FOCUS ON® THERAPEUTIC OUTCOMES INC

FOTO OUTCOMES MANAGER

SUPPORT STAFF TRAINING GUIDE

Canadian Physiotherapy Association | Association canadienne de physiothérapie

OUTCOMES MANAGER

Version CPA092015

1.800.482.3686 | fotoinc.com

Focus On Therapeutic Outcomes, Inc.

PO Box 11444 ● Knoxville ● TN ● 37939

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Why FOTO?

BENEFITS FROM MEASURING OUTCOMES WITH FOTO

More Efficient Evaluations

At Intake, your patient spends a few minutes at the computer answering questions about how well they are able to do their usual activities. This information is printed on a report that the therapist has immediate access to and can use to focus the patient evaluation quickly.

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Better Patient Management

The Patient Specific Reports that print as each survey is completed help physiotherapists monitor patient progress against the risk adjusted (age, severity, acuity, body part) aggregate in FOTO's database. Immediately identifies if the patient is not achieving expected functional change.

Better Patient Communication

The Patient Specific Reports can be used to better communicate with patients about expectations for progress and the course of treatment. One client reports that using the predictive information on number of visits and duration to gain patients' buy in has resulted in a reduction of the no show / cancellation rate to 4%.

Better Communication with Referring Physicians and Payers

The Patient Specific Reports can be used to fortify communication with Referral Sources, Physicians and Payers. The Functional Health Status Summary provides a very easy to read graph – if it is going up, the patient is getting better. Some clients circle the graph and the measure of patient satisfaction – very quick recap of progress with patient episode.

Enhanced Marketing to Referral Sources

The Outcomes Profile Reports provide a unique Marketing Opportunity to Referring Physicians and Payers. To begin with, many clients send the first graph page of the reports with a letter to their referral sources explaining that their top priority is providing quality care for their patients and that they can prove it. That page compares the percent of physical functional change, average visits, functional change per visit, average duration, and patient satisfaction to the national aggregate. You can go a step further than that and use custom referral tracking in the software to actually provide an outcomes profile report sorted only for the patients from that referral source. This encourages the referral source to send more of their referrals to you because this is information they would have difficulty obtaining elsewhere.

▶ Enhanced Marketing Directly to Patients

FOTO provides awards and recognition for excellence in patient care. These can be displayed in your facility. We also provide press release templates that have been very effective in announcing honors to your local news media and articles generated from that. That is the kind of press that has a credibility that money can't buy.

INDUSTRY TRUSTED

FOTO is the trusted choice for measuring rehabilitation outcomes . . .

▶ Endorsed by the National Quality Forum

FOTO's Functional Status Change Measures have been endorsed by the National Quality Forum (NQF) whose mission is to improve the quality of American healthcare. NQF sets national priorities and goals for performance improvement, endorses national consensus standards for measuring and publicly reporting provider performance and promotes the attainment of national quality goals through education and outreach programs.

▶ Chosen by the Canadian Physiotherapy Association

The CPA selected FOTO to power their electronic Outcomes Measures (eOM).

. . . FOTO is the Outcomes Measurement Standard

ENDORSEMENTS

FOTO *IS* THE STANDARD FOR MEASURING PATIENT OUTCOMES IN PHYSICAL REHABILITATION

FOTO is a private sector outcomes measurement company that has been selected by many national organizations and publications:

- **ENDORSED BY AMERICAN PHYSICAL THERAPY ASSOCIATION (APTA) SECTIONS**
  The APTA Private Practice Section and Section on Women's Health have endorsed FOTO as the recommended tool for their members in measuring outcomes.

- **MANDATED BY THE PHYSICAL THERAPY PROVIDER NETWORK (PTPN)**
  PTPN, the country's first and largest network of independent rehabilitation therapists in private practice, has required the use of FOTO since 2007 for Quality Assurance and for participation in Pay-for-Performance Initiatives.

- **CHOSEN BY INSURANCE COMPANIES FOR PAY-FOR-PERFORMANCE**
  FOTO's Outcomes Measurement Tools and Reporting Services are currently being used in Pay-for Performance initiatives by HealthPartners (Minnesota) and Louisiana Blue Cross Blue Shield. Additional projects with health insurance plans are in development.

- **INTEGRATED WITH ELECTRONIC HEALTH RECORD VENDORS**
  FOTO has all the essential elements to accomplish integration with any electronic health record, documentation or billing system. Currently, nine EHRs have live integrations with FOTO, and development is ongoing.

- **PUBLISHED IN RESPECTED SCIENTIFIC JOURNALS**
  FOTO currently has 87 articles published in peer-reviewed journals including:
  - American Journal of Occupational Therapy
  - Archives of Physical Medicine & Rehabilitation
  - International Journal of Therapeutic Rehabilitation
  - Journal of Clinical Epidemiology
  - Journal of Hand Therapy
  - Journal of Manual & Manipulative Therapy
  - Journal of Occupational and Environmental Medicine
  - Journal of Orthopedic and Sports Physical Therapy
  - Journal of Prosthetics and Orthotics
  - Journal of Rehabilitation Outcomes
  - Measurement
  - Medicine
  - Physical Therapy
  - Physiotherapy Canada
  - Quality of Life Research Applied Measurement
  - Spine

SYSTEM REQUIREMENTS

Your FOTO Practice Administrator will manage most of these requirements for you but this information may be helpful to you in troubleshooting any access problems you may experience.

Basic System Requirements

Browser Compatibility (all versions since 2008 unless otherwise noted)

- Mozilla Firefox
- Internet Explorer (v7 or later)
- Chrome
- Safari

JavaScript and cookies

- Must be enabled

Portable Document Format (PDF)

(Only required for viewing reports)

- Any recent Adobe Acrobat Reader (with browser plugin)
- Any 3rd-party compatible viewer (non-preferred)
- Note that Chrome and Firefox browsers have built-in PDF rendering that satisfies this requirement

Whitelist Information

Please be sure to Whitelist the following for internet, email and at the organization server level if needed:

- Patient-inquiry.com
- Fotoinc.com
- Mandrillapp.com

SETTING THE STAGE

UNDERSTANDING YOUR ROLE IN THE FOTO OUTCOMES MEASUREMENT SYSTEM

THE What

It is important that you understand the WHAT and WHY. WHAT exactly is the FOTO Outcomes Measurement System? The better you understand the WHAT and WHY and how Outcomes will improve quality of care for your patients, the more excited you will be to use Outcomes Measures.

FOTO outcomes will assist with:

- Improving Quality of Patient Care through Evidence Based Practice
- Facilitating Research and Advocacy Opportunities
- Marketing Services to Patients

Since 1992, FOTO has established an impressive track record of delivering comprehensive, cost-effective, and high-quality outcomes analysis. FOTO combines integrity, dedication and state-of-the art methods to develop measures that are precise, efficient, valid and reliable. Using the most sound and defensible science, we provide analysis and assistance to physiotherapists facilitating the most effective rehabilitation therapy

What is the FOTO Outcomes Measurement System?

The FOTO Outcomes Measurement System determines, very efficiently, three primary scores for your patient:

- The **initial** functional status measure,
- The **predicted** change in functional status measure, and
- The **actual** change in functional status measure.

When you understand these three main measures, and how they work together, you will begin to discover the power and value of the FOTO Outcomes Measurement System to your outpatient rehabilitation practice.

- **Initial Functional Status Measure**
  At admission, the patient completes an assessment specific to the body part or impairment that needs treatment. From these responses the functional status measure score is calculated. This is a score between 0-100 that represents the patient's functional ability.
- **Predicted Change in Functional Status Measure**
  FOTO uses 1O risk-adjustment factors to ensure that the predictions we make are reflective of the patient's characteristics. This is important both for accuracy and precision in national comparative and functional limitation reporting.
- **Actual Change in Functional Status Measure**
  Patients complete an assessment as needed during care and on the last visit to track the improvement of function. That amount of change is then compared to risk-adjusted national predictions from FOTO, providing a measure of treatment effectiveness.

The Why

The Power and Value of Outcomes

Value in Predicted Outcomes per Patient

Immediately after the initial survey, but before your patient begins treatment, FOTO provides not only the functional status measure, but also, based on a very large data sample, FOTO provides:

- A risk-adjusted, predicted change in function, and
- The average number of visits required to achieve that predicted outcome.

On a case-by-case basis, the predicted change and visits help set expectations and reasonable goals with your patient and contributes to improved compliance during the course of treatment. Of course, each case and patient will be different. Some will exceed the predicted outcome, some will not for various reasons. However, as the FOTO Outcomes Measurement System is adopted into the workflow of your practice, data accumulates and patterns begin to emerge. Here begins the payoff.

Power of Aggregated Outcomes

Each quarter, FOTO publishes outcome profile reports. Your outcomes are compared against a national mean of outcomes drawn from over 3000 other clinics. Since the comparison is a benchmark against a risk-adjusted mean, the comparison is a useful "apples-to-apples" one which is highly instructive.

Our scorecards and reports show the data multiple ways:

- by effectiveness (how much patients are improving),
- by efficiency (how many visits it takes to achieve that improvement),
- by utilization (how much improvement per visit), and
- by patient satisfaction.

The Who

Each staff member in your practice will play an important role in the success of your FOTO Implementation and data collection: the FOTO Champion team. Your practice Owner/ Administrator, the Support Staff, the Physiotherapists, and yes, the Patients are all a part of the Team. Discussing your work/office flow and developing parameters to make the FOTO system a part of your day-to-day operations will help you meet your goals. For example, as a team decide:

- Who is responsible to setting up the intake survey? Support staff?
- Who is responsible for the status surveys? Support staff or the physiotherapist?
- Who is responsible for patient discharge? If it is support staff, how does the physiotherapist communicate when a patient is ready for discharge?

Remember, if the initial process you develop doesn't work, regroup and try a different flow. You will be surprised at how quickly you will find a process that works well in your office.

The How

Your team should discuss how you will be capturing your patient information.

- By tablet or kiosk at the clinic?
- By email at home prior to their first appointment?

Since it takes on average 5-10 minutes for your patient to complete the intake survey, it is always a good idea to have your staff start to request that your patients arrive a few minutes before the scheduled appointment so that they have plenty of time to complete the survey **prior to seeing the physiotherapist**.

The When

It is important that support staff and physiotherapists know when to collect each of the assessments required to complete an episode. By communicating your collection procedures, this allows for a higher completed episode rate and more data collected.

- **The Intake Survey**- It should be given before the patient begins treatment, ideally before meeting the physiotherapist. This allows the physiotherapist to have access to the important information on the survey report and helps establish the expectations and goals of therapy sessions.

- **The Status Survey**- Communicate when your patients should take their status survey. The #1 recommendation is to get at least 1 status on an interim basis, in addition to the final/discharge status. Research suggests that having at least 2 total statuses is associated with better outcomes. It may be because this gives the therapist an opportunity to make sure the therapists' perception of the patient's function matches the patient's perception, to facilitate communication with the patient, and be a tool to help inform clinical decision-making just like other tests and measures would be utilized throughout the course of the patient's care. So, a general guideline might be "every 5th visit".

Ideas for Status Assessment Frequency

- A standard # of visits throughout the episode (e.g. every 5th visit) ***and*** on last date of service /or/ at least 1 status on an interim basis in addition to the final discharge status.
- Perhaps every Thursday & Friday are set as Status Assessments days (Thursday's for those patients who are seen 2x/week and Fridays for patients who are seen 3x/week)
- When the patient is returning to the MD
- Any visit when the clinician identifies significant change in physical activity status or achievement toward treatment goals
- At time of re-evaluation or when Plan of Care is revised
- Any time when the clinician suspects the patient may not return for continued care

- **The Final Status Survey**- It is very important that the final status survey be taken as close to the date of the last appointment. Ideally the survey is taken either at check-in or check-out the day of the last appointment. Often, a patient will self-discharge, so you may not know when the actual last visit is. That is why we recommend you get the patient to complete a status survey, for example every 5th visit so you can still get an accurate outcome from patients who self-discharge.

- **The Staff Discharge**- Set a timeframe for completing the patient discharge information in the FOTO system. The day of the final visit just after completion of the Final Status Survey? A specified day of each week? An episode in FOTO will not be complete until the Patient has completed a status assessment and staff has recorded the discharge in the FOTO system.

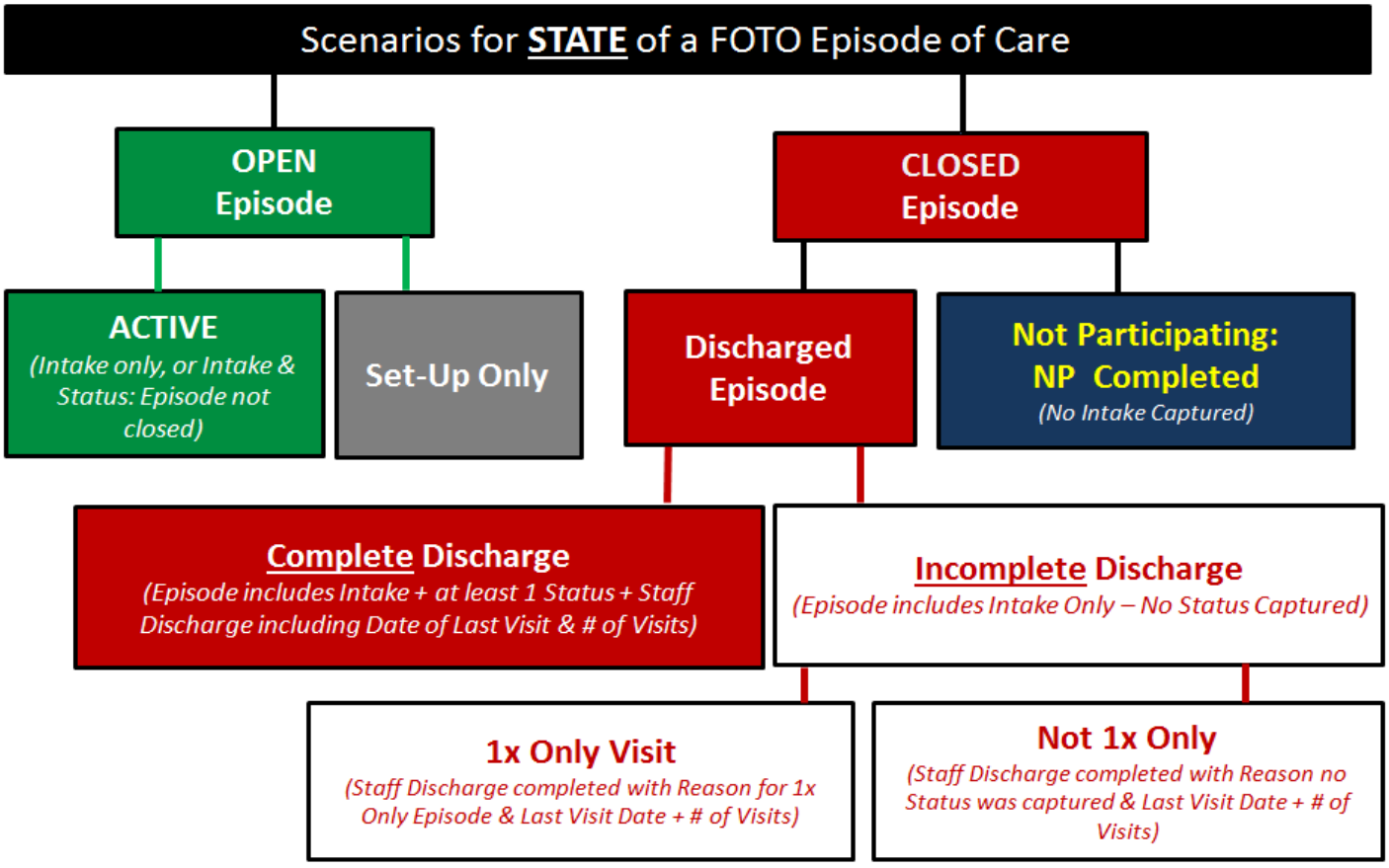
The Goal

- Use the FOTO Patient Specific Report Information to monitor and enhance functional improvement of the patient as a direct result of care received.
- As a Team, capture as many Complete Discharged Episodes as possible to maximize the quality of your care.

The remainder of this guide will provide detailed information on Navigating the FOTO Outcome Manager Web screens and capturing assessments and managing patients in the system.

(ACTIVE & CLOSED)

EPISODE STATE FLOW CHART



PATIENT MANAGEMENT FLOW CHART

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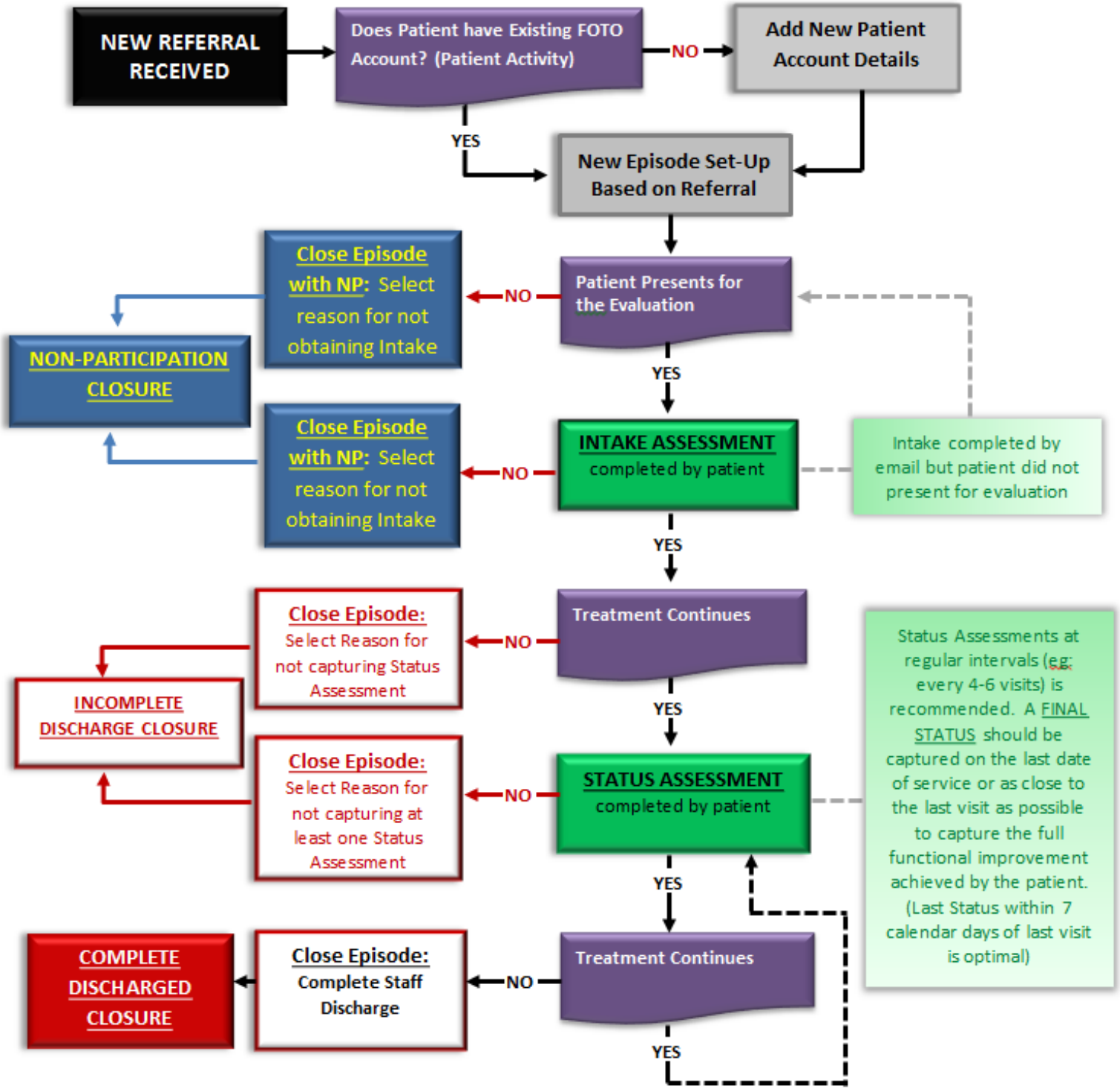


DEFINITIONS

The following definitions will assist you in our communications regarding the FOTO Outcome System. (*Listed alphabetically*)

Account – The basic patient information entered in the software including name, gender, DOB, language, email, and an ID #. An account may include multiple episodes

Active Episode – An open episode that contains an Intake only or an Intake and Status that has not been closed

Activity – the state of patient episodes

ADL – Activities of Daily Living clinician-driven additional assessment module

Assessment – Sometimes referred to as "surveys" or "questionnaires", FOTO refers to these as Assessments

Auto-Print / Auto-Save – An optional feature which automatically sends completed PSFRs to a default printer or a folder.

Body Part – The specific body part the patient is seeking intervention for such as Shoulder, Wrist, Elbow, Knee, Lumbar, etc. Some Care Types do not require a body part selection

Care Type – The primary distinction of the treatment for the patient's presenting problem: Orthopedic, Neurologic, Cardiovascular/Pulmonary, Industrial, Pelvic Floor Dysfunction, etc.

CAT – Computerized Adaptive Testing (FOTO's Electronic Assessments)

Closed Episode – An episode that has been discontinued with a Staff Discharge or a Non-Participation reason

Complete Discharged Episode – Episode that contains an Intake assessment, Status assessment(s) and the Staff Discharge

Electronic Assessments – Assessments completed by patient on a tablet, laptop, kiosk or by email. *Optimal/Preferred method of assessment completion*

EMR – Electronic Medical Record

Episode – The presenting problem or reason the patient is receiving treatment that is tied to the patient account. There may be multiple problems/reasons or Episodes tied to a single patient account

External ID – will populate if a patient is pulled from one of the EMR systems that integrates with FOTO

FLR – Medicare's Functional Limitation Reporting criteria, requiring G-Code sets and Complexity Modifiers on claims to adjudicate payment

FS – Functional Status Measure. This represents the score associated with the level of function reported by the patient based on their ability to perform the body or impairment specific functional activities

Impairment – The condition or cause of the presenting problem

Incomplete Discharged Episode (or Status Incomplete Discharge) – Episode that contains an Intake but no Status Assessment to produce an FS change score was captured from the patient and the reason for no status was documented on the Staff Discharge

Intake – The FOTO initial assessment completed by the patient before or on the first date of service that will generate an initial FS score and predictions for the episode of care

Interruption Days – A field on the Staff Discharge to document the number of calendar days (not visits) missed by the patient due to vacation, travel, illness, etc., if any.

Linked Episodes – two body-part episodes combined at Intake or Status so the specific functional questions for each condition can be asked of the patient in one assessment

Non-Participation (NP) – Patient episode set-up in FOTO but an Intake was not captured

Open Episode – Patient's account is set-up in the FOTO database and has not been closed

Optional Surveys – Optional surveys can be selected as useful additions to the FOTO standard assessments on an individual patient level but are only available for electronically completed FOTO assessments

Paper Assessments – Assessments completed by the patient using the paper assessment forms which requires practice staff to transfer the patient responses into the system to generate the PSFRs

Patient ID – The account identifier for the patient. The type of ID is established by your practice and can be a number or a combination of numbers and letters, etc.

Pay Source – The general type of payer responsible for the episode (not insurance company specific) such as Preferred Provider, HMO, Medicare, Indemnity, etc.

Proxy – An individual who answers all questions on the assessments on behalf of the patient. The proxy determines the content of the answer upon their perception of the patient's abilities. A proxy is used when a patient cannot give accurate answers about their health or cannot answer reliably

PQRS – Medicare's Physician Quality Reporting System

PSFRs / PSRs – The FOTO Patient Specific Functional Reports (Intake, Status and Discharge)

Quarter – FOTO utilizes Calendar Quarters

- Qtr 1: Jan-March
- Qtr 2: April-June
- Qtr 3: July-Sept
- Qtr 4: Oct – Dec

Recorder – An individual who records all answers provided by the patient who can respond verbally and reliably. The Recorder must NOT influence the responses or answer on behalf of the patient

Risk-Adjustments – Criteria used to assure comparison of patient outcomes by adjusting for the differences in risk among specific patients. FOTO has 10 risk adjustment factors to assure "apples to apples" comparisons within the database

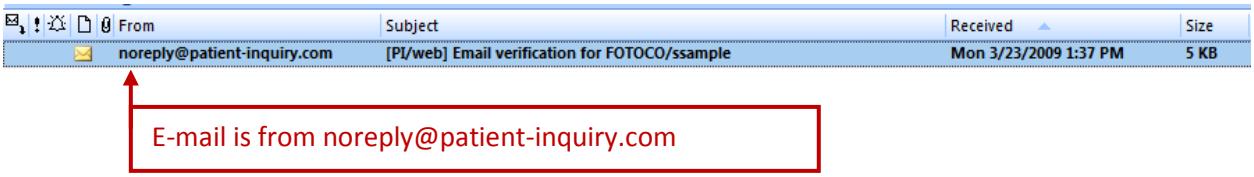
Status – The FOTO subsequent assessments completed by the patient at regular intervals during the episode and on the last date of service that will produce the points of FS improvement (and comparison to predicted change)

Staff Discharge – The clinical information required to close an episode of care related to number of visits, last date of service, etc. Until the staff discharge is completed, the FOTO episode is considered Open or active

GETTING STARTED

SUPPORT STAFF SET-UP & SECURITY

When your Practice FOTO Administrator registers a Support Staff User, an e-mail is generated which is immediately sent to the new user. The email is generated from noreply@patient-inquiry.com. If the e-mail is not received, PLEASE CHECK any spam or junk e-mail folders. Also check that e-mails containing links are not being blocked by your organization's IT department. If the e-mail is still not available, notify the person serving as the FOTO Administrator for the Practice or FOTO Support.



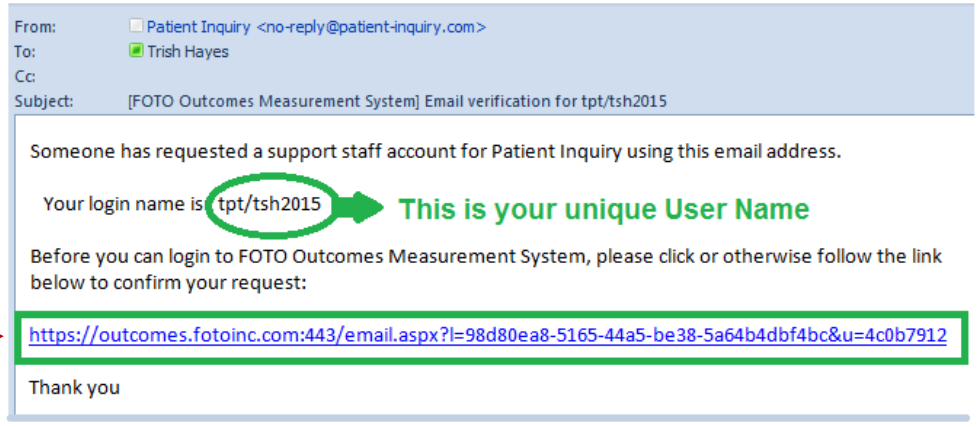
The following outlines the steps Support Staff Users need to follow to finish the Email Verification, Set-Up, and Security process.

Support Staff User E-Mail Verification & Security Setup Process

On receipt of your verification email from your Practice FOTO Administrator, note that the email contains your User Name that you will use when logging into FOTO. Until you get use to logging in, you may want to jot this user name down in a secure location.

The e-mail contains a link which will allow the Support Staff User to verify their e-mail address and complete the registration process.

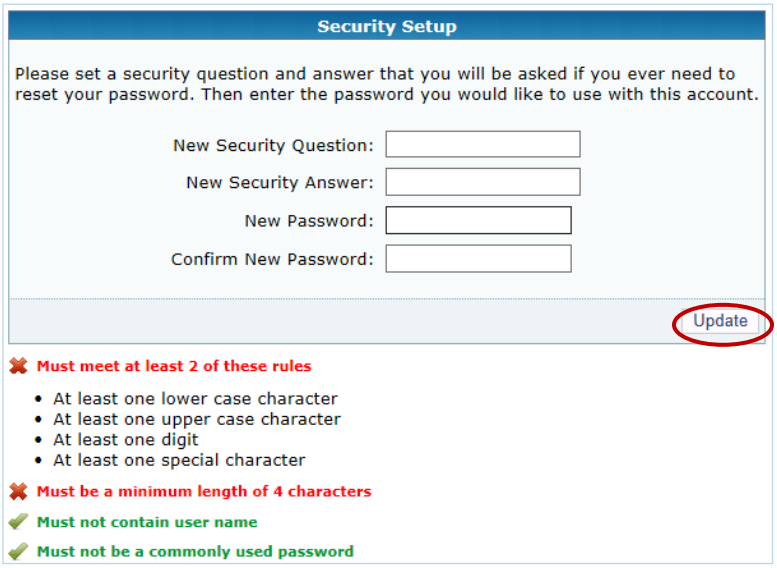
Click on the Link to open the verification / security set up process.



Clicking the link in the verification e-mail will open the Security Setup screen (below). Enter the required information and then select **UPDATE** to save this information as follows.

- **Security Question** – This should be something that you would easily remember, but others would not easily know, such as your mother's maiden name, your first pet's name, etc.

- **Security Answer** – This is the answer to the Security Question. If you forget your password, the system will ask you the security question and you must supply the answer in order to reset the password.



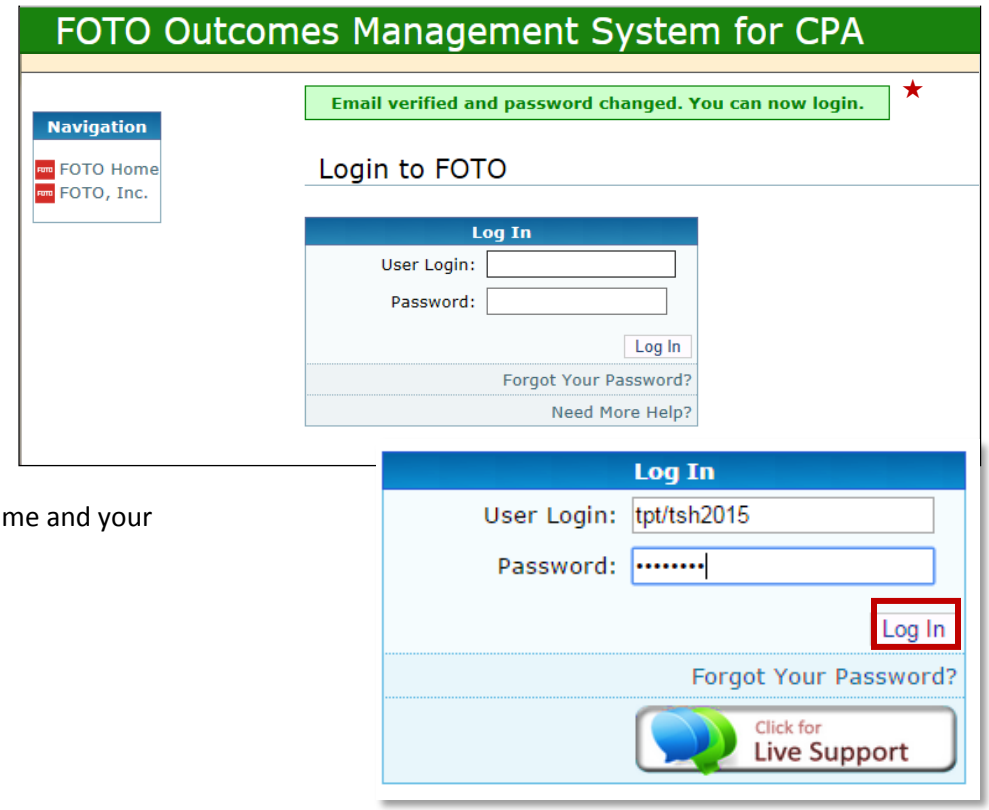
- **New Password** – you will enter your desired password in this first field box, following the criteria at the bottom of the screen. The password requirements will turn green as the requirements are met. If the requirements are not met, the criteria will remain red. If the password contains the user's name, the requirement in green will turn red and will not allow the password to be created.

- **Confirm New Password** – simply re-enter the password as you entered in the previous password field.

- When done, click UPDATE.

Once the Security Setup is complete, you will see the below green message indicating that you are ready to login.★

It is advised that you set a bookmark or favorite at this point, before logging into the system, using the instructions in the next section.



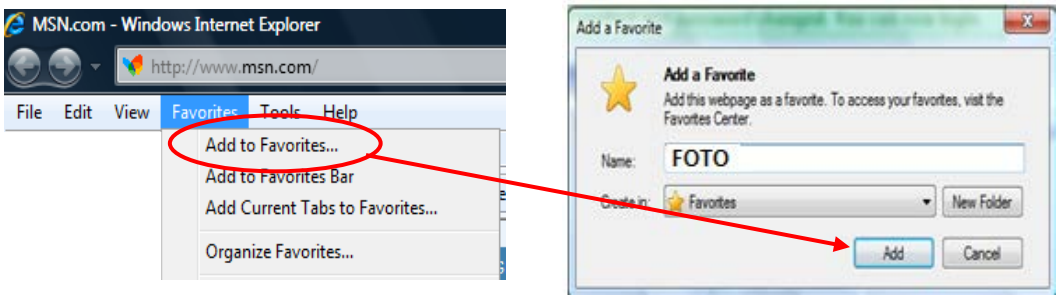
Once you have set your bookmark, you can login at any time using your User Name and your established/verified password.

Bookmarking / Setting Favorite in your Internet Browser

Saving the Login Page to your Internet Favorites or Bookmarks will make accessing the login screen very efficient. The instructions for saving the page follow based on the browser you may be using.

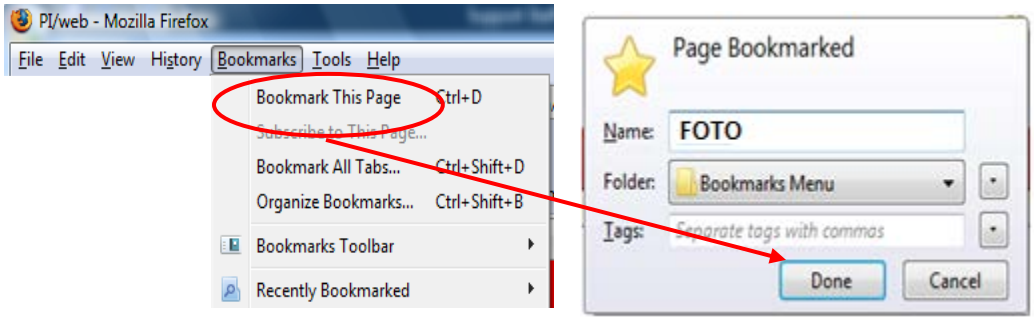
INTERNET EXPLORER

Select Favorites > Add to Favorites. (Right-click anywhere on the page if you do not have a toolbar at the top.)



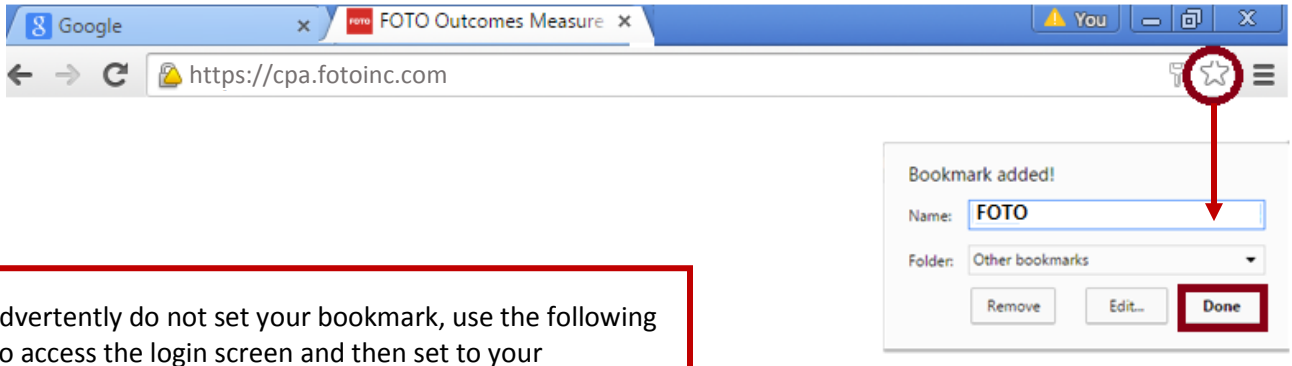
FIREFOX

Select Bookmarks > Bookmark This Page



CHROME

Click on the Star in the address bar, setting the location of the bookmark (Main browser bar or Other Bookmark drop down).



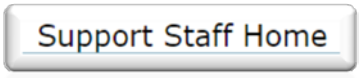
If you inadvertently do not set your bookmark, use the following address to access the login screen and then set to your internet favorites/bookmarks:

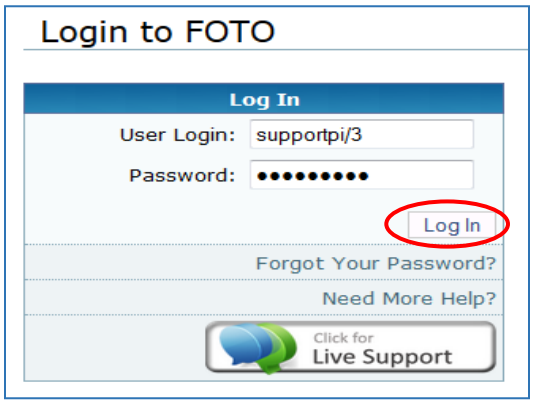
https://cpa.fotoinc.com/

LOGIN & MANAGING ACCOUNT

Enter your User Login and Password in the login screen, then click **Log In**.

If your login is successful, you will immediately open the Support Staff Home page.





In the Main Support Staff Home page that opens, you will have access to:

- Ribbon Bar Status Notices
- View the Release Notes
- Select your Clinic Location
- Edit your Account Information & Reset Forgotten Password

Ribbon Bar Status

The Ribbon Bar at the top of the FOTO screens will alert you to any status changes in the FOTO program.

The standard ribbon appears as:

FOTO Outcomes Management System for CPA

When an upgrade is planned, the ribbon bar will alert you to the date and time of the planned program upgrade. Access to the program will be unavailable during the upgrade period. However, please note that upgrades are always completed during late evening hours to minimize/alleviate user downtime. Such as:

FOTO Outcomes Management System for CPA – Planned Upgrade 08/28/2015 at 10:00 Eastern

When the upgrade is completed, and for the next week, the ribbon will alert you that there has been upgrade, directing you to be sure to review the Release Notes related to the upgrade. After a week, the ribbon returns to the standard ribbon (although release notes continue to be available to you after the ribbon returns to the standard status).

FOTO Outcomes Management System for CPA – Upgrade Completed 08/28/2015 – Refer to Release Notes

Every effort is made to provide you with immediate access to the FOTO System. However, occasionally we do experience performance issues that may need to be resolved during working hours. If this occurs, the ribbon will alert you to the access problem and once resolved, the ribbon will return to the standard status.

FOTO Outcomes Management System for CPA – We are experiencing performance issues. We are working to resolve the issue.

Release Notes

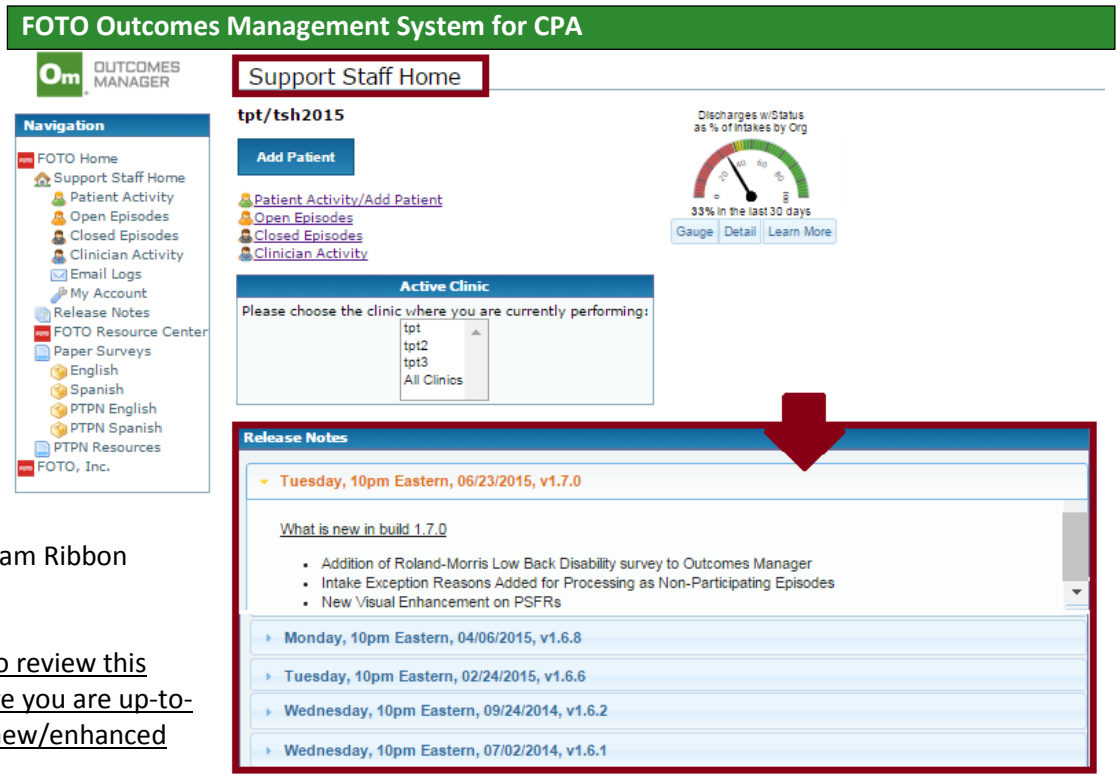
Once the Login button is clicked, the very first screen that opens is the Support Staff Home Screen which contains a section called "Release Notes".

As FOTO upgrades the system, the updates are downloaded to all FOTO Users.

To keep you informed of these changes and provide you with instructional materials regarding these changes, the release notes will appear in this first Support login screen.

Notifications will appear about one week prior to upgrade releases in the Program Ribbon Bar at the top of your screen.

FOTO encourages our users to review this Release note screen to be sure you are up-to-date with any upgrades and new/enhanced features.



Selecting Your Clinic

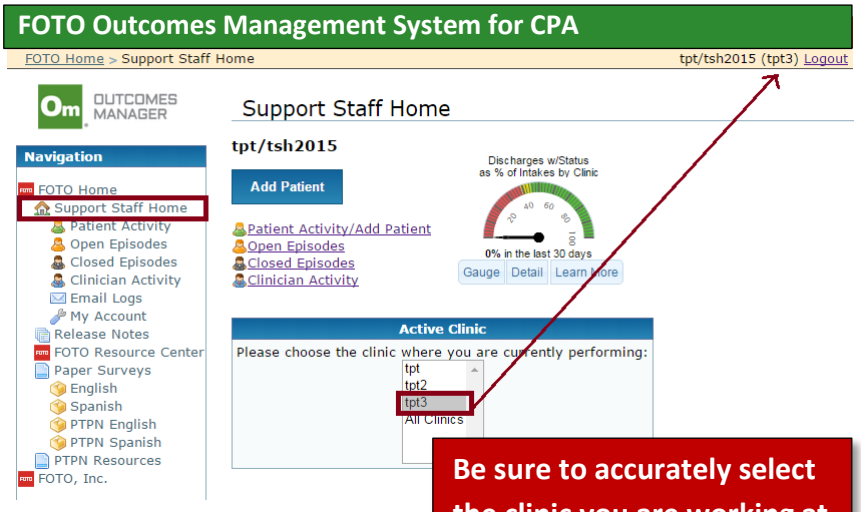
If the organization has more than one clinic, the **USER MUST SELECT THE CLINIC AT WHICH THEY ARE CURRENTLY WORKING**.

Once a clinic is chosen, it will show next to the user login name in the upper right corner.

If a single site organization, you will not be asked to select a clinic after login.

If you work at more than one clinic within the organization, you can switch to a different clinic by clicking on Support Staff Home in the Navigation bar and then selecting an alternate clinic from the drop down list of sites.

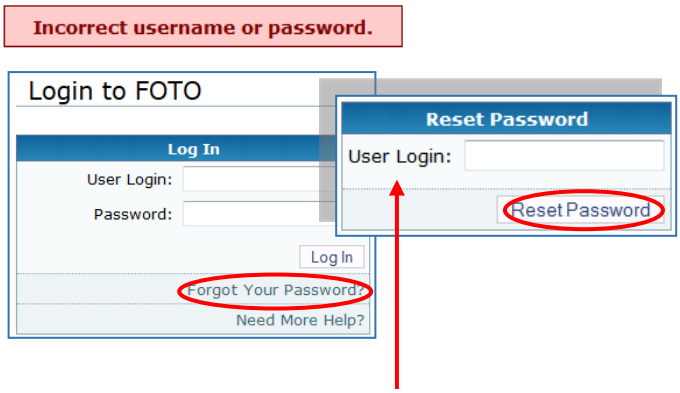
If you need to view all patients in the organization regardless of clinic, select "All Clinics" from the clinic drop down list.



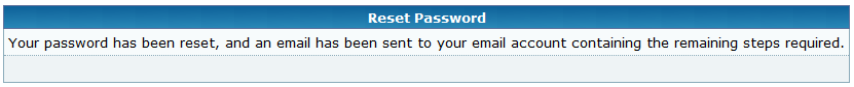
Be sure to accurately select the clinic you are working at when logging in. This will assure the patient episodes are tied to the correct site for Profile Report purposes.

Password Reset

If you forget your Support Staff User password, click **Forgot Your Password?** from the login screen.

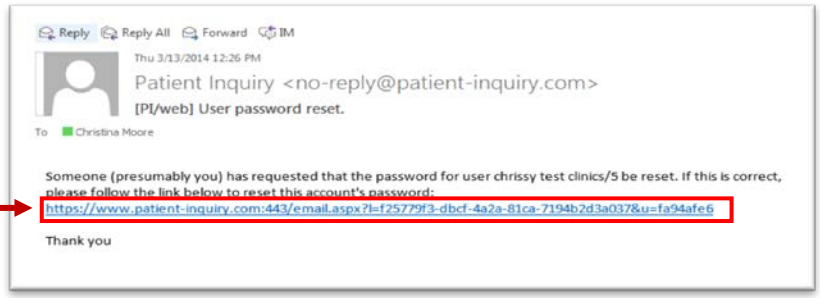


1. Enter your User Login (e.g. FOTOCO/Clinician) in the next screen and click **Reset Password.**
   - A Reset Password notification message will appear**.**



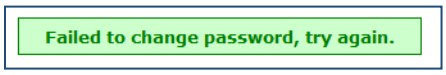
   - If nothing happens, the User Login is either incorrect or is the Administrator login**.**

2. When you receive the email, click the link contained in the e-mail (the email will be sent to the address associated with your User Login).



3. You must answer your security question in order to change your password.
4. Enter and confirm the new password
   - If all password requirements at the bottom are **green**, you have successfully met the requirements.
   - Click **Update**

5. However, if you still receive a failure message to try again,



   this means your security answer is not recognized. Try to enter it again and remember the response is case-sensitive.

6. If you cannot remember the answer, your Practice FOTO Administrator can change your password for you or you can contact FOTO Support.

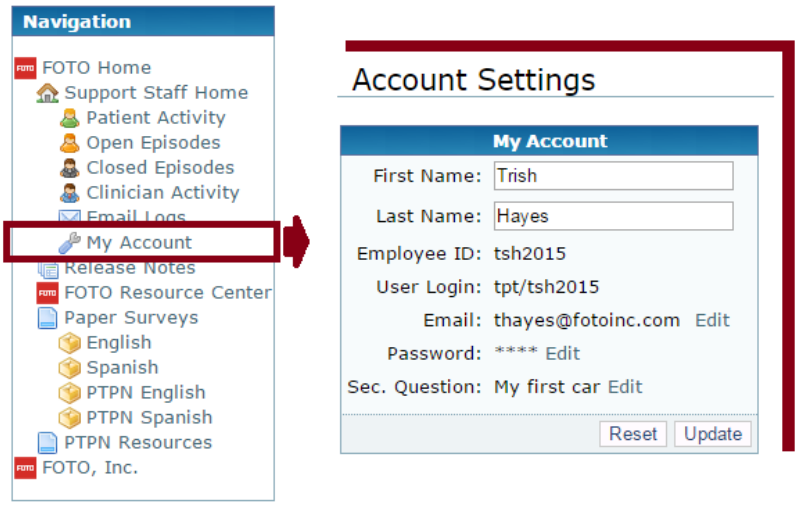
Editing Support Staff User Account

Once you log into FOTO, you can change your Staff User account settings by clicking **My Account** in the Navigation bar.

Fields you can edit are:

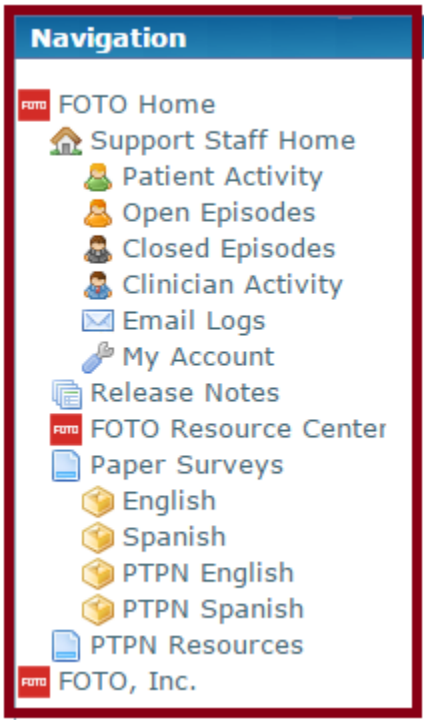
- First Name
- Last Name
- Email address
- Password
- Security Question

Be sure to click "UPDATE" when you have completed your edits to save the information.



AN INTRODUCTION TO THE

NAVIGATION BAR MENU



The Navigation Menu on the left side of the screen provides immediate access to the screens needed to manage patient accounts and episodes.

The FOTO Home link opens a screen that outlines the system requirements, whitelist information, etc.

The Support Staff Home section includes the **MAIN PATIENT MANAGEMENT LINKS or Activity Lists** that you will use to **Establish New Patients** and access and **manage your established patient accounts and episodes**. Activity Lists are:

Patient Activity – View all patient records by Account ID

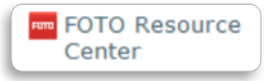
Open Episodes – Opens a table of individual patients by body part episode

Closed Episodes – Opens a table of all Closed patients by episode.

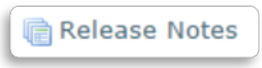
Clinician Activity –Opens a table of all patient episodes by the clinician assigned to the episode.

Opens a table showing distribution & status of all patient assessments distributed by email.

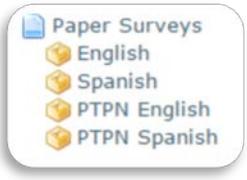
Opens screen to edit your FOTO account settings (ie: email address, passwords, etc.).



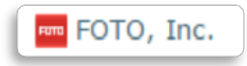
Directs you to the resource center to access other reference materials, On-Demand trainings, without having to log out or log back into the system. Once in the Resource Center, you can use your "back" button in your browser to take you back to the FOTO Support screens.



Gives you immediate access to the Release Notes regarding upgrade enhancements, etc.



Access to zip files containing master set of paper Intake and Status Assessment forms. These are only needed if you are not capturing electronic assessments. Master paper assessments are available in English and Spanish.

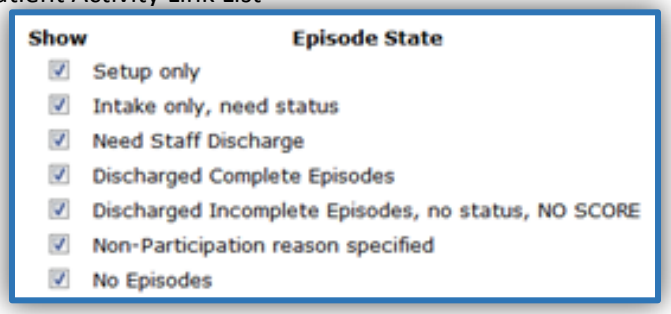


Directs you to the FOTO website, providing you with valuable information on FOTO, the Outcomes Measurement System, using the system, and much more. It should be noted that this link will take you out of the system and you will need to log back in to FOTO Support screens.

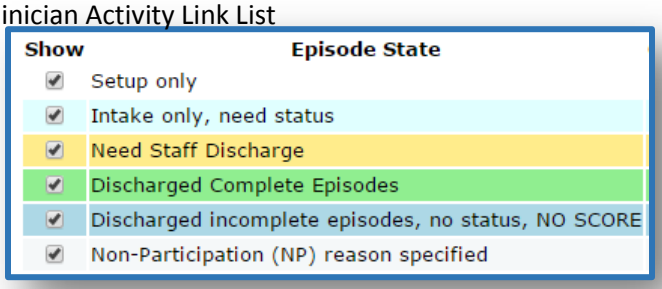
EPISODE STATE FILTERS

On the **Patient Activity** and **Clinician Activity** Lists, you will have an option of sorting the columns or filtering the data based on the Episode State to assist you in managing these episodes to maximize your outcome information. You can filter or sort the Patient Activity list by the Episode State. You can filter or sort the Clinician Activity List by the Episode State and the State and Episodes are color coded as well for easy reference.

Patient Activity Link List



Clinician Activity Link List



The State filters are as follows:

☑ **Setup Only**: The patient Account and/or Episode have been set-up in FOTO but an Intake Assessment has not yet been captured.

☑ **Intake Only – Needs Status**: An Intake Assessment has been captured for the episode but no subsequent Status Assessments have yet been captured. Filtering your list by Intake Only provides a list of the patients' episodes that need a Status Assessment /or/ perhaps are no longer attending for closure.

☑ **Need Staff Discharge:** Episodes that contain both an Intake Assessment and at least one (1) Status Assessment that are still open. FOTO is not directing that the episodes be discharged. The filter is to help you identify and evaluate if the patient continues in active clinical care to determine if another Status Assessment is needed /or/ if closure is indicated because the patient is no longer in active clinical care.

☑ **Discharged Complete Episodes**: Episodes that contain an Intake, Status Assessment(s) and are closed with a Staff Discharge.

☑ **Discharged Incomplete Episodes – No Score**: Episodes that contain an Intake and have been closed but NO Status Assessment was captured to produce the points of functional status improvement for the patient.

☑ **Non-Participation**: Episodes where an Intake was not captured (or the Intake was completed by email but the patient never presented for the evaluation) and a reason was listed to close the episode.

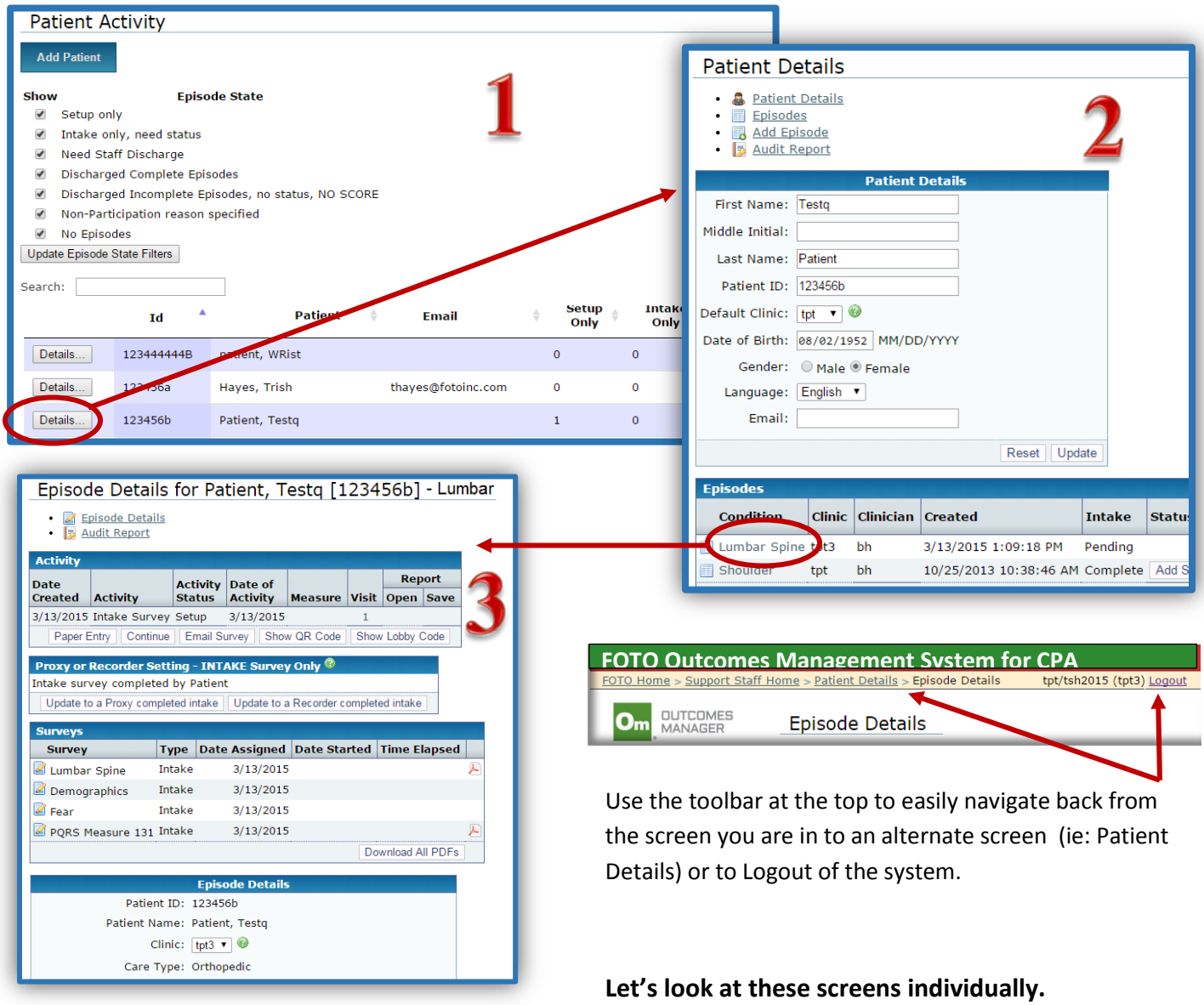
☑ **No Episode**: An Account was established for the patient but an episode was never set up and tied to the account.

To activate the filter to show in the table list, click in the checkbox ☑ .
To deactivate the filter from showing in the list, click in the ☑ to remove the checkmark to ☐.
In Patient Activity after revising filters, click the Update Filter button to revise the list. Update Episode State Filters
In Clinician Activity, simply activating/deactivating the filter will revise your list.

NAVIGATING PATIENT SCREENS

When managing a patient in FOTO, there are 3 main screens from which most activities are performed:

1. **Activity** – You will use one of the Activity lists to manage your patients, add or find a patients or add assessments to an episode, depending on the state of the episode. From these lists you will click on Details or the Account # to access the Patient Detail screen. The **Main Account** screen is **Patient Activity.**
2. **Patient Details** – Manage patient account information, add new episodes to an existing account & select an episode from the list by clicking the condition to access the Episode Detail Information
3. **Episode Details** – View and manage details for the selected episode, view/print reports & link episodes



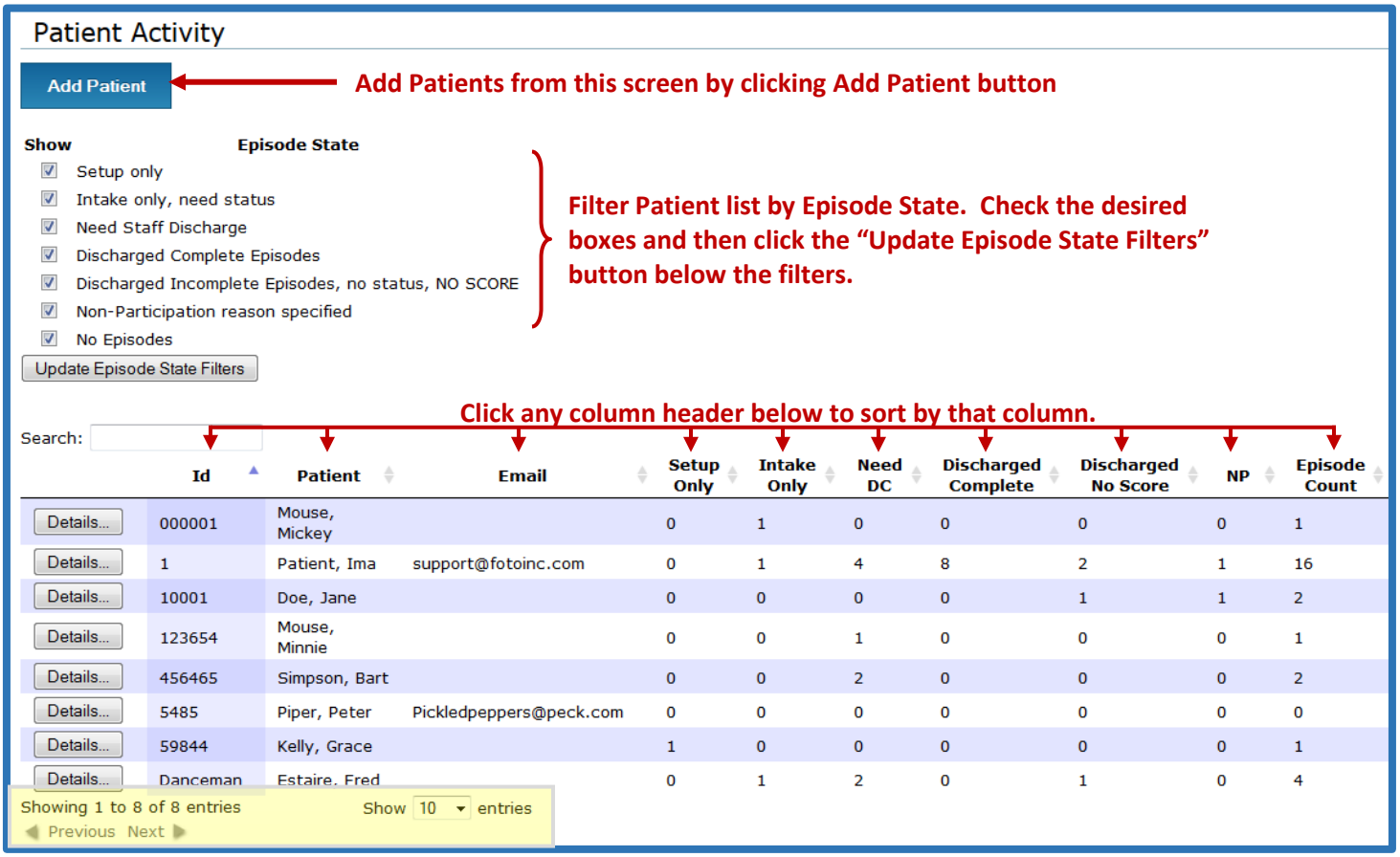
Use the toolbar at the top to easily navigate back from the screen you are in to an alternate screen (ie: Patient Details) or to Logout of the system.

Let's look at these screens individually.

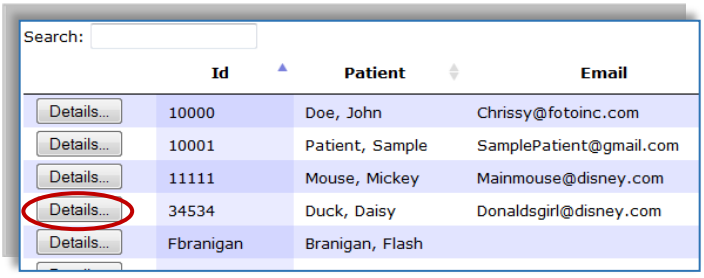
Patient Activity Screen

This screen provides a list of your **PATIENT ACCOUNTS**. It will show you the # of episodes tied to each patient account and the state of each of these episodes. In this screen you can:

- Add a New Patient
- Open the Patient Detail Screen to view the patient's account information and episodes



To show more than 10 Patients at a time in your list, change the selection in the drop down menu at the bottom. The change will be reflected in the "Showing" message to the left. Click **Next** to go to the next page if needed.



- To select a patient, click the **Details** button to open the Patient Details screen.

- The **Search** field can be used to search the patient list by Patient ID, name or email.

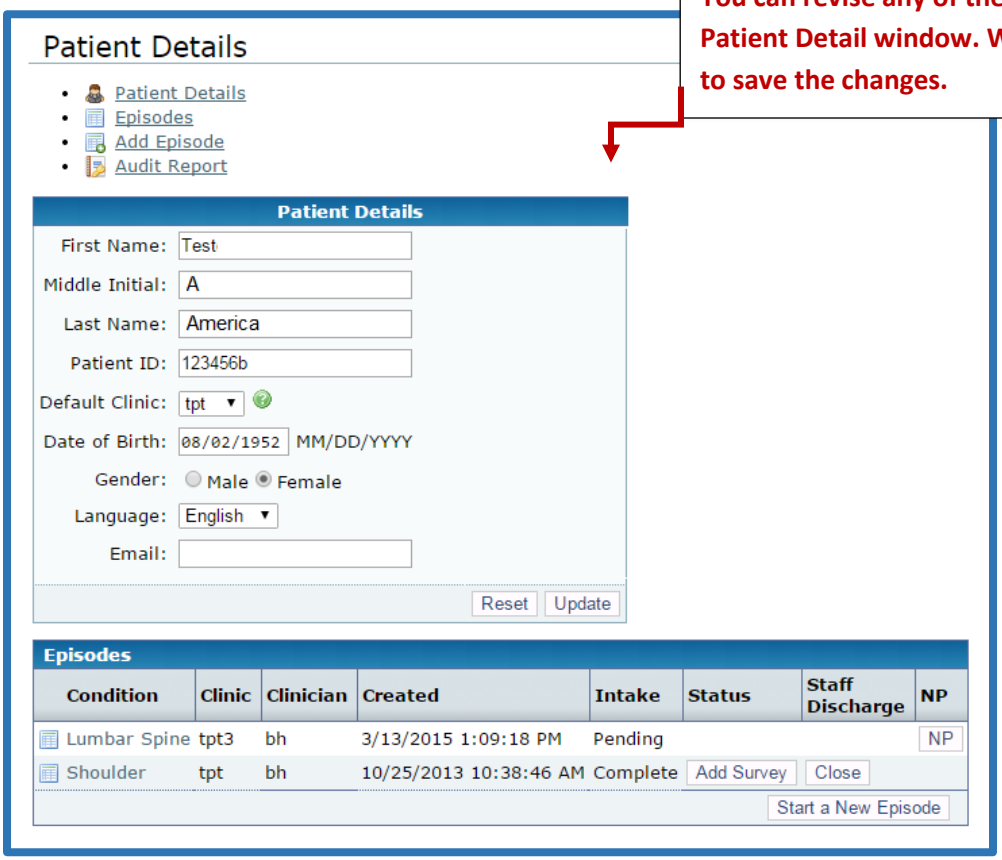
The screen will hold any selected filters or searches until changed or the user logs out.

Patient Details Screen

This screen outlines the Account information for the patient and also shows the Episodes tied to the Account. In this screen you can:

- Update or edit the Account Information
- Access the Episode Detail screen for any episode tied to the Account
- Changing the Default Clinic Site

You can revise any of the Account Information in the Patient Detail window. When finished editing, click UPDATE to save the changes.



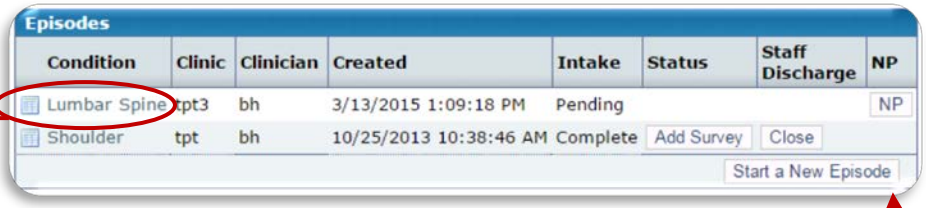
Default Clinic – For Multi-Site organizations, the default clinic will be the clinic the user was logged in under when the patient was created.

If this is incorrect or perhaps the patient is transferring care to another site, simply select the needed clinic from the drop down and click **Update.**

If the needed clinic is not available for selection in the drop down, it means that there is already a patient under the needed clinic with the same Patient ID.

Episodes Box: The Episodes box lists all episodes associated with the patient.

Click on the Episode Condition to open the Episode Details screen



- Clinic, Clinician and date created are shown for each episode.
- The Intake and Status columns show assessments completed for the episode.
- Status Assessments (if applicable), Staff Discharge or NP may be added as appropriate for the episode by clicking the corresponding buttons.
- Click Start a New Episode to begin a brand new episode of care in the same Account.

Episode Details Screen

The Episode Details Screen shows all information associated with the episode and corresponding surveys. In this screen you can:

- Capture Assessments
- Revise Details for the episode
- Designate a Proxy or Recorder
- Complete PQRS data fields if appropriate & activated
- Add ADL clinician assessments to the episode
- Link episodes in the account

To perform these activities, there are **6 Windows** in the Episode Detail Screen:

Activity Window

- Add, begin, enter and email assessments
- View or download patient specific reports
- Manage visit number associated with completed assessments

Proxy/Recorder Window

- Designate a proxy or recorder for the episode.

Surveys Window

- Lists assessments added, date started and time taken to complete each portion of the assessment
- Download PDFs needed if using paper assessments

Episode Details Box

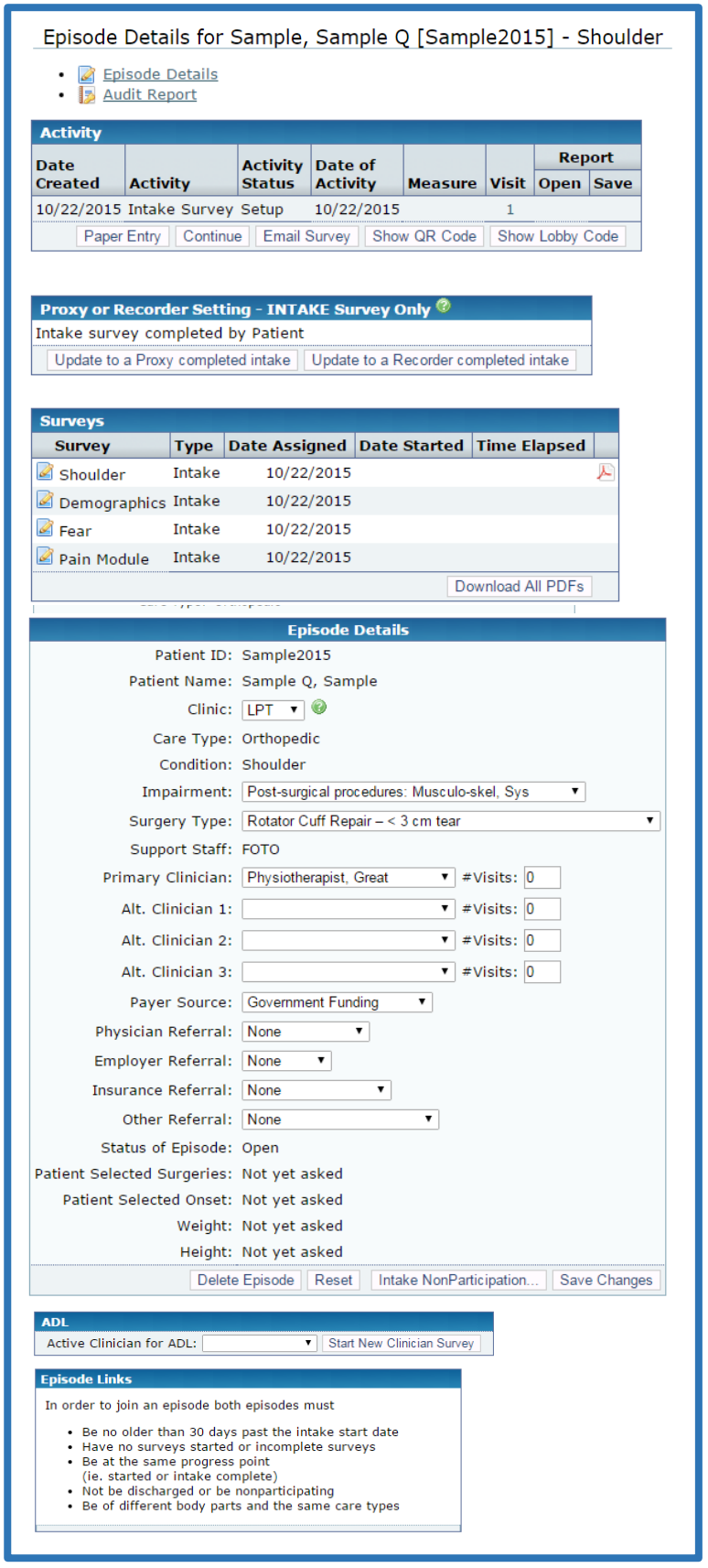
- Add or change episode details *(Note: Care Type & Body Part cannot be revised. If these are incorrect, a New Episode will need to be established.)*
- Add Staff Discharge
- Add an Intake Non-Participation
- Reopen discharged episode

ADL

- Initiate & manage clinician completed ADL assessment(s) and print / view reports.

Episode Links

- Combine two episodes by meeting the Link criteria



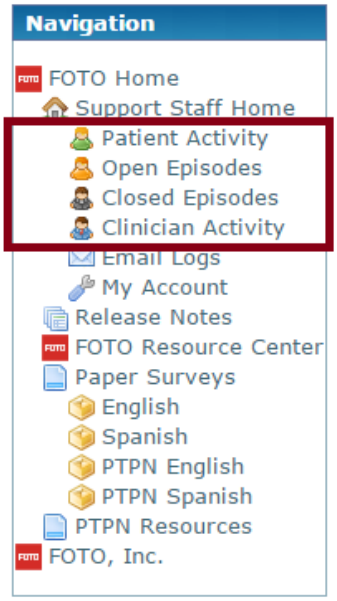
The fields will be explained in greater detail under section ***Patient / Episode Set Up***.

Note: If an episode has been discharged, the discharge will need to first be removed by clicking **Edit/Reopen** before making any changes to the Episode Details box.

(See section, ***Reopening Discharged Patient Episode***)

NAVIGATING EPISODE SCREENS

There are 4 screens from which episodes can easily be viewed and sorted.



- **Patient Activity** – As referenced in the previous section, this opens a list of your Patient Accounts and shows the State of each episode in the account.
- **Open Episodes** – Opens a list of your open (or active) patient episodes. Surveys and Staff Discharge information can be accessed directly from this open episode list.
- **Closed Episodes** – Opens a list of all closed episodes. This includes all complete discharged episodes, incomplete discharged episodes and non-participation episodes.
- **Clinician Activity** – Opens a list of the episodes assigned to each clinician in the organization that can be opened/selected by the clinician. This list will show ALL episodes tied to the clinician, Open and Closed.

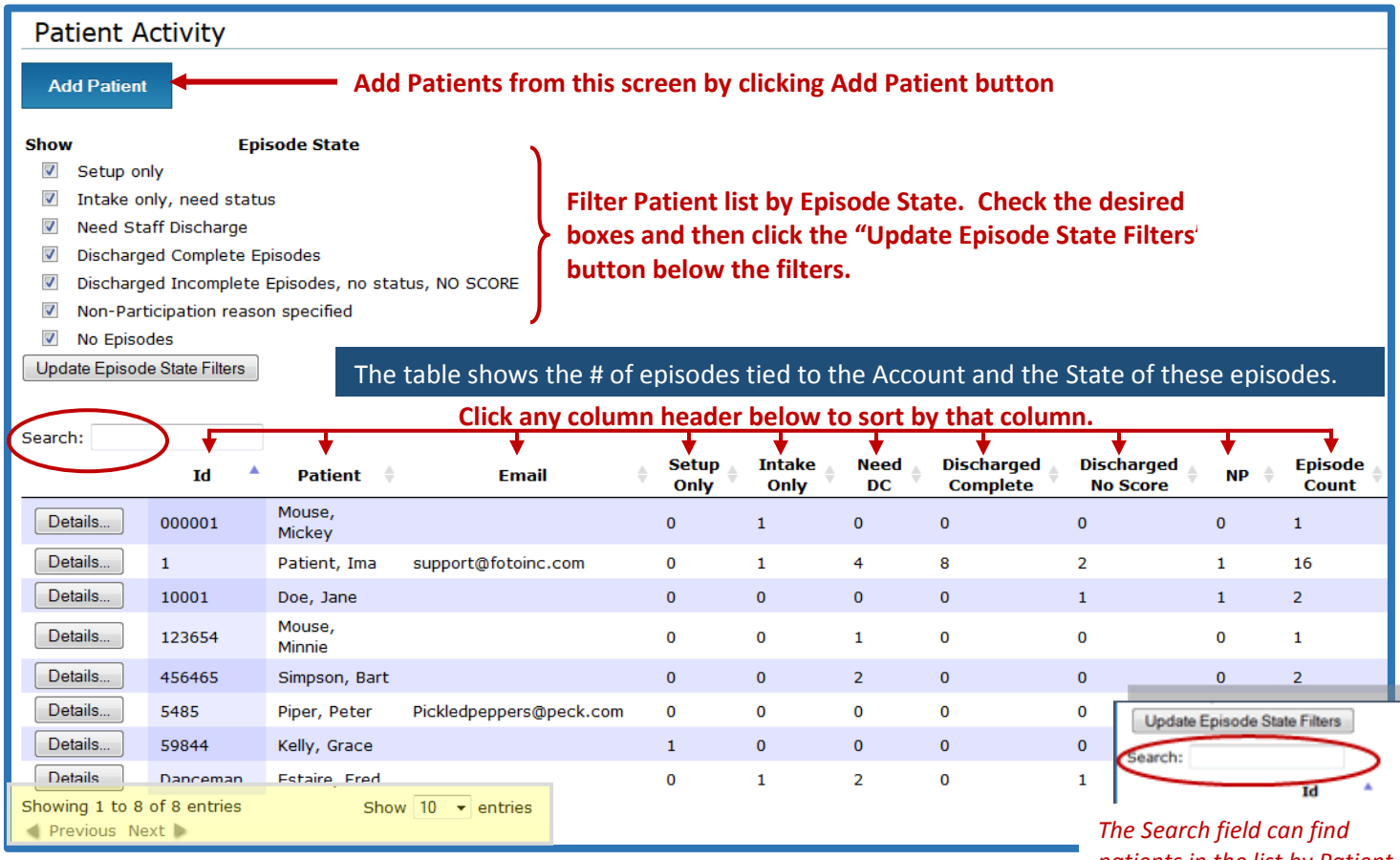
The following reviews how you can navigate these screens before we begin setting up a new patient, capturing assessments, and closing episodes.

Patient Activity Screen

Patient Activity

This screen provides a list of your **Patient Accounts**. It will show you the # of episodes tied to each patient account and the state of each of these episodes. In this screen you can:

- Add a New Patient
- Open the Patient Detail Screen to view the patient's account information and the episodes tied to that account.

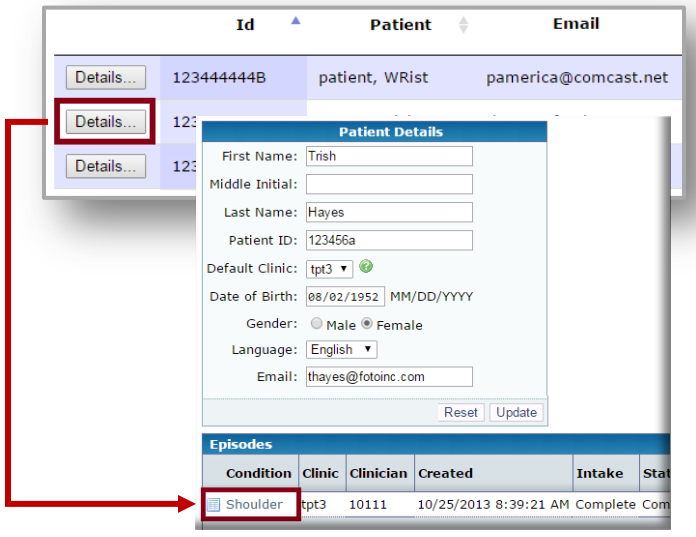


The Search field can find patients in the list by Patient ID, name or email.

To show more than 10 Patients at a time in your list, change the selection in the drop down menu at the bottom. The change will be reflected in the "Showing" message to the left. Click **Next** to go to the next page if needed.

- To select a patient to view the episode informaton, click the **Details** button to open the Patient Details screen.

- From Patient Details you can click on the Condition in the Episode window to view the Episode Details.

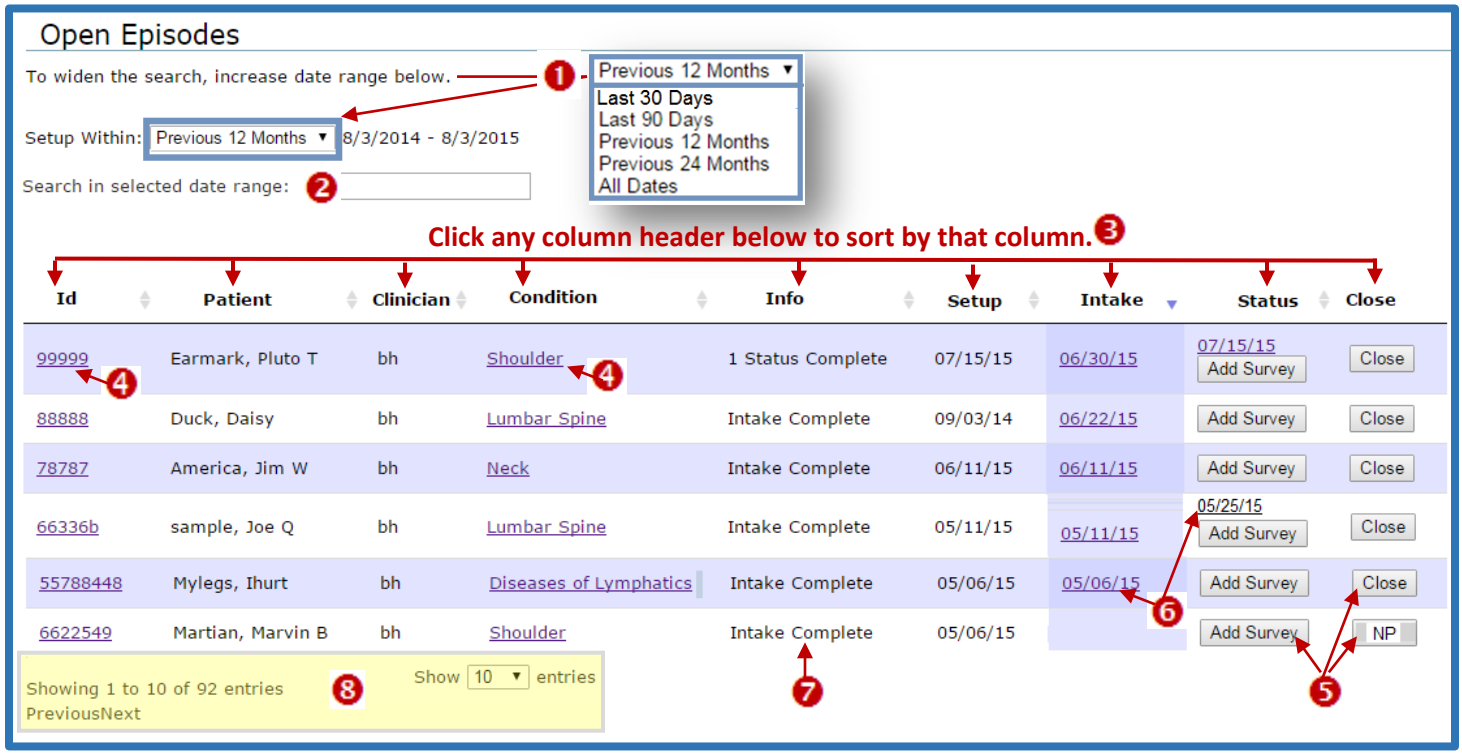


Open Episodes Screen

Open Episodes

The **Open Episodes** screen shows all active episodes that have not been closed either with a discharge or NP. It also shows patients who have no episodes created. If a patient has multiple episodes, the patient will be listed multiple times in this table, one line entry per episode. This is probably the most used screen in the Activity Screen selections. You can:

- Access the Patient Detail screen and Episode Detail screens by clicking on the ID# in this list
- Manage the completion of Intake Assessments and Status Assessments from this list
- NP or Close episodes from this table list



1. Date range for table defaults to Previous 12 Months. However, the date range can be revised by opening the drop down list.
2. The Search field can be used to search by Patient ID, Name, Clinician, or key words in the Info column.
3. Table can be sorted by any of the column headers.
4. Patient Details and Episode Details may be viewed by clicking on the "ID" and "Condition" respectively.
5. Assessments, NPs and Staff Discharges may be added to the episodes from this table.
6. Patient Specific Intake and Status Assessment (PSFRs) reports may be viewed by clicking on the date listed in the corresponding column.
7. Info Column will report if the Intake is Complete or Incomplete, if a survey has been emailed to the patient, the number of Status Assessments captured for the episode (only the date of the MOST RECENT Status will show in the Status column).
8. To show more than 10 Patient Episodes, change the selection in the drop down menu at the bottom. The change will be reflected in the "Showing" message to the left. Click Next to go to the next page if needed.

PSFRs will open in a separate window. If the browser is set to block all Pop-ups, a message should appear asking to allow Pop-ups from this site. Click "Always Allow" to ensure the reports can be easily viewed. If this message does not appear, the browser may need to be set to allow all Pop-ups.

Clinician Activity

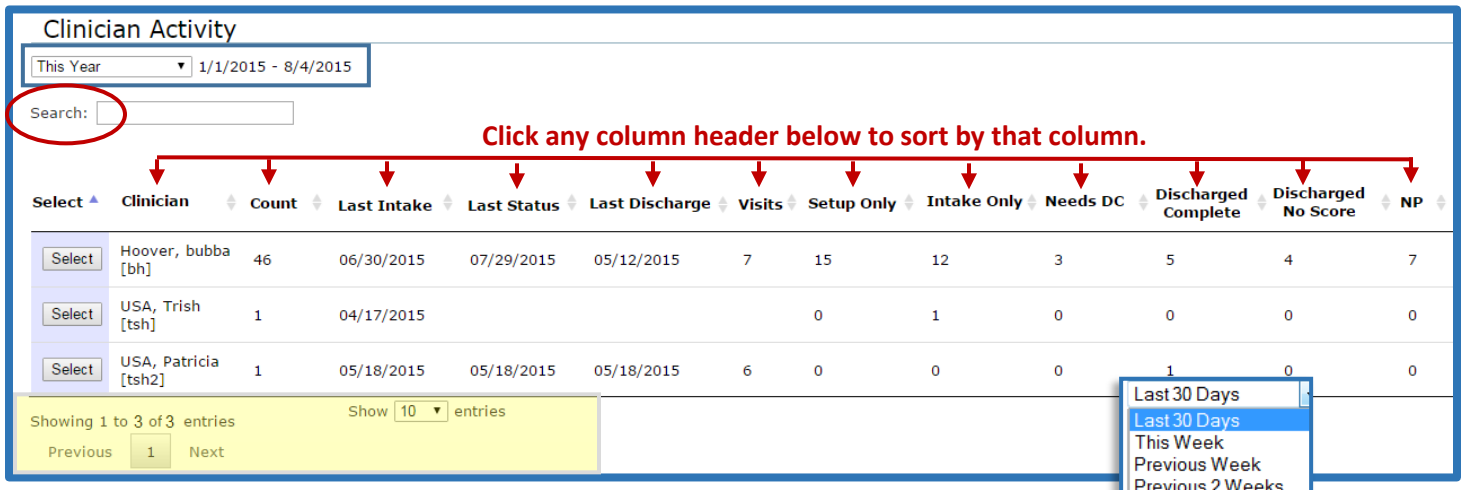
Clinician Activity

The **Clinician Activity Screen** screen shows a summary of ALL episodes by the primary clinician tied to the episodes in your office to help maximize the assessment process, including the State of these episodes. In addition you can manage the patient episodes assigned to each clinician from this screen (adding Status Assessments, completing Staff Discharges, etc.) From this screen you can:

- View and monitor the episodes tied to each clinician & the state of each episode in your office during a given specific timeframe.
- Select a specific clinician to review the episodes assigned to them which you can filter by color-coded episode state.
- Status Assessments, Staff Discharges and NPs can be added to the episodes from this screen (just as you can in Open Episodes)
- The table list by clinician can be exported to an excel spreadsheet for use in enlisting the clinicians input regarding the need to capture Status Assessments, complete Discharges, etc.

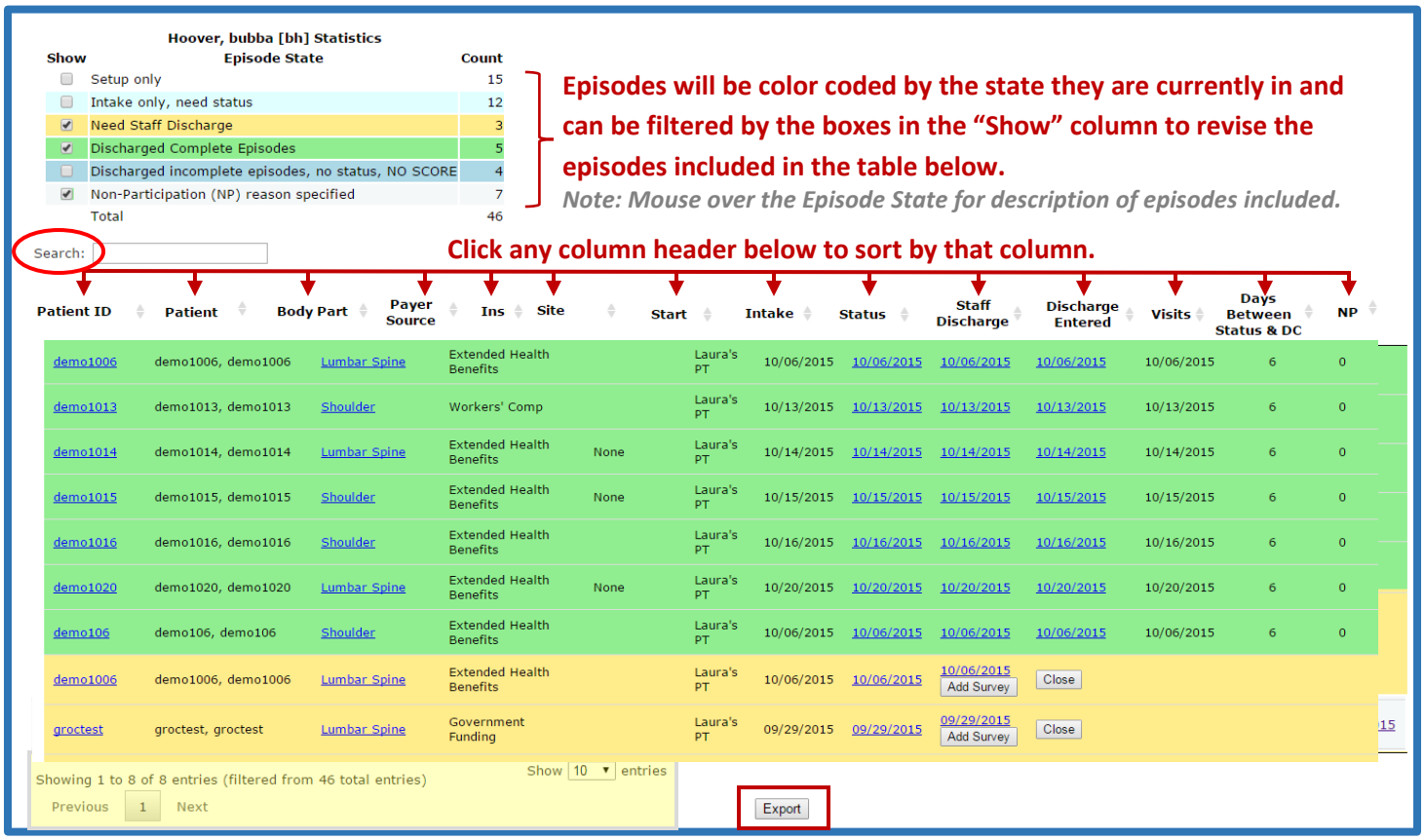
If you are logged in as a **SUPPORT STAFF MEMBER ONLY**, all clinicians and their associated episodes for the clinic may be viewed.

If you are a **CLINICIAN** with login rights as a support user, only the episodes assigned to this user will be shown in the Clinician Activity Screen.



1. Select the desired time frame from the drop down menu.
   - The range will default to "Last 30 Days" but can be changed using the drop down list.
   - All patient episodes Setup within this date range will be included
   - To show more than 10 Clinicians, change the selection in the drop down menu at the bottom of the clinician table list. The change will be reflected in the "Showing" message to the left.
     - Click **Next** to go to the next page of Clinicians if needed.
   - The **Search** field can be used to search for a specific clinician.
2. If you are a clinician, go to step 3.
   If you are not a clinician, **click Select by the clinician for which you would like to view patient episodes information.**

3. If you are the clinician, or you have selected a clinician, the associated patient episodes created during the selected time frame will appear at the bottom of the screen. Episodes will only be listed if the clinician is listed as the Primary Clinician for the episode. In this example, we selected B. Hoover from the clinician list as the clinician so only the episodes tied to this clinician are included in the table.



This episode list functions similarly to the list on the Open Episodes screen:

- To show more than 10 Patient Episodes, change the selection in the drop down menu at the bottom. The change will be reflected in the "Showing" message to the left.
- Click **Next** to go to the next page if needed.
- The **Search** field can be used to search by any keyword, number, or date.
    - If searching for a specific patient episode, be certain that the episode was created during the selected time frame (date range).
- Click **Export** to drop the data into an Excel spreadsheet. This will be data only; the formatting will not transfer.
- From this screen, you can also add assessments, NPs and Staff Discharges for the episodes.
- Patient Specific Intake or Status Reports, Staff Discharge and NP reports may be viewed by clicking on the date listed in the corresponding column.

> **Note:** The reports will open in a separate window. Pop-up blockers may need to be disabled.

- The Patient Details and Episode Details may be viewed by clicking on the "Patient ID" and "Condition" respectively.

CARE TYPE DESCRIPTIONS

The following list gives examples of the typical types of diagnoses that would be included within a Care Type to assist with the selection of the appropriate care type for your patient episodes.

ORTHOPEDIC

- Arthropathies
- Spine Pathology
- Muscle, Tendon & Soft Tissue Disorders
- Osteo, Chondropathies & Acquired Musculoskeletal deformities
- Fractures / Dislocations
- Sprains / Strains
- Wounds and Traumatic Amputation
- Contusions
- Crushing Injuries
- Burns
- Post-surgical procedures: Musculoskeletal system
- NOC*-Musculoskeletal disorders

ORTHOPEDIC BODY PART
Shoulder
Pelvis
Hip
Upper Leg
Knee
Lower Leg (w/o Knee)
Ankle
Foot
Craniofacial
Neck
Ribs – Trunk
Thoracic spine
Lumbar spine
Upper Arm
Elbow
Forearm
Wrist
Hand

PELVIC FLOOR DYSFUNCTION

- Urinary Incontinence
- Failure to store – Bowel
- Failure to empty – Urinary Retention
- Failure to empty – bowel constipation
- Other Urinary or Bowel Dysfunctions
- Pelvic Floor Pain
- Supportive Dysfunction

CARDIOVASCULAR & PULMONARY

- Rheumatic and Heart Disease
- Diseases of Arterial System
- Diseases of Veins and Lymphatics
- Lung Disease

NEUROLOGICAL

- Cerebrovascular Disorders
- Endocrine, Metabolic, Immunity Disorders
- Psychotic Conditions
- Neurotic, Personality & Other Non-Psychotic Disorders
- Inflammatory Diseases of the Nervous System
- Degenerative CNS disorders
- Multiple Sclerosis
- Non Traumatic CNS Dysfunction
- Quadriplegic Syndromes
- Paraplegic Syndromes
- Other Paralytic Syndromes
- Peripheral nervous system disorders Vertigo
- Congenital anomalies
- Brain Injury
- Vertigo
- Post-surgical procedures: Nervous system
- NOC*-Neuromuscular disorders

INDUSTRIAL

- Select only if patient is being treated in a Work Hardening or Work Conditioning Program

PAIN MANAGEMENT

- Select only if patient is being treated in a Multidisciplinary Pain Management Program

**NOC – Not Otherwise Classified*

Orthopedic Care Type is classified with a **Body Part** (cervical, thoracic, lumbar, knee, wrist, hand, shoulder, etc.) and Impairment.

The exception to this is when the patient has a diagnosis that does not localize to one area of the body – such as a diagnosis of general weakness / deconditioning, general balance disorder not associated with a Neuro Care Type issue, etc. These patients can be set up in the Orthopedic Care Type **without a body part selection**, as long as an Impairment is selected in lieu of the body part.

Patients in the **Neurological, Cardiovascular and Pelvic Floor Care Types** DO NOT REQUIRE A BODY PART SELECTION – only the impairment is needed to assure comparison with analogous episodes nationally.

Industrial and Pain Management Care types require the Body Part and Impairment as listed shown under Orthopedic Care Type.

PAYER SOURCE DESCRIPTIONS

Litigation – Select when the majority of payment for a treatment episode will be or currently is derived from a lawsuit or other legal settlement.

Government Funding – Select when the payment for a treatment episode is derived from provincial or federal public funding.

Extended Health Benefits – Select when the majority of payment for a treatment episode is derived from a health care coverage with a private insurer or a third-party administrator.

Patient – Select when the majority of payment for a treatment episode is derived from private pay from the patient.

Workers Compensation – Select when the majority of payment for a treatment episode is derived from a form of insurance that provides compensation medical care for employees who are injured in the course of employment.

Other – Select when the majority of payment for a treatment episode is derived from any type of payment source other than those ones on this list.

No Charge – Select when there will be no charge for the patient treatment episode.

Auto Insurance – Select when the majority of payment for a treatment episode is derived from a form of insurance that provides compensation medical care for a motor vehicle accident.

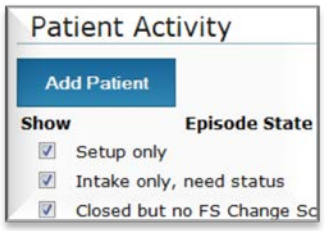
SETTING UP NEW PATIENT & EPISODE

FOTO FOCUS ON® THERAPEUTIC OUTCOMES INC

Adding a New Patient Account

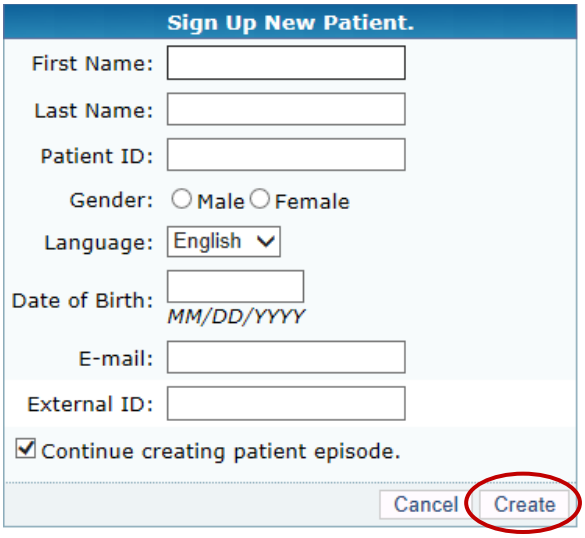
Select **Patient Activity** from the Navigation Menu.

- Click **Add Patient**



Enter information for the patient.

- First Name
- Last Name
- Patient ID#
- Select Gender
- Language (Select either English or Spanish from the drop down)
- Date of Birth
- E-Mail (this is an optional field, however, patient surveys cannot be sent by e-mail if left blank.)
- External ID (this will populate if a patient is pulled from one of the EMR systems that integrates with FOTO. Manual entry is not recommended, see ***EMR Integration***.)
- To create a patient ACCOUNT without creating an episode, uncheck the box next to **Continue creating patient episode**.
- When finished, click **Create**



You can now set up the Episode for the patient in the Create a New Episode screen that opens.

Creating Test Patients

Creating a test patient is an excellent way to learn and practice using the FOTO Outcomes Management System.

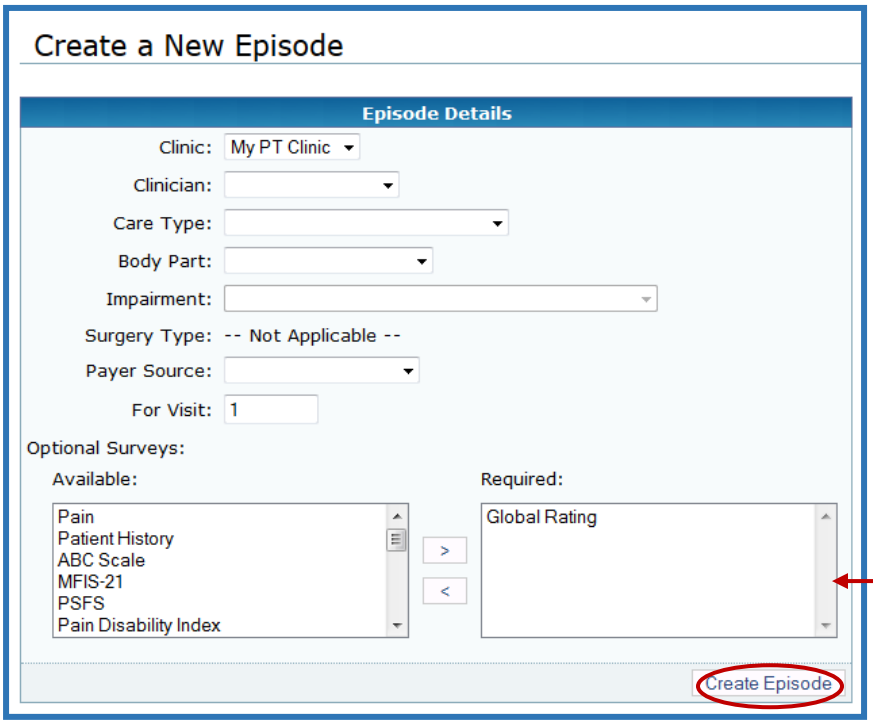
- Click **Add Patient** from the Patient Activity screen as above
- Test patients can have any first and last name you want, however, **the word "test" must be in the prefix of the Patient ID** (Example: Test1234) to ensure the results are not included in the clinic reports.
- Test patients can be deleted by the clinic FOTO administrator **as long as the word "test" is in the Patient ID**.
- Enter your e-mail address for the test patient to practice using the e-mail survey option

Creating an Episode for the Account

Now that you have set up the patient Account, you can enter the Episode in the Create New Episode screen which opens when you selected Create in the Sign Up New Patient screen.

Enter the appropriate information for the episode from the drop down lists and click **Create Episode** when finished.

- **Clinic** – Ensure the correct clinic is selected from the drop down if you have a multi-site organization
- **Clinician** – The Physiotherapist who will be managing the patient's care. If the correct physiotherapist is not listed, notify your FOTO Practice Administrator to add this staff member
- **Care Type, Body Part -** determines the type of assessment that will be created for the patient episode
- **Impairment** - The condition or cause of the presenting problem
- **Surgery Type** - Only required if the impairment selected is post-surgical
- **Payer Source** is HOW the cost of the service will be covered.



- **For Visit** – Defaults to "1" to indicate the first visit, but can be changed if the Intake Survey will be taken on a subsequent visit

If the Impairment and Surgery Type are not known at the time of the set-up, these fields can be completed post-evaluation by the clinician or support staff member in the Episode Detail Screen (Refer to section on Editing Episode Details).

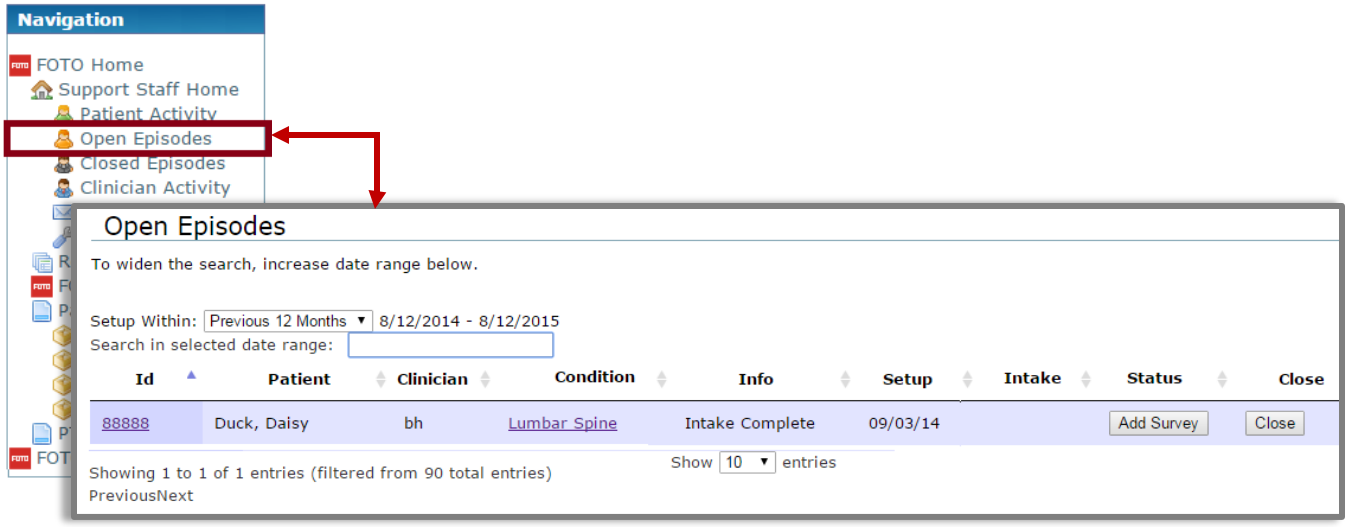
- **Optional Surveys** - Optional surveys that can be selected for inclusion in the Patient Assessment process for **electronic assessments** (completed on the computer/tablet/email). Only the Abbreviated ABC scale may be completed via Paper Survey Assessments. Only the optional surveys showing in the Required window will be added to the patient episode.

  - Optional Surveys must be selected during the set-up process: **these cannot be added once the episode is created.**
  - To select an Optional Survey, click on the name of the survey in the 'Available' window, click on the arrow > to move the survey into the 'Required' window.
  - To remove or change optional surveys after episode creation, close the episode as an "incorrect set-up" NP and start over.
  - For more information about each of the optional surveys, click on **FOTO Resource Center** in the Navigation menu. Select **Instructional Guides** then click on **Optional Survey Descriptions**.

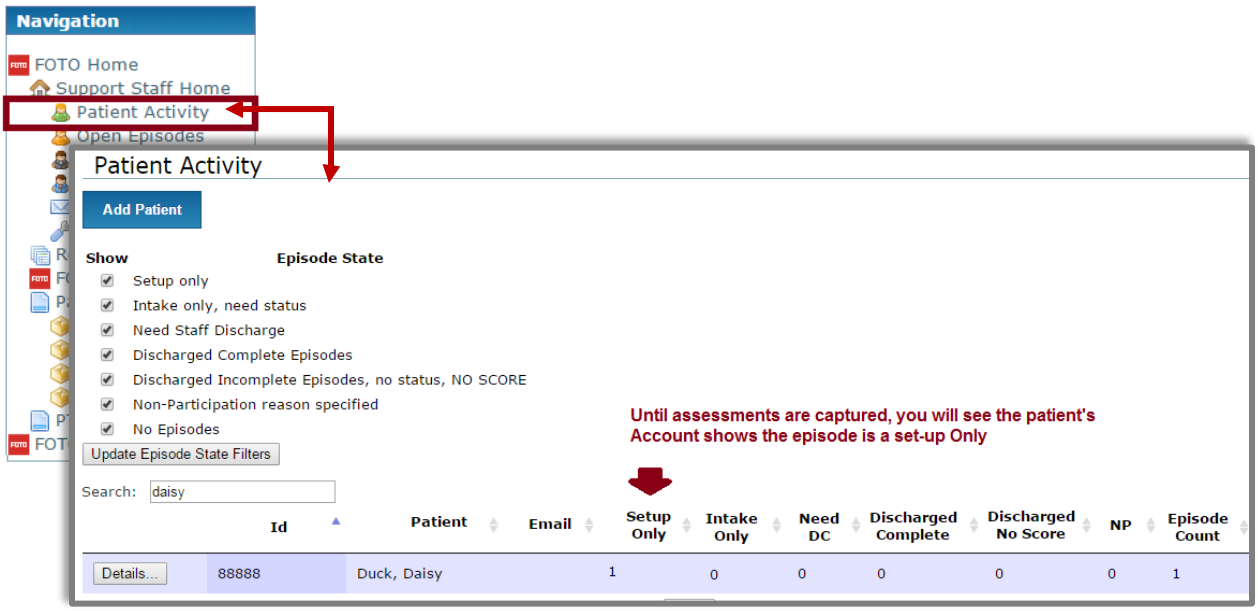
Note: Your Administrator may have preselected optional surveys as required for all patients. If so, these will automatically appear in the Required window.

When you click on Create Episode, the system will take you to the Episode Detail screen. You may want to view the Episode Details and complete any required fields at this time (See Editing Episode Details).

If not, simply go to your Navigation bar and go to Open Episodes and you will see this patient in your Active episode table.



If you go to Patient Activity, you will see the patient's account listed as a set-up only.



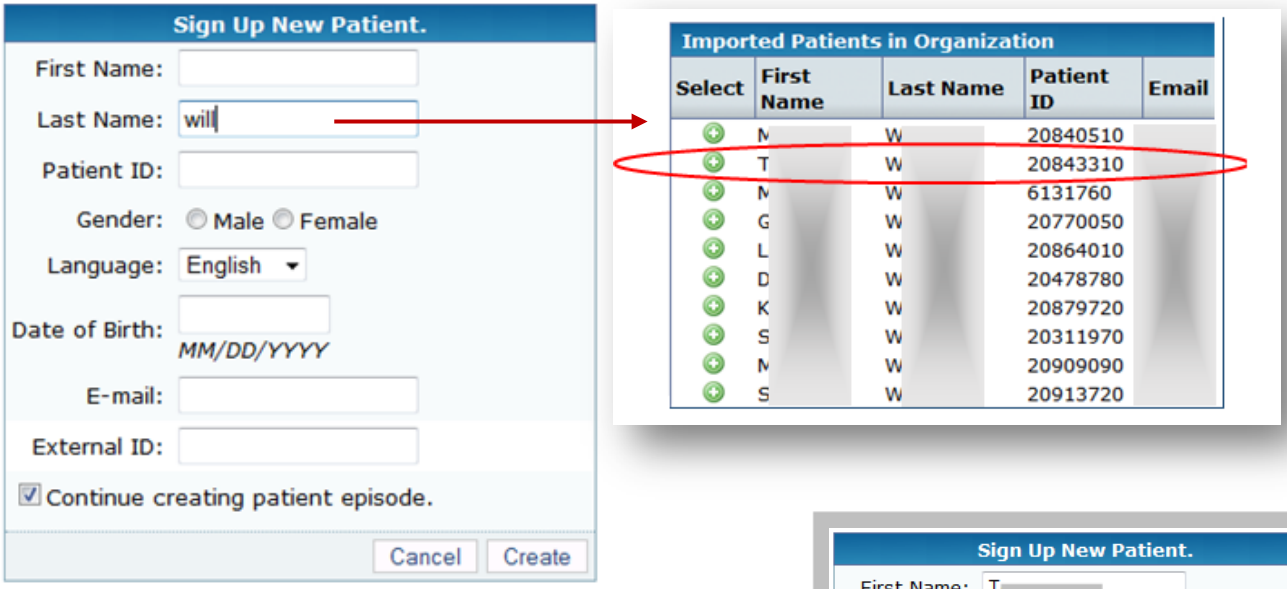
You are now ready to capture your FOTO Assessments for this patient.

CREATING AN EPISODE WITH AN

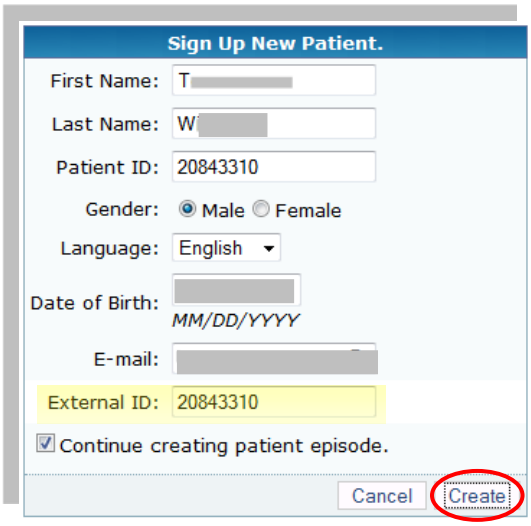
EMR INTEGRATION

If you have an EMR software that integrates with FOTO and your Practice/Organization FOTO Administrator has established the integration connection via the API key, you can begin to add patients into FOTO by pulling them from the EMR, which alleviates the need for you to enter the Patient Set-Up field information (Episode set-up is still required).

- Enter the patient into the EMR first.
- Begin to add the Patient in FOTO (see section, ***Setting Up <u>New</u> Patient***).
  - Type in the first few letters of the patient's name.
  - A box will pop up to the right of the new patient screen from which to select the needed patient by clicking the ⊕ symbol beside the patient's name.

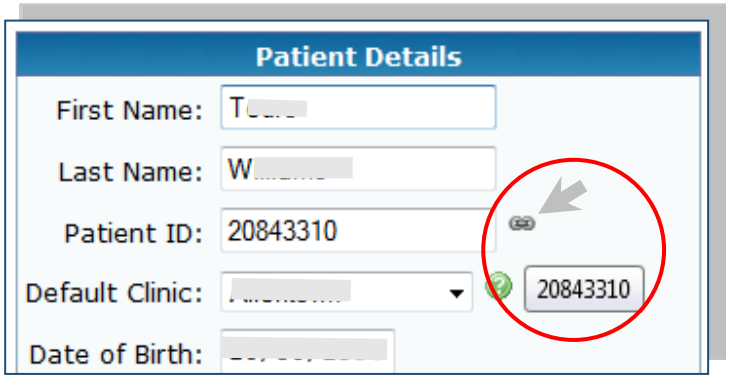


  - Once selected, the patient information will be populated automatically from the EMR, including the patient's name, gender, date of birth, email address (if included in EMR).
  - **The External ID should not be changed once it is pulled over from the EMR.**



- Click **Create** to enter the patient into FOTO.

- The patient will show as linked to the EMR with the chain symbol next to the Patient ID.
  - Mouse over the to view the External ID which will surface.



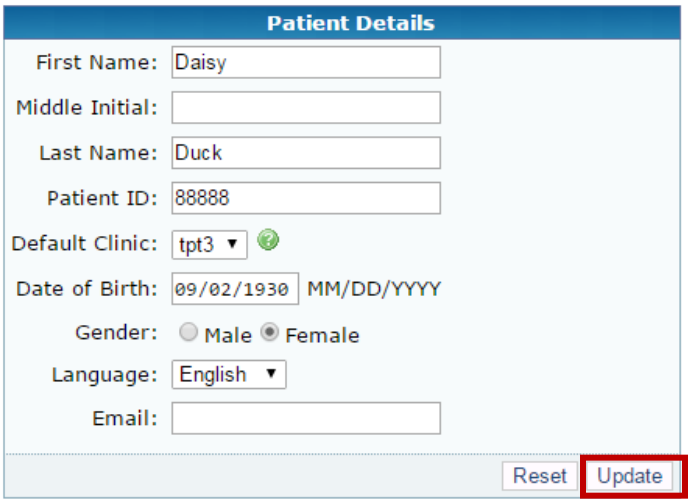
EDITING PATIENT ACCOUNT DETAILS

There may be times when you find it necessary to correct the Patient Account Details (ie: an incorrect birthdate was entered, the name was misspelled, perhaps the patient married and the last name needs to revised, email address change, etc.).

You can easily correct this data by locating the patient in the Patient Activity or Open Episode link and then clicking on Details or Patient ID buttons respectively, which will open the Patient Detail Screen.

Make the changes necessary and then select **UPDATE** to save the changes.

The change(s) will be reflected on all PSFRs (Patient Specific Functional Reports) captured as well.



EDITING EPISODE DETAILS

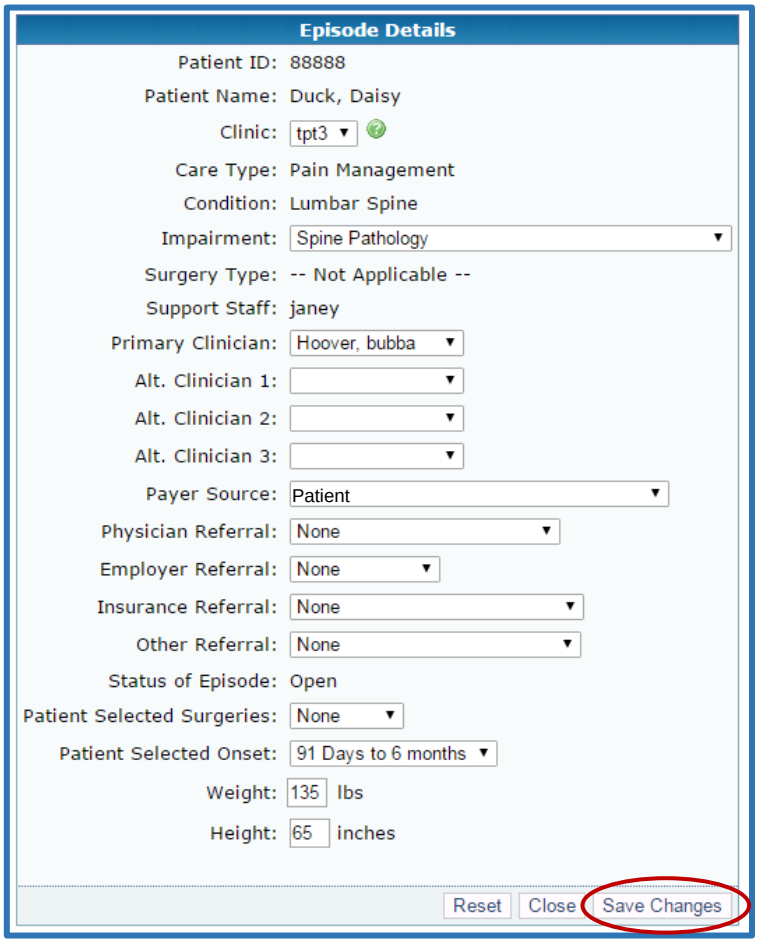
Information may be edited or added in the Episode Details box if needed at any time during the episode of care. Be certain to click **Save Changes** when finished.

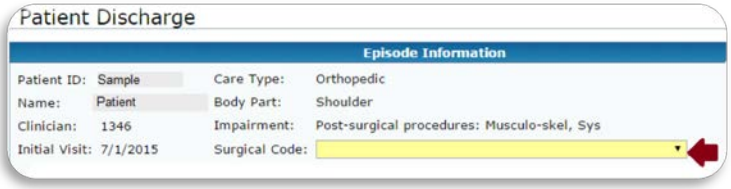
- **Clinic** – to change the clinic for the episode, select the correct clinic from the drop down menu. This will remove the episode from the current clinic's episode screens. If the needed clinic is not available in the drop down list, a patient with the same Patient ID already exists at that clinic. Contact FOTO to merge duplicate patients.

- **Care Type** - The Care Type **CANNOT** be edited once the episode set-up is completed. If the Care Type is incorrect, it is best to close the episode with an "incorrect set-up" NP and start over (see NP/IDC Process).

- **Impairment** – The Impairment may not have been added initially during the set-up process /or/ it may be identified the impairment selected is not correct. You can revise the Impairment at any time during the episode of care and the PSFRs will recalibrate to reflect the correct impairment. (Note: Impairments for episodes in the Neurological, Cardiovascular or Pelvic Floor Care Types **CANNOT** be revised.)

- **Surgery Type** – Is required if the impairment is post-surgical. This selection can be made at any time during the episode of care in the Episode Detail Screen. If it is not included on the Episode Detail screen, it will be required on the Staff Discharge screen.



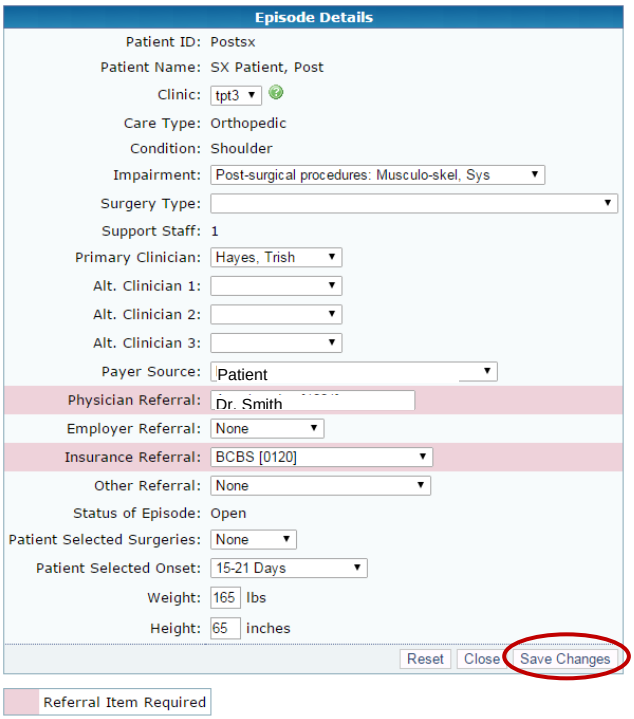


- **Primary Clinician** – This is the clinician that will be tied to the episode. (Special Note: If the Clinic site is revised, please be sure to reassign the primary clinician to the therapist that will be tied to the episode at the new site. This is critical to assure the episode is tied to the correct location and the correct clinician).

- **Alt. Clinician** – up to 3 additional clinicians may be added, however, only the primary clinician will show on the reports.

- **Payer Source** – This field will affect certain surveys and can be changed here if needed.

- **Referrals** – Fields are available to track the referral source information for the episode including the Physician Referral, Employer Referral, Insurance Referral or Other Referral. Your organization's Administrator will determine if these fields are needed and will build out the drop down tables for these referral field selections.



Referral Item Required

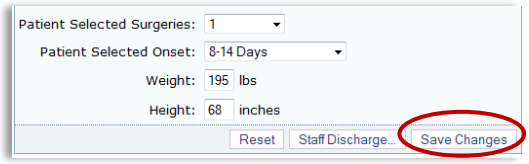
  - If your Administrator has designated these fields as REQUIRED, you will notice that the referral field will be highlighted in the Episode Detail Screen. (In this example Physician and Insurance Referral have been set as Required by the Administrator.)

  - Select the referral from the drop down list in the Episode Detail Screen at any time during the episode of care. (If the needed referral source does not appear in your drop down list, notify your organization's Administrator.)

  - If these required fields are not completed and Closure is attempted, you will receive a warning message that these fields must be completed prior to closing the episode.

  - If you receive this warning notice, return to the Episode Detail screen, make your referral selections, save the changes, and then proceed with the episode closure.

- **Surgeries**, **Onset**, **Weight**, **and Height** – Once the patient completes the Intake Assessment, these fields will be populated with information provided by the patient. If the staff identify the patient provided incorrect information related to these fields, this information can be revised.



Click **Save Changes** when finished.

STANDARDS FOR ADMINISTRATION OF ASSESSMENTS

Experience has shown that patients do not mind providing information as long as they understand that it is **used** and **valued**. The way the survey is presented has a great impact on the patient's willingness to share the information.

The following are Administration Standards that will assist in providing these instructions and responding to patient questions about the assessments to avoid inadvertently presenting a response bias.

*Experience has shown us that patients do not mind providing functional information – as long as it is **used** and **valued**.*

*This is a great opportunity to show your patients that you care & are listening to their concerns about their limitation, **making them a part of the rehab team**.*

ADMINISTRATION GUIDELINES:

I. Background – definition of administration, why important
II. Patient Instructions Prior to Answering Survey Questions
III. General Guidelines for Helping Patients Who Request Assistance
IV. Supplemental Instructions
V. How to Handle Common Scenarios
VI. Non-verbal Communication
VII. Paraphrasing Instructions
VIII. When to Administer FOTO Surveys
IX. How Much Assistance is Too Much?

I. Background

- **What does Administration mean?**

  The term "administration" in this context refers to the manner in which each FOTO Intake and Status assessment is presented to the patient.

- **Why is this important?**

  Adhering to standards for administering FOTO measures promotes validity, reliability and responsiveness. These properties are critical to physiotherapists and others who expect consistency and accuracy in measurement of outcomes. Using standard procedures for survey administration allows for more accurate benchmarking of performance across clinics.

  At least as importantly, patients deserve evidence-based care informed by the highest caliber of research, and accurate outcomes measurement is a critical component of evidence-based practice. Researchers, scholars, and policymakers similarly desire measurement that produces the most meaningful & precise results.

Insuring that all patients receive the same instructions prior to answering survey questions preserves the integrity of the assessment. It is also important that guidelines are consistently followed when patients have questions or need help in responding. Standardization seeks to minimize coaching and other external influences on patient responses. When interacting with a patient who is completing FOTO measures, physiotherapists and others who have the best of intentions can inadvertently bias reporting just by what they say or how they act.

Standardization helps insure that patients at different clinics and in different settings are all responding to questions based on their own perspectives and experiences. Scores that are obtained under standardized conditions are more trustworthy and the subsequent interpretations more sound.

II. Patient Instructions Prior to Answering Survey Questions

- **INTAKE-** These instructions will be displayed for the patient at the start of the survey. The survey administrator is advised to state or paraphrase these instructions verbally. Keep in mind the importance of tone of voice and body language, and deliver the verbal patient instructions in a manner that communicates that the assessments are valuable.

> **The following assessment will ask you about difficulties you may have with certain activities.**
>
> **It's an important part of your evaluation. It will help us:**
> - **understand how your condition is affecting your activities, and**
> - **develop treatment goals with you.**
>
> **Please answer the questions with respect to the problem for which we are seeing you.**
>
> **Respond based on how you have been over the past few days.**

- **STATUS** – The guidelines are the same as for Intake.

> **Please answer these questions to help us assess your progress since starting therapy.**
>
> **Remember:**
> - **Answer the questions with respect to the problem for which we are seeing you.**
> - **Respond based on how you have been over the past few days.**

III. General Guidelines for Helping Patients Who Request Assistance

- Keep in mind that **patient self-report measures are intended to assess <u>the patient's perception.</u>**

DO	DO NOT
• Follow the standardized instructions • Re-read • Re-emphasize • Objectively re-state	• Interpret the question for the patient • Tell the patient how to answer

- **Illustration of General Guidelines using the Fear Avoidance Beliefs question(s).**

    - Re-read the instructions on the computer screen (okay to paraphrase): "It's asking you to rate how strongly you agree or disagree with this statement, 'I should not do physical activities which might make my pain worse.'"
    - Re-emphasize: "….'I **should not do** physical activities which (might) make my pain worse.'"
    - Objectively re-state: "Mr. Smith, how strongly do you agree or disagree with this statement: 'I **should not do** physical activities which (might) make my pain worse?'"

IV. Supplemental Instructions

- In response to patient questions or other special circumstances, the following are supplemental instructions that may be delivered verbally to the patient, in addition to the Intake and Status instructions. Remember to remind the patient of key points from the Intake and Status instructions when applicable.

    - "There are no wrong answers. We want to know what YOU think."
    - "If you are asked about something you haven't done recently, estimate how hard it would be if you tried to do it now."
    - "Keep in mind that the assessment does not know who you are. These are standardized questions. If a question does not seem to apply to you, choose the response closest to the right answer for you…or…select the 'best fit' answer."
    - "The computer is assessing your abilities. In order to find out what you can do, it has to find out what you cannot do."
    - "Your physiotherapist is interested in learning more about how your condition may or may not be affecting you either physically and/or emotionally."
    - "You also will have the opportunity to respond regarding your satisfaction with your experience at this facility." (for Status if Satisfaction not turned off.)
    - "The information you give is a part of your medical record, and subject to regulations that protect health care information."
    - "This assessment usually takes about 5-10 minutes." (Okay to say longer if you feel that will be the case. The point here is that you give the patient a time estimate.)

V. Common Scenarios

This section applies the general guidelines and other standardized wording for common scenarios.

- **A patient's function may be limited due to medical contraindications, such as post-operative rotator cuff repair:**

    - Do not tell the patient which response to choose. Re-state the instructions and/or the question and/or the patient's perception. For example,

Patient: "I'm not supposed to raise my arm because my doctor told me not to yet. How should I answer this question about reaching a shelf at shoulder height?"

Response: "Remember that the instructions for this questionnaire said that you are supposed to answer based on how you are presently. You said that you are not supposed to raise your arm; how do you think that applies to this question about reaching up to a shelf at shoulder height? There are no wrong answers; choose what you feel is the best-fit response."

- Let's say the patient decides that even though they aren't supposed to reach to shoulder height, that they could do it if they tried and thus they select "moderate difficulty" rather than "Unable;" that would be the correct response because it is the patient's perception!

- Notice that the response above only takes into account what the patient said or knows, that their doctor said they are not to raise their arm. Thus, either a clinical or non-clinical staff member can do this.

- **A patient feels that certain questions are inappropriate, such as an older adult being asked about running or hopping:**
  - For example,

    Patient: "I'm 80 years old, so why am I being asked if I can run?"

    Response: "The computer is assessing your abilities. In order to find out what you can do, it has to find out what you cannot do."

- **Administering optional questionnaires about psychosocial topics contain questions some patients may consider sensitive**.
  - For example,

    Patient: "Why is this asking about things that are not my problem??"

    Response: "Keep in mind that the assessment does not know who you are. These are standardized questions. If a question does not seem to apply to you, choose the response closest to the right answer for you…or…select the 'best fit' answer."

    Patient: "Why is it asking me about worry and distress? My problem is physical. Do you guys think I am faking it?!"

    Response: "Your physiotherapist is interested in learning more about how your condition **may or may not be** affecting you **either** physically **and/or** emotionally."

- **A patient asks if they should respond based on their function with or without their assistive device:**

  - Instruct the patient to respond based on what the patient feels would be normal function for them. For example,

    - Someone who has used a walker for several years might consider that their normal function means how they can walk using a walker,…or they might not!

    - Someone who is using an assistive device short-term due to the injury/condition might consider that their normal function means how they could perform without the device.

- Always default to affirming to the patient that their perception is correct.

- **A patient is uncertain whether to respond based on their function using the affected extremity relative to the unaffected extremity**

  - Re-state for the patient any relevant Intake or Status instructions with emphasis on the key words within the questionnaire being taken. For example,

    Response: "I can see that on the question you are being asked it says, 'Using your affected arm how much difficulty do you have…?' How much difficulty do you feel you have because of your affected arm? Remember, there are no wrong answers; however you interpret that is correct."

  - Instruct the patient to respond based on what the patient feels would be normal function for them.

VI. Non-verbal Communication

- Keep in mind the importance of tone of voice and body language, and deliver the verbal patient instructions in a manner that communicates that the assessments are valuable. The patient's responses may be more thoughtful and accurate if the patient understands the assessment process is an important component of their care episode.

VII. Paraphrasing Standardized Patient Instructions

- It is generally acceptable to paraphrase or restate the sentences. Remain true to the message and be objective. Often it is best to start by using the scripted sentences verbatim, and as you become more comfortable with remembering the responses, you might evolve into putting things in your own words.

VIII. When to Administer FOTO Assessments

- It is recommended that patients complete their FOTO assessments prior to the evaluation with the physiotherapist. Completing the assessment post-evaluation is the preferred option only if the alternative would be not getting the assessment at all.

IX. How Much Assistance Is Too Much?

- After delivering the Intake or Status instructions verbally, the survey administrator may wish to remain with the patient until the first functional question in order to make sure the patient is comfortable navigating the survey. Once survey setup is complete and the patient has started answering the functional survey, DO step away and let the patient know that you are available if the patient needs help.

- If the patient asks for help, follow the guidelines provided above under Supplemental Instructions and Common Scenarios. For patients who seem to need the close presence or guidance of another, see FOTO guidelines for Proxy and Recorder survey administration options.

USE OF PROXY OR RECORDER

FOTO Intake and Status Assessments may be completed by a Proxy or a Recorder if the patient is unable to complete the assessments themselves due to cognitive issues, language, vision or reading barriers, etc.

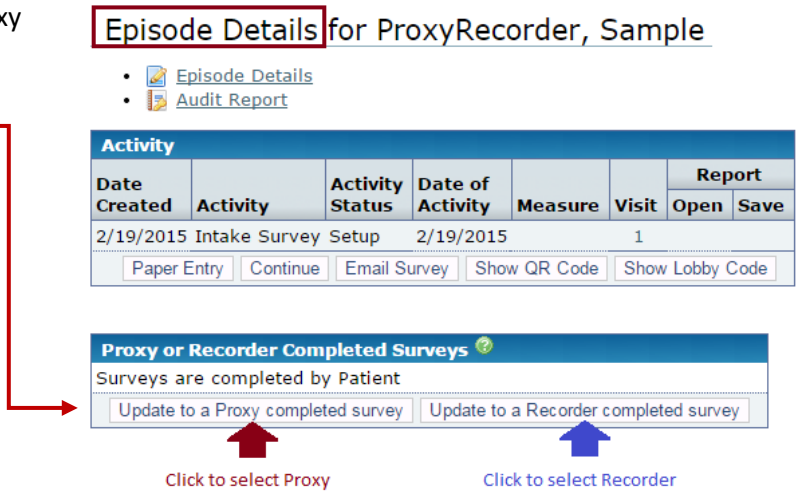
Definition: A **RECORDER** is someone who records all answers provided by the patient who can respond verbally and reliably. The Recorder must NOT influence the responses or answer on behalf of the patient.

PROXY is someone who answers all questions on behalf of the patient. The proxy determines the content of the answer upon their perception of the patient's abilities. A proxy is used when a patient cannot give accurate answers about their health or cannot answer reliably.

You can document if the Intake and Status Assessments were completed by a Recorder or Proxy as well as indicate the individual serving as the patient's proxy or recorder.

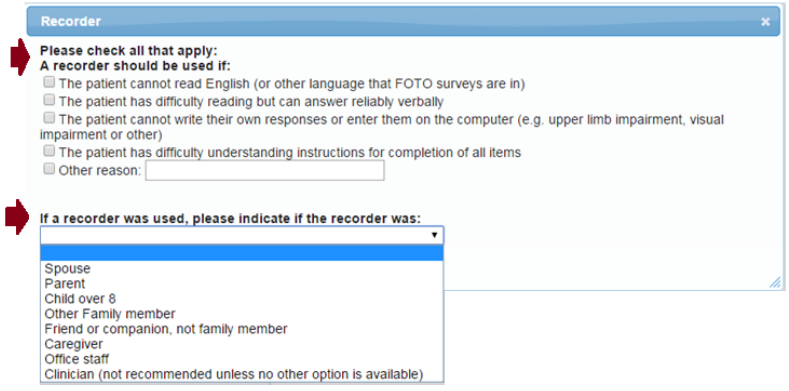
When you are ready to capture the Intake and a proxy will be used, go to the Episode Detail screen.

Click on either the Proxy or Recorder button.

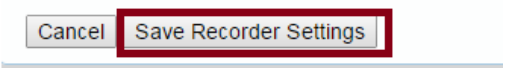


In the next screen that opens, select the reason a Recorder / Proxy is being used. *If Other, please include a brief reason in the open text field.*

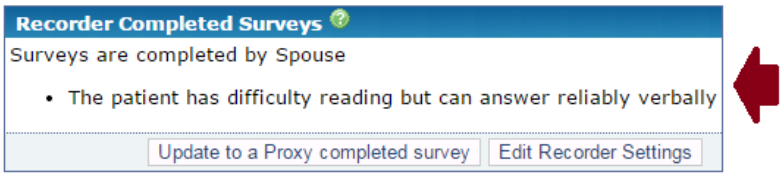
Then click the down arrow to identify the Recorder / Proxy completing the assessment.



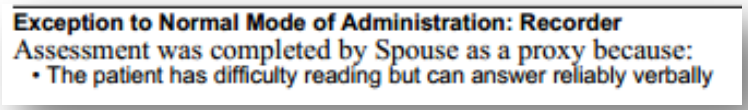
Once the reason and the recorder/proxy have been selected, be sure to click the Save Recorder Settings (or Save Proxy Settings)



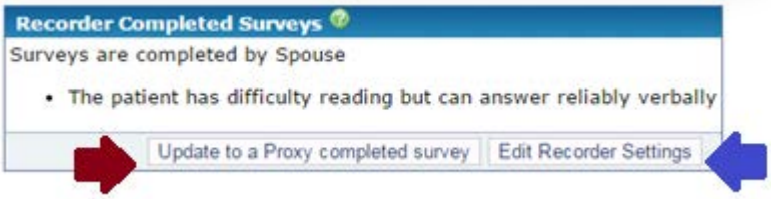
The Proxy/Recorder selected will continue to show in the Episode Detail Screen unless Edited or Updated.



The Proxy/Recorder completion of the survey will surface on the Patient Specific Functional Reports following the Predictor information section .



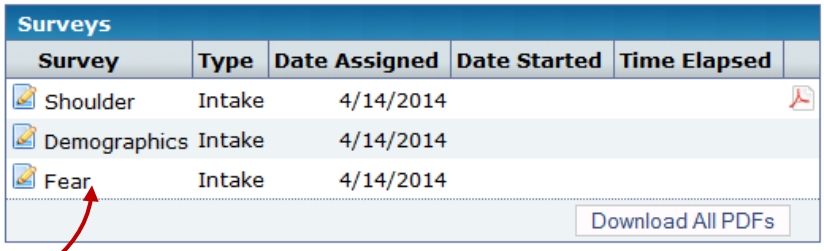
If indicated, you can Update to a Proxy completion /or/ edit the recorder settings by clicking the desired revision from the Proxy/Recorder field in the Episode Detail screen at any time.



SURVEY COLLECTION METHODS

Once the Account and the episode are created, the intake assessment will be available for the patient to complete. The intake assessment is automatically linked when the episode is created, based on the care type and body part/condition set up for the episode.

The assessments in the survey window from Episode Details will be completed by the patient.

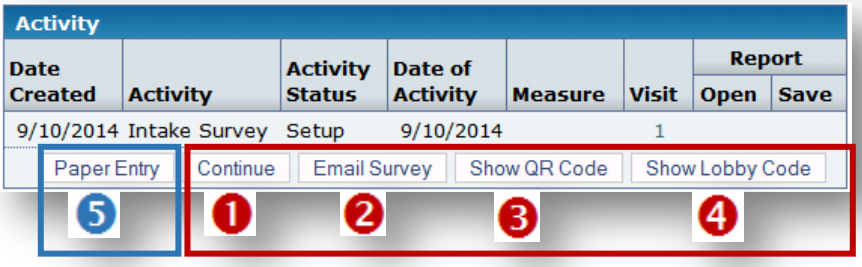


If no optional surveys are selected, only the basic surveys will be created:

- Body part, general or med/neuro
- Demographics
- Fear

There are two types of COLLECTION METHODS as follows:

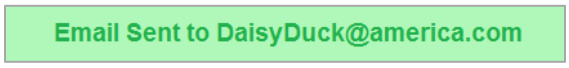
- **Electronic**
- **Paper**



Electronic Assessments (Optimal Method)

Assessments can be gathered electronically, where the patient responds to survey questions directly on the computer screen. This can be done in the clinic or the survey can be emailed to the patient to be completed on their own computer or tablet. To have the patient complete the intake electronically, select one of the 4 options below:

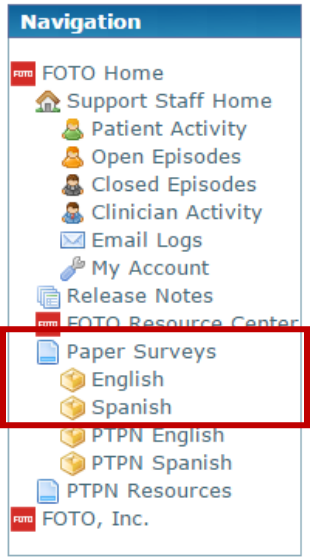
- Click **Continue** ❶ to immediately begin the intake survey in the clinic, or
- Click **Email Survey** ❷ to send an email to the patient containing a secure link to the survey.
  - A verification notice will appear at the top of the screen indicating that the email was sent.



- Click **Show QR Code** ❸ if using a tablet with a camera.
- Click **Show Lobby Code** ❹ to reveal an access code for use with a tablet or kiosk.

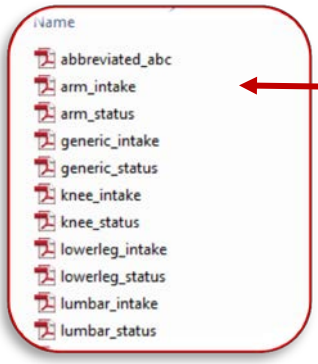
See section, ***Electronic Intake and Status Collection*** for specific instructions.

Paper Assessments



The patient can take the survey by documenting their responses to the functional condition questions on the Paper Assessment Forms. Note this method does require data entry by a staff member to enter the patient responses into Patient Inquiry.

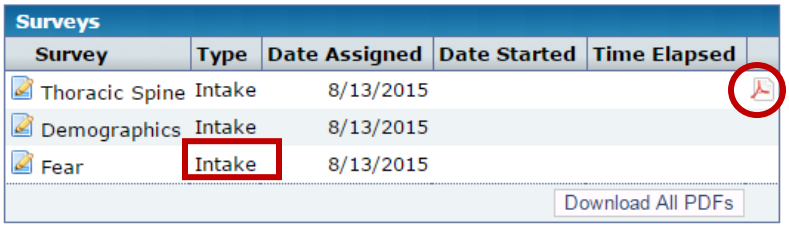
- Paper assessments can be downloaded from the Navigation Bar from the English or Spanish Paper Survey link.



  - The links open a zip file which contains blank master Intake and Status paper assessments, by body part or condition.
  - **If you use this option, it is very important that you are careful to select the correct body part/condition assessments that match your patient episode condition.**
  - It is a good idea to have these forms downloaded onto the computer as backup in case the website or the clinic internet is down for any reason.

/OR/

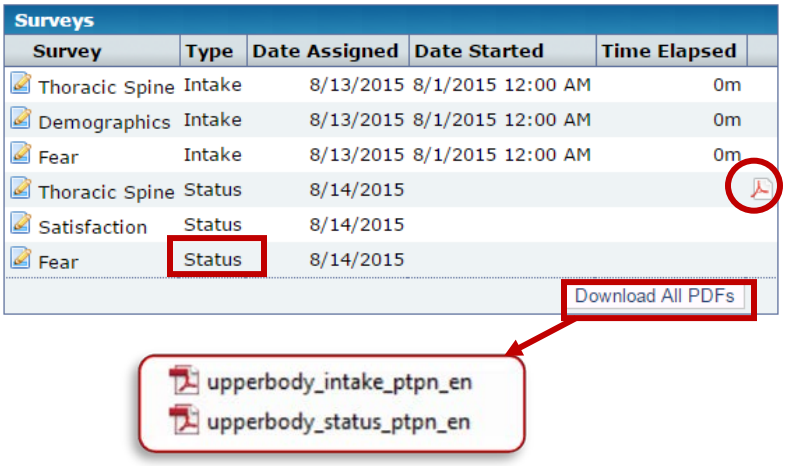
- From the Episode Detail Screen, scroll to the **Surveys window.**



  - Click on the PDF icon to open and Print the blank paper Intake assessment for patient completion.
  - You will need to repeat this process when it is time for the patient to complete the Status Assessment.

/OR/ **(Preferred)**

- From this same window, you can click on the "Download all PDFs" button, which will open a zip file with the Intake & Status Assessments you need for the episode.



Once the patient has completed the paper Intake or Status Assessment, the information must be entered into FOTO by a designated staff member by Clicking **Paper Entry** 5 to enter the data entry screen.

See section, ***Paper Intake and Status Collection*** for specific instructions.

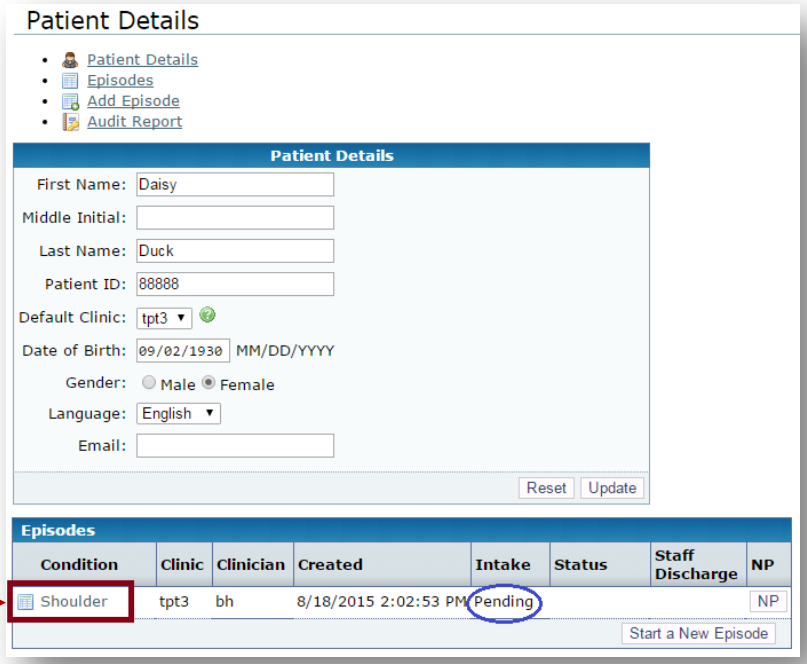
COLLECTING THE

ELECTRONIC INTAKE ASSESSMENT

FOCUS ON® THERAPEUTIC OUTCOMES INC

After setting up the patient Account and/or Episode, you are ready to capture the Intake Assessment which should be **completed by patient on their first visit or prior to their first visit by email**.

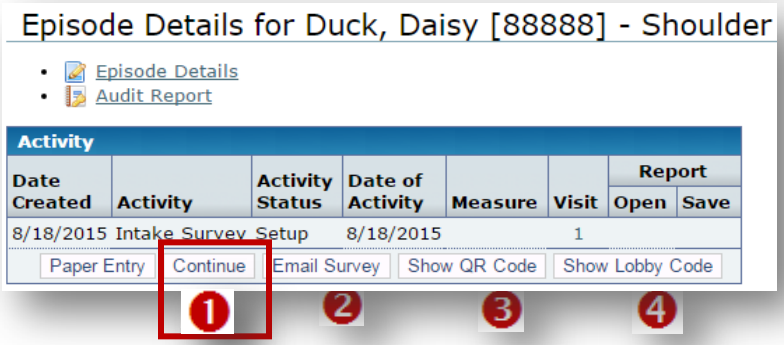
- **Locate your patient** in the Patient Activity or Open Episode Table.
- Click on **"Details" or "Patient ID"** (depending on which navigation link you are using).
- The Patient Detail screen will open. **Click on the Condition** for the patient in the Episode screen.
- The **Episode Detail** screen will open. In the Activity window, to have the patient complete an electronic survey, you can:

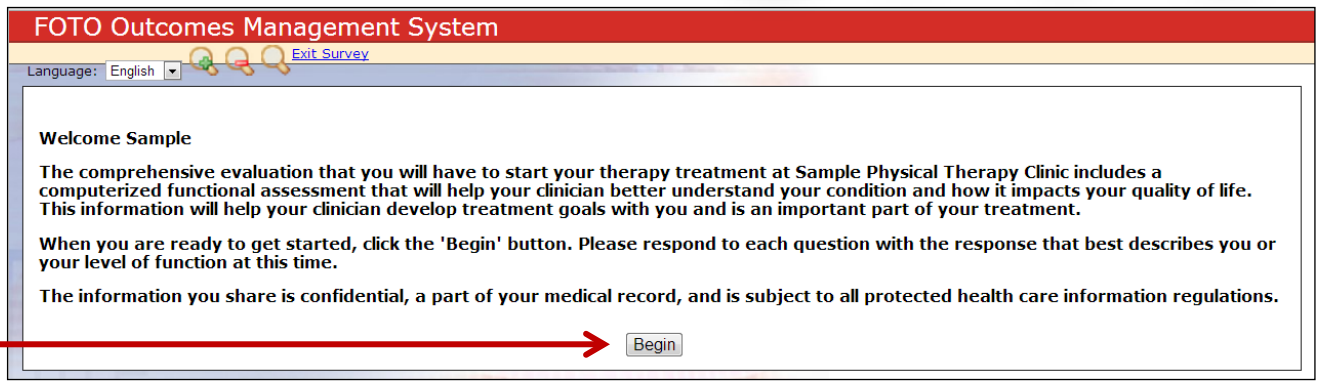


1. Click **CONTINUE** to immediately open the electronic patient survey on the device you accessed the patient episode on for patient completion.

   Completing the Survey

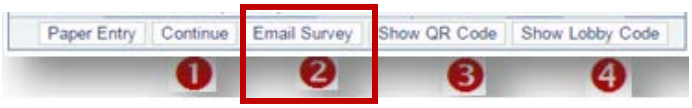
   - The Patient Survey Instruction Page will appear on screen and the survey will start when the patient selects **Begin**. The patient should select the best response for each question.



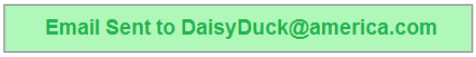


- The Exit Survey button at the top of the screen allows the patient to exit the survey if needed. The survey can be restarted at the " leave off " point by clicking **Continue** again.
- If the patient has difficulty seeing the words on screen, the size can be adjusted by clicking the  icons at the top of the screen. The icon  will reset the size to 100%.

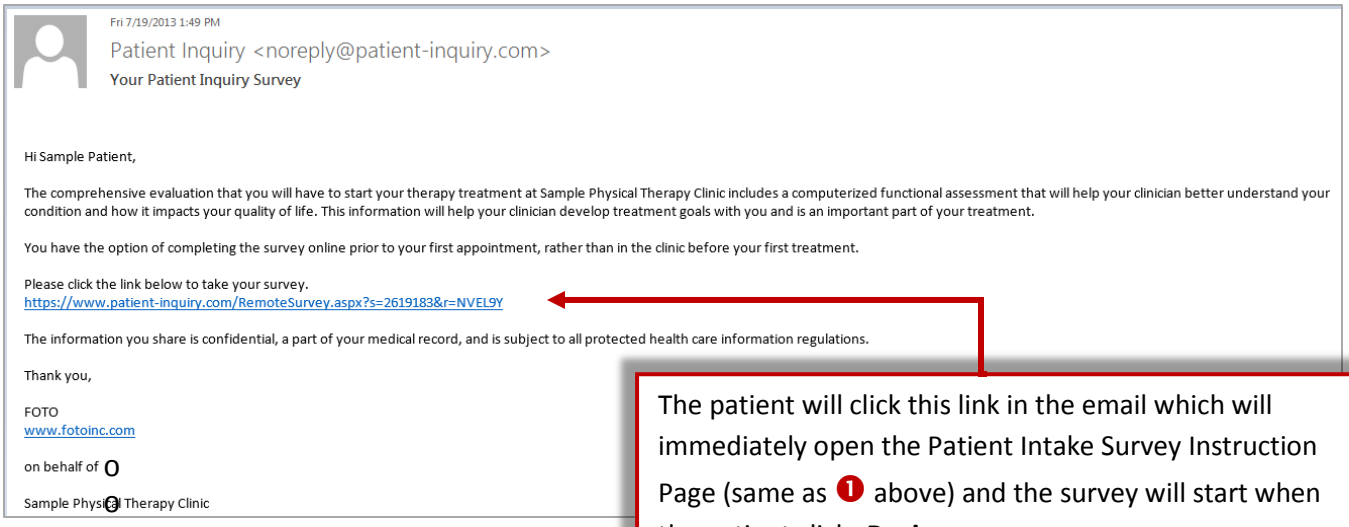
❷ Click **EMAIL SURVEY** to send an email to the patient containing a secure link to the survey.



- In order to send the assessment to the patient, the patient's email address must be in the Email field on the Patient Detail Screen.
- A verification notice will appear at the top of the screen indicating that the email was sent.

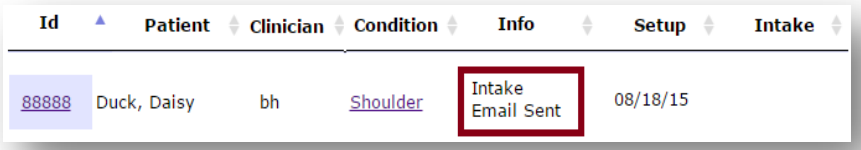


- The patient will receive an email from noreply@patient-inquiry.com containing a link to the survey similar to the one below:



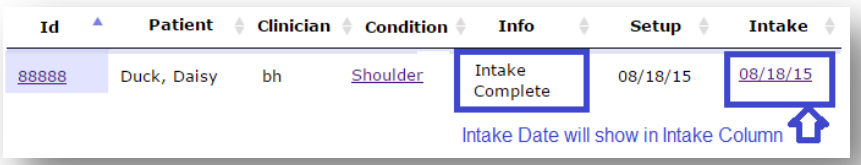
The patient will click this link in the email which will immediately open the Patient Intake Survey Instruction Page (same as ❶ above) and the survey will start when the patient clicks **Begin**.

- The Information Column in Open Episodes will show that the Intake was emailed to the patient.



Id	Patient	Clinician	Condition	Info	Setup	Intake
88888	Duck, Daisy	bh	Shoulder	Intake Email Sent	08/18/15	

- Once the patient completes the survey, the Information column will show the Intake as Complete and the Intake Date will appear.



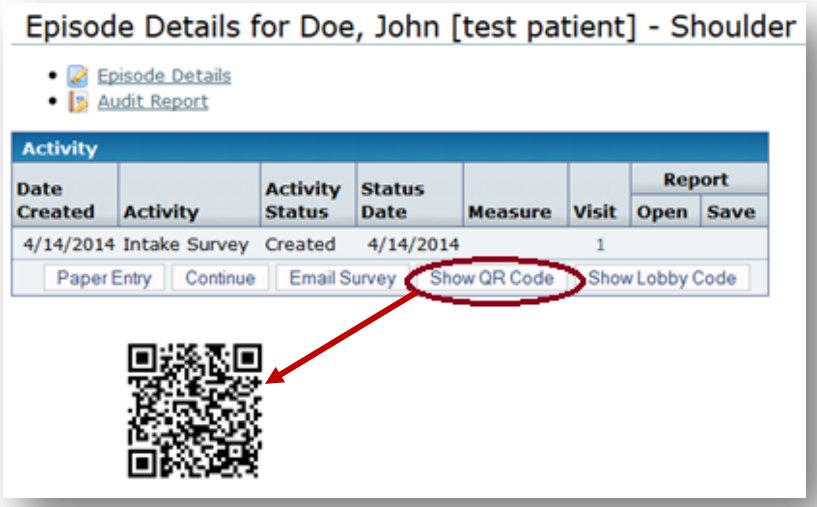
Id	Patient	Clinician	Condition	Info	Setup	Intake
88888	Duck, Daisy	bh	Shoulder	Intake Complete	08/18/15	08/18/15

Intake Date will show in Intake Column

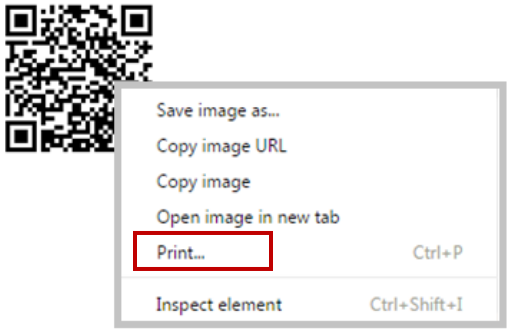
- If the patient <u>does not complete</u> the Survey through the email, you can select the "**Continue**" button when the patient presents for the evaluation to capture the Intake.

❸ Click **SHOW QR CODE** if using a tablet with a camera to capture your patient assessments.

- When this button is selected, a QR code will be revealed on the screen.
- Use the tablet's camera to scan the code from the computer screen to bring up the patient's survey on the tablet.
- Once the Patient Survey Instruction Page has loaded, simply hand the tablet to the patient to begin the survey.
- The patient will review the instruction screen and click "Begin" to complete the Intake Assessment just as outlined above for ❶

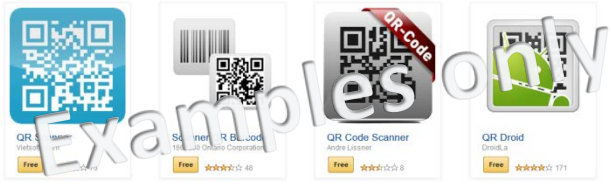


- **Idea**: Because the QR Code will initiate both the Intake as well as the subsequent Status Assessments, some of our users have found that printing the QR code and placing this in the front of the patient's medical record is an easy/efficient method to scan the code to initiate a survey at any time without having to access the patient's episode in the FOTO Program. To do this:
  - Generate the QR Code initially.
  - Right click on the QR code on screen to bring up the task screen.
  - Select Print from the list.



Note

Select and download a QR Reader app from the tablet you want the patients to use for completion of the survey. Many of these apps can be downloaded for free, however, **be sure to read the reviews before downloading as many contain ads.**



❹ Click **SHOW LOBBY CODE** to reveal an access code for use with a tablet or kiosk.

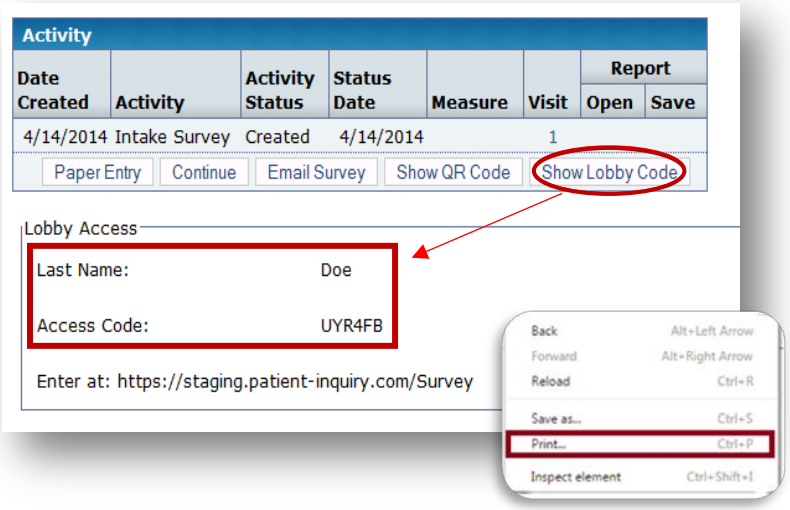
It may be that you are not using tablets with QR readers to capture the patient electronic surveys but instead you are using tablets, laptops or a kiosk desk-top computer. You can use the Lobby Code which allows the patient to access the login screen themselves to complete their assessments.

It is helpful (but not required) if you set a bookmark/desktop icon to the lobby code login screen which can easily be accessed by your patients. The URL for the lobby code: → https://staging.patient-inquiry.com/Survey

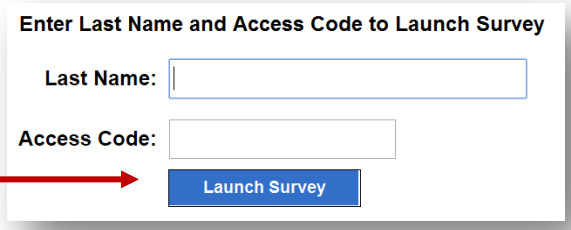
To generate the Lobby Code for the patient:

- Select the **Lobby Code button** to reveal an access code.
- Give this information to the patient.
- You can print the Lobby Access code information for the patient by using a right-mouse click to open the print screen.

  Note: The Lobby Code will initiate both the Intake and all subsequent Status Assessments for the patient. A separate lobby code is NOT needed for each assessment completed.



- On the tablet, laptop or Kiosk, the patient (or a staff member) enters the web address listed beneath the Access Code to bring up the login screen. **OR**, the patient can be instructed to use the bookmark or Icon from the desktop to open the login screen.
- The patient enters this information and clicks the Launch Survey button. →

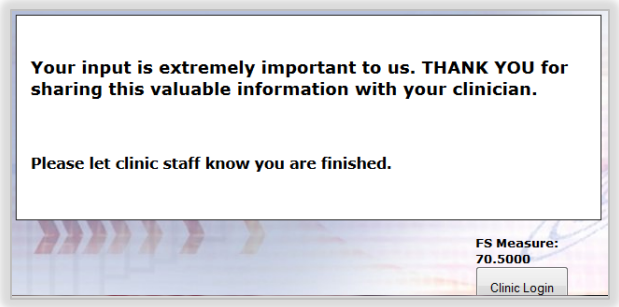


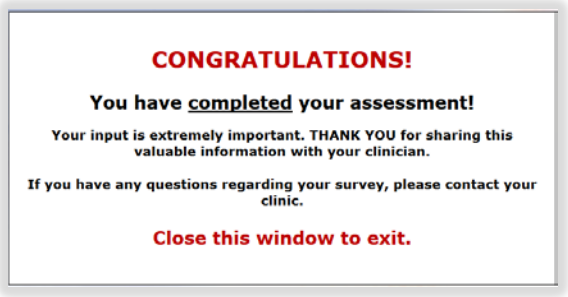
- The patient will review the instruction screen and click "Begin" to complete the Intake Assessment just as outlined above for ❶

Emailing the Lobby Code

If you prefer to have emails sent to your patients from your clinic email address instead of from noreply@patient-inquiry.com, you can create your own emails to include the Lobby Access Code information and instruct them to enter this code and their last name at https://www.patient-inquiry.com/Survey.

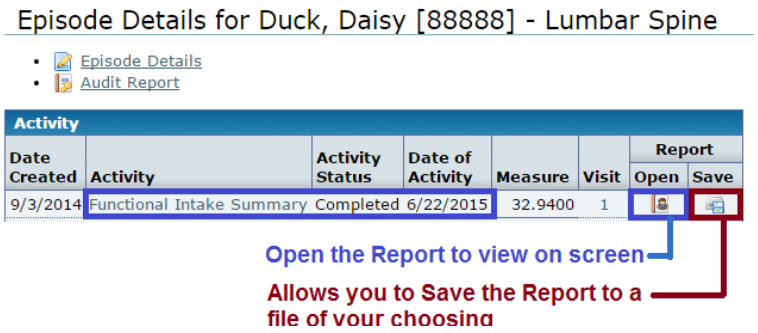
REGARDLESS OF HOW YOU COLLECTED THE PATIENT'S ELECTRONIC INTAKE (❶, ❷, ❸ or ❹), as soon as the patient completes the assessment, they will see one of the following closure screens to indicate the Intake Assessment is completed.



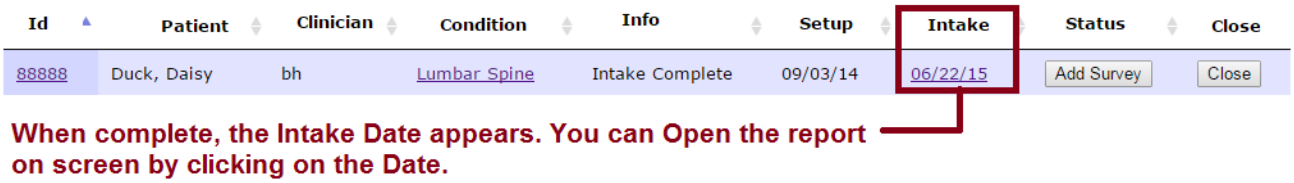


- The Completed Intake date will now show in the Open Episode List, Clinician Activity Table List, as well as in the Patient Episode Detail Screen (activity window). The Patient Specific Functional Intake Report can be accessed to view or print from these screens as follows:

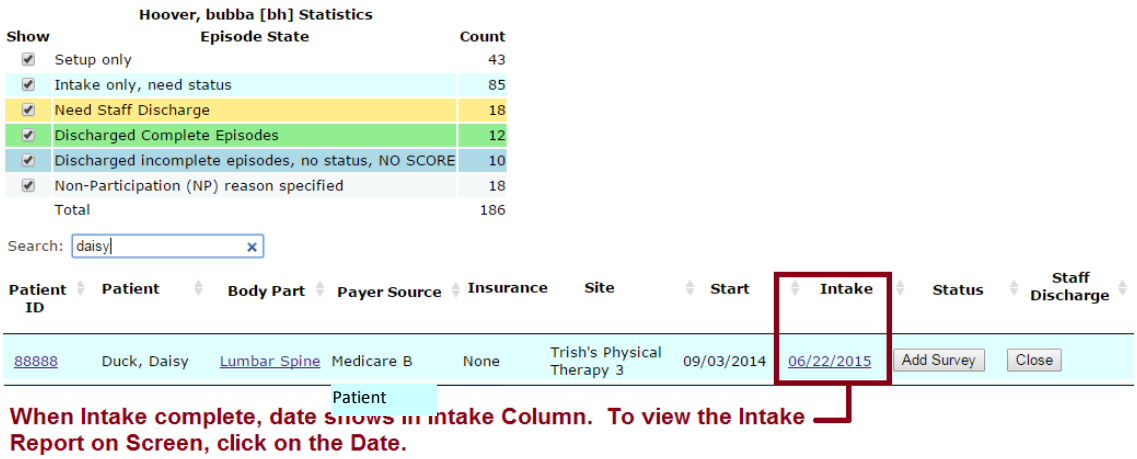
Episode Detail Screen



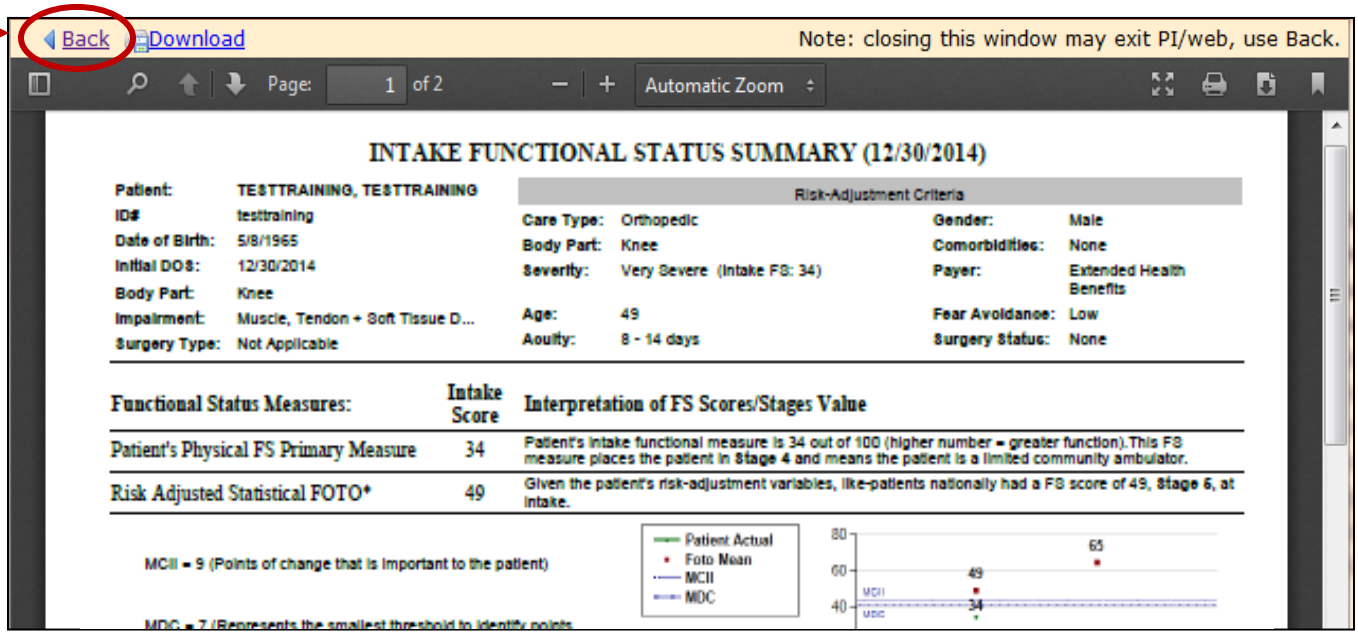
Open Episode Table



Clinician Activity Table

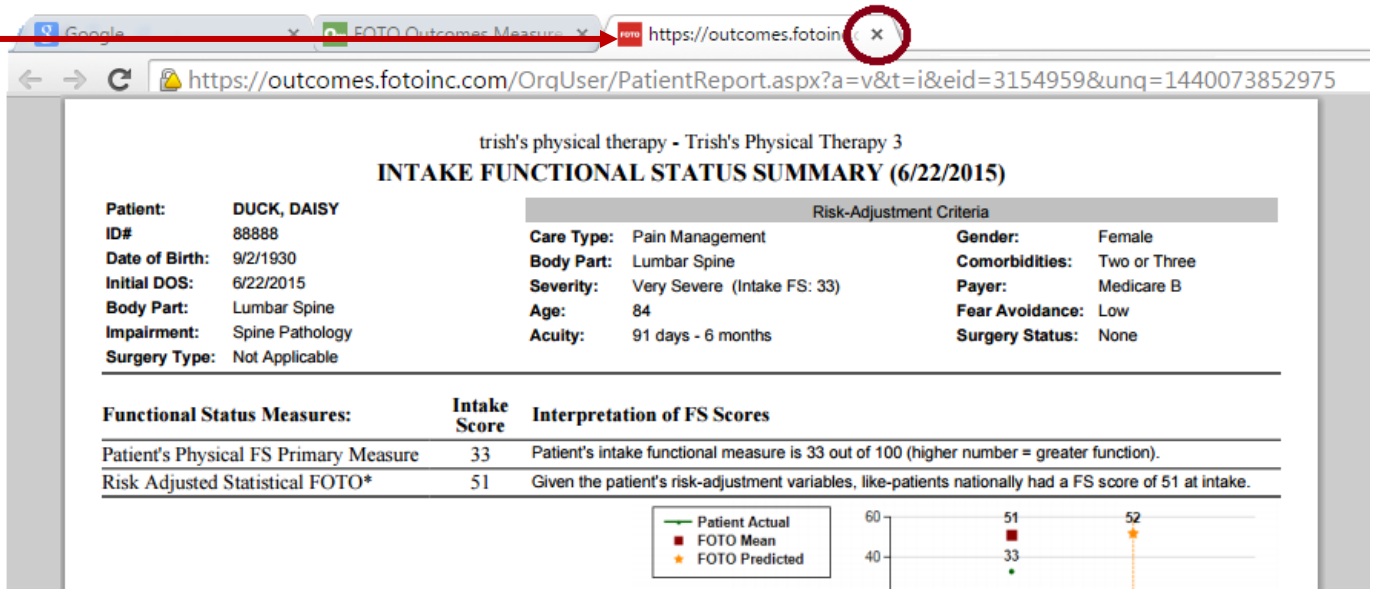


- Once accessed, the Intake Report opens:



Closing the Report after viewing/printing:

- If the Report was accessed from Episode Details, when you have finished viewing/printing the report, be sure to click on the "**back**" button or ⇦ arrow – which will close the report and take you back to the patient's episode detail screen.
- If the Report was accessed by clicking on the date in the Open Episode or Clinician Activity Tables, the Report opens in a new internet tab. To close, simply close the tab.



Refer to section, ***Printing Patient Specific Survey Reports***

COLLECTING

ELECTRONIC STATUS ASSESSMENTS

A minimum of one Status Assessment is required on the last date of service or as close to the last date of service as possible.

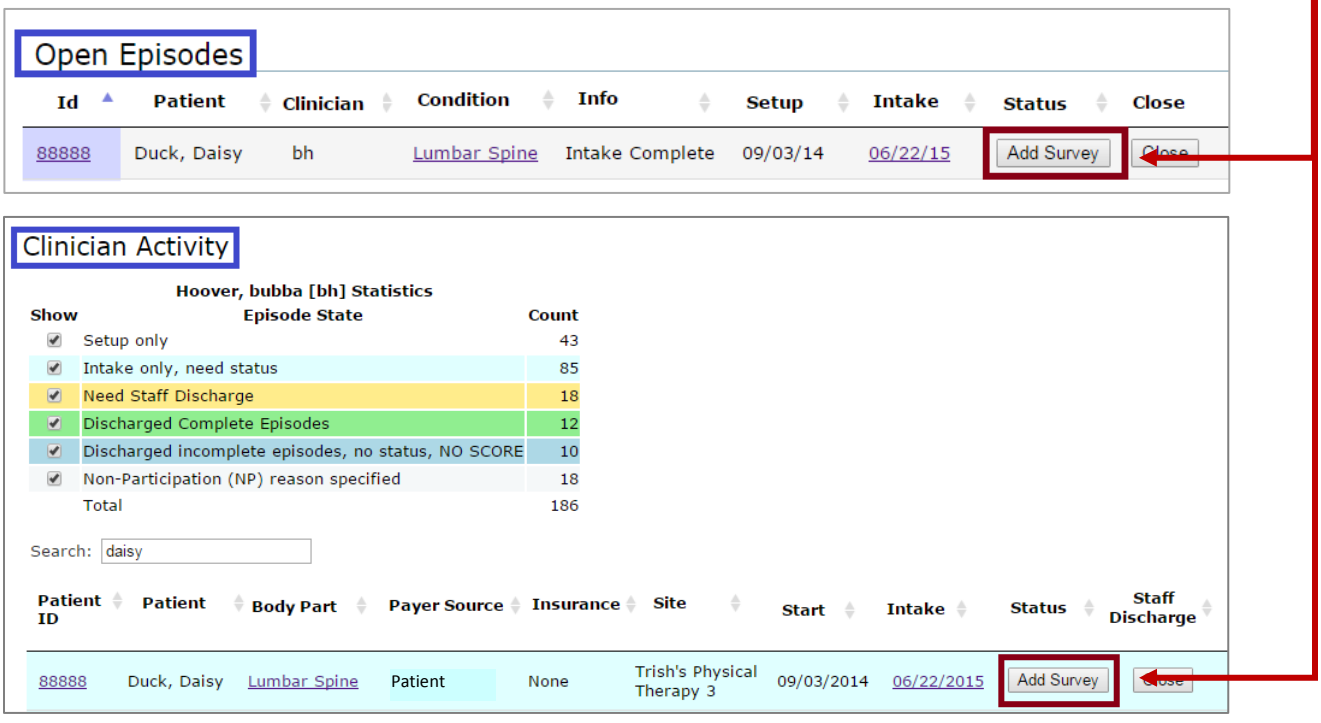
However, Status Assessments captured at **regular intervals** throughout the patient episode are **recommended** with **the last Status being captured on the patient's last date of service** (or as close to the last date of service as possible) to capture the maximum functional improvement achieved by the patient as a direct result of care received.

Note: If a Status Assessment is NOT captured during the episode, it is classified as an Incomplete Episode. Refer to the Non-Participation-Incomplete Discharge Process for details.

A Status Survey is added the same way whether it is being captured at regular intervals during care and/or on the final visit (last date of service).

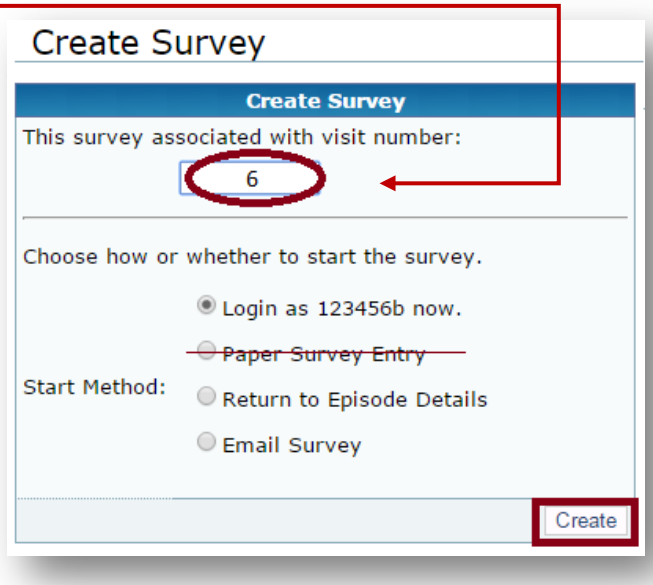
To Add a Status:

- Locate your patient in Open Episodes or the Clinician Activity Table.
- Click on the "Add Survey" button found in the Status column of these tables.



- When the Add Survey button is selected, a **Create Survey** screen will open.

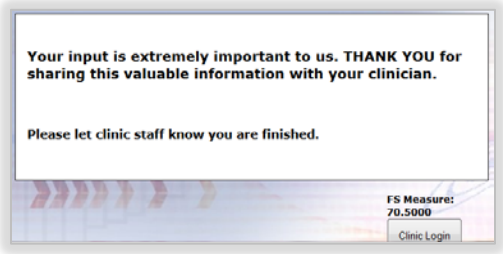
- Enter the **visit number** for the status survey

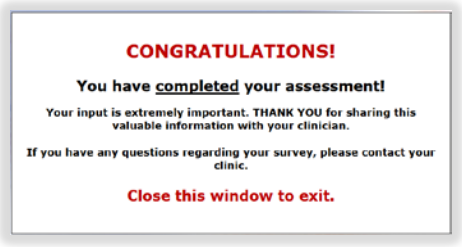


- Select one of the radial buttons to select the electronic collection method you desire for the patient and click **Create**:
  - **Login as <Patient ID> now.** – The survey will begin immediately on the device you are using.

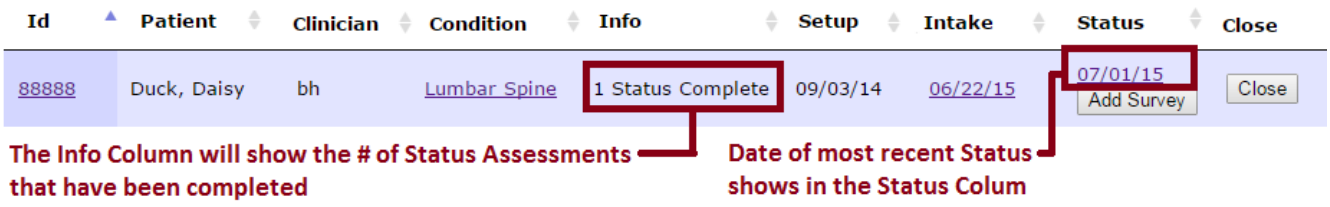
    (Note "123456b" in the example to the right is the Patient ID and will differ for each patient.)
  - Paper Survey Entry – *You will NOT use this button for electronic surveys.*
  - **Return to Patient Details** – returns to the Episode Details screen. This button is selected if you want to initiate (or cue) a Status Assessment for the episode but the patient will access the survey using the **Lobby Code or QR Reader**.
  - **Email Survey** – Immediately emails the survey link to the patient.

- The same closure messages will appear once the patient completes the Status Assessment electronically.





- The Completed Status date will now show in the Open Episode List, Clinician Activity Table List, as well as in the Patient Episode Detail Screen (activity window). The Patient Specific Functional Status Report can be accessed to view or print from these screens by clicking on the Status Date in the Status Column, using the same process as outlined for viewing Intake Reports.



  - Note that the Add Survey button still appears in the Status Column. To add another Status, simply click on the Add Survey button and repeat the above Electronic Status Assessment collection process.

Refer to section, ***Printing Patient Specific Survey Reports***

COLLECTING

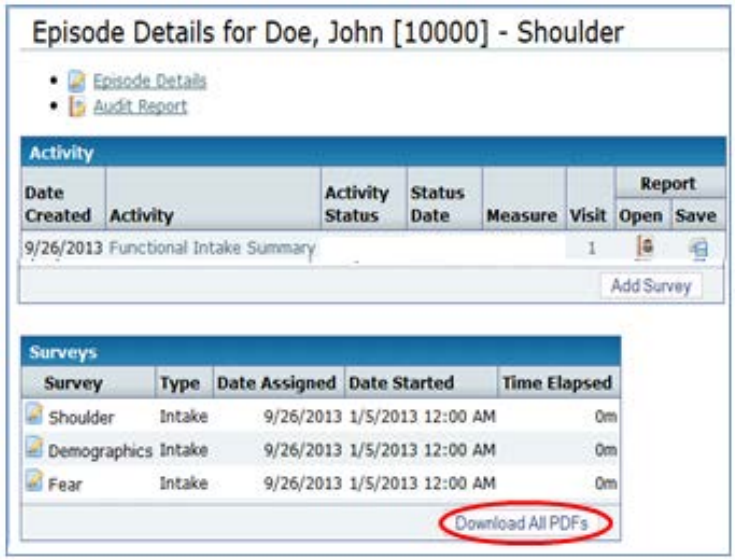
PAPER INTAKE ASSESSMENTS

To capture Paper Intake Assessments, it is necessary for you to print the blank paper surveys that are appropriate for the patient's episode. (Refer to **Survey Collection Methods – Paper Assessments** for options to print the paper surveys). The preferred method follows.

Printing Blank Forms

To print the paper surveys to be completed by the patient, click on the **Download all PDFs** button from the Episode Details screen to download the PDFs to the computer, then select the appropriate forms and sent to your default printer.

Forms that will download include:



- **Body part, general or med/neuro Intake Survey** – Print this form if it is the first survey the patient needs to complete for the episode. (The Assessment appropriate for the patient's body part/condition in the episode set-up will be included in the download file.)
- **Body part, general or med/neuro Status Survey** – Print this form if the patient has already completed the intake survey. OR, you can opt to print all forms in the download and maintain these in the medical record for easy access when needed.
- **PQRS 131 and 154 –** (US Medicare B Only)
- **Abbreviated ABC** – Print if selected as an optional survey.

Patient Completion of Paper Assessments

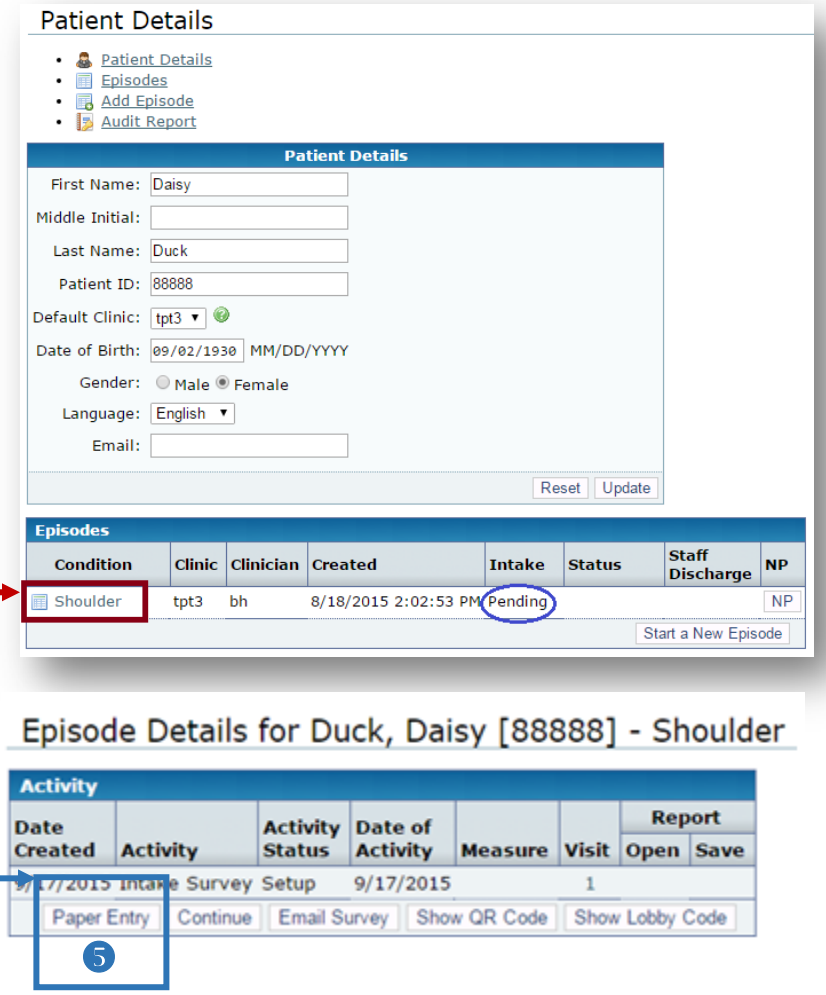
At Intake, the patient will complete the body part/condition specific Intake Assessment.

When completed, the patient should return this Intake Assessment to the practice staff for data entry. It is recommended that this data entry occur as soon as the patient has comleted the assessment so the Intake PSFR can be printed and provided to the clinician for use during the evaluation.

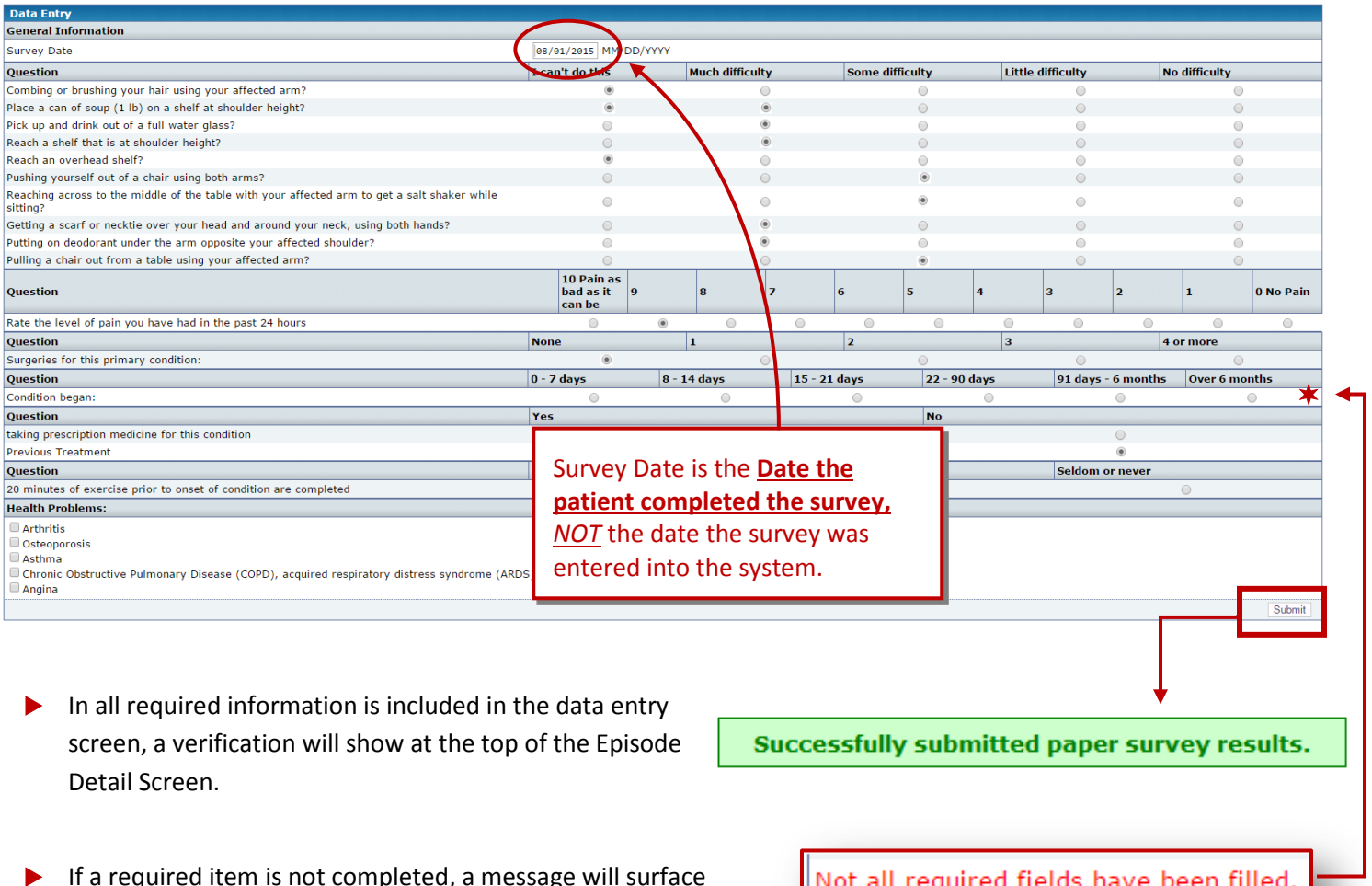
Data Entry of Paper Intake Assessment

When the patient has completed the paper Survey Form, a staff member **must enter the patient's responses into the FOTO Outcomes Measurement System**.

- **Locate your patient** in the Patient Activity or Open Episode Table.
- Click on **"Details" or "Patient ID"** (depending on which navigation link you are using).
- The Patient Detail screen will open. **Click on the Condition** for the patient in the Episode screen.
- The **Episode Detail** screen will open. In the Activity window that opens, click on ❺ for Paper Entry.



- The Data Entry screen will open. This data entry screen mirrors the format of the paper survey form that the patient completed.
  - Enter the Date the patient completed the Intake Assessment.
  - Transfer the patient's responses as marked on the paper completed assessment on the data entry screen.
    - Simply click on the radial (○) buttons for the appropriate response or click in the checkbox to select the other health problems.
    - To enter height and weight, simply use your key pad on your keyboard (or use the number keys).
      - For height, it is not necessary to use two digits for feet (ie: 05). Just enter the single digit for feet.
  - When all responses have been completed, click on the '**SUBMIT**' BUTTON in the bottom right corner of the data entry screen.



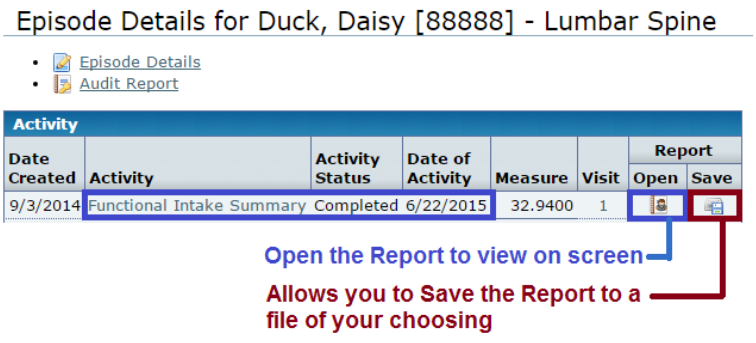
- In all required information is included in the data entry screen, a verification will show at the top of the Episode Detail Screen.

- If a required item is not completed, a message will surface after selecting Submit, stating that not all required data fields have been completed.

  - The system will put a red (✶) on the line item missing a response.
  - When corrected, return to the bottom of the data entry screen and click on SUBMIT.

- Just as with Electronic Assessment Collection, the Completed Intake date will now show in the Open Episode List, Clinician Activity Table List, as well as in the Patient Episode Detail Screen (activity window). The Patient Specific Functional Intake Report can be accessed to view or print from these screens as follows:

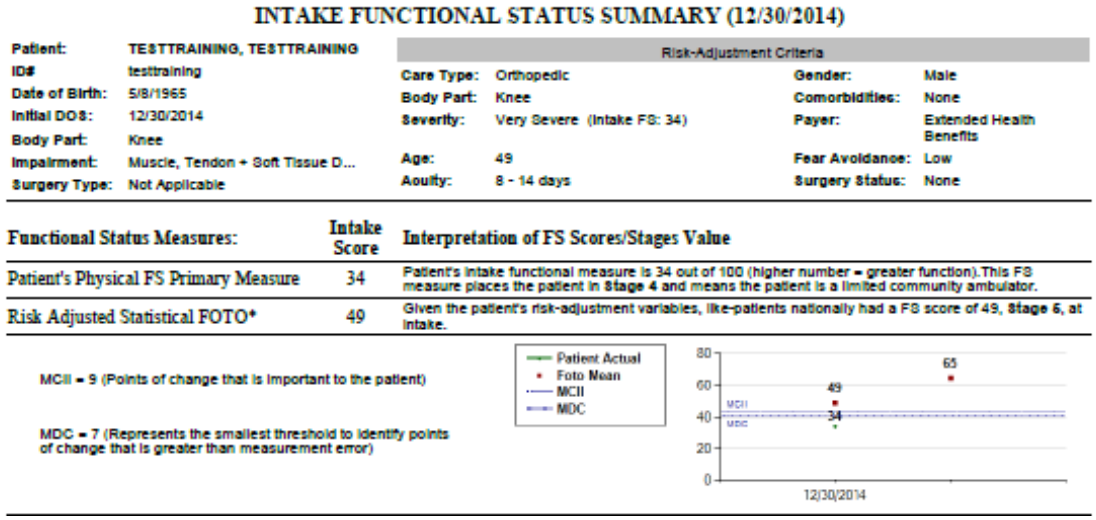
Episode Detail Screen



Open Episode Table

Id	Patient	Clinician	Condition	Info	Setup	Intake	Status	Close
88888	Duck, Daisy	bh	Lumbar Spine	Intake Complete	09/03/14	06/22/15	Add Survey	Close

When complete, the Intake Date appears. You can Open the report on screen by clicking on the Date.



INTAKE FUNCTIONAL STATUS SUMMARY (12/30/2014)

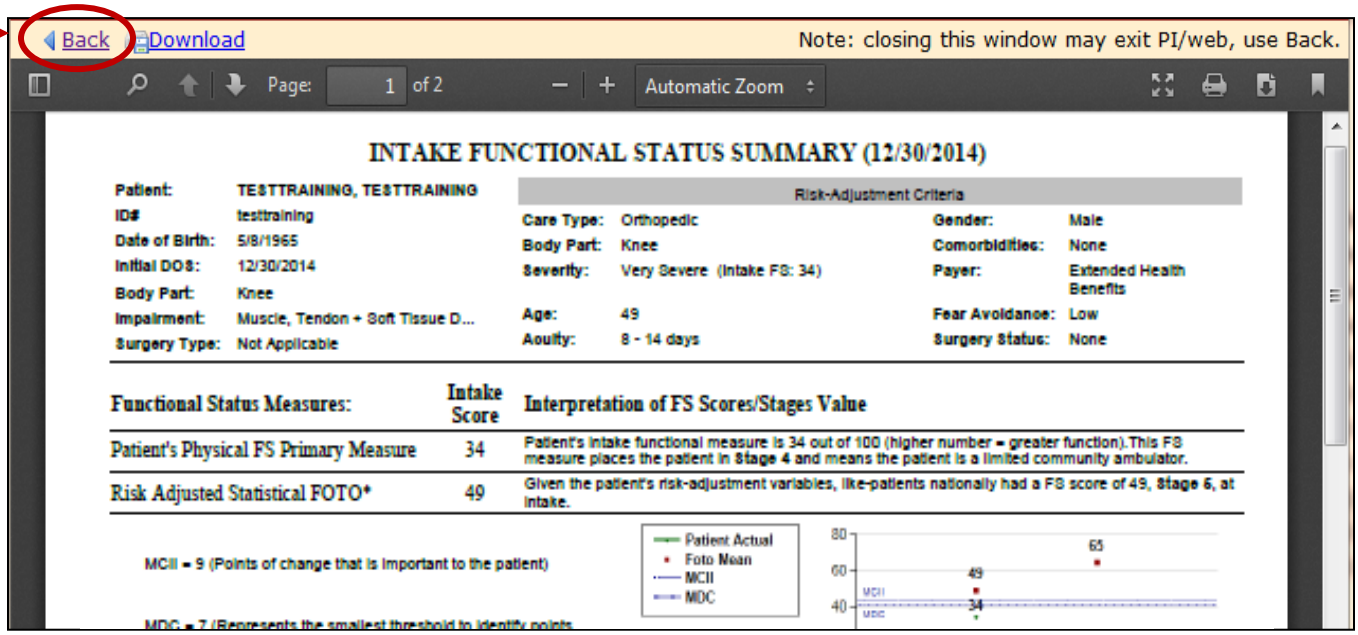
Patient:	TESTTRAINING, TESTTRAINING	Risk-Adjustment Criteria			
ID#	testtraining	Care Type:	Orthopedic	Gender:	Male
Date of Birth:	5/8/1965	Body Part:	Knee	Comorbidities:	None
Initial DOS:	12/30/2014	Severity:	Very Severe (Intake FS: 34)	Payer:	Extended Health Benefits
Body Part:	Knee	Age:	49	Fear Avoidance:	Low
Impairment:	Muscle, Tendon + Soft Tissue D...	Acuity:	8 - 14 days	Surgery Status:	None
Surgery Type:	Not Applicable				

Functional Status Measures:	Intake Score	Interpretation of FS Scores/Stages Value
Patient's Physical FS Primary Measure	34	Patient's intake functional measure is 34 out of 100 (higher number = greater function). This FS measure places the patient in Stage 4 and means the patient is a limited community ambulator.
Risk Adjusted Statistical FOTO*	49	Given the patient's risk-adjustment variables, like-patients nationally had a FS score of 49, Stage 6, at intake.

MCII = 9 (Points of change that is important to the patient)

MDC = 7 (Represents the smallest threshold to identify points of change that is greater than measurement error)

- Once accessed, the Intake Report opens:



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Impairment:	Muscle, Tendon + Soft Tissue D...	Acuity:	8 - 14 days	Surgery Status:	None
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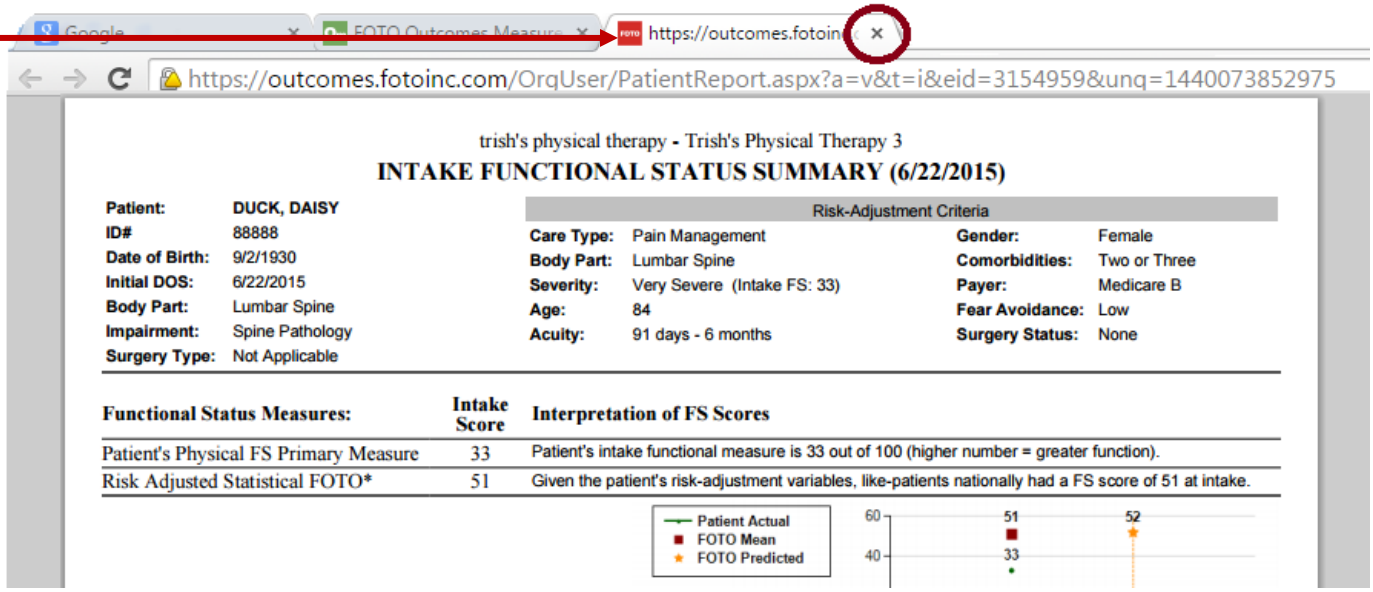
Risk Adjusted Statistical FOTO*	49	Given the patient's risk-adjustment variables, like-patients nationally had a FS score of 49, Stage 6, at intake.

MCII = 9 (Points of change that is important to the patient)

Closing the Report after viewing/printing:

- If the Report was accessed from Episode Details, when you have finished viewing/printing the report, be sure to click on the "**back**" button or ⇦ arrow – which will close the report and take you back to the patient's episode detail screen.

- If the Report was accessed by clicking on the date in the Open Episode or Clinician Activity Tables, the Report opens in a new internet tab. To close, simply close the tab.



Refer to section, ***Printing Patient Specific Survey Reports***

COLLECTING

PAPER STATUS ASSESSMENTS

A minimum of one Status Assessment is required on the last date of service or as close to the last date of service as possible, for both electronic and paper Status collection methods.

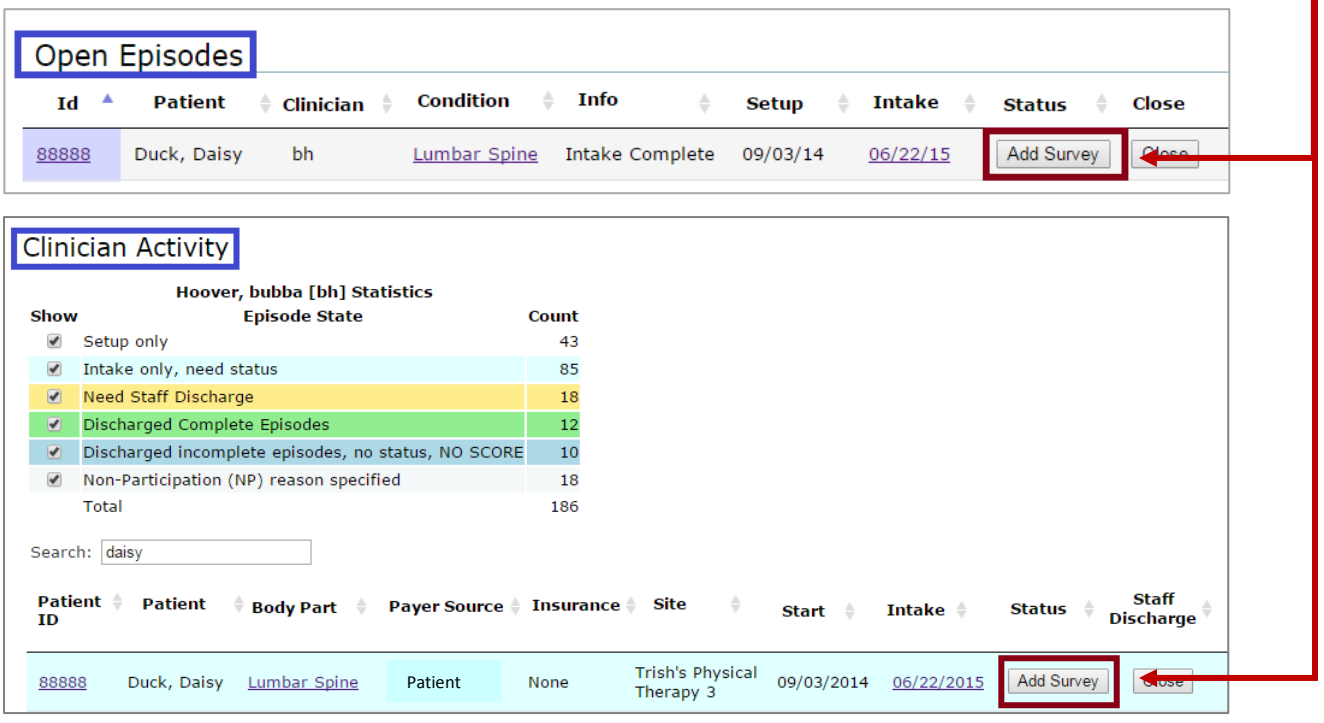
However, Status Assessments captured at **regular intervals** throughout the patient episode are **recommended** with **the last Status being captured on the patient's last date of service** (or as close to the last date of service as possible) to capture the maximum functional improvement achieved by the patient as a direct result of care received.

Note: If a Status Assessment is NOT captured during the episode, it is classified as an Incomplete Episode. Refer to the Non-Participation-Incomplete Discharge Process for details.

A Status Survey is added the same way whether it is being captured at regular intervals during care and/or on the final visit (last date of service).

To Add a Status:

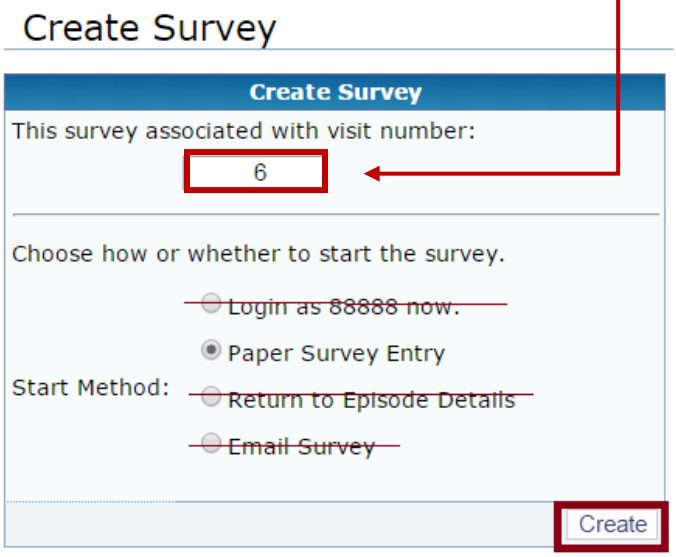
- Locate your patient in Open Episodes or the Clinician Activity Table.
- Click on the "Add Survey" button found in the Status column of these tables.



- When the Add Survey button is selected, a **Create Survey** screen will open.

- Enter the **visit number** for the status survey

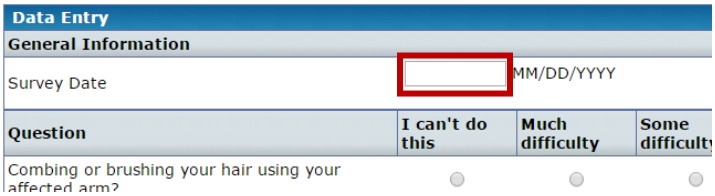
- Select one of the radial buttons to select the electronic collection method you desire for the patient and click **Create**:



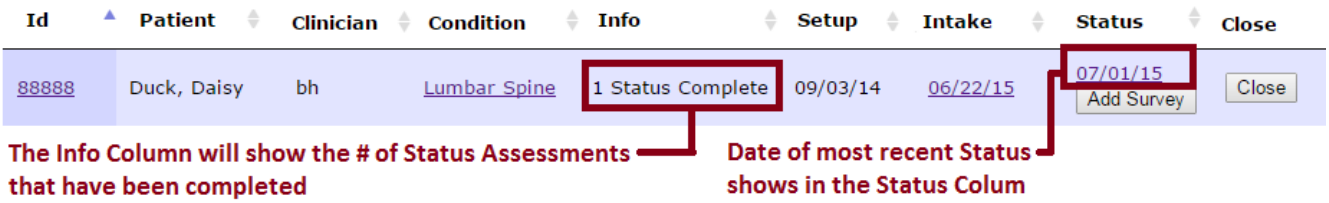
  - **Login as <Patient ID> now.** – The survey will begin immediately on the device you are using. *You will NOT use this button for paper surveys.*
  - **Paper Survey Entry** – Click this radial button when you have a patient completed Status and you are ready to complete the Data Entry of these responses into the system.
  - **Return to Patient Details** – returns to the Episode Details screen. This button is selected if you want to initiate (or cue) a Status Assessment to print the blank form for the episode but you are not ready for the Data Entry Screen.
  - **Email Survey** – Immediately emails the survey link to the patient. *You will NOT use this button for paper surveys.*
  - Click the Create button.

- The Data Entry screen will open. This data entry screen mirrors the format of the paper Status survey form that the patient completed.

- Complete the steps to enter the Status Data Entry screen as you did for the Intake, remembering to enter the date **the patient completed the Status** in the Date field.



- The Completed Status date will now show in the Open Episode List, Clinician Activity Table List, as well as in the Patient Episode Detail Screen (activity window). The Patient Specific Functional Status Report can be accessed to view or print from these screens by clicking on the Status Date in the Status Column, using the same process as outlined for viewing Intake Reports.

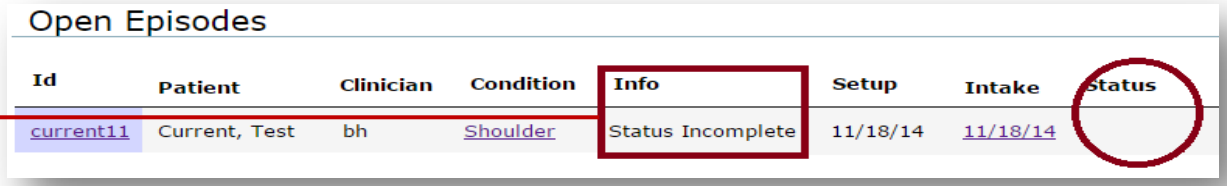


  - Note that the Add Survey button still appears in the Status Column. To add another Status, simply click on the Add Survey button and repeat the above Paper Status Assessment collection process.

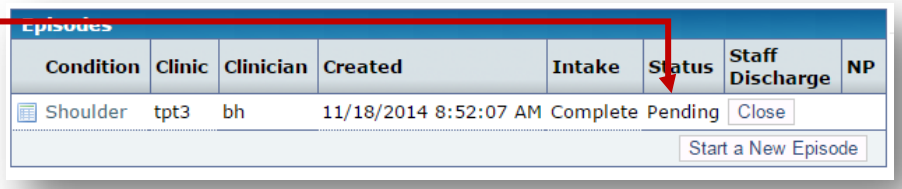
Refer to section, ***Printing Patient Specific Survey Reports***

TROUBLESHOOTING ASSESSMENTS

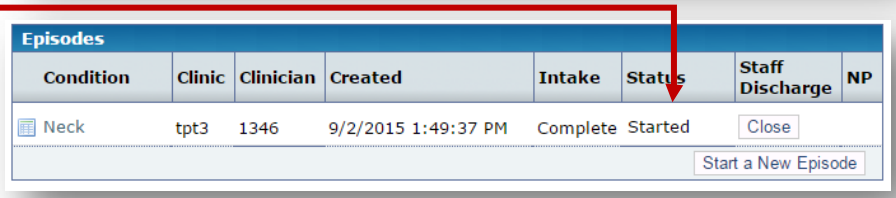
Until an Intake is captured, there will not be an "Add Suvey" button available. However, if the Intake has been completed and the 'Add Survey' button is not available on the Open Episode or Clinician Activity screen, the previous status survey initiated for completion may not have been completed.



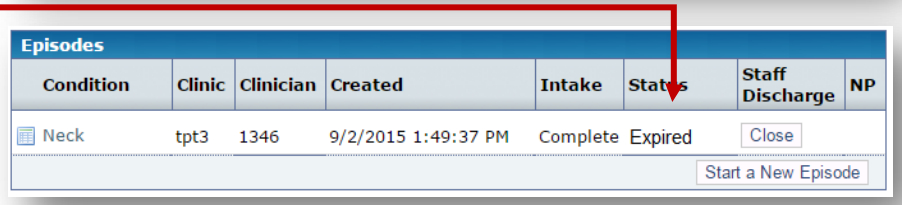
- Check the Intake or Status column of the Open Episode (or Clinician Activity) screens to see the assessment status (sample above), *OR*
- Check the Episode Screen from Patient Details to see the assessment completion message:
  - **Pending** = the assessment queued in the system but has not been initiated.



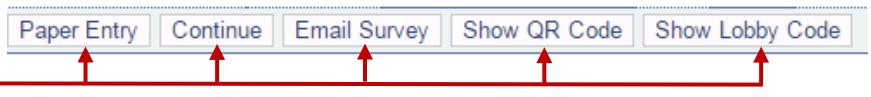
  - **Started / Incomplete** = the patient began the assessment but exited the assessment before completion



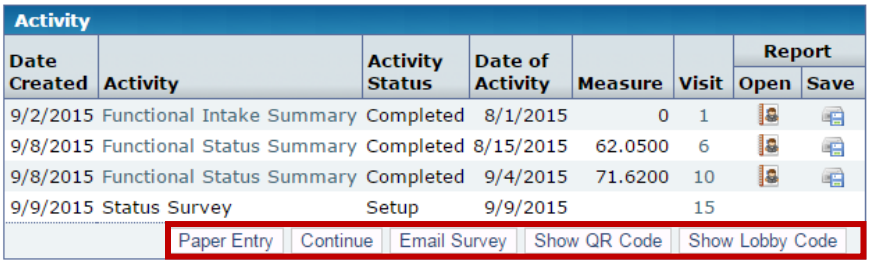
  - **Expired** = the patient began completion of the assessment but the session expired (inactivity on the screen for more than 40 minutes).



- If Pending, simply click on the collection method to capture the survey from the beginning.



- If “Incomplete” or “Expired,” click one of the options from the Activity window in Episode Details to allow the patient to finish the intake survey in the clinic or to resend the link to the patient by email.



The system will begin the patient at the assessment point where the previous assessment ended (the patient will not have to complete the entire assessment).

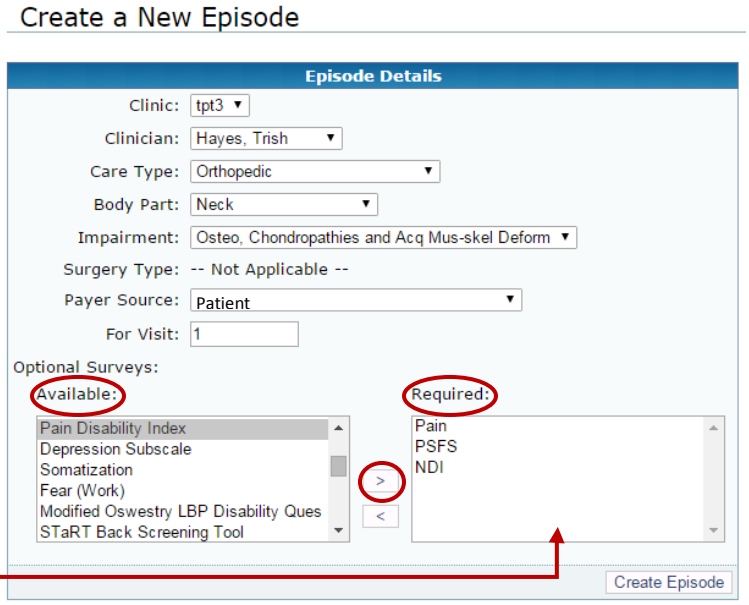
COLLECTING

OPTIONAL SURVEY SET-UP & COMPLETION

Optional surveys can be selected for inclusion in the Patient Assessment process for **electronic assessments** (completed on the computer/tablet/email).

Before using Optional Surveys, it is recommended that you review the information about each of the optional surveys by clicking on the **FOTO Resource Center** in the Navigation Menu. Select **Instructional Guides**, then click **on Optional Surveys**.

- Optional Surveys must be selected during the episode set-up process: **these cannot be added once the episode is created.**
- To select an Optional Survey, click on the name of the survey in the 'Available' window, click on the arrow > to move the survey into the 'Required' window.
- Some optional surveys are only available with pecified care types or body part conditions (for example an NDI will only be available for a cervical episode).
- Only the optional surveys showing in the Required window will be added to the patient episode.



Electronic Optional Survey Collection

All Optional Surveys are available for electronic collection. Optional Surveys selected during the Episode Set up will automatically be included in the electronically completed Intake and/or Status Assessments (some electronically surveys must be captured in the Intake as well as each subsequent Status Assessment).

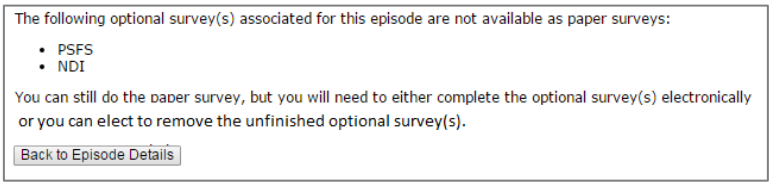
Paper Entry of Optional Surveys

If the patient completes a paper Intake survey and other optional surveys were selected, the optional surveys selected for the episode must either be completed electronically or removed from the episode before the Intake can be completed or a Status can be captured.

- In the example to the right, a patient's Neck episode contains the following optional surveys:
  - NDI
  - PSFS

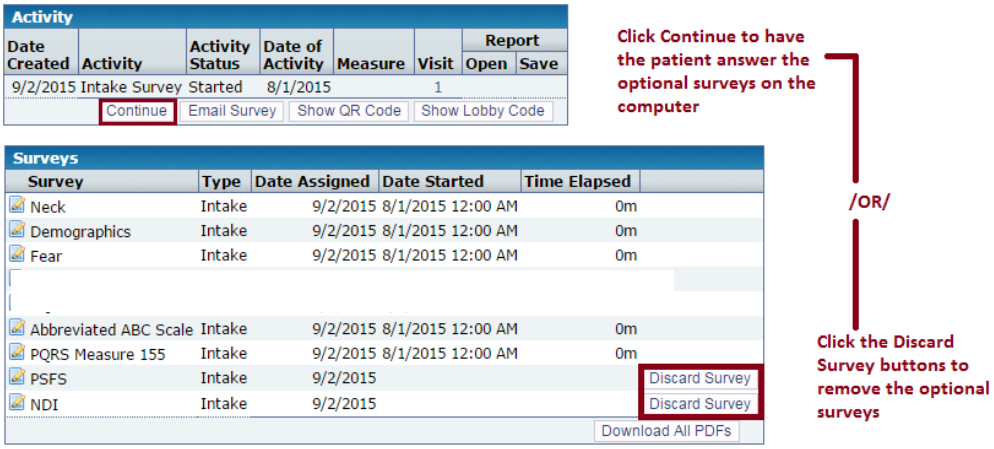
  However, paper surveys are not available for NDI or the PSFS. So the patient completes only the Neck paper Intake.

- Enter the patient's responses from the paper Intake Assessment by clicking the **Paper Entry** button from the Activity box, following the paper data entry process, transferring the Intake information in the data entry screen.
  - A message will show at the top of the Data Entry screen:

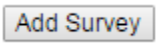


- When you have completed the data entry of the paper Intake or Status Assessment, click SUBMIT.
- The Episode Detail screen will show a message that the Report is not completed, directing the patient complete the survey electronically or they should be removed from the episode.

- The Episode Details screen will reappear. At this point either:
  - Click the **Continue** button to allow the patient to take the optional surveys electronically on the computer, or
  - Remove the optional surveys by clicking the **Discard Survey** button for each survey.
  - Until you have completed the assessment or discarded the selected optional surveys, you will NOT be able to produce an Intake Patient Specific Report or generate a Status Assessment.



- Once the optional surveys are either completed or removed, the Intake Patient Specific Report date will appear in the Intake Column of the Open Episode or Clinician Activity tables, and

- **Add Survey**  button will be available to add a Status when needed.

CLOSING EPISODES

All episodes are considered "Active" and will remain in your Open Episode or Clinician Activity Tables, until closure is completed by the Staff. Therefore, it is very important that attention be given to closure of episodes in the system.

Closures can be completed by Support Staff or Clinicians (depending on the work flow in your office) as long as the information required to close the episode is accessible/known by the staff member assigned to this responsibility. Information required to close an episode depends on the type of closure as well as the Administrative activated Staff Discharge Default fields selected.

As outlined in the Episode State Flow Chart and the Patient Management Flow Chart, there are three types of episode closures:

- **COMPLETE DISCHARGED EPISODE** – An episode containing an Intake a minimum of 1 Status Assessment plus the Staff Discharge completion.

  - Minimum closure fields are the last date of service and the total # of visits for the episode.
  - Your Practice FOTO Administrator may have activated other fields as "available" or "required on the Staff Discharge Screen (such as compliance, exercises/modalities/procedures, who made the discharge decision, etc. If set as Available – the Staff Discharge can be completed without these fields being completed. However, if set as Required, these fields must be completed in order to complete the Staff Discharge.

- **STATUS INCOMPLETE DISCHARGED EPISODE** – An episode containing an Intake Assessment but does not contain a Status Assessment: reason for no Status is documented in Staff Discharge Screen /OR/ Intake captured on wrong body part or perhaps captured by email but the patient did not present for the evaluation.

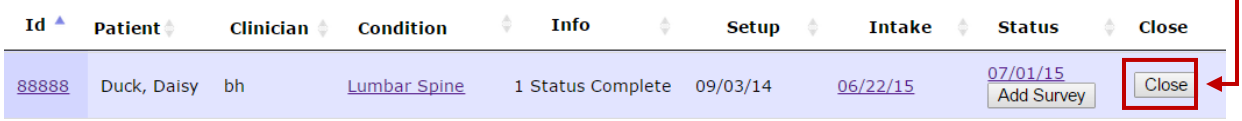
- **NON-PARTICIPATION** – An Intake attempted but not captured.

Regardless of the closure reason, you will close the episode by clicking on the appropriate Close or NP button in the Close column of the Open Episode or Clinician Activity Table as outlined in the following processes.

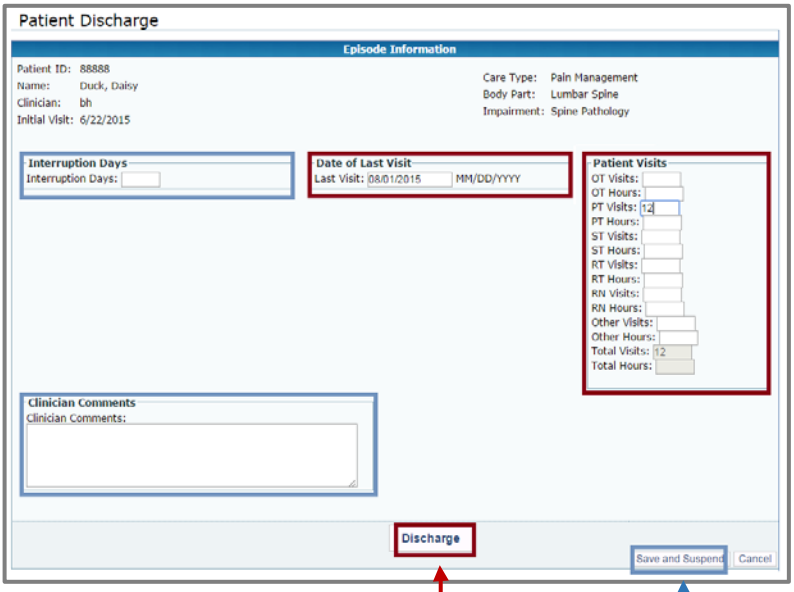
COMPLETE DISCHARGED EPISODE

To close an episode containing the **INTAKE AND STATUS**, use the following process.

- Locate your patient episode in the Open Episode or Clinician Activity Table
- Click on the CLOSE button in the column labeled Close



- The Staff Discharge Screen will open.
- Complete the required fields in the Staff Discharge Screen. Enter the base required discharge information as appropriate:



  - **Interruption Days*** – an optional field for the number of days (not visits) missed by the patient due to vacation, travel, illness, etc., if any. Note this does not include hospitalization. If the patient is admitted, the episode should be closed and a new episode established if the patient returns for continued care after release.
  - **Date of Last Visit** – Enter the date of the last visit for the patient.
  - **Patient Visits** – The number of visits must be entered for the appropriate discipline(s), however, the number of hours are optional.
  - **Clinician Comments*** – This is a free form text field where the physiotherapist may enter whatever they deem appropriate. These comments will print on the Staff Discharge Report.
  - Click **Discharge** to complete the closure of the episode /or/
  - Click **Save and Suspend** to save the data entered and return to the discharge later.

(*If there was no interruption of care or the clinician does not include comments, it is not necessary to put a '0' and 'NA' in these fields – simply bypass the fields).

- If your Practice FOTO Administrator has activated any of the Other Staff Discharge fields as Required, these will show in the Staff Discharge Screen as well for completion in order for the system to save / process the Discharge. These fields may include any of the following:

  - **APTA Practice Pattern** – documents the Musculoskeletal, Neuromuscular, Cardiovascular/Pulmonary and Integumentary practice pattern code based on the classification of the patient as a result of the physical therapist's evaluation history, systems review, and tests and measures.
  - **Smart Tracks Code** – If you use this documentation system, this field allows you to enter the unique tracking code for impairment.
  - **Global Rating Scale** – Documents the amount of improvement achieved by the patient during the episode valued by the clinician from -7 to +7 (0=baseline status of the patient at the time of the evaluation). *(Note: The patient may also complete the same Global Rating scale if activated in the optional surveys).*
  - **Staff Utilization** – Documents the percentage of time the patient was treated by staff during the episode based on role: PT, PTA, OT, OTA, etc.
  - **Goals / Results** – Documents the percentage of goals achieved during the episode of care (by clinician report).
  - **Who Discharged** – Documents who made the decision to discharge the patient from clinical therapeutic care.
  - **Exercises, etc.** - Documents the type of procedures, exercises, and modalities (physical agents) that were provided to the patient during the episode of care to track treatment regime.
  - **ICD9 / ICD10** – Allows tracking of specific diagnosis codes tied to the patient's episode of care, allows for 1 primary diagnosis code and 1 secondary code.
  - **Patient Co-pay** - Documents the insurance co-pay based on insurance plan/verification
  - **Net Revenue** – Documents the anticipated net revenue for the episode (minus insurance adjustments/ discounts, etc.).
  - **Compliance** - Documents the Acceptable or Unacceptable patient compliance with Attendance, Home Program, and Effort.
  - **Show Net Revenue** – If checked, the anticipated Net Revenue entered for this episode will surface on the Staff Discharge Report, compared with the average Net Revenue of risk-adjusted episodes nationally who are tracking net revenue.
  - **Referral Source Type** - Allows selection of the type of referral source for this episode as an additional dimension such as Neurologist, Orthopedist, General Practice, Podiatrist, etc.

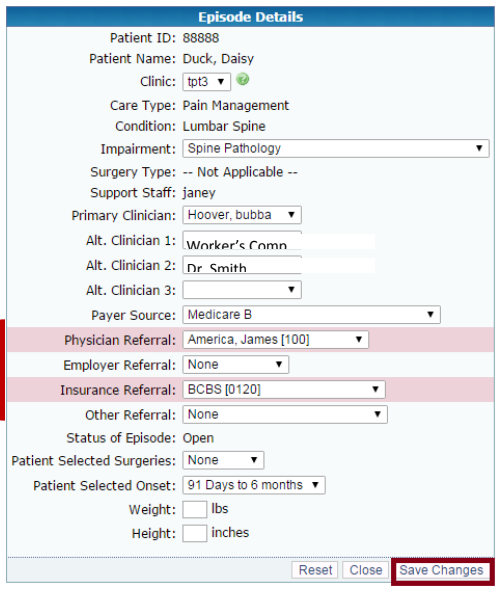
These optional Staff Discharge fields may appear on the Staff Discharge but only be set as "Available" in which case you can complete the Staff Discharge screen without completing these fields. Check with your Practice FOTO Administrator.

- You may see a warning message if you attempt to complete a Staff Discharge for an episode where Required Referral fields have not been completed in Episode Details (***See Editing Episode Detail section***).

Cannot discharge until required referrals are set. See highlighted items in Episode Details.

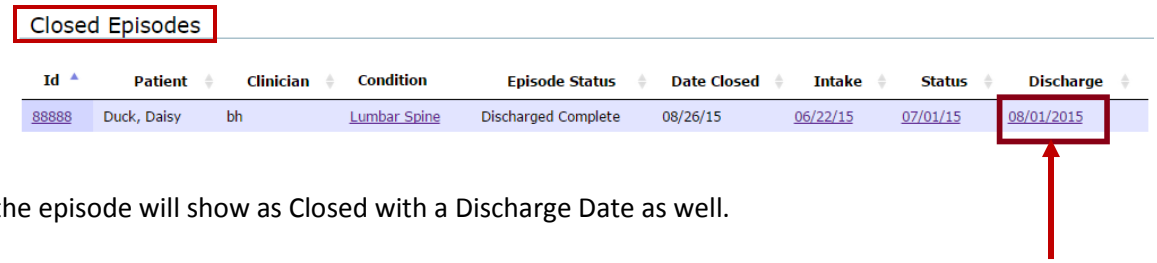
When this message appears, the system will automatically take you to the Episode Detail screen to complete these fields and Save Changes.

Then you can proceed again with Closure with the Staff Discharge.

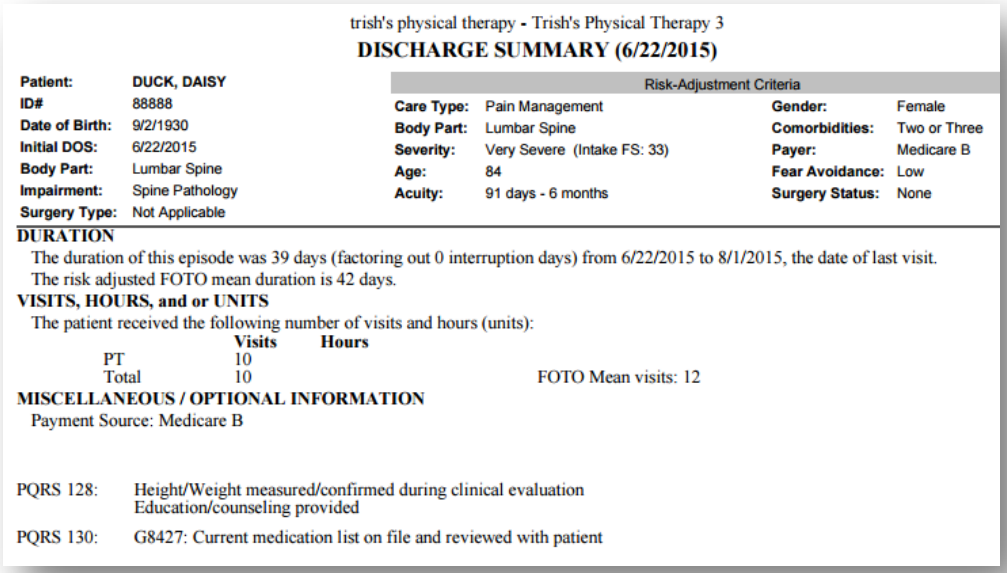


- **As soon as the Staff Discharge has been completed**, you will see a verification message at the top of the Episode Detail window.

- The patient episode will no longer surface in the Open Episode List.
- The system moves the episode to the **Closed Episode** Navigation link table.



- In Clinician Activity, the episode will show as Closed with a Discharge Date as well.
- From either the Closed Episode Screen or the Clinician Activity screen, you can click on the date of the Discharge to open the Report on screen.
- The Discharge Report contains a summary of the outcome episode including points of FS change achieved compared with predicted, visits compared with predicted, duration of the episode, etc.



trish's physical therapy - Trish's Physical Therapy 3

DISCHARGE SUMMARY (6/22/2015)

Patient:	**DUCK, DAISY**
ID#	88888
Date of Birth:	9/2/1930
Initial DOS:	6/22/2015
Body Part:	Lumbar Spine
Impairment:	Spine Pathology
Surgery Type:	Not Applicable

Risk-Adjustment Criteria

Care Type:	Pain Management	**Gender:**	Female
Body Part:	Lumbar Spine	**Comorbidities:**	Two or Three
Severity:	Very Severe (Intake FS: 33)	**Payer:**	Medicare B
Age:	84	**Fear Avoidance:**	Low
Acuity:	91 days - 6 months	**Surgery Status:**	None

DURATION

The duration of this episode was 39 days (factoring out 0 interruption days) from 6/22/2015 to 8/1/2015, the date of last visit.
The risk adjusted FOTO mean duration is 42 days.

VISITS, HOURS, and or UNITS

The patient received the following number of visits and hours (units):

	Visits	Hours
PT	10	
Total	10	

FOTO Mean visits: 12

MISCELLANEOUS / OPTIONAL INFORMATION

Payment Source: Medicare B

PQRS 128: Height/Weight measured/confirmed during clinical evaluation
Education/counseling provided

PQRS 130: G8427: Current medication list on file and reviewed with patient

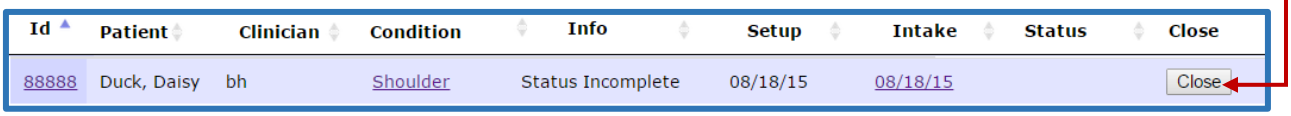
Refer to section, ***Printing Patient Specific Survey Reports***

STATUS INCOMPLETE DISCHARGE

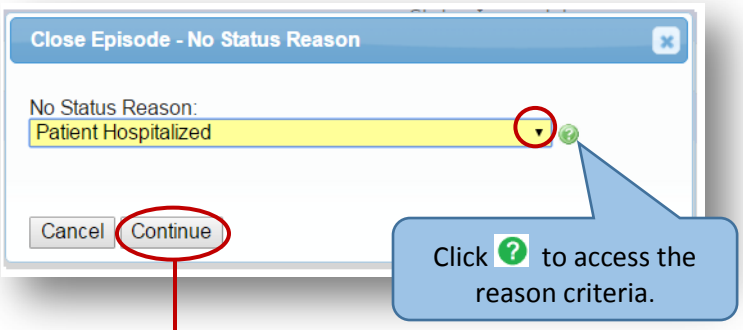
If a **STATUS ASSESSMENT HAS NOT BEEN CAPTURED during the episode of care,** the reason for not capturing a Status is to be provided on the Staff Discharge Screen. The Staff Discharge can be accessed using the Open Episodes or Clinician Activity navigation links.

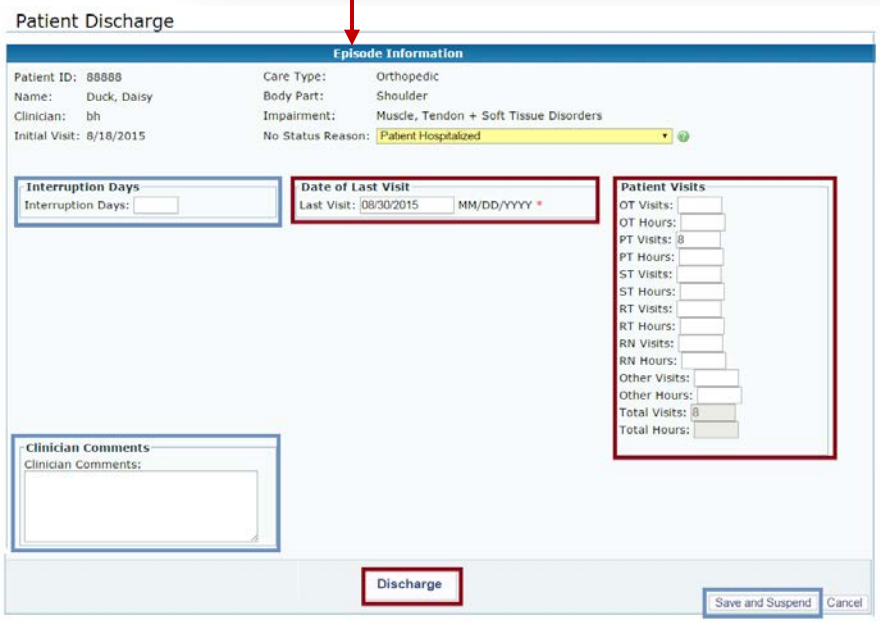
Episodes without a Status Assessment will not generate an FS change score but still need to be closed to remove them from the Open Episode list.

- Locate your patient episode in the Open Episode or Clinician Activity Table
- Click on the CLOSE button in the column labeled Close



- The FOTO program identifies no Status Assessment is recorded for the episode and a sub-screen opens.
- Click on the down arrow to select the applicable reason that a Status Assessment was not captured. (See Status Incomplete Episode Reason criteria table on next page.)
- Select Continue when the reason is selected for this field.
- Once Continue is selected, the Staff Discharge screen opens.
  - Just as with a Complete Discharged Episode, the Staff Discharge screen is completed with the required fields and optional fields as appropriate, including last visit date, # of visits, etc.
  - (You will notice the reason selected in the previous screen is pulled into the Discharge.)
- When finished, click on **DISCHARGE** (or Save & Suspend as appropriate).





The following Status Incomplete Episode reasons may be used.

1/x Only Visit Episodes Reason	Criteria
Treatment not indicated	When an Intake Assessment ONLY has been captured but it is **immediately identified** that continued care is not indicated, refused, patient referred to another service provider, etc., use the appropriate selection from this section to enter an incomplete episode reason.
Referred to another facility	
Home program only	
Wheelchair evaluation/pressure mapping only	
Splinting/TENS only/Orthotics	
WC Assessment/FCE Only	
Consult Only	

Status Incomplete Discharge Reasons	Criteria
Proxy / Recorder not Available	Intake Assessment completed by proxy recorder; however, proxy or recorder were not available to complete the Status Assessment
Scheduled for Surgery	**Prior to conclusion of treatment episode, an unexpected surgery was performed**. **For patients who are referred for pre-op treatment, the Intake and status assessment(s) and staff discharge are required.** Patients returning for care post-surgery require a new Intake.
Patient Hospitalized	**Prior to conclusion of treatment episode, patient is hospitalized unexpectedly**: Patient will require new Intake episode if they return for care post release.
Patient returned to MD for further diagnostics/testing	Patient did not return to clinic for status update
Physician requests care discontinuation	Clinician recommends continued care but physician requests discharge
Insurance requests care discontinuation	Clinician recommends continued care but Insurance requests discharge (does not authorize additional visits)
Self-Discharged: Reason Unknown	Intake completed & treatment initiated; however, patient self-discharged (did not return for completion of care).
Self-Discharged: Patient Defers treatment	Intake completed but patient indicates they are not interested in pursuing further care.
Self-Discharged: Transportation/ family /work issues	Intake completed but transportation/family/work issues prohibit continuation of care.
Self-Discharged: Financial/copay reasons	Intake completed but patient unable to continue treatment due to financial/co-pay reasons.
Refused	Should only be used if the patient refuses to complete Status Assessment
Staff did not capture a Status during episode	For example, staff forgot or ran out of time.
Deceased	

Intake Exceptions	Criteria
Incorrect Set-Up - Wrong Body Part	If it is not identified that the incorrect body part / impairment was set-up for the patient and an intake was completed, use the Status Incomplete Episode Reason as part of the Staff Discharge process to document the 1x episode intake as incorrect and then a correct episode can be established for completion.
Intake Completed by Email: Patient did not attend for evaluation.	When an intake is emailed to a patient and it is completed but the patient never presents for the evaluation, this reason can be selected to close out the incomplete episode of care as Non-Participating.

If you select an "Intake Exception" reason in the "Close Episode – No Status Reason" window, the system will ask you to confirm this closure. Once confirmed, this closure will be handled by the system as a Non-Participation (NP) and the Staff Discharge Screen will NOT open for completion, as follows:

- **If Intake Exception Reason selected in No Status Reason window, when you click on 'Continue' a sub-screen will open asking you to confirm this closure.**
- **Select Confirm.**
- **This will close the episode and process the closure as a Non-Participating (NP) episode.**

- Once completed the episode will now show in the Closed Episode Table (or show as closed in the Clinician Activity Table) as a Status Incomplete Discharge or a Non-Participating episode, depending on the reason selected.
- The Reason for No Status will show in the Info column.

Closed Episodes - **No Status Reason Selected**

Id	Patient	Clinician	Condition	Episode Status	Date Closed	Intake	Status	Discharge	NP	Info
88888	Duck, Daisy	bh	Shoulder	Discharged, NoScore	08/26/15	08/18/15		08/26/2015		Patient Hospitalized

- You can access the Discharge or Non-Participation Report by clicking on the Report Date in the table.

Closed Episodes - **Intake Exception Reason Selected**

Id	Patient	Clinician	Condition	Episode Status	Date Closed	Intake	Status	Discharge	NP	Info
88888	Duck, Daisy	bh	Shoulder	Non-Participation	09/08/14	08/01/14			09/08/14	Incorrect Set-Up - Wrong Body Part

- You can access / print the Discharge Report as outlined in Complete Discharged Episodes

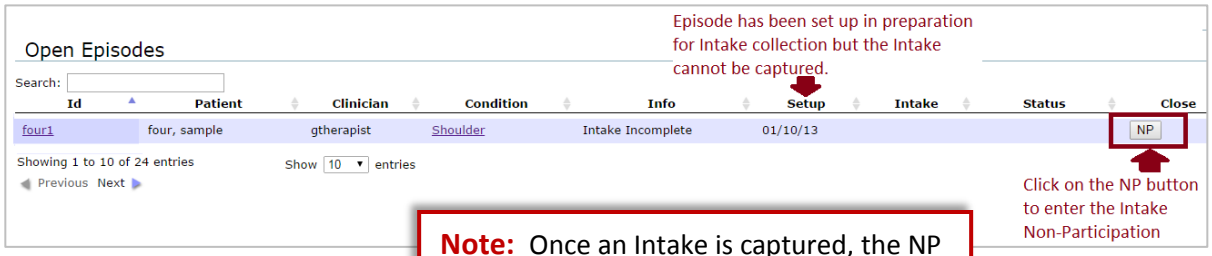
Refer to section, ***Printing Patient Specific Survey Reports***

NON-PARTICIPATION (NP) EPISODE

If you were unable to complete an Intake Assessment with a patient, an Intake NP reason is to be entered to close the episode. The reason for the NP will be logged in the account and the episode will automatically be removed from the Open Episodes List.

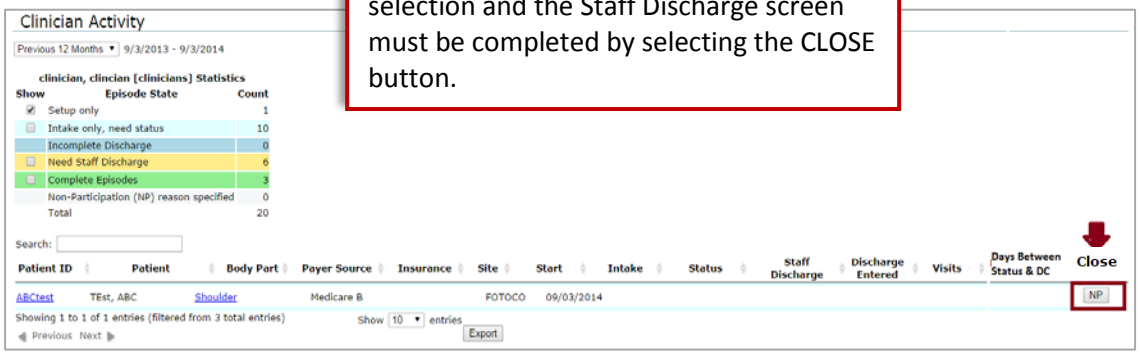
- The Intake NP reason is entered by selecting the NP button in the Episode Screen (Open Episodes List or Clinician Activity List).

In Open Episodes Screen:



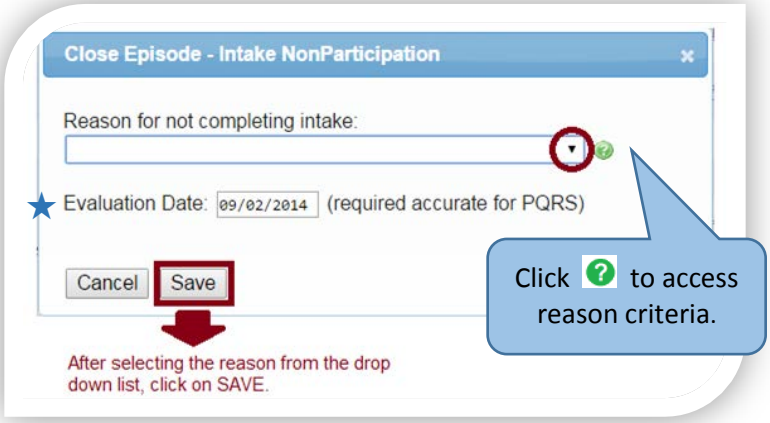
Note: Once an Intake is captured, the NP button will no longer be available for selection and the Staff Discharge screen must be completed by selecting the CLOSE button.

In Clinician Activity Screen:



- After clicking on NP, a screen will open with a drop down to select the NP reason.

★ **The date defaults to the set-up date. If your patient attended for the evaluation but an Intake was not captured, please enter the evaluation date in this field. This is particularly important if you are participating in the FOTO PQRS Data Registry to finalize validations.**



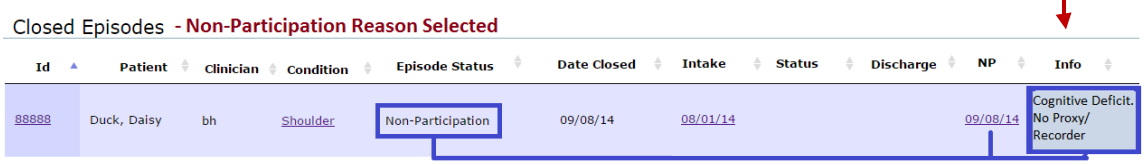
(See NP Reason Criteria table on next page.)

Select the appropriate Intake NP reason using the criteria as follows:

Intake Non-Participation (NP) Reason	Criteria
Cognitive Deficit/Dysphasia: No recorder or proxy	Recorder or proxy completion of the Intake/Status surveys are acceptable. A **RECORDER** is someone who records all answers provided by the patient who can respond verbally and reliably. The Recorder must NOT influence the responses or answer on behalf of the patient.
Vision/Reading/Language Barrier: No recorder or proxy	**PROXY** is someone who answers all questions on behalf of the patient. The proxy determines the content of the answer upon their perception of the patient's abilities. A proxy is used when a patient cannot give accurate answers about their health or cannot answer reliably. If no proxy or recorder are available to complete the initial survey assessment, use the No Recorder or No Proxy NP to document the inability to capture outcome information.
Patient did not present for evaluation	Patient set-up in FOTO; however, patient did not follow through with referral and did not attend the evaluation visit. No evaluation completed.
Refused	Should only be used if the patient refuses to complete Intake Assessment.
Incorrect Set-Up: Wrong Body Part	Prior to Intake completion it is identified that the wrong body part /impairment was selected.
Excluded Conditions	Practice imposed restriction ❶
Staff did not capture	Limit use: implies staff did not capture Intake Assessment for Episode

❶ **Exclusion Criteria.** Your practice may internally set exclusion criteria and, if so, this Intake NP may be used. **A mandatory text field is required to describe the condition exclusion.**

- Once completed the episode will now show in the Closed Episode Table (or show as closed in the Clinician Activity Table) as a Non-Participating episode.
- The Reason for Non-Participation will show in the Info column.
- You can access the Discharge or Non-Participation Report by clicking on the Report Date in the table.



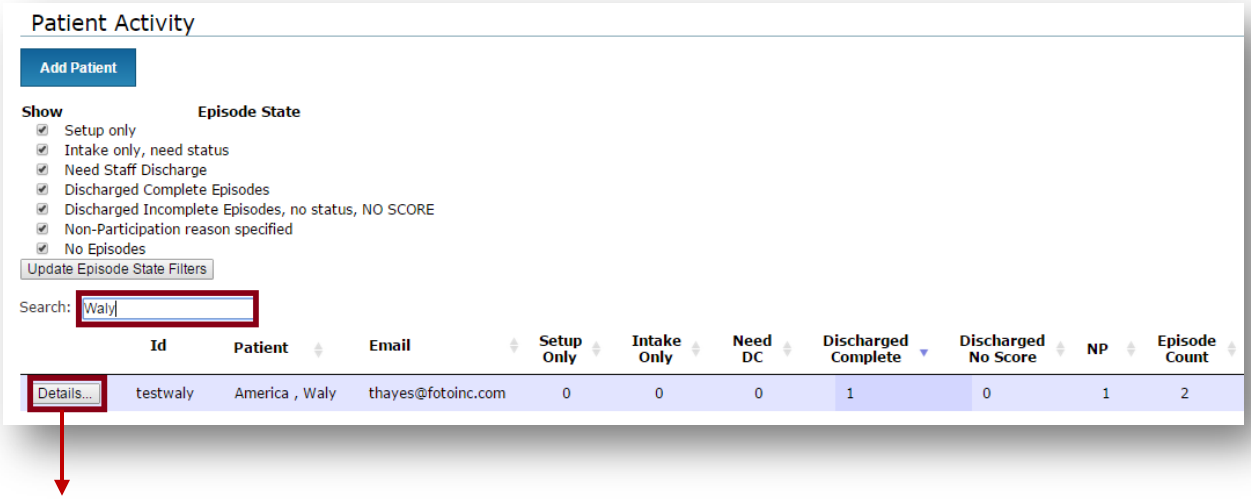
- You can access / print the Non-Participation Report as outlined in Complete Discharged Episodes

Refer to section, ***Printing Patient Specific Survey Reports***

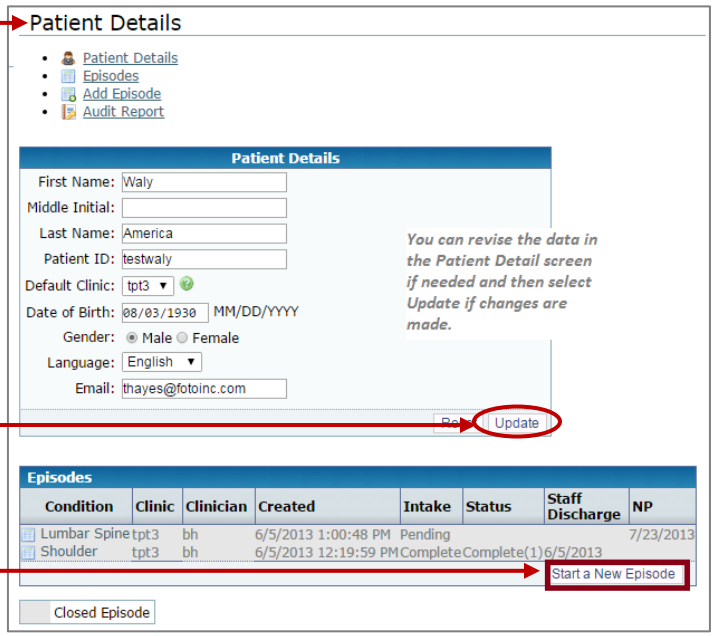
ADDING NEW EPISODE: EXISTING ACCOUNT

If a patient returns for another episode of care or requires treatment for more than one condition at the same time, a new episode can be added as follows:

- Find your patient in the Patient Activity Link.
  - Using the Search field can be very helpful to filter this list to easily find the existing account for your patient.



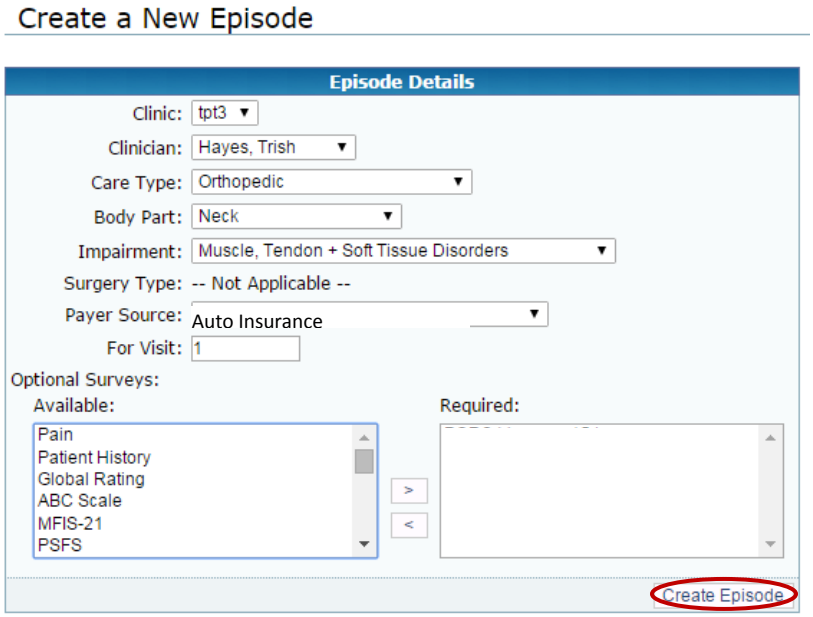
- Click on the Detail button to open the Patient Detail screen.
  - Edit necessary Patient Detail information (such as Name, email address, pay source, etc.) and if changes made, click on the Update button to save the changes.



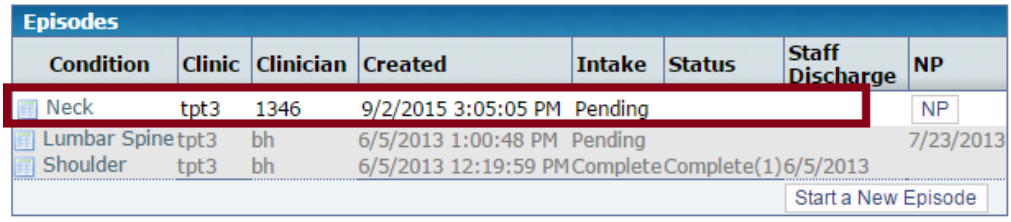
- Click **Start a New Episode** from the Patient Details screen in the "Episodes" box.

- Create the episode as previously shown (see section, ***Creating an Episode***).

- After completing the New Episode Detail screen for the additional episode, click on **CREATE EPISODE**.



- The new episode will show in the Patient Account, Open Episode, and Clinician Activity tables.



- **You are ready to capture an Intake and Status Assessments for the episode.**

Please check with your practice Administrator regarding Adding an episode to an existing Patient Account **vs.** establishing a New Account for each episode.

Some EMR/EHR systems require a new account structure with each episode and some do not.

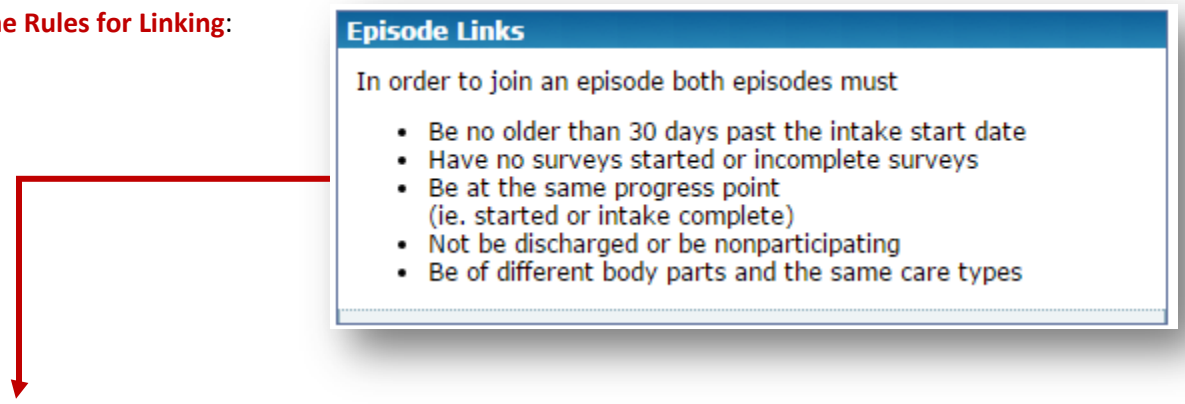
Follow the directive for establishing a New Account or adding new episodes to an Existing Account set for your Organization by your Administration.

LINKING EPISODES

FOTO has a feature that allows you to **link two simultaneous episodes** so the **Patient Electronic (or emailed) Intake Assessment (or subsequent Status Assessments)** will ask the patient the body-part specific functional questions for each body part problem without having to complete two separate surveys. The system will separate the data and will produce a Functional Intake (or Status) Report for each body-part episode to deliver risk-adjusted predictor data specific for each body part impairment. *(Linking episodes is not a functional feature with the paper surveys collection method.)*

You have the flexibility to ask the patient to complete the episode specific Status Surveys at varying times as well as completing the Staff Discharge by body-part specific episode, to allow you to discharge the patient from active care for one of the body parts while continuing to provide care for the other.

The Rules for Linking:



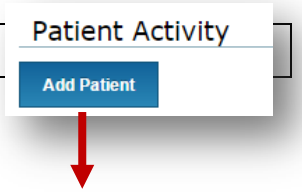
Link Parameters: In order to join episodes, BOTH episodes must:

- **Be different body parts with the same Care Type**
  - For example: You can link a Shoulder and a Neck episode in the Orthopedic Care Type; a Hip and a Lumbar episode in the Orthopedic Care type.
  - You should not link a wrist and a hand episode (even though both are in the Orthopedic Care Type as the wrist and hand body-part impairments utilize the same FS survey assessment).
  - You cannot link a Neuro Care Type episode with an Orthopedic Care Type episode.
- **Be no older than 30 days past the intake start date**
  - For example: An Elbow episode initiated on January 1 with an Intake cannot be linked to a new body-part episode initiated more than 30 days after the elbow intake date.

- **Be at the same progress point (i.e.: started or intake complete)**
- **Have no surveys in process or incomplete surveys**
- **Not be discharged or be closed with an Intake NP**

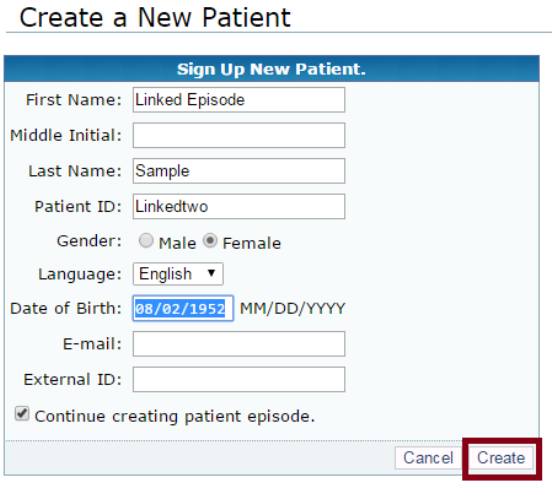
- Both episodes must be ready to capture an intake assessment or both episodes must be ready for status.
- If you have captured an intake for one body part impairment and then one week later you want to begin a second body part, you will first need to capture the intake for the second body part and then join the episodes.
- If a patient is in the process of completing an Intake for one body-part impairment (but has not finished the Intake) you cannot join another body-part episode until the initial intake has been completed. Once the initial body-part impairment intake is completed, the second body part intake can be completed and then the episodes may be joined.

Setting up a Patient with Two Simultaneous Body-Part Episodes

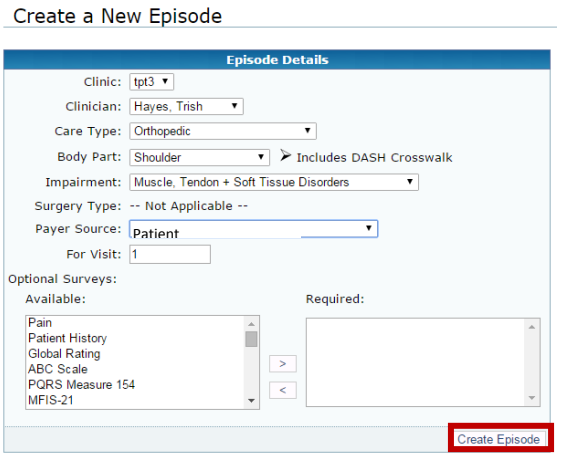


The First Episode:

- Just as you do for any new patient, select Patient Activity from the navigation bar, and then select "Add a Patient".
- Enter the patient information in the "Create New Patient" screen to establish the patient's Account and select **CREATE.**



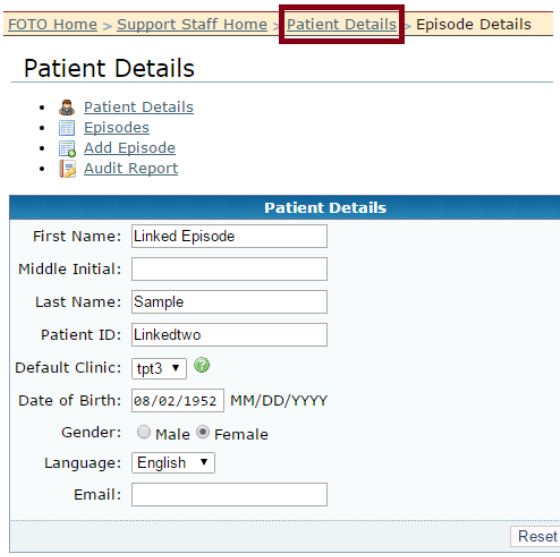
- In the Create New Episode screen that opens, select the Clinician, Care Type, Body Part and Payer Source **for the first episode**. When fields are completed, select **CREATE EPISODE**.



This will be verified with the message:

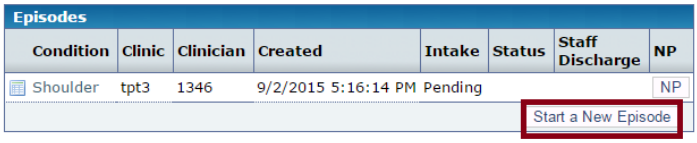
Successfully created patent episode 3645830

To Set Up Second Simultaneous Episode:

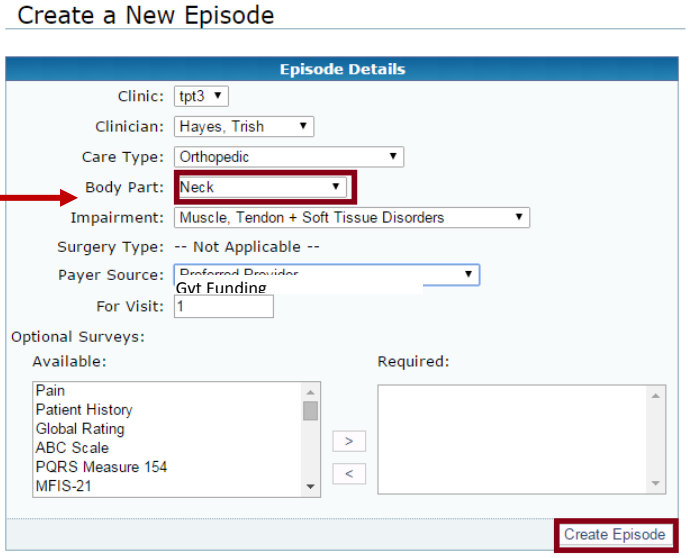


- Click on Patient Details to return to the Patient Detail screen /or/ using the Open Episode List, click the patient ID you just set-up to access the Patient Detail screen.

  You will notice that, as in this example, the shoulder body part episode that you just set up shows in the Episode Screen.



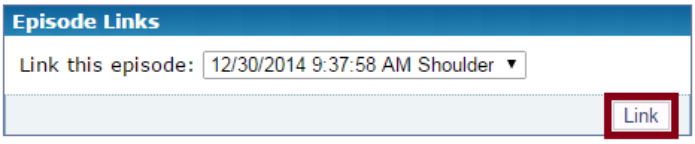
- Click on Start a New Episode button in the episode screen to create the second body-part episode.
- A new Create New Episode screen will open.
- **Complete this screen with the second body part information** (in this example, we added a Neck episode).
- When complete, click Create Episode.



- When you click on CREATE Episode (after setting up the second episode), the screen will return to the **Episode Detail Screen** and the system will verify that the second episode has been set up.

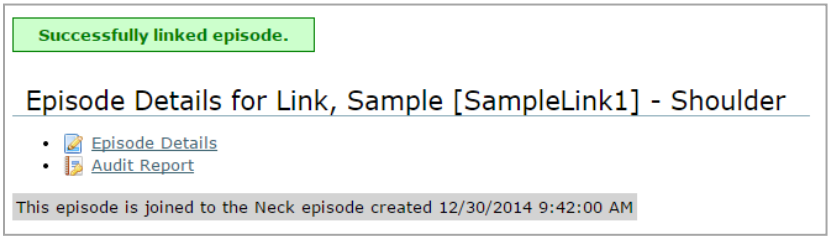
- **In this same screen**, scroll down to the bottom of the page. You will see a box field to Link Episodes.

In our example, we set up the shoulder episode first and the second episode was for the neck. This window shows that the second Neck episode that was established can be linked to the first episode (shoulder).



- Click on the **LINK** button to link the episodes (in this example, we are linking the shoulder episode to the neck episode).

- Once you have clicked on the LINK button, you will see a message at the top of the screen, showing you that you have successfully linked the lumbar episode to the shoulder episode.

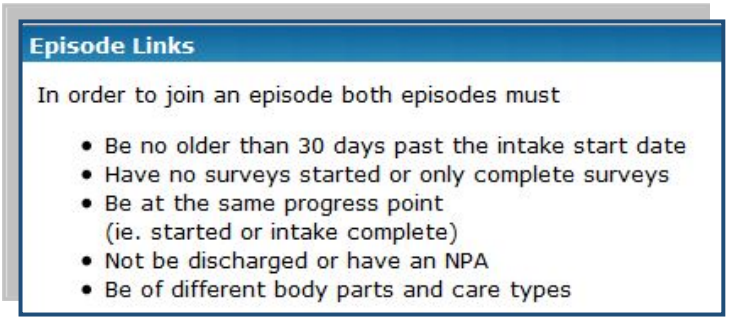


Linking Episodes Created at Different Times

If the episodes to be linked were not created at the same time, check that the episodes meet the Linking criteria.

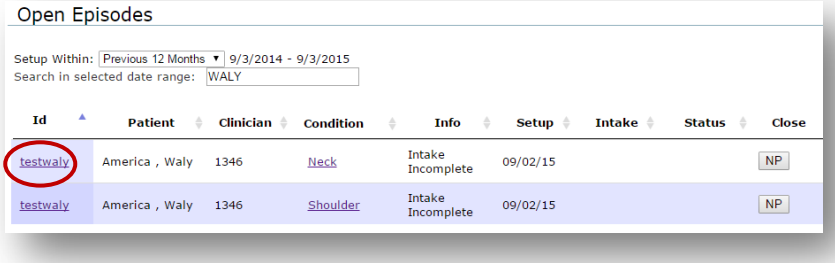
- If the Intake Survey for the first episode has been completed, the patient must take the Intake for the second episode before the episodes may be linked.

- If it has been more than 30 days since the patient took the first Intake survey, the episodes cannot be linked.



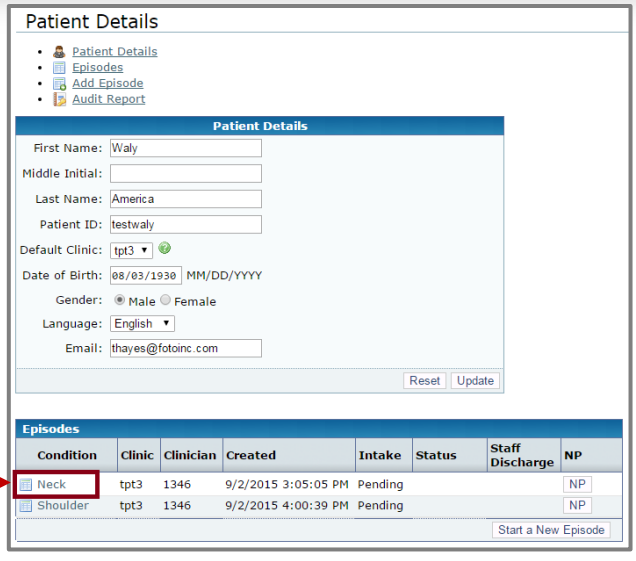
Capturing the Intake Assessment for Linked Episodes

- In the Open Episode window, you will see both episodes listed separately for the account. To capture the Intake, simply click on the ID for the first episode listed *(in this example, the Neck*).



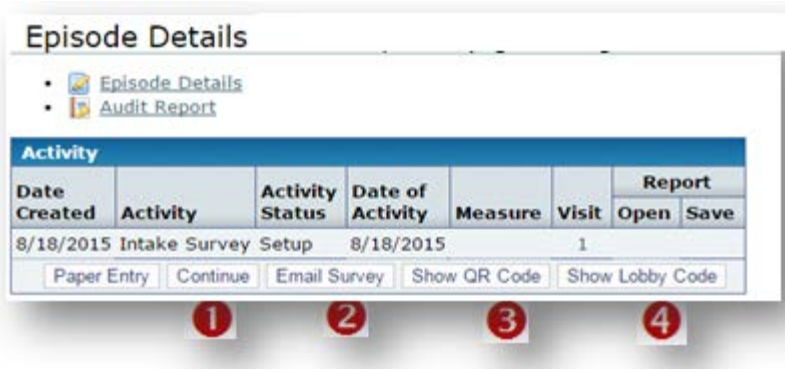
- This will open the patient's Patient Details Screen and will show both body part conditions in the Episode window.

  - Click on the Neck (or shoulder) condition.



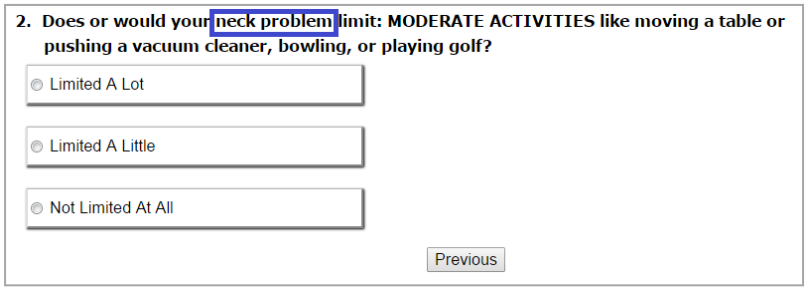
(It is only necessary to select one of the episodes in the Condition column to generate a linked electronic intake that will combine both the body-part intake questions of the patient in a single survey tool.)

- Follow the instructions for an Electronic Intake to initiate (or email) the electronic survey.

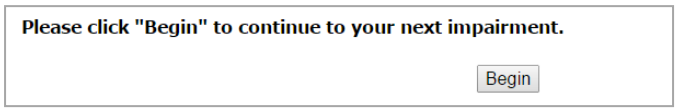


- The electronic survey will ask the body-part specific functional questions for the first body-part at the beginning of the survey, then a "break screen" appears to separate and identify the questions that will be asked for the second body-part impairment to assist the patient in discriminating their responses based on how the different impairments affects function.

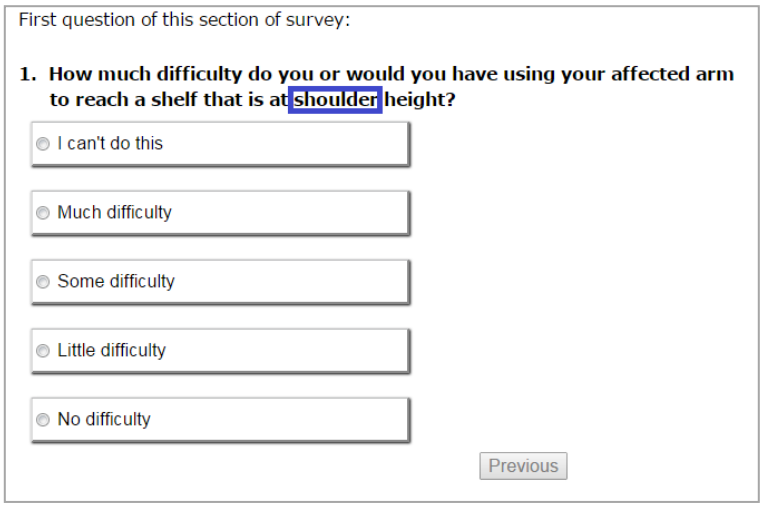
For example, the functional questions related to the Neck impairment are asked first.



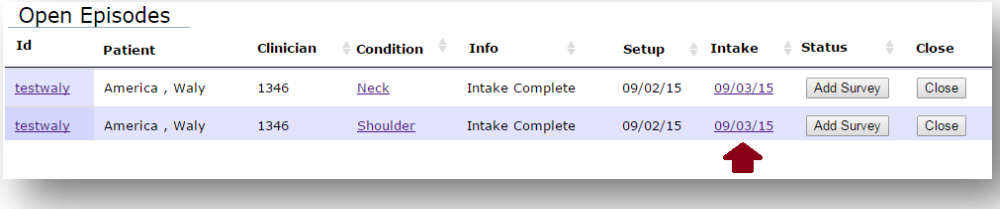
When all questions are completed for the Neck, the next screen alerts the patient that the survey is now moving to the next body part impairment.



The next section asks the functional questions related to the Shoulder impairment.



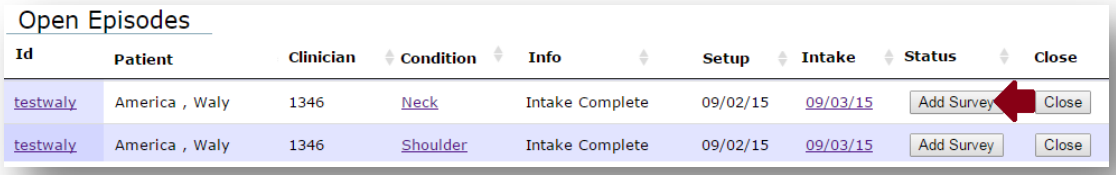
- As soon as the patient has completed the survey, FOTO will separate the data by body part and will produce two separate patient specific intake reports – one for each body part. This facilitates predictor information by body part impairment and also allows the independent management of the episodes during care.



- These Intake reports can be accessed as by clicking on the date in the Intake column in Open Episodes or Clinician Activity tables.

Capturing Status Assessments for Linked Episodes

- Click on the Add Survey button to initiate a Status Assessment.


Open Episodes

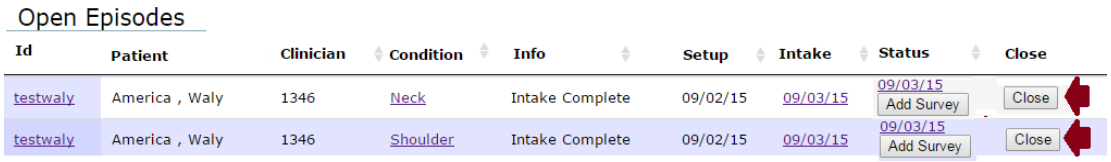
Id	Patient	Clinician	Condition	Info	Setup	Intake	Status	Close
testwaly	America , Waly	1346	Neck	Intake Complete	09/02/15	09/03/15	Add Survey	Close
testwaly	America , Waly	1346	Shoulder	Intake Complete	09/02/15	09/03/15	Add Survey	Close

- As long as the episodes remain linked, it is only necessary to select one of the episodes to capture the Status.
- Just as seen with the Intake Assessment, the survey will ask body-part specific questions for each of the impairments in one survey but the system will split the data apart into two separate Patient Specific Status Assessment reports.

Discharging Linked Episodes

When closing linked episodes, it is necessary to **complete a separate Staff Discharge for each of the body part episodes** that you have established. This will close the episodes with the correct number of visits/duration for care provided for each body-part impairment.

- To close the episodes, from the Open Episode table click on the Close button for the first episode, completing the Staff Discharge screen process.

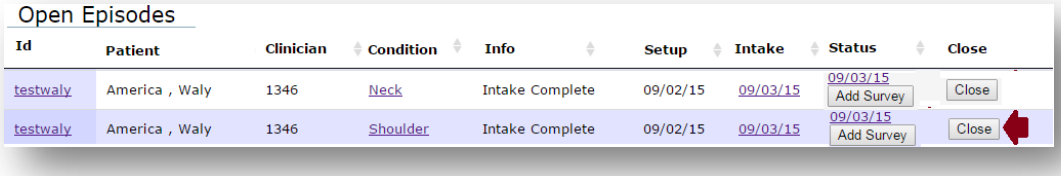

Open Episodes

Id	Patient	Clinician	Condition	Info	Setup	Intake	Status	Close
testwaly	America , Waly	1346	Neck	Intake Complete	09/02/15	09/03/15	09/03/15 Add Survey	Close
testwaly	America , Waly	1346	Shoulder	Intake Complete	09/02/15	09/03/15	09/03/15 Add Survey	Close

- After completing the Staff Discharge for first episode, click on Discharge.
- Repeat this process for the second episode.
- The episodes will be considered closed in your patient management list tables.

However, there may be occasions when clinical treatment is completed for one of the body-part impairments but treatment will be continuing for the other body-part impairment.

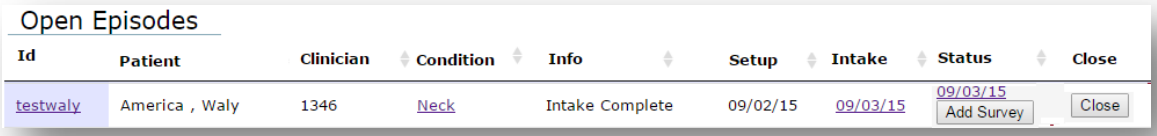
- Complete the Staff Discharge for the episode you are discontinuing. In this example, treatment has been completed for Shoulder episode, so we selected the Close button for the Shoulder Episode only and completed the Staff Discharge Screen.


Open Episodes

Id	Patient	Clinician	Condition	Info	Setup	Intake	Status	Close
testwaly	America , Waly	1346	Neck	Intake Complete	09/02/15	09/03/15	09/03/15 Add Survey	Close
testwaly	America , Waly	1346	Shoulder	Intake Complete	09/02/15	09/03/15	09/03/15 Add Survey	Close

- Then UNLINK the episodes

- Now, when you return to Open Episodes, you will only see the Neck episode for the patient and you can continue to capture Status Assessments until the patient is discharged from clinical care and the Staff Discharge is completed to close the Neck FOTO episode.

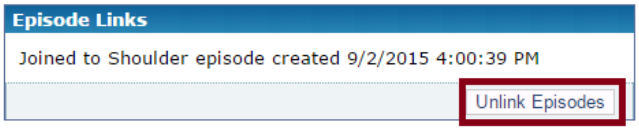


UNLINKING EPISODES

In order to complete the episode specific Status Surveys at varying times (instead of both at the same time), or to allow you to discharge the patient from active care for one of the episodes while continuing to provide care for the other, the episodes will need to be unlinked.

At the bottom of either episode, click **UNLINK EPISODES** from the Episode Links box.

- **UNLINK episodes** by going to the bottom of the Episode Detail screen to access the Linked Episode window and click "Unlink Episodes".



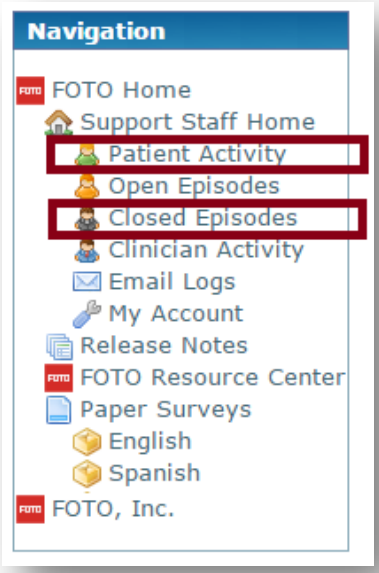
REOPENING AN EPISODE DISCHARGED IN ERROR

Note: ***DO NOT Re-open an older discharged episode if:***

- A previously discharged patient returns at a later date for care to the same body part or another body part – **create a new episode**
- A patient returns for treatment following a surgical intervention (for example) **– create a new episode**

Occasionally, episodes are discharged prematurely in error. If this occurs, you can reopen the episode in FOTO by following the steps outlined below.

To reopen an episode:

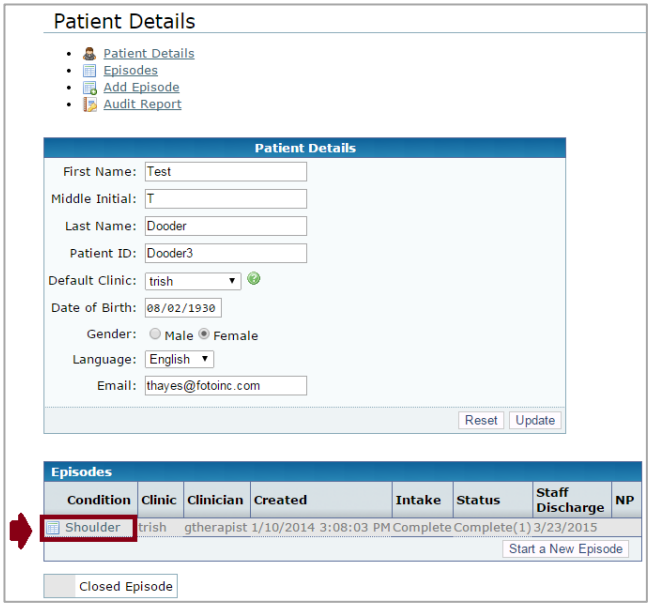


- From the Navigation Bar, select either the Patient Activity link /OR/ the Closed Episode link.

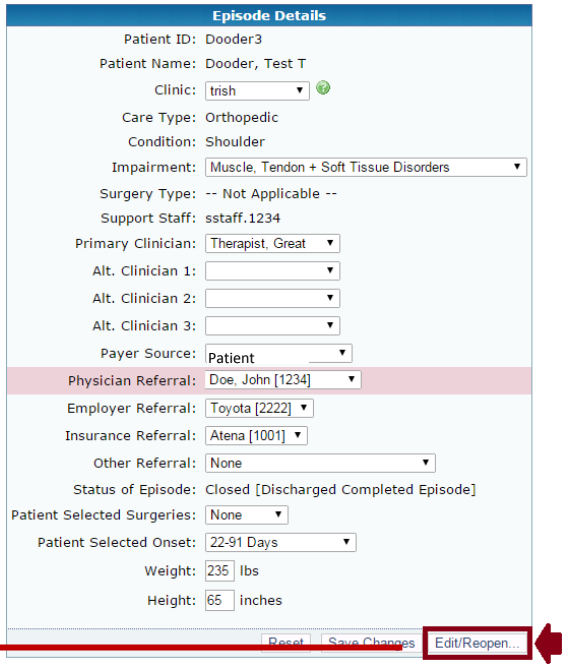
- In either screen (*the example uses the Closed Episode screen*), type in the patient's last name /or/ the ID number for the patient in the Search Field.

- Click the ID# for the patient that was discharged in error.

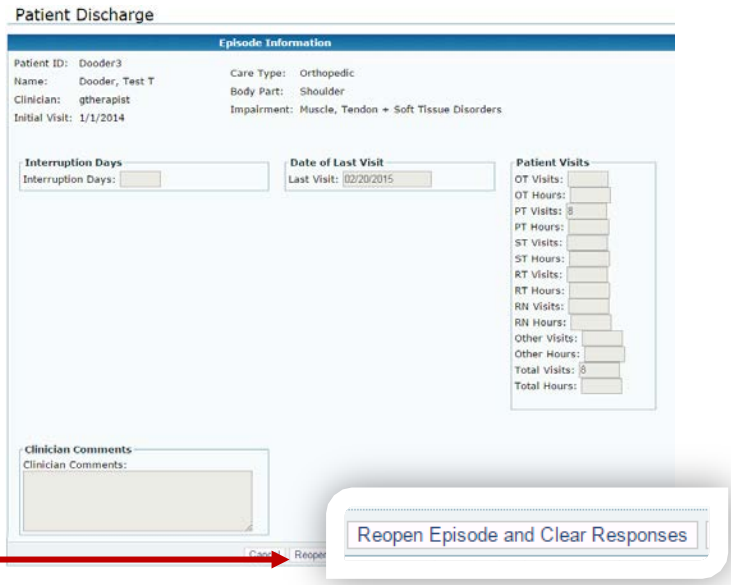
- The Patient Detail window will open. Click on the Episode/Condition of the Discharged Episode that was entered in error.



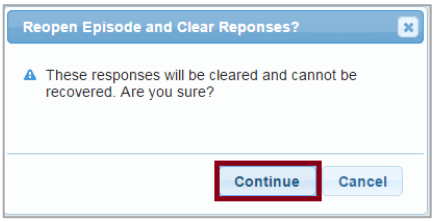
- The Episode Detail window opens.
  - Click on the button for Edit/Reopen.



- The Staff Discharge opens on the screen.
- Scroll down to the bottom of the Staff Discharge and select ***Clear Responses and Reopen Episode.***



- When you do this, a follow-up screen will open asking you to confirm that you want to reopen the episode and clear the discharge responses. If Yes, select CONTINUE.



- After selecting **CONTINUE**, you will see a green box at the top of the episode detail window stating that you successfully reopened the episode.

Successfully re-opened the episode and cleared values.

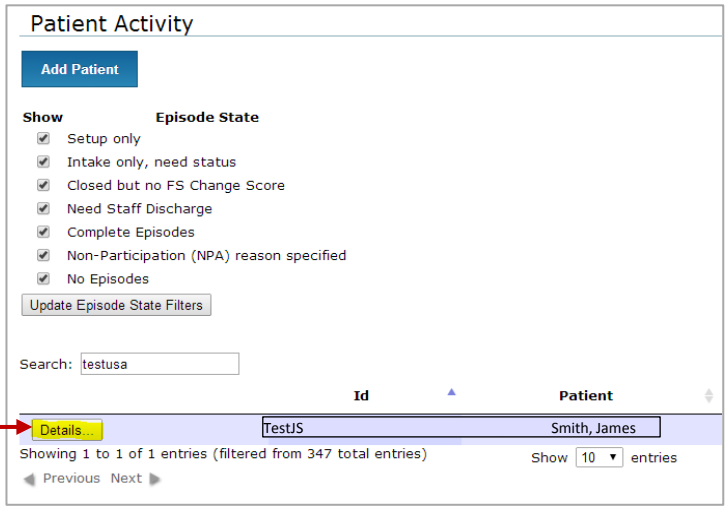
When you return to Open Episodes, you will see this patient listed in your active patient table.

EDITING CLOSED EPISODES

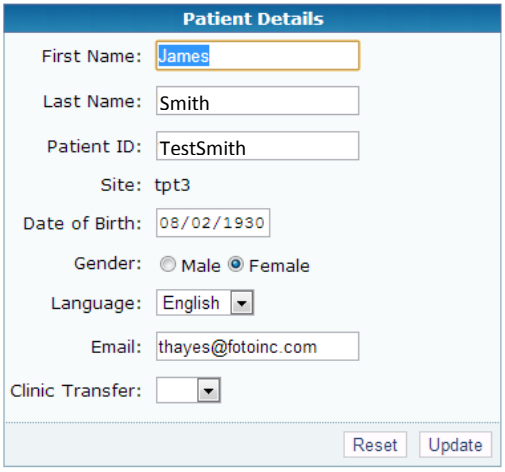
Occasionally, it may be necessary to Edit information entered on an episode due to incorrect payer source / insurance referral or managing clinician assignment entry, discharge information entered, etc.

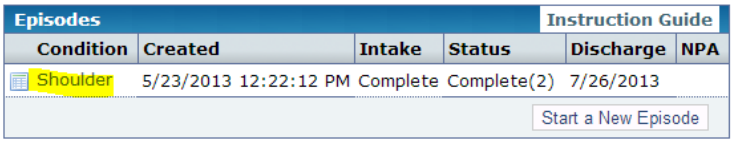
The instructions below will walk you through how to reopen the episode to edit this information without losing the staff discharge information.

- Locate and access the patient's account from the Patient Activity link (or Closed Discharge Table link)
- Click on the Details button for the episode (or ID # for Closed Episode table).



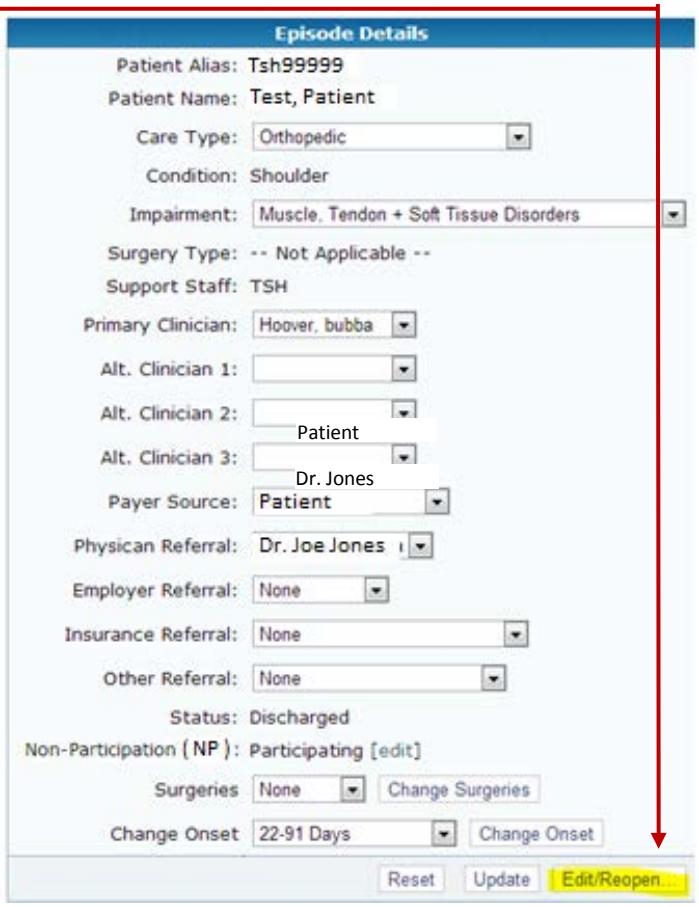
- In the Episode window that opens, click on the episode condition.





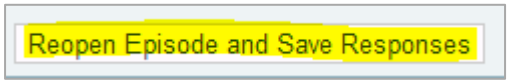
- The Episode Detail Window will open.

- Click on the Edit/Reopen button.

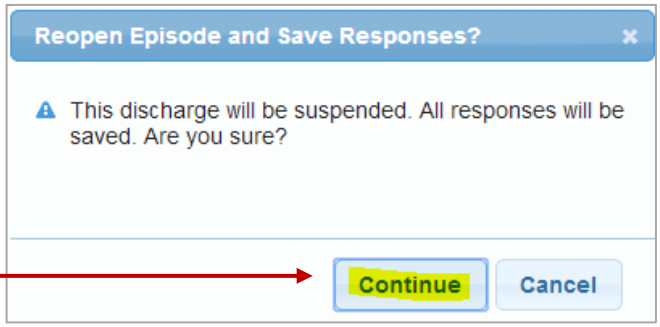


<u>This will open the Staff Discharge that has been completed on the episode.</u>

- Scroll down to the bottom of the Staff Discharge screen, and click the "Reopen Episode and Save Response" button on the lower right corner.



- A verification window will open asking if you want to Reopen the Episode and Save the DC responses.
  Click Continue.



- This will take you back to the patient's Episode Detail Screen. You see a verification at the top of the Episode Detail Screen stating the episode was successfully reopened and the values were saved.

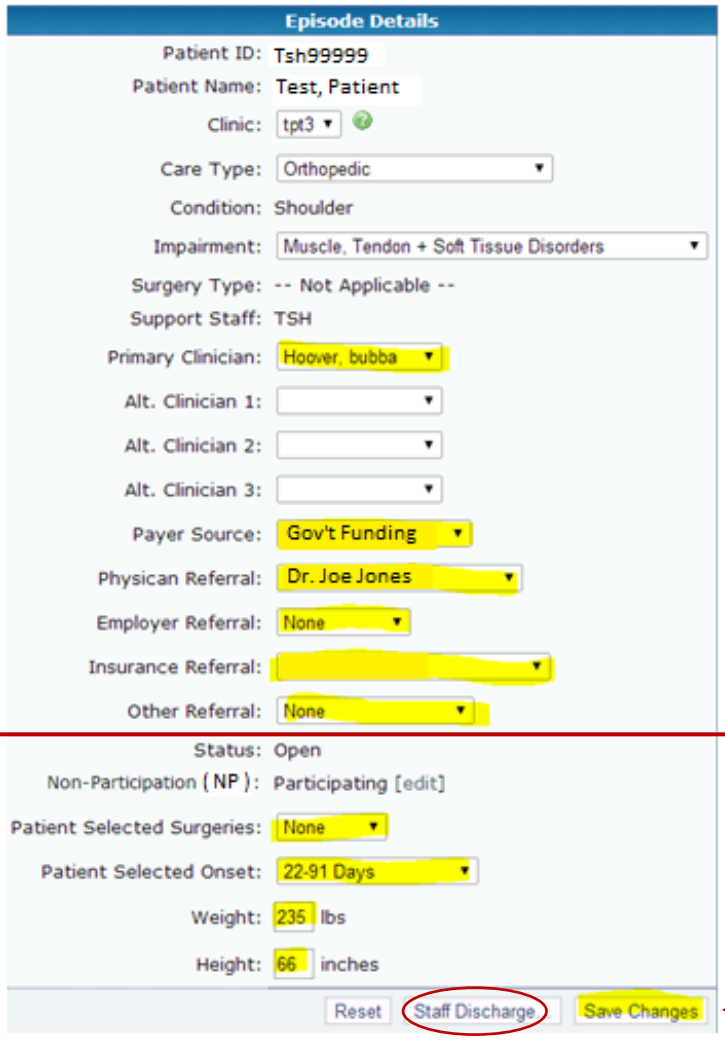
- You can now make necessary corrections to the Episode Detail fields (if needed) as follows.

  You can Edit the:

  - Primary Clinician
  - Payer Source

- Physician Referral
- Employer Referral
- Insurance Referral
- Other Referral
- # of Patient Surgeries
- Onset/Acuity
- Weight/Height

(See sample screen)

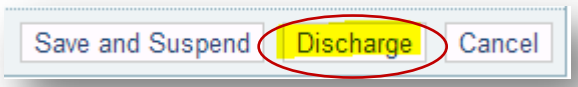


- When finished, be sure to click the Save Changes button in the window.

  Any changes you make & save on this screen will re-calibrate the Patient Specific Functional Reports.

If no changes are needed in the episode data, and only staff DC information needs to be edited, simply proceed to the next step below.

- When editing is completed, click on Staff Discharge.
- This will open the completed Staff Discharge screen (all of the fields that were completed previously will surface).
- Check to be sure to see if revisions are needed to the information included on the Staff Discharge. If you need to edit the last visit date, visit count, or change selections to any other required discharge fields activated by your Administrator, etc. please do so in the discharge screen.
- When all changes are made, go to the bottom of the Staff Discharge screen and select DISCHARGE.



NOTE: *It may be that only the incorrect number of visits or the incorrect last visit date was entered on the staff discharge screen (all other episode detail information is correct). If so, follow the process to reopen the episode and save responses. Then immediately go back to the Staff Discharge button. In the Staff Discharge screen, correct/edit the last visit date or the number of visits and then click the Discharge button as instructed above.*

PATIENT EPISODE MANAGEMENT

PRINTING PATIENT SPECIFIC REPORTS

Patient Intake and Status Assessments as well as the Staff Discharge reports (Patient Specific Functional Reports or PSFRs) are a part of the patient's medical record and should be handled as PHI (Private Healthcare Information) under HIPAA using your organization's guidelines.

The FOTO reports also provide physiotherapists with useful information regarding the patient's functional status level, functional improvements and history information pertinent to treatment. It is recommended that physiotherapists have access to the Intake Assessment information for use during the initial evaluation either in print or by viewing on-screen from the FOTO program as well as the subsequent Status Assessments captured during clinical treatment or at the time of discharge.

These reports can also be accessed and **printed manually** as soon as the Electronic Patient Intake or Status are completed by the patient or as soon as the Paper Patient Intake and Status Survey have been entered into FOTO Outcomes Measurement System, and following completion of the Staff Discharge screen.

The Outcomes Manager subscription includes the option to activate and use the FOTO Print Client (Auto Print) or the Auto Save feature which will print or save these reports automatically as soon as they are completed in the system. Contact FOTO Support for more information and/or to set-up these automated features in your office.

The PSFRs can be accessed for printing from the:

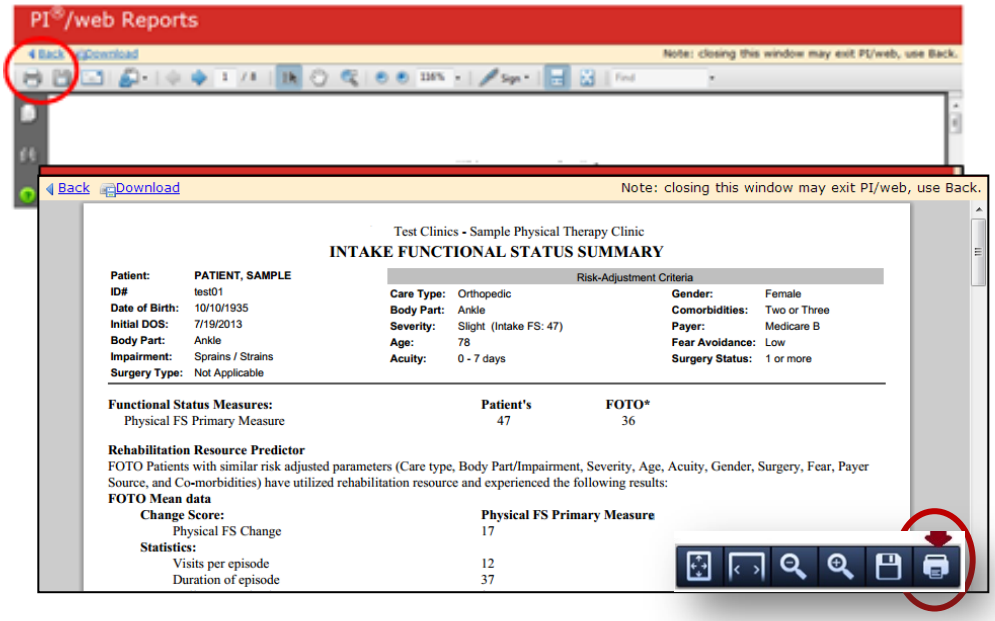
- Episode Detail Screen
- Open Episode Table List
- Clinician Activity Table List or
- Closed Episode List

Printing from Episode Details

- Select the patient and the episode to enter the Episode Detail Screen.
  - At the top of the Episode Details screen is a box labeled "Activity."
  - The reports associated with the surveys that have been completed for this patient's episode will be listed.
- Click on the Name of the Report you want to print /or/ click on the Open icon
  - The report you selected will open on screen.

All Assessments will be listed in this window that you have captured, including all Status Assessments.

- Depending on the type of browser used, to print either:
  - Click on the print icon from the tool bar at the top, or
  - Move the mouse toward the bottom of the screen and a tool bar will appear.



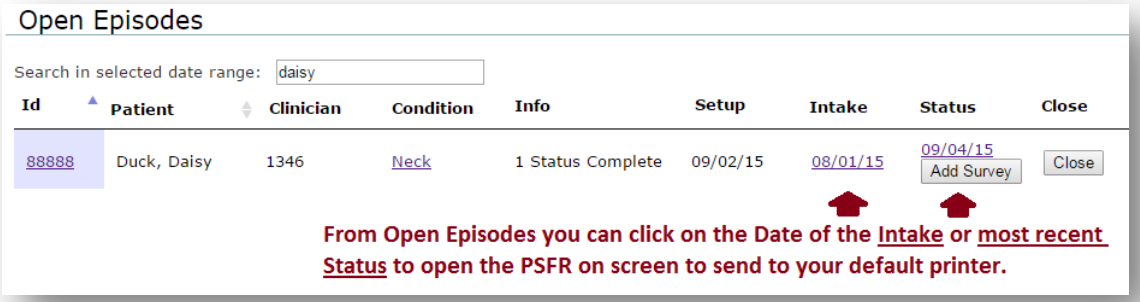
- The report will print to the printer set up as your default printer.
  - If these toolbars do not show, check your browser settings

- When finished, please click on ← Back in the upper left corner of the report toolbar.

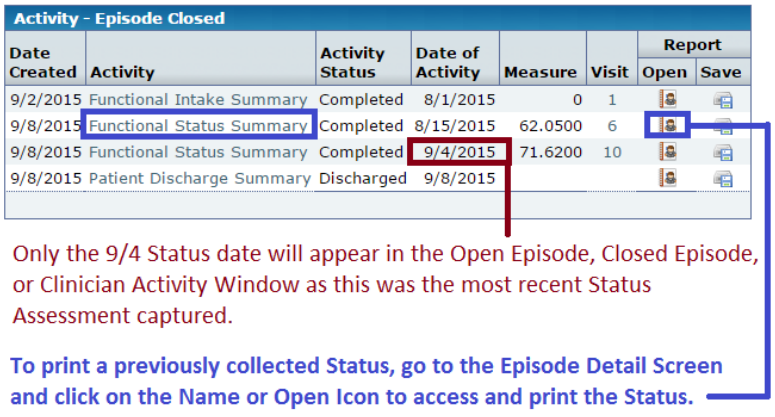
Printing from Open Episode List

- Click on the Date of the Intake or Date of the most recent Status Report from Open Episodes to open the PSFR on screen.

- Then follow instructions for Printing from Episode Details- depending on your browser- to send the PSFR to your default printer.



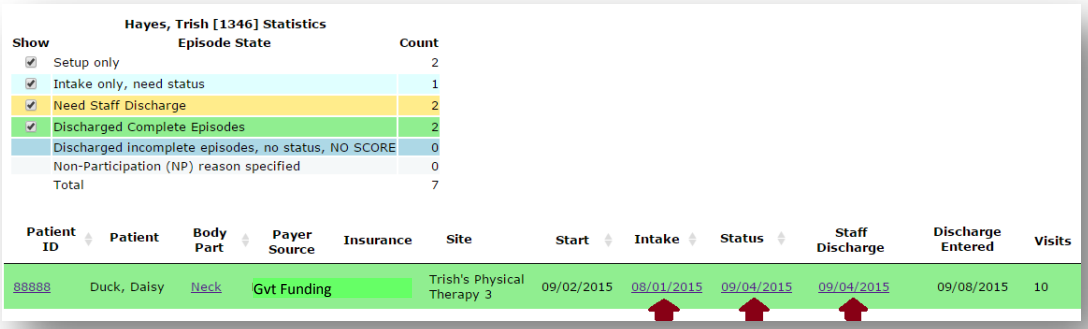
Please note that you may only access and print the MOST RECENT Status Assessment captured for the episode from the Open Episode List. If you captured multiple status assessments and need to print one prior to the most recent status collected, access the Status survey from the Episode Detail Screen.



Printing from Clinician Activity List

- From the Clinician Activity List you can open and print the Intake, most recent Status, and the Staff Discharge PSFR by clicking on the date of the report.

- Following the instructions for Printing from the Episode Detail section – depending on your browser – send the report to your default printer and return by clicking the Back button.

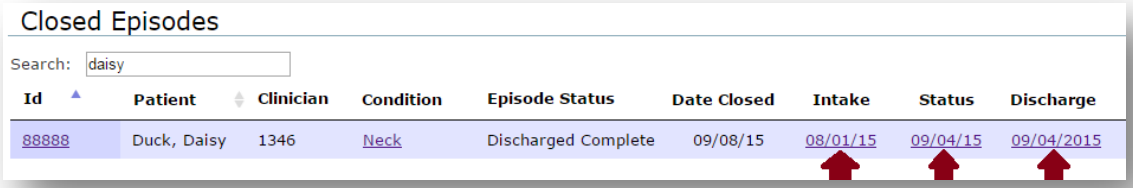


Please note that you may only access and print the MOST RECENT Status Assessment captured for the episode from the Open Episode List. If you captured multiple status assessments and need to print one prior to the most recent status collected, access the Status survey from the Episode Detail Screen

Printing from Closed Episode List

- From the Clinician Activity List you can open and print the Intake, most recent Status, and the Staff Discharge PSFR by clicking on the date of the report.

- Following the instructions for Printing from the Episode Detail section – depending on your browser – send the report to your default printer and return by clicking the Back button.



Please note that you may only access and print the MOST RECENT Status Assessment captured for the episode from the Open Episode List. If you captured multiple status assessments and need to print one prior to the most recent status collected, access the Status survey from the Episode Detail Screen

Printing from a Tablet

Reports can usually be viewed on a tablet by clicking the **Save** icon. Unless you have Auto Print installed on your desktop computer, contact the tablet manufacturer for information on printing a PDF from the tablet.

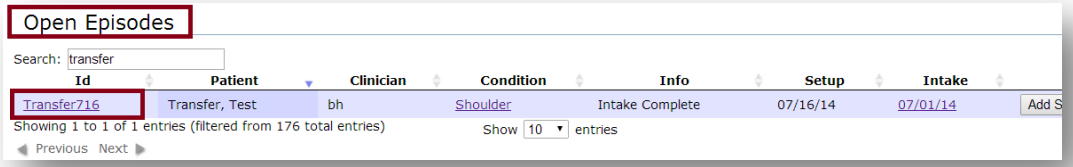
EPISODE MANAGEMENT

TRANSFERRING EPISODES

If you have multiple clinics in your organization, patient care may be initiated at one office location but the patient may need to continue care at another one of the your offices due to location access, treatment hours, etc. If so, you can "transfer" the patient's account or just a single episode within an account to one of your organization's other facilities using the following process.

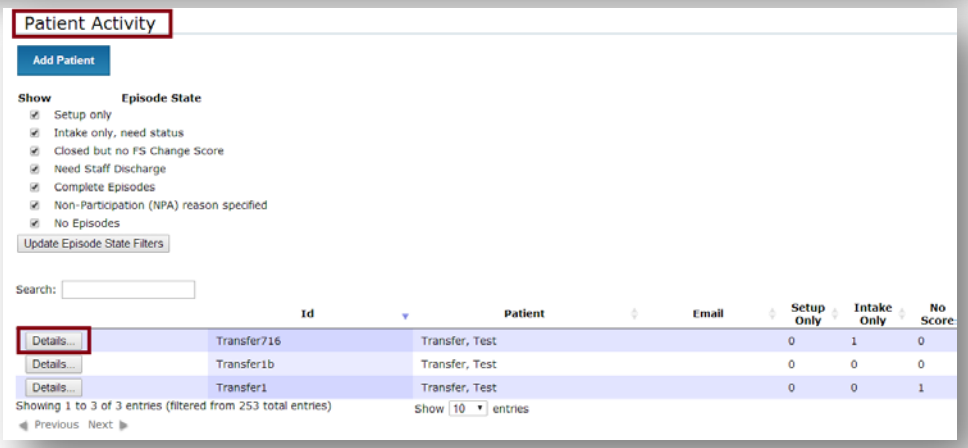
If the patient has only one episode in the account or there are multiple episodes and the ENTIRE ACCOUNT should be transferred, locate the patient by using the Open Episodes /or/ Patient Activity navigation links. Once located:

- Click on the ID# from the Open Episode screen,



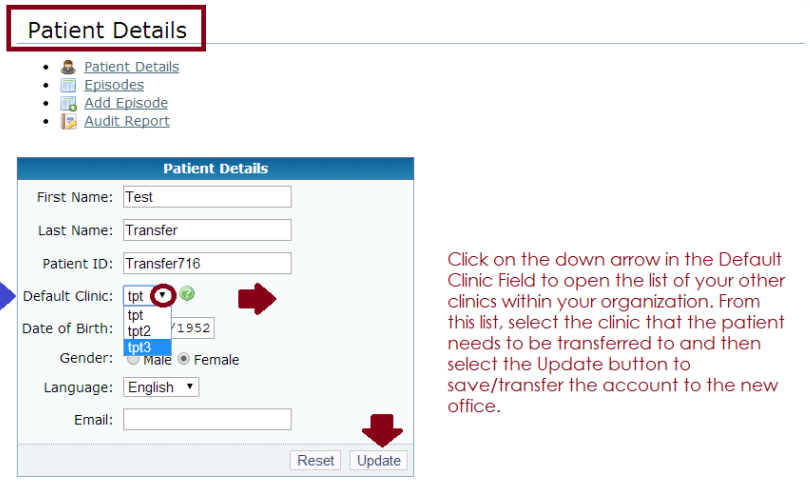
OR

- Click on the Detail button from the Patient Activity screen.



This will open the Patient Detail screen.

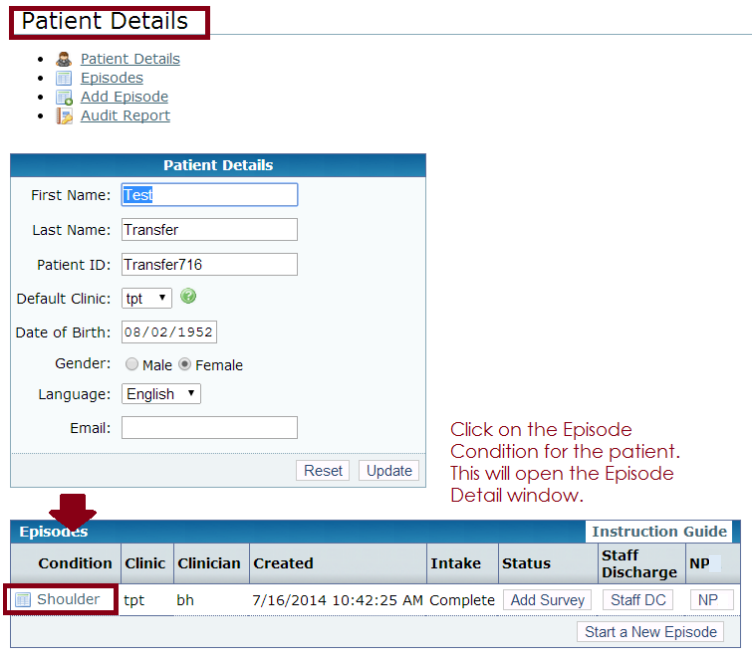
- In the Default Clinic field, click on the down arrow to select the clinic the patient is transferring to.
- Then Select UPDATE to save and transfer the account to the new location database.



The patient account is now transferred to the new location. It is necessary, however, **for the new clinic to verify / correct the clinician now managing the patient account.**

The transferring office should access the patient's episode from the Open Episode or Patient Activity Screen (as previously outlined) to open the Patient Detail Screen.

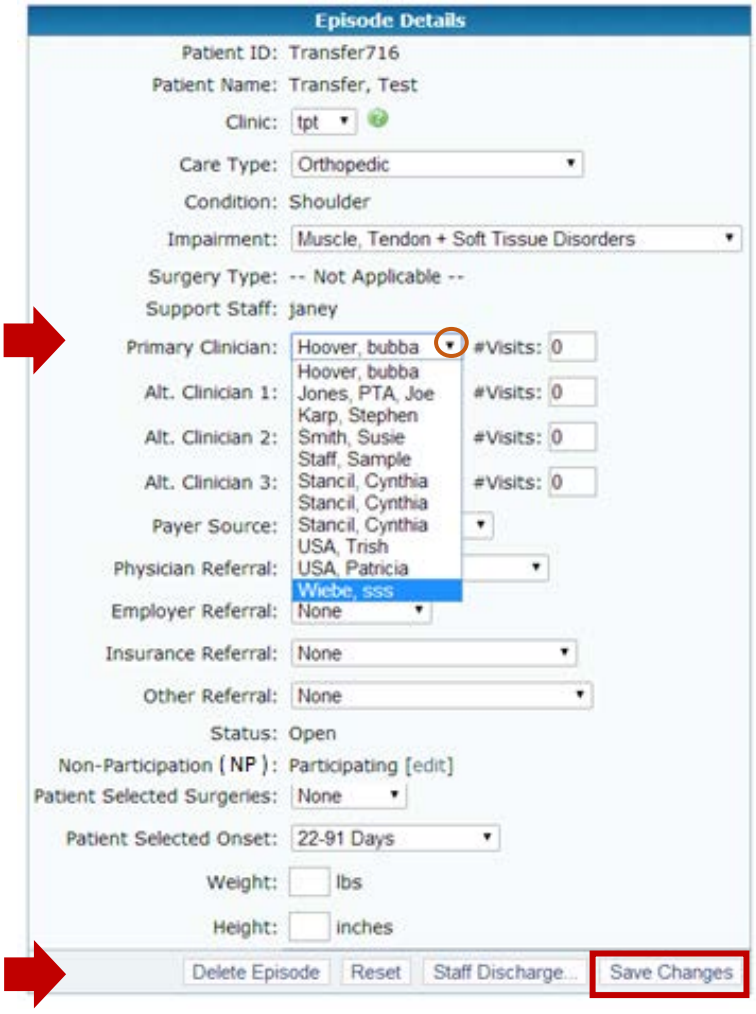
- Click on the episode condition to open the Episode Detail Window.



- In the Primary Clinician field, click on the down arrow to open the list of clinicians and select the clinician that is accepting management for the patient at the new location (if different).

NOTE: It is very important that the correct clinician be tied to the episode to assure the data collected is assigned to the correct clinician on the Quarterly Profile Reports, report portal screens, etc.

- Then click on the SAVE CHANGES button to save this clinician as the primary managing therapist.

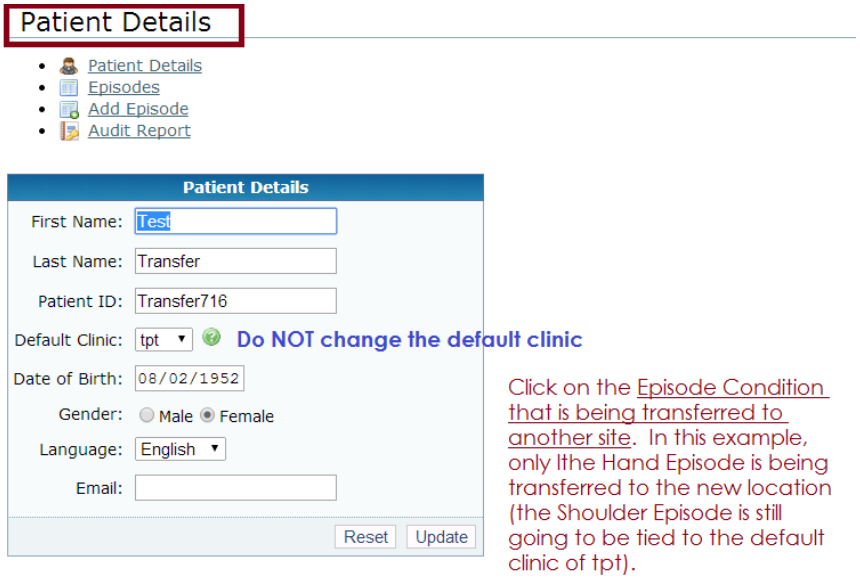


If the patient has more than one episode in the account and ONLY ONE of the episodes is to be transferred to another site within the organization, locate the patient by using the Open Episodes /or/ Patient Activity navigation links. Once located:

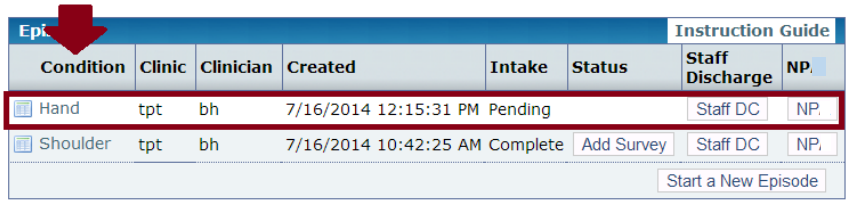
- Locate the patient's account from the Open Episode or Patient Activity navigation lists as previously outlined.

- In Patient Details, go to the Episode window and select the episode condition that is being transferred to one of your other locations.

NOTE: Do NOT change the default clinic in this screen, unless you want to transfer all episodes in the account to the new location.



- Click on the Condition episode to be transferred.

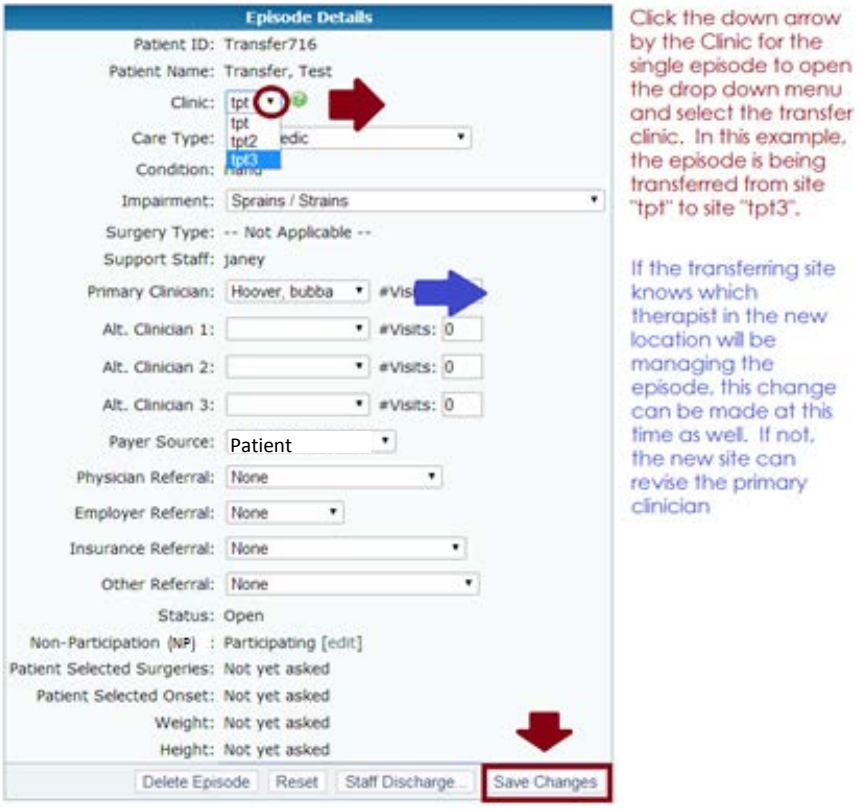


This opens the Episode Detail Window.

- Go to Clinic and select the new site.

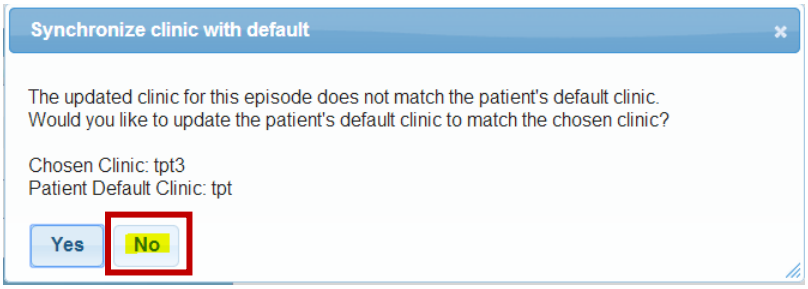
- If the transferring site knows which therapist will be responsible for managing the episode at the new site, this can be changed in this window as well. If not, the new site can revise this post transfer.

NOTE: It is very important that the correct clinician be tied to the episode to assure the FS survey data collected is assigned to the correct clinician on the Quarterly Profile Reports, report portal screens, etc.



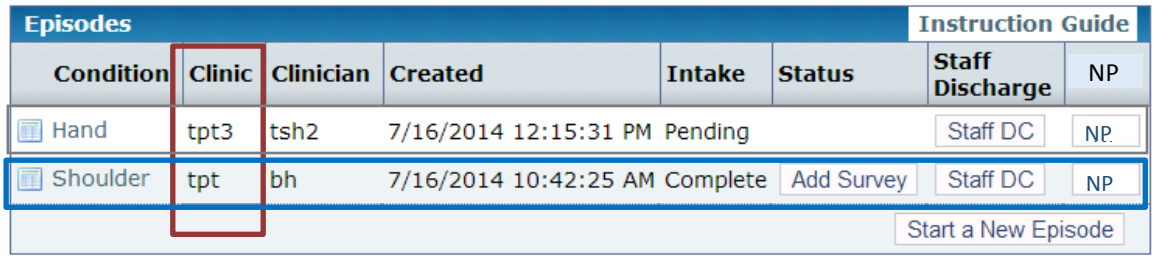
Be sure to click on **SAVE CHANGES** to initiate the transfer.

- A screen will appear asking if you want to change the default clinic to match the updated clinic selected. Select **NO**.



The transfer is complete.

When this patient's account is selected by either the default clinic or the clinic to which the episode has been transferred, the site (clinic) assignment surfaces in the Episode window.



SPECIAL NOTES ABOUT TRANSFERRING EPISODES:

- If your organization has multiple sites but you have elected separate organization logins for each of your offices, transfer of episodes cannot be done at the clinic level. Please contact your FOTO Provider Representative who can assist you with transferring patient episodes from one Organization to another.

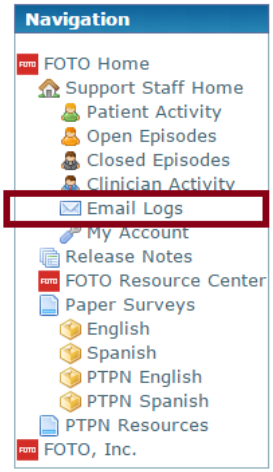
- If you attempt to transfer an episode but the location the patient is transferring to does not show in the clinic drop down list, then an episode already exists in the transfer site with the same ID number.

  - If this is because the SAME patient has been set up at both sites with the same ID, please notify FOTO to "merge" the episodes into one account.

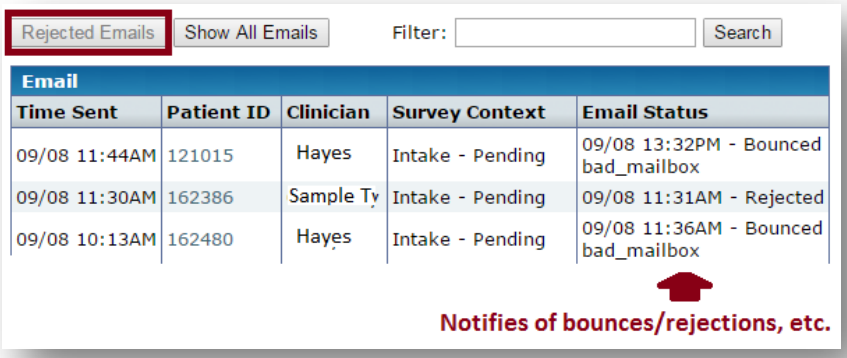
  - If the duplicate ID at the transfer site is a DIFFERENT patient, it will be necessary to alter the ID slightly (for example, putting an 'A' at the end of the ID#). Save the change and then you can transfer.

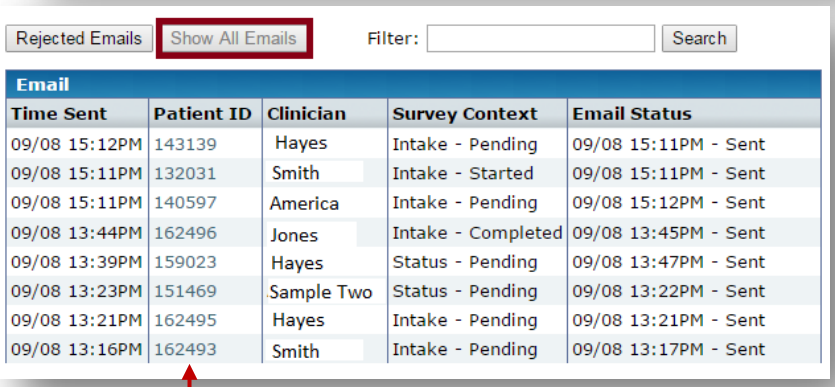
EMAIL LOGS

You can monitor the email processes using the Email Log.



- Click **Email Logs** from the Navigation menu to view all emails or just the rejected emails sent from your organization's FOTO account.

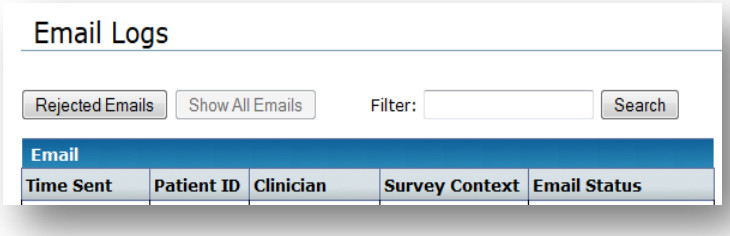




- The tables include the date/time the email was sent, the ID # of the patient, the clinician tied to the episode, the Survey sent and the status of the emailed survey (pending, started, completed, rejected, bounced, etc.).

- To follow up on an emailed assessment, correct email address, etc., click on the Patient ID and the system will take you directly to the Patient Detail screen.

- Enter the Patient ID in the filter to search for all emails sent to a specific patient.

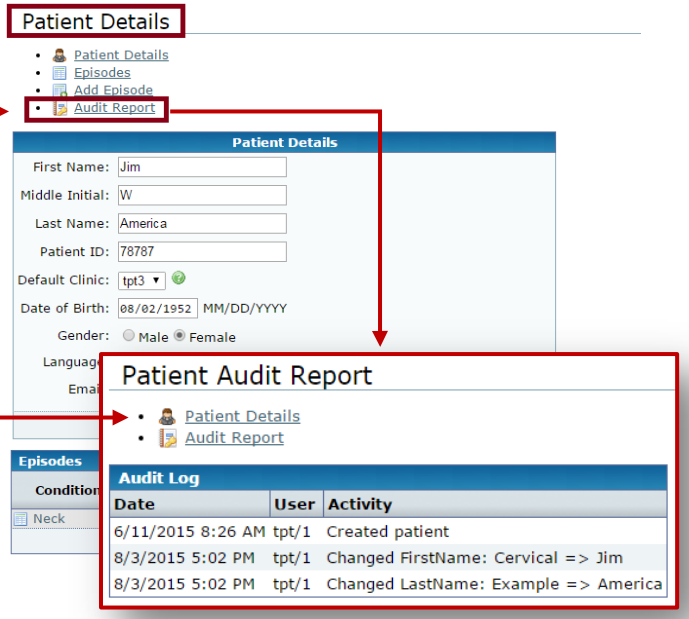


AUDIT LOGS

Audit logs are available to track changes or activities performed in patient Account and Episode information. Audit information is available to outline changes/activities in:

- Patient Details
- Episode Details

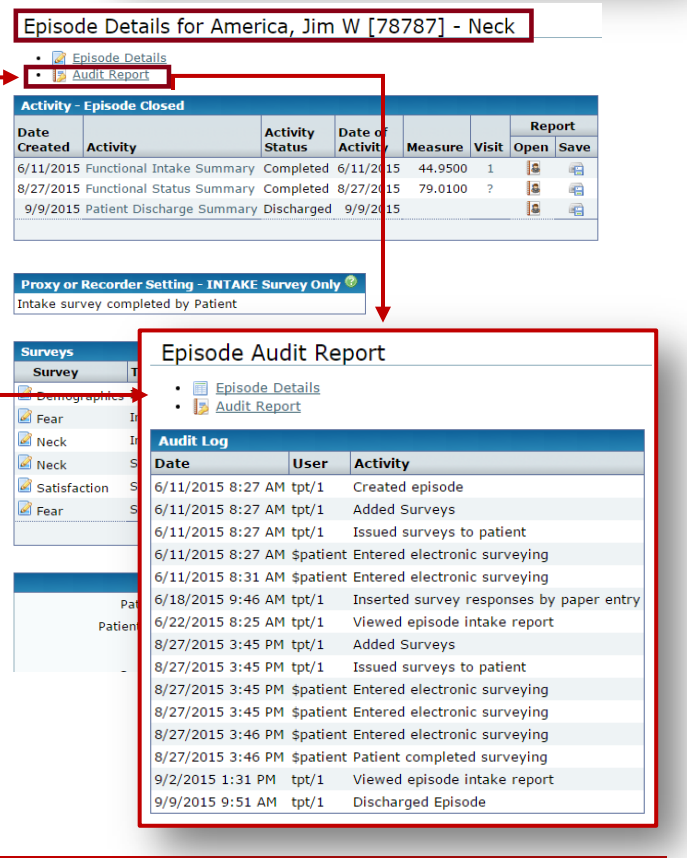
From the **Patient Detail** screen, click on Audit Report.



- The Audit log will open showing the:
  - Date of activity
  - User Login of the staff member performing the activity
  - Activity performed

- You can return to the Patient Detail screen when you are finished reviewing with Audit Log, by clicking the link for Patient Details.

From the **Episode Detail** screen, click on Audit Report.



- The Audit log will open showing the:
  - Date of activity
  - User login of the staff member performing the activity
    - $patient = patient completed activity
  - Activity performed

- You can return to the Episode Detail screen when finished reviewing the Audit Log, by clicking the link for Episode Details.

EPISODE MANAGEMENT

COMPLETION RATE GAUGE

Your **COMPLETION RATE** significantly impacts the outcome data captured in your Quarterly Profile Report and Scorecard. The completion rate gauge, which appears in your Open Episode Screen, will make it easy to keep up-to-date on how you are managing your patient episodes through discharge.

What is the completion rate?
It is the percentage of complete discharged episodes to intakes.

What is a complete discharged episode? Patient episodes that contain:

- **Intake Assessment**: *Initial assessment completed by the patient on the first visit (or prior to the first visit by email)*
- **Status Assessment**: *Subsequent assessments completed by the patient during treatment. The final Status captured from the patient produces the points of functional status (FS) improvement achieved by the patient as a direct result of the care received.*
- **Staff Discharge**: *Completed by your staff to close the FOTO episode of care.*

GOAL:

- Keep your completion rate in the **GREEN!** The higher the better!
- Access the details of your completion rate by clicking the Detail button under the gauge.

Note: It is not anticipated that patients with an Intake will be discharged in the same rolling 30 day period. The intent of the gauge is to show the # of episodes completed in the last rolling 30 days compared to the intakes to give you "real time" information for your organization compared to the national 30 day percentage. Remember, the final completion rate reflected on the Quarterly Profile Report is always based on episodes during the rolling 12 month period.

STEPS TO IMPROVE YOUR COMPLETION RATE:

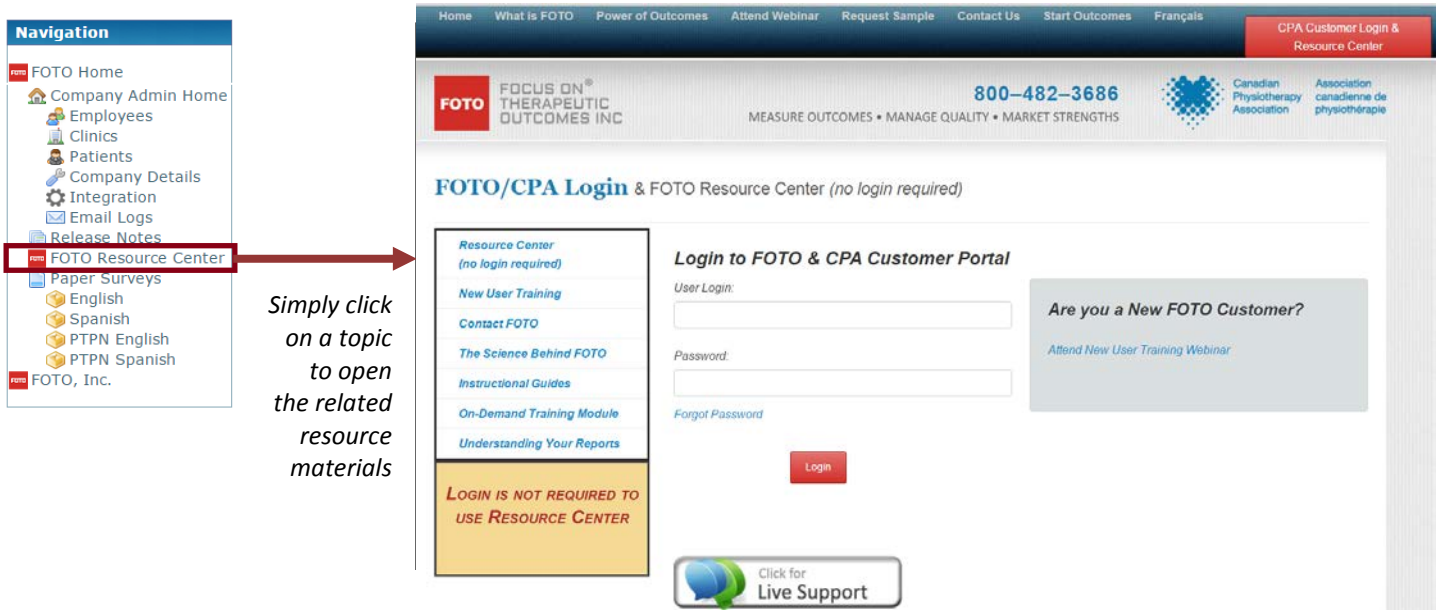
- Check your Completion Rate Gauge frequently.
- Establish & monitor a process to capture Status Assessments regularly throughout the episode of care. Establish a practice process that works well for your clinic so that it becomes a part of your daily workflow routine.
- Establish a process to capture a final status from the patient **on the last date of service** or as close to the last date of service as possible.
- If not on the last date of service, final Status Assessments captured less than 7 calendar days prior to the last date of service are recommended. If a patient self-discharges or you missed the final status before the patient left your office, you may choose to email the status to the patient to get an outcome for the episode that reflects the full improvement achieved by the patient under your care.
- Complete the Staff Discharge as soon as possible once the patient has been discharged from clinical care.
- Review Open Episode List / Clinician Activity List regularly to assure Status Assessments & Staff Discharges are captured according to your set process.
- **Encourage Clinician and Support Staff coordination in establishing and performance of your outcome processes and ownership of the completion rate. Consider setting your own practice Completion Rate Goal.**

Ideas for Status Assessment Frequency

- A standard # of visits throughout the episode (eg. every 5th visit) ***and*** on last date of service /or/ get at least 1 status on an interim basis, in addition to the final/discharge status.
- Perhaps every Thursday & Friday are set as Status Assessments days (Thursday's for those patients who are seen 2x/week and Fridays for patients who are seen 3x/week)
- When the patient is returning to the MD
- Any visit when the clinician identifies significant change in physical activity status or achievement toward treatment goals
- At time of re-evaluation or when Plan of Care is revised
- Any time when the clinician suspects the patient may not return for continued care

FOTO Online Resources/Training

For assistance with any of your Outcomes Manager processes, <u>once logged into the system</u>, click on FOTO Resource Center in the Navigation menu. You will automatically be taken to FOTO's website.



- **<u>New User Training</u>** – Sign up for an open live webinar training session with a FOTO representative covering how to use the system from setup to discharge and everything in between.
- **<u>New Features Training</u>** - Sign up for a webinar training session covering new features
- **<u>Contact FOTO</u>** – FOTO contacts, phone numbers and e-mail addresses
- **<u>Marketing Tools</u>** – Contains template letters and press releases that can be used to announce your participation with FOTO and for those who receive the Outcomes Excellence Certificate.
- **<u>Medicare Compliance</u>** – Contains a video on use of the FOTO information for Functional Limitation Reporting
- **<u>The Science Behind FOTO</u>** – Contains articles & published papers (including functional staging information)
- **<u>Instructional Guides</u>** – Contains Administrator and Support Staff Training PDFs and other resource documents
- **<u>On-Demand Training Module</u>** – Contains videos on how to perform various functions within the application
- **<u>Understanding Your Reports</u>** – Administrator Guides to understanding Report Portal reports & management tools

LIVE SUPPORT CHAT FEATURE

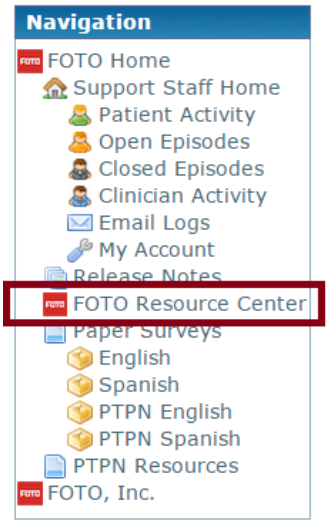
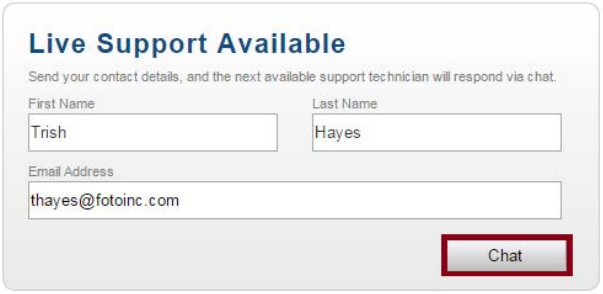


FOTO has implemented a Live Chat Feature with our Technical Support Team. This is a great feature to access to gain immediate access to our Support Service Team.

To gain access to the Live Support Chat feature, simply click on the FOTO Resource Center from your Navigation Bar. In the upper right corner of the screen, you will see the Live Support Button. Click to open the Chat screen.

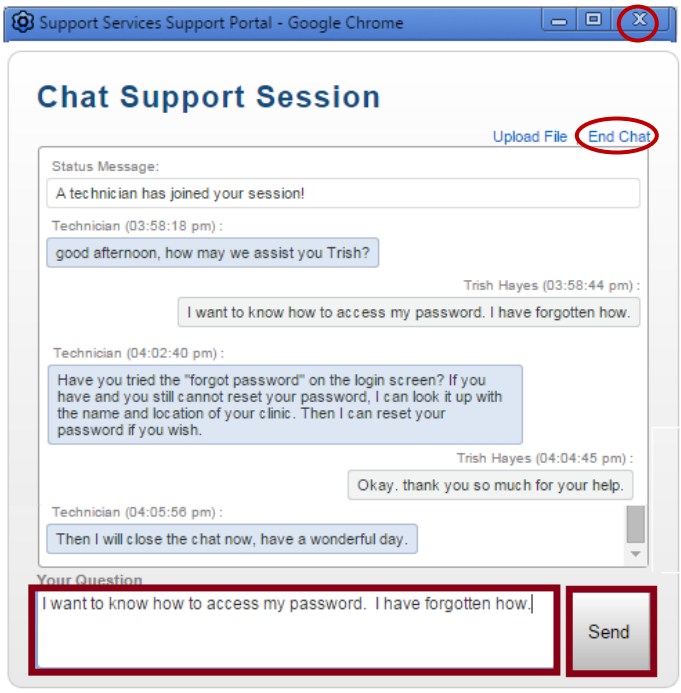
Type in your name and email address and click the Chat button.



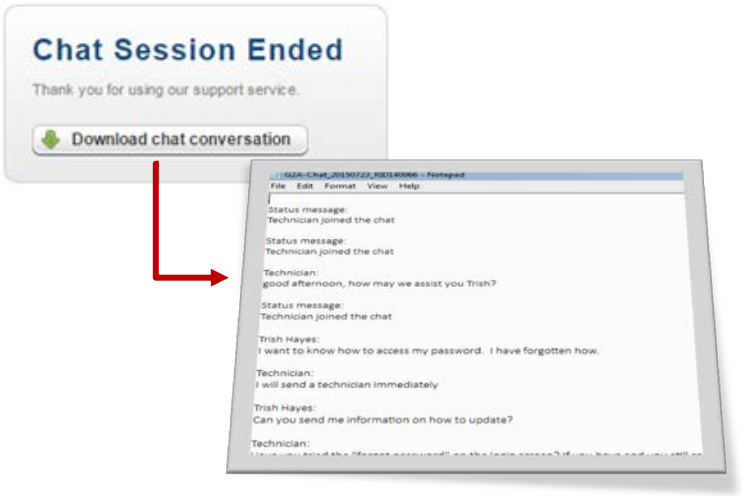
Simply type in your questions and click the send button.

Continue your conversation with Support Services and when done you close the session by:

- Clicking the End Chat button or
- Clicking the X button.



If you select End Chat you will have the option to download the chat conversation for future reference if you like.



You can also contact your FOTO Provider Representative at any time. Please refer the FOTO Contact List for full details.

FOTO Contact Information

Please contact FOTO Provider staff at any time for assistance, as follows:

	800 • 482 • 3686	Email
Judy Holder **Director of Account Development**	Extension 238	judyholder@fotoinc.com
Provider Relations Staff		
Trish Hayes **Director of Provider Relations**	Extension 223	thayes@fotoinc.com
Cynthia Stancil U.S. Provider Representative	Extension 235	cynthiastancil@fotoinc.com
Kimberly Jones U.S. Provider Representative	Extension 232	kimberlyjones@fotoinc.com
Mimi Einstein U.S. Provider Representative	Extension 227	mimieinstein@fotoinc.com
Laura Mensch Canadian Provider Representative	Extension 240	lauramensch@fotoinc.com
Technical/Support Services Staff		
Deborah Debord **Director of Support Services**	Extension 234	ddebord@fotoinc.com
John Sutter Support Services Specialist	Extension 221	johnsutter@fotoinc.com
Chrissy Moore Support Services Specialist	Extension 219	chrissy@fotoinc.com
David Hafner Support Services Specialist	Extension 241	davidhafner@fotoinc.com