MDlog User Guide

Contents

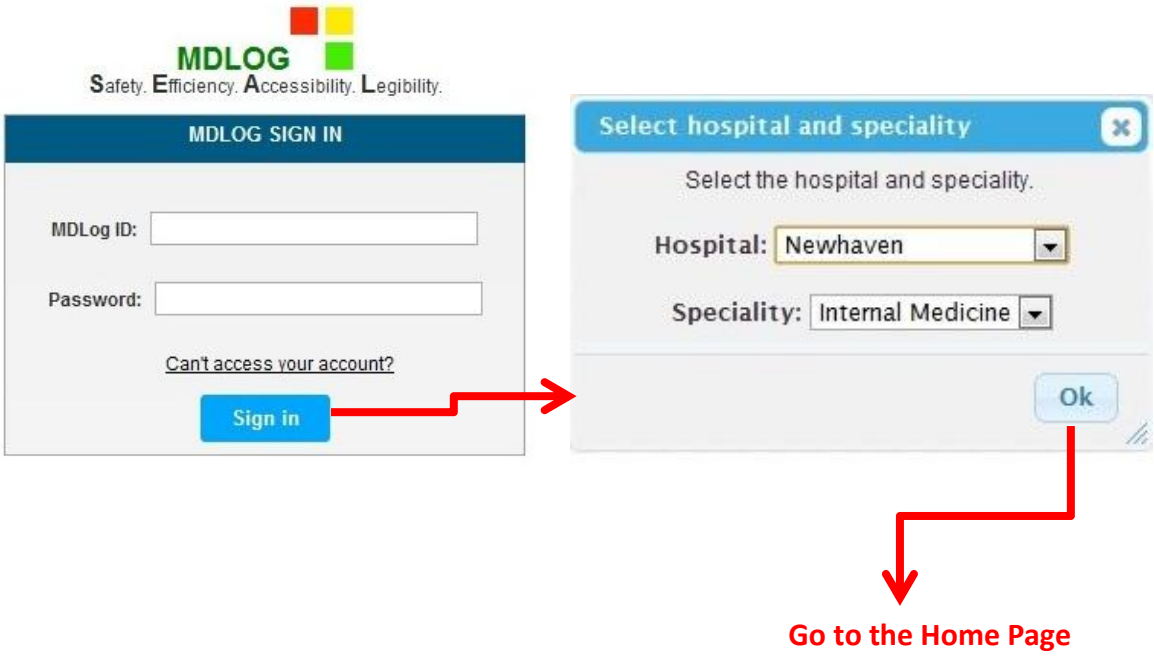
Overview

MDlog application is a Cloud based EMR application designed for the use by Medical staff that include Physicians, Nurse Practitioners and Physician Assistants. The primary purpose of the application is to let the medical staff document progress notes as they attend to patients in Skilled Nursing Facilities, Long Term Acute Care Hospitals, In-Patient Rehabilitation Facilities, Assisted Living and other types of Long Term and Post-Acute Care facilities.

Login

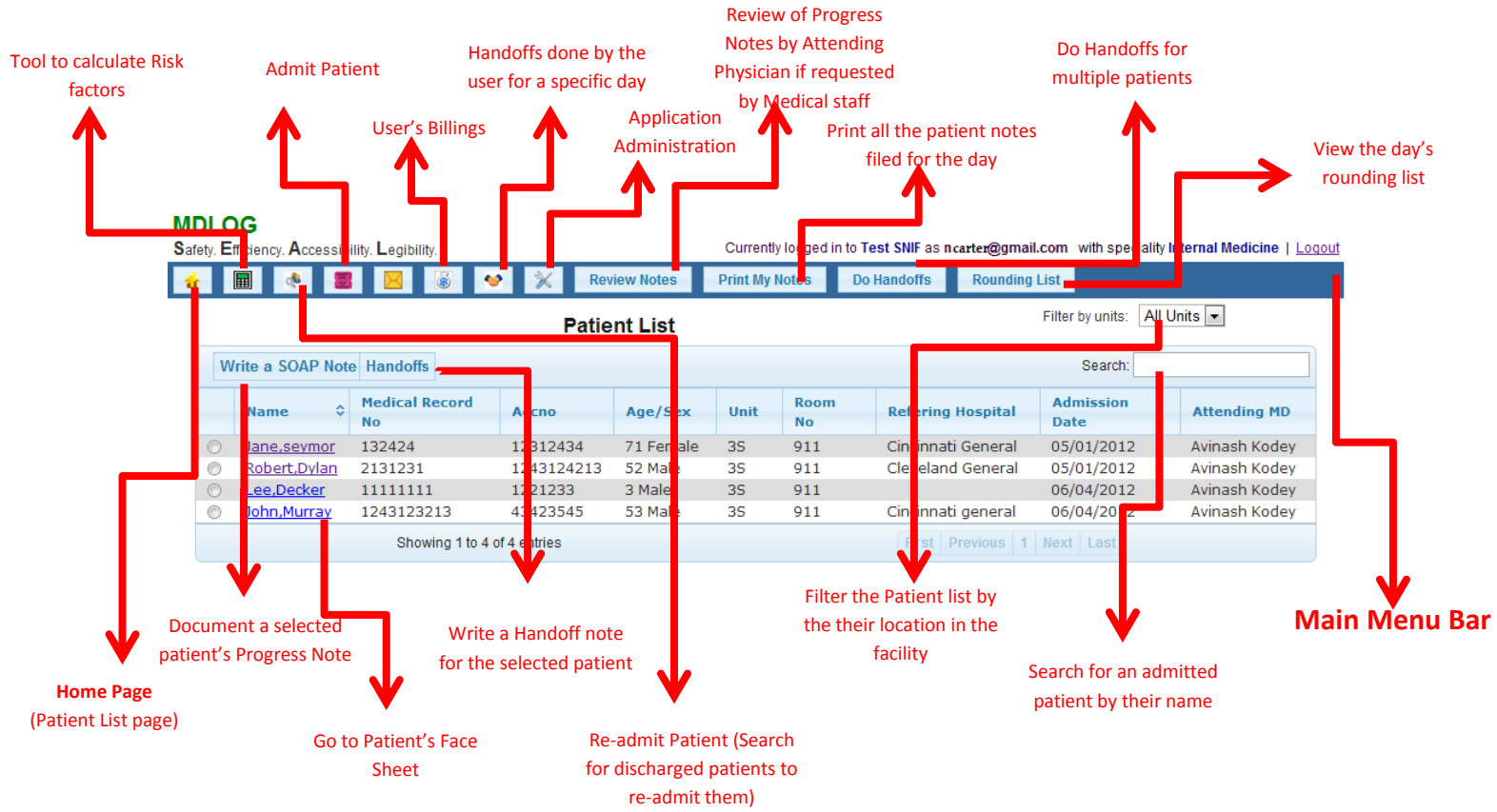
In order to access and use the MDlog application, users need a PC or a Tablet like an iPad with internet connectivity. Type the string "https://MDlog.MDops.com" into the address bar of a supported Internet browser to access the application. The supported Browsers include Microsoft's Internet Explorer, Google's Chrome and Apple's Safari.

The Email address used for creating the user account for MDlog account will be the user ID. Please check with office administrator to ensure the correct user ID is used for logging into the application. After successful login into MDlog, the users will be prompted to choose from a drop down list of all facilities they are registered to. Physicians with multiple specialties can also choose the preferred one at this point. Once the users select the facility they will attend for the day all the patients in that facility being covered by the user will be listed as seen in the following image. This will the "Home" page for the application.



Home Page

The application's Home page contains the list of patients that the user is to attend for the day. The patients can be filtered by their location in the facility i.e. the unit where they are located. The user can also search of a patient by their name. The following image indicates the functionality of each of the buttons and links in the Home Page and the Main Menu Bar. Clicking on any patient name will take the user to the patient Facesheet. Selecting a patient and clicking on "Write a SOAP Note" button will allow user to start writing that patient's Progress Note. Selecting a patient and clicking on "Handoffs" page will allow user to start writing the patient's handoff note.



Speech Recognition

MDlog application offers integrated speech recognition service. Users can click the buttons on any application page that is speech enabled to capture comprehensive text in the fields marked with the symbol by simply speaking into the device. The speech recognition capability is powered by Nuance with its 360| Speech Anywhere service.

NOTE: Users need to have subscription to Nuance's "360|Speech Anywhere" service to use this service. Please contact MDops Corporation to activate the speech recognition service. The service requires a quality microphone and Internet connection to capture the voice of the user and pass to the Nuance service over the internet to convert voice to text.

Main Menu Bar

The menu bar seen in the above Home Page image is available to users in all the pages of the application. But the buttons on the Menu Bar are available to users based on their assigned roles. The following are descriptions for the buttons on the Main Menu Bar

Re-Admit Patient

Let's users search for patients from the entire repository for discharged patients with the option to readmit them without re-entering all the demographic information

Admit Patient

It lets a user with "New Admissions" role to admit patients by recording patient demographic and insurance information. Once that information is recorded the medical staff can record the patient's medical information and admission notes during their first encounter with the patient. Please refer to "Patient Admission" section for more details.

User's billing

Users who are a part of the medical staff can review their billings for the day. Each billing entry will include encounter information like the patient's Assessment/Plans and billing code (CPT code) along with the key patient details.

Handoffs

It shows all the handoff notes written done by the user for the day and optionally for the previous day or for a specific date.

Application Administration

This link takes user to administration page where a user can manage the facilities, user accounts, billing codes, custom Assessment/Plans. For more details please refer to Application Administration section.

Review Notes

List of progress notes filed by medical staff in all facilities that require review and co-sign by the attending physician as warranted by Payer guidelines in certain cases.

Print My Notes

The Medical staff can use this button to print all patient Progress Notes they have filed for the day with a single click.

Do Handoffs

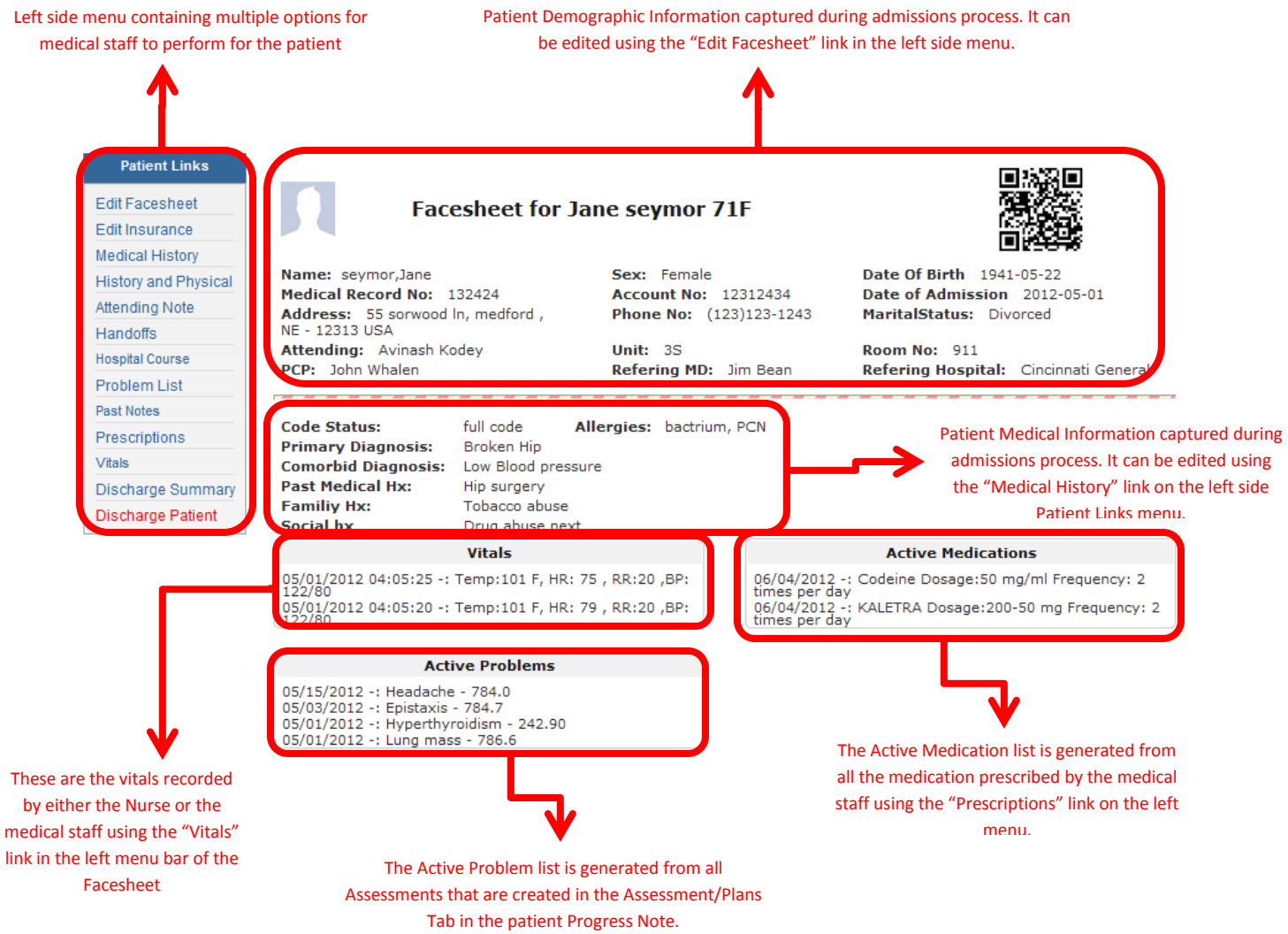
The Medical staff can write handoff notes for all the patients they each attended for the day from a single page instead of going to each patients individual Facesheet.

Rounding List

This presents the medical staff with a printable version of a patient rounding list which contains key medical information like Primary Diagnosis, Comorbid Diagnosis, Age, Allergies and other pertinent details of each patient. The primary intent of this view is for medical staff to complete their patient note quickly with this printed copy of the rounding list.

Patient Facesheet

Patient face sheet page can be reached by simply clicking on the name of the patient listed in the user's "My Patients" or "Covering Patients". The following image describes each element of the face sheet



Facesheet Menu

The patient facesheet has a menu (list of patient links) on its left side. Each of the links provides medical staff with access to key information and functionality to be performed for the patient. The following are the descriptions of each of the links in the menu.

Edit Facesheet

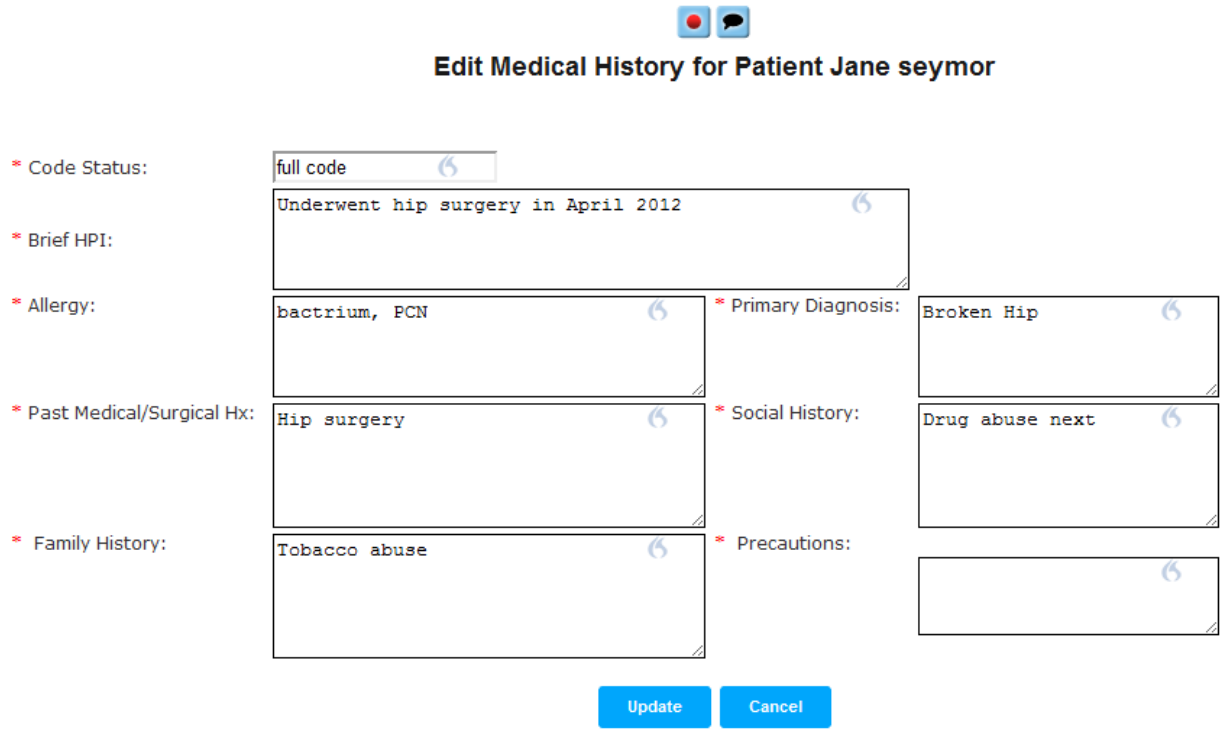
This allows user to edit patients existing demographic information in the facesheet

Edit Insurance

This link allows user to update patient's existing Insurance Information recorded during their admission.

Medical History

This link allows user to edit and update patient's medical history that was recorded during the admission. The following screen shows the information that can be updated in the medical history.



History and Physical

This allows user to document a patient admitting note. The structure of this note is same as a patient progress note but will be marked as an Admission Note in the list of patient's past notes. So when the medical staff reviews the patient's past notes, this note marked as the admission note will let them determine the patient's medical condition at the time of admission. All the Assessments and plans recorded as part of the "History and Physical"(Admission Note) get carried over to patients subsequent progress note.

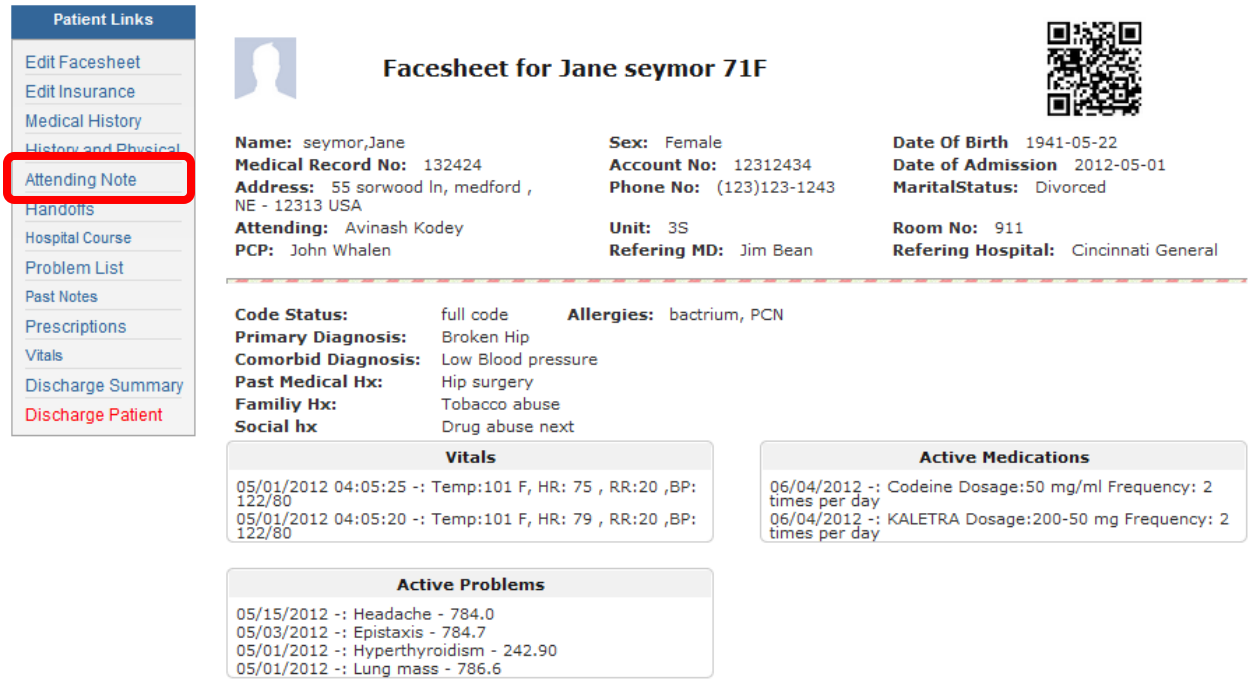
Attending Note (Documenting Patient's Progress note)

The Medical Staff can document a patients progress note (SOAP note) either by clicking "Write Soap Note" in the Home Page (Patient List Page) or by clicking "Attending Note" located in the left menu in patient's "Face sheet" page as indicated in the following image. The patient progress note has been segmented into multiple tabs to capture clinical data in a structured SOAP format. Although it is not mandatory to complete all the tabs doing so will generate a more comprehensive progress note, help justify the billing codes selected and help during Audits. To simplify this documentation process, the application offers users the option of completing the note either through simple clicks or through speech recognition software to dictate comprehensive notes directly into the application.

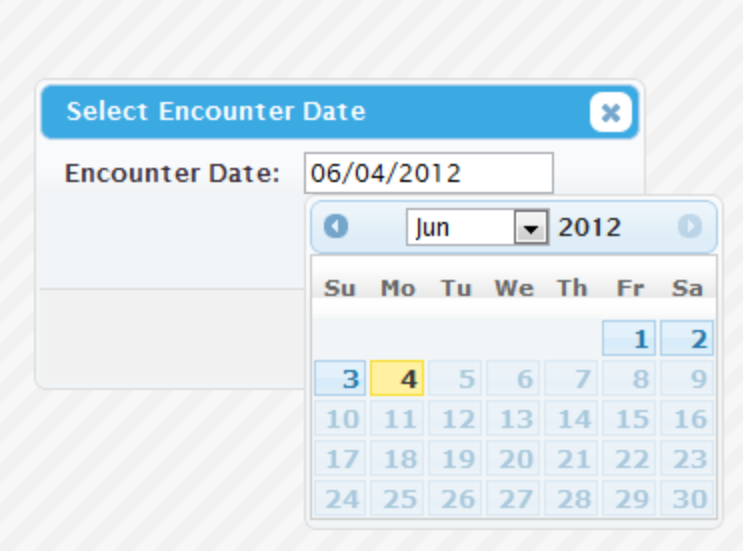
The Following are the available tabs in the patient progress note

a. Handoff Notes
b. Subjective
c. Review of Systems
d. Risk Factors
e. Exam
f. Lab
g. Assessment and Plan
h. Preview of the Progress note
i. File the Note

The following sequence of images starting with the patient facesheet will help the user understand the usage of this feature. The documenting of a patient progress note can be initiated by clicking on the "Attending Note" in the left side Menu in the patient Facesheet

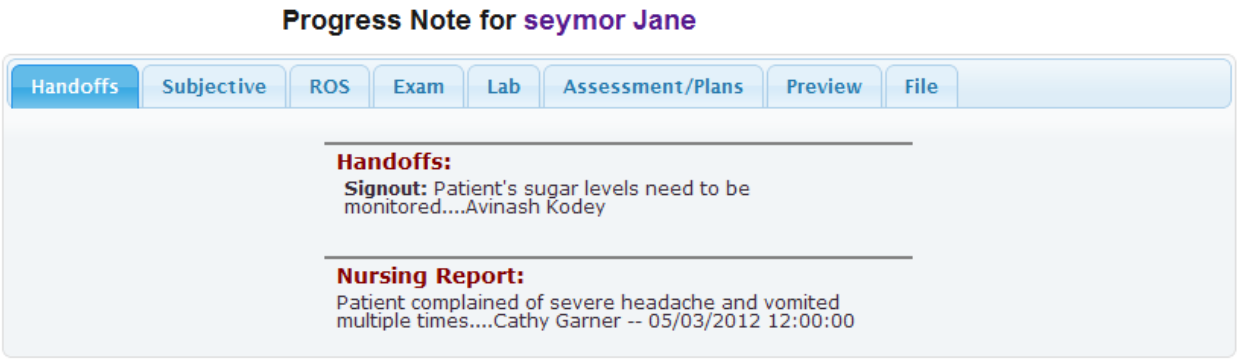


The medical staff is immediately prompted to select the date of patient encounter so that the progress note is recorded with that date.



Handoffs Tab

This first tab in the Progress Note will show the handoff note from the last attending physician or the member of the medical staff. It will also show the last documented nursing note. Users in a Nurse role have the ability to record such a note for all patients who are admitted into same facility as the one that the user belongs to. Please see "Creating User Account" for assigning various roles and facilities to users.

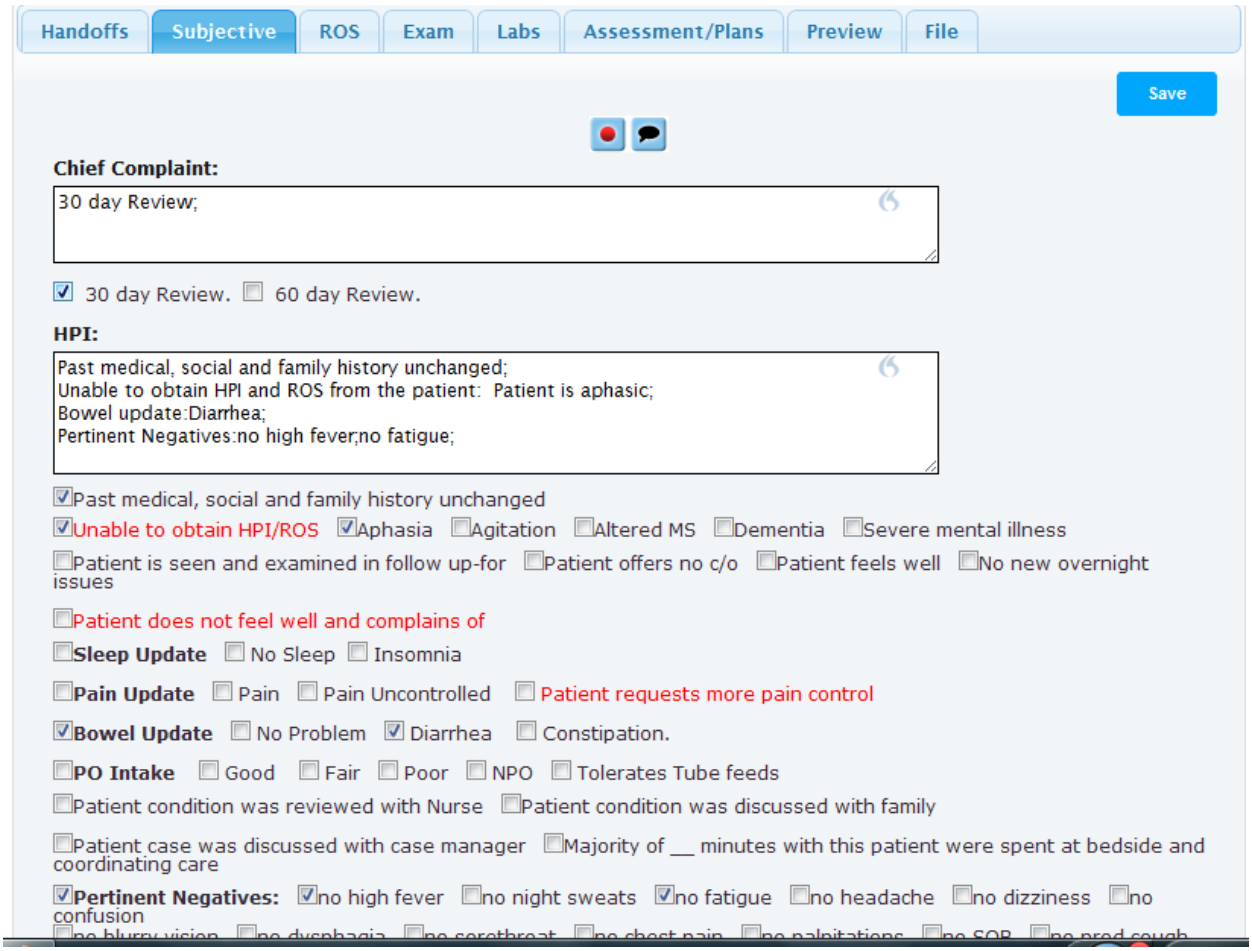


Subjective Tab

The next tab is where the medical staff can document subject notes. Users can use the buttons  if available on this page to record text through speech recognition in the subjective field marked with the symbol .

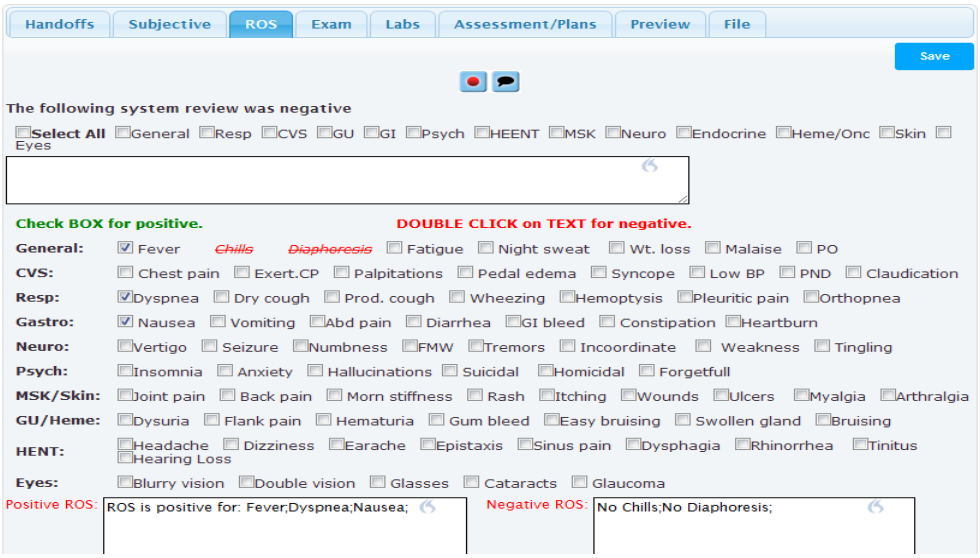
NOTE: User needs to have subscription to Speech Recognition service to use this capability. Please contact MDops Corporation to activate the speech recognition service.

The users also have the option to choose any of the listed options by clicking on each of them to populate them into the subjective field. Once you move to the next tab, the selected options or dictated text will automatically be saved till the note is filed.



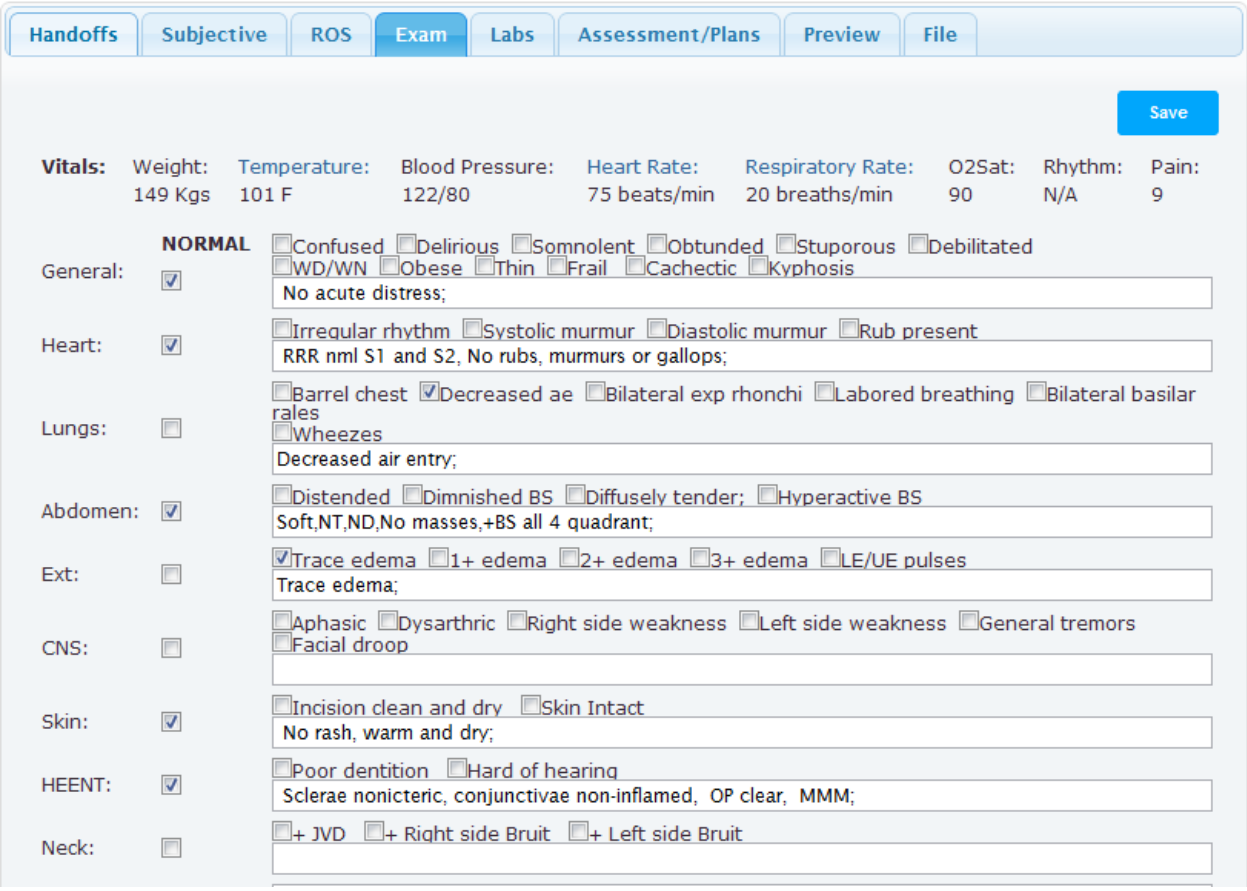
Review of Systems (ROS) Tab

The users can simply select listed options to be recorded as either Positive ROS or Negative ROS in the text boxes at the bottom of the page. Clicking on the check box will mark the option as Positive ROS and clicking on the text of the option will mark it as Negative ROS.



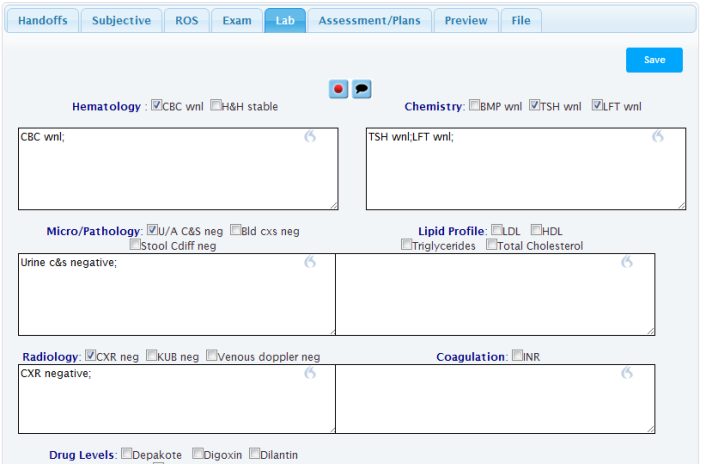
Physical Exam Tab

The Medical staff can view the last recorded vitals and document the results of the physical exam by simply clicking on the available options as depicted in the following image.



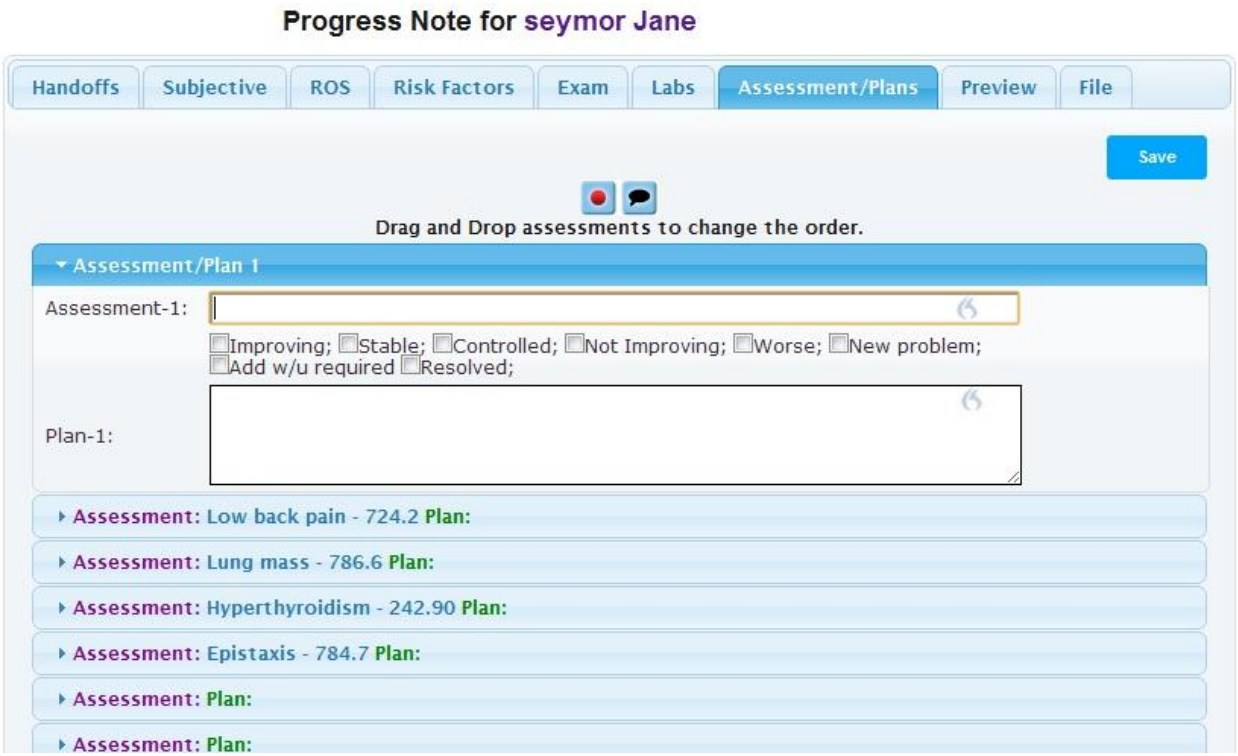
Labs Tab:

Since each Long Term and Post-Acute Care facility has its own arrangements with a laboratory services, this tab offers a simple interface for the medical staff to quickly record the abnormal values found in the lab test results into the application with few simple clicks.

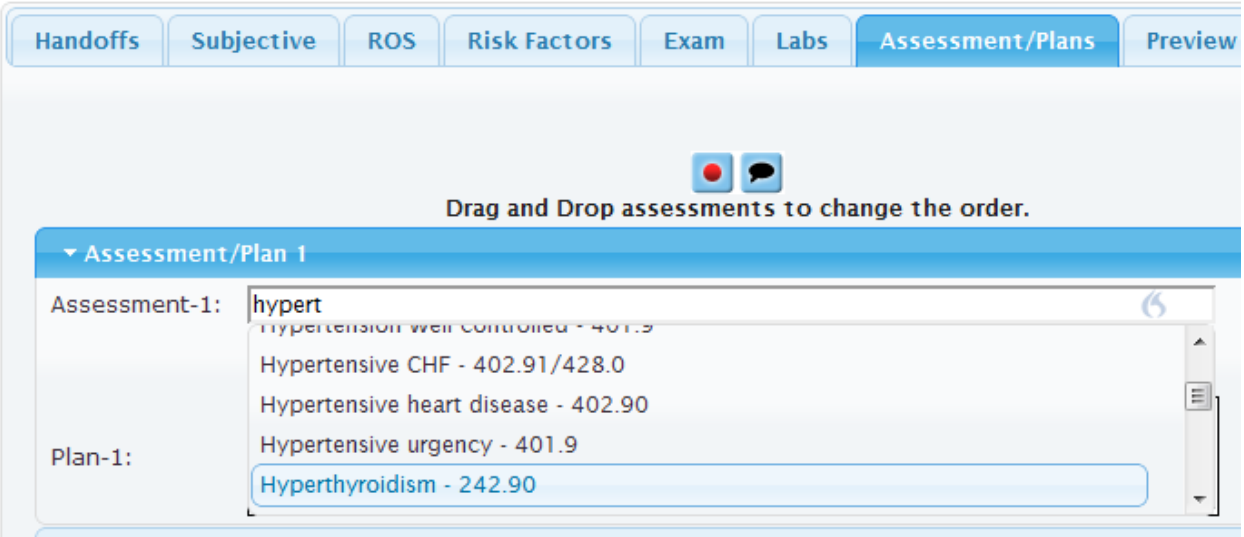


Assessment / Plans Tab

The Medical staff can review existing Assessment/Plans and if warranted record new ones in this tab. The users also have option of re-arranging the order of the Assessment/Plans to reflect their importance or acuteness by simply dragging each Assessment/Plan object into the appropriate slot in the list.

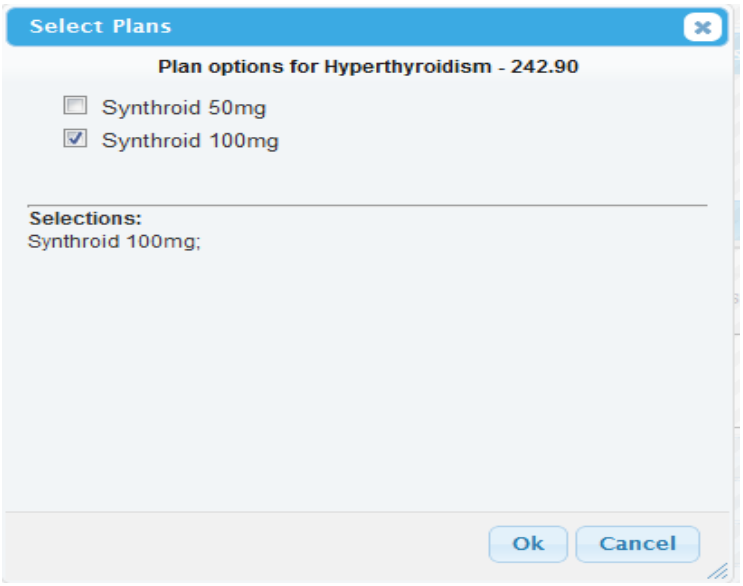


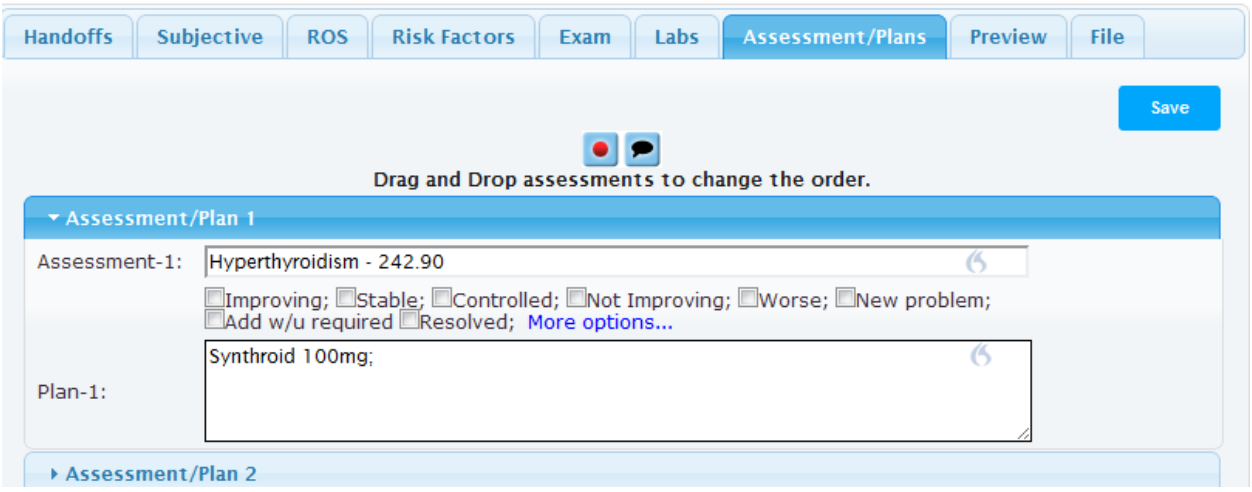
Recording New Assessment /Plan: The user can either type or dictate a custom Assessment or select from the standard ICD 9 Codes. As the user starts typing a string into the Assessment field, the application instantaneously uses it to search for the matching ICD 9 codes and presents the filtered list in a drop down fashion. The user can thus select from the list of the ICD9 codes without typing the whole code.



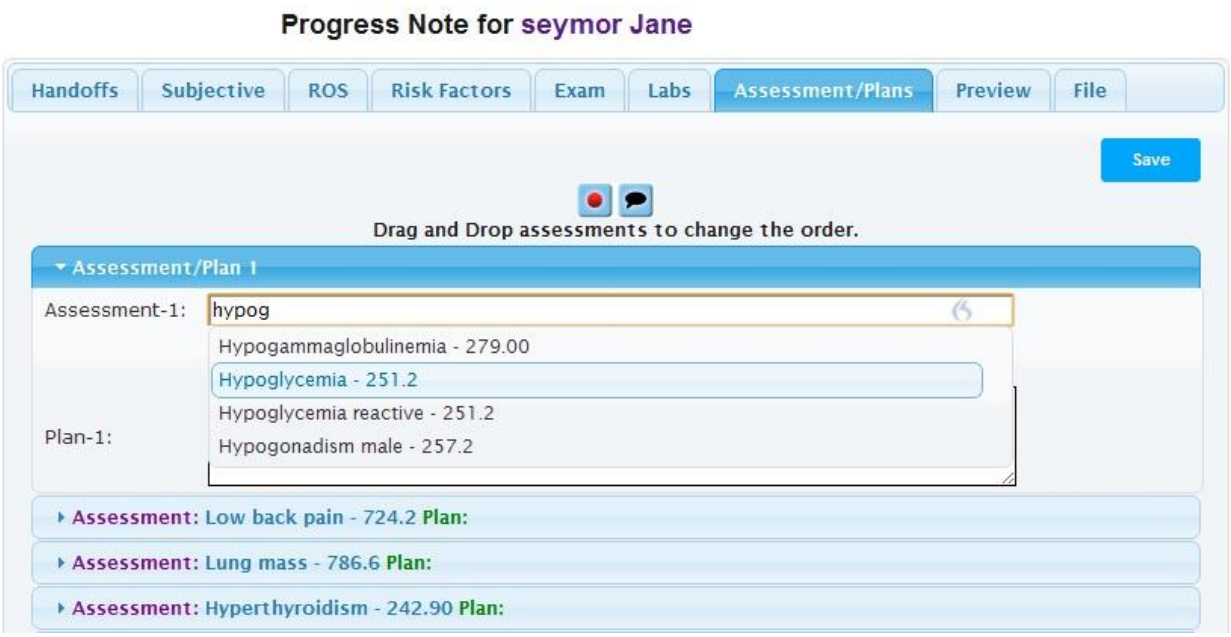
Once the ICD9 code is chosen, the user has the following options for documenting a plan for the new Assessment

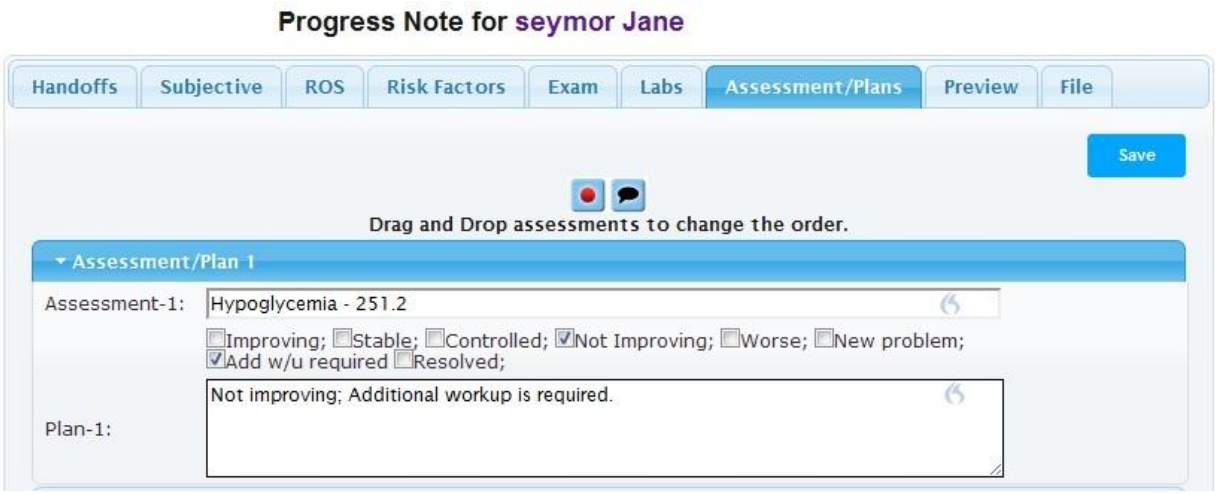
a. Select a custom Plan created by the user for that specific ICD 9 Code as shown in the following image. The chosen values in the custom plan will be populated into the Plan field. Please see “Create Custom Assessment Plan” on how medical staff members can create their own custom plans for various ICD 9 codes. It allows them to document the assessment and plans for most frequent conditions they are faced with in their patients.





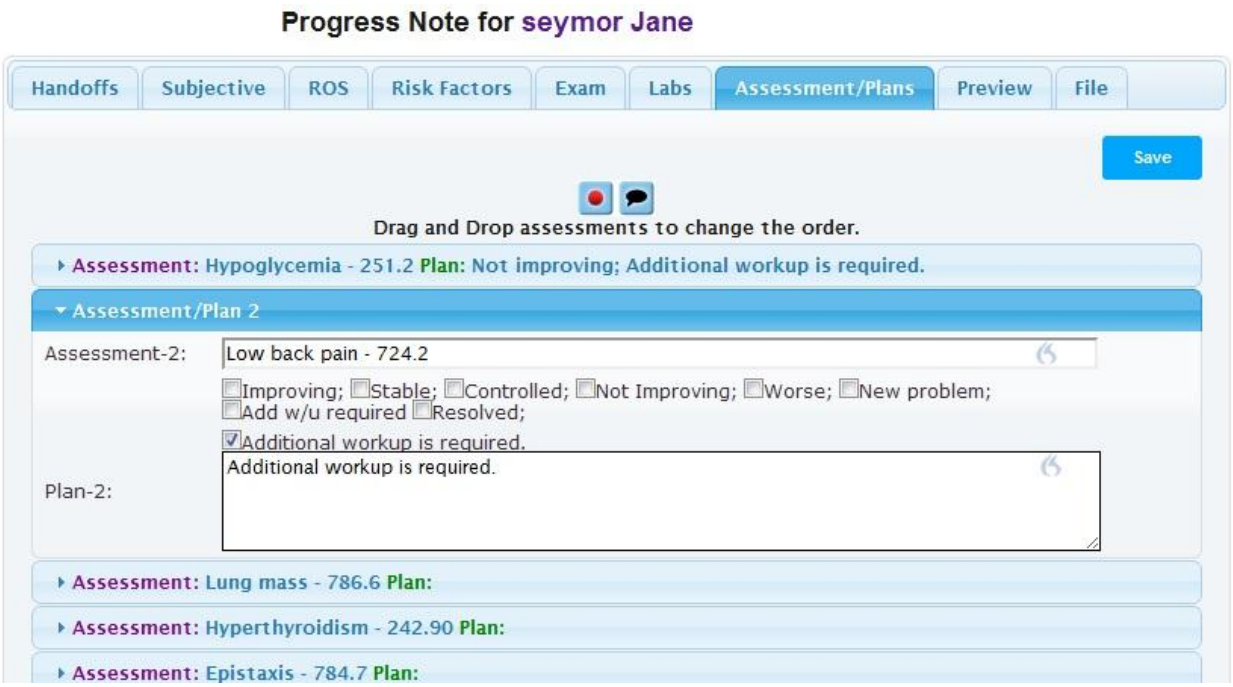
b. Click on the built-in options to populate them into the Plan field. Selecting the “Resolved” option marks the assessment as inactive and thus will be removed from patient’s active Problem list. So it will not appear for the medical staff when they are writing the next progress note.





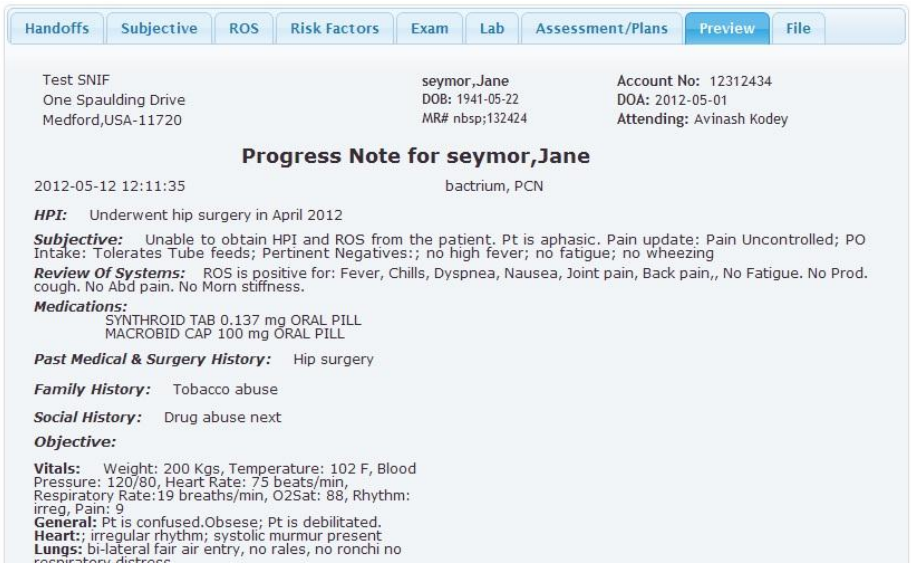
Updating Existing Assessment /Plan: Just like in the case of a new Assessment/Plan the user can click on the built-in options to populate them into the Plan field. Selecting the “Resolved” option marks the assessment as inactive and thus will be removed from patient’s active Problem list. So it will not appear for the medical staff when they are writing the next progress note.

The user can also simply click on the last Plan documented by the previous attending medical staff member to quickly continue it for the current note. The following image shows the user clicking on the last Plan (which appears on the top of the current Plan’s field) to continue with it as the current plan.



Preview Tab

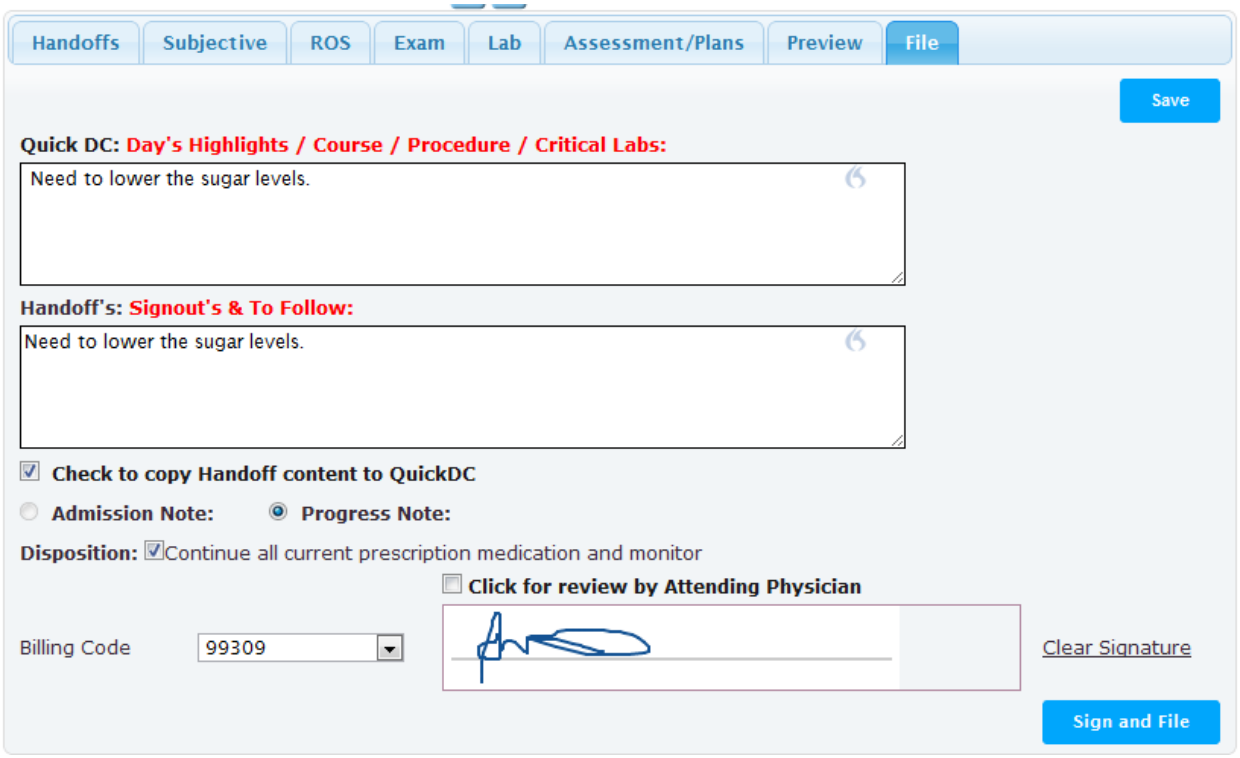
This tab shows the progress note preview so user can identify any errors or warranted changes that need addressing before finalizing the Progress Note.

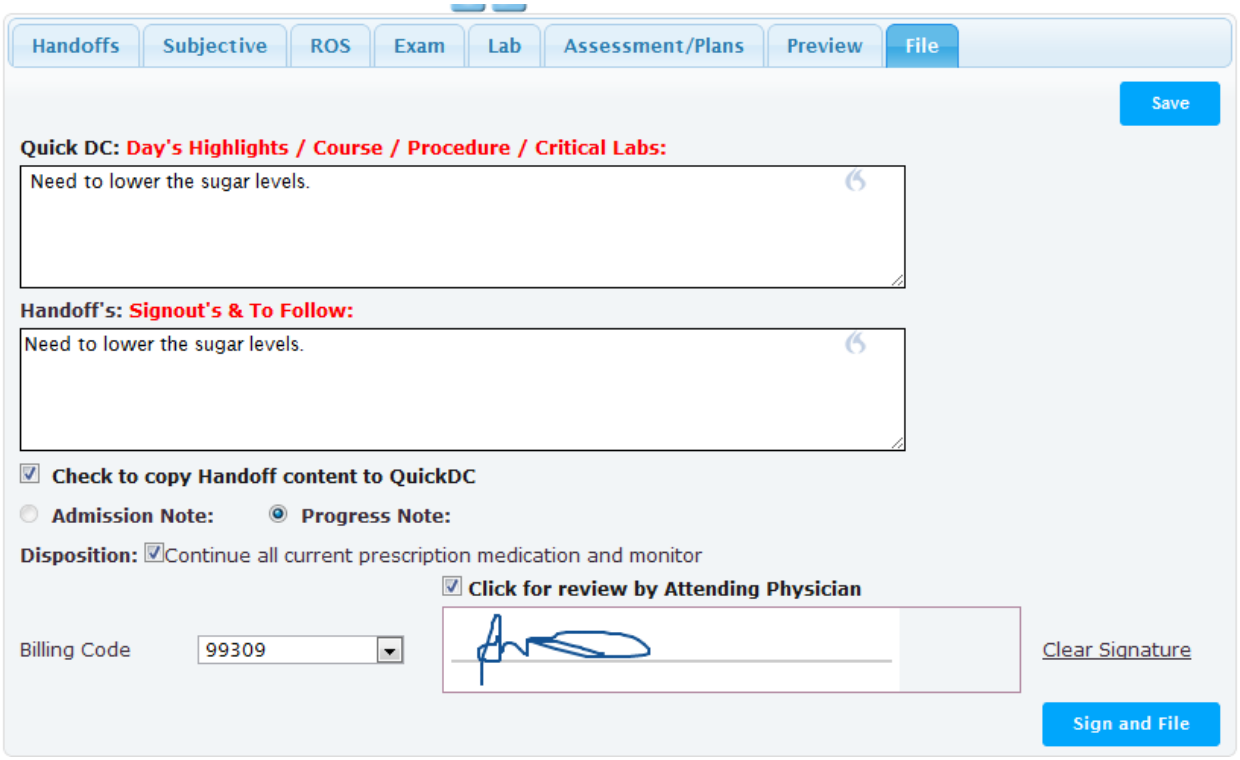


File Tab

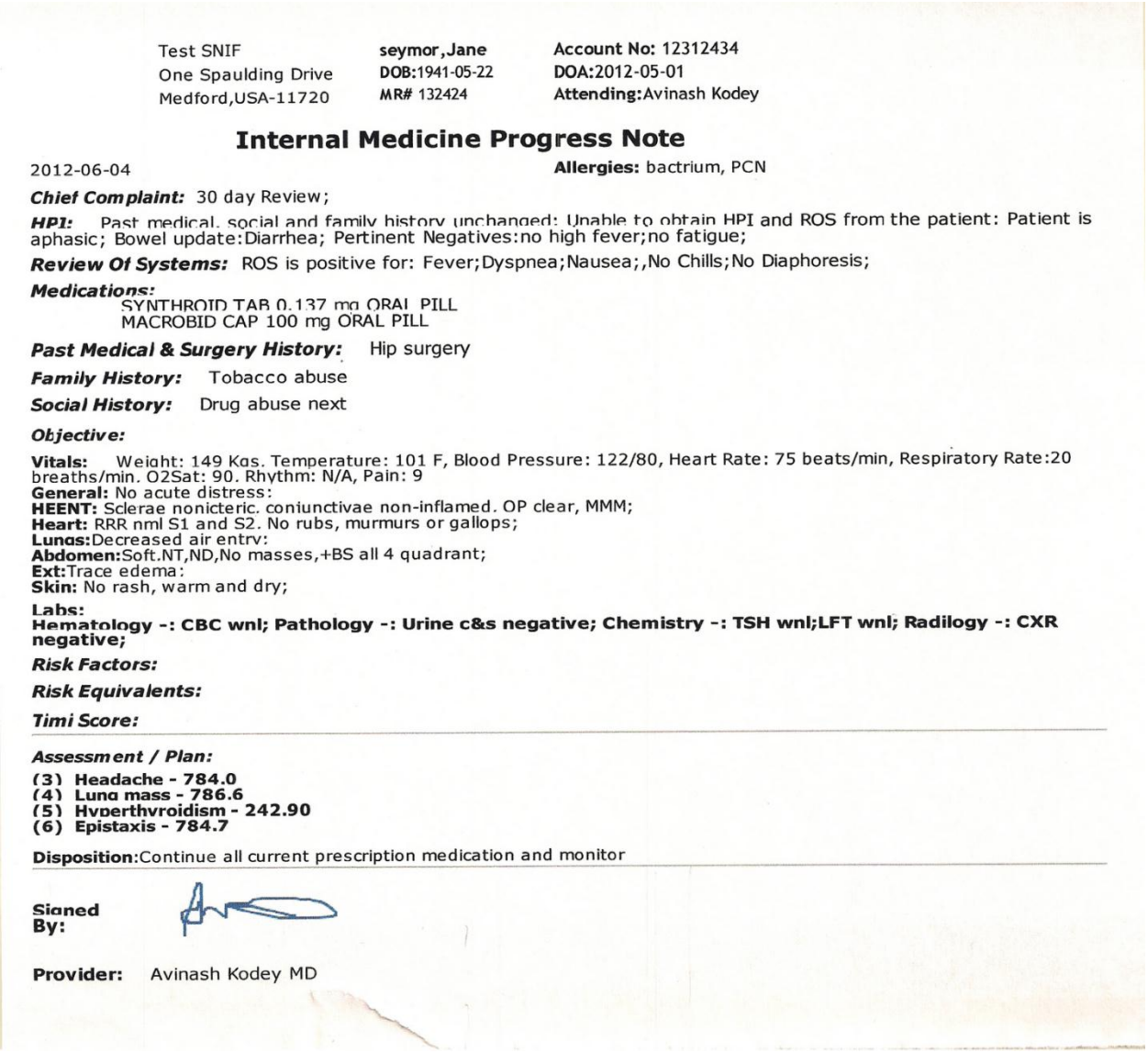
This tab lets users document the day's course, procedure, critical lab result or some other critical information as the Day's highlight. The application can thus offer medical staff a view of the chronological Hospital Course of a patient during the stay at the facility. It avoids medical staff from going through all the past progress notes to fully understand the patient history. It also allows the medical staff to provide a handoff note to the next attending staff member. The users can also select

their billing codes on this page to be filed as part of the progress note. The application makes this billing information available along with the encounter information to the billing manager instantaneously so that they can be mailed immediately to the Payers.





Once users click on the “Sign and File” they are offered the option to print the progress note in the format shown in the following image so that the hardcopy of the patient note can be handed to the facility for their records.



Test SNIF
One Spaulding Drive
Medford,USA-11720

seymor,Jane
DOB:1941-05-22
MR# 132424

Account No: 12312434
DOA:2012-05-01
Attending: Avinash Kodey

Internal Medicine Progress Note

2012-06-04

Allergies: bactrium, PCN

Chief Complaint: 30 day Review;

HPI: Past medical, social and family history unchanged: Unable to obtain HPI and ROS from the patient: Patient is aphasic; Bowel update:Diarrhea; Pertinent Negatives:no high fever;no fatigue;

Review Of Systems: ROS is positive for: Fever;Dyspnea;Nausea;,No Chills;No Diaphoresis;

Medications:
SYNTHROID TAB 0.137 mg ORAL PILL
MACROBID CAP 100 mg ORAL PILL

Past Medical & Surgery History: Hip surgery

Family History: Tobacco abuse

Social History: Drug abuse next

Objective:

Vitals: Weight: 149 Kgs. Temperature: 101 F, Blood Pressure: 122/80, Heart Rate: 75 beats/min, Respiratory Rate:20 breaths/min. O2Sat: 90. Rhythm: N/A, Pain: 9
General: No acute distress:
HEENT: Sclerae nonicteric. coniunctivae non-inflamed. OP clear, MMM;
Heart: RRR nml S1 and S2. No rubs, murmurs or gallops;
Lungs: Decreased air entry:
Abdomen: Soft.NT,ND,No masses,+BS all 4 quadrant;
Ext: Trace edema:
Skin: No rash, warm and dry;

Labs:
Hematology -: CBC wnl; Pathology -: Urine c&s negative; Chemistry -: TSH wnl;LFT wnl; Radilogy -: CXR negative;

Risk Factors:

Risk Equivalents:

Timi Score:

Assessment / Plan:
(3) Headache - 784.0
(4) Lung mass - 786.6
(5) Hyperthyroidism - 242.90
(6) Epistaxis - 784.7

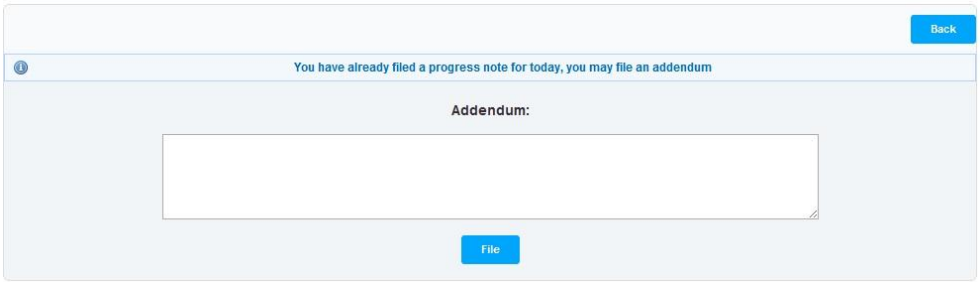
Disposition: Continue all current prescription medication and monitor

Signed By:

Provider: Avinash Kodey MD

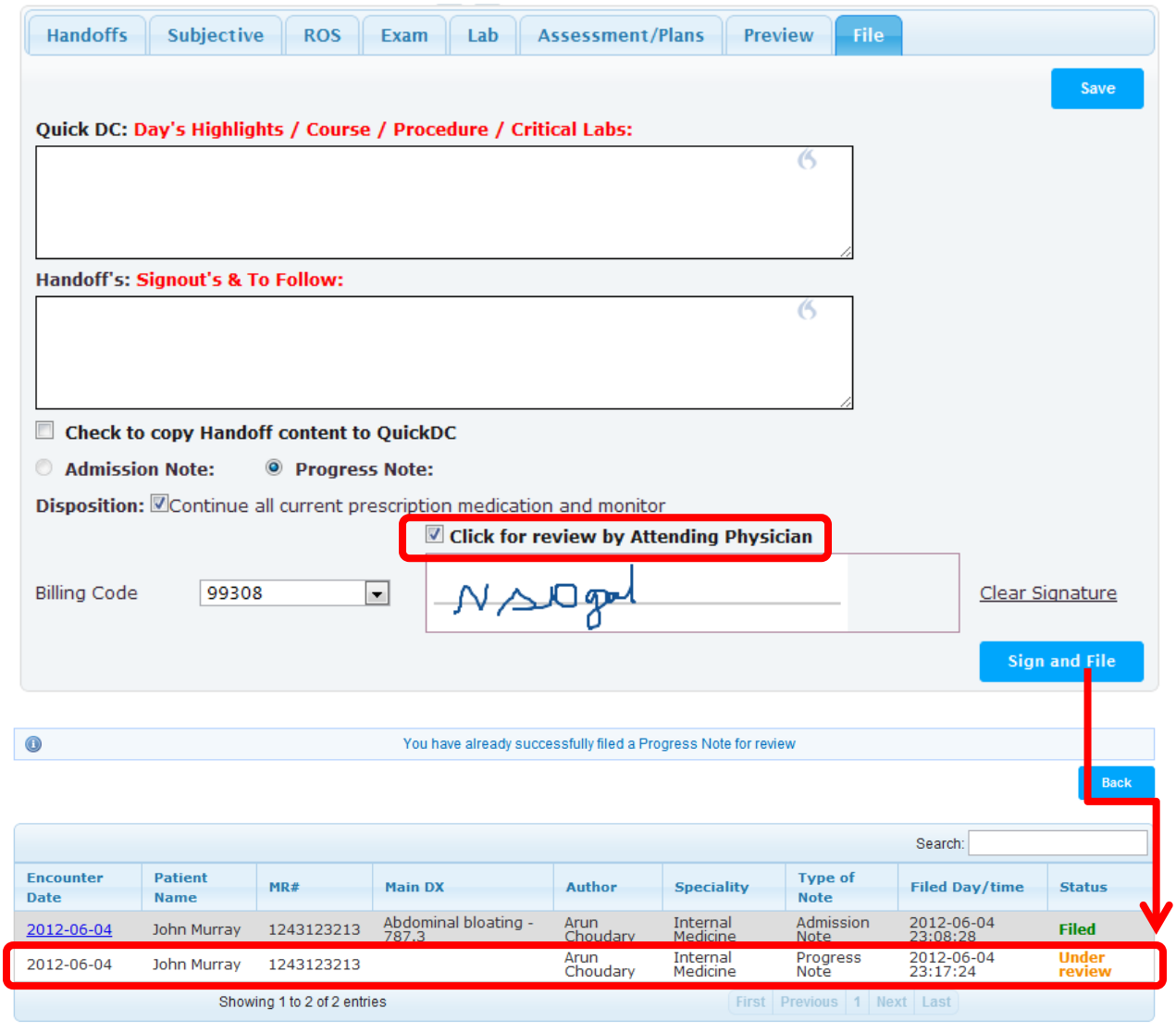
Addendum

Once the user clicks on the “Sign and File” the patient’s Progress note is filed and locked for the day. In case the users need to add any additional information to the Progress note after filing it, they have the option of adding an Addendum. They just have to click on the “Progress Note” link in the left side menu of the Patient’s Face sheet to add the addendum. MDlog does not allow a provider to file multiple progress notes for the same patient for a single day of care.

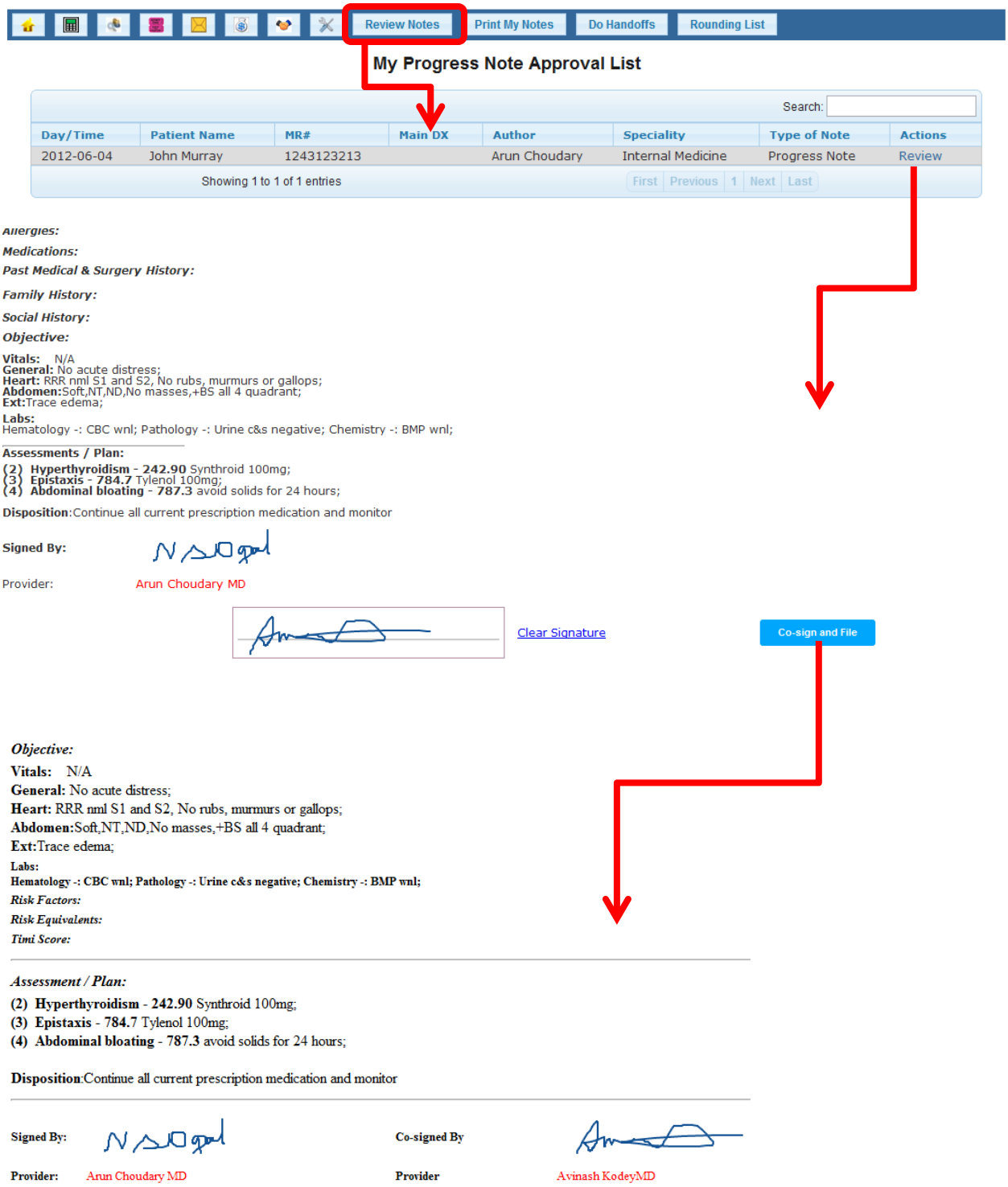


Review of Progress Note by Attending Physician

In cases where the medical staff needs their filed progress note to be reviewed by the attending physician as per the payer guidelines, they can choose the option “Click for review by Attending Physician” in the File tab of the progress note as shown in the following image to pass the progress note to attending physician for review.



The attending physician upon login into the application can click on “Review Notes” in the main menu bar to see the list of all progress notes for all facilities awaiting review. The physician can then select each entry to review the progress note and co-sign for it. The resulting progress note will have the signatures of attending physician and the medical staff member who requested the review. This filed progress note will appear as a billable activity of the attending physician in the billing portal.

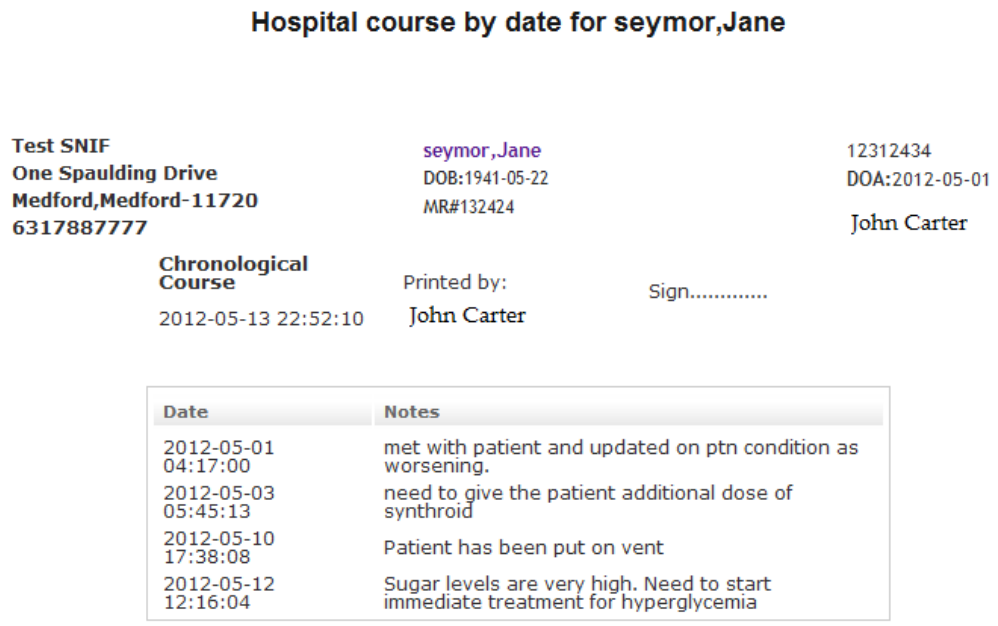


Handoffs

One member of the medical staff can pass pertinent medical information about the patient to next attending or covering member of the medical staff through the Handoff feature to ensure patient safety. The Handoff note will then be available in the Handoff tab in the progress note for the next attending or covering medical staff member when attempting to write a progress note for the patient. Review the Handoffs section for more detailed information.

Hospital Course

This link shows in chronological order the patients treatment highlights during the stay in the facility. It gives medical staff a quick view of the patient's progress without going through all the detailed progress notes.



Hospital course by date for seymor,Jane

Test SNIF
One Spaulding Drive
Medford,Medford-11720
6317887777

seymor,Jane
DOB:1941-05-22
MR#132424

12312434
DOA:2012-05-01
John Carter

Chronological Course
2012-05-13 22:52:10

Printed by:
John Carter

Sign.....

Date	Notes
2012-05-01 04:17:00	met with patient and updated on ptn condition as worsening.
2012-05-03 05:45:13	need to give the patient additional dose of synthroid
2012-05-10 17:38:08	Patient has been put on vent
2012-05-12 12:16:04	Sugar levels are very high. Need to start immediate treatment for hyperglycemia

Problem List

It shows patients Problem List. The list gets populated with assessments added in patients Progress Note in the Assessment/Plans tab. Both the Assessments in Assessment/Plans list and the problem list stay in synch. Moving any of the problems to inactive list will remove the corresponding Assessment from the Assessment/Plans Tab in the Patient progress note.

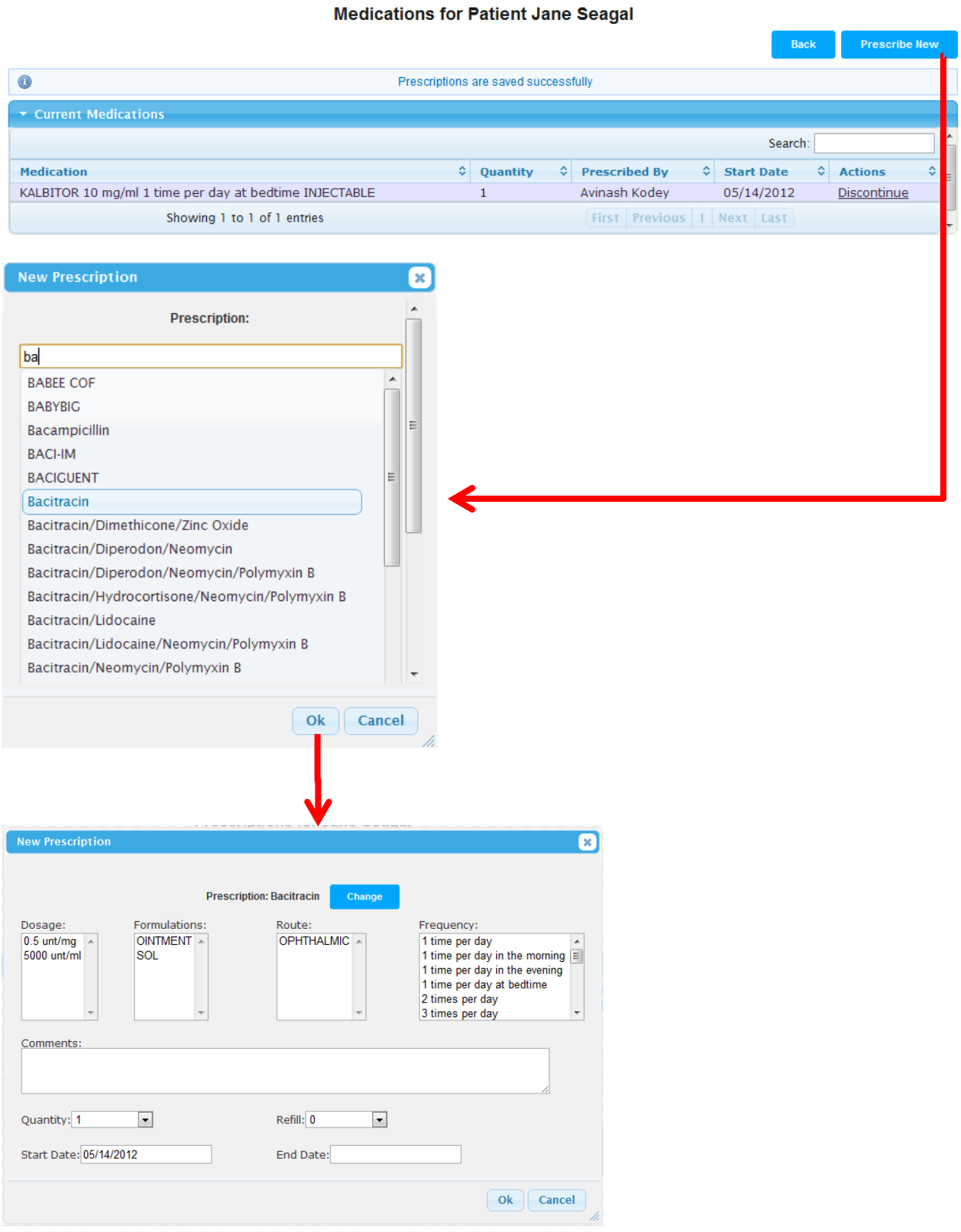
Past Notes

This provides list of patient's past progress notes including admission and discharge notes and they are listed in chronological order. Clicking on any of them will show that detailed progress note.

Prescription

This allows medical staff to prescribe medication to patients. The application allows medical staff to search for a specific medication and lets them choose the dosage, formulation, route, frequency and other relevant details and print a hard copy of prescription slip so facility staff can get the medication

from their preferred pharmacy and administer it to patient as prescribed. The following images show the steps to go through to prescribe medication to a patient



Discharge Summary

The medical staff can use this link to generate a patient's discharge summary for follow-up care. Since the discharge summary includes patient's progress note for the day of discharge, the application prompts user to file a patient progress note for generating the discharge summary. As part of generating the summary the medical staff is also prompted to provide the following information so it can be included in the discharge summary

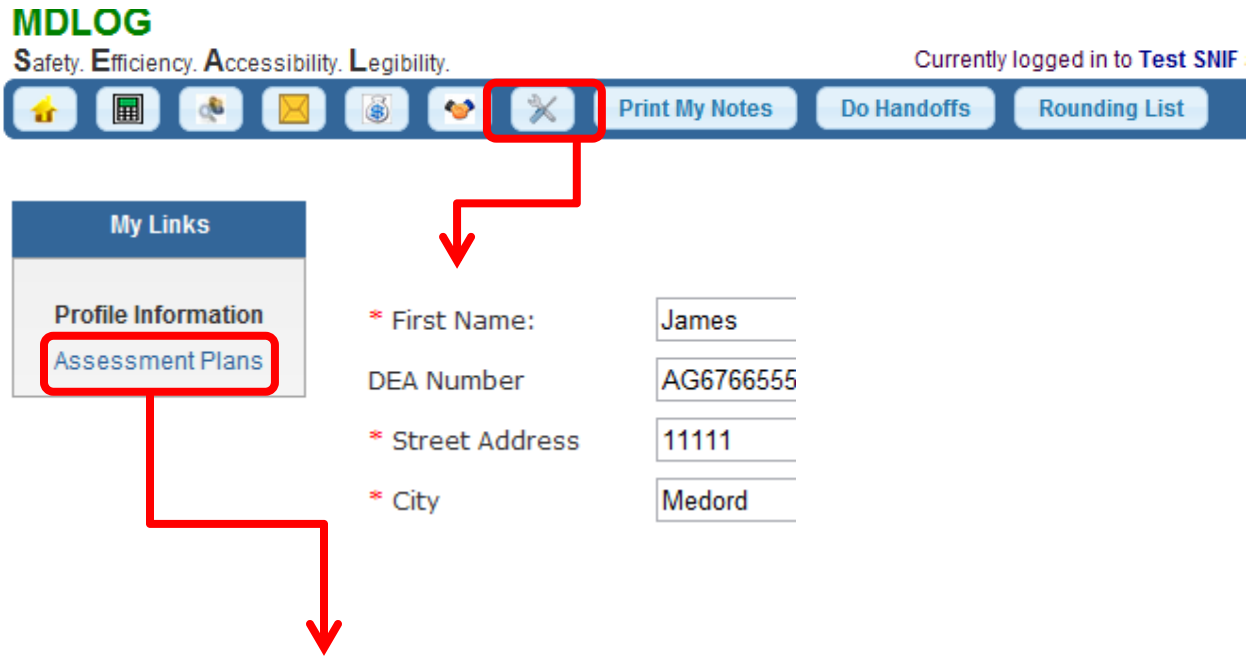
a. Discharge Diagnosis
b. Diet
c. Activity
d. Follow-up Instructions

Discharge Patient

It lets the medical staff discharge the patient. Once the patient is discharged, the patient is removed from the patient list. The discharged patients can be searched for through the search option available in the main menu bar.

Define Custom Assessment Plans

The medical staff has the option to define custom Plans for various ICD9 based Assessments. This allows the medical staff to quickly document patient's Progress Notes by simply selecting those custom Plans with a click for the most frequent Assessments. Multiple custom plans can be defined for each Assessment, in which case the user can select one or multiple of the custom Plans defined for the Assessment while documenting the Assessment/Plans in the patient's Progress Note. The following sequence of images will show how to define custom Plans. Refer to "Documenting Patient's Progress (SOAP) Notes" to see how the custom Plans appear during the documenting of the Progress Note.



Add New Assessment Plan

* Speciality: Internal Medicine

* Assessment: --Select--

* Plan:

Save Cancel

Assessment Plans

Search:

Assessment	Plan	Date Created	Actions
Hyperthyroidism - 242.90	synthroid .333mg	05/01/2012	Delete
Hypoglycemia - 251.2	Monitor sugar levels	05/01/2012	Delete
Hypoglycemia - 251.2	low carb diet	05/01/2012	Delete

Showing 1 to 3 of 3 entries First Previous 1 Next Last

Add New Assessment Plan

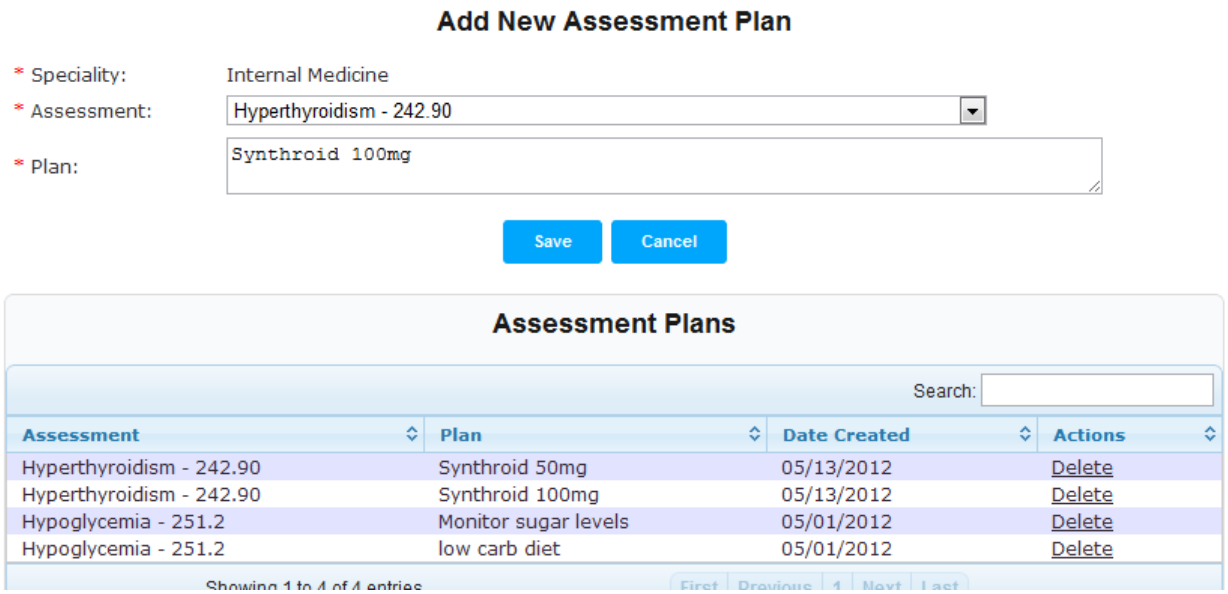
* Speciality: Internal Medicine

* Assessment: Hyperthyroidism - 242.90

* Plan:

Hypersomnia - 780.54
Hypertension - 401.9
Hypertension uncontrolled - 401.9
Hypertension well controlled - 401.9
Hypertensive CHF - 402.91/428.0
Hypertensive heart disease - 402.90
Hypertensive urgency - 401.9
Hyperthyroidism - 242.90
Hyperthyroidism subclinical - 242.90
Hypertriglyceridemia - 272.1
Hypertrophic scar - 701.4
Hypertrophy of adenoid - 474.12
Hypertrophy of nasal turbinates - 478.0
Hypertrophy of tonsil - 474.11
Hypertrophy of tonsil and adenoid - 474.10
Hypertropia - 378.31
Hyperuricemia - 790.6
Hypervolemia - 276.69
Hypoalbuminemia - 273.8
Hypocalcemia - 275.41
Hypoesthesia - 782.0

Assessment
Hypoglycemia - 251.2
Hypoglycemia - 251.2

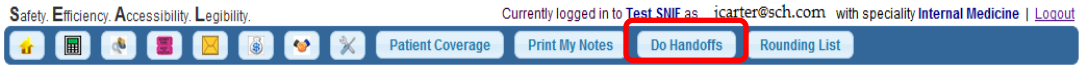


NOTE: The custom Assessment Plans are shared by all the members of the medical staff. So any new custom Plans or updates to an existing custom Plan will be immediately available to all the other members of the medical changes.

Handoffs and Nursing Notes

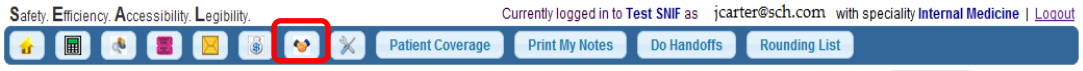
One member of the medical staff can pass pertinent medical information about the patient to next attending or covering member of the medical staff through the Handoff feature to ensure safe transfer of patient care. Similarly a user belong to a Nursing Role can login and add a nursing note for a patient. The Handoff and Nursing notes will be available in the Handoff tab in the progress note for the next attending or covering medical staff member when attempting to write a progress note for the patient. The medical staff has multiple ways of writing Handoff notes.

a. Write Handoff notes for multiple patients from a single screen. It is accessible through “Do Handoffs” Button on the main menu bar



b. Write the note in the Handoff field in the “File” tab of the patient’s Progress note
c. Use “Handoff” link in the left menu of the Patient Facesheet

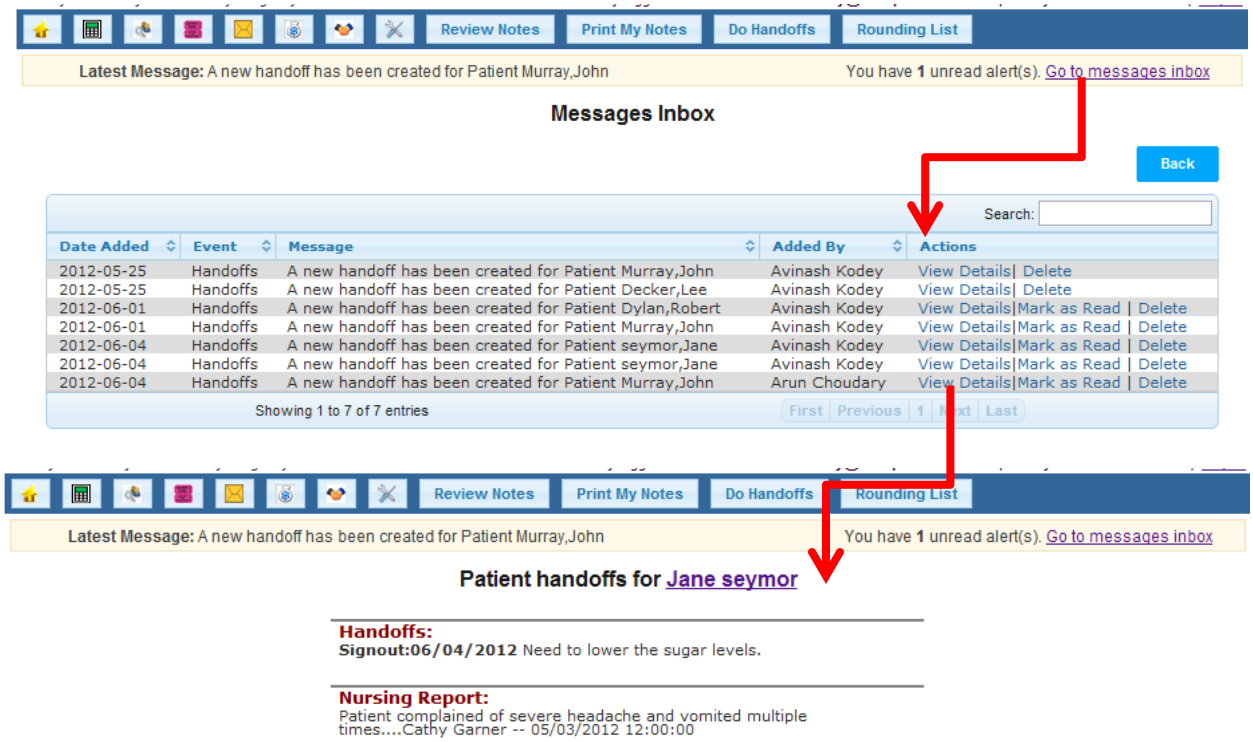
The medical staff can check the Handoff notes they have written for the day or the day before of for a specific date through the highlighted link in the main menu bar as shown below



Handoff Notifications

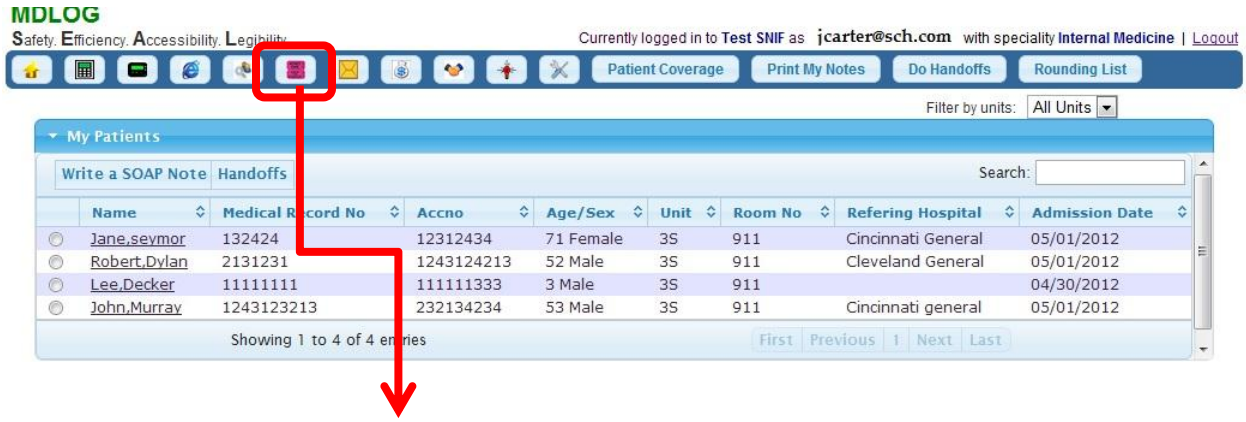
Once a handoff note or a nursing note is created by a medical staff member or a nurse respectively, all medical staff members get notification through an inbox below the mail menu bar when they login into

the facility where the patient is admitted. Clicking on the inbox shows the list of all outstanding patient handoffs or nursing notes for that facility. Once they have reviewed the handoff and the nursing notes, the users can mark them as either read or unread. They can also delete them in which case the deleted notifications will stop appearing in the inbox.



Patient Admission

To create a patient entry in the application, click on the "Admit Patient" button as indicated in the following image. It will start the patient admission process that will let user capture patients demographic, Insurance and other admitting details including medically relevant information. Any field marked with " * " is a mandatory field. The flow of the admission process is indicated by the sequence of screen shots shown below.



Admit New Patient

Step-1 Patient Identification | Step-2 Demographics Information | Step-3 Insurance Information | Step-4 Choices | Step-4 Visit Information

Patient Identification

Please enter an accurate Medical Record Number. This is a critical step for identification of this patient.

* Medical Record No: Numeric digits only	12344431	* Account No:	34254356	* Date of Admission	05/12/2012
* Last name:	Seagal	Middle Initial		* First name:	Jane
* Sex:	Female	* Date Of Birth	05/20/1953	MaritalStatus:	Widowed
* Attending:	John Weisman	* Unit:	3S	Room No:	911
Social Security No:	123-45-6789				

Next >

Admit New Patient

Step-1 Patient Identification | **Step-2** Demographics Information | Step-3 Insurance Information | Step-4 Choices | Step-4 Visit Information

Demographics Information

* Medical Record No:	12344431	* Account No:	34254356		
Address	76 Marwin Lane				
City	St Louis	State	ME		
Country	USA	Zipcode	76876		
Home Phone Number	(876)876-8686	Cell Phone Number	(768)768-7686	Work Phone Number	
Email Address		Emergency Contact	Tom Seagal	Emergency Phone Number	(899)798-7978

< Back | Next >

Admit New Patient

Step-1 Patient Identification | Step-2 Demographics Information | **Step-3** Insurance Information | Step-4 Choices | Step-4 Visit Information

Insurance Information

Primary Insurance Provider:	Anthem Blue Cross and Blue Shield				
Plan Name:	PPO1	Effective Date:	05/03/2012		
Policy Number:	12345255	Group Number:	S65436543		
Copay:	30	Accept Assignment:	YES		
Subscriber Name:	Tom Seagal	Relationship:	Spouse	Sex:	Male
Subscriber D.O.B:	04/16/1952	Subscriber SSN:	234-56-7890		
Subscriber Address:	34 carlisle way	City:	St Louis	Zipcode:	98798
State:	ME	Country:	USA		
Subscriber Employer:	PGA Corp	Subscriber Phone Number:	(789)797-9878		

< Back | Next >

Admit New Patient

Step-1 Patient Identification | Step-2 Demographics Information | Step-3 Insurance Information | **Step-4** Choices | Step-4 Visit Information

Choices

PCP:	John Morrison		
Pharmacy:	CVS, 11 Horsblock Rd, St Louis, 98090 ME		
HIPPA Notice Received:	Yes	Allow Email Communication:	Yes

< Back | Next >

Admit New Patient

Step-1 Patient Identification | Step-2 Demographics Information | Step-3 Insurance Information | Step-4 Choices | **Step-4 Visit Information**

Visit Information

Refering MD: John Morrison

Refering Hospital: St Louis General

Code Status: Full Code

Allergy: Penicillin, Bacterium

Primary Diagnosis: Dementia

Comorbid Diagnosis: Diabetes

< Back | Admit

Patient Seagal Jane has been succesfully admitted.

Edit Medical History for Patient Jane Seagal

* Code Status: Full Code

* Brief HPI: Patient has been diagnosed with dementia 9 months back. Has undergone treatment at St Louis general

* Allergy: Penicillin, Bacterium

* Primary Diagnosis: Dementia

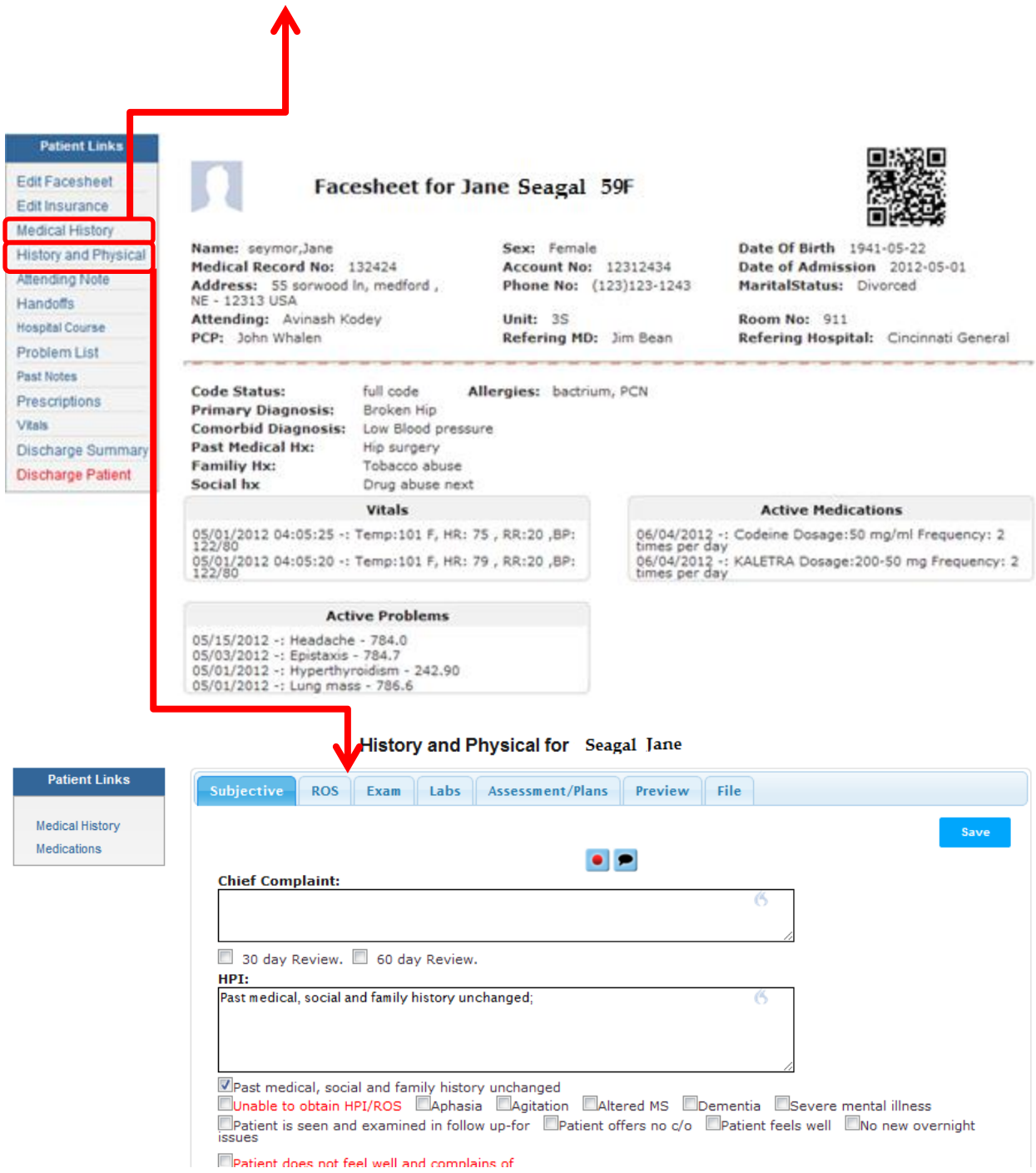
* Past Medical/Surgical Hx: Broken Hip Surgery

* Social History: Drug Abuse

* Family History: Diabates

* Precautions:

Update | Cancel



If the admitting person is not a part of the medical staff, then the medical information of the admitted patient can be captured after the admission. The assigned physician can choose the following links in the left side menu in patient's Facesheet for documenting specified details

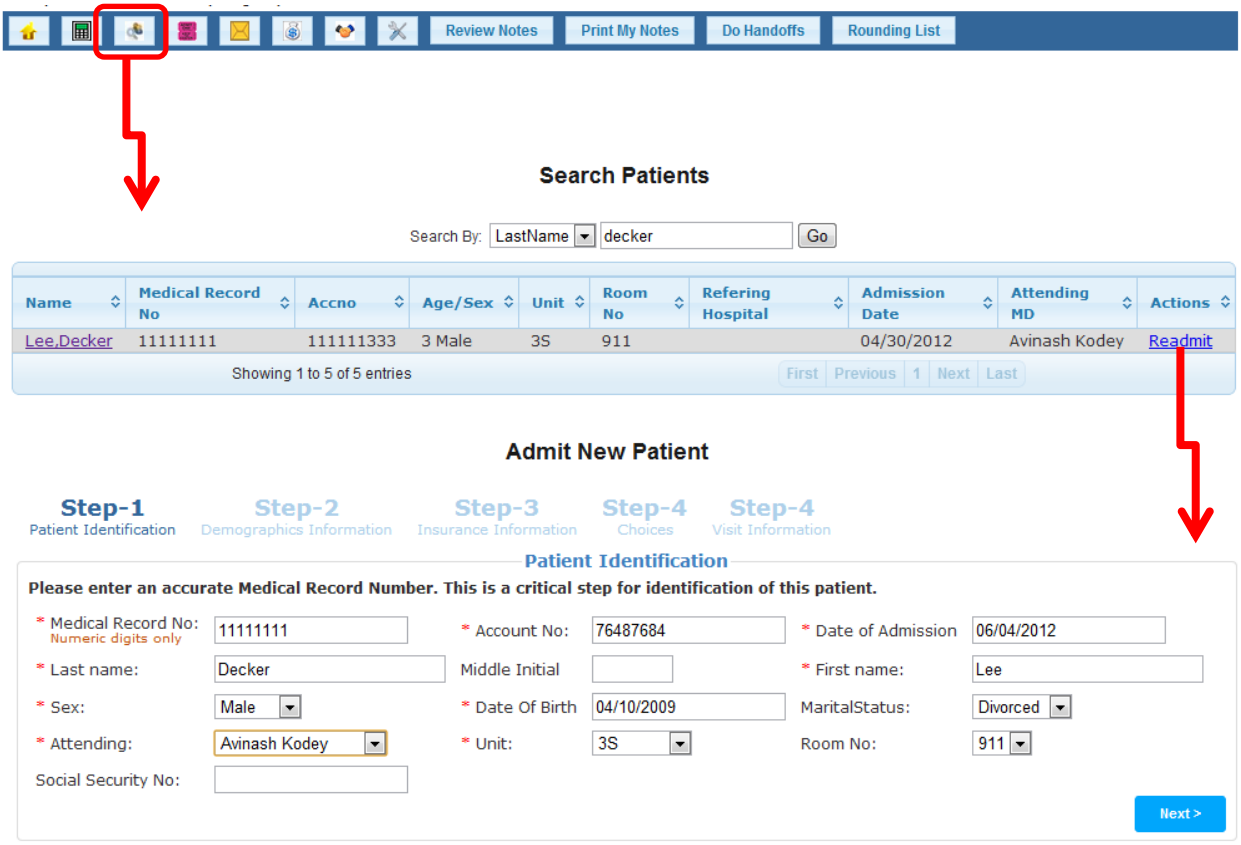
d. **Edit Face Sheet**: Link can be used to update any details recorded during the admission
e. **Medical History**: Link can be used to update patients medical information captured during the admission process
f. **History and Physical**: For documenting a full admission note in the form of SOAP note. It will be marked as "Admission Note" in patients Past notes.

Users can use the buttons  if available on any application page to record text through speech recognition in the fields marked with the symbol .

NOTE: User needs to have subscription to Speech Recognition service to use this capability. Please contact MDops Corporation to activate the speech recognition service.

Patient Re-Admission

When re-admitting a discharged patient, it is not required to re-enter the patient demographic information. The discharged patient record can be searched by the last name through the link on the main menu bar as indicated in the image below.



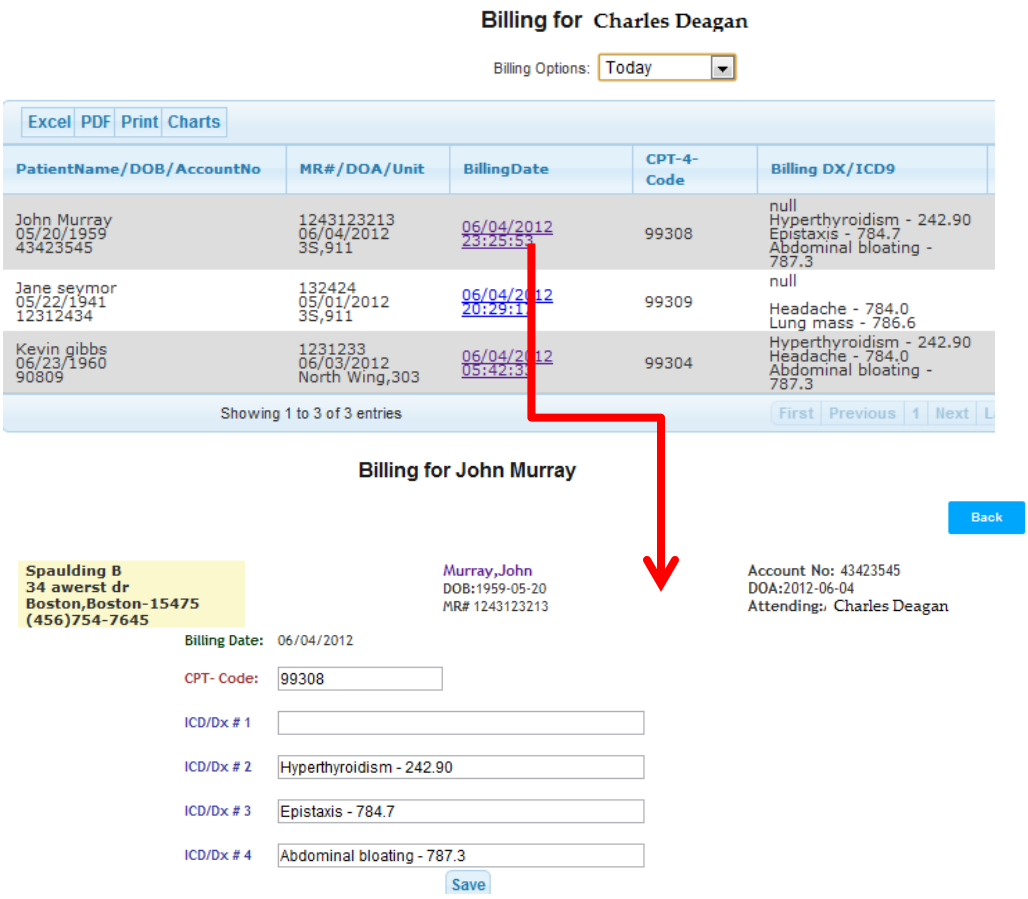
In the resulting “Admit New Patient” page, the patient will have to be assigned new values for the following fields

1. Account No
2. Marital Status
3. Attending (Physician)
4. Unit
5. Room No

The remaining fields in this admission process are pre-populated with the information recorded during patient's last stay at the facility. This allows the re-admission process to complete much faster.

Billing Portal

A user with the Accounting role has access to all the billable encounters of all the medical staff for the facility. Upon login such user will see the list of all medical staff members and for each of them the user can see the billable encounters for the day or last 7 or 14 days. The user even has the option to see billable encounters for a custom period. Each encounter entry contains patient's key identification, billing code (CPT code) and the Assessments with the ICD 9 codes. The encounter list of each provider can be either exported into an excel spreadsheet or PDF format or printed. The user can also do analysis billing analysis by creating charts of the billing codes used by the provider.



Application Administration

Customers are recommended to assign one person in their group to administer the application.

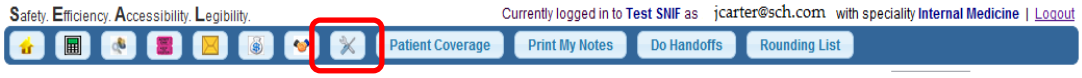
Initial Setup

The application offers the following administrative functionality and requires that they be performed as part of the initial setup in the order listed

a. Define the PCP group

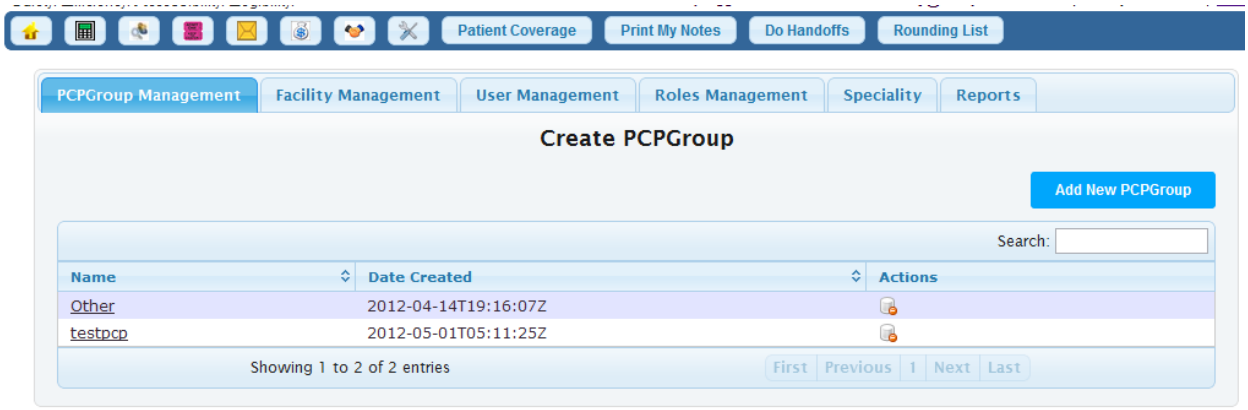
b. Define facilities that the medical staff attends to
c. Define the units and rooms for each facility so that new patients can be assigned the location
d. Define Billing codes for each facility so medical staff can assign billing code for every patient note that they file
e. Create User accounts including those of medical staff

All these administrative functions can be accessed through the highlighted button on the Main Menu Bar as shown in the following image



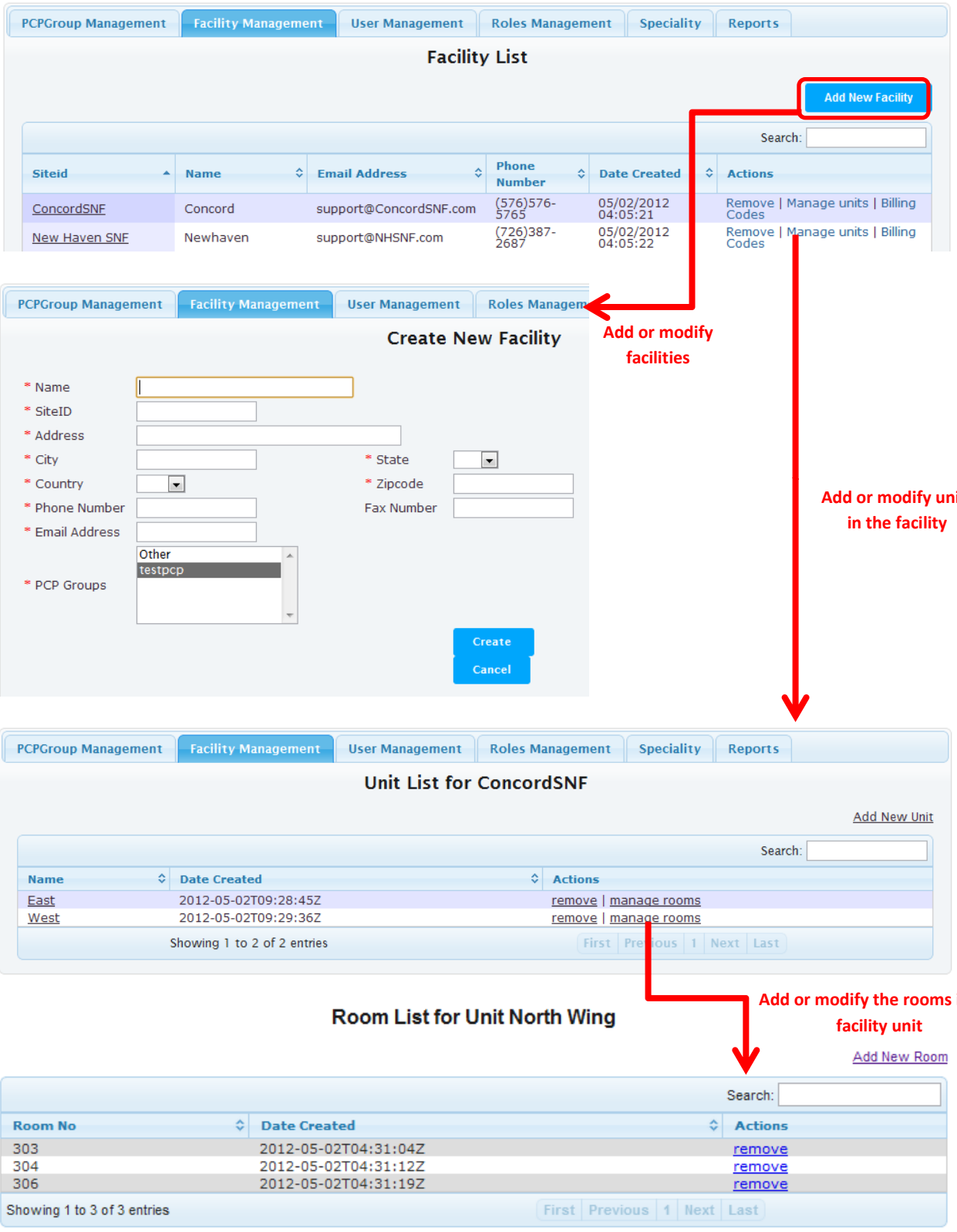
Define PCP Group

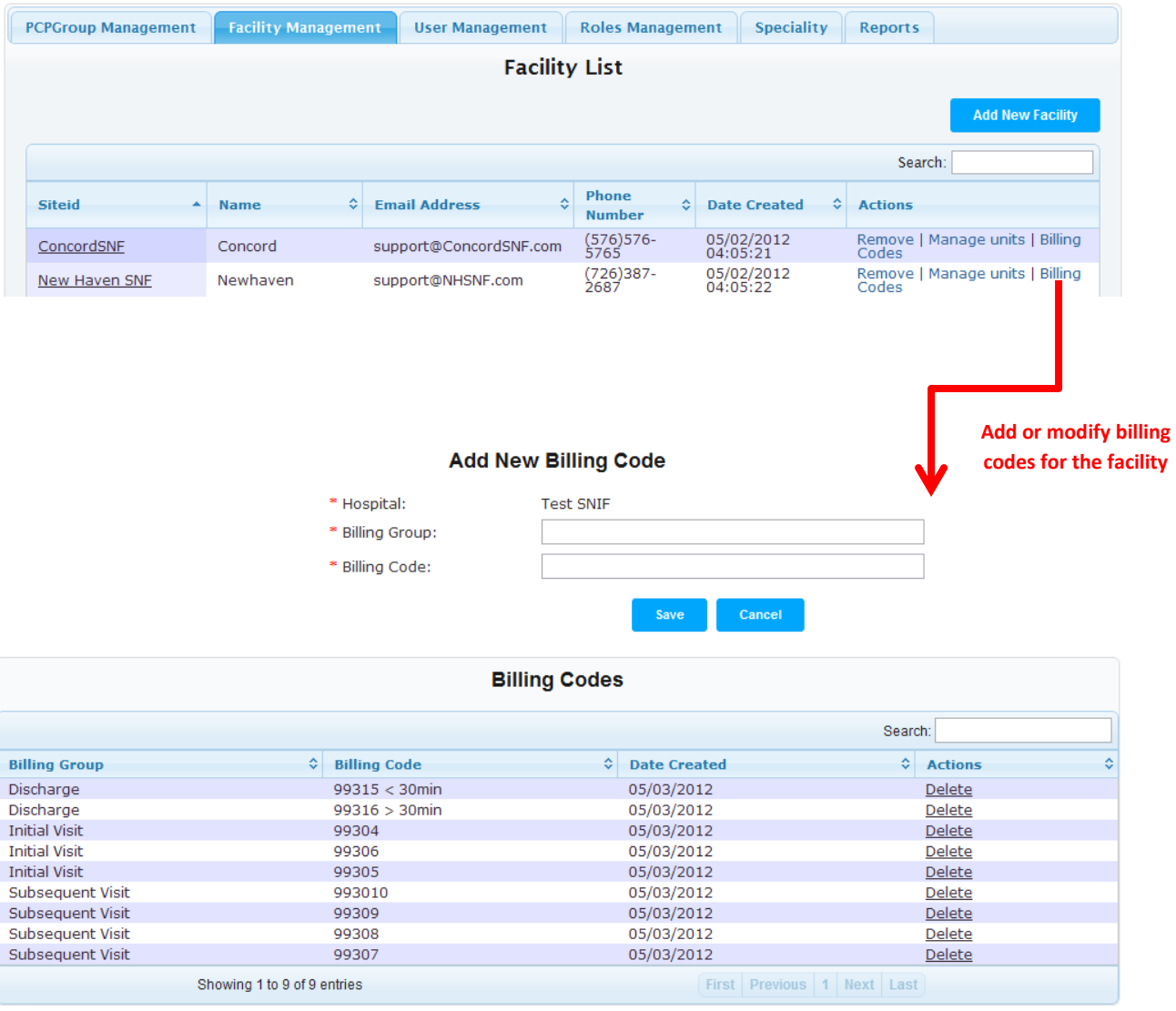
This allows administrator to define the customers Practice name by clicking “Add New PCP group”



Facility Management

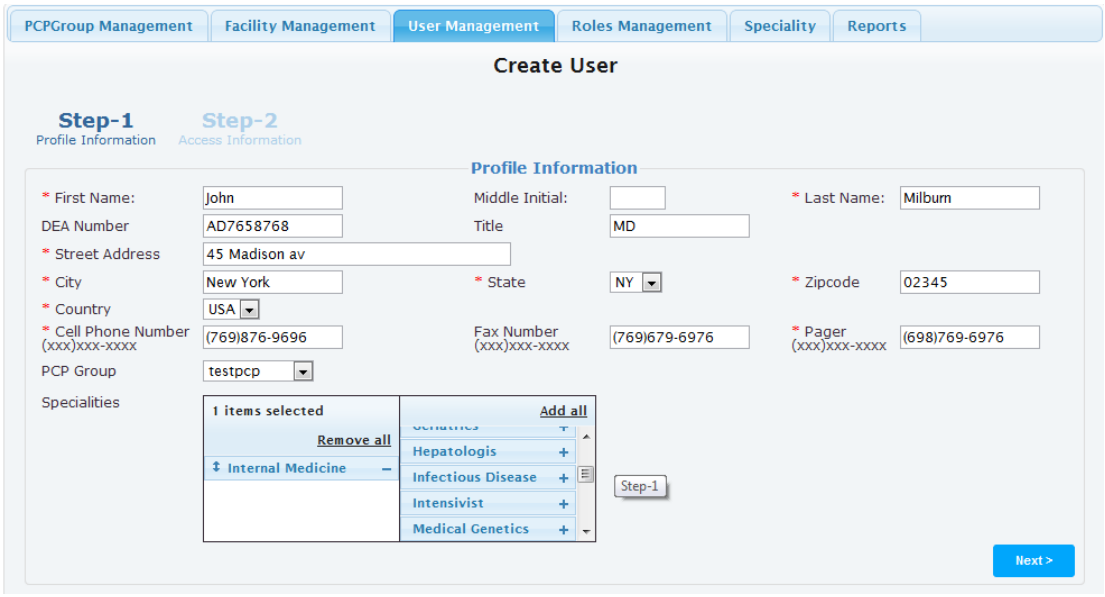
It lets an administrator define all the facilities that the medical staff attends. Additionally it can define the units and corresponding room numbers. Once defined, the units and the room # assigned to a patient in a facility can be recorded in the patient record so that the medical staff can easily locate the patient and complete their rounds faster. For each facility the administrator needs to define billing codes so they can be used by medical staff while filing patient notes. The accounts manager of the group responsible for submitting claims to payers can then gather the billing codes along with encounter information and include them in those claims.

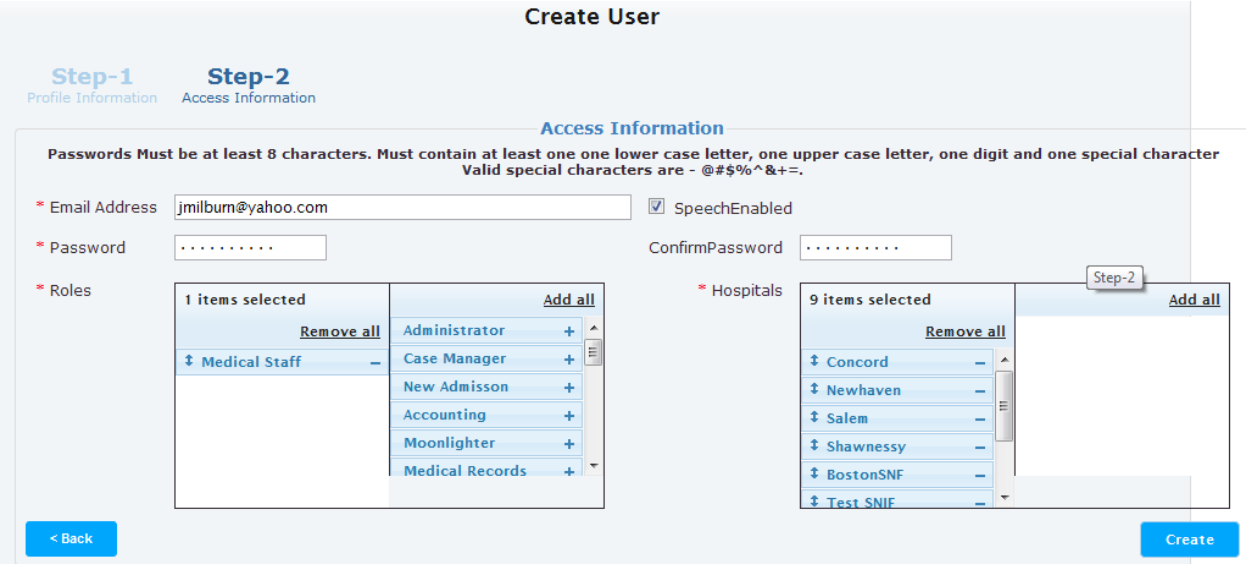

PCPGroup Management
Facility Management
User Management
Roles Management
Speciality
Reports
Facility List
Add New Facility
Search:
Siteid
Name
Email Address
Phone Number
Date Created
Actions
ConcordSNF
Concord
support@ConcordSNF.com
(576)576-5765
05/02/2012 04:05:21
Remove | Manage units | Billing Codes
New Haven SNF
Newhaven
support@NHSNF.com
(726)387-2687
05/02/2012 04:05:22
Remove | Manage units | Billing Codes
Add or modify facilities
Create New Facility
* Name
* SiteID
* Address
* City
* State
* Country
* Zipcode
* Phone Number
Fax Number
* Email Address
* PCP Groups
Other
testpcp
Create
Cancel
Add or modify units in the facility
Unit List for ConcordSNF
Add New Unit
Search:
Name
Date Created
Actions
East
2012-05-02T09:28:45Z
remove | manage rooms
West
2012-05-02T09:29:36Z
remove | manage rooms
Showing 1 to 2 of 2 entries
First
Previous
1
Next
Last
Add or modify the rooms in the facility unit
Room List for Unit North Wing
Add New Room
Search:
Room No
Date Created
Actions
303
2012-05-02T04:31:04Z
remove
304
2012-05-02T04:31:12Z
remove
306
2012-05-02T04:31:19Z
remove
Showing 1 to 3 of 3 entries
First
Previous
1
Next
Last



User Management

The administrator creates users and records their key information including the DEA number in case of medical staff. In addition the user needs to be assigned the specialty (in case of medical staff), the role and the facilities/Hospitals that attend to. The administrator is required to assign temporary password to the user. So the users are prompted to reset the password when they login with the temporary password for the first time.





The Roles

The different roles offered by the application offer different level of access to the users. So based on their assigned roles users will have access to different functionality of the application. The following are the primary roles available with the key functionality accessible by each of them

Role	Functionality Available
Medical Staff	Ability to document and access Patient's medical information
New Admission	Ability to record and view patients demographic, insurance and other information that can be recorded at the time of patient admission
Nurse	Record Patient's Vitals and submit Nursing notes for patients
Accounting	Access to the encounter information along with the billing code of all filed

	patient notes
Administrator	Access to Administration module and Reports
Medical Records Administrator	Read access to all the filed progress notes in the application

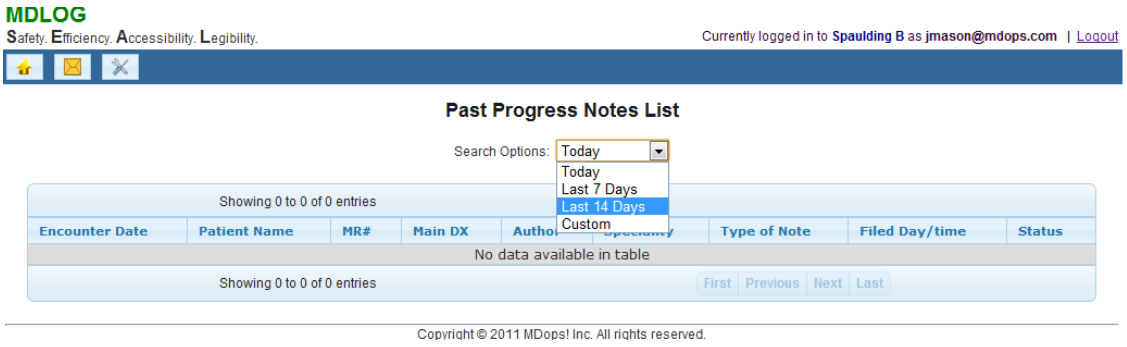
Reports

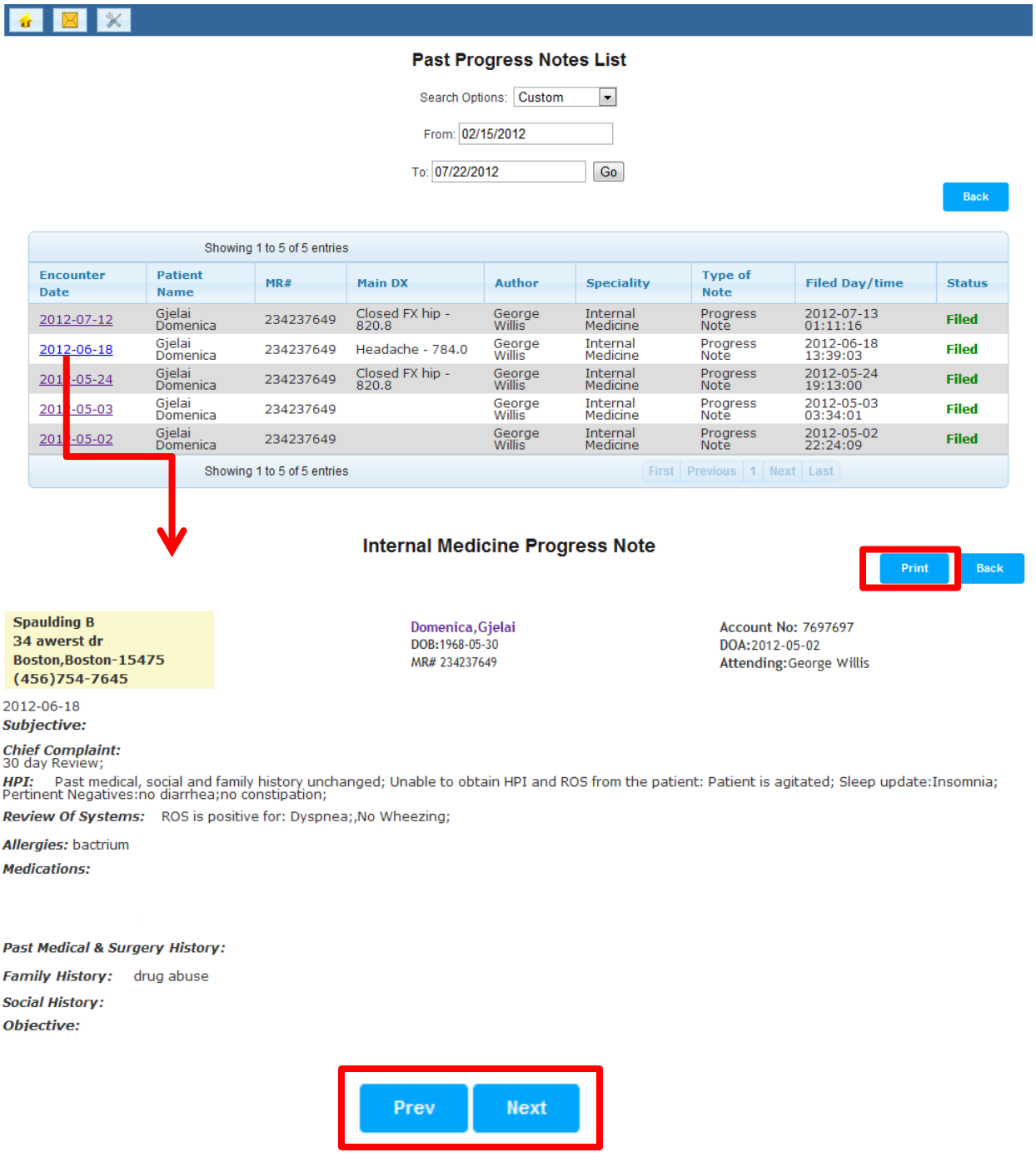
The administrator also has access to built-in reports available with the application. They include

a. Failed Login reports
b. Successful Login reports
c. Application Audit Report: It lists all the application events performed by the users along with time stamps

Medical Records Administration

Any user assigned the role of Medical Records Administration can access all patient progress notes filed in the assigned facilities. The primary use of this role is to print the progress notes so they can be filed in the facilities. As soon as the user does a login into the application, is prompted to choose from a list of assigned facilities. Once chosen the user is listed the progress notes listed for the day (Today). The user has option to choose different criteria as shown in the image below for filtering the patient progress notes. The progress notes can be listed for the current date, Last 7 days, Last 14 days or a custom time period. Once the progress notes are listed as per the chosen criteria the user can click on a progress note to open it and print it using the “Print” Button. At the bottom on each progress note are “Prev” and “Next” buttons that let use traverse to previous or the next progress note in the filtered list. The user can thus open each of the listed progress notes and print them.




Past Progress Notes List
Search Options: Custom
From: 02/15/2012
To: 07/22/2012
Go
Back
Showing 1 to 5 of 5 entries
Encounter Date
Patient Name
MR#
Main DX
Author
Speciality
Type of Note
Filed Day/time
Status
2012-07-12 Gjelai Domenica 234237649 Closed FX hip - 820.8 George Willis Internal Medicine Progress Note 2012-07-13 01:11:16 Filed
2012-06-18 Gjelai Domenica 234237649 Headache - 784.0 George Willis Internal Medicine Progress Note 2012-06-18 13:39:03 Filed
2012-05-24 Gjelai Domenica 234237649 Closed FX hip - 820.8 George Willis Internal Medicine Progress Note 2012-05-24 19:13:00 Filed
2012-05-03 Gjelai Domenica 234237649 George Willis Internal Medicine Progress Note 2012-05-03 03:34:01 Filed
2012-05-02 Gjelai Domenica 234237649 George Willis Internal Medicine Progress Note 2012-05-02 22:24:09 Filed
Showing 1 to 5 of 5 entries
First Previous 1 Next Last
Internal Medicine Progress Note
Print
Back
Spaulding B
34 awerst dr
Boston,Boston-15475
(456)754-7645
Domenica,Gjelai
DOB:1968-05-30
MR# 234237649
Account No: 7697697
DOA:2012-05-02
Attending:George Willis
2012-06-18
Subjective:
Chief Complaint:
30 day Review;
HPI: Past medical, social and family history unchanged; Unable to obtain HPI and ROS from the patient: Patient is agitated; Sleep update:Insomnia; Pertinent Negatives:no diarrhea;no constipation;
Review Of Systems: ROS is positive for: Dyspnea;,No Wheezing;
Allergies: bactrium
Medications:
Past Medical & Surgery History:
Family History: drug abuse
Social History:
Objective:
Prev
Next