

Health Tracking

Therap assists agencies to keep a detailed and accurate medical history for each individual that they support. If, when starting to use Therap, an agency has an existing medical history document, it can be scanned into the system or uploaded to become a part of the permanent Therap record. Therap's Health Tracking module has been designed to be a simple, yet efficient tool for users to record different individual health information and generate reports on them as per the users' needs. The Health Tracking module consists of various useful features, which allow users to document daily medical issues and also makes it easier to track changes in the medications prescribed to the individuals. This module makes it easier to observe how the individual responds to the changes in their medication. The Health Tracking module currently includes the following sections to help staff members provide enhanced health care:

▶ Blood Glucose:

This section has been designed to let users track blood glucose information for an individual. It can be used to record information such as date of reading, level of blood glucose, method used, and amount of insulin that was given. Users can also refer to the individual's Medication History section to view information on the list of medications and select the appropriate blood glucose treatment.

▶ **Height/Weight:** This section can be used to enter height and weight measurements for individuals supported by a Provider. Results can then be produced on a graphical or tabular format

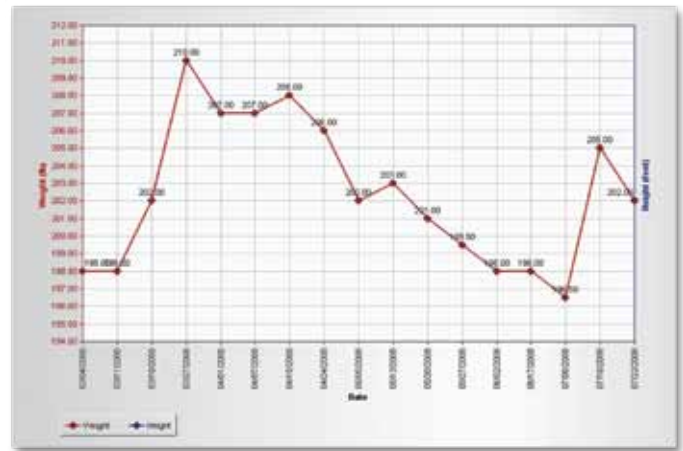


Figure: Height/Weight Graph in HT

infection type, its location and the medication that has been given to heal the infection. Users can specify the infection type from an extensive list of infections with their codes. There is also a body diagram which can be used to select the location of infection. It also lets users refer to the individual's medication history so the medication that is being used to treat the individual's infection can be selected.

▶ **Intake / Elimination:** The Health Tracking Intake / Elimination section is designed for users to quickly record fluid and food intake on a daily basis. Users can enter information on a grid with hourly slots for the entire day. Information such as bowel movements and other output can easily be tracked on the grid.

The total percentages and counts can also be viewed at the end of the grid.

Date	Form ID	Tot. Fluid Intake (cc)	Avg. % Meals Eaten	Tot. # Voids	Tot. Voids (cc)	# of BM's	BM Type	BM Amount	Bowel to BM
02/04/2009	HTI-DEMOCT-34037FA3EY	0.0	0.0	0	0.0	0	N	M	No
04/02/2009	HTI-DEMOCT-364316M64H	150.0	65.0	8	0.0	1	N	M	No
04/07/2009	HTI-DEMOCT-3493HGULB3	34.0	50.0	2	0.0	1	N	M	No

Figure: Intake and Elimination Report

▶ **Appointments:** It lets users enter details of upcoming appointments for individuals. Contact information of physicians/specialists and hospitals is made available from pre-populated lists. Users can specify in detail the reason for appointment and record appointment results such as diagnosis, medication changes, and lab results and also follow-up on future appointments.

over a period of time for comparison of the height/weight readings.

▶ **Immunization:** This section allows users to record the 'New', 'Ongoing', and 'Scheduled' immunization records for an individual.

▶ **Infection Tracking:** This section can be used to record detailed information on

▶ **Lab Test Result:** This section lets staff members schedule lab tests for an individual and track the outcome of those tests. Using the Lab Test module, users can create new lab tests by providing information on the Type, Unit, Maximum or Minimum ranges. These Lab Tests can then be added into the Lab Test Result Form.

► **Menses:** This section records and tracks information on the menstrual period for women supported by a Provider. The results can be graphed or a table can be produced which can be exported to Excel for further analysis.

► **Respiratory Treatment:** The Respiratory Treatment section can be used to track respiration treatment an individual is undergoing. One can document important information such as pulse, respiration, oxygen saturation, and lung sound before and after a treatment. Results can then be listed and reviewed.

► **Seizures:** With this section, users can enter detailed information regarding a seizure. Users can simply choose from a list of descriptive options and also specify respiration and skin color conditions related to the seizure. Descriptions of post seizure behaviors, precipitating factors, resulting injuries and staff action can also be added.

► **Skin/Wound:** In this section, users can enter wound information for individuals who are undergoing close monitoring and treatment of both injuries and conditions such as skin breakdown. Information such as wound type, wound stage and size can easily be recorded. Users can

The screenshot shows a web-based form titled "Medication History". At the top, it displays "Form ID: HTHH-DEMOCT-45W3HF9C3B" and "Status: Approved". Below this, it lists "Entered By: Administrator, Justin / Justin Administrator Roles 2 on 03/28/2006 01:32 PM" and "Reported By: Administrator, Justin / Program Director". The form is divided into sections: "Section 1 - General Information" and "Section 2 - Medication History Information". Section 2 contains fields for "Medication Name" (Flouride Rinse), "Medication Category" (Neurologic), "Medication Subcategory" (Other), "Dose" (10.0), "Total Count" (1.0), "Form" (Other), "Route" (Oral (mouth)), "Prescriber", "Purpose" (Oral Hygiene), "Side Effects", "Begin Date" (03/28/2006), "End Date", and "Comments". There are also radio buttons for "Prescription" and "Over the Counter", and "Scheduled" and "PRN" options. A "Look Up" button is present next to the "Prescriber" field.

Figure: Different Sections of the Medication History Form

also enter information on the skin conditions; attach photographs, and document causes and conditions of skin wound.

► **Vital Signs:** This section has been designed to allow users to enter readings for pulse, temperature, respirations, and blood pressure. Users can specify the method that has been used for these readings. Other relevant information such as lung sound and pulse rhythm can also be selected from dropdown menu. The results can easily be generated in graphical or tabular form which can be

exported to Excel for further analysis.

► **Medication History:** The Medication History section makes it easy for users to track current and discontinued medications for an individual. Users can simply select from a list of categories and maintain information such as dose, form, count, frequency, and route among others. Users can also look-up the physician/specialist who prescribed the medication from the common medical contact database. Relevant information such as side effects of the medication can also be recorded. The new 'Drug Lookup' option in Medication History will allow users to refer to the First DataBank drug database for detailed information on a medication. The Medication History section does not only help the users to record an individual's daily dosage of medication, but also gives them the history of dosage changes over a time period. Discontinued medications can also be tracked along with the discontinuation date, reason for discontinuance, and the effect of the medications.



Figure: Vital Signs Data in HT

► **Consultation Forms:** Therap also provides the option of generating Consultation Forms from the Appointment Forms that are created in the system. Consultation Forms normally contain the current medications prescribed to the individual in the Medi-

► **Health Care Reports:** The Therap system allows users to generate health care reports for given time ranges, with summaries from an individual's approved data across different Therap modules. These may include information extracted from the Individual Data Form, General

Event Reports (Incident Reports), and all Health Tracking Forms. Once a report is generated, users can save the report within the system. Comments may also be added to this report by any user having appropriate privilege on the individual.

Consultation Form

Individual Name: Mary Active, 000001 Date: 04/27/2009 04:00 pm
 Program Name: 1st Street Group Home
 Medicare Number: 111-11-1111 Medicaid Number: 123456789
 Allergies: None
 Medical Diagnosis:

Code	Description
317	Mental Retardation, Mild
345.40*	Epilepsy, partial, with impairment of consciousness (temporal lobe)
318.1	Mental Retardation, Severe
759.83	Fragile X syndrome
759.81	Prader-Willi syndrome

Medical Diagnosis Comments: 759.83 some comments

Current Medications:

Medication Name	Prescriber	Begin Date	End Date	Dose	Total Count	Frequency	Purpose
<input checked="" type="checkbox"/> BM Monitoring	Prescriber A	04/01/2009					
<input checked="" type="checkbox"/> Lipitor	Prescriber B	04/01/2009	04/30/2009	40 mg	1	2	Cardiology
<input checked="" type="checkbox"/> Zetia	Prescriber A	04/01/2009		10	30	once daily	high cholesterol

Physician's Signature: Reviewed by

Name: Title: Date:

Name: Title: Date:

Name: Title: Date:

Figure: Sections of Consultation Form

cation History form. Some other data, which are imported from the Individual Data Form, such as Medicaid & Medicare Number, Medical Diagnosis etc are included in the Consultation Form. This information may be of use to the Physician concerned. There are also fields which may be completed by the Physician, such as the details of future appointments, findings and recommendations. Each time data is entered into one of these forms, it becomes a part of the ongoing, permanent Therap record. For example, all medical appointments of an individual that has been stored within Therap will always be available to medical and nursing staff. Having all the data instantly available allows for historical reports to be produced on subjects such as medication changes, seizures, blood glucose levels, and more. Whenever a Health Care Report is produced, it can be saved within the system for future review and retrieval.

► **Monthly and Detailed Reports:** Monthly and Detailed Reports can be generated for all Health Tracking Forms. This reveals clearly illustrated trends and changes of an individual's medical issues over a period of time. Using the Health Tracking Monthly Report staff members can create a report to view and compare important health information such as temperature, pulse, high and low blood pressure readings among other documented Health Tracking data. The Health Tracking Detailed Report can be used to see a list of all Health Tracking data that have been entered for an individual. Both the Monthly and Detailed Reports can be exported to an Excel file for further comparison and analysis.

Health Care Report

Report Information

Report Name: Demo Report
 Individual Name: Active, Mary / 000001
 Report Date: 05/18/2009
 Report Duration: 05/01/2009 - 05/17/2009
 Time Zone: US/Eastern

Individual Data

Skin/Wound Assessment

Date and Time	Wound Type	Body Part(s)	Wound Stage	Wound Size	Wound Infected?	Treatment/Dressing
05/08/2009 02:42 pm	Decubitus	Foot Right	Blisters with skin break	Length (cm) = 1.0 Width (cm) = 1.5 Depth (cm) = 0.5	No	Dry Dressing

Vital Signs

Date	Temperature	Time	Pulse	Time	Respiration	Time	Blood Pressure (Systolic/Diastolic)	Time
05/08/2009	98.6		80	02:46 pm	24	02:46 pm	110 / 80	02:46 pm

Summary of General Event Reports

Date	Event Type	Description
05/07/2009	Injury	Cut, Hand Left, Self Injurious Behavior

Comments/Recommendations

Comments: movements right side, sw, Skin Color - Pale al control,

Figure: Health Care Report