

Progress Notes AASL Procedure for Occupational Therapists

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1. Tracking Progress Note Due Dates

- It is the responsibility of the treating therapist(s) to:
 - o track due dates for re-evaluations/progress notes
 - keep their dashboard up-to-date (i.e., remove discharged or covered clients)
 - ensure due dates are accurate (i.e., conversion note clients require manual updates)
- To track upcoming Progress Notes and Re-evaluations, use the chart below:

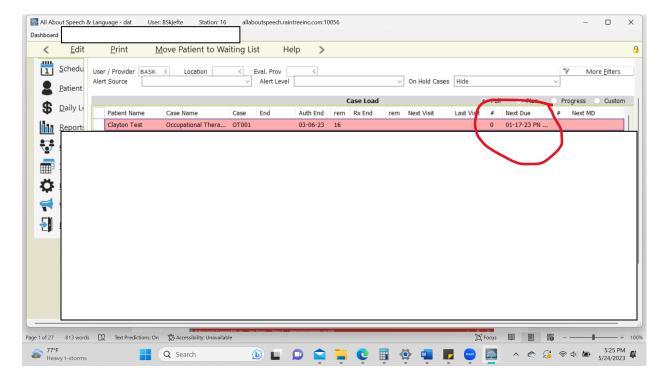
Raintree is a tool that should be utilized to efficiently track these due dates and this document contains the procedure for utilizing the Caseload Tab in a therapist's Dashboard to do so. Login to Raintree and go to your respective Dashboard, locating your Caseload Tab. See chart below for tracking to ensure no progress notes are missed. Change appointment type in Raintree to PNOT3 or PNOT6 accordingly for the appointment with the date closest to when the Progress Note is due (not after due date).

Date to start scheduling	Upcoming Re-eval/Progress Note Dates
End of January	March and April
End of February	April and May
End of March	May and June
End of April	June and July
End of May	July and August
End of June	August and September
End of July	September and October
End of August	October and November
End of September	November and December
End of October	December and January



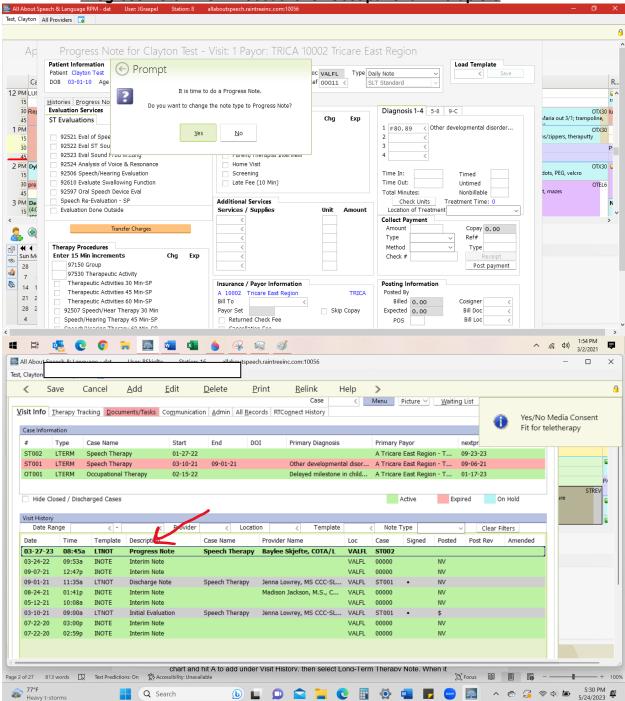
End of November	January and February
End of December	February and March

2. Caseload Tab



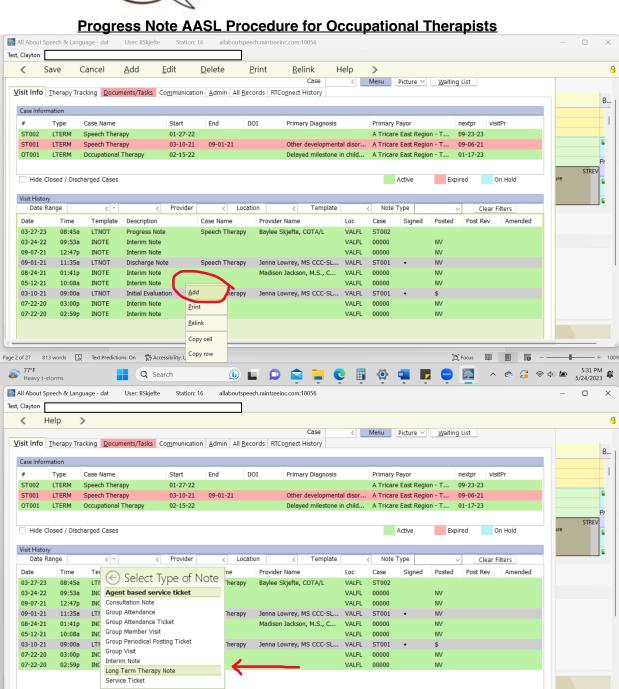
- Use dashboard to determine what progress notes are upcoming
- EMR system will also auto-prompt you when you log into daily notes when progress notes
 are due and will auto-change the note type for you if you complete during a treatment
 session OR you can go in and change the note type under TYPE to Progress note with OT
 Standard.





 If completing a Progress Note outside a treatment session, you can also go into the patient chart and hit A to add under Visit History, then select Long-Term Therapy Note. When it populates the note going forward on the upper right hand side you will then need to change the Note Type to Progress Note and then under that make sure you add from the dropdown





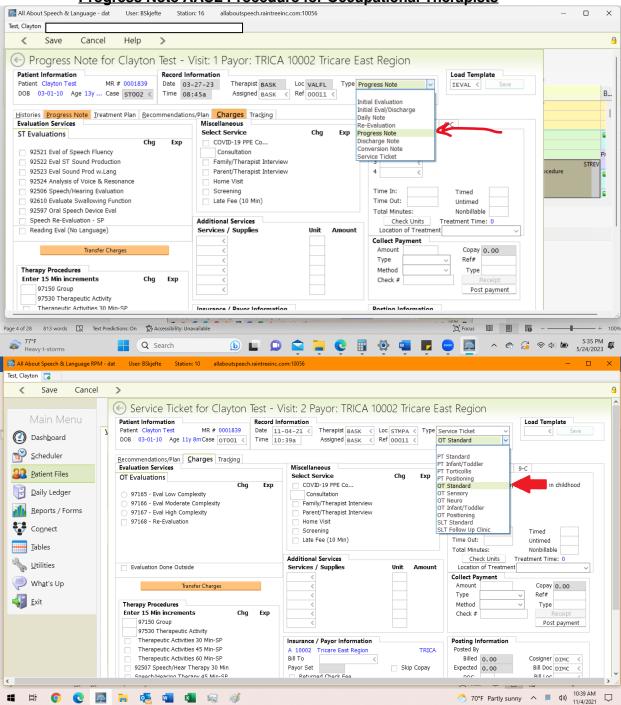
[D] Focus III | III -----

Page 3 of 27 813 words 💢 Text Predictions: On 💥 Accessibility: Unavailable

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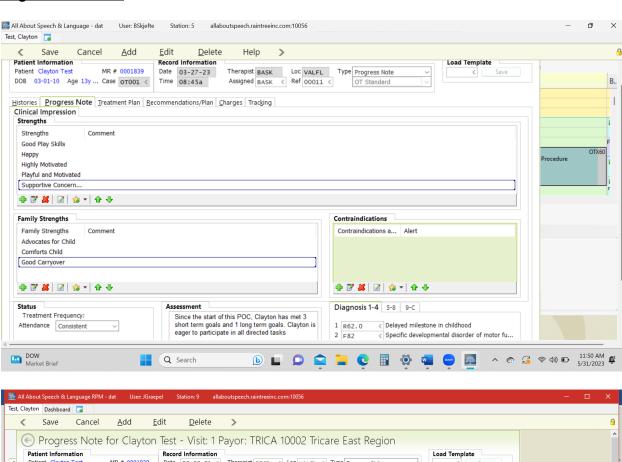


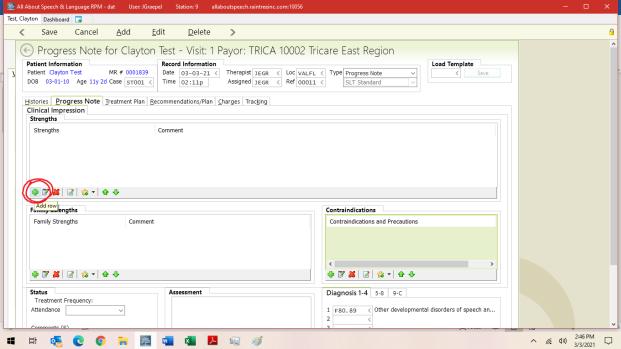


- Then go through the tabs and update across the following:
 - Progress Note
 - Treatment Plan
 - Recommendations/Plan
 - Charges

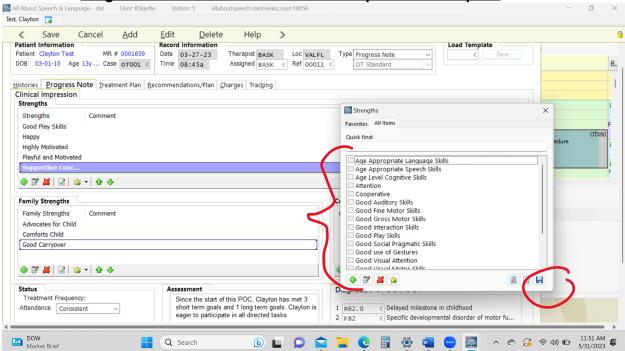


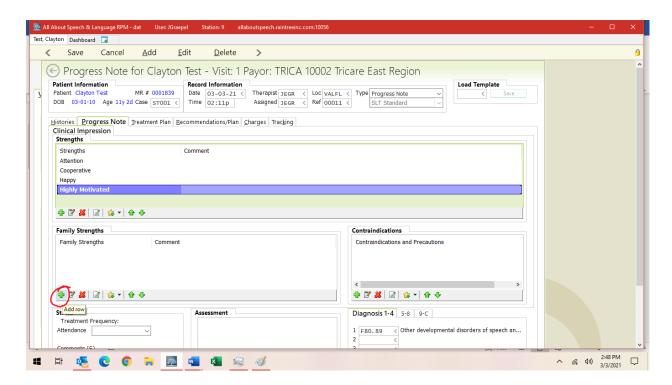
3. Progress Note Tab



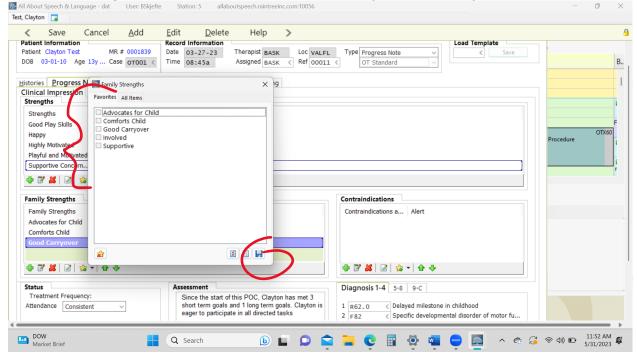




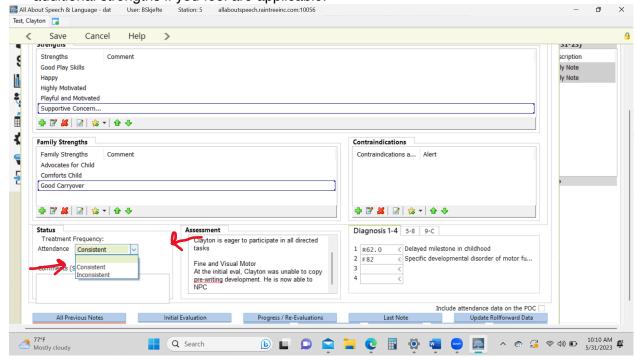








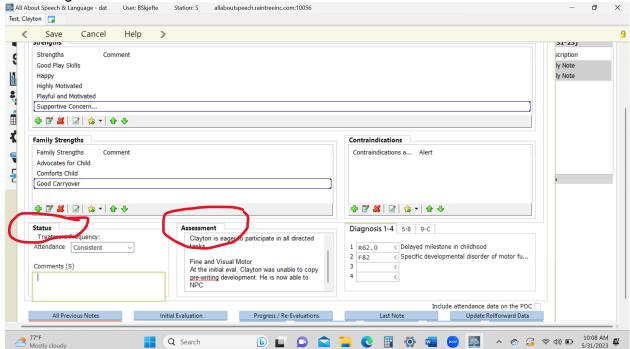
 Strength and family strengths: This will auto-populate from the evaluation. Add any additional strengths if you feel are applicable.



Status:



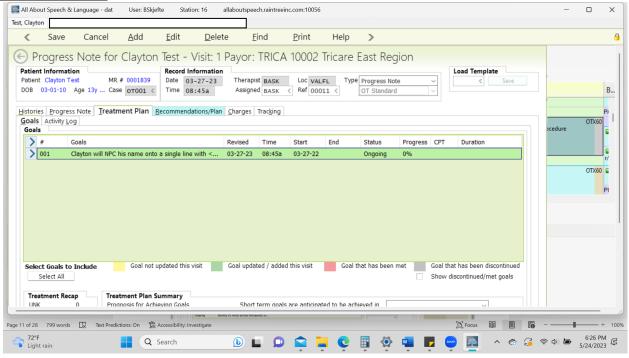
 Treatment Frequency- Select from the drop-down box if the client is consistent or inconsistent. In the Comment, feel free to comment on how the clients attendance is. For example, if "Limited progress towards goals 2/2 high cancellation rate".



Assessment: Right click on the box below "Assessment" and click "Edit". This will
open up the text box. Here you will write a narrative note comparing any progress
made from the evaluation and current level of status on the goal areas. See your CM
to provide you examples.



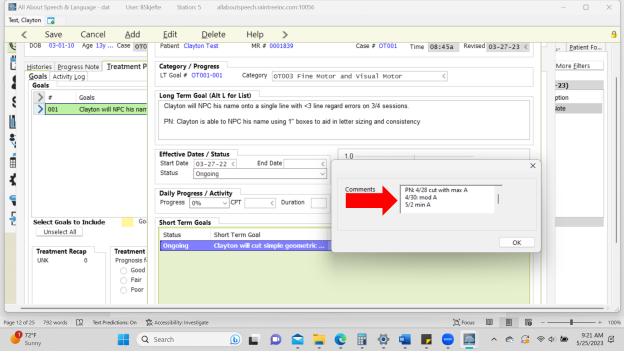
4. Treatment Plan Tab

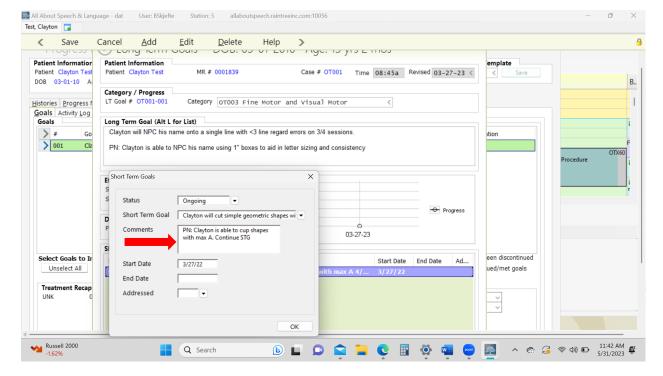


 Click on each LTG and then hit address and for each STG. Add in commentary of progress for each short and long term goal. Note the box has text limits so be to the point when commenting on each STG objective! *You must DOUBLE CLICK to edit any portion of a row for a STG

- Update and/or add any new goals (COTAs, check in with OTR signing off on your notes, if warranted, or change the status of the goal per the drop down in this section (i.e. Ongoing, Hold, Discontinued, Met etc.) COTAs will meet & discuss goals w/ OTR during weekly meetings.
- Starting a month out, you MUST include the following information in your daily note:
- Date & assist level related to that goal (example below)

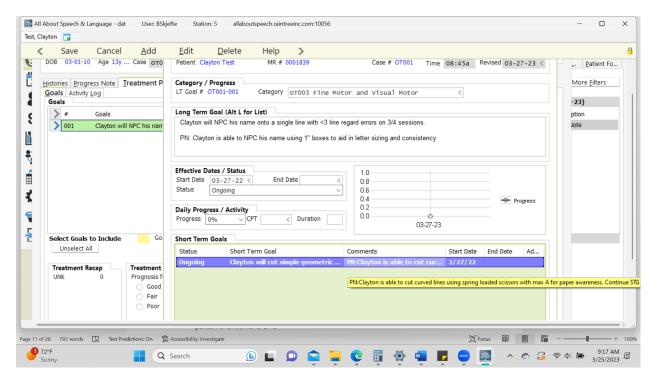




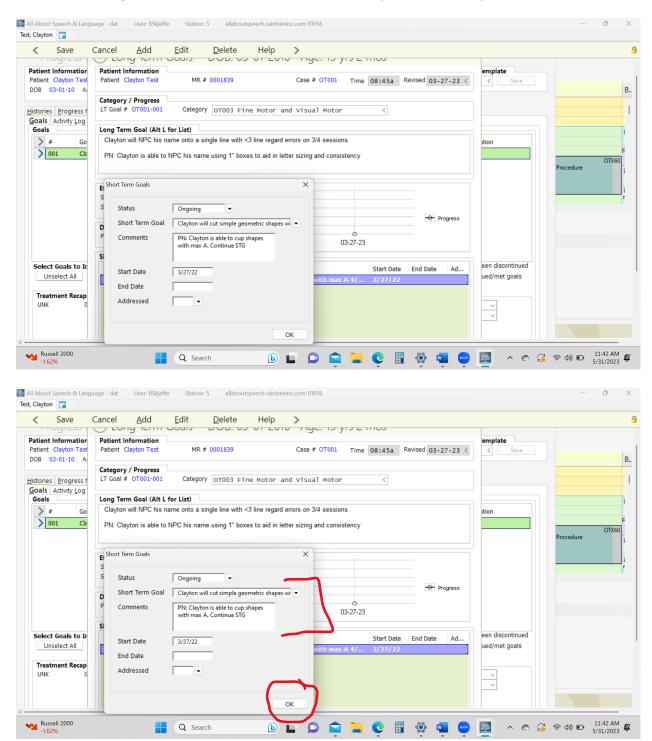


 Upon the date of the progress note, this prior information will be used to report most recent progress. At this time, you will remove these comments (located in the short term goal comment box, they should be populating from the previous month's daily notes) and provide data for an accurate goal measure.

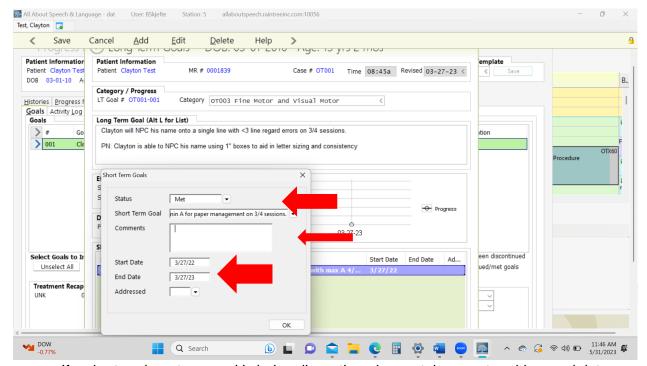




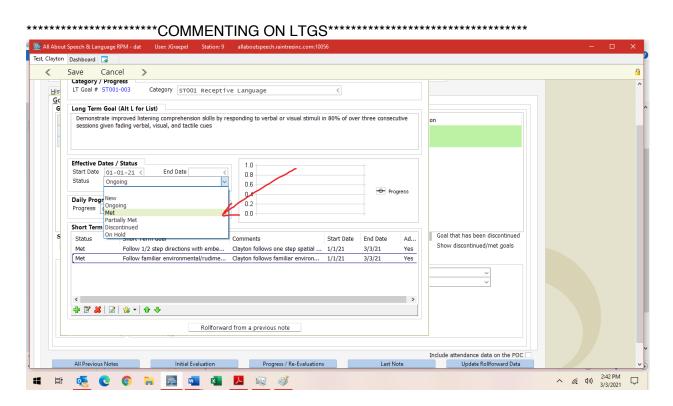




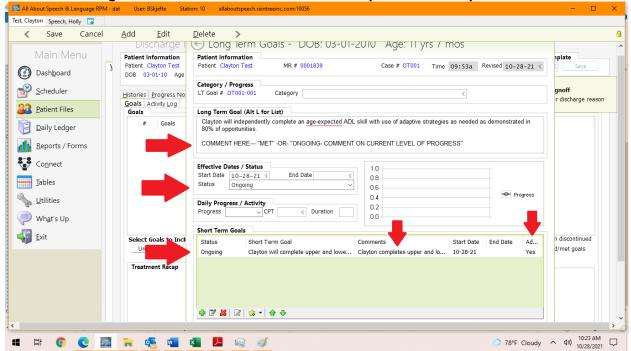




• If a short- or long-term goal is being discontinued or met, be sure to add an end date.

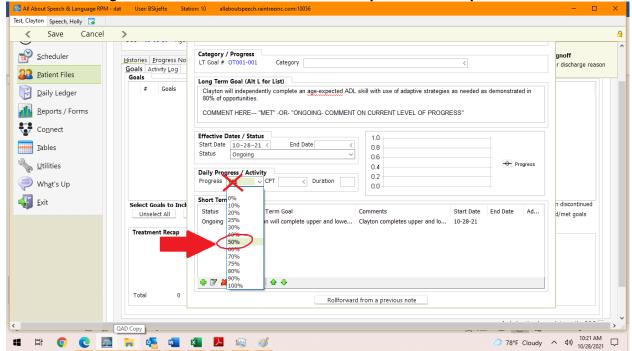


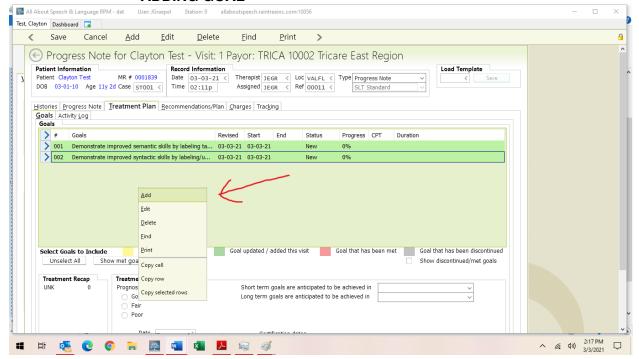




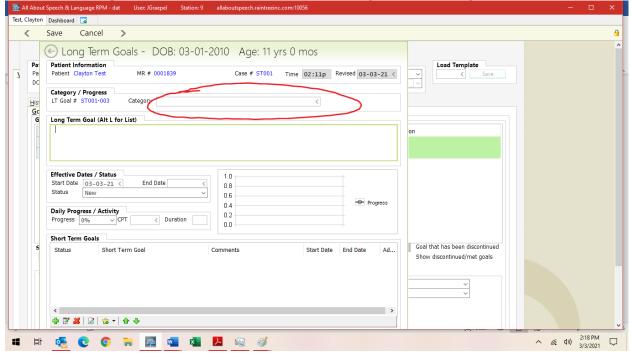
DO NOT select any percentage for the LTG

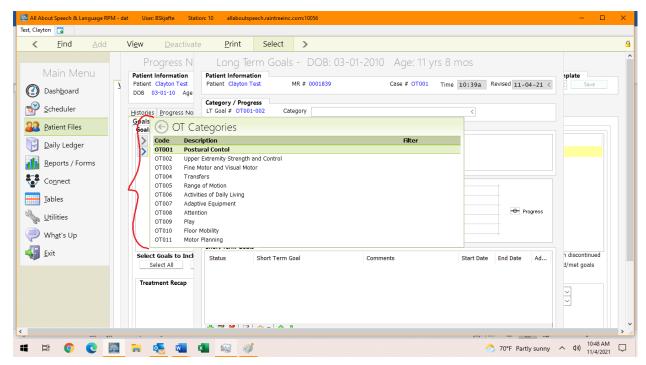




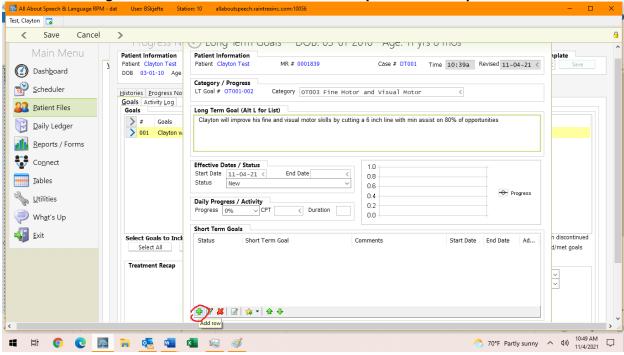


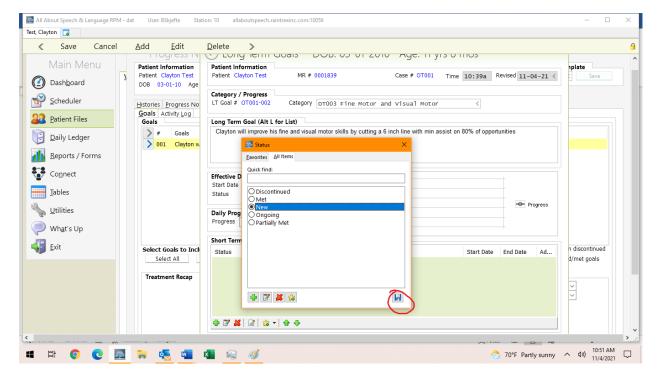




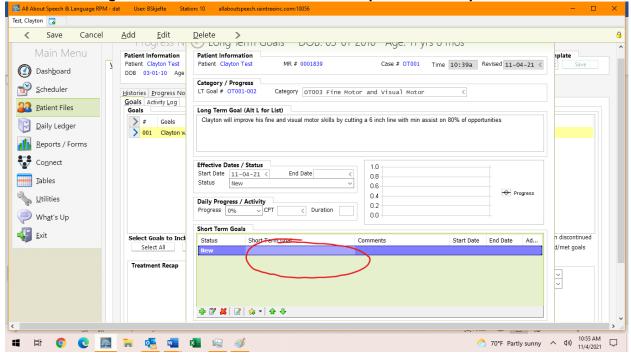




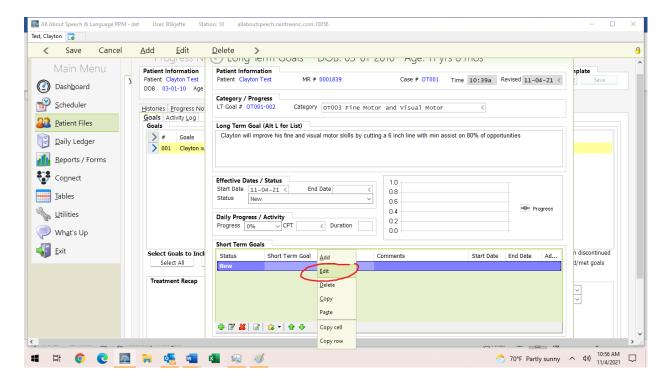






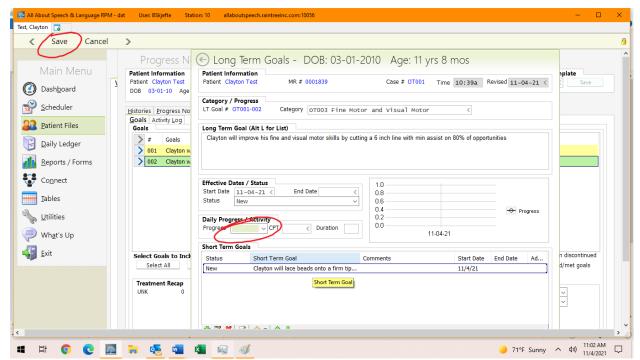


**Right click to edit and type in the goal





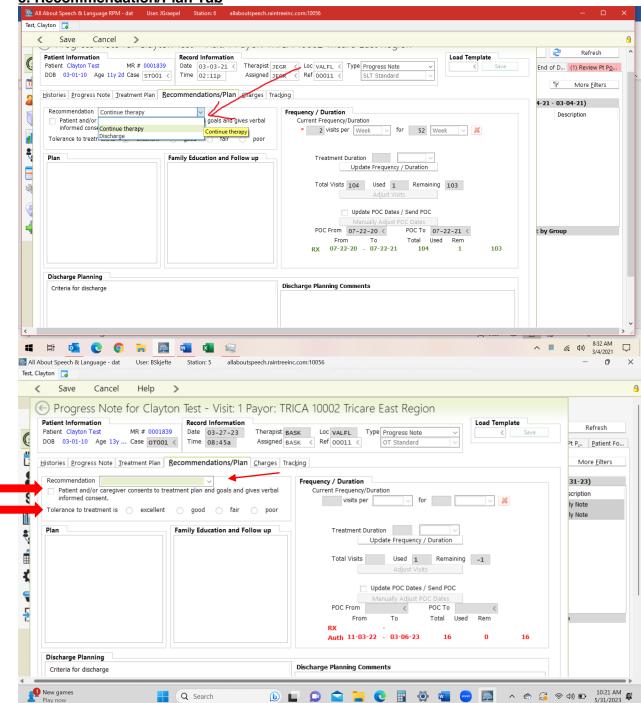
Progress Note AASL Procedure for Occupational Therapists All About Speech & Language RPM - dat Test, Clayton 🌄 Save Cancel <u>A</u>dd <u>E</u>dit <u>D</u>elete Storig letti doais DOB. 03 01 2010 Age. 11 yrs 0 mos Patient Information Patient Information Patient Clayton Test Patient Clayton Test MR # 0001839 Case # OT001 Time 10:39a Revised 11-04-21 < Dashboard DOB 03-01-10 Age Category / Progress Scheduler Histories Progress No LT Goal # OT001-002 Category OT003 Fine Motor and Visual Motor Goals Activity Log 2 Patient Files Clayton will improve his fine and visual motor skills by cutting a 6 inch line with min assist on 80% of opportunities > # Goals <u>Daily Ledger</u> > 001 Clayton w Reports / Forms Connect Effective Dates / Status Start Date 11-04 <u>T</u>ables Status Progress <u>U</u>tilities Daily Progress / A Progress 0% Short Term Goal Clayton will lace beads onto a firm tip string What's Up Short Term Goals <u>E</u>xit discontinued Select Goals to Incl Status End Date Select All Start Date 11/4/21 Treatment Recap End Date Addressed # 2 2 2 OK → 71°F Sunny へ Ф)) 10:58 AM 💶 🛱 🧿 🥲 💹 🥫 👊 🗖 \Box



You can get with your CM to get current clients as examples,



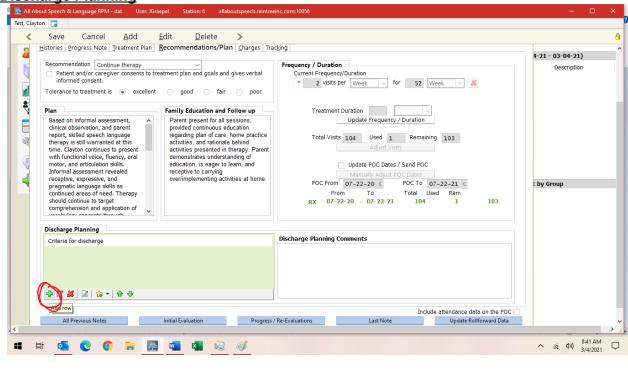
5. Recommendation/Plan Tab

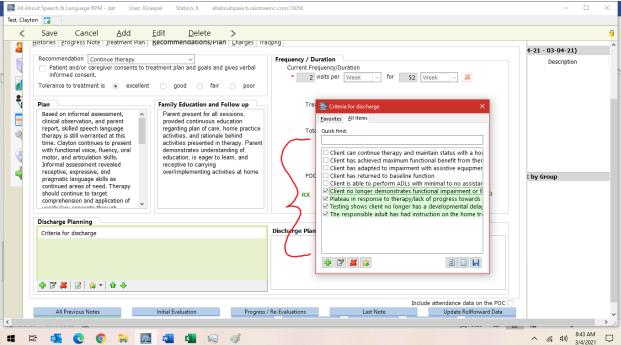


- Recommendation: Select continue therapy or discharge
- Select the parent consent box
- Select tolerance for treatment



6. Discharge Planning







Progress Note AASL Procedure for Occupational Therapists All About Speech & Language RPM - dat User: JGraepel Test, Clayton < Save Cancel Add <u>E</u>dit Delete > a Recommendation Continue therapy

Patient and/or caregiver consents to treatment plan and goals and gives verbal informed consent. Frequency / Duration

Current Frequency/Duration Ī Description * 2 visits per Week v for 52 Week v Tolerance to treatment is

excellent

good

fair

poor 8 Treatment Duration Family Education and Follow up Based on Informal assessment, clinical observation, and parent report, skilled speech language therapy is still warranted at this time. Clayton continues to present with functional voice, fluency, oral motor, and articulation skills. Informal assessment revealed receptive, expressive, and pragmatic language skills as continued areas of need. Therapy should continue to target comprehension and application of manufactures. Based on informal assessment, Parent present for all sessions, Parent present for all sessions, provided continuous education regarding plan of care, home practice activities, and rationale behind activities presented in therapy. Parent demonstrates understanding of education, is eager to learn, and receptive to carrying over/implementing activities at home. Criteria for discharge Tota <u>F</u>avorites <u>A</u>ll Items S Quick find: ☐ Client can continue therapy and maintain status with a ho☐ Client has achieved maximum functional benefit from ther☐ Client has adapted to impairment with assistive equipmer t by Group Client has returned to baseline function Client is able to perform ADLs with minimal to no assistar
Client is able to perform ADLs with minimal to no assistar
Client no longer demonstrates functional impairment or to
Plateau in response to therapylack of progress towards
Testing shows client no longer has a developmental delay RX Discharge Planning ✓ The responsible adult has had instruction on the home tr Discharge Plan Criteria for discharge 💠 📝 🚜 😘 🖶 📝 🚜 | 📝 | 🈘 🕶 | 春 🤚 Include attendance data on the POC All Previous Notes Initial Evaluation Progress / Re-Evaluations Last Note Update Rollforward Data Patient Menu Treatment Summary POC signed Plan of Care

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7. Charges

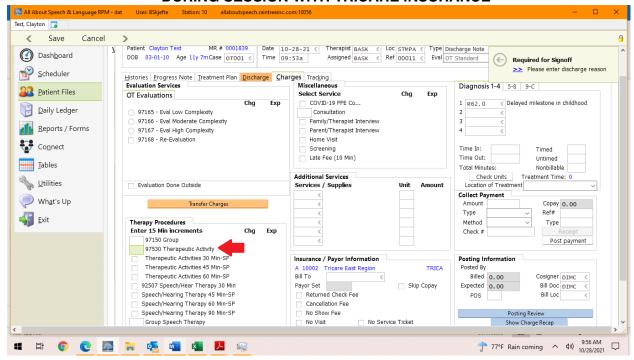
Assign charges only if you made the weekly treatment session the Progress Note; if you did it separately via the client chart, there will be no visit/no service ticket selected so charges are not enabled

All About Speech & Language RPM - dat Test, Clayton Speech, Holly 🌄 Save Cancel Scheduler Required for Signoff <u>Histories Progress Note Treatment Plan Discharge Charges Tracking Evaluation Services</u>

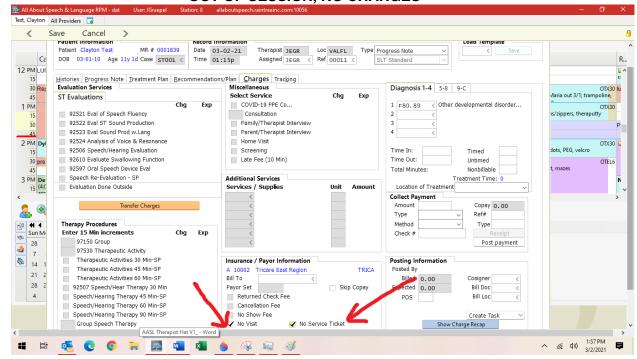
Miscellaneous >> Please enter discharge reason Diagnosis 2 Patient Files OT Evaluations Select Service Chg Exp COVID-19 PPE Co... 1 R13.11 < Dysphagia, oral phase Daily Ledger 97165 - Eval Low Complexity Consultation Family/Therapist Interview 97166 - Eval Moderate Complexity Reports / Forms 97167 - Eval High Complexity Parent/Therapist Interview 97168 - Re-Evaluation Home Visit Connect Time In: Timed Late Fee (10 Min) Time Out: Untimed ______ <u>T</u>ables Total Minutes: Nonbillable Additional Services Check Units Treatment Time: <u>U</u>tilities Evaluation Done Outside Services / Supplies Collect Payment What's Up Transfer Charges Copay 0.00 <u>E</u>xit Therapy Procedures Enter 15 Min increments Method Туре Check # 97150 Group Post payment 97530 Therapeutic Activity Therapeutic Activities 30 Min-SP Insurance / Payor Information Posting Information Therapeutic Activities 45 Min-SP P 00003 + Patient Resp Therapeutic Activities 60 Min-SP Bill To Billed 0.00 Cosigner DIMC < 92507 Speech/Hear Therapy 30 Min Payor Set Skip Copay Expected 0.00 Bill Doc DIMC < Speech/Hearing Therapy 45 Min-SP Returned Check Fee Bill Loc Speech/Hearing Therapy 60 Min-SP Cancellation Fee Speech/Hearing Therapy 90 Min-SP Group Speech Therapy ☐ No Visit No Service Ticket Show Charge Recap ↑ 77°F Rain coming ^ 4») 10:01 AM 10/28/2021 □

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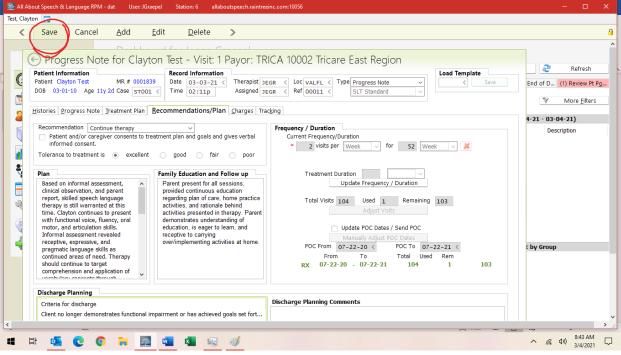


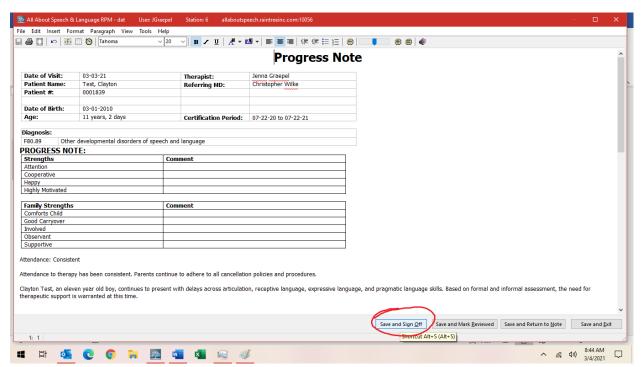


*****************************OUT OF SESSION, NO CHARGES*************************



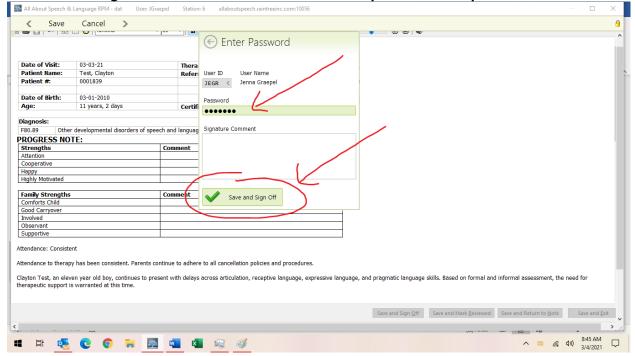






Save and Exit and/or Save and Sign off on the note





- Be sure to give the note a read-through to ensure no glaring typos or errors before signing off on the document. This is a last impression a doctor, family, or insurance reviewer will be seeing from us, so take care in your review.
- If a parent/caregiver requests to have the progress note sent to them or another professional, please inform the Front Desk. Please do so by providing client name, parent name, and specific request. They will send documentation to parents or other professionals as requested, ensuring necessary releases of information are on file.