Nextech

MEETING MINUTES

Meeting date [08/25/2021]   **Time** [1:00 EST]

Client Name His Vision Eye Care	**Attendees:** Dr. Groves, Scott, Sarah and techs
Note Taker Shannon Chaney	

AGENDA TOPICS: EMR SESSION 2

Discussion:

- Brief Discussion of the workflow and locating Doe charts to practice in
- Completed tabs on Summary Page
  - Glaucoma Flowsheet- pulls data from Exams/Encounters, default for group but Doctors can set their own preferences(see handout)
  - Studies (process of creating, reviewing, finalizing)
  - Consents (work like procedures-can add from this page, will pull from within chart)
  - Images and Documents (sorting, how they get populated, flagging staff member for review)
  - Scanning
  - Reports (Exam notes and Letters are found here, how it populates, can fax)
  - Portal (printing patient portal, giving access for quality measure)
- Discussed important features of chart: Creating a new encounter, Save/close and items along left column, Header, Settings wheel
- Charting Basics: How open and close controls (segments), clicking plus vs clicking on word to change and add findings/items
- Reviewed how to complete elements including:
- Initial Problem List/Reason for Visit
  - For new patients, techs should populate ALL OCULAR HISTORY here. The diagnoses/primary diagnoses will always be completed by the providers after seeing the patient. Techs can type in the yellow box next to the encounter type if techs would like to indicate the reason the patient was referred without entering a primary diagnosis (for ex: referred by Dr. Smith)
  - For established patients, the diagnoses from the last visit will be here, so the techs will not have to worry about this field unless they are updating the ocular history
- History and documenting Chief Complaints
  - Get creative! The more the merrier! This is where I find most techs have difficulty-getting used to what and where things are located for documenting the chief complaints
  - Be sure to mark mental status as complete/checked
  - If patient is a Diabetic add in last blood sugar and A1C- do not write "unknown" or "?" in the A1C area, this is a MIPS field
- Specialty Medications-Ocular
  - Remember to check off the box "systemic meds reviewed". This is your one stop shop button if there happens to be no changes when you go over the systemic meds with your patient

- o Choose from the pick list, **do not free type-**if nothing populates use the magnifying glass to search
- PSFH/ROS
  - o Remember, the systemic meds should always have that green check box marked off, but the LARGE green box should be checked off whenever the techs update the complete PSFH section
  - o Remember to document smoking status in the Social History
  - o Don't leave blank fields, always populate (negative, none, noncontributory)

- V& P
  - o Only access the sections you need

- Best practices of signing charts, locking charts, saving and exiting charts
- <mark>Rule about 2 open charts: Charts do not update in real time, the last person to save for that encounter will win their changes.</mark>

Reminders/Action Items:

- ANY RED X- deletes information!!!
- Your techs are also free to log in and practice as well. I would say a great practice would be to grab an old chart and pretend like they are "working" up the patient in the system, documenting the medical history, etc. It allows them to get familiar with the different fields in the system.
- Session 3 we will continue and complete documenting in the clinical chart starting with V&P section, Keratometry

Remember to use the Community Portal as your resource for educational webinars and helpful how-to's if you have questions in between phone sessions!
Login here: http://www.nextech.com/client-support

Review these webinars:

https://nextechsupport.force.com/nextech/s/topic/0TO33000000Lpu0GAC/intellechartpro-step-3-getting-started