

See What's New from PayDC!

Here's what's in this release (June 13, 2018)

Important announcement:

PayDC is constantly working to bring you the latest and greatest improvements. We have elected to discontinue support for the windows mobile application for PayDC due to lack of active users.

This will only affect you if you downloaded the app from the windows store for windows mobile devices. The standard login and launch of the program will remain unchanged.

This will go into effect as of this release on **June 13, 2018**.

Improvements to SOAP Notes > Patient History

The following changes were made to Patient History:

- **Improved workflow for tracking Patient History:** Historically providers have had to manually generate the Patient History portion of each SOAP Note narrative one tab at a time. As of this release, when starting a new case for a patient, providers can interact with the various tabs of the History dialog without needing to manually "generate narrative".

As long as that initial Note or Exam has not been signed, the provider can return to the Patient History and continue to make changes. Once the note is signed all of the Patient History information is automatically included in the SOAP Note Narrative.

Some points to note about this new approach:

- o Throughout the process of building the Patient History, providers can check the progress of how the "History of Present Illness" section of the

Note is going to appear in the narrative by clicking on “Preview Narrative”:

- o During subsequent visits, providers can review Patient History from within the note by clicking on Patient History and viewing the Patient History narrative:

- o If providers want to make any additional changes to Patient History, they can include an update to Patient History:

SOAP Notes - Patient History

History of Present Illness from 6/10/2018
 Accident occurred on 6/1/2018 at approximately 10:16 AM.
 The patient stated: My wife swerved trying to miss hitting a chipmunk and ran into another car. The back of my head hit the window.
 Symptoms reported: My head hurts. I have bad headaches now.

Mr. Crush stated he was a passenger in the vehicle, at the time of the accident. He indicated that there was driver side damage to the other vehicle. The damage condition of the other vehicle, a 2001, Ford, F150.
 The weather was clear. Street surface was dry. The impact on the vehicle was at the rear end, and the brakes on impact were locked and the car did not move. Mr. Crush indicated he was seated in the vehicle and was not wearing a seat belt without the shoulder harness without the head rest. The vehicle is equipped with air bags. Mr. Crush didn't see the impact coming. Upon impact his head was looking ahead and was facing forward. Mr. Crush also indicated he does not remember the accident happening.

Surgeries/hospitalizations: None reported.
 Allergies: Sulfa drugs.
 Medications: Atenolol.
 Prior conditions: High Blood Pressure and Severe acne.
 He reported that he experienced a similar condition before. He stated: Patient experienced a head injury 20 years ago when in high school playing Lacrosse.
 Family Health History: None reported.

History Update
 Since we last met, patient has started taking Lipitor as directed by his primary care physician.

OK Cancel

This will appear in that Note's Narrative as "Update to Patient History" without the entire Patient History appearing again:

Subjective:

Primary Complaint: left head

The patient presents with sharp, stabbing pain located in left head that has **decreased** to **2** out of 10 from 8 out of 10.

The patient presents with tingling located in left head that has **increased** to **7** out of 10 from 3 out of 10.

Update to Patient History from 6/10/2018:

Since we last met, patient has started taking Lipitor as directed by his primary care physician.

Objective:

Spinal Fixation/Malposition/Palpatory findings: C2.

Assessment:

Diagnoses: 1. Other cervical disc displacement and unspecified cervical region (M50.20).

- **Optional import into Patient History from Patient Questionnaires:**
 Information from the Patient Questionnaires is no longer automatically imported into Patient History. Instead providers have the option to include or not include that information.

To make use of the information from the Questionnaires, while in the Patient History dialog, click the "Import from Questionnaire" button:

Relationship	None	Conditions	Comment
Father	☐		
Mother	☐		
Brother	☐		
Sister	☐		
Son	☐		
Daughter	☐		
Half-sibling	☐		

Additional Notes:

Import from Questionnaires Preview Narrative OK Cancel

If you plan to import from a questionnaire, it is highly recommended to do so before adding any further information in the Patient History dialog. The act of importing from questionnaire results in overwriting any existing changes already made to the Patient History.

Once information is imported from questionnaires, it can be modified without changing the initial questionnaires.

- **Additional Notes section available for each tab of Patient History:** Each tab of the Patient History has an optional “Additional Notes” field. This information is included in the SOAP Note Narrative under the appropriate section of the Patient History:

Relationship	None	Conditions	Comment
Father	☐		
Mother	☐		
Brother	☐		
Sister	☐		
Son	☐		
Daughter	☐		
Half-sibling	☐		

Additional Notes:

Import from Questionnaires Preview Narrative OK Cancel

Each of these Additional Notes fields support multiple lines and are enabled for Macros.

- **Improvements to specific tabs, including:**
 - o **Accident Details (auto):** As of this release providers have the ability to show/hide which lines of the Accident Details tab gets included in the narrative:

The screenshot shows the 'SOAP Notes - Patient History' window with the 'Accident Details' tab selected. A red box highlights the 'Select All' checkbox and the first two rows of the form, which include checkboxes for 'Patient's position in the vehicle', 'Automobile details', 'Vehicle damage', 'Damage estimate', 'Other automobile details', and 'Other vehicle damage'. The form contains various input fields for accident information, including year, make, model, damage amount, condition, location, and weather.

Note that each line can be individually added or removed from the narrative by checking the checkbox. Additionally, there is the option to check/uncheck all by clicking on the “Select All” control at the top.

- o **Additional HPI:** For this tab, we removed the precise date control for “Experience this before”. We also removed the redundant fields that were asking for primary complaint, aggravated by and relieved by.

Improvements to SOAP Notes > Review of Systems (ROS)

As of this release, Review of Systems (ROS) will no longer be included as part of Patient History. Providers will instead have the option to review and make changes with each visit.

To access this dialog, click on the ROS button in the Subjective section:

Care Plan Category: None
Secondary Ins: -
Progress Graph

☐ Wellness ☐ Evaluation ☐ Addendum

Subjective: #1 L-Head Pain(8) Tingling(3)

History: ROS Additional Notes:

Objective: Additional Notes:

In addition to making minor improvements to various category names (i.e. Men's Health Issues, etc.) an optional Additional Notes field has been added to this dialog as well.

Improvements to SOAP Notes > Subjective

The following improvements were made to SOAP Notes > Subjective:

- **Selected symptoms appear at the top of the complaint's list:** For each complaint, when selecting symptoms, those selected will automatically appear at the top of the list. Unselected symptoms are still available but are moved below the selected:

- **Patient's complaint information is available for review after they check-in:** When a patient checks in and provides updated information about existing complaints, there will be a link in the Complaint section of SOAP Note >

Subjective indicating when the patient checked-in:

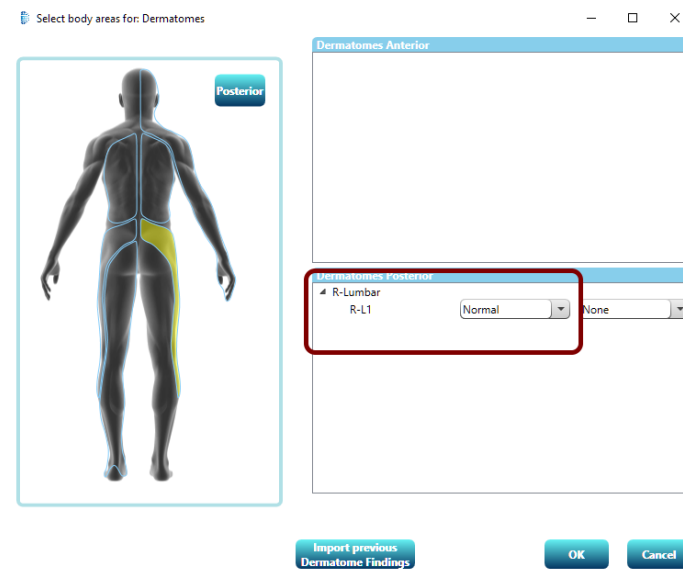
Clicking on that link gives providers the opportunity to compare the patient's information with information from the previous visit:

Patient's Check-in: 02:23 PM Yesterday	Last note: June 02, 2018
The patient presents with infrequent dull pain located in neck and describes intensity as minimal rated at 5 out of 10 which is decreased by standing. The patient presents with stiffness in neck rated at 5 out of 10.	The patient presents with dull pain located in neck rated at 4 out of 10. The patient presents with stiffness in neck rated at 4 out of 10.

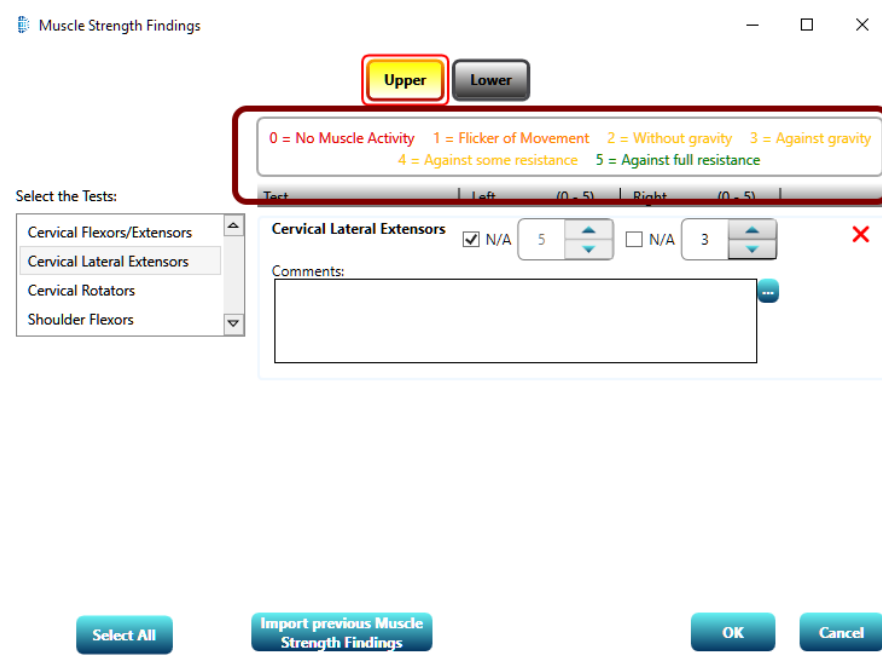
Improvements to SOAP Notes > Objective

The following improvements were made to SOAP Notes > Objectives:

- **Exam Findings > Dermatomes:** Added a default option called “Normal”:



- **Exam Findings > Strength:** Changed the scale to match the commonly-used Oxford Strength Scale:



- Added an “N/A” option for each side of bilateral tests. This applies to each of the following Exam Findings:
 - o Ortho/Neuro
 - o ROM
 - o Strength

Muscle Strength Findings

Upper Lower

0 = No Muscle Activity 1 = Flicker of Movement 2 = Without gravity 3 = Against gravity
4 = Against some resistance 5 = Against full resistance

Select the Tests:

- Cervical Flexors/Extensors
- Cervical Lateral Extensors
- Cervical Rotators
- Shoulder Flexors

Test: Cervical Lateral Extensors

Left (0 - 5) Right (0 - 5)

☒ N/A 5 ☐ N/A 3

Comments:

Select All Import previous Muscle Strength Findings OK Cancel

Improvements to SOAP Notes > Assessment

The following improvements were made to SOAP Notes > Assessment:

- **Added Long-term goals to the SOAP Notes:** Now providers can track during each visit the Long-term Goals:

Long-term Goals:

- lift 20 pounds pain free
- avoid surgery
- increase core strength

In order to return to work, the patient must be able to lift at least 20 po...

% Goal Reached

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Comment

Edit Goals

☐ Include in Subsequent Notes

Some things to note about this new feature:

- o If Long-term goals are defined in the Care Plan prior to completion of the first Note, these goals will automatically appear in the SOAP Note.
- o Providers can add, modify, and review any goal as long as the SOAP Note is editable:

Long-term Goals:

- lift 20 pounds pain free
- avoid surgery
- increase core strength

In order to return to work, the patient must be able to lift at least 20 po...

% Goal Reached

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Comment

Edit Goals

☐ Include in Subsequent Notes

- o The progress of all goals can be tracked via visit-specific comments. In addition, practices can configure goals to be tracked each visit by percentage of goal reached:

Long-term Goals:

lift 20 pounds pain free
avoid surgery
increase core strength

% Goal Reached
0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Comment

Edit Goals

☐ Include in Subsequent Notes

- o Administrators can configure a long-term goal to be tracked via percentage at Advanced Settings > Functional Preferences > CarePlans > Long-term Goals:

Add/Edit Settings

File Help

Subscriber Profile
(i) Add1 Branch Locations (31)
(i) Users (67)
- Patient Tasks
- Payment Processing
- Patient Data Export
- Patient Data Import
- Insurance Carrier Import
- Scheduler Preferences
- Appointment Types
- Office Hours/Zones/Notification
- Healthcare Provider
- Blocks
- Billing Preferences
- Insurance Carriers
- CMS 1500 Printer Settings
- Billing Address
- Tax
- Referring Providers
- Functional Preferences
- CarePlans
- CarePlan Categories
- CarePlan Stages
- Resolution Types
- Conditions
- ICD-9
- ICD-10
- Diagnostic Tests
(i) E/M Services
(i) **Long-term Goals**
(i) Procedures
- CarePlan Templates
(i) Discounts
(i) Payment Plans
(i) SOAP Notes
(i) Subjective

Long-term Goals

Name	Track Progress	Include
Lift 10 pounds pain free	☒	☒
track 1	☒	☒
track 1	☒	☒
LG Third	☒	☒
LG by unknown	☒	☒
Long by test	☒	☒
lift 20 pounds pain free	☒	☒
newly added LG by mpr	☒	☒
convert to wellness	☒	☒
avoid surgery	☒	☒
no increase in symptoms for future flareup	☒	☒
increase core strength	☒	☒
Return to work	☒	☒
restoring functional independence	☒	☒
decreasing pain	☒	☒
Use the Verbal Numeric Scale to evaluate pain	☒	☒
Evaluate care based on outcome measurement tools	☒	☒
restoring tolerance to normal activities of daily living	☒	☒
at for 5 hrs at a time	☒	☒
sustain current lifestyle	☒	☒
test goal	☒	☒

Enter the text of a Long-term Goal for CarePlans. Options you check to "Include" will be the available options to select from when creating Care Plans. (This text is used mid-sentence in

Add New Long-term Goal

Move First Up Down Move Last

Note: CarePlans already exist, using some of the previously included items. Items that are already being used in CarePlans cannot be changed, except for the Fee, and certain Names or Titles. If you uncheck include for an item already in use, it will not be available for future CarePlans.

Save **Close**

- o Long-term goals, percentage improved, and comments appear in the Narrative under the Assessment section:

Assessment:

Diagnoses: 1. Other cervical disc displacement and unspecified cervical region (M50.20).
Prognosis: Excellent - Full symptomatic and functional recovery expected within 2-4 weeks.
Patient is progressing as anticipated. Intensity is un-changed since the prior visit.

Long-term goals:

lift 20 pounds pain free: **Progressed from 0% to 20%.**

Patient has demonstrated that he can lift up to 5 lbs but get fatigued very easily.

increase core strength:

Patient has continued to do the prescribed exercises at home and is reporting that he feels stronger.

- **Added ability to track Prognosis:** Providers now have the option during each visit to select a prognosis from a pre-defined list:

NOTES:

Assessment

Add Diagnoses

Stage of Care:

Progress:

Regressed

Slightly Regressed

None

Slightly

Improved

Resolved

Slower

As Anticipated

Faster

Intensity:

Decreased

Slightly Decreased

Un-changed

Slightly Increased

Increased

Prognosis: Excellent

Long-term goals:

lift :
avo
incr

Edi

When a prognosis is selected it appears in the Narrative under the Assessment section:

Assessment:

Diagnoses: 1. Other cervical disc displacement and unspecified cervical region (M50.20)

Prognosis: Excellent - Full symptomatic and functional recovery expected within 2-4 weeks.

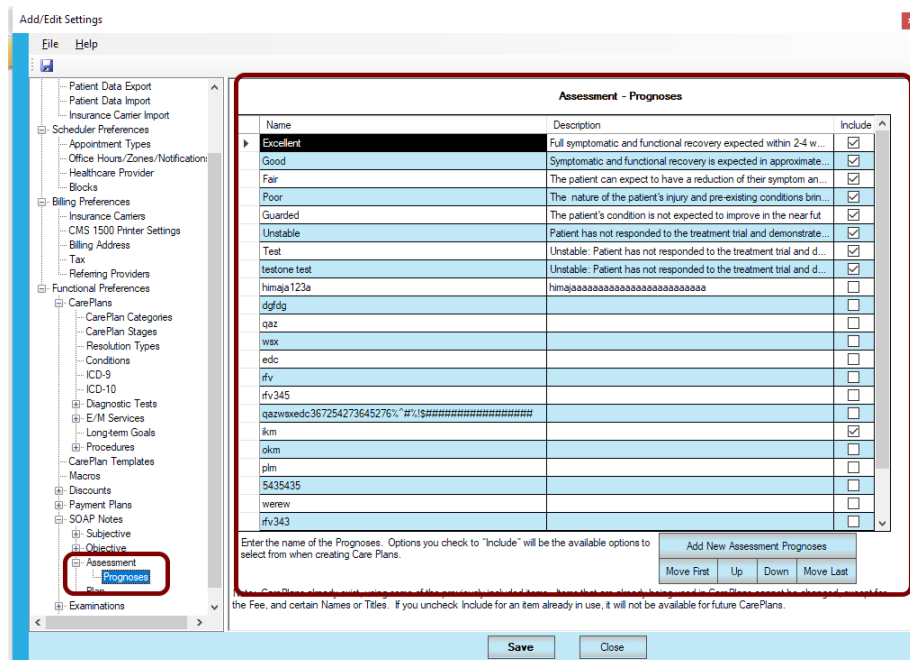
Long-term goals:

Goal added: lift 20 pounds pain free. In order to return to work, the patient must be able to lift at least 20 pounds without assistance.

Goal added: avoid surgery.

Goal added: increase core strength. The patient feels "weak" and "flabby" as a result of this ordeal.

Prognoses and their descriptions can be added, removed and modified in Advanced Settings > Functional Preferences > Assessment > Prognoses:



Support Items

In addition, we have added fixes to the following support items:

- Advanced Settings > Subscriber Profile > Add'l Branch Locations: Fixed an issue in which deleting a branch caused an error.
- Advanced Settings: Expanded the number of characters allowed in various user-defined lists (i.e. Extremities, Ortho/Neuro, etc.)
- Appended "DO NOT REPLY" to the beginning of every Text Reminder.

Thank you!

PayDC/APS Development Team

Questions? You can always contact the Service Desk.

- If you are a PayDC customer, the phone number is [\(888\) 306-1257](tel:888-306-1257); please choose option 4 for Service Desk.
- If you are an Advanced Provider Solutions customer, the phone number is (855) 283-4940; please choose option 4 for Service Desk.



- If you would like to contact the Service Desk via e-mail, please use the [Contact Us form on our website](#). Please note: the Contact Us form is now secure, so you can include PHI in your description.