



## MDlog User Guide

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## 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 be the "Home" page for the application.

The image shows two screenshots of the MDLOG application interface. The left screenshot is the 'MDLOG SIGN IN' screen, featuring the MDLOG logo (three colored squares: red, yellow, green) and the tagline 'Safety. Efficiency. Accessibility. Legibility.' Below the logo are two input fields: 'MDLog ID:' and 'Password:'. A blue 'Sign in' button is at the bottom. A red arrow points from the 'Sign in' button to the right screenshot. The right screenshot is a dialog box titled 'Select hospital and speciality' with a close button (X) in the top right corner. It contains the instruction 'Select the hospital and speciality.' and two dropdown menus: 'Hospital:' with 'Newhaven' selected, and 'Speciality:' with 'Internal Medicine' selected. A blue 'Ok' button is at the bottom right. A red arrow points from the 'Ok' button to the text 'Go to the Home Page' below it.

## 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.



The screenshot shows the MDLOG application interface. At the top, there is a navigation bar with icons for Home, Dashboard, and other functions. Below this is a header with the MDLOG logo and the tagline "Safety. Efficiency. Accessibility. Legibility." The user is logged in as "Test SNF as ncarter@gmail.com with speciality Internal Medicine". The main menu bar includes "Review Notes", "Print My Notes", "Do Handoffs", and "Rounding List".

The central "Patient List" section features a table with columns: Name, Medical Record No, Acno, Age/Sex, Unit, Room No, Referring Hospital, Admission Date, and Attending MD. The table contains four entries for patients: Jane seymor, Robert Dylan, Lee Decker, and John Murrav. Below the table are navigation controls like "First", "Previous", "1", "Next", and "Last".

Red arrows point from various UI elements to descriptive text boxes:

- Home Page (Patient List page)**: Points to the "Home" icon in the top left.
- Tool to calculate Risk factors**: Points to the "MDLOG" logo.
- Admit Patient**: Points to the "Write a SOAP Note" button.
- User's Billings**: Points to the "Handoffs" button.
- Handoffs done by the user for a specific day**: Points to the "Handoffs" button.
- Application Administration**: Points to the "Handoffs" button.
- Review of Progress Notes by Attending Physician if requested by Medical staff**: Points to the "Handoffs" button.
- Do Handoffs for multiple patients**: Points to the "Handoffs" button.
- Print all the patient notes filed for the day**: Points to the "Print My Notes" button.
- View the day's rounding list**: Points to the "Rounding List" button.
- Home Page (Patient List page)**: Points to the "Home" icon in the top left.
- Document a selected patient's Progress Note**: Points to the "Write a SOAP Note" button.
- Go to Patient's Face Sheet**: Points to a patient name in the table.
- Write a Handoff note for the selected patient**: Points to the "Handoffs" button.
- Re-admit Patient (Search for discharged patients to re-admit them)**: Points to the "Handoffs" button.
- Filter the Patient list by their location in the facility**: Points to the "Filter by units: All Units" dropdown.
- Search for an admitted patient by their name**: Points to the "Search:" input field.
- Main Menu Bar**: Points to the top navigation bar.

## 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

Left side menu containing multiple options for medical staff to perform for the patient

Patient Demographic Information captured during admissions process. It can be edited using the "Edit Facesheet" link in the left side menu.

**Patient Links**

- Edit Facesheet
- Edit Insurance
- Medical History
- History and Physical
- Attending Note
- Handoffs
- Hospital Course
- Problem List
- Past Notes
- Prescriptions
- Vitals
- Discharge Summary
- Discharge Patient

**Facesheet for Jane seymor 71F**

**Name:** seymor,Jane      **Sex:** Female      **Date Of Birth:** 1941-05-22  
**Medical Record No:** 132424      **Account No:** 12312434      **Date of Admission:** 2012-05-01  
**Address:** 55 sorwood ln, medford, NE - 12313 USA      **Phone No:** (123)123-1243      **MaritalStatus:** Divorced  
**Attending:** Avinash Kodey      **Unit:** 3S      **Room No:** 911  
**PCP:** John Whalen      **Referring MD:** Jim Bean      **Referring Hospital:** Cincinnati General Hospital

**Code Status:** full code      **Allergies:** bactrium, PCN  
**Primary Diagnosis:** Broken Hip  
**Comorbid Diagnosis:** Low Blood pressure  
**Past Medical Hx:** Hip surgery  
**Family Hx:** Tobacco abuse  
**Social Hx:** Drug abuse next

Patient Medical Information captured during admissions process. It can be edited using the "Medical History" link on the left side Patient Links menu.

**Vitals**

05/01/2012 04:05:25 -: Temp:101 F, HR: 75, RR:20, BP: 122/80  
05/01/2012 04:05:20 -: Temp:101 F, HR: 79, RR:20, BP: 122/80

These are the vitals recorded by either the Nurse or the medical staff using the "Vitals" link in the left menu bar of the Facesheet

**Active Problems**

05/15/2012 -: Headache - 784.0  
05/03/2012 -: Epistaxis - 784.7  
05/01/2012 -: Hyperthyroidism - 242.90  
05/01/2012 -: Lung mass - 786.6

The Active Problem list is generated from all Assessments that are created in the Assessment/Plans Tab in the patient Progress Note.

**Active Medications**

06/04/2012 -: Codeine Dosage:50 mg/ml Frequency: 2 times per day  
06/04/2012 -: KALETRA Dosage:200-50 mg Frequency: 2 times per day

The Active Medication list is generated from all the medication prescribed by the medical staff using the "Prescriptions" link on the left menu.

## 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.

**Edit Medical History for Patient Jane seymor**

\* Code Status: full code

\* Brief HPI: Underwent hip surgery in April 2012

\* Allergy: bactrium, PCN

\* Primary Diagnosis: Broken Hip

\* Past Medical/Surgical Hx: Hip surgery

\* Social History: Drug abuse next

\* Family History: Tobacco abuse

\* Precautions:

**Update** **Cancel**

## 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

**Patient Links**

- Edit Facesheet
- Edit Insurance
- Medical History
- History and Physical
- Attending Note**
- Handoffs
- Hospital Course
- Problem List
- Past Notes
- Prescriptions
- Vitals
- Discharge Summary
- Discharge Patient

**Facesheet for Jane seymor 71F**

**Name:** seymor,Jane      **Sex:** Female      **Date Of Birth:** 1941-05-22  
**Medical Record No:** 132424      **Account No:** 12312434      **Date of Admission:** 2012-05-01  
**Address:** 55 sorwood ln, medford , NE - 12313 USA      **Phone No:** (123)123-1243      **MaritalStatus:** Divorced  
**Attending:** Avinash Kodey      **Unit:** 3S      **Room No:** 911  
**PCP:** John Whalen      **Referring MD:** Jim Bean      **Referring Hospital:** Cincinnati General

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**Code Status:** full code      **Allergies:** bactrium, PCN  
**Primary Diagnosis:** Broken Hip  
**Comorbid Diagnosis:** Low Blood pressure  
**Past Medical Hx:** Hip surgery  
**Family Hx:** Tobacco abuse  
**Social hx:** Drug abuse next

**Vitals**

05/01/2012 04:05:25 -: Temp:101 F, HR: 75 , RR:20 ,BP: 122/80
05/01/2012 04:05:20 -: Temp:101 F, HR: 79 , RR:20 ,BP: 122/80

**Active Medications**

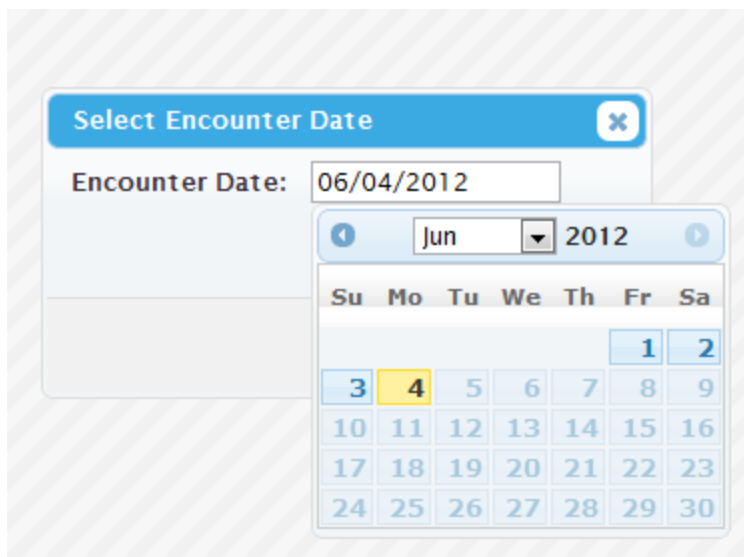
06/04/2012 -: Codeine Dosage:50 mg/ml Frequency: 2 times per day
06/04/2012 -: KALETRA Dosage:200-50 mg Frequency: 2 times per day

**Active Problems**

05/15/2012 -: Headache - 784.0
05/03/2012 -: Epistaxis - 784.7
05/01/2012 -: Hyperthyroidism - 242.90
05/01/2012 -: Lung mass - 786.6

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.

### Progress Note for seymor Jane

Handoffs	Subjective	ROS	Exam	Lab	Assessment/Plans	Preview	File
<p><b>Handoffs:</b></p> <p><b>Signout:</b> Patient's sugar levels need to be monitored....Avinash Kodey</p> <hr/> <p><b>Nursing Report:</b></p> <p>Patient complained of severe headache and vomited multiple times....Cathy Garner -- 05/03/2012 12:00:00</p>							

### 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.

Handoffs Subjective ROS Exam Labs Assessment/Plans Preview File

Save

Chief Complaint:

30 day Review;

30 day Review.  60 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;

Past medical, social and family history unchanged  
 Unable to obtain HPI/ROS  Aphasia  Agitation  Altered MS  Dementia  Severe mental illness  
 Patient is seen and examined in follow up-for  Patient offers no c/o  Patient feels well  No new overnight issues  
 Patient does not feel well and complains of  
 Sleep Update  No Sleep  Insomnia  
 Pain Update  Pain  Pain Uncontrolled  Patient requests more pain control  
 Bowel Update  No Problem  Diarrhea  Constipation.  
 PO Intake  Good  Fair  Poor  NPO  Tolerates Tube feeds  
 Patient condition was reviewed with Nurse  Patient condition was discussed with family  
 Patient case was discussed with case manager  Majority of \_\_ minutes with this patient were spent at bedside and coordinating care  
 Pertinent Negatives:  no high fever  no night sweats  no fatigue  no headache  no dizziness  no confusion  
 no blurry vision  no dysphagia  no sorethroat  no chest pain  no palpitations  no SOB  no prod cough

### 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.

Handoffs Subjective ROS Exam Labs Assessment/Plans Preview File

Save

The following system review was negative

Select All  General  Resp  CVS  GU  GI  Psych  HEENT  MSK  Neuro  Endocrine  Heme/Onc  Skin  Eyes

Check BOX for positive. DOUBLE CLICK on TEXT for negative.

General:  Fever *Chills* *Diaphoresis*  Fatigue  Night sweat  Wt. loss  Malaise  PO  
 CVS:  Chest pain  Exert.CP  Palpitations  Pedal edema  Syncope  Low BP  PND  Claudication  
 Resp:  Dyspnea  Dry cough  Prod. cough  Wheezing  Hemoptysis  Pleuritic pain  Orthopnea  
 Gastro:  Nausea  Vomiting  Abd pain  Diarrhea  GI bleed  Constipation  Heartburn  
 Neuro:  Vertigo  Seizure  Numbness  FMW  Tremors  Incoordinate  Weakness  Tingling  
 Psych:  Insomnia  Anxiety  Hallucinations  Suicidal  Homicidal  Forgetfull  
 MSK/Skin:  Joint pain  Back pain  Morn stiffness  Rash  Itching  Wounds  Ulcers  Myalgia  Arthralgia  
 GU/Heme:  Dysuria  Flank pain  Hematuria  Gum bleed  Easy bruising  Swollen gland  Bruising  
 HENT:  Headache  Dizziness  Earache  Epistaxis  Sinus pain  Dysphagia  Rhinorrhea  Trinitus  
 Hearing Loss  
 Eyes:  Blurry vision  Double vision  Glasses  Cataracts  Glaucoma

Positive ROS: ROS is positive for: Fever,Dyspnea;Nausea;

Negative ROS: No Chills;No Diaphoresis;

### 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.

**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:**  **NORMAL**     Confused     Delirious     Somnolent     Obtunded     Stuporous     Debilitated  
 WD/WN     Obese     Thin     Frail     Cachectic     Kyphosis  
No acute distress;

**Heart:**  **NORMAL**     Irregular rhythm     Systolic murmur     Diastolic murmur     Rub present  
RRR nml S1 and S2, No rubs, murmurs or gallops;

**Lungs:**  **NORMAL**     Barrel chest     Decreased ae     Bilateral exp rhonchi     Labored breathing     Bilateral basilar rales  
 Wheezes  
Decreased air entry;

**Abdomen:**  **NORMAL**     Distended     Diminished BS     Diffusely tender;     Hyperactive BS  
Soft, NT, ND, No masses, +BS all 4 quadrant;

**Ext:**  **NORMAL**     Trace edema     1+ edema     2+ edema     3+ edema     LE/UE pulses  
Trace edema;

**CNS:**  **NORMAL**     Aphasic     Dysarthric     Right side weakness     Left side weakness     General tremors  
 Facial droop

**Skin:**  **NORMAL**     Incision clean and dry     Skin Intact  
No rash, warm and dry;

**HEENT:**  **NORMAL**     Poor dentition     Hard of hearing  
Sclerae nonicteric, conjunctivae non-inflamed, OP clear, MMM;

**Neck:**  **NORMAL**     + JVD     + Right side Bruit     + Left side Bruit

### 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.

**Hematology:**  CBC wnl     H&H stable

**Chemistry:**  BMP wnl     TSH wnl     LFT wnl

**Micro/Pathology:**  U/A c&s neg     Bld cxs neg     Stool Cdiff neg

**Lipid Profile:**  LDL     HDL  
 Triglycerides     Total Cholesterol

**Radiology:**  CXR neg     KUB neg     Venous doppler neg

**Coagulation:**  INR

**Drug Levels:**  Depakote     Digoxin     Dilantin

### 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.

#### Progress Note for seymor Jane

Handoffs Subjective ROS Risk Factors Exam Labs **Assessment/Plans** Preview File

Save

Drag and Drop assessments to change the order.

Assessment/Plan 1

Assessment-1:

Improving;  Stable;  Controlled;  Not Improving;  Worse;  New problem;  
 Add w/u required  Resolved;

Plan-1:

▶ Assessment: Low back pain - 724.2 Plan:

▶ Assessment: Lung mass - 786.6 Plan:

▶ Assessment: Hyperthyroidism - 242.90 Plan:

▶ Assessment: Epistaxis - 784.7 Plan:

▶ Assessment: Plan:

▶ Assessment: Plan:

**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.

Handoffs Subjective ROS Risk Factors Exam Labs **Assessment/Plans** Preview

Drag and Drop assessments to change the order.

Assessment/Plan 1

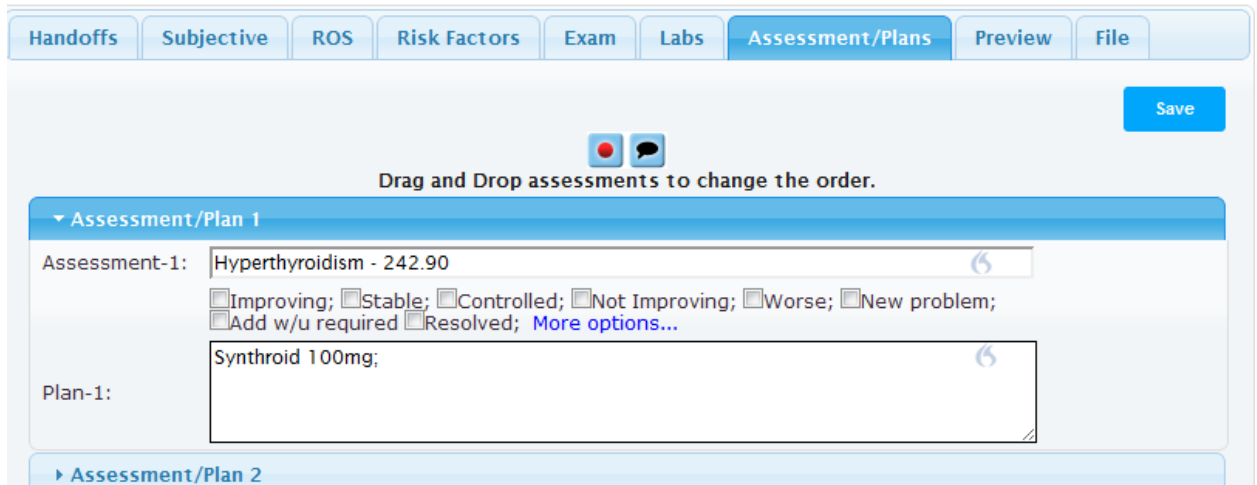
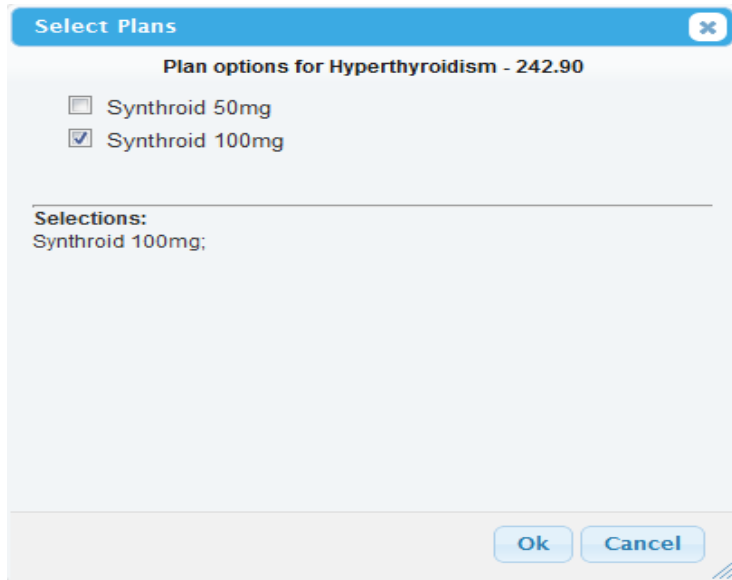
Assessment-1:

Hypertension well controlled - 401.9  
Hypertensive CHF - 402.91/428.0  
Hypertensive heart disease - 402.90  
Hypertensive urgency - 401.9

Plan-1:

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.

## Progress Note for seymor Jane

Handoffs Subjective ROS Risk Factors Exam Labs **Assessment/Plans** Preview File

Save

Drag and Drop assessments to change the order.

▼ Assessment/Plan 1

Assessment-1: hypog  
Hypogammaglobulinemia - 279.00  
Hypoglycemia - 251.2

Plan-1:  
Hypoglycemia reactive - 251.2  
Hypogonadism male - 257.2

▶ Assessment: Low back pain - 724.2 Plan:

▶ Assessment: Lung mass - 786.6 Plan:

▶ Assessment: Hypertthyroidism - 242.90 Plan:

## Progress Note for seymor Jane

Handoffs Subjective ROS Risk Factors Exam Labs **Assessment/Plans** Preview File

Save

Drag and Drop assessments to change the order.

▼ Assessment/Plan 1

Assessment-1: Hypoglycemia - 251.2  
 Improving;  Stable;  Controlled;  Not Improving;  Worse;  New problem;  
 Add w/u required  Resolved;

Plan-1:  
Not improving; Additional workup is required.

**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.



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.

Handoffs Subjective ROS Exam Lab Assessment/Plans Preview **File**

Save

**Quick DC: Day's Highlights / Course / Procedure / Critical Labs:**

Need to lower the sugar levels.

**Handoff's: Signout's & To Follow:**


Need to lower the sugar levels.

Check to copy Handoff content to QuickDC

Admission Note:  Progress Note:

Disposition:  Continue all current prescription medication and monitor  Click for review by Attending Physician

Billing Code 99309



Clear Signature

Sign and File

Handoffs Subjective ROS Exam Lab Assessment/Plans Preview **File**

Save

**Quick DC: Day's Highlights / Course / Procedure / Critical Labs:**

Need to lower the sugar levels.

**Handoff's: Signout's & To Follow:**


Need to lower the sugar levels.

Check to copy Handoff content to QuickDC

Admission Note:  Progress Note:

Disposition:  Continue all current prescription medication and monitor  Click for review by Attending Physician

Billing Code 99309



Clear Signature

Sign and File



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
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**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. conjunctivae non-inflamed. OP clear, MMM;

**Heart:** RRR nml S1 and S2. No rubs, murmurs or gallops;

**Lungs:**Decreased air entrv:

**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; **Radiology --:** CXR negative;

**Risk Factors:**

**Risk Equivalents:**


**Timi Score:**

---

**Assessment / Plan:**  
(3) Headache - 784.0  
(4) Lung mass - 786.6  
(5) Hypertroidism - 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.

Back

You have already filed a progress note for today, you may file an addendum

Addendum:

File

### 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.

Handoffs Subjective ROS Exam Lab Assessment/Plans Preview **File**

Save

**Quick DC: Day's Highlights / Course / Procedure / Critical Labs:**

**Handoff's: Signout's & To Follow:**


Check to copy Handoff content to QuickDC

Admission Note:     Progress Note:

**Disposition:**  Continue all current prescription medication and monitor

Click for review by Attending Physician

Billing Code:



Clear Signature

Sign and File

You have already successfully filed a Progress Note for review

Back

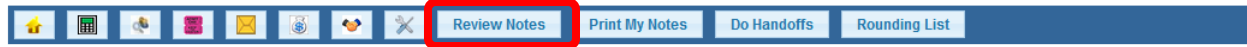
Search:

Encounter Date	Patient Name	MR#	Main DX	Author	Speciality	Type of Note	Filed Day/time	Status
<a href="#">2012-06-04</a>	John Murray	1243123213	Abdominal bloating - 787.3	Arun Choudary	Internal Medicine	Admission Note	2012-06-04 23:08:28	Filed
2012-06-04	John Murray	1243123213		Arun Choudary	Internal Medicine	Progress Note	2012-06-04 23:17:24	Under review

Showing 1 to 2 of 2 entries

First Previous 1 Next Last

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.



**My Progress Note Approval List**

Day/Time	Patient Name	MR#	Main DX	Author	Speciality	Type of Note	Actions
2012-06-04	John Murray	1243123213		Arun Choudary	Internal Medicine	Progress Note	Review

Showing 1 to 1 of 1 entries

Search:

First Previous 1 Next Last

**Allergies:**  
**Medications:**  
**Past Medical & Surgery History:**  
**Family History:**  
**Social History:**  
**Objective:**  
**Vitals:** N/A  
**General:** No acute distress;  
**Heart:** RRR nml S1 and S2, No rubs, murmurs or gallops;  
**Abdomen:** Soft,NT,ND,No masses,+BS all 4 quadrant;  
**Ext:** Trace edema;  
**Labs:**  
 Hematology -: CBC wnl; Pathology -: Urine c&s negative; Chemistry -: BMP wnl;  
**Assessments / Plan:**  
 (2) **Hyperthyroidism** - 242.90 Synthroid 100mg;  
 (3) **Epistaxis** - 784.7 Tylenol 100mg;  
 (4) **Abdominal bloating** - 787.3 avoid solids for 24 hours;  
**Disposition:** Continue all current prescription medication and monitor

**Signed By:**   
**Provider:** Arun Choudary MD



[Clear Signature](#)

[Co-sign and File](#)

**Objective:**  
**Vitals:** N/A  
**General:** No acute distress;  
**Heart:** RRR nml S1 and S2, No rubs, murmurs or gallops;  
**Abdomen:** Soft,NT,ND,No masses,+BS all 4 quadrant;  
**Ext:** Trace edema;  
**Labs:**  
 Hematology -: CBC wnl; Pathology -: Urine c&s negative; Chemistry -: BMP wnl;  
**Risk Factors:**  
**Risk Equivalents:**  
**Timi Score:**

**Assessment / Plan:**  
 (2) **Hyperthyroidism** - 242.90 Synthroid 100mg;  
 (3) **Epistaxis** - 784.7 Tylenol 100mg;  
 (4) **Abdominal bloating** - 787.3 avoid solids for 24 hours;

**Disposition:** Continue all current prescription medication and monitor

**Signed By:**   
**Provider:** Arun Choudary MD

**Co-signed By:**   
**Provider:** Avinash Kodey MD

## 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

### Medications for Patient Jane Seagal

Back Prescribe New

Prescriptions are saved successfully

Current Medications

Search:

Medication	Quantity	Prescribed By	Start Date	Actions
KALBITOR 10 mg/ml 1 time per day at bedtime INJECTABLE	1	Avinash Kodey	05/14/2012	Discontinue

Showing 1 to 1 of 1 entries

First Previous 1 Next Last

New Prescription

Prescription:

ba

- BABEE COF
- BABYBIG
- Bacampicillin
- BACI-IM
- BACIGUENT
- Bacitracin**
- Bacitracin/Dimethicone/Zinc Oxide
- Bacitracin/Diperodon/Neomycin
- Bacitracin/Diperodon/Neomycin/Polymyxin B
- Bacitracin/Hydrocortisone/Neomycin/Polymyxin B
- Bacitracin/Lidocaine
- Bacitracin/Lidocaine/Neomycin/Polymyxin B
- Bacitracin/Neomycin/Polymyxin B

Ok Cancel

New Prescription

Prescription: Bacitracin [Change](#)

Dosage: 0.5 unt/mg  
5000 unt/ml

Formulations: OINTMENT  
SOL

Route: OPHTHALMIC

Frequency: 1 time per day  
1 time per day in the morning  
1 time per day in the evening  
1 time per day at bedtime  
2 times per day  
3 times per day

Comments:

Quantity: 1 Refill: 0

Start Date: 05/14/2012 End Date:

Ok Cancel

## 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.

The screenshot shows the MDLOG application interface. At the top, the logo 'MDLOG' is displayed in green, followed by the tagline 'Safety. Efficiency. Accessibility. Legibility.' and the user status 'Currently logged in to Test SNIF'. Below this is a navigation bar with several icons and buttons: a home icon, a calendar icon, a person icon, an envelope icon, a shield icon, a gear icon (highlighted with a red box), and buttons for 'Print My Notes', 'Do Handoffs', and 'Rounding List'. A red arrow points from the gear icon to a 'My Links' sidebar on the left. The sidebar contains 'Profile Information' and 'Assessment Plans' (highlighted with a red box). Another red arrow points from 'Assessment Plans' to a form on the right. The form contains the following fields:

* First Name:	James
DEA Number	AG6766555
* Street Address	11111
* City	Medord

### Add New Assessment Plan

\* Speciality: Internal Medicine

\* Assessment:

\* Plan:

Assessment Plans			
			Search: <input type="text"/>
Assessment	Plan	Date Created	Actions
Hyperthyroidism - 242.90	synthroid .333mg	05/01/2012	<a href="#">Delete</a>
Hypoglycemia - 251.2	Monitor sugar levels	05/01/2012	<a href="#">Delete</a>
Hypoglycemia - 251.2	low carb diet	05/01/2012	<a href="#">Delete</a>

Showing 1 to 3 of 3 entries

### Add New Assessment Plan

\* Speciality: Internal Medicine

\* Assessment:

\* Plan:

Assessment	Plan
Hypoglycemia - 251.2	
Hypoglycemia - 251.2	

Hyperthyroidism - 242.90

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

## Add New Assessment Plan

\* Speciality: Internal Medicine  
\* Assessment: Hyperthyroidism - 242.90  
\* Plan: Synthroid 100mg

Save Cancel

### Assessment Plans

Search:

Assessment	Plan	Date Created	Actions
Hyperthyroidism - 242.90	Synthroid 50mg	05/13/2012	<a href="#">Delete</a>
Hyperthyroidism - 242.90	Synthroid 100mg	05/13/2012	<a href="#">Delete</a>
Hypoglycemia - 251.2	Monitor sugar levels	05/01/2012	<a href="#">Delete</a>
Hypoglycemia - 251.2	low carb diet	05/01/2012	<a href="#">Delete</a>

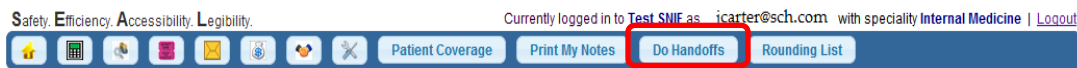
Showing 1 to 4 of 4 entries

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

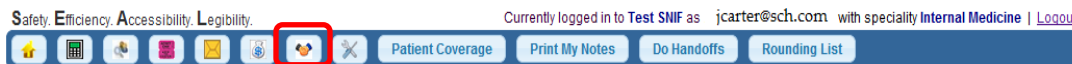
One member of the medical staff can pass pertinent medical information about the patient to next attending or covering member of the medical staff through the Handoff feature to ensure safe transfer of patient care. Similarly a user belong to a Nursing Role can login and add a nursing note for a patient. 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.

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



- Write the note in the Handoff field in the “File” tab of the patient’s Progress note
- 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: <small>Numeric digits only</small>	<input type="text" value="12344431"/>	* Account No:	<input type="text" value="34254356"/>	* Date of Admission	<input type="text" value="05/12/2012"/>
* Last name:	<input type="text" value="Seagal"/>	Middle Initial	<input type="text"/>	* First name:	<input type="text" value="Jane"/>
* Sex:	<input type="text" value="Female"/>	* Date Of Birth	<input type="text" value="05/20/1953"/>	MaritalStatus:	<input type="text" value="Widowed"/>
* Attending:	<input type="text" value="John Weisman"/>	* Unit:	<input type="text" value="3S"/>	Room No:	<input type="text" value="911"/>
Social Security No:	<input type="text" value="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:	<input type="text" value="12344431"/>	* Account No:	<input type="text" value="34254356"/>		
Address	<input type="text" value="76 Marwin Lane"/>				
City	<input type="text" value="St Louis"/>	State	<input type="text" value="ME"/>		
Country	<input type="text" value="USA"/>	Zipcode	<input type="text" value="76876"/>		
Home Phone Number	<input type="text" value="(876)876-8686"/>	Cell Phone Number	<input type="text" value="(768)768-7686"/>	Work Phone Number	<input type="text"/>
Email Address	<input type="text"/>	Emergency Contact	<input type="text" value="Tom Seagal"/>	Emergency Phone Number	<input type="text" value="(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:	<input type="text" value="Anthem Blue Cross and Blue Shield"/>						
Plan Name:	<input type="text" value="PPO1"/>	Effective Date:	<input type="text" value="05/03/2012"/>				
Policy Number:	<input type="text" value="12345255"/>	Group Number:	<input type="text" value="S65436543"/>				
Copay:	<input type="text" value="30"/>	Accept Assignment:	<input type="text" value="YES"/>				
Subscriber Name:	<input type="text" value="Tom Seagal"/>	Relationship:	<input type="text" value="Spouse"/>	Sex:	<input type="text" value="Male"/>		
Subscriber D.O.B:	<input type="text" value="04/16/1952"/>	Subscriber SSN:	<input type="text" value="234-56-7890"/>				
Subscriber Address:	<input type="text" value="34 carlisle way"/>	City:	<input type="text" value="St Louis"/>	Zipcode:	<input type="text" value="98798"/>	State:	<input type="text" value="ME"/>
Country:	<input type="text" value="USA"/>						
Subscriber Employer:	<input type="text" value="PGA Corp"/>	Subscriber Phone Number:	<input type="text" value="(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:	<input type="text" value="John Morrison"/>				
Pharmacy:	<input type="text" value="CVS, 11 Horsblock Rd, St Louis, 98090 ME"/>				
HIPPA Notice Received:	<input type="text" value="Yes"/>	Allow Email Communication:	<input type="text" value="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

Referring MD:	<input type="text" value="John Morrison"/>	Referring Hospital:	<input type="text" value="St Louis General"/>	Code Status:	<input type="text" value="Full Code"/>
Allergy:	<input type="text" value="Penicillin, Bacterium"/>				
Primary Diagnosis:	<input type="text" value="Dementia"/>				
Comorbid Diagnosis:	<input type="text" value="Diabetes"/>				



ⓘ Patient Seagal Jane has been successfully admitted.

## Edit Medical History for Patient Jane Seagal

* Code Status:	<input type="text" value="Full Code"/>		
* Brief HPI:	<input type="text" value="Patient has been diagnosed with dementia 9 months back. Has undergone treatment at St Louis general"/>		
* Allergy:	<input type="text" value="Penicillin, Bacterium"/>	* Primary Diagnosis:	<input type="text" value="Dementia"/>
* Past Medical/Surgical Hx:	<input type="text" value="Broken Hip Surgery"/>	* Social History:	<input type="text" value="Drug Abuse"/>
* Family History:	<input type="text" value="Diabetes"/>	* Precautions:	<input type="text"/>



**Patient Links**

- Edit Facesheet
- Edit Insurance
- Medical History
- History and Physical
- Attending Note
- Handoffs
- Hospital Course
- Problem List
- Past Notes
- Prescriptions
- Vitals
- Discharge Summary
- Discharge Patient

**Facesheet for Jane Seagal 59F**

**Name:** seymor,Jane      **Sex:** Female      **Date Of Birth:** 1941-05-22  
**Medical Record No.:** 132424      **Account No.:** 12312434      **Date of Admission:** 2012-05-01  
**Address:** 55 sorwood ln, medford , NE - 12313 USA      **Phone No.:** (123)123-1243      **MaritalStatus:** Divorced  
**Attending:** Avinash Kodey      **Unit:** 3S      **Room No.:** 911  
**PCP:** John Whalen      **Referring MD:** Jim Bean      **Referring Hospital:** Cincinnati General

**Code Status:** full code      **Allergies:** bactrium, PCN  
**Primary Diagnosis:** Broken Hip  
**Comorbid Diagnosis:** Low Blood pressure  
**Past Medical Hx:** Hip surgery  
**Family Hx:** Tobacco abuse  
**Social hx:** Drug abuse next

**Vitals**

05/01/2012 04:05:25 -: Temp:101 F, HR: 75 , RR:20 ,BP: 122/80  
05/01/2012 04:05:20 -: Temp:101 F, HR: 79 , RR:20 ,BP: 122/80

**Active Medications**

06/04/2012 -: Codeine Dosage:50 mg/ml Frequency: 2 times per day  
06/04/2012 -: KALETRA Dosage:200-50 mg Frequency: 2 times per day

**Active Problems**

05/15/2012 -: Headache - 784.0  
05/03/2012 -: Epistaxis - 784.7  
05/01/2012 -: Hyperthyroidism - 242.90  
05/01/2012 -: Lung mass - 786.6

**History and Physical for Seagal Jane**

**Patient Links**

- Medical History
- Medications

Subjective    ROS    Exam    Labs    Assessment/Plans    Preview    File

Save

**Chief Complaint:**

30 day Review.     60 day Review.




**HPI:**

Past medical, social and family history unchanged;

Past medical, social and family history unchanged  
 Unable to obtain HPI/ROS     Aphasia     Agitation     Altered MS     Dementia     Severe mental illness  
 Patient is seen and examined in follow up-for     Patient offers no c/o     Patient feels well     No new overnight issues  
 Patient does not feel well and complains of

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

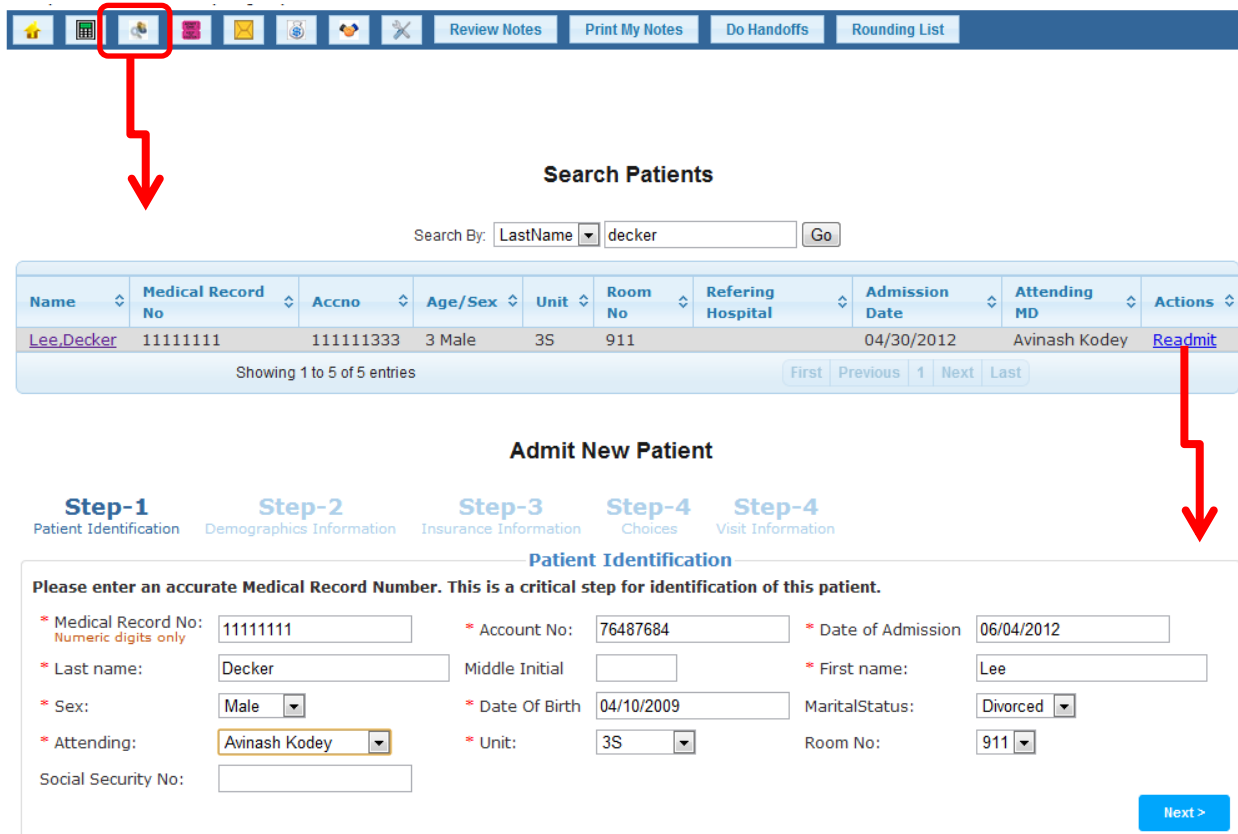
- d. **Edit Face Sheet:** Link can be used to update any details recorded during the admission
- e. **Medical History:** Link can be used to update patients medical information captured during the admission process
- f. **History and Physical:** For documenting a full admission note in the form of SOAP 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.



**Search Patients**

Search By:

Name	Medical Record No	Accno	Age/Sex	Unit	Room No	Referring Hospital	Admission Date	Attending MD	Actions
<a href="#">Lee,Decker</a>	11111111	111111333	3 Male	3S	911		04/30/2012	Avinash Kodey	<a href="#">Readmit</a>

Showing 1 to 5 of 5 entries

**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: <small>Numeric digits only</small>	<input type="text" value="11111111"/>	* Account No:	<input type="text" value="76487684"/>	* Date of Admission	<input type="text" value="06/04/2012"/>
* Last name:	<input type="text" value="Decker"/>	Middle Initial	<input type="text"/>	* First name:	<input type="text" value="Lee"/>
* Sex:	<input type="text" value="Male"/>	* Date Of Birth	<input type="text" value="04/10/2009"/>	MaritalStatus:	<input type="text" value="Divorced"/>
* Attending:	<input type="text" value="Avinash Kodey"/>	* Unit:	<input type="text" value="3S"/>	Room No:	<input type="text" value="911"/>
Social Security No:	<input type="text"/>				

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.

**Billing for Charles Deagan**

Billing Options:

PatientName/DOB/AccountNo	MR#/DOA/Unit	BillingDate	CPT-4-Code	Billing DX/ICD9
John Murray 05/20/1959 43423545	1243123213 06/04/2012 3S,911	<a href="#">06/04/2012 23:25:53</a>	99308	null Hyperthyroidism - 242.90 Epistaxis - 784.7 Abdominal bloating - 787.3
Jane seymor 05/22/1941 12312434	132424 05/01/2012 3S,911	<a href="#">06/04/2012 20:29:11</a>	99309	null Headache - 784.0 Lung mass - 786.6
Kevin gibbs 06/23/1960 90809	1231233 06/03/2012 North Wing,303	<a href="#">06/04/2012 05:42:33</a>	99304	Hyperthyroidism - 242.90 Headache - 784.0 Abdominal bloating - 787.3

Showing 1 to 3 of 3 entries

[First](#) [Previous](#) [1](#) [Next](#) [L](#)

**Billing for John Murray**

[Back](#)

<b>Spaulding B</b> 34 awerst dr Boston,Boston-15475 (456)754-7645	<b>Murray, John</b> DOB:1959-05-20 MR# 1243123213	Account No: 43423545 DOA:2012-06-04 Attending: Charles Deagan
--	---	---

Billing Date: 06/04/2012

CPT- Code:

ICD/Dx # 1:

ICD/Dx # 2:

ICD/Dx # 3:

ICD/Dx # 4:

[Save](#)

## Application Administration

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

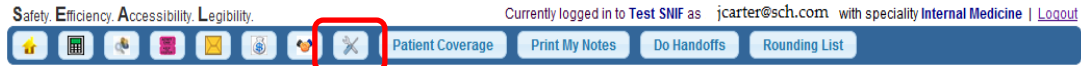
### Initial Setup

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

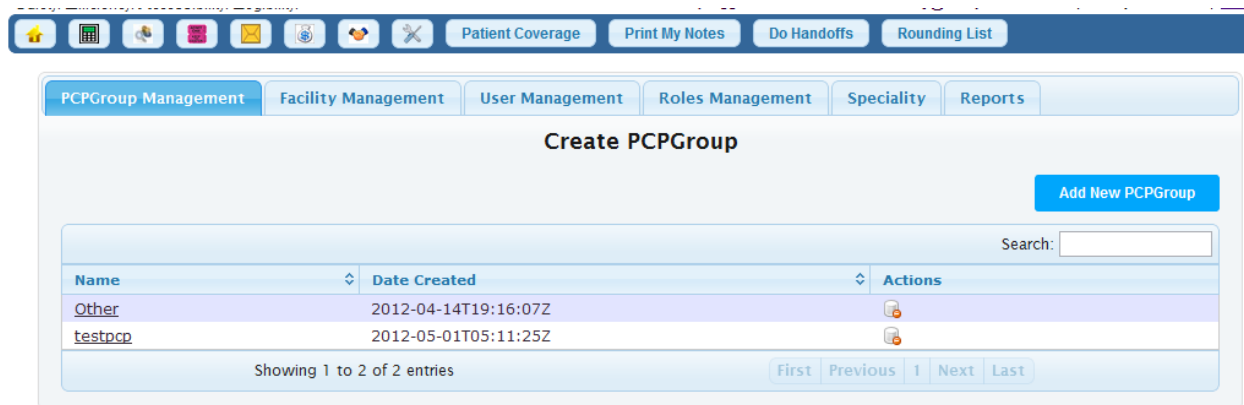
- b. Define facilities that the medical staff attends to
- c. Define the units and rooms for each facility so that new patients can be assigned the location
- d. Define Billing codes for each facility so medical staff can assign billing code for every patient note that they file
- e. Create User accounts 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
<a href="#">ConcordSNF</a>	Concord	support@ConcordSNF.com	(576)576-5765	05/02/2012 04:05:21	<a href="#">Remove</a>   <a href="#">Manage units</a>   <a href="#">Billing Codes</a>
<a href="#">New Haven SNF</a>	Newhaven	support@NHSNF.com	(726)387-2687	05/02/2012 04:05:22	<a href="#">Remove</a>   <a href="#">Manage units</a>   <a href="#">Billing Codes</a>

PCPGroup Management **Facility Management** User Management Roles Management

### Create New Facility

\* Name

\* SiteID

\* Address

\* City  \* State

\* Country  \* Zipcode

\* Phone Number  Fax Number

\* Email Address

\* PCP Groups  Other testpcp

Add or modify facilities

Add or modify units in the facility

PCPGroup Management **Facility Management** User Management Roles Management Speciality Reports

### Unit List for ConcordSNF

[Add New Unit](#)

Search:

Name	Date Created	Actions
<a href="#">East</a>	2012-05-02T09:28:45Z	<a href="#">remove</a>   <a href="#">manage rooms</a>
<a href="#">West</a>	2012-05-02T09:29:36Z	<a href="#">remove</a>   <a href="#">manage rooms</a>

Showing 1 to 2 of 2 entries First Previous 1 Next Last

### Room List for Unit North Wing

Add or modify the rooms in the facility unit

[Add New Room](#)

Search:

Room No	Date Created	Actions
303	2012-05-02T04:31:04Z	<a href="#">remove</a>
304	2012-05-02T04:31:12Z	<a href="#">remove</a>
306	2012-05-02T04:31:19Z	<a href="#">remove</a>

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



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 billing codes for the facility**

### Add New Billing Code

\* Hospital:

\* Billing Group:

\* Billing Code:

Billing Group	Billing Code	Date Created	Actions
Discharge	99315 < 30min	05/03/2012	<a href="#">Delete</a>
Discharge	99316 > 30min	05/03/2012	<a href="#">Delete</a>
Initial Visit	99304	05/03/2012	<a href="#">Delete</a>
Initial Visit	99306	05/03/2012	<a href="#">Delete</a>
Initial Visit	99305	05/03/2012	<a href="#">Delete</a>
Subsequent Visit	993010	05/03/2012	<a href="#">Delete</a>
Subsequent Visit	99309	05/03/2012	<a href="#">Delete</a>
Subsequent Visit	99308	05/03/2012	<a href="#">Delete</a>
Subsequent Visit	99307	05/03/2012	<a href="#">Delete</a>

Showing 1 to 9 of 9 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.

PCPGroup Management Facility Management **User Management** Roles Management Speciality Reports

### Create User

**Step-1** Profile Information **Step-2** Access Information

**Profile Information**

\* First Name: John Middle Initial: Title: \* Last Name: Milburn  
 DEA Number: AD7658768 Title: MD  
 \* Street Address: 45 Madison av  
 \* City: New York \* State: NY \* Zipcode: 02345  
 \* Country: USA  
 \* Cell Phone Number (xxx)xxx-xxxx: (769)876-9696 Fax Number (xxx)xxx-xxxx: (769)679-6976 \* Pager (xxx)xxx-xxxx: (698)769-6976  
 PCP Group: testpcp  
 Specialities: 1 items selected  
 Remove all Add all  
 Internal Medicine + Hepatologis +  
 Infectious Disease +  
 Intensivist +  
 Medical Genetics +

Step-1

Next >

**Create User**

**Step-1** Profile Information **Step-2** Access Information

**Access Information**

Passwords Must be at least 8 characters. Must contain at least one one lower case letter, one upper case letter, one digit and one special character  
 Valid special characters are - @\$%^&+=.

\* Email Address: jmilburn@yahoo.com  SpeechEnabled  
 \* Password: ..... ConfirmPassword: .....  
 \* Roles: 1 items selected  
 Remove all Add all  
 Medical Staff + Administrator +  
 Case Manager +  
 New Admisson +  
 Accounting +  
 Moonlighter +  
 Medical Records +  
 \* Hospitals: 9 items selected  
 Remove all Add all  
 Concord +  
 Newhaven +  
 Salem +  
 Shawnessy +  
 BostonSNF +  
 Test SNIF +

Step-2

< Back Create

## 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

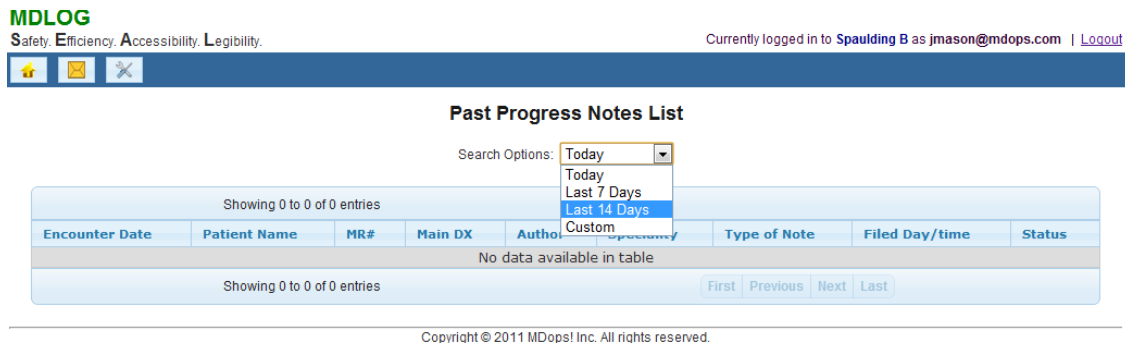
## Reports

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

- Failed Login reports
- Successful Login reports
- 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.



**MDLOG**  
Safety. Efficiency. Accessibility. Legibility. Currently logged in to Spaulding B as jmason@mdops.com | [Logout](#)

**Past Progress Notes List**

Search Options: 

- Today
- Last 7 Days
- Last 14 Days
- Custom

Showing 0 to 0 of 0 entries

Encounter Date	Patient Name	MR#	Main DX	Autho...	Specialty	Type of Note	Filed Day/time	Status
No data available in table								

Showing 0 to 0 of 0 entries First Previous Next Last

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### Past Progress Notes List

Search Options: Custom

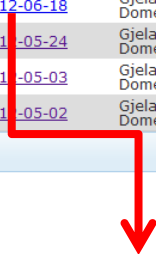
From: 02/15/2012

To: 07/22/2012

Showing 1 to 5 of 5 entries

Encounter Date	Patient Name	MR#	Main DX	Author	Speciality	Type of Note	Filed Day/time	Status
<a href="#">2012-07-12</a>	Gjelai Domenica	234237649	Closed FX hip - 820.8	George Willis	Internal Medicine	Progress Note	2012-07-13 01:11:16	Filed
<a href="#">2012-06-18</a>	Gjelai Domenica	234237649	Headache - 784.0	George Willis	Internal Medicine	Progress Note	2012-06-18 13:39:03	Filed
<a href="#">2012-05-24</a>	Gjelai Domenica	234237649	Closed FX hip - 820.8	George Willis	Internal Medicine	Progress Note	2012-05-24 19:13:00	Filed
<a href="#">2012-05-03</a>	Gjelai Domenica	234237649		George Willis	Internal Medicine	Progress Note	2012-05-03 03:34:01	Filed
<a href="#">2012-05-02</a>	Gjelai Domenica	234237649		George Willis	Internal Medicine	Progress Note	2012-05-02 22:24:09	Filed

Showing 1 to 5 of 5 entries



### Internal Medicine Progress Note

**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:**