



NightingaleMD

Florence AI Navigator

Comprehensive Sales Manual

Version 2.0 – With Visual Walkthrough

February 2026

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PART 1

Strategic Context & Value Proposition

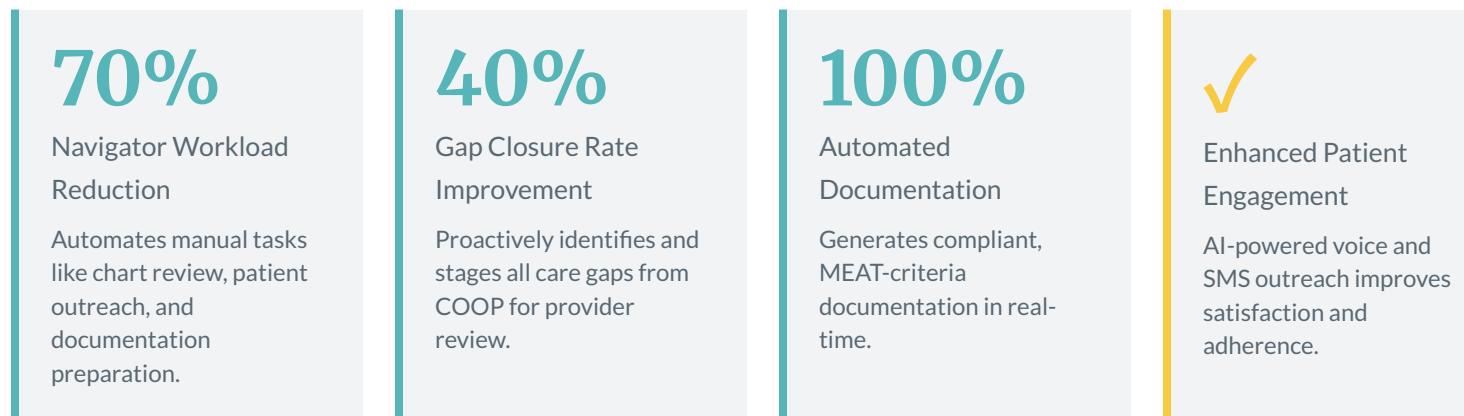
Chapter 1: Introduction

Audience: This manual is designed for **sales representatives** at NightingaleMD. It provides the strategic context, workflow knowledge, and demo scripts needed to effectively showcase the Florence AI Navigator to prospective clients, including clinical stakeholders (CMOs, quality directors) and practice managers.

Purpose: The primary purpose of this manual is to serve as a comprehensive guide for conducting **live client demos**. It will equip you with the knowledge to not only demonstrate the features of Florence but also to articulate its profound value proposition within the complex ecosystem of Comprehensive Care Assessment (CCA).

Key Value Propositions

By automating and enhancing the CCA lifecycle, Florence delivers a powerful return on investment:



Chapter 2: The Traditional CCA Process

The traditional Comprehensive Care Assessment (CCA) process is a manual, time-consuming, and often inefficient workflow that places a heavy burden on care navigators and providers. Understanding these pain points is critical to articulating the value of Florence.

The Manual CCA Workflow

- 1. Manual Data Review:** The care navigator manually reviews data from the Care Opportunities and Outcomes Platform (COOP) to identify patients due for a CCA.

- 2. Manual Chart Review:** The navigator manually reviews the patient's chart in the EHR to identify all potential care gaps, including suspect diagnoses, quality measures, and frailty indicators.
- 3. Manual Patient Outreach:** The navigator manually calls the patient to schedule a Transitional Care Management (TCM) call and a follow-up appointment.
- 4. Manual Documentation Preparation:** Before the appointment, the navigator manually prepares all necessary documentation, including a summary of care gaps and supporting evidence.
- 5. Provider Encounter:** During the visit, the provider must manually review the patient's chart and the navigator's notes to address care gaps, often without real-time decision support.
- 6. Manual Follow-up:** After the visit, the navigator manually coordinates any necessary follow-up, such as specialist referrals or patient education.

Key Pain Points

Pain Point	Description
Time-Consuming	The manual process can take 4–6 hours of navigator time per patient, limiting patient volume.
Inconsistent Gap Identification	Manual chart review is prone to human error, leading to missed care gaps and lost revenue.
Provider Documentation Burden	Providers spend significant time on documentation, taking away from patient care.
Missed Follow-up	Manual follow-up is often inconsistent, leading to poor care coordination.
Limited Scalability	The manual process is not scalable for growing patient populations.

Chapter 3: The CCA Lifecycle with Florence

Florence transforms the CCA process by automating and enhancing each phase of the lifecycle, from trigger to ongoing management. This integrated approach ensures a seamless, efficient, and effective workflow.

The 5 Phases of the CCA Lifecycle

- 1. Trigger:** Florence automatically detects CCA triggers from COOP in real-time, including hospital discharge notifications, Annual Wellness Visit (AWV) due dates, new quality measure gaps, and suspect diagnosis gaps.

- 2. Pre-Encounter:** Once a trigger is detected, Florence compiles all necessary CCA components from COOP and the EHR, conducts the TCM outreach call using the **Engage** workflow, confirms the follow-up appointment, and stages all identified care gaps for provider review.
- 3. Encounter:** During the patient visit, Florence acts as a real-time copilot — displaying all staged gaps with supporting evidence, allowing one-click accept/reject/defer, and auto-generating MEAT-criteria documentation.
- 4. Post-Encounter:** After the visit, Florence coordinates specialist referrals, sends automated patient education materials, and uses the **Convene** workflow to facilitate care team meetings.
- 5. Ongoing Management:** Florence provides ongoing support using the **Check-In** workflow for routine SMS monitoring, tracking medication adherence, and escalating to a human navigator when necessary.

PART 2

The Pre-Encounter Workflow & Demo Scripts

Chapter 4: The Navigator's View

This chapter details the pre-encounter workflow from the care navigator's perspective. The goal is to demonstrate how Florence automates the most time-consuming manual tasks, allowing navigators to operate at the top of their license.

DEMO SCENARIO

Patient: Jane Doe, 68 y/o female, recently discharged from St. Joseph's Hospital after an acute MI.

Trigger: Florence receives a real-time discharge notification from COOP.

Objective: Demonstrate how Florence automates the TCM call, schedules the follow-up appointment, and stages all relevant care gaps for provider review.

1 Open the Florence Dashboard

When you first open the Florence AI Navigator, you see the side-by-side view: the athenaOne EHR on the left and the Florence Copilot sidebar on the right. The patient's chart is already loaded with all relevant clinical data.

Figure 1: The Florence AI Navigator integrated into athenaOne. The left panel shows the patient's EHR chart, while the right panel displays the Florence Copilot with patient summary, workflow buttons, and care gaps.

2 Review the Patient Summary

The Florence Copilot sidebar immediately shows the patient's key information at a glance. Jane Doe is flagged as **High Risk** and enrolled in **CCM** (Chronic Care Management). The three workflow buttons – **Engage**, **Convene**, and **Check-In** – are prominently displayed, along with tabs for Overview, Transcript, and Documentation.

The screenshot shows the Florence Copilot sidebar interface. At the top, there's a purple header bar with a "Sign & Close" button. Below it is a green header bar with a NightingaleMD logo, a "Connected" status indicator, and a bell icon. A note on the right says "<- Improve UX for sales trigger deploy -->".

On the left, there are several greyed-out sections: "HPI / ROS", "stage 3a was owing", "it cardiac", "rolol", "e, Lisinopril", "e tired and", "ss of breath", "nt confirms", "flag", "February 18, 2026", and "nversation.".

Below these are sections for "/ Exam / Findings", "lbs", and "°F".

The main content area starts with a teal header bar containing "Sync from athenaOne" and "Post-Visit Tasks".

The patient summary card for "Jane Doe (68 y/o F)" is displayed, showing "High Risk" and "CCM" status, and MRN: 202070. It includes buttons for "Engage", "Convene", and "Check-in", and tabs for "Overview" (which is selected), "Transcript", and "Documentation".

A dropdown menu titled "Florence Summary" is open, showing "Care & Diagnosis Gaps" (9 items). It includes a search bar, filters for "All (9)", "Recapture (0)", "Suspect (4)", "Quality (3)", and "Frailty (2)", and a checkbox for "Show staged items".

Two gaps are listed:

- Chronic Kidney Disease Stage 3a**
ICD-10: N18.31 • HCC 138
eGFR 52 mL/min/1.73m² (range 45-59) indicates CKD Stage 3a.
Stage for MD Review button and "Details" link.
- Major Depressive Disorder, Recurrent, Moderate**
ICD-10: F33.1 • HCC 59
Florence AI flagged recurrent major depressive disorder based on previous episodes, but current PHQ-9 score of 8 (mild) may not support moderate severity coding.

Figure 2: The Florence Copilot sidebar showing patient summary (Jane Doe, 68 y/o F, High Risk, CCM), workflow action buttons, and the Overview tab with Florence Summary.

3 Review Care & Diagnosis Gaps

Scrolling down in the Copilot sidebar, you can see all **9 Care & Diagnosis Gaps** that Florence has automatically identified from COOP. The gaps are organized by category using filter buttons: **All (9)**, **Recapture (0)**, **Suspect (4)**, **Quality (3)**, and **Frailty (2)**.

The screenshot shows the Care & Diagnosis Gaps section of the Florence AI Navigator. On the left, there's a sidebar with patient information: Name, Date of Birth, Discharge Date, and a list of medications. Below that is a section for 'Exam / Findings'. The main area has a header 'Florence Summary' with a dropdown arrow. Below it is a title 'Care & Diagnosis Gaps' with a red circle containing the number '9'. To the right is a 'View Pre-Work Summary' button. Underneath is a search bar with placeholder text 'Search gaps...'. Below the search bar are five filter buttons: 'All (9)' (highlighted in blue), 'Recapture (0)', 'Suspect (4)', 'Quality (3)', and 'Frailty (2)'. There's also a checkbox for 'Show staged items'. Two gaps are listed: 1. 'Chronic Kidney Disease Stage 3a' (SUSPECT, COOP ↑ High). It includes ICD-10 codes N18.31 • HCC 138 and a note about eGFR. It has a 'Stage for MD Review' button and a 'Details' button. 2. 'Major Depressive Disorder, Recurrent, Moderate' (SUSPECT, COOP ↑ High). It includes ICD-10 code F33.1 • HCC 59 and a note about Florence AI flagging recurrent episodes. Both gaps have checkboxes next to their names.

Figure 3: The Care & Diagnosis Gaps section showing all 9 identified gaps with category filters. Each gap shows its type (Suspect/Quality/Frailty), source (COOP), and priority level.

DEMO SCRIPT

Sales Rep: "What you're seeing here is the Florence AI Navigator, which is integrated directly into athenaOne. The moment Jane Doe was discharged from the hospital, Florence received a notification from COOP and automatically initiated the pre-encounter workflow."

Sales Rep: "First, Florence automatically compiled all of Jane's relevant information, including her discharge summary, medications, and all of her open care gaps from COOP. You can see here that Florence has identified 9 gaps in total: 4 suspect gaps, 3 quality measures, and 2 frailty gaps."

4 Expand Gap Details

Clicking the **Details** button on any gap reveals comprehensive information including the full ICD-10 description, supporting evidence from the patient's chart, and the clinical rationale for the gap identification.

The screenshot shows the NightingaleMD software interface. On the left, there is a vertical sidebar with patient information: 'ss of breath', 'nt confirms', 'flag', 'February 18, 2026', 'nversation.', '/ Exam / Findings', 'lbs', and '°F'. The main area has a header 'Florence Summary' with a dropdown arrow. Below it is a section titled 'Care & Diagnosis Gaps' with a red notification badge showing '9'. To the right is a 'View Pre-Work Summary' button. A search bar contains 'Search gaps...'. Below the search bar are four buttons: 'All (9)' (highlighted in green), 'Recapture (0)', 'Suspect (4)', and 'Quality (3)'. Underneath these buttons is a link 'Frailty (2)'. There is also a checkbox 'Show staged items'. A specific gap is expanded, showing a checkbox 'SUSPECT COOP ↑ High', the diagnosis 'Chronic Kidney Disease Stage 3a', the ICD-10 code 'N18.31 • HCC 138', and the note 'eGFR 52 mL/min/1.73m² (range 45-59) indicates CKD Stage 3a.' A teal button labeled 'Stage for MD Review' is at the bottom of this expanded section, and a 'Hide' button is to its right. Below this is a section titled 'Full ICD-10 Description' with the text: 'Chronic kidney disease, stage 3a. Stage 3a is defined as eGFR 45-59 mL/min/1.73m². Stage 3b is eGFR 30-44 mL/min/1.73m²'. At the bottom of the expanded section is a link 'Supporting Evidence from Chart' with a magnifying glass icon.

Figure 4: Expanded details for the Chronic Kidney Disease Stage 3a suspect gap, showing ICD-10 code N18.31, HCC 138, and the eGFR value of 52 mL/min that supports the diagnosis.

5 View the Pre-Work Summary

Clicking **View Pre-Work Summary** opens a comprehensive overview of all the pre-encounter preparation that Florence has completed automatically. This includes the patient's clinical summary, all identified gaps, and recommended actions.

The figure displays two side-by-side screenshots of healthcare software interfaces. On the left, the athenaOne platform shows a patient chart for 'Doe, Jane' (68 y/o F, DOB: 05/27/1955, MRN: 202070). The chart includes sections for Subjective (Chief Complaint: Post-hospital discharge follow-up (TCM call)) and Objective (Vitals: BP 142/88 mmHg, HR 76 bpm, Weight 198 lbs; BMI 29.3, SpO2 97%, Temp 98.4°F). On the right, the NightingaleMD platform shows a summary for 'Jane Doe (68 y/o F)' with status 'High Risk' and 'CCM'. It lists care gaps, including 'Chronic Kidney Disease Stage 3a' (ICD-10: N18.31 • HCC 138) and 'eGFR 52 mL/min/1.73m² (range 45-59) indicates CKD Stage 3a.' A prominent blue button labeled 'Stage for MD Review' is visible.

Figure 5: The Pre-Work Summary view showing Florence's automated pre-encounter preparation, including clinical summary and all identified care gaps ready for review.

6 Stage Gaps for Provider Review (Bulk Staging)

Each gap has a "Stage for MD Review" button. The navigator can stage individual gaps or use bulk staging to prepare all gaps for the provider encounter. This is the workflow that **80% of clients use** because it is so efficient.

The screenshot shows the Florence Summary interface. At the top, it displays "Care & Diagnosis Gaps" with a red notification badge showing the number 9. Below this is a search bar labeled "Search gaps...". Underneath the search bar are several filter buttons: "All (9)", "Recapture (0)", "Suspect (4)", "Quality (3)", and "Frailty (2)". There is also a checkbox for "Show staged items". A specific care gap is highlighted, showing "SUSPECT" and "COOP ↑ High". The gap details "Chronic Kidney Disease Stage 3a" with ICD-10 code N18.31 and HCC 138. It notes that eGFR 52 mL/min/1.73m² (range 45-59) indicates CKD Stage 3a. A large teal button labeled "Stage for MD Review" is prominently displayed. To the right of this button is a "Hide" button with an upward arrow icon.

Figure 6: The "Stage for MD Review" buttons visible on each care gap, allowing navigators to quickly prepare gaps for provider review during the encounter.

DEMO SCRIPT

Sales Rep: "Now, let's look at how Florence prepares for the provider encounter. The most powerful feature here is bulk staging. With a single click, the navigator can stage all 9 of Jane's care gaps for the provider to review during the visit. This is the workflow that 80% of our clients use because it's so efficient."

Sales Rep: "Just like that, all of Jane's care gaps are staged and ready for the provider. Florence has also automatically generated the necessary MEAT criteria documentation based on the information from COOP."

Chapter 5: The 'Engage' Workflow

The **Engage** workflow is Florence's AI-powered voice outreach tool. It is designed to automate a wide range of patient communication tasks, from TCM calls to appointment reminders.

Key Features

Feature	Description
Natural Language Conversation	Engage uses advanced NLP to have human-like conversations with patients.
Automated Scheduling	Engage can automatically schedule appointments based on the provider's availability.
Real-time Escalation	If a patient expresses confusion or distress, Engage can automatically escalate to a human navigator.
Full Transcription	Every call is transcribed in real-time and saved to the patient's record.

7

Initiate the Engage Workflow

Clicking the **Engage** button initiates the AI-powered TCM outreach call. The button changes to "In Call..." to indicate the call is in progress. Florence automatically dials the patient and begins the conversation.

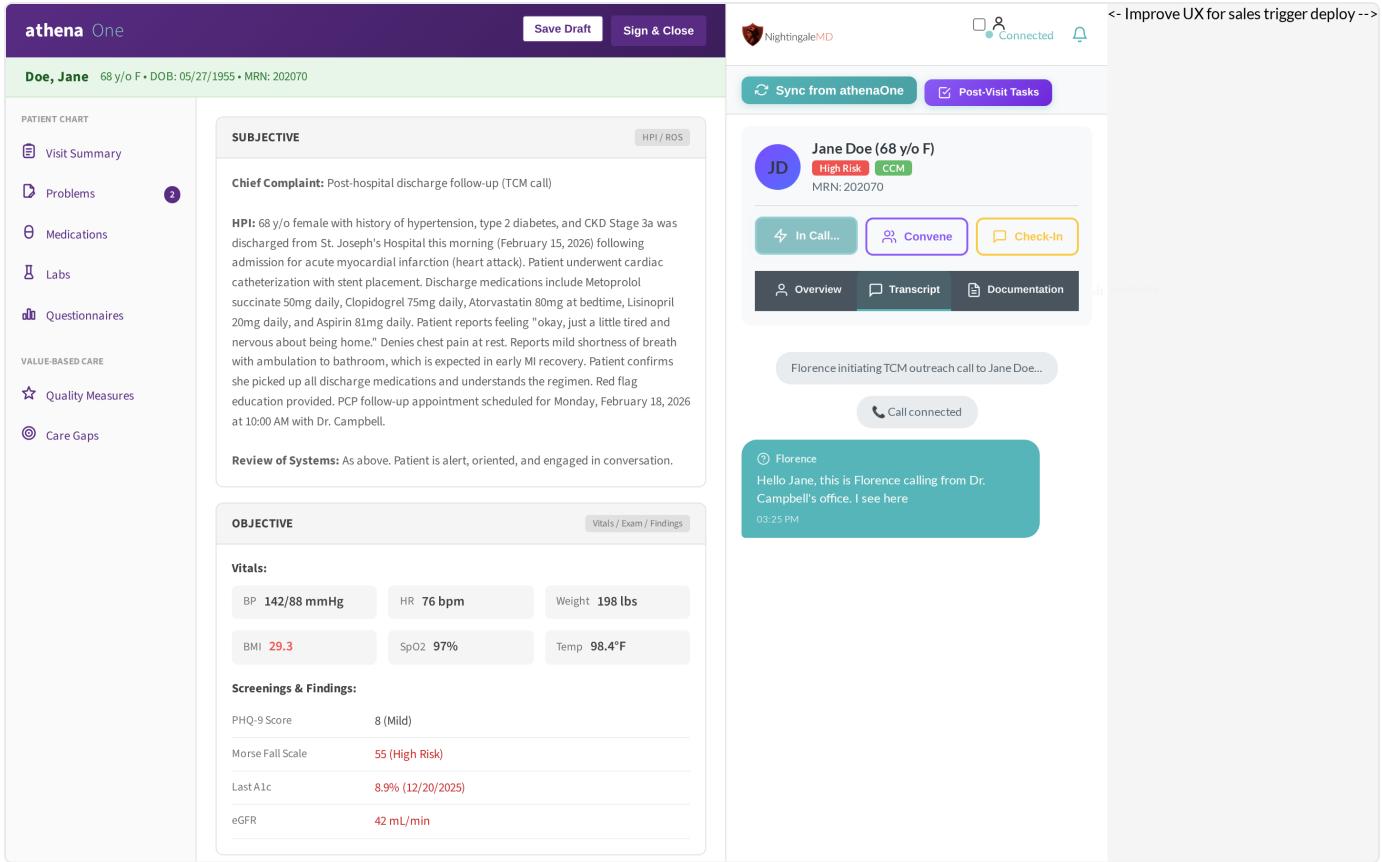


Figure 7: The Engage workflow in progress. The Engage button shows "In Call..." status, and the Transcript tab displays the real-time conversation between Florence and the patient.

8 View the Live Transcript

Switching to the **Transcript** tab shows the real-time conversation between Florence and the patient. Florence initiates the call with a warm, professional greeting and confirms the patient's identity before proceeding with the TCM protocol.

The image displays two side-by-side screenshots of a healthcare application interface.

Left Screenshot (athenaOne Patient Chart):

- Header:** athena One, Save Draft, Sign & Close.
- Patient Information:** Doe, Jane, 68 y/o F • DOB: 05/27/1955 • MRN: 202070.
- MENU (PATIENT CHART):**
 - Visit Summary
 - Problems (2)
 - Medications
 - Labs
 - Questionnaires
- SUBJECTIVE:**

Chief Complaint: Post-hospital discharge follow-up (TCM call)

HPI: 68 y/o female with history of hypertension, type 2 diabetes, and CKD Stage 3a was discharged from St. Joseph's Hospital this morning (February 15, 2026) following admission for acute myocardial infarction (heart attack). Patient underwent cardiac catheterization with stent placement. Discharge medications include Metoprolol succinate 50mg daily, Clopidogrel 75mg daily, Atorvastatin 80mg at bedtime, Lisinopril 20mg daily, and Aspirin 81mg daily. Patient reports feeling "okay, just a little tired and nervous about being home." Denies chest pain at rest. Reports mild shortness of breath with ambulation to bathroom, which is expected in early MI recovery. Patient confirms she picked up all discharge medications and understands the regimen. Red flag education provided. PCP follow-up appointment scheduled for Monday, February 18, 2026 at 10:00 AM with Dr. Campbell.

Review of Systems: As above. Patient is alert, oriented, and engaged in conversation.
- OBJECTIVE:**

Vitals:

BP 142/88 mmHg	HR 76 bpm	Weight 198 lbs
BMI 29.3	SpO2 97%	Temp 98.4°F

Screenings & Findings:

PHQ-9 Score	8 (Mild)
Morse Fall Scale	55 (High Risk)
Last A1c	8.9% (12/20/2025)
eGFR	42 mL/min

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NightingaleMD Connected

Sync from athenaOne **Post-Visit Tasks**

Jane Doe (68 y/o F)
High Risk CCM
MRN: 202070

In Call... Convene Check-in

Overview Transcript Documentation

Florence initiating TCM outreach call to Jane Doe...

Call connected

Florence
Hello Jane, this is Florence calling from Dr. Campbell's office. I see here that you were released from St. Joseph's Hospital this morning after your heart attack. How are you feeling?
03:25 PM

• • •

Figure 8: The Engage transcript showing Florence's initial greeting and the natural, empathetic conversation with the patient about their post-discharge care.

Full Engage Transcript: Jane Doe TCM Call

Florence: "Hello, I'm calling from Dr. Campbell's office on behalf of Nightingale Health. May I please speak with Jane Doe?"

Jane Doe: "This is she."

Florence: "Hi Jane, my name is Florence, and I'm an AI assistant with Nightingale Health. I'm calling to check in with you after your recent discharge from St. Joseph's Hospital. How are you feeling?"

Jane Doe: "Oh, hello. I'm feeling a little tired, but I'm doing okay."

Florence: "I'm glad to hear that. I'm calling to make sure you have everything you need for a smooth recovery. I see that you were prescribed a few new medications. Have you been able to pick them up from the pharmacy?"

Jane Doe: "Yes, I have them right here."

Florence: "That's great. It's also very important that you have a follow-up appointment with your primary care provider, Dr. Campbell, within the next week. I see one has been scheduled for you on Monday, February 18th at 10:00 AM. Does that time still work for you?"

Jane Doe: "Yes, that's perfect."

Florence: "Wonderful. We look forward to seeing you then. If you have any questions before your appointment, please don't hesitate to call our office. Have a great day, Jane."

Jane Doe: "Thank you, you too."

DEMO SCRIPT

Sales Rep: "As you can see, Florence had a natural, empathetic conversation with Jane, confirmed her medications, and even scheduled her follow-up appointment with Dr. Campbell. This entire process was fully automated, saving the care navigator hours of work."

9

Review Auto-Generated Documentation

After the Engage call completes, switching to the **Documentation** tab shows the auto-generated clinical documentation. Florence automatically creates a structured summary of the call, including key findings, patient responses, and next steps.

The image displays two side-by-side screenshots of healthcare software interfaces.

athena One (Left):

- Patient Chart:** Shows a patient summary for "Doe, Jane" (68 y/o F, DOB: 05/27/1955, MRN: 202070).
- SUBJECTIVE:** Includes the Chief Complaint ("Post-hospital discharge follow-up (TCM call)"), HPI / ROS, and a detailed History and Physical (HPI) section describing a 68-year-old female with hypertension, type 2 diabetes, and CKD Stage 3a who was discharged from St. Joseph's Hospital this morning (February 15, 2026) following admission for acute myocardial infarction (heart attack). The patient underwent cardiac catheterization with stent placement. Discharge medications include Metoprolol succinate 50mg daily, Clopidogrel 75mg daily, Atorvastatin 80mg at bedtime, Lisinopril 20mg daily, and Aspirin 81mg daily. Patient reports feeling "okay, just a little tired and nervous about being home." Denies chest pain at rest. Reports mild shortness of breath with ambulation to bathroom, which is expected in early MI recovery. Patient confirms she picked up all discharge medications and understands the regimen. Red flag education provided. PCP follow-up appointment scheduled for Monday, February 18, 2026 at 10:00 AM with Dr. Campbell.
- OBJECTIVE:** Includes Vitals (BP 142/88 mmHg, HR 76 bpm, Weight 198 lbs, BMI 29.3, SpO2 97%, Temp 98.4°F), Screenings & Findings (PHQ-9 Score 8 (Mild), Morse Fall Scale 55 (High Risk), Last A1c 8.9% (12/20/2025), eGFR 42 mL/min), and a Review of Systems.

NightingaleMD (Right):

- Header:** Shows the NightingaleMD logo, a shield icon, and a "Connected" status with a bell icon. A note says "<- Improve UX for sales trigger deploy -->"
- Patient Summary:** Displays "Jane Doe (68 y/o F)" with "High Risk" and "CCM" status, and MRN: 202070.
- Action Buttons:** "In Call...", "Convene", and "Check-in".
- Navigation:** "Overview", "Transcript", "Documentation" (selected).
- Clinical Note:** Labeled "Auto-Generated". A placeholder message says "Documentation will appear here after completing a workflow."

Figure 9: The Documentation tab showing Florence's auto-generated clinical documentation from the Engage call, including call summary, medication verification, and appointment confirmation.

10 View Analytics

The **Analytics** tab provides real-time metrics and tracking for all Florence workflows, including call completion rates, gap closure progress, and patient engagement statistics.

The image displays two side-by-side screenshots of healthcare software interfaces. On the left is the athenaOne interface, showing a patient chart for 'Doe, Jane' (68 y/o F, DOB: 05/27/1955, MRN: 202070). The chart includes sections for Subjective (Chief Complaint: Post-hospital discharge follow-up (TCM call), HPI: 68 y/o female with history of hypertension, type 2 diabetes, and CKD Stage 3a, etc.), Objective (Vitals: BP 142/88 mmHg, HR 76 bpm, Weight 198 lbs, BMI 29.3, SpO2 97%, Temp 98.4°F, etc.), and a Review of Systems. On the right is the NightingaleMD interface, showing a dashboard for 'Jane Doe (68 y/o F)' (High Risk, CCM, MRN: 202070). The dashboard includes tabs for Overview, Transcript, Documentation, and Analytics. The Analytics tab shows real-time metrics for Florence workflows, including gap closure tracking (e.g., 'STAGED FOR MD REVIEW') and patient engagement statistics (e.g., 'OPEN' status for various items). A header at the top right indicates '<- Improve UX for sales trigger deploy -->'.

Figure 10: The Analytics tab showing real-time metrics for Florence workflows, including gap closure tracking and patient engagement statistics.

PART 3

The Encounter Workflow & Provider Perspective

Chapter 6: The Provider's View

This chapter focuses on the provider's experience during the patient encounter. The key is to demonstrate how Florence acts as an intelligent copilot, streamlining the provider's workflow and enabling them to focus on patient care, not documentation.

DEMO SCENARIO

Patient: Jane Doe, 68 y/o female, is in the office for her post-discharge follow-up appointment.

Provider: Dr. Campbell is seeing Jane for the visit.

Objective: Demonstrate how Dr. Campbell uses Florence to review and accept the staged care gaps, and how Florence automatically generates the necessary documentation.

11 Toggle to Provider View

Clicking the **Provider View** toggle at the top of the Florence sidebar switches from the Navigator View to the Provider View. The gap details automatically expand to show additional clinical information, including the full ICD-10 description and supporting evidence from the chart.

Figure 11: The Provider View showing expanded gap details with full ICD-10 descriptions, supporting evidence, and MEAT criteria attestation options. Note the blue Provider View toggle at the top.

DEMO SCRIPT

Sales Rep: "We're now looking at Dr. Campbell's view in athenaOne. As you can see, the Florence AI Navigator is seamlessly integrated into the EHR, providing real-time decision support right at the point of care."

Sales Rep: "You'll notice the Florence sidebar on the right. It displays all 9 of Jane's care gaps that were staged by the navigator. The gaps are organized by type – Suspect, Quality, and Frailty – making it easy for Dr. Campbell to review them!"

12 Review Provider Documentation

The **Documentation** tab in Provider View shows the auto-generated MEAT-criteria documentation. As the provider accepts gaps and attests to the MEAT criteria, Florence automatically generates compliant documentation in real-time.

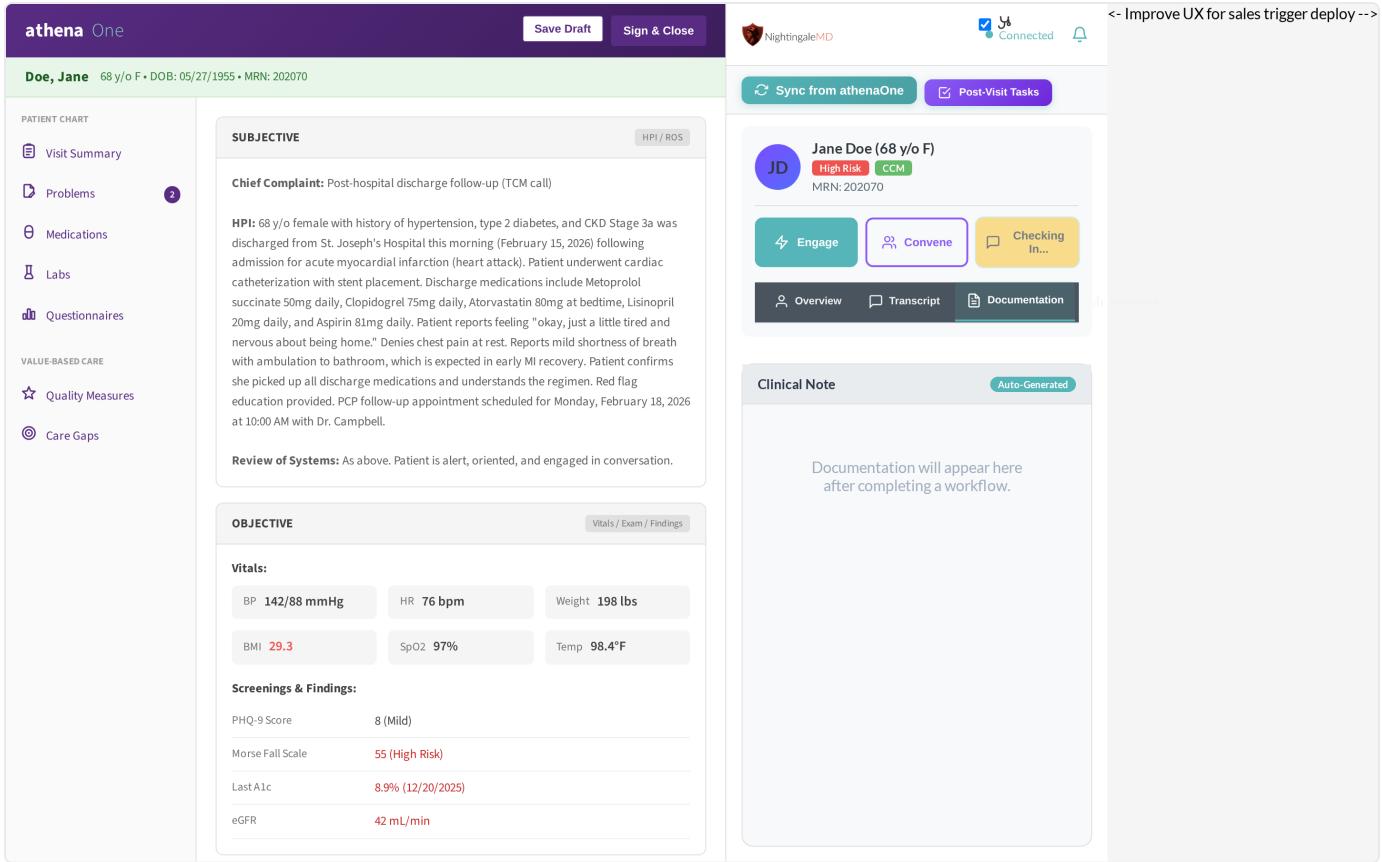


Figure 12: The Provider Documentation tab showing auto-generated MEAT-criteria documentation. Florence creates compliant clinical notes in real-time as the provider reviews and accepts care gaps.

DEMO SCRIPT

Sales Rep: "As Dr. Campbell attests to the MEAT criteria, Florence automatically generates the compliant documentation in the background. This eliminates the need for the provider to manually type out notes, saving a significant amount of time."

Sales Rep: "The documentation includes all of the necessary MEAT criteria elements – Monitored, Evaluated, Assessed, and Treated – along with the supporting evidence from COOP!"

13 Review the EHR Patient Chart

The left panel of the dashboard shows the full athenaOne EHR patient chart, including the Subjective section (HPI, ROS), Objective section (Vitals, Screenings), Problem List, Medications, Referrals, and more. Florence integrates seamlessly alongside this existing workflow.

Doe, Jane 68 y/o F • DOB: 05/27/1955 • MRN: 202070

PATIENT CHART

Visit Summary

 Problems 2

Medications

Labs

Questionnaires

VALUE-BASED CARE

Quality Measures

Care Gaps

SUBJECTIVE

Chief Complaint: Post-hospital discharge follow-up (TCM call)

HPI: 68 y/o female with history of hypertension, type 2 diabetes, and CKD S discharged from St. Joseph's Hospital this morning (February 15, 2026) following admission for acute myocardial infarction (heart attack). Patient underwent catheterization with stent placement. Discharge medications include Metoprolol succinate 50mg daily, Clopidogrel 75mg daily, Atorvastatin 80mg at bedtime, 20mg daily, and Aspirin 81mg daily. Patient reports feeling "okay, just a little nervous about being home." Denies chest pain at rest. Reports mild shortness of breath with ambulation to bathroom, which is expected in early MI recovery. Patient has been oriented to time and place. She picked up all discharge medications and understands the regimen. Red education provided. PCP follow-up appointment scheduled for Monday, February 20, 2026 at 10:00 AM with Dr. Campbell.

Review of Systems: As above. Patient is alert, oriented, and engaged in conversation.

OBJECTIVE

Vitals

Vitals:

BP 142/88 mmHg

HR 76 bpm

Weight 198 lbs

BMI 29.3

SpO2 97%

Temp 98.4° F

Screenings & Findings:

PHQ-9 Score 8 (Mild)

Morse Fall Scale 55 (High Risk)

Last A1c 8.9% (12/20/2025)

eGFR 42 mL/min

Figure 13: The athenaOne EHR patient chart showing Jane Doe's clinical data, including Chief Complaint (Post-hospital discharge follow-up), Vitals (BP 142/88, HR 76, BMI 29.3), and Screenings (PHQ-9: 8, Morse Fall Scale: 55 High Risk, A1c: 8.9%).

Chapter 7: Provider Best Practices

To maximize the value of Florence, providers should follow these best practices during the patient encounter:

Best Practice	Description
Trust the Staged Gaps	The care gaps staged by Florence are based on real-time data from COOP, which is the source of truth for gap validation. Providers can trust that these gaps are accurate and up-to-date.
Leverage the Sidebar	The Florence sidebar is designed to be an at-a-glance resource. Providers should use it to quickly review all open gaps and supporting evidence without leaving the patient's chart.
Embrace One-Click Attestation	The one-click MEAT criteria attestation is a powerful time-saving feature. Providers should use it to quickly document their clinical decisions.
Review Auto-Generated Docs	While Florence's documentation is highly accurate, providers should always give it a quick review before signing the note to ensure clinical accuracy.

PART 4

Post-Encounter & Ongoing Management

Chapter 8: The 'Convene' Workflow

The **Convene** workflow is designed to facilitate seamless communication and collaboration among the patient's care team. It allows navigators to quickly schedule and launch three-way calls between the patient, the provider, and any other relevant stakeholders.

Feature	Description
Three-Way Calling	Easily initiate three-way calls with the patient and other care team members.
Automated Scheduling	Schedule calls in advance and send automated reminders to all participants.
Real-time Transcription	All calls are transcribed in real-time and saved to the patient's chart.

14 Initiate the Convene Workflow

Clicking the **Convene** button initiates a three-way call. The button changes to "In Session..." to indicate the call is in progress.

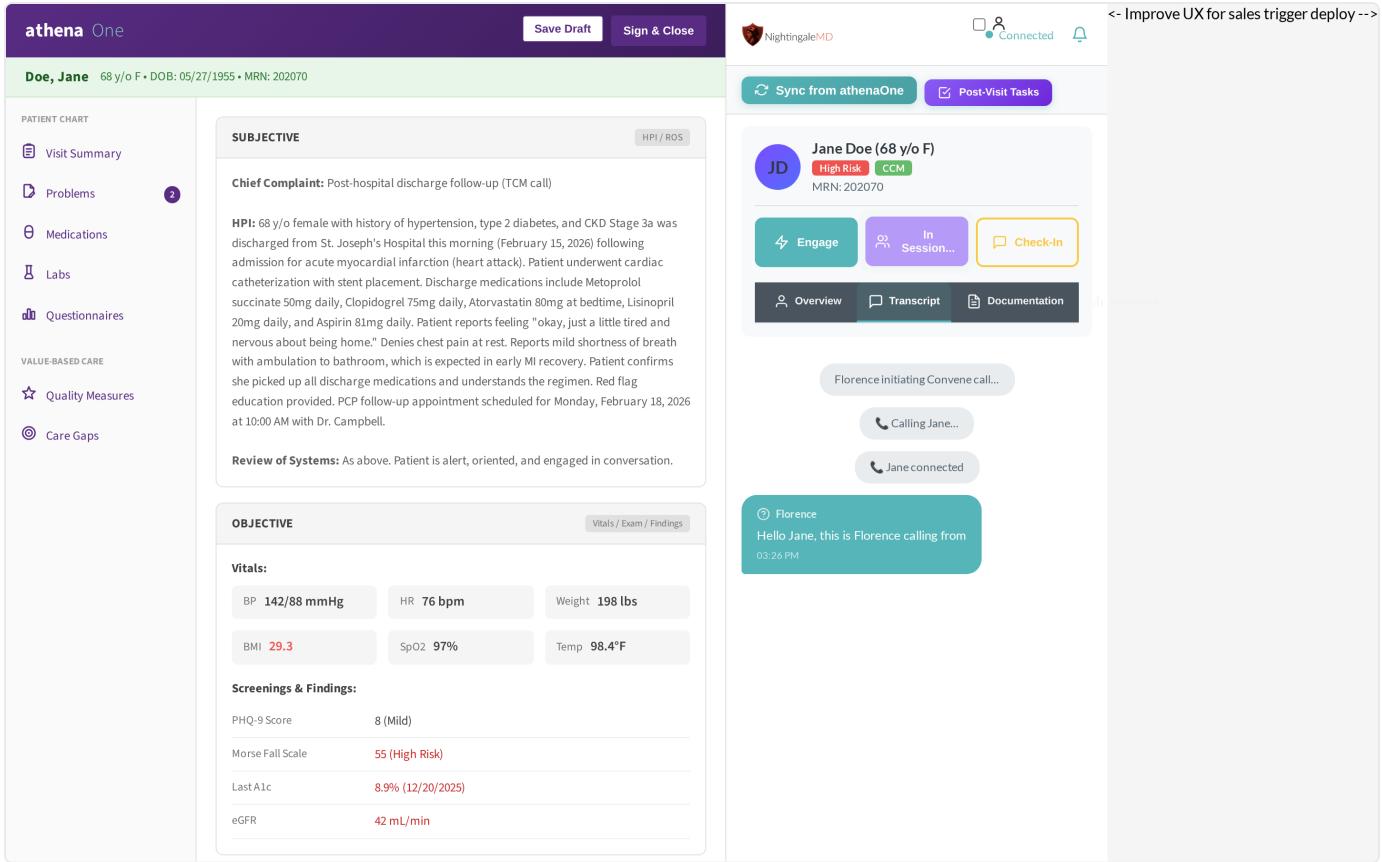


Figure 14: The Convene workflow in progress. The Convene button shows "In Session..." status as Florence initiates the three-way call between the patient, care manager, and provider.

15 View the Convene Transcript

The **Transcript** tab shows the real-time conversation during the Convene call. Florence facilitates the introduction and manages the call flow.

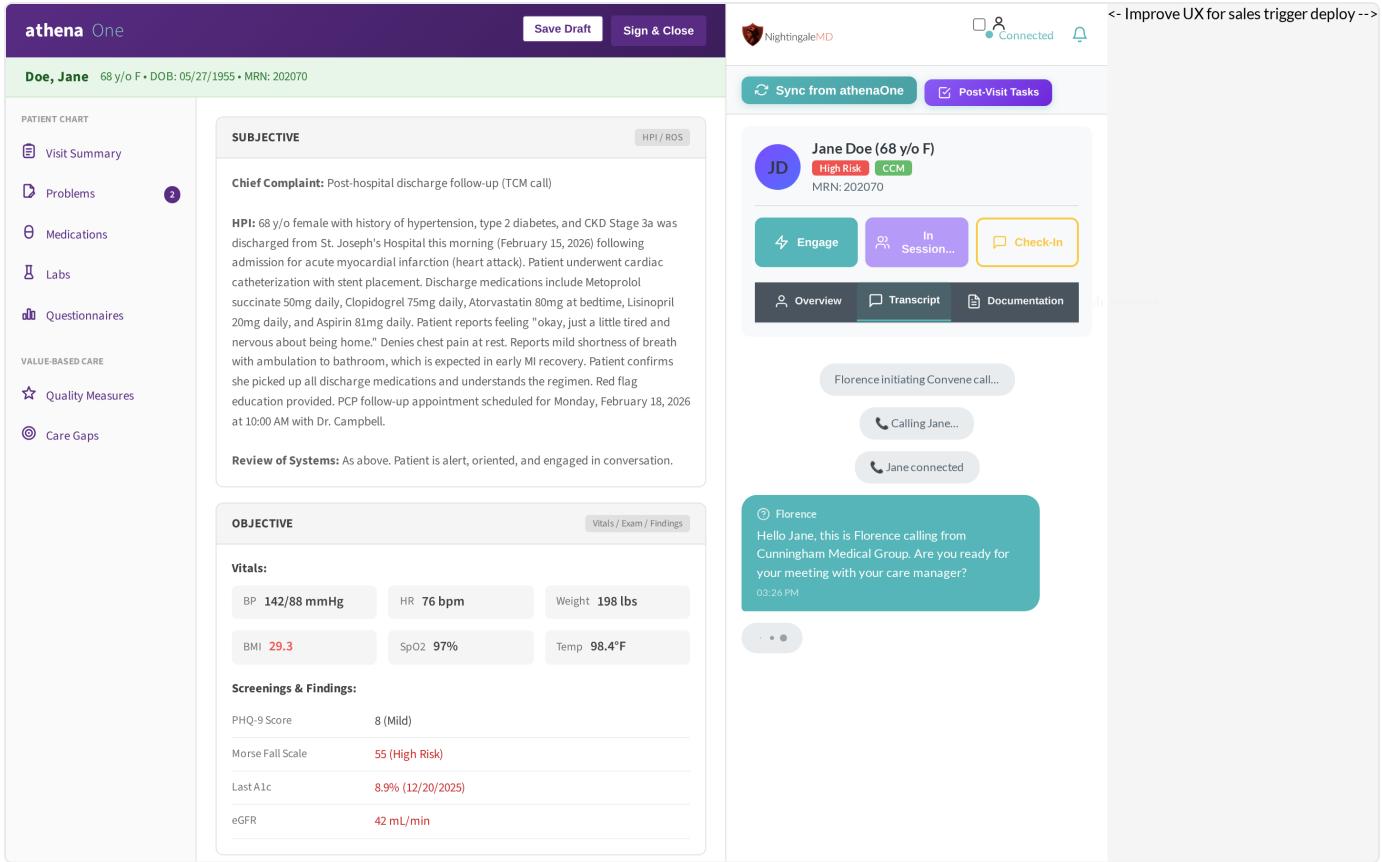


Figure 15: The Convene transcript showing Florence initiating the three-way call and facilitating the conversation between all participants.

DEMO SCRIPT

Sales Rep: "With Florence, the provider doesn't have to waste time playing phone tag. The navigator can schedule a three-way call using the Convene workflow. All parties receive automated reminders, and the entire conversation is transcribed in real-time and saved to the patient's chart."

Chapter 9: The 'Check-In' Workflow

The **Check-In** workflow is Florence's automated patient monitoring tool. It uses SMS to proactively check in with patients, track their progress, and identify potential issues before they become serious.

Feature	Description
Automated SMS Outreach	Send automated, personalized SMS messages to patients to check on their health status.
Customizable Protocols	Create custom check-in protocols for different chronic conditions (e.g., diabetes, hypertension, CHF).
Real-time Alerts	If a patient reports a concerning symptom, Florence can automatically alert the care navigator.

16 Initiate the Check-In Workflow

Clicking the **Check-In** button initiates the SMS-based patient monitoring workflow.

The image shows two side-by-side screenshots of a healthcare software interface. On the left is the athenaOne interface for patient Doe, Jane, 68 y/o F. It displays the patient chart with sections for Subjective (Chief Complaint: Post-hospital discharge follow-up (TCM call), HPI: 68 y/o female with history of hypertension, type 2 diabetes, and CKD Stage 3a, etc.), Objective (Vitals: BP 142/88 mmHg, HR 76 bpm, Weight 198 lbs, BMI 29.3, SpO2 97%, Temp 98.4°F, etc.), and Screening & Findings (PHQ-9 Score 8 (Mild), Morse Fall Scale 55 (High Risk), Last A1c 8.9% (12/20/2025), eGFR 42 mL/min). On the right is the NightingaleMD interface, which is connected to athenaOne. It shows the patient summary for Jane Doe (High Risk, CCM, MRN: 202070) and three buttons: Engage (green), Convene (purple), and Checking In... (yellow). Below these buttons are tabs for Overview, Transcript, and Documentation. A message bubble from Florence says: "Florence initiating automated Check-In with Jane Doe..." and "SMS sent to (555) 202-0700". Another message bubble from Florence says: "Hi Jane, this is Florence from your doctor's office. Quick check-in! How are you? 03/26 PM".

Figure 16: The Check-In workflow in progress. The Check-In button shows "Checking In..." status as Florence initiates the SMS-based patient monitoring protocol.

17 View the Check-In Transcript

The **Transcript** tab shows the SMS conversation between Florence and the patient, including symptom monitoring and medication adherence checks.

The image displays two side-by-side screenshots of healthcare software interfaces. On the left is the athenaOne platform, showing a patient chart for 'Doe, Jane' (68 y/o F). The chart includes sections for Subjective (Chief Complaint: Post-hospital discharge follow-up (TCM call), HPI: 68 y/o female with history of hypertension, type 2 diabetes, and CKD Stage 3a, etc.), Objective (Vitals: BP 142/88 mmHg, HR 76 bpm, Weight 198 lbs, BMI 29.3, SpO2 97%, Temp 98.4°F), and Screenings & Findings (PHQ-9 Score 8 (Mild), Morse Fall Scale 55 (High Risk), Last A1c 8.9% (12/20/2025), eGFR 42 mL/min). On the right is the NightingaleMD platform, showing a patient profile for 'Jane Doe (68 y/o F)' with 'High Risk' and 'CCM' status, and an MRN of 202070. It features tabs for Engage, Convene, and Checking In..., with 'Transcript' selected. A message from Florence initiates a check-in: 'Florence initiating automated Check-In with Jane Doe...'. Below it, a message from Florence reads: 'Hi Jane, this is Florence from your doctor's office. Quick check-in! How are you feeling today? Reply 1 for Good, 2 for Okay, 3 for Not well.' The timestamp is 03:26 PM.

Figure 17: The Check-In transcript showing the SMS-based conversation between Florence and the patient, including symptom monitoring and medication adherence checks.

DEMO SCRIPT

Sales Rep: "Florence's support for Jane doesn't end when she leaves the office. Using the Check-In workflow, the care navigator can set up a protocol to monitor Jane's recovery via daily SMS messages."

Sales Rep: "If Jane reports any issues, like shortness of breath or dizziness, Florence will immediately alert the care navigator. This proactive approach helps prevent hospital readmissions and improve patient outcomes."

Chapter 10: Filing to the EHR

Once the provider has reviewed and accepted the care gaps, Florence makes it incredibly easy to file all the necessary documentation to the EHR. This is a critical step in closing the loop and ensuring that the patient's chart is complete and up-to-date.

Feature	Description
Generative Browsing	Florence uses generative browsing (not an API) to securely and reliably file documentation to athenaOne.
One-Click Filing	With a single click of the "File to EHR" button, all auto-generated documentation is filed to the patient's chart.
Real-time Sync	The sync between Florence and the EHR is real-time, ensuring the patient's chart is always up-to-date.

18 Post-Visit Tasks

The **Post-Visit Tasks** view provides a summary of all remaining actions after the encounter, including documentation filing, referral coordination, and follow-up scheduling.

Post-Visit Task List

Florence Active | Run Demo | Back to Gaps

0 CONFIRMED	7 PENDING	0 DISMISSED	0 AUTOMATED
-------------	-----------	-------------	-------------

PENDING ORDERS (2)

- BMP Lab Order Basic Metabolic Panel - CKD monitoring (eGFR 42) Automate
- HbA1c Lab Order Hemoglobin A1c - Diabetes monitoring (last: 8.9%) Automate

REFERRALS TO SCHEDULE (2)

- Nephrology Referral CKD Stage 3a management - eGFR 42 mL/min Schedule
- Statin Therapy Follow-up Atorvastatin 20mg initiated - 6-week lipid panel needed Automate

PATIENT EDUCATION (3)

- CKD Patient Education Send kidney health education materials via patient portal Automate
- Diabetes Self-Management Send blood sugar monitoring guide and dietary recommendations Automate
- Fall Prevention Guide Send home safety checklist and exercise program Automate

PATIENT COMMUNICATION TIMELINE (3)

- TCM Outreach Call Post-discharge call completed. Medications verified. Appointment scheduled for Mon 2/18. 2:15 PM
- Appointment Confirmation SMS Sent to (555) 202-0700: "Your appointment with Dr. Campbell is confirmed for Mon, Feb 18 at 10:00 AM." 2:20 PM

Figure 18: The Post-Visit Tasks view showing all remaining actions after the encounter, including documentation filing and follow-up coordination.

DEMO SCRIPT

Sales Rep: "Now for the final step. Dr. Campbell has addressed all of Jane's care gaps, and the documentation has been automatically generated. All that's left to do is file it to the EHR. With Florence, this is a one-click process."

Sales Rep: "Dr. Campbell simply clicks the 'File to EHR' button, and Florence takes care of the rest. Using our innovative generative browsing technology, Florence securely files all of the documentation to Jane's chart in athenaOne."

Chapter 11: Conclusion — The Future of CCA

Florence is more than just a tool; it is a new way of thinking about Comprehensive Care Assessment. By automating the manual, time-consuming tasks that have traditionally burdened care navigators and providers, Florence empowers them to focus on what they do best: providing high-quality, patient-centered care.

70%

Workload Reduction

Dramatically improve efficiency by reducing navigator workload.

40%

More Gaps Closed

Increase gap closure rates with proactive identification.

100%

Auto Documentation

Eliminate the documentation burden entirely.



Patient Engagement

Improve satisfaction with AI-powered outreach.

Florence is the future of CCA.

A future where technology and human expertise come together to create a more efficient, effective, and patient-centered healthcare system.

Appendix A: Screenshot Reference Guide

Step	Screenshot	Description
1	01_full_dashboard_overview	Full dashboard overview – Navigator View
2	02_copilot_sidebar_overview	Florence Copilot sidebar with patient summary
3	03_care_diagnosis_gaps	Care & Diagnosis Gaps list with filters
4	04_gap_details_expanded	Expanded gap details for CKD Stage 3a
5	05_prework_summary	Pre-Work Summary view
6	06_stage_buttons_visible	Stage for MD Review buttons
7	07_engage_workflow_started	Engage workflow – "In Call..." status
8	08_engage_transcript	Engage transcript with Florence greeting
9	10_engage_documentation	Auto-generated documentation from Engage
10	11_analytics_tab	Analytics tab with workflow metrics
11	16_provider_view_overview	Provider View with expanded gap details
12	18_provider_documentation	Provider Documentation with MEAT criteria
13	19_ehr_patient_chart	athenaOne EHR patient chart
14	12_convene_workflow_started	Convene workflow – "In Session..." status
15	13_convene_transcript	Convene transcript with three-way call
16	14_checkin_workflow_started	Check-In workflow – "Checking In..." status
17	15_checkin_transcript	Check-In SMS transcript
18	23_post_visit_tasks	Post-Visit Tasks summary

Appendix B: Quick Reference — Demo Flow Cheat Sheet

For a quick demo, follow this streamlined 18-step flow:

#	Action	What to Show
1	Open Dashboard	Side-by-side EHR + Copilot layout
2	Review Patient Summary	High Risk flag, CCM enrollment, workflow buttons
3	Review Gaps	9 auto-identified gaps from COOP
4	Expand a Gap	CKD Stage 3a details with ICD-10 and evidence
5	View Pre-Work Summary	Automated pre-encounter preparation
6	Stage All Gaps	Bulk staging for provider review
7	Click Engage	AI-powered TCM call initiation
8	Show Transcript	Natural conversation with patient
9	Show Documentation	Auto-generated clinical notes
10	Show Analytics	Workflow metrics and tracking
11	Toggle Provider View	Provider's perspective with MEAT criteria
12	Show Provider Docs	Auto-generated MEAT documentation
13	Show EHR Chart	Seamless integration with athenaOne
14	Click Convene	Three-way calling
15	Show Convene Transcript	Real-time transcription
16	Click Check-In	SMS monitoring
17	Show Check-In Transcript	Patient SMS conversation
18	Show Post-Visit Tasks	One-click EHR filing

TOTAL DEMO TIME

15–20 minutes for the full walkthrough. For a condensed demo, focus on Steps 1, 3, 7–8, 11–12, and 18.

Application URL: florence-intel-dashboard.vercel.app

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