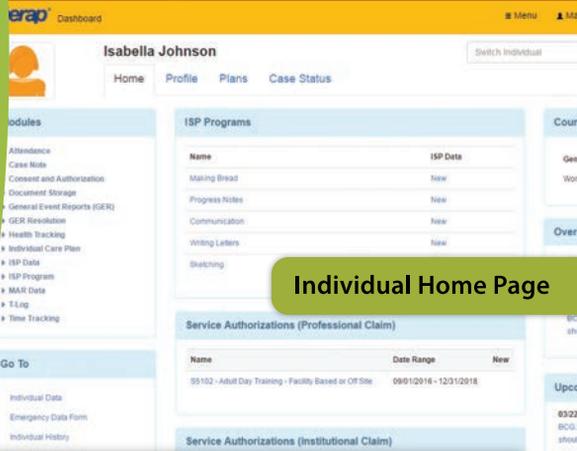




Comprehensive System for

# Electronic Documentation for I/DD Service Providers

- Real-Time Notifications
- Enhanced Risk Analysis
- Measure Health Outcomes
- Track Outcomes and Performances
- Person-Centered Data and Trends
- Electronic Billing
- Mobile Applications (GPS Location/EVV)
- Electronic Health Records
- HIPAA Compliant
- ONC Certified



Individual Home Page

## Business Intelligence

### Demographic Dashboard

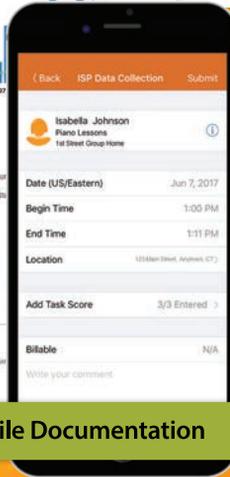
Aggregated reports on individual demographic data for comparison across providers and programs

### Incident Reports Dashboard

Identify Incident Reports trends at the state, provider and program levels



Mobile Documentation



## Recent Enhancements

- ✓ Business Intelligence Dashboards
- ✓ Health Information Exchange
- ✓ Case Management and Oversight
- ✓ Pharmacy Interface
- ✓ Case Notes
- ✓ Staff Ratio Tracking

Last updated on: 07/2017

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## About Therap

Therap is the industry leader in providing electronic records and documentation in long-term care services for people with Intellectual or Developmental Disabilities. Therap is a web-based application suite designed to provide a comprehensive solution for the planning, documentation, reporting, communication and billing needs of organizations which support people with intellectual and developmental disabilities in home and community-based services (HCBS), and other Long Term Services and Supports (LTSS) settings. Using secure cloud technology, the Therap system improves the quality of service within day programs, assisted living facilities, ICF/IID facilities, community support programs and state organizations. Daily communication and reporting between the state agencies, administrators, health care professionals, case managers, quality assurance teams and families become seamless. Therap currently supports over 400,000 individuals across the United States and internationally.

# Product Packaging

## Therap Basic

- Individual Home Page
- Individual Data Forms
- Emergency Data Forms
- General Event Reports (Incident Reports)
- Abuse & Neglect Reports
- Medication Error Reports
- Witness Reports
- Management/Event Summaries
- GER Resolution
- Activity Tracking/Audit Trails
- Individual Services Plans (Goal Tracking)
- Global ISP Template Library
- Behavior Plans & Tracking
- IPOP (Individual Plan of Protective Oversight and Safeguards)
- T-Logs (Nursing/Progress Notes)
- Secure Communications
- Demographics (Census Report)
- Time Tracking
- Notifications
- Advance Directives
- T-Notes (Sticky Notes)
- Calendar
- Caseworker Access
- Family Access
- Customer Support and Training
- Individual Based Caseloads
- Appointments
- Blood Glucose
- Height/Weight
- Immunization
- Infection Tracking
- Menses
- Respiratory Treatment
- Seizures
- Skin/Wound
- Vital Signs
- Intake/Elimination
- Monthly and Detailed Reports
- Quarterly Nursing Reports
- Lab Test

Health Tracking Applications allow users to track different categories of health data and create detailed or monthly reports.

## Health Plus

- Care Plans
- eCHAT
- Orders
- Individual History
- Health Passport
- HITSP C32 Document using HL7 CCD component (V2.5)
- Consent Forms

## MAR Plus

- Mobile MAR
- Medication Due
- Medication History
- Live Drug Database
- Monthly Reports

## Pharmacy Interface

- MAR Plus is a prerequisite to add module

- Pharmacy participation and payment of annual interface connection & maintenance fee also required

## Billing

- Attendance
- Billing Record Entry
- Service Authorization

## Billing Plus

- Electronic Billing / Direct Billing
- Attendance
- Billing Record Entry
- Service Authorization

## IB Billing

Contact Regional Representative for pricing

## Mobile Basic

- Mobile ISP Data
- Mobile T-Log

## Letter Module

- Generate letters
- Publish template for letters

## TMS

- Manage Class/Course/Session
- Manage Staff Certification
- Track Staff Training

## Therap Clinical-Meaningful Use

Contact Regional Representative for pricing

## Case Notes

- Agency Wide
- Billable Case Note

## HIPAA Secure Document Storage

2 GB Total/ per Individual with 10 MB file upload size limit

## Health Information Exchange

Contact Regional Representative for pricing

## Staff Ratio

- Record ratio of staff to individuals

## Personal Finance

- Track Financial Transactions
- Enter Deposits to an Account
- Track Expenses & Receipts

## Employment History

- Track Phases & Milestones
- Career pathway planning
- Job Development/Job Coaching

## Business Intelligence for Demographics and GERs

- Contact Regional Representative for pricing

## Therap for States & Counties

- Report Generation
- Case Management
- Intake and Referrals
- Track Linked Provider activities
- Waiting Lists
- Eligibility
- Level of Care

Subject to change

[Call for pricing](#)

# Support Plans & Tracking

- ✔ Document the planning process for individual based services
- ✔ Determine goals, objectives & assess using scoring methods
- ✔ Track progress & generate reports for review & analysis

**Individual Support Plan**

ISP Form Info  
 Status: Approved  
 Form ID: CDP-TCT-736850174190  
 Approved By: Theresa Hill, Administrator on 03/27/2017 05:02 PM  
 Entered By: Anthony West, Program Manager on 03/01/2017 04:07 PM

Update History

Individual Name: Jacob Smith, 12345 Date of Birth: 1/1/2001

Does Individual Have a Legal Representative/Guardian? Yes Name: Mike Cole

ISP Starting Date: 03/01/2017

ISP Start Date: 03/01/2017

ISP End Date: 12/31/2017

What is most important to the individual?  
 JACOB WISHES TO PLAY OUTSIDE. HE BECOMES SAD IF HE IS NOT TAKEN OUT FOR A WALK IN THE AFTERNOON. JACOB WISHES TO MOVE TO A NEW HOUSE. IT IS IMPORTANT FOR JACOB TO GET A COMFORTABLE ACCOMMODATION, SOMETHING MEANINGFUL TO DO DURING THE DAY, COMPANY OF FRIENDS WITH WHOM HE WILL BE ABLE TO SHARE GOOD TIMES. IT IS IMPORTANT FOR HIM TO HAVE THE OPPORTUNITY TO MAKE HIS OWN DECISIONS ABOUT THINGS.

Risks  
 Individual is at risk of, or has a risk related to, the following (as identified on the Risk Tracking Record)

Risk Type	Support Documents	Home	Where Kept	Work	Where Kept
At Home without Support	Regional Guidelines.pdf	01/16/2017	In the absence of suitable staff in Jacob's room	01/16/2017	Office Room

Professional Services Individual Data/Needs

Name (phonetic)	Organization	Contact Information	Specific reasons for this encounter	How Often or for how long	Where to occur	Notes
Dr. David Powell/Therap Clinic	Physician	123 Main St, Anytown, CT General Practice 123-123-1234	Annual physical, general care, and check diabetes	Every 6 months	Therap	Examination also includes diabetes check. Continue medications and diabetic diet as prescribed. Lab work done annually or more often as necessary.

Does this person have a Housing Care Plan at home? Yes Where Focused: Therap

Does this person have a Housing Care Plan at work? Yes Where Focused: Therap

Individual Support Plans facilitate methodical and concise individual planning. Provider agencies can use Therap's service plans and goal tracking tool to plan, organize and implement services for each individual in a HIPAA compliant manner. The ISP module includes program definition and service data collection which covers a flexible way of tracking an individual's progress in achieving their goals. ISP Reports provide detailed information about individual's goals and outcomes.

## Individual Support Plan

The Individual Support Plan (ISP) provides an enhanced workflow for planning and documenting supports for an individual. The support plan application captures:

- Individual's personal preferences
- Risks - for instance, at home/employment without support with unsupervised time or seizure activity
- Professional Services - look up contacts, add service providers
- Action Plans - link to ISP Programs, Personal Focus Worksheets
- Discussion records
- Service supports - add from a Service Directory

The Individual Support Plan application can be used to plan, organize and implement support plans for each individual in an agency. The ISP module includes program definition, data collection and report generation features that offer flexibility in tracking an individual's progress in achieving their goals.

The ISP module contains details of the supports, activities, and resources required for the individual to achieve personal goals. Therap's ISP module helps articulate decisions and agreements made during a person-centered process of planning and information gathering.

The ISP module is designed to be intuitive and to reflect what's important to and for the individual. You can add personal preferences when setting goals, and establish networks of support. Major health risks and safety issues at home and community environments can be assessed and recorded as well.

In the Therap Multi-Provider system, a Unified Search option is available for individuals who receive services from multiple Linked Provider agencies.

## ISP Agenda

The ISP Agenda allows the agency to develop an electronic agenda of topics to be discussed in the ISP planning meeting. The ISP Agenda gives ISP Team Members an account of the previous year's progress of an individual, providing a glimpse into factors that worked well and made sense to implement for the individual. Development of the Agenda is a crucial step in the care planning process. The ISP Agenda links to the Individual Support Plan being reviewed as well as the Personal Focus Worksheet, which gathers pertinent information about the individual. Notable features include:

- Add Individualized Agenda topic, including topics from the Personal Focus Worksheet

### ISP Agenda

**ISP Agenda**  
 Individual: Jacob Smith, 12345  
 Status: Approved  
 Form ID: AGR-TICT-F8H4QB7YD2A6U

Created by Brian Harris, Program Manager on 06/15/2017 11:12 AM  
 Approved by Steven Hall, Supervisor on 06/15/2017 11:39 AM  
 ISP Meeting Minutes Saved by Steven Hall, Supervisor on 06/15/2017 11:39 AM  
 Updated by Steven Hall, Supervisor on 06/15/2017 12:12 PM  
[Show All Activities](#)

[Update History](#)

**ISP Meeting date:** 06/14/2017  
**Meeting Type:** Annual  
**Review Period Start Date:** 06/01/2017  
**Review Period End Date:** 12/31/2017  
**Linked PFW:** PFW-TICT-F8H4QB7YD2A6Y  
**Linked ISP being Reviewed:** OIGP-TICT-F8H4Q32N4895U

Individualized Items		
Title	Action Taken	Comment
1. Jacob's communication development	Action Plan	Jacob is p...

Progress Towards Outcome			
Desired Outcome	Periodic Progress	Linked ISP Report	Comment
Physically and mentally ready for work. <i>(Linked to Action Plan 1)</i> <i>Linked to ISP Program: ISP Program (Cleaning Room)</i>	Maintaining		Jacob has
Jacob will be able to get ready by herself. <i>(Linked to Action Plan 2)</i>	Maintaining		Making pro...
Jacob will be able to play the piano.	Maintaining		Jacob undi...

Required Items		
Title	Action Taken	Comments
1. Does this person want to self-administer medications? <i>Consider any training needs this person may have and how self-administration will be monitored.</i>	Deferred	--
2. Does this person need a Health Care Representative?	Deferred	Not required.
3. Are the hours of school less than entitled?	Deferred	--

### Personal Focus Worksheet

Status: Approved  
 Form ID: PFW-TICT-F8H4QB7YD2A6Y  
 Approved By: Steven Hall, Supervisor on 06/15/2017 11:39 AM  
 Last Updated By: Steven Hall, Supervisor on 06/15/2017 11:39 AM  
 Created By: Brian Harris, Program Manager on 06/12/2017 04:12 PM

[Update History](#)

**Person Receiving Services:** Jacob Smith, 12345

**Start Date:** 06/01/2017 **End Date:** 12/31/2017 [Jump to](#)

**Section 1 : Describes what is important to this person from his/her perspective**

**Question 1. Describe the relationships in this person's life:**  
 Jacob has good relationship with his parents. He likes to spend time with his family.  
**Agenda Question: Are there any relationships that should be developed or changed?**  
 Jacob wishes to spend more time with his sister. His sister lives in a different town which makes it difficult for him to get in touch with her more often.

[Edit](#)

**Question 2. Describe what this person enjoys and list his/her interests:**  
 He likes painting and likes it when others read books to him.  
**Agenda Question: Which of these interests are not happening as much as the person would like? From the team's perspective, which of these interests, if any, need to be limited?**  
 There has not been many book reading sessions lately.

[Edit](#)

**Question 3. Describe what this person dislikes:**  
 He does not like to wake up early in the morning.  
**Agenda Question: Which of these dislikes needs to be developed or changed?**

[Edit](#)

Personal Focus Worksheet

- Record progress towards outcomes of action plans
- Display regulatory items including hours of employment/ school
- Attach external documents and add notes after the ISP meeting

## Personal Focus Worksheet

The Personal Focus Worksheet is built around the requirements of the Individual Support Plan to gather pertinent information about an individual. It is a questionnaire about the individual where you can fill out five sections to record and share information about the current state of the individual.

Personal Focus Worksheet includes:

- Factors important to the individual including personal preferences, interests and aspirations
- Ongoing events, social interaction, living arrangement, employment, spiritual, religious, and cultural considerations
- Reflections/comments of others who know and care about the individual on how to improve the person's support needs
- Ways in which the person's quality of life can be enhanced through more independence, community involvement, and higher income capacity
- Conflict between desires and objectives for the individual's support needs



## Individual Support Planning

Once a meeting with the information from the individual's Worksheet and ISP reports are concluded, the decisions are recorded as minutes within the approved agenda and used in creating future plans.

## ISP Program

Therap's ISP Program module is designed to facilitate the documentation of a detailed Individual Service Plan. The ISP Program module is used to design and document teaching programs that chart the goals or training objectives. It consists of scoring details, tasks and teaching methods that track an individual's progress towards an outcome and their specific goals. An ISP Program for an individual can include one or more tasks which can be evaluated by using various Scoring Methods including Yes/No responses, the level of independence in completing tasks, and approaches defined by users. These scores determine successful completion of tasks and the level of progress.

## ISP Data

ISP Data is used to collect data for the associated ISP Programs. ISP Data Collection allows you to track progress of individuals on a regular basis. ISP Data can be collected by:

- Entering the details of a program session
- Specifying begin and end times or time duration of services that were provided during a session
- Intuitive interface for recording data
- Efficient recording of scores over a period of time

## ISP Reports

Generate reports on the services provided to the individuals to track service delivery and progress towards goals. These reports assist in tracking the progress of the individuals and also in planning future steps. There are four types of reports:

### Programmatic Reports

- Shows task scores and the calculated deviation from baseline for specific periods
- Represents scores in bar graph, line graph, and table formats

### Clinician Report

- Shows comments & observations recorded during the sessions
- Displays detailed information about the days and times during which training or supervision is provided

### Data Collection Monthly Report

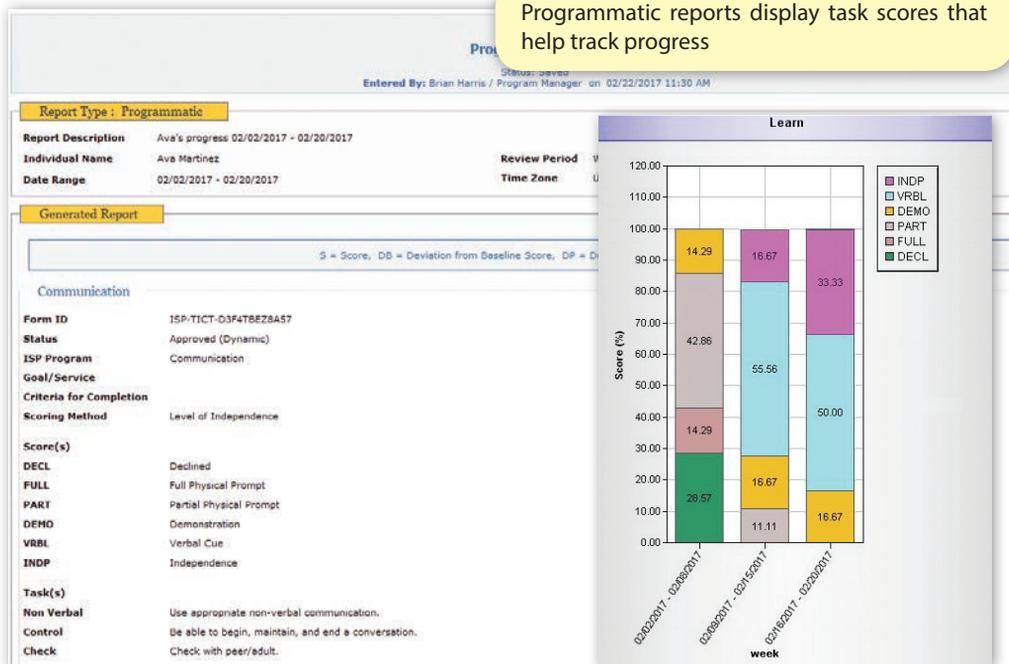
- Provides a monthly view of data entered
- Shows the scores selected for tasks along with staff initials

### Hab Documentation Record

- Displays documentation of programs and their tasks and scores combined
- Shows reportable entries made by staff along with their initials

### Programmatic Report

Programmatic reports display task scores that help track progress



# T-Logs:

## Daily Notes & Logs

- ✔ Document daily logs, notes & follow ups
- ✔ Record staff-to-staff communication
- ✔ Categorize health notes, behavior notes, contact & general information

T-Logs are an alternative to your logbooks and the daily notes that you share with other staff members at your agency. You may write T-Logs for specific individuals or for a particular program. These logs are automatically shared with co-workers based on their caseload of individuals. Updates made to T-Logs can be seen from Update History.

### Types of T-Logs

The T-Logs can be categorized using one or more of the preset labels – Health, Notes, Follow-up, Behavior, Contacts and General. Types of T-Logs help staff to organize the notes into the relevant categories.

### Tracking T-Logs

T-Logs carry information that needs to be seen and known by those supporting an individual in an agency. Thus, Therap's To Do list on the Dashboard helps to keep track of information by displaying a count of T-Logs that are yet to be read. The 'Acknowledge & Next' feature makes it easy to read through large numbers of unread T-Logs. This also reduces the count of T-Logs from your Dashboard, helping you to keep an exact count of T-Logs that you need to acknowledge.

### Notifications

The notification level of T-Logs automatically defaults to low and the agency then decides which criteria each notification level meets. A user has the ability to configure the system to

receive notifications based on these levels - High/Medium/Low. You may choose to receive notifications over email, text messages or through Therap's Secure Communications (SComm) messages.

### Attachments

Two types of external attachments can be added to T-Logs:

- External attachments from computer
- External attachments from scanner

Photos can be attached to T-Logs as well. The maximum size of a single attachment is 3 MB.

### Scanner Interface

The Scanner Interface allows you to scan multiple-paged documents. You can also rotate, delete, and crop pages in preview mode before attaching them to a T-Log.

### Additional Features:

- Update submitted T-Logs
- Add follow-ups to existing T-Logs
- Review acknowledgement list to view list of readers
- Send T-Log via SComm
- Download T-Logs as PDFs on your computer
- Record Time In/ Time Out
- Add Reporter to T-Logs
- Track actions performed by users with the Activity Tracking module

# Individual Data

- ✔ Individual's background data
- ✔ Emergency family/physician contacts
- ✔ Diagnoses, advance directives & dietary guidelines
- ✔ Program enrollment & discharge information

**Individual Data**

Ethan Williams (Admitted)  
Form ID: IDF-DEMOTCT-EDQNETZKA37H  
Admitted By: Jacob Anderson, Case Manager  
Entered By: John Sanders, Case Manager on 11/22/2016 01:13 PM  
Last Updated By: David Powell, Executive Director on 01/02/2017 04:57 PM

Update History (4)

**Identification Data**

First Name: Ethan Last Name: Williams  
Middle Name: Jack Suffix:  
SSN: 000-65-1888 Birth Date: 11/01/1998  
Photo 1: [Placeholder] Photo 2: [Placeholder]

**Active Program & Site Information**

Program Name	Enrollment Date	Site Name	Address	Primary Contact	Secondary Contact
2nd Street	03/05/2017	Group Home	CT, USA	Name: Mia Cole, Phone(x): 111-123-4567	Name: Lisa Bryant, Phone(x): 123-456-7890

**Discharged Program & Site Information**

Program Name	Enrollment Date	Discharge Date	Site Name	Address	Primary Contact	Secondary Contact
1st Street	03/05/2017	04/05/2017	Group Home	CT, USA	Name: Brian Harris, Phone(x): 111-234-5678	Name: Taylor Collins, Phone(x): 112-345-6789

**Addresses**

Residential Address: 123 Main St., Ansonia, USA, CT 12345, USA Phone(x): 111-123-4567, 111-234-5678  
Mailing Address: 123 Main St., Ansonia, USA, CT 12345, USA Phone(x): 111-123-4567, 111-234-5678  
E-mail:

The Individual Data module is used to record the basic demographic, health and emergency information for individuals. Other Therap forms that are created for them will refer to this information, making sure the care providers are well informed. Modules titled Individual Data, Emergency Data Form (EDF), Individual Home Page, and Individual Medical Information are designed for storing and viewing different information of an individual.

## Individual Data Form

The Individual Data (ID) form is designed to help you record and maintain essential information regarding the individuals you support. The page contains basic information such as first and last names, gender, date of birth, SSN, medicaid number, admission date, physical features, etc. You are able to attach two photographs of the individual and add external files or attach scanned documents to this module.

## Custom Fields

For custom fields to populate in an IDF is going to depend on the provider agency who are going to define their own custom fields. Each field added here counts toward an agency-wide demographic field for reporting purposes, so there may be new fields such as driver's license details, or a question inquiring if the person has a photo release, or the last date for review of human rights community. Data entered in Custom Fields can be included in an EDF and other custom reports.

## Medical Information

General medical information regarding the individual is recorded in this section. This includes blood type, disabilities, adaptive equipment, emergency orders, primary care physician and other information, which are available from other modules for cross reference and as an aid in decision making and planning.

## Diagnoses

Diagnoses and their descriptions can be entered for an individual. A lookup box helps you search and pick out the diagnosis from a predefined list. The system provides a comprehensive list of ICD-9/ICD-10 and DSM-5 diagnoses, state based codes, and other common lists. Another lookup box helps locate who diagnosed the individual with the condition. The Axis (1/2/3/4/5) and the diagnosis dates are specified too. Diagnoses for conditions that are no longer applicable or no longer exist can be resolved and the details of when and by whom they were resolved is recorded in the system.

## Guidelines

Guidelines and restrictions on diet, mobility, communication, supervision and other factors that affect daily living are recorded in this section. These can be written in narrative form and drop-down menus are available for the ones that have a known set of options - e.g. for mobility needs, a user can select from preset options of 'Walks on own', 'Walks with assistance', 'Uses a cane', etc. as well as entering an optional descriptive comment.

Other information such as Insurance, Assessment Score, Team Members and Contacts are recorded on this form. Agencies can include data of their choosing by the use of Custom Fields. When creating the custom fields the type of the field can be chosen from different available field types such as Text, Numeric, Radio Buttons and Dropdown lists.

## Emergency Data Forms

The Emergency Data Forms (EDFs) display a set of information that may be essential in case of emergencies. Data is automatically extracted from an approved Individual Data form and shown in a read only view. Users are also given notifications if emergency information has been changed. On these forms, a 'Read and Acknowledge' count is shown to the user on their Dashboard so they can follow up. It can be printed or exported to PDF format. The EDF's usage also extends to temporary staff who need

to get an overview of the individual.

### Emergency Contacts

Contacts labeled as 'Emergency Contact' in an Individual Data form will show up on the Emergency Data Form (EDF) with available details including provider agency's contact information.

### Medical Contacts

The EDF displays contact information of an individual's physician, hospital, pharmacy, and dentist, to be used for medical needs and emergencies.

### Other Data

The EDF shows other data entered into Individual Data including the individual's identification data, insurance plans, medical data, behavior information and guidelines for attending to the individual's needs. With proper authorization, you will be able to view an EDF and track whether the latest EDF has been printed.

**Guidelines**

**Dietary Guidelines** Low Fat, Low Cholesterol, 1500 Calorie, Soft food is preferred.

**Eating Guidelines** Eats and drinks independently. Needs a straw while drinking.

**Communication Modality** Partially Verbal **Other**

**Communication Comments** Ethan has serious hearing loss, staff must stand in front of him directly, speak and utilize both cards, hand sign language and his choice board as detailed in his Speech Therapy Plan.

**Mobility** Uses walker **Other**

**Mobility Comments** Ethan uses a wheelchair for long distances and a gait belt for safety during short walks.

**Supervision** Supervision for personal care **Other**

**Supervision Comments** Ethan uses shower chair for bathing. Needs reminders and guidance to take his medications. He requires assistance with dressing. Ethan bathes on a shower chair with supervision. He maintains his own oral hygiene care twice a day.

**Food Texture** Food consistency altered-Chopped

**Liquid Consistency** Thin

**Referral Source** Home and Community Based Services

**Toileting Status** Incontinent/Requires Disposable Briefs **Bathing Status** Requires Support to Bath/Shower

**Mealtime Status** Eats Independently (with or without adaptive equipment)

**Individual Data Form**  
 The Guidelines and Contacts sections of the IDF

**Contacts** [Jump to](#)

**Individual Contacts**

**Guardian of Self** No

Name	Contact Type	Agency	Address	Mailing Address	Action
Carol Ellis	Emergency Contact (24 hr), Parent		<b>Address:</b> 123 Spruce St., Anytown, CT 12345, USA , <b>Phone(s):</b> 111-123-4567	<b>Address:</b> 123 Spruce St., Anytown, CT 12345, USA	<a href="#">Edit</a>

[Create Contact](#)

**Shared Contacts**

## Demographic Report

Active/Inactive Individual	
Active	900
Inactive	33
Total Individual	933

Count by Gender	
Male	483
Female	417
Unknown	0

Count by Age	
0-5 (Children)	43
6-17 (Adolescents)	74
18-40 (Adults)	335
41-65 (Adults)	292
66-85 (Adults)	126
86+ (Adults)	30
Unknown	0

Count by Oral Language	
English	891
Spanish	9

Count by Written Language	
English	891
Spanish	9

Count by Communication Modality	
Communication Device	45
Non-Verbal	153
Partially Verbal	134
Sign	90
The individual uses picture communication cards for communication.	38
The individual uses picture communication cards for communication.	7
Unknown	2
Verbal	431

Count by Citizenship	
USA	900

Count by Location (State)	
NJ	288
NY	236
PA	376

Count by Race	
American Indian/Alaskan Native	7

Count by Supervision	
Arm's Length	164
Assistance for personal care	137
Assistance for everything	109
Line of Sight	164
Never Attended	54
No supervision	109
Supervision for personal care	163

Count by Program	
1st Street Group Home	89
2nd Street Group Home	45
3rd Street Group Home	35
4th Street Group Home	31
5th Street Group Home	40

Top 10 Diagnosis [ICD-9/DSM-4/Other]	
299.0 Infantile Autism	19
300.02 Generalized Anxiety Disorder	17
300.3 Obsessive-Compulsive Disorder	12
309.0 Adjustment Disorder With Depressed Mood	9
309.1 Posttraumatic Stress Disorder	7

## Demographic Report

Each agency can generate a demographic report, which is based on the information entered in the Individual Data forms. The report displays the relevant demographic statistics by active/inactive individual, gender, age, mobility, communication modality, top 10 diagnoses and others. The report also shows counts of individuals enrolled in different programs and supervision schemes.

### Export to Excel

Users have the option to export the Demographic Report results to an Excel file by clicking on the 'Export to Excel' link at the bottom of the 'Demographic Report' page.

Demographic Report										
<b>Active/Inactive Individual</b>		<b>Count by Oral Language</b>			<b>Count by Race</b>					
Active	900	English	891	American Indian/Alaskan Native	7					
Inactive	33	Spanish	9	Asian	81					
Total Individual	933				Black/African American	163				
<b>Count by Gender</b>		<b>Count by Written Language</b>			<b>Count by Program</b>					
Male	483	English	891	White	554					
Female	417	Spanish	9							
Unknown	0	<b>Count by Communication Modality</b>								
<b>Count by Citizenship</b>		Communication Device	45							
USA	900	Non-Verbal	153							
<b>Count by Age</b>		Partially Verbal	134							
0-5 (Children)	43	Sign	90							
6-17 (Adolescents)	74	The individual uses picture communication cards for communication.	38							
18-40 (Adults)	335	The individual uses picture communication cards for communication.	7							
41-65 (Adults)	292	Unknown	2							
66-85 (Adults)	126	Verbal	431							
86+ (Adults)	30	<b>Count by Country</b>								
Unknown	0	USA	900							
<b>Count by Location (State)</b>		<b>Count by Location (State)</b>								
		NJ	288							
		NY	236							
		PA	376							
<b>Count by Race</b>										
		Arm's Length	164							
		Assistance for Personal Care	137							
		Assistance for everything	109							
		Line of Sight	164							
		Never Attended	54							
		No supervision	109							
		Supervision for personal care	163							

# Health Records

- ✔ Schedule & document appointments with doctors, therapists, pathologists & others
- ✔ Track lab tests, immunizations & skin integrity/infections
- ✔ Generate detailed & monthly health care reports

Therap's Health Tracking module allows you to efficiently track different types of health data and create detailed and monthly reports. It provides a flexible way to record and follow up on medical issues such as:

- Vital Signs
- Blood Glucose
- Appointments
- Medication History
- Height/Weight
- Intake/Elimination
- Seizures
- Health Care Reports
- Lab Test
- Immunization
- Infection Tracking
- Menses
- Respiratory Treatment
- Skin/Wound

## Vital Signs

This form contains sections for recording an individual's pulse, temperature, respiration, and blood pressure. Users entering data can view a reference table that displays the normal range for each vital sign (mandated criteria for

Therap's appointment calendar allows a user to see their caseload's appointments and you can see appointment details and add follow up by clicking on the appointment on the appointment calendar.

**Vital Signs**  
Form ID: HTV-GEMO-REQ4ALYK0A82  
Status: New  
Entered By: Brian Harris, Supervisor

**Section 1 - General Information**

Individual Name: Jacob Smith  
Program Name: 1st Street Group Home (Group Home)  
Time Zone: US/Central  
Entered By: Brian Harris, Supervisor  
Reported By: Harris, Brian / Supervisor  
Date: 02/05/2017  
Notification Level: Low

**Section 2 - Vital Signs Information**

**Temperature**  
Value: 98.1  
Time: 02:47 am  
Site: Temporal

Gender	App From	App To	Normal Range	Unit
Any	18Y 0M	110Y 0M	97.6 - 99	F

**Pulse**  
Value: 62

Gender	App From	App To	Normal Range	Unit
Any	18Y 0M	110Y 0M	60 - 110	BPM

**Oxygen Saturation**  
Value: 97

Gender	App From	App To	Normal Range	Unit
Any			95 - 100	%

LTPAC EHRs). The system has the ability to detect an out-of-range value and displays an 'Outside Range' message beside the particular entry. It also prompts for a high notification level to be assigned to the record. This helps alert the relevant teams and/or decision makers.

## Blood Glucose

The Blood Glucose module allows users to record and keep track of the blood glucose level of an individual in detail, including the method of measurement and the administration of Insulin. These records for an individual can be summarized into periodic reports and exported to Microsoft Excel to effectively analyze the trends.

## Appointments

With the Appointments module, users are able to enter details and track upcoming appointments for individuals. Contact information of physicians, specialists and hospitals are available from pre-populated lists. You can specify reason for appointment and record appointment result information

**Appointments Calendar**  
View: view=calendar

Month: August 2017

Therap Calendar

such as diagnoses, medication changes, and lab results. Follow-up appointments can also be set. A consultation form can be generated from appointments that includes information useful at appointments such as current medications, medicaid & medicare numbers and medical diagnoses.

## Medication History

The Medication History module is a tool for keeping records of medications given to individuals. Integrated with First Databank - a leading drug database - Medication History forms are equipped with drug lookup tools that also provide detailed information on side effects, drug-allergy reactions and drug-drug interactions.

**Medication History**  
Form ID: HTHH-CEND-EE745V3QAH5  
Status: Approved  
Entered By: Matthew Hill, Registered Nurse on 12/05/2016 03:00 PM  
Reported By: Matthew Hill, Registered Nurse  
Approved By: Angela Murray, Registered Nurse on 12/05/2016 03:00 PM  
Last Updated By: Angela Murray, Registered Nurse on 12/05/2016 03:05 PM

Review LHM      Update History(!)

**Section 1 - General Information**

Program Name: 10th Street  
Individual Name: King, Anthony  
Reported By: Hill, Matthew / Registered Nurse  
Date: 12/05/2016      Time Zone: US/Central  
Notification Level: Low

**Section 2 - Pharmacy/Prescriber Information**

Prescriber: Jacob Anderson

**Section 3 - Medication History Information**

General Drug Information

Medication Name: LASIX 20 MG TABLET      Drug Details  
Drug Code: 0039-0060-13      Drug Coding System: NDC  
Strength: 20      Strength Unit: mg  
Medication Type: Scheduled (Medication)      Dose Form: tablet

Drug-Allergy Interaction

- This medication does not have any adverse interaction with individual's active allergy(ies)

You may add multiple schedules for the same medication, schedule daily, weekly or monthly PRN and other medications or treatments, and view past or future schedules on the MAR form. Medication History forms can also be generated for individuals by using the Pharmacy Messages received through Pharmacy Interface and then be tracked using MAR.

To learn more about **Pharmacy Interface**, see page 28

## Height/Weight

The Height/Weight module allows you to record the height and weight of the individuals being supported. The collected data can be viewed on a graph, table, or exported to an Excel spreadsheet, for further analysis. BMI of the individual is displayed in this module once the height and weight information is entered.

## Intake and Elimination

The Intake/Elimination form has a highly configurable and user friendly input screen for saving multiple data entries during the day. With this module, you can track and record intake of fluids and/or solids and output of urine and/or bowel.

## Seizures

Seizure reports allow you to record and view the duration of a seizure, date and time, and other relevant information, including what actions were taken by staff, what the precipitating factors were, a description of the event, and a comments box to capture other information.

## Health Care Reports

Health Care Report can be generated for a given time/date range, with summaries from an individual's data. These may include information extracted from Health Tracking forms, along with key information such as allergies, dietary guidelines, and medical diagnoses. A summary of General Event Reports created within this date range is also displayed in the report. Once a report is generated, you can save the report within the system. Comments can be added to this report by users having appropriate privileges. Options to generate detailed and monthly health care reports are available.

## Lab Test Result

The Lab Test Result module gives you the ability to create new lab tests, keep track of scheduled lab tests, and record results of lab tests for an individual. Therap provides an option to generate summary reports based on lab test results and tools to follow up on them.

## Immunization

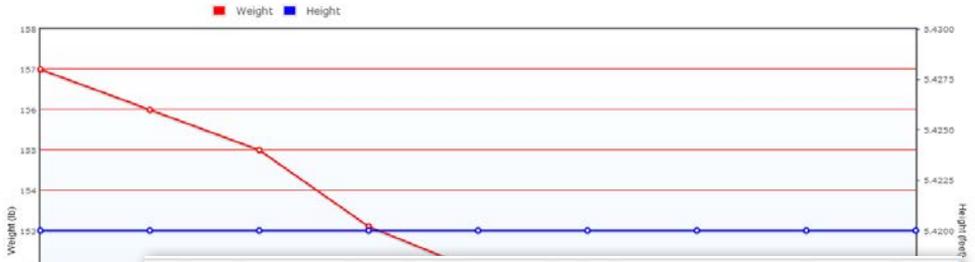
The Immunization module helps you keep track of an individual's Immunization records. Using this module you can select an individual's 'New', 'Scheduled', and 'On-Going' vaccine names from the system and enter detailed information.

## Infection Tracking

The Infection Tracking module helps you to record and track an individual's infections. You can access infection codes from the system and add them from a drop-down menu. Users can enter information about infected body parts, and look up and add existing medications as well.

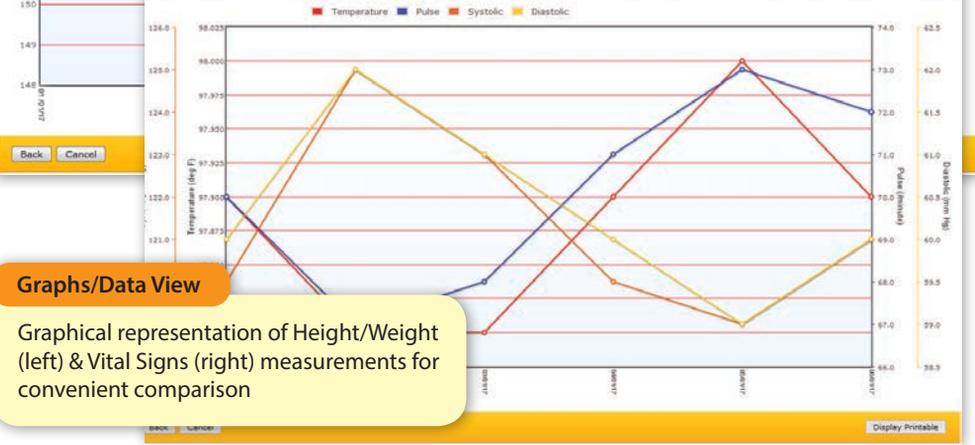
Height/Weight Data View

Individual Name : Jacob Smith  
Time Zone : US/Central



Vital Signs Data View

Individual Name : Jacob Smith  
Time Zone : US/Central



Graphs/Data View

Graphical representation of Height/Weight (left) & Vital Signs (right) measurements for convenient comparison

Health Care Report

Status: Saved

Entered By: Brian Harris / Supervisor on 06/12/2017 11:41 PM

Report Information

**Report Name** Health Care Report of Jacob Smith  
**Individual Name** Smith, Jacob / 12345  
**Report Date** 06/10/2017  
**Report Duration** 01/05/2017 - 06/10/2017  
**Time Zone** US/Central

Individual Data

**Developmental Disability** Epilepsy, Autism, Other  
**Allergies** Advil Allergy Sinus (02/01/2016); Nut  
**Dietary Guidelines** Low Fat, Low Cholesterol, 1500 Calor Tolerated

Health Care Report

Extracts information from different Therap modules including Individual Data Form, General Event Report, and Health Tracking forms to provide a summary over a given time range

Active Diagnoses

ICD-10	ICD-9/DSM-4/Other	Axis	DSM-5	Description	Diagnosis Date	Diagnosed By
F32.1 - Major depressive disorder, single episode	296.22 - Major depressive disorder, single episode, moderate	Axis 2	Major depressive disorder, single episode, moderate	Jacob's test for active diagnosis	06/10/2017	Anderson, Jacob / Dr

Appointments

Appointment Date and Time	Appointment With (Contact Type)	Type	Appointment Result/Description	Appointment Status
			Changes to or new medications or treatments	

# Secure Communications

- ✔ HIPAA compliant, secure messaging and sharing
- ✔ Email notifications
- ✔ Attachment support for external documents

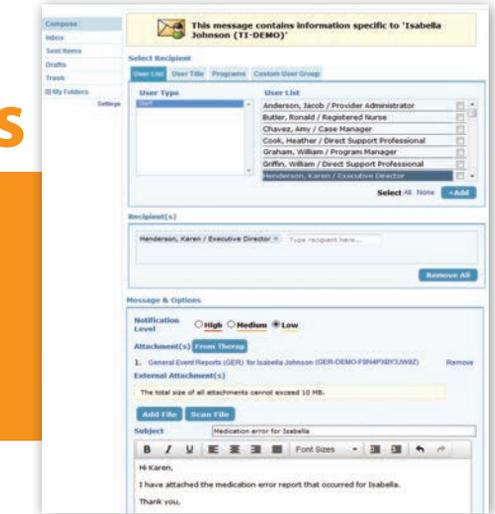
Secure Communications (SComm) messages facilitate the exchange of information among users in an agency, in a secure, HIPAA compliant way. SComm messages help improve communication related to services as well as the operations of the company, e.g. agency wide meeting announcements.

## Sending and Tracking Messages

When sending messages, different options are available, including features like Compose, Reply, Reply to All and Forward. Internal reports (e.g. ISP, Individual Data and others within the Therap system) as well as external documents (e.g. Word and Excel among others) can be attached to an SComm message. These options help senders and receivers to filter or search for messages. Users who have marked messages as 'Read' are listed in the Reader's List of each SComm message.

## Sharing Data

You can share both general and individual specific information and attach various files and individual specific plans, forms and reports from other Therap modules through SComm messages. Sharing forms or reports from most modules, e.g. an ISP Program or a GER (incident report), with



co-workers, is possible from both the SComm interface and the module's interface.

## Providing Access

SComm allows you to select multiple recipients based on recipient names, titles and program names. You can also create fixed mailing lists, called 'Custom User Groups'. Upon request, Therap allows the exchange of SComm messages between multiple agencies who provide support to the same individuals. Communication with Therap Customer Support is possible using the SComm module. With special roles, users in Oversight Agencies can send SComm messages within that agency and to other providers linked to that agency. The provision of this role in SComm allows a user from a provider agency to share relevant information with oversight organizations within Therap.

## Notification

SComm messages can be prioritized with 'High', 'Medium' and 'Low' notification levels. You may choose to receive notifications for SComm messages on email and/or text messages by configuring the notification level needed to receive notifications via your chosen media.

## Security

The forms that are sent via SComm also follow Therap's security protocols and only the recipients with appropriate access privileges are able to open the form attachments. Communication through SComm is processed using Therap's secure, HIPAA compliant servers and information shared remains safe and secure.



# Incident Reporting (GER)

- ✔ Instant event reporting
- ✔ Real-time sharing
- ✔ Reviews & follow-up tracking
- ✔ Alerts & notifications
- ✔ Witness reports

The General Event Reports (GER) tool helps you record incidents comprehensively, with dropdown menus of options to choose details from as well as the ability to record witness details and accounts. Events can be prioritized using the High, Medium and Low labels to ensure proper follow-up by support professionals.

## Record Multiple Incidents in a Single Report

With the GER module, multiple events, for instance an injury and the use of restraints, can be recorded on the same incident report. Each event type includes the option to enter detailed information specific to the event.

### Injury

Detailed information regarding the cause of injury, type of injury, severity of the event, treatment details, among various other options, can be added to a GER. To allow more flexibility, you are provided with a body diagram, a visual tool where service providers can select body parts that sustained injuries in the incident.

### Medication Error

Incidents caused due to a medication error can be documented here. This GER event contains fields for medication error type, error details (e.g., medication ordered and medication given), prescriber notification and reason for errors among other options.

## Restraint Related to Behavior and Restraint Other

The GER module allows you to add information about events where physical, chemical, mechanical, or other types of restraints were administered. Summary notes on restraints may be added as well. Detailed information on restraint related to behavior, including time and date, status and summary can be recorded using GERs. This section is integrated with Therap's Behavior Tracking module to facilitate reporting or generating clinical reports.

## Recording Abuse, Neglect & Exploitation

Therap's GER module has the ability to flag incidents for which abuse, neglect and exploitation allegations are suspected. This allows agencies to track whether such allegations involve actual physical, psychological or sexual abuse or neglect. Therap ensures automatic and real-time alerts of incidents and allegations of abuse, neglect and exploitation via email and Secure Communications (Therap's internal, HIPAA compliant messaging system).

## Approve, Review and Follow-up Counts

Submitted GER forms can be tracked by support staff for approval, review, and follow-up. Therap's 'To Do' section of the Dashboard displays a list of counts for new/unread event reports

### General Event Reports (GER) New ? !

1      2      3      4      5

Basic Information      **Event Information**

**Event Injury**

\* Time of Injury: 03:00 pm 🕒

Unknown

\* This event was:  Observed  Disc

Discovered Date/Time: 06/12/2017

Specific Location: Activity Area

---

\* Type: Bruise

\* Cause: Fall

\* Severity: Very Minor (No treat

Color: Purple

Size: 3

\* Body Part(s): Foot Left

**Body Diagram** ✕

Front    Back

Systemic Internal

Selected Body Parts

Foot Left

**Injury Information and Body Diagram**

Clear All    **Submit**

- Please Select -    - Please Select -

in pending review and/or approval status. This view varies depending on access privileges.

## Alerts and Notifications

GER's flexible notification mechanism allows you to enable notifications for a specific set of actions (e.g. submission, reviewing or approval, returned GERs, follow-up), and a specific level of notification (e.g. high, medium or low). You can also select the appropriate media (email, text messages, and Secure Communication) via which you will be alerted.

## Comply with State Regulations

GER form enables the provider to stay in compliance with state regulations. Therap includes state specific GER forms, which have been designed according to the policy of different states. You are able to take printable version of the state specific information regarding an incident. The forms for each particular state are visible only to users in agencies of these states. The following is a list of the states where Therap offers state specific Incident Reporting forms: Arizona, California, Colorado,

To Do	Modules	High	Medium	Low	Event Tracking
Individual	T-Log - New   Search		2		My Issues
Health	General Event Reports (GER) - New   Search				My Comm
Agency	Followup		1		Inbox (5)
Billing	ISP Data - New   Search		2		Sent Items
Admin	Individual Support Plan - New   Search				Drafts
Agency Reports	Worklist	1			Custom User Group
Individual Home Page	Worklist	1			Letter
Settings	Comprehensive Health Search				New Search
	Approve				Task
	IPDP General Information - New   Search		2		Task Search
	Acknowledge				Task Search

**GER Counts on Dashboard**

Connecticut, Delaware, Georgia, Maine, Minnesota, New Jersey, New York, Tennessee, and Utah.

Contact us to see how we can meet your state requirements

## Multi-Individual Event Section

Save time and effort without the need to enter similar information in multiple forms for an incident involving more than one individual with Therap's Multi-Individual Event.

Multi-Individual Event offers the chance to create a single form containing linked GERs for multiple individuals involved in the same incident.

**New T-Note**

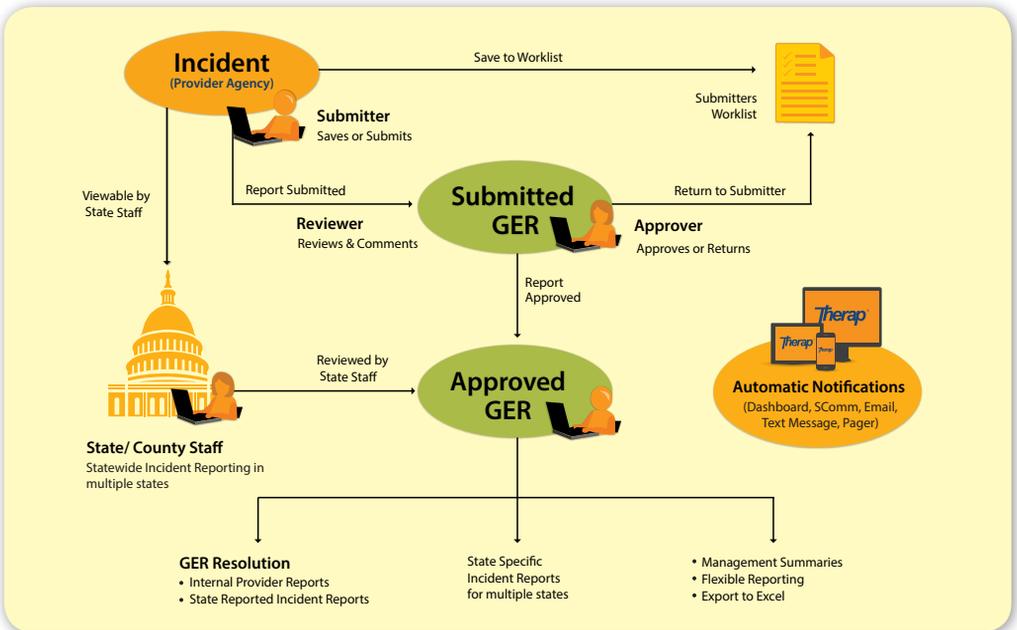
\* **Description** Please attach injury photo. |  
About 72 characters left

**Choose Color**

**Electronic Sticky Notes**

'T-Notes' is a handy Therap feature for attaching digital sticky notes to GERs and other modules. These can be used to convey small pieces of information or to make notes to oneself or to others working on a particular GER

## Electronic Workflow Management



The GER module provides a robust and effective solution for documenting, reporting and tracking subsequent investigations and results regarding incidents of an individual receiving services. The electronic workflow of the application increases efficiency by simplifying the processes of documentation, reviewing, approval and oversight. Users can submit, review, approve, follow-up, view, and delete GERs based on their assigned access privileges. Once a GER form is entered, it is automatically made available to authorized users for reviewing and approval. This ensures

that the GER can be properly reviewed by all involved parties. Relevant comments can be added to the report as needed. If a report is found to be incomplete or incorrect, it can be sent back to the submitter for further work. This ensures integrity of the information recorded on the GER form. Depending upon the actions performed, the status of the GER gets updated. This helps users (for example: Incident Management Coordinators) to track the progress of GERs. Thus all the details are well-preserved and any changes made are also recorded.

## GER Resolution

The GER Resolution module allows you to record the final outcome of an incident separately from the initial incident report, but is still linked. This means that staff may be able to view the initial report but not the final resolution. GER Resolution is a place to record the findings and recommendations of an investigation and related information. You can mark an incident as being open or closed, making it easier to keep track of those incidents where follow up is not yet complete.

The GER Resolution form has its own set of roles allowing for full control over who can view or edit the form. It works in both Oversight (State/County/Multi-State Provider) accounts and in regular provider accounts. Oversight providers can open a resolution for the GERs in the linked provider accounts.

### GER Resolution

Record investigation details for ongoing and closed investigation reports on a GER

### GER Resolution

Form ID: GERR-DEMO-F8E4XR8Z94968  
 Entered By: David Powell, Admin User on 02/21/2017 07:07 AM

Update History

#### GER Information

<b>Individual Name:</b>	Isabella Johnson	<b>Event Date:</b>	02/21/2017
<b>GER Form ID:</b>	GER-DEMO-F8E4XR8Z94968	<b>Approve Date:</b>	02/21/2017
<b>MIE Form ID:</b>	The corresponding GER is not linked to an MIE	<b>Notification Level:</b>	Medium
<b>Abuse/Neglect/Exploitation Suspected:</b>	No		

#### General Information

**Date Opened: \***

**Date Closed:**

**Status:**  Open  Closed

**Was this a critical event?**  Yes  No

**Is an investigation needed?**  Yes  No

#### Recommendations

**Recommended By:**

**Date Recommended:**

**Person Responsible:**

**Date Completed:**

**Recommendations:**

About 2940 characters left

Add

#### Inv

#### Supporting Documents

The total size of all attachments cannot exceed 10 MB.

File Name	Description	Size	Date	Attached By	Action
Isabella_meds.png		477.41 KB	01/03/2017	John Sanders, Admin User	Download   Remove

Total uploaded **477.41 KB** and remaining **9.53 MB**.

# Time Tracking

- ✔ Track behavior changes & activities
- ✔ Create templates for periodic data collection
- ✔ Analyze patterns from reports



This module is for monitoring behavior and other items such as sleep charts, CPAP, positioning, etc. of an individual over a time span at regular intervals. You can create Time Tracking Templates, listing up to 10 options, outlining what to track, what observations are expected, and the length of an interval. Each observation is assigned a color which helps identify patterns of behavior from the data collected.

## Informative Reports

You can generate comprehensive reports containing data recorded for a date range. The reports show the maximum, minimum and average durations and total counts for each of the observations recorded for an individual to determine the duration and frequency of an individual's behaviors.

# Behavior Tracking

- ✔ Track interventions
- ✔ Compare the frequencies of different behaviors
- ✔ Determine behavior trends
- ✔ Map behaviors to interventions

INTERVENTIONS	BEHAVIORS			
	Being Self	Crying	Yelling	Other
Choice Selection	DIS	REC	LOC	
Exercise	DIS	REC	REC	
Redirection	REC			
1-1 Time				
VERBAL REDIRECTION		LOC	DIS	
Line Of Sight Supervision	REC	LOC	LOC	
Other				

The Behavior Event Records (BER) module is used to record the details of behaviors of individuals and the intervention techniques for those behaviors. Individuals may have a behavior plan defined for them or have their BER recorded.

## Reporting Feature

The detailed reporting feature of the BER module allows you to generate the following four types of reports - Behavior Event Frequency, Behavior Intervention Frequency, Interval Frequency and Interval Percentage. The reports can be displayed

in tabular or graphical format for daily to yearly ranges. The reporting mechanism enables analysis of individuals' behavior patterns and assesses the effectiveness of interventions within a span of time.

## Interval Data

You can enter interval data on the occurrence of behaviors to note the number of instances of that behavior, in a day or an hour, allowing for accurately determining the frequency of an individual's behavior.

# Individual Home Page

Therap provides a concise yet comprehensive view of individual focused information. You can obtain summaries regarding an individual's health, allergies, medications and services received using the Individual Home Page.

- Individual Specific Notifications
- Identification Data
- Service Plans, Goal Tracking, Behavior Plans, Custom Forms
- Medications, Diagnoses and Allergies
- Program Enrollment Details

## T-Log Entry and Dashboard Count

The Individual Home Page includes a Home tab that allows for viewing documentation updates easily and direct data entry for the individual. These options include:

- Modules activated for the individual show up on the left hand side of the Individual Home Page which includes shift notes, daily logs, incident reports and more
- Individual specific Dashboard counts - Notifications for T-Log, ISP Data, ISP Program and GER
- Notifications for upcoming and overdue appointments and immunizations
- Option for data collection for the corresponding ISP Programs and Billing data entry for Services Authorizations
- Links to the Individual Data Form, Emergency Data Form, Individual History, and Health Passport

**Isabella Johnson** Switch Individual

Home Profile Plans Case Status

**Modules**

- ▶ Attendance
- ▶ Case Note
- ▶ Consent and Authorization
- ▶ Document Storage
- ▶ General Event Reports (GER)
- ▶ GER Resolution
- ▶ Health Tracking
- ▶ Individual Care Plan
- ▶ ISP Data
- ▶ ISP Program
- ▶ MAR Data
- ▶ T-Log
- ▶ Time Tracking

**Go To**

- Individual Data
- Emergency Data Form
- Individual History
- Employment History

**ISP Programs**

Name	ISP Data
Making Bread	New
Progress Notes	New
Communication	New
Writing Letters	New
Sketching	New

**Service Authorizations (Professional Claim)**

Name	Date Range	New
S5102 - Adult Day Training - Facility Based or Off Site	09/01/2016 - 12/31/2018	

**Service Authorizations (Institutional Claim)**

**Counts**

General Event Reports (GER)

Worklist 0 0 2

**Overdue**

**03/15/2017**  
Diphtheria-Tetanus (DT pediatric) should have been administered

**03/15/2017**  
BCG: Bacillus of Calmette & Guerin should have been administered

**Upcoming**

**03/22/2017**  
BCG: Bacillus of Calmette & Guerin should be administered

**03/22/2017**

## Profile

- Summary of the Individual Data form including **Medical Information, Guidelines, and Language and Ethnicity**
- Lists Active Medications, Allergies and Diagnoses
- **Contacts, team members,** and staff who have access to the individual's caseload
- **Photos:** Create photo albums and upload pictures

**Isabella Johnson** Switch Individual

Home Profile Plans Case Status

**Health Information**

Weight: 85 lb  
Date: 12/05/2016

Height: 5 ft  
Date: 12/05/2016

**Contacts**

Emily Mason (Guardian)

Open

**Go To**

Active Orders  
Team Members  
Involved Staff  
Album

**Identification Data**

Basic Information Medical Information Address And Timezone

Guidelines Language and Ethnicity Other Information

Show All Open

**Active Allergies**

poten extracts (Environment Allergy)  
Severity: Mild

nut - unspecified (Food Allergy)  
Severity: Moderate

penicillin G (Drug Allergy)  
Severity: Moderate

No Known Drug Allergy or Adverse Reaction: No

Comments: As a precaution, consult with a nurse or the direct care staff for meal plans.

Open

**Profile**

The Individual profile options offer users to view key individual information at a glance

## Plans

- The Plans tab of the Individual Home Page displays the approved plans designed for the individual, including available approved dates, review dates, start and end dates for each form
- Available plans include Behavior Plan, Care Plan, ISP Plan, Custom Form and more
- Count section displays counts for acknowledging ISP Plan, Individual Care Plan and Behavior Plan

**Ashley Wilson** Switch Individual

Home Profile Plans Case Status

**Counts**

Plan Type	Acknowledge	Count
ISP Plan	Acknowledge	1
Individual Care Plan	Acknowledge	2
Behavior Plan	Acknowledge	1

**Plans**

Name	Approved Date	Review Date	Start Date	End Date
Individual Care Plan - Individual Care Plan of Ashley Wilson	03/10/2017			
Medication Administration Assessment Tool	03/05/2017			
ISP Agenda	03/02/2017		08/04/2016	09/14/2017
Individual Support Plan	03/16/2017		02/03/2014	05/24/2017
Habilitation Plan (IRA Residential Habilitation Plan) - 9th street	02/18/2017	04/18/2017		

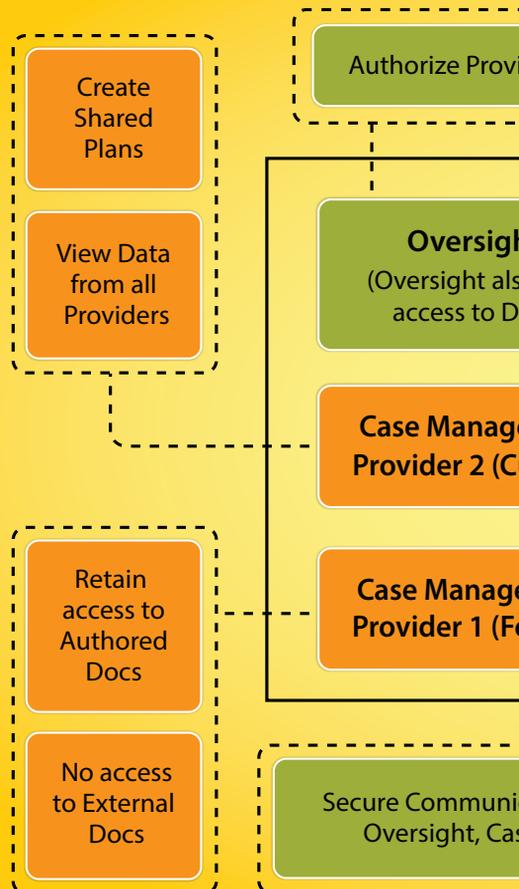
# Case Management & Oversight

Therap's Case Management system allows case managers to view information recorded for the individuals that they support across multiple provider agencies, while giving them the ability to document on individuals that they support within their own agencies. Through a combination of user types, profiles and caseloads pertinent to the case management system, users are able to sort the data that is relevant to them and to the individuals they support within their own agencies and beyond.

## Case Management

Case Managers can view person centric information including service plans, individualized case notes, incident reports, medication administrations and an assortment of other health records that range from doctor's appointments and scheduled lab tests to immunizations and active allergies. Case managers are also able to view documents created by day and residential providers outside of their agency with the help of a set of access privileges assigned by the State.

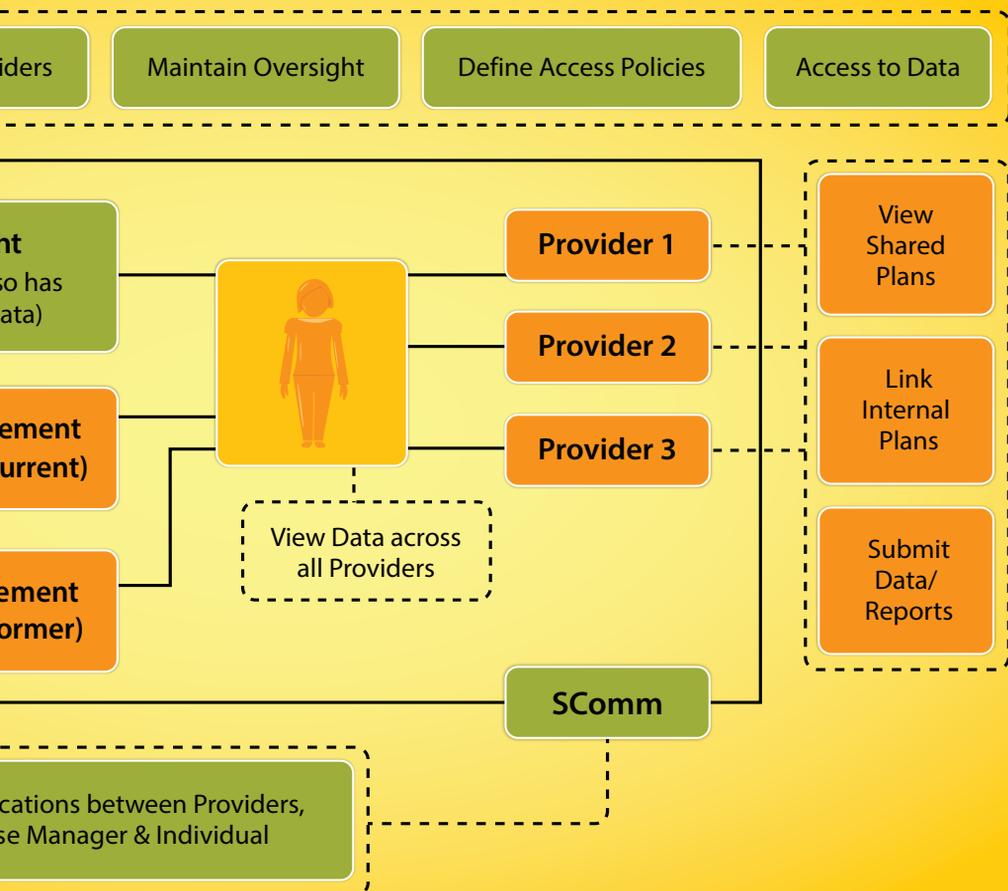
Contact your local Therap representative to learn more



Therap's Oversight accounts apply a unified access and data management to the documentation system in use, creating a unique solution for case managers, auditors and other state oversight personnel to access data across accounts. It allows for shared access to plans and viewable forms across multiple providers. Additionally, oversight accounts allow case managers and oversight users to authorize providers, define access and communicate across providers, securely to authorized users.

- Individual Intake
- Referral
- Eligibility
- Level of Care
- Waiting List
- Budget

## Shared Plan Access



# Medication Administration Record

- ✔ Track scheduled & PRN medications and treatments
- ✔ Check due/overdue medications
- ✔ Generate reports on medication administrations

With Therap's electronic Medication Administration Record, you get a tool with features designed to reflect the conventional kardex for administration of medications. This offers nurses and other staff a familiar interface for data entry on Therap's MARs.

## Flexible Scheduling and Efficient Administration

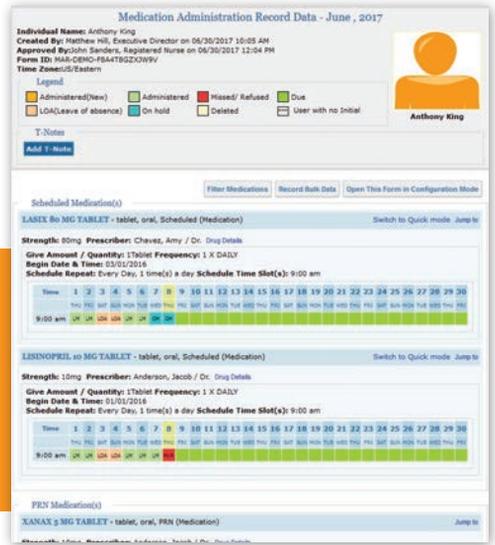
Medications can be scheduled automatically and manually on the MAR form. You can highlight respective cells on the grid to understand when medications are due for administration to individuals (for example, every other day). To schedule medications, you can select from an extensive list of items and specify the give amount/quantity, frequency, begin date, timing and schedule of the medication. Therap's electronic MAR significantly reduces the amount of time required by staff members to record medication administrations as they can record medications by single clicks on the cells of a grid.

## Color Coded Information

Color codes are provided for due medications, newly administered medications, previously administered medications, the current day, and others. These inform you of the current state of the MAR form.

## Due Medications

The Due Medications report can be used to generate a list of due medications for a particular date. This report also provides the functionality



of showing overdue medications. This tool can be effectively used to identify which medications need to be administered to an individual at a particular time and also to track if medication administrations are being carried out effectively within an agency.

## Interface with Industry Standard Drug Database

Therap's Medication History and MAR modules interface with First Databank database - one of the world's most comprehensive and trusted industry standard drug knowledge databases. This provides the modules with easy access to relevant drug information including identification, dosage information, precautions, side effects, and more. This substantially lowers the risk of medication errors and leads to informed decision making.



## Real-Time Notifications

You can choose to receive real time notifications when a MAR is locked for data entry, when information on medications have been updated, or when a medication has been recorded as missed or refused from being administered.

## Filters and Jumps

Therap allows you to filter medications for individuals by the medication types (e.g. PRN Medications or PRN Treatments), the program from where it was scheduled, or the time period

## Administer and record medications using Android devices

- View allergies, diagnoses, and images of medication
  - Access shared medical contacts
  - Reference data for reduced medication errors
- See more on page 43



during which a medication is to be administered. You can access the part of the screen where you want to record data using the 'Jump to' menu with just a single click.

## General Features

- Medication configuration and approval on the MAR form
- Staff's initials recorded when data is entered on the MAR form
- Time-stamped archives of a Medication History and complete audit trail for reviews
- Record medication purposes and comments from prescribers
- Bulk data entry when individuals are away from the program
- Download a variety of useful reports, exportable to Microsoft Excel, PDF for offline analysis, or printing

## MAR Configuration

MAR Configuration page displays medications for an individual for the current month. Scheduled medications or treatments are highlighted in green which makes the medication administration process seamless. It grabs the attention of users and informs them about when they need to administer medications to individuals. Details regarding PRN and other medications are also displayed on this page.

**Allergies**

nut - unspecified; pollen extracts

MAR Data Page

---

**Shared Contact**

Name	Organization Name	Specialty	Phone
James Lee	Demo Pharmacy 1	Allergy & Immunology	123-456-7890

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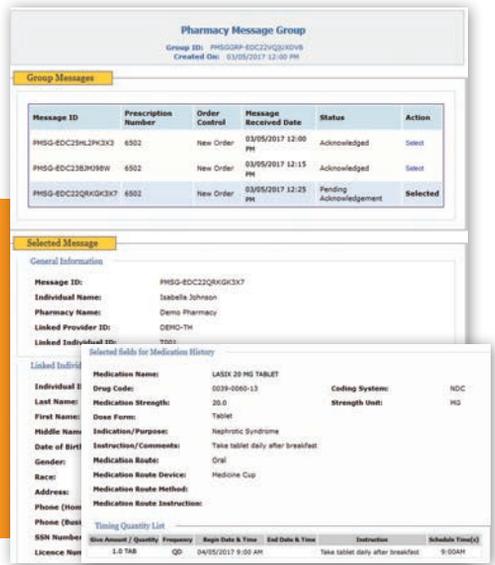
**Medical Diagnosis**

**Active Diagnoses**

ICD-10	DSM-5	ICD-9/DSM-4/Other	Axis	Description	Diagnosis Date	Diagnosed By
F32.1 - Major depressive disorder, single episode, moderate	Major Depressive Disorder, Single episode, Moderate	296.22 - Major Depressive Disorder, Single Episode, Moderate	Axis 1	Anthony loses interest in normal daily activities, feels hopeless, lacks productivity, and has low self-esteem during his bouts.	02/15/2016	Anderson, Jacob / Dr
F42 - Obsessive-compulsive disorder	Obsessive-Compulsive Disorder	300.3 - Obsessive-Compulsive Disorder	Axis 1	Anthony has reoccurring thoughts (obsessions) and behaviors (compulsions) that he feels the urge to repeat over and over.	02/17/2016	Anderson, Jacob / Dr

# Pharmacy Interface

- ✔ Interface with pharmacies and receive pharmacy messages
- ✔ Create medication history forms from pharmacy messages
- ✔ Reduced time between receipt of medications and medication input to MAR



Therap's Pharmacy Interface module allows for direct information exchange between provider agencies and the pharmacies they work with to receive updated medication information of individuals. With the pharmacy interface module, Therap users can link individuals in the pharmacy system to individuals on Therap to receive prescriptions and medication orders. Once linked, pharmacies will be able to send Pharmacy Messages to the agency.

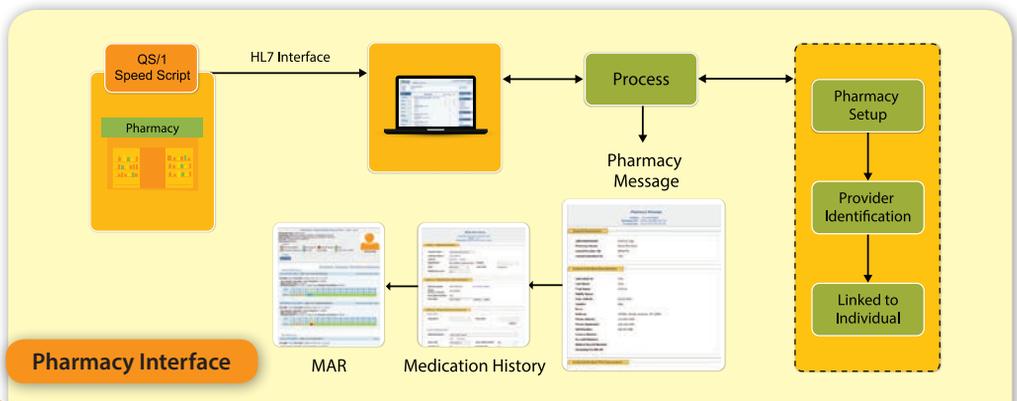
## Pharmacy Message

A pharmacy message contains various medication information for a particular individual such as the name of the medication, amount of medication to be administered, the administration details and much more. Once the pharmacy message is received by the provider agency, users are able to create Medication History forms directly from the message itself. Selected fields from the message will automatically populate into fields on the Medication History form, reducing the amount

of time users would otherwise need to copy information from one form to another. Additionally, the Medication History tool allows Registered Nurses and Licensed Practical Nurses to keep record of medications and update the medication information according to the required needs of the individuals. With the medication history tool, nurses have the necessary information to avoid or minimize medication errors.

## Pharmacy Message to MAR

While messages are received directly from pharmacies, Therap users have flexibility as to how the information is managed and recorded in the Therap system. RNs and LPNs use the medication administration records (MAR) module which is integrated with industry standard drug database First Databank (FDB) to track medications and the administrations. The medication orders associated with a pharmacy message can be tracked using the MAR module.



# eCHAT:

## Comprehensive Health Assessment

- ✔ Record & view health related information in a single form
- ✔ Maintain checklists for safety issues & risk factors
- ✔ Identify & document health needs
- ✔ Evaluate summarized health assessment records

**Comprehensive Health Assessment**

Individual Name: King, Anthony  
Form ID: CHAT-DEMO-FBE4XLY0Y7678  
Status: Approved  
Entered By: Matthew Hill, Executive Director on 06/12/2017 03:48 PM  
Last Updated By: John Sanders, Administrator on 06/13/2017 04:19 PM  
Approved By: John Sanders, Administrator on 06/13/2017 04:19 PM

Create Summary Report

<b>Reason for Assessment</b>	Quarterly Nursing Assessment
<b>ISP Effective date</b>	Date: 06/01/2017
<b>Date of Assessment</b>	06/12/2017 - 12/31/2017

Jump to

**Diagnoses and Conditions**

1	Active Diagnoses	ICD-10	ICD-9/DSM-4/Other	Axis	DSM-5	Description	Diagnosis Date	Diagnosed By
	F32.1 - Major depressive disorder, single episode, moderate	296.22 - Major Depressive Disorder, Single Episode, Moderate		Axis 1	Major Depressive Disorder, Single Episode, Moderate	Anthony loses interest in normal daily activities, feels hopeless, lacks productivity, and has low self-esteem during his bouts.	02/15/2016	Jacob Anderson/ Dr
	F42 - Obsessive-compulsive disorder	300.3 - Obsessive-Compulsive Disorder		Axis 1	Obsessive-Compulsive Disorder	Anthony has recurring thoughts (obsessions) and behaviors (compulsions) that he feels the urge to repeat over and over.	02/16/2016	Jacob Anderson/ Dr

**Other Medical Information**

**Historical/Inactive Diagnoses or Conditions** N/A

1.n **Comments** Diagnoses are most recent and active.

The Comprehensive Health Assessment Tool, also known as eCHAT, provides health and support professionals with an exhaustive list of options to conduct health evaluation of an individual.

It is an online assessment of an individual's health, symptoms, and history. It works out the overall acuity level and creates a summary of health assessment along with recommendations where greater care may be required.

# Care Plan

- ✔ Identification of problem, goal and approaches of care
- ✔ Tailored Care Plan for each individual
- ✔ Nurse-approved standard Care Plan templates

**Individual Care Plan of Wilson, Sophia / 123456**

Form ID: ICP-DEMO-FBE4Z42H4995  
Status: Approved  
Author: Karen Henderson, Registered Nurse on 06/18/2017 11:02 AM  
Submitted By: Karen Henderson, Registered Nurse on 06/18/2017 11:04 AM  
Approved By: Steven Hall, Supervisor on 06/18/2017 03:06 PM  
Last Updated By: Steven Hall, Supervisor on 06/18/2017 03:06 PM  
Time Zone: US/Central

Jump to

**Individual Care Plan**

**Care Plan Name:** Asthma Care Plan

**Problem(s):** Wheezing, difficulty in breathing.

**Goal(s):** Individual will manifest signs of decreased respiratory effort.

**Approach(es)**

Approach	Responsible Party
Encourage deep breathing and coughing exercises.	Health Care Practitioner(s)
Encourage opportunities for rest and limit physical activities.	Health Care Practitioner(s)

**Attachment(s)**

File Name	Description	Size	Date	Attached By
Instructions.docx	Contains detailed instructions on how to care for individual	9.87 KB	06/18/2017	Karen Henderson, Registered Nurse

Jump to

**Reviews**

Reviewed By	Comment
Name: Steven Hall Title: Supervisor Review Date: 06/18/2017 3:06 PM	This has been reviewed.

Jump to

**Team Meeting Discussions**

Notes	Meeting Date	Documented By
Sophia needs to see physician next Monday.	06/26/2017	Steven Hall on 06/18/2017

The Care Plan module provides a platform for documentation of standard Care Plans for individuals. It comes equipped with Standard Care Plans in the Global Template Library which had been approved by a panel of experienced nurses.

Using this module, Care Plans can be created for each problem with clearly identified

goals and required approaches. This module also allows features like:

- Team Meeting Discussions
- Tracking Acknowledgment of Plans
- Sharing Care Plans Globally
- Tracking Care Plan Reviews and Comments
- Delete Individual specific Care Plans

# Billing

- ✔ Generate billing units from attendance, service data and direct input
- ✔ Submit 837P and 837I Claims electronically and/or manually
- ✔ Create billing reports for Utilization, statistical analysis & accounting uploads

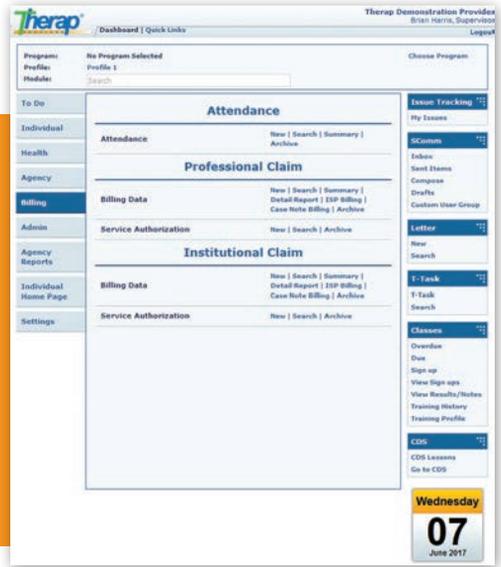
Therap's Billing solutions are designed to be effective tools for finance departments, executives, program managers, and case managers. These Billing modules can be used for Medicaid billing services by doctors, nurses, healthcare professionals, or other staff involved in the billing cycle of an I/DD agency, state or county.

Therap provides options to generate billing from service documentation - ISP Data, attendance (per diem, hourly, monthly units) or direct input e.g. mileage tracking, employment supports, etc. Then, you can submit and track 837P and 837I claims electronically. Therap Billing support features a number of reports for claim status, attendance and utilization of service units.

To learn more about **Case Notes**, see page 38

## Administrative Features

Therap Billing support includes creation of a master record of services that contains the rendering or billing provider such as Adult Day Training, Residential Habilitation (ResHab), Supervised IRA, PREVOC, ICF, etc., service description/codes, procedure modifier, unit of measure/rate, cost center type, and claim type: professional or institutional. Funding sources or payer information such as Florida Medicaid, KMAP, eMedNY, MNITS, DMAP, etc., can be identified as electronic or manual claim status. The information stored in the administrative sections is used in the process to create both Institutional and Professional claims.

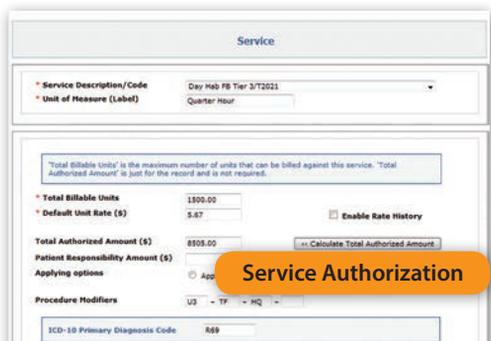


## Service Authorization

Record services provided such as Day/Residential Habilitation, in-home supports, personal care and many more.

- Authorize number of units per period (daily, weekly, monthly, quarterly, half yearly, yearly) for billing
- Automatic notifications of low balance and expiration dates
- Methods of data collection: Direct Billing Data input, Attendance, ISP Data and Case Note
- Unit rate history tracking

For each authorized service, the funding source, authorization period, type of unit, unit rates, procedure codes, unit limits per period and authorized amounts are specified. The system provides the flexibility to set the maximum units for daily, weekly, monthly, quarterly, half-yearly and yearly consumption. With service authorizations in place, you are ready to track billing units from billable service records, attendance logs, ISP goal tracking data and billable Case Note records.



## Attendance

The Attendance module allows comprehensive recording of attendance data for individuals receiving services with options to track time in/out and use flags to mark present/absent. It allows updating, approving and generating billing for the recorded attendance data from the same page. You can record and update attendance data for multiple individuals for multiple services using the attendance grid, and even view details of an attendance type.

Attendance features include the following:

- Time calculation of units for billing data
- Per diem, hourly, monthly units
- Track billable/non-billable units (present, absent, hospital, training days)
- Direct entry of Billing Units from Attendance
- Rounding algorithms: half up, half down, round up, round down, quarter up, quarter down, three quarter up, three quarter down, none
- Multiple time in/time out entries per day
- Robust search mechanism
- Record, update, and approve Attendance to generate billing data

- Use attendance data to generate statistics and other reports

You can search for attendance data with automated filtering mechanism and generate automated attendance reports including attendance record report, attendance statistics report, and attendance summary. Authorized users will be able to view printable version of attendance data to use for official purposes.

### ISP Data as Supporting Document

Therap now provides a flexible link to ensure that when attendance data is collected, there is also the appropriate amount of supporting documentation being done using ISP Data.

When setting up (or updating) attendance you can define whether to look for any ISP Data, ISP Data at a particular location, or a specific ISP program. Then for each attendance option you can define how many ISP Data entries are required to make a billable session. Upon approval and prior to the generation of billing data, any entry that does not have enough supporting ISP data will be marked with a red box and a warning is given that there is insufficient supporting documentation.

**Attendance**  
 Program(Site): 1st Street Group Home(Group Home)  
 Service Description (Code): Adult Day Training - Facility Based or Off Site(SS102)  
 Attendance Type Name: ADT Attendance  
 Start Date: June, 01, 2017; End Date: June, 05, 2017  
**June, 2017**

Attendance Type Details

Input Update Approve Generate Billing Data Change Service: Adult Day Training - Facility Based or Off Site

Attendance Options: Present (P) - [Billable]  
 General Comment:  
 350 characters left

Time In: 8:15 am [Now]  
 Time Out: 2:15 pm [Now]  
 Service Provider: Jacob Anderson, Case Manager  
 Non Billable:

Select All Attendance Show All:  Incomplete  In Prep  Approved  Submitted for Billing

Individual Name	1 Thu	2 Fri	3 Sat	4 Sun	5 Mon
Johnson, Isabella	P [Icon]	A [Icon]	P [Icon]	A [Icon]	P [Icon]
Smith, Jacob	P [Icon]	A [Icon]	P [Icon]	[Icon]	[Icon]
Williams, Ethan	P [Icon]	[Icon]	P [Icon]	A [Icon]	[Icon]
Green, Emily	P [Icon]	A [Icon]	P [Icon]	A [Icon]	P [Icon]
Wilson, Sophia	P [Icon]	A [Icon]	P [Icon]	[Icon]	P [Icon]

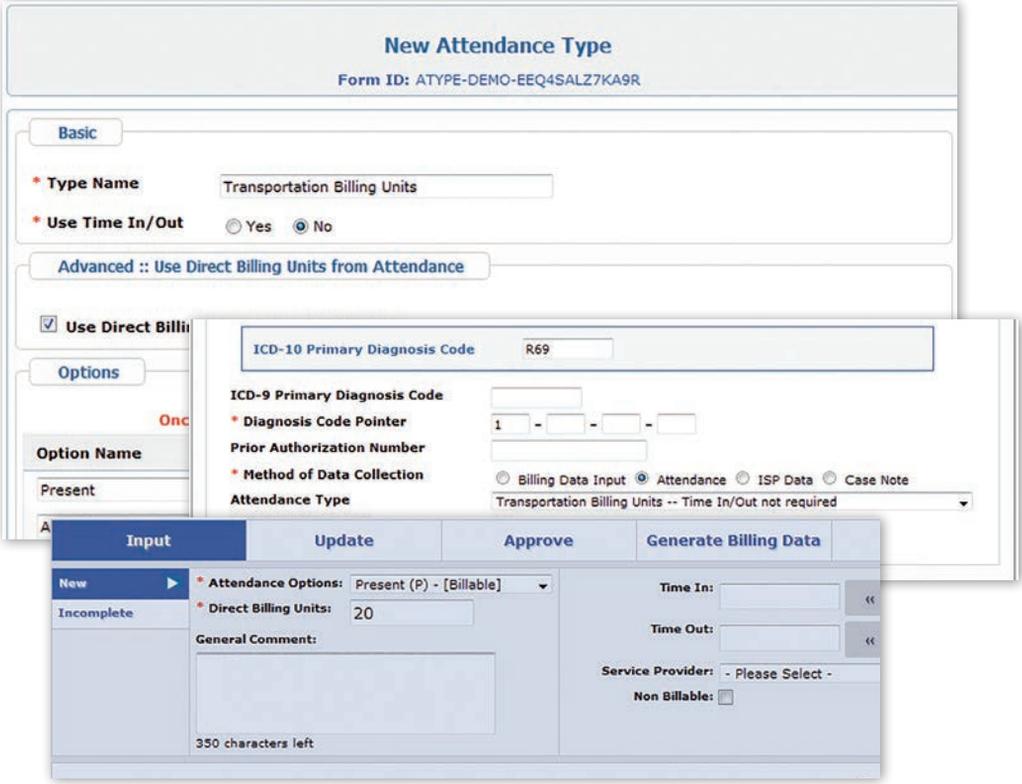
Attendance Report Statistics Report

Attendance

### Direct Billing Units from Attendance

Therap now provides users with the flexibility to enter billable units directly from Attendance in order to allocate the correct units to each attendance entry when the units worth of services provided on the days are different

and depend on factors such as mileage when providing transportation services. When entering (or updating) attendance data you can directly allocate billable data. For each billable attendance entry you can allocate the number of units worth of service that has been provided.



### Claims & Utilization Reports

With Therap's electronic billing, agencies can create Professional and Institutional claims in ANSI X12 837 format, and submit claims electronically to state Medicaid, ensuring compliance with HIPAA 5010 Electronic Billing Standard. Claims, generated in a printable PDF format, can be submitted manually to private payers. For submitted claims, Therap automatically updates status with information received from Medicaid and from uploaded X12 835 remittance reports.

- Track unclaimed billing data that result from administrative errors
- System reader produces RA, claim status, EOB- adjustments
- Medicaid data requirements validation: name, DOB, Medicaid number, gender and address
- Generate reconciliation reports to view paid amount, payer name, check number, etc.
- Track service units utilized and remaining over a period of time, and view remaining days, expiration status and unit costs with the utilization report

- Submit claims on daily, weekly, semi-monthly, and monthly cycles, with bundled or individual claims for each service line
- Create recurring claim templates with billing, rendering provider, service code and prior authorization numbers
- Send void and replacement claims with associated TCN/ICN numbers
- Resubmit denied or rejected claims

Therap has Trading Partner Agreements with MMIS vendors, ACS/Xerox, EDS/HP & CSC for Medicaid claim submission in several states. Therap acts as a billing agent for providers throughout the US for Professional and Institutional claims.

### Billing Summary Report

Enables ad-hoc reporting by selecting output columns from a range of options including service provider's name, agency name, begin and end date, billable/non-billable units, unit rate, funding source, authorization number, service description/code, claim ID and more.

### Utilization Report

Tracks service units utilized and remaining over a period of time. It can further chart percentages of total utilization and remaining service units, and provide a view into remaining days, expiration status, and unit costs. This report can be generated monthly or annually.

### Attendance Summary

View summarized information on individual's attendance and customize columns according to your preference for attendance type, attendance data form ID, and billable time slot among other fields.

### Claims & Utilization Report

### Unclaimed Report

Displays month, service code and description, program and site, individual names and billing data count for services which have not been claimed yet. This report can be generated monthly or half-yearly.

### Aging Report

View claim age based on claim create date, queued date, sent date or service date, by setting an aging date and claim information, by selecting output columns from a range of options including claim status, program cost center number, total amount, paid amount and more.

### Utilization Report

Track service units utilized over a given period of time

**Professional Claim**  
 Form ID: CLM-DEMO-F3C4PUBZ8F28Q  
 Status: Billable  
 Created By: Steven Hill, Supervisor  
 Create Date: Tue, 10 Jan 2017 12:18:53 AM

**Claim Information**

Payer: Manual Billing  
 Billing Provider: DEMO Billing Provider (EIN: 12-3456789, NPI# 0987654321)  
 Referring Provider: DEMO Billing Provider (EIN: 12-3456789, NPI# 0987654321)  
 Service Facility Location: Select  
 Individual Name: Smith, Jacob (Medicaid Number: )  
 Signature On File: Yes  
 Place Of Service: 14-Group Home  
 Claim Frequency Type Code: 1-Original (Admit thru Discharge Claim)  
 Release of Information Code: C-Not Assigned  
 Patient Signature Source Code: Y-Yes, Provider has a Signed Statement Permitting Release of Medical Billing Related to a Claim  
 Billing Indicator: Medicaid  
 Payer Responsibility: Self  
 Special Program Code: Select  
 Primary Diagnosis Code: ICD-10: R69  
 Delay Reason Code: Select  
 Prior Authorization Number: Select

**Service Lines**

Delete #	Billing Data ID	Date of Service	Service Code	Service Description	Procedure Modifiers	Primary Diagnosis Code	Diagnosis Code	Unit rate (\$)	Billable Units	Unit of Measure	Amount Billed (\$)	Paid #
1	BILL-DEMO-F3C4PUBZ8F28Q	12/05/2016 - 12/05/2016	82021	Day HMB FB Tier 3	US-TF-HQ	R69	1	\$7.00	24	Quarter Hour	\$168.00	
2	BILL-DEMO-F3C4PUBZ8F28Q	12/05/2016 - 12/05/2016	82021	Day HMB FB Tier 3	US-TF-HQ	R69	1	\$7.00	22	Quarter Hour	\$154.00	
3	BILL-DEMO-F3C4PUBZ8F28Q	12/05/2016 - 12/05/2016	82021	Day HMB FB Tier 3	US-TF-HQ	R69	1	\$7.00	22	Quarter Hour	\$154.00	
4	BILL-DEMO-F3C4PUBZ8F28Q	12/05/2016 - 12/06/2016	82021	Day HMB FB Tier 3	US-TF-HQ	R69	1	\$7.00	24	Quarter Hour	\$168.00	
5	BILL-DEMO-F3C4PUBZ8F28Q	12/07/2016 - 12/07/2016	82021	Day HMB FB Tier 3	US-TF-HQ	R69	1	\$7.00	24	Quarter Hour	\$168.00	

Total Claim Amount (\$) 791.00  
 Amount Paid (\$) 0.00  
 Patient Responsibility Amount (\$)

### Billing Reports

With Billing module reports, you can chart percentage utilization from total units of service, view TCN/ICN numbers, billing provider, total amount paid, and an overall summary. Billing reports can be used for A/R revenue report and cash management statements.

### Reconciliation Report

Generate reconciliation information with 49 elements including program cost center number, site cost center number, description/code account number, funding source, funding source vendor ID and more. Reconciliation Reports also indicate total amount to be paid for a particular payer.

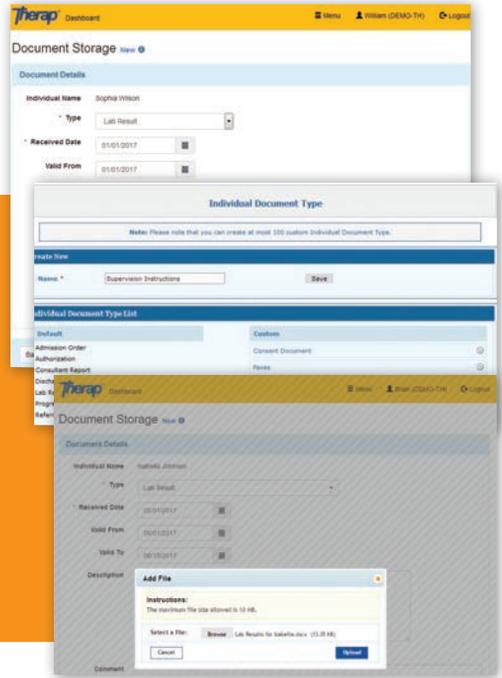
### Denied Claim Report

Displays claim ID, queue date, and total amount for the list of denied 837 Professional and Institutional claims.

Individual Name	Medicaid No.	Authorization ID	Prior Auth Number	Begin Date	End Date	Remaining Days	Expire Status	Total Auth Units	Total Used Units	Total Amount	Utilization (%)	Current Remaining Units of this Service
<b>Service Description: Adult Day Habilitation - Facility Based/ S6102</b>												
Smith, Jacob		SA-DEMO-EDFAWCR26F287		01/01/2015	03/25/2017	291	Active	1000	16	128	1.6	984
									16.00	128.00		
<b>Service Description: Supported Employment-Job Training/ H2023</b>												
Smith, Jacob		SA-DEMO-EH2HWKUZGD8V		01/01/2013	03/25/2017	291	Active	800	9.5	95	1.19	790.5
									9.50	95.00		
<b>Service Description: WORK SUPPORT (supported employment) (Maine)/ H2023</b>												
Smith, Jacob		SA-DEMO-EDRAN2XJHG08Q		01/01/2014	01/30/2017	291	Active	1200	302.5	3630	25.21	897.5

# Document Storage

- ✔ HIPAA compliant storage for external documents
- ✔ Documents collected in a central location
- ✔ Customization of document types
- ✔ Quick reference to document validity
- ✔ Attach documents in multiple formats



The Document Storage module has been designed to enable storing of external documents relating to an individual or agency in order to view those documents from one convenient place. Different types of external documents including admission/discharge orders, authorizations, consultant reports, historical paperwork, and referral documents can be stored. The types of documents that are stored can be customized by administrators at provider level to suit agency requirements.

## Agency Specific Documents

The Document Storage module allows you to store agency-specific documents. Users with the appropriate administrative access privileges will be able to add and search for agency-specific documents stored in the Document Storage module. Details such as Type, Received Date,

and Description can be recorded in these documents. Additional details such as Validity Range and Comments can be added while storing agency-wide documents.

## Additional Storage Space

The Document Storage module allows you to upload files up to 10 MB in size. The total storage limit per individual varies from provider to provider according to the storage capacity requested by Provider Administrators. Additional space can be added to Document Storage module.

This screenshot shows the main Document Storage interface. At the top, there are 'Document Details' for an 'Admission Order' received on 01/01/2017 and valid until 12/31/2017. Below this is a table listing documents. The table has columns for Form ID, Description, Upload Date, Updated Date, Type, Received Date, File Size, and Document. Below the table are options to 'Export To Excel' and 'New Search'.

Form ID	Description	Upload Date	Updated Date	Type	Received Date	File Size	Document
DOC-DEMO-F4T4KTVMCQXY6	Orders for admission of individuals	02/05/2017	02/28/2017	Admission Order	02/01/2017	9.711 MB	order.pdf
DOC-DEMO-F4H2QYX3R98WVN	Referral document	02/15/2017	02/15/2017	Referral	02/01/2017	1.000 MB	New_Referral.jpg
DOC-DEMO-F4H2QUB9E98WU	Contains admission order details	02/11/2017	02/11/2017	Admission Order	02/01/2017	1.000 MB	order2.pdf
DOC-DEMO-F3A2PYMKX3Q	Training details for new staff	01/08/2017	01/08/2017	Training Material	01/01/2017	0.005 MB	Training.docx

# Employment History

- ✔ Document employment services & supports in real time
- ✔ Record service data as they are provided
- ✔ Document from a convenient location in the home or community

Therap's Employment History module allows providers to document employment services and supports in real time as services are being provided in the community, at the work site or at a program setting. The Employment History module enables providers to track information essential for the individual's employment. Users with administrative privileges are able to create new templates that include employers, contact persons, and jobs for individuals. This module has an integrated search engine which can be used to search jobs and employers. Using this search engine, suitable jobs can be located depending on the needs of an individual.

## Employment Referral

Employment Referral allows you to record referral information about an individual's Employment History. You will be able to record

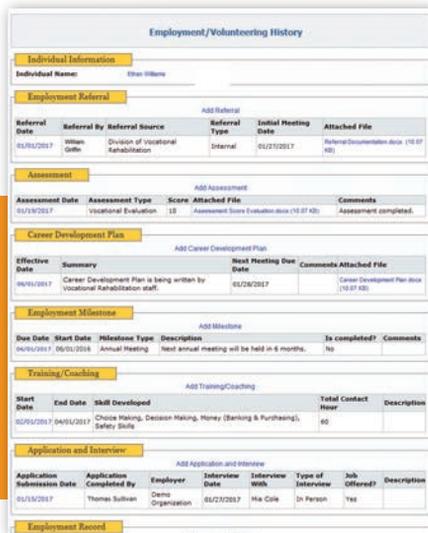
source of referral, referral type, referral date, and other information related to an Employment Referral in this section. External documents can also be attached here.

## Assessment

The Assessment score and date can be recorded in this section of the module, along with the type of assessment, from a pre-populated drop down list. Additional comments and external attachments can be added to the assessment form.

## Career Development Plan

This feature helps to plan and keep track of the career development of an individual. You will be able to enter effective date and document the summary of the career development plan in this form.



Employment Referral						
Add Referral						
Referral Date	Referral By	Referral Source	Referral Type	Initial Meeting Date	Attached File	
01/01/2017	William Griffin	Division of Vocational Rehabilitation	Internal	01/27/2017	Referral Documentation.docx (10.07 KB)	

Assessment					
Add Assessment					
Assessment Date	Assessment Type	Score	Attached File	Comments	
01/19/2017	Vocational Evaluation	10	Assessment Score Evaluation.docx (10.07 KB)	Assessment completed.	

Career Development Plan				
Add Career Development Plan				
Effective Date	Summary	Next Meeting Due Date	Comments	Attached File
06/01/2017	Career Development Plan is being written by Vocational Rehabilitation staff.	01/28/2017		Career Development Plan.docx (10.07 KB)

## Employment Milestone

The Employment Milestone feature of this module allows you to create Milestones for an individual's career. Different types of milestones such as job discovery, annual meeting, completion of trainings etc. can be recorded under Employment Milestone. Users will also be able to document milestone types, start date and due date of milestones in the Employment Milestone form. Milestones related to job placement, stability and 30-60-90-120 day bench-marks and comments can be noted.

## Training/Coaching

Training and coaching information of an individual can be recorded here. You are able to select skills developed from a given list. Total contact hours along with the start date and end

date of the training/coaching program can be recorded in this form.

## Application and Interview

The application and interview information such as application submission date, interview date, type of interview, employer name etc. can be entered in this section of the module. To allow more flexibility, there is a section for entering detailed description of the application and interview on this form.

## Employment Record

Details of an individual's previous and current job information is recorded under this section of the module. Job details such as the position title, contact person, benefits, work schedule, job type, etc. can be stored under the Employment Record section.

**Employment Milestone**

[Add Milestone](#)

Due Date	Start Date	Milestone Type	Description	Is completed?	Comments
06/01/2017	06/01/2016	Annual Meeting	Next annual meeting will be held in 6 months.	No	

**Training/Coaching**

[Add Training/Coaching](#)

Start Date	End Date	Skill Developed	Total Contact Hour	Description
02/01/2017	04/01/2017	Choice Making, Decision Making, Money (Banking & Purchasing), Safety Skills	60	

**Application and Interview**

[Add Application and Interview](#)

Application Submission Date	Application Completed By	Employer	Interview Date	Interview With	Type of Interview	Job Offered?	Description
01/15/2017	Thomas Sullivan	Demo Organization	01/27/2017	Mia Cole	In Person	Yes	

**Employment Record**

[Add Employment Record](#)

<b>Position Title:</b>	Assistant Staff (Current)	<b>Organization Name:</b>	Demo Organization
<b>Job Type:</b>	Paid	<b>Job Duration:</b>	12/01/2017 -
<b>Wage per Hour:</b>	\$10.00	<b>Effective Date:</b>	12/01/2017
<b>Hours per Week:</b>	35	<b>Hours of Support per Week:</b>	
<b>Contact Person:</b>	Jacob Anderson, Assistant Supervisor	<b>Work Schedule:</b>	Day
<b>Benefits:</b>	Dental, Paid Sick Leave		

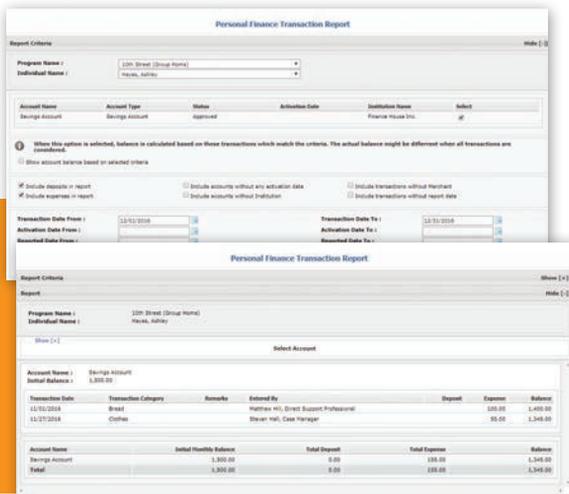
Job Outcome Data List

## How to enable this module for your agency?

For existing Therap users, an administrator at the agency will need to make a request to Therap's Regional Sales Representative to purchase the module for their agency. Contact a Regional Sales Representative at 203-596-7553.

# Personal Finance

- ✔ Define different types of finance accounts
- ✔ Record details of deposits & expenses
- ✔ Generate reports of an individual's transactions



The Personal Finance module posts current account balances for each individual's assets, funeral trusts, saving accounts, consolidated fund accounts, cash on hand, expenses and incomes (social security, room and board, wages etc.) in real time. You can record various information including transaction category, date, amount, check, and receipt numbers. You can also attach scanned or electronic copies of transaction receipts for each transaction. Individuals, case managers, family members, guardians and program staff, and auditors can view these transactions.

It can provide consolidated master reports on assets, post scanned documents of receipts, and generate expense reports re-determinations for Medicaid. For each individual, you can generate a report that includes all of their accounts or selected ones. The report can be generated for particular types of transactions as well, such as expenses on food and entertainment, or cash deposits or deposits from work, etc. These reports show periodic trends. Sorting the report by institutions and merchant allows more flexibility in how the reports are generated.

Personal Finance Transaction



**Form Information**

Individual Name : Wilson, Sophia  
 Program Name : 10th Street  
 Site Name : Group Home

**Transaction Information**

To maintain chronology of transactions on s... tion recor...

Deposit / Expense Type *	Account Name *	Transaction Category *	Transaction Date *	Amount	Check / Receipt #	Remarks	Attachments
Expense ▼	Please Select ▼	Please Select ▼	03/01/2017	200			Attach Scan
Deposit ▼	Please Select ▼	Please Select ▼	03/01/2017	50			Attach Scan
Expense ▼	Please Select ▼	Please Select ▼	03/05/2017	140			Attach Scan
Expense ▼	Please Select ▼	Please Select ▼	03/07/2017	50			Attach Scan
Please Select ▼	Please Select ▼	Please Select ▼					Attach Scan
Please Select ▼	Please Select ▼	Please Select ▼					Attach Scan
Please Select ▼	Please Select ▼	Please Select ▼					Attach Scan
Please Select ▼	Please Select ▼	Please Select ▼					Attach Scan
Please Select ▼	Please Select ▼	Please Select ▼					Attach Scan

**Personal Finance Account 1**  
Regular Expenditures

- Expense - Food
- Expense - Movie
- Walk in the park, expense - Soda

**Personal Finance Account 2**  
Main Account

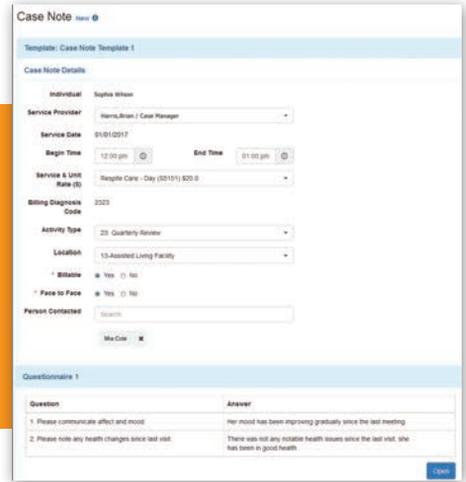
- Income - Part-time work
- Major expense - Clothes
- Transfer to second account

**Personal Finance Transaction Report**  
Comprehensive report that can show all the transactions and their types, for the accounts separately or both accounts at once

Clear Form 

# Case Notes

- ✔ Detailed record of meetings/sessions
- ✔ Billable Case Notes
- ✔ Linking to service authorizations and questionnaire
- ✔ Configurable templates



The Case Note module is a private area to record information or counselling sessions. Provider Administrators can create templates for Case Notes with Location, Activity Type, Time Format, and Questionnaire. Approved and Default Templates can be selected for the agency, where fields from the Template auto-populate on the Case Note. There is also the ability to add questionnaires to the Case Notes.

Case Notes can be determined as billable and can be linked to the individual's Service Authorization. Persons who were present at the meeting can be noted down on the Case Note. The text area has a 30,000 word character limit which is helpful for recording detailed description of the meeting and any relevant information. Files of up to 10 MB can be attached to the Case Note.

## Case Note Template

**Template Details**

<b>Name</b>	Case Note Template 1		
<b>Time Format</b>	Begin-End Time		
<b>Show Billable</b>	Yes	<b>Required?</b>	Yes
<b>Show Face to Face</b>	Yes	<b>Required?</b>	Yes
<b>Location(s)</b>	• 1st Street		
<b>Activity Type(s)</b>	• Planning		
<b>Questionnaire</b>	Questionnaire 1		

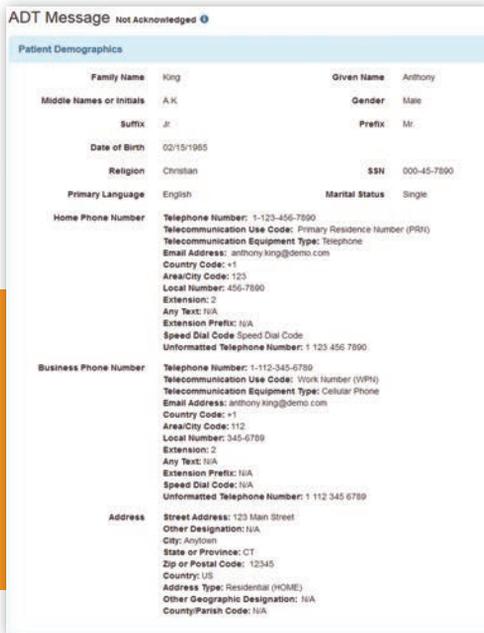
Cancel
Back
Discontinue

### Billable Case Notes

Case Notes marked as Billable generate professional claims for services provided. Service Authorization may also be set up so that Case Note is utilized as the method for data collection. Users can define how billable units are to be calculated from Case Notes. They can use the Unit Calculation Rule option, which allows them to select bundles rules (bundle for each day or for a date range), time in/time out and rounding algorithms.

# Health Information Exchange

- ✔ Receive individual admit, discharge and transfer information
- ✔ Acknowledge ADT Messages
- ✔ Create Medical History from ADT Messages



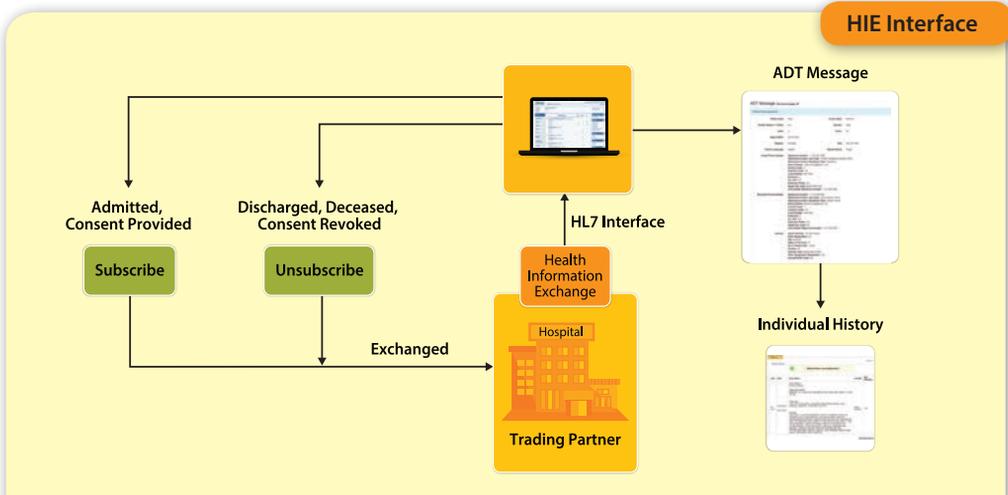
Therap has introduced the Health Information Exchange (HIE) module for the ease of exchange of health information between hospitals and agencies using Therap Applications. With the help of this module, Admit Discharge Transfer (ADT) Messages regarding individuals can be sent by the hospitals i.e. Trading Partners to agencies in HL7 format, allowing flexible tracking and maintaining of individual admit, discharge and transfer information.

## ADT Message

An individual's demographics, hospital visit information, observation results, diagnoses and allergies are some of the information which are conveyed in ADT Messages to ensure caregivers have access to each individual's updated information.

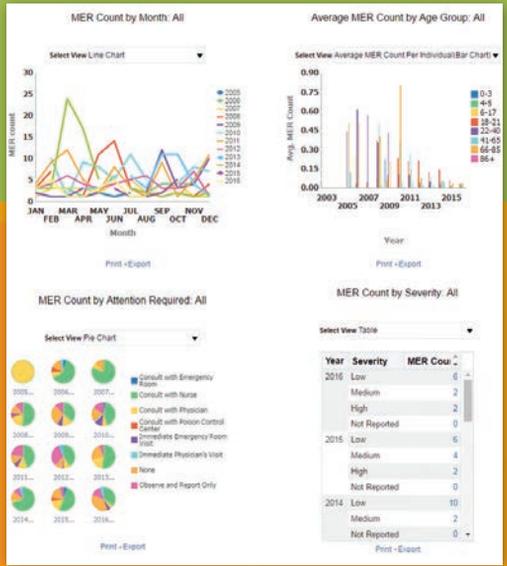
## Individual History

The Individual History module enables users to access and record historical information of individuals they support. Users can keep track of complaints, history of illnesses, family history, reviews, status and much more while accessing necessary medical information from one form. Once the provider agency receives the ADT message regarding an individual, the information may then be acknowledged and imported to the Individual History forms as a new medical history for the individual. Availability of these information in one specific location helps caregivers obtain an overview of an individual's historical details, allowing them to take decisions accordingly.



# Business Intelligence

- Meaningful reports and trends
- Identification of trends to evaluate agency-wide performance
- Data mining and presentation of intuitive graphical dashboards



Therap has introduced the Business Intelligence module for aggregating agency-wide data and serving meaningful reports for various modules. Using Business Intelligence module, Providers are able to create meaningful aggregate data reports/ dashboards that allow for identification of trends, execution of quality assurance activities, and assessment of overall agency performance in supporting individuals. Two Business Intelligence Dashboards are available for agencies: Demographic Dashboard and GER Dashboard.

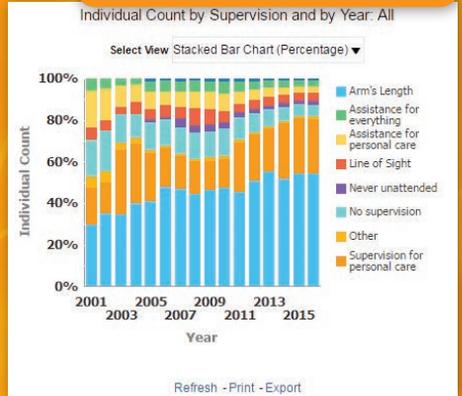
## Demographic Dashboard

The Demographic Dashboard provides aggregated reports on individual demographic data, allows for aggregation and comparison of data across providers and programs. Providers can recognize and respond to patterns at different levels of their organizations using the Demographic Dashboard.

Users can generate graphs in different forms such as:

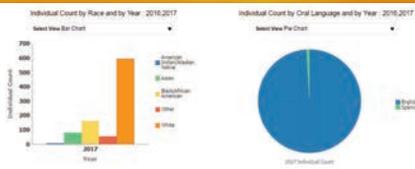
- Bar Chart
- Stacked Bar Chart
- Pie Chart
- Stacked Pie Chart
- Table

### Individual Count by Supervision



Individual Count by Age Group and by Year: All

Age Group	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
0-3	2	3	0	0	1	3	3	3	2	1	10	12	11	9	7	9
4-5	0	1	4	3	0	0	0	1	2	2	4	6	5	11	8	6
6-17	3	2	3	4	8	10	12	14	15	16	24	29	34	46	52	56
18-21	7	8	11	12	16	24	36	42	55	76	97	107	121	141	160	152
22-30	2	3	7	8	13	22	36	46	51	62	69	80	87	102	114	127
31-45	0	1	1	3	3	2	5	5	8	9	17	20	28	29	48	48
46-65	0	0	1	1	2	1	0	4	4	4	8	12	14	10	23	27
66+	0	0	0	0	0	0	2	0	0	0	0	0	0	0	1	1



### Demographic Dashboard

View individual count by Age Group, Race, Oral Language, Supervision, Gender and more

# GER Dashboard

The GER Dashboard provides the ability to identify GER (Incident Reports) trends at the state, provider, program type, and program levels. Providers can perform comparative analyses of variables including type, cause, severity, and location of incidents to enhance overall quality assurance and reduction of incidents.

Oversight Providers can view information for both Oversight agency and Linked agencies in order to get a quick overview of the vast number of individuals being provided services.

## GER Dashboard for Other Events



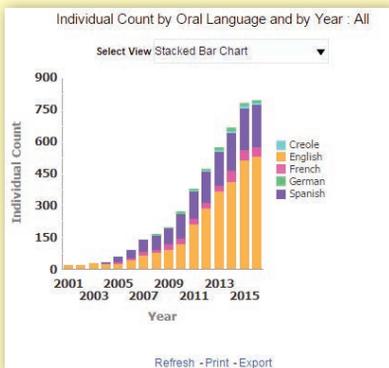
For more information on how to enable the Business Intelligence Dashboards for your agency, please contact us at [sales@therapservices.net](mailto:sales@therapservices.net)

## General Dashboard



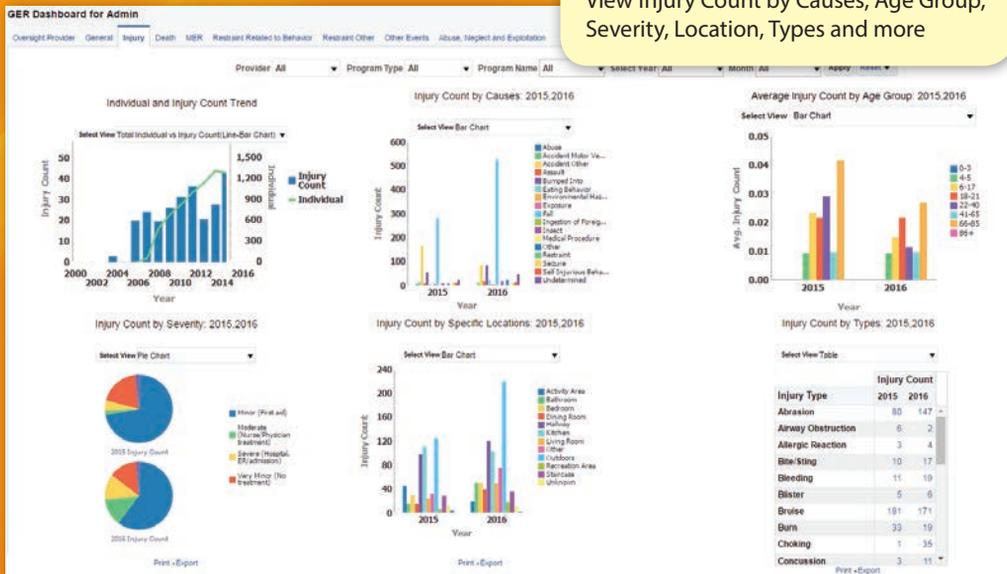
## Dashboard Features

Dashboards can be customized, and users can select multiple favorite dashboards. Default dashboards and graph types can also be selected for easier access. Generated graphs can be exported to Excel, PDF, CSV, and other formats.

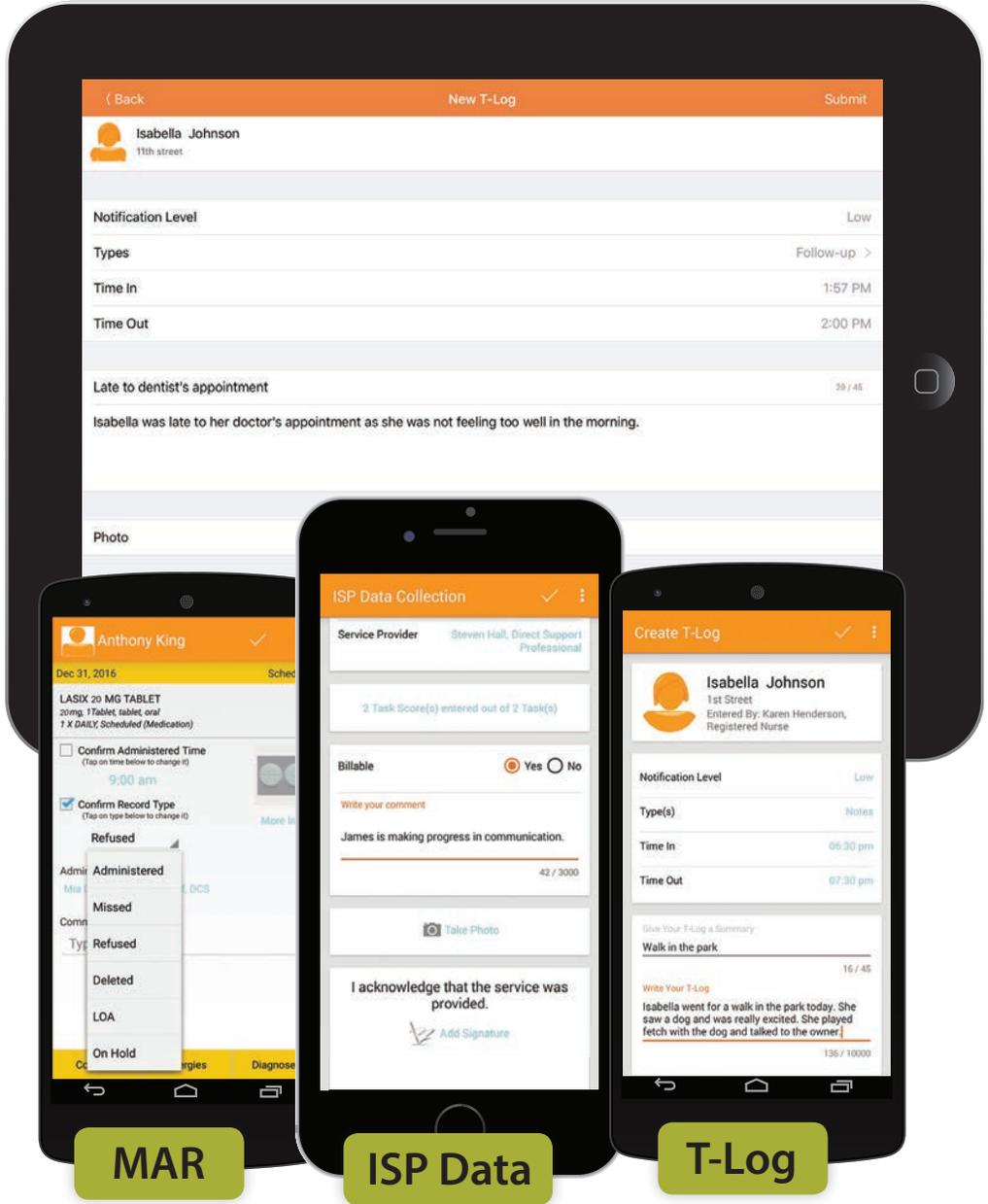


## GER Dashboard

View Injury Count by Causes, Age Group, Severity, Location, Types and more



# Therap Mobile Apps



MAR

ISP Data

T-Log

## Therap on iOS

- ISP Data
- T-Log
- Password Reset

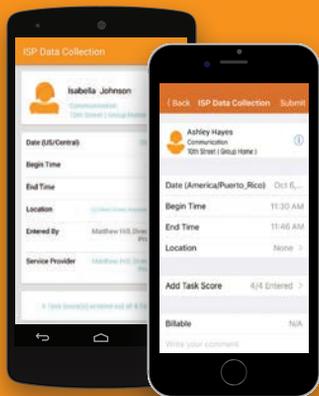
## Therap on Android

- MAR
- ISP Data
- T-Log
- Password Reset

For more information on Therap App, visit

- Google Play
- AppStore

## ISP Data for Android & iOS



- Remotely collect service data
- Electronic visit verification (EVV) using GPS location
- Collect signatures to verify service delivery (EVV)
- Take photographs as part of documentation
- View service data from a convenient location

## T-Log for Android & iOS



- Document daily logs, notes and follow-ups
- Categorize health notes, behavior notes, contact & general information
- Track daily logs from your mobile device

## Mobile MAR for Android



- Administer and record scheduled and PRN medications
- View allergies, diagnoses, and images of medication
- Access shared medical contacts
- Reference data for reduced medication errors

# Training Management System

- ✔ Setup & schedule training sessions for staff
- ✔ Record staff certification and attach certificates to publish results
- ✔ Conduct training sessions, view & publish results

**Training Profile**  
Trainee: David Poveff, Direct Support Professional  
Dates: 1/27/2016 12:39 PM

**Assigned Training Curricula**

Curriculum Name	Assignment Date	Assigned By
DSP Curriculum	08/07/2016 04:24 PM	Jacob Anderson

**Assigned Training Courses**

NOTE: Assigned courses include all training courses that are directly assigned, as well as those training courses that are part of assigned training curricula.

Course Name	Assignment Date	Assigned By
CPR Course	07/07/2016 02:26 PM	Jacob Anderson
First Aid Course	08/07/2016 01:07 PM	Jacob Anderson

**Assigned Training Classes**

NOTE: Assigned classes include all training classes that are directly assigned, as well as those training classes that are part of assigned training courses or curricula.

Class Name	Assignment Date	Certificate Created On	Certification Start Date	Certification Expiry Date	Due	Attached Certificate	Attached By
CPR	07/22/2016 04:19 PM	10/21/2016 01:36 PM	11/01/2016	11/30/2017	Due for 339 Days	CPR Certificate.pdf	Jacob Anderson
Health Tracking	06/18/2016 11:04 AM	07/01/2016 10:30 AM	08/01/2016	Never	Not Applicable	Health Tracking Certificate.pdf	Sophia Wilson
First Aid Training	08/07/2013 08:28 AM	Never			Overdue for 1299 Days	First Aid Training.pdf	Jacob Anderson

**Upcoming Training Sessions**

Class Name	Session Date	Session Time	Session Length	Instructors
DSP Training	10/24/2017	10:00 AM	9 Hour(s), 30 Minute(s)	Jacob Anderson

**Certificates on Training Classes Not Currently Assigned**

Class Name	Certified At	Certification Start Date	Certification Expiry Date	Attached Certificate	Attached By
First Aid Training	11/20/2016 08:23 PM	12/21/2016	12/31/2018	First Aid Training Certificate.pdf	Jacob Anderson

The Training Management System helps track staff members' training histories and allows real-time scheduling of sessions through the system. Authorized users can track detailed information about agency wide staff training and certifications as well as records of staff credentials at the agency. This module enables monitoring and management of training classes, courses and curricula based on state requirements and agency policies and

procedures. Users can manage class notes and deleted records as well.

## Training Profile

This provides an overview of trainees' training information for the training sessions in Therap. Assignments to classes, courses, curricula, upcoming training sessions to attend, information related to certification, certificates attached and staff under supervision can be viewed from here.

# Staff Ratio Tracking

- ✔ Track overlapping attendance time of staff to individuals
- ✔ Enter multiple in/out times throughout the shift, day, etc.
- ✔ Generate report with data of staff to individual present at a program over a timeframe

**Staff Ratio Tracking - Attendance**

Template Information

Title: 1st Street Weekends  
Time: 12:00 AM - 11:59 PM  
Program: 1st Street Group Home  
Effective Date: 12/01/2016 -  
Time Zone: US Eastern

< February 12th, 2016 >

Individual(s)

Ethan Williams

More

9:00 AM 10:00 AM 11:00 AM

11:00 AM 4:00 PM

In Site Out Site

Lauren Cox

More

9:00 AM 4:00 PM

In Site Out Site

Staff(s)

Therap's staff ratio tool is designed to help agencies record in real time the ratio of staff to individuals that are present in a program on a given day. It captures in/out attendance quickly and easily and as often as required. The data

collected is electronically signed and has the ability to be captured in real time. Supervisors can check in from a central office during the day to verify staffing ratios at central or remote locations.

# Data Integrity

- ✔ Time-stamped documents with electronic signatures
- ✔ Records of activities on documents & reports
- ✔ Multi-level access control & data security

Therap strives to ensure data integrity and security. Therap is implemented on state-of-the-art infrastructure, ensuring regular backups at geographically non-contiguous locations so that users benefit from a system that stores and protects data in a transparent and reliable manner. Therap improves communication within an agency so that support staff are aware of the overall progress and medical status of an individual. Therap understands that shared information should be accessed by the right people; this is done through setting appropriate privileges. Additionally, data exchange between an end user's browser and Therap is carried out over encrypted channels.

## Information on Forms

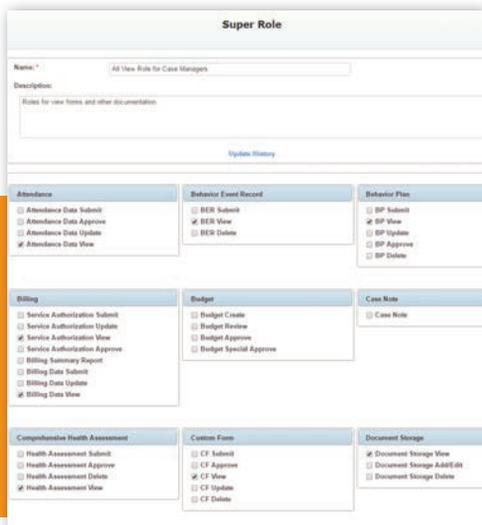
Forms in Therap show when data was entered and by which user. The Entered By and Approved By fields are instances showing how records of different activities are kept.

**Individual Data**

**Ethan Williams (Admitted)**  
 Form ID: IDF-DEMOTCT-EDQ4NETZXAS7H  
 Admitted By: Jacob Anderson, Case Manager  
 Entered By: John Sanders, Case Manager on 11/22/2016 01:13 PM  
 Last Updated By: David Powell, Executive Director on 01/02/2017 04:57 PM

## Audit Trails

Therap's Activity Tracking module keeps records of operations performed by users inside the system. This module shows who has been using the system, when they were using it and for what purpose. These features are helpful for audits and for monitoring actions performed by staff.

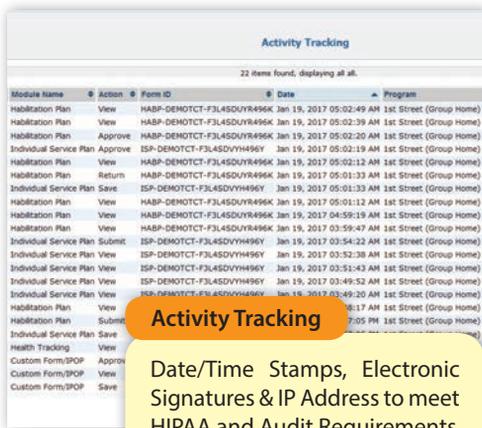


## Electronic Signatures

Therap forms carry electronic signatures of the users working on the form including date and time stamps. Thus, any entry of data can be easily traced back to the originator. Agencies may also display their policy agreement to users right after logging into Therap to make sure they understand the implications of online documentation.

## Multi-Level Access Control

The access privileges of user accounts are set and managed by a separate class of users within the agency who have administrative privileges. Administrators are able to set the privileges for the rest of the staff depending on the services they provide, and individuals for whom they are responsible. Therap's multi-level access control mechanism allows users to define the level of access they have on a particular record and the actions they are able to perform.



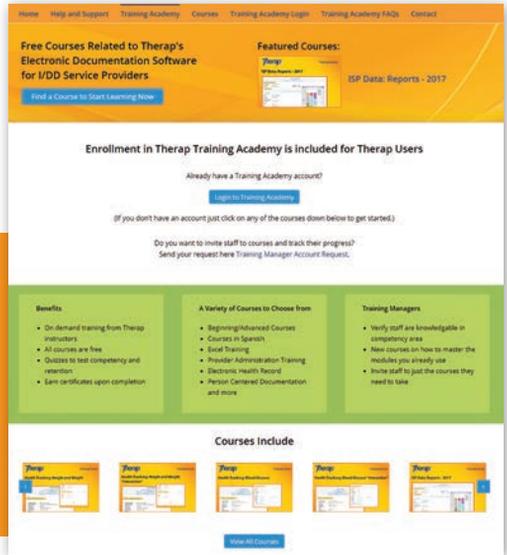
# Training Academy

- ✔ On-demand training from Therap instructors
- ✔ Quizzes to test competency and retention
- ✔ Earn certificates upon completion

Therap offers flexible online courses designed for users to take during agency trainings or at their convenience from their homes or work sites across the community. Therap's Training Academy offers self paced, on-demand courses for both beginner and advanced users. Course topics include incident reporting, employment, health tracking, individual support plans, attendance, person centered documentation and behavior tracking. Courses are available 24/7, allowing users to take the courses at their own pace and schedule. The courses include review quizzes, handouts and a certificate upon training completion.

Courses are available for the following modules:

- T-Logs
- General Event Reports
- Secure Communications
- Health Tracking
- Updating/Discontinuing ISP Program
- Emergency Data Form
- Creating and Editing IDF
- ISP Data
- Medication Administration Records
- Individual Data Form
- ISP Programs & Templates



- Behavior Tracking
- ISP Data Reports
- Medication Histories
- Attendance

And more...

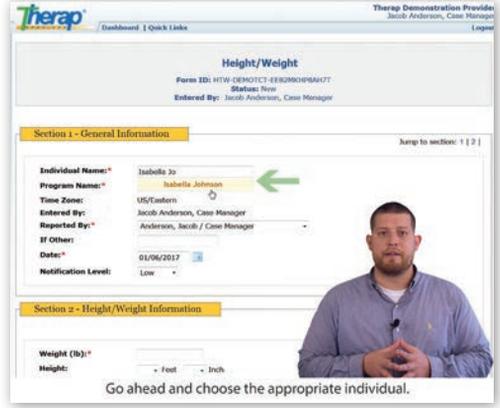


Visit [www.therapservices.net/trainingacademy/](http://www.therapservices.net/trainingacademy/) to view courses

## Interactive Training with Demo Account Access

Training Academy courses are available with an interactive question and answer portion where users are given a live walkthrough within a demo training account. Users are prompted to navigate the system and find answers to the questions posed in the video by logging on to the demo account. This gives a user an opportunity to follow along with the instructor within the system and practice implementing the module that they are learning about in the course.

Users are given a view-only access to the demo account where they are able to search for different forms available for multiple modules and can generate reports as well. As they watch a course, users are invited to simultaneously look through the system and see the type of data that is entered on Therap and how it relates to their day-to-day work at their own agencies.

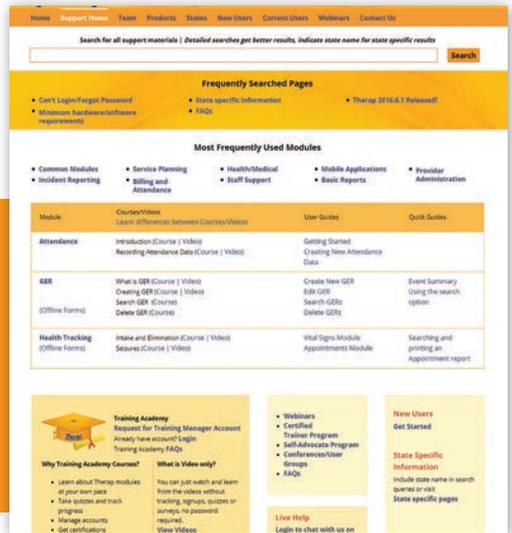


## Training Manager Account

Do you want to invite staff to training courses and track their progress? Users with Training Manager Accounts are able to invite staff to courses and manage their progress.

# Support & Training

- ✔ Extensive documentation & user guides
- ✔ Interactive training materials
- ✔ Multiple channels for customer feedback



Therap provides agencies with various necessary training, support and information resources, from the very first stages of implementation to day-to-day usage. These include a broad array of training options, support materials and technical assistance, designed to cater to different learning scenarios and user needs.

Therap staff regularly visit agencies and state offices across the country to provide necessary training and to form a better understanding of users' needs. Various support materials can be accessed through Therap's Help and Support website.

## Training Materials

- User guides & FAQs
- State pages
- Automated training videos

## My Issues

You can submit your questions, suggestions and problems within the application via 'My Issues' located on your Dashboard. Therap's Training and Implementation specialists will respond to your issue within 24 hours. You are provided assistance in troubleshooting difficulties and are communicated with regarding issues.

