
This flyer outlines the workflow for the Outpatient Physical, Occupational, and Speech Therapists.

Workflow for PT/OT/SLP

- The patient has been **checked into** the **Outpatient Rehab Clinic**.
 - Checking the patient in for the first or subsequent visit will fire the documentation task for the visit to the **Multi-patient Task List (MPTL)**.
- From the **MPTL**, the therapist will locate the patient and double-click the task to open the documentation form.
 - **Evaluation, Certification Letter, Daily Notes, and Progress Notes** will be tasked to the MPTL.

NOTE: Documentation of charges occurs within the **Evaluation, Daily Note, Progress Note, and Discharge Summary forms**.

- **Certification letters** will be sent to providers from within Cerner.
- **Review the Rehabilitation Organizer** to track **Certification** periods and how close the patient is to needing a **Progress Note**.
 - Click [here](#) for information on the **Rehabilitation Organizer**.
- **Discharge Summary** documentation forms will be accessed from the **Adhoc** folder.

Adhoc Folder Structure

- Therapists only see Note types in Adhoc for their discipline.

Documenting a Task from the MPTL

- **Double-click** the desired task to open the documentation form.
- If all the required documentation fields have been completed, the task on the MPTL will have a green checkmark and have a status of **Complete**.



- **Refresh** the MPTL by clicking the **minutes ago button** to remove the task from the MPTL.
- Forms that do not have all required fields documented will go to the MPTL with a status of **In-Process**.
 - Clicking an **In-Process task** will open the previously started form.

Evaluation Forms

- Double-click the **Evaluation task** in the MPTL to document the Evaluation form.
 - Document the required fields and those sections that are applicable to the patient.
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- Documenting **Evaluation Complete** in the **Plan** section will fire a **Cert Send task** to the **MPTL** if the patient has **Medicare Insurance**.

NOTE: If the Patient requires a Certification and does not have Medicare Insurance, the therapist will access the Certification Letter from the Outpatient Therapy folder in Adhoc.

- In the **Assessment** section for **Physical and Occupational Therapy**, **Evaluation Complexity** will populate **Low, Moderate, or High Complexity** based on documentation in the Evaluation.
 - Documentation fields that feed into this calculation are:
 - **Examination of Body Systems** – located in the **Assessment** section.
 - OT has **Occupational Profile/Medical and Therapy History**.
 - **Clinical Decision Making** – located in the **Assessment** section.
 - **History of Comorbidities/Personal Factors Impacting Plan of Care** – located in the **Past Medical History, Problems, and Diagnosis** section.
 - **Presentation of Characteristics** – located in the **General Information** section.
 - OT does not have this documentation field.
 - If the **Evaluation Complexity** calculation differs from what the therapist has documented, the therapist should review the documentation fields that contribute to the calculation and adjust as needed.
- **Documenting a Problem**
 - Problems should be added if the problem for which the patient is being seen for is not on the **Problem list**, and when the patient reports a new problem.
 - Use the **IMO search** field for entering a **new Problem**.
 - Click + **Add** to search for Problems that do not come up in IMO Search.
 - Right-click the newly added Problem to add details such as **Age** or **Date of Onset**.

NOTE: Therapists do NOT add a Problem under **Diagnosis (Problem) being Addressed this Visit**.

- **Documenting an Allergy**
 - In the Allergy section, click **+Add button** to add a new allergy reported by the patient.
 - **Pain Screening**
 - Pain Screening should be completed for all patients.
 - For **Physical and Occupational Therapy**, in the **General Information** section, documenting **Yes in Pain Present**, will open the **Pain Assessment** section.
 - For **Speech Therapy**, in the **General Information** section, **Pain Interfering with Session**, **Pain Negatively Impacts**, **Pain Interventions**, and **Pain Notifications** are documented as applicable for the patient.
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➤ **Coordination of Care**

- Use this section to document who care of the patient was coordinated with.

➤ **Hybrid Time Based Charges and Time Spent with Patient Sections**

- Refer to the **Rehab Therapy Charge** flyer specific to the discipline for detailed information on documenting charges.

➤ **Additional Information**

- Document in this free text box information that there is not a discrete field for the documentation.

➤ Click the green checkmark to sign the **Evaluation** form.

➤ **Refresh** the MPTL.

Certification Letter

➤ Double-click the **Cert Send** task to open the **Certification Letter**.

NOTE: This form will pull in data documented in the Evaluation form. Open each section to pull in the data.

➤ **Interval Start Date** is the same as the **Date of Evaluation**.

➤ In the **Plan** section, document **Certification Letter Complete**.

- Documentation of **Certification Letter Complete** will fire a **Recert Send** task to the MPTL **seven days** before the current certification expires.

➤ **Forward** the Certification Letter to the referring Provider using the **Forward functionality** in **Documentation** or **Notes**.

- Click [here](#) for more information on Forwarding a Document.

➤ Click the green checkmark to sign the **Evaluation** form.

➤ **Refresh** the MPTL.

Daily Note Forms

NOTE: If the patient receives a treatment on the day of the Evaluation, the therapist should complete the Evaluation and a Daily Note.

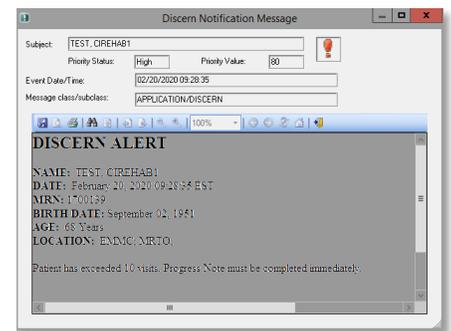
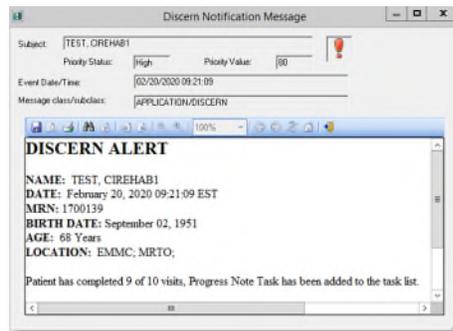
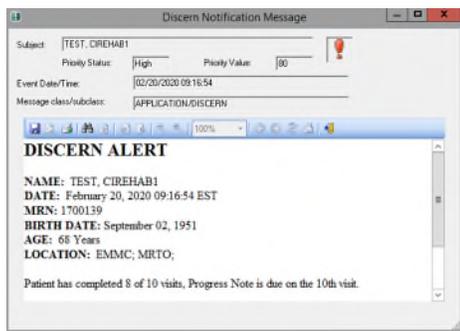
➤ Double-click the **Daily Note** task in the MPTL to document the Daily Note form.

➤ Document the required fields and those sections that are applicable to the patient.

NOTE: Certain documentation from the Evaluation form will pull forward to the Daily Note. Click in the documented sections to pull in data from the Evaluation.

Progress Note Forms

- **On the 8th visit**, on chart open, the therapist will receive a pop-up Discern Alert reminding the therapist that a Progress Note is due on the 10th visit.
- **On the 9th visit**, on chart open, the therapist will receive a pop-up Alert reminding the patient that the Progress Note is due on the 10th visit.
 - Both the **Daily Note task** and the **Progress Note task** will go to the MPTL on the 9th visit.
 - If the **Progress Note is completed** on this visit, the therapist should **chart the Daily Note task as Not Done** by right-clicking the task.
 - A **Reason** for not completing the **Daily Note** should be documented by choosing from the dropdown or by selecting **Other** and stating a Progress Note was documented.
- **On the 10th visit**, if the Progress Note has not been completed, on chart open, the therapist will receive a pop-up Discern Alert stating the Progress Note is due immediately. The alert will continue to fire until the Progress Note is completed.



- In the **Plan** section, document **Progress Note Complete**.
 - Documenting the Progress Note is complete, resets the counter so alerts will fire for the next Progress Note.

Documenting Cancelled/Missed Units

- If the patient is late for an appointment, is too fatigued to continue the treatment, or misses part of their therapy session due to another reason, the number of **missed Units** and the **Reason** is documented at the bottom of the **Time Spent with Patient** section located in each of the documentation forms.
- If the patient misses an entire therapy session, document in the **Missed Therapy Minutes form** for the discipline located in **Adhoc**.

Discharge Summary Forms

- The Discharge Summary forms are NOT tasked to the MPTL.

- On the patient's last visit, the therapist will access their disciplines **Outpatient Treatment/Discharge Summary** form from the **Outpatient Therapy** folder in **Adhoc**.
- Documentation from the **Daily Note** and **Progress Note** will pull forward to the **Outpatient Treatment/Discharge Summary** form.
 - Click in each previously documented section to pull data forward into the Discharge Summary.
- If the patient is **discharged from therapy** because they have stopped coming, or have exceeded the number of allowed missed sessions, the **Outpatient Discharge Summary** form for their discipline should be documented based on the last visit.

Student Documentation

- After a student therapist completes a documentation form, the licensed therapist will get a task on the **MPTL** for the form with a Status of **Pending Validation**.
- The student's documentation forms will display in **Form Browser** with a status of **(In-Process)**.
- The licensed therapist will double-click the task to open the student's documentation.
- The documentation should be reviewed. The therapist is required to document something in the note in order to sign the form.
- After the licensed therapist signs the form, in **Form Browser** the status of the form will display as **(Auth (Verified))**.

Saving a Note

- If a therapist is working on a documentation form and is not able to complete it in one sitting, the form should be **Saved** rather than signed.
- Click the **Save Form** disc icon next to the **Sign** icon.
- If the saved note has **required fields that have not been documented** yet, navigate to the **MPTL**, and click the task to open the previously started note.
 - In **Form Browser**, this note would have a **red tile** and have a status of **(In-Progress)**.
- To complete a saved note that had **all required fields documented**, navigate to **Form Browser** and locate the saved form.
 - In **Form Browser**, this note would have a **blue tile** and a status of **(In-Progress)**.
 - Right-click the form and select **Modify** form.
 - Once the form is completed, click the **Sign** icon.
 - The status in **Form Browser** will update to **(Auth (Verified))**.