SMART Therapy Training Manual

TX Resident Part 2

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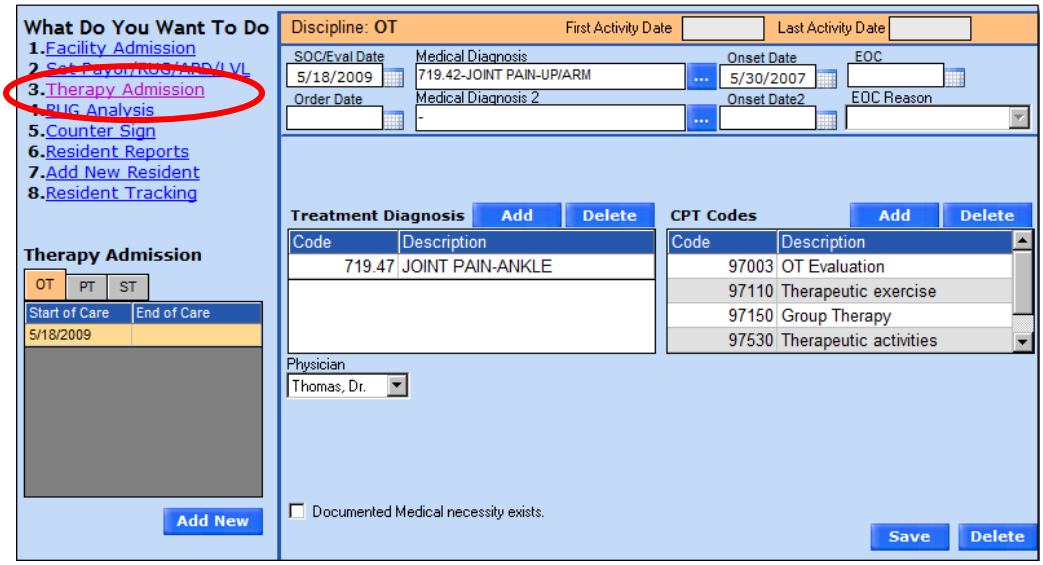
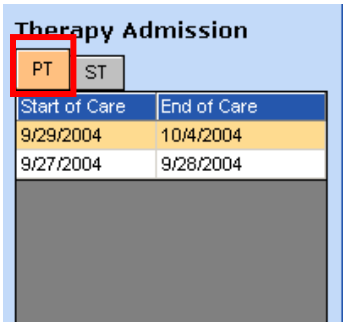
THERAPY ADMISSION

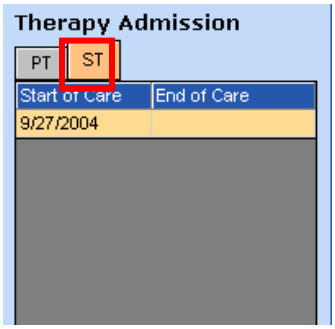
THERAPY ADMISSION OVERVIEW

The Therapy Admission screen allows the user to enter independent Start of Care Dates and End of Care Dates for each discipline. The discipline will default to the user's discipline. To select another discipline, press the OT, PT, or ST buttons. Other disciplines can be viewed in read only, but cannot be edited. Only users with Team Lead access in SMART can add or edit all 3 disciplines.

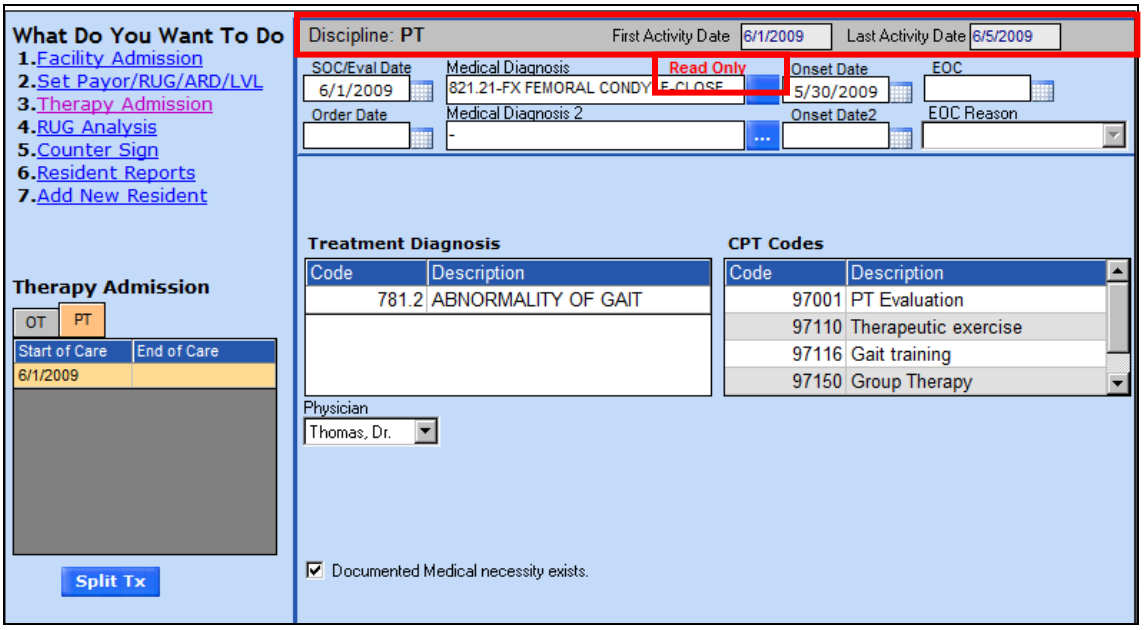


Selecting a Tab for a Discipline will display the history of that Discipline's admissions under the Therapy Admission area of the screen.

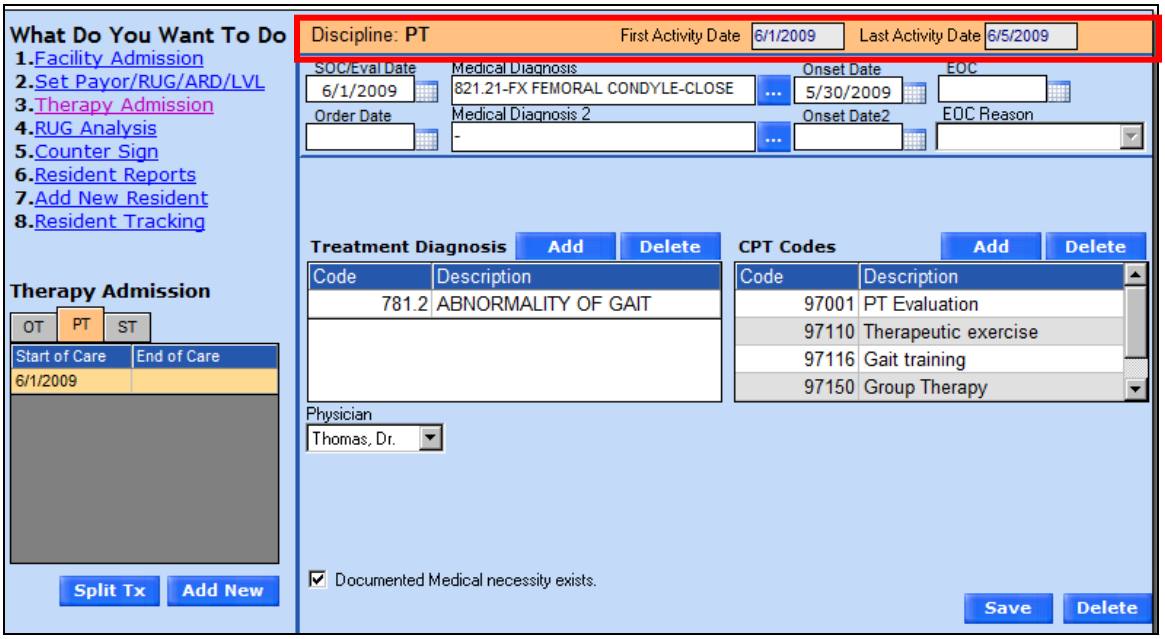




When the selected Discipline is not the Discipline of the currently logged in User, the screen will be 'Read Only'. The Header Information Bar will be gray and the Add and SAVE buttons are not available. No changes to any information will be allowed.



When the selected Discipline is the same discipline as the currently logged in User, the Header Information Bar is orange and the buttons are available.



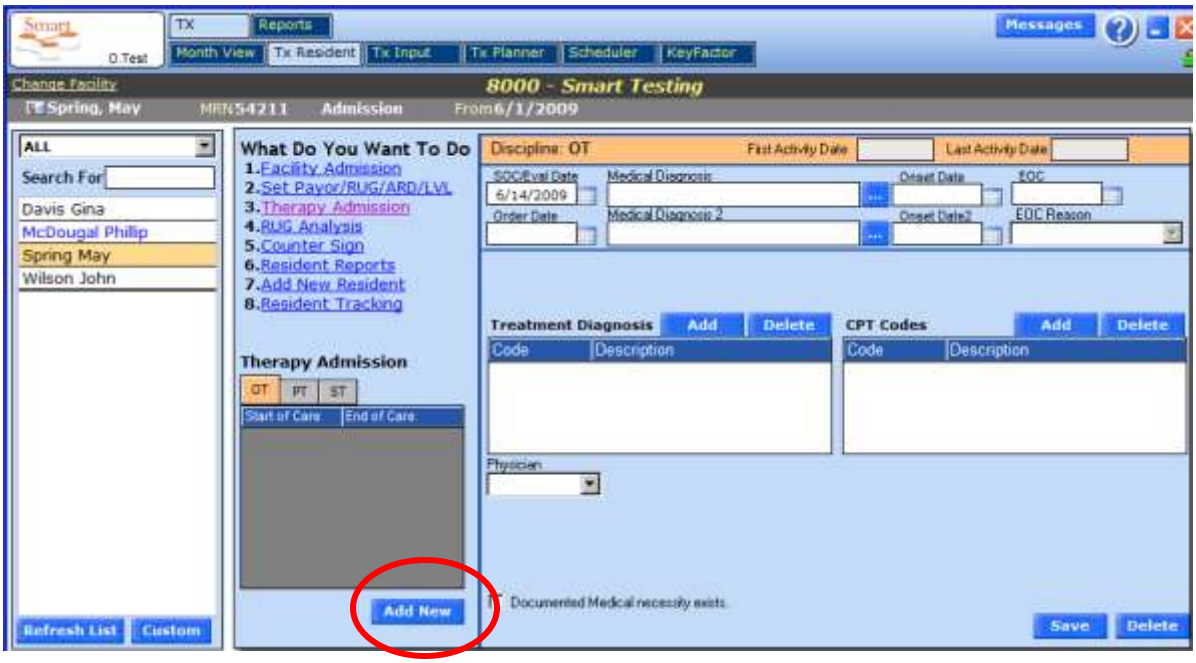
TIP

** **If the user is marked as TEAM LEAD on the user screen, the user will be able to add/edit all three discipline's information on the Therapy Admission screen.**

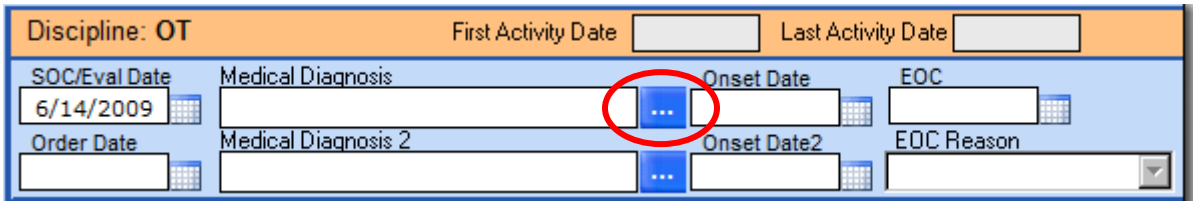
ADDING A NEW THERAPY ADMISSION

Select the patient name from the list and Select #3 Therapy Admission. Once the Therapy Admission window opens, click on the Add New button.

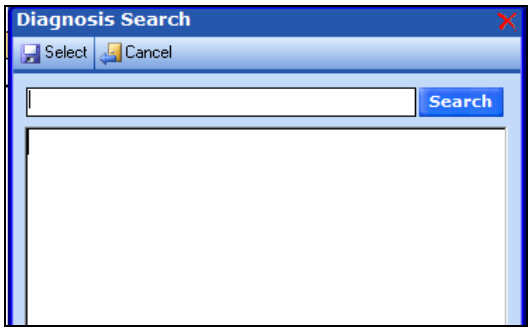
The SOC/Eval Date will automatically populate with today's date. The date can be changed using the calendar.

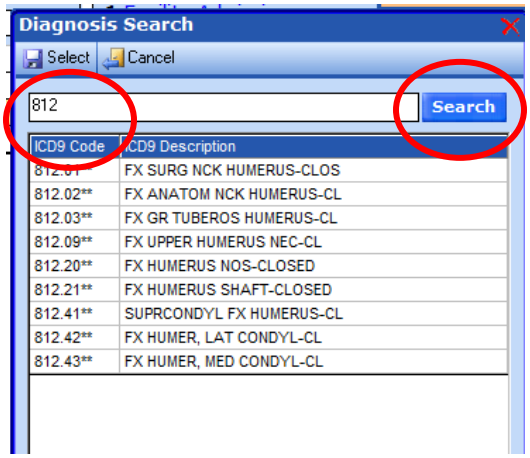


Use the Ellipsis to enter a Medical Diagnosis.



The Diagnosis Advanced Search window will open





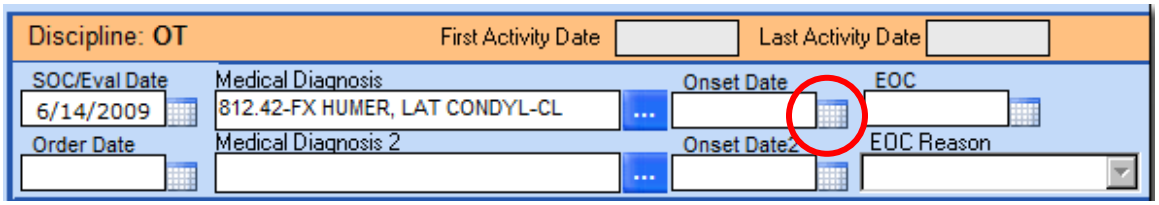
Type in the ICD9 code that applies, and then click on the Search button.

A list of ICD9 Codes and ICD9 Descriptions will display. Choose a code and click on the Select button.

The ICD9 Code will then be inserted into the field.

Click on the Cancel button to close the screen without selecting the code.

Enter the Medical Diagnosis Onset Date by clicking on the small calendar. **Note: The Onset Date cannot be after the SOC/Eval date.**



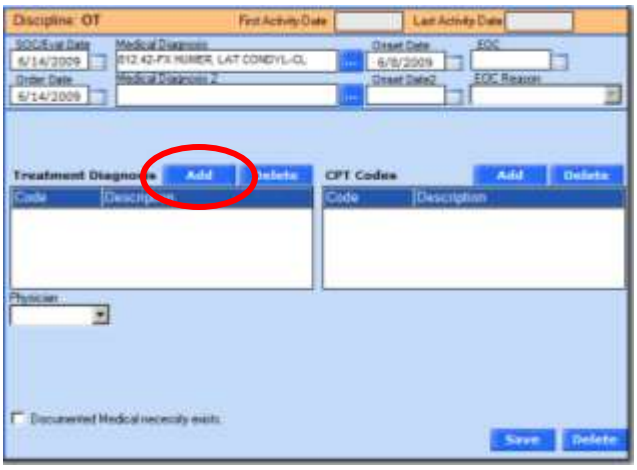
The EOC can also be added by clicking on the small calendar for its field. EOC Reason can be entered by using the dropdowns. The EOC will be entered later once the care has ended for the specific discipline, leave it blank for now.

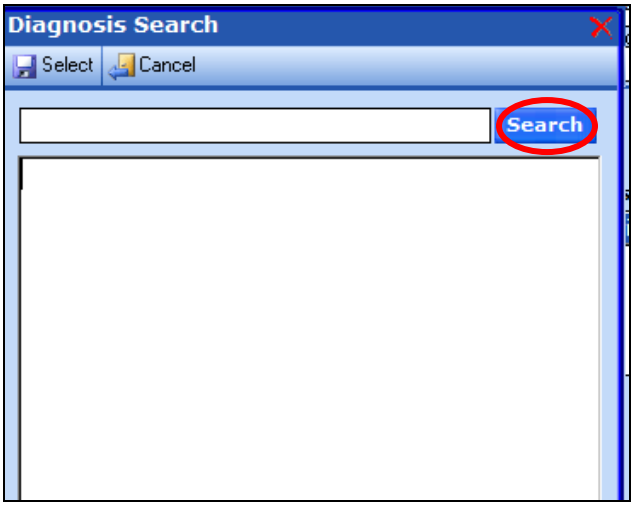
The Order Date can be inserted using the calendar.

A secondary Medical Diagnosis and Onset date can be enter following the same steps used for the Primary Medical Diagnosis and Onset Date.

Next add the Treatment Diagnosis by clicking on the Treatment Diagnosis Add button.

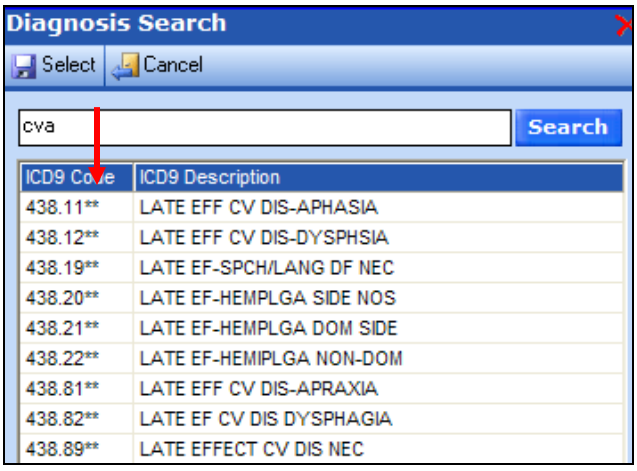
Note: At least one Treatment Diagnosis must be entered for each discipline.





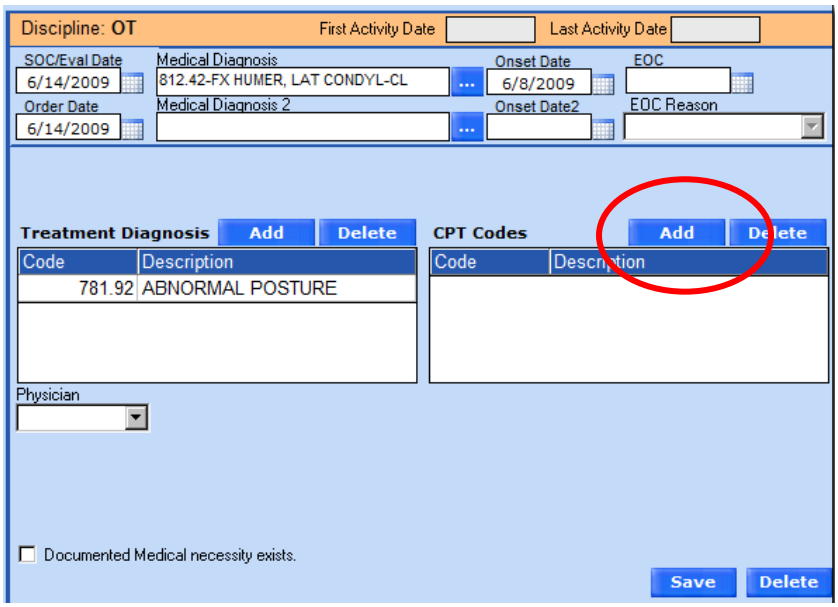
The Diagnosis Advanced Search window will open. Type in the ICD9 code that is appropriate, and then click the Search button. A list of ICD9 Codes and ICD9 Descriptions will display. Choose a code and click on the Select button.

To add in a secondary treatment diagnosis code, repeat the process.



Published automatic or complexity ICD-9 codes are highlighted with an asterisk (*) in the Diagnosis Search boxes. This is applicable for both Medical and Treatment Diagnosis searches.

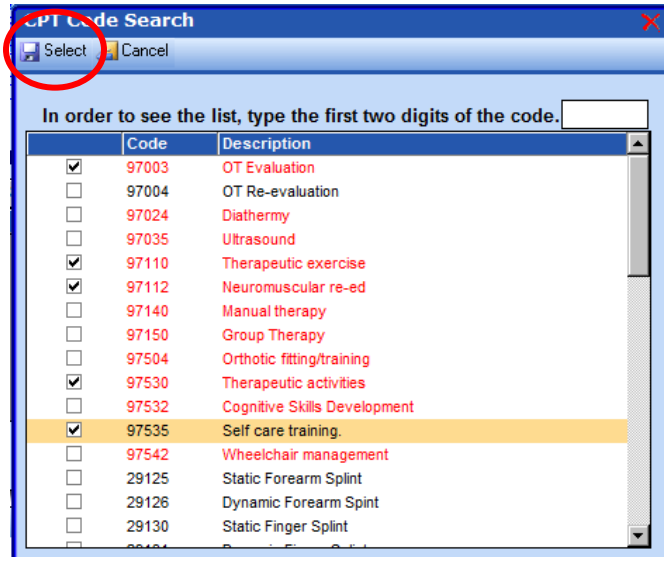
To add a CPT code, click on the Add button.



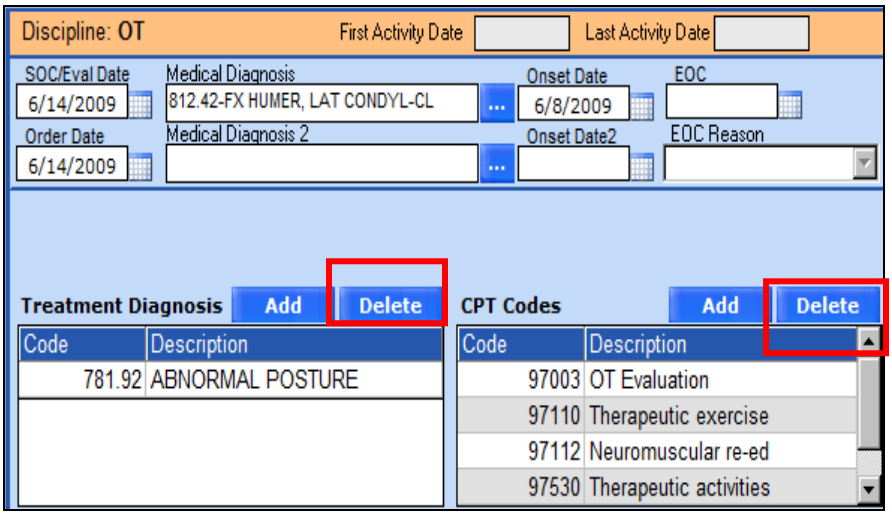
The CPT Code Search window opens. The codes that display in RED are the codes most commonly used with the Treatment DX code selected. Codes in BLACK can still be selected.

To see specific codes, type the first two digits of the code in the box. The search box will shorten the display window of codes.

Click on as many CPT Codes as appropriate and then click on the Select button to set the CPT Codes. At least one CPT Code must be added to a Therapy Admission.



The CPT Code Search window opens. The codes that display in RED are the codes most commonly used with the Treatment

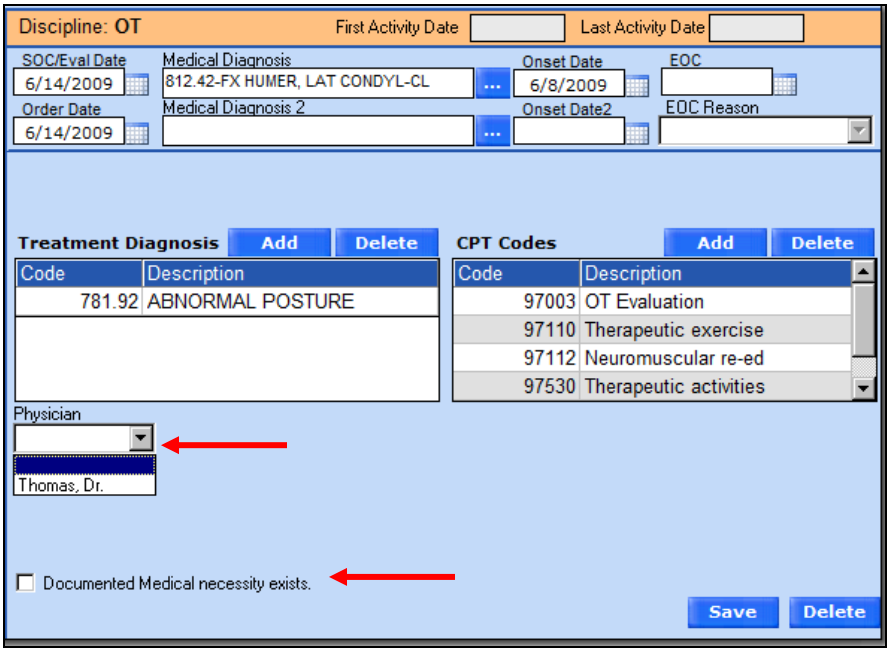


The CPT Codes and Treatment Diagnosis will display.

To add another CPT Code or Treatment Diagnosis, repeat the Add process.

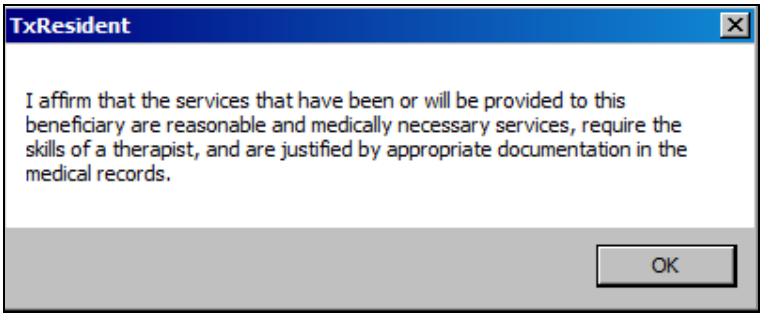
To remove CPT Codes or Treatment Diagnosis select the code and click on the DELETE button.

Note: The CPT Codes that are added are the codes that will be used to add treatment in Tx Input.



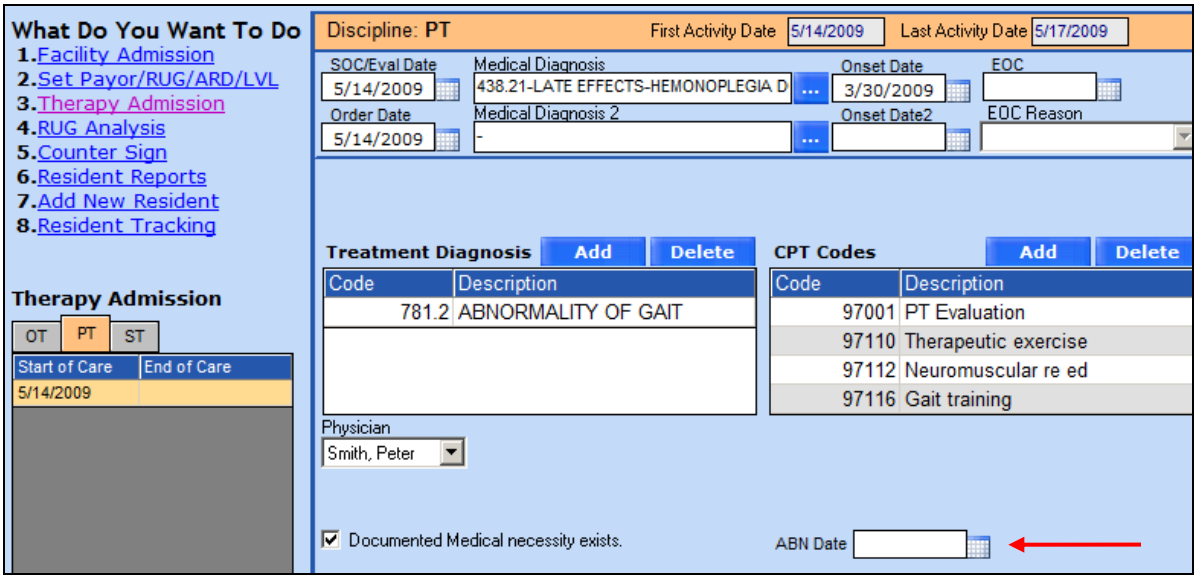
Select the Physician by using the Dropdown Arrow button.

The 'Documented Medical necessity exists' checkbox will be selected when the services that have been or will be provided are reasonable and medically necessary services, require the skills of a therapist, and are justified by appropriate documentation in the medical records. This is used as part of the Medicare Part B exception process and KX modifier if the patient exceeds the cap.



When selected, an affirmation message displays.
Click on: OK.

An optional field for ABN (Advanced Beneficiary Notice) date is also available. If medical necessity is not checked, SMART will require the therapist to insert the date the ABN was signed in order to Save. This setting can be set at the facility level.



Once all information is entered, click on SAVE at the bottom of the screen.

EDIT A THERAPY ADMISSION

To edit or remove a therapy admission, select the admission date under Therapy Admission. Make any necessary edits and click the Save button. To remove the therapy admission, press the Delete button. If there are any treatments entered in the TX Input screen these will need to be removed before the therapy admission can be deleted.

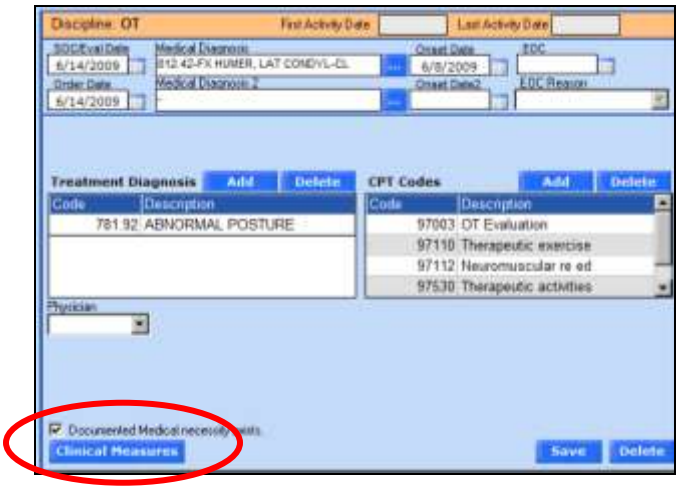
DISCHARGING A THERAPY ADMISSION

To discharge a therapy admission, select the open admission from the Therapy Admission screen. Enter the EOC date, select an EOC Reason from the drop down, and click on the Save button. The EOC Date must be equal to or greater than the Last Activity Date for the discharge information to save.

CLINICAL MEASURES

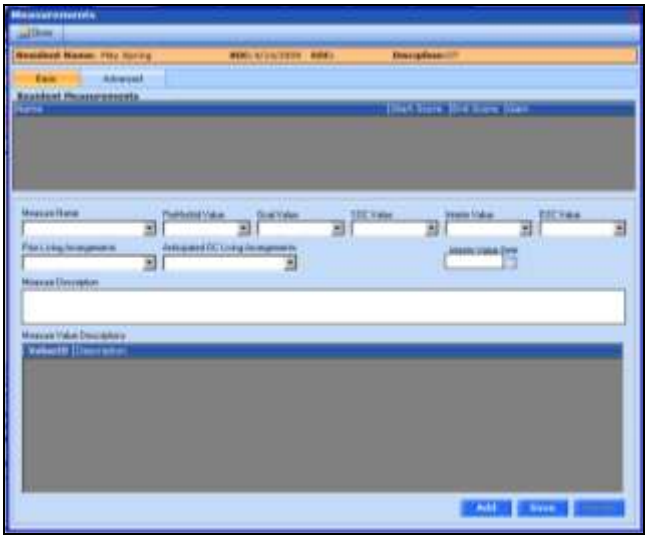
Clinical Measures is an optional module in Smart. This screen can be used to collect outcome measures for the patient. Clinical Measures measure the resident's performance at the beginning of care and the end of care.

Click on Clinical Measures button on the Therapy Admission screen.



The Measurements window will open.

The '**Measure Name**' drop down refers to the item being measured.
The '**PreMorbid Value**' drop down refers to the pre hospitalization value/ Patient's pre SOC value.
The '**Goal Value**' is the value anticipated at EOC.
The '**SOC Value**' is the rating at the beginning of treatment.
The '**Interim Value**' is the value the patient achieved at some point during treatment. Typically this value would be entered when the resident is reassessed.
The '**Interim Value Date**' is the date the resident was reassessed for the Interim Value score.
The '**EOC Value**' is the score at the end of treatment.
The '**Prior Living Arrangements**' indicates where the resident was admitted from.
The '**Anticipated DC Living Arrangements**' indicates the resident anticipated discharge location.



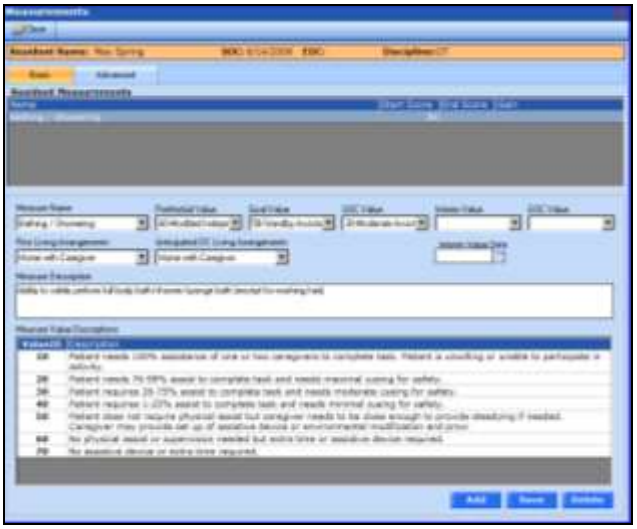
NOTE: The Prior Living Arrangements as well as Anticipated Living Arrangements should be supplied to your Casamba representative to be entered into a table in the database.
L_MeasuresLivingArrangements

BASIC MEASURES

Enter the information by using the dropdown Arrow buttons. Then click on the SAVE button.

To clear the Clinical Measurements dropdown and add a new one, click on the ADD button.

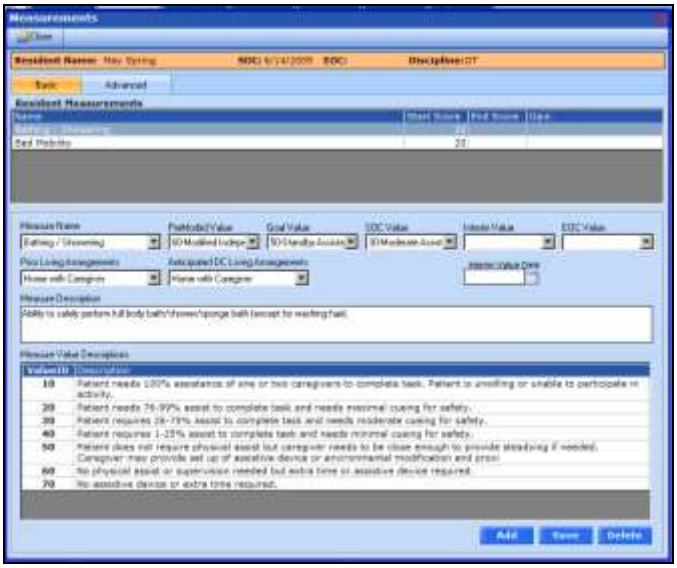
To delete an already saved indicator, select the item from the list and click on the DELETE button.



Continue adding until all the measures evaluated are listed in the Resident Measurements box.

To close the window without saving, click on the Close button.

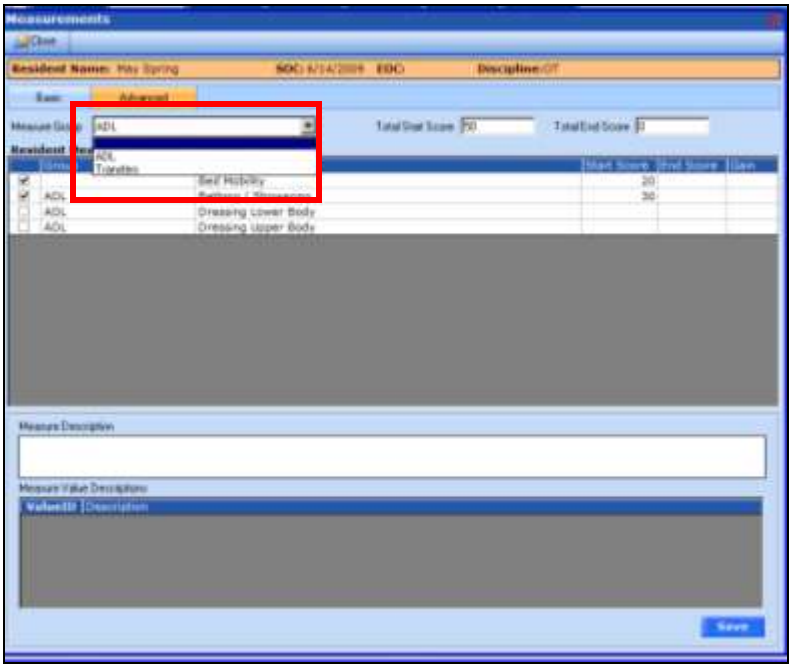
At end of care-click on the appropriate measurement in the box and enter the EOC measurement and Save.



Note: This area is completed by the Evaluating Therapist and the Therapist who completes the discontinuation of therapy.

ADVANCED MEASURES

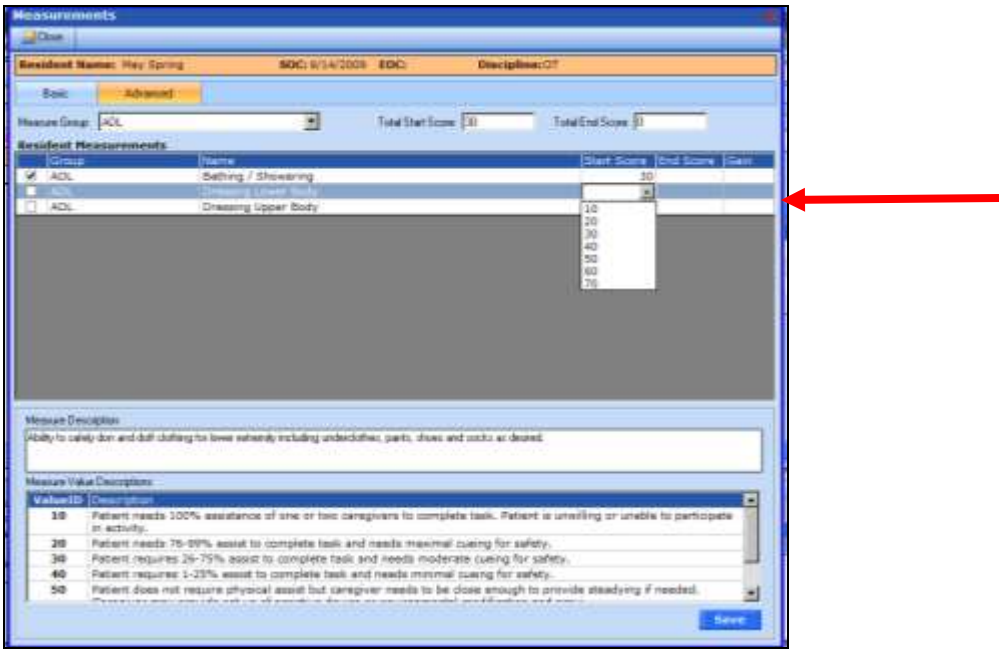
Measures can also be set using the Advanced Tab. Individual Measures can be grouped.



Choosing a Measure Group from the dropdown will display all measures associated within the group.

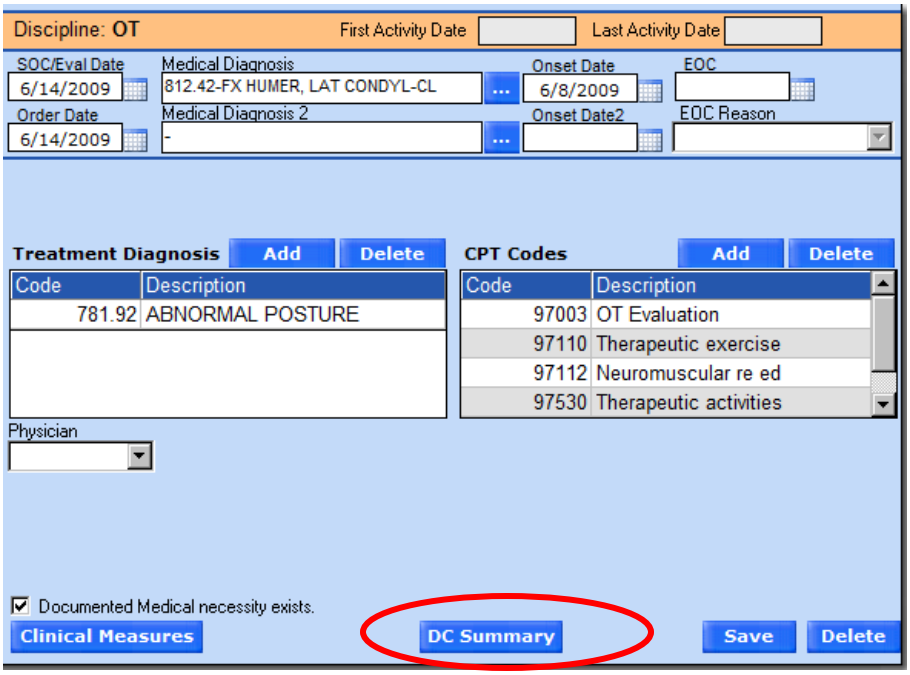
Click on the Start Score and a dropdown will appear. Select the appropriate score. Repeat for each measure.

End Scores will be entered the same way. Click on Save.

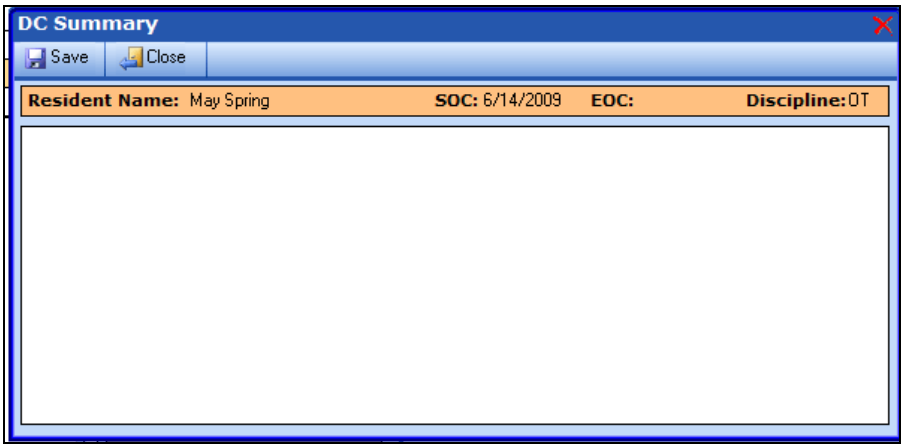


ENTERING A DISCHARGE SUMMARY

Each discipline can enter a Summary per Discipline. This Summary will display on the Outcome Summary Report.



Click on DC Summary and the Discharge Summary window appears. Enter in the Summary information, then click on SAVE.



PATIENT OUTCOME SUMMARY REPORT

The Patient Outcome Summary Report is created from the data entered in the Measures and DC Summary Screens.

Report Example:

CASAMBA

Patient Outcome Summary

8/1/2006 - 8/31/2006

8989 - Angelica Manor

Patient: Jane Smith
DOB: Jan 10, 1945
Medical Record Number:
Admission Date: Nov 29, 2005
Onset Date: 9/26/2005
Diagnostic Group:

Payer:
Rehab LOS: 276
Physician: Trol Frida
Referral Source: Marys Hospital
Rehab Discharge Date: Sep 02, 2006
Discharge Destination: Acute Hospital

	PT			OT			ST		
Medical Dx:	342.02 - FLCCD HMIPLG NONDMNT SDE			342.02 - FLCCD HMIPLG NONDM SDE			191.2 - MAL NEO TEMPORAL LOE		
Treatment Dx:	719.45 - JOINT PAIN-PELVIS			719.45 - JOINT PAIN-PELVIS			333.1 - TREMOR NEC		
Start of Care:	Nov 30, 2005			Nov 30, 2005			Aug 28, 2006		
End of Care:	Sep 01, 2006			Sep 01, 2006			Sep 01, 2006		
Length of Stay:	276 Days			276 Days			5 Days		
		Admit	D/C		Admit	D/C		Admit	D/C
Scores:	Ambulation	2.0	5.0	Hygiene/Grooming	2.0	5.0	Self Feeding	2.0	3.0
	Step Negotiation	5.0	5.0	Self Feeding	3.0	4.0	Hygiene/Grooming	2.0	4.0
	Self Feeding	3.0	5.0	Toileting	5.0	3.0	Words Pronunciation	5.0	4.0
	Toileting	2.0	5.0				Swallowing	0.0	7.0
	Hygiene/Grooming	5.0	4.0						

OT - Patient significantly demonstrated progress in rehab and met all goals

PT - Demonstrated significant progress in all areas. All goals met and ready to go home with care giver. Patient will be followed up with home care services.

****Report example is shown with the DC Summary information.

CASAMBA

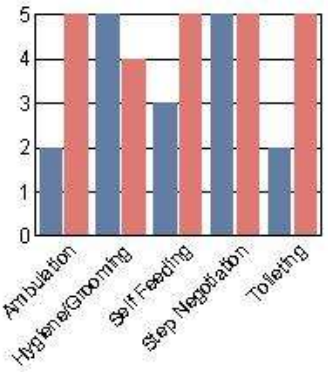
Patient Outcome Summary

8/1/2006 - 8/31/2006

8989 - Angelica Manor

Patient: Jane Smith

PT



Ambulation
2 Total
3 Maximum
4 Moderate
5 Minimum

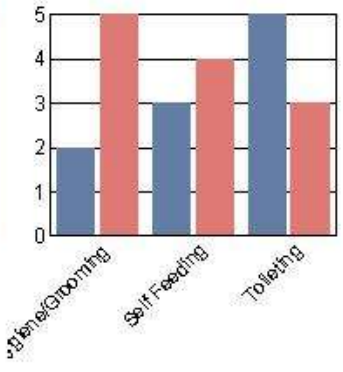
Hygiene/Grooming
2 Total
3 Maximum
4 Moderate
5 Minimum

Self Feeding
2 Total
3 Maximum
4 Moderate
5 Minimum

Step Negotiation
2 Total
3 Maximum
4 Moderate
5 Minimum

Toileting
2 Total
3 Maximum
4 Moderate
5 Minimum

OT

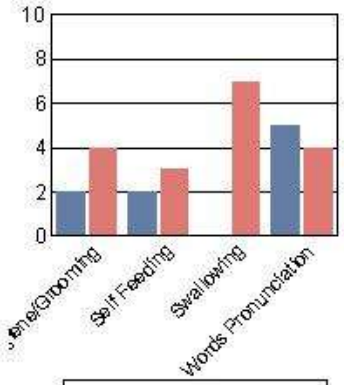


Hygiene/Grooming
2 Total
3 Maximum
4 Moderate
5 Minimum

Self Feeding
2 Total
3 Maximum
4 Moderate
5 Minimum

Toileting
2 Total
3 Maximum
4 Moderate
5 Minimum

ST



Hygiene/Grooming
2 Total
3 Maximum
4 Moderate
5 Minimum

Self Feeding
2 Total
3 Maximum
4 Moderate
5 Minimum

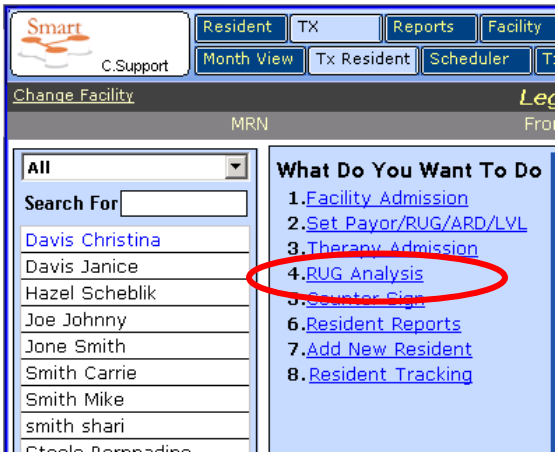
Swallowing
0 Dependent
1 Maximum
2 Moderate
3 Minimal
4 Standby
5 Independent
6 test1
7 test2

Words Pronunciation
2 Total
3 Maximum
4 Moderate
5 Minimum

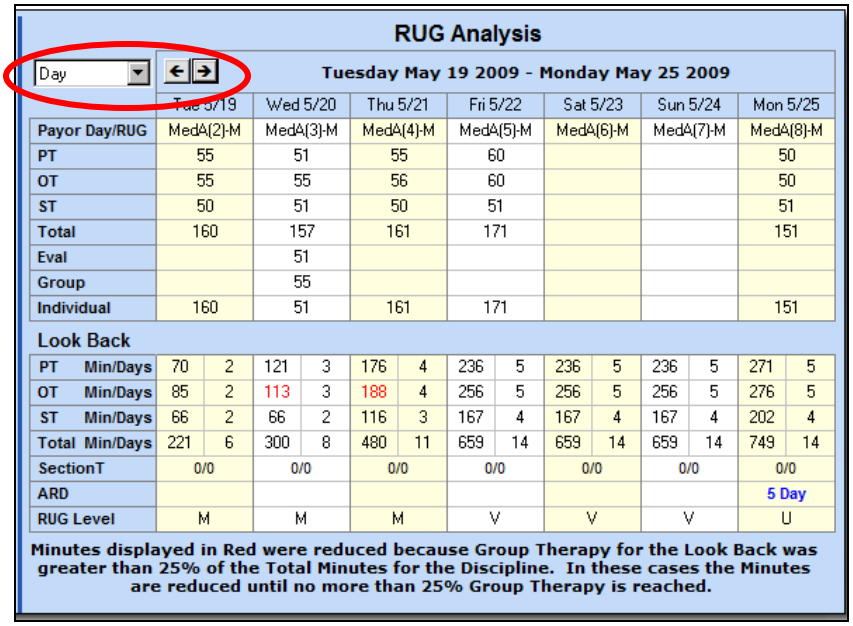
RUG ANALYSIS

The RUG Analysis screen displays the 7 day look back minutes and calculated RUG category for each day of the residents' Facility Admission.

Begin by clicking on RUG Analysis- option4



The RUG Analysis screen will display.



RUG Analysis

Day — Tuesday May 19 2009 - Monday May 25 2009

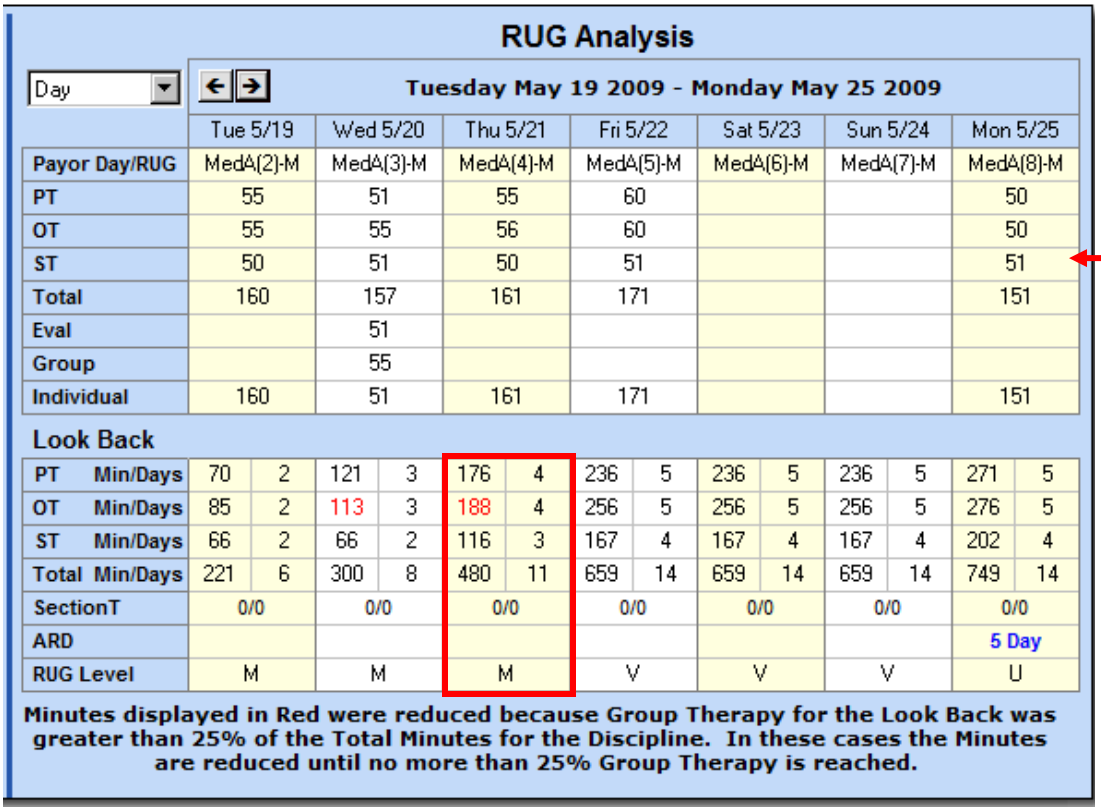
	Tue 5/19	Wed 5/20	Thu 5/21	Fri 5/22	Sat 5/23	Sun 5/24	Mon 5/25
Payor Day/RUG	MedA(2)-M	MedA(3)-M	MedA(4)-M	MedA(5)-M	MedA(6)-M	MedA(7)-M	MedA(8)-M
PT	55	51	55	60			50
OT	55	55	56	60			50
ST	50	51	50	51			51
Total	160	157	161	171			151
Eval		51					
Group		55					
Individual	160	51	161	171			151

Look Back

PT Min/Days	70	2	121	3	176	4	236	5	236	5	236	5	271	5
OT Min/Days	85	2	113	3	188	4	256	5	256	5	256	5	276	5
ST Min/Days	66	2	66	2	116	3	167	4	167	4	167	4	202	4
Total Min/Days	221	6	300	8	480	11	659	14	659	14	659	14	749	14
SectionT	0/0		0/0		0/0		0/0		0/0		0/0		0/0	
ARD													5 Day	
RUG Level	M		M		M		V		V		V		U	

Minutes displayed in Red were reduced because Group Therapy for the Look Back was greater than 25% of the Total Minutes for the Discipline. In these cases the Minutes are reduced until no more than 25% Group Therapy is reached.

This is a read only screen and data cannot be entered into it. The current week will be displayed with today as the last day. The dropdown arrow allows the screen to be moved by month, day, or week using the Forward/Backward buttons.



RUG Analysis

Day | Tuesday May 19 2009 - Monday May 25 2009

	Tue 5/19	Wed 5/20	Thu 5/21	Fri 5/22	Sat 5/23	Sun 5/24	Mon 5/25
Payor Day/RUG	MedA(2)-M	MedA(3)-M	MedA(4)-M	MedA(5)-M	MedA(6)-M	MedA(7)-M	MedA(8)-M
PT	55	51	55	60			50
OT	55	55	56	60			50
ST	50	51	50	51			51
Total	160	157	161	171			151
Eval		51					
Group		55					
Individual	160	51	161	171			151

Look Back

PT Min/Days	70	2	121	3	176	4	236	5	236	5	236	5	271	5
OT Min/Days	85	2	113	3	188	4	256	5	256	5	256	5	276	5
ST Min/Days	66	2	66	2	116	3	167	4	167	4	167	4	202	4
Total Min/Days	221	6	300	8	480	11	659	14	659	14	659	14	749	14
SectionT	0/0		0/0		0/0		0/0		0/0		0/0		0/0	
ARD													5 Day	
RUG Level	M		M		M		V		V		V		U	

Minutes displayed in Red were reduced because Group Therapy for the Look Back was greater than 25% of the Total Minutes for the Discipline. In these cases the Minutes are reduced until no more than 25% Group Therapy is reached.

The screen displays the Payor day and actual RUG level for the patient that was entered on the ARD screen.

The top area of the screen displays the actual minutes delivered for the day from the TX Input screen. This is separated by discipline with a total for the day. Eval and individual minutes are then separated on the next rows.

Look Back area displays totals for the previous seven days. If any of the Discipline totals were reduced due to the total group being greater than 25% for the previous seven days, then the total displays in RED.

Section T displays the estimated minutes and days from the 5 day ARD screen.

ARD displays the ARD type for the date the ARD is set.

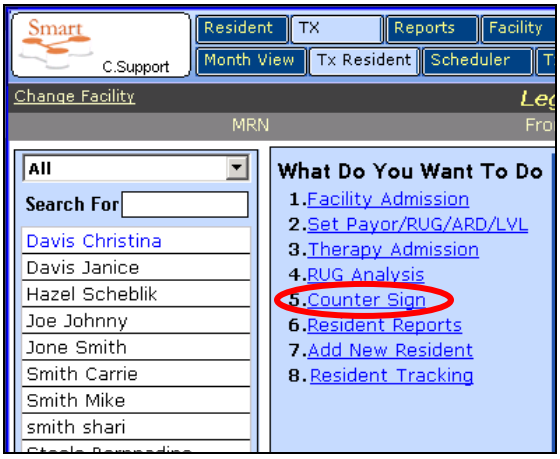
The RUG Level is calculated for each Look Back day as if that day were an ARD day.

TIP: RUG Analysis can also be viewed on the TX Planner Screen.

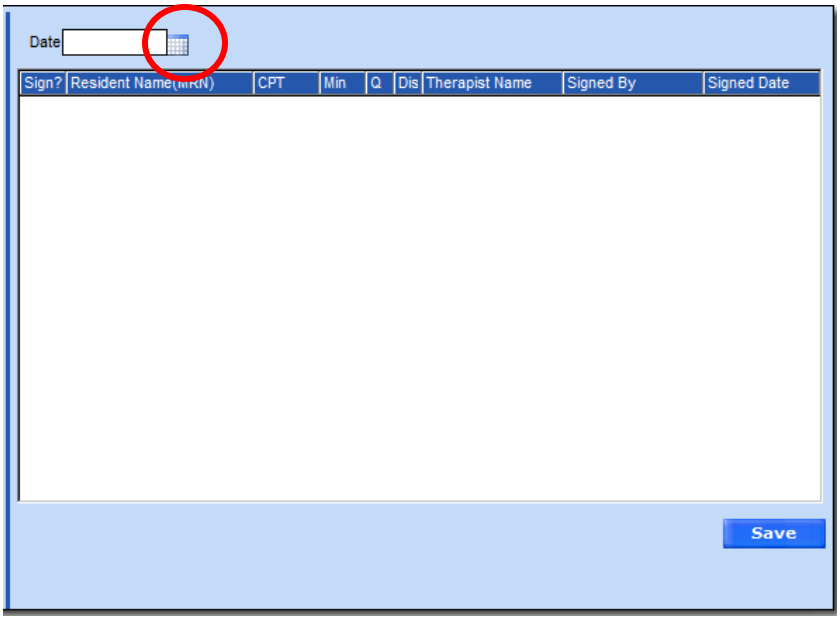
COUNTER SIGN

This screen is used to confirm the minutes/ daily notes that Therapist Assistants or any staff member who requires supervision, documented with the residents.

Begin by clicking on Counter Sign- option5

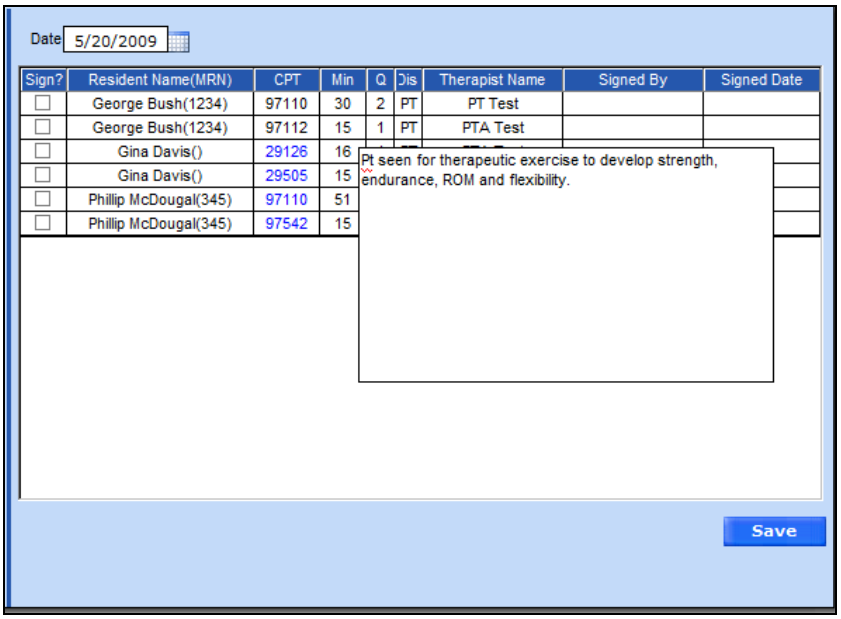


The Counter Sign screen will open.



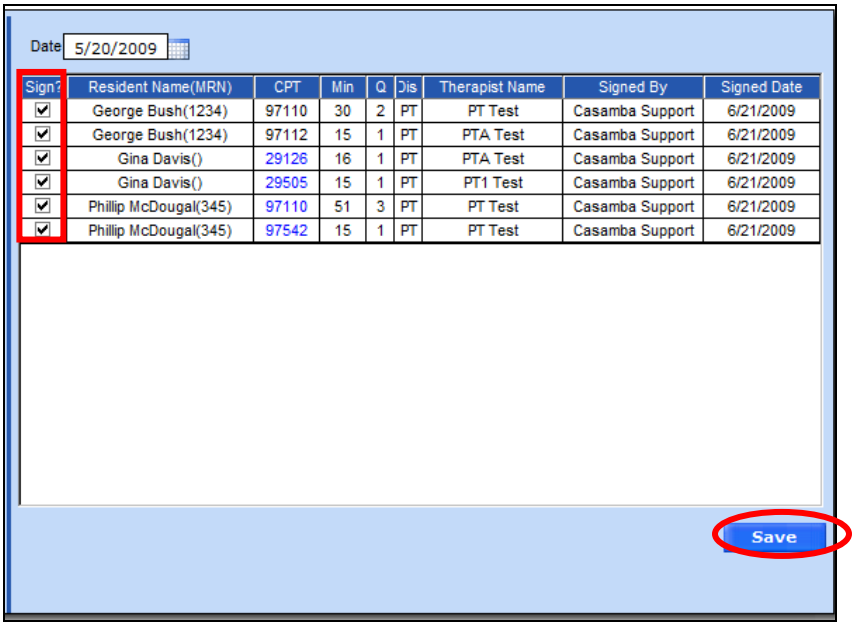
Click on the Calendar button to select the day to review for counter sign.

Once the user selects a date, a list of residents who had treatment rendered within the same discipline as the user will display.



The CPT column will display daily notes in BLUE. CPT codes without a daily note written on the TX Input screen will display in BLACK.

Hovering the mouse over CPT Notes in BLUE will display on the screen for easy review before countersigning.



Check the Sign? boxes of the treatment supervised, and click on the SAVE button.

The signed by field and date will be inserted.

The counter sign appears on the service logs for the patient.

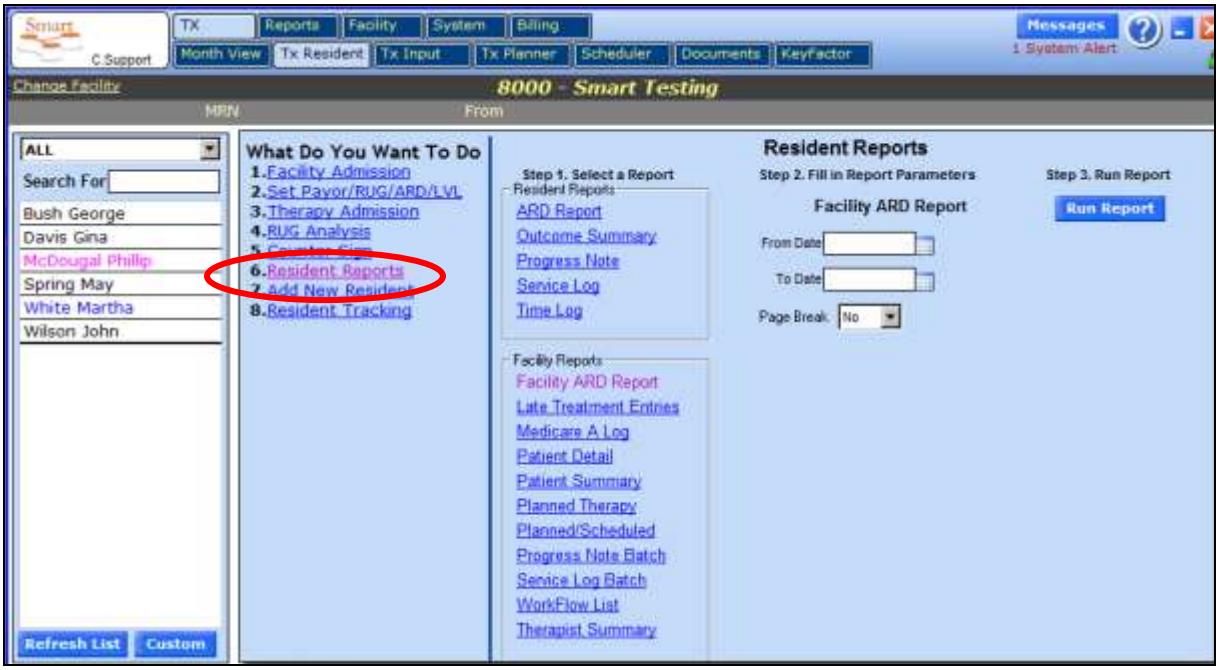
Counter signing any treatment will lock the TX Input screen so that changes can't be made to any treatment which has been counter signed.

TIP

Only a licensed therapist can counter sign. This page is read only if you are not licensed.

RESIDENT REPORTS

Resident reports are reports which are used the most frequently by the therapy staff. Begin by clicking on Resident Reports.



The Resident Reports screen displays.

- Reports under the Resident Reports will display data only for the selected resident.
- Reports under the Facility Reports will display data for all residents for the parameter the report is run.

To run a report, select the report, enter the requested parameters for the report, and select Run Report. The report will calculate and automatically pull up in Adobe PDF.

TIP

**Refer to the TX Resident Report Manual for details on the reports in this section.

RESIDENT TRACKING

Resident Tracking is used to prompt the Therapy team for periodic screening of Facility Residents. It is also used to track the progress of the screen process. Additionally, screening forms are available for each discipline.

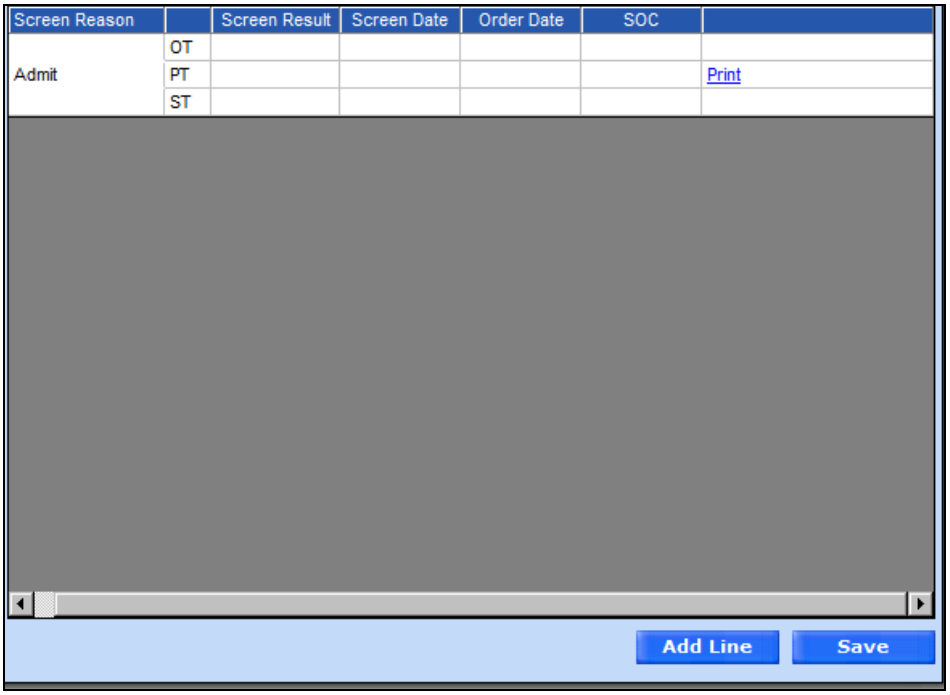
Residents are triggered for a screen based on one of the following events:

- New Admission or Re Admission to the Facility
- Two weeks after discharge off of Medicare
- Three weeks prior to when the next OBRA assessment is due

Screens can also be added by the Therapy team for non triggered reasons.

An alert is also available that can display residents who are due for screening.

Select the Resident from the list and select Resident Tracking. The screen will display.



‘Screen Reason’ displays the trigger reason.

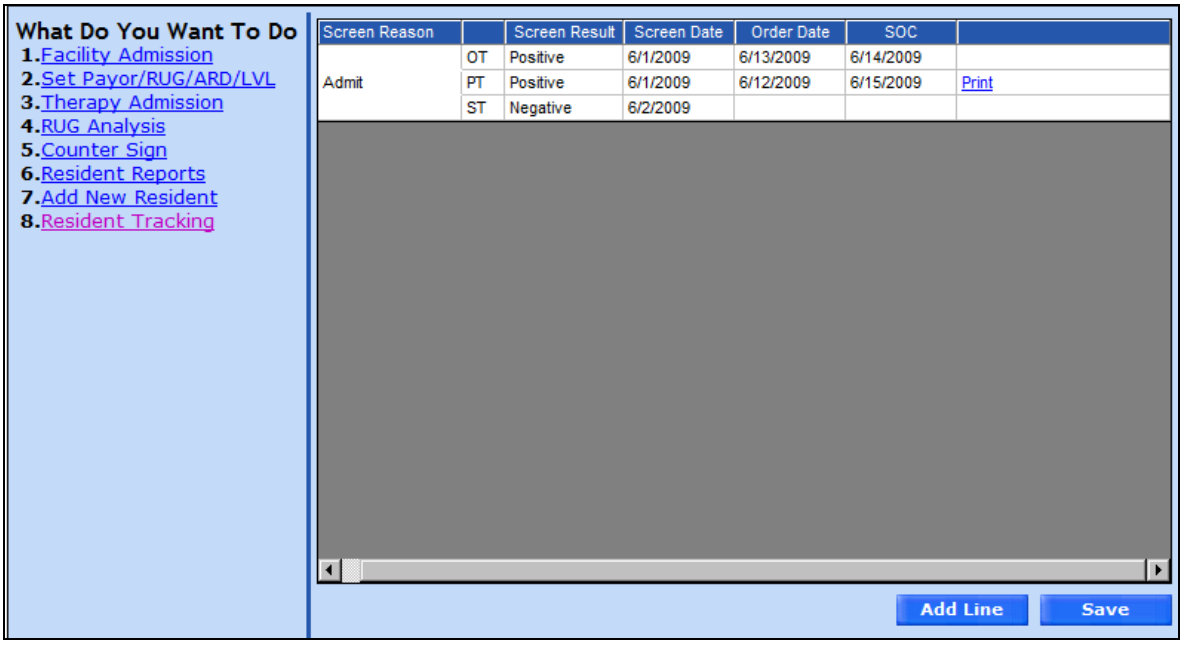
‘Screen Result’ allows the Therapist to document whether the screen was Negative (no further action required) or Positive (deficit was identified that could benefit from skilled Therapy services).

‘Screen Date’ is used to indicate the date of the screen.

‘Order Date’ is used to indicate the date the Eval was ordered.

‘SOC’ is the Therapy Start of Care Date.

‘Print’ will print the therapy screening form which can be completed for the resident.



DASHBOARD

The Dashboard is located at the bottom of the Tx Resident screen.

This screen allows the user to view messages and alerts for the facility logged into.

The message dashboard will display any SMART update information for the facility. These messages can be from the Corp office, manager or from Casamba support.

The alerts dashboard will display any alerts on missing information for residents in the facility. Refer to the Smart Quick Cards for more information on specific alerts.