Therap
Resource Packet

Therap Resource Packet Tips for Use

- Please save a copy of this Resource Packet electronically.
- Take some time to thoroughly review all the required components in Therap
- In the future, you can navigate through this packet by clicking on the hyperlinks in the Table of Contents *OR* you can search this packet by keyword by typing “CTRL” + “F”

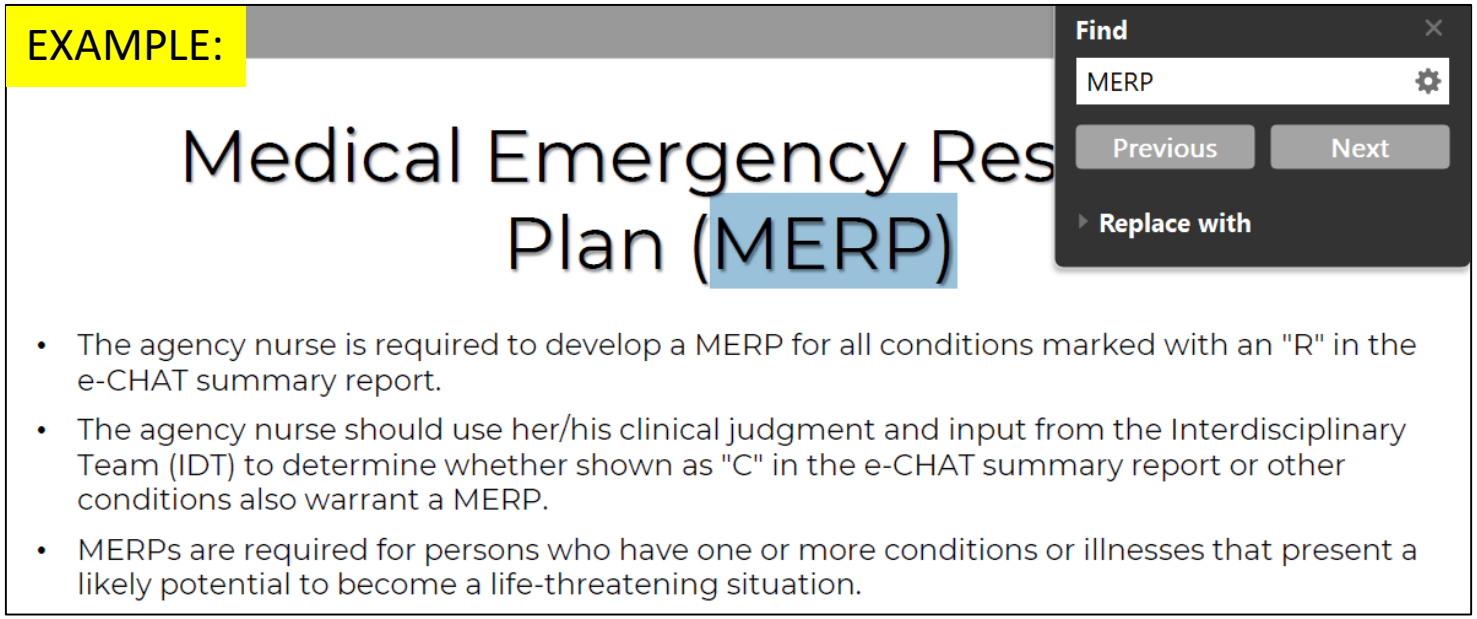

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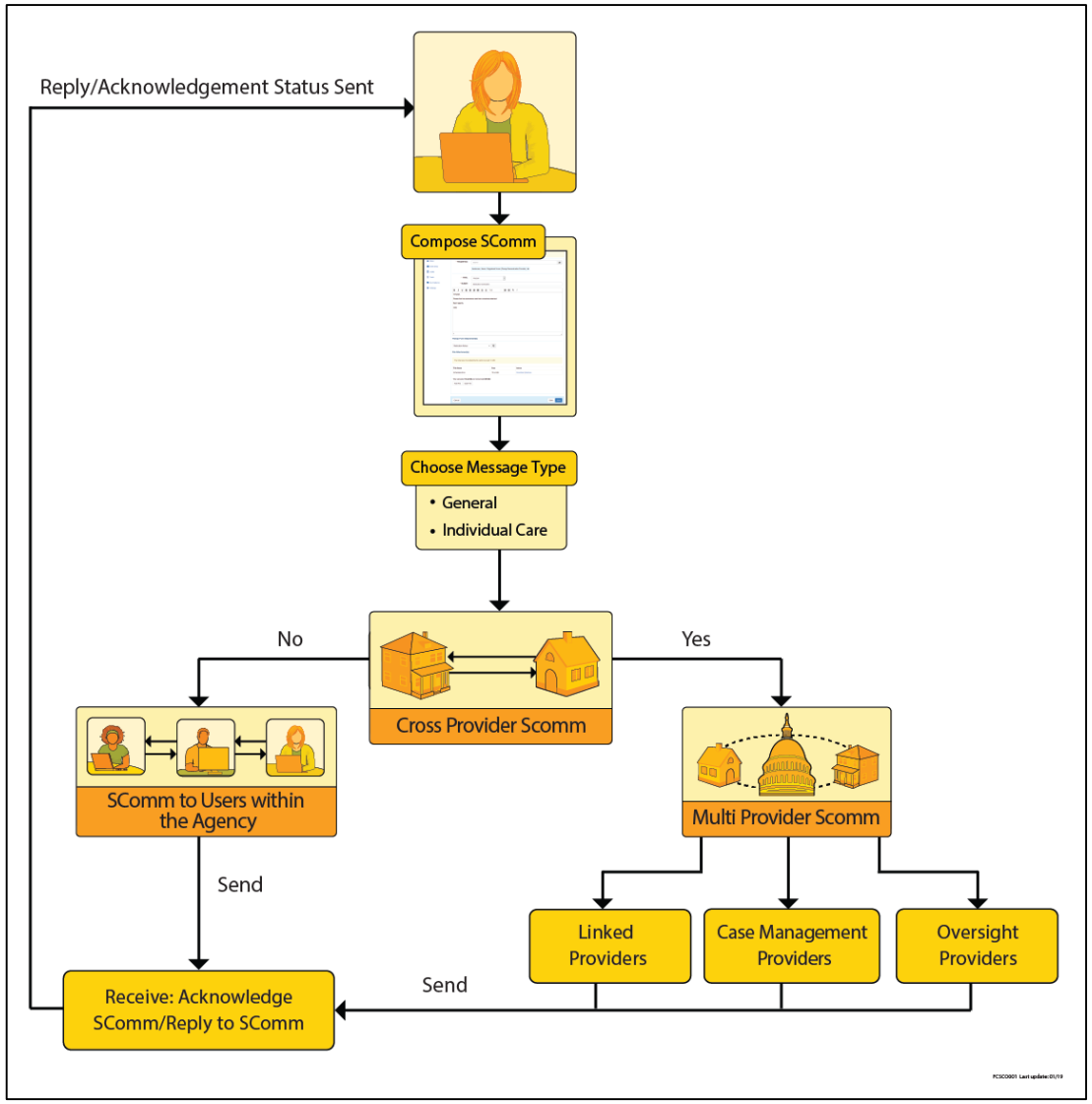
Table of Contents

Click on each topic area to go to that topic or navigate via the bookmark column on the left.

S-COMM

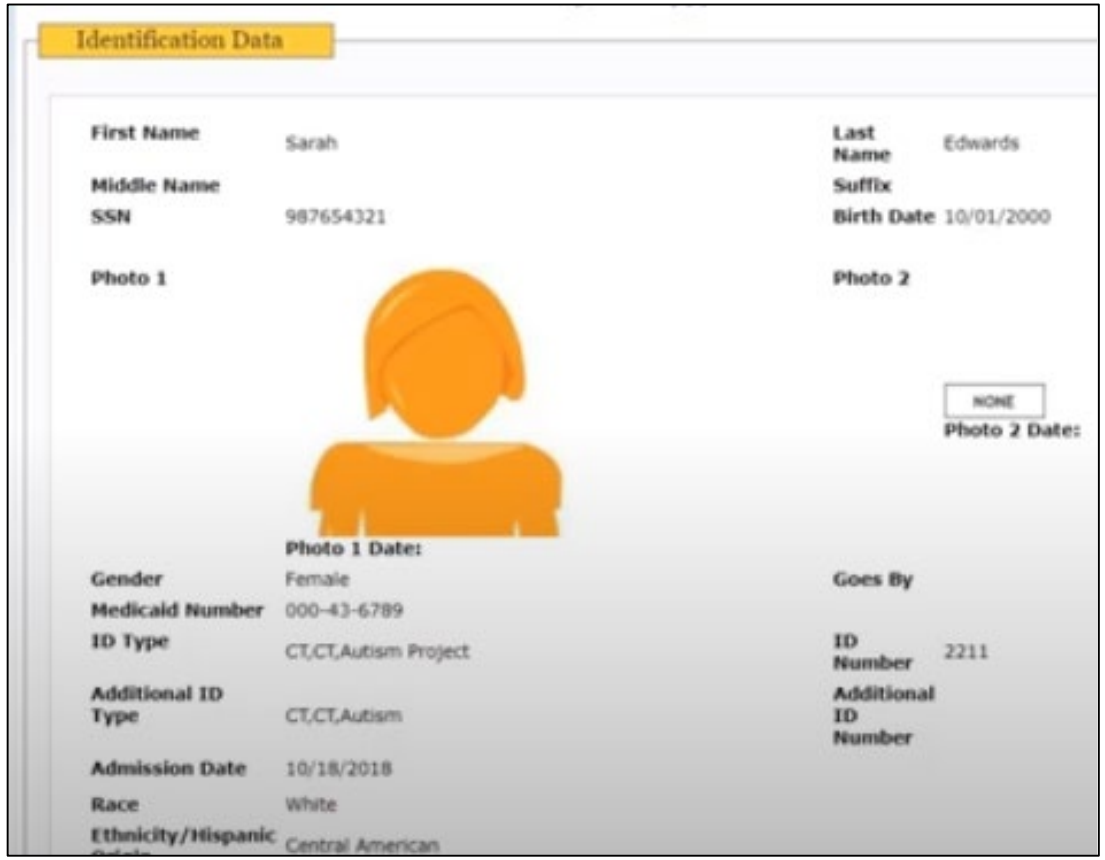


- Secure Communications (S-COMM) is the only email system to be used for all secure communication with the person's interdisciplinary team members.

Therap Tutorial(s): S-COMM

- https://help.therapservices.net/app/results/kw/s-comm

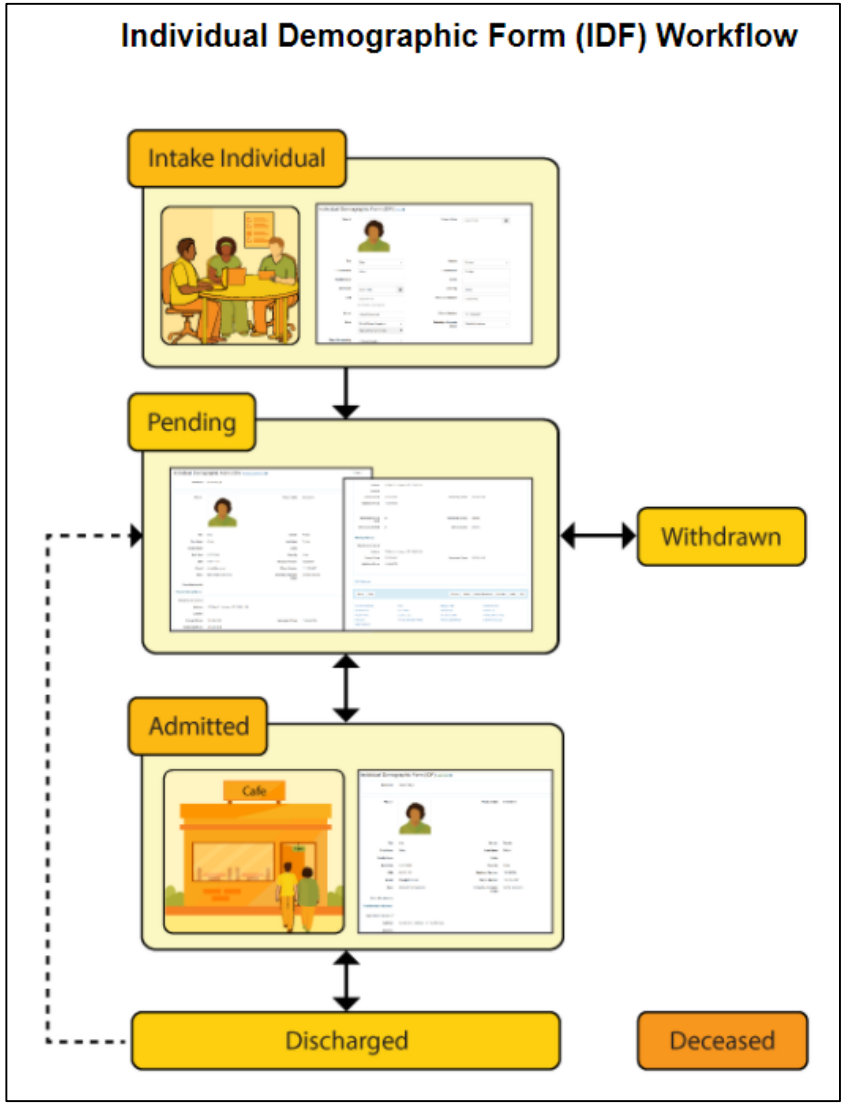
Individual Demographic Form (IDF)



Provides:

- An overview of demographic information as well as other key personal, programmatic, insurance, and health related information.
- Medical information
- Assistive technology or adaptive equipment
- Diagnoses
- Allergies
- Information about whether a guardian or advance directives are in place
- Information about behavioral and health related needs
- Contacts of provider agencies and team members and other critical information.

Individual Demographic Form (IDF)

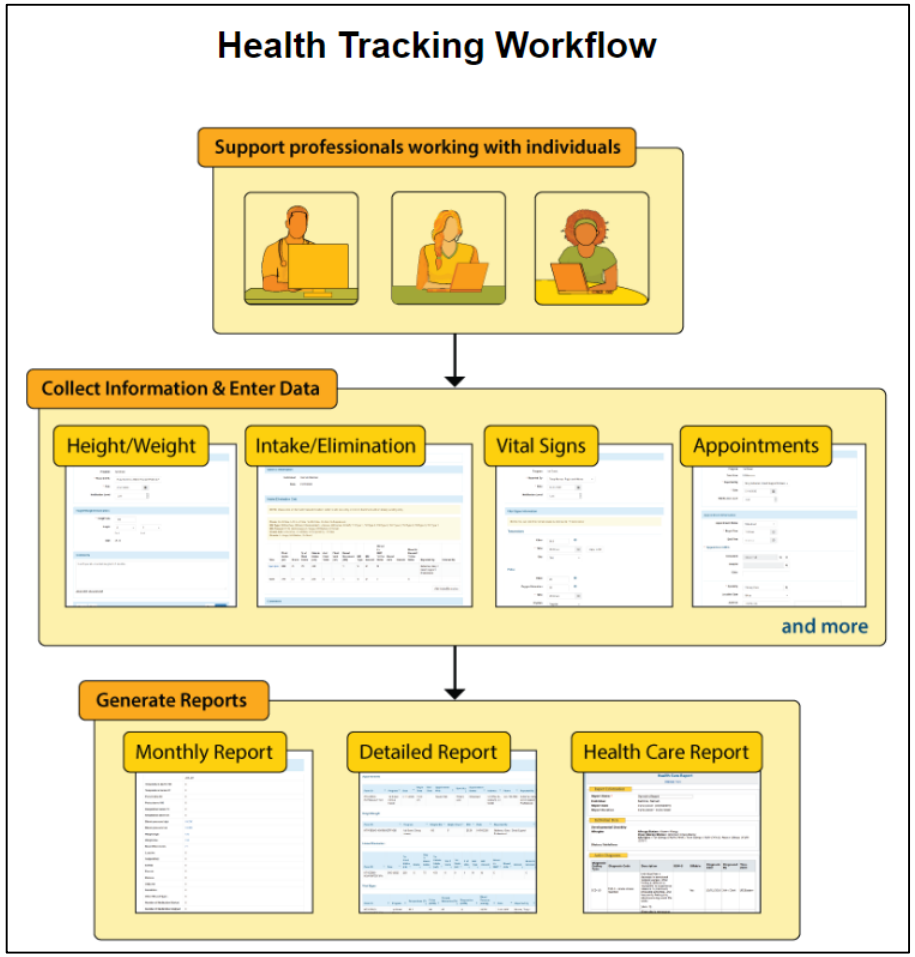


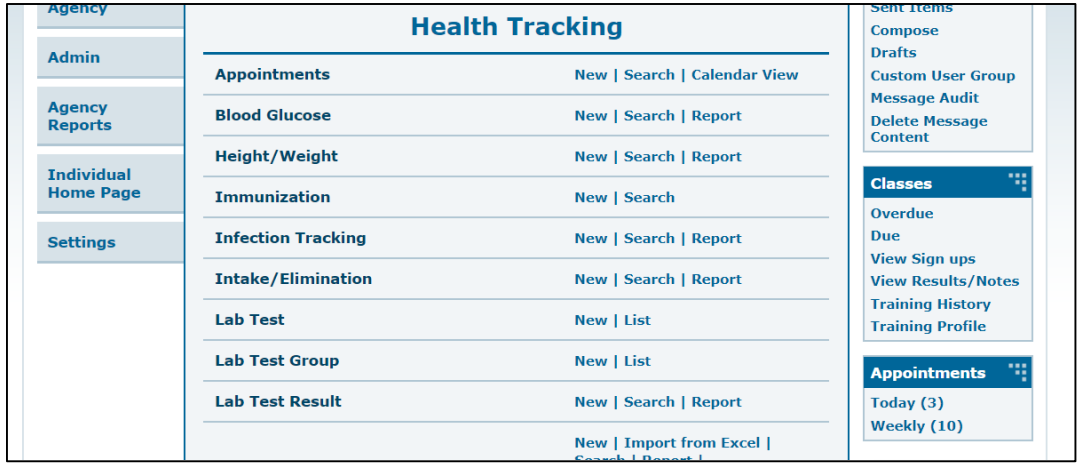
- The IDF is initiated by the CM.
- The IDF must be updated by Living Supports, CCS-Group, ANS, CIHS and case management when applicable in order to ensure accurate data will be auto populate to other documents such as the Health Passport and Physician Consultation Form.
- Although the Primary Provider Agency is responsible for keeping this form current, each provider **collaborates and communicates** critical information to update this form.
- The IDF automatically loads information into other fields and forms and must be complete and kept current.

Therap Tutorial(s): IDF

- https://help.therapservices.net/app/results/kw/individual%20demographic%20form

Health Tracker





The Health Tracker contains multiple required elements designed to support the Healthcare Coordinator, DSP, supervisors, nurses, CMs in tracking, communicating and acting upon changes in health status.

Information from Health Tracker may be shared with other members of the IDT as needed.

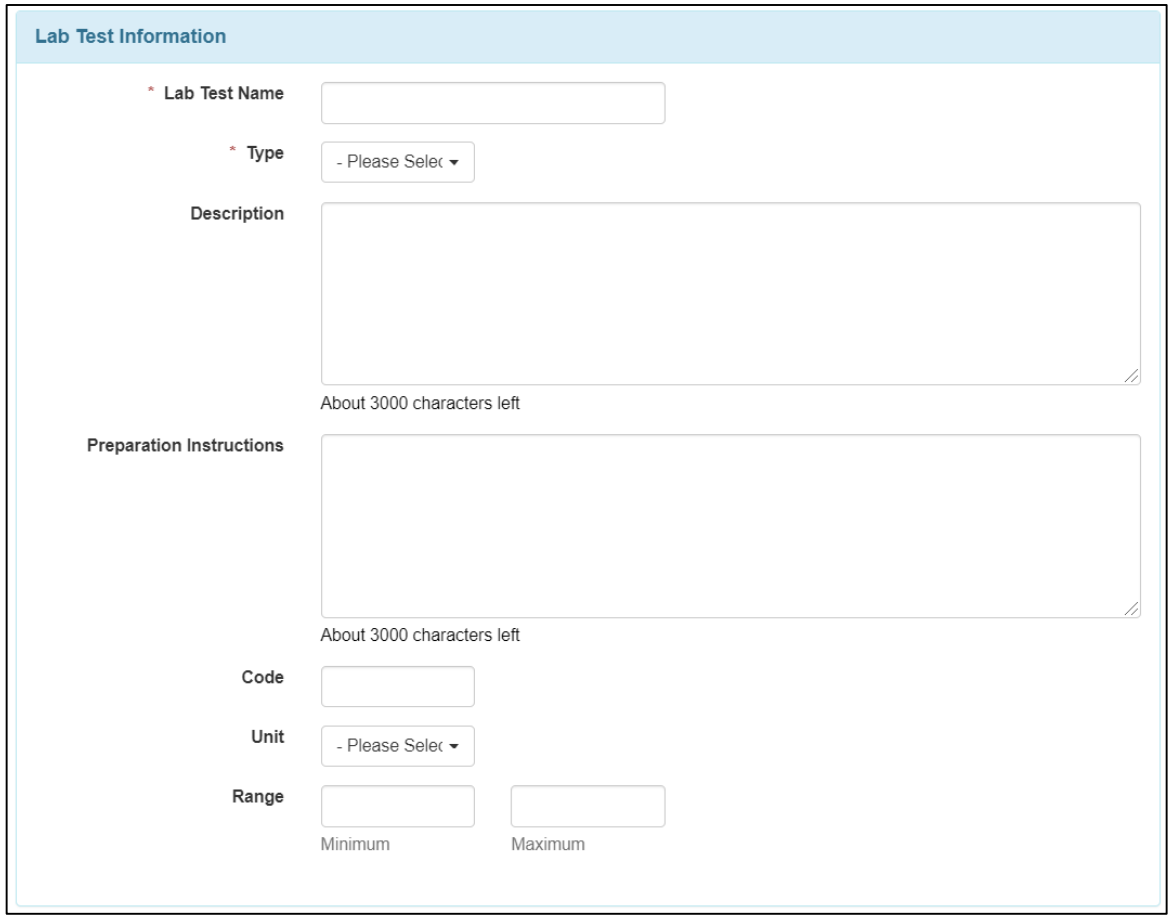
Appointments, Results, and Follow-Up

Appointments, results and follow Ups must be entered in Therap within **seven calendar days** of the related activity for all appointments that the provider (Primary or Secondary) assisted the person to arrange or to attend.

Therap Tutorial(s):

- https://help.therapservices.net/app/answers/detail/a_id/276/kw/enter%20appointments

Lab Tests and Results



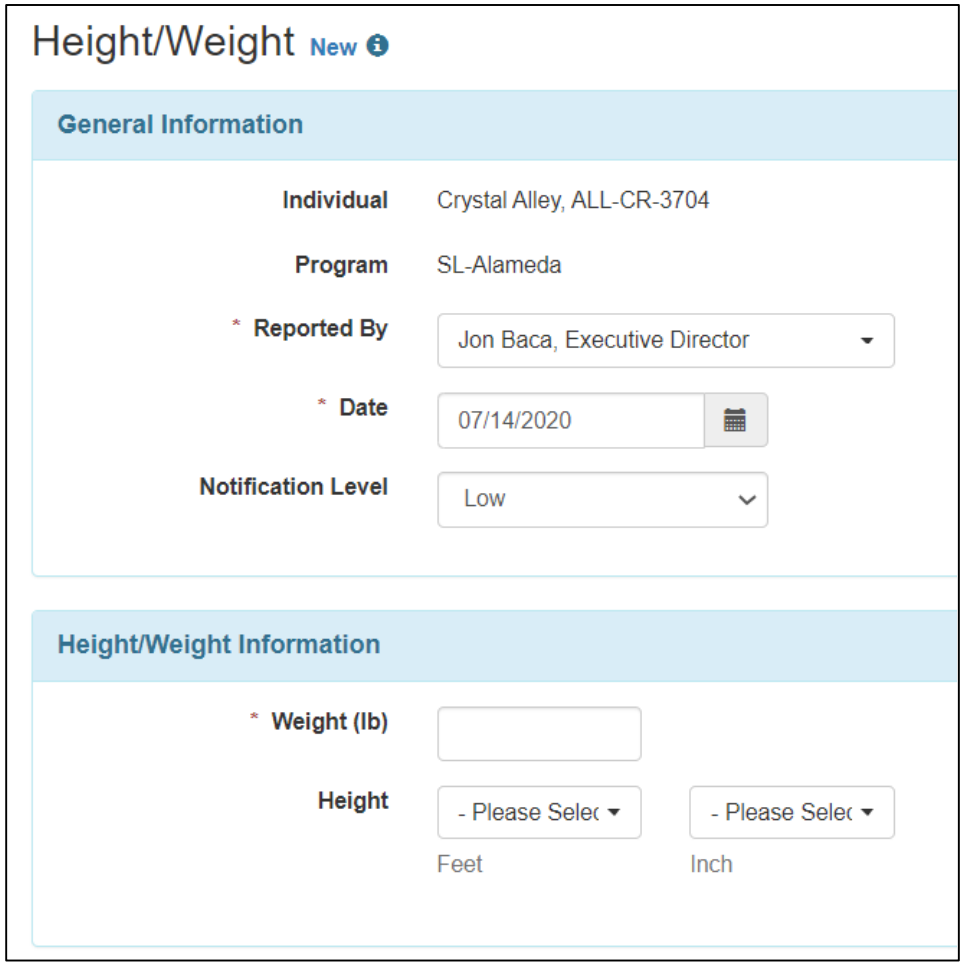
Lab tests and Results must be entered in Therap by the Primary Provider Agency within **seven calendar days** of receiving results, if the person has routine or standing lab orders and the Provider Agency assists the person to arrange or obtain such lab work.

Lab results may be attached to an appointment titled as “Lab Results”.

Therap Tutorial(s):

- https://help.therapservices.net/app/answers/detail/a_id/306

Height and Weight



Height and weight must be completed by both the Primary Provider Agency and any Secondary Provider Agencies that support the person at least annually.

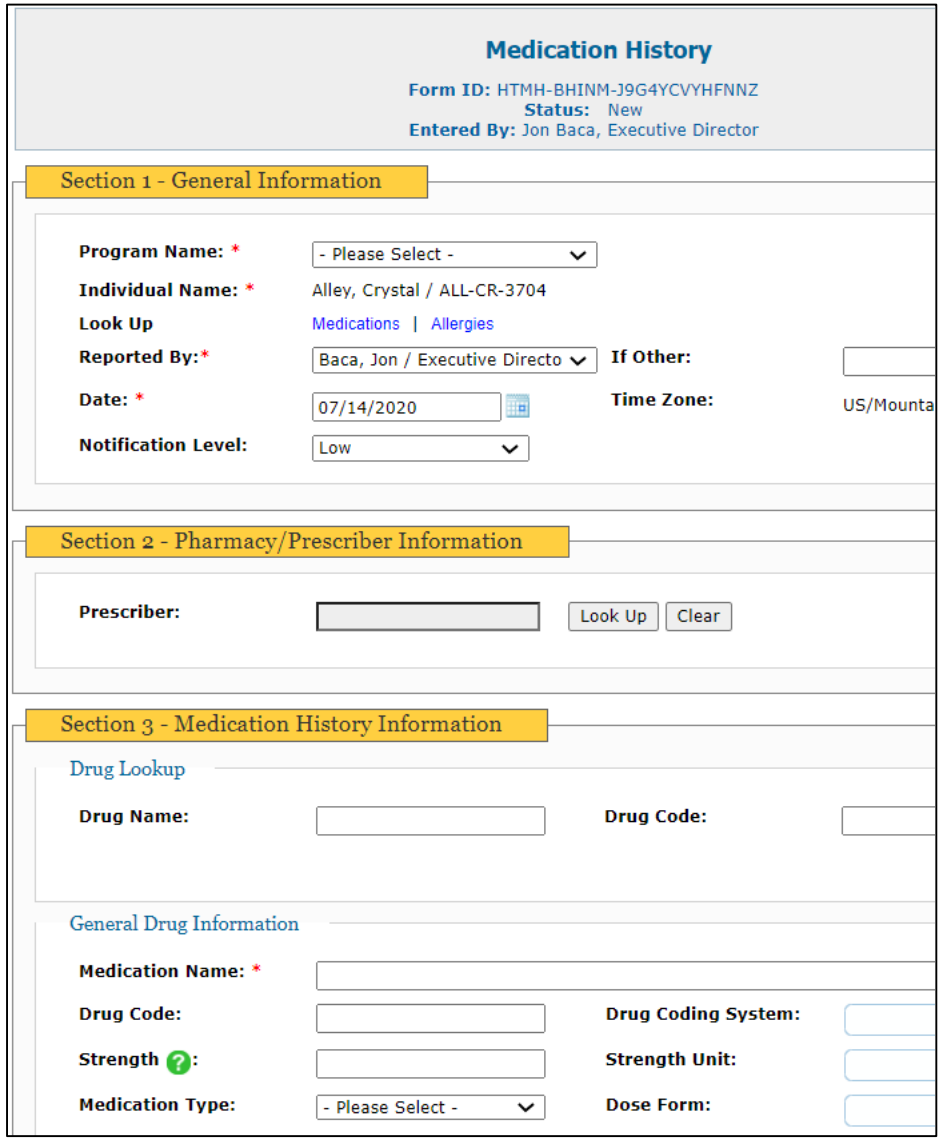
The frequency of data collection depend on orders from the physician, recommendations from IDT members, HCPs, or prudent nursing judgement.

Data collected must be entered in this section of Health Tracker within 24 hours of the data collection.

Therap Tutorial(s):

- https://help.therapservices.net/app/answers/detail/a_id/285/kw/enter%20height%20and%20weight

Medication History



Medication history must be completed by the Primary Provider Agency for all individuals.

If the CM is the Primary Provider Agency responsible for data entry, the only required element of the Health Tracker is Medication History.

New medications or treatments and any changes to medication or treatment orders for the person must be updated in this section as soon as possible but no later than 24 hours after the change.

Therap Tutorial(s):

- https://help.therapservices.net/app/results/kw/enter%20medication%20history/page/1

Medical Emergency Response Plan (MERP)

- The agency nurse is required to develop a MERP for all conditions marked with an "R" in the e-CHAT summary report.
- The agency nurse should use her/his clinical judgment and input from the Interdisciplinary Team (IDT) to determine whether shown as "C" in the e-CHAT summary report or other conditions also warrant a MERP.
- MERPs are required for persons who have one or more conditions or illnesses that present a likely potential to become a life-threatening situation.
- The MERP cannot be combined with or replace the HCP. Measures to prevent a life-threatening condition are addressed in the HCP.
- The MERP must be written in clear, jargon-free language
- MERPs must be linked/attached into the Therap system and available in the service setting.
- Revisions authored by an LPN must have RN review and approval as indicated by review date and signature.
- If the emergency response involves delivery of a PRN medication, the prior consultation with the agency nurse is required
- The aspiration MERP may not be combined with any other condition.

Medical Emergency Response Plan (MERP)

The MERP must include at a minimum the following information:

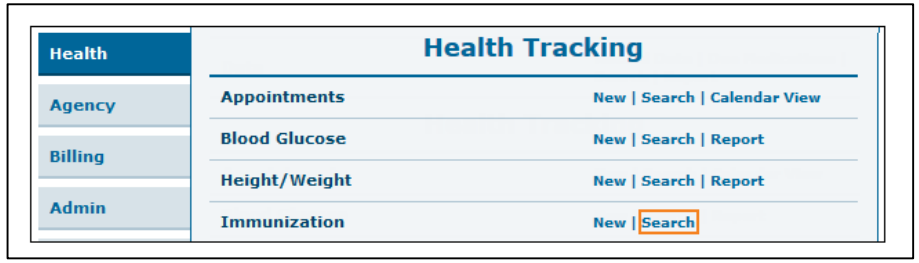
- A brief and simple description of the condition or illness with the most likely life-threatening complications that might occur.
- How those complications may appear to an observer.
- Clear, jargon free, step-by-step instructions regarding the actions to be taken by DSP and/or others to intervene in the emergency, including criteria for when to call 911 directly.
- List of emergency contacts with phone numbers.
- Reference to whether the person has advance directives or not, and if so, where the advance directives are located if pertinent to the MERP.

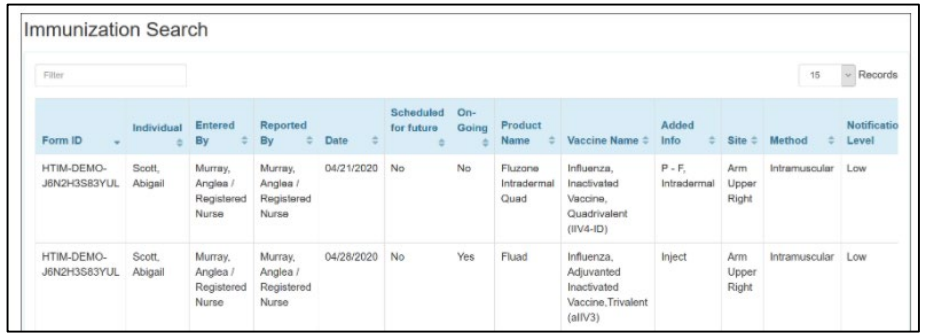
Healthcare plans and MERPS are discussed in more detail in the Care Planning training.

Therap Tutorial:

- https://help.therapservices.net/app/results/kw/enter%20medication%20history/page/1

Other Health Tracker Entries





Therap Tutorial(s): Immunizations

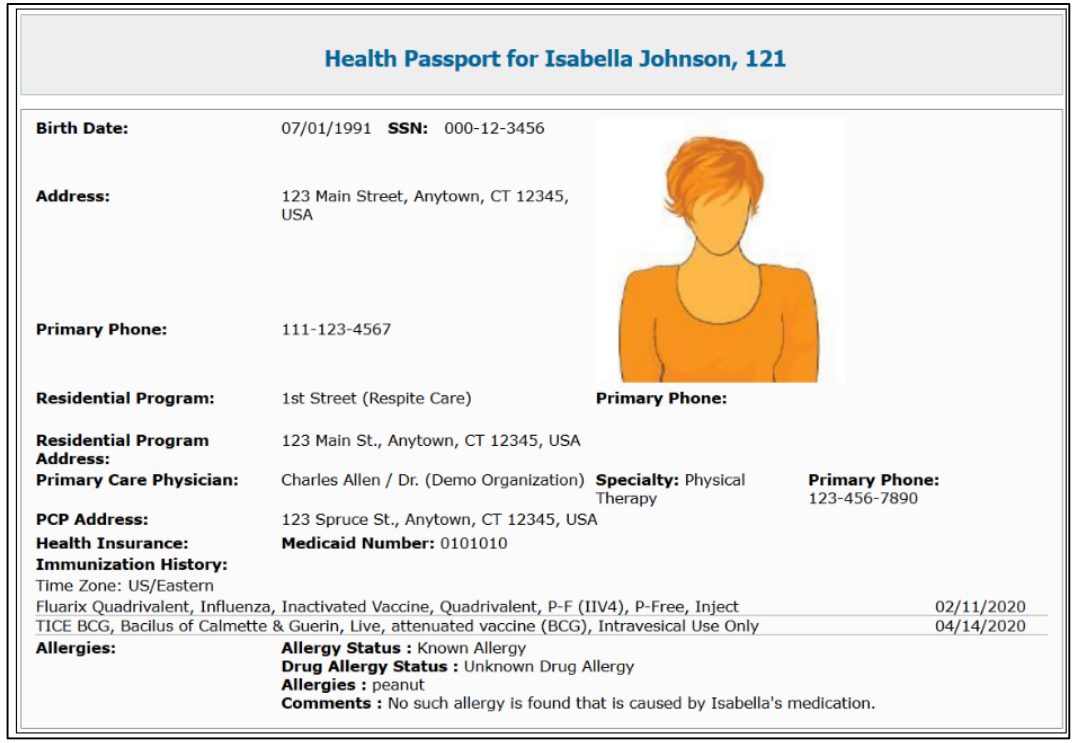
- https://help.therapservices.net/app/results/kw/immunizations/page/1

All Provider Agencies are responsible for entering Blood Glucose, Height/Weight, Infection, Intake/Elimination, Menses, Respiratory Treatment, Seizures, Skin/Wound, and Vital Signs in Therap within 24 hours of the data collection when these tasks, data collection or tracking are part of a BSP, HCP or a MERP during the time of service delivery.

All pressure ulcers are assessed for size, stage and healing and documented by nurses at least weekly.

Immunizations – must be entered in Therap within seven calendar days of any completed immunizations

Health Passport and Physician Consultation Form



Health Passport for Isabella Johnson, 121

Birth Date: 07/01/1991 **SSN:** 000-12-3456

Address: 123 Main Street, Anytown, CT 12345, USA

Primary Phone: 111-123-4567

Residential Program: 1st Street (Respite Care)

Primary Phone:

Residential Program Address: 123 Main St., Anytown, CT 12345, USA

Primary Care Physician: Charles Allen / Dr. (Demo Organization) **Specialty:** Physical Therapy **Primary Phone:** 123-456-7890

PCP Address: 123 Spruce St., Anytown, CT 12345, USA

Health Insurance: **Medicaid Number:** 0101010

Immunization History:

Time Zone: US/Eastern

Fluarix Quadrivalent, Influenza, Inactivated Vaccine, Quadrivalent, P-F (IIV4), P-Free, Inject	02/11/2020
TICE BCG, Bacilus of Calmette & Guerin, Live, attenuated vaccine (BCG), Intravesical Use Only	04/14/2020

Allergies:

Allergy Status : Known Allergy
Drug Allergy Status : Unknown Drug Allergy
Allergies : peanut
Comments : No such allergy is found that is caused by Isabella's medication.

Therap Tutorial(s): Health Passport

- https://help.therapservices.net/app/results/kw/health%20passport/page/1

All Primary and Secondary Provider Agencies must use the Health Passport and Physician Consultation form when generated from an e-CHAT in the Therap system.

This standardized document contains individual, physician and emergency contact information, a complete list of current medical diagnoses, health and safety risk factors, allergies, and information regarding insurance, guardianship, and advance directives.

The Health Passport also includes a standardized form to use at medical appointments called the Physician Consultation form.

The Physician Consultation form contains a list of all current medications.

Requirements for the Health Passport and Physician Consultation Form

- Provider Agencies must document that the Health Passport, Physician Consultation form, and Advanced Healthcare Directives were delivered to the treating healthcare professional by one of the following means:
  - Document delivery using the Appointments Results section in Therap Health Tracking Appointments; and
  - Scan the signed Physician Consultation Form into Therap after the person returns from the healthcare visit.
- The CM and Primary and Secondary Provider Agencies must communicate critical information to each other and will always keep all required sections of Therap updated in order to have a current and thorough Health Passport and Physician Consultation Form available .
- Required sections of Therap include the IDF, Diagnoses, and Medication History.
- The Primary and Secondary Provider Agencies must ensure that:
  - A current copy of the Health Passport and Physician Consultation form are printed and available at all service delivery sites.
  - The current Health Passport and Physician Consultation form accompany the person to a medical appointment, urgent care, emergency room, or when admitted to a hospital or nursing home.
- The Physician Consultation form must be reviewed, and any orders or changes must be noted and processed as needed by the provider **within 24 hours.**

Nursing Assessment Tools

Nursing assessment tools includes the:

- e-CHAT (Comprehensive Health Assessment)
- ARST (DDSD Aspiration Risk Screening Tool)
- MAAT (Medication Administration Assessment Tool)
- When a LPN completes the ARST and MAAT and contributes to the e-CHAT, the RN is required to review, edit if needed, and approve the e-CHAT within three business days

The tools includes developing and training Health Care Plans (HCP) and Medical Emergency Response Plans (MERP).

The hierarchy for Nursing Assessment and Planning responsibilities is:

- Living Supports: Supported Living, IMLS or Family Living via ANS;
- Customized Community Supports- Group; and
- Adult Nursing Services (ANS):
    - for persons in Community Inclusion with health-related needs; or
    - if no residential services are budgeted but assessment is desired and health needs may exist..

e-CHAT

An e-CHAT is required for persons in FL, SL, IMLS, or CCS-Group. All other DD Waiver recipients may obtain an e-CHAT if needed or desired by adding ANS hours for assessment and consultation to their budget.

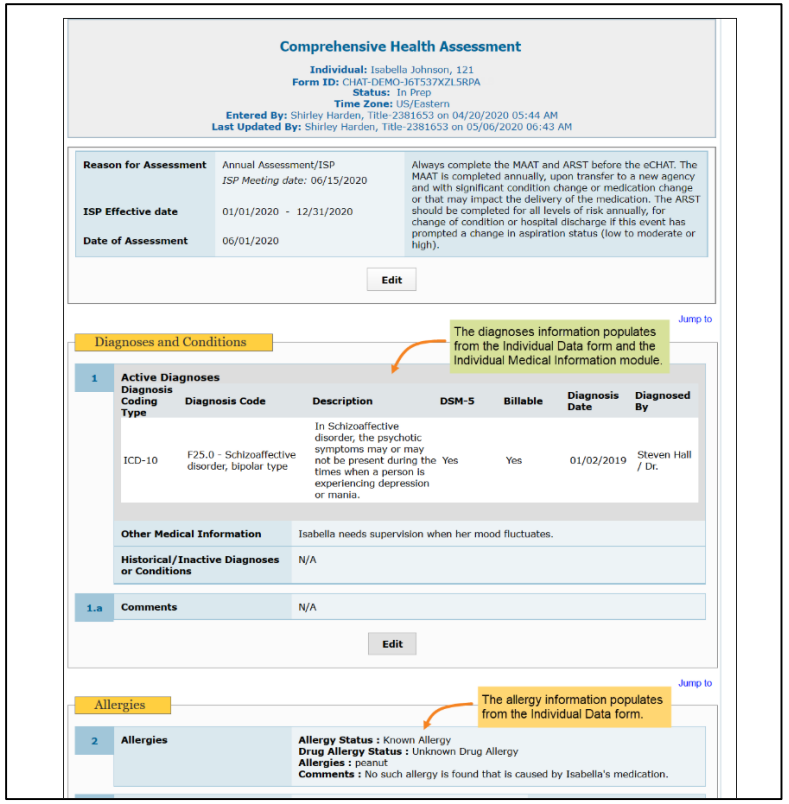
The e-CHAT is a nursing assessment. It may not be delegated by a licensed nurse to a non-licensed person.

LPN may contribute to but may not approve the e-CHAT.

Non-nurses may not complete or approve the e-CHAT.

- Non-nurses may only enter data into the e-CHAT.
- This data may only be from a paper version of the e-CHAT that has been completed, signed, and dated by an RN.
- Data entry must occur within **three business days of completion**.
- The RN is required to review and electronically approve the e-CHAT within three business days after data entry.
- The original signed and dated paper version must be retained in the agency file.

e-CHAT



Therap Tutorial(s): e-CHAT

- https://help.therapservices.net/app/results/kw/echat/page/1

The nurse must see the person face-to-face to complete the nursing assessment.

Additional information may be gathered from members of the IDT and other sources.

When completing the e-CHAT, the nurse is required to review and update the electronic record and consider the diagnoses, medications, treatments, and overall status

Discussion with others may be needed to obtain critical information.

The nurse is required to complete all the e-CHAT assessment questions and add additional pertinent information in all comment sections.

The final comment section will reflect the nurse's complete clinical assessment of the person's current health status which must include:

- Additional narrative notes regarding any health-related issues that were not previously captured;
- A synopsis of progress toward achieving care planned goals for persons with established plans; and
- The actions and decisions regarding HCPs or MERPs.

e-CHAT Summary Report

- Once the e-CHAT is completed THERAP automatically generates a “Summary Report”. Dates for HCPs and MERPs must be noted on the e-CHAT Summary Sheet and updated as plans are created or revised.
- The narrative section of the e-CHAT Summary Sheet is used to document when persons, or guardians of persons, who reside with biological Family Living providers opt out of Ongoing Adult Nursing Services.
    - The notes will indicate the reason why the nurse did not proceed with plans that are required or were to be considered based on the e-CHAT.
- Each field from the e-CHAT is included in the Summary Report.
- If there is information in a particular e-CHAT field that needs a health care plan will show on the Summary Report.
- Finally the Summary Report assigns an acuity (Low, Moderate or High) rating for each individual.
    - This acuity together with the aspiration risk level will decide how often the nurse will do their face-to-face visits.
- In collaboration with the IDT, the agency nurse is required to create HCPs that address all the areas identified as required (“R”) in the most current e-CHAT summary.
- The nurse should use nursing judgment to determine whether to also include HCPs for any of the areas indicated by “C” on the e-CHAT summary report.

Therap Tutorial(s): https://help.therapservices.net/app/answers/detail/a_id/1353

Aspiration Risk Management Screening Tool (ARST)

- For all adults and young adults allocated to the DD Waiver who do not receive CCS-Group or Living Supports, but receive other DD Waiver services, Aspiration Risk Screening and ARM supports are optional. If there is a concern about possible aspiration risk, Adult Nursing Services (ANS) must be added to the budget so that the nursing assessment, including aspiration risk screening may be completed.
- A nurse screen for aspiration risk at specific indicated times by using the ARST.
    - Annually, 45-14 calendar days prior to the annual IDT meeting;
    - Within three business days after a significant change of condition, or unplanned weight loss greater than or equal to 10% of body weight or 10 lbs. in the last six months,
    - Initiation of enteral feeding,
    - Following any hospital admission and following outpatient treatment for aspiration pneumonia,
    - Transfer or admission to a new living support agency.

Care must be taken with the last high-risk criteria because it has two parts.

The person will be at high risk only if ***both*** parts are present.

Care should also be taken to the statement as to the end of the ARST.

- Example: "*Clearly documented viral pneumonia is not an indicator of aspiration. However, if type of pneumonia is unknown, assume high risk if in conjunct with any other risk factor on this form.*"

Aspiration Risk Management Screening Tool (ARST)

If the person is *initially* determined to be moderate- or high-aspiration risk:

Within **TWO** business days the nurse will:

- documents the result and notify the CM
- Contacts the PCP within to discuss the need for diagnostic procedures for the initial finding.

Within **THREE** calendar days the nurse will:

- develop and train an interim Health Care Plan (HCP) with the Eating Specialist (when available)

The CM will do the following after they are notified of the result

- notify the IDT of the result, within **two business days**.
- notify and consult with the person, guardian, and IDT members to determine if additional services are needed to complete the **Collaborative Aspiration Risk Assessment.**
- schedules the Comprehensive Aspiration Risk Assessment within **30 calendar** days from the date of the initial screening.

When a CARMP is in place, the IDT continues with the current CARMP while the IDT reviews the CARMP and makes changes as indicated.

Therap Tutorial(s): https://help.therapservices.net/app/answers/detail/a_id/1033/kw/Aspiration%20Risk%20Management%20Screening%20Tool

DDSD Medication Administration Assessment Tool (MAAT)

Decisions about medication delivery are made by the IDT to promote a person's maximum independence and community integration. The IDT will reach consensus regarding which criteria the person meets, as indicated by the results of the MAAT and the nursing recommendations, and the decision is documented this in the ISP. Options include:

- Self-administration;
- Self-administration with physical assistance by staff;
- Assistance with medication delivery (AWMD) by staff;
- Medication administration by licensed/certified personnel (RN, LPN and CMA); or
- Mode of medication delivery determined by the guardian when a consensus cannot be reached.

After the IDT determines which criteria the person meets, the agency nurse will obtain needed orders from the PCP.

A licensed nurse completes the MAAT at least two weeks before the annual ISP meeting.

The nurse will present the level of assistance with medication delivery (AWMD) to the IDT.

A copy of the MAAT will be sent to all the team members two weeks before the annual ISP meeting and the original MAAT will be retained in the Provider Agency records.

Therap Tutorial(s): https://help.therapservices.net/app/answers/detail/a_id/348/kw/MAAT

Health Care Plans

- At the nurse's discretion, based on prudent nursing practice, **interim HCPs** may be developed to address issues that must be implemented immediately after admission, readmission or change of medical condition to provide safe services prior to completion of the e-CHAT and formal care planning process. This includes interim ARM plans for those persons newly identified at moderate or high risk for aspiration. All interim plans must be removed if the plan is no longer needed or when final HCP including CARMPs are in place to avoid duplication of plans.
- HCPs must include a statement of the person's health conditions and needs, and with measurable goals to be achieved by implementing the HCP.
- HCP must be reviewed semi-annually to determine its effectiveness and must be revised as needed. **The review must be documented.**
- HCPs or revisions authored by an LPN must have RN review and approval.
- Each HCP must be reviewed, developed, or revised within *five business days* of hospital or rehabilitation discharge or change of medical condition.
- Interventions that may prevent a medical emergency must be addressed in each HCP to support the actions identified in the corresponding MERP.
- HCPs (including the CARMP) and MERPs must be linked and attached in Therap.
- The CARMP is the designated HCP for Aspiration Risk Management (ARM). All aspiration-related plans (tube feeding and oral hygiene) must be incorporated into the CARMP and removed.
- HCPs and goals should be revised when: a person's needs have changed; the goal has been met; there is potential to attain a new or additional goal; a maintenance or palliative goal is no longer appropriate; or the person no longer requires supports to attain the goal.

Health Care Plans

- HCPs must be personalized to reflect the person's unique needs,
- HCPs should provide guidance to the DSP and should be designed to support successful interactions.
- HCPs should include person-specific subtle or atypical signs of illness or pain so that DSP and other staff are able to promptly identify these.
- Some interventions may be carried out by DSP, family or other team members, while other interventions may be carried out exclusively by an agency nurse.
    - The persons responsible for each intervention or strategy must be specified in the plan by discipline and/or title.
- Interventions or strategies must be written in plain language that is easily understood.
- Include the person's name and date of birth on the HCP and on each paper page.
- The HCP must be signed by the author.
- When Hospice or Palliative care services are utilized, DD Waiver Provider Agency nurses must develop new or edit existing HCPs and MERPs to reflect the person's condition and desires.
- Plans must clearly indicate steps that DSP need to take and who to contact first when health conditions change.

Comprehensive Aspiration Risk Management Plan (CARMP)

- CARMP Draft in Questionnaire forms in Therap is where the Multidisciplinary development or the revision process of the CARMP is shared. CARMP Draft eliminates the need to use any email system during the development/revision of the CARMP. The CARMP Draft in Therap provides a secure, shared point of access for team members to access, download, and upload a working CARMP Draft.
  All teams will start using "CARMP Draft in Questionnaire forms" in Therap on June 1, 2020.
- The initial CARMP will be developed, trained, and implemented within 90 days after the ARST was completed.
- Annual re-evaluation of the CARMP is done 45 -14 days prior to the annual IDT and completed 21 days prior to new ISP cycle.
- Annual training of ongoing CARMP must be completed within 30 days of ISP effective date
- New or revised CARMP strategies will be trained within 30 days of induction.
- Attach finalized CARMP in plans within Therap.

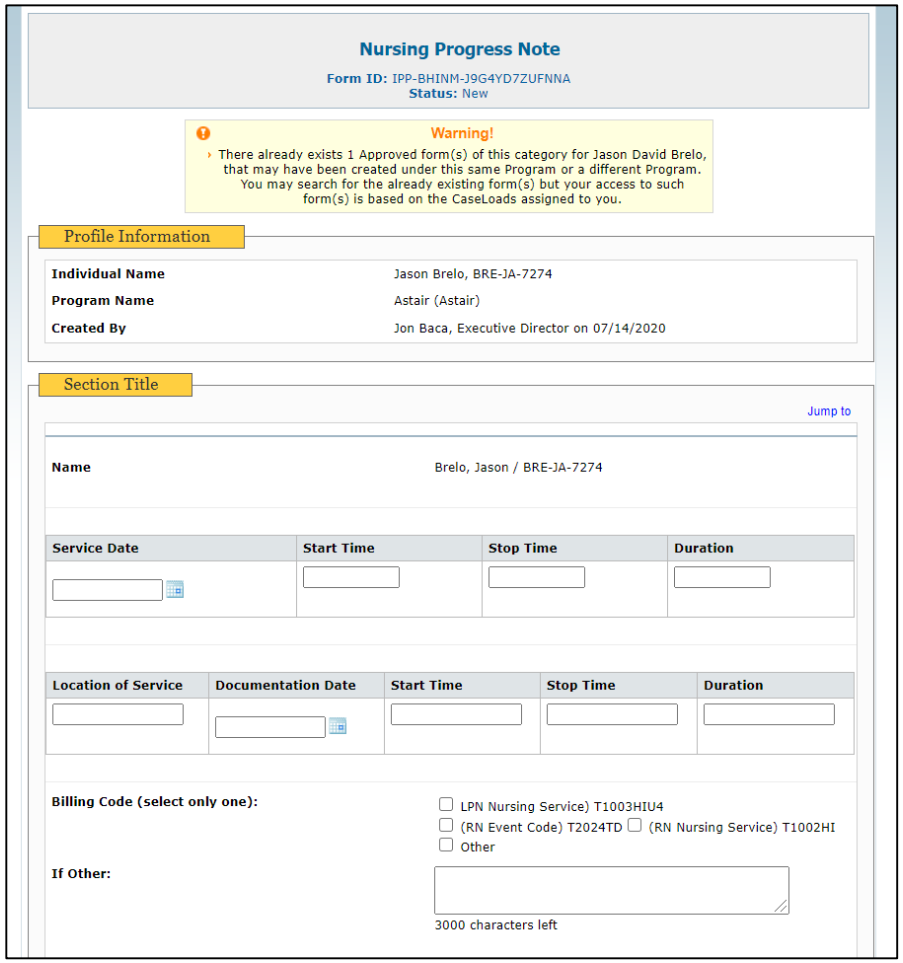
Therap Tutorial(s): CARMP

- https://help.therapservices.net/app/answers/detail/a_id/3789

Documentation for Nurses

- Documentation of all professional nursing activities is required to be timely, accurate and in accordance with these standards.
- All interactions with the person, healthcare providers, families, and DSP are documented in a signed progress note or log indicating time, date, reason for the call or visit, the outcome, and any planned next steps.
- Nursing visits conducted to monitor health status or to evaluate a change of clinical condition must be documented in a signed, legible progress note that records both date and time.
- Documentation may be handwritten, typed and printed, or in an electronic format.
- Out-of-sequence charting or late entry may be used to note information that was missed or not written in a timely manner. The new entry must be dated and timed and identified as an “out of sequence” or “late entry”. The late entry must contain the date, time and a summary of the missed events.
- Electronic signatures are acceptable with the nurse’s credentials identified.

Documentation for Nurses



Nursing Progress Note

Form ID: IPP-BHINM-J9G4YD7ZUFNNA
Status: New

Warning!
› There already exists 1 Approved form(s) of this category for Jason David Brelo, that may have been created under this same Program or a different Program. You may search for the already existing form(s) but your access to such form(s) is based on the CaseLoads assigned to you.

Profile Information

Individual Name	Jason Brelo, BRE-JA-7274
Program Name	Astair (Astair)
Created By	Jon Baca, Executive Director on 07/14/2020

Section Title

Jump to

Name: Brelo, Jason / BRE-JA-7274

Service Date	Start Time	Stop Time	Duration

Location of Service	Documentation Date	Start Time	Stop Time	Duration

Billing Code (select only one):
- LPN Nursing Service) T1003HIU4
- (RN Event Code) T2024TD
- (RN Nursing Service) T1002HI
- Other

If Other:

3000 characters left

This progress note will contain:

- Subjective information including the person's complaints and symptoms and observations reported by DSP, family, or other team members;
- Objective information including
  - Apparent signs,
  - Physical examination and assessments including vital signs, weight, and
  - Other pertinent data for the given situation;
- Nursing assessment; and
- A nursing plan that address the person's health issues, including all interventions and interactions with healthcare providers.

Documentation for Nurses

- **Follow-up** on any recommendations from a medical consultants will be documented.
- **Semi-annual reports** provided to the IDT must report the person's
  - current health status,
  - all significant changes to date, and
  - all progress towards planned health-related goals.
- Nurse will collaborate with the CM to support appropriate discharge planning in order to implement all new orders and revise assessments and plans.

The nurse will collaborate with the CM to support appropriate discharge planning and to implement all new orders, including revision of assessments and plans.

Semi-Annual Report: Requirements

- DD Waiver Provider Agencies, except AT, EMSP, Supplemental Dental, PRSC, SSE and Crisis Supports, must complete semi-annual reports.
- A Respite Provider Agency must submit a semi-annual progress report to the CM that describes progress on the Action Plan(s) and Desired Outcome(s) when Respite is the only service included in the ISP other than Case Management, for an adult age 21 or older.
- The first semi-annual report will cover the time from the start of the person's ISP year until the end of the subsequent six-month period (180 calendar days) and is due ten calendar days after the period ends (190 calendar days).
- The second semi-annual report is integrated into the annual report or professional assessment/annual re-evaluation when applicable and is due 14 calendar days prior to the annual ISP meeting.

Semi-Annual Report: Elements

Semi-annual reports must contain at a minimum written documentation of:

- ❑ the name of the person and date on each page;
- ❑ the timeframe that the report covers;
- ❑ timely completion of relevant activities from ISP Action Plans or clinical service goals during timeframe the report is covering;
- ❑ a description of progress towards Desired Outcomes in the ISP related to the service provided;
- ❑ a description of progress toward any service specific or treatment goals when applicable (e.g. health related goals for nursing);
- ❑ significant changes in routine or staffing if applicable;
- ❑ unusual or significant life events, including significant change of health or behavioral health condition;
- ❑ the signature of the agency staff responsible for preparing the report; and
- ❑ any other required elements by service type that are detailed in these standards.
- ❑ the current ARST result and whether the risk level changed since the previous report;
- ❑ a synopsis of the past year's CARMP monitoring results including the frequently reported individual signs and symptoms of aspiration and the effectiveness of risk management strategies; and
- ❑ strategies and/or interventions that need to be initiated, revised, or discontinued.

When A Person Changes Providers

- It is the responsibility of both the existing and new providers to develop and implement a transition plan.
- The transition plan ensures
  - the exchange of health-related information and effective communication of individual preferences.
  - the transfer of required documentation and implementation of appropriate logistics.
- The nurse prepares a discharge summary report and provides it to the CM and receiving provider on the day of discharge, regardless of length of stay.
- The nurse must collaborate with the other agency nurses as needed to facilitate a smooth transition of care.
- The Summary Report must contain a synopsis of the person's stay and reflect current health status and needs at time of discharge.
- Any impact to the person's Level of Care (LOC) due to health or functional status changes must be discussed with the CM prior to the discharge.

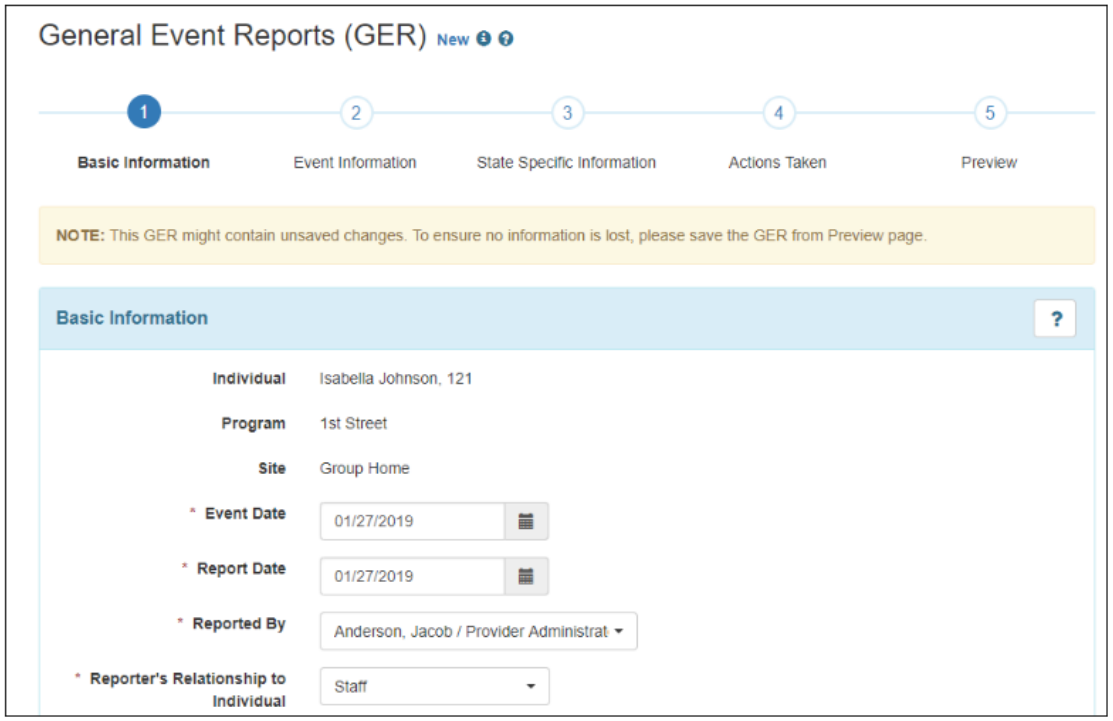
General Events Reporting (GER)

The following events need to be reported in the Therap GER:

- Emergency Room/Urgent Care/Emergency Medical Services
- Falls Without Injury
- Injury (including Falls, Choking, Skin Breakdown and Infection)
- Law Enforcement Use
- Medication Errors
- Medication Documentation Errors
- Missing Person/Elopement
- Out of Home Placement (Medical: Hospitalization, Long Term Care, Skilled Nursing or Rehabilitation Facility Admission)
- PRN Psychotropic Medication
- Restraint Related to Behavior
- Suicide Attempt or Threat

DDSD Standard Regarding GERs: https://www.therapservices.net/wp-content/uploads/2014/12/GER_Provider_Guide_10-24-14_FINAL.pdf

General Events Reporting (GER)



Provider Agencies must enter and approve GERs within **2 business days**, with the exception of "Medication Errors" which must be entered at least on a monthly basis.

ALL medication errors are required to be entered into GER, with the exception of those required to be reported to DHI-Incident Management Bureau. No alternative methods for reporting are permitted.

Therap Tutorial(s): GER https://help.therapservices.net/app/results/kw/GER/page/1