

NextGen – Clinical Workflow User Manual

NextGen 5.8 KBM 8.3

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December 31, 2014


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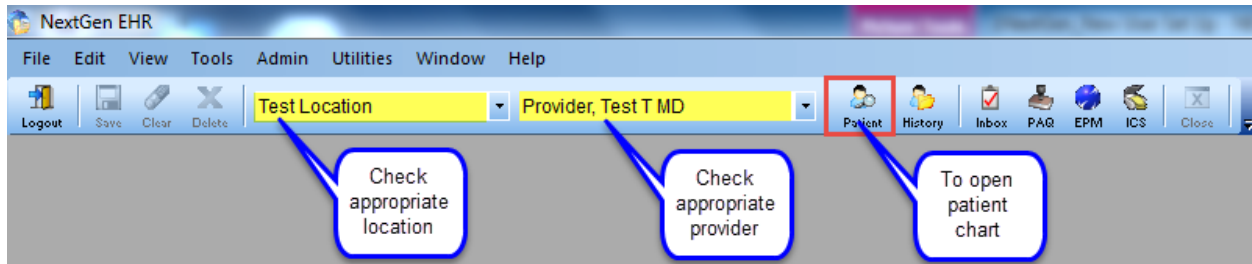
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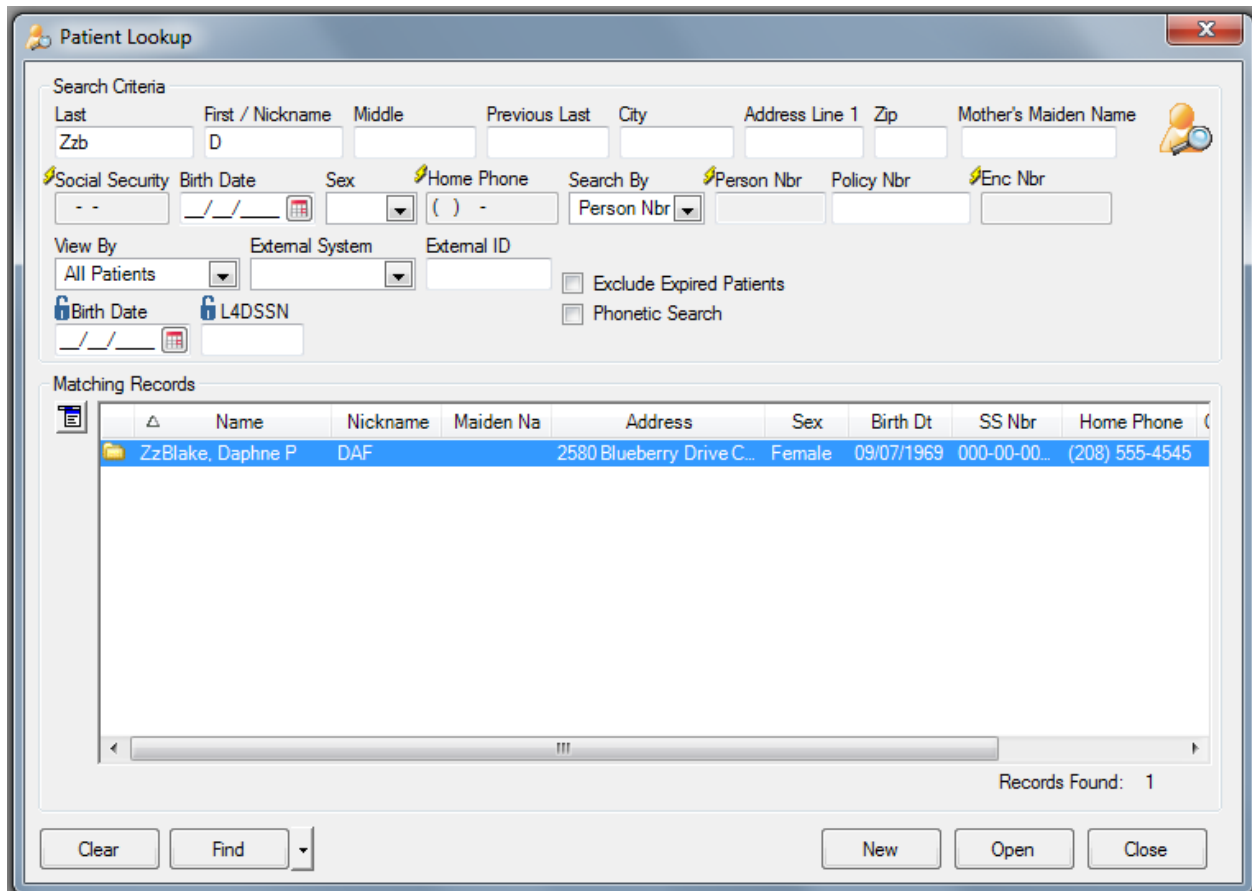
Basic Layout

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**.



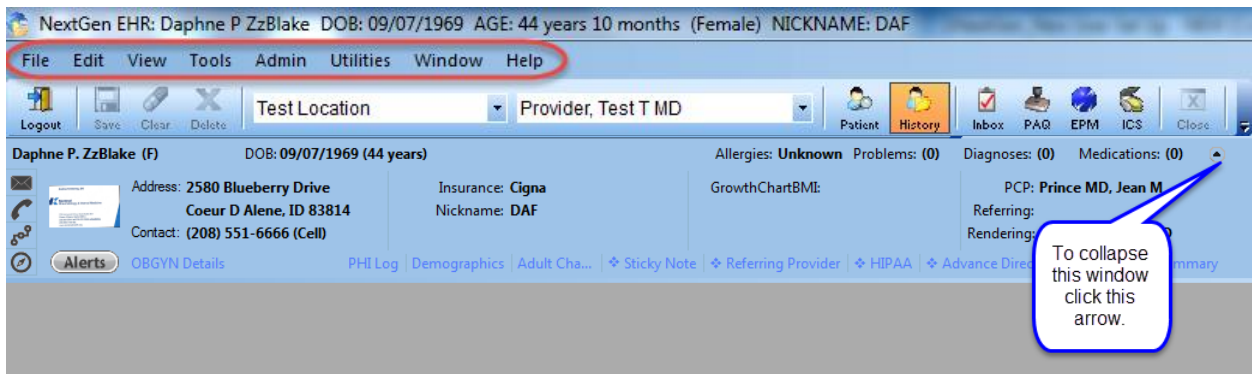
Title Bar

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.



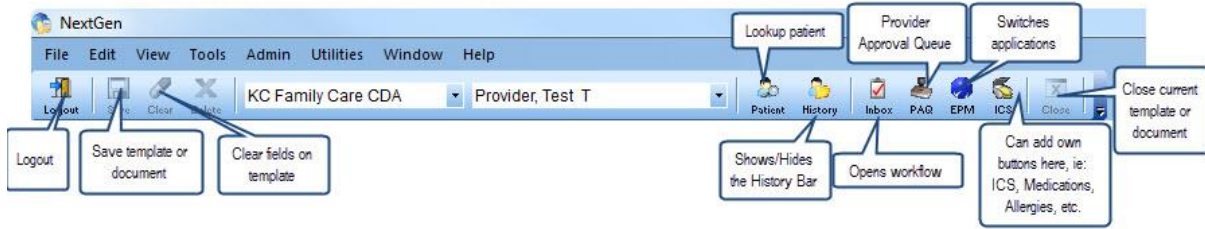
Main Menu Bar












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



Top Toolbar

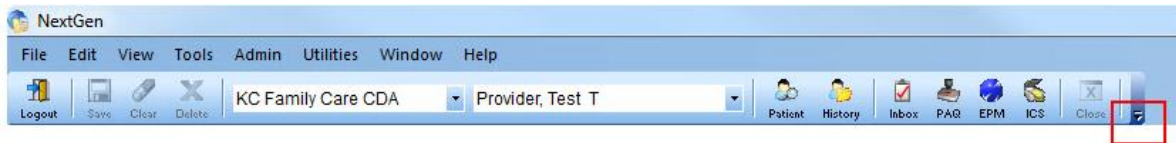
The **Top Toolbar** contain most of the icons that control the basic functions of the system.



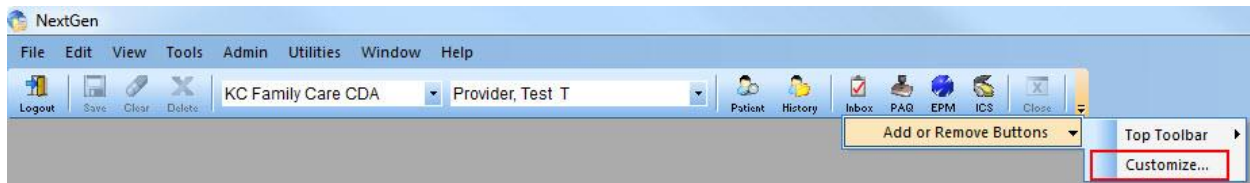
Icon	Name	Description
	Logout	Logs out from, but does not close, the application.
	Save	Saves the work in the active window.
	Clear	Clear the data you have entered in the active window.
	Delete	Deletes the data you have entered in the active window.
	Patient	Prompts the <i>Patient Lookup</i> dialog box.
	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 <i>Logon</i> window, automatically selected the current patient.
	ICS	Opens NextGen ICS directly from the NextGen EHR bypassing the <i>Logon</i> window, automatically selected the current patient.
	Close	Closes the current open window.

Additional Tollbar Icons

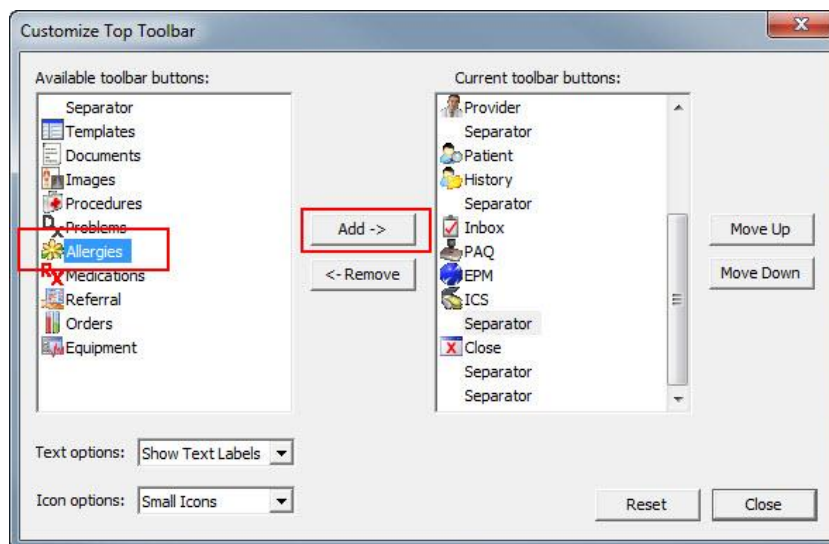
To add the **Allergies**, **Medications** and **Templates** icons to the **Top Toolbar**, select the drop-down arrow next to the **Close** button.



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



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



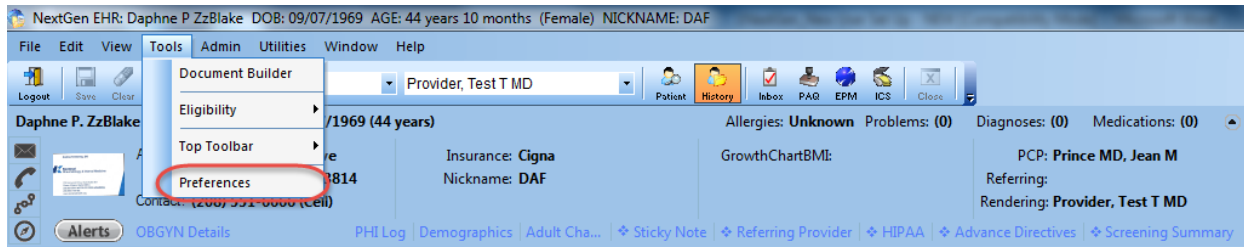
Repeat for **Medications**, **Templates**, and/or any other icons you want to be added to the **Top Toolbar**. When completed, select **Close**.

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



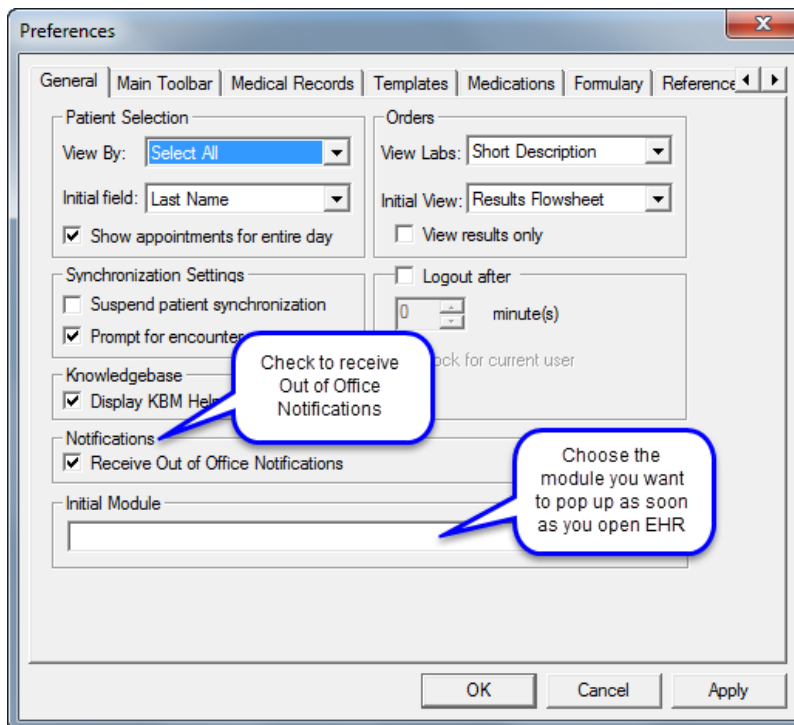
User Preferences

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

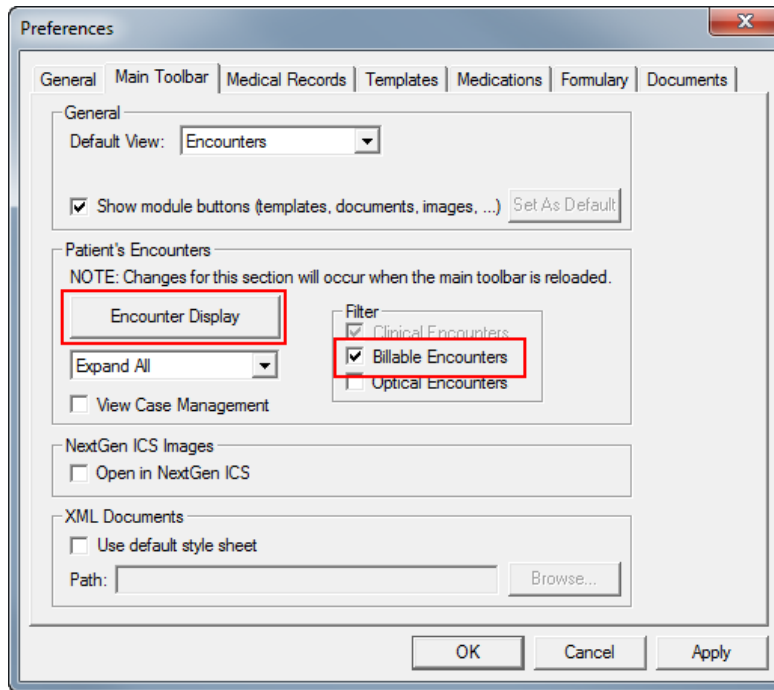


There are 8 tabs in **Preferences**

General:

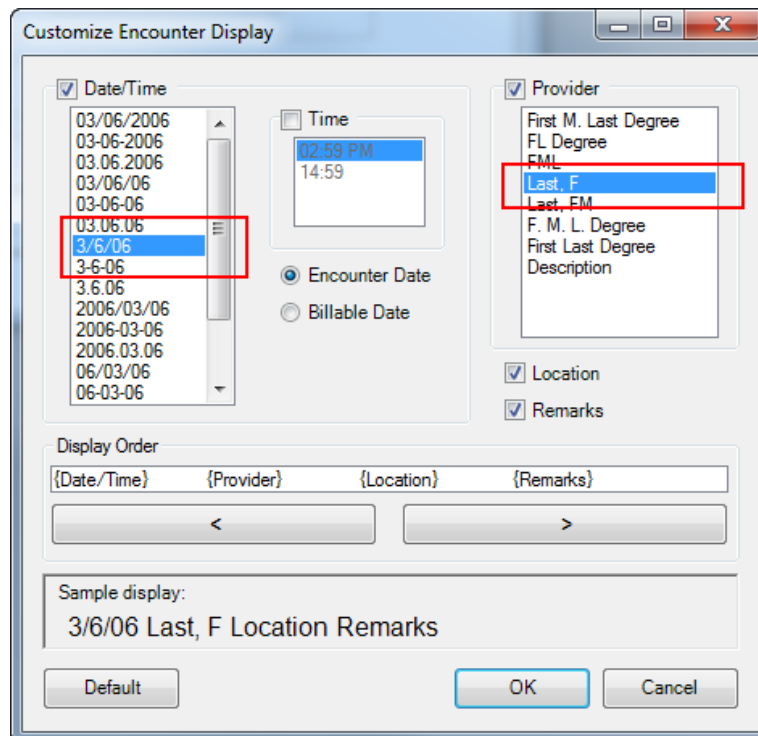


Main Toolbar:

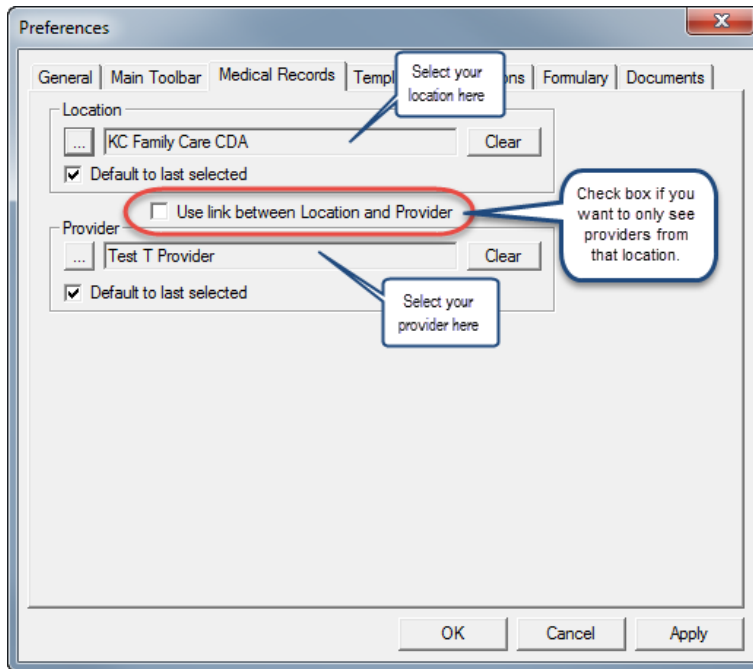


Customize the encounter display by selecting the **Encounter Display** button.

Customize Encounter Display:

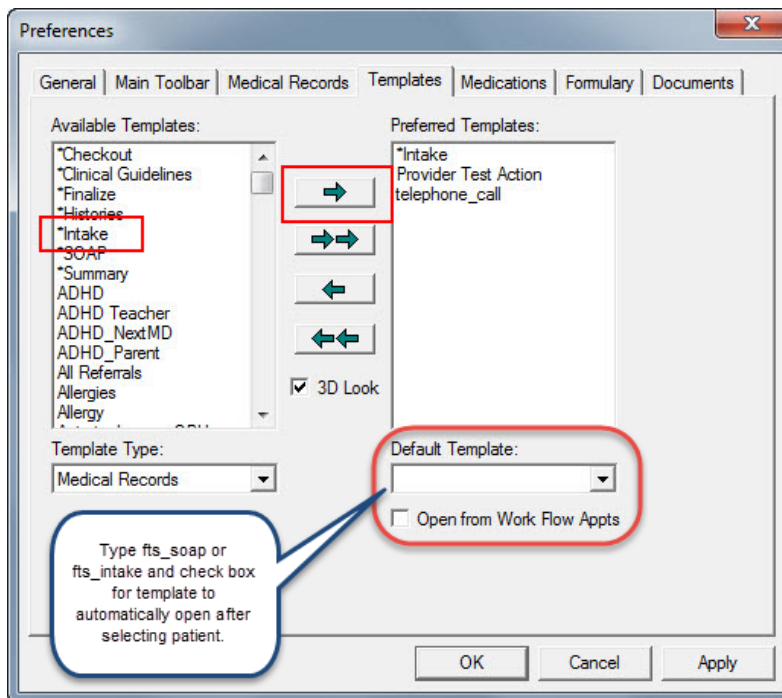


Medical Records:

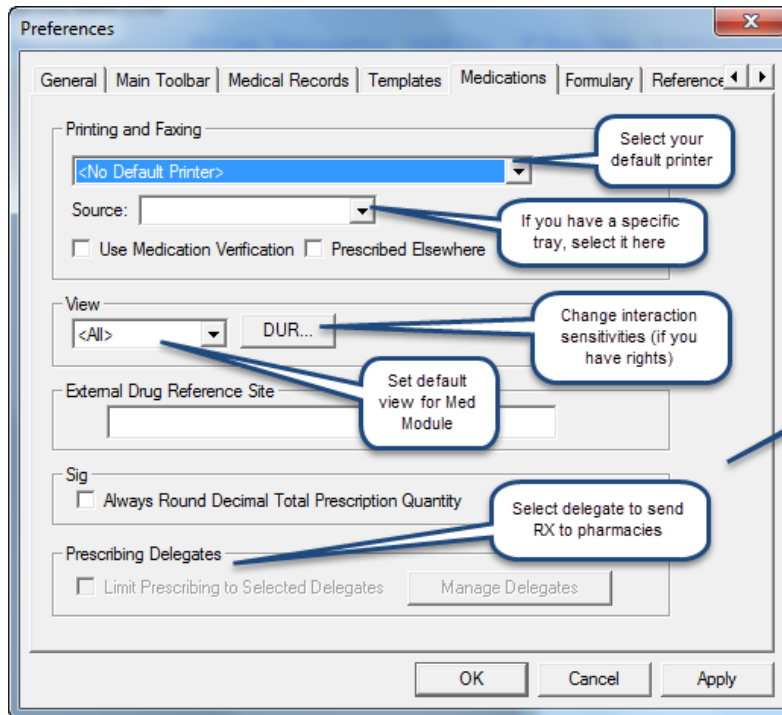


Templates:

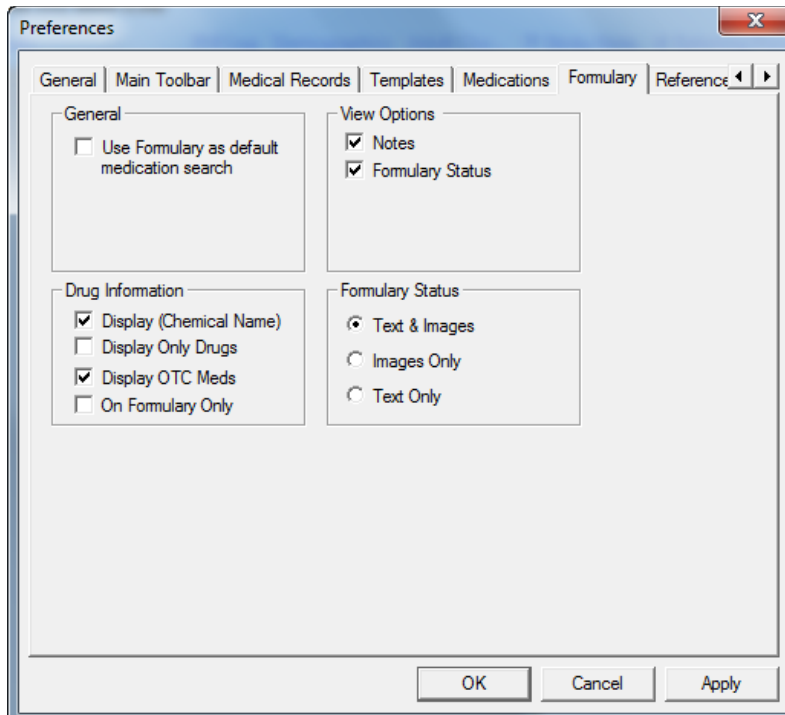
Select ***Intake** from your **Available Templates** and select the arrow to add ***Intake** to your **Preferred Templates**. Repeat for **Telephone Call Template** and any other templates you want added to your **Preferred Templates**.



Medications:



Formulary:



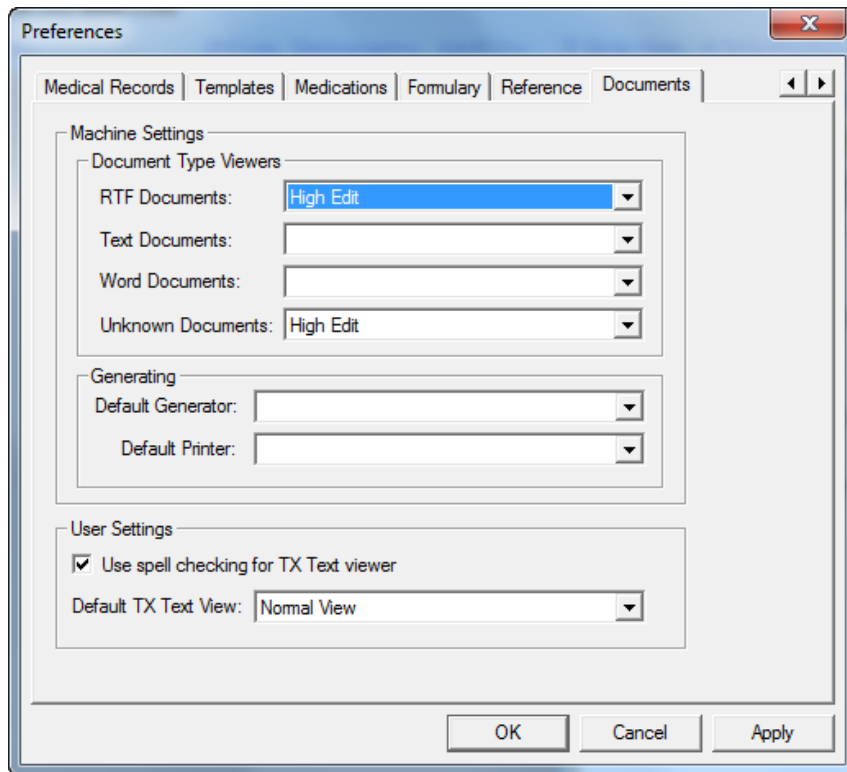
Reference:
Type commonly used web sites to be accessed in each one of these modules.

The image shows a 'Preferences' dialog box with the 'Reference' tab selected. The dialog contains five main sections, each with an empty text input field:

- External Provider Reference
 - Diagnosis & Problem Modules
- Procedure Module
- Medication Module
- Medication Allergy Module
- Order Module - Lab Results

At the bottom of the dialog are three buttons: 'OK', 'Cancel', and 'Apply'.

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 medications.
- 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.

The image shows three screenshots of the Patient Information Bar for a patient named Grace Adler (F), DOB: 10/03/1972 (41 years), Weight: 125.00 lb (56.70 Kg), Allergies: (2), Problems: (3), Diagnoses: (16), Medications: (4).

Top Screenshot: The bar is expanded. A red box highlights the "Problems: (3)" link, with a red arrow pointing to it and the text "Click to minimize". Below the bar, a red arrow points to the text "Active text links".

Middle Screenshot: The bar is expanded. A dropdown menu is open under "Problems: (3)", showing a table of problems:

Problem Description	Onset Date
Hyperlipidemia	12/23/2013
Benign hypertension	10/30/2013
Gastro-esophageal reflux disease with esoph...	10/30/2013

Bottom Screenshot: The bar is collapsed. A red arrow points to the text "Collapsed Bar".



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

Allergies: (3) Problems: (4) Diagnoses: (26) Medications: (6) ▲

- Allergies
- Problems
- Diagnoses
- Medications
- Alerts

It provides easy access to view and change information.

2 (41 years) Weight: 158.00 lb (71.67 Kg) Allergies: (3)		Weight: 158.00 lb (71.67 Kg) Allergies: (3) Problems: (4)	
Medication Allergy	Reaction	Problem Description	Onset Date
CELECOXIB	GI Upset	Atrial fibrillation	01/03/2014
ETODOLAC	Myalgias	Hypertension	12/26/2013
SULFA (SULFONAMIDE ANTIBIOTICS)	Itching	Hyperlipidemia	12/26/2013
		Angina	01/01/0001

Weight: 158.00 lb (71.67 Kg) Allergies: (3) Problems: (4) Diagnoses: (26) Medications: (6)	
Medication	SIG Description
carvedilol 6.25 mg tablet	take 1 tablet by oral route 2 times every day with food
Celebrex 100 mg capsule	take 1 capsule by oral route 2 times every day
hydrochlorothiazide 25 mg tablet	take 1 tablet by oral route every day
Lipitor 20 mg tablet	take 1 tablet by oral route every bedtime
lisinopril 20 mg tablet	take 1 tablet by oral route every day
warfarin 2.5 mg tablet	take 1 tablet by oral route every day

General Information

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




- Send Email to patients via NextMD
- Telephone Call
- To Do (Tasking)
- Patient Tracking

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

	Address:	MRN: 00000000201
	Contact: (215) 555-5555 (Home)	Insurance: Nickname:

Encounter Based Information

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

PCP: Referring: Rendering: Broadway MD, Thomas

- 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:

PHI Log	Demographics	Sticky Note	Referring Provider	HIPAA	Advance Directives	Screening Summary
-------------------------	------------------------------	-----------------------------	------------------------------------	-----------------------	------------------------------------	-----------------------------------

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



History Toolbar

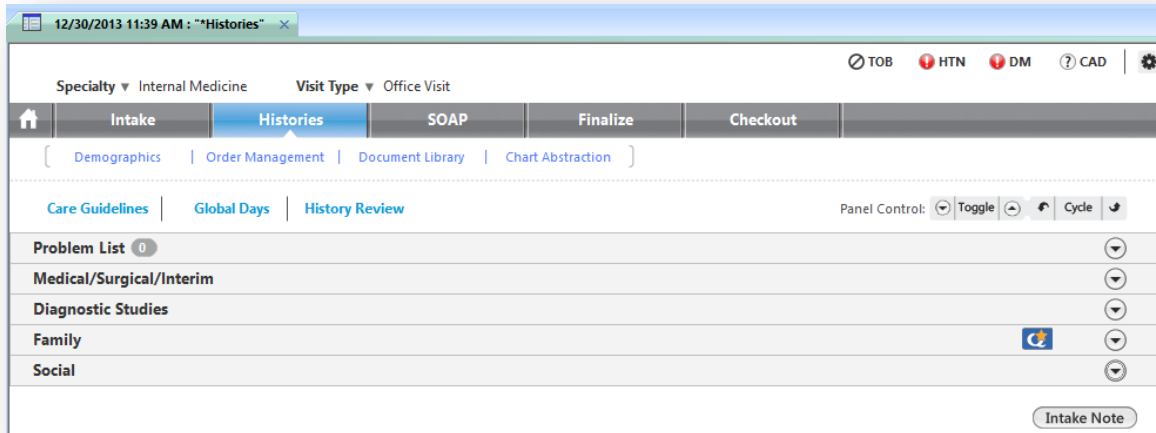
To open the **History Toolbar** – select the icon **History** icon from the **Top Toolbar**

The screenshot shows the 'Patient History' window. The top toolbar includes icons for Patient, History (circled in red), Inbox, and PAQ. The main area displays a list of patient encounters with columns for Date, Provider, and Encounter Date. A 'Tic-Tac-Toe' bar at the bottom contains icons for templates, documents, images, and modules. Callouts provide the following information:

- History icon:** Displays Categories (scanned items)
- Top Toolbar:** Displays demographics
- Buttons:** Create New Encounter, Templates, Documents, Images, Modules
- Encounter List:** Filter search criteria, Locks encounter, Encounter Date
- Tic-Tac-Toe Bar:** "Tic-Tac-Toe" bar launches templates, modules, and images
- Customization:** Choose what you want to see in the history bar by clicking here

Panels

Documentation in EHR is broken into panels. The panels are present on each tab within 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



Social

Diagnostic Studies

Display: All Specialty

Status	Order	Ordered	Interpretation	Result/Report	Recorded	Completed	Ordering Comments
completed	BRMA-MAMMOGRAM DIGITAL SCREENING	//		See scanned report.	08/12/2013	08/12/2013	
completed	PAP	//		See scanned report.	12/04/2012	12/04/2012	

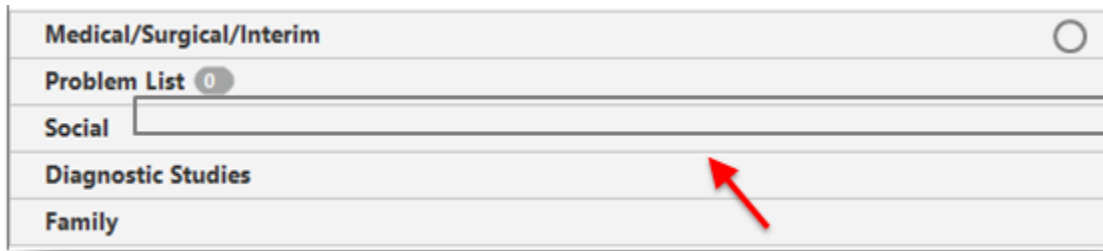
Add



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.

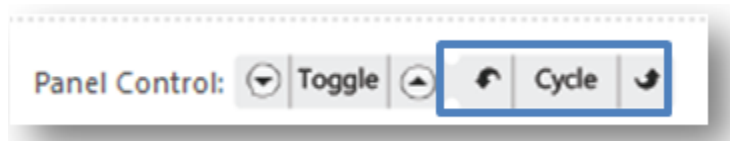
Note: Releasing directly onto another panel will position the new one in the space below it.



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.

Time	Room	Patient/Subject	Reason	Status
09:00 AM		Adler, Grace/Est Patient F/U	F/U on multiple issues	KEPT
09:30 AM		Campbell, Terry/Est Patient F/U	New patient	BOOKED
10:30 AM		Evans, Sandra/New Patient Physical		KEPT
11:30 AM		Brady, Mike/Est Patient Sick		BOOKED

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 Appointments: Adler, Grace

When: 09:00 AM Now 08/20/2013

Provider: Thomas Broadway PA

Location: Coastal Internal Medicine

Room:

Reason: F/U on multiple issues

Status: KEPT

View: By Resource By Provider

Buttons: Close, Clear, Search, Add, Update, Delete

When	Room	Resource
08/20/2013 09:00 AM		James Goodby MD
08/16/2013 08:40 AM		Thomas Broadway PA
08/09/2013 08:40 AM		Thomas Broadway PA
08/02/2013 08:40 AM		Thomas Broadway PA

Go to Patient's Chart

Edit...

Check Eligibility

<Refresh>



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.

Grace Adler (F) DOB: 10/03/1972 (41 years) Weight: 148.00 lb (67.13 Kg) Allergies: (4) Problems: (3) Diagnoses: (17)

Address: 795 Horsham Rd
Horsham, PA 19044
Contact: (215) 657-7010 (Home)

MRN: 00000000032
Pref. Language: English
NextMD: No

PCP: Ab
Referring: Br
Rendering: Br

Alerts OBGYN Details PHI Log Patient Dem... Sticky Note Referring Provider HIPAA Advance Directive

Today's Patient Tracking

Appointment date: 12/26/2013

Appointment information:
11:30 AM Goodway MD, Thomas Reason: BP Check

Room: Status: KEPT (Entries uploaded on "Save and Close".)

Patient Tracking:

Appt Time	Room	Status	Time	Documented By

Task EHR Appointments Save & Close Cancel

- 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**.

Today's Patient Tracking

Appointment date: 08/27/2013

Appointment information:
10:00 AM Goodby MD, James Reason: Blood Pressure follow-up

Room: Status: (Entries uploaded on "Save and Close".)

Patient Tracking:

Appt Time	Room	Status	Time	Documented By
10:00 AM	Exam 1	with nursing	10:11 AM	Patty Parker

Work Flow [Broadway, Thomas]

Appointments 12/26/2013 Thomas Broadway PA

Time	Room	Patient/Subject	Reason	Status
10:00 AM		Brady, Mike/Est Patient Physical	CPX	
10:40 AM		Judson, Marvin D/Est Patient F/U	BP check	
11:00 AM		Knight, Martin/Est Patient Work In	Cough	
11:20 AM		Campbell, Terry/Est Patient Annual Exam	Annual	
11:50 AM	Exam 1	Adler, Grace/Est Patient F/U	BP Check	with nursing

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

Today's Patient Tracking

Appointment date: 08/27/2013

Appointment information:

Room: Status: (Entries uploaded on "Save and Close")

Patient Tracking:

Appt Time	Room	Status	Time	Documented By
10:15 AM		checked out	10:17 AM	Patty Parker
10:15 AM		ready for check-out	10:16 AM	Patty Parker
10:15 AM	Exam 1	with provider	10:15 AM	Patty Parker
10:00 AM	Exam 1	with nursing	10:11 AM	Patty Parker

Task EHR Appointments Save & Close Cancel

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

Work Flow [Parker, Patty]

Appointments 08/20/2013 James Goodby MD;Thomas Broadway PA

Time	Room	Patient/Subject	Reason	Status
09:00 AM		Adler, Grace/Est Patient F/U	F/U on multiple issues	chart complete
09:00 AM		Adler, Grace/Est Patient F/U	F/U on multiple issues	chart complete
09:30 AM		Campbell, Terry/Est Patient F/U	New patient	BOOKED
09:30 AM		Campbell, Terry/Est Patient F/U	New patient	BOOKED
10:30 AM		Evans, Sandra/New Patient Physical		KEPT
10:30 AM		Evans, Sandra/New Patient Physical		KEPT
11:30 AM		Brady, Mike/Est Patient Sick		BOOKED
11:30 AM		Brady, Mike/Est Patient Sick		BOOKED



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**.

The screenshot shows the NextGen software interface. At the top, there is a menu bar with 'Admin', 'Utilities', 'Window', and 'Help'. Below it is a toolbar with icons for 'Delete', 'Patient', 'History', 'Inbox', 'PAQ', 'EPM', 'ICS', and 'Close'. The 'Inbox' icon is highlighted with a red box. Below the toolbar is a header for 'Work Flow [EHLY, KIMBERLY]' with 'Appointments' and '11/18/2014' selected, and 'Dr. Smith' as the user. A table of appointments is displayed with columns for Time, Room, Patient/Subject, Reason, and Status. The appointment for 'Zzcharmin, Cindy' at 09:00 AM is highlighted in blue, and its status 'KEPT' is also highlighted with a red box. A context menu is open over this appointment, with 'Go to Patient's Chart' highlighted by a red box. Other menu items include 'Edit...', 'Check Eligibility', and '<Refresh>'. At the bottom left, there is a 'Tasks' section with an 'All Tasks' button.

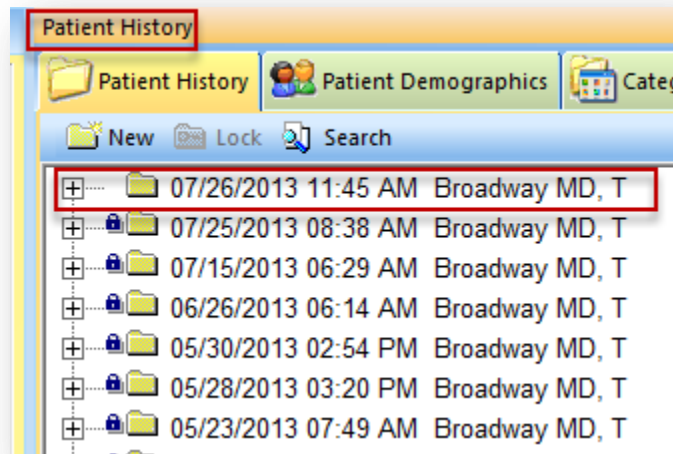
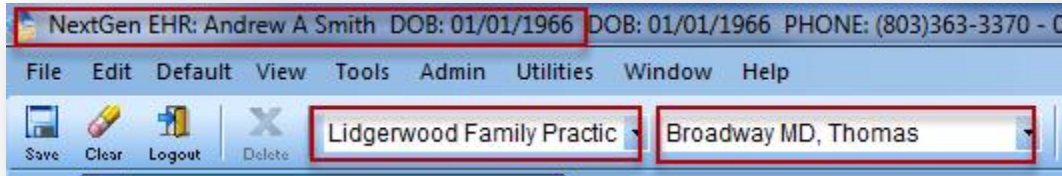
Time	Room	Patient/Subject	Reason	Status
06:00 AM		Zz Curious, George/New Patient		KEPT
06:40 AM		Zz, Gor/Established Patient		KEPT
07:00 AM		Zz, Jessica/Established Patient		KEPT
07:20 AM		Zz, Laura/Established Patient		KEPT
07:40 AM		Zz, Penelope/Established Patient		KEPT
08:00 AM		Zz, Thomas/Established Patient	reason for visit	KEPT
08:20 AM		ZzCube, Ice/Established Patient		KEPT
08:40 AM		ZzCharming, Prince/Established Patient		KEPT
09:00 AM		Zzcharmin, Cindy/Established Patient		KEPT
09:20 AM		Zztest, Trainer		KEPT



Patient Check In – 4 Point Check

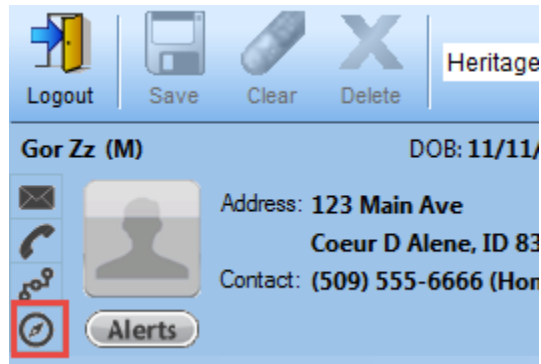
Before documenting in a patient's chart you should perform a 4 point check.

- Verify that you are in 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**.



Today's Patient Tracking

Appointment date: 12/10/2014

Appointment information:
10:45 AM Reason: 90 min appts thru end of Oct

Room: Exam 1 Status: with nursing (Entries uploaded on "Save and Close".)

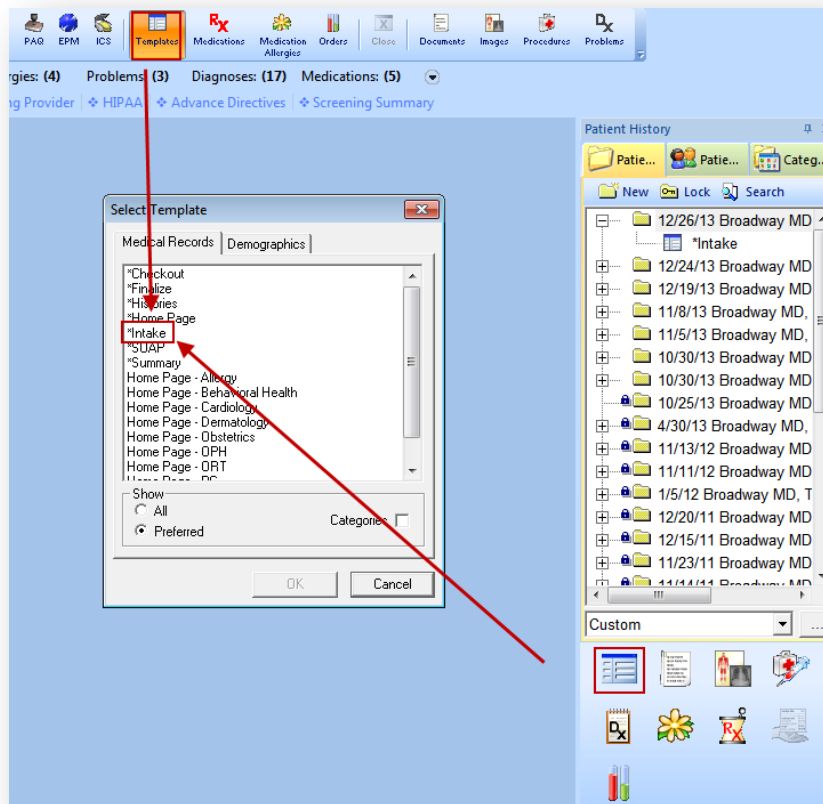
Patient Tracking:

Appt Time	Room	Status	Time	Documented By

Task EHR Appointments Save & Close Cancel

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.

Specialty ▼ Family Practice Visit Type ▼ Office Visit

Intake Histories SOAP

MU Check Immunizations Standing Orders C

Care Guidelines Global Days

General

Established patient New patient | H

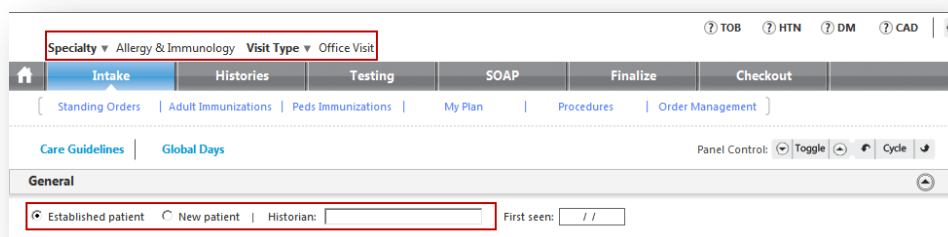
Ngkbn Get Dbpicklist Items

List Item
Allergy & Immunology
Behavioral Health
Cardiology
Care Management

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.

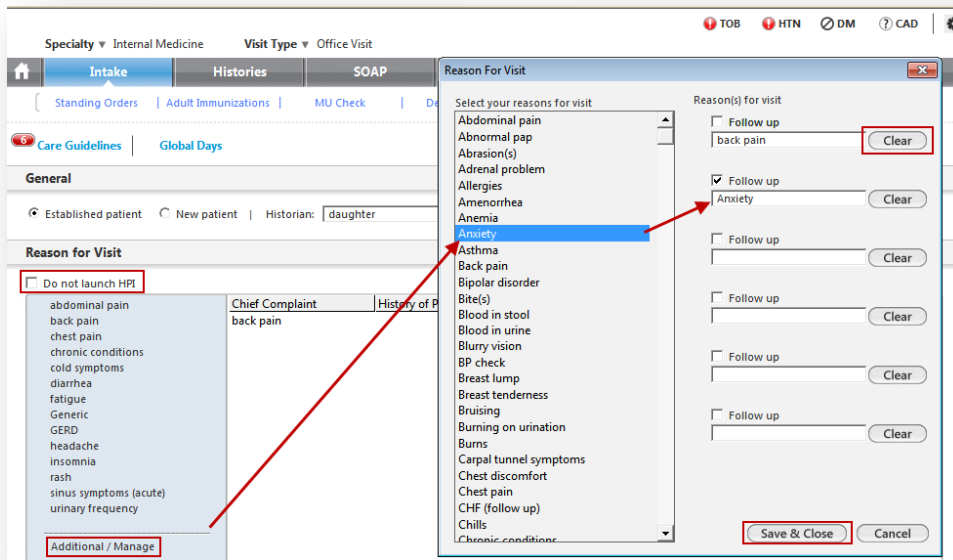


The screenshot shows the 'General' panel in an EHR system. At the top, there are dropdown menus for 'Specialty' (set to 'Allergy & Immunology') and 'Visit Type' (set to 'Office Visit'). Below these are navigation tabs: 'Intake' (highlighted), 'Histories', 'Testing', 'SOAP', 'Finalize', and 'Checkout'. Underneath the tabs are links for 'Standing Orders', 'Adult Immunizations', 'Peds Immunizations', 'My Plan', 'Procedures', and 'Order Management'. There are also links for 'Care Guidelines' and 'Global Days'. On the right, there is a 'Panel Control' section with a 'Toggle' button and a 'Cycle' button. The main section is titled 'General' and contains two radio buttons: 'Established patient' (which is selected) and 'New patient'. To the right of these is a text field for 'Historian:' and a 'First seen:' field with a date input.

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.

Reason for Visit

Do not launch HPI Intake Comments

<ul style="list-style-type: none"> abdominal pain anxiety back pain chronic conditions depression diabetes hypertension lab draw musculoskeletal pain pelvic pain preventive exam rash URI UTI <p>Additional / Manage</p>	<table border="1"> <tr> <th>Chief Complaint</th> <th>History of Present Illness</th> </tr> <tr> <td>Anxiety</td> <td></td> </tr> </table>	Chief Complaint	History of Present Illness	Anxiety	
Chief Complaint	History of Present Illness				
Anxiety					

Mood Disorders - HPI

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

Concern: Status: No Yes Level of function

Initial visit Follow up visit
 Continued initial symptoms Not difficult

Improvement of initial symptoms Somewhat difficult

Worsening of previously reported symptoms Very difficult

Extremely difficult

Date of initial visit this episode: / /

Year of onset:

Frequency of symptoms:

[Screening Instrument](#) [Suicidal/Homicidal Risk](#) [Risk Factors](#)

Date	Instrument	Score	Severity	MDD Classification	Completed By	Comr	No	Yes
							<input type="radio"/>	<input type="radio"/>

Alcoholism
 Childhood abuse or neglect
 Chronic illness

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

Reason for Visit

Do not launch HPI Intake Comments

<ul style="list-style-type: none"> abdominal pain anxiety back pain chronic conditions depression diabetes hypertension lab draw musculoskeletal pain 	<table border="1"> <tr> <th>Chief Complaint</th> <th>History of Present Illness</th> </tr> <tr> <td>Anxiety</td> <td>This is a follow up visit. The first episode occurred in 2013. There is continuation of initial symptoms and improvement of initial symptoms. The patient reports functioning as somewhat difficult. The patient presents with anxious/fearful thoughts, compulsive thoughts and decreased need for sleep. The patient's risk factors exclude alcoholism and childhood abuse or neglect.</td> </tr> <tr> <td>back pain</td> <td>Onset: 1 day ago. Location of pain is upper back. Pain is radiated to the back. The patient describes the pain as burning. Context: sitting. Symptoms are aggravated by sitting. The patient denies relieving factors.</td> </tr> </table>	Chief Complaint	History of Present Illness	Anxiety	This is a follow up visit. The first episode occurred in 2013. There is continuation of initial symptoms and improvement of initial symptoms. The patient reports functioning as somewhat difficult. The patient presents with anxious/fearful thoughts, compulsive thoughts and decreased need for sleep. The patient's risk factors exclude alcoholism and childhood abuse or neglect.	back pain	Onset: 1 day ago. Location of pain is upper back. Pain is radiated to the back. The patient describes the pain as burning. Context: sitting. Symptoms are aggravated by sitting. The patient denies relieving factors.
Chief Complaint	History of Present Illness						
Anxiety	This is a follow up visit. The first episode occurred in 2013. There is continuation of initial symptoms and improvement of initial symptoms. The patient reports functioning as somewhat difficult. The patient presents with anxious/fearful thoughts, compulsive thoughts and decreased need for sleep. The patient's risk factors exclude alcoholism and childhood abuse or neglect.						
back pain	Onset: 1 day ago. Location of pain is upper back. Pain is radiated to the back. The patient describes the pain as burning. Context: sitting. Symptoms are aggravated by sitting. The patient denies relieving factors.						



Vital Signs Panel

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

A screenshot of the "Vital Signs" template form. The form has a header with "Vital Signs" and "Health Promotion Plan | History | Graph" links. Below the header is a table with columns for Time, HR (n), Wt (kg), BMI, BP, Pulse, Respiration, Temp (F), Pulse O2 Rest, BSA, Pain level, and Comments. The table is currently empty. At the bottom right of the form, there are three buttons: "Add", "Edit", and "Remove". The "Add" button is highlighted with a red box.

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.

"Adult Vital Signs" - [New Record]

Height/length measurements:
 4 ft 0 in total in 121.92 cm Position: Standing Lying
 Last Measured: 11/28/2014 Measured today Carried forward

Weight measurement:
 123 lb 55.792 kg Context: Dressed with shoes Dressed without shoes

BMI/BSA calculation:
 BMI: 37.53 kg/m² [BMI Plan](#)
 BSA: m² Calculate Unobtainable: Patient Refused:

Temperature: 98.6 F 37 C Site:

Blood Pressure and pulse: **BP is out of expected range. Further review is indicated.**
 Systolic: 120 Diastolic: 99 mm/Hg Position: Sitting Standing Lying Side: Right Left Site:
 Pulse: 88 /min Pulse pattern: Regular Irregular Method: Manual Automatic Home monitor Cuff size: Pediatric Adult Large Thigh
[Neck/Waist/Hip Circumference](#)
[Audiometry Exam](#)
[Vision Screening](#)
[Orthostatic Vital Signs](#)

Respiration and Pulse Ox:
 Respiration: 19 /min Pulse Ox Rest: % Pulse Ox Amb: %
 Method: Source: Room air Oxygen: L/min
 Room air FiO2: % L/min Measured: Pre-treatment Post-treatment
 Finger Probe: Method:
 Peak flow: L/min Pre-treatment Post-treatment Method:

Pain scale:
 Pain score: Method: [HAQ-DI](#)

Comments: Historical entry 12/03/2014



Measured date: 12/03/2014 Time: 2:16 PM
 Measured by: KIMBERLY EHLY

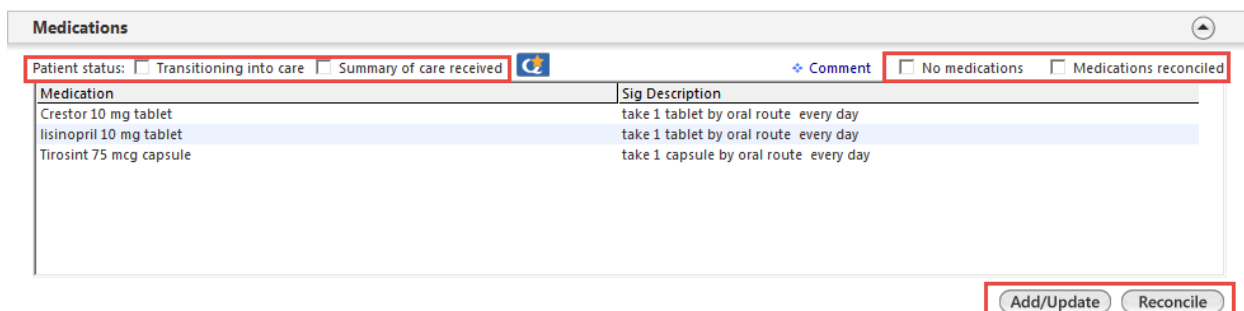
Clear For Add Delete Save Close




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** ^{Meaningful Use}  box if the patient is new to the provider or returning from a hospital stay. Check the **Summary of care received** ^{Meaningful Use}  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	Sig Description
Crestor 10 mg tablet	take 1 tablet by oral route every day
lisinopril 10 mg tablet	take 1 tablet by oral route every day
Tirosint 75 mcg capsule	take 1 capsule by oral route every day




Medication Reconciliation ^{Meaningful Use}  - 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** .

Medication Review

How to conduct a medication review: 

Panel Control:  Toggle  Cycle 

Reconciliation Type

Manual reconciliation: Manual medication reconciliation completed with: Electronic reconciliation:

Source: Medication list confirmed with:

Medication Module

Medication Review

To move items from the Medication List to Medication Review, select the checkbox and click individual grid rows, or "Review All - Taken As Directed" button.

Medication List Review - adherence:

Medication	Sig Desc	Last Refilled
Tirosint 75 mcg capsule	take 1 capsule by oral route every day	20141204

Go to Medication Module above to add/edit medication list.

Medication Review

Adherence	Medication Name	Sig Desc	Start Date	Stop Date	Rx Else	Last Refilled	Status
taking as directed	Crestor 10 mg tablet	take 1 tablet by oral route every day	12/04/2014	12/25/2014	N	/ /	Verified
taking as directed	lisinopril 10 mg tablet	take 1 tablet by oral route every day	12/04/2014	/ /	N	12/04/2014	Verified

Medication: Sig desc: Adherence:



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.

SureScripts, CCD or CCDA documents

Provider and Patient Information
Provider Name: **Thomas Broadway MD** Patient Name: **Adler, Grace**
Location: **Abington Office** Date of Birth: **10/3/1972**
User Name: **Broadway, Thomas** Gender: **Female**

EHR

Action	Match	Medication Name	Generic Name
Keep		lisinopril 20 mg tablet	LISINOPR
Keep		warfarin 2.5 mg tablet	WARFARI
Keep		Celebrex 100 mg capsule	CELECOX
Keep		hydrochlorothiazide 25 mg tablet	HYDROCI
Stop		Tylenol 8 Hour 650 mg Tab	ACETAMI

Import

Reconciliation Summary

Medication Name	Generic Name	Directions	Original Start
Stop EHR item			
Tylenol 8 Hour 650 mg Tab	ACETAMINOPHEN	take 2 tablet (1300MG) by ORAL route every 8 hours as needed	
Unchanged - no action performed			
lisinopril 20 mg tablet	LISINOPRIL	take 1 tablet by oral route every day	10/30/2013
warfarin 2.5 mg tablet	WARFARIN SODIUM	take 1 tablet by oral route every day	10/30/2013
Celebrex 100 mg capsule	CELECOXIB	take 1 capsule by oral route 2 times every day	12/24/2013
hydrochlorothiazide 25 mg tablet	HYDROCHLOROTHIAZIDE	take 1 tablet by oral route every day	10/30/2013

Match Unmatch **Confirm** Cancel Close



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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**.

Comment
 No known allergies
 Reviewed, updated
 Reviewed, no changes

Allergen	Reaction	Medication Name	Comment
IBUPROFEN	Stomach Pain		

Date	Description	Onset/Sympt	Resolved	Type	Comment
12/03/2014 01:06 PM	IBUPROFEN	00/00/0000	00/00/0000	Ingredient	

Include Resolved Allergies
 No Unresolved Allergies

Allergy:

egg

Location:

Provider:

Recorded Elsewhere
 Source:

Intolerance

Severity: mild

Onset/Sym:

Resolved:

Allergy Comments:

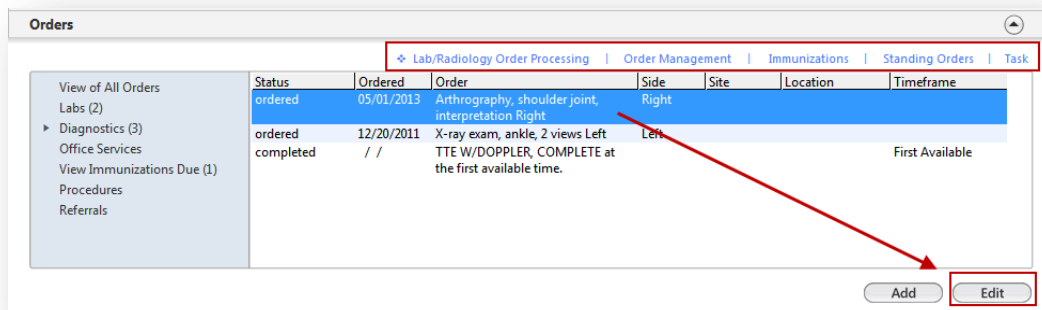
Reaction:

Allergy type:

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.



The screenshot shows the 'Orders' panel with a navigation menu on the left and a table of orders. The table has columns for Status, Ordered, Order, Side, Site, Location, and Timeframe. The first row is highlighted in blue. Below the table are 'Add' and 'Edit' buttons. A red arrow points from the 'Edit' button to the 'Order' column of the first row.

Status	Ordered	Order	Side	Site	Location	Timeframe
ordered	05/01/2013	Arthrography, shoulder joint, interpretation Right	Right			
ordered	12/20/2011	X-ray exam, ankle, 2 views Left	Left			
completed	/ /	TTE W/DOPPLER, COMPLETE at the first available time.				First Available

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).

Office Services ⌵

Orders
(Highlight a row to select) Display category: ALL

Order Category	Lab Name	Proc. Code	Side	Diagnosis Description
ALL	Smear, stain & interpret, wet	87210		
ALL	Urinalysis, non-automated, w/o scope	81002		
ALL	Urinalysis, non-automated, w/scope	81000		
ALL	Urine bacteria culture, by count	87086		
ALL	Urine flow measurement, complex	51741		
ALL	Urine pregnancy test	81025		

Diagnosis

Order: Procedure code: Side:

Diagnosis: Dx code: Status:

Results/Report

Interpretation: [Details](#) Normal value/range: Unit of measure: [Protocols](#)

Clinical indication:

Details: [My Phrases](#) | [Manage My Phrases](#)

Today's Orders Submit to Superbill Verbal order/needs sign-off Send task automatically [Additional Orders](#) | [Task](#)

Status	Office Diagnostic Description	Side	Interpretation	Result	Performed By	CI
completed	Urinalysis, non-automated, w/o scope		normal			



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.

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

ROS Defaults: Globally Normal Adult

Constitutional All neg

Neg Pos

- Chills
- Fatigue
- Fever
- Malaise
- Night sweats
- Weight gain
- Weight loss
- Other:

Cardiovascular All neg

Neg Pos

- Chest pain
- Claudication
- Edema
- Palpitations
- Other:

Reproductive All neg

Neg Pos

- Abnormal Pap
- Dysmenorrhea
- Dyspareunia
- Hot flashes
- Irregular menses
- Vaginal discharge
- Other:

Neurological All neg

Neg Pos

- Dizziness
- Extremity numbness
- Extremity weakness
- Gait disturbance
- Headache
- Memory loss
- Seizures
- Other:

Musculoskeletal All neg

Neg Pos

- Back pain
- Joint pain
- Joint swelling
- Muscle weakness
- Neck pain
- Other:

HEENT All neg

Neg Pos

- Ear drainage
- Ear pain
- Eye discharge
- Eye pain
- Hearing loss
- Nasal drainage
- Sinus pressure
- Sore throat
- Visual changes
- Other:

Gastrointestinal All neg

Neg Pos

- Abdominal pain
- Blood in stools
- Change in stools
- Constipation
- Diarrhea
- Heartburn
- Loss of appetite
- Nausea
- Vomiting
- Other:

Integument

Neg Pos

- Bruising
- Dry skin
- Hair loss
- Hirsutism
- HIV
- Pruritus
- Rashes
- Skin lesions
- Other:

Respiratory All neg

Neg Pos

- Chronic cough
- Cough
- Known TB exposure
- Shortness of breath
- Wheezing
- Other:

All others negative

Ngkbn Td Dbp Filter

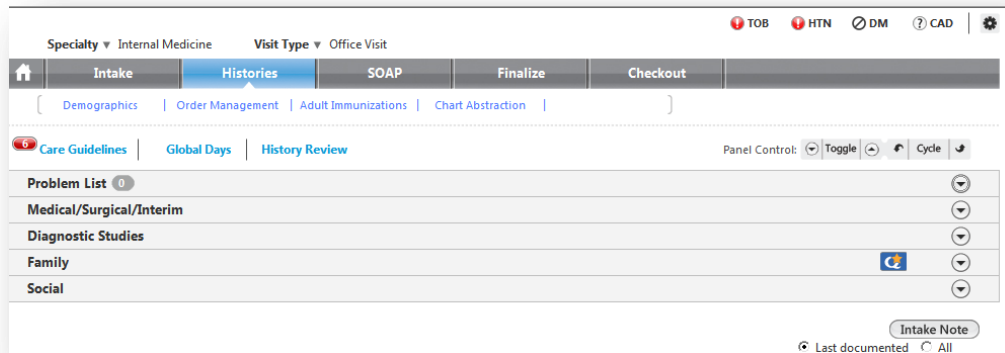
Set Name: normal ROS

Refresh OK Cancel

Save & Close Cancel

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**

Problem List | Billing ICD List

Refresh Preferences Show ICDs Only Show Chronic Problems Only

No Active Problems

Concept Id | Fully Specified Name | Chronic | Secondary Condition | Problem Status | Last Addressed Date | Onset Date | Resolved Date

Search hypertension

Description	Fully Specified Name	Concept Id
Hypertension	Hypertensive disorder	38341003
Hypertension complicating pregnancy, childbirth and the puerperium	Hypertension complicating pregnancy, childb...	198941007
Hypertension resolved	Hypertension resolved	162659009
Hypertension in the obstetric context	Hypertension without albuminuria AND witho...	367390009
Hypertension in the obstetric context	Pregnancy-induced hypertension	48194001
Hypertension induced by pregnancy	Pregnancy-induced hypertension	48194001
Hypertension monitoring deleted	Hypertension monitoring deleted	185724004
Hypertension monitoring status	Hypertension monitoring status	308502002
Hypertension secondary to renal disease in obstetric context	Hypertension secondary to renal disease in ob...	111438007
Benign essential hypertension	Benign essential hypertension	1201005
Pregnancy induced hypertension	Pregnancy-induced hypertension	48194001
Venous hypertension of lower limb	Venous hypertension of lower limb	234076003
Accelerated secondary hypertension	Malignant secondary hypertension	89242004

Add Problem Re-Code F View

Add to Billing ICD List Add to Mjems

Add to My Tracked Problems

Results are limited to top 100. Consider refining search.

Select Cancel

- 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.

Problem List | Billing ICD List

Refresh Preferences Show All Statuses Show My Tracked Problems Only Show Chronic Problems Only Patient Age: 54 years

Concept Id	Description	Fully Specified Name	Chronic	Secondary Condition	Problem Status	Last Addressed Date
Active						
Diabetes mellitus						
73211009	Diabetes	Diabetes mellitus	<input type="checkbox"/>	<input type="checkbox"/>	Active	

Concept Id: 73211009
 Description: Diabetes Fully Specified Name: Diabetes mellitus

Onset Date: 12/05/2014 Resolved Date: 12/05/2014 Last Addressed:
 Resolved By: Resolved Reason:
 Problem Status: Active Clinical Status:
 Chronic: Recorded Elsewhere: Source: EHR
 Secondary Condition:
 Provider: Joseph A Abate MD Location: Heritage Rathdrum
 Side: Site:



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.

The screenshot shows the 'Past Medical History' window. At the top, the 'Specialty' is set to 'Family Practice'. Below this is the 'Medical' section with a list of conditions. The 'Allergies' checkbox is highlighted with a red box. To the right of the main list are two columns of conditions, each with an 'Onset Date' field. At the bottom right of the main window are 'Add To Grid' and 'Clear' buttons. A sub-popup window titled 'Ngkbn Get PMH Sec Diag' is open, showing a list of specific allergy types under the heading 'Diagnose': Allergies, environmental; Allergies, food; Allergies, insect sting; Allergies, multiple; Allergies, pet; Allergies, seasonal. The sub-popup has 'Refresh', 'OK', and 'Cancel' buttons.

Manage Past Medical History

Disease/Disorder		Management	
Disease/disorder: <input type="text"/>		Management: <input type="text"/>	
SNOMED code: <input type="text"/>		SNOMED code: <input type="text"/>	
Onset date: <input type="text"/> / <input type="text"/> / <input type="text"/>	Side: <input type="text"/>	Date: <input type="text"/> / <input type="text"/> / <input type="text"/>	Side: <input type="text"/>
		Facility: <input type="text"/>	
		Provider: (Last) <input type="text"/> (First) <input type="text"/>	
Outcome/Comments			
Outcome: <input type="text"/>			
Comments: <input type="text"/>			
KE 12/05/2014 -			
Characters left: 985			
		Save to Grid & Close	
		Cancel	



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

Past Medical History

Specialty: Panel Control:

Medical

Surgical

To add comments, click manage. Date: Date: Date:

<input type="checkbox"/> Angioplasty	<input type="checkbox"/> Cataract extraction	<input type="checkbox"/> LASIK
<input type="checkbox"/> Appendectomy	<input type="checkbox"/> Cholecystectomy	<input type="checkbox"/> Mastectomy
<input type="checkbox"/> Arthroscopy	<input type="checkbox"/> Colectomy	<input type="checkbox"/> Myomectomy
<input type="checkbox"/> Back surgery	<input type="checkbox"/> Colostomy	<input type="checkbox"/> ORIF
<input type="checkbox"/> Bilateral tubal ligation	<input type="checkbox"/> D&C	<input type="checkbox"/> Thyroidectomy
<input type="checkbox"/> Blood transfusion	<input type="checkbox"/> Gastric bypass	<input type="checkbox"/> Tonsillectomy
<input type="checkbox"/> Breast augmentation	<input type="checkbox"/> Hernia repair	<input type="checkbox"/> Other
<input type="checkbox"/> CABG	<input type="checkbox"/> Hip replacement	
<input type="checkbox"/> Cardiac pacemaker	<input type="checkbox"/> Hysterectomy	
<input type="checkbox"/> Carpal tunnel release	<input type="checkbox"/> Knee replacement	

Past Medical History Grid

Disease/Disorder	Side	Onset Date	Management	Side	Date	Encounter Type	Outcome	Comment
Cancer, leukemia								
Allergies, seasonal			Tonsillectomy					
			LASIK					

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

Medical/Surgical/Interim

No relevant past medical/surgical history History Review

Disease/Disorder	Side	Onset Date	Management	Side	Date	Encounter Type	Outcome
Cancer, leukemia							
Allergies, seasonal			Tonsillectomy				
			LASIK				

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**.

Panel Control: Toggle Cycle

Diagnostic History Entry

<p>Study Type Diagnostic study type: <input type="text" value="CT Head/spine"/></p> <p>Study Performed <input type="checkbox"/> Ordered elsewhere Side: <input type="text"/> Site: <input type="text"/> Diagnostic study: <input type="text" value="CT scans, lumbar spine, w/o fo"/> Procedure code: <input type="text" value="72133"/></p> <p>Study Date Date performed: <input type="text" value="12/18/2013"/> <input type="checkbox"/> Approx. date performed Specialty: <input type="text"/> Performed by: <input type="text"/> Location: <input type="text"/></p>	<p>Study Result <input checked="" type="checkbox"/> See scanned report My Phrases Manage My Phrases</p> <p>Interpretation: <input type="text"/></p> <p>Result: <input type="text" value="See scanned report."/></p> <p>Comments: <input type="text"/></p> <p style="text-align: right;"> <input type="button" value="Add To Grid"/> <input type="button" value="Update"/> <input type="button" value="Delete"/> </p> <p style="text-align: right;"><input type="checkbox"/> Add to HPI</p>
---	---

Performed	Study	Interpretation	Result
12/18/2013	CT scans, lumbar spine, w/o foll by w/ contr		See scanned report.

Save & Close Cancel


Diagnostic Studies

Display: All Specialty

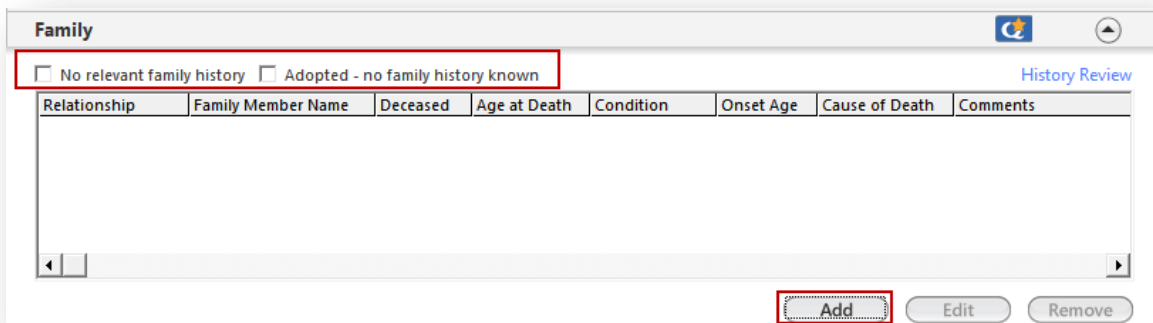
Status	Order	Ordered	Interpretation	Result/Report	Recorded	Completed	Ordering Comments
completed	CT scans, lumbar spine, w/o foll by w/ contr	/ /		See scanned report.	12/18/2013	12/18/2013	



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.



Relationship	Family Member Name	Deceased	Age at Death	Condition	Onset Age	Cause of Death	Comments
--------------	--------------------	----------	--------------	-----------	-----------	----------------	----------

- 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.

Family Health History

Specialty:

No family history of:

Relationship: Family member name: Alive and well Deceased

Onset age: Cause of death: Onset age: Cause of death: Onset age: Cause of death:

ADD/ADHD
 Alcoholism
 Allergies
 Alzheimer's disease
 Arthritis
 Asthma
 Blood disorder
 Cancer
 Cardiovascular disease
 Coronary artery disease
 Coronary artery disease, prema...
 Depression
 Developmental delay
 Diabetes
 Eczema

Elevated lipids Other

Family History Expanded Conditions

Arthritis

Relationships: Names: On:

Condition:

Thyroid disorder

Ngkbn Get Family Sec Diag

Diagnosis

- Ankylosing spondylitis
- Arthritis
- Juvenile rheumatoid
- Osteoarthritis
- Psoriatic
- Rheumatoid



- 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.

The screenshot shows a window titled "Family" with a "History Review" link. At the top, there are checkboxes for "No relevant family history" and "Adopted - no family history known". Below is a table with the following data:

Relationship	Family Member Name	Deceased	Age at Death	Condition	Onset Age	Cause of Death	Comments
Father				Alzheimer's disease	65	N	
Father				Hypertension		N	
Mother				Coronary artery disease	62	N	

At the bottom right of the window, there are three buttons: "Add", "Edit", and "Remove". The "Add" and "Edit" buttons are highlighted with a red box.

- 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.

The screenshot shows a window titled "Social" with a "History Review" link. At the top right, there are radio buttons for "Last documented" (selected) and "All". Below is a table with the following data:

Encounter Date	Tobacco Use	Tobacco Type	Smoking Status	Usage Per Day	Pack Years	Date Quit
10/30/2013	Yes	Cigarette	Former smoker			01/01/1998

Below the table, there is a section for "Encounter Date:Time" with an input field. On the left side, there is a navigation bar with the following categories: Substances (Tobacco, Alcohol/Caffeine), Statuses, Lifestyle, Occupation, Comment, Diet History, and Environmental. At the bottom right of the window, there are two buttons: "Confidential History" and "Add". The "Add" button is highlighted with a red box.

- 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**.

Tobacco Use

Have you ever used tobacco? No/never Yes Unknown [Exclusions](#) Reviewed Updated: 12/26/2013

Smoking Tobacco Use						Non-Smoking Tobacco Use						
Tobacco type:	Use daily:	Usage per day:	Years used:	Pack year:	Age started:	Age stopped:	Tobacco type:	Use daily:	Usage per day:	Years used:	Age started:	Age stopped:
<input checked="" type="checkbox"/> Cigarette	<input checked="" type="checkbox"/>	5 Cigarettes	10	2.50	0	0	<input type="checkbox"/> Chewing	<input type="checkbox"/>	0 units	0	0	0
<input type="checkbox"/> Cigarillo	<input type="checkbox"/>	0 cigarillos	0	0.00	0	0	<input type="checkbox"/> Smokeless	<input type="checkbox"/>	0 units	0	0	0
<input type="checkbox"/> Cigar	<input type="checkbox"/>	0 cigars	0	0.00	0	0	<input type="checkbox"/> Snuff	<input type="checkbox"/>	0 units	0	0	0
<input type="checkbox"/> Pipe	<input type="checkbox"/>	0 pipes	0	0.00	0	0						

*Smoking status: Light tobacco smoker Tobacco use status: Light cigarette smoker (1-9 cigs/day)

Efforts To Quit Tobacco

Have you ever tried to quit using tobacco? No/never Yes Unknown

Tobacco type:	Month:	Day:	Year:	Longest tobacco free:	Cessation method:	Relapse reason:
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>
<input type="button" value="Add"/> <input type="button" value="Update"/> <input type="button" value="Clear"/>						

Encounter Date	Tobacco Type	Date Quit	Longest Tobacco Free	Cessation Method	Relapse Reason

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

Historical Use ▲

[Click here to see tobacco history prior to 7.9.1](#)

Encounter Date	Tobacco Type	Usage Per Day	Years Used	Pack Year	Status	Age Started	Age Stopped
12/24/2013	Cigarette	5 Cigarettes	10.00	2.50	Light tobacco smoker		
10/30/2013	Cigarette		5.00		Former smoker	21	26

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

Passive Smoke Exposure ▲

Have you ever had passive smoke exposure? No/never Yes

Tobacco type: Comments:

Length of exposure:

Level of exposure:

Characters left: 208

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

History Review Last documented All ⓘ

Substances	Encounter Date	Tobacco Use	Tobacco Type	Smoking Status	Usage Per Day	Pack Years	Date Quit
Tobacco	12/24/2013	Yes	Cigarette	Light tobacco smoker	5 Cigarettes	2.50	

Last documented All ⓘ

Substances
 Tobacco
 Alcohol/Caffeine
 Statuses
 Lifestyle
 Occupation
 Comment
 Diet History
 Environmental

Encounter Date:Time	12/24/2013 08:35 AM
Passive Smoke Exposure	Yes
Passive Smoke Type	Cigarette
Passive Smoke Duration	20 Years
Passive Smoke Exposure Level	Moderate

Concluding the Visit

Patient Tracking

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

Todays Patient Tracking

Appointment date: 12/26/2013

Appointment information:
11:50 AM Broadway MD, Thomas Reason: BP Check

Room: Exam 1 Status: waiting for provider (Entries uploaded on "Save and Close".)

Patient Tracking:

Appt Time	Room	Status	Time	Documented By
11:50 AM	Exam 1	waiting for provider	5:08 PM	Thomas Broadway
11:50 AM	Exam 1	with nursing	5:06 PM	Thomas Broadway

Buttons: Task, EHR Appointments, Save & Close, Cancel

Work Flow [Broadway, Thomas]

Appointments 12/26/2013 Thomas Broadway PA

Time	Room	Patient/Subject	Reason	Status
10:00 AM		Brady, Mike/Est Patient Physical	CPX	
10:40 AM		Judson, Marvin D/Est Patient F/U	BP check	
11:00 AM		Knight, Martin/Est Patient Work In	Cough	
11:20 AM		Campbell, Terry/Est Patient Annual Exam	Annual	
11:50 AM	Exam 1	Adler, Grace/Est Patient F/U	BP Check	waiting for provider

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.

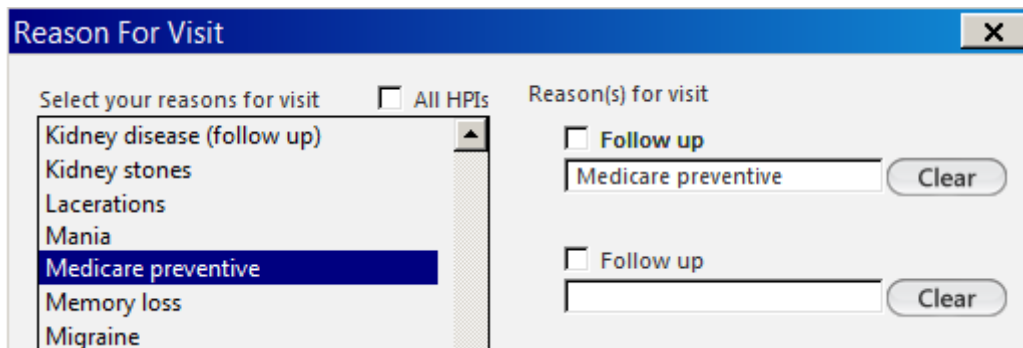
Visit Details

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.



The screenshot shows a window titled "Reason For Visit" with a close button (X) in the top right corner. On the left, under "Select your reasons for visit", there is a list of reasons: "Kidney disease (follow up)", "Kidney stones", "Lacerations", "Mania", "Medicare preventive" (highlighted in blue), "Memory loss", and "Migraine". Above this list is a checkbox labeled "All HPIs" which is currently unchecked. On the right, under "Reason(s) for visit", there are two "Follow up" sections. The first section has a checked checkbox, a text input field containing "Medicare preventive", and a "Clear" button. The second section has an unchecked checkbox and an empty text input field with a "Clear" button.

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 teams 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:

Coronary Heart Disease Risk
Risk Assessment Tool for Estimating 10-year Risk of Developing Hard CHD (Myocardial Infarction and Coronary Death)

Gender: Male Female

Age: [Exclusions](#)

Smoker: Yes No [Tobacco Usage](#) The patient's risk score is:

Systolic blood pressure: mm

Currently on medication to treat hypertension: Yes No [ATP III](#)

HDL cholesterol: mg/dl [ATP III at a Glance](#)

Total cholesterol: mg/dl [ATP Executive Summary](#)

[Framingham Risk Score Tables](#)

Comments:
Characters left: 100

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.

Medicare Preventative - HPI

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

Concern: **Medicare preventative** [Referring Provider](#) | [Advance Directives](#) | [Confidential Information](#)

Welcome to Medicare (IPPE) [ECG Order](#) Annual Wellness Visit (First) Subsequent Annual Wellness Visit [Framingham risk score:](#)

[Care Guidelines](#) Panel Control: [Toggle](#) [↶](#) [↷](#) [Cycle](#) [↴](#)

History Summary

[History Review](#) No relevant past medical/surgical history Confidential

	Disease/Disorder	Side	Onset Date	Management	Side	Date	Encounter Type
--	------------------	------	------------	------------	------	------	----------------

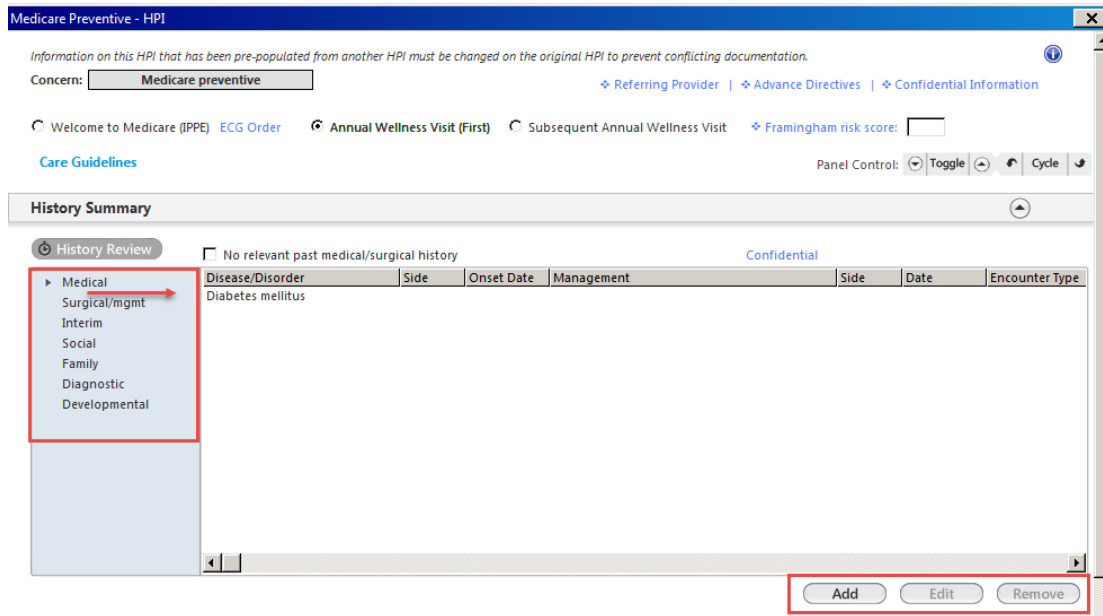
Care Guidelines

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.

The screenshot shows a software window titled "*Care Guidelines 83". The interface includes a sidebar on the left with "Outstanding guidelines: 1" and "Health Maintenance" (indicated by a red circle with a white exclamation mark). Below this is a "Measure status:" section with a "CQM Check" button. The main area contains a list of categories, each with a dropdown arrow: "Recent Orders", "Clinical Guidelines" (highlighted with a red box), "Screening Questions", "Metrics", "Vital Signs", "Immunizations" (highlighted with a red box), "Nutrition", and "Drug Therapy". At the top right of the main area is a "Save & Close" button. At the bottom right are "Save & Close" and "Cancel" buttons. A "Panel Control:" section with "Toggle", "Cycle", and other icons is located at the top right of the main area.

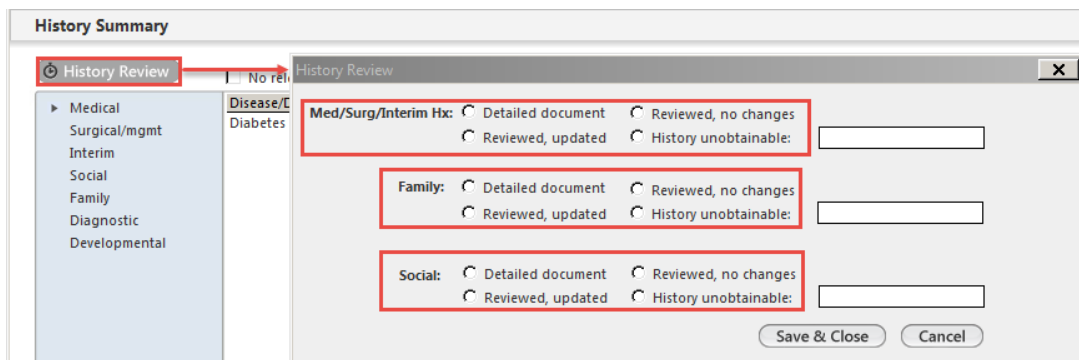
History Summary Panel

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.

Vital Signs

Time	Ht (in)	Wt (lb)	BMI	BP	Pulse	Respiration	Temp (F)	Pulse Ox Rest	Waist Circ	Pain Level	Comments
------	---------	---------	-----	----	-------	-------------	----------	---------------	------------	------------	----------


Add Edit Remove

Encounter Date Time	Visual Acuity - OU Corrected	Visual Acuity - OU Uncorrected
---------------------	------------------------------	--------------------------------

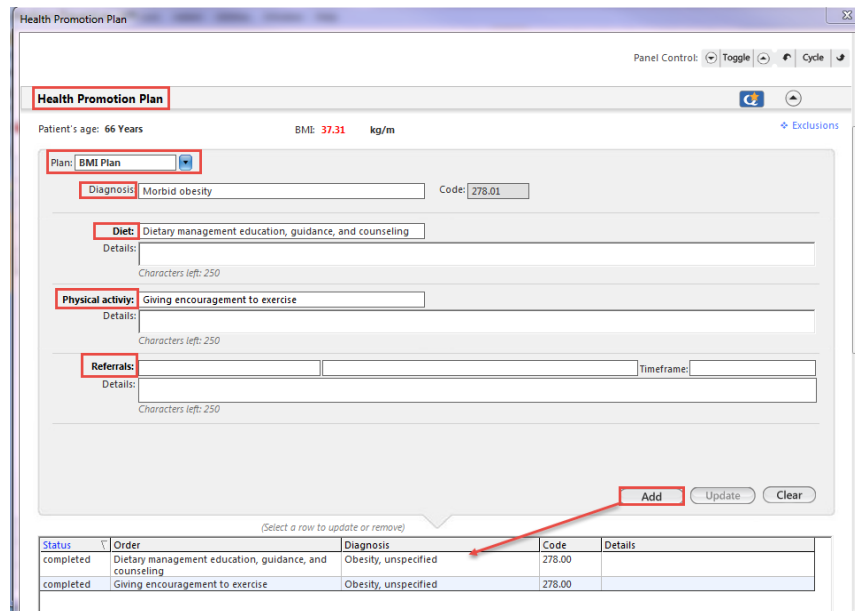
Encounter Date Time	Hearing Screen Right	Hearing Screen Left
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Providers can create personalized plans based on recorded measurements by utilizing the ***Health Promotion Plan*** link. See below for details.

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.



Health Promotion Plan

Panel Control: Toggle Cycle

Health Promotion Plan

Patient's age: 66 Years BME: 37.31 kg/m Exclusions

Plan: BMI Plan

Diagnosis: Morbid obesity Code: 278.01

Diet: Dietary management education, guidance, and counseling
Details: Characters left: 250

Physical activity: Giving encouragement to exercise
Details: Characters left: 250

Referrals: Timeframe: Details: Characters left: 250

(Select a row to update or remove)

Status	Order	Diagnosis	Code	Details
completed	Dietary management education, guidance, and counseling	Obesity, unspecified	278.00	
completed	Giving encouragement to exercise	Obesity, unspecified	278.00	

Add Update Clear

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**.

The screenshot displays the Medicare Preventive - HPI interface. At the top, there is a warning message: "Information on this HPI that has been pre-populated from another HPI must be changed on the original HPI to prevent conflicting documentation." Below this, the "Concern" is set to "Medicare preventive". There are links for "Referring Provider", "Advance Directives", and "Confidential Information".

The main section is titled "Depression Screening" and contains two questions:

- No
- Yes
- Recently, has the patient felt down, depressed or hopeless?
- Recently, has the patient felt little interest or pleasure in doing things?

A red box highlights the "Depression Screening" link and a score of "10".

Below the screening panel is the "Cognitive Assessment" section, which includes a table of categories:

Cognitive Assessment
Functional Ability/Safety/Home Environment
Nutrition
Tobacco/Alcohol
Review of Systems
History Summary
Vital Signs

To the right of the Cognitive Assessment is "The Geriatric Depression Scale" with a list of 9 questions and "Yes/No" radio buttons:

1. Are you basically satisfied with your life? Yes No
2. Have you dropped many of your activities and interests? Yes No
3. Do you feel that life is empty? Yes No
4. Do you often get bored? Yes No
5. Are you in good spirits most of the time? Yes No
6. Are you afraid that something bad is going to happen to you? Yes No
7. Do you feel happy most of the time? Yes No
8. Do you often feel helpless? Yes No
9. Do you prefer to stay at home, rather than going out and doing new things? Yes No

There is an "Exclusions" link at the top right of the scale.

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.

Medicare Preventive - HPI

Cognitive Assessment

History:

Date	Instrument	Score	Severity/interpretation	Completed By	Comments

Add Edit Remove

- 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**.

Screening Tools

Interactive Screening Tools

Behavioral Health Assessments

- CAGE Questionnaire
- Drug Abuse Screening Tool (DAST)
- Geriatric Depression Scale (GDS)
- Major Depression Inventory (MDI-10)
- Patient Health Questionnaire (PHQ-9)
- Suicidal/Homicidal Risk

Health Status Assessments

- Framingham 10 year Risk for CAD
- The Saint Louis University Mental Status (SLUMS) Examination

Self Assessments

- Edinburgh Postnatal Depression Scale
- Veterans Rand 12 Item Health Survey (VR-12)

Website Screening Tools

- Web Bipolar Spectrum Diagnostic Scale (BSDS)
- Web Goldberg Depression Questionnaire
- Web Hamilton Anxiety Scale (HAM-A)
- Web Hamilton Rating Scale for Depression (HAM-D)
- Web Zung Self-Rating Depression Scale

Screening instrument: Patient Health Questionnaire (PHQ-9) Score: Severity/interpretation: Comments: Major Depressive Disorder (MDD) pre-treatment

See scanned document Exclusions

Add Update Clear

Screening Tool Health Promotion Plan

Date	Instrument	Score	Severity/Interpretation	Completed By	Comments	MDD Classification



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.

Cognitive Assessment

History:

Date	Instrument	Score	Severity/interpretation	Completed By	Comments
11/14/2014	Saint Louis University Mental Status (SLUMS) Examination	23	Mild Neurocognitive Disorder	KIMBERLY EHLY	

Add Edit Remove

Saint Louis University Mental Status (SLUMS) Examination

Level of Education:

1. What day of the week is it? Correct Incorrect

2. What is the year? Correct Incorrect

3. What state are we in? Correct Incorrect

4. Please remember these five objects. I will ask you what they are later.
Apple Pen Tie House Car

5. You have \$100 and you go to the store and buy a dozen apples for \$3 and a tricycle for \$20. How much did you spend? Correct Incorrect
How much do you have left? Correct Incorrect

6. Please name as many animals as you can in one minute.
animals 0-4 5-9 10-14 15+

7. What were the five objects I asked you to remember?
correct 0 1 2 3 4 5

8. I am going to give you a series of numbers and I would like you to give them to me backwards. For example, if I say 4-2, you would say 2-4.
8-7 Correct Incorrect 6-4-8 Correct Incorrect 8-5-3-7 Correct Incorrect

9. This is a clock face. Please put in the hour markers and the time at ten minutes to eleven o'clock. *(Go to Document Library to print the diagram)*
Hour markers OK: Correct Incorrect
Time correct: Correct Incorrect

10. Please place an X in the triangle.
Which of the figures is the largest? Correct Incorrect

11. I am going to tell you a story. Please listen carefully because afterwards, I'm going to ask you some questions about it.
Jill was a very successful stockbroker. She made a lot of money on the stock market. She then met Jack, a devastatingly handsome man. She married him and had three children. They lived in Chicago. She then stopped work and stayed home to bring up her children. When they were teenagers, she went back to work. She and Jack lived happily ever after.
What was the female's name? Correct Incorrect
When did she go back to work? Correct Incorrect
What work did she do? Correct Incorrect
What state did she live in? Correct Incorrect

Comments:

Total Score: Add To Grid

Generate and print the SLUMS results document via Document Library.

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

Cognitive Assessment

History:

Date	Instrument	Score	Severity/Interpretation	Completed By	Comments
11/14/2014	Saint Louis University Mental Status (SLUMS) Examination	23	Mild Neurocognitive Disorder	KIMBERLY EHLI	

Add Edit Remove

Saint Louis University Mental Status (SLUMS) Examination

1. What day of the week is it? C D
 2. What is the year? C D
 3. What state are we in? C D
 4. Please remember these five objects. I will ask you what they are.
 Apple Pen Tie House Car
 5. You have \$100 and you go to the store and buy a dozen eggs for \$20. How much do you have left? 4
 6. Please name as many animals as you can in one minute.
 # animals 0-4 5-9 10-14 15-19
 7. What were the five objects I asked you to remember?
 # correct 0 1 2 3 4 5
 8. I am going to give you a series of numbers and I would like you to repeat them back to me.

Interactive Screening Tools

Behavioral Health Assessments

- PHQ-2 Questionnaire
- Drug Abuse Screening Tool (DAST)
- Geriatric Depression Scale (GDS)
- Major Depression Inventory (MDI-15)
- Patient Health Questionnaire (PHQ-9)
- Suicidal/Homicidal Risk

Health Status Assessments

- Frailty Index 10 year Risk for CAD
- The Saint Louis University Mental Status (SLUMS) Examination

Self Assessments

- Edinburgh Postnatal Depression Scale
- Veterans Rand 12 Item Health Survey (VR-12)

Website Screening Tools

- Bipolar Spectrum Diagnostic Scale (BSDS)
- Goldberg Depression Questionnaire
- Hamilton Anxiety Scale (HAM-A)
- Hamilton Rating Scale for Depression (HAM-D)
- Zung Self-Rating Depression Scale

Screening Instrument: Score: Severity/Interpretation: Major Depressive Disorder (MDD) pre-treatment

See scanned document Add Update Clear

Screening Tool

Date	Instrument	Score	Severity/Interpretation	Completed By	Comments	MDD Classification
11/14/2014	Saint Louis University Mental Status (SLUMS) Examination	23	Mild Neurocognitive Disorder	KIMBERLY EHLI		
11/14/2014	Geriatric Depression Scale (GDS)	10	Moderate depression	KIMBERLY EHLI		

Remove Save & Close Cancel

Vital Signs

Medications



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Functional 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.

Health Promotion Plan ✕

Save & Close Cancel

Panel Control: Toggle ↶ ↷ Cycle ⬇

Health Promotion Plan ⌵

Pain Management ⌵

Fall Risk ⬆

Fall Risk/Plan of Care: ✦ Exclusions

Falls in the last year? No Yes

Number of falls:

Did the fall(s) result in injury? No Yes

Details:

Follow-up plan of care:

Assistive devices: [My Phrases](#) | [Manage My Phrases](#)

Characters left: 300

Balance, strength, and gait training: [My Phrases](#) | [Manage My Phrases](#)

Characters left: 300

Functional Status ⬆

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**.

The screenshot shows a web-based interface for a Medicare Preventive Health Physical Examination (HPI). The main section is titled "Nutrition" and contains the following fields and options:

- BMI:** 37.31
- Diet:** high calorie (with a red box around the "Detail" link next to it)
- Weight Change:** Radio buttons for "Weight gain" and "Weight loss", each with input fields for lbs and kgs, and a "Timeframe" field.
- Counseling:** Checkboxes for "Counseled on weight reduction" and "Counseled on dietary changes", both of which are checked.
- Supplements:** Radio buttons for "Calcium" and "Multivitamin", both checked. "Calcium" has sub-options for "Dietary sources" and "Supplement" (both with "mg/day" input fields) and a "Contraindication" field. "Multivitamin" has sub-options for "Daily" and "Occasionally".
- Vitamins:** Radio buttons for "Vitamin D" and "Folic acid", both checked. "Vitamin D" has sub-options for "Supplement" and "Adequate sunlight exposure". "Folic acid" has sub-options for "Daily" and "Occasionally".

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.

The screenshot shows the 'Medicare Preventive - HPI' interface. At the top, there is a warning: 'Information on this HPI that has been pre-populated from another HPI must be changed on the original HPI to prevent conflicting documentation.' Below this, the 'Concern' is set to 'Medicare preventive'. There are links for 'Referring Provider', 'Advance Directives', and 'Confidential Information'. The visit type is 'Annual Wellness Visit (First)'. A 'Framingham risk score' field is present. A 'Care Guidelines' section is visible with a '14' icon. The 'Tobacco/Alcohol' panel is expanded, showing three questions with radio buttons for 'No', 'Yes', and 'Former'. Each question has a 'Detail' link highlighted with a red box:

No	Yes	Former	
<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	Uses tobacco Detail
<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	Passive smoke exposure
<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	Drinks alcohol Detail

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.

This screenshot is identical to the one above, showing the 'Tobacco/Alcohol' panel. The 'Detail' links for 'Uses tobacco' and 'Drinks alcohol' are highlighted with red boxes.

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

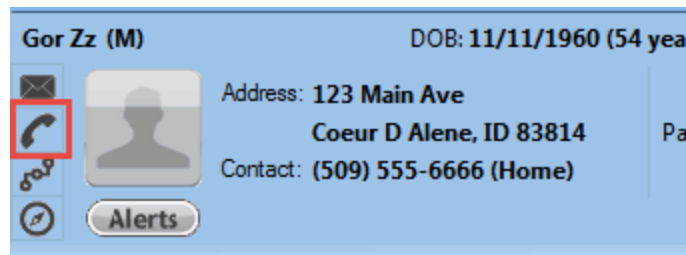
Summary

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**.
- Perform a 4 Point check
- Select the **Telephone Icon** on the **Patient Information Bar**.

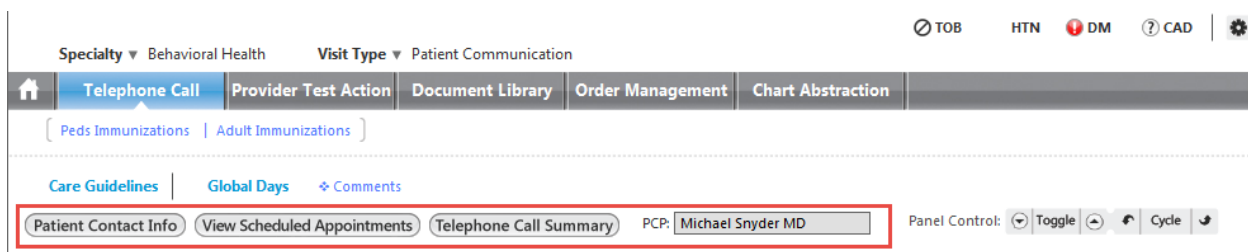


Patient Contact Information will reflect patient's contact information and is read only.

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.

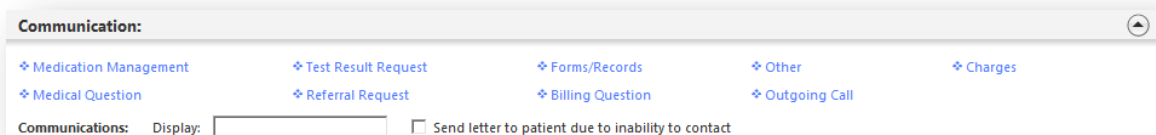
PCP will reflect the documented Primary Care Provider.



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



The screenshot shows a software interface titled "Communication:". Below the title is a grid of ten call detail template options, each with a blue diamond icon and a plus sign. The options are arranged in two rows of five. The first row includes: Medication Management, Test Result Request, Forms/Records, Other, and Charges. The second row includes: Medical Question, Referral Request, Billing Question, and Outgoing Call. Below the grid, there is a "Communications:" label, a "Display:" text box, and a checkbox labeled "Send letter to patient due to inability to contact".

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 medication 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 screenshot shows the 'Medication Management - Telephone' window. The 'Tasking' field is highlighted with a red box and contains the number '13'. Below it, the 'Priority' is set to 'Normal' and there is a 'Send & Close' button. The window also displays a list of medications, including Humira 40 mg/0.8 ml Sub-Q Kit, and a table for Medication Refill with columns for Medication, Strength, Sig, Comment/quantity/refills, and various status checkboxes.

The screenshot shows the 'Select Task Recipients' window. On the left, there is a tree view of 'Available Users / Workgroups' with categories like Users, Workgroups, and CMC. On the right, there is a table for 'Task Recipients' with columns for Name and Type. The table is currently empty. At the bottom, there are buttons for 'New Group', 'Delete', 'Modify', 'OK', and 'Cancel'.

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)

The screenshot displays a medical software interface with three main components:

- Communication Form:** Located at the top, it includes fields for "Concern:" (containing "Chest pain" with a red '6' next to it), "Duration of symptoms:" (containing "5 Minutes"), and a "Comment:" field (containing "Call regarding chest pain. Duration of 5 Minutes."). Below these fields are buttons for "Meds/Allergies/Chronic Probs" (with a red '7' next to it), "Manage My Phrases", and "My Phrases".
- Actions Panel:** A red-bordered box on the right side of the communication form. It contains a "Schedule appointment:" checkbox (checked) with a "Details:" field (containing "2 weeks") and a "Completed:" checkbox (unchecked). Other actions include "Send referral:" (checked), "Place new medication order:" (unchecked), "Adjust medication:" (unchecked), "Send test result(s):" (checked) with a "to family fax" field, "Counsel patient:" (checked), and "Other:" (unchecked).
- Complaint / Concern Pick List:** A green-bordered window on the left side, labeled with a red '6'. It lists various medical conditions such as "chronic conditions", "cold symptoms", "congestive heart failure", "constipation", "confusion", "cough", "degenerative disc disease", "depression", "diabetes", "diabetes (follow up)", "diabetes insipidus", "diarrhea", "diminished urinary stream", "discuss test results", "dizziness", "DM/HTN", "DM/lipids", "earache", "eye problems", "fatigue", "fatigue (chronic)", "fever", "flu-like symptoms", "follow up on lab test(s)", "foot ulcers", "galactorrhea", "gastroenteritis", "genital lesion", "GERD", "gestational diabetes", "gout", "headache", "heart disease", "heart disease (follow up)", "heartburn", "heavy periods", "hematomas", "hemorrhoids", "HIV", "HIV follow up", "hoarseness", "hot flashes", and "hyperchromia".
- Meds Allergies Problems Summary:** A pink-bordered window on the right side, labeled with a red '7'. It contains three sections:
 - Medications:** A table with columns for "Medication", "Form", and "Sig".
 - Allergies:** A table with columns for "Allergy" and "Reaction", containing the entry "PEANUT".
 - Chronic Problems:** A table with columns for "Chronic Problem", "Code", and "Additional Info".

- 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.

Meds/Allergies/Chronic Probs Manage My Phrases My Phrases Counsel patient: Other:

9 Review of Test(s)

This Communication History:

Date	Time	Employee	Comments	Tasked To

Admin Action Release of Info Log (PHI)

Tasking: Priority: 10
Normal

Send & Close

Telephone Call Summary Status: Open Complete

Save & Close Cancel

Review of Test

Category: Diagnostic study Referrals Other reports Lab orders Lab results (Double click on the order to open)

Status	Date Ordered	Date Completed	Text/Study	Interpretation	Results/Value

Add My Phrases Clear

Action Details/Notes:

Free Text

Save & Close Cancel

Select Task Recipients

Available Users / Workgroups:

Priority: Normal

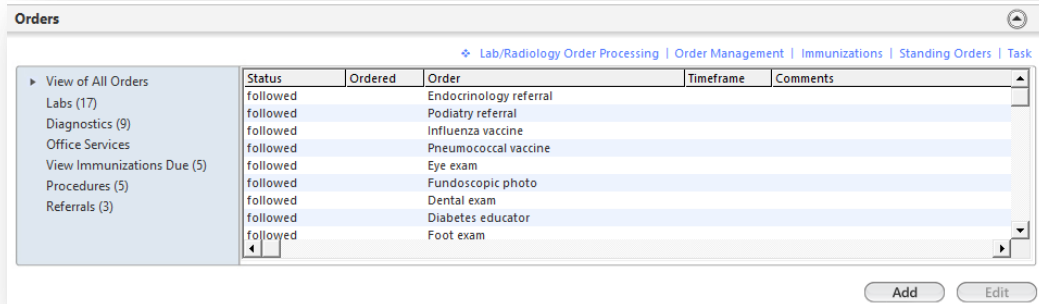
Add (User) Add (Group) Remove Clear

Name	Type

New Group Delete Modify OK Cancel

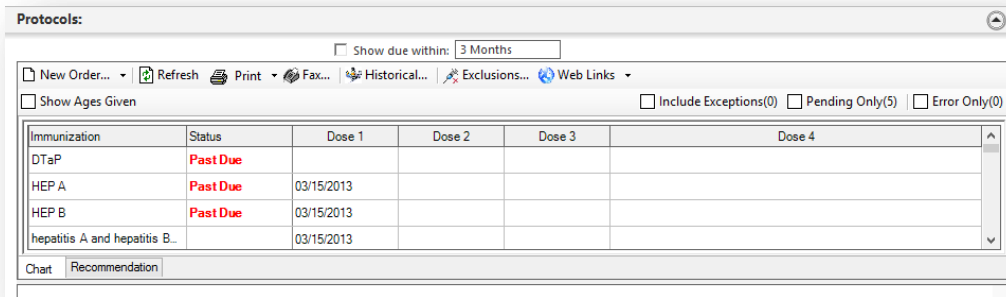
Orders Panel

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.

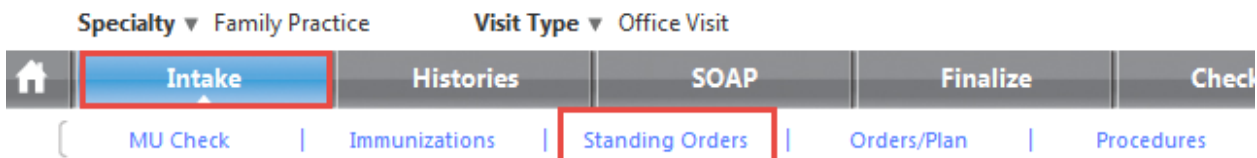
Launching Office Services

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**.



Reason for Visit



Do not launch HPI

[Intake Comments](#)

	Chief Complaint	History of Present Illness
abdominal pain anxiety back pain chronic conditions depression diabetes hypertension lab draw musculoskeletal pain pelvic pain preventive exam rash URI UTI	Mood swings	The symptoms are reported as being severe. The symptoms occur constantly. He states the symptoms are chronic and are of new onset.
Additional / Manage	Medicare preventive (FP)	

Diagnostics

Show All



Office Services Panel

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

Office

Orders
(Highlight a row to select)

Order Category	Lab Name	Proc. Code	Side	Diagnosis Description
ALL	Rapid RSV	87420		
ALL	Rapid strep	87900		
ALL	Semen analysis, presence/motility	89300		
ALL	Smear/sped stain incisional bodies/parasites	87207		
ALL	Smear, stain & interpret, wet	87210		
ALL	Historic stain, interpret, with count	81900		

Diagnosis
Order: **Rapid strep** Procedure code: 87900 Side:
Diagnosis: **Cough** Dx code: 786.2 Status: **For Control**
[Add or Update Assessment](#) [Clear](#)

Results/Report
Interpretation: Details Normal value: **negative** Unit of measure:
Clinical indication:
Details: [My Phrases](#) | [Manage My Phrases](#)

Today's Orders
 Submit to Superbill Verbal order/needs sign-off Send task automatically [Additional Orders](#) | [Task](#)

Status	Office Diagnostic Description	Side	Interpretation	Result	Performed By	Cl
--------	-------------------------------	------	----------------	--------	--------------	----

[Place Order](#) [Update](#)

Click in the Interpretation box. And select the interpretation.

Office Services

Office

Orders
(Highlight a row to select)

Order Category	Lab Name	Proc. Code	Side	Diagn
ALL	Rapid RSV	87420		
ALL	Rapid strep	87900		
ALL	Semen analysis, presence/motility	89300		
ALL	Smear/sped stain incisional bodies/parasites	87207		
ALL	Smear, stain & interpret, wet	87210		
ALL	Historic stain, interpret, with count	81900		

Diagnosis
Order: **Rapid strep** Procedure code: 87900
Diagnosis: **Cough** Dx code: 786.2 [Add or](#)

Results/Report
Interpretation: **negative** Normal value: **negative**
Clinical indication:
Details: [My Phrases](#) | [Manage My Phrases](#)

Today's Orders
 Verbal order/needs sign-off Send task

Status	Office Diagnostic Descript	Side	Interpretation	Result
ordered	Rapid strep			

[Close](#)



- 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.

Panel Control:

Office

Orders
(highlight a row to select) Display category: ALL

Order Category	Lab Name	Proc. Code	Side	Diagnosis Description
ALL	Rapid RSV	87420		
ALL	Rapid strep	87880		
ALL	Semen analysis, presence/motility	89300		
ALL	Smear spec stain incisional bodies/parasites	87207		
ALL	Smear, stain & interpret, wet	87210		
ALL	Urinalytic non-automated w/in crone	81000		

Diagnosis

Order: Procedure code: Side:

Diagnosis: Dx code: Status:

Results/Report

Interpretation: [Details](#) Normal value: Unit of measure:

Clinical indication:

Details:

Today's Orders

Submit to Superbill Verbal order/needs sign-off Send task automatically [Additional Orders](#) | [Task](#)

Status	Office Diagnostic Description	Side	Interpretation	Result	Performed By	CI
ordered	Rapid strep					

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 after editing any information.

Office

Panel Control: Toggle Cycle

Office 1

Orders
(Highlight a row to select)

Display category: ALL

Order Category	Lab Name	Proc. Code	Side	Diagnosis Description
ALL	Rapid RSV	87420		
ALL	Rapid Strep	87880		
ALL	Semen analysis, presence/motility	89900		
ALL	Smear spec stain incisional bodies/parasites	87207		
ALL	Smear, stain & interpret, wet	87210		
ALL	Urinalytic non-automated w/in zone	81000		

Diagnosis

Order: Rapid strep Procedure code: 87880 Side:

Diagnosis: Cough Dx code: 786.2 Status:

Add or Update Assessment Clear

Results/Report

Interpretation: negative Details Normal value: negative Unit of measure: Protocols

Clinical indication:

Details: negative My Phrases | Manage My Phrases

Double-Click on Office Diagnostic

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

Status	Office Diagnostic Description	Side	Interpretation	Result	Performed By	Cl
ordered	Rapid strep					

Place Order Update

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

"All Order Management" - [1 of 1]

Order: Rapid strep Reason (for referral): Clinical information/ comments: Attachments/ description:	Code: 87880	Diagnosis: Cough Code: 786.2
Authorization Authorization req'd: <input type="radio"/> No <input type="radio"/> Yes Authorization #: Effective: Expiration: # Visits: <input type="checkbox"/> Performed: Consent <input type="checkbox"/> Performed: Scheduling <input type="checkbox"/> Performed:		Result/report <input type="checkbox"/> Received: On: Reason/comment: <input type="checkbox"/> Completed: On: Reason/comment: Interpretation: Report details:
Obtained/performed/placed <input type="checkbox"/> Performed: Seq: Strength: Dose: Units: Route: Side: Site: Position: Lot #: Expiration: Brand name: Qty: Reaction: (Clear) Manufacturer:		Billing codes Order: 87880 Mod 1: Mod 2: Bill units: 1.00 Service date: ##### Admin/other 1: Clear Admin/other 2: Clear Venipuncture: Clear Submit to Superbill
Education/instructions <input type="checkbox"/> Performed: On: Instruction(s) provided:		Additional information Ordering provider: Thomas Broadway MD <input checked="" type="checkbox"/> Ordered: 12/26/2013 <input type="checkbox"/> Verbal/standing order: <input type="checkbox"/> Cosigned/signed off: <input type="checkbox"/> Canceled:



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 screenshot shows the 'Orders' section of a software interface. On the left is a navigation menu with options: View of All Orders, Labs, Diagnostics (2), Office Services (1) (highlighted with a red arrow), View Immunizations Due, Procedures, and Referrals. The main area contains a table with the following data:

Status	Ordered	Order	Timeframe	Completed
ordered	12/26/2013	Rapid strep		/ /

At the bottom right of the table area are 'Add' and 'Edit' buttons.

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

The screenshot shows the 'Assessment/Plan' section. On the left is a navigation menu with options: Assessments, My Plan, A/P Details, Labs, Diagnostics, Referrals, Office Procedures, Review/Cosign Orders, View Immunizations, Office Diagnostics, Physical Therapy Orders, and Health Promotion Plan. The main area contains a list of entries:

1. Assessment	Diarrhea NOS (787.91).
2. Assessment	Pain, abdominal, right lower quadrant (789.03).
Impression	Add Impression/Comments for highlighted assesment.; Differential diagnosis - My differential diagnosis goes here.
Patient Plan	Avoid exposure to tobacco smoke and/or polluted air. Couseled re: potential co-morbidities include nephropathy.
Provider Plan	Couseled re: potential co-morbidities include nephropathy. Couseled regarding importance of weight loss.
3. Assessment	Fever (780.60).
Impression	Add Impression/Comments for Fever here..
Patient Plan	Patient Detail for Fever here
Provider Plan	Details
4. Assessment	Cough (786.2).
Plan Orders	The patient is to have Rapid strep and Rapid strep performed.
5. Assessment	Upper respiratory infection, Acute (402.9).

The entry for 'Cough (786.2)' and its corresponding 'Plan Orders' is highlighted with a red box.

Diagnostic History Panel

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

Office Services

Panel Control: Toggle Cycle

Office

Diagnostic History

Study Type
Diagnostic study type: Ultrasound Body

Study Performed
Diagnostic study: Procedure code:
 Ordered elsewhere Side: Site:

Study Date
Date performed: / / Approx. date performed Specialty:
Performed by:
Location:

Study Result
 See scanned report [My Phrases](#) | [Manage My Phrases](#)
Interpretation: Detail
Result:
Comments:

Add To Grid Update Delete

Performed	Study	Interpretation	Result

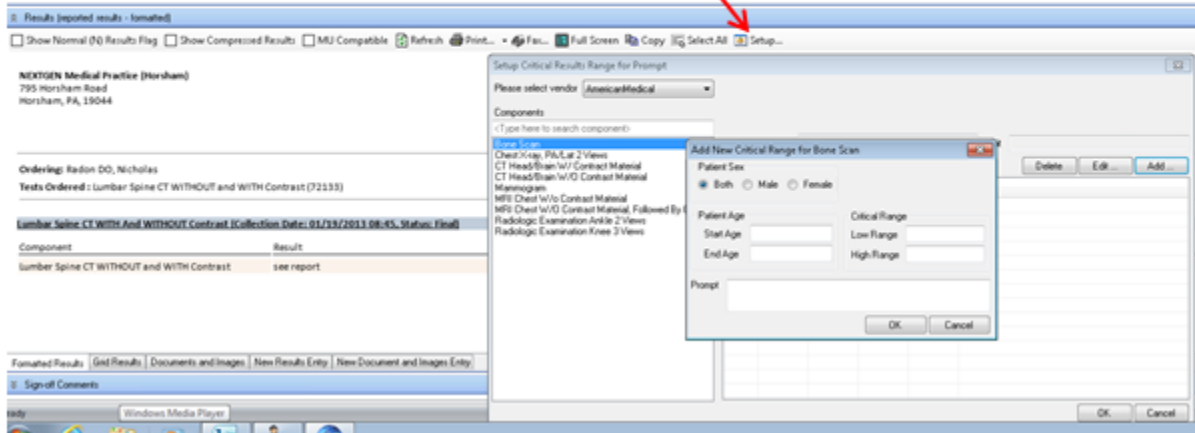
Add to HPI

Save & Close Cancel

Orders Module

Critical Range Alert

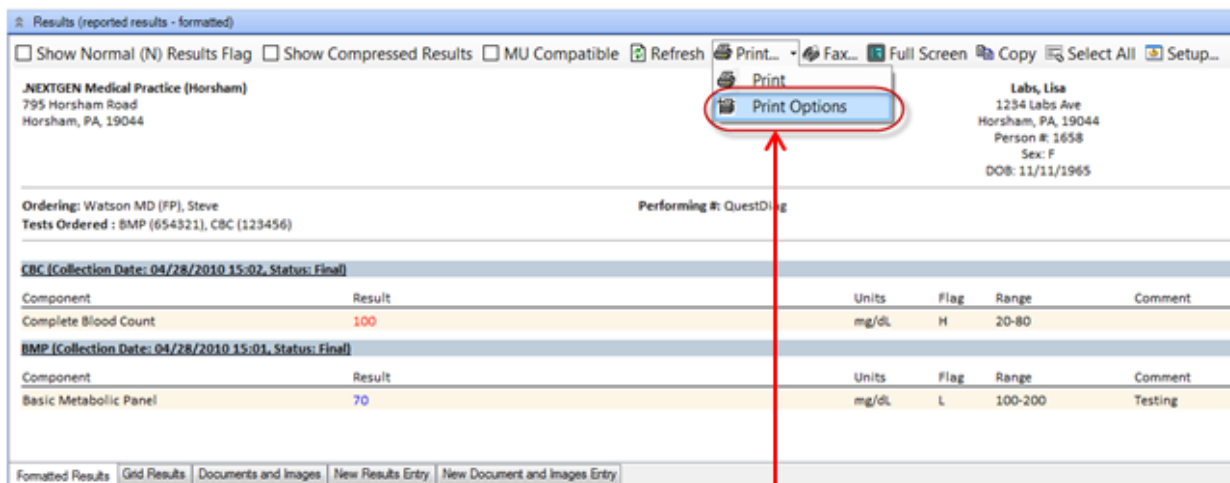
This **Setup** can be used only if the user has **System Admin Rights**.



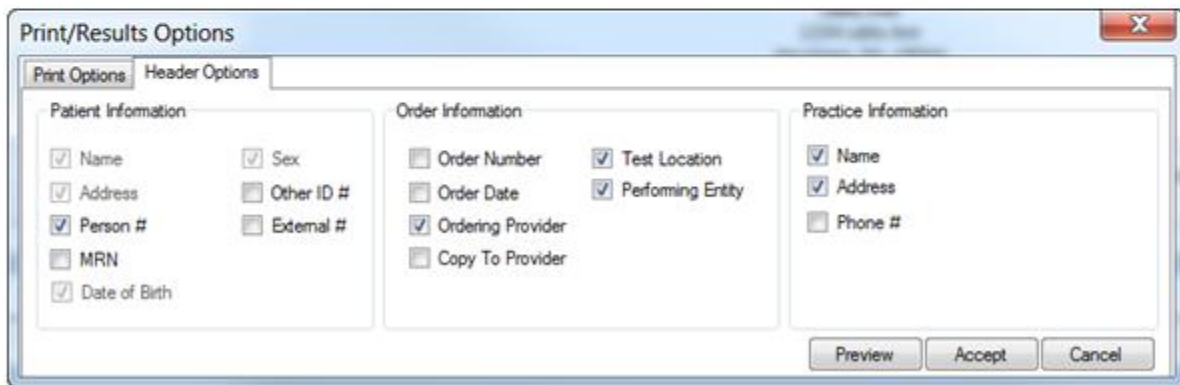
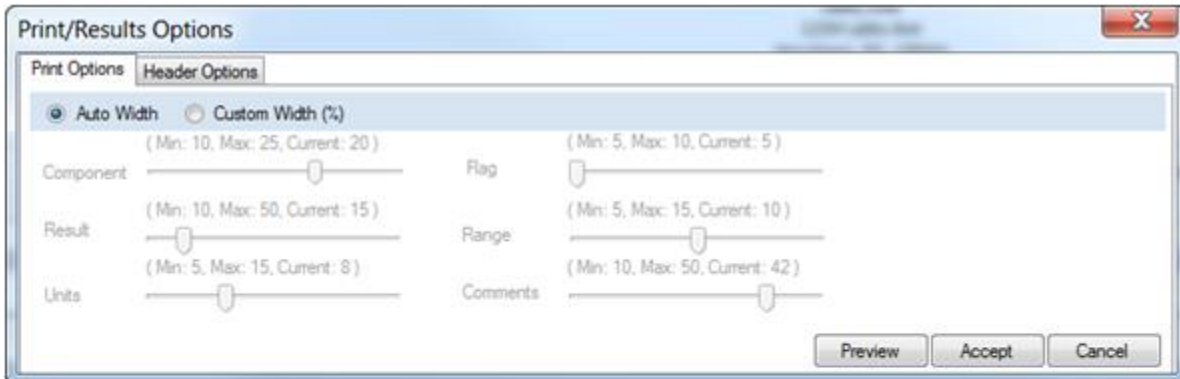
Once setup, the alerts will display when the user is on the **Orders** tab and **Results Panel** is expanded.

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.

Set Order Filter

Display Lab Orders
 Display Radiology Orders
 Display Immunization Orders

Date range
 From
 To

Check providers to filter

- 58Provider, 58Provider
- 58provider1, 58provider1 58provider1
- 58provider2, 58provider2 58provider2
- 58providerNEW, 58providerNEW 58providerNEW
- 58providerTwo, 58providerTwo 58providerTwo
- AM_TestProvider, Test

Check statuses to filter

- New
- Ordered
- Cancelled
- Deleted
- Sent
- Sent Failed

Check locations to filter

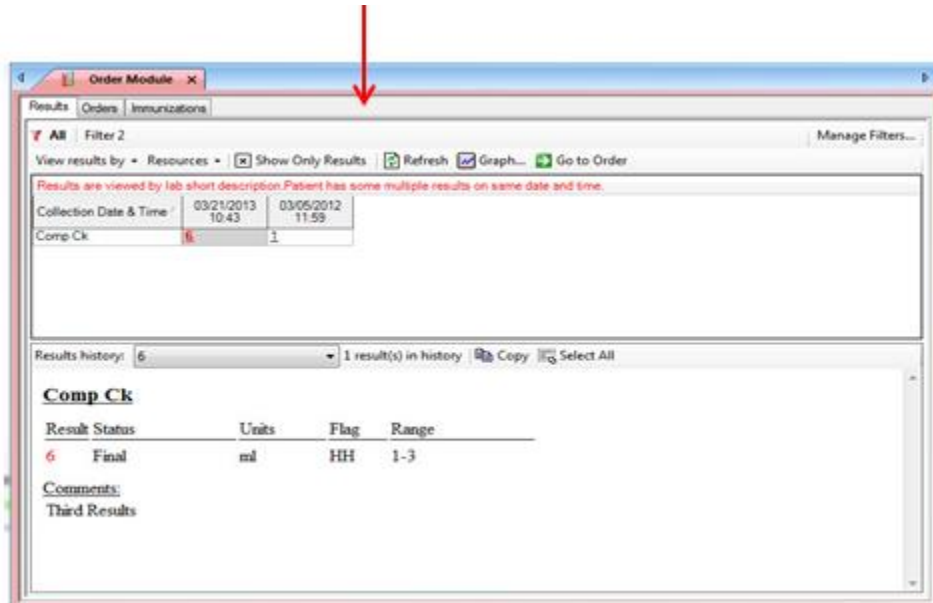
- Abington PEDS - Jemson
- Abington PEDS - York Road
- ACP 5.7 Location 1
- ACP 5.8 Location 1
- ACP 5.8 Location 2
- ACP Golden Branch Location 1

Check performing entities to filter

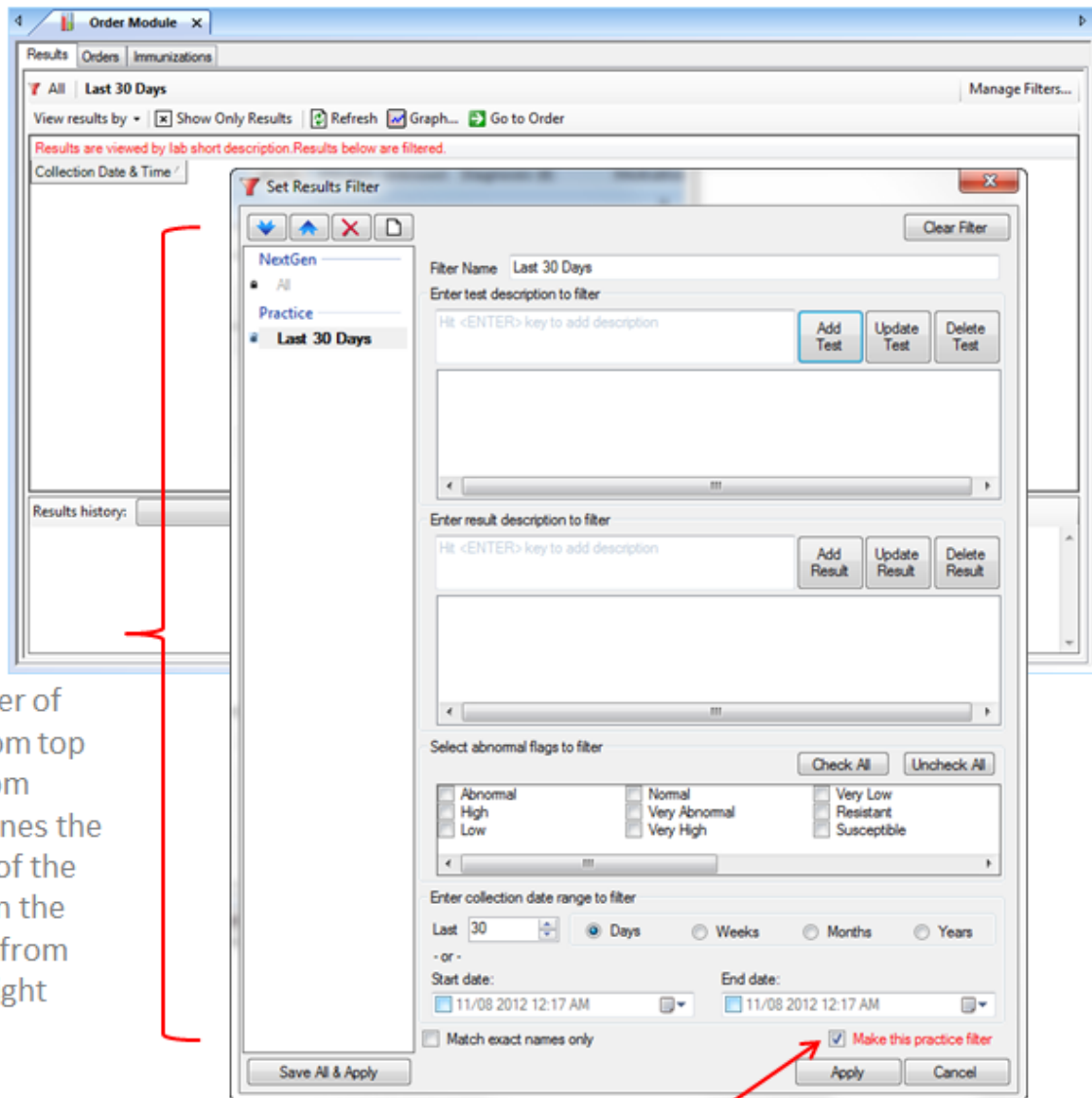
- AmericanMedical
- ClinicalDiag
- InHouseLab
- LabCorp
- Lab Trak
- Medcom



When there are multiple results that come back from 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



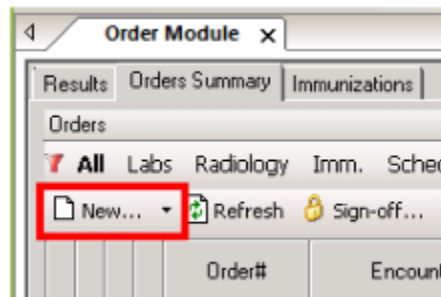
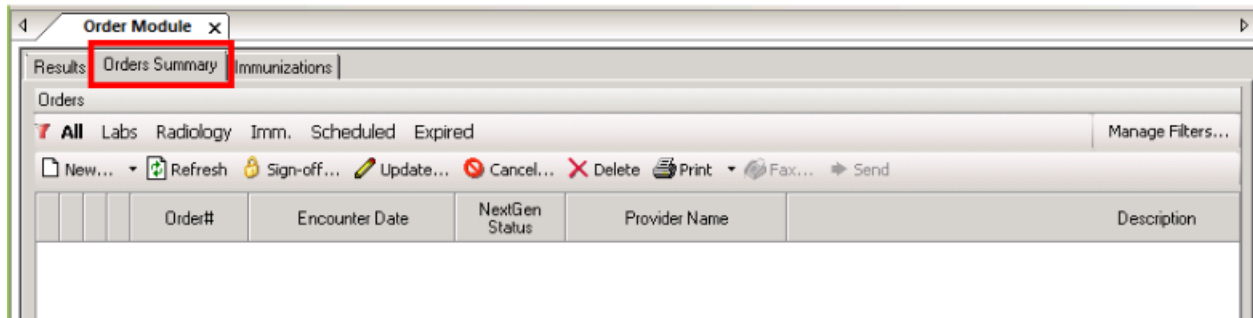
The order of filter from top to bottom determines the display of the filters on the toolbar from left to right

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

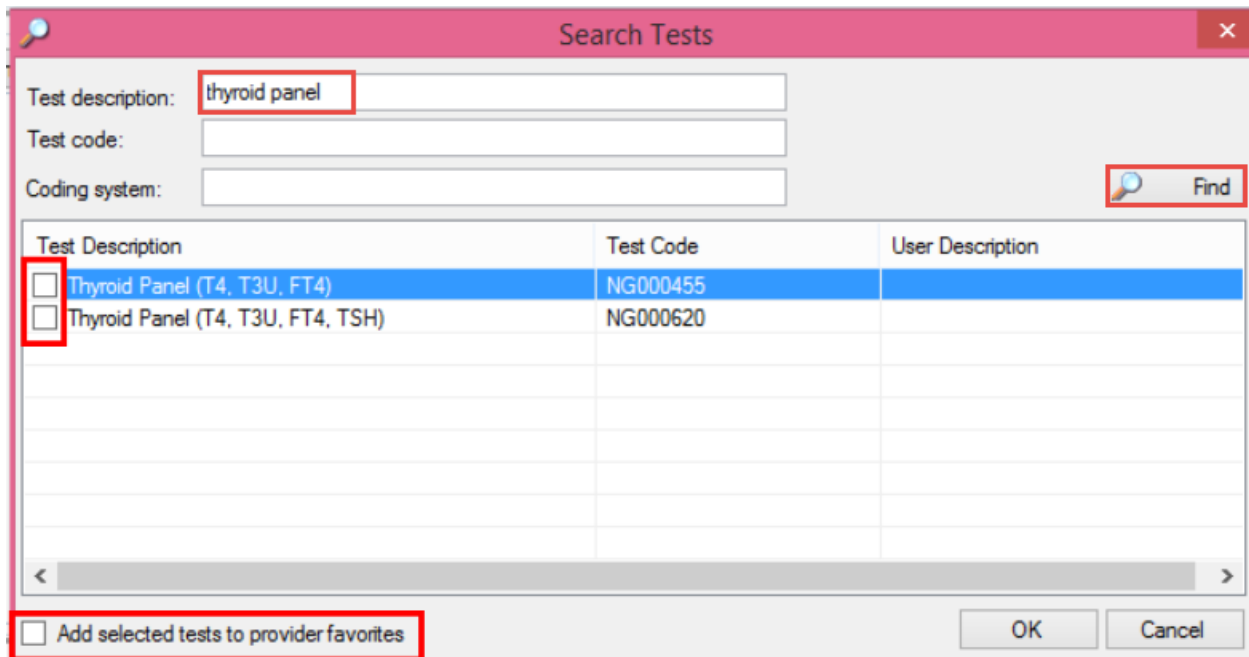


- The test ordering section will display in the middle of the screen.

- 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**



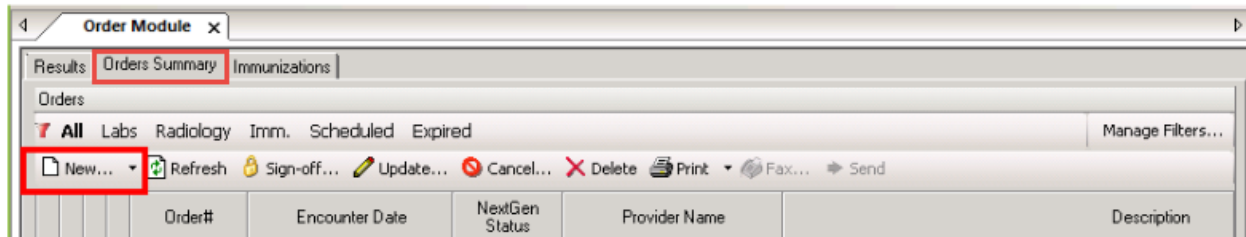
- Once favorites are created, they will display automatically when you create a new order. You can also view them if you navigate away by clicking the **Show Favorites** button.

Recurring Orders

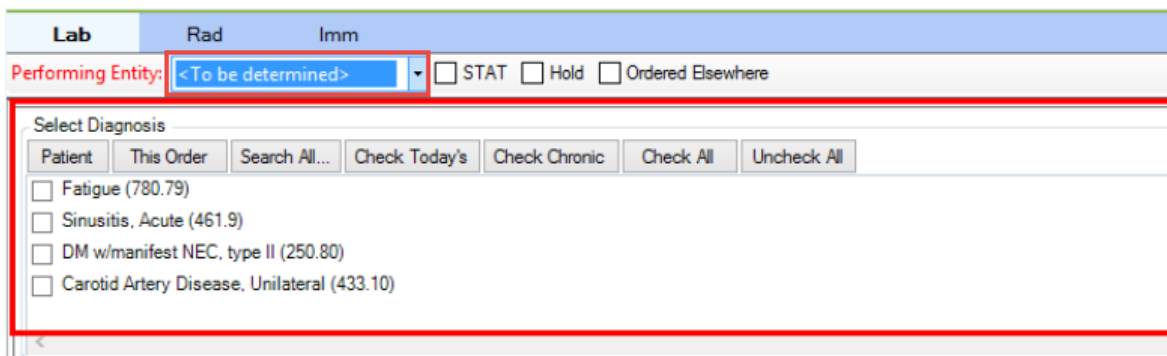
New Order

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).

Search Tests

Test description: thyroid panel

Test code:

Coding system:

Find

Test Description	Test Code	User Description
<input type="checkbox"/> Thyroid Panel (T4, T3U, FT4)	NG000455	
<input type="checkbox"/> Thyroid Panel (T4, T3U, FT4, TSH)	NG000620	

OK Cancel

Scheduling Order

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

Lab Rad Imm

Performing Entity: <To be determined>
 STAT
 Hold
 Ordered Elsewhere
 Specimen Charge <

Select Diagnosis

Patient This Order Search All... Check Today's Check Chronic Check All Uncheck All

<input type="checkbox"/> Fatigue (780.79)	<input type="checkbox"/> Impacted cerumen (380.4)
<input type="checkbox"/> Sinusitis, Acute (461.9)	<input type="checkbox"/> Laryngitis, acute (464.0)
<input type="checkbox"/> DM w/manifest NEC, type II (250.80)	
<input type="checkbox"/> Carotid Artery Disease, Unilateral (433.10)	

Select Tests

Show Favorites By Category This Order Search All... Check All Uncheck All
 Use NextGen Compendium

Assign Diagnosis to Selected Tests

NBV



- 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**.

Set Order Schedule

Check All Uncheck All

Items Available for Schedule

Thyroid Panel (T4, T3U, FT4, TSH)

Schedule for Thyroid Panel (T4, T3U, FT4, TSH)

Future order (one-time only)

Schedule in: 1 Days Weeks Months Years

Wednesday, July 23, 2014

Expires * Thursday, October 22, 2015

Recurring order

Start in: Start Today

1 Days Weeks Months Years

Wednesday, July 23, 2014

Repeat every: 1 Days Weeks Months Years

Expires * Thursday, October 22, 2015

* Expiry date is set by the Practice

Accept

Move To Unscheduled

Accept & Close Cancel

Managing Schedule

To change the date of the patient's next test

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

Order Module

Results Orders Summary Immunizations

Orders

All Labs Radiology Imm. **Scheduled** Expired Manage Filters...

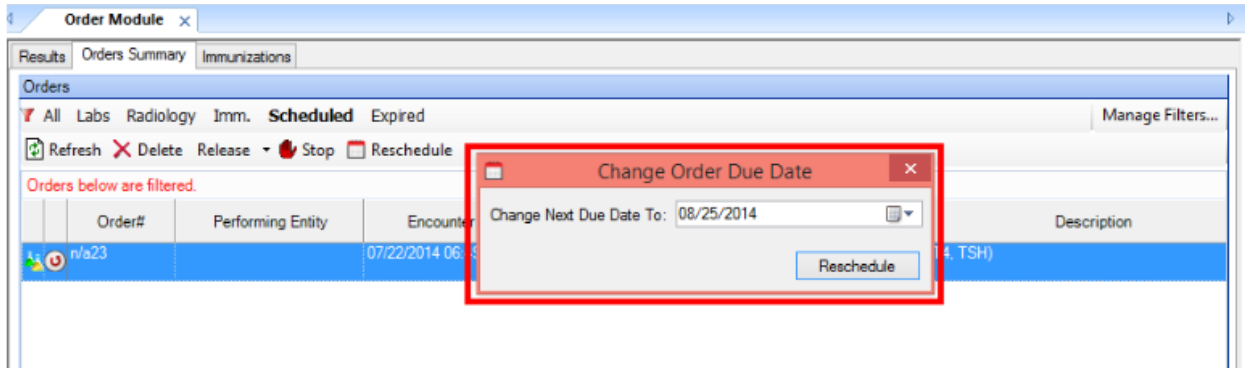
Refresh Delete Release Stop Reschedule

Orders below are filtered.

Order#	Performing Entity	Encounter Date	Provider Name	Description
n/a23		07/22/2014 06:49 PM	Broadway MD, Thomas	Thyroid Panel (T4, T3U, FT4, TSH)



- 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
- Select the **Renew** button.

User Preferences

Users have the choice of:

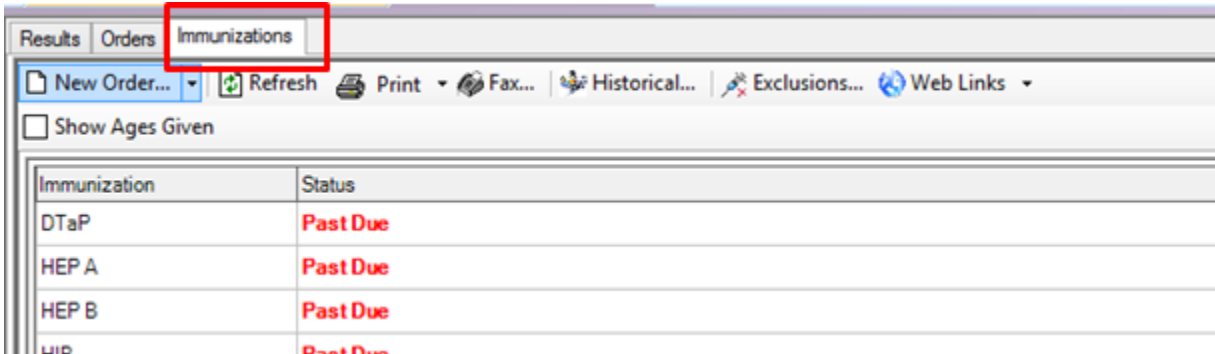
- Results
- Orders
- Immunizations Chart
- Immunizations Schedule

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



The screenshot shows a software interface with a navigation menu at the top containing 'Results', 'Orders', and 'Immunizations'. The 'Immunizations' tab is highlighted with a red box. Below the menu is a toolbar with buttons for 'New Order...', 'Refresh', 'Print', 'Fax...', 'Historical...', 'Exclusions...', and 'Web Links'. A checkbox labeled 'Show Ages Given' is also present. The main area contains a table with two columns: 'Immunization' and 'Status'.

Immunization	Status
DTaP	Past Due
HEP A	Past Due
HEP B	Past Due
UIP	Past Due

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

Results Orders Immunizations

New Order... Refresh Print Fax... Historical... Exclusions... Web Links

Show Ages Given Include Exceptions(0) Pending Only(0) Error Only(6)

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			

Chart Recommendation

Results Orders Immunizations

New Order... Refresh Print Fax... Historical... Exclusions... Web Links

Show Ages Given Include Exceptions(0) Pending Only(0) Error Only(0)

DOR: 04/06/1960 AGE: 53 year(s) 4 month(s)

Immunization	Status	Birth	1 Month	2 Months	4 Months	6 Months	12 Months	15 Months	18 Months	4 - 6 Years	11 Years
DTaP	Past Due			DTaP	DTaP	DTaP			DTaP	DTaP	
HEPA	Past Due						HEPA		HEPA		
HEPB	Past Due	HEPB	HEPB			HEPB					
HIB	Past Due			HIB	HIB	HIB	HB				
HPV	Past Due										HPV
INFLUENZA	Due Now								INFLUENZA(Yearly)		
MBNNGOCOCCAL	Past Due										MBNNGOCOCCAL
MMR	Past Due						MMR			MMR	
PNEUMOCOCCAL	Past Due			PNEUMOCOCCAL	PNEUMOCOCCAL	PNEUMOCOCCAL	PNEUMOCOCCAL				
POLO	Past Due			POLO	POLO		POLO			POLO	
ROTAVIRUS	Past Due			ROTAVIRUS	ROTAVIRUS						
Td	Due Now										
Tdap	Past Due										Tdap
VARICELLA	Past Due						VARICELLA			VARICELLA	
ZOSTER	Current										

Chart Recommendation



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

Immunization	Status	Dose 1	Dose 2
INFLUENZA	Current	10/30/2013	
MENINGOCOCCAL	Past Due		
MMR	Pending	12/31/2013	Pending
PCV13		--/--/2007	
PNEUMOCOCCAL	Past Due		
POLIO	Past Due		
ROTAVIRUS	Past Due		
Td	Due Now		
TDaP	Current	--/--/2010	
VARICELLA	Pending	Pending	Pending

Dose	Vaccine	CPT	Status	Date Ordered	Admin Date/Time	Administered By	Amount	Lot	Expiration Date	Manufacturer	Route	Site	Notes	Entered By
1	flu (split) preservative free, 3 yrs or older	90656	Completed	10/30/2013	10/30/2013 07:03 AM	Broadway, Thomas	0	15554	06/30/2013	Greer Laboratories, Inc.	Intramuscular	Left Upper Arm		Broadway, Thomas

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.

The screenshot shows a medical software interface with the following components:

- Registry:** <All>
- VFC Reason:** (dropdown)
- Funding Source:** (dropdown)
- Verbal Order:** (checkbox)
- Web Links:** (icon)
- Select Diagnosis:**
 - Buttons: Patient, This Order, Search All..., Check Today's, Check Chronic, Check All, Uncheck All
 - Diagnoses: Reflux esophagitis (530.11), Other and unspecified hyperlipidemia (272.4), Non autoimmune hemolytic anemia (283.10), 3 vessel CAD (414.01), Lumbar back sprain (847.2), Benign essential hypertension (401.1), Cystitis, acute (595.0), Dysuria (788.1), Enteritis, regional, small intestine (555.0), Atrial fibrillation (427.31), Benign renovascular hypertension (405.11), HX TRAUMATIC FRACTURE (V15.51)
- Select Vaccines:**
 - Buttons: Pediatrics, Adult, By Category, This Order, Search All..., Check All, Uncheck All
 - Vaccines: Hep A (adult) (90632), Hep B (adult) (90746), Hep B (adult 2 dose) (90743), Influenza (Current), Flu (split) (3 yrs or older) (90658), MMR (Past Due), **MMR (90707)**, PPSV23, Pneumo (2 yrs or older) (PPV23) (90732), Tdap (Current), Tdap (90715), Varicella (Past Due), **Varicella (90716)**, Zoster (Current), Zoster (90736)
- Assign Diagnosis to Selected Vaccines:**
 - Buttons: Check Interactions..., Delete Vaccine
 - Table:

Assign Diagnosis to Selected Vaccines	COUNSELED
MMR (90707)	<input type="checkbox"/>
Varicella (90716)	<input type="checkbox"/>

- Review any existing allergies and select, if applicable.

Review Allergies

Neomycin **Egg** **Latex** **Gelatin**
 Yes Yes Yes Yes
 No No No No

Existing Allergies:

Description	Onset	Resolved	Reaction	Comment
PEANUT OIL				
IODINE				
EGG	12/27/2013			

You must click Save to add new allergy to patient chart. If not, interaction check will miss them.

- 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

Create New Immunization Order for Zz. Gor

Lab Rad **Imm**

Registry: IRIS VFC Reason: Ineligible Funding Source: State funds Verbal Order Allergies...

Select Diagnosis

Select Vaccines

Pediatrics Adult By Category This Order Search All... Check All Uncheck All

Hep B (Past Due)

Adult Hep B (90746)

Influenza (Due Now)

Adult > 18 flu (90658)

Tdap (Past Due)

Adult Tdap (90715)

Assign Diagnosis to Selected Vaccines

Check Interactions... Delete Vaccine

Mark As Exception

COUNSELED V05.3

Adult Hep B (90746)

General Select Vaccines Vaccine Details

Save & Task... Save & Print Save & Send Save



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.**

Create New Immunization Order for Zz_Gor

Lab Rad **Imm**

Registry: IRIS | VFC Reason: | Funding Source: | Verbal Order | Allergies...

The admin date will not save unless status is completed or partially completed

Vaccine Name	Status	Lot #	Admin By	Vaccine Date	VFC Reason	Funding Source	Mark As Error
Adult Hep B (90746)	Completed	Engerix Enter Lot#...	EHLY, KIMBERLY	12/12/2014			<input type="checkbox"/>

Adult Hep B (90746)

Lot #: Show all Strength: NDC ID: -Waste Date:

Sequence: Booster Amount: Billing units: Reason:

Expiration date: Units: Admin CPT4: Counselor

Manufacturer: Route: Site:

Brand name: Vaccine date:

Status: Completed Partially Administered Excluded Refused Not Administered

Not administered reason:

Comment / notes:

Open VIS

Vaccine Name	VIS Description	VIS Publish Date	Language	Given Date	Given By
Adult Hep B	vis-hep-b 020212	02/02/2012	English	12/12/2014	EHLY, KIMBERLY

General | Select Vaccines | Vaccine Details



- 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

Status: Completed Partially Administered Excluded Refused Not Administered

Not administered reason:

Comment / notes:

- 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**.

Results Orders Immunizations

New Order... Refresh Print Fax... Historical... Exclusions... Web Links

Show Ages Given

Immunization	Status
DTaP	Past Due
Hep A	Past Due
Hep B	
HIB	
HPV	
Influenza	
Meningococcal	
MMR	
Pneumococcal	
Polio	
Rotavirus	
Td	
Tdap	
Varicella	

Vaccine Exclusion Form

Exclusions Series Completion Other Exclusions

Check All

- DTaP
- Hep A
- Hep B
- HIB
- HPV
- Influenza
- Meningococcal
- MMR
- Pneumococcal
- Polio
- Rotavirus
- Td

Hep A

Patient has met recommended schedule for vaccine/vaccination series

Comment

Save & Close Save Cancel

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.

The screenshot displays the 'Create New Immunization Order' application. The top window, titled 'Create New Immunization Order for Mak, Adi', shows a 'Select Vaccines' section with a list of vaccines and their status. The 'Selected Vaccines Details' window is open below, showing a table with columns for Vaccine, Month, Day, Year, Lot#, Source, and Comments. The 'Month' dropdown is open, showing options from 'Unknown' to 'July'. Buttons for 'Save & Send', 'Save All', and 'Cancel' are at the bottom.

Vaccine	Month	Day	Year	Lot#	Source	Comments
Varicella	Unknown					
	January					
	February					
	March					
	April					
	May					
	June					
	July					

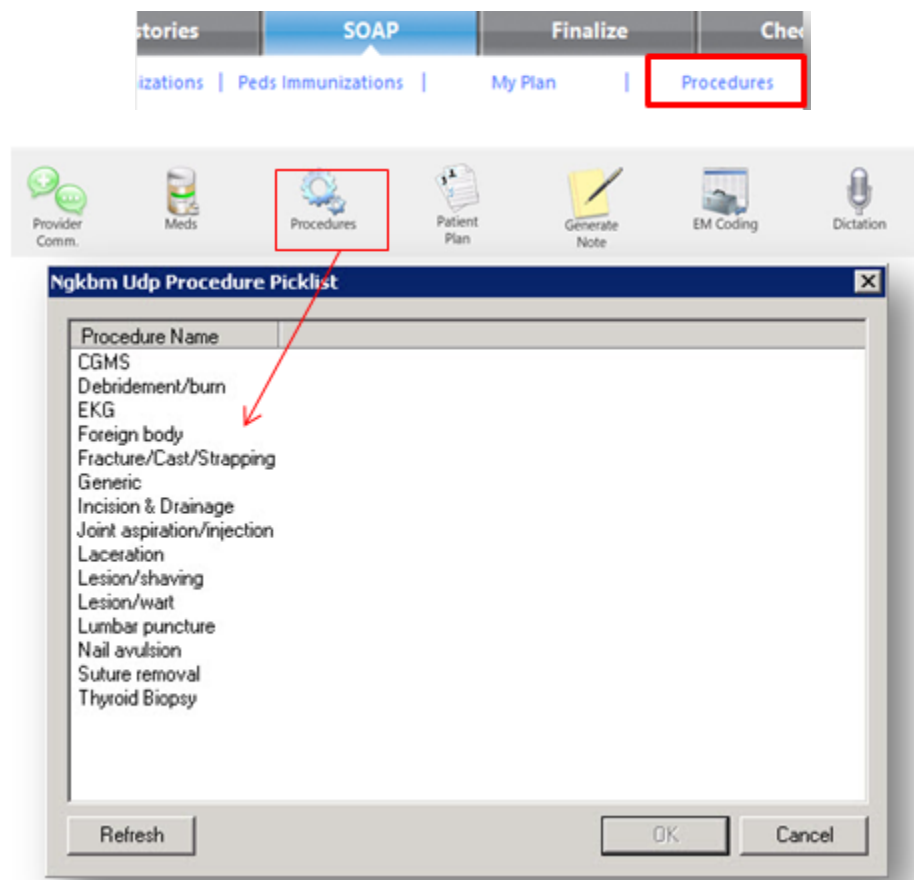
Procedures

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**.

Incision & Drainage - Procedure

Pre-procedure care:

Consent was obtained Procedure/risks were explained Questions were answered [Consent](#)

Procedure:

Abscess prepped and draped using sterile technique [PE Skin](#)

	Diagnosis 1:	Code:	Status:	Diagnosis 2:	Code:	Status:
<input type="checkbox"/> Acne surgery						
<input type="checkbox"/> Incision and drainage of abscess, simple or single						
<input type="checkbox"/> Incision and drainage of abscess, complicated or multiple						
<input type="checkbox"/> Incision and drainage of pilonidal cyst, simple						
<input type="checkbox"/> Incision and drainage of peritonsillar abscess						

Anesthetic:

Lidocaine 1% plain

Lidocaine 1% w/epinephrine

Lidocaine 2% plain

Lidocaine 2% w/epinephrine

Marcaine 0.5%

Lidocaine topical 5%

Ethyl chloride

Packing:

None

Iodoform gauze 1/4 in

Iodoform gauze 1/2 in

Plain gauze 1/4 in

Plain gauze 1/2 in

Anesthetic Amount

< 1 mL

1 - 2 mL

2 - 3 mL

3 - 4 mL

> 4 mL

Dressing, wound care & follow up:

Applied sterile dressing and discussed wound care instructions

Patient tolerated procedure well

Wound check: Return for follow up:

If symptoms persist

PRN

Comments:

[Submit to Superbill](#)

Charges submitted

[Save & Close](#) [Cancel](#)

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**.

Lesion/Wart/Punch/Other - Procedure

Pre-procedure care:

Consent was obtained
 Procedure/risks were explained
 Questions were answered
 Area was prepped and draped using sterile technique

Punch biopsy:

Single lesion RT LT Location: [] Size: [] cm Assessment: []
 Each additional lesion Location: [] Size: [] cm Assessment: []
 Simple
 Extensive

Destruction pre-malignant lesions: 14 or less 15 or more (Select the number of lesions destroyed today)

First Lesion RT LT Location: [] Qty: [] Assessment: [] Method: Electrocautery Salicylic acid 60%
 2nd through 14th lesion Location: [] Qty: [] Assessment: [] Method: Formaldehyde Silver nitrate
 Liquid nitrogen
 15 or more lesions Location: [] Qty: [] Assessment: [] Method: []

Destruction benign lesions: (Other than skin tags)

Lesions 1-14 Location: [trunk, back of hand, leg] Qty: [0] Assessment: [702.0] Method: Liquid nitrogen Other: []
 15 or more lesions Location: [] Qty: [] Assessment: [] Method: Salicylic acid 60%
 Simple
 Extensive

Paring or cutting:

Paring/cutting: benign RT LT Location: [] Assessment: []
 hyperkeratotic lesion, single lesion Location: [] Qty: []
 Paring/cutting: 2 - 4 lesions Location: [] Qty: []

Skin tag:

Removal < 15 lesion Location: [neck] Qty: [2] Assessment: [216.4] Method: Electrocautery Scissors
 Each additional 10 lesions Location: [] Qty: [] Assessment: [] Method: Liquid nitrogen Silver nitrate

Anesthetic:

Lidocaine 2% Lidocaine 2% w/epinephrine: Ethyl chloride
 Lidocaine 1% w/epinephrine Marcaine 0.5%
 Lidocaine 2% Lidocaine topical 5%

Dressing, wound care & follow:

Applied sterile dressing Discussed wound care instructions Wound check: [] Suture removal: []
 Biopsy sent to pathology Silver nitrate for wound cauterization

Comments:

Patient advised that multiple treatments may be necessary to completely eradicate the keratosis.

Charges submitted

Save & Close Cancel



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**.

Pe General Exam

Default: []

◆ Constitutional:
Overall appearance: Normal [] []

◆ Eyes: ◆ Vision Screening:
Conjunctiva: R Normal [] []
 L Normal [] []
Pupil: R Normal [] []
 L Normal [] []
Fundus: R Normal [] []
 L Normal [] []

◆ Vascular: ◆ Extremity ◆ Diabetic Foot Exam
Pedal pulses: Normal [] []
Edema: No Yes
Capillary refill: Less than 2 seconds
 Greater than 2 seconds

◆ Abdomen:
Inspection: Normal [] []
Auscultation: Normal [] []
Neg Pos
 Abdominal tenderness: [] []
 Hepatic enlargement: [] cm below margin Crosses midline
 Spleen enlargement: [] cm below margin Crosses midline

Fill out as appropriate

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

Save Template Defaults

Default Set Category: PE

Specialties Access:

All Specialties

Current Specialty Only: ENT

Templates to Save:

Save All Templates (Saves Templates you have gone to in this Visit, that are Defaults Ready)

Save Current Only: pe_general_exam

Select Templates to Save:

Clear

Default Set Name (For Exam gender specific defaults, use 'male' or 'female' in the default set name and for full exam include Specialty in the default set name.):

Normal Male Exam

Add

PE Quick Saves

Number of Templates	Title
Multiple	physical
Multiple	ENT adult
Multiple	PE_lite
Multiple	PE_lite2
Single	same day exam 2
Single	cold season

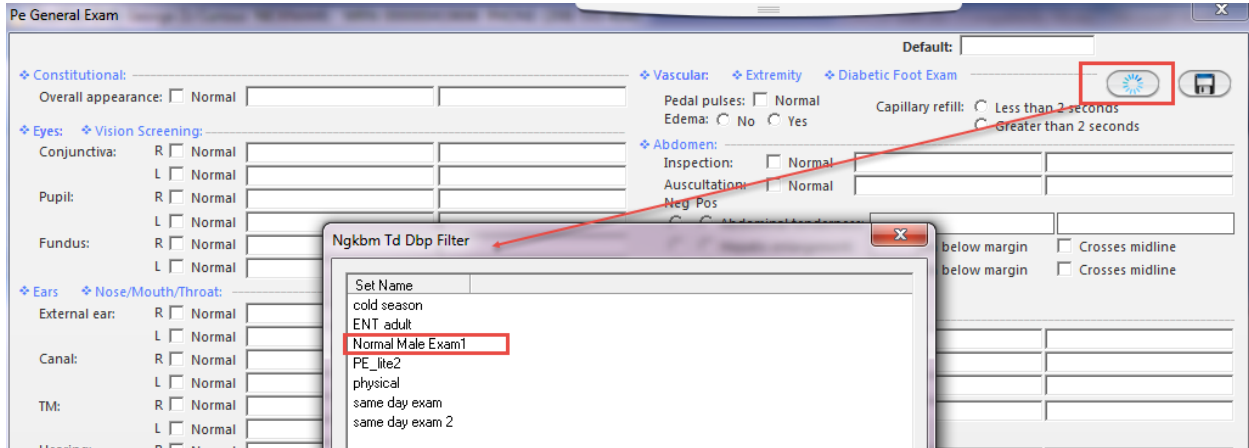
Update Remove

Save & Close Cancel



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.

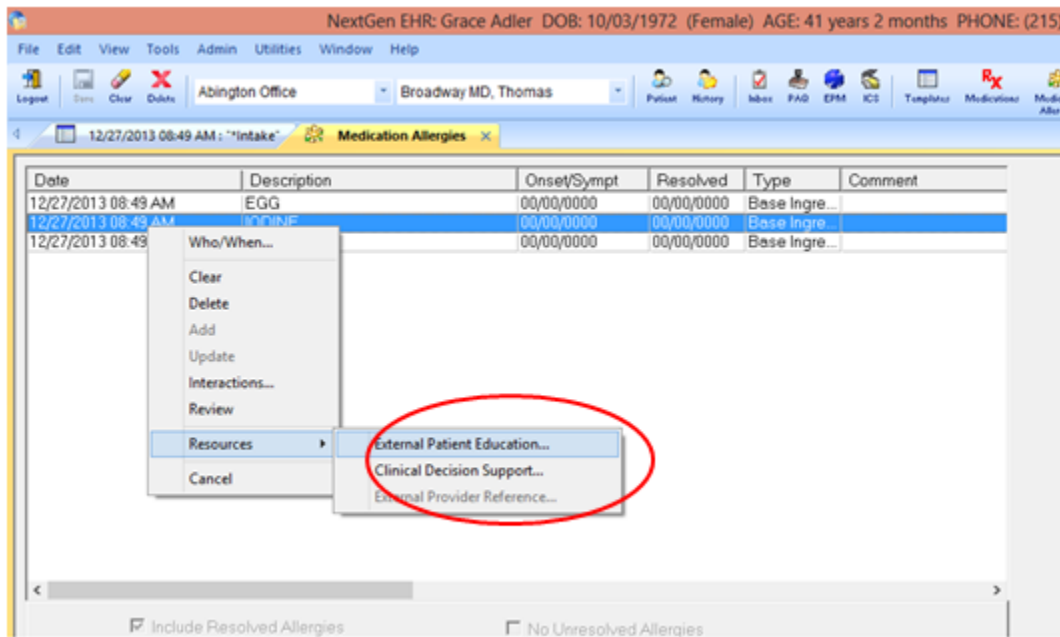


Allergy Module

When the **Allergy Module** is accessed, the resources collect 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 access resources for the **Diagnosis Module**

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

The screenshot displays a web application interface for the Diagnosis Module. At the top, there are navigation options: Refresh, Preferences, Show All Statuses, Show My Tracked Problems Only, and Show Chronic Problems Only. Below this is a table with columns: Description, Fully Specified Name, Chronic, Secondary Condition, and Problem Status. The table is filtered to show 'Active' diagnoses. The first row is highlighted in blue and contains 'Hypertension, Benign' with a fully specified name of 'Benign hypertension'. A context menu is open over this row, with the 'Resources' button highlighted. The menu options are: Internal Patient Education..., External Patient Education..., Clinical Decision Support..., and External Provider Reference... Below the table, there are action buttons: Add Problem, Re-Code, Resolve, Set Chronic, and Delete. Below these are input fields for Concept Id (10725009), Description (Hypertension, Benign), and Fully Specified Name (Benign hypertension). At the bottom, there are date pickers for Onset Date (03/21/2013), Resolved Date (12/15/2014), and Last Addressed, along with a Resolved By field and a Resolved Reason field.



Medication Module

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

To access resources for the **Medication Module**

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

Select **External Patient Education**.

The screenshot displays a medication management interface. At the top, there is a table with columns for 'Status', 'Drug Name', 'Strength', and 'Form'. The table contains two rows for 'ATORVASTATIN CALCIUM' with a strength of '80 mg' and form of 'ORAL TABLET'. Below the table is a toolbar with buttons for 'Prescribe New', 'Print', 'Send', 'Renew', 'Interactions', 'Stop', 'Resources', 'Dose Range', 'Delete', and 'Rx Eligibility'. The 'Resources' button is highlighted with a red box, and a dropdown menu is open, showing options: 'Monograph...', 'External Patient Education...', 'Clinical Decision Support...', 'External Provider Reference...', and 'PDR® BRIEF...'. The 'External Patient Education...' option is selected. Below the toolbar, the medication name 'Aggrenox 200 mg-25 mg 12 hr Cap' is displayed, along with its signature 'Sig: take 1 capsule by oral route 2 times every day in the morning and evening'. There are fields for 'Quantity', 'Units', 'Refills: 0', 'Start: 11/29/2011', 'Stop: 01/31/2013', and 'Duration'. A 'Comments' field contains a note for the pharmacist. The provider is listed as 'Daugharty MD, Barbara A'.

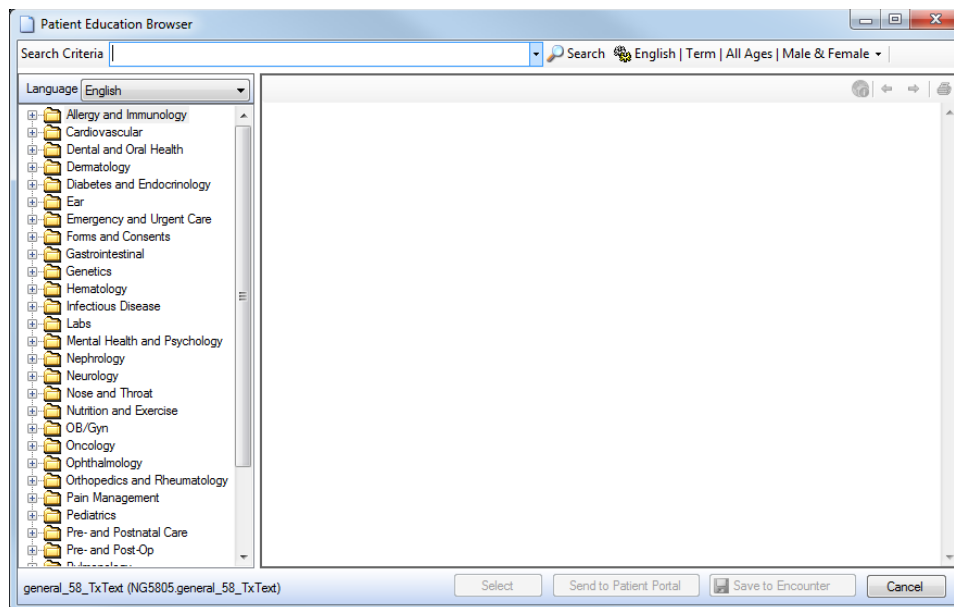
The user can also access the **External Patient Education** in the **Orders and Procedures Module** as well.

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.

The screenshot shows a 'General' panel with the following fields: PCP: Thomas Broadway MD; Care Manager: Susan; Historian: daughter-in-law; Admitted to: Swedish Home Care; Date: 12/17/2013; From: home; Discharged to: Home; Date: 01/03/2014; Reason for referral (to Care Management): SNF/ECF discharge.

- 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 selecting the **Discharge Diagnosis field**.
 - The **Diagnosis Search** window will display.
 - Select a diagnosis and appropriate radio buttons.

The screenshot shows a 'Discharge Diagnosis' panel with the following fields: Discharge diagnosis: Chronic obstructive asthma, unsp 493.20; Atrial fibrillation 427.31; Previous hospital admission in last 30 days? (radio buttons: No, Yes); Complete D/C summary received? (radio buttons: No, Yes).

- 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.

Problem List after Discharge

ADL's
 Equipment/supplies
 Home care services
 Home safety
 Medication management
 Nutrition
 Pain management

ADL: Home safety, Nutrition

Characters left: 970

Show chronic
 Show my tracked problem
 No active problems

Last Addressed	Problem Description	Onset Date	Chronic	Secondary	Clinical Status	Provider	Location	Notes
	Atrial fibrillation	01/06/2014	Y	N	S2FABDC9-48B5	Broadway MD, Thomas	Abington Office	
	Degenerative joint disease of hip	01/06/2014	Y	N	S2FABDC9-48B5	Broadway MD, Thomas	Abington Office	
	Benign essential hypertension	01/06/2014	Y	N	S2FABDC9-48B5	Broadway MD, Thomas	Abington Office	

Comp Assessment

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

General

PCP: Last related office visit with PCP: Care Manager:

Historian: Reason for referral:
(to Care Management)

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

Recent ER Visits (in last 12 months)

Location: Date: Diagnosis: Summary report received: No Yes

Location	Date	Diagnosis	Summary Report Received
Swedish medical Center	12/04/2013	COPD Exacerbation	Y

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

Recent Hospitalizations

Location: Admit date: D/C date: Summary report received: No Yes

D/C diagnosis:

Location	Admit	Discharge	Discharge Diagnosis	Summary Report Received
Swedish Medical Center	12/09/2013	12/17/2013		Y



- 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.

Problem List 3

Show chronic Show my tracked problem No active problems Reviewed

Last Addressed	Problem Description	Onset Date	Chronic	Secondary	Clinical Status	Provider	Location	Notes
	Atrial fibrillation	01/06/2014	Y	N	52FABDC9-48B5	Broadway MD, Thomas	Abington Office	
	Degenerative joint disease of hip	01/06/2014	Y	N	52FABDC9-48B5	Broadway MD, Thomas	Abington Office	
	Benign essential hypertension	01/06/2014	Y	N	52FABDC9-48B5	Broadway MD, Thomas	Abington Office	

- 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.

Active and Managed Problems

Active problems:

A new or existing problem requiring further evaluation to establish a treatment plan, or that may have a plan established but with limited or no evidence of treatment effectiveness.

Managed problems:

A problem that has been fully evaluated and a treatment plan is in place with sufficient evidence of effectiveness, modification to improve an effective treatment plan may be over time.

Q copd Search

Clinical Description and ICD Code	Billing Description
COPD 496	CHR AIRWAY OBSTRUCT NEC
COPD 496	Obstruction, chronic airway NEC
COPD - Chronic obstructive pulmonary disease 496	CHR AIRWAY OBSTRUCT NEC
COPD - Chronic obstructive pulmonary disease 496	Obstruction, chronic airway NEC
Acute exacerbation of COPD 491.21	Bronchitis, obstructive chronic w/e
Acute exacerbation of COPD 491.21	OBS CHR BRONC W(AC) EXAC
Acute exacerbation of COPD 496	CHR AIRWAY OBSTRUCT NEC
Acute exacerbation of COPD 496	Obstruction, chronic airway NEC
Asthma w/ COPD 493.21	Asthma, chronic obstruct w/status i
Asthma w/ COPD 493.21	CH OB ASTHMA W STAT ASTH
Asthma with COPD 493.21	Asthma, chronic obstruct w/status i
Asthma with COPD 493.21	CH OB ASTHMA W STAT ASTH
Asthma with COPD 493.22	Asthma, chrn obst w/acute exacerb

48 rows returned

Select Cancel



- 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**.

Care Plan History Generate Care Plan History

Problem	Goal	Intervention	Role	Status	Start Date	Next Review
Chronic pain; related to Osteoarthritis as evidenced by pain scale 2/10 or greater.	Patient will report pain less than 2/10 on pain scale.	Administer pain medications as prescribed for pain 2/10 or greater on pain scale.		Continued	01/06/2014	01/22/2014
Patient is at risk for falls due to	Patient will not experience any falls.	Assess home environment for safety.		Discontinued	01/06/2014	01/27/2014

Add Edit

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

Care Plan Data Common Phrases | Previous Problems

Problem:

Common Phrases | Previous Goals

Goal:

Common Phrases | Previous Outcomes

Outcome:

Common Phrases

Intervention:

Status: Start date: Next team review date:

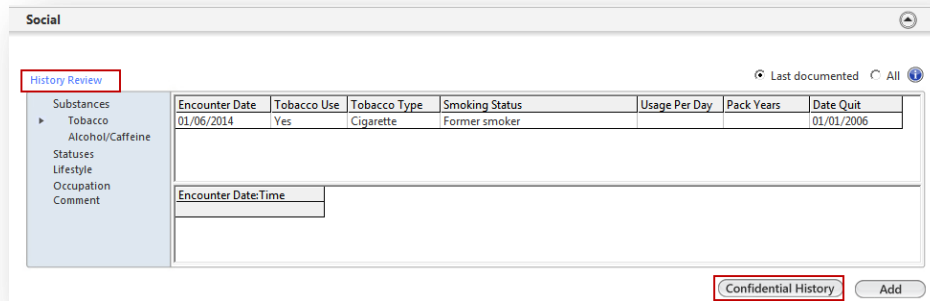
Team member: Role:

Intervention frequency: Next intervention due date: Intervention complete

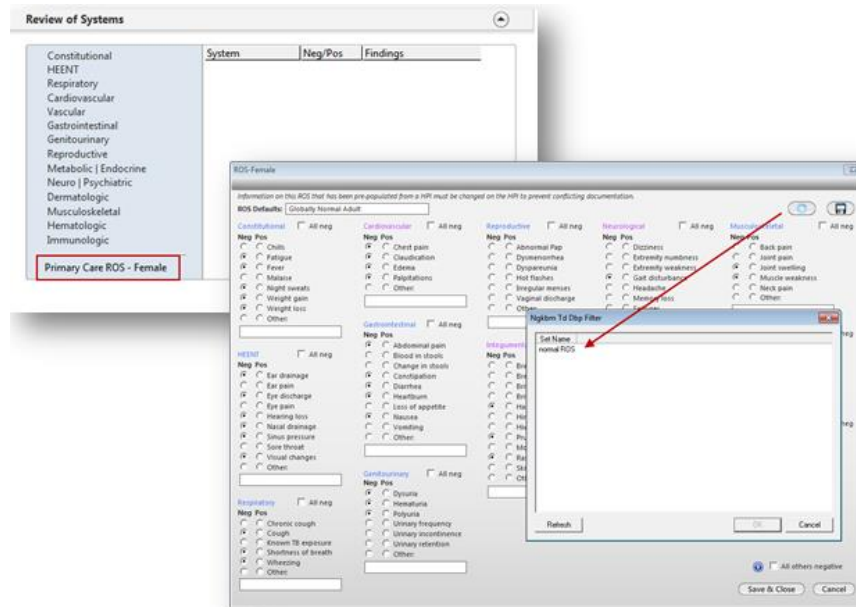
Intervention progress:

Save & Add New Intervention Save & Add New Save & Close Cancel

- 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 information 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.

The screenshot shows a window titled "Care Coordination Team". It contains two main sections: "Agencies" and "Interdisciplinary team".

Agencies:

Agency Type	Agency Name	Agency Phone	Agency Fax
Home health	Hospital Home Health	2062152014	

Buttons: Add, Edit, Remove

Interdisciplinary team:

Role	Name	Location	Phone
Social work	Nancy Jones		2062152015

Buttons: Add, Edit, Remove

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

The screenshot shows a window titled "Care Plan Interventions". It contains a "Problem" field, a "Goal" field, and a table of interventions.

Problem: Chronic pain; related to Osteoarthritis as evidenced by pain scale 2/10 or greater.

Goal: Patient will report pain less than 2/10 on pain scale.

Interdisciplinary Team Member:	Due *	Interventions	Due Date	Role
All	Due	Administer pain medications as prescribed for pain 2/10 or greater on pain scale.		

Buttons: Task, Add, Edit, Remove

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

Care Coordination

Family/caregivers
 Homecare
 SNF/ECF/Assisted living
 Community agencies
 Specialists
 DME services
 Pharmacy
 Other:

Care Coordination comments:

enter comments

Characters left: 986

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

Education/Recommendations

Advance care planning discussed
 Education on disease process/condition/treatment
 Caregiver questions/concerns answered
 Labs/diagnostic tests advised
 Accurate patient teach-back Yes No
 Office visit w/ provider advised
 Referral advised
 Provided pt w/ community resource information
 Follow up w/ Care Manager advised
 Self management discussed
 Patient questions/concerns answered
 patient to set up Care manager to contact patient

Education/Recommendations comments:

Characters left: 1000

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

Action Items

Labs/diagnostic tests ordered
 PCP updated on patient condition
 Referral ordered
 PCP aware and in agreement of plan
 Rx filled/refilled
 Health maintenance updated
 Medication reconciliation completed
 Disease management updated

Follow - up: _____

Office visit w/ provider scheduled
 Follow up w/ Care Manager scheduled
 Date: 01/21/2014
 Time: 10 : 30 A.M. P.M.

Action Items/Follow up comments:

- 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**.

Comprehensive	Face To Face	Phone Call	Group Education
Comprehensive Assessment Completed			

Care and Consent Visits

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

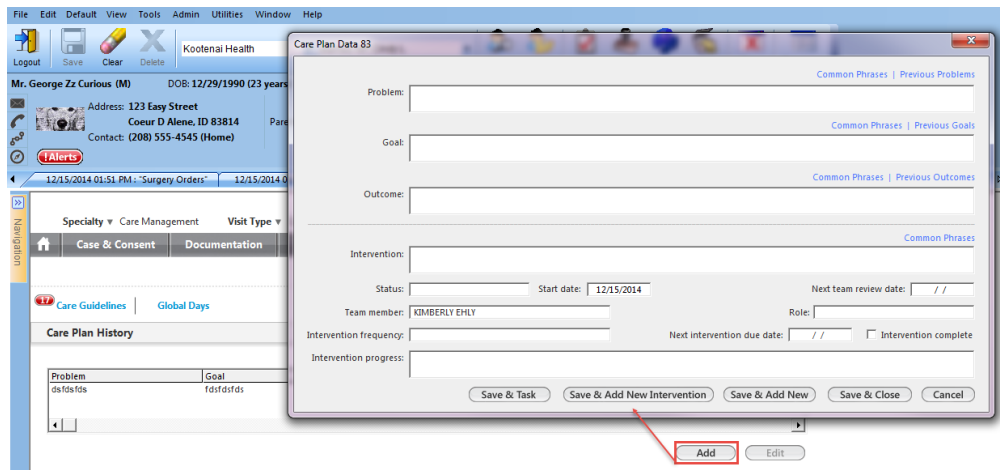
- Select the **Care Plan Home** template.
- Select the **Care Management** specialty and **Case and Consent** for the **Visit Type**.

Case & Consent

Case & Consent Panel is where the user 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 Interactions, face-to-Face Interactions, Care Coordination Interaction Panels all document any necessary comments concerning the patient care.

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



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[Home](#) | [Case & Consent](#) | **[Documentation](#)** | [Tools](#) | [Tracking](#)

[Standing Orders](#) | [Adult Immunizations](#) | [Peds Immunizations](#) | [My Plan](#) | [Procedures](#) | [Order Management](#) | [Screening Tools](#)

[Care Guidelines](#) | [Global Days](#)

Panel Control: Toggle Cycle

Provider Interactions

Date	Time	Actions	Case



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**.

Document

Generate Care Plan Summary | Generate Transition of Care | Generate Comp Assess | Generate Return Visit

Diagnosis:

Type of visit:

Comprehensive Assessment Completed Face to face Phone Call Group Education

Comprehensive Assessment Face to Face (no charge) Face to Face (no charge) Phone Call (no charge) Group Education (no charge)

Comprehensive Assessment Phone (no charge) Minutes Num. of patients

Comprehensive	Face To Face	Phone Call	Group Education

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.

Screening

	Date	Instrument	Score	Severity/Interpretation	Completed by	Comments	Case
<input type="checkbox"/> ADLs <input type="checkbox"/> Asthma Control Test <input type="checkbox"/> Cognitive Assessment <input type="checkbox"/> Depression	12/16/2014	Health Assessment Questionnaire Disability Index (HAQ-DIc)	incomplete		KIMBERLY EHLY		



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.

The screenshot displays the "Action Item List" interface. At the top, there is a header bar with the title "Action Item List" and a filter dropdown set to "all". Below the header is a table with the following data:

Date	Time	Due Date	Priority	Status	Details	Staff
12/16/2014	9:57 AM	12/18/2014	High	in progress	type in details	KIMBERLY EHLY

Below the table is a modal window titled "cm_tasks" - [New Record]. The modal contains the following fields and controls:

- Today's date: 12/16/2014
- Time: 9:57 AM
- Staff: KIMBERLY EHLY
- Due date: //
- Priority: [empty]
- Details: [empty text area]
- Status: [empty]
- Task: [empty]
- Buttons: Add, Edit, Remove
- Footer: Clear For Add, Delete, Save, Close

A red box highlights the "Add" button in the modal, and a red arrow points from this box to the "Add" button in the table's action bar.

Care Coordination

This template is used by providers or other care team members to document patient care information such as Care Coordination Team, Referrals, and Barriers to care. This template is used in coordination 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.

Care Coordination Team

Agencies:

Agency Type	Agency Name	Agency Phone	Agency Fax
-------------	-------------	--------------	------------

Interdisciplinary Team:

Role	Name	Location	Phone
Provider	Dr Green	123 Green St	2087778888

Care Coordination Team (Modal Dialog)

Agency Information:

Agency type: Agency name: Agency phone: - Agency fax: -

Interdisciplinary Team Information:

Name: Interdisciplinary team role:

Address: Phone: -

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.

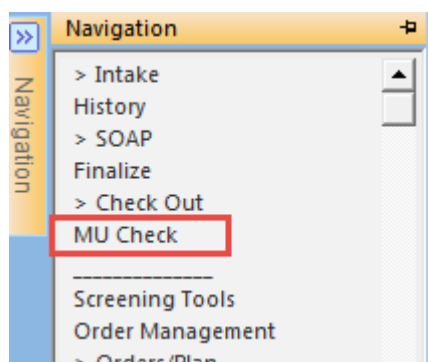
Communication Panel is a panel to review all communications concerning this patient. The user can add from this panel by selecting the **Add** button.




 Care Guidelines Global Days	Panel Control:  Toggle   Cycle 
Care Coordination Team	
Referral History	
Barriers to Care	
Care Plan History	
Communication 	

Meaningful Use

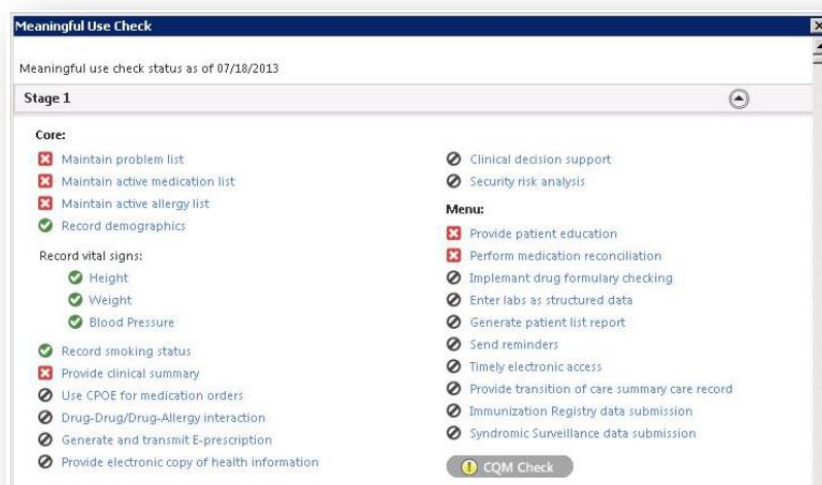
This pop up allow clinical staff and providers to verify that selected Stage 1 and Stage 2 Meaningful Use (MU) measures were completed for the current patient. To access the MU:

- 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 met 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 explaining 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.

Specialty ▾ Family Practice
Visit Type ▾ Consult

[Intake](#)

[Histories](#)

[SOAP](#)

[Finalize](#)

[Checkout](#)

[[Demographics](#) | [Order Management](#) | [Document Library](#) | [Tobacco Cessation](#)]

24 [Care Guidelines](#) | [Global Days](#)

 Panel Control: ⌵ [Toggle](#) ⌵ ↺ ↻ [Cycle](#) ⌵

Today's Orders
⌵

↔ [Lab/Radiology](#) [Order Processing](#) | [Task](#) | [Immunizations](#)

	Status	Order	Side	Site	Location	Timeframe
<div style="border: 1px solid #ccc; padding: 2px;"> Labs ▶ Diagnostics (1) Referrals Office Services (1) Procedures (1) Follow up (1) Medications (1) Patient Education Physical Therapy </div>	ordered	Allergen immunotherapy, one injection				

Given to Patient/Verified
⌵

<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th>Yes</th> <th>Refused</th> <th>Comments:</th> </tr> </thead> <tbody> <tr> <td>Lab orders:</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input style="width: 100%;" type="text"/></td> </tr> <tr> <td>Diagnostic tests: (1)</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input style="width: 100%;" type="text"/></td> </tr> <tr> <td>Referrals:</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input style="width: 100%;" type="text"/></td> </tr> <tr> <td>Office services ordered: (1)</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input style="width: 100%;" type="text"/></td> </tr> <tr> <td>Procedures: (1)</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input style="width: 100%;" type="text"/></td> </tr> </tbody> </table>		Yes	Refused	Comments:	Lab orders:	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 100%;" type="text"/>	Diagnostic tests: (1)	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 100%;" type="text"/>	Referrals:	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 100%;" type="text"/>	Office services ordered: (1)	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 100%;" type="text"/>	Procedures: (1)	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 100%;" type="text"/>	<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th>Yes</th> <th>Refused</th> <th>Comments:</th> </tr> </thead> <tbody> <tr> <td>Follow up(s) scheduled: (1)</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input style="width: 100%;" type="text"/></td> </tr> <tr> <td>Medication(s): (1)</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input style="width: 100%;" type="text"/></td> </tr> <tr> <td>Educational materials:</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input style="width: 100%;" type="text"/></td> </tr> <tr> <td>Patient plan:</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input style="width: 100%;" type="text"/></td> </tr> <tr> <td>Transportation arranged:</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input style="width: 100%;" type="text"/></td> </tr> </tbody> </table>		Yes	Refused	Comments:	Follow up(s) scheduled: (1)	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 100%;" type="text"/>	Medication(s): (1)	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 100%;" type="text"/>	Educational materials:	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 100%;" type="text"/>	Patient plan:	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 100%;" type="text"/>	Transportation arranged:	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 100%;" type="text"/>
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Transportation arranged:	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 100%;" type="text"/>																																														

Checked out by: EM Code Submitted:

[Patient Portal Upload](#)
[Checkout](#)
[Patient Plan](#)



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.

Given to Patient/Verified:

Lab orders: (1)	Yes	Refused	Comments:	Follow up(s) scheduled: (1)	Yes	Refused	Comments:
Diagnostic tests: (2)	<input type="checkbox"/>	<input type="checkbox"/>		Medication(s):	<input type="checkbox"/>	<input type="checkbox"/>	
Referrals:	<input type="checkbox"/>	<input type="checkbox"/>		Educational materials:	<input type="checkbox"/>	<input type="checkbox"/>	
Office services ordered:	<input type="checkbox"/>	<input type="checkbox"/>		Patient plan:	<input type="checkbox"/>	<input type="checkbox"/>	
Procedures:	<input type="checkbox"/>	<input type="checkbox"/>		Transportation arranged:	<input type="checkbox"/>	<input type="checkbox"/>	

Checked out by: EM Code Submitted:

Grace Adler (F) DOB: 10/03/1972 (41 years) Weight: 150.00 lb (68.04 Kg) Allergies: (3) Problems: (0) Diagnoses: (0)

Address: 795 Horsham Rd MRN: 00000000032
 Horsham, PA 19044 Insurance: BCBS Of California
 Contact: (215) 657-7010 (Home) Nickname:

Alerts OBGYN Details Sticky Note Referring Provider HPAA Advance D

12/27/2013 Today's Patient Tracking

Appointment date: 12/26/2013 Today's date: 12/27/2013

Appointment information:

Room: Exam 1 Status: (Entries uploaded on "Save and Close")

Patient Tracking: The inbox will update today's calendar and not the appointment date shown.

Appt Time	Room	Status	Time	Documented By

Task EHR Appointments Save & Close Cancel

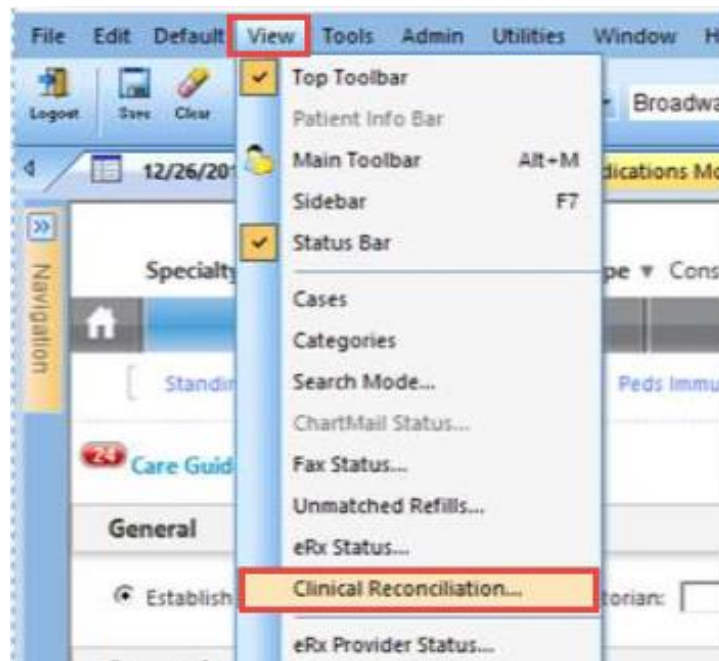


Clinical Reconciliation

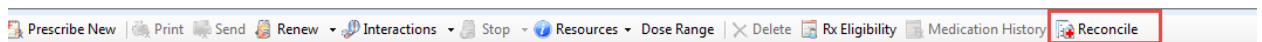
Accessing the Reconciliation Module

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

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

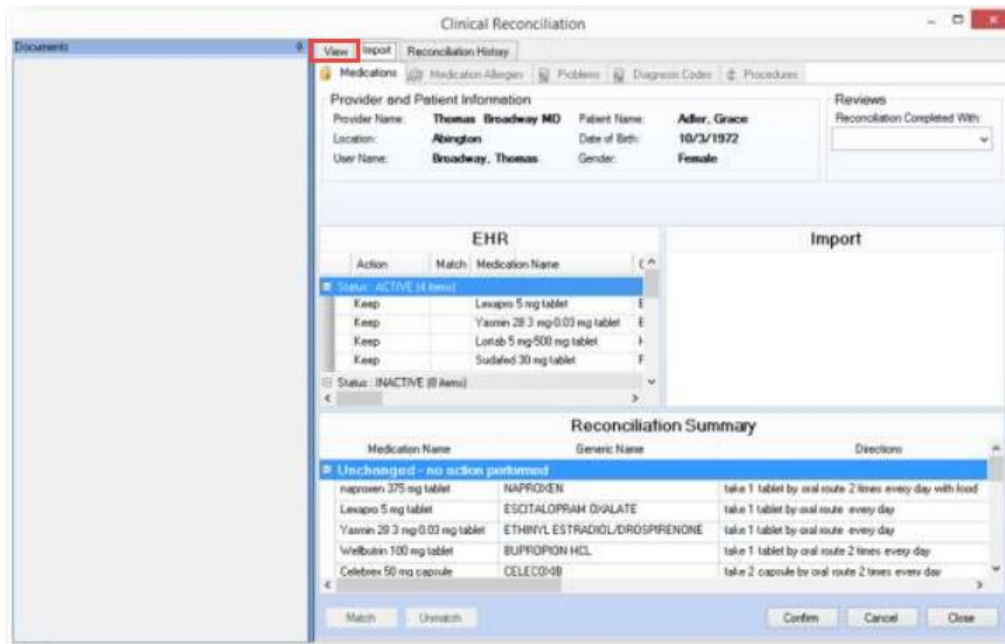


The user can also access by selecting the **Reconcile** button on the **Medication Module** toolbar.



The **Clinical Reconciliation Module** will display.

- Select documents to view, by selecting 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 from 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 **Procedures** tabs display just the **Import** section.

The screenshot displays the 'Medications' tab interface. At the top, there are navigation tabs: 'View', 'Import', and 'Reconciliation History'. Below these are sub-tabs: 'Medications', 'Medication Allergies', 'Problems', 'Diagnosis Codes', and 'Procedures'. The 'Medications' sub-tab is active. The interface is divided into three main sections:

- Provider and Patient Information:** Displays details for Thomas Broadway MD (Provider) and Grace Adler (Patient), including location (Abington), date of birth (10/3/1972), and gender (Female).
- Reviews:** A dropdown menu labeled 'Reconciliation Completed With:'.
- EHR Section:** A table with columns 'Action', 'Match', and 'Medication Name'. It shows a list of active medications (4 items) with actions like 'Keep' and 'Lexapro 5 mg tablet'.
- Import Section:** A large empty area for imported medication data.
- Reconciliation Summary:** A table with columns 'Medication Name', 'Generic Name', and 'Directions'. It shows a list of unchanged medications (8 items) with no action performed, such as 'naproxen 375 mg tablet' and 'Lexapro 5 mg tablet'.

- 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 corresponds 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

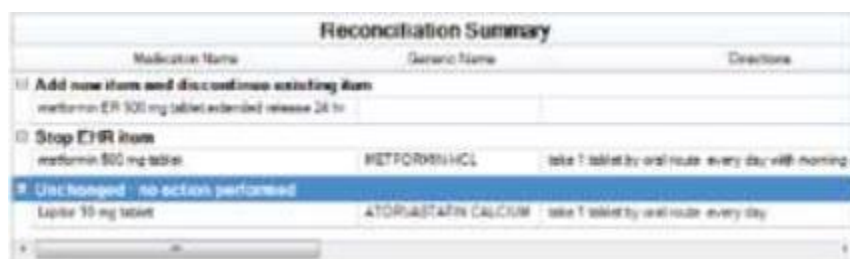
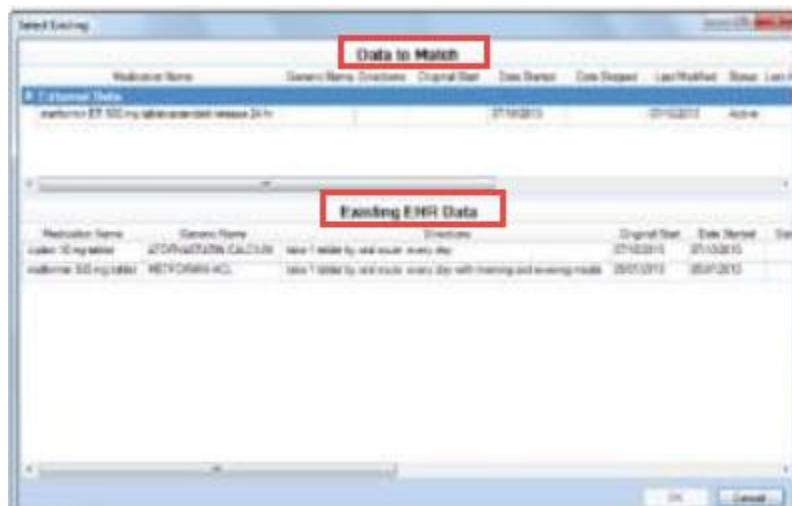
To process the items in the **Import** section

- 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**.

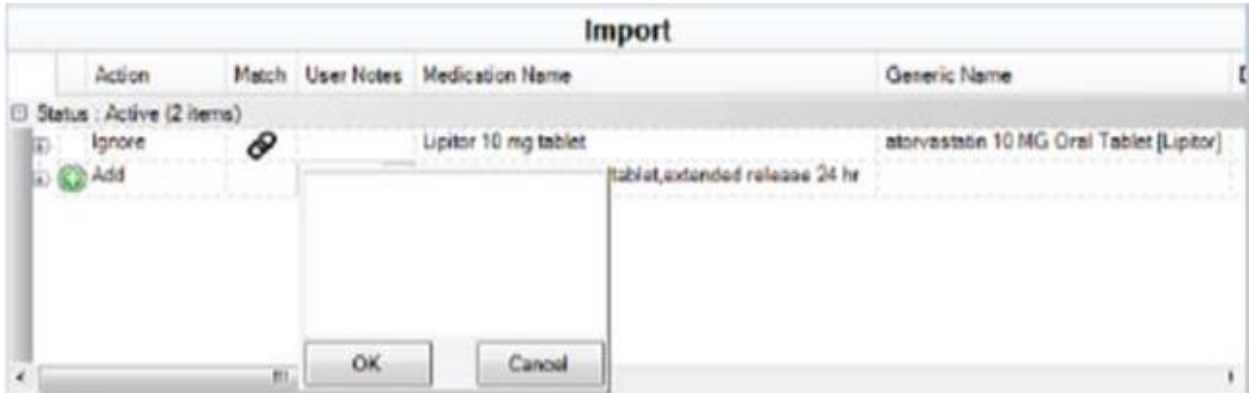
The change will display in the **Reconciliation Summary** section.



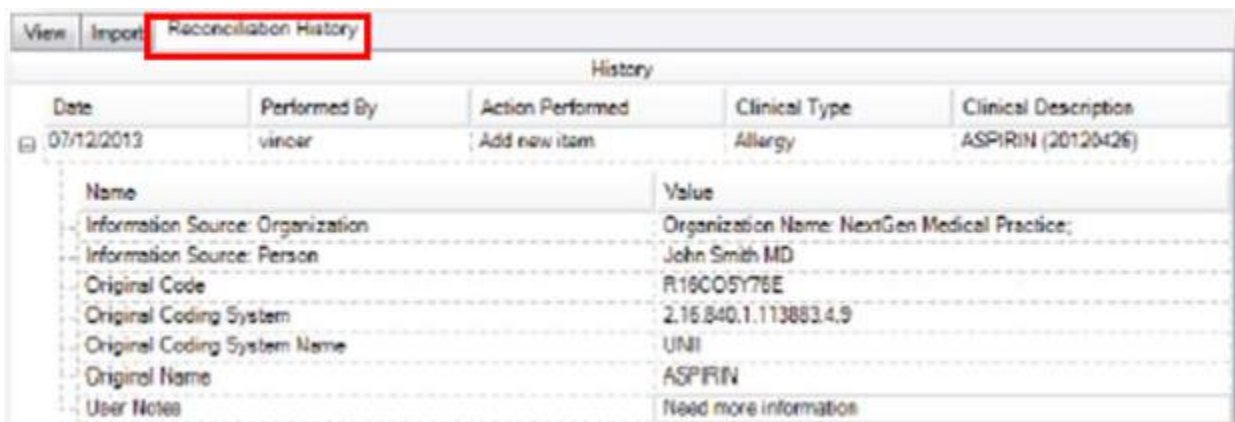
A user can add comments to the **Import** section by

- 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** column: **Keep**, **Stop**, **Resolve** or **Delete**
- Match/Unmatch clinical items as needed by right clicking in the **Import** section

Clinical Reconciliation

View Import Reconciliation History

Medications* Medication Allergies Problems Diagnosis Codes Procedures

Provider and Patient Information

Provider Name: **Thomas Broadway MD** Patient Name: **Adler, Grace**
 Location: **Abington** Date of Birth: **10/3/1972**
 User Name: **Broadway, Thomas** Gender: **Female**

EHR

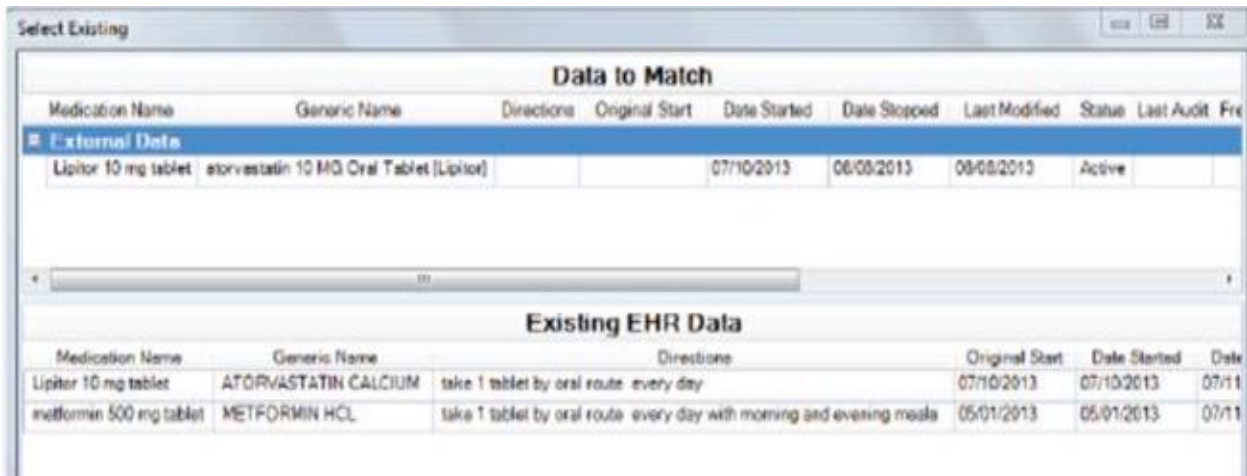
Action	Match	Medication Name	Generic Name
Status: ACTIVE (4 items)			
Keep		Lexapro 5 mg tablet	ESCITALOPRAM OXALATE
Keep		Yasmin 28 3 mg-0.03 mg tablet	ETHINYL ESTRADIOL/DROSPIRENE
Keep		Lortab 5 mg-500 mg tablet	HYDROCODONE BIT/ACETAMINO
Keep		Sudafed 30 mg tablet	PSEUDOEPHEDRINE HCL
Status: INACTIVE (8 items)			

EHR					Import			
Action	Match	Medication Name	Generic Name	Directions	Action	Match	User Notes	Medication Name
Status: ACTIVE (2 items)					Status: Active (2 items)			
Keep		Lupitor 10 mg tablet	ATORVASTATIN CALCIUM	take 1 tab	Import			10 mg tablet
Keep		metformin 500 mg tablet	METFORMIN HCL	take 1 tab	Add			500 mg tablet, extended release 24 h



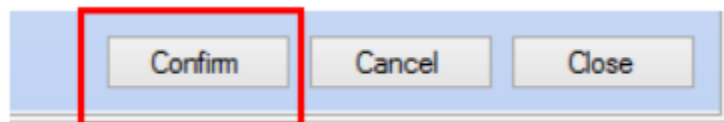
When choosing to match an item, the **Select Existing** pop up opens and displays two sections

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

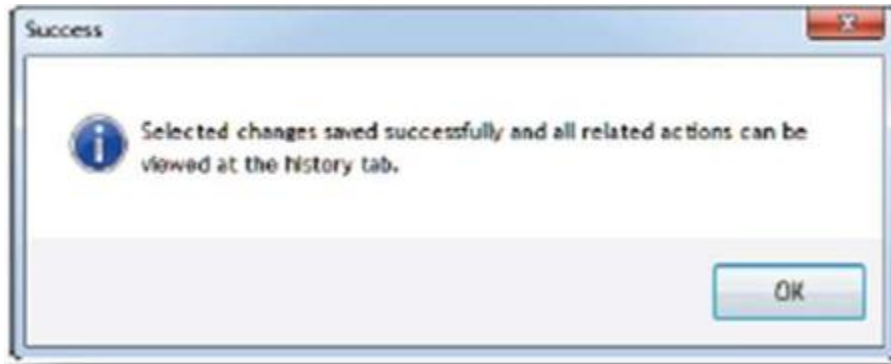


Once items have been processed in the **Import** section, **EHR** section, and clinical items have **Matched/Unmatched** as needed

- Select **Confirm** to complete processing

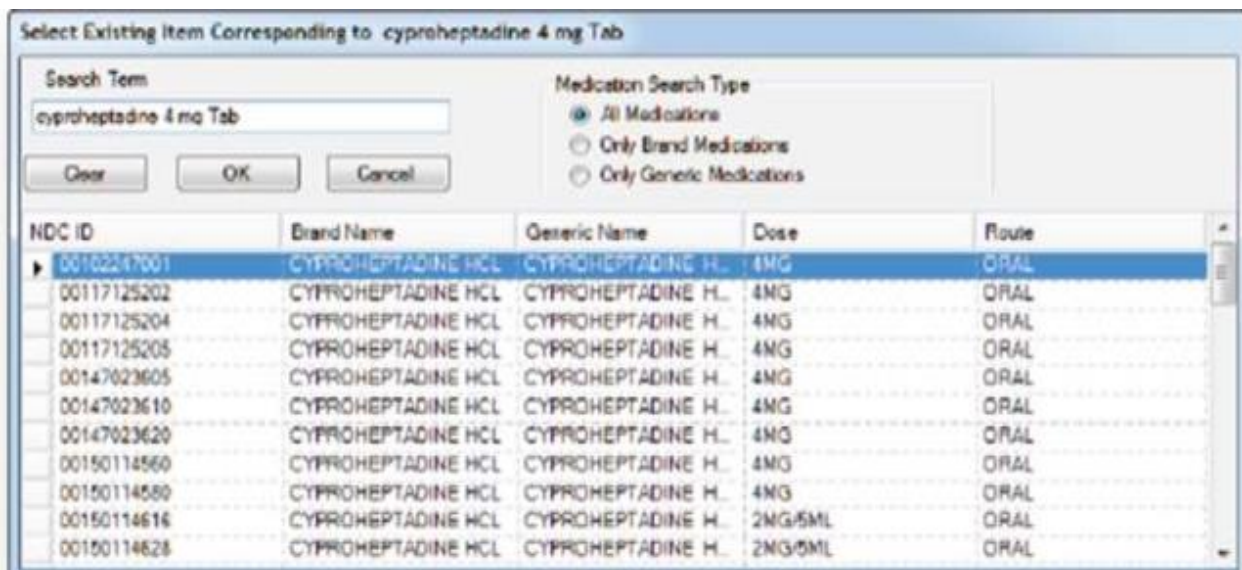


A message will display that the changes were saved successfully.



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

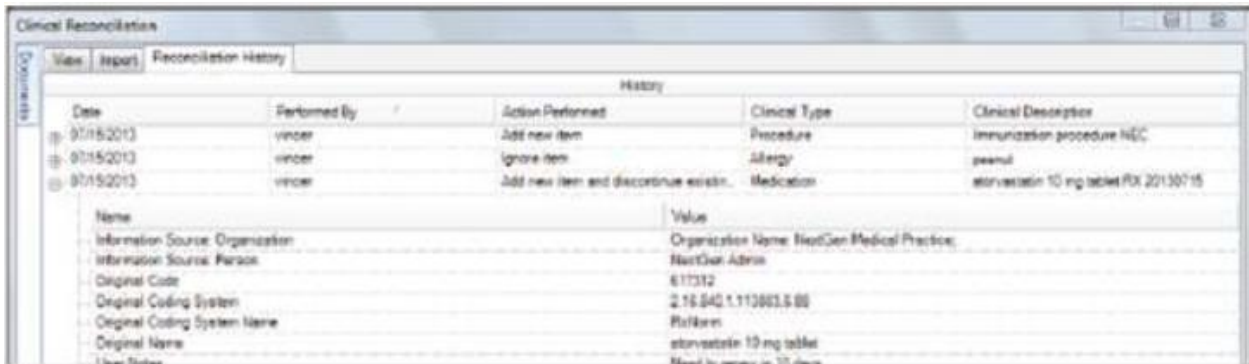
To view the **Reconciliation History**

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



Clinical Reconciliation window showing the Reconciliation History tab selected. The table displays reconciliation actions performed on 07/15/2013.

Date	Performed By	Action Performed	Clinical Type	Clinical Description
07/15/2013	vincer	Add new item	Procedure	Immunization procedure NEC
07/15/2013	vincer	Ignore item	Allergy	peanut
07/15/2013	vincer	Add new item and discontinue existing item	Medication	atorvastatin 10 mg tablet RX 20130715



Clinical Reconciliation window showing the Reconciliation History tab selected. The table displays reconciliation actions performed on 07/15/2013. Below the table, details for the selected item are shown.

Date	Performed By	Action Performed	Clinical Type	Clinical Description
07/15/2013	vincer	Add new item	Procedure	Immunization procedure NEC
07/15/2013	vincer	Ignore item	Allergy	peanut
07/15/2013	vincer	Add new item and discontinue existing item	Medication	atorvastatin 10 mg tablet RX 20130715

Name	Value
Information Source: Organization	Organization Name: NextGen Medical Practice
Information Source: Person	Name: Vincer, Adam
Original Code	617312
Original Coding System	2.16.840.1.113883.5.88
Original Coding System Name	RxNorm
Original Name	atorvastatin 10 mg tablet
Unit Name	Based on quantity in 30 days

NextGen Share Portal

Introduction

Share is a communication 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.

The screenshot shows the 'Referrals Order' form in the NextGen Share Portal. The 'Referrals' tab is highlighted in red. The form includes the following sections:

- Insurance:** Regence Blue Shield Of Id, Policy #: []
- To:** Specialty/specialist name/site: [] (with a red 'M' icon), Provider name: [Address Detail], Location: []
- Diagnosis:** A table with 4 rows and 2 columns (Description, Code).

Description:	Code:	Description:	Code:
1. []	[]	3. []	[]
2. []	[]	4. []	[]
- Services requested:** Radio buttons for Consult, Evaluate and treat, Follow-up and treat, Assume care, Surgery, Diagnostic testing.
- Clinical indications:** Reason for referral: [], Time limit: [], Timeframe: []
- Clinical information/Comments:** []



Sending a Referral

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

The screenshot shows the 'Referrals Order' form with the following fields and options:

- Insurance name: Regence Blue Shield Of Id
- Policy #: []
- Specialty: [] (highlighted with a red box)
- Provider name: []
- Location: []
- Internal referral:
- Authorization required: No Yes

The screenshot shows the 'NextGen Share Search' interface with the following search results:

Name	Specialty	Organization	DIRECT Address	Phone	Fax
Crosta, Quinn		Neighborcare Hea...	quinn.crosta.p5@direct.ptso.stag...		
Quinn MD, Connor	Orthopaedic Surgery	Action Orthopedi...	connor.quinn.p88@direct.kootenal...	+1 208 215-2055	+1 208 665-0922
Quinn MD, Timothy	Surgery	Kootenai Health	timothy.quinn.p79@direct.kootena...	+1 208 667-1588 3291	+1 208 667-3788
Quinn, Jeremy	Nurse Practitioner	HealthPoint NGTe...	jeremy.quinn.p3@direct.ptso.stag...	+1 206 439-3289	+1 206 439-3273



Referrals Order

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

Insurance name: Blue Cross Of Idaho Policy #: Rmp54564654

To: Specialty/specialist name/site: Orthopedic Surgery Provider name: Quinn MD, Connor Location: Internal referral

Diagnosis:

Description	Code	Description	Code
1. Backache	724.5	3.	
2.		4.	

Services requested: Consult Evaluate and treat Follow-up and treat Assume care Surgery Diagnostic testing

Clinical indications: Reason for referral: Time limit: Timeframe:

Clinical information/Comments: Details

Instructions: Patient referral/instructions given [Instructions Detail](#)

Attachments: [Details](#)

Continuity of Care Document/Record sent

Referrals ordered this encounter: [Add](#) [Send Task](#)

Code	Diagnosis	Order	Order Comments	Comments
724.5	Backache	Referrals: Orthopedic Surgery, Quinn MD, Connor, Consult		Palpitations during exam ** 07/30/2014 07:27 AM PDT: CCD sent. ** 07/30/2014 07:27 AM PDT: Message delivered to the recipient.

[Quick Task](#) [Edit](#) [Share](#) [Close](#)

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

Services requested: Consult Evaluate and treat Follow-up and treat Assume care Surgery Diagnostic testing

Clinical indications: Reason for referral: Time limit: Timeframe:

Clinical information/Comments: Details

Instructions: Patient referral/instructions given [Instructions Detail](#)

Attachments: [Details](#)

Continuity of Care Document/Record sent

Referrals ordered this encounter: [Add](#) [Send Task](#)

Referral Attachments

Attachment 1:

Attachment 2:

Attachment 3:

Attachment 4:

Attachment 5:

Attachment 6:

Attachment 7:

Attachment 8:

Save & Close Cancel

Ngkbn Dbp Pat Documents

Document	Dated
Neoplasm (image)	07/30/2014
Master_Im	07/30/2014
ABN	07/29/2014
Master_Im	07/28/2014
DM Foot Exam (image)	07/28/2014
Feet DM (image)	07/28/2014
Master_Im	07/23/2014
Procedures	06/12/2014
Referral: Burn Treatment Center	06/10/2014
Master_Im	06/06/2014
sym_Patient_Demog	05/15/2014
KH_MedicareLet_KBM81	03/27/2014
Chest lump (image)	03/24/2014
intake_note	03/11/2014
Referral: Dennis Cooke MD. Evaluate and	03/10/2014
Master_Im	03/09/2014
Patient Demog	02/09/2014

Refresh OK Cancel

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

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

Master_Im (07/30/2014)

Continuity of Care Document/Record sent

Referrals ordered this encounter:

Code	Diagnosis	Order	Order Comments	Comments
724.5	Backache	Referrals: Orthopedic Surgery, Quinn MD, Connor, Consult		Palpitations during exam ** 07/30/2014 07:27 AM PDT: CCD sent. ** 07/30/2014 07:27 AM PDT: Message delivered to the recipient.

Quick Task Edit

Share Close



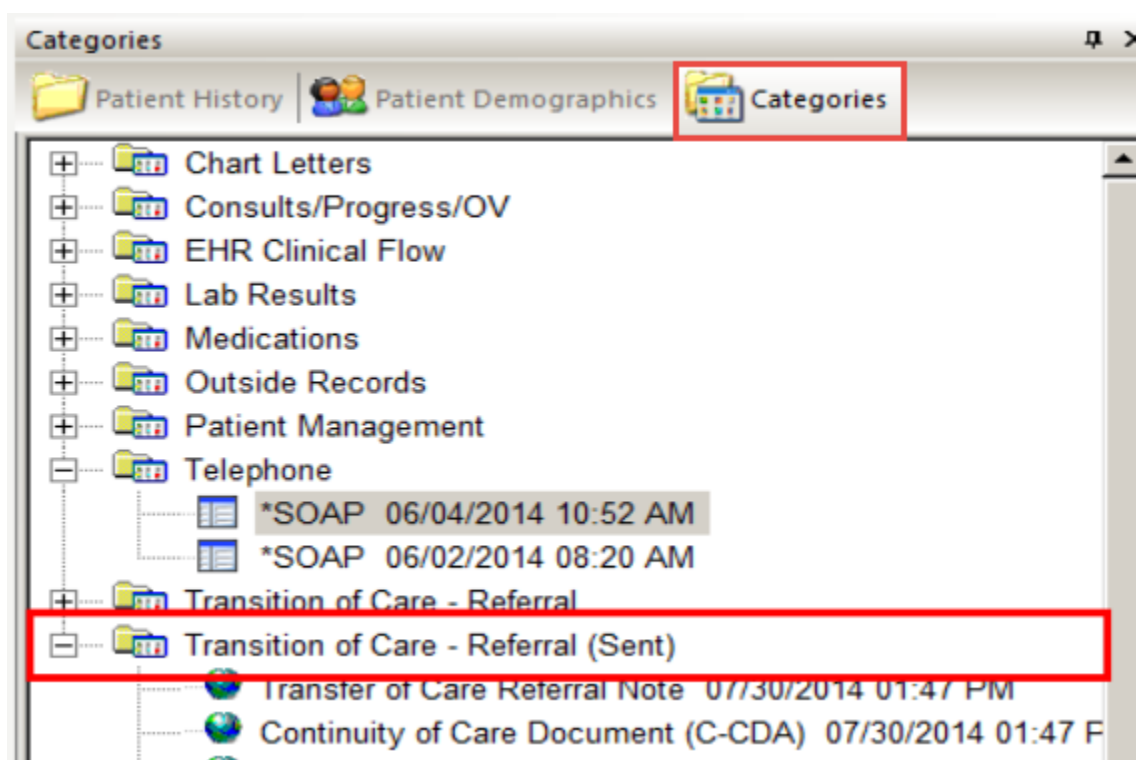
Once you send the referral, the order and its attachment(s) are sent to an interface for processing. It may take a few moments for the order to show in the patient's chart.

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

"All Order Management" - [33 of 53]

Order: Referrals: Orthopedic Surgery, Quinn MD, Connor. Evaluate and treat. Code: []

Diagnosis: Backache Code: 724.5

Reason (for referral): []

Clinical information/ comments: details here...
 ** 07/30/2014 01:46 PM PDT: CCD sent.
 ** 07/30/2014 01:46 PM PDT: Message delivered to the recipient.

Attachments/ description: Master_In 07/30/2014.

Authorization
 Authorization req id: No Yes
 Authorization #: [] Effective: [] Expiration: [] Visits: []

Performed: [] [] [] []
 Consent
 Performed: [] [] [] []
 Scheduling

Result/report
 Received: On: [] Reason/comment: []
 Completed: On: [] Reason/comment: []

Interpretation: []

Report details: []

Billing codes

Referrals Order

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

Insurance name: Blue Cross Of Idaho Policy #: Xmp545464654

To: Specialty/physician name/site
 Obstetrics
 Therapies/Rehabilitation Examinations
 DME

Specialty: Orthopedic Surgery Provider name: Quinn MD, Connor Location: [] Internal referral

Authorization required: No Yes

Diagnosis:

Description	Code	Description	Code
1. Backache	724.5	3. []	[]
2. []	[]	4. []	[]

Services requested:
 Consult Evaluate and treat Follow-up and treat Assume care Surgery Diagnostic testing

Clinical indications:
 Reason for referral: [] Time limit: [] Timeframe: []

Clinical information/Comments:
 Details: []

Instructions:
 Patient referral/instructions given Instructions Detail

Attachments: [] Details

Continuity of Care Document/Record sent

Referrals ordered this encounter: [Add] [Send Task]

Code	Diagnosis	Order	Order Comments	Comments
724.5	Backache	Referrals: Orthopedic Surgery, Quinn MD, Connor. Consult		Palpitations during exam ** 07/30/2014 07:27 AM PDT: CCD sent. ** 07/30/2014 07:27 AM PDT: Message delivered to the recipient.

[4] []

[Quick Task] [edit]
 [< Share] [Close]

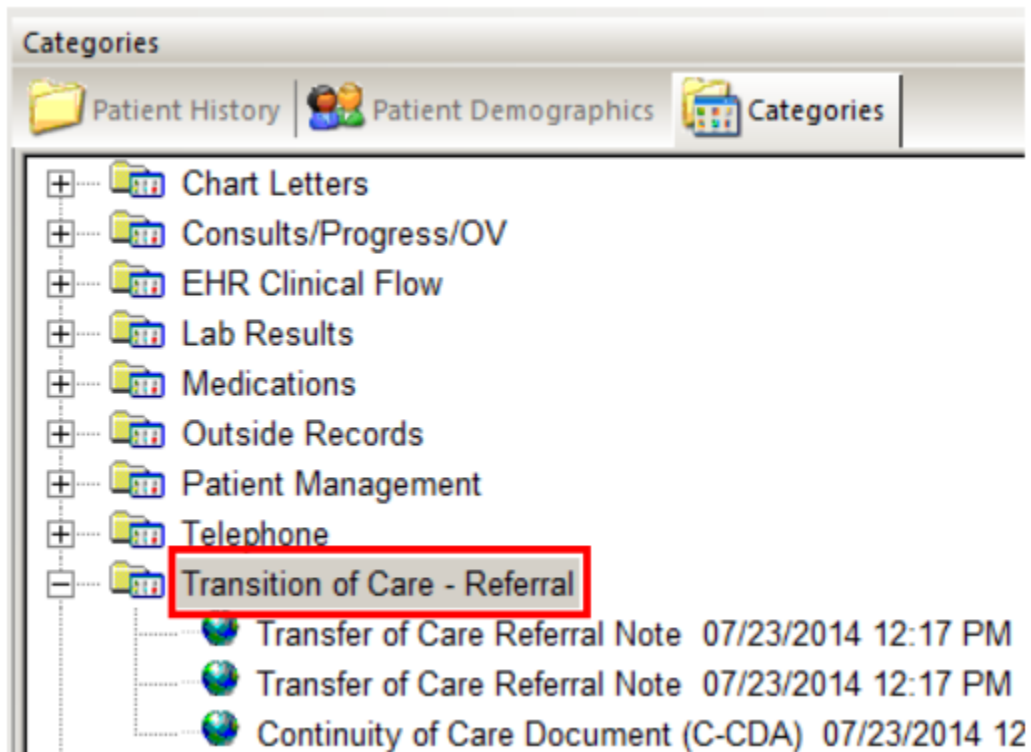


Incoming Referrals

Providers receiving 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.