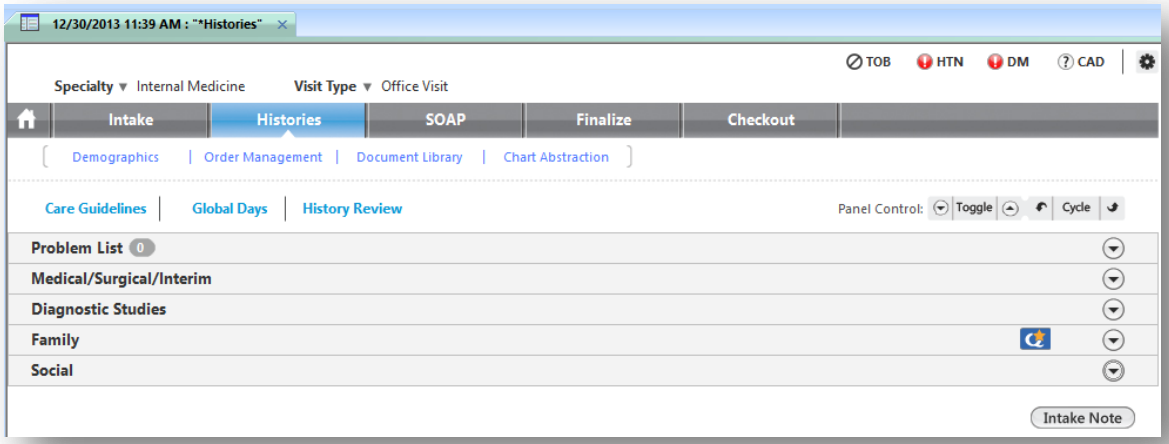
History Toolbar

To open the **History Toolbar** – select the icon ***History*** icon from the **Top Toolbar**



Panels

Documentation in EHR is broken into panels. The panels are present on each tab with in the EHR and enable you to choose how and when you wish to document.



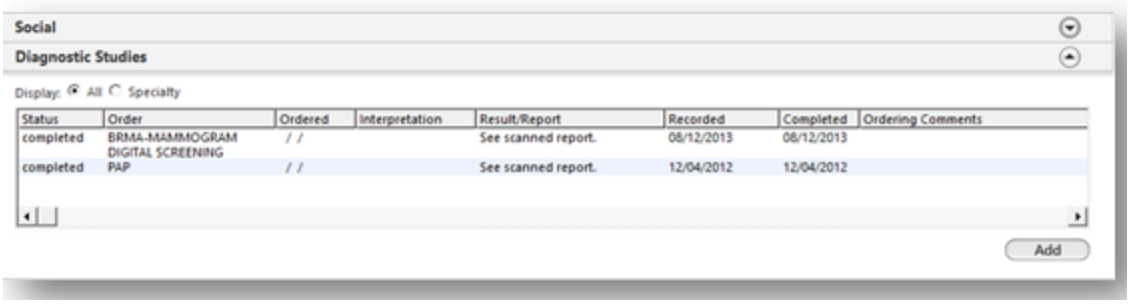
To streamline the workflow, panels can be:

- Moved
- Cycled
- Toggled

Panels: Toggling

The user can expand and collapse panels to gain instant access to the information needed most. NextGen will remember your settings. The process is called toggling, and can be done in two ways.

- Locate the arrow beside the title of each panel.
- Select once to toggle your view to its opposite



Panels: Moving

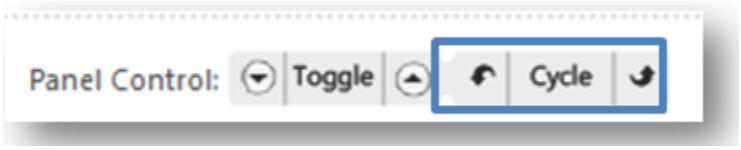
To arrange the panels into the documentation sequence that works best for you, collapse all panels. Select the panel you wish to move by placing the cursor in the gray area of the panel. Hold the left mouse button and drag slowly to desired sequence (you will see an outline appear). Release before or after another panel.

Note: Releasing directly onto another panel will position the new one in the space below it.

Panels: Cycling

As you document, progress from one panel to the next by using the **Cycle** feature.

- Locate the **Panel Control** bar directly above the panels.
- Select the ***Cycle Up***  arrow to move to the next panel.
- Select the ***Cycle Down***  arrow to move to a previous panel.

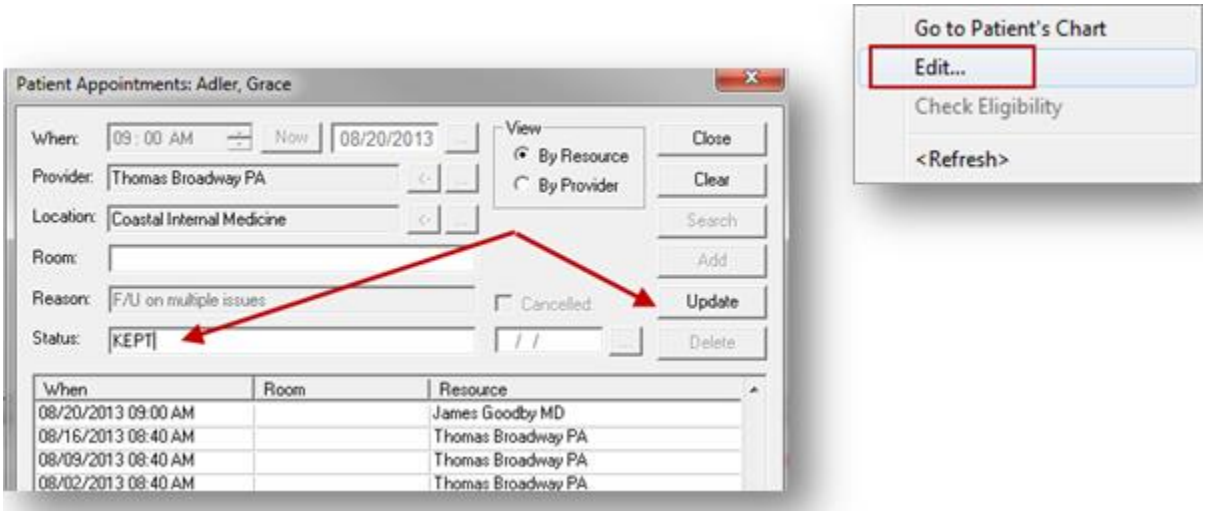


Appointment Window: Inbox

To display the Inbox, select the Inbox icon 

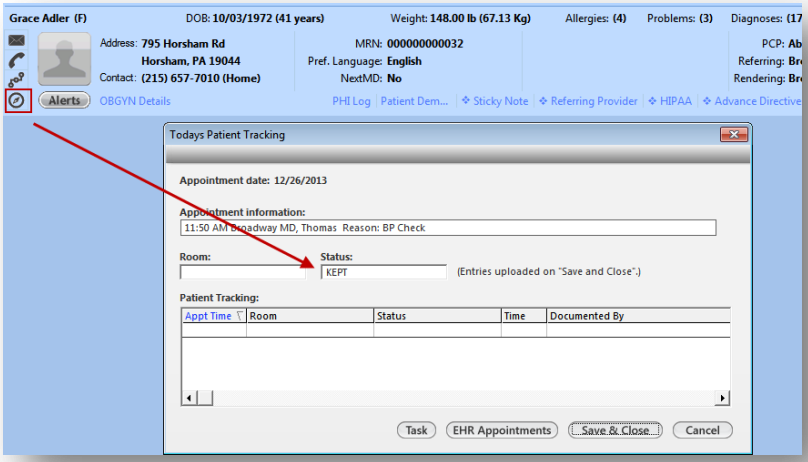
. Patients scheduled but not checked in have a status of **BOOKED.** Patients who have checked in at the Front Desk have a status of **KEPT** and are ready to be roomed.

The status can be updated from the Appointment Window however it is best practice to update from the Intake template. Right-select on the patient's name and select ***Edit***. Type in the ***Status*** field.



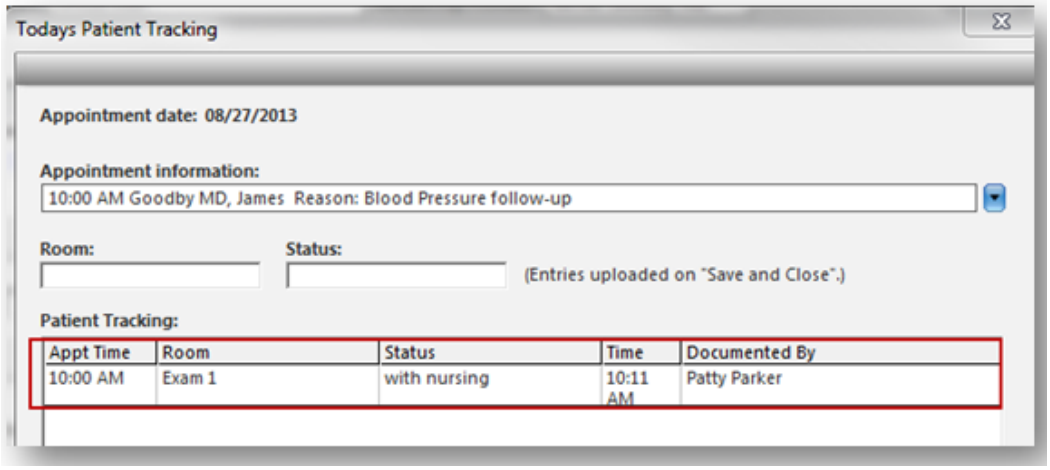
Patient Tracking

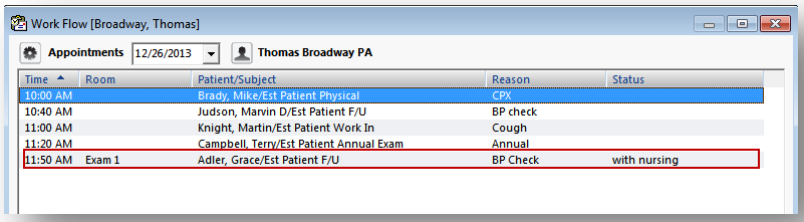
Select on the ***Patient Tracking*** icon on the left hand side of the **Patient Information Bar.** This opens the **Patient Tracking** pop up.



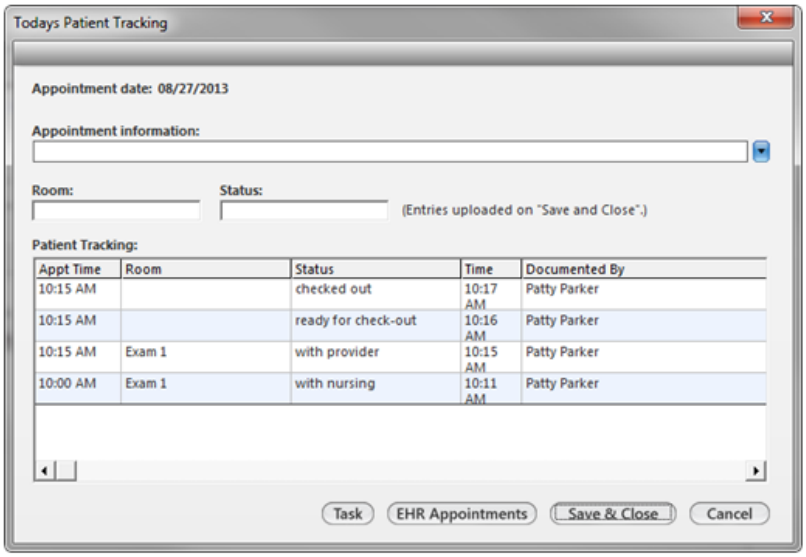
- Select in the ***Room*** field and choose the room from the picklist.
- Select in the Room field and choose the room from the picklist.
- Select ***Save & Close*** to update the status.

The **Status** is now updated in the **Patient Tracking** pop up as well as in the **Inbox**.





When clinical staff is finished with the patient, update the status to ***"waiting for provider."*** Providers update the status to ***"with provider."*** Repeat the process until the visit is complete and the patient is discharged



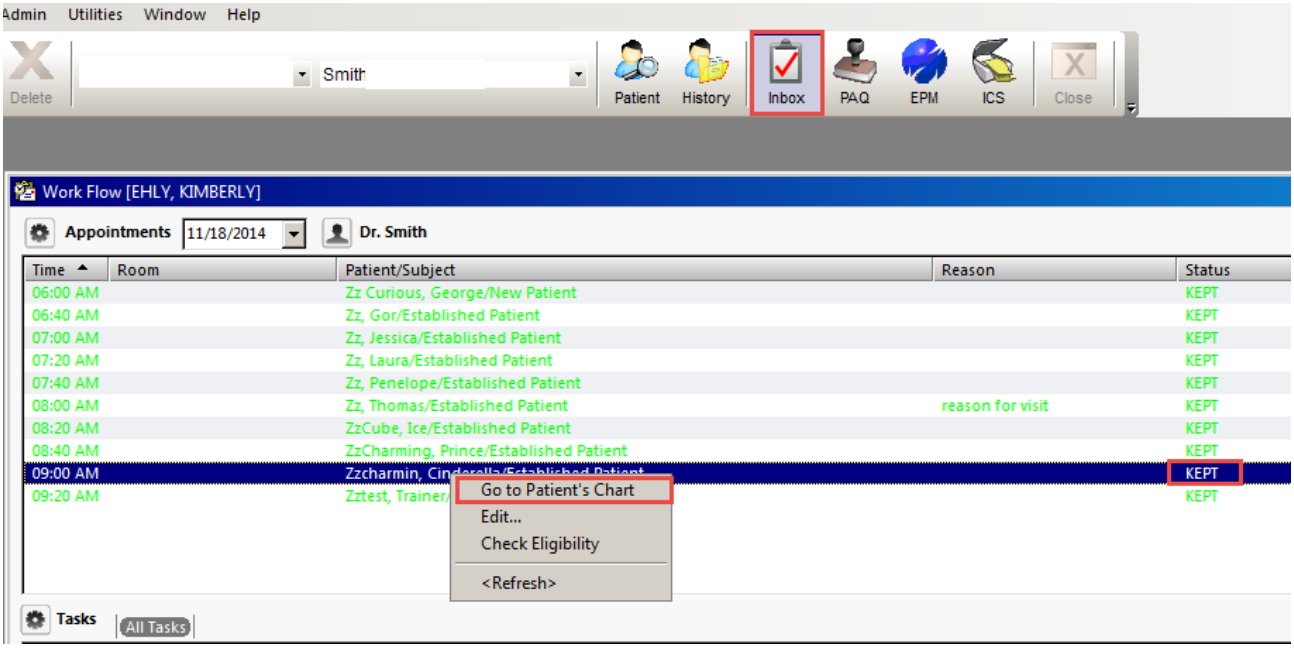
The status will automatically update to ***"chart complete"*** or another defined status when charges have been submitted.

Clinical Staff Workflow

Accessing the Chart

Select on the ***Inbox*** icon on the **NextGen Tool Bar**. Double-click on the patient name in the **Appointments** section of the **Inbox** to open the patient's chart.

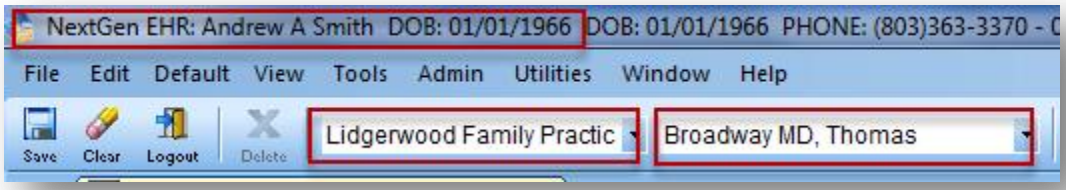
Note: When a patient is checked in, the status will change to **KEPT**. You may also right-select on the patient name and select ***Go to Patient's Chart***.

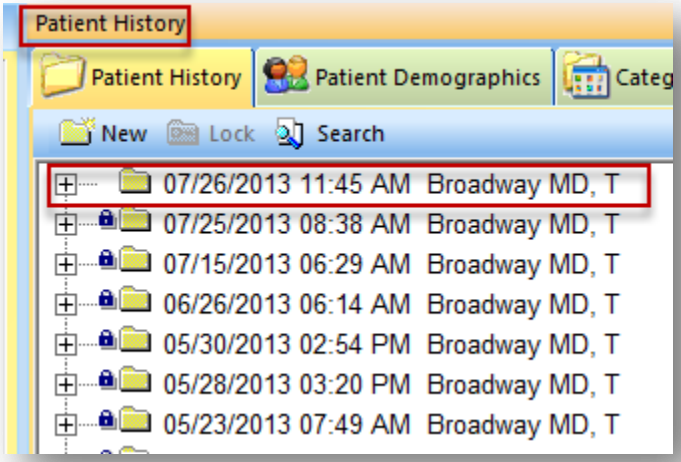


Patient Check In – 4 Point Check

Before documenting in a patient's chart you should perform a 4 point check.

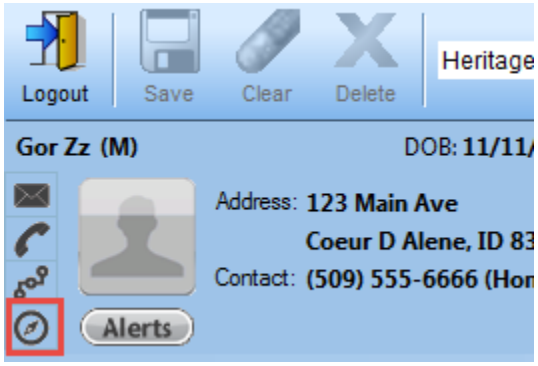
- Verify that you are I the correct patient's chart.
- Verify that the correct service location is selected.
- Verify that the correct provider is selected.
- Verify that you are on the current day encounter and the correct provider is displayed..

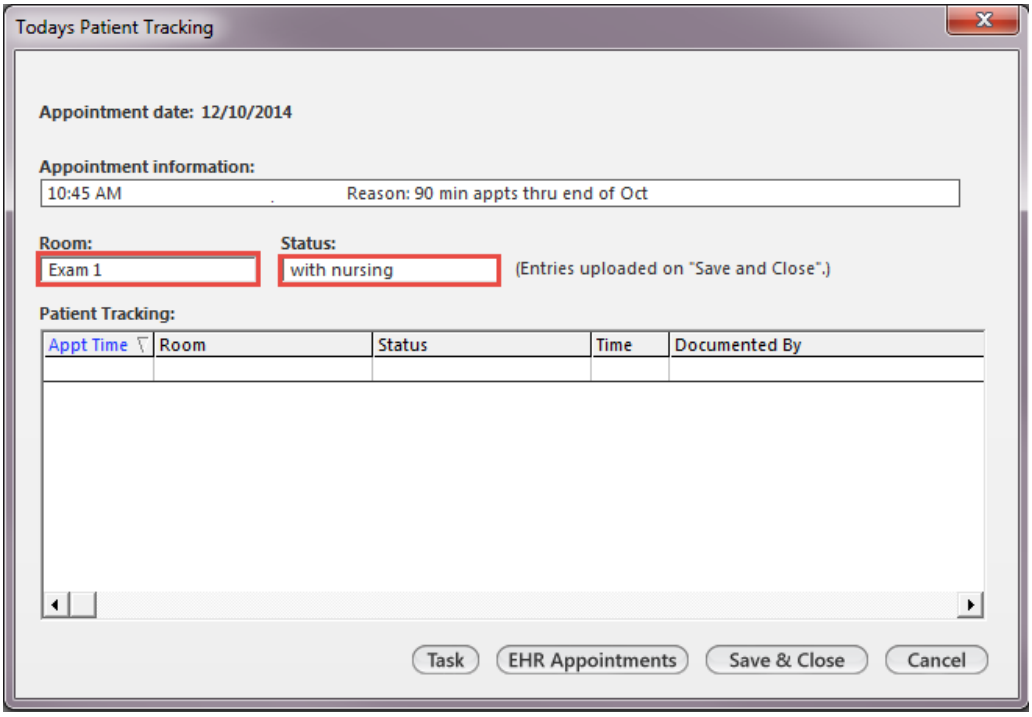




Patient Tracking

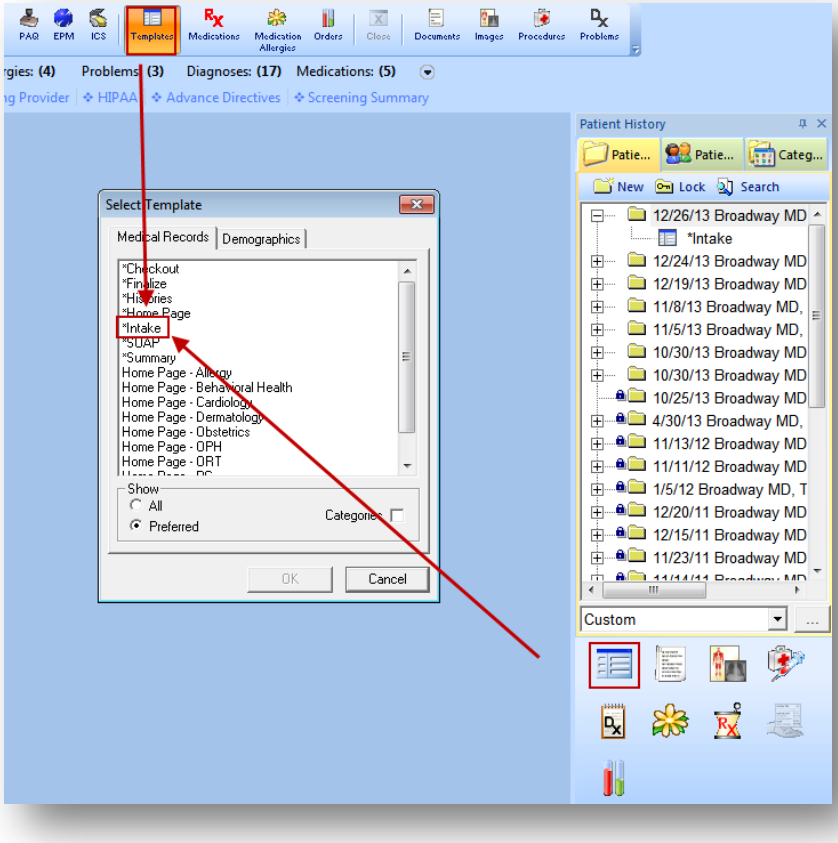
The user will select the ***Patient Tracking*** icon in the **Patient Information Bar** in order to track patient's progress throughout the visit. Once the **Today's Patient Tracking** displays, select the appropriate ***Room*** and ***Status.***



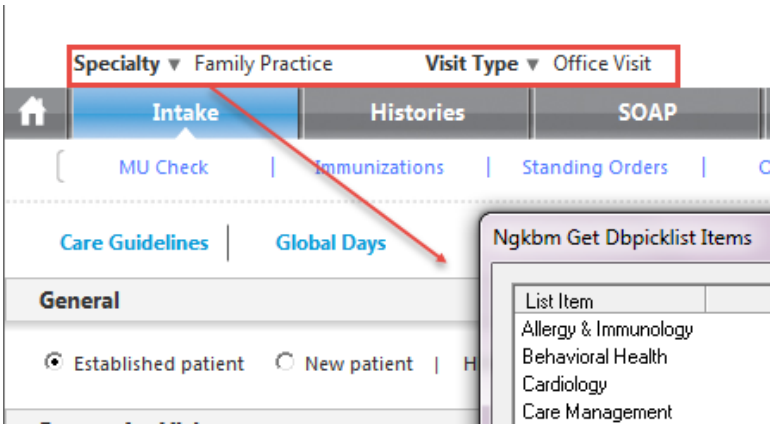


Intake Template

Open the *Intake template to begin documentation of today's visit. Select the ***Templates*** icon and select ****Intake***. The **Intake** template is used to document the Reason for Visit, Vital Signs, Medication and Allergy reconciliation and ROS. Sections of the **Intake** template are divided into panels that can be expanded and collapsed to navigate through the template with ease.



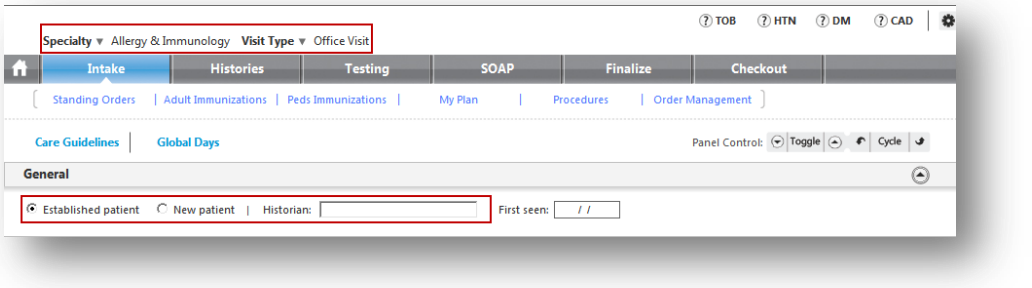
Select the arrow next to the ***Specialty*** and ***Visit Type*** fields and select appropriate values from the picklist.



General Panel

Select ***Established*** or ***New Patient***.

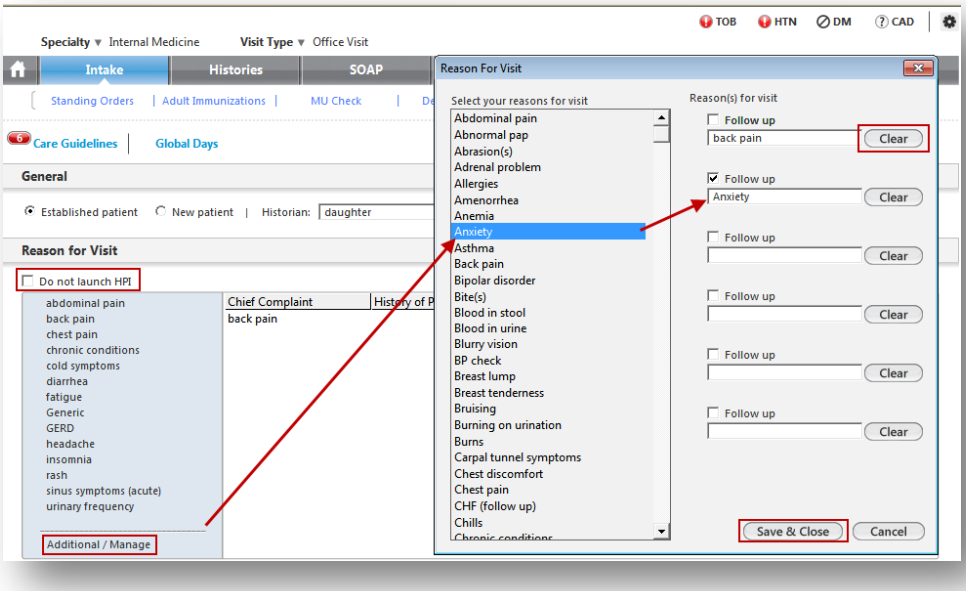
- If the patient is established with the provider but new to EHR, choose Established Patient.
- Indicate the Historian, if applicable.



Reason for Visit Panel

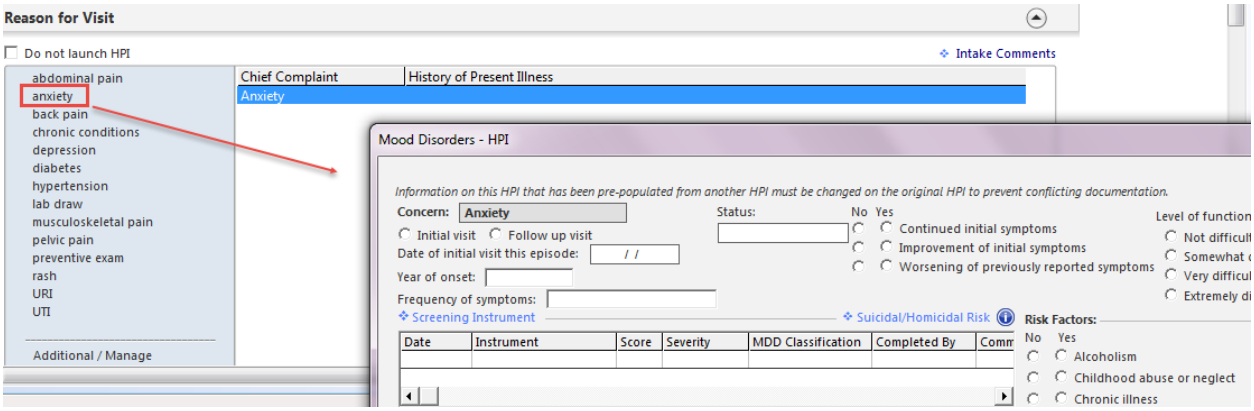
Select the reason(s) for the visit from the list to the left. This list contains the top reasons for the specialty or practice. The applicable HPI template will launch. If you do not want the HPI template to launch, check the ***Do not launch HPI*** box.

- If the reason(s) are not on the list, select the ***Additional/Manage*** link to launch the full reason for visit list.
- Check box on top to see ***All HPI*** templates.
- HPI items may be removed by selecting the ***Clear*** button in Additional/ Manage.
- Check the ***Follow up*** box to indicate this is a subsequent visit for the problem.
- Select ***Save & Close*** to return to the Intake Tab.

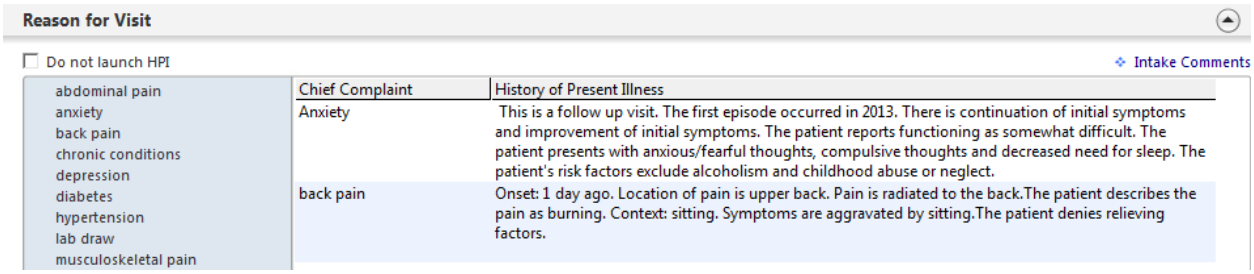


- Select on the appropriate ***Reason for Visit*** to launch the associated HPI template.

The amount of information entered in the HPI is practice and/or provider dependent. As a minimum, clinical staff should complete the top section for Onset, Severity and Status as this is included in coding calculations.



Repeat the process until all HPI's have been addressed.



Vital Signs Panel

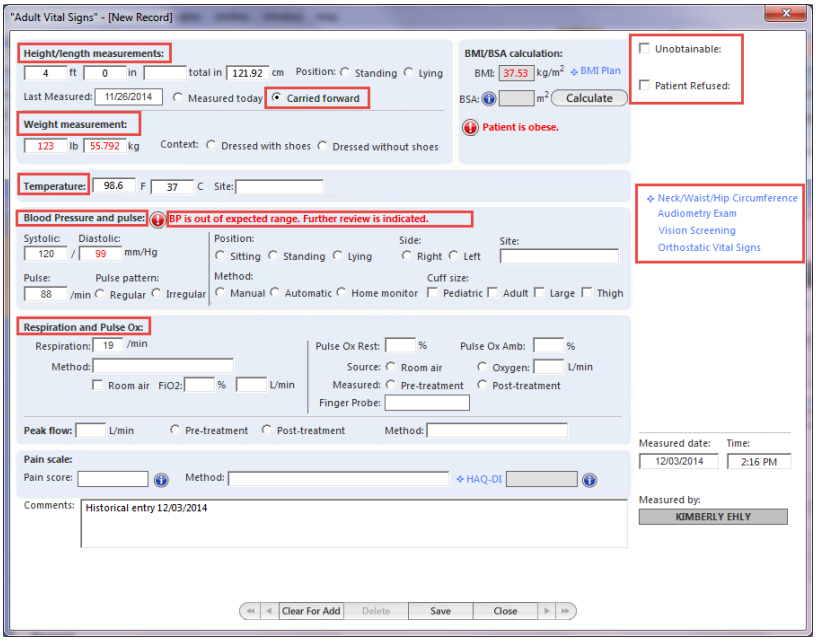
Select the ***Add*** button below the **Vital Signs** grid to launch the template.

Follow practice guidelines for which vital signs to enter. At a minimum, enter the patient's height, weight and blood pressure as these are required for **Meaningful Use**.
You may use the **Carried forward** radio button to enter the patient's height from the last recording.

Proceed with entering vital signs as appropriate, noting the following:

- Values outside of system ranges will prompt an **ALERT** at the top of the template.
- Record site and context as appropriate.
- Enter additional comments, if needed.
- Access audiometry and visual screening templates.
- BMI is automatically calculated if height and weight are entered.
- Check the ***Unobtainable*** box if you are unable to obtain a value.
- Check the ***Patient Refused*** button if the patient refuses any or all vital signs.

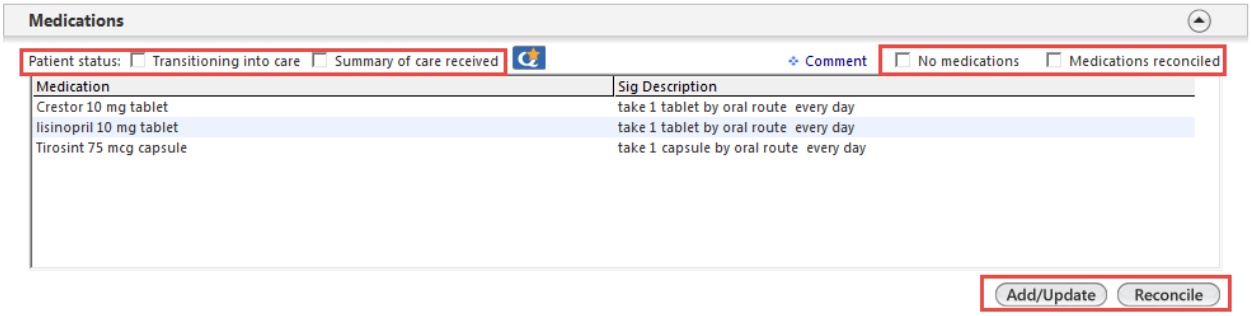
Select ***Save > Close*** to close the template. The Vital Signs are now displayed in the **Vital Signs** grid.
To edit the vital signs, highlight the row and select the ***Edit*** button
Select the ***History & Graph*** text links to view the complete V/S history and graph values.



Medications Panel

The **Medication** panel contains the patient's active medication list.

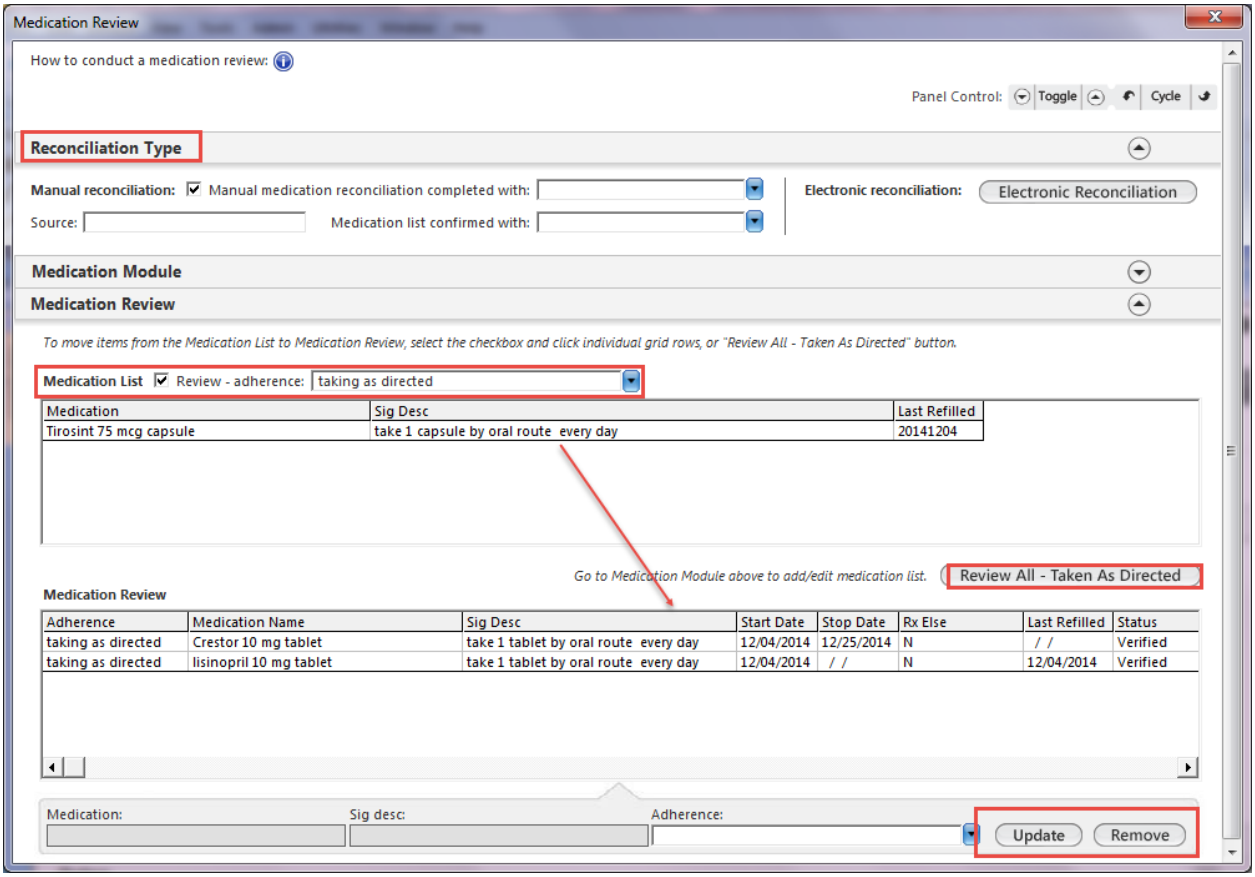
- Check the ***No Medications*** box if the patient does not take any medications.
- Patient Status – check the ***Transitioning into care*** box if the patient is new to the provider or returning from a hospital stay. Check the ***Summary of care received*** box if an electronic or paper medication list was received from another provider or hospital.
- To add medications to the list select the ***Add*** button or double-select in the grid to launch the **Medication Module**.



Medication Reconciliation - review of patient's adherence to prescribed medications. Should be completed for new patients, periodically for established patients, after hospitalization, after care by another provider and any other time deemed appropriate.

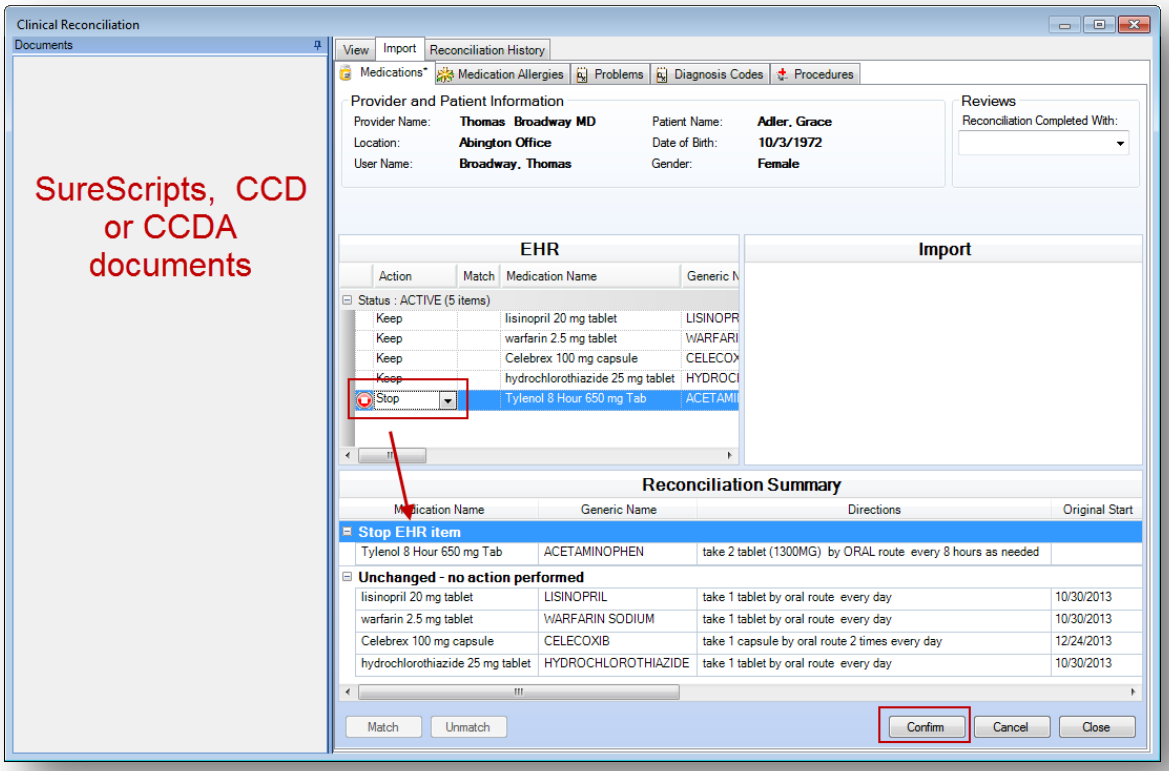
- Select the ***Reconcile*** button to launch the **Medication Review** template.
- Open the ***Reconciliation Type*** panel and select the ***Manual medication reconciliation completed*** checkbox.
- Open the ***Medication Review*** panel and select the ***Review – adherence*** checkbox.
- The *"**taking as directed**"* adherence comment defaults in the field. Use the drop-down to select another adherence comment (select the blank line to manually enter a comment)

- Select the ***Review All – Taken As Directed*** button and the medications will move to the **Medication Review** grid. To review meds individually, select a different adherence comment and highlight the row. This will move the med to the **Medication Review** grid.
- To move a medication back to the **Medication List**, highlight the row and select ***Remove.***
- To modify an adherence comment, highlight the row, select a new adherence comment and select the ***Update*** button.
- If applicable, update the patient's status for **Transition of care** or **Summary of care received** .



Electronic Reconciliation button will launch the Clinical Reconciliation module.

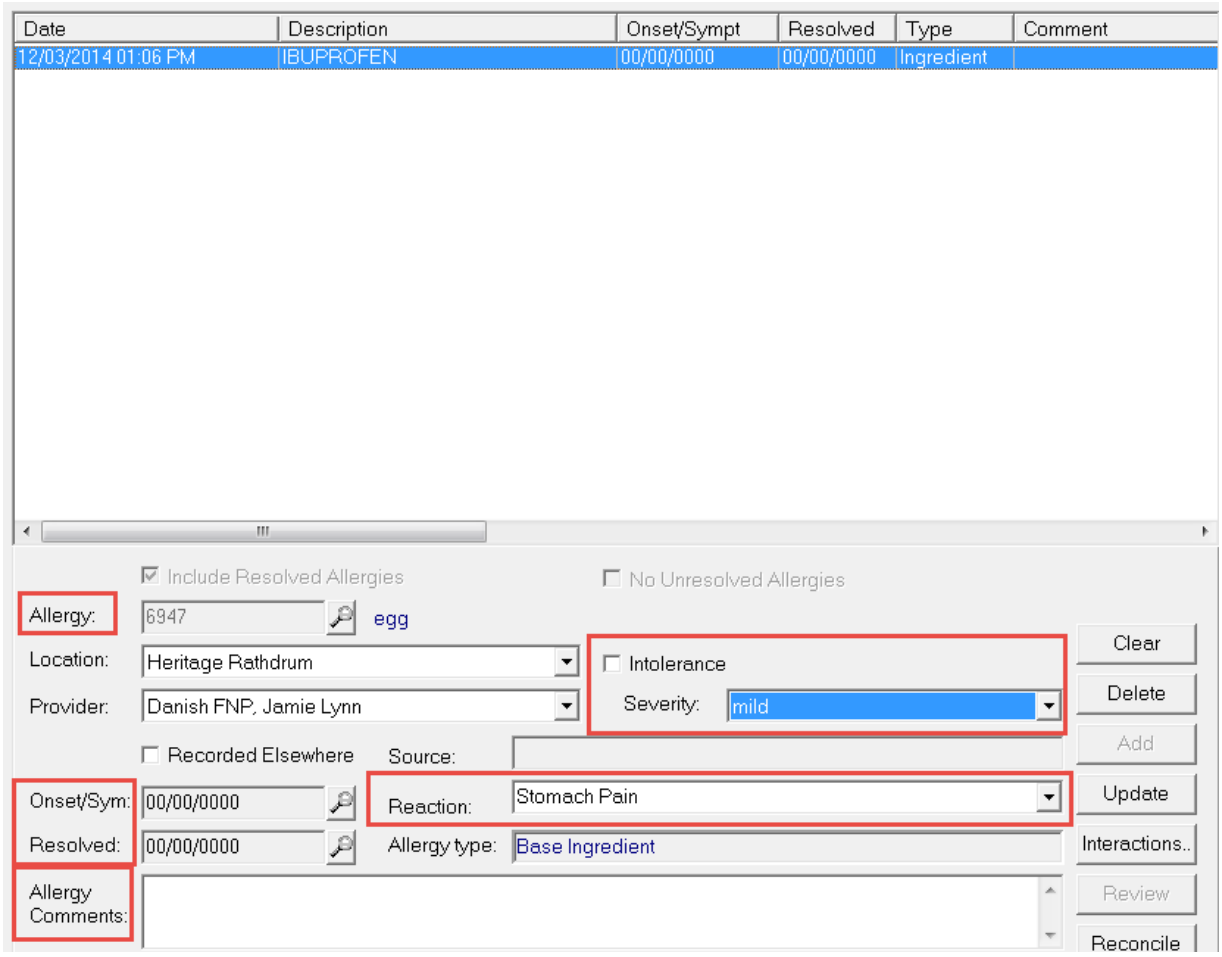
- In the ***Documents*** section, select the SureScripts® mediation history file. This will populate the Import section.
- Perform reconciliation between the medications in the EHR section and the Import section. Choose whether to Add, Replace or Ignore the medication.
- Select ***Confirm*** when completed.
- Address any DUR notifications that appear.
- Select ***Close.***
- Document patient adherence, if necessary.



Allergies Panel

The **Allergies** panel contains the patient's active allergy list.

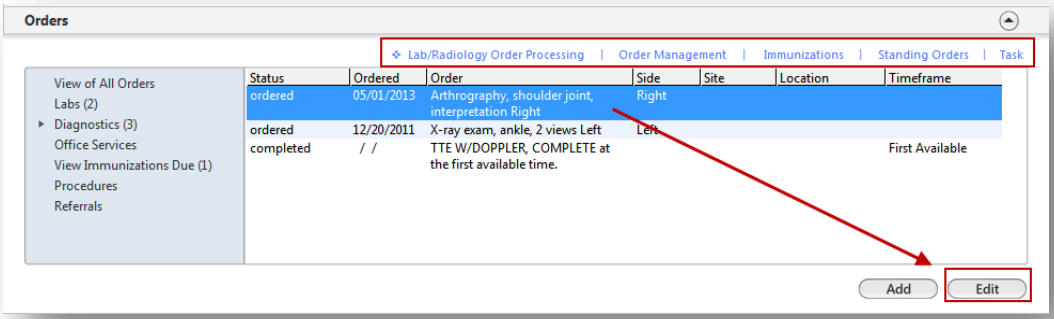
- Check the ***No known allergies*** radio button if the patient does not have any allergies.
- Review allergies with the patient. If there are no updates, select the ***Reviewed, no change*** button.
- To add allergies, select ***Update*** to launch the Allergy Module. Manage allergies through the **Allergy Module.**



Orders Panel

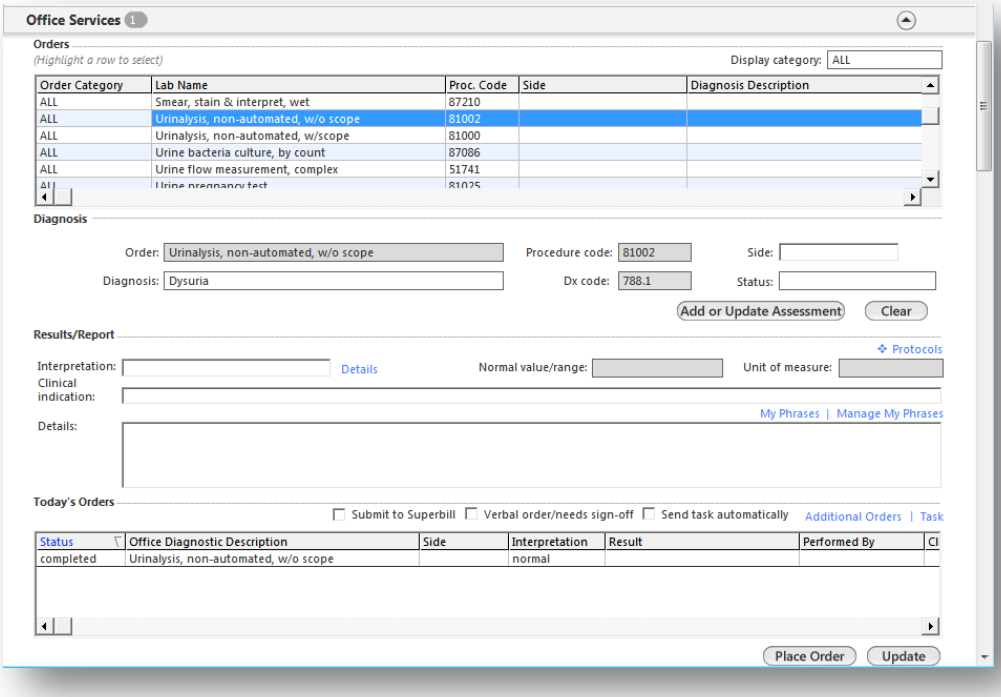
The Orders panel Includes the ability to process, manage, add, edit or remove an order as well as access Immunizations, Order Management and Standing Orders.

- Default view is ***View of All Orders***; select the category to view only those items with the selected category.
- To update or complete an order, highlight the row and select the ***Edit*** button or select the ***Order Management*** active text link to open the **Order Management** template.



Standing Orders link is used to order and result point of care tests such as urinalysis, glucose fingersticks, and xrays.

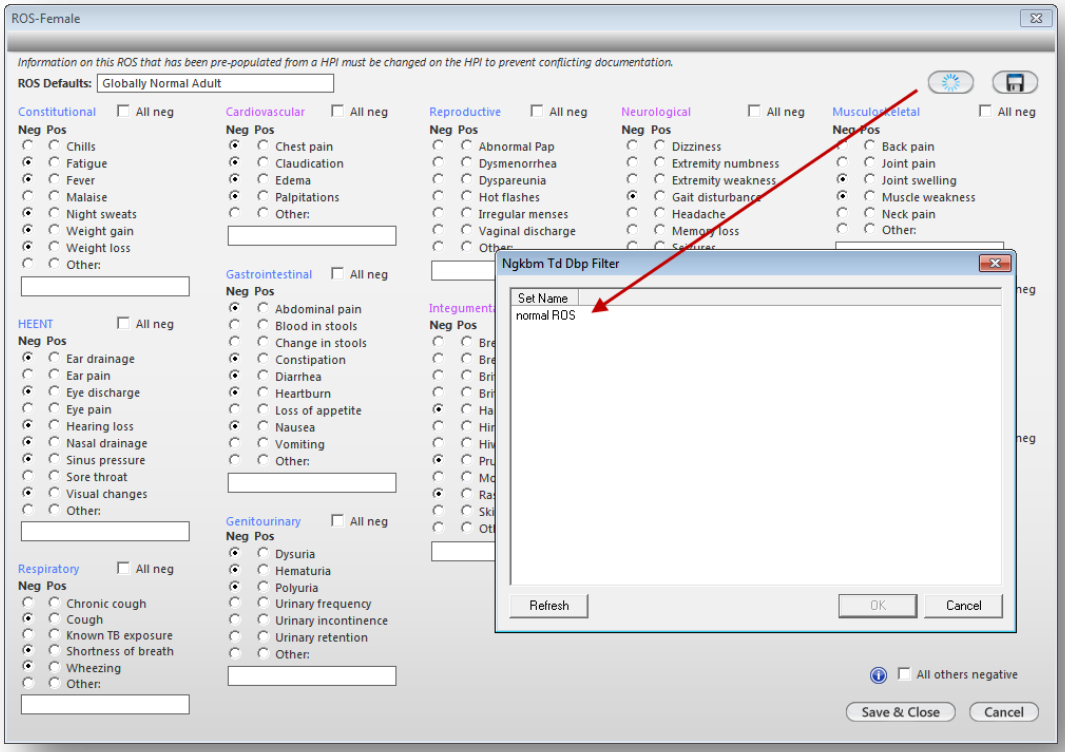
- Select the ***Standing Orders*** active text link to launch the Office Services template.
- Order and document the applicable tests (see Office Services/Standing Orders section of this manual for detailed instructions).



Review of Systems Panel

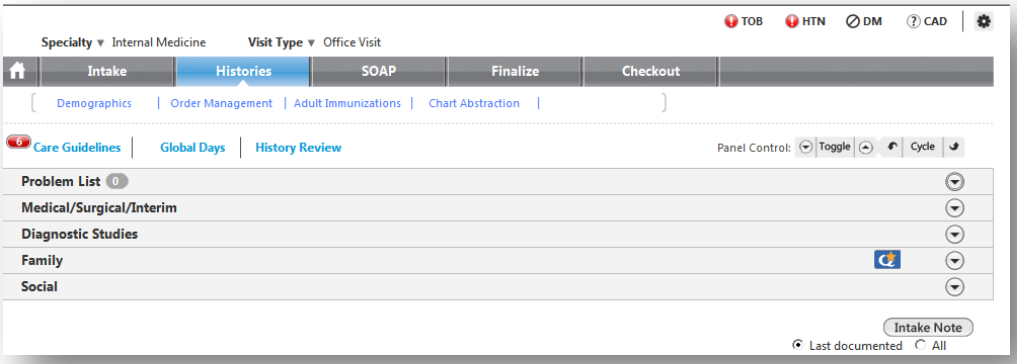
If applicable to your practice and/or provider, enter the review of systems. NOTE: Based on information entered in the HPI, there may be some ROS items already entered.

- Select the ***ROS – Female or ROS – Male*** (or the ROS assigned for the specialty).
- Use either system or provider defaults to enter a predetermined ROS. Change any default negative values to positive values as applicable. NOTE: ROS values from the HPI will not be overwritten by using a default ROS.



Histories Template

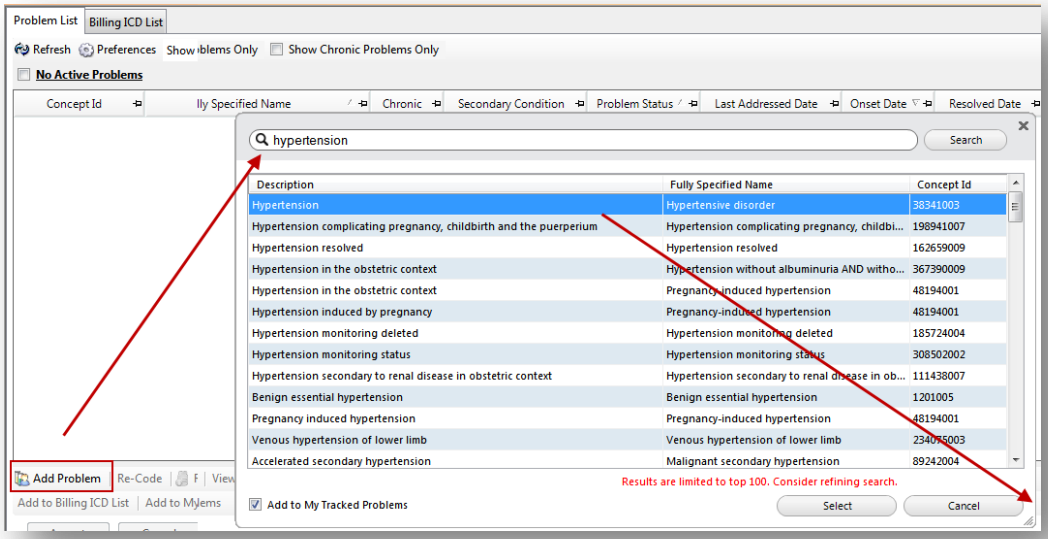
This area gives the user the ability to enter chronic medical problems, social, family, diagnostic study and past medical/surgical histories.



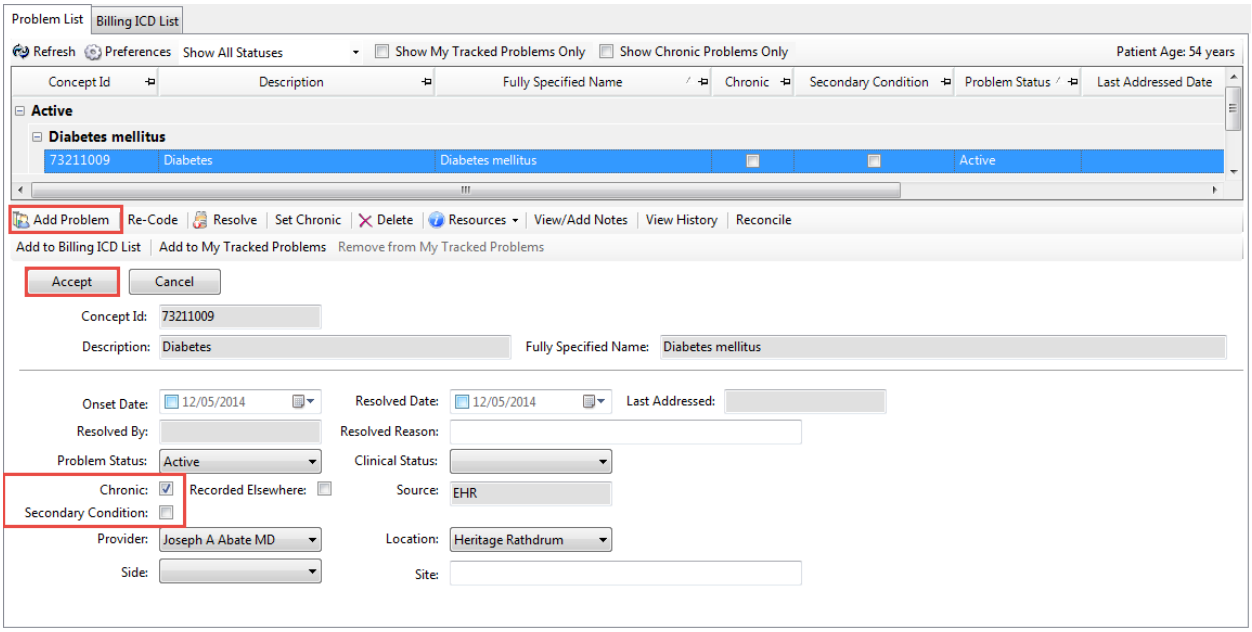
Problem List Panel

This area is for documenting a list of the patient's ongoing problems.

- If the patient has no ongoing problems, check the ***No active problems*** box.
- Select the ***Add*** button to launch the **Problems Module**.
- Select the ***Add Problem*** button in the middle of the screen to launch the search window.
- Enter the full or partial name of the problem in the search field. Select ***Search***.
- Highlight the problem and click **Select**



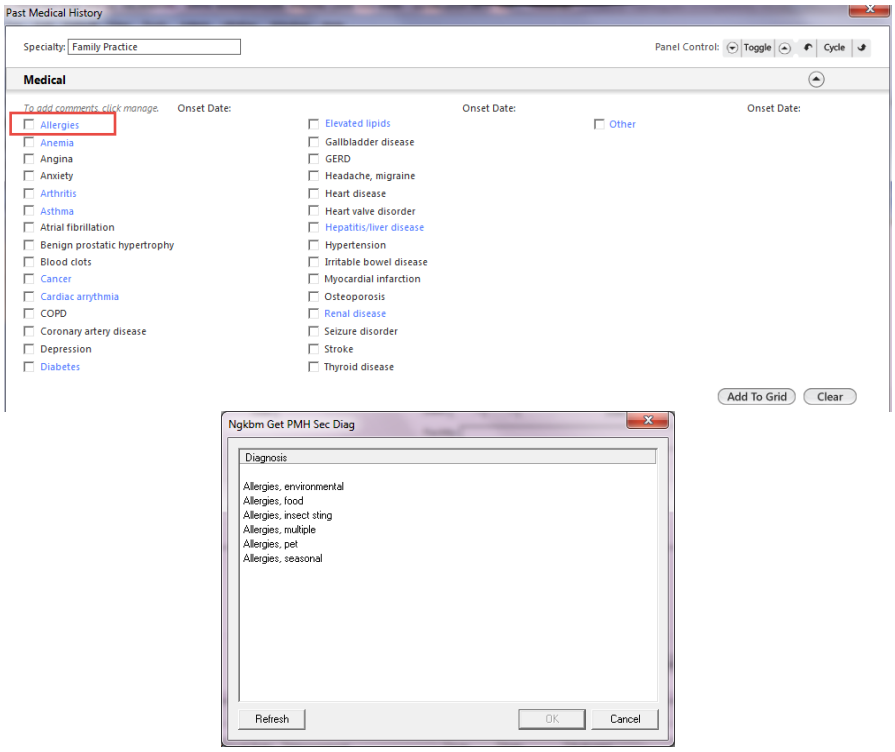
- In the lower area of the module, assign a status to the problem from either the drop-down list or by checking the ***Chronic*** or ***Secondary Condition*** box.
- Select the ***Accept*** button to move the problem to the active list above.
- Close the **Problems Module** and return to the **Histories** template.

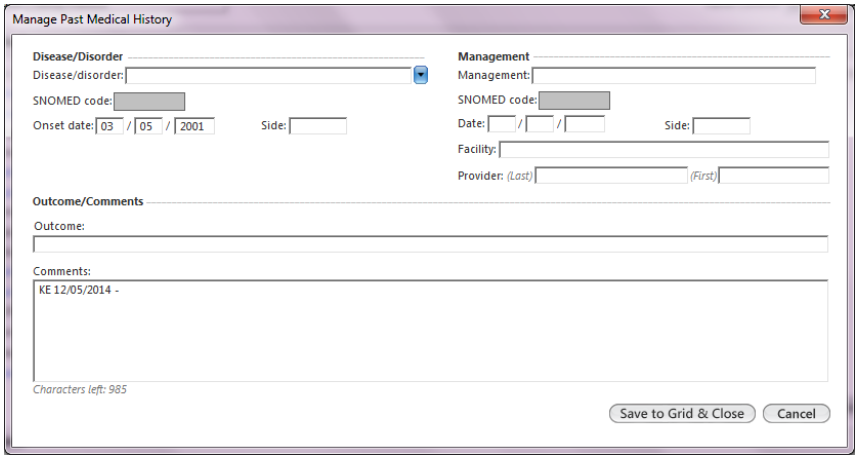


Medical/Surgical/Interim Panel

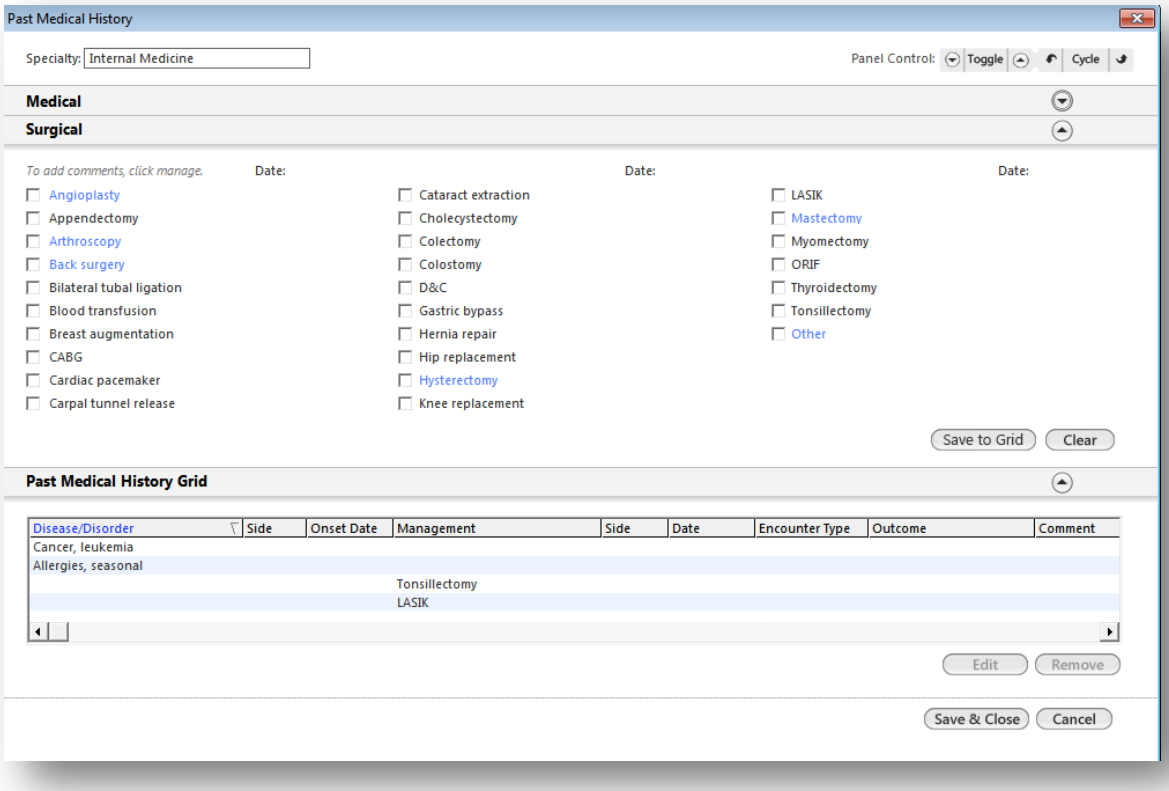
This panel is used to document the patient's past medical/surgical or interim care.

- If the patient has no history, check the ***No relevant past medical/surgical history*** box.
- Select the ***Add*** button to launch the **Past Medical History** pop up. By default, the ***Specialty*** field is populated with the current specialty. Select in the field to change the specialty.
- In the ***Medical*** panel, check either an individual medical condition or a condition group (in blue font). If a condition group is selected, a popup is launched to select a more specific description.
- Upon selecting a condition, the ***Date*** and ***Manage*** fields appear. Assign an onset date from the popup (if known).
- Additional information may be entered in the ***Manage Past Medical History*** popup.

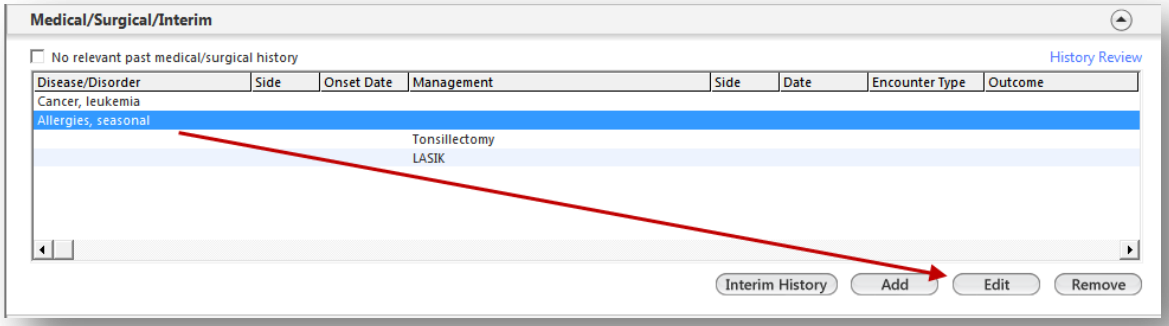




- Continue until all medical histories are added.
- Repeat the process in the ***Surgical Panel***.
- Entries are viewed in the **Past Medical History** grid



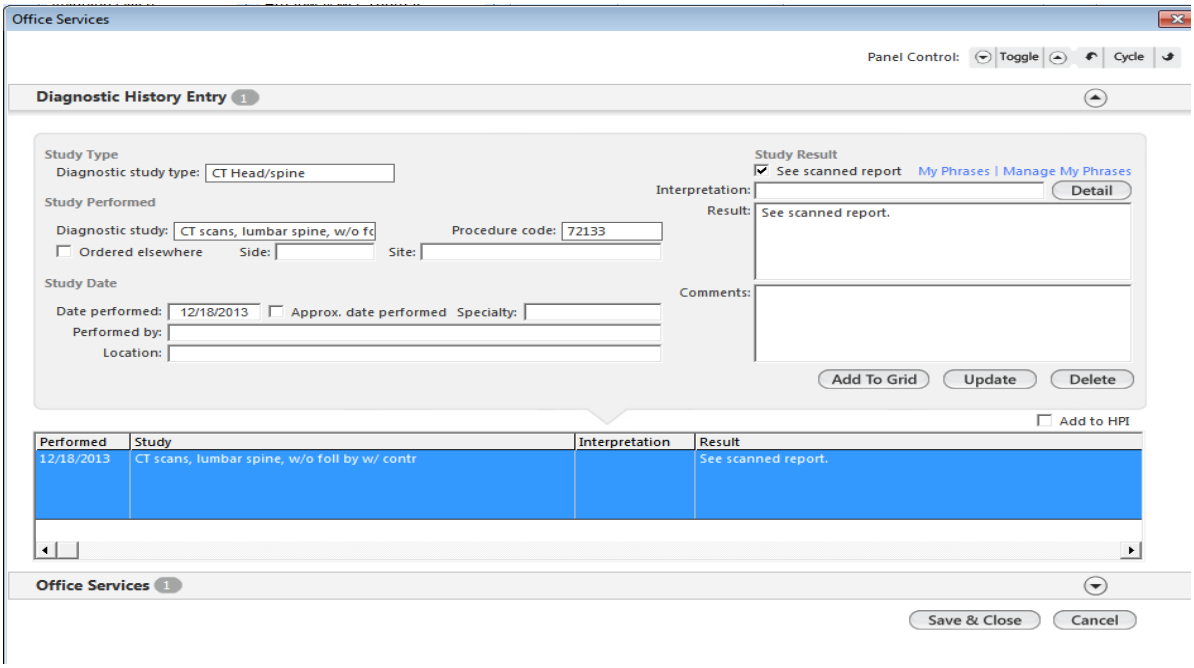
To modify an entry, highlight the row and select the ***Edit*** button.

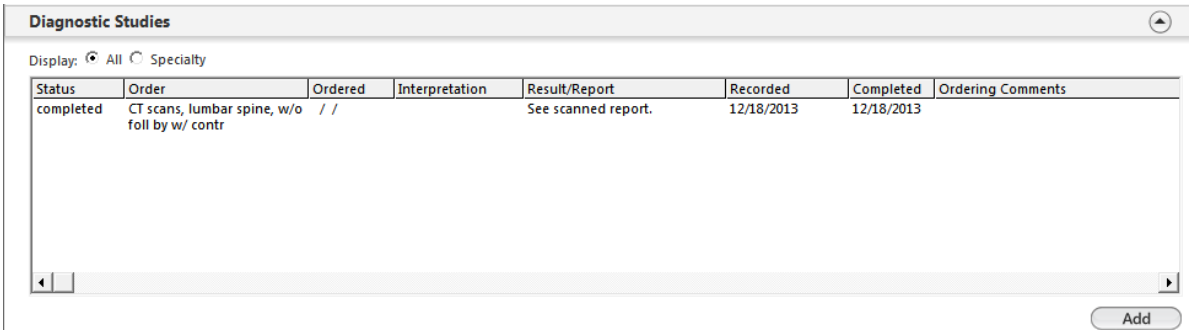


Diagnostic Studies Panel

This panel contains diagnostic studies ordered in the NextGen system or outside studies that have been manually entered.

- Select the ***Add*** button to launch the **Office Services** template.
- Select the ***Diagnostic study type*** field to enter the study type.
- Entered the date the study was performed. The other fields in this area are optional.
- Enter an interpretation/result (based on practice/provider preference). At the minimum, check the ***See scanned report*** box. The provider will enter the result details at a later time.
- Select the ***Add to Grid*** button.
- Select ***Save & Close***.

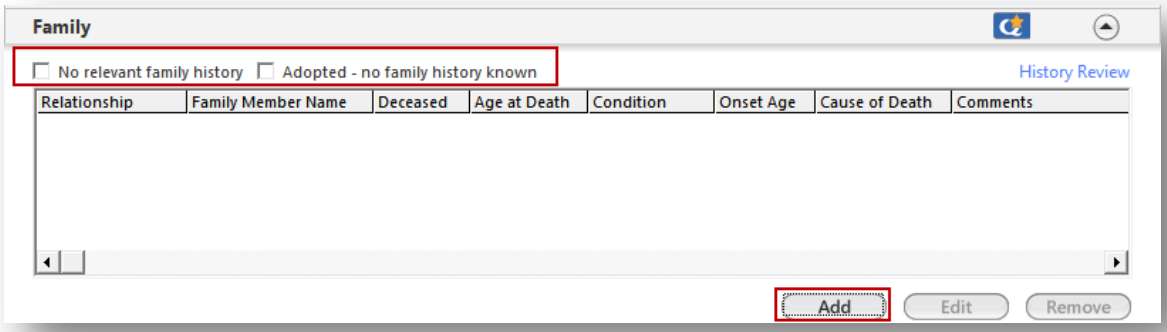




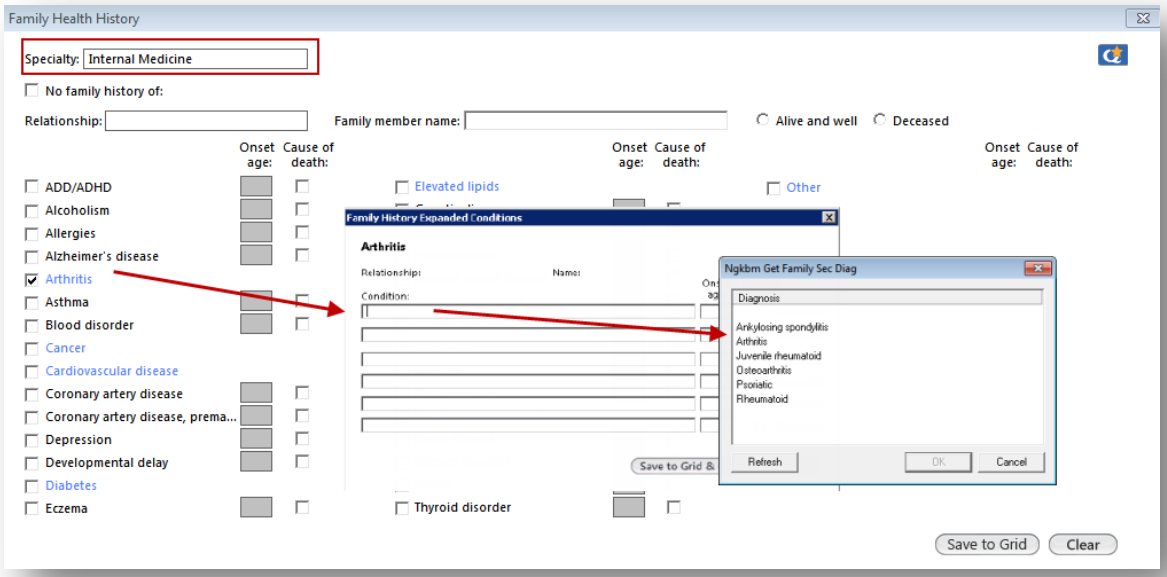
Family History Panel

This panel is to document family histories of the patient. Staff will document at minimal the 1st degree relative (mother, father, brother, sister, etc) of the patient for Meaningful Use.

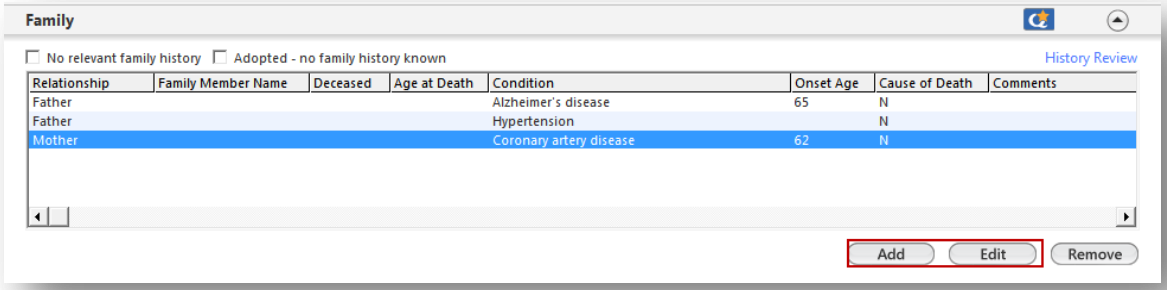
- If the patient has no relevant family history, check the ***No relevant family history*** box. If the patient is adopted, check the ***Adopted – no family history known*** box.
- Select the ***Add*** button to launch the **Family Health History** pop up. By default, the ***Specialty*** field is populated with the current specialty.
- Select in the field to change the specialty if desired.



- Select the family relationship.
- Check either a individual condition or a condition group (in blue font). If a condition group is selected, a popup is launched to select a more specific description.



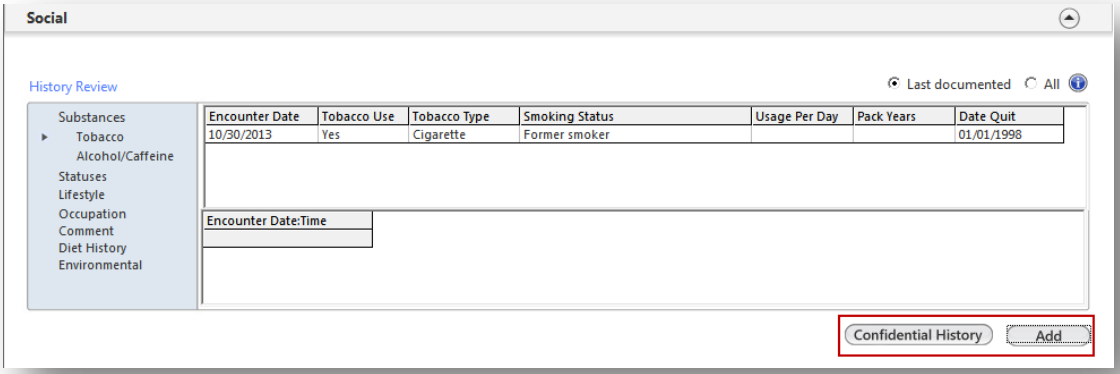
- Enter an age of onset, if known. Check the ***Cause of Death*** box if applicable.
- Additional information may be entered in the ***Family History Comments*** popup.
- Select the ***Save to grid*** button when finished entering completed histories on a family member.
- Continue the process until all histories have been entered for each family member.



- Select ***Save & Close***. To modify an entry, highlight the row and select the ***Edit*** button.

Social History Panel

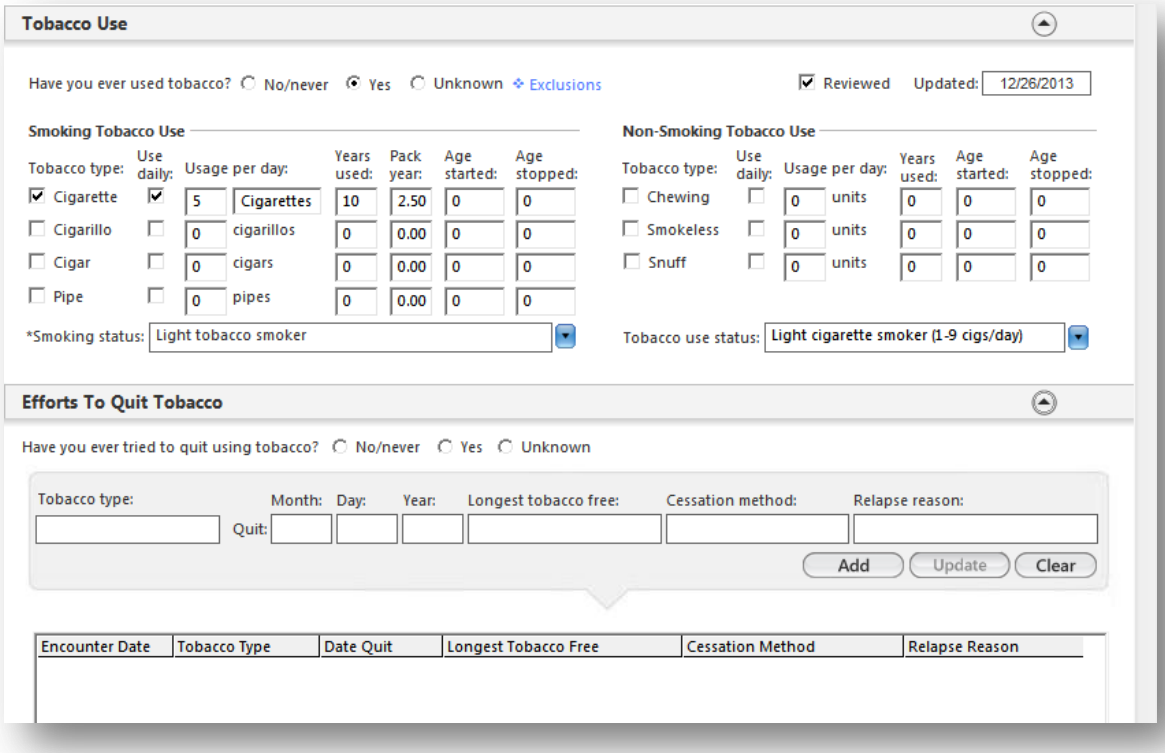
This area is used to document tobacco use , alcohol and caffeine usage, lifestyle, and employment status.



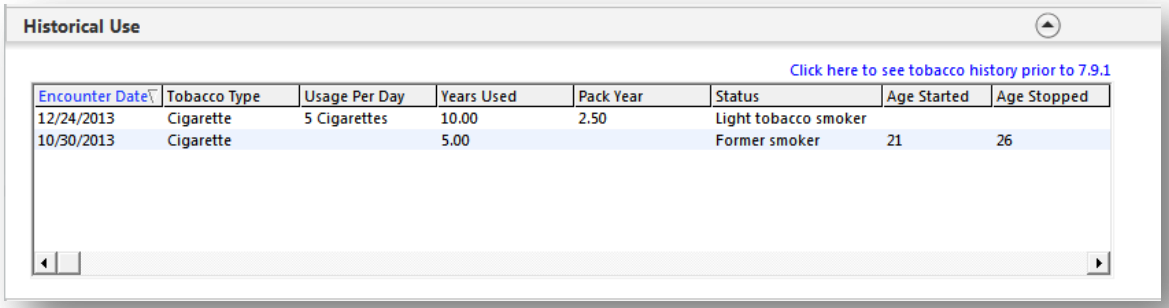
- Select the ***Add*** button to launch the **Social History** template.
- Select the social history category from the left navigation bar.

- ***Tobacco Use Panel***
  - Indicate No/Never, Yes or Unknown tobacco use. If No/Never is selected, the **Passive Smoke Exposure** panel may be completed. Otherwise, no additional documentation is required.
  - Complete the Smoking or Non-smoking **Tobacco Use** sections with the type and amount of tobacco used. NOTE: the Pack year value is automatically calculated.
  - Based on the amount of tobacco used, the **Smoking Status** and **Tobacco Use** status are assigned. To modify the status, select in the field and select from the picklist.

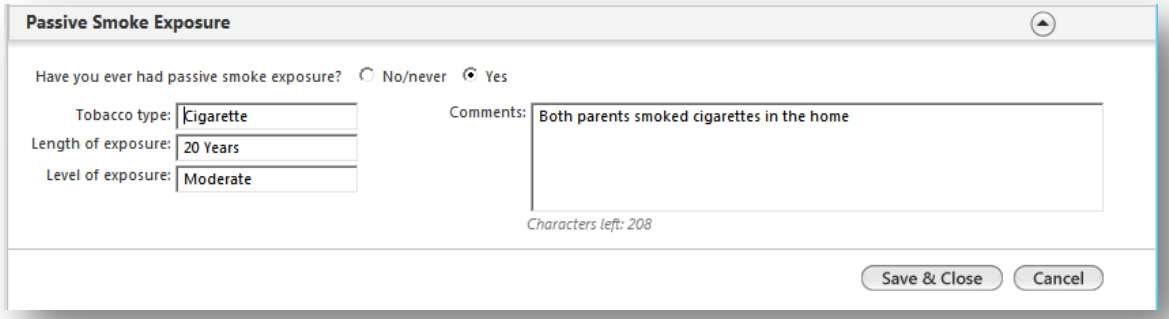
Attempts to quit tobacco use can be documented in the **Efforts to Quit Tobacco.**



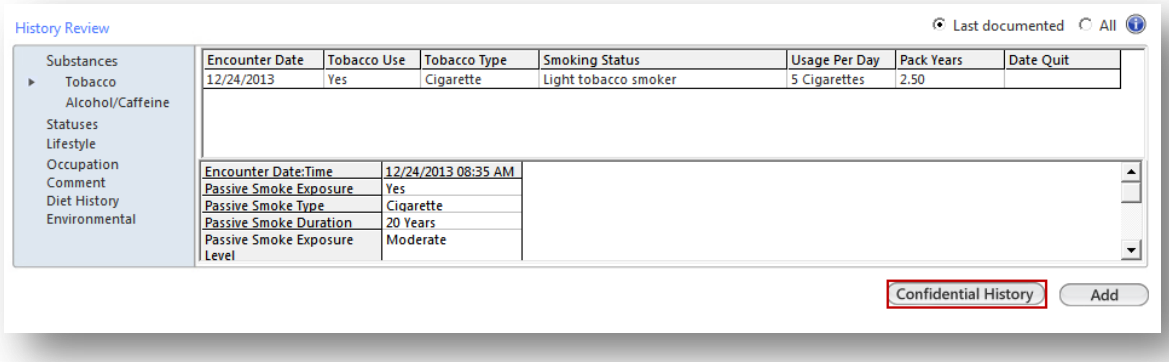
The patient's documented tobacco use can be viewed in the **Historical Use** panel.



Use the **Passive Smoke Exposure** panel to document exposure.



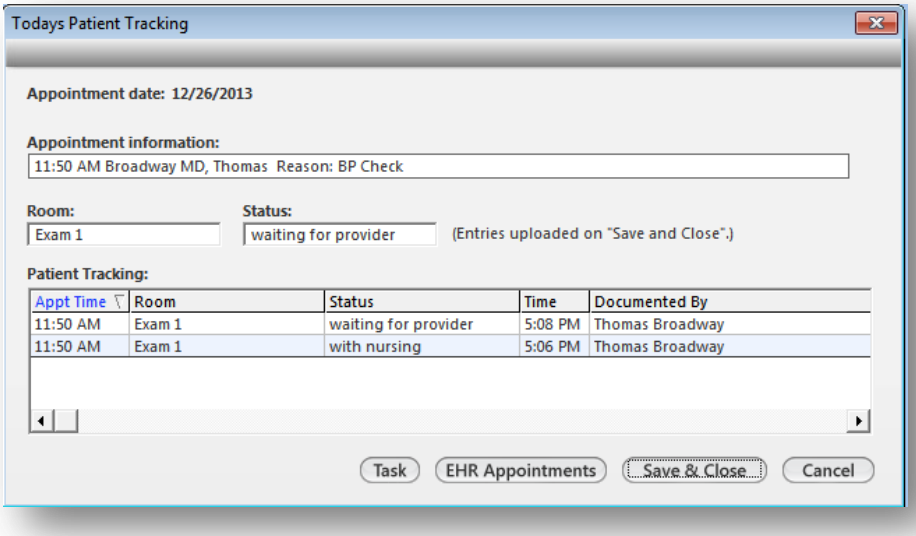
Access additional social histories from the left navigation bar in the same manner. Select ***Save & Close*** to return to the **Histories** template. Selectt the **Confidential History** button to document information such as abuse, incarceration and alcohol/drug dependence

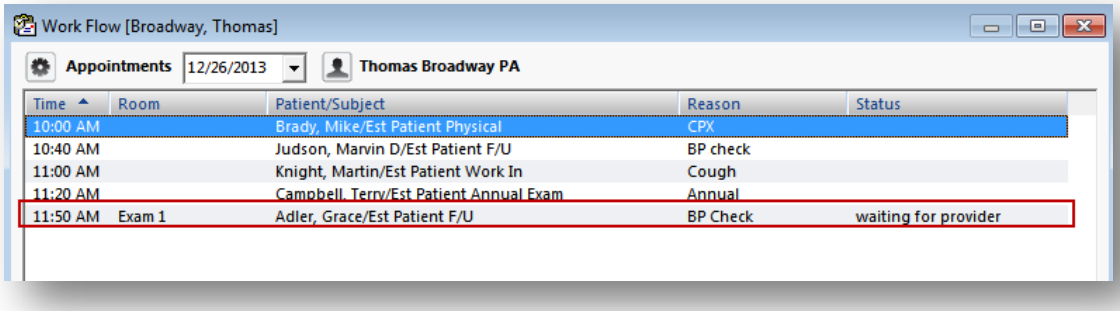


Concluding the Visit

Patient Tracking

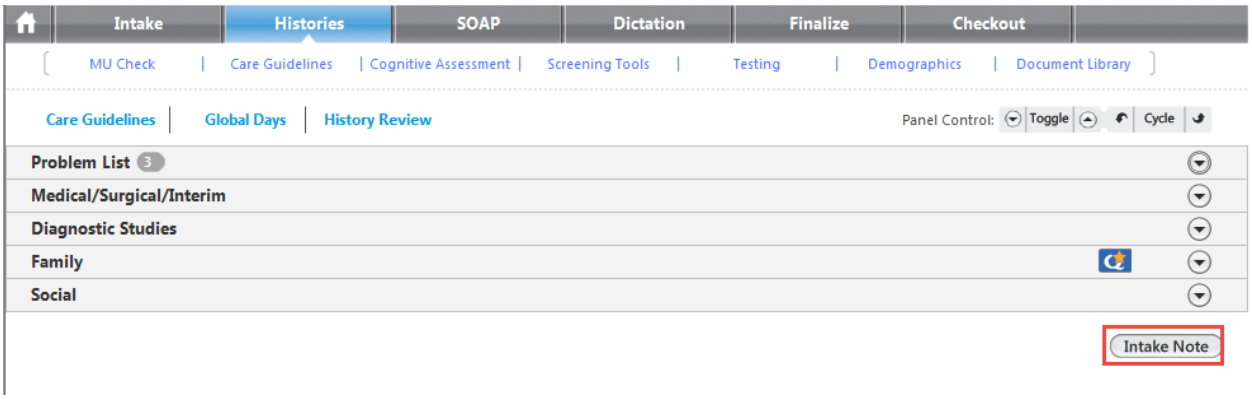
Update ***Patient Tracking*** to an appropriate status.





Intake Note

Generate the intake note by select the ***Intake Note*** button at the bottom of the template. This will generate a document of all information that has been entered so far.



PATIENT: Gor Zz
DATE OF BIRTH: 11/11/1960
DATE: 12/05/2014 8:26 AM
VISIT TYPE:

General
Start time: 9:00 am
End time: 10:00 am
Total minutes: 01 hours, 00 minutes

Presenting Concerns
Reason for visit *(Note Symptoms, Presenting Problem, Behavioral and Functional Needs)*:
Client's counselor from school said that this client is socially isolated and wanted him to have counseling.

Living Situation
Where is the individual currently living?
Patient lives in Foster care home.

Comments:
Parents are in jail and he is currently in and out of foster care.

Family Information
Does the individual have children?
Has children:

Family health history:

Relation	Name	Deceased	Death Age	Condition	Onset Age	COD
Daughter				Alcoholism	29	Y

This concludes the **Clinical Workflow** for clinical staff. The remaining of the manual will cover different types of visits, HPIs, telephone calls, etc.

Medicare Preventive Exam HPI Template

Summary

This guide describes the use of the **Preventive Exam HPI** template to document both the initial **Welcome to Medicare Exam** and subsequent **Annual Wellness Visits**. It differs from most HPI templates in the way that it can be used for risk assessment and plan creation.

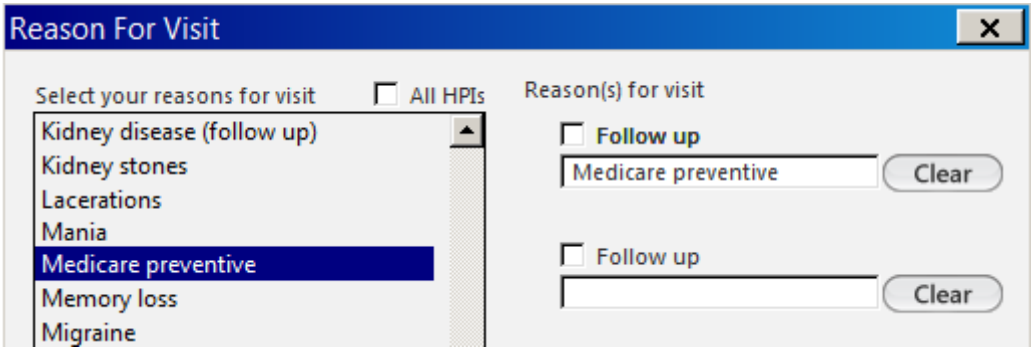
Visit Details

The **Medicare Preventive** template is designed to be used in addition to the **Intake** and **SOAP** templates. Visit details should be chosen according to your present method.

- Choose the Family Practice **or** Internal Medicine specialty.
- Choose the **Medicare Preventive** visit type.
- Select the **Intake** or **SOAP** template according to normal staff/provider workflow

Reason for Visit Panel

The **Medicare Preventive** template is listed among HPI templates under the **Reason for Visit** panel. If not listed among the links on the left, select **Additional/Manage** to select the template.

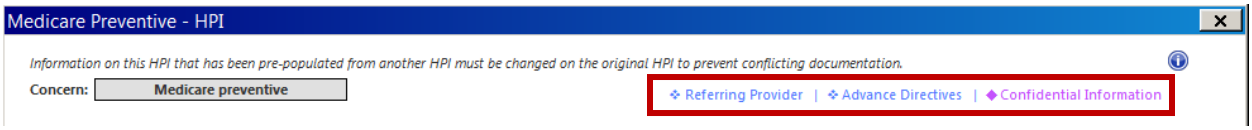


Medicare Preventative Template

The **Medicare Preventive** template gathers necessary screening and risk reduction tools into one location.

Quick Links

Use the quick links at the top right of the template to document the following information.

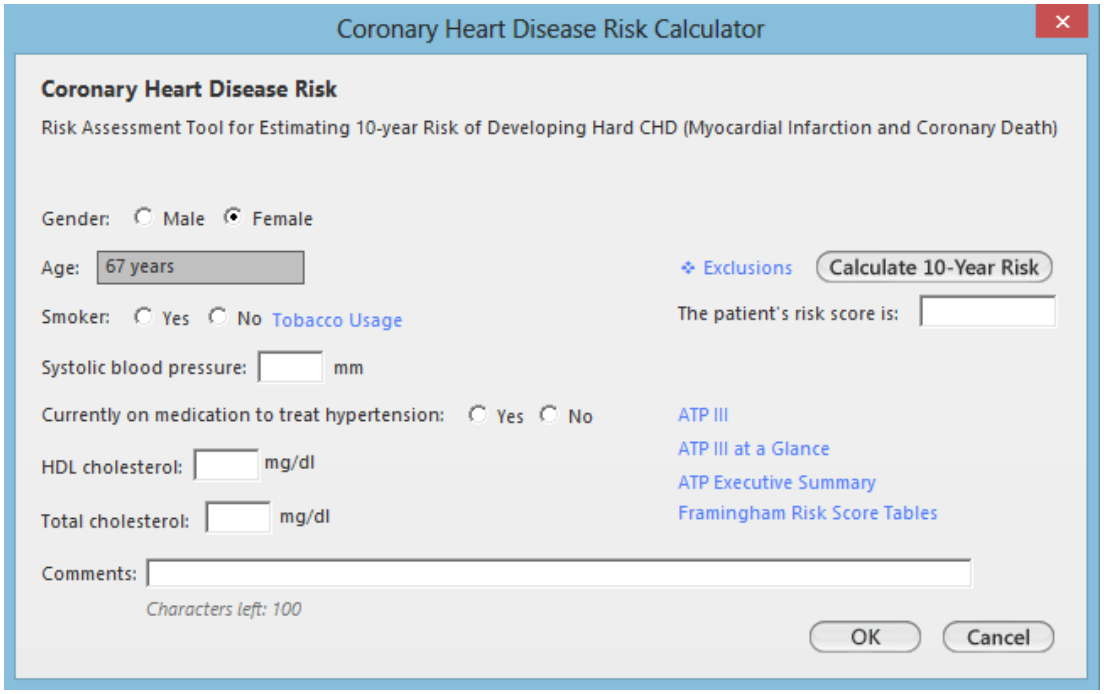


- Referring Providers record a patient's current providers for Medicare visits.
  - Verify **PCP**
  - Select the checkbox to ***Include in Document***
- Enter or verify **other providers** actively involved in the patient's care. The use of the **Care Coordination** template is required to document agencies and Interdisciplinary tems for the patient (instructions available in Care Coordination section)
  - Select the checkbox to ***Include in Document***

- **Advanced Directives** offer written or verbal instruction regarding the patient's ability to create an Advanced Directive and the provider's willingness to abide by the directives. This should be documented during the **Welcome to Medicare** visit.
  - Enter the *date reviewed*.
  - Enter or verify the details of the directive including *effective date*, type of *documents*, *location of documents*, and the *directives on file*.
  - Specify the *type of verification* performed.
  - Indicate the *status* of the review.
  - Type *comments* as necessary

- **Confidential Information** discuss history of alcohol and illicit drug use for the **Welcome to Medicare** visit, and review as necessary for risk assessment.

- **Framingham Risk Score** is used when necessary during initial and annual visits to assess the patient's risk of heart disease. This tool is not available for patients with a current diagnosis of diabetes or CHD.
  - Update information when necessary by selecting the links for:
    - Tobacco Usage
    - Hypertension medication use
    - Exclusions
    - Missing/scanned laboratory results
  - Select ***Calculate 10 Year Risk*** button
  - Evaluate using reference links and ***Comments*** field as necessary:

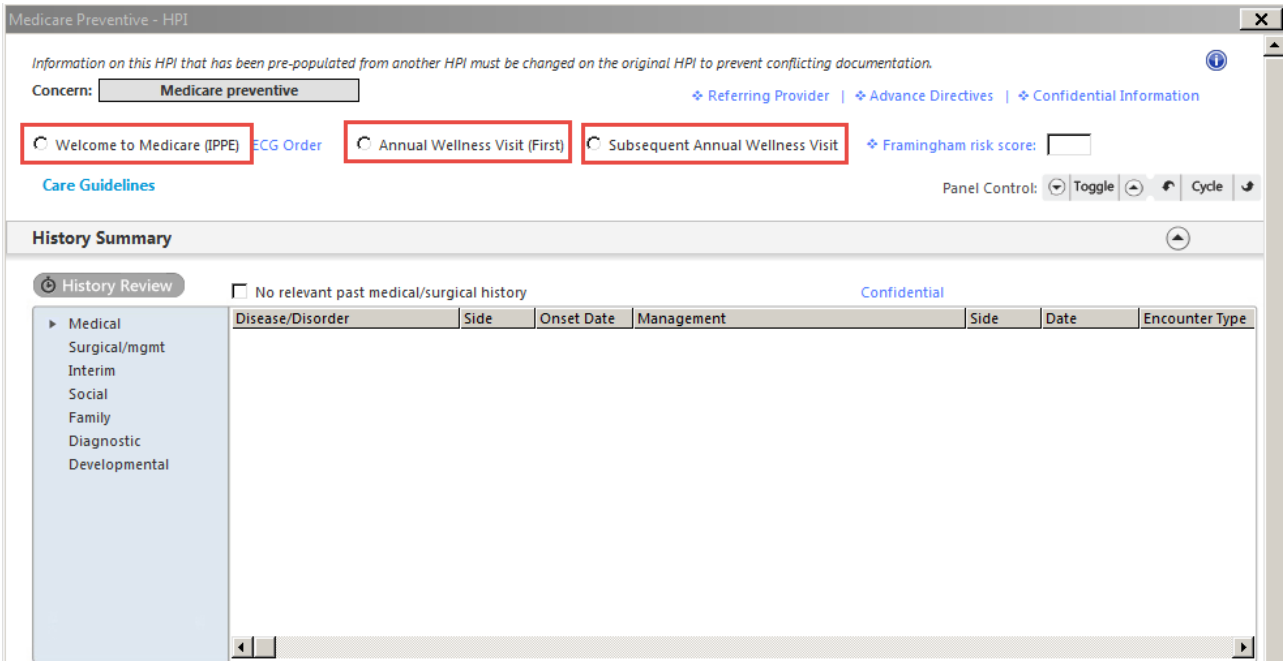


Type of Exam

The Medicare Preventative HPI requires that the end user select what type of preventative exam is scheduled.

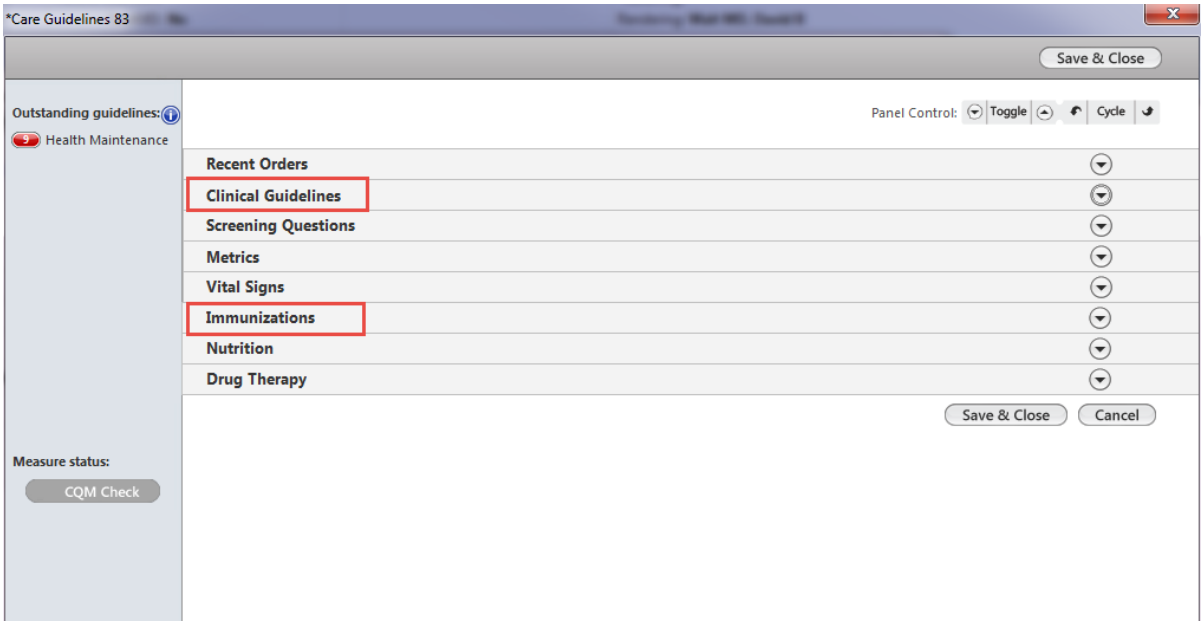
Welcome to Medicare Selected when the patient is new to Medicare

- Annual Wellness Visit Selected when the patient is scheduled for his/her first annual physical with Medicare (this would be if the patient was an existing Medicare patient prior to CMS providing preventative care)
- Subsequent Annual Wellness Visit Selected when the patient is scheduled for his/her subsequent annual physicals.



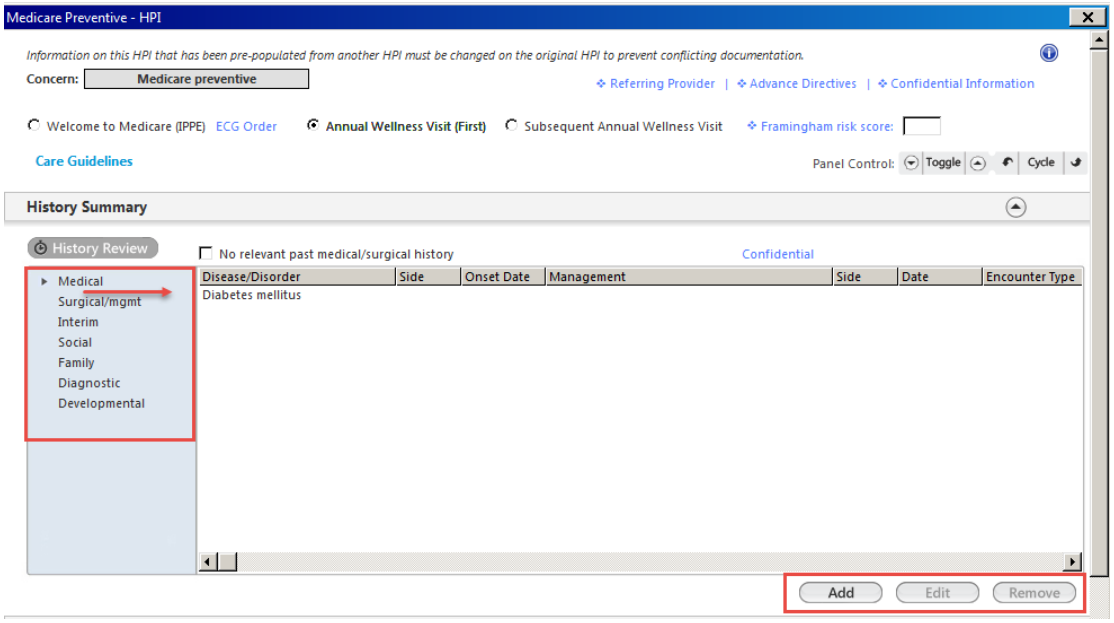
Care Guidelines

Utilize the link for **Care Guidelines** to review a variety of information for the Medicare exam and to create Medicare's goal of a schedule/checklist of care for the patient.



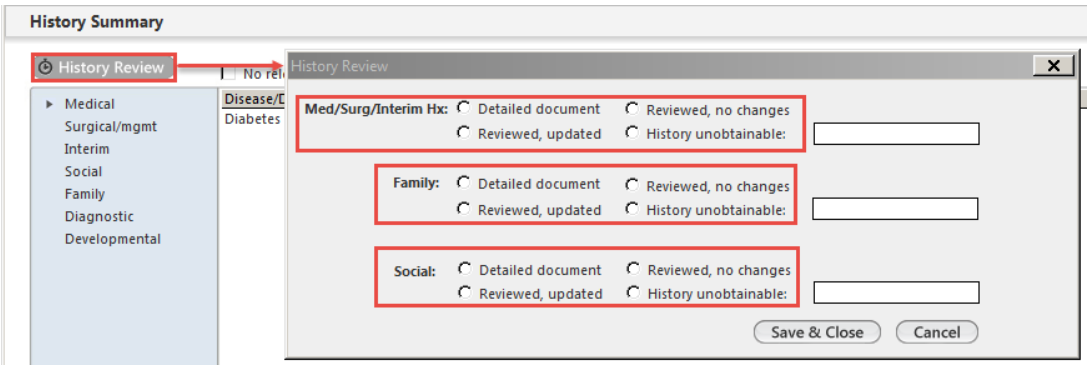
History Summary Panel

This panel reflects **any Medical, Interim, Social, Family, Diagnostic** or **Developmental** history of the patient. To add or edit the history of the patient, the end user will select the appropriate history from the blue side bar and then select the **Add, Edit** or **Remove** button at the bottom of the grid.



Once the end user has reviewed all histories, select the **History Review** button. Here you will indicate the reviewing action of the provider. Note that the **History Review** is a bullet for coding purposes.

- Detailed Document will reflect all documented histories in the document.
- Reviewed, updated will reflect only that the histories were reviewed and updated.
- Reviewed, no changes will reflect only that histories were reviewed and no changes occurred.
- History unobtainable will reflect only that the histories were unobtainable.

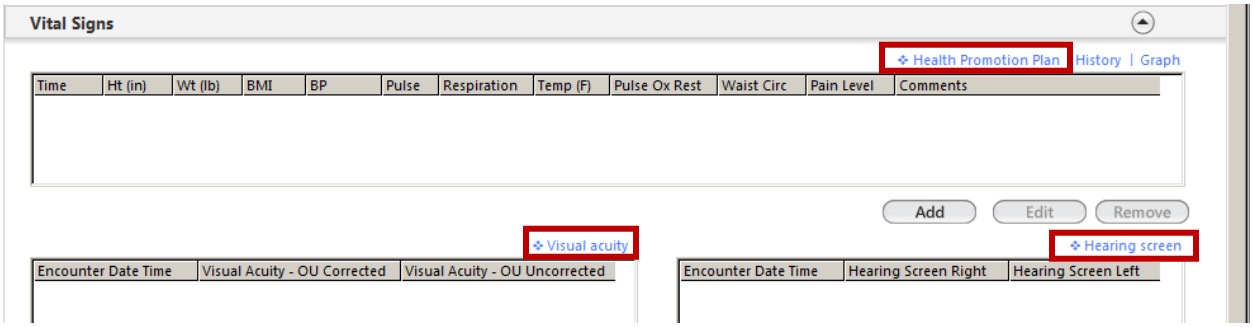


Vital Signs Panel

Specific vital signs (below) must be captured at all visits. In addition, vision and hearing tests are offered at the Welcome visit.

- Enter height, weight, and blood pressure for all preventive visits.
  - Ensure that height ***measured today*** is selected.
  - BMI automatically calculates to meet the requirement.
  - Other measurements may be captured as appropriate.

- For **Welcome to Medicare** visits, use the links provided for vision and hearing testing.
  - Note that these templates allow the saving and reuse of documentation.

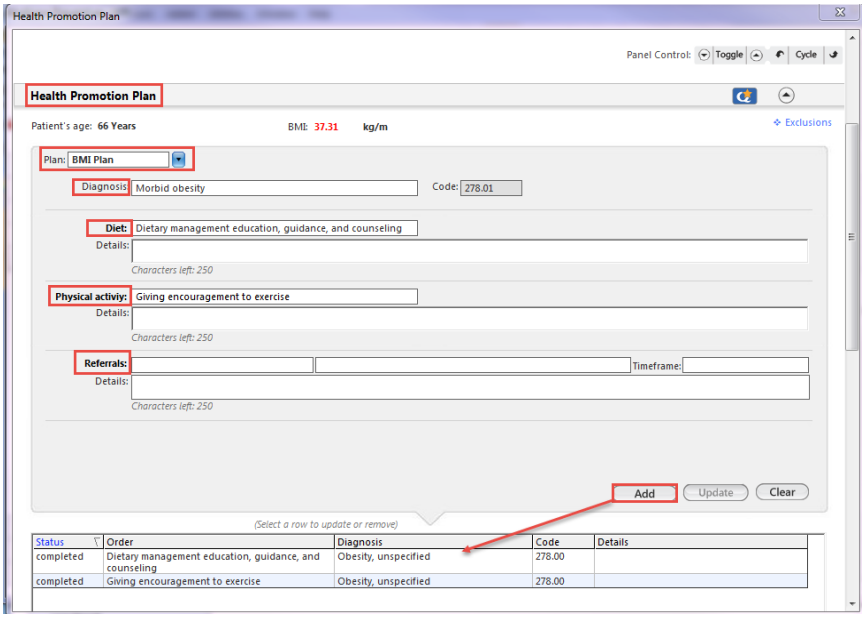


Providers can create personalized plans based on recorded measurements by utilizing the ***Health Promotion Plan*** link. See below for details.

The **Health Promotion Plan** template is accessible from the **Vital Signs** and **Cognitive Assessment** panels. It can also be accessed via the **Fall Risk Plan** in the **Functional Ability** *panel*. This allows providers to evaluate and counsel the patient efficiently without leaving the HPI template. It also facilitates an easier entry of referral orders.

Select a saved plan by using the Quick Load button  to the top right. Or, add a new plan by completing the following steps.

- Select a ***Plan*** type (BMI, Depression, or Hypertension).
- Enter a ***Diagnosis***.
- For each section, select an *order* from a pick list.
- Add ***Details*** into the fields below, as necessary. Note character limits.
- Save the plan if desired.
- Select ***Add*** when complete.
- Repeat to enter an additional plan.

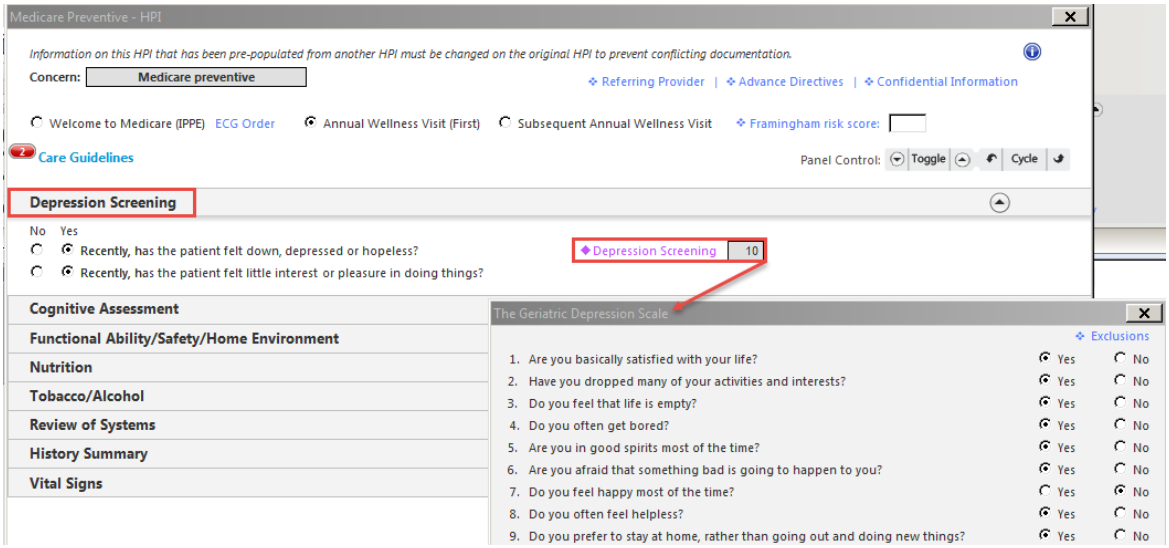


Depression Screen Panel

Patients are to be screened at the **Welcome to Medicare** visit for potential risk for depression using a standard screening tool. This step is unnecessary if a current diagnosis of depression exists in the chart.

- Ask the patient the two questions in the panel.
- If either answer is positive, select the ***Depression Screening*** link.
  - Continue to ask questions using the screening tool.
  - A score will calculate automatically.
  - Select ***Save and Close***.

Note: Depression plans and referrals can be created from the next section, **Cognitive Assessment.**

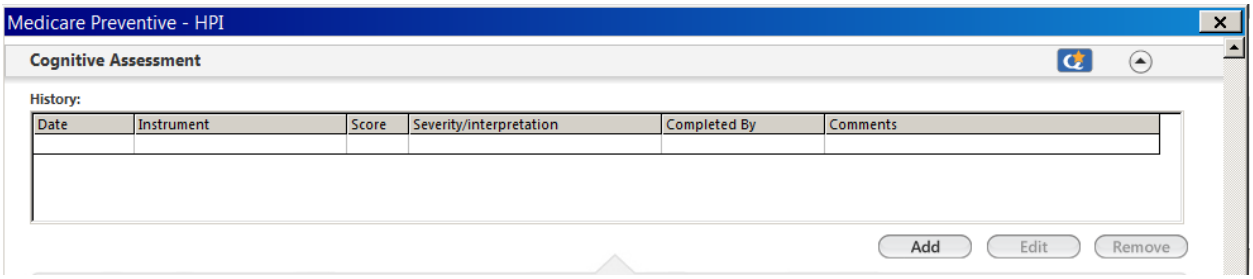


Cognitive Assessment Panel

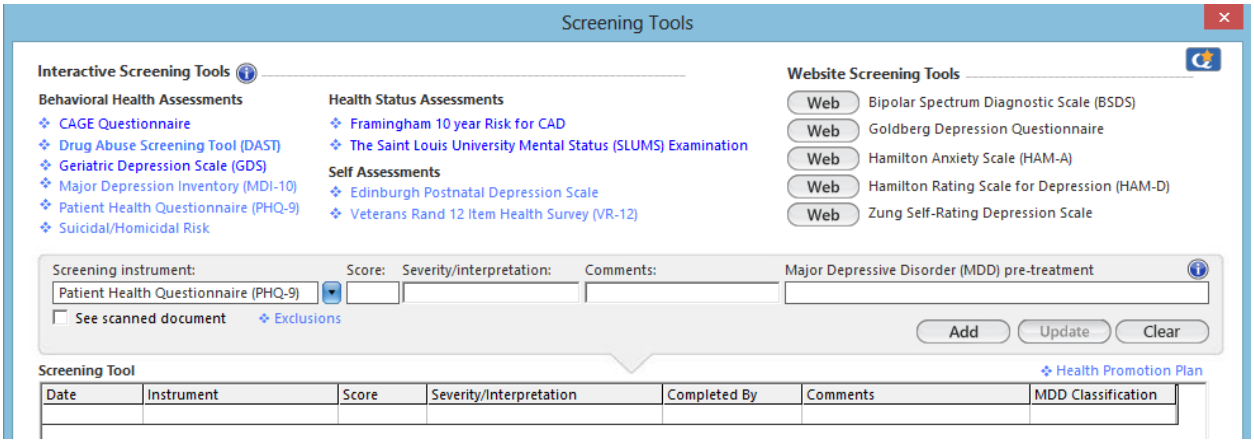
Detection of cognitive impairment is a yearly benefit to Medicare patients at annual wellness visits. In addition, the **Cognitive Assessment** section contains links to additional screenings and the **Health Promotion Plan**, which can be used to create a depression plan or referral.

The St. Louis University Mental Status tool displays automatically.

- To access all **Screening Tools**, select the ***Add*** button.

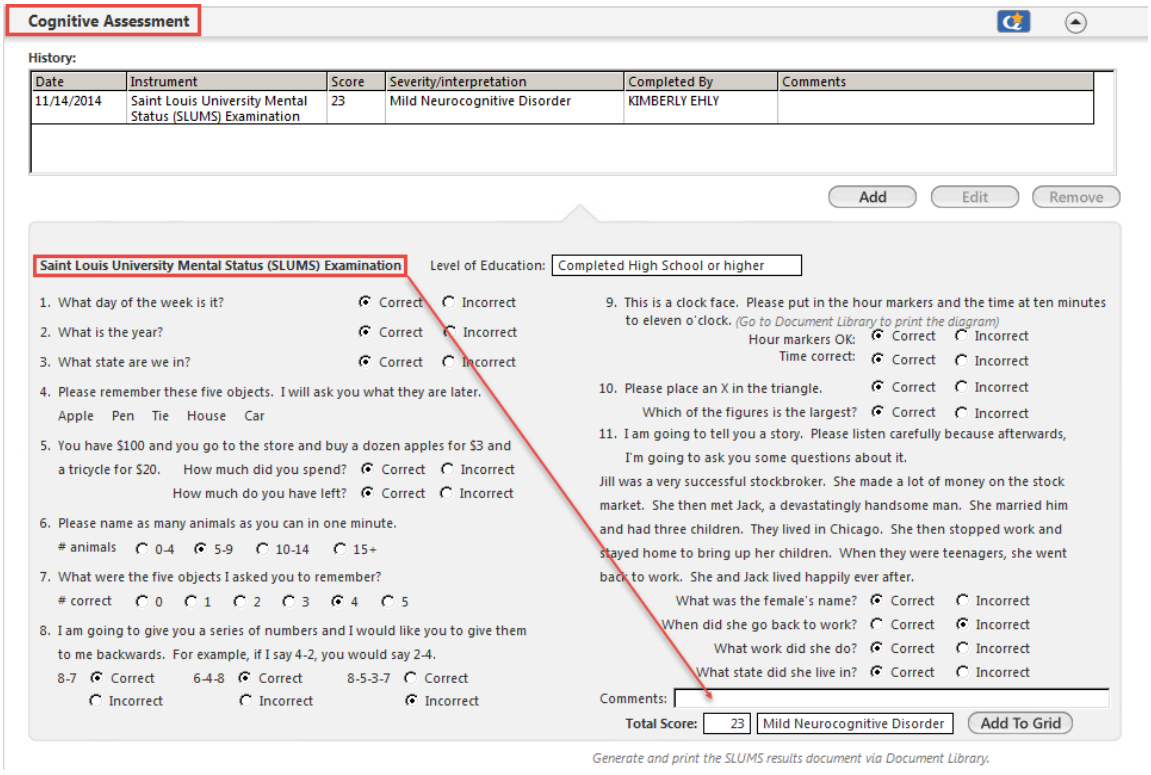


- Select the screening tool to launch the associated template.
  - Details from the template then populate the Screening Instrument Section.
- Select ***Add*** to save the results to the grid.
- To create a plan based on the results, select on ***Health Promotion Plan***.

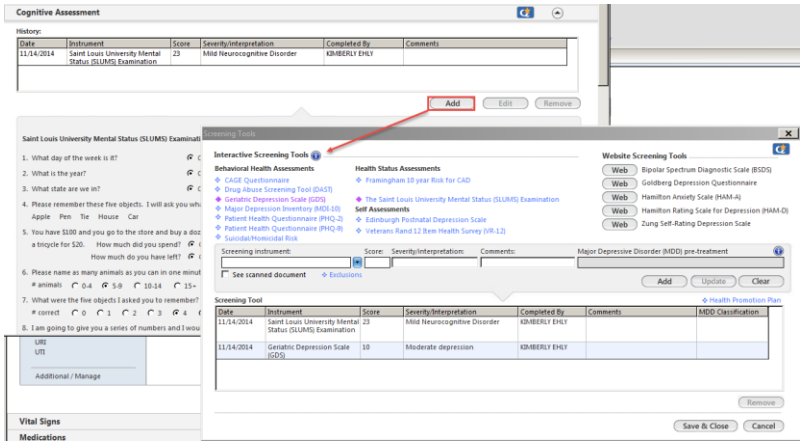


To use the **St Louis University Mental Status** Examination:

- Pre-print one or more of the SLUMS diagram(s) from the Document Library.
- Select the patient's ***level of education***.
- Ask the patient the questions provided, and select either ***correct* or *incorrect*** after each.
- To ask questions 9 and 10, provide the patient with a copy of the diagram.
- Select ***Add to Grid*** when complete.
- The results from this template can be printed from the ***Document Library*** by selecting the appropriate ***SLUMS Results*** option.

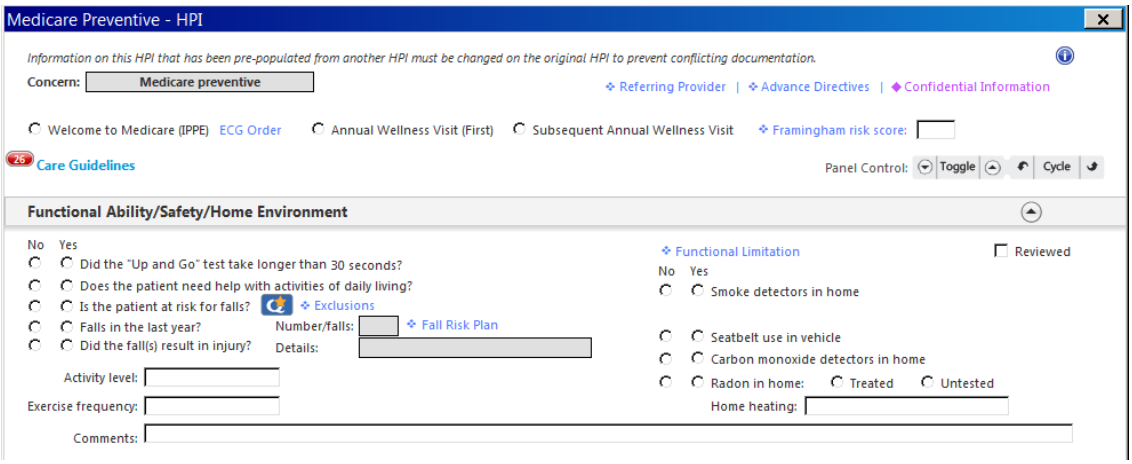


To access the other **Interactive Screening Tools**, the user can select the ***Add*** button.

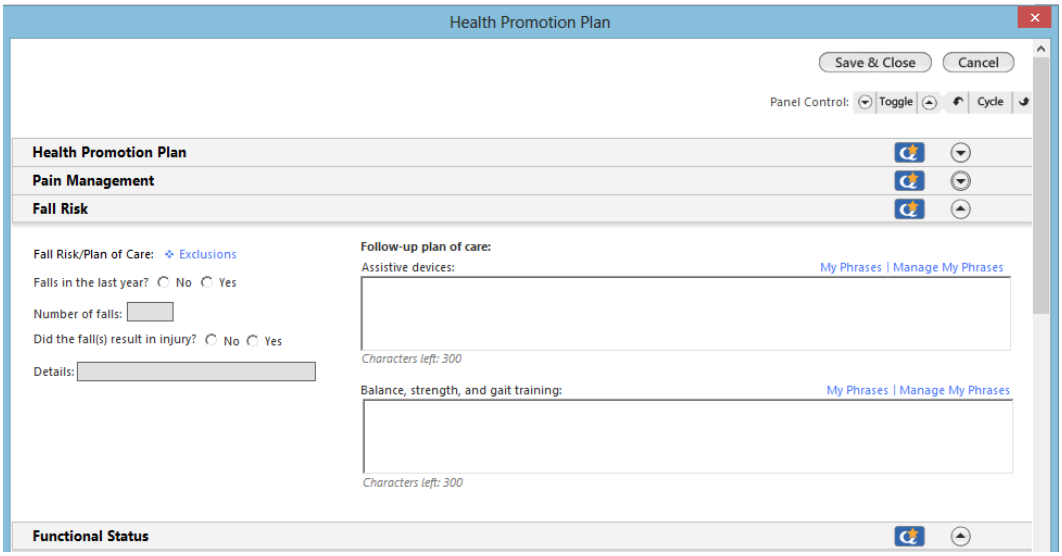


Functinal Ability/Safety/Home Environment Panel

Medicare patients are evaluated for functional ability, home safety, fall risk, and activities of daily living during the **Welcome to Medicare** visit. Risks are reviewed and updated at annual visits.



- Utilize clinical/medical training to evaluate and document items such as the “Up and Go” test, the patient’s comfort with activities of daily living, and risk for falls.
  - Use the **Functional Limits** link to evaluate the patient’s ability to perform various activities.
    - Select the ***No*** and ***Yes*** radio buttons to document, along with pick lists and the ***Comments*** field as necessary.
- Select ***Reviewed*** when complete.
- To create a risk reduction plan from this template, use the **Fall Risk Plan** template.
  - Free-text plans or **My Phrases** can be entered into the **Fall Risk** section for assistive devices and physical therapy.
  - The **Health Promotion Plan, Pain Management**, and **Functional Status** panels are also accessible if necessary.

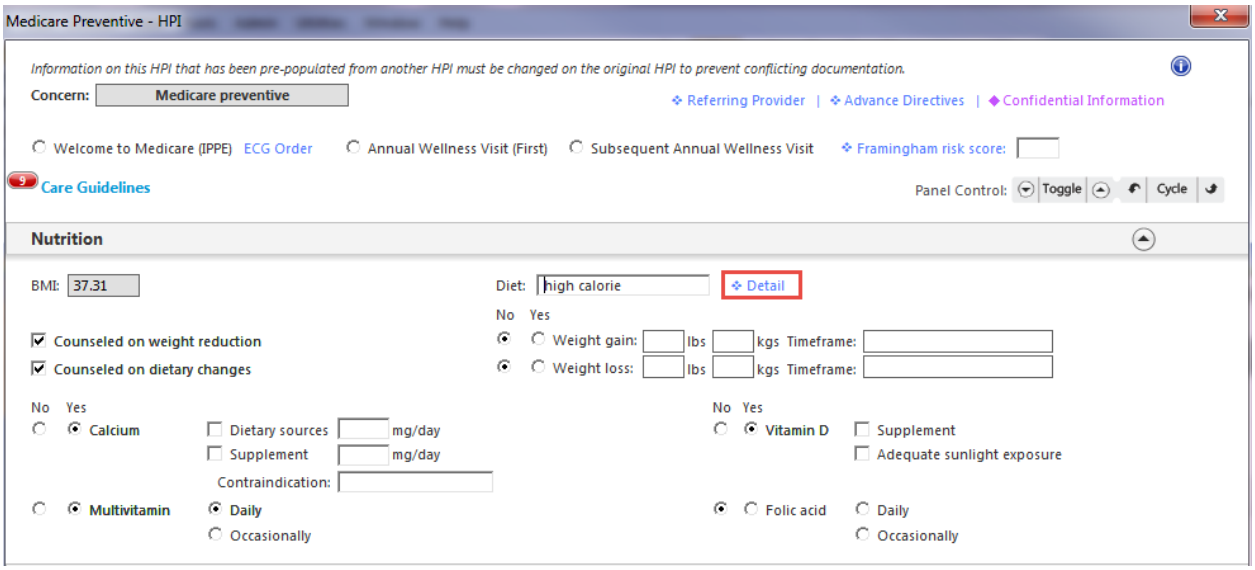


Nutrition Panel

Patients are entitled to education and counseling based on risk assessments and services, particularly during a **Welcome to Medicare** visit**. Medical Nutrition Therapy** is a benefit as deemed necessary. After reviewing the patient's diet (available in the **History Summary** panel), the **Nutrition** template can be used to document nutrition counseling.

To use this template,

- Document the dietary changes discussed with the patient.
- Standard diet recommendations can be selected by selecting into the field beside **Diet**.
- Additional counseling documentation, such as materials provided and patient barriers, can be entered by selecting ***Details***.

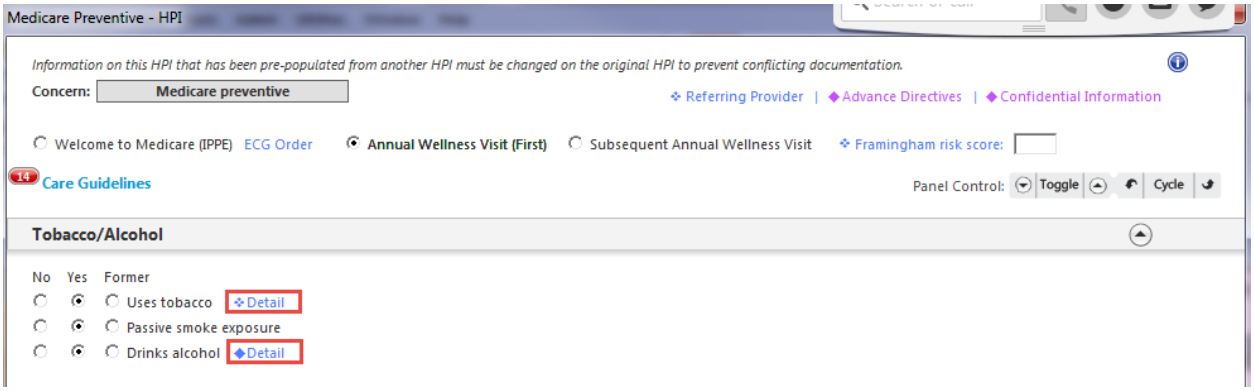


Tobacco/Alcohol Panel

Tobacco and alcohol usage is to be evaluated during the **Welcome to Medicare** visit, and is a component of various risk assessments at annual visits.

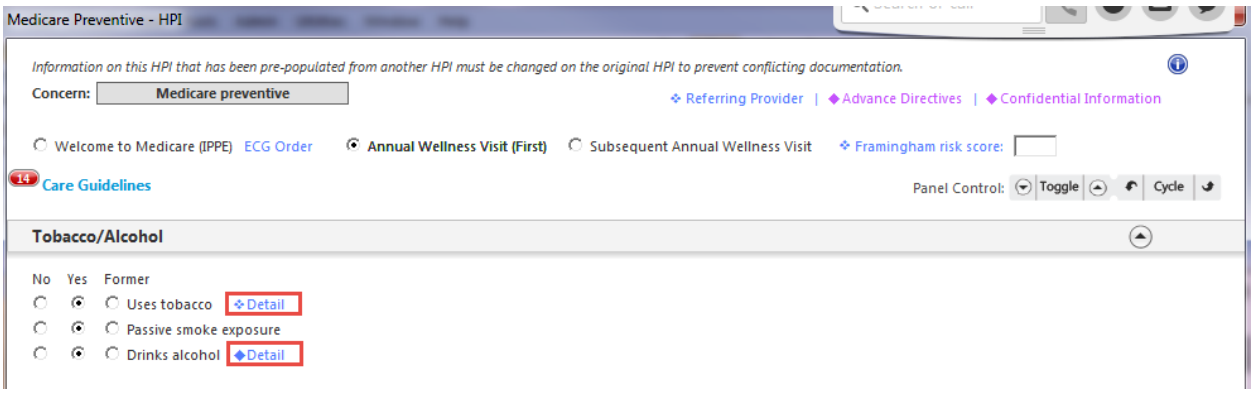
To use this template

- Select the radio buttons for No, Yes, or Former as appropriate for the three questions.
- To provide additional information, select the Details links.
  - The appropriate social history templates are launched for entering new information.



Review of Systems Panel

The last panel is **Review of Systems**. The user will document the current ROS of the patient by using the **One Page ROS** or documenting within each system. The ROS will carry forward into the **SOAP** template.



Once completed with all documentation, the user will select the ***Save & Close*** button and finish with the rest of the visit.

Clinical staff should utilize the remaining panels of the **Intake** template for activities such as reconciling medications, updating allergies, and administering or updating orders. When complete, the ***Intake Note*** should be generated.

Providers should utilize the remaining panels of the **SOAP** template for activities such as updating or adding medications, entering orders, and creating additional plans. When complete, the ***Master Document*** should be generated.

Providing a **Patient Plan** for this visit is essential.

Telephone Call

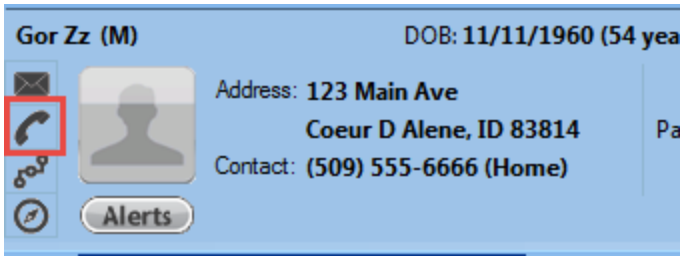
Summary

The **Telephone Call** template is used to document patient encounters outside of a visit. This can include incoming and outgoing calls as well as patients walking in requesting to speak to a nurse. The person who is the first line of contact is responsible for initiating the **Telephone Call** template. The template is then sent to the appropriate person via tasking

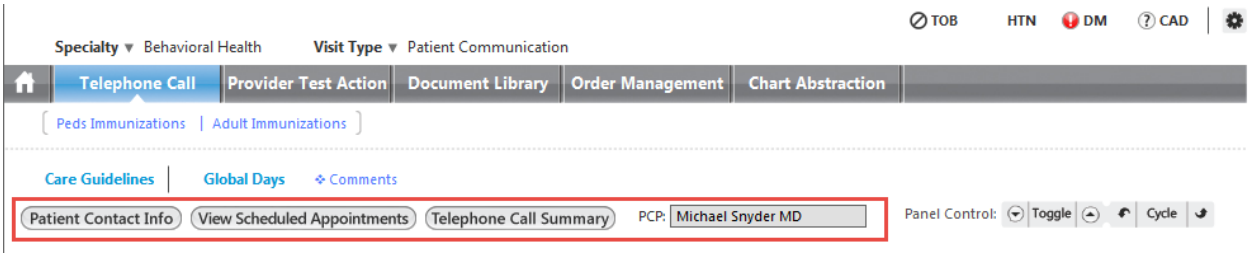
Launching the template

To launch the **Telephone Call** template you must have the patient's chart open.

- Create a new encounter by selecting the ***New*** button on the **History Toolbar.**
- Peform a 4 Point check
- Select the ***Telephone Icon*** on the **Patient Information Bar.**



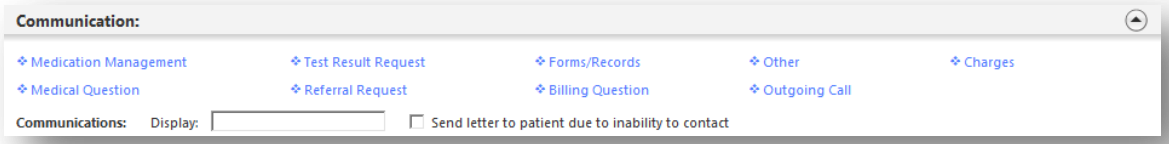
Patient Contact Information will reflect patient's contact information and is read only.
Scheduled Appointments will reflect patient's past and future appointments.
Telephone Call Summary will reflect a summary of all calls documented on patient's chart.
PCP will reflect the documented Primary Care Provider.



Communication Panel

The communication section allows users to choose the appropriate call detail template to document the details of the call. Detail templates are:

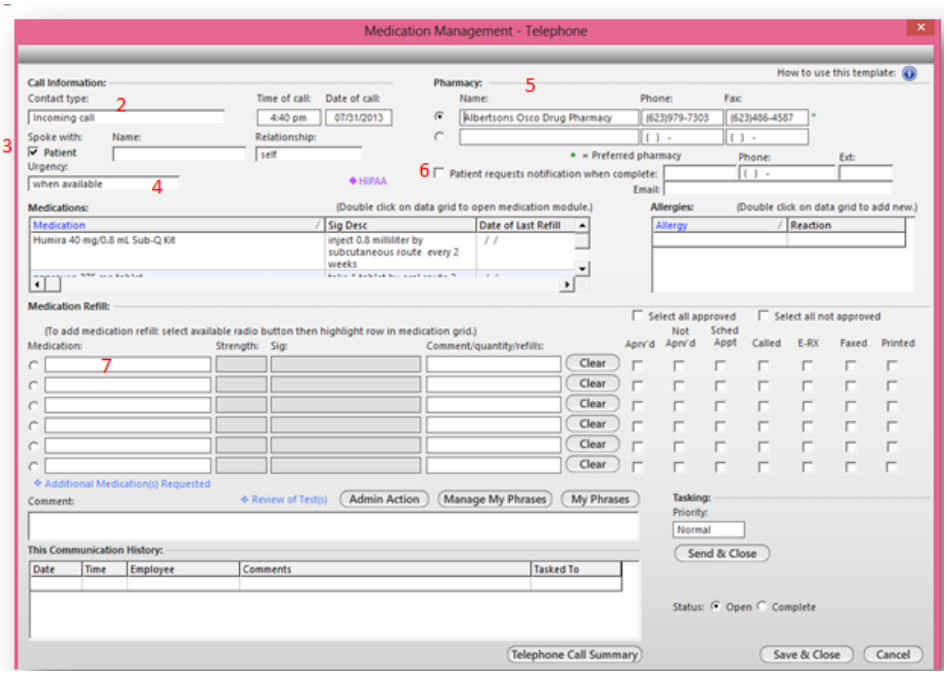
- Medication Management
- Medical Question
- Test Result Request
- Referral Request
- Form/Records
- Billing Questions
- Other
- Outgoing Call
- Charges



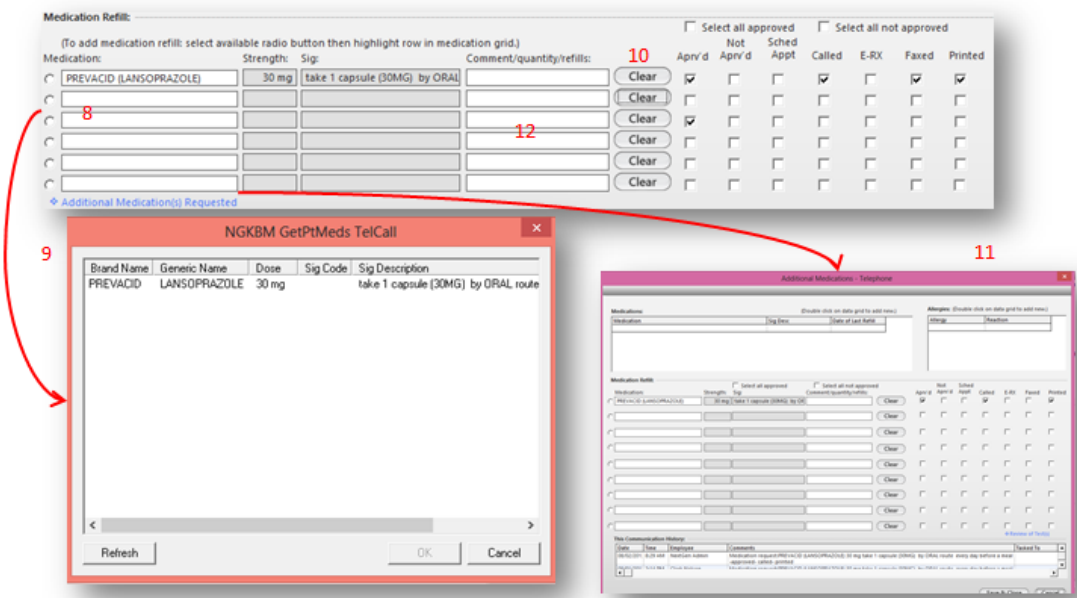
Medication Management is used to document refill requests. To document the request:

- Select on the ***Medication Management*** link under communications to open the call detail template (1)
- Select in the ***Contact type*** field to indicate whether it is an incoming call, voicemail or fax or walk-in. the date & time of the call will populate with the date & time the template was accessed. Select in the field to modify.(2)
- Place a checkmark next to ***Patient*** if you spoke to the patient or select in the ***Name*** field to enter the name of the caller. Select in the ***Relationship*** field to document the relationship the caller has to the patient.(3)

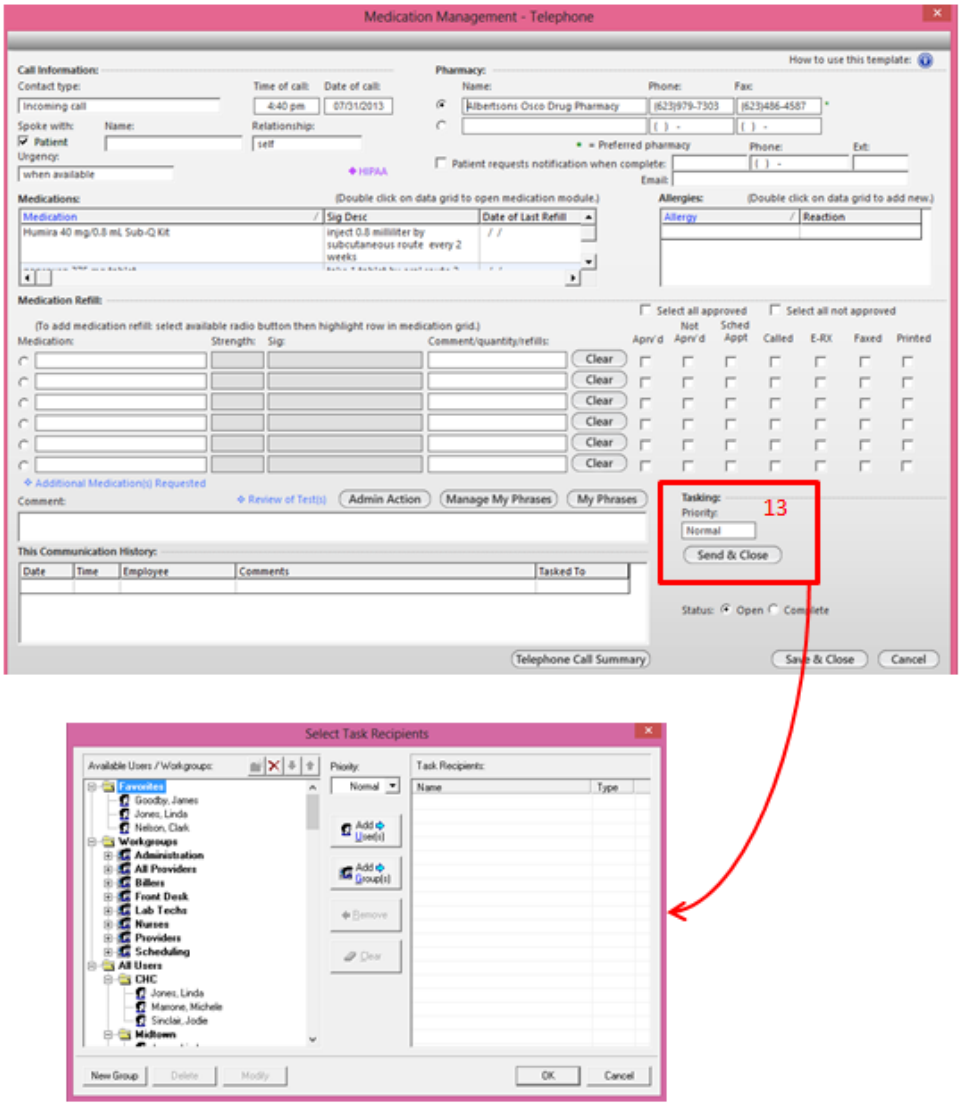
- Select in the ***Urgency*** field to indicate when the patient would like a response.(4)
- If a preferred pharmacy(s) have been entered, they will appear in the ***Pharmacy*** window. Select the radio button next to the pharmacy the patient would like the refill sent to. If no pharmacy is listed, select in the field and search and select the pharmacy.(5)
- Check the box if the patient would like notification when the refill is complete.(6)
- The patient's mediation list is displayed. Select in the grid to open the **Medication Module**.(7)



- Select in the first field for the first medication. This will open a pick list of the patient's active medications. Highlight the medication and select ***OK*****.**(8)

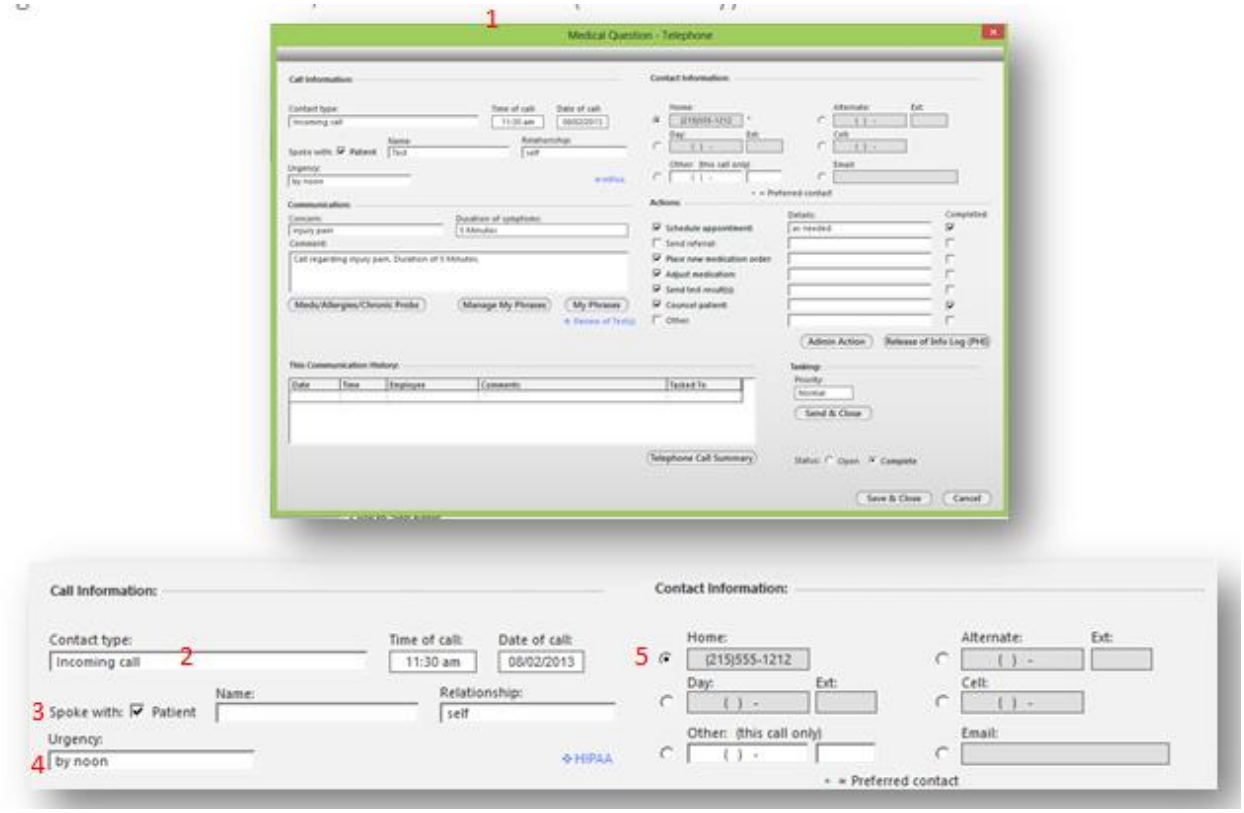


- The field will populate the medication name, strength and sig.(9)
- To remove an entry, select the Clear button.(10)
- Repeat the process in the next field until all medication requests have been entered. If there are more than 6 medications requested, select the ***Additional Medication(s) Requested*** link. This will allow you to add up to 9 additional medications.(11)
- Use the comment field to enter any additional information provided by the patient.(12)
- If further action or approval is required, you may task the request to the appropriate person.(13)
    - Modify the task priority, if necessary
    - Select the ***Send & Close*** button to open the ***Select Task Recipient*** window. Choose the recipient(s) and select ***OK***.
- The **Medication Management** call detail template will close and then you will see the main **Telephone Call** template.(14)

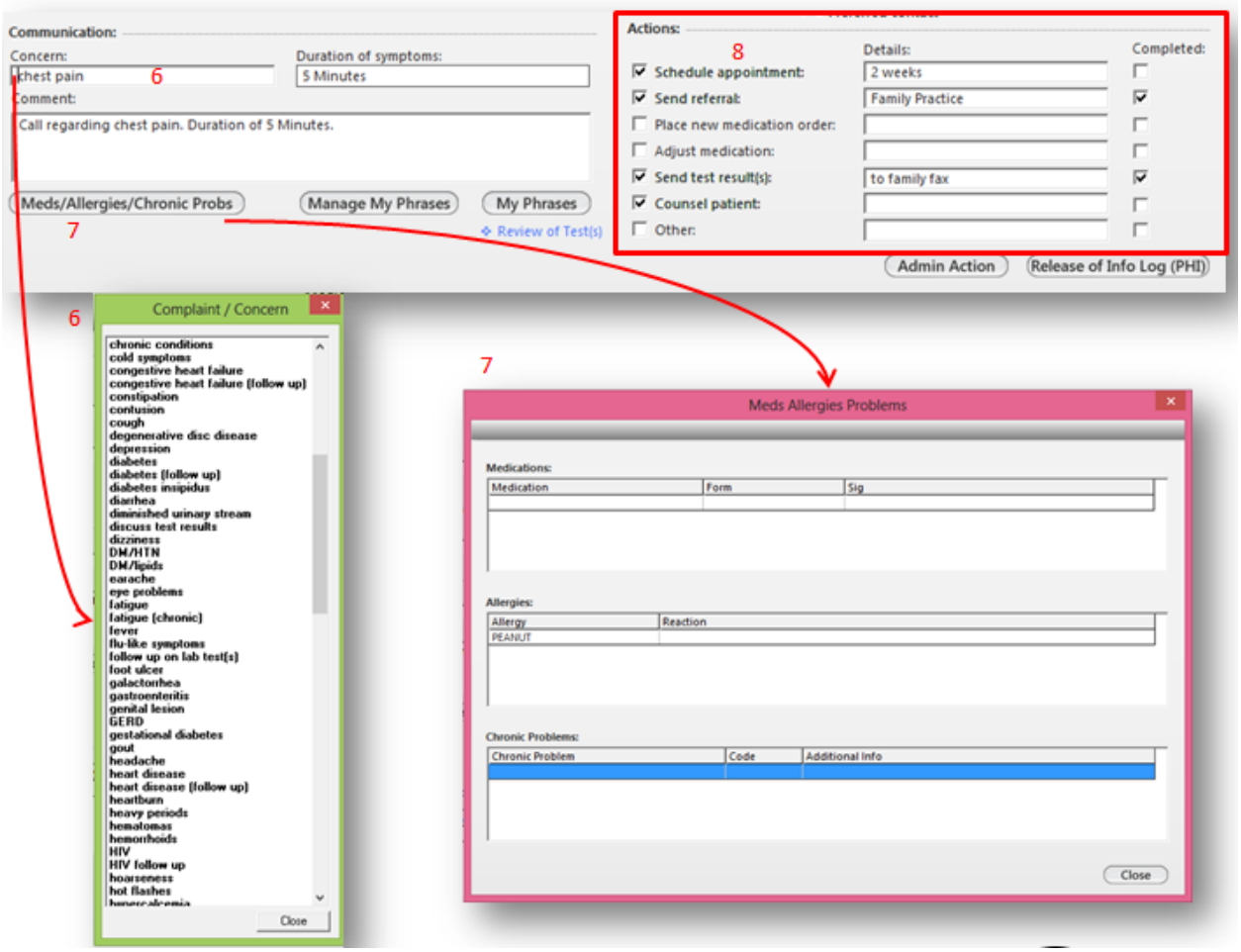


The **Medical Question** is to document any medical questions for the patient. To document:

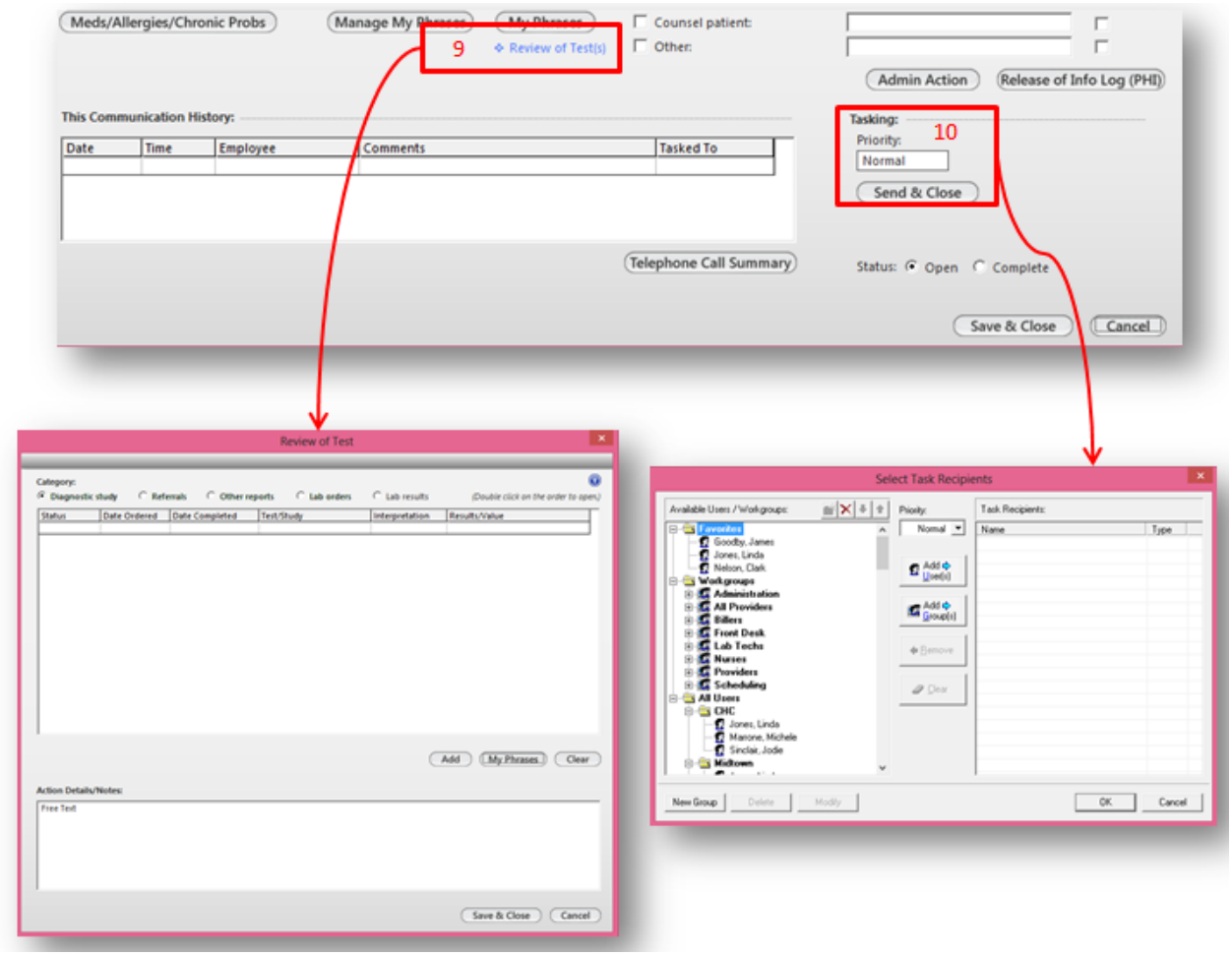
- Select on the ***Medical Question*** link under the **Communications** panel to open the call detail template.(1)
- Select in the ***Contact type*** field to indicate whether it is an incoming call, voicemail or fax or walk-in. the date & time of the call will populate with the date & time the template was accessed. Select in the field to modify.(2)
- Place a checkmark next to Patient if you spoke to the patient or select in the Name field to enter the name of the caller. Select in the Relationship field to document the relationship the caller has to the patient.(3)
- Select in the ***Urgency*** field to indicate when the patient would like a response.(4)
- Select the appropriate radio button to indicate the return contact number.. The phone numbers are populated from EPM and are not editable in EHR. If the caller gave a number not listed, enter it in the **Other**: (this call only) field.(5)



- In the **Communication** field, select in the ***Concern*** field to open a pick list of common complaints/concerns. If the complaint is not listed; close the pick list and type in the field.(6)
    - Select in the ***Duration of symptoms*** field and enter the data. The **Comment**: section will populate the concern and duration. Enter additional information as indicated. Use **My Phrases** to add common phrases available to the logged in user
- Select the ***Meds/Allergies/Chronic Problems*** button to see a summary of these items.(7)
- Use the ***Actions*** section to quickly document common actions and details and allow the staff to note when the action is completed.(8)

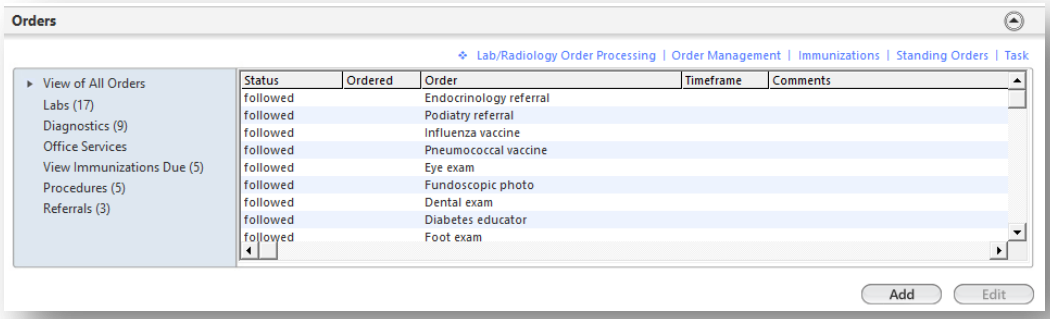


- Select the ***Review of Test(s***) link to review completed test results.(9)
- If further action or approval is required, you may task the request to the appropriate person. Modify the task priority, if necessary.(10)
- Select the ***Send & Close*** button to open the **Select Task Recipient** window. Choose the recipient(s) and select ***OK*.**
- The **Medical Question** detail template will close and then you will see the main **Telephone Call** template.



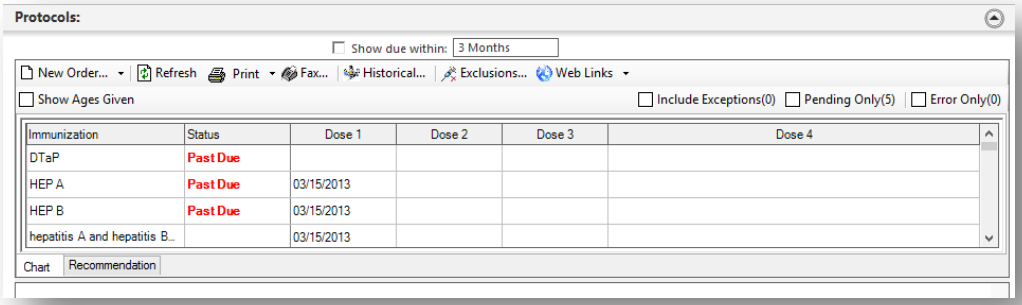
Orders Panel

Allows you to view the patient's orders and add an order by selecting ***Add.***



Protocols Panel

Displays any health maintenance or disease management testing that is due.



Office Services

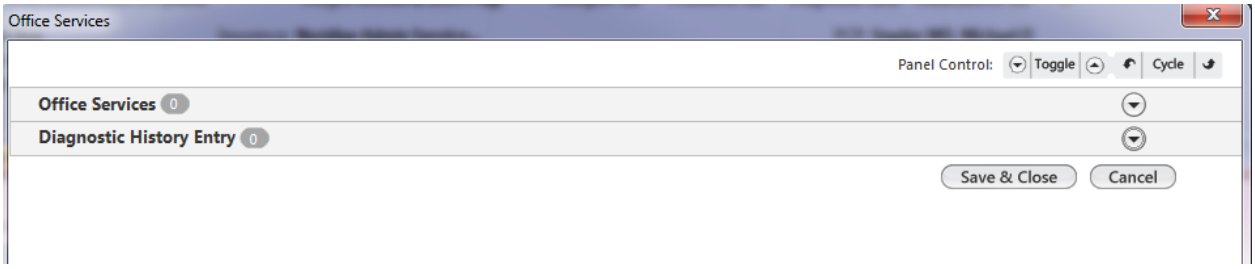
Summary

The **Office Services** is used to order, result and bill for office tests, office medications, office procedures and office supplies as **Standing Orders**. It is also used to document historical diagnostic tests on the patient. It is located on several templates as a sub navigation link. It is also located on the **Intake** template and **SOAP** under the **Office Diagnostics** button.

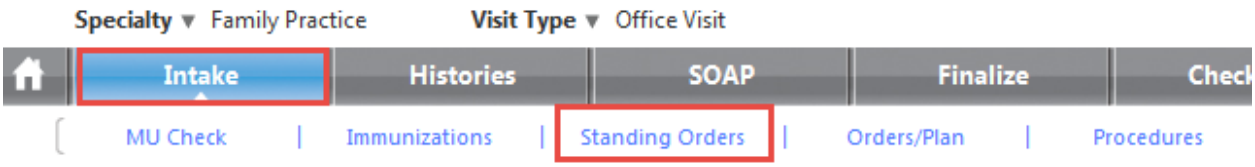
Launching Office Services

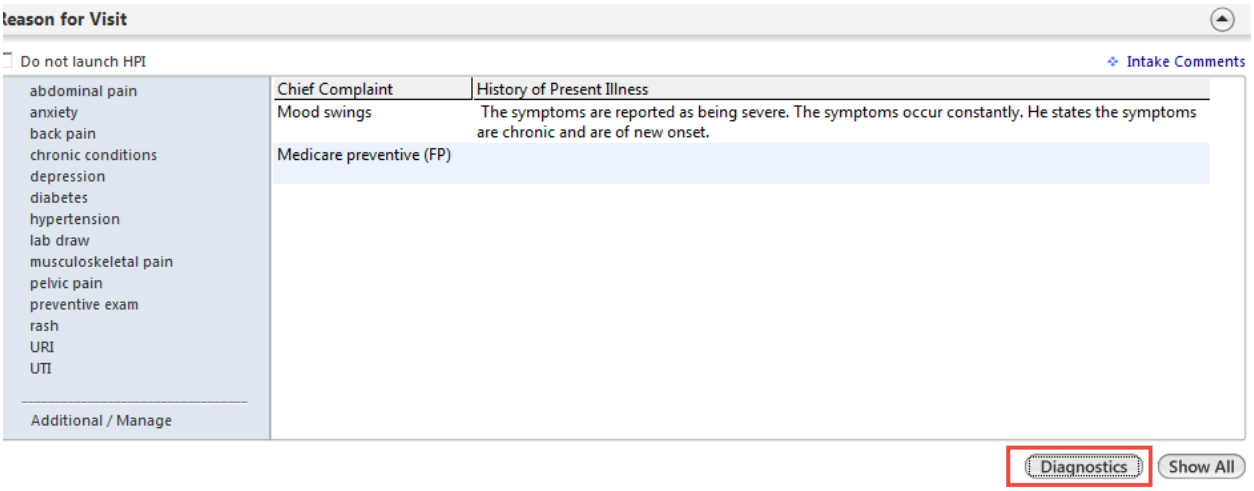
There are two panels on this pop up.

- Office Services
- Diagnostic History Entry



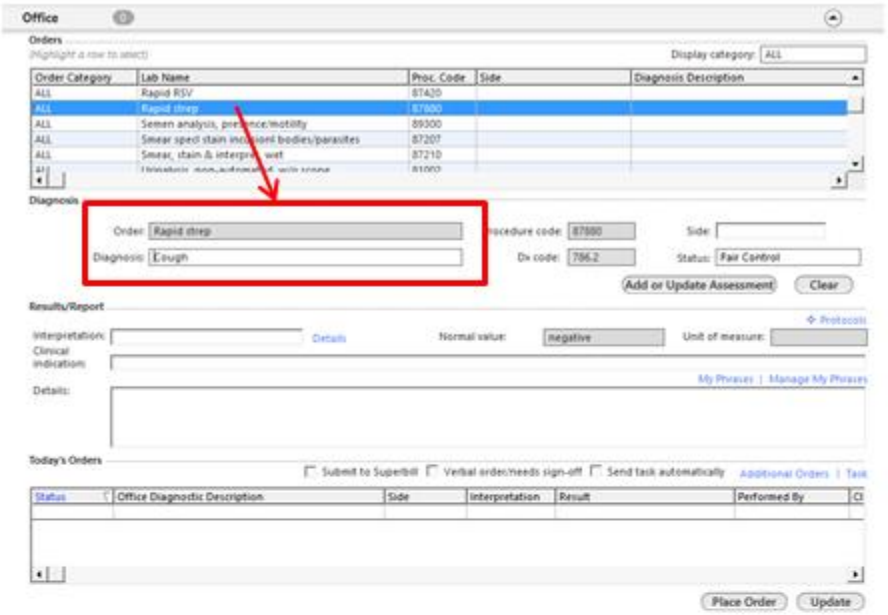
Select the ***Standing Orders*** link or ***Office Diagnostics*** button to launch the **Office Service.**

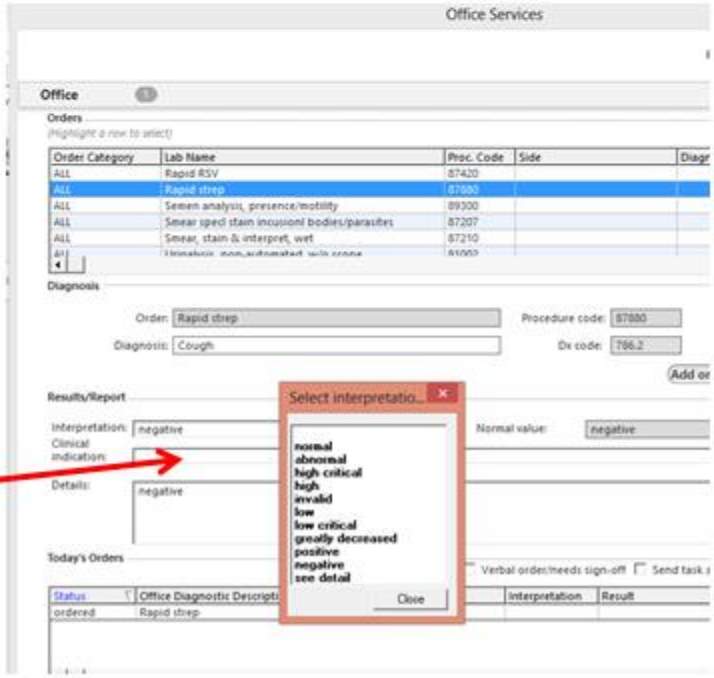




Office Services Panel

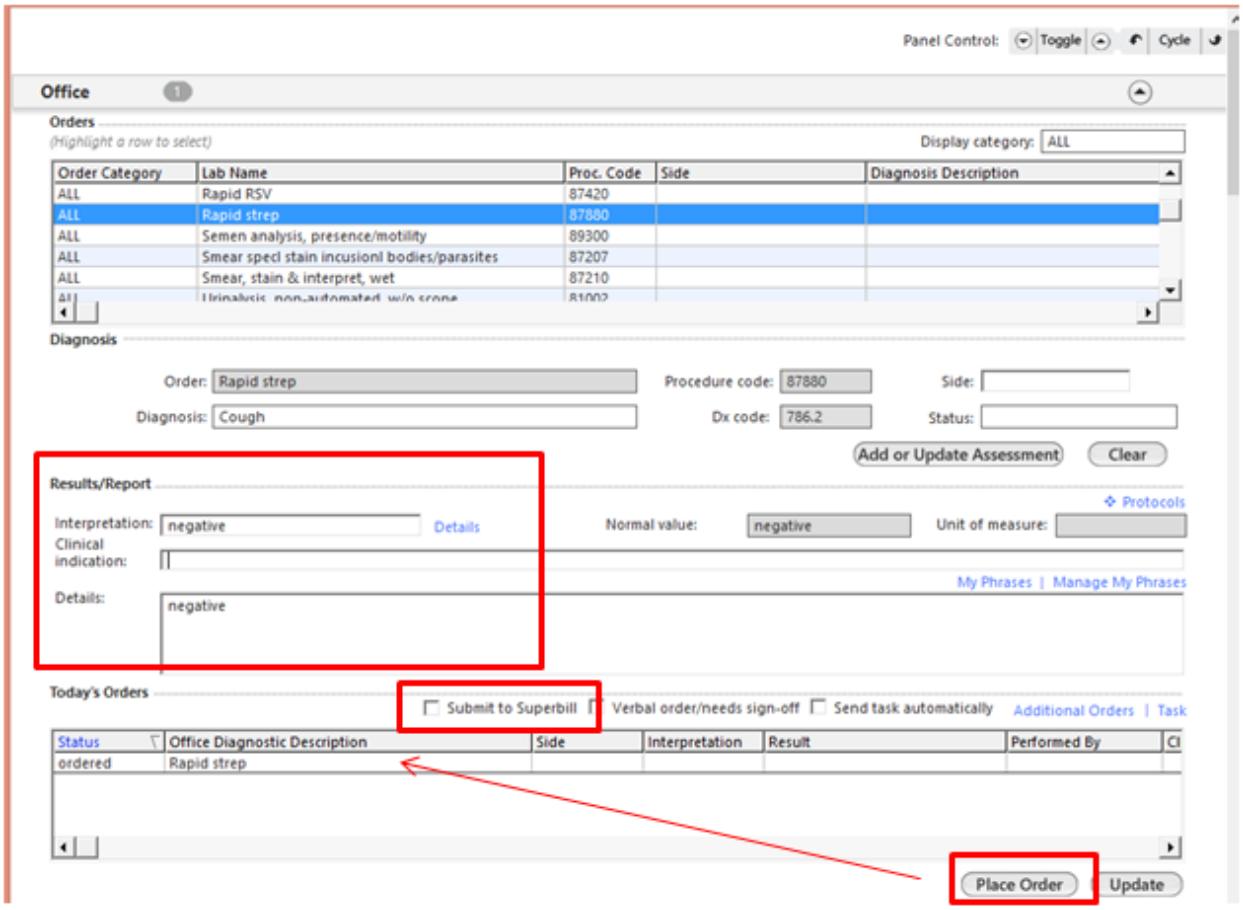
Search for and highligh an entry in the list of office procedures/tests.





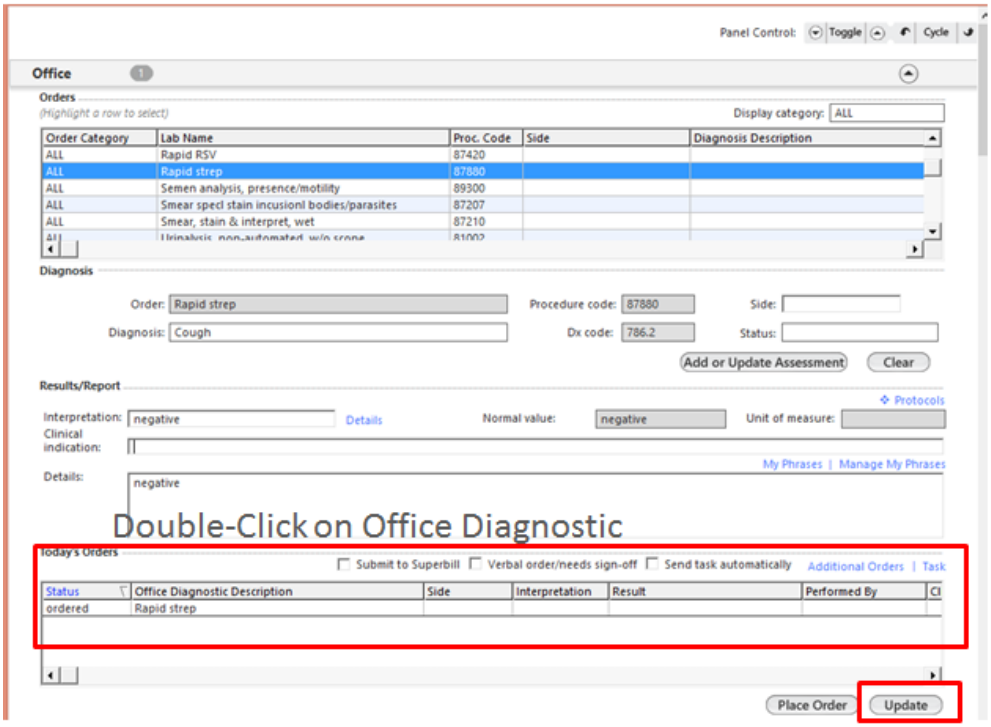
Click in the Interpretation box. And select the interpretation.

- Select the ***Detail*** button to open a dialog box to enter more complicated results.
- ***Clinical Indication*** text box is an optional field to enter free-text if it was unclear from the diagnosis.
- Enter free-text in the ***Detail*** text box.
- Select the ***Submit to Superbill*** check box if billing for the procedure.
- Select the ***Place Order*** button to finish.

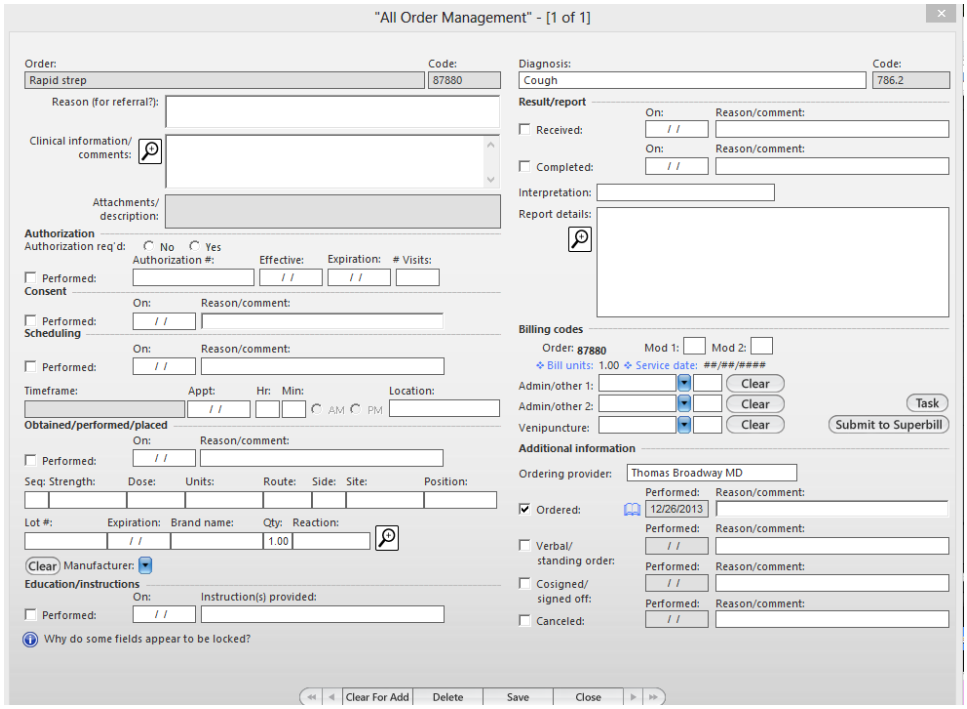


If a test is done per standing order by a nurse or medical assistant, a provider can sign off on the test ***by double-selecting on the item in the grid*** at the bottom of the dialog box.

- Select the ***Update*** button, in the lower right-hand corner aftering editing any information.



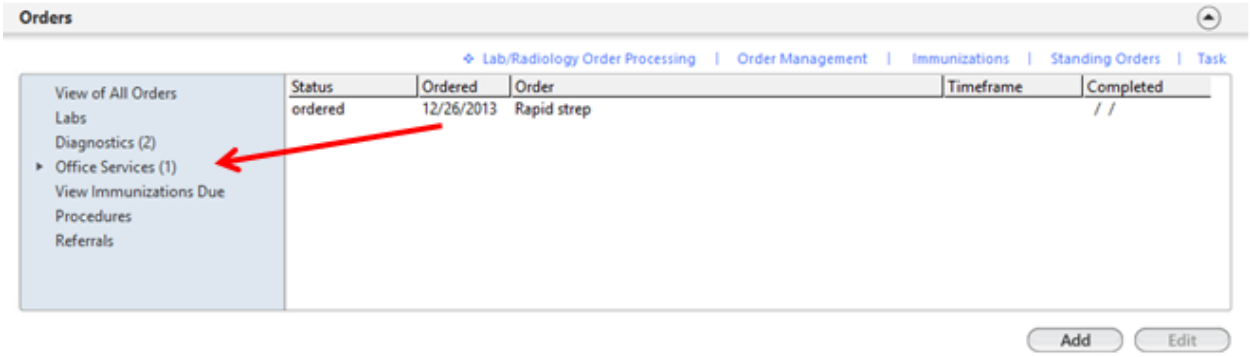
The ***All Order Management*** dialog box will display once you double click on the order.



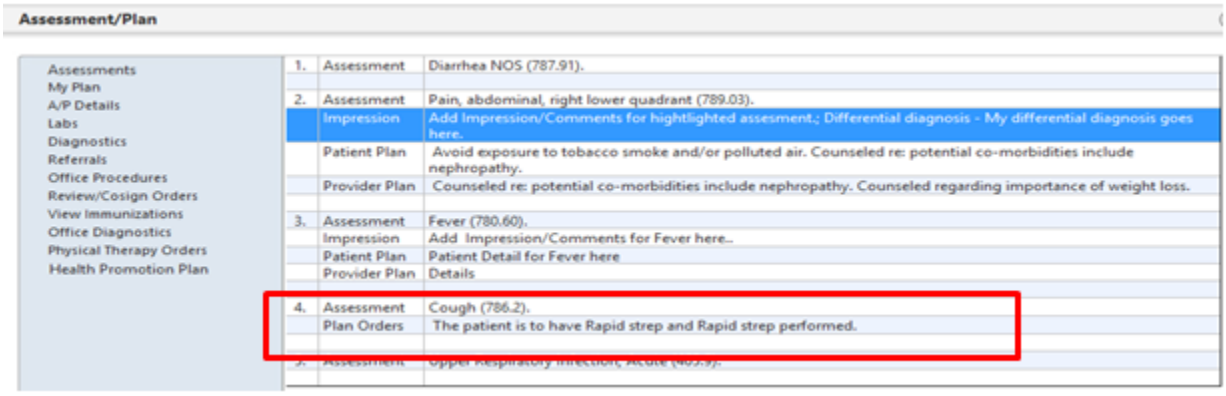
There are several things that can be done on this template to document management of the order:

- The co-signed/signed off check box can be selected.
- If a medication is given, the lot number and site can be entered on this dialog box.
- Select the ***Submit to Superbill*** button on the All Order Management dialog box to bill.

Once the **Office Service** is closed, all orders will display on the **Intake** template under the **Orders** pane.

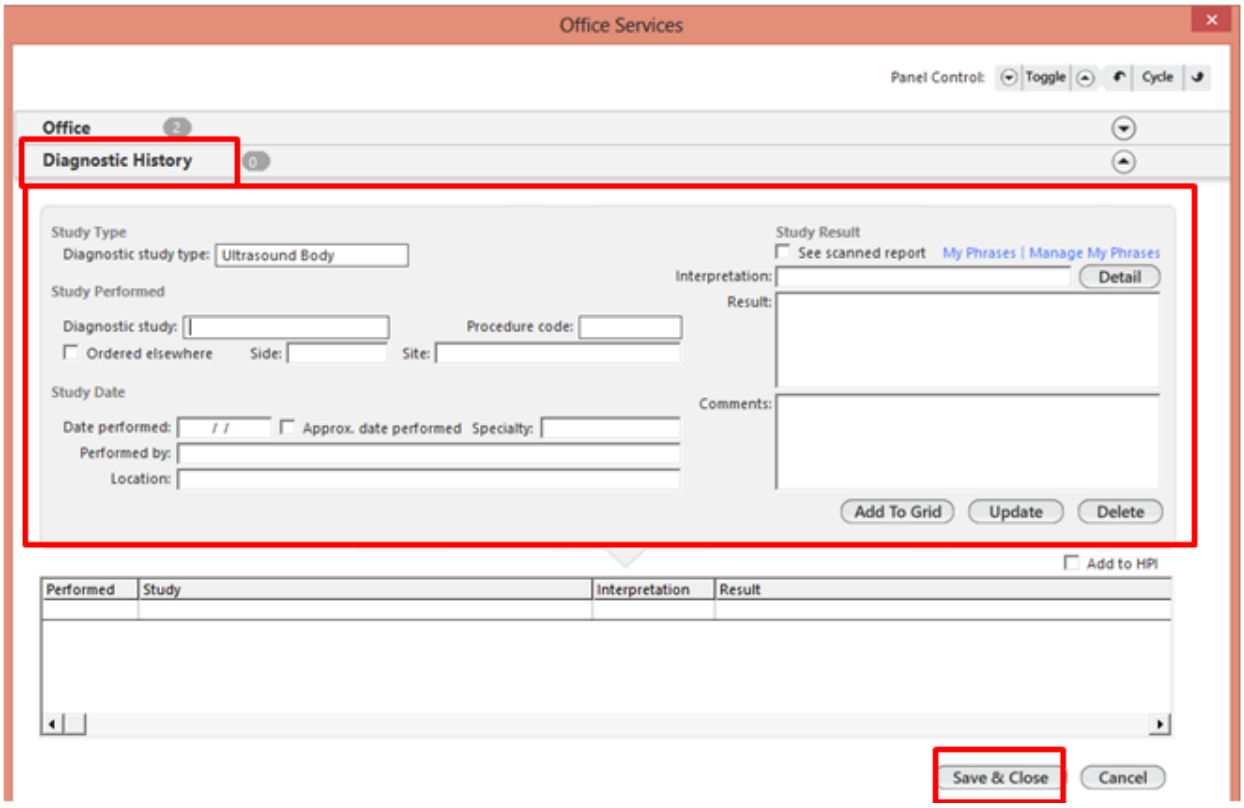


The information entered on the **Order Services** automatically becomes part of today's assessment/plan. This can be edited by the provider, as needed.



Diagnostic History Panel

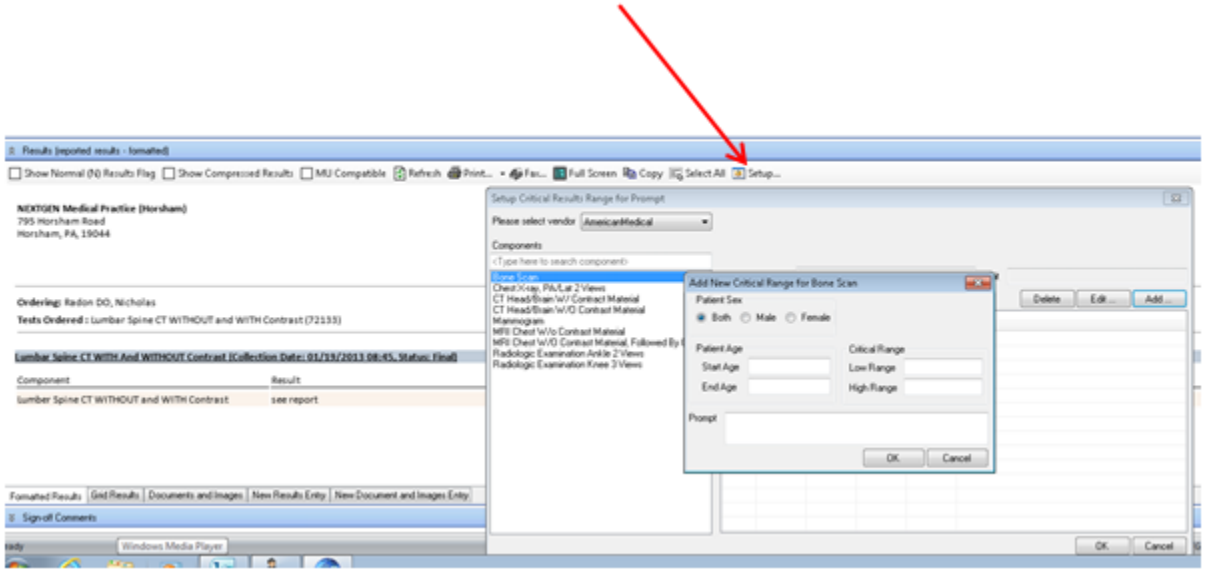
Use the **Diagnostic History Entry** panel to enter past diagnostics, procedures, and results.



Orders Module

Critical Range Alert

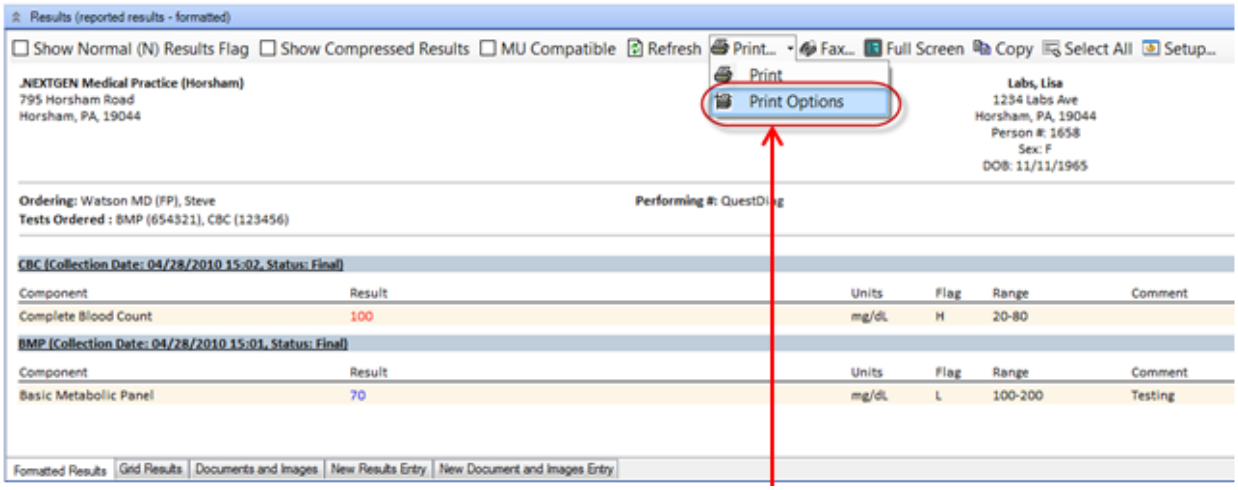
This **Setup** can be used only if the use has **System Admin Rights.**



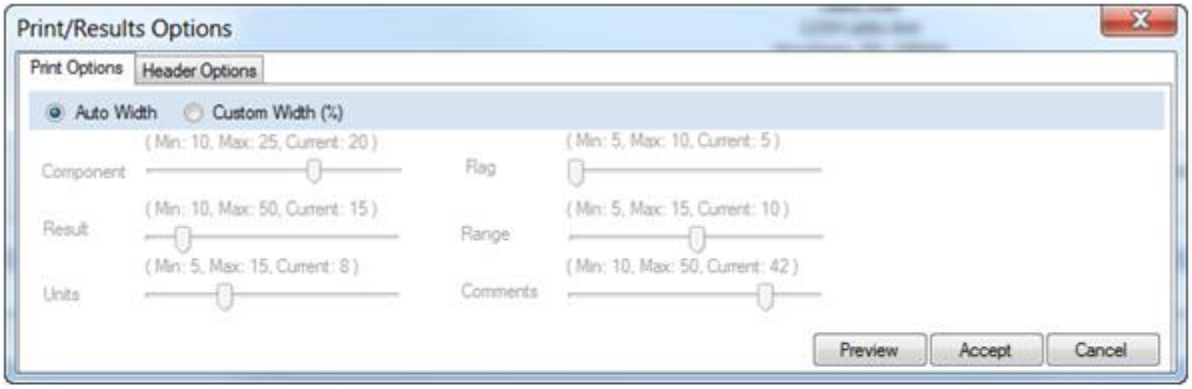
Once setup, the alerts will display when the user is on the ***Orders*** tab and ***Results Panel*** is expanded.

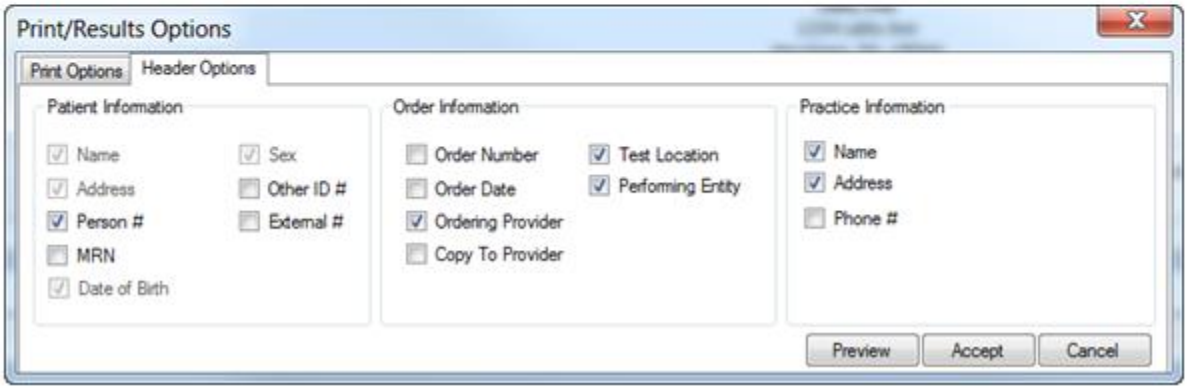
Printing Options – Result Panel

Printing options are located in the ***Results Panel***.



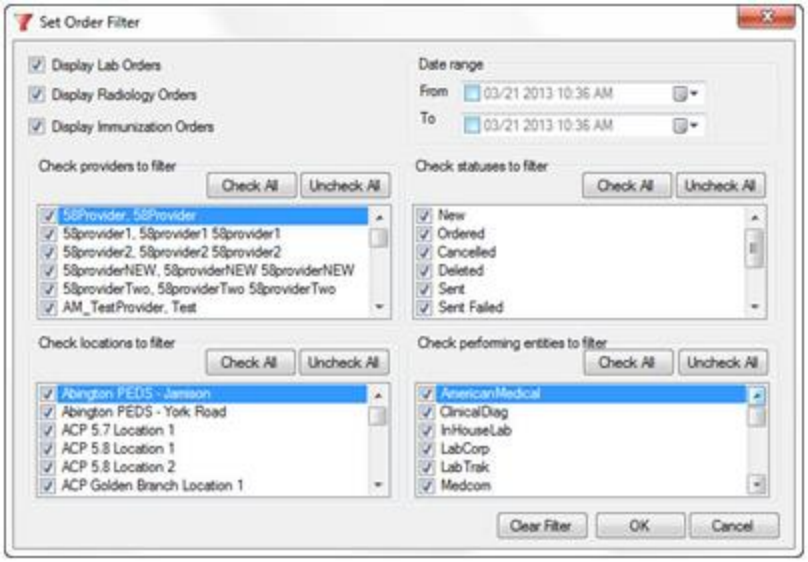
The options allow for the configuration of the columns. Header options allow the user to configure what will appear on a printed document.



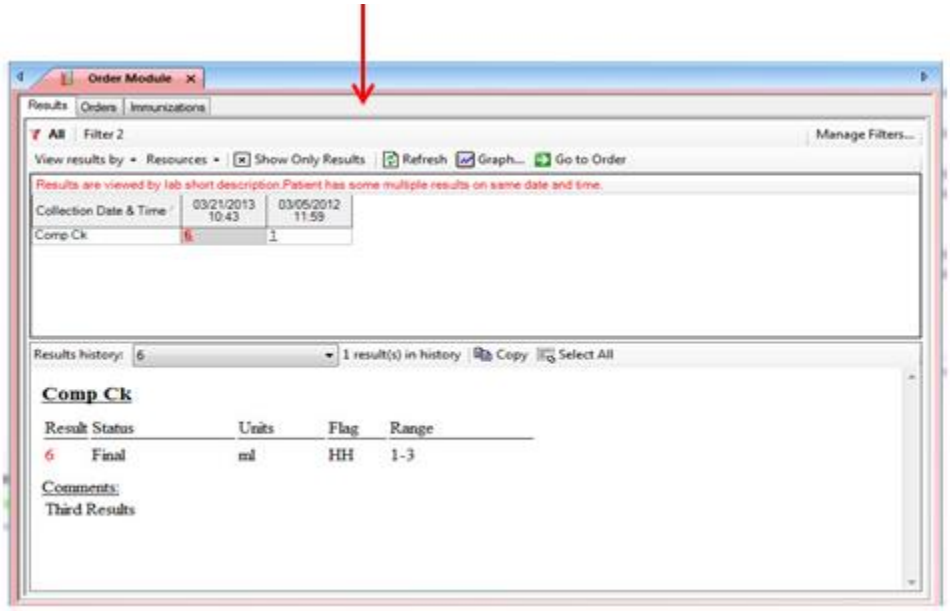


Filters

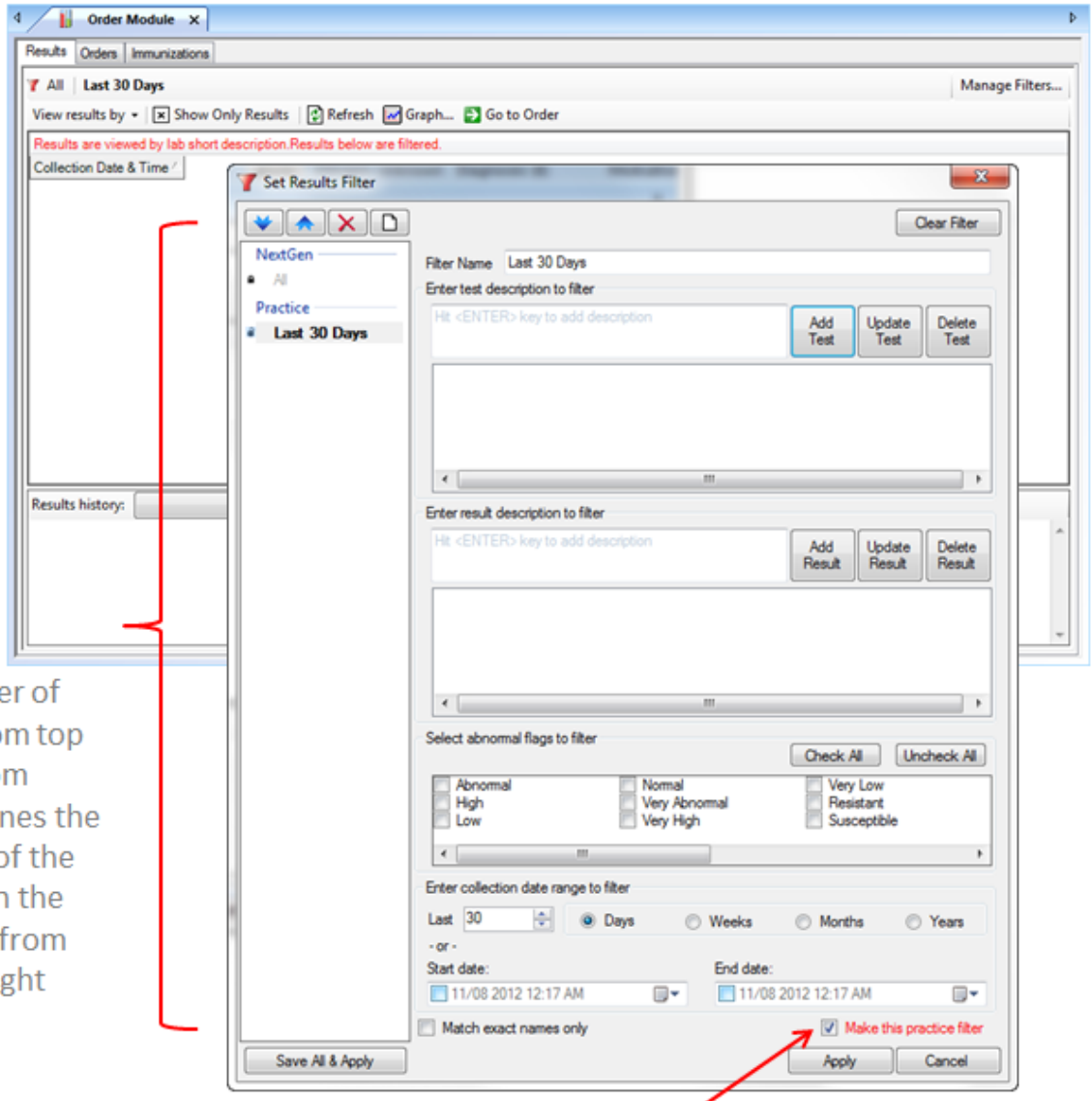
The user has the ability to filter by Provider, NG Statues, Locations and performing Entities.



When there are multiple results that come back fro the same component, the background of the field will be grayed indicating that there are additional results. A message will display for same Date/Time Results.



Results Filter Enhancement



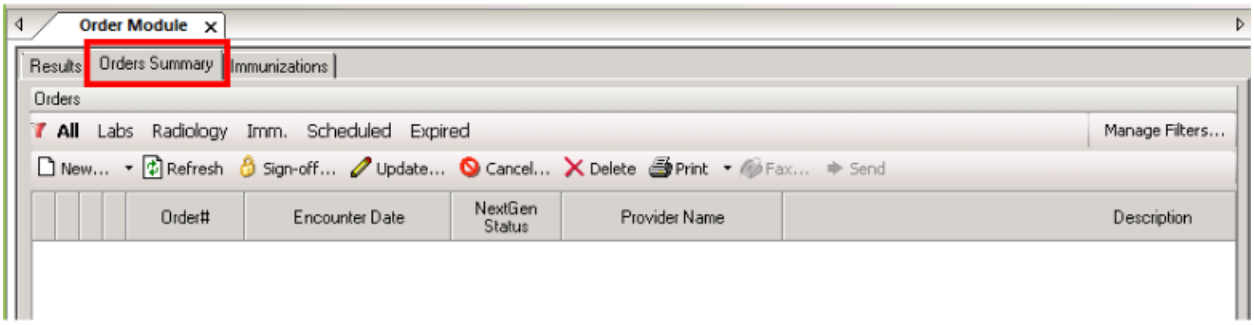
The order of filter from top to bottom determines the display of the filters on the toolbar from left to right

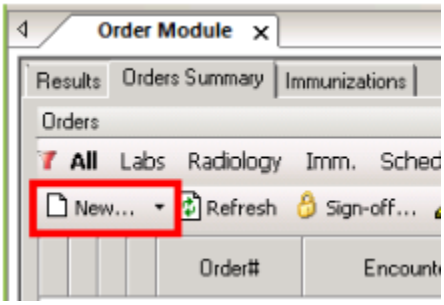
If this checkbox is not selected, the filter is a private filter; available for use by this user only

Provider Favorites

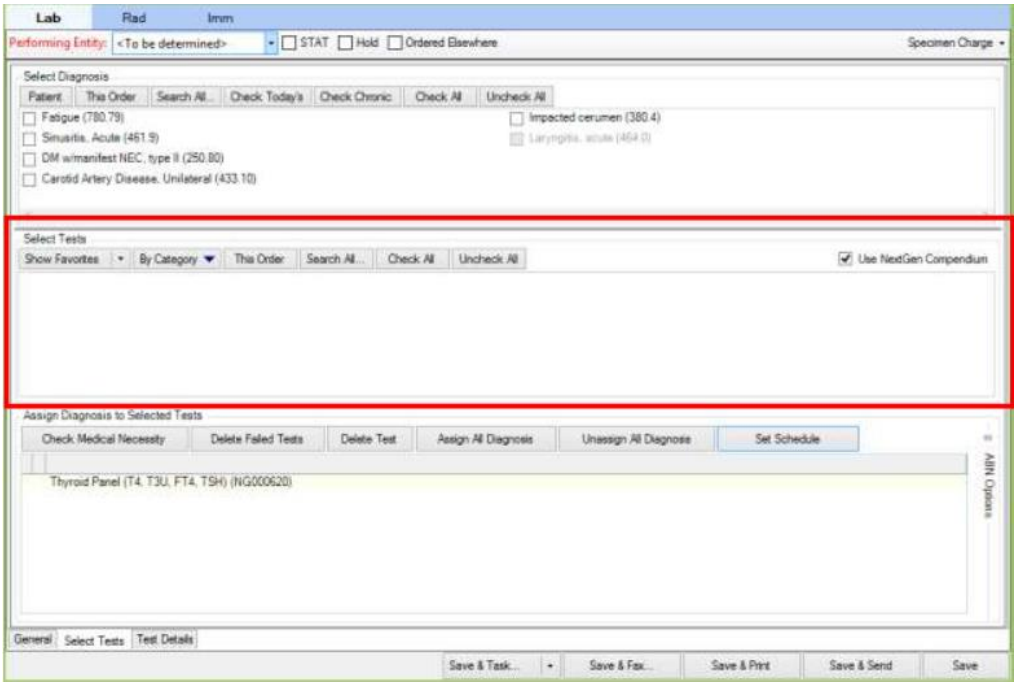
Provider favorites are easily accessed in the module and prevent the need to search each time. To create a provider favorite

- Select the ***Orders Summary*** tab
- Select the ***New*** button



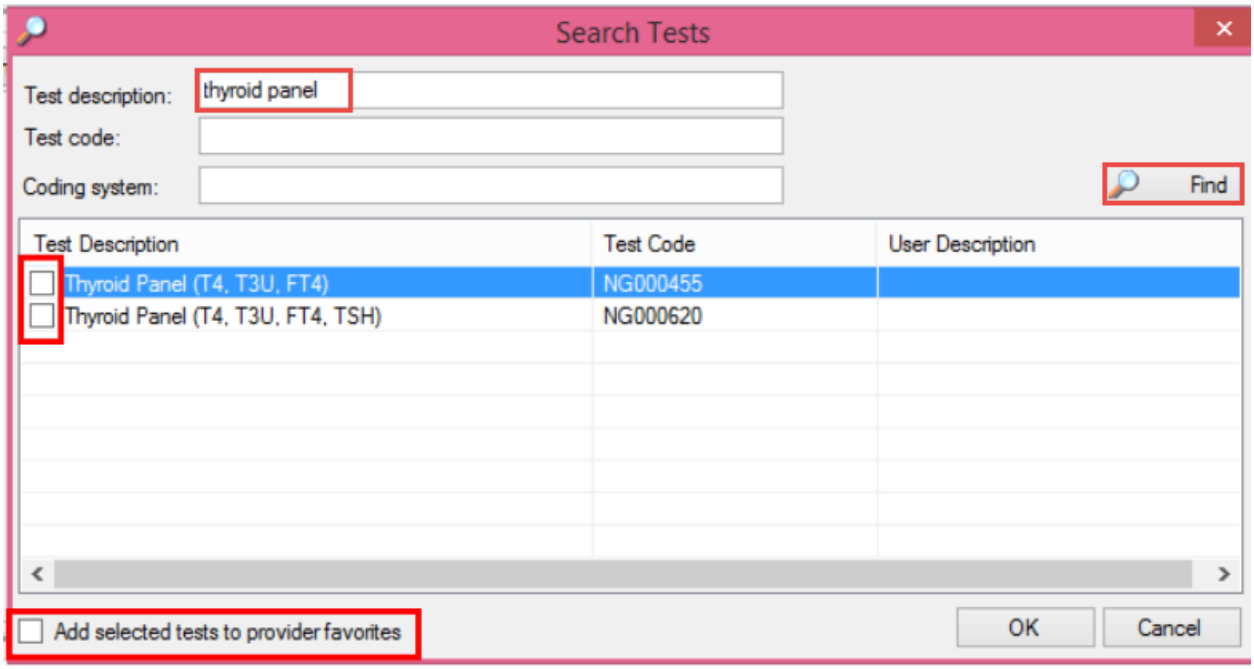


- The test ordering section will display in the middle of the screen.



- Search for the test by selecting the ***Search All*** button.

- Type name of test in **Test Description** field
- Select ***Find.***
- Select the checkbox next to the test you wish to add to favorite.
- Select the ***Add selected tests to provider favorites***



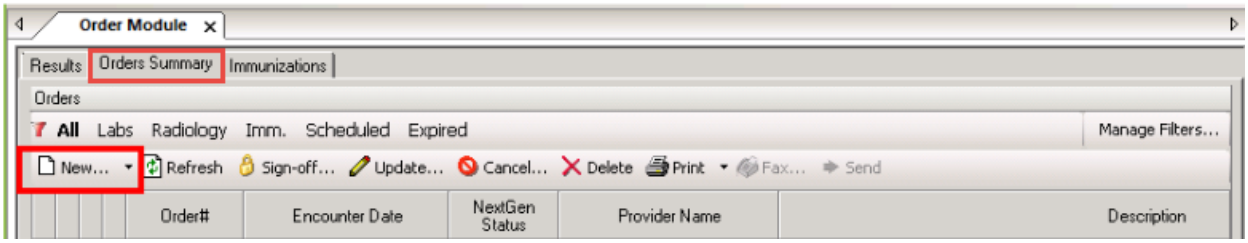
- Once favorites are created, they will display automatically when you create a new order. You can also view them if you nabigate away by clicking the **Show Favorites** button.

Recurring Orders

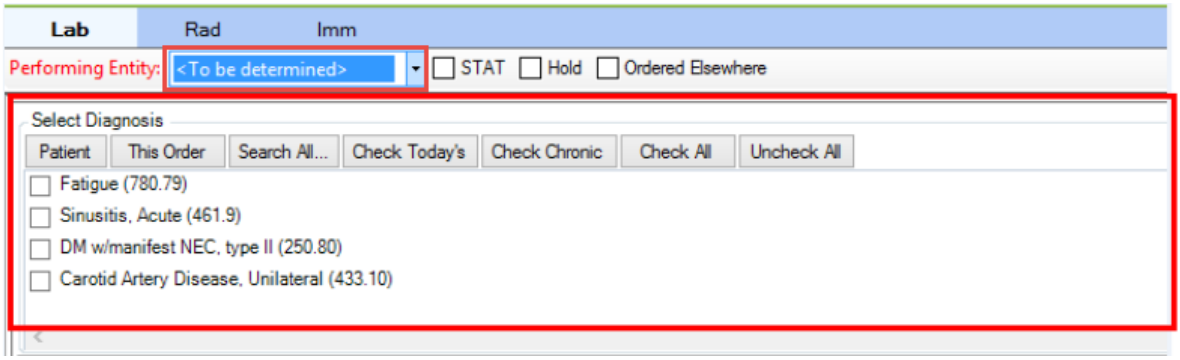
New Order

Recurring orders allows the user to create an order for the patient once, then schedule it for multiple uses. To create an order

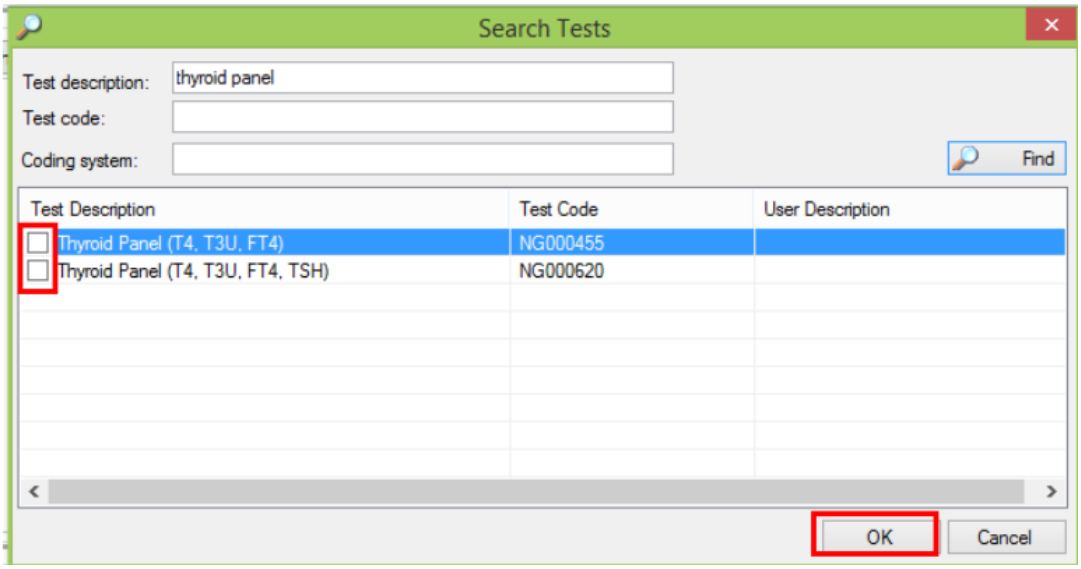
- Select the ***Orders Summary*** tab.
- Select the ***New*** button.



- Select the ***Performing Entity*** from the drop down box.
- Select the diagnosis by selecting appropriate checkbox(es).

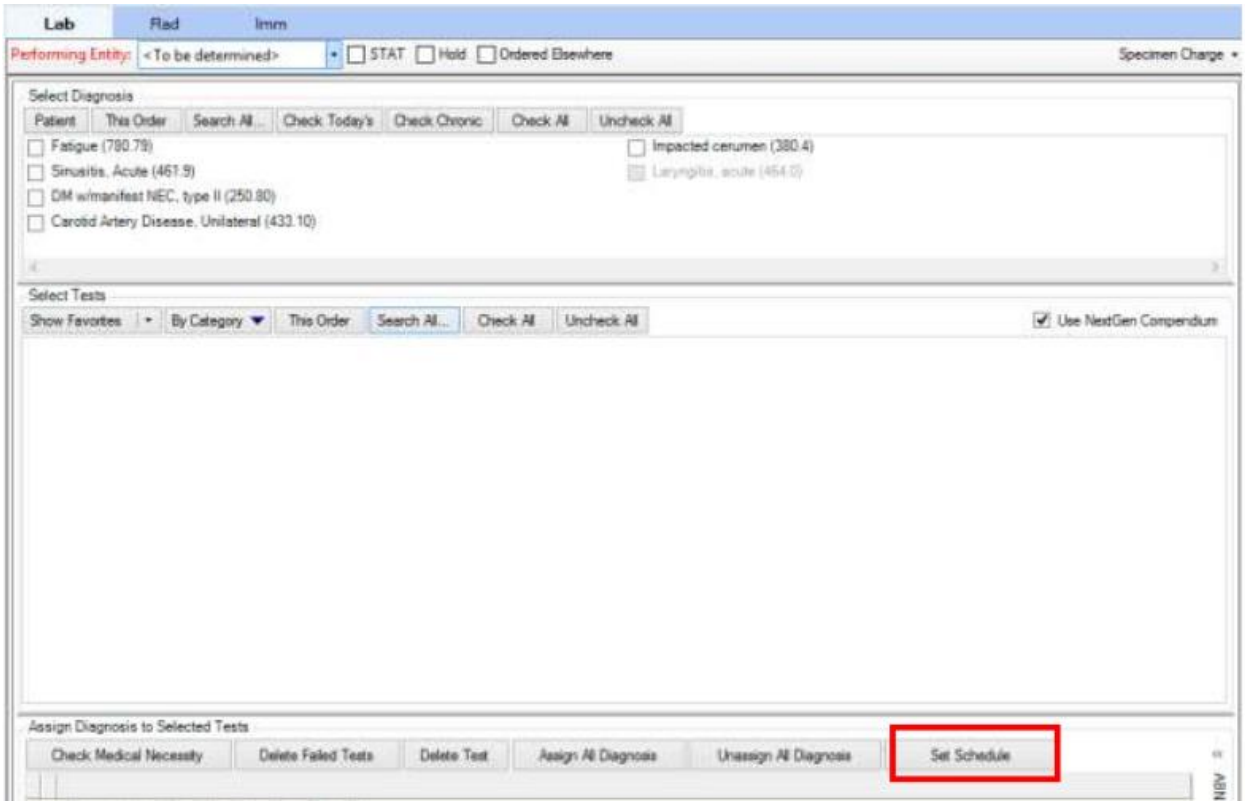


- Search for appropriate tests vis favorites, category or this order.
- Select the appropriate test you wish to repeat by selecting checkbox(es).

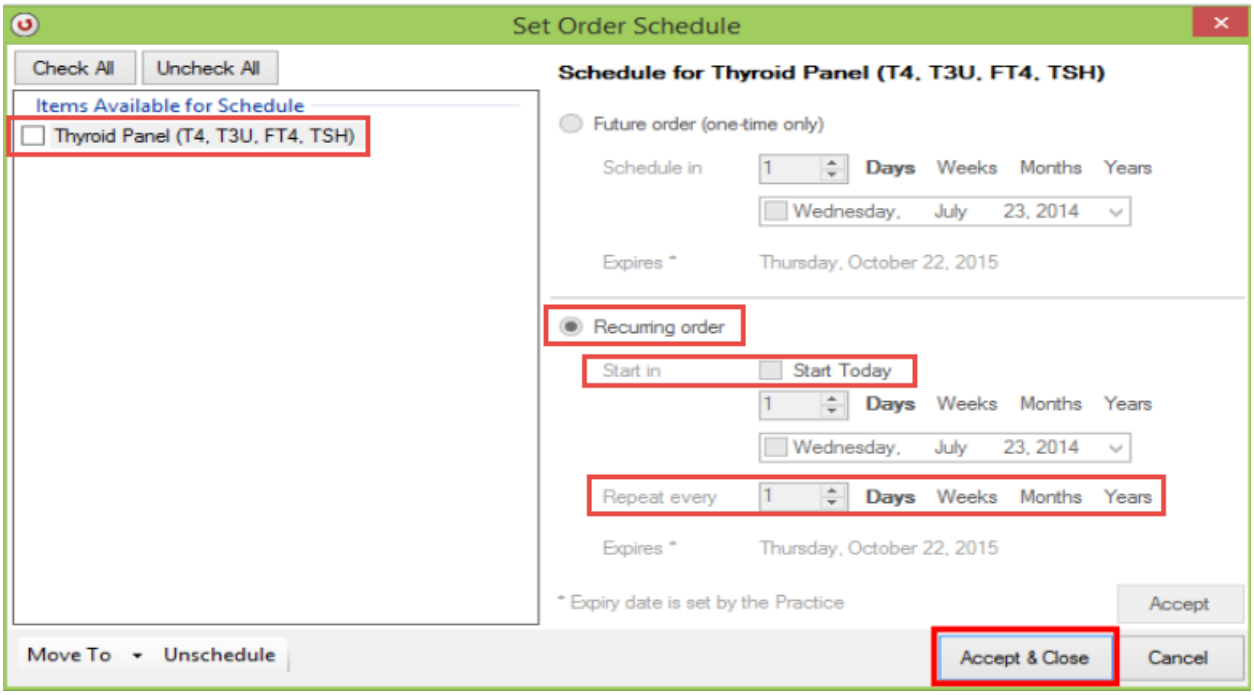


Scheduling Order

- In the lower panel, select ***Set Schedule*** button.



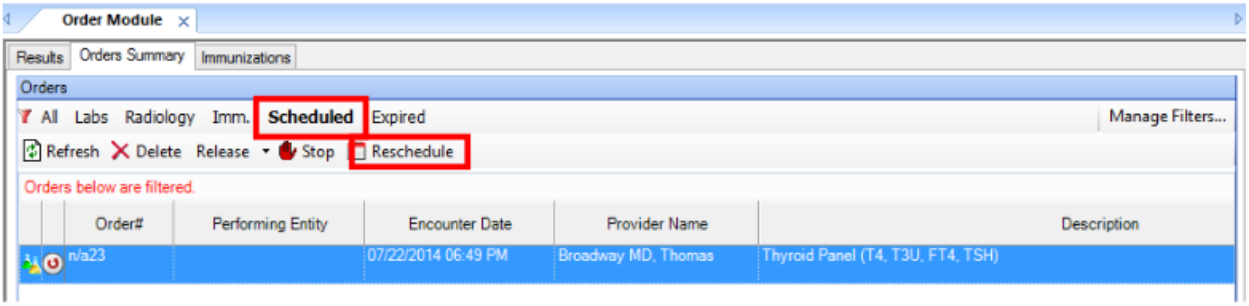
- Multiple tests can be scheduled at once, so choose the appropriate test from the left side window.
- Select the ***Recurring Order*** radio button.
- Select the ***Start in*** checkbox
- Select the ***Repeat every*** criteria.
- Select the ***Accept & Close.***



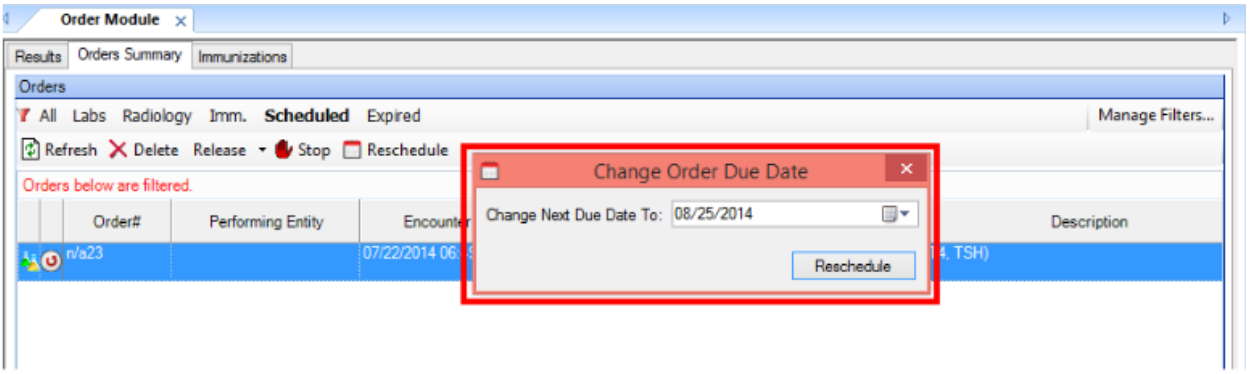
Managing Schedule

To change the date of the patient's next test

- Select the ***Scheduled*** filter
- Select the ***Reschedule*** link.



- The user will be prompted to select the next test date for the patient.



Expired Orders

After the practice expiration date, orders will no longer display under **Scheduled** orders. To reactivate an order

- Select the ***Expired*** button
- Selct the ***Renew*** button.

User Preferences

Users have the choice of:

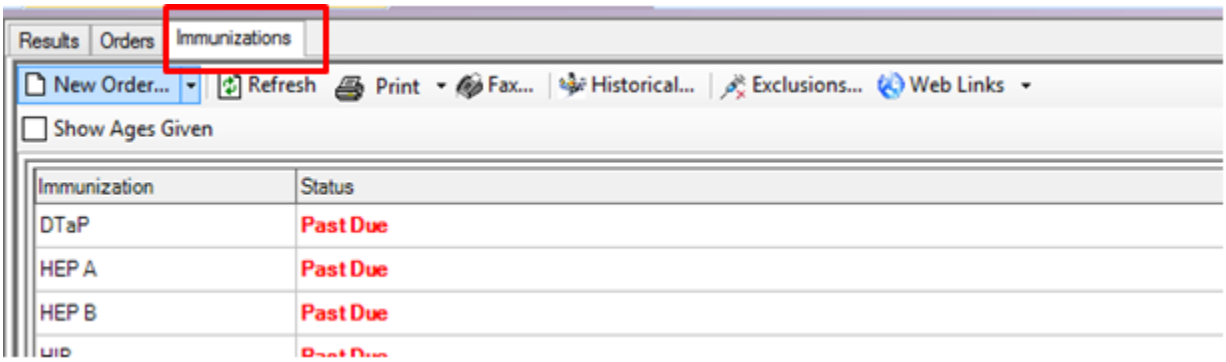
- Results
- Orders
- Immunizations Chart
- Immunizations Schedule

Immunization

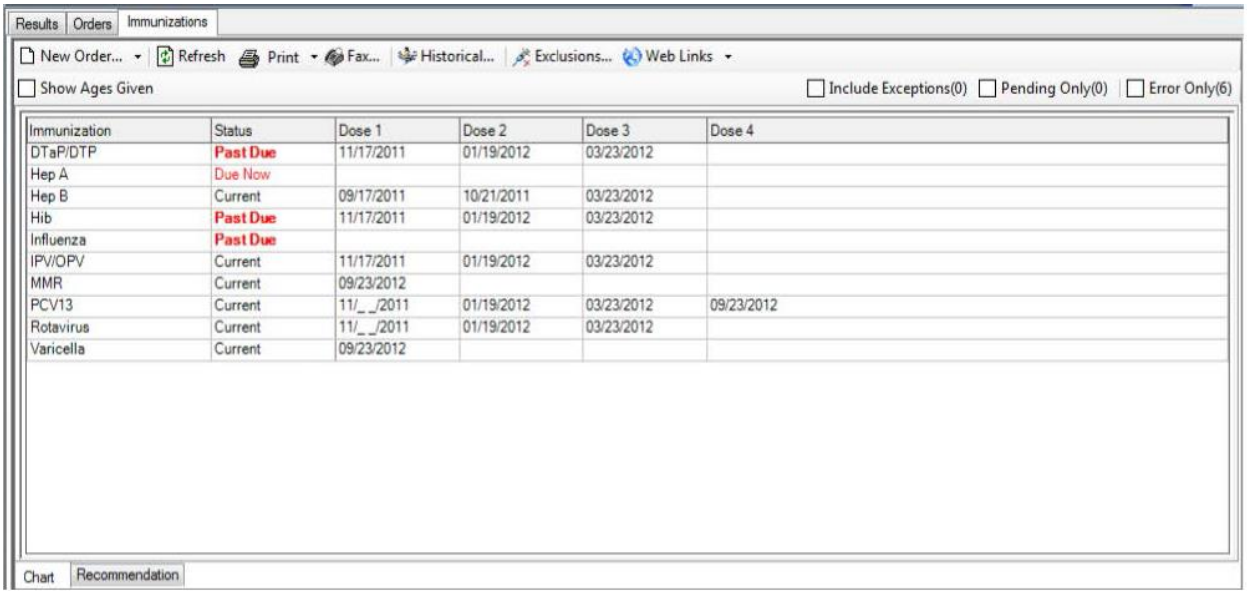
Immunizations orders are ordered, documented and billed in the **Orders Module**. To access the Immunizations function:

Overview

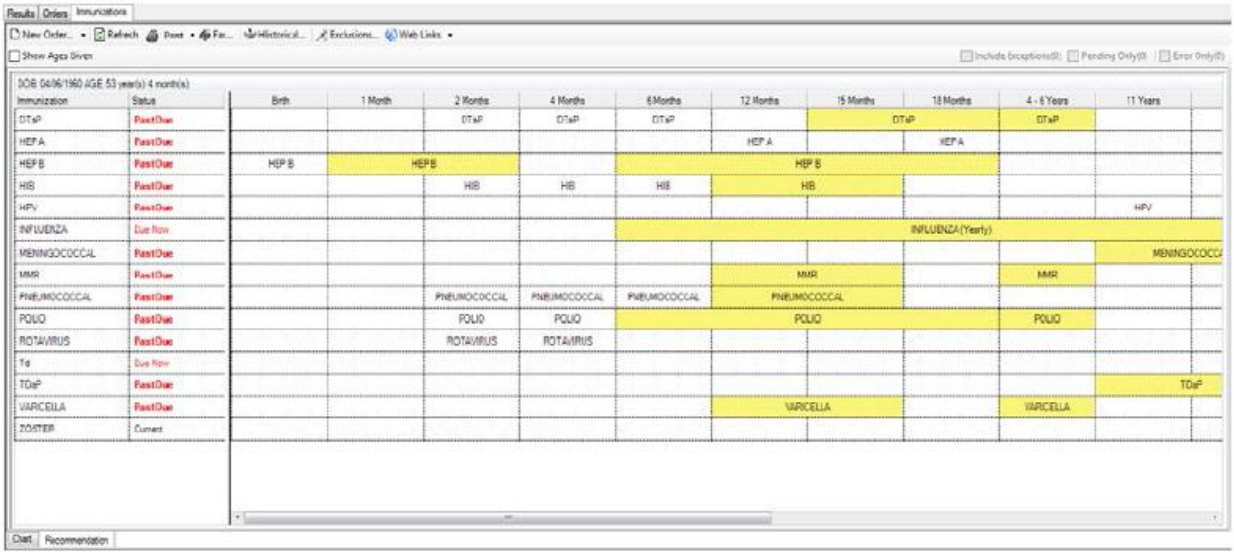
- Select a patient
- Access the ***Orders Module***
- Select the ***Immunization*** tab



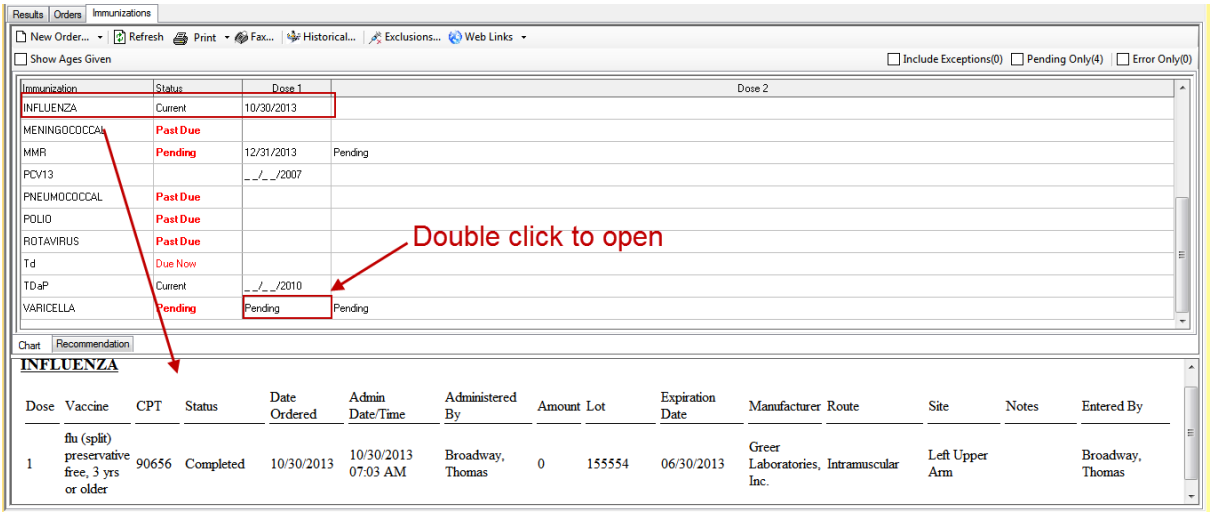
- Depended on user preferences, there are two viewing options
  - Chart View
  - Recommendation View



Immunization	Status	Dose 1	Dose 2	Dose 3	Dose 4
DTaP/DTP	Past Due	11/17/2011	01/19/2012	03/23/2012	
Hep A	Due Now				
Hep B	Current	09/17/2011	10/21/2011	03/23/2012	
Hib	Past Due	11/17/2011	01/19/2012	03/23/2012	
Influenza	Past Due				
IPV/OPV	Current	11/17/2011	01/19/2012	03/23/2012	
MMR	Current	09/23/2012			
PCV13	Current	11/_ _/2011	01/19/2012	03/23/2012	09/23/2012
Rotavirus	Current	11/_ _/2011	01/19/2012	03/23/2012	
Varicella	Current	09/23/2012			

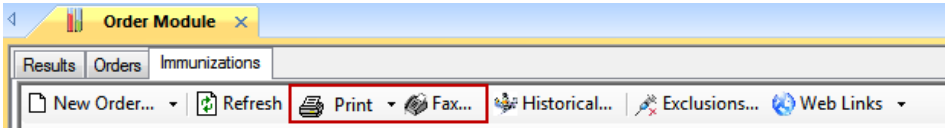


- Highlight a row to view the administration details.
- Double click on the ***Status*** for any vaccine to open the **Immunization** order.



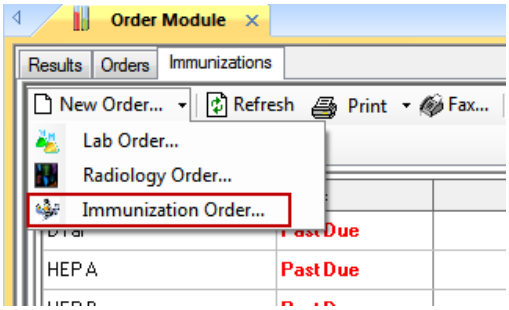
Print/Fax Immunizations

- Select the ***Print*** or ***Fax*** button to print/fax patient's immunizations.

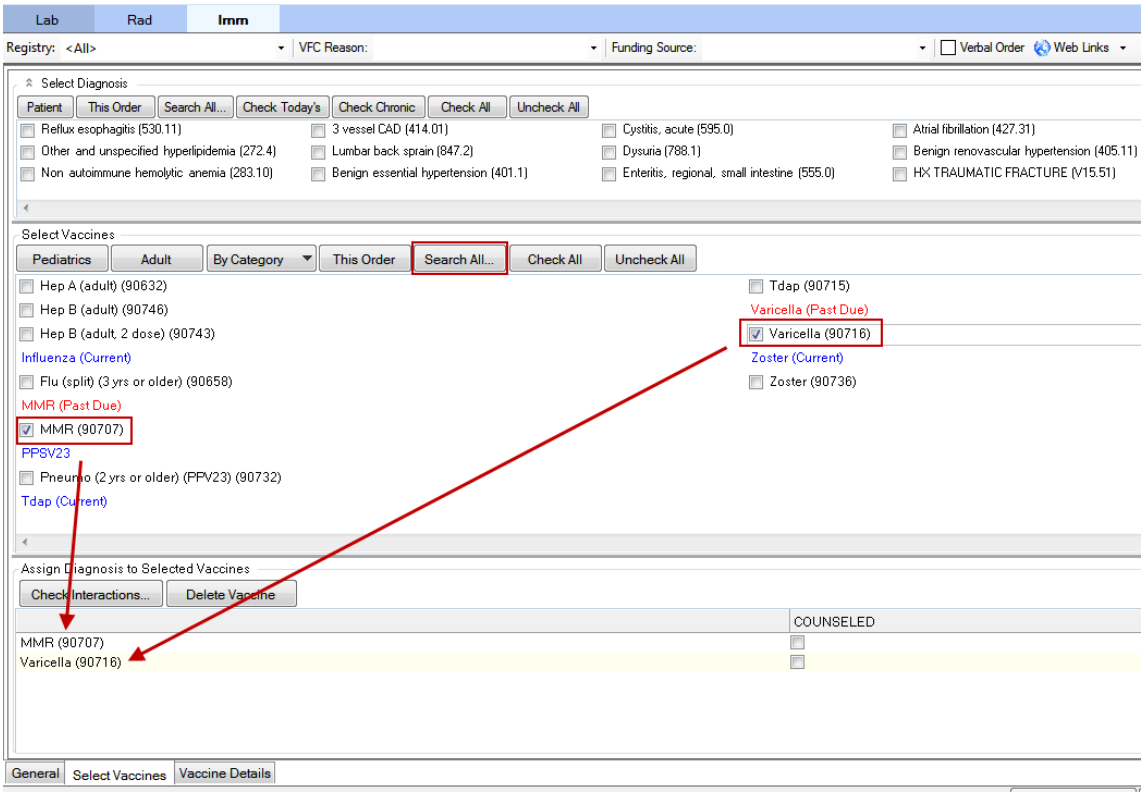


Ordering Immunizations

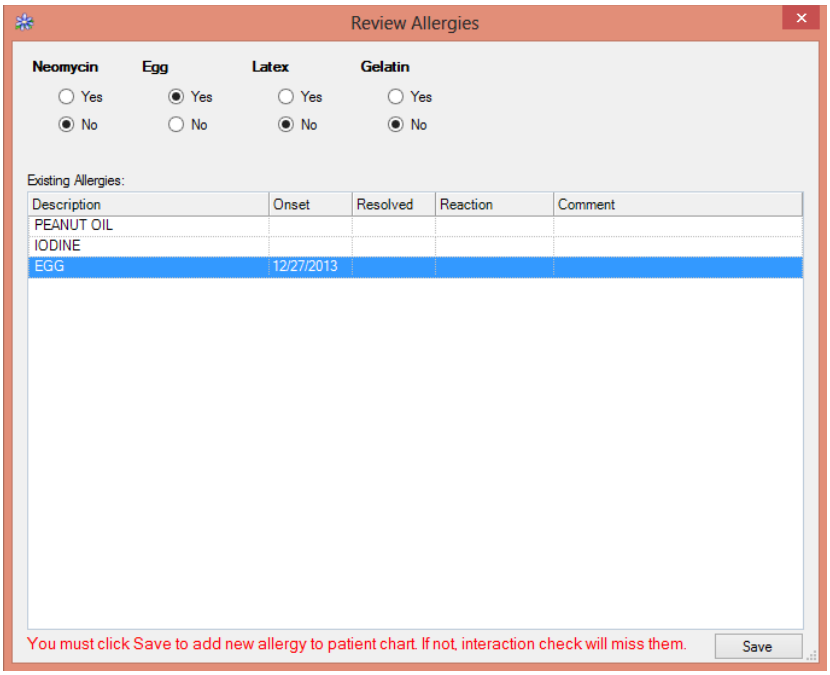
- From the Immunizations tab, select the ***New Order*** list, and select ***Immunization Order.***



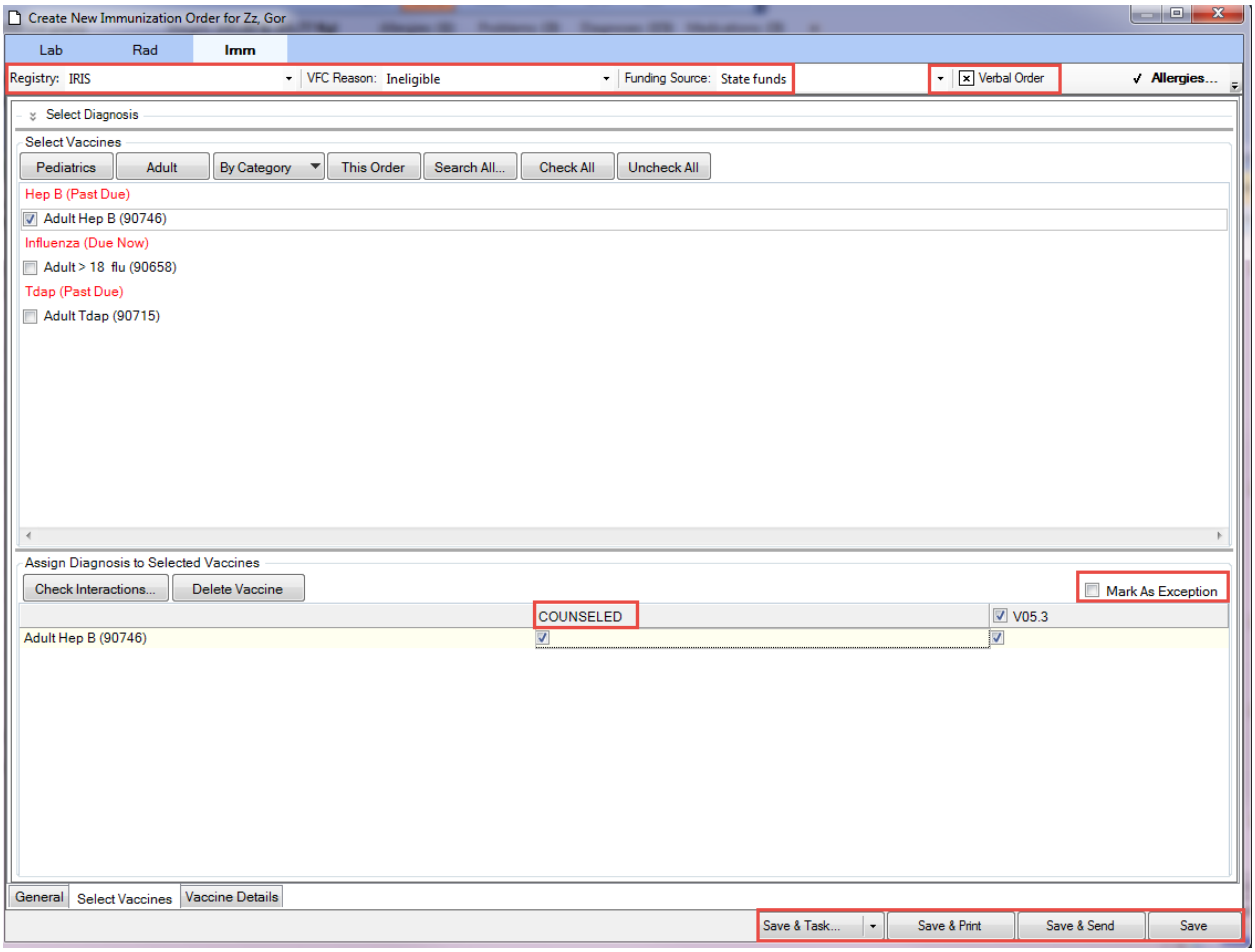
- Select scheduled vaccine(s) for the patient using the appropriate option.
- Use the **Search All** button search for vaccine not listed in the favorites list.



- Review any existing allergies and select, if applicable.



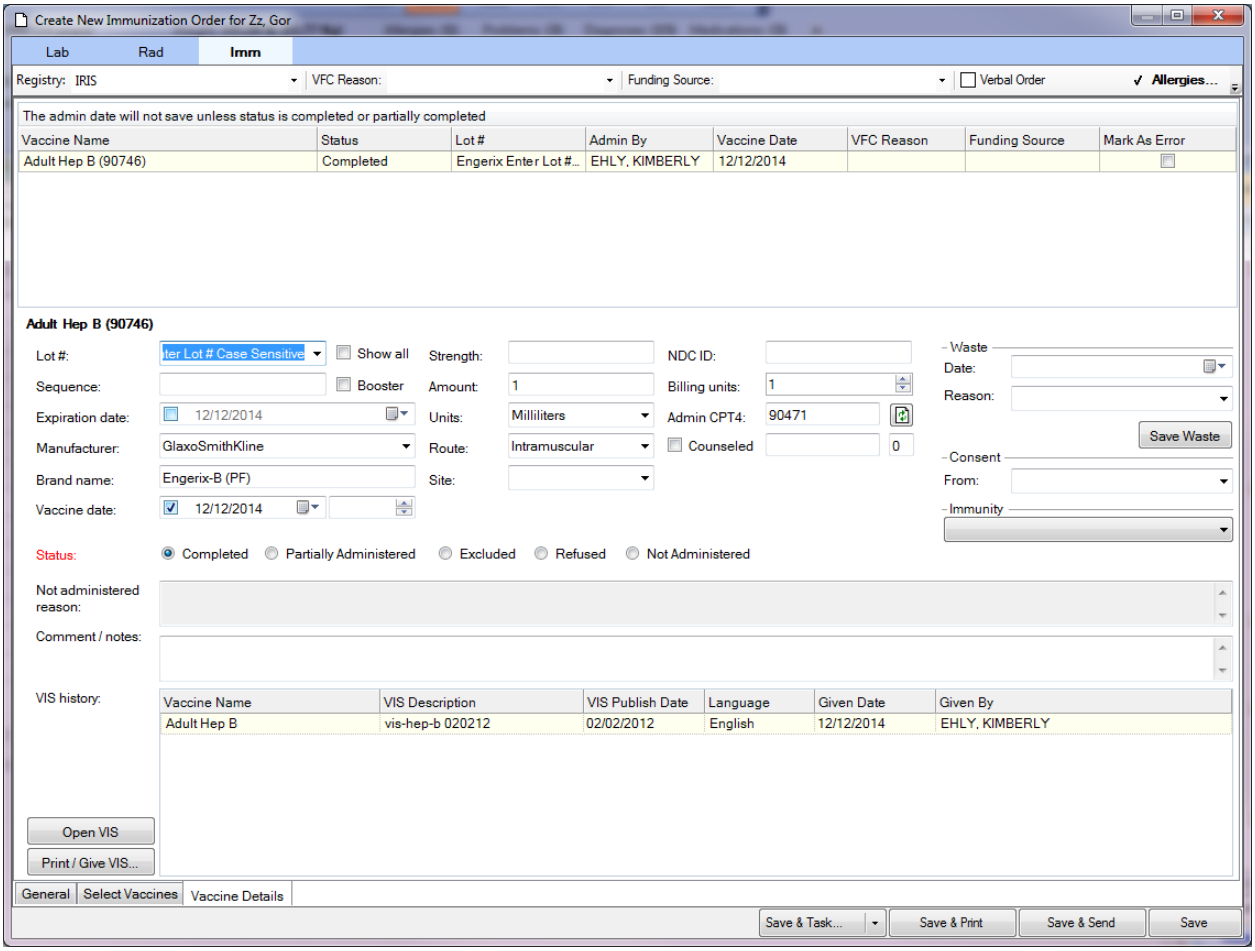
- If vaccine is **VFC,** document in ***VFC Reason*** and ***Funding Source.***
- If vaccine was verbally orders, select ***Verbal Order***.
- If counseling was provided, select ***Counseled.***
- If a vaccine is an exception, select ***Mark as Exception***
- Select the appropriate ***Save*** option



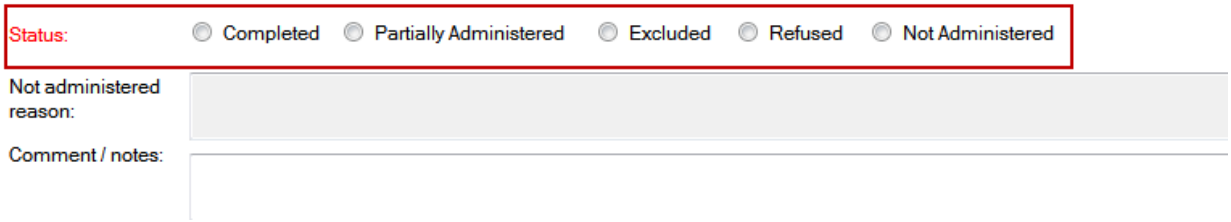
Administering Immunizations

After the Immunizations are selected on the Select Vaccines tab, you can administer them to the patient.

- Select the **Imm** from the **Orders tab.**
- When you select the **Immunizations Order**, the **Create New/Update Immunizations Order** for (patient name) dialog box displays (on the Vaccine Details tab).
- Select the vaccine and appropriate LOT# in the detail section. If the vaccine is not your inventory, enter the Lot# manually. The vaccine data defaults from the Vaccines Inventory. **NOTE: If the vaccine was ordered verbally, select Verbal Order.**



- Enter the appropriate information: Vaccine date, received counseling, if the immunizations order requires **Consent**.
- If the vaccine was administered successfully, select ***Completed*** in the **Status** section

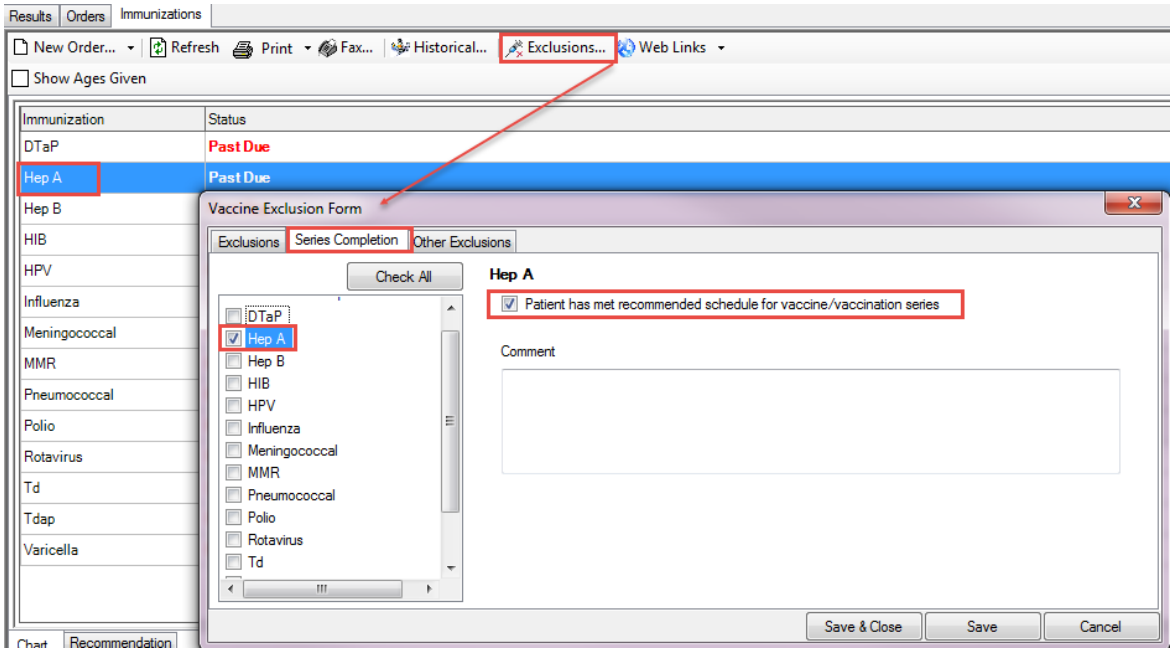


- Document the reason in the **Not administered reason** section if the vaccine was not completely administered.
- Select the appropriate ***Save*** option to complete the immunizations administration process.
  - **Save & Print** saves changes and prints **VIS** documents.
  - **Save & Send** saves changes and sends the immunization data to the appropriate registry.
  - **Save** saves all changes.

Immunization Series

This area allows the user to document the completion of a series of immunizations. To document **Series Completion**:

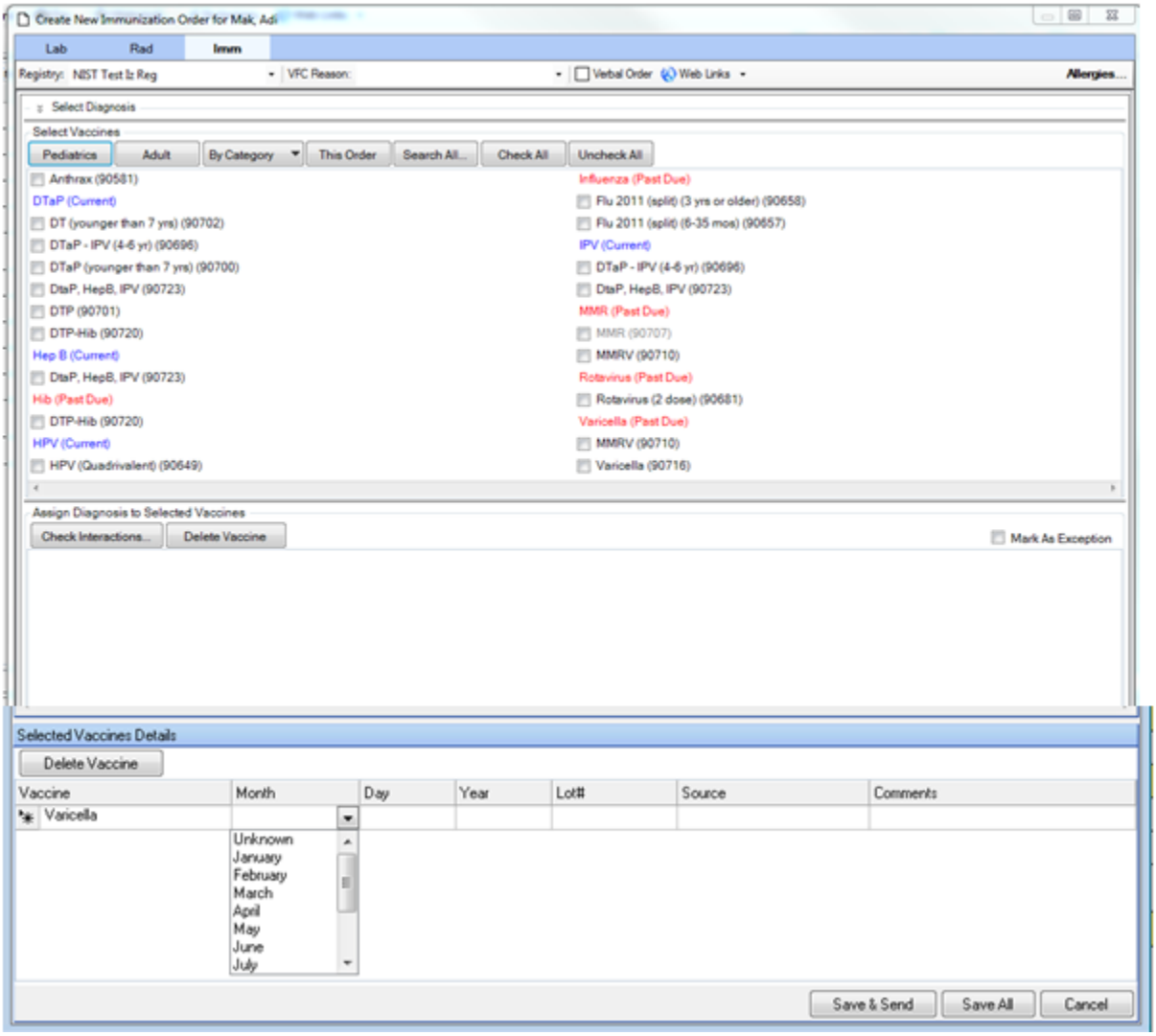
- Highlight on the ***Display Name*** for recommended series that patient has completed.
- Select the ***Exclusion*** link.
- Select the ***Series Completion*** tab.
- Select ***checkbox*** next to completed series.
- Select checkbox next the ***Patient has met recommended schedule for vaccine/vaccination series.***



Historical Immunizations

Historical immunizations may be entered with partial dates of administration. To enter historical values:

- Select the ***Historical*** link
- The **Selected Vaccine Details** window will display.
- Enter the **Vaccine, Month, Day, Year, Source.** Lot number and Comments are optional.
- Select the appropriate ***Save*** option.



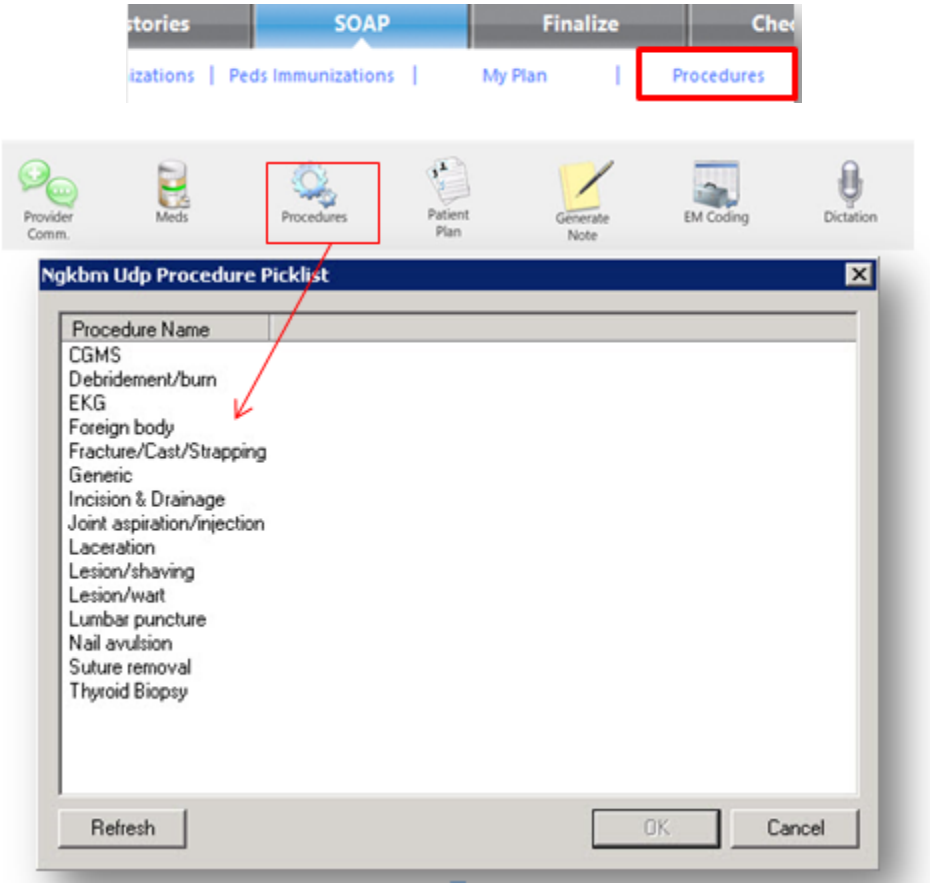
Procedures

Overview

The **Procedure** templates are used to document a procedure performed in the office setting. Examples of procedures would include:

- Incision & Drainage
- Joint Injection/Aspiration
- Suture Removal
- Wart Removal

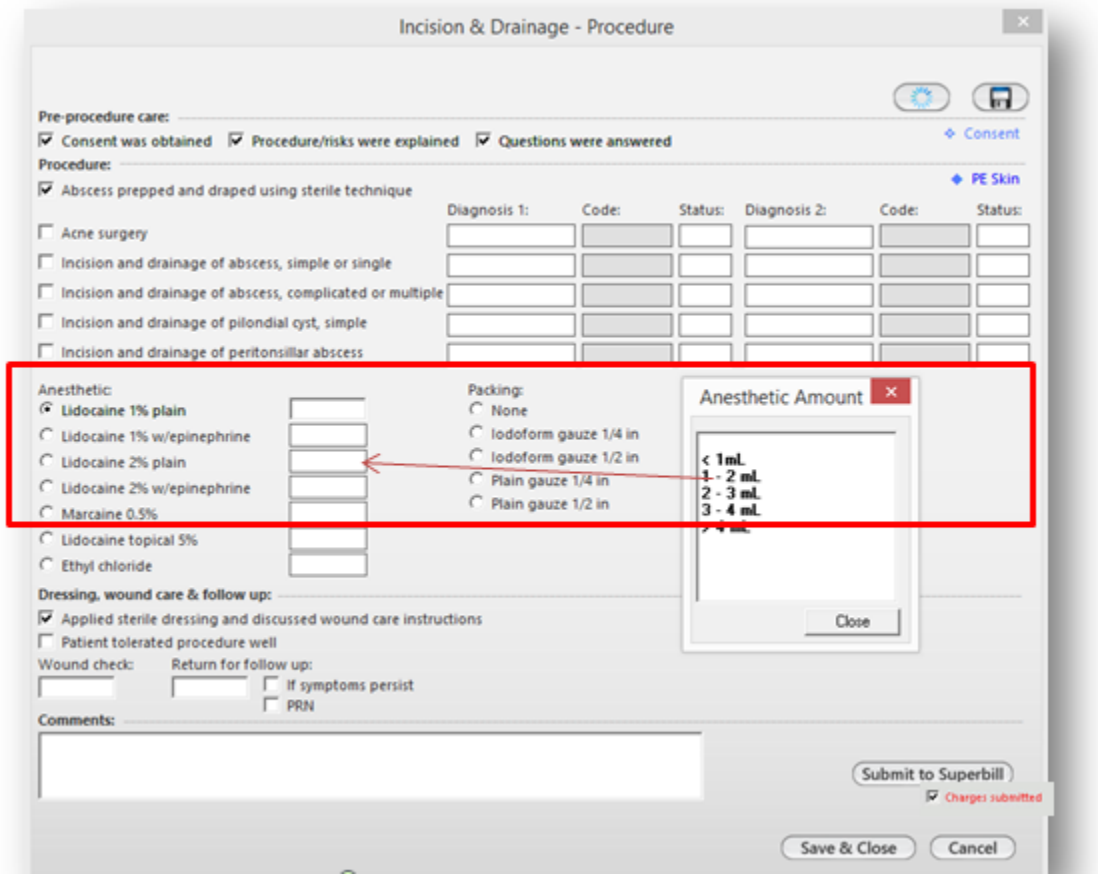
To navigate to the **Procedure** template the user can select the blue active text in the subnavigation. It can also be found on the **Left Side Navigation** bar, as well as the **Procedure** options on the **SOAP** template.



Incision & Drainage

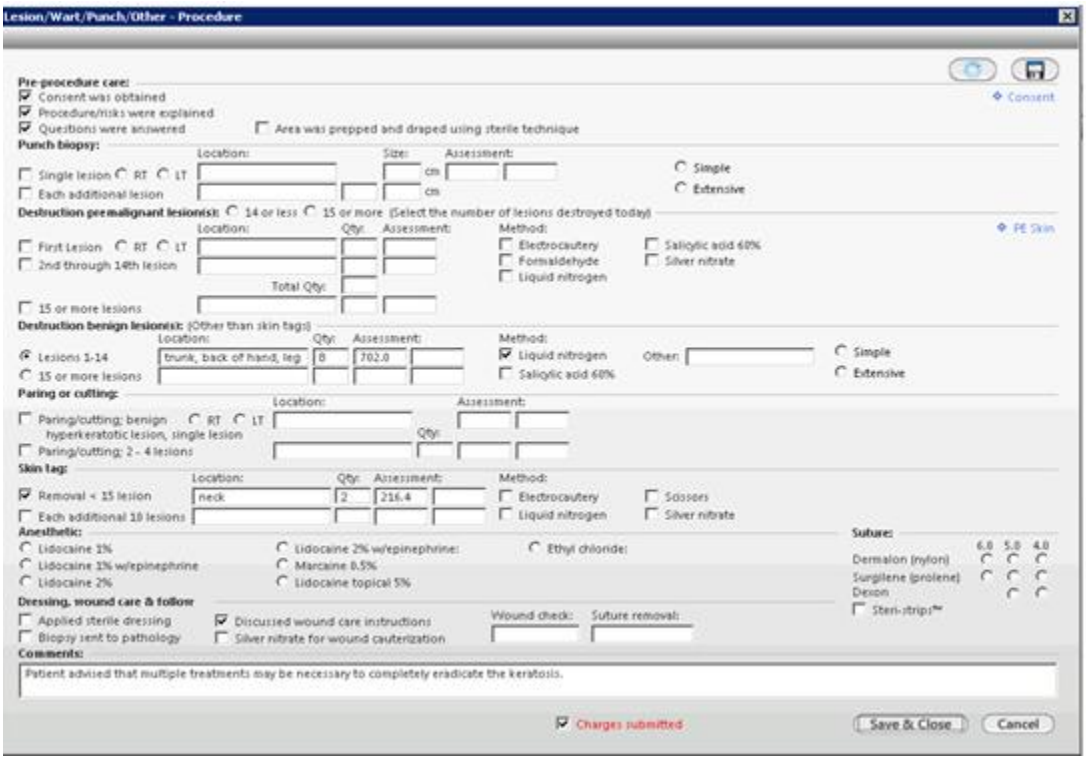
To document an incision and drainage:

- Select the ***Incision & Drainage*** template from the picklist
- Complete the **Pre-Procedure Care** items as appropriate
- Check mark the type of I&D you are performing. This opens a picklist of diagnoses from which to choose.
- Complete the appropriate fields by either entering data, choosing from picklists or selecting radio buttons.
- Select the ***Submit to Superbill*** button to submit billing. The **Submit to Superbill** button is now replaced with the **Charges Submitted** check box.
- Select ***Save & Close***.



Wart/Lesion Removal

- Select the ***Lesion/Wart*** template from the picklist.
- Complete the **Pre-Procedure Care** items as appropriate.
- In the appropriate section, select the type and/or number of removals (this affects billing) you are performing.
- Picklists are opened in sequential order as you enter data. When selecting the location the picklist remains open to allow you to select the ***Close*** button when you are done.
- Complete the appropriate fields by either entering data, choosing from picklists or selecting radio buttons.
- Select the ***Submit to Superbill*** button to submit billing. The **Submit to Superbill** button is now replaced with the **Charges Submitted** check box.
- Select ***Save & Close***.



Template Defaults

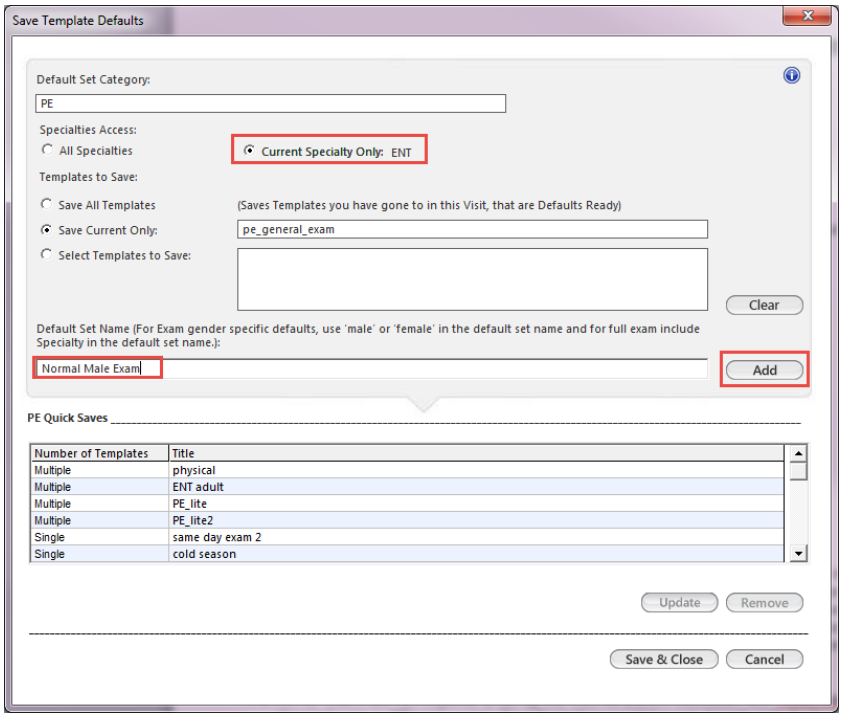
Through the system, the user has the ability to create **Template** Defaults. Some areas already have defaults build. For example, they can be created in:

- Physical Exam
- Procedures
- ROS
- HPI

To create a **Template Default:**

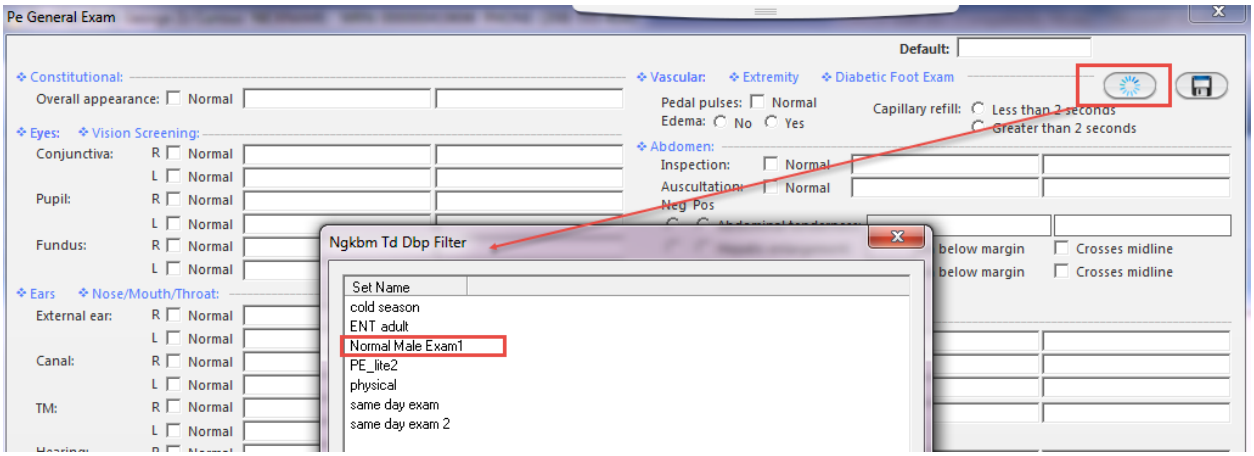
- Fill out the appropriate template through series of checkboxes, picklists and/or free text.
- Select the ***Floppy disk*** button to launch the **Quick Save Template.**

- Fill out the **Quick Save Template**.
- Select the ***Add*** button.
- Selct the ***Save & Close*** button.



To access your saved **Template Default**.

- Select the ***Sunburst*** icon.
- Select the appropriate default from the picklist.
- Once selected, the template will auto populated saved documentation.



Patient Education

Overview

Meaningful Use Stage 2 requires that providers should have access to additional information for diagnoses, medications, procedures, allergies, lab test, values and results, demographics and vital signs. This information is available now with the deployment of the HL7 context-aware knowledge retrieval InfoButton. The InfoButton, is accessible through External Patient Education and Clinical Decision Support, provides access to external references for context-sensitive information from various NextGen modules

External Patient Education: Refers to the education resources that are available when connecting a code (such as ICD9, ICD-10 or CPT) or description (such as RxNorm) to an external resource accessible through a url that is entered into NextGen File Maintenance. Alternative urls can be entered by the provider as desired in user preferences. When you right-select on a code or term, the HL7 InfoButton accesses a URL (which is set to the external resource) and launches a new Internet Explorer window and a Web exchange is activated.

Clinical Decision Support: An external resource that provides evidence-based decision support interventions. This enables a limited set of identified users to select one or more electronic clinical decision support interventions based on each and at least one combination of the following: Problem List, Medication list, Medication allergy list, Demographics, Laboratory tests and values/results and Vital signs.

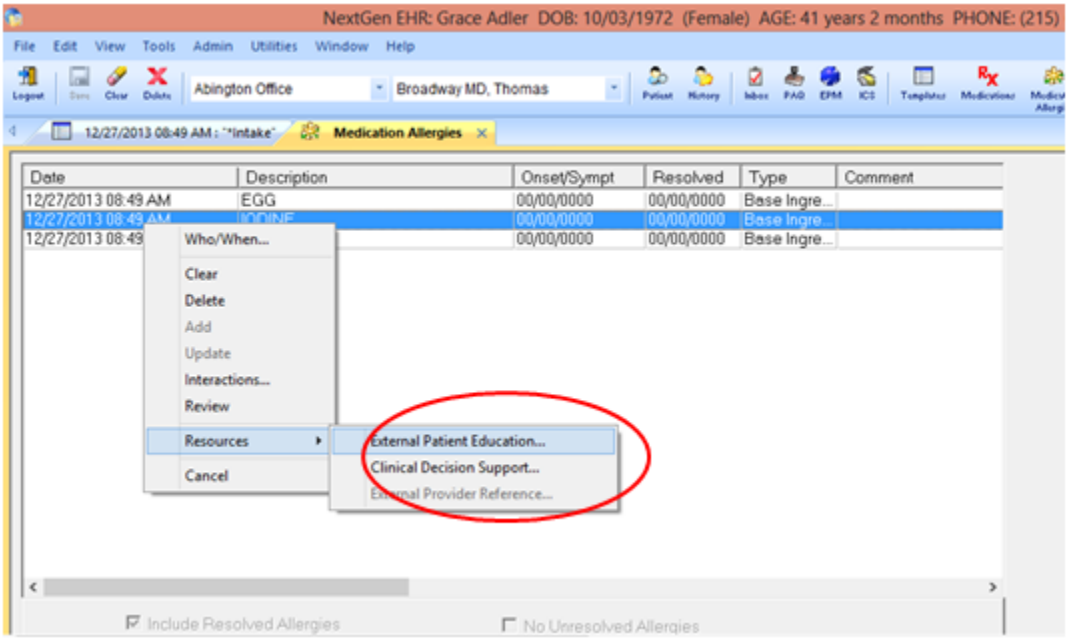
External Provider Reference: The external provider reference is an additional external reference you can set up for your personal use. This can be any site that you want to refer to for additional information. However, the external provider reference is not connected to the HL7 InfoButton, so context-sensitive information must be manually mapped into your templates.

Allergy Module

When the **Allergy Module** is accessed, the resources collects RxNorm information for the selected allergy, as well as the patient's age, age range and gender. This information is passed through the InfoButton into the external system.

To access resources from the **Allergy Module**

- Highlight the allergy.
- Select ***External Patient Education*** to direct you to the external URL set up in **NextGen File Maintenance**.

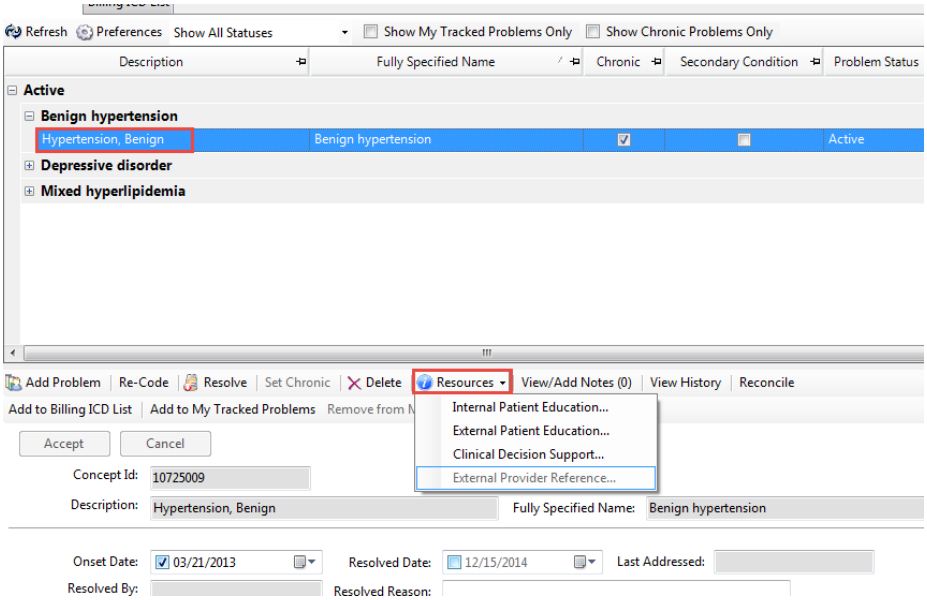


Diagnosis Module

These resources collect ICD9, ICD10 or SNOMED CT code information for the selected diagnosis. This information is passed through the InfoButton into the external system.

To acces resources for the **Diagnosis Module**

- Highlight the diagnosis.
- Select the ***Resources*** button.
- Select ***External Patient Education***.



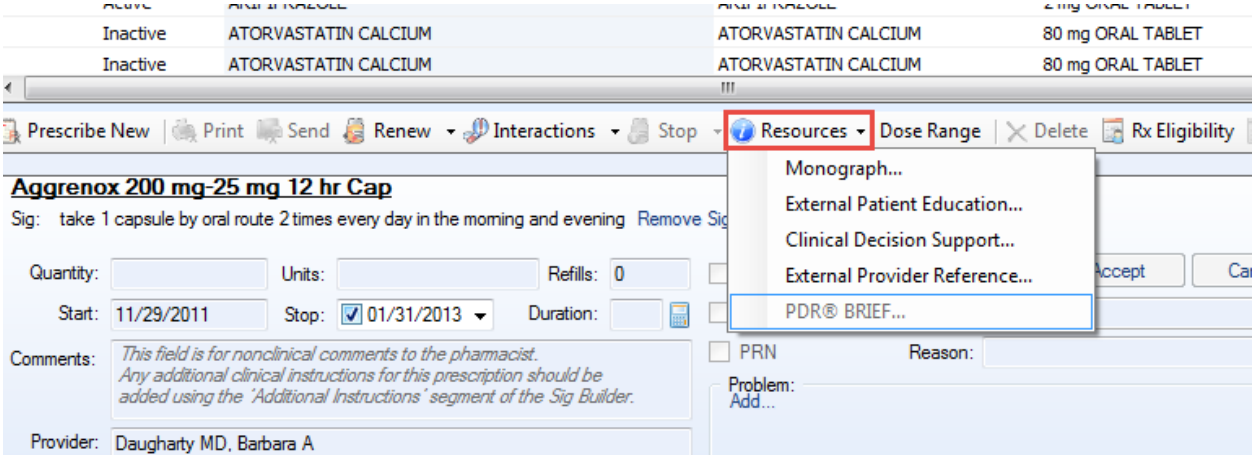
Medication Module

When the **Medication Module** is accessed, the resources collect the RxNorm information for the selected result, as well as the patent's age, age range and gender.

To acces resources for the **Medication Module**

- Highlight the diagnosis.
- Select the ***Resources*** button.

Select ***External Patient Education.***



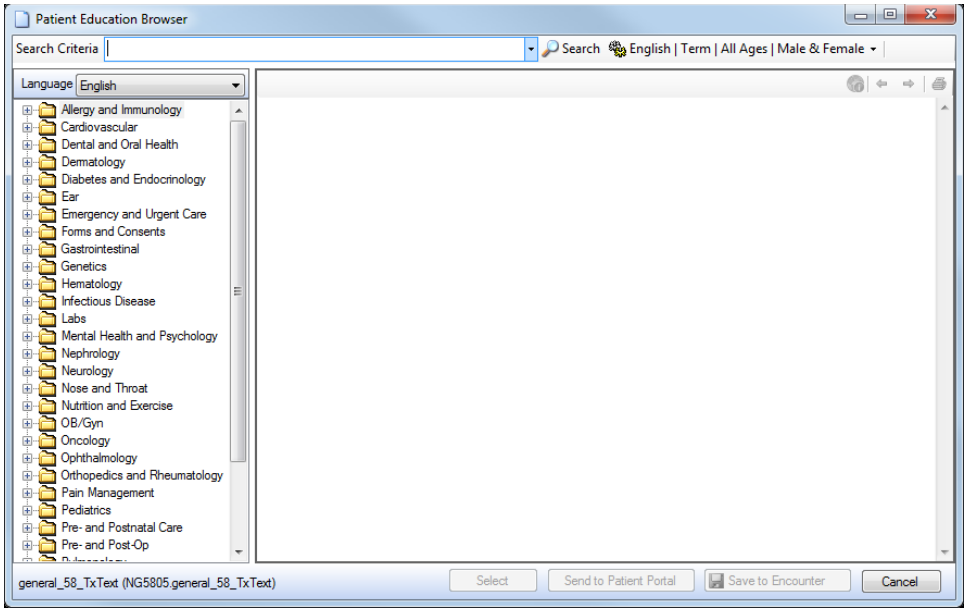
The user can also access the **External Patient Education** in the **Orders** and **Procedures Module** as well.

Healthwise Patient Education

Healthwise Patient Education*:* Healthwise Patient Education Module (PEM) is a third-party software package used with NextGen Ambulatory EHR. It enables you to access educational material that covers a variety of health topics that can be printed and given to patients

To access **Healthwise Patient Education**

- Select ***Patient Education*** from the **File** menu
- The patient education consists of three major components:
  - **Search Pane Allows:** You to enter search criteria for patient education materials. Search criteria can be filtered by language, topic (ICD9 Code, CPT Code, Title and Term), age range, and gender.
  - **Browse Pane Allows:** You to manually browse through categories for patient education materials. You can set a language filter, and browse by age and gender within categories.
  - **Display Pane Displays:** A preview of the selected patient education material. You can use the display pane to access the Knowledgebase for additional information on a topic. You can also save patient education materials to an encounter or send materials to patient portal from the display pane.



Care Management – Care Management/Case and Consent Visits

Care Management Visits

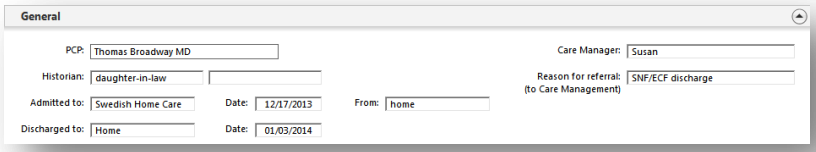
The **Home Page** is the starting point for this visit.

- Select the ***Care Plan Home*** template.
- Select the ***Care Management*** specialty as well as **Visit Type.**

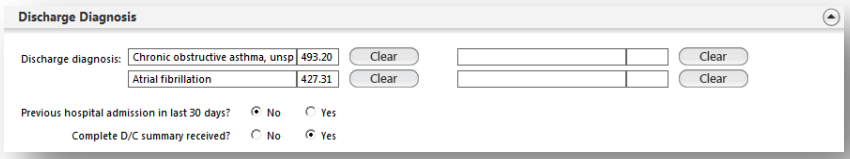
Care Transitions

This panel focuses on instructions for documenting a patient' transition of care.

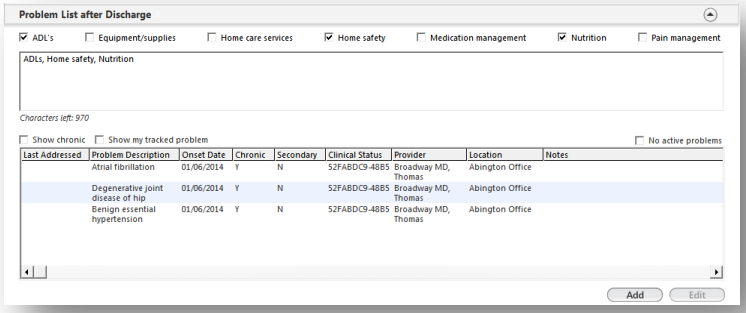
- General Panel
  - Document the patient's discharge by the hospital or other facility.



- Discharge Diagnosis Panel
  - Record one or more diagnosis for a patient who is being transitioned to another provider or who is being referred to a specialist by selecing the ***Discharge Diagnosis field.***
  - The **Diagnosis Search** window will display.
  - Select a diagnosis and appropriate radio buttons.

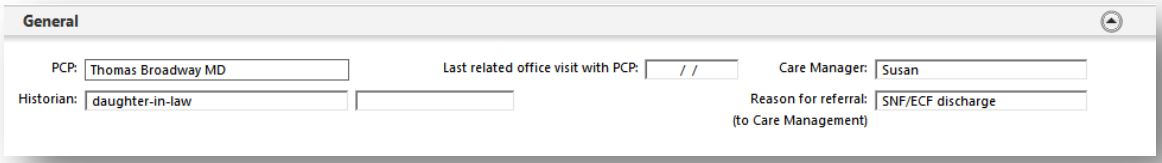


- The Problem List after Discharge Panel allows an update of the patient's problem list.
  - Select the ***Add*** button.
  - Document problem as instructed earlier in manual.

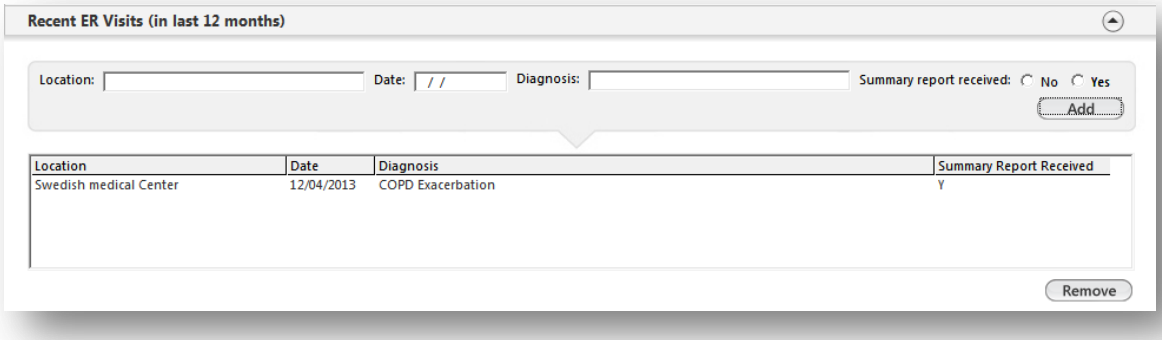


Comp Assessment

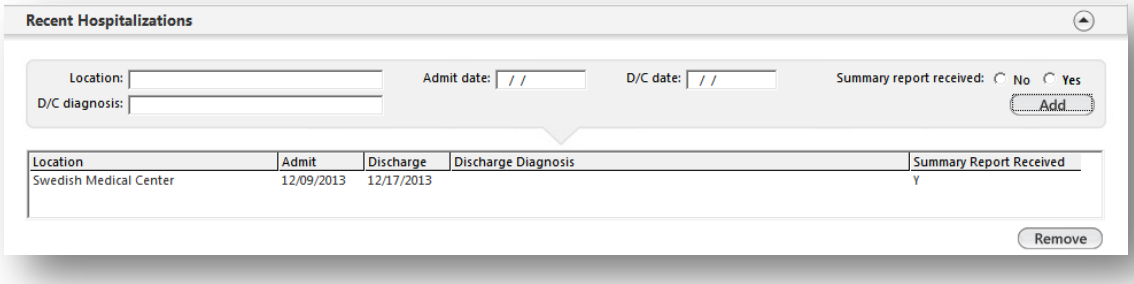
- General Panel
  - Contains information carried forward from the **Care Transitions** template.



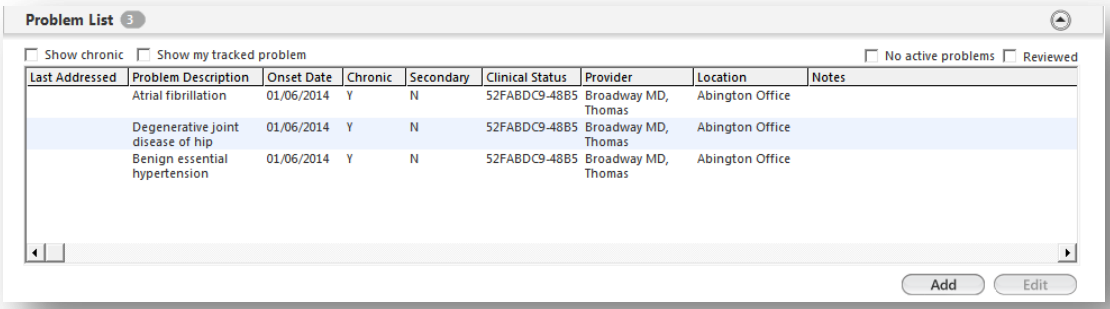
- Recent Er Visits Panel
  - Document any ER visits within the past 12 months.



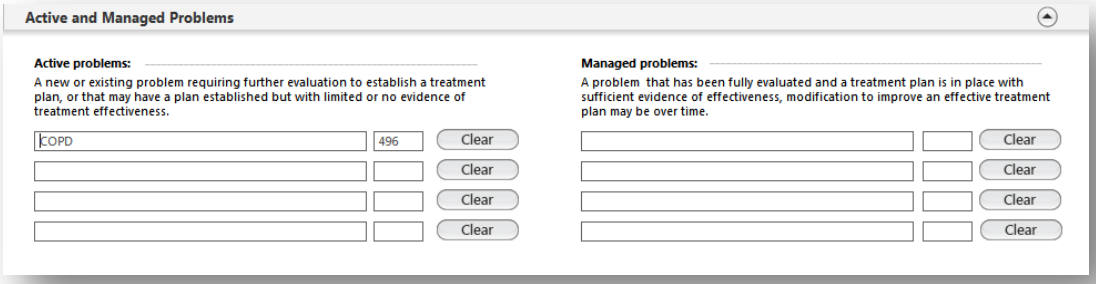
- Recent Hospitalizations Panel
  - Document any hospitalizations.
  - Free text information in appropriate fields.
  - Select the ***Add*** button

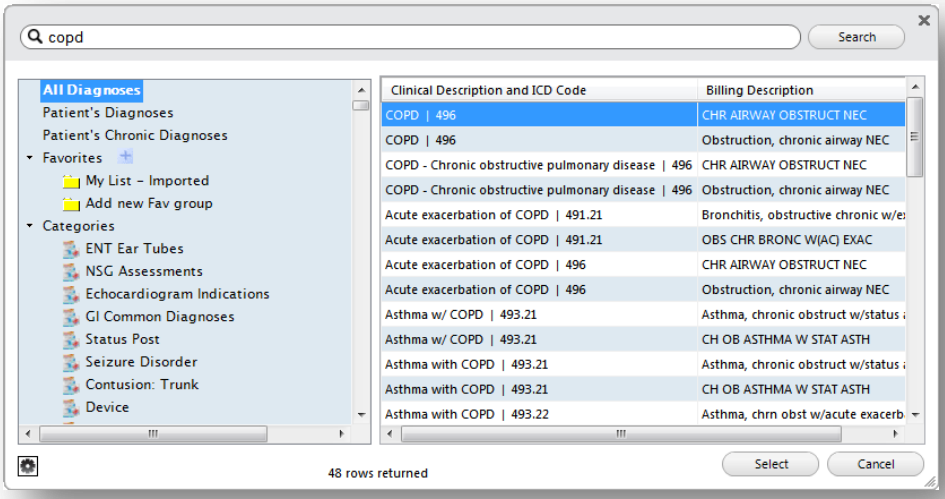


- The Problem List after Discharge Panel allows an update of the patient's problem list.
  - Select the ***Add*** button.
  - Document problem as instructed earlier in manual.

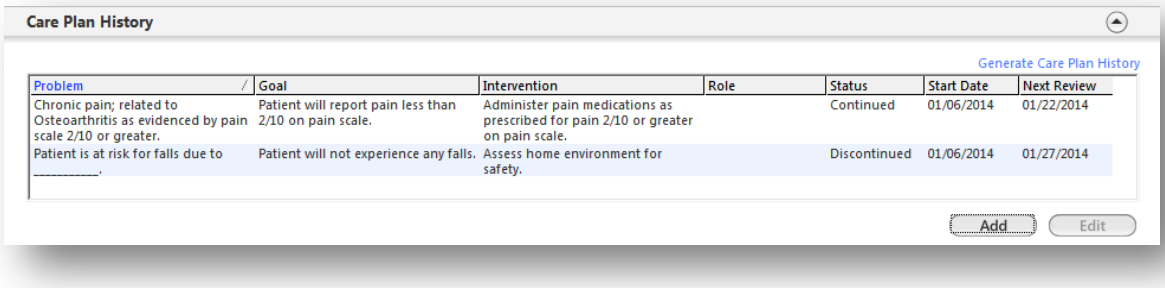


- Active and Managed Problems Panel is for documenting new or existing problems that require further evaluation as well as to show evidence of treatment of fully evaluated problems.
  - Place cursor in field.
  - Search for appropriate code.
  - Select appropriate code.

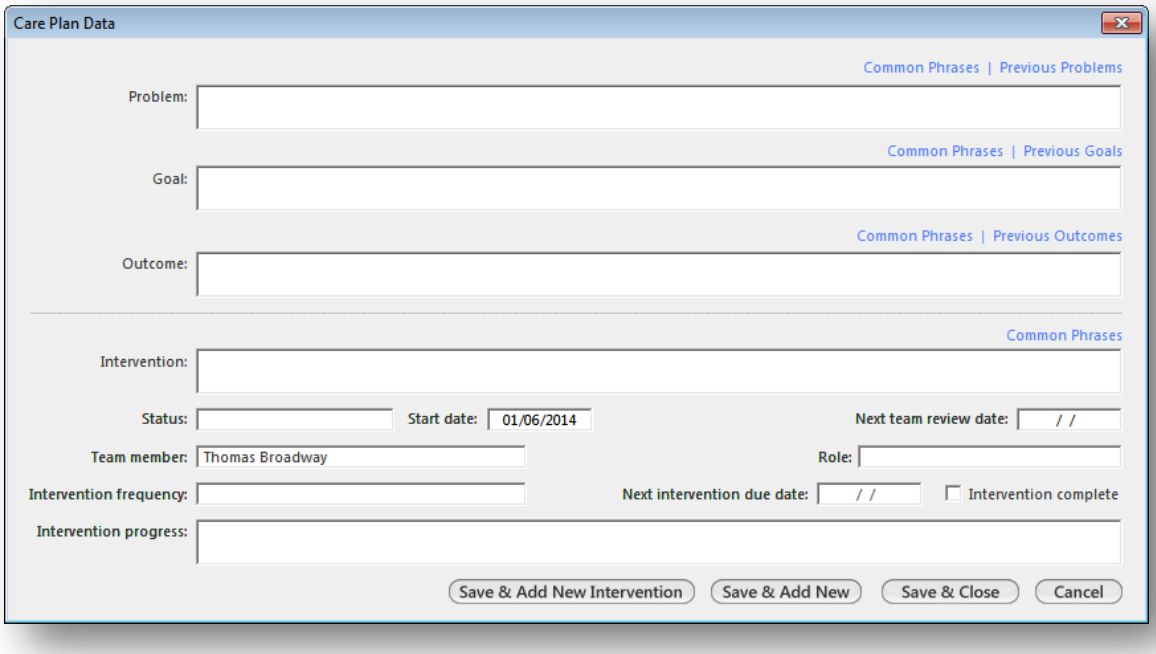




- Care Plan History Panel lists all of the care plans that have been created for the patient.
  - The plans can be created on the Care Plan template, on the Care Plan History panel of the Plan/Intervention template or below by selecting ***Add.***

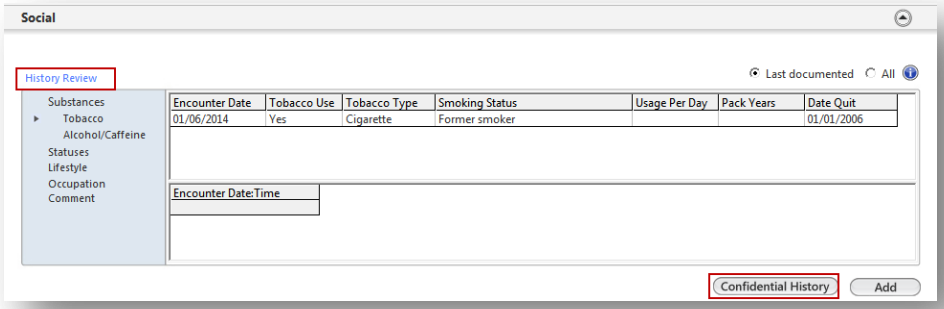


- The Care Plan Data pop up will display when select ***Add***. Free type in the problem, goal, outcome, and intervention section.

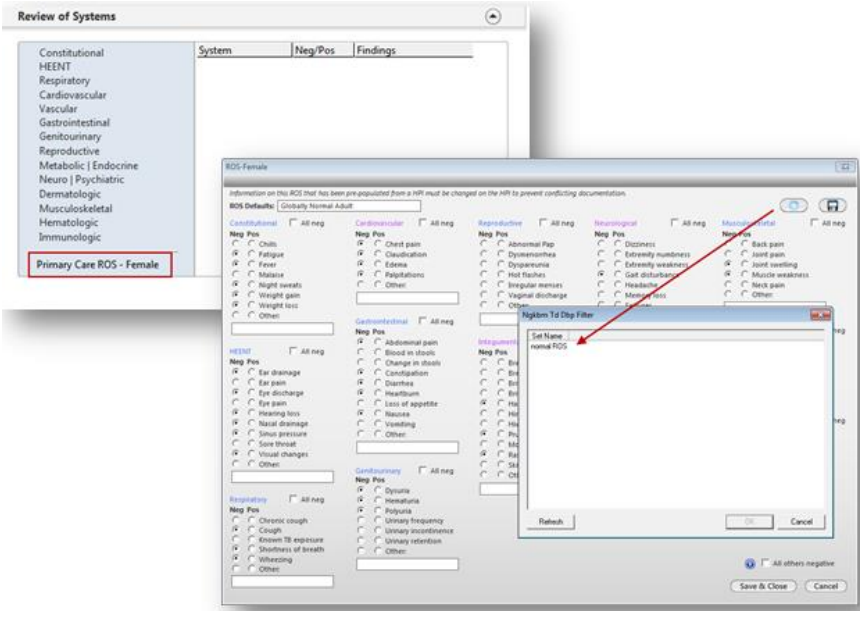


- MedicationPanel
  - Document all current medications by selecting the ***Add*** button.
  - Continue document as instructed earlier in this manual.

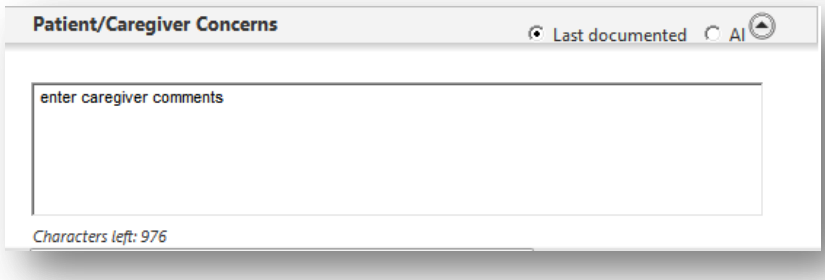
- Social Panel
  - Document all social information by selecting the ***Add*** button.
  - If confidential information needs documenting, select the ***Confidential History****/ button.*
  - Select the ***History Review*** button to indication detail of review.
  - Continue document as instructed earlier in this manual.



- ROS Panel
  - Document all current ROS by selecting the ***Primary Care ROS*** button.
  - Continue document as instructed earlier in this manual.

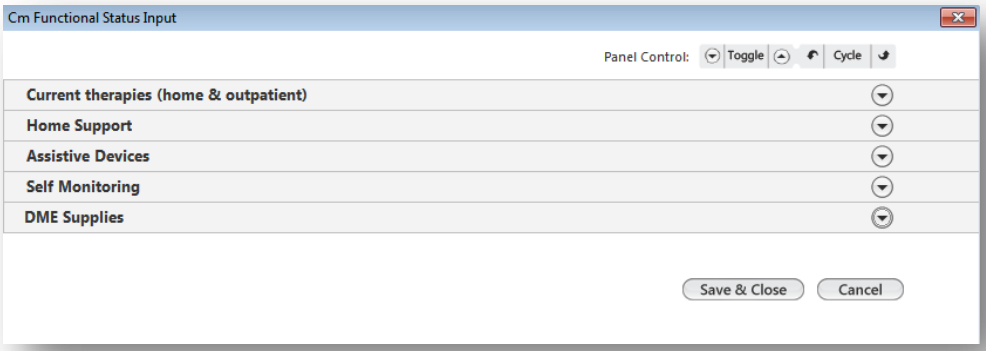


- The Patient/Caregiver Concerns Panel documents any concerns expressed by the patient, family members and/or caregivers.
  - Place cursor in field and free text.



Functional Status

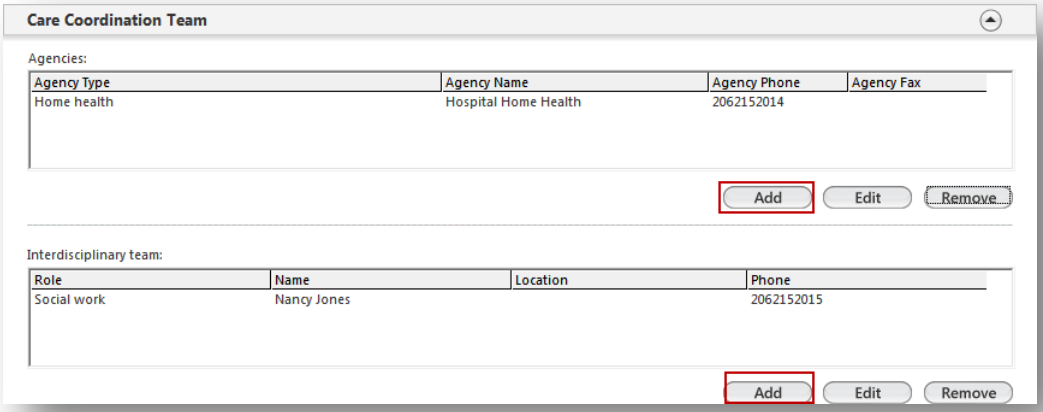
- Functional Status Summary Panel
  - Select ***Add/Update*** button to launch the **CM Functional Status Input** template.
  - Enter the corresponding inforamtion for **Current Therapies, Home Support, Assistive Devices, Self Monitoring** and **DME Supplies.**



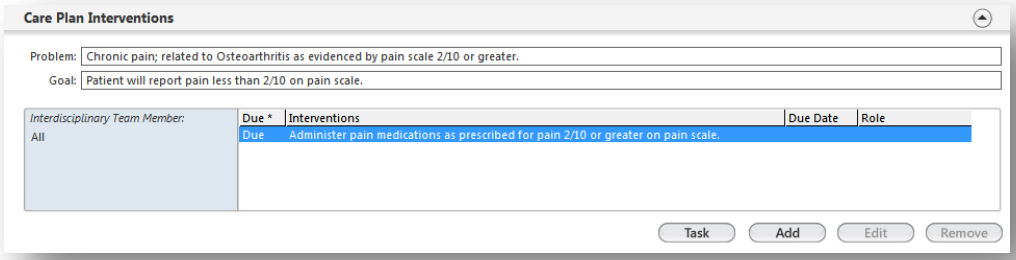
  - The collected orders display in the **Functional Status Summary Panel.**

Plan/Intervention

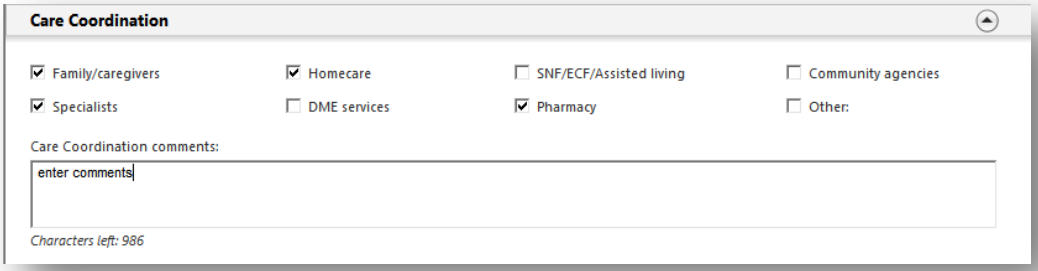
- Care Coordination Team Panel defines the team members providing healthcare for the patient.
  - Select the ***Add*** button to define agency, team member or both.



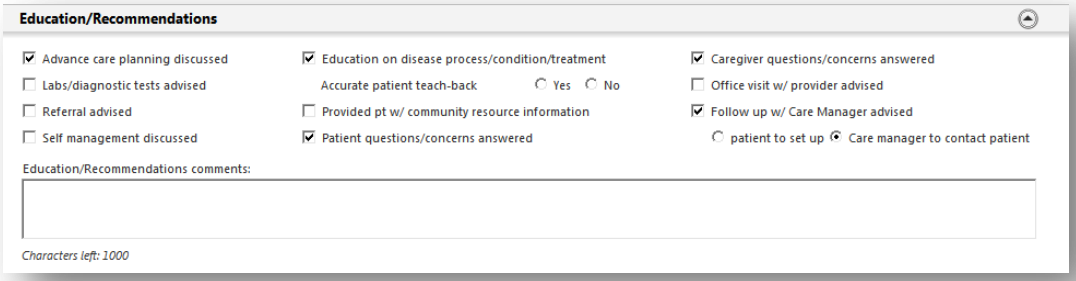
- Care Plan Intervention Panel
  - Complete intervention if goal has been achieved.
    - Highlight the intervention and select the ***Edit***
    - Mark it completed.



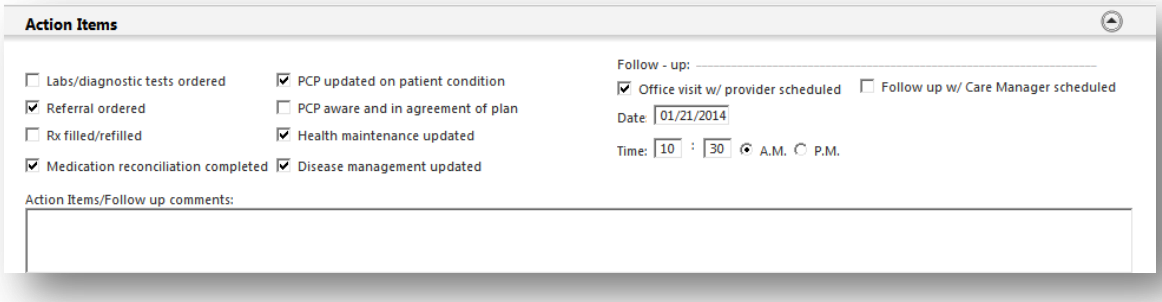
- Care Coordination Panel displays everone involved in the patient's care.



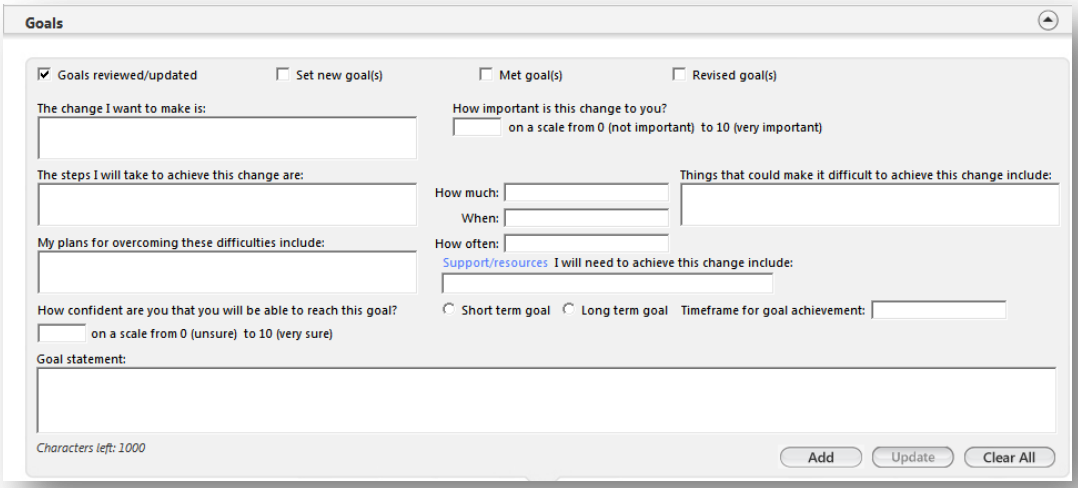
- Education/Recommendations Panel allows documentation for material provided to the patient.



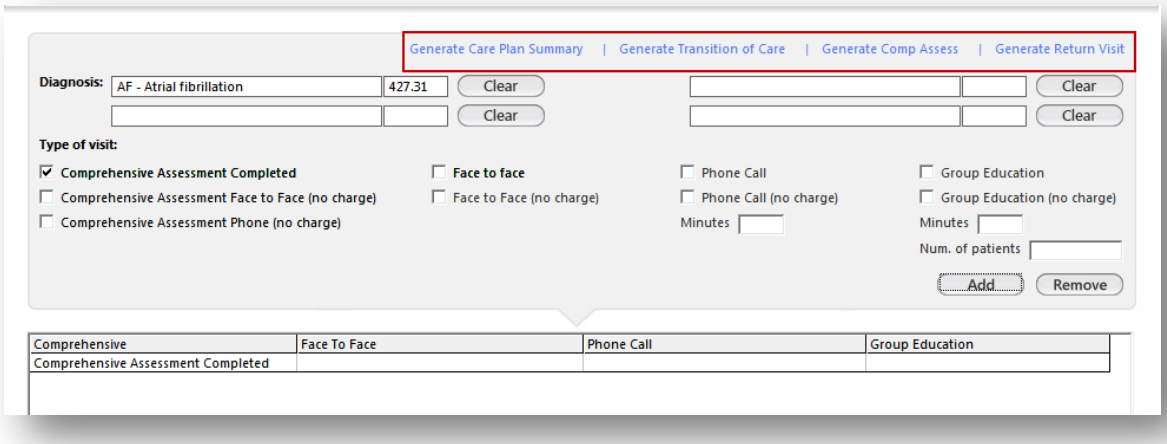
- Action Items Panel displays a list of all actions performed during the visit.



- The Goals Panel displays patient's goals in detail.
  - Select ***Add, Update*** or ***Remove*** button to edit goals.



- The Document Panel is used to generate documents and the **Superbill** can be submitted by selecting ***Submit to SuperbillBI.***



Care and Consent Visits

The **Home Page** is the starting point for this visit.

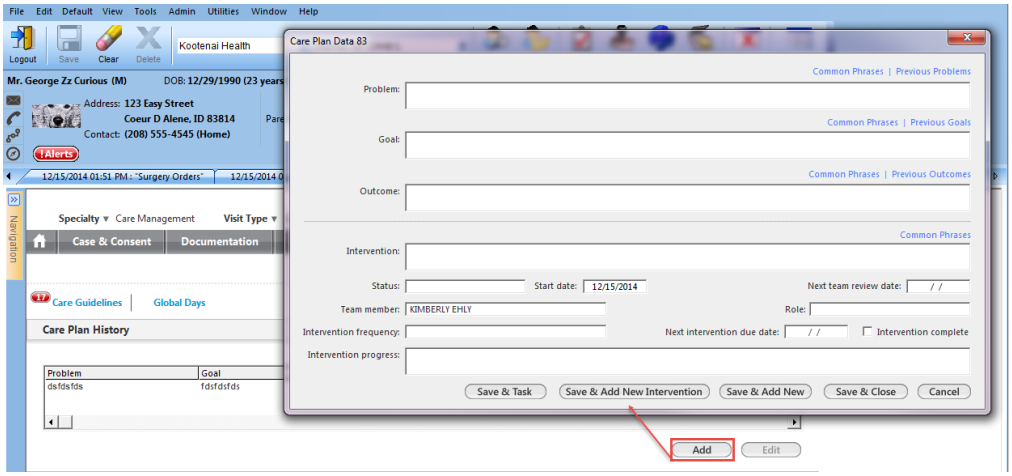
- Select the ***Care Plan Home*** template.
- Select the ***Care Management*** specialty and ***Case and Consent*** for the **Visit Type.**

Case &Consent

Case & Consent Panel is where the usesr documents all patient's consents.

Care Plan History Panel is used to update case functionality.

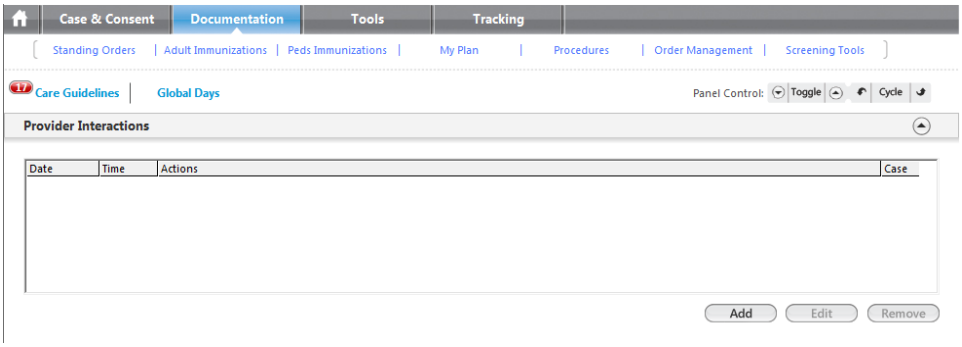
- Select the ***Add/Edit*** buttons
- The **Care Plan Data** pop up will display.
- The user can add and edit interventions.



Documentation

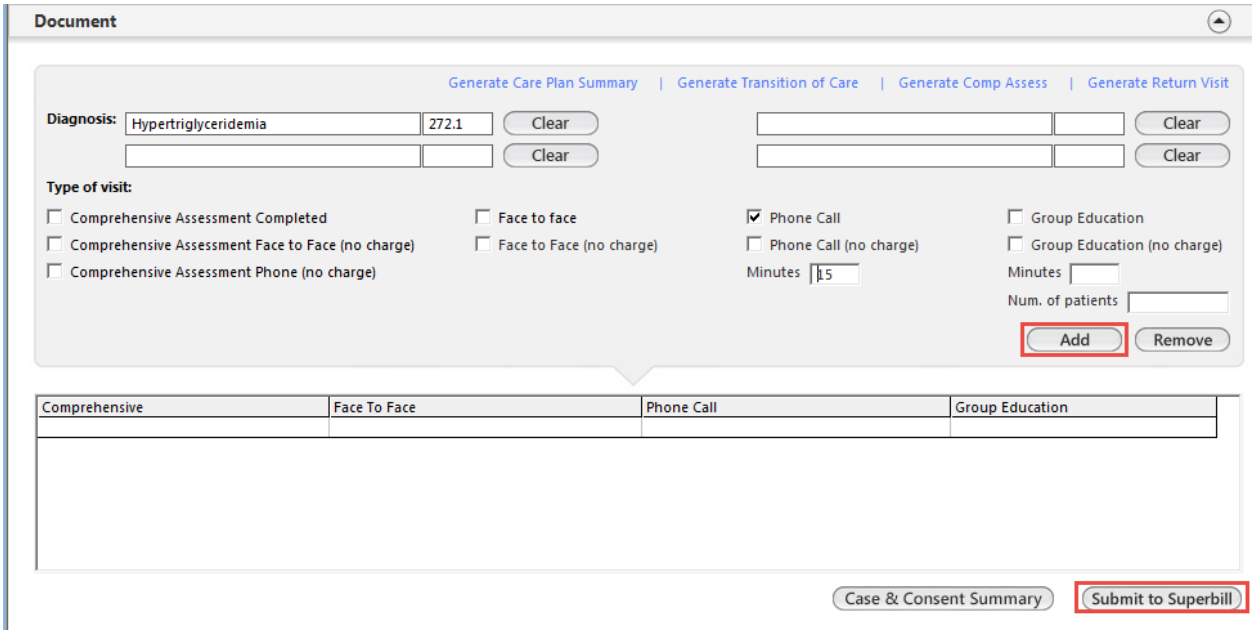
Provider Interactions, Telephone Interations, face-to-Face Interactions, Care Coordination Interaction Panels all document any necessary comments concerning the patient care.

- Select the ***Add/Edit*** buttons.



Document Panel is to document details of the visit for billing purposes as well as generate documentation.

- Once fields are populated, select the ***Add*** button to populate the grid.
- Once all documentation is in the grid, select the ***Submit to Superbill***.

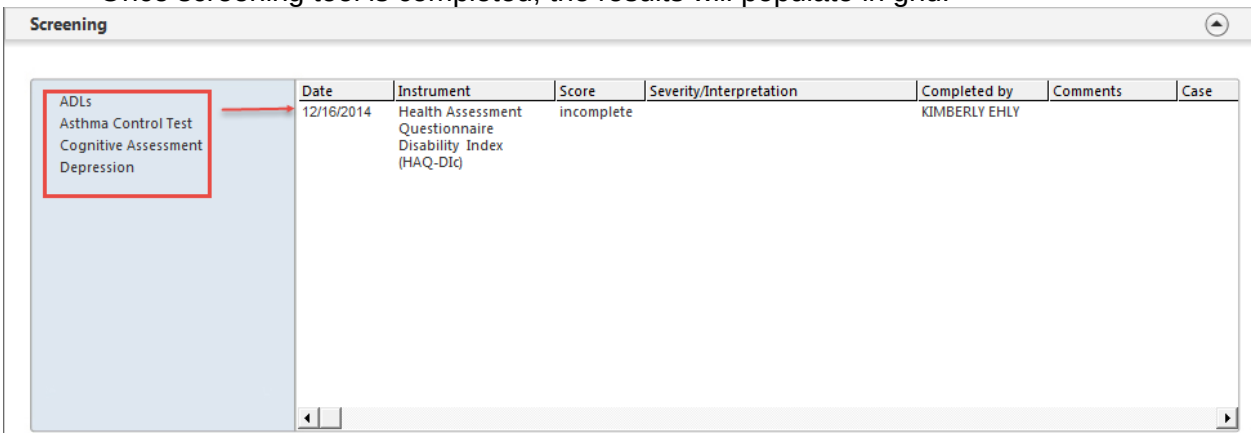


Tools

The **Tools** template provides links to common screening tools and presents the results of completed questionnaires.

The Screening Panel

- To access screening tools, navigate the left side of the grid.
- Once screening tool is completed, the results will populate in grid.

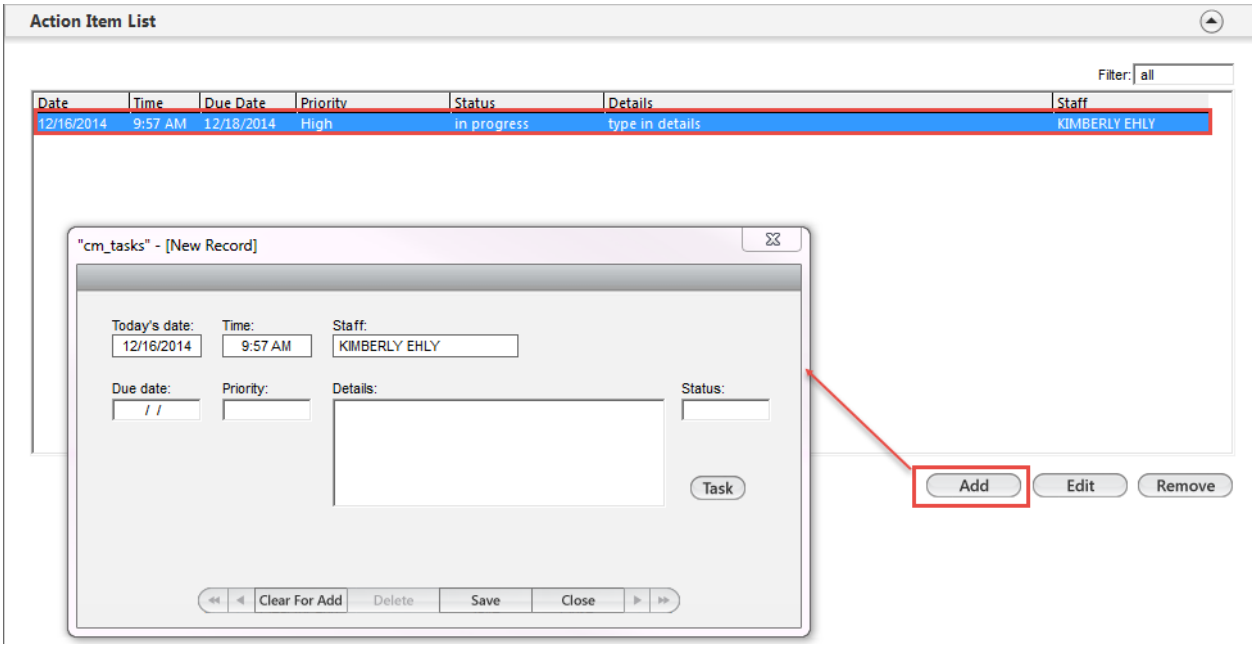


Tracking

The **Tracking** template is where action items can be added and managed.

The Action Item List Panel

- Select the ***Add/Edit*** buttons to manage items.
- Document item and select ***Save*** when completed.
- The action item will populate in grid.



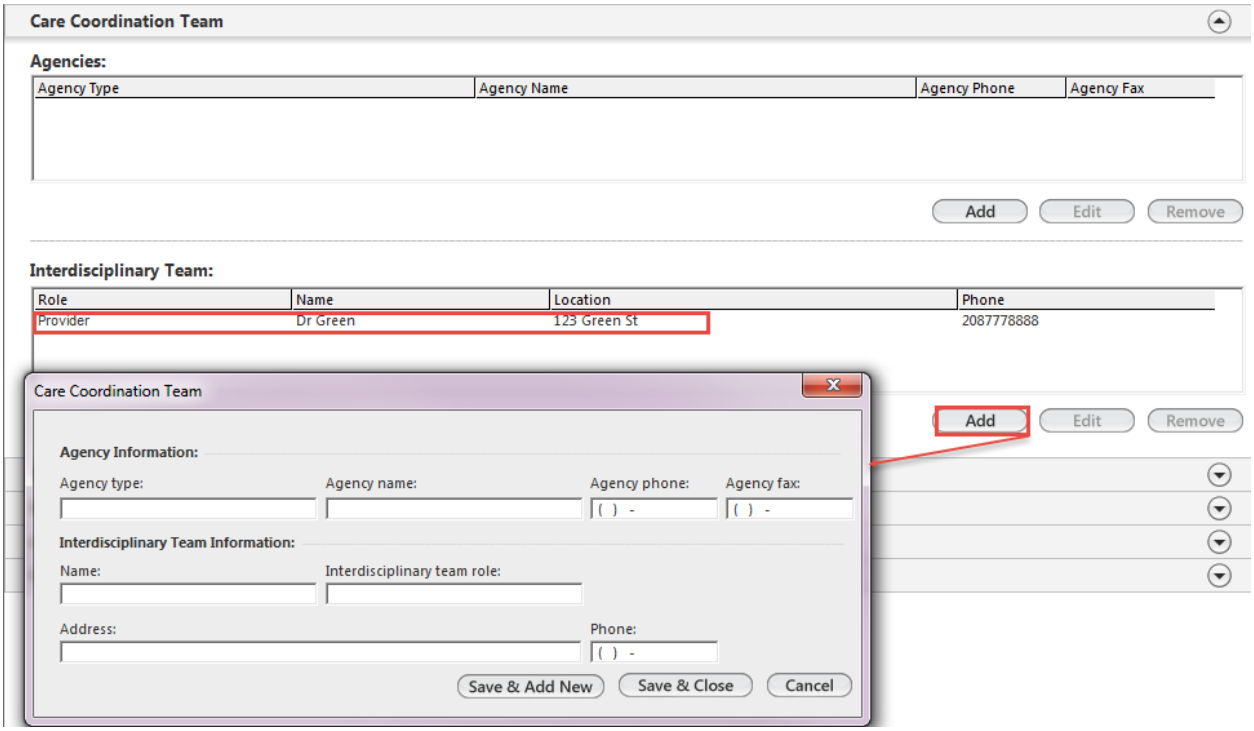
Care Coordination

This template is used by providers or other care team members to document patient care inforamtion such as Care Coordination Team, Referrals, and Barriers to care. This template is used in cordination with **Medicare Preventative** exams.

Select the ***Care Coordination*** template from the **Left Hand Navigation.**

Care Coordination Team Panel allows user to manage patient's care team.

- Select the ***Add/Edit*** buttons
- Populate fields
- Select the appropriate ***Save*** option
- Information populates in appropriate grid.



Referral Panel

- Select the ***Add/Edit*** buttons
- Populate fields
- Select the ***Place Order*** option
- Information populates in appropriate grid.

Barriers to Care Panel

- Select the ***Add/Edit*** buttons
- Populate fields
- Select the appropriate ***Save*** option
- Information populates in appropriate grid.

Care Plan History Panel

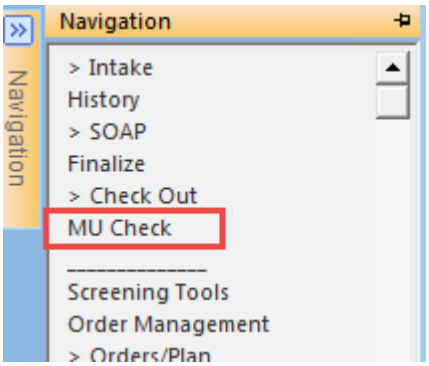
- Select the ***Add/Edit*** buttons
- Populate fields
- Select the appropriate ***Save*** option
- Information populates in appropriate grid.

Communication Panel is a panel to review all communications concerning this patient. The user can add from this panel by selecting the ***Add*** button.

Meaningful Use

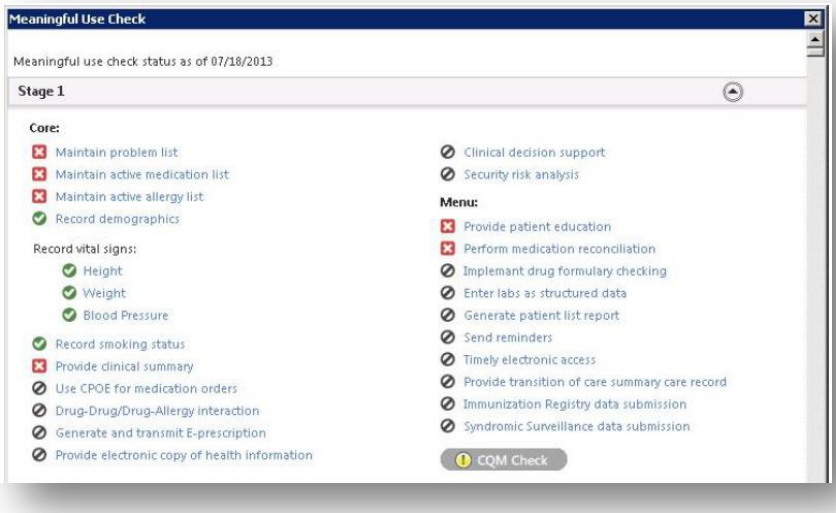
This pop up allow clinical staff and providers to verify that selected Stage 1 and Stage 2 Meaningful Use (MU) measures were completed for the current patient. To access the MU:

- Navigate to the **Left Hand Navigation** or use the **MU Check** sub navigation
- Select ***MU Check***



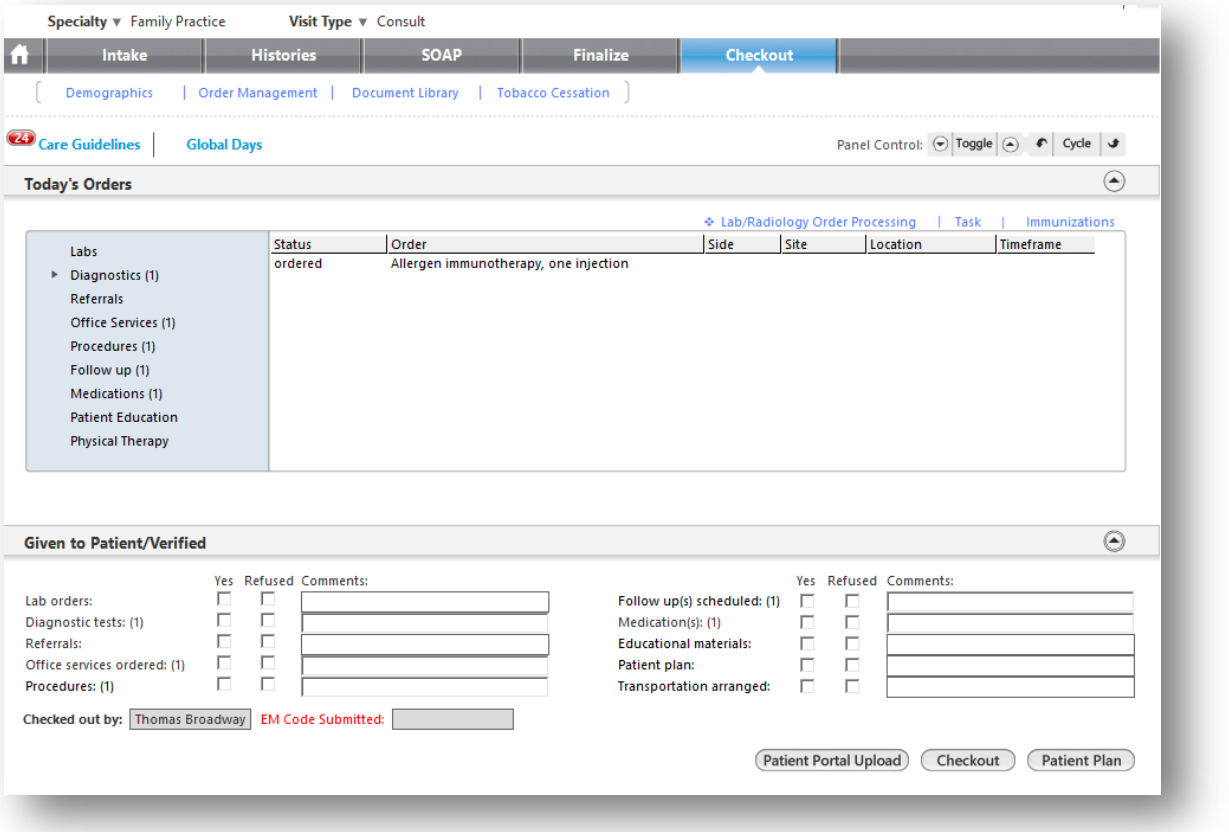
- The **Meaningful Use Check** pop up will display.
- A green checkmark means you have met the MU requirements.
- A red X indicates you have not me MU requirements.
- A black cross out sign means that measure cannot be tracked using the system.

The user can select on any of the measure and the system will navigate to that measure within NextGen, give more information explaing the requirement, or review the specific measure.



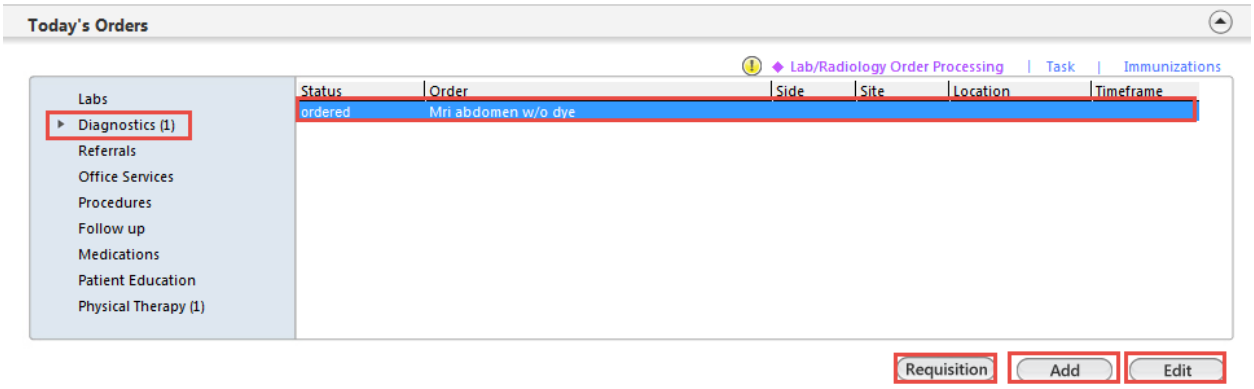
Checkout

The **Checkout** template allows the user to view today's orders, give patient education, print lab/diagnostic requisitions, view medications and verify information given to the patient.

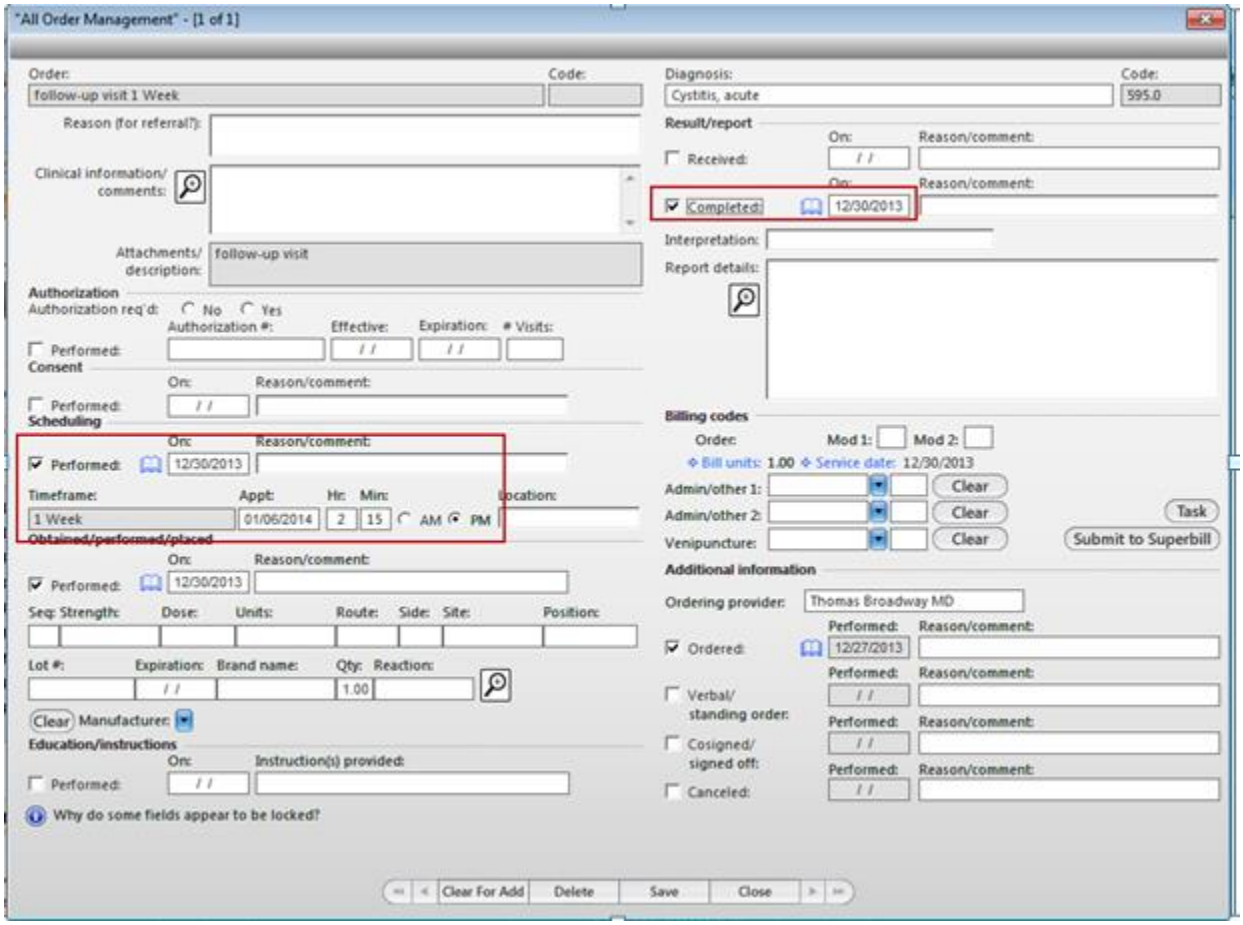


Today's Orders Panel

- Select order from the left side navigation bar to review.
- Hightlight the order
- If appropriate, print or task the lab/diagnostic requisition.
- Update the order by selecting the ***Edit*** button.

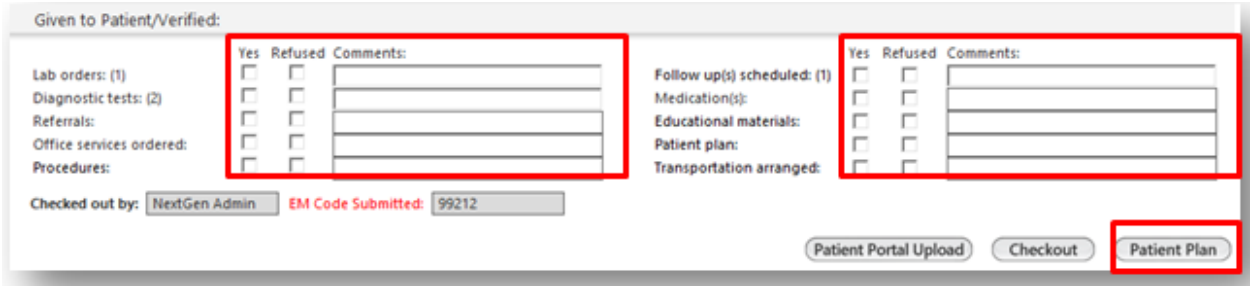


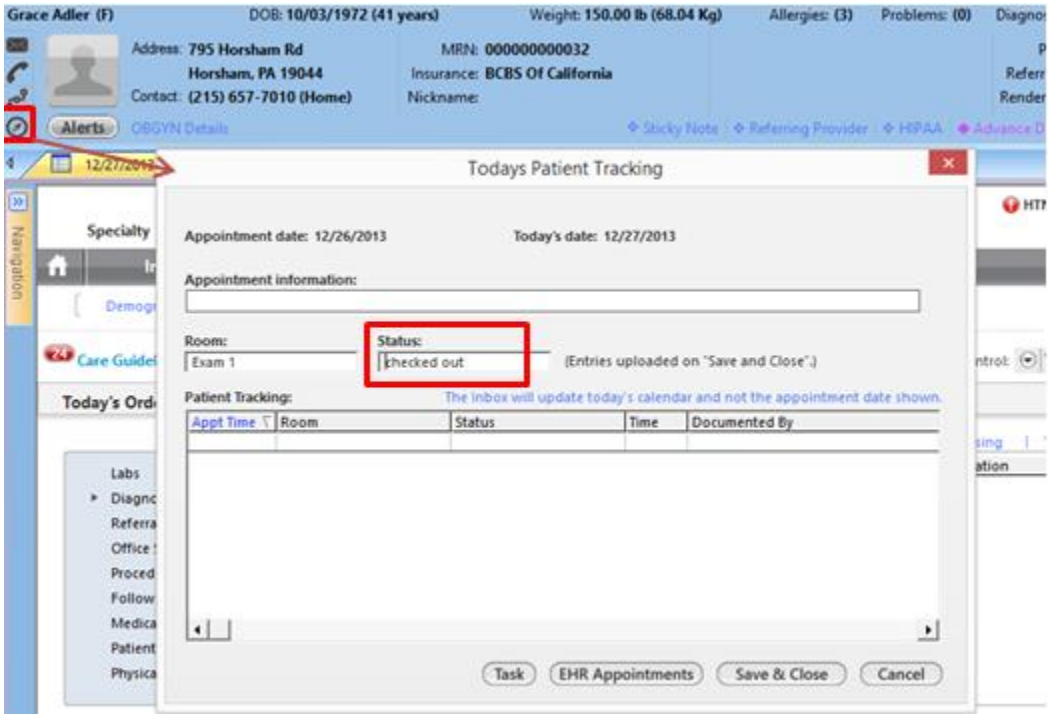
- Document the follow up appointment if appropriate.



Given to Patient/Verified Panel

- Select the appropriate checkboxes to indicate the patient's acceptance or refusal of documentation offered to the patient.
- Select the ***Patient Plan*** button to generate the patient plan which is required for MU.
- When completed, select the ***Checked out*** button to change the patient's status.



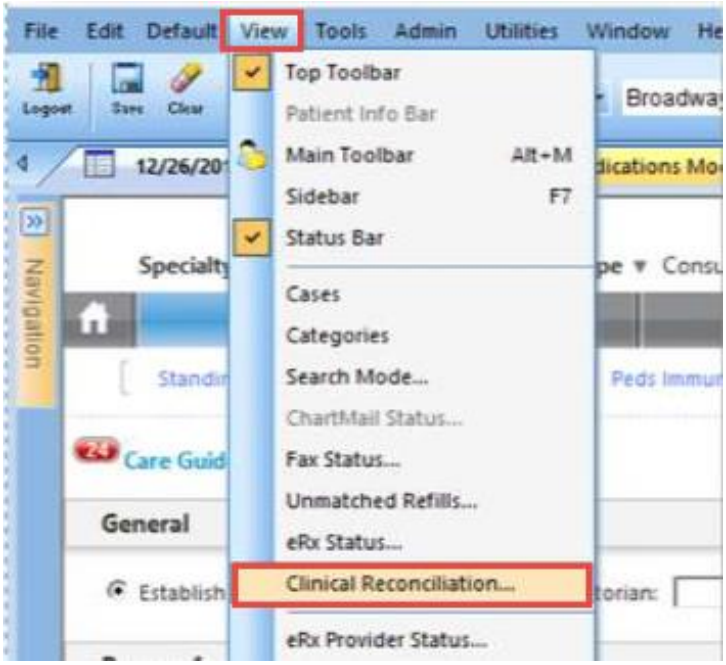


Clinical Reconciliation

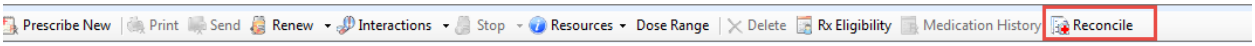
Accessing the Reconciliation Module

The **Clinical Reconciliatiton Module** allows the user to review a patient's existing data from CCD, CCDA, PCC documents or a patient's medication hisotry file from an ePrescribing vendor. To access the **Clinical Reconciliation Module**

- Open patient's chart
- Select ***View>Clinical Reconciliation***

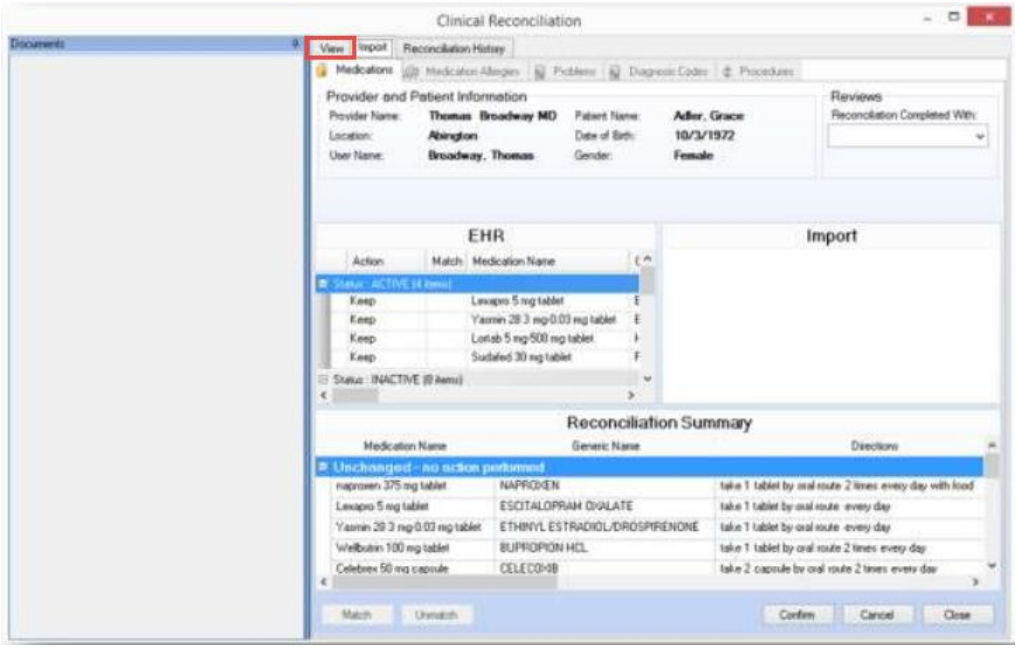


The user can also access by selecting the ***Reconcile*** button on the **Medication Module** toolbar.



The **Clinical Reconciliation Module** will display.

- Select documents to view, by selecing the ***View*** tab.



The following icons describe the type of documents available.

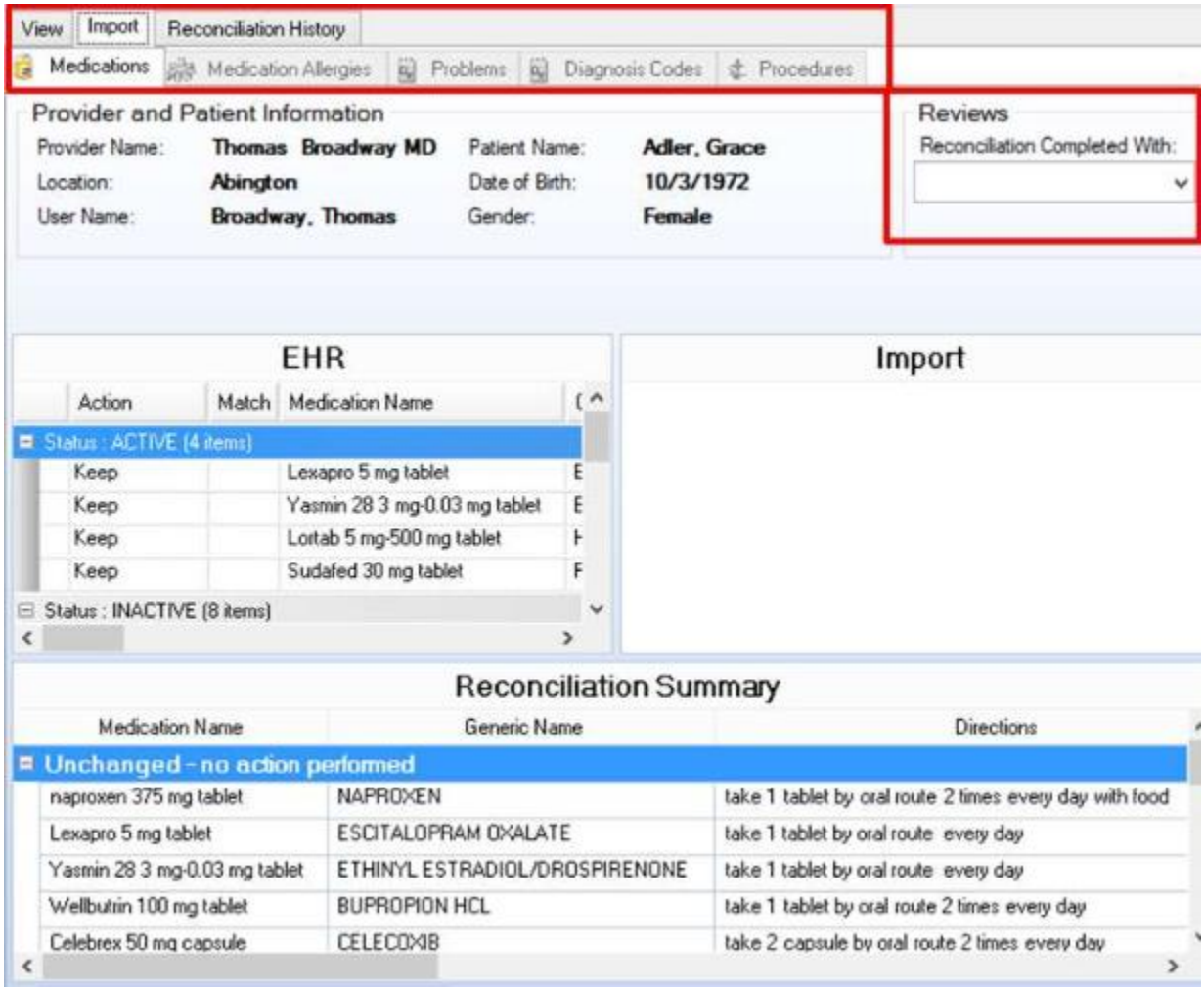
Icon	Description
	Imported document
	Replacement document
	Addendum
	On Demand document
	Snapshot document (occurs when an on-demand document is unavailable, but an available copy is retrieved form the repository)
	Imported document from another practice or external system

Reconciling Clinical Data

The **Medications, Medication Allergies**, and **Problems** tabs display three sections.

- EHR
- Import
- Reconciliation Summary

The **Diagnosis** and **Prcedures** tabs display just the **Import** section.



- The **Import** section displays information from the selected document that corresponds to the tab selected.
- The **EHR** section displays information stored in the patient's chart that correspsonds to the tab selected.
- The **Reconciliation Summary** displays a list of items from both the **Import** and **EHR** sections and indicates the selected actions to be performed.

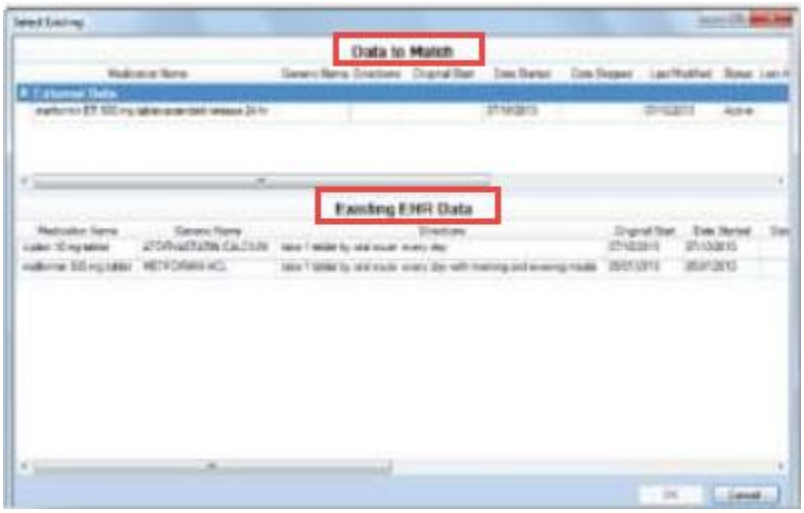
Processing Items in Import Section

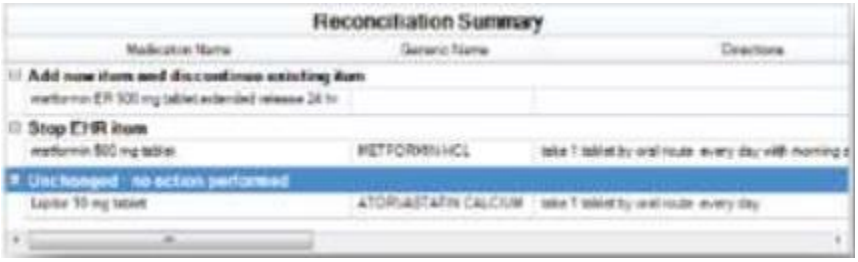
To process the items in the **Import** section

- Select the type of clinical data and the item you want to reconcile
- Select the ***Action*** column and select ***None, Ignore, Add,*** *or* ***Replace.***

- If you select ***Replace***, the **Data to Match** box will display.
- Select the item in the **Existing EHR Data** section you wish to replace
- Select ***OK.***

The change will display in the **Reconciliation Summary** section.

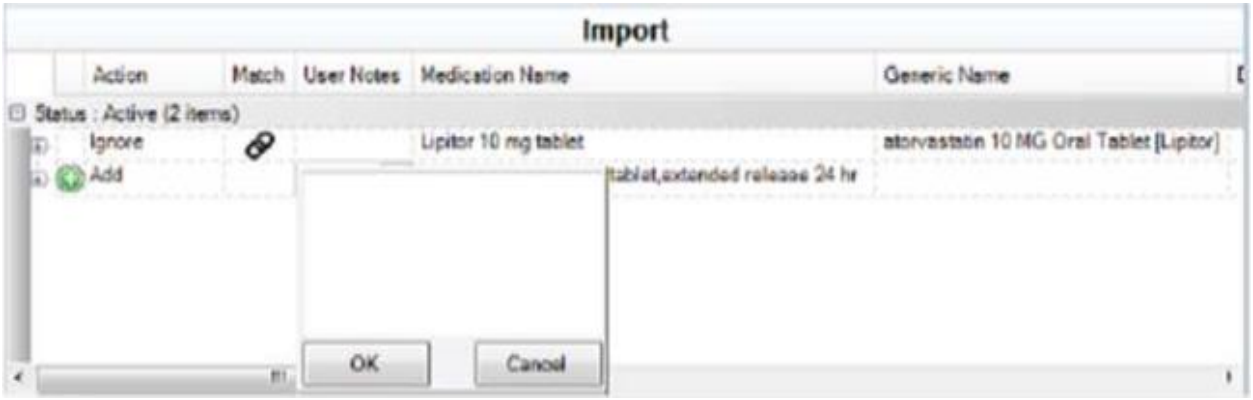


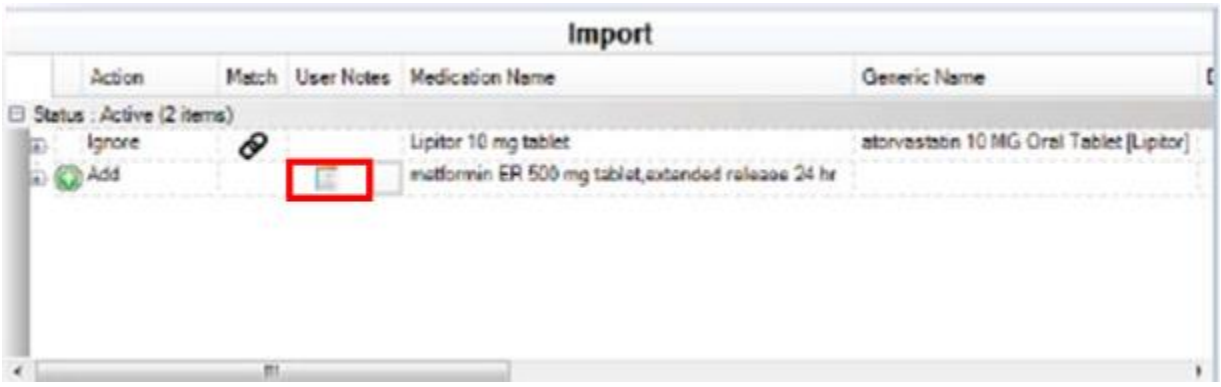


A user can add comments to the **Import** section by

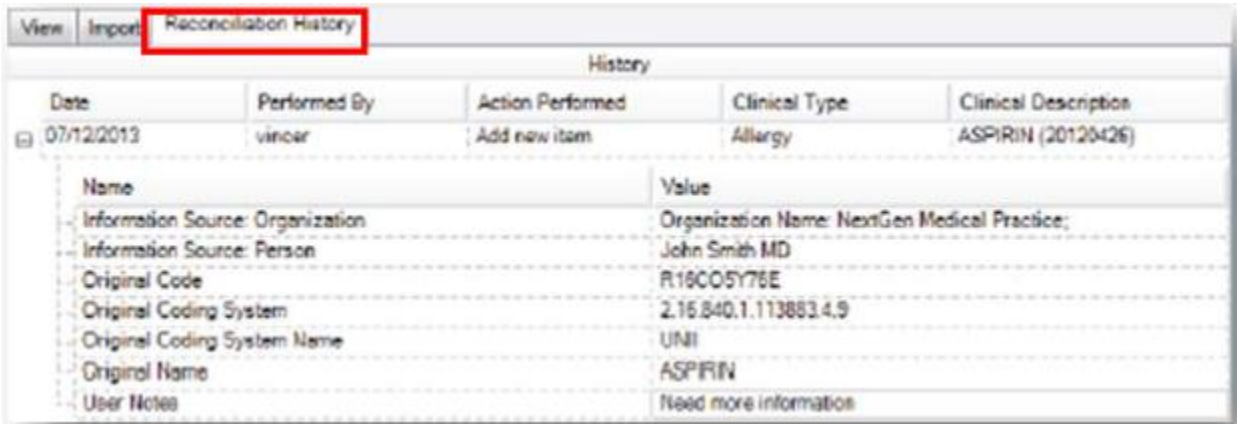
- Highlight item within section
- Select ***User Notes*** column
- Enter comments in text box
- Select ***OK.***

An icon now displays in the **User Notes** column to indicate a comment.





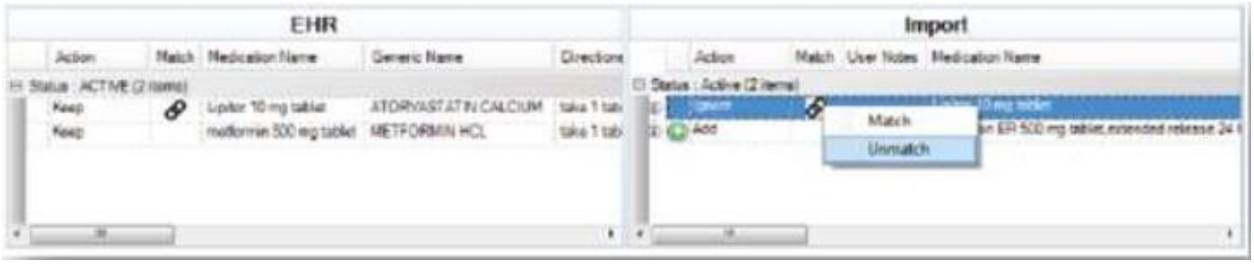
The user can view the comments by selecting the ***Reconciliation History*** tab and expanding the row that corresponds to the date the comments were entered.



Processing Items in EHR Section

To process within the **EHR** section

- Select the item to be reconciled
- Select from the drop down in the ***Action*** colum: ***Keep, Stop, Resolve*** or ***Delete***
- Match/Unmatch clinical items as needed by right clicking in the ***Import*** section

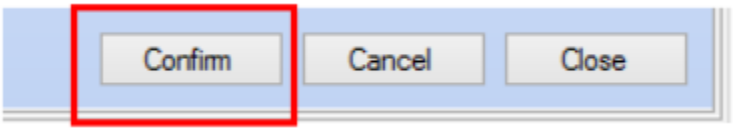


When choosing to match an item, the **Select Existing** pop up opens and displays two sections

- **Data to Match**
- **Existing EHR Data**
- Select the item to match in the **Existing EHR Data**
- Select ***OK.***

Once items have been processed in the **Import** section, **EHR** section, and clinical items have **Matched/Unmatched** as needed

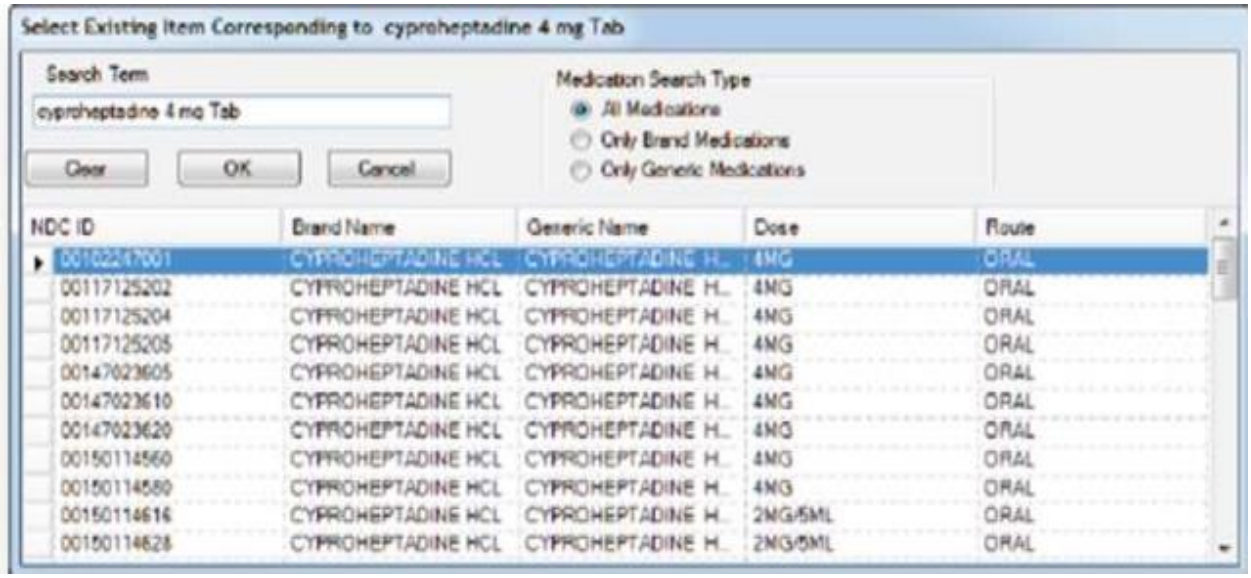
- Select ***Confirm*** to complete processing



A message will display that the changes were saved successfully.

If there is missing or incorrect data, a search dialog box will display. A list of potential matches will appear. The user can perform a manual search by

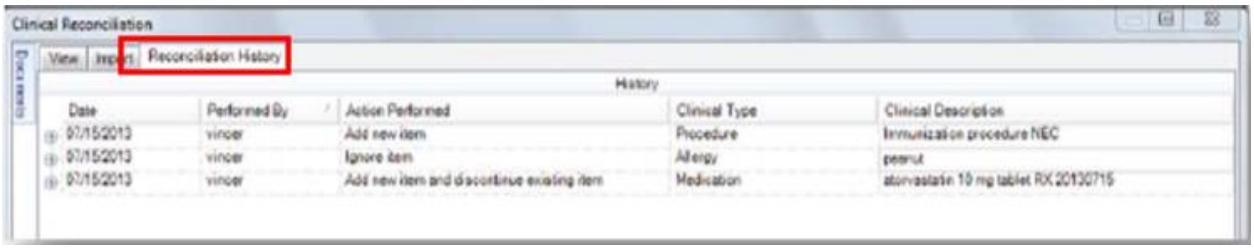
- Selecting the ***Clear*** and typing in the search bar.
- Select an item in the grid
- Select the ***OK***

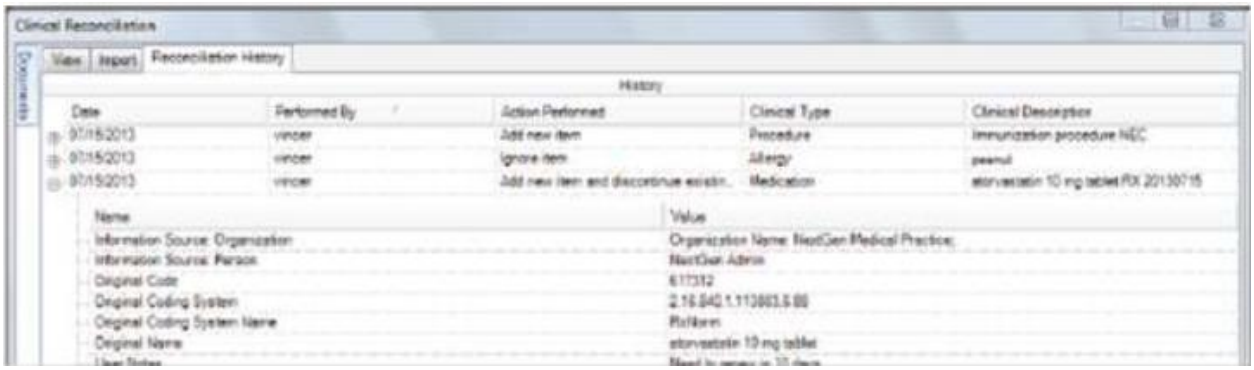


Reconciliation History

To view the **Reconciliation History**

- Select a document
- Select ***Reconciliation History*** tab
- Select the ***Plus sign*** icon to view details





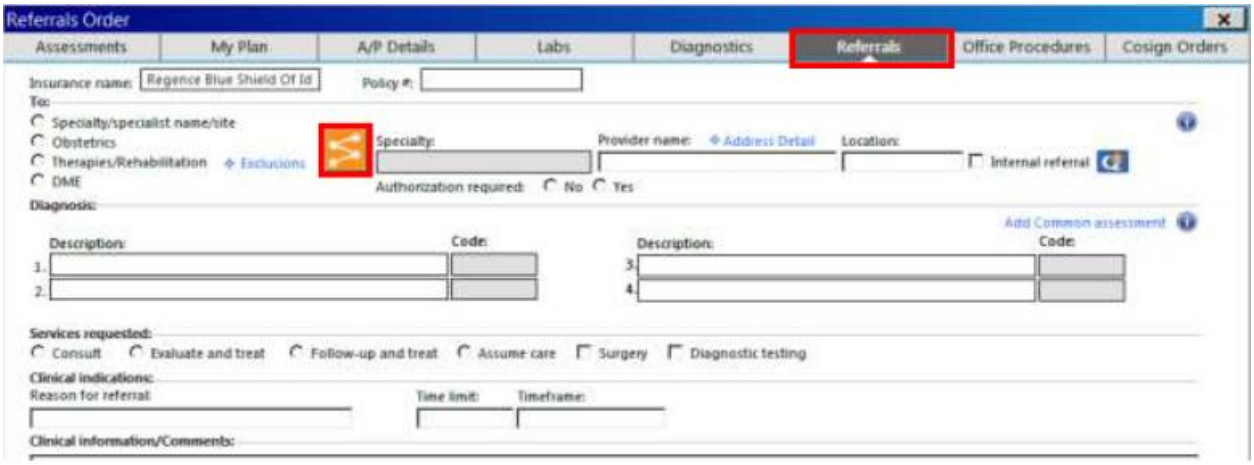
NextGen Share Portal

Introduction

Share is a communiation tool for creating electronic referrals that include Continuity of Care Documents (CCDs) for your patient. It utilizes a nationwide provider directory and enables providers to meet data sharing requirements for Meaningful Use, Stage 2, Measure 15.

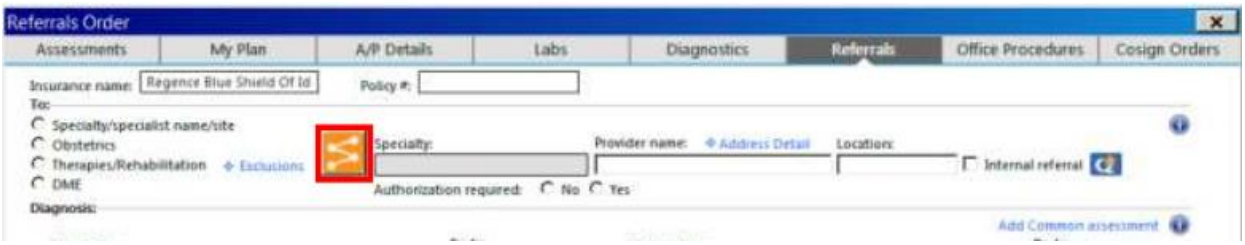
The Share Tool

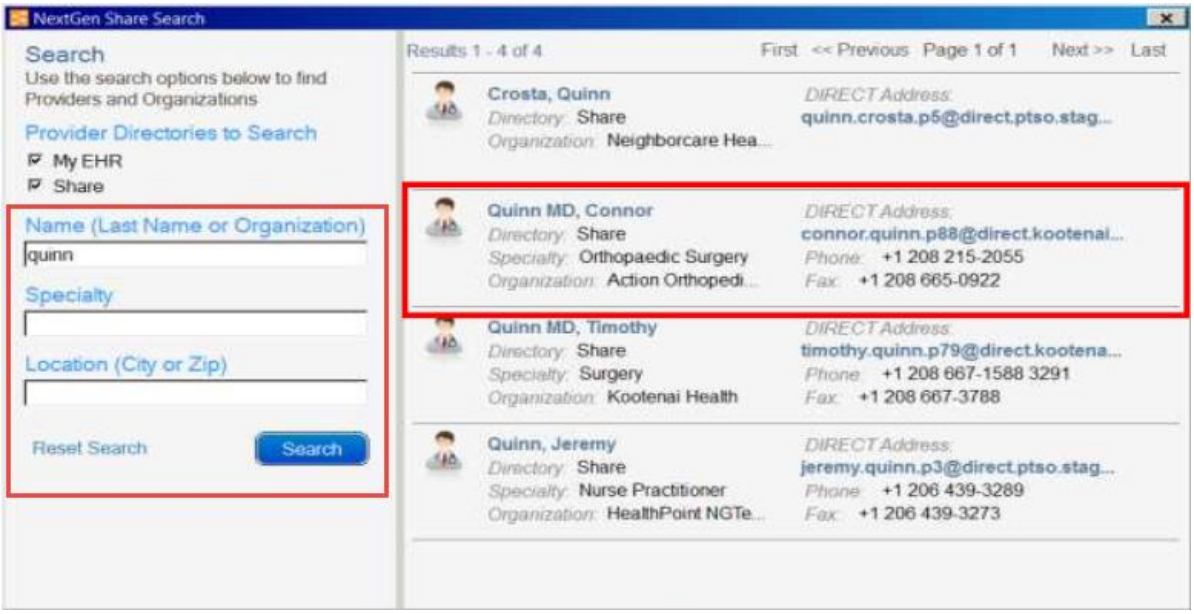
The **Share** tool is located on the **Referrals** template in the **Assessments/Plan** area of the **SOAP** template. The **Share** tool automatically creates a CCD document when you complete the process. It is best practice to complete all documentation prior to generating the referral. This should include the **Master** document at a minimum, but may also include a letter or image.

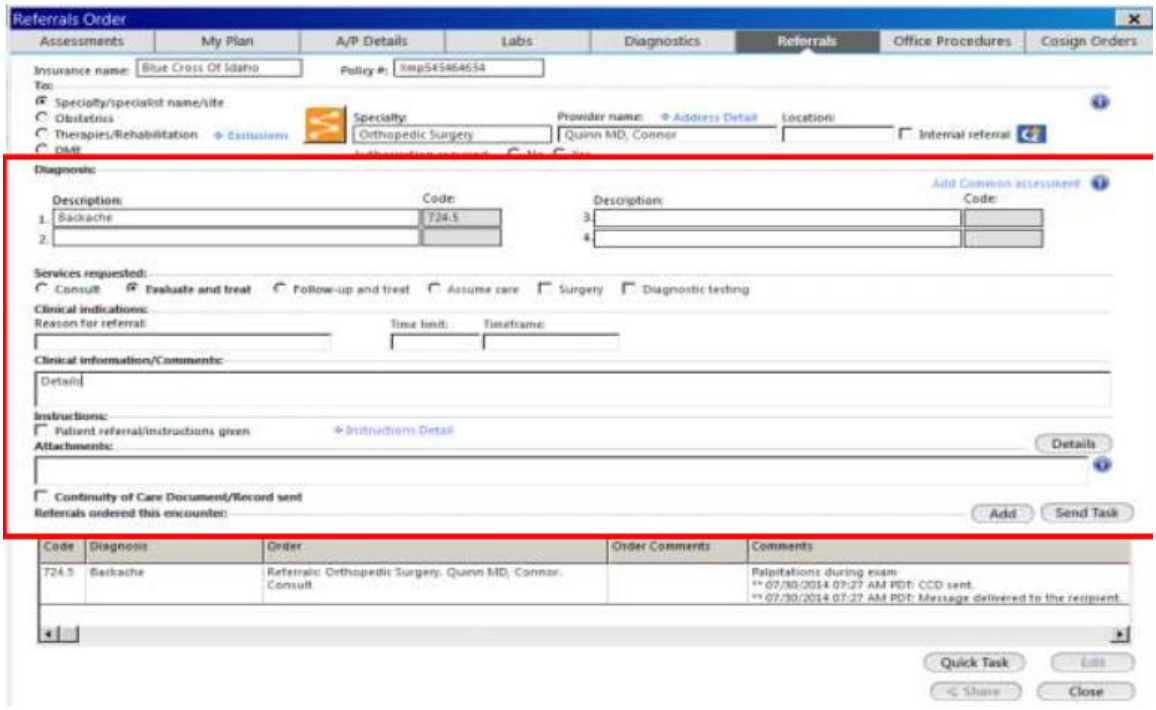


Sending a Referral

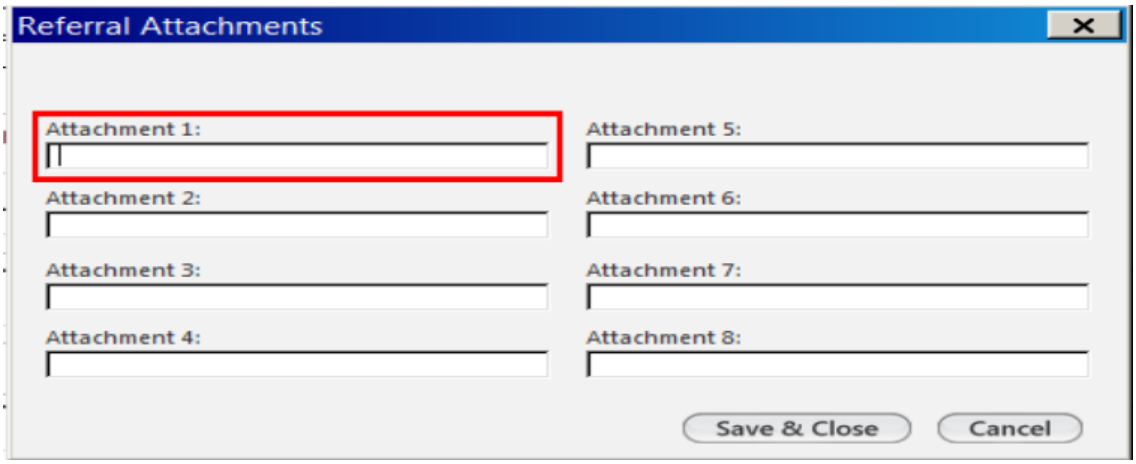
- Click on the **Share** tool located to the left of the **Speciality** box.
- Search for the recipient by entering the name, specialty, or location
- Select the provider
- Complete the referral order as usual

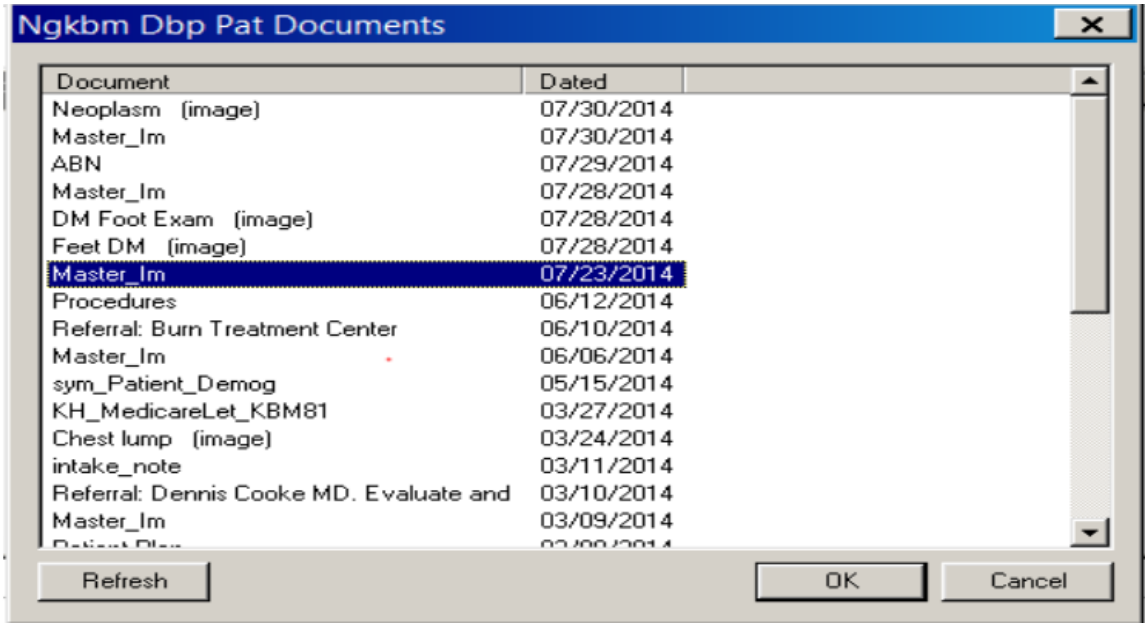






- Attach the document by selecting the ***Details*** button
- Select the ***Attachment*** box
- Select the attachement from the pop up list





Once the referral is complete, send it immediately or task it to your staff for authorizations or scheduling.

- Highlight the referral
- Select eith ***Quick Task*** or ***Share***

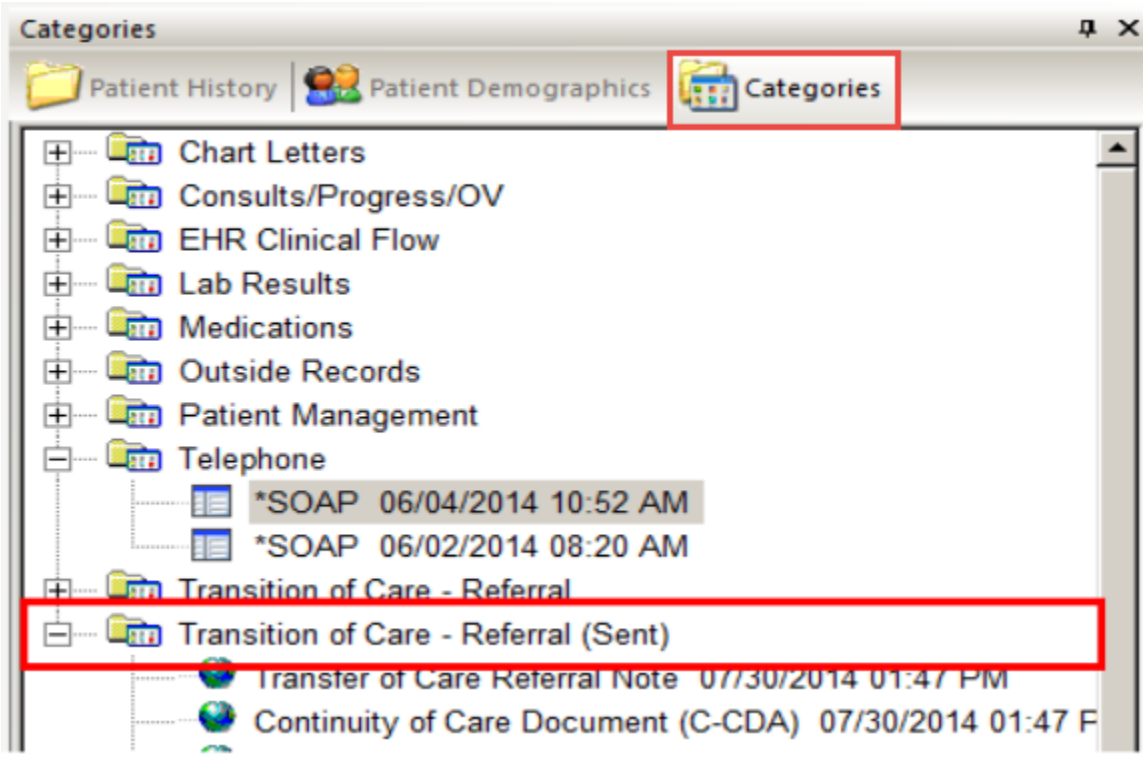
Once you send the referral, the order and it's attachment(s) are sent to an interface for processing. It may take a few moments for the order to show in the patient's chart.

Please note that new patient referrals will require an administrative process at the receiving provider's office. Due to this, be sure to expedite urdent referrals with additional communication.

Resulting Documentation

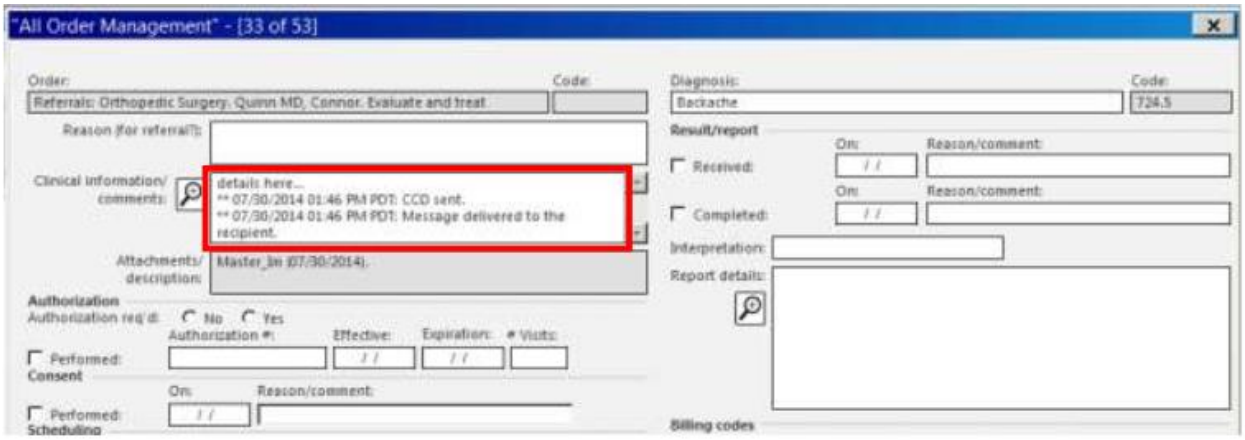
To view the transaction

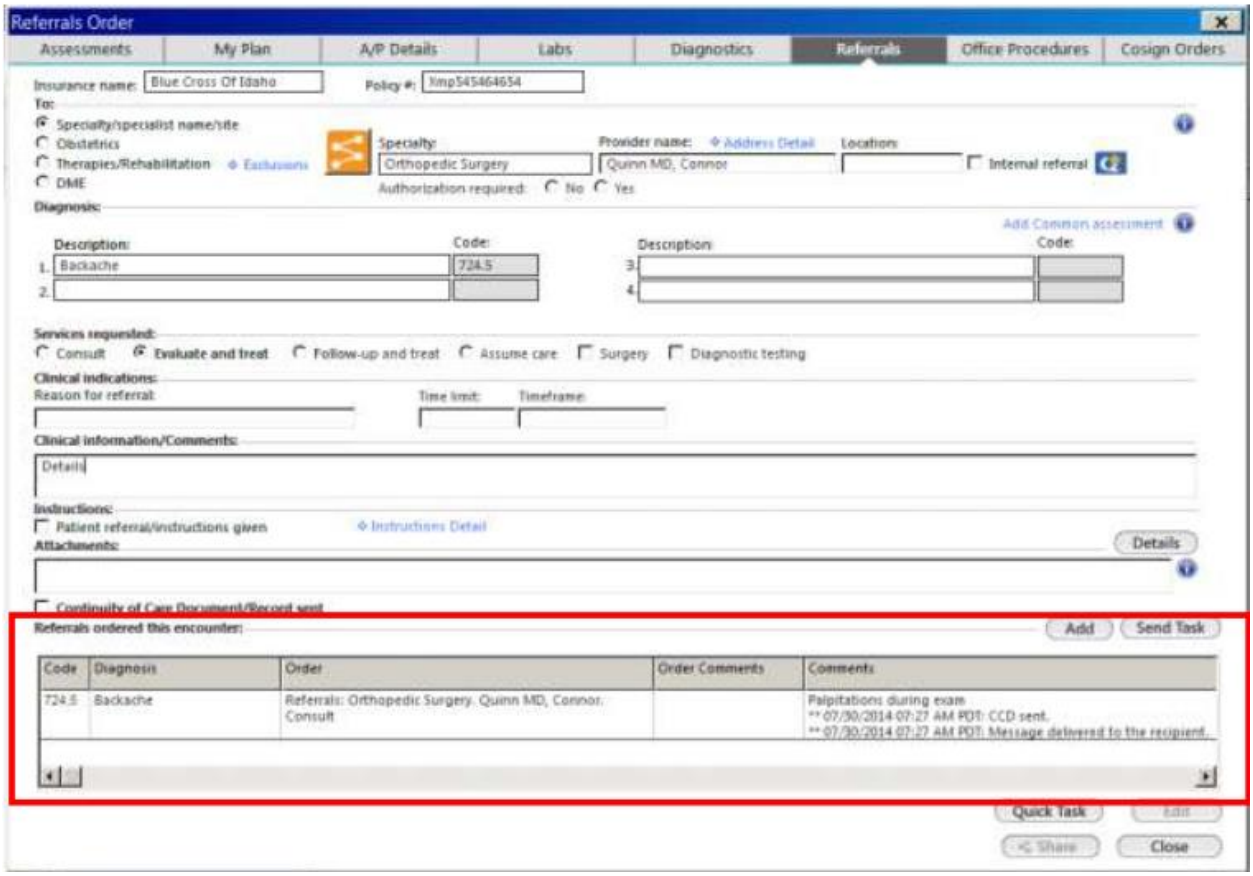
- Select ***Categories*** tab in the **History Toolbar**
- **Transition of Care – Referral (Sent)** will display



This will include the CCD document, as well as each document attached with the order. Please note these will all be listed as **Transfer of Care Referral Note**. Note that these are not duplicates, but distinct documents with the same title.

The **Share** details can be viewed in **Order Management**, and also in the **Referrals** tab. The highest degree of detail can be seen by selecting the order and clicking on the ***Edit*** button.



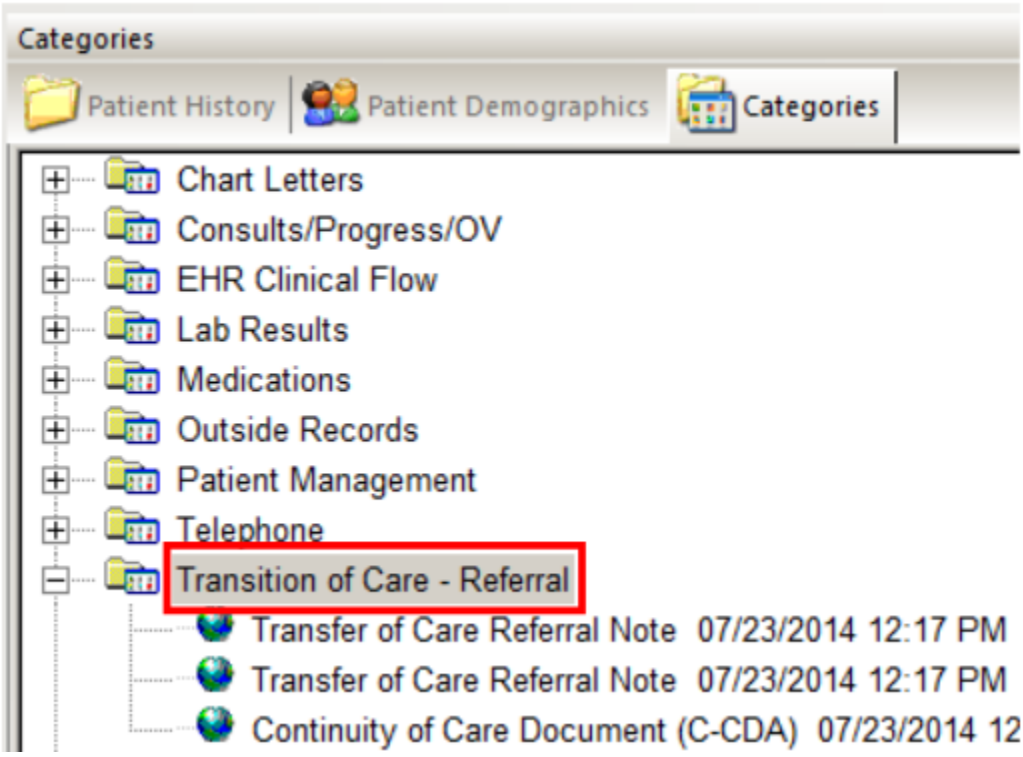


Incoming Referrals

Providers receving your referrals will be notified by a message, and will receive all the documents that you have sent. They may also have the opportunity to import certain pieces of data, like medications and allergies, directly from your NextGen chart into their own templates; thereby eliminating the need to enter the information into their own software.

When you receive an electronic referral in NextGen, you will see a task in your **Inbox**.

- Open patient's chart
- **Categories** tab will automatically open
- Select ***Transition of Care – Referral***



This contains a cover letter that lists the contents of the imported documents, as well as the CCD document. Each additional document from the referring provider will be listed as a **Transfer of Care Referral Note**. Although these share the same name, they are distinct documents and images. Be sure to open each one to view the items you have received.