POINT OF CARE

THERAPY ASSESSMENT

BUSINESS MODEL SOFTWARE TRAINING

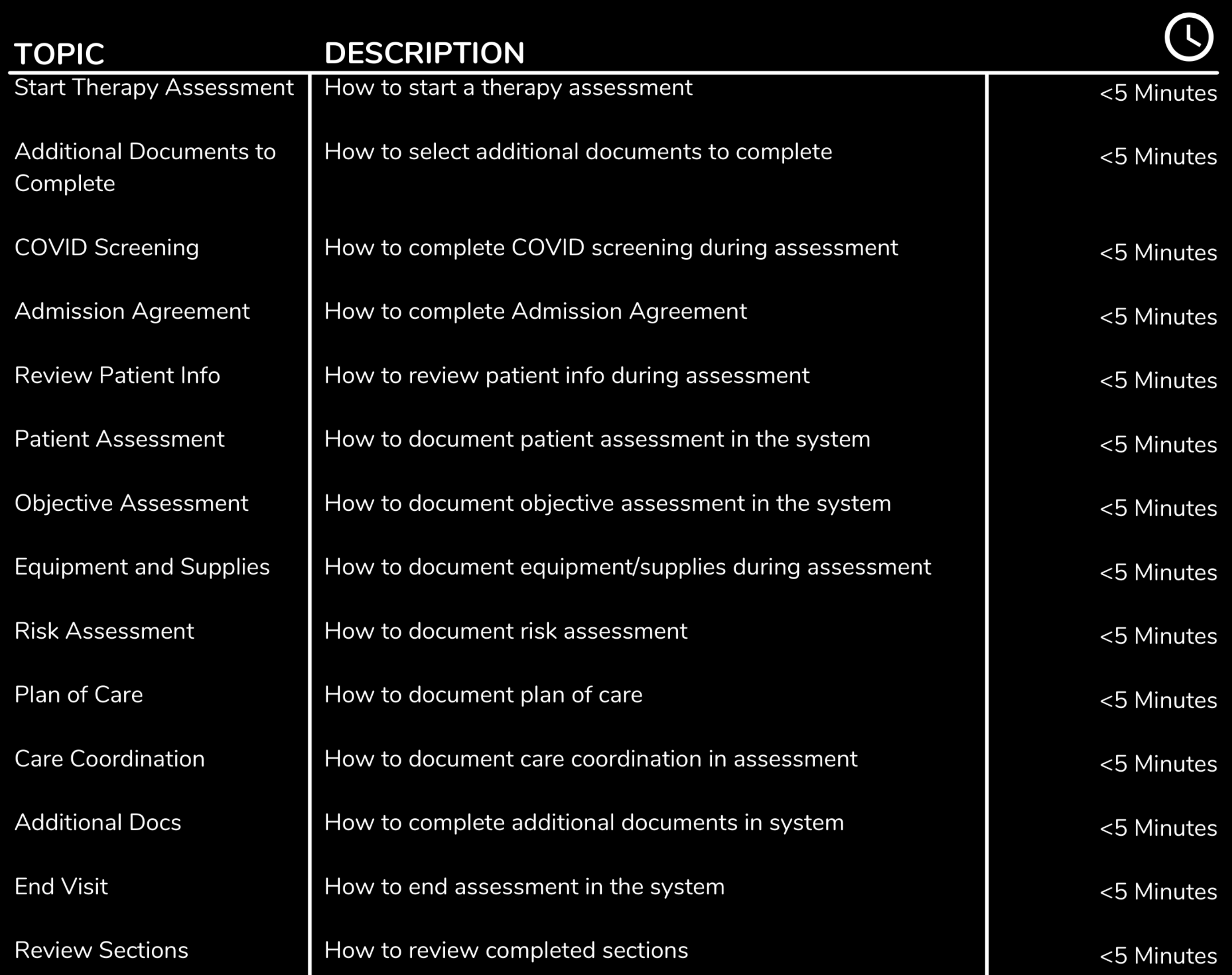
HealthTrust
SOFTWARE

Therapy Assessment: Recommended Training Course Agenda

Course Purpose: We recommend using the following training outline to ensure that training participants receive clear instructions on how a therapy assessment is to be performed for a patient in the system. The sequence of courses can be changed based on agency training needs and schedule; however the content of each course should remain as stated.

Recommended Course Attendees: Therapists-All disciplines, Clinical Staff

Estimated Duration: 1 hour 10 minutes - 1 hour 30 minutes



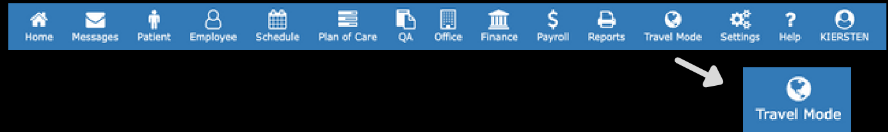
POINT OF CARE (THERAPY ASSESSMENT)

TOPIC	DESCRIPTION	(time)
Start Therapy Assessment	How to start a therapy assessment	<5 Minutes
Additional Documents to Complete	How to select additional documents to complete	<5 Minutes
COVID Screening	How to complete COVID screening during assessment	<5 Minutes
Admission Agreement	How to complete Admission Agreement	<5 Minutes
Review Patient Info	How to review patient info during assessment	<5 Minutes
Patient Assessment	How to document patient assessment in the system	<5 Minutes
Objective Assessment	How to document objective assessment in the system	<5 Minutes
Equipment and Supplies	How to document equipment/supplies during assessment	<5 Minutes
Risk Assessment	How to document risk assessment	<5 Minutes
Plan of Care	How to document plan of care	<5 Minutes
Care Coordination	How to document care coordination in assessment	<5 Minutes
Additional Docs	How to complete additional documents in system	<5 Minutes
End Visit	How to end assessment in the system	<5 Minutes
Review Sections	How to review completed sections	<5 Minutes

Start Therapy Assessment

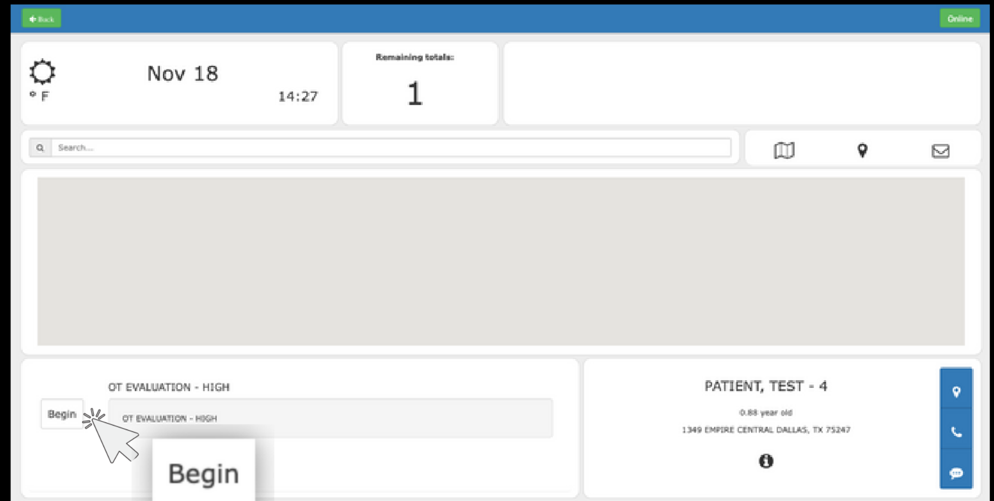
1 Go to 'Travel Mode' Tab

- On your home page, click the 'Travel Mode' tab at the top tool bar.



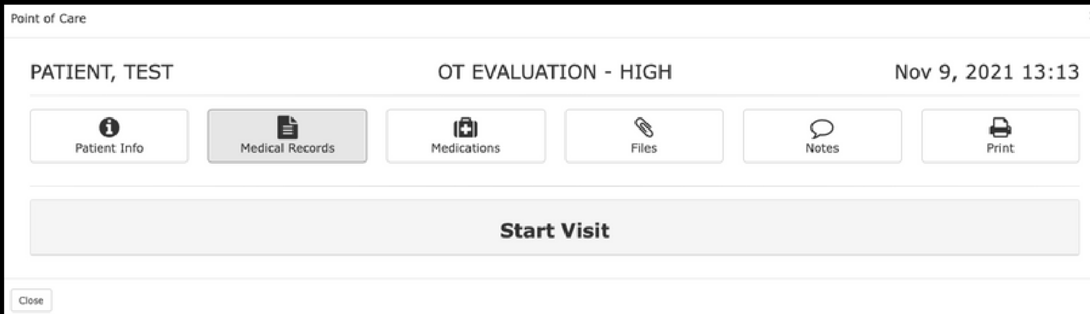
2 Click on the Scheduled Visit

- The page will present a list of your visits for that day. Click on the 'Begin' button next to the scheduled visit with the specific patient you are assessing.



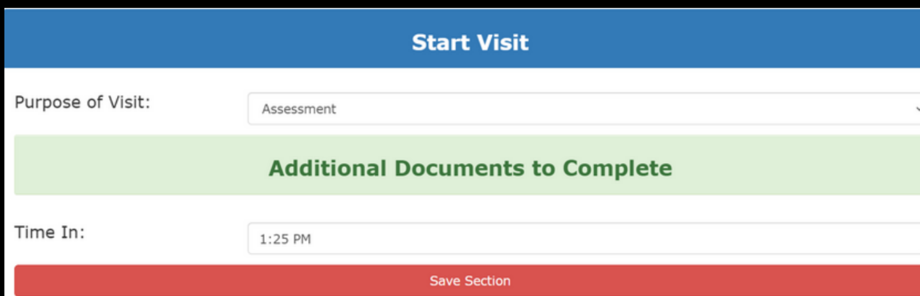
3 Start Visit

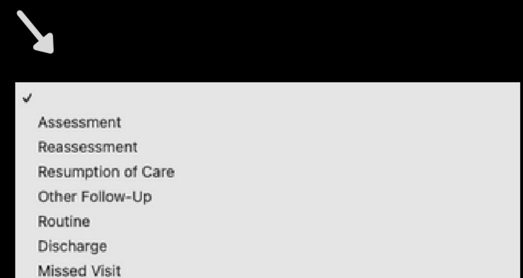
- On the Point of Care page, click the 'Start Visit' button and begin your patient assessment process.



4 Complete the Start Visit Section

- When you clickk on 'Start Visit,' there will be drop down open.
- For 'Purpose of Visit' choose 'Assessment' from the drop down menu.





Additional Documents to Complete

1 Additional Documents to Complete

- If you click on the 'Additional Documents to Complete' button, a drop down will open. Use the check boxes for any items relevant to the patient assessment.

Additional Documents to Complete

- [x] Admission Documents
- [ ] Homebound Assessment
- [ ] Authorization Request
- [ ] Employee Supervision
- [ ] Patient Supervision
- [ ] Progress Summary
- [ ] Discharge Summary
- [ ] Care Coordination Summary
- [x] Create HHA Plan of Care
- [x] OASIS — 01 - Start of Care (further visits planned)
- [ ] Hospice Information Set
- [ ] Bereavement Assessment
- [ ] Spiritual Assessment

2 Save Section

- Record the Time you clocked in and the travel information by dragging the toggle buttons.
- Once you have completed the Start Visit items, click 'Save Section'.

Start Visit

Purpose of Visit: Assessment

Additional Documents to Complete

Time In: 1:25 PM

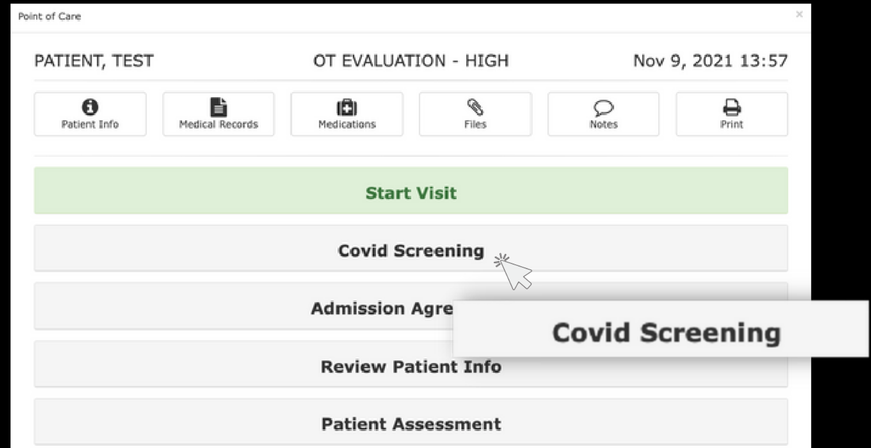
Save Section

Save Section

COVID Screening

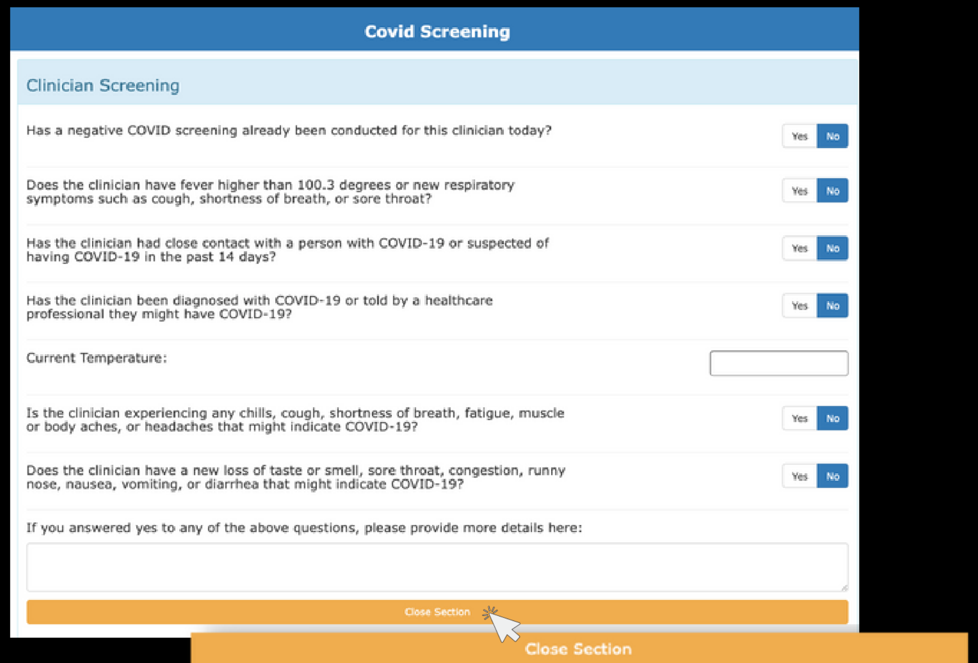
1 COVID Screening

- After you have started the visit, the visit items to go through will be listed. Click on the 'Covid Screening button.



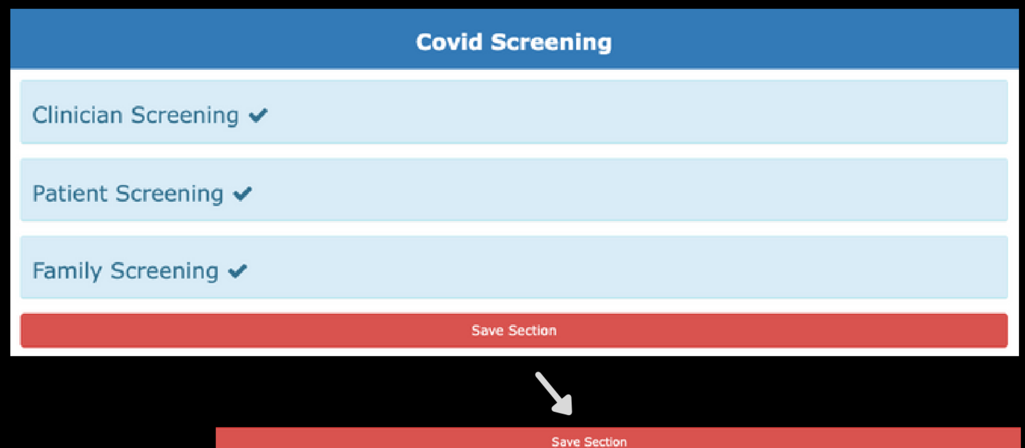
2 Answer the Screening Questions

- When the 'COVID Screening' section opens, the screening questions will be automatically populated to 'No'. If you select 'Yes' for any of the questions, use the open texxt box at the bottom to explain.
- Use the open field to input their temperature.
- Once you have completed the screening click the 'Close Section' button.



3 Save 'Covid Screening' Section

- When you click the 'Close Section' button, it will condense. You will repeat the same process for the 'Patient Screening' and 'Family Screening' sections.
- After they are complete, click the red 'Save Section' button.



Review Patient Info

1 Open Review Patient Info

- After you complete Admission Agreement section, click on the 'Review Patient Info' button.

2 Review and Updating Line Items

- When the drop down opens, you will see line items for the Patient's Demographics and Service Information.
- If an item needs to be updated, simply click the ellipsis to the right. A form will open.
- Input the correct information and click the 'Update' button on the bottom right.

Review Patient Info

Demographics

Patient Name:	ALFRED TEST	Medicare #:	
MR #:	1	Payer:	
Address:		Insurance ID #:	
Email:		DOB:	
Sex:		Phone:	
SS #:	UK	Race / Language:	
Medicaid #:	NA	Physician:	

Save Section

Update Vital Info

Physician:

Search...

NA - Not applicable

UPDATE

UPDATE

3 Finish Updating Info

- Perform this for the remainder of the line items.
- Once everything is up-to-date, click the 'Save Section' button.

Review Patient Info

Demographics

Patient Name:	ALFRED TEST	Medicare #:	
MR #:	1	Payer:	
Address:		Insurance ID #:	
Email:		DOB:	
Sex:		Phone:	
SS #:	UK	Race / Language:	
Medicaid #:	NA	Physician:	

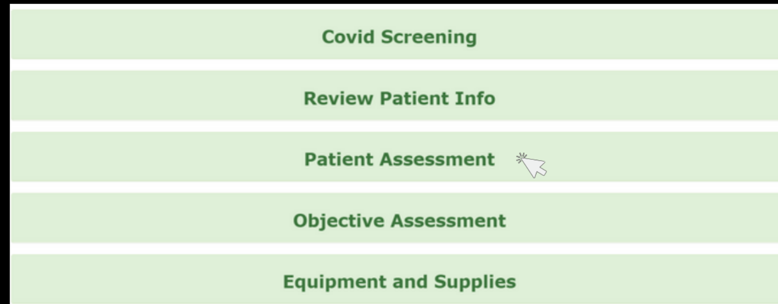
Save Section

Save Section

Patient Assessment

1 Open Patient Assessment

- After you Review the Patient Info, click the 'Patient Assessment' button.



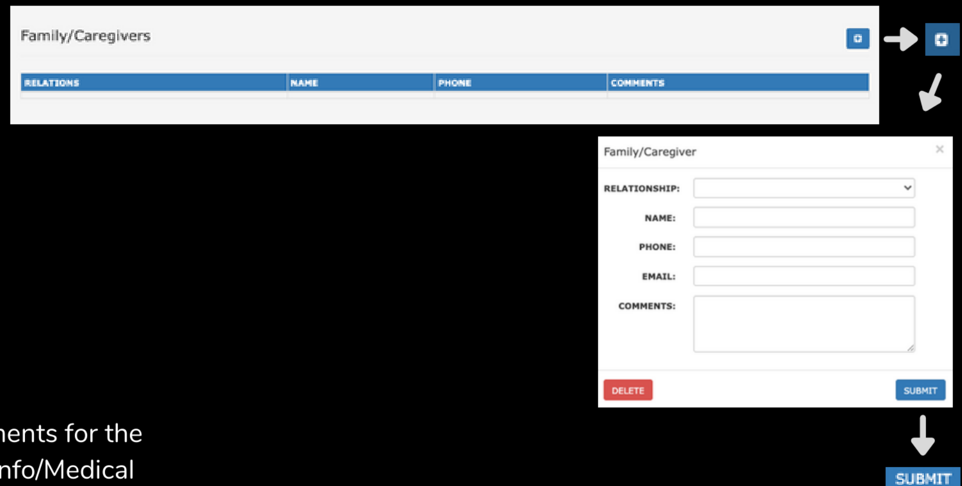
2 Begin Assessment

- When the drop down opens, you will see line items for the Assessment. Choose the type of residence the assessment is being held at, the patient's family/caregivers information, and the patient history.

Patient Assessment
Type of Residence: House | Apartment | Mobile Home | Group or Boarding Home | Institution | Other
Family/Caregivers
RELATIONS | NAME | PHONE | COMMENTS

Add Family/Caregivers

- To add the Family/Caregivers, click on the '+' button to the far right of the section. A form will open.
- Complete the Family/Caregiver's information in the fields and click 'Submit' on the bottom right of the form.



Written Assessment

- Use the text boxes to write comments for the following sections: 'Background Info/Medical History'; 'Reason for Therapy Referral'; 'Parent/Caregiver Goals'; and 'Comments'.

Background Info/Medical History:

Reason for Therapy Referral:

Parent/Caregiver Goals:

Comments:

Patient Assessment Continued

3 Communication Assessment

- Perform the Communication portion of assessment by selecting their Primary Language.
- Use the drop down menu to the right of 'Ability to Communicate' to input the patient's level of ability to communicate.
- Drag the toggle buttons to record their assessment for:
  - Vision
  - Hearing
  - Verbal Understanding
  - Speech/Oral Expression
  - Telephone use

Communication

Primary Language: English | Spanish | Sign Language | Augmented Communication | Other

Ability to Communicate:

comments...

Vision: 00 02 Partially Impaired

Hearing: 00 02 Severely Impaired ✖ Unable To Assess

Verbal Understanding: 00 03 Sometimes Understands ✖ Unable To Assess

Speech/Oral Expression: 00 05 Moderate Difficulty

Telephone use: 00 05 Requires Adapted Telephone ✖ No Telephone

Comments:

✖ Unable To Assess

If an item isn't applicable or you are unable to access that information, you can click the 'Unable to Access' or 'No Telephone' buttons to the right of the item.

✖ No Telephone

4 Input Mental Status Information

- After you have recorded the Communication assessment information, begin inputting the Mental Status info.
- Selecting the 'Impaired' button next to the 'Mental/Cognitive Status' section will bring up the 'Impaired' section.
- Selecting any of the options next to the 'Impaired' section will bring up a text box for comments below.

Mental Status

Mental/Cognitive Status: Alert/Oriented for age | Impaired

Impaired: Disoriented | Unresponsive | Cognitive Deficit | Other

Unresponsive Comment: Comment

Patient Assessment Continued

5 **Perform the Pain Assessment**

The Pain Assessment provides you with different options for assessing the patient's pain level. Simply click on the methodf you would like to use.

Pain Assessment Tools: 1-10 | Faces ☺ | Mankoski | FLACC

1-10

- For this option, use the toggle button to drag to the number indicating the patient's pain level.

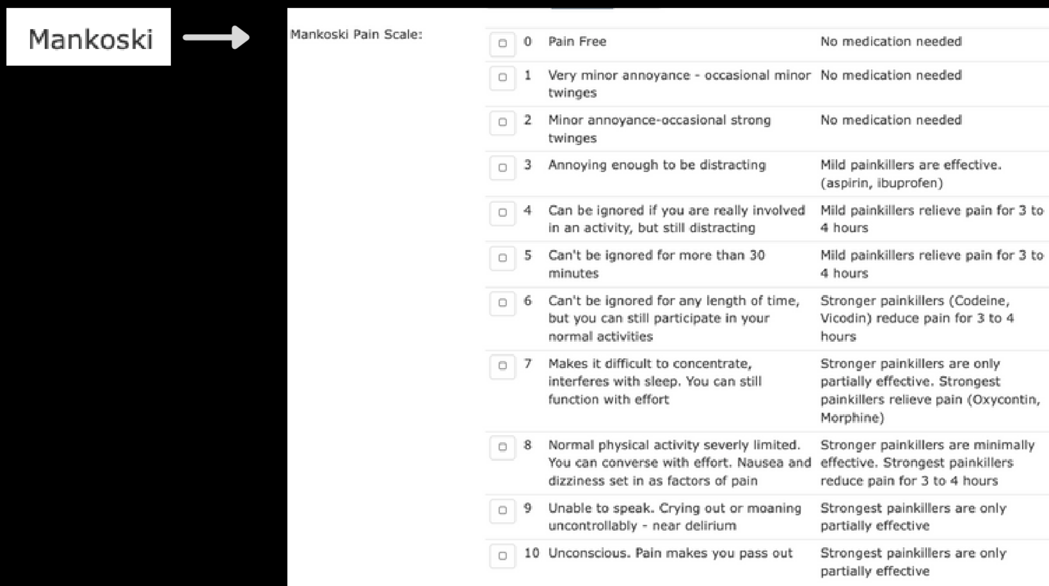
Faces Scale

- For this option, select the face that best reflects their pain.

Mankoski

- If you select Mankoski, it will display a pain scale from 0-10 with the pain level description and suggested treatment associated to that pain level.

Mankoski



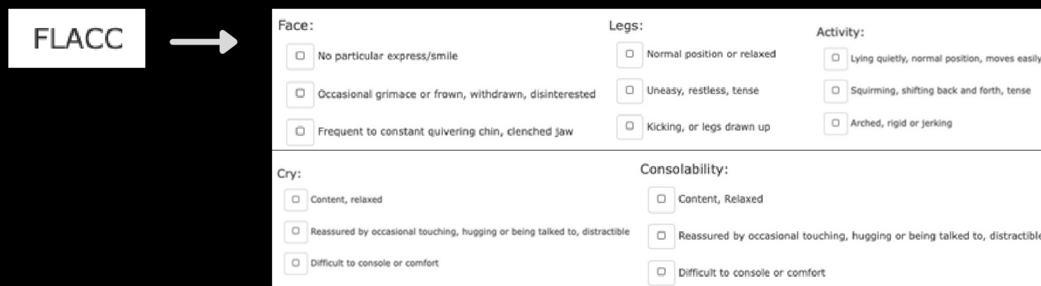
Mankoski Pain Scale:

	Level	Description	Treatment
▢	0	Pain Free	No medication needed
▢	1	Very minor annoyance - occasional minor twinges	No medication needed
▢	2	Minor annoyance-occasional strong twinges	No medication needed
▢	3	Annoying enough to be distracting	Mild painkillers are effective. (aspirin, ibuprofen)
▢	4	Can be ignored if you are really involved in an activity, but still distracting	Mild painkillers relieve pain for 3 to 4 hours
▢	5	Can't be ignored for more than 30 minutes	Mild painkillers relieve pain for 3 to 4 hours
▢	6	Can't be ignored for any length of time, but you can still participate in your normal activities	Stronger painkillers (Codeine, Vicodin) reduce pain for 3 to 4 hours
▢	7	Makes it difficult to concentrate, interferes with sleep. You can still function with effort	Stronger painkillers are only partially effective. Strongest painkillers relieve pain (Oxycontin, Morphine)
▢	8	Normal physical activity severly limited. You can converse with effort. Nausea and dizziness set in as factors of pain	Stronger painkillers are minimally effective. Strongest painkillers reduce pain for 3 to 4 hours
▢	9	Unable to speak. Crying out or moaning uncontrollably - near delirium	Strongest painkillers are only partially effective
▢	10	Unconscious. Pain makes you pass out	Strongest painkillers are only partially effective

FLACC (Face, Legs, Activity, Cry, Consolability)

- Selecting FLACC will display 5 categories where you will select the patient's actions associated with the category.

FLACC



Face:
- ▢ No particular express/smile
- ▢ Occasional grimace or frown, withdrawn, disinterested
- ▢ Frequent to constant quivering chin, clenched jaw

Legs:
- ▢ Normal position or relaxed
- ▢ Uneasy, restless, tense
- ▢ Kicking, or legs drawn up

Activity:
- ▢ Lying quietly, normal position, moves easily
- ▢ Squirming, shifting back and forth, tense
- ▢ Arched, rigid or jerking

Cry:
- ▢ Content, relaxed
- ▢ Reassured by occasional touching, hugging or being talked to, distractible
- ▢ Difficult to console or comfort

Consolability:
- ▢ Content, Relaxed
- ▢ Reassured by occasional touching, hugging or being talked to, distractible
- ▢ Difficult to console or comfort

Patient Assessment Continued

Pain Frequency

- Once you have recorded their pain level, indicate the frequency of their pain by using the toggle button to show how it's interference with their activity or movement.

Pain Indicators

- Use the button options to select how the patient's pain is indicated

6 Record the Vitals

- Once you have completed the pain assessment, go through the categories below and record the vitals for each item.
- To update the vital, click on the item so a form opens up.
- Complete the form fields for that vital and then click the 'Update' button on the bottom right. The vital information will be listed next to the item.
- Repeat this process for the remaining vitals.

7 Record Patient Allergies

- When the drop down opens, you will have two categories of allergies to record.
- Simply click on the items the patient is allergic to so it is highlighted.

8 Record Patient Medications

- Use the text box to the right of 'Medications' to input any medication notes.
- Select the check box to the left of the below statement to input the default language:
  - 'Therapists do not administer medications. This medication list is provided for informational purposes only. The medication list is recorded and updated based on caregiver report.'

Patient Assessment Continued

Medication Profile

- To view the Medication Profile, click the 'Profile' button above the toggles.
- A page will open listing their meds. To view the Patient's interactions, click the 'View Drug Interactions button on the bottom right and a form will open listing their interactions

Medications

Med Profile | Add Pharmacy

Medications:

Templates

Prev Answer

Therapists do not administer medications. This medication list is provided for informational purposes only. The medication list is recorded and updated based on caregiver report.

Medications

Medication List

Filter

Priority	Med	Strength	Dose	Frequency	Last Administered		
15	ARYMO ER	15 MG/8 TO 12 HR	30MG (2 TABLETS)	PRN Q12H FOR SEVERE PAIN. SCORE OF 6 OR >.		MAR	History
						MAR	History
	CHILDREN'S TYLENOL	160 MG/5 ML	240MG (7.5ML)	PRN Q4-6H FOR PAIN OR FEVER. MAX OF 5 DOSES IN 24 HOURS.		MAR	History
	MOTRIN CHILDRENS	100 MG/5 ML	10ML (200MG)	PRN Q6 HOURS FOR PAIN OR FEVER		MAR	History

Med Review | View Drug Interactions

Drug Interactions

Med Review (Drug Interactions)

Drug 1	Drug 2	Interaction	Severity

Print Interactions

CANCEL

Med Review

- To view the Medication Review, Click on the 'Med Review' next to the 'View Drug Interactions' button.
- A form will open where you will answer the listed items by clicking the "Yes' 'No' or 'N/A' buttons. Input your comments and sign the Med Review. Make sure to click 'Save' on the bottom.

Medications

Medication List

Filter

Priority	Med	Strength	Dose	Frequency	Last Administered		
15	ARYMO ER	15 MG/8 TO 12 HR	30MG (2 TABLETS)	PRN Q12H FOR SEVERE PAIN. SCORE OF 6 OR >.		MAR	History
						MAR	History
	CHILDREN'S TYLENOL	160 MG/5 ML	240MG (7.5ML)	PRN Q4-6H FOR PAIN OR FEVER. MAX OF 5 DOSES IN 24 HOURS.		MAR	History
	MOTRIN CHILDRENS	100 MG/5 ML	10ML (200MG)	PRN Q6 HOURS FOR PAIN OR FEVER		MAR	History

Med Review | View Drug Interactions

Med Review

Review History

Review Questionnaire

1. Are there any potential adverse effects or drug reactions? Yes No N/A
2. Are there any significant side effects? Yes No N/A
3. Are there any significant drug interactions? Yes No N/A
4. Are there any duplicate drug therapies? Yes No N/A
5. Are there any therapies that are ineffective? Yes No N/A
6. Does the patient understand the medication instructions? Yes No N/A
7. Are there any potential non-compliance with drug therapies? Yes No N/A

Comments...

Sign Med Review

CANCEL | SAVE

Patient Assessment Continued

Pharmacy

- To view the Patient Pharmacy information click the yellow 'Pharmacy' button next to profile.
- Type in the pharamcy in the open field and then click the 'Update' button.

Medications

Med Profile | Add Pharmacy

Medications:

Templates

Prev Answer

Therapists do not administer medications. This medication list is provided for informational purposes only. The medication list is recorded and updated based on caregiver report.

Update Vital Info

Pharmacy:

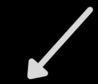
UPDATE

9 Input Diagnosis Information

- Select the '+' button to the right of Diagnosis Codes to input a new diagnosis code.
- Type in the Diagnosis in the search bar.
- To set the new diagnosis code as the primary diagnosis, select the check box to the left of 'Set as Primary for Occupational Therapy'
- Use the drop down menu to the left of 'Priority of Diagnosis in Patient's Chart' to set the order of diagnoses for patient.

Diagnosis Codes

DX 1: A0101 - TYPHOID MENINGITIS



Add DX Code

DX: Search...

Set as Primary for Occupational Therapy

2 Priority of Diagnosis in Patient's Chart

Close | Submit

10 Save Patient Assessment

- Select the 'Save Section' button when you have finished recording the Patient Assessment.

Save Section

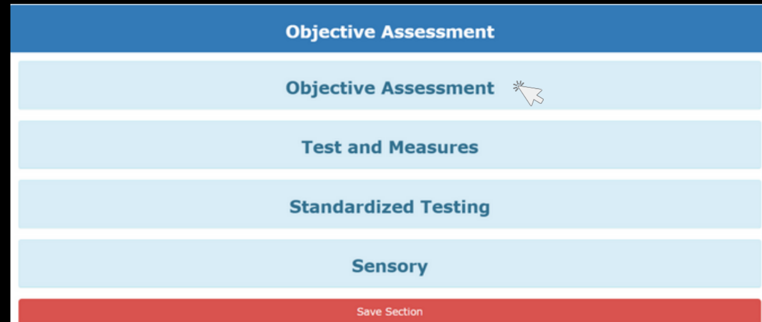
Objective Assessment

1 Open Objective Assessment

- Click the 'Objective Assessment' button in the Evaluation list.

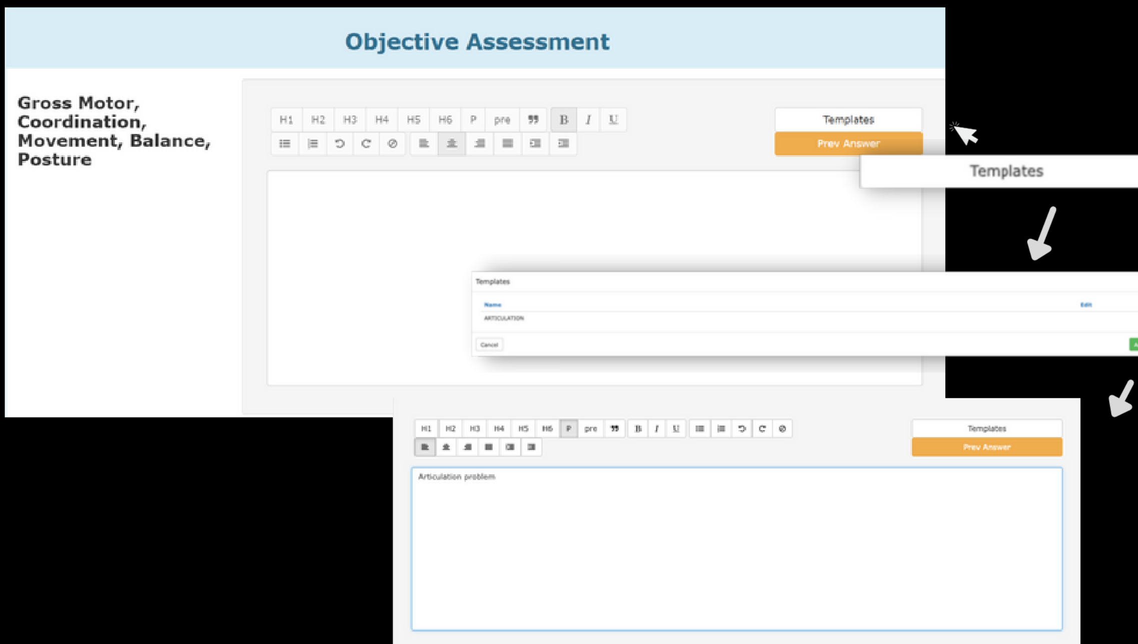
2 Begin Objective Assessment

- When the drop down opens, you will have four categories of to assess. Select the first category by clicking the 'Objective Assessment' button.
- A drop down on items and text boxes will appear.



3 Record the Objective Assessment

- To record the assessment, simple click the text box and type in your comments.
- To add a template click on the 'Templates button on the top right of the text box.
- A window will open with your templates. Select the one you would like to input and it will populate into the comments box.

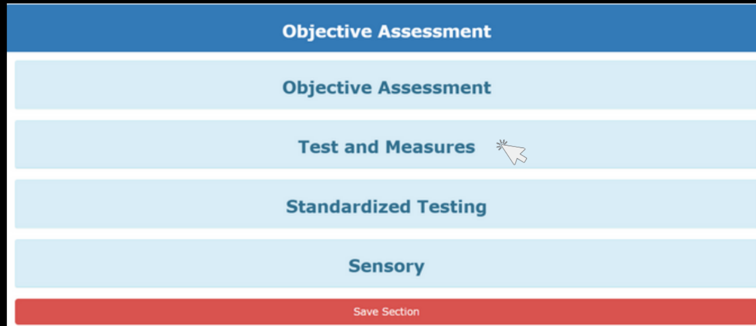


- Complete this process for the following Objective Assessment items:
  - Gross Motor, Coordination, Movement, Balance, Posture
  - Transitions, Transfers, Gait, Functionality Mobility
  - Endurance, Strength, Muscle Tone, Skin Assessment, Range of Motion
  - Fine Motor Skills
  - ADLs, Adaptive, Feeding
  - Cognitive, Sensory, Reflexes, Visual Motor, Behavioral

Objective Assessment Continued

4 Go to Test and Measures

- Once the Objective Assessment category has been completed, click on the 'Test and Measures' category.



Complete the Test and Measures

- You will see a drop down that inlcudes 3 fields.
- Click on the 'Actvity' drop down and select the item you are assessing.
- Type the 'Assist Score' in the middle field for that activity.
- Include any comments you have in the far left 'Assistive Device/Comments' field on the left.

Test and Measures

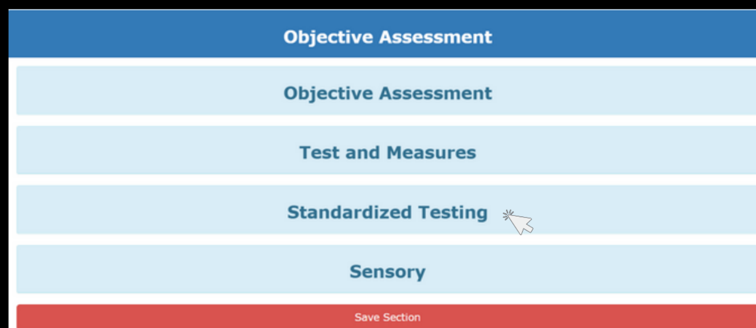
Scale: Ind, Sup, SBA, CGA, Min, Mod, Max, Dep

Activity	Assist Score	Assistive Device / Comments
Bathing		

ADLs
Bathing
UE Dressing
LE Dressing
Grooming
Toileting
Feeding
Meal Prep
House Cleaning
Home Safety
Bed Mobility
Rolling
Supine to Sit
Sit to Stand
Scooting
Gait
Level
Unlevel
Step / Stairs

5 Standardized Testing

- Once you have input the Test and Measures, click on the 'Standardized Testing' category.



Complete Standardized Testing

- Select the 'Test' from the drop down and fill in the open fields next to it.
- Write your conclusion in the open text box below.

Standardized Testing

Test:

Test	Area Tested	Raw Score	Standard Score	%	Age Equivalent	Scaled Score	Stanine	Severity	Other

Conclusion

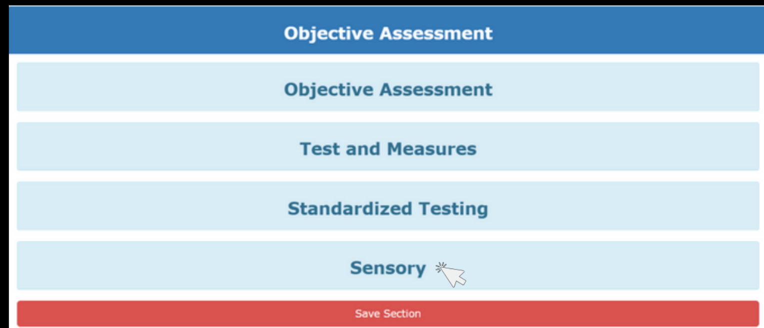
H1 H2 H3 H4 H5 H6 P pre

Templates Prev Answer

Objective Assessment Continued

6 Sensory Assessment

- Click on the fourth and final category within the 'Object Assessment' list: 'Sensory'.



Complete the Sensory Assessment

- Perform the Sensory Assessment and input the information into the corresponding section/menu.

Sensory

Main Category	Category	Raw Score Total	Percentile Range	Scale
Quadrants	Seeking/Seeker	/95		
	Avoiding/Avoider	/100		
	Sensitivity/Sensor	/95		
	Registration/Bystander	/110		
Sensory Sections	Auditory	/40		
	Visual	/30		
	Touch	/55		
	Movement	/40		
	Body Position	/40		
	Oral	/50		
Behavioral Sections	Conduct	/45		

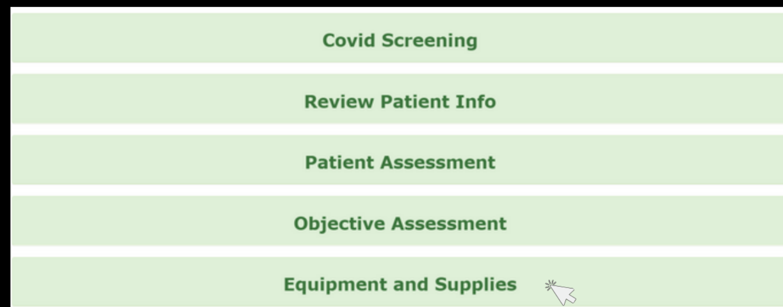
7 Save Objective Assessment Section

- Once you have completed all four categories within the Objective Assessment, click the red 'Save Section' button.

Equipment and Supplies

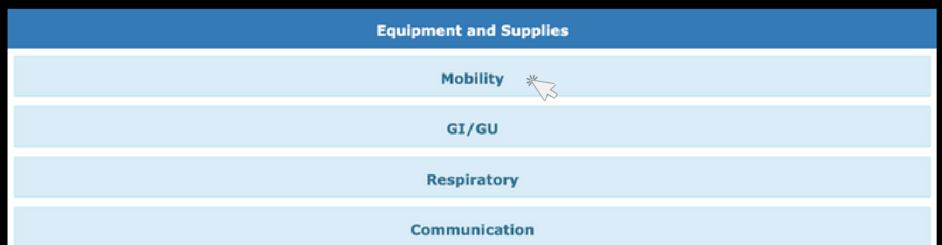
1 **Open Equipment and Supplies**

- Click the 'Equipment and Supplies' button in the Evaluation list.



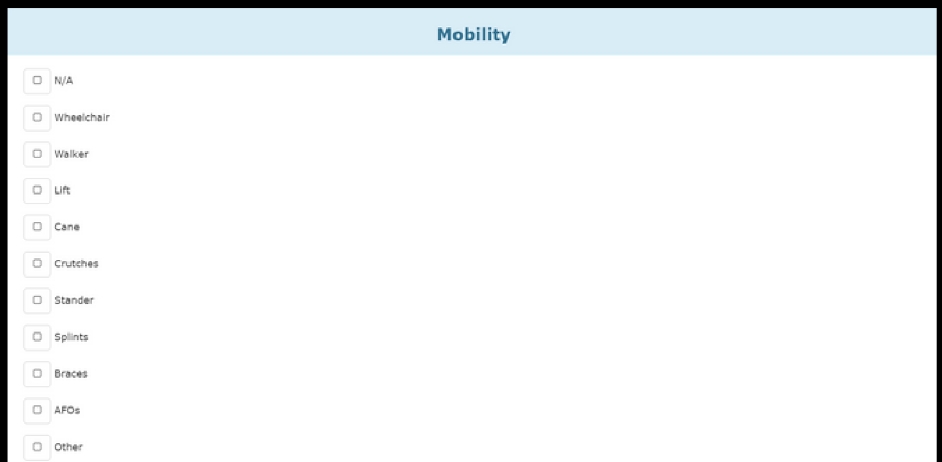
2 **Click 'Mobility'**

- When the drop down opens, you will have four categories to assess. Select the first category by clicking the 'Mobility' button.
- A drop down with listed items will appear.



Input Mobility Info

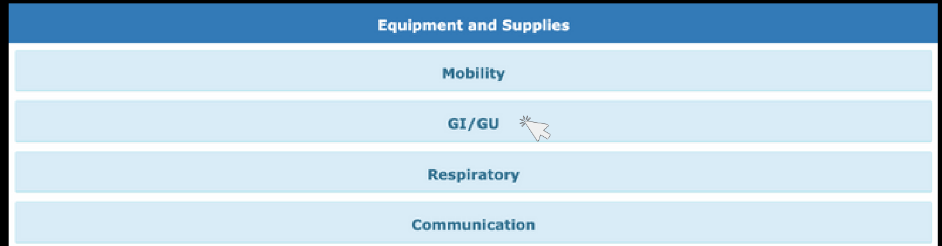
- Within the list options, simply click the open box to indicate which mobility equipment the patient needs.



Equipment and Supplies Continued

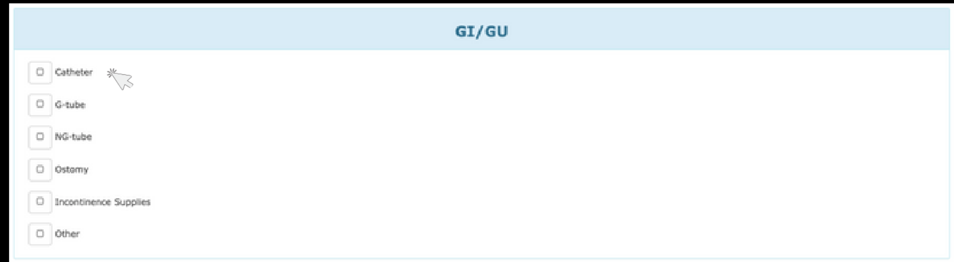
3 **Click 'GI/GU'**

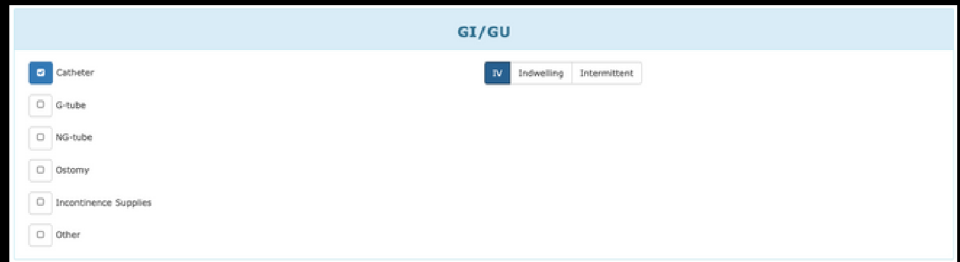
- Under Equipment and Supplies, Select the second category by clicking the 'GI/GU' button.
- A drop down with listed items will appear.



Input GI/GU Info

- Within the list options, click the open box to indicate which GI/GU equipment the patient needs.
- When you click a check box, it will automate a secondary option. Click the associated button to indicate the type.



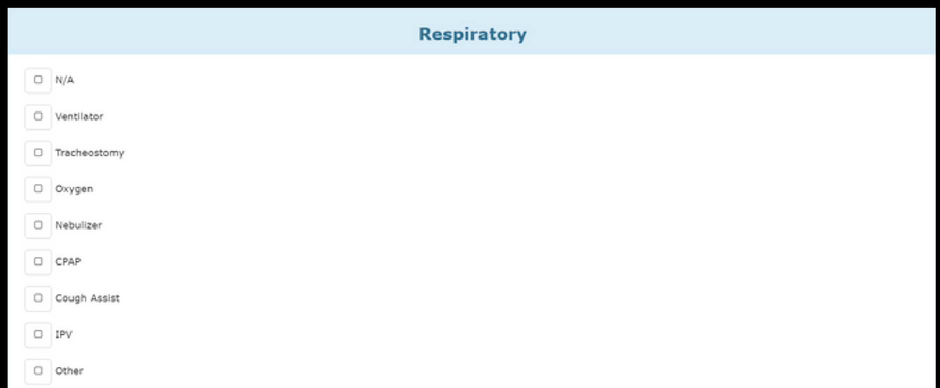


4 **Click 'Respiratory'**

- Under Equipment and Supplies, Select the third category by clicking the 'Respiratory' button.
- A drop down with listed items will appear.

Input Respiratory Info

- Within the list options, click the open box to indicate which Respiratory equipment the patient needs.
- When you click a check box, it will automate a text box to input comments associated with the item you checked.



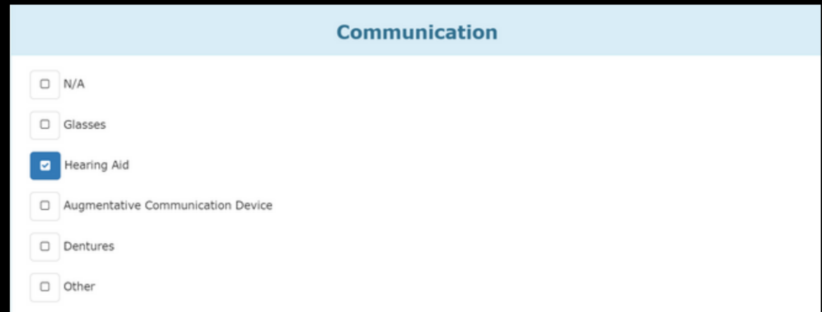
Equipment and Supplies Continued

5 **Click 'Communication'**

- Under Equipment and Supplies, Select the fourth category by clicking the 'Communication' button.
- A drop down with listed items will appear.

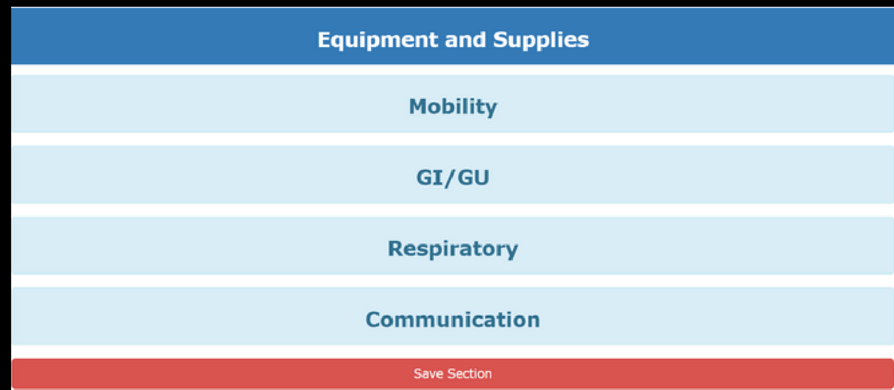
Input Communication

- Within the list options, click the open box to indicate which Communication equipment the patient needs.



6 **Save Equipment and Supplies Section**

- Once you have completed all four categories within the Equipment and Supplies Assessment, click the red 'Save Section' button.



Risk Assessment

1 **Open 'Risk Assessment'**

- Click the 'Risk Assessment' button in the Evaluation list.
- A drop down will open with 7 categories.

2 **Prognosis**

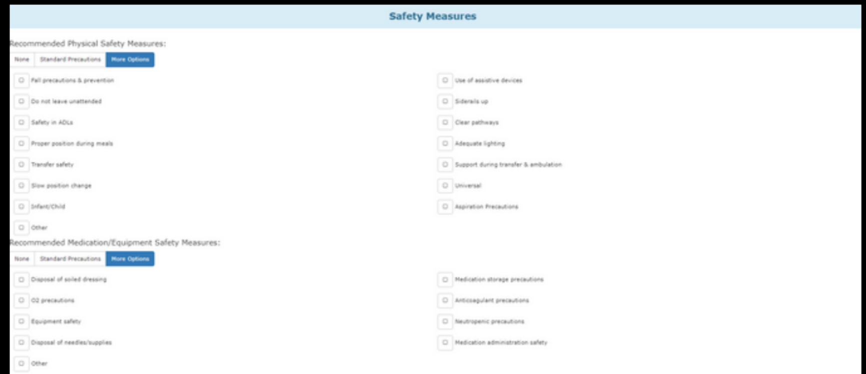
- In the top category, select the prognosis by clicking the severity level.

3 **Rehab Potential**

- In the Rehab Potential section, use the toggle button to drag to the level that the patient needs based on their stability.

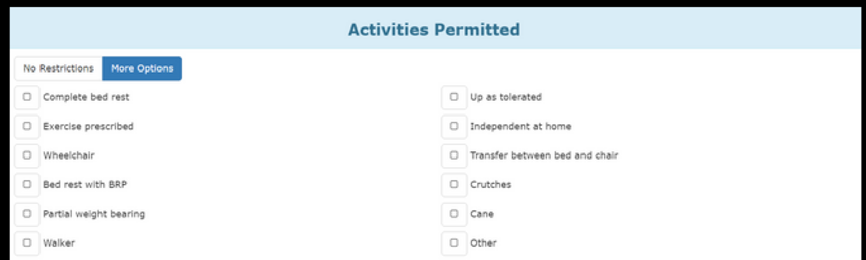
4 **Safety Measures**

- Use the Safety Measures section to select your 'Recommended Physical Safety Measures' and 'Recommended Medication/Equipment Safety Measures' by click the check box next to the item.



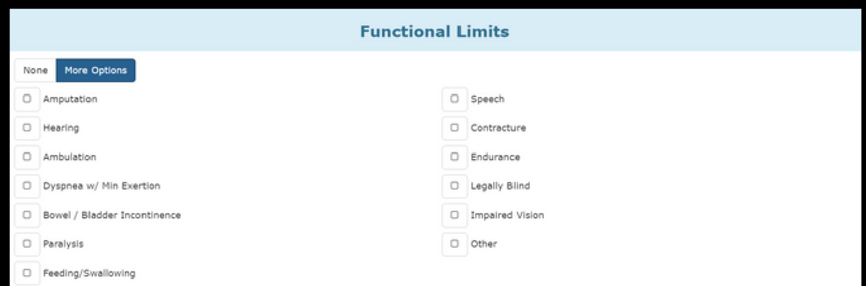
5 **Activities Permitted**

- Click the check box next to all activities within the 'Activities Permitted' the patient is able to perform.



6 **Functional Limits.**

- Click the check box next to any Functional Limitations the patient has.



Risk Assessment Continued

7 **Abuse / Neglect Indicators**

- Select the items by checking the box next to any indicators of abuse or negelct.

Abuse / Neglect Indicators

None | More Options

- ☐ Exploitation of Funds
- ☐ Left Unattended if constant supervision needed
- ☐ Unexplained Bruises
- ☐ Sexual Abuse
- ☐ Inadequate Food
- ☐ Neglect
- ☐ Fearful of Family Member
- ☐ Other

8 **Emergency Preparation**

- Complete the line items and required fields for the patients emergency preparation plan.

Emergency Preparation

Code Status:

Triage / Risk Level:

Emergency Contact:

Evacuation Plans: Comments

☐ Will require ambulance transfer

Reviewed With:

9 **Save Risk Assessment Section**

- Once you have completed all seven categories within the Risk Assessment, click the red 'Save Section' button.

Save Section

Plan of Care

1 Open 'Plan of Care'

- Click the 'Plan oof Care' button in the Evaluation list.
- A drop down will open.

2 Input Dates

- Select the dates of the order as well as the frequency and days of the episode from the drop down.

Plan of Care

Frequency

Verbal Order MM/DD/YYYY

From 12/20/2022 Through MM/DD/YYYY Episode

Missed visits may be made up within the certification period, which may exceed the frequency above if necessary but will not exceed the total authorized visits within the certification period.

3 Add Goals and Tasks

- Click on the 'Template' button for either 'Short Term Goals' or 'Long Term Goals'. A form will open. You can use the drop down menu to select a default goal.
- If you need to input a new goal from scratch, click the 'Add' button. It will open a form with a text box where you can type in the goal.
- Once you have input the goal's information, click the 'Submit' button.

Short Term Goals Add Template

Long Term Goals Add Template

'Add'

'Template'

Goal

Description

Close Submit

Add Goal

Filter by Problem

Close Submit

4 Discharge Plan

- Use the text box to type in your Discharge plan.

Discharge Plan

Templates Prev Answer

Patient will be discharged when all goals or maximum potential met.

5 Save Plan of Care Section

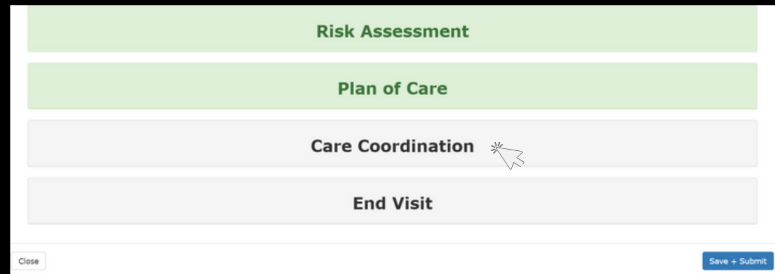
- Once you have completed all items in the Plan of Care section, click the red 'Save Section' button.

Save Section

Care Coordination

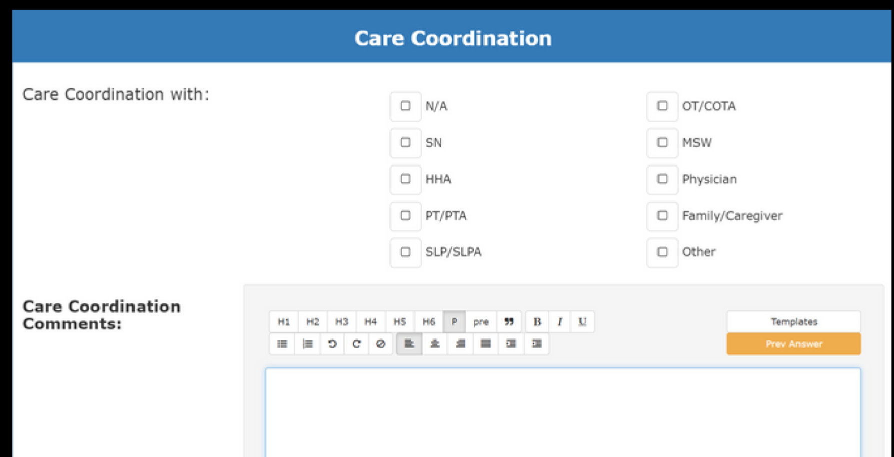
1 **Open 'Care Coordination'**

- Click the 'Care Coordination' button in the Evaluation list.
- A drop down will open.



2 **Input Personnel & Comments**

- Select who the coordination will be done with by clicking the open check box.
- Include your Care Coordination comments in the text box below.



3 **Save Care Coordination Section**

- Once you have completed all items in the Care Coordination section, click the red 'Save Section' button.

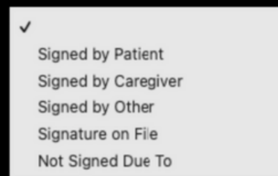
End Visit

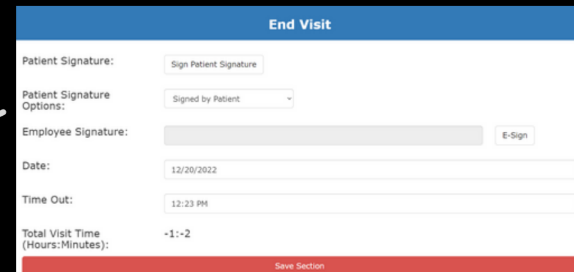
1 Open 'End Visit'

- Click the 'End Visit' button in the Evaluation list.
- A drop down will open.

2 Input Signatures

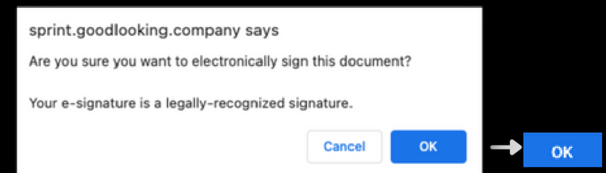
- Next to the 'Patient Signature' item, click the 'Sign Patient Signature' button. A form will open.
- Using the mouse, the patient or caregiver sign the open box. Click the 'Submit' button in the bottom right.
- Click the 'Patient Signature Options' drop down and select who signed for this visit.





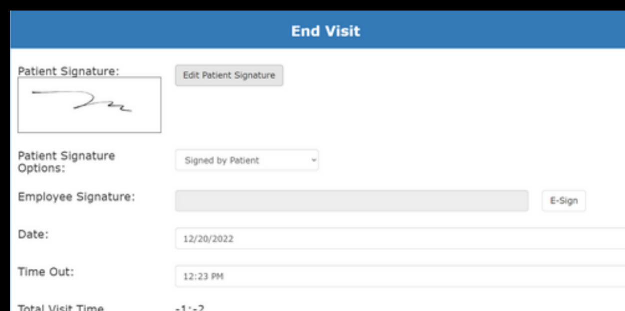
3 Employee Signature

- Next to the 'Employee Signature' item, click the 'E-Sign' button to the left of the open field. A pop-up message will open.
- It will ask if you are sure you want to electronically sign the document. Click the 'Ok' button. You electronic signature will be populated into the Employee Signature Field.



4 Finish the form & Save the End Visit Section

- Input the required information in the form's remaining line items.
- Once every field is complete and all signatures have been included, click the red 'Save Section' button.



Review Sections

1 **Review Sections**
- Once you have gone through every section, they will be highlighted green.
- You are able to review any section simply by click on the button and it will drop down.

TEST, ALFRED | OT RE-EVALUATION | Dec 27, 2022 12:30

Patient Info | Medical Records | Medications | Files | Notes | Print

Start Visit

Covid Screening

Review Patient Info

Patient Assessment

Objective Assessment

Equipment and Supplies

Risk Assessment

Plan of Care

Care Coordination

End Visit

Close | Save + Submit

2 **Save & Submit**
- When you are ready, click the 'Save + Submit' button on the bottom right.

Save + Submit

×

★ Visit has been Completed Successfully! ★

Return