This demonstration reviews a typical intake prenatal visit. Details of the workflow will likely vary somewhat, depending on practice policy & clinic layout, though this should give you a good idea of the prenatal functionality within NextGen.

This has been prepared for EHR 5.8 & KBM 8.3, though some screen shots of older versions may appear if they don’t compromise the presentation. Subsequent updates may display cosmetic and functional changes.

Use the keyboard or mouse to pause & resume as necessary.
Our patient is in for an intake prenatal exam. She’s an established patient, but this is the 1st time she’s been seen using NextGen, so we’ll be entering some known medical history as we go. For a patient with data already entered into NextGen this would be much more streamlined. And you actually have several options on the order you do things & what parts are done by the nursing staff vs. providers, but this will provide you one example of a reasonable workflow.

The nurse begins by double-clicking on the patient from her provider’s appointment list.
Always begin by performing the 4-Point check.

**Patient** | **Location** | **Provider** | **Date**

When you first open the chart to the Intake Tab, you’ll note all the tabs are blank, & **Specialty** & **Visit type** are in red, demanding attention.
Click select a specialty & pick Obstetrics.

Note to Family Medicine Users: You can choose Family Practice here.

On the Visit types picklist select OB Prenatal - Initial.
Note whether the patient is listed as **New** or **Established**, since this sometimes needs to be changed. A patient seen elsewhere in the USA system might initially appear as **Established**, but if it’s the first time she’s been to your office, that would need to be changed to **New**. Our patient is **Established**.
It's always good to begin by noting whether there are any Sticky Note or Alerts entries; there are none here.
You can select a **Historian** from the picklist that appears if you click in that box; you can also type in an entry. This is most pertinent if the patient is a child or adult unable to speak for herself.

**Note the PCP.**

If you need to update the PCP, you can do so by clicking **Patient** to open the **patient_demographics** template.
The Navigation Bar is normally hidden at the left; it will slide out if you hover over it. But you probably won’t need it very often.

You can make the History Bar do the same auto-hide trick if you click on the thumbtack to turn it sideways.

You can also show or hide the History Bar by clicking the History icon at the top.
You can collapse the **Information Bar** down to a narrower strip if desired; that is particularly helpful on the small-screened laptops. Click this button.

The nurse will probably next enter Vital Signs. It would be more convenient if that section were at the top of this template. So if it’s not there already, let’s move it there. Click on the **Vital Signs heading bar**, & drag it up over **Reason for Visit**. (It can be a little touchy to make the drag work right, you’ll eventually get it.)
The Info Bar is collapsed, & Vital Signs are at the top.

To enter Vital Signs, click Add.
Enter Vital Signs. (Details are reviewed in another demo.)

LMP: ~11 wks before encounter date (4/3/14 used here).
Ht: 65 inches, measured today.
Wt: 146 lbs, dressed with shoes.
Temp: 98.8.
BP: 118/76.
HR: 74.
RR: 16.

When done click **Save** then **Close**.
Before we go any further, note the **OBGYN Details** link. This is actually available at the top of all the templates, but this is as good a time as any to look at it.
Some details can be entered directly here. We’ve added that she’s *sexually active*, not practicing *safer sex*, & using *no birth control*.

To enter pregnancy history, click **Details**.
Enter data in the white boxes & they'll be summarized in the gray boxes above. She’s had one term vaginal delivery & one miscarriage, & is currently pregnant.

To enter details about each pregnancy, double-click on the grid.
Begin by entering Pregnancy #1. (Unless there was a multiple gestation, it is unnecessary to enter Baby #.) Using the combination of available entry methods, enter the following data:

Male, born March 2008, at 40 weeks gestation, 6 lbs 8 oz, via NSVD, at USAC&W. She had Preeclampsia, requiring magnesium, & had an epidural. Enter as much information as is known/pertinent.

When done click **Clear For Add.**
Enter Pregnancy # 2.

Data used here: Gender-unknown miscarriage July 2009, at 12 weeks gestation.

When done click Save then Close.
The details entered display.

Click **Save & Close**.
Click Save & Close again.
Now enter Chief Complaints, or Reasons for Visit. The most common complaints used in each clinic will appear on this list. Select routine prenatal & any other complaints the patient has. (Family Medicine users may need to just type this in.) We won’t add any other complaints for this example.
The Reason for Visit you’ve entered displays.

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

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

In this example, our patient is taking: **Prenatal Vitamin tablet**.

Add this medication, then close the **Med Module** to return to the **Intake Tab**.
The vitamin displays on the med list. Click the **Medications reviewed** checkbox.

Next, review allergies. If there are no allergies, just click the **No allergies** box.

But our patient states she is allergic to sulfa, so click **Add**.
Add the patient’s allergy to **Sulfa**; she gets a **Rash** from it. (A detailed discussion of the **Allergy Module** is covered in a separate exercise.)

When done click **Save & Close**.
Sulfa now displays in the Allergies grid. Since this was just added, the Reviewed, updated bullet is checked.

There are a couple other things to do on the Intake Tab. The nurse might actually do these a little later, but for demonstration purposes we’ll look at them now.
The clinic has standing orders to perform a urine pregnancy test on all new OB patients, & a urinalysis at all OB visits. Click one of the Standing Orders links.
On the Standing Orders popup, click in the Display category box. In the ensuing popup, double-click Office Tests.
Scroll down to **Urinalysis, dipstick associated with pregnancy.** Click this.
Click **Detail** & enter results. The data used in this example are shown.

When done click **OK**.
The results display in the Detail field. Click Submit to Superbill.

Then click Place Order.
In a similar manner, enter a **positive** urine pregnancy test. When done click **Save & Close**.
While we’re here let’s review vaccinations. Click **Immunizations**.
It’s not flu season, so there’s nothing we’ll need to give today. Close the *Immunizations* template, returning you to the Intake Tab.
Now click **Gestational Age** to move into the Prenatal templates.
Since we've already entered some data, the LMP, EDD, & EGA display. She's sure about LMP, so we'll click **Definite**.
Looking at the bottom half of this template, you have the opportunity to add a little more history, as illustrated.

When done, move on to the Histories tab.
This tab allows you to record most aspects of the past medical, family, & social history, as well as several items specific to pregnancy that are line items on the ACOG prenatal form. Since we recorded OBGYN Details earlier, they display here; you could add it at this point if you didn’t enter it earlier.
Navigating down the template, enter **Symptoms Since LMP**. You can just type in the box, or click the **Add** button & choose from the popup. We’ll enter **breast tenderness, nausea/vomiting, & teeth itching**.

Also click in the **Medication comments** box & type entries as necessary. We’ll enter **Prenatal vitamins**.
Scrolling down the template, we come to the Medical History section. It is often most efficient to “document by exception” by clicking Default All to Negative, then changing answers to positive as necessary. Our patient has a history of postpartum depression, seasonal allergic rhinitis, & a medication allergy (the sulfa allergy we entered earlier), so we’ll make those adjustments.
In a similar fashion, document her **Infection History**. Her only positive response is for **Chlamydia**.
There are several pregnancy-related questions to answer here, as illustrated.

### Medical/Surgical/Interim

<table>
<thead>
<tr>
<th>Disease/Disorder</th>
<th>Side</th>
<th>Onset Date</th>
<th>Management</th>
<th>Side</th>
<th>Date</th>
<th>Encounter Type</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnancy</td>
<td></td>
<td></td>
<td>NSVD</td>
<td></td>
<td></td>
<td></td>
<td>Unknown</td>
</tr>
<tr>
<td>Pregnancy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>40W0D week 6lb(s) 8 oz Male</td>
</tr>
</tbody>
</table>

### General

- **Patient agrees to transfusion**: [ ] Yes, [ ] No
- **Antepartum anesthesia consult planned**: [ ] Yes, [ ] No
- **Patient desires sterilization**: [ ] Yes, [ ] No

### Planned feeding

- [ ] Breast
- [ ] Bottle
- [ ] Both

### Other

- [ ] Seat belt use
- [ ] Cats in home
- [ ] Latex allergy?
The Medical/Surgical/Interim grid is the same as on the Histories Tab you see on non-obstetrical encounters, so for an established patient, you’d probably already have all this info entered. For this example we’ll add that she’s had an appendectomy. Click Add.
Click Appendectomy, then add 2002.

That’s all we have to enter, so click Add To Grid, then Save & Close.
This history now displays.

The Family History grid is similarly shared with regular medical templates, but for this example we’ll add a few details by clicking the Add button.
Enter this Family History:
Her maternal grandmother died from colon cancer at age 68.
(Family History is covered in detail in the Histories lesson.)

When done click **Save & Close**.
This addition displays in the grid.

Now move down to **Social History** & click the **Add** button.
Social History is covered in detail in the Histories lesson.

Data used in this example:
- Never smoked.
- Stopped drinking when she became pregnant.
- Married.
- Preferred language is English.
- High school education.
- Occupation is Domestic Goddess.
- Sedentary activity level.
- House has smoke & CO detectors, but hasn’t been tested for radon.
- Wears seat belts.

When done click **Save & Close**.
The details display in the grid.

Scrolling down further, you come to the Genetic Screening section. We'll again select Default to All No to document by exception; she has no positive answers to document.

(Technically #19 Medications could be a yes since she's taking prenatal vitamins, but this seems redundant since you've just answered that question above.)
You've got space to enter comments if necessary.

Now go back to the top of the template.
This is a good time to review Risk Factors, though links to this are available on other templates as well. Click Risk Factors.
Some of the answers are already populated from previous answers. For the rest, go through & click Yes where appropriate, then click Set all unanswered to No.

The provider will complete Risk level assignment later.

When done click Save & Close.
You can see that Risk Factors have been addressed.

The workflow you’ve seen thus far has the advantage of better combining the regular medical history with the obstetric-specific medical history than did prior versions of NextGen, but there is a potential gotcha: We haven’t reviewed the Problem List, so you could overlook a chronic problem like asthma or hypertension.
If this is a patient who is already established in your practice, the Problem List has probably already been completed. Here we see there is 1 Problem recorded. And if you hover the cursor over the (1)...

The Problem List will display.
If you need to add something to the **Problem List**, either click on the (1) or the **Problem Module icon** on the History Bar, as illustrated in the Histories lesson.
Note the Risk Indicators. Since we just recorded tobacco history in the Social History, it indicates she's tobacco-free. Click the Configure button to complete the other Risk Indicators.
Tobacco has already been addressed. Click the bullets for **Hypertension No**, **Diabetes No**, & **Coronary Artery Disease No**. When done click **Save & Close**.
All Risk Indicators are now configured.

Now move to the Education Tab.
Under the First Trimester section, click the Add/Update button.
Check the checkbox as you discuss each issue.

When done, click the **Save & Close** button.
Education documentation now appears in the grid.

Check the **Education documented as complete** checkbox. (You may have noticed this checkbox on the previous popup as well.)

You can add further comments here as well.

Now move to the **Prenatal Detail** tab.
Several items are summarized from previous entries. Add others as appropriate. In particular, add pre-pregnancy weight & the date of that weight; often you’ll need to approximate.

In this example, our patient weighed 140 lbs on the day of her LMP, 4/3/14.
Total weight gain is calculated.

The nurse will leave the OB Problem List to the provider, so navigate on down the template.
After the intake OB information has been entered, the Prenatal Visits grid will be the main focus of OB visit documentation for the rest of the pregnancy. (For those familiar with the ACOG prenatal forms, this is the equivalent of the flow sheet pages on which you make all of the one-line entries at each visit.) Click Add.
This is where flow sheet data is entered. Since vital signs & urinalysis results were previously entered, they display here. If not previously done, they could be keyed in now. But since that's all here, the nurse doesn't need to do anything else, so just click **Save** then **Close**.
These details now appear in the grid. (The provider will add more to this later.)

The nurse notifies the provider the patient is ready. Click the Tracking icon. (Expand the Information Bar if necessary to display it.)
Enter Room Number, then click in the Status box.

Double-click waiting for provider.

When done click Save & Close.
In an actual encounter, this might be the time the nurse completes the urinalysis & pregnancy test, so do that now if not already entered.

One last thing for the nurse to do. Go back to the Intake tab.
Navigate to the bottom & click **Generate Intake Note**.
The Intake Note is created, & the nurse can move on to the next patient.
The provider then opens the chart from the appointment list and performs the 4-point check.
The provider generally starts on the Home Page tab.

It's good to begin by looking for Sticky Notes & Alerts; there are none on this patient.

Also take note of the Risk Indicators.
You can select any of the headings on the left to view various aspects of the chart. You can also just review the intake_note to see a summary as well. Regardless of the method chosen, the provider is responsible for reviewing & confirming this information, & updating it as necessary.

When you’re done reviewing the chart, move to the Gestational Age tab.
Review information that has been entered, clarifying any details with the patient as necessary. Navigate down to see the rest of the template. After your exam, you will confirm your impression of dating by exam.

Now move on to the Histories Tab.
Review information that has been entered, navigating down the page, & discussing any details with the patient as necessary.

This is also a good time to review the Risk Factors. Click Risk Factors.
Review & discuss with patient. Then click in the Risk level box & make a selection. This patient's risk is low.

You can add comments as desired.

When done click Save & Close.
Risk Level displays.

Now move to Education.
You'll see the education items that have been discussed with the patient. You can click Add/Update or use the Comments box to add further detail.

If not already done, click Education documented as complete.

Now move to the Prenatal Detail tab.
Review the information that has been entered. But notice the Prenatal Visits section. Since this is the flowsheet that is the meat & potatoes of our routine documentation, it might be nice to have that higher on the template. So click on the Prenatal Visits heading & drag it up over the OB Problem List section.
The flowsheet has been moved up. And we’ll figure by now you’ve examined the patient. Now click on today’s line on the grid, then click Edit.
Review information entered by nurse & add further information from your history & exam. For this example, we'll record no pain, no fetal movement, no contractions or fluid leakage, FHR 128, no edema, & 2+ DTRs.

In the Progress Note box, type your plans, e.g., U/S in next wk. Add a Return Appointment plan, e.g. 4 weeks.

When done click Save then Close.
You have an opportunity to document your intake exam at this point. Click OB Initial Exam.

Your entries appear in the grid, & when you click on the line on the grid you can see your entries in the Comments box. For most routine prenatal visits, this may be all the plan you need to enter.
Click here to **Lock** the initial exam, then click **Save & Close**.

This gives you a one-screen opportunity to record details of the initial physical exam.
Now that that’s done, I’ve navigated a little farther down the template to show the OB Problem List. We don’t have any problems to enter, but we’ll review how to do that.

Click Add.
Click the Problem/Detail dropdown arrow to make a selection from the picklist, or just type in a problem. Here I’ll pick Constipation.
You can assign a priority & type plans/instructions.

Click **Clear for Add** to make more entries, or **Save & Close** to finish.
At this point you could do one of several things. Let's generate prescriptions. Open the Medication Module.
Medication Module details are reviewed in another lesson.

We’ve refilled & ERx’d her prenatal vitamins. Closing the med module, you’ll return to the Prenatal Detail tab.
At the top of the Prenatal Detail tab, notice you have access to the SOAP template, just like you would for any office visit. You might use this if the patient had several other medical complaints, & you wanted to have access to the full HPI, physical exam, assessment/plan, etc. resources there. And maybe you’d like to document a more complete physical exam on your intake visit. But most of the time you won’t have to go to SOAP on a routine prenatal encounter. 

But let’s go back to Gestational Age for a moment.
Click in the **Initial Exam Date** box & enter today’s date.

Then click in the ensuing popup enter *11 wks* as your impression from today’s exam.

Now, with that out of the way, let’s go back to **Prenatal Detail**.
Here I’ve navigated down below the flow sheet & OB Problem List. You may notice a link that says Order Labs. Technically, with some extra steps, that can work, but for us there are fewer steps if you place lab orders through the Order Module.

Click the Order Module Icon.
The **Order Module** opens on the **Results Tab**. Click the **Orders Summary** tab.

On the **Orders Summary** tab click **New**.
Select the Supervision of pregnancy... diagnosis.

If it’s not already in your personal favorites, display Practice Favorites & select Prenatal Lab Initial USA, & any other labs you need.

When done click Save & Send.
Select a local printer & print the order. Then close the **Order Module** & navigate back to the **Prenatal Detail Tab**.

Click the **Print** dropdown arrow & then **Print Preview**.
Here we’ve navigated farther down the Prenatal Detail tab. Notice you have an Assessment/Plan section similar to that on non-obstetrical encounters. So if you need to add more diagnoses or plans, you can click Add/Update...
...and you have the full Assessment/Plan suite. So you can add more diagnoses, plans (including use of My Phrases), & diagnostic studies if needed, without having to go the SOAP template. We don't need any of that on this encounter, so we'll close this to move on with the demonstration.
From here you can generate the Patient Plan. Click the icon.
Admittedly, the Patient Plan isn’t a document that is all that germane or useful for a prenatal visit, compared to a regular office visit.

Print if desired, then close this to return to the Encounter Detail tab.
Now click the **Prenatal Record** button.
It takes a few moments, but this generates a summary of the visit formatted very much like the ACOG form. This takes the place of generating any other type of visit note for prenatal visits. After it has been generated, close the report to return to the Prenatal Detail Tab.
Now click the EM Coding button.
Almost all of our obstetrical charges, including Medicaid, are paid globally, but there’s not a direct way to indicate that in NextGen. Until a better method is derived, just click Prenatal Visit 4-6, then Submit Code. (HSF billing handles the conversion to the global charge.)

Residents should indicate the degree of attending participation by clicking Resident-Attending discussion took place or Attending saw patient.
Residents should notify the attending that this encounter needs to be countersigned by clicking Submit to supervising physician for review.

Select your attending & click Add User(s).

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

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

How much deeper would the ocean be without sponges?

R. Lamar Duffy, M.D.
Associate Professor
University of South Alabama
College of Medicine
Department of Family Medicine