



# CONTENTS

- CONTENTS..... 2
- ABOUT THIS GUIDE .....3
- LEARNING OUTCOMES ..... 4
- 1. ACCESSING POINT OF CARE ..... 5
- 2. CLOCKING IN ..... 5
- 3. MANAGING PATIENTS FROM HOME SCREEN.....5
- 4. PREPARING FOR A PATIENT ENCOUNTER ..... 7
- 5. COMPLETING AN EVALUATION ..... 7
- 6. CREATING THERAPY TRACKS..... 11
- 7. MANAGING UPLOADS .....12
- 8. MANAGING APPOINTMENTS .....12
- 9. COMPLETING AN ENCOUNTER ..... 13
- 10. CREATING PROGRESS REPORTS ..... 16
- 11. USING THE TO DO LIST ..... 17
- 12. SAVING INFORMATION TO THE SERVER ..... 18
- 13. CLOCKING OUT ..... 18

## ABOUT THIS GUIDE

Course Title:	Point of Care Participant Guide
Purpose of this Guide	This participant guide is an adjunct learning tool for users who have completed Net Health POC training. This guide is designed as a “quick reference guide” to assist you while performing your daily tasks in Net Health’s Point of Care application. The Participant Guide provides simple, step-by- step instructions for completing tasks. We recommend that you use this guide in conjunction with the short micro- learning videos available on Net Health’s YouTube channel.
Target Audience:	Clinicians, Administrative Net Health Therapy users who want to understand how Net Health Therapy and POC interact can also benefit from this curriculum.
Prerequisites:	While no pre-requisites are required for clinicians, it is recommended that administrative staff attend Point of Care training AFTER completing Net Health 101 and Net Health 102.

# LEARNING OUTCOMES

This Participant Guide will help you:

- List ways in which Point of Care differs from Net Health Therapy
- Apply the steps to access Point of Care
- Apply the steps to Clock In to Point of Care
- Manage Patients from the Home Screen in Point of Care
- Use the process to identify tasks in Point of Care
- Follow the steps to complete an evaluation in Point of Care
- Follow the steps to create a therapy track in Point of Care
- Manage uploads and appointments in Point of Care
- Create and complete encounters in Point of Care
- View Treatment Approaches in Point of Care
- Create progress reports in Point of Care
- Use Point of Care to Manage tasks
- Use the Options menu in Point of Care
- Apply the steps to save information to the server in Point of Care
- Follow the steps to clock out of Point of Care

## 1. ACCESSING POINT OF CARE

Point of Care is a mobile app clinicians use to log all aspects of the patient encounter and it works from anywhere, with or without an Internet connection

Key feature	Benefit
Mobile	Point of Care was built for clinicians to use at the Point of Care.
Offline	While an Internet connection is needed for the initial login, Point Care Can be used offline when there's no Internet connection available.
Sync with Net Health	When the clinician goes online again, the data he or she entered can be uploaded to Net Health Therapy in just a few clicks.

To log into Point of Care, follow these steps:

Step	Action
1.	Open Chrome or Safari browser.
2.	Access the URL <a href="https://yourorgcode.optimahcs.com/pointofcare">https://yourorgcode.optimahcs.com/pointofcare</a>
3.	Enter your Username.
4.	Enter your Password.
5.	Choose your Facility on the Sign-In window.
6.	The Home Screen opens.
This completes accessing Point of Care.	

## 2. CLOCKING IN

If you have Time Clock active, the first window will be your Clock In screen.

To clock into Point of Care, follow these steps:

Step	Action
1.	From the Clock In screen, click the clock icon.
2.	The current time defaults in the field.
3.	If you have access to back-date the time change the time if required.
4.	Enter Variance Notes.
5.	Press Clock In.
This completes the process to clock into Point of Care.	

## 3. MANAGING PATIENTS FROM HOME SCREEN

Once you are clocked in, the Home Screen opens up. On the Home Screen you have three tabs:

My Patients tab, Tasks tab and Appointments tab.

My Patients is automatically going to show you all Patients you are currently associated with i.e.

- You have scheduled appointments with,
- You are listed as the primary care provider or responsible therapist, or
- You have a document that is due or incomplete of which you are the author.

You will find the following filter views and icons on the My Patients tab:

Filter view/ Icon	Description
Filter Arrow	Press the down arrow on the My Patients tab, see the filter options.
My Patient's	Select My Patient's to show all patients associated with you.
Today's Appointments	Select Today's Appointments to only show patients with scheduled appointments for that day.
Due Documents	Select Due Documents to view patients who have upcoming or incomplete document pending with you.
Download icon	Click the Download icon (Cloud with down arrow) to download the Patient to your mobile devise.
Refresh icon	Click the Refresh icon (arrow circle with minute count) to refresh the Patient's information on your mobile devise.

To search for a Patients, follow these steps:

Step	Action
1.	Press the Patient Search button.
2.	Enter First Name, Last name, both or part of either name.
3.	Press the Search button.
4.	Select the correct Patient for the search results.
5.	The selected Patient now appears on the My Patient list.

This completes the process to search for a patient.

To create a Therapy Track for the new Patient, follow these steps:

Step	Action
1.	Click the plus sign (+) next to the new Patient's name.
2.	Select the Document you need to create.

Step	Action
3.	Specify Type of Therapy.
4.	Select Certification Date From and Thru
5.	Press the Create button.
This completes the process to create a Therapy Track.	

## 4. PREPARING FOR A PATIENT ENCOUNTER

Before you start the evaluation, you can check that everything is in place.

To prepare for a patient, follow these steps:

Step	Action
1.	Check that you've downloaded and refreshed the patient's information from the server.
2.	Click the small blue triangle in the lower right hand corner to expand the patient's Therapy Card.
3.	View the Documents that are Pending or Due.
4.	Notice the document's status and due date.
This completes the preparation for a patient encounter.	

## 5. COMPLETING AN EVALUATION

Once you are sure you have everything you need in Point of Care, you are ready to begin the Evaluation. To complete the Evaluation for a patient, you do not need internet connection.

To easily navigate through the Evaluation information, let's look at the functions available on the Evaluations screen:

Function	Description
Options menu	The Options menu contains three options you can view or perform: Issues, Overview and Copy from Document.
Issues	Select Issues from the Options menu to display all required fields on the document.
Overview	Select Overview from the Options menu to show the information on the Evaluation document in Print View.
Copy from Document	Select Copy from Document on the Options menu to copy information from existing documents.

Below the Options menu are several tabs. Let's go through the process to complete each of them:

### 1.1 Evaluation - Details Tab

To complete the Details Tab, follow these steps:

Step	Action
1.	Click on the Details tab.
2.	Click the Author magnifying glass.
3.	Select the Author.
4.	Click the Physician magnifying glass.
5.	Select the Physician.
6.	Select and deselect Types of Therapy as needed.
7.	Select Special options if required.
This completes the Details Tab.	

### 1.2 Evaluation - Diagnosis Tab

To add Diagnosis Codes, follow these steps:

Step	Action
1.	Click on the Diagnosis tab.
2.	Press the Medical Diagnosis +ICD-10 button.
3.	Choose your search option: <ul style="list-style-type: none"><li>- Search by Chapter/Section,</li><li>- Search by Code</li><li>- Search by Keyword</li><li>- Map from ICD-9</li></ul>
4.	Enter search criteria.
5.	Press the Search button.
6.	Select the Code.
7.	The Code will appear at the bottom of the screen.
8.	To remove a Code, just click on it at the bottom of the screen.
9.	Press the Done button when you've added all your codes.
10.	Specify your Onset Date.
11.	Press the Done button.
12.	Follow the same steps for Treatment Diagnosis.
You have now successfully added Medical and Treatment Diagnosis Codes.	

Note that at least one Diagnosis Code and one Treatment Code are required. To rank your

Diagnosis Codes in a specific order, follow these steps:

Step	Action
1.	Click the Rank Dx button.
2.	Drag and drop the Diagnosis Codes in the required order.



Step	Action
3.	Press the Done Ranking button.
This completes the Diagnosis Codes tab.	

### 1.3 Evaluation – Assessment Tab

You will notice as you complete different document in Point of Care, the functionality is similar, the content and context will change for each document.

To complete the Assessment tab, follow these steps.

Step	Action
1.	Click on the Assessment tab.
2.	To view all the specific section on the Assessment tab, click the Section menu.
3.	Next to each Section the number of required fields are displayed in a red square.
4.	Select the Section you want to complete.
5.	Complete the Free text fields by typing the text out.
6.	Complete the Build text fields using the text build button. Build your sentence from the pre- defined phrases.
7.	Select values using the color coded buttons, where required.
8.	Complete any checkbox selection fields, which are indicated by an upside down triangle.
9.	Click on the Comment icon to add free text comment to your field. These are only available on certain fields.
10.	If a Goal icon appears next to a field, you can immediately create a Goal, while in the Assessment tab. (See the Evaluation – Goals tab section below for steps on how to create a Goal.)
11.	Continue to complete all required field by using the Sections menu.
This completes the Assessment tab.	

### 1.4 Evaluation – Goals Tab

You can build all your Short Term and Long Term goals in this tab, using the Custom Goal or Build function.

To add a Custom Short or Long Term Goal, follow these steps.

Step	Action
1.	Click on the Goals tab.
2.	Any Goals you completed in the Assessment tab will already appear here.
3.	Click the +STG or +LTG buttons.
4.	Press Skip Impairment/Deficit to gain access to the longer list to choose from.
5.	Press the Create Custom Goal.
6.	Complete the Goal text field.

Step	Action
7.	Select Target Date.
8.	Enter PLOF and Baseline.
9.	Press Done.
You have now successfully added a Custom Goal.	

To Build a new Short or Long Term Goal, follow these steps.

Step	Action
1.	Click on the Goals tab.
2.	Any Goals you completed in the Assessment tab will already appear here.
3.	Click the +STG or +LTG buttons.
4.	Select the Impairment/ Deficit.
5.	Make your selections from the pre-defined phrases.
6.	Press Goal Complete.
7.	Select Target Date.
8.	Enter Baseline and PLOF.
9.	Press Done.
This completes the Goals tab.	

### 1.5 Evaluation – Plan Tab

To complete the Plan tab, follow these steps.

Step	Action
1.	Click on the Plan tab.
2.	Enter Frequency.
3.	Enter Duration.
4.	Enter Intensity.
5.	Select the Treatment Approaches.
6.	Complete the Assessment Summary fields.
This completes the Plans Tab.	

### 1.6 Evaluation – Deficits Tab

The Deficits tab is a view only tab where you can view a list of all the deficits pulling from the assessment.

To view the Deficits, follow these steps.

Step	Action
1.	Click on the Deficits tab.
2.	View the list of deficits.
This completes the Deficits tab.	

### 1.7 E-Sign the Evaluation

Once you have satisfied all the required field in the Evaluation, the green E-Sign button will appear in the top right hand corner of the screen.

If you've finalized and E-Signed the document, any changes to the document will require a revision signature. All revisions will be saved to the change history for this document.

To E-Sign the, follow these steps:

Step	Action
1.	Press the E-Sign button.
2.	Press the Attest button.
3.	Press OK on the popup message.
4.	The document will be E-Signed when you upload it to the server.
You have now successfully E-Signed the Evaluation.	

## 6. CREATING THERAPY TRACKS

After you've completed a Document or billing, you will be re-directed to the Therapy Track Details for the specific patient. You can also access this screen from the link on the patient's therapy card.

The Therapy Track Details screen consists of five tabs:

Tab	Description
Timeline tab	The Timeline tab shows you all activities that have occurred with this patient from the day the track has started.
Profile tab	The Profile tab shows you Patient information: Name, DOB, Gender, Marital Status, Address, Contacts and Care Team.
Medical tab	The Medical tab shows you a summary of medical information, (which includes Treatment Approaches, Medical and Treatment Diagnoses and Precautions), Test and Outcomes and Goals.
Encounters tab	The Encounters tab shows all Scheduled Appointments for Today and Recent Encounters. You can also add an Encounter or log a missed visit from this tab.

Documents tab	The Documents tab allow you to view all historical documents. You can open the document and, if necessary, you can unlock it to make edits. You can also all new documents from here.
---------------	---

Tab	Description

## 7. MANAGING UPLOADS

Once you have finished your work day, it is time to upload the data from your device. Navigate back to the Home Screen by using the back buttons. In the upper left hand corner of the screen an upload icon appears (cloud with an up arrow and a number). This count shows how many changes you have to upload to the server.

To view your pending uploads, follow these steps:

Step	Action
1.	Click on the Upload icon.
2.	The list of uploads will appear.
3.	Click the Save to Server to upload the data.
This completed the Upload to Server process.	

## 8. MANAGING APPOINTMENTS

The Appointments tab on the Home Screen allows you to view all scheduled appointments across any facility for the week.

To manage your appointments, follow these steps:

Step	Action
1.	Click on the Appointments tab. For each appointment you will see the Patient name, amount of minutes scheduled and the Facility.
2.	Press the Week arrows to scroll through the weeks.
3.	Click on the My Patient's tab.
4.	Click on one of the Patients who has an appointment
5.	The patient card will open
6.	You will see the Start Encounter button to the right.
7.	You can start the Encounter from this screen.
This completes managing your Appointments.	

## 9. COMPLETING AN ENCOUNTER

To start an Encounter, follow these steps:

Step	Action
1.	From the My Patients screen, click on the patient's name (who has an appointment).
2.	Press the Start Encounter button.
3.	Click the Options menu.
4.	From the Options menu you can view the Issues, Overview of Encounter or Delete the Encounter.
This completes starting an Encounter.	

On the Encounters screen there are five tabs to complete: Details, Treatment Log, Treatment Encounter Notes, Precautions and Goals.

### 1.8 Encounter - Details Tab

The Details tab will show you the Visit counts per day. If it is a BID and the second visit, the Visit # will be "Two". The only information you can change in this tab is the Date of Service.

### 1.9 Encounter – Treatment Log Tab

The Treatment Log will pre-populate any service codes that you have listed on the document. If nothing has been entered yet, it will be blank.

To add Treatment Codes, follow these steps:

Step	Action
1.	Click on the Tx Log tab.
2.	Click the + Service Codes button.
3.	Search for the Service Codes.
4.	Select the Service Codes you want.
5.	Press Done.
This completes adding Treatment Codes.	

To add Minutes to the Codes, follow these steps:

Step	Action
1.	Select the Code.
2.	Enter the minutes on the keypad to the right.
3.	Continue to add minutes for each code.
4.	If the Payer Plan allows for Concurrent minutes or Co-Treatment, you have the option to add minutes for it, listed below your codes.
5.	View the summary of minutes at the bottom of the screen.
This completes adding Minutes to the Codes.	

1.10 Encounter – TEN (Treatment Encounter Note) Tab To add a

Treatment Encounter Note, follow these steps:

Step	Action
1.	Click on the TEN tab.
2.	Press the +Add Note button.
3.	Choose the Area of the Note.
4.	Enter all required fields.
5.	Click the Sections menu.
6.	Choose the Area of the Note.
7.	Enter all required fields.
8.	Continue until you've entered all required fields.
This completes adding a Treatment Encounter Note.	

1.11 Encounter – Precautions Tab Click

on the Precautions tab.

The Precautions tab will list all the precautions pulling from the most recently completed document.

1.12 Encounter – Goals Tab Click

on the Goals tab.

The Goals tab will list all your Short and Long Term Goals.

### 1.13E-Sign the Encounter

To E-Sign the Encounter, follow these steps:

Step	Action
1.	Once all the required fields are completed, the green E-Sign button will appear.
2.	Click on the E-Sign button.
3.	Press the Attest button.
4.	Press OK on the popup window.
5.	Your Encounter will automatically be E-Signed once you upload to the server.
This completes E-Signing the Encounter.	



## 10. CREATING PROGRESS REPORTS

While completing the Progress Report you will notice that all document functionality is the same as other documents in Point of Care.

To complete a Progress Report, follow these steps:

Step	Action
1.	From the Home Screen, click on a Patient's name.
2.	Click on the Progress Report hyperlink in the Patient's Therapy Card.
3.	Complete the Details tab required information.
4.	Click on the Diagnosis tab.
5.	Complete all required fields in the Diagnosis tab.
6.	Click on the Assessment tab.
7.	Complete all required fields in the different Sections of the Assessment tab.
8.	Notice the History button (H in a square) on some assessment items.
9.	Click the History button.
10.	The History will appear on the right.
11.	Click on the relevant historical information, to copy it into your Progress Report field.
12.	Make changes to the text if required.
13.	Click on the Goals tab.
14.	Update the required fields in the Goals tab.
15.	Click on the Plan tab.
16.	Complete all required fields in the Plan tab.
17.	Click on the Deficits tab.
18.	Review the Deficits.
19.	Click on the E-Sign button.
20.	Click the Attest button.
21.	Click OK.
22.	Your Progress Report will automatically be E-Signed once you upload to the server.
This completes the Progress Report.	

## 11. USING THE TO DO LIST

The To Do list is a feature Net Health added to make your life easier. It can be used to set reminders for yourself about work issues or personal things you need to do. Items on your To Do list are not tied to patients and no one else can see them.

To create a To-Do, follow these steps:

Step	Action
1.	Click on the Tasks tab.
2.	You will see a list of reminders on the Reminders tab.
3.	Click on the To-dos tab.
4.	A list of To-Dos will display.
5.	Enter a name for your To-Do in the free text field.
6.	Press the Add button.
7.	Click on the To-Do name.
8.	Select a Due Date.
9.	Add additional notes in the Notes field.
10.	Press the Done button.
11.	Press the heart icon to favorite the To-Do and place it at the top of your list.
12.	To mark a To-Do as complete, press the check box next to it.
13.	It will drop to the bottom of the list and be greyed out.
14.	Remove the checkmark to activate the To-Do again.
This completes adding a To-Do.	

Completed To-Dos will remain on your list for 7days, on the 8<sup>th</sup> day all completed To-Dos will automatically be discarded.

## 12. SAVING INFORMATION TO THE SERVER

When you completed all information remotely, and you are ready to upload all the information to the server, you need to have internet connection. Once you are connected to the internet, you can upload all your changes to the server.

To upload your changes to the server, follow these steps:

Step	Action
1.	Click on the Upload icon (Cloud with a number count)
2.	Review you list of changes.
3.	Look for any error/ validation messages.
4.	Clear the error by clicking on the message and following the instructions to complete required information.
5.	Click on the trashcan, next to a change, to discard any changes you do not need anymore.
6.	Remove the checkmark for any changes you do not want to upload yet.
7.	Press the Save to Server button.
8.	The E-Sign window will appear, if there are still items that require a signature.
9.	Enter your Password.
10.	Press the E-Sign button. The upload will start.
11.	When upload is complete, choose your option from the popup window: Continue Working or Sign Out.
This completes saving changes to the server.	

## 13. CLOCKING OUT AND SIGNING OUT OF POC

Once you finished your work day or shift, you can clock out of the system.

To clock out for the day, follow these steps:

Step	Action
1.	Click on the Options Menu.
2.	Select the Time Clock.
3.	The current time prepopulates in the Clock Out field. If you have access, you can change the clock out time, if needed.
4.	Enter Lunch minutes if required.
5.	Press Done.
6.	Review your Time and Labor Summary.
7.	Press Done.
This completes Clocking Out of Point of Care.	

To Sign Out of the system, follow these steps:

Step	Action
1.	Click on the Options Menu.
2.	Select Sign Out.
This completes Signing Out of Point of Care.	