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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.

![Title Bar Example](image)

**Main Menu Bar**

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

![Main Menu Bar Example](image)

To collapse this window, click this arrow.
Top Toolbar

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

<table>
<thead>
<tr>
<th>Icon</th>
<th>Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image" alt="Logout" /></td>
<td>Logout</td>
<td>Logs out from, but does not close, the application.</td>
</tr>
<tr>
<td><img src="image" alt="Save" /></td>
<td>Save</td>
<td>Saves the work in the active window.</td>
</tr>
<tr>
<td><img src="image" alt="Clear" /></td>
<td>Clear</td>
<td>Clear the data you have entered in the active window.</td>
</tr>
<tr>
<td><img src="image" alt="Delete" /></td>
<td>Delete</td>
<td>Deletes the data you have entered in the active window.</td>
</tr>
<tr>
<td><img src="image" alt="Patient" /></td>
<td>Patient</td>
<td>Prompts the Patient Lookup dialog box.</td>
</tr>
<tr>
<td><img src="image" alt="History" /></td>
<td>History</td>
<td>Toggles the History Toolbar on/off.</td>
</tr>
<tr>
<td><img src="image" alt="Inbox" /></td>
<td>Inbox</td>
<td>Toggles Workflow Module on/off.</td>
</tr>
<tr>
<td><img src="image" alt="PAQ" /></td>
<td>PAQ</td>
<td>Prompts the Provider Approval Queue (PAQ).</td>
</tr>
<tr>
<td><img src="image" alt="EPM" /></td>
<td>EPM</td>
<td>Opens NextGen EPM directly from the NextGen EHR bypassing the Logon window, automatically selected the current patient.</td>
</tr>
<tr>
<td><img src="image" alt="ICS" /></td>
<td>ICS</td>
<td>Opens NextGen ICS directly from the NextGen EHR bypassing the Logon window, automatically selected the current patient.</td>
</tr>
</tbody>
</table>

![NextGen](image)
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:**

![Preferences window with selected options]

- **Check to receive Out of Office Notifications**
- **Choose the module you want to pop up as soon as you open EHR**
Main Toolbar:

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

Customize Encounter Display:
Medical Records:

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

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

Documents
Patient Information Bar

Overall View

The Patient Information Bar is:

- A toolbar enabled by your practice
- Customized to present the most valuable information for your workflow
- Always present above the current template or module
- Minimized or maximized with one select (note the small arrow beside Medications)
- The Patient Information Bar displays when a patient’s chart is open regardless of whether a template or module is open.
- Consists of static and configurable components.
- Patient Summary Medical Information section includes a list of the patient’s allergies, problems, diagnoses and 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.
Patient Summary Medical Information displays a summary of the patient’s data, even while minimized:

- Allergies
- Problems
- Diagnoses
- Medications
- Alerts

It provides easy access to view and change information.

General Information

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

- 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

![Image of demographic information]

Encounter Based Information

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

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

![Image of encounter based information]

Template Shortcuts

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

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

To open the History Toolbar – select the icon History icon from the Top Toolbar.
Panels

Documentation in EHR is broken into panels. The panels are present on each tab 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
<table>
<thead>
<tr>
<th>Status</th>
<th>Order</th>
<th>Ordered</th>
<th>Interpretation</th>
<th>Result/Report</th>
<th>Recorded</th>
<th>Completed</th>
<th>Ordering Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>completed</td>
<td>0</td>
<td>/</td>
<td>See scanned report.</td>
<td>08/12/2013</td>
<td>08/12/2011</td>
<td></td>
<td></td>
</tr>
<tr>
<td>completed</td>
<td>1</td>
<td>DIGITAL SCREENING</td>
<td>PAP</td>
<td>See scanned report.</td>
<td>12/04/2012</td>
<td>12/04/2012</td>
<td></td>
</tr>
</tbody>
</table>

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.

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

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

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

The *Status* is now updated in the *Patient Tracking* pop up as well as in the *Inbox*.
When clinical staff is finished with the patient, update the status to “waiting for provider.” Providers update the status to “with provider.” Repeat the process until the visit is complete and the patient is discharged.

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

Accessing the Chart

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

**Note:** When a patient is checked in, the status will change to **KEPT**. You may also right-select on the patient name and select **Go to Patient's Chart**.
**Patient Check In – 4 Point Check**

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

- Verify that you are 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.
Intake Template

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

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

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

Reason for Visit Panel

Select the reason(s) for the visit from the list to the left. This list contains the top reasons for the specialty or practice. The applicable HPI template will launch. If you do not want the HPI template to launch, check the Do not launch HPI box.
- If the reason(s) are not on the list, select the Additional/Manage link to launch the full reason for visit list.
- Check box on top to see All HPI templates.
- HPI items may be removed by selecting the Clear button in Additional/Manage.
- Check the Follow up box to indicate this is a subsequent visit for the problem.
- Select Save & Close to return to the Intake Tab.
• Select on the appropriate **Reason for Visit** to launch the associated HPI template. The amount of information entered in the HPI is practice and/or provider dependent. As a minimum, clinical staff should complete the top section for Onset, Severity and Status as this is included in coding calculations.

Repeat the process until all HPI’s have been addressed.
Vital Signs Panel

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

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

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

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

Select Save > Close to close the template. The Vital Signs are now displayed in the Vital Signs grid.

To edit the vital signs, highlight the row and select the Edit button. Select the History & Graph text links to view the complete V/S history and graph values.
Medications Panel

The Medication panel contains the patient’s active medication list.

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

![Medication Panel](image)

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

- Select the **Reconcile** button to launch the **Medication Review** template.
- Open the **Reconciliation Type** panel and select the **Manual medication reconciliation completed** checkbox.
- Open the **Medication Review** panel and select the **Review – adherence** checkbox.
- The “taking as directed” adherence comment defaults in the field. Use the drop-down to select another adherence comment (select the blank line to manually enter a comment)
• Select the **Review All – Taken As Directed** button and the medications will move to the **Medication Review** grid. To review meds individually, select a different adherence comment and highlight the row. This will move the med to the **Medication Review** grid.

• To move a medication back to the **Medication List**, highlight the row and select **Remove**.

• To modify an adherence comment, highlight the row, select a new adherence comment and select the **Update** button.

• If applicable, update the patient’s status for **Transition of care** or **Summary of care received**.
Electronic Reconciliation button will launch the Clinical Reconciliation module.

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

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

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

![Allergies Panel](image)
Orders Panel

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

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

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

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

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

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

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

Problem List Panel

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

- If the patient has no ongoing problems, check the No active problems box.
- Select the Add button to launch the Problems Module.
- Select the Add Problem button in the middle of the screen to launch the search window.
- Enter the full or partial name of the problem in the search field. Select Search.
- Highlight the problem and click Select.
- In the lower area of the module, assign a status to the problem from either the drop-down list or by checking the *Chronic* or *Secondary Condition* box.
- Select the *Accept* button to move the problem to the active list above.
- Close the *Problems Module* and return to the *Histories* template.

![Diagram of Problems Module](image-url)
Medical/Surgical/Interim Panel

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

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

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

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

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

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

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

- Select the family relationship.
- Check either an individual condition or a condition group (in blue font). If a condition group is selected, a popup is launched to select a more specific description.
- Enter an age of onset, if known. Check the **Cause of Death** box if applicable.
- Additional information may be entered in the **Family History Comments** popup.
- Select the **Save to grid** button when finished entering completed histories on a family member.
- Continue the process until all histories have been entered for each family member.

![Family History Grid](image)

- 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.

![Social History Template](image)

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

Attempts to quit tobacco use can be documented in the Efforts to Quit Tobacco.
The patient’s documented tobacco use can be viewed in the **Historical Use** panel.

![Historical Use Panel]

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

![Passive Smoke Exposure Panel]

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.

![Confidential History Panel]
Concluding the Visit

Patient Tracking

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

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

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

Summary

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

Visit Details

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

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

Reason for Visit Panel

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

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

Quick Links

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

- Referring Providers record a patient’s current providers for Medicare visits.
  - Verify PCP
  - Select the checkbox to Include in Document
- Enter or verify other providers actively involved in the patient’s care. The use of the Care Coordination template is required to document agencies and Interdisciplinary 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 Calculator](image-url)

**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: 67 years
- Smoker: Yes, No
- Systolic blood pressure: mm
- Currently on medication to treat hypertension: Yes, No
- HDL cholesterol: mg/dl
- Total cholesterol: mg/dl
- 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.
Care Guidelines

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

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

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

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

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

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

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

Providers can create personalized plans based on recorded measurements by utilizing the **Health Promotion Plan** link. See below for details.
The **Health Promotion Plan** template is accessible from the **Vital Signs** and **Cognitive Assessment** panels. It can also be accessed via the **Fall Risk Plan** in the **Functional Ability panel**. This allows providers to evaluate and counsel the patient efficiently without leaving the HPI template. It also facilitates an easier entry of referral orders.

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

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

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

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

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

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

The St. Louis University Mental Status tool displays automatically.

- To access all **Screening Tools**, select the **Add** button.
- Select the screening tool to launch the associated template.
  - Details from the template then populate the Screening Instrument Section.
- Select **Add** to save the results to the grid.
- To create a plan based on the results, select on **Health Promotion Plan**.
To use the **St Louis University Mental Status** Examination:
- Pre-print one or more of the SLUMS diagram(s) from the Document Library.
- Select the patient’s **level of education**.
- Ask the patient the questions provided, and select either **correct** or **incorrect** after each.
- To ask questions 9 and 10, provide the patient with a copy of the diagram.
- Select **Add to Grid** when complete.
- The results from this template can be printed from the **Document Library** by selecting the appropriate **SLUMS Results** option.

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

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

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

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

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

Review of Systems Panel

The last panel is Review of Systems. The user will document the current ROS of the patient by using the One Page ROS or documenting within each system. The ROS will carry forward into the SOAP template.
Once completed with all documentation, the user will select the **Save & Close** button and finish with the rest of the visit.

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

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

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

Summary

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

Launching the template

To launch the Telephone Call template you must have the patient’s chart open.
- Create a new encounter by selecting the New button on the History Toolbar.
- 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

**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)
  o Modify the task priority, if necessary
  o Select the Send & Close button to open the Select Task Recipient window. Choose the recipient(s) and select OK.
• The Medication Management call detail template will close and then you will see the main Telephone Call template.(14)
The **Medical Question** is to document any medical questions for the patient. To document:

- Select on the **Medical Question** link under the **Communications** panel to open the call detail template.(1)
- Select in the **Contact type** field to indicate whether it is an incoming call, voicemail or fax or walk-in. The date & time of the call will populate with the date & time the template was accessed. Select in the field to modify.(2)
- Place a checkmark next to **Patient** if you spoke to the patient or select in the **Name** field to enter the name of the caller. Select in the **Relationship** field to document the relationship the caller has to the patient.(3)
- Select in the **Urgency** field to indicate when the patient would like a response.(4)
- Select the appropriate radio button to indicate the return contact number. The phone numbers are populated from EPM and are not editable in EHR. If the caller gave a number not listed, enter it in the **Other** (this call only) field.(5)
- In the **Communication** field, select in the **Concern** field to open a pick list of common complaints/concerns. If the complaint is not listed; close the pick list and type in the field. (6)
  - Select in the **Duration of symptoms** field and enter the data. The **Comment** section will populate the concern and duration. Enter additional information as indicated. Use **My Phrases** to add common phrases available to the logged in user.
- Select the **Meds/Allergies/Chronic Problems** button to see a summary of these items. (7)
- Use the **Actions** section to quickly document common actions and details and allow the staff to note when the action is completed. (8)
- Select the **Review of Test(s)** link to review completed test results. (9)
- If further action or approval is required, you may task the request to the appropriate person. Modify the task priority, if necessary. (10)
- Select the **Send & Close** button to open the **Select Task Recipient** window. Choose the recipient(s) and select **OK**.
- The **Medical Question** detail template will close and then you will see the main **Telephone Call** template.
Orders Panel

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

_protocols_panel_image_

Protocols Panel

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

_protocols_panel_image_
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.
<table>
<thead>
<tr>
<th>Chief Complaint</th>
<th>History of Present Illness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mood swings</td>
<td>The symptoms are reported as being severe. The symptoms occur constantly. He states the symptoms are chronic and are of new onset.</td>
</tr>
<tr>
<td>Medicare preventive (FP)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>abdominal pain</th>
<th>anxiety</th>
</tr>
</thead>
<tbody>
<tr>
<td>back pain</td>
<td>chronic conditions</td>
</tr>
<tr>
<td>depression</td>
<td>diabetes</td>
</tr>
<tr>
<td>hypertension</td>
<td>lab draw</td>
</tr>
<tr>
<td>musculoskeletal pain</td>
<td>pelvic pain</td>
</tr>
<tr>
<td>preventive exam</td>
<td>rash</td>
</tr>
<tr>
<td>UTI</td>
<td>UI</td>
</tr>
</tbody>
</table>

**Additional / Manage**
Office Services Panel

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

Click in the Interpretation box. And select the interpretation.
- Select the **Detail** button to open a dialog box to enter more complicated results.
- **Clinical Indication** text box is an optional field to enter free-text if it was unclear from the diagnosis.
- Enter free-text in the **Detail** text box.
- Select the **Submit to Superbill** check box if billing for the procedure.
- Select the **Place Order** button to finish.
If a test is done per standing order by a nurse or medical assistant, a provider can sign off on the test by **double-selecting on the item in the grid** at the bottom of the dialog box.

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

The **All Order Management** dialog box will display once you double click on the order.
There are several things that can be done on this template to document management of the order:

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

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

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

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

Critical Range Alert

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

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

Printing Options – Result Panel

Printing options are located in the Results Panel.
The options allow for the configuration of the columns. Header options allow the user to configure what will appear on a printed document.

### Filters

The user has the ability to filter by Provider, NG Statues, Locations and performing Entities.
When there are multiple results that come back 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.

![Search All button](image)

• 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**

![Search Tests](image)

• 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 via favorites, category or this order.
- Select the appropriate test you wish to repeat by selecting checkbox(es).

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

### Managing Schedule

To change the date of the patient’s next test
- Select the **Scheduled** filter
- Select the **Reschedule** link.
- The user will be prompted to select the next test date for the patient.

![Image of Order Module with Expired Orders feature](image)

**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
- Depended on user preferences, there are two viewing options
  - Chart View
  - Recommendation View
• Highlight a row to view the administration details.
• Double click on the Status for any vaccine to open the Immunization order.

Print/Fax Immunizations

• Select the Print or Fax button to print/fax patient’s immunizations.

Ordering Immunizations

• From the Immunizations tab, select the New Order list, and select Immunization Order.
- Select scheduled vaccine(s) for the patient using the appropriate option.
- Use the **Search All** button search for vaccine not listed in the favorites list.

- Review any existing allergies and select, if applicable.
### Review Allergies

<table>
<thead>
<tr>
<th>Neomycin</th>
<th>Egg</th>
<th>Latex</th>
<th>Gluten</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

#### Existing Allergies

- **Description**: PEANUT OIL IODINE
- **Onset**: 12/27/2013
- **Resolved**: 
- **Reaction**: 
- **Comment**: 

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

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

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

- Select the **Immunizations** from the **Orders tab**.
- When you select the **Immunizations Order**, the **Create New/Update Immunizations Order** for (patient name) dialog box displays (on the Vaccine Details tab).
- Select the vaccine and appropriate LOT# in the detail section. If the vaccine is not your inventory, enter the Lot# manually. The vaccine data defaults from the Vaccines Inventory. **NOTE:** If the vaccine was ordered verbally, select Verbal Order.
- Enter the appropriate information: Vaccine date, received counseling, if the immunizations order requires **Consent**.
- If the vaccine was administered successfully, select **Completed** in the **Status** section.

<table>
<thead>
<tr>
<th>Status:</th>
<th>Completed</th>
<th>Partially Administered</th>
<th>Excluded</th>
<th>Refused</th>
<th>Not Administered</th>
</tr>
</thead>
</table>

**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.
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**Historical Immunizations**

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

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

Overview

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

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

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

To document an incision and drainage:

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

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

![Wart/Lesion Removal Form](image-url)
Template Defaults

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

- Physical Exam
- Procedures
- ROS
- HPI

To create a Template Default:

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

- Fill out the Quick Save Template.
- Select the Add button.
- Select the Save & Close button.
To access your saved **Template Default**:
- Select the **Sunburst** icon.
- Select the appropriate default from the picklist.
- Once selected, the template will auto populated saved documentation.
**Patient Education**

**Overview**

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

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

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

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

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

To access resources from the Allergy Module
- Highlight the allergy.
- Select External Patient Education to direct you to the external URL set up in NextGen File Maintenance.
**Diagnosis Module**

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

To access resources for the **Diagnosis Module**
- Highlight the diagnosis.
- Select the **Resources** button.
- Select **External Patient Education**.
Medication Module

When the Medication Module is accessed, the resources collect the RxNorm information for the selected result, as well as the 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 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's transition of care.
- General Panel
  - Document the patient’s discharge by the hospital or other facility.

- Discharge Diagnosis Panel
  - Record one or more diagnosis for a patient who is being transitioned to another provider or who is being referred to a specialist by selecting the Discharge Diagnosis field.
  - The Diagnosis Search window will display.
  - Select a diagnosis and appropriate radio buttons.
The Problem List after Discharge Panel allows an update of the patient’s problem list.

- Select the **Add** button.
- Document problem as instructed earlier in manual.
Comp Assessment

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

![General Panel Image]

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

![Recent ER Visits Panel Image]

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

![Recent Hospitalizations Panel Image]
• The Problem List after Discharge Panel allows an update of the patient’s problem list.
  o Select the Add button.
  o Document problem as instructed earlier in manual.

![Problem List Panel](image)

• 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.
  o Place cursor in field.
  o Search for appropriate code.
  o Select appropriate code.

![Active and Managed Problems Panel](image)
- 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 Panel](image1)

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

![Care Plan Data](image2)
\begin{itemize}
  \item **Medication Panel**
    \begin{itemize}
      \item Document all current medications by selecting the \textit{Add} button.
      \item Continue document as instructed earlier in this manual.
    \end{itemize}

  \item **Social Panel**
    \begin{itemize}
      \item Document all social information by selecting the \textit{Add} button.
      \item If confidential information needs documenting, select the \textit{Confidential History} button.
      \item Select the \textit{History Review} button to indicate detail of review.
      \item Continue document as instructed earlier in this manual.
    \end{itemize}

  \item **ROS Panel**
    \begin{itemize}
      \item Document all current ROS by selecting the \textit{Primary Care ROS} button.
      \item Continue document as instructed earlier in this manual.
    \end{itemize}
\end{itemize}
- The Patient/Caregiver Concerns Panel documents any concerns expressed by the patient, family members and/or caregivers.
  - Place cursor in field and free text.

![Patient/Caregiver Concerns Panel](image)

**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**.

![CM Functional Status Input](image)

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

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

- Care Plan Intervention Panel
  - Complete intervention if goal has been achieved.
    - Highlight the intervention and select the *Edit*
    - Mark it completed.
• Care Coordination Panel displays everyone involved in the patient’s care.

![Care Coordination Panel](image)

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

![Education/Recommendations Panel](image)

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

![Action Items Panel](image)
• The Goals Panel displays patient’s goals in detail.
  o Select Add, Update or Remove button to edit goals.

• The Document Panel is used to generate documents and the Superbill can be submitted by selecting Submit to SuperbillBI.
Care and Consent Visits

The Home Page is the starting point for this visit.
- Select the Care Plan Home template.
- Select the Care Management specialty and Case and Consent for the Visit Type.

Case & Consent

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

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

---

Tools

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

The Screening Panel

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

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

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

This template is used by providers or other care team members to document patient care 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.
Referral Panel
- Select the Add/Edit buttons
- Populate fields
- Select the Place Order option
- Information populates in appropriate grid.

Barriers to Care Panel
- Select the Add/Edit buttons
- Populate fields
- Select the appropriate Save option
- Information populates in appropriate grid.

Care Plan History Panel
- Select the Add/Edit buttons
- Populate fields
- Select the appropriate Save option
- Information populates in appropriate grid.

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

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

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

- The Meaningful Use Check pop up will display.
- A green checkmark ✔️ means you have met the MU requirements.
- A red X ✗ indicates you have not 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.
Today’s Orders Panel
- Select order from the left side navigation bar to review.
- Highlight the order
- If appropriate, print or task the lab/diagnostic requisition.
- Update the order by selecting the *Edit* button.

- Document the follow up appointment if appropriate.
Given to Patient/Verified Panel
- Select the appropriate checkboxes to indicate the patient's acceptance or refusal of documentation offered to the patient.
- Select the **Patient Plan** button to generate the patient plan which is required for MU.
- When completed, select the **Checked out** button to change the patient’s status.
Clinical Reconciliation

Accessing the Reconciliation Module

The **Clinical 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.

<table>
<thead>
<tr>
<th>Icon</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image" alt="Icon" /></td>
<td>Imported document</td>
</tr>
<tr>
<td><img src="image" alt="Icon" /></td>
<td>Replacement document</td>
</tr>
<tr>
<td><img src="image" alt="Icon" /></td>
<td>Addendum</td>
</tr>
<tr>
<td><img src="image" alt="Icon" /></td>
<td>On Demand document</td>
</tr>
<tr>
<td><img src="image" alt="Icon" /></td>
<td>Snapshot document (occurs when an on-demand document is unavailable, but an available copy is retrieved from the repository)</td>
</tr>
<tr>
<td><img src="image" alt="Icon" /></td>
<td>Imported document from another practice or external system</td>
</tr>
</tbody>
</table>
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 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
When choosing to match an item, the **Select Existing** pop up opens and displays two sections

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

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

- Select **Confirm** to complete processing
A message will display that the changes were saved successfully.

If there is missing or incorrect data, a search dialog box will display. A list of potential matches will appear. The user can perform a manual search by
- Selecting the Clear and typing in the search bar.
- Select an item in the grid
- Select the OK
Reconciliation History

To view the Reconciliation History

- Select a document
- Select Reconciliation History tab
- Select the Plus sign icon to view details
NextGen Share Portal

Introduction

Share is a 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.
Sending a Referral

- Click on the **Share** tool located to the left of the **Speciality** box.
- Search for the recipient by entering the name, specialty, or location
- Select the provider
- Complete the referral order as usual
• Attach the document by selecting the **Details** button
• Select the **Attachment** box
• Select the attachement from the pop up list
Once the referral is complete, send it immediately or task it to your staff for authorizations or scheduling.

- Highlight the referral
- Select either Quick Task or Share
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

![Image of Categories tab showing Transition of Care - Referral and Transition of Care - Referral (Sent) documents]

This will include the CCD document, as well as each document attached with the order. Please note these will all be listed as **Transfer of Care Referral Note**. Note that these are not duplicates, but distinct documents with the same title.
The Share details can be viewed in Order Management, and also in the Referrals tab. The highest degree of detail can be seen by selecting the order and clicking on the Edit button.
Incoming Referrals

Providers 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.