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# HIMSS 2016 Demo Guide: Fluency Direct, Computer Assisted Physician Documentation, CDI Assess – Engage - Collaborate

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# Read Me

This document includes the background information and talking points needed to demo and discuss Fluency Direct, Computer Assisted Physician Documentation (CAPD), CDI Assess, CDI Engage, and CDI Collaborate.

After reading this document, you will be able to walk through our solutions suite in the scope of real examples – both the Fluency Direct scripts and the Closed Loop CDI Demo are adapted from real patient (de-identified) case documents.

**Learning how to have the conversation about our solutions with a customer or prospect is just as, if not more, important than learning how to do the demonstration.**

Not everyone you talk to will want to know about the whole suite, as all of our solutions might not be relevant to their organization.

By understanding the content, intent, and purpose of each piece in the demo, you will be able to successfully navigate the customer to right place and focus the demo and discussion around their interest.

Though this document is 19 pages long, there are only 8 pages (pages 4-11) that include information to read and learn. The remaining pages include scripts and other demo material. Look for the highlights to quickly identify key points.

Note that the Closed Loop CDI HTML pages were built on a 1080p monitor; please let Dan Engel know if you have resolution and display issues.

## Fluency Direct and CAPD

*For full Fluency Direct* [*user guide*](https://docs.mmodal.com/direct/index.php/user-guide/fluency-direct-9-0)*,* [*sales handbooks*](https://docs.mmodal.com/direct/index.php/employees-1/sales-handbooks/fd-sales-handbooks/436-dragon-medical-360-network-edition-competitive-analysis)*, and* [*technical references/FAQs*](https://docs.mmodal.com/direct/index.php/technical/knowledge-base-1)*, see*[***https://docs.mmodal.com/direct/***](https://docs.mmodal.com/direct/)***.***

Computer Assisted Physician Documentation (CAPD) is a feature of Fluency Direct that provides real-time feedback without disrupting the documentation workflow.

CAPD feedback is triggered by configured Natural Language Understanding (NLU) applications in M\*Modal’s single cloud-based platform. CAPD messages are triggered by text entered to the note through any modality – dictation, typing, text macros, or copy/paste.

Two CAPD applications that we will demo at the HIMSS trade show are **CDI Engage** and **Precyse University**.

### CDI Engage

Part of the M\*Modal CDI solution suite, CDI Engage delivers real-time feedback to physicians based on clinical condition documentation requirements for ICD-10 compliance.

CDI Engage messages will communicate how to satisfy documentation best practices, preventing the need for downstream queries from the Clinical Documentation Improvement (CDI) or Coding groups.

Before delivering the real-time messages to physicians, CDI Engage rules can be run in Silent Mode to identify areas of opportunity, which help to ensure the most relevant and impactful messages are delivered to each physician.

### Precyse University

M\*Modal has partnered with Precyse, a leader in healthcare learning solutions with credentialed industry expertise, to redefine the manner in which ICD-10 physician education is delivered – moving training from the classroom into the real time physician documentation workflow.

Utilizing M\*Modal’s NLU platform and CAPD workflow, the Precyse University “Documentation Tips” for ICD-10 education and training can be presented to physicians using Fluency Direct, informing them of the condition-specific documentation requirements for ICD-10 compliance.

### Connecting CDI Engage and Precyse University

CDI Engage and Precyse University Documentation Tips complement one another – the CDI Engage messages specifically identify conditions that are in need of more specificity, while the Precyse ICD-10 Education material is higher level and are intended to provide continuous access to physician education and training material.

Customer can choose which one they would like to use with their physicians and both can be enabled together.

### FD CAPD Demo Script Instructions

The **words in bold** will trigger CDI Engage message(s) indicated in the script titles.

The words underlined will trigger Precyse University ICD-10 Education material.

The *[words in brackets & italics]* will resolve the CDI Engage messages. You can leave these out during initial dictation and then correct the text.

The ***words* *in red italics*** are voice commands/ text macros. See text for these macros at the end of this document.

***See FD CAPD demo scripts on page 12.***

### Notes on FD CAPD Demo Scripts 1 and 2

1. Demo script 1 includes several underspecified chronic conditions as well as abnormal lab results. This is a good demo to show if the customer only has time for a quick review of CDI Engage and Precyse University.
2. Demo script 2 shows both underspecified conditions and the tying together of several pieces of evidence (fever, tachycardia, elevated white blood cells, altered mental status) in the document indicating a condition is present (septic shock). This shows the intelligence of our Information Models and that we are not just “text matching.” Using the SOAP template with this script also shows how we can navigate fields and customize a workflow based on physician documentation patterns.
3. Build out FD Abbreviations for “CKD,” “CHF,” and other acronyms that are in the script to show how we can help improve document quality by not introducing abbreviations into the medical record.

### Understanding NLU Reasoning in these examples

Try dictating (or typing) the following sentences as examples of how the NLU reasons over the document and is not text matching. Unlike in the scripts above, you **should** **not** receive CAPD messages for the following sentences:

* The patient does not have congestive heart failure.
* The patient’s father has chronic kidney disease.
* Possible pneumonia.
* Past medical history of MI.

If these sentences are changed to indicate the condition is present, positively mentioned, and about the patient, you will see a CAPD message.

Unlike in the second script above, you **should** receive a CAPD message for this sentence:

* I gave the patient 10 cc of fluid.

If this sentence is changed to include “cc” in a compliant manner (i.e. talking about carbon copy or chief complaint), then you will not receive a CAPD message (as in the demo script).

## Closed Loop CDI Demo

Use this document and demo system to learn all of the solutions included in the CDI Suite. This demo is adapted from a real patient case, and uses 5 web pages to tell a story. The goal of this demo is to show how we can impact patient care across the continuum, not conduct several discrete demonstrations.

Telling a story, focusing on the concepts of our solutions and not the solutions themselves, is critical for making what we do personal and relevant to customers and prospects.

When talking with a customer you do not have to go through the whole thing. Have a conversation, ask questions, let them tell you what they are interested in and struggle with, and then navigate to the appropriate place in the demonstration. Use the right tool based on their needs and interests.

### M\*Modal FD-CAPD-CDI Slides

The first page is a compliment to the default slide deck that plays on loop at the booth. Use the “slides” on this page as conversation starters and place to jump to more detailed and specific reference material.

This page also includes some real customer examples and testimonials:

* CDI KLAS scores, December 2015 – at this point we had the top score (94.9)
	+ The asterisk indicates that we don’t have enough “Konfidence” to officially be listed as best in KLAS.
	+ As we gain more customers and KLAS responses we will gain the Konfidence needed to be officially listed in the ranks.
	+ Customer comments and responses to KLAS surveys are available in the CDI report. Ask Aaron Brauser for details.
* Press release from AHIMA 2015, including favorable quote from Dr. Melahn (CMIO, St. Claire Regional Medical Center) about CAPD and CDI Engage: “The timely and relevant feedback delivered by M\*Modal is critical to physician engagement as it helps physicians work smarter and faster, not harder. The M\*Modal CDI solution not only helps monitor and improve physician behavior through strong reporting capabilities, it gives us unprecedented insight into what physicians are thinking naturally, not when merely checking a box. M\*Modal bridges the gap between physician minds and where EMRs should be.”
	+ Hyperlink to full press release available below the quote
	+ By keeping a close eye on documentation quality, query rates, and CAPD activity, Dr. Melahn has found a balance in making the best use of all tools available.
	+ Currently, we have a focus on Cardiology-related CDI Engage rules (i.e. CHF, MI, Cardiomyopathy, A. Fib) with many others rules running silently.
	+ Most active users are Residents and Interns who recently finished their residency (i.e. those who need the real time-guidance most), and many Attendings remain in Silent Mode for in person follow up pending review of CAPD reporting data.
* Video testimonial from Dr. Danhauer and link to case study reviewing M\*Modal solutions implementation at Owensboro.
* Quote from Becky Slagell (Division VP of Case Management, Kindred Hospital) about how use of our CDI technology helps improve their documentation quality, support their analytics processes, and overall patient care management.
* CAPD reports from outcomes at CHS – two graphs for specific hospitals and one that combines data across 22 sites:
	+ We are seeing trends that show that as CAPD messages are being resolved, the number of CDI (concurrent) and coding (retrospective) queries that match the CAPD messages are decreasing, and CDI is able to review more cases.
	+ This aligns with the initial goal we started with of removing need for CDI and Coding queries for “low hanging fruit,” allowing them to spend their time on more complex cases that require their clinical judgment.
* Fluency One outcomes – as front end speech recognition is introduced we see number of transcription minutes go down, thus lowering the overall cost to the facility. This results in more documentation being created by physician self-entry to the EHR, and hence, documentation creation is timelier.

### Introduction

#### Meet Mr. Allen!

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name** | William Allen | **Date of Birth** | May 8, 1949 | **C:\Users\dan.engel.ISI\Desktop\HIMSS-2016\Details\Cdi\img\WillAllen.jpg** |
| **Gender** | Male | **Age** | 66 years-old |
| **MRN** | 12524765 |
| **Known Medical Conditions** | Congestive heart failure, hypertension, and coronary artery disease |
| **Reason for admission to Gotham General Hospital** | Chest pain and difficulty breathing |

This demonstration will follow his inpatient encounter and highlight the ways in which M\*Modal helps to capture clinical documentation, perform chart reviews, and drive advanced workflows that ensure documentation is of quality to reflect the level of care provided and severity of patient's illness.

#### Gotham General Hospital goals:

* Increase the frequency with which Pneumonia and Heart Failure are completed and accurately documented
	+ Heart Failure and Pneumonia were identified as conditions that frequently lacked fully specified documentation. Click here, or scroll down, for details behind this analysis.
* Improve patient outcomes and communication
* Improve accuracy of reimbursement capture

#### CDI Assess

*The HTML walkthrough includes the CDI Assess information documented here as well as shows graphs that compare Gotham General hospital to their peers (other hospitals of similar size and similar DRGs being submitted on claims). The assessment identifies opportunities for improvement at Gotham General based on documentation that exists today, looking for conditions and physicians that are in need of documentation improvement assistance.*

*The purpose of our CDI Assess service is to ensure that we deliver a targeted solution that delivers value to the customer. Defining goals and conducting discovery allows us to evaluate our impact after implementation, helping the customer to prove ROI from our CDI solutions.*

To enable targeted action for optimized, cost-effective impact, it is first important to know where the problems lie. M\*Modal CDI Assess allows the customer to gain instant visibility into patient data typically trapped in the narrative and identify opportunities for improving the quality of clinical documentation to drive improvement in both patient and organizational outcomes.

Below you will see examples of how this is done automatically across all narrative documents, reducing the need for costly manual abstraction, by leveraging the following:

1. Publicly available MEDPAR data to provide transparency into customer Medicare population and create peer groups for comparison
2. Data available in narrative documents created by M\*Modal Transcription services
3. CAPD Silent Mode data to understand potential real-time interactions *before* introducing messages to physicians during their documentation workflow

##### 1. MEDPAR Analysis

The following metrics are derived from the content of clinical documentation and represent key hospital operational benchmarks. Therefore, examining these metrics within the context of a peer group allows us to identify opportunities for improving clinical documentation that will improve an organization’s operational margins.

* How does your CMI compare to that of your peers?
* Are your complication or co-morbidity (CC) and major complication or co-morbidity (MCC) capture rates at or near best practices?
* Do your cases have average lengths of stay above the expected rates?

By analyzing the diagnosis codes submitted to Medicare, we can identify conditions and clinical concepts that are most frequently lacking complete documentation. These conditions are then recommended as focus areas for the customer’s CDI initiative moving forward.

##### 2. Document Insights Analysis

M\*Modal Fluency for Transcription is the only transcription service that natively creates Clinical Document Architecture (CDA) documents. CDA is an HL7 standard for structuring and encoding information; this standard format is used by all of our NLU-driven solutions. Document Insights is an NLU application that provides dashboards for reviewing transcription documents based on quality measures, clinical conditions, authors, work types, and other data included in the CDAs.

##### 3. CAPD Silent Mode Analysis

It is critical that every real-time message shown to a physician via CAPD is of value and highly accurate. When in Silent Mode, physicians will not experience any change in their use of Fluency Direct, however, behind the scenes we will keep track of which messages *would have been shown to them* if they were in CAPD Active Mode. This helps to identify areas of opportunity for real-time CDI Engage messages and ensure that we have the right and highest value conditions enabled per physician.

### Day 1 - Admit Note

*The HTML walkthrough includes a video recording of this script as well as ability to demonstrate this document yourself.*

***See the Admit note in Script and Print versions on page 13 of this document.***

The patient was seen in ED because of chest pain, dyspnea, and respiratory distress. The documenting physician suspects pneumonia and admits patient, ordering labs and chest x-ray to confirm the pneumonia condition and identify causative organism for proper treatment.

Comments on Admit Note

* CAPD message for CHF, asking physician to fully specify the type and acuity (if known) of the patient’s chronic condition at time of documentation. If these details are unknown, can ignore message and CDI specialists will review; however, since this patient was recently in the ED, physician is able to look at chart and see the specific type of HF.
* NO CAPD MESSAGE for myocardial infarction because it was mentioned in the context of “history.” If, however, you change the sentence around MI so that it is a present concern, CAPD will ask physician to specify type (i.e. STEMI / NSTEMI)
* NO CAPD MESSAGE for Pneumonia because it was mentioned in the context of “possible.” If, however, this was documented as a present condition (as seen in the Assessment of the progress note), a CAPD message will be received asking the physician to specify the causative organism.

### Day 2 - CDI Specialist review of encounter

*The HTML walkthrough includes a video of a CDI Specialist reviewing William Allen’s encounter. In the video you see –*

* *Obesity being ignored, meaning there is no need for query;*
* *Heart failure documentation is reviewed to confirm the NLU identification of the condition being fully specified;*
* *Pneumonia documentation is reviewed, including labs and x-ray results, and a query is sent to the physician asking for type (causative organism). The query form (PDF) shows all supporting evidence in the current encounter and provides relevant options for physician to document in the next progress note.*
* *Launching the TruCode encoder to select principal diagnosis of Pneumonia and CC for heart failure.*

### Day 3 - Progress Note

*The HTML walkthrough includes a video recording of this script as well as ability to demonstrate this document yourself.*

***See Progress Note in Script and Print version on page 16 of this document.***

*Notice on the upper right hand side of the page, the Inbox now has 1 new message (the admit note also has this inbox, but no new messages). Clicking this link will open the same query that was created in CDI Collaborate by the CDI Specialist.*

By now pneumonia has been confirmed and the physician started the patient on antibiotics. Notice in the upper right hand corner of the HTML page the physician inbox now has a CDI query (PDF from CDI Collaborate) and he also receives a CAPD message asking for pneumonia causative organism. Notice the CHF CAPD message is not asking for Type and Acuity, but reminding the physician that CHF has already been fully specified in this encounter.

Comments on Progress Note:

* Upon dictation, the physician received a message asking for type of organism because of the context of the documentation. The CDI query form included all results and evidence necessary to specify the causative agent and fully specify pneumonia as Gram-negative nosocomial pneumonia.
* NO CAPD MESSAGE was received for Underspecified CHF because it was already fully specified in this encounter.
	+ Notice CHF message is a reminder that CHF is already fully specified
	+ Encounter-based reasoning is currently being used to drive the CDI collaborate evidence sheet. It is not yet available for CAPD, but it is under development. This will be a huge differentiator for us and is capable because of our single platform.

### Day 4 - Discharge

With the help of M\*Modal's Natural Language Understanding platform, the physician received real-time messages to help fully specify documentation at time of capture, and the CDI Specialist was able to efficiently review the patient encounter and query the physician when it was appropriate.

Complete and accurate documentation of Pneumonia and Congestive Heart Failure:

* Enables Case Management to appropriately initiate and conduct discharge planning process
	+ This drives accurate and improved length of stay (LOS)
* Empowers Mr. Allen and his family with an appropriate post-discharge plan
	+ This reduces risk or readmission and improves communication across the care team and with the patient
* Enables Coding to assign the appropriate codes to Mr. Allen's hospital stay resulting in complete and accurate reimbursement
	+ This helps ensure the hospital is paid correctly, according to patient severity of illness and level of service provided

### Outcomes

Throughout the previous 5 HTML pages you should have focused on the patient and documentation. Now, let’s look at the outcomes and impact we had across the continuum…

Remember the goals we established in the beginning?

* Increase the frequency with which Pneumonia and Heart Failure are completed and accurately documented
* Improve patient outcomes and communication
* Improve accuracy of reimbursement capture

What impact did we have?

* CAPD helped the physician to fully specify heart failure at the time of documentation. In addition to driving care and communication through complete documentation, this also shifted the encounter DRG by adding an MCC.
* The CDI Specialist was able to efficiently review the patient chart and quickly identify documented conditions. Once all the supporting evidence was available she sent a query to the physician asking for him to document pneumonia causative organism. The query was helpful to the physician because it included a summary of relevant findings from the EHR. CAPD also reminded him to document pneumonia organism at the appropriate time, which also shifted the DRG to one with higher reimbursement.
* The complete and accurate documentation drives patient care and communication among the care team. Also, the patient and his family receive fully specified discharge instructions, enabling them to appropriately follow up after leaving the hospital.
* The extra $6,300 the hospital receives in reimbursement for this encounter ensures they are paid for the patient’s severity of illness and level of care provided.

*Notice now is the first time our solutions are presented with bullet points about how each one impacts the care continuum. The purpose of that is to focus on the patient story until this point, where now you can identify the impact CDI Assess, Engage, and Collaborate all had in the care and documentation workflows.*

#### MEDPAR and Document Insights Analyses – Before and After

In this section you see the graphs from the Introduction page – *Heart Failure and Pneumonia, Before* – and their representation of impact over time. The graphs *Heart Failure and Pneumonia, After* show reduction in underspecified documentation for these conditions. This reduction is significant as it drives improvement in both patient and financial outcomes.

What’s next? With a real customer, after seeing such a shift, we would identify the next “low hanging fruit” to target for CAPD feedback and CDI focus.

We also track changes per physician over time and can see that most physicians are responding to the real time feedback and CDI queries, resulting in the reduction of underspecified documents.

# Demo Scripts

## FD CAPD Demo Script 1: CHF, CKD, Diabetes Mellitus, Electrolyte Imbalance

HPI: The patient is a 61-year-old female who was brought to the Emergency Room this morning by her husband following a syncopal episode. She vomited twice and is having significant malaise. She is status post CABG, surgery was last month.

Her problem list includes *[type 2]* **diabetes mellitus** with neuropathy, **CKD**, dyslipidemia and **CHF**.

Lab: Chem 7 results indicate **potassium 2.7** and **sodium 129**.

Impression: *[Chronic systolic congestive heart failure and CKD Stage II]* are well controlled. She should continue her normal medications and treatment plan. Patient is not on Dialysis and she is recovering well after surgery. Her *[hypokalemia*and*hyponatremia]* are concerning, likely due to fluid overload and diuretics. Will order follow up lab panel and consult with Nutritional Services to review diet plan.

FD CAPD Demo Script 2: CHF, Sepsis

***Insert SOAP Template***

Subjective:

The patient is a 45-year-old male here today for follow up after a visit to the ED 6-days-ago. He was there because of a fall and confusion and is known to have *[chronic systolic]* **heart failure** and hypertension. CT scan was negative for stroke, but he was found to have a UTI. He started Macrobid that day and blood work was done yesterday. Today he feels ill, “as if I have the flu.” He is febrile, complains of right flank pain, and is having a hypertensive crisis.

Objective:

The patient still has an **altered mental status** and I am unable to conduct a full exam. He has **tachycardia** and a **fever of 102 degrees Fahrenheit**. No known drug allergies.

***Pull CBC results***

Assessment:

*[Septic shock]* and accelerated hypertension. Considering his disposition, recent hospital contact, and high WBC count I am going to send the patient back to the hospital for observation.

Plan:

Order immediate CBC, start IV fluids, rule out septic shock. CC Dr. Jones of the critical care team.

## Closed Loop CDI Demo: Encounter Documents

### Encounter Day 1 - Admit Note

1. Script version

HPI: The patient is a 66-year-old old white male with a past medical history including congestive heart failure, MI, hypertension, and CAD. The patient presents to the ED per family request with a chief complaint of dizziness, respiratory distress and hypotension. Family reports a BP of 82/50 and states that the patient was seen about 2 weeks ago for chest pain and dyspnea. A workup was done in the ED followed by an arteriogram. Following the procedure the patient was discharged and started on Lipitor. The patient reports still experiencing chest pain <open paren> epigastric <close paren> and shortness of breath. He has been less active and is eating less than usual. <new paragraph>

<insert history template>

* Past Medical History: Heart failure, MI, Hypertension, Hypothyroidism, CAD
* Past Surgical History: Cholecystectomy, Cardiac surgery stents x2, Cardiac cath, Left knee surgery
* Family History: CKD and breast cancer in the mother. Father died following ischemic stroke.
* Social History: Former Smoker and drinks 6 cans of beer per week.
* Allergies: No known drug allergies.

<insert normal exam>

Review of Systems:

* Constitutional: Positive for decreased appetite and fatigue. Negative for fever and chills.
* Respiratory: Positive for coughing and dyspnea.
* Cardiovascular: Positive for intermittent chest pain. Negative for palpitations. Hypotension today, 82/50 at home.
* Gastrointestinal: Positive for epigastric abdominal pain. Negative for nausea, vomiting, diarrhea and constipation.

Physical Exam

* Pulmonary: Respiratory distress. Wheezing and mild rales.
* Abdominal: There is tenderness in the epigastric area.

<remove all fields>

<pull vitals>

Impression: Possible pneumonia. Order chest x-ray to follow up for his respiratory distress.

<insert before congestive>

chronic systolic

1. Print version

HPI: The patient is a 66-year-old white male with past medical history including congestive heart failure, myocardial infarction, hypertension, and coronary artery disease. The patient presents to the Emergency Department per family request with a chief complaint of dizziness, respiratory distress, and hypotension. Family reports a BP of 82/50 and states that the patient was seen about 2 weeks ago for chest pain and dyspnea. Workup was done in the Emergency Department followed by an arteriogram. Following the procedure the patient was discharged and started on Lipitor. The patient reports still experiencing chest pain (epigastric) and shortness of breath. He has been less active and is eating less than usual.

Past Medical History: Congestive heart failure, myocardial infarction, hypertension, hypothyroidism, coronary artery disease.

Past Surgical History: Cholecystectomy, cardiac surgery stents x2, cardiac catheterization, left knee surgery.

Family History: Chronic kidney disease and breast cancer in the mother. Father died following and ischemic stroke.

Social History: Former smoker and drinks 6 cans of beer per week

Allergies: NKDA

Review of Systems:

Constitutional: Positive for decreased appetite and fatigue. Negative for fever and chills.

HEENT: Negative for congestion, ear pain, rhinorrhea and sore throat.

Respiratory: Positive for coughing and dyspnea.

Cardiovascular: Positive for intermittent chest pain. Negative for palpitations. Hypotension today, 82/50 at home.

Gastrointestinal: Positive for epigastric abdominal pain. Negative for nausea, vomiting, diarrhea and constipation.

Genitourinary: Negative for dysuria, urgency, frequency, and hematuria.

Neurological: Negative for dizziness, weakness, light-headedness and headaches.

All other systems reviewed and are negative.

Physical Exam:

Constitutional: He is oriented to person, place, and time. He appears well-developed and well-nourished. No acute distress.

Head: Normocephalic and atraumatic.

Eyes: EOM are normal.

Neck: Normal range of motion. Neck supple.

Cardiovascular: Normal rate, regular rhythm, normal heart sounds and intact distal pulses.

Pulmonary: Respiratory distress. Wheezing and mild rales.

Abdominal: There is tenderness in the epigastric area.

Neurological: He is alert and oriented to person, place, and time.

Skin: Skin is warm and dry. He is not diaphoretic.

Psychiatric: He has a normal mood and affect.

Vitals:

BP 100/56 mmHg

Pulse 87

Temp (Oral) 98.3 °F (36.8 °C)

Resp Rate 16

SpO2 84% MDM

Impression: Possible pneumonia. Order chest x-ray to follow up for his respiratory distress.

### Encounter Day 3 - Progress Note

1. Script version

<insert SOAP template>

SUBJECTIVE

Patient is alert and oriented to person, place, and time. Patient will be followed by me. We will keep on vancomycin.

<next field>

OBJECTIVE

Pneumonia revealed on Chest study. He is feeling better, but will complete antibiotic course. We will monitor complete resolution on chest x-ray.

<next field>

ASSESSMENT

Number 1 pneumonia <new line>

Number 2 CHF <new line>

Number 3 hypertension <new line>

Number 4 CAD <new line>

Number 5 hyperlipidemia <new line>

<next field>

PLAN

I discussed patient status with his daughter, and he will continue antibiotic treatment.

<insert before pneumonia>

Gram-negative bacilli nosocomial pneumonia

1. Print version

SUBJECTIVE

Patient is alert and oriented to person, place, and time. Patient will be followed by me. We will keep on vancomycin.

OBJECTIVE

Pneumonia revealed on Chest study. He is feeling better, but will complete antibiotic course. We will monitor complete resolution on chest x-ray.

ASSESSMENT

1. Gram-negative nosocomial pneumonia
2. Chronic systolic congestive heart failure
3. Hypertension
4. Coronary artery disease
5. Hyperlipidemia

PLAN

I discussed patient status with his daughter, and he will continue antibiotic treatment.

# Appendix / Setup Information

## Preparing to Demo

***Note: You should be using Fluency Direct version 9.1.60 with CAPD version 7.6.3 or later.***Contact David Gross if you have different versions or are unable to see CDI Engage and/or Precyse University Documentation Tips.

If you are using an FD user in the Pittsburgh CDS Demo account (i.e. username@demo), please email Dan Engel or David Gross and ask to be added to the “HIMSS-2016” group to inherit voice commands and abbreviations used in the demo scripts.

### CAPD Enablement and System Check

When launching Fluency Direct you should see a Ribbon on your Control Bar, indicating that your user is active for CAPD. Use the System Check feature to ensure that configurations and CAPD connections are working as expected:

* Sign in to Fluency Direct
* Hold SHIFT and click the Control Bar
* Select “System Check” to run a CAPD diagnostic

Contact Dan Engel, and send System Check results, if you do not see the ribbon, have errors in System Check results, or CAPD is otherwise not working.

### Demo System

[Click Here to access the HTML-based faux-EHR and Closed Loop CDI demo from the Fluency Direct documentation site](https://docs.mmodal.com/direct/index.php/employees-1/demo-support)

* Demo credentials:
	+ Username: MModal
	+ Password: M\*Modal1710
* Use FD-CAPD-Demo.html for regular demonstration of FESR, CAPD, and other FD features
	+ ***Note: There are two “EHRs” available to demo in – Epix and Cermer***
		- These were built to resemble the actual EHRs, Epic and Cerner, respectively
		- Click the “Others” link to launch the EHR compatibility list on the FD Documentation site, which can be shown to customers to help the discussion around how FD can work in their actual environment
	+ Be sure to use Internet Explorer or Firefox for best CAPD performance
* Use CDI-Demo.html for in depth conversations and demonstration of M\*Modal CDI solutions
	+ ***Note: This document includes talk tracks and description for this demonstration and this demo is designed to tell a story following a full patient encounter***
	+ Be sure to understand all pages and components of this demo in order to guide and lead the conversation with customer and so you can navigate to the right part of the demo based on their interests
	+ Be sure to use Internet Explorer or Firefox for best CAPD performance

## Fluency Direct Voice Commands for Included Scripts

Ask to be added to the “HIMSS-2016@demo” group to inherit these commands.

### Insert SOAP Template

1. Insert this Text

Subjective:

[ ]

Objective:

[ ]

Assessment:

[ ]

Plan:

[ ]

2. Run this built-in Command: First Field

### Pull CBC Results

Complete Blood Count:

WBC 13,200 /mcl \*\*\*\*

RBC 6,200,000 /mcl

HGB 14 g/dl

HCT 48%

MCV 55.9 fl

MCH 18.2 pg

MCHC 33.5 g/dl

PLT 210/mcl \*\*\*\*

### Insert History Template

1. Insert this Text

Past Medical History: [ ]

Past Surgical History: [ ]

Family History: [ ]

Social History: [ ]

Allergies: [ ]

2. Run this built-in Command: First Field

### Insert Normal Exam

1. Insert this Text

Review of Systems:

Constitutional: [\*\*\*]

HEENT: [ Negative for congestion, ear pain, rhinorrhea and sore throat.]

Respiratory: [ Negative for cough and shortness of breath.]

Cardiovascular: [ No chest pain. Regular rate and rhythm. Negative for murmurs. Negative for palpitations.]

Gastrointestinal: [ Abdomen soft. Normal bowel sounds. Negative for nausea, vomiting, diarrhea and constipation.]

Genitourinary: [ Negative for dysuria, urgency, frequency, and hematuria.]

Neurological: [ Negative for dizziness, weakness, light-headedness and headaches.]

All other systems reviewed and are negative.

Physical Exam:

Constitutional: [ He is oriented to person, place, and time. He appears well-developed and well-nourished. No acute distress.]

Head: [ Normocephalic and atraumatic.]

Eyes: [ EOM are normal.]

Neck: [ Normal range of motion. Neck supple.]

Cardiovascular: [ Normal rate, regular rhythm, normal heart sounds and intact distal pulses.]

Pulmonary: [ Effort normal and breath sounds normal. No respiratory distress. No wheezing or rales.]

Abdominal: [ Soft. Bowel sounds are normal.]

Neurological: [ He is alert and oriented to person, place, and time.]

Skin: [ Skin is warm and dry. He is not diaphoretic.]

Psychiatric: [ He has a normal mood and affect.]

2. Run this built-in Command: First Field

### Pull Vitals

Vitals:

BP 100/56 mmHg

Pulse 87

Temp (Oral) 98.3 °F (36.8 °C)

Resp Rate 16

SpO2 84% MDM