PAC-Metrix™
Assessment and Patient Management Tool
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About PAC-Metrix

A key to assessing a patient’s progress is the ability to accurately measure how the patients perceive their own ability to perform routine activities. The Boston University Activity Measure—Post-Acute Care (AMPAC™) instrument is designed and validated specifically for this purpose—providing Computer Adaptive Testing technology to facilitate accurate measurement. And only MediServe’s PAC-Metrix™ has it!

PAC-Metrix provides unparalleled, objective visibility into the functional status of patients across the post-acute care continuum. What’s more, it provides a risk-adjusted comparison of patients’ outcomes with regional and national benchmarks. Use our comparative reports to differentiate yourself and market your services more effectively to patients, physicians, and payers.

PAC-Metrix monitors outcomes in patients with a wide range of conditions and functional abilities. The computerized version matches test questions to a patient’s functional ability level, which maximizes measurement precision while reducing test burden. PAC-Metrix is easy to administer and can be completed by the patient alone or with the assistance from clinicians or care givers. In addition, a variety of administrative reports are available to track serial testing results and to perform statistical and comparative analysis.

Preparing to Use the Patient Assessment Tool

The following discussion outlines the steps required to prepare your organization for using the assessment tool, including configuring the environment to ensure that the necessary resources are in place prior to releasing the application to the rest of your users.

Basic Requirements

Keep in mind that the assessment tool is a web application that runs on your computer while it is connected to the internet. In order to function properly, the following basic requirements must be met.

- Anyone who intends to use the system must have a computer that is connected to the internet.

  **Note:** The assessment tool is functional over a wireless network connection provided that the network has access to the internet.

- All computers running the tool must have an internet browser and have security settings configured to allow cookies to be stored on the computer.

  The assessment tool runs on most common browsers, having been successfully tested on Internet Explorer 8.0 and 9.0, Netscape, Chrome and Safari, and Firefox.

- To avoid horizontal scrolling, users should configure a minimum resolution of 1024 x 768. At this resolution or lower, however, the potential for vertical scrolling still exists on various forms, depending on the amount of data displayed. A resolution of 800 x 600 will result in both vertical and horizontal scrolling.
Organization and Administrator

The first two steps required to configure the environment of the assessment tool are completed by MediServe on behalf of each participating organization. These include the creation of

1. Your organization within the PAC-Metrix database, which is used to identify and manage your data.

2. An organizational administrator (OA) who is responsible for configuring and maintaining the rest of your working environment.

Once these steps have been completed, the person designated as the OA is provided with a user account—a User ID and Password—to log in to the system.

Key Considerations

- MediServe creates each organization in cooperation with the Hospital or Health System that is contracted to use the assessment tool, employing any naming convention that the designated OA provides to us.

- Once the organization and the OA have been created, the system is ready for the administrator to configure the rest of the working environment.
Logging in to the Administration Environment of PAC-Metrix

The Patient Assessment Tool is composed of two basic environments:

a. **The administration interface (Admin) or PAC-Metrix Application**: This is where the OA manages the environment in which the assessments tool is used. It is also where the OA and associate users (clinicians) manage patients and their assessments.

b. **The assessment environment or PAC-Metrix Assessment Kiosk**: This is where patients or caregivers actually conduct the assessments. Therapists can conduct assessments with patients in this environment or through the administrative environment. The authorization (configuration) of these environments is discussed later in this guide.

As with any software application, the first step to using the assessment tool is to log in to the application.

**Logging in to the Administration Environment**

To begin using the administrative environment,

1. Open your browser and navigate to the administration interface:

   [https://login.pac-metrix.com](https://login.pac-metrix.com)

   The administration Login screen will appear.

   - **Kiosk** This link directs users to the assessment Login page, which is where associate and OAs authorize computers for assessments. Once authorized, patients perform their self-assessments. Refer to the “Authorizing and Using the PAC-Metrix Kiosk” section later in this guide.

   - **Forgot Password** Refer to the “Resetting Your Password” section for complete instructions about obtaining a new password if you lose or forget yours.

2. Enter the **User ID** and **Password** provided by MediServe, and then click **Login**.

   Upon successful login, the program opens with the Search Assessment screen in context.

   Observe that the user description and some navigation links appear along the top portion of the screen. The user name verifies the user who is currently logged into the system.
links provide navigation to the functions of the program. Simply click one to open the main screen for that particular feature.

First Login
The first time that users log in to the assessment tool, they will be prompted to create a password of their own making: Once a user clicks Login from step 2 above, the Patient Assessment Tool Change Password screen will appear:

1. Complete the form according to the following descriptions:

   **User ID:** Enter the User ID that you use to log in to the assessment tool

   **Old Password:** Enter your existing password.

   **New Password:** Enter the password that you would like to use. Keep in mind that passwords are alphanumeric and they must contain at least one upper case character, one lower case character, and one number. In addition, they must be at least 8 characters in length.

   **New Password (Confirm):** Re-enter the new password.

2. Click **Save** to commit your changes. Note that the Save function will not be enabled until the form is complete. Click **Clear** at any time prior to saving to restart the process.

3. Once you click Save, you will be returned to the Login screen where you must re-enter your account information using the new password you just created.

   Alternatively, if you log in to the Kiosk on your first login, you can click the **Re-launch Assessment** button to complete the login once your password has been reset.
Facility Maintenance

Once the OA is able to log in to the assessment tool, he or she must configure the environment in which all other users within the organization will operate. The first step for this is the creation of the facilities that are required.

Facilities are a) the locations where patients are treated within your organization and (b) the locations with which the assessments will be associated.

To begin,

1. Log in to the application according to the previous section.
2. Once the Search Assessment screen is visible, click the Facility link in the top menu.

![Facility screen](image)

The Manage Facility screen will appear.

![Manage Facility screen](image)

Any facilities that currently exist will be listed in the table at the center of the screen.

3. Use this screen to
   - Add New Facilities
   - Edit Existing Facilities
   - Delete Existing Facilities

Adding a Facility

1. While on the Manage Facility screen, click the Add Facility button to the right of the Organization field. The Add Facility screen will appear.
The **Organization Name** is populated automatically. **Red** asterisks (*) on this screen and elsewhere in the application indicate that a field is required to complete the record.

2. Enter the facility information according to the following descriptions and definitions:

   **Facility Name**: Click the field and enter a description as you would like it to appear within the application. Though the field will accommodate 100 characters, we find that a description greater than 20 characters to be impractical in regard to usability.

   **Facility Code**: Enter a code for the new facility according to your normal business workflow requirements. Consideration to usability should be applied here as well.

   **State**: Enter the standard 2-digit code for the state in which the facility is located. This field accepts any value so be sure to verify your entry.

3. Click **Save** to commit the new facility record to the database. You will be returned the **Manage Facility** screen, and the new record will appear in the facilities list table at the center of the screen.

   Click **Cancel** at any time to abort the new entry process. Click **Clear** to remove any unsaved data and prepare the screen for a new entry.

### Editing a Facility

To edit an existing facility,

1. Navigate to the **Manage Facility** screen.

2. Locate the line item for the facility you wish to edit.

3. Click the **Pencil** icon in the appropriate line item. The line will refresh with the fields that can be edited, as illustrated in the following screen shot.
Note: The information for the selected facility appears in editable text fields (highlighted) and the Edit and Delete icons have changed to Save and Cancel icons.

4. Click-and-drag over the text within the field you wish to edit and change the information as needed. Double-click to select the entire field.

5. Click **Save** to commit your changes. Click **Cancel** to abort your changes.

**Deleting a Facility**

To delete a facility that has been created in error,

1. Navigate to the Manage Facility screen.

2. Locate the line item for the facility you wish to delete.

3. Click **Delete** in the appropriate line item. A confirmation pop-up will appear similar to the following screen shot.

4. Click **Continue** to complete the process, **Return** to abort the process.

**Note:** If you attempt to delete a facility that has users associated with it, a message similar to the following will appear.

Click **OK** to return the Manage Facility screen. In the user sections you will learn how to associate and disassociate users with facilities so that you can delete facilities that are no longer needed.
User Maintenance

Once the facilities for the assessment environment have been created, the OA can then begin the process of creating the users that will work within the environment. This is a two-step process that involves (a) creating the individual users and then (b) associating those users with the facilities (these were just created in the previous sections) in which they are authorized to work.

To begin,

1. Click the User link at the top of the screen. The Manage Users screen will appear.

   Any existing users within the organization will be listed in the table in the center of the screen. In the previous example, only the OA has been created thus far.

2. Use this maintenance screen to
   - Add a User
   - Edit a User
   - Delete a User

Adding Users

To add a new user,

1. Click the Add User button. The Add User screen will appear.

2. Complete the user parameters according to the following descriptions and definitions. Keep in mind that red asterisks (*) indicate that the field is required to save a new user.

   *User ID*: Assign IDs according to your organization’s conventions. Keep in mind that IDs form the first piece of account information required to log in to the assessment tool. The field accommodates 4 to 50 characters, and it is required.
**Title**: Assign any title appropriate to the user. This field is optional and is for administrative use only. Enter up to 50 characters.

**User Name**: Enter the First and Last name of the user. This is how the user is identified throughout the application. The field accommodates 4 to 50 characters and is required.

**Organization**: This display field lists the OA’s organization and is not editable.

**Email**: Enter the user’s e-mail address. E-mail addresses are used to recover lost passwords, so it is especially important that this field is accurately maintained (e.g., the program does not perform any validation). The field accommodates 4 to 50 characters and is required.

**Admin Type**: Click the drop-down menu and choose from the available options:

- Organizational Administrator (OA)—Users who are assigned to manage the assessment environment for the organizations that have contracted to use the Patient Assessment Tool.
- Associate—The general users of the system.

**Password**: Passwords complete (with User Name) the requirements for logging in to the assessment tool. Enter 8–20 characters that includes at least one upper case, lower case, and numeric character each.

  **Note**: Passwords that are assigned when users are created expire automatically on initial login. Refer to the “First Login” section earlier in this guide for a discussion.

**Confirm Password**: Re-enter the password to confirm its accuracy.

**Locked**: The Locked option is a security feature that is triggered by five (5) consecutive failed attempts of a user trying to log in. It is aimed at preventing someone from phishing for account access. Any user whose account becomes locked cannot log in until the Locked flag has been reset by an administrator.

  **Note**: If an account does become locked, then the OA simply has to edit the user and click the checkbox for the Locked option once to re-enable it.

3. Click **Save** to commit the new user record to the database. Alternatively, click **Cancel** to abort the new entry.

A confirmation screen will appear.

![User Saved Successfully](image)

Click **OK** to continue. The Add User screen will refresh with the user entry fields disabled and a new User Facility Maintenance panel will appear at the bottom of the screen.
4. At this point the user is saved and you could click the **Back to User List** button to return to the **Manage Users** screen.

However, many of the features in assessment tool remain unavailable until a user has been assigned to at least one facility, so most likely you will want to assign those at this time.

5. Click the **Add** button in the User Facility Maintenance panel. The **Select Facility** screen will appear.

The facilities that (a) are part of the organization and (b) have not yet been associated with the user appear in the table (so, for example, all facilities are listed for new users).

6. Click the checkbox next to the facilities as appropriate to the current user definition.

7. Click the **Select Facility** button.

The selected facilities are immediately saved to the user’s account and the **Add User** screen will refresh with facilities listed in the User Facility Maintenance panel.
Editing a User

1. Navigate to the Manage User screen.

2. Locate the user you wish to edit (e.g., Robert Hoggenwash in the following example).

3. Click the Pencil icon in the appropriate user line item. The Add User screen will appear pre-populated with the user’s current information.

4. Edit the user according to your current need. Simply click in the field you wish to edit, or double-click to select the entire field.

   The requirements for editing a patient are identical to those when as creating one. The one exception is that the Password field is not required in that it already exists. Although administrators can reset the field here if necessary.

Associating Facilities with Existing Users

To add a facility to an existing user’s account,

1. Navigate to the Manage User screen.

2. Locate the line item for the user you wish to edit.

3. Click the Pencil icon in the appropriate user line item. The Add User screen will appear pre-populated with the user’s current information.

4. Locate the User Facility Maintenance panel at the bottom of the screen. (Note that new users won’t have any facilities associated with their account.

5. Click the Add button. The Select Facility screen will appear.

6. Click the checkbox next to the facilities as appropriate to the current user.
7. Click the Select Facility button.

8. Click Save to commit any changes you may have made to the user’s demographic information (i.e., any of the fields that define the user).

**Key Considerations**
- Once the appropriate facilities have been added to the user, it is not necessary to re-save their profile unless you actually change their account demographics.
- Click the checkbox in a facility line item and then click the Delete button that appears in the User Facility Maintenance panel to remove a facility from a user profile. It is not necessary to save the user unless you have also made changes to their demographics.

**Deleting Users**
The application provides two places where users can be deleted:

a. The Manage Users screen
b. The Edit Users screen

Each of these workflows is outlined in the following discussion.

**Deleting Users from the Manage Users Screen**

1. Click the User link to navigate to the Manage User screen.

2. Locate the line item of the user you wish to delete (e.g., Robert Hoggenwash in the following example).

3. Click the Delete icon in the appropriate user line item. A confirmation message similar to the following will appear.

4. Click Continue to complete the delete operation. Click Return to abort the process and return to the Manage Users screen.

   **Note:** Once you click Continue, the user will be removed from the list. They are not, however, completely removed from the database. Therefore, if you try to re-create a user (e.g., one you created in error), you can potentially run into an error that the “user already exists.” If a user is deleted in error, and they must be reinstated, then you should contact MediServe to have the database administrator update their status.

**Deleting Users from the Edit Users Screen**

1. Navigate to the Manage User screen.
2. Locate the line item for the user you wish to edit.

3. Click the **Pencil** icon in the appropriate user line item. The Add User screen will appear. When existing users are edited, note that a Delete function has been added to this screen.

4. Click the **Delete** button to remove the user.

**Key Considerations**
- Keep in mind that the delete function does not have a confirmation prompt. Once you click Delete, the action will be performed. So apply the appropriate care and consideration when deleting a user.
- Users are not actually deleted; rather, they are marked “deleted” and omitted from the screen display.
- A “duplicate user” error may occur if you attempt to re-create the user once they have been deleted. The only way to resolve this situation is to contact MediServe to have the database administrator reinstate a user that has been deleted.

**Password Management**
While using the PAC-Metrix tool, you will come across circumstances in which it will be necessary to manage your password. The following discussion outlines these situations and provides instructions regarding the procedures to follow when they do occur.

**Resetting Your Password**
If you attempt to log in to the PAC-Metrix tool but cannot recall your password, you can request a new password be sent to you. This is a system managed function and does not require any involvement from an administrator.

- **Note:** Resetting your password after logging in to the program for the first time was previously covered in the “First Login” section.

To request a new password,

1. Navigate to the **Login** screen for the administration interface:
   
   **https://login.pac-metrix.com**

   Click the **Forgot Password** link. The **Forgot Password** screen will appear.
2. Enter your **User ID** and **e-mail address**, then press the Submit button.

An e-mail containing a new password will be sent to the e-mail address recorded with your user account. Note that if the ID and e-mail that you enter do not match the one on record, a message similar to the following will appear.

![Forgot Password](image)

Otherwise, the e-mail will be sent immediately to your in-box.

- Though e-mails are generated immediately on a successful new password request, the actual delivery time may take a few minutes. If you do not receive the e-mail within 10 minutes, be sure to check any junk mail folders or anti-spam systems as these may have incorrectly intercepted the e-mail.

- Using the Forgot Password function will reset your password the moment you push the Submit button. So, for example, if you remember your password after submitting a request but before receiving the e-mail you will not be able to use it to log in.

- Click the [Login Screen](#) link to return to the Login screen at any time.

**Changing Your Password**

In the event that you feel your password has been compromised, or if you just want to change it to something different, you can do so very easily within the administration interface of the assessment tool.

1. Navigate to [https://login.pac-metrix.com](https://login.pac-metrix.com) and then log in to the program.

2. Click the **Change Password** link at the top of the page. The Change Password screen will appear.
3. Complete the form according to the following descriptions:

**User ID:** Enter the User ID that you use to log in to the assessment tool.

**Old Password:** Enter your existing password.

**New Password:** Enter the password that you would like to use. Keep in mind that passwords are alphanumeric and they must contain at least one upper case character, one lower case character, and one number. In addition, they must be at least 8 characters in length.

**New Password (Confirm):** Re-enter the new password.

4. Click **Save** to commit your changes. Note that the Save function will not be enabled until the form is complete. Click **Clear** at any time prior to saving to restart the process.

**Account Lock-out**

The assessment tool will automatically lock out user accounts after 5 consecutive unsuccessful login attempts. This security measure prevents unauthorized personnel from attempting to guess your password through trial and error.

If you run into this situation or one in which you have accidentally entered your password incorrectly five times in a row, your account will be locked, and you will not be allowed to access your account until you do either of the following:

- Contact your organization administrator to unlock your account.
- Contact MediServe support to unlock your account.

Once your account has been unlocked, you simply need to enter your valid User ID and Password to log in. No other changes are required.
Therapist Maintenance

During patient registration, users can associate the therapists assigned to treat the patient in each of the following domains of function:

- Daily Activity
- Mobility
- Applied Cognitive

These records are maintained by OA users only, and they must exist before a patient record is created (i.e., there is no on-the-fly data entry option).

To begin,

1. Click **Therapist** once. The *Manage Therapists* screen will appear.

   ![Manage Therapists Screen](image)

   Any existing therapists will appear in the table at the center of the screen.

2. Click **Add Therapist** to display the *Add Therapist* screen.

   ![Add Therapist Screen](image)

   Required fields are indicated by red asterisks.

3. Complete the parameters according to the following definitions:

   - **NPI:** Enter the provider’s National Provider Identifier (NPI).
   - **First Name:** Enter the first name of the provider. This field is required.
   - **Last Name:** Enter the last name of the provider. This field is required.
   - **Is Active:** This flag toggles the therapist between active and inactive. Only active therapists can be assigned in patient registration in the three assessment domains. The default status for this field is enabled.
   - **Facilities:** All of the available facilities for the organization are displayed in a checkbox list. Click the checkbox next to each facility that applies to the current therapist.
4. Click **Save** to complete the record. Click **Cancel** to clear the unsaved data and return to the **Manage Therapist** screen.

**Edit Therapists**

1. Navigate to the **Manage Therapist** screen.

2. Click the Pencil icon 🖋 in the therapist line item you wish to edit. The **Add Therapist** screen will appear populated with the therapist’s information.

3. Edit the information as needed according to the “add” instructions in the previous section.

4. Click **Save** to complete the edits. Click **Cancel** to abort them.

As an alternative, you may need to delete an obsolete therapist from your system. In these instances,

1. Click the Delete icon ✗ in step 2 above. A confirmation window will appear similar to the following:

![Confirmation Window]

2. Click **Continue** to complete the deletion. Click **Return** to abort the process and return to the **Manage Therapist** screen.
Patient Maintenance

Patients are the core of the Patient Assessment Tool, the purpose of which is

a. To measure the outcomes progress of the patients at your facility.

b. To provide comparisons with comparable patients elsewhere within your organization.

Use the following to guide your steps required to manage patients and to obtain these outcomes and comparisons.

Registering a Patient

Before anything else, a patient must be registered. This will establish the necessary record that is later used to create assessments.

To begin,

1. Log in to PAC-Metrix as described earlier in this guide. The Search Assessment (or Home) screen should be in context by default.

2. Click the Patient Registration link to initiate a new registration. The screen will refresh with the Enter a Patient ID field, as illustrated the following screen shot.

3. Enter the Patient ID that you have assigned to the patient. For example, this will often be the patient’s MRN.

   Note: Be aware that whatever number your organization chooses, the ID is used for all episodes of care.

4. Click the Next button. A basic registration screen similar to the following example will appear.
5. Complete the parameters according to the following descriptions and definitions.

**Note:** Fields that are marked with an asterisk and in Red text are required to complete the form.

**Patient ID:** This field is populated automatically with whatever was entered on the Patient ID page.

*Last Name:* Enter the patient’s last name.

*First Name:* Enter the patient’s first name

*Date of Birth:* Enter the patient’s birth date in the format of mm/dd/yyyy. Alternatively, click the calendar icon and choose a date visually. This field does not accept future dates.

**Gender:** Click the drop-down menu and choose either Male or Female.

*Date of Admission:* Enter the date the patient was admitted into your care in the format of mm/dd/yyyy. Alternatively, click the calendar icon and choose the date visually.

**Date of Onset:** Enter date (mm/dd/yyyy) on which the condition being treated began. Alternatively, click the calendar icon and choose the date visually.

**Facility:** Click the drop-down menu and choose the appropriate option from among those provided.
**Note:** Only those facilities for which this user has been authorized are displayed in the drop-down menu. If the desired facility is not included in the list, contact your OA to have the appropriate facilities added to your user account.

**Daily Activity, Mobility, Applied Cognitive Therapist:** Click the drop-down menu and choose the appropriate therapist for the current patient in each of the three domains of function. The options available for each therapist field are based on your selection in the **Facility** field.

- A Therapist field appears for each of the three domains regardless of whether the patient is assessed in all or just one of the domains.
- If you choose a therapist and then change the facility, your original selection will remain until you change it. If you do change the therapist, however, he or she may not be available with the new facility, depending on his or her assignment.

**Service:** Click the drop-down menu and choose from among the following options:

- Outpatient
- Inpatient
- Day Treatment
- Spinal Cord Wellness Clinic

**Condition Type:** Click the drop-down menu and choose from among the following options:

- Orthopedic
- Neurologic
- Cardiopulmonary
- Major Medical
- Other

**Body Part:** If the condition type is Orthopedic, check the appropriate options from those illustrated in the following screen shot:

Condition Type of Orthopedic require at least one Body Part selection.

- **Run all three Domains:** Orthopedic Condition Types also give users the option of requiring that all three domains of function (e.g., Daily Active, Mobility, Applied Cognitive) are assessed during an assessment. Body Part selections are still required.

**Primary Financial Category:** Click the drop-down menu and choose from among the following options:
None Medicaid
Medicare Auto Liability
Workers Compensation Attorney Liability
Commercial (include HMO/PPO/BCBS) Self-Pay
Prevention

**Referral Source:** Click the field and enter the referral source for the patient.

**Active:** This is the patient’s current status. Patients are “active” by default: i.e., the option is enabled.

6. Once the form is complete, click **Save** to commit the patient record to the database. A confirmation screen will appear.

Click **OK** to continue.

Once a patient has been registered, his or her account is ready for an assessment. This can be performed by a therapist, or the patient can perform their own assessment at a computer designated as a kiosk for self-assessments. Each assessment workflow is discussed in detail later in this guide. The patient will require two pieces of information to run assessment:

a. Their Last Name as it was entered in the system.

b. Patient ID
Retrieving Registered Patient Information

Use the descriptions and definitions provided in the following discussion to retrieve patient information and view assessment scores.

1. Log in to the program and navigate to the Search Assessments (or Home) screen.

![Image of Search Assessments screen]

2. Complete the search parameters according to the following:

**Organization**: This field will be pre-populated and disabled.

**Facility**: Click the drop-down menu and choose the facility in which you would like to conduct your search.

- **Note**: At least one of the three remaining parameters (Assessment Date, Patient ID, or Last Name) must be used in the search. But any combination of all three is acceptable.

**Assessment Date**: Enter the date corresponding to the assessments for which you are searching, or click the calendar icon to choose the date visually.

- Once the facility and assessment date are entered, you could click the Search button to locate all patients in the selected facility who have completed an assessment on the date provided.

  **Note**: Patients who do not have an assessment but who were entered into the system on the same date as the search parameter are included in the search results.

Or you could refine the search further by entering **Patient ID** or **Last Name** information.

**Patient ID**: Enter the ID string on which you want to search. The search utility looks for matches that “contain” the search string entered into the field.

- For example, if you enter the complete Patient ID without an Assessment Date, the search will return all the assessments for that ID, each one on a separate line item.

![Image of patient search results]

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PAC-Metrix™ Assessment and Patient Management Tool
• If you include an Assessment Date, only those assessments that appear on that date will appear—one line item for each assessment completed on that day.

![Assessment Search Results List](image)

• If, however, you enter a partial Patient ID number, the program will return all patients whose ID contains the search string.

If you enter the search string 12345, examples of the IDs that would be returned by the search include 012345, 123456, 98712345. But IDs that contain only a portion of the string—e.g., 123 or 1234—would not be returned.

**Note:** Patients who do not have an assessment but who match the search criteria are included in the results.

**Last Name:** Enter the Patient’s last name. Similar to the Patient ID, your search results will include all patients whose last name contains the text (search string) you enter.

• So, for example, when you enter Steven, the results will not only return all matches for Steven but also for names such as Stevens, Stevenson, and Stevensen.

If you include and Assessment Date as well as a Last Name, only those assessments that match both the date and name will be returned in the results.

**Navigating the Assessment Search Results List**

Once the user clicks **Search**, the screen will refresh with a list of patients that match the criteria. For example the results are for the Mesa facility in the Test Organization for October 18, 2012 for patients whose ID contains “7” are displayed in the following screen shot.

![Assessment Search Results List](image)

The results not only provide a list of assessments that match the criteria but also include some additional options for reviewing the data and managing patients. These are discussed in the following sections.

**Patient Name Link**

One of the first features to note about the result list is that **Patient Name** is a hyperlink: Consider Spagnoli, Anna Maria, for example.
1. Click the patient’s name once to display the Manage Assessment screen.

   ![Image of Manage Assessment screen]

In general, this is simply a re-presentation of the data listed in the patient line item in the results list. It is simply presented in a more user-friendly format.

2. Click the **Back to Assessment List** button to return to your search.

   **Note:** If the patient does not have an assessment, their description will not be displayed as a hyperlink: See **Treadstone, Arthur** in the previous example.

**Patient ID Link**

As with the Patient Name, the **Patient ID** is also a navigation link to patient information.

1. Click the ID once. A summary of patient registration information similar to the following example will open in a separate browser tab.

   ![Image of Patient ID summary]

2. Review the information as needed.

   Alternatively, use the **Discharge** and **Create New Episode** features according to the following instructions.
**Discharge Button**

Discharge simply toggles the patient between an active and inactive status. It is a flag to the program and users that the patient has completed a given episode of care, and it is used in reporting to identify active patients.

1. Search for the patient whom you need to discharge as described at the beginning of this section and then click the **Patient ID** link in the appropriate line item.

2. Click **Discharge** once you have verified that the correct patient and episode have been selected.

   The **Active** status will change from True to False and the **Discharge** button will become the **Admit** button.

   ![Active: False Admit](image)

3. Alternatively, click **Admit** to readmit a patient for a given episode of care. The **Active** status will return to True and the **Admit** button will become **Discharge** again.

   Using the Discharge feature to indicate that the patient’s episode of care is complete is also a highly effective indicator to help your staff manage subsequent visits patients may have with your facility.

**Create New Episode Button**

Treatment for new episodes of care require that you create a new episode with the appropriate diagnosis for your patient. To begin,

1. Search for the patient for whom you need to create a new episode as described at the beginning of this section and then click the **Patient ID** link in the appropriate line item.

2. When the patient summary appears, click the **Create New Episode** button. The screen will refresh to reveal the editable required fields for the new episode.
3. Refer to the “Registering a Patient” section as necessary to complete the following fields according to your business workflow:

- **Date of Admission**
- **Date of Onset**
- **Facility**
- **Therapist fields**
- **Service**
- **Condition Type**
- **Primary Financial Category**
- **Referral Source**

4. Click **Save** once you have finished. A confirmation screen will appear. Simply click **OK** to continue.

**Note:** You cannot edit the patient details such as ID, name, birth date, or gender. These are fixed once the patient has been saved the first time and cannot be changed.

**Key Considerations**

- Once the patient information is saved, it cannot be edited. So be sure to be sure to verify the information prior to saving the record.
➢ All treatment for the same incident of care should be assessed under the same episode.

➢ Assessments are always created on the most recent episode.

➢ As episodes are created, the chain of documentation is broken for the previous episode. Consequently, if you create a new episode for continued treatment on a previous incident, you will lose any ability to demonstrate progress between initial and subsequent assessments. The ongoing history (a key point of assessments) is lost to reporting, and cannot easily demonstrated through the assessments on different episodes.

Episodes, therefore, should only be created when the intention is to identify a truly new clinical diagnosis or incidence of care. Even so, careful consideration should be applied if the patient is continuing to receive care for the original episode.
Authorizing and Using the PAC-Metrix Kiosk

One of the goals of the assessment workflow is to allow both patients and therapists (some care giver) to administer assessments. Patients who conduct a self-assessment must do so at the care facility in that the assessment tool is not designed to be used from an outside location. In order to allow for this, some clinician (the OA or an associate administrator) must (a) log in on the computer that is being provided to conduct assessments and (b) authorize it for the appropriate facility.

The authorization is required for “kiosks” (i.e., unattended computers that are used in public areas for patient self-assessments).

To begin the authorization,


2. Enter your account information (i.e., your User ID and Password).

3. Click the Login button.

If this is the first time you have logged into either environment (admin or assessment), you will be asked to reset your password. Refer to the “First Login” section earlier in the guide. Once you have successfully logged in, you will be presented with a list of facilities for which your user account is authorized to conduct assessments, as illustrated by the following screen shot.

Note: These are the facilities that the OA has associated with your user account.

4. Click the description of the facility that you wish to authorize the current interface (computer). Selected facilities are displayed with a blue background and white text.

5. Click the Launch Assessment button to complete the authorization.

   • A computer that has been authorized will display the Welcome page in a new
browser window that completely fills the screen (illustrated by the following partial screen shot).

![PAC-Metrix™ Welcome to the Patient Assessment Tool](image)

- This screen indicates that the computer is ready for patients to complete their self-assessments.
  
  See the “Performing an Assessment” section for further discussion.

**Key Considerations**

- Keep in mind that each computer used for patient assessments must
  - Be connected to the internet
  - Have a browser installed that is configured to accept cookies. The first time the computer is authorized for an assessment, the browser saves a small encrypted file called a “cookie” to the computer’s hard drive. This file contains the information that is necessary to allow the computer to present the assessments. If your browser is designed to clear cookies on exit, you will have to reauthorize it each time you log in.
  - Any user who is assigned to an organization and at least one facility can authorize a computer for patient assessments.
  - If your browser’s pop-up blocker is enabled, the Welcome page may be suppressed. Generally, if this occurs, a message will appear across the top of the web page to indicate what has happened and your options. Choose the option to prevent further blocking of the page.
  - For computers in a public area, this page indicates that the environment is ready to begin a new assessment. The browser will not allow a user to navigate to or enter a URL outside of the environment. It will only allow users to interact with the web pages as they are presented in the assessment environment.

**Re-Launching the Patient Assessment Tool on an Authorized Computer**

Once a computer has been authorized for assessments at a given facility, users can quickly re-launch the assessment tool by doing the following:

1. Navigate to the for the Login screen.
2. Click the Re-Launch Assessment button. The screen will refresh and the Welcome page will appear.

If the Re-Launch Assessment button doesn’t appear, you can simply complete the authorization steps again.

**Key Consideration**

- If you encounter the following message when attempting to re-launch the Patient Assessment Tool:

  ![MediServe Error Page](image)

  Click the Back to Login Page link to return to the Login screen. Once there, you can try the Re-launch button or re-enter your account information to log back into the tool.

- The system will generate the following message when a user logs into a system that has been authorized previously.

  ![PAC-Metrix Error Page](image)

  Click OK to continue with the reauthorization. For example, you may want to authorize the computer using a different location. Alternatively, click Cancel to return to the Login screen and click the Re-Launch button.
Performing an Assessment

Once a computer has been authorized and the Welcome page is displayed, start a new assessment by clicking the large button: **Click Here to Begin Your Assessment.**

![Click Here to Begin Your Assessment](image)

Each assessment is composed of the following:

- **Patient Last Name and ID:** The patient must be given their ID number and be sure as to how their last name was entered into the system.

- **Context Questions:** Preliminary question that establish the patient’s status prior and up to onset of patient’s illness or injury.

- **Assessment Questions:** Note that this portion of the assessment will vary in length depending on the patient’s condition type.

- **Assessment Delivery:** A couple of questions as to the method in which the assessment was conducted or delivered to the patient.

**Patient Last Name and ID**

As patients enter an assessment session, a screen similar to the following will appear.

![Patient ID and Last Name Entry Screen](image)

1. Complete the fields according to the following definitions:
   - **Patient ID:** Enter the ID as it was entered to register the patient in the assessment tool. This is often the MRN so that the patient can easily remember or have access to it. Regardless of what it might be, be sure that it has been provided to the patient.
   - **Last Name:** Enter the patient’s last name as it was entered during registration.

2. Click **Continue** to proceed. The Patient Information screen will appear.

**Patient Information**

The Patient Information screen provides a basic summary of the patient for whom the assessment is being conducted.
1. Verify that the information is correct.

2. Choose the appropriate **Language**: Click the drop-down menu and choose **Spanish** as necessary. Otherwise, accept English as the default.

3. Click **Start** to proceed with the assessment. The first of several context questions will appear.

   Alternatively, click **Cancel** to abort the assessment and return to the Welcome screen.

**Context Questions**

Once the patient information has been verified, the next three pages of the assessment are designed to provide some context to the patient’s treatment by capturing some basic information about the patient’s condition and living situation. These are illustrated by the following example screen shots.

**Note**: In each case, click the button that most represents the correct answer.

**Context Question 1**

*What was your living condition prior to this medical event?*

**Context Question 2**

*Which sentence is the best to describe your walking situation?*
Context Question 3

Overall, how severe is the primary illness or injury that brought you to therapy? Would you say …

Key Considerations

- Blue Progress Indicator Bar: Throughout the assessment, a blue bar appears at the bottom of the page, displaying the current progress as a percentage the assessments completion. The bar progresses as questions are answered. An example of where the progress bar appears on the screen is shown in the highlighted portion of the previous screen shot.

Completing the Body of the Assessment

Once the patient information and context questions have been completed, the assessor (whether therapist or patient) is presented with a series of task-related questions that patients must answer according to the level of difficulty the task presents them. The potential responses to the questions include

- **Unable:** The patient requires assistance to perform the task, or cannot complete the task.
- **A Lot:** The patient experiences A Lot of difficulty performing this task on their own.
- **A Little:** The patient experiences A Little difficulty performing this task on their own.
None: The patient experiences No difficulty performing this task on their own.

Keep in mind that each page of the assessment contains only a single question.

**Key Guidelines for Completing an Assessment**

Some patients may be unsure how to respond to specific items. The following guidelines have been provided to help you move them forward in a consistent fashion.

- **Never Performed Activity**: If the question is about an activity that the patient has never performed, and therefore does not know how much difficulty would be associated, click **Skip** to move on to another question. This will not affect the scoring process.

- **“I don’t know how to do that”**: If the patient responds to an item by saying “I don’t know how to do that,” the patient should be instructed to press **Skip** to move to the next question.

- **“I don’t do”**: If the patient responds to an item with “I don’t do,” ask the patient, “You don’t do the activity because it is difficult for you to do?” or “Is it because you don’t know how to do the activity?” or “Is it that you have not tried the activity recently?” Press Skip if the patient does not know how to do the activity or has not tried it recently. If the patient responds they do not do the activity because of difficulty, ask the patient to pick one of the choices listed with the item.

- **Repetitive**: In some cases there are items that patients might feel they have already answered, but the items are actually in a hierarchy of ability (e.g., climbing one flight of stairs; going up and down 3 flights of stairs).

- **Confusion about Activity**: Within each section, the items vary from simple actions to complex activities. In some cases, the item is an action or activity that is part of a complex activity or task. For example, one item in the Personal Care and Instrumental Activities Domain refers to inserting a key in a lock and turning it to unlock a door. If the person is focusing on the broader activity instead of the specific item (e.g., they say “my door is too heavy for me to open”), redirect them to the item as written (e.g., the simpler activity of inserting a key in a lock and turning it, not the complex task of opening a locked door).

- **Help or Supervision Required**: If the patient requires physical help or supervision to do the activity, the appropriate answer is “Unable.” For example, if the person says, “I can only do it if someone is there with me,” the answer is “unable.”

- **Incorrectly Answered**: If a question is answered incorrectly, click the Back button and provide the correct response.

**Scope of the Assessment**

The Patient Assessment Tool assesses patients on three different domains of function:

- Basic Mobility
- Daily Activity
- Applied Cognitive

The questions are not in any way labeled as to which domain they support, and it is not important for the patient or anyone helping them take the assessment to know the domains being assessed.
Each domain presents a maximum of 10 questions. Therefore, the maximum *assessment* questions any patient will be required to answer is 30. The 10 question limit is imposed to ensure that the assessment is not excessive.

A given assessment may present fewer than 10 questions per domain if the patient answers in such a way that the Standard Error of the answer is 2.0 or less. The more consistently the patient answers, the fewer questions will be required to determine statistical validity.

**Conclusion of the Assessment**

At the conclusion of each assessment, the assessor is asked two questions regarding the method used for completing the assessment.

Did the study participant respond for themselves to questions in this e-CAT assessment or was a proxy respondent used?:

- If the patient took the assessment themselves and entered their own answers, the **Self-respondent** answer is correct.
- If the patient received assistance to complete the assessment, then use the Proxy answer that is most appropriate—i.e., who provided the assistance?.

**What was the mode of survey administration?:**
• If the patient completed a self-assessment or was present at the computer during the assessment, the correct answer is **In Person**.

• If the patient was taking the assessment via proxy over the telephone, select **Telephone**.

• If neither of the above is correct, click the text entry field below the **Other** button and enter the mode in which the assessment was taken. Once you have entered the text, **Other** will become enabled: Click the button once.

**Results of the Assessment: Printing the Report**

After completing the last question of the assessment, the user is be presented with the opportunity to print a report that summarizes their assessment and provides some explanation of the different scores. This step is required in that it contains the data that the therapist must enter into MediLinks for the patient documentation.

A standard print dialog similar to the following will appear over the **Print Your Report** screen.

1. Click **OK/Print** to output the report. Click **Cancel** to abort the printing. Once the report has been printed, the print dialog will disappear.

If you clicked Cancel or cleared the dialog in error, then click the **Reprint** button in the lower half of the **Print Your Report** screen to reprint the report.
• Keep in mind that the goal of PAC-Metrix is to create a report. All therapists and office personnel should be aware of this and be ready to support patients who have questions at this stage of the assessment.

• The Print Your Report screen also displays the scores that are generated during the assessment, reproducing the top half of the printed report. Therapists who are conducting the assessment on their own computer can, therefore, use the scores to input into Medilinks instead of waiting for the printed output.

2. Once the report has been printed, Click the Close button in the middle of the screen. This will return the user to the Welcome page.

Refer to the “Assessment: Single Assessment Detail” discussion in Reports for a detailed description of the assessment summary report generated at the conclusion of an assessment.

Running an Assessment from within the Administration Interface
If for some reason, the clinician is proctoring an assessment for the patient (i.e., they are in the office and the therapist is helping the patient), it is possible to generate the assessment from within the administration interface.

1. Simply login into the administration interface as discussed previously.

2. When the Search Assessments screen appears on successful login, click the Run Assessment link at the top of the page.

The Patient ID and Last Name screen will appear.

3. Proceed with the assessment as described in the previous sections of “Performing an Assessment.”
Reports

In general, reports are only available OA users. The one exception is the Assessment: Single Assessment Detail report, which simply re-creates the assessment results report that is generated at the conclusion of each assessment. Use the following descriptions and definition as a guide to each of the reports offered.

Assessment Data Export

The Assessment Data Export report outputs patient assessment data for the specified date range by patient and facility (facility may also be referred to as site). Each organization can pull the data into a spreadsheet platform to manipulate and view it as they see fit. Generate the report by completing the following report parameters. Use Table R.1 and Table R.2 following the report generation instructions to interpret and manipulate the data that is generated.

To begin,

1. Click the Reports menu to navigate to the PAC-Metrix reports.

2. Click the Assessment Data Export link in the side menu. The screen will refresh with the following report parameters.

3. Complete the parameters according to the following descriptions:
   - **Facility:** Click the checkbox next to the facilities on which to export data.
   
     - As an alternative, click the Select All link to choose all of them. Click Unselect All to clear the selections and start over.

   - **Start Date/End Date:** Enter the date range from which the data should be pulled. The range will filter patients who have had an assessment completed on their account.

   - **Format:** The Excel option should be selected by default. Otherwise, click the drop-down menu and choose it from the menu. The report will output the data to an native Excel file that can be directly in Excel.

4. Click the Run Report button.

5. The first time the report is generated, an “output” dialog will appear, similar to the following example.
Choose from among the following options:

- **Open with:** The default program is *Microsoft Office Excel*. But you could choose an alternative program capable of opening Excel files. Click **OK** once the appropriate program has been selected.

- **Save File:** Click the radio button and then click **OK**. A standard files screen will appear: (a) Navigate to the location where the file should be saved, (b) name the file, and (c) click **Save**.

- **Do this automatically for files like this from now on:** Check this option to bypass this screen in the future. Every subsequent time you generate this report, the program will automatically open it or prompt you to save it according to your selection.

  This a browser setting, so you can reset the option through the native browser tools if necessary.

  Do not enable this option if you want the ability to easily choose what to do with the report each time it is generated.

An example of how the report appears in its unformatted state is illustrated in the following partial screen shot.
A version in which the column width has been automatically fitted for each field appears similar to the following screen shot of a portion of the report.

![Screen Shot](image)

**Data Export Specifications**

The tables in the following pages describes the data export specifications for the *Assessment Data Export* report. Table R.1 lists each data field in order as it appears in the Excel file that is generated. The *Excel Column* (or field position) is followed by its corresponding *Field Name* and its associated *Data Type*. Table R.2 provides a list of fields that contain a fixed range of values. Once the file has been generated, reference the tables here to guide your manipulation and interpretation of the output.
Table R.1: Data Export Specifications

<table>
<thead>
<tr>
<th>Excel Column</th>
<th>Field Name</th>
<th>Data Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Organization</td>
<td>String</td>
</tr>
<tr>
<td>B</td>
<td>SiteName</td>
<td>String</td>
</tr>
<tr>
<td>C</td>
<td>LastName</td>
<td>String</td>
</tr>
<tr>
<td>D</td>
<td>FirstName</td>
<td>String</td>
</tr>
<tr>
<td>E</td>
<td>PID</td>
<td>String</td>
</tr>
<tr>
<td>F</td>
<td>Date/Time (Assessment Completed)</td>
<td>Date-Time</td>
</tr>
<tr>
<td>G</td>
<td>DOB</td>
<td>Date-Time</td>
</tr>
<tr>
<td>H</td>
<td>Gender</td>
<td>Integer</td>
</tr>
<tr>
<td>I</td>
<td>DOA (Date of Admit)</td>
<td>Date-Time</td>
</tr>
<tr>
<td>J</td>
<td>DOO (Date of Onset)</td>
<td>Date-Time</td>
</tr>
<tr>
<td>K</td>
<td>Service</td>
<td>Integer</td>
</tr>
<tr>
<td>L</td>
<td>Condition</td>
<td>String</td>
</tr>
<tr>
<td>M</td>
<td>Shoulder</td>
<td>Boolean</td>
</tr>
<tr>
<td>N</td>
<td>Arm</td>
<td>Boolean</td>
</tr>
<tr>
<td>O</td>
<td>Elbow</td>
<td>Boolean</td>
</tr>
<tr>
<td>P</td>
<td>Forearm</td>
<td>Boolean</td>
</tr>
<tr>
<td>Q</td>
<td>Wrist</td>
<td>Boolean</td>
</tr>
<tr>
<td>R</td>
<td>Hand</td>
<td>Boolean</td>
</tr>
<tr>
<td>S</td>
<td>Hip</td>
<td>Boolean</td>
</tr>
<tr>
<td>T</td>
<td>Thigh</td>
<td>Boolean</td>
</tr>
<tr>
<td>U</td>
<td>Knee</td>
<td>Boolean</td>
</tr>
<tr>
<td>V</td>
<td>Calf</td>
<td>Boolean</td>
</tr>
<tr>
<td>Excel Column</td>
<td>Field Name</td>
<td>Data Type</td>
</tr>
<tr>
<td>--------------</td>
<td>---------------------------------------------------------------------------</td>
<td>--------------</td>
</tr>
<tr>
<td>W</td>
<td>Ankle</td>
<td>Boolean</td>
</tr>
<tr>
<td>X</td>
<td>Foot</td>
<td>Boolean</td>
</tr>
<tr>
<td>Y</td>
<td>Cervical</td>
<td>Boolean</td>
</tr>
<tr>
<td>Z</td>
<td>Thoracic</td>
<td>Boolean</td>
</tr>
<tr>
<td>AA</td>
<td>Lumbar</td>
<td>Boolean</td>
</tr>
<tr>
<td>AB</td>
<td>Other</td>
<td>Boolean</td>
</tr>
<tr>
<td>AC</td>
<td>FC</td>
<td>Integer</td>
</tr>
<tr>
<td>AD</td>
<td>ReferralSource*</td>
<td>String</td>
</tr>
<tr>
<td>AE</td>
<td>PIN (Assessment Record ID)</td>
<td>String</td>
</tr>
<tr>
<td>AF</td>
<td>LastName, FirstName (Basic Mobility Therapists)*</td>
<td>String</td>
</tr>
<tr>
<td>AG</td>
<td>ScoreLevel — Basic Mobility Domain</td>
<td>Varchar</td>
</tr>
<tr>
<td>AH</td>
<td>Precise (StdError Basic Mobility Domain)</td>
<td>Decimal</td>
</tr>
<tr>
<td>AI</td>
<td>Calculation Basic Mobility Domain CBOR</td>
<td>String</td>
</tr>
<tr>
<td>AJ</td>
<td>LastName, FirstName (Daily Activity Therapists)*</td>
<td>String</td>
</tr>
<tr>
<td>AK</td>
<td>ScoreLevel - Daily Activity Domain</td>
<td>Varchar</td>
</tr>
<tr>
<td>AL</td>
<td>Precise (StdError, Daily Activity Domain)</td>
<td>Decimal</td>
</tr>
<tr>
<td>AM</td>
<td>Calculation Daily Activity Domain CBOR</td>
<td>String</td>
</tr>
<tr>
<td>AN</td>
<td>LastName, FirstName (Applied Cognitive Therapists)*.</td>
<td>String</td>
</tr>
<tr>
<td>AO</td>
<td>ScoreLevel (Applied Cognitive Domain)</td>
<td>Varchar</td>
</tr>
<tr>
<td>AP</td>
<td>Precise (StdError, Applied Cognitive Domain)</td>
<td>Decimal</td>
</tr>
<tr>
<td>AQ</td>
<td>Calculation Applied Cognitive Domain CBOR</td>
<td>String</td>
</tr>
</tbody>
</table>
Fixed Range of Data Values

Certain fields contain a fixed range of possible values. For example, the Gender field can have a value of “0” or a “1.” Only two possibilities — Male (a “1” value) or Female (a “0” value)—so no other value is possible. A list of the fields that have a fixed range of values is provided in Table R.2.

Table R.2: Column Value Definition Key

<table>
<thead>
<tr>
<th>Column</th>
<th>Values for</th>
</tr>
</thead>
<tbody>
<tr>
<td>H</td>
<td>Gender</td>
</tr>
<tr>
<td></td>
<td>1 = M</td>
</tr>
<tr>
<td></td>
<td>2 = F</td>
</tr>
<tr>
<td>K</td>
<td>Service</td>
</tr>
<tr>
<td></td>
<td>100 = None</td>
</tr>
<tr>
<td></td>
<td>1 = Outpatient</td>
</tr>
<tr>
<td></td>
<td>2 = Inpatient</td>
</tr>
<tr>
<td></td>
<td>3 = Day Treatment</td>
</tr>
<tr>
<td></td>
<td>4 = Spinal Cord Wellness Clinic</td>
</tr>
<tr>
<td>L</td>
<td>Condition</td>
</tr>
<tr>
<td></td>
<td>1 = Orthopedic</td>
</tr>
<tr>
<td></td>
<td>2 = Neurologic</td>
</tr>
<tr>
<td></td>
<td>3 = Cardiopulmonary</td>
</tr>
<tr>
<td></td>
<td>4 = Major Medical</td>
</tr>
<tr>
<td></td>
<td>5 = Other</td>
</tr>
<tr>
<td>M–AB</td>
<td>Body Part Values</td>
</tr>
<tr>
<td></td>
<td>0 = False (Not selected for Patient)</td>
</tr>
<tr>
<td></td>
<td>1 = True (Selected for Patient)</td>
</tr>
<tr>
<td>AC</td>
<td>Financial Category (FC)</td>
</tr>
<tr>
<td></td>
<td>0 = None</td>
</tr>
<tr>
<td></td>
<td>1 = Medicare</td>
</tr>
<tr>
<td></td>
<td>2 = WorkersComp</td>
</tr>
<tr>
<td></td>
<td>3 = Commercial</td>
</tr>
<tr>
<td></td>
<td>4 = Medicaid</td>
</tr>
<tr>
<td></td>
<td>5 = AutoLiability</td>
</tr>
<tr>
<td></td>
<td>6 = Not currently in use</td>
</tr>
<tr>
<td></td>
<td>7 = Not currently in use</td>
</tr>
<tr>
<td></td>
<td>8 = AttorneyLiability</td>
</tr>
<tr>
<td></td>
<td>9 = SelfPay</td>
</tr>
<tr>
<td></td>
<td>10 = Prevention</td>
</tr>
</tbody>
</table>
Assessment: Single Assessment Detail

The Assessment: Single Assessment Detail report duplicates the report generated at the conclusion of each patient assessment. It simply provides therapists an alternative for printing the results of the assessment for patient records and documentation.

To begin,

1. Click the Reports menu to navigate to the PAC-Metrix reports.

2. Click the Assessment: Single Assessment Detail link in the side menu. The screen will refresh with the following report parameters.

3. Identify the patient for the *Search by Patient ID then select Assessment parameter according to the following:
   a. Enter the desired patient’s exact Patient (Episode) ID
   b. Click the Search link.
      This will not only identify the patient but will also filter the associated assessments for that patient.
   c. The assessment that have been completed for the selected patient appear in the drop-down menu by their associated date and time stamp. Click the drop-down menu and choose the assessment for which you want to generate the details.


5. After a moment both the report and a print dialog will be displayed automatically in your browser (see the following partial screen shot).
Configure the printer parameters and then click OK to output the report to the printer.

The first two pages of the report summarizes the information captured in the assessment and then graphically illustrates the expected capability the patient will have based on the scores in each of three domains of function:

- Basic Mobility
- Daily Activity
- Applied Cognitive

Key Considerations

- Assessment: Single Assessment Detail is the only report accessible to associate users from the Reports menu. The following screen shot illustrates what associate users see when they click the menu item.

Your browser must allow pop-ups or this report will not function properly.
Assessment Summary Page 1: “Give This to Your Therapist”
In addition to the scores in the domains of function, the balance of the first page provides a summary of the questions presented to the patient and the patient's answers. Its sole purpose is to inform the therapist as to how the assessment was conducted, and to allow the therapist to review answers to specific questions as input when setting the patient's Outcome goals.

Assessment Summary Page 2: Patient Summary of Scores
The second page is a duplicate of the first with the exception of the instruction to give it to the therapist. This is the patient's record as to how the assessment was conducted and the results.
Note: It is important that the patient not use the results of an old assessment to drive the completion a subsequent survey.

Assessment Summary Page 3: Daily Activity Results

The third page presents the patient's score for Daily Activity above a graphic that illustrates different levels of capability and how they relate to different scores. By drawing a vertical line on the chart approximately along the score (at the x-axis), you can determine the expected level of difficulty a patient will have performing a number of tasks associated with Daily Activities.
This chart was developed as a part of the testing of the AMPAC tool and has scientific validity. A given patient may vary slightly from it, but the chart is statistically valid over a population of patients.

**Key Considerations**

- This chart should be used with the patient to discuss therapy outcome goals and the different levels of function that the patient would like to achieve. Using this graph, the patient and therapist can arrive at a goal value for the Daily Activity AMPAC Score, which in turn can be used as a means of measuring progress during the course of therapy.

- Daily Activities may not apply to all patients. It is up to the discretion of the therapist to determine its relevance and then communicate this to the patient.

- Below the graphic is an explanation of five different stages of functional ability. This text will provide the patient and therapist with a base understanding of the information represented in the graph.

**Assessment Summary Page 4: Basic Mobility Results**

The fourth page presents a patient’s Basic Mobility score above a graphic that illustrates different levels of capability and how they relate to different scores. By drawing a vertical line on the chart approximately along the score (at the x-axis), you can determine the expected level of difficulty a patient will have performing a number of tasks associated with Basic Mobility.
This chart was developed as a part of the testing of the AMPAC tool and has scientific validity. A given patient may vary slightly from it, but the chart is statistically valid over a population of patients.

**Key Considerations**

- The Basic Mobility chart should be used with the patient to discuss therapy outcome goals and the different levels of function that the patient would like to achieve. Using this graph, the patient and therapist can arrive at a goal value for the Basic Mobility AMPAC Score and use this as a means of measuring progress during the course of therapy.

- Basic Mobility may not apply to all patients. It is up to the discretion of the therapist to determine its relevance and then communicate this to the patient.

- Below the graphic is an explanation of five different stages of functional ability. This text will provide the patient and therapist with a base understanding of the information represented in the graph.

**Assessment Summary Page 5: Applied Cognitive Results**

The fifth page presents the patient’s Applied Cognitive score above a graphic that illustrates different levels of capability and how they relate to different scores. By drawing a vertical line on the chart approximately along the score (at the x-axis), you can determine the expected level of difficulty a patient will have performing a number of tasks associated with Applied Cognitive functions.
This chart was developed as a part of the testing of the AMPAC tool and has scientific validity. A given patient may vary slightly from it, but the chart is statistically valid over a population of patients.

**Key Considerations**

- The Applied Cognitive chart should be used with the patient to discuss therapy outcome goals and the different levels of function that the patient would like to achieve. Using this graph, the patient and therapist can arrive at a goal value for the Applied Cognitive AMPAC Score and use this as a means of measuring progress during the course of therapy.

- Applied Cognitive may not apply to all patients. It is up to the discretion of the therapist to determine its relevance and then communicate this to the patient.

- Below the graphic is an explanation of five different stages of functional ability. This text will provide the patient and therapist with a base understanding of the information represented in the graph.
**Improvement: Condition Type & Body Part**

The *Improvement by Condition Type and Body Part* report lists patients who have had an assessment in the date range provided and sorts those patients first by *facility* and then by *condition type*. And then if it is relevant to the condition type, they are further sorted by *body part*.

The scores included in the report are a basic comparison of the patient's first assessment and their most recent assessment (within the date range) in each of the three domains of function (Activity, Mobility, and Cognitive) and then sorted by condition type. Finally, a raw “statistic” that measures the net improvement between the patient's assessments in each domain function is provided in the last column set. A positive number indicates that the patient's function improved and a negative number indicates a loss.

The scores for the patients in each subsection of the report are averaged to provide a general impression of the progression of patient with a given condition. For example, a hypothetical Chandler facility may have 3 patients categorized as having a Major Medical Condition over a given date range whose initial average Basic Mobility score was 54.55 and whose most recent average score was 56.37.

**Note:** Averages are reported as population-based reference. Caution should be exercised when making subpopulation comparisons requiring case next adjustment. Averages are unweighted.

To generate the report,

1. Click the **Reports** menu to view a list of reports.
2. Click the **Improvement: Condition Type & Body Part** link in the side menu. The screen will refresh with the following report parameters.

3. Complete the parameters according to the following descriptions:

   **Facility:** Click the checkbox next to the facilities on which to generate data.

   ➢ As an alternative, click the **Select All** link to choose all of them. Click **Unselect All** to clear the selections and start over.

   Facilities provide the top level sorting for the report.

   **Start Date/End Date:** Enter the date range for the report. Any patients who have received an assessment within the range are included in the report.
**Condition Type:** Choose from among the options provided.

- Cardiopulmonary
- Major Medical Condition
- Neurologic
- Orthopedic
- Other

Click the **Select All** link to choose all of them. Click **Unselect All** to clear the selections.

Condition types provide sorting for the report within each facility subsection.

**Body Parts:** If you choose the condition type orthopedic, you will also be required to choose the body parts on which to report. Choose from among any of the options provided. Click the **Select All** link to choose all of them. Click **Unselect All** to clear the selections.

**Format:** Choose the output file format: Accept PDF as the default or click the drop-down menu to choose Excel as an alternative.

4. Click the **Run Report** button.

5. Choose whether to output the report to a file or to open it in the appropriate application for viewing files of the given type. The output for the report appears similar to the following screen shot.

**Note:** Patients must have an active episode to appear on improvement reports. Patients who do not have assessments subsequent to their initial assessment should not appear at all.
Improvement: Facility & Admit Date

The Improvement by Facility and Admit Date report provides the same general statistics as the Improvement by Condition Type and Body Part report. The differences simply lie in how the data is filtered. Essentially, all of the patients who have an admission date within the date range provided for the report are grouped alphabetically by facility. Then the patient’s first and most recent assessments are compared for each of the three domains of function (Basic Mobility, Daily Activity, and Cognitive) to provide a basic net improvement statistic. Again averages are reported as a population-based reference, and are unweighted. Caution should be exercised when making subpopulation comparisons requiring case next adjustment.

To generate the report,

1. Click the Reports menu to view a list of reports
2. Click the Improvement: Facility and Admit Date link in the side menu. The screen will refresh with the following report parameters.

3. Complete the parameters according to the following descriptions:
   - **Facility:** Click the checkbox next to the facilities on which to generate data.
     - As an alternative, click the Select All link to choose all of them. Click Unselect All to clear the selections and start over.
   - Facilities provide the top level sorting for the report.
   - **Start Date/End Date:** Enter the date range for the report. Patients whose date of admission falls within the date range will be included in the report.
   - **Format:** Choose the output file format: Accept PDF as the default or click the drop-down menu to choose Excel as an alternative.

4. Click the Run Report button.
5. Choose whether to output the report to a file or to open it in the appropriate application for viewing files of the given type. The output for the report appears similar to the following screen shot.

**Note:** Patients must have an active episode to appear on improvement reports. Patients who do not have assessments subsequent to their initial assessment should not appear at all.
Improvement: Facility & Financial Class

The final improvement report— *Improvement by Facility and Financial Class*— not only provides the same score comparisons as the facility/condition and facility/admit date reports but also illustrates how those patients are distributed across the standard financial class categories.

None | Medicaid
Medicare | Auto Liability
Workers Comp | Attorney Liability
Commercial | Self-Pay
Prevention

Keep in mind that the same concerns discussed for the previous improvement reports apply to this report as well.

To generate the report,

1. Click the **Reports** menu to view a list of reports
2. Click the **Improvement: Facility & Financial Class** link in the side menu. The screen will refresh with the following report parameters.

3. Complete the parameters according to the following descriptions:
   - **Facility**: Click the checkbox next to the facilities on which to generate data.
     - As an alternative, click the **Select All** link to choose all of them. Click **Unselect All** to clear the selections and start over.

   Facilities provide the top level sorting for the report.

   - **Start Date/End Date**: Enter the date range for the report. Any patients who have received an assessment within the range are included in the report.

   - **Format**: Choose the output file format: Accept PDF as the default or click the drop-down menu to choose Excel as an alternative.

4. Click the **Run Report** button.

5. Choose whether to output the report to a file or to open it in the appropriate application for viewing files of the given type. The output for the report appears similar to the following screen shot.
**Note:** Patients must have an active episode to appear on improvement reports. Patients who do not have assessments subsequent to their initial assessment should not appear at all.
Most Recent Assessment: List by Facility & Date

The *Most Recent Assessment* report provides scores for the most recent assessment within the date range provided, and then it lists patients alphabetically by facility. In addition to the raw number score and standard deviation, the Claims-based Outcomes Reporting (CBOR) codes are also included for each domain of function as appropriate.

To run generate the report,

1. Click the **Reports** menu to view a list of reports
2. Click the **Most Recent Assessment: List by Facility & Date** link in the side menu. The screen will refresh with the following report parameters.

3. Complete the parameters according to the following descriptions:

   **Facility**: Click the checkbox next to the facilities on which to generate data.
   - As an alternative, click the **Select All** link to choose all of them. Click **Unselect All** to clear the selections and start over.

   Facilities provide the top level sorting for the report.

   **Start Date/End Date**: Enter the date range for the report. Patients who have received an assessment within the range along with the scores for the most recent assessment within the date range are included.

   **Format**: Choose the output file format: Accept PDF as the default or click the drop-down menu to choose Excel as an alternative.

4. Click the **Run Report** button.
5. Choose whether to output the report to a file or to open it in the appropriate application for viewing files of the given type. The output for the report appears similar to the following screen shot.
<table>
<thead>
<tr>
<th>Facility</th>
<th>Date</th>
<th>SM Score</th>
<th>SM Std Error</th>
<th>SM CHDR</th>
<th>Dia Score</th>
<th>Dia Std Error</th>
<th>Dia CHDR</th>
<th>Cog Score</th>
<th>Cog Std Error</th>
<th>Cog CHDR</th>
</tr>
</thead>
<tbody>
<tr>
<td>East Niantic</td>
<td>03/01/10</td>
<td>65.35</td>
<td>1.35</td>
<td>74.74</td>
<td>1.02</td>
<td>74.74</td>
<td>0.98</td>
<td>65.35</td>
<td>1.02</td>
<td>65.35</td>
</tr>
<tr>
<td>West Niantic</td>
<td>03/01/10</td>
<td>65.35</td>
<td>1.35</td>
<td>74.74</td>
<td>1.02</td>
<td>74.74</td>
<td>0.98</td>
<td>65.35</td>
<td>1.02</td>
<td>65.35</td>
</tr>
</tbody>
</table>

**Facility Count:** 2

**County:**

<table>
<thead>
<tr>
<th>Facility</th>
<th>Date</th>
<th>SM Score</th>
<th>SM Std Error</th>
<th>SM CHDR</th>
<th>Dia Score</th>
<th>Dia Std Error</th>
<th>Dia CHDR</th>
<th>Cog Score</th>
<th>Cog Std Error</th>
<th>Cog CHDR</th>
</tr>
</thead>
<tbody>
<tr>
<td>York County</td>
<td>03/01/10</td>
<td>65.35</td>
<td>1.35</td>
<td>74.74</td>
<td>1.02</td>
<td>74.74</td>
<td>0.98</td>
<td>65.35</td>
<td>1.02</td>
<td>65.35</td>
</tr>
</tbody>
</table>

**Facility Count:** 2

**Test:**

<table>
<thead>
<tr>
<th>Facility</th>
<th>Date</th>
<th>SM Score</th>
<th>SM Std Error</th>
<th>SM CHDR</th>
<th>Dia Score</th>
<th>Dia Std Error</th>
<th>Dia CHDR</th>
<th>Cog Score</th>
<th>Cog Std Error</th>
<th>Cog CHDR</th>
</tr>
</thead>
<tbody>
<tr>
<td>York County</td>
<td>03/01/10</td>
<td>65.35</td>
<td>1.35</td>
<td>74.74</td>
<td>1.02</td>
<td>74.74</td>
<td>0.98</td>
<td>65.35</td>
<td>1.02</td>
<td>65.35</td>
</tr>
</tbody>
</table>

**Facility Count:** 2

**County:**

<table>
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<tr>
<th>Facility</th>
<th>Date</th>
<th>SM Score</th>
<th>SM Std Error</th>
<th>SM CHDR</th>
<th>Dia Score</th>
<th>Dia Std Error</th>
<th>Dia CHDR</th>
<th>Cog Score</th>
<th>Cog Std Error</th>
<th>Cog CHDR</th>
</tr>
</thead>
<tbody>
<tr>
<td>York County</td>
<td>03/01/10</td>
<td>65.35</td>
<td>1.35</td>
<td>74.74</td>
<td>1.02</td>
<td>74.74</td>
<td>0.98</td>
<td>65.35</td>
<td>1.02</td>
<td>65.35</td>
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**Facility Count:** 2

**County:**

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<td>03/01/10</td>
<td>65.35</td>
<td>1.35</td>
<td>74.74</td>
<td>1.02</td>
<td>74.74</td>
<td>0.98</td>
<td>65.35</td>
<td>1.02</td>
<td>65.35</td>
</tr>
</tbody>
</table>
Patient Detail: Assessment History

The Patient Detail report is a straightforward history of the assessments that have been completed for a patient for a given episode. In addition to the name and ID, the following registration information is included:

<table>
<thead>
<tr>
<th>Condition Type</th>
<th>Financial Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic Mobility Therapist</td>
<td>Daily Activity Therapist</td>
</tr>
<tr>
<td>Cognitive Therapist</td>
<td></td>
</tr>
</tbody>
</table>

The patient’s assessments are listed by date-time stamp in the order of most recent to first. The scores for each domain of function (and the corresponding CBOR code) are displayed for each assessment and then averaged for each domain to provide a basic net progression statistic.

**Note:** The patient’s demographic information is used to separate the list of assessments for multiple episodes. For example,

Patient: Bear, Smokey
Patient ID: xxxxxxxxxxxx (1)
Demographic Info
List of assessments

Patient: Bear, Smokey
Patient ID: xxxxxxxxxxxx (2)
Demographic Info
List of assessments

Where the number in parentheses (x) is the episode.

To generate the report,

1. Click the Reports menu to view a list of reports
2. Click the Patient Detail: Assessment History link in the side menu. The screen will refresh with the following report parameters.

3. Complete the parameters according to the following descriptions:
   - **Patient ID:** Enter the patient’s ID (episode) number.
   - **Format:** Choose the output file format: Accept PDF as the default or click the drop-down menu to choose Excel as an alternative.
4. Click the Run Report button.
5. Choose whether to output the report to a file or to open it in the appropriate application for viewing files of the given type. The output for the report appears similar to the following screen shot.

![Patient History Chart]

Patient History

<table>
<thead>
<tr>
<th>Date</th>
<th>Basic Mobility</th>
<th>Daily Activity</th>
<th>Cognitive</th>
</tr>
</thead>
<tbody>
<tr>
<td>03/21/13</td>
<td>0.00</td>
<td>41.97</td>
<td>0.00</td>
</tr>
<tr>
<td>03/22/13</td>
<td>0.00</td>
<td>41.97</td>
<td>0.00</td>
</tr>
<tr>
<td>03/28/13</td>
<td>0.00</td>
<td>56.97</td>
<td>0.00</td>
</tr>
<tr>
<td>03/31/13</td>
<td>0.00</td>
<td>54.64</td>
<td>0.00</td>
</tr>
</tbody>
</table>

Total Gain: 8.77
Patients List: New Patients

The Patient List: New Patients report lists patients who were registered within the date range provided and then groups them according the facility in which they were registered. In addition to the patient description and registration date, the date of the first assessment and the subsequent scores for each domain of function are displayed with their standard error (SE).

To generate the report,

1. Click the Reports menu to view a list of reports
2. Click the Patient List: New Patients link in the side menu. The screen will refresh with the following report parameters.
3. Complete the parameters according to the following descriptions:
   - **Facility**: Click the checkbox next to the facilities on which to generate data.
     - As an alternative, click the Select All link to choose all of them. Click Unselect All to clear the selections and start over.
   - Facilities provide the top level sorting for the report.
   - **Start Date/End Date**: Enter the date range for the report. Any patient who was registered within the range are included in the report.
   - **Format**: Choose the output file format: Accept PDF as the default or click the drop-down menu to choose Excel as an alternative.
4. Click the Run Report button.
5. Choose whether to output the report to a file or to open it in the appropriate application for viewing files of the given type. The output for the report appears similar to the following screen shot.
Practitioner List

The *Practitioner List* is a straightforward administrative report listing the users you have been created in your organization, including their name, ID, role, associated facilities, and status.

To generate the report,

1. Click the *Reports* menu to view a list of reports

2. Click the *Practitioner List* link in the side menu. The screen will refresh with the following report parameters.

![Practitioner List menu](image)

3. Choose the output file format: Accept PDF as the default or click the drop-down menu to choose Excel as an alternative.

4. Click the *Run Report* button.

5. Choose whether to output the report to a file or to open it in the appropriate application for viewing files of the given type. The output for the report appears similar to the following screen shot.

![Practitioner List output](image)