

MAT Quick Start Guide

MAT (Mobile Assessment Tool) is an extension of SAM (Service Agency Manager) that allows the clinical documentation for a patient to be entered on a Tablet PC away from the office and transmitted to the office over the internet via a cable connection, Wi-Fi, or Air Card.

MAT Office



MAT Mobile Tablets



MAT Office is used to review the clinical documents submitted from the **MAT Mobile** users. The documents can either be sent back to the MAT Mobile users for rework (a feature called conferencing) or sent to SAM, where they automatically create such things as Care Plans, Verbal Orders, patient demographic and status updates, and new and verified visits so that payroll and billing operations can be more quickly and accurately performed. MAT provides for the documentation of a patient's care from the start of care document through visit notes, care coordination notes, re-certifications, transfers, resumptions, verbal orders, and follow-ups. A complete list of MAT documents is available in the help at the bottom of the "New Document" item of the patient menu.

SAM and MAT are supported by the same staff, share the same SQL database and, in the future, the terms SAM and MAT will be replaced with RiverSoft Office and RiverSoft Mobile. Great care was taken to provide the caregiver with the most straight-forward user interface possible to minimize the tasks of training and support. Using MAT should greatly reduce the clinical paper chase, increase document accuracy, reduce the time spent on clinical documentation, and greatly increase an agency's billing efficiency.

Basic Workflow Description

A patient is initially entered into SAM at referral time with a status of incomplete. All incomplete patients show on the tablets by default. The patient's admitting caregiver creates a Start of Care document and sends it to the office, where it is reviewed and sent to SAM. The SAM patient is marked as admitted, a care plan is automatically created so that it can be sent to the doctor and tracked, a verified visit is automatically added to the schedule so that the caregiver can be paid and the billing for the patient can be triggered, and authorization rules are created to provide warnings for unauthorized visits. Subsequent documents flow from the tablets into the office for the patient until finally the review of the patient's discharge document causes the patient to be marked as discharged in SAM.

If I Have SAM, How Do I Get MAT?

There is no additional charge for using MAT in the office – anyone who has access to SAM has access to MAT in the office – MAT is considered to be just another part of SAM and is covered under the same licensing rules. There is an additional charge for using MAT on a mobile device along with some additional configuration and training. Please call RiverSoft (321.242.1347) to arrange for this installation and training. The installation can be done in less than an hour. One or two internet trainings, each about 90 minutes long, should provide you with all of the information you need to get your first wave of caregiver's using MAT Mobile.

To be successful with MAT, you must gain an understanding of this list of topics covered in this guide:

1. Giving SAM users access to MAT
2. Install MAT in the office
3. Installing MAT on Tablet PCs – there is a separate training on this to work out any setup/network issues.
4. Entering a patient referral in SAM and starting a patient in MAT

5. Every patient must have a Start of Care document in order for information to flow correctly in MAT. Patients active at the time MAT is installed in your agency need only a Start of Care (Brief).
6. MAT documents overview – Help Menu under New Document portion of Patient menu.
7. MAT's Patient View and Patient Menu – New Document, New OASIS, Care Profile, Med Profile, Patient Referral, Revision History, Visit Schedule, Filed Documents, Show Patient's Documents, Show OASIS, and Reports.
8. MAT's Incomplete Document view important for mobile users.
9. Completed Document (normal and visit only), and (only on MAT Mobile) Schedule views – left click opens document, right click shows document dates and allows list filters to be set.
10. Only the author and the system administrators may edit a document.
11. Navigating through a MAT document – Navigation Panel, Complete/Incomplete pages, auto-save, bottom info bar, search-save-delete-? features, skip logic, problem triggers, body diagram, med page, only completed documents can be synced (sent to the office).
12. The power of the problems and interventions feature is that ongoing problems along with their ongoing interventions flow forward to each new document giving all caregivers a simple view the status of a patient's problems and the care that is being delivered to resolve those problems. Patient teaching and wound care are both documented using this feature.
13. Information that flows from previous documents – demographics, medications, problems/interventions, and goals. Goals and Problems/Interventions are defined on the Start of Care (SOC) and once the document is Sent to SAM, they flow forward. They can be updated on Recert/Resumptions, Follow-Ups, and verbal orders. The status of goals and problems/interventions may be updated on most documents.
14. Printing complete, partial, blank documents, and printlets.
15. Recert-Due and Authorization Due Reports.
16. Conference feature and conference document view.
17. Reviewing a document – Outcomes available for Discharges.
18. Case Synopsis report for Transfers and Discharges provides at-a-glance summary of case.
19. Sending a document to SAM.
20. Accepting a document – Care Coordination notes, HHA Orientation and SOC (Brief).
21. Only the active patients a caregiver has seen over the last month or is scheduled to see in the future are sent to the caregiver's tablet. All caregivers see the incomplete and hold patients. Options are available to reduce number of patients sent to a tablet.
22. Other patients may be requested by a mobile caregiver during synchronization via the "Select on Demand Patients" feature – very handy for On-Call caregivers.
23. Synchronization and Dashboard Reports.
24. Mobilegrams and Announcements.
25. Link Documents.
26. MAT's Audit Login.
27. MAT Document Data Exchange and Mastership.
28. Application Details Page – MAT Support, Quick Start and Operations Guide, Phrase and Meds editors, SAM flow options, document counts.

At the end of the document is a list of frequently asked questions. Understanding the answers to these questions will aid in a basic understanding of MAT. A list of RiverSoft's current hardware recommendations for MAT is on the MAT page of the RiverSoft web site along with this document.

If using Windows 7 Starter, you must "Disable visual themes".

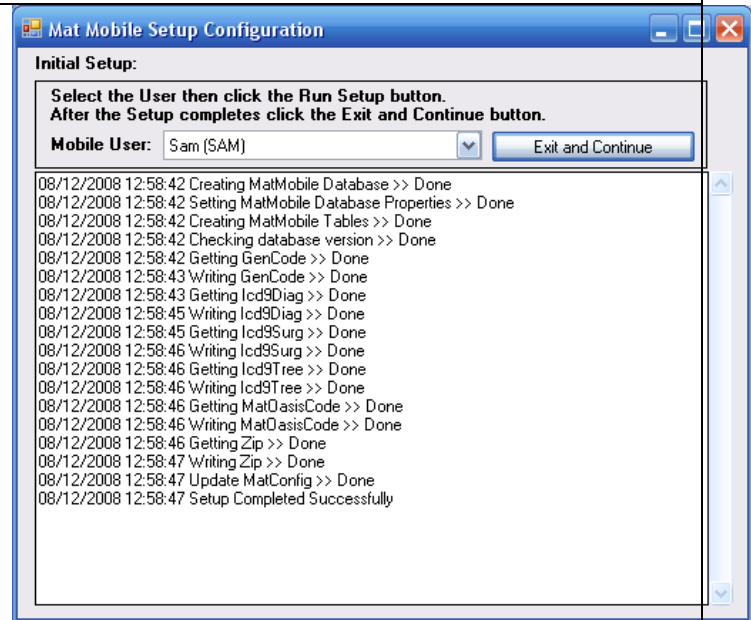
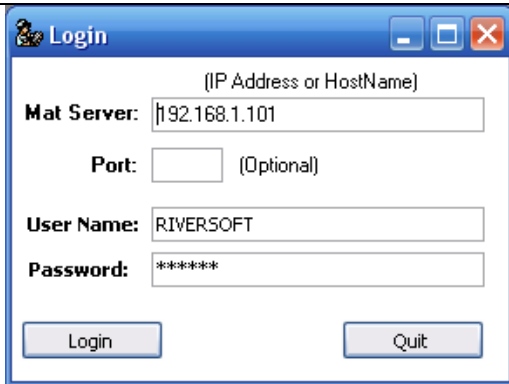
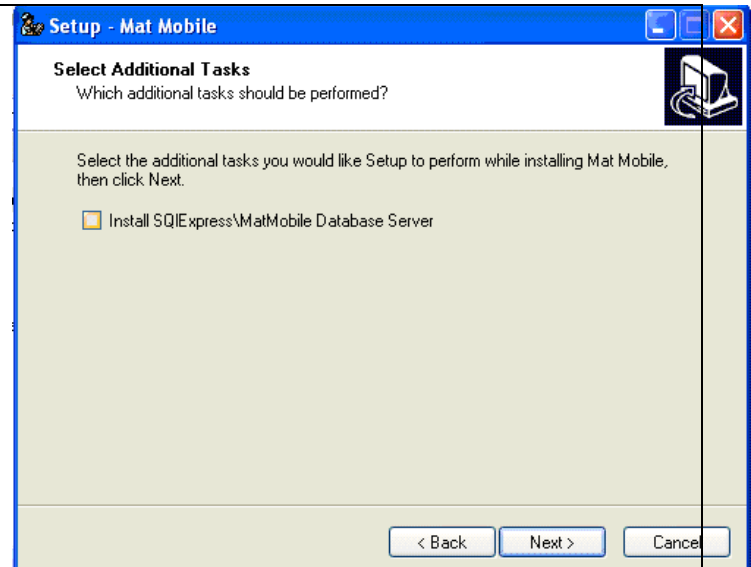
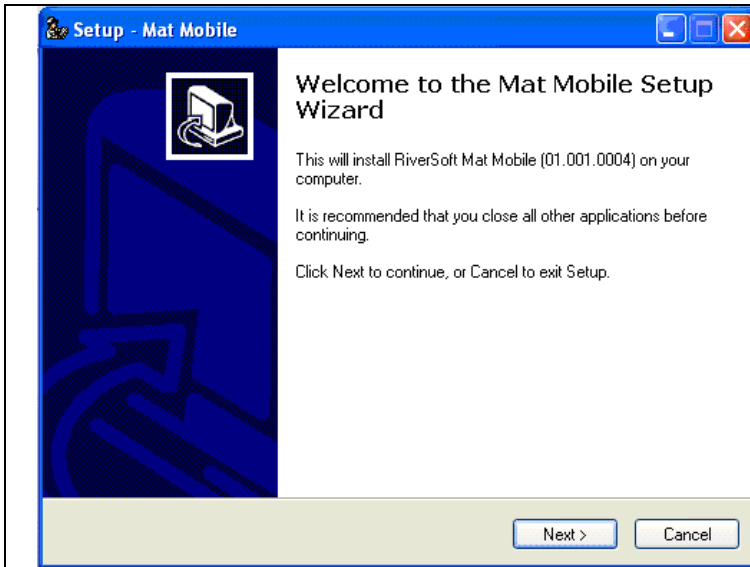
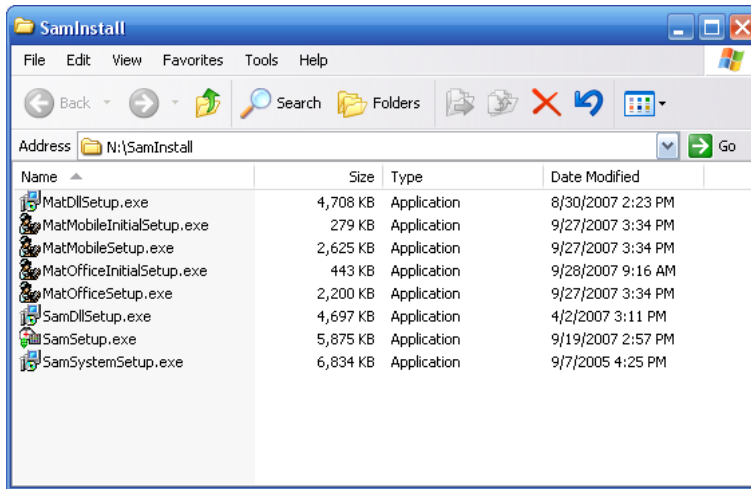
1. Head to **Start**
2. Select **Control Panel**
3. Select **Appearance and Personalization**
4. Select **Personalization**
5. Select **Theme**
6. Under Basic and High Contrast Themes, select "**Windows Classic**"

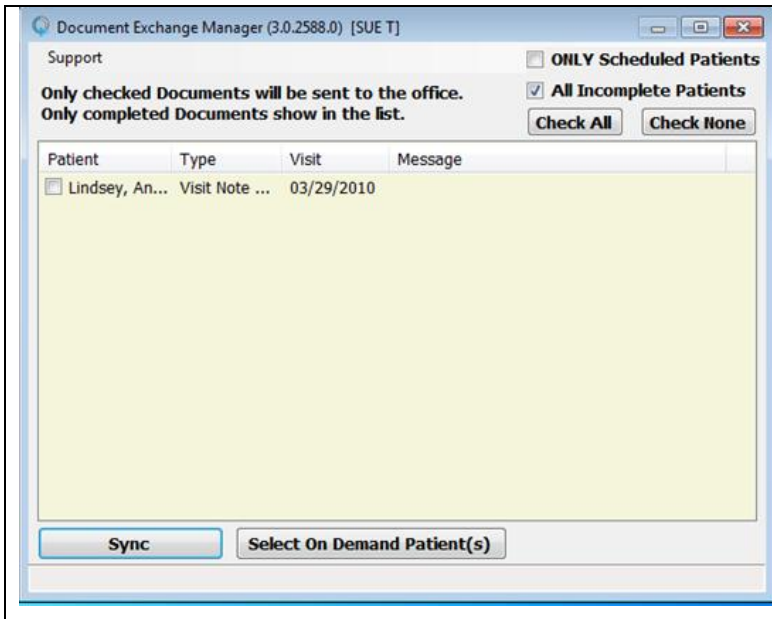
If you don't do this, the fields on MAT documents that are required combo boxes will not show as the normal yellow and you will have no visual queue that fields are required.

If using Windows Vista Tablet PCs, BE SURE TO...

- 1) Set the theme to Windows Classic – if you don't, required combo boxes will not show as the normal yellow and the document pane of the window will not have enough left-right real estate.
- 2) Set the power setting plan to High Performance – if you don't, resource on the machine will spin down during your visit and the machine may lock up.

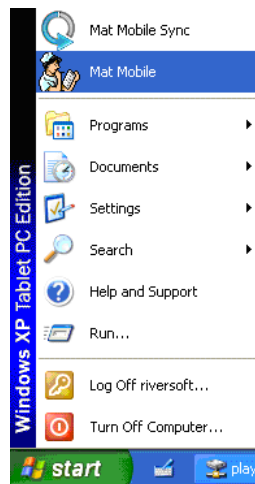
MAT Mobile Setup



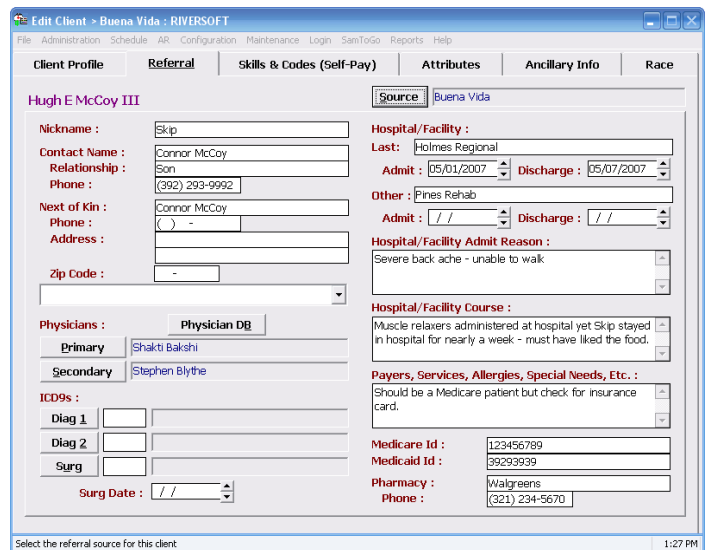
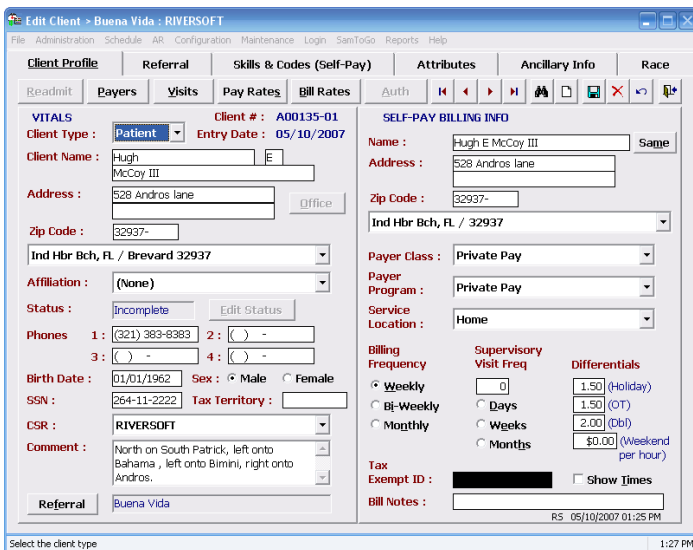


MATMobileInitialSetup.exe can optionally install the SQL database on the tablet PC – if MAT has never been installed on the tablet PC, check the “Install SQLExpress\MatMobile Database Server”. Choose the user that will be assigned to the tablet PC. **Only SAM users with the MAT permit will show in the list.**

Select the “Run Setup” button – the setup will take about a minute. Click the “Exit and Continue” button to show the Sync screen. Click the Sync button to perform the first data synchronization. Setup installs the Mat Mobile and Mat Mobile Sync shortcuts onto your start menu. Once this is done, the laptop is ready to go mobile. As long as the laptop can connect to the MAT Exchange Server IP Address (devices used outside the office must sync to a static IP or VPN), the sync will work. **The average sync time is less than 3 minutes. Please sync AT LEAST each morning before visiting patients.**



To use MAT for a patient, the initial patient / referral information must be entered into SAM (Administration/Client). Not only will this information flow to the referral portion of MAT’s patient information, it will flow to the Start of Care saving the admitting nurse or therapist entry time.



When a patient is entered into SAM, their status is incomplete and the patient will show in the main view in MAT, the patient list. There are five data views in MAT, the default being the patient list. In this view you can quickly find a patient by typing in the first few characters of the last name to the right of the binoculars at the top of the screen.

Patient (191)	Status	Admit	Birth Date	Sex	City	Phone
Accola, Nancy J	A	01	06/01/1948	F	Taftville	(555) 383-2614
Adzhabakyan, Mary T	A	A2	12/08/1982	F	Mystic	(555) 572-4122
Anna, Thomas	A	01	12/02/2009	M	New London	(555) 389-4590
Bahls, Jason C	A	01	01/26/1938	M	Norwich	(555) 889-2327
Balque, Edward E	A	01	05/06/1955	M	Fitchville	(555) 887-5852
Ramford, Steven R	T	A2	06/05/1943	M	Uncasville	(555) 668-6280

By default, patients that have a status of active, hold (hospitalized), incomplete, or pending show in the patient list. By left-clicking the status header, patients with other status may be selected.

- ✓ Active
- Discharged (All)
- Discharged (Within last 12 Months)
- Discharged (Within last 6 Months)
- Discharged (Within last Month)
- ✓ Hold
- ✓ Incomplete
- Non-Admitted
- ✓ Pending

From this patient view you can access any patient's complete patient record – left clicking on any patient row will cause the patient menu to display.

Patient	Status	Admit	Birth Date	Sex	City	Phone	Menu
Einstein, Sarah L	A	A3	08/03/1918	F	Lisbon	(555) 82	Coord Note
Everage, Sandra	A	01	04/11/1926	F	Preston	(555) 88	Discharge...
Faglie, Susan B	A	A5	09/22/1921	F	Norwich	(555) 88	Evaluation...
Fambro, Lisa A	H	01	03/18/1927	F	Norwich	(555) 88	Follow-Up (Change In Condition)
Feder, Linda E	A	B0	10/19/1920	F	Lebanon	(555) 64	HHA Orientation
Fillmore, Helen L	A	A4	10/11/1922	F	Taftville	(555) 88	Mobilegram
Fossett, Jennifer	A	01	05/25/2010	F	Jewett City	(555) 38	Recertification...
Fujimura, Sandra	A	01	04/26/1980	F	Amston	(555) 42	Reconciliation...
Gambrel, Elizabeth J	H	B1	05/22/1942	F	Norwich	(555) 89	Resumption...
Garmon, Mark R	A	A5	01/11/1962	M	Norwich	(555) 33	Start Of Care...
Gillim, Donald							Transfer...
Giovannini, Mark							Verbal Order
Gosney, Donald							Visit Attempted But Not Made
Grosbier, Christopher							Visit Note...
Guerrero, Jennifer L							Visit Not Attempted
Hadden, Linda							Adjunct Documents...
Hafemeister, Sandra C							BETA Documents...
Hailes, Maria T							Last Year's Documents...
Haubrich, Anthony							Help...
Hektner, David							
Hemsley, Laura A							
Herceg, Dorothy							
Hertl, George							
Hevessy, Linda E							
Hintson, Michelle							

The **incomplete document** view, like other views, can be sorted by left-clicking on the column headings. If a document has any pages that have empty required fields, the document is incomplete and will show on this view. This view is most useful to the mobile caregivers as it provides them with a list of the documents that they are actively attempting to complete as well as any documents returned to them from the office (via the conference feature) for rework or updates.

Patient Name	Document (48)	Date/Time	User Name	\$	R	S	H
Anna, Thomas	Visit Note (SN)	08/24/2010 (Created)	RIVERSOFT				
Bahls, Jason C	Visit Not Attempted	06/10/2010 (Planned)	CHERYL S				
Bahls, Jason C	Visit Not Attempted	06/11/2010 (Planned)	CHERYL S				
Balque, Edward E	Visit Not Attempted	06/09/2010 (Planned)	CHERYL S				
Burrs, Michelle A	Visit Not Attempted	06/13/2010 (Planned)	CHERYL S				
Burrs, Michelle A	Visit Note (SN)	09/08/2010 (Created)	RIVERSOFT				

The **completed document** view list all documents that have had all of their required fields completed but have not been sent to SAM. Once a document is reviewed and sent to SAM, it will no longer show in the view, but can be accessed from either the "Filed Documents" or the "Show Patient Documents" options of the patient menu.

Patient Name	Document (71)	Date/Time	User Name	\$	R	S	H
Bamford, Steven R	Evaluation (PT)	06/07/2010 11:00 AM (Visit)	KAREN L		R		
Bastic, Kimberly A	Recertification [C]	06/10/2010 03:00 PM (Visit)	SUE T		R		
Blancarte, Jennifer	Visit Note (SN)	06/10/2010 10:30 AM (Visit)	PORTIA				

The **view documents to send only visits** view is a subset of the completed documents view, as it is a list of the completed documents that contain the visit page. This view is used to review and send the visit portion of these documents to SAM so that the visit may be paid and billed, while the remaining clinical pages of the document will cause the document to remain accessible in the completed view. By splitting the review workload into a clinical review and a payroll/billing review, more people can help in reviewing the documents coming in from the field.

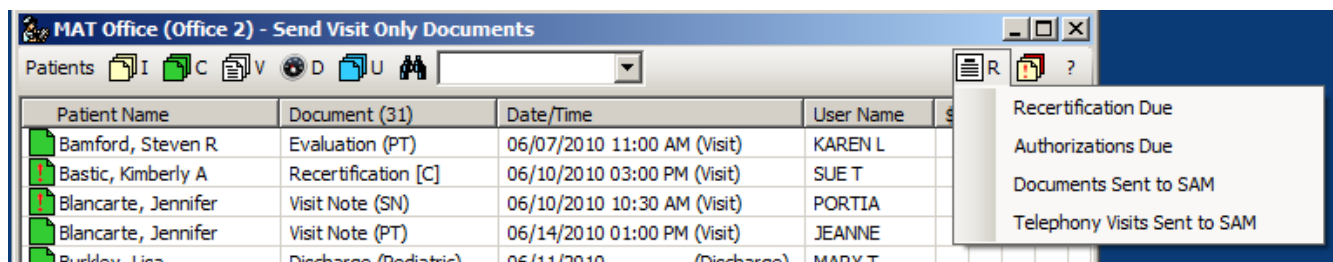
Patient Name	Document (31)	Date/Time	User Name	\$	R	S	H
Bamford, Steven R	Evaluation (PT)	06/07/2010 11:00 AM (Visit)	KAREN L		R		
Bastic, Kimberly A	Recertification [C]	06/10/2010 03:00 PM (Visit)	SUE T		R		
Blancarte, Jennifer	Visit Note (SN)	06/10/2010 10:30 AM (Visit)	PORTIA				
Blancarte, Jennifer	Visit Note (PT)	06/14/2010 01:00 PM (Visit)	JEANNE				
Burkley, Lisa	Discharge (Pediatric)	06/11/2010 (Discharge)	MARY T				
Dalley, Ruth	Visit Note (PT)	06/14/2010 02:50 PM (Visit)	KARFN I				

The **dashboard** reports show real-time issues, such as visits being done without authorizations, documents with questionable creation and completion dates, and documents with time issues. If a visit is done after the last authorized date for that patient, they show on the first report. Documents created after their visit date are flagged on the second report, and documents created after the visit was done, but on the same day, are flagged on the third report. On any of these three dashboard reports, the question mark on the far right of the selection screen will explain the report in detail.

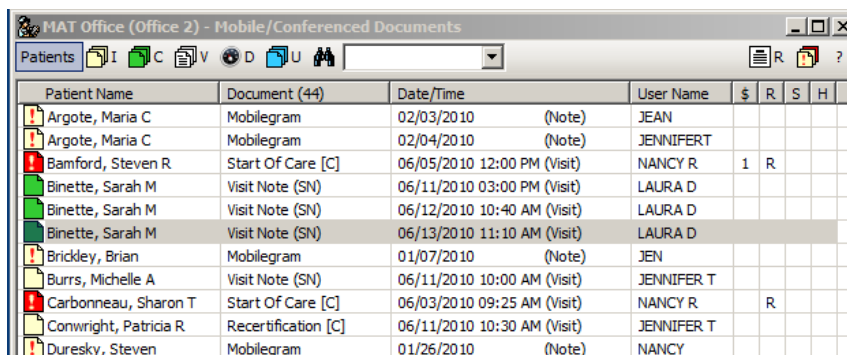
Patient Name	Document (31)	Date/Time	User Name	\$	R	S	H
Bamford, Steven R	Evaluation (PT)	06/07/2010 11:00 AM (Visit)	KAREN L		R		
Bastic, Kimberly A	Recertification [C]	06/10/2010 03:00 PM (Visit)	SUE T		R		
Blancarte, Jennifer	Visit Note (SN)	06/10/2010 10:30 AM (Visit)	PORTIA				

- View Unauthorized Visits
- View Document Date Differences
- View Same Day Time Differences

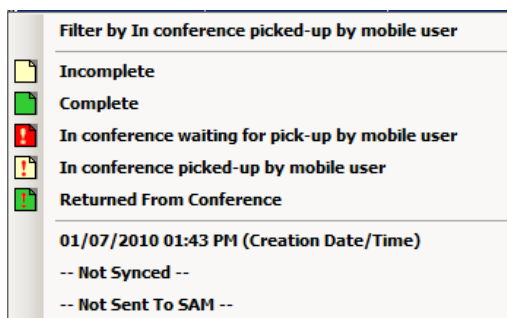
MAT also has a report of all patients due for recertification and a report of authorizations that are coming due. These reports are available to office as well as mobile users and are based on the care plan and authorization data in SAM.



The **documents owned by mobile users** view shows the documents that are either on the mobile devices, or are in the queue to be sent to a mobile device at the next synchronization. The office maintains a copy of all documents on each mobile device. This office copy is only as up-to-date as each mobile device's last successful synchronization. This is another reason why it is important that each device synchronize at least once per day.



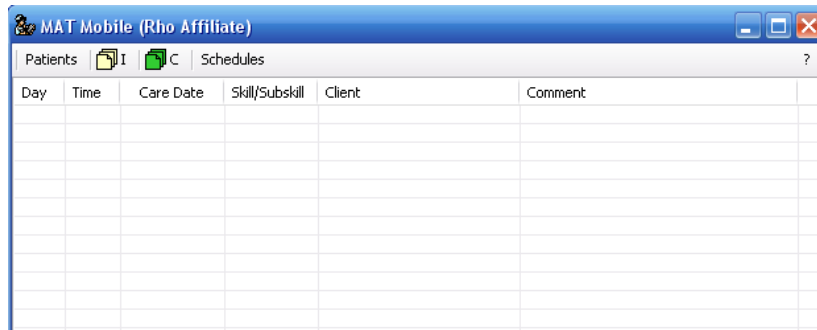
Right-clicking on a document icon will present a legend of the document icons showing the different document statuses and their corresponding document symbols.



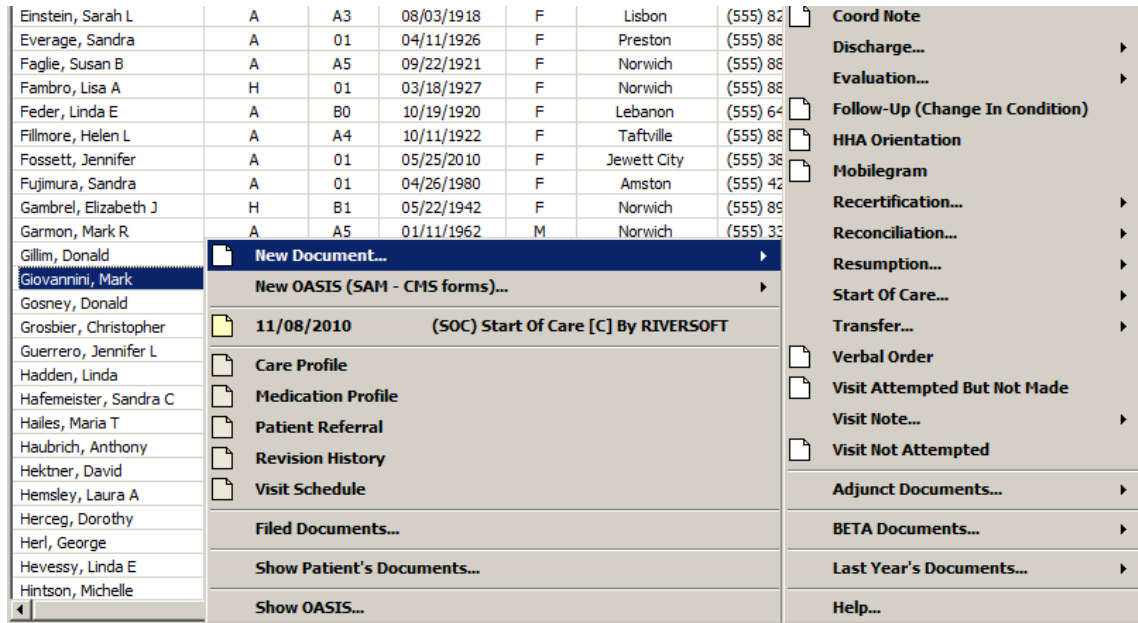
The question mark at the far right of the top menu provides access to the **Application Details** page which allows access to administration and configuration features like editing of the standard problems and interventions – this will be described later in this document.



MAT mobile has a fourth data view – the caregiver's schedule – but this one is only available for MAT Mobile users. This view will show all visits scheduled for the caregiver assigned to the mobile device. Visit comments entered by the scheduler to indicate special information about each visit will show in the last column. If your agency does not pre-schedule visit, this view will be empty.



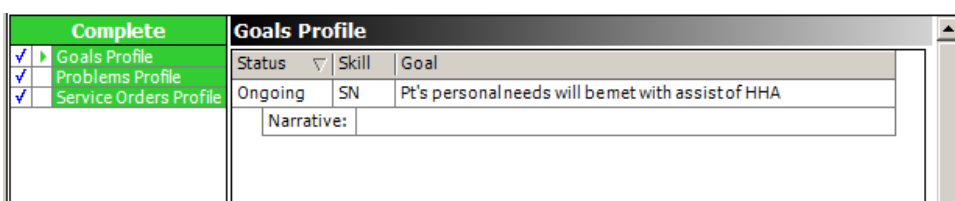
Most features in MAT are concerned with a particular patient and are therefore available from the patient menu. From the patient list, left clicking on any patient row will display the patient menu.



To create a new MAT document, select the patient in MAT's patient list, select "New Document", and select the type of document from the list. A SOC (Start of Care) document or SOC (Brief) document should exist in order to create any other MAT document because all MAT documents pull basic information from the SOC document. **The SOC document is the only document that can update SAM basic patient info (name, address, phone, SSN, birth date, etc). If these items must be changed after the SOC document is sent to SAM, the change must be done in SAM and in MAT.** The SOC Brief document is a very short document containing only the information MAT needs to carry forward to other documents (SAM basic patient info, legal, language, religion, etc.) and may be entered instead of a normal SOC document for already active patients that have a plan of care in SAM. Incomplete patients must be started by a Start of Care and not a SOC (Brief).

To document missed visits, use either the Visit Attempted but Not Made (if the caregiver actually went to the patient's location) or the Visit Not Attempted (if no caregiver actually went to the patient's location).

The Goals established for a patient, the problems and interventions identified, and the services ordered can all be seen at a glance in the patient's **Care Profile**. The print menu of the care profile provides access to the history of each goal and problem/intervention.



Problems Profile		
Ongoing	SN	ADL Alteration
Ongoing		HHA-assist with ambulation
Narrative:		
Ongoing		HHA-light housekeeping
Narrative:		
Ongoing		HHA- partial/complete bed bath
Narrative:		
Ongoing		HHA-tub/shower bath
Narrative:		
Ongoing		HHA to report to nurse any reddened or open areas, falls, or changes in pt's condition
Narrative:		

Service Orders Profile	
Service	Comment
HHA 1 Hour per Day 2 X Week for 10 Weeks	assist with personal care and other ADLS/IADLS
SN 1 Visit Every 60 Days	renewal of MD orders and supervision of HHA

The **Medication Profile** displays the patient's current and historic medications that have been entered into MAT's various documents. By default, all medications are shown but there is the option to view only the active medications.

Status	Date	Medicine Name	Regimen	Purpose	D/C Date
Existing	12/07/2007	Advair Diskus	500/50 1 PUFF ...	STER...	
Existing	12/07/2007	Amaryl	4MG PO BID	HYP0...	
Existing	12/07/2007	COMBIVENT ...	4PUFFS QID INH	BRON...	
Existing	12/07/2007	Glucophage	1000MG PO BID	HYP0...	
Existing	12/07/2007	K-Dur	20MEQ PO BID	SUPPL...	
Existing	12/07/2007	Lastix	80MG PO BID	DIURE...	
Existing	12/07/2007	Lovenox	30MG SUBCUTA...	ANTIC...	
Existing	12/07/2007	Protonix	40MG PO DAILY...	ANTI...	
Existing	12/07/2007	SPIRIVA 18M...	1 INHALATION ...	ANTIC...	
Existing	12/07/2007	Synthroid	225MCG PO DA...	THYR...	
Existing	12/07/2007	VICODIN 5/500	1 TAB QID PRN ...	NARC...	

Only show active medications Remove Selected Med from Profile

Primary Prescriber/Physician:

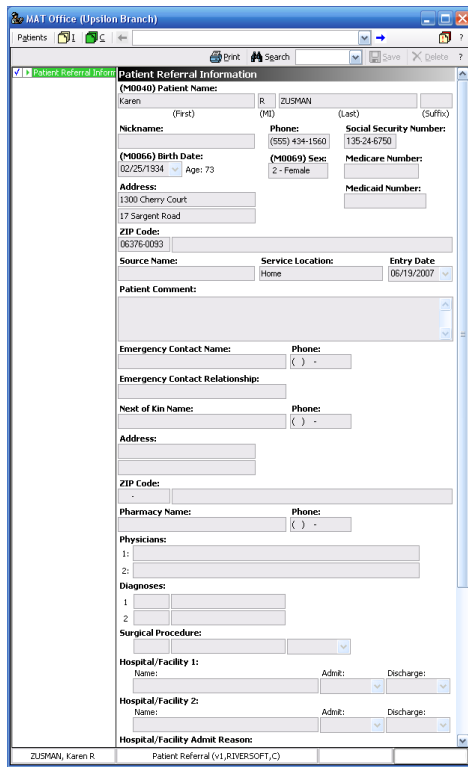
Secondary Prescriber/Physician:

Pharmacy Name: **Phone:** () -

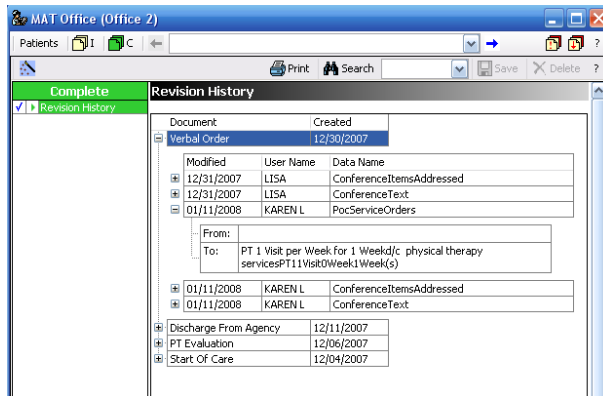
Allergies:

NKDA

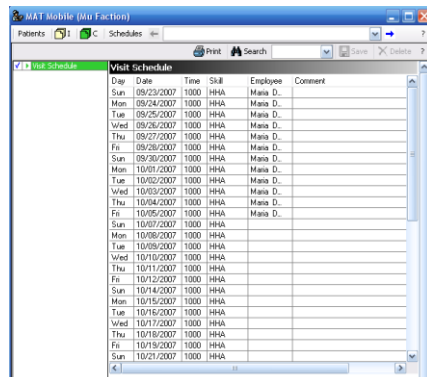
All basic demographic and referral information is viewable in MAT using the **Patient Referral** screen. This screen does not allow changes – SAM is the master of this data although the start of care has the ability to update a small portion. This information is useful to the admission caregiver and much of the information is defaulted in the SOC document.



Once a document is sent to the office or sent to SAM, all changes are tracked in the **Revision History**, accessible from the patient menu. Every document changed after initially being submitted by the author is listed. By selecting the plus sign to the left of a document, all of the changes to the document can be viewed.



Each patient's SAM schedule is available from the **Visit Schedule**. If pre-scheduling is not done in SAM, this view will be empty.



When **viewing/editing a document**, the left side contains the Navigation Panel (Nav Panel) and the right side contains the document. Each row in the Nav Panel represents a page of the document. The current page will have a green arrow in its corresponding Nav Panel row. When a page is complete, the corresponding Nav Panel row is checked. To go quickly to any page in the document, click or tap on the corresponding Nav Panel row. Navigation through the document can also be done with the tab key, the scroll bar, and the mouse wheel. Selecting or tapping one of the grey headings in the document will scroll the document so that the page heading is at the top. When all rows on the Nav Panel are checked and turn green, the document is complete.

Incomplete pages are yellow and contain incomplete required fields which are also yellow. As the last of the incomplete required fields on a page is completed, the page row in the nave panel turns from yellow to green and the page is marked as completed.

The search field at the top of the document allows navigation directly to any matching phrase in the document. For instance, to find M0100 just type M0100 into the search field and click to search. MAT will navigate to the first instance.

To quickly go to another of the patient’s documents, select the document from the pull down list at the top-middle, or use the left and right arrows to go to the previous and next documents – this is the fastest way to review a patient’s complete chart.

The bottom left of the document shows the current patient. The bottom middle shows the document type and in parentheses the version, the author’s user name, and the document’s status.

While editing a document, a save will occur automatically after each page is completed. The document can be saved, deleted, or edited at any time until is it sent to the office or sent to SAM. The print feature is available at all times.

All MAT document fields with the phrase "Problems/Comments" have a feature that allows you to pick from a library of phrases and a library of comments (which will automatically flow to the Clinical Summary section of the Care Plan's Orders). These phrases are configurable for each RiverSoft customer via the Phrase Editor in the applications details page.

Living Arrangements Comments/Problems: N/A

Phrase Editor

Problems
<New Problem>
<New Comment>
ADL alteration
Bowel Incontinence
Bowel incontinence frequency on daily or weekly basis
Bowel Ostomy
Bowel ostomy was related to an inpatient stay or did necessitate change in medical or treatment regimen
Braden Scale score below limit (18)
Comfort alteration
Compromised family coping
Constipation
Dyspnea or Short Of breath with moderate or no exertion
Fall risk factor present: due to patient's number of falls in the last year
Fluid volume deficit risk
Fluid volume excess risk
HA Intervention
Problems
<input checked="" type="checkbox"/> Physical mobility impairment - stairs in the house are in need of repair and cannot be used.

When clicked the question mark at the top right of the document will show the document's properties.

Document	
GUID	9c915ec4-8cc2-42a2-b55d-cc1aeaa1f82
Reassign GUID	<input type="button" value="Reassign"/>
Type	Start Of Care
Change Doc Type	<input type="button" value="Change"/>
Description	Start Of Care
Version	6
Style	SendToSamDocStyle
Active Status	Active
Saved Status	Complete
Office Mastered	True <input type="button" value="Toggle Office Mastered"/>
Document TStamp	05/10/2010 01:09 PM <input type="button" value="Update TStamp"/>
Author	JENNIFER T
User is Author	False
User can Edit	True
ReadOnly Office	False
Creation Date	04/30/2010 01:04 PM
Enter Creation Date (mm/dd/yyyy hh:MM)	<input type="button" value="Change Creation Date"/>
In Conference	False

Oasis	
Oasis Version	C-072009:02.00

Client	
Office Code	0002
Client Number	A05563
Change Admit	Can not change. Only one admit
Admit Number	01
Client Key	0002A0556301
Change Client Key	<input type="button" value="Change"/>

Send To SAM	
Status	Sent To SAM <input type="button" value="Clear Sent To Sam"/>
Date	05/10/2010 01:09 PM
User	KATHRYN

Sync	
Status	Synchronized <input type="button" value="Clear Synced"/>
Date	05/10/2010 01:02 PM
User	JENNIFER T
Unit ID	6c552b0a-8a72-40b8-b929-eb384e6fd1cb

RiverSoft Only	
Handle Count	354
Show DLL Activity	<input type="button" value="Show DLL Activity"/>

Document Audit	
2010-05-04 13:06 JENNIFER T Add Medication:PREVACID Regimen:40MG PO DAILY-AM	
2010-05-04 13:06 JENNIFER T Add Medication:LEVOXYL Regimen:150MCG PO DAILY-AM	
2010-05-04 13:07 JENNIFER T Add Medication:REGLAN Regimen:10MG PO TID	
2010-05-04 13:07 JENNIFER T Add Medication:ZOLOFT Regimen:150MG PO DAILY-AM	
2010-05-04 13:07 JENNIFER T Add Medication:TOPAmax Regimen:150M GPO DAILY-AM	
2010-05-04 13:08 JENNIFER T In-Place Edit Medication:TOPAmax Regimen:150M GPO DAILY-AM	
2010-05-04 13:08 JENNIFER T Add Medication:OXYCONTIN Regimen:20MG PO DAILY BID	
2010-05-04 13:08 JENNIFER T Add Medication:Oxy IR Regimen:5MG - 1 TAB PO EVERY 4 HRS PRN PAIN	
2010-05-04 13:09 JENNIFER T Add Medication:ferrous sulfate Regimen:325MG PO DAILY-AM	
2010-05-04 13:10 JENNIFER T Add Medication:ARXTRA Regimen:2.5MG SUBCUTANEOUSLY DAILY-PM X 11 DAYS, THEN D/C AND BEGIN ASPIRIN THERAPY	
2010-05-04 13:10 JENNIFER T Add Medication:ASPIRIN Regimen:325MG PO DAILY-AM	
2010-05-10 13:09 KATHRYN Patient status updated to Active on 04/30/2010. Plan of Care (A0020721) was successfully created in SAM. OASIS Assessment (A0008040) was successfully created in SAM. Visit (0002A13333A0001) was successfully Verified in SAM.	

The document properties page is used to move a document from one client admssion to another, the recover a document from a dead tablet, to track document revisions, and other high level technical tasks seldom done by the typical user.

Problems and Interventions – Overview

MAT has a database of standard clinical problems. Each problem has an associated list of interventions or actions that can be taken to resolve each problem. The Problem/Intervention database is configurable for each RiverSoft client and is accessible from the application details page.

Administration	
Edit Phrases	<input type="button" value="Edit Phrases"/>
View Phrases	<input type="button" value="View Phrases"/>
Edit Problems	<input type="button" value="Edit Problems"/>
View Problems	<input type="button" value="View Problems"/>
Edit Medications	<input type="button" value="Edit Medications"/>
Edit Announcements	<input type="button" value="Edit Announcements"/>
Edit Options	<input type="button" value="Edit Options"/>

The “Edit Problems” button displays the Problem/Intervention editor.

					<input type="button" value="Close"/> <input style="border: none; padding: 0 5px;" type="button" value="?"/>
✖	Type	Category	Auto Trigger	Problem	▲
+					
[-] Common					
+	✖	Problems	Common		ADL Alteration
+	✖	Problems	Common		Behavioral Health Alteration
+	✖	Problems	Common		Cardiac/circulatory System Alteration
+	✖	Problems	Common		Comfort Alteration
+	✖	Problems	Common		Endocrine System Alteration
+	✖	Problems	Common		GI Alteration
+	✖	Problems	Common		GU Alteration
+	✖	Problems	Common		Health Care Management
+	✖	Problems	Common		Immune System Alteration
+	✖	Problems	Common		Integument System Alteration
+	✖	Problems	Common		Knowledge Deficit
+	✖	Problems	Common		Nervous System Alteration
+	✖	Problems	Common		Nutrition Alteration
+	✖	Problems	Common		Physical Mobility Alteration
+	✖	Problems	Common		Respiratory System Alteration
+	✖	Problems	Common		Risk for Rehospitalization
+	✖	Problems	Common		Safety Alteration
+	✖	Problems	Common		Sensory / Perceptual Alteration
+	✖	Problems	Common	WoundProblem	Skin Integrity Alteration
+	✖	Problems	Common		Sleep Pattern Alteration
+	✖	Problems	Common		SN Intervention
+	✖	Problems	Common		Therapy Intervention
[-] Pediatric					
+	✖	Problems	Pediatric		Health Care Management

You can add new problems, modify the text of existing problems, or delete problems with the editor. By clicking the + box to the left of each row, the interventions belonging to the problem can be viewed and edited. The standard problem database is organized into broad problem descriptions because early in our Beta testing we found that more problems addressing more detail only caused caregivers to be confused about which problems to choose. For example, there are dozens or problems concerning a patient’s need to understand their part in self-care. Therefore, most of a patient’s teaching is done using the “Knowledge Deficit” problem with the associated interventions being the main areas of patient teaching. That is why the Knowledge Deficit problem has so many standard interventions – below is only a partial list.

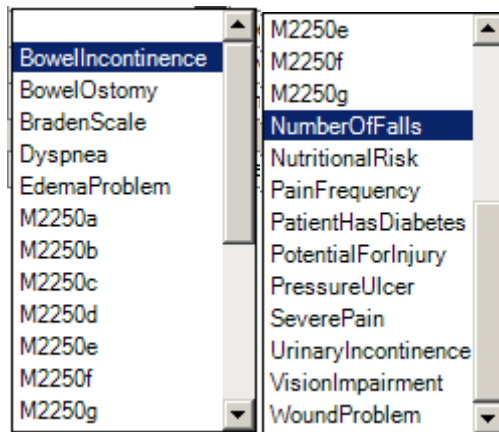
<input checked="" type="checkbox"/>	Problems	Common	<input checked="" type="checkbox"/> Knowledge Deficit
<input checked="" type="checkbox"/>			
<input checked="" type="checkbox"/>			
<input checked="" type="checkbox"/>			Instruct pt/CG regarding the need to take prescribed medications and/or on medication management.
<input checked="" type="checkbox"/>			Instruct pt/CG regarding the: purpose of medications as related to their disease process and/or diagnoses.
<input checked="" type="checkbox"/>			Assess: effectiveness of teaching and patient / caregiver's understanding and response ()
<input checked="" type="checkbox"/>			Instruct how to monitor I&O, hydration status, daily weight (or measuring dependent edema) and when to report to physician
<input checked="" type="checkbox"/>			Instruct pt/CG in the use of pressure relieving devices (List)
<input checked="" type="checkbox"/>			Instruct pt/CG regarding alternative non-pharmacological methods to relieve pain.
<input checked="" type="checkbox"/>			Instruct pt/CG regarding measures to reduce pressure on bony prominences and repositioning techniques to relieve pressure.
<input checked="" type="checkbox"/>			Instruct pt/CG regarding the desired response of the medication therapy, side effects, possible adverse or drug reactions, and when to notify nurse or MD with any undesirable side effects, adverse reactions, or ineffective therapy.
<input checked="" type="checkbox"/>			Instruct pt/CG to reposition patient Q1-2 hours while in bed or to shift position & shift weight Q15min while in chair.
<input checked="" type="checkbox"/>			Instruct regarding home safety, infection control, equipment/oxygen safety, disposal of hazardous waste and/or sharps
<input checked="" type="checkbox"/>			Instruct regarding prescribed fluid requirements, rationale for fluid plan
<input checked="" type="checkbox"/>			Instruct regarding recognizing trigger symptoms and appropriate actions to take
<input checked="" type="checkbox"/>			Instruct regarding: Energy conservation, comfort measures, relaxation techniques, balance of rest and activity
<input checked="" type="checkbox"/>			Instruct regarding: infection control procedures ()
<input checked="" type="checkbox"/>			Instruct regarding: inspecting skin daily, especially feet and bony prominences;
<input checked="" type="checkbox"/>			Instruct self-monitoring techniques signs and symptoms of hyper/hypoglycemia
<input checked="" type="checkbox"/>			Instruct: bladder training
<input checked="" type="checkbox"/>			Instruct: Dyspnea trigger symptoms and appropriate actions to take
<input checked="" type="checkbox"/>			Instruct: Energy conservation techniques
<input checked="" type="checkbox"/>			Instruct: pelvic floor muscle exercises
<input checked="" type="checkbox"/>			Instruct: regarding other self-monitoring techniques ()
<input checked="" type="checkbox"/>			Instruct: regarding wound care protocol
<input checked="" type="checkbox"/>			Instruct: Symptoms that should be reported to the RN or MD in an effort to prevent a hospitalization.
<input checked="" type="checkbox"/>			Instruct: Use, safety and cleaning of incentive spirometer
<input checked="" type="checkbox"/>			Instruct: Use, safety and cleaning of nebulizer
<input checked="" type="checkbox"/>			Instruct: Use, safety and cleaning of O2 equipment
<input checked="" type="checkbox"/>			Instruct: Use, safety and cleaning of peak flow meter
<input checked="" type="checkbox"/>			Instruct: Use, safety and cleaning of pulse oximeter
<input checked="" type="checkbox"/>			Instruct: adequate nutrition (high fiber) and adequate hydration
<input checked="" type="checkbox"/>			Instruct: alternative methods of pain relief
<input checked="" type="checkbox"/>			Instruct: Appropriate administration of prescription and non-prescription analgesic medications.
<input checked="" type="checkbox"/>			Instruct: bowel program ()
<input checked="" type="checkbox"/>			Instruct: catheter care ()
<input checked="" type="checkbox"/>			Instruct: effect of activity on elimination
<input checked="" type="checkbox"/>			Instruct: effects of incontinence, such as skin breakdown.
<input checked="" type="checkbox"/>			Instruct: Foot assessment and immediate report of non-healing wounds on LE's
<input checked="" type="checkbox"/>			Instruct: home management skills
<input checked="" type="checkbox"/>			Instruct: Intermittent catheterization ()
<input checked="" type="checkbox"/>			Instruct: low cholesterol, high viscous fiber diet for lowering cholesterol
<input checked="" type="checkbox"/>			Instruct: management of bowel elimination to prevent straining
<input checked="" type="checkbox"/>			Instruct: methods to control bowel incontinence.
<input checked="" type="checkbox"/>			Instruct: methods to enhance desired response and manage side effects of relief measures;
<input checked="" type="checkbox"/>			Instruct: patient / CG to report pain levels to nurse / MD that are > ()
<input checked="" type="checkbox"/>			Instruct: prescribed wound care protocol ()
<input checked="" type="checkbox"/>			Instruct: regarding annual foot exam by health care provider
<input checked="" type="checkbox"/>			Instruct: regarding appropriate footwear

Linking a Problem to a Document Answer (Problem Triggers)

The Auto Trigger column of the Problem/Intervention editor allows a problem to be associated with the answer of certain key clinical questions. If a problem is so linked, it will automatically be added to the Orders: Interventions area of the document (which flows to locator 21 of the 485). This is done to force the caregiver to at least think about addressing the problem on the care plan.

For example, if the problem "Respiratory System Alteration" is associated with the Auto Trigger of Dyspnea, when M1400 is answered with answers 2 thru 4, the problem will automatically be added to the Orders: Interventions page of the document.

There are about 20 key clinical questions that can be linked to problem triggers, with some defaulting to problems that will automatically flow to the Orders: Interventions page without doing any configuration work. These are listed below. It is suggested that you override the defaults by configuring existing problems in the database to the Auto Triggers.



Current Problem Triggers	Default Problem Copied to Orders: Interventions Page
Braden Scale Assessment Score is <= 18	Braden Scale score below limit (18)
M1400 is one of : 2 - With moderate exertion 3 - With minimal exertion or with agitation 4 - At rest (during day or night)	Dyspnea or Short Of breath with moderate or no exertion
M1242 is one of: 2 - Daily, but not constantly 3 - All of the time	Pain frequency interfering with patient's activity or movement
M1200 is one of: 1 - partially impaired 2 - severely impaired	Partial or Severe vision impairment even with the use of corrective lenses
M1615 is 2 - During the day and night	Urinary incontinence occurs day and night
M1620 is one of: 2 - One to three times weekly 3 - Four to six times weekly 4 - On a daily basis 5 - More often than once daily NA - Patient has ostomy for bowel elimination	Bowel incontinence frequency on daily or weekly basis
M1630 is one of: 1 - Patient's ostomy was not related to an inpatient stay and did not necessitate change in medical or treatment regimen 2 - The ostomy was related to an inpatient stay or did necessitate change in medical or treatment regimen	Bowel ostomy was related to an inpatient stay or did necessitate change in medical or treatment regimen
Musculoskeletal: Number of falls in the last year is greater than 0	Fall risk factor present due to patient's number of falls in the last year
Nutritional Screening Total is greater 2	Nutrition identified as moderate or high risk

Fall Risk Assessment: Function Risk greater than or equal to 4) or Pharmacy Risk greater than 7	No Default Phrase – must be configured
When M1240 is 2	Patient is experiencing severe pain
Pressure Ulcer	Patient at risk for developing pressure ulcer
M2250a	No Default Phrase – must be configured
M2250b	No Default Phrase – must be configured
M2250c	No Default Phrase – must be configured
M2250d	No Default Phrase – must be configured
M2250e	No Default Phrase – must be configured pain
M2250f	No Default Phrase – must be configured
M2250g	No Default Phrase – must be configured
Patient Has Diabetes	Patient has Diabetes
Wound Problem	Wound Problem
Edema Problem	Edema Problem

How Problems and Interventions flow forward in MAT

MAT provides a Problems & Interventions tracking feature so that a patient’s problems and the tasks (interventions) that must be done to address those problems can be easily seen and updated by all of a patient’s caregivers and then finally dispositioned at the time of discharge. Each problem may have one or more interventions. Any problem that is still ongoing at the time of discharge will cause an alert during the review of the discharge document. A problem is ongoing until all of its interventions are marked as “completed” and the problem is marked as “resolved”.

Problems & Interventions defined for a patient’s care should be done in the Start of Care document. Each problem is associated with a skill, like skilled nursing or physical therapy, and begins life with a status of ongoing. **Once the document is Sent-To-Sam, these problems flow to subsequent documents, with skilled nursing problems flowing to skilled nursing documents, and only physical therapy problems flowing to the PT evaluation and PT notes, and so on.** This delay in waiting for a document to be Sent-To-SAM before its information is inherited prevents un-verified, un-reviewed information from defaulting onto new documents. During a visit note, a caregiver can mark any ongoing problem as “resolved” that has had all of its interventions “completed”. Resolved problems are considered to be ended and do not flow forward. Also, any of interventions may be marked as “completed”.

If a new problem is identified during a visit, it must be added using a verbal order document so that it will flow to SAM’s verbal order allowing the patient’s doctor to be notified. For this reason new problems cannot simply be added on a visit note.

When a Start of Care document is sent to SAM, the problems and interventions flow to locator 21 of SAM’s plan of care (485). When a verbal order is sent to SAM, only the changed verbal order’s problems & interventions flow to SAM’s verbal order under the problems & interventions section. There is a flow option that governs how these changes flow to SAM:

VoFlowItems	VoFlowOnlyModifiedInterventions	<input type="checkbox"/> false
-------------	---------------------------------	--------------------------------

If this is off (set to false), and if any of a problem’s interventions are updated, then the problem and all of its interventions will flow to the verbal order – this could lead to VERY verbose verbal orders in SAM if your problems are very general and contain many interventions. By turning this flow option on (set to true), only the problem and the interactions that have been updated will flow to the verbal order, greatly reducing the size of the verbal order.

Whenever the Care Profile or any MAT document containing the “Orders: Interventions” page is opened, MAT reads the problems & interventions from previous documents and displays its findings on the current document.

For a legend of background colors and a detailed explanation of how MAT problems & interventions flow, click on the question mark (?) at the top right of the “Orders: Interventions” page.

Orders: Interventions ?

Problems/Interventions View Edit

Resolved	SN	Alteration in Bowel Status
Complete		Assess: Usual elimination patterns, skin integrity
Narrative:		
Complete		Eliminate underlying cause of diarrhea (e.g., decrease use of stool softeners or laxatives)
Narrative:		

Wound Tracking is achieved with the Problem/Intervention Model

To place markers on the body or foot diagram, click the marker (it will highlight in red) then click on its location. Delete a marker by clicking it then clicking the trash can. If the marker being added is a Wound/Incision, the wound is automatically numbered and information about the wound is gathered via the Wound Editor.

The screenshot displays the MAT Office software interface. On the left is a navigation pane with categories like 'Incomplete', 'Integumentary', and 'Body Diagram'. The 'Body Diagram' section is active, showing two human figures (front and back views) and foot diagrams (Right Foot, Left Foot, Lateral View, Medial View, Ventral View). A legend for markers includes (A) Amputation, (O) Ostomy, (E) Edema, (S) Scar, (V) IV Site, (T) Tube, (B) Bruise, (R) Rash, and (X) Other. A red plus sign indicates the 'Add Wound/Incision' function.

The 'Wound Editor' dialog box is open, showing the following fields:

- Wound Definition:** Correlates to a problem on the Orders: Intervention page. Wound #: 1, Loc: [dropdown], Type: [dropdown].
- Wound Assessment:** Correlates to the Assess Wound Intervention on the Orders: Intervention page for the defined problem. Consultation Finding: [dropdown].
- Measurement (cm):** Un-Observable, Healed, Not Assessed, Not Measured, Length, Width, Depth, UK.
- Stage:** [dropdown], Edema: [dropdown].
- Wound Edges:** [dropdown], Color: [dropdown].
- Peri wound Skin:** [dropdown], Odor: [dropdown].
- Drainage:** Amount: [dropdown], Type: [dropdown], Color: [dropdown].
- Comment:** [text area].

At the bottom of the Wound Editor, there is a table with columns for Status, Skill, and Problem. The table contains several rows of interventions, including 'Assess Wound', 'Asses wound status Q visit', 'Assess skin integrity Q visit', 'Daily skilled nursing is expected to be required until', 'Instruct pt/CG in the use of pressure relieving devices (List)', 'Instruct pt/CG regarding measures to reduce pressure on bony prominences and repositioning techniques to relieve pressure.', and 'Instruct pt/CG to reposition patient Q1-2 hours while in bed or to shift position & shift weight Q15min while in chair.' Each row has a status dropdown (e.g., Ongoing) and a skill dropdown (e.g., SN).

As wound information is entered into the Wound Editor, it is stored in the main intervention tied to a problem "Alteration in Skin Integrity Related to" followed by the type of wound, in this case **Burn**, the wound number, in this case **#1**, and the location of the wound, in the case **head**.

Wound Editor

Wound Definition:
 Correlates to a problem on the Orders: Intervention page.
 Wound #: 1 Loc: head Type: Burn

Wound Assessment:
 Correlates to the Assess Wound Intervention on the Orders: Intervention page for the defined problem.
 Consultation Finding:
 Un-Observable Healed Not Assessed

Measurement (cm)
 Not Measured Length: 1 Width: 1 Depth: .5 UK

Stage: Edema: None
 Wound Edges: Scarred Color: Pink
 Periwound Skin: Skin Loss Odor: None

Drainage:
 Amount: None Type: Color:

Comment:

Status	Skill	Problem
Ongoing	SN	Alteration in Skin Integrity Related to Burn #1 : head
+ Click the plus sign to add a non-standard Intervention		
Ongoing		Assess Wound
Narrative:		L x W x D (cm): 1 x 1 x .5 Edema: None Wound Edges: Scarred; Color: Pink Periwound Skin: Skin Loss; Odor: None Drainage - Amount: None

This problem is tied to the wound for the remainder of the case and this wound will be referred to wound number one for the remainder of the case. It will flow to subsequent documents, where ongoing narrative can be added to the wound until, as a problem, it is resolved or at the time of discharge it is documented why the problem could not be resolved. In this way the status and care of multiple wounds and edemas can be tracked throughout the patient's care.

Tracking Medications in MAT

Most documents provide the ability to change the patient's **medication profile** via the **Allergies & Medications** page. This page allows the entry of new medications along with their discontinuation and update. It also provides High-Risk drug and contraindication checking and the creation of medical teaching sheets in both English and Spanish.

Allergies & Medications ? ▲

Allergies: View Edit

Penicillin,sulfonamides

Only those medications that are new to this document will be sent to SAM as a Verbal Order.

Status	Date	Medicine Name	Regimen	Purpose	D/C Date	
◇ Changed	05/21/2010	furosemide	20mg p...	diuretic		
◇ Changed	02/19/2010	Coumadin	3mg po...	antico...		
◇ Changed	07/28/2009	Simvastatin	80MG T...	ANTIL...		
◇ Existing	01/21/2010	gabapentin	600 mg...	anti c...		
◇ Existing	07/28/2009	Oxytrol Patch	1 patch...	urinar...		
◇ Existing	07/28/2009	Paxil	40 mg ...	anti d...		
◇ Existing	07/28/2009	oxybutrin	10 mg ...	antide...		
◇ Existing	07/28/2009	multi vitamin	1 po da...	vitamin		
◇ Existing	07/28/2009	Namenda	10 mg ...	rx of ...		
◇ Existing	07/28/2009	Wellbutrin XL	150 mg...	anti d...		
◇ Existing	07/28/2009	Vitamin C	500 mg...	vitamin		
◇ Existing	07/28/2009	ritalin	10mg p...	attent...		
◇ Existing	07/28/2009	Synthroid	100 mc...	thyroi...		
◇ Existing	07/28/2009	nystatin	apply t...	antifu...		

Med Teaching Reference: ▼

Check for High-Risk Drugs

**To Add a new med, click Add New or Add Existing.
To Change or Discontinue a med, Select an active med.**

Add New Change Regimen Place On Hold Take Off Hold Edit In Place
Add Existing Add Changed Discontinue Change To Existing Delete

Medications Not Present

Med Status:

Medicine Name: Date: Purpose:

Regimen:

Save Changes Cancel

Patient medications have been reviewed by nurse for potential adverse effects and drug reactions, ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy and non-compliance with drug therapy.

Medications have been reviewed as described above.

Patient was instructed on potential side effects of high risk medications

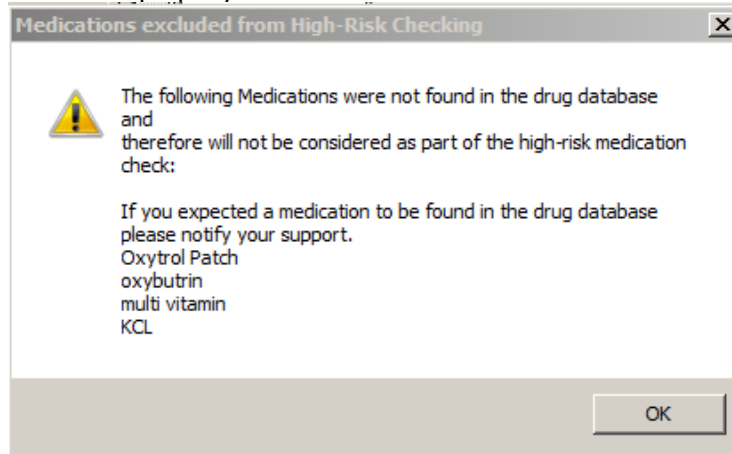
Patient was instructed on when to report problems to physician

Was physician contacted about any significant medication issues?

Did physician respond within one calendar day?

Allergy And Medication Comments View Edit N/A

Selecting the "Check for High-Risk Drugs" button triggers a check of each drug against the Lexi-Comp drug database. Unknown drugs (drugs not entered using the Lexi-Comp drug database lookup) will be flagged. These must be reconciled with the proper drug name in order to be properly evaluated for risk.



All other drugs will participate in the checking and a report like this will be generated...

High Risk Medications

Drug to Drug Interaction		
Drug 1	Drug 2	Interaction Comment
Haldol (haloperidol)	Wellbutrin XL (bupropion)	<p>MONITOR CLOSELY: The use of bupropion is associated with a dose-related risk of seizures. The estimated incidence of seizures is approximately 0.1% at dosages up to 300 mg/day and 0.4% at dosages between 300 to 450 mg/day, but increases almost tenfold between 450 mg and 600 mg/day. The risk may also be increased during coadministration with selective serotonin reuptake inhibitors (SSRI antidepressants or anorectics), monoamine oxidase inhibitors, neuroleptic agents, central nervous system stimulants, opioids, tricyclic antidepressants, other tricyclic compounds (e.g., cyclobenzaprine, phenothiazines), systemic steroids, and/or any substance that can reduce the seizure threshold (e.g., carbapenems, cholinergic agents, fluoroquinolones, interferons, chloroquine, mefloquine, lindane, theophylline). These agents are often individually epileptogenic and may have additive effects when combined.</p> <p>MANAGEMENT: Extreme caution is advised if bupropion is administered with any substance that can reduce the seizure threshold, particularly in the elderly and in patients with a history of seizures or other risk factors for seizures (e.g., head trauma; brain tumor; severe hepatic cirrhosis; metabolic disorders; CNS infections; excessive use of alcohol or sedatives; addiction to opiates, cocaine, or stimulants; diabetes treated with oral hypoglycemic agents or insulin). Bupropion as well as concomitant medications should be initiated at the lower end of the dose range and titrated gradually if feasible. The total dose of bupropion should generally not exceed 450 mg/day (or 150 mg every other day in patients with severe hepatic cirrhosis). Bupropion should be discontinued and not restarted in patients who experience a seizure during treatment.</p>
Wellbutrin XL (bupropion)	Ritalin (methylphenidate)	<p>MONITOR CLOSELY: The use of bupropion is associated with a dose-related risk of seizures. The estimated incidence of seizures is approximately 0.1% at dosages up to 300 mg/day and 0.4% at dosages between 300 to 450 mg/day, but increases almost tenfold between 450 mg and 600 mg/day. The risk may also be increased during coadministration with selective serotonin reuptake inhibitors (SSRI antidepressants or anorectics), monoamine oxidase inhibitors, neuroleptic agents, central nervous system stimulants, opioids, tricyclic antidepressants, other tricyclic compounds (e.g., cyclobenzaprine, phenothiazines), systemic steroids, and/or any substance that can reduce the seizure threshold (e.g., carbapenems, cholinergic agents, fluoroquinolones, interferons, chloroquine, mefloquine, lindane, theophylline). These agents are often individually epileptogenic and may have additive effects when combined.</p> <p>MANAGEMENT: Extreme caution is advised if bupropion is administered with any substance that can reduce the seizure threshold, particularly in the elderly and in patients with a history of seizures or other risk factors for seizures (e.g., head trauma; brain tumor; severe hepatic cirrhosis; metabolic disorders; CNS infections; excessive use of alcohol or sedatives; addiction to opiates, cocaine, or stimulants; diabetes treated with oral hypoglycemic agents or insulin). Bupropion as well as concomitant medications should be initiated at the lower end of the dose range and titrated gradually if feasible. The total dose of bupropion should generally not exceed 450 mg/day (or 150 mg every other day in patients with severe hepatic cirrhosis). Bupropion should be discontinued and not restarted in patients who experience a seizure during treatment.</p>
Wellbutrin XL (bupropion)	Paxil (paroxetine)	<p>MONITOR CLOSELY: The use of bupropion is associated with a dose-related risk of seizures. The estimated incidence of seizures is approximately 0.1% at dosages up to 300 mg/day and 0.4% at dosages between 300 to 450 mg/day, but increases almost tenfold between 450 mg and 600 mg/day. The risk may also be increased during coadministration with selective serotonin reuptake inhibitors (SSRI antidepressants or anorectics), monoamine oxidase inhibitors, neuroleptic agents, central nervous system stimulants, opioids, tricyclic antidepressants, other tricyclic compounds (e.g., cyclobenzaprine, phenothiazines), systemic steroids, and/or any substance that can reduce the seizure threshold (e.g., carbapenems, cholinergic agents, fluoroquinolones, interferons, chloroquine, mefloquine, lindane, theophylline). These agents are often individually epileptogenic and may have additive effects when combined.</p> <p>MANAGEMENT: Extreme caution is advised if bupropion is administered with any substance that can reduce the seizure threshold, particularly in the elderly and in patients with a history of seizures or other risk factors for seizures (e.g., head trauma; brain tumor; severe hepatic cirrhosis; metabolic disorders; CNS infections; excessive use of alcohol or sedatives; addiction to opiates, cocaine, or stimulants; diabetes treated with oral hypoglycemic agents or insulin). Bupropion as well as concomitant medications should be initiated at the lower end of the dose range and titrated gradually if feasible. The total dose of bupropion should generally not exceed 450 mg/day (or 150 mg every other day in patients with severe hepatic cirrhosis). Bupropion should be discontinued and not restarted in patients who experience a seizure during treatment.</p>

High Risk Medications

Wellbutrin XL (bupropion)	Aricapt (donepezil)	<p>MONITOR CLOSELY: The use of bupropion is associated with a dose-related risk of seizures. The estimated incidence of seizures is approximately 0.1% at dosages up to 300 mg/day and 0.4% at dosages between 300 to 450 mg/day, but increases almost tenfold between 450 mg and 600 mg/day. The risk may also be increased during coadministration with selective serotonin reuptake inhibitors (SSRI antidepressants or anorectics), monoamine oxidase inhibitors, neuroleptic agents, central nervous system stimulants, opioids, tricyclic antidepressants, other tricyclic compounds (e.g., cyclobenzaprine, phenothiazines), systemic steroids, and/or any substance that can reduce the seizure threshold (e.g., carbapenems, cholinergic agents, fluoroquinolones, interferons, chloroquine, mefloquine, lindane, theophylline). These agents are often individually epileptogenic and may have additive effects when combined.</p> <p>MANAGEMENT: Extreme caution is advised if bupropion is administered with any substance that can reduce the seizure threshold, particularly in the elderly and in patients with a history of seizures or other risk factors for seizures (e.g., head trauma; brain tumor; severe hepatic cirrhosis; metabolic disorders; CNS infections; excessive use of alcohol or sedatives; addiction to opiates, cocaine, or stimulants; diabetes treated with oral hypoglycemic agents or insulin). Bupropion as well as concomitant medications should be initiated at the lower end of the dose range and titrated gradually if feasible. The total dose of bupropion should generally not exceed 450 mg/day (or 150 mg every other day in patients with severe hepatic cirrhosis). Bupropion should be discontinued and not restarted in patients who experience a seizure during treatment.</p>
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BEERS CRITERIA

2002 Criteria for Potentially Inappropriate Medication Use in Older Adults: Independent of Diagnoses or Conditions. (Only High Severity Risk Drugs according to the Beers Criteria are included)

Patient Drug (Generic Name)	Beers Criteria	Concern
Ritalin (methylphenidate)	Amphetamines and anorectic agents	These drugs have potential for causing dependence, hypertension, angina, and myocardial infarction.

Subset of ISMP High-Risk Drugs (Most probable for homecare)

Drugs found in this section should be handled according to your agency's policy. Additional information for each Drug can be found on the Drug's Med Teaching Reference.

Patient Drug	Generic Name	Drug Classification
Coumadin	warfarin	ANTICOAGULANT
Klonopin	clonazepam	MODERATE SEDATION AGENT

The following Medications from the patient's Medication Profile were not found in the drug database and therefore were not considered as part of the high-risk medication check:

Oxytrol Patch
oxybutrin
multi vitamin
KCL

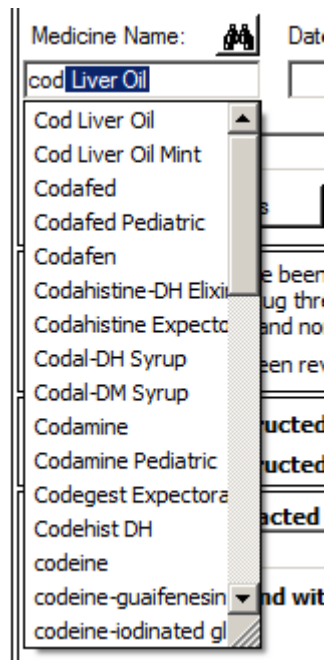
This product utilizes the Lexi-Comp's Integrated™ platform, which contains information provided by Lexi-Comp, Inc. and other firms. Lexi-Comp, Inc. (collectively "Provider"). Efforts have been made to ensure that the information provided by Provider is accurate, up-to-date, and complete. However, it is not possible to ensure that the information is 100% accurate. Provider's information has been compiled for use by healthcare practitioners and End-Users in the United States. Provider does not warrant that the use of the Lexi-Comp database is appropriate.

Lexi-Comp and other firms' drug information does not constitute a diagnosis, drug recommendation, or recommendation to use. The Provider's product is designed to help you make decisions about your care. It is not intended to replace your knowledge and judgment as a healthcare practitioner. The healthcare practitioner or user of this product shall assume full responsibility for the use of this product. The user of this product shall assume full responsibility for any aspect of the product's use, including but not limited to, the accuracy, completeness, timeliness, or appropriateness of any data provided. Lexi-Comp and other firms' information is not intended to constitute a diagnosis, drug recommendation, or recommendation to use. The Provider's product is designed to help you make decisions about your care. It is not intended to replace your knowledge and judgment as a healthcare practitioner. The healthcare practitioner or user of this product shall assume full responsibility for the use of this product. The user of this product shall assume full responsibility for any aspect of the product's use, including but not limited to, the accuracy, completeness, timeliness, or appropriateness of any data provided.

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The "Add New" and "Add Existing" buttons are used to add a medication that the patient has just begun to take (new) or is already taking (existing) at the time of the assessment.

As the name of the medication is entered, MAT will attempt to auto-complete the name using the Lexi-Comp drug database



If you are unsure of the name of the drug, or the medication you are attempting to enter appears to be unknown, use the binoculars button to perform a search. The **Medication Selection** screen provides three different methods of searching for a medication, defaulting to a "Name Begins With search text".

Remember, if you enter a medication that is not in the Lexi-Comp database, the chances of duplicate medication entries in the patient's medication profile goes up, and the ability for MAT to flag high risk drugs is defeated.

Medication Selection

Search For:

Name Begins With search text
 Word in the Name begins with the search text
 Search text is contained in the name

Selected Medication:

Medication Name	Generic Name
Cod Liver Oil	multivitamin
Cod Liver Oil Mint	multivitamin
Codafed	codeine/guaifenesin/PSE
Codafed Pediatric	codeine/guaifenesin/PSE
Codafen	codeine-guaifenesin
Codahistine Expectorant	codeine/guaifenesin/PSE
Codahistine-DH Elixir	chlorpheniramine/codeine/pseu...
Codal-DH Syrup	hydrocodone/phenylephrine/p...
Codal-DM Syrup	dextromethorphan/phenylephr...
Codamine	hydrocodone-phenylpropanola...
Codamine Pediatric	hydrocodone-phenylpropanola...
Codegest Expectorant	codeine/guaifenesin/phenylpro...
Codehist DH	chlorpheniramine/codeine/pseu...
codeine	codeine
Codeine Phosphate-Promethazine HCl	codeine-promethazine
codeine-guaifenesin	codeine-guaifenesin
codeine-iodinated glycerol	codeine-iodinated glycerol
codeine-phenylephrine	codeine-phenylephrine
codeine-promethazine	codeine-promethazine
codeine-pseudoephedrine	codeine-pseudoephedrine

The Medication Selection screen allows you to search for a specific medication.

To search for a medication enter starting character(s) of the medication in the Search For: text area then click the Go button.

All medications who's name starts with the characters entered in the Search For: text area will be displayed in the Search Results list.

Select one of the medications by clicking on the medication name in the Search Results list.

The selected medication will be shown in the Selected Medication text area.

Once the medication you want is selected, click the Keep Selected Medication button.

OR double-click the medication name and will be automatically selected.

If you don't wish to select a medication click the Cancel button.

The “**Change Regimen**” button allows a medication’s regimen to be changed. Highlighting a medication and clicking this button automatically discontinues the medication and initiates a new entry for the medication with the status of “Changed”. The user must supply the new regimen and the date of the change.

The “**Discontinue**” button changes the status of a selected medication entry to Discontinued. This should be done when a medication is no longer in use by a patient.

Medications added on the current document with the “Add New” or “Add Existing” buttons have a tan background. These entries can be edited in place with the “**Edit in Place**” button and can be deleted with the “**Delete**” button. This allows mistakes to be corrected easily while entering medications. These buttons are disabled on the current document once a later document is exists – in other words, these buttons only exists on a patient’s most current document.

Medications entered on previous documents will appear in the profile with a white background. The “Edit in Place” and “Delete” buttons are disabled for these.

Regardless of whether a medication was entered on a previous document or the current document, its status may be updated with the “Place on Hold”, “Take off Hold”, and “Change to Existing” buttons. The “**Place on Hold**” button allows a medication with the status of New, Existing, or Changed to be changed to Hold. The “**Take of Hold**” button allows a medication with the status of Hold to be changed to the status of Existing. The “**Change to Existing**” button allows a medication with the status New to be updated to the status of Existing.

Medication entries altered on the current document have a blue background. This includes alterations in regimen, discontinuations, and status changes.

What is a duplicate medication entry? This is two or more entries documenting the same medication and regimen. For example:

Aspirin (ASA) BID
Aspirin (ASA) twice daily
Aspirin (ASA) 2 per day
Aspirin BID

In this example, a patient taking aspirin 2 times per day would have 4 entries in the medication profile because a medication’s name and regimen define an entry in the medication profile. If a medication name is spelled differently, or a regimen is entered differently Mat WILL TREAT IT AS DISTINCT MEDICATIONS.

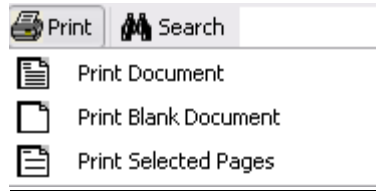
How do duplicate entries happen? If the Start of Care or Recertification documents are not completed in a timely manner, subsequent documents like visit notes will be completed without being able to display medications. If the caregiver entering the visit note assumes that they are responsible for entering all of the medications they will enter them. Then, when the Start of Care or Recertification document is completed, it too will have a complete list of all of the patient’s medications. If every medication entered on the two documents does not exactly match, there will be duplicate entries. Entering medications that are not found in the Lexi-Comp drug database can lead to duplications.

How do you fix duplicate entries? If one of the duplicate entries was entered on the most recent document for the patient, it may be deleted by that document’s author or MAT Administrator by using the delete button. If the duplicate entries are discovered later, the delete button will not be available and the duplicate entries must be resolved by discontinuing one of the entries with a comment explaining the entry error. We recommend that a Medication Reconciliation document be created to perform these discontinuations because it can be easily documented that they were discontinued in order to fix data entry errors.

How do you enter a known medication: When entering a medication, you may either type the name or use the binoculars to access the Lexi-Comp powered medication database. It is STRONGLY advised that the database be used to either select or verify a medication so that the it may participate in the “High Risk Drug Check”, which is a button available on the screen that checks for high risk drugs and high risk drug-to-drug interactions. Also available for known drugs are “Med Teaching References” in multiple languages.

How medications flow in MAT is described in detail in the MAT-SAM Operations Manual.

Printing a document or a blank document is done while viewing a document. Select the print button then choose from the three options: Print Document prints all pages of the current document, Print Blank Document prints a blank version of the current document, and Print Selected Pages allows individual or groups of pages to be selected for printing.



When Print Selected Pages is chosen, the list of possible pages for the document is presented.



Only completed documents can be sent to the office or sent to SAM. Only the author or the MAT administrator can edit a document that is sent to the office or sent to SAM.

More on the Completed Document View

The completed document view is the main work view in the office. A document must be either Sent to SAM, accepted, or conferenced to be removed from this view.

Patient Name	Document	Date/Time	User Name
Billingsly, Phil8	Verbal Order	01/09/2008 (VO)	RIVERSOFT
Billingsly, Phil8	Verbal Order	01/09/2008 (VO)	RIVERSOFT
Isleman, Alota8	Visit Note (SN)	01/16/2008 08:55 AM (Visit)	PORTIA
Omanreader, Roxanne6	Visit Note (SN)	01/17/2008 10:25 AM (Visit)	SUE T
Quooker, Ima8	Visit Note (SN)	01/17/2008 10:45 AM (Visit)	SUE T
Someteller, Ima6	Visit Note (SN)	01/16/2008 10:45 AM (Visit)	PORTIA
Xavier, Roxanne3	Visit Note (SN)	01/15/2008 11:25 AM (Visit)	PORTIA
Zipcode, Roxanne6	Visit Note (SN)	01/14/2008 03:57 PM (Creation Date/Time)	PORTIA

Filter by Visit Note (SN)

- 01/14/2008 03:57 PM (Creation Date/Time)
- 01/18/2008 12:31 PM (Sync Date/Time)
- 01/18/2008 12:31 PM (Send Date/Time)

Right clicking a document will show the document's creation, sync, and send-to-sam dates. Right clicking on the document and user name columns will allow filters to be placed and removed on those columns. For instance, by right clicking on the document column on a Visit Note (SN), a filter can be created to show only Visit Note (SN) documents and by right clicking on the user column, an additional filter can be created to show only documents for a particular user (caregiver). The filters can be removed by right clicking the appropriate column and choosing to remove the filter.

To review a document, open the document and click the Review button at the top left. In the first window of the document MAT will list any document inconsistencies. These are warnings and will not cause OASIS transmission errors. Mobile users are required to review the document at least once in order to complete the document.

Clinical Review of Document

Clinical Review Summary of Document:

- When (M0690) Transferring > 01, then (M0670) Bathing should be > 01
- When (M0690) Transferring > 01, then (M0690) Toileting should be > 00
- When patient assistance is required for (M0690) Transferring then (M0350) Assisting Person(s) should be 1, 2, or 3
- When patient assistance is required for (M0690) Transferring then (M0360) Primary Caregiver cannot be empty
- When patient assistance is required for (M0690) Transferring then (M0370) Primary Caregiver Assistance Frequency cannot be empty
- When patient assistance is required for (M0690) Transferring then (M0380) Type of Primary Caregiver Assistance (1 - ADL Assistance) should be checked
- To qualify for Medicare Homebound Status, all of the following should be > 00:
 - (M0730) Transportation
 - (M0740) Laundry
 - (M0750) Housekeeping

Patient/Payer Information

(M0040) Patient Name: [First] E [MI] McCoy III [Last] [Suffix]

(M0150) Current Payment Sources for Home Care: (Mark all that apply)

- 0 - None; No charge for current services
- 1 - Medicare (Traditional Fee-for-service)
- 2 - Medicare (HMO/Managed Care)
- 3 - Medicaid (Traditional Fee-for-service)
- 4 - Medicaid (HMO/Managed Care)
- 5 - Workers' Compensation
- 6 - Title Programs (e.g., Title III, V, or XX)
- 7 - Other Government (e.g., CHAMPUS, VA, etc.)
- 8 - Private Insurance
- 9 - Private HMO/Managed Care
- 10 - Self-Pay
- 11 - Other (specify) _____
- UK - Unknown

(M0064) Social Security: UK 264-11-2222

(M0063) Medicare Number: NA 123456789

(M0065) Medicaid Number: NA 39293939

Visit Information

Visit performed on: 05/11/2007 09:00 AM 10:00 AM

Visit Date Start Time End Time

Referral Information

Medicare Number: 123456789 Medicaid Number: 39293939

Services, Interventions, Allergies, Special Needs: Should be a Medicare patient but check for insurance card.

Orders

Service: PTV1-3W9W

PPS M00 Values

Clinical Review Summary of Document with PPS Changes:

(M0090) Date Assessment Completed: 05/11/2007

(M0100) Reason for Assessment: 1 - Start of Care - further visits planned

(M0175) From which of the following Inpatient Facilities was the Patient Discharged during the last 14 days? (Mark all that apply):

- 1 - Hospital
- 2 - Rehabilitation Facility
- 3 - Skilled nursing facility
- 4 - Other nursing home
- 5 - Other (specify) _____
- NA - Patient was not discharged from an inpatient facility

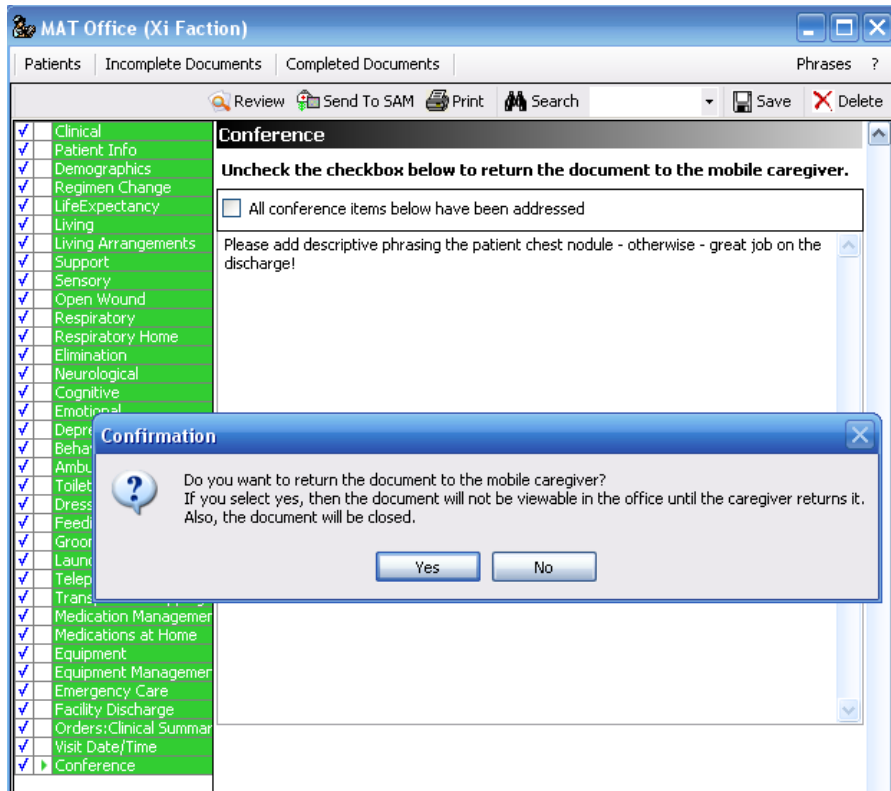
(M0230) Primary Diagnosis: a 38030 DISORDER OF PINNA NOS

(M0240) Other Diagnosis: b _____

(M0245) Payment Diagnosis (Optional): If a V code was reported in M0230 in place of a case mix diagnosis, list the primary _____

After addressing the clinical review, you may wish to address PPS M00 Values (the questions on the document that effect the PPS payment). These values may be altered on the review screen (by the author or Mat Administrator).

If there is an issue with the document that the caregiver/author should address, the conference feature should be used to send the document back to the caregiver. The conference page is the last page of every MAT document.

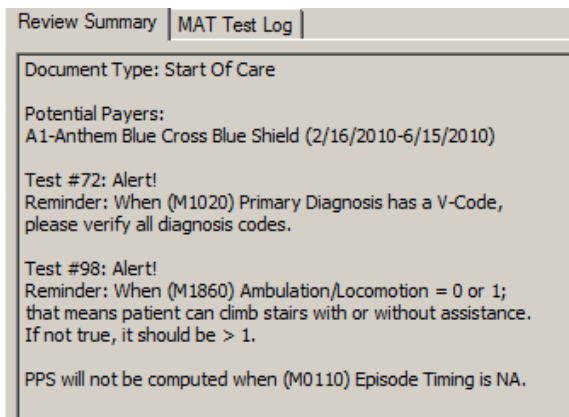


To "conference" a document back to a mobile caregiver, on the conference page of the document add a description of the document's issue and instructions to the caregiver. The descriptive text and the document are sent back to the caregiver's device by unchecking the "All Conference items below have been addressed". After reading the confirmation window, selecting "Yes" will close the document and remove it from the offices' view – the next time the caregiver syncs, the document will appear in their incomplete document view. Once they address and complete the conference page, they can sync the document back to the office. This loop can continue indefinitely.

To view a list of documents that have been marked to go back to the caregiver but have not been sent to the caregiver's device, use the "**documents owned by mobile users**" view. Caregivers who habitually have documents in this view either have many documents sent back for re-work or do not sync with the office often enough.

In the completed view, the document icons with exclamation marks represent documents that have been "Sent To SAM" or Accepted and then conferenced to the caregiver and returned to the office.

Before a document can be completed on a mobile unit the caregiver is forced to click the review button at least once. The review feature runs through dozens of consistency checks and notifies the user of any issues.



Before sending a SOC document to SAM, use the review function to automatically check for document inconsistencies, and to aid in verifying that MAT's Patient/Payer, Referral Information, and Orders correctly correspond to SAM's patient setup.

Do the correct payer, payer dates, and skills exist in SAM? Add the payer to the patient in SAM if needed, and add the payer-skills to the patient in SAM if needed, then press the "Send to SAM" button. If the send is successful, the SAM patient will receive an active status, start of care date, source of admission, plan of care, Start of Care OASIS, and a verified visit. If the send is not successful a message will appear detailing the issue as well as the action that should be taken. When an assessment document causes a visit to be verified, the visit will also receive one of the standard sub-skills (MATSOC, MATxfer, MATresume, MATrecert, MATfollowup, or MATdischarge) so that you can tell at a glance from the SAM schedule which assessments have been done.

Certain clinical information will flow from MAT documents (such as Vitals) directly to a formatted area in SAM's clinical summary on the Plan of Care. If for any reason the format must be changed, it can be edited using SAM's plan of care screens.

All other assessments and notes can be sent without using the review feature. However, since the review feature will show PPS payment information, will show the projected gross margin for the episode, and will flag clinical inconsistencies, the review feature should be used for all assessments prior to sending them to SAM. This feature alone can save you many hours a week in clinical quality review.

The "Send To SAM" Feature

When a Start of Care (of any type) is sent to SAM, if there is more than one payer associated with the patient, the sender will be asked to select the payer – the payer selected will be used to create the plan of care as well as the visit.

Document Date: 7/4/2010

Please select one of the following active SAM payer sources which have plans of care to apply to this recertification document:

Payer	Poc No	Cert Begin	Cert End
Medicaid - Title 19	A0159136	5/5/2010	7/3/2010

Or, select one of the following active SAM payer sources to apply to this recertification document:

Payer	Start Date	End Date
Medicaid - Title 19	10/16/2001	12/31/2010

OK Cancel

This is the "Select Payer" screen that is presented when a visit note is sent to SAM and there is more than one payer associated with the SAM patient.

Select Payer

The visit data on this document are as follows:

Visit performed by: Wade, Portia E (RN)

Visit performed on: 02/18/2008 09:55 AM 10:45 AM

Visit Date Start Time End Time

Please select one of the SAM payer sources from the list below to apply to this document.

Payer	Start Date	End Date
Medicaid - EDS Title XIX	12/5/2005	3/23/2008
Access One - MEDICAID	1/1/2008	12/31/2008

OK Cancel

Before the visit portion of the document can flow to SAM, if there is any ambiguity in which scheduled visit can be related to the incoming document, the user will be asked to choose among the possible visits. If the incoming document is not a verification of any of the listed visits, the user can choose to cancel or create a new visit.

Select Visit

The visit data on this document are as follows:

Visit performed by: Wade, Portia E (RN)

Visit performed on: 02/18/2008 09:55 AM 10:45 AM
 Visit Date Start Time End Time

Please select one of the SAM scheduled visits from the list below to which this document refers.

Day	Time	Care Date	Skill/Subskill	P	B	Employee	Payer	Comment
Tue	0900	02/19/2008	RN/Hourly	H	H		Medicaid - EDS Title XIX	
Tue	1000	02/19/2008	RN/Primary Care Nu	V	V	Portia E Wade	Medicaid - EDS Title XIX	From MAT
Fri	1045	02/22/2008	RN/Medication Admi	V	V	Portia E Wade	Medicaid - EDS Title XIX	
Mon	1045	02/25/2008	RN/Primary Care Nu	V	V		Medicaid - EDS Title XIX	
Fri	1045	02/29/2008	RN/Medication Admi	V	V		Medicaid - EDS Title XIX	
Mon	1045	03/03/2008	RN/Primary Care Nu	V	V		Medicaid - EDS Title XIX	
Fri	1045	03/07/2008	RN/Medication Admi	V	V		Medicaid - EDS Title XIX	

Use Selected Visit Create New Visit Cancel

Selecting the "Create New Visit" button will cause the "Select Schedule Order" screen to appear where the payer-skill-subskill-units can be chosen. This information along with the incoming visit's date and time will be used to create a new verified visit.

Select Schedule Order

The visit data on this document are as follows:

Visit performed by: Wade, Portia E (RN)

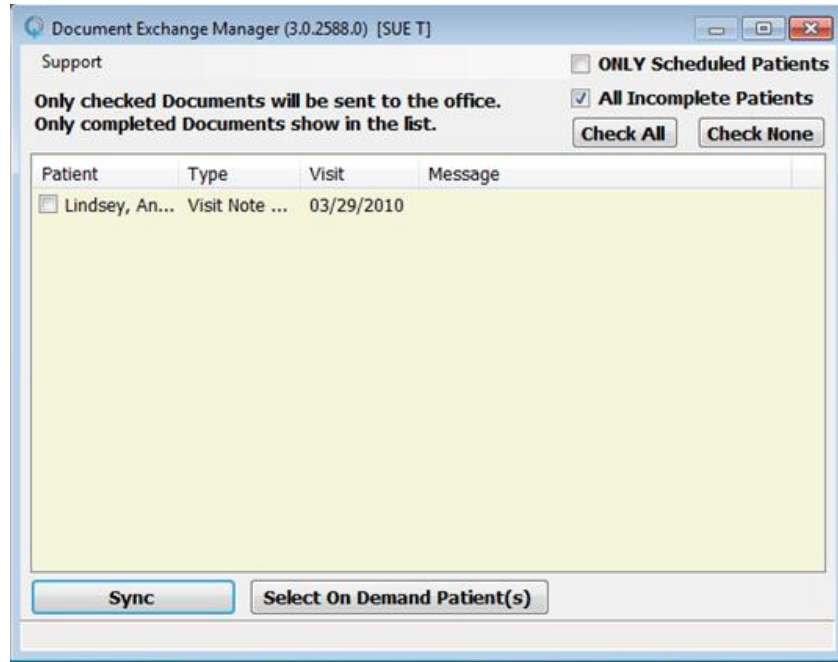
Visit performed on: 02/18/2008 09:55 AM 10:45 AM
 Visit Date Start Time End Time

Please select one of the SAM schedule orders from the list below to apply to this visit.

Skill/Sub-Skill	Pay Unit	Bill Unit
RN	V	V
RN/Case Management	V	V
RN/Hourly	H	H
SN	H	H
SN	V	V

OK Cancel

When a MAT device synchronizes, all completed documents that the user checks are sent to the office. It will then retrieve a new patient list including all incomplete/pending/hold patients as well as any patients scheduled to the employee assigned to the device within the last month. All assessments, the last few visit notes, the schedule for each patient in the list, and the caregiver's schedule will be retrieved to the device. MAT devices can sync via WiFi or the office's LAN. If you want a patient's data to go to an employee's MAT device, the patient must either be incomplete/pending/hold or the employee must be scheduled to perform at least one visit for the patient on any day later than one month ago. Sync time can be reduced if you choose either the "ONLY Scheduled Patients" because only the patient charts for your patients will be sent to your Tablet. If you uncheck "All Incomplete Patients", incomplete patients will not be sent to your tablet – this will also result in a faster sync. **MAT can synchronize with the office from any Wi-Fi hotspot from which you can access the internet. If the sync fails to connect, make sure you can access a web page. Some hotspots (like libraries) require you to login before you have access to the internet.**

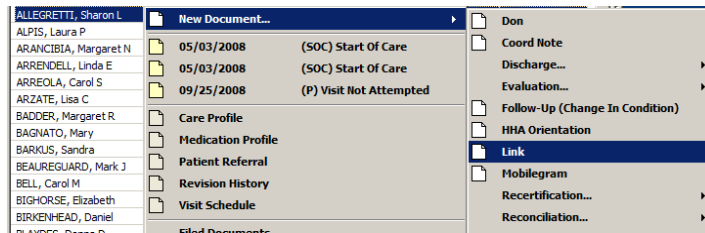


All MAT installations have a special SAM/MAT user named **Audit**. Each agency controls the password to this account using SAM's Configuration/Users feature. This account is specifically designed to give clinical and state Audits access to the system without access to the conference page or the review button.

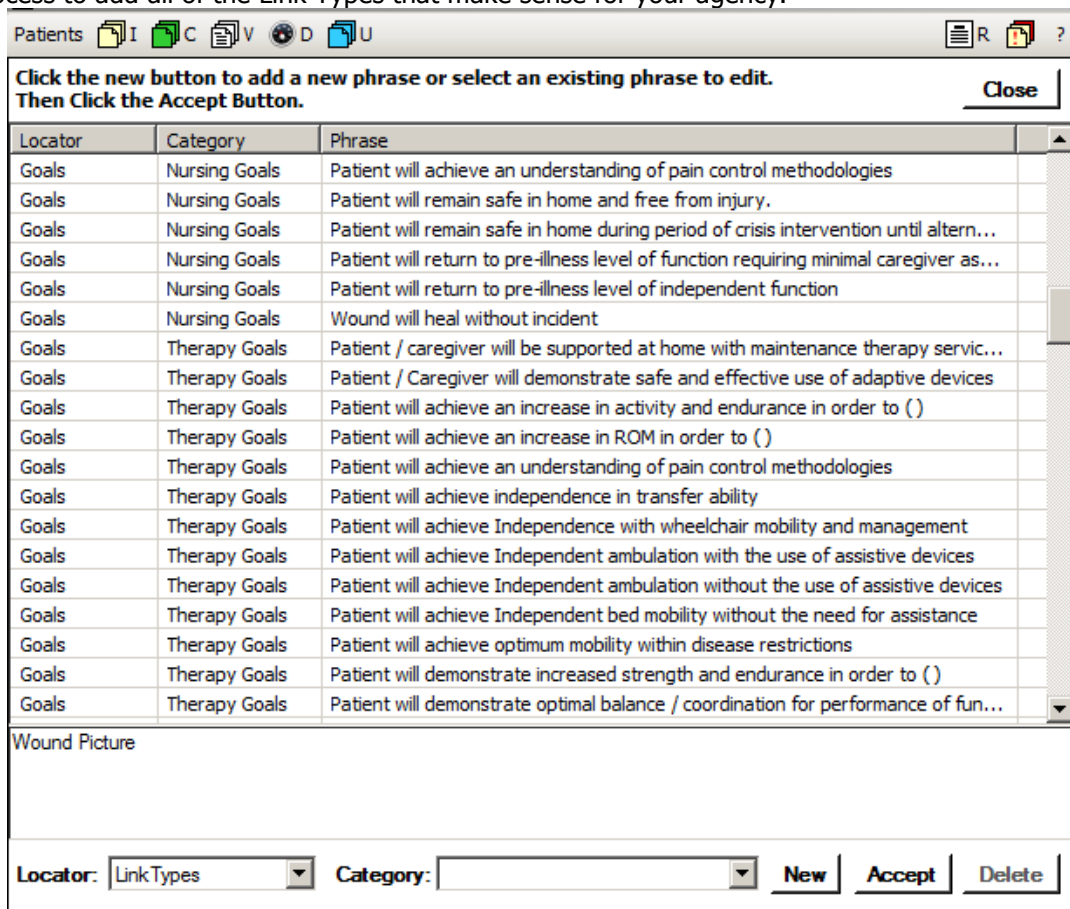
For multi-site organizations currently using Data Exchange, it is important to know that MAT Documents participate in this exchange. During the installation of MAT for each site, either the front or back office is chosen as the MAT Document Master for that office. Designating the front office as the master removes the ability to edit MAT Documents at the back office (for that office). Designating the back office as the master removes the ability to edit MAT Documents at the front office (for that office). Mastership must be assigned to either the front or the back office for each office. If a change in document mastership is needed, please call RiverSoft as RiverSoft is the only one capable of making this configuration change.

We recommend for most multi-site organizations that the MAT Exchange Server be installed at the Back Office location and that mastership for MAT Documents be assigned to each front office. This gives the organization the ability to have caregiver's service patients for many offices while still giving each office the ability to maintain the quality of their clinical documentation.

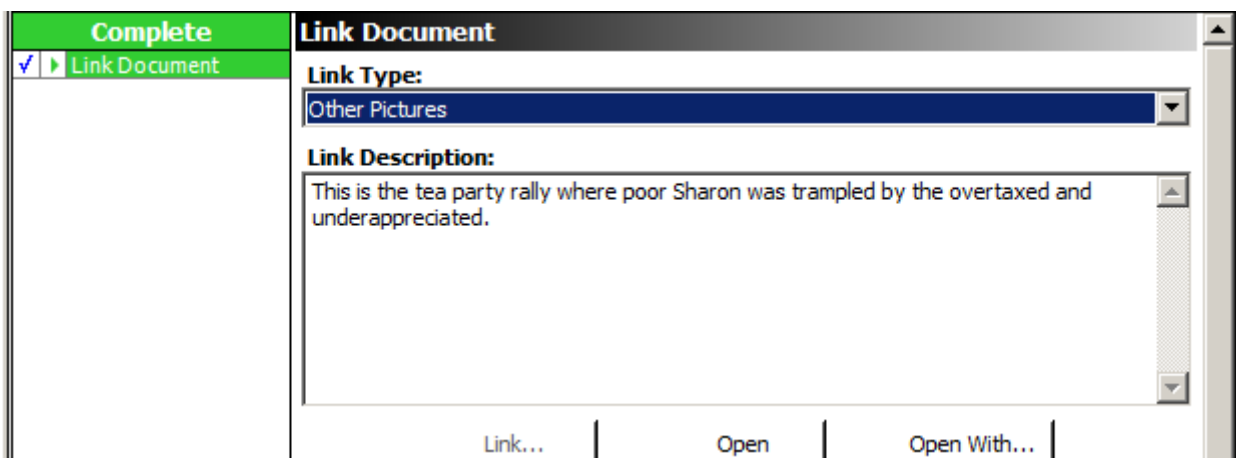
Link Documents provide the ability to add any electronic document to the MAT patient chart. This could be PDF documents regarding legal agreements or surveys that a patient has signed, wound pictures, or any other item of clinical importance to the patient's chart. Because unregulated use of this feature will swell the size of your database, the feature must be explicitly switched on by setting the UserConfig.AllowLinkDocuments MAT Option to "true" on the application details page. Once this is switched on, exit MAT and start MAT again. You will then see the Link menu entry on the patient menu.



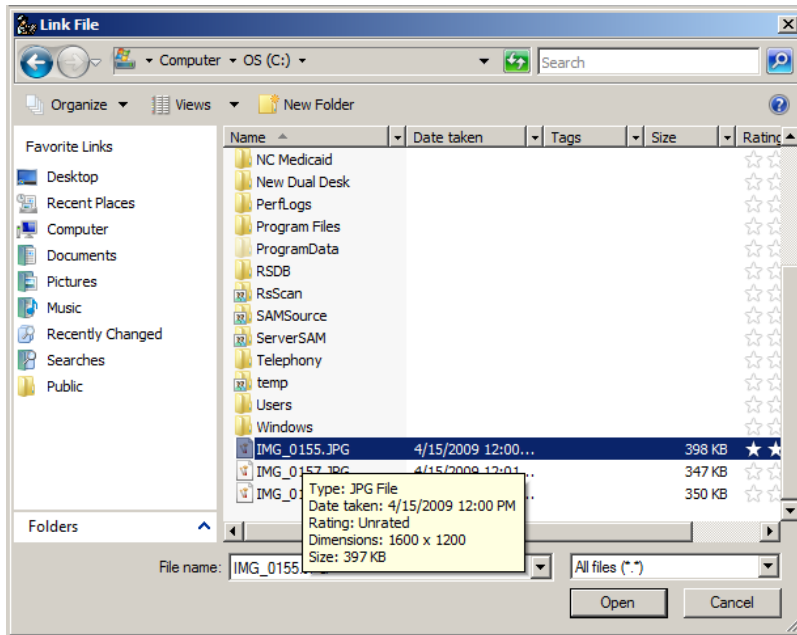
Before adding your first Link document, it is important to think about what types of clinical documents you will be linking to MAT, for instance, wound pictures, legal documents, surveys, etc. You can create these types by adding them to the MAT Phrases (Application Details, Edit Phrases). Find the "link types" entry in the **Locator:** drop down list, add the description of the link type you want to create in the yellow box (like Wound Picture), and click the Accept button. Repeat this process to add all of the Link Types that make sense for your agency.



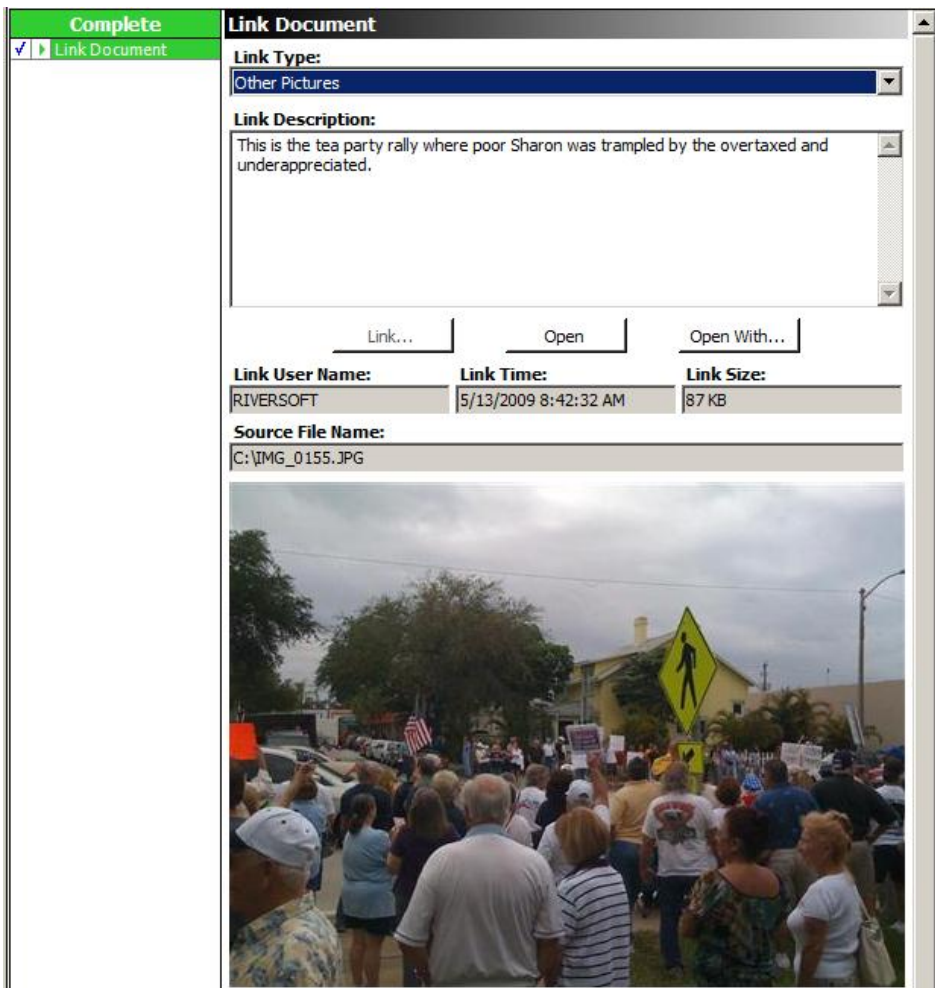
To add a link document, start by choosing the Link Type and entering a description of the document...



Then use the Link... button to locate and link the electronic document, in this case a picture.



Highlight the desired document and click the open button. This screen will close and the document will be placed into the MAT link document.

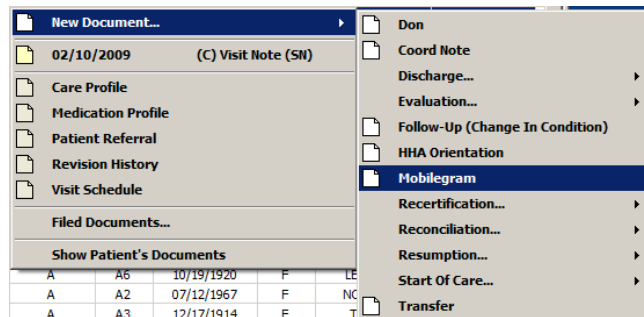


The time the link was made as well as the size of the link and source file name all become part of the MAT document, AS WELL AS THE CONTENTS OF THE LINK DOCUMENT. The picture will be stored in your SAM database inside this MAT document, so that there is no longer any need to retain the original source electronic file. You can open the file in its native environment (a PDF document will be opened in Adobe, JPGs will be opened in Paint, etc.) by clicking the open button once a link has been made. To open a document in something other than the document's original environment, use the "Open With" button.

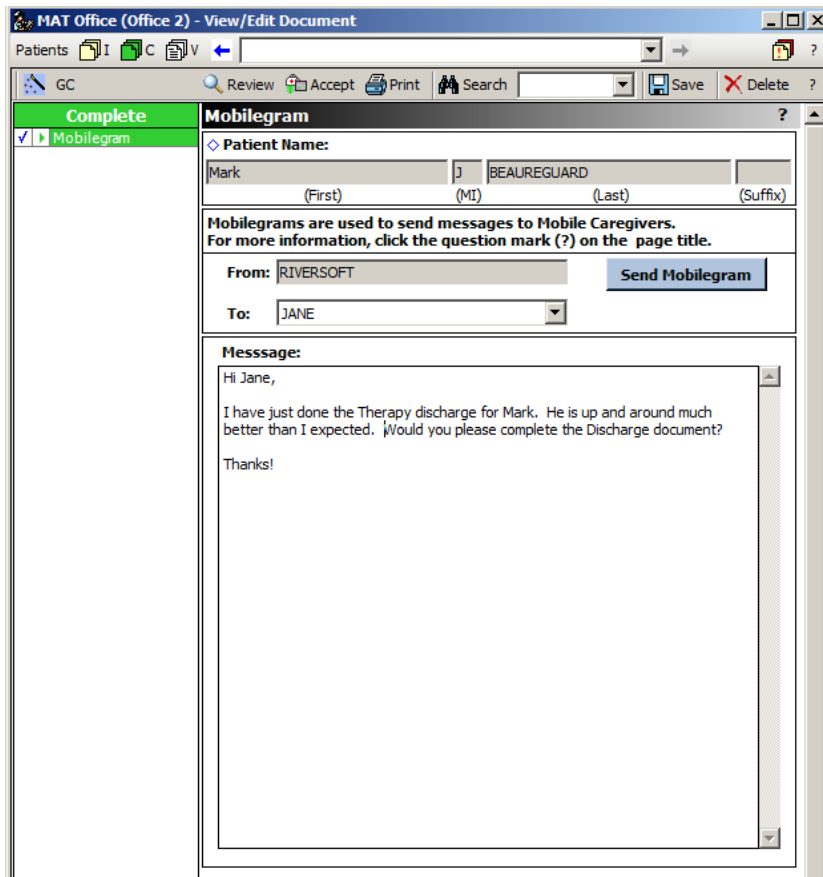
Configuring and using Link Types is important because it will mark the document with the type wherever the document appears in a list in MAT...



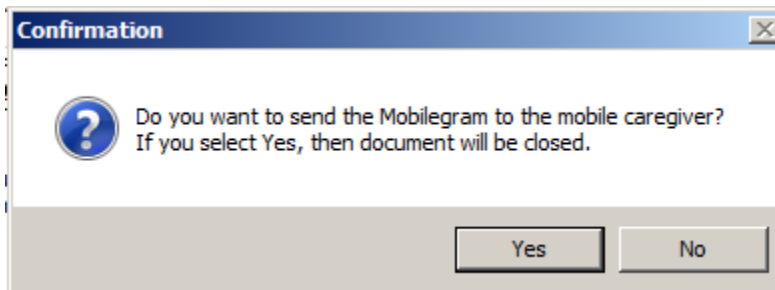
Mobilegrams provide the ability to send messages to mobile caregivers regarding a particular patient. Any office or mobile user may create a Mobilegram. From the new document menu for any patient, select Mobilegram.



There are only two required items on a Mobilegram: the person to whom the message is to be sent and the text of the message. Once these are entered, the Mobilegram is complete.



Once completed, the Send Mobilegram button may be pressed and the following message will appear...



Once the document is closed, it is only viewable in the "View Documents Owned By Mobile Users" list. The document will lay there, waiting for the mobile caregiver to whom the document was sent to sync. Once they sync, the document will be in their incomplete view. When the mobile caregiver logs in, they will be notified that they have a Mobilegram. They then open the Mobilegram from their incomplete document view and complete the document by clicking the "Mark as Read" button.

Remember, Mobilegrams are to be used to send messages to Mobile caregivers who have Tablet PCs. If you send a Mobilegram to a MAT office user, the Mobilegram will be stuck in the "Document Owned by Mobile Users" View.



It will get stuck in this view because all Mobilegrams pass through this view on the way to their mobile recipient, and since a Mobilegram sent to an office user has no mobile recipient, it will languish here in Mobilegram purgatory – until someone rescues it. To rescue a Mobilegram, open the "Document Owned by Mobile Users" view and right-click the doctype field on the Mobilegram and select "Redirect the Mobilegram to the office". This will place the Mobilegram in the "Incomplete Document" view so that the person to which the Mobilegram is addressed can mark it as read.

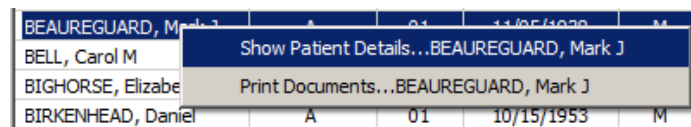
Announcements

Sending a message to all of your mobile caregivers, or all of your mobile caregivers within an office, is done with the Announcements feature, available from the Applications Detail page (the question mark at the far right of the main MAT menu provides access to the application details page).

User Name	Announcement
BETTINA	Apr 28 2009 1:05PM Friday, May 1st, is the last day to get your free flue shot.
BOB	Apr 28 2009 1:05PM Friday, May 1st, is the last day to get your free flue shot.
CAROL R	Apr 28 2009 1:05PM Friday, May 1st, is the last day to get your free flue shot.
CAROLYN	Apr 28 2009 1:05PM Friday, May 1st, is the last day to get your free flue shot.
CHRISTINE	Apr 28 2009 1:05PM Friday, May 1st, is the last day to get your free flue shot.
DEB S	Apr 28 2009 1:05PM

Select the offices for which you want the announcement to go – the announcement will be sent to every mobile caregiver in that office. Then enter the announcement and click the “Send Announcement All Selected Offices” button. The bottom window will show the users to which the announcement will go, and the text of the announcement. The next time each mobile caregiver synchronizes, they will receive the announcement and it will no longer show on this screen. You can enter as many announcements as you wish – each pending announcement for a user will be delivered to that user the next time they sync.

There are two very handy features available to office users from the patient menu. By right clicking on any patient, a menu containing these two features will display.



Show Patient Details provides technical information to the RiverSoft staff, and also allows you to see if on of the patient’s documents was deleted by whom and when.

Patient	
Office Code	0002
Client Number	A02808
Admit Number	01
Client Key	0002A0280801

Administration	
Document List	Show Document List
Deleted Document List	Show Deleted Document List
EOE Date	
Show EOE Documents	Show EOE Documents

Print Documents provide a fast way to select multiple documents from a patient's chart for printing.

Print Selected Documents		Cancel
Date/Time	Document	
<input type="checkbox"/> 02/15/2008 12:30 PM (V)	Visit Note (SN)	
<input type="checkbox"/> 04/21/2008 (N)	Coord Note	
<input type="checkbox"/> 06/08/2007 10:04 AM (V)	Visit Note (SN)	
<input type="checkbox"/> 12/26/2007 (O)	Verbal Order	
<input type="checkbox"/> 03/09/2008 (O)	Verbal Order	
<input type="checkbox"/> 10/16/2007 11:15 AM (V)	Visit Note (SN)	
<input type="checkbox"/> 06/21/2007 01:15 PM (V)	Visit Not Made	
<input type="checkbox"/> 04/01/2008 (N)	Coord Note	
<input type="checkbox"/> 11/27/2007 08:45 AM (V)	Visit Note (SN)	
<input type="checkbox"/> 09/17/2007 10:15 AM (V)	Visit Note (SN)	
<input type="checkbox"/> 11/26/2007 (O)	Verbal Order	
<input type="checkbox"/> 01/30/2008 10:45 AM (V)	Visit Note (SN)	
<input type="checkbox"/> 07/05/2007 10:00 AM (V)	Visit Note (SN)	
<input type="checkbox"/> 08/03/2008 08:30 PM (V)	Visit Note (SN)	
<input type="checkbox"/> 06/05/2007 (C)	Start Of Care (Brief)	
<input type="checkbox"/> 01/25/2008 (CB)	Recertification	
<input type="checkbox"/> 04/28/2008 (O)	Verbal Order	
<input type="checkbox"/> 09/01/2007 05:25 PM (V)	Resumption Of Care	
<input type="checkbox"/> 01/17/2008 (T)	Transfer	
<input type="checkbox"/> 02/15/2008 (O)	Verbal Order	
<input type="checkbox"/> 09/27/2007 (N)	Coord Note	
<input type="checkbox"/> 09/13/2007 (N)	Coord Note	
<input type="checkbox"/> 09/21/2008 (CB)	Recertification	
<input type="checkbox"/> 01/18/2008 01:30 PM (V)	Resumption Of Care	
<input type="checkbox"/> 06/19/2007 (O)	Verbal Order	
<input type="checkbox"/> 10/23/2007 11:45 AM (V)	Visit Note (SN)	
<input type="checkbox"/> 06/18/2008 11:45 AM (V)	Visit Note (SN)	
<input type="checkbox"/> 08/20/2008 11:30 AM (V)	Visit Note (SN)	
<input type="checkbox"/> 09/15/2008 12:00 PM (V)	Visit Note (SN)	
<input type="checkbox"/> 11/13/2007 11:00 AM (V)	Visit Note (SN)	
<input type="checkbox"/> 07/09/2007 09:00 AM (V)	Visit Not Made	
<input type="checkbox"/> 06/05/2007 09:50 AM (V)	Visit Note (SN)	
<input type="checkbox"/> 02/21/2008 01:00 PM (V)	PT Evaluation	
<input type="checkbox"/> 06/15/2007 08:30 AM (V)	Visit Note (SN)	
<input type="checkbox"/> 01/17/2008 (O)	Verbal Order	
<input type="checkbox"/> 11/26/2007 (CB)	Recertification	
<input type="checkbox"/> 09/10/2007 11:00 AM (V)	Visit Note (SN)	
<input type="checkbox"/> 07/29/2007 (CB)	Recertification	
<input type="checkbox"/> 08/01/2008 (O)	Verbal Order	
<input type="checkbox"/> 08/08/2008 (O)	Verbal Order	
<input type="checkbox"/> 02/28/2008 11:30 AM (V)	Visit Note (SN)	
<input type="checkbox"/> 09/03/2007 (N)	Coord Note	
<input type="checkbox"/> 08/31/2007 (T)	Transfer	
<input type="checkbox"/> 03/25/2008 (CB)	Recertification	
<input type="checkbox"/> 10/19/2007 (N)	Coord Note	
<input type="checkbox"/> 08/03/2008 (O)	Verbal Order	
<input type="checkbox"/> 12/26/2007 11:15 AM (V)	Visit Note (SN)	
<input type="checkbox"/> 08/08/2008 11:30 AM (V)	Visit Note (SN)	

Select All Deselect All

The question mark at the far right of the main MAT menu provides access to the MAT's application details.

Patient	Status	Admit	Birth Date	Sex	City	Phone
BESS, Sharon V	H	01	07/17/1929	F	OLDSAYBROOK	(555) 915-0041
BAGGZILL, Helen	A	01	06/14/1909	F	Old Lyme	(555) 434-7059
BENSCH, Patricia J	A	04	06/03/1919	F	Old Lyme	(555) 434-5112
BLONDEAU, George	H	01	11/01/1927	M	ESSEX	(555) 767-6871
BRIEGER, Paul N	A	02	04/05/1919	M	Lyme	(555) 434-8021
CADY, Dorothy	A	01	05/02/1936	F	Niantic	(555) 739-4712
CAHILLANE, John	A	01	09/06/1930	M	Old Saybrook	(555) 399-3797
DELUISE, Sharon	A	01	01/03/1929	F	Chester	(555) 526-4155
GOODNESS, Sharon	A	01	09/12/1912	F	Westbrook	(555) 399-9832
HARWARD, Jennifer H	A	02	02/15/1923	F	Waterford	(555) 442-4778
HEIL, Donna B	A	02	07/12/1926	F	Lyme	(555) 434-1582
HOOGLAND, Patricia D	I	04	10/09/1919	F	Old Lyme	(555) 434-2211
JAVARONE, Margaret	H	02	09/03/1911	F	Old Lyme	(555) 434-9515
KARL, Kenneth C	A	03	11/08/1913	M	Lyme	(555) 434-3937
KERKER, Betty M	A	02	02/04/1983	F	WESTBROOK	(555) 399-7640
KRIEGER, Donald H	A	01	08/31/1944	M	OLD LYME	(555) 434-3711
LABATE, Mary	A	01	12/10/1973	F	Niantic	(555) 627-5331
LEVENTHAL, Karen C	A	02	03/07/1925	F	Niantic	(555) 739-0763
MATHURIN, Deborah	A	01	04/10/1920	F	Old Saybrook	(555) 388-0415
MOUNTCASTLE, Barbara	I	01	05/04/1930	F	Old Lyme	(555) 434-4932
OGASAWARA, Jeff M	A	01	01/23/1916	M	LYME	(555) 526-6942
OLMEDA, Brian A	A	01	10/07/1922	M	OLD SAYBROOK	(555) 388-9572
PAVLAT, Linda E	H	02	12/13/1922	F	Niantic	(555) 691-2651
PEGUESE, Sarah	A	02	04/23/1926	F	Niantic	(555) 739-0545
PETERSEN, Daniel	A	01	08/05/1945	M	Niantic	(555) 235-8525
PROA, Helen L	H	06	03/08/1923	F	Niantic	(555) 739-6760
ZERCK, Nancy	A	02	03/22/1921	F	Old Lyme	(555) 434-0099
ZUSMAN, Karen R	A	02	02/25/1934	F	South Lyme	(555) 434-1560

Show Application Details

Besides detailed information about the version and status of the application, this page allows access to the phrase and medication editors (for logins with proper privilege), access to the latest copy of the MAT Quick Start Guide and the MAT-SAM Operations Manual, and can provide RiverSoft with the ability to see and drive your computer.

MAT Office (Office 2) - Application Details

Patients I C V D U R ?

RiverSoft Home Close

RiverSoft, Inc.

Web Address	Click here to visit RiverSoft's Web Site
Email Address	Click here to Email RiverSoft's Help Desk
Phone	321-242-1347
FAX	321-242-1368
Quick Start Guide	Click Here to download the MAT Quick Start Guide
MAT-SAM Operations Manual	Click Here to download the MAT-SAM Operations Manual

MAT© (2007-2010)

Mat Version	3.0.2469.0
View Release Notes	<input type="button" value="View Release Notes"/>
Directory	C:\Program Files (x86)\RiverSoft\Mat30

Database

Server	SQL1
Name	RSDEMO
Version	03.016
SamHubDir	N:

User

Name	RIVERSOFT
Office Code	0002
At the Back Office	True
Readonly Office	False
Employee Number	
User is Mat Administrator	True
User is Sam System Administrator	True
User is Audit User	False
User is Super User	True
User is Send to SAM User	True
User is Allowed to enter Travel Pay	True

Administration

Edit Phrases	<input type="button" value="Edit Phrases"/>
View Phrases	<input type="button" value="View Phrases"/>
Edit Problems	<input type="button" value="Edit Problems"/>
View Problems	<input type="button" value="View Problems"/>
Edit Medications	<input type="button" value="Edit Medications"/>
Edit Announcements	<input type="button" value="Edit Announcements"/>
Edit Options	<input type="button" value="Edit Options"/>

Administrative users will be able to see document user and document usage information for the previous month by using the "View Document Counts" button.

Document

Document Counts	<input type="button" value="View Document Counts"/>
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Time for 20 (or so) Questions!

1. How does MAT know which patients to send to a caregiver's device? Patients with status of incomplete, pending, or hold + Patients with incomplete documents authored by the caregiver + Patients visited by the caregiver within the last month
2. Which documents go to a caregiver's device? All assessment documents for caregiver's patients + All other documents not older than 7 days for the caregiver's patients + All incomplete documents (due to conferencing) authored by the caregiver
3. How do you create a new document? Select a patient from the patient list, select the "New Document" menu item, and select the type of document to add.
4. How do you see the incomplete documents for an office and how do you see just the incomplete documents for a caregiver? In MAT Office, select the yellow documents icon to the right of the "Patients" button. This list of documents can be sorted by any of the columns by clicking the column header. Click on the column header "User Name" to group incomplete documents by caregiver.
5. How do you send a document back to a caregiver with change instructions? In MAT Office, navigate to the conference page of the document, enter instructions regarding the changes required, and uncheck the "All conference items below have been addressed" box. This will cause the document to be incomplete and will also place the document in MAT's outbox to be sent back to the caregiver.
6. How does a caregiver see just the documents that have been sent back to them for changes? In MAT Mobile, select the yellow document icon. The documents with the red exclamation marks have conference items.
7. How do you see all of the documents that have conference items and how do you tell if the document has been sent to the caregiver's device? In MAT Office at the far right of the main menu bar select the yellow document icon with the red exclamation point. Yellow documents have been sent to their caregiver – red documents are waiting for their caregivers to sync.
8. How do you see all of the documents that are completed but not sent to SAM? In MAT Office, select the green document icon.
9. Can a document that has already been Sent-To-SAM be "conferenced" and changed and where do completed documents go after they are Sent-To-SAM? A document may be Sent-To-SAM only once, but it may be changed in MAT and sent back to the caregiver even after it has been Sent-To-SAM. Documents that have been Sent-To-SAM are available from the patient list by selecting a particular patient and then choosing the "More Document..." menu item.
10. What does MAT check for in its "Review"? The types of checks vary by document – choose the "Test Log" tab on the review screen for a complete list of the checks done for that document and the results of the check.
11. How often should a caregiver synchronize and what kinds of problems will occur if they don't sync often? It is recommended that each caregiver sync in the morning before each work day. An average sync takes less than 3 minutes and having up-to-date data will prevent problems like creating documents for admissions that have been recently discharged.
12. If a document is created under the last patient admission and it should actually belong to a more current admission, how do I move the document? From the document, click the "?" mark (which is to the right of the "delete" button). This is the document detail screen. If the patient has a later admission, a button will be available to increment the admission number of the document to the next admission.
13. If a patient is transferred into a facility and then we resume care for them under another payer program, how to I enter another start of care into MAT under the same admission? Use the Payer Discharge document to tell MAT and SAM that the last payer is to be discharged from the current plan of care. This will cause the payer discharge information on the current plan of care in SAM to be updated with the date entered and will let MAT know that another Start of Care document is now required.
14. When a discharge document is sent to SAM, is the patient always discharged from the agency? No. Only a patient with a single payer source will be discharged from the agency. A patient with multiple payer sources will only be discharged from the payer under which their start of care assessment was done (look at the payer on the plan of care in SAM to determine this).
15. Can anyone edit a caregiver's document? No. Only a caregiver or a user with the MAT Administrator privilege may edit a caregiver's document.
16. How do you see who changed what on a document and when does this "change tracking" begin? Select a patient from the patient list and choose the "Revision History" menu item. This will list all documents for the patient that have a revision history. By clicking on any of the "+" signs, you can view the detailed document changes. MAT tracks the changes to a document once it has been synced or Sent-To-SAM.
17. What kind of access to MAT can be provided to a clinical Audit? The MAT username "Audit" is specifically designed to give clinical and state Audits read-only access to the system without access to the conference page or the review button.

18. Can I change MAT's phrase database (problems, interventions, etc.)? Yes. Select the "?" from the main MAT menu to view the application details page. At the bottom of this page is button for editing your agency's phrases database which is only visible to MAT Administrators.
19. Can I print blank documents and can I print just certain sections of a document? Print blank documents or selected sections of a normal document by choosing the "Print" button while viewing a document.
20. What is the quickest way to review a patient's chart? Use the patient list to find and view the first document. Then use the document pull-down at the top of the document (or the left and right arrows) to move to the patient's other documents.
21. Is the data backed up? How long does it stay in the database? All MAT data is inside your SAM database, which is backed-up nightly. The database transactions during the day are backed up every hour. Most sites are configured to keep 7 days of backups. The data will stay in the database forever, unless you are using the archive feature in which case it may disappear from the live database but will still be available in the archive database.
22. How do we re-assign a device to another caregiver? From the laptop, use the Windows explorer to navigate to the MATMobileInitialSetup.exe in the SAMInstall folder (normally on your N: drive). Run this setup as you would in order to give it to a new employee EXCEPT uncheck the "Install SQL Express..." option.
23. What happens if a caregiver steals or misplaces a device? RiverSoft recommends that you call the police to report the theft. Then, to see what patient information is at risk, assign a laptop to that employee (see question 20). MAT Document data is stored in a RiverSoft proprietary format within the SQL database, which is itself username and password protected. Information is encoded by MAT when it is written to the database and decoded when it is retrieve from the database. Browsing the SQL database with SQL front-end software would only show the encoded data and would look like gibberish to the browser.
24. If an office has a front and back office in RiverSoft, can we edit the documents at both places? No – either the front or back office is configured with the ability to edit documents – the other location can only view and print.
25. What do we do if the sync does not work? If your device CANNOT access the internet then it will not be able to connect to your sync server. RiverSoft will not be able to help you with internet access problems so contact your IT support. If you can access the internet but cannot access your sync server, verify your sync server is on and then call RiverSoft for support.
26. What type of device does MAT Mobile work on? See our website for the most current hardware recommendations. Currently the Asus T101 tablet with 2 Gig of memory is our favorite – it has good performance and battery life and it cost less than \$500. If the screen proves too small for some of your users, we suggest incurring the extra expense of using a tablet that has a 12 inch screen.