Step-by-Step Guide: Nextgen Documentation

1. Open patient chart: Find today's visit—make sure it's the correct encounter (Date, Attending name, Medical Gardner Packard) and open **INTAKE** form
2. Make sure in top header "Visit Type" for appt is labeled correctly as "Pediatrics" and,
    a. Acute visit or follow up= Office Visit
    b. Well child check or 1st Newborn Visit=Well child
3. Chief complaint/HPI
    a. Typically, the "reason for visit" is entered by the MA
    b. To open a free text template to document your HPI, double click inside the HPI box
        i. You may have to change the reason for visit to avoid bringing up generic check box templates (ex, rash, asthma) rather than free text HPI—DO NOT USE THOSE TEMPLATES!
            1. To change chief complaint: click "Additional/Manage," and edit/or use asterisks at the end of the complaint to block the pre-populated template (ie, Rash***, 4y WCC**, ADHD**)
    c. In the free text template, you do NOT need to complete the top section (onset, duration, etc)
        i. Free text HPI. Can use bullet points!
    d. Entering Templates (WCC, newborn, etc)
        i. On the top toolbar, scroll to **SOAP** and click the "blue starbust icon" above the HPI box to get a list of available templates→double click on the preferred template and it will populate into the HPI box
            1. *Newborn Well Child Checks: (steps below must be done before able to access templates or document in HPI)*
                a. *Click "Birth History" hyperlink directly below INTAKE*
                b. *Click "Detailed document" radio button*
                c. *Enter birth time, birth weight, gestation*
                    i. *If birth time not available, enter 12am*
                    ii. *BW/gestation: allows tracking & premature growth charts if needed*
                    iii. **Do NOT enter additional BHx in this section (will be documented in other sections)*
                d. *Return to INTAKE & change chief complaint as above if needed (NB WCC*, Newborn*)*
    e. Scroll back to **INTAKE** and document in HPI per visit. If WCC/newborn, complete all sections in template. You will copy/paste the A/P in template into the "Assessment/Plan" section (you can do it either now or during A/P section later)
4. Medications
    a. Med rec the patient (should be done in room to actively confirm/update). Click the "add/update" button if anything needs to be updated
    b. Make sure the medications are accurate—click STOP for old/inaccurate meds. For new ones (Rx'ed elsewhere, but taken daily), enter them and click "accept", but do not send to the pharmacy.
    c. If no medications, click "No medications"
    d. Click "Medications reconciled"
5. Allergies

a. Make sure allergies are accurate (should be done in room to actively confirm/update).
b. No allergies: click “no known allergies” and “reviewed, no changes”
c. If allergy already listed, confirm and click “Reviewed, no changes”
d. If allergy needs to be added, click “Add” to add allergy and reaction type and when finished click “reviewed, updated”
e. If allergy needs to be updated (ex, reaction type), click “Update” to make changes and when finished click “reviewed, updated”

6. Review of Systems *(Required for any acute visit/follow-up, but not WCC)*
    a. On the bottom left-hand of section, click “Pediatric ROS”
    b. Optional: add simple ROS template by clicking “blue starburst icon” in right corner and select “GARDNER PACKARD ATTENDING ROS”.
        i. Add or change pre-populated answers to reflect responses for symptoms you <u>directly</u> asked about
            1. DO NOT CLICK “all neg” unless you asked all questions in that system
        ii. Click Save and Close
7. Scroll to the top and open the **HISTORIES** tab
8. History Review
    a. Click on the “History Review” button directly below histories tab
    b. Click “Detailed document” button for Medical/Surgical. This will ensure that the information in this section shows up in your note.
9. Problem List:
    a. Our group does NOT utilize the problem list; prefer pertinent medical, family, or chronic social problems to be listed in “Medical/Surgical/Interim” as it is able to be edited over time and add comments that are easier to view in notes
    b. Do not delete problems put in by OD, PhD, or DDS because these are problems used by our optometry, psychology, and dental colleagues.
10. Medical/Surgical History
    a. If no medical history: click “No relevant past medical/surgical history”
    b. If there is medical history, click “Add” under the Medical/Surgical/Interim section
        i. Select “Other” to free text diagnoses *(selecting a pre-populated diagnosis listed makes it harder to edit/add comments)*
            1. Free text diagnosis in “Disease/Disorder” (Ex, OSA)
            2. You can add information about current status of the condition in “Management” section. (Ex, follow LPCH ENT s/p T&A in 7/2018)
            3. Click “Save to grid & close.”
        ii. If there is medical history already listed, but change in status/management, click on “edit” and edit within management section and “save”
11. Family history
    a. Same as above. If pertinent, place in “Medical/Surgical”
12. Social history
    a. **DO NOT DOCUMENT IN THIS SECTION. Free text all social history in HPI
13. Scroll up to top toolbar, go to **SOAP.** You will see that HPI and ROS have pulled from INTAKE.
14. Physical exam
    a. Scroll down to the Physical Exam section
    b. Click “One Page Exam”
    c. Optional: add simple PE template by selecting “blue starburst icon” in right corner
        i. If you use a template, you MUST edit to add or remove portions completed
    d. Click “normal” box on the selected portions of the exam completed that are normal

i. **Do NOT use the small free text boxes for abnormal findings—they have very limited character limits and do not allow adequate description.
ii. For abnormal findings or pertinent negatives (anything more than clicking the "normal" button), click designated hyperlink for that section, and free text information in "Comments."

e. Click "save and close"

15. Assessment/Plan
    a. Click "Assessments." Another screen will open.
    b. If well visit/newborn, diagnosis typically pre-populated already, but confirm accurate
    c. You need to select/add a diagnosis for this visit
        i. If chronic issue previously seen for, diagnoses might already be under "Billing Diagnosis History". If so, find and select the diagnosis and it will move to "Today's Assessments"
        ii. If new diagnosis, Click "IMO SEARCH." On the bottom panel, select "Assessment" only. Search for your diagnosis (be as specific as possible). Click the plus sign to the left of the diagnosis. This will add the diagnosis to the list of assessments. Save and close.
            1. Do this same step to document each diagnosis addressed at the visit
        iii. If you want to re-order the diagnoses by priority in your note, you can select "Sort" (ie, for a WCC the primary diagnosis must be WCC code for billing)
    d. Across the top panel, click on the "A/P details" tab.
        i. Highlight the relevant assessment.
        ii. Write your assessment and plan in the "**Provider Details**" section.
            1. Leave the Impressions/Comments, DDx, and Patient Details sections blank.
        iii. Save and close
16. Generate note & send to Attending
    a. Click on "EM coding" icon at the bottom of the page. It will take you to the FINALIZE tab on the top scroll bar
    b. Under Provider Sign Off, look for "For Residents Only" and click "Submit to Supervising Attending for review"
    c. A box will open. Search for your attending's name and click "Add."
    d. Click "OK" and then your note will generate
    e. Review your note!!! If you find errors, go back to appropriate tabs and fix
    f. Once reviewed and finalized, click the blue check mark in the upper right corner to sign your note

ADDITONAL INFO:

- Confidential HEADSS assessments should be handwritten on structured forms in **BLACK** ink. Place a patient label on both sides, sign, and put in your folder to be scanned into chart.
- Any papers left in the patient folders is scanned into the medical record so do NOT put any incomplete documentation (ex, if you use a WCC encounter form to jot notes during visit, throw away)!