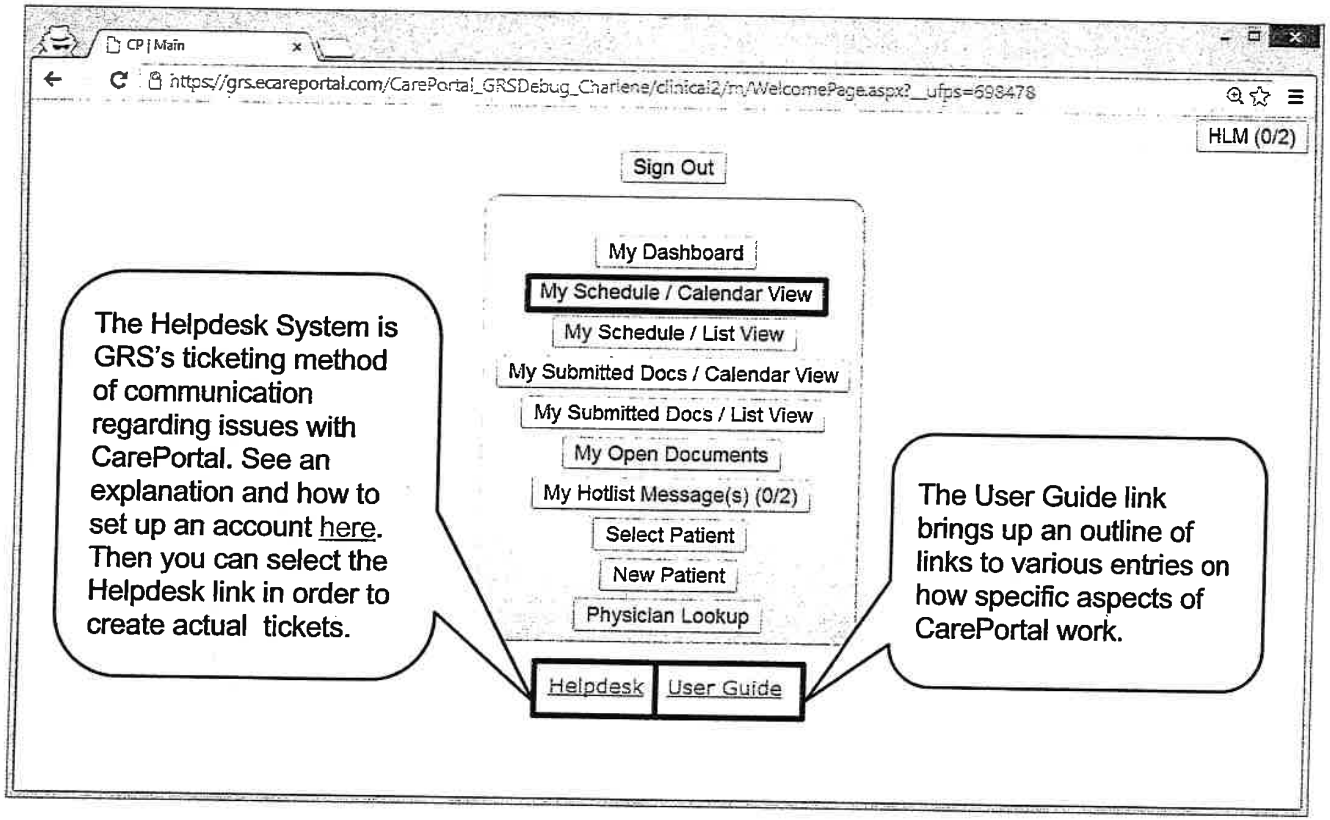
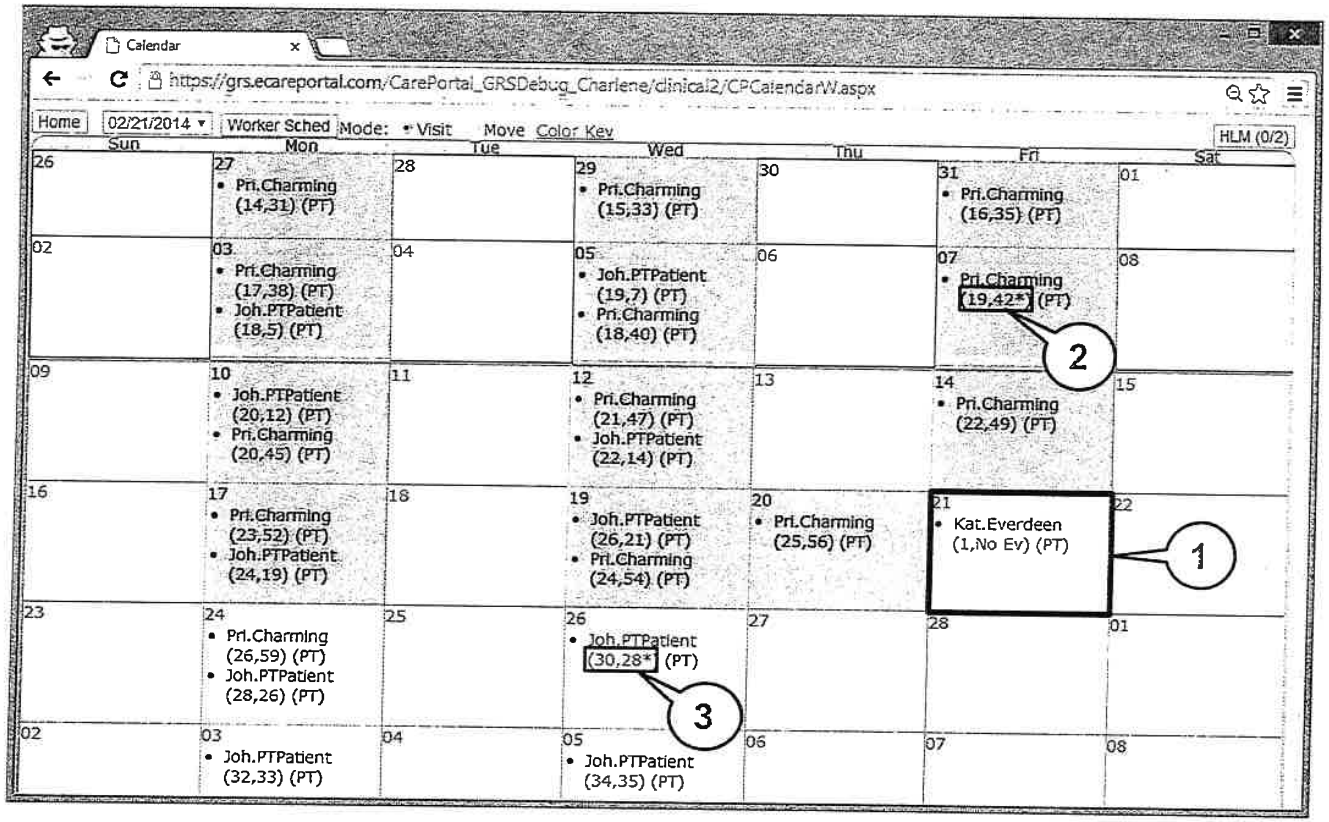
# How to enter therapy evaluations and revisits in Care Portal

# At Home Quality Care

**Note the two helpful links at the bottom of the screen. Select My Schedule / Calendar View.**



**In Calendar View, 1. here is how the scheduled visit for Katniss will look. Notice the parentheses with numbers under each patient's name. The first number tells you which therapy visit number this is for this patient, followed by the number of days since the eval was performed, ending with the therapy initials. For Katniss, this is visit #1, and the No Ev means no eval has been performed yet; PT is the therapy. An asterisk will alert you to visits nearest the 13th and 19th therapy visits and 30th day, when re-evals are due. Note 2. Prince Charming's 19th visit and 3. John's 28th day. See here for further explanation. 1. Select Katniss's scheduled visit.**



**1. Choose Note for therapy evals, not OASIS/485.** **(If and ONLY if this is a therapy-only patient, and 2. the Comment says "Start of Care", then you will need to choose 3. OASIS/485 and fill out an SOC assessment which will automatically include elements of a therapy eval as well when you choose the note name "1-PT Start Of Care" .)**

Choose **Note** for:

-Evaluations

-Reevaluations

-Revisit notes

-Discharge summary

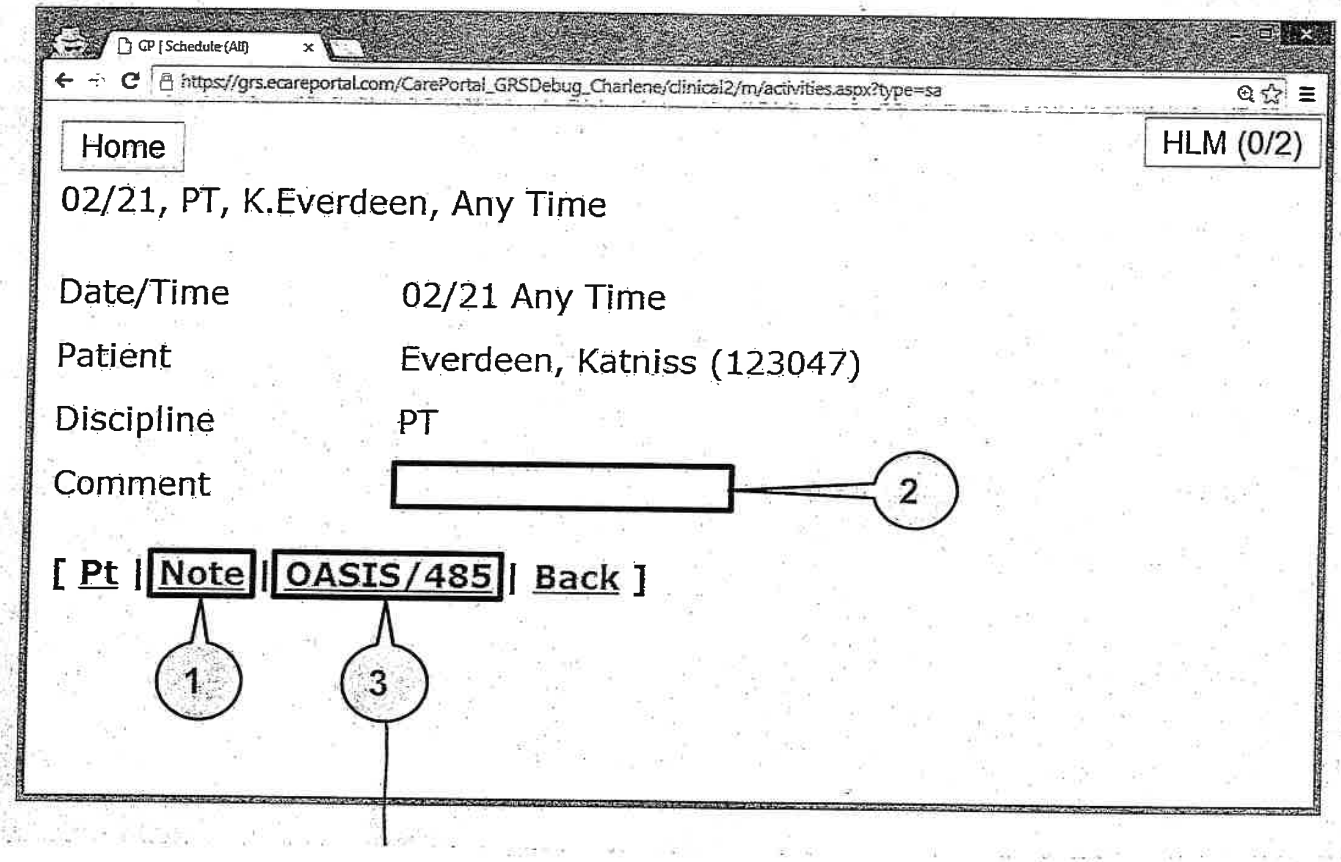
Choose **OASIS** for:

(**THERAPY ONLY** patient)

-PT Start of Care

-PT Recertification

-PT Resumption of Care



**1. Select the proper note name from the dropdown menu. Check to make sure that the other provided information is correct, then 2. choose the right HCPCS code. 3. You can see further explanations about these codes in this link (see link to therapy codes at bottom of nursing page). 4. Next.**

Choose **Note** name from drop down menu:

-Care Portal PT Evaluation

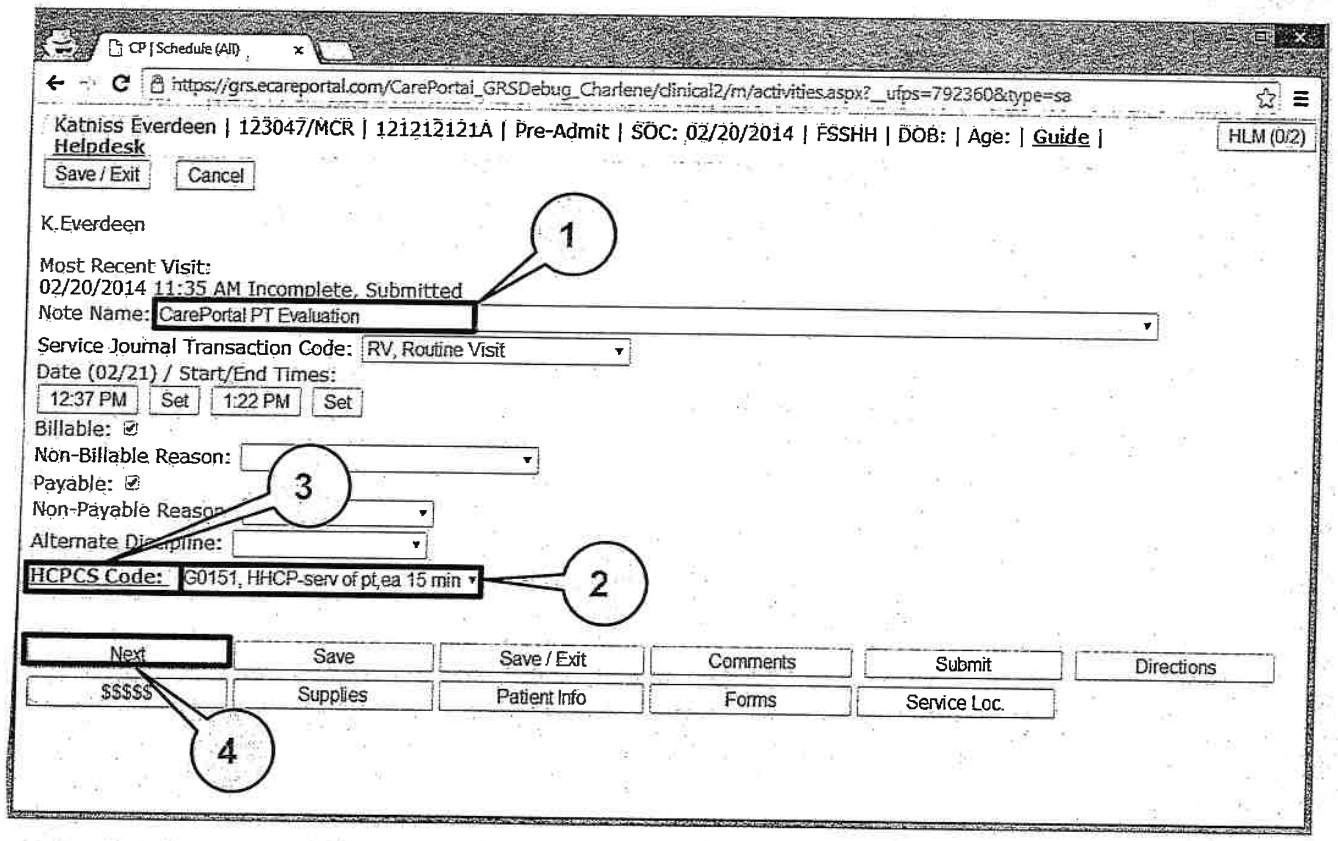
-Care Portal PT Re-eval

-Care Portal PT Revisit note

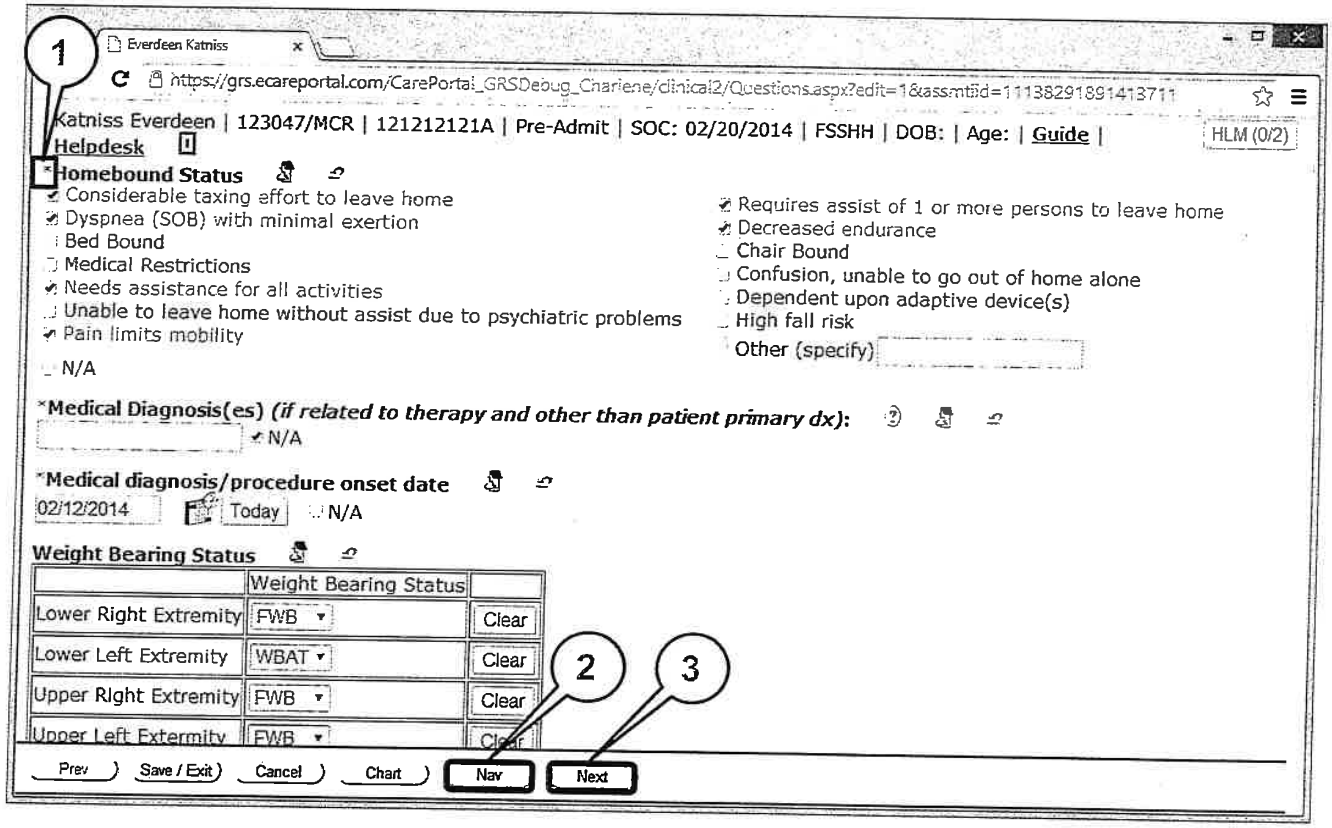
-Care Portal PT Discharge summary

**If you need to **CHANGE** the **DATE** click on start/end time box

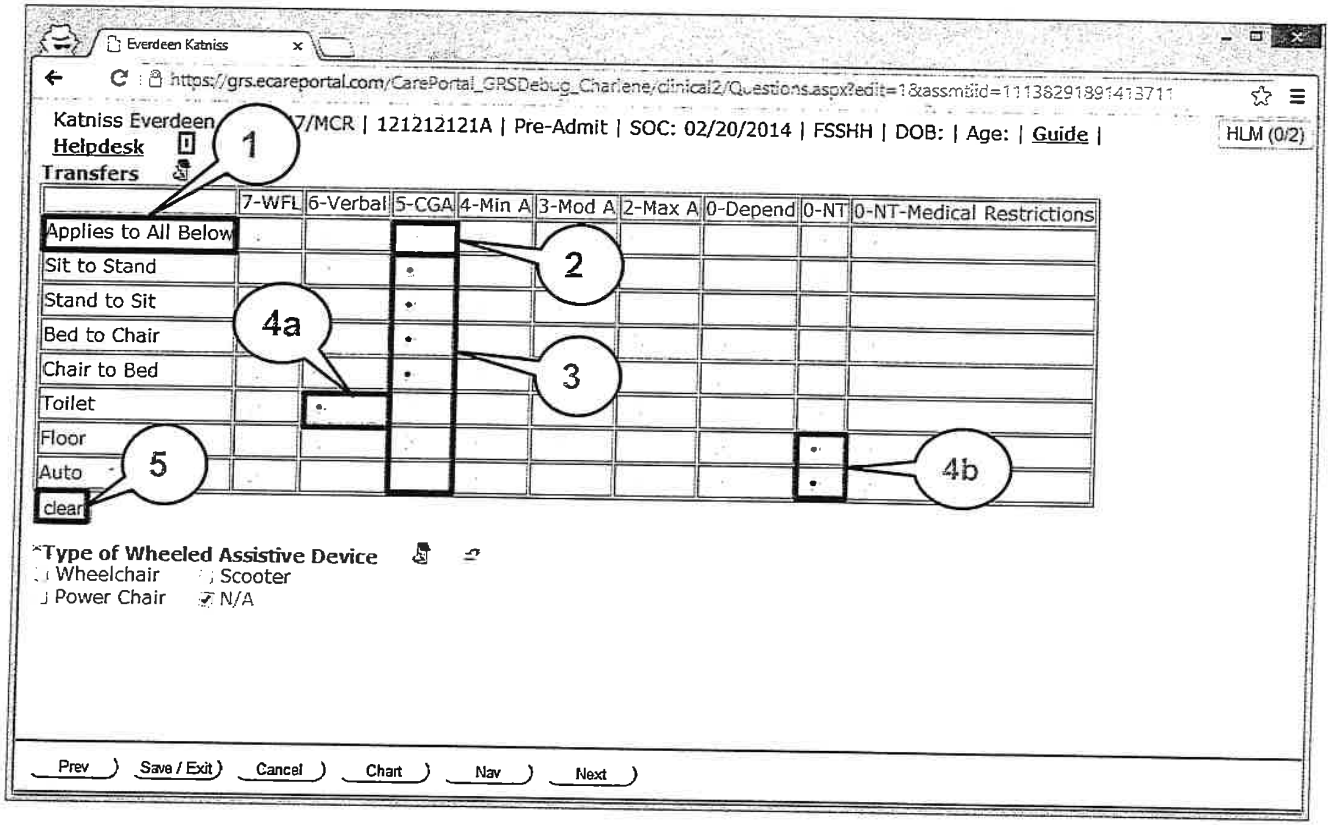
Next screen will allow you to change date and start time of the visit by clicking on appropriate box



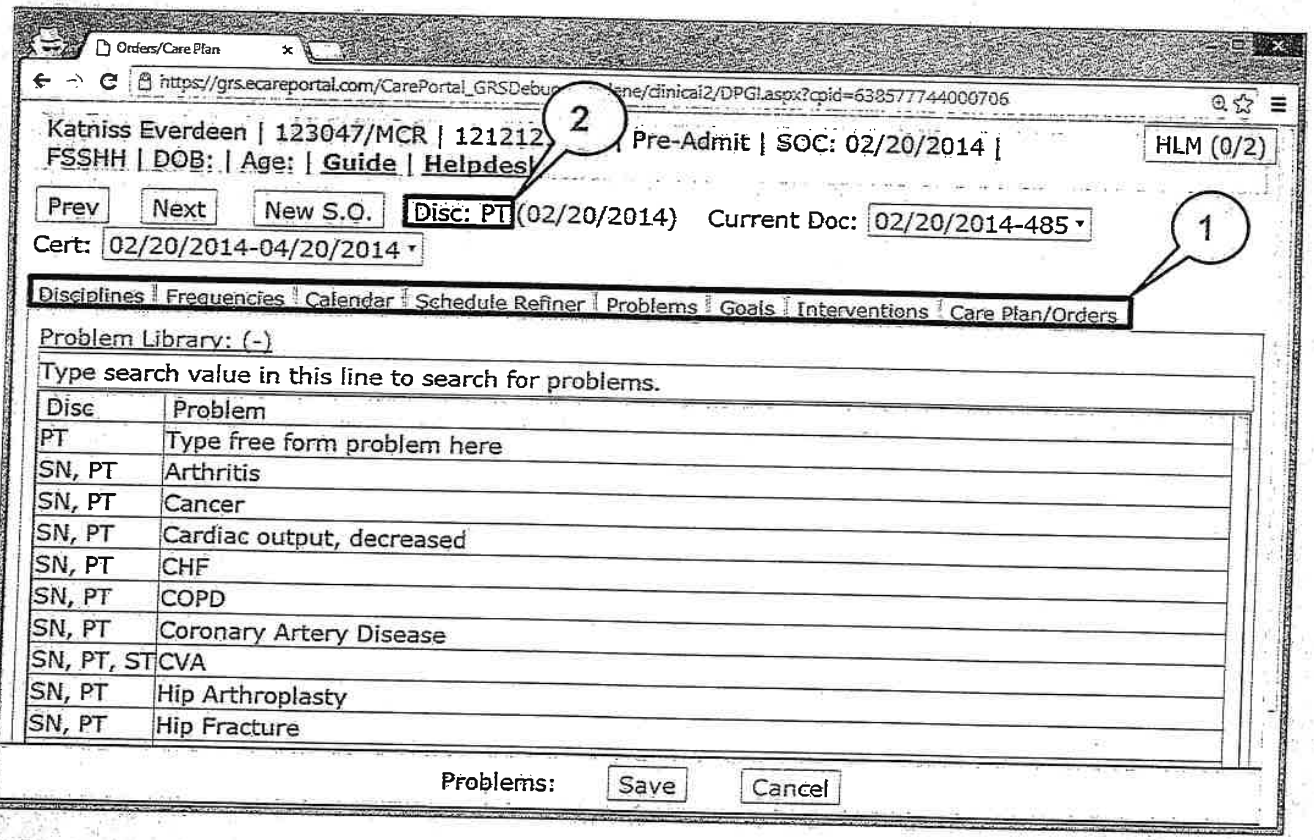
**Continue through each page, 1. filling in all required fields (marked by *) and any other pertinent ones. 2. You can navigate to a more specific area of the eval using this button (see Navigation link for further information). 3. Next and continue.**



**Throughout the eval you will find grids such as this one. 1. When you see the "Applies to All Below" option, you can select a radio button (or in some cases a dropdown) in that row, 2. such as 5-CGA, and 3. that will select all the buttons in that column. 4.a&b. If needed, you can then override any that may deviate from the original. 5. Clear removes all selected options. Continue....**



**Eventually you will come to the Care Plan, which begins on this screen. (1. Please follow this link for general information on how to step through these tabs.) 2. Note that PT has already been added as a discipline by the RN who filled out the original SOC.**



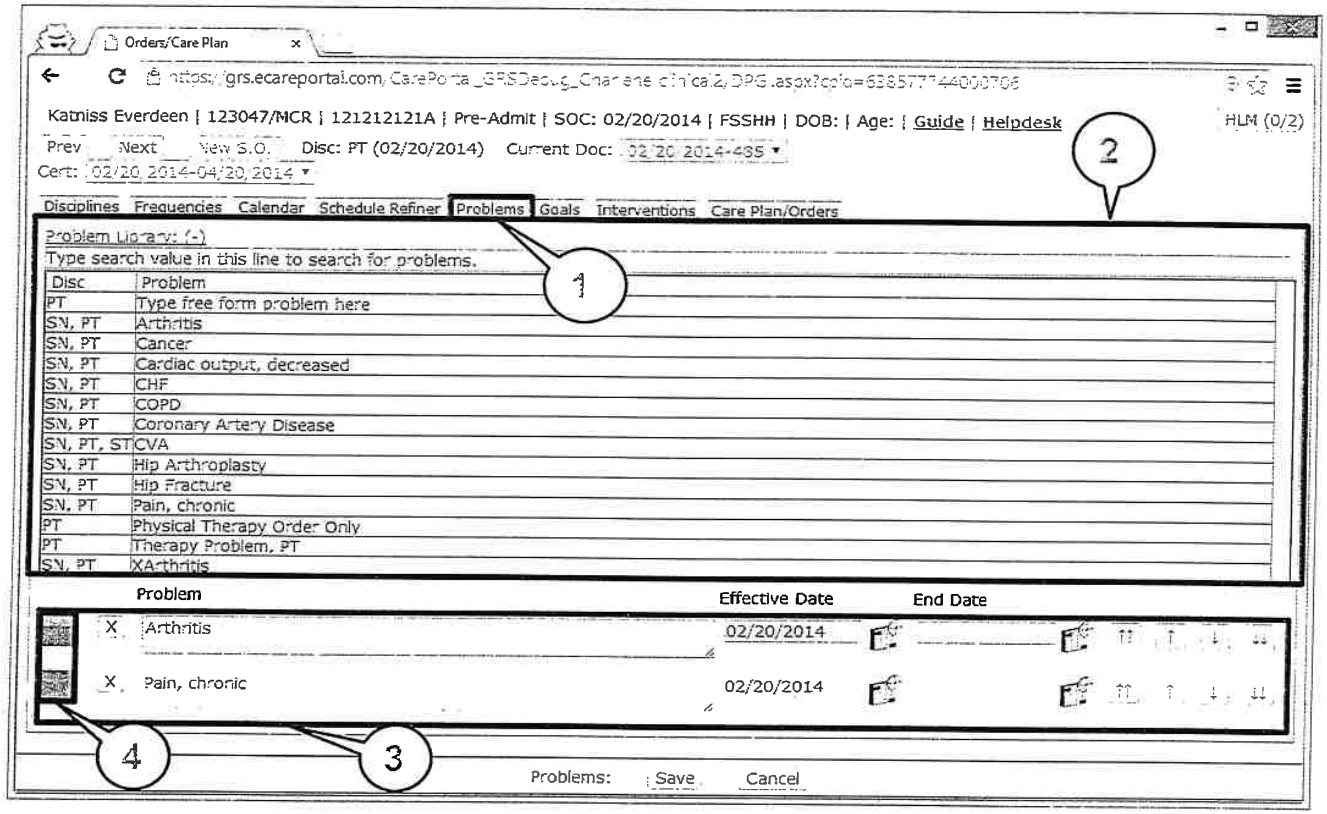

Choose New SO
SO type: New/Change Discipline

No need to enter frequency as office will enter frequency and schedule visits

Re-evaluation

Choose NEW SO
SO type: Frequency Change

**1. Under Problems tab, 2. select the appropriate entries from the Problem Library or type them in free form and 3. they will appear at the bottom. The yellow highlighted Problem Arthritis will be featured in the next two tabs. (4. Change the Problem later by clicking the dark gray box.)**




If therapy only patient and PT doing SOC/OASIS:

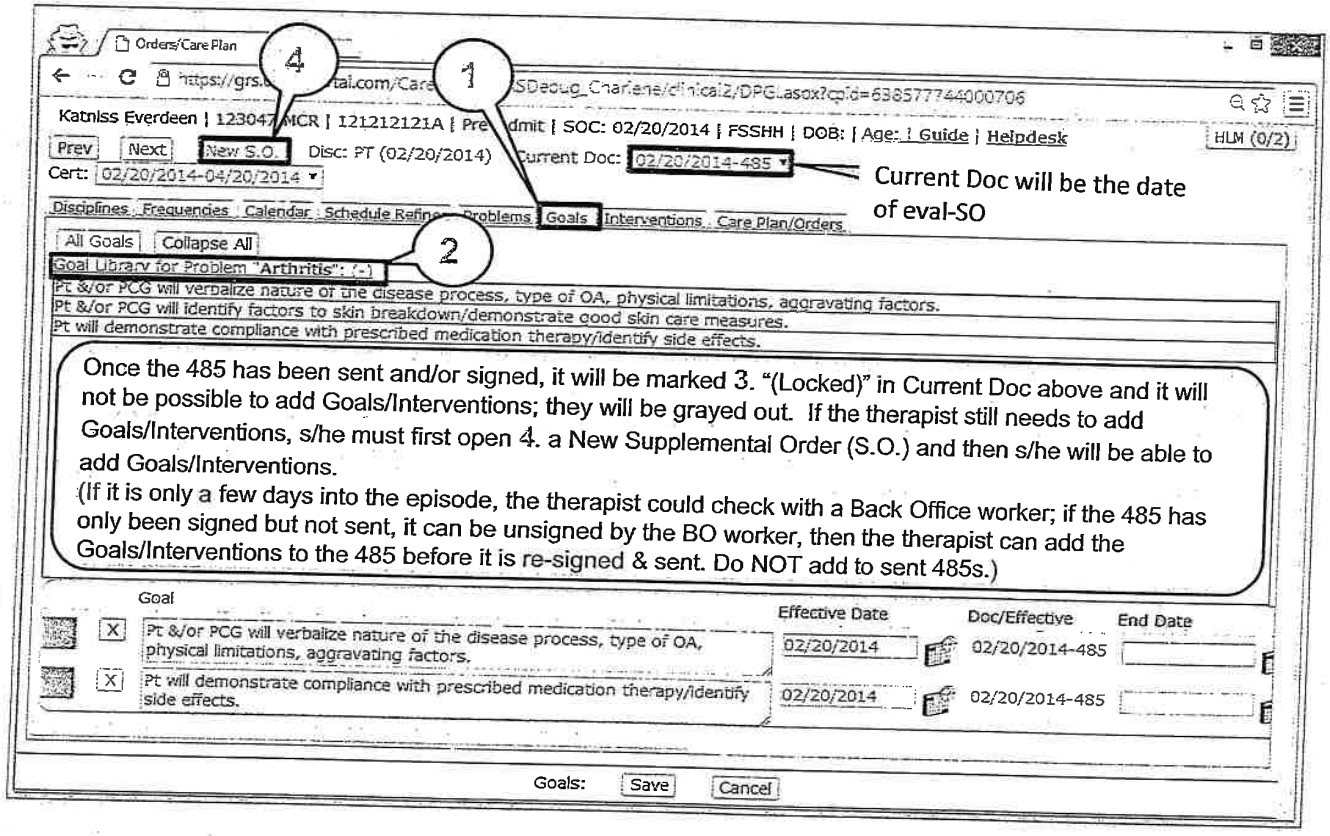
1st problem needs to be: General Parameters

Then therapy problems

Final problem:

Other problems

## Choose 1. the Goals for this Problem, 2. "Arthritis". *Please note important additional information highlighted below.*




You need to include your timeframe for EACH goal. You must have a STG (short-term goal) and a LTG (long-term goal) for each problem.

Ex. STG patient will ambulate 200' feet within 2 weeks

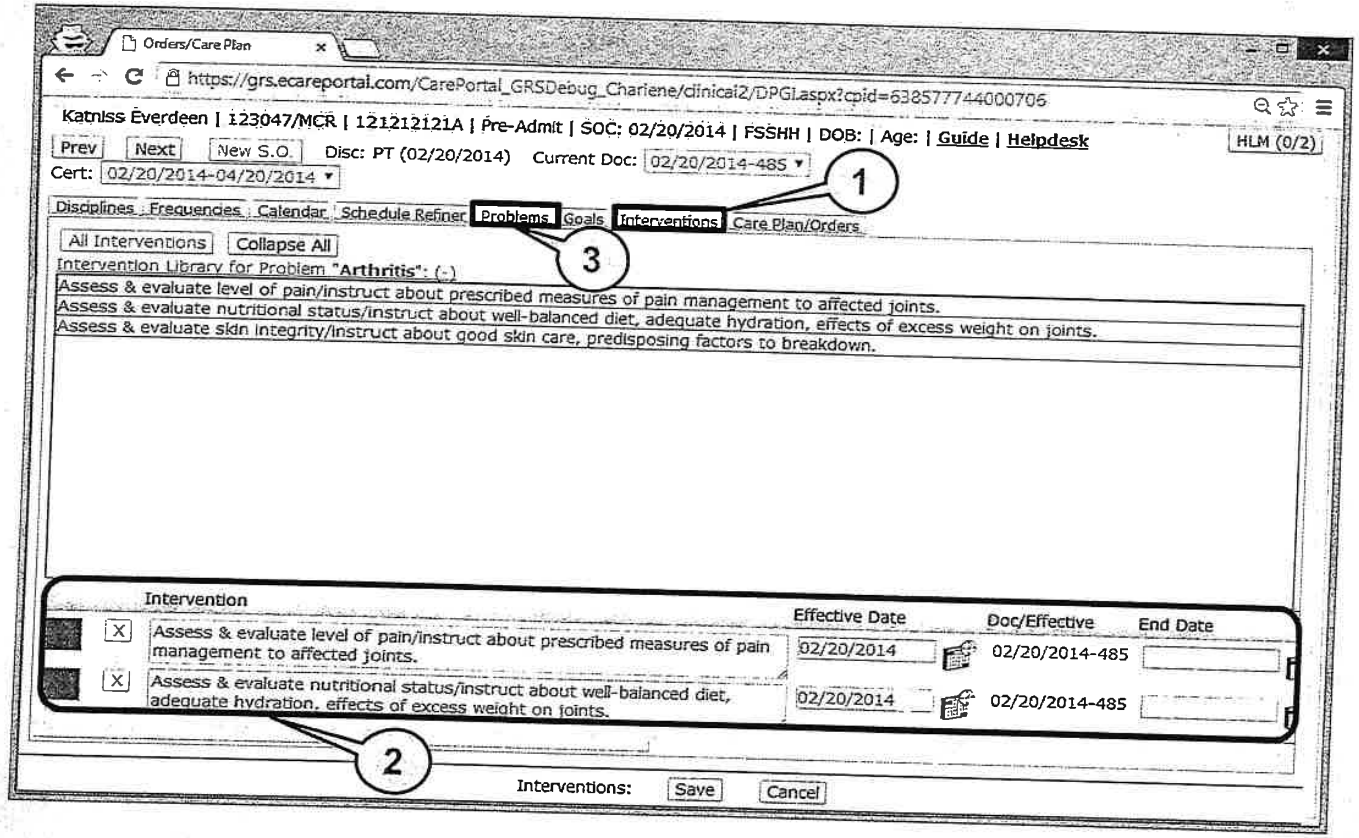
EX. LTG patient will ambulate 400' feet within 4 weeks.

DO NOT WRITE:
BY CERTIFICATION END DATE

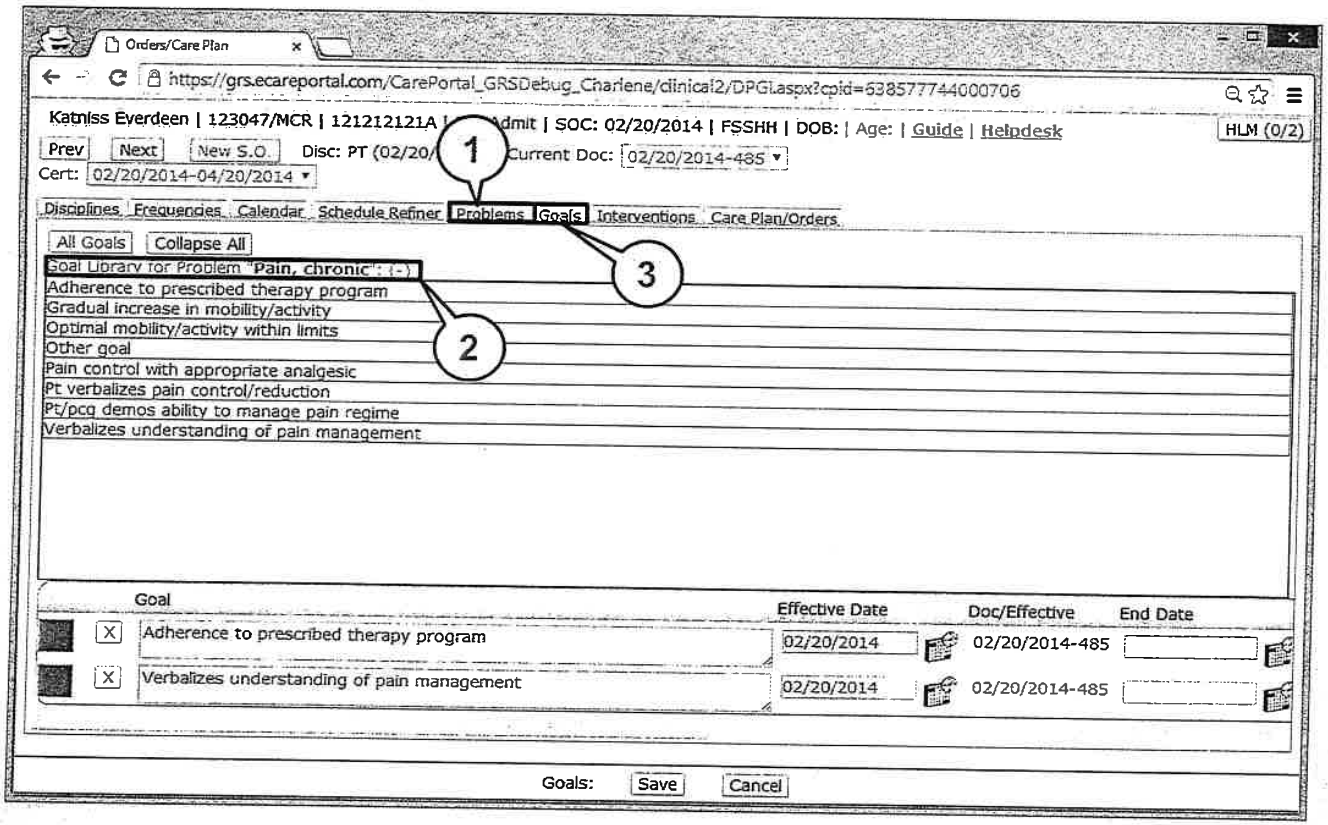
Leave effective date as the start of care date

**DO NOT** put end date (when you write your goals that is where you will write your projected end date)

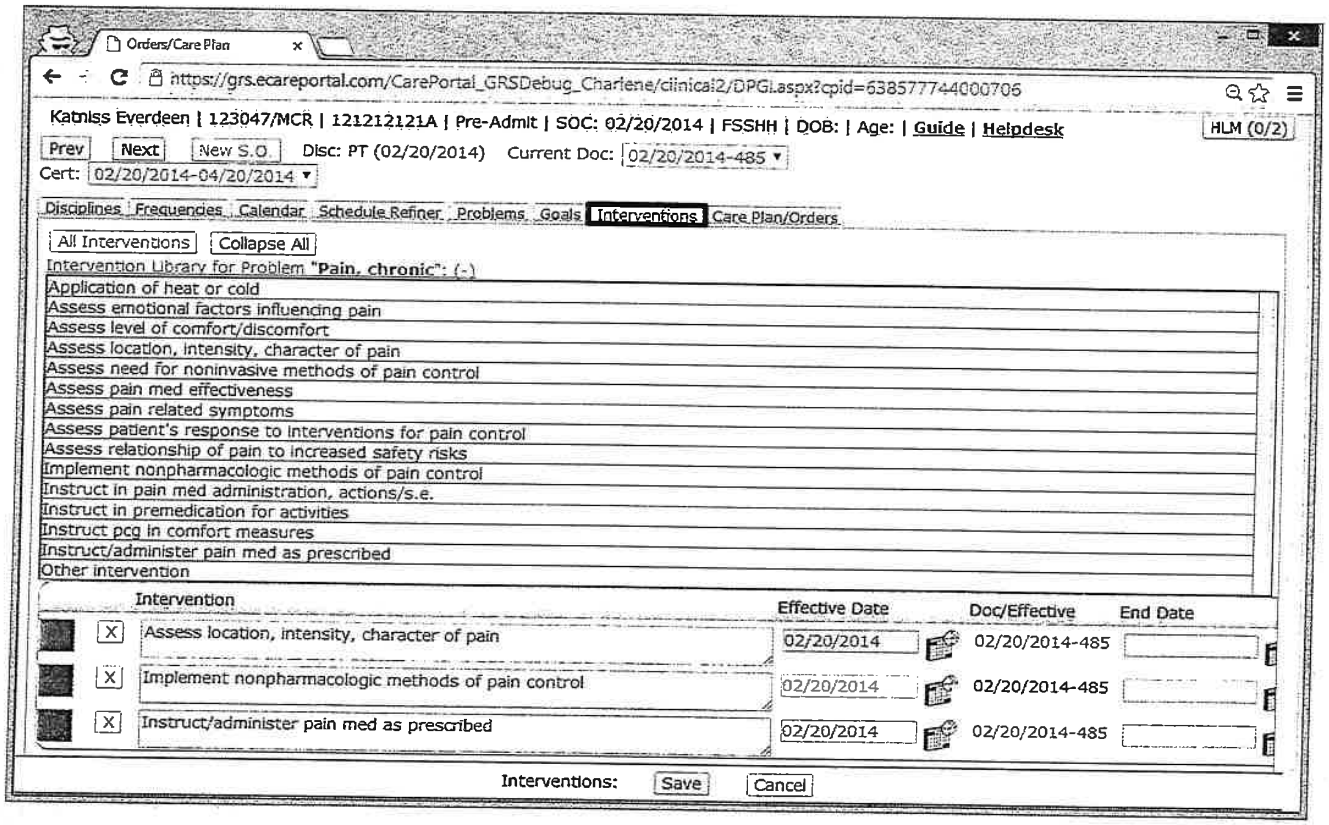
**1. Select any appropriate Interventions for Arthritis. 2. Two have been chosen below. 3. Then go back to Problems.**



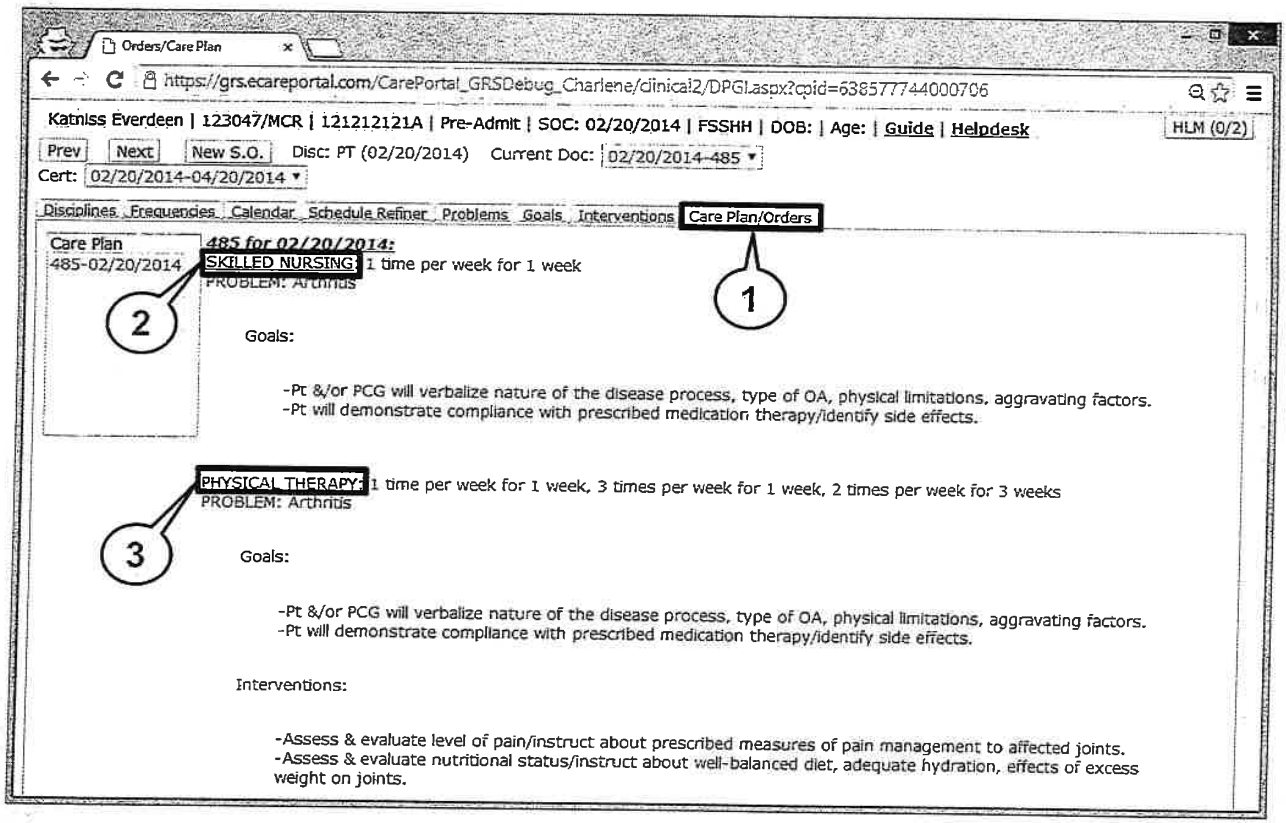
**1. In the Problems tab, click on the left box to highlight the next Problem (2. here, "Pain, chronic"). 3. Then choose Goals from this library for that Problem.**



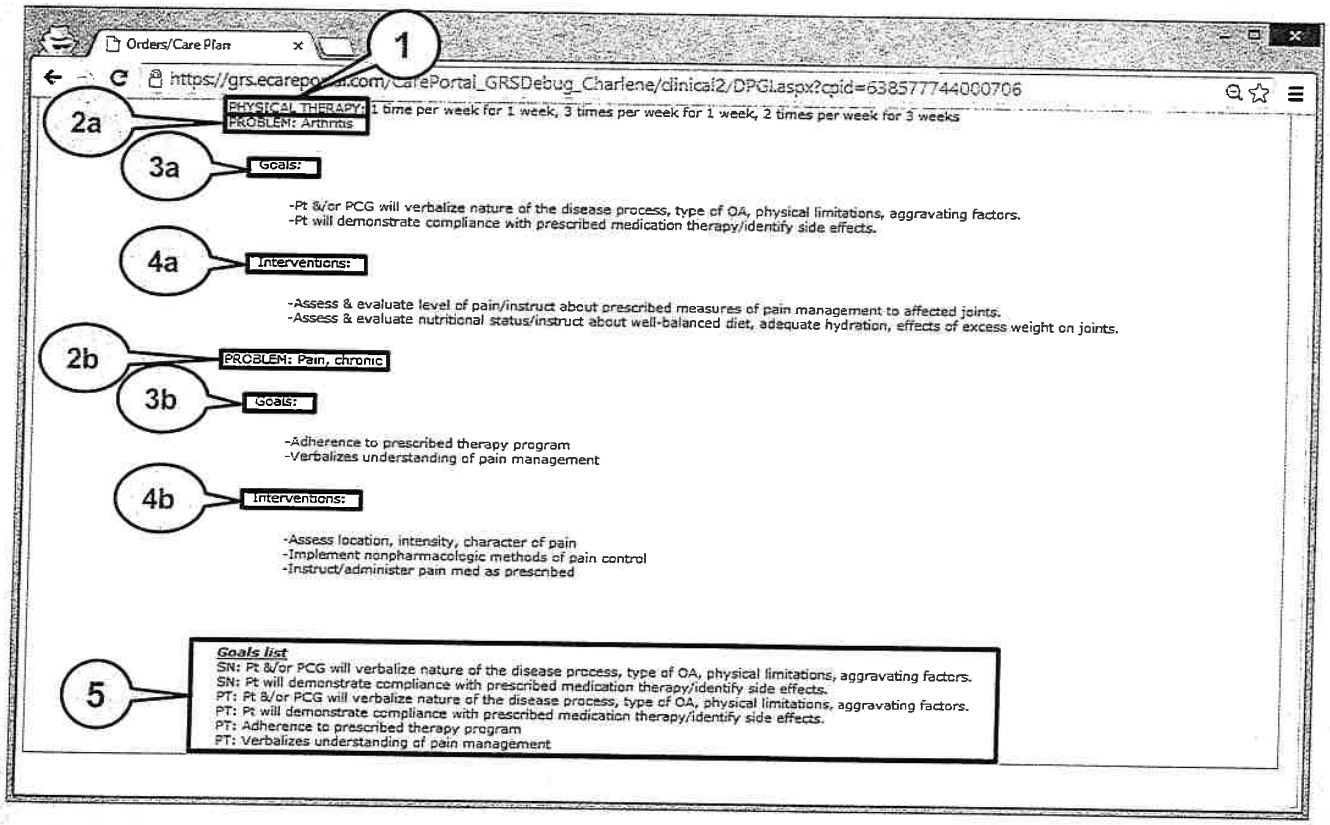
## And Interventions for the same Problem.



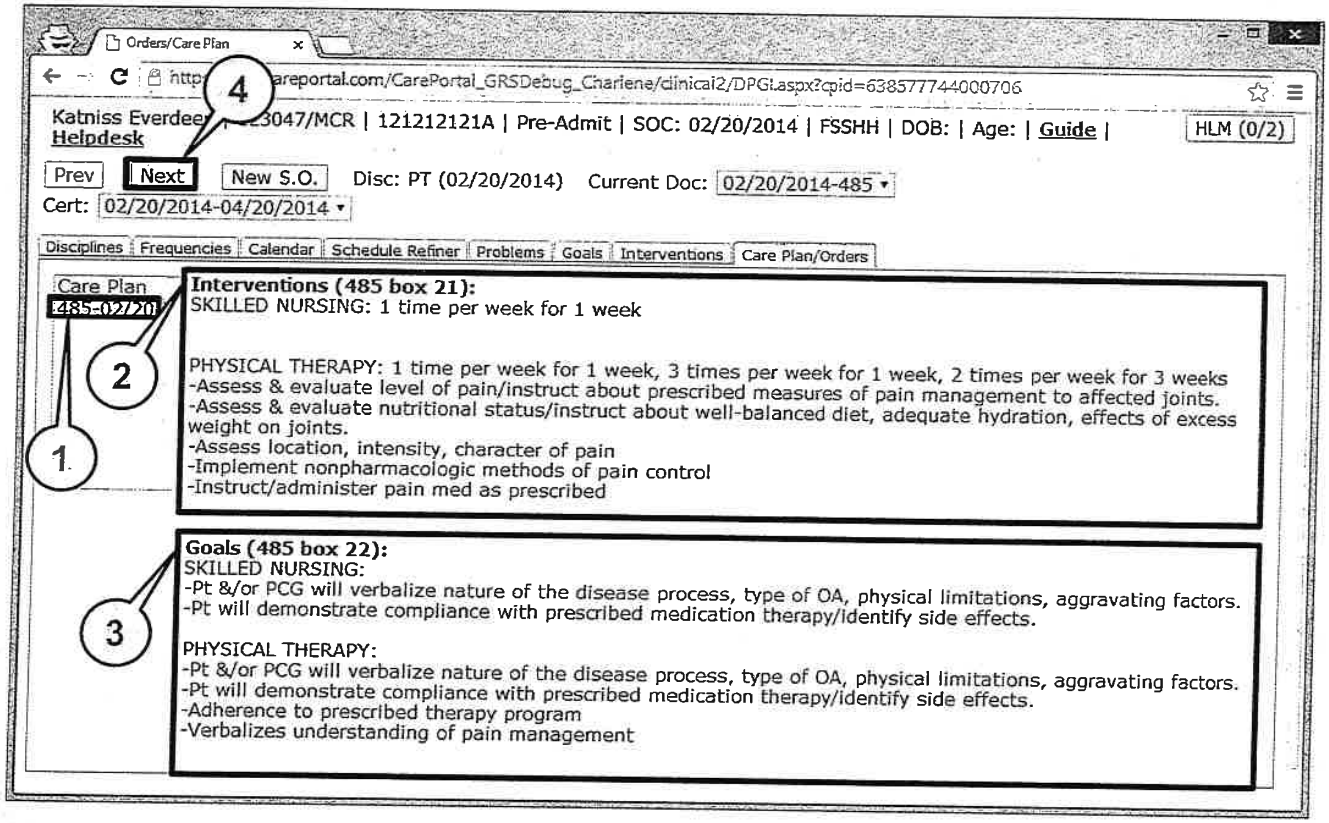
**1. The final tab, Care Plan/Orders, looks like this (the top of the page). Note that all disciplines show, in this example 2. SN and 3. PT.**



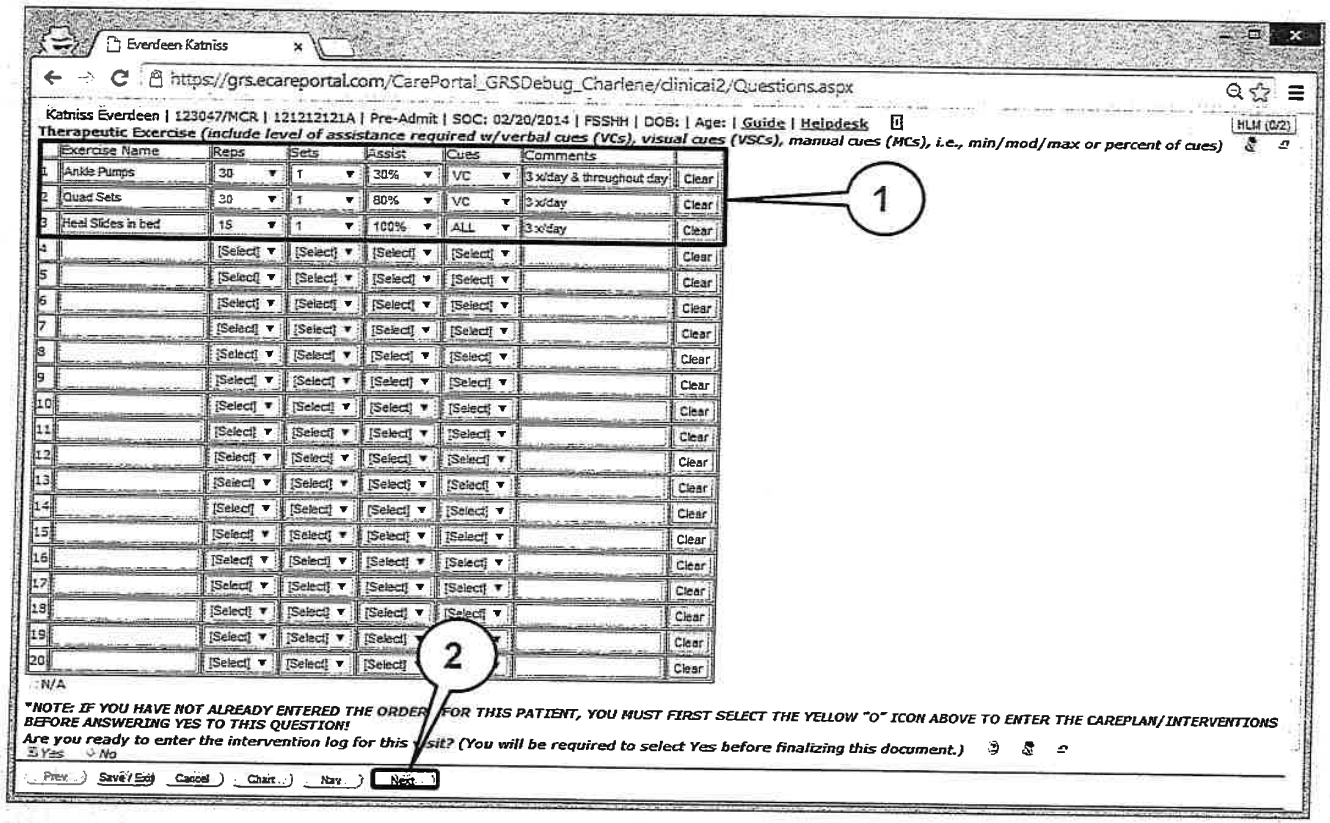
**This screen shot is zoomed in to 1. the PT portion of the Care Plan, with 2.a&b. the two Problems listed, each followed by its 3.a&b. Goals and 4.a&b. Interventions; 5. an integrated Goals list at the bottom includes all disciplines.**



**1. Highlight 485 on the left to see what boxes 2. 21 (Interventions) and 3. 22 (Goals) will look like on the 485. 4. Next.**



## 1. Enter as many exercises with details as desired. 2. Next.



IF Interventions DO NOT appear on intervention log, revisit may have occurred prior to PT eval being submitted to the office.

**HOW TO REFRESH INTERVENTION LOG (only will work once PT EVAL complete)**

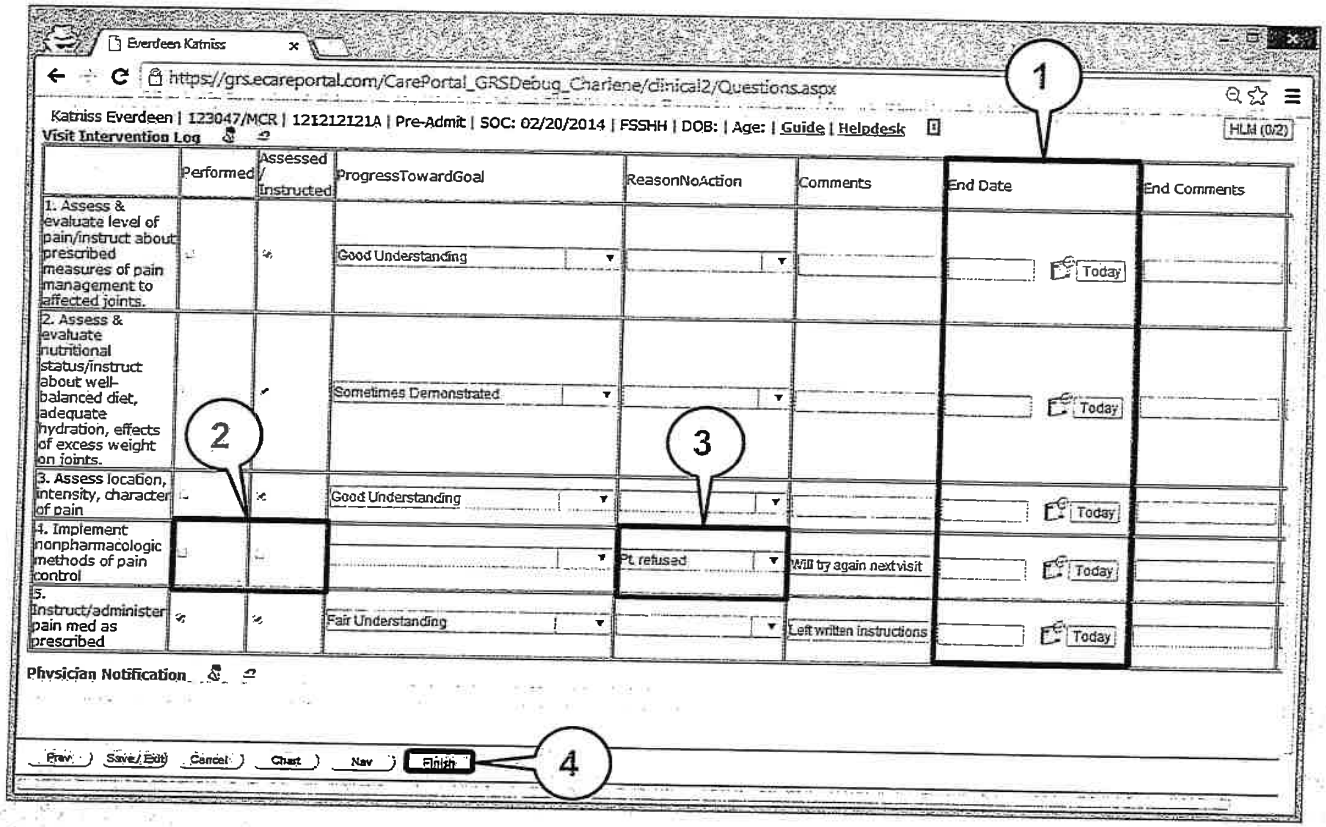
Select NO to "Are you ready to enter the intervention log for this visit?'

Select previous screen

Then answer YES to "Are you ready to enter the intervention log for this visit?"

Interventions should populate. Ensure that you answer progress toward goal with drop down choices. See next page.

**The Visit Intervention Log is populated by the Care Plan interventions and will appear in all future visits until/unless 1. an End Date is entered; fill in the table for this visit/eval. For each row, 2. if you don't select Performed or Assessed/Instructed, 3. then you must specify a ReasonNoAction in order to complete the eval. 4. Select Finish.**



Mickey xxxMouse | 0000/PI | Pre-Admit | SOC: 07/06/2017 | MHH | DOB: 01/01/1923 | Age: 94 | HLM (0/1)

**Guide** | **Helpdesk**

**Visit Intervention Log**

| | Performed | Assessed / Instructed | ProgressTowardGoal | ReasonNoAction | Comments | End Date | End Comments |
|---|---|---|---|---|---|---|---|
| 1. Theraputic Excercise | | | Fair Understanding | | | Today | |
| 2. Therapeutic Activities | | | | | | Today | |

***NEW GOALS OR UPDATED GOALS WITH TIME FRAMES**

Continue with additional 2 wk 2 as patient is still working towards ambulating 400' without assistance. Currently patient is able to ambulate 275' without SOB or fatigue.

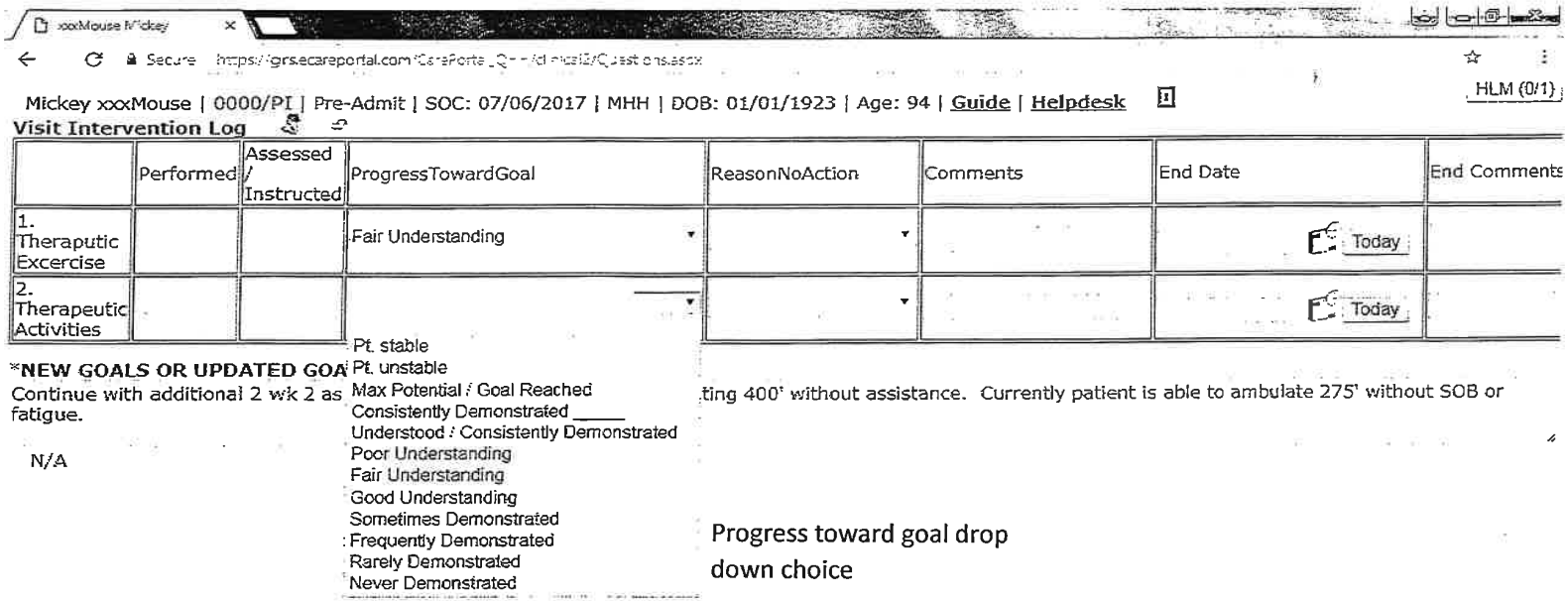
N/A

**Intervention log:**

Please check if intervention performed or assessed/instructed and include progress towards goal

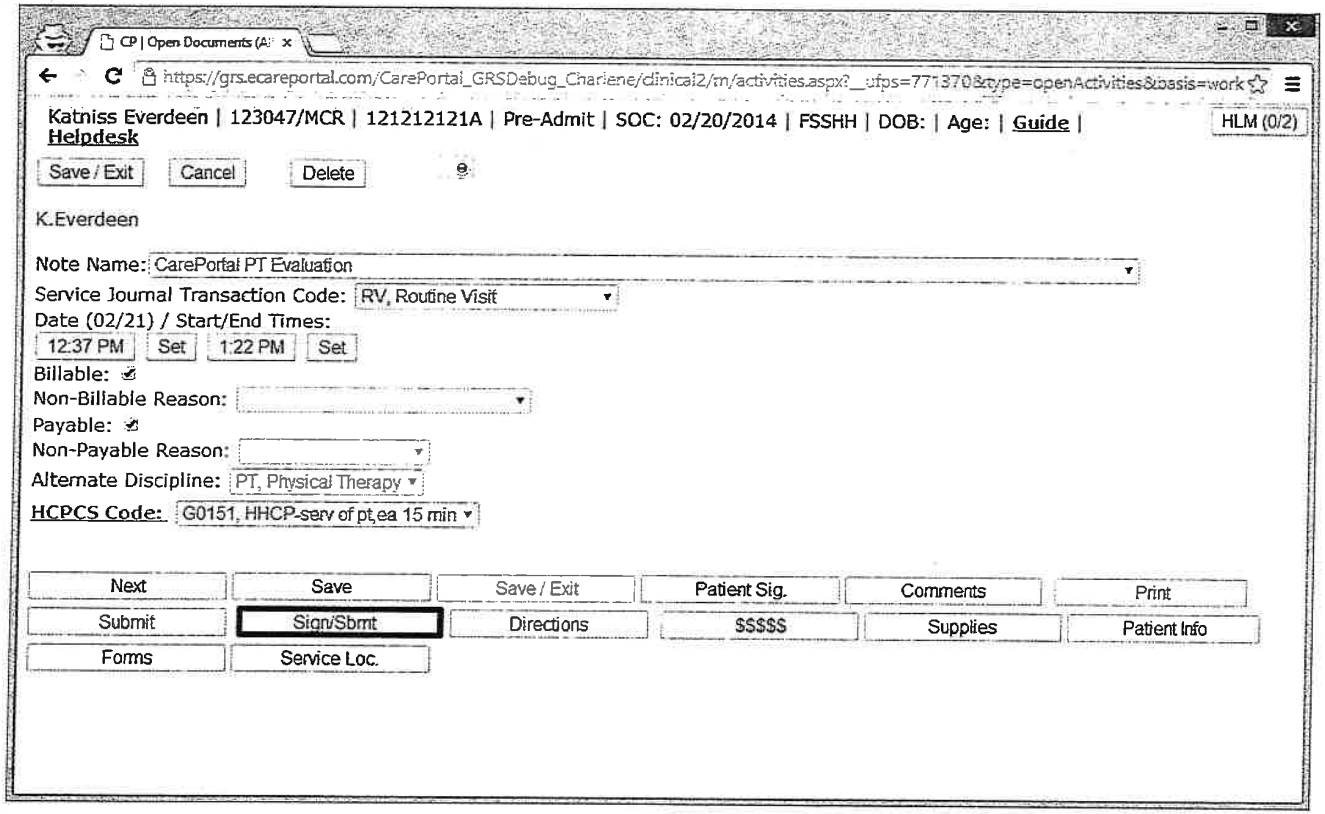
**Re-evaluations:**

Immediately after the intervention log, please write a narrative in "new goals or updated goals with time frames" for continuation of visits. Please include frequency and reason why continuation.

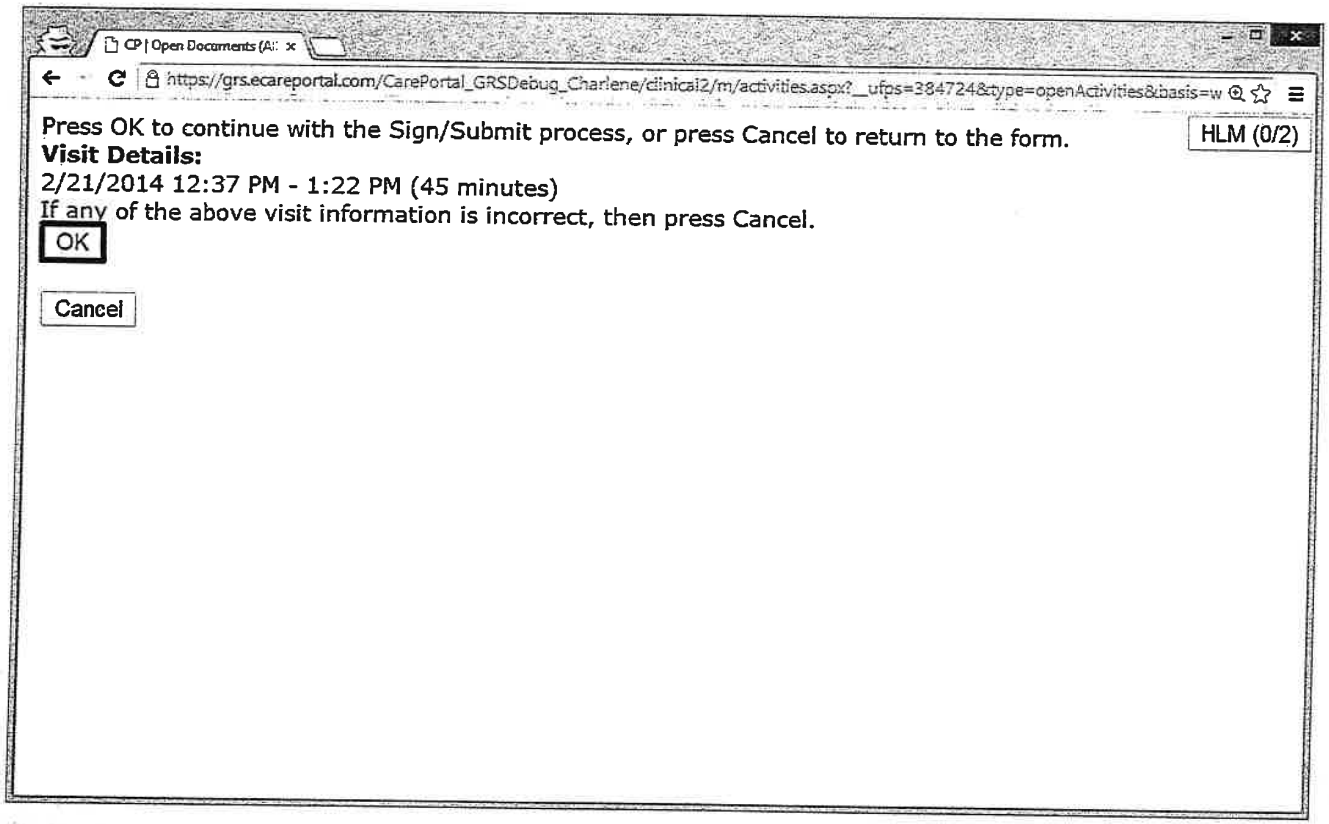



Progress toward goal drop down choice

**At this point, if you are ready to sign and submit the eval to the back office, choose Sign/Sbmt.**

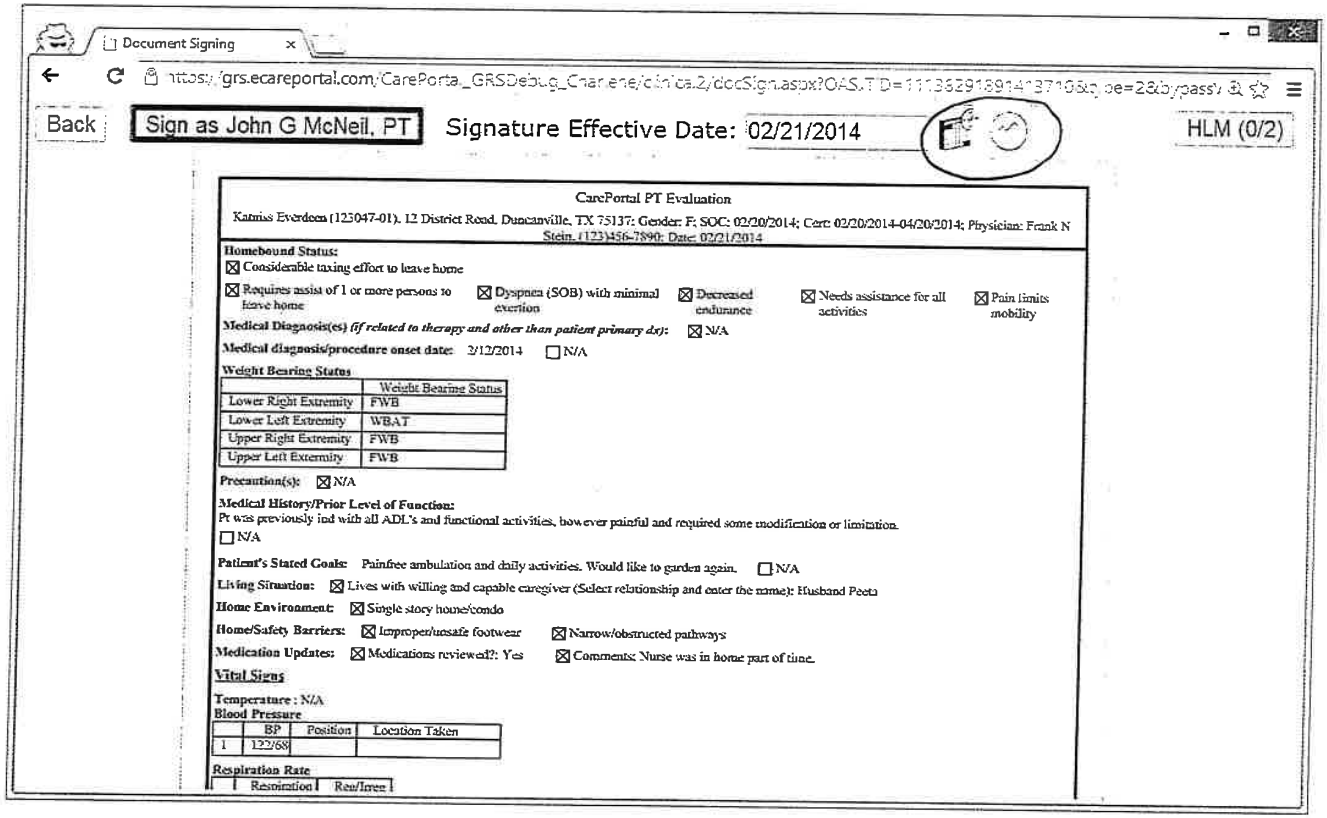


## Select OK.

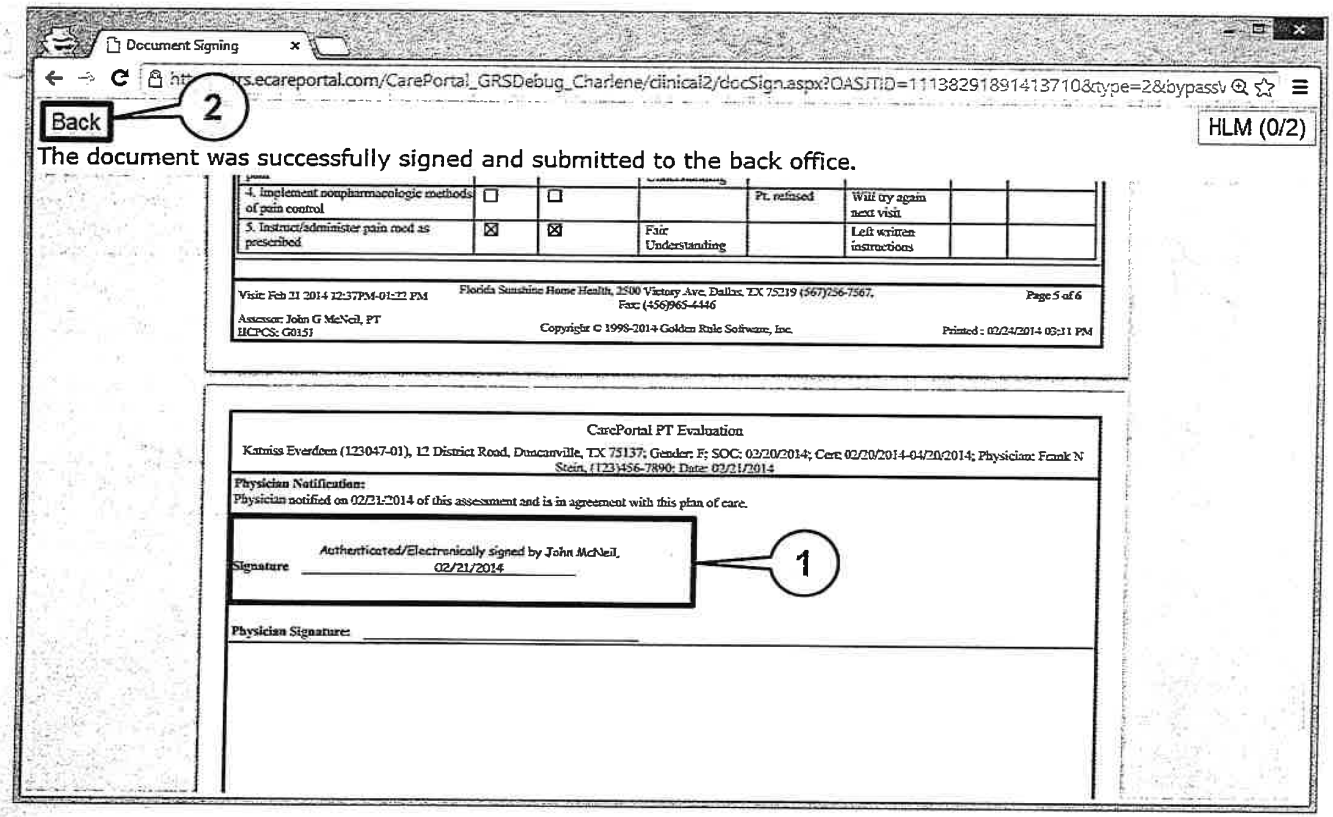

CP | Open Documents (Al:
https://grs.ecareportal.com/CarePortal_GRSDebug_Charlene/clinical2/m/activities.aspx?__ufps=384724&type=openActivities&basis=w
Press OK to continue with the Sign/Submit process, or press Cancel to return to the form.
HLM (0/2)
Visit Details:
2/21/2014 12:37 PM - 1:22 PM (45 minutes)
If any of the above visit information is incorrect, then press Cancel.
OK
Cancel

**If you wish, you may skim the actual eval portrayed below to verify that everything looks correct, then Sign > OK.**

Signature effective date should be the date of the eval/visit not day of completion and submission. Click on the calendar icon to change date.



## Scrolling down, 1. here is what a successful signature looks like. 2. Back.



***Medical Diagnosis(es)** ***(if related to therapy and other than patient primary dx)*:**

GENERALIZED MUSCLE V N/A

## COMPARATIVE STANDARDIZED DATA/MEASUREMENTS AND FUNCTIONAL ACCOMPLISHMENTS

| | SOC/EVAL | CURRENT | |
|---|---|---|---|
| 1 | | | Clear |
| 2 | | | Clear |
| 3 | | | Clear |
| 4 | | | Clear |
| 5 | | | Clear |

## PROGRESS TOWARD GOALS

| | Unmet Goals | Progress Toward Goal | |
|---|---|---|---|
| 1 | | | Clear |
| 2 | | | Clear |
| 3 | | | Clear |
| 4 | | | Clear |
| 5 | | | Clear |
| 6 | | | Clear |
| 7 | | | Clear |
| 8 | | | Clear |
| 9 | | | Clear |
| 10 | | | Clear |

Prev | Save / Exit | Cancel | Chart | Nav | Next

https://grs.ecareportal.com/CarePortal_QHH/clinical2/Questions.aspx?edit=1&assmtiid=51015625142071613

Comparative Standardized Data/Measurements and Functional Accomplishments need to be completed in the Re-evaluation.

Two examples

| | SOC/EVAL | CURRENT |
|---|---|---|
| 1 | Min A in transfers | SBA in transfers with RW |
| 2 | Min/CGA in transfers with RW | SBA in gait with RW indoor; CGA with RW outdoor |
| 3 | Min A in stair negotiation 5 steps with handrail | SBA in stair negotiation with handrails/grab bars |
| 4 | Right hip pain PS 6/10 | Right hip pain PS 2/10 |
| 5 | Standing balance: Fair Minus | Standing balance: Fair/Fair minus |

**PROGRESS TOWARD GOALS**

| | Unmet Goals | Progress Toward Goal |
|---|---|---|
| 1 | Modified Indep in all transfers with RW | SBA in transfers with RW |
| 2 | Modified Indep in stair negotiation x 6 steps with handrail | SBA in stair negotiation with handrails/grab bars |
| 3 | Modified Indep in gait with RW x 200-300 ft + | SBA in gait with RW indoor; CGA with RW outdoor |
| 4 | Increase standing balance to fair plus | Standing balance: Fair/Fair minus |

| | SOC/EVAL | CURRENT |
|---|---|---|
| 1 | Tinetti score- 12 | 20/28 |
| 2 | TUG 18 secs | 14 |
| 3 | Pain- 7/10 RUE | 2-3/10 |
| 4 | Transfers CGA | SBA |
| 5 | Gait - CGA | SBA |

**PROGRESS TOWARD GOALS**

| | Unmet Goals | Progress Toward Goal |
|---|---|---|
| 1 | Unsteady gait w/ assist,CGA | MI with RW w/ safety |
| 2 | impaired dyn. stand. bal F- | to improve to F/F+. |
| 3 | transfers CGA x1 | To improve transfers to MI |
| 4 | pain 2-3/10 R shoulder | 1/10 right shoulder |

**Weight**

| Weight (lbs) | How Taken | Weight Gain | Weight Loss | Change Since | |
|---|---|---|---|---|---|
| 136 | Stated | 0 | 0 | Today | Clear |

N/A

**Height**

| Height | Actual/Stated | |
|---|---|---|
| 5'7" | Actual | Clear |

N/A

Pain Assessment needs to be completed at EVERY visit.

If NO pain, put a 0

**Pain Assessment (Smiling Faces/Numeric Scale: 0: None; 1-3: chronic/tolerable; 4-6: requires nursing intervention; 7-9: requires MD intervention; 10: requires acute care intervention)**

| | Location | Onset | Current | Worst | Least | Type | PainIntervention | Intervention2 | Other | Breakthrough M |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | [Select] | Today | 0 | | | | | | | |
| 2 | [Select] | Today | | | | | | | | |
| 3 | [Select] | Today | | | | | | | | |
| 4 | [Select] | Today | | | | | | | | |
| 5 | [Select] | Today | | | | | | | | |
| 6 | [Select] | Today | | | | | | | | |
| 7 | [Select] | Today | | | | | | | | |
| 8 | [Select] | Today | | | | | | | | |
| 9 | [Select] | Today | | | | | | | | |
| 10 | [Select] | Today | | | | | | | | |
| 11 | [Select] | Today | | | | | | | | |
| 12 | [Select] | Today | | | | | | | | |
| 13 | [Select] | Today | | | | | | | | |
| 14 | [Select] | Today | | | | | | | | |
| 15 | [Select] | Today | | | | | | | | |
| 16 | [Select] | Today | | | | | | | | |
| 17 | [Select] | Today | | | | | | | | |
| 18 | [Select] | Today | | | | | | | | |
| 19 | [Select] | Today | | | | | | | | |

Prev | Save / Exit | Cancel | Chart | Nav | Next

# CarePortal PT Discharge Summary

Mickey xxxMouse (0000-05), 5901 N. Cicero Ave. , Chicago, IL 60646, (773)685-9025; DOB: 01/01/1923; Gender: M; Allergies: Biaxin, Ativan; SOC: 07/06/2017; Cert: 07/06/2017-09/03/2017; Physician: John Acquaye Awah, MD, (773)807-0555; Date: 07/21/2017

**Include Visit-Related Questions?:**
(●) Yes ( ) No

**Primary Diagnosis:** [X] N/A

**Mental Status:** [X] Oriented

**Vital Signs**

**Temperature** : N/A
**Blood Pressure** : N/A
**Respiration Rate** : N/A
**Pulse** : N/A
**Weight** : N/A
**Height** : N/A

**PRESENCE OF PAIN:**
( ) N/A ( ) Yes (●) No

**Reasons for Discharge:**
[ ] N/A
[X] Goals Met
[ ] MD Request
[ ] Refused Service
[ ] Another Agency/Hospice
[ ] Admitted to Facility
[ ] Patient moved, area out of coverage
[ ] Expired
[ ] Goals Not Met, Reasons:
[ ] Other(s)

**SKILLED AREAS - EVALUATION STATUS**

| | Ind. | Mod. Ind. | Sup. | SBA | Min. | Mod. | Max. | Total | N/A |
|---|---|---|---|---|---|---|---|---|---|
| Bed Mobility | [ ] | [ ] | [ ] | [X] | [ ] | [ ] | [ ] | [ ] | [ ] |
| Supine - Sit | [ ] | [ ] | [ ] | [X] | [ ] | [ ] | [ ] | [ ] | [ ] |
| Sit - Stand | [ ] | [ ] | [ ] | [ ] | [X] | [ ] | [ ] | [ ] | [ ] |
| Ambulation | [ ] | [ ] | [ ] | [ ] | [X] | [ ] | [ ] | [ ] | [ ] |
| Curb /Ramp | [ ] | [ ] | [ ] | [X] | [ ] | [ ] | [ ] | [ ] | [ ] |
| WC-Scooter Prop/Mgmt | [ ] | [ ] | [ ] | [X] | [ ] | [ ] | [ ] | [ ] | [ ] |
| Tub / Shower Transfer | [ ] | [ ] | [ ] | [ ] | [X] | [ ] | [ ] | [ ] | [ ] |
| Toileting Transfer | [ ] | [ ] | [ ] | [ ] | [X] | [ ] | [ ] | [ ] | [ ] |

**SKILLED AREAS - DISCHARGE STATUS**

| | Ind. | Mod. Ind. | Sup. | SBA | Min. | Mod. | Max. | Total | N/A |
|---|---|---|---|---|---|---|---|---|---|
| Bed Mobility | [ ] | [X] | [ ] | [ ] | [ ] | [ ] | [ ] | [ ] | [ ] |
| Supine - Sit | [ ] | [X] | [ ] | [ ] | [ ] | [ ] | [ ] | [ ] | [ ] |
| Sit.- Stand | [ ] | [X] | [ ] | [ ] | [ ] | [ ] | [ ] | [ ] | [ ] |
| Ambulation | [ ] | [ ] | [X] | [ ] | [ ] | [ ] | [ ] | [ ] | [ ] |
| Curb /Ramp | [ ] | [X] | [ ] | [ ] | [ ] | [ ] | [ ] | [ ] | [ ] |
| WC-Scooter Prop/Mgmt | [ ] | [X] | [ ] | [ ] | [ ] | [ ] | [ ] | [ ] | [ ] |
| Tub / Shower Transfer | [ ] | [ ] | [X] | [ ] | [ ] | [ ] | [ ] | [ ] | [ ] |
| Toileting Transfer | [ ] | [ ] | [X] | [ ] | [ ] | [ ] | [ ] | [ ] | [ ] |

**Home Exercise Program: Instructed:**
[ ] N/A [X] Yes [ ] No [ ] Written [ ] Verbal [ ] Visual Format

**Post Discharge Needs/DME's:** [X] N/A

**Comments:** [X] N/A

**Is patient still Homebound?:**
(●) Yes ( ) No

**Recommend Outpatient / Med B Therapy?:**
( ) Yes (●) No

**Discharge Coordination:**
[ ] N/A [X] MD [ ] Patient / CG [X] SN [ ] PT / PTA [ ] OT / COTA [ ] ST [ ] SW [ ] Other

**Signature** _____

PT DC Summary

Complete the skilled areas-evaluation status and discharge status.

You may need to refer back to your intial eval to recall patient's status level for the skilled areas listed.


Copyright © 1998-2017 Golden Rule Software, Inc.

## CARE PORTAL

1. Login – Username and Password
2. Mode – POINT OF CARE
3. MENU –
    - MY DASHBOARD
    - MY SCHEDULE / CALENDAR VIEW
    - MY SCHEDULE / LIST VIEW
    - MY OPEN DOCUMENTS
    - MY HOTLIST MESSAGES
    - SELECT PATIENT
    - NEW PATIENT
    - PHYSICIAN LOOKUP

## OPENING A VISIT IN CARE PORTAL

1. Scheduled visit is found in My Dashboard, My Schedule / Calendar View, My Schedule / List view.
2. Click on the scheduled visit you want to open.
3. Pt / Note / OASIS/485 / Back (are options to choose from)
4. PT doing the **SOC/OASIS**= Choose OASIS then **1-PT Start of Care** (OASIS/485/Eval) (service transaction code automatically set to AD, admission visit)
5. For **PT evaluation (RN did the SOC)** = Choose Note then **Care Portal PT evaluation** (service journal transaction code automatically set to TEV, therapy evaluation visit)
6. For Follow up visit **NOTES** = Choose Note then **Care Portal PT Revisit Note** (service journal transaction code automatically set to RV, routine visit)
7. For **30-day re-evaluation**= Choose Note then **Care Portal PT Re-evaluation Note**/choose service journal transaction code as RV, routine visit
8. PT **discharging PT services** (other disciplines remain) = Choose Note then **Care Portal DC Summary/**select appropriate service journal transaction code: either DC, discharge visit or NB, Non-Billable (if no visit made)

9. PT doing the **DC/OASIS** = Choose OASIS then **9-Discharge from Agency-Not to an Inpatient Facility** (service journal transaction code automatically set to DC, Discharge visit)
10. If **PT did SOC/OASIS** & patient is **hospitalized** = Choose OASIS then **6-Trasferred to an Inpatient Facility-Patient not discharged from agency** (service journal transaction code automatically set to DO, documentation only)
11. If PT completed TIF, upon hospital discharge= Choose OASIS then **PT Resumption of Care (OASIS/Eval)** (service journal transaction code automatically set to ROC, resumption of care)
12. PT doing the **recertification** =Choose OASIS then **4-PT Recertification (OASIS/485)** (service journal transaction code automatically set to RCV, recert visit)

## HOW TO CHANGE DATE OF VISIT

1. Click on MY SCHEDULE / CALENDAR VIEW.
2. Click on the MOVE menu.
3. Click on the SCHEDULED DATE you want to move on the calendar.
4. Double click on the CORRECT DATE to open it.

## HOW TO MAKE THE PATIENT SIGN ON CARE PORTAL

OASIS AND NOTES:

1. Once in the first page of the document, click the NEXT tab,
2. Answer the questions especially with the BLUE ASTERISK.
3. Click on SAVE / EXIT tab.
4. The first page of the document will show again but the tab PATIENT SIG. will show up.
5. Click on PATIENT SIG. and let patient sign on top of the line and do not forget to SAVE.