RT Standard
Login and Main Menu Navigation



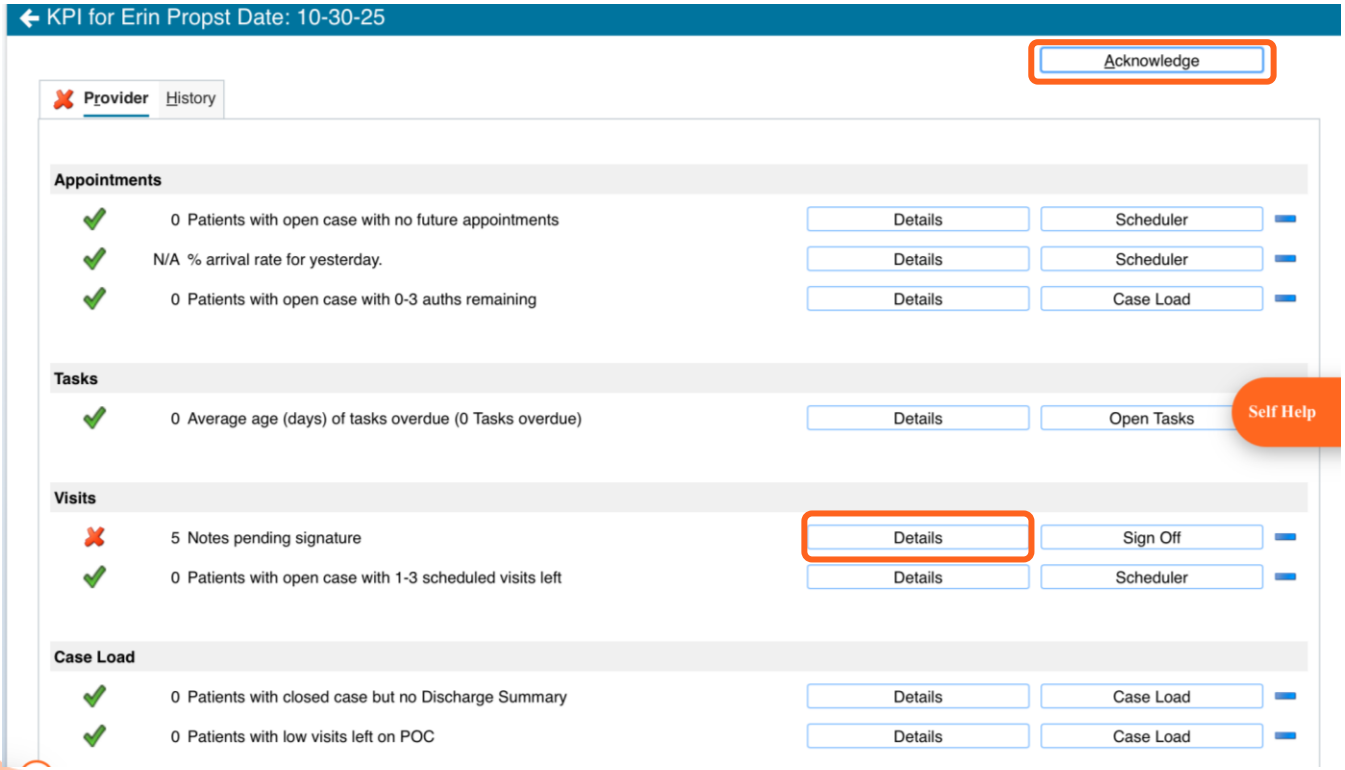
RT Standard Login



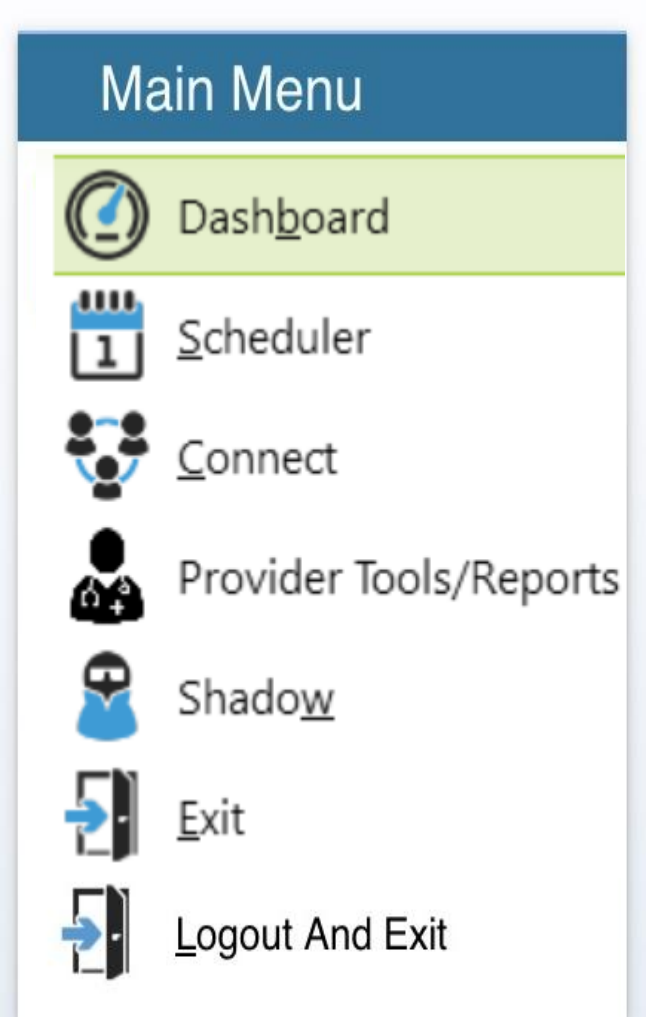
- RT Web (Non-SSO) - Fox Rehabilitation Services
- VERY important to add this link to your favorites to access documentation system throughout your experience
- Active students switching to RT Standard during clinical must use password: “**Str3ngth26!**” for first log in
- Students will not have access to FOXTRAX but will observe their CI/FWE utilize the app for scheduling and communicating with patients

Key Performance Indicator (KPI) Dashboard

- At first login each day, you will see Key Performance Indicator (KPI) Dashboard populate for your review
- For items with a red X, click "details" to show which need to be addressed
- During review, you can shortcut to the item that needs to be addressed
- Acknowledge your KPIs by entering your RT user ID and clicking "Acknowledge"



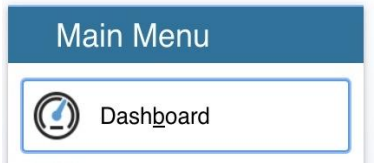
Main Menu

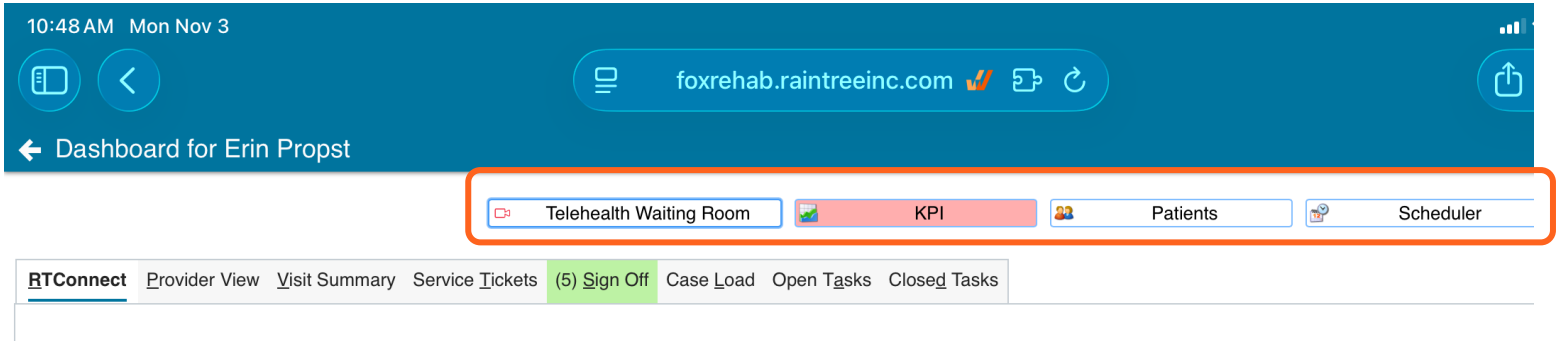


- **Dashboard**
  - Will be used most frequently. Access your caseload, daily visits, tasks and other priorities from here
- **Scheduler**
  - Where work schedules are set and viewing appointments
- **Connect**
  - Stores options for communicating with patients electronically via email, text, etc.
- **Provider Tools/Reports**
  - Access Tracking log and tracking log related reports from here
- **Shadow**
  - May occasionally be used for IT support
- **Exit**
  - Closes current RT sessions and can re-open without entering credentials
- **Logout and Exit**
  - All active RT sessions are closed.

Dashboard Overview

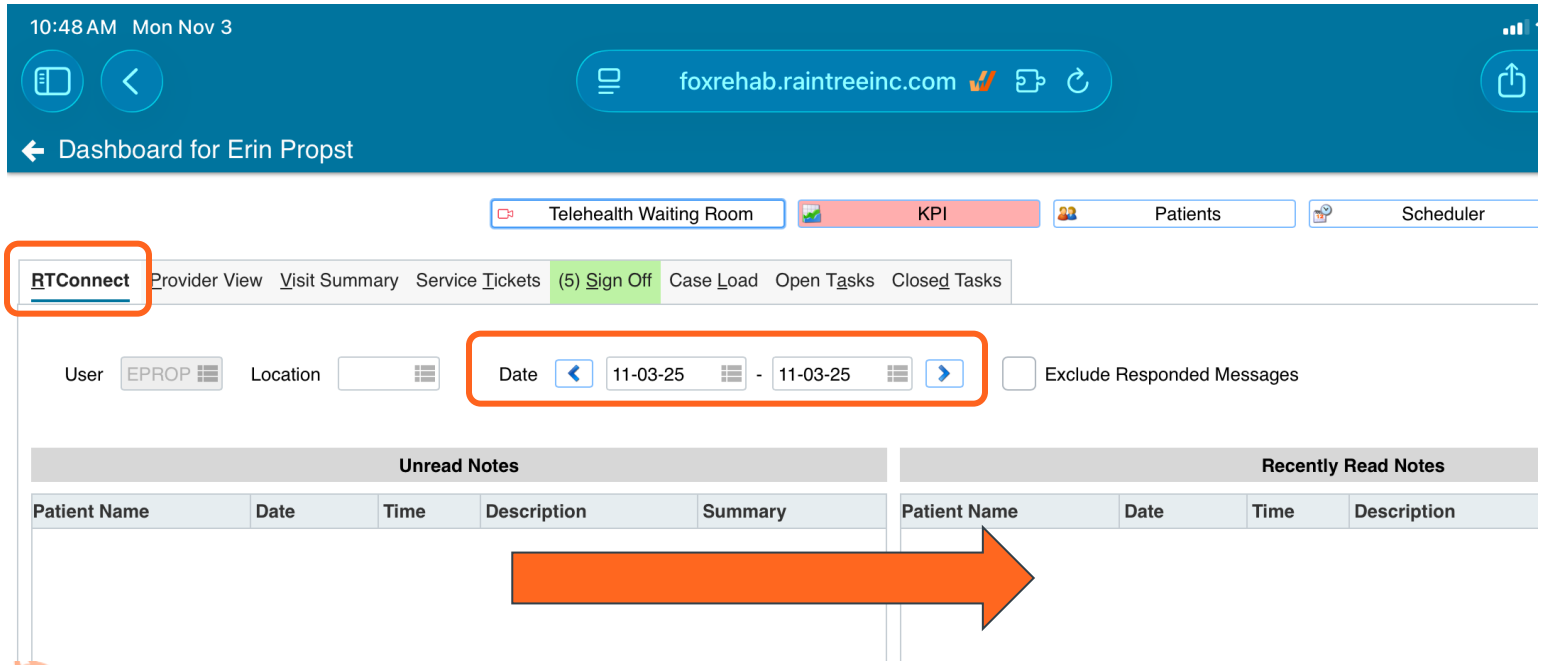
- From the **Main Menu** access **Dashboard**
  - **Telehealth Waiting Room**
    - Access to telehealth patients' queue (*you will learn more about telehealth in another training*)
  - **KPI**
    - Opens the Key Performance Indicator screen if you need to access it again after initial view
  - **Patients**
    - Access to all patient files
  - **Scheduler**
    - You will set your work schedules here and you can view scheduled appointments





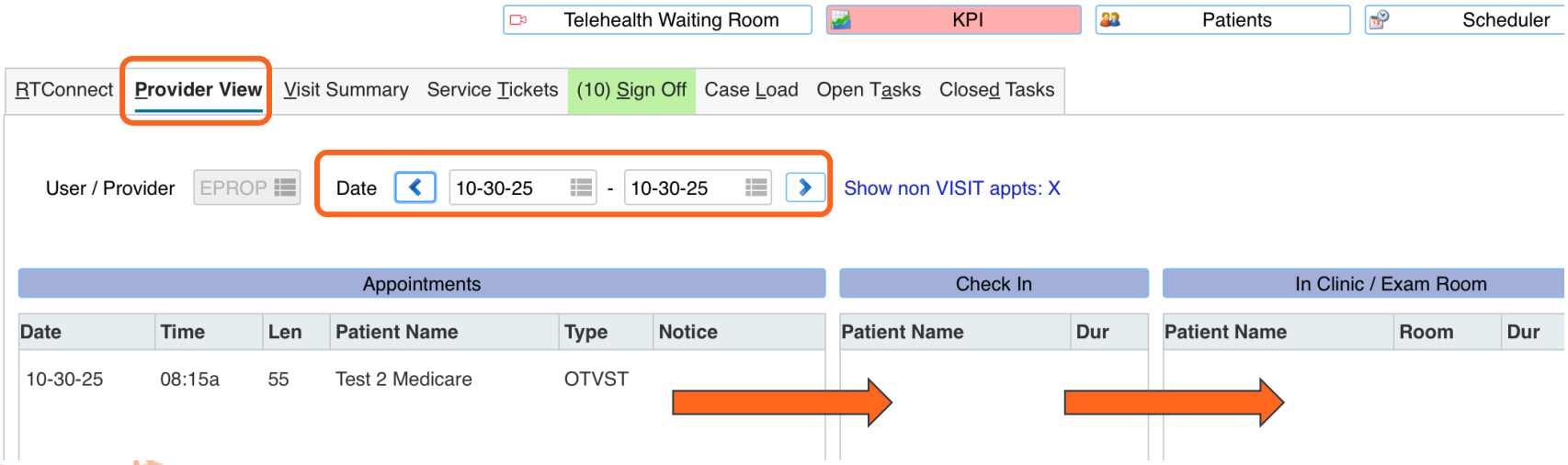
Dashboard: RT Connect

- **RTConnect** tab: change dates by clicking arrows or selecting a date
- View any messages sent from a patient in the **Unread Notes** section
  - Open the message and reply from the screen (like a chat or text message)
- Once you read the notes, the message will move to **Recently Read Notes**
  - You will learn more about RT Connect in another training



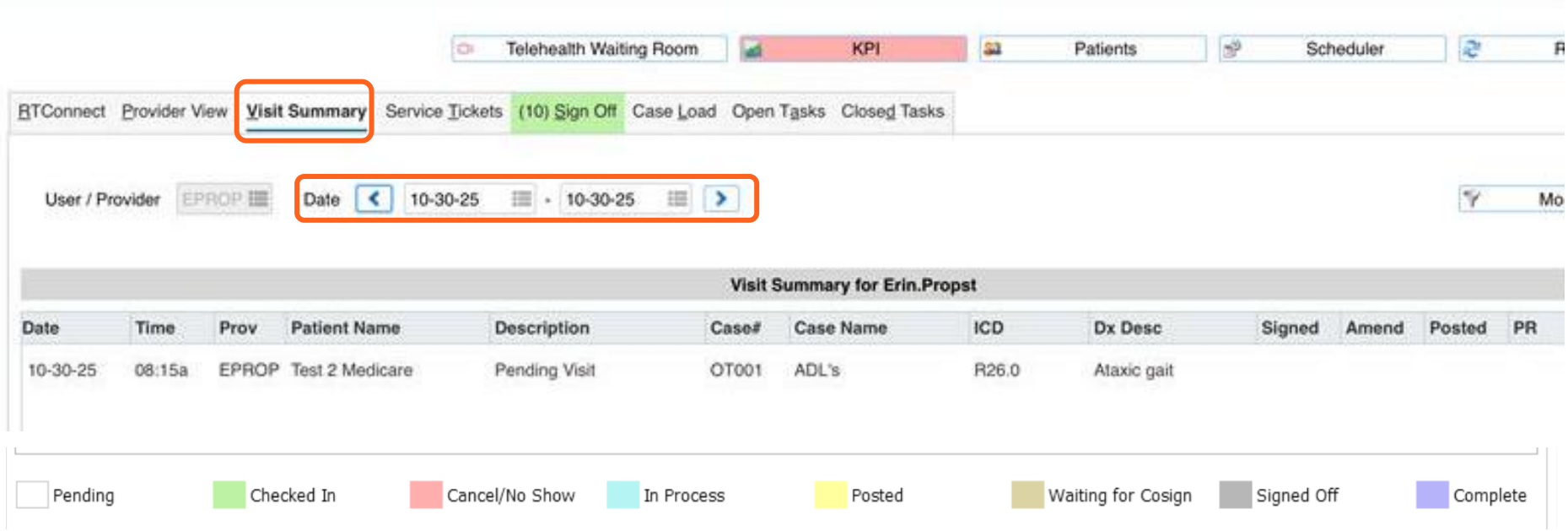
Dashboard: Provider View

- **Provider View tab** displays appointments for the selected dates in the filter under "Appointments" panel
  - Can filter appointments by a specific date range or location (click More FIters to access this filter)
- Use arrows or calendar icon to adjust date range
- Appointments scheduled in FOX Trax will display here
- Appointments will move through other panels as they are checked in, notes started and signed off etc.
- ***PROVIDER VIEW IS THE BEST PLACE TO ACCESS YOUR NOTES***



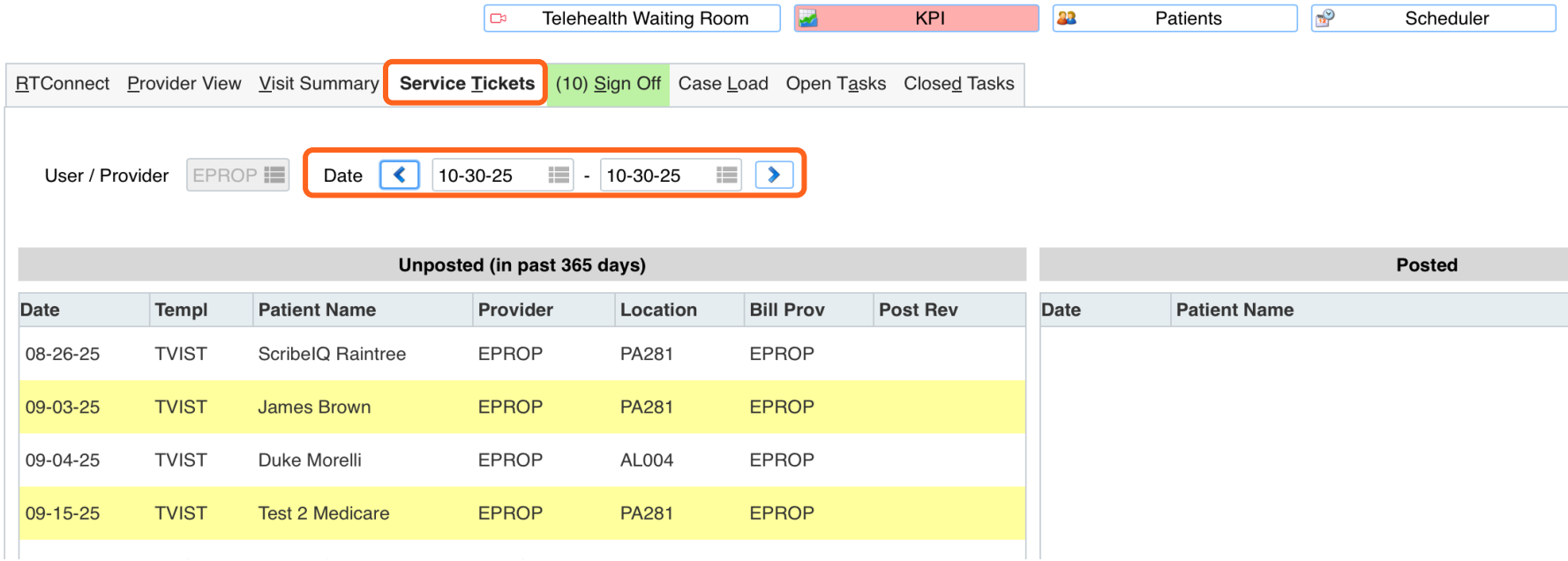
Dashboard: Visit Summary

- **Visit Summary** tab displays visits based on date range filter
  - You can adjust date range by using arrows or clicking the calendar icon to select date
- You can see which visits are pending, which notes have been signed, and which charges have been posted
- Color coding provides easy reference to the given status of the visit



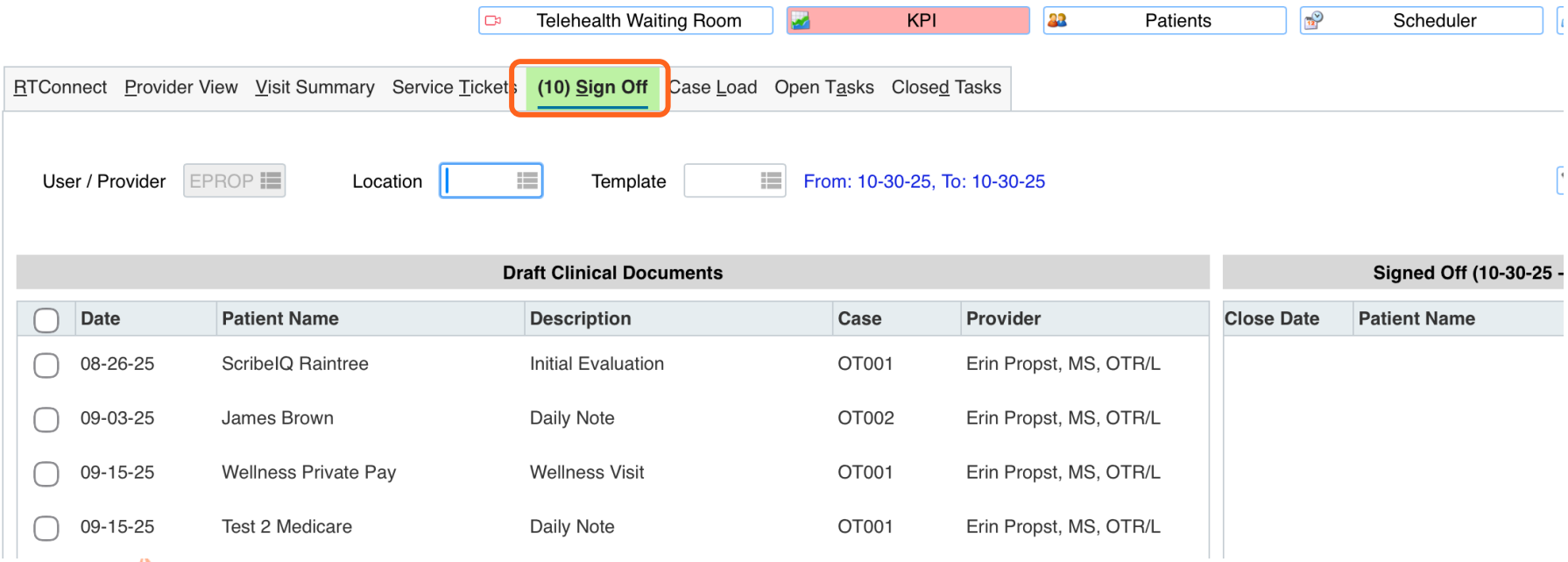
Dashboard: Service Tickets

- **Service Tickets** tab displays a list of service tickets related to your patients
  - You can adjust date range by using arrows or clicking the calendar icon to select date
- It is possible to sign a note and the charges **do not** post. Best practice for billable notes is **"Sign and Post"**, but it is helpful to monitor this tab for visibility into unposted visits



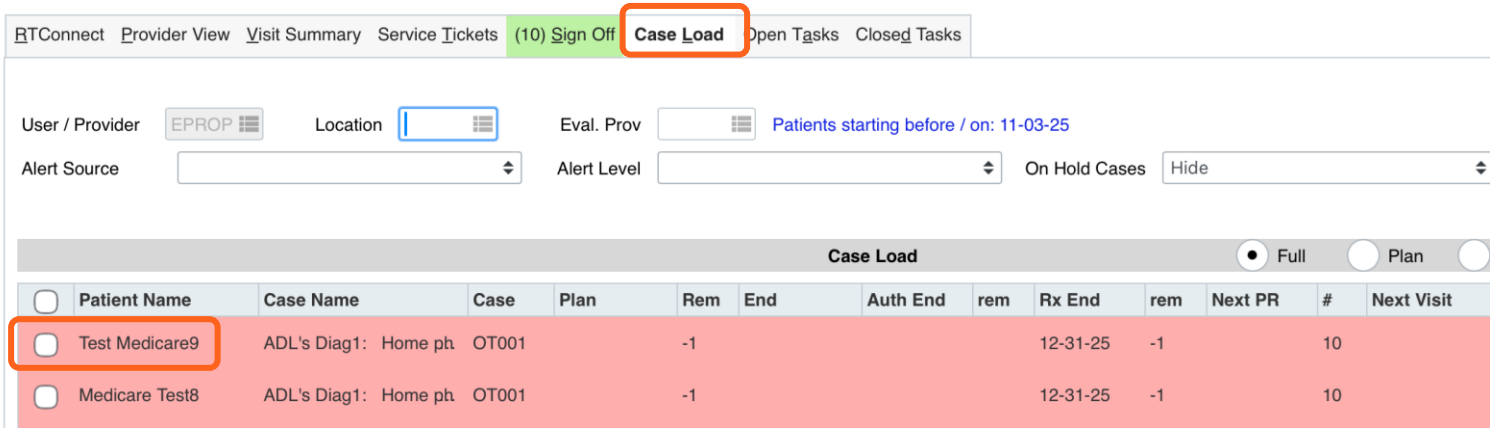
Dashboard: Sign Off

- The **Sign Off** tab provides you with a list of notes that have not been signed. This includes billable and unbillable notes.
- You can open notes from this list and complete/review them
  - Any prompts should be reviewed – these notes need attention before sign off

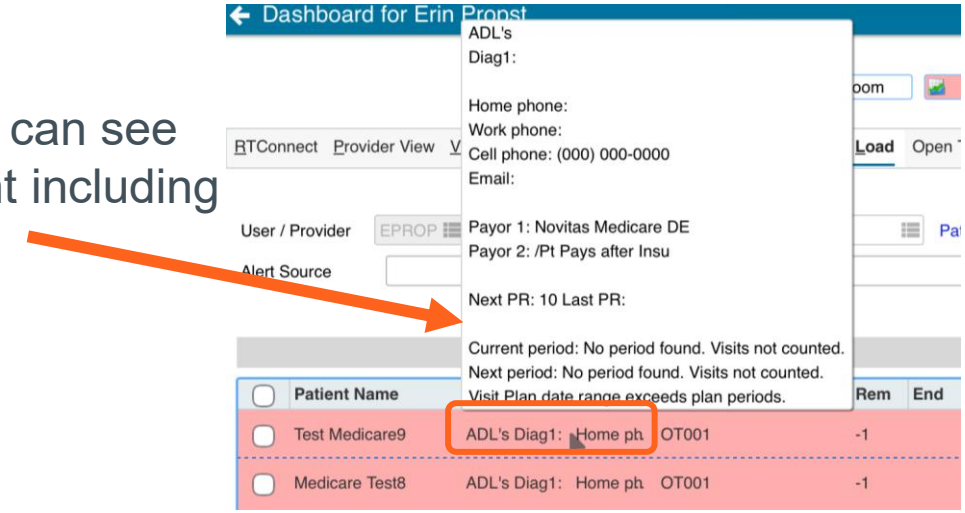


Dashboard: Caseload

- The **Caseload** tab is a list of any patient on your caseload

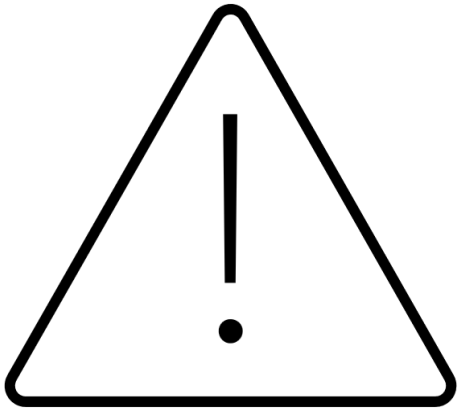


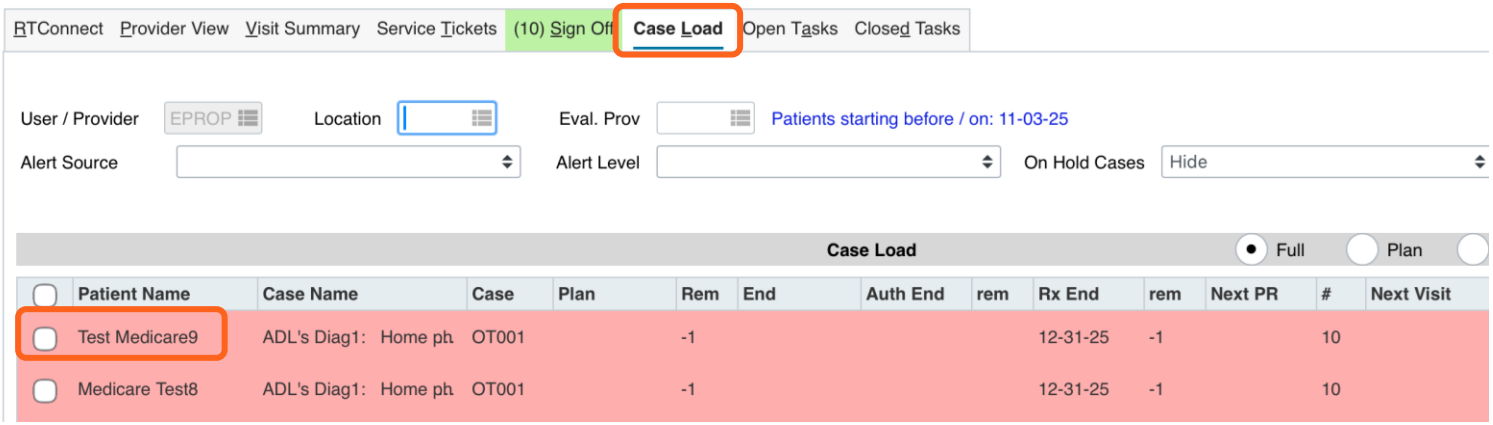
- If you hover over the **case name** you can see additional details related to the patient including **contact information** for the patient



Dashboard: Caseload

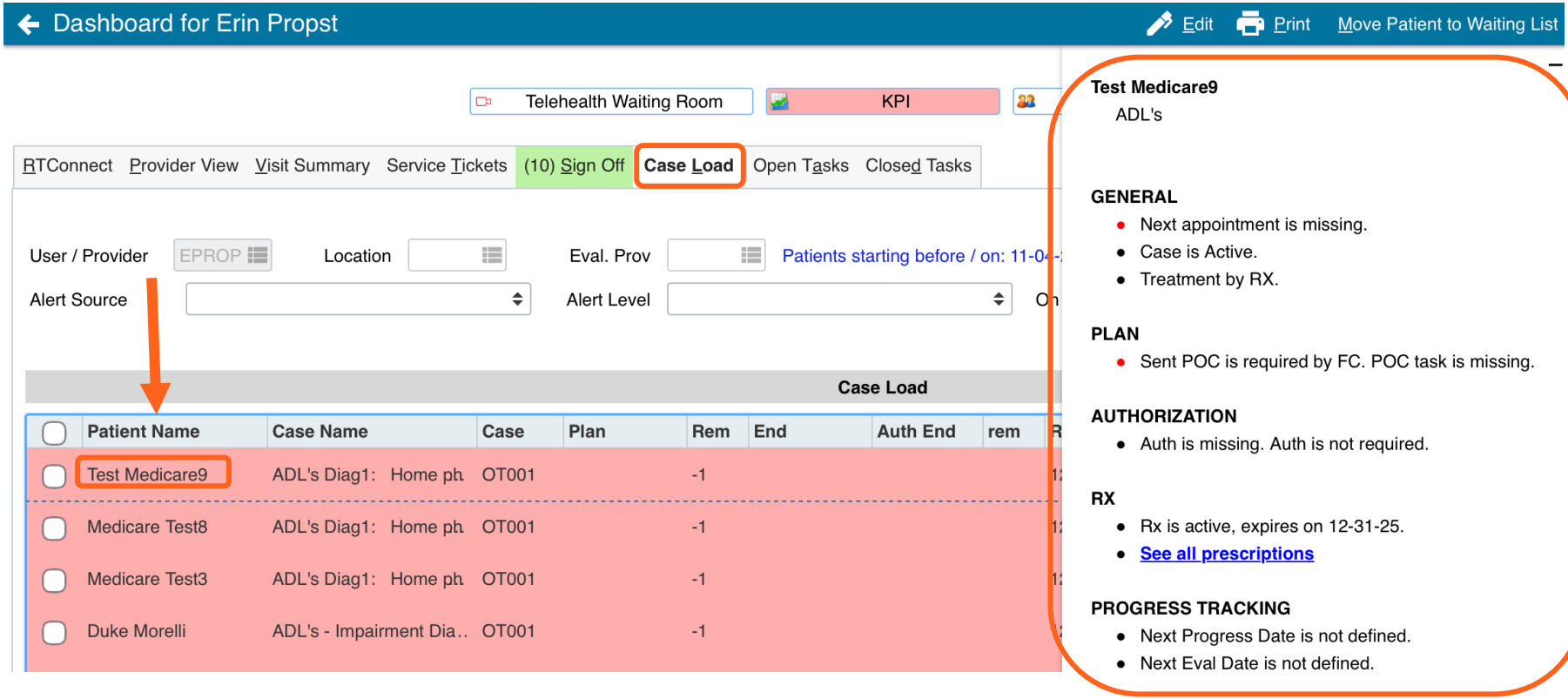
- New admissions will only display on your caseload tab AFTER you have scheduled the first evaluation/visit in FOX Trax.
  - Scheduling of the appointment in FOX Trax initiates the record to be created in Raintree





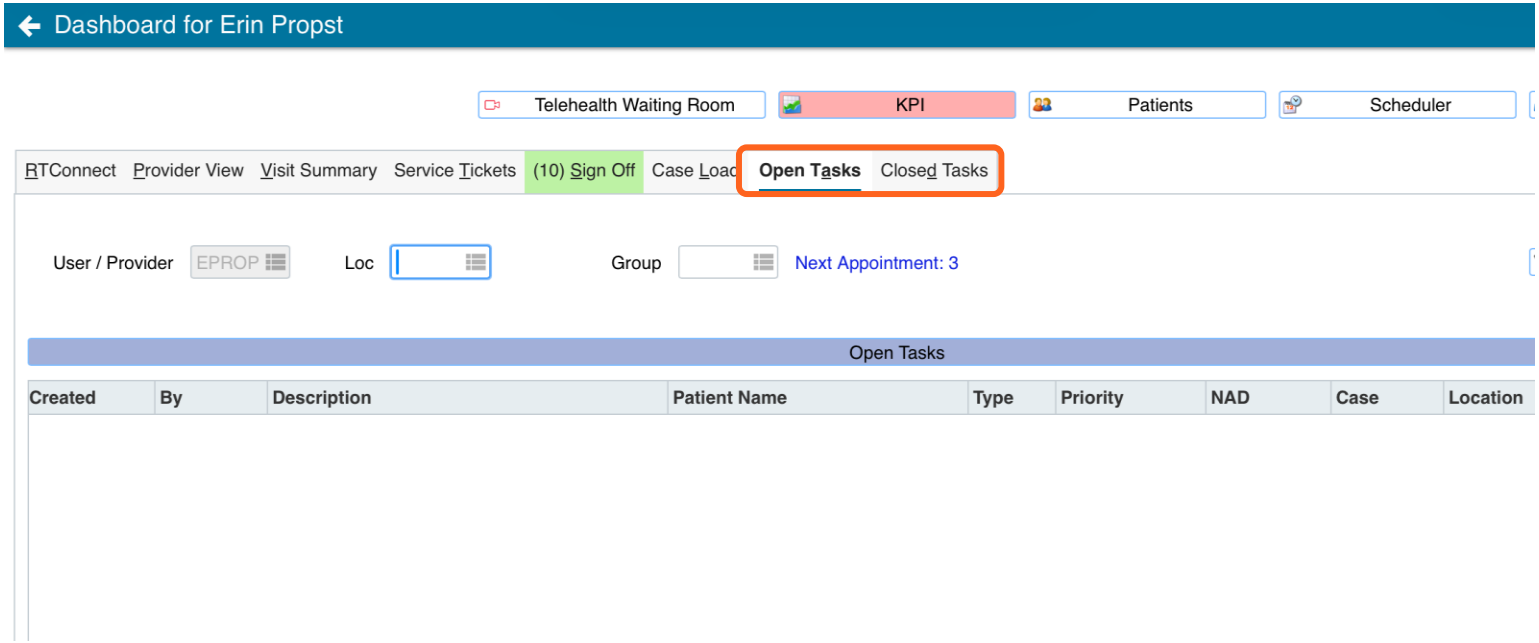
Dashboard: Caseload

- Cases in red need attention - click on the **patient name** and review the hoverbox to determine what area needs attention
- Caseload tab is **NOT** the best place to access notes (See PROVIDER VIEW)



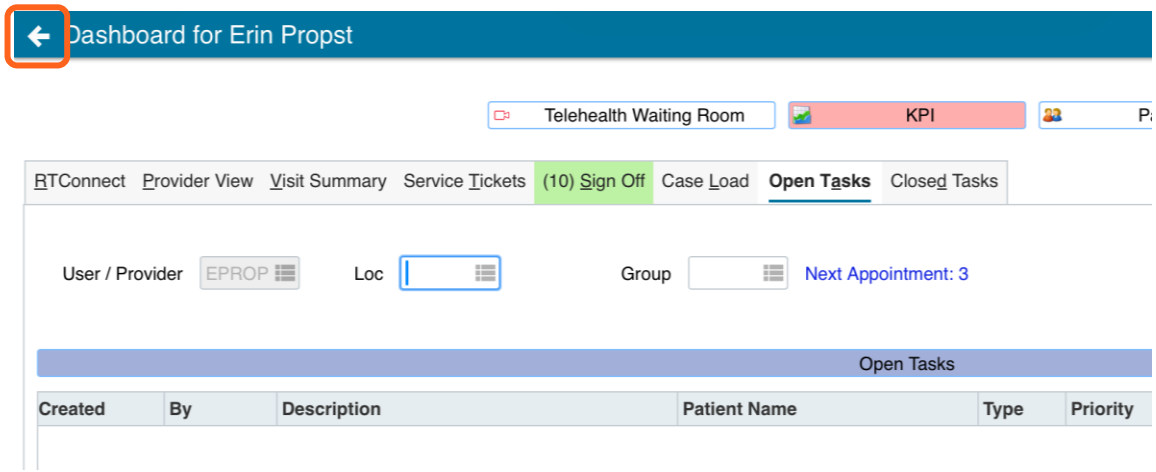
Main Menu – Dashboard: Tasks

- The **Tasks** tabs show all tasks assigned to you (open and closed)
  - *You will learn more about tasks in another training*



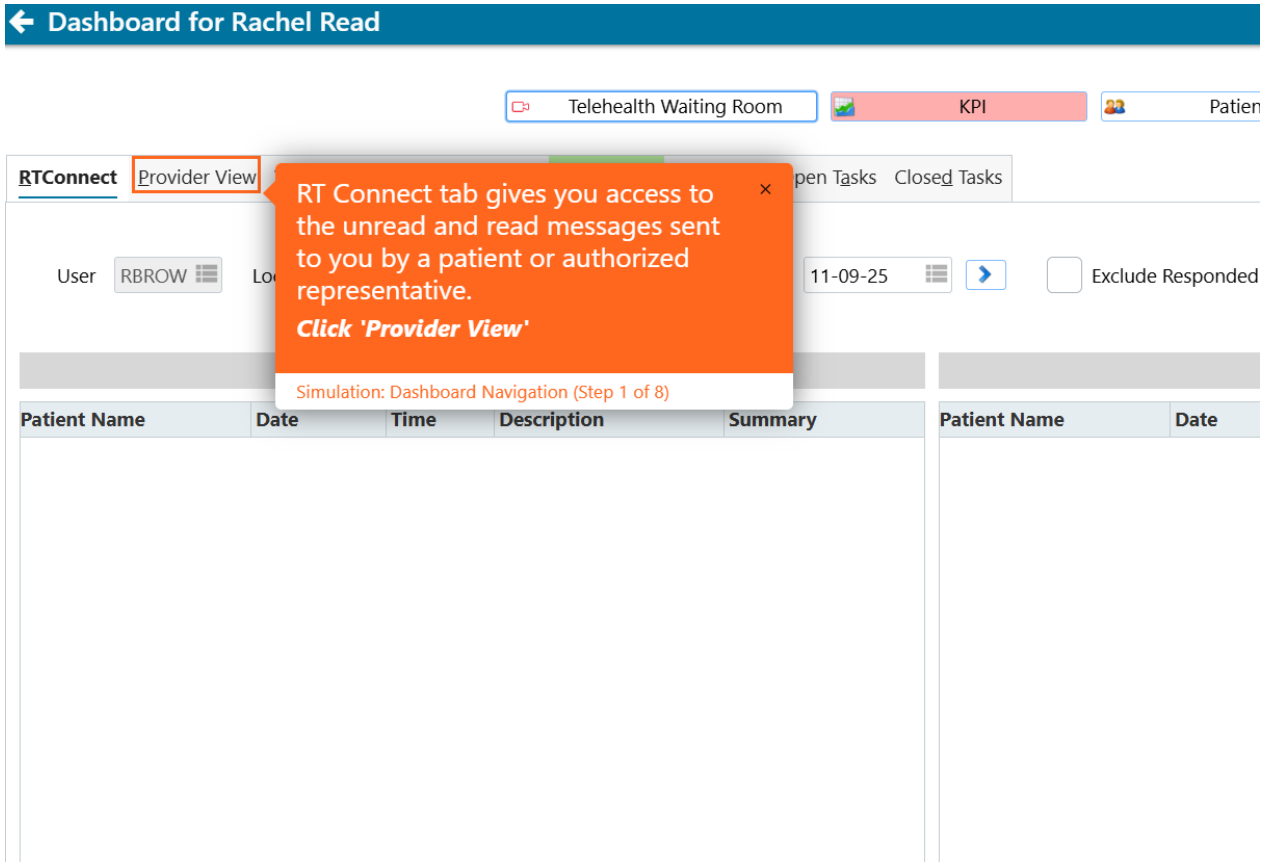
Main Menu – Exit

- Click the Back Arrow to exit back to Main Menu



SIMULATION TIME:

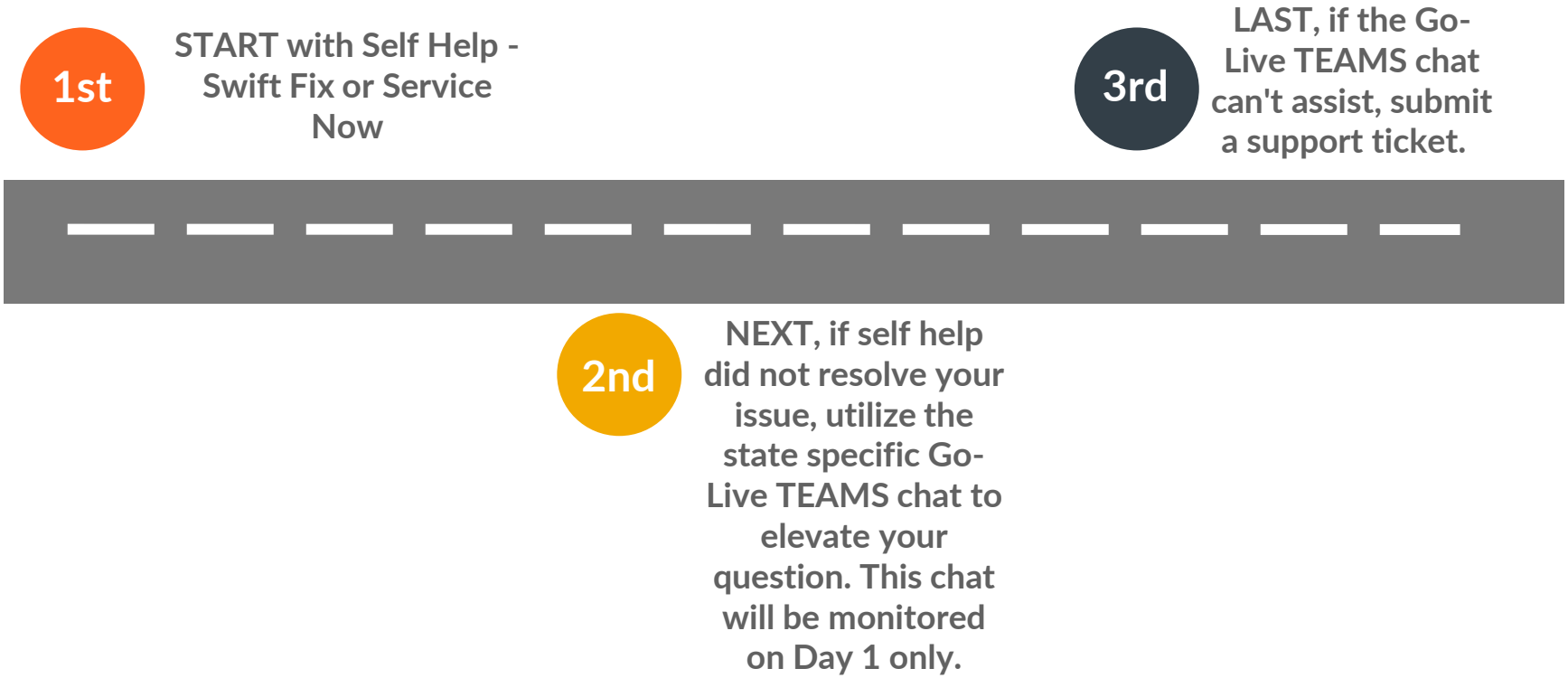
Try it NOW!
Click Image Below to Start the Simulation



**If the simulation does not automatically display an orange pop up box, refresh your browser.

Support Roadmap: Start Smart, Escalate Right

Have a question? Follow the path to resolution!

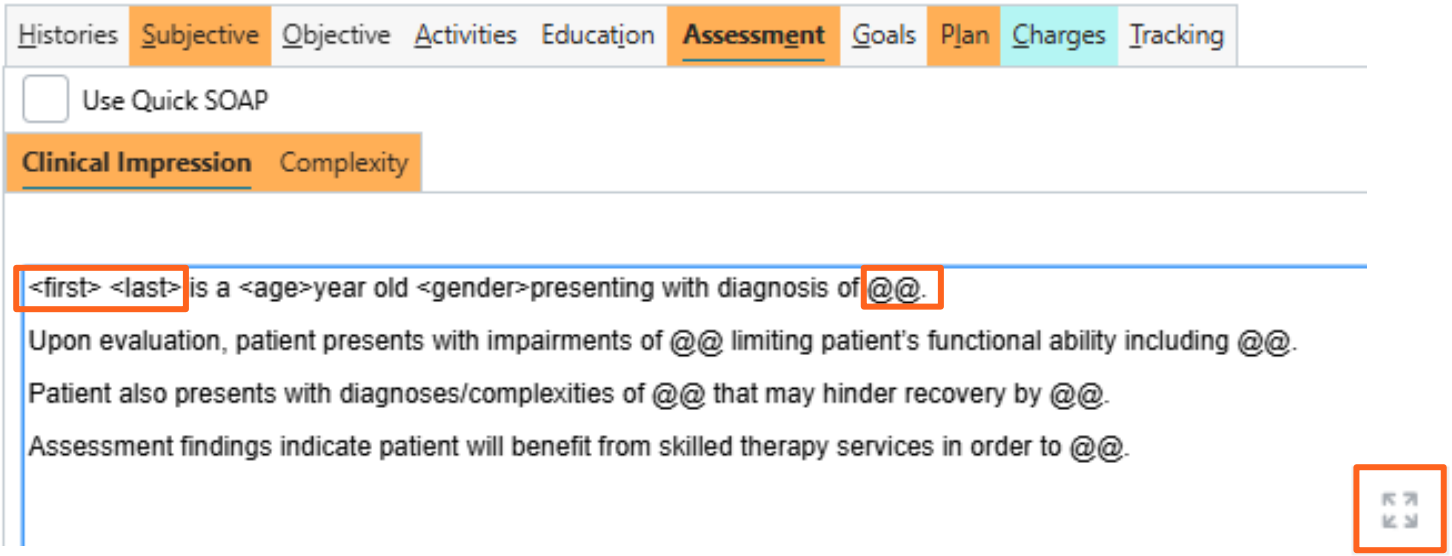


RT Standard: Basic Functionality



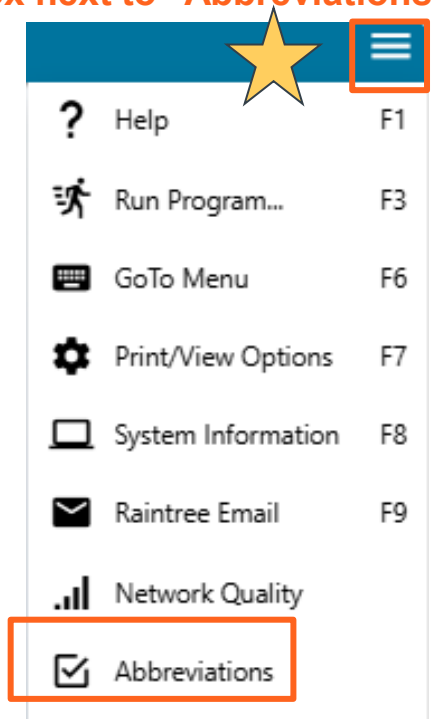
RT Standard: Efficiency Features

- **Jump markers** – ("@@")
  - These serve as required fields for important documentation throughout clinical notes. On an iPad, quickly navigate through jump markers by pressing **"ctrl"** and **"cmd"** and **"."** to navigate through. (non-iPad users can navigate through jump markers by pressing **"ctrl"** and **"."**)
- **Merge tags** – ("<first>, <last>, <name>)
  - These require NO manual data entry and will pull patient data directly into documentation
- **Expand text fields** –
  - This icon can be clicked to enlarge text fields for better visibility when documenting in that section



RT Standard: Efficiency Features

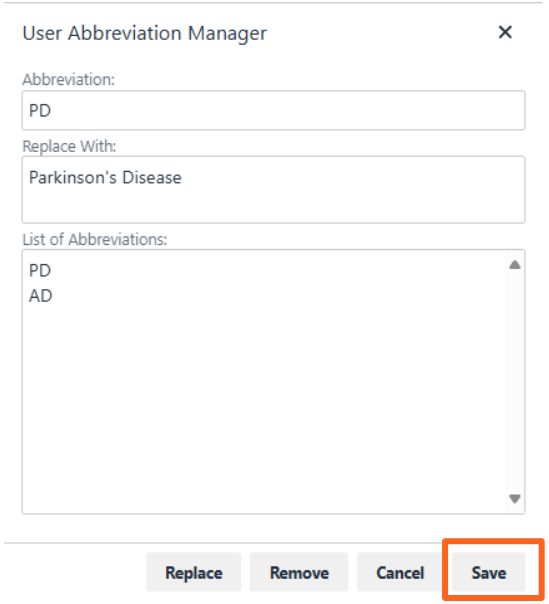
- **Abbreviations**
  - There are some templates that will load in abbreviations to help guide documentation
  - **IMPORTANT:** To ensure abbreviations are turned on, click this icon in top right corner > **check the box next to "Abbreviations"**



  - You can set your own abbreviations if you expand the text box of any free text box
  - Select ; to open abbreviation manager



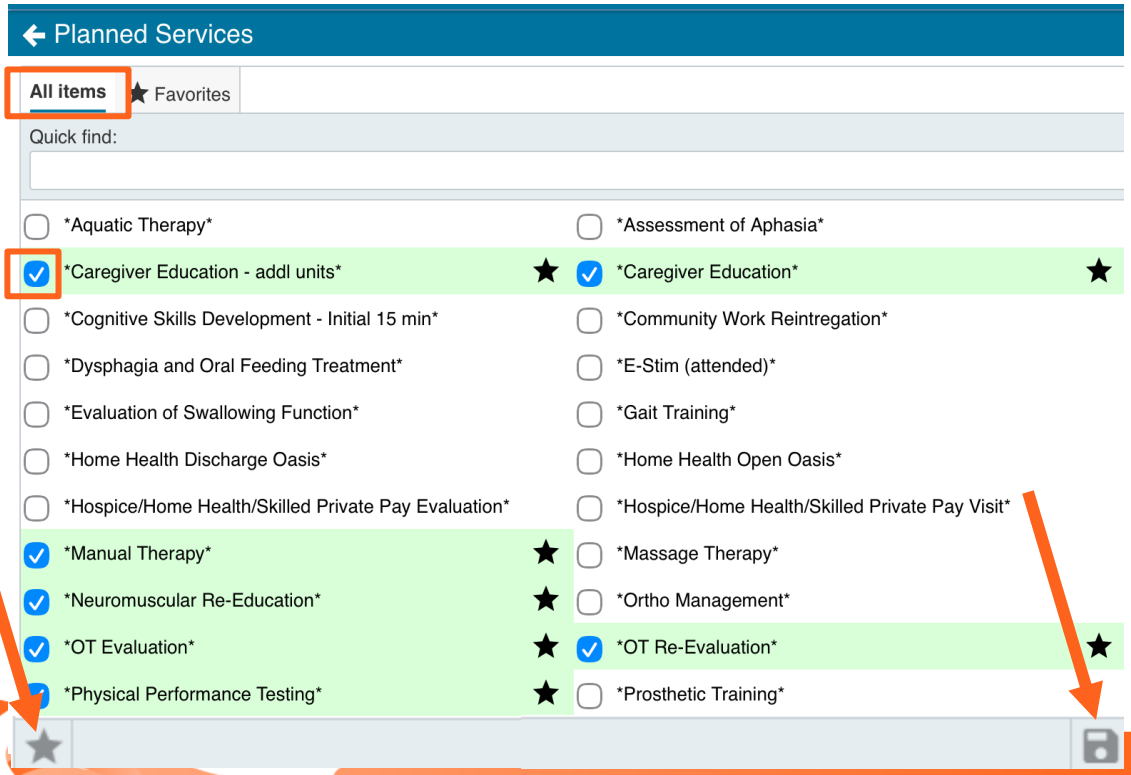
  - Create desired abbreviations
  - Save

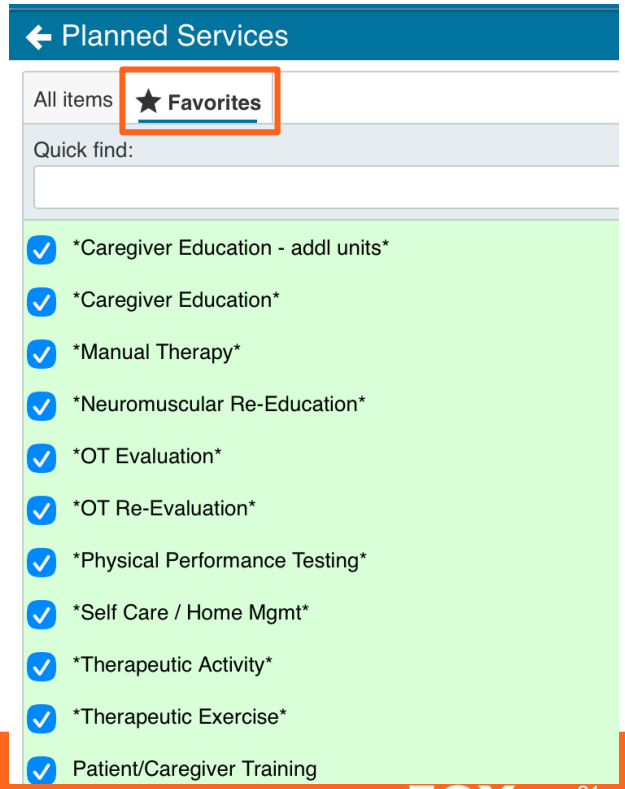


RT Standard: Picklist Efficiencies

Setting favorites helps to easily locate picklist items

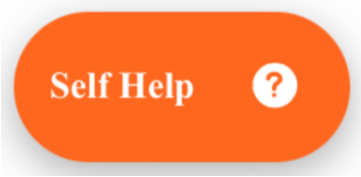
- **Favorites**
  - Select items that will be used most often in picklists (charges, precautions, etc) by locating and selecting the box next to the item, clicking the "Star" in the bottom left corner to add these items to "Favorites" tab. Those items will now default to your "Favorites" tab on any future note. **Watch this video** on setting favorites to see the process.





RT Standard: Other Efficiencies

To find other effeciences that help navigate Raintree, open Self Help and type the below items:



1. **Quick Keys/Hot Keys**
   - Allow navigation to different tabs through keyboard clicks
2. **Line Default**
   - Allows specific items to populate by default when you add a row to a picklist (exercises, activities, ADL, etc.)
3. **Setting Abbreviations**
   - You must turn abbreviations on, but you can choose to add as many abbreviations as you would like for improved clinical documentation efficiency

RT Standard: Case Review

To **review previous notes** for your patient

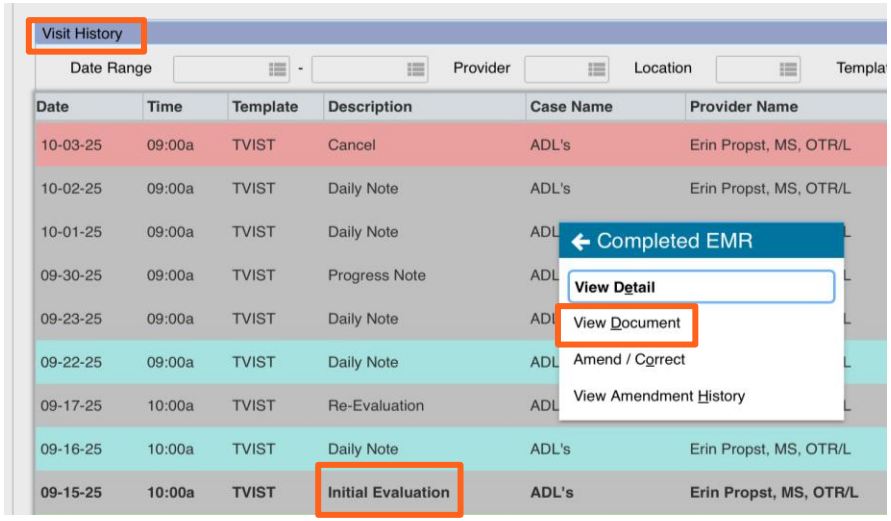
- Patient coverage for PTO
- Supervisor and assistant sharing patients
- Evaluating a patient previously on caseload (previous plan of care)

Watch this video for an overview, then find steps for case review on the next slides

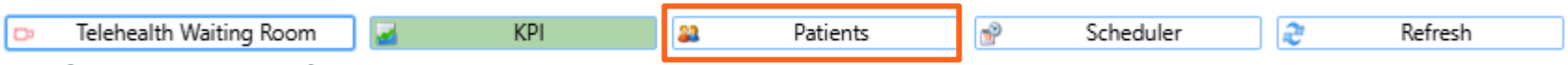
RT Standard: Case Review

Follow these steps to locate and review previous cases or notes when appropriate:

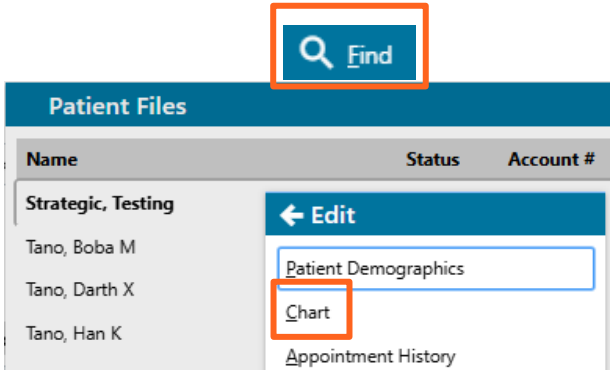
1. **If the patient <u>is</u> on Case Load:**
   - Locate patient on Case Load tab and double click Patient Name to open chart
   - Locate the note you want to review in Visit History and double click to open
   - Select View Document to see a narrative preview of the note. Select View Detail to open read only view of the note and navigate through tabs.



2. **If the patient <u>is not</u> on Case Load:**



   - Click "Patients" from Dashboard and use "Find" feature to search patient's Last Name, First Name
   - Double click on pt's name, then Chart
   - Follow steps above to locate the note you want to review in Visit History
   - Double click to open note, then View Document

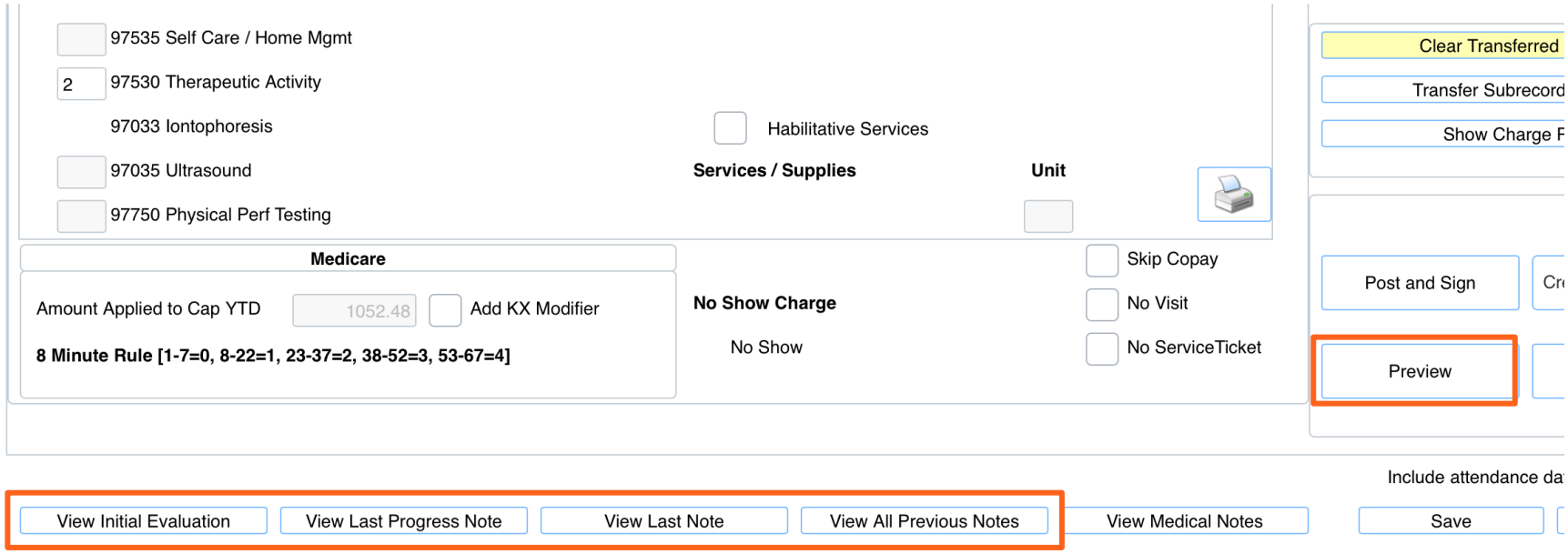


RT Standard: Case Review

Follow these steps to locate and review previous cases or notes when appropriate:

3. From within a note:

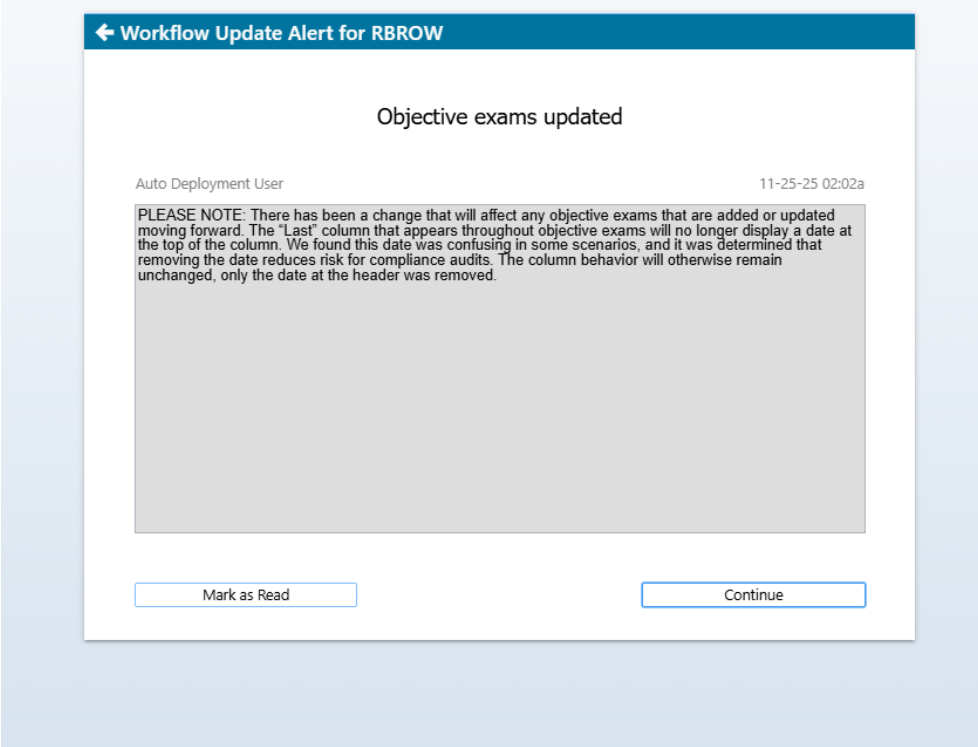
- Scroll to bottom of screen
- Click **View Last Note** or **View All Previous Notes** to preview previous notes for this patient
- Click "**Preview**" to view narrative draft of your current note



Raintree Release Notes & Alerts

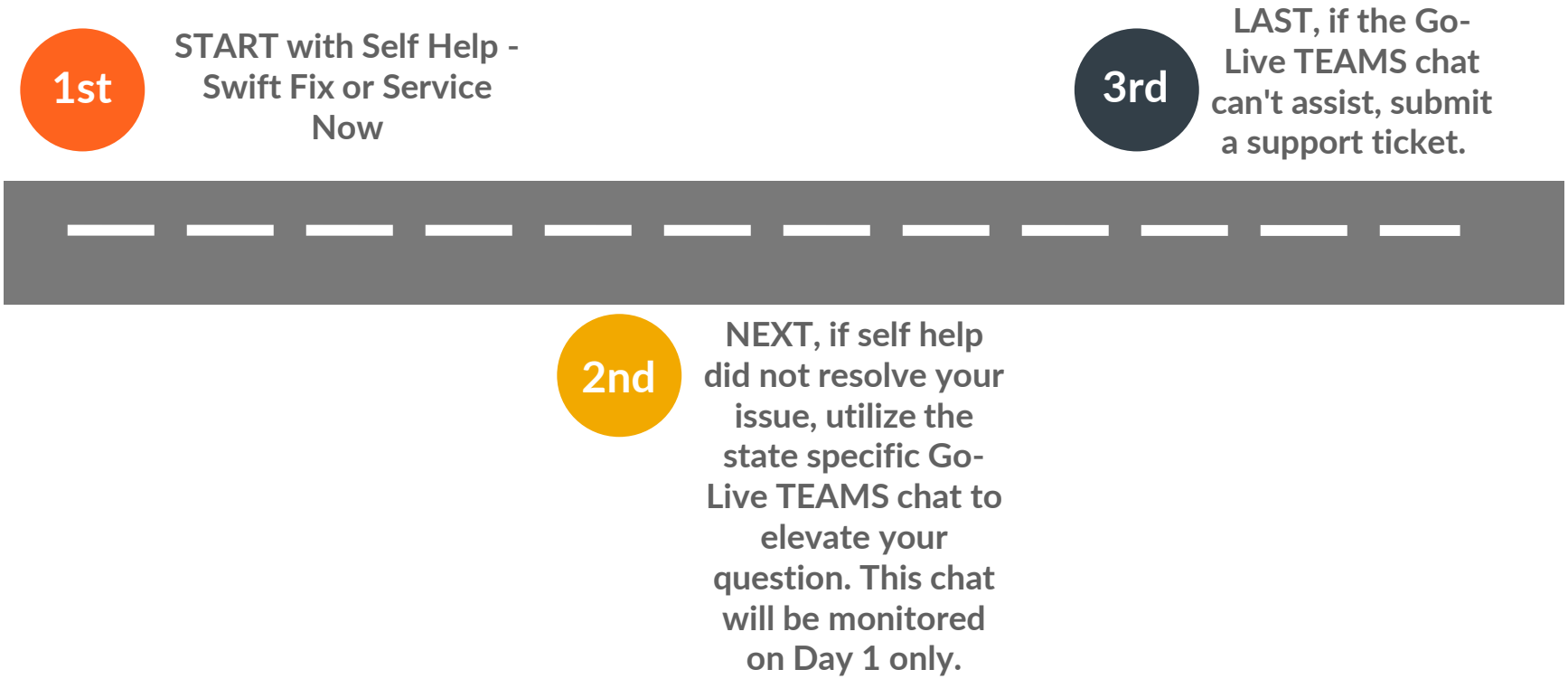
Raintree Standard will alert of any updates or enhancements made to the system.

- This will be the primary mechanism to communicate these changes.
- Controlled and created by Raintree (not FOX)
- Click continue if you cannot read now
  - The alert will continue to display until marked as read.
- Mark as Read after read. It will not prompt again



Support Roadmap: Start Smart, Escalate Right

Have a question? Follow the path to resolution!




FOX

TASKS | RT Standard



Task

- Tasks in RT Standard are used to communicate and make requests, with other RT users.



Send To

- Tasks can be sent to individual RT users or user groups which represent different departments within the practice.



Final Route

- Tasks are also designed to be final routed back to you to ensure that you receive a response and acknowledge a response. Keeping your tasks up to date is an important part of your workflow.

The basic function of tasks work as it did in RT Custom however, in RT Standard we cannot launch tasks from specific buttons embedded in the notes (DME, Referrals, Hospice etc.). Tasks in RT Standard must be created for the communication/requests needed.

Task Types & Defaults

Task Types

- Clinicians & Fitness Specialists should ***only*** use tasks which begin with “Clinical_”

Task Type Defaults

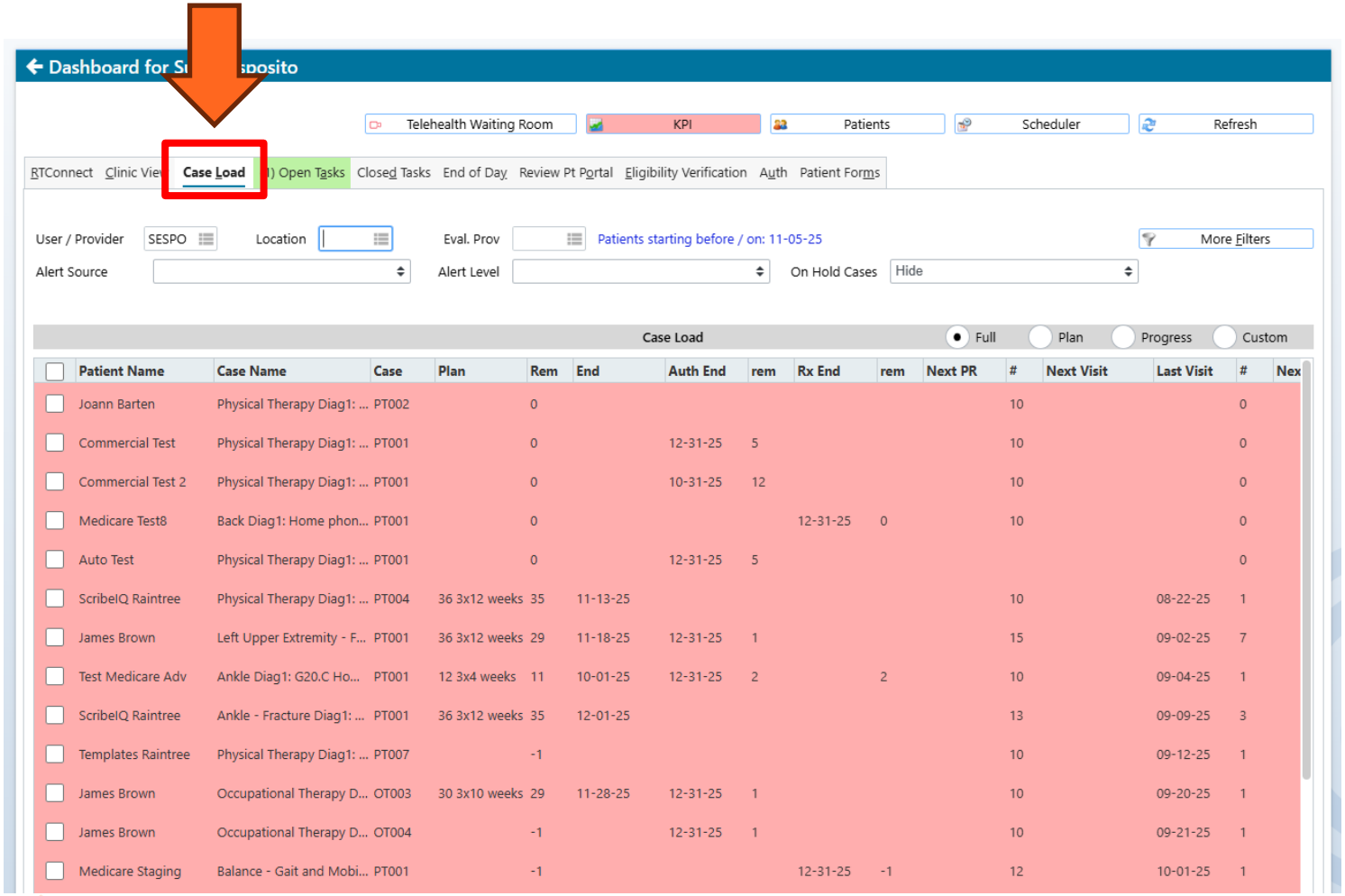
- These task types have defaults set so they route to the correct team for work.

Creating Tasks

- It is best to create tasks from within the patient account so that patient details automatically pull into that specific task.

Accessing & Adding Patient Tasks

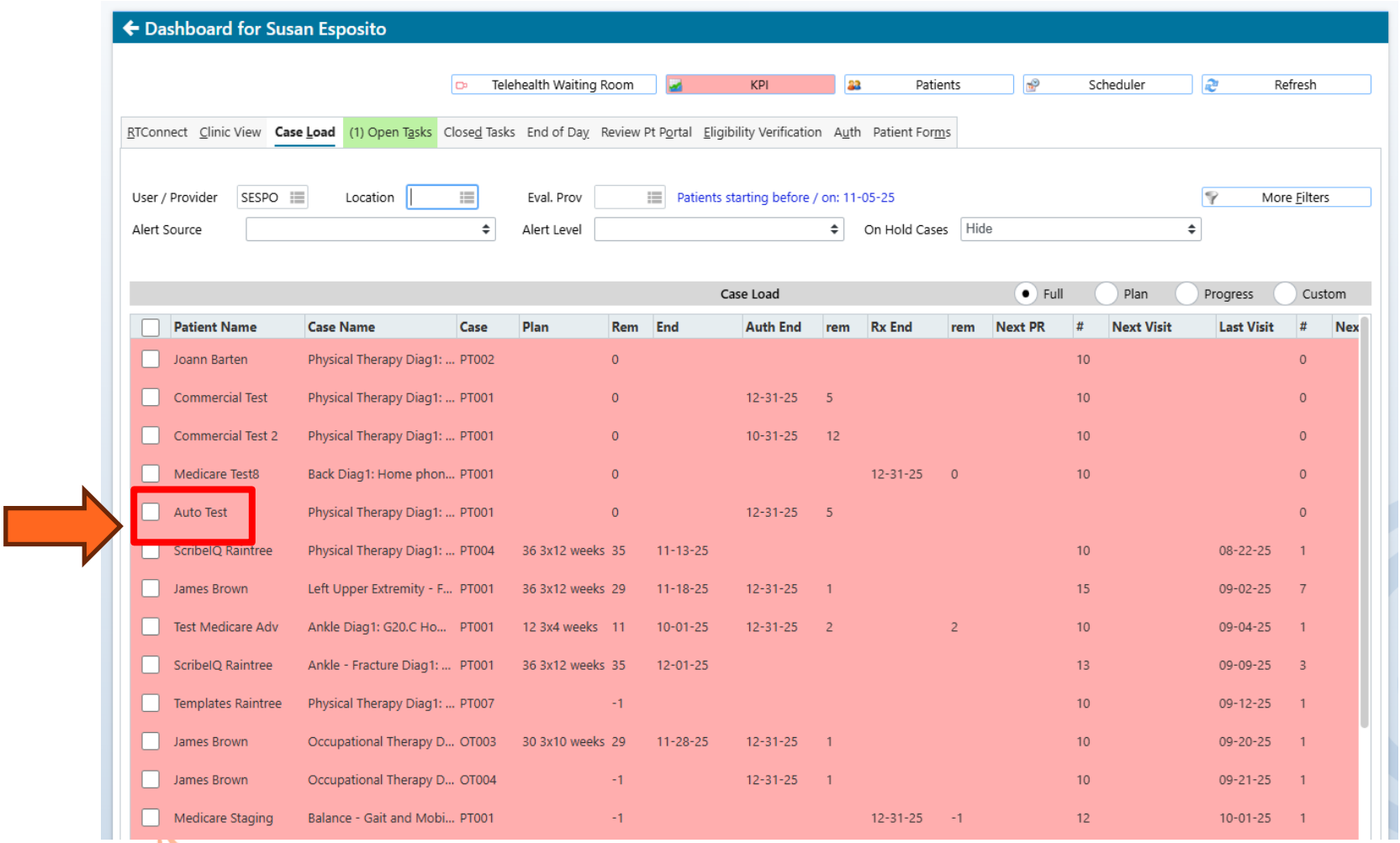
From your Dashboard, Select “Case Load” tab



Patient Name	Case Name	Case	Plan	Rem	End	Auth End	rem	Rx End	rem	Next PR	#	Next Visit	Last Visit	#	Nex
Joann Barten	Physical Therapy Diag1: ...	PT002		0							10			0	
Commercial Test	Physical Therapy Diag1: ...	PT001		0		12-31-25	5				10			0	
Commercial Test 2	Physical Therapy Diag1: ...	PT001		0		10-31-25	12				10			0	
Medicare Test8	Back Diag1: Home phon...	PT001		0				12-31-25	0		10			0	
Auto Test	Physical Therapy Diag1: ...	PT001		0		12-31-25	5							0	
ScribeIQ Raintree	Physical Therapy Diag1: ...	PT004	36 3x12 weeks	35	11-13-25						10		08-22-25	1	
James Brown	Left Upper Extremity - F...	PT001	36 3x12 weeks	29	11-18-25	12-31-25	1				15		09-02-25	7	
Test Medicare Adv	Ankle Diag1: G20.C Ho...	PT001	12 3x4 weeks	11	10-01-25	12-31-25	2		2		10		09-04-25	1	
ScribeIQ Raintree	Ankle - Fracture Diag1: ...	PT001	36 3x12 weeks	35	12-01-25						13		09-09-25	3	
Templates Raintree	Physical Therapy Diag1: ...	PT007		-1							10		09-12-25	1	
James Brown	Occupational Therapy D...	OT003	30 3x10 weeks	29	11-28-25	12-31-25	1				10		09-20-25	1	
James Brown	Occupational Therapy D...	OT004		-1		12-31-25	1				10		09-21-25	1	
Medicare Staging	Balance - Gait and Mobi...	PT001		-1				12-31-25	-1		12		10-01-25	1	

Accessing & Adding Patient Tasks

Double click on the patient you want to create a task for

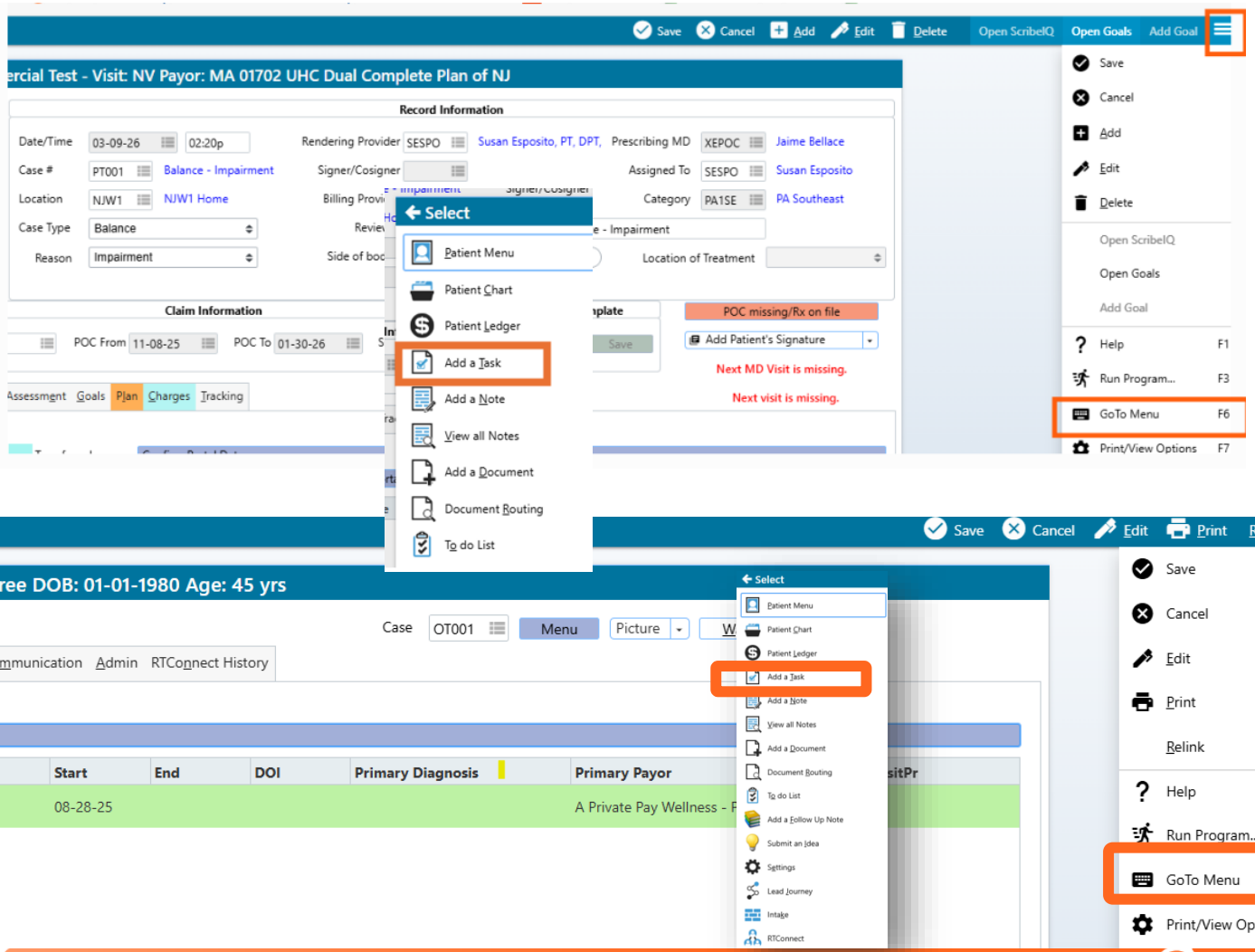


Patient Name	Case Name	Case	Plan	Rem	End	Auth End	rem	Rx End	rem	Next PR	#	Next Visit	Last Visit	#	Nex
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Commercial Test	Physical Therapy Diag1: ...	PT001		0		12-31-25	5				10			0	
Commercial Test 2	Physical Therapy Diag1: ...	PT001		0		10-31-25	12				10			0	
Medicare Test8	Back Diag1: Home phon...	PT001		0				12-31-25	0		10			0	
Auto Test	Physical Therapy Diag1: ...	PT001		0		12-31-25	5							0	
ScribeIQ Raintree	Physical Therapy Diag1: ...	PT004	36 3x12 weeks	35	11-13-25						10		08-22-25	1	
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Test Medicare Adv	Ankle Diag1: G20.C Ho...	PT001	12 3x4 weeks	11	10-01-25	12-31-25	2		2		10		09-04-25	1	
ScribeIQ Raintree	Ankle - Fracture Diag1: ...	PT001	36 3x12 weeks	35	12-01-25						13		09-09-25	3	
Templates Raintree	Physical Therapy Diag1: ...	PT007		-1							10		09-12-25	1	
James Brown	Occupational Therapy D...	OT003	30 3x10 weeks	29	11-28-25	12-31-25	1				10		09-20-25	1	
James Brown	Occupational Therapy D...	OT004		-1		12-31-25	1				10		09-21-25	1	
Medicare Staging	Balance - Gait and Mobi...	PT001		-1				12-31-25	-1		12		10-01-25	1	

Adding Patient Task: Option 1

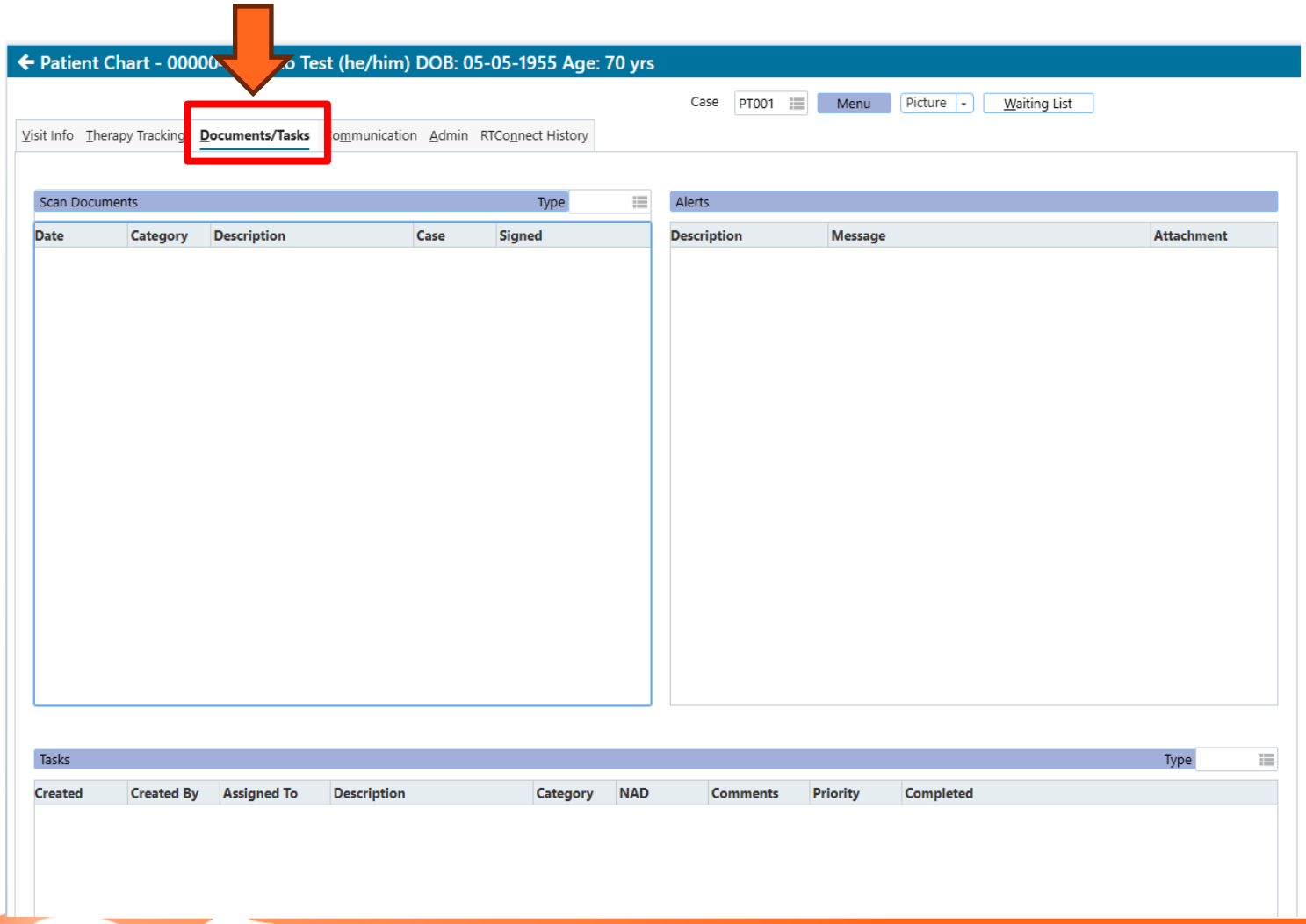
Can add a task within the patient chart **or** within the clinical note

- Click the hamburger menu
- Click Go to Menu
- Click Add a Task



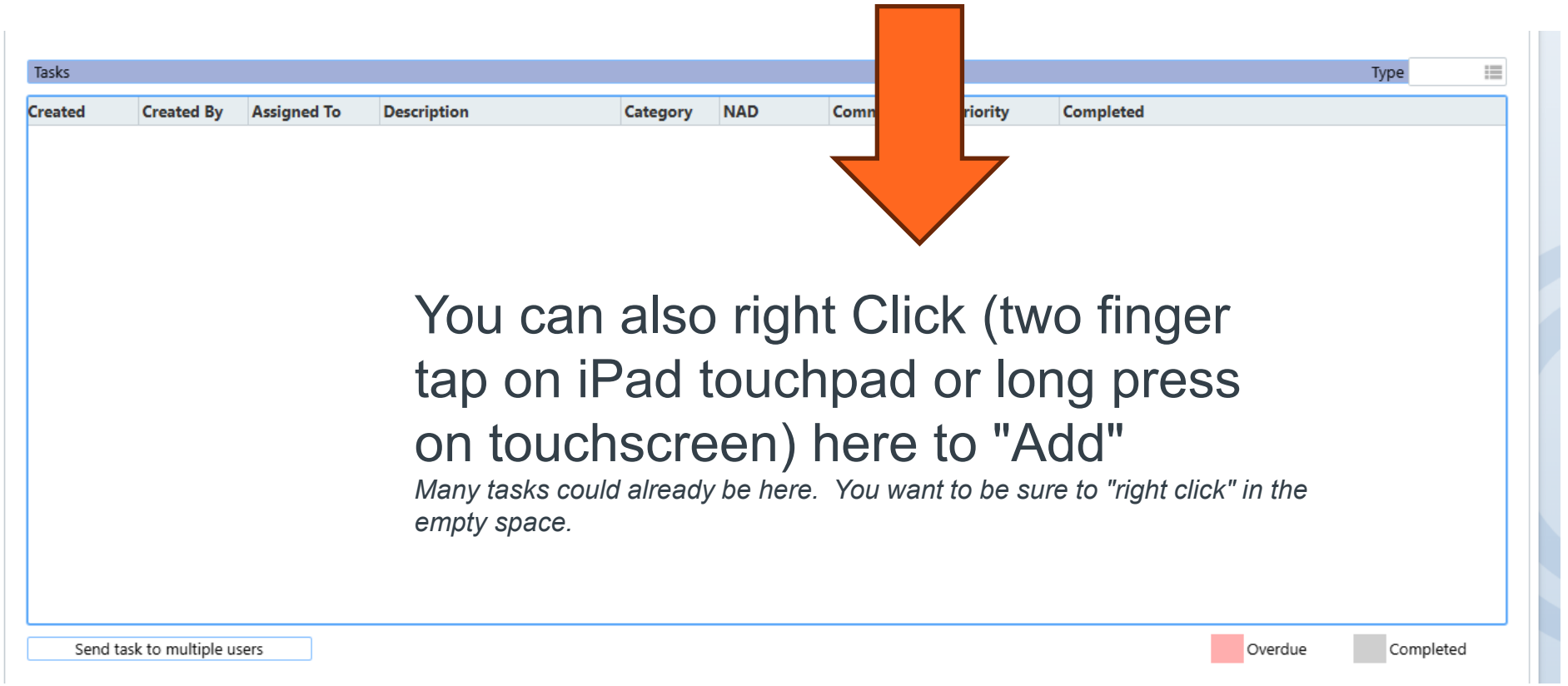
Adding Patient Task: Option 2

Or Select “Document/Tasks” tab



Adding Patient Tasks: Option 2

Located at the bottom, under “Tasks”, **tap into the blank area** and then hit “A” on your keyboard to add new task

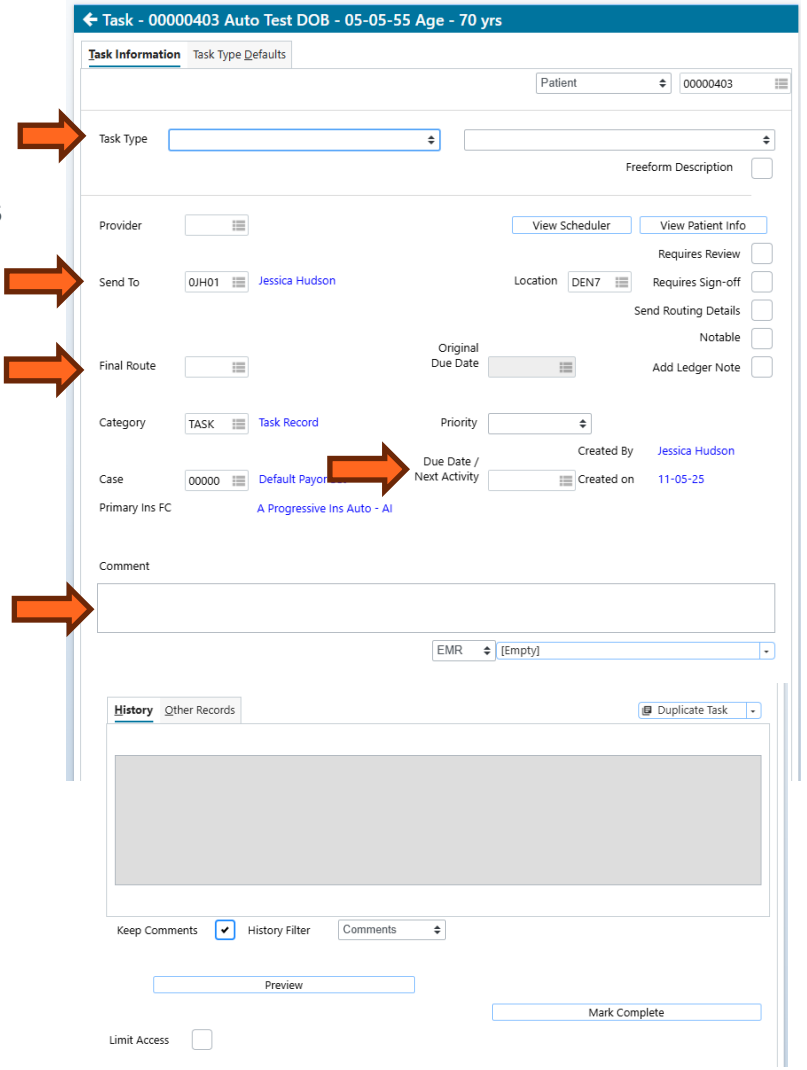


Types of Tasks (clinicians may create)

Task Type	Purpose
Clinical_Billing Correction Request	In the event that you require an edit to your billing and you need your note unposted
Clinical_Demographic Corrections	This task can be used for any address corrections or DOB. If there is any demographic corrections that is not patient or contact phone numbers and emails, those should be managed directly in patient demographics and contacts
Clinical_Durable Medical Equipment	Typical DME orders will be placed into Parachute. This task will be used to let us know you would like to put an order in. We will then enter in all demographics and insurance information to Parachute and notify you once complete to put your DME in
Clinical Medical Records Request	This task can be used if you need to notify if the PCP listed is incorrect or if you need to communicate any information with the medical records team.
Clinical_Home Health Episode	If you are concerned or know there is be a new home health episode open and you would like us to verify certification. Include home health name, contact number (if available) and discharge date (if available)
Clinical_Hospice Alert	Advise if applicable “Patient active with hospice” include company name and DX” (if available)
Clinical_Insurance Term or Change	Additional secondary insurance verification, change/terminated insurance. Include insurance name and ID #
Clinical_Patient Expired	Advise if patient has passed away
Clinical_Refer to Group Exercise	If you have a patient and you want to refer them to an exercise class, create this task to the specific user who runs the exercise class. The Task Type will be “Clinical_Refer to Group Exercise” and the SEND TO will be the specific user
Clinical_Wellness Continuum	Request patient be referred to Wellness Continuum Care. Include contact name and phone number, which disciplines referring for (PT/OT/ST/FS), include if you discussed pricing
Clinical_For Your Information	This can be used to send tasks within your clinical team. The SEND TO will be the specific user you are sending the task to

Navigating Tasks

- A new task will open up
  - **Task Type**: Select the drop-down arrow to show all task types
  - Select the appropriate Task Type, previous slide of all Task Types
- Once you select the task type, the **SEND TO** will auto populate with the correct user group to receive the request.
- The "**Final Route**" will automatically be populated to be sent back to you once completed.
- **Due date** will also automatically populate to the current date
- Add in a detailed comment for your request. Include all information you can give to assist the team completing your request. Include any names, phone numbers, etc. depending on your ask.

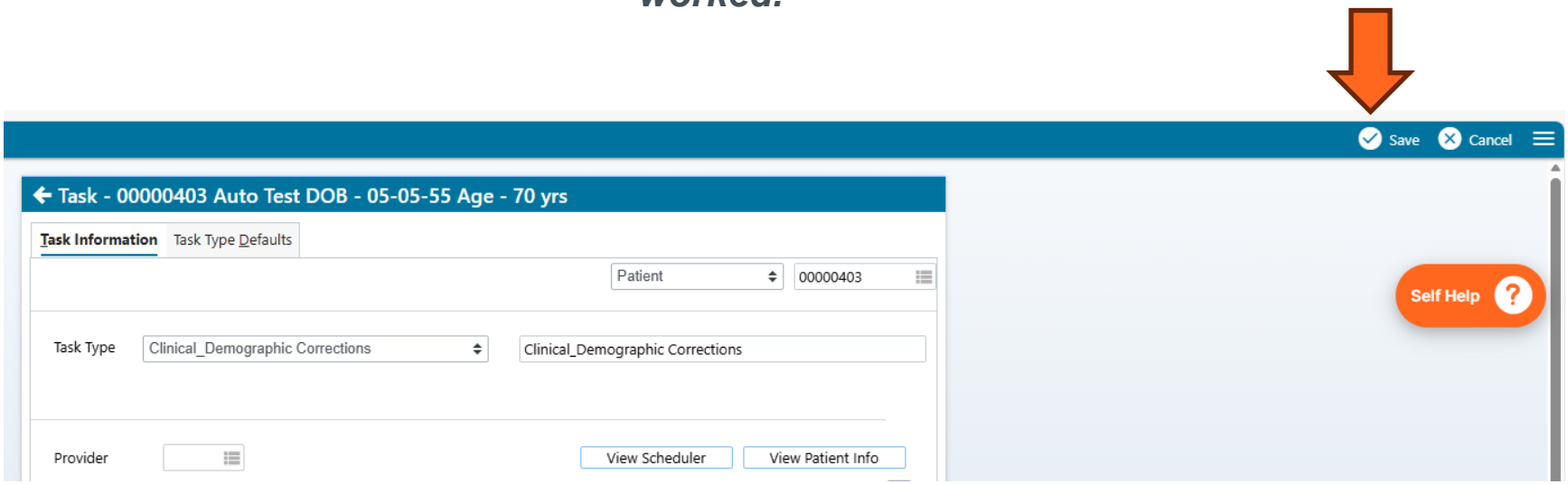


Sending Tasks

Save your task by selecting the “SAVE” button up at the top right-hand corner

Disclaimer:

Do NOT hit the Mark Complete button when creating a task, this will not send your request and just complete it. You must hit SAVE to send your task to be worked.

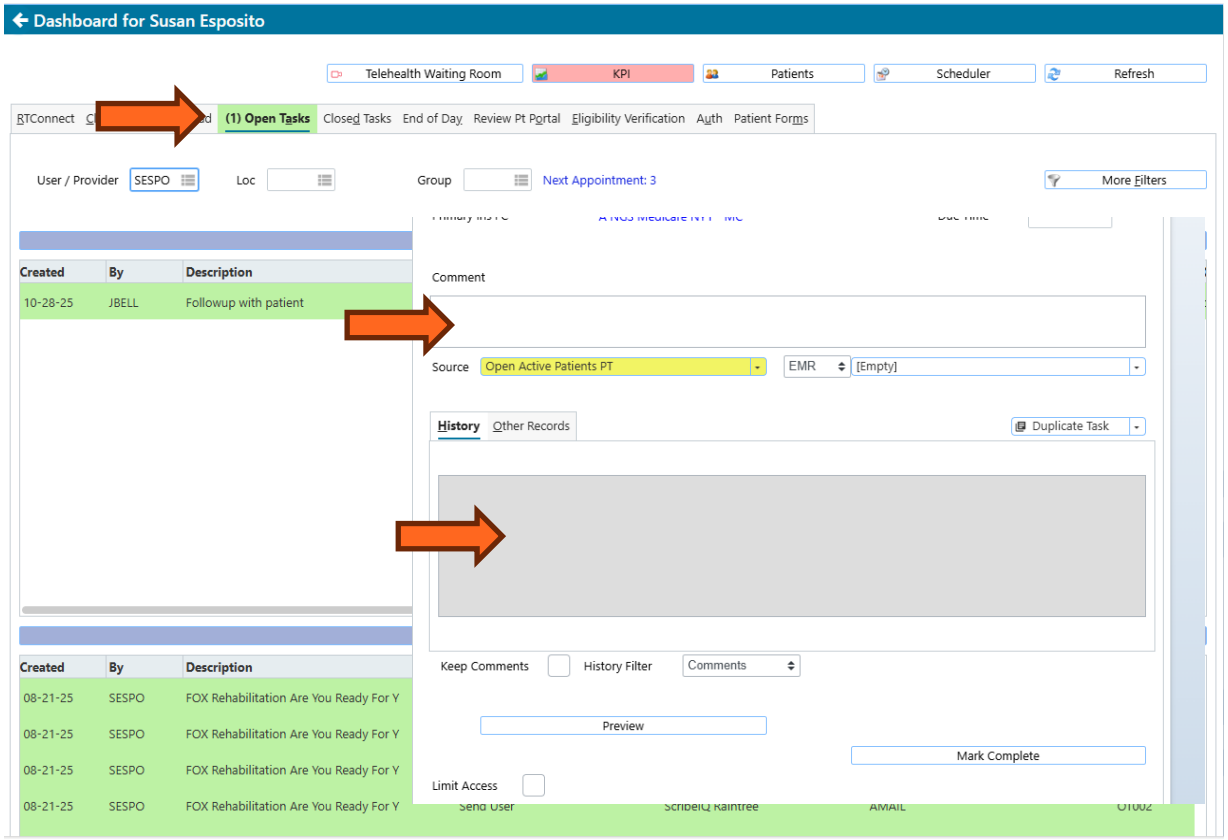


Clinical Medical Records Request ccccc

- Utilize this task when the referring physician is not the Primary Care Physician
- The medical records team will determine which physician should be on the clinical documentation
- For example
  - If the patient was referred by a Hospitalist/SNF provider or a provider that DOES NOT sign the plans of care, Medical Records will update the Primary Care Physician into the case billing provider which will then reflect on your treatment, progress and re-evaluation notes.
  - If the patient was referred by a provider that does not indicate they do not sign plans of care, that provider will remain within the case for plan of care and treatment note documentation, however Medical Records will add the Primary Care Physician to the patient account for documentation purposes and potential future needs.
- **Do not send duplicate tasks if the PCP is not changed on your POC**
  - If you send in a task to update the physician but medical records deems this is not the physician that should be on the clinical documentation, they will communicate this back to you via the task. Please then close the task.
  - If you do not hear back from medical records, then they have updated the case and they have closed the task.

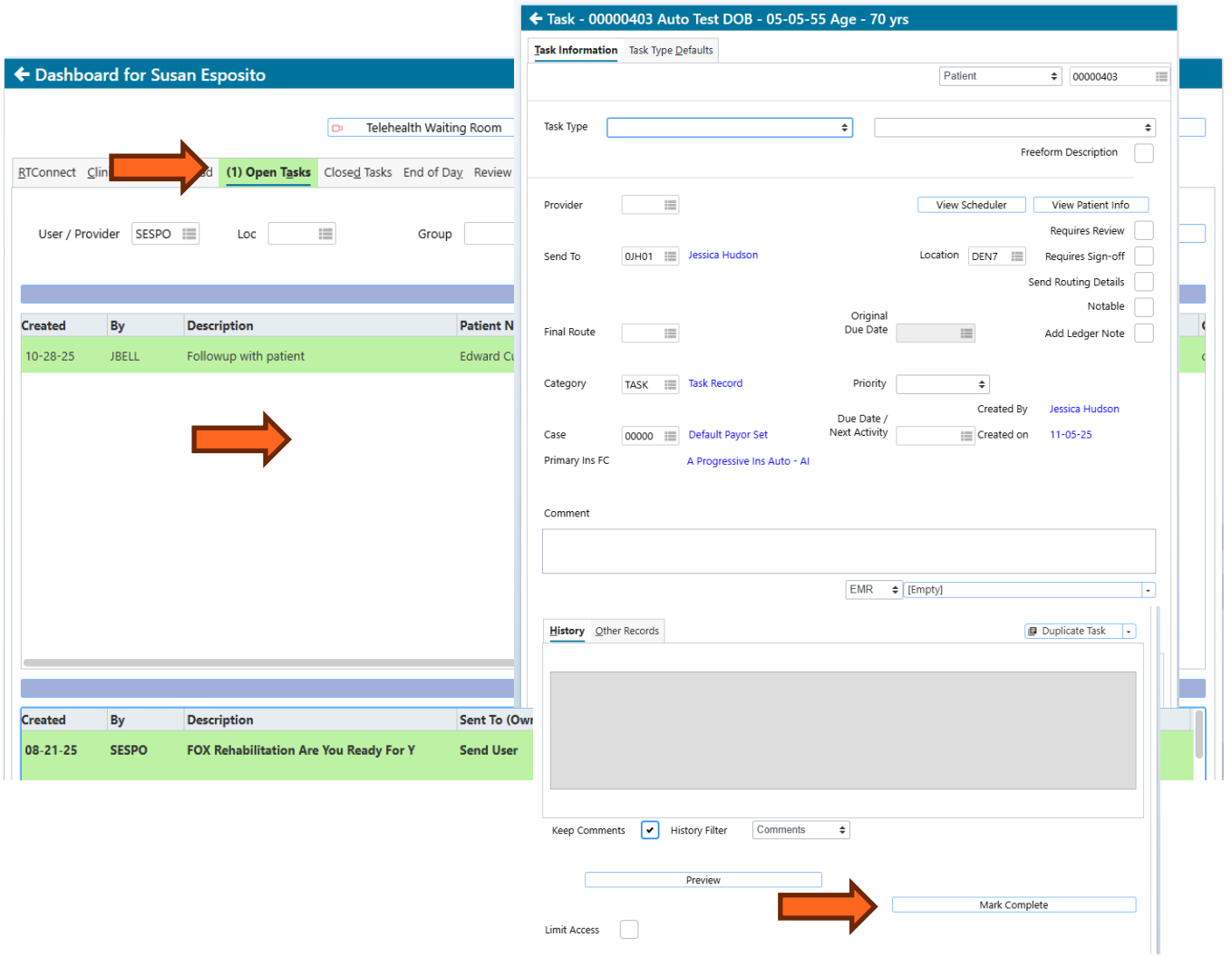
Reviewing Tasks

- Review any Sent Tasks to check status. From your dashboard, select **Open Tasks** Tab
- Located at the bottom you will see all your **Open Sent Tasks**. By double clicking the patient name, it will open the task.
- Here you can add any additional comments for the team to review who is working your task.
- Underneath, you will see the history of any comments regarding the request.



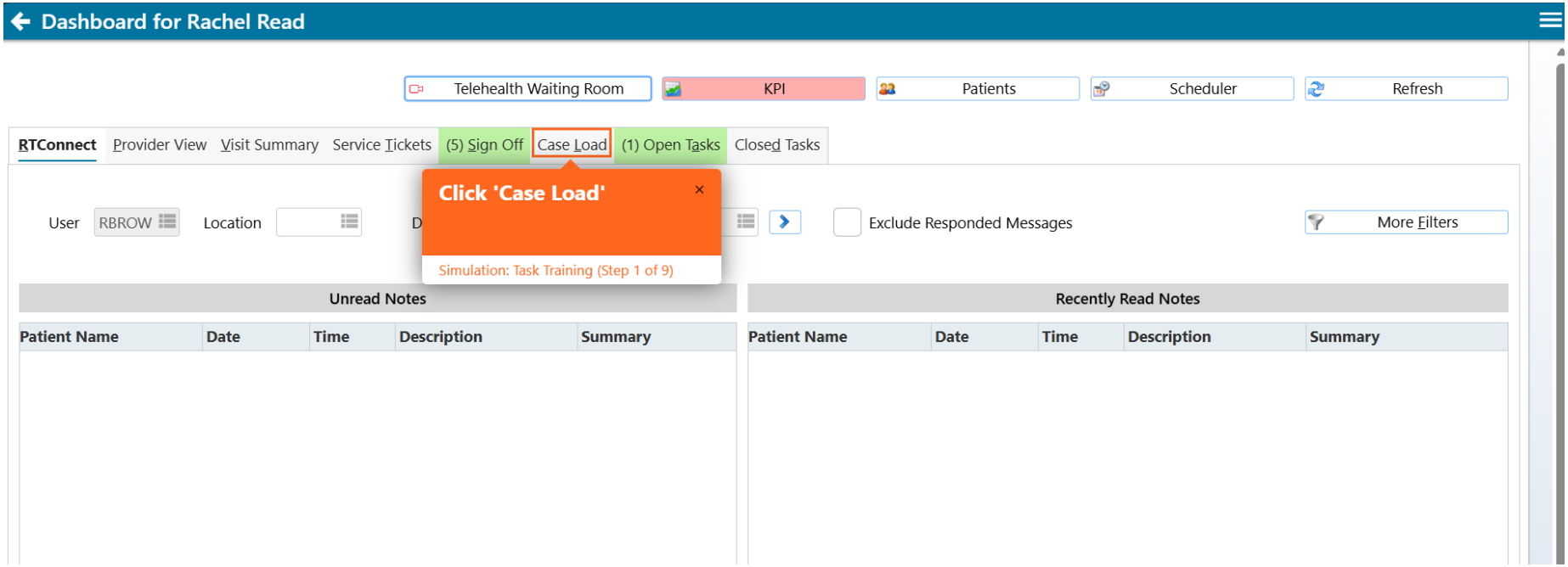
Reviewing Tasks

- Any tasks sent to you to review, respond or mark complete will be located in your “**Open Tasks**” tab under “**Open Tasks**”
- In this section you can double click to open the task and review any comments written back to answer or if completed, you can **Mark Complete**.



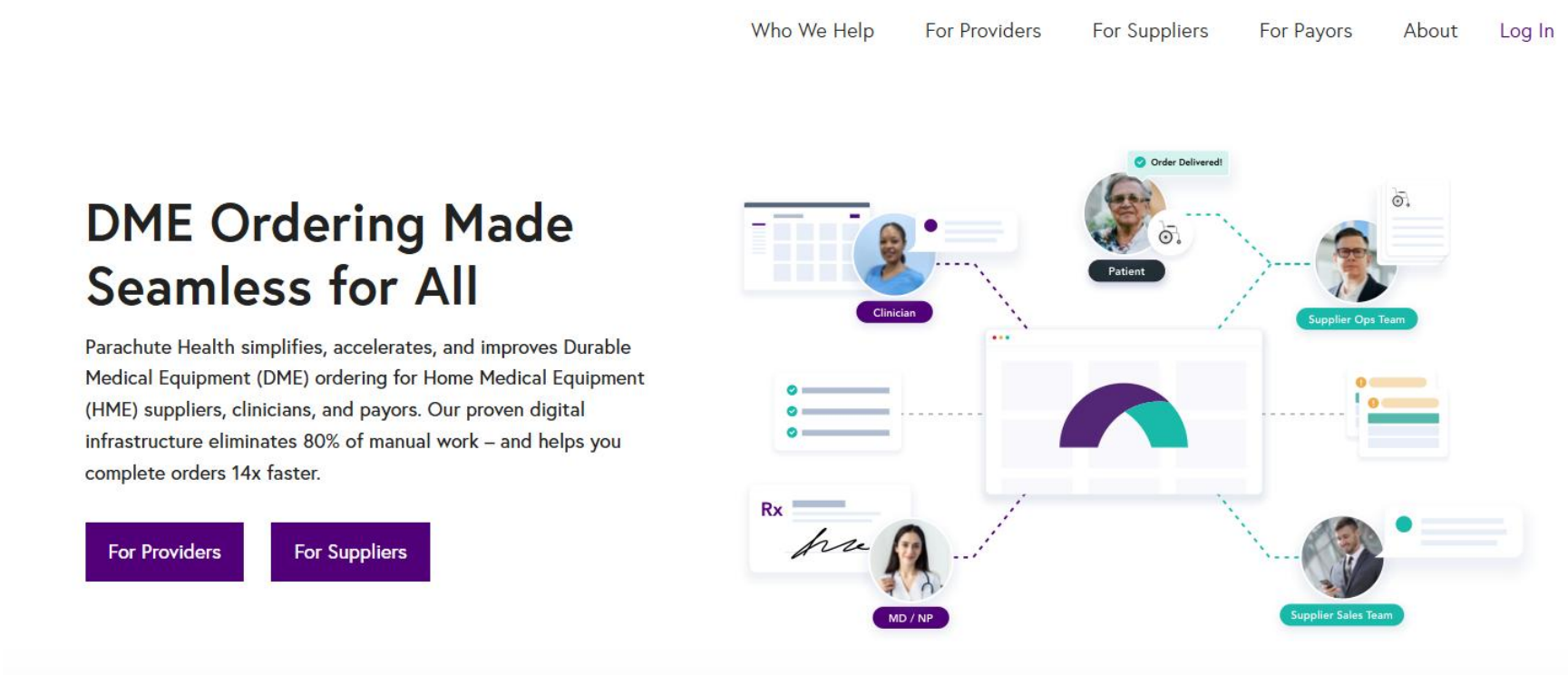
SIMULATION TIME: Tasks

Try it NOW!
Click the Image Below to Start the Simulation



**If the simulation does not automatically display an orange pop up box, refresh your browser.

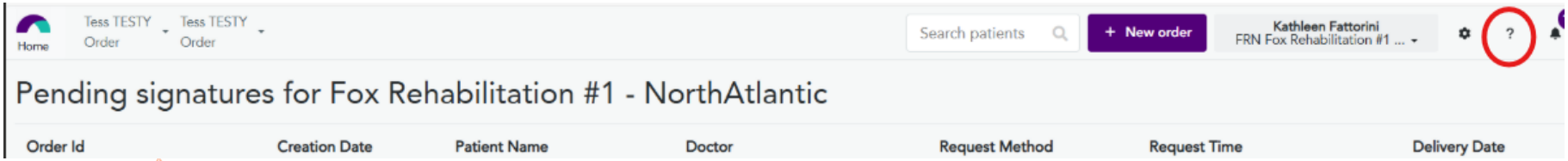
DME Ordering | Parachute Health



FOX will be using Parachute Health for DME ordering, making the process easy, efficient and fast!

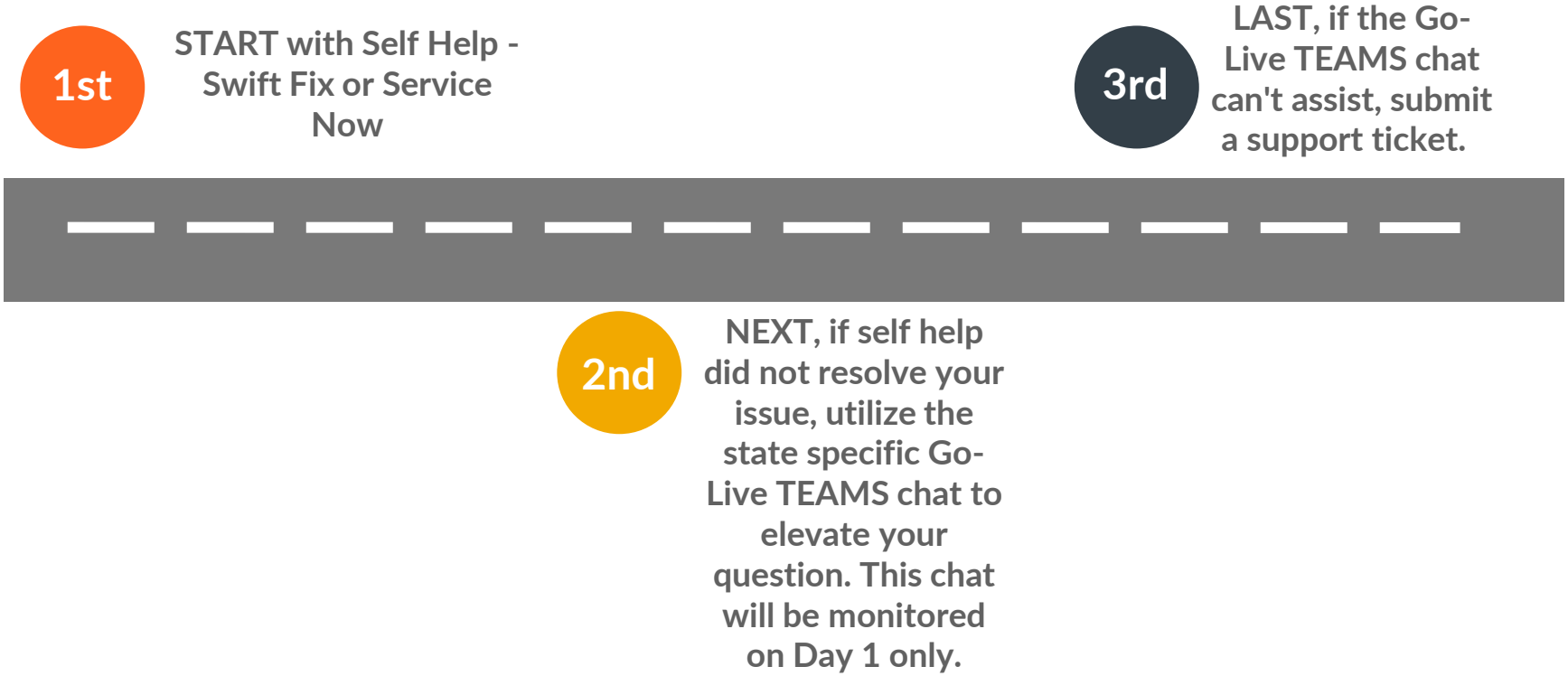
DME Ordering | Parachute Health

- You will be receiving a **Welcome Email from Parachute Health** the week after your Go-Live date.
  - Please notify your Practice Liaison if you have not received it by the 2nd Friday after your go-live.
- Important Notes about Parachute Health:
  - In Parachute, **clinician = physician.** So don't go signing off on your own requests :-)
  - Your only option is to **CREATE** a chart note and answer the questions that pop up. Only physicians can upload chart notes.
  - Orthotics or splint order cannot be entered into Parachute. Please reach out to your Practice Liaison via "**Clinical_Durable Medical Equipment**" task if you need assistance with equipment not in Parachute
  - This same Task can be used to request your Practice Liaison team enter demographics and insurance information in Parachute before you place an order.
- **Parachute Makes Ordering and Tracking Progress Easy**
  - Prior to submitting your first order, review the **DME Ordering Guide** which can be accessed by clicking the "?" located on the top right-hand side of the screen after you log in.
  - If you need assistance reach out to your Practice Liaison!



Support Roadmap: Start Smart, Escalate Right

Have a question? Follow the path to resolution!



RT Standard Scheduler



FOX Trax & Raintree Standard

- **Fox Trax will continue to be the primary location for scheduling.**
  - Despite Raintree's scheduler, FOX Trax provides a more seamless user experience for scheduling and visit verification
  - FOX Trax appointments will pass to RT Standard and display in various locations (Scheduler, Provider View tab, etc.)
  - A “new” version of FOX Trax will be connected to RT Standard. No action is required for you to manage. We will adjust this based on your phase roll out.
    - Visits scheduled in RT Custom version of FOX Trax will NOT be able to sync over and will require you to enter them again into the “new” version connected to RT Standard. Instructions for this will be in your **Go Live Readiness Checklist**
- **Visit Verification will be completed exclusively in FOX Trax**
  - There is no visit verification option in Raintree
- **Appointment Reminders and e-Consent to Care will be completed in Raintree**
  - These options in FOX Trax have been disabled since they will only go out via RT Standard

Scheduling Workflow

IMPORTANT

Before scheduling in FOX Trax, "Work Schedules" need to be created in the Raintree Scheduler.

"Work Schedules" control the calendar AND are location based. Without a work schedule for a SLC or region-based home location, you will not be able to schedule in FOX Trax or the RT Scheduler!

REMINDER: "Work Schedules" are not your actual weekly patient schedule.

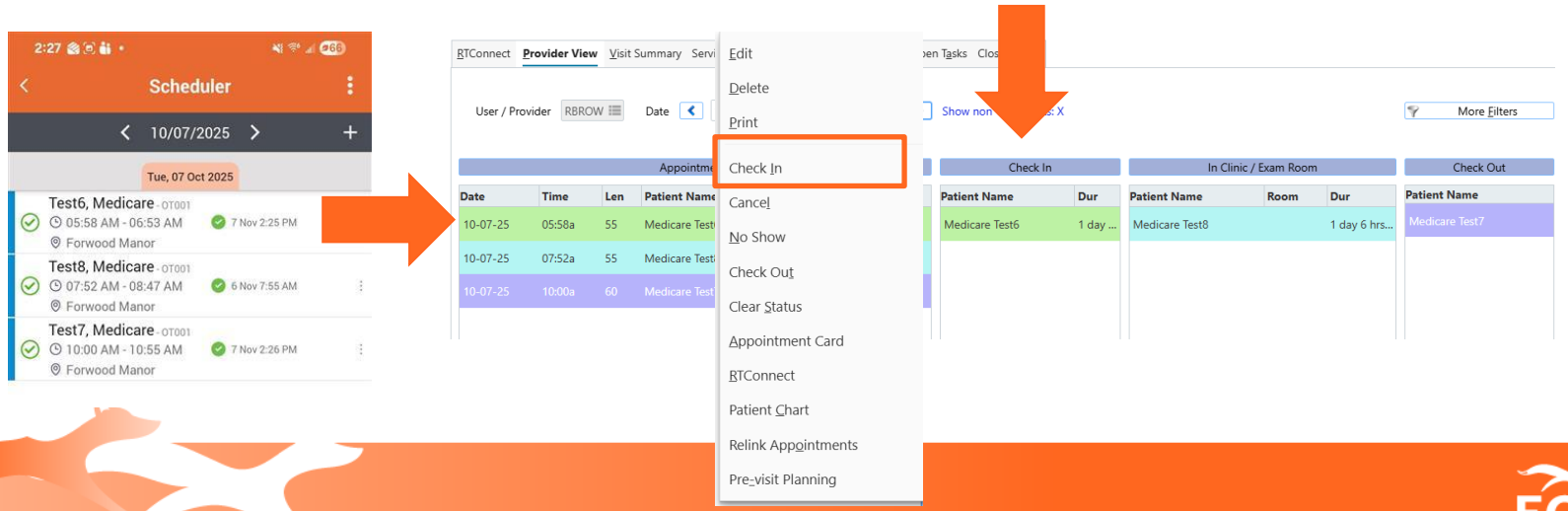
Once you set a work schedule for a location, there is nothing else you need to do to manage.

If you begin to work in a new SLC or region, you will have to add another work schedule. Training for this is at the end of this presentation or can be easily found in Swift Fix when ready to create a new work schedule.

Your RDs will be creating your work schedules for your Go-Live or Start with FOX.

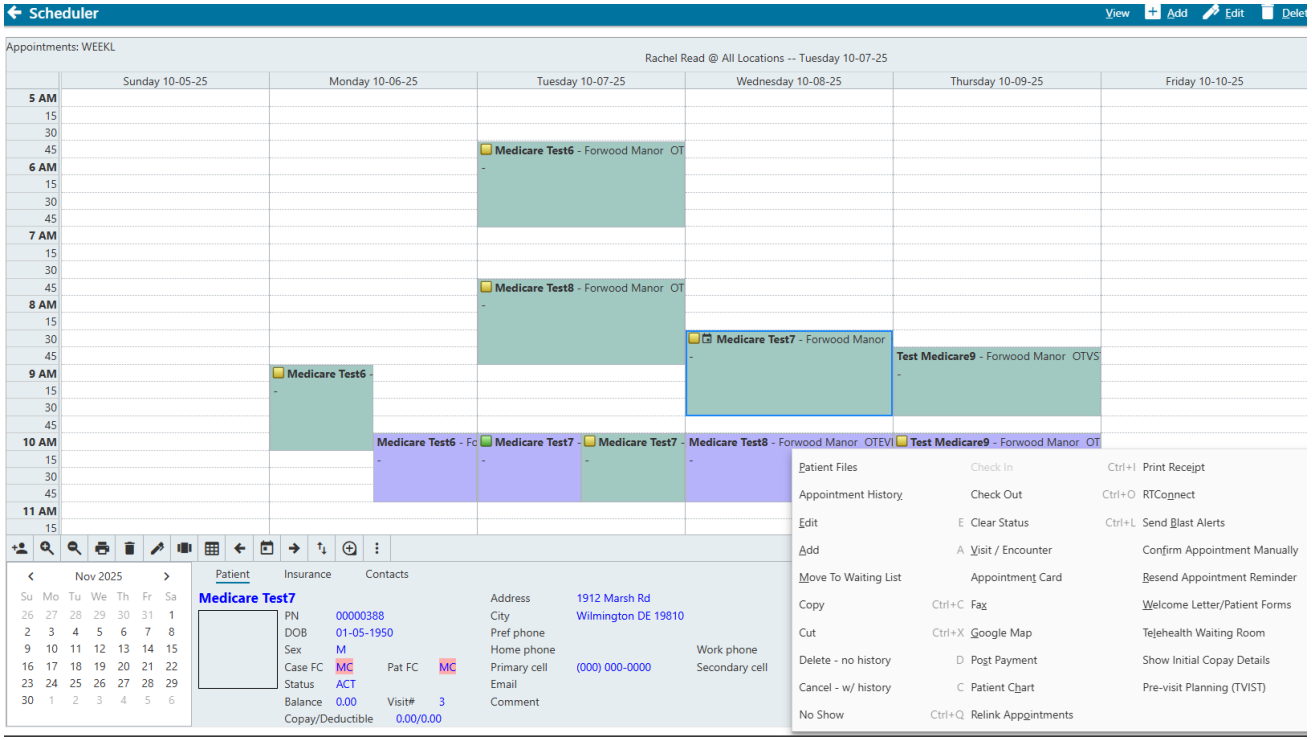
Scheduling Workflow

- Schedule in FOX Trax
  - Visit will display in RT Standard scheduler and **Provider View tab** under **Appointments**
  - Visits **MUST** be scheduled to start a note. RT Standard does not allow for notes to be created without an appointment.
- In **FOX Trax,** complete visit verification, ideally at the start of the session
- In **RT Standard**, right click the appointment and select **Check In**
  - The appointment will display in the "**Check In** " window
    - Double click or right click> edit to open the clinical note when ready to document.
  - In the event action is needed (due to patient forms being unsigned or previous notes not completed), prompts will display and then the appointment will display in the Check In window
    - See Consent Training for details on patient forms.
  - Read any additional prompts related to the patient so you are aware of any notices/alerts



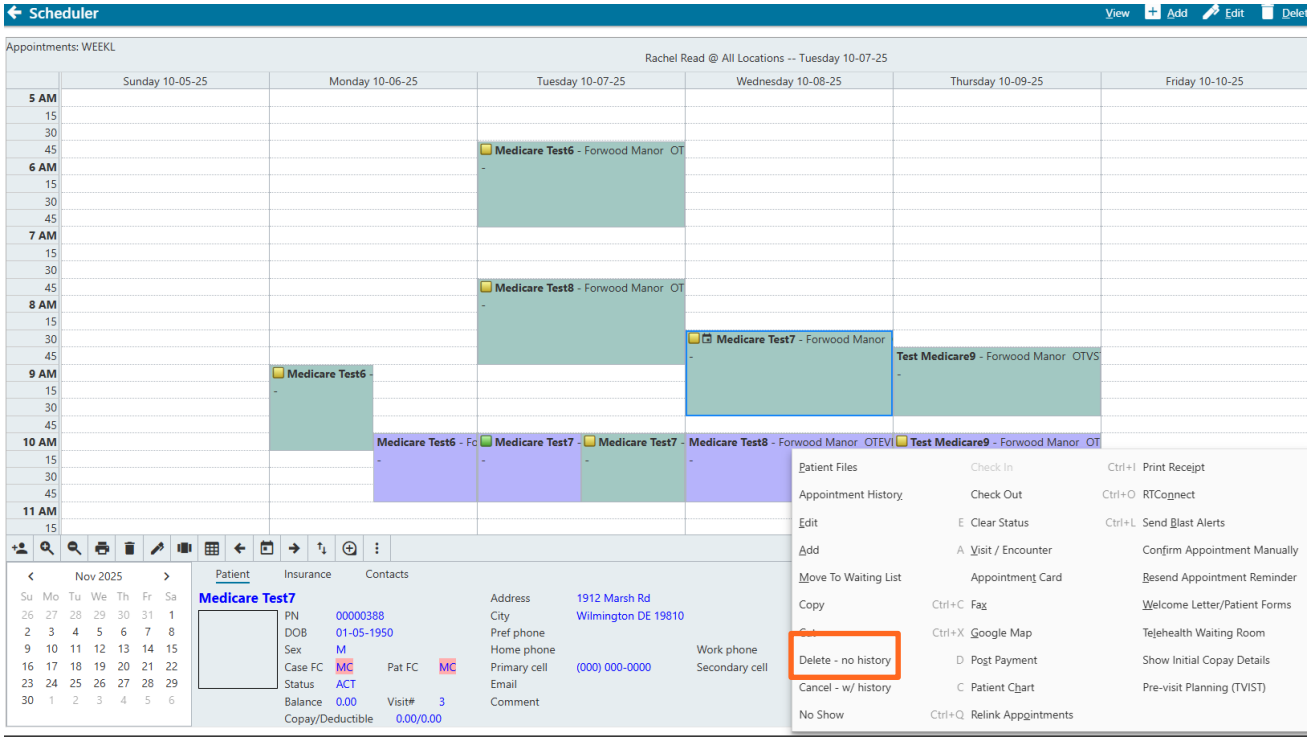
RT Standard: Scheduler

- The primary access point to scheduled visits will be the Provider View tab however the Scheduler does offer benefits based on your preference.
- Appointments are color coded based on visit type (evaluations, PRs/Re-evals/DCs, telehealth, etc.)
- Icons also display based on appointment's status.
- Right click on an appointment to see options



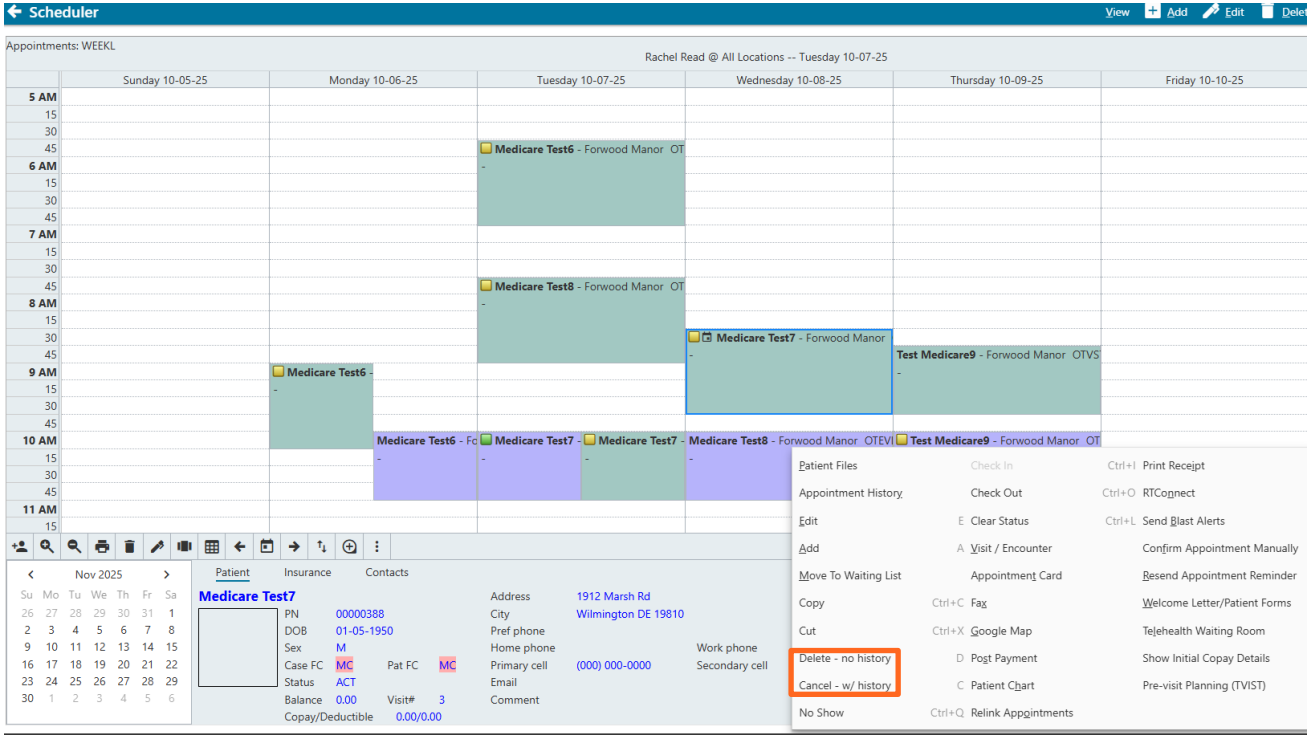
RT Standard: Deleting a Visit

- If you need to delete (error in scheduling) or reschedule (schedule change) a visit, you should do that in FOXTrax
- When you delete a visit in FOXTrax, you may need to delete the visit from your RT Scheduler
  - From "Scheduler" right click on the appointment and select "**Delete – no histor**y"
  - Select Verify Delete (top right corner) > Yes – Delete VERIFIED > select Reason for delete > Save
  - This will remove the appointment from your scheduler



RT Standard: Cancelling a Scheduled Visit

- If you need to cancel a scheduled visit...



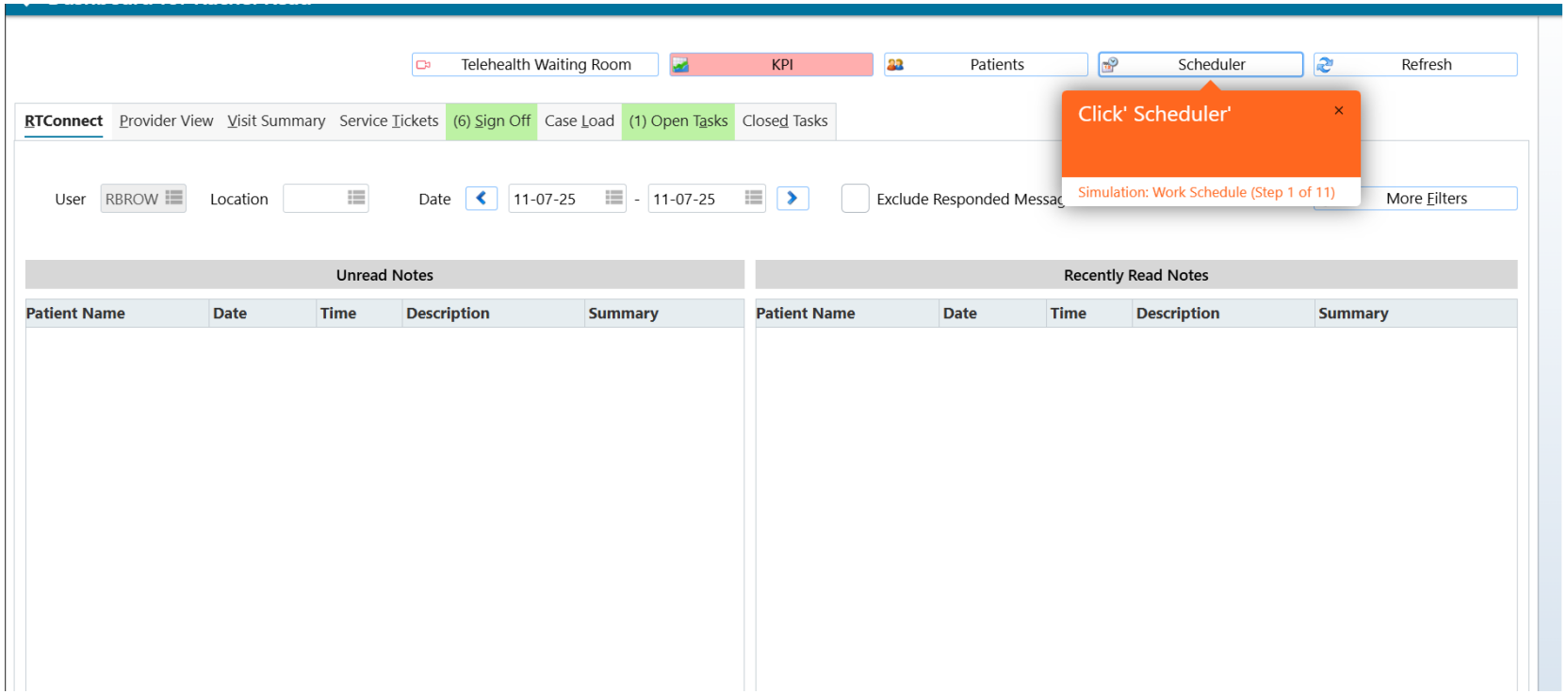
Appointment Icons

- Appointment Status Icons
  - Checked In
  - Checked Out
  - Cancelled
  - No Show
  - Reschedule

- Appointment Flag Icons
  - Appointment reminder sent to the patient
  - Sending the appointment reminder failed
  - Patient confirmed the appointment
  - Appointment reminder was intentionally not sent

SIMULATION TIME: Work Schedules

Try it NOW!
Click the Image Below to Start the Simulation



**If the simulation does not automatically display an orange pop up box, refresh your browser.

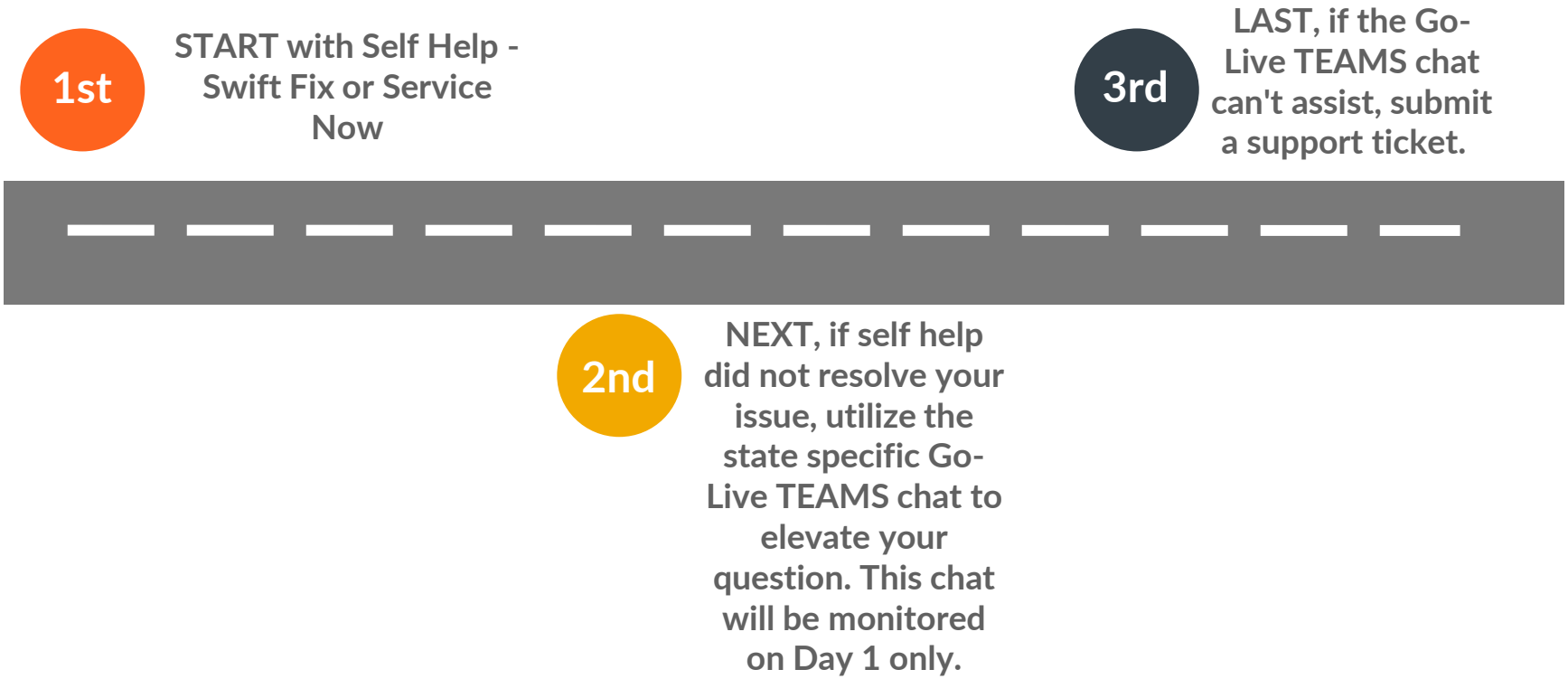
Creating Work Schedules: Step by Step Guide

- Click Scheduler
- Click Calendar Icon
- Click Maintain Schedules
- Click Add
- Check Automatic Apply. This will set the work availability indefinitely for that work schedule location.
- Click to open the location table. Once in the table click Find to search for your location and select the location.
- If you know the location code, you can enter it directly into the location field. Click Next once you have selected or entered your location.
- Click 'Copy Availability Data'
- Click "Show only work schedule templates"
- Double click to select "-Default". Do not single select and hit save. This will not apply the default work schedule if you hit save.
- Confirm you see light yellow across the default line in the below schedule view. Click 'Save'

Watch a Video of the Steps - Work Schedules

Support Roadmap: Start Smart, Escalate Right

Have a question? Follow the path to resolution!

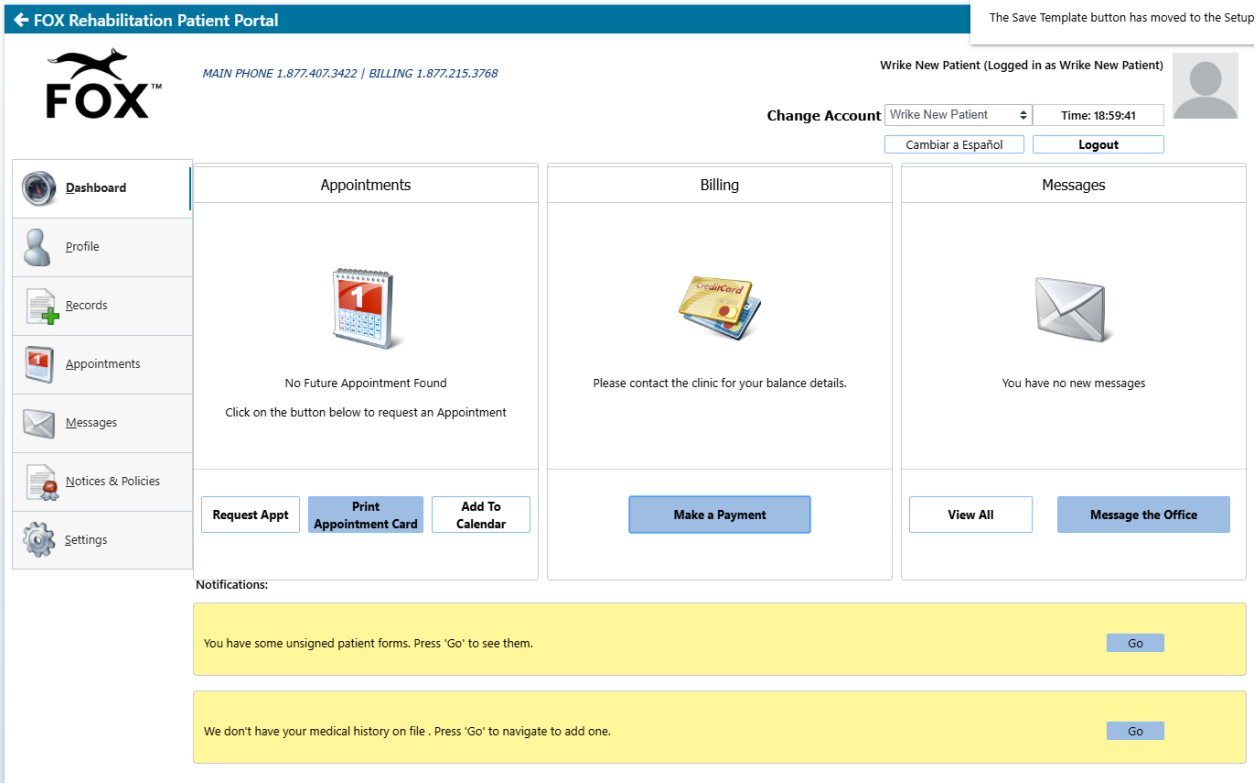


RT Standard:
RT Connect



RT Connect

The new communication platform built in Raintree, aimed at boosting patient engagement and communication through its electronic patient portal.



RT Connect

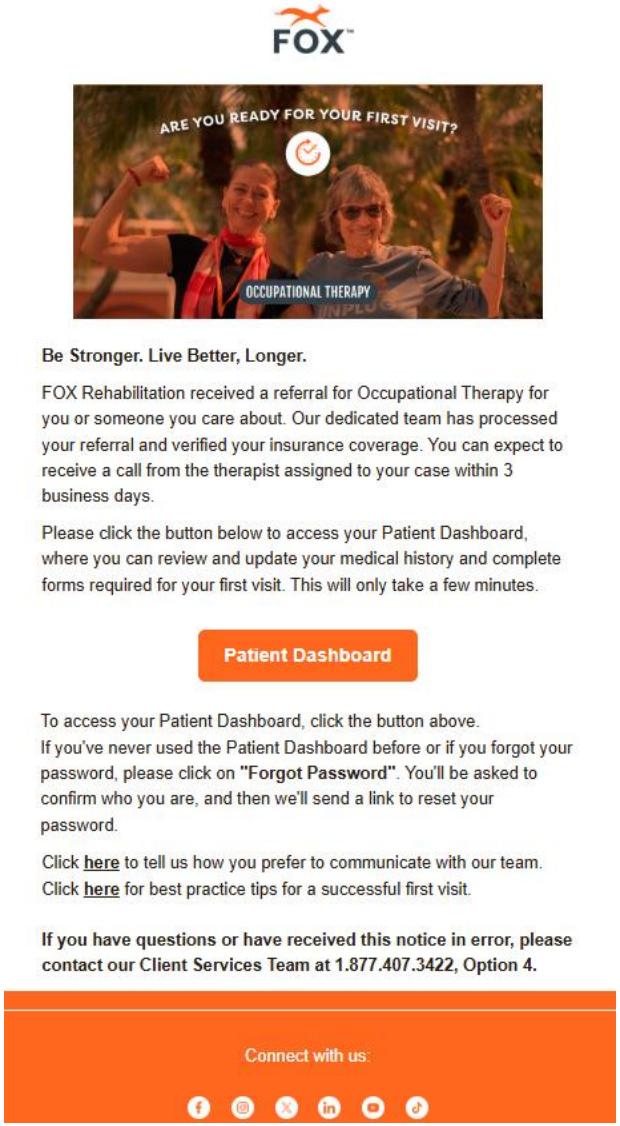
Why is this a Clinical Win?

- Say hello to convenience and goodbye to piecing together medical history! When a patient completes the medical history themselves, YOU save your precious time.
- Digital tools mean less paperwork and more time for what matters: caring for patients.
- If you are submitting referrals, make sure to **collect an email address** from the patient and/or caregivers to help facilitate digital communication.
- Remind your patients and caregivers to complete any forms and medical history ahead of your appointments so you can spend more time evaluating your patients and less time entering documentation.

RT Connect

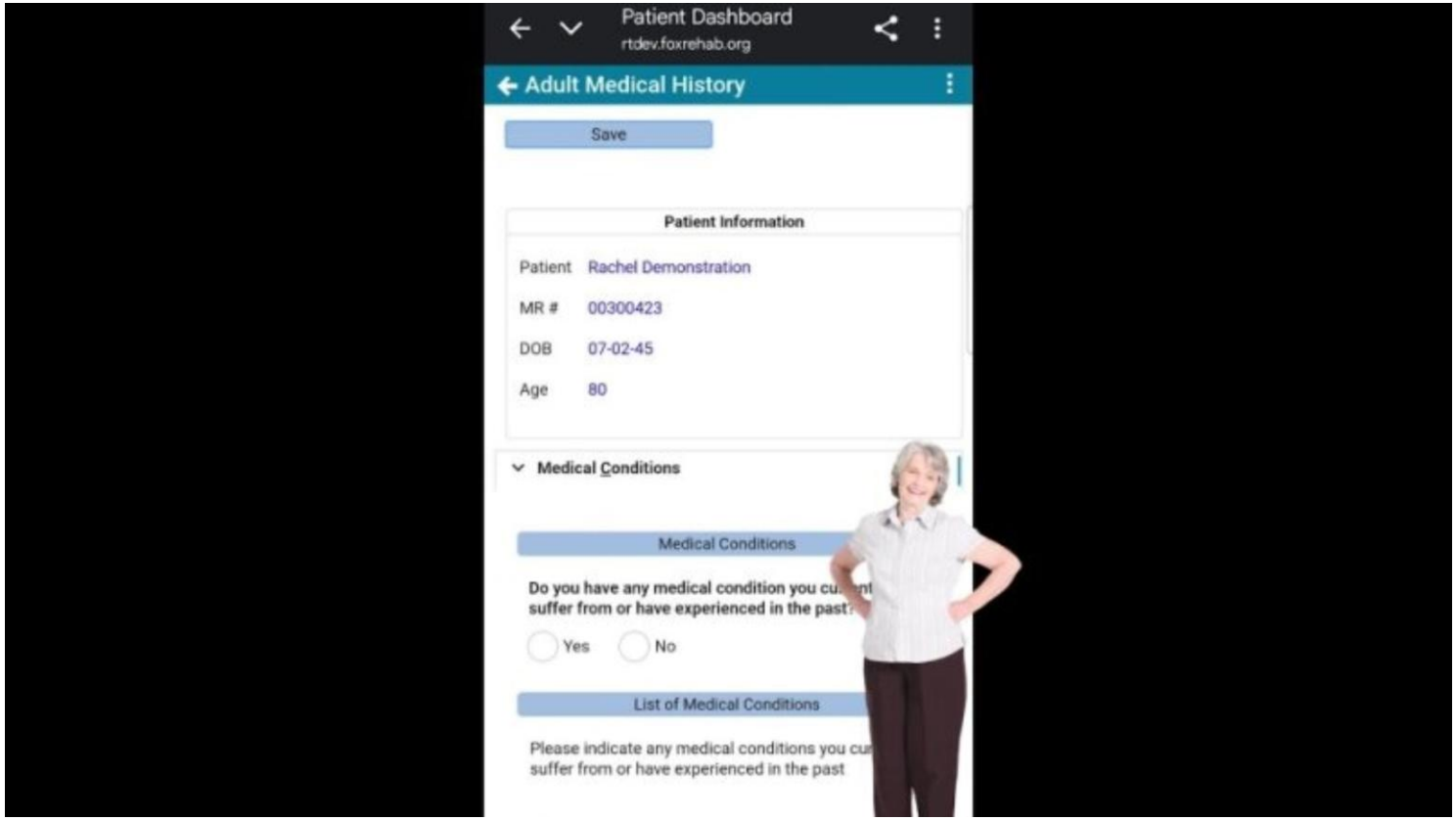
What Can Patients Expect?

- Raintree Connect will begin sending welcome emails, appointment reminders, wellness campaigns, post therapy follow-ups and more.
- Online, patients can update personal and insurance information, complete intake forms, consent, and enter medical history!
- If patients ask about emails and texts, assure them they are legit and coming from our new patient portal!



VIDEO TIME: RT Connect

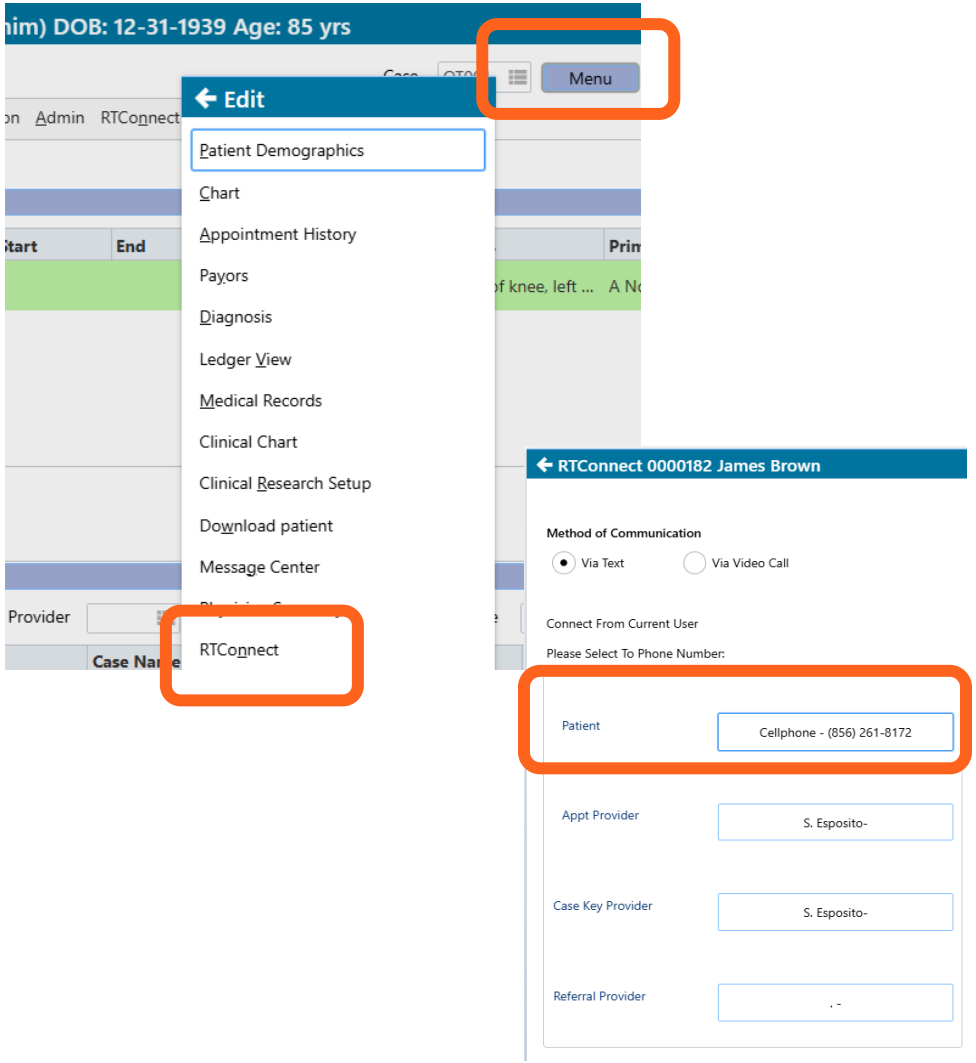
Watch it NOW!



RT Connect Demo

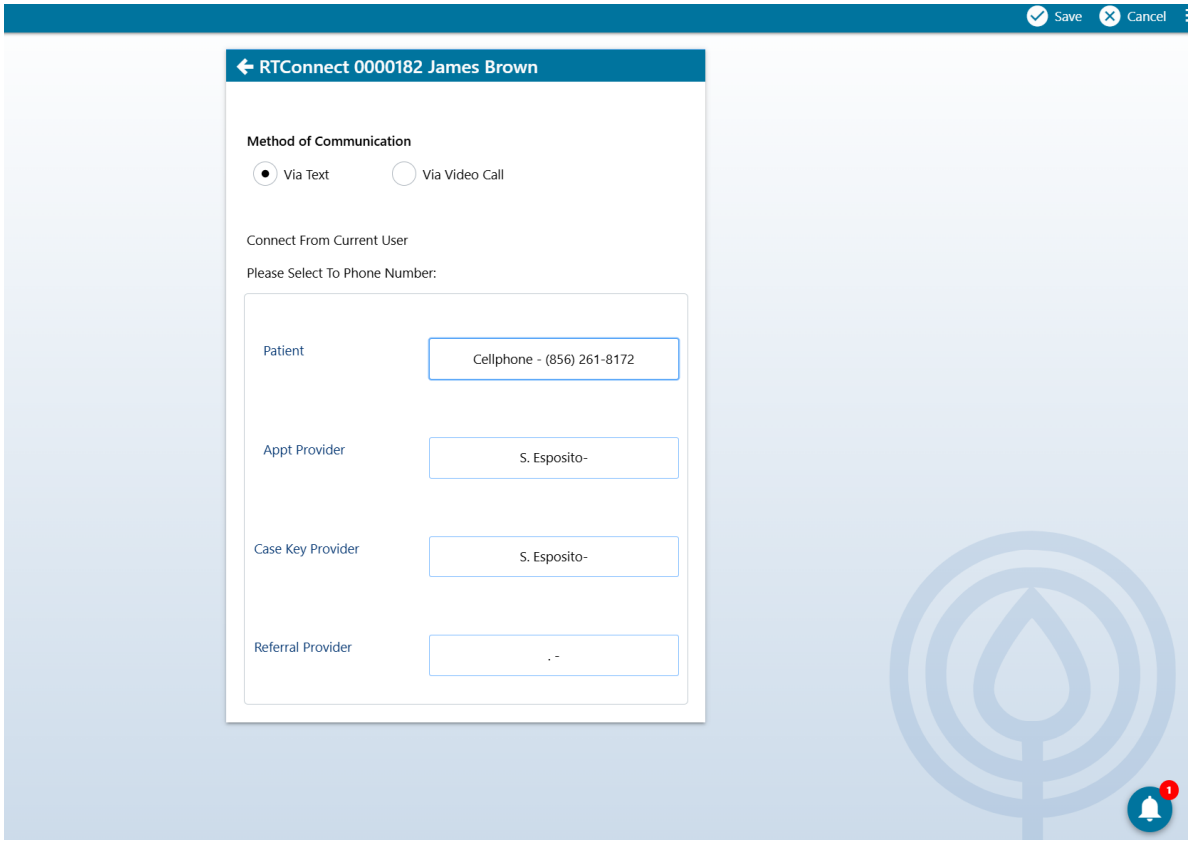
RT Connect Messages

- To initiate a message
  - Caseload Tab, double click to enter patient chart
  - Click Menu
  - Click RT Connect
  - Select the contact to message
  - A text screen will appear. Type message and hit send SMS



SIMULATION TIME: RT Connect Messages

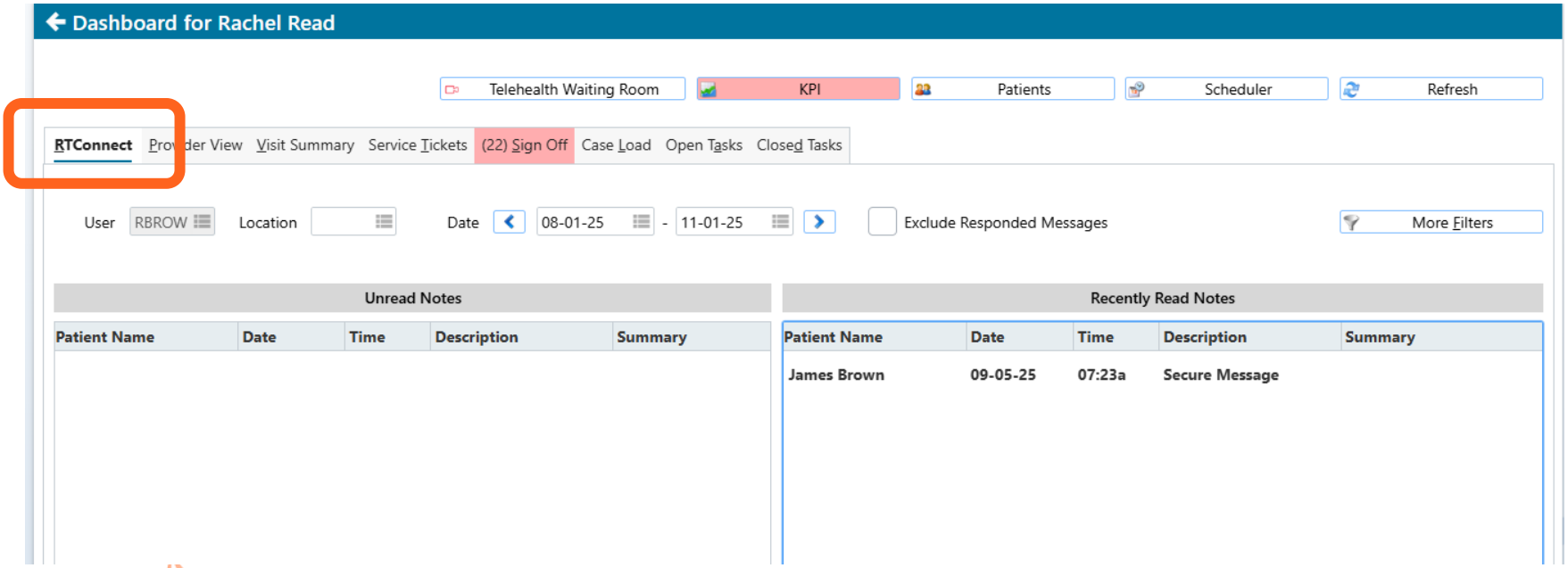
Try it NOW!
Click the Image Below to Start the Simulation



**If the simulation does not automatically display an orange pop up box, refresh your browser.

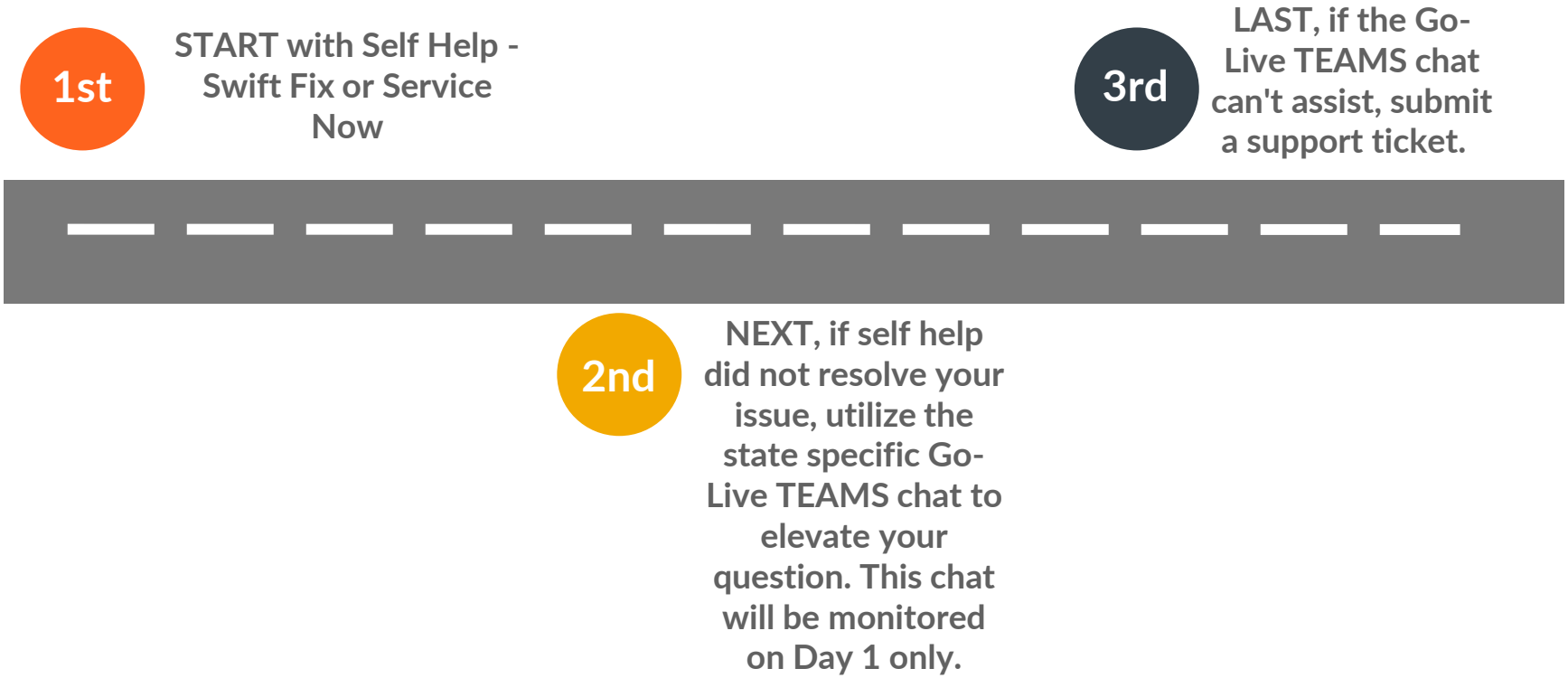
RT Connect Messages

- RT Connect Tab alerts you of messages sent from patients and/or authorized representatives to you.
  - The tab will be red if there are unread messages
  - Double click to open and respond
  - Messages move from unread to read



Support Roadmap: Start Smart, Escalate Right

Have a question? Follow the path to resolution!

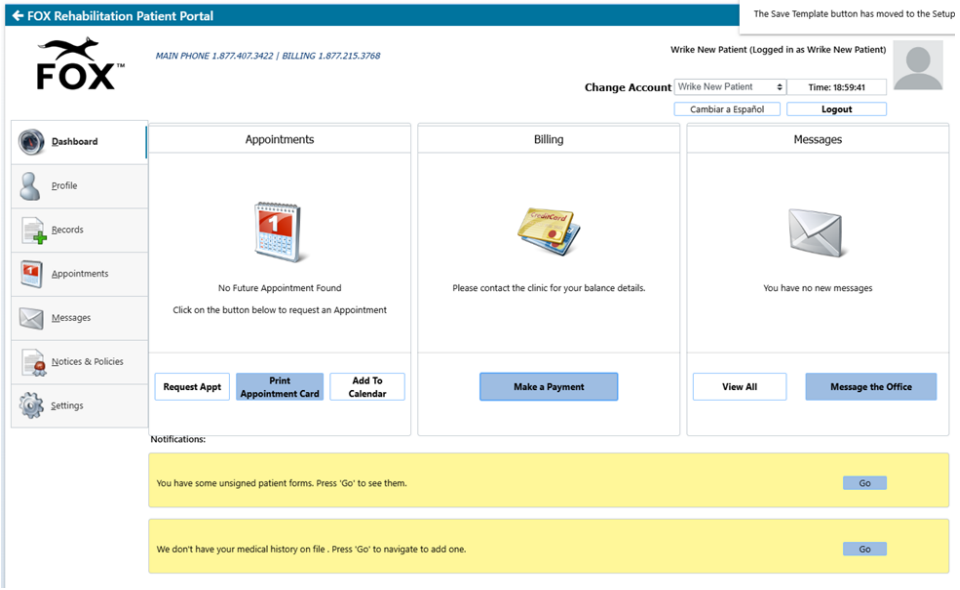


RT Standard: Admission Workflow & Consent to Care



RT Standard Admission, Consent, and Patient Portal

- **Ideal Workflow:**
  - All patients admitted with an email address
  - Immediate access to the Patient Portal
  - Completion of patient forms online (Consent to Care, Medical History)
  - Minimizes administrative tasks for clinicians
- **Training Focus:**
  - Steps to take when the ideal workflow is not possible
  - How to obtain patient email addresses
  - Ensuring consent forms are completed



RT Standard: Admission Workflow for Ideal Scene

1. Upon receipt of a new referral, the admissions team is provided an **email or mobile number** for the patient or their authorized representative
    a. An authorized representative can be:
        i. Power of Attorney
        ii. Medical Power of Attorney
        iii. Financially Responsible Party
        iv. Financial Power of Attorney
2. If not provided with email or mobile, admissions will be requesting this information:
    a. Community Patients ONLY:
        i. Admissions will contact the physician's office prior to admitting if not received.
        ii. If a Welcome Call is made or the patient is placed on our "Waitlist" the team will attempt to receive from the patient or Authorized Representative at that time.
3. If email or mobile is present at the time a patient account is created a Welcome Email is sent.
4. When a Case is assigned to you, a second email is sent letting the patient know they should hear from you within 3 business days.
    a. A distinct email is sent for each discipline.
5. The patient or Authorized Representative is requested to login to the "Patient Dashboard"
    a. E-sign & Acknowledging the Patient Bill of Rights
    b. E-sign & Acknowledge any Financial Obligation
    c. E-sign & Acknowledging FOX's HIPPA and Patient Privacy Practices
    d. E-sign & Acknowledge Consent to Care (Including FOXs Cancellation Policy)

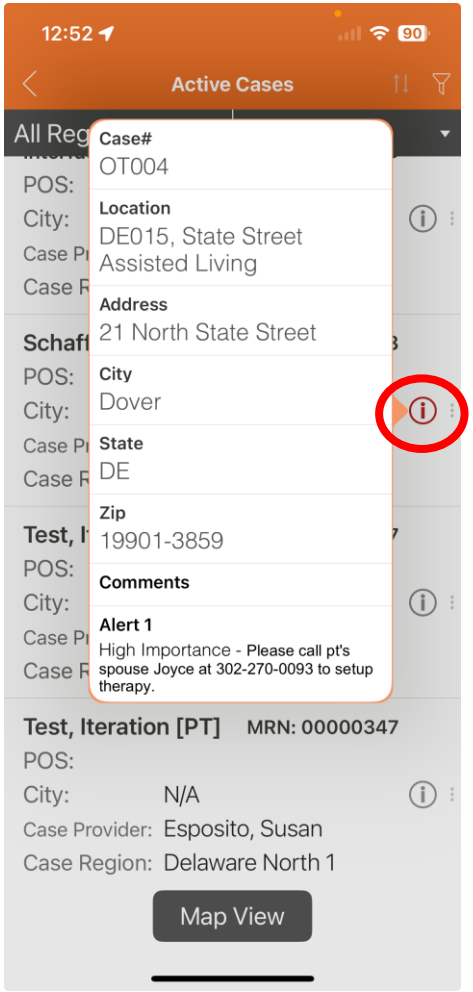
New Referrals

- Transition Period
  - As new states are moved over to the new system:
    - All Referral Sources within a state will be identified so that any referral which comes from a fax we have on file within that state will auto-move to the new system.
    - The Admit Portal linked to Custom RT will be blocked from adding a POS with the migrating state in the address.
    - Admissions Team will manually move any other patient to be worked within the correct system.
    - Temporary Fax to the New Admit Portal | 1(818) 237-3346
    - Direct Email | dtfoxemails@carecloud.com
  - FOX Trax is still the preferred method of submitting referrals

Assignment Details & Alerts

- Your new assigned patient will be in FOX Trax
  - You will also receive an email with the assignment details which will come from Foxrehab@Carecloud.com

- **In FOX Trax**
  - **Review "Alerts"**
  - **Review Case Details:** Check here to see if there is a **cell or email** on file for the patient or Authorized Representative?



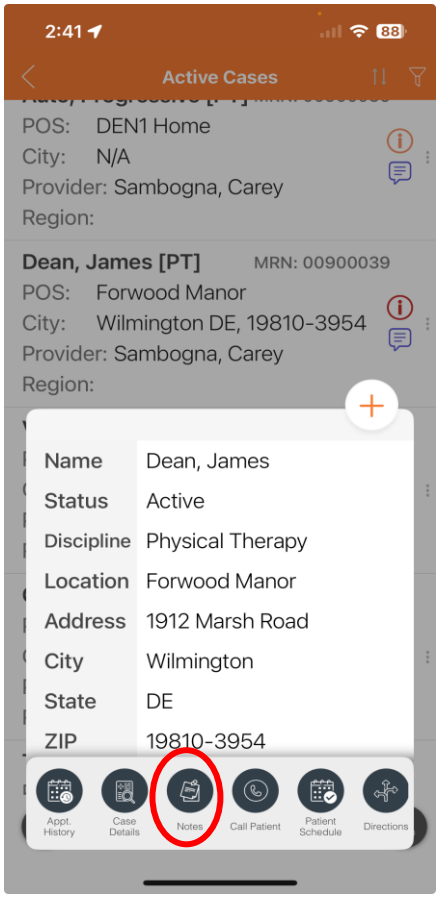
Call Patient

The "**Alert**" will indicate if Admissions was able to reach the patient and review financial responsibility and confirm the cell and email for the Patient Dashboard

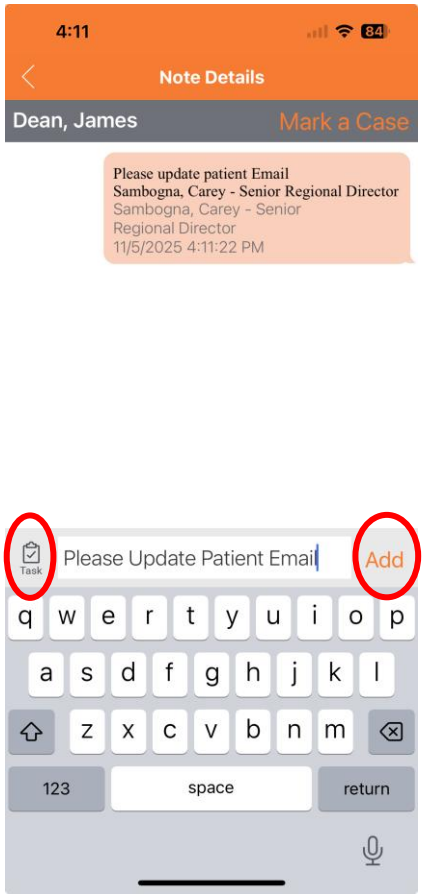
- **Call** your patient and introduce yourself & **ask** if they received the email or text notification from FOX.
  - Email would come from **raintreenotice.foxrehab.org**
    - **YES**
      - Schedule evaluation
      - Ensure they were able to sign the forms and ask them to complete medical history and medications in the Patient Dashboard, if not already done, prior to your evaluation.
    - **NO**
      - Review their Insurance Benefits if not previously done.
      - Schedule Evaluation
      - Ask if they have an email, you can send their forms to.
      - ***If the Patient can provide an Email add it in* FOX Trax**
        1. Add a "Note" and submit a "Task" to update demographics and send invite to the Patient Dashboard.

Workflow Option 1:Enter Email in Notes & General Notes in FOX Trax

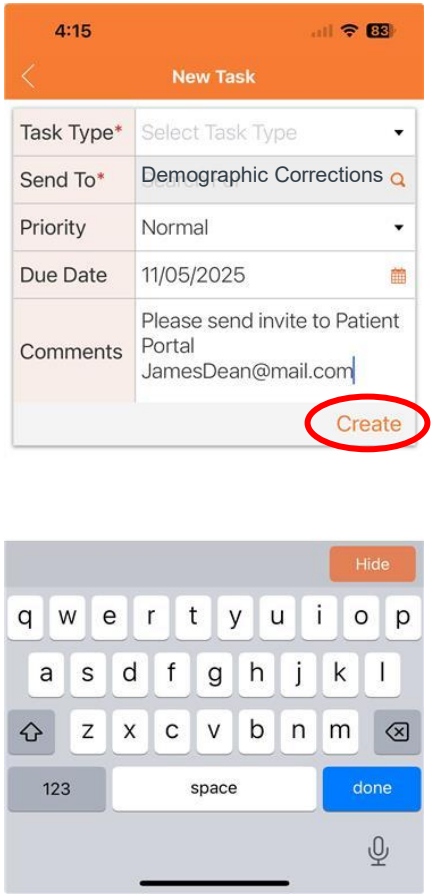
If completed, admissions will send invite to patient dashboard & forms can be signed



Select “Notes”



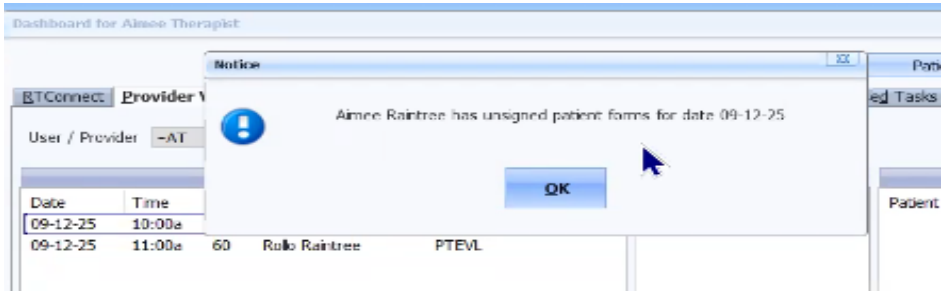
- Enter Brief Note > select “Add”
- Once the “Note” is added click the “Task” Icon



- Select Task Type “Demographic Corrections”
- Enter in the comments > select “Create”

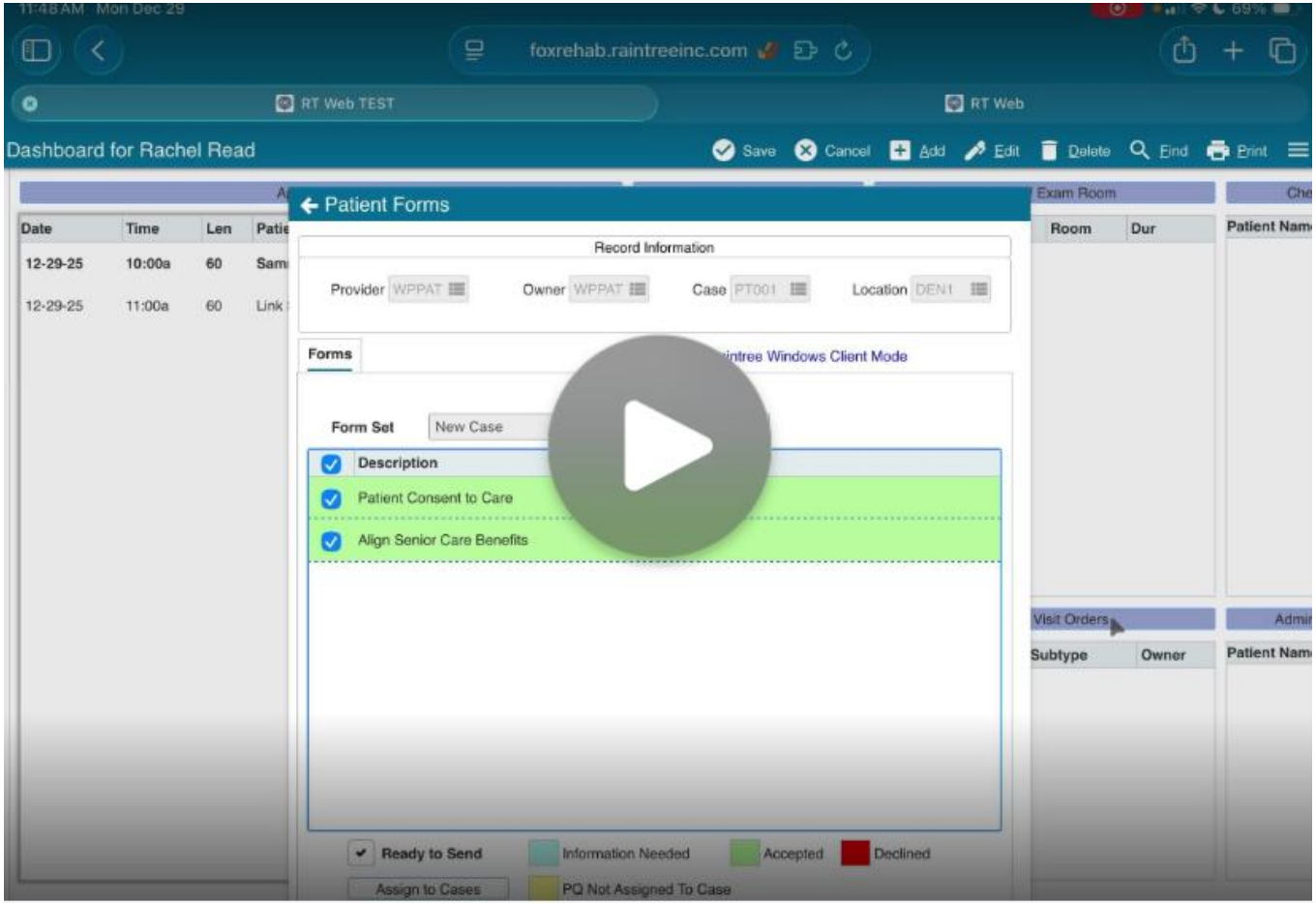
Workflow Option 2: At Eval | Signing Forms in Person

- If patient/authorized rep did not complete the patient forms/consent prior to your arrival, at check in, you will receive a prompt.
- You can have them sign the forms when you are with them.
  - After reviewing all the forms and the patient or authorized representative has signed, **select finish & save** and **complete**
  - **Review the training video (next slide)**



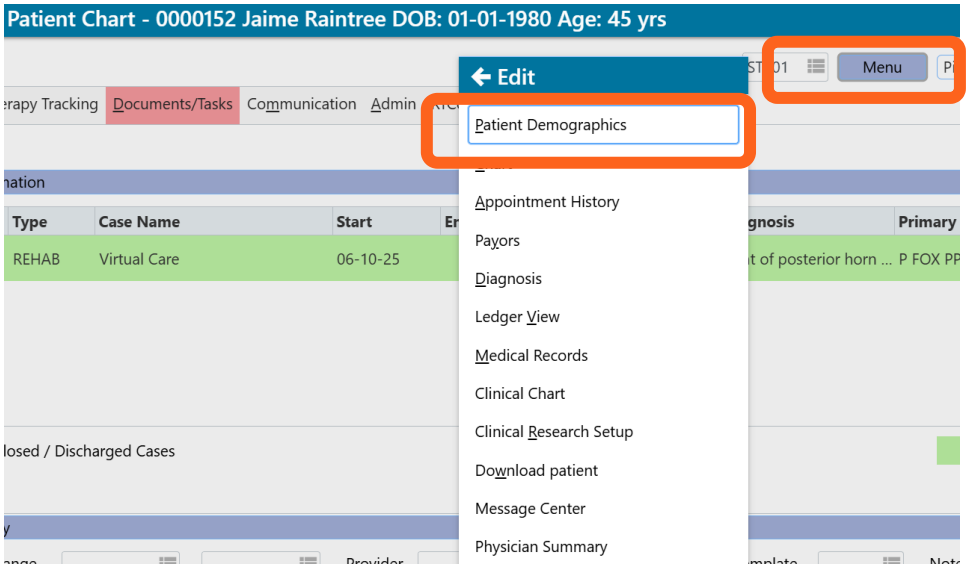
Workflow Option 2: At Eval | Signing Forms in Person

Review Video



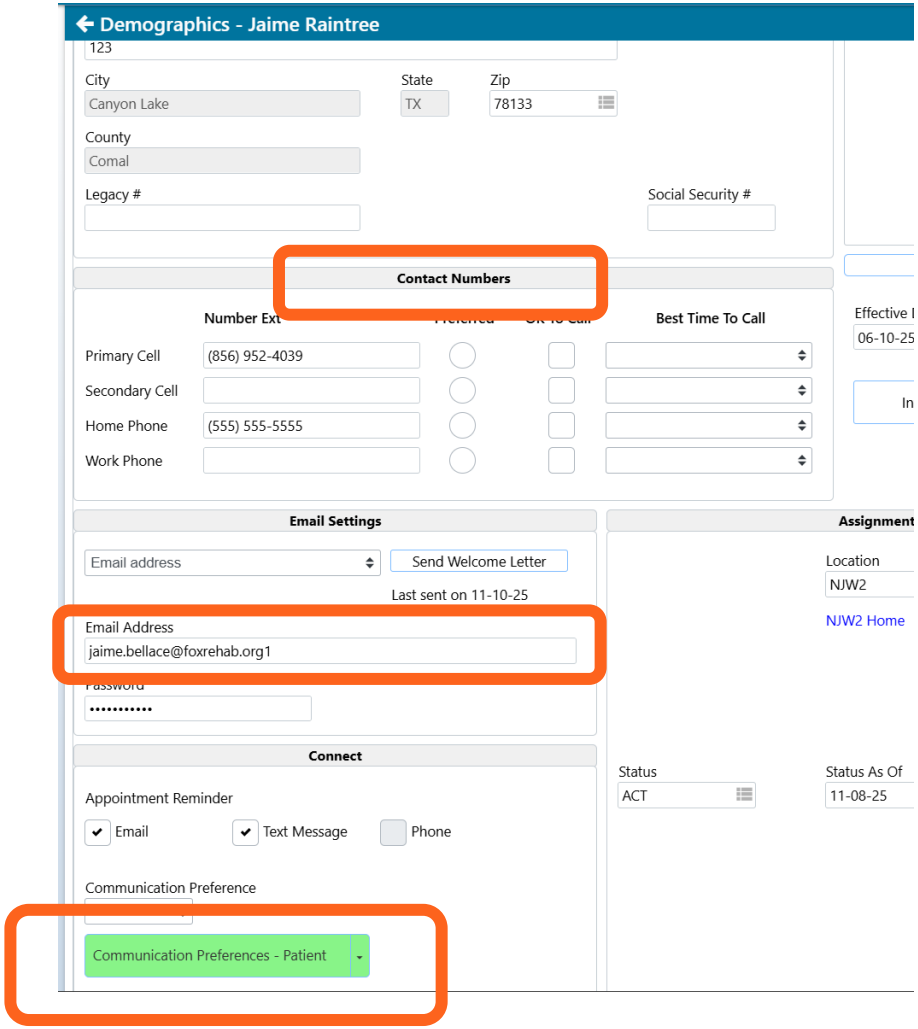
Workflow Option 3: At Eval| Unsigned Forms, Patient Not Signing in Person, Update Patient Demographics

- If the patient does not want to sign their own forms in person OR wants to review the forms in detail and receive in email.
  - Obtain email and update communication preference in Raintree
- Go to:
  - Case Load
  - Menu
  - Patient Demographics



Workflow Option 3: At Eval| Unsigned Forms, Patient Not Signing in Person, Update Patient Demographics

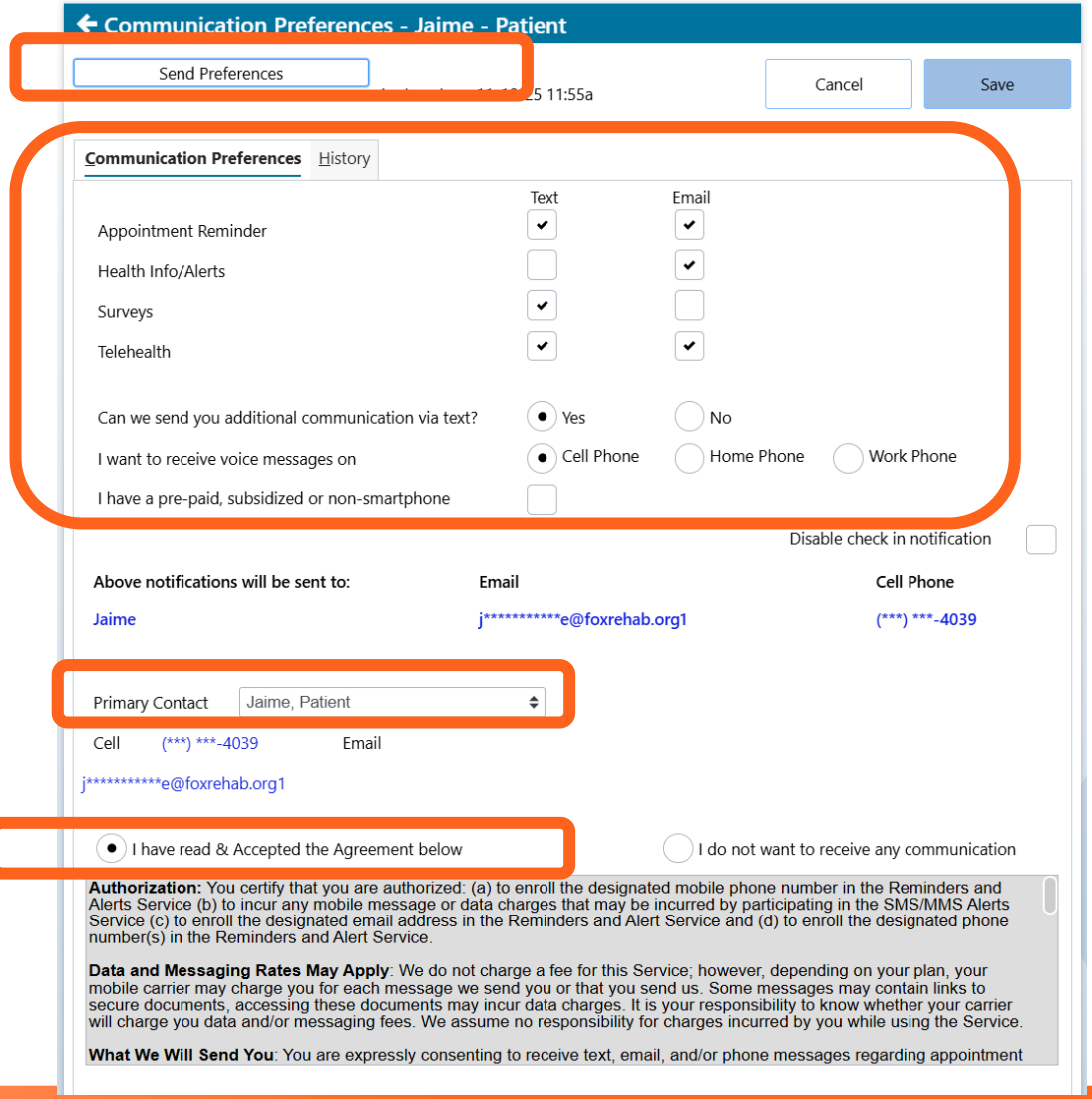
1. Update/add Contact Numbers (if needed)
2. Update/add email in Email Settings
3. Click Communication Preferences



Workflow Option 3: At Eval| Unsigned Forms, Patient Not Signing in Person, Update Patient Demographics

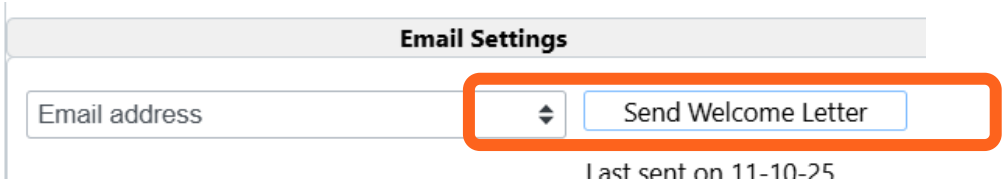
In Communication Preference:

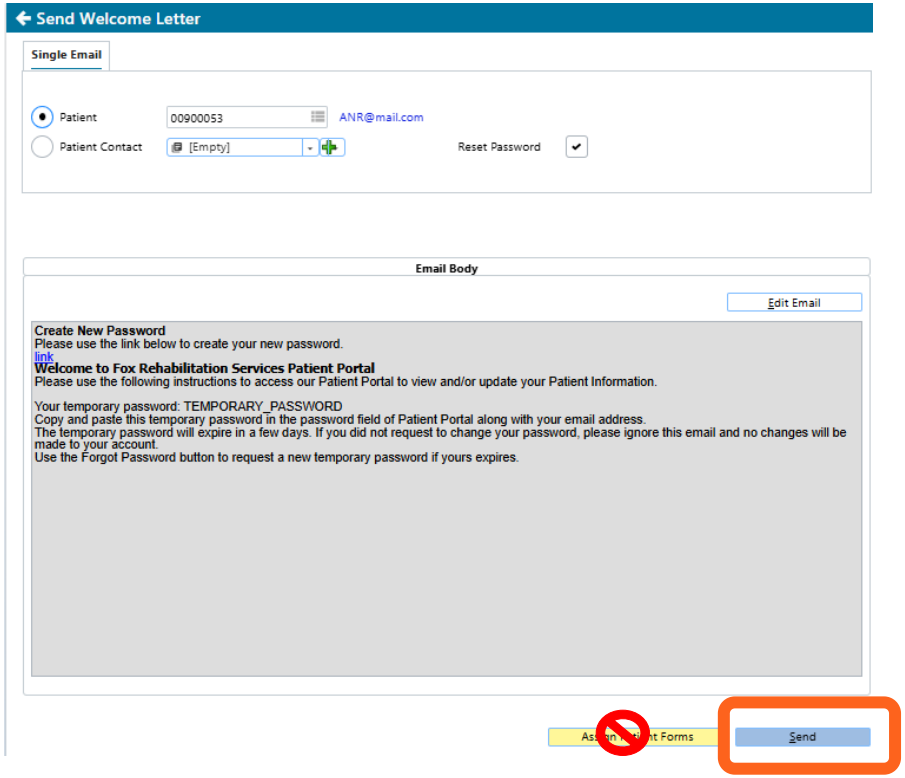
1. Check off “Communication Preferences”
2. Confirm “Patient” as Primary Contact.
3. Select “I have read & accepted..”
4. “Send Preferences” CLICK THIS LAST
   - This sends the preferences to their email
   - This enables the patient to update the information at any time and therefore it is “ok” to not spend a lot of time and simply check all, and they can make changes if they choose.
   - You will be returned to the Patient Demo screen.



Workflow Option 3: At Eval| Unsigned Forms, Patient Not Signing in Person, Update Patient Demographics

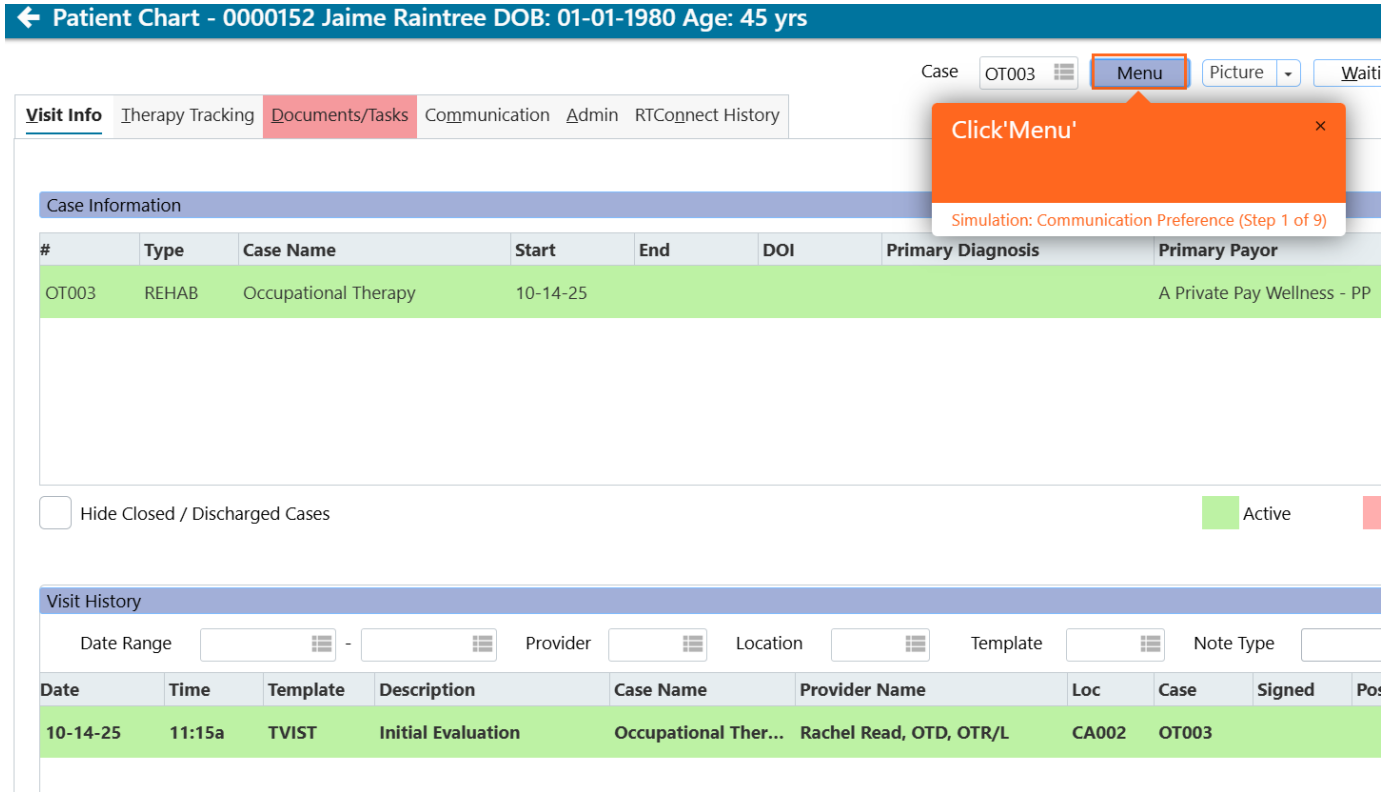
- Back in the Patient Demo Screen, locate **Send Welcome Letter** in the email settings section
- This is an abbreviated version of the original Welcome Letter which auto sends if we had an email on file.
- Patients will need to do a password reset.
- Select “Send”
- Do not re-assign forms, they are auto created when a case is made active. *(You will see where those can be viewed in a couple slides, if you don’t see them reach out to your PL)*





SIMULATION TIME: Communication Preferences

Try it NOW!
Click the Image Below to Start the Simulation



**If the simulation does not automatically display an orange pop up box, refresh your browser.

Workflow Option 4: “Verbal Consent” | Authorized Representative

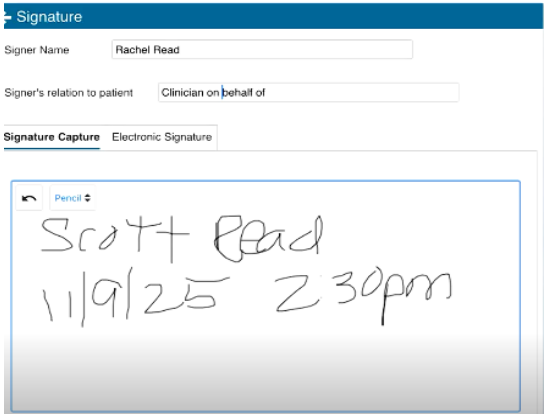
“Verbal Consent” does NOT replace the need for an Authorized representative to sign forms.

- Call Authorized Representative, confirm if they received an email from FOX
- Email would come from raintreenotice.foxrehab.org
  - **YES**
    - Ensure they were able to sign the forms and ask them to complete medical history and medications in the Patient Dashboard if not already done prior to your evaluation.
  - **NO**
    - Confirm Contact Information
      - Cell, Email, Mailing Address
    - Review insurance benefits if not previously indicated in the “Alert”
    - Obtain “Verbal Consent,” let the Authorized Representative know that they will receive an email and let them know we still need them to sign the forms electronically when received.
    - Enter your Verbal Consent in “Notes” in FOX Trax
    - Schedule Evaluation in FOX Trax

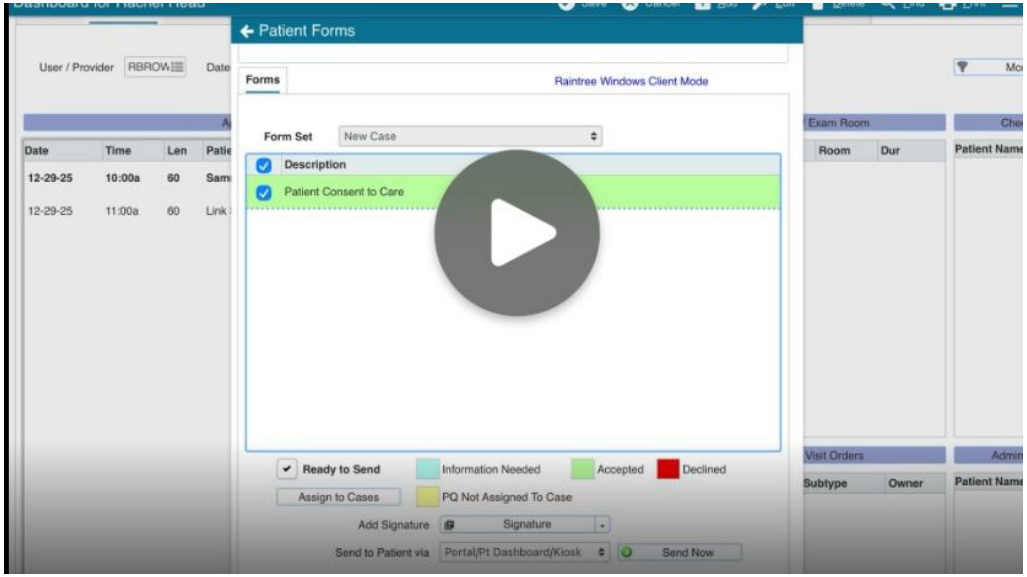
***If the Authorized Representative is unwilling or does not have an email, when you are at the next visit and prompted regarding the unsigned forms. Document your Verbal Consent on the Signature Pad. Date, Time, Name of Authorized Representative, Relation.*

Workflow Option 4: “Verbal Consent” | Authorized Representative

- If the Authorized Representative is unwilling to provide an email and cannot be in person to sign forms the clinician can sign on behalf of them.



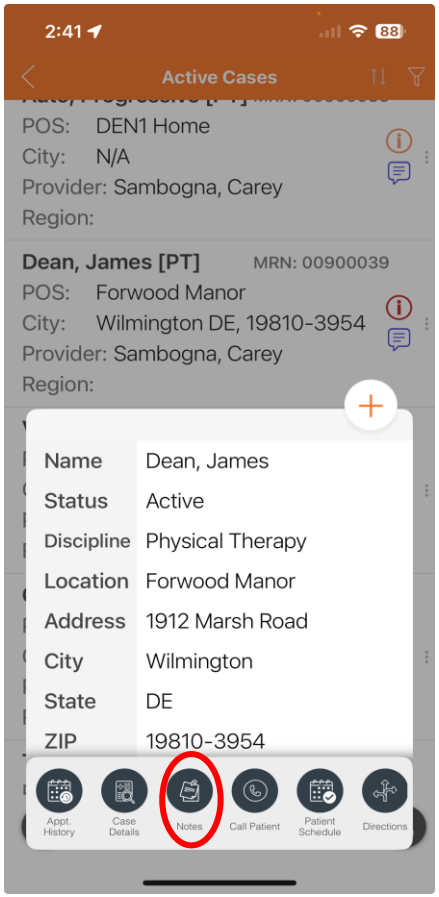
- Review Video to learn how to complete the verbal consent



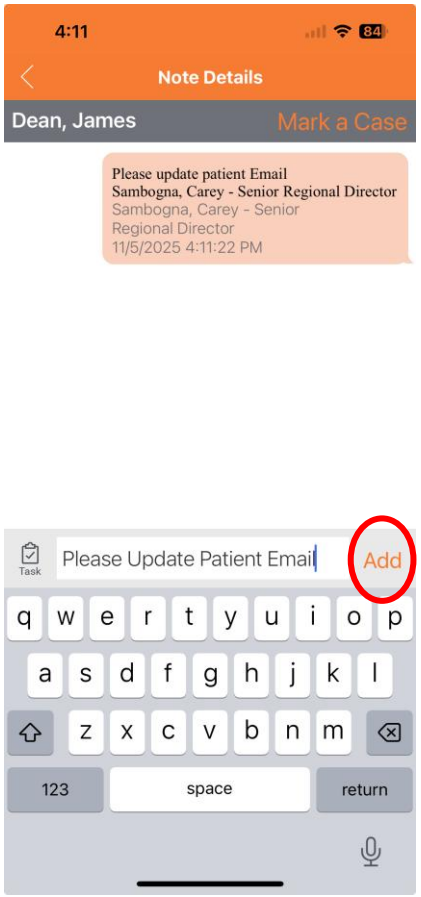
- **Consent should include:** Reviewing insurance benefit coverage, HIPPA and Patient Privacy Practices, Cancellation Policy

Workflow Option 4: “Verbal Consent” | Authorized Representative

FOX Trax (Used only if you are "on the go" and just need to get a note in to reference later)



Select “Notes”

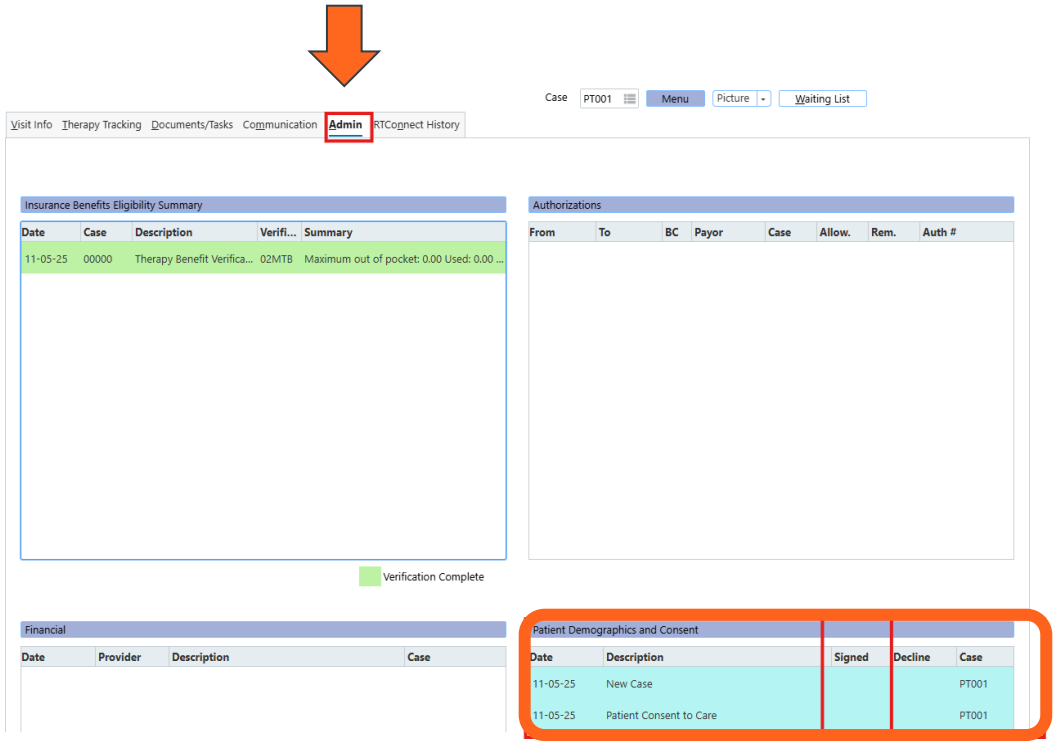


- Enter Brief Note > select “Add”

Best Practices for Consent, Updating Contacts & More

How to Verify Forms are Signed

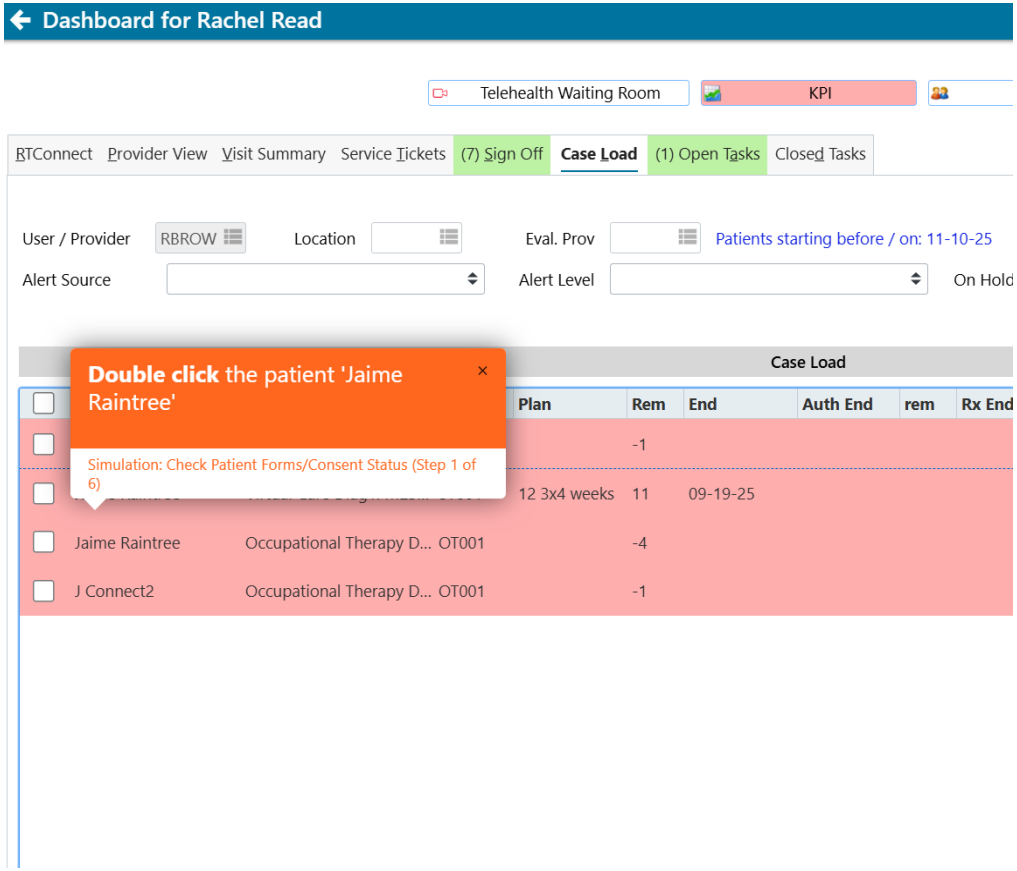
- You can view the Forms which were added to the Patient Portal for the Patient or Authorized Representative.
  - Dashboard
  - Caseload
  - Double Click Patient
  - “Admin” tab
  - Verify if they were signed with (dot will appear in the signed column)



SIMULATION TIME: Check Patient Forms/Consent Status

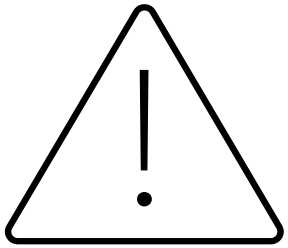
Try it NOW!

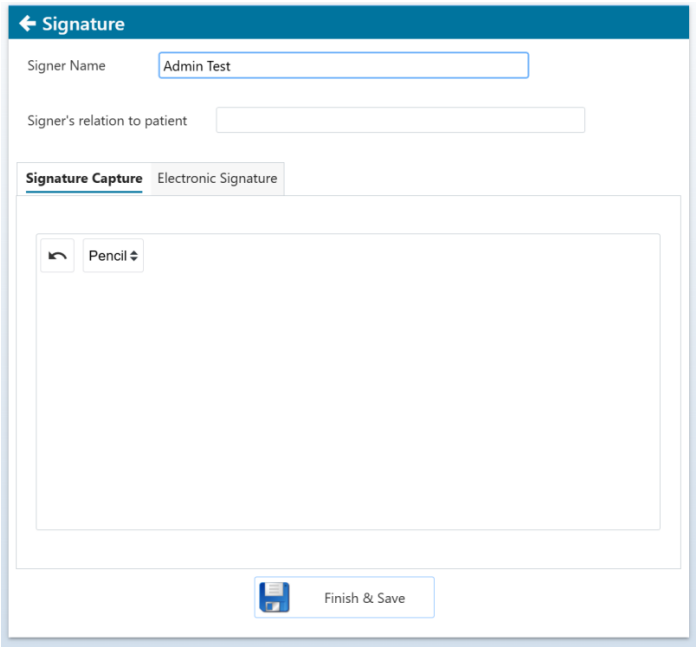
Click the Image Below to Start the Simulation



**If the simulation does not automatically display an orange pop up box, refresh your browser.

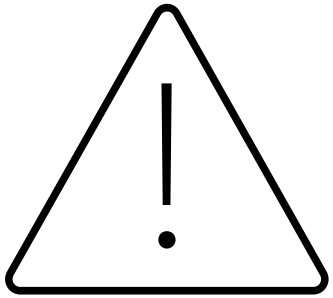
Consent Previously Completed in Custom | Migrated Patients

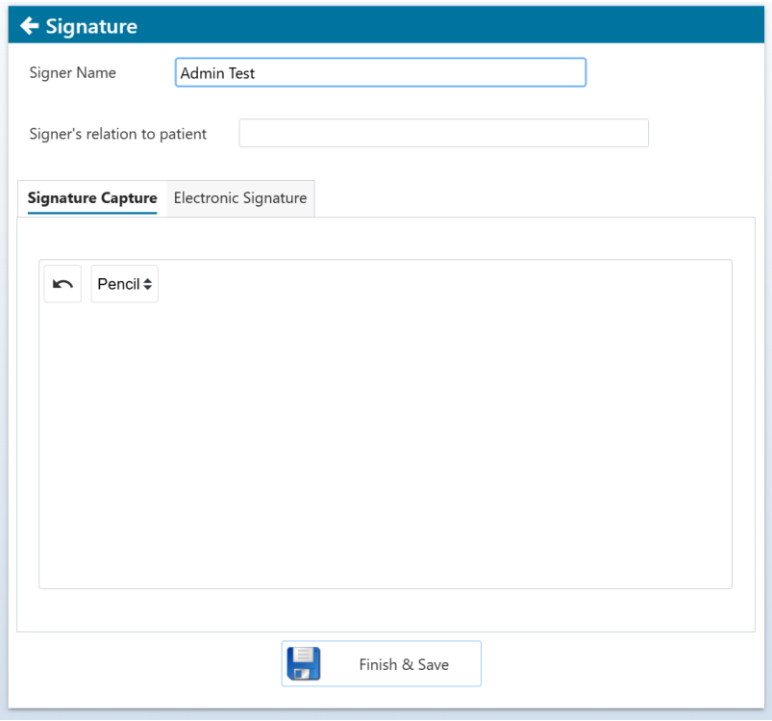




- You may be prompted to sign forms other than the Consent to Care in RT Standard.
  - Even though we are pulling over signed "Consent to Care" in RT Standard, the Notice of Privacy Practices, Patient Bill of Rights and Insurance Details are individual forms where in RT Custom they were a single form.
  - For the additional forms, if prompted to complete:
    - Click Signature
    - In Signature box enter ***"Consent documented in RT Custom"***
  - Otherwise, you will be continually prompted to complete at each "check-in"

Consent NOT Required | Strategic Accounts





- You may be prompted to sign Patient Forms for patients where it is not required for Strategic Account patients.
  - For the additional forms, if prompted to complete:
    - Click Signature
    - In Signature box enter ***"Strategic Account, RT Consent not required"***
  - Otherwise, you will be continually prompted to complete at each "check-in"

Best Practices for Consent, Updating Contacts & More



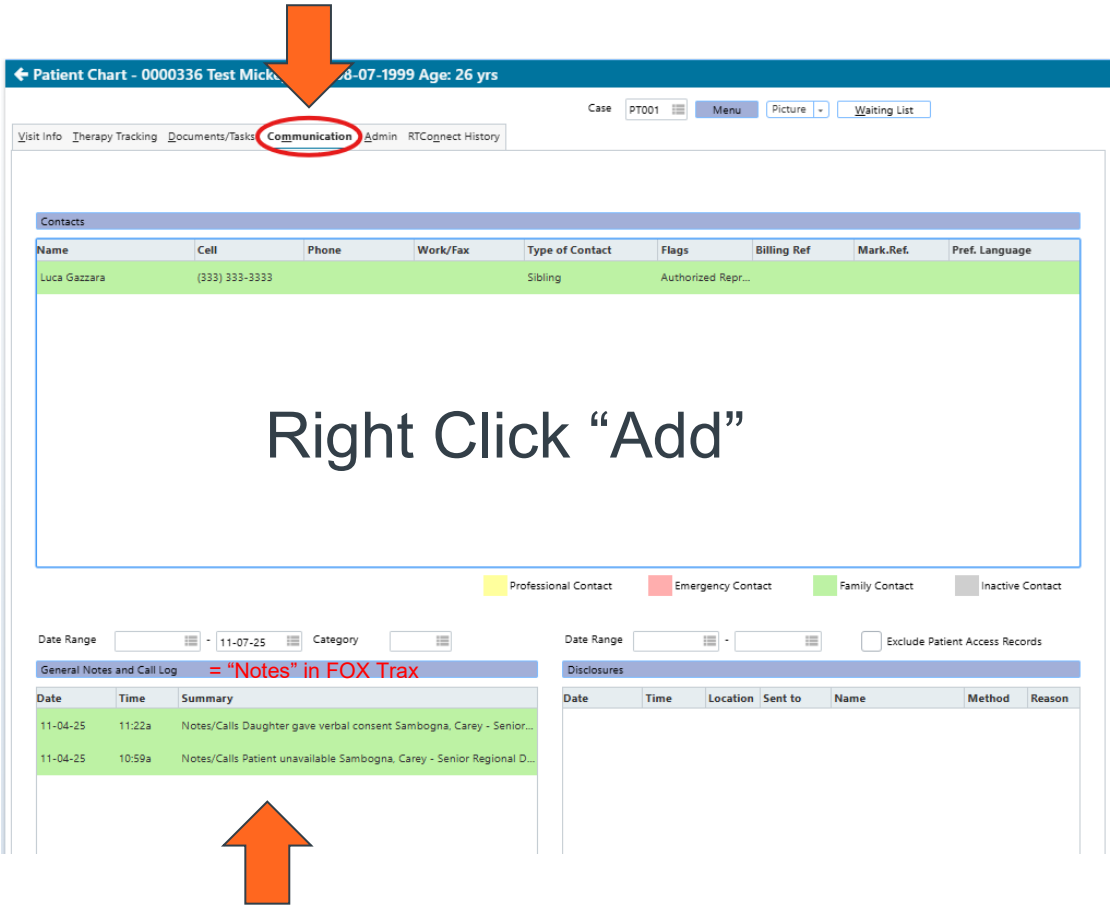
EMAIL RULES

- *ONLY* the patient's own email should ever be in the Patient Demographics!
- A patient's email can only ever be added to the system one time.
- Any email for a relative of the patient must be entered in as a complete Contact.
- For example; If a husband and wife share an email, only one of them can use as their own email in patient demos. If the wife has it as her email the husband should have his wife as a contact and the same email could be entered in contacts.

Best Practices for Consent, Updating Contacts & More

Updating Contacts or Adding Authorized Representative:

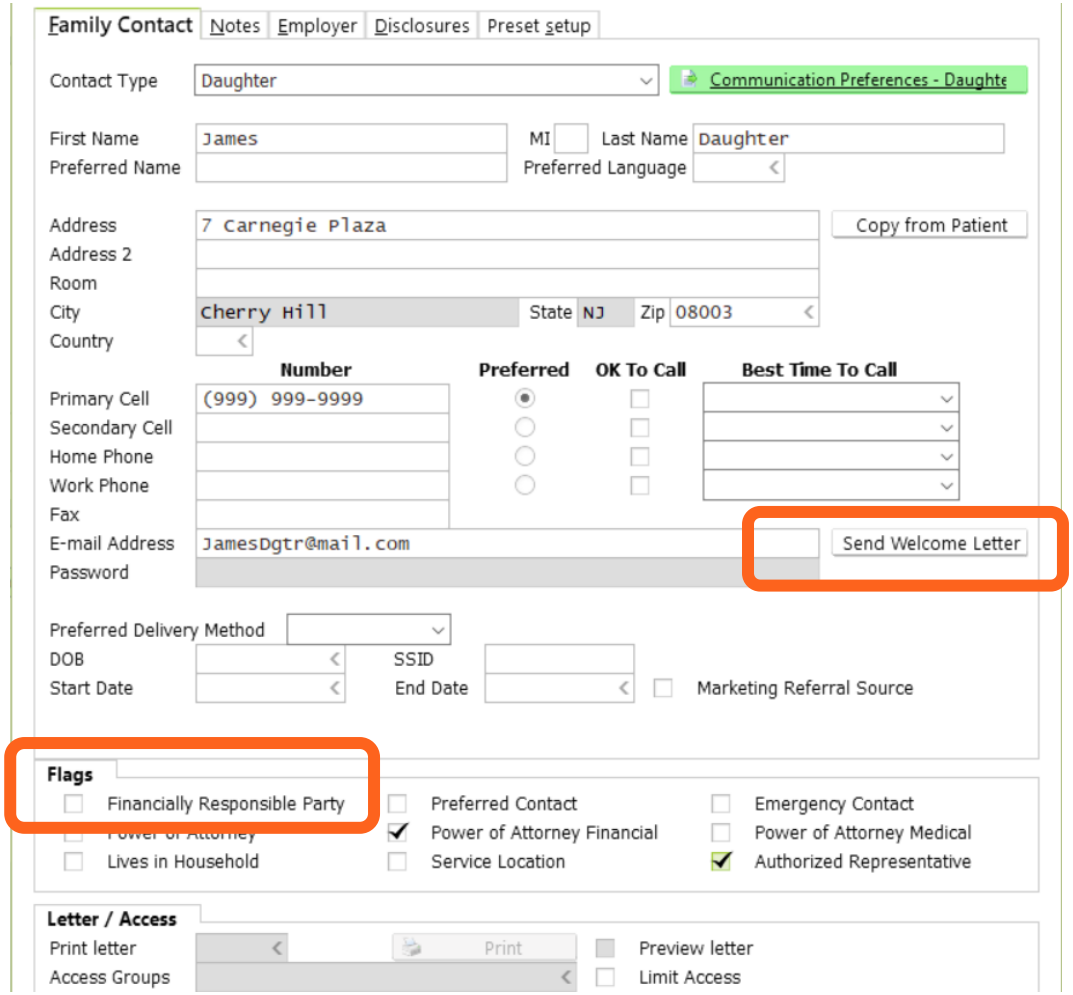
- Click in the white space, type “A” to add a new contact record or right click
- Tip: You can review any previously entered notes from FOX Trax that may have entered while you “were on the go” with an email or at the time of your visit. This section corresponds to FOX Trax “Notes”



Best Practices for Consent, Updating Contacts & More

Add New Contact

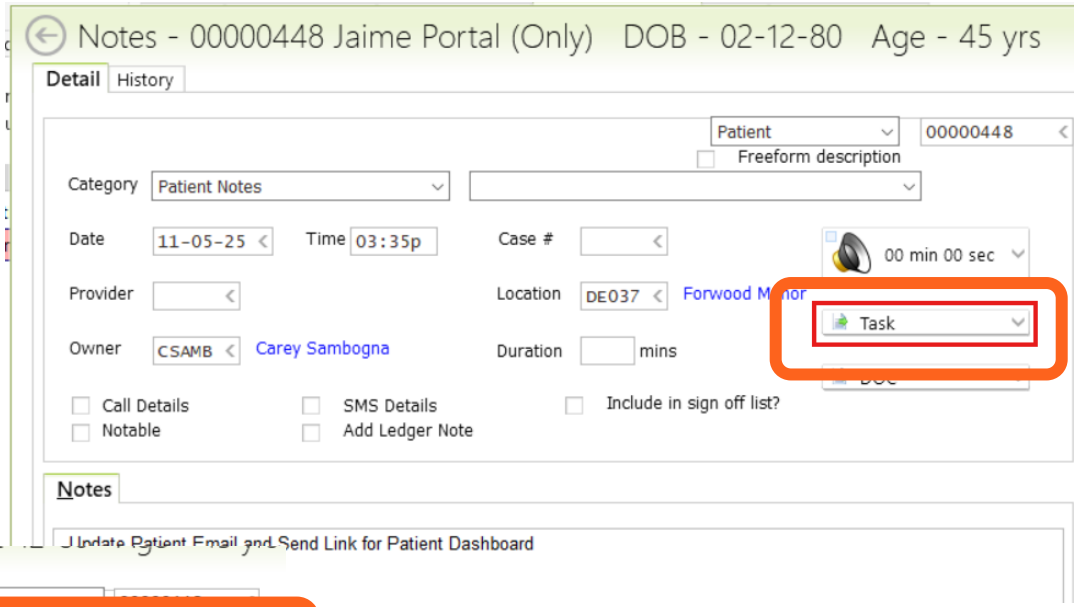
- To send an invite to the Patient Dashboard
  - Enter Name, Address and Email
  - Confirm mailing address for billing statements – Must check “Financially Responsible Party” (FRP)
  - 95% of SLC patients should have a FRP this is imperative to ensuring billing statements are sent to the correct address.
  - “Save” record, then re-open to click “Send Welcome Letter”

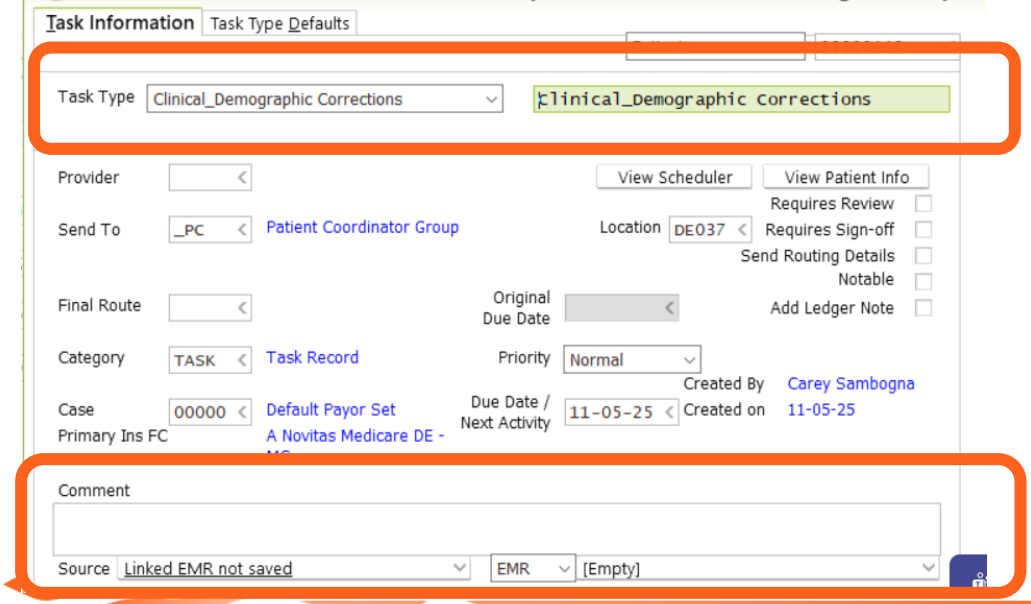


Best Practices for Consent, Updating Contacts & More

General Notes & Tasks

Enter Brief Comment > Select Task





Select Task Type = “Clinical Demographic Corrections”

Types of Patient Forms

Patient Specific Forms: Required 1x a year

- Patient Bill of Rights
- Notice of Privacy Practices

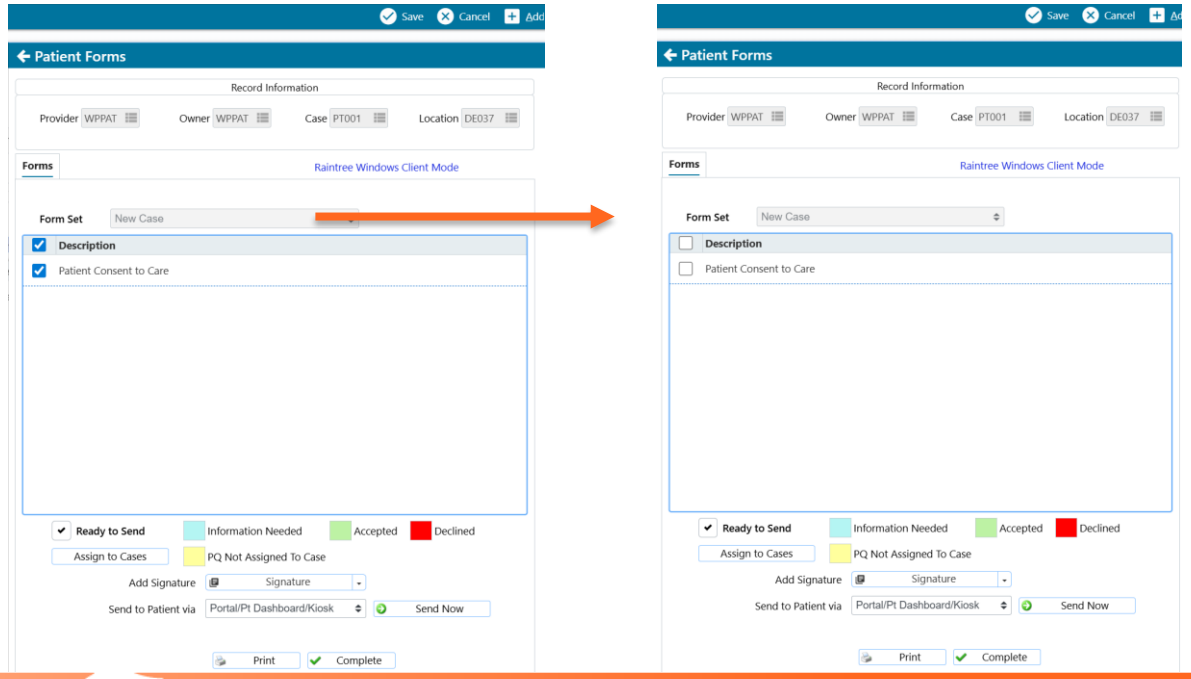
Case Specific Forms: Required for each case

- Financial Obligation/Verification of Benefits
- Consent to Care (Including FOXs Cancellation Policy)

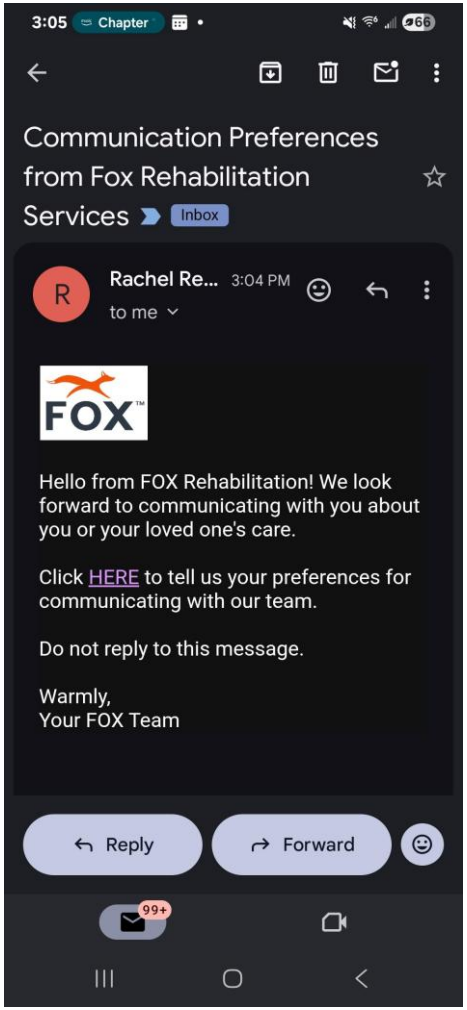
Depending on if the patient signed the forms already, you may not be prompted to complete the forms that are required only 1x a year.

Prompting for Patient Forms

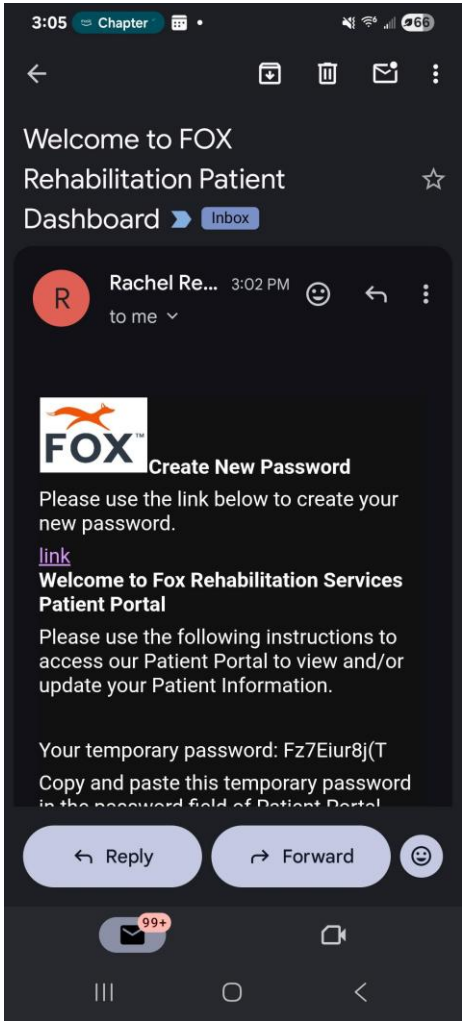
- When prompted for patient forms at check in, you may be prompted for all unsigned patient forms for that patient not just your case specific forms. (example- PT/OT/SLP)
  - **Uncheck** the patient forms and hit **save** if you want to bypass sending or completing the forms if they are not your case specific forms.
    - You can get consent for other disciplines (will continue to receive the alert until signed)
  - Note, this may be required multiple times if multiple cases have unsigned forms



Best Practices for Consent, Updating Contacts & More



Example: Communication Preference

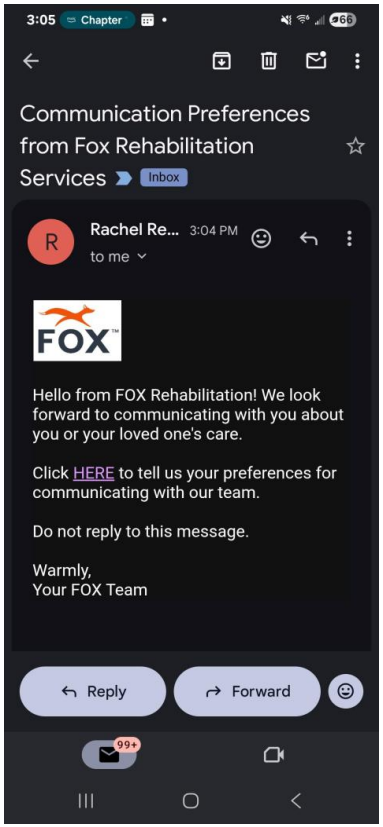


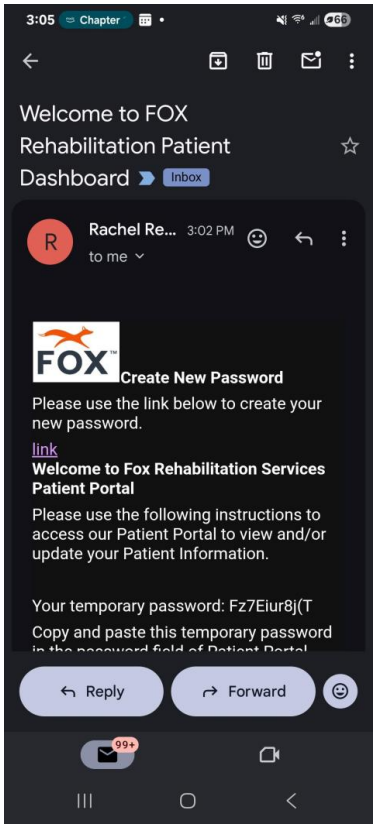
Example: Welcome Email Password Reset

RT Standard Comms Preference & Welcome Emails

Please note! All patients with email or text on file will get another set of emails to sign up to the patient portal on RT Standard!

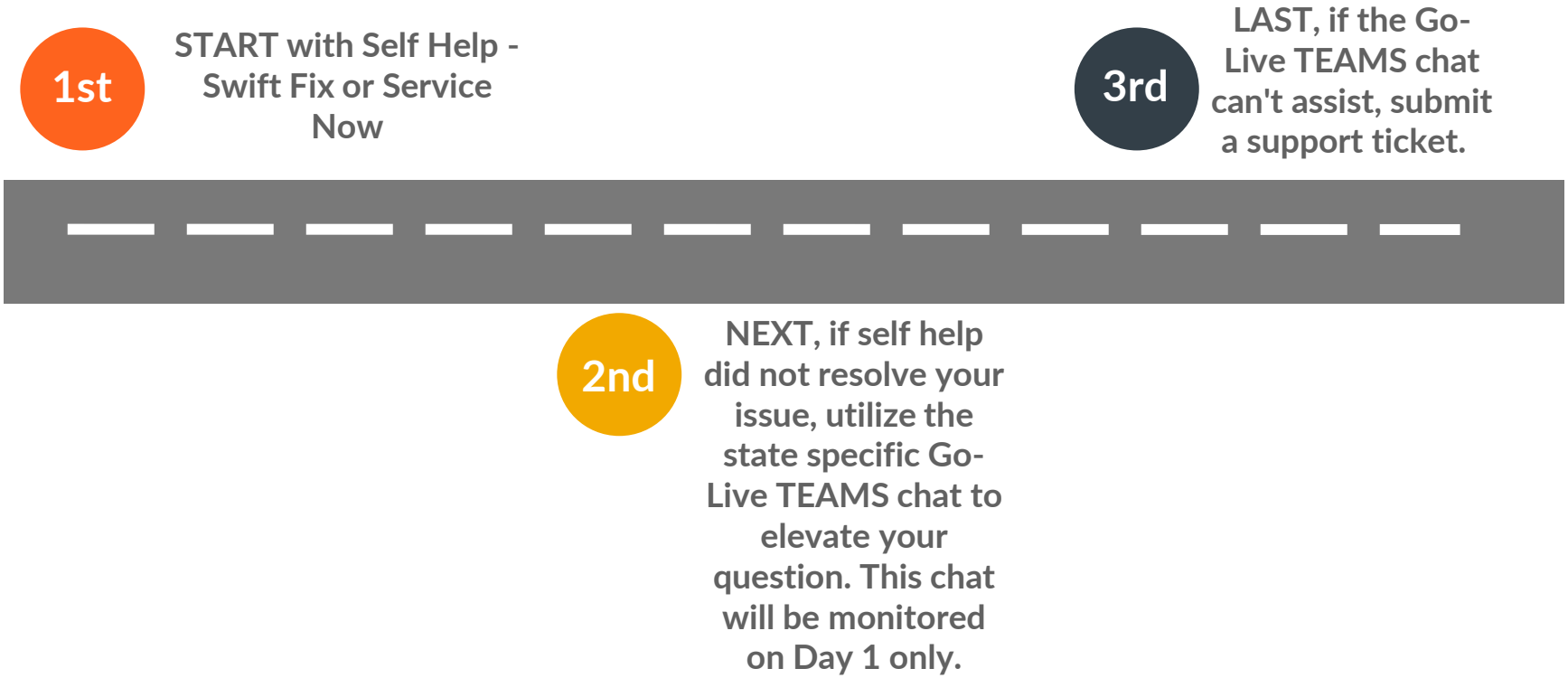
Please discuss with patients that this is accurate and not in error!





Support Roadmap: Start Smart, Escalate Right

Have a question? Follow the path to resolution!

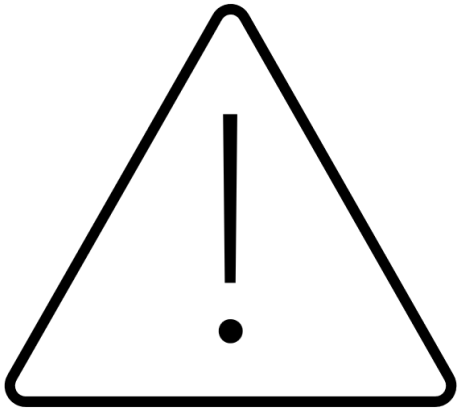


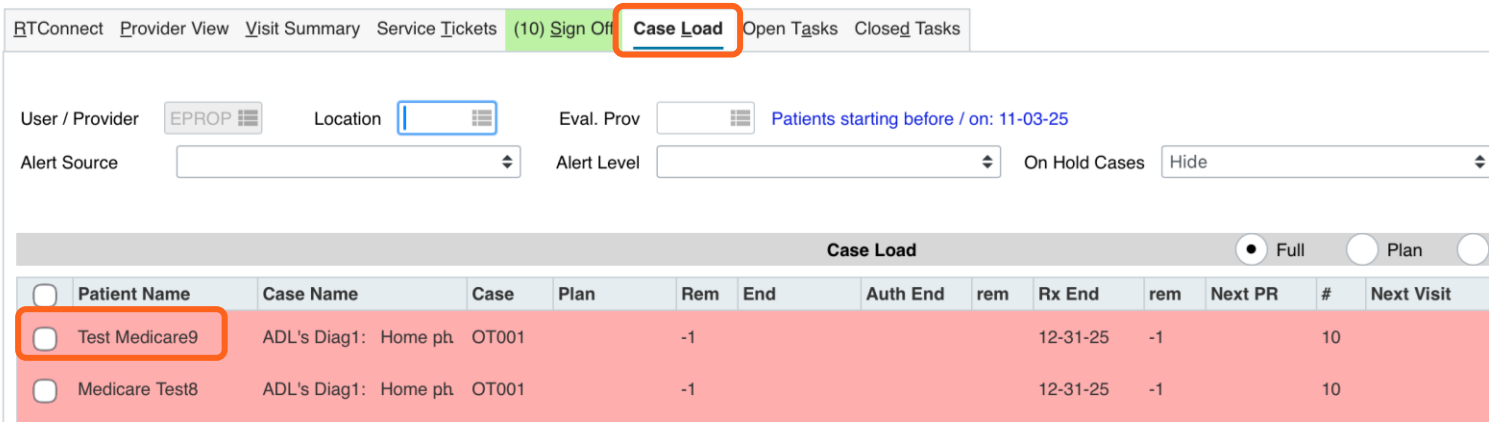
RT Standard
PT/OT Initial Eval and Tx on Day of Eval
(TVIST)



Starting New Cases

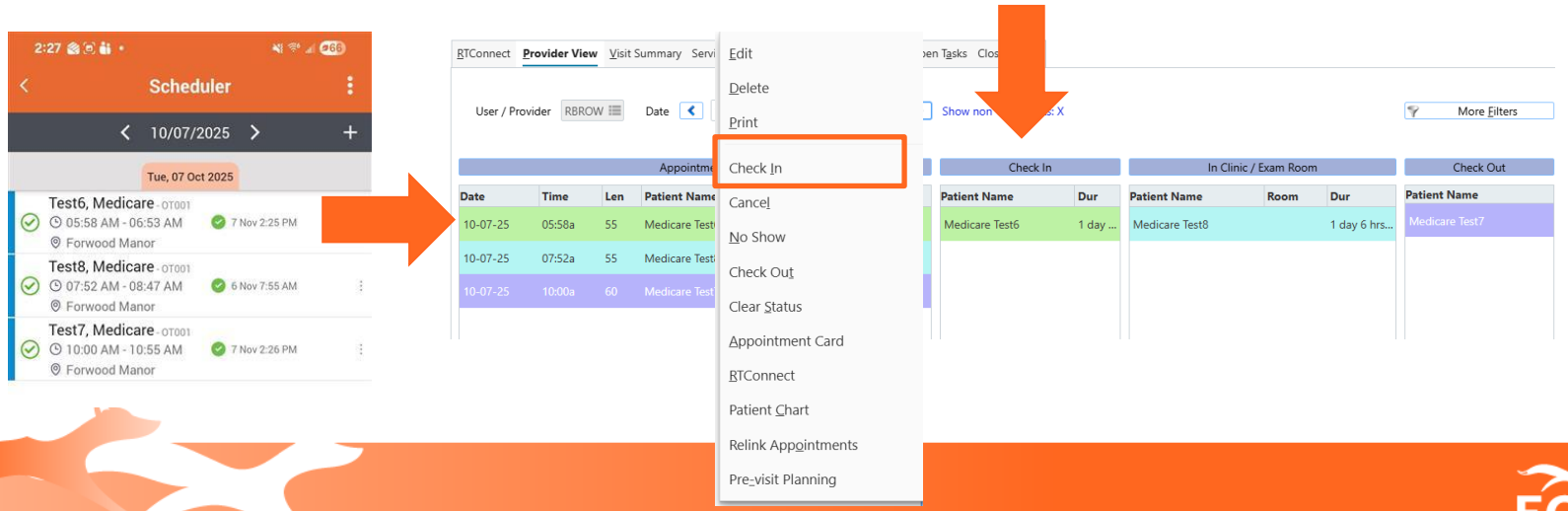
- New admissions will only display on your caseload tab AFTER you have scheduled the first evaluation/visit in FOX Trax.
  - Scheduling of the appointment in FOX Trax initiates the record to be created in Raintree





Launching a Note

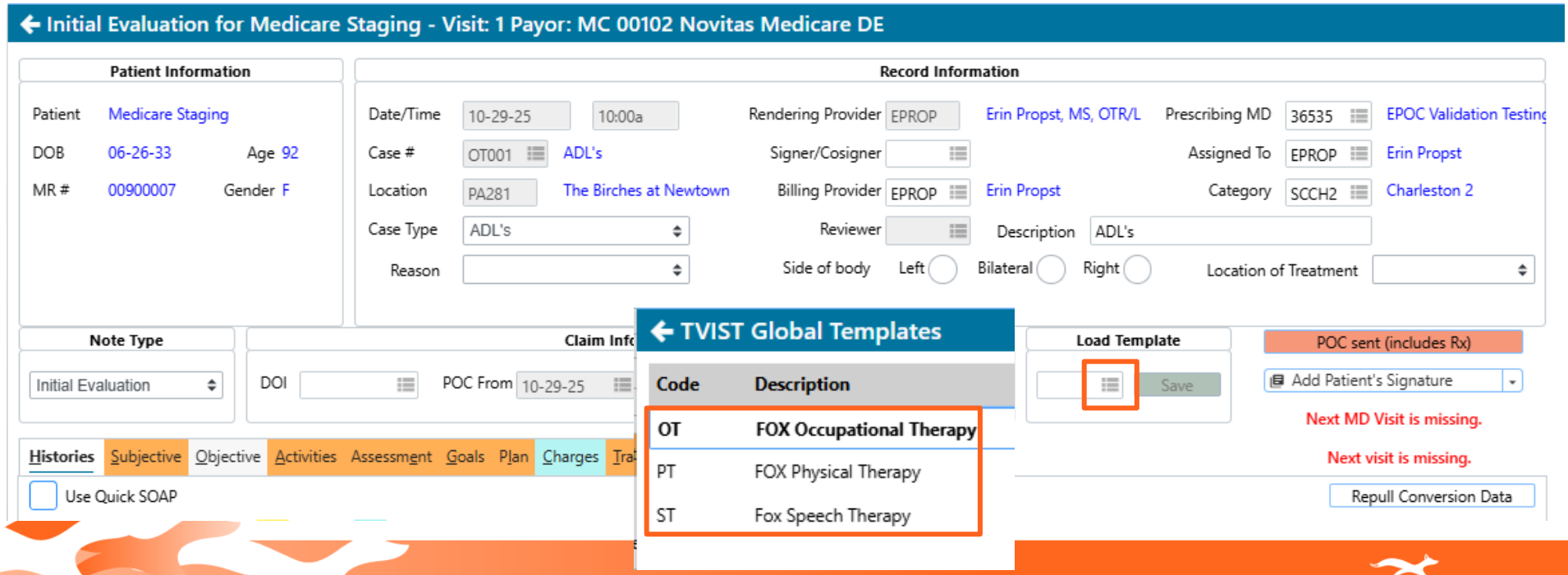
- Schedule in FOX Trax- select the appropriate Reason for Visit (Evaluation)
  - Visit will display in RT Standard scheduler and **Provider View tab** under **Appointments**
  - Visits **MUST** be scheduled to start a note. RT Standard does not allow for notes to be created without an appointment.
- In **FOX Trax,** complete visit verification, ideally at the start of the session
- In **RT Standard**, right click the appointment and select **Check In**
  - The appointment will display in the "**Check In** " window
    - Right click > edit to open the clinical note when ready to document.
  - In the event action is needed (due to patient forms being unsigned or previous notes not completed), prompts will display and then the appointment will display in the Check In window
    - See Consent Training for details on patient forms.
  - Read any additional prompts related to the patient so you are aware of any notices/alerts



Loading Template

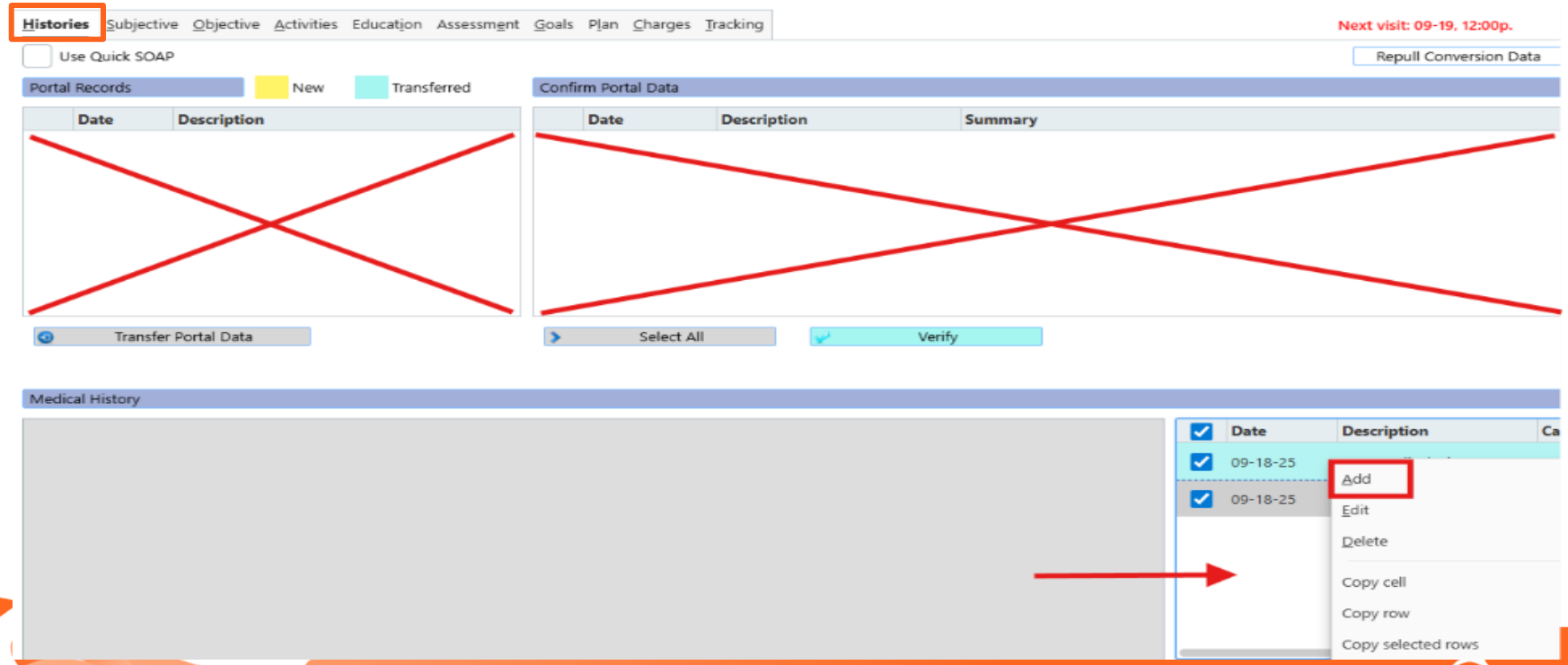
IMPORTANT!! Before beginning your eval documentation, you **MUST load FOX Template**

- Click on the menu icon in the **"Load Template"** box to see the list of Global Templates, **select FOX template** for your discipline
- This will load the FOX EVAL template and will **ONLY** be done during Evals (not subsequent tx notes)



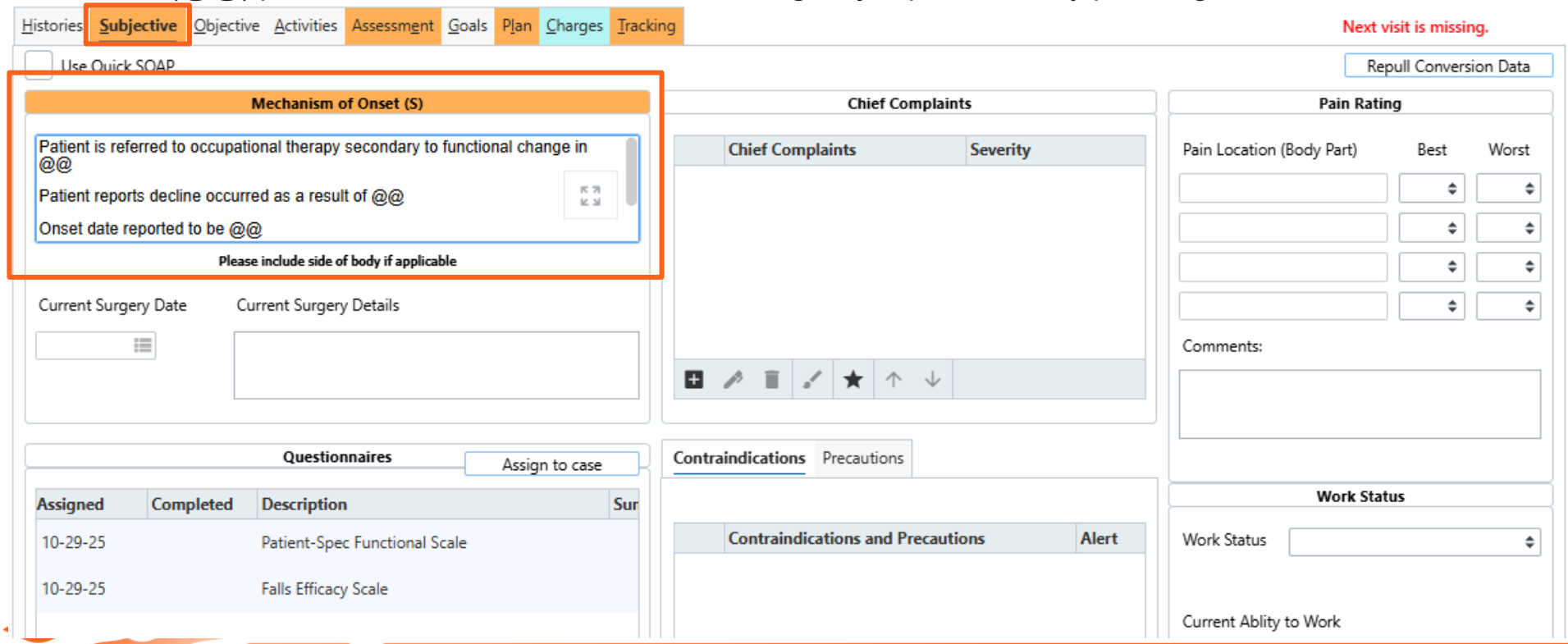
Histories

- You will Add or Edit your patient's Medical History from "Histories" tab
- Click into Past Medical History in the bottom right panel
  - If a **Medical History has been started**, double click/right click and **Edit** to open and update Medical History
  - If a **Medical History does not exist**, right click in the panel and select **Add**
- Review/Complete all necessary parts of the Medical History for the patient
- Save the record



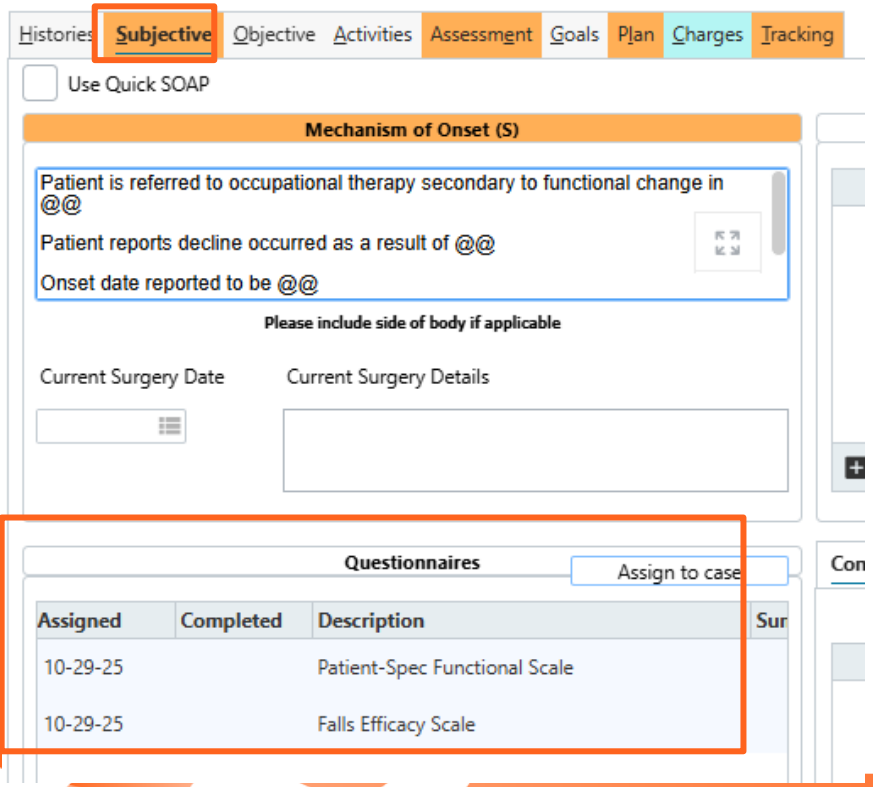
Subjective – Mechanism of Onset (History of Present Illness)

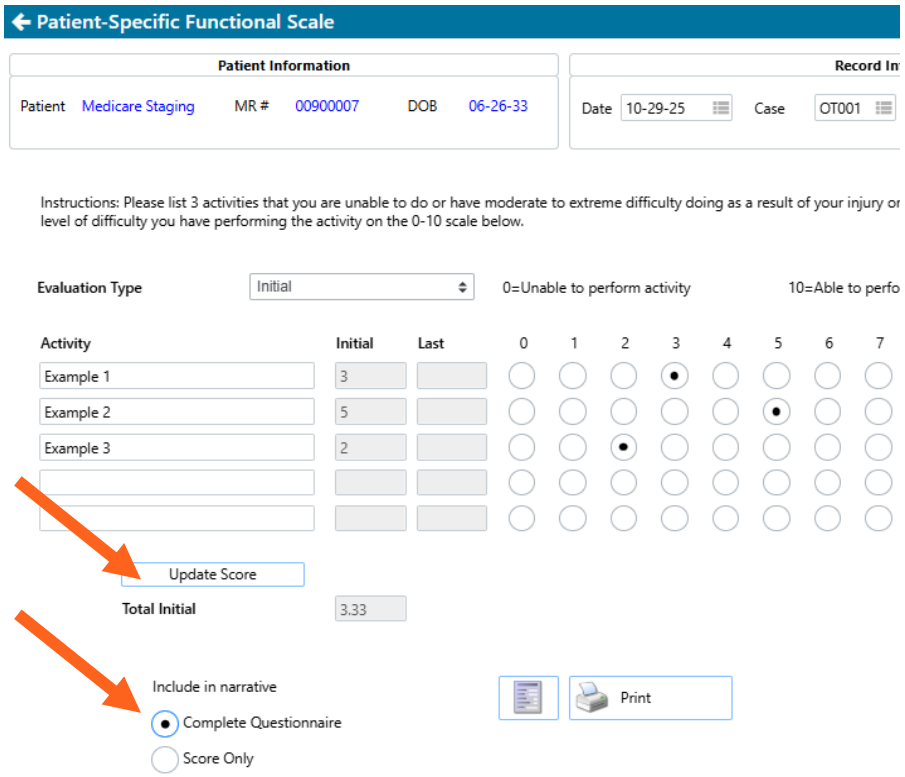
- Mechanism of onset should detail WHAT, WHEN and WHY a functional change has occurred
- Complete all areas with @@ (jump markers) and add any additional information such as surgery date, details, etc
  - iPad users – use keyboard shortcut "**ctrl**" and "**cmd**" and "**.**" or navigate with mouse to complete all (@@) place holders. Non-iPad users can navigate jump markers by pressing **"ctrl"** and **"."**



Subjective – Questionnaires

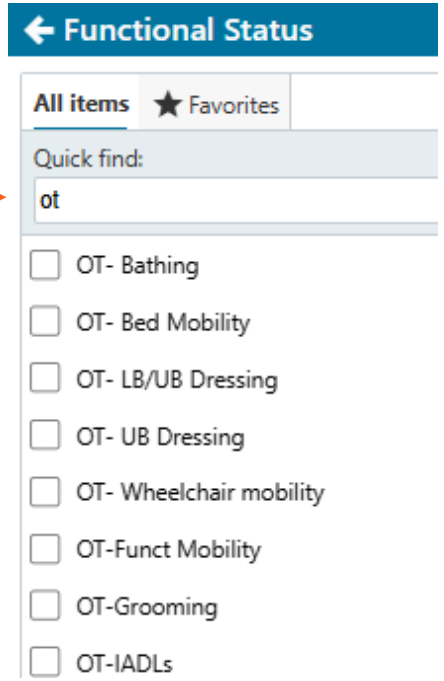
- The Patient Specific Functional Scale (PSFS) will be completed in the Questionnaires box
  - Right click to open & complete, "Update Score", and choose "Complete Questionnaire" to include in narrative
- You can add new with right click > Add (or click into box > click Add in top function bar)
  - PSFS is required and will be preloaded in the Questionnaires box
  - Explore the list of available questionnaires (ex: ABC Scale, EAT-10, Falls Efficacy Scale, Quick DASH)
- You could also add the Questionnaires within the Objective tab alongside the FOMs (this is clinician preference)

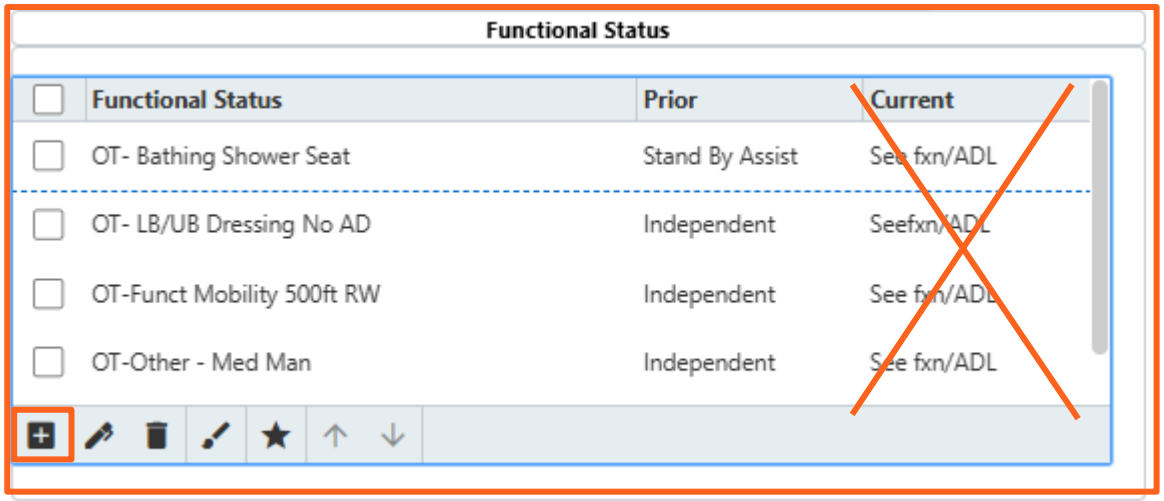




Subjective – Functional Status (Prior Level of Function)

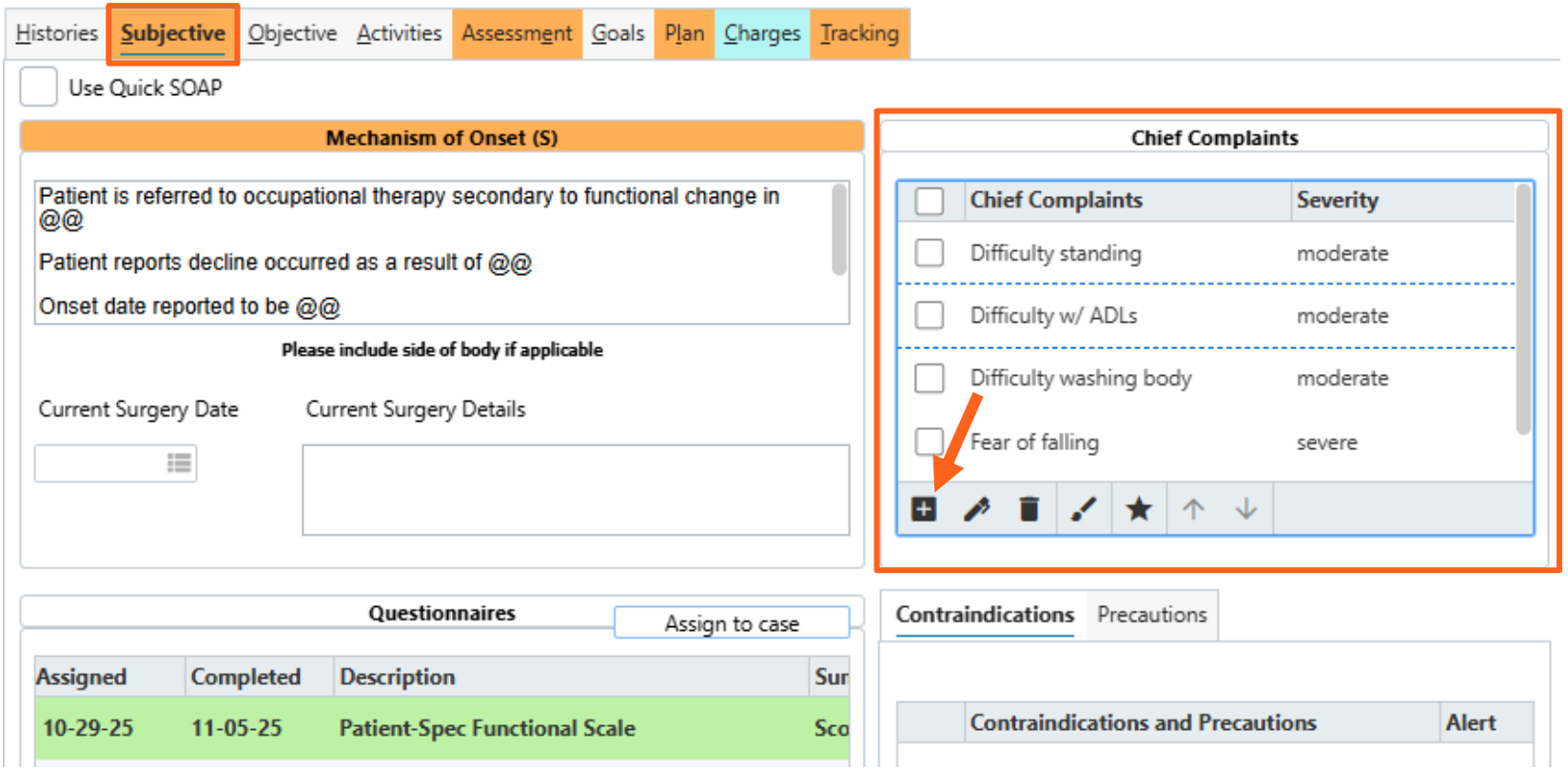
- Add Functional Status by finding items using + to open picklist
  - This picklist will show Functional Status for all disciplines – you can filter this picklist by typing your discipline in the Quick Find space
  - **MUST add details** related to each topic (AD use, distance)
- Update the "Prior" level by double clicking into Prior column and selecting Prior assist level
- **DO NOT** document "Current" status here (this should be added to objective tab)





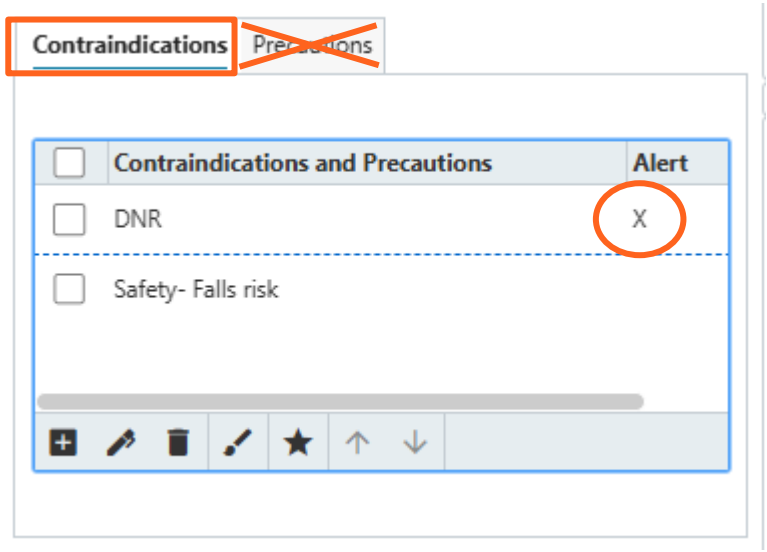
Subjective – Chief Complaints

- Click in the **Chief Complaints** panel and click + to add items from the picklist, then save
  - This picklist would be a good place to set and use Favorites



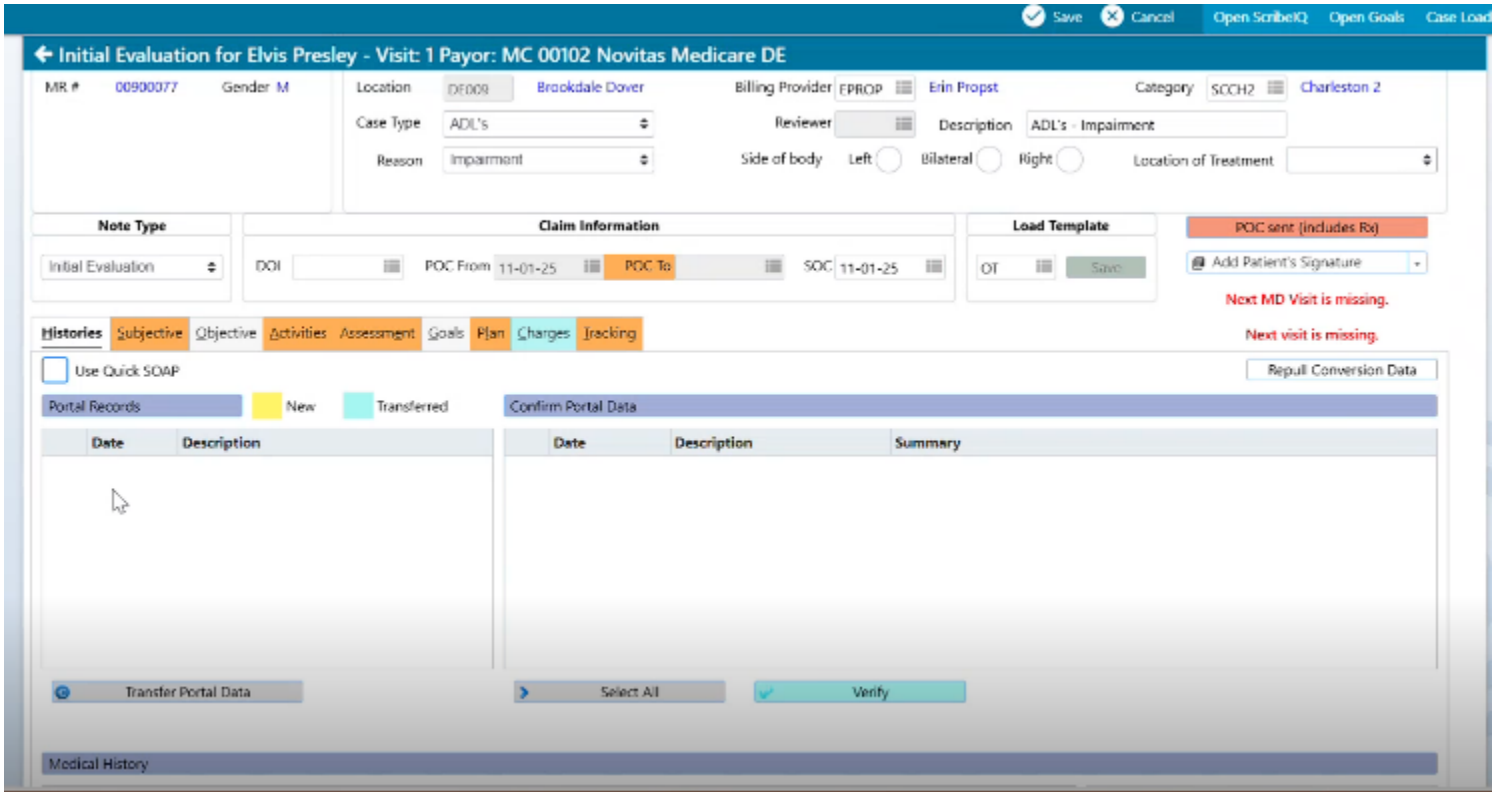
Subjective – Contraindications/Precautions

- Any Contraindications or Precautions should be added in the Contraindications table (Do NOT use the "Precautions" table)
- Add items in the picklist using the +
- Create an "Alert" for your entry if any covering clinician would need to be aware of an allergy, emergency procedure, etc.
  - Right click into the "Alert" column for that item until you see an "X" indicate alert is on
  - The "Alert" will pop up every time a note is opened for this patient.



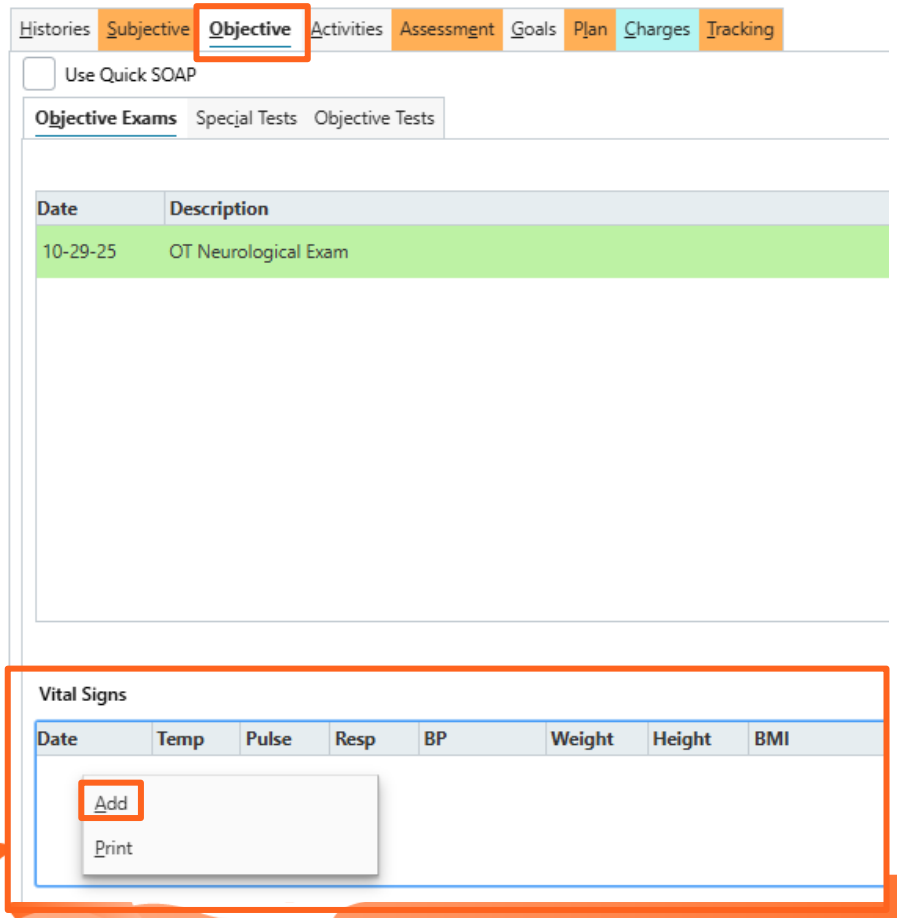
VIDEO TIME: IE Template, Histories & Subjective

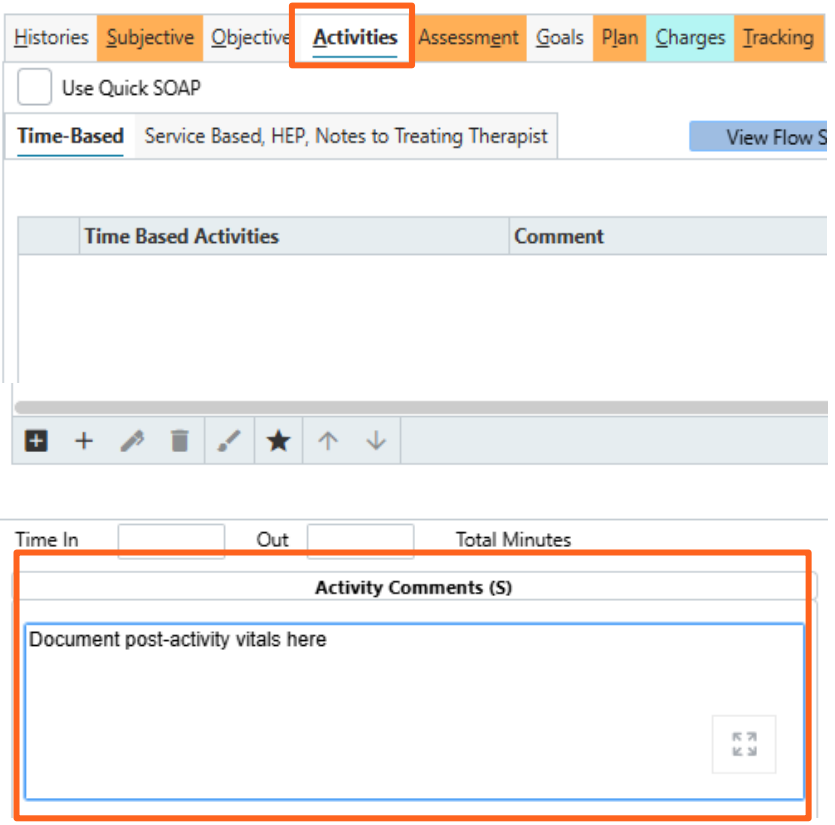
Watch it NOW!
Click Image Below to Watch A Video



Objective – Vital Signs

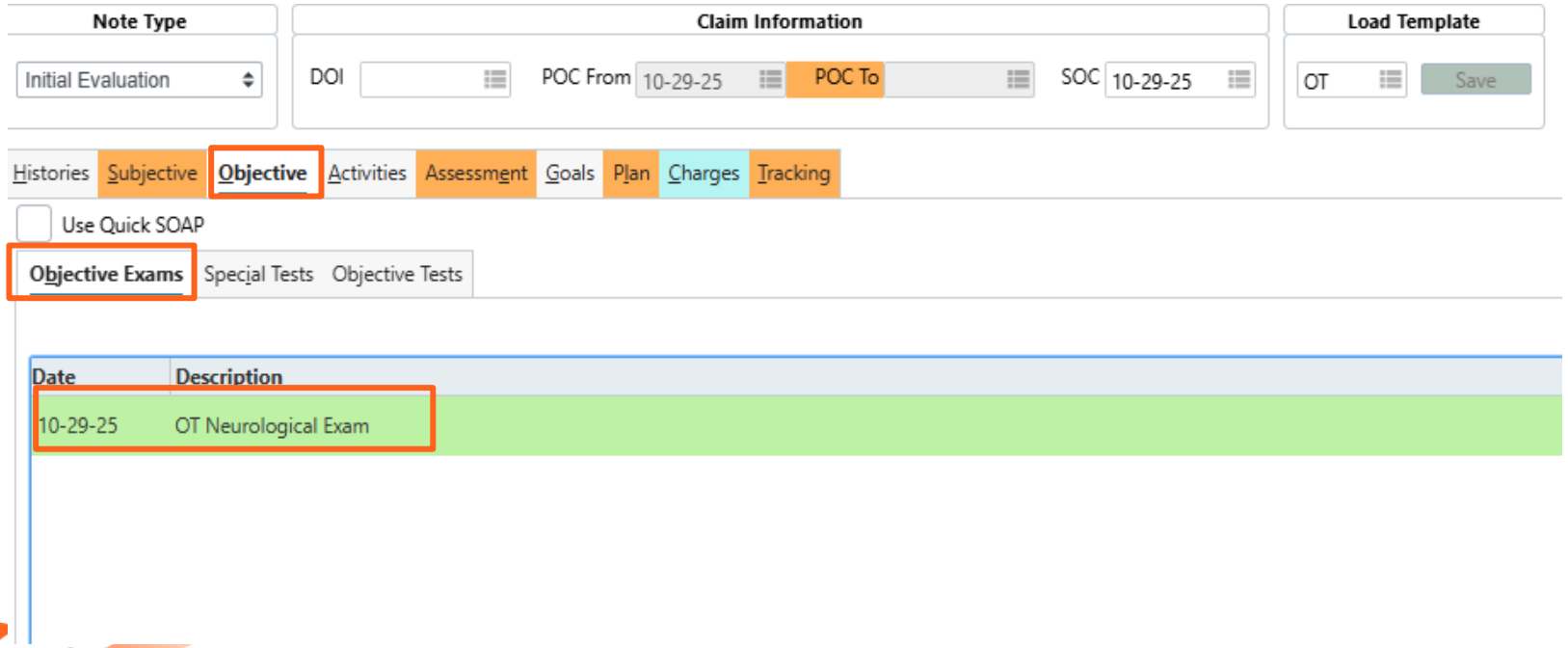
- Baseline **Vital Signs** can be documented on the Objective Tab, in Vital Signs panel
- Right click in the panel, then select Add or click Add on the top function bar
- Populate the vital signs and save the record
- **Post-activity vital signs** can be recorded on Activities tab, in "Activity Comments"





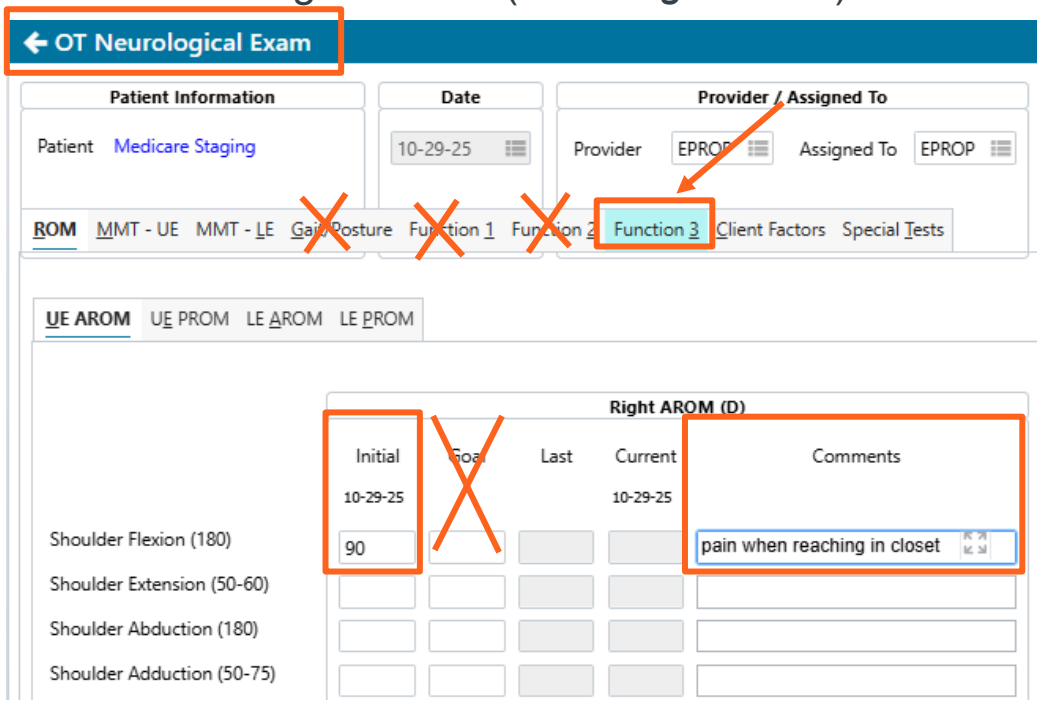
Objective - Exams

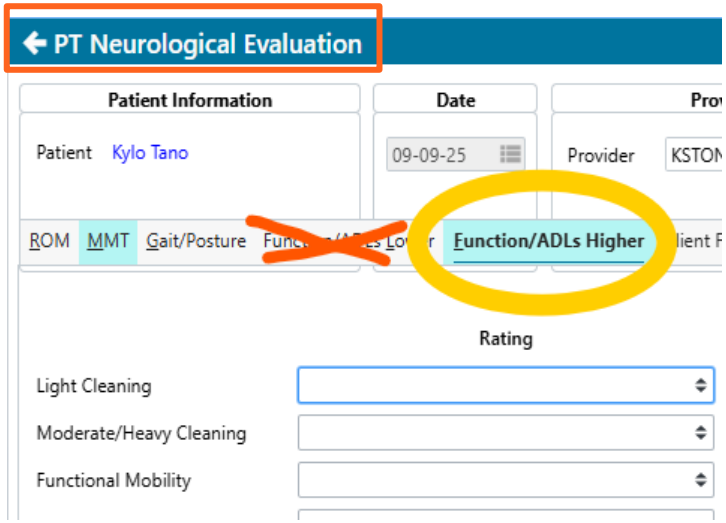
- A discipline-specific **Objective Exam** should populate in your Objective Exams: This is where you will document all of your objective findings
  - If there is no Exam, add one by right clicking > Add (Neuro Exam is best for PT and OT)
  - The **OT/PT neuro exams** should be appropriate for the majority of patients; if you have a pt that is referred for vestibular, wheelchair positioning, pelvic floor or lymphedema, there are exams that may be helpful to load and document within
- Double click to open and document within the exam (see next slide for details)



Objective - Exams

- Navigate through the Exam to document relevant objective findings
  - You DO NOT need to complete everything – only what is relevant (Look and Listen)
- You will document relevant objective findings (ROM, MMT) by typing in the "Initial" box and adding comments where appropriate
- Functional activities should be documented in the tab that is blue – **"Function 3" tab for OT Neuro Exam**; **Function/ADL Higher tab for PT** (ignore other function and gait/posture tabs)
- Do NOT add goals here (*add on goals tab*)





Objective – Exams

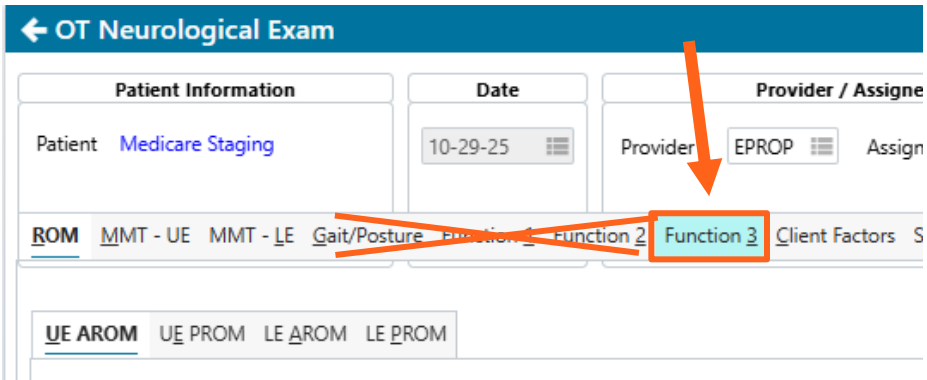
IMPORTANT!! A note about documenting functional objective findings

DO NOT use the Gait tab and ONLY use the functional tab that is highlighted blue to document objective findings (gait, transfers, bed mobility, ADL, IADL, etc)

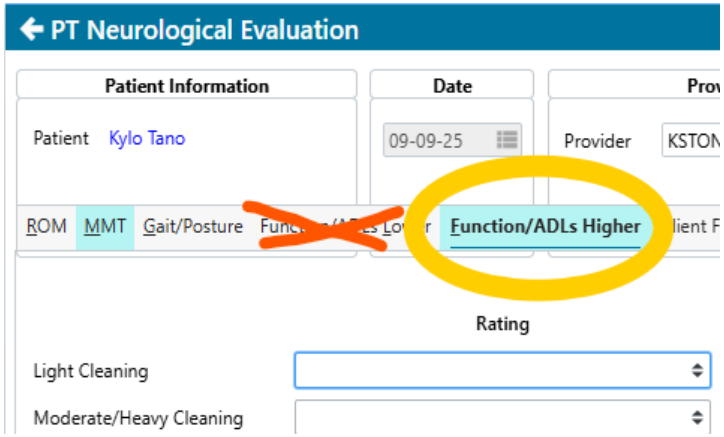
This is because it makes updating functional status at progress reports much easier

Instead, follow the workflow on the next slide to document functional objective findings (gait, transfers, bed mobility, ADL, IADL, etc)

OT



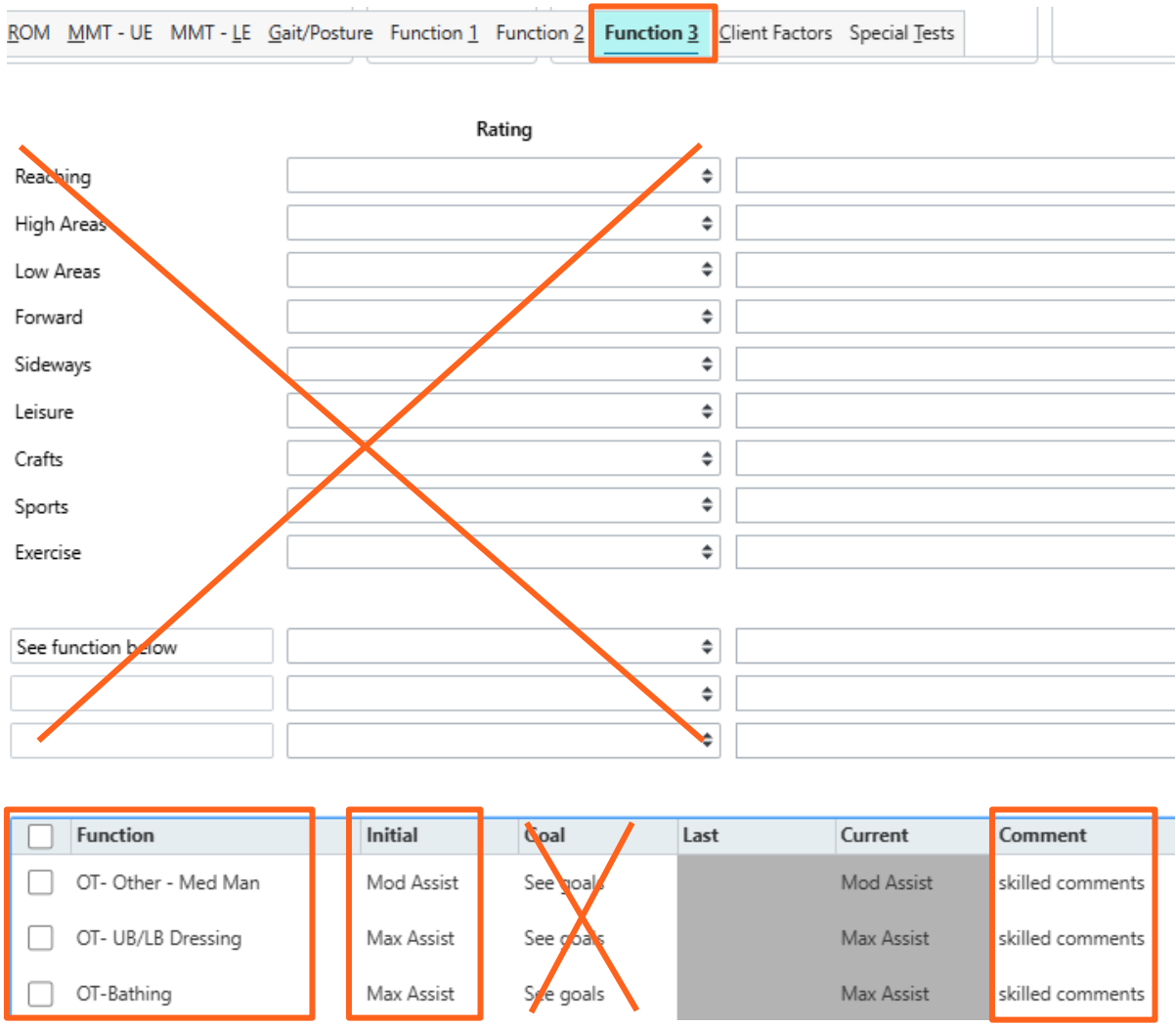
PT



Objective - Exams

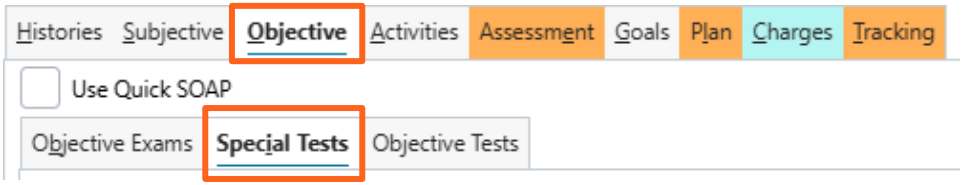
Functional Objective baselines will be documented on the blue **Function Tab** ("Function 3" for OT; "Functional/ADL Higher" for PT)

- Click on the tab, scroll down to the **Function Table**
- Add items relevant to your pt's POC using +
  - Transfers, bed mobility, functional mobility, ADL, IADL, etc
- Update **Initial** Objective Status for each item
- Add skilled comments in **Comment** box
  - AD used, cues required
- **DO NOT add goals here** (add on goals tab)

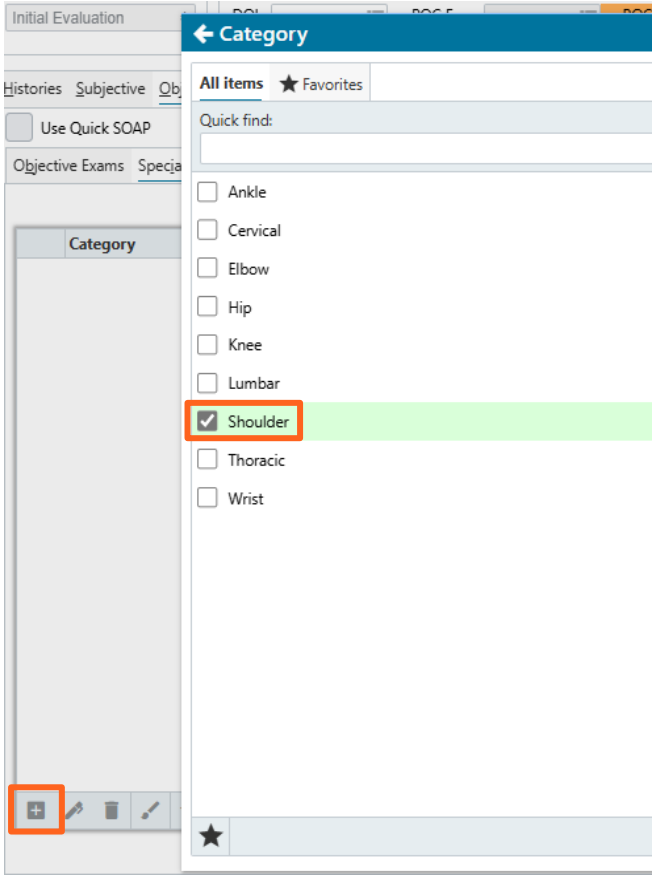


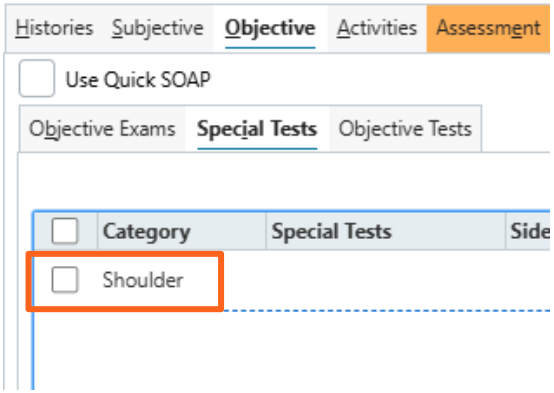
Objective – Special Tests

1. Navigate to **Special Tests** Tab



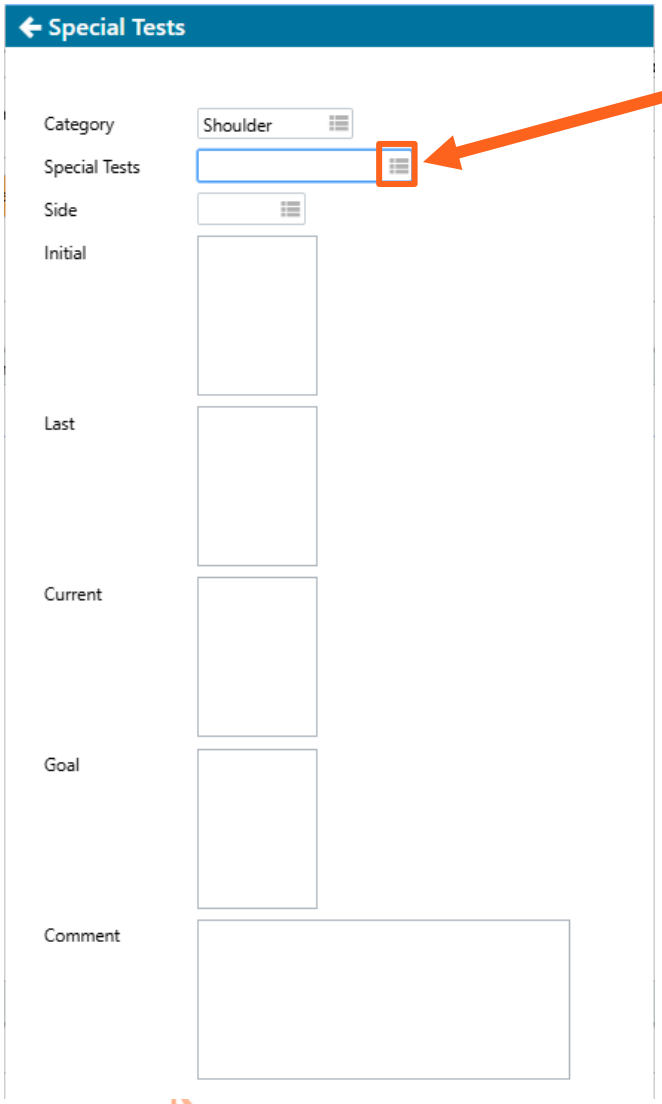
2. To add special test, click in Category column, click + and **select category** from picklist, **save**





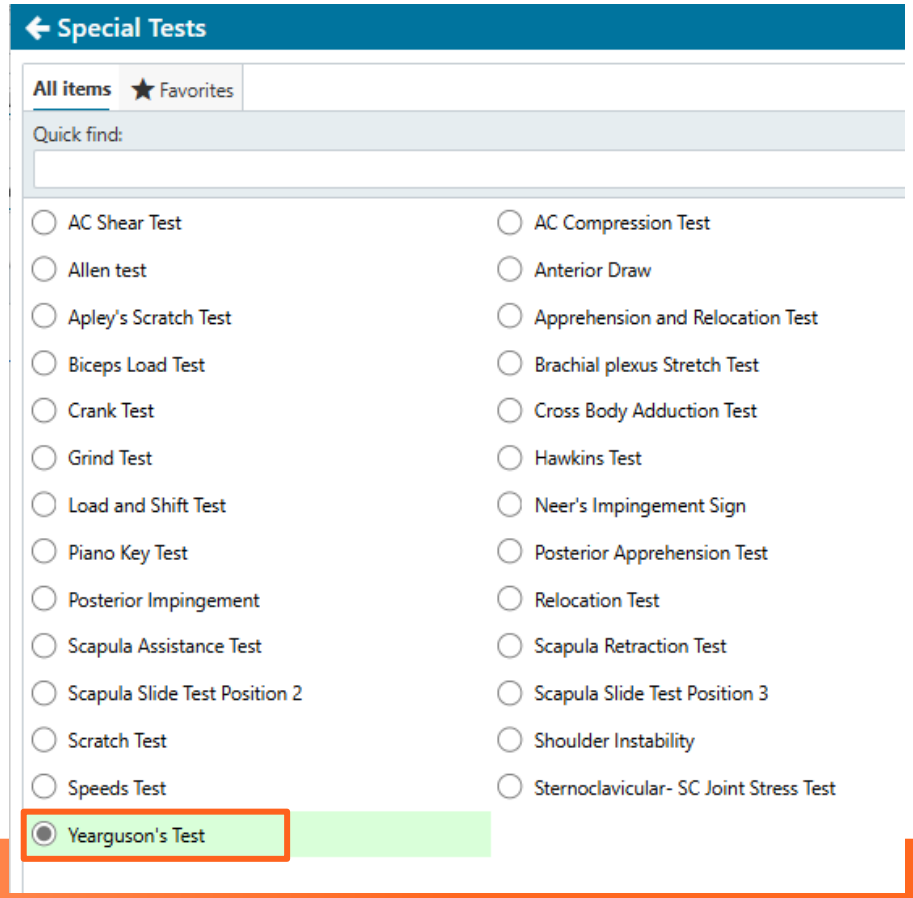
3. Double click the category name to open and select from relevant special tests

Objective – Special Tests (continued)



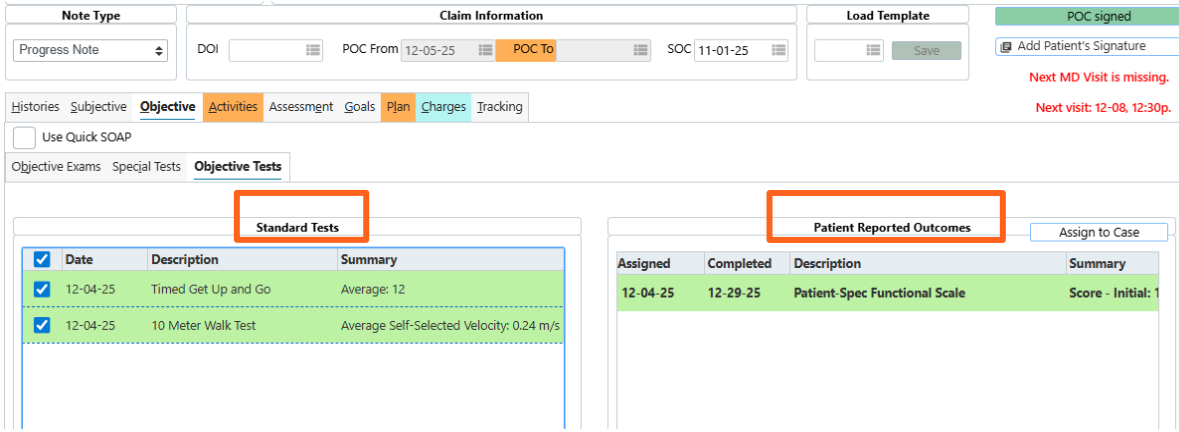
4. Select **menu icon** of Special Tests box to open and select appropriate test, click save

5. Fill out relevant details from the test (side, initial result, comment); click OK



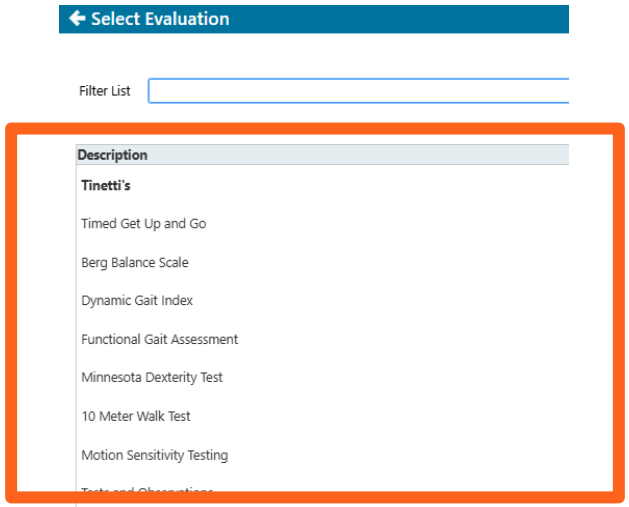
Objective – Objective Tests

- Select **Objective Tests** tab
  - Standard Test= FOMs/Standardized Tests
  - Patient Reported Outcomes= Questionnaires (the same ones that are available on the subjective tab)



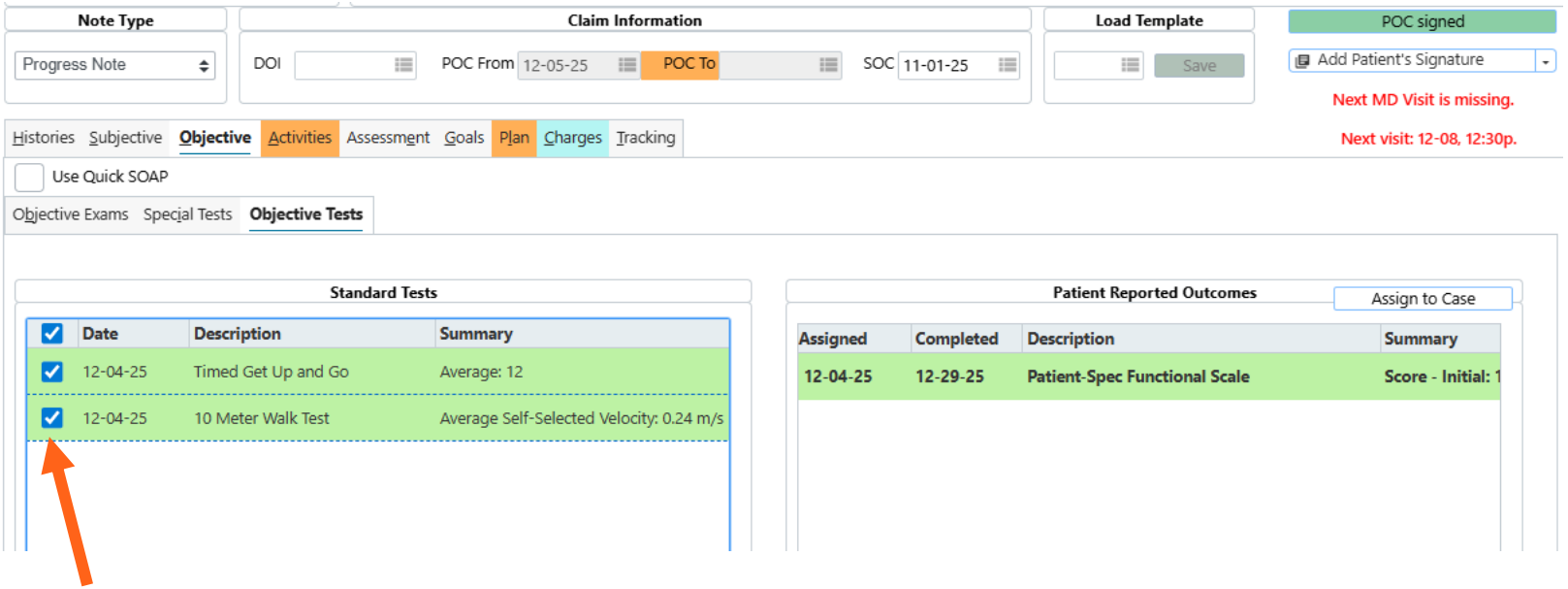
- Right click in either section and click Add to open list of available Objective Tests/Questionnaires; select test you would like to complete

- Fill out the appropriate information related to the test, and then click save



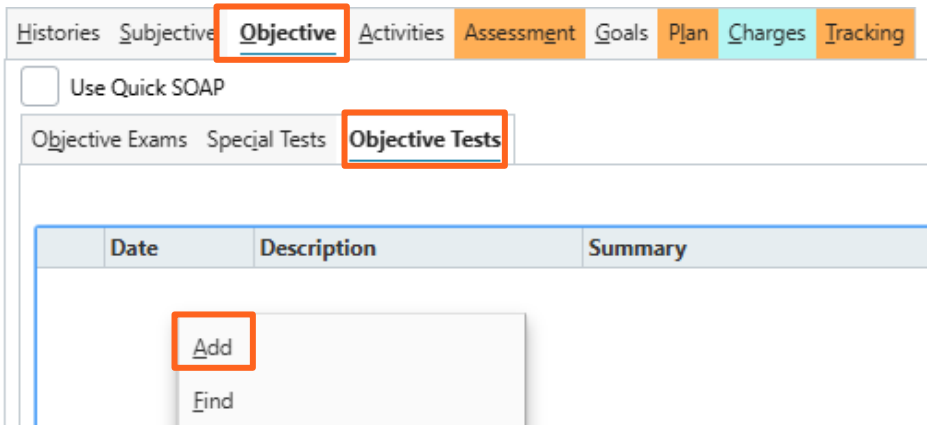
Objective – Objective Tests

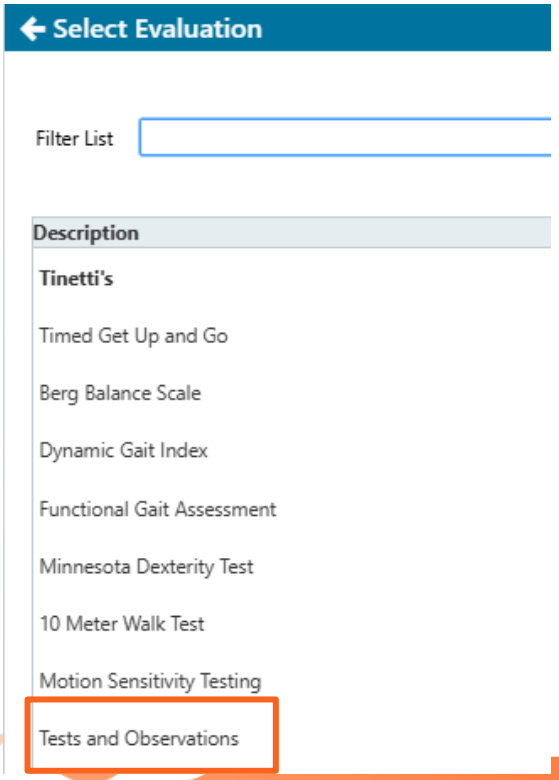
- In the Objective Tests tab, ensure the test you completed is Green and has a check mark next to it so it will populate in the narrative



Objective – Objective Tests

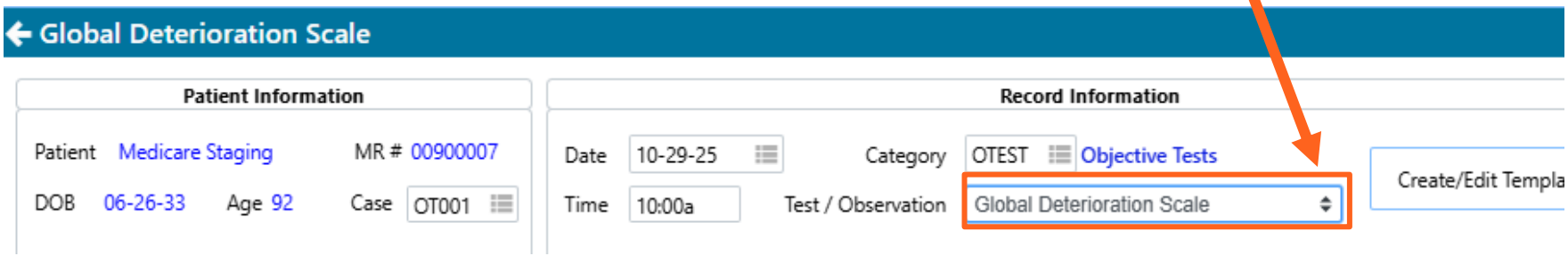
- You can find more Tests in the "Test/Observations" item
- Right click into panel and select Add
- Click into "**Tests/Observations**" from the list to find more Tests





Objective – Objective Tests

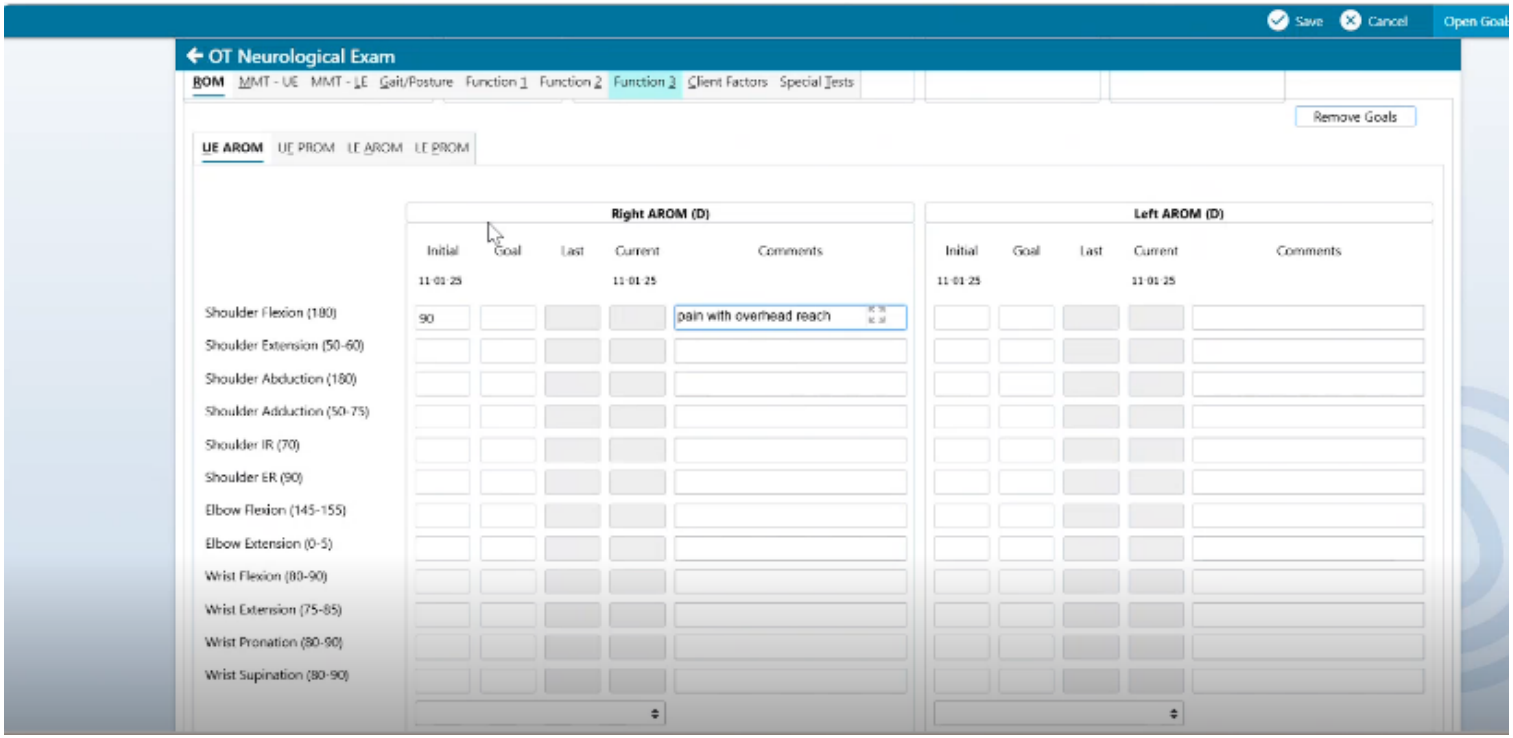
- When the **Test/Observation** box opens, use the **drop down arrows** to view and select the test you would like to complete
- Complete the test, and then save at the top right of your screen



If you need instructions or a form to complete an Objective Test, type the name of the test in **"Self Help"** and you will find a link or PDF to most test instructions

VIDEO TIME: IE Objective

Watch it NOW!
Click Image Below to Watch A Video



Remember

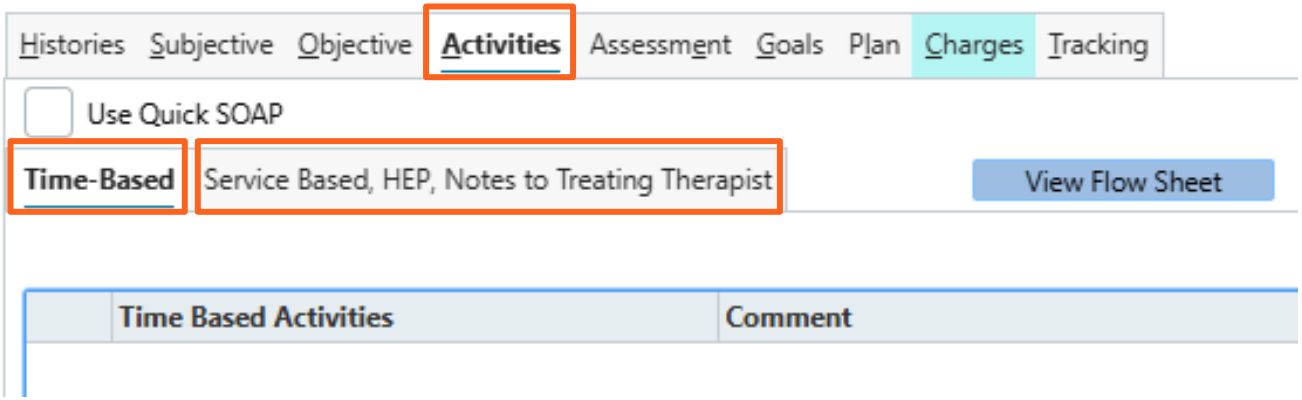
For OT Neuro Exam: Function 3

For PT Neuro Exam: Function/ADL Higher

Activities

All billable treatment interventions are documented on the Activities Tab

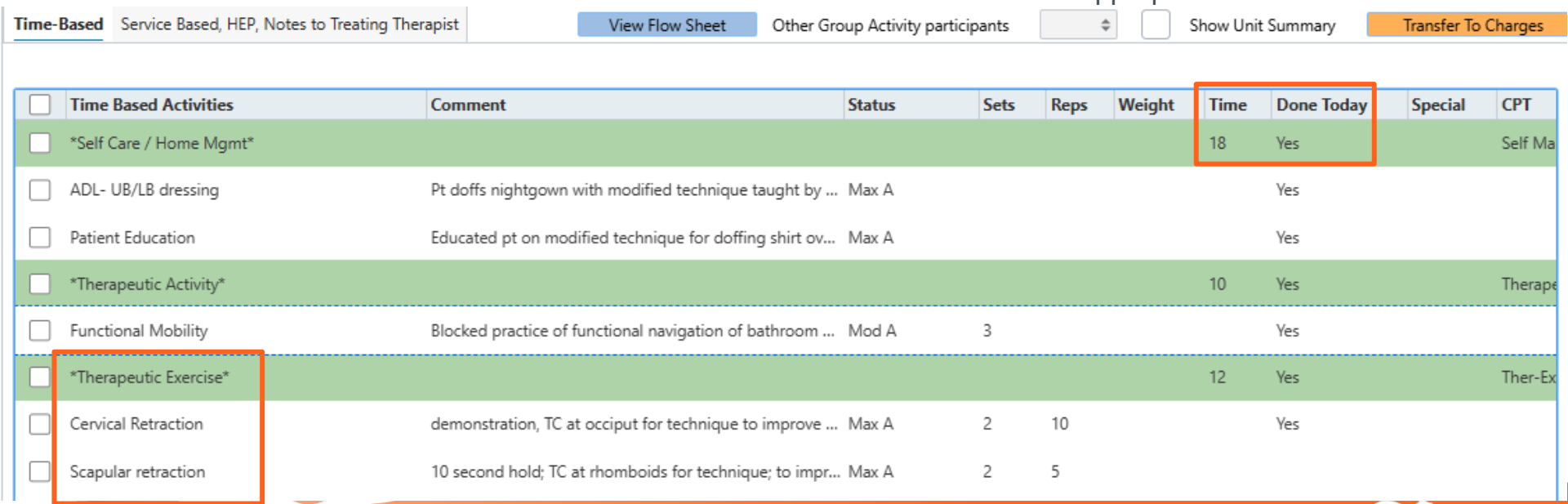
REMINDER: any CPT code (items marked with *asterisks*) that you plan to bill in the plan of care MUST be included in the Planned Services (Plan Tab)



You will enter time-based interventions on the "**Time-Based**" tab and service-based interventions on the "**Service Based/HEP/Notes**" tab

Activities – Time Based

- **Green items** with *asterisks* are tied to CPT codes and will pull to charges tab
  - You must **enter time** for each CPT code item and **indicate "Done Today"**
  - **DO NOT DOCUMENT ANY COMMENTS OR SKILLED CARE IN THE GREEN ITEMS**
- Document skilled intervention supporting each CPT code **underneath** the relevant Green CPT line item (NOT IN THE GREEN LINE ITEM)
  - Click the CPT code you are going to add intervention for, then use + to add appropriate items from the picklist (ex: *Therapeutic Exercise* > Cervical Retraction and Scapular Retraction)
  - All skilled intervention must have measurable assist level, quantification (sets/reps) when appropriate. "Comments" is where you should add skilled components (modifications, response). Do not enter time here (enter time on green line)
- **IMPORTANT!! Do NOT** click the top/title of each column to sort
  - This will cause the items to sort and interventions will not be under the appropriate CPT code

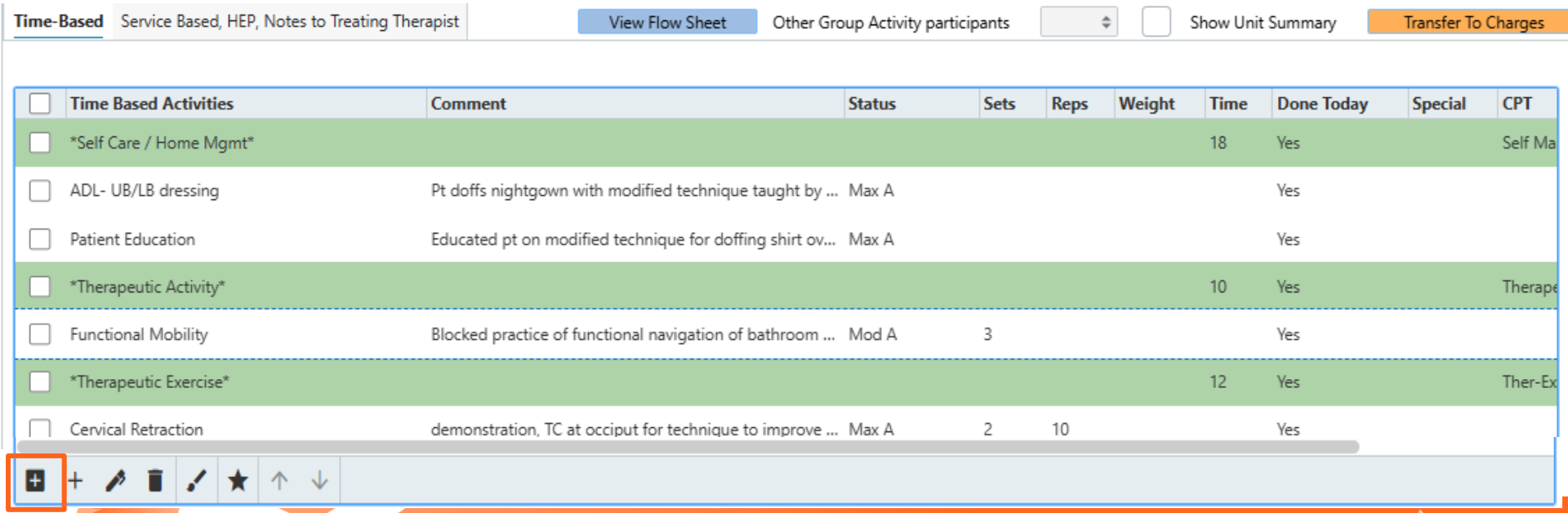


Time Based Activities	Comment	Status	Sets	Reps	Weight	Time	Done Today	Special	CPT
Self Care / Home Mgmt						18	Yes		Self Ma
ADL- UB/LB dressing	Pt doffs nightgown with modified technique taught by ...	Max A					Yes		
Patient Education	Educated pt on modified technique for doffing shirt ov...	Max A					Yes		
Therapeutic Activity						10	Yes		Therape
Functional Mobility	Blocked practice of functional navigation of bathroom ...	Mod A	3				Yes		
Therapeutic Exercise						12	Yes		Ther-Ex
Cervical Retraction	demonstration, TC at occiput for technique to improve ...	Max A	2	10			Yes		
Scapular retraction	10 second hold; TC at rhomboids for technique; to impr...	Max A	2	5					

Activities – Time Based (other tips)

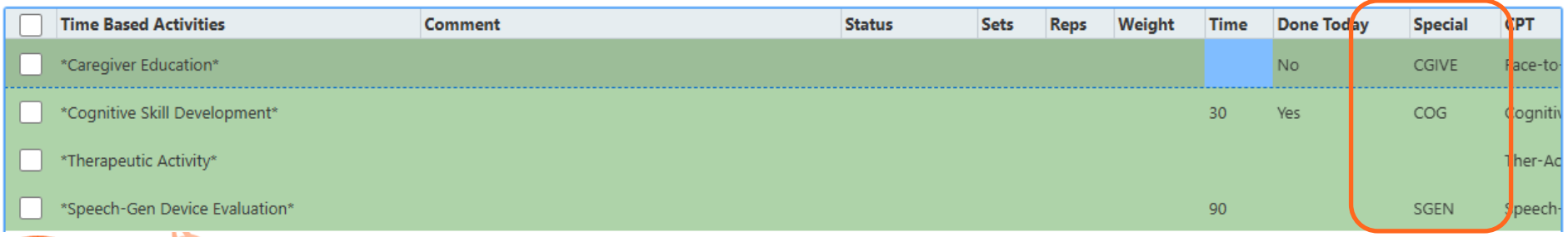
To add items to the Time-Based Activity grid:

- Use the + to open and search picklist
  - Use **Quick Find** to search for specific activities (this list is long; **favorites** will be helpful)
- You can check off multiple items, then Save
- Update status (assist), sets, reps, weight as applicable. You can also customize name of activity or create your own. **IMPORTANT: ALL ITEMS MUST HAVE MEASURABLE ASSIST LEVEL!!**
- **Reminder:** Time should only be added to Green CPT code items (these are tied to billing)
- Select **Done Today = Yes** (if not the charges will not transfer)
  - You can have activities in the log that are not done every visit to save time documenting in future visits



Activities – Time Based (Special Codes)

- Special Codes
  - A few codes listed in the Time Based Activities picklists are considered "special codes"
    - These are CPT codes that have time threshold that must be met prior to opening access to the second / add on CPT code
      - 97129 / 97130 Cognitive Skills Development (SLP)
      - 97550 / 97551 Caregiver Education
      - 92607 / 92608 Speech Generating Device Eval (SLP)
    - You only need to add one CPT code line item within the Time Based Activity grid
      - Raintree will calculate the correct distribution of time within each code set listed above.
      - Example – 30 minutes entered for "Cognitive Skills Development"
        - 15 minutes will be applied to 97129 and 15 minutes will be applied to 97130 for 2 Total units

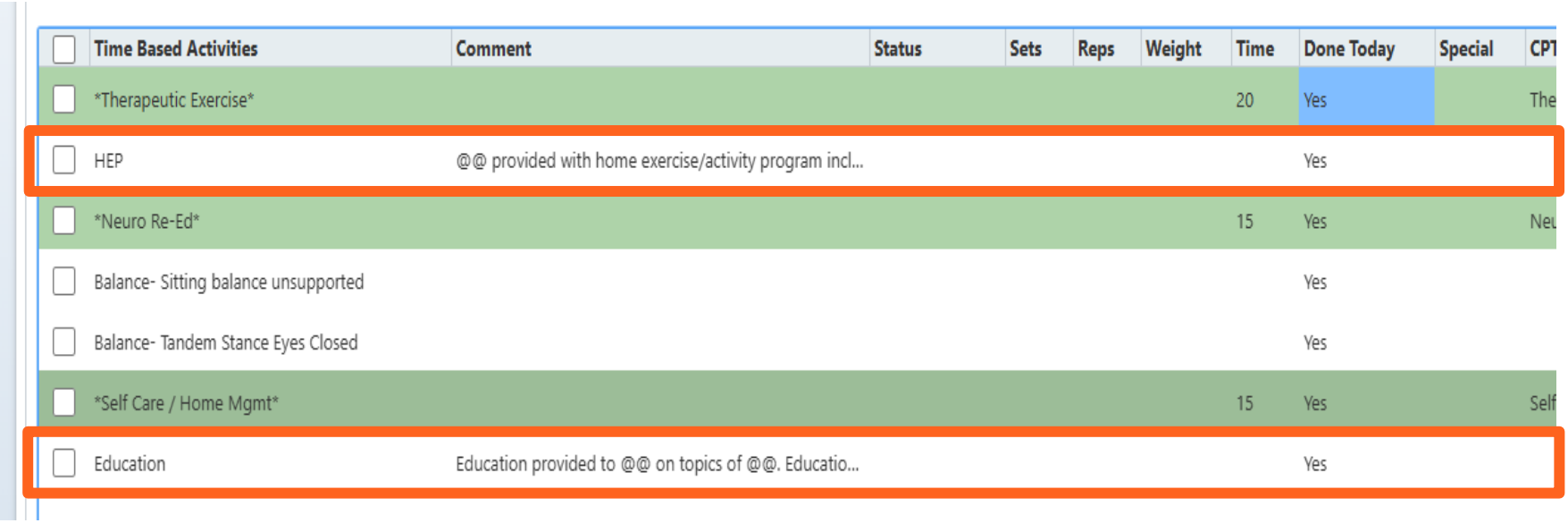


	Time Based Activities	Comment	Status	Sets	Reps	Weight	Time	Done Today	Special	CPT
☐	*Caregiver Education*							No	CGIVE	Face-to-
☐	*Cognitive Skill Development*						30	Yes	COG	Cognitiv
☐	*Therapeutic Activity*									Ther-Ac
☐	*Speech-Gen Device Evaluation*						90		SGEN	Speech-

Activities – Education

Education should be documented early and often throughout the plan of care

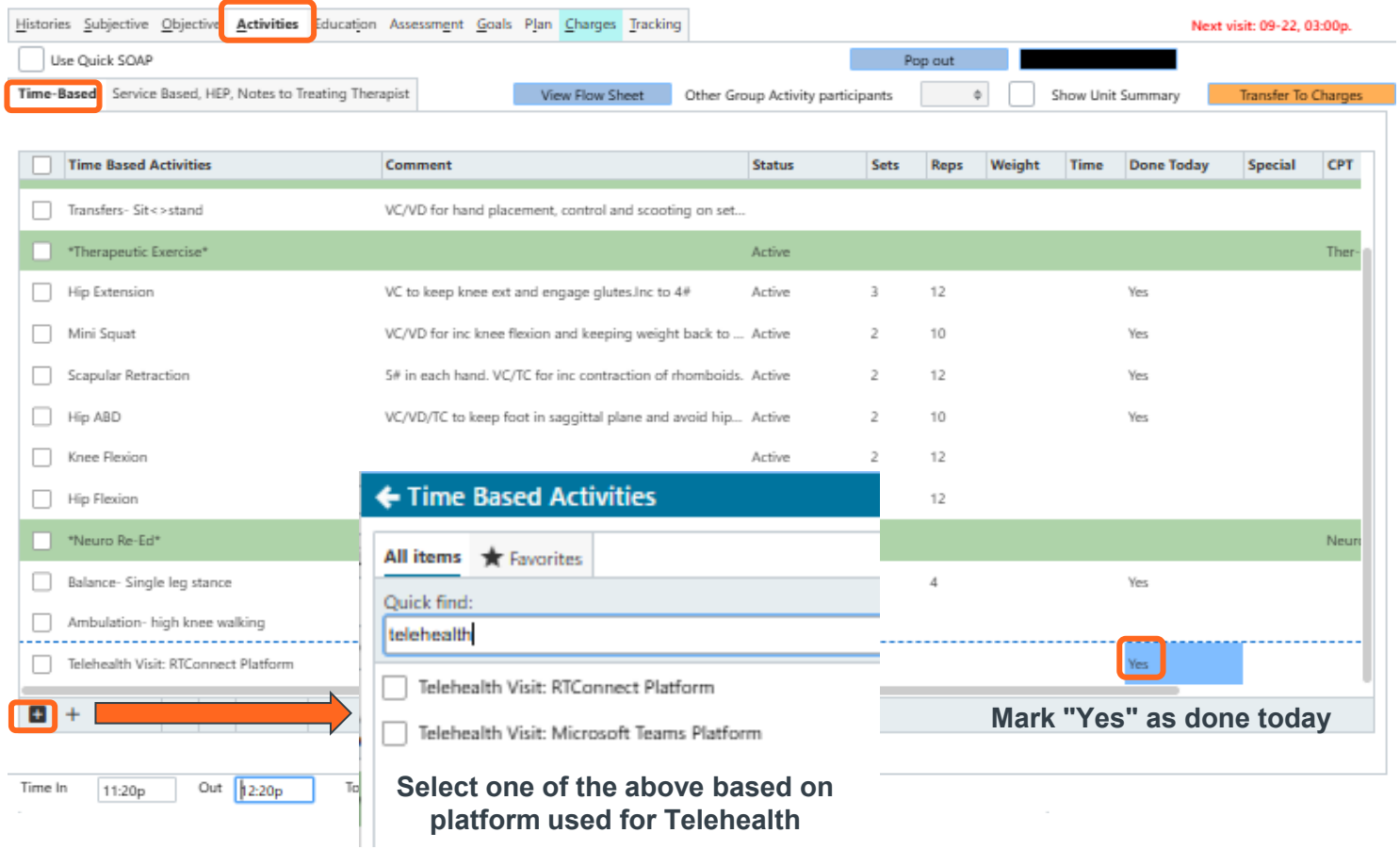
- Add Education as an item under the relevant CPT code in the Time-Based Activity log; there are @@ within this item to prompt you on what details to document.
- Add in HEP in this section to add more details and tie into the correct CPT code
  - You can use MedBridge HEP link (on Service Based, HEP, Notes to Treating Therapist tab) to create HEP document that is sharable with patient. Details of HEP can be copied/pasted into the HEP line item in Time-Based Activities grid



Time Based Activities	Comment	Status	Sets	Reps	Weight	Time	Done Today	Special	CPT
Therapeutic Exercise						20	Yes		The
HEP	@@ provided with home exercise/activity program incl...						Yes		
Neuro Re-Ed						15	Yes		Neu
Balance- Sitting balance unsupported							Yes		
Balance- Tandem Stance Eyes Closed							Yes		
Self Care / Home Mgmt						15	Yes		Self
Education	Education provided to @@ on topics of @@. Educatio...						Yes		

Activities - Telehealth Documentation

- If performing a telehealth visit, you MUST Select "Telehealth Visit" item from picklist and mark as "Done Today" within "Time Based Activities" picklist
  - This ensures documentation of platform used



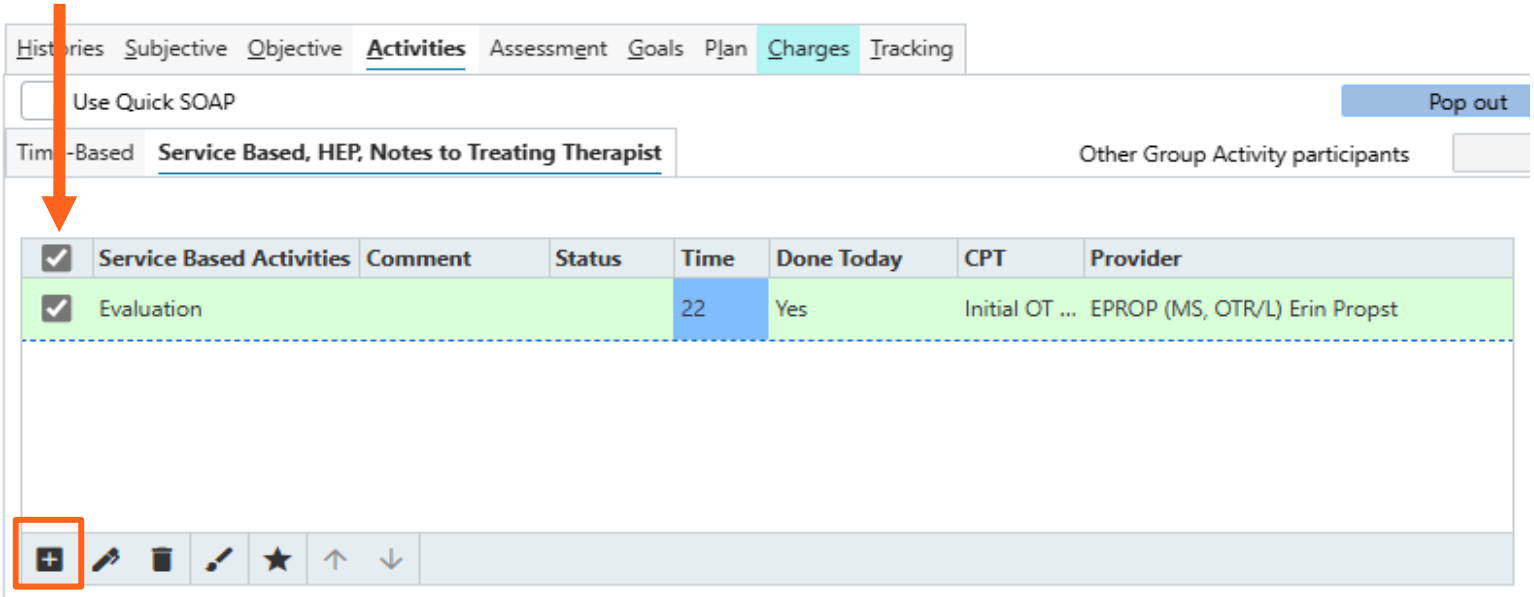
Activities – Service Based

Any service-based billing (CPT) interventions are added on Service Based tab

- The picklist here functions the same as on the Time-Based tab *(exception: CPT items on Service-Based grid are not green unless the check box is selected)*
- Click + and search/find the service-based activity in the picklist > Save
- Update comment, status, time, indicate done today

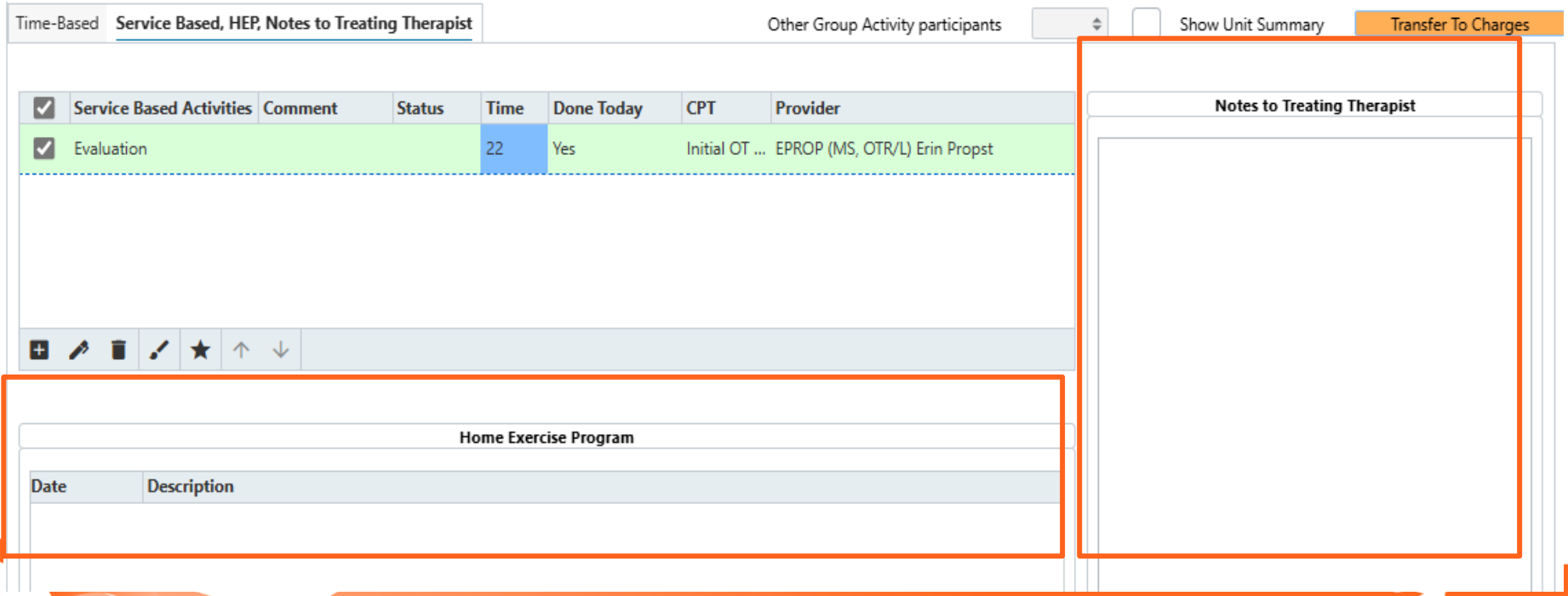
Your **Initial Evaluation** is a Service Based code and should populate here automatically after selecting Complexity (Assessment tab)

NOTE-When unchecked, CPT code line items will not show in green like Time Based.



Activities – HEP, Notes to Treating Therapist

- **Home Exercise Programs** can be added/uploaded in the Home Exercise Program box by right clicking > Add
  - Medbrige HEP function similar to RT Custom. See training for details
    - CI has access to training and will walk students through process
  - It is still important to document HEP education on Time-Based activity grid to add details about who was educated, level of assist and returned level of understanding.
- **Notes to Treating Therapist** can be used to communicate to other therapists – KEEP IN MIND THESE DO NOT END UP IN THE NARRATIVE



Activities – Time In and Out

Time In and Time Out is required to sign off on notes in RT Standard

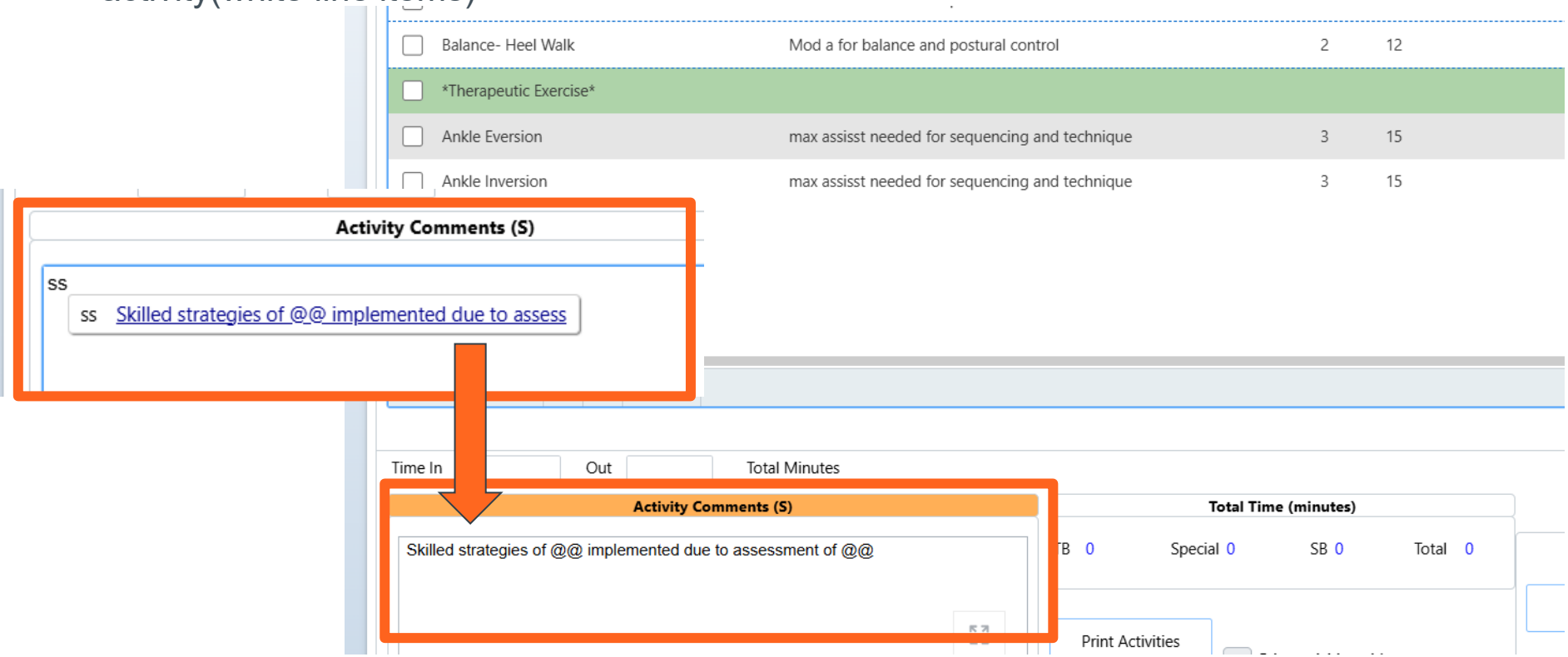
- Time In and Time Out will be entered on the Activities tab, under Activities log
  - Time should be entered in (hh:mm a/p)
    - **a** indicates AM and **p** indicates PM
  - Raintree will allow underbilling (billing for less than total minutes), but not overbilling (billing for more time than total minutes)
  - If you split a session (multiple time in/out), enter the first IN time and last OUT time, then specify additional time IN/OUT in the Activity Comments box
    - Supervisors should also be specifying time of a shared visit in the Activity Comments box



You can also use the Activity Comments box to document **Post Activity Vitals**

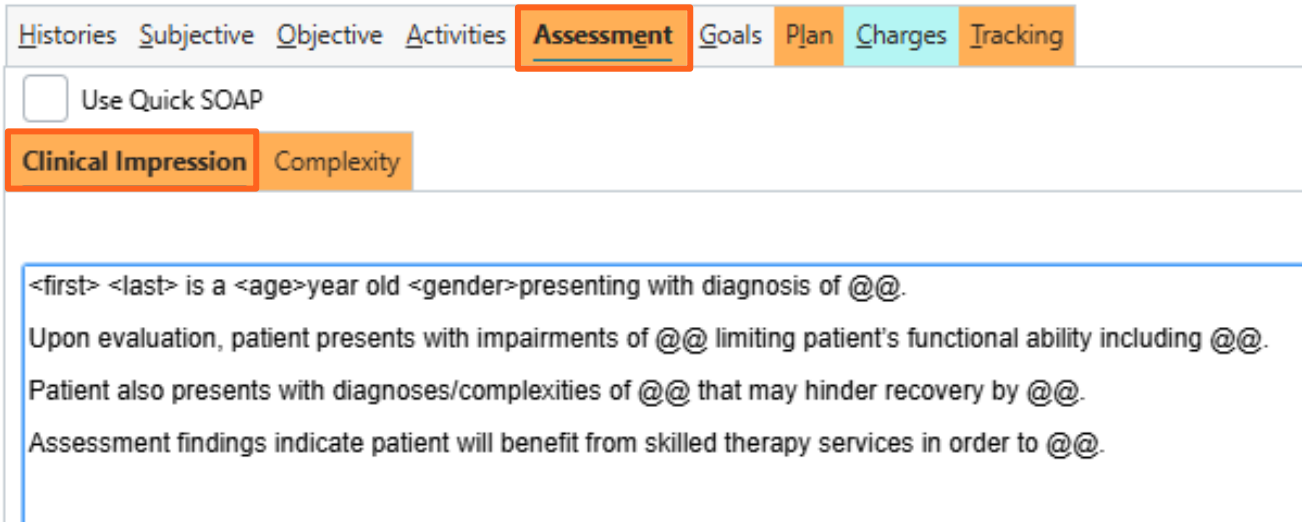
Activities – Skilled Strategy Statement

- In the activity comments box, you can document the skilled strategy that was provided this session
- You can type "ss" + space in the Activity Comments box to load the prompts for the skilled strategy statement that includes jump markers
- Skilled components may also be documented in the "Comment" section of each activity(white line items)



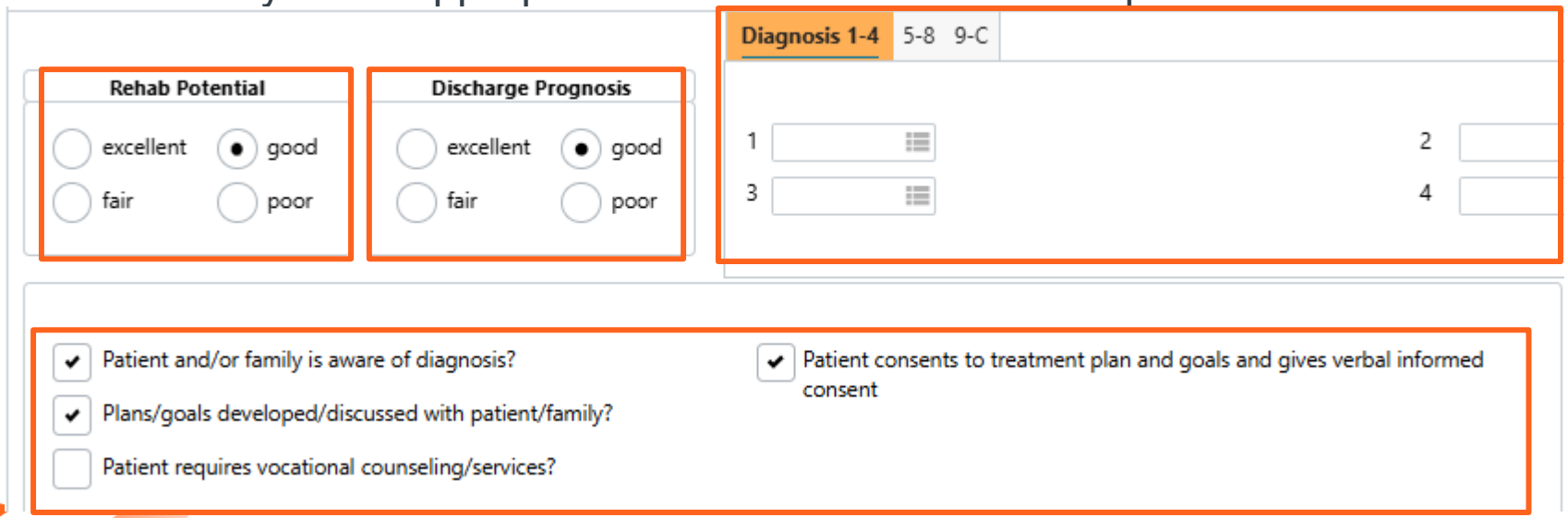
Assessment – Clinical Impression

- Navigate to the **Clinical Impression** of the Assessment tab
- **DO NOT** change entries for merge tags (<first> <last> etc) - this data will pull directly into your narrative from patient's chart
- Complete the Clinical Impression by filling out appropriate information
  - iPad users – use keyboard shortcut "**ctrl**" and "**cmd**" and "**.**" or navigate with mouse to complete all (@@) place holders. Non-iPad users can navigate jump markers by pressing **"ctrl"** and **"."**



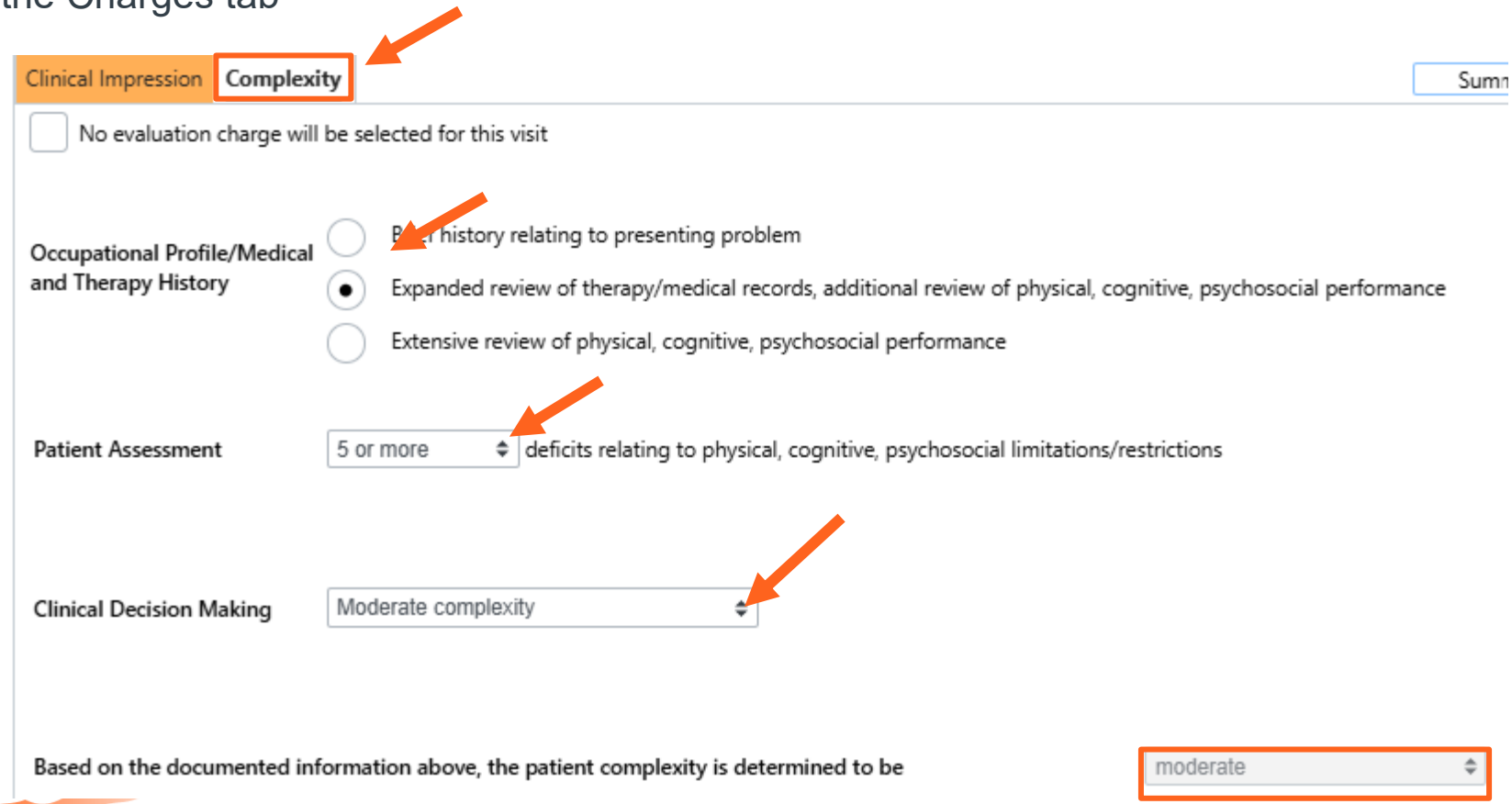
Assessment – Other

- Scroll down to find the following items under Clinical Impression
- Confirm/change **Rehab Potential** to the appropriate selection for patient
- Confirm/change **Discharge Prognosis** to the appropriate selection for patient
- Enter **ICD 10 Diagnosis Codes** by typing directly into the box or using menu icon to open and search for your code
  - #1 needs to be a Rehab diagnosis
  - Additional rehab diagnosis listed after #1 (optional)
  - Primary Medical diagnosis listed LAST (no additional medical codes are needed)
- Check off any other appropriate selections related to the plan of care



Assessment – Complexity

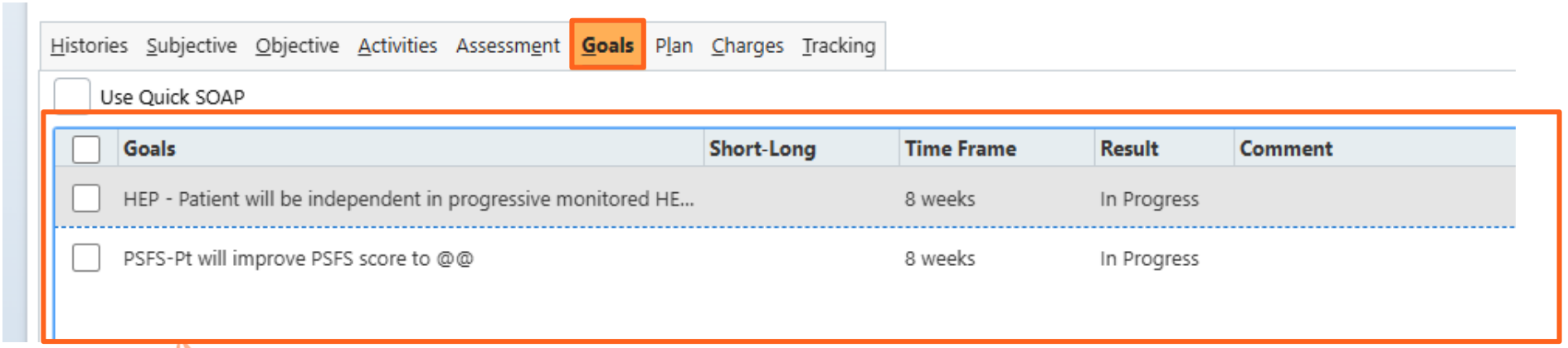
- Navigate to "**Complexity**" tab
- Select appropriate radio buttons or use drop down arrows to make appropriate selections for Eval Complexity (PT and OT Eval Complexity differ a bit)
- You will see the eval complexity populate at the bottom of the screen (read only) and onto the Charges tab



Goals

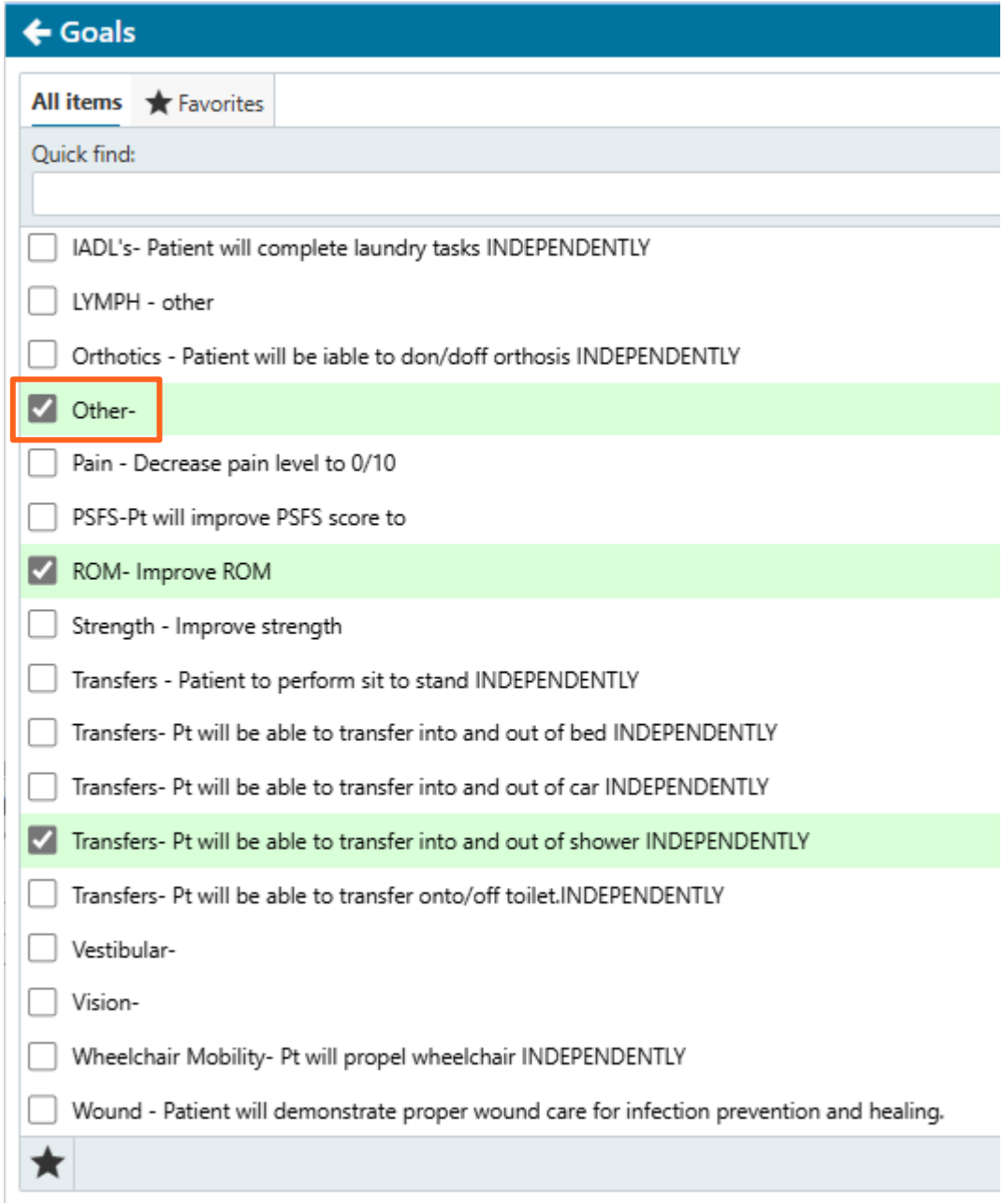
All functional deficits documented must have a goal addressing them, or documentation about why no goal is being set

- Goals should be added from the **Goals** tab
- 2 goals will pre-load automatically:
  - **HEP** goal – All patients must have a Home Exercise or Home Activity Program goal
  - **PSFS** goal – All patients must have a PSFS assessment and goal; this goal has @@ to make sure you document the WHY behind this goal
- Double click on the goal to open and edit the goal so that it is patient specific
- Add **time frame** for goal
- All goals need a **functional component** added to the goal
  - Ex. *"Improve B shoulder ROM to 100 degrees for independence with item retrieval from closet"*



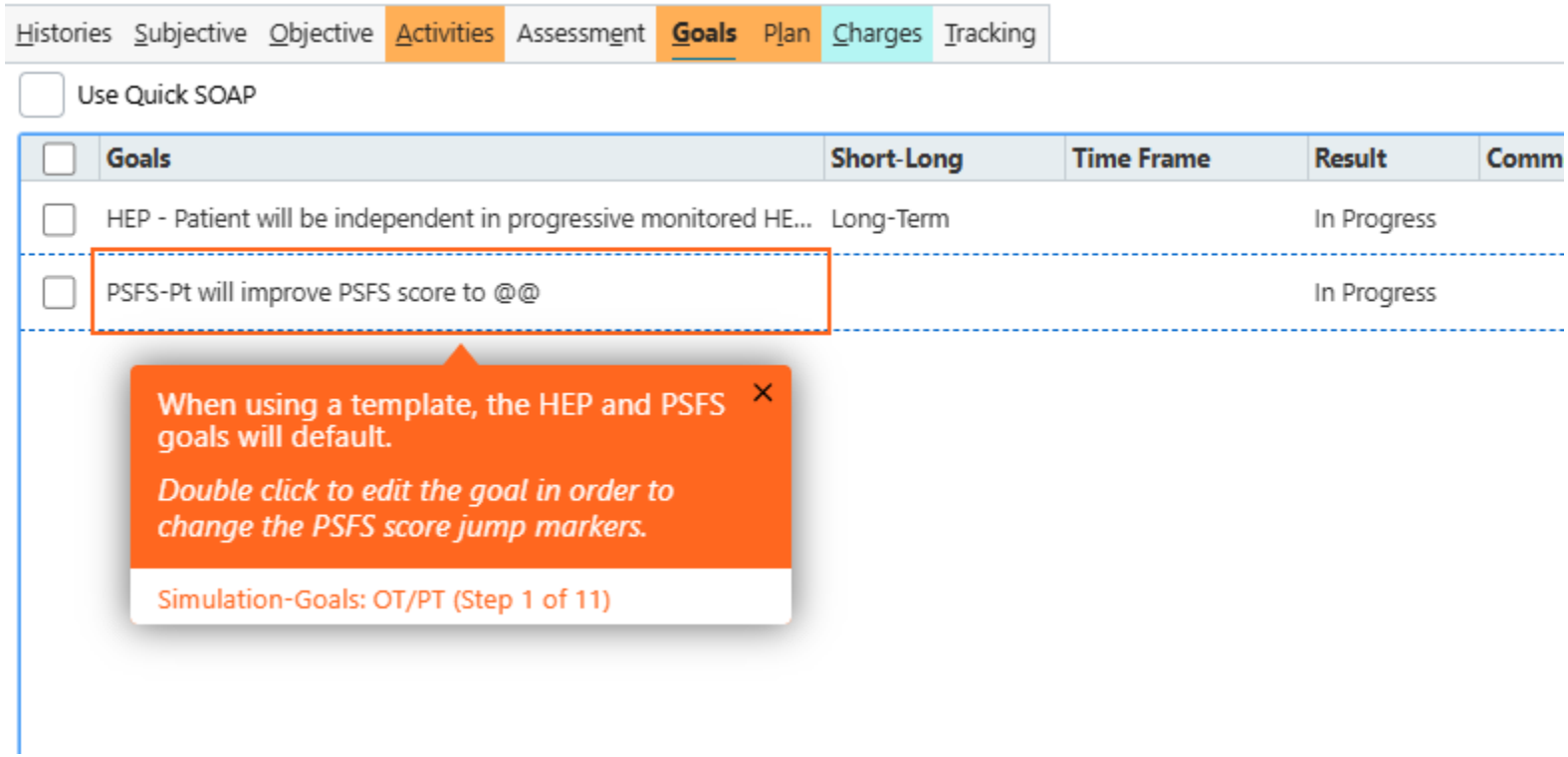
Goals

- Other relevant goals can be added using + to add items from picklist
- Check the goals you want to include, then Save
  - **"Other"** can be used to create your own goal (delete "other" and free text your goal
- Once goals are selected, double click to edit and make each goal patient specific
  - **IMPORTANT:** update the desired assist level (most default to INDEPENDENT, but this is not appropriate for all patients)
  - **IMPORTANT:** all goals need a functional component added and a time frame
    - Ex. *"Improve B shoulder ROM to 100 degrees for independence with item retrieval from closet"*



SIMULATION TIME: Goals

Try it NOW!
Click Image Below to Start the Simulation

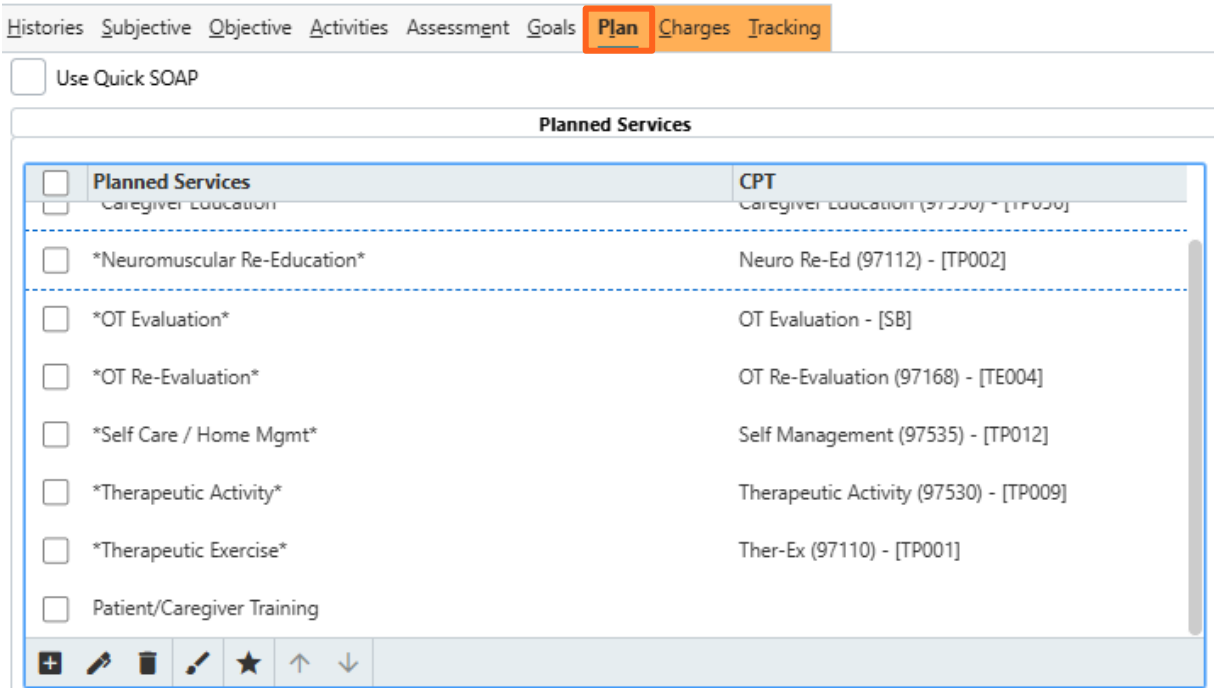


**If the simulation does not automatically display an orange pop up box, refresh your browser.

Plan – Planned Services

IMPORTANT!!! All interventions that might be included in the plan of care **MUST** be added in the "Planned Services" picklist on the Plan tab

- Click + to open picklist and select all appropriate interventions
  - This picklist has items for all disciplines – would be a great use of **Favorites** to save items you use frequently
  - Items marked with **asterisks (*)** are tied to CPT codes. **YOU WILL NOT BE ABLE TO BILL THESE UNLESS YOU MARK THEM IN THE PLANNED SERVICES PICKLIST.**

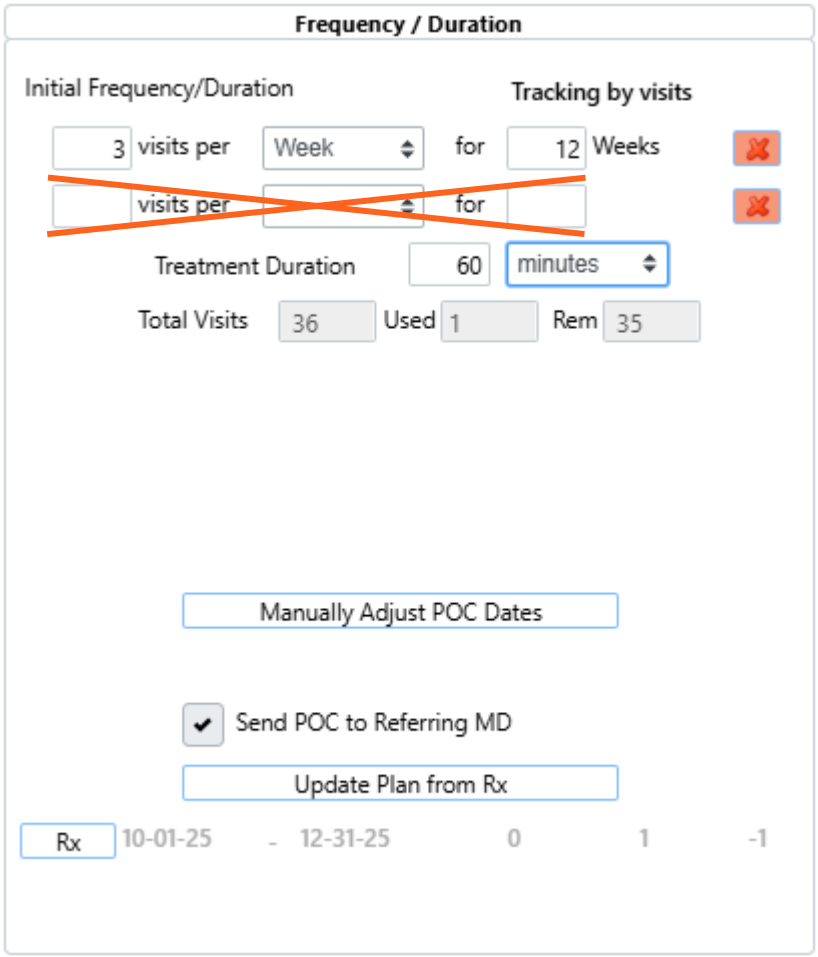


Plan – Frequency/Duration

- Enter the **frequency** and **duration** (in weeks) for the plan of care
- Recommend NOT to taper on evaluation. Best practice would be to complete a progress report when you decide to taper.

- Treatment duration will default to 60 minutes. Adjust duration if appropriate. If you select 60 minutes this does not mean you have to comply with 60 minutes every visit.

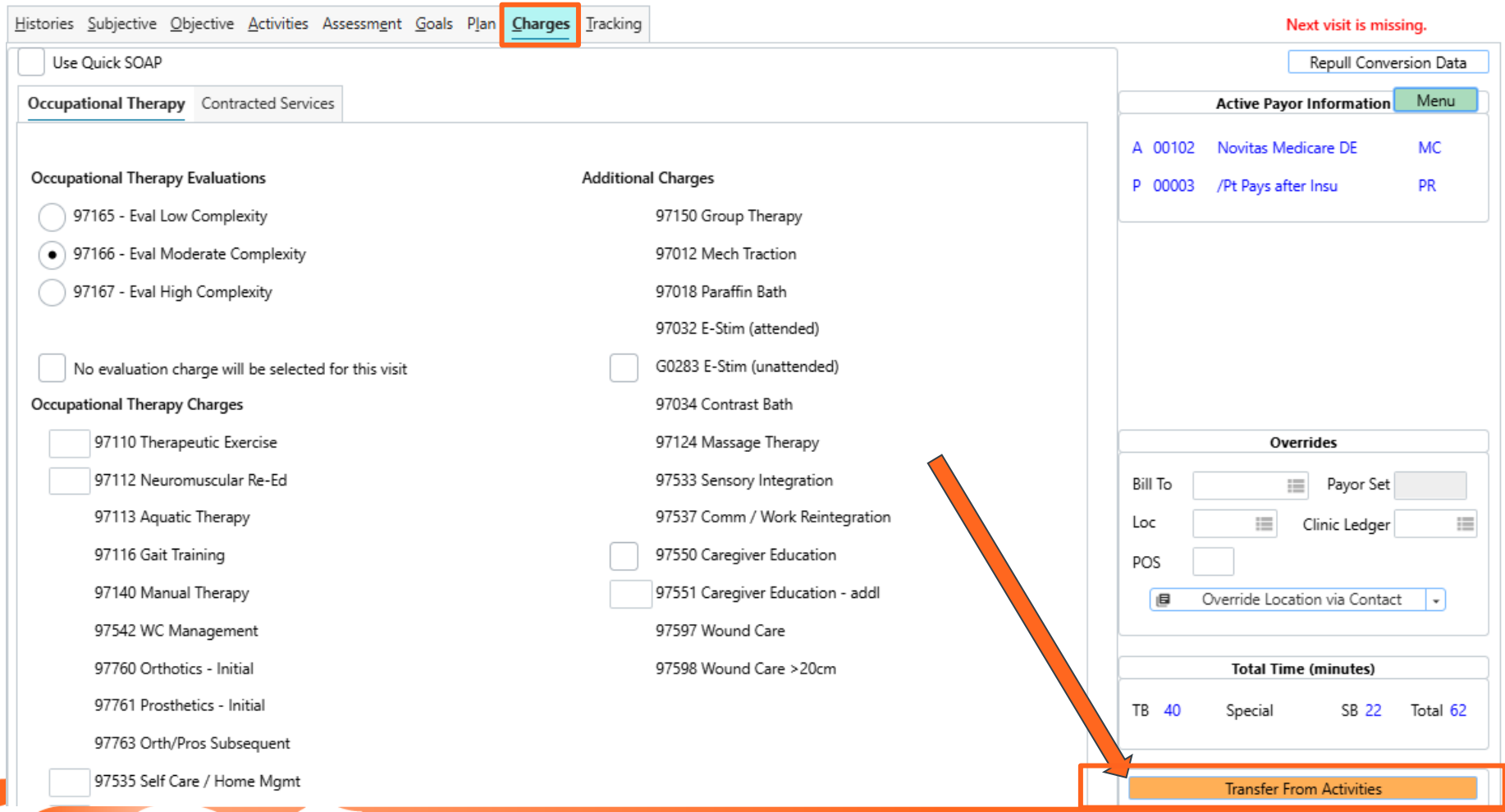
- Adding frequency and duration will populate the POC "from" and "to" dates and begin progress tracking



Charges

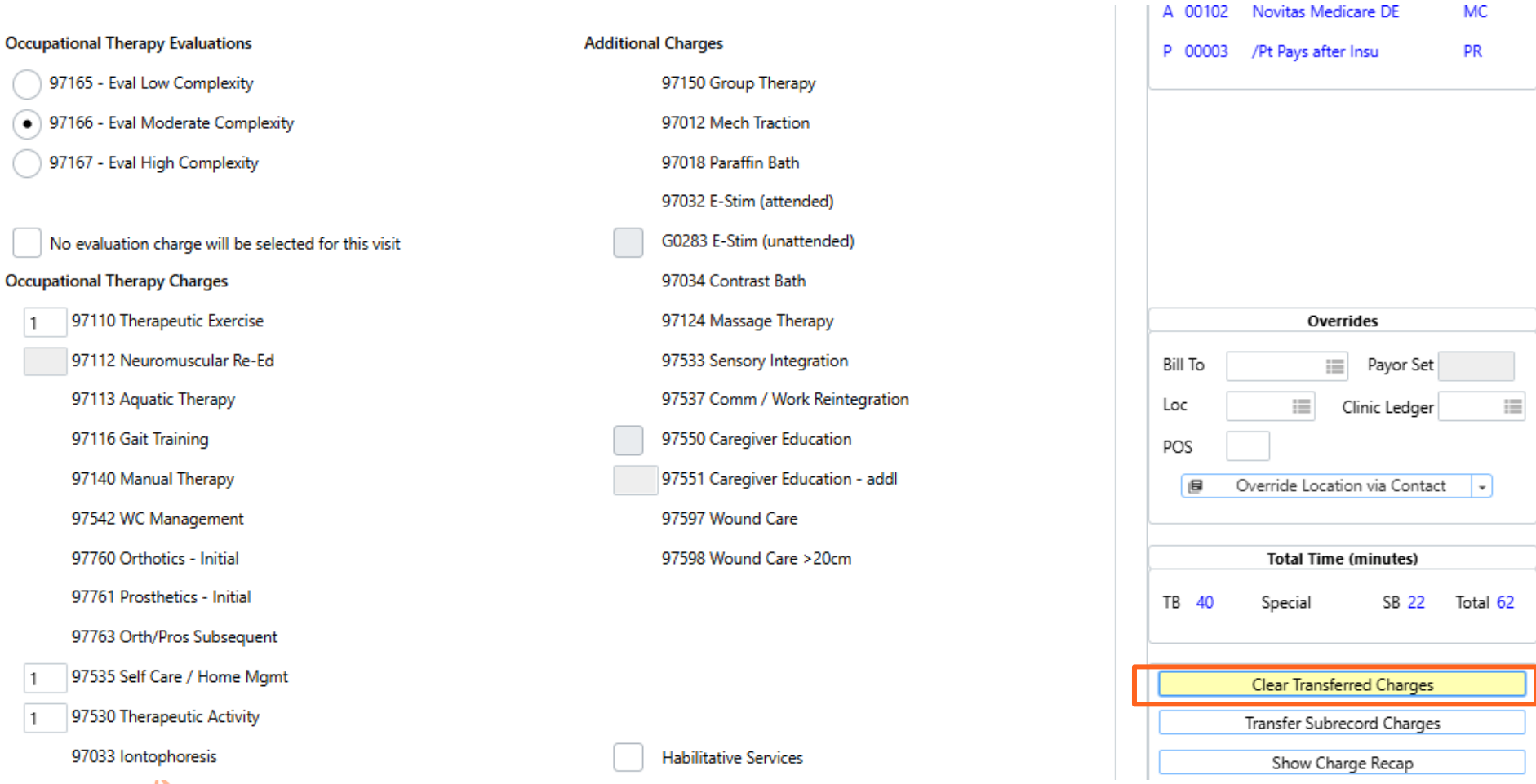
Once Eval is complete and all activities are documented, click **Charges** tab

- Click **Transfer from Activities** button to pull charges over



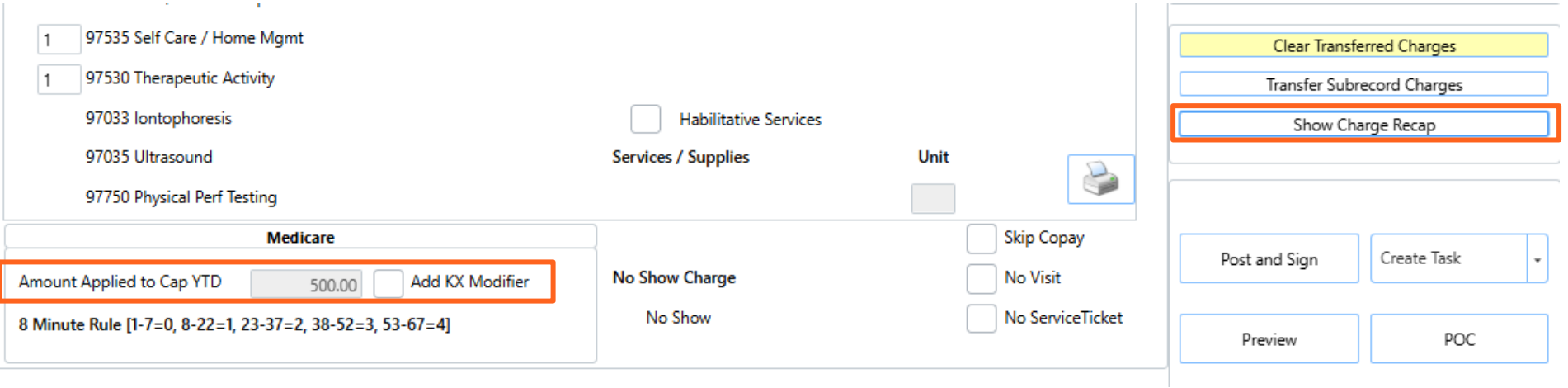
Charges

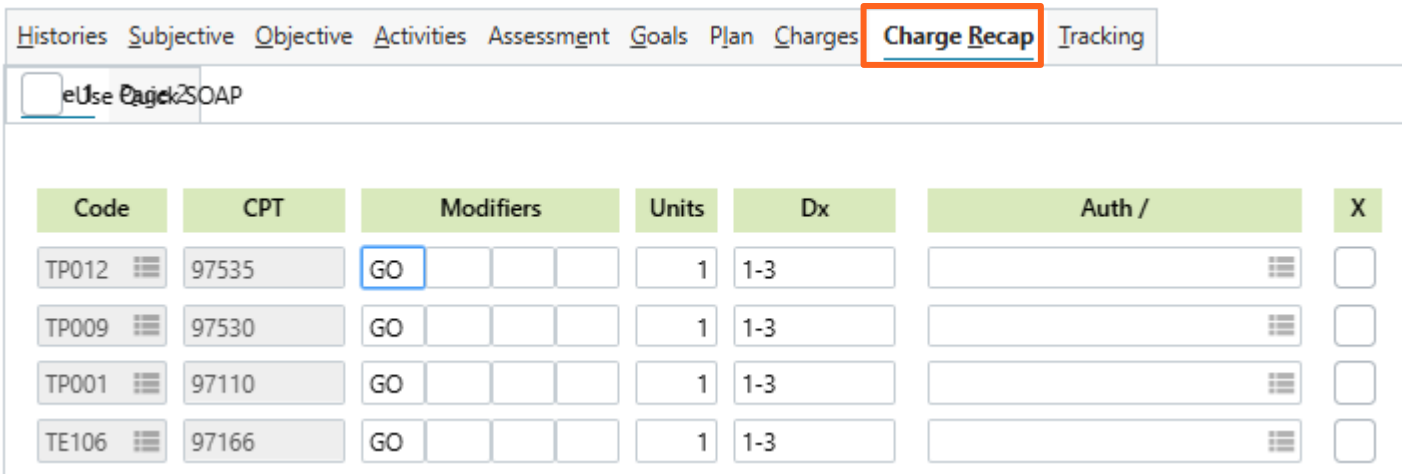
- Confirm units are appropriate based on documentation and 8 min rule
- If any changes are needed, "Clear Transferred Charges" and edit on Activities tab



Charges

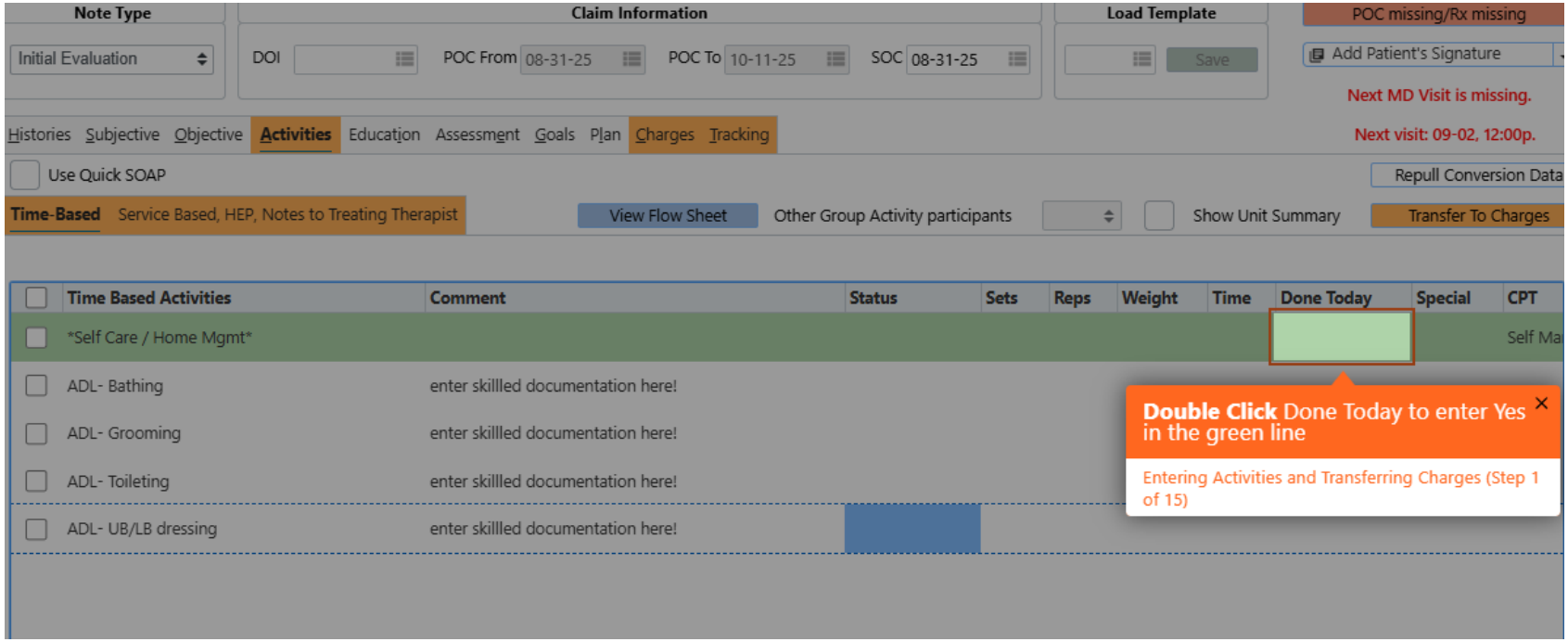
- **Medicare threshold** is visible at the bottom of the charge ticket
- **Modifiers** are visible on the charge recap (**"Show Charge Recap"**)





SIMULATION TIME: Transferring Charges

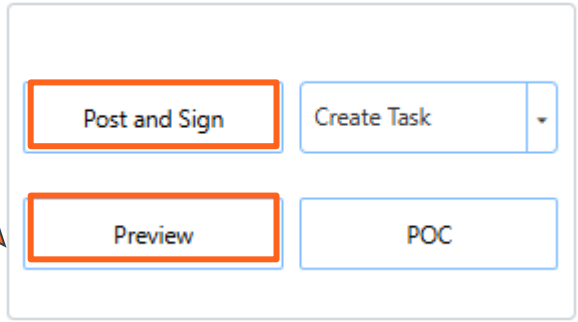
Try it NOW!
Click Image Below to Start the Simulation

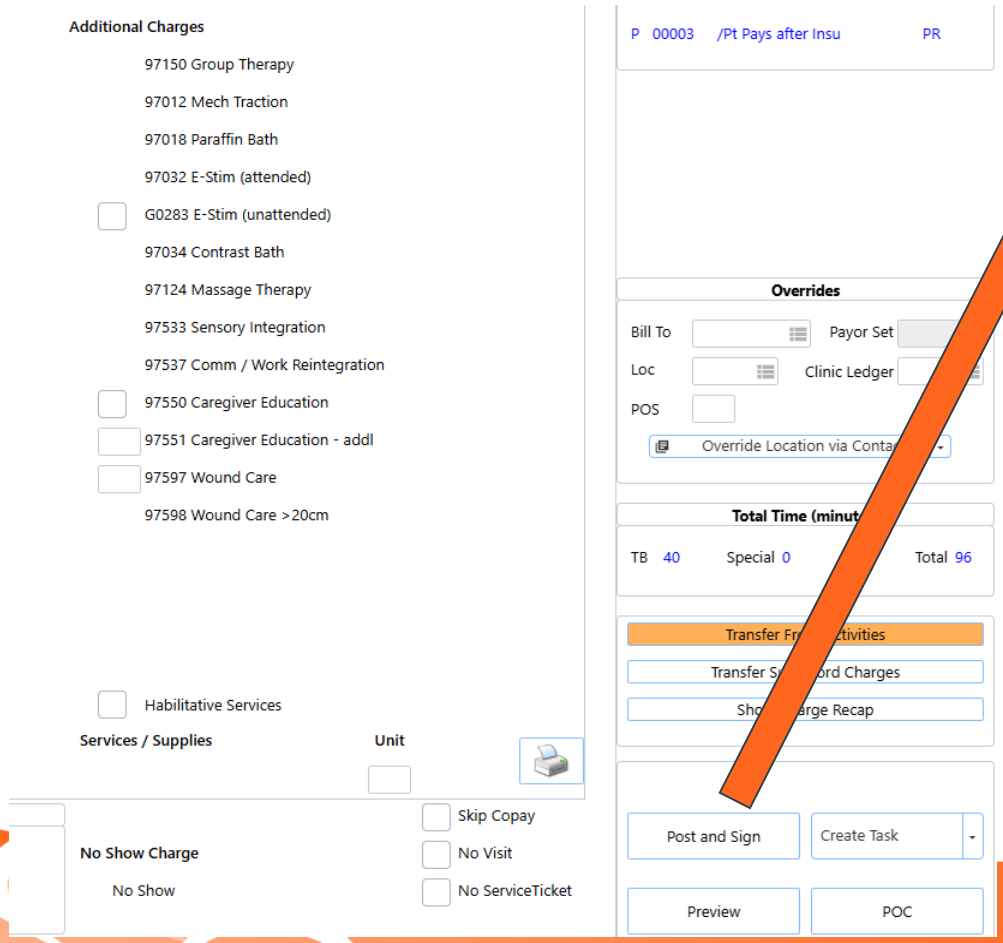


**If the simulation does not automatically display an orange pop up box, refresh your browser.

Narrative Preview and Sign Off

- Preview to review the narrative to ensure all information looks correct before signing off
- Post and Sign when you are ready to sign the note and post charges

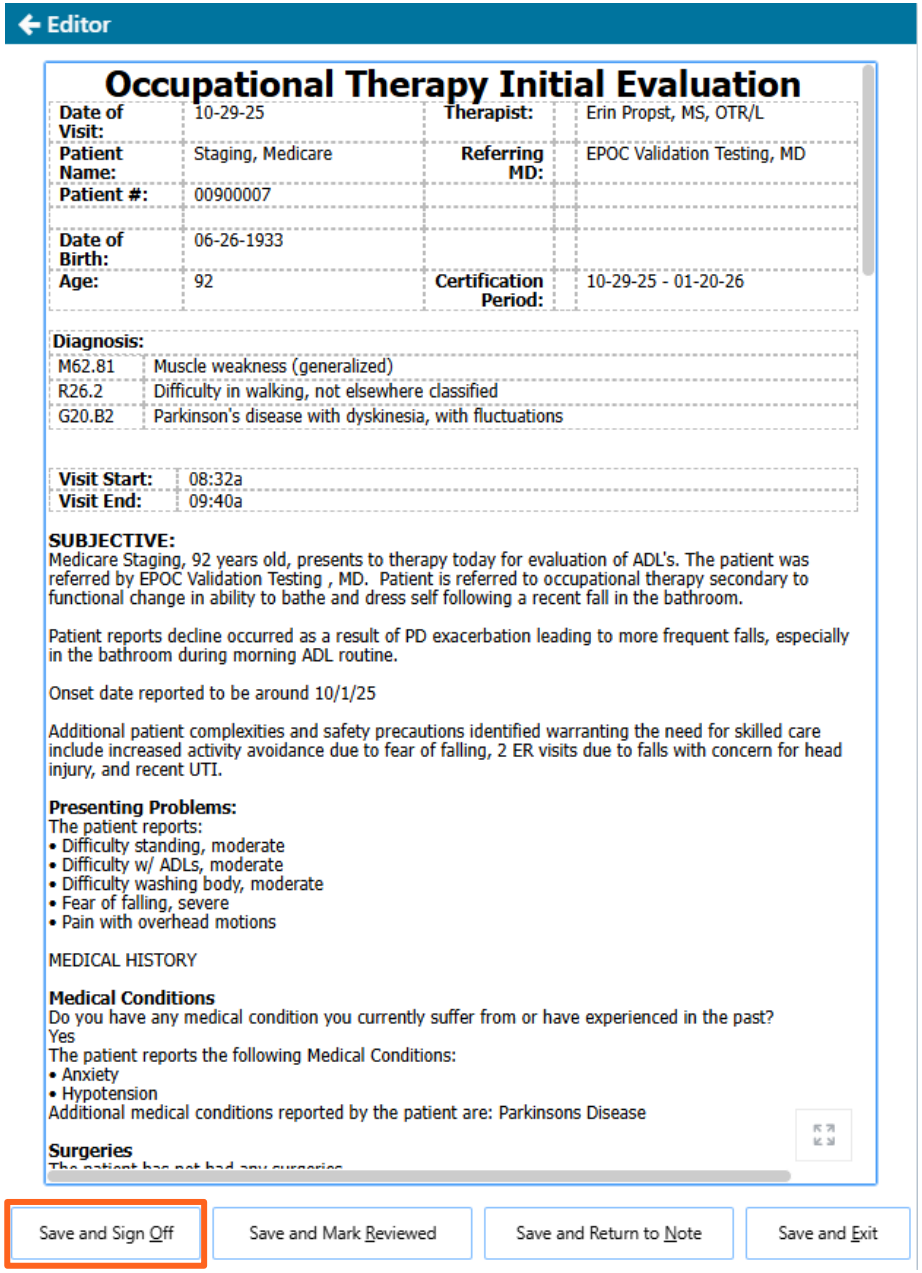




Save and Sign-off

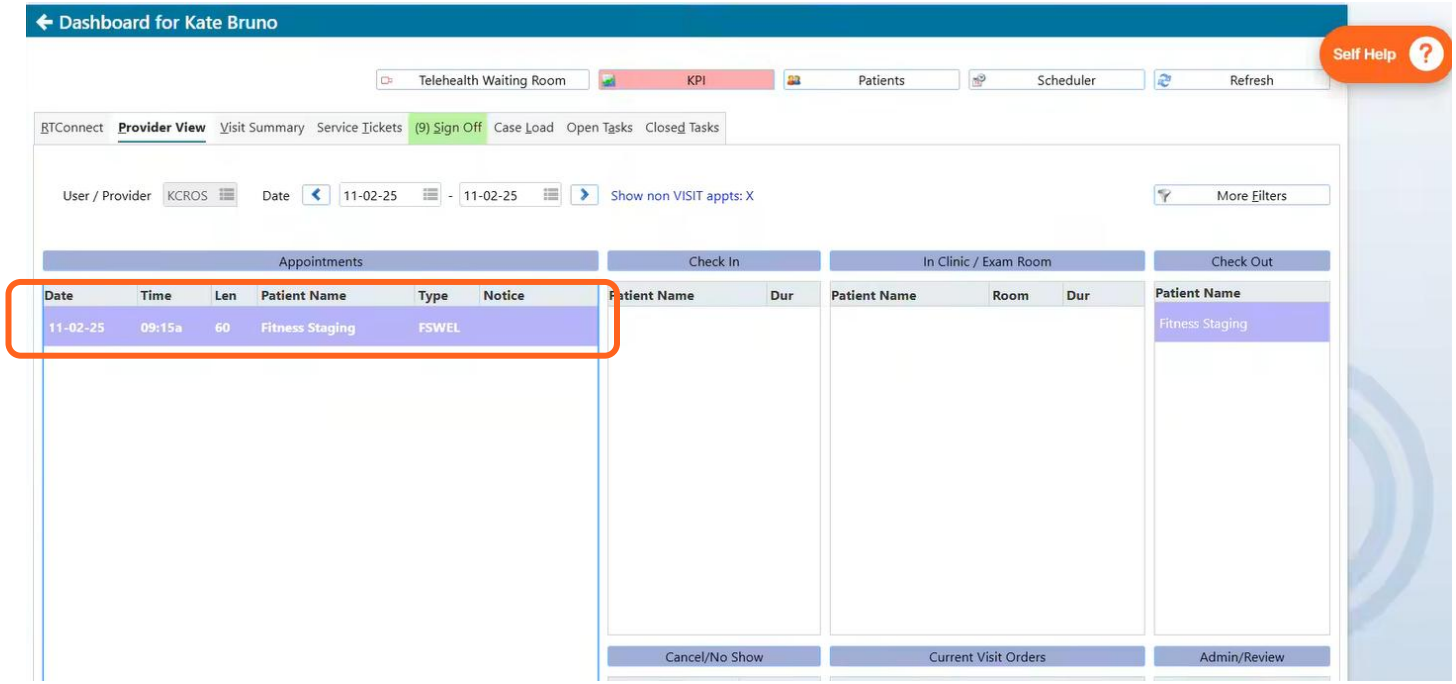
Complete final narrative review

- Click **Save and Sign Off** if you are complete
- Save and Return to Note to return and make edits
- Save and Exit to exit the note if you plan to return later for final sign-off



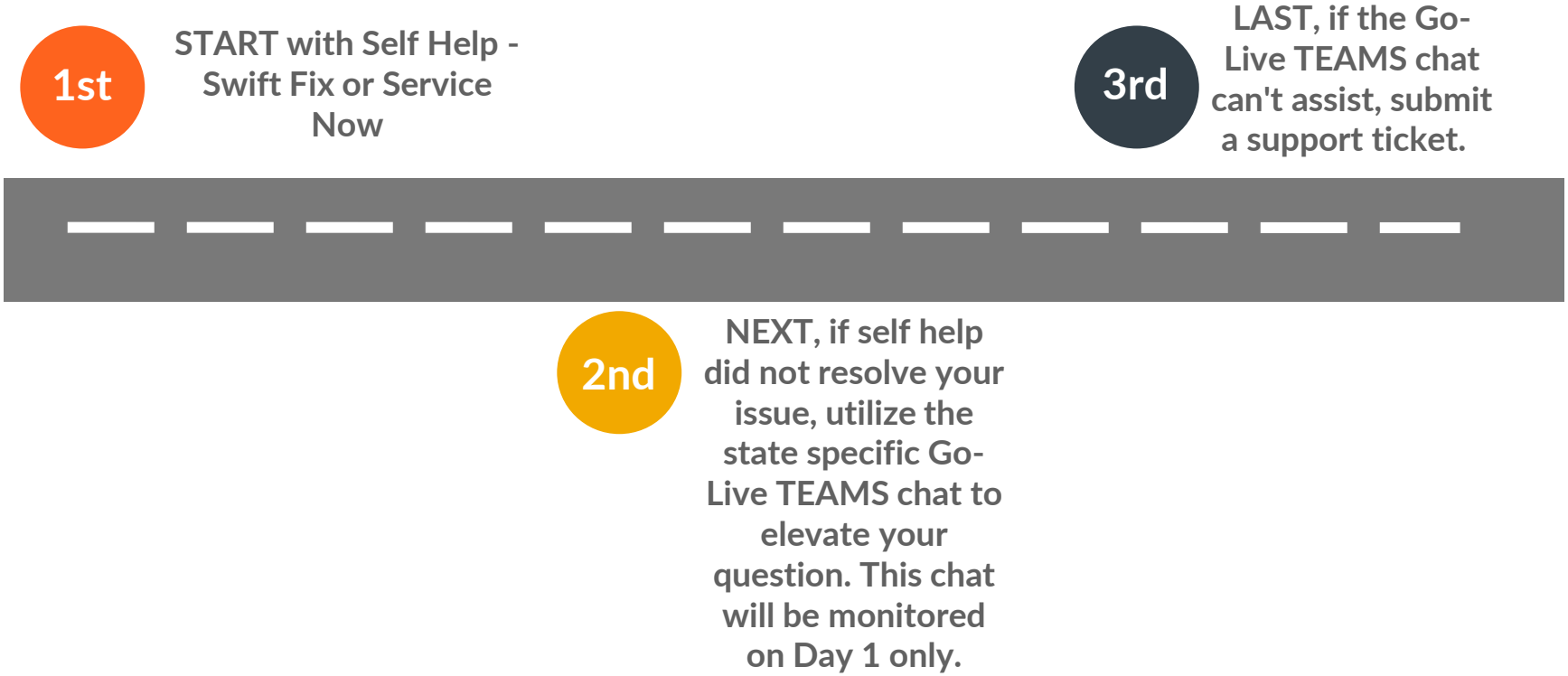
Confirmation

- After successful Sign and Post, visit will turn Purple
- If it is gray, it did not bill and you will need to go back into the note to post again.



Support Roadmap: Start Smart, Escalate Right

Have a question? Follow the path to resolution!



RT Standard
PT/PTA and OT/OTA Subsequent Treatment (TVIST)

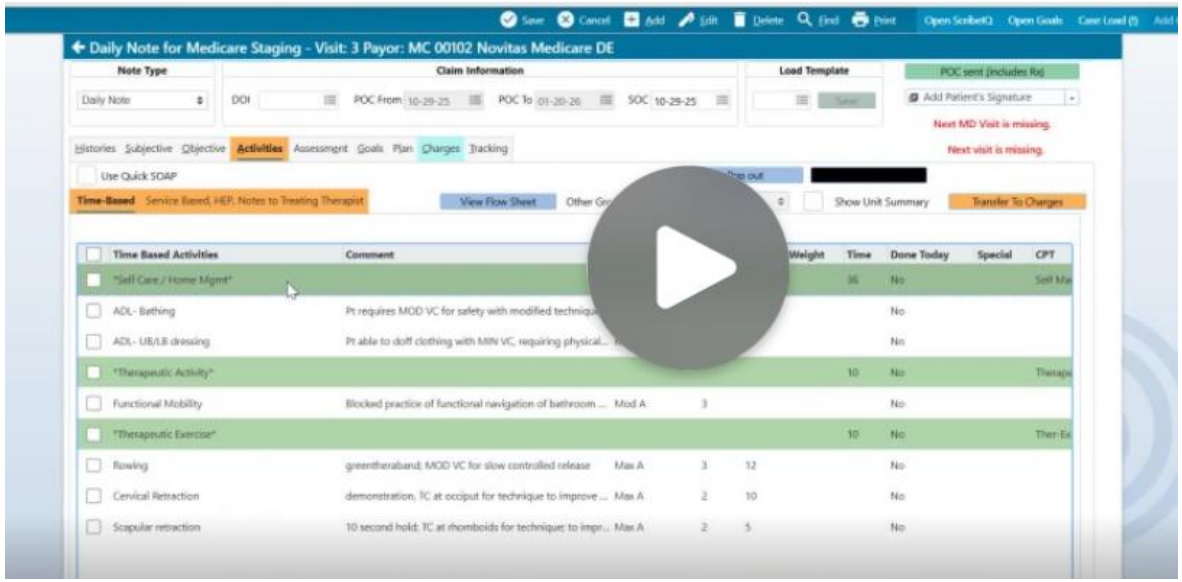


Subsequent Treatment Notes

- For OT/PTs Who Reviewed the IE/TX Visit presentation: Most treatment visits will follow the same steps described in the treatment part of the initial evaluation presentation.
- A 15-minute video covers the entire treatment visit process from beginning to end.
  - Video chapters are added so you can easily reference specific ones covering the various tabs of the daily note.
  - The slides after the video outlines the process with steps, directions and screenshots

VIDEO TIME: Subsequent Treatment Visits

Watch it NOW!
Click the Image Below to Launch the Video

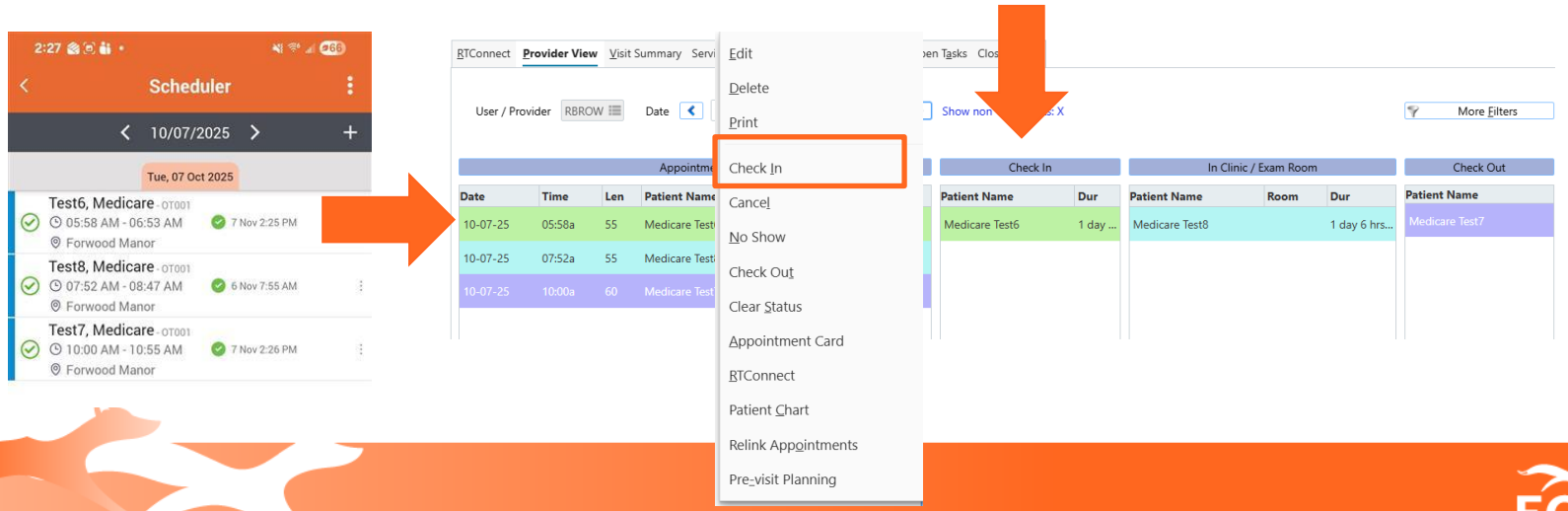


Interested in a Specific Chapter of the Video? Click Below

00:00:00 Confirming Notetype, Edits to Med History
00:01:12 Subjective
00:03:15 Objective
00:04:50 Activities
00:11:02 Assessment, Goals, Plan
00:12:30 Charges, Post & Sign

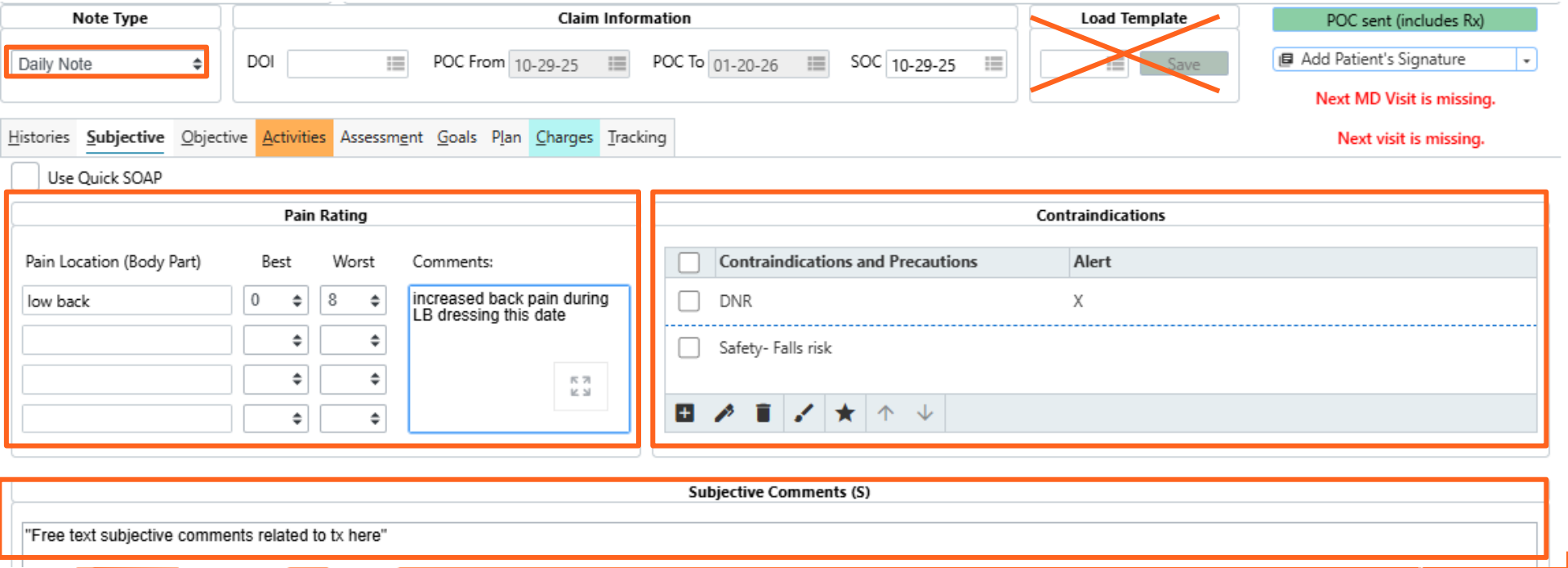
Launching a Note

- Schedule in FOX Trax- select the appropriate Reason for Visit (Visit)
  - Visit will display in RT Standard scheduler and **Provider View tab** under **Appointments**
  - Visits **MUST** be scheduled to start a note. RT Standard does not allow for notes to be created without an appointment.
- In **FOX Trax,** complete visit verification, ideally at the start of the session
- In **RT Standard**, right click the appointment and select **Check In**
  - The appointment will display in the "**Check In** " window
    - Double click or right click> edit to open the clinical note when ready to document.
  - In the event action is needed (due to patient forms being unsigned or previous notes not completed), prompts will display and then the appointment will display in the Check In window
    - See Consent Training for details on patient forms.
  - Read any additional prompts related to the patient so you are aware of any notices/alerts

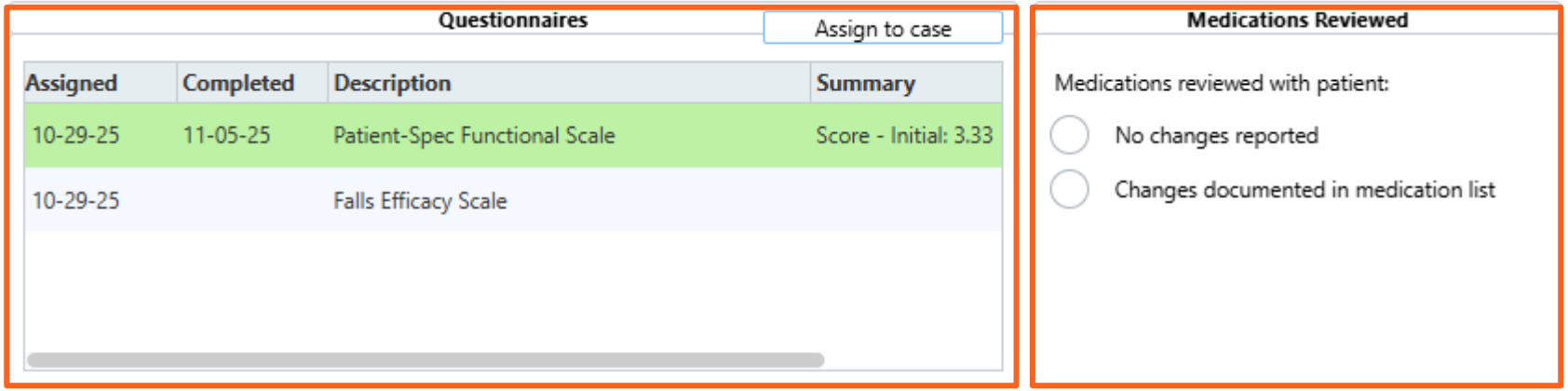


Subjective

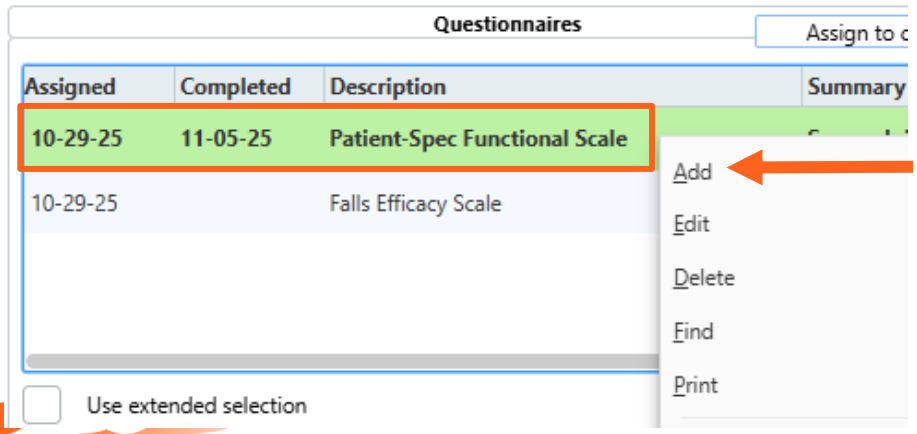
- Ensure the note type is a **Daily Note**
  - You can use the arrows ⇕ to change note-type if needed
    - Appointments scheduled as a telehealth visit will automatically select "Daily Note" type; Please be sure to change this as needed to reflect Telehealth Visit
  - **DO NOT** load a template for Daily Notes
- On **Subjective tab** you can document:
  - **Pain rating** – if applicable
  - **Subjective Comments** – Free text subjective comments to support tx encounter
  - **View Contraindications/Precautions** (and add/remove/update as needed)

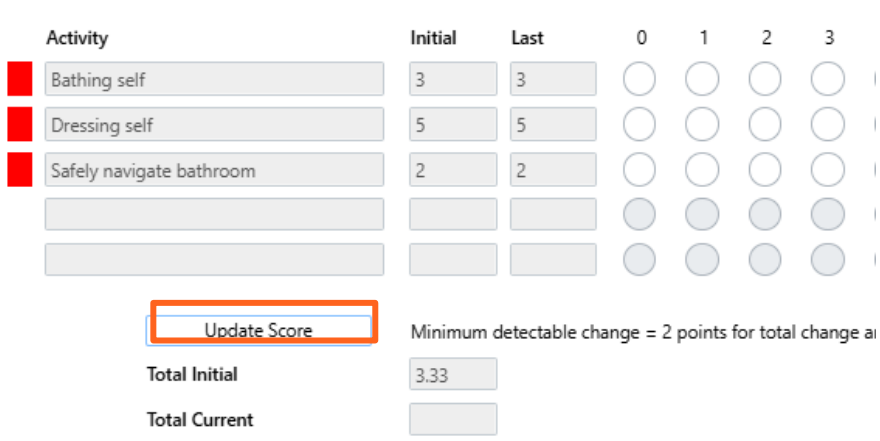


Subjective



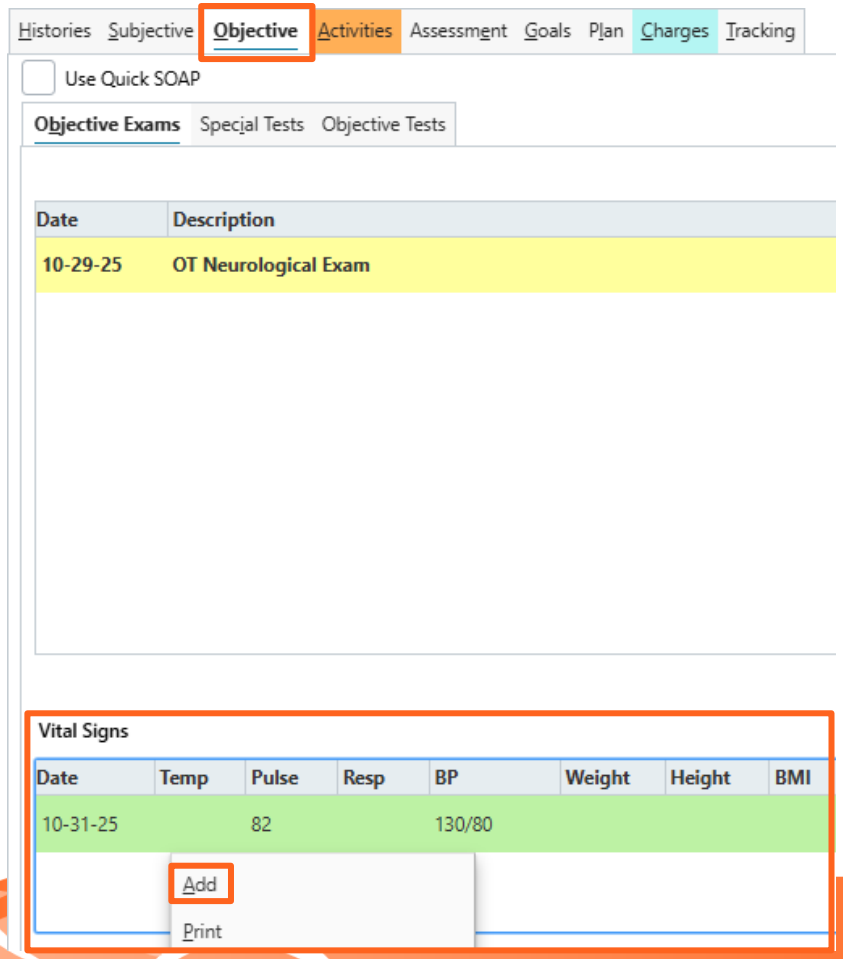
- On **Subjective tab** you can document:
  - **Questionnaires –** add or update any appropriate questionnaires from the visit
    - To update or add, right click on the item description > select **Add** > locate and select desired item
    - Click **Update Score** to make this form editable and update the current response
    - You could also add the Questionnaires within the Objective tab alongside the FOMs (this is clinician preference)
  - **Medications Reviewed –** make selection in Medications Reviewed panel, if appropriate

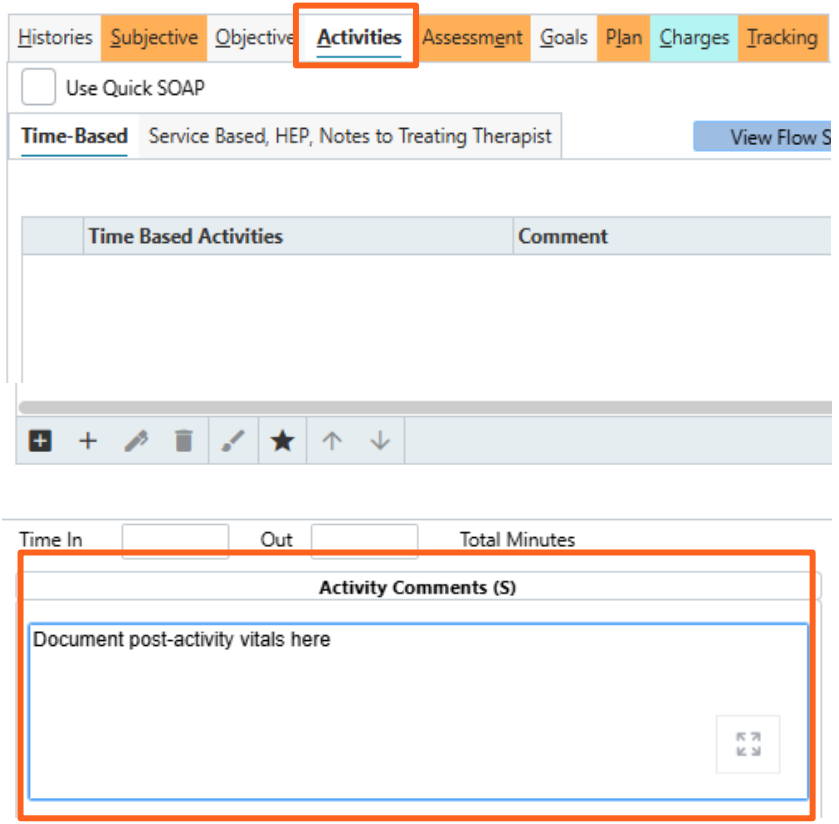




Objective – Vital Signs

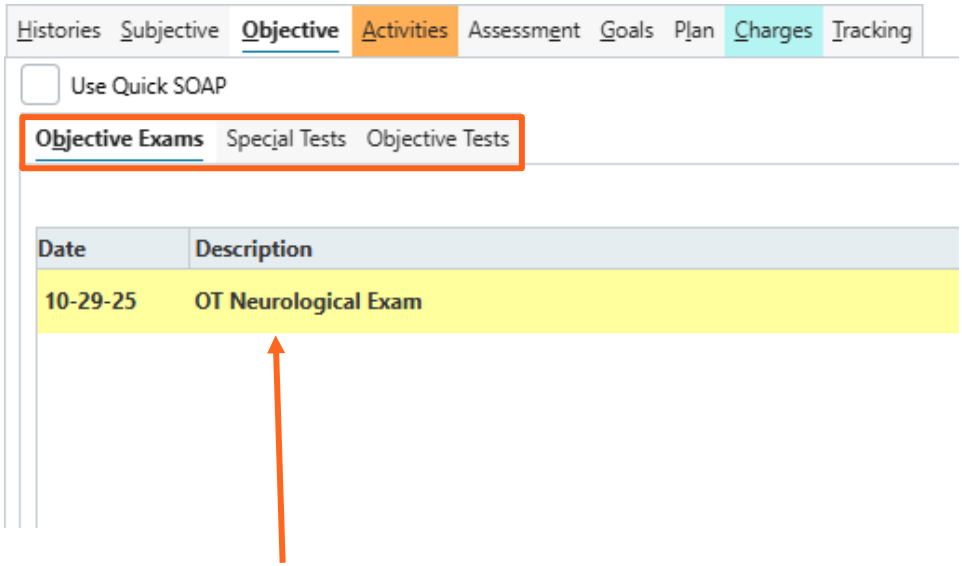
- **Baseline Vital Signs** can be documented on the Objective Tab, in Vital Signs panel
  - Right click in the panel, the select Add or click Add on the top function bar
  - Populate the vital signs and save the record
  - You can view a history of previous Vital Signs or Print from this table, too
- **Post-activity vital signs** can be recorded on Activities tab, in "Activity Comments"





Objective – Objective Exams, Tests

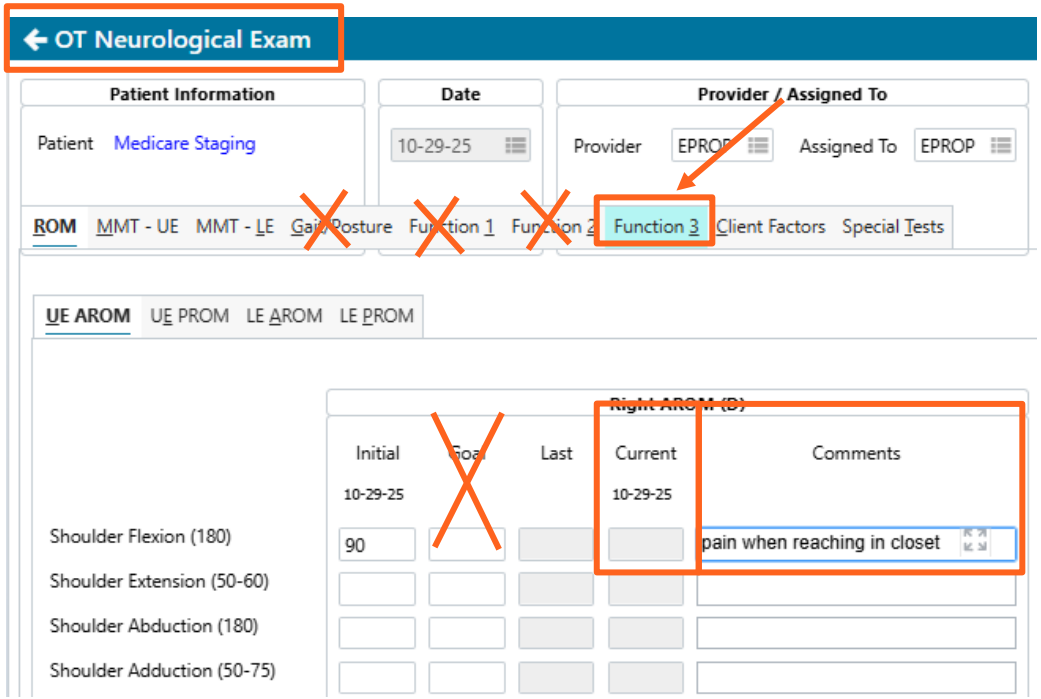
- You may review or update any Objective Exams or Tests on a treatment encounter, if needed (NOT required for treatment note workflow, but may need to review or update for PRs)

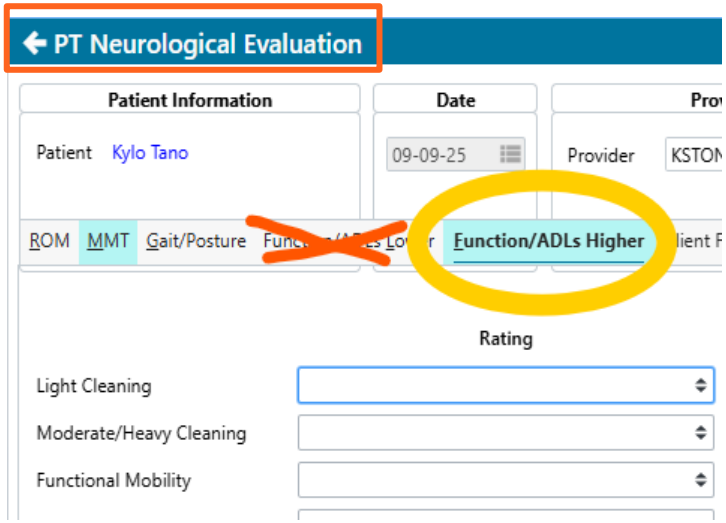


- The **OT/PT Neurological Exam** should be appropriate for the majority of patients; if a pt is referred for vestibular, wheelchair positioning, pelvic floor or lymphedema, you may notice other exams that have been used to document objective findings
- Right click the exam to open, review or document within the exam (see next slide for details)

Objective - Exams

- Navigate through the Exam to review or update relevant objective findings
  - You DO NOT need to complete everything – only what is relevant (Look and Listen)
  - "Initial" will show a read-only version of the Initial measurement from evaluation
  - You will update relevant objective findings by typing in the "Current" box and adding comments where appropriate
- Functional activities should be documented in the tab that is blue – "Function 3" tab for OT Neuro Exam; Function/ADL Higher tab for PT (ignore other function and gait/posture tabs)

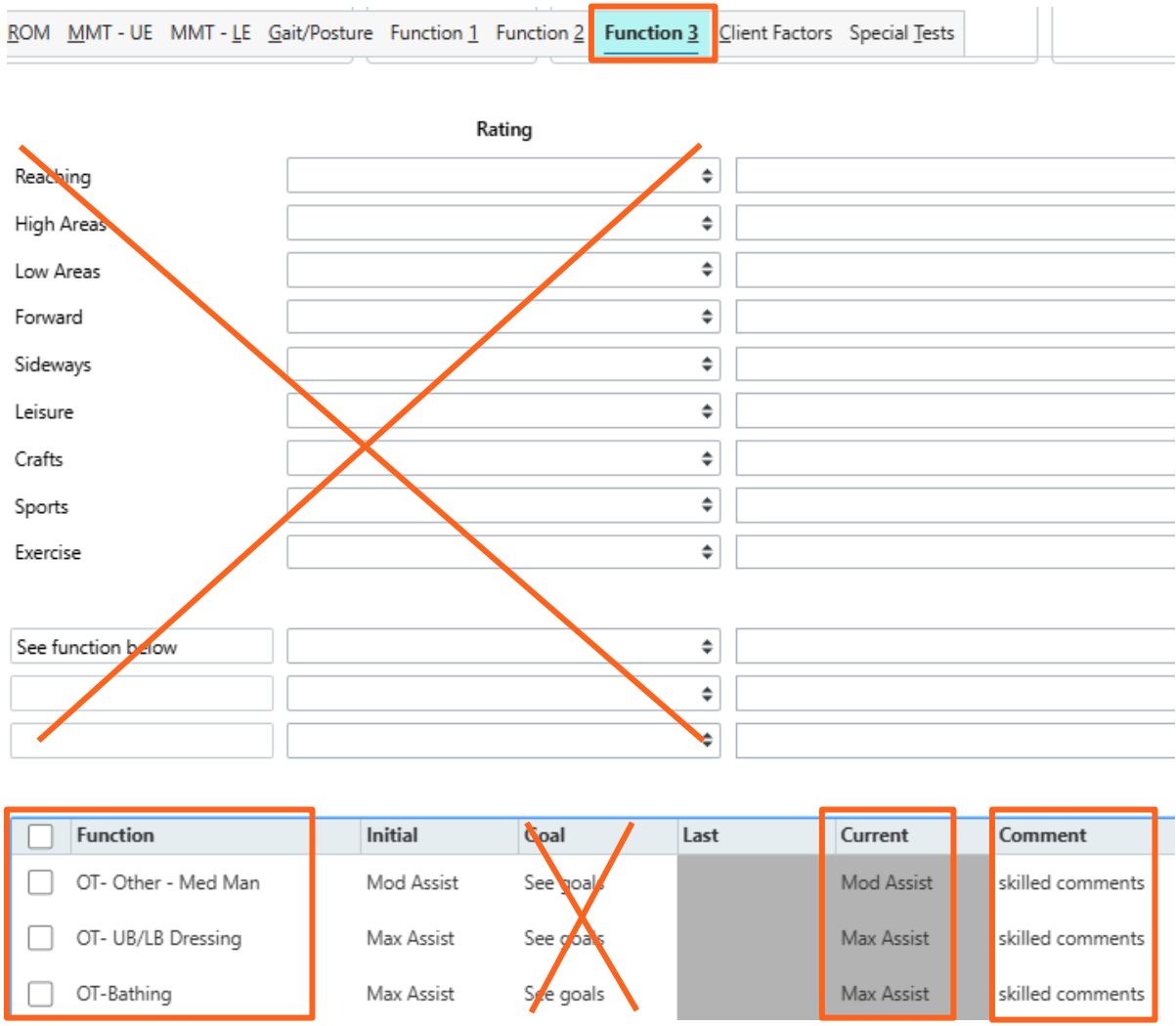




Objective - Exams

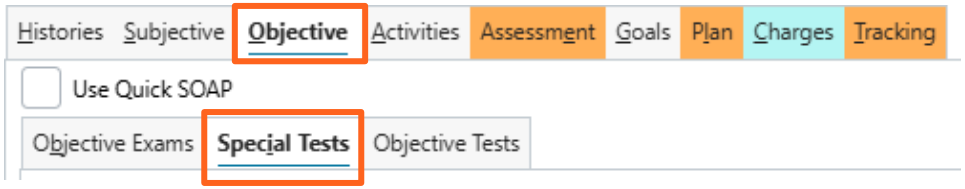
Functional Objective updates will be documented on the blue **Function Tab** ("Function 3" for OT; "Functional/ADL Higher" for PT)

- Click on the tab, scroll down to the **Function Table**
- Add items relevant to your pt's POC using +
  - Transfers, bed mobility, functional mobility, ADL, IADL, etc
- Update **Current** Objective Status for each item
- Add skilled comments in **Comment** box
  - AD used, cues required

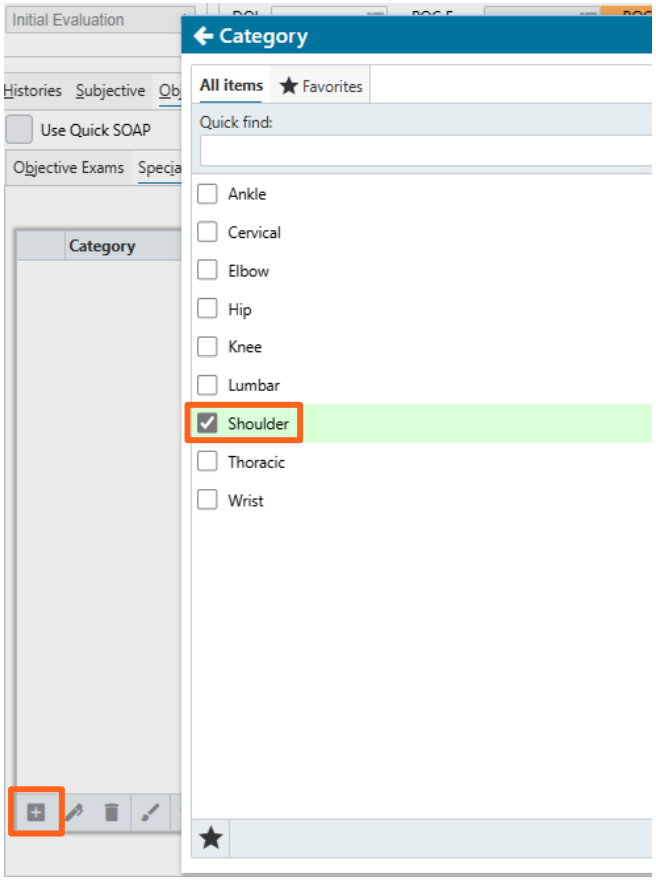


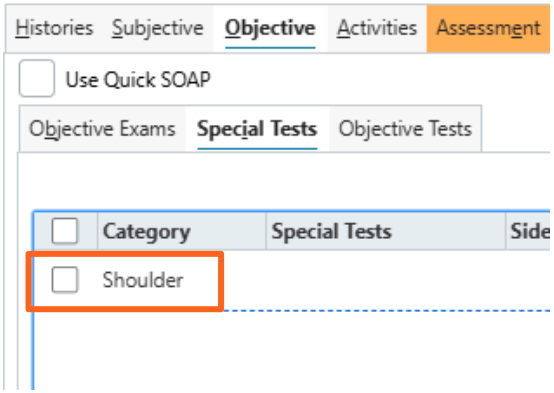
Objective – Special Tests

1. If you need to add or update a Special Test after collaboration with supervisor, navigate to **Special Tests** Tab



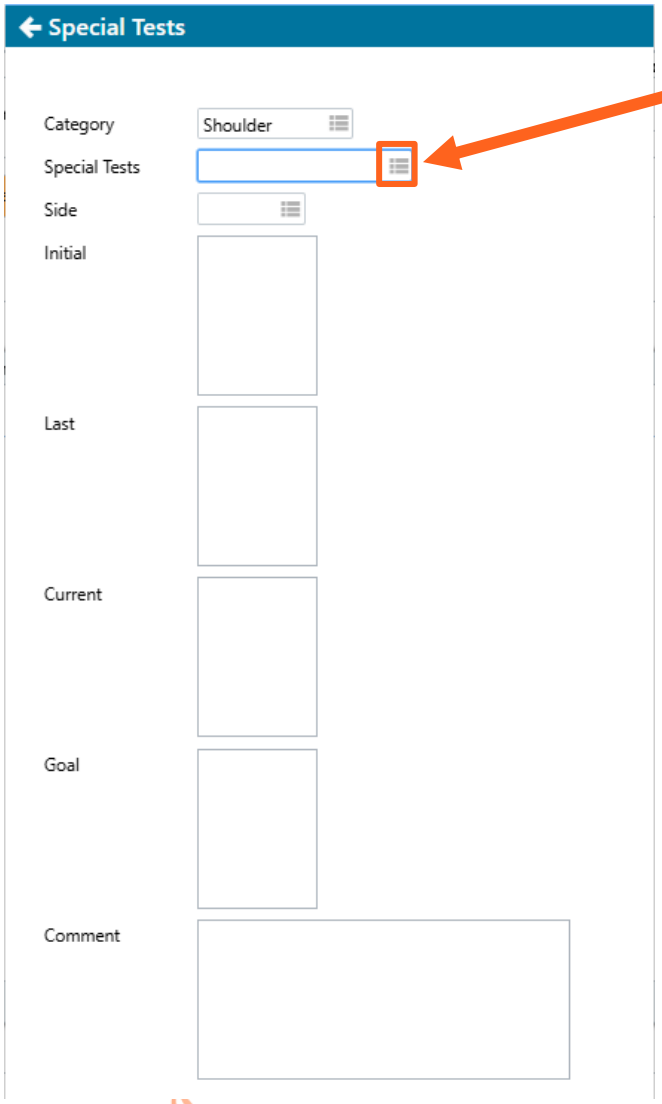
2. To add special test, click in Category column, click + and **select category** from picklist, **save**





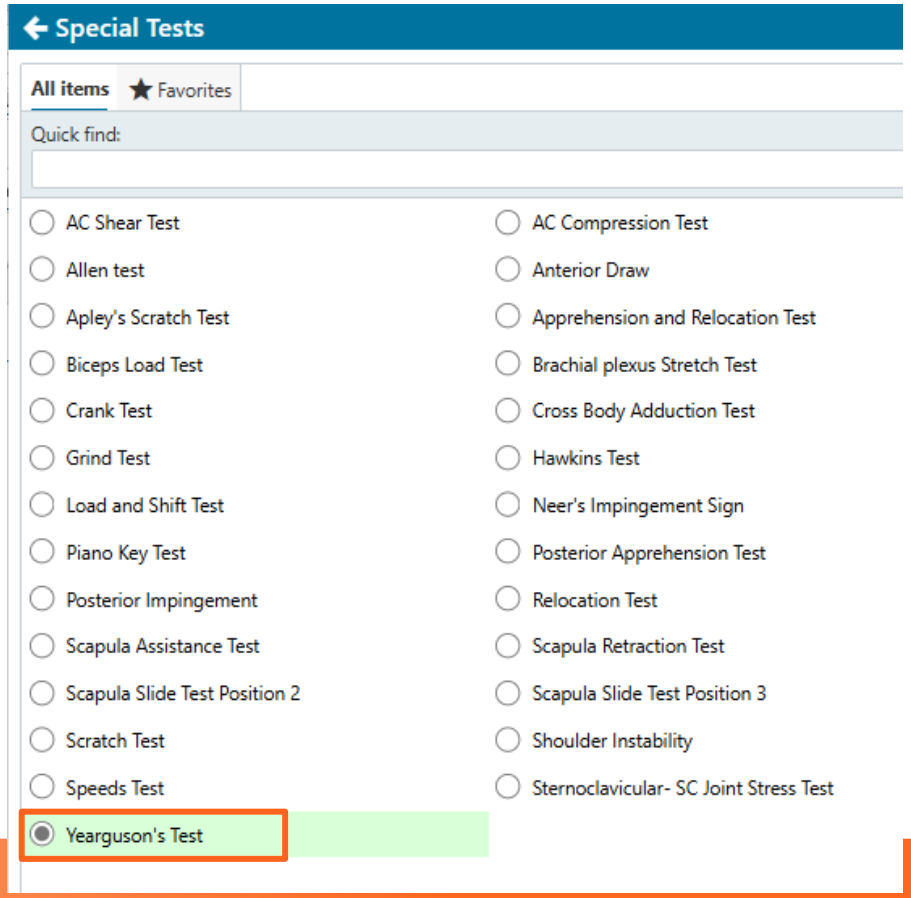
3. Double click the category name to open and select from relevant special tests

Objective – Special Tests (continued)



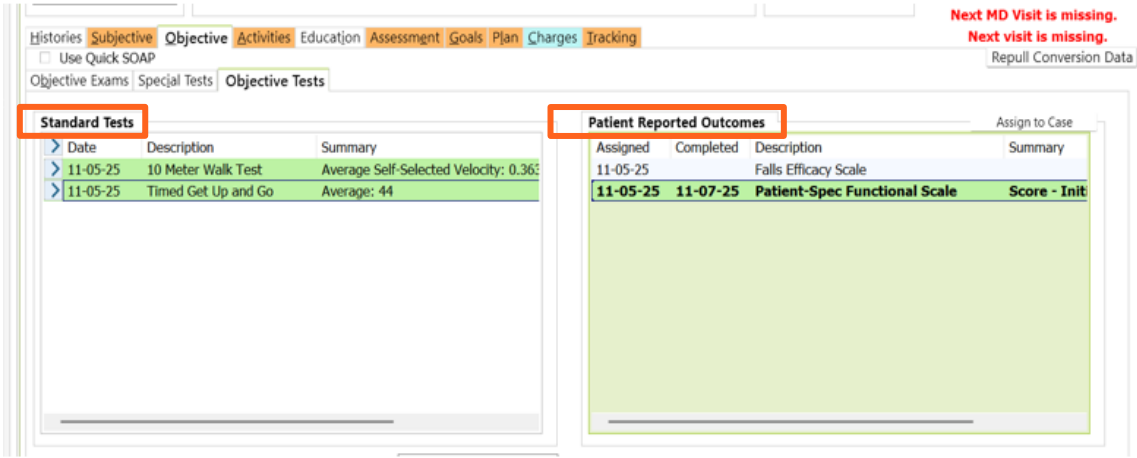
4. Select **menu icon** of Special Tests box to open and select appropriate test, click save

5. Fill out relevant details from the test (side, initial result, comment); click OK



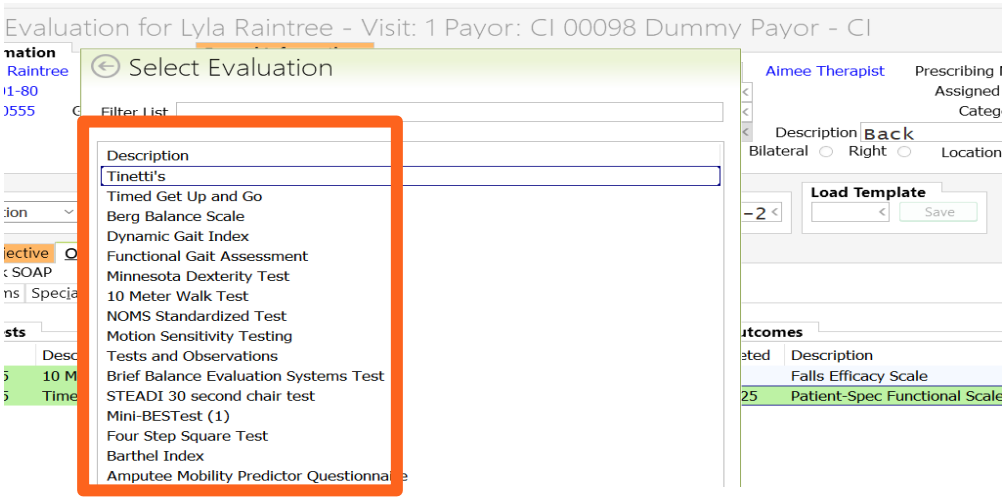
Objective – Objective Tests

- Select **Objective Tests** tab
  - Standard Test= FOMs/Standardized Tests
  - Patient Reported Outcomes= Questionnaires (the same ones that are available on the subjective tab)



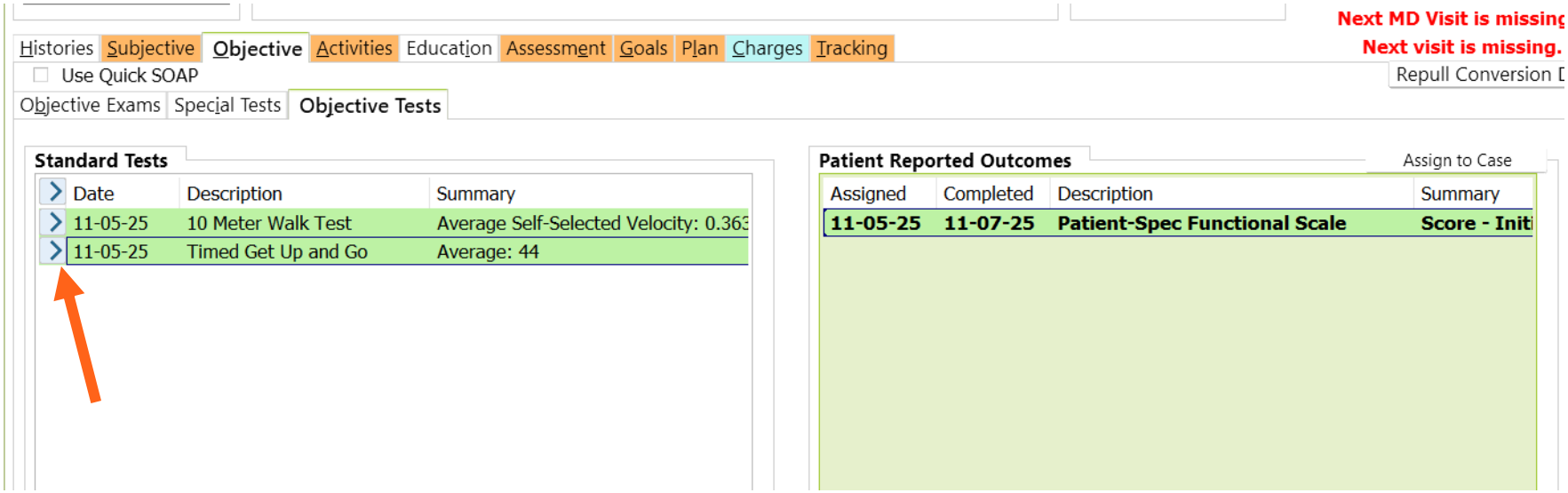
- Right click in either section and click Add to open list of available Objective Tests/Questionnaires; select test you would like to complete

- Fill out the appropriate information related to the test, and then click save



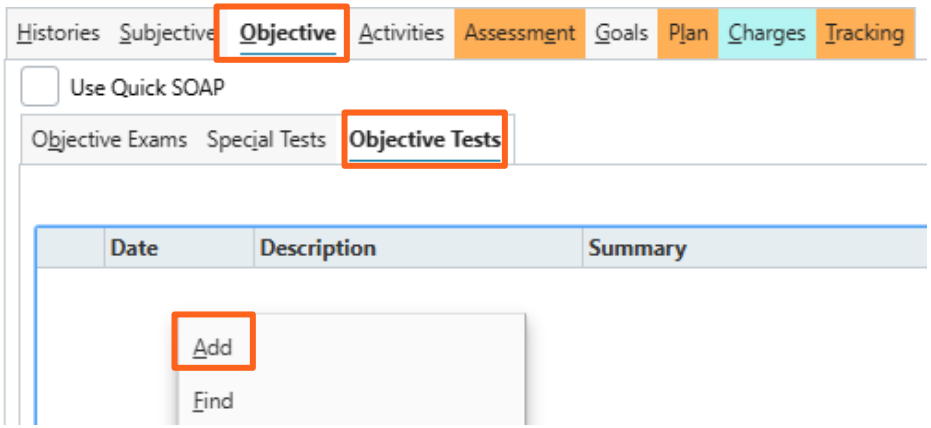
Objective – Objective Tests

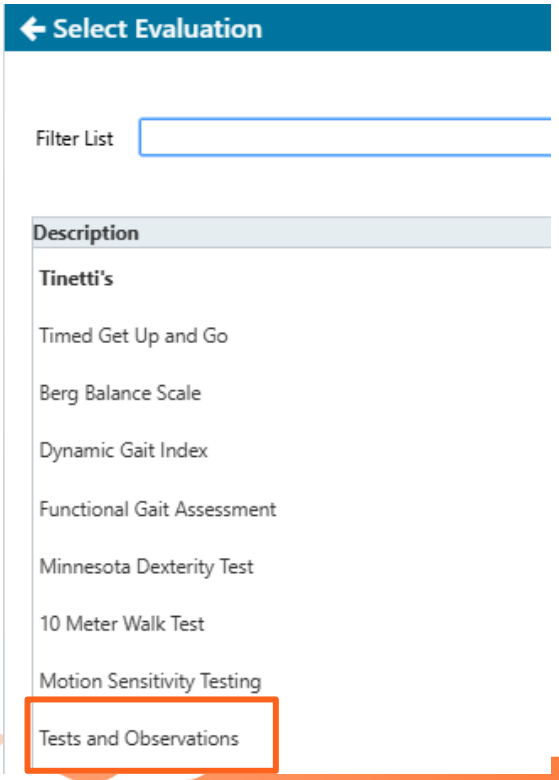
- In the Objective Tests tab, ensure the test you completed is Green and has a check mark next to it so it will populate in the narrative



Objective – Objective Tests

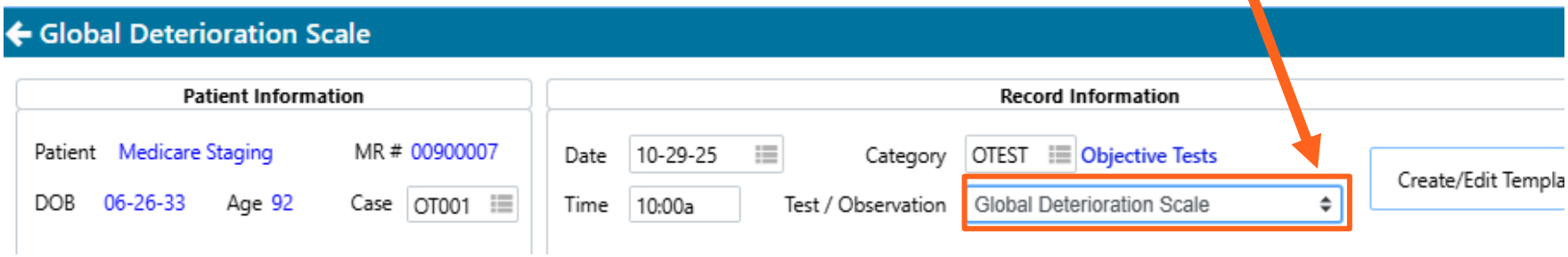
- You can find more Tests in the "Test/Observations" item
- Right click into panel and select Add
- Click into "**Tests/Observations**" from the list to find more Tests





Objective – Objective Tests

- When the **Test/Observation** box opens, use the **drop down arrows** to view and select the test you would like to complete
- Complete the test, and then save at the top right of your screen

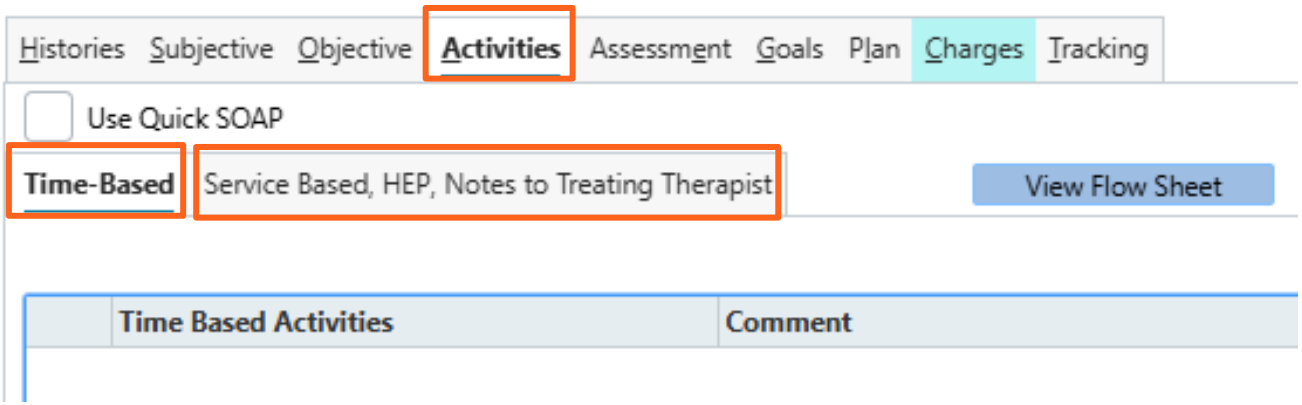


Activities

All **billable treatment interventions** are documented on the **Activities** Tab

REMINDER: you will only be able to bill **CPT code items** (marked with *asterisks*) that were included in the Planned Services (Plan Tab) of Eval

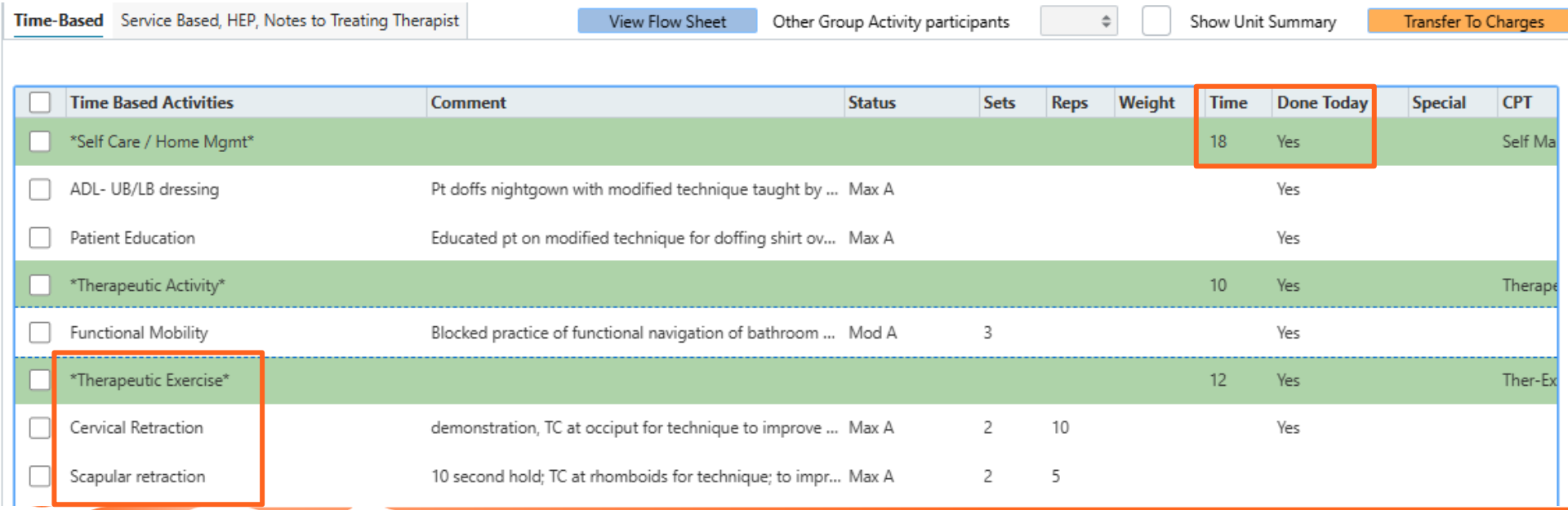
- *If you need to add planned services, speak with your supervisor for them to complete a Progress Report*



You will enter time-based interventions on the "**Time-Based**" tab and service-based interventions on the "**Service Based/HEP/Notes**" tab

Activities – Time Based

- **Green items** with *asterisks* are tied to CPT codes and will pull to charges tab
  - You must enter time for each CPT code item and indicate "Done Today"
  - **DO NOT DOCUMENT ANY COMMENTS OR SKILLED CARE IN THE GREEN ITEMS**
- Document skilled intervention supporting each CPT code **under** the relevant Green CPT line item (NOT IN THE GREEN LINE ITEM)
  - Click the CPT code you are going to add intervention for, then use + to add appropriate items from the picklist (ex: "*Therapeutic Exercise* > Cervical Retraction and Scapular Retraction)
- **IMPORTANT!!** Do NOT click the top/title of each column to sort
  - This will cause the items to sort and interventions will not be under the appropriate CPT code

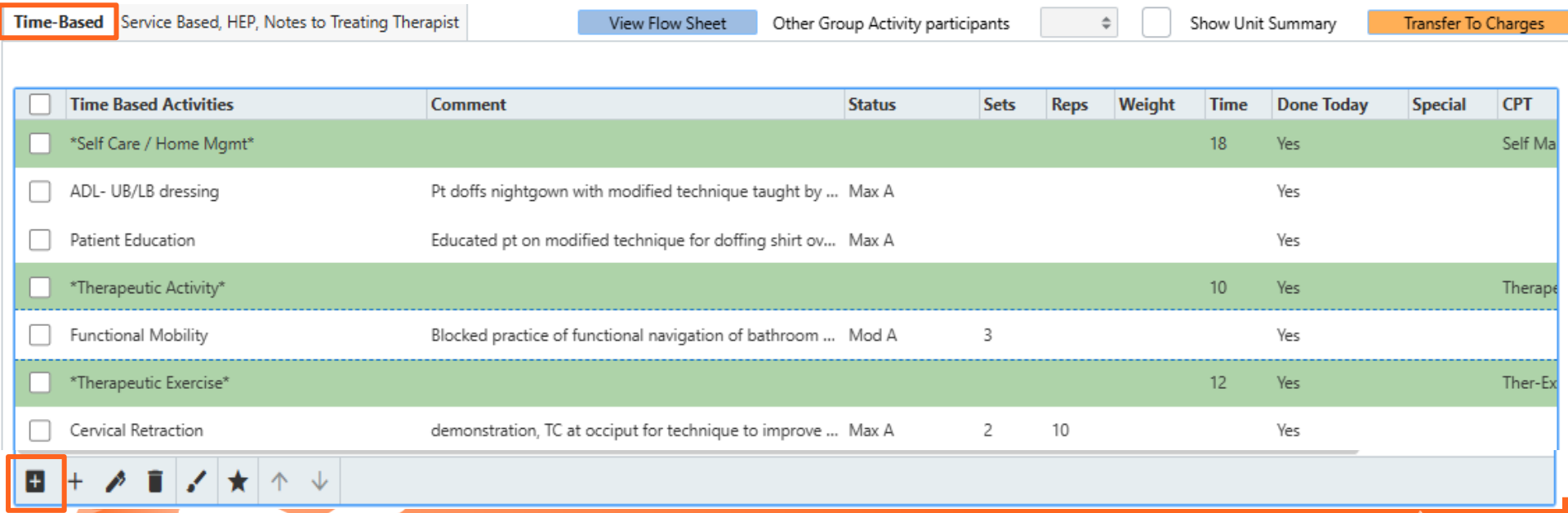


Time Based Activities	Comment	Status	Sets	Reps	Weight	Time	Done Today	Special	CPT
Self Care / Home Mgmt						18	Yes		Self Ma
ADL- UB/LB dressing	Pt doffs nightgown with modified technique taught by ...	Max A					Yes		
Patient Education	Educated pt on modified technique for doffing shirt ov...	Max A					Yes		
Therapeutic Activity						10	Yes		Therape
Functional Mobility	Blocked practice of functional navigation of bathroom ...	Mod A	3				Yes		
Therapeutic Exercise						12	Yes		Ther-Ex
Cervical Retraction	demonstration, TC at occiput for technique to improve ...	Max A	2	10			Yes		
Scapular retraction	10 second hold; TC at rhomboids for technique; to impr...	Max A	2	5					

Activities – Time Based

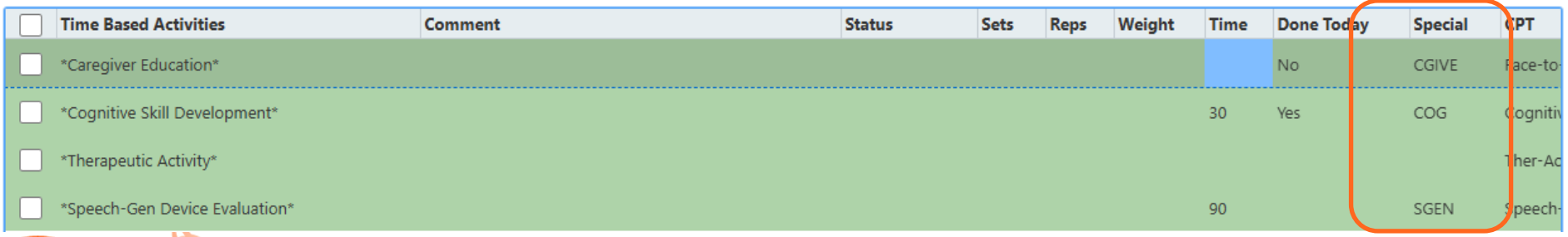
To add items to the Time-Based Activity grid:

- Use the + to open and search picklist
  - Use **Quick Find** to search for specific activities (this list is long; **favorites** will be helpful)
- You can check off multiple items, then Save
- Update status (assist), sets, reps, weight as applicable. You can also customize name of activity or create your own.
- Time should only be added to Green CPT code items (these are tied to billing)
- Select Done Today - if not the charges will not transfer
  - You can have activities that in the log that are not done every visit to save time documenting in future visits



Activities – Time Based (Special Codes)

- Special Codes
  - A few codes listed in the Time Based Activities picklists are considered "special codes"
    - These are CPT codes that have time threshold that must be met prior to opening access to the second / add on CPT code
      - 97129 / 97130 Cognitive Skills Development (SLP)
      - 97550 / 97551 Caregiver Education
      - 92607 / 92608 Speech Generating Device Eval (SLP)
    - You only need to add one CPT code line item within the Time Based Activity grid
      - Raintree will calculate the correct distribution of time within each code set listed above.
      - Example – 30 minutes entered for "Cognitive Skills Development"
        - 15 minutes will be applied to 97129 and 15 minutes will be applied to 97130 for 2 Total units

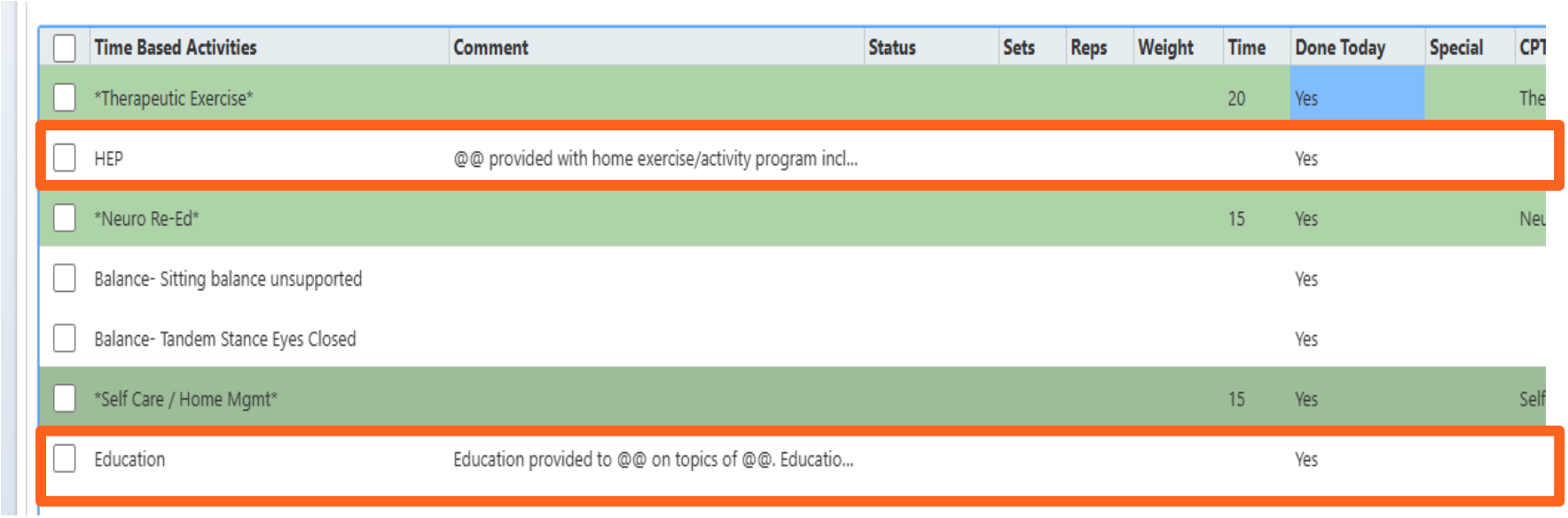


	Time Based Activities	Comment	Status	Sets	Reps	Weight	Time	Done Today	Special	CPT
☐	*Caregiver Education*							No	CGIVE	Face-to-
☐	*Cognitive Skill Development*						30	Yes	COG	Cognitiv
☐	*Therapeutic Activity*									Ther-Ac
☐	*Speech-Gen Device Evaluation*						90		SGEN	Speech-

Activities – Education

Education should be documented early and often throughout the plan of care

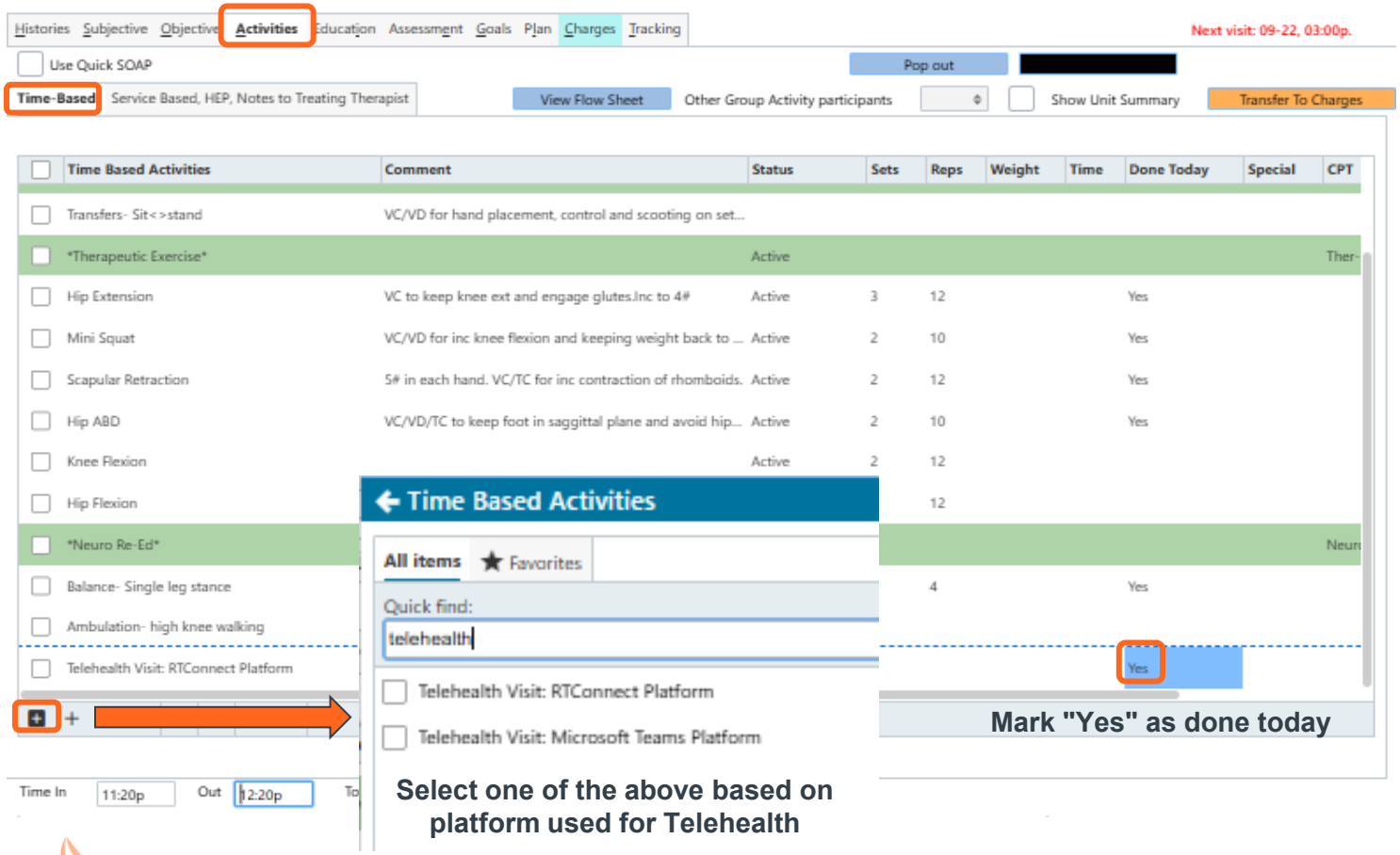
- Add Education as an item under the relevant CPT code in the Time-Based Activity log; there are @@ within this item to prompt you on what details to document.
- Add in HEP in this section to add more details and tie into the correct CPT code
  - You can use MedBridge HEP link (on Service Based, HEP, Notes to Treating Therapist tab) to create HEP document that is sharable with patient. Details of HEP can be copied/pasted into the HEP line item in Time-Based Activities grid



Time Based Activities	Comment	Status	Sets	Reps	Weight	Time	Done Today	Special	CPT
Therapeutic Exercise						20	Yes		The
HEP	@@ provided with home exercise/activity program incl...						Yes		
Neuro Re-Ed						15	Yes		Neu
Balance- Sitting balance unsupported							Yes		
Balance- Tandem Stance Eyes Closed							Yes		
Self Care / Home Mgmt						15	Yes		Self
Education	Education provided to @@ on topics of @@. Educatio...						Yes		

Activities - Telehealth Documentation

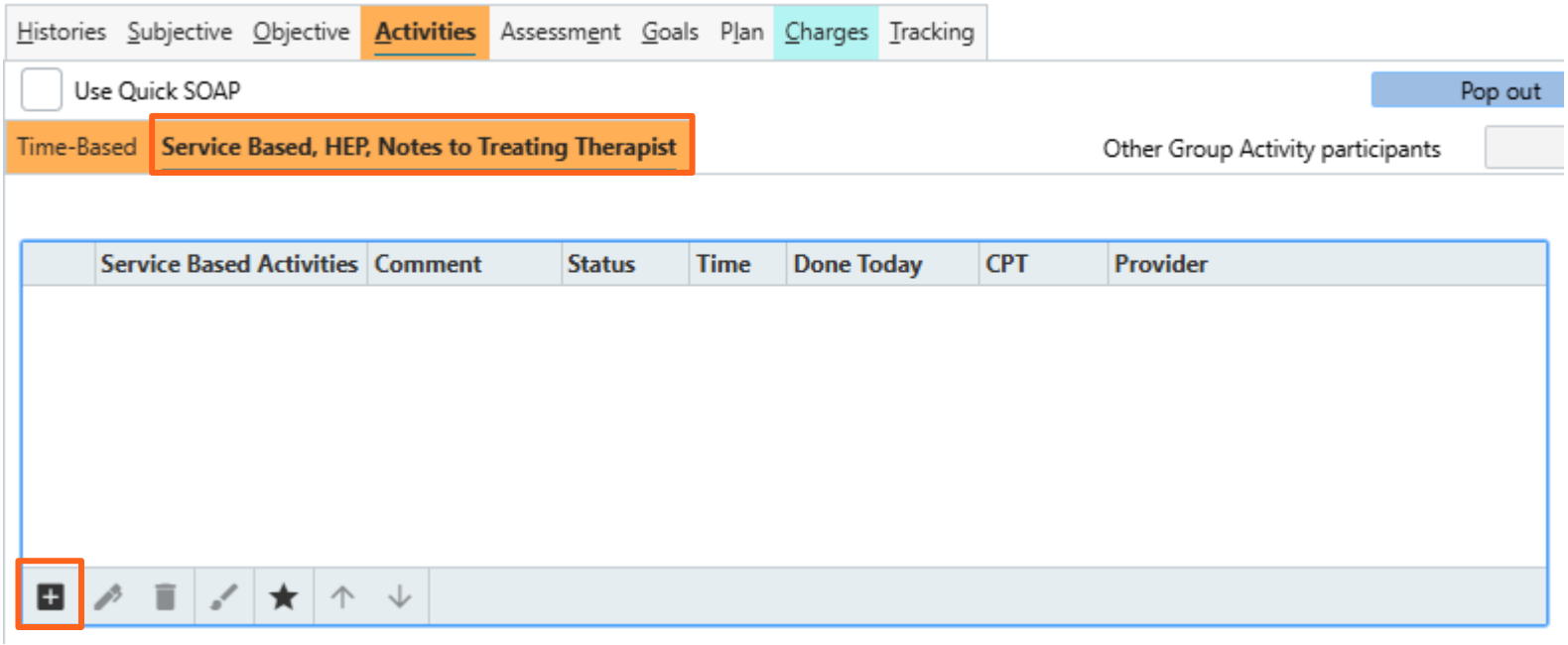
- If performing a telehealth visit, you MUST Select "Telehealth Visit" item from picklist and mark as "Done Today" within "Time Based Activities" picklist
  - This ensures documentation of platform used



Activities – Service Based

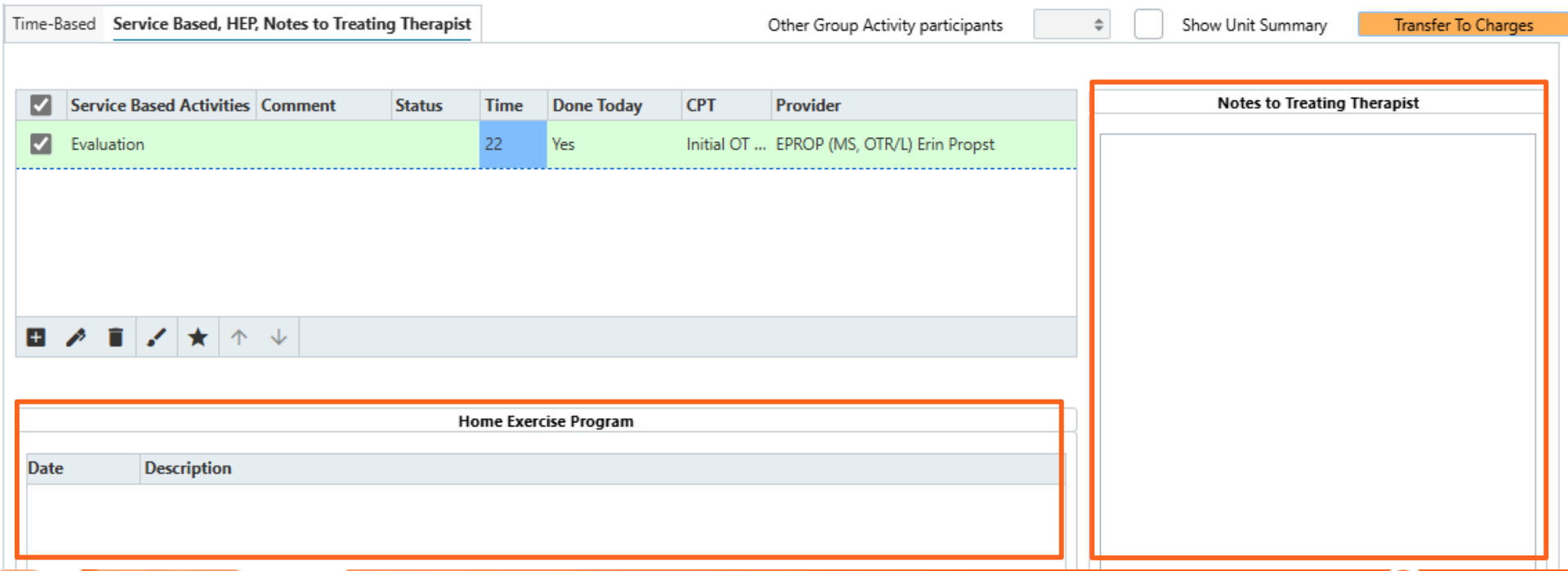
Any service-based billing (CPT) interventions are added on Service Based tab

- The picklist here functions the same as on the Time-Based tab *(exception: CPT items on Service-Based grid are not green unless the check box is selected)*
- Click + and search/find the service-based activity in the picklist > Save
- Update comment, status, time, indicate done today



Activities – HEP, Notes to Treating Therapist

- **Home Exercise Programs** can be added/uploaded in the Home Exercise Program box by right clicking > Add
  - Medbrige HEP function similar to RT Custom. See training for details
    - CI has access to HEP training and will show student if appropriate
  - It is still important to document HEP education on Time-Based activity grid to add details about who was educated, level of assist and returned level of understanding.
- **Notes to Treating Therapist** can be used to communicate to other therapists – KEEP IN MIND THESE DO NOT END UP IN THE NARRATIVE



Activities – Time In and Out

Time In and Time Out is required to sign off on notes in RT Standard

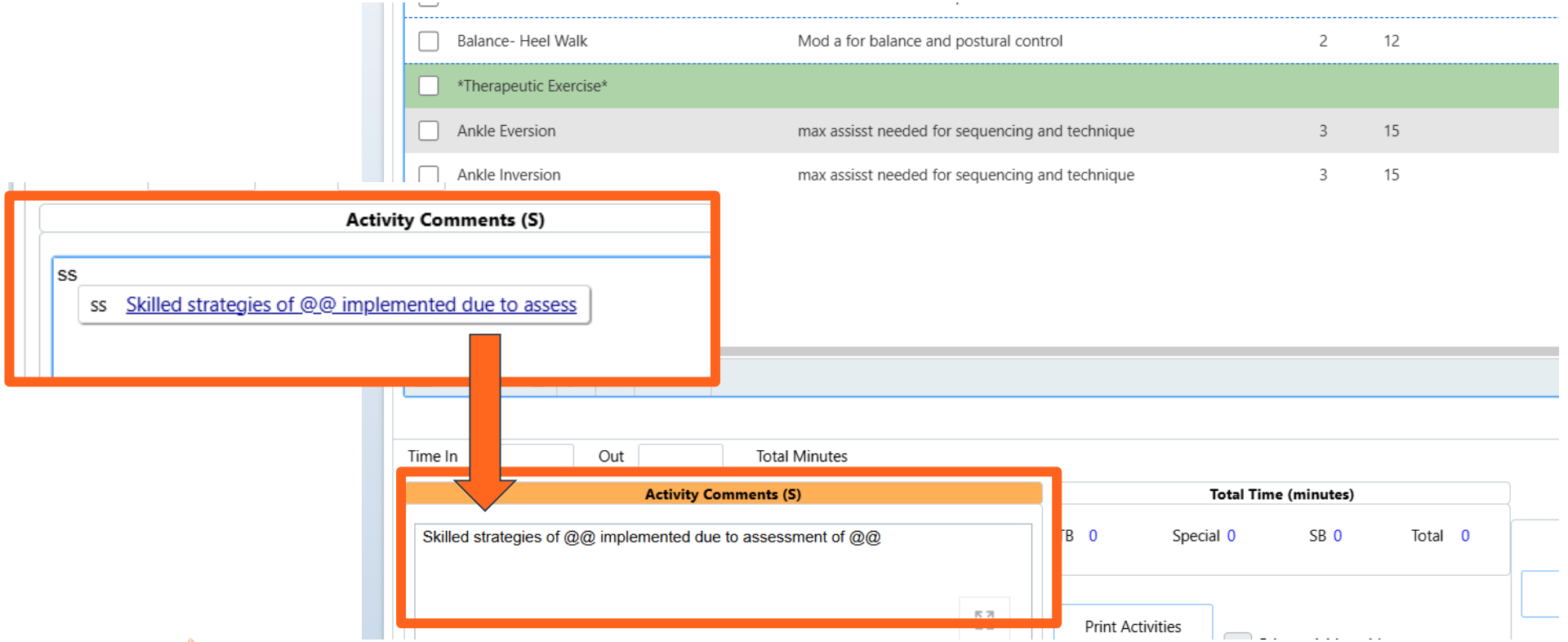
- Time In and Time Out will be entered on the Activities tab, under Activities log
  - Time should be entered in (hh:mm a/p)
    - **a** indicates AM and **p** indicates PM
  - Raintree will allow underbilling (billing for less than total minutes), but not overbilling (billing for more time than total minutes)
  - If you split a session (multiple time in/out), enter the first IN time and last OUT time, then specify additional time IN/OUT in the Activity Comments box
    - Supervisors should also be specifying time of a shared visit in the Activity Comments box



You can also use the Activity Comments box to document **Post Activity Vitals**

Activities – Skilled Strategy Statement

- In the activity comments box, you can document the skilled strategy that was provided this session
- You can type "ss" + space in the Activity Comments box to load the prompts for the skilled strategy statement that includes jump markers
- Skilled components may also be documented in the "Comment" section of each activity (white line items)

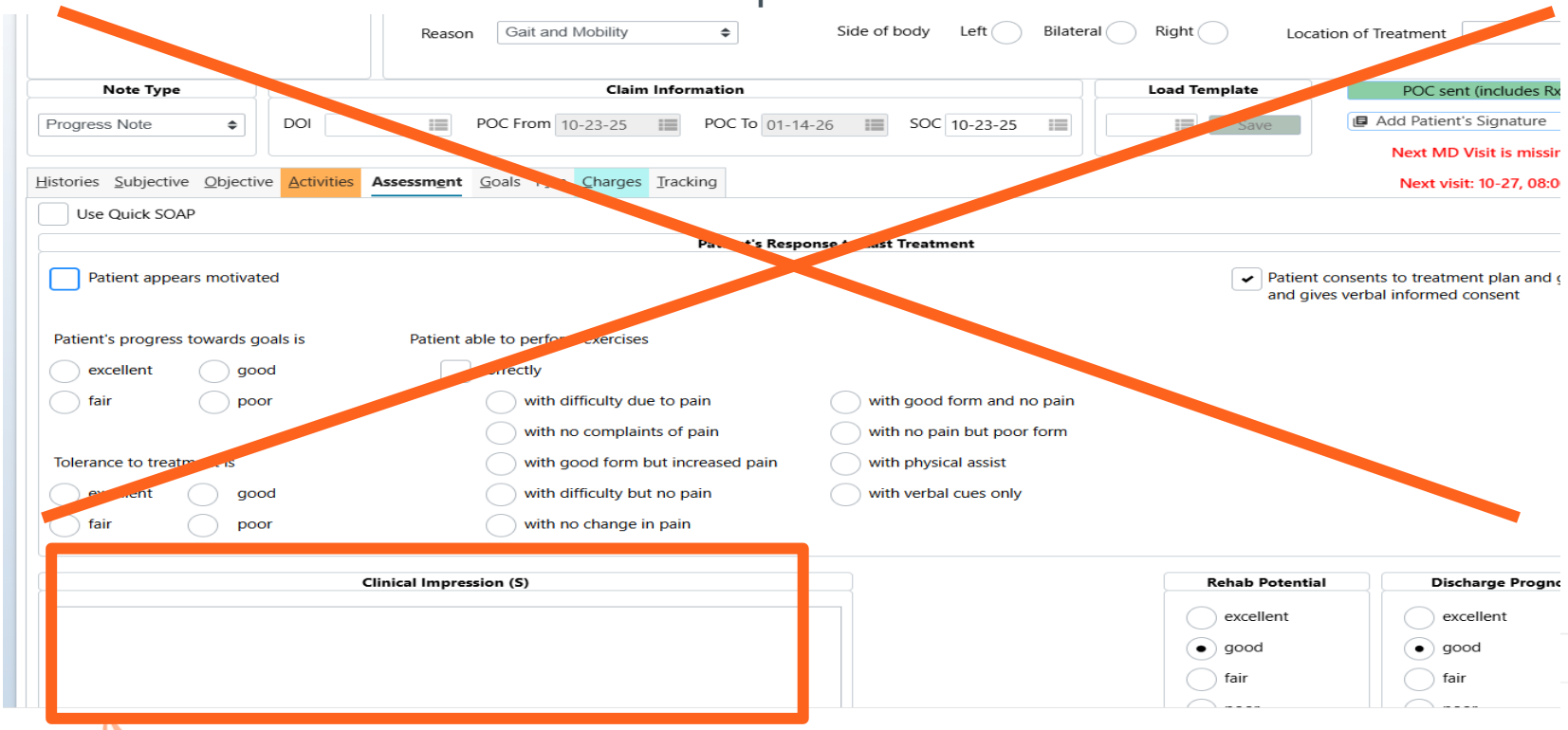


Assessment

The daily clinical impression should be documented in the **Activities comments within the Time based activity... see previous slide**

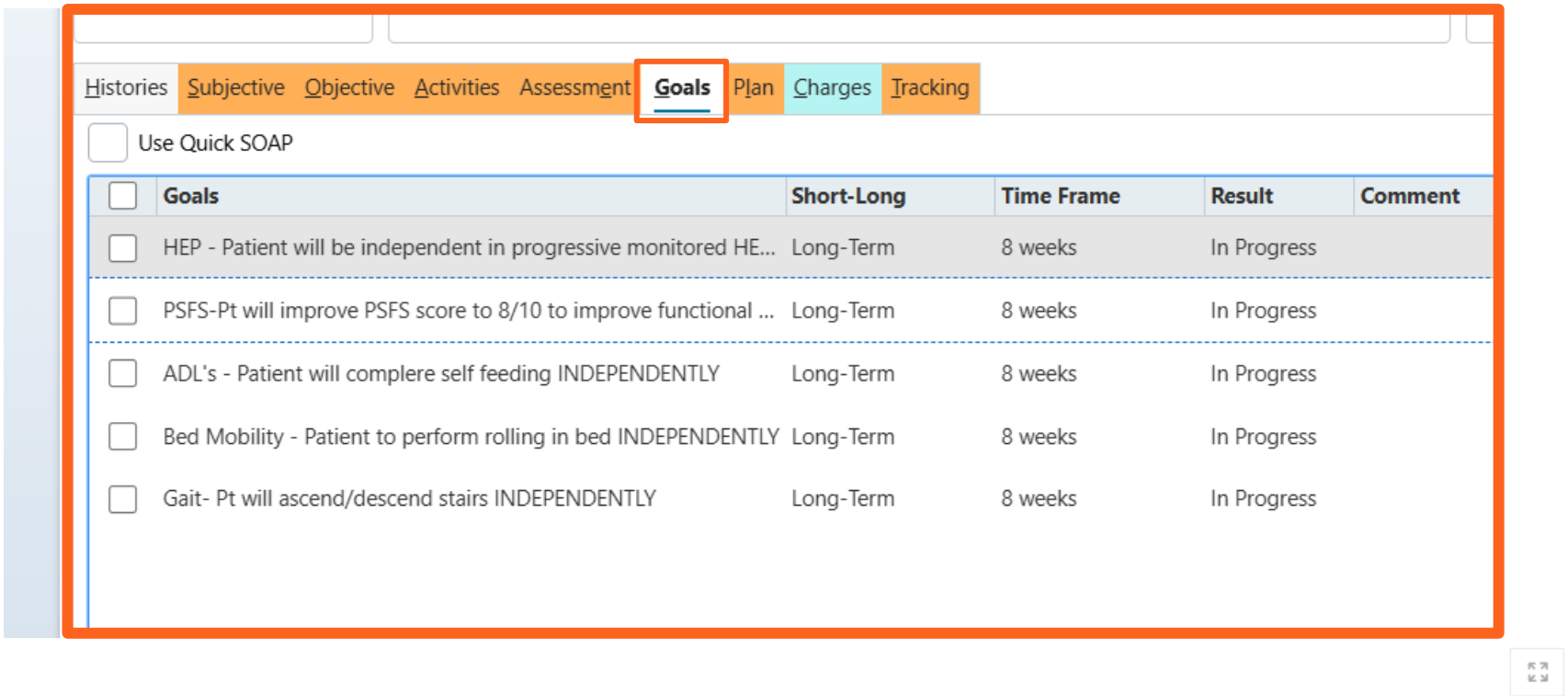
- If you documented skilled strategies within the activity comments, it is not necessary to document anything within this tab

- If you want to document details beyond a skilled strategy statement, this can be documented below under clinical impression



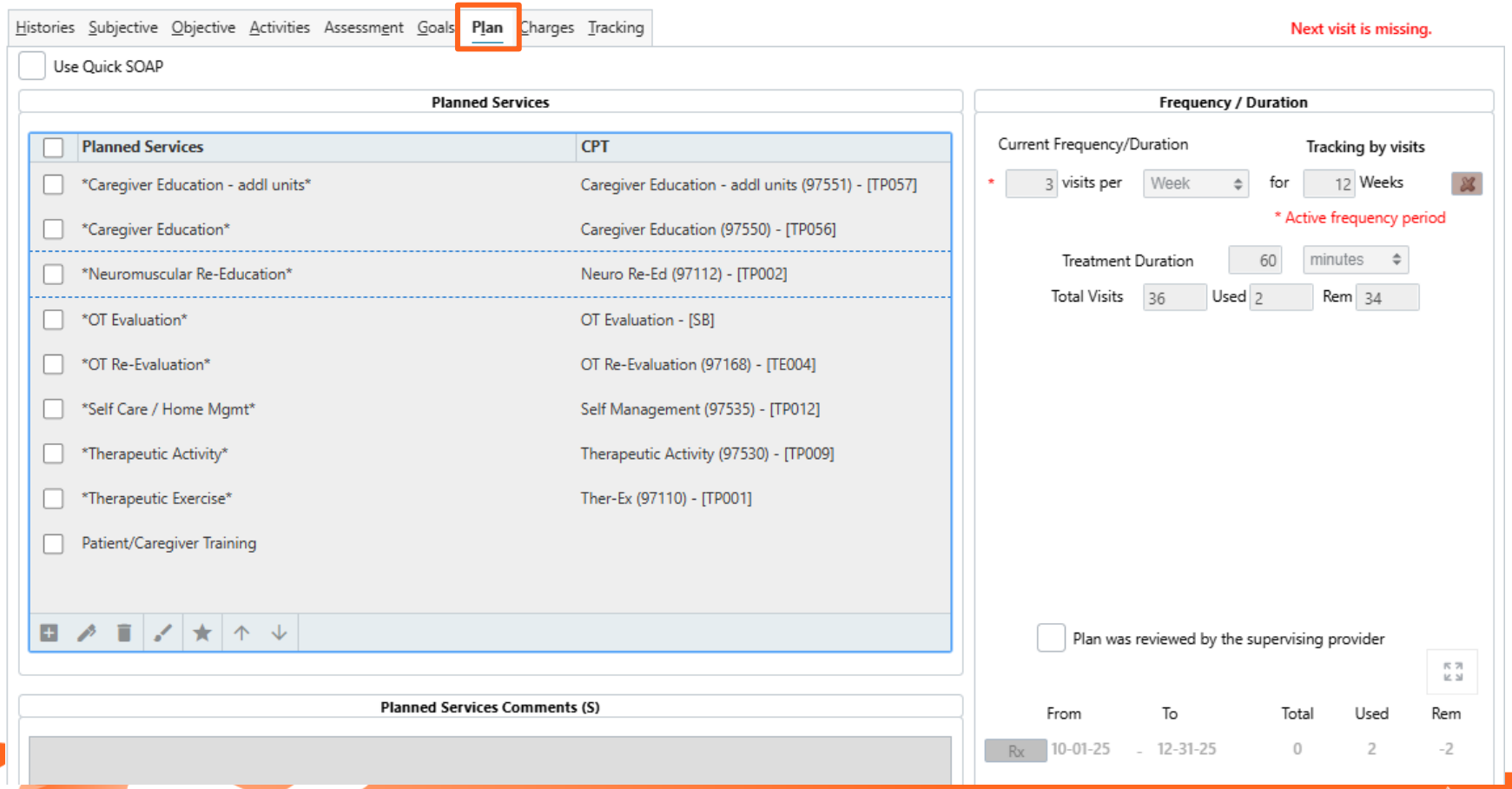
Goals

- **Goals will be read only on a Daily Note**, but you can review them on Goals tab (helpful for visit coverage, assistant workflow)
- If you believe **a goal should be added**, speak to your supervisor to complete a **progress report** to add the goal



Plan

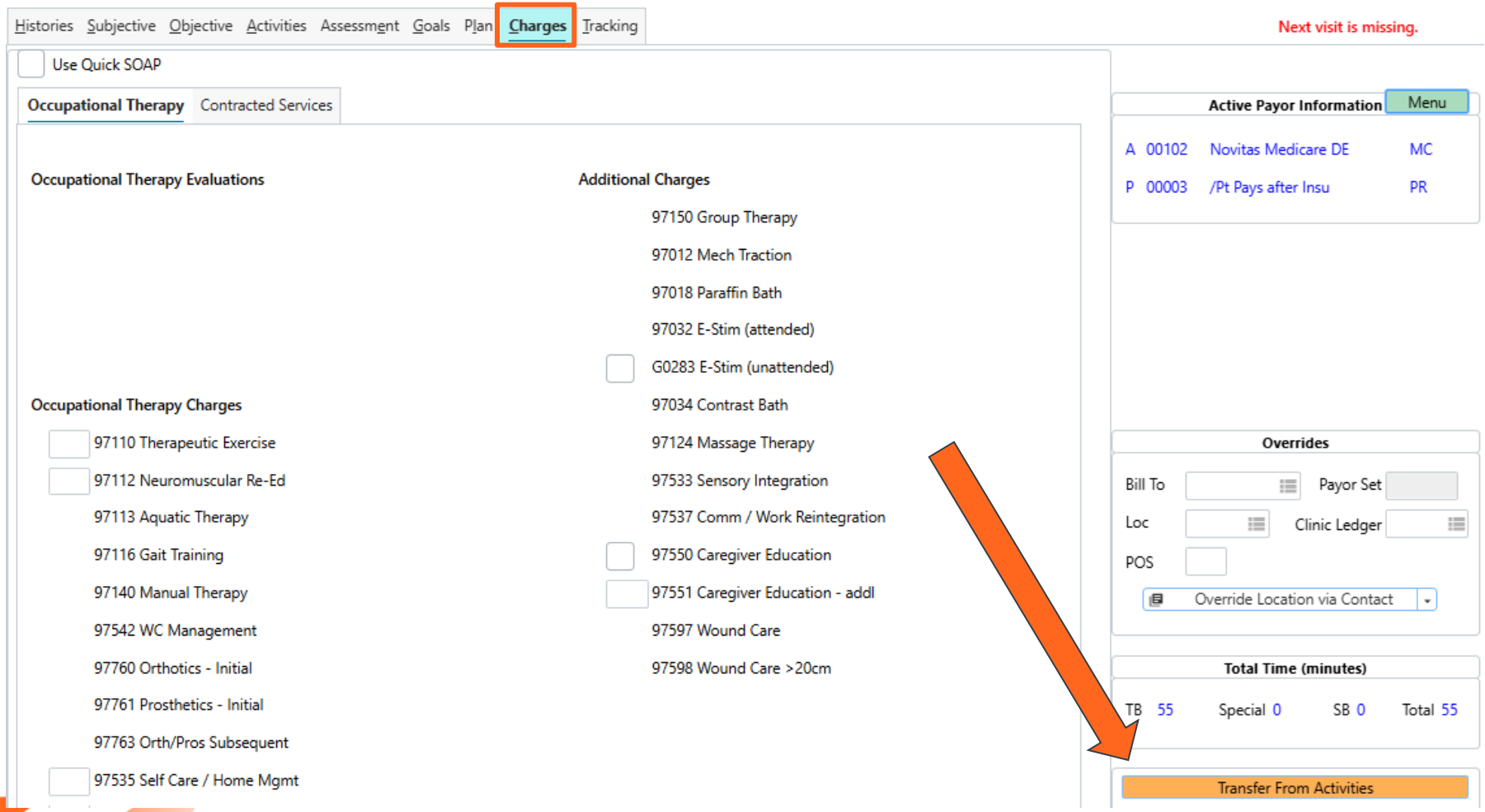
- **Plan will be read only on a Daily Note**, but you can review the planned services and Frequency/Duration on the Plan tab (helpful for visit coverage, assistant workflow)
- If you believe **planned services** should be added or **treatment frequency** should be adjusted, speak to your supervisor to complete a **progress report.**



Charges

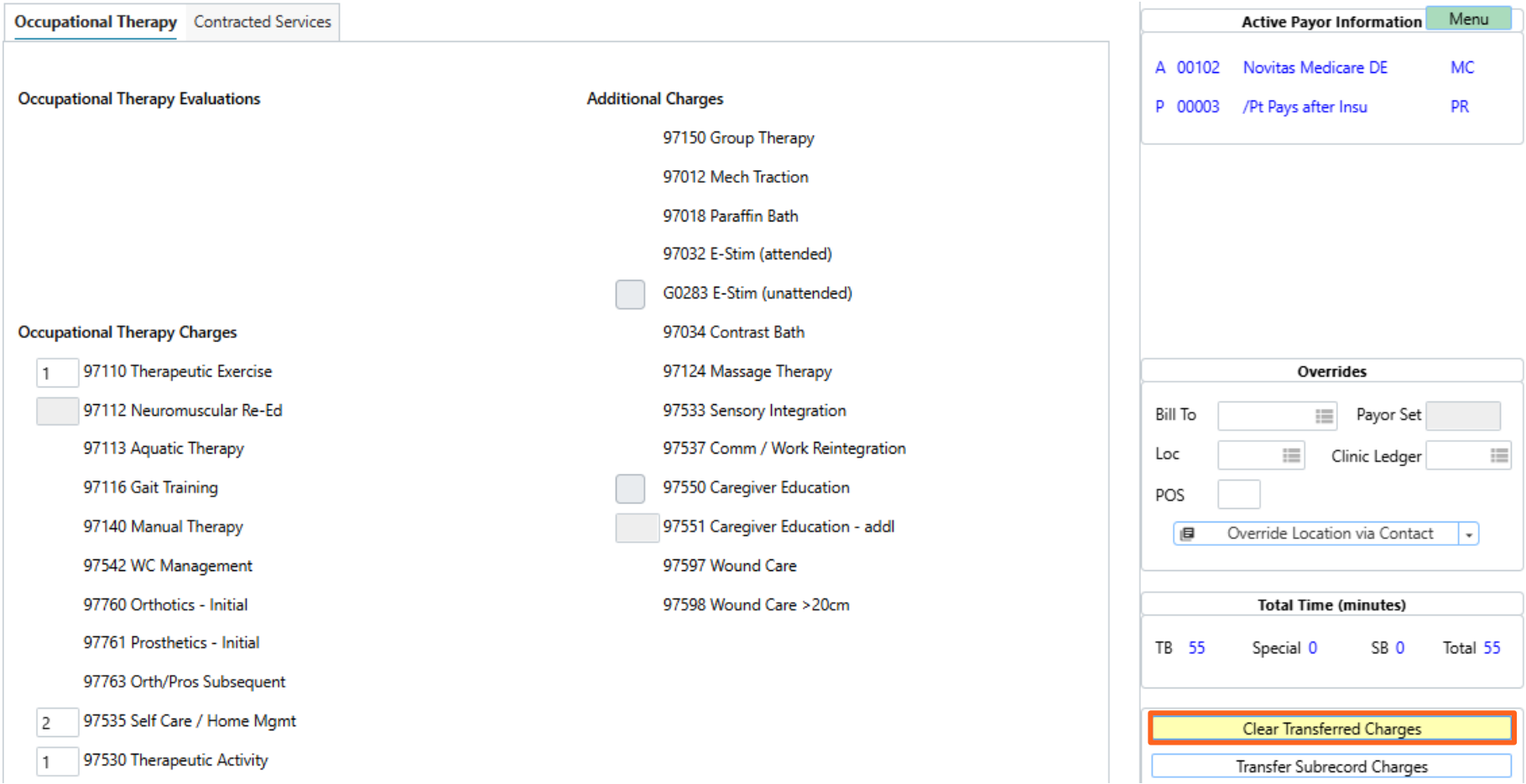
Once Eval is complete and all activities are documented, click **Charges** tab

- Click **Transfer from Activities** button to pull charges over



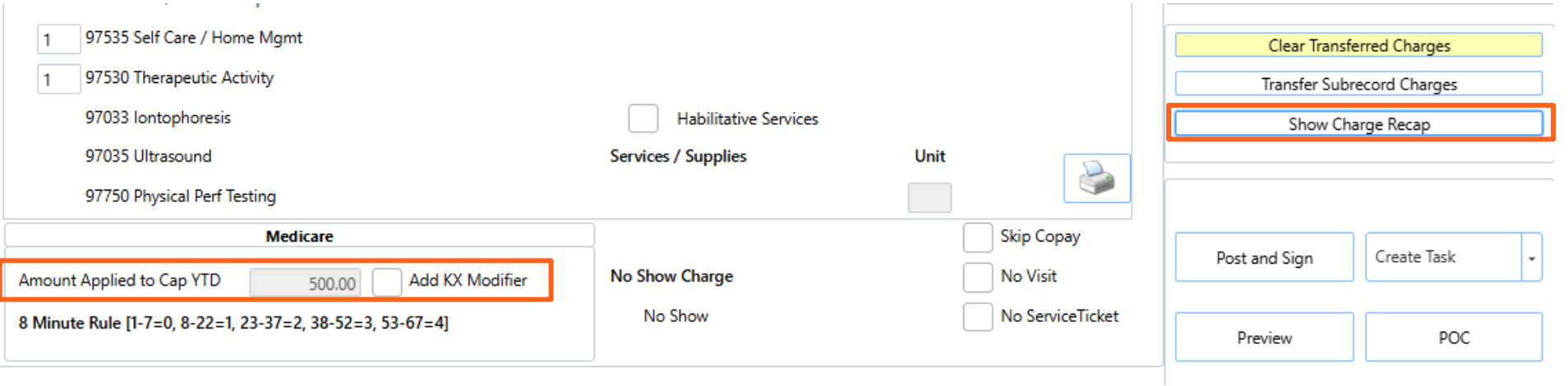
Charges

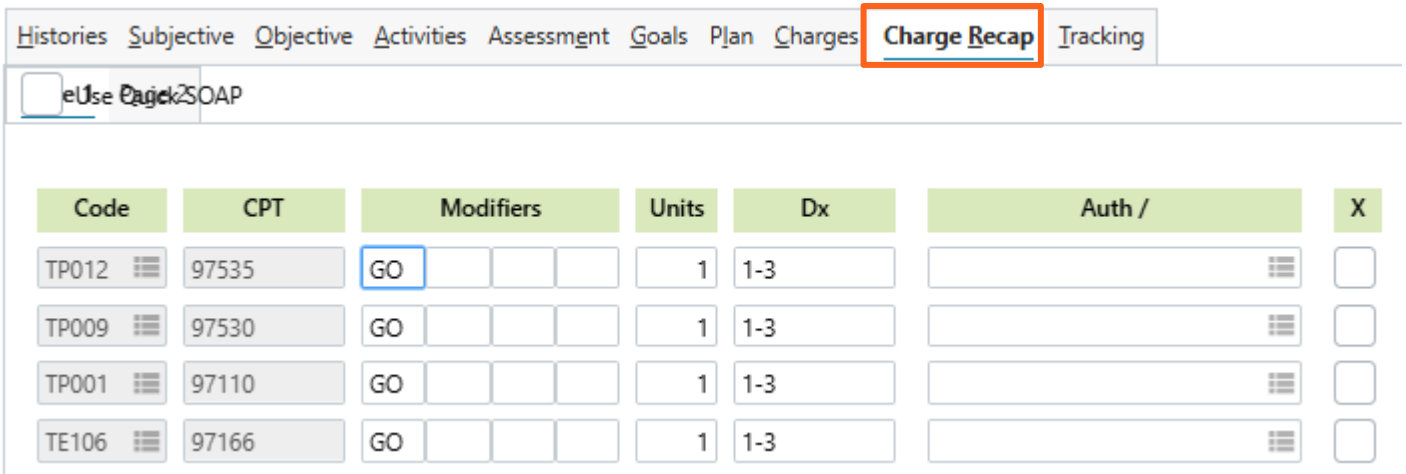
- Confirm units are appropriate based on documentation and 8 min rule
- If any changes are needed, "Clear Transferred Charges" and edit on Activities tab



Charges

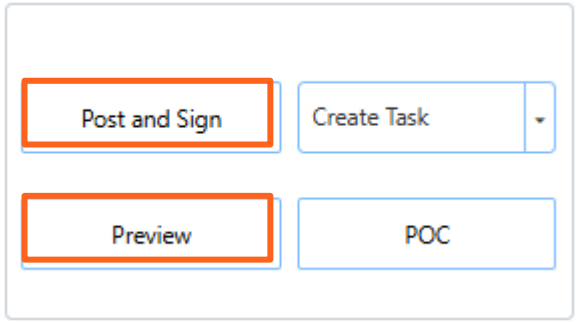
- **Medicare threshold** is visible at the bottom of the charge ticket
- **Modifiers** are visible on the charge recap (**"Show Charge Recap"**)





Narrative Preview and Sign Off

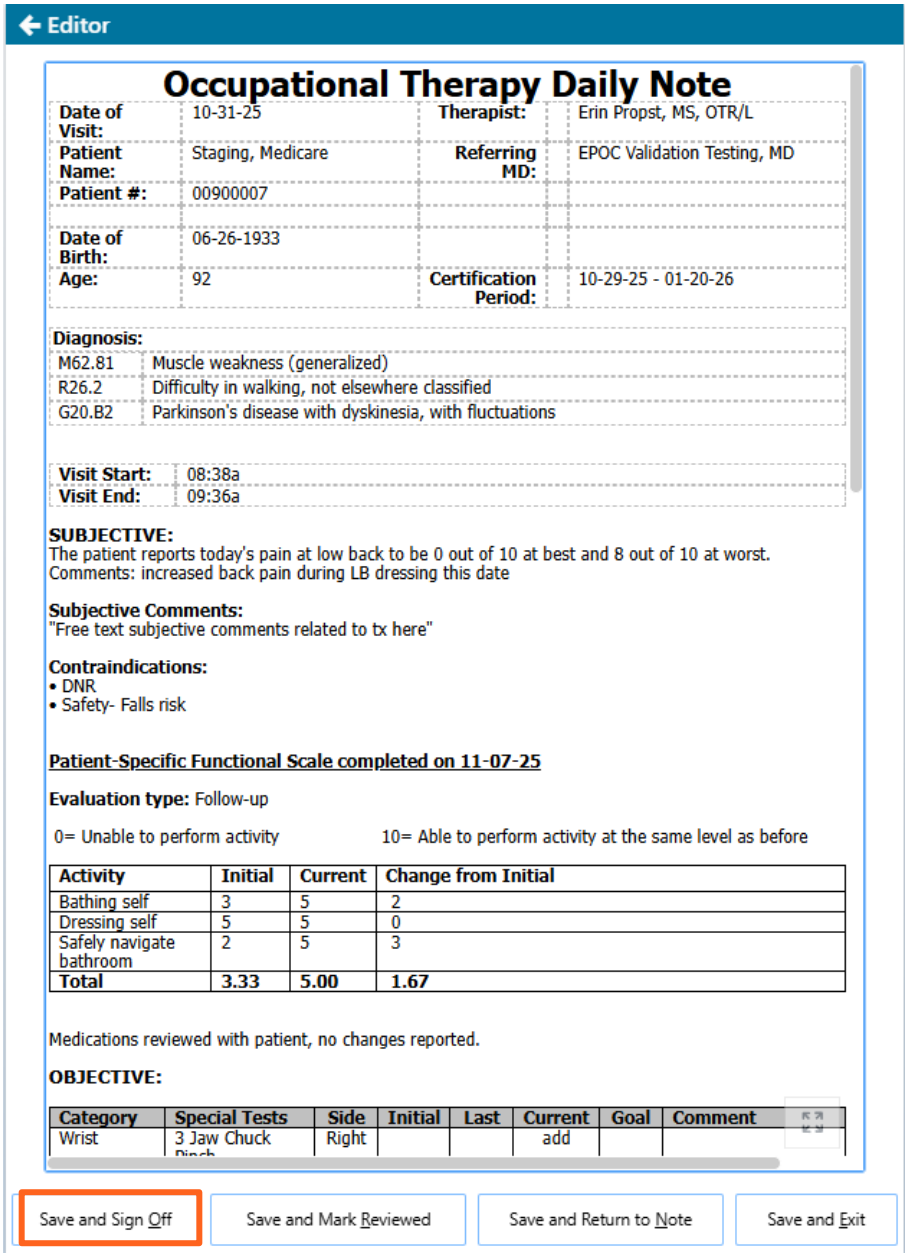
- Preview to review the narrative to ensure all information looks correct before signing off
- Post and Sign when you are ready to sign the note and post charges



Save and Sign-off

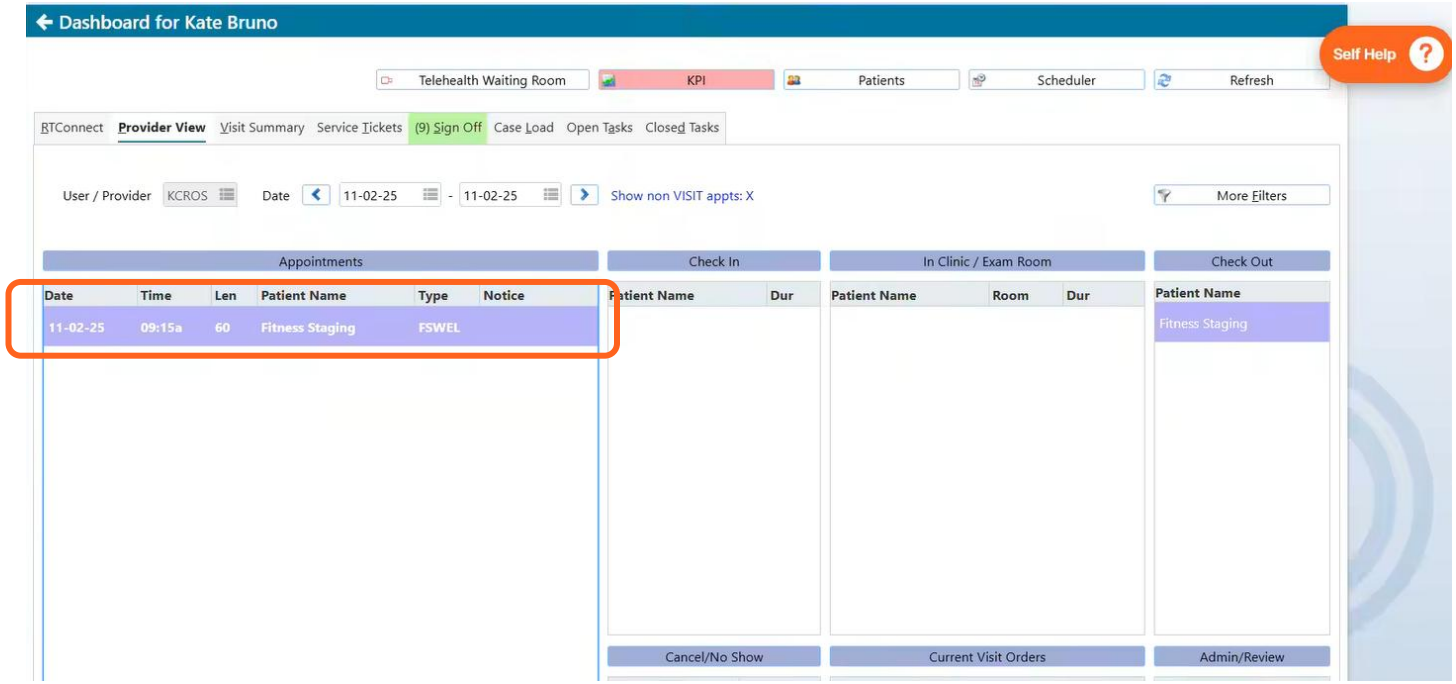
Complete final narrative review

- Click **Save and Sign Off** if you are complete
- Save and Return to Note to return and make edits
- Save and Exit to exit the note if you plan to return later for final sign-off



Confirmation

- After successful Sign and Post, visit will turn Purple
- If it is gray, it did not bill and you will need to go back into the note to post again.

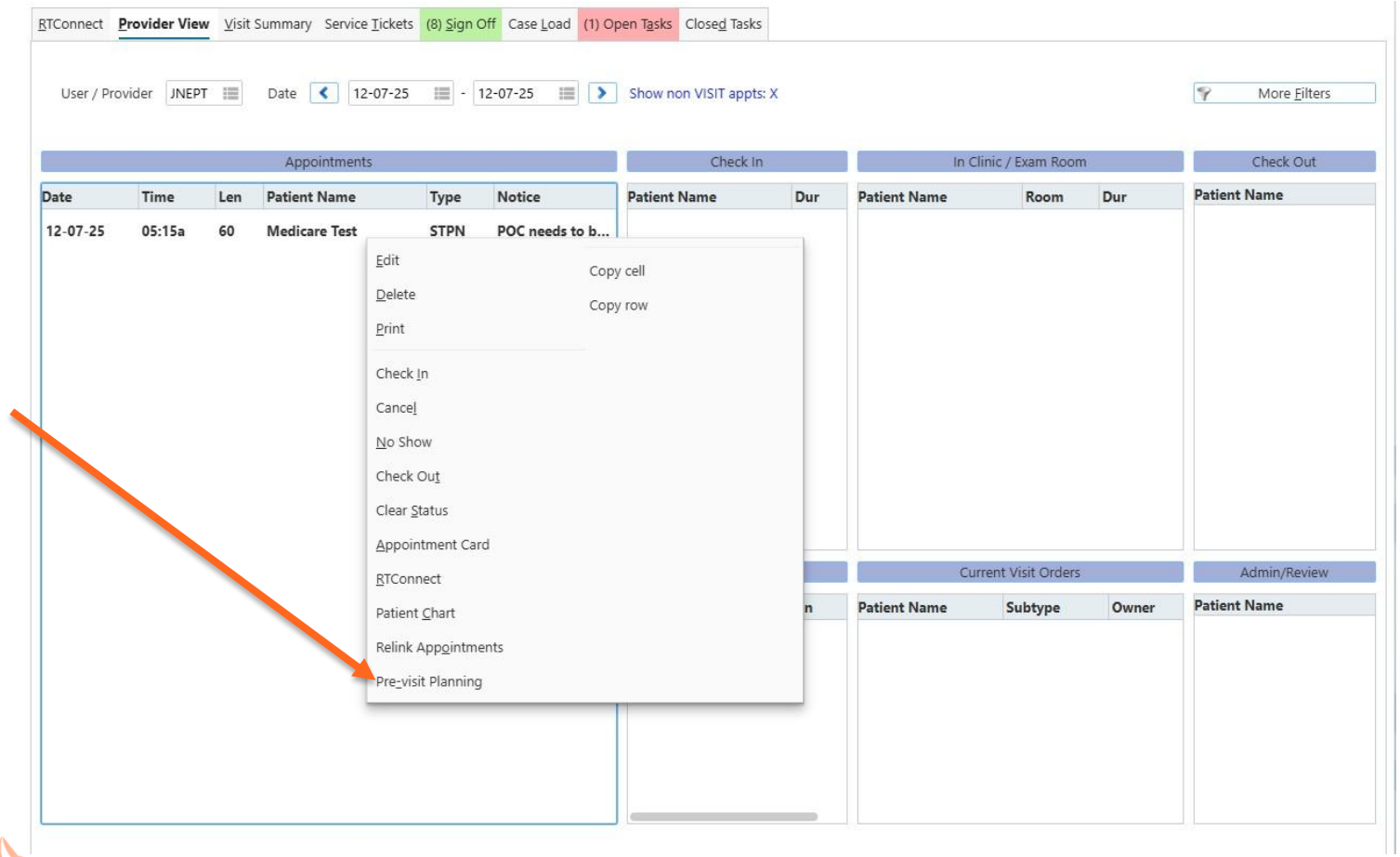


Pre Visit Planning

- Raintree Standard allows for pre-visit planning through a special feature
  - Allows for pre documentation within the following
    - Time Based Activities / Service Based Activities
      - Activities can be accessed and edited prior to the start of a visit
      - Edits will display once the visit is checked in
    - Notes to Treating Therapist
      - This section can be accessed and edited prior to the start of a visit
      - Edits will display once the visit is checked in
  - Can be used for visit planning that can lead to efficiency pick-ups for individual workflows. (setting up the planned activities with known details
  - Can be used to set up visits for a covering therapist, or used to enhance the clinician / assistant collaboration

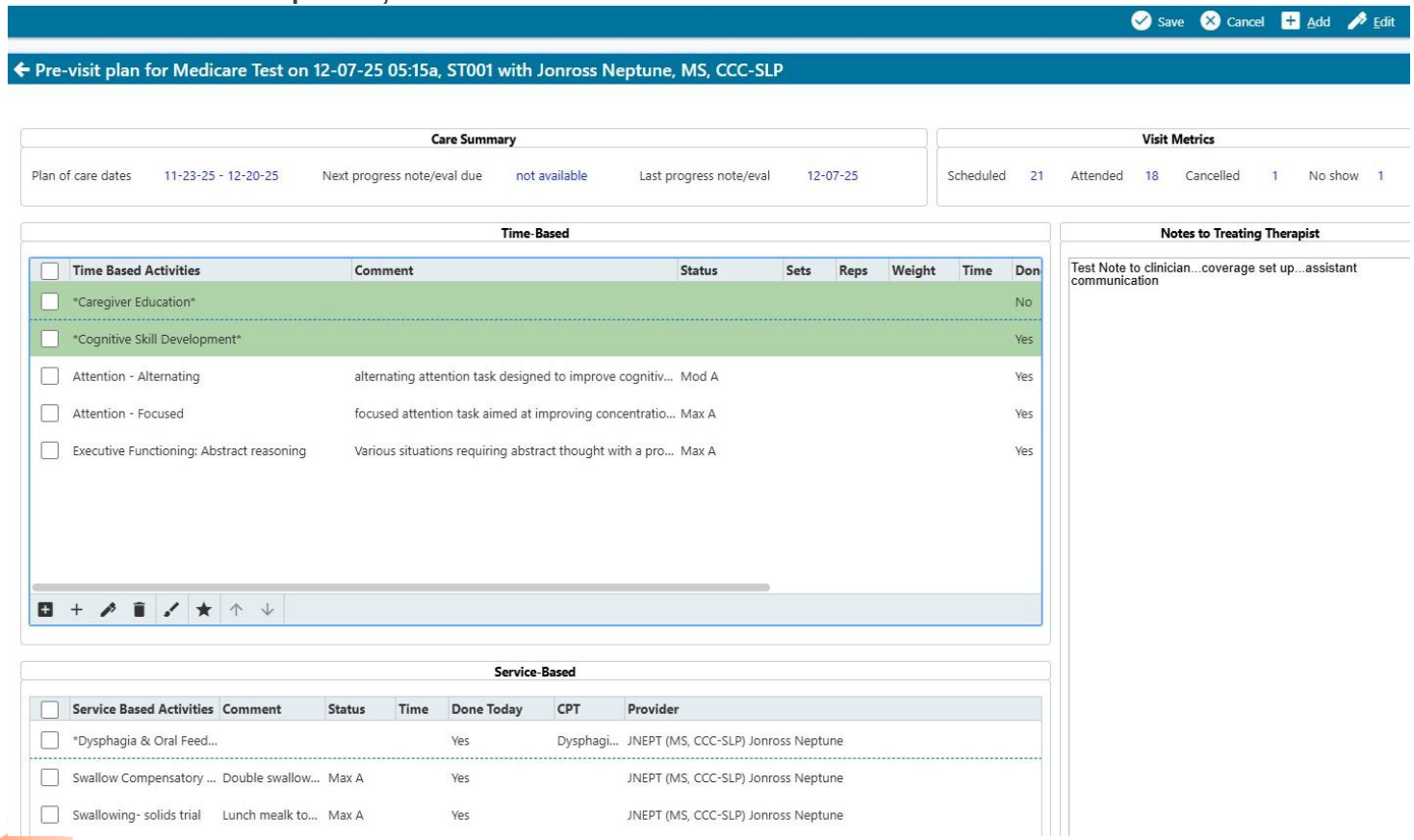
Pre Visit Planning

- Once a visit is scheduled you can access pre-visit planning by R-click on the visit from the provider tab and choosing Pre-Visit Planning from the list



Pre Visit Planning

- You will be brought into the Pre-Visit Planning and now have access to make any updates to “Time Based”, “Service Based”, and “Notes to Treating Therapist”
- Once edits are complete, click save

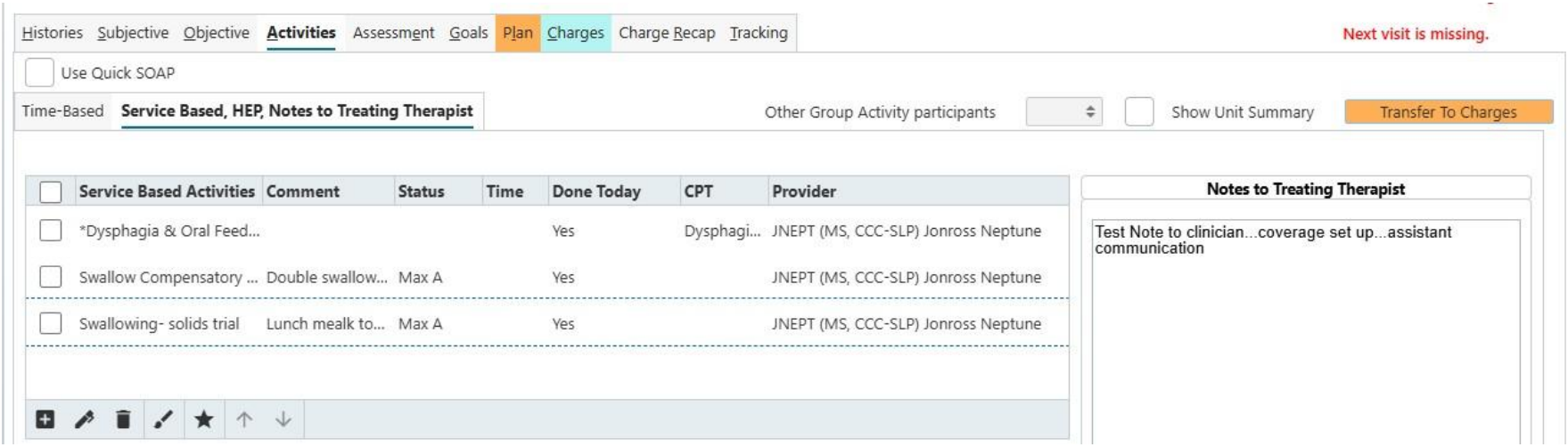


Pre Visit Planning

- At the visit check in, you will see an alert that notified of updates

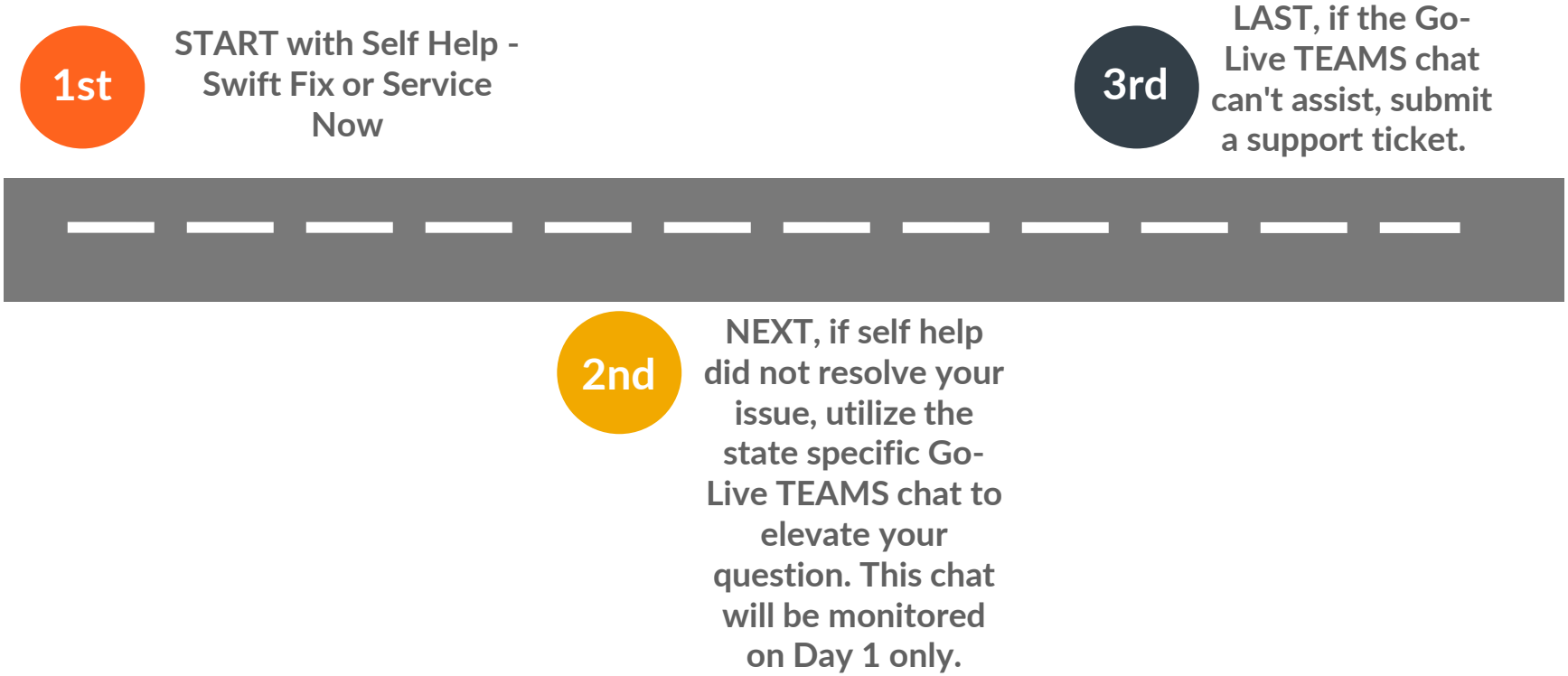


- You will see the updates within the Time Based, Service Based, and Notes to Treating Therapist sections



Support Roadmap: Start Smart, Escalate Right

Have a question? Follow the path to resolution!

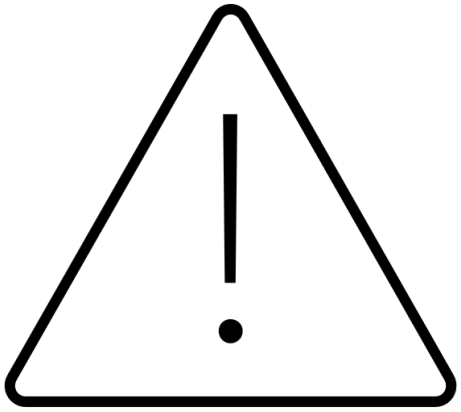


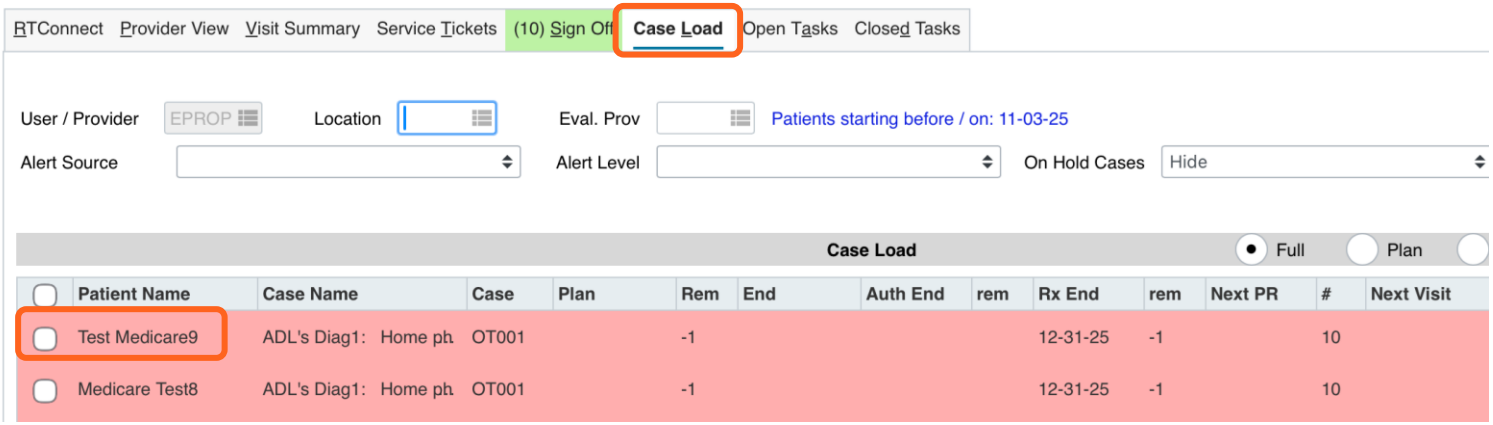
RT Standard
SLP Initial Eval and Tx on day of Eval
(TVIST)



Starting New Cases

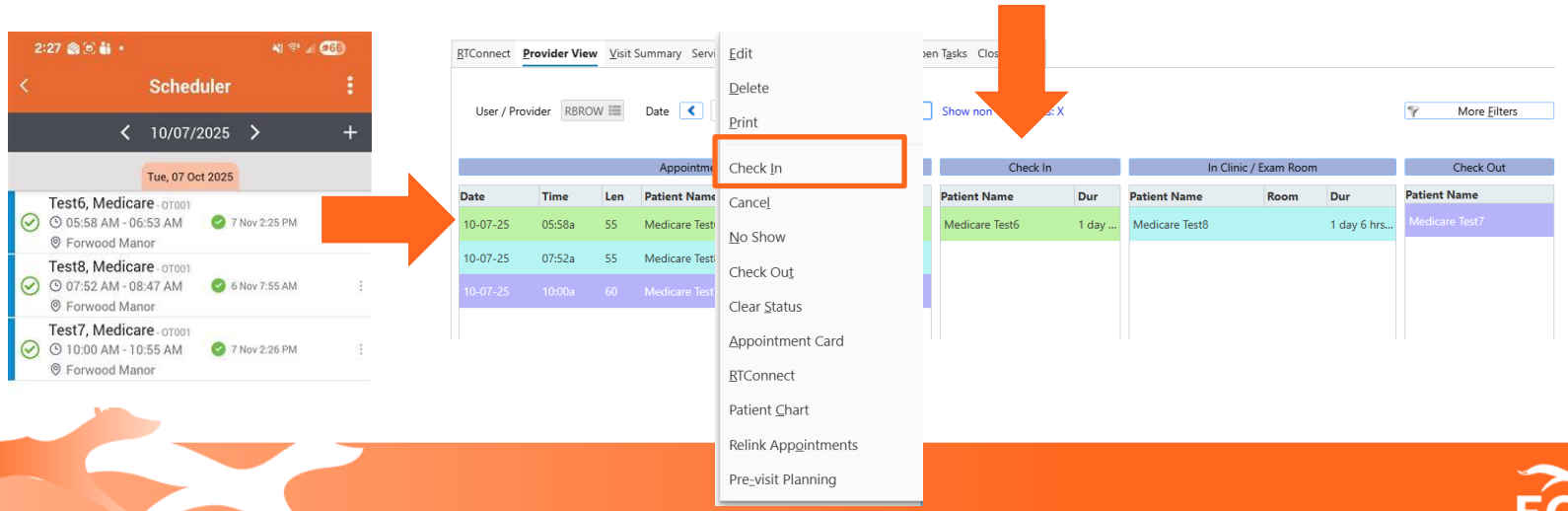
- New admissions will only display on your caseload tab AFTER you have scheduled the first evaluation/visit in FOX Trax.
  - Scheduling of the appointment in FOX Trax initiates the record to be created in Raintree





Launching a Note

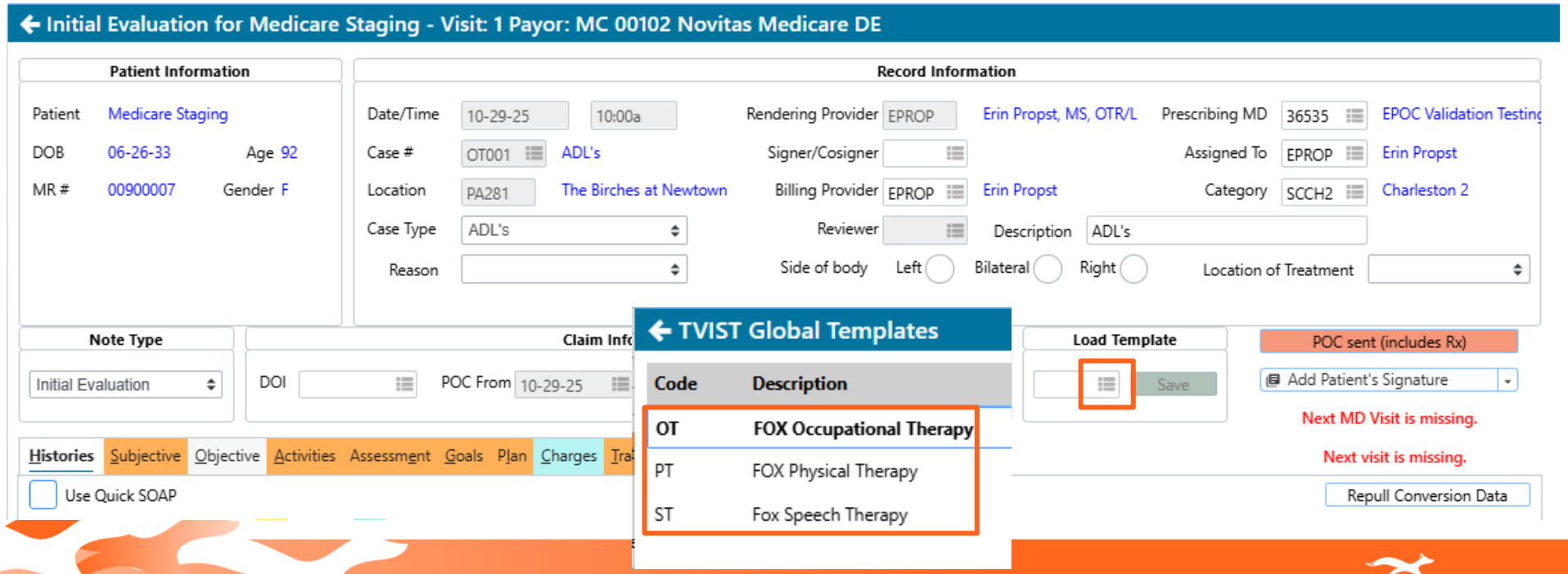
- Schedule in FOX Trax- select the appropriate Reason for Visit (Evaluation)
  - Visit will display in RT Standard scheduler and **Provider View tab** under **Appointments**
  - Visits **MUST** be scheduled to start a note. RT Standard does not allow for notes to be created without an appointment.
- In **FOX Trax,** complete visit verification, ideally at the start of the session
- In **RT Standard**, right click the appointment and select **Check In**
  - The appointment will display in the "**Check In** " window
    - Right click > edit to open the clinical note when ready to document.
  - In the event action is needed (due to patient forms being unsigned or previous notes not completed), prompts will display and then the appointment will display in the Check In window
    - See Consent Training for details on patient forms.
  - Read any additional prompts related to the patient so you are aware of any notices/alerts



Loading Template

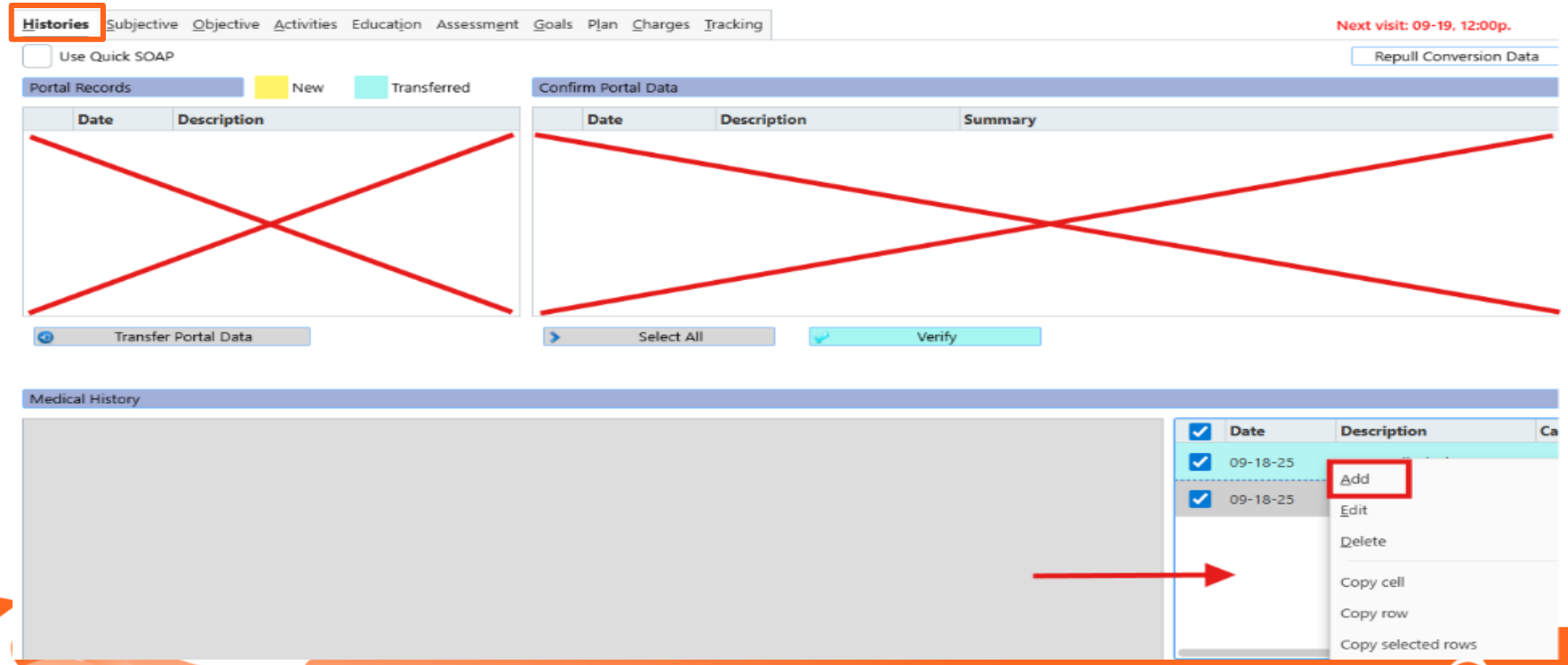
IMPORTANT!! Before beginning your eval documentation, you **MUST load FOX Template**

- Click on the menu icon in the **"Load Template"** box to see the list of Global Templates, **select FOX template** for your discipline
- This will load the FOX EVAL template and will ONLY be done during Evals (not subsequent tx notes)



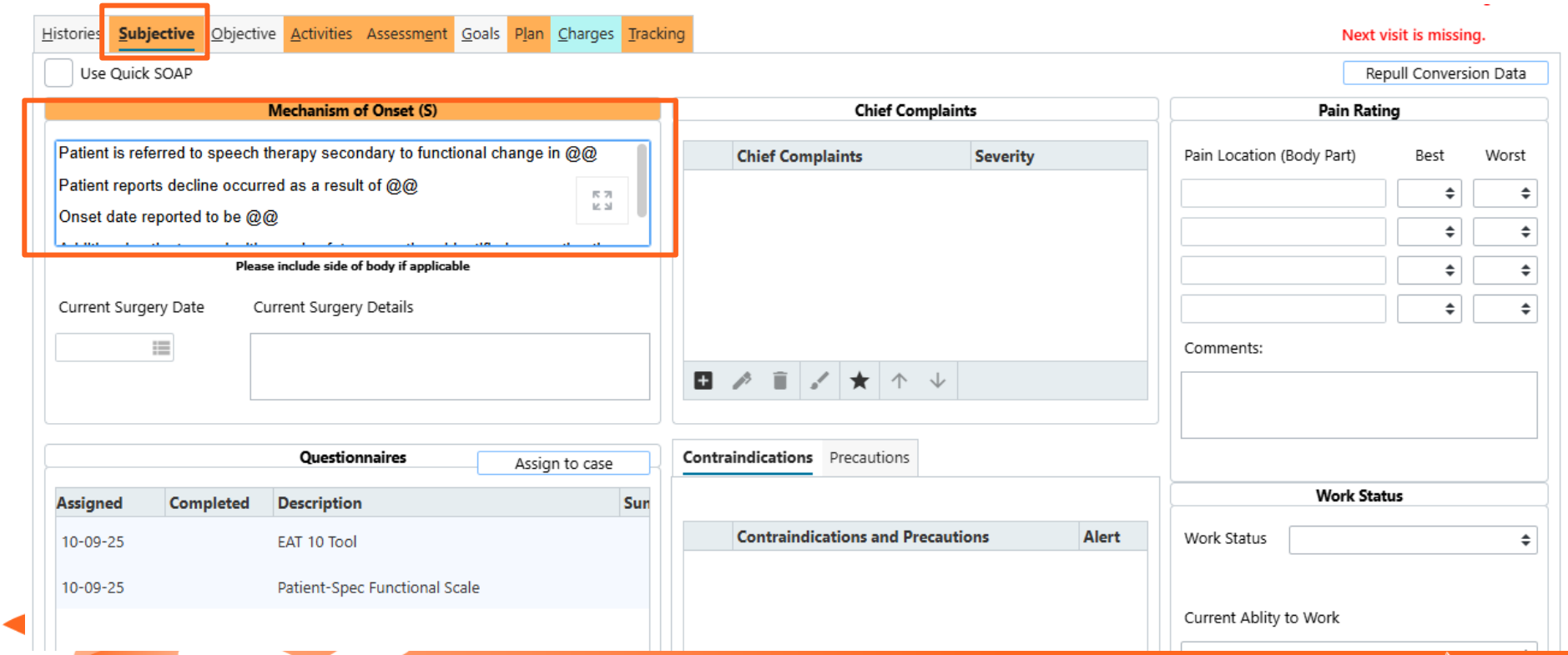
Histories

- You will Add or Edit your patient's Medical History from "Histories" tab
- Click into Past Medical History in the bottom right panel
  - If a **Medical History has been started**, double click/right click and **Edit** to open and update Medical History
  - If a **Medical History does not exist**, right click in the panel and select **Add**
- Review/Complete all necessary parts of the Medical History for the patient
- Save the record



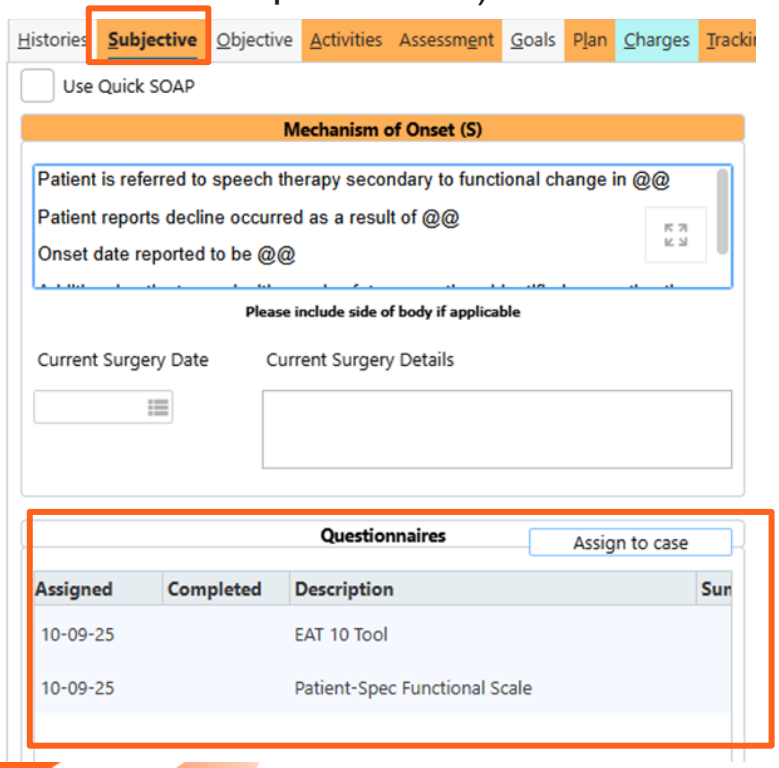
Subjective – Mechanism of Onset (History of Present Illness)

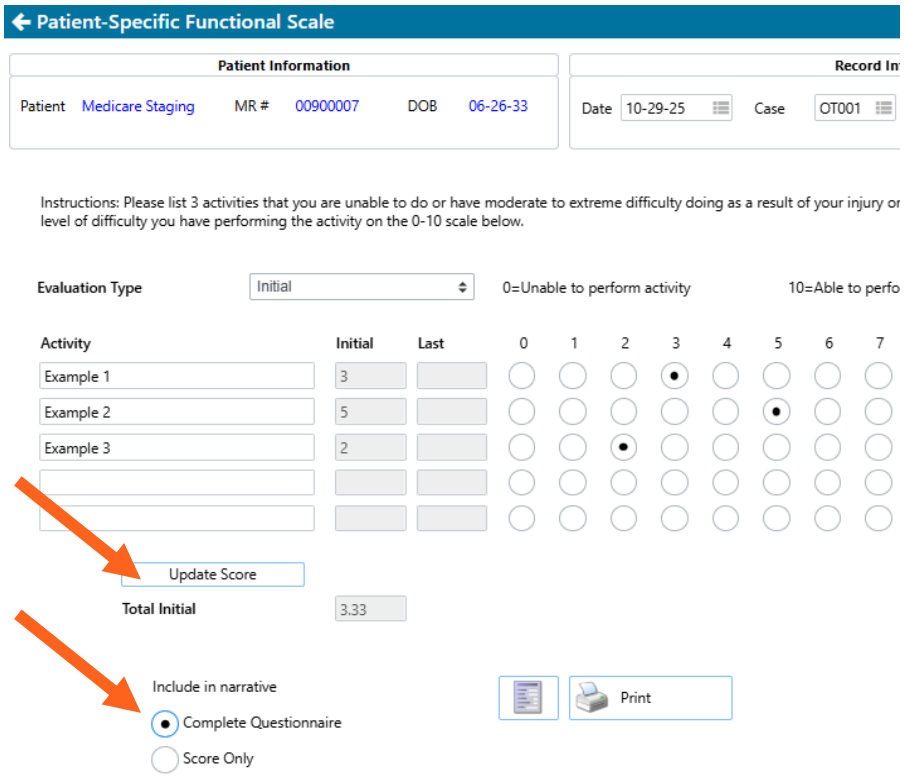
- Mechanism of onset should detail WHAT, WHEN and WHY a functional change has occurred
- Complete all areas with @@ (jump markers) and add any additional information such as surgery date, details, etc
  - iPad users – use keyboard shortcut "**ctrl**" and "**cmd**" and "**.**" or navigate with mouse to complete all (@@) place holders. Non-iPad users can navigate jump markers by pressing **"ctrl"** and **"."**



Subjective – Questionnaires

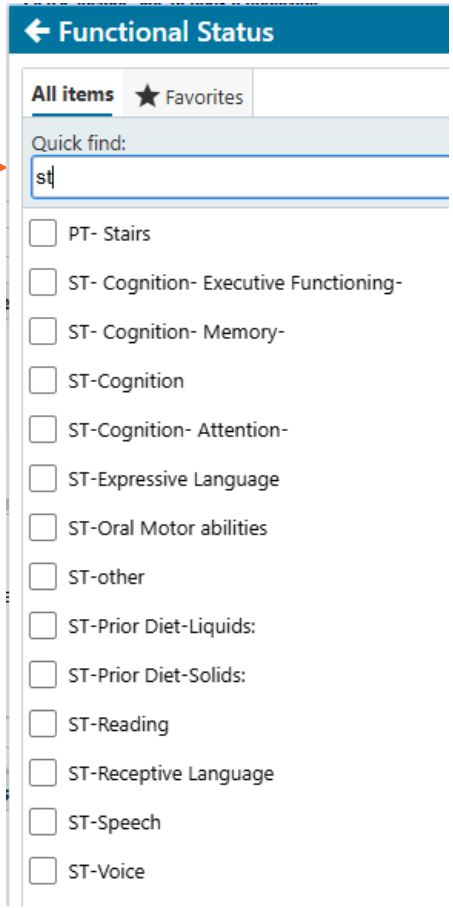
- The Patient Specific Functional Scale (PSFS) will be completed in the Questionnaires box
  - Right click to open & complete, "Update Score", and choose "Complete Questionnaire" to include in narrative
- You can add new with right click > Add (or click into box > click Add in top function bar)
  - PSFS is required and will be preloaded in the Questionnaires box
  - Explore the list of available questionnaires (ex: ABC Scale, EAT-10, Falls Efficacy Scale, Quick DASH)
- You could also add the Questionnaires within the Objective tab alongside the FOMs (This is clinician preference)

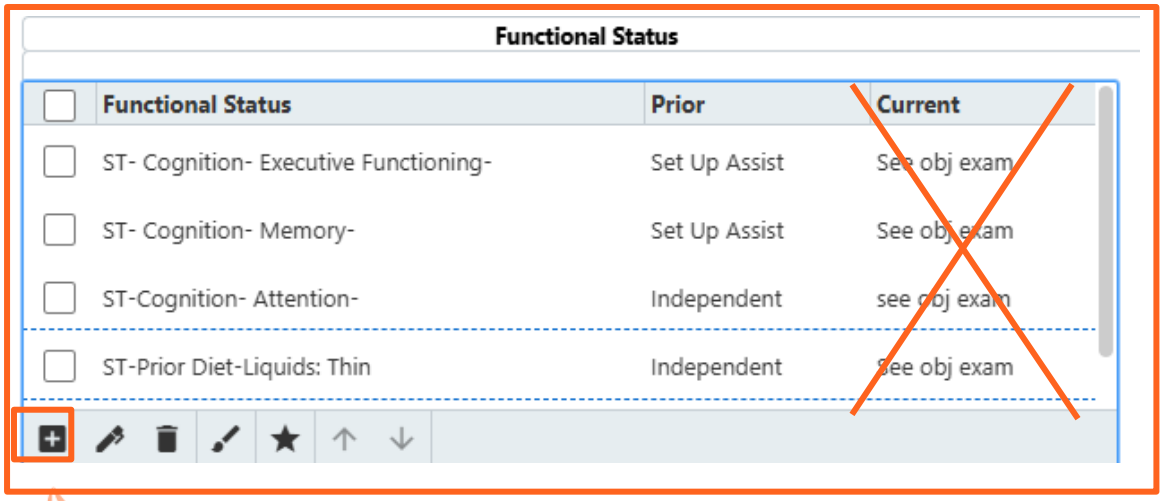




Subjective – Functional Status (Prior Level of Function)

- Add Functional Status by finding items using + to open picklist
  - This picklist will show Functional Status for all disciplines – you can filter this picklist by typing your discipline in the Quick Find space
  - **MUST add details** related to each topic (communication level, diet level)
- Update the "Prior" level by double clicking into Prior column and selecting Prior assist level
- **DO NOT** document "Current" status here (this should be added to objective tab)





Subjective: Functional Status (Prior Level of Function)

- Due to the change to Raintree Standard, our SLP cueing will be documented differently. We will be aligned with industry terminology and will no longer utilize the ASHA Cueing Hierarchy

- FOX components of skilled care
  - Effort of the clinician
    - Tactile, verbal, visual, auditory, physical

- Strategies to demonstrate skill
  - Break down types and levels of assistance provided
    - “Max verbal cues and min tactile cues” vs “min assistance”

Subjective: Functional Status (Prior Level of Function)

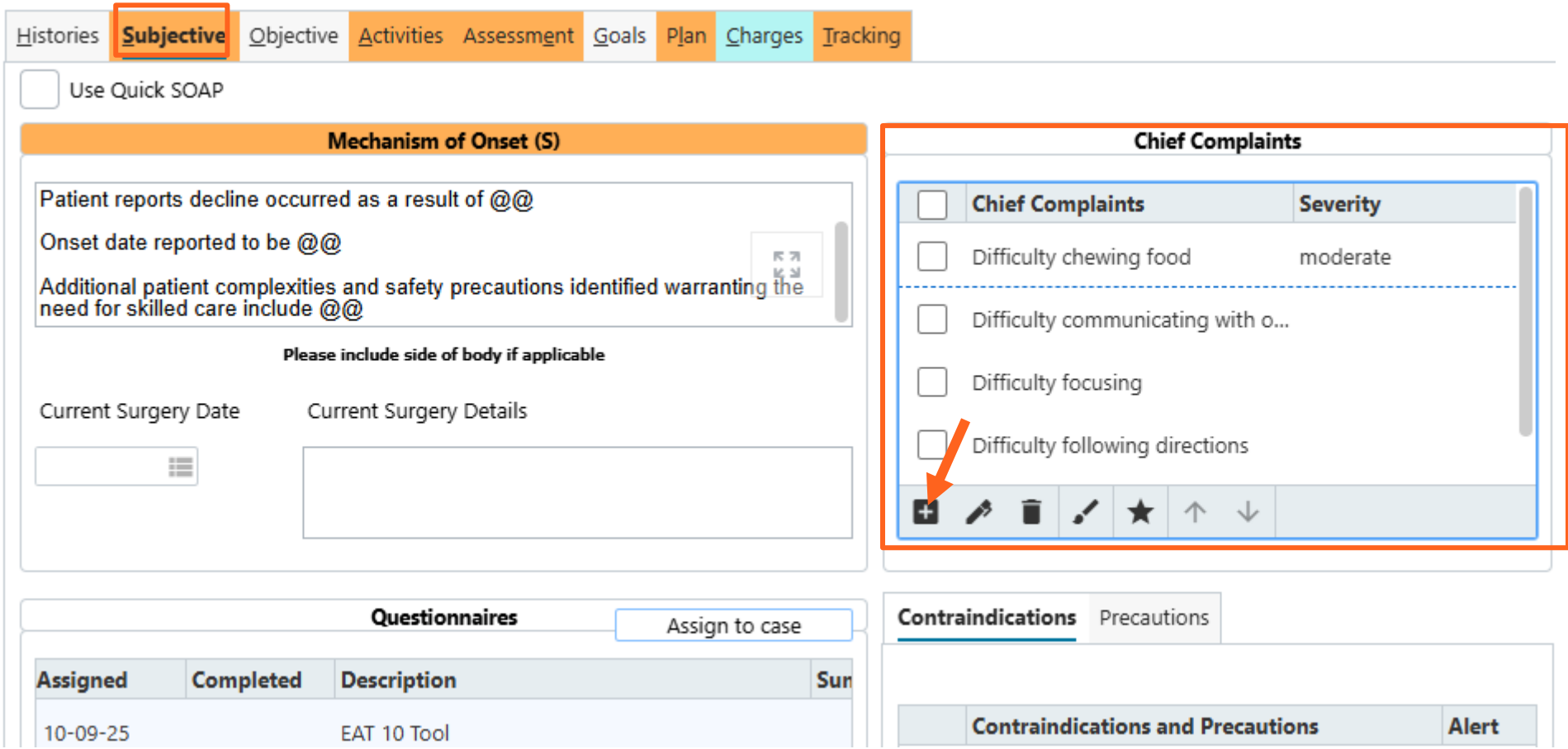
- **Unable**
- **Dependent or Total Assistance (Total A)**
  - 75-100% effort from one or more helpers
- **Maximum Assistance (Max A)**
  - 50-74% of effort from one helper
- **Moderate Assistance (Mod A)**
  - 25-49% of effort from one helper
- **Minimal Assistance (Min A)**
  - 1-24% of effort from one helper
- **Standby Assistance (SBA)**
  - Supervision without physical contact or cueing
- **Setup Assistance**
  - Necessary items arranged in advance of activity
- **Independent Status (Ind)**
  - No assistance or supervision required
  - If the patient performs the task independently, but requires equipment, they are still considered independent

As soon as you provide one tactile, verbal, or visual cue, no matter how small, it is at least Min A

Setup is any placement needed for patient to complete a task
Example: setting out utensils, opening memory journal, laying out clothing

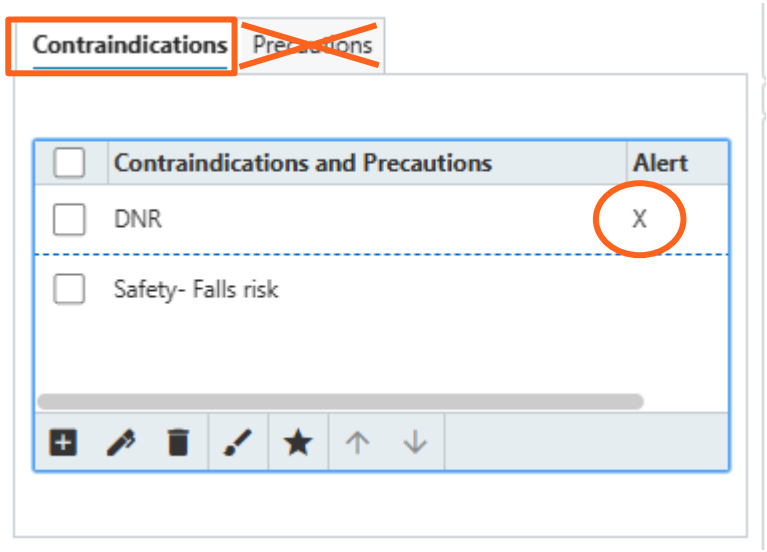
Subjective – Chief Complaints

- Click in the **Chief Complaints** panel and click + to add items from the picklist, then save
  - This picklist would be a good place to set and use Favorites



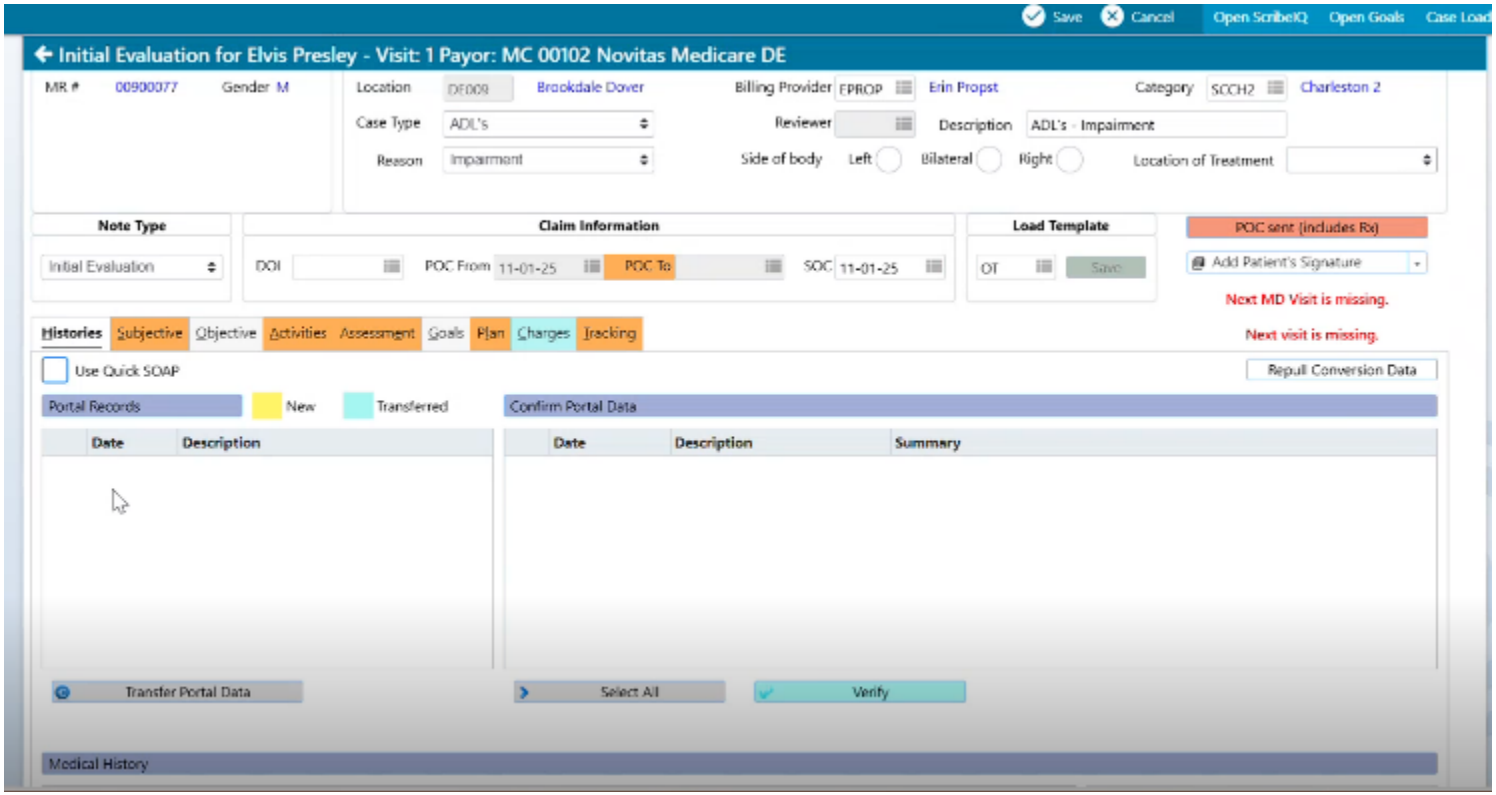
Subjective – Contraindications/Precautions

- Any Contraindications or Precautions should be added in the Contraindications table (Do NOT use the "Precautions" table)
- Add items in the picklist using the +
- Create an "Alert" for your entry if any covering clinician would need to be aware of an allergy, emergency procedure, etc.
  - Double click into the "Alert" column for that item until you see an "X" indicate alert is on
  - The "Alert" will pop up every time a note is opened for this patient.



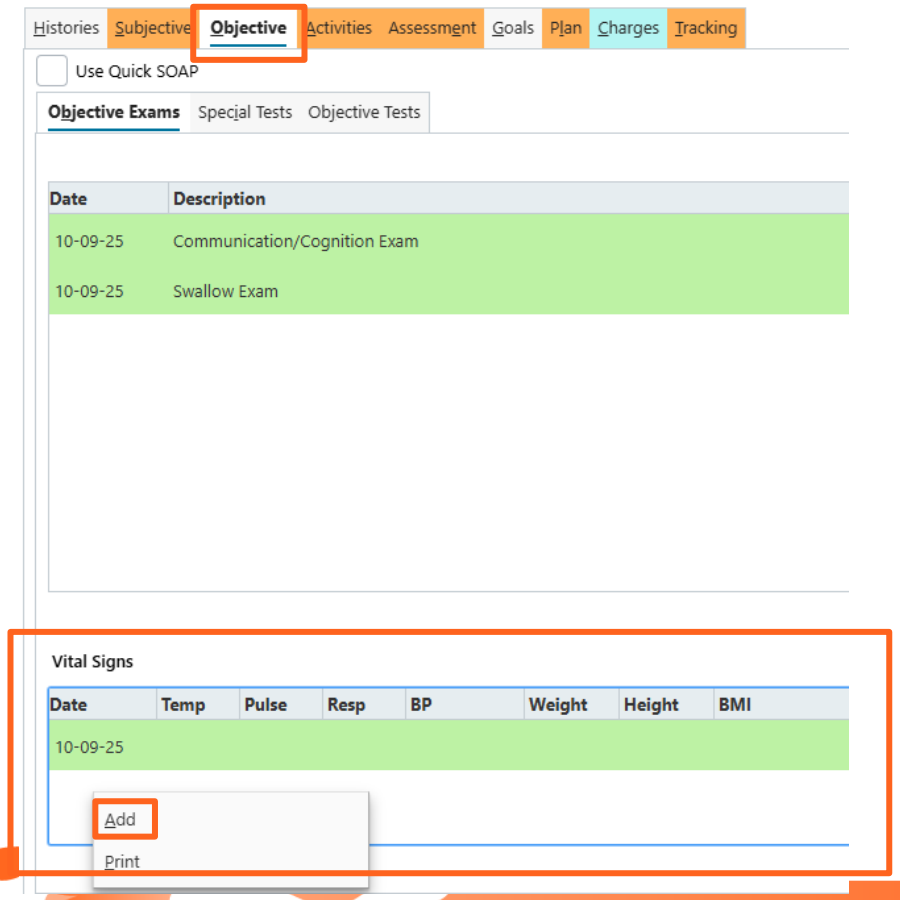
VIDEO TIME: IE Template, Histories & Subjective

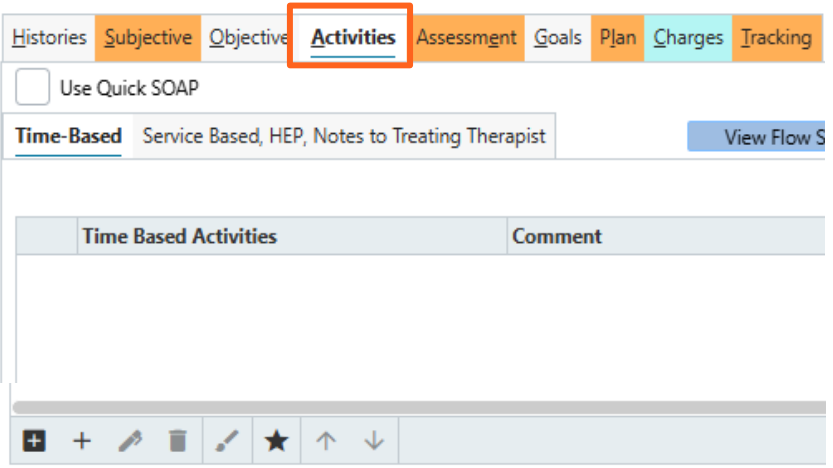
Watch it NOW!
Click Image Below to Watch A Video

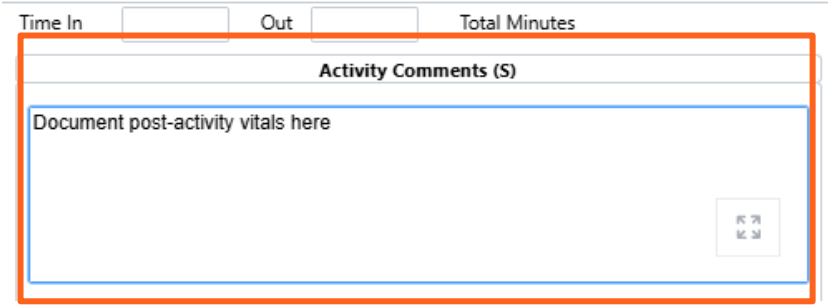


Objective – Vital Signs

- Baseline **Vital Signs** can be documented on the Objective Tab, in Vital Signs panel
- Right click in the panel, the select Add or click Add on the top function bar
- Populate the vital signs and save the record
- **Post-activity vital signs** can be recorded on Activities tab, in "Activity Comments"



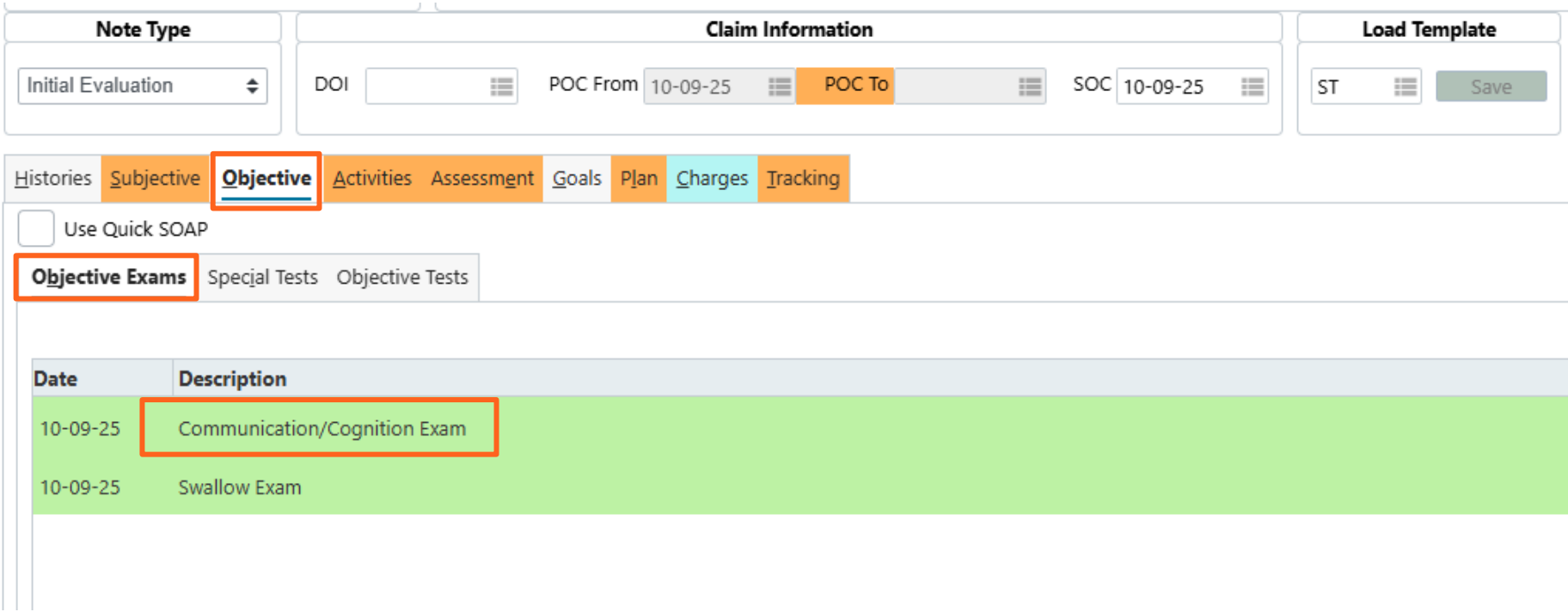




Objective - Exams

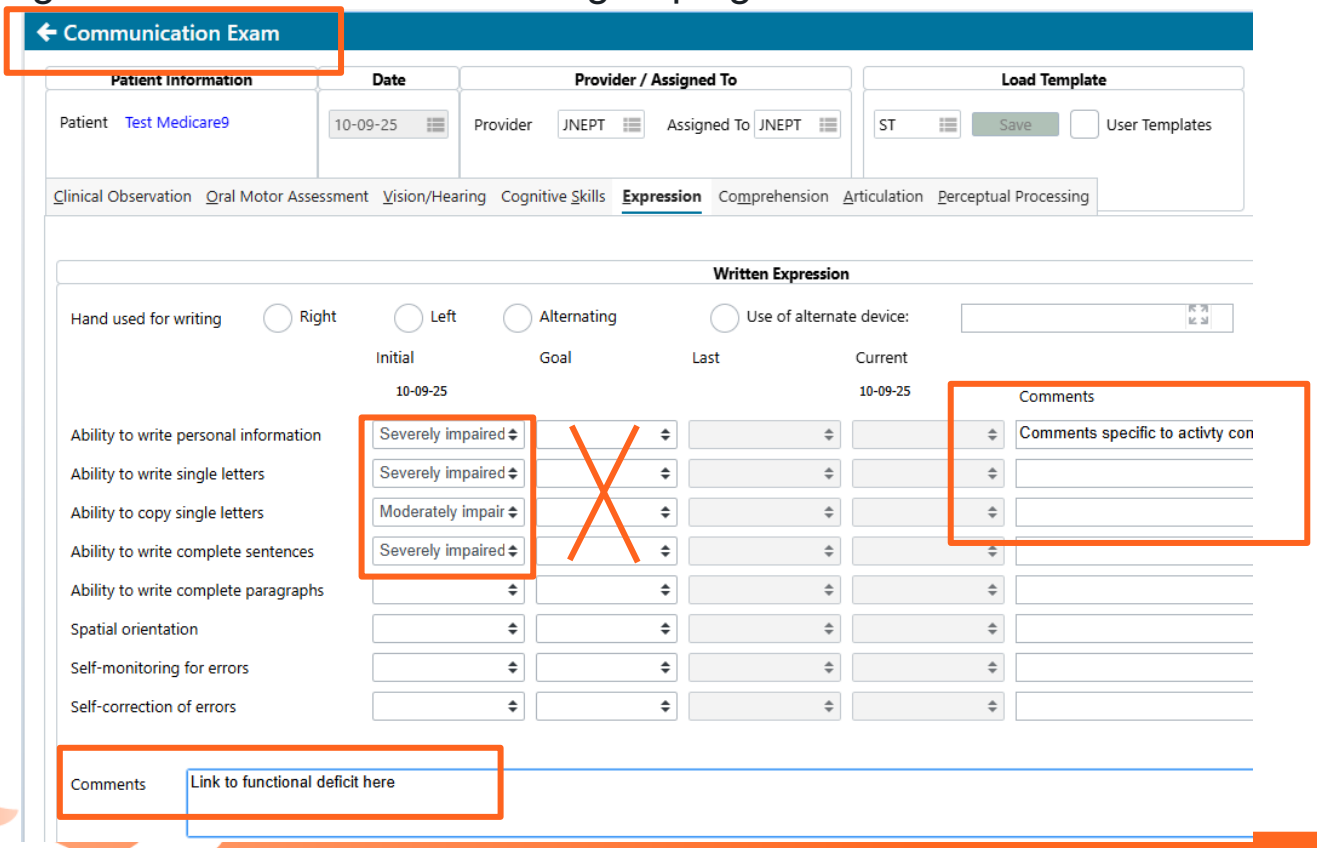
- Discipline-specific **Objective Exams** should populate in your Objective Exams: This is where you will document all of your objective findings
  - If there is no Exam loaded, add one by right clicking > Add (Communication/Cognition and Swallow Exams will be used most often by SLP)

- Double click to open and document within the exam (see next slide for details)



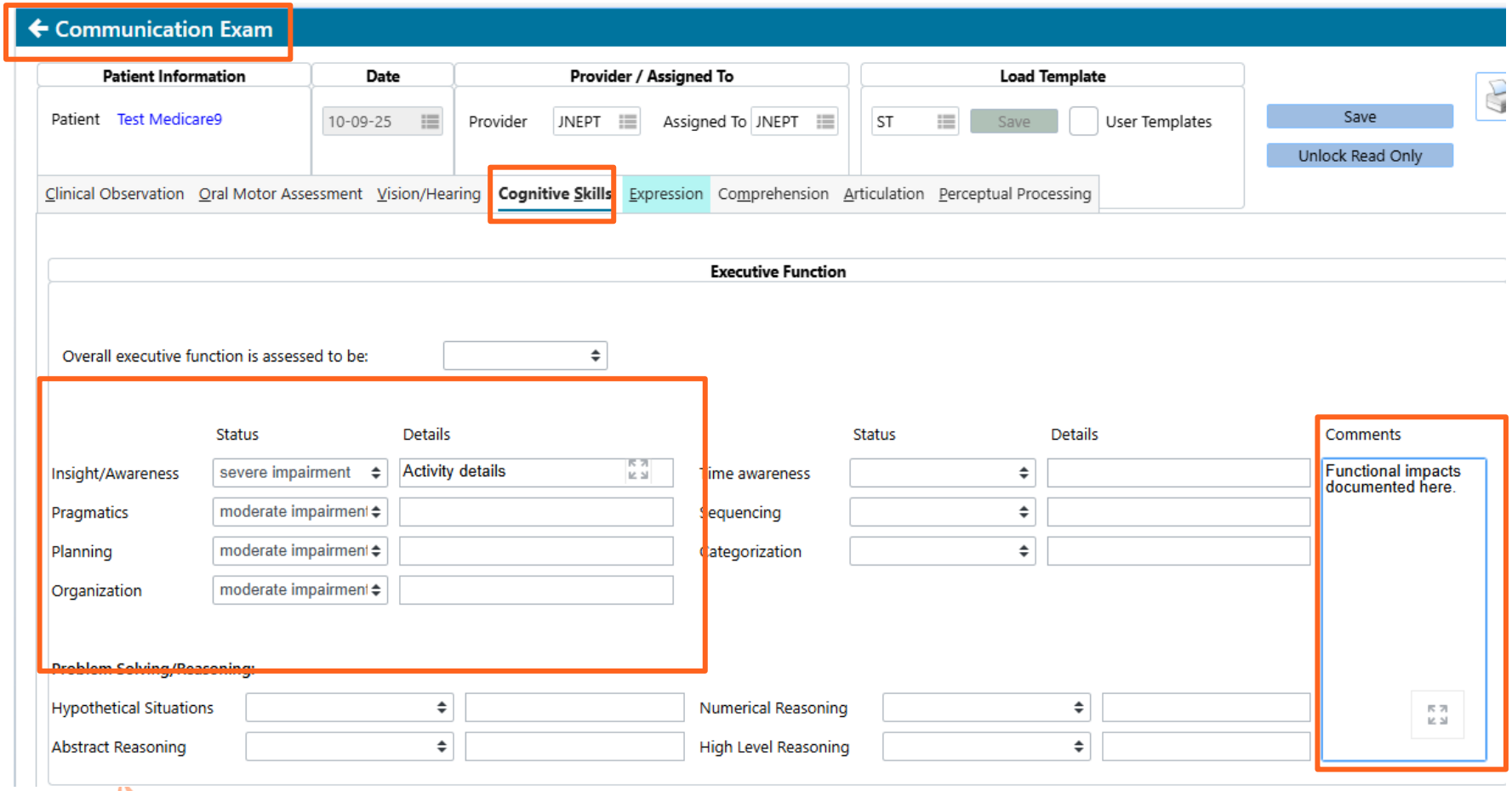
Objective - Exams

- Navigate through the Exam to document relevant objective findings
  - You DO NOT need to complete everything – only what is relevant (Look and Listen)
- You will document relevant objective findings by typing in the "Initial" box and adding comments where appropriate (except for the Cognitive Skills Section)
- Do NOT add goals here (*add on goals tab*)
- Use the large comment box below each grouping to document the functional impacts



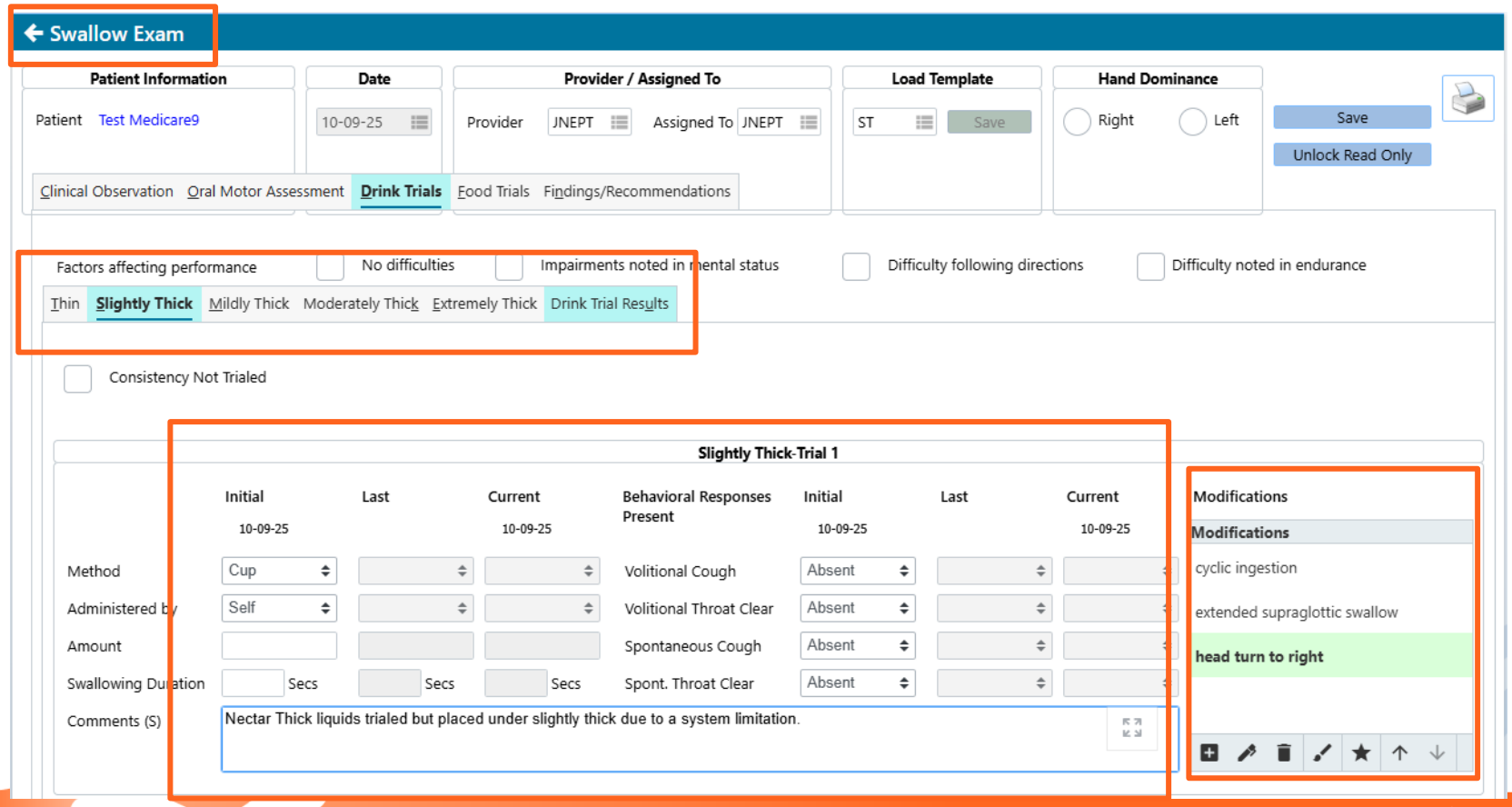
Objective - Exams

- Cognitive Skills- You will document relevant objective findings by completing the ‘Status” and documenting specific details related to deficit area
- Again, make sure to describe functional limitations within the comment boxes



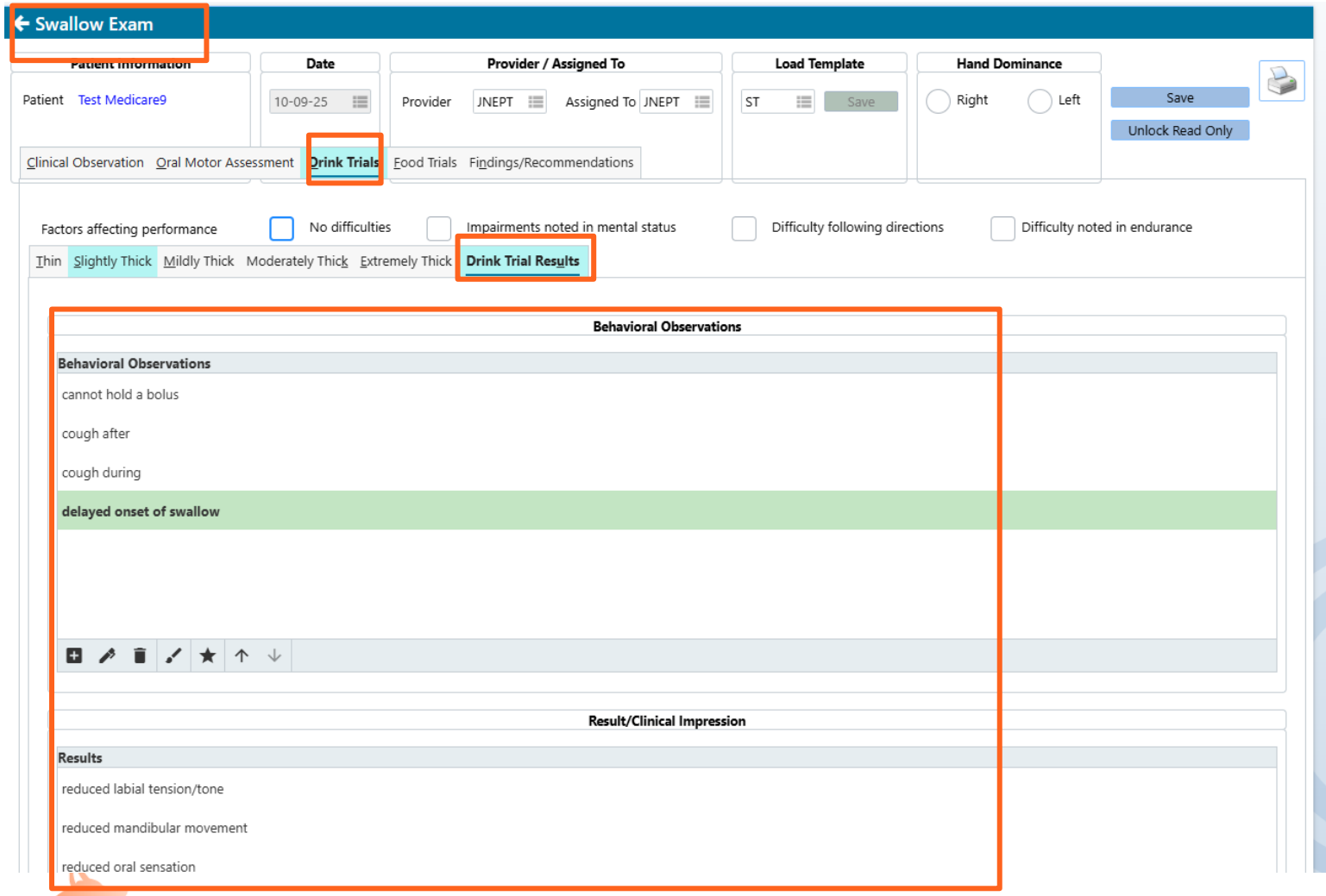
Objective - Exams

- **Swallow Exam** – Food and Drink Trials
- Raintree Standard only has IDDSI diet levels included in the swallow exam
- In situations where it is not possible to document IDDSI (ie SLC that does not offer IDDSI) choose the closest diet level to what you are assessing and note the difference in a comment box. (Shown below)



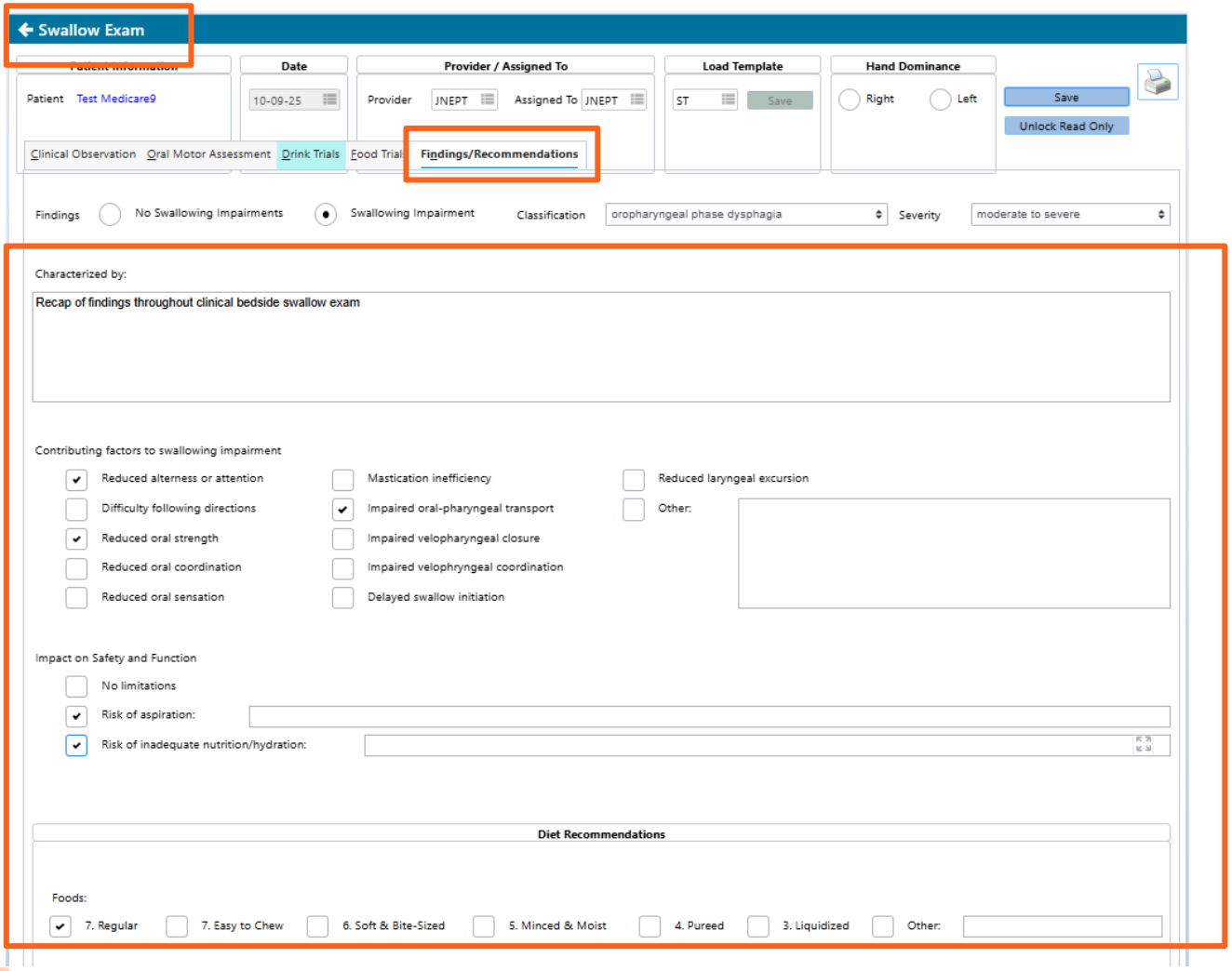
Objective - Exams

- **Swallow Exam** – Food and Drink Trial Results
  - Document behavioral observations, and result/clinical impression



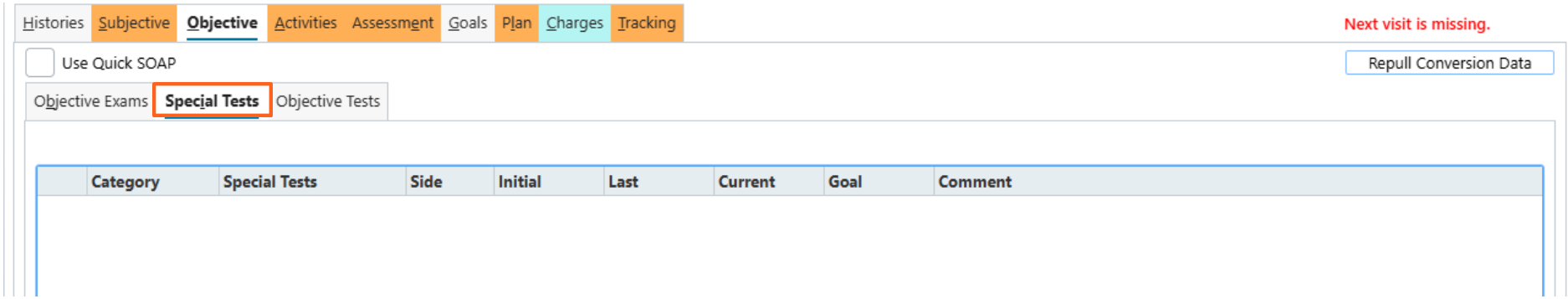
Objective - Exams

- **Swallow Exam** – Findings / Recommendations
  - Document findings, and diet recommendations



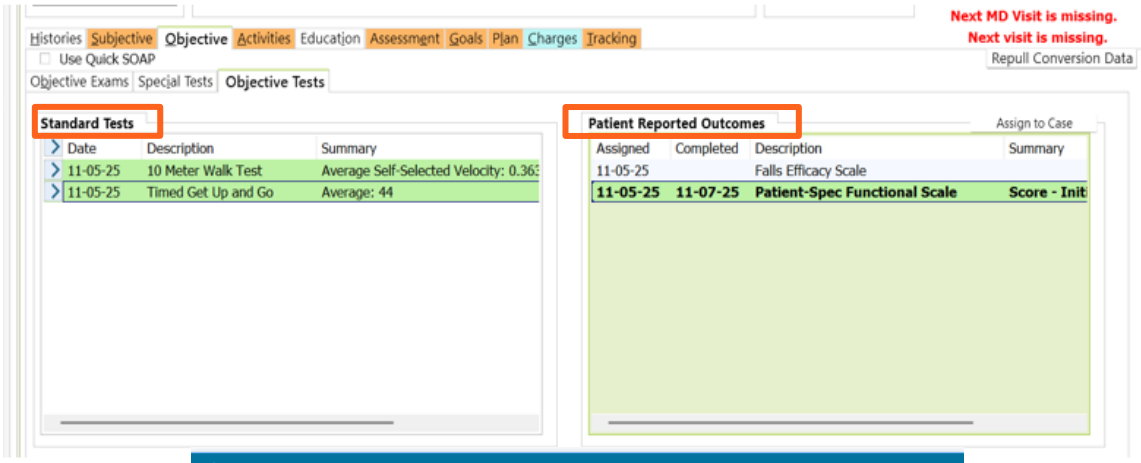
Objective - Special Tests

- This tab will **NOT** be used by FOX SLPs as these are all PT/OT special tests
- You may **skip** over this tab

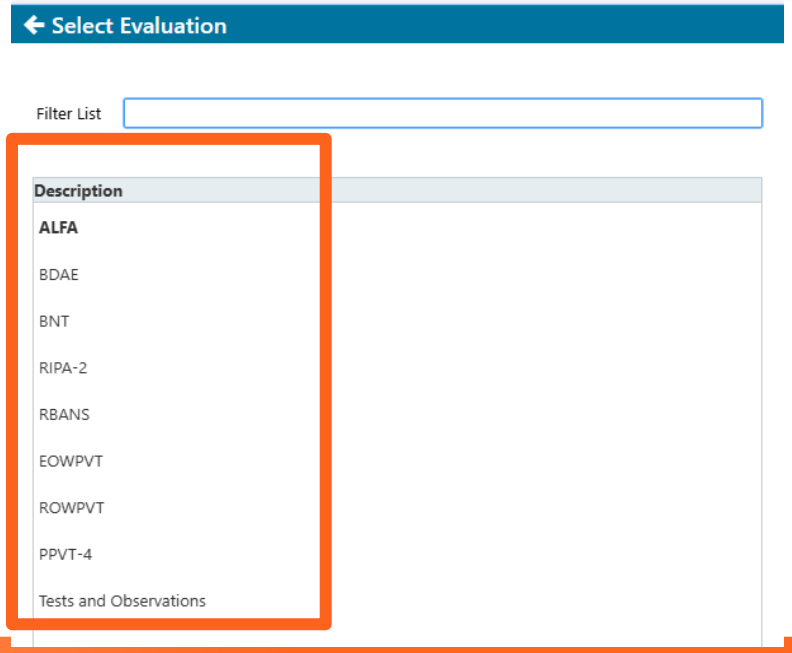


Objective – Objective Tests

- Select **Objective Tests** tab
  - Standard Test= FOMs/Standardized Tests (RIPA, ALFA) Only complete if you have personal access to the exam)
  - Patient Reported Outcomes= Questionnaires (the same ones that are available on the subjective tab)



- Right click in either section and click Add to open list of available Objective Tests/Questionnaires; select test you would like to complete

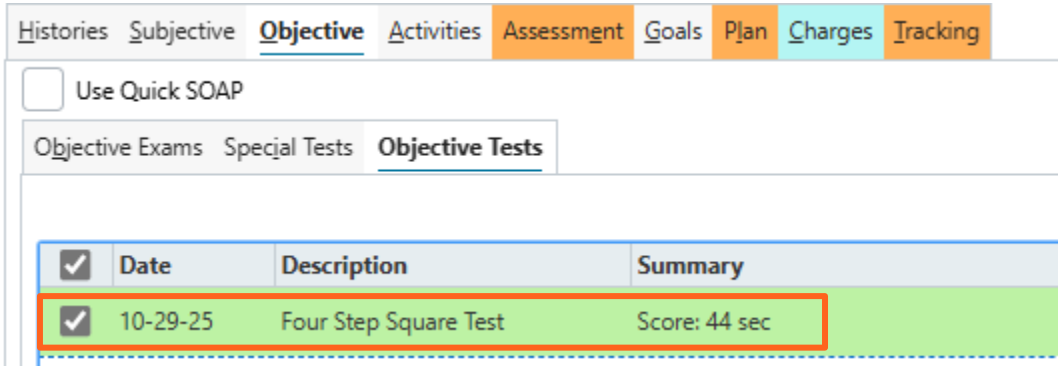


- Fill out the appropriate information related to the test, and then click save

Objective – Objective Tests (continued)

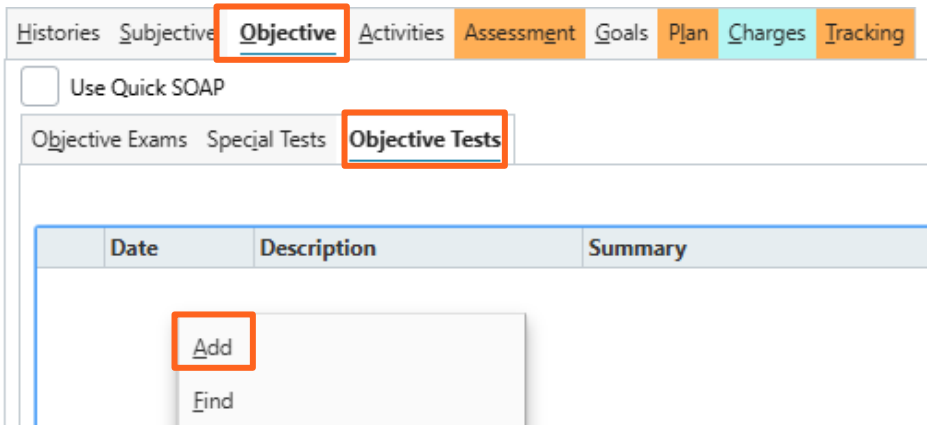
- In the Objective Tests tab, you can document FOMs under the standardized test section AND Questionnaires under the patient reported outcomes section
- In the Objective Tests tab, ensure the test you completed is Green and has a check mark next to it so it will populate in the narrative

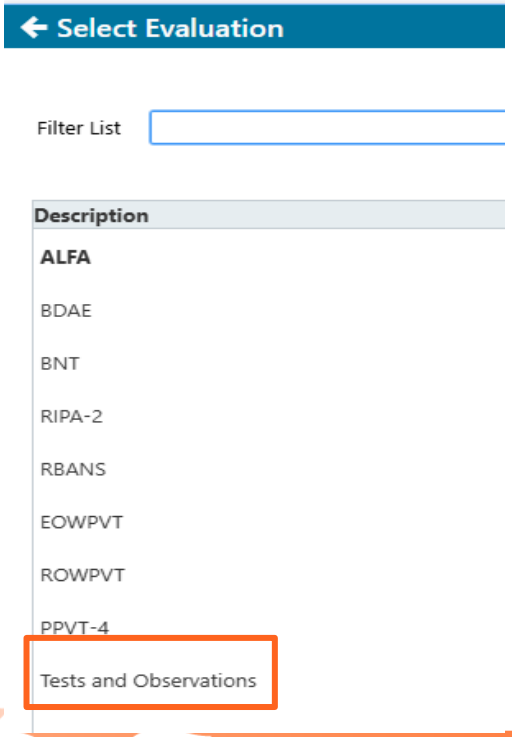
- Yellow items were completed in previous visits



Objective – Objective Tests (Continued)

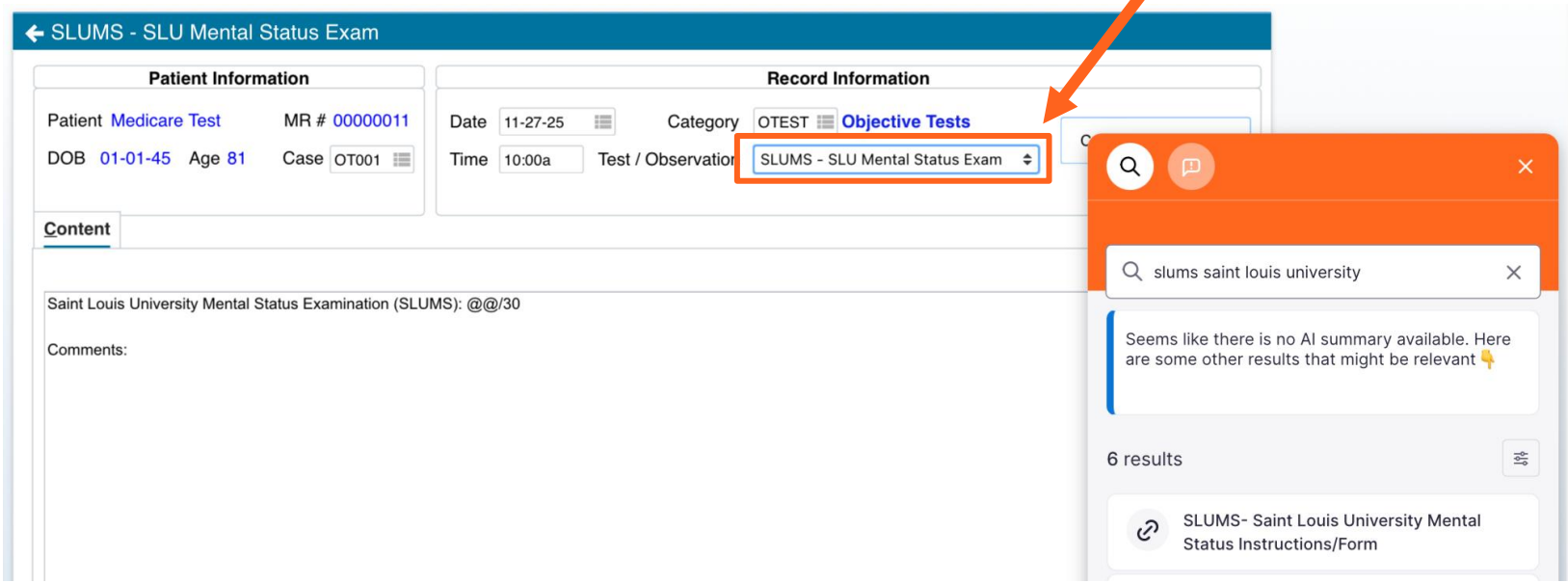
- You can find more Tests in the "Test/Observations" item (SLUMS, VHI-10)
- Right click into panel and select Add
- Click into "**Tests/Observations**" from the list to find more Tests





Objective – Objective Tests (Continued)

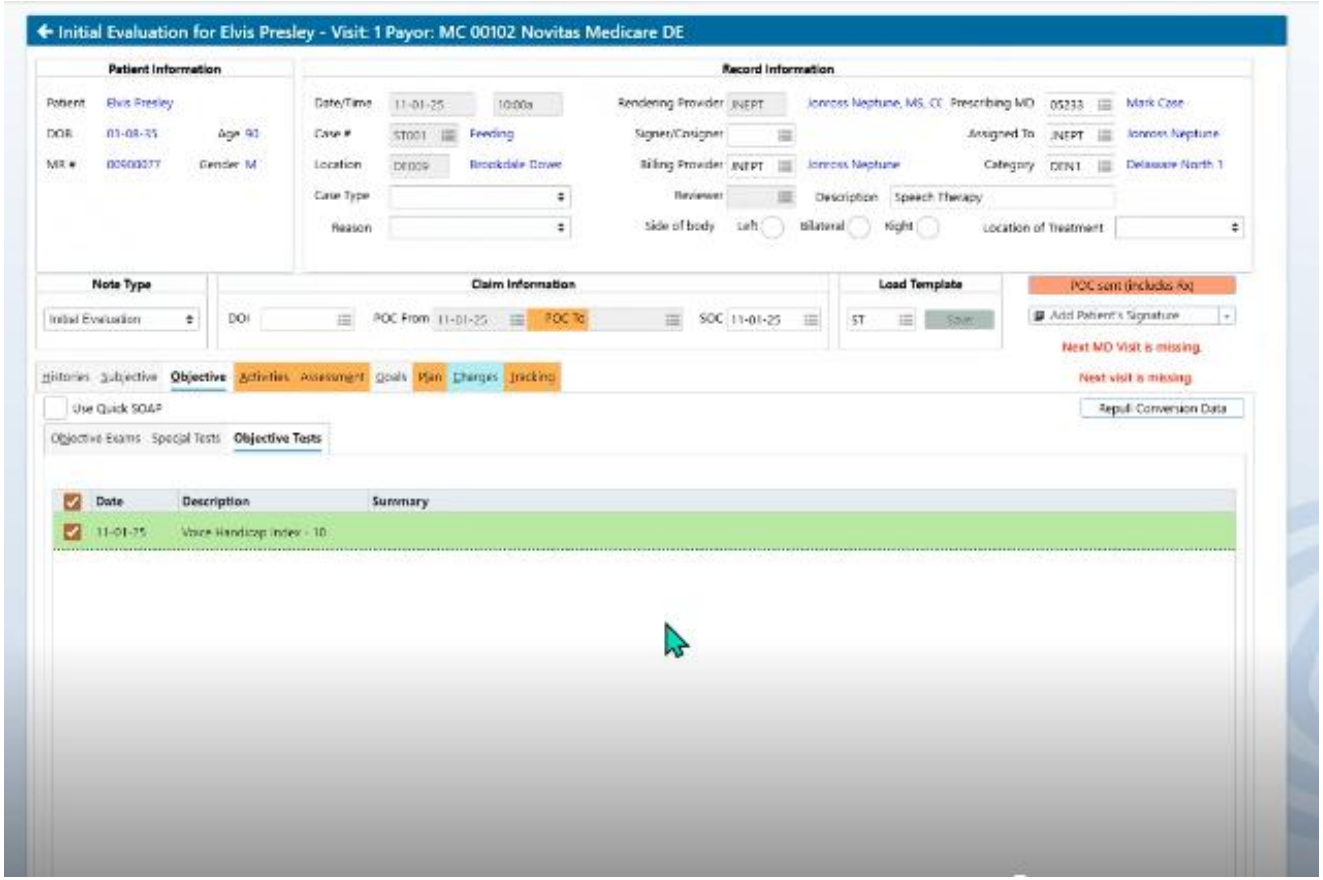
- When the **Test/Observation** box opens, use the **drop down arrows** to view and select the test you would like to complete
- Complete the test, and then save at the top right of your screen



If you need instructions or a form to complete an Objective Test, type the name of the test in **"Self Help"** and you will find a link or PDF to most test instructions

VIDEO TIME: IE Objective

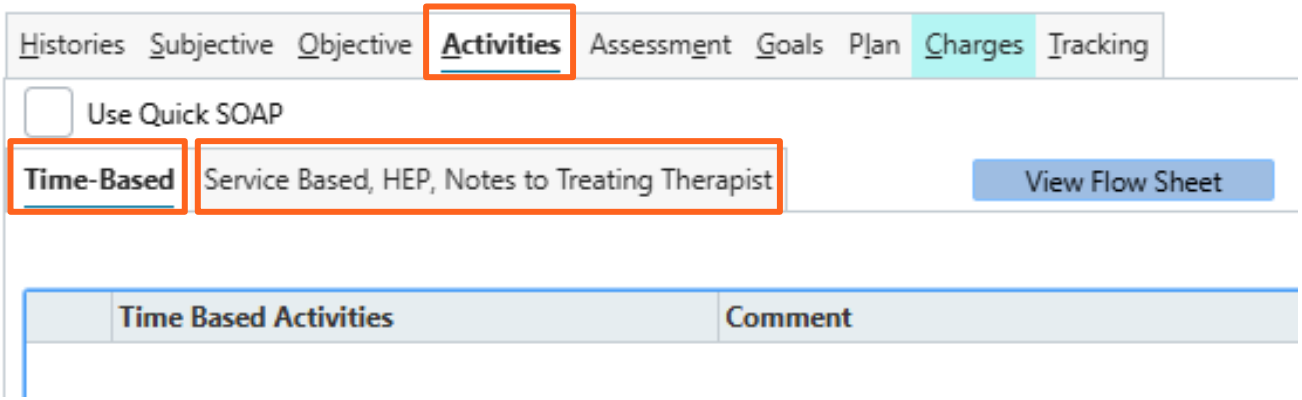
Watch it NOW!
Click Image Below to Watch A Video



Activities

All billable treatment interventions are documented on the Activities Tab

REMINDER: any CPT code (items marked with *asterisks*) that you plan to bill in the plan of care MUST be included in the Planned Services (Plan Tab)

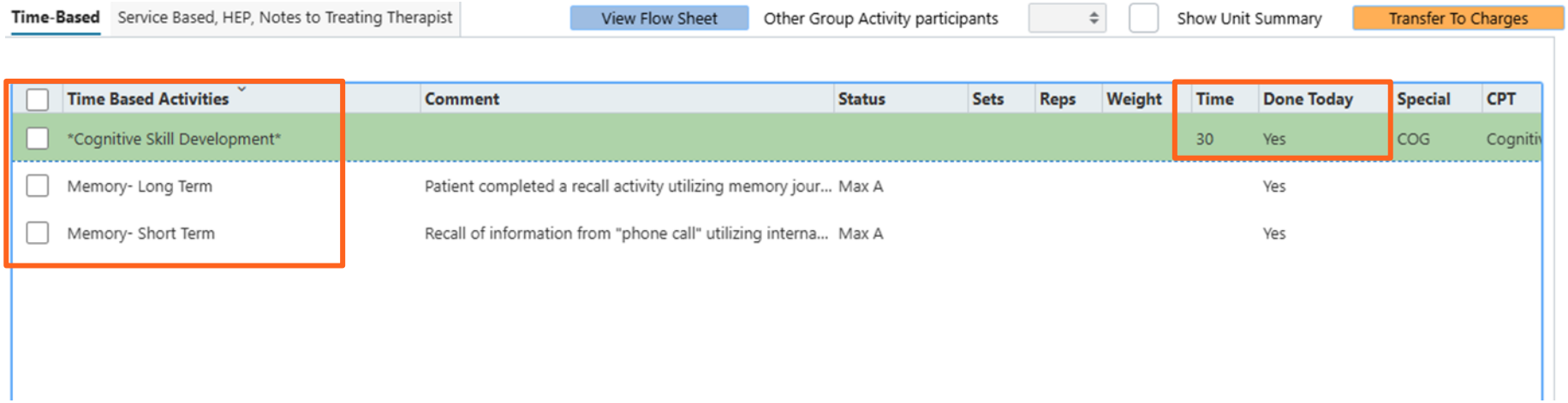


You will enter time-based interventions on the "**Time-Based**" tab and service-based interventions on the "**Service Based/HEP/Notes**" tab

Example- Cognitive Skills Dev is listed on Time-Based, and Speech/Language and Dysphagia are listed on Service Based

Activities – Time Based

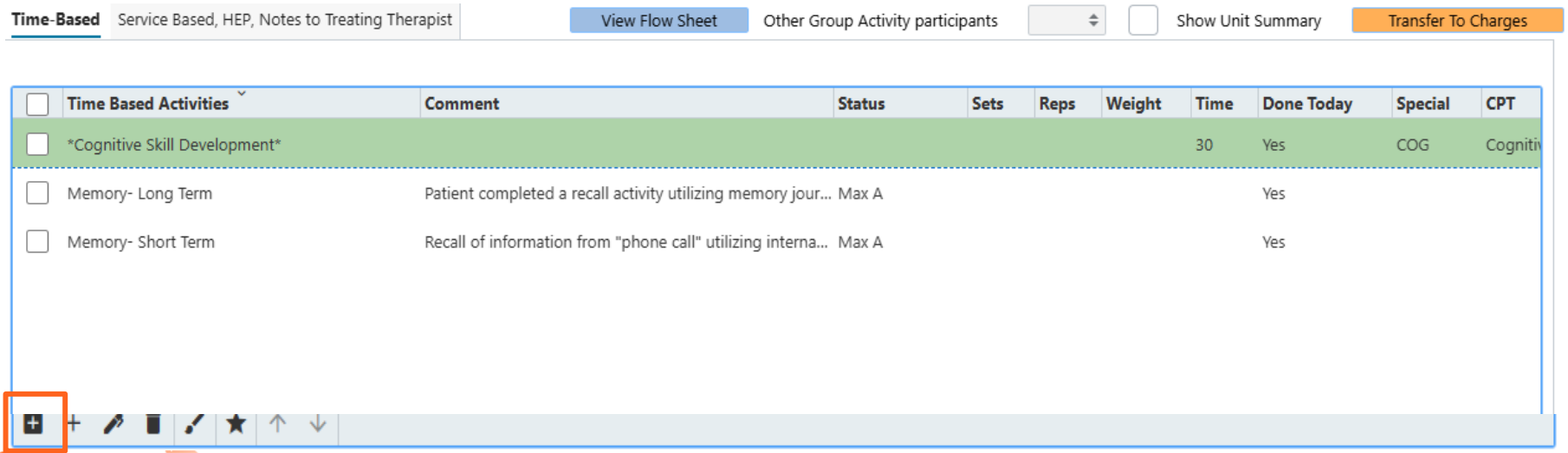
- **Green items** with *asterisks* are tied to CPT codes and will pull to charges tab
  - You must **enter time** for each CPT code item and **indicate "Done Today"**
  - **DO NOT DOCUMENT ANY COMMENTS OR SKILLED CARE IN THE GREEN ITEMS**
- Document skilled intervention supporting each CPT code **under** the relevant Green CPT line item (NOT IN THE GREEN LINE ITEM)
  - Click the CPT code you are going to add intervention for, then use + to add appropriate items from the picklist (ex: "*Cognitive Skills Dev* > Memory-Long term and Short Term)
  - All skilled intervention must have measurable assist level, quantification (sets/reps) when appropriate, and must include skilled care comments. Do not enter time here (enter time on green line)
- **IMPORTANT!!** Do NOT click the top/title of each column to sort
  - This will cause the items to sort and interventions will not be under the appropriate CPT code



Activities – Time Based (other tips)

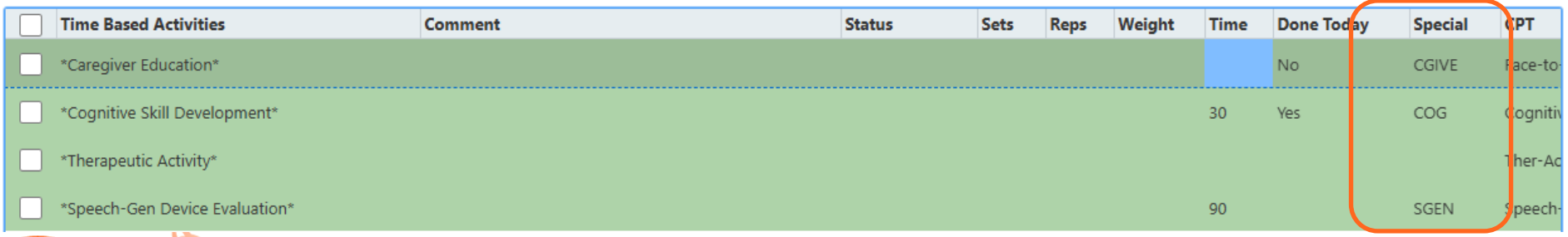
To add items to the Time-Based Activity grid:

- Use the + to open and search picklist
  - Use **Quick Find** to search for specific activities (this list is long; **favorites** will be helpful)
- You can check off multiple items, then Save
- Update status (assist), sets, reps, weight as applicable. You can also customize name of activity or create your own. **For SLP, much of your treatment information will be documented under the comment sections.**
- **Reminder:** Time should only be added to Green CPT code items (these are tied to billing)
- Select Done Today - if not the charges will not transfer
  - You can have activities in the log that are not done every visit to save time documenting in future visits



Activities – Time Based (Special Codes)

- Special Codes
  - A few codes listed in the Time Based Activities picklists are considered "special codes"
    - These are CPT codes that have time threshold that must be met prior to opening access to the second / add on CPT code
      - 97129 / 97130 Cognitive Skills Development (SLP)
      - 97550 / 97551 Caregiver Education
      - 92607 / 92608 Speech Generating Device Eval (SLP)
    - You only need to add one CPT code line item within the Time Based Activity grid
      - Raintree will calculate the correct distribution of time within each code set listed above.
      - Example – 30 minutes entered for "Cognitive Skills Development"
        - 15 minutes will be applied to 97129 and 15 minutes will be applied to 97130 for 2 Total units



	Time Based Activities	Comment	Status	Sets	Reps	Weight	Time	Done Today	Special	CPT
☐	*Caregiver Education*							No	CGIVE	Face-to-
☐	*Cognitive Skill Development*						30	Yes	COG	Cognitiv
☐	*Therapeutic Activity*									Ther-Ac
☐	*Speech-Gen Device Evaluation*						90		SGEN	Speech-

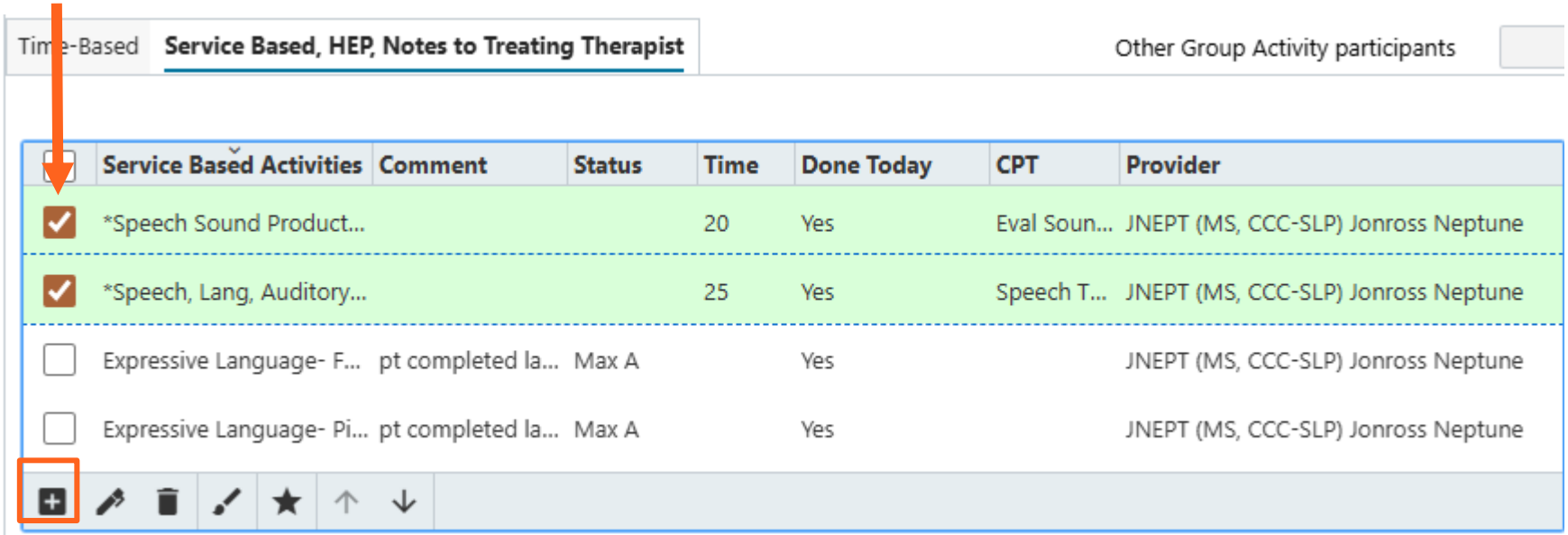
Activities – Service Based

Any service based billing (CPT coded) and interventions are added on the Service Based tab

- The picklist here functions the same as on the Time Based tab (exception: CPT items on Service-Based grid are not green unless the check box is selected)
- Click + and search/find the service based activities in the picklist > Save
- Update comment, status, time, indicate done today

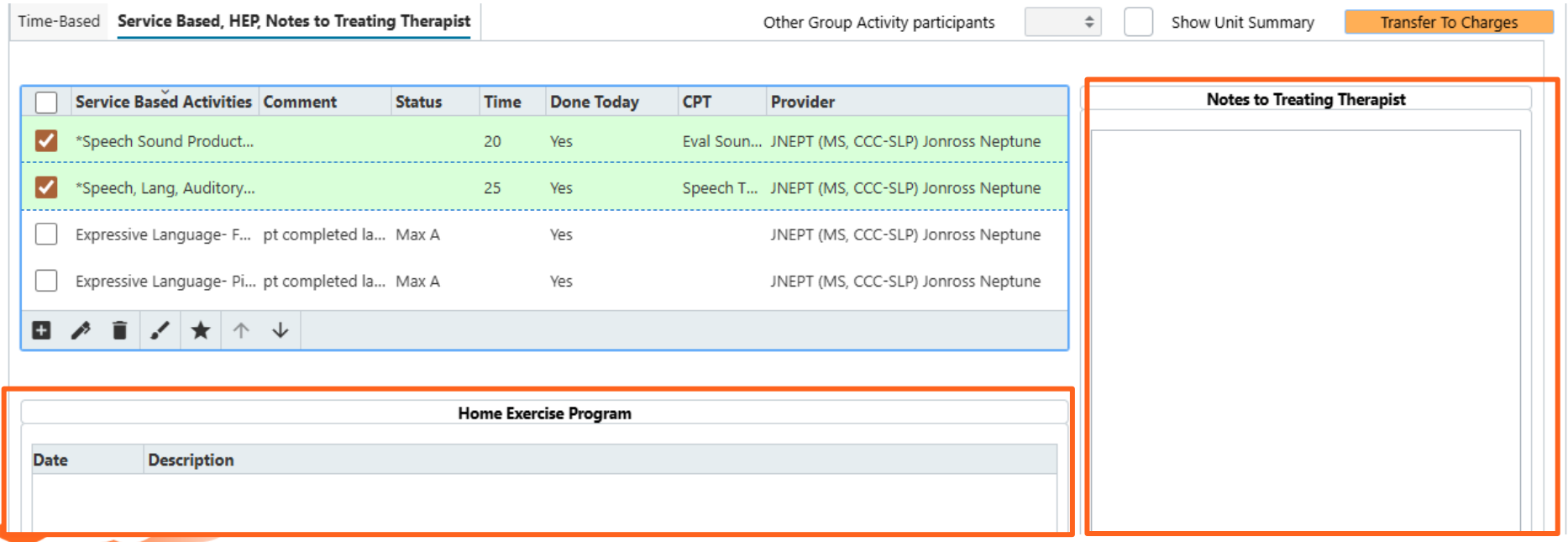
Evaluation Codes, Speech/Language, Dysphagia, and SGD are Service Based codes and will need to be populated here for proper documentation and billing.

- *NOTE-When unchecked, CPT code line items will not show in green like Time Based.*



Activities – HEP, Notes to Treating Therapist

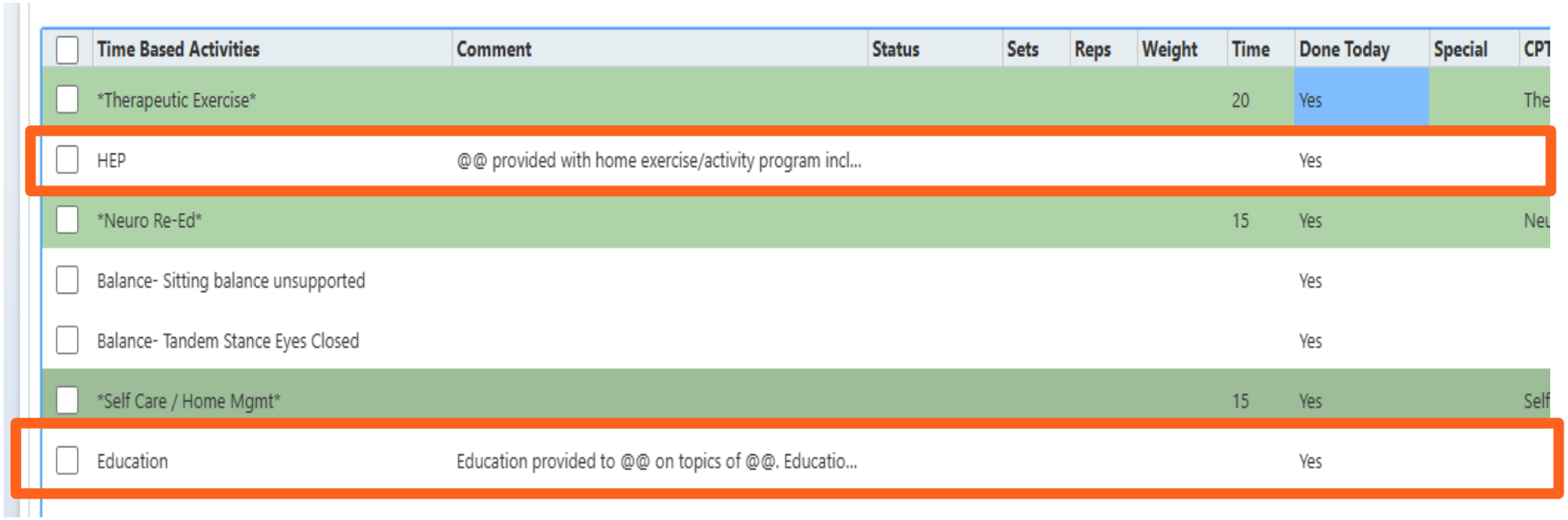
- **Home Exercise Programs** can be added/uploaded in the Home Exercise Program box by right clicking > Add
  - Medbrige HEP function similair to RT Custom. See training for details
    - Medbridge Standard Transition
  - It is still important to document HEP education on Time-Based or Service-Based activity grid to add details about who was educated, level of assist and returned level of understanding.
- **Notes to Treating Therapist** can be used to communicate to other therapists – KEEP IN MIND THESE DO NOT END UP IN THE NARRATIVE



Activities – Education

Education should be documented early and often throughout the plan of care

- Add Education as an item under the relevant CPT code in the Time-Based Activity log; there are @@ within this item to prompt you on what details to document.
- Add in HEP in this section to add more details and tie into the correct CPT code
  - You can use MedBridge HEP link (on Service Based, HEP, Notes to Treating Therapist tab) to create HEP document that is sharable with patient. Details of HEP can be copied/pasted into the HEP line item in Time-Based Activities grid



Time Based Activities	Comment	Status	Sets	Reps	Weight	Time	Done Today	Special	CPT
Therapeutic Exercise						20	Yes		The
HEP	@@ provided with home exercise/activity program incl...						Yes		
Neuro Re-Ed						15	Yes		Neu
Balance- Sitting balance unsupported							Yes		
Balance- Tandem Stance Eyes Closed							Yes		
Self Care / Home Mgmt						15	Yes		Self
Education	Education provided to @@ on topics of @@. Educatio...						Yes		

Activities – Time In and Out

Time In and Time Out is required to sign off on notes in RT Standard

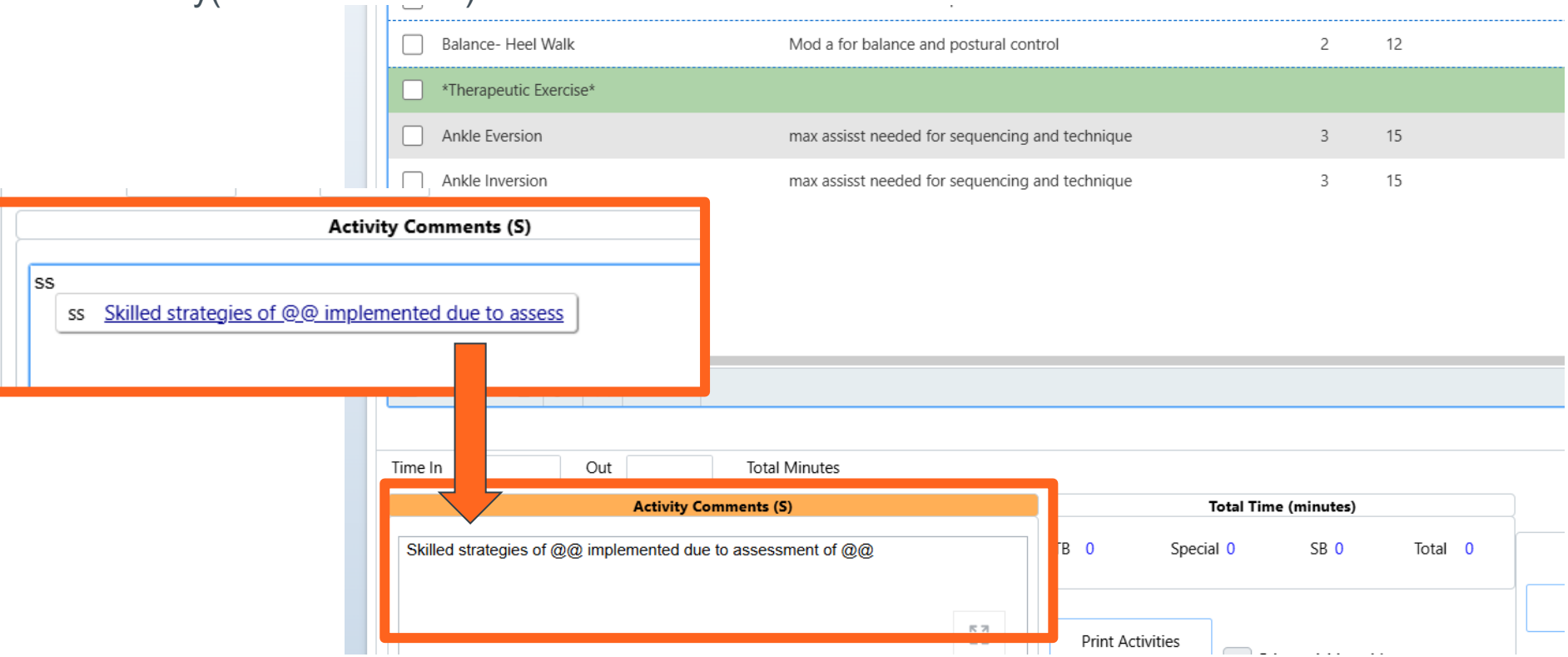
- Time In and Time Out will be entered on the Activities tab, under Activities log
  - Time should be entered in (hh:mm a/p)
    - **a** indicates AM and **p** indicates PM
  - Raintree will allow underbilling (billing for less than total minutes), but not overbilling (billing for more time than total minutes)
  - If you split a session (multiple time in/out), enter the first IN time and last OUT time, then specify additional time IN/OUT in the Activity Comments box



You can also use the Activity Comments box to document **Post Activity Vitals**

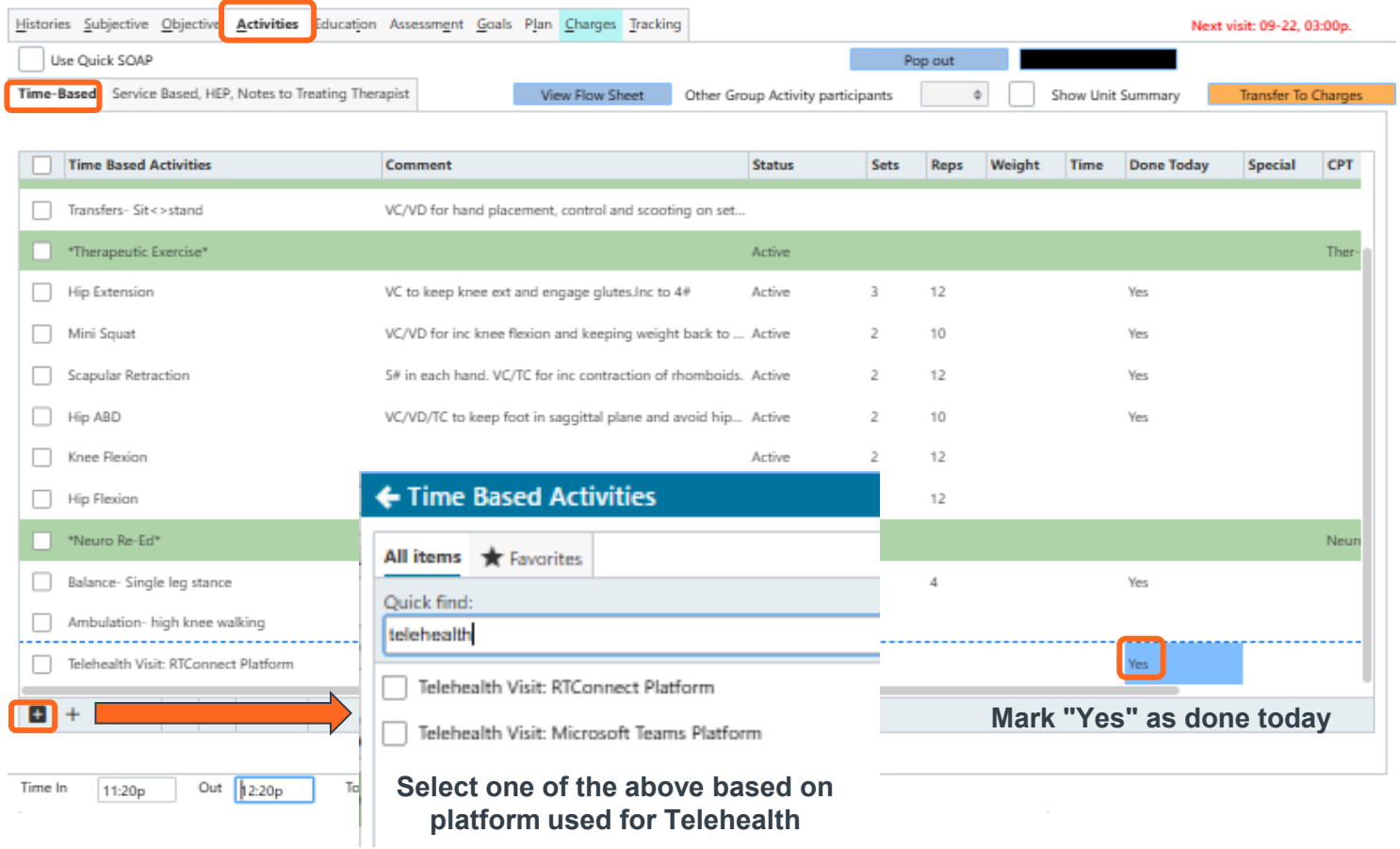
Activities – Skilled Strategy Statement

- In the activity comments box, you can document the skilled strategy that was provided this session
- You can type "ss" + space in the Activity Comments box to load the prompts for the skilled strategy statement that includes jump markers
- Skilled components may also be documented in the "Comment" section of each activity(white line items)



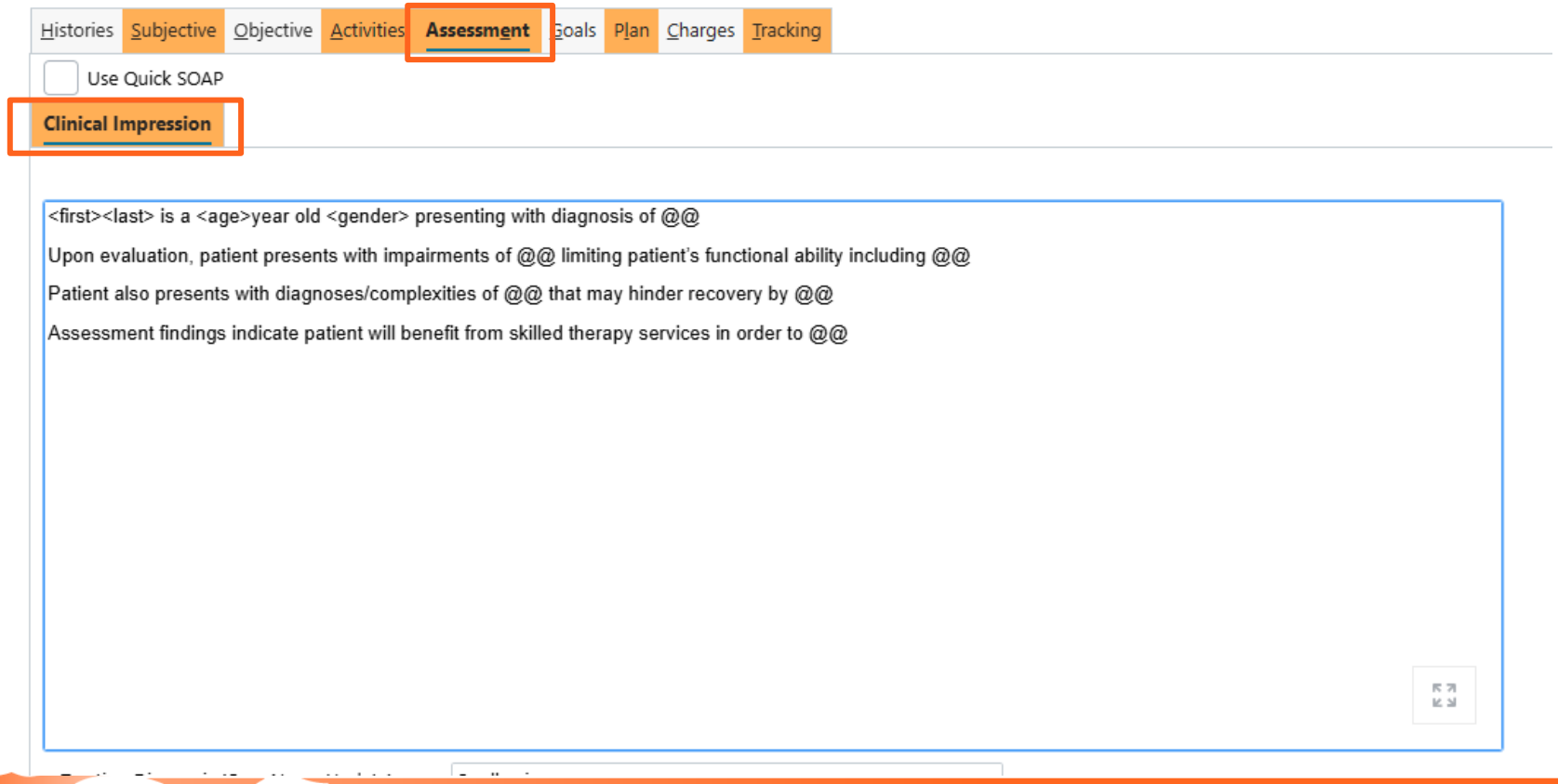
Activities - Telehealth Documentation

- If performing a telehealth visit, you MUST Select "Telehealth Visit" item from picklist and mark as "Done Today" within "Time Based Activities" picklist
  - This ensures documentation of platform used



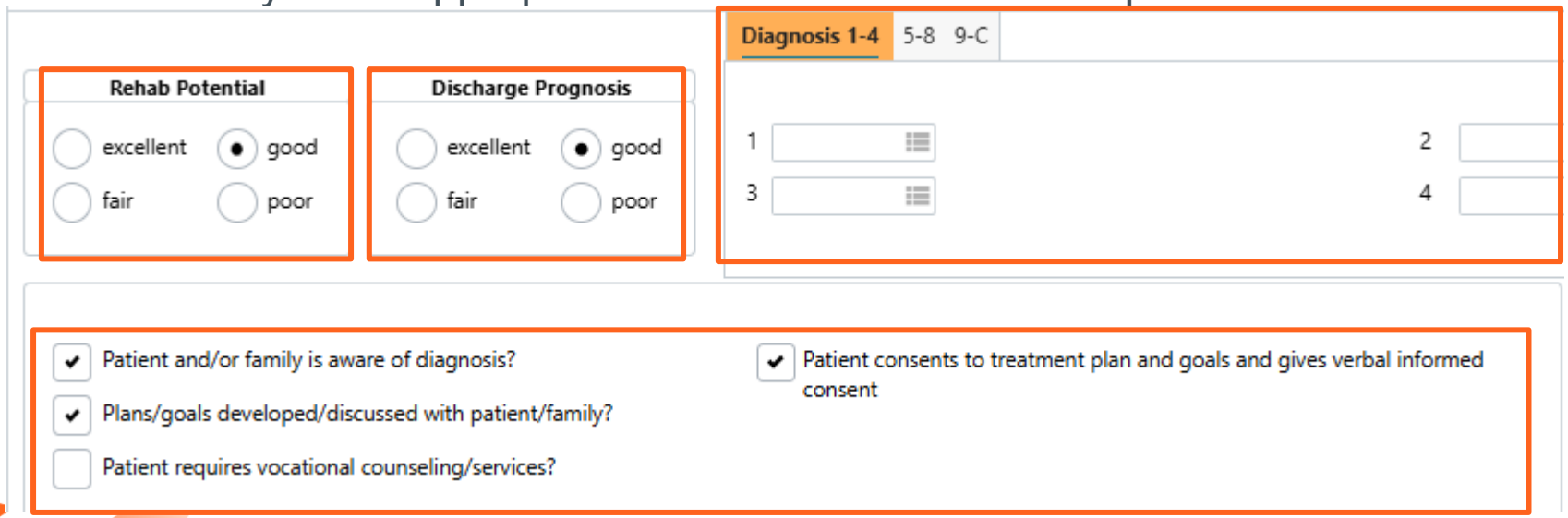
Assessment – Clinical Impression

- Navigate to the **Clinical Impression** of the Assessment tab
- **DO NOT** change entries for merge tags (<first> <last> etc) - this data will pull directly into your narrative from patient's chart
- Complete the Clinical Impression by filling out appropriate information
  - iPad users – use keyboard shortcut "**ctrl**" and "**cmd**" and "**.**" or navigate with mouse to complete all (@@) place holders. Non-iPad users can navigate jump markers by pressing **"ctrl"** and **"."**



Assessment – Other

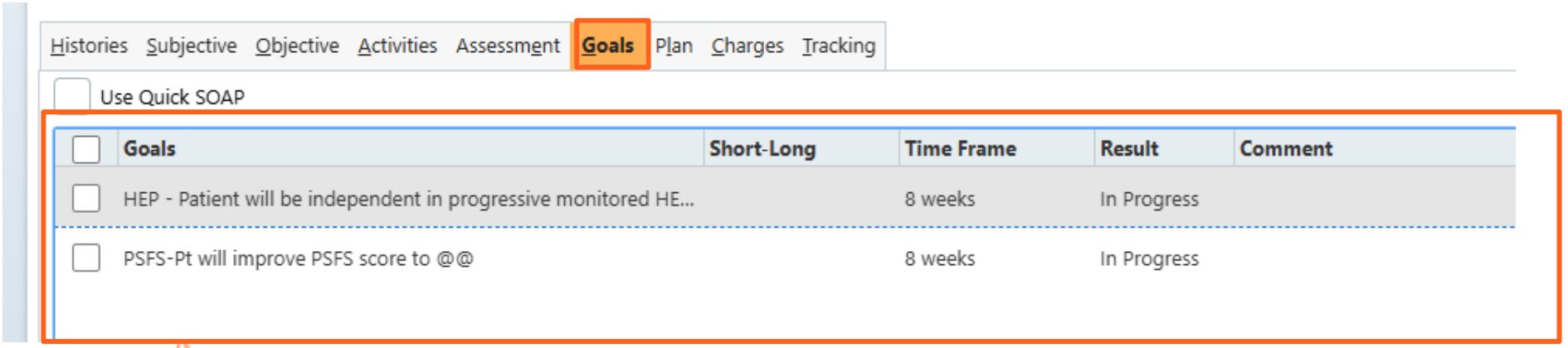
- Scroll down to find the following items under Clinical Impression
- Confirm/change **Rehab Potential** to the appropriate selection for patient
- Confirm/change **Discharge Prognosis** to the appropriate selection for patient
- Enter **ICD 10 Diagnosis Codes** by typing directly into the box or using menu icon to open and search for your code
  - #1 needs to be a Rehab diagnosis
  - Additional rehab diagnosis listed after #1 (optional)
  - Primary Medical diagnosis listed LAST (no additional medical codes are needed)
- Check off any other appropriate selections related to the plan of care



Goals

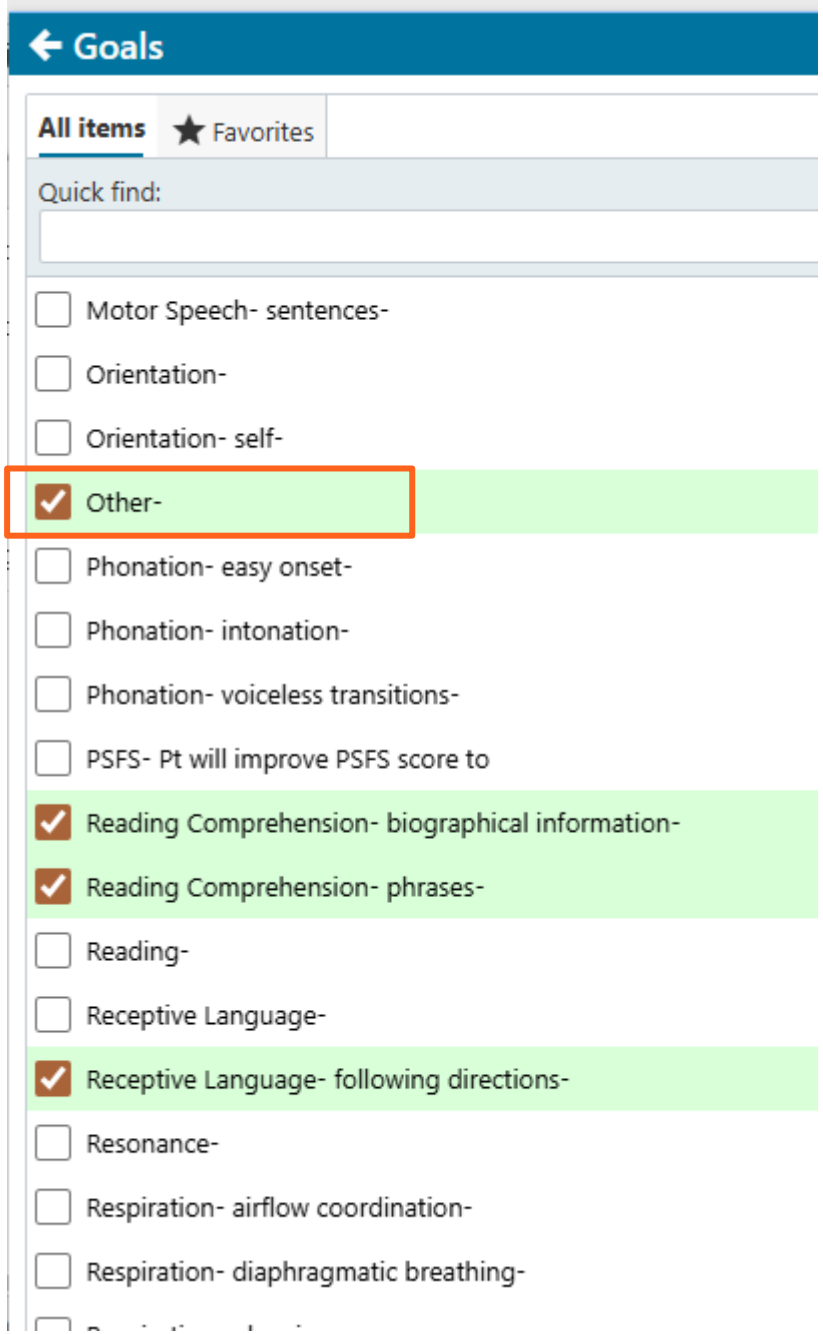
All functional deficits documented must have a goal addressing them, or documentation about why no goal is being set

- Goals should be added from the **Goals** tab
- 2 goals will pre-load automatically:
  - **HEP** goal – All patients must have a Home Exercise or Home Activity Program goal
  - **PSFS** goal – All patients must have a PSFS assessment and goal; this goal has @@ to make sure you document the WHY behind this goal
- Double click on the goal to open and edit the goal so that it is patient specific
- Add **time frame** for goal
- All goals need a **functional component** added to the goal
  - Ex. *"Improve speech intelligibility to 80% in all speaking situations in order to communicate wants and needs"*



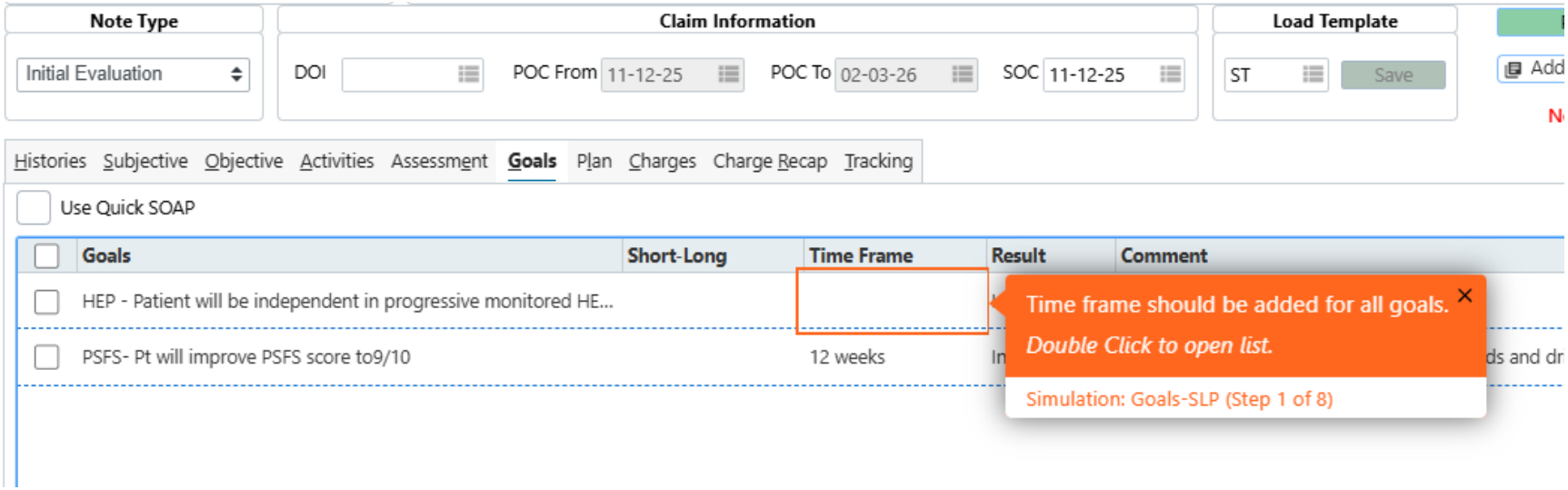
Goals

- Other relevant goals can be added using + to add items from picklist
- Check the goals you want to include, then Save
  - **"Other"** can be used to create your own goal (delete "other" and free text your goal
- Once goals are selected, double click to edit and make each goal patient specific
  - **IMPORTANT:** Add relevant goal specifics and update the desired assist level
  - **IMPORTANT:** all goals need a functional component added and a time frame
    - Ex. *"Receptive Language – Following Directions- 3 step written directions with IND in order to complete daily activities"*



SIMULATION TIME: Goals

Try it NOW!
Click Image Below to Start the Simulation

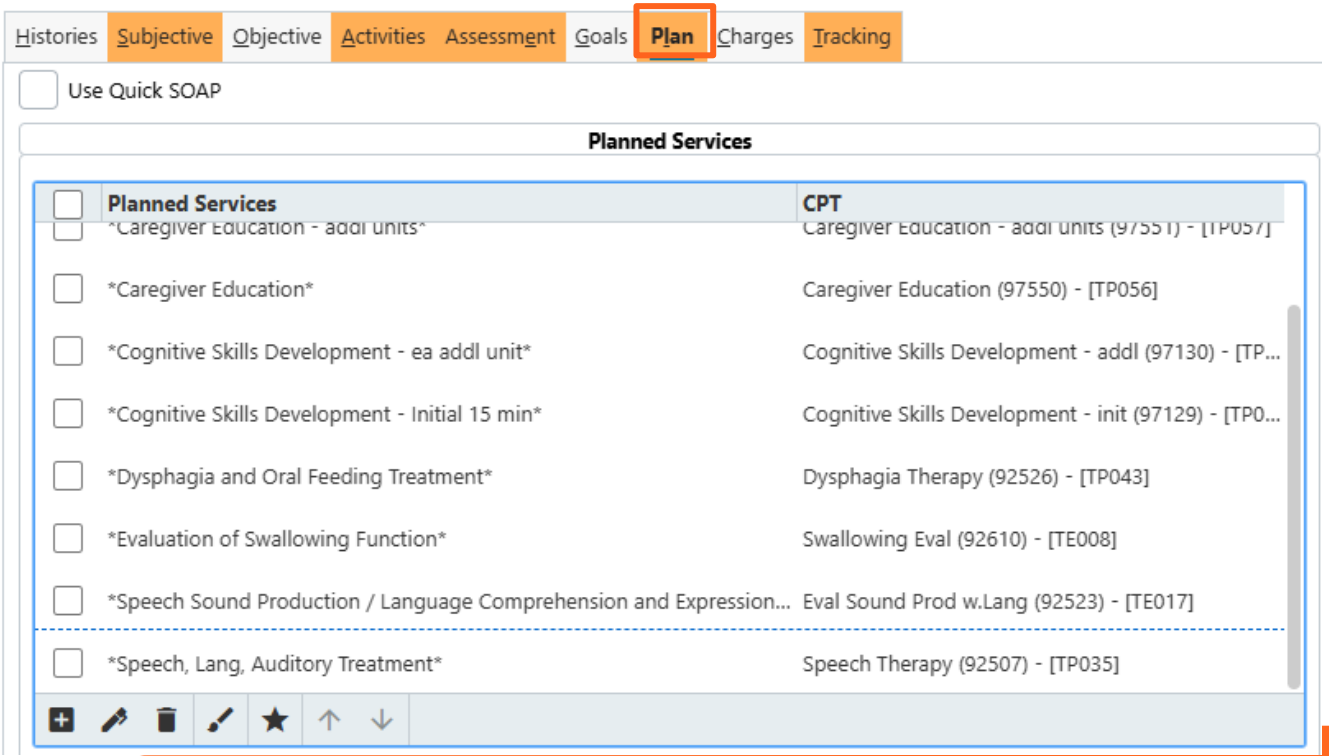


**If the simulation does not automatically display an orange pop up box, refresh your browser.

Plan – Planned Services

IMPORTANT!!! All interventions that might be included in the plan of care **MUST** be added in the "Planned Services" picklist on the Plan tab

- Click + to open picklist and select all appropriate interventions
  - This picklist has items for all disciplines – would be a great use of **Favorites** to save items you use frequently
  - Items marked with **asterisks (*)** are tied to CPT codes. **YOU WILL NOT BE ABLE TO BILL THESE UNLESS YOU MARK THEM IN THE PLANNED SERVICES PICKLIST.**

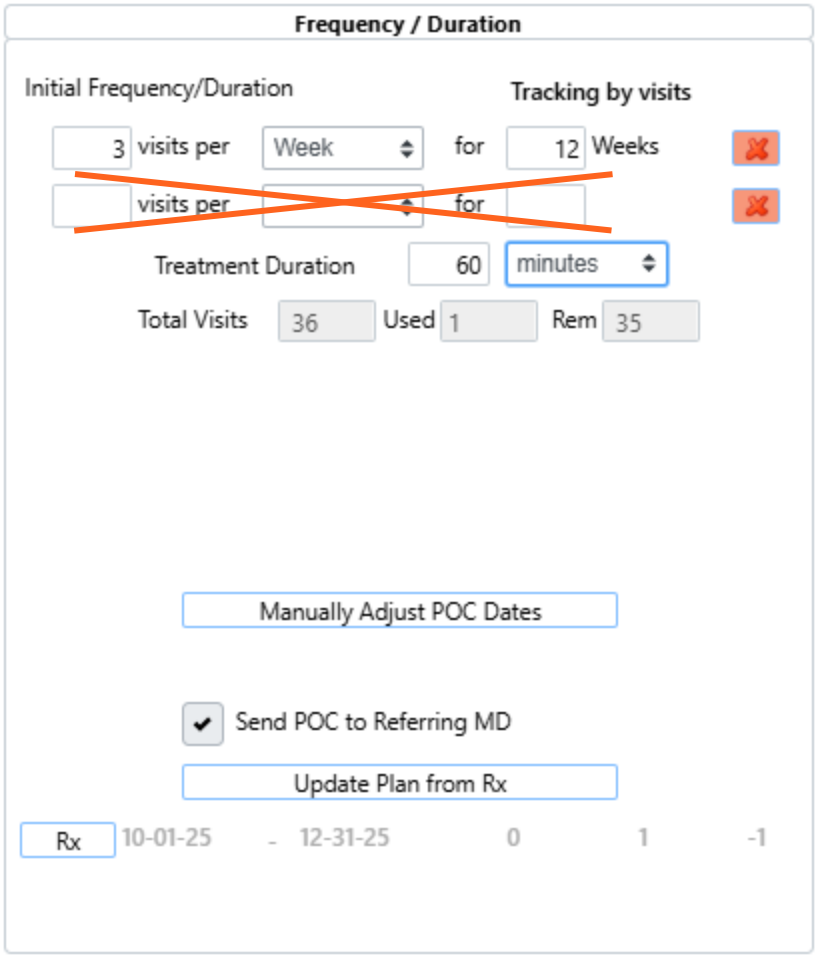


Plan – Frequency/Duration

- Enter the **frequency** and **duration** (in weeks) for the plan of care
- Recommend NOT to taper on evaluation. Best practice would be to complete a progress report when you decide to taper.

- Treatment duration will default to 60 minutes. Adjust duration if appropriate. If you select 60 minutes this does not mean you have to comply with 60 minutes every visit.

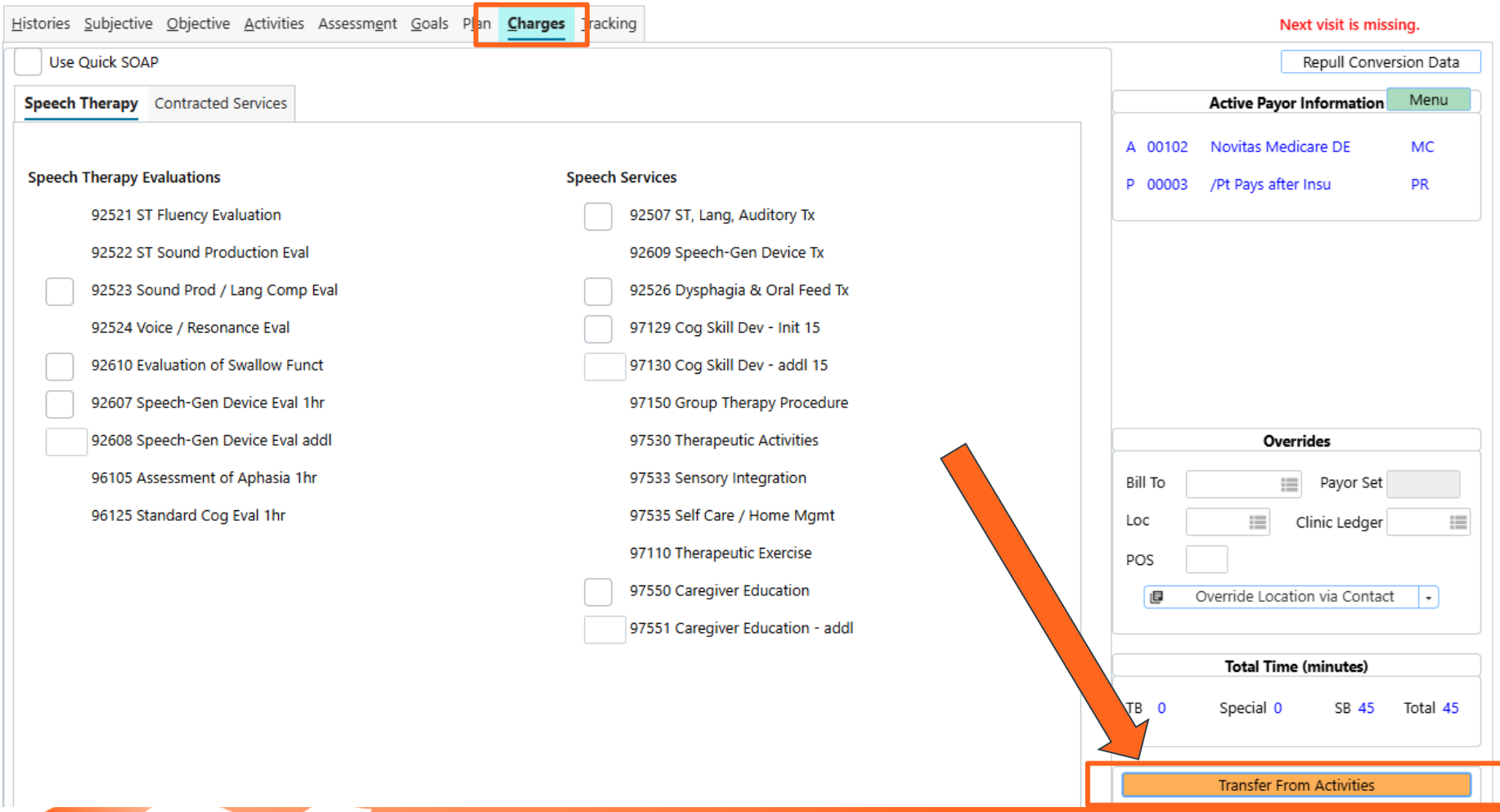
- Adding frequency and duration will populate the POC "from" and "to" dates and begin progress tracking



Charges

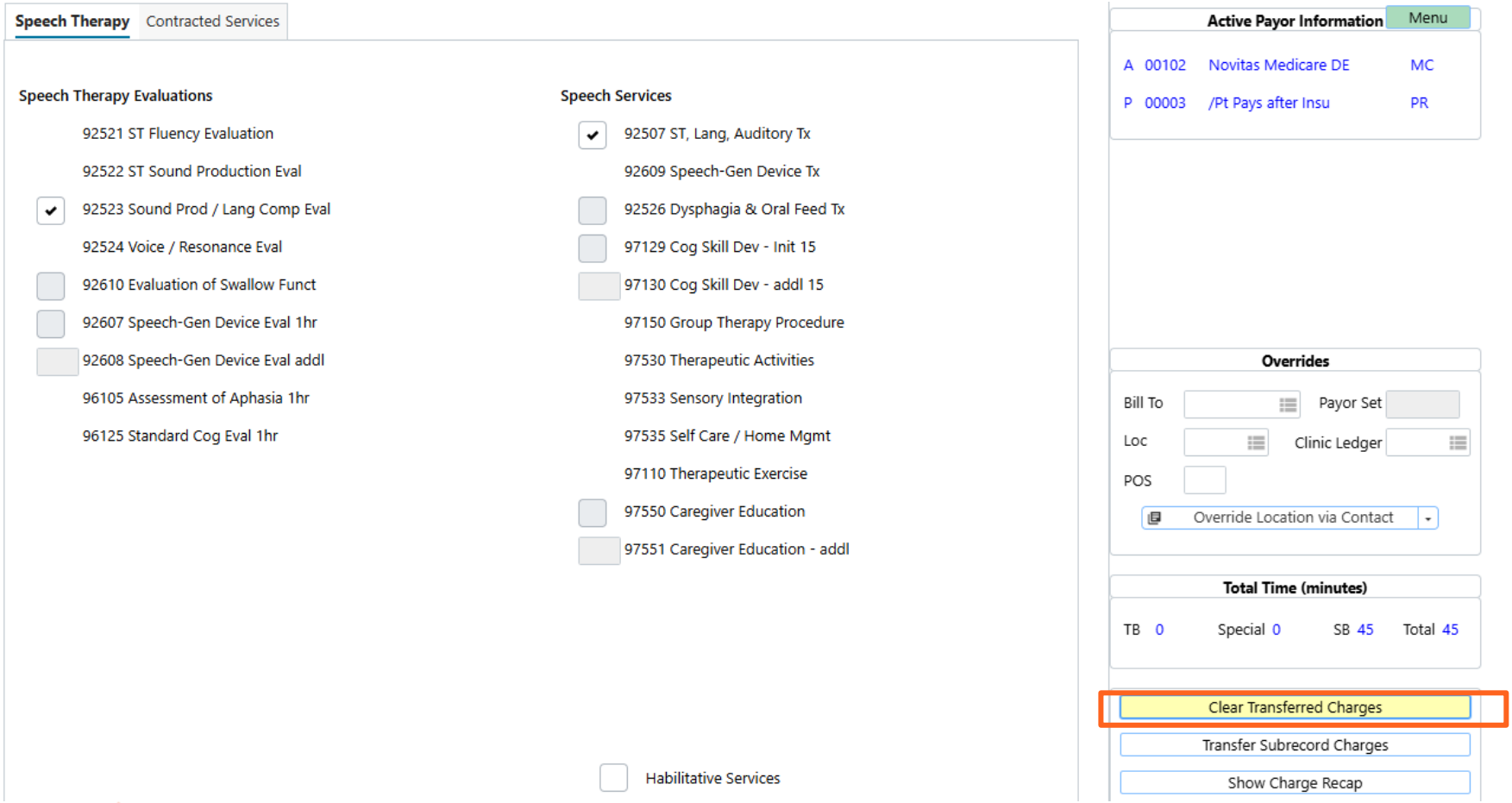
Once Eval is complete and all activities are documented, click **Charges** tab

- Click **Transfer from Activities** button to pull charges over



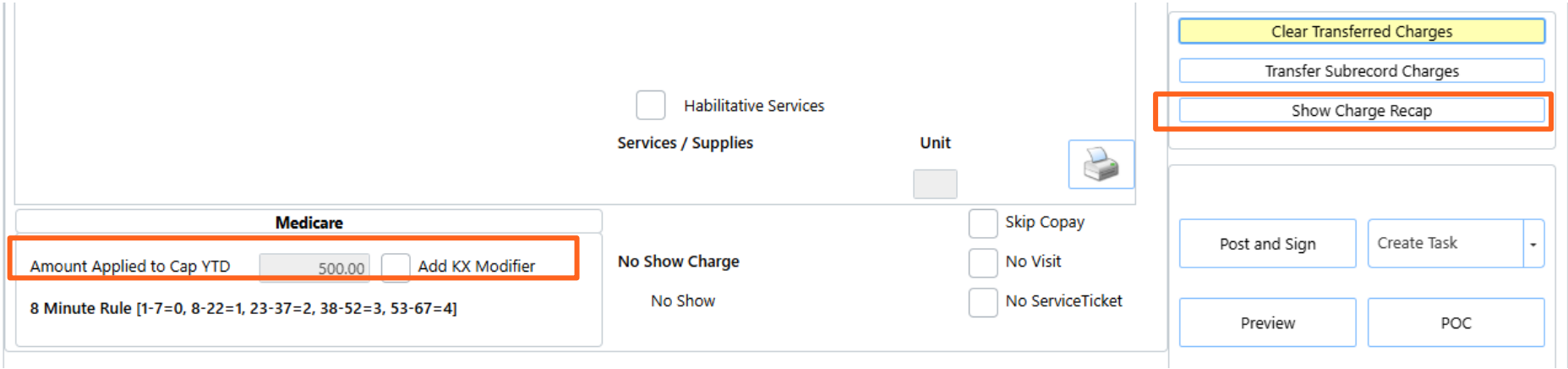
Charges (continued)

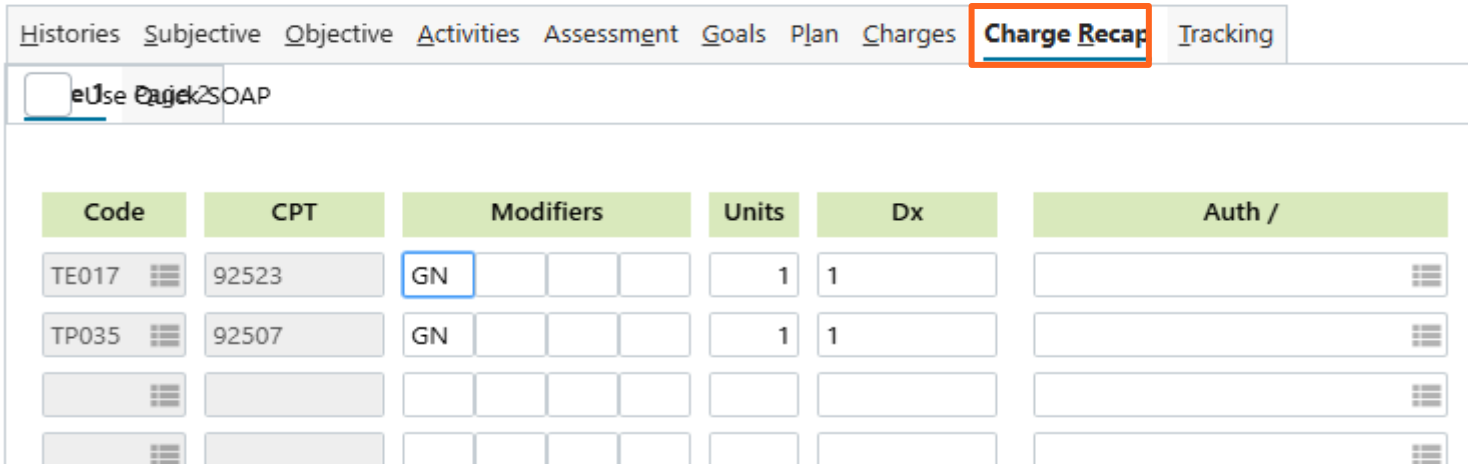
- Confirm units are appropriate based on documentation and 8 min rule
- If any changes are needed, "Clear Transferred Charges" and edit on Activities tab



Charges (continued)

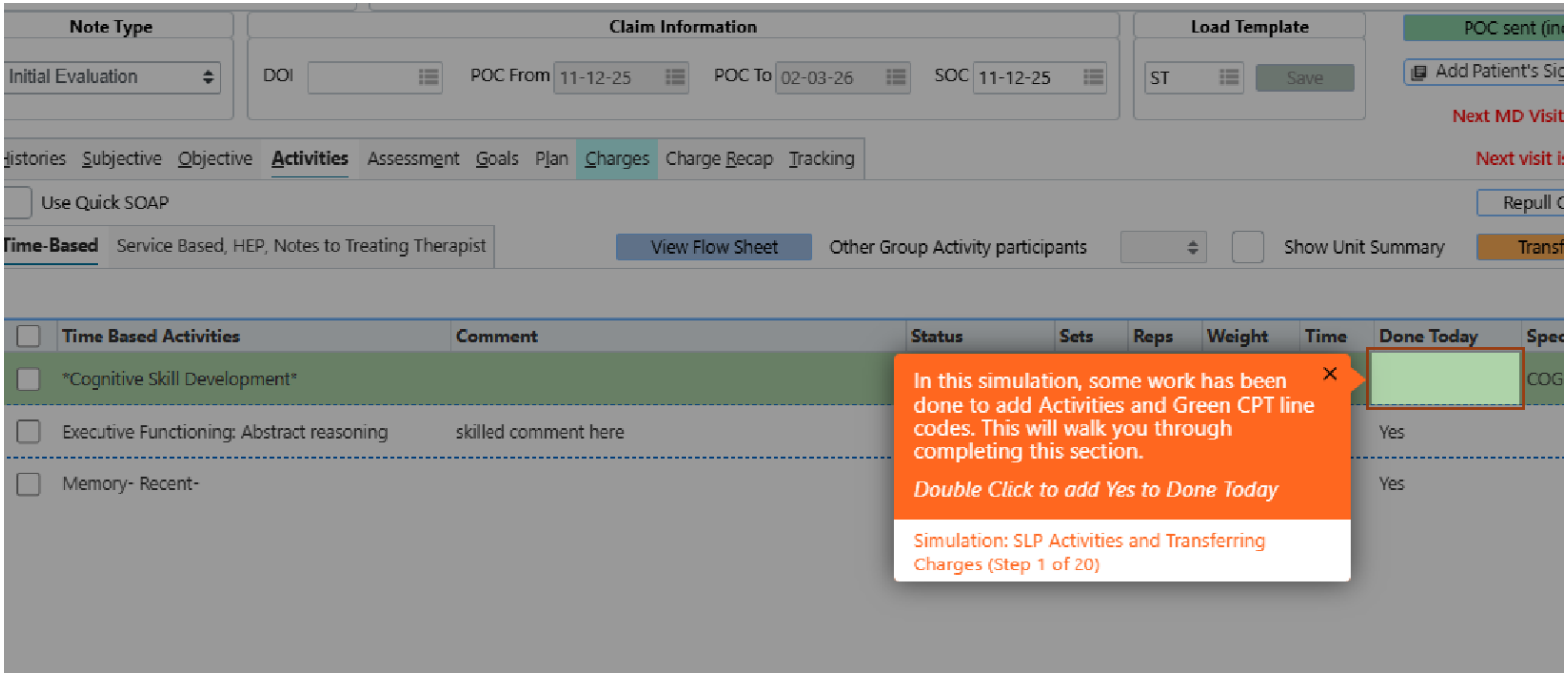
- **Medicare threshold** is visible at the bottom of the charge ticket
- **Modifiers** are visible on the charge recap (**"Show Charge Recap"**)





SIMULATION TIME: Transferring Charges

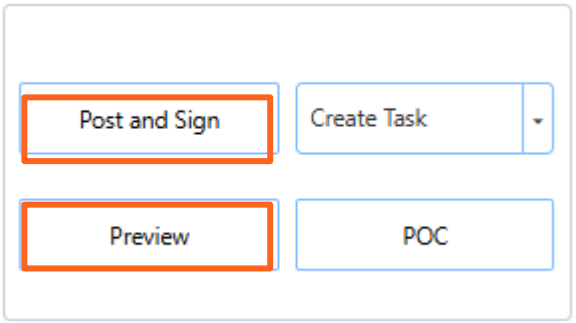
Try it NOW!
Click Image Below to Start the Simulation

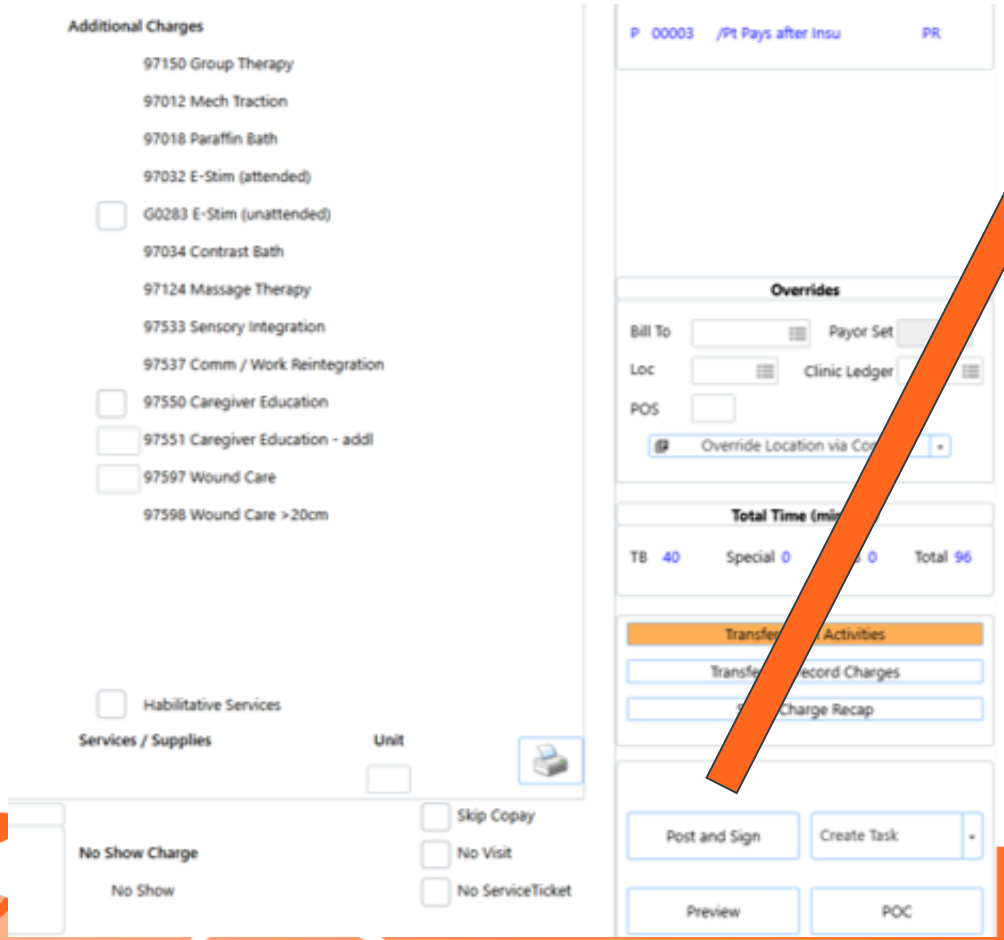


**If the simulation does not automatically display an orange pop up box, refresh your browser.

Narrative Preview and Sign Off

- Preview to review the narrative to ensure all information looks correct before signing off
- Post and Sign when you are ready to sign the note and post charges

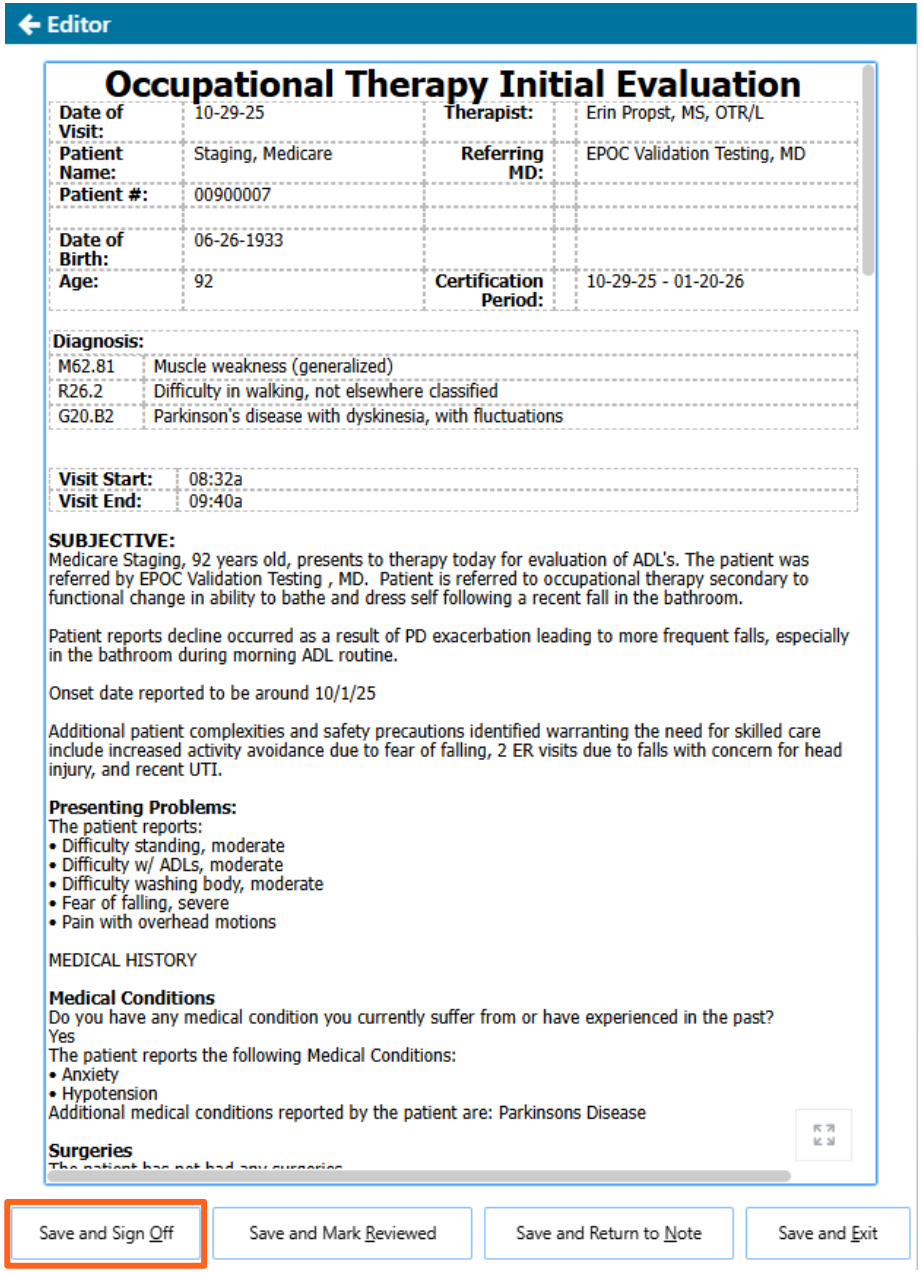




Save and Sign-off

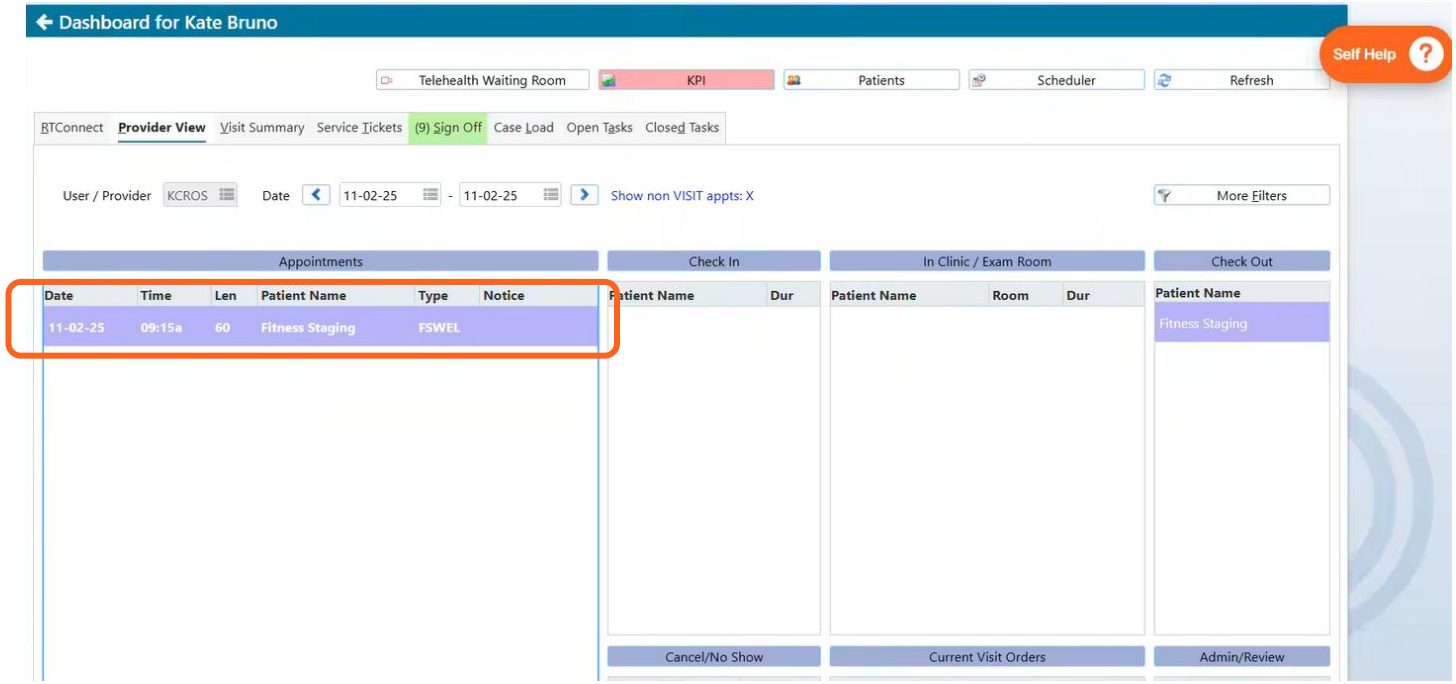
Complete final narrative review

- Click **Save and Sign Off** if you are complete
- Save and Return to Note to return and make edits
- Save and Exit to exit the note if you plan to return later for final sign-off



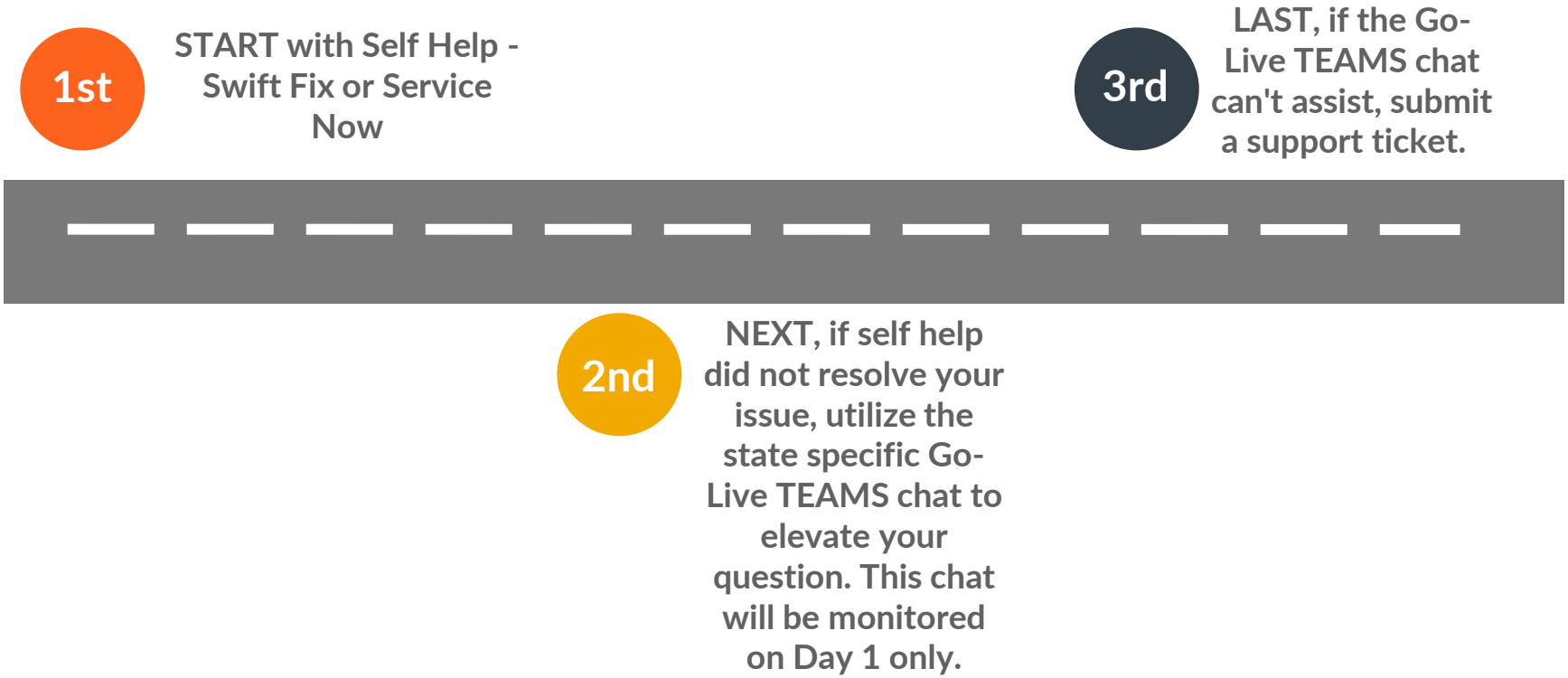
Confirmation

- After successful Sign and Post, visit will turn Purple
- If it is gray, it did not bill and you will need to go back into the note to post again.



Support Roadmap: Start Smart, Escalate Right

Have a question? Follow the path to resolution!



RT Standard
SLP Subsequent Treatment
(TVIST)



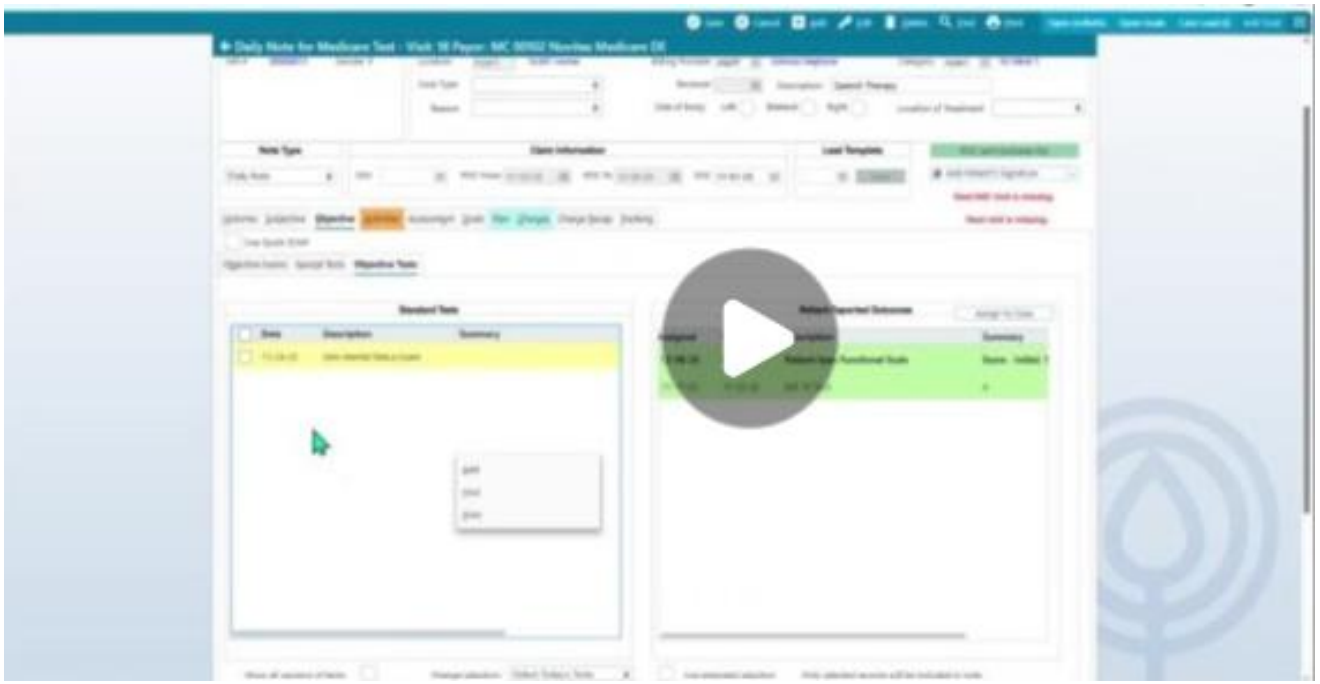
Subsequent Treatment Notes

- For SLPs Who Reviewed the IE/TX Visit presentation: Most treatment visits will follow the same steps described in the treatment part of the initial evaluation presentation.
- An 8-minute video covers the entire treatment visit process from beginning to end.
  - The slides after the video outlines the process with steps, directions and screenshots

VIDEO TIME: Subsequent Treatment Visits

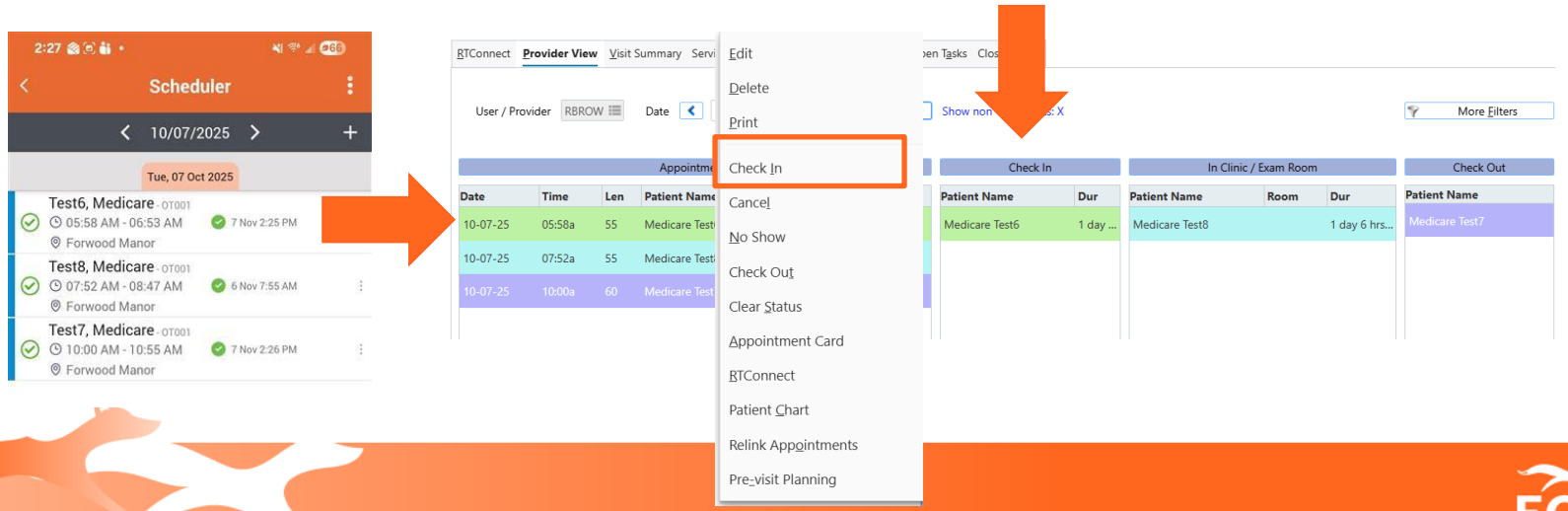
Watch it NOW!

Click the Image Below to Launch the Video



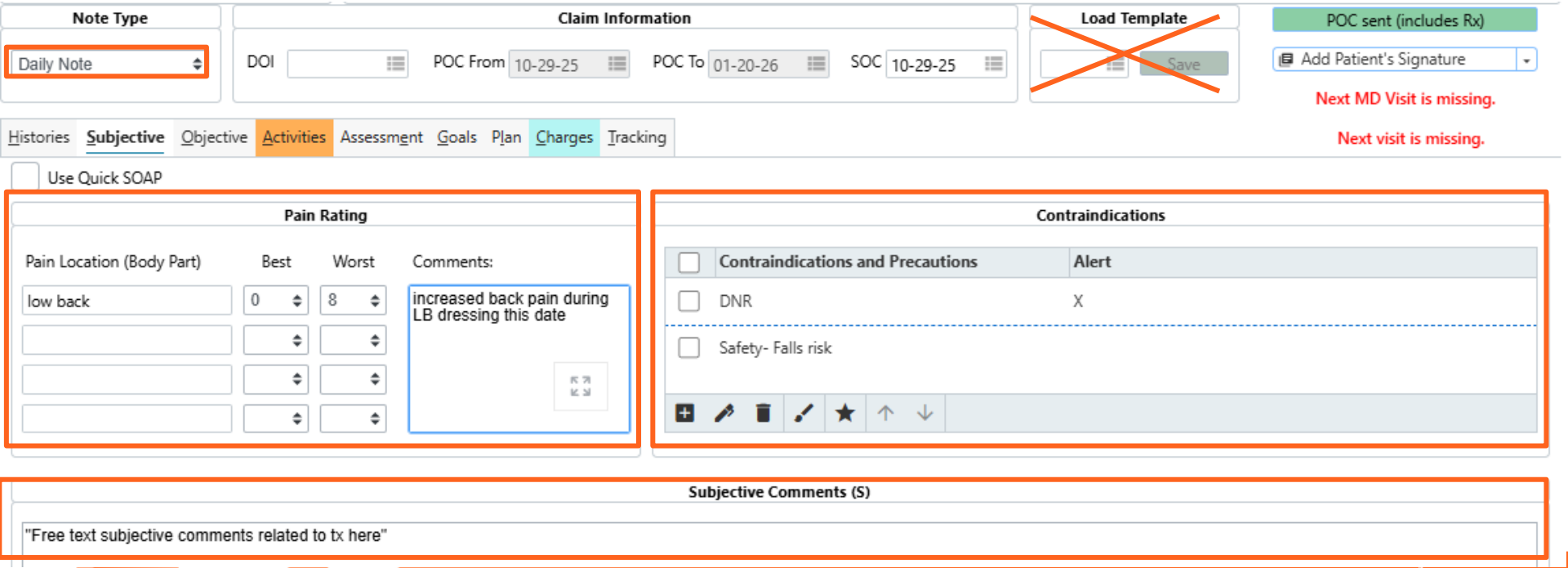
Launching a Note

- Schedule in FOX Trax- select the appropriate Reason for Visit (Visit)
  - Visit will display in RT Standard scheduler and **Provider View tab** under **Appointments**
  - Visits **MUST** be scheduled to start a note. RT Standard does not allow for notes to be created without an appointment.
- In **FOX Trax,** complete visit verification, ideally at the start of the session
- In **RT Standard**, right click the appointment and select **Check In**
  - The appointment will display in the "**Check In** " window
    - Double click or right click> edit to open the clinical note when ready to document.
  - In the event action is needed (due to patient forms being unsigned or previous notes not completed), prompts will display and then the appointment will display in the Check In window
    - See Consent Training for details on patient forms.
  - Read any additional prompts related to the patient so you are aware of any notices/alerts

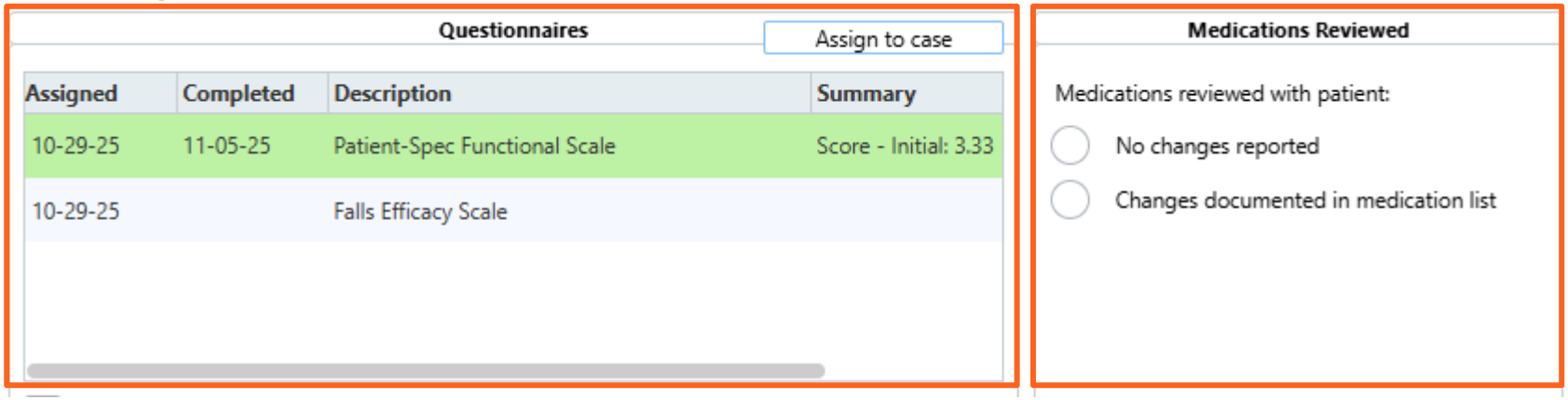


Subjective

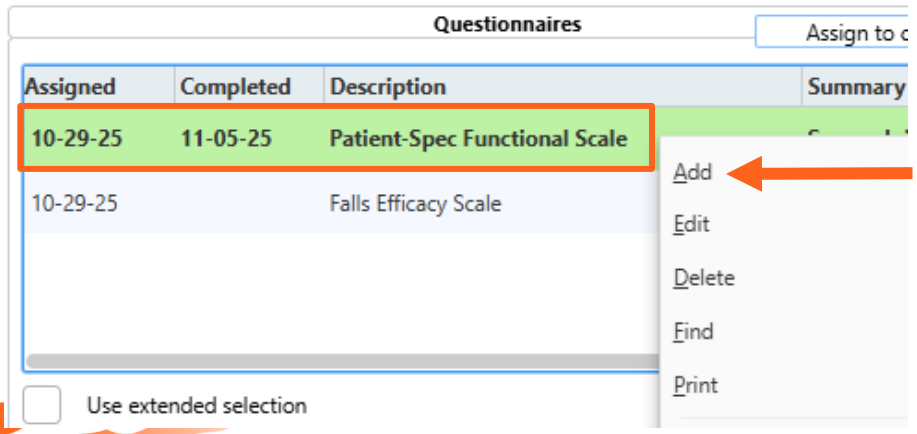
- Ensure the note type is a **Daily Note**
  - You can use the arrows ⇕ to change note-type if needed
    - Appointments scheduled as a telehealth visit will automatically select "Daily Note" type; Please be sure to change this as needed to reflect Telehealth Visit
  - **DO NOT** load a template for Daily Notes
- On **Subjective tab** you can document:
  - **Pain rating** – if applicable
  - **Subjective Comments** – Free text subjective comments to support tx encounter
  - **View Contraindications/Precautions** (and add/remove/update as needed)

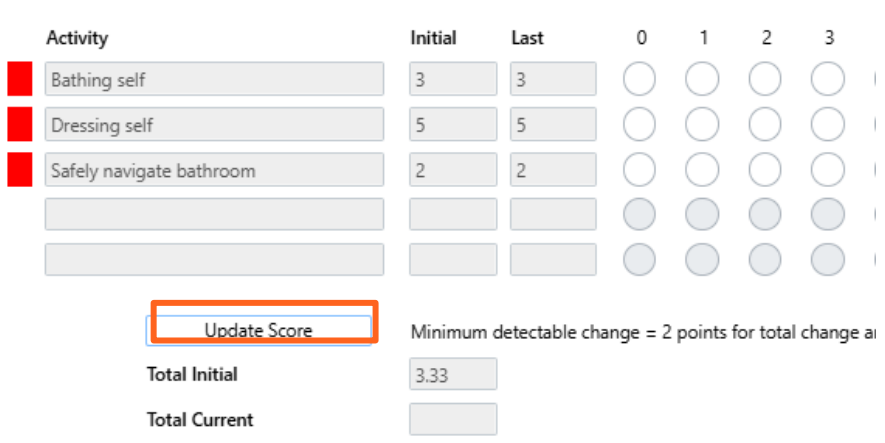


Subjective



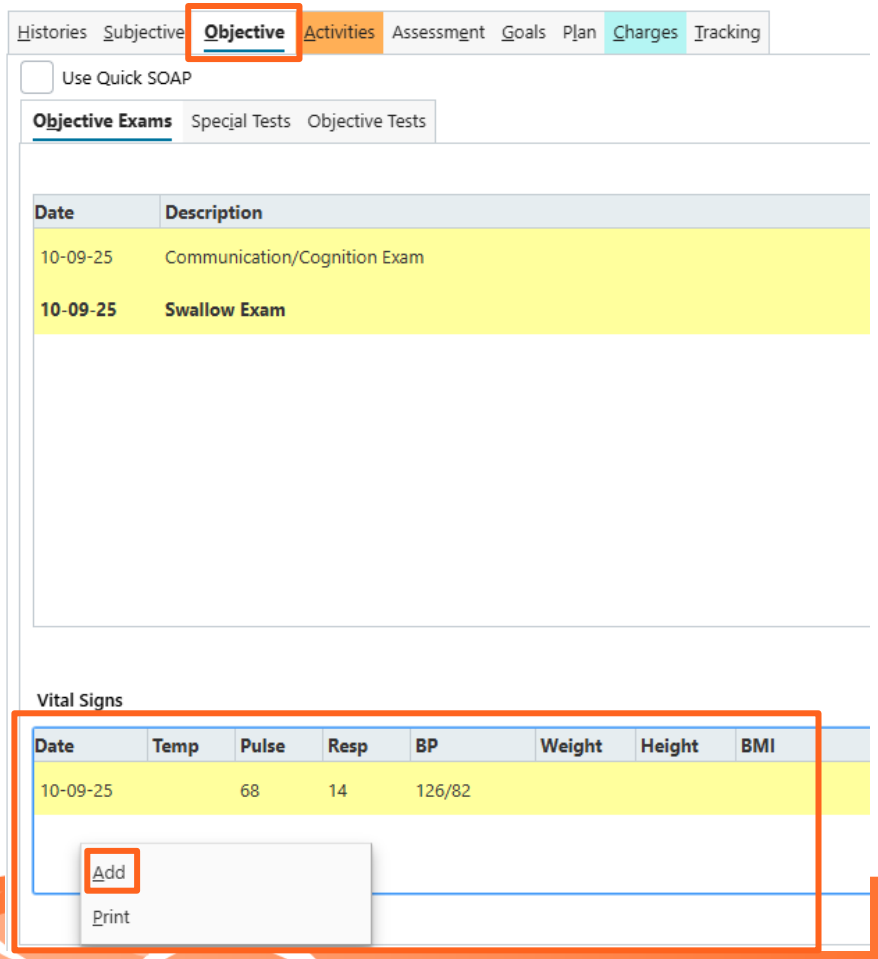
- On **Subjective tab** you can document:
  - **Questionnaires –** add or updated any appropriate questionnaires from the visit (can also document this in objective tab)
    - To update or add, right click on the item description > select **Add** > locate and select desired item
    - Click **Update Score** to make this form editable and update the current response
    - You could also add the Questionnaires within the Objective tab alongside the FOMs (this is clinician preference)
  - **Medications Reviewed –** make selection in Medications Reviewed panel, if appropriate

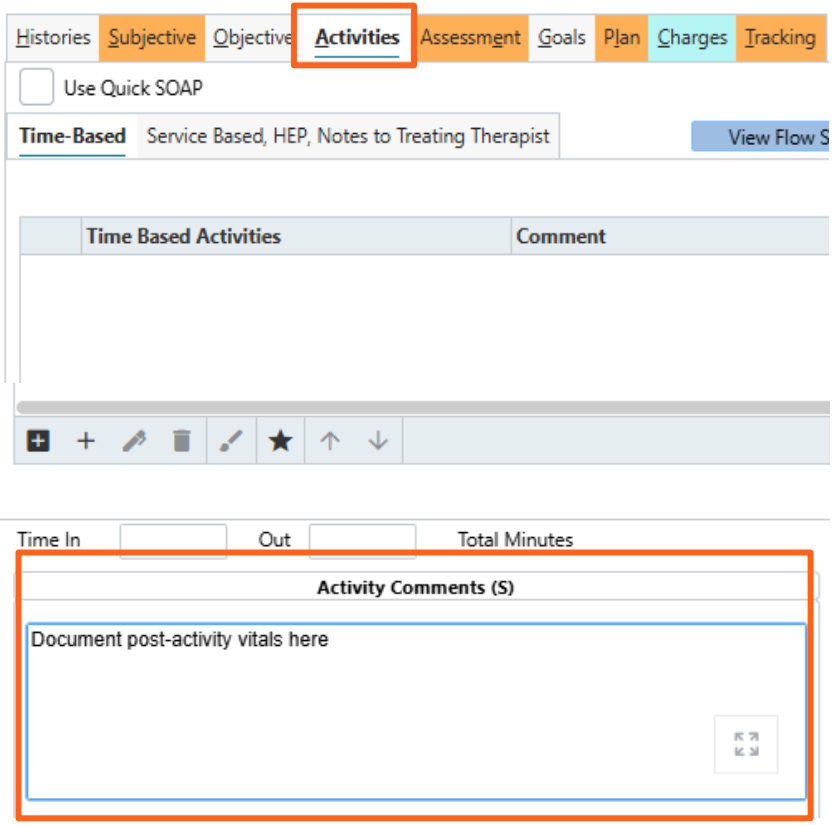




Objective – Vital Signs

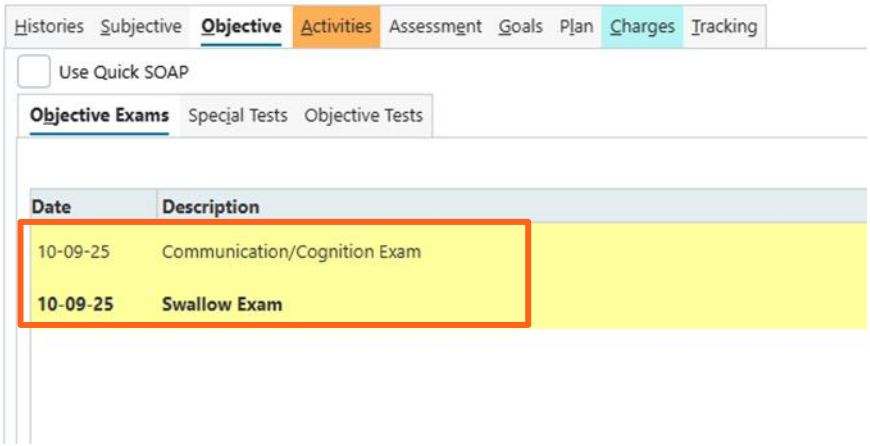
- **Baseline Vital Signs** can be documented on the Objective Tab, in Vital Signs panel
  - Right click in the panel, the select Add or click Add on the top function bar
  - Populate the vital signs and save the record
  - You can view a history of previous Vital Signs or Print from this table, too
- **Post-activity vital signs** can be recorded on Activities tab, in "Activity Comments"





Objective – Objective Exams, Tests

- You may review or update any Objective Exams or Tests on a treatment encounter, if needed (NOT required for treatment note workflow)

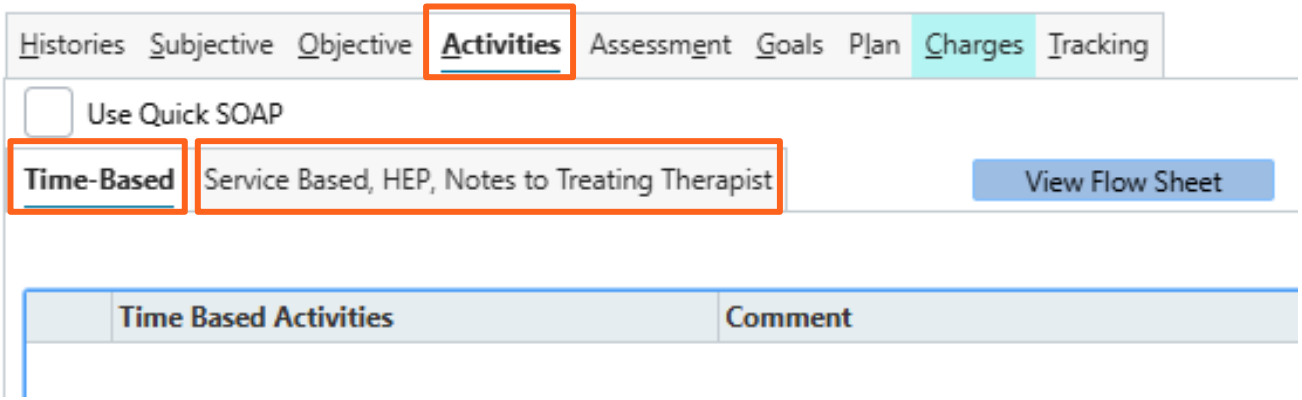


Activities

All **billable treatment interventions** are documented on the **Activities** Tab

REMINDER: you will only be able to bill **CPT code items** (marked with *asterisks*) that were included in the Planned Services (Plan Tab) of Eval

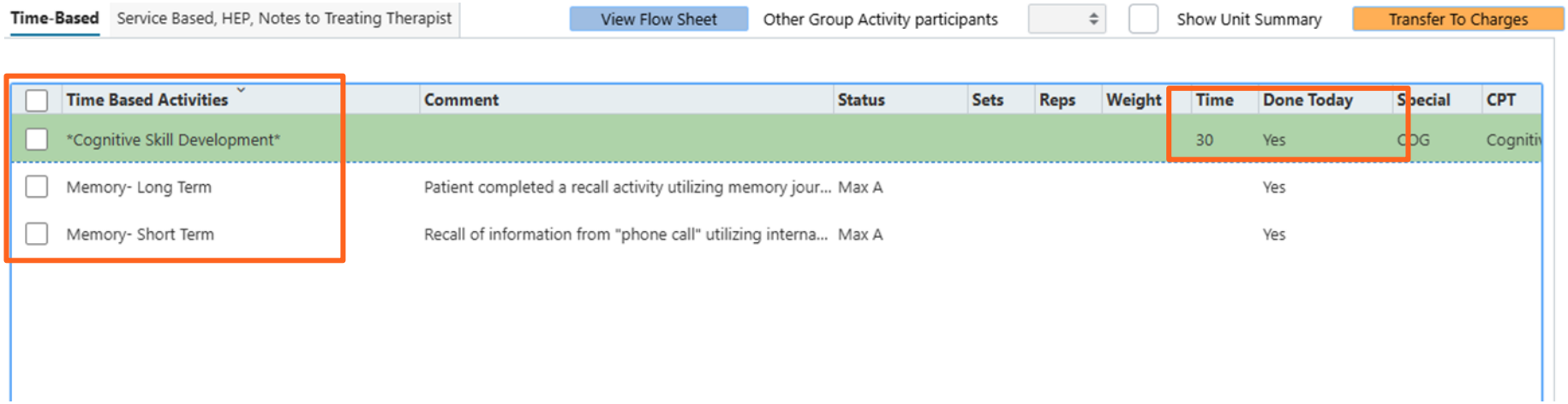
- *If you need to add planned services, you must complete a Progress Report*



You will enter time-based interventions on the "**Time-Based**" tab and service-based interventions on the "**Service Based/HEP/Notes**" tab

Activities – Time Based

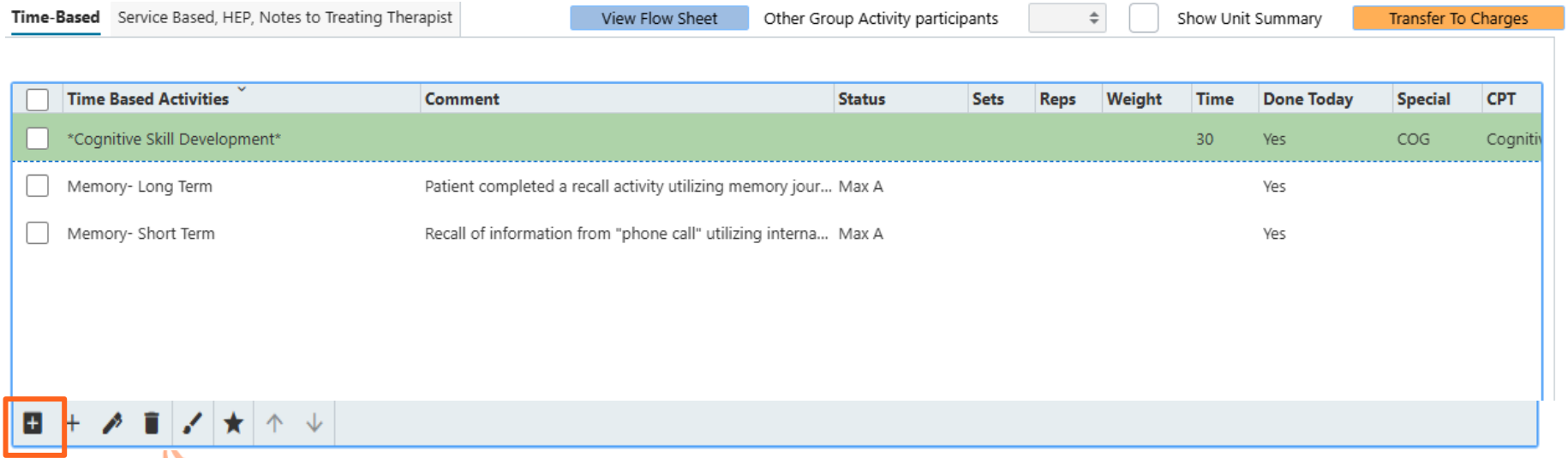
- **Green items** with *asterisks* are tied to CPT codes and will pull to charges tab
  - You must enter time for each CPT code item and indicate "Done Today"
  - **DO NOT DOCUMENT ANY COMMENTS OR SKILLED CARE IN THE GREEN ITEMS**
- Document skilled intervention supporting each CPT code **under** the relevant Green CPT line item (NOT IN THE GREEN LINE ITEM)
  - Click the CPT code you are going to add intervention for, then use + to add appropriate items from the picklist (ex: "*Cognitive Skills Dev* > Memory-Long term and Short Term)
- **IMPORTANT!!** Do NOT click the top/title of each column to sort
  - This will cause the items to sort and interventions will not be under the appropriate CPT code



Activities – Time Based

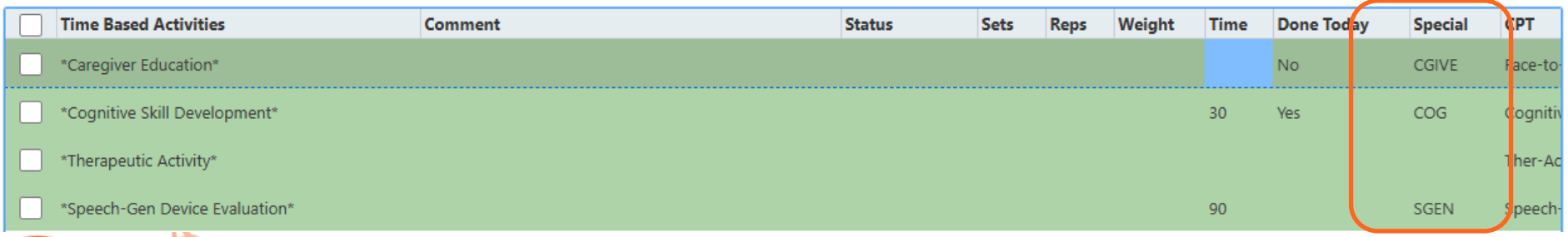
To add items to the Time-Based Activity grid:

- Use the + to open and search picklist
  - Use **Quick Find** to search for specific activities (this list is long; **favorites** will be helpful)
- You can check off multiple items, then Save
- Update status (assist), sets, reps, weight as applicable. You can also customize name of activity or create your own. **For SLP, much of your treatment information will be documented under the comment sections.**
- **Time should only be added to Green CPT code items (these are tied to billing)**
- Select Done Today - if not the charges will not transfer
  - You can have activities in the log that are not done every visit to save time documenting in future visits



Activities – Time Based (Special Codes)

- Special Codes
  - A few codes listed in the Time Based Activities picklists are considered "special codes"
    - These are CPT codes that have time threshold that must be met prior to opening access to the second / add on CPT code
      - 97129 / 97130 Cognitive Skills Development (SLP)
      - 97550 / 97551 Caregiver Education
      - 92607 / 92608 Speech Generating Device Eval (SLP)
    - You only need to add one CPT code line item within the Time Based Activity grid
      - Raintree will calculate the correct distribution of time within each code set listed above.
      - Example – 30 minutes entered for "Cognitive Skills Development"
        - 15 minutes will be applied to 97129 and 15 minutes will be applied to 97130 for 2 Total units

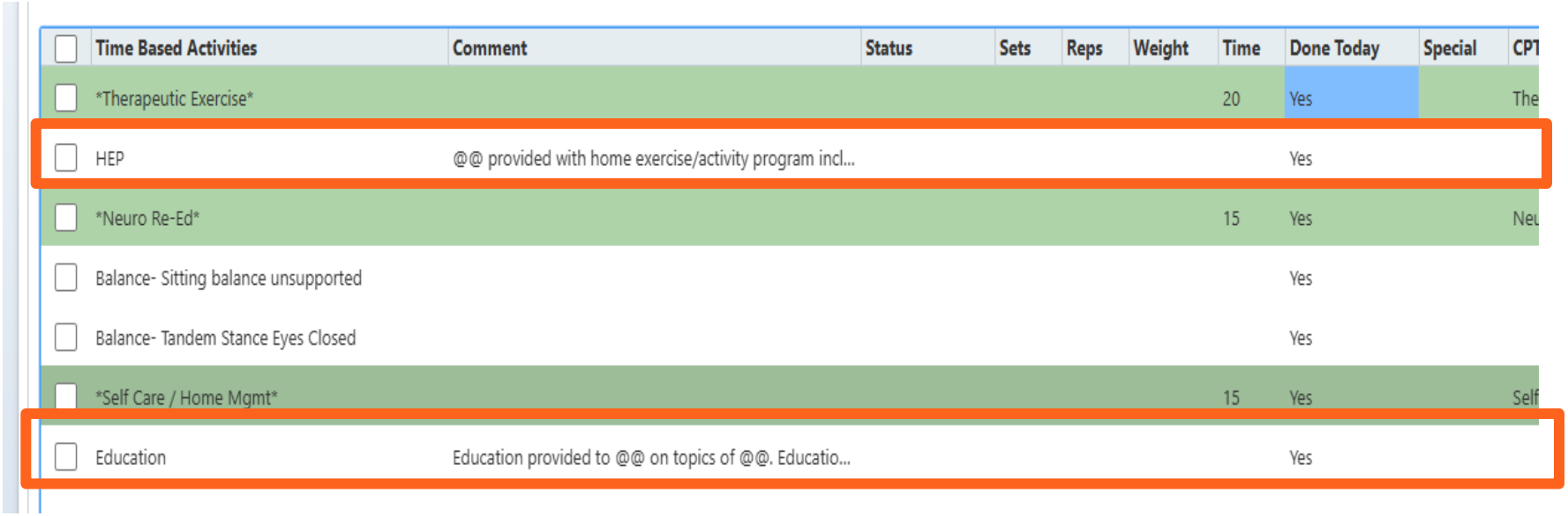


	Time Based Activities	Comment	Status	Sets	Reps	Weight	Time	Done Today	Special	CPT
☐	*Caregiver Education*							No	CGIVE	Face-to-
☐	*Cognitive Skill Development*						30	Yes	COG	Cognitiv
☐	*Therapeutic Activity*									Ther-Ac
☐	*Speech-Gen Device Evaluation*						90		SGEN	Speech-

Activities – Education

Education should be documented early and often throughout the plan of care

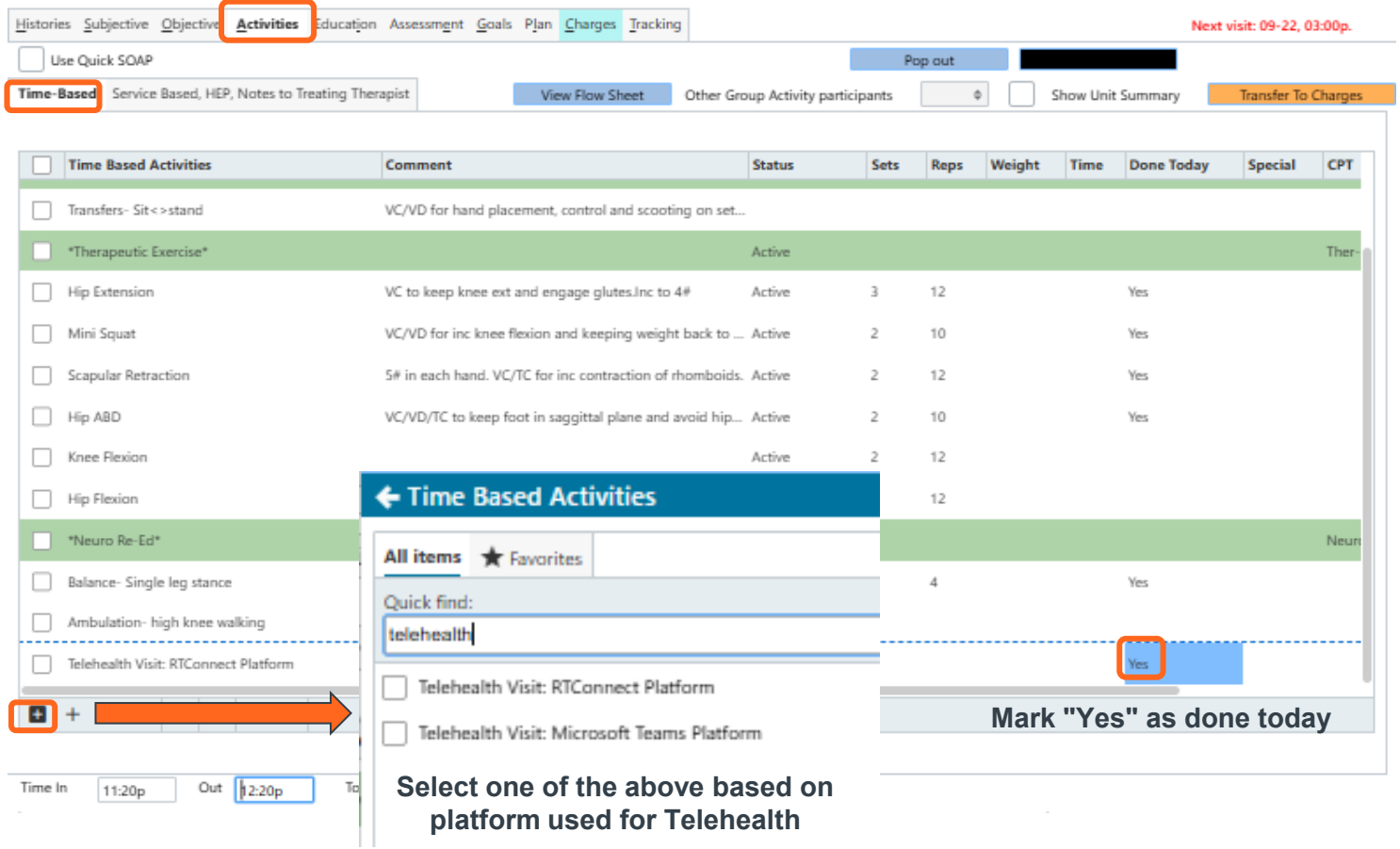
- Add Education as an item under the relevant CPT code in the Time-Based Activity log; there are @@ within this item to prompt you on what details to document.
- Add in HEP in this section to add more details and tie into the correct CPT code
  - You can use MedBridge HEP link (on Service Based, HEP, Notes to Treating Therapist tab) to create HEP document that is sharable with patient. Details of HEP can be copied/pasted into the HEP line item in Time-Based Activities grid



Time Based Activities	Comment	Status	Sets	Reps	Weight	Time	Done Today	Special	CPT
Therapeutic Exercise						20	Yes		The
HEP	@@ provided with home exercise/activity program incl...						Yes		
Neuro Re-Ed						15	Yes		Neu
Balance- Sitting balance unsupported							Yes		
Balance- Tandem Stance Eyes Closed							Yes		
Self Care / Home Mgmt						15	Yes		Self
Education	Education provided to @@ on topics of @@. Educatio...						Yes		

Activities - Telehealth Documentation

- If performing a telehealth visit, you MUST Select "Telehealth Visit" item from picklist and mark as "Done Today" within "Time Based Activities" picklist
  - This ensures documentation of platform used



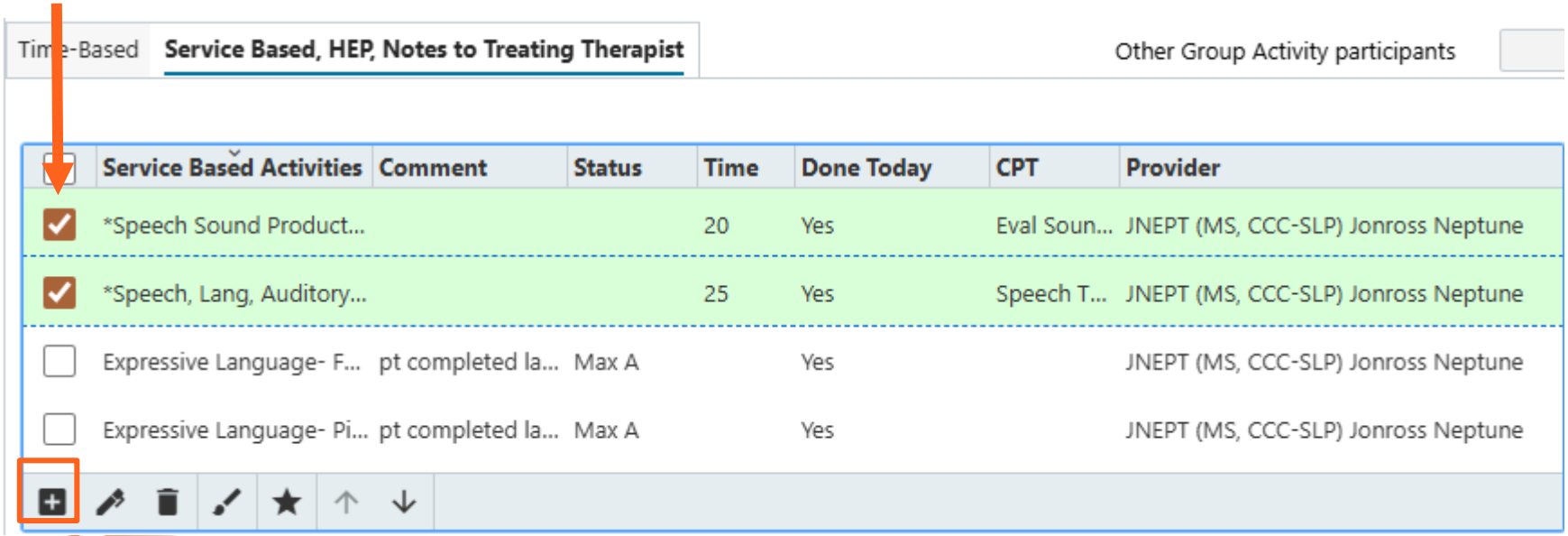
Activities – Service Based

Any service based billing (CPT) and interventions are added on Service Based tab

- The picklist here functions the same as on the Time Based tab *(exception: CPT items on Service-Based grid are not green unless the check box is selected)*
- Click + and search/find the service based activities in the picklist > Save
- Update comment, status, time, indicate done today

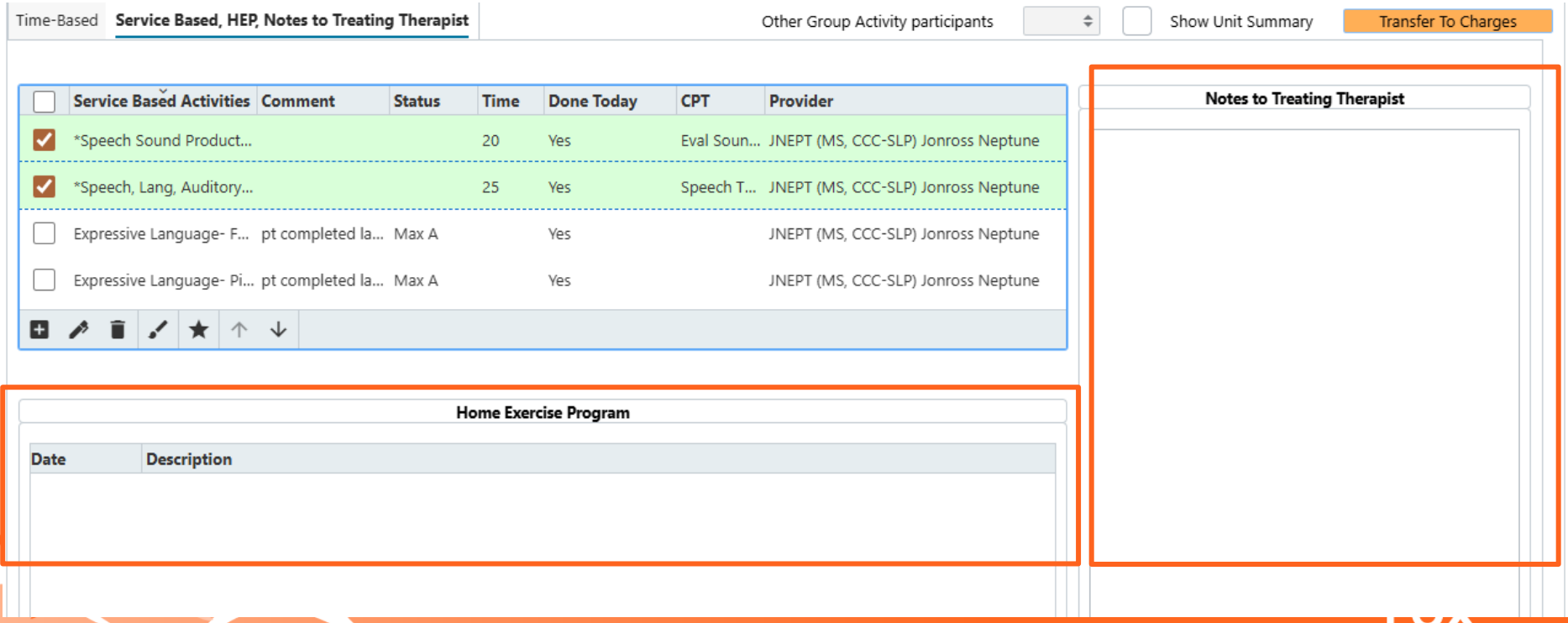
Speech/Language, Dysphagia, and SGD are Service Based codes and will need to be populated here for proper documentation and billing.

- *NOTE-When unchecked, CPT code line items will not show in green like Time Based.*



Activities – HEP, Notes to Treating Therapist

- **Home Exercise Programs** can be added/uploaded in the Home Exercise Program box by right clicking > Add
  - Medbrige HEP function similar to RT Custom. See training for details
    - CI has training and will share with student if appropriate
  - It is still important to document HEP education on Time-Based or Service-Based activity grid to add details about who was educated, level of assist and returned level of understanding.
- **Notes to Treating Therapist** can be used to communicate to other therapists – KEEP IN MIND THESE DO NOT END UP IN THE NARRATIVE



Activities – Time In and Out

Time In and Time Out is required to sign off on notes in RT Standard

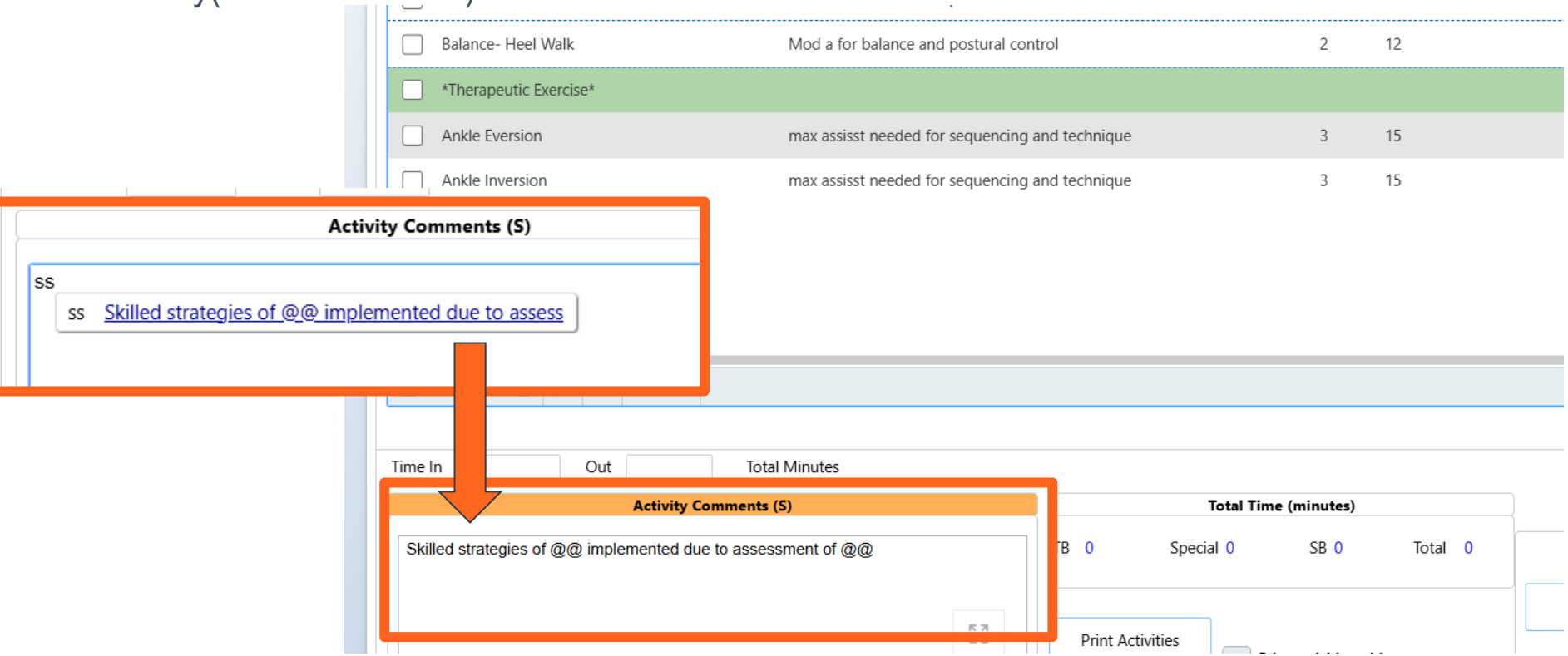
- Time In and Time Out will be entered on the Activities tab, under Activities log
  - Time should be entered in (hh:mm a/p)
    - **a** indicates AM and **p** indicates PM
  - Raintree will allow underbilling (billing for less than total minutes), but not overbilling (billing for more time than total minutes)
  - If you split a session (multiple time in/out), enter the first IN time and last OUT time, then specify additional time IN/OUT in the Activity Comments box



You can also use the Activity Comments box to document **Post Activity Vitals**

Activities – Skilled Strategy Statement

- In the activity comments box, you can document the skilled strategy that was provided this session
- You can type "ss" and space in the Activity Comments box to load the prompts for the skilled strategy statement that includes jump markers
- Skilled components may also be documented in the "Comment" section of each activity(white line items)

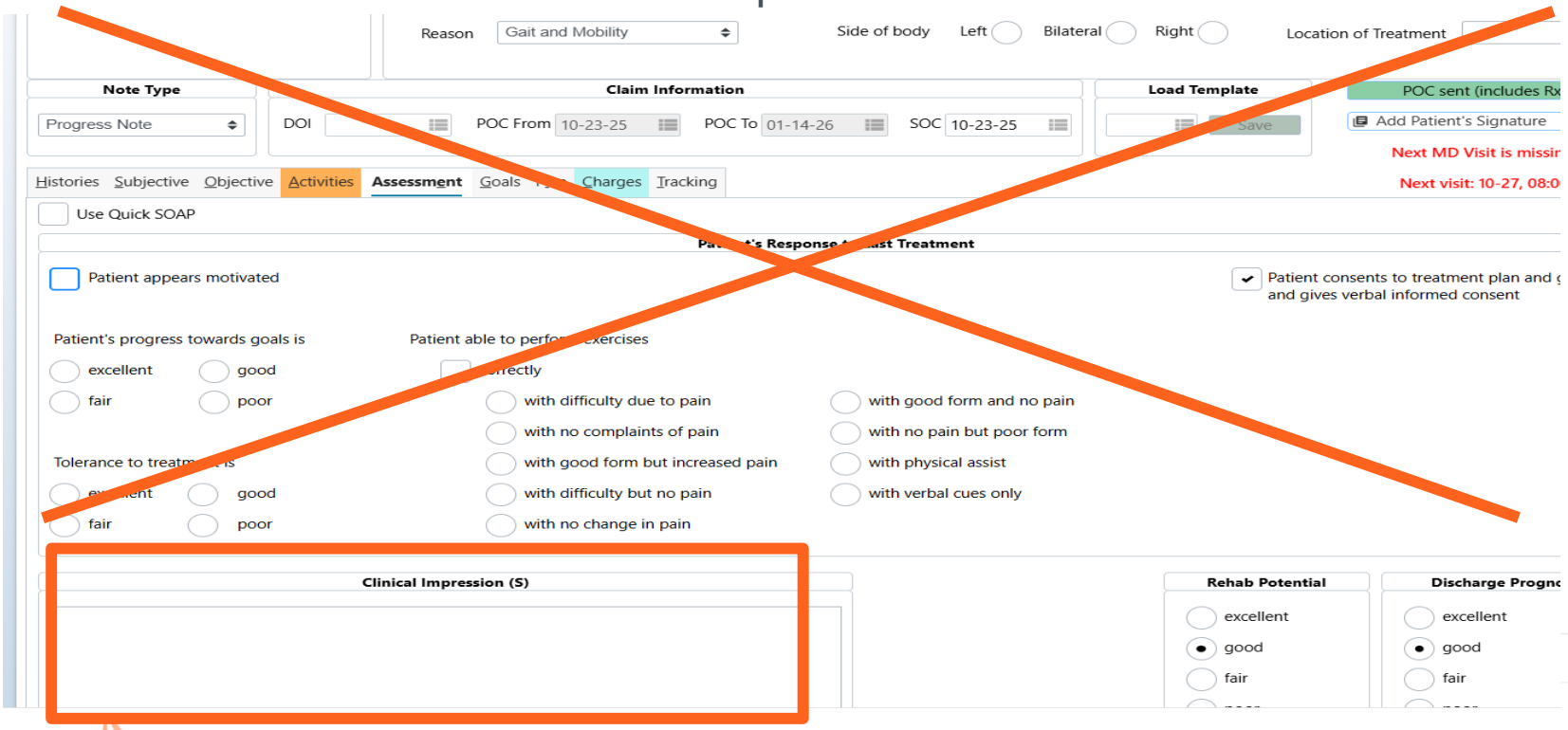


Assessment

The daily clinical impression should be documented in the **Activities comments within the Time based activity... see previous slide**

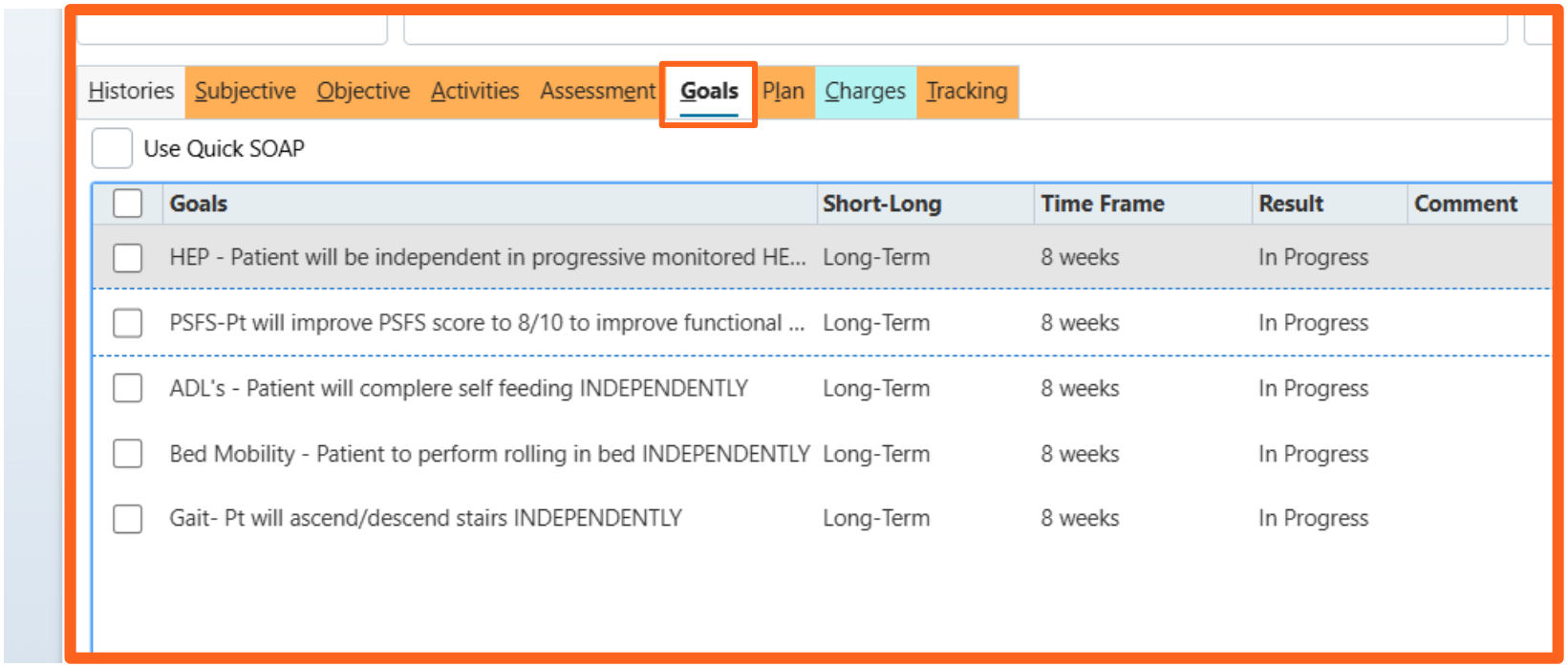
- If you documented skilled strategies within the activity comments, it is not necessary to document anything within this tab

- If you want to document details beyond a skilled strategy statement, this can be documented below under clinical impression



Goals

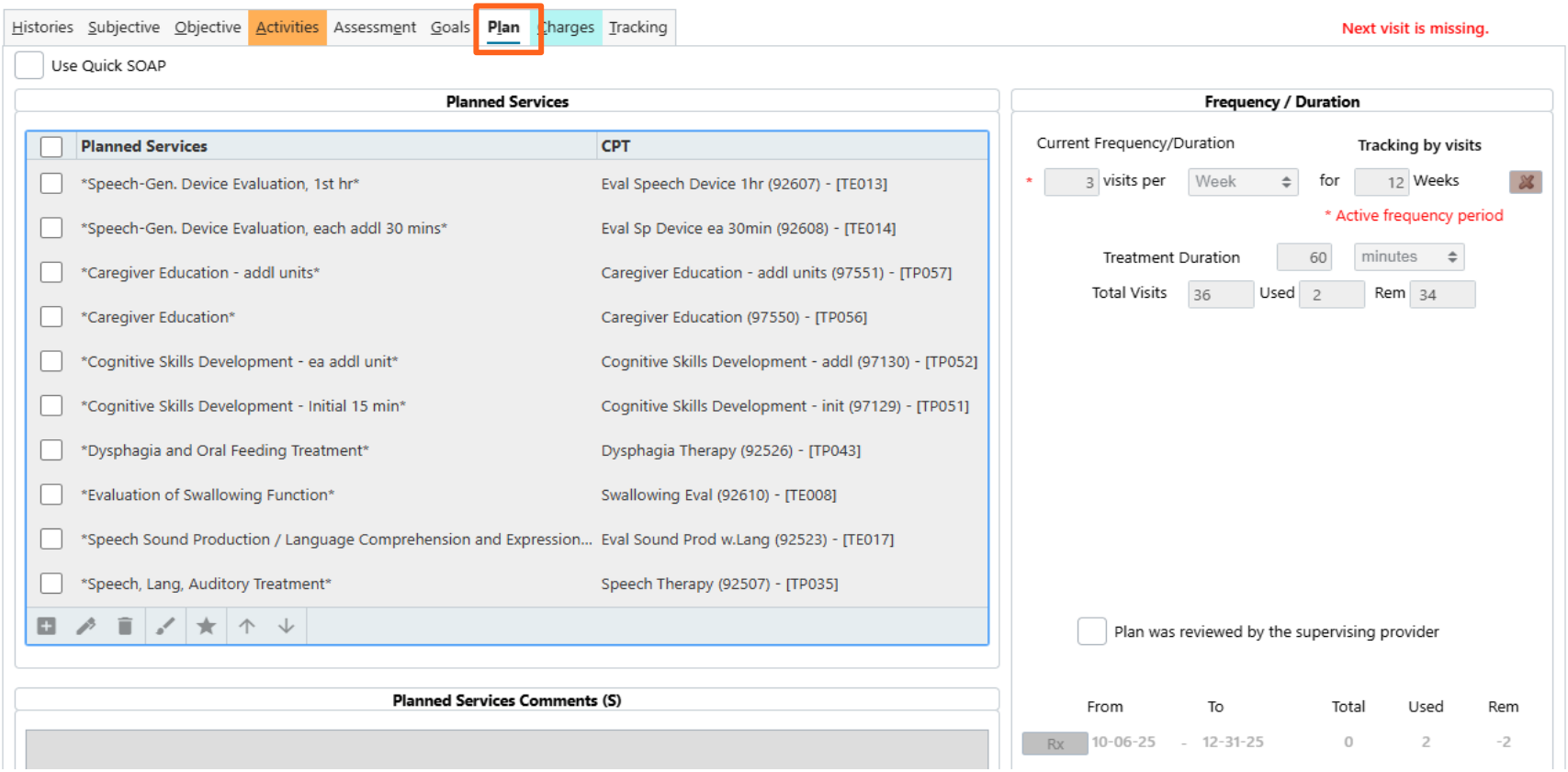
- **Goals will be read only on a Daily Note**, but you can review them on Goals tab (helpful for visit coverage, assistant workflow)
- If you need to **add a goal**, you will need to change note type to Progress Report and complete **Progress Report workflow**



Goals	Short-Long	Time Frame	Result	Comment
HEP - Patient will be independent in progressive monitored HE...	Long-Term	8 weeks	In Progress	
PSFS-Pt will improve PSFS score to 8/10 to improve functional ...	Long-Term	8 weeks	In Progress	
ADL's - Patient will complere self feeding INDEPENDENTLY	Long-Term	8 weeks	In Progress	
Bed Mobility - Patient to perform rolling in bed INDEPENDENTLY	Long-Term	8 weeks	In Progress	
Gait- Pt will ascend/descend stairs INDEPENDENTLY	Long-Term	8 weeks	In Progress	

Plan

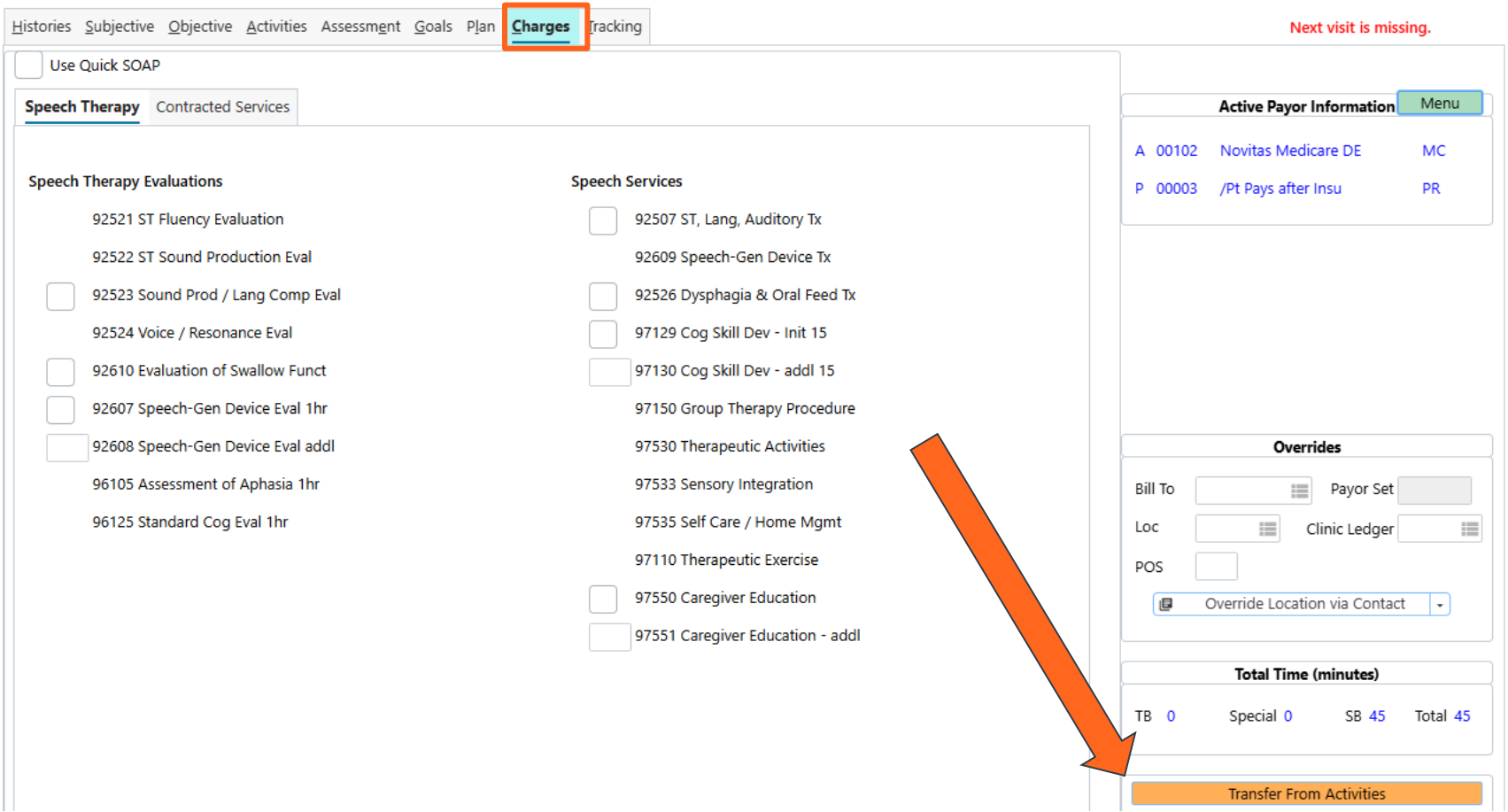
- **Plan will be read only on a Daily Note**, but you can review the planned services and Frequency/Duration on the Plan tab (helpful for visit coverage, assistant workflow)
- If you need to **add planned services or change treatment frequency**, you will need to change note type to Progress Report and complete **Progress Report workflow**



Charges

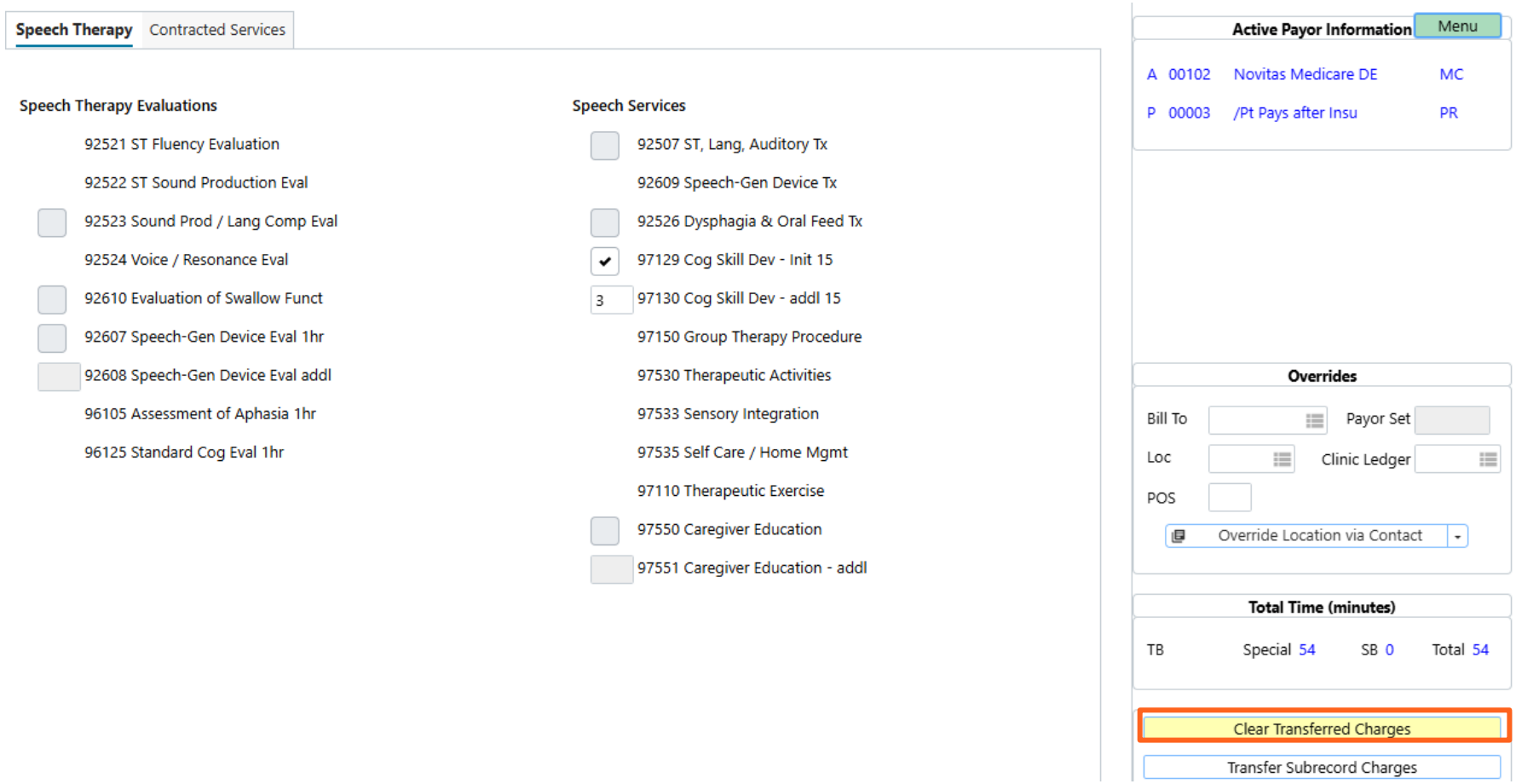
Once Eval is complete and all activities are documented, click **Charges** tab

- Click **Transfer from Activities** button to pull charges over



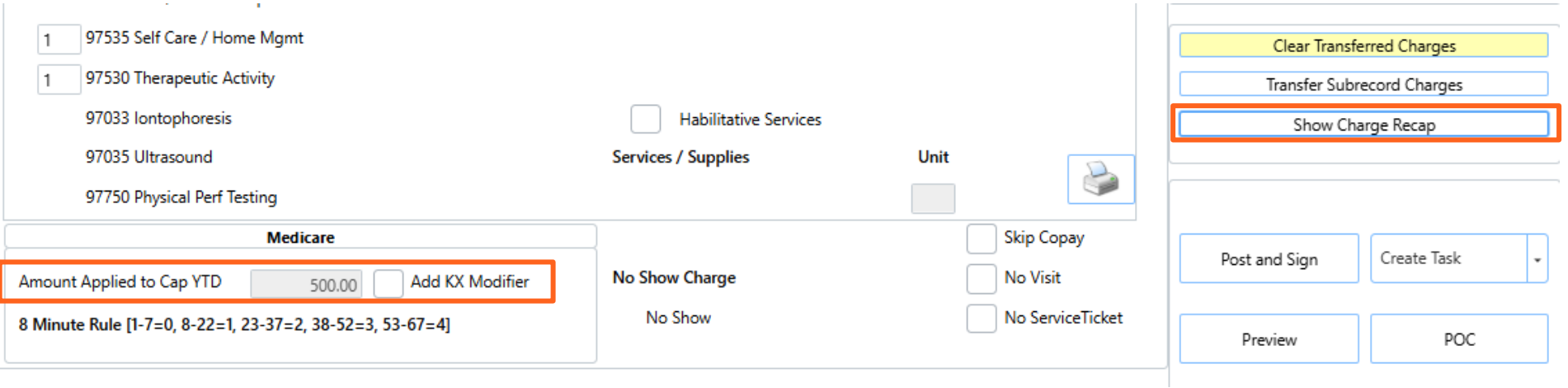
Charges

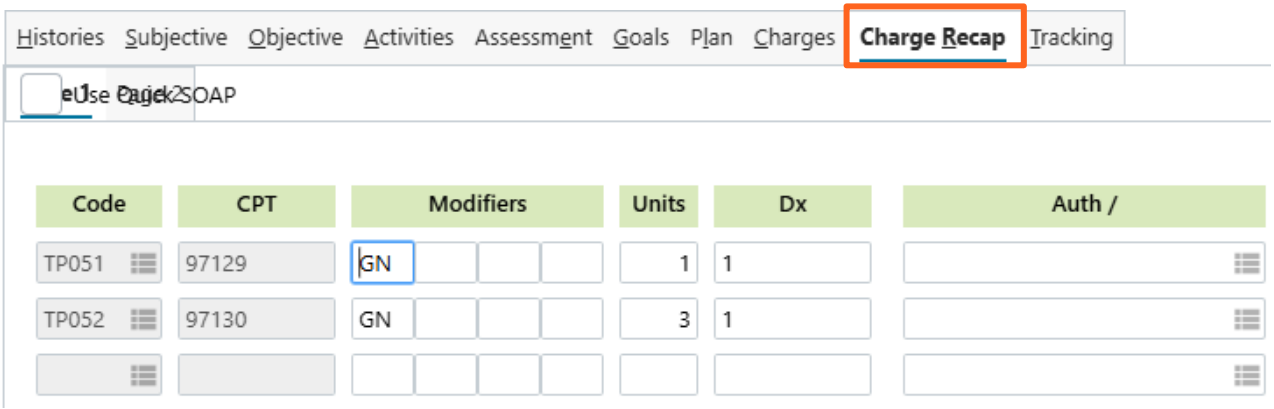
- Confirm units are appropriate based on documentation and 8 min rule
- If any changes are needed, "Clear Transferred Charges" and edit on Activities tab



Charges

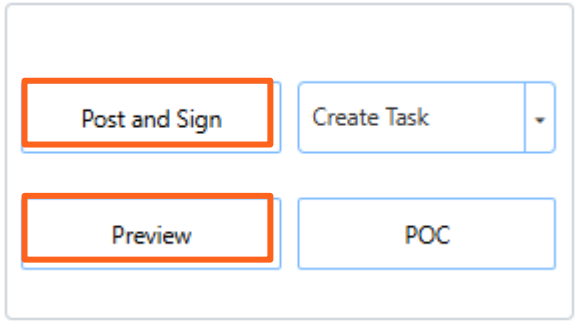
- **Medicare threshold** is visible at the bottom of the charge ticket
- **Modifiers** are visible on the charge recap (**"Show Charge Recap"**)





Narrative Preview and Sign Off

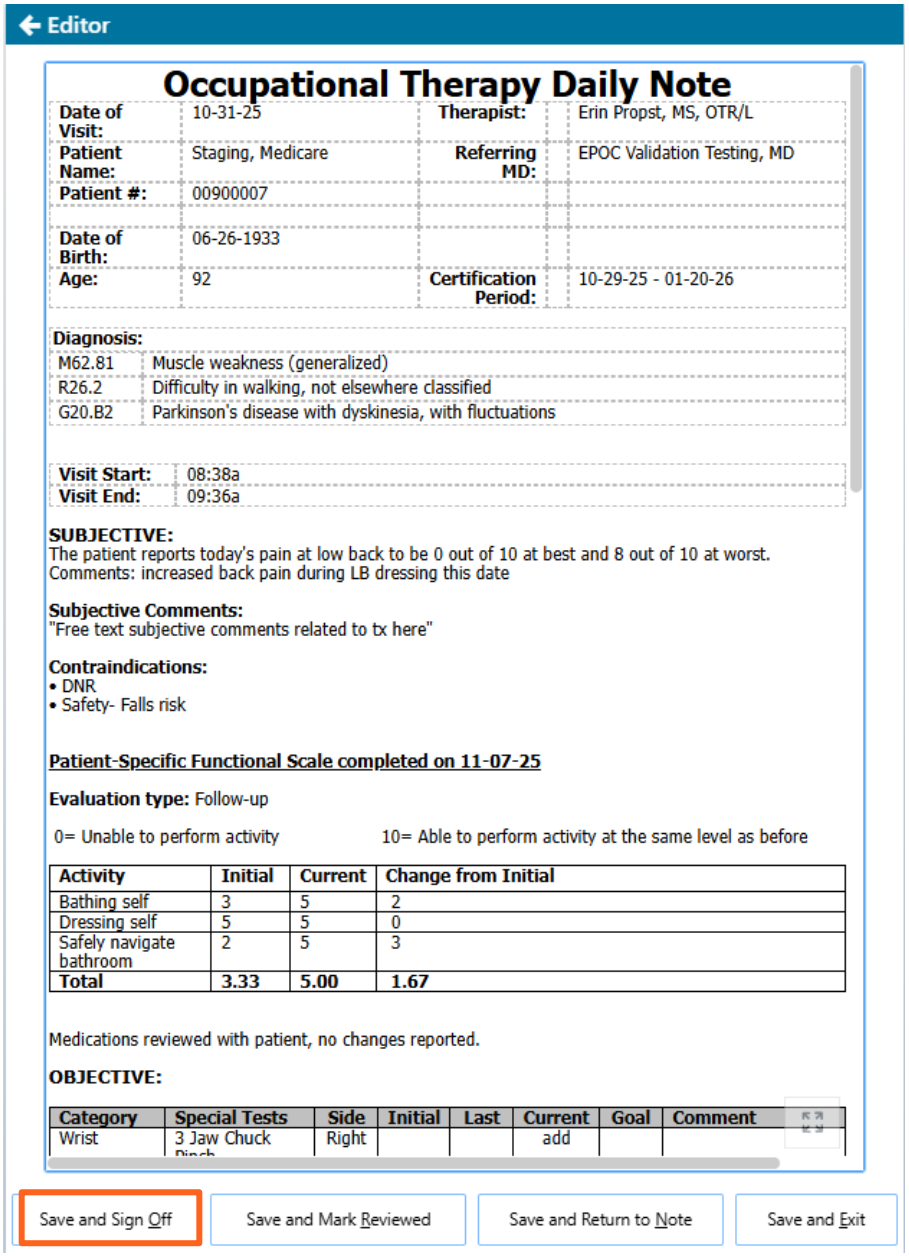
- Preview to review the narrative to ensure all information looks correct before signing off
- Post and Sign when you are ready to sign the note and post charges



Save and Sign-off

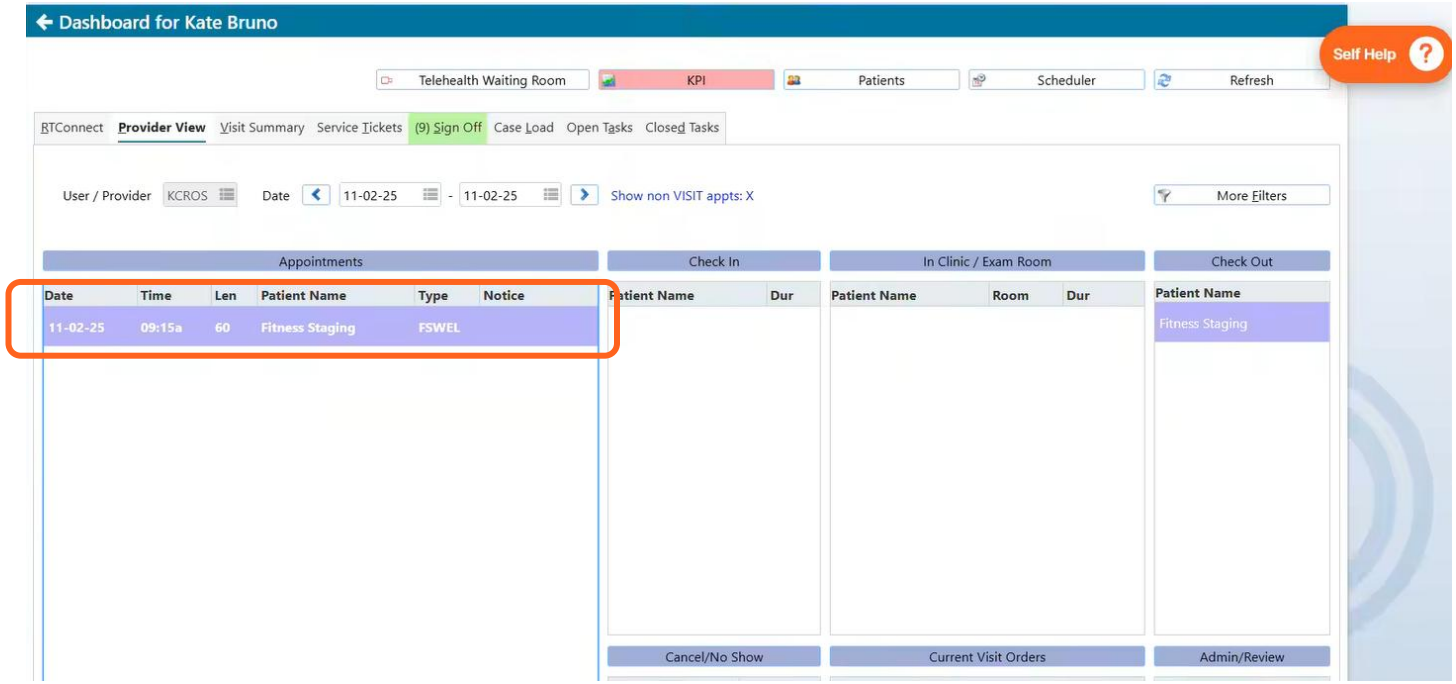
Complete final narrative review

- Click **Save and Sign Off** if you are complete
- Save and Return to Note to return and make edits
- Save and Exit to exit the note if you plan to return later for final sign-off



Confirmation

- After successful Sign and Post, visit will turn Purple
- If it is gray, it did not bill and you will need to go back into the note to post again.

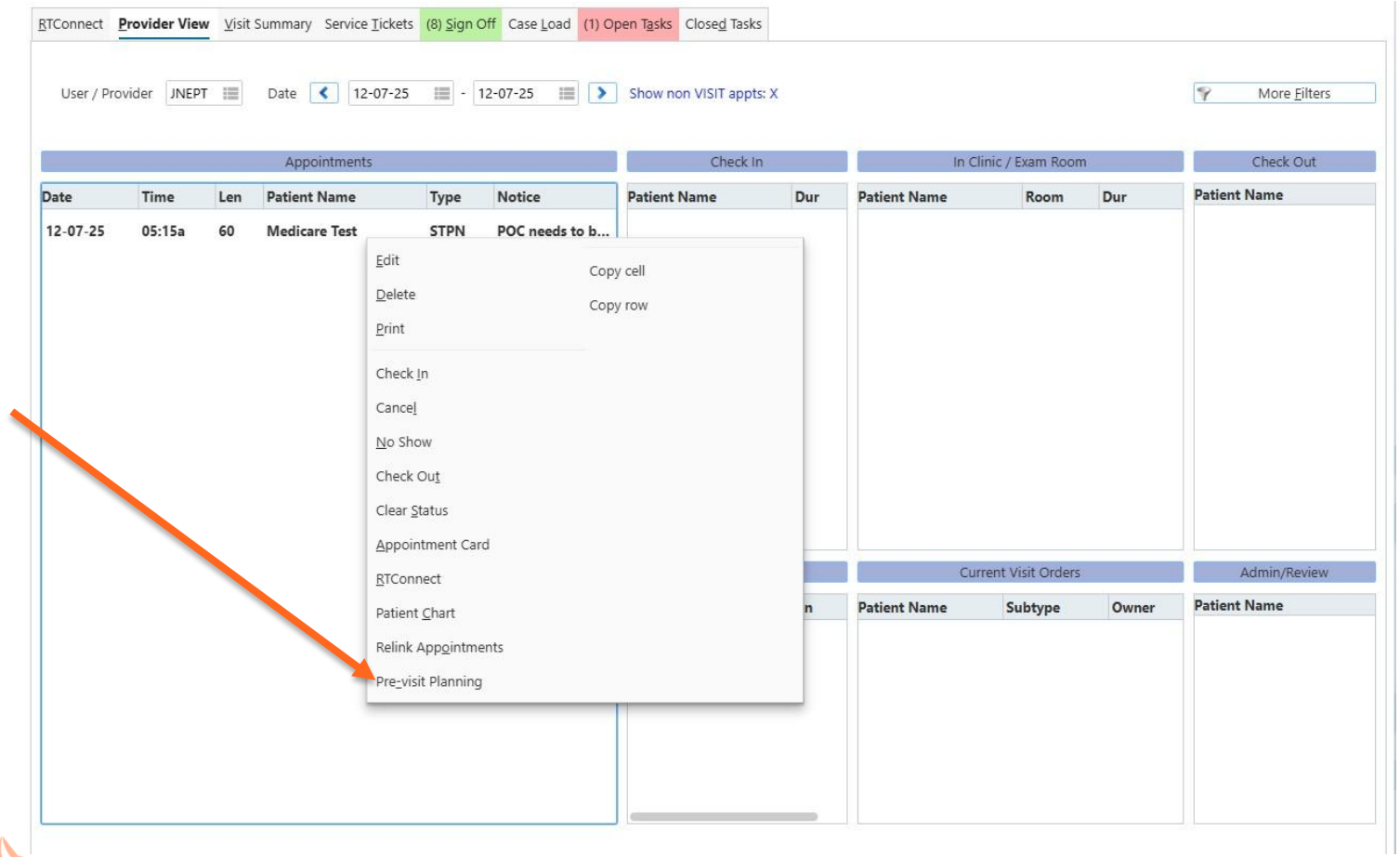


Pre Visit Planning

- Raintree Standard allows for pre-visit planning through a special feature
  - Allows for pre documentation within the following
    - Time Based Activities / Service Based Activities
      - Activities can be accessed and edited prior to the start of a visit
      - Edits will display once the visit is checked in
    - Notes to Treating Therapist
      - This section can be accessed and edited prior to the start of a visit
      - Edits will display once the visit is checked in
  - Can be used for visit planning that can lead to efficiency pick-ups for individual workflows. (setting up the planned activities with known details
  - Can be used to set up visits for a covering therapist, or used to enhance the clinician / assistant collaboration

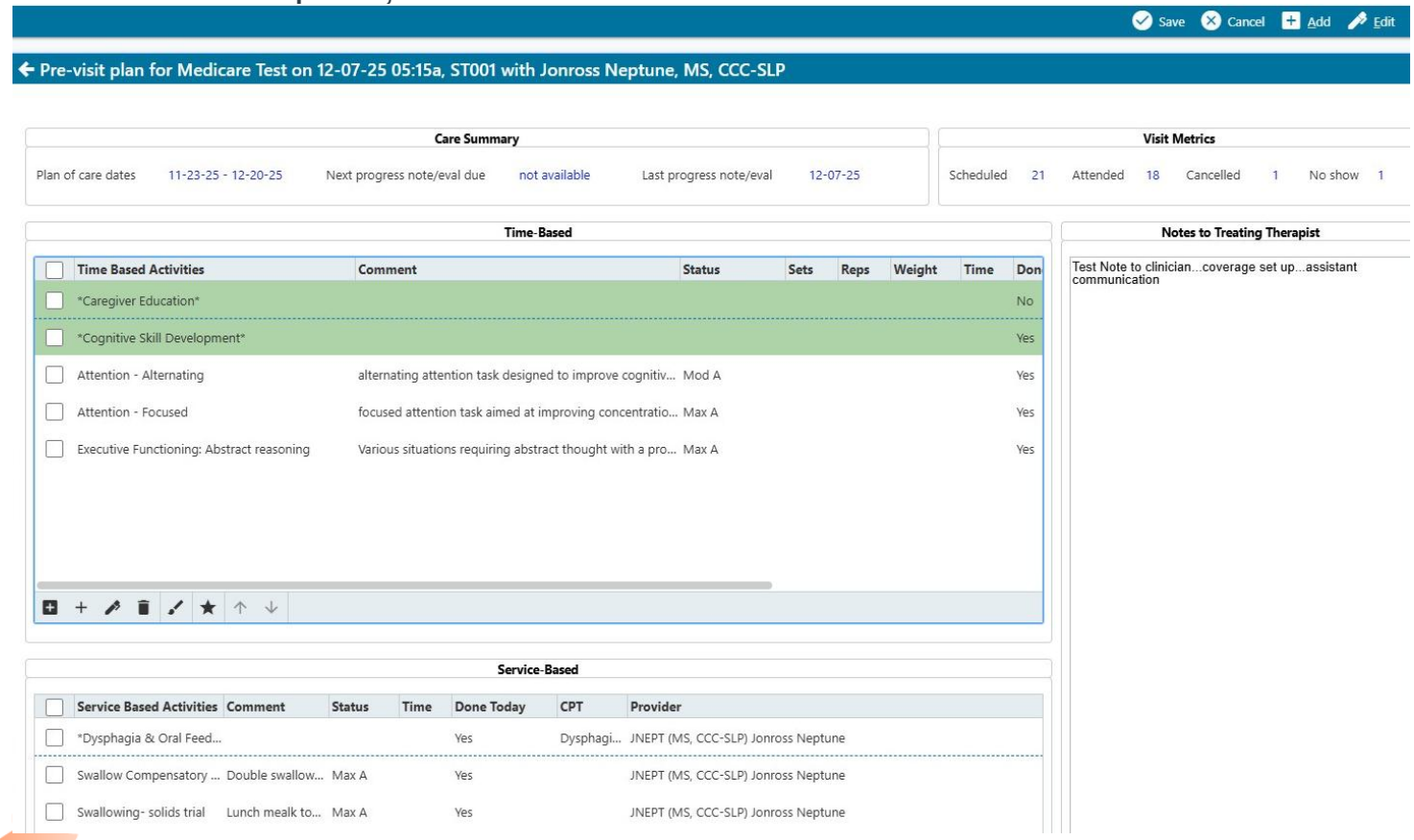
Pre Visit Planning

- Once a visit is scheduled you can access pre-visit planning by R-click on the visit from the provider tab and choosing Pre-Visit Planning from the list



Pre Visit Planning

- You will be brought into the Pre-Visit Planning and now have access to make any updates to “Time Based”, “Service Based”, and “Notes to Treating Therapist”
- Once edits are complete, click save

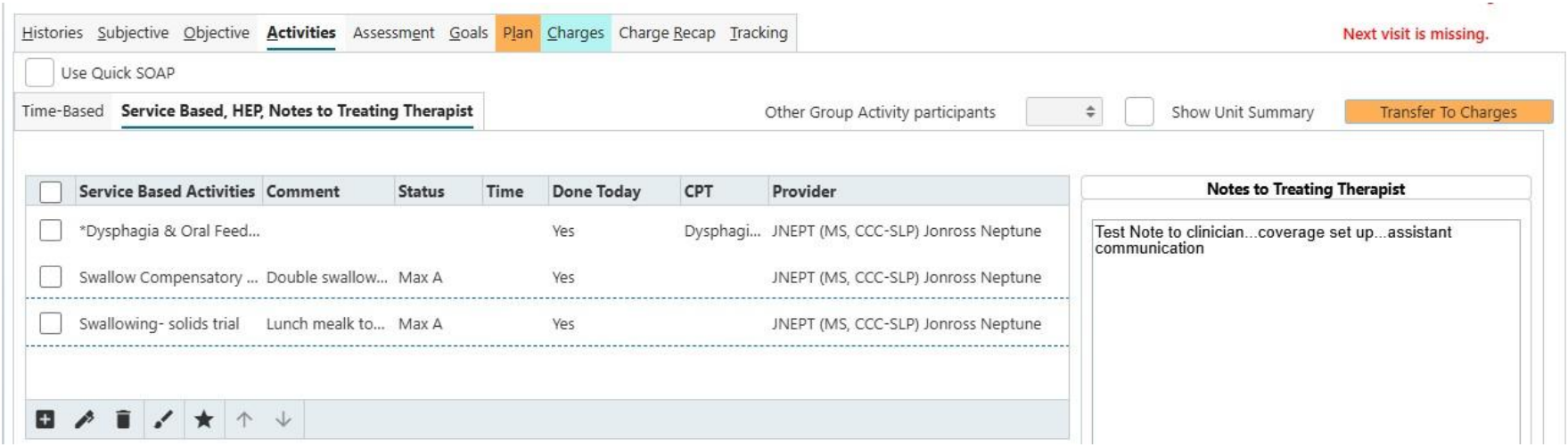


Pre Visit Planning

- At the visit check in, you will see an alert that notified of updates

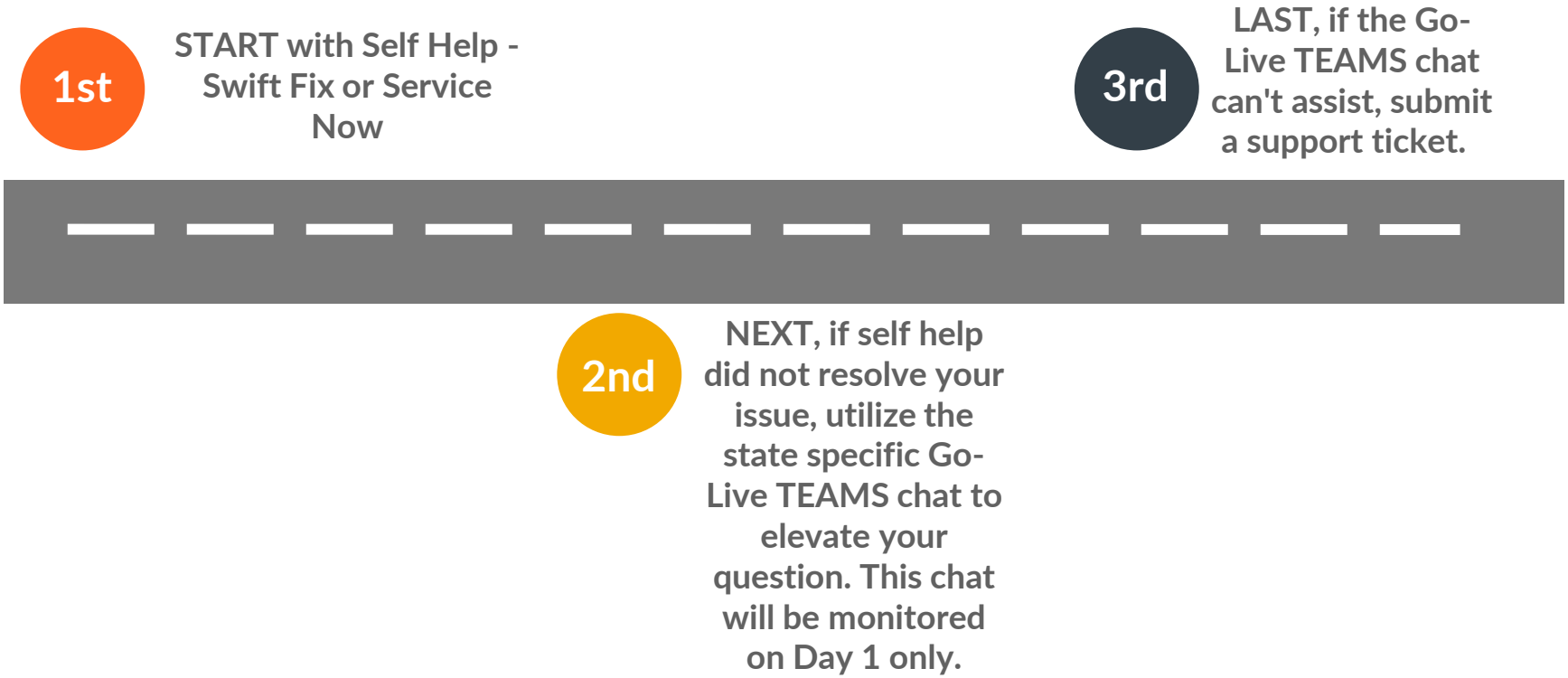


- You will see the updates within the Time Based, Service Based, and Notes to Treating Therapist sections



Support Roadmap: Start Smart, Escalate Right

Have a question? Follow the path to resolution!



RT Standard
Progress Note / Re-eval / DC

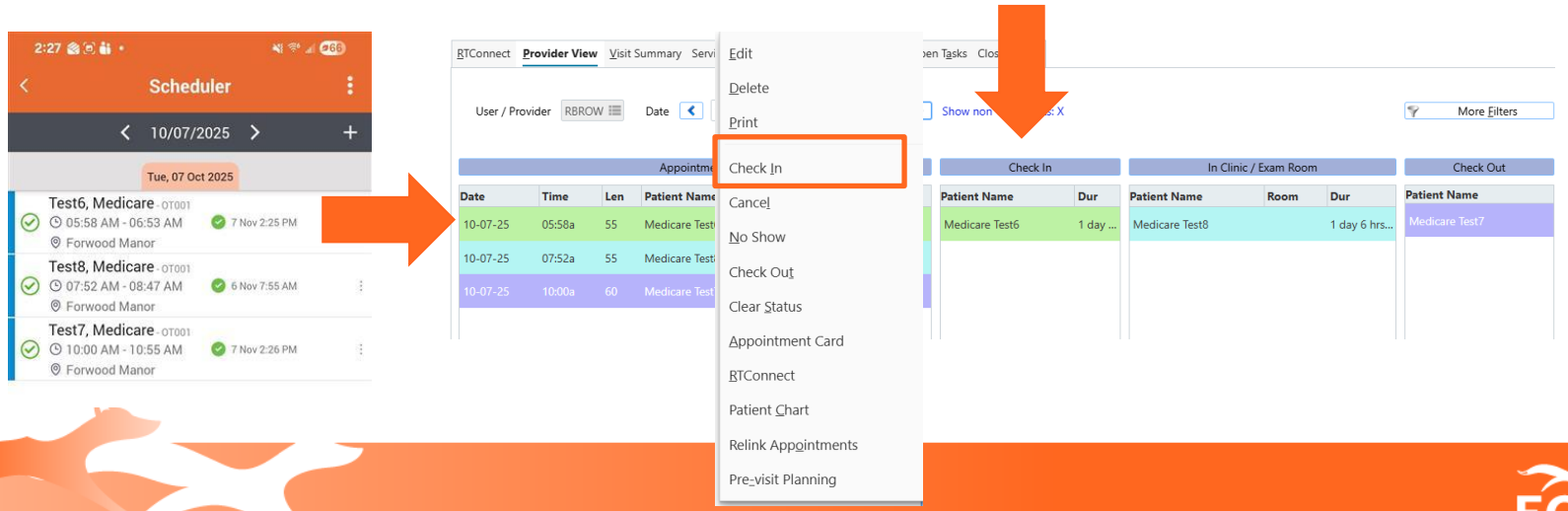


Overview: Progress Note / Re-Eval / DC

- Schedule all visits through FOX Trax for the corresponding note type
- These note types are built into the treatment note setup allowing for improved efficiencies
  - You will complete one note that includes documentation of billable treatment interventions, and the progress report updates
- Progress Note (recert) can be a nonbillable note, however, you still need to schedule the visit to complete the note
- Raintree Standard does not have a specific recertification note
- To complete a recertification, you will complete a Progress Note with the extra step of updating the plan of care
  - Once you update the plan of care, it will automatically become a recertification note and be sent to the referral source for signature (this step will be shown in Progress Note workflow)

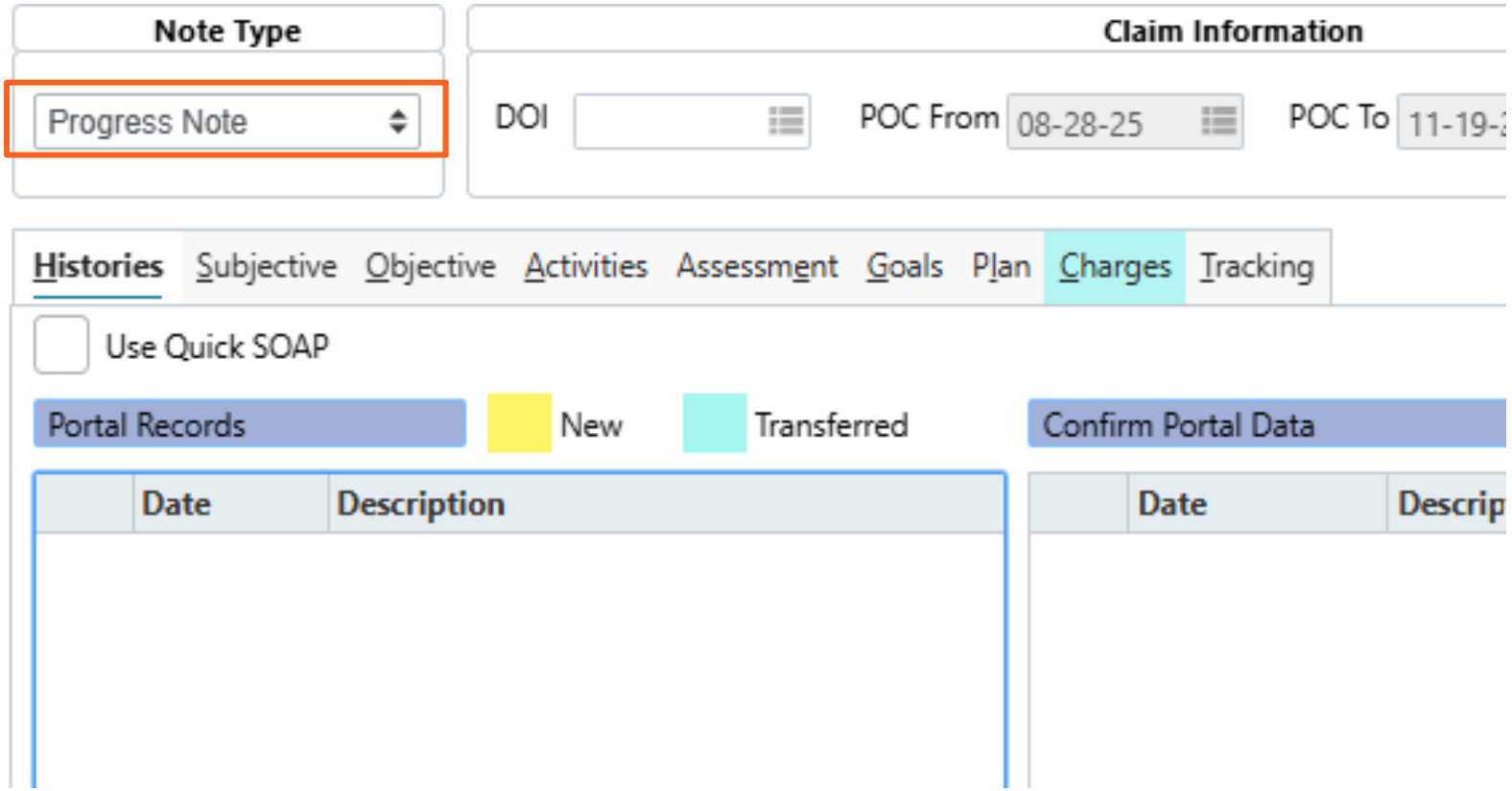
Launching a Note

- Schedule in FOX Trax select the appropriate Reason for Visit (Progress, Re-Eval, DC)
  - Visit will display in RT Standard scheduler and **Provider View tab** under **Appointments**
  - Visits **MUST** be scheduled to start a note. RT Standard does not allow for notes to be created without an appointment.
- In **FOX Trax,** complete visit verification, ideally at the start of the session
- In **RT Standard**, right click the appointment and select **Check In**
  - The appointment will display in the "**Check In** " window
    - Double click or right click> edit to open the clinical note when ready to document.
  - In the event action is needed (due to patient forms being unsigned or previous notes not completed), prompts will display and then the appointment will display in the Check In window
    - See Consent Training for details on patient forms.
  - Read any additional prompts related to the patient so you are aware of any notices/alerts



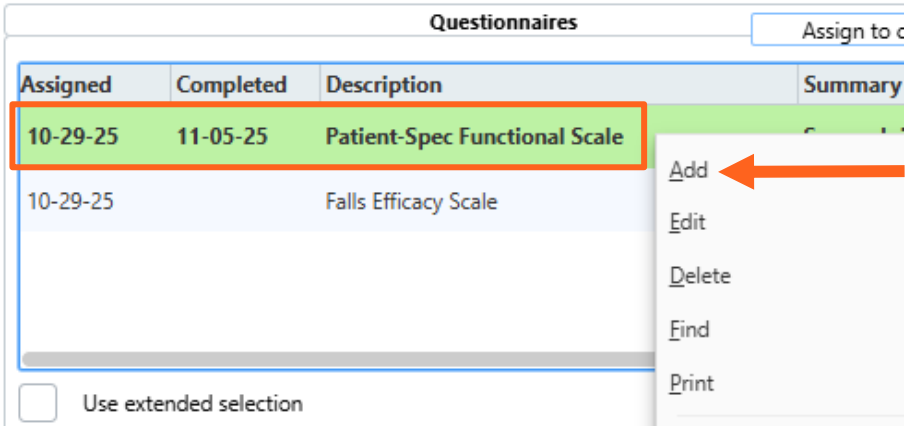
Progress Note

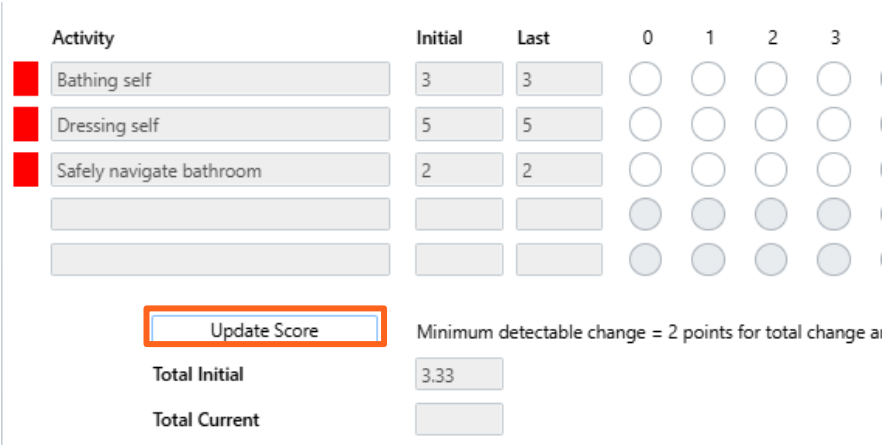
- Ensure the note type is a **Progress Note**; if not, use arrows to select Progress Note



Progress Note
Subjective Updates

- Update Questionnaires as needed (can update here or in the objective exam section)
  - Example - Add new PSFS
    - Update Evaluation type (Initial, Follow-up, DC)
    - Enter new scoring and click "Update Score", and choose "Complete Questionnaire" to include in narrative
- Update Chief Complaints, Pain, Contraindications, Medications as appropriate

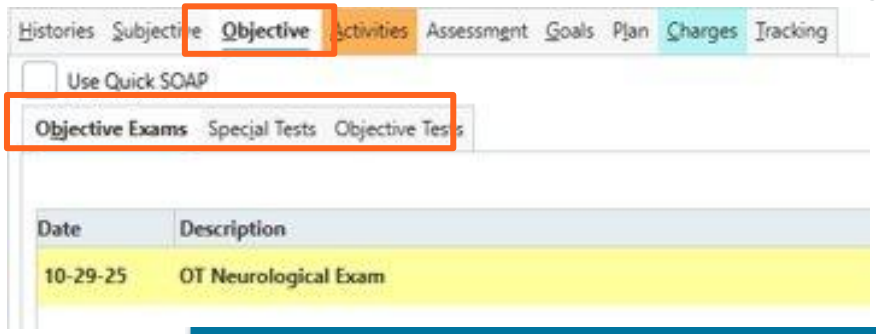


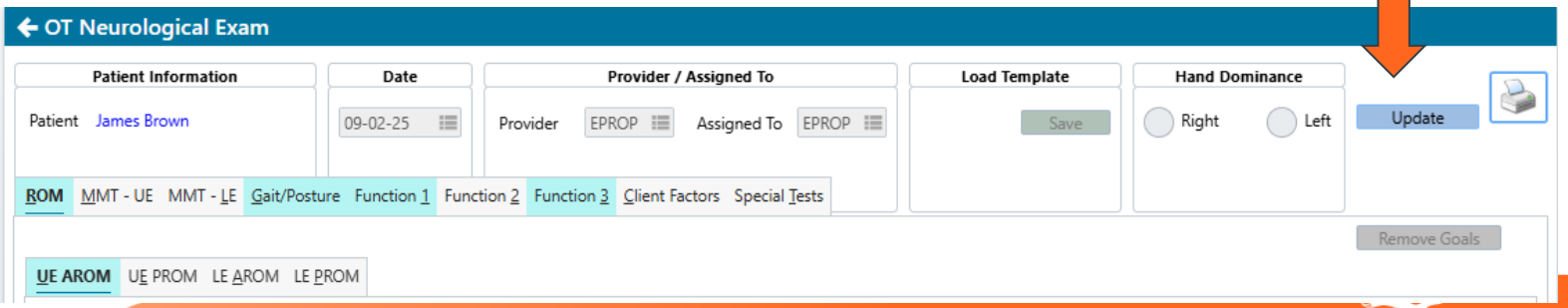


Progress Note
Objective Updates

Update Objective Exams / Special Tests / Objective Tests

- Objective Exams
  - Double click on your completed exams that are highlighted in yellow
  - Once opened, click on **update** to unlock the exam for current status documentation
    - You can add a new functional task, MMT, ROM, etc at this time if appropriate. REMEMBER to add a goal to any new items you add
  - Enter the "**current status**" in the appropriate sections and update the comments as needed
    - Special note for SLP- Cognitive Skills section does not have current status update boxed. You will simply overwrite the info for your update in this section
  - Once complete, click **save**, the record will turn green



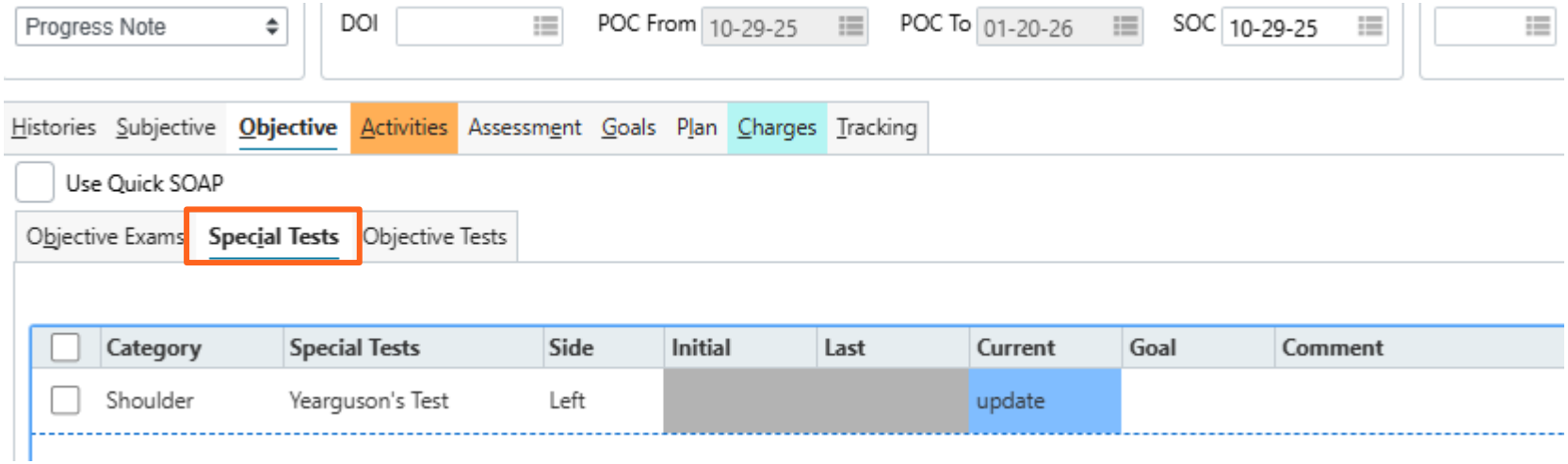


Progress Note

Objective Updates

Update Objective Exams / Special Tests / Objective Tests

- Special Tests (PT/OT only)
  - Navigate to Special Tests
  - Update special tests by entering a "current" status, and update comments as needed

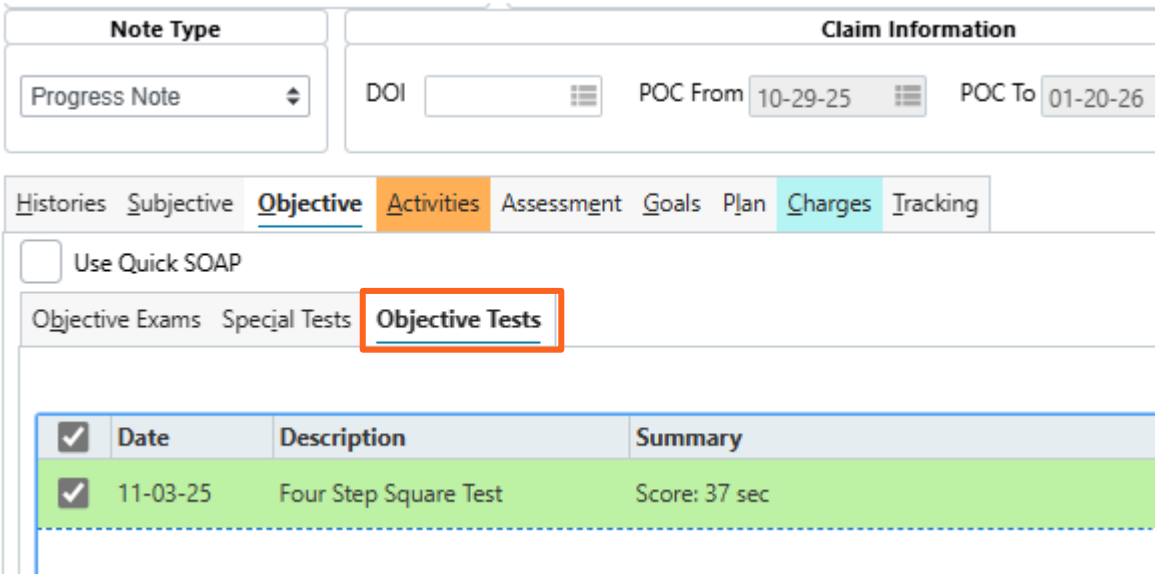


Progress Note

Objective Updates

Update Objective Exams / Special Tests / Objective Tests

- Objective Tests
  - Navigate to Objective Tests
  - Double click on a test highlighted in yellow, then click update to unlock for updates
  - Document updated score and other comments as needed and click save
  - You can add more FOMs/Standardized test as you see fit (remember to add a goal)
    - Remember: if the FOM/Test you want to add is not in the list, click on TESTS and OBSERVATIONs
  - The updated item will turn green



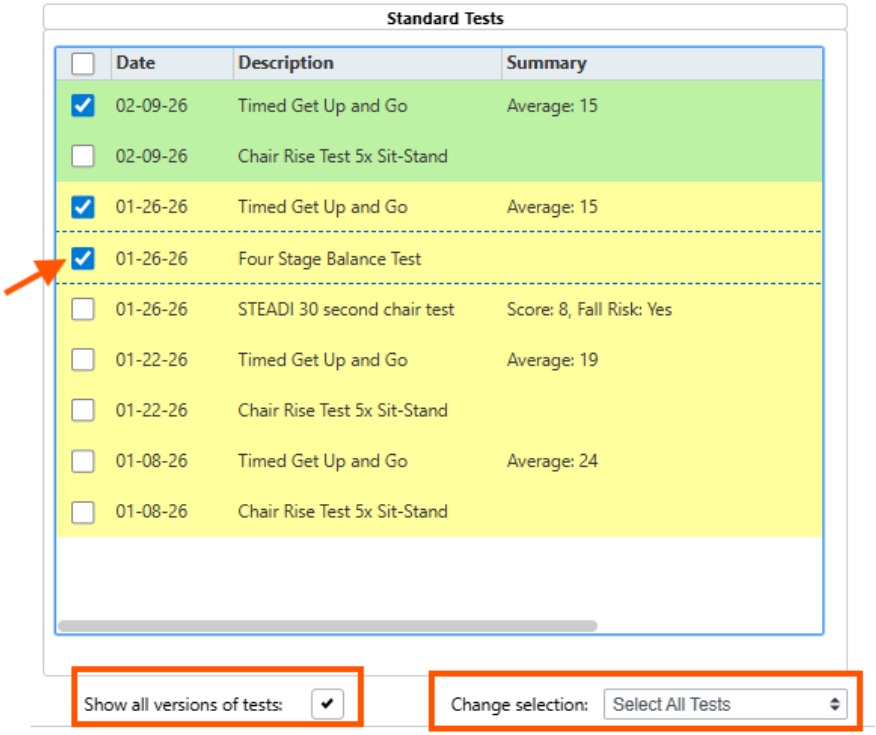
Progress Note

Objective Updates

Update Objective Exams / Special Tests / Objective Tests

For PR only (no treatment) and for FOMs completed prior to PR date

- Select "Show all versions of tests" and change drop down to "Select All tests"
- Now click the check box for any FOMs you want to include in the Progress Note

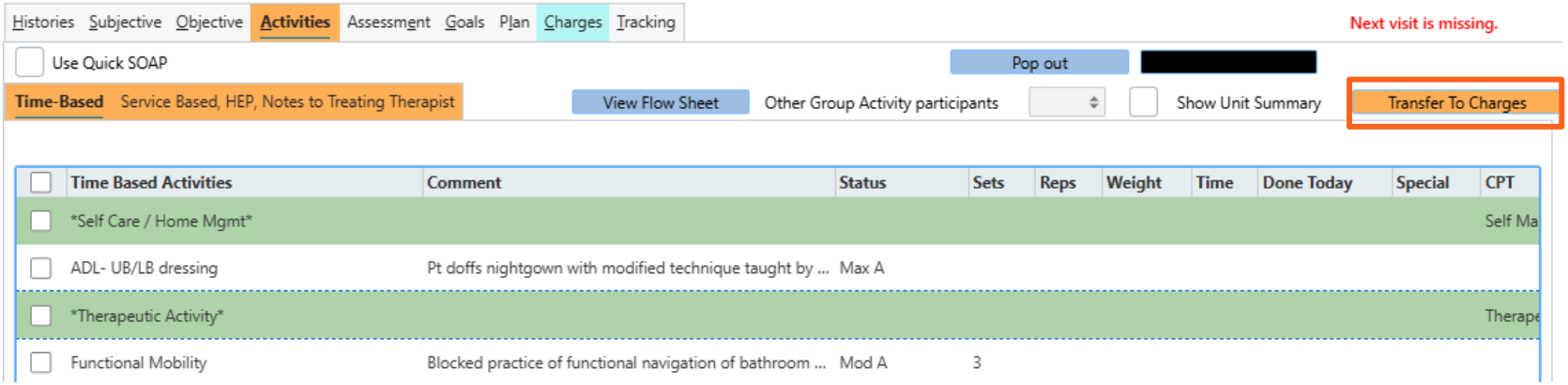


Progress Note

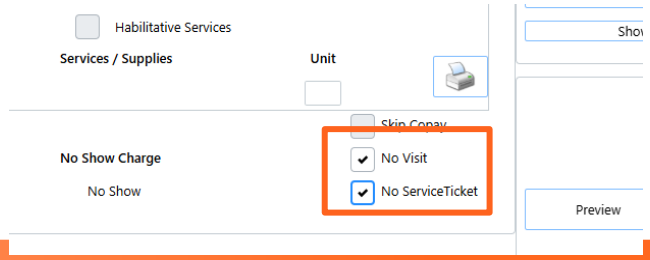
Activities

Since Progress Note is built into the treatment note, you can document a treatment session within the Activities tab

- Complete your activity tab in the same way as a treatment visit day
  - Add billable activities with measurable assist level under appropriate CPT code
  - Add Time In/Time Out (HH:MMa or HH:MMp)
- Once updated, **Transfer Charges**



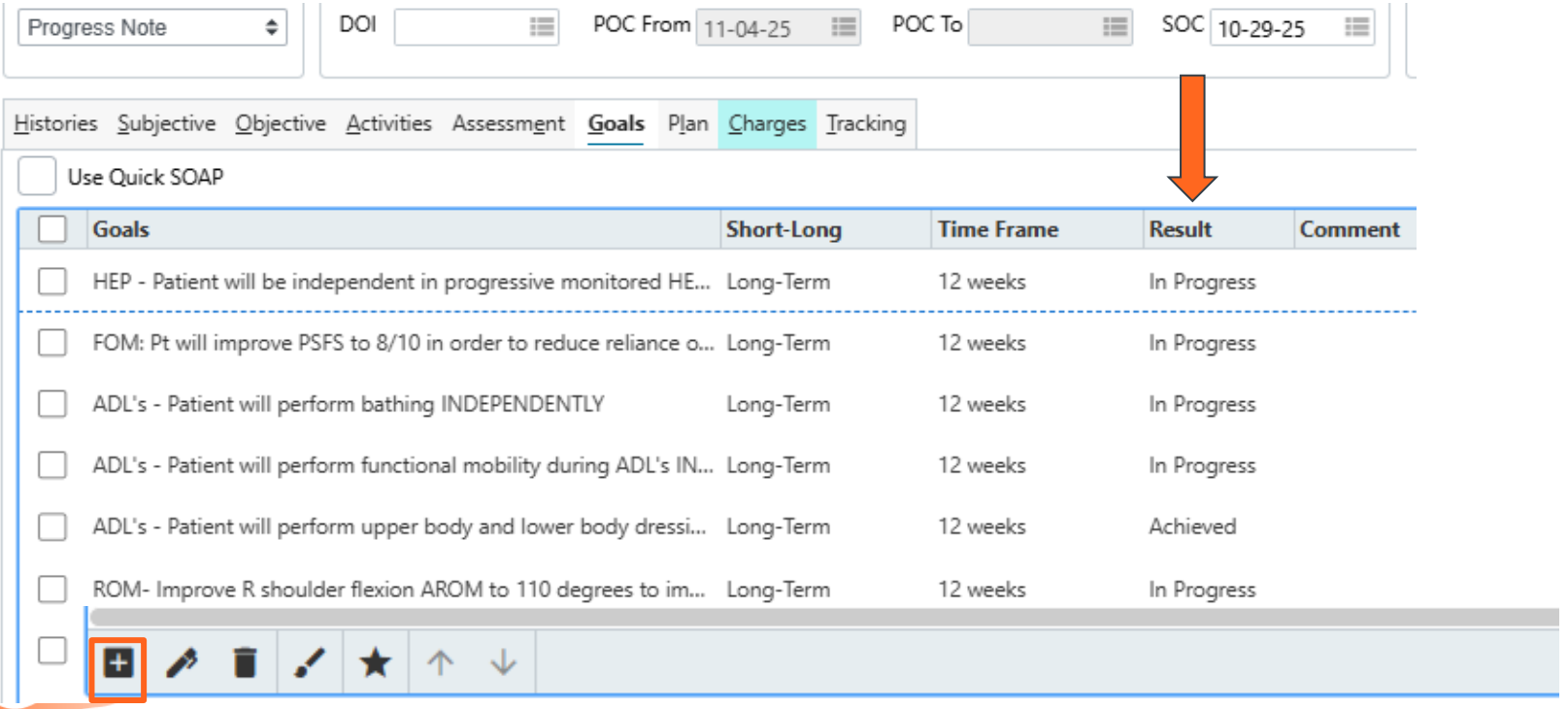
- If you are not completing a treatment note (progress note only), you will not add skilled documentation on Activities tab > check **"No Service Ticket"** and **"no visit"** checkbox on the **Charge** tab



Progress Note

Goals

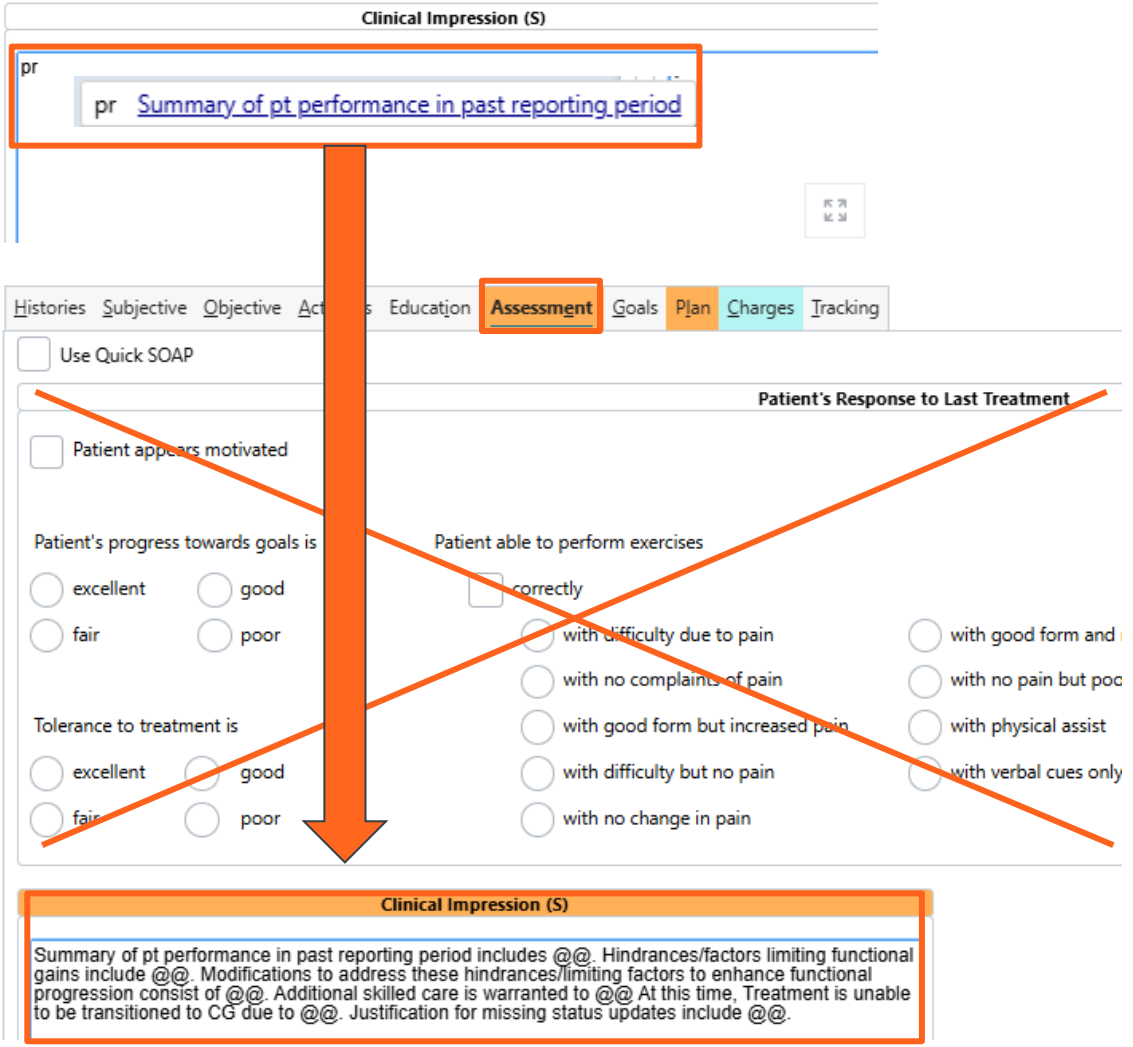
- Review all goals on the **Goals** tab
- Update/modify goals if needed
  - **Update** the Result if needed by double clicking to select appropriate status (Achieved, Discontinued, In Progress Modified, Partially Achieved)
  - Add any **new goals** using the + button. Note if you add new goals, it will initiate a change of plan of care and require new frequency/duration and plan of care be sent to the physician.
  - Tip: You can select multiple items to edit more than one goal



Progress Note
Assessment

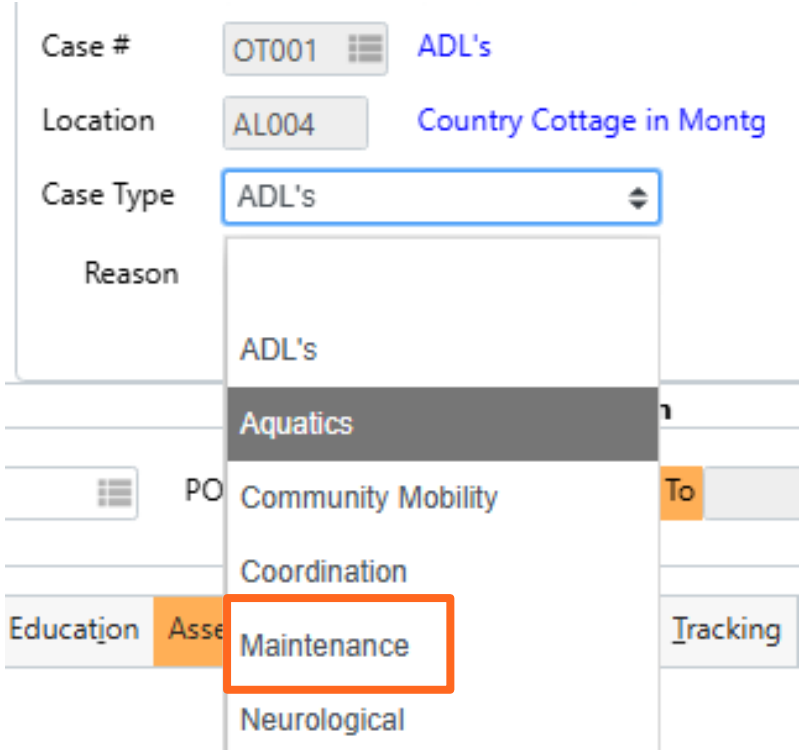
Your Progress Note Clinical Impression should outline progress, barriers and ongoing plan.

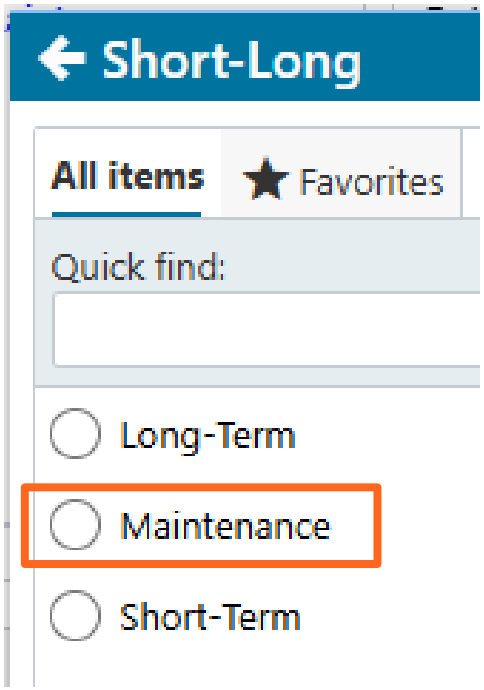
- **IMPORTANT!!!** You must type "pr" + space in the clinical impression box to load the stock statement for the progress report that includes jump markers
  - If the plan of care requires update, this note will become a recertification and you should type "**recert**" in box to load recertification clinical impression
- Fill out the Clinical Impression by completing all required areas (@@)
- You do not need to fill out Patient's Response to Last Treatment



Progress Note
Maintenance

- To transition a case to maintenance within Raintree
  1. Note type must be a progress report
  2. First, change case type to "Maintenance"
  3. Update each goal to "Maintenance" within the short – long term section within the goals picklist. (FOMs should not be used)

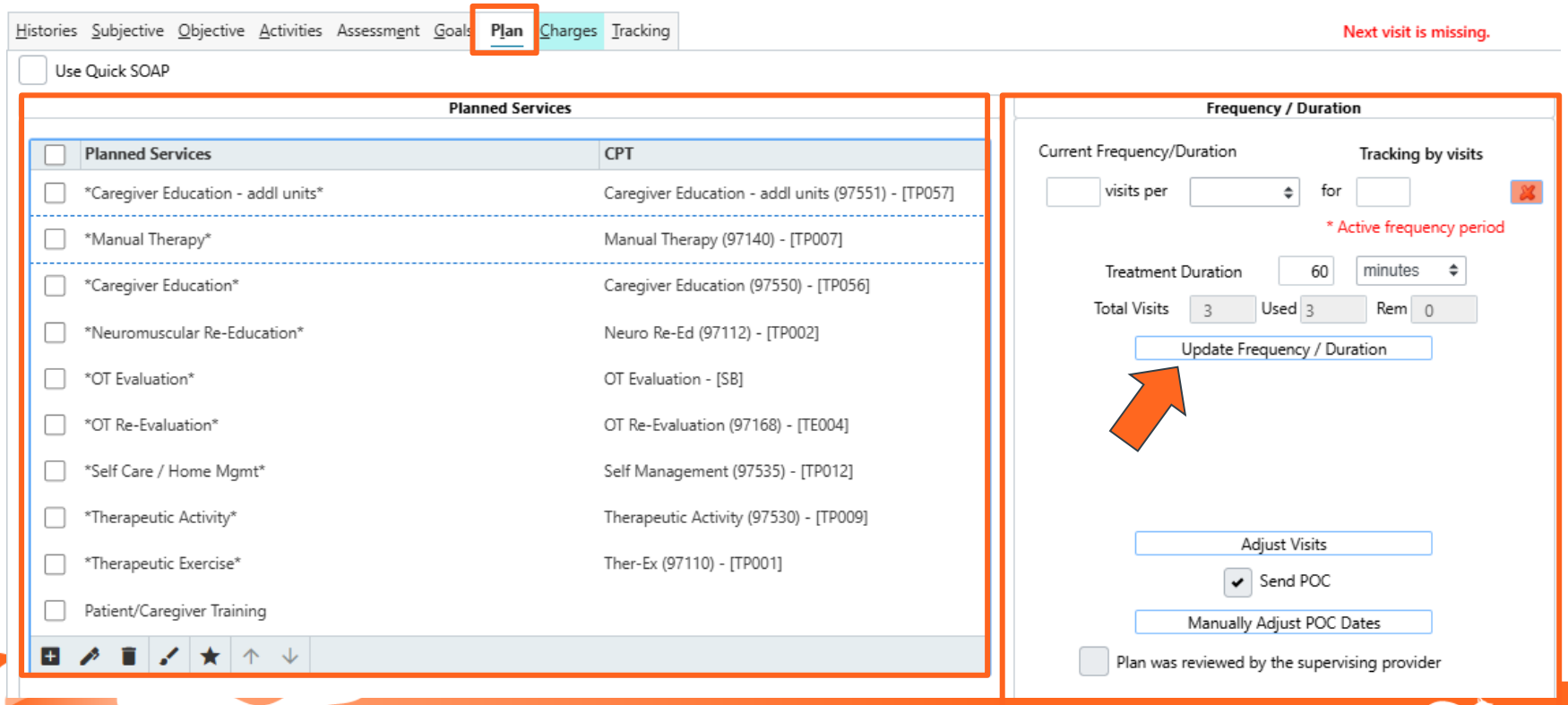




Progress Note

Plan

- Add any additional planned services if appropriate. Note if you add new planned services, it will initiate a change of plan of care and require new frequency/duration and plan of care be sent to the physician.
- If you need to update Frequency/Duration, you may click "Update Frequency/Duration"
  - Your note will automatically become a recert
  - This Sends POC to the physician for signature and is the process you will follow for tapering, when certification needs to be extended, etc

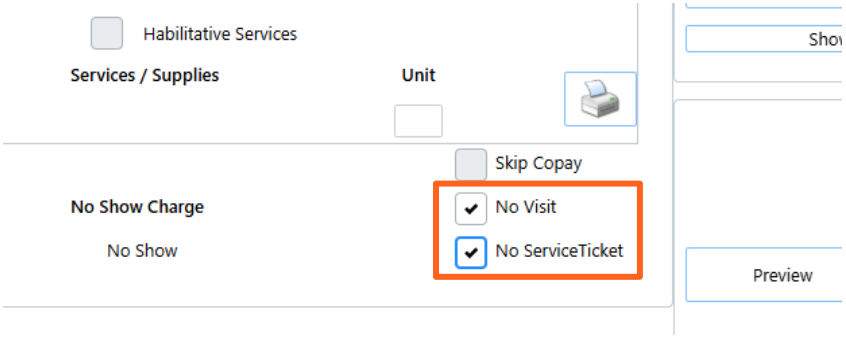


Progress Note

Charges

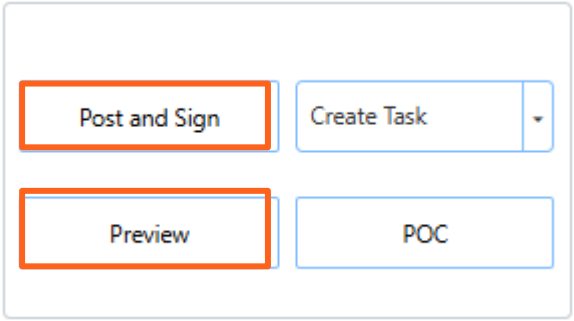
- If you already transferred charges from Activities tab, you will see charges populated on Charges tab
  - Check the total time, units and CPT codes to ensure selection is correct based on 8 minute rule and skilled care provided

- If you are NOT completing a treatment note, you will not add skilled documentation on Activities tab > check "**No Service Ticket**" and "**No visit**" checkbox on the **Charge** tab
  - i.e. If the patient's certification expires prior to next scheduled visit with Assistant, the Supervisor can write a No Visit No Service Ticket Progress Note and update the certification



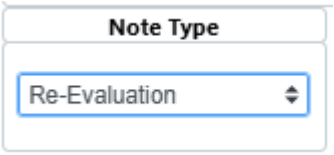
Progress Note
Sign Off

- Preview to review the narrative to ensure all information looks correct before signing off
- Post and Sign when you are ready to sign the note and post charges



Re-evaluation

- Re-evaluations should be completed when there is a major change in status and any goals needed to be changed or added
- Schedule a Re-Eval in FOX Trax or change notetype to Re-Evaluation



- Your re-evaluation workflow will largely follow the Progress Report workflow with a few exceptions:
  - You will use the "re" abbreviation to load re-evaluation Clinical Impression stock statement on Assessment tab
  - It is important to discontinue any goals that are no longer appropriate, update current ongoing goals and add new goals to address new deficits

Re-evaluation

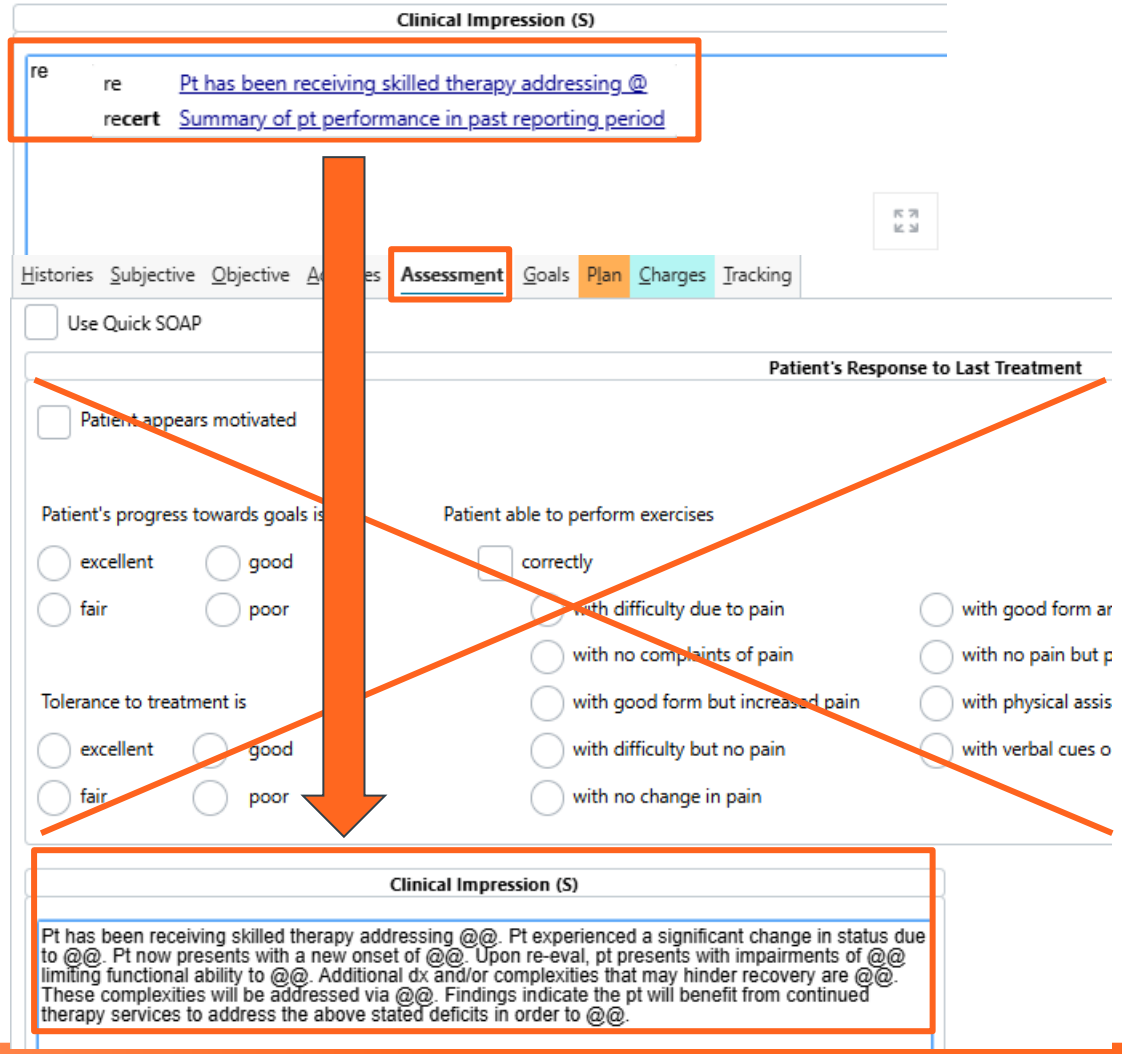
Assessment

Your Re-evaluation Clinical Impression should outline reason for re-evaluation, progress, barriers and ongoing plan.

- **IMPORTANT!!!** You must load the narrative for re-evaluation by typing "**re**" in the blank clinical impression box > press space or select the re-eval abbreviation to load template with jump markers

- Fill out the Clinical Impression by completing all required areas (@@)

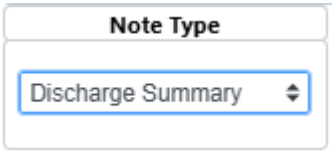
- You do not need to fill out Patient's Response to Last Treatment



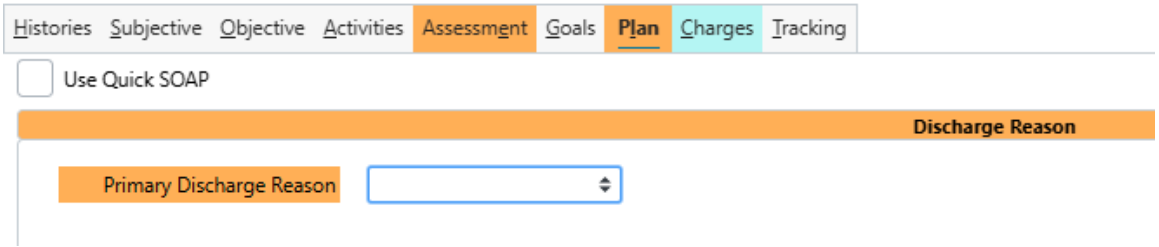
Discharge (with Treatment Visit)

When you are discharging a skilled plan of care on a treatment encounter, the discharge can be completed within the same treatment note

- Schedule a Discharge Summary in FOX Trax or change notetype to Discharge Summary



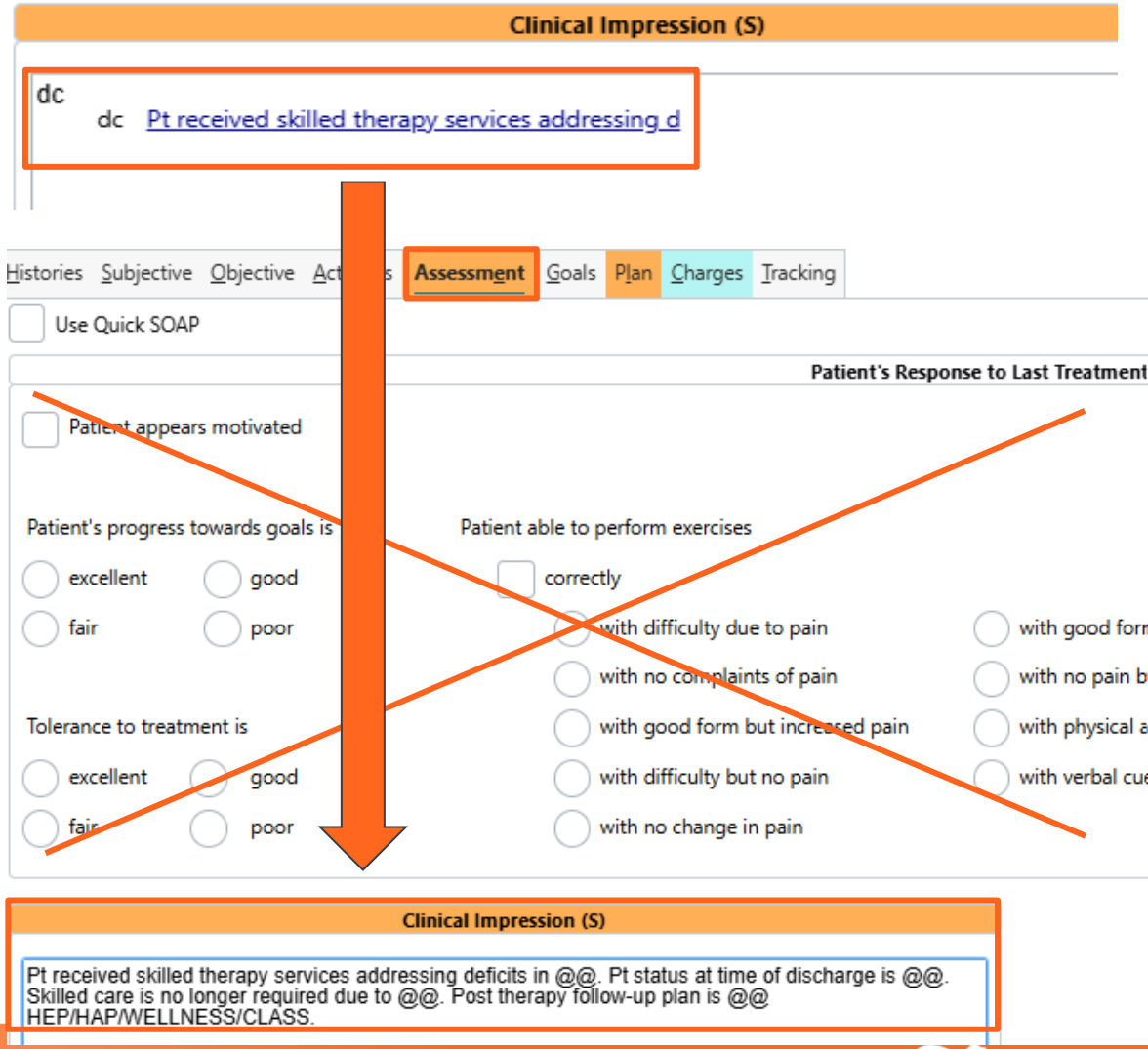
- Your Discharge workflow will largely follow the Progress Report workflow with a few exceptions:
  - You will use the "dc" abbreviation to load discharge Clinical Impression stock statement on Assessment tab
  - Goal status must be marked as Achieved, Partially Achieved or Discontinued (no goals should be "New" or left "In Progress"
  - On the Plan tab, you will select the Primary Discharge Reason using drop down arrows



Discharge
Assessment

Your Discharge Clinical Impression should outline reason for discharge, gains made and hinderances during the plan of care

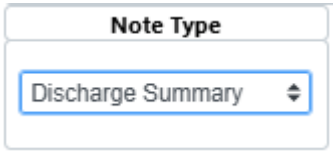
- **IMPORTANT!!!** You must load the narrative for discharge by typing "**dc**" in the blank clinical impression box > press space or select the discharge abbreviation to load template with jump markers
- Fill out the Clinical Impression by completing all required areas (@@)
- You do not need to fill out Patient's Response to Last Treatment

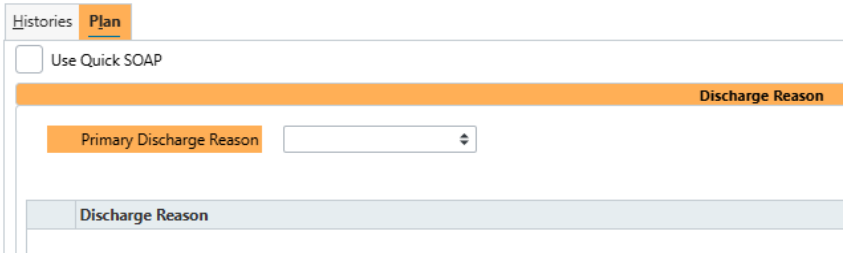


Other Discharge Workflow

You may need to discharge a case without billing for services that date (discharge without IE, unexpected discharge, pt expired, etc.). You will use the same Discharge Summary note and indicate "no visit/no service" on Charge tab

- Schedule a **Discharge Summary** in FOXTrax or change notetype to Discharge Summary





- **IF there is visit history:** follow the Discharge workflow on previous slides *(Clinical Impression, update goal status as appropriate, select reason for discharge)* and select "Show versions of all tests" on the Objective Tests tab



- **IF the case is being discharged without initial evaluation :** indicate reason for discharge *(there will be no goal history to update)* and include diagnosis code.

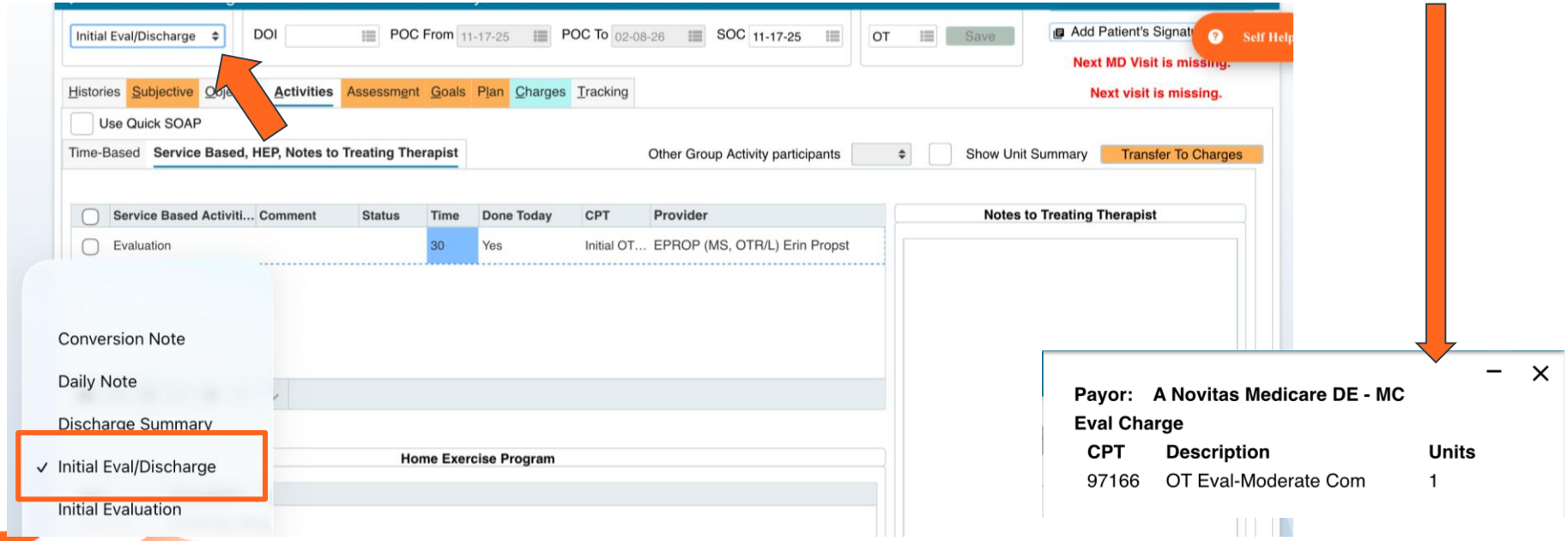
- **IMPORTANT!!!** When discharging a case without billing for services, you must indicate **"No Visit"** & **"No Service Ticket"** on Charges tab. This will allow sign-off without billing.



Initial Evaluation only with Discharge

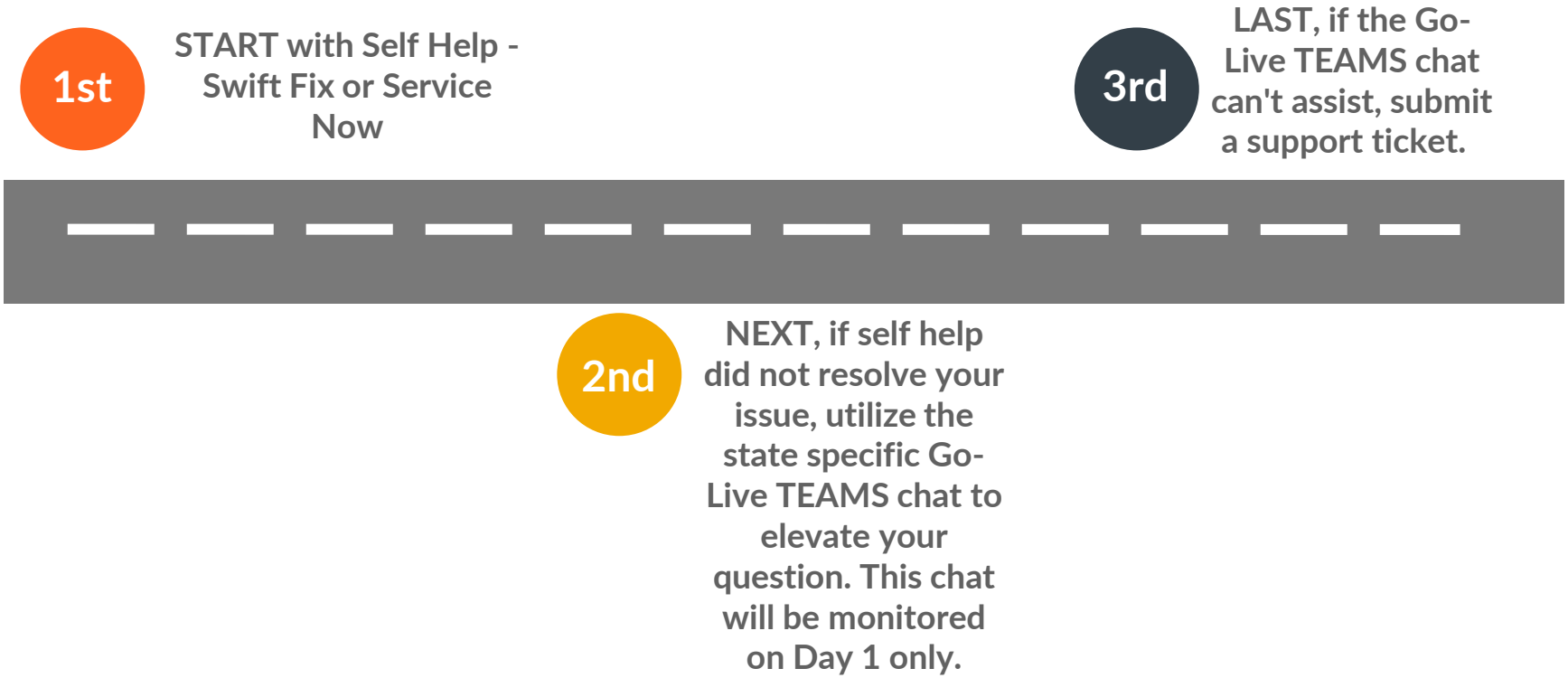
You may complete an initial evaluation that will not have a plan of care set (no deficits, no goals, pt refuses intervention). Therefore, you will discharge following the evaluation.

- After determining that care will not continue, change the note type from "Initial Evaluation" to "**Initial Eval/Discharge**"
- Follow Initial Eval workflow to document including objective, assessment and eval CPT code(s), then "Transfer to Charges" to pull eval CPT code(s) to Charges tab. Ensure you see the eval code(s) on charges tab and ensure you document reason for discharge.



Support Roadmap: Start Smart, Escalate Right

Have a question? Follow the path to resolution!



RT Standard
TVIST Assistant Workflow/Supervisory Visits



PTA/OTA Workflow

- All states have their specific regulations on requirements for co-signature, supervisory visits, face to face collaboration, etc. Please defer to supervisor for guidance
- Prior to treating, PTA/OTA should review clinical impression, plan of care, patient diagnosis, and goals.
- All treatments should be directly related to a goal
- **Assistants can only complete "Daily" treatment notes;** evaluations, progress reports, re-evaluations, and discharges must be completed by supervisor
  - These visits can be shared visits if appropriate. **Refer to slides 13-15**

    ****With this new workflow, all supervisory visits should be a PR**

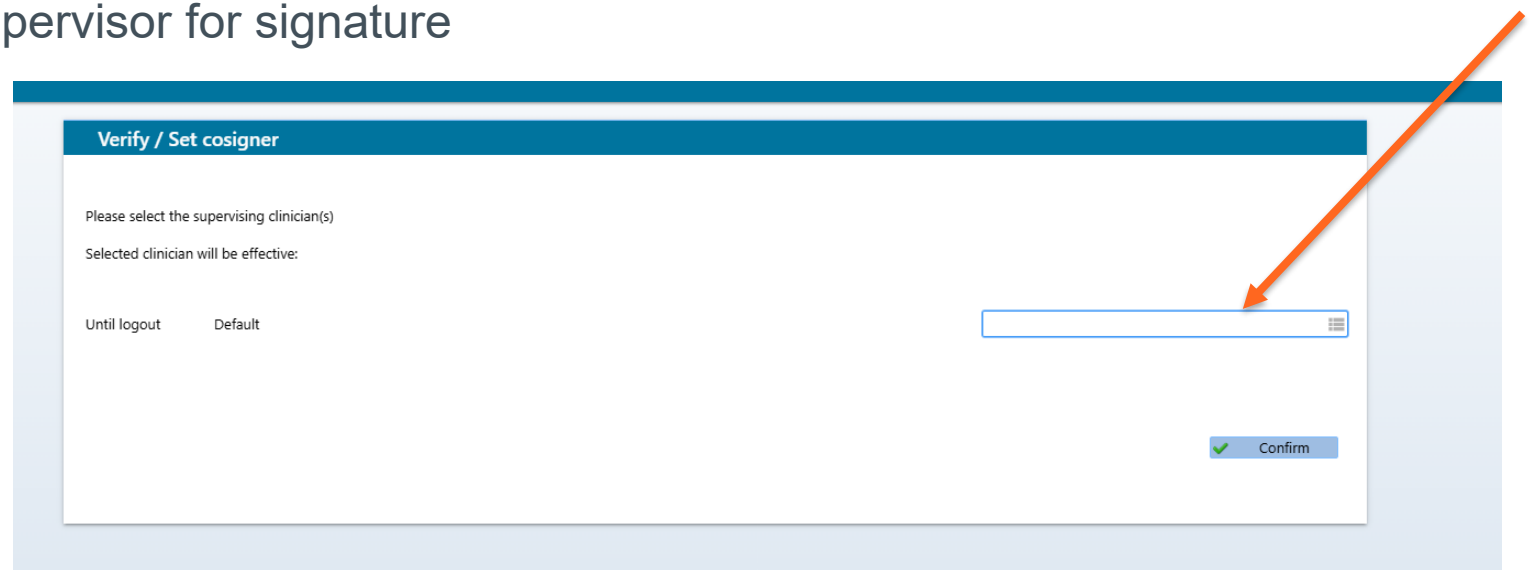
Cosignature- Required

The following states/disciplines require co-signature for each daily note

STATE	DISCIPLINE
Arizona	PT
Indiana	OT
New Jersey	PT
Ohio	PT
Virginia	OT

Cosignature- Required

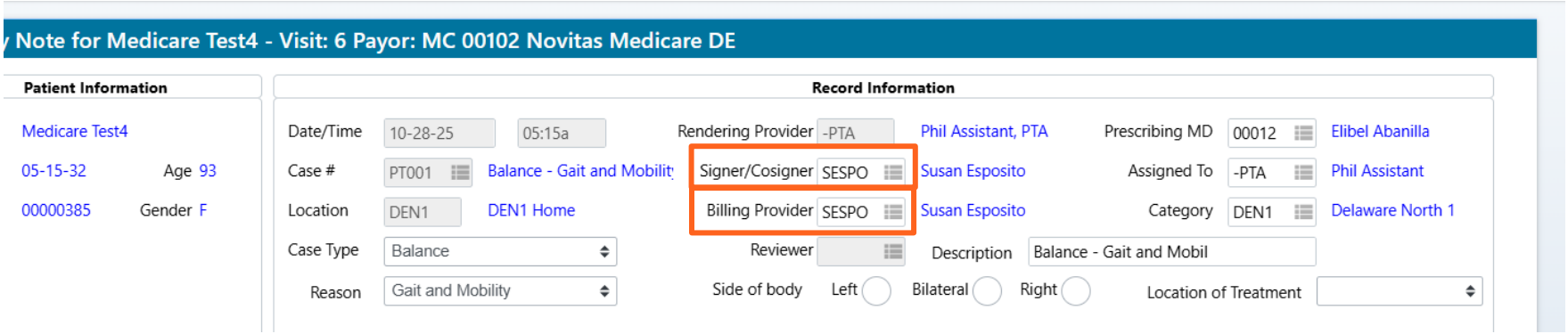
- If your state requires co-signature...
  - Upon sign in, select cosigner; once selected ALL notes will be sent to this supervisor for signature



  - If you need to switch the supervisor, log out of Raintree and upon sign in, select a different supervisor. You can also change the supervisor within the note. See next slide

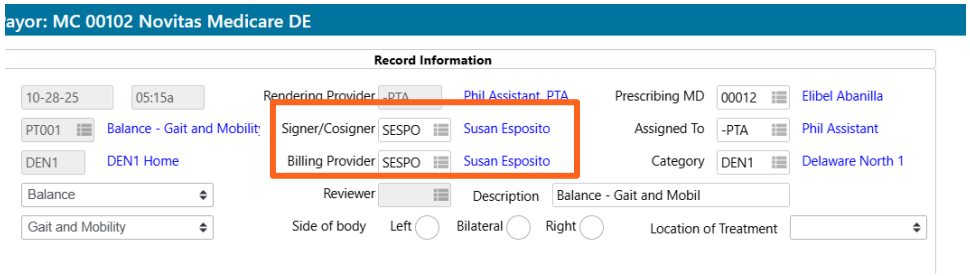
Cosignature-Required

- If you selected the incorrect cosigner upon sign in, or you need to change the cosigner for some reason, you can do this within the note.
  - The Signer/cosigner & Billing provider will default to the supervisor chosen when you signed into RT.
  - You can delete and add the appropriate supervisor within the note here if needed



Co-signature Required Workflow

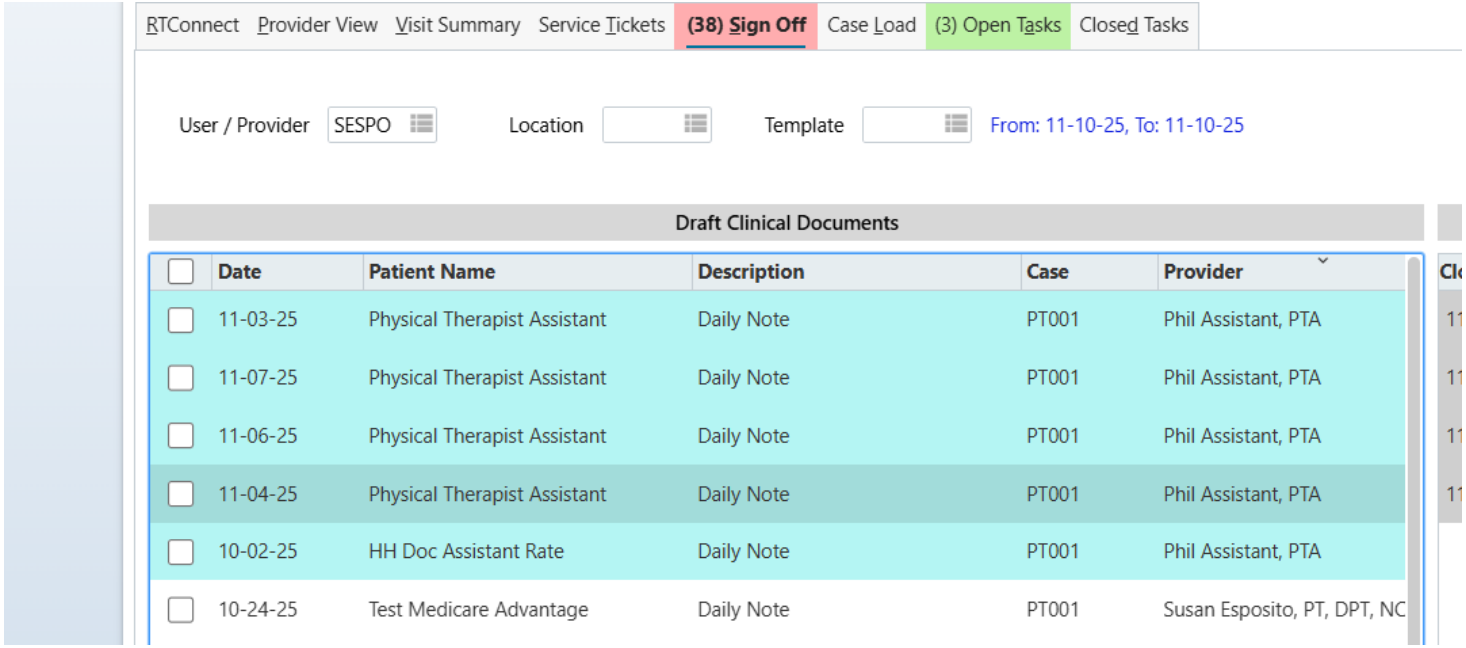
- Schedule visit in Foxtrax
- Complete Visit verification
- Open note in Raintree
- Confirm cosigner/billing provider is correct
- Treat pt and document
- Transfer charges
- Click Save in top right



- Click Save and Sign off after reviewing the narrative
- Post and sign will NOT be an option you see
- Note will now be sent to supervisor for sign off

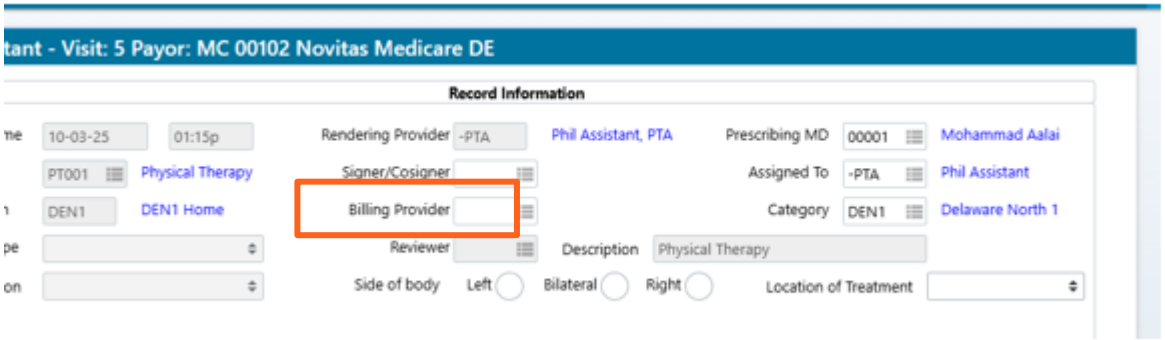
Cosignature-Required

- Supervisors can view which notes are ready for cosignature on the sign off tab...
  - All line items that are blue require cosignature
  - Assistant notes will **NOT** post to the tracking log until the note is cosigned by the supervisor.

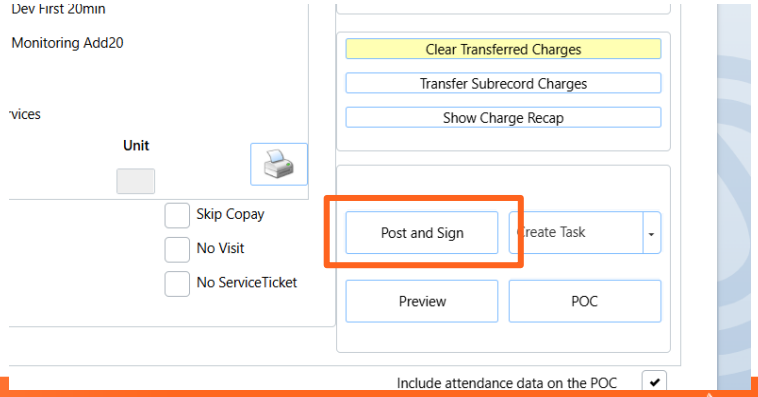


Cosignature NOT required

- Cosignature is NOT REQUIRED in certain states. If your state does not require cosignature....
  - Upon opening note, need to add the SUPERVISOR's userID to the "Billing Provider"

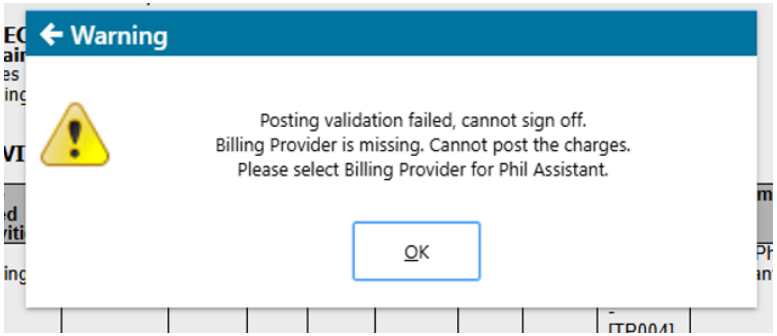


  - Treat pt and document
  - Transfer charges
  - In Charges Tab> Click POST AND SIGN



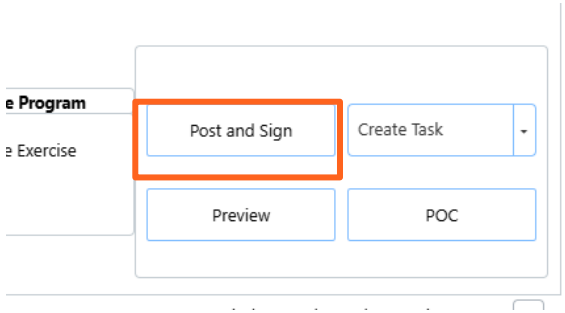
Cosignature- NOT required

- Upon signing the note, if you forgot to add in the supervisor as the billing provider, you will get this error alert...



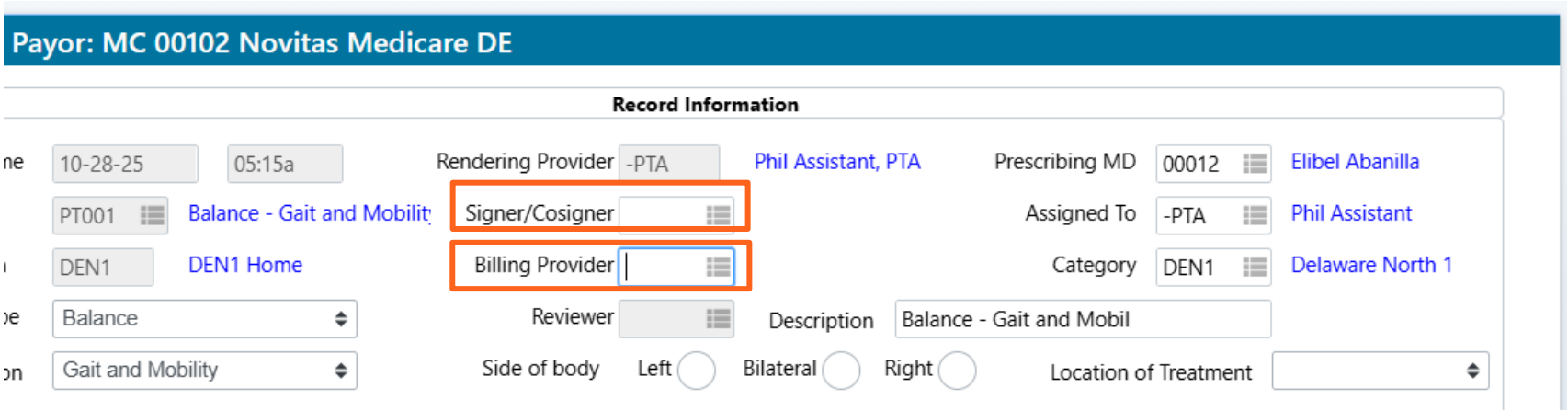
- Open the note back up, put supervisors UserID into Billing provider tab; and POST note.





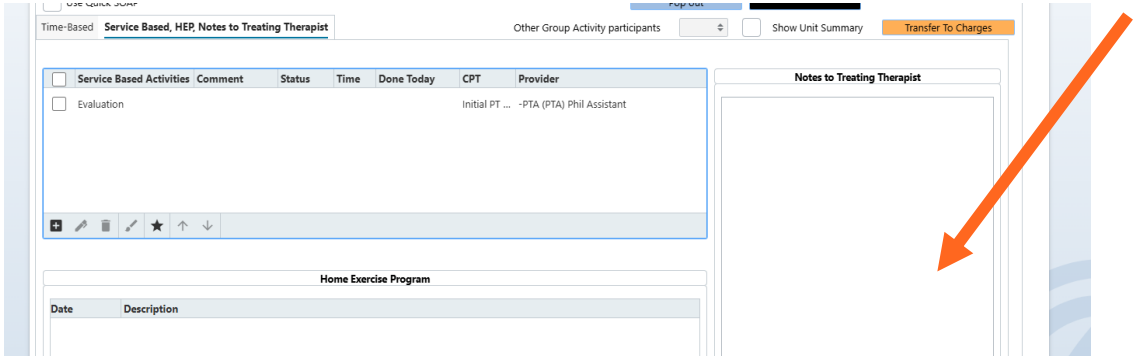
Cosignature- NOT required

- If a supervisor WANTS to cosign notes even though the state does not require cosignature...
  - Supervisor should advise assistant to add supervisors user ID to cosigner AND billing provider
  - Follow workflow of cosignature required



Communication

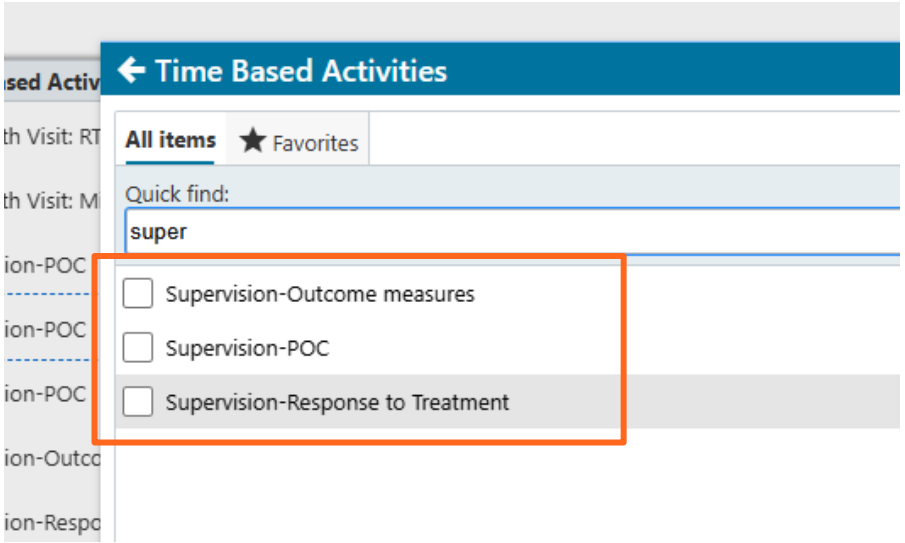
- Outside of medical record
  - Document under "note to treating therapist" under activities in service-based tab. This will carryover each note.



- Inside medical record
  - Recommend documenting any communication between assistant/supervisor that you want included in the time-based activity grid
  - Make sure to select YES under DONE TODAY but do not put time in since we are not billing for collaboration time
  - See next slide

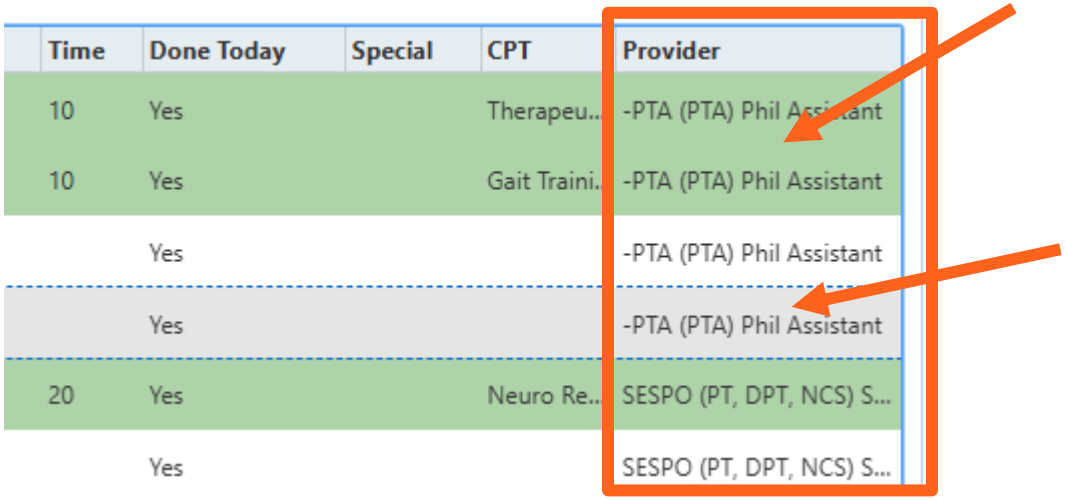
Supervisor/Assistant Communication

- Select one of the three options in the time base exercise grid. Make sure to select YES under DONE TODAY category, but do not put in time
  - Supervising clinician and assistant collaborated on patient care plan via face to face collaboration or supervisory visit
  - Supervising clinician and assistant discussed patient response to interventions
  - Outcome measures performed under the direction of the supervising clinician
- Add details as appropriate



Shared Visits/Split Visits within SAME note

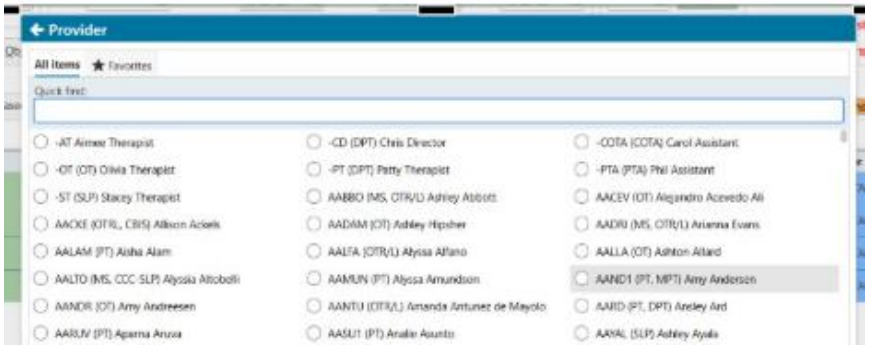
- Supervisor and Assistant can both treat a pt on the same day at different times within one note.
  - Will occur most frequently on eval, progress reports, recerts, re-evals, and discharges
  - The provider in the activities grid defaults to the clinician that OPENED the note first.



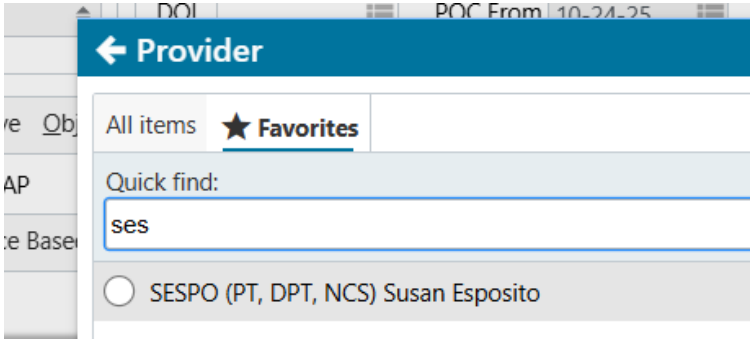
Time	Done Today	Special	CPT	Provider
10	Yes		Therapeu...	-PTA (PTA) Phil Assistant
10	Yes		Gait Traini...	-PTA (PTA) Phil Assistant
	Yes			-PTA (PTA) Phil Assistant
	Yes			-PTA (PTA) Phil Assistant
20	Yes		Neuro Re...	SESPO (PT, DPT, NCS) S...
	Yes			SESPO (PT, DPT, NCS) S...

  - In order to get unit credit for the activities you completed, make sure you change the provider to your UserID.
    - Recommend "favoriting" your user ID

Shared Visits/Split Visits within SAME note



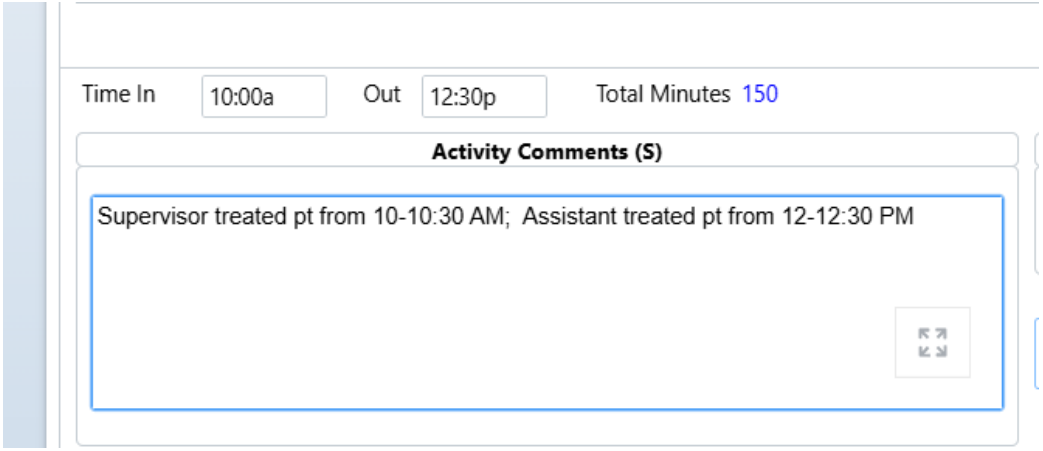
- Click provider in Activities column
- Search for your user ID
- Favorite your user ID
- Click star at the bottom right
- User ID will now be found in favorites for easy access



- If both the supervisor and assistant completed Therapeutic Exercises, there should be two lines items for this same CPT code

Time in/Time out Shared visits

- Time in and Time out should be inclusive of both sessions
  - If a supervisor treated a pt from 10-10:30AM and the assistant treated them from 12-12:30 PM; Time in/Time out= 10:00A-12:30 P
  - In the activity comments, there should be documentation of time in and time out for each session



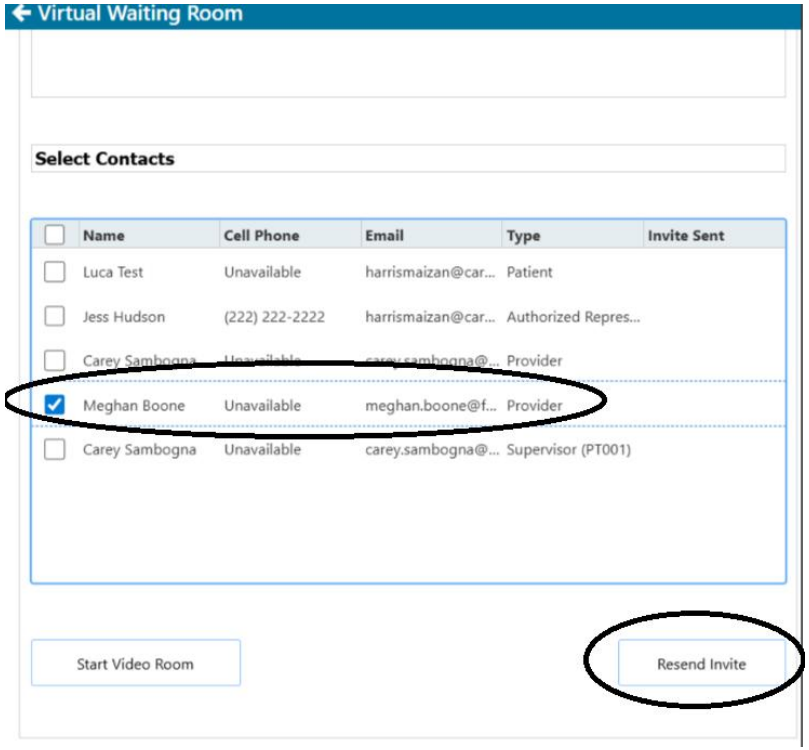
  - You can use the abbreviation "share" to generate this stock statement... Supervisor treated pt from @@-@@ Assistant treated pt from @@-@@

Split Visits – 2 separate notes

- A visit needs to be split when one clinician is conducting a portion of the visit via telehealth, and the other clinician is in person (ie a supervisory visit).
- In this instance, 2 separate visits must be scheduled.
- The clinician that treats the pt first, needs to sign off on the note PRIOR to the second clinician opening up the note.
- The Second clinician MUST complete the note on that same date of service to ensure accurate billing is completed in the backend
- If the supervision is virtual and the patient is being discharged, both clinicians must complete a daily note and then a separate DC note is completed.

Telehealth Supervisory Visits – Using a FOX Device

- If using a FOX device (shared or assistant's device) the supervisor will need to do the following from the Virtual Waiting Room on the date of the appointment
  - Select the on-site provider (assistant) from the list of contacts
  - Resend the telehealth appointment invite

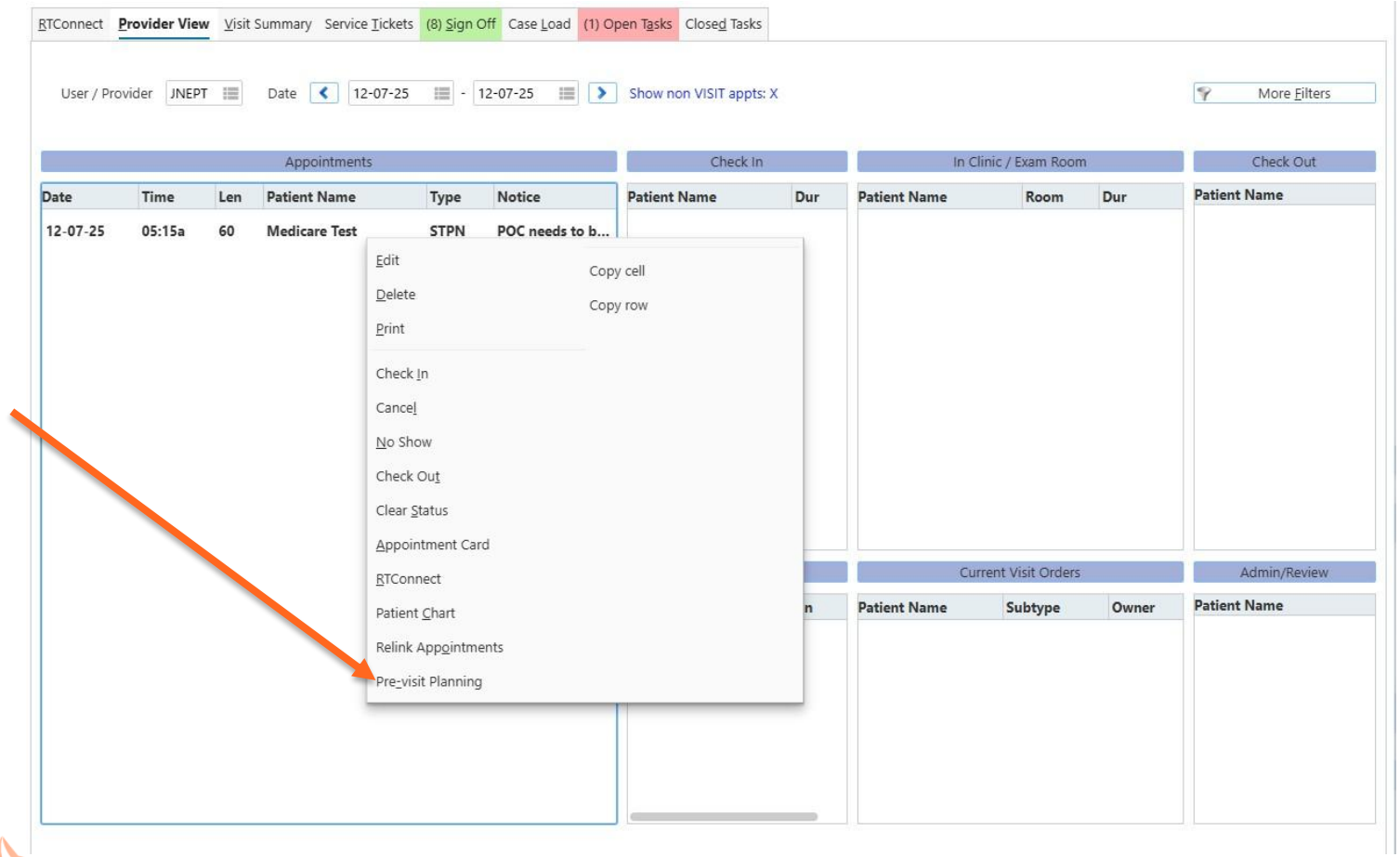


Pre Visit Planning

- Raintree Standard allows for pre-visit planning through a special feature
  - Allows for pre documentation within the following
    - Time Based Activities / Service Based Activities
      - Activities can be accessed and edited prior to the start of a visit
      - Edits will display once the visit is checked in
    - Notes to Treating Therapist
      - This section can be accessed and edited prior to the start of a visit
      - Edits will display once the visit is checked in
  - Can be used for visit planning that can lead to efficiency pick-ups for individual workflows. (setting up the planned activities with known details
  - Can be used to set up visits for a covering therapist, or used to enhance the clinician / assistant collaboration

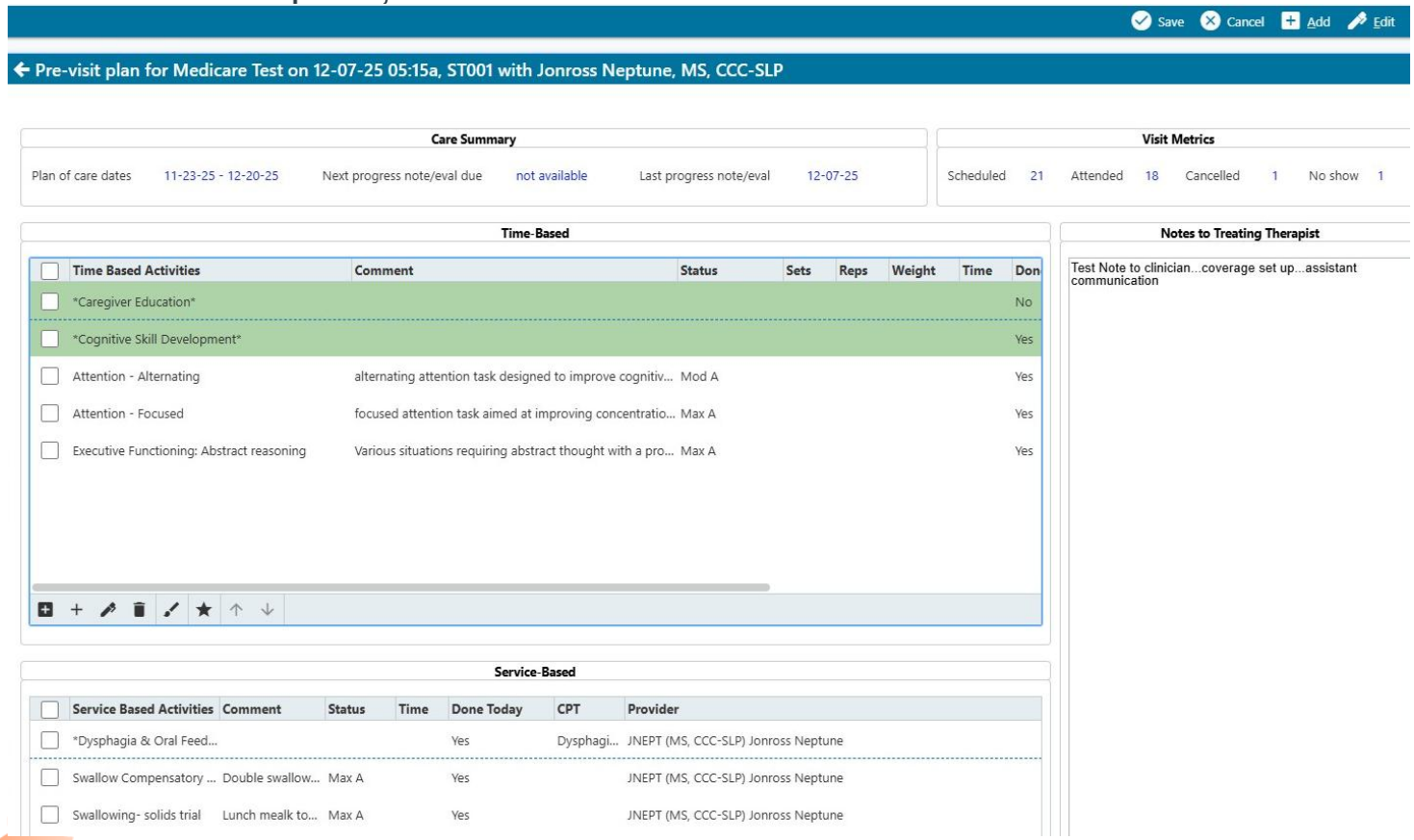
Pre Visit Planning

- Once a visit is scheduled you can access pre-visit planning by R-click on the visit from the provider tab and choosing Pre-Visit Planning from the list



Pre Visit Planning

- You will be brought into the Pre-Visit Planning and now have access to make any updates to “Time Based”, “Service Based”, and “Notes to Treating Therapist”
- Once edits are complete, click save

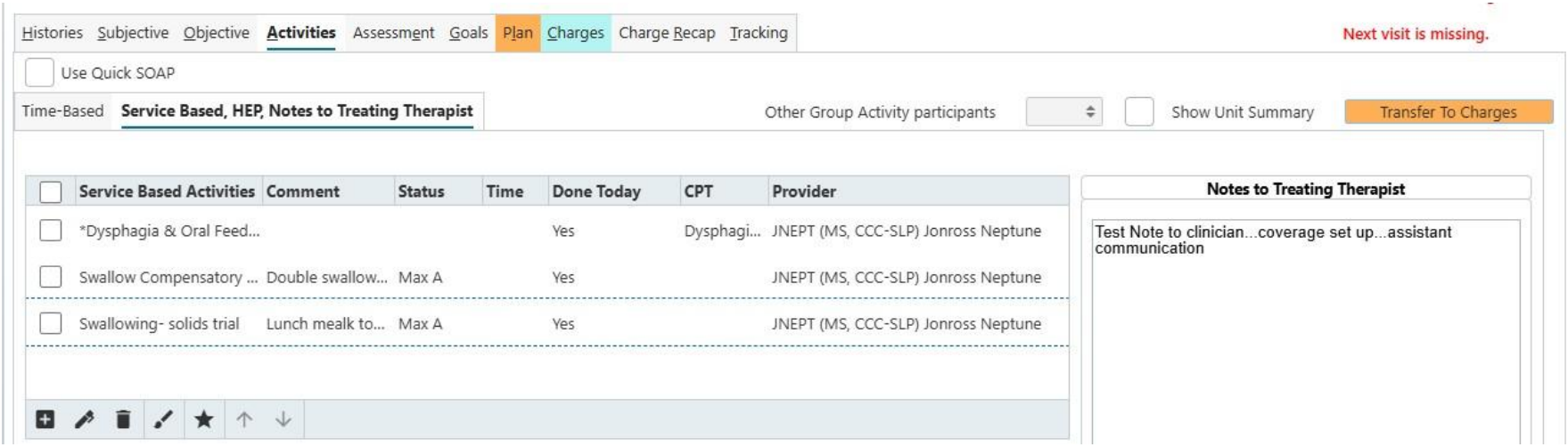


Pre Visit Planning

- At the visit check in, you will see an alert that notified of updates

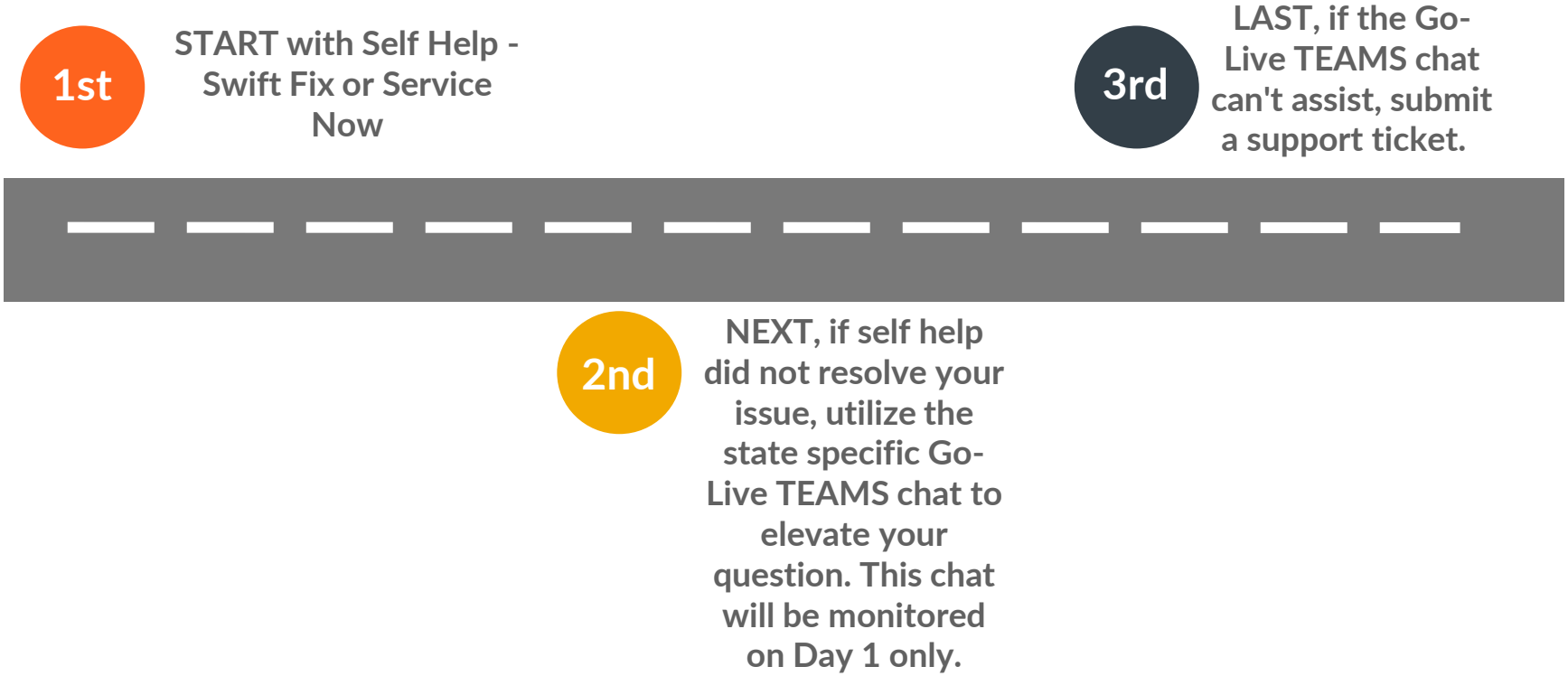


- You will see the updates within the Time Based, Service Based, and Notes to Treating Therapist sections



Support Roadmap: Start Smart, Escalate Right

Have a question? Follow the path to resolution!



RT Standard:
Telehealth



Raintree Telehealth Considerations

- Raintree telehealth platform should be used for telehealth visits
  - Microsoft Bookings workflow is not compatible with the iPad
  - A regular Teams meeting can be used as a BACKUP solution AFTER troubleshooting Raintree

- Must use Chrome or Safari Browser
  - Microsoft Edge is NOT compatible
    - If Edge opens automatically for patient or clinician, copy URL to another browser

- Screensharing DOES NOT work on iPad
  - If you perform telehealth often and screenshare regularly – reach out to telehealth@foxrehab.org

Raintree Telehealth Considerations

- Must have work schedule setup for patient's location
  - *You will learn more about work schedules in the Scheduling training*

- Only Medicare (MC), Medicare Advantage (MA) and MCHO primary insurances will allow telehealth appointment scheduling

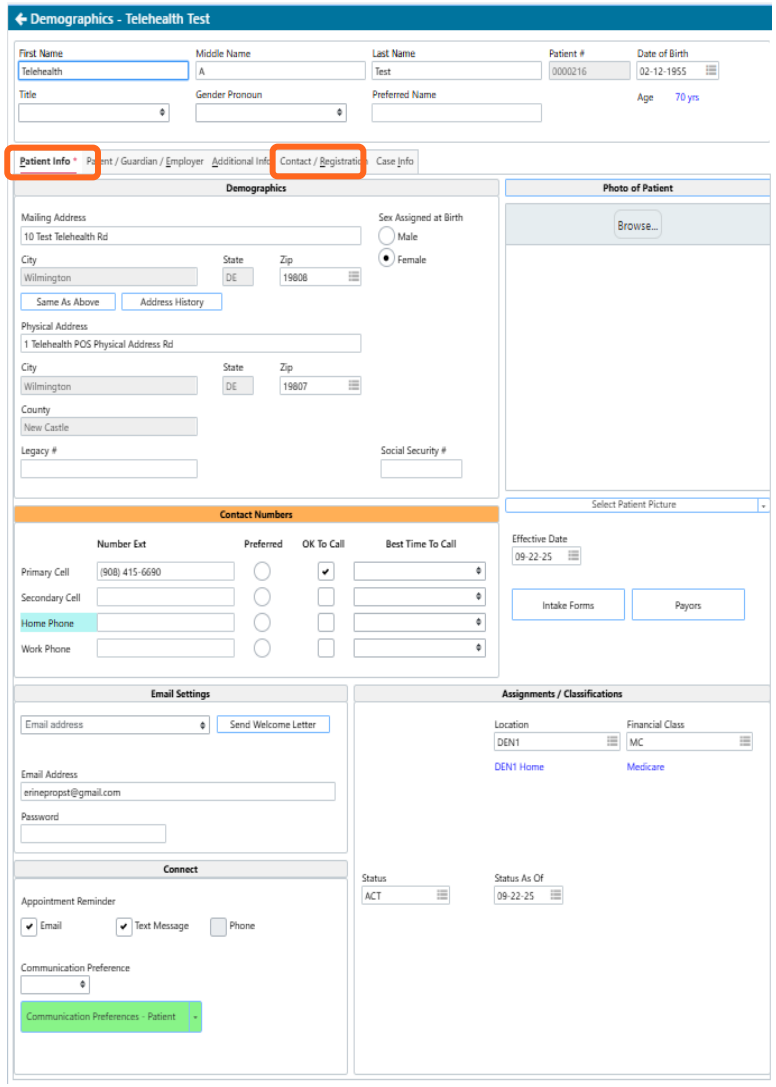
- Initial steps before scheduling a telehealth appointment should include:
  - Updating patient and/or authorized representatives contact information
  - Updating communication preferences (COMPR) to ensure telehealth appointment messaging goes to the appropriate contacts
  - *You will learn more about updating patient/contact information and COMPR in the Consent to Care training*

- *Supervisory visits follow a slightly different process when done over telehealth*
  - *You will learn more about this process in the Supervisory Visit training*

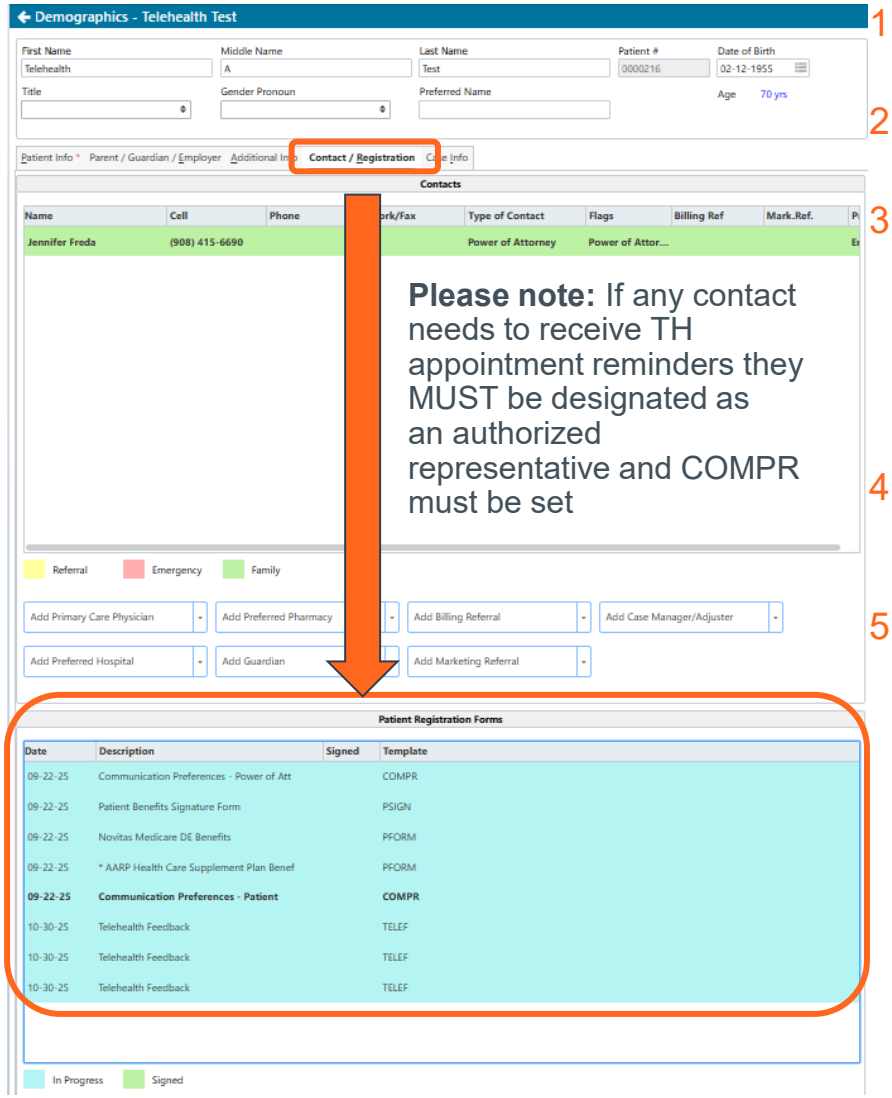
Updating Contacts

1. Dashboard > Caseload Tab > Select Patient (Double Click) > Menu > Patient Demographics

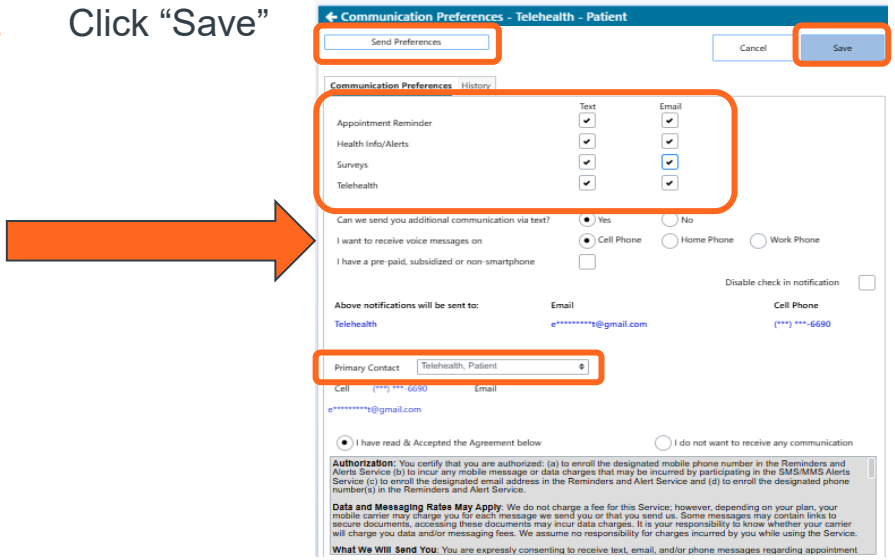
2. Use Patient Info or Contact/Registration tabs to update contacts
    - Patient and contacts should **NOT** have the same contact information
        - Only the patients email and/or phone number should be listed under the patient contact



Updating Communication Preferences (COMPR)



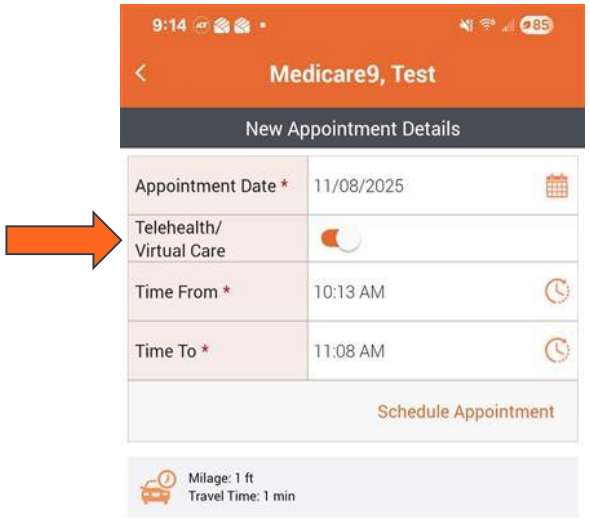
1. Dashboard > Caseload Tab> Select patient (double click) > Menu > Patient demographics
2. Select Contact/Registration tab and scroll down to Patient Registration Forms
3. Double click Communication Preference document to edit and update
   - "Appointment Reminder" AND "Telehealth" should be checked to receive telehealth appointments
   - If COMPR not present, update contact information and mark as authorized representative
4. Click “Send Preferences”
   - This enables the patient/authorized rep to read, accept and update the information as needed
5. Click “Save”

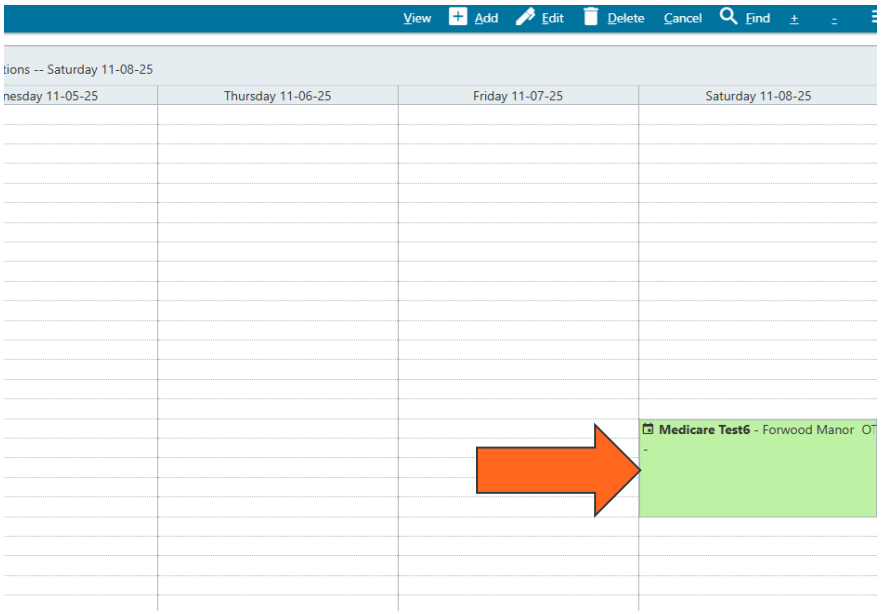


Scheduling Telehealth Visits

- Telehealth visits should be scheduled, edited or cancelled via FOXTRAX
  - When scheduling in FOX Trax, toggle on Telehealth/Virtual Care
  - Telehealth appointments will display as green on the scheduler

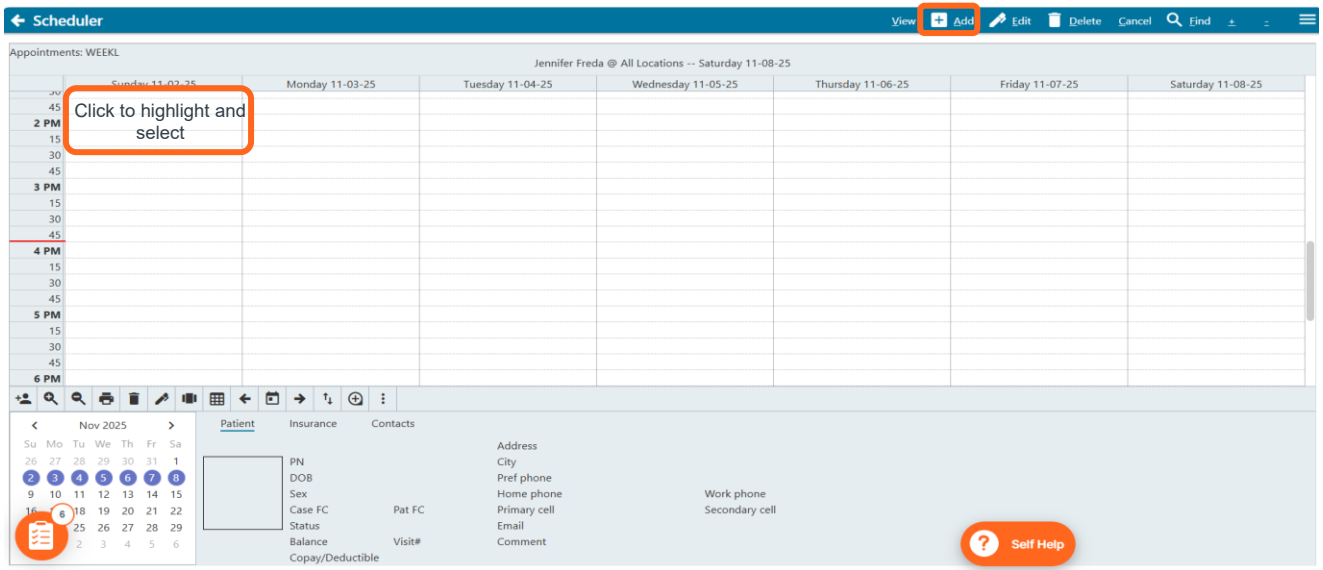
- Appointment messaging is sent to patient and/or authorized representatives:
  - **24hrs before appointment time** when the appointment is scheduled greater than 24 hours in advance
  - **Immediately** when the appointment is scheduled less than 24 hrs. in advance OR appointment reminder resent





Scheduling a Telehealth Visit

- IF you are unable to schedule the telehealth visit in FOXTrax, you are able to schedule in Raintree using the Scheduler (FOXTrax is best practice)
- Scheduling in Raintree should only be used as a back-up OR when scheduling a patient outside of your time zone.
  - The Raintree scheduler can be accessed through the Main Menu or Dashboard
    - ***To add an appointment outside of FOXTrax:*** *Click on a timeframe and click "Add" OR double click on a timeframe within the scheduler*

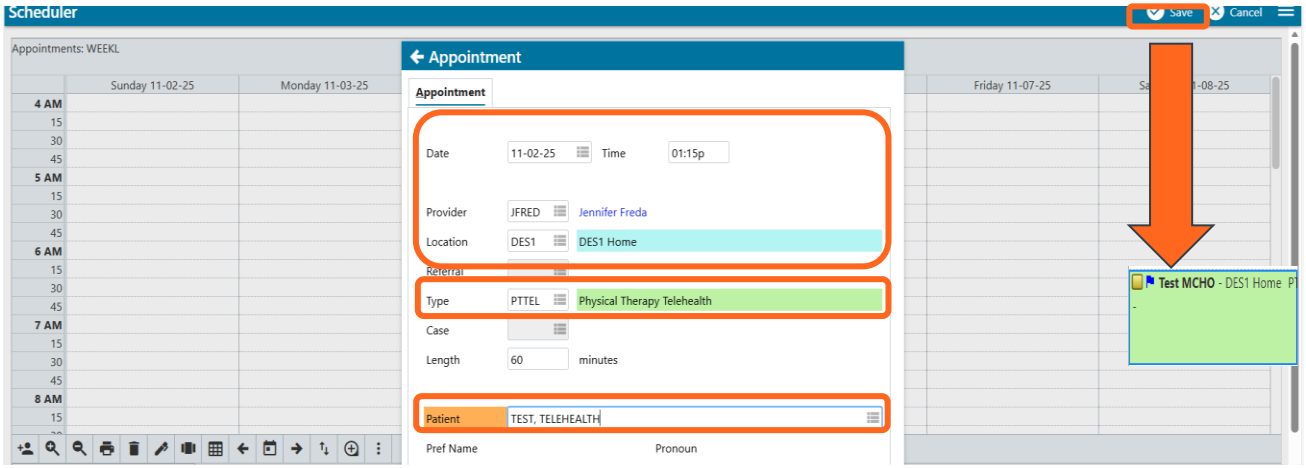


Telehealth visits are the ONLY visits that can be scheduled via the RT scheduler, and not FOXTrax, as telehealth does not require visit verification.

Scheduling a Telehealth Visit

Patient within your time zone

- Verify correct Date, Time, Provider and **Patient** Location
- Type MUST be entered as PTTEL, OTTEL, STTEL or FSTEL
  - Ensures visit is identified as a telehealth visit and telehealth modifier is added to billing
  - Length of session will automatically update to 60 minutes but can be adjusted as needed
- Enter patient by (Last name, First name) or patient number
  - Can also search patient files by clicking the icon to the right of the patient field
  - May receive a prompt to select appropriate patient or case
- Save

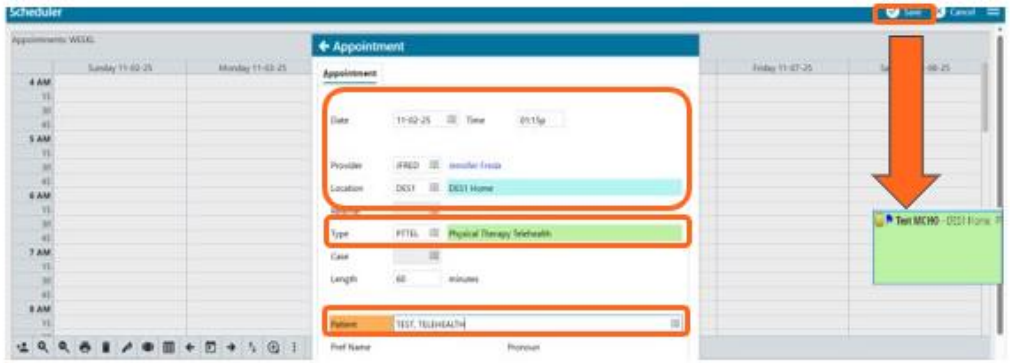


If prompted to change appointment type due to a progress note etc., DO NOT change and "Continue with current type" to ensure Telehealth modifier is added when billing

Scheduling a Telehealth Visit

Patient outside of your time zone

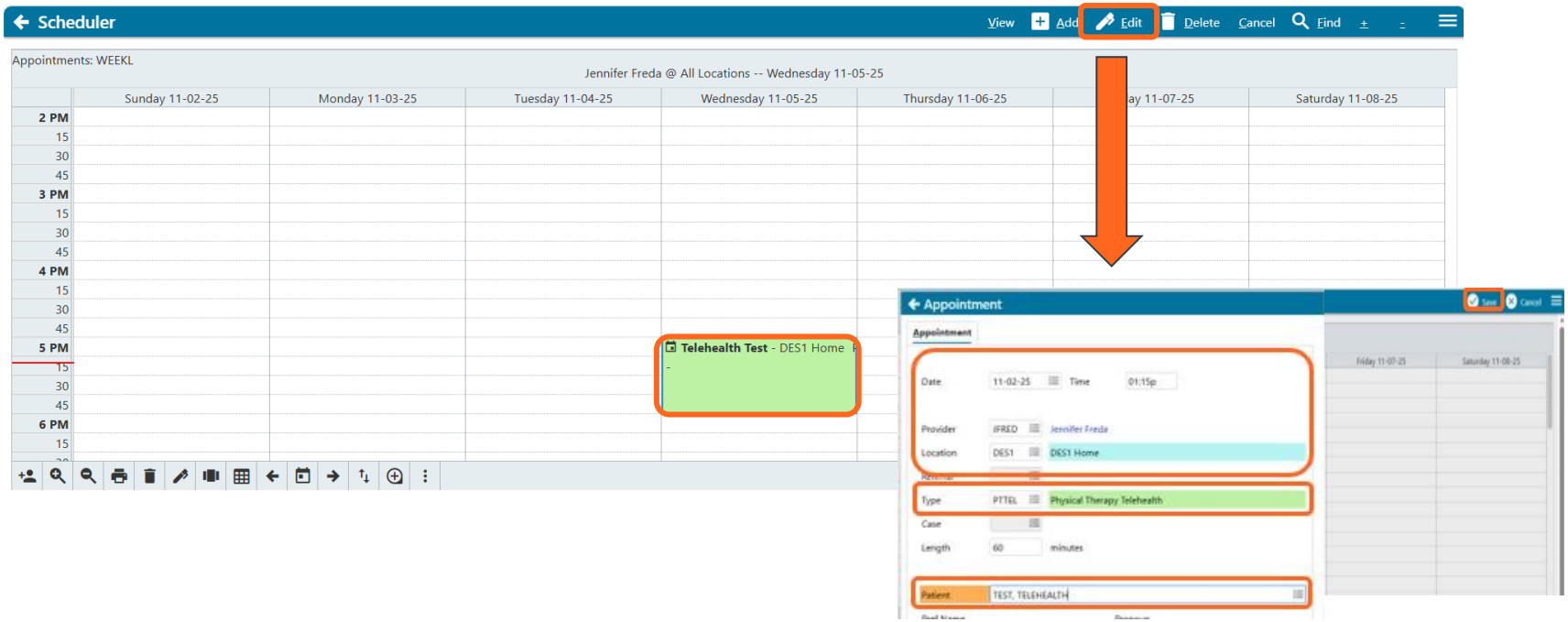
- Must Schedule via the RT Scheduler
- Verify correct Date, Time, Provider and **Clinician** Location
  - Location MUST be set to your **YOUR** region (i.e., DEN1)
  - **Please note:** The appointment reminder will be sent in the clinician's time zone and patients should be made aware
- Type MUST be entered as PTTEL, OTTEL, STTEL or FSTEL
  - Ensures visit is identified as a telehealth visit and telehealth modifier is added to billing
  - Length of session will automatically update to 60 minutes but can be adjusted as needed
- Enter patient by (Last name, First name) or patient number
  - Can also search patient files by clicking the icon to the right of the patient field
  - May receive a prompt to select appropriate patient or case
- Save



If prompted to change appointment type due to a progress note etc., DO NOT change and "Continue with current type" to ensure Telehealth modifier is added when billing

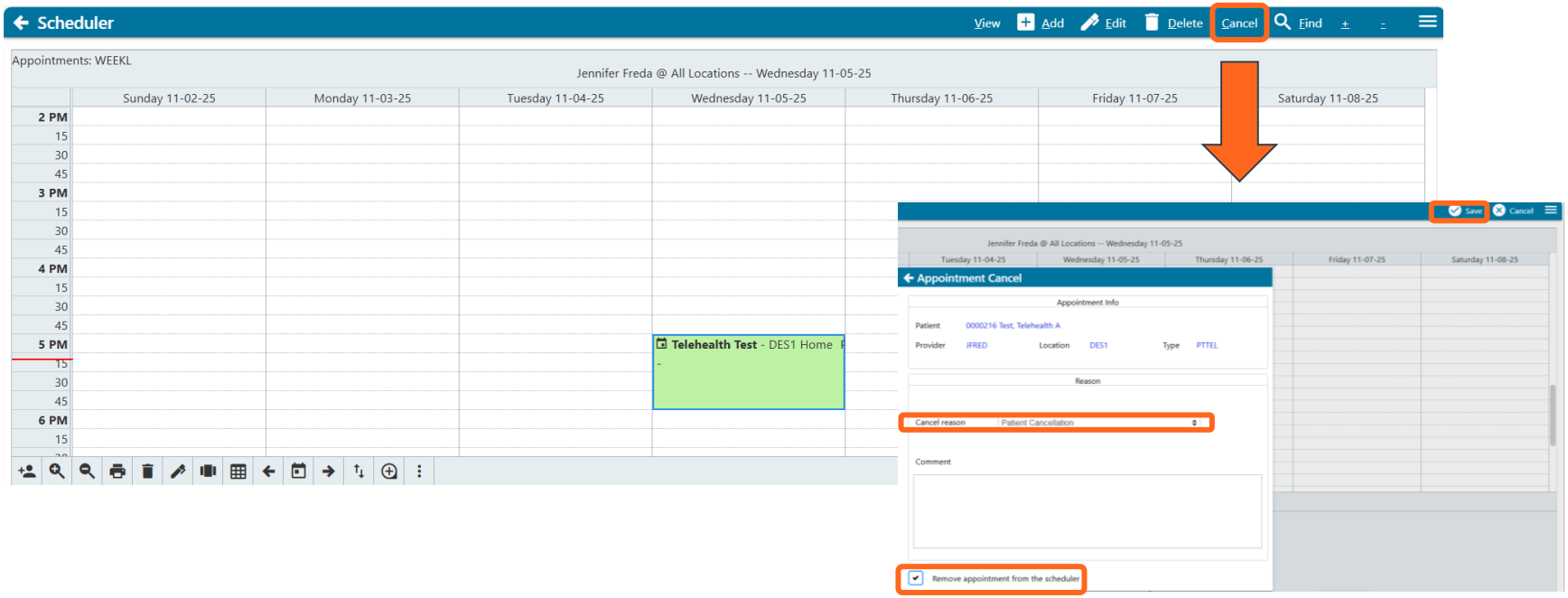
Editing a Telehealth Visit

- Click on appointment and select "Edit"
- Update appointment details
- Save



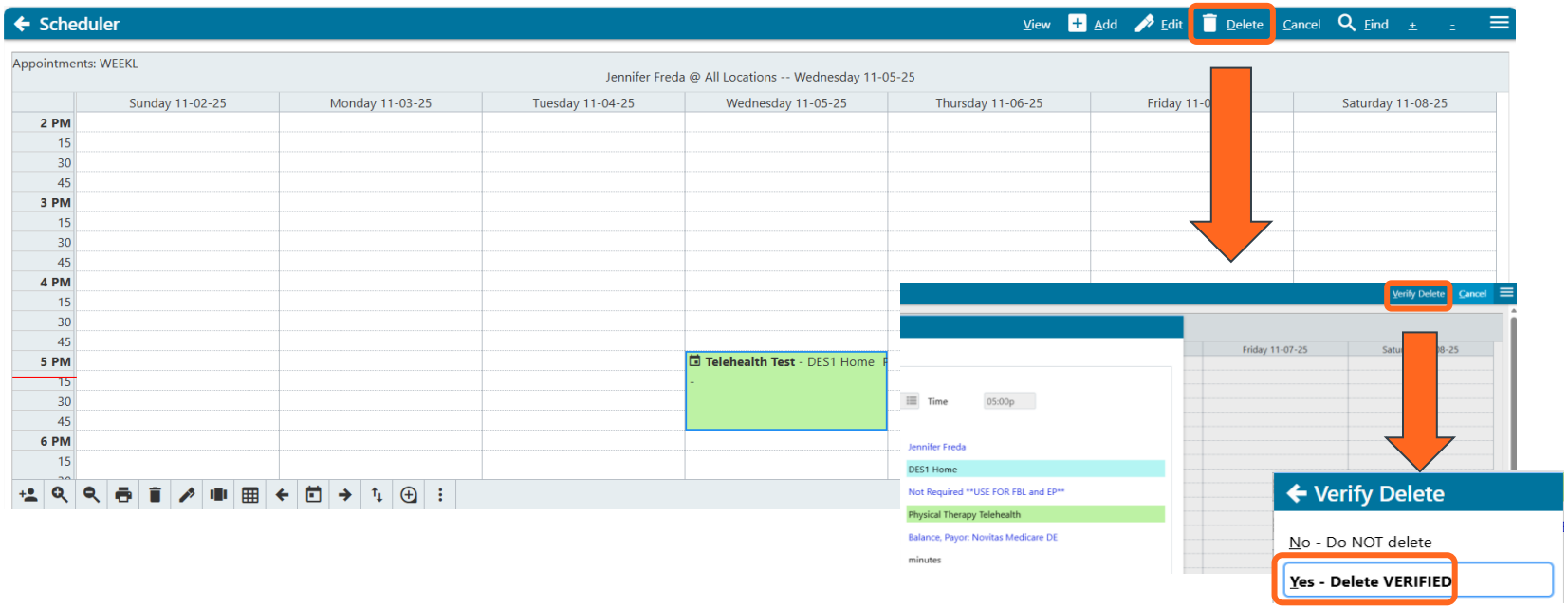
Cancelling a Telehealth Visit

- Click on appointment and select "Cancel"
- Select cancel reason from drop down
- Check "Remove appointment from the scheduler"
- Save

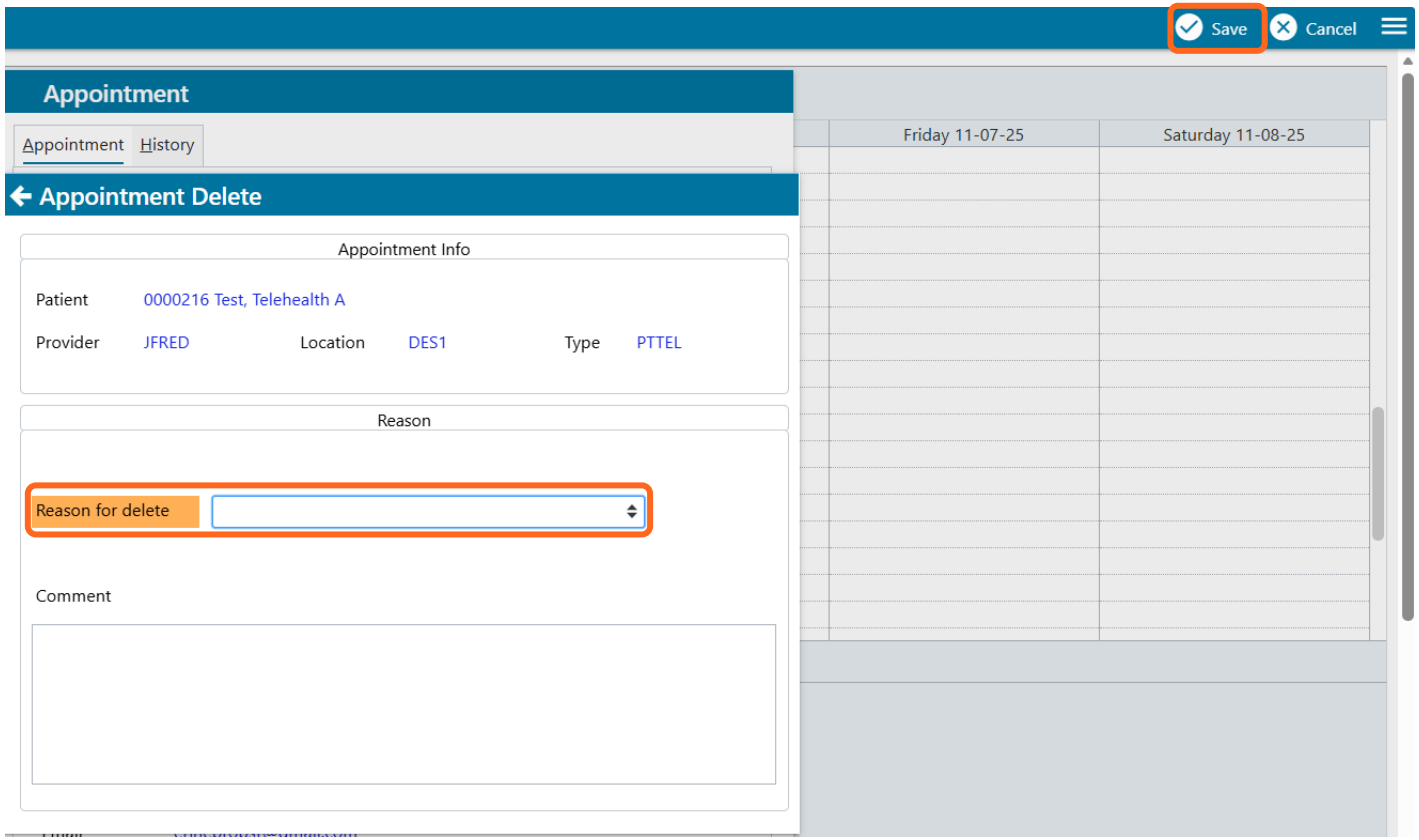


Deleting a Telehealth Visit

- Click on appointment and select "Delete"
- Click "Verify Delete"
- Select "Reason for delete"
- Save



Deleting a Telehealth Visit



Appointment Icons

- Appointment Status Icons
  - Checked In
  - Checked Out
  - Cancelled
  - No Show
  - Reschedule

- Appointment Flag Icons
  - Appointment reminder sent to the patient
  - Sending the appointment reminder failed
  - Patient confirmed the appointment
  - Appointment reminder was intentionally not sent

The appointment flag icons will show the status of any appointment reminders sent and alert you if you might need to edit contact information, communication preferences or resend the appointment reminder

Reminder: *When scheduling in advance, appointment reminders go out 24 hrs. prior to appointment time and therefore may not show any flag icons until then*

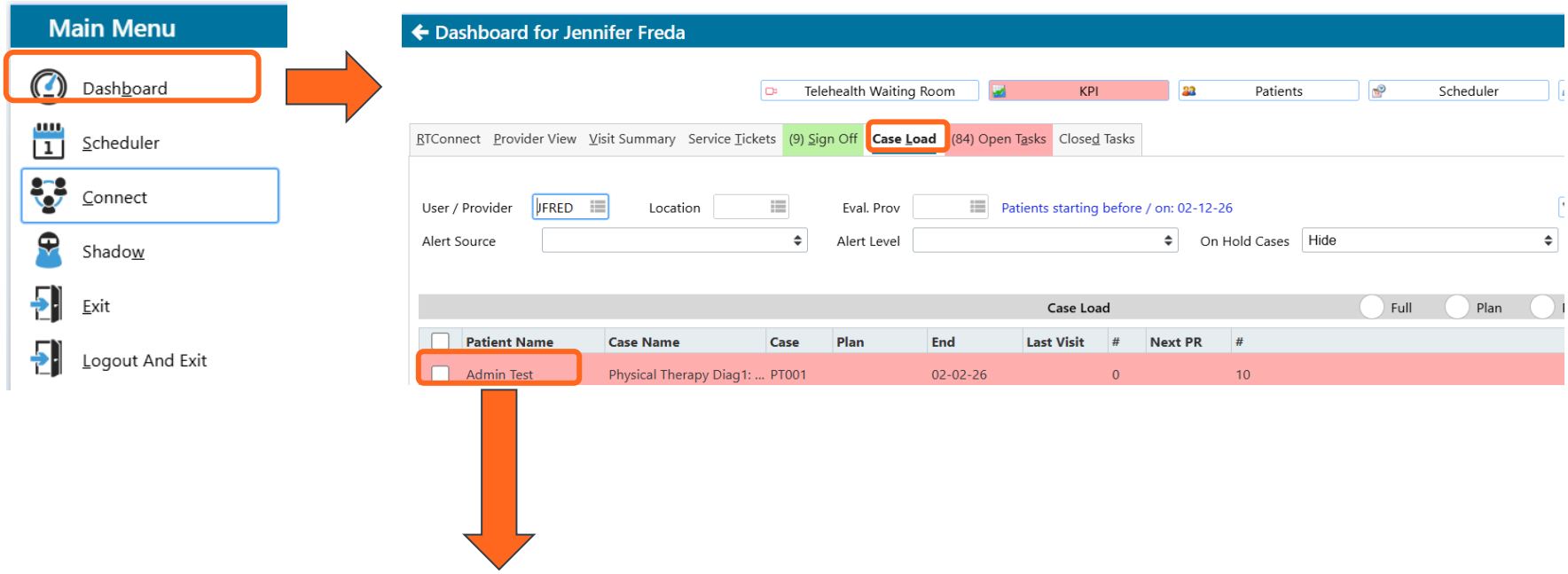
RT Connect History

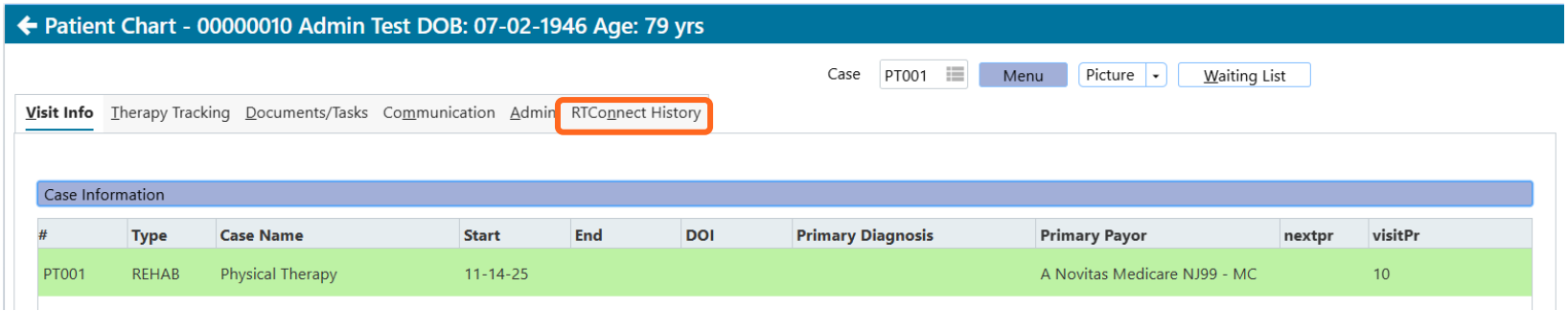
- Dashboard > Caseload > Select patient (double click) > RT Connect History Tab

- Shows all notifications sent via email and/or text to the patient and/or any authorized representative/s

- Check the RT Connect History when:
  - The appointment flag shows the appointment reminder was intentionally not sent or failed to send
    - Resolution = Check and update contact information and/or communication preferences for patient and/or authorized representative and then resend the appointment from the scheduler
  - The appointment flag shows the appointment reminder sent but the patient and/or authorized representative report they did not get the appointment reminder
    - Resolution = Resend appointment reminder from scheduler or TH waiting room (See resending appointment reminder slide to differentiate)

RTConnect History





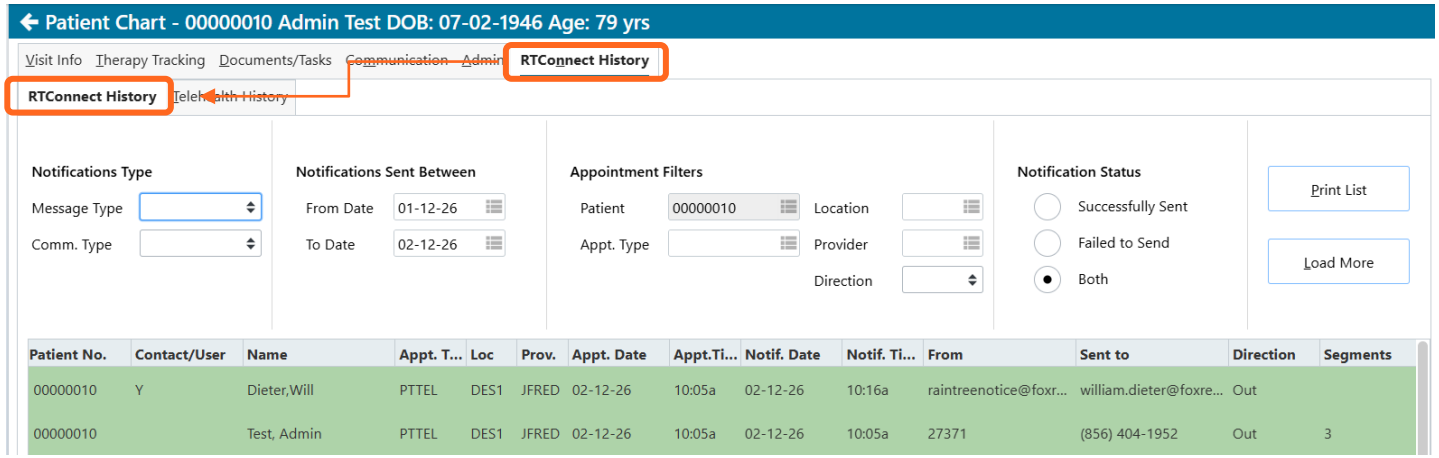
RTConnect History

- Search by select fields and click refresh list to see:
  - Status of message

Notification sent successfully | Waiting for verification | No verification received | Failed to send notification

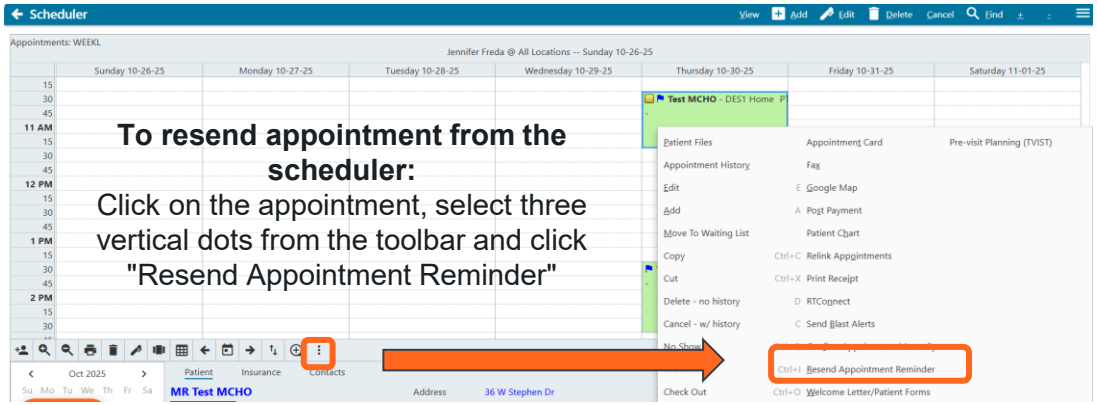
Red text indicates the appointment was changed after sending the reminder

  - When message was sent (Notification Date and Time)
  - Who message came from
    - Emails come from **raintreenotice@foxrehab.org**
    - Texts come from **27371**



Resending Appointment Reminders

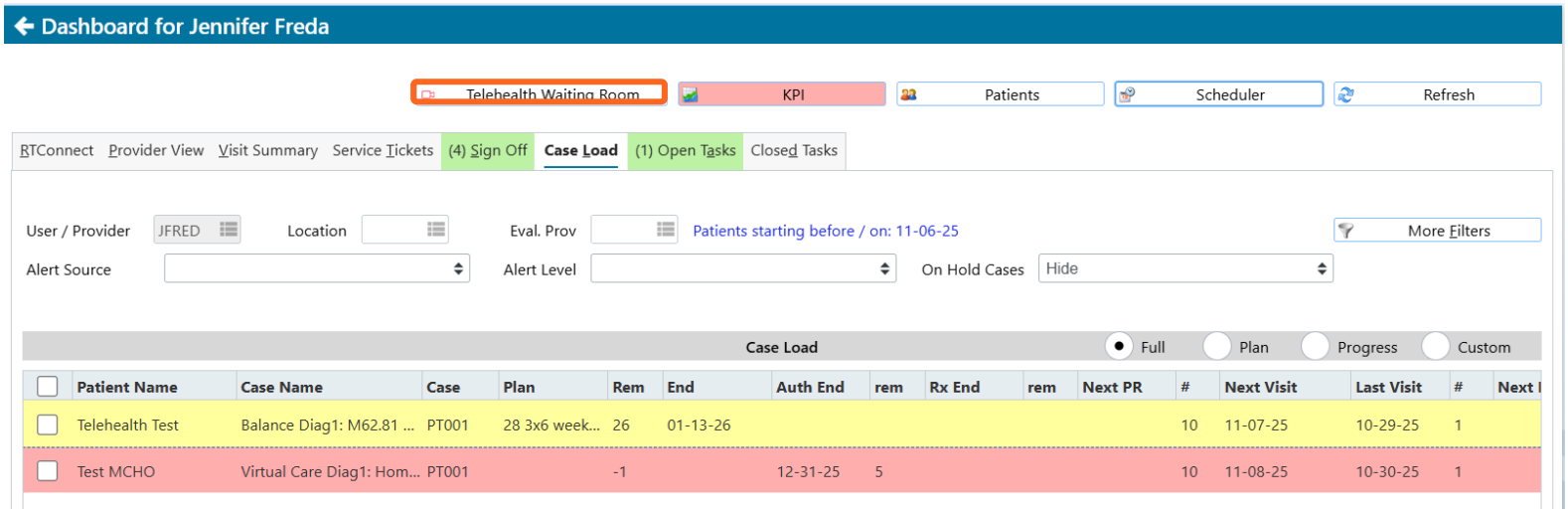
- Can be done via Scheduler OR Telehealth Waiting Room
  - Resending via **Scheduler** = Resending **INITIAL** appointment link (APREM)
    - Should be used when the patient/authorized representative cannot find the appointment reminder or they just simply need an additional reminder closer to the appointment time



  - Resending via **Telehealth Waiting Room** = Sending **NEW** appointment link (TELEH)
    - Initial appointment link sent to the patient will be dead.
      - Once resent from the waiting room, clinician must resend appointment reminders from the waiting room for any additional resend.
    - Should be used **ONLY** when:
      - having an issue with initial appointment (i.e., audio/visual issues)
      - clinician exits an appointment prior to a session being completed
      - patient enters the appointment > 60 minutes prior (join now button will not work)
      - performing a supervisory visit (See supervisory training)

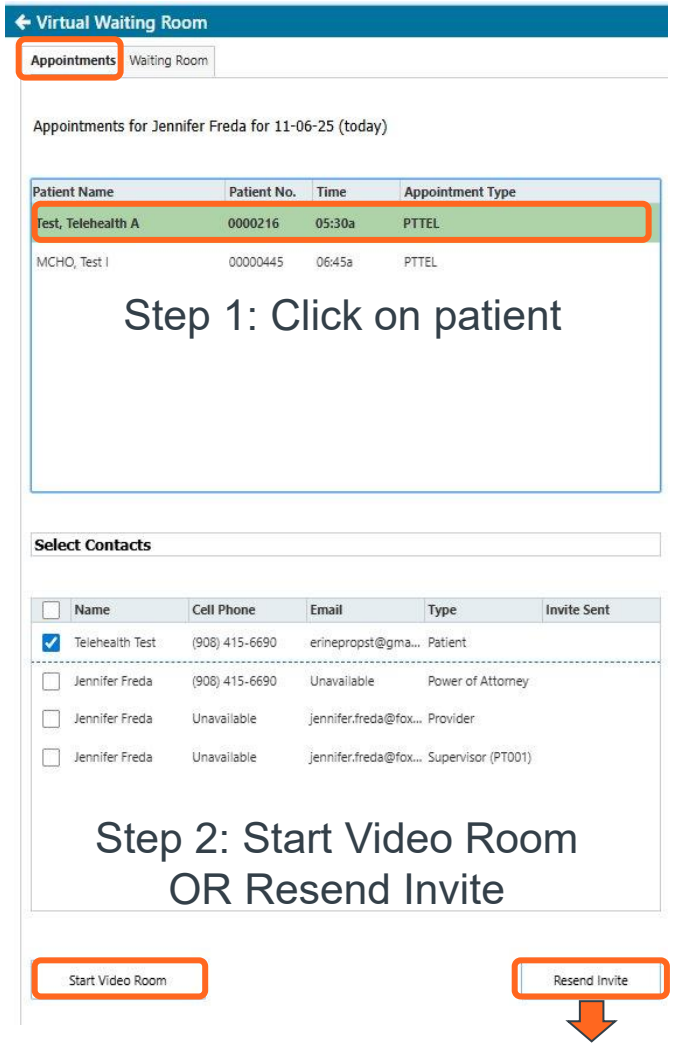
Telehealth Waiting Room

- Accessed from the Dashboard

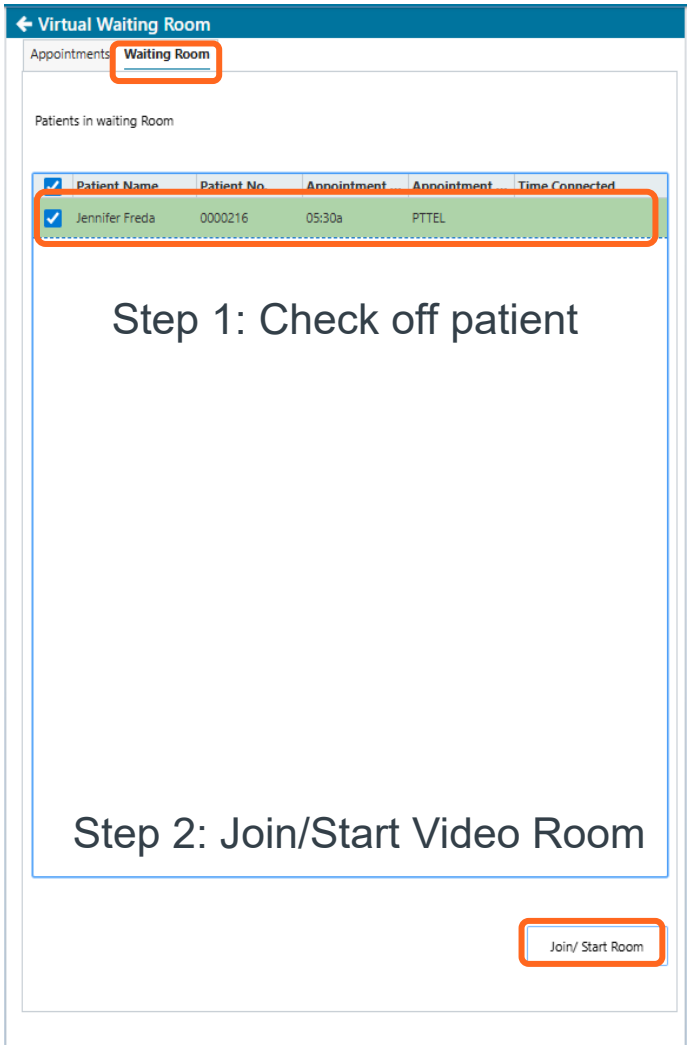


- Has "Appointments" and "Waiting Room" tabs
  - Clinician can join/start room from either tab
    - Patient will be in waiting room until clinician has launched telehealth appointment
      - Once clinician joins, patient will have to take an action on their device to "Join room"
    - If patient and/or authorized representative try to join session prior to 60 minutes before appointment time, join button will never present.
  - Waiting room alerts clinician if patient has already attempted to join telehealth session prior to clinician

Telehealth Waiting Room



OR

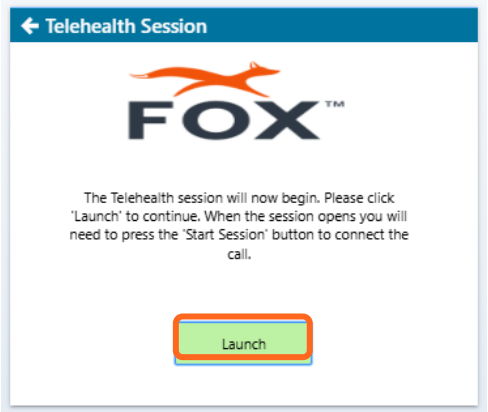


Reminder: Resend from Telehealth Waiting Room should ONLY be used if there was an issue with the original appointment and a NEW link needs to be sent

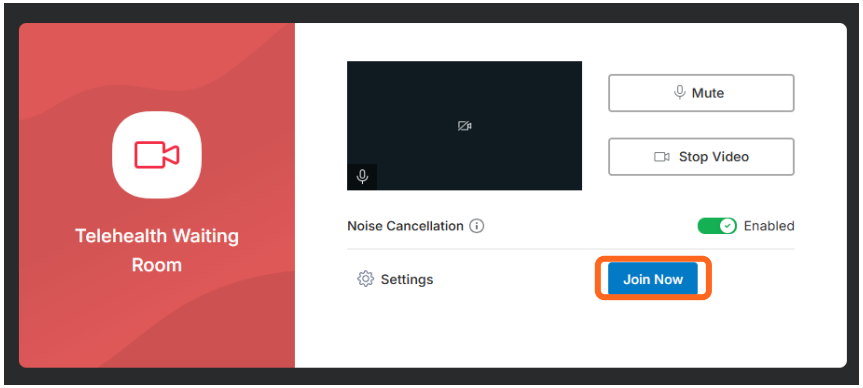
Joining Telehealth Appointment - Clinician

Step ① Clinician clicks "**Join/Start room**" from TH Waiting Room

Step ② "**Launch**" Session



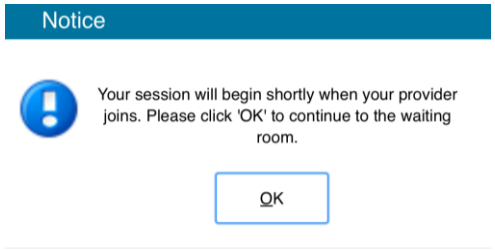
Step ③ Click "**Join Now**"



Joining Telehealth Appointment – Patient

Step: 1
Patient and/or authorized representative opens email/text for appointment and **clicks link**

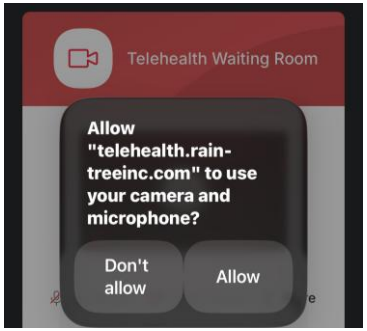
Step 2
Click "**OK**" to join waiting room



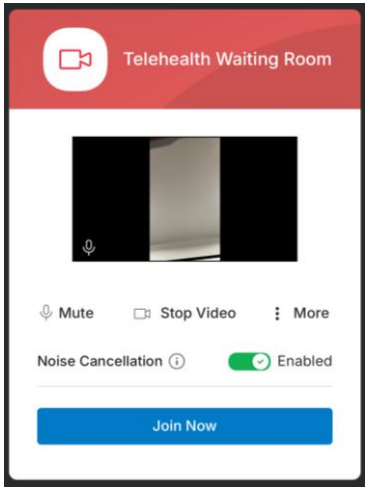
Step 3
"**Launch**" Session



Step 4
"**Allow**" camera and microphone



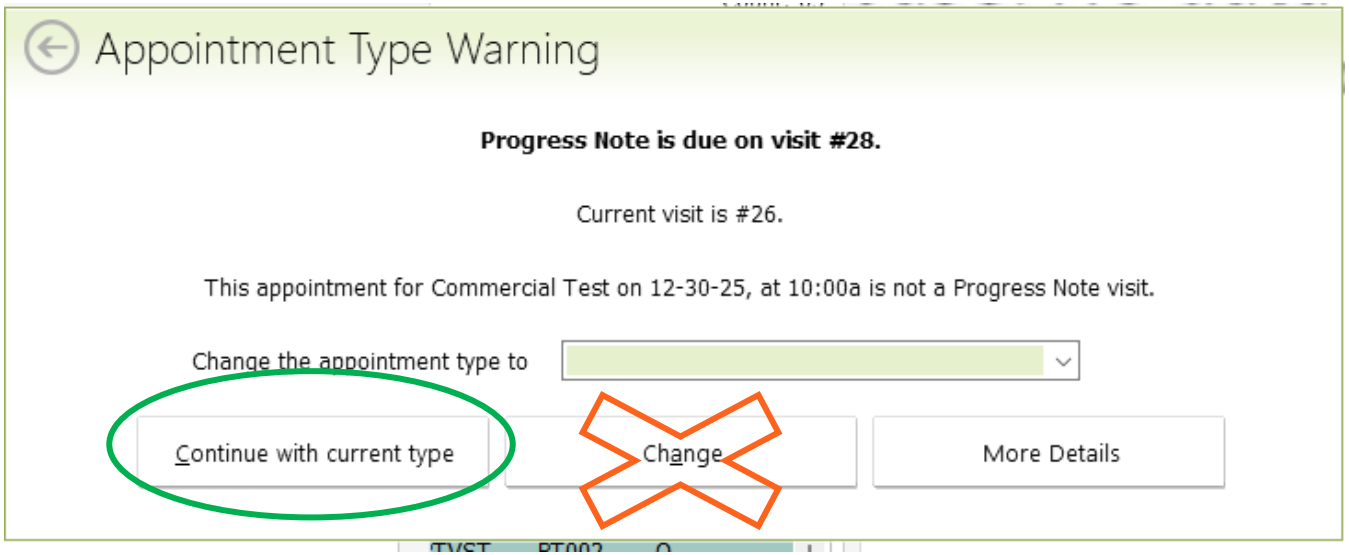
Step 5
Click "**Join Now**"



Please note: *The patient will not be able to see or perform this step until clinician has entered the session*

Checking in/Opening a Telehealth Note

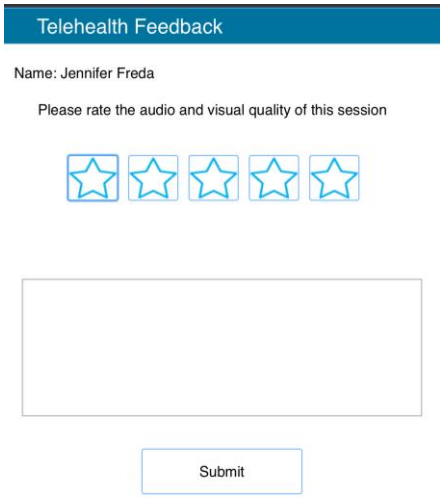
- Do NOT check in appointment until after you and the patient have joined the session
  - *You will learn more about checking in appointments in another training*
- *If you receive an appointment type warning DO NOT change – ALWAYS "Continue with current type"*
  - *The **APPOINTMENT** type triggers the 95 Telehealth Modifier to be added to billing*
  - *Once IN the note you can change the **NOTE** TYPE to whatever note type is desired*



Please note: If you accidentally select change, you will need to edit the appointment AND resend the appointment reminder via the scheduler

Performing Telehealth Appointment

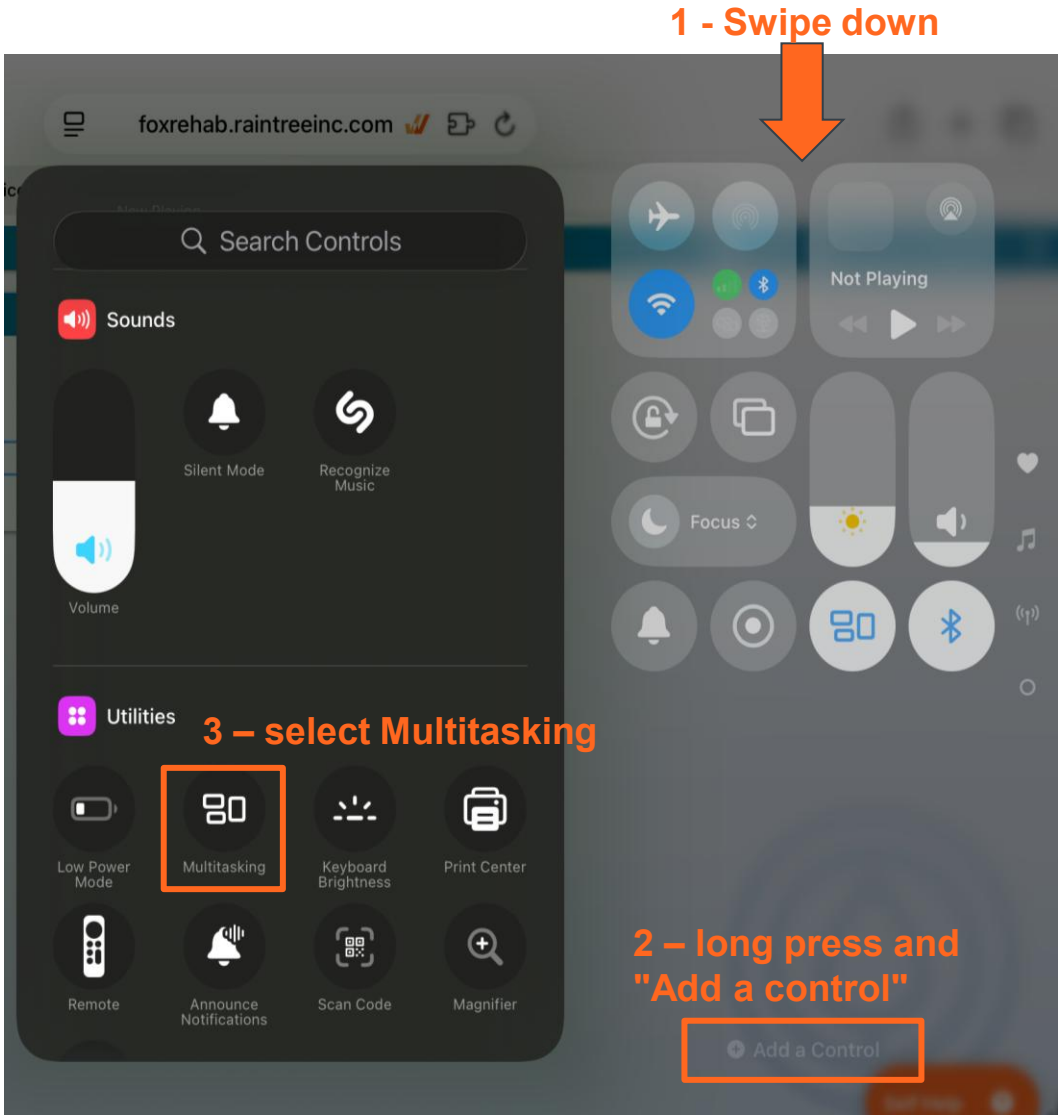
- Use split screen/multi-tasking feature to maintain visual on patient while documenting point of service *(See next slide)*
- Utilize in appointment features:
  - Audio and Video – Noise Cancellation
  - Backgrounds or Blur feature
  - Speaker or Gallery View
  - Share Screen
  - Whiteboard
- Encourage survey feedback
  - Patient automatically prompted upon ending session



Split Screen: Multitasking on iPad

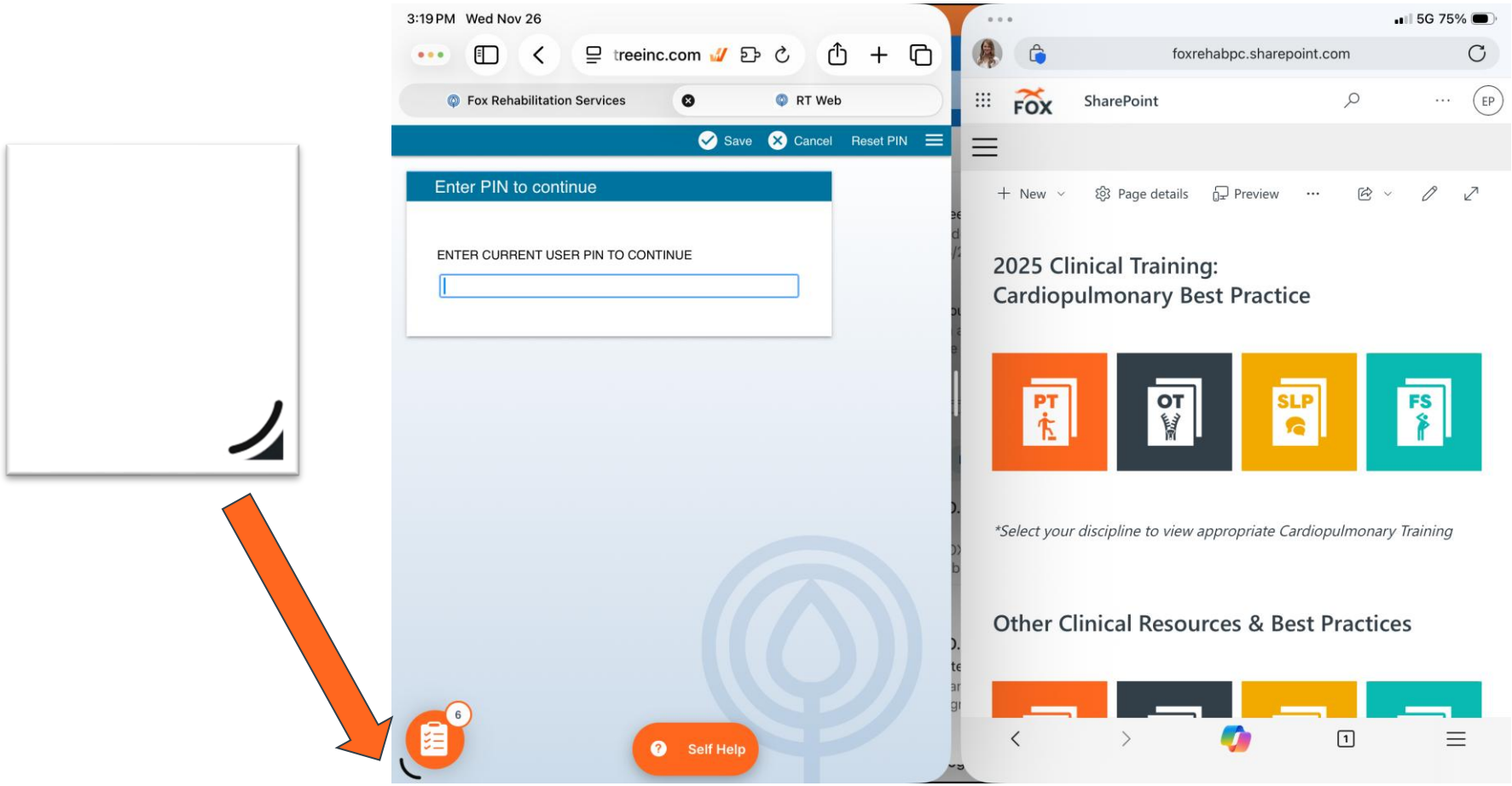
- The Multitasking feature on iPad allows you to **split screen** to remain in telehealth appointment while completing documentation on the same device

- To add Multitasking control:
  - Swipe down from top right corner of iPad to open Control Center
  - Press and hold on the right side of the screen until controls flash
  - Select "Add a Control"
  - Locate and add "Multitasking", then ensure Multitasking is turned on
  - Touch the left side of your screen to return to your main screen



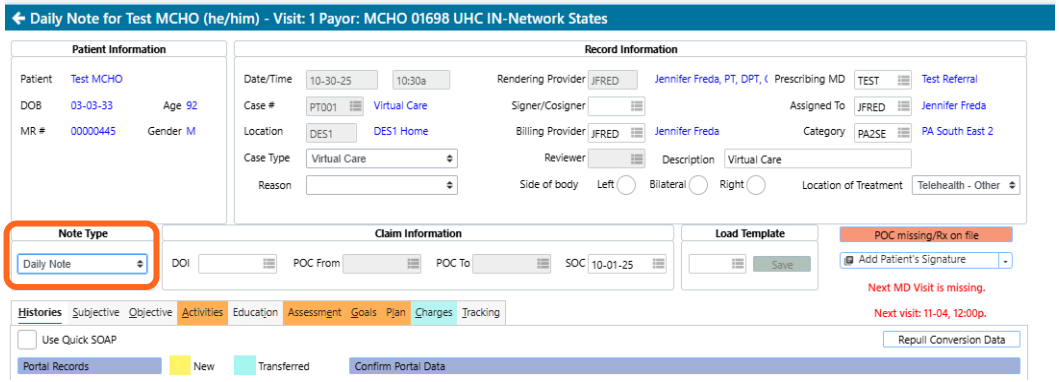
Utilizing Multitasking to split screen

- Once Multitasking is turned on, click and drag the corner of your screen(s) - indicated with a bold black "C" to resize, then drag the screens to reposition as needed

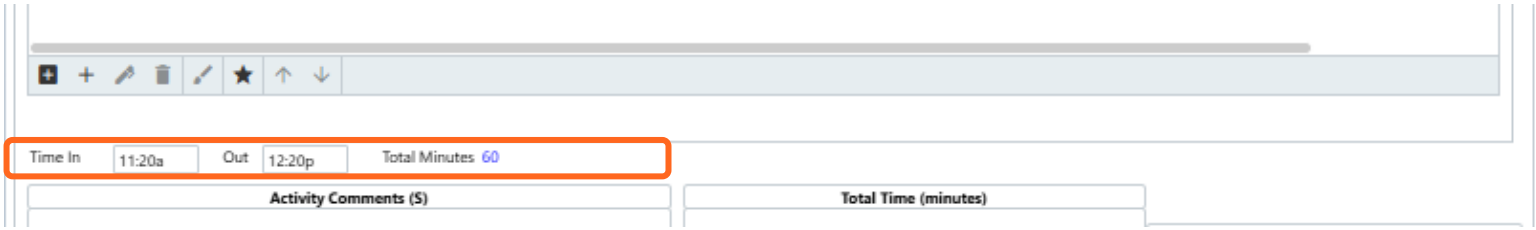


Telehealth Documentation

- **MUST select appropriate note type** upon open of **EVERY telehealth note**
  - Due to telehealth note configuration, every telehealth visit will be initially be set as a "Daily Note" and will need to be manually changed to the desired note type

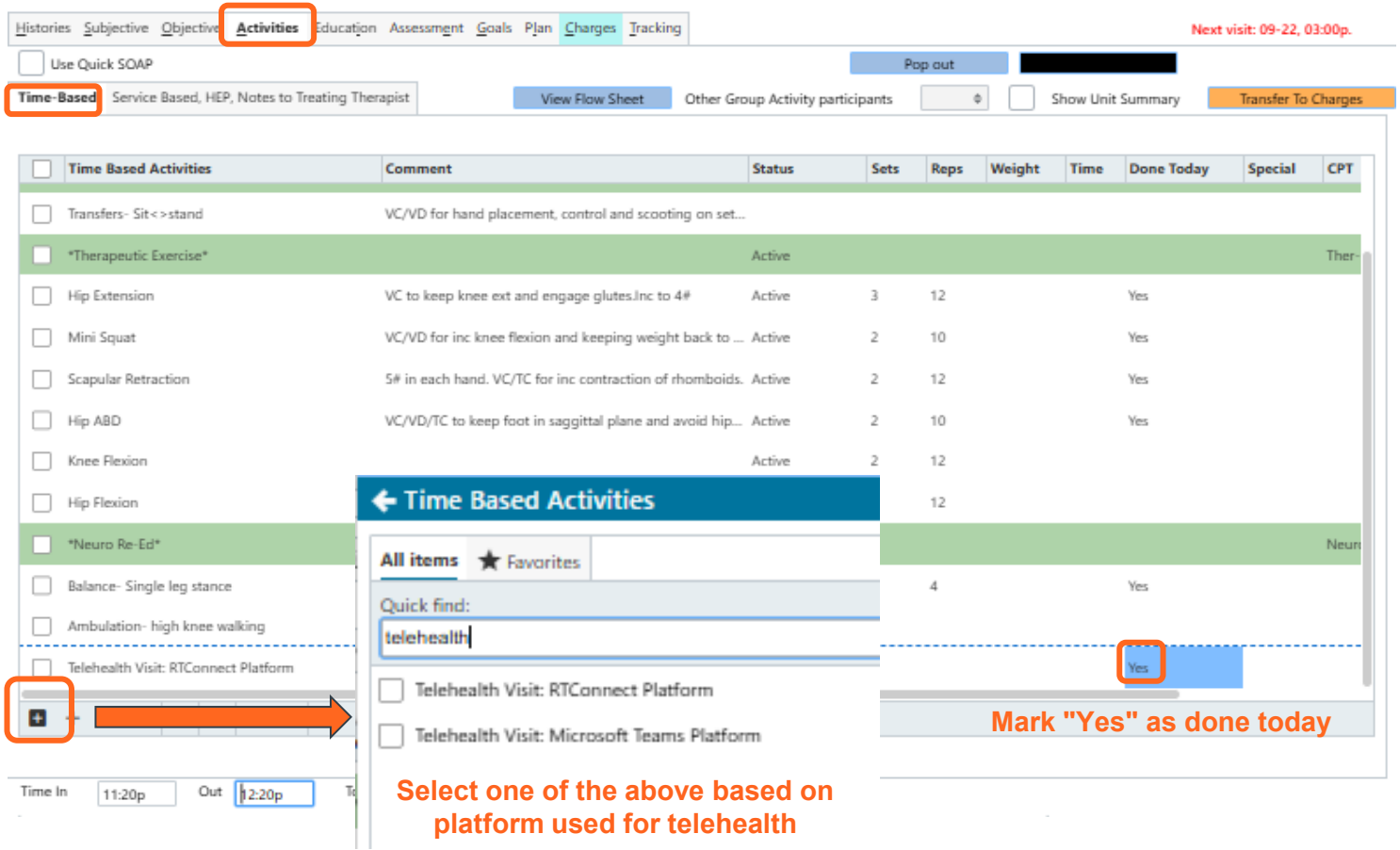


- **MUST** enter time in and out under "Activities" tab
  - If you split a session or have multiple time in/out times, enter the first IN time and last OUT time, then specify additional time IN/OUT in the Activity Comments box



Telehealth Documentation (Continued)

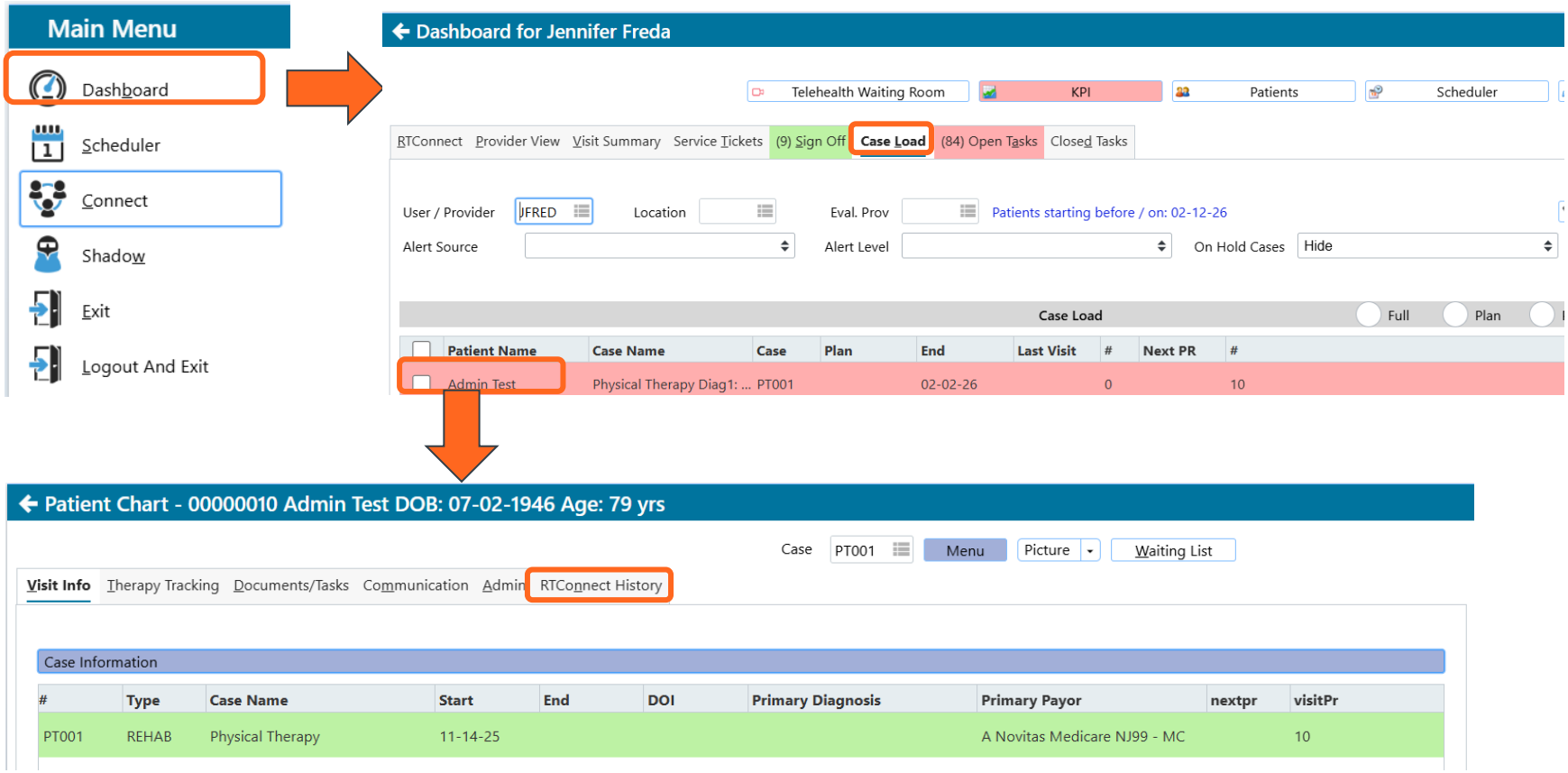
- **MUST** Select "Telehealth Visit" item from picklist and mark as "Done Today" under Time Based Activities



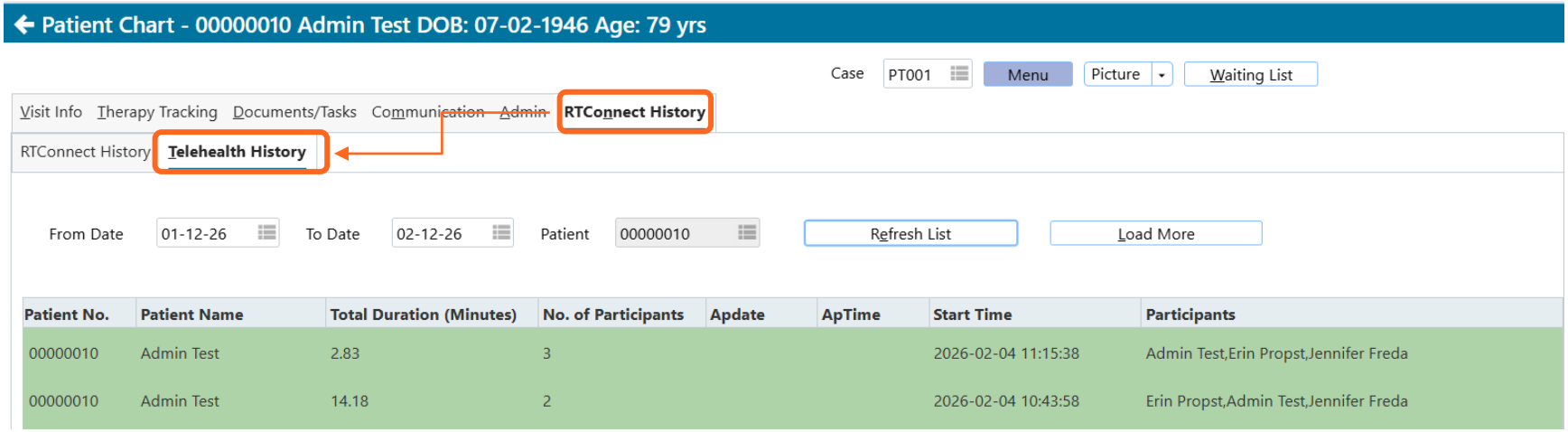
Note: SLP's can add the platform from the Service based picklist as well, and platform only needs to be added once.

Telehealth History

- Dashboard > Caseload > Select Patient (Double Click) > RTConnect Hx > Telehealth History
- Can be used to check time in and time spent



Telehealth History



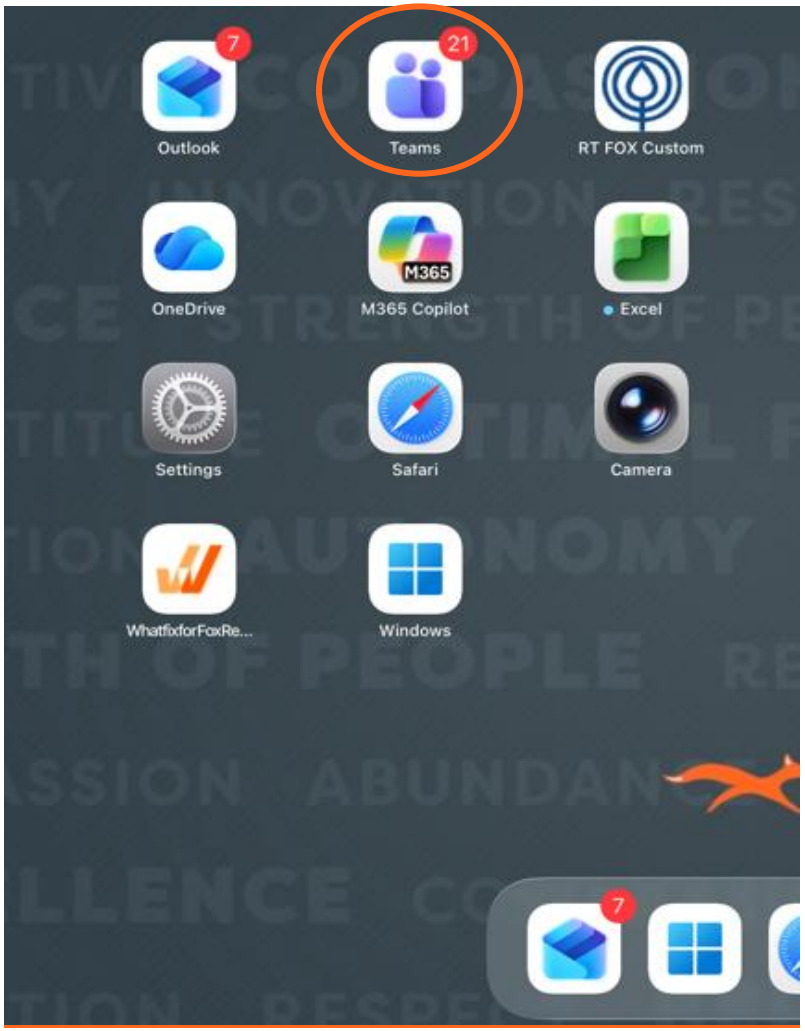
To see specific participant in/out details (in UTC) go to Main Menu > Connect > Message Hx > Telehealth History > Double click on session

Team's Telehealth Considerations

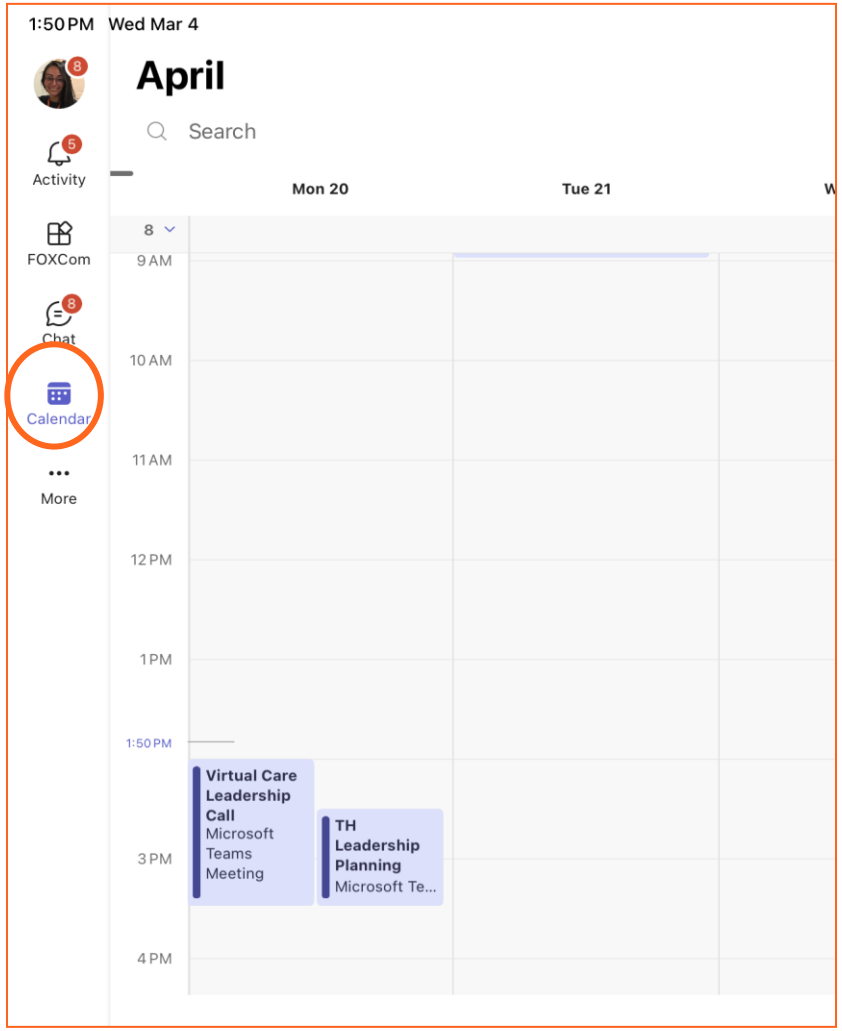
- Should be used as a BACKUP to Raintree's telehealth platform
- CANNOT be sent to a phone number
- Can ONLY be used in Chrome browser
  - Safari (i.e., Apple products default browser) does not allow meeting to open without pushing patient to download the app



Scheduling a Teams appointment

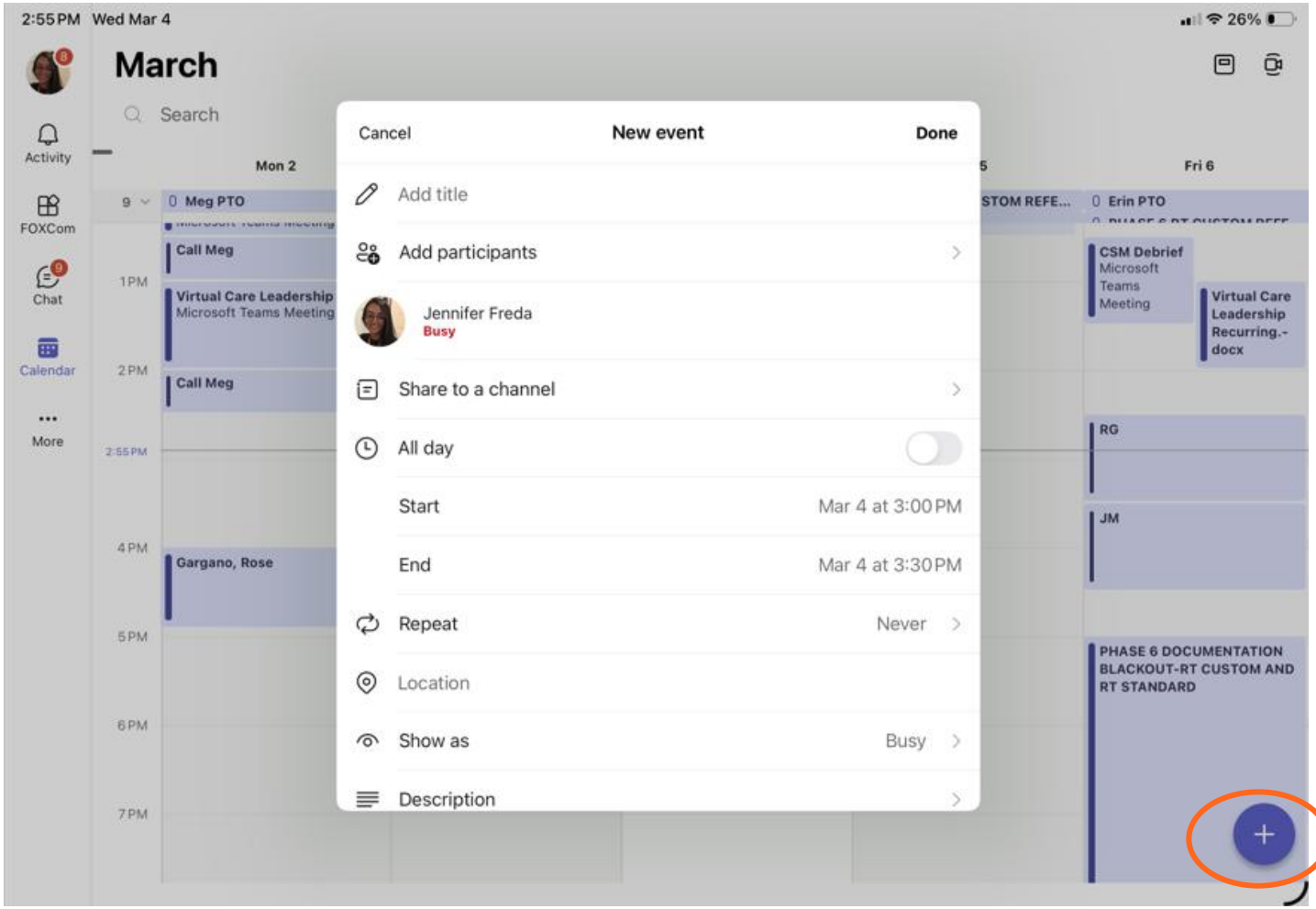


Open Teams App



Click calendar icon

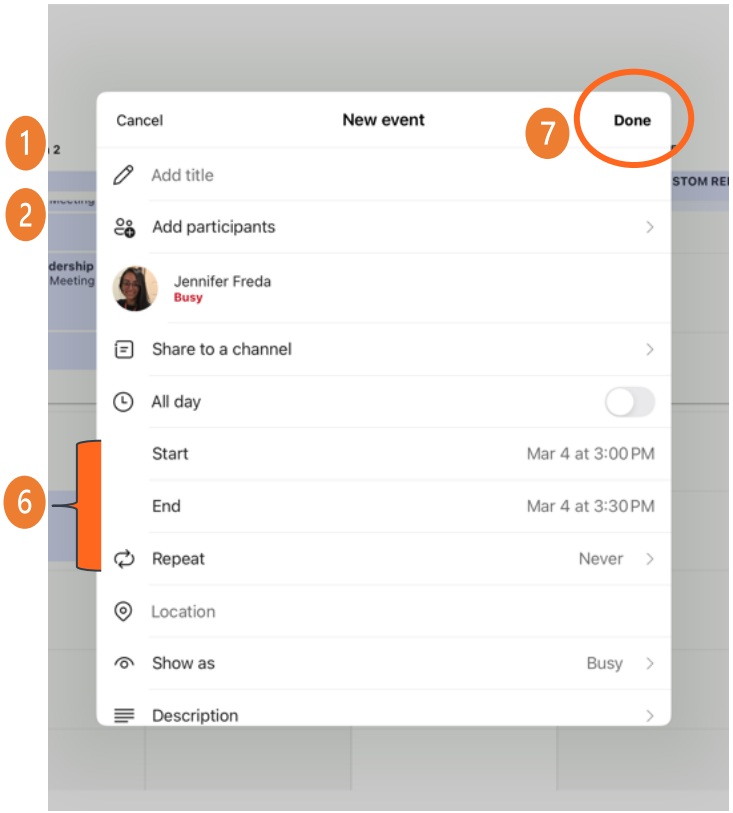
Scheduling a Teams appointment

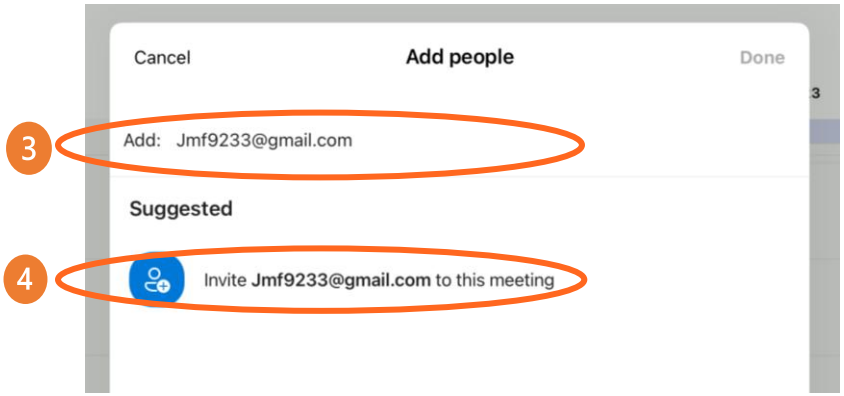


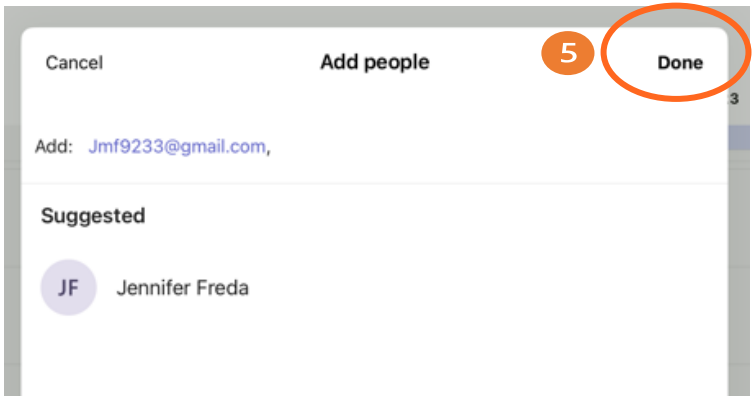
Click the "+"

Scheduling a Teams appointment

1. Add Title
   - Ex: PT Telehealth Appointment
2. Click "Add Participants"
3. Add patient's email address
4. Click the email address under suggested
5. Click done

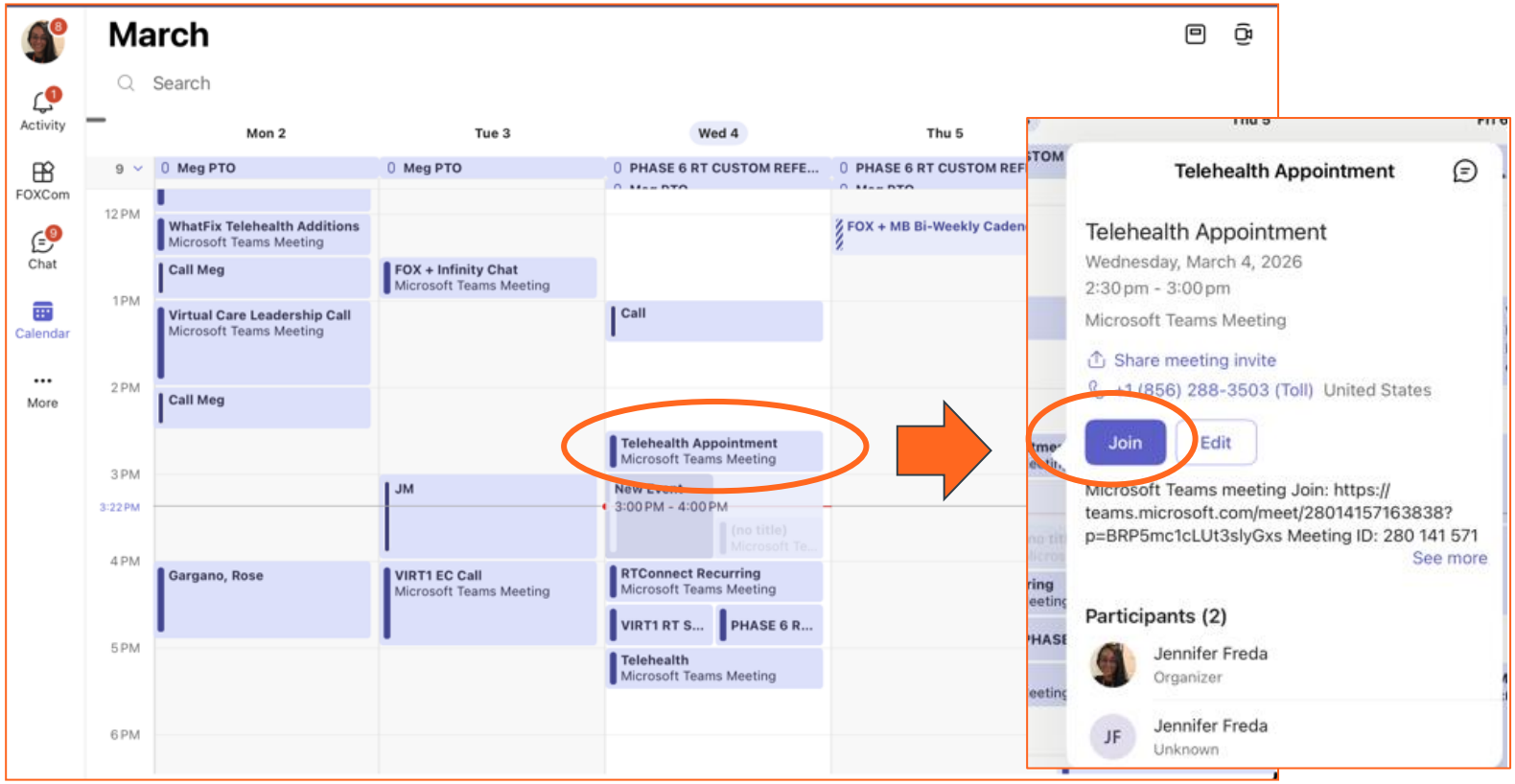






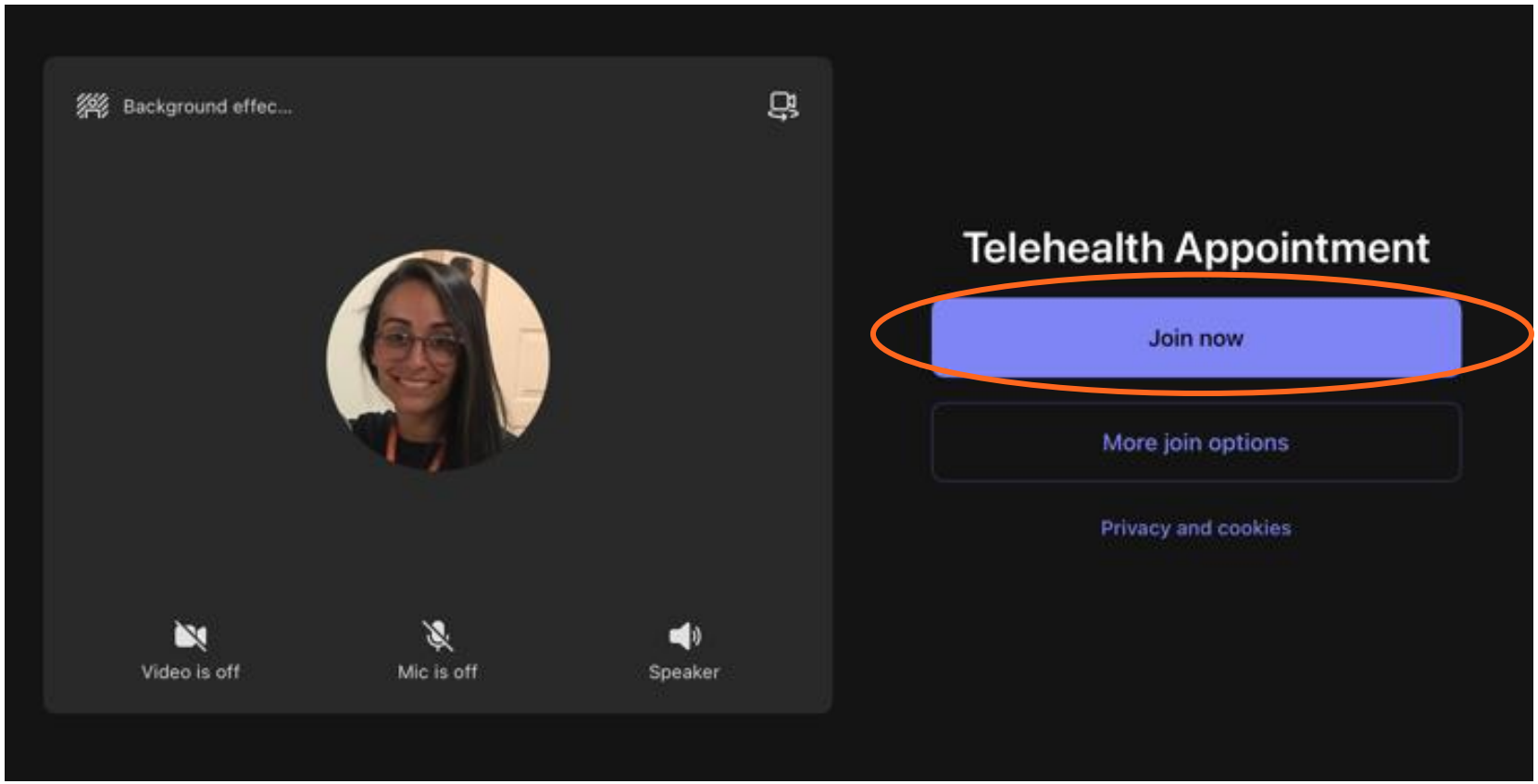
6. Add additional appointment details
7. Click done

Starting a Teams Appointment - Clinician



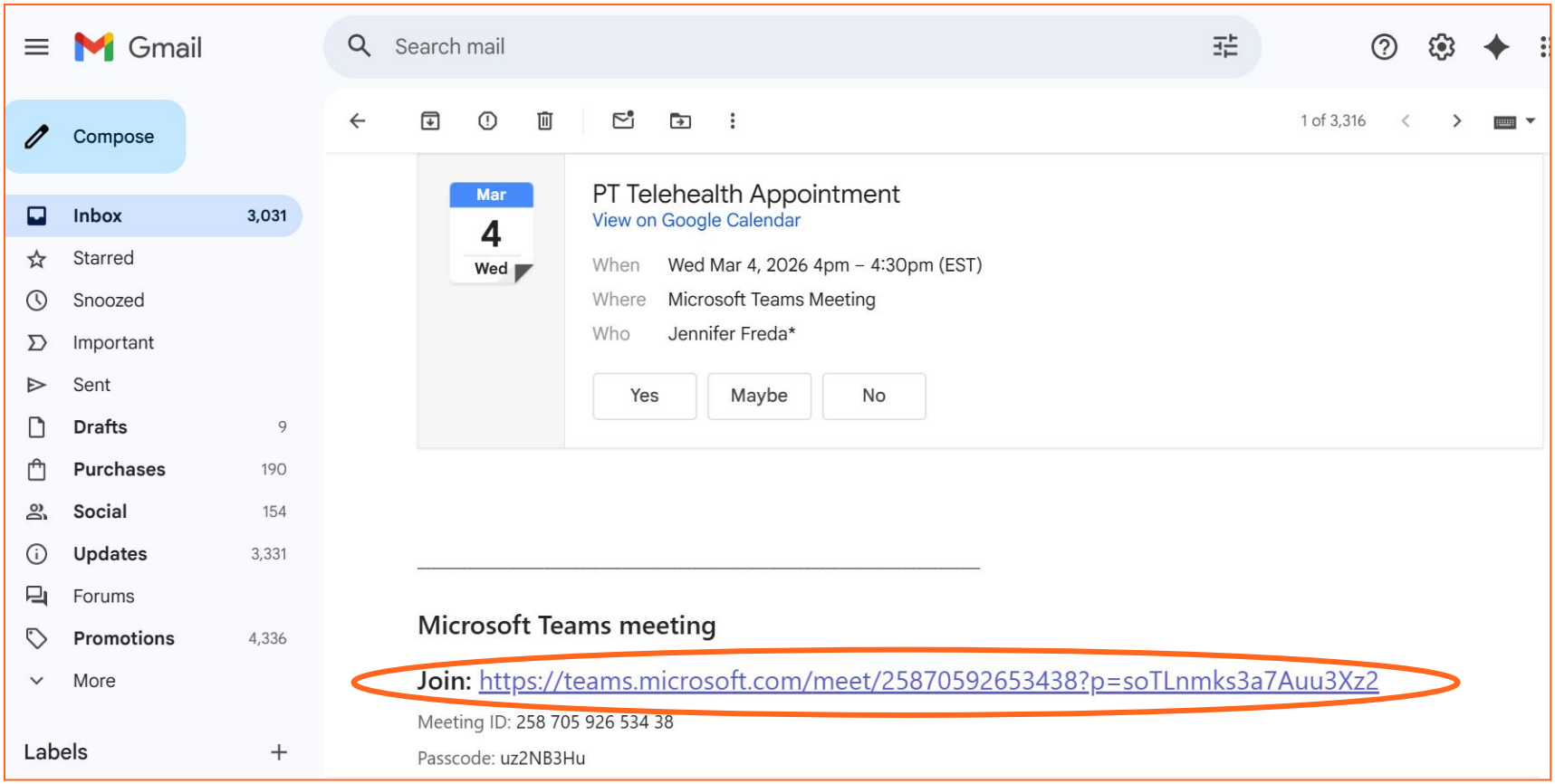
Click on your telehealth appointment from your calendar > Click "Join"

Starting a Teams Appointment - Clinician



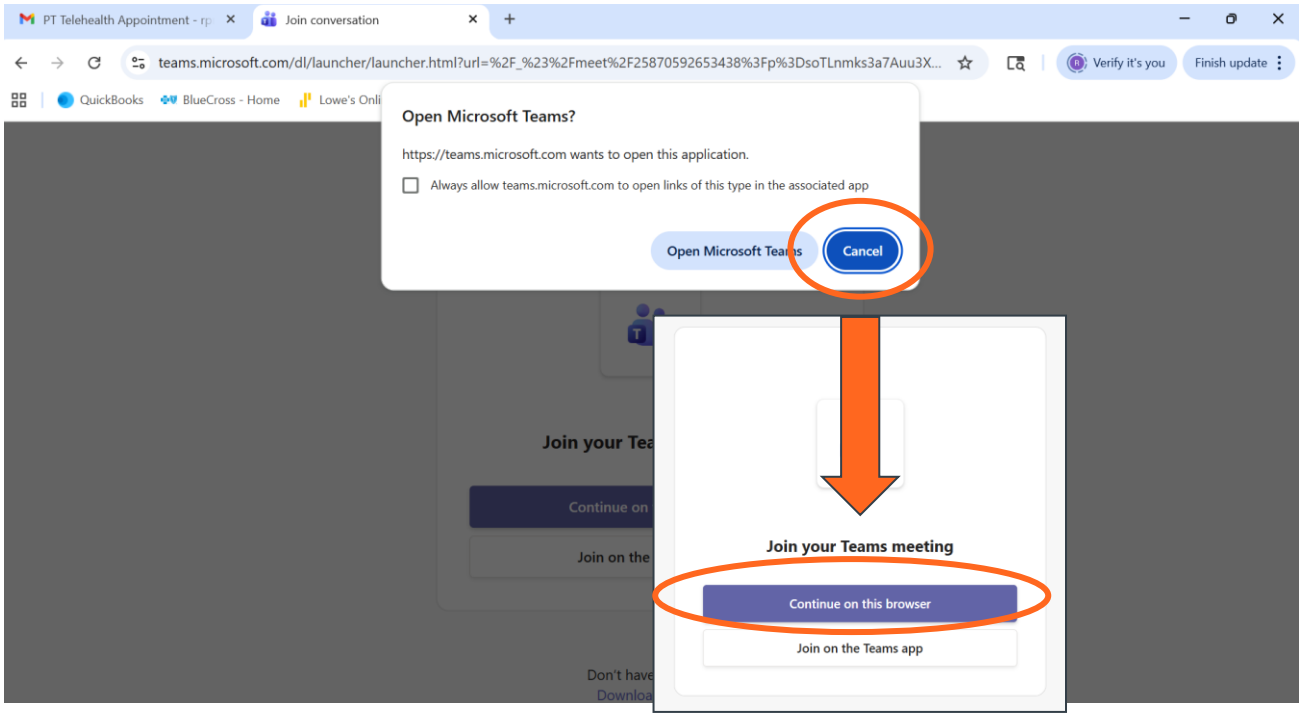
Click "Join now"

Starting a Teams Appointment - Patient



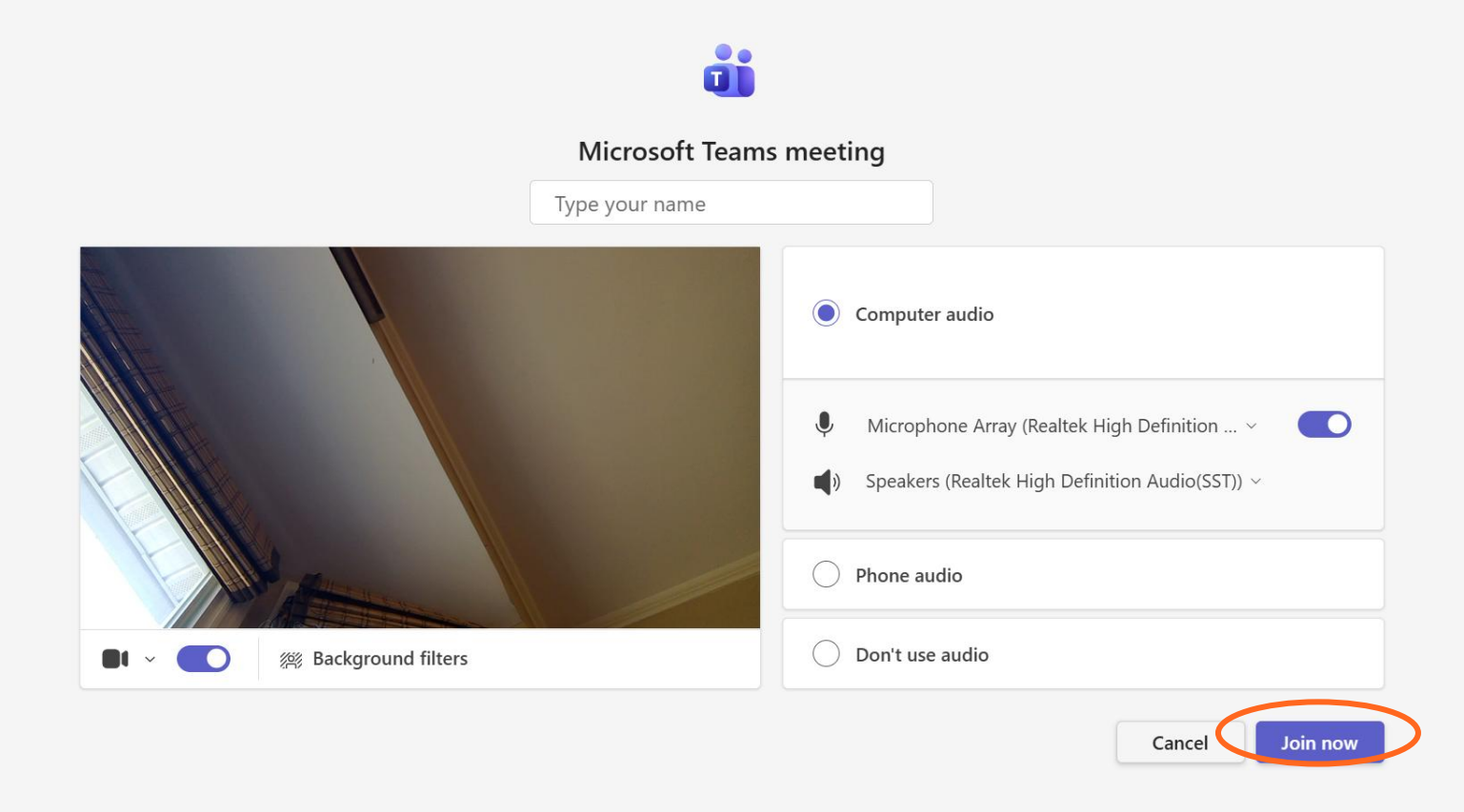
Patient should go to their email and find the appointment invite > Click link

Starting a Teams Appointment - Patient



Patient should select "Cancel" and then "Continue on this browser"

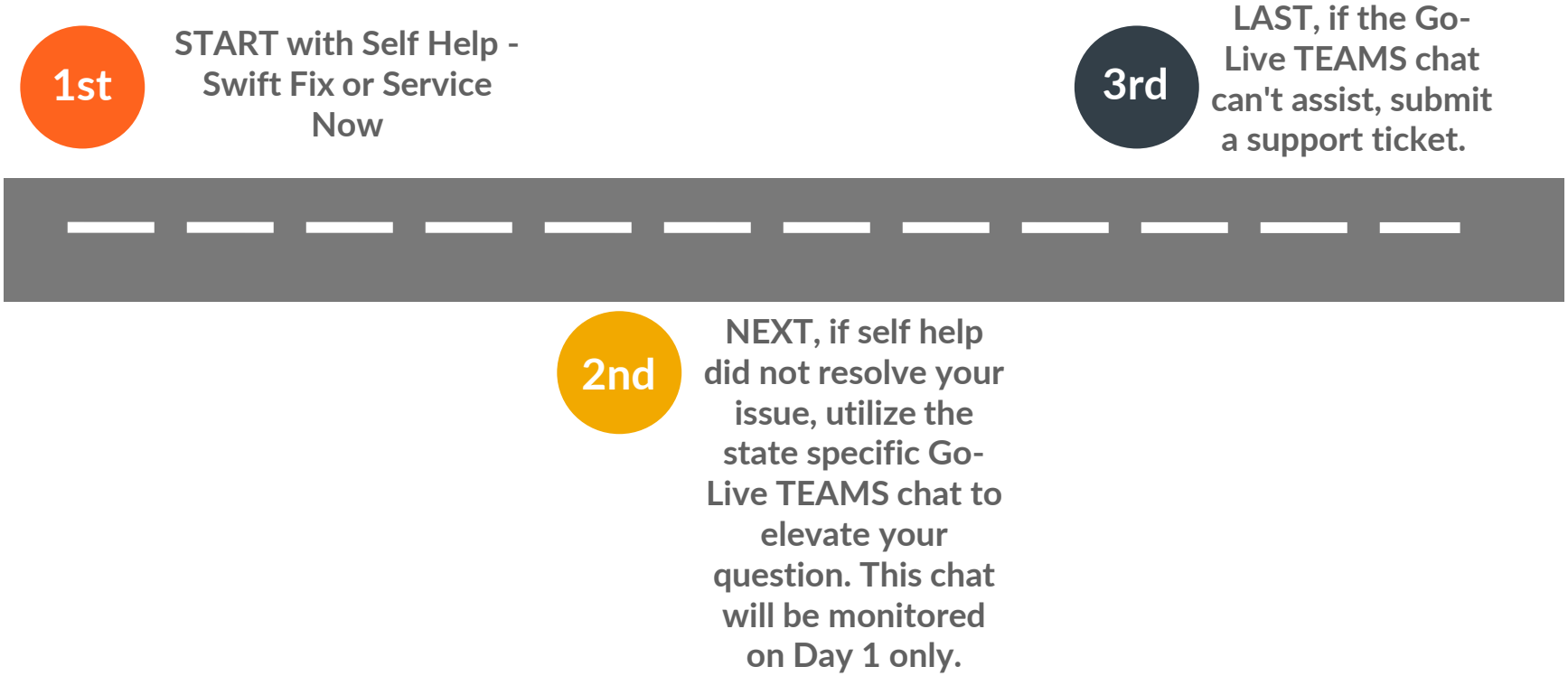
Starting a Teams Appointment - Patient



Patient should select "Join Now"

Support Roadmap: Start Smart, Escalate Right

Have a question? Follow the path to resolution!

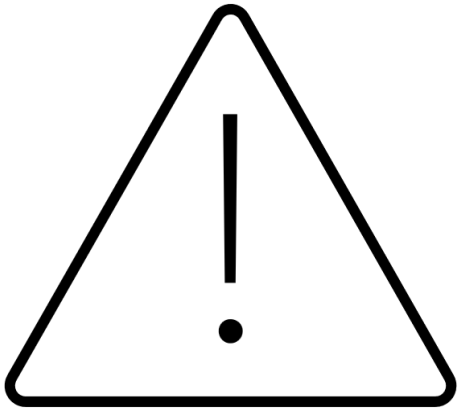


RT Standard
ENOTE – Wellness Documentation



Starting New Cases

- New admissions will only display on your caseload tab AFTER you have scheduled the first evaluation/visit in FOX Trax.
  - Scheduling of the appointment in FOX Trax initiates the record to be created in Raintree



RTConnect | Provider View | Visit Summary | Service Tickets | (10) Sign Off | **Case Load** | Open Tasks | Closed Tasks

User / Provider: EPROP | Location: | Eval. Prov: | Patients starting before / on: 11-03-25

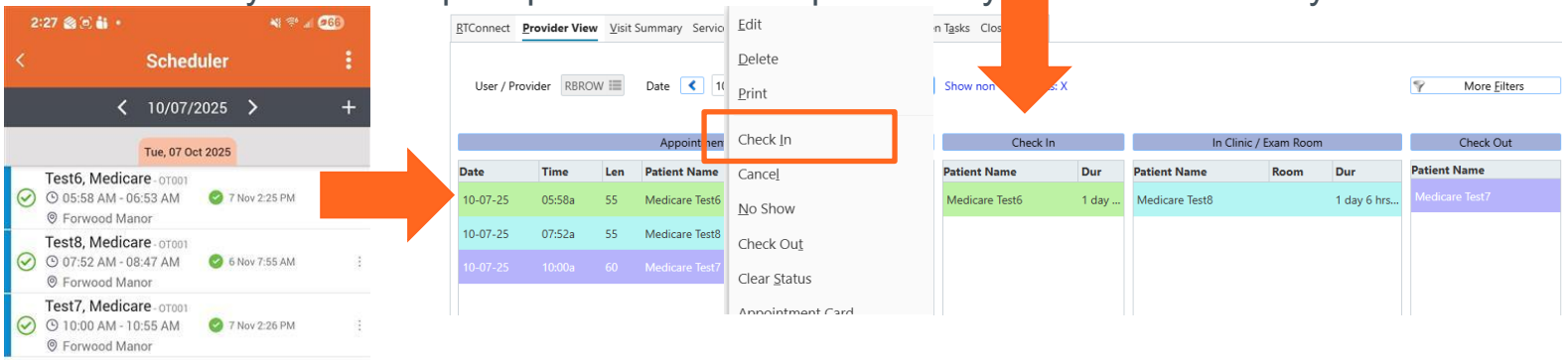
Alert Source: | Alert Level: | On Hold Cases: Hide

Case Load — Full / Plan

Patient Name	Case Name	Case	Plan	Rem	End	Auth End	rem	Rx End	rem	Next PR	#	Next Visit
Test Medicare9	ADL's Diag1: Home ph	OT001		-1				12-31-25	-1		10	
Medicare Test8	ADL's Diag1: Home ph	OT001		-1				12-31-25	-1		10	

Launching a Note

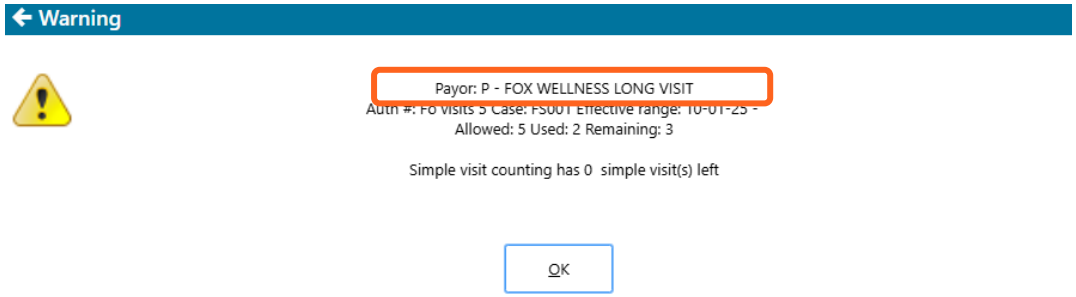
- Schedule in FOX Trax
  - Visit will display in RT Standard scheduler and **Provider View tab** under **Appointments**
  - Visits **MUST** be scheduled to start a note. RT Standard does not allow for notes to be created without an appointment.
- In **FOX Trax,** complete visit verification, ideally at the start of the session
- In **RT Standard**, right click the appointment and select **Check In**
  - The appointment will display in the "**Check In** " window
    - Double click or right click> edit to open the clinical note when ready to document.
  - In the event action is needed (due to patient forms being unsigned or previous notes not completed), prompts will display and then the appointment will display in the Check In window
    - See Consent Training for details on patient forms.
  - Read any additional prompts related to the patient so you are aware of any notices/alerts



Screenshots do not represent wellness visit appointments. Example is for visual display of scheduling workflow

Payor “P”

- Wellness visits Payor is “P”
- On pop-up window, select “OK” or “Yes” to continue

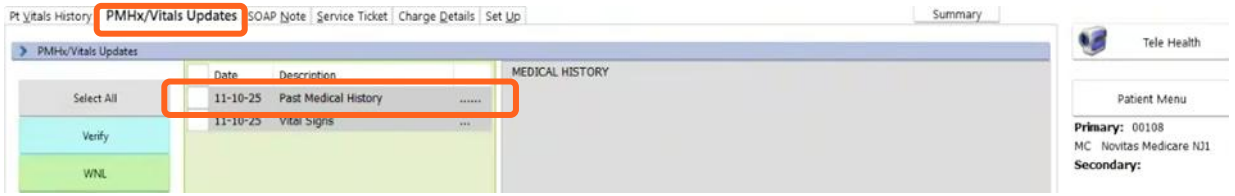


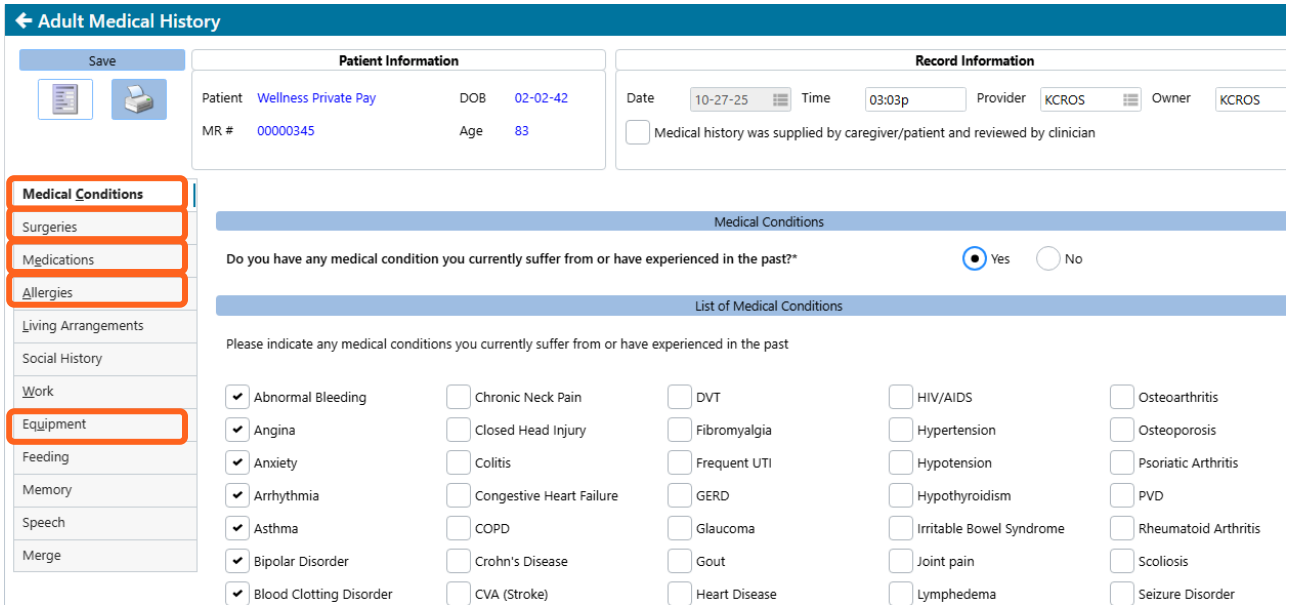
- Please pay specific attention to # of visits remaining to ensure you are not treating outside of pre-paid authorized visits.

ENOTE Billable Visit Documentation

PMHx/Vitals Updates: Past Medical History

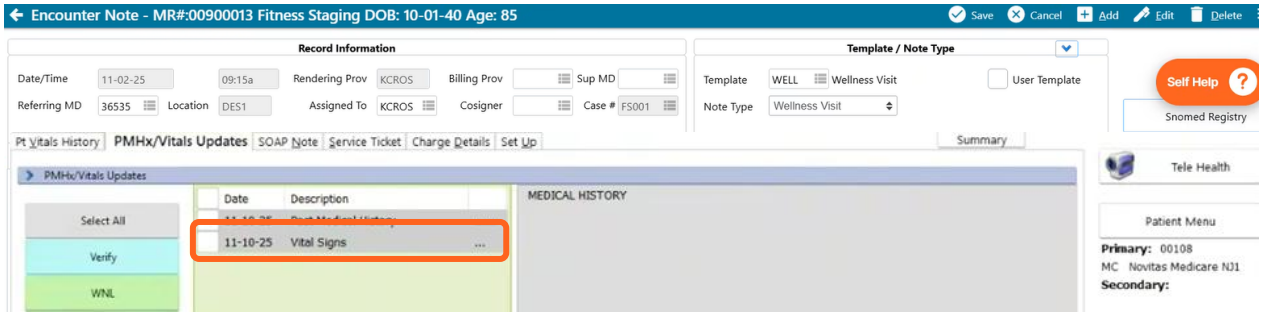
- Note will auto populate to "PMHx/Vitals Updates" tab to complete Medical History and Vitals
- Double-click on **Past Medical History** to open **Adult Medical History** window
- Add Past Medical History if not present, recommended tabs to complete:
  - Medical conditions
  - Surgeries
  - Medications
  - Allergies
  - Equipment
- Only needs to be accessed at first visit or for major medical updates



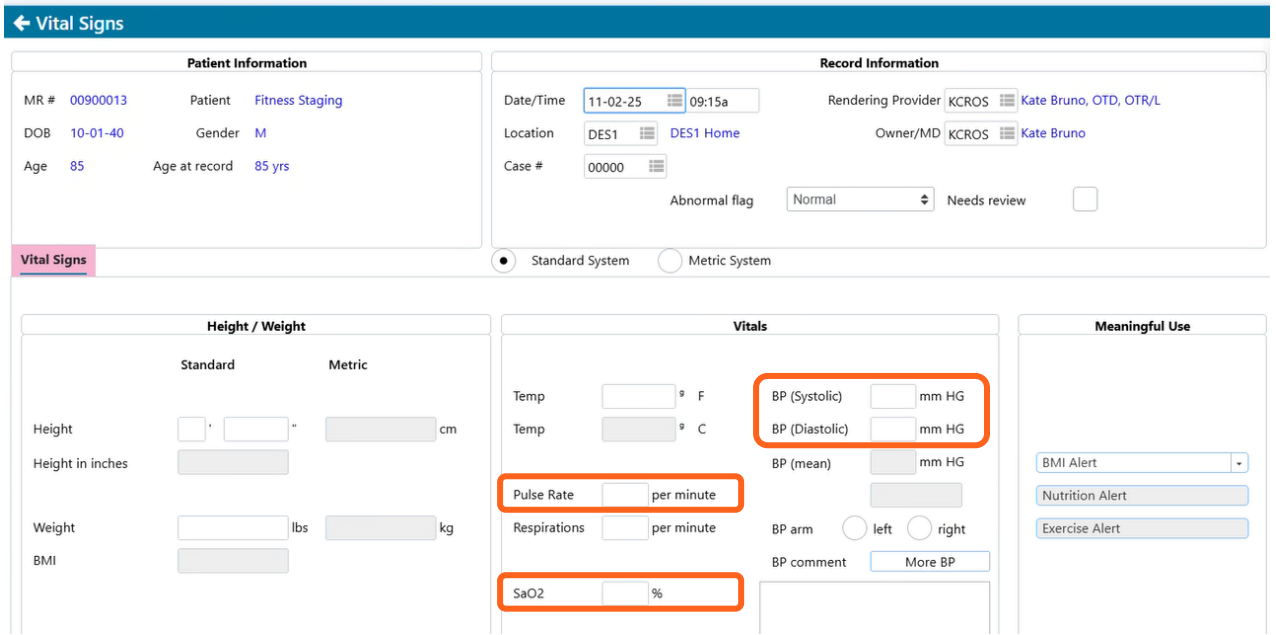


PMHx/Vitals Updates: Vital Signs

- Double-click on **Vital Signs** to open Vital Signs window

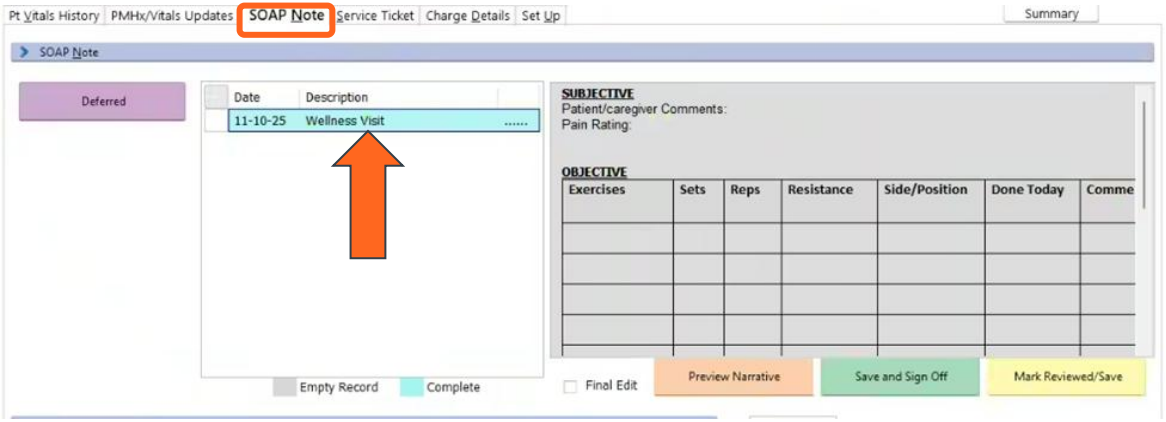


- **Vital Signs** Window
  - Enter:
    - BP(Systolic)
    - BP(Diastolic)
    - Pulse Rate
    - SpO2
  - SAVE after entering data
  - Disregard all other areas



SOAP Note

- Double click on "Wellness Visit"
  - Will bring to SOAP note format
  - Do not access any other tabs in the "Wellness Visit"



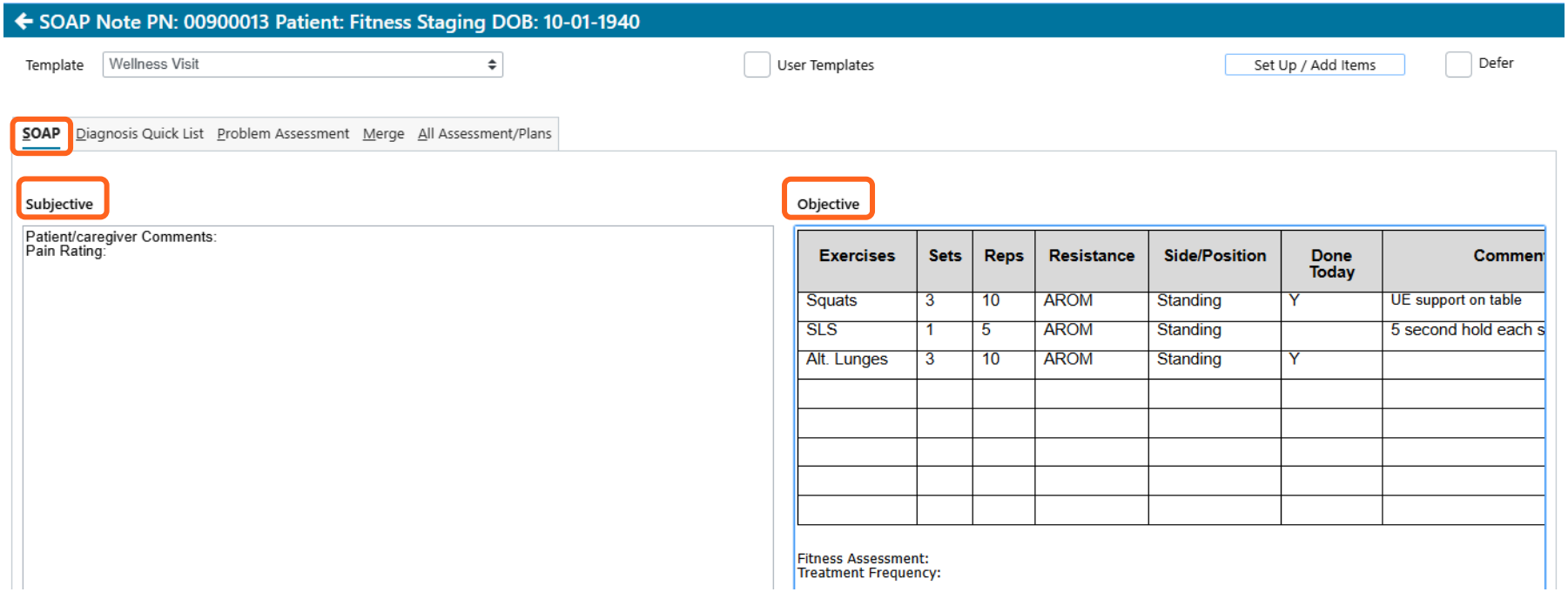
Subjective: This section includes the client's verbalized symptoms, feelings, medical history. Enter what the client reports, to include their chief complaint or goal for wellness.

Objective: This section includes measurable, observable data collected. Enter exercises and activities completed.

Assessment: This section allows for insight from the Subjective and Objective sections. Enter your professional impression based on Subjective and Objective data.

Plan: This section outlines the action steps for the client. Enter details for ongoing wellness plan.

SOAP Note: Subjective, Objective



Subjective

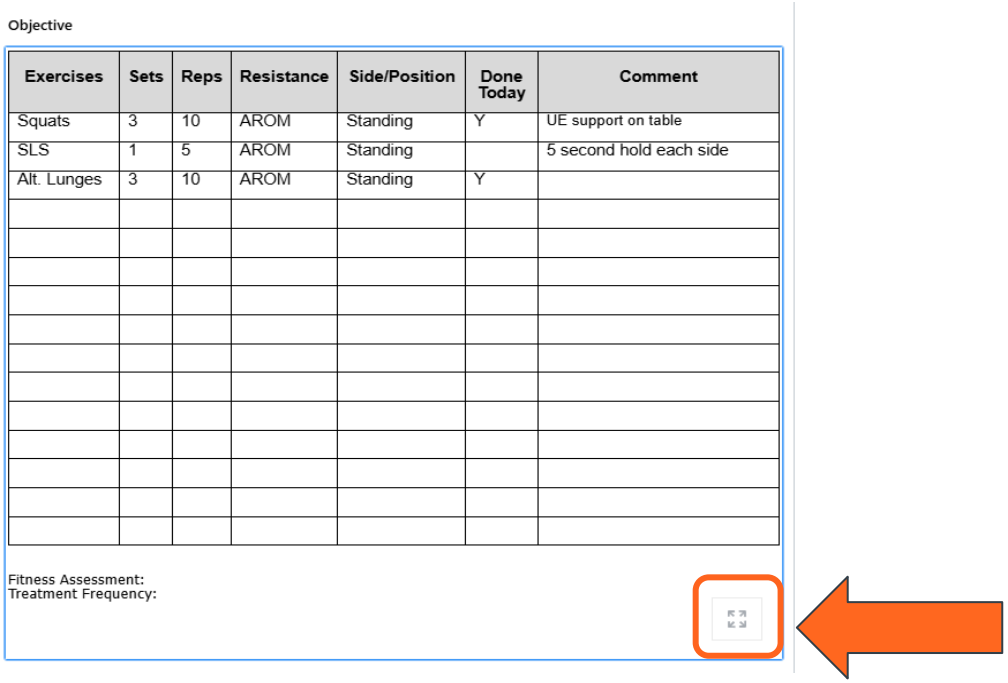
- Enter Patient and/or Caregiver comments
- Enter Pain Rating
- Utilize as appropriate based on client

Objective (this section carries over visit to visit)

- Utilize this section for the details of exercises and activities from the visit
- Fitness Assessment: if initial/quarterly assessment is done for client, write “Done Today, data in FOXSLC” and enter results in FOXSLC
- Treatment Frequency: Recommended frequency should be added at first visit and will carry over to each future visit. (Ex: 2x/week)
- Section is required
- See next slides for details on how to document in this section

SOAP Note: Objective Access Instructions

- To document in Objective section, either type directly into the box or the Objective note screen or expand the section by single clicking on the box and pressing "Ctrl + E" or clicking the square with four arrows on the lower right section of the objective box



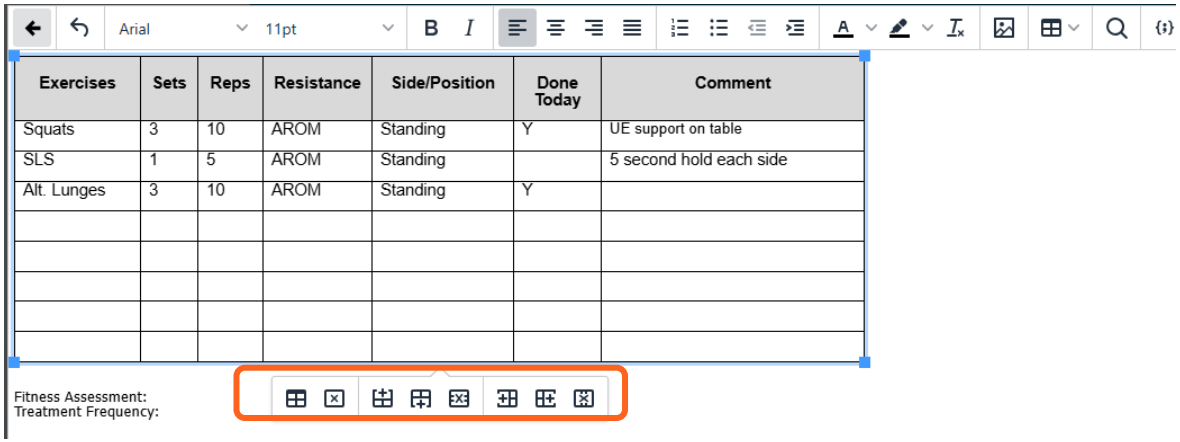
Objective

Exercises	Sets	Reps	Resistance	Side/Position	Done Today	Comment
Squats	3	10	AROM	Standing	Y	UE support on table
SLS	1	5	AROM	Standing		5 second hold each side
Alt. Lunges	3	10	AROM	Standing	Y	

Fitness Assessment:
Treatment Frequency:

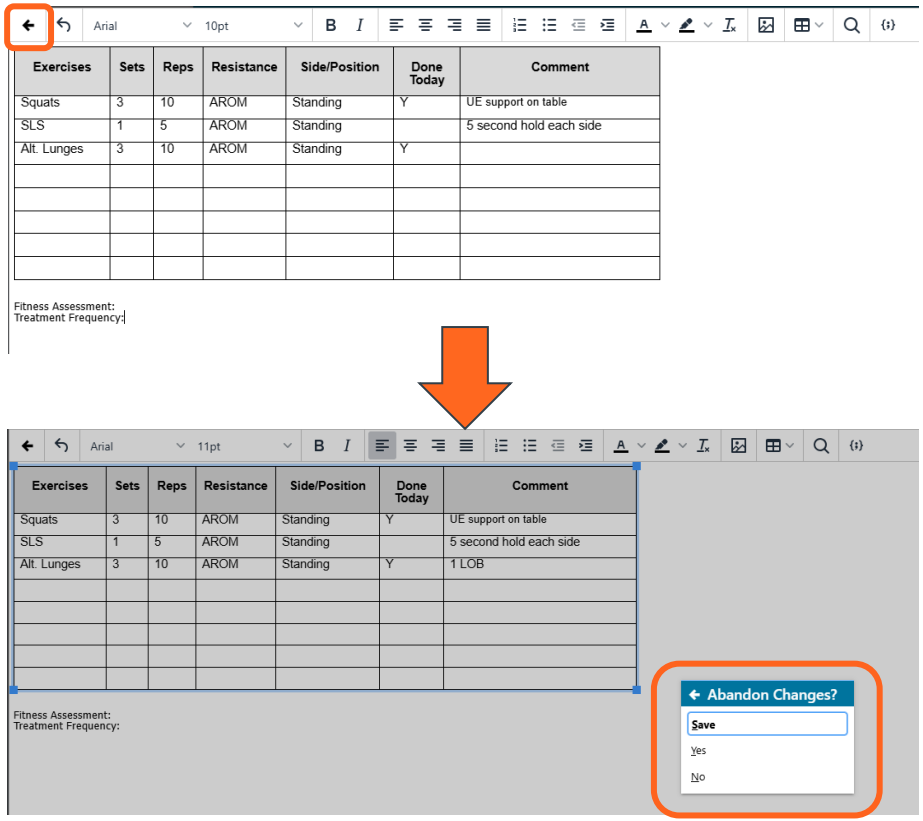
SOAP Note: Objective Grid Instructions

- Utilize exercise grid to document any exercises or activities in your session.
- Any activities that do not apply to the grid can be documented via free text below the grid
- In the "Done Today" column of grid, enter "Y" for exercises done today. If not done today, leave blank.
- Utilize arrow keys or mouse to change cells in grid (do not use the tab button)
- If you need additional lines added to the grid, single click anywhere in the exercise column and click to add row above or to add row below.
- Click to delete a row
- Do not add or delete columns in this grid

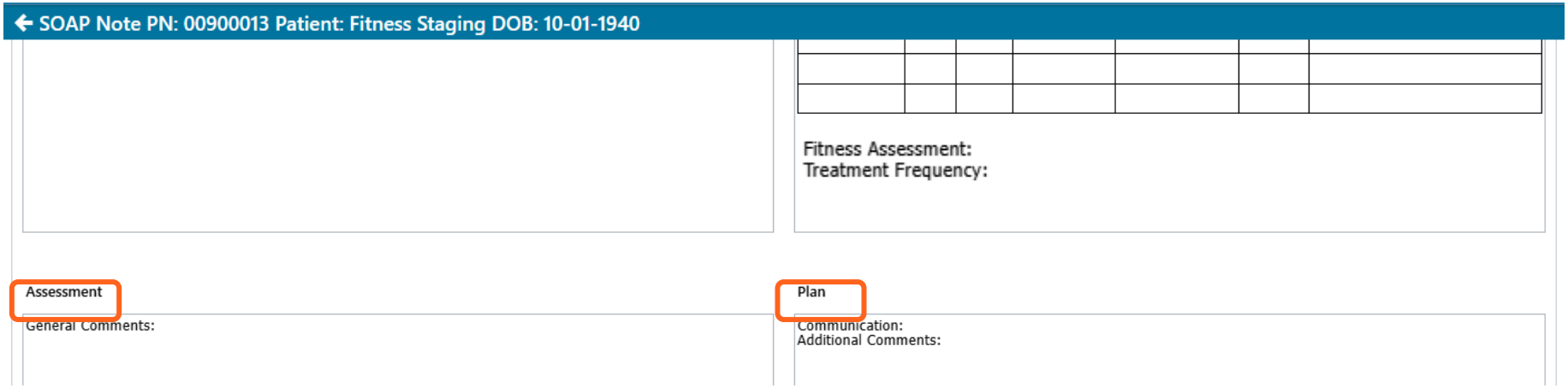


SOAP Note: Saving Objective Section

- If you expanded the Objective box and have completed documentation, click the left arrow at upper left of box and click "Save" on pop up



SOAP Note: Assessment, Plan



Assessment

- Utilize as appropriate based on client

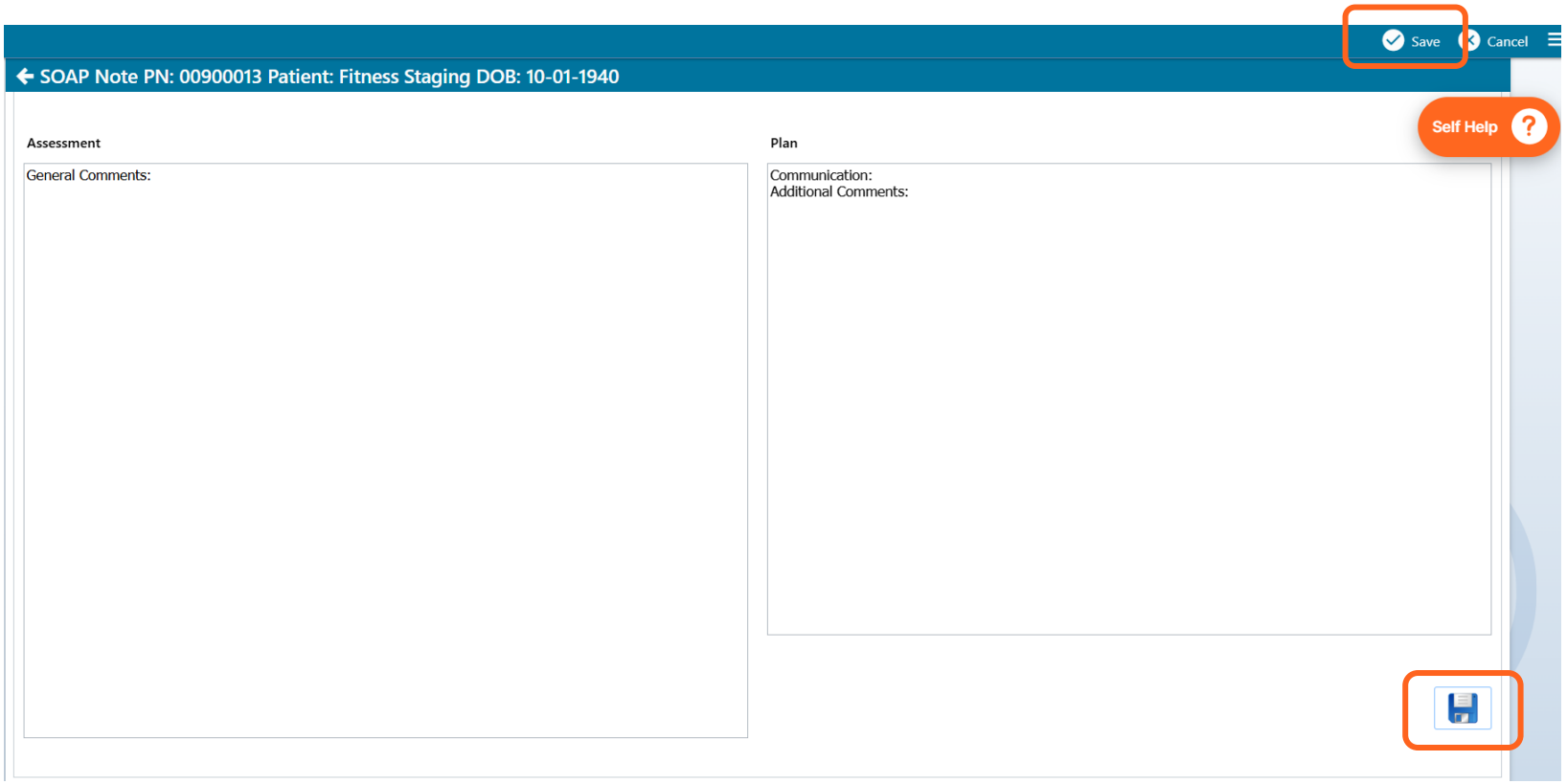
Plan

- Communication is to document any applicable conversation with client/POA regarding this visit
- Additional Comments can be used as needed if not applicable to other categories
- Utilize as appropriate based on client

Reminder: Do not access any other tabs in this section other than the SOAP note.

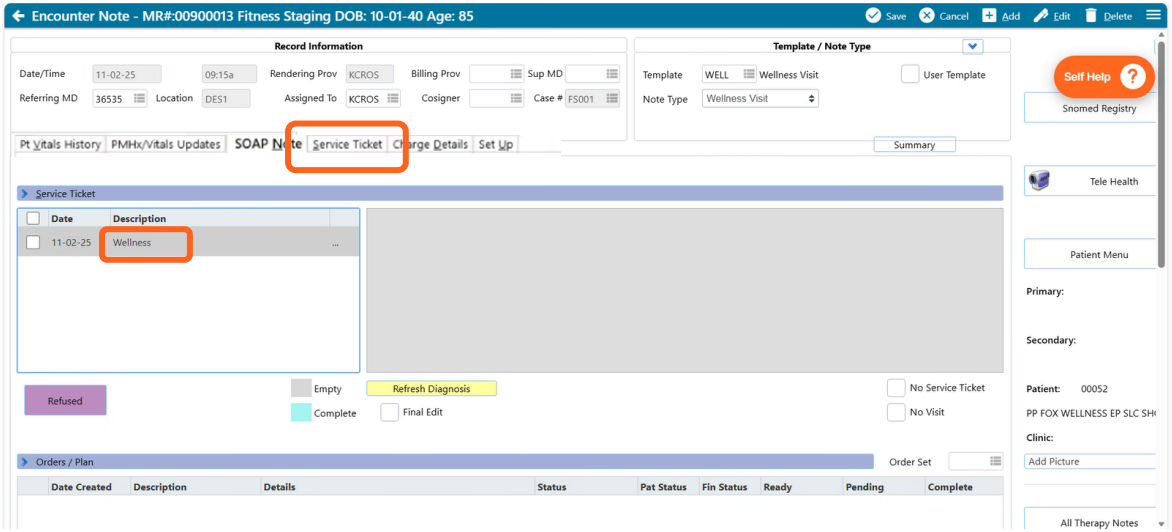
SOAP Note: SAVE

- When note is complete hit "Save“ in top right corner or Disk icon in bottom right corner



Service Ticket

- Navigate to Service Ticket tab
- Double click on "Wellness" under service ticket box



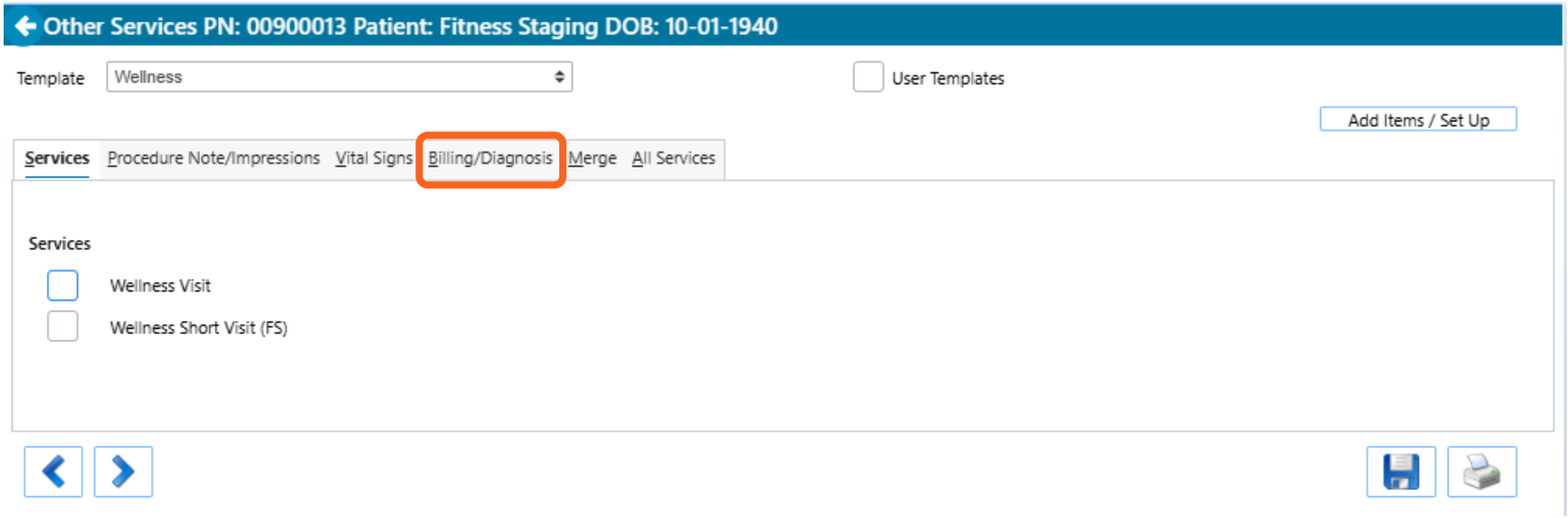
- Select appropriate Service
  - Wellness Visit = Long Visit
    - Can be utilized by all disciplines
  - Wellness Short Visit (FS) = Short visit for FS only



Time in and Time out

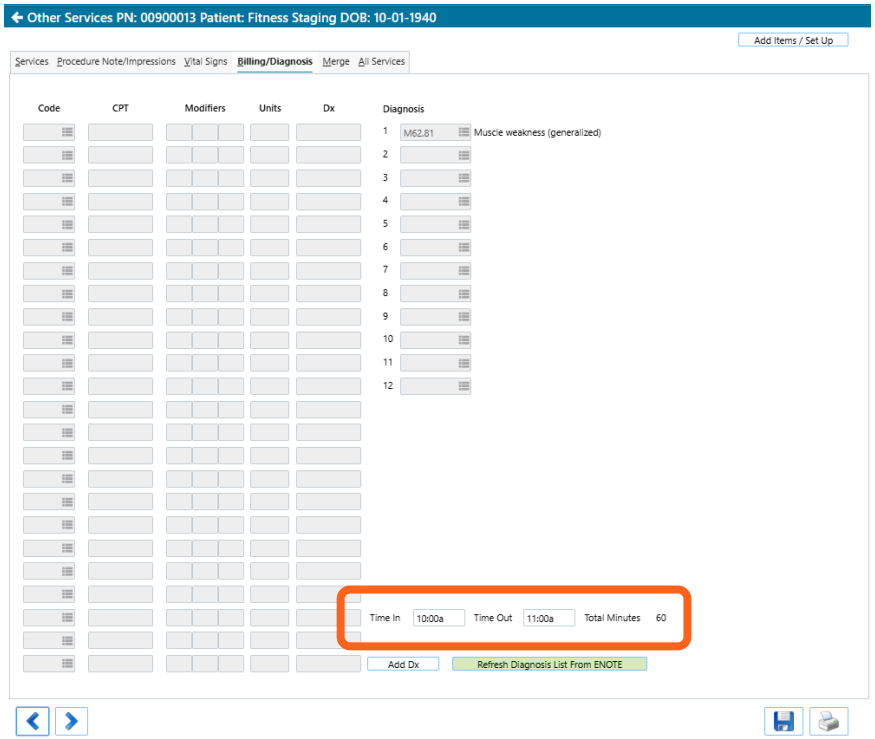
- Please enter time in and time out in all ENOTEs to ensure compliance with visit length expectations.

- Navigate to the “Billing/Diagnosis” tab



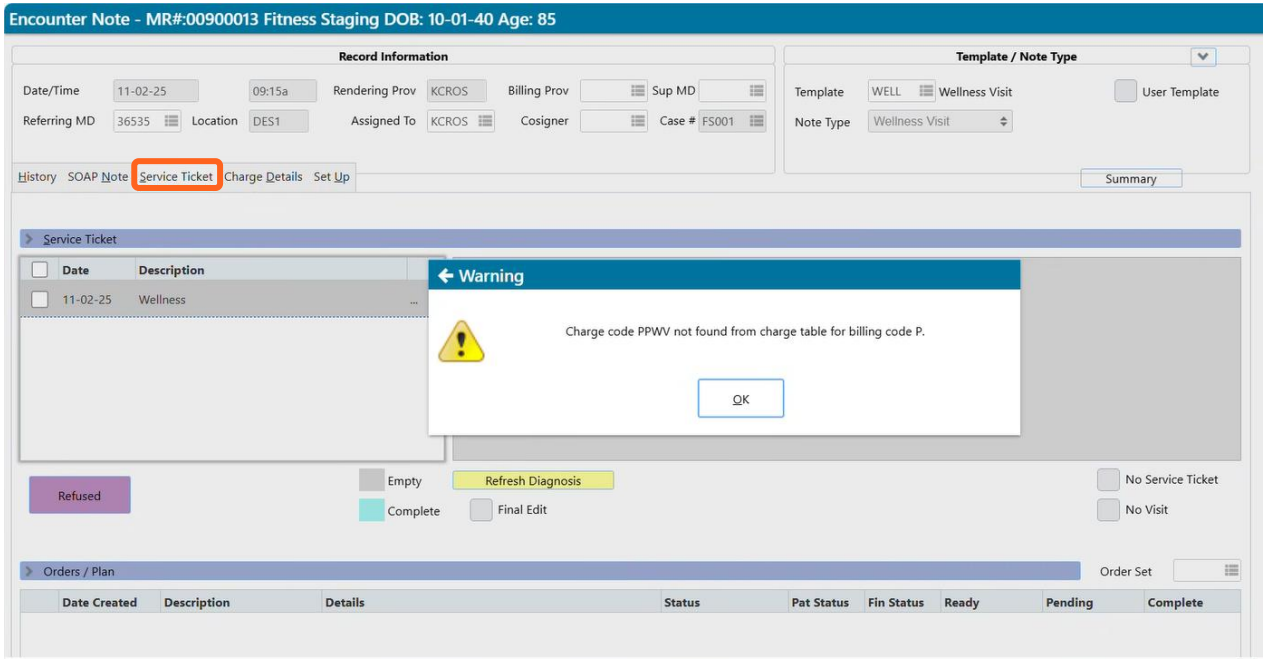
Time In and Time Out

- Enter Time in (start time of session) and time out (end time of session) using the format HH:MMa or HH:MMp
- Total minutes will automatically calculate based on times entered
- After completion click Save in upper right corner or in lower right corner



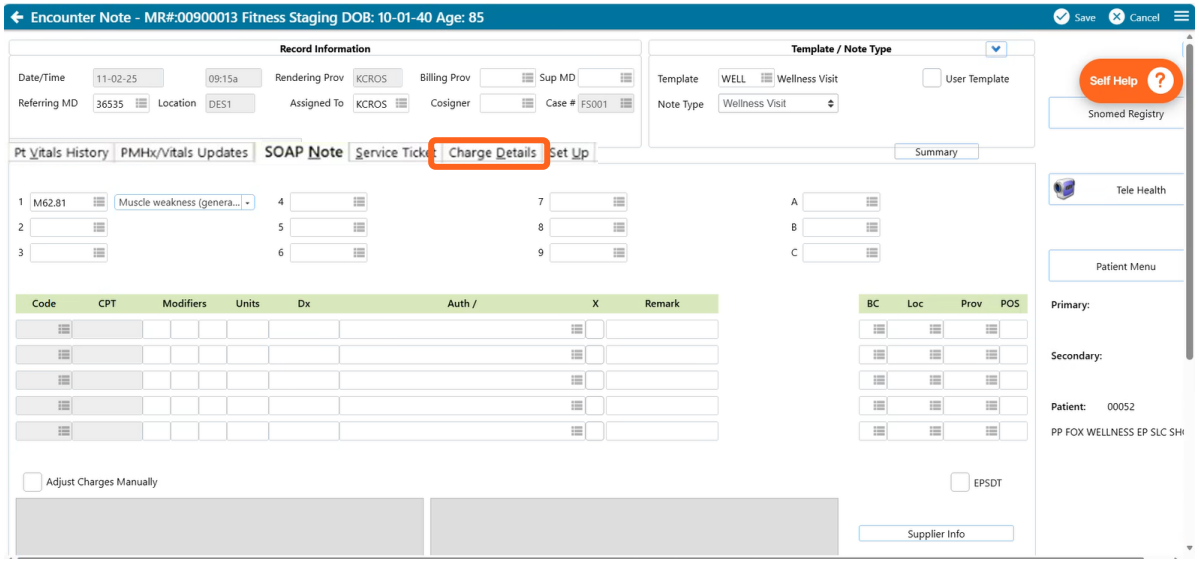
Service Ticket: Warning Pop-up

- If the wrong service is selected, this warning pop-up will show
- Go back and select correct service type



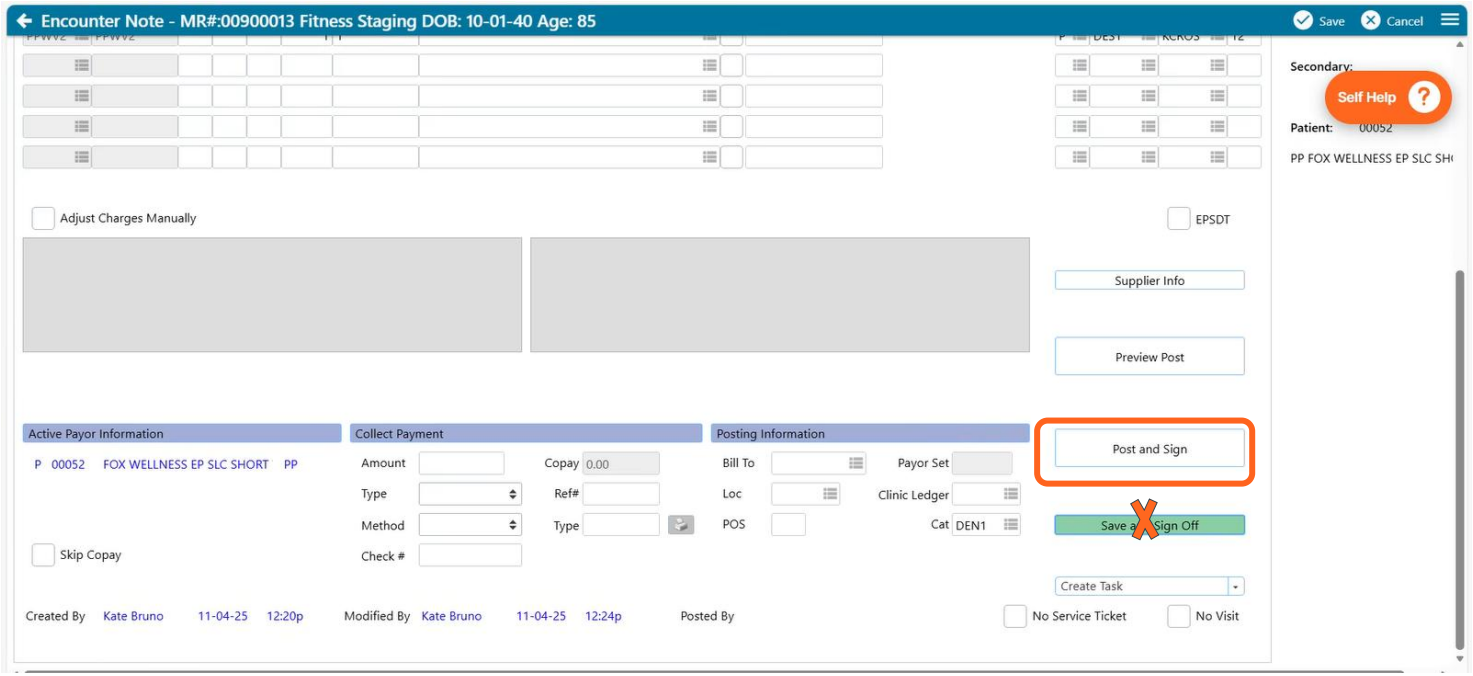
Charge Details

- Navigate to Charge Details tab
- Code and units will auto populate from the selection entered under service ticket.



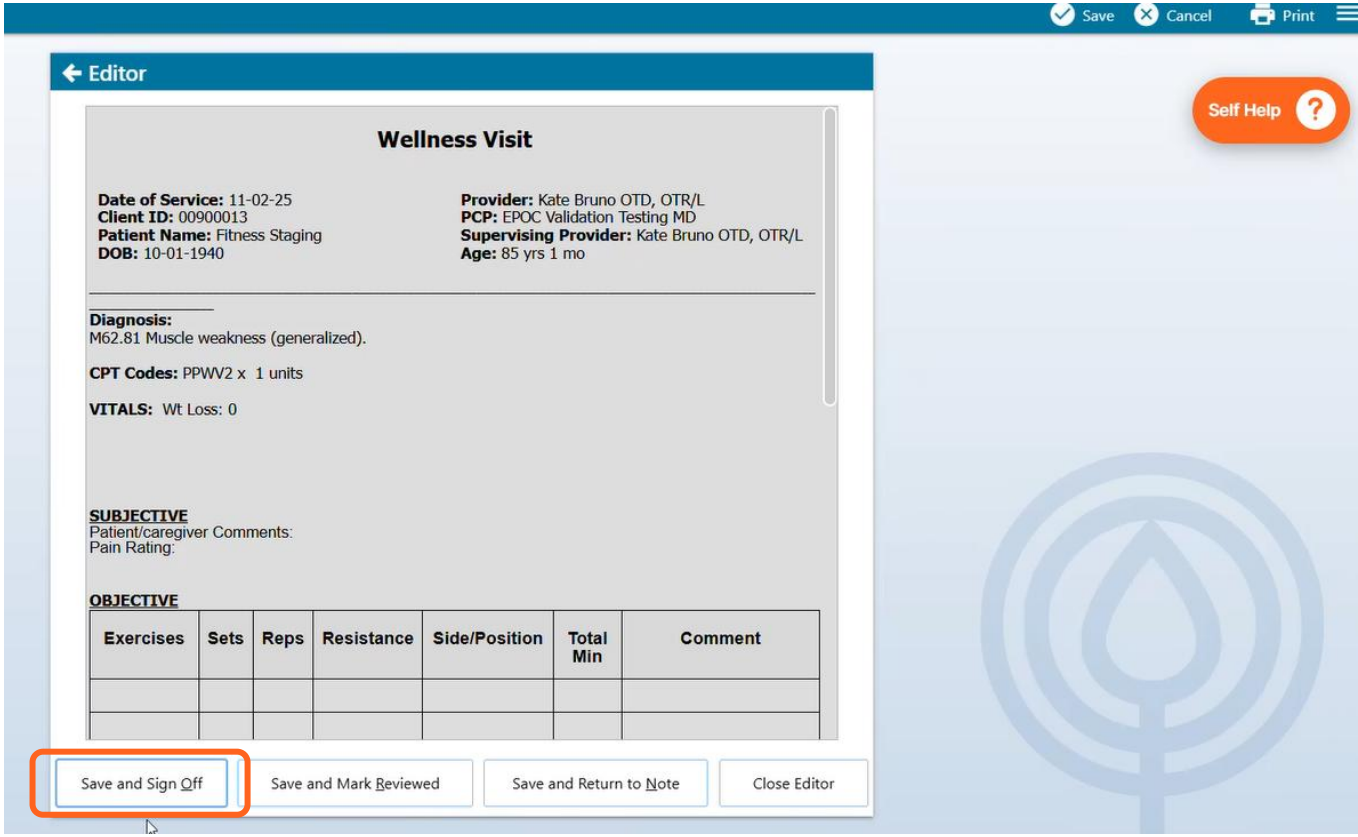
Charge Details: Post and Sign

- Scroll down and on right side click "Post and Sign“



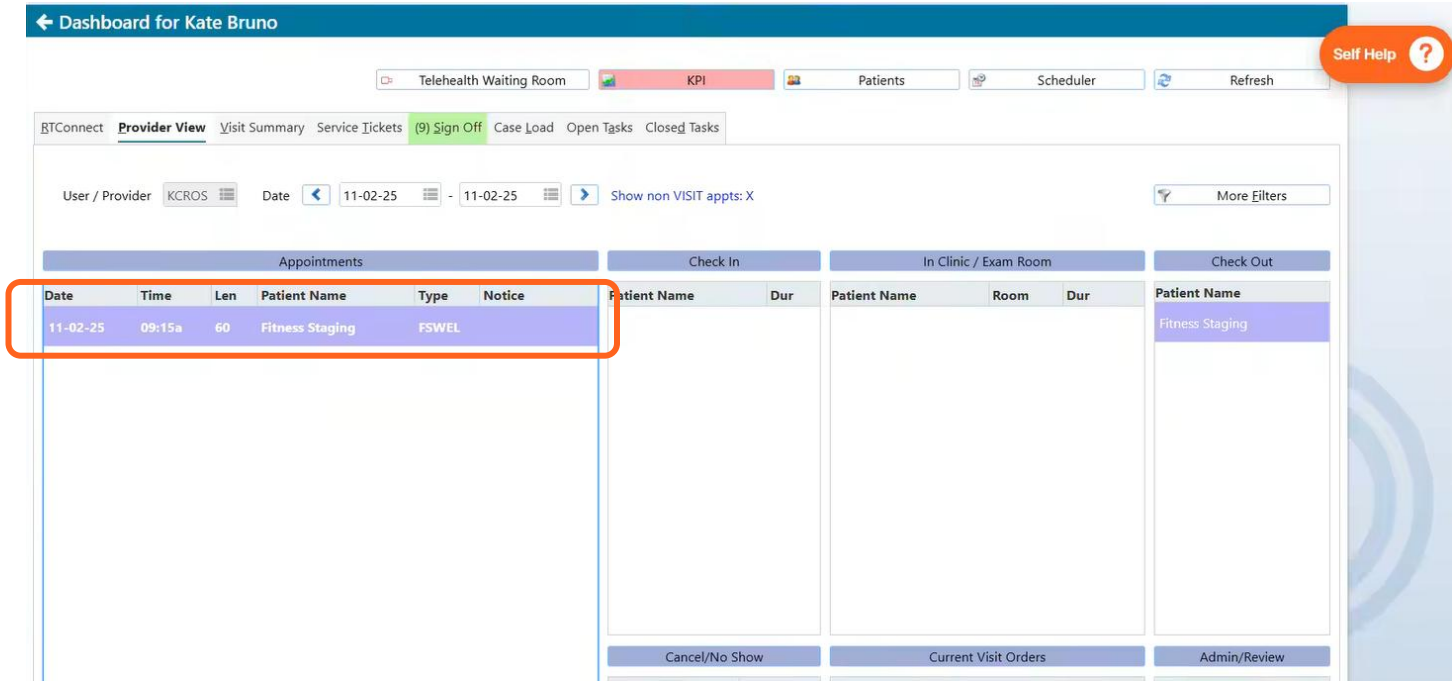
Save and Sign Off

- Click “Save and Sign Off“
- Input pin in pop-up and click "Save and Sign Off“



Confirmation

- After successful Sign and Post, visit will turn Purple
- If it is gray, it did not bill and you will need to go back into the note to post again.

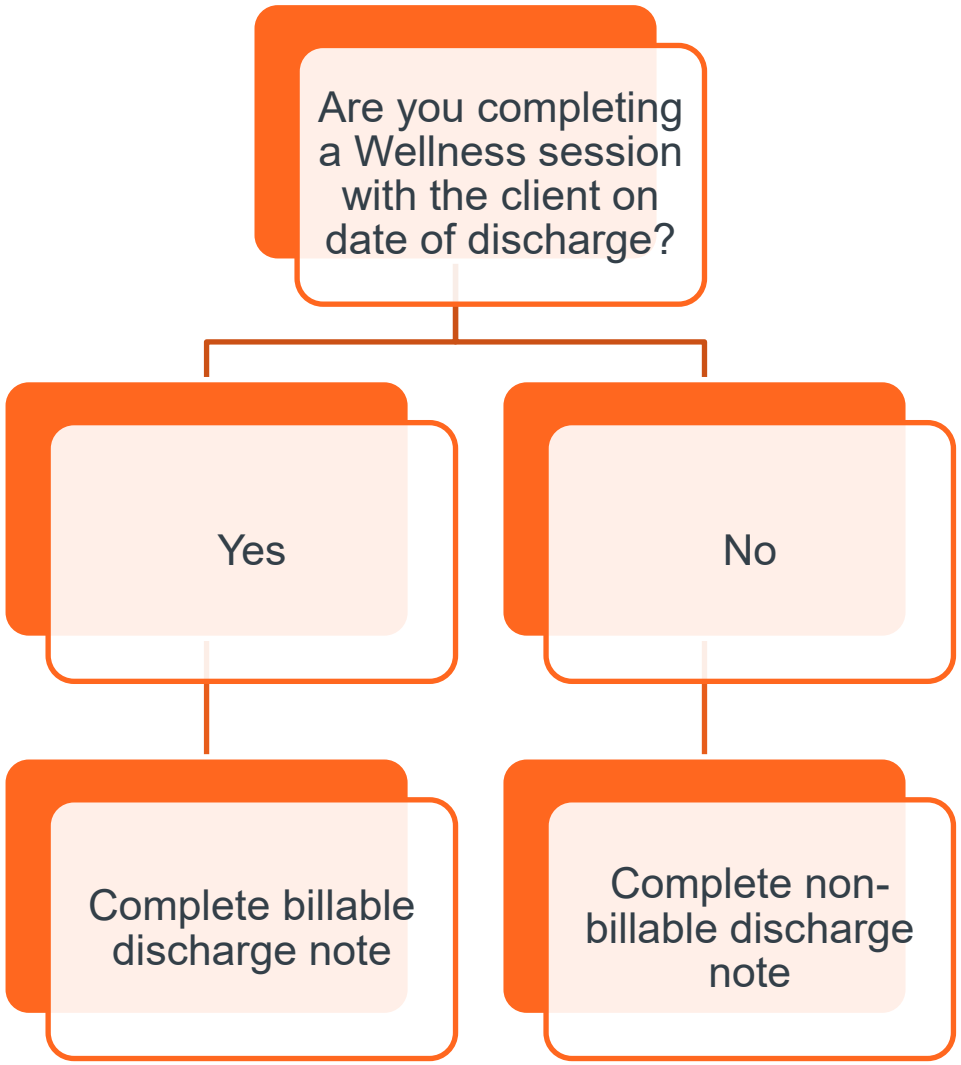


Discharge Documentation

Discharge Note Usage

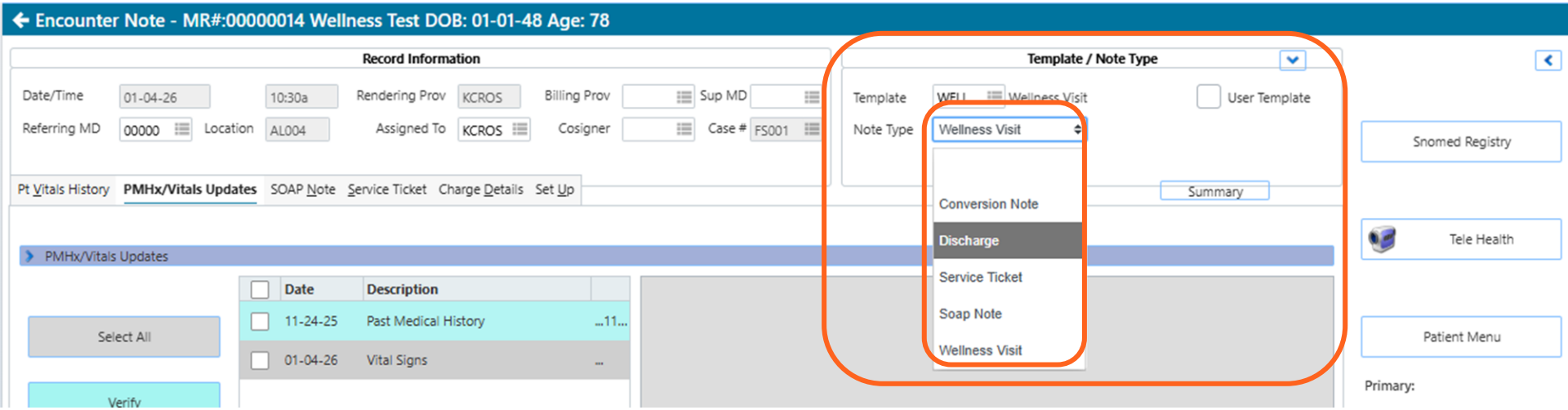
- Discharge notes are utilized to end a case in Raintree (planned or unplanned) at completion of a Wellness case.
  - Our goal is to educate our clients on the benefit of continuing Wellness engagement throughout their life however there are some cases where that does not occur.
- Discharge notes can be billable or non-billable depending on the scenario
  - Billable – completing the planned final client visit note in a Wellness case and tagging as a discharge to remove case from active list
  - Non-billable – an unplanned discharge from Wellness where a billable client visit is not completed on date of discharge

Decision Tree for Billable vs. Non-Billable DC



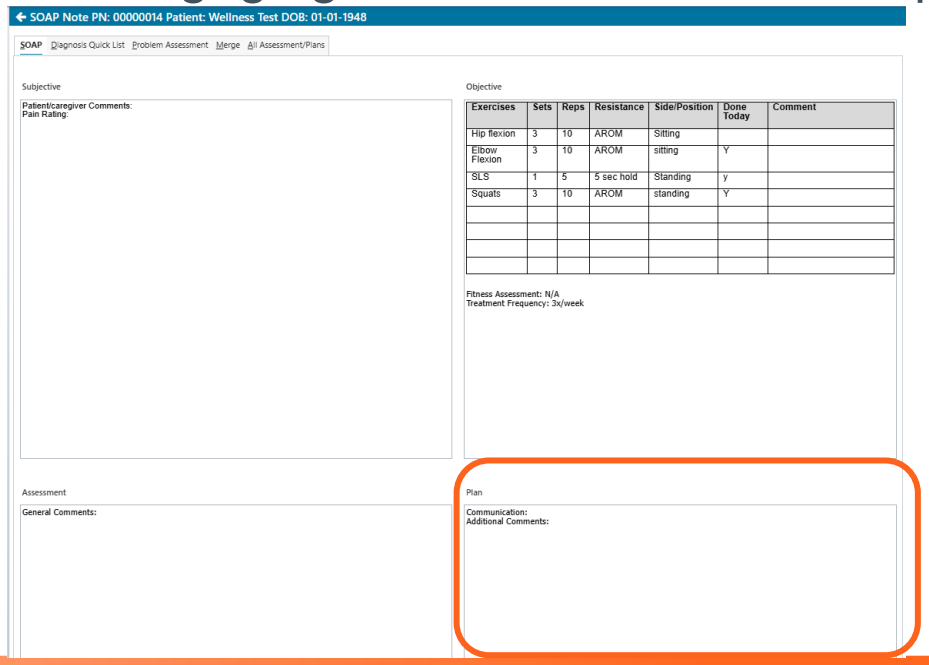
Opening a Discharge (DC) Note

- Schedule visit in FOX Trax, complete check in, and open note based on instructions previously outlined in this training.
- Navigate to upper panel in the "Template/Note Type" box and click ▼ next to "Note Type".
- Select "Discharge"



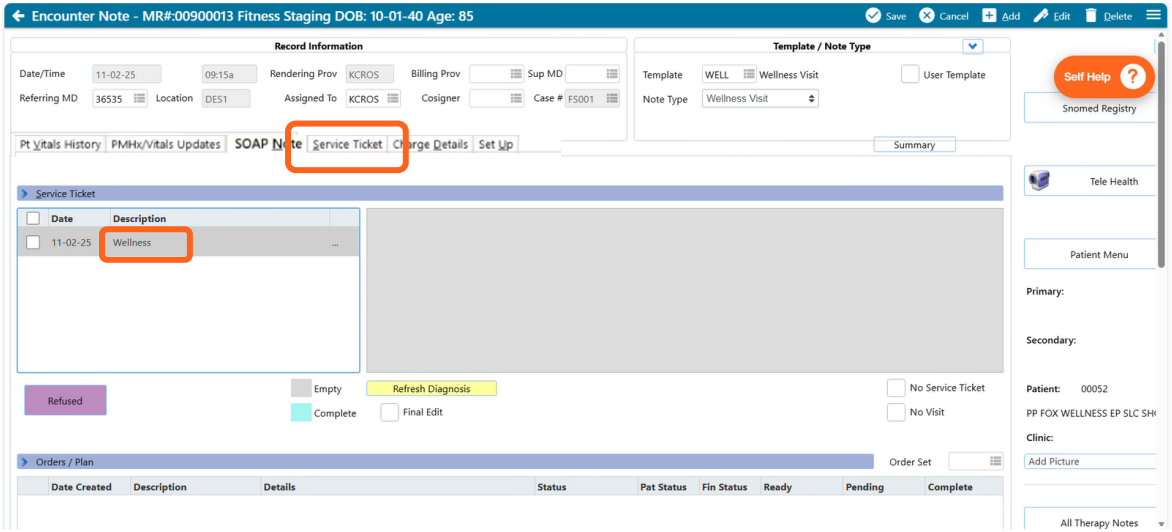
Billable DC Note

- Complete client visit note content based on guidance from this training.
- In the "Plan" Tab under "Additional Comments" enter reason for discharge.
  - Ex: "Client requesting discharge due to financial reasons", "client expired", "client engaging with skilled care and requesting discharge"



Billable DC: Service Ticket

- Navigate to Service Ticket tab
- Double click on "Wellness" under service ticket box



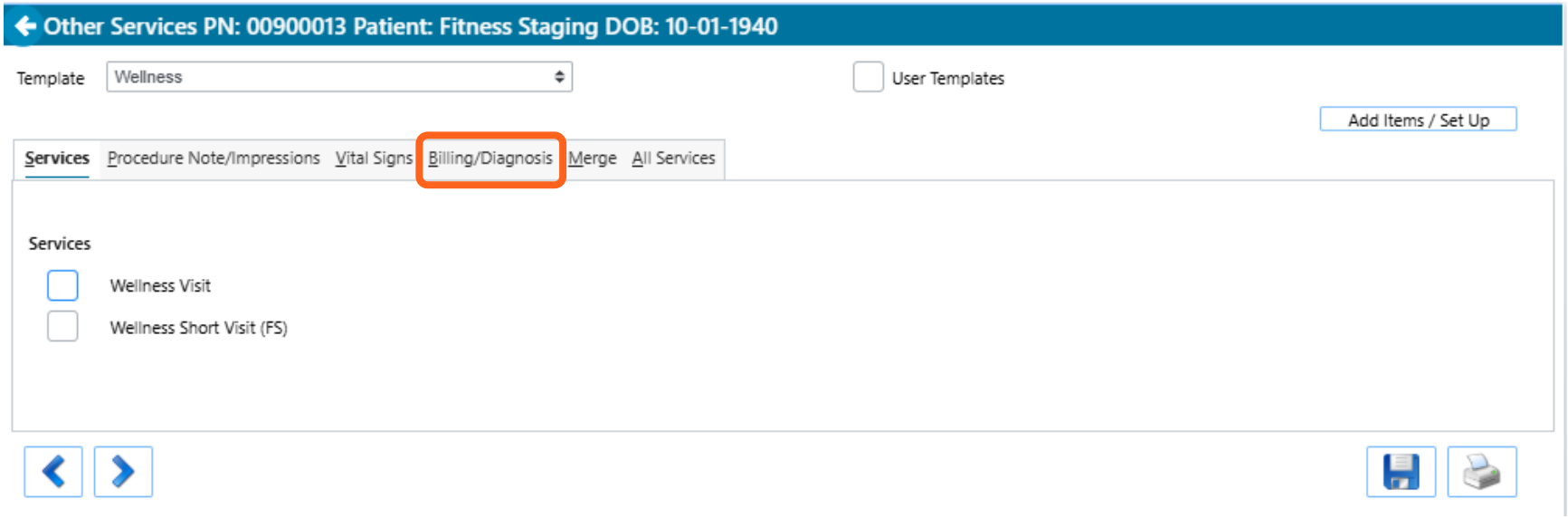
- Select appropriate Service
  - Wellness Visit = Long Visit
    - Can be utilized by all disciplines
  - Wellness Short Visit (FS) = Short visit for FS only



Billable DC: Time in and Time out

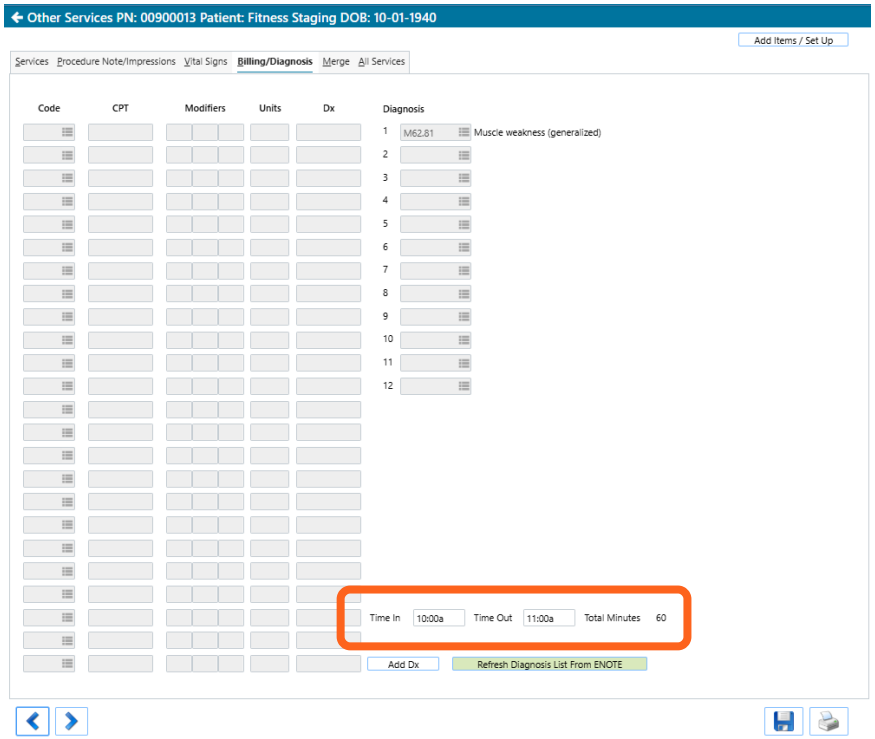
- Please enter time in and time out in all ENOTEs to ensure compliance with visit length expectations.

- Navigate to the “Billing/Diagnosis” tab



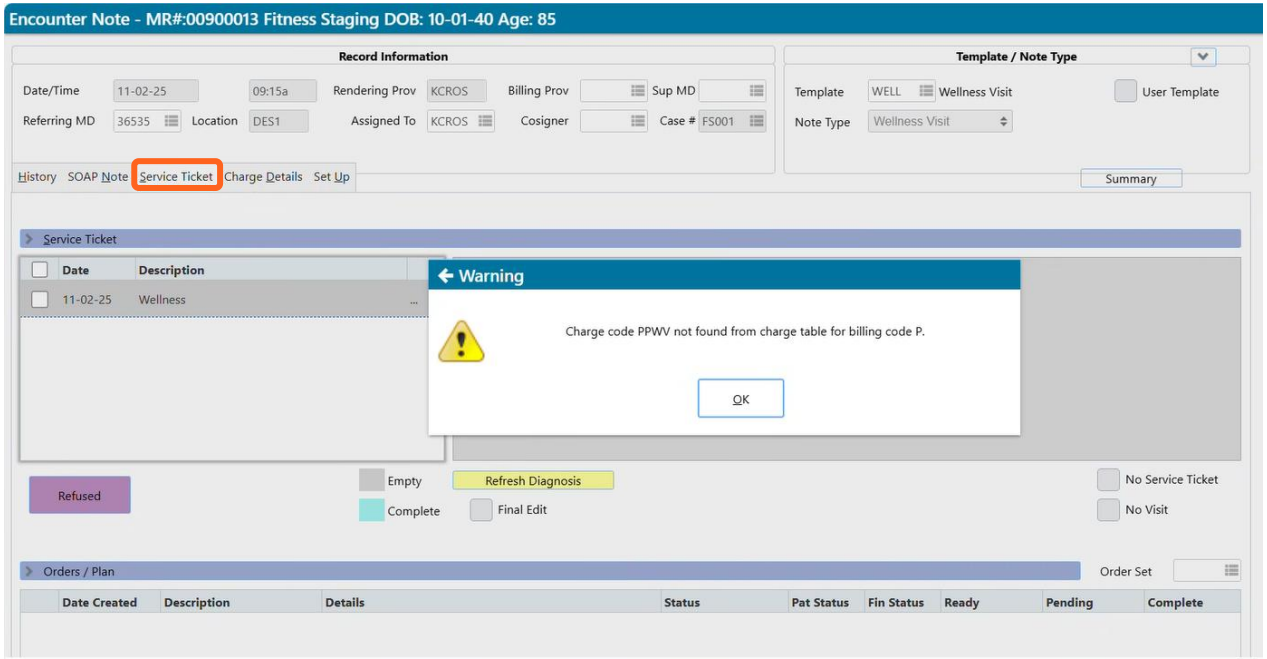
Billable DC: Time In and Time Out

- Enter Time in (start time of session) and time out (end time of session) using the format HH:DDa or HH:DDp
- Total minutes will automatically calculate based on times entered
- After completion click Save in upper right corner or in lower right corner



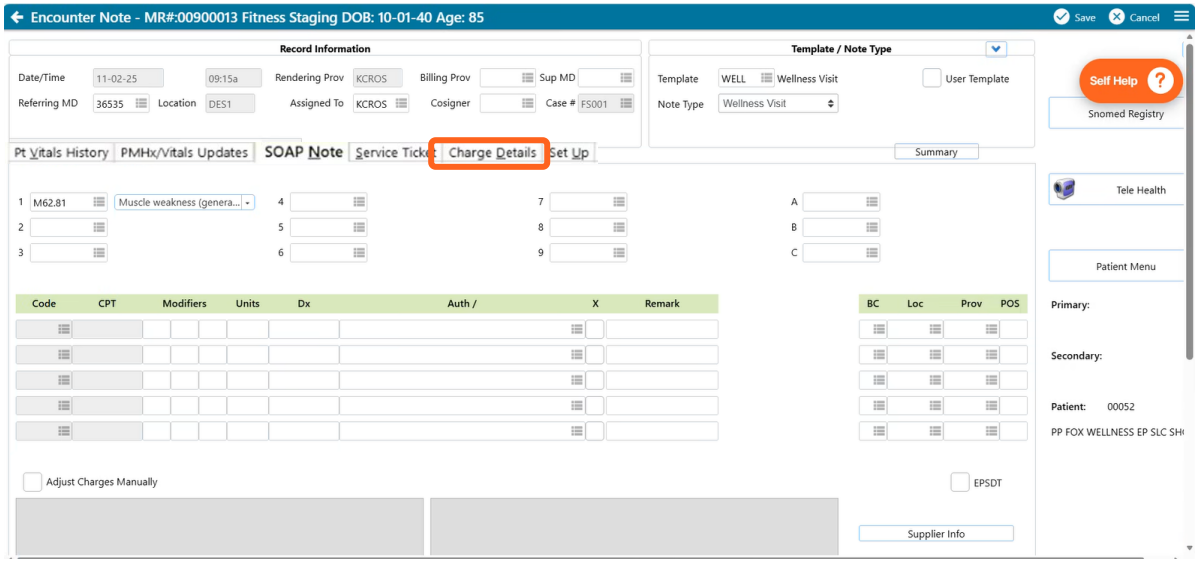
Billable DC Service Ticket: Warning Pop-up

- If the wrong service is selected, this warning pop-up will show
- Go back and select correct service type



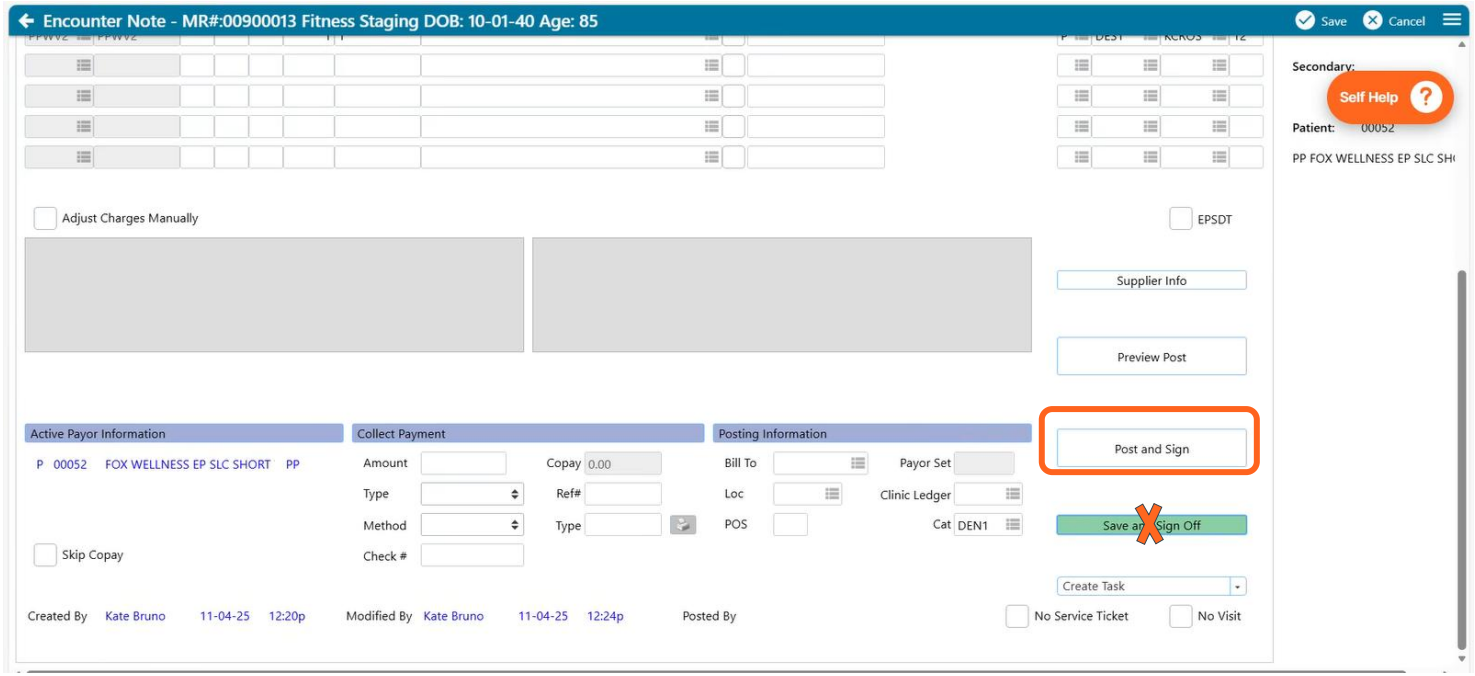
Billable DC: Charge Details

- Navigate to Charge Details tab
- Code and units will auto populate from the selection entered under service ticket.



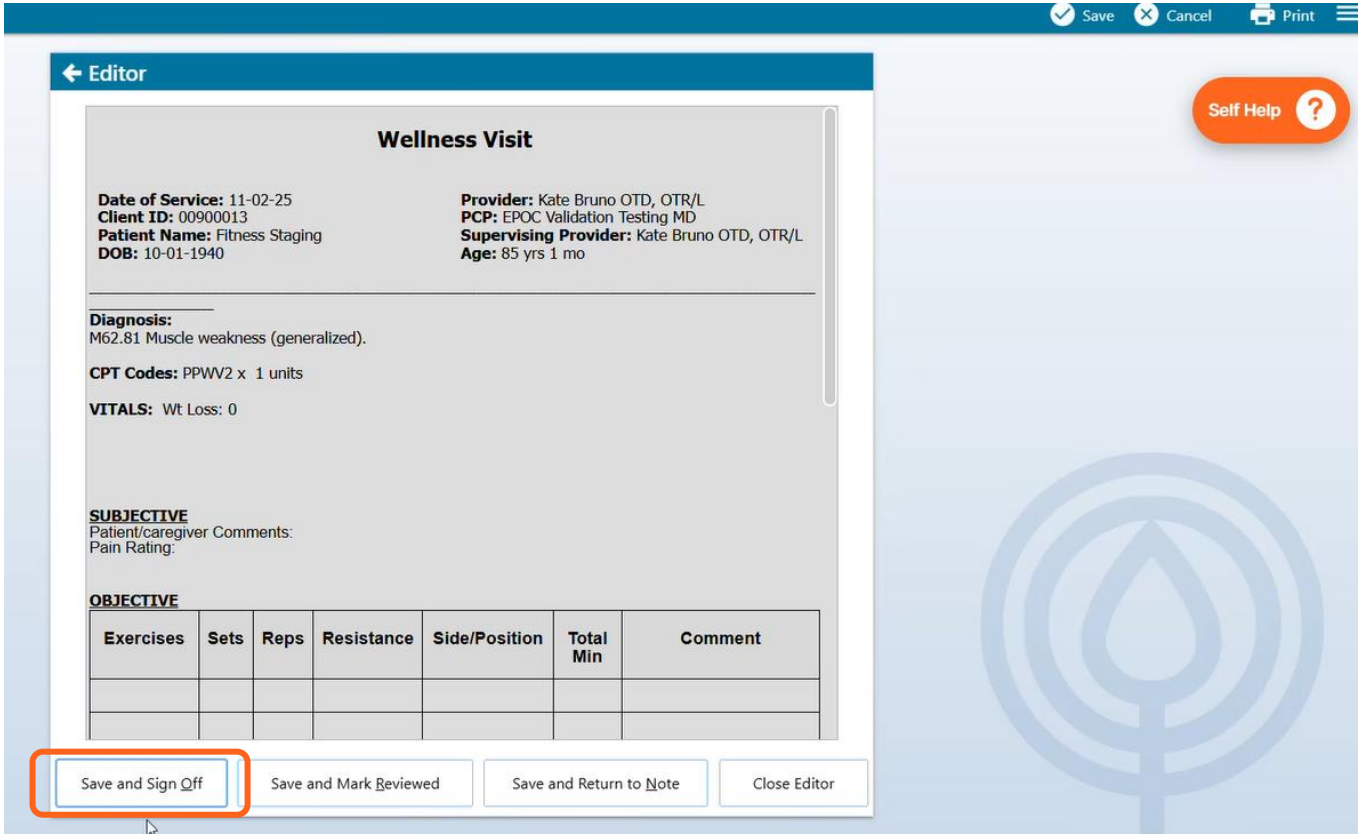
Billable DC: Charge Details > Post and Sign

- Scroll down and on right side click "Post and Sign“



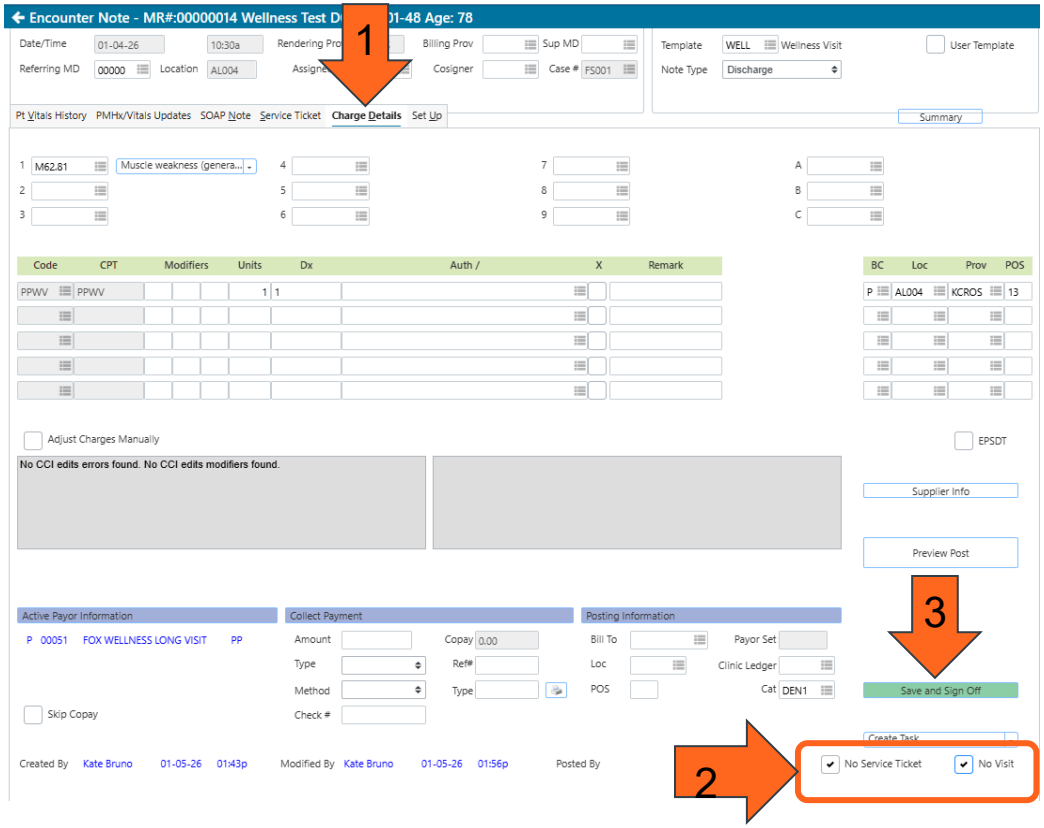
Billable DC: Save and Sign Off

- Click “Save and Sign Off“
- Input pin in pop-up and click "Save and Sign Off“



Non-Billable Discharge Note

- Should ONLY be used for an unplanned discharge from Wellness where a billable client visit is not performed.
- Open Discharge Note and navigate to SOAP Note. Add reason for DC in "Plan".
- Navigate to "Charge Details"
- Check off boxes for "No Service Ticket" and "No Visit" to document that a visit did not occur on that day and should not be billed.
- Click "Save and Sign Off" and follow prompts



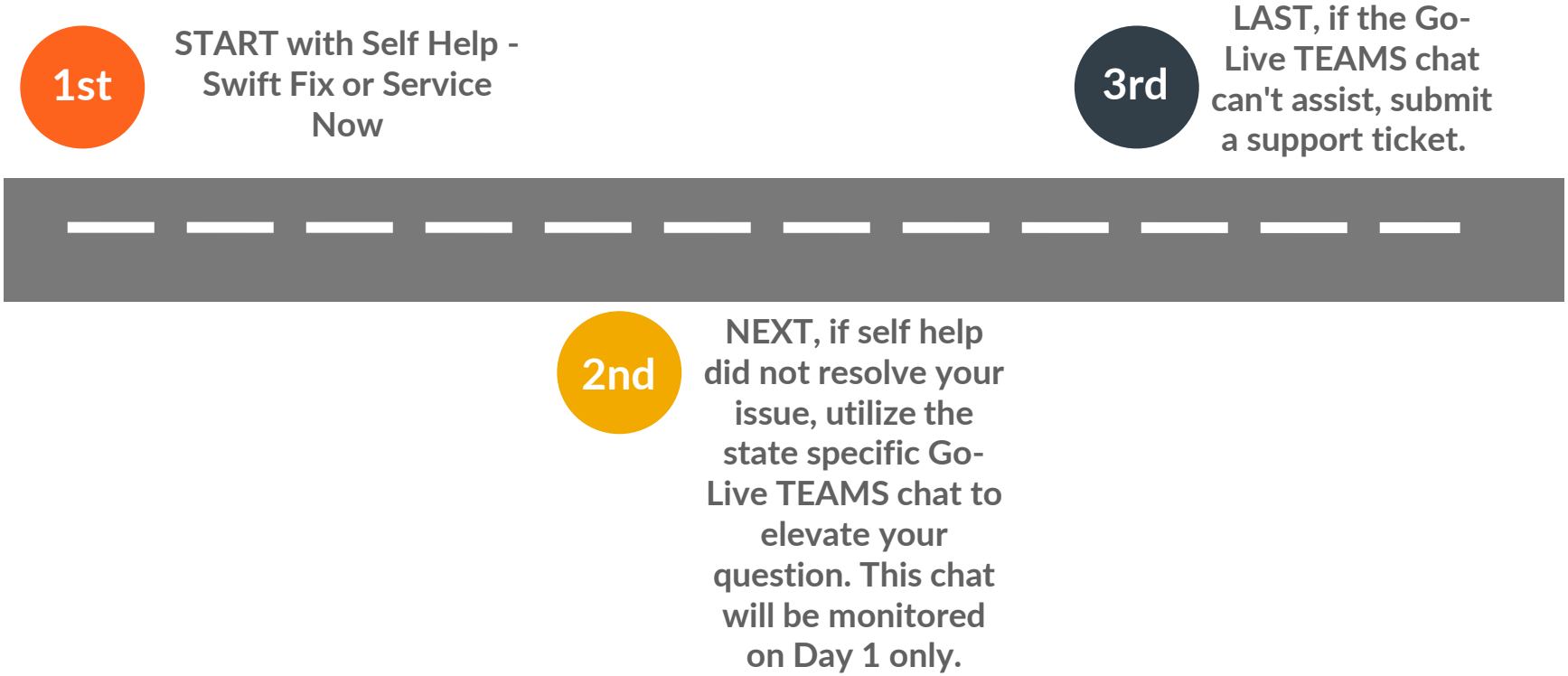
Confirmation of Discharge Completion

- Once the billable or non-billable discharge note is signed off in Raintree, the case will be automatically removed from the "Caseload" tab indicating successful discharge.



Support Roadmap: Start Smart, Escalate Right

Have a question? Follow the path to resolution!



RT Standard
ENOTE – Exercise Class Documentation

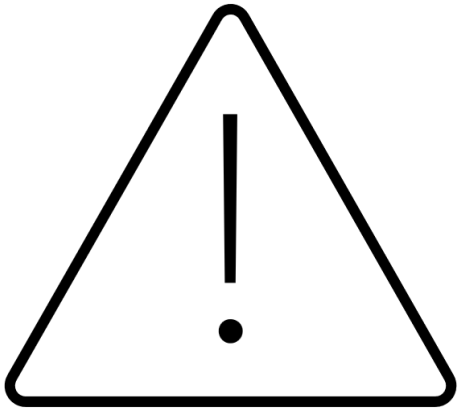


Important Points to Consider

- The Exercise Class Attendance Roster **MUST** be completed for every class.
  - CI has access to the above link
- Best practice is to enter all exercise class documentation point of service or on date of class completion
- All Exercise Class documentation/service tickets must be entered by end of month to allow for timely invoicing to communities
- A CS account can only be billed one time per day
  - If there are two or more classes being completed per day in a SLC, each class must be billed under a different CS account
  - Please reach out to your RD if you need additional CS accounts added.

Starting New Cases

- New admissions will only display on your caseload tab AFTER you have scheduled the first evaluation/visit in FOX Trax.
  - Scheduling of the appointment in FOX Trax initiates the record to be created in Raintree



RTConnect | Provider View | Visit Summary | Service Tickets | (10) Sign Off | **Case Load** | Open Tasks | Closed Tasks

User / Provider: EPROP | Location: | Eval. Prov: | Patients starting before / on: 11-03-25

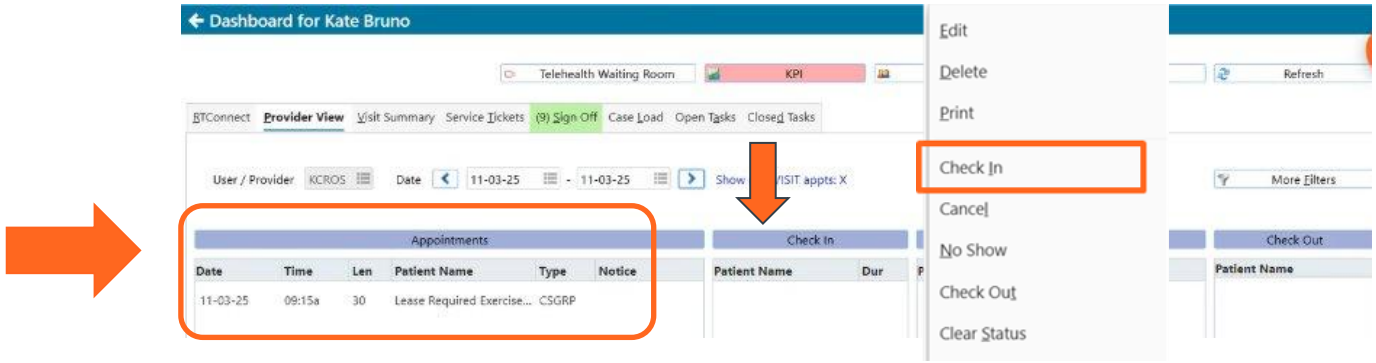
Alert Source: | Alert Level: | On Hold Cases: Hide

Case Load — Full / Plan

Patient Name	Case Name	Case	Plan	Rem	End	Auth End	rem	Rx End	rem	Next PR	#	Next Visit
Test Medicare9	ADL's Diag1: Home ph	OT001		-1				12-31-25	-1		10	
Medicare Test8	ADL's Diag1: Home ph	OT001		-1				12-31-25	-1		10	

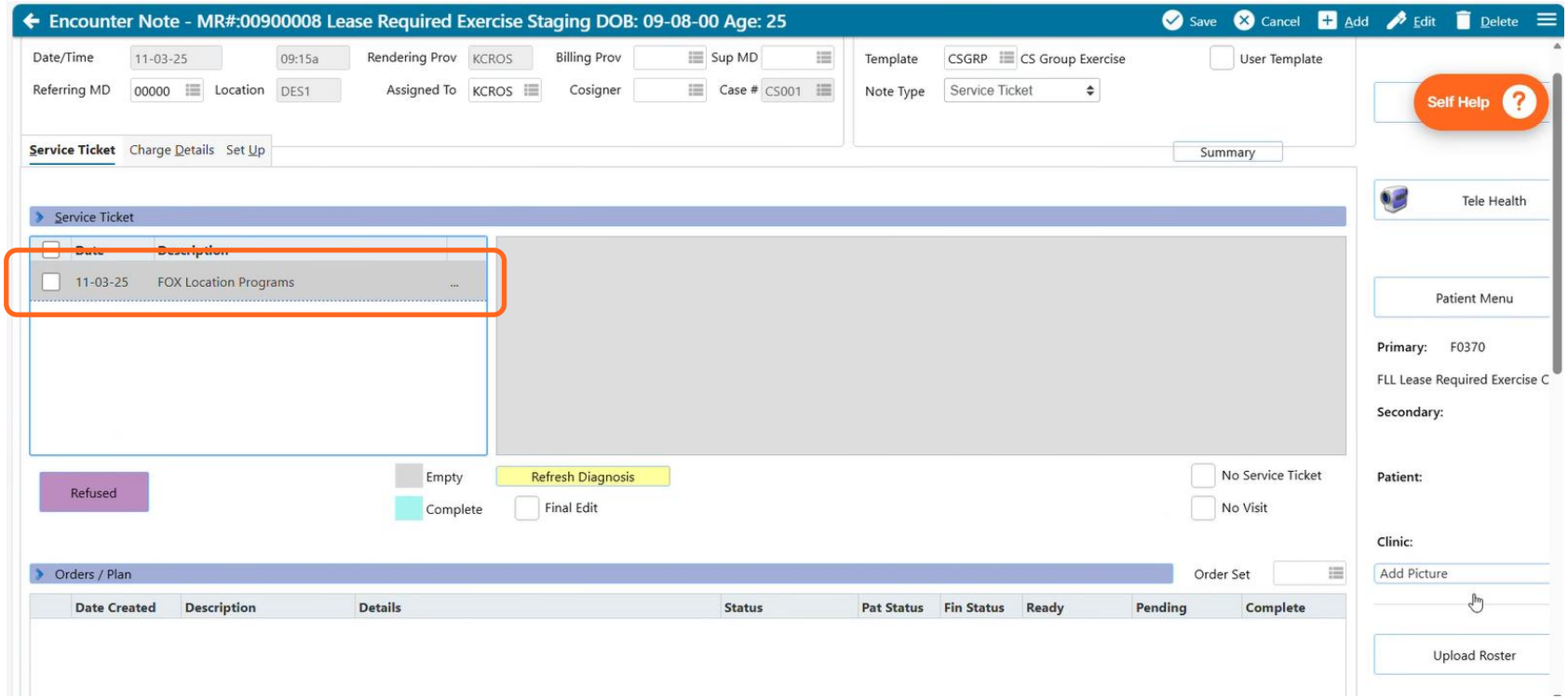
Launching a Note

- Schedule in FOX Trax
  - Visit will display in RT Standard scheduler and **Provider View tab** under **Appointments**
  - Visits **MUST** be scheduled to start a note. RT Standard does not allow for notes to be created without an appointment.
- In **FOX Trax,** complete visit verification, ideally at the start of the session
- In **RT Standard**, right click the appointment and select **Check In**
  - The appointment will display in the **"Check In "** window
    - Double click or right click> edit to open the clinical note when ready to document.
  - In the event action is needed (due to patient forms being unsigned or previous notes not completed), prompts will display and then the appointment will display in the Check In window
    - See Consent Training for details on patient forms.
  - Read any additional prompts related to the patient so you are aware of any notices/alerts



Screenshots do not represent wellness exercise class appointments. Example is for visual display of scheduling workflow

Entering Service Ticket Information



- Double click on "FOX Location Programs" to enter service ticket information

Inputting Visit Credit Information

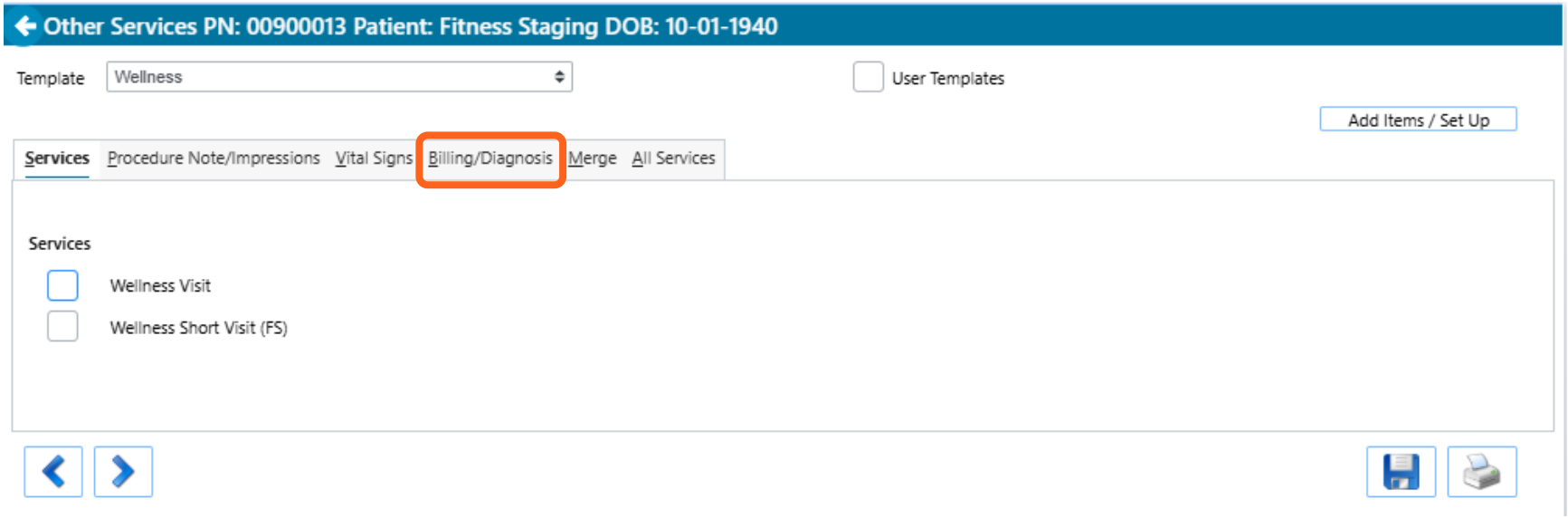


- Enter appropriate value into "Group Exercise Class"
  - For a 30-minute class input "2"
  - For a 60-minute class input "4"

- Once data is entered, go to upper right corner and click Save

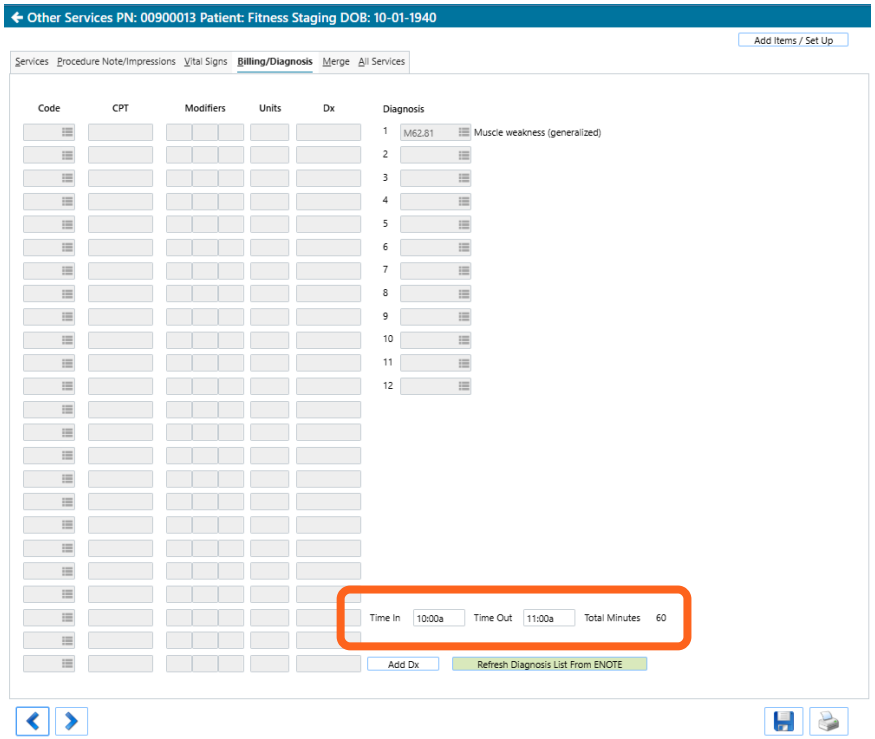
Time in and Time out

- Please enter time in and time out in all exercise class appointments to ensure compliance with class length expectations.
- Navigate to the “Billing/Diagnosis” tab



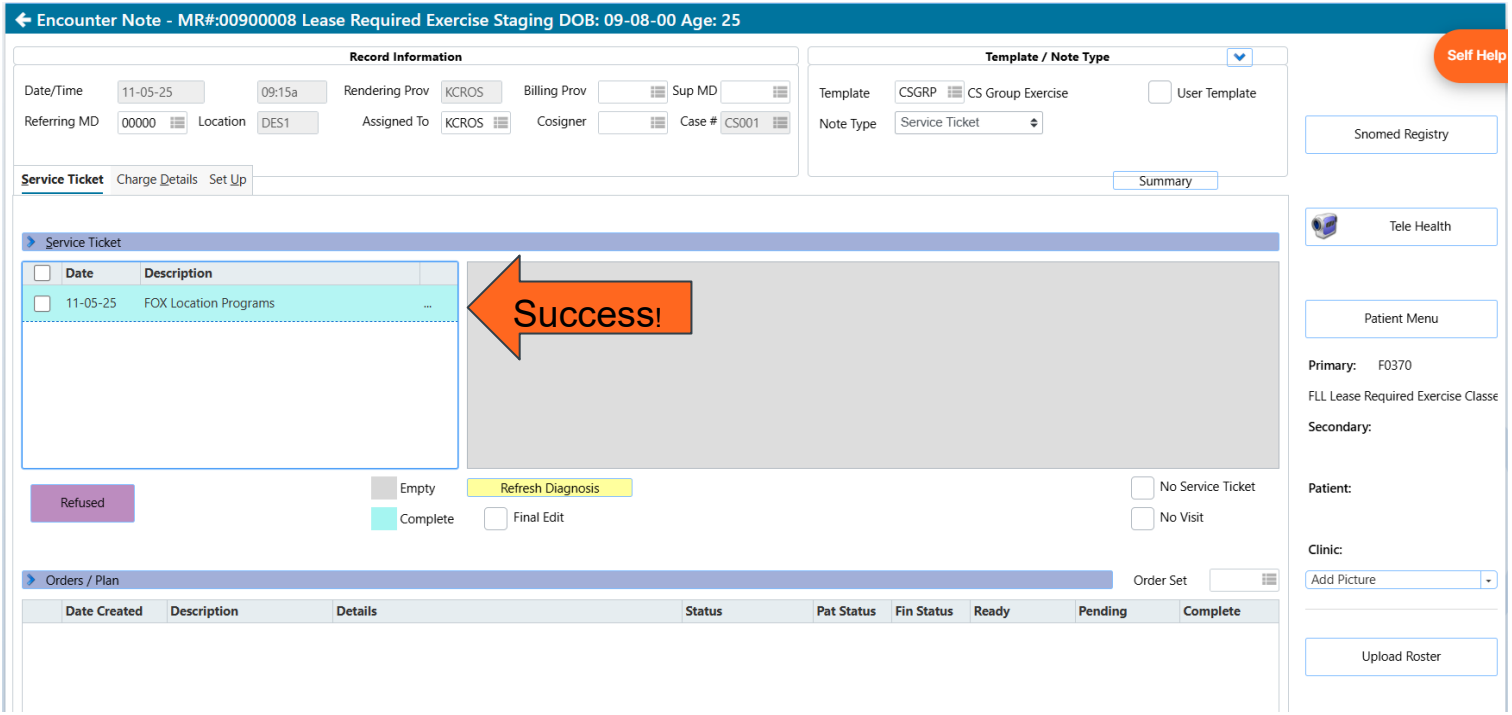
Time In and Time Out

- Enter Time in (start time of session) and time out (end time of session) using the format HH:MMa or HH:MMp
- Total minutes will automatically calculate based on times entered
- After completion click Save in upper right corner or in lower right corner



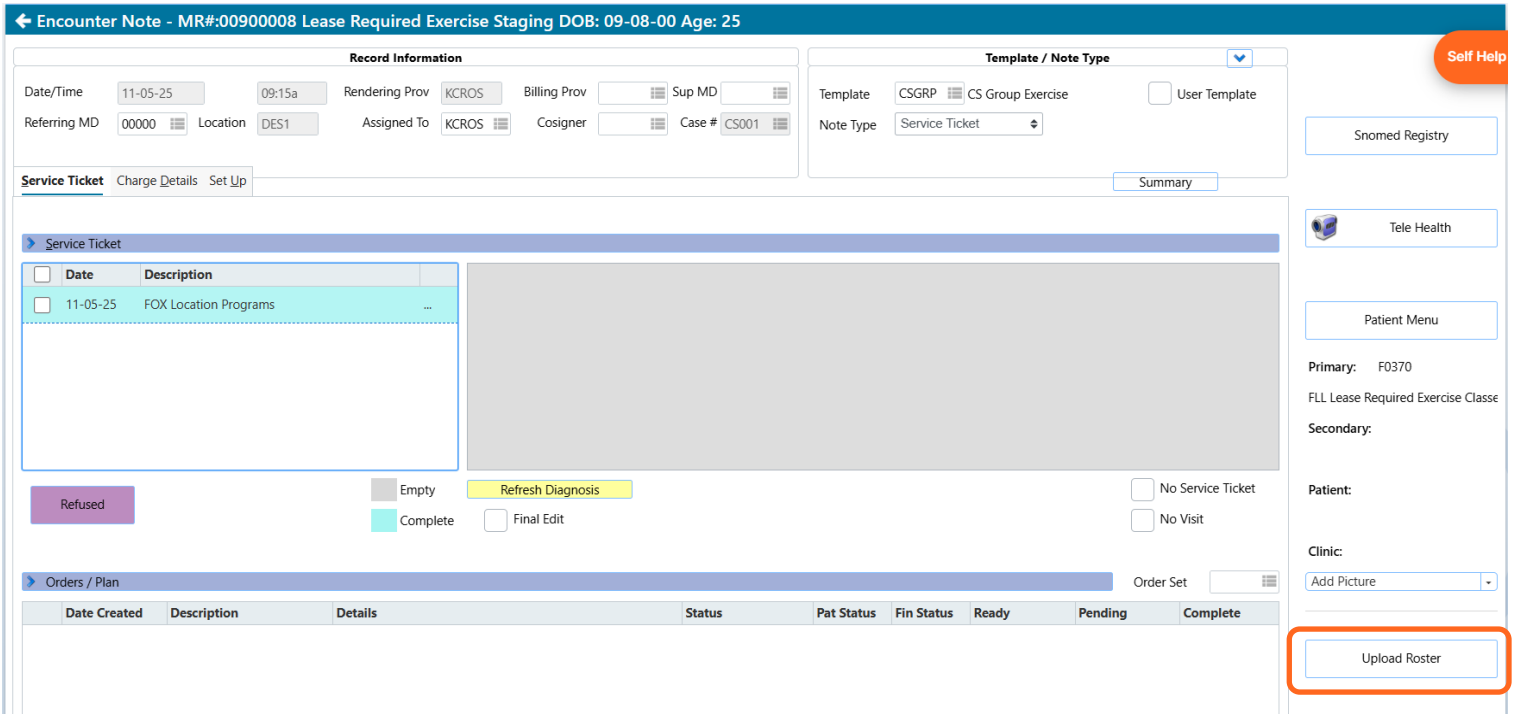
Confirmation of Successful Service Ticket

- The "FOX Location Programs" line will change color indicating successful addition of service ticket for group exercise class



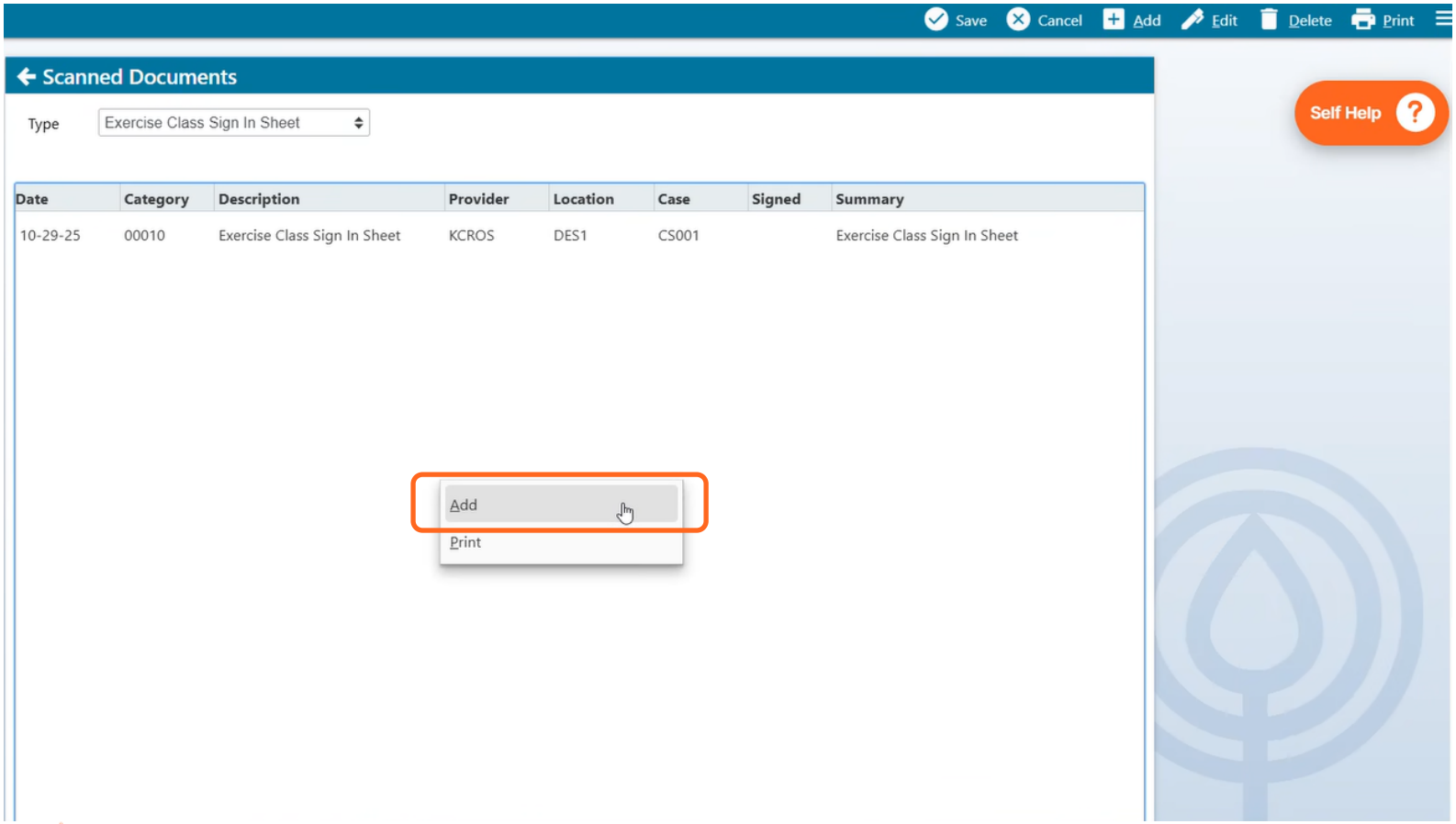
Upload Roster

- Click "Upload Roster" on the lower right side of screen to add the exercise class sign in sheet. As a reminder, this is **required** for all exercise classes



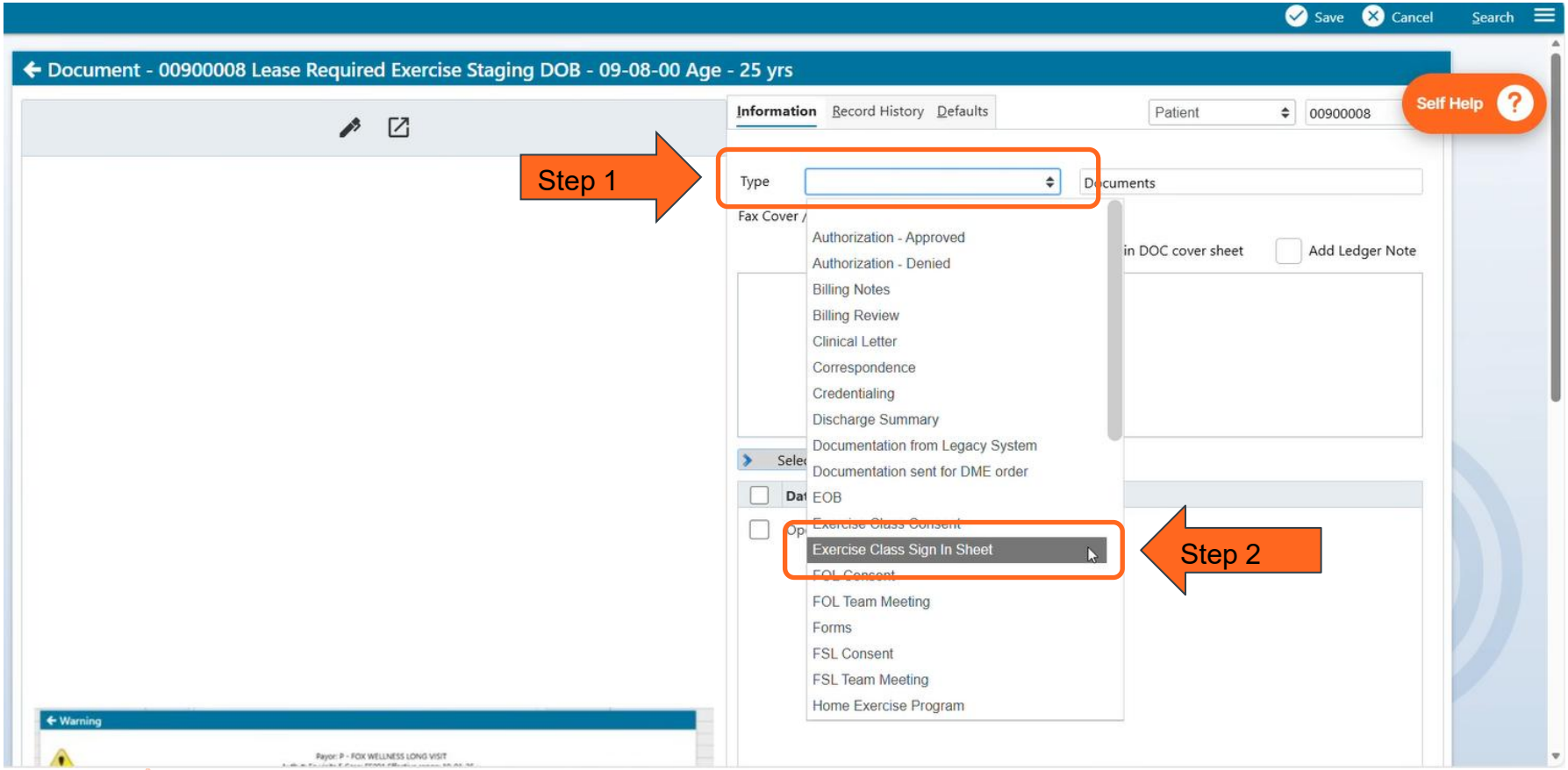
Opening Upload Screen

- Click anywhere in white area and single left click on "Add" in pop-up or click "+ Add" in upper right corner



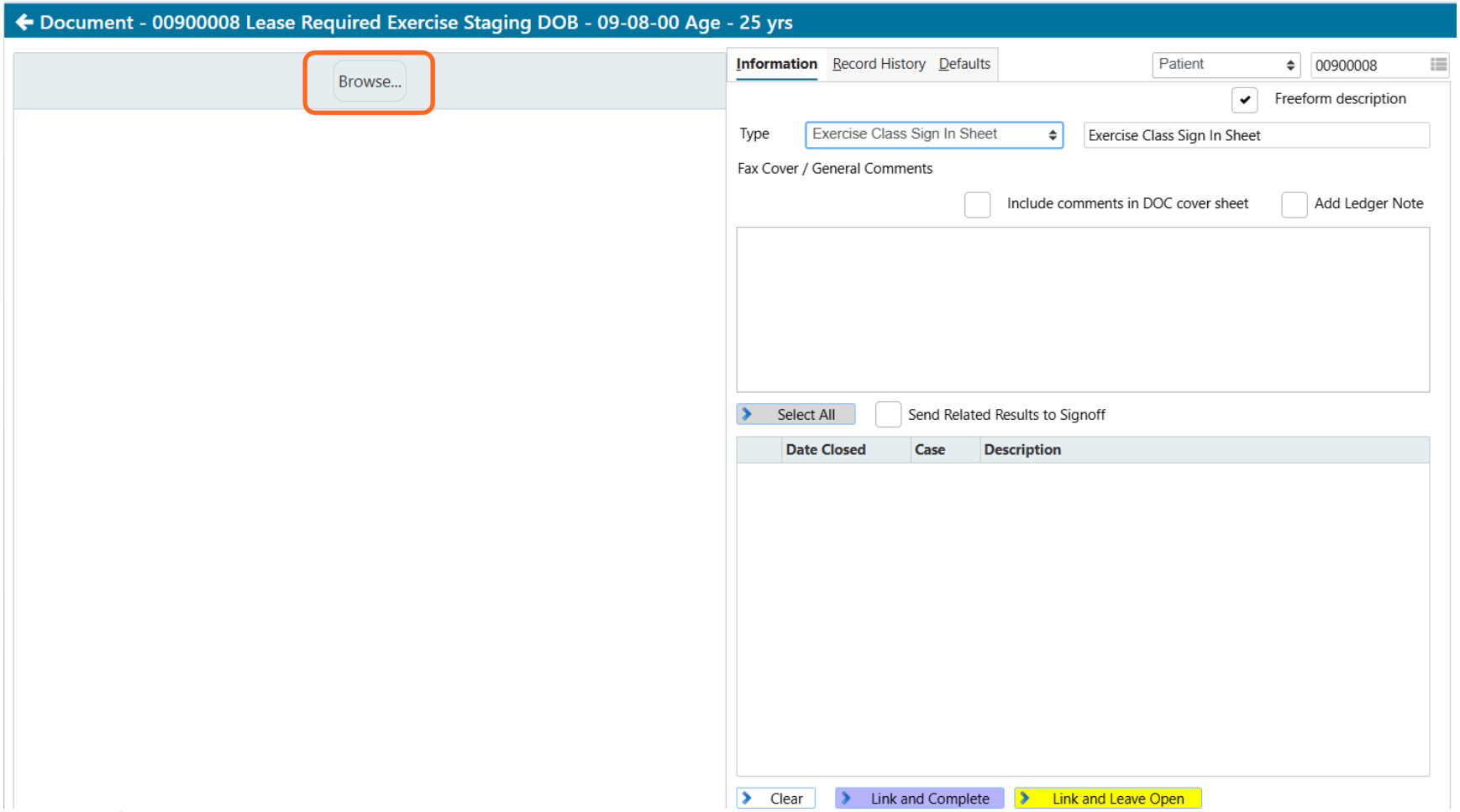
Selection of Upload Type

- Single click on "Type" drop down
- Select "Exercise Class Sign in Sheet"



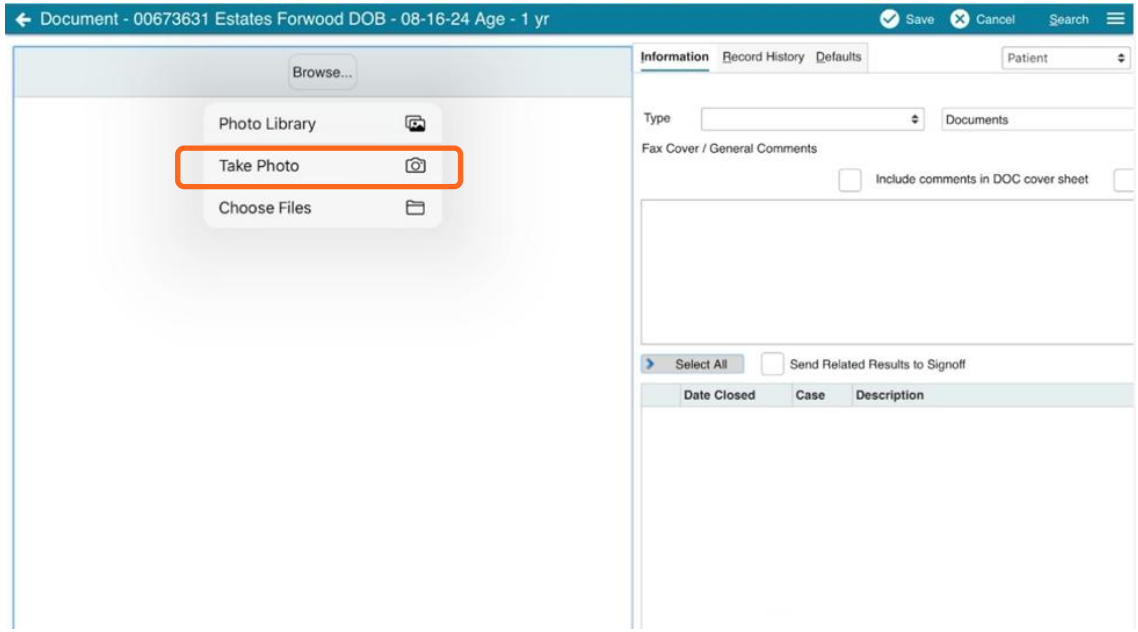
Uploading Class Roster

- Single left click on "Browse"



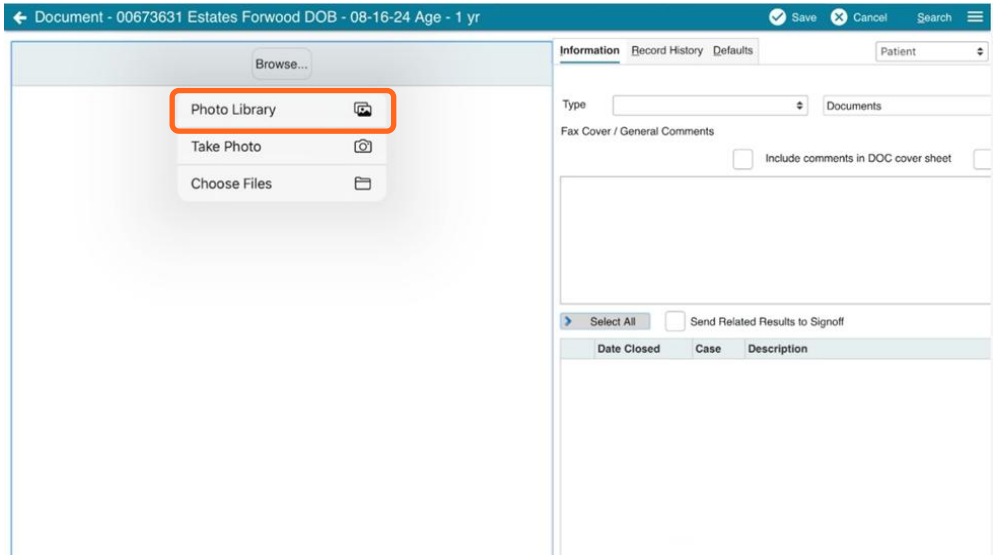
Uploading Class Roster via "Take Photo"

- Select "Take Photo" and take a picture of class roster with iPad then click "Save" in upper right corner
- Best practice is to upload the roster point of service via this method
  - If unable to complete at time of class, take a picture with the camera app and upload via "Photo Library" (see next slide)

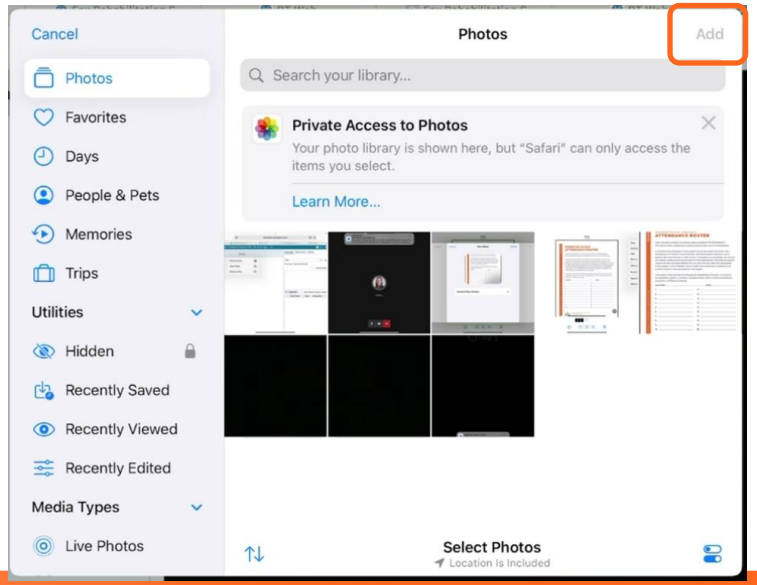


Uploading Class Roster via "Photo Library"

- Select "Photo Library"

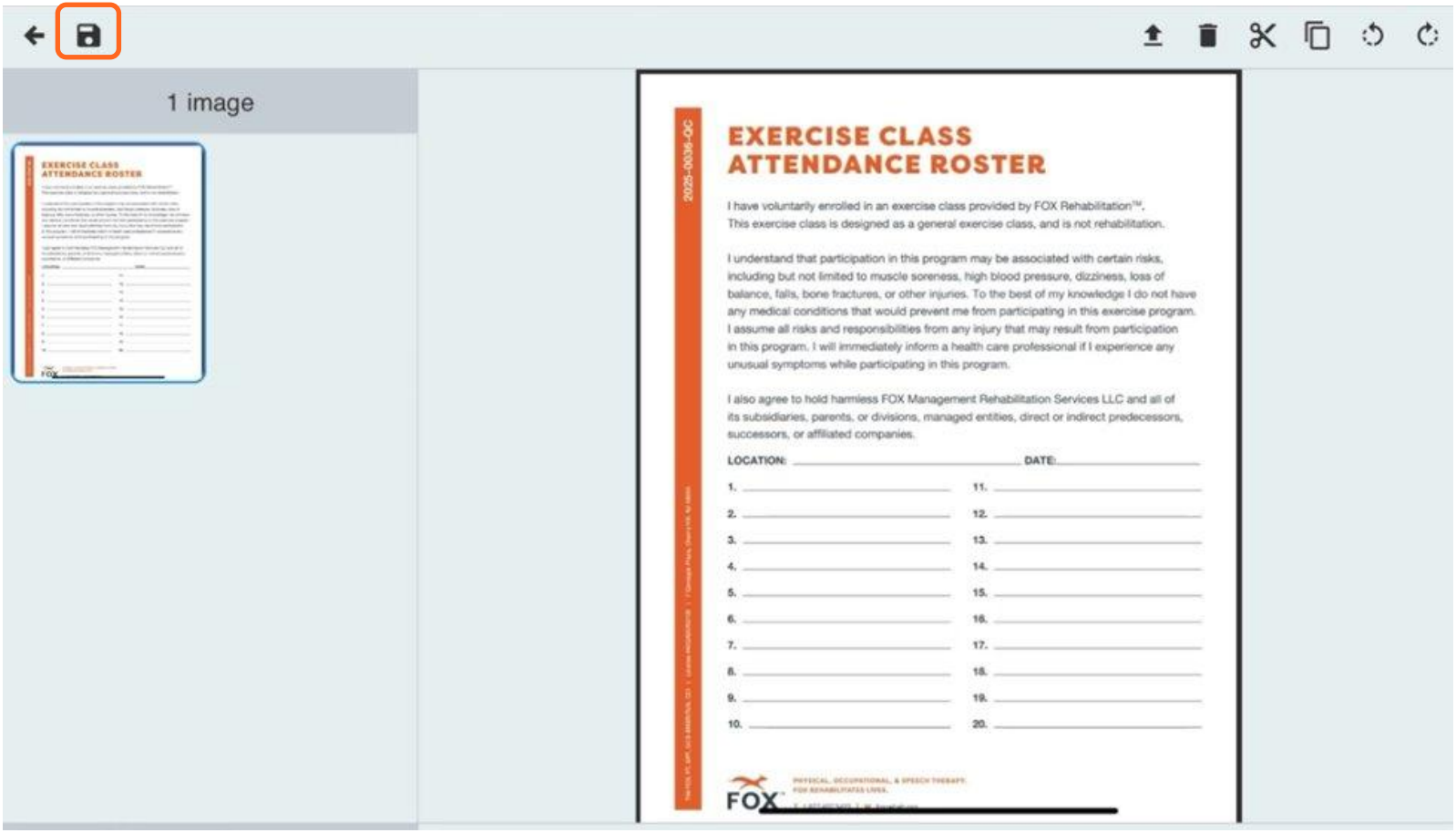


- Click on photo of class roster and select "Add"



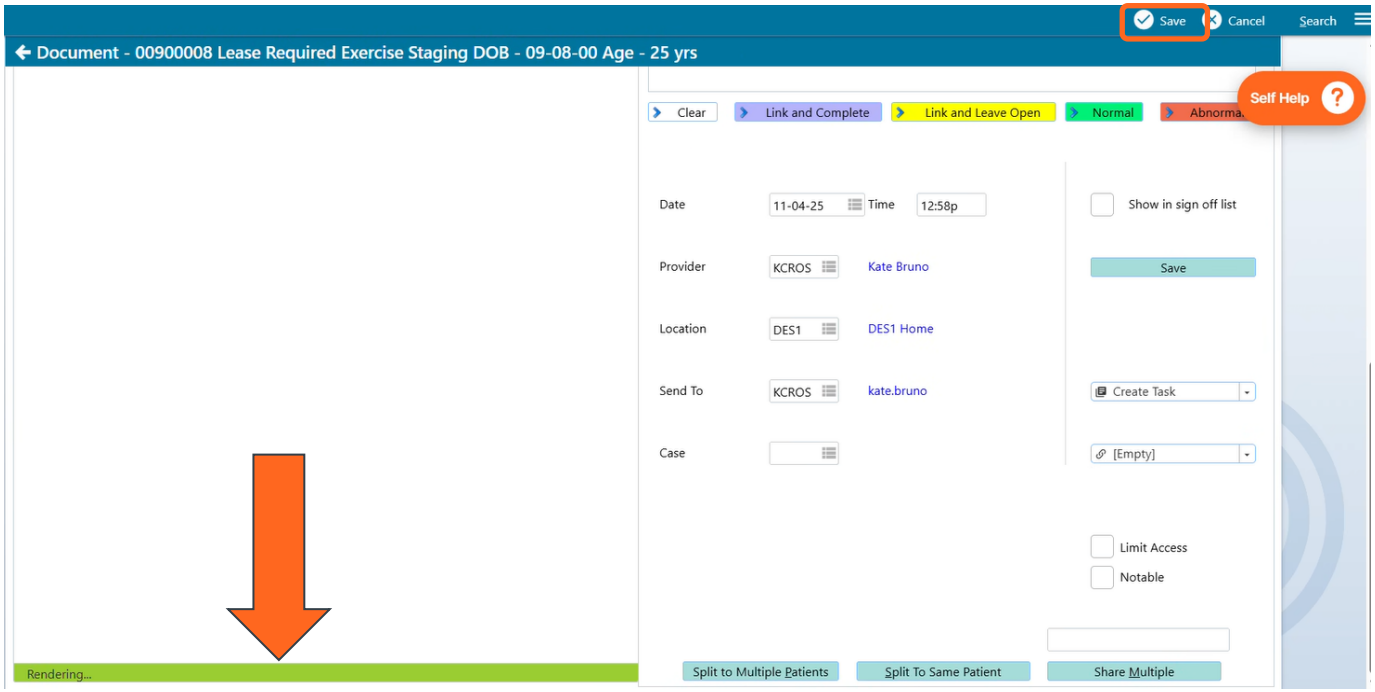
Uploading Class Roster via Photo Library

- Click "Save" in upper left corner



Uploading Class Roster

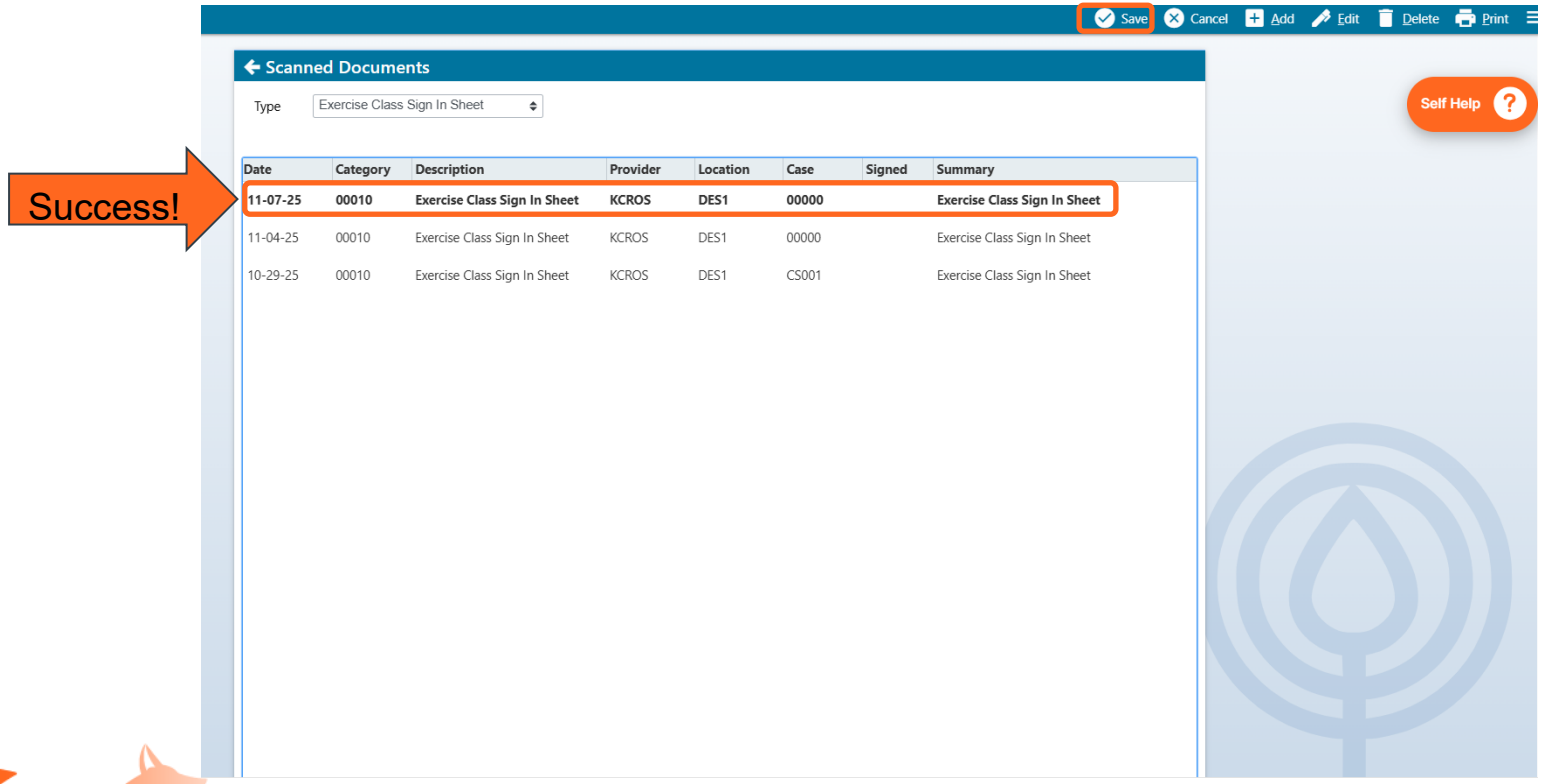
- The image may not show up immediately however, if you scroll to the bottom of the screen and see a green line, your document correctly uploaded



- Click in the upper right 

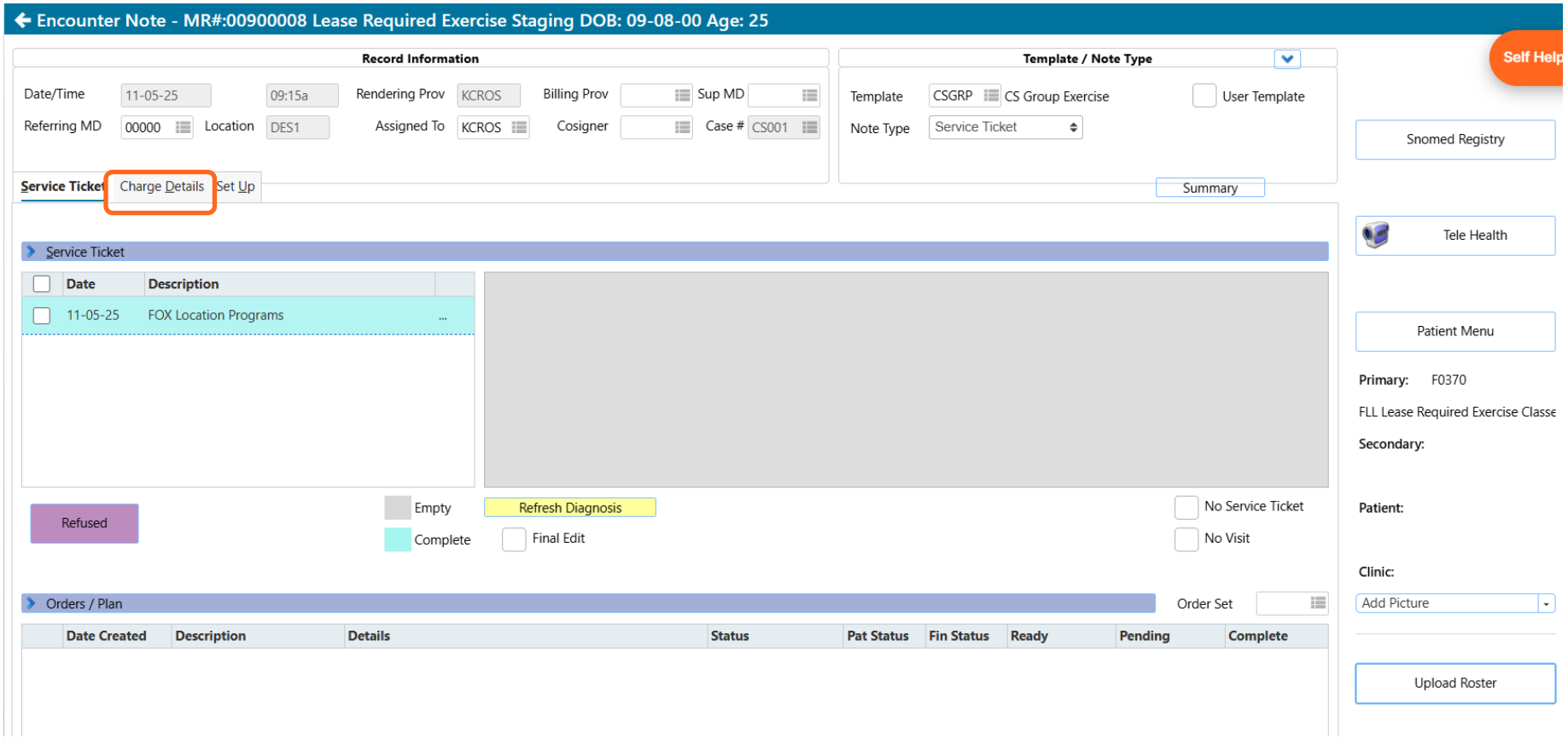
Confirmation of Successful Roster Upload

- Raintree will return to this screen. If there is a line for the date of the class, and under "Summary" it states "Exercise Class Sign-In Sheet", the roster was uploaded correctly. Click Save in upper right corner



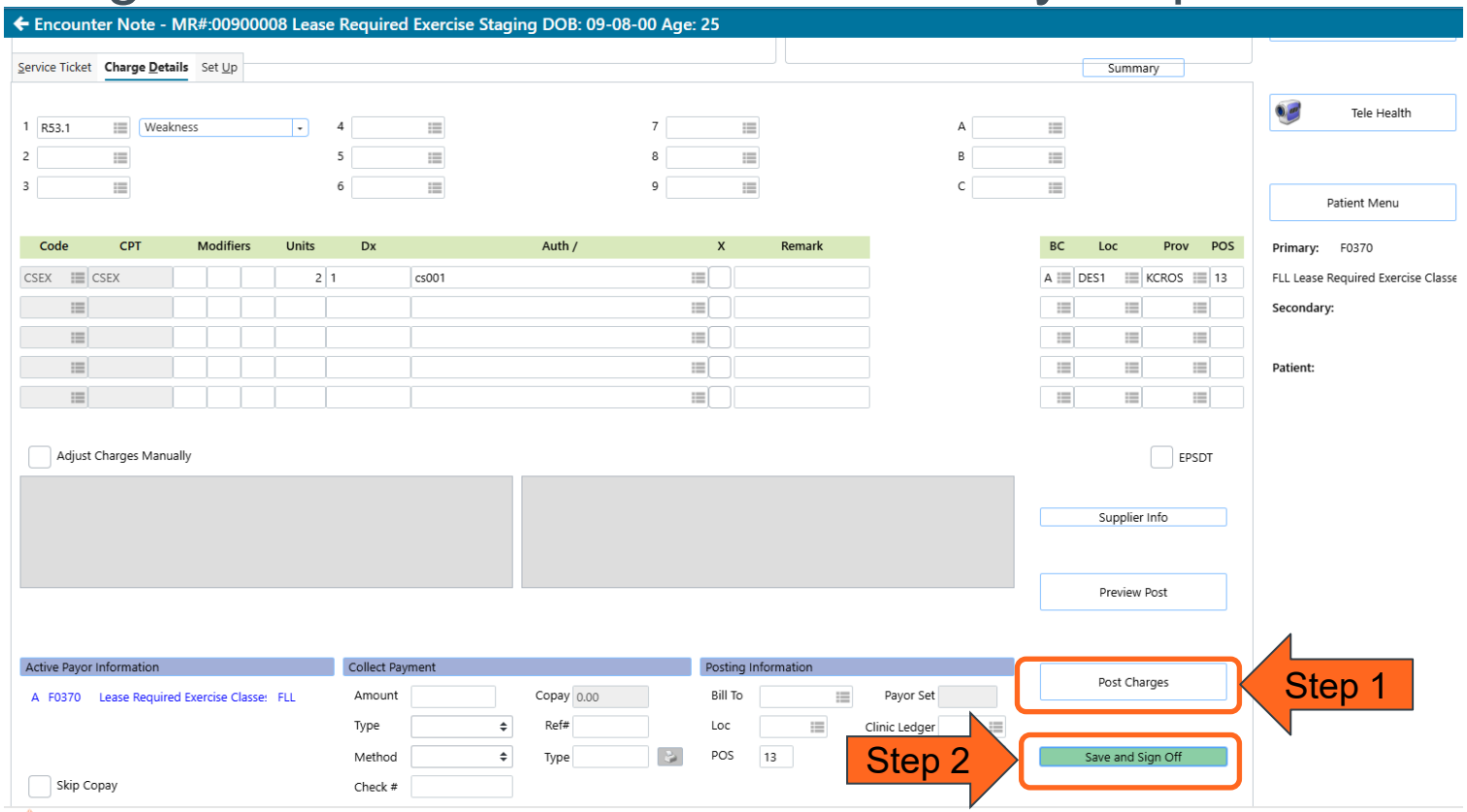
Navigate to Charge Details

- Single left click on "Charge Details" tab



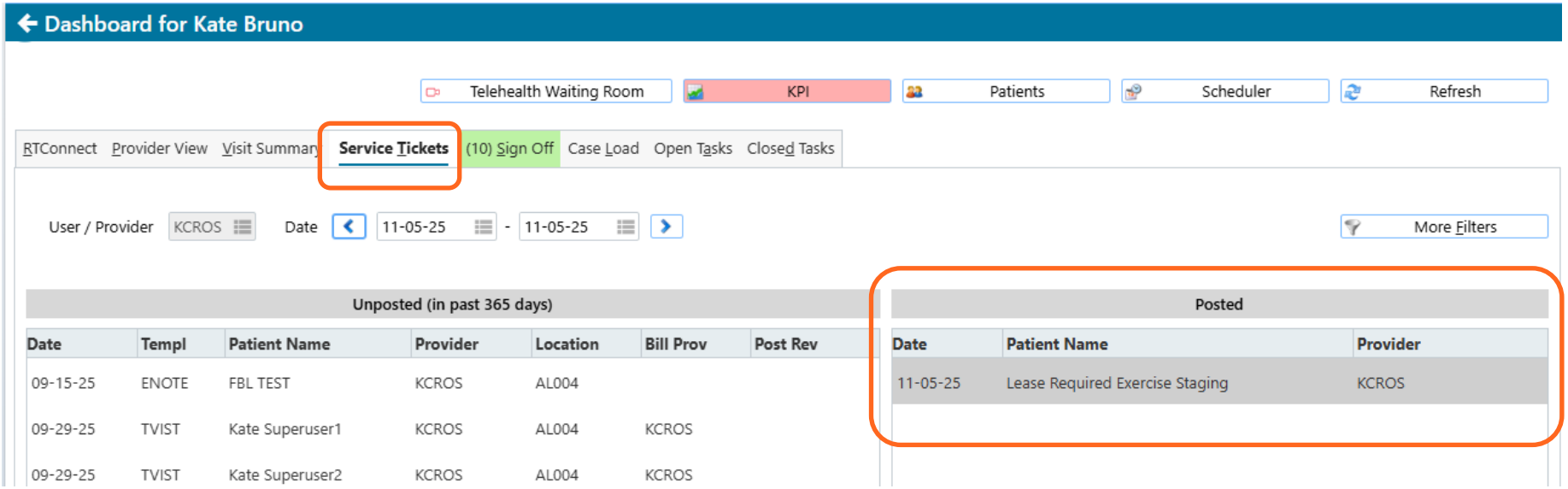
Post and Sign/Save and Sign Off

- All information needed will automatically populate based on previous actions. First click "Post Charges" then click "Save and Sign Off". You do not need to enter your password



Verify Successful Service Ticket Posting

- To determine if your exercise class service ticket correctly posted, go to tab "Service Tickets" and locate ticket under "Posted"



- You have now successfully completed a service ticket for a group exercise class!

Support Roadmap: Start Smart, Escalate Right

Have a question? Follow the path to resolution!



RT Standard

Hospice, Home Health, Skilled Private Pay, Hospital at Home

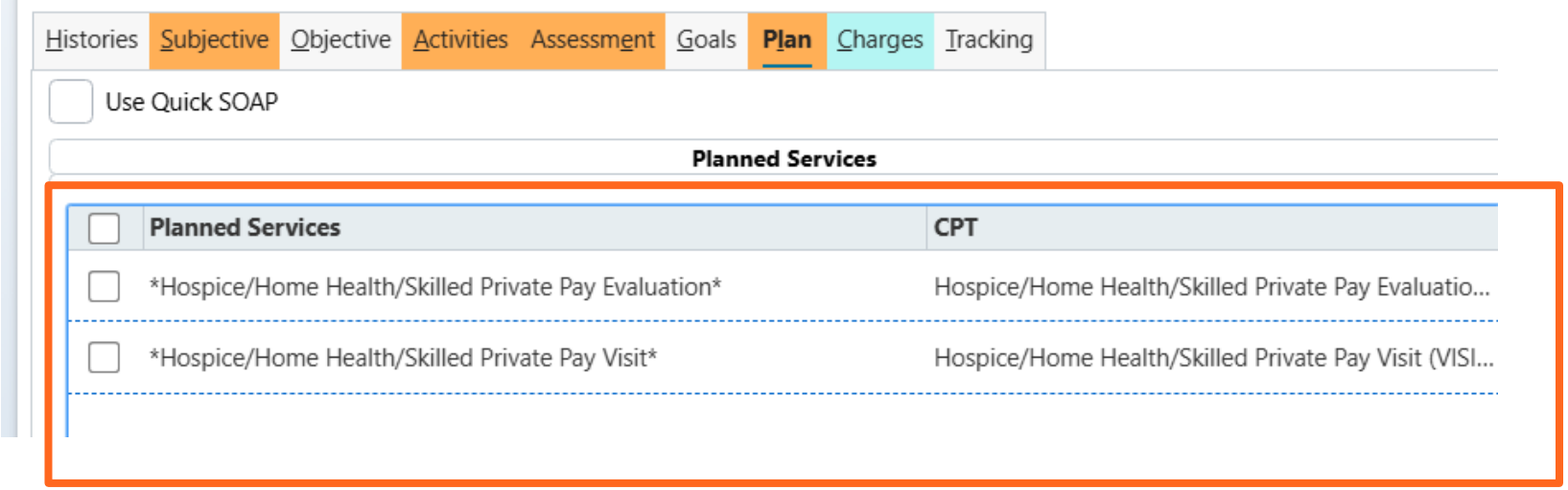


Hospice Contract/Home Health Documentation/Skilled Private Pay)

- If you are treating a patient under a Hospice contract (not through GW), Home Health in RT, Hospital at Home, or Skilled Private Pay you will complete documentation as demonstrated in the TVISTS training with a couple of modifications.
- What is the Same: You still need to schedule visits in Fox Trax and complete visit verification
- For the Evaluation
  - Load Fox Discipline specific Global Template
  - Unique workflow needed for:
    - Planned services tab
    - Service based tab

Hospice Contract/Home Health Documentation/Skilled Private Pay

- Planned Services tab
  - In order to bill for a Hospice/Home Health/PP Skilled Evaluation, you must have these item selected in the PLANNED Tab.



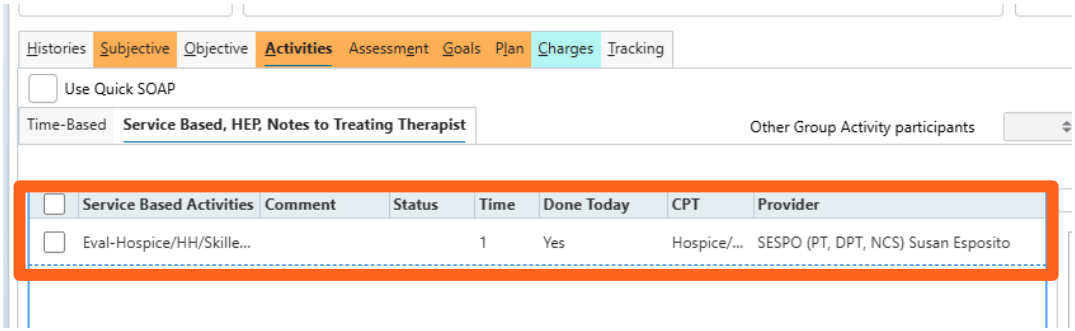
  - You also need to add your standard planned services you will work on through the plan of care (Gait training, Therapeutic Activity, Dysphagia, etc)

Hospice Contract/Home Health Documentation/Private Pay Skilled in RT- Evaluation

- Service- Based tab for **Evaluation**
  - The Evaluation will default to DONE TODAY “YES”.... you need to **DELETE** this entry



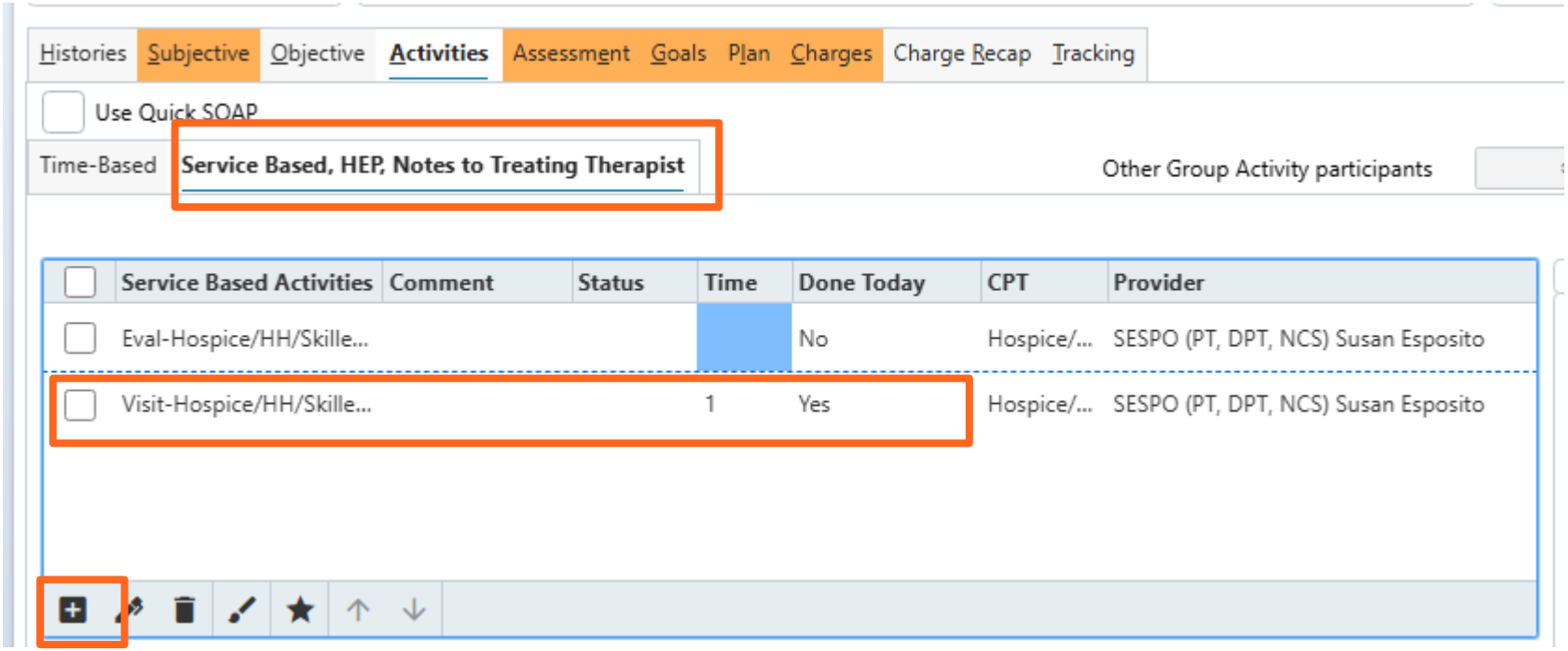
  - Manually select " **Eval- Hospice/HH/Skilled PP**



It will default to 1 minute and Done Today YES; **you will then have to put your actual time under the correct CPT codes in the time based/service-based tab as appropriate**

Hospice Contract/Home Health Documentation/Private Pay Skilled in RT- Daily Note

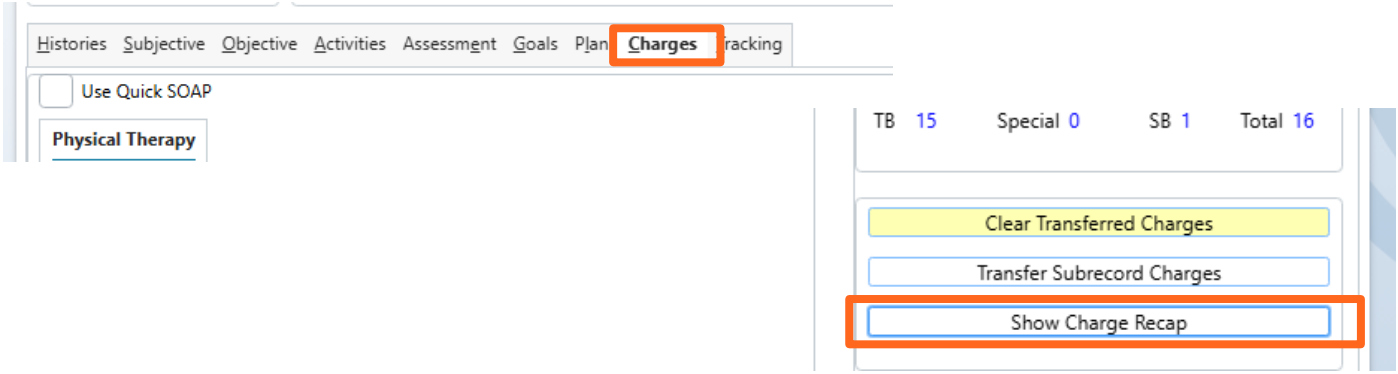
- Time Based service tab for **Treatment** (Treatment/PRs/DC billable visits)
  - **MUST add in Visit-Hospice/HH/Skilled PP to get unit credit for this visit**
  - Select YES in Done Today and confirm 1 minute populated for treatment/PR/DC billable notes in order to get unit credit.



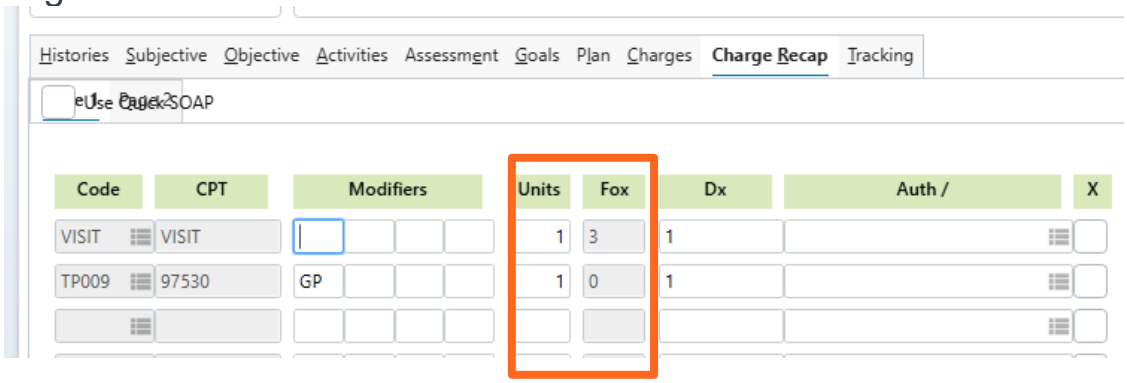
  - **You will then have to put your actual time under the correct CPT codes in the time based/service based tab as appropriate**

Hospice Contract/Home Health Documentation/Private Pay Skilled in RT

- Charges
  - To view charges for these notes…
    - Go to charges tab> select " Show Charge Recap" in bottom right



- The number of units received per visit is based on the contract rate NOT on CPT codes selected; this information is within the assignment email



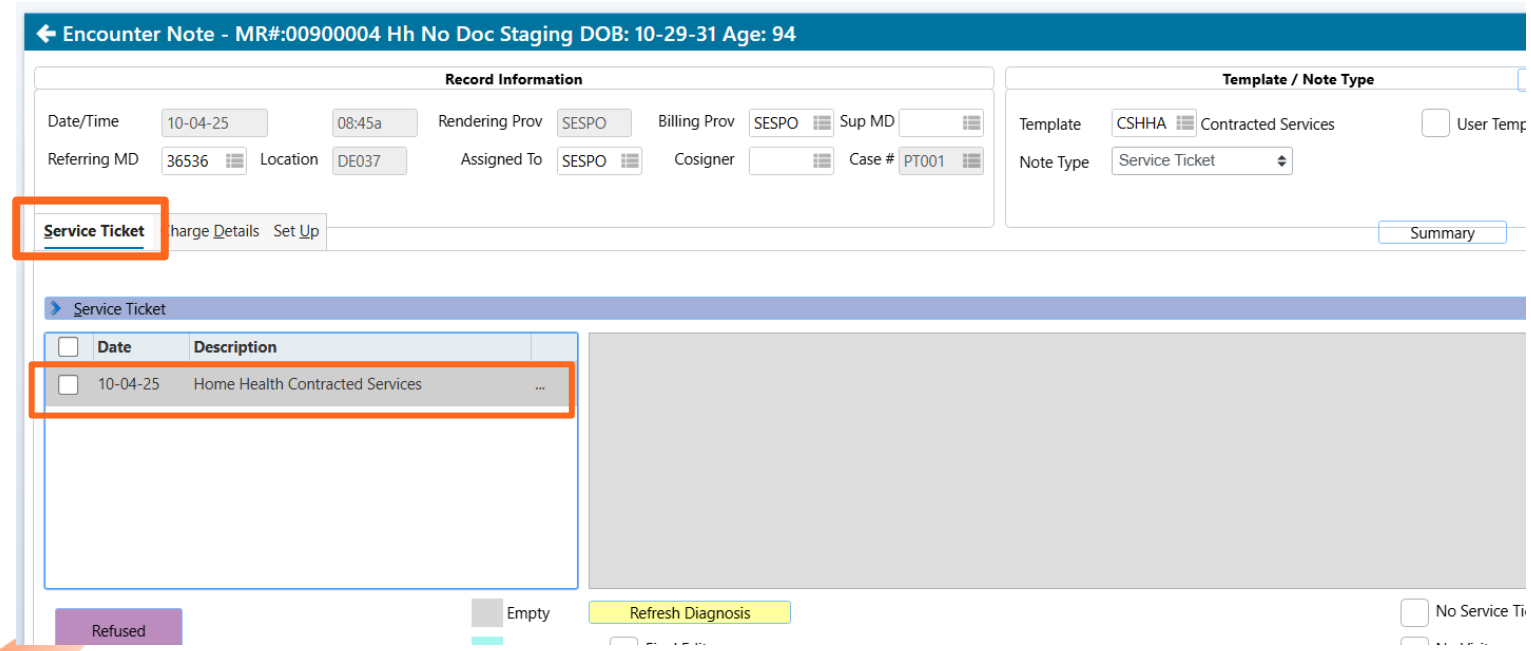
*** This visit was 3 units

Hospice (No Contract) | GW Modifier

- Pre-Admission
  - If an open Hospice certification is identified when running eligibility, Admissions will add the information on the patients insurance.
  - An “Alert” will be added to the account which is visible in FOX Trax and when accessing the patient account in RT *(This patient has an active Hospice case, please verify that care you are providing is not related to the hospice diagnosis and document this acknowledgement in your clinical note)*
  - The GW modifier will be automatically added to any charges during the certification date range.
- Post-Admission
  - If a clinician finds out or a patient enrolls in hospice after our start of care and determines that their treating diagnosis’ do not relate to the hospice diagnosis.
  - Create a TASK in RT “Clinical_Hospice Alert” to notify the Admissions Team to update the insurance information in order to have the GW modifier applied.

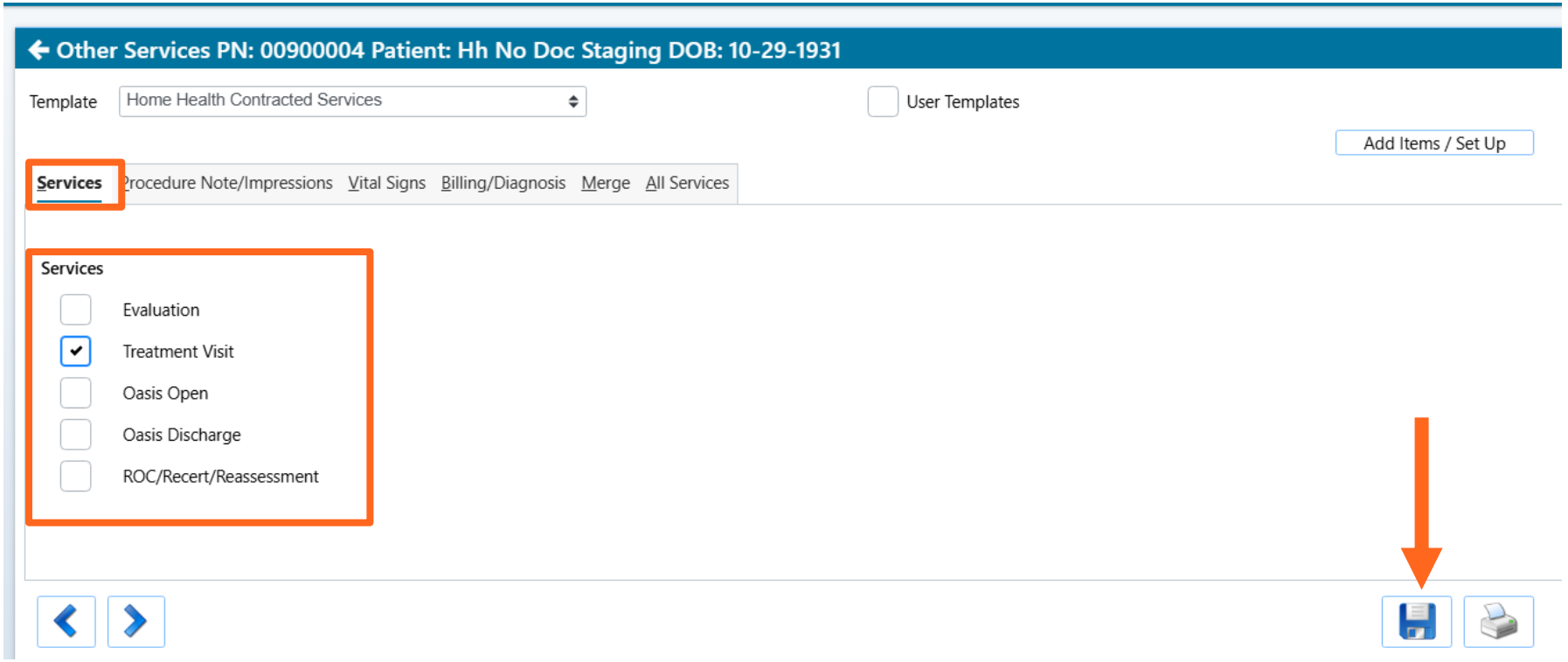
Med A / Home Health- No documentation in RT

- If you are completing documentation for home health in a different platform, you will still need to create a service ticket in order to get unit credit for the home health visit
- Schedule visit in FoxTrax; if you do not schedule the visit in Foxtrax, you will not be able to create a service ticket
- Check In visit. This will initiate an Encounter Note (e-note)
- Click into “Home Health Contracted Services” in the Service Ticket tab
-



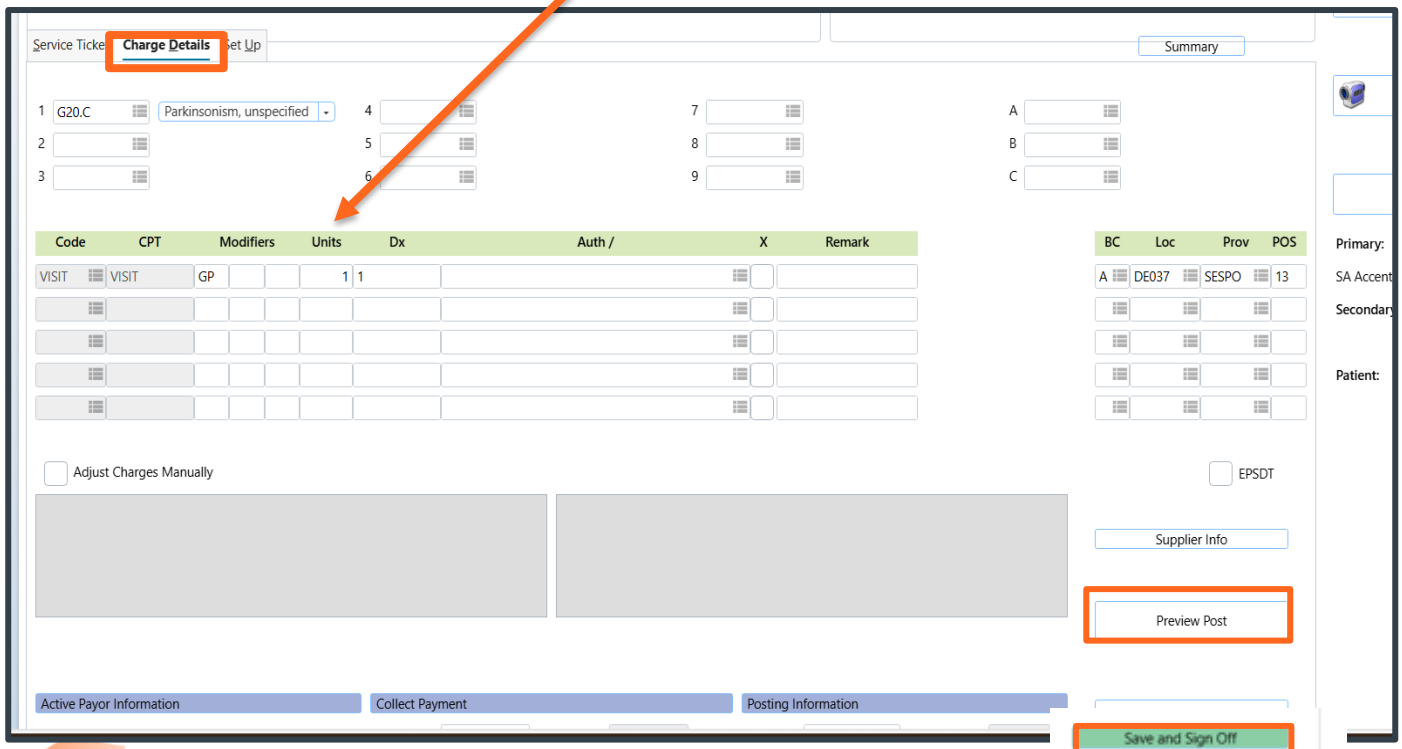
Med A / Home Health- No documentation in RT

- Select appropriate visit type for that date of service
- Select Save in bottom right



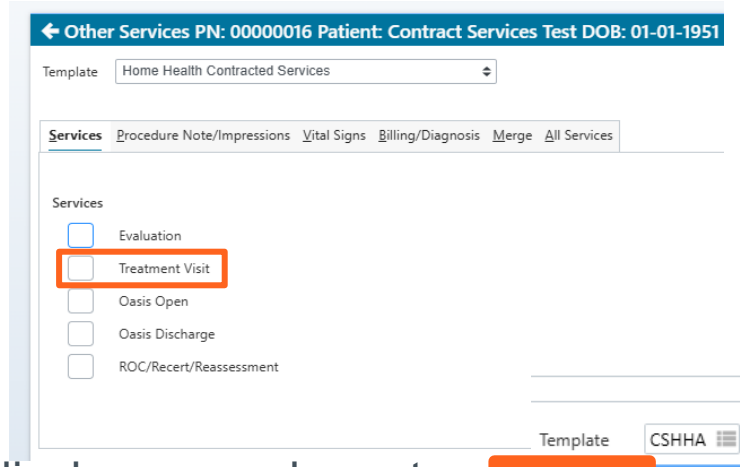
Med A / Home Health- No documentation in RT

- Click on charge details tab
  - Do not have to type anything into any of these boxes
    - There will be an ICD10 code preloaded into this box; do not need to add/modify/remove this
- Click Post charges in bottom right (You will see 1 unit for these cases, true units will be displayed on your Tracking Log)
- Save and Sign off.. You will not have to put in your PIN number upon signing.

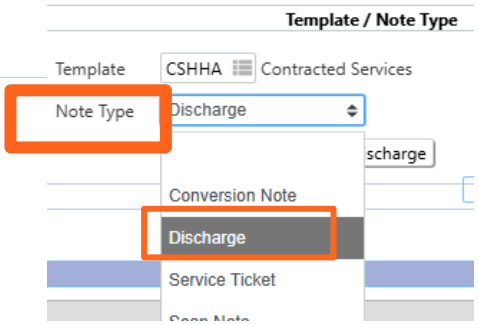


Med A / HH- No documentation -Billable Discharge

- If you are completing a billable discharge visit (not a DC OASIS)
- Complete ENOTE like you would for each treatment note selecting and under services select " treatment“

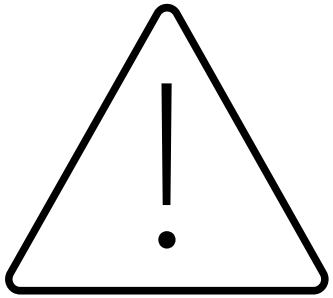


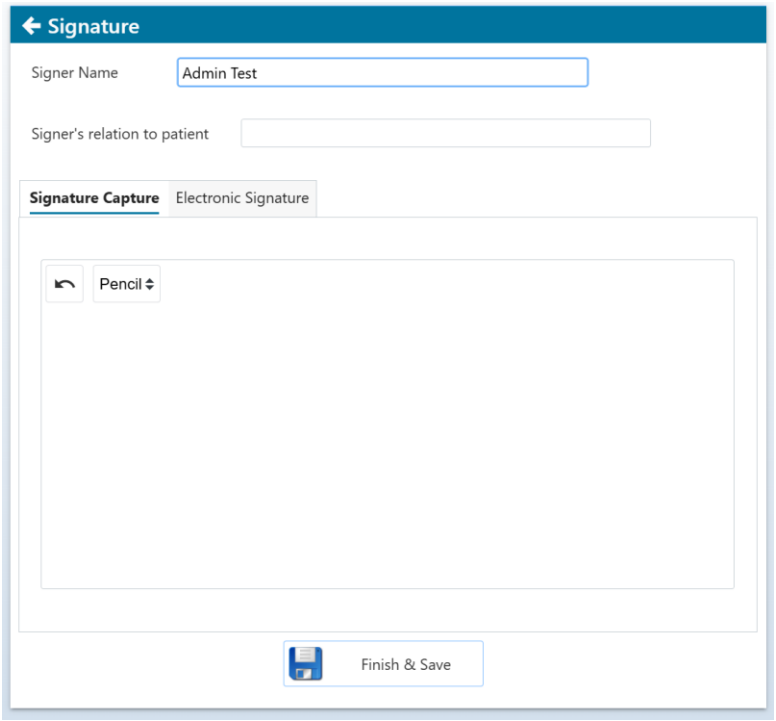
- In order to label this visit as a discharge, under note type select “ discharge”
- If it is a NO VISIT discharge; change note type to discharge and select no visit/no service code under service ticket tab





Consent NOT Required | Strategic Accounts

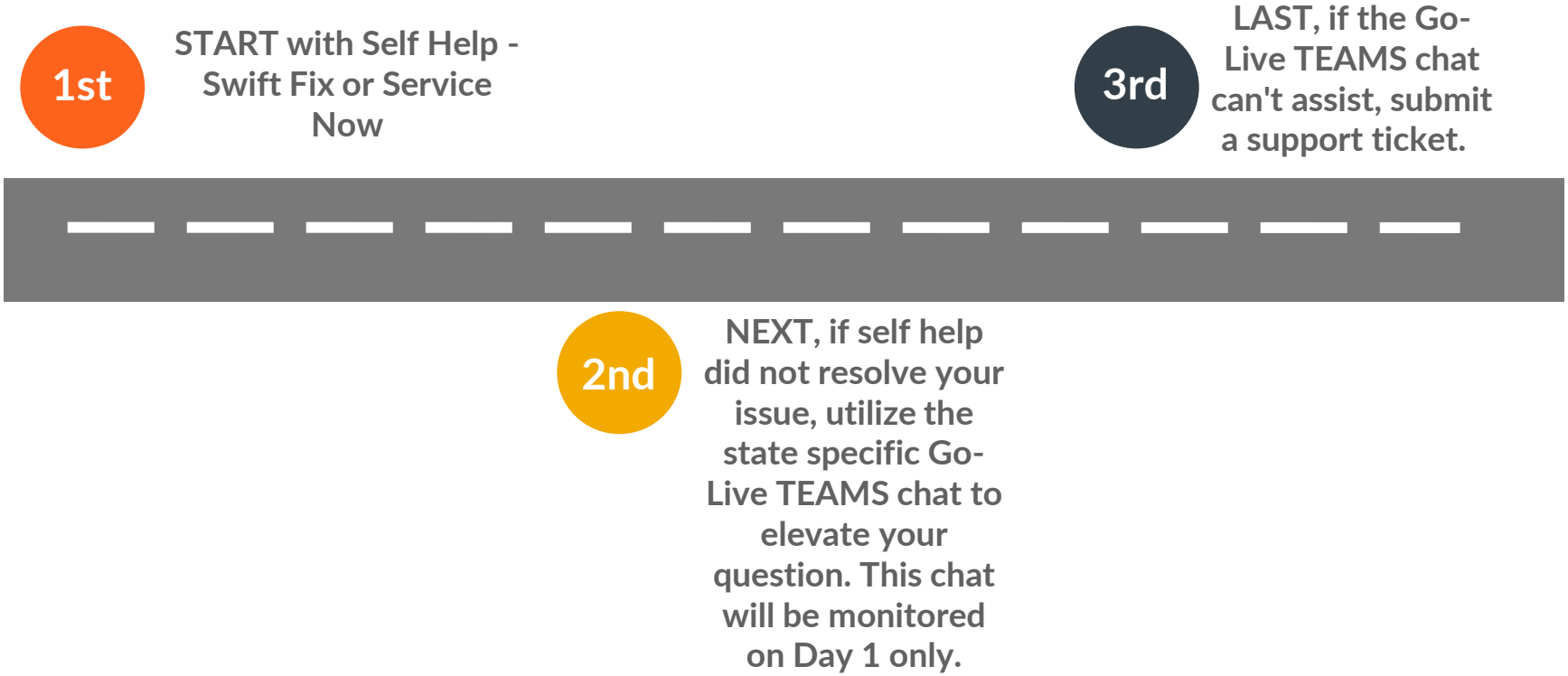




- You may be prompted to sign Patient Forms for patients where it is not required for Strategic Account patients.
  - For the additional forms, if prompted to complete:
    - Click Signature
    - In Signature box enter ***"Strategic Account, RT Consent not required"***
  - Otherwise, you will be continually prompted to complete at each "check-in"

Support Roadmap: Start Smart, Escalate Right

Have a question? Follow the path to resolution!



RT Standard: Self Help & Support



What is Self Service Support

- **Self-service support** allows users to solve common problems on their own using technology.
- FOX implements this through:
  - **Swift Fix** Self Help (powered by Whatfix)
  - New **ServiceNow** Support Ticketing System



How it Supports the RT Transition

- As FOX moves from RT Custom to RT Standard, self-service tools will:
  - **Accelerate onboarding** by providing immediate answers.
  - **Reduce dependency** on live support for routine issues.
  - **Enable proactive learning** through searchable knowledge bases and guided workflows.
  - **Support scalability** as more clinicians adopt RT Standard.
  - Allows for dynamic learning and updates
    - DO NOT download any documents or PowerPoints. We are continually updating these.



Self Service Support

servicenow +

- New support ticketing system launched Oct 2025
- App based
- Self-service support
- Track ticket history
- Real time updates
- Virtual Chatbot (planned for early 2026)

swift fix Self Help ?

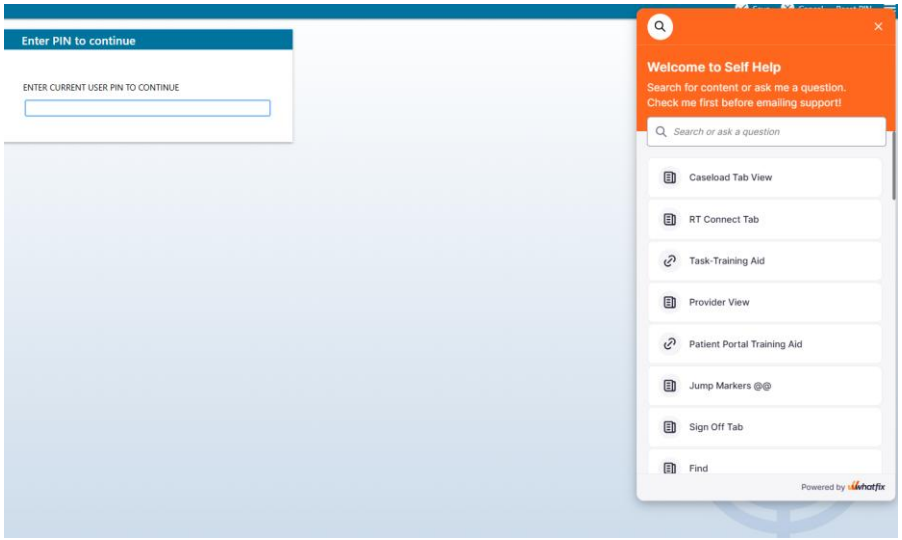
- Swift Fix Self-help in Raintree (powered by Whatfix)
- Available in RT Custom and RT Standard
- Provides AI-generated responses
- Allows launching Service Now support tickets
- Accessible only on FOX-issued devices (not available on BYOD)



How It Works: Swift Fix

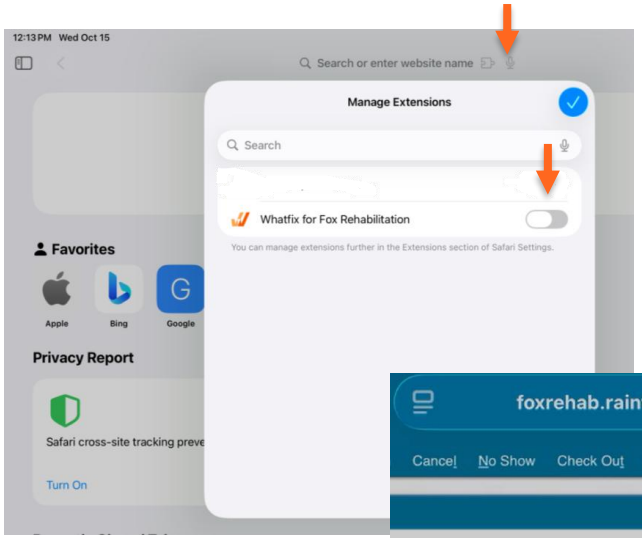
Swift Fix Self Help in Raintree

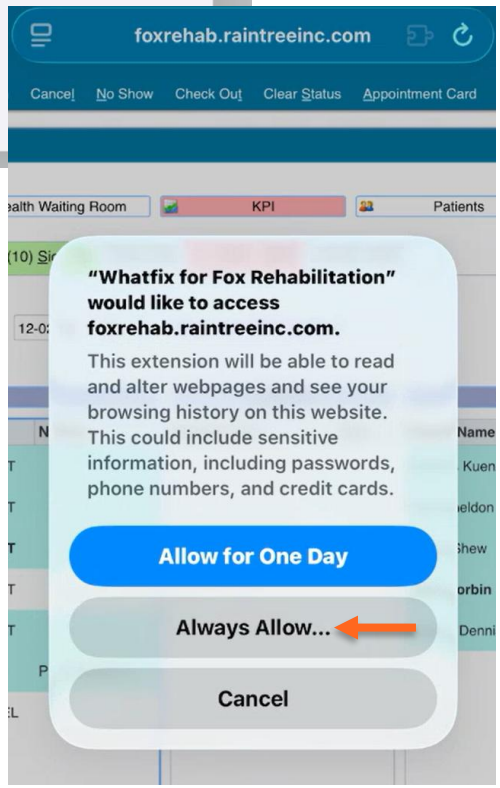
- Provides articles, videos, and guided workflows to assist users step-by-step.
- The **Self Help** feature lets clinicians quickly ask questions and find answers without leaving Raintree.
- For iPad, follow next slide to ensure Swift Fix is turned on
  - For Chromebook and Window devices, the Self Help will automatically display.



How it Works

- **Whatfix (Swift Fix)**
  - The app will show on the FOX home screen, but it will need to be turned on in the Safari Browser on the iPad
  - Once it is turned on, it will display when you open the RT web app(s).
  - Click **Safari**
    - Click the puzzle icon in the search bar
    - Click Manage Extension
    - Toggle on Whatfix so the button turns green and click blue check box
    - Click puzzle icon again and Whatfix.
      - Prompt to allow access will display
      - Click Always Allow
      - Next prompt, click Allow on Every Website





How it Works: Swift Fix

Swift Fix Self Help in Raintree

- Self Help enables you to interact with different of types of content.



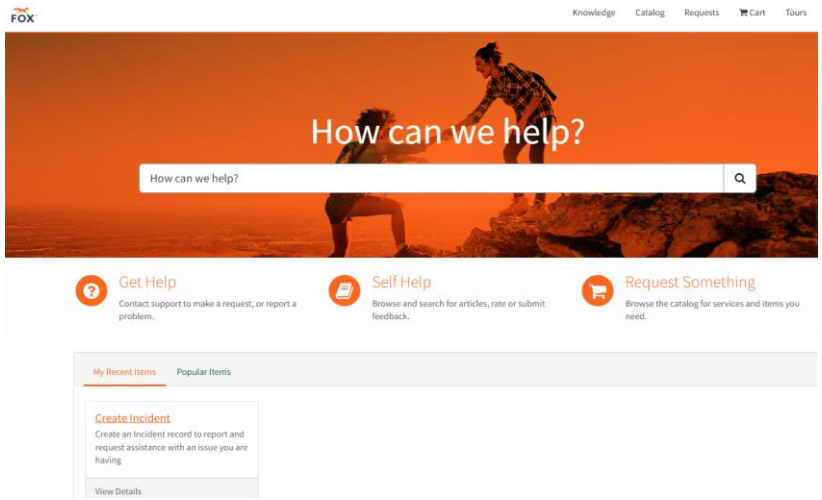
Feature	Icon	Description
Flows	Flow	Add Flows within the Self Help widget that help your end users learn an objective or complete a task.
Video	Video	Add Video content in the Self Help widget to enhance your content with additional information.
Article	Article	Use Articles to provide relevant information to end users within the Self Help widget.
Link	Link	Link your external resources, such as support articles or content hosted externally to Whatfix.
Image	Image	Add Images within the Self Help widget to make your content more visual .
PDF	PDF	Use PDFs within the Self Help widget to provide additional information.
Group	Group	Use groups to organize content within the Self Help widget.

How It Works: Service Now

servicenow

ServiceNow Support Ticketing System

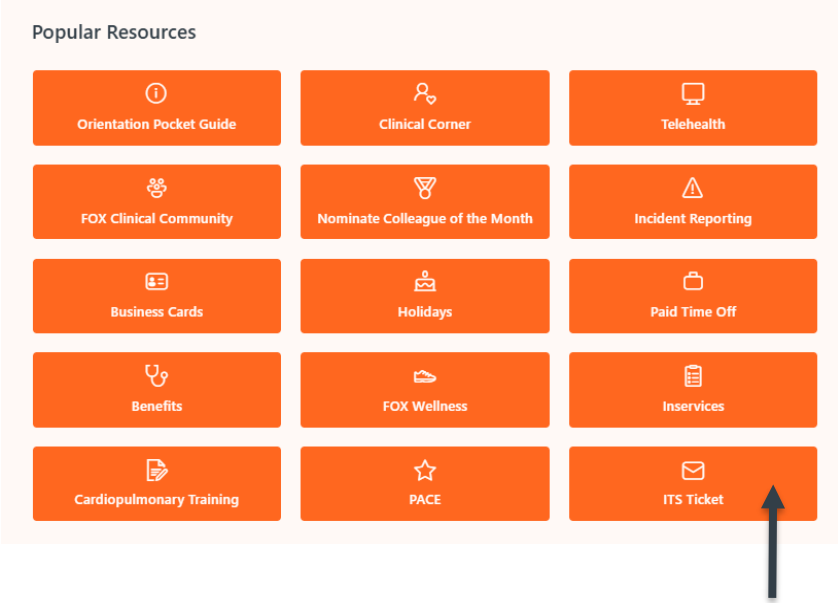
- Replaces Zendesk (old ticketing system) with a more robust platform for submitting and tracking support tickets.
- Key features include:
  - Real-time ticket updates
  - History tracking
  - Integrated Self-Help portal
  - Future virtual agent/chatbot support
- Users can submit tickets via the ServiceNow portal or email address (support@foxrehab.org)



How It Works: Service Now

ServiceNow Support Ticketing System

- Access from FOX4U home page under Popular Resources
- Coming soon-App on iPad



How It Works: Video Demos

Click for Swift Fix Video



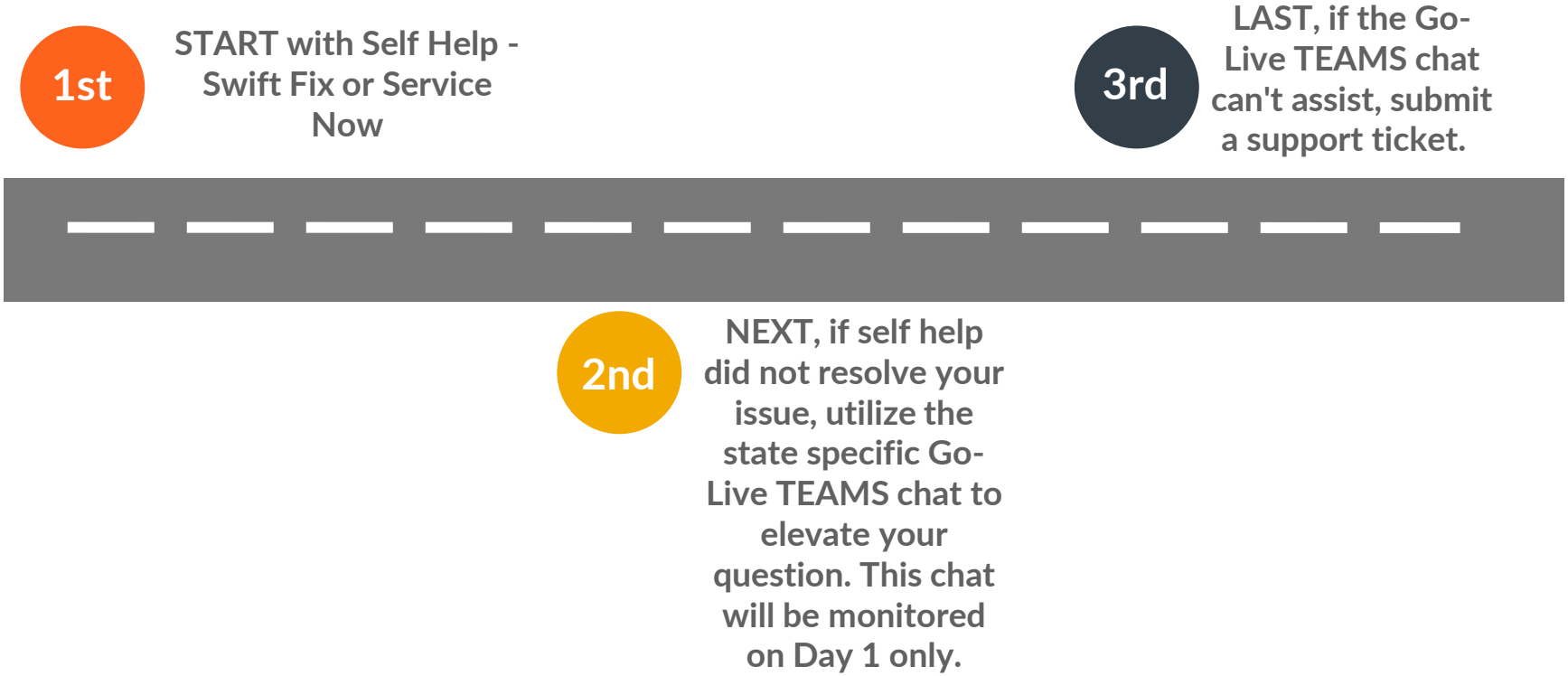
How It Works: Video Demos

Click for Service Now Video



Support Roadmap: Start Smart, Escalate Right

Have a question? Follow the path to resolution!



RT Standard

Conversion Notes

and first Progress Report after Conversion



What Are Conversion Notes?



Conversion notes are informational documents that help bridge the transition from RT Custom to RT Standard



Provide key case details in one place without needing a new evaluation or progress note



Conversion notes are not signed and have no associated charges (will remain green).



Goals and Planned Interventions from conversion note carry forward to allow addition of activities and treatment interventions in the first tx note.

How Conversion Notes Work



This process maintains the plan of care, visit tracking and required fields needed for daily note sign off.



Conversion notes are generated for all PT, OT and SLP cases, including wellness cases however reviews are not required for wellness cases; this documentation will be different in RT Standard.



Conversion note data is pulled from the latest note in RT Custom, even if the data isn't visibly displayed, it does exist in the background.



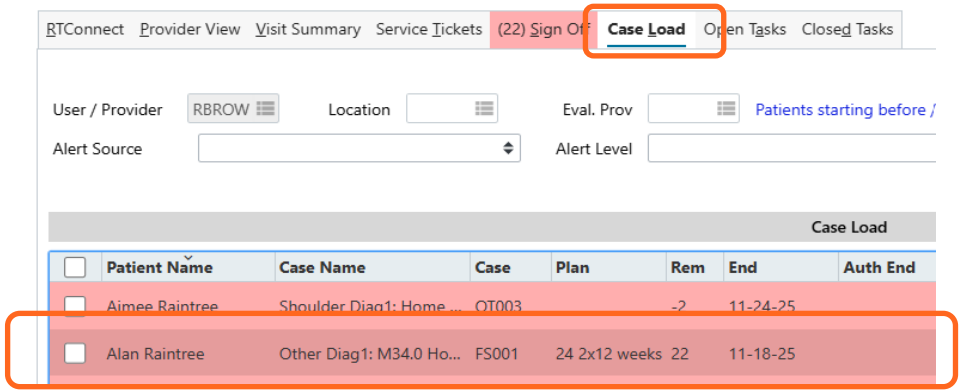
The conversion note WILL NOT include daily treatment interventions.

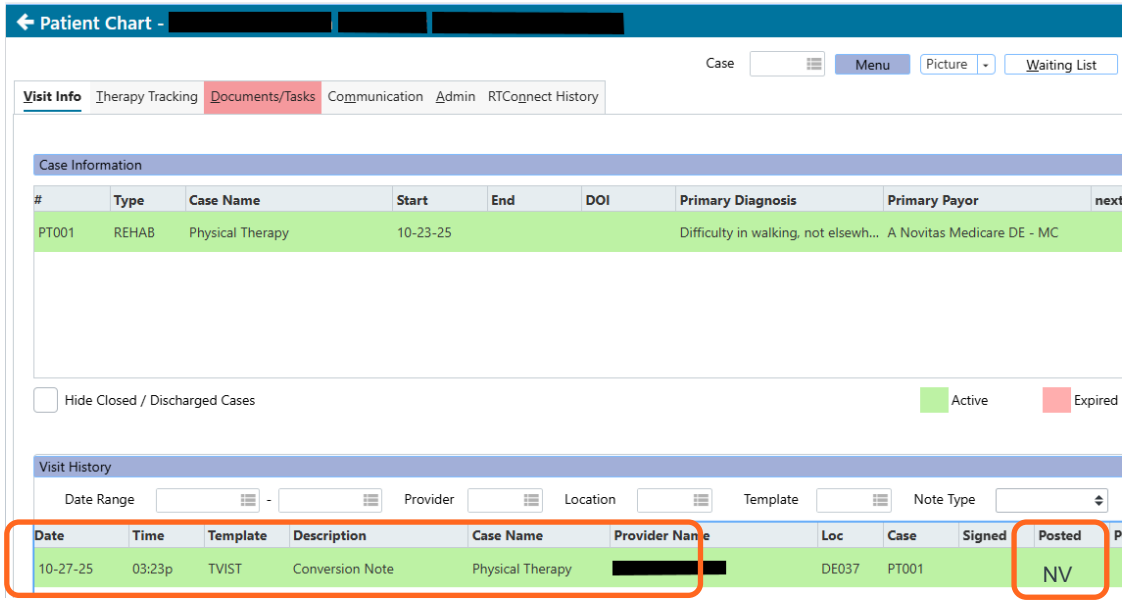
Accessing Conversion Notes

Access Conversion Notes:

- Double-click the Caseload Tab to open a case.
- Double-click under Visit History to open.
- Once reviewed and saved you will see "NV" (No Visit) populate under posted.

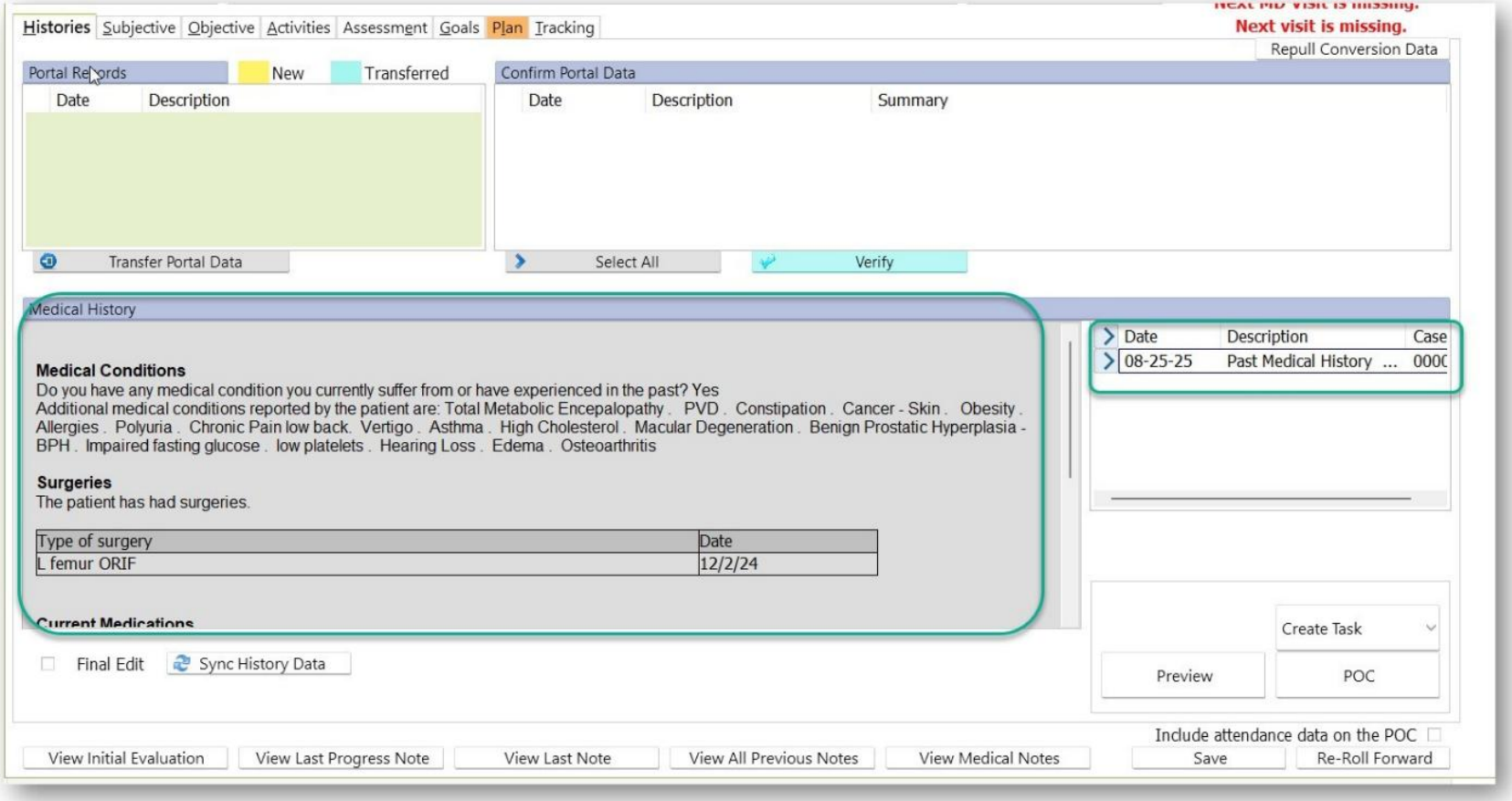
Do not open a clinical note before completing the conversion note, as this may cause important information to be missing and affect your ability to post the note.





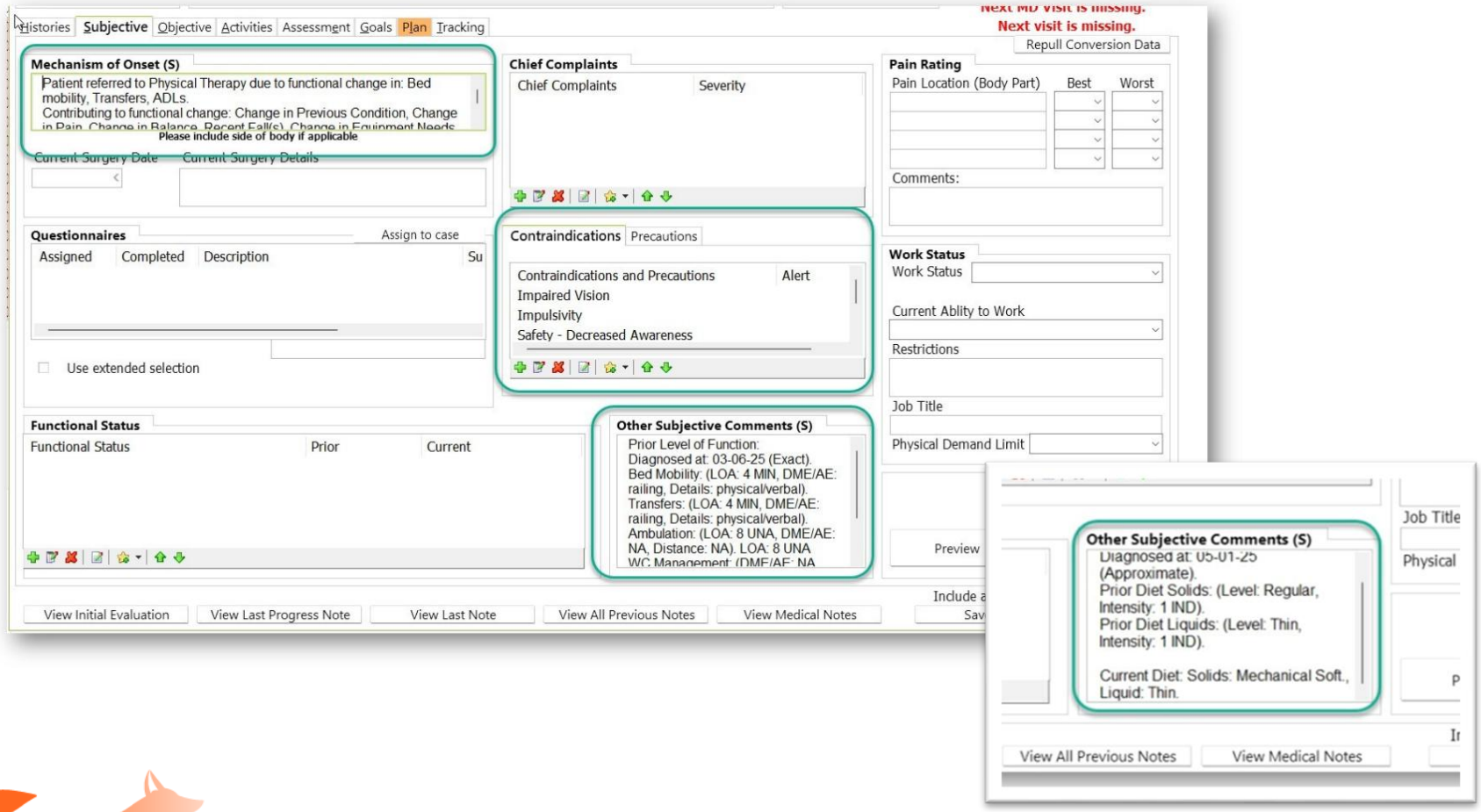
Conversion Note Review

Histories> Medical History: Review Required



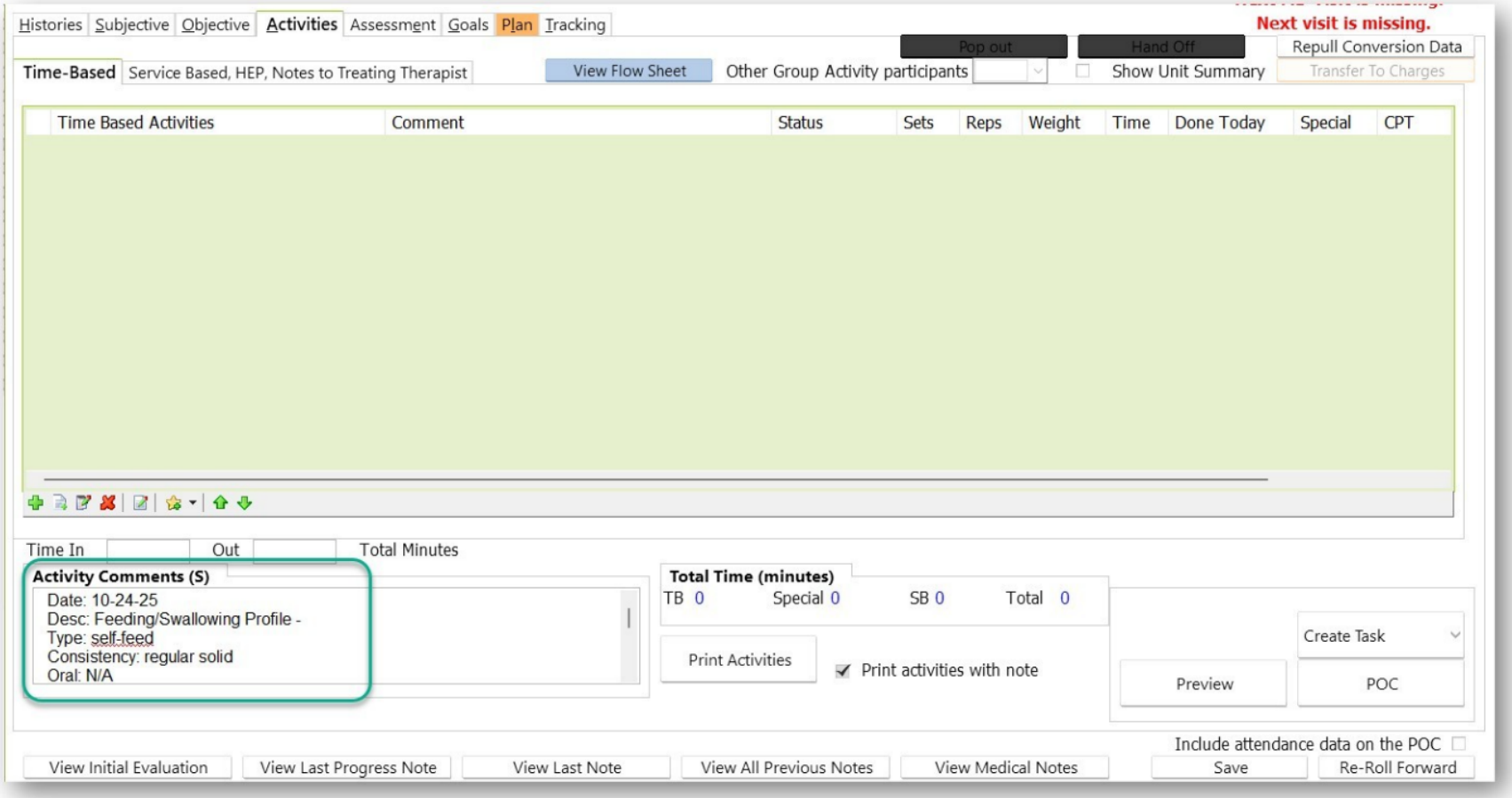
Conversion Note Review

Subjective > Mechanism of Onset (HPI), Contraindications & Prior Level of Function (Current Diet-SLP): Review Required



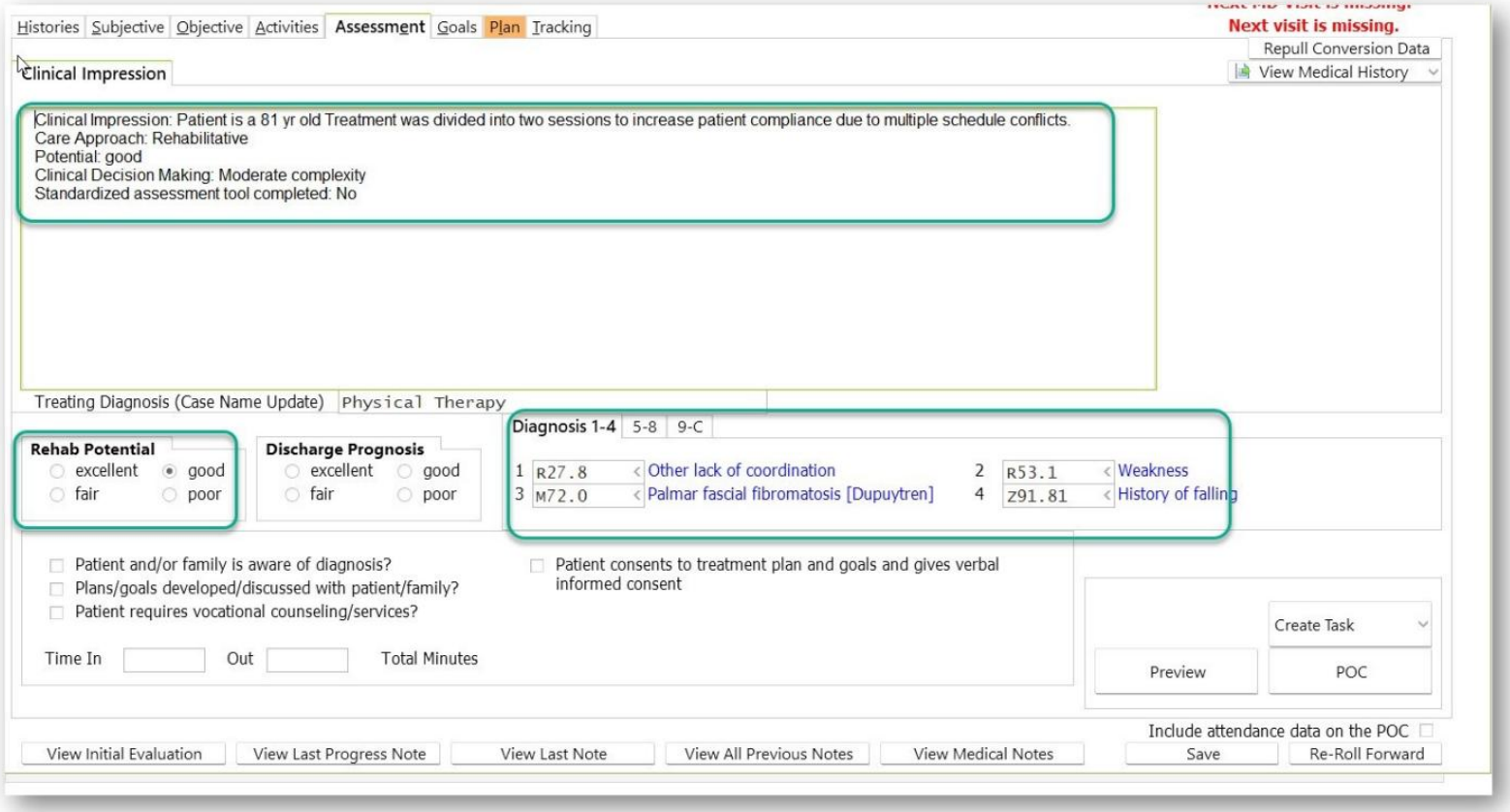
Conversion Note Review

Activities > SLP Swallowing/Feeding: Review Required



Conversion Note Review

Assessment > Clinical Impression, Rehab Potential & ICD-10 Codes: Review Required

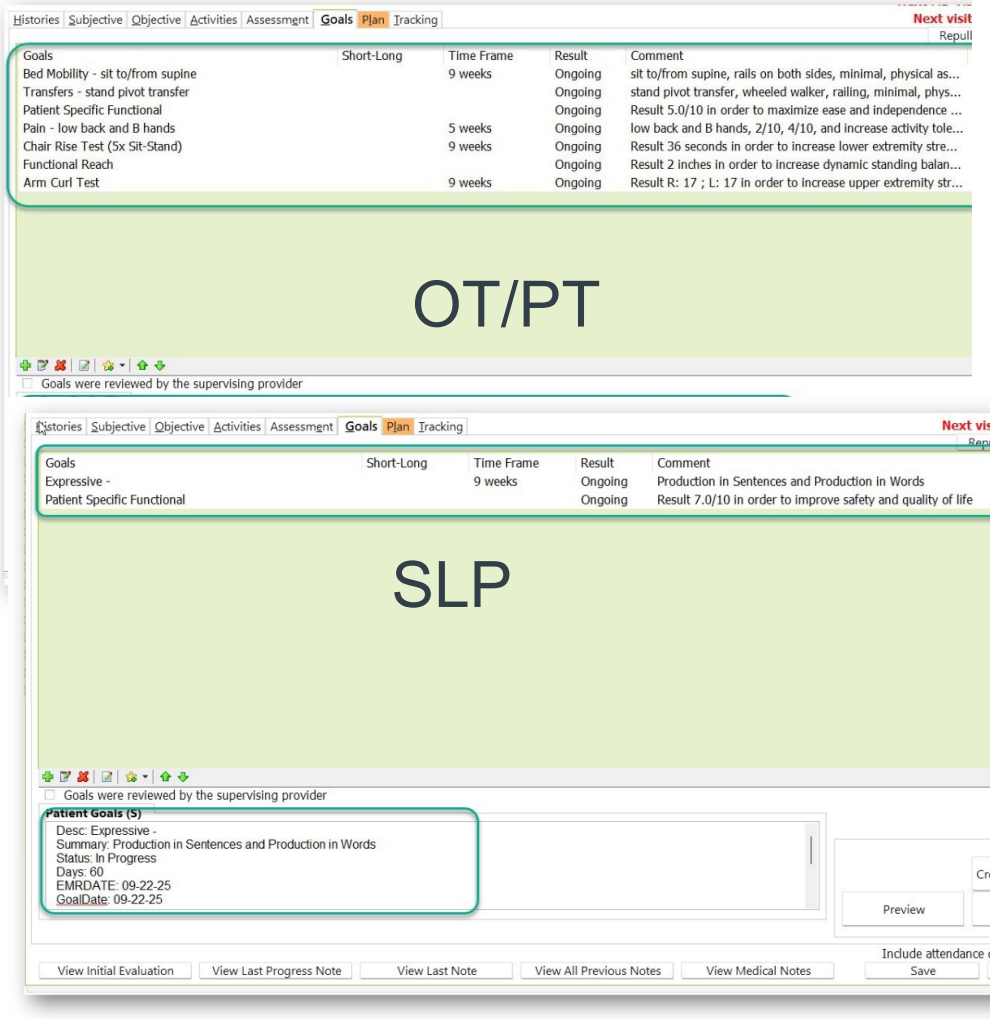


Conversion Note: ACTION REQUIRED

Goals: Action Required

Edits to goal appearances must be done **now**.

- **Review goals:** This is necessary as goals do not always fully transfer to RT Standard
- Goals cannot be edited on daily notes
- Editing goals on progress notes triggers plan changes and recertification
- Only fix wording or mapping; do not alter the original goal from the plan of care
- **All goals must be objective, measurable and tied to a function. Refer back to RT Custom if you are unsure of goal details**



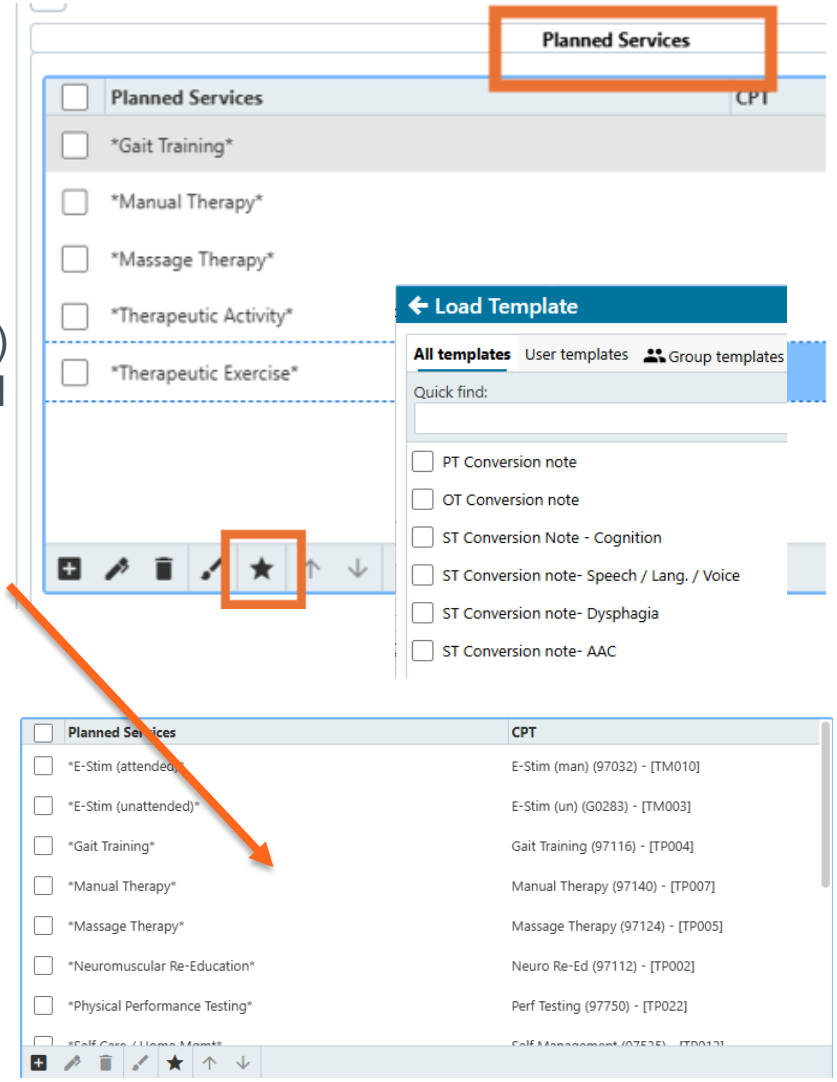
Conversion Note: ACTION REQUIRED

Plan: Action Required!

- **Tap the Star Icon & Load Template**
- Choose your discipline template(s) and save.
- *SLP - select as many as needed to ensure your CPT codes populate (Dysphagia and Cognition)*
- You will see several items (common CPT codes) populate in addition to the items that were pulled in from RT Custom
- This ensures that you have CPT codes listed on planned interventions
- If the patient is contracted with a Hospice Case, Home Health, or Private Pay Skilled, you MUST add the code in planned services manually by clicking the +.

Missing codes will prevent billing on the daily note!

- Verify Frequency and Duration are correctly displayed



Responsibilities on Day 1

Verify Migrated Data Accuracy

- Check conversion notes for each patient to confirm data accuracy.

Update Goals

- Edit goals now if needed; avoid changes in daily or progress notes that affect care plans.

Update Planned Services

- **Add CPT codes** to planned services
  - **Tap the Star Icon** and **click Load Template** (Choose the template(s) for your discipline)
  - This ensures that you have CPT codes listed on planned interventions. Without CPT codes listed on planned services, you will be blocked from signing / posting and risk losing documentation.
- RT Standard will only pull frequency from IE, Recert, Re-eval. Therefore, if you have titrated your care on a daily note or PR, you may see an incorrect frequency. You can update to the correct frequency on the conversion note.

Optional: Add Extra Details

- Unmapped information appears in comments and can be added to fields if desired but is not required.

Exceptions!

Exceptions That Do Not Require Conversion Note Review

- ✓ Wellness cases from RT Custom will generate a conversion note in RT Standard **BUT** will **NOT** require a conversion review.
  - This is because these cases will be documented using an encounter note aka e-note in RT Standard and they do not require the level of documentation that impacts sign off requirements.

Extra Info: OT & PT Conversion Notes Mapping

RT Custom Field	Map to RT Standard
Medical History	Medical History
History of Present Illness	Mechanism of Onset (Free Text)
Prior Level of Function	Other Subjective Comment (Free Text)
Precautions and Contraindications	Contraindications and Precautions (Picklist). If not 1:1 match, added to comment box
Clinical Impression	Clinical Impression (Free Text)
Rehab Potential	Rehab Potential (Radio Dial); Excellent = Excellent, Good = Good, Other = Fair
Care Approach	Clinical Impression (Free Text)
Complexity (Only Clinical Decision-Making Options)	Clinical Impression (Free Text)
Plan of Care Interventions - Planned Services	Planned Services Picklist; If not 1:1 match in picklist, added to comment box
Frequency Duration	Plan comments & Frequency/Duration
Certification Period	Plan comments & Frequency/Duration
Diagnosis 1-8	ICD10 fields
Goals	Goals Picklist - Free text

Extra Info: SLP Conversion Notes Mapping

RT Custom Field	Map to RT Standard
Medical History	Medical History
History of Present Illness	Mechanism of Onset (Free Text)
Prior Level of Function & Current Diet	Other Subjective Comment (Free Text)
Precautions and Contraindications	Contraindications and Precautions (Picklist). If not 1:1 match, added to comment box
Clinical Impression	Clinical Impression (Free Text)
Rehab Potential	Rehab Potential (Radio Dial); Excellent = Excellent, Good = Good, Other = Fair
Care Approach	Clinical Impression (Free Text)
Complexity (Only Clinical Decision-Making Options)	Clinical Impression (Free Text)
Plan of Care Interventions - Planned Services	Planned Services Picklist; If not 1:1 match in picklist, added to comment box
Frequency Duration	Plan comments & Frequency/Duration
Certification Period	Plan comments & Frequency/Duration
Diagnosis 1-8	ICD10 fields
Goals	Goals Picklist - Free text
Feeding/Swallowing (Most recent of each type of compensatory strategies, feeding/swallowing profile & oral motor)	Activities Comments

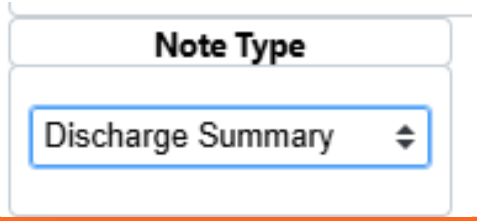
First Treatment Note after Conversion Note

- **REMINDER**: do not open a treatment note until you have completed and saved your conversion note

- Adding planned services and planned CPT codes in your conversion note simply allows billing of those codes in treatments
  - Your first **treatment note** for each patient in RT Standard will not have any items in the Activity grids. This is not an error.
  - Follow your disciplines' training for instructions on adding activities to the time-based and service-based activities grids to document and bill for skilled intervention provided that day
  - Treatment activities added in the activities tab of the treatment note will carry forward to subsequent treatment notes

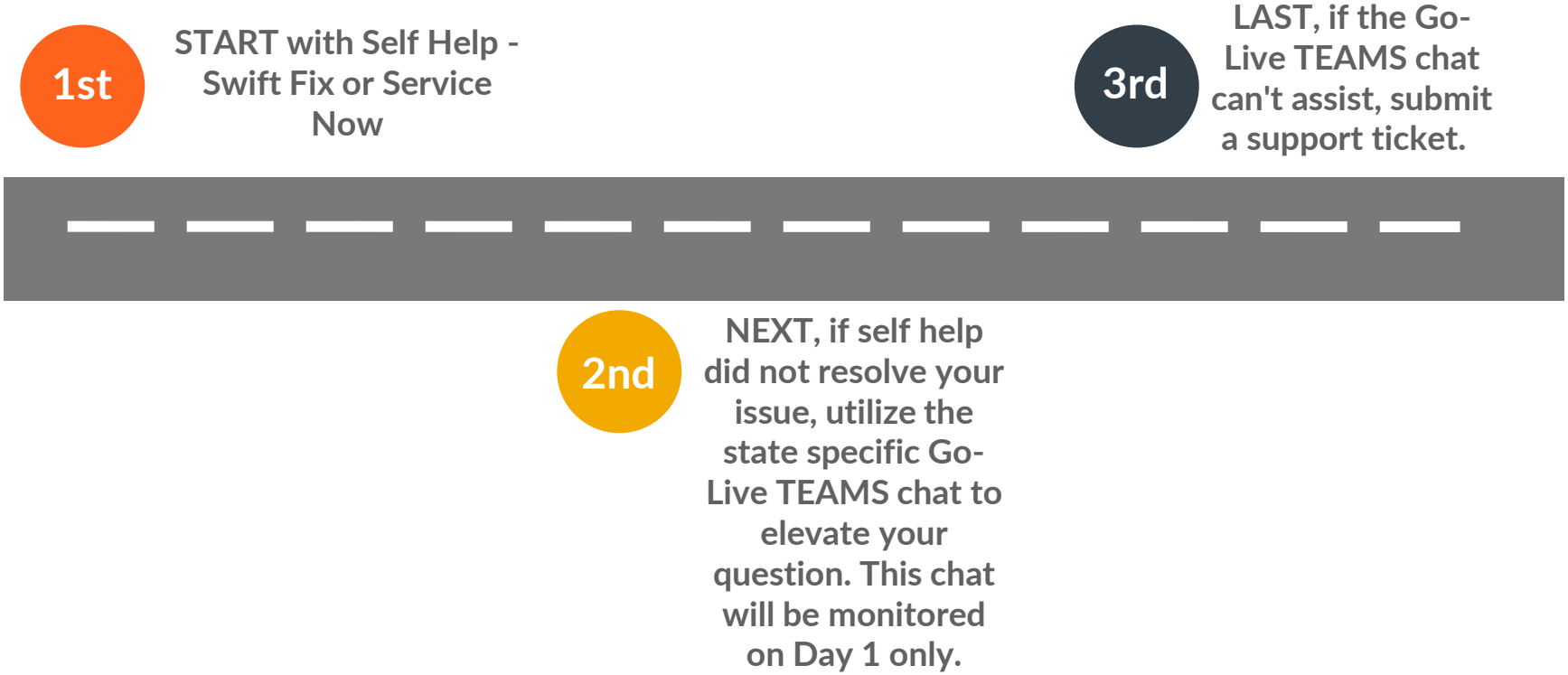
First Progress Note / DC after Conversion Note

- **Progress Note**
  - The first Progress Note within RT Standard following a case with a conversion note will not include baseline data that was documented in RT Custom.
  - Clinicians should add / open the appropriate objective exams, special tests, and objective tests and document the status.
    - These status updates will display as "initial" even though you may have documented the "true" initial status in RT Custom prior to our transition to RT Standard
    - Please use the comment boxes as needed to describe the current status as it relates to their true initial status.
  - **Goals Review – Ensure goals are objective, measurable, and tied to function as the goals do not always fully transfer to RT Standard. If not, please update.**
  - Please review planned services for accuracy and remove any that are not applicable to your plan of care.
- **Discharge**
  - A discharge for a case that was started with a conversion note will always be "Discharge Summary"



Support Roadmap: Start Smart, Escalate Right

Have a question? Follow the path to resolution!



RT Standard
Tracking Log

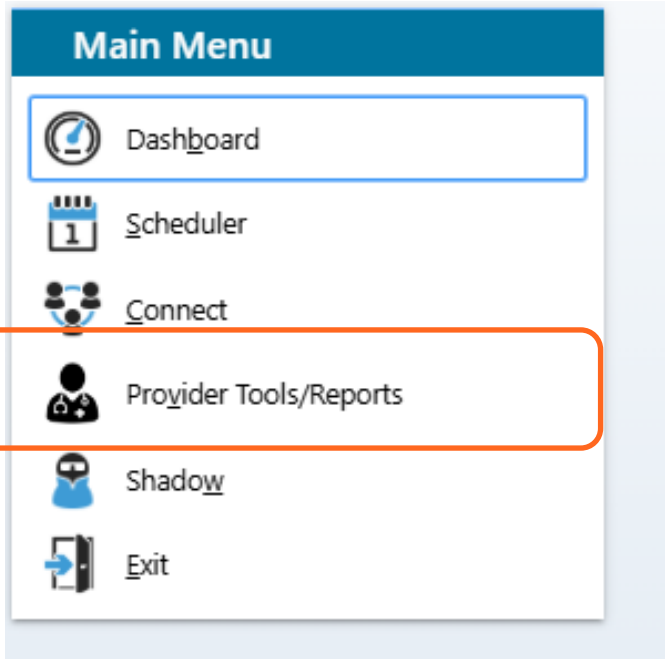


Tracking Log in RT Standard

- The tracking log is in the Provider Tools/Report section of the Main Menu.

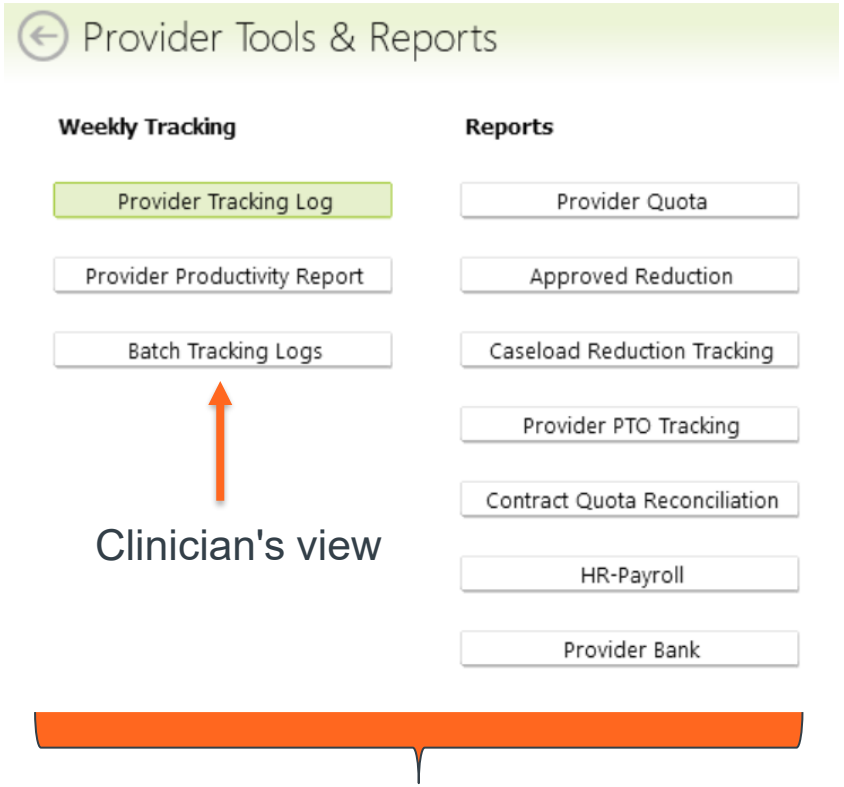
- The tracking log in RT Standard will function pretty much like it did in Raintree Custom EXCEPT for:

    - **No Contract Service tracking logs:** These were previously used to track home health, special accounts or exercise classes. These are now documented and billed using either a Therapy Note(TVIST) or an Encounter Note (E-Note).
    - **NO SLC Outcome Tracking:** This will be moved out of RT entirely in the future, so it was not included in the transition to RT Standard. If you need to document outcome tracking (census, capacity etc.), please discuss with your RD.
    - **Idle cases** will be its own tab in the tracking log since Idle case tasks will not exist in RT Standard.



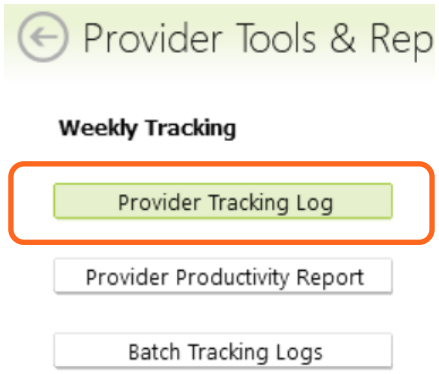
Tracking Log in RT Standard

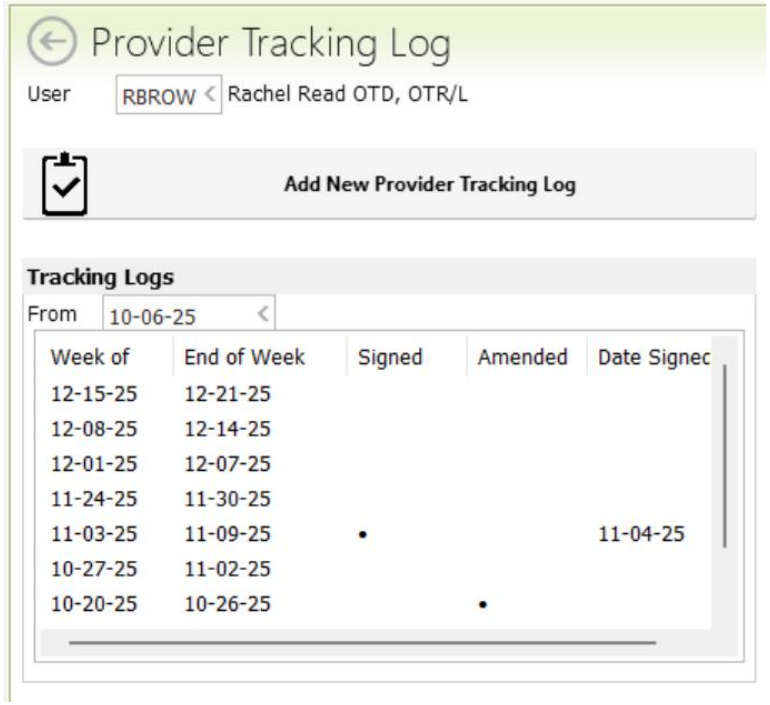
- In the Provider Tools and Reports
  - Clinicians will only see the Weekly Tracking column
  - RDs will have both Weekly Tracking and Reports columns



Tracking Log in RT Standard

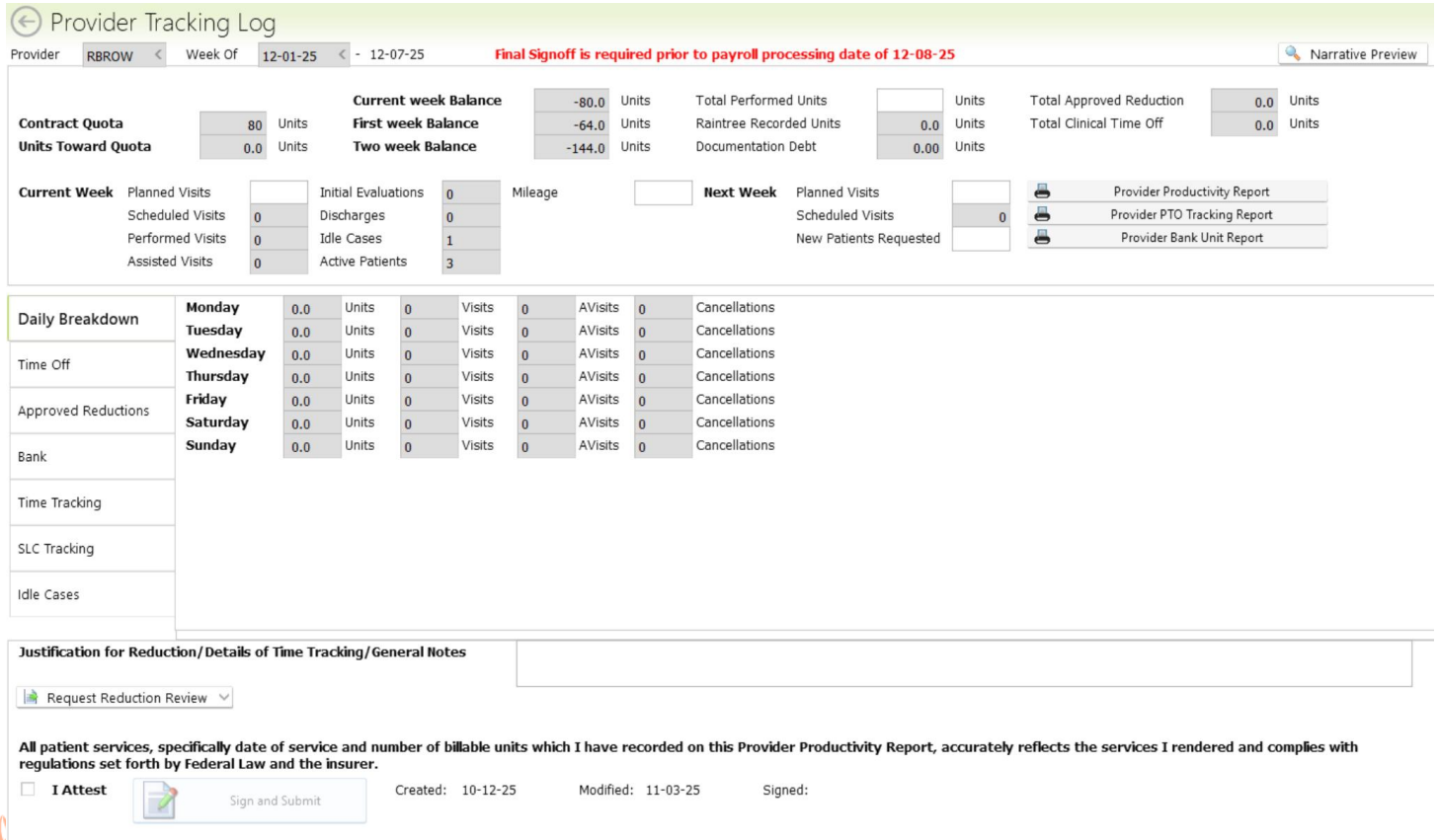
- To add/view tracking logs, click Provider Tracking Log
  - You will be alerted of any unsigned tracking logs
  - Add New Provider Tracking Logs
  - See list of tracking logs
  - All same functionality and rules of the tracking log in RT Custom
    - Amending a tracking log functions the same way as it did in RT Custom





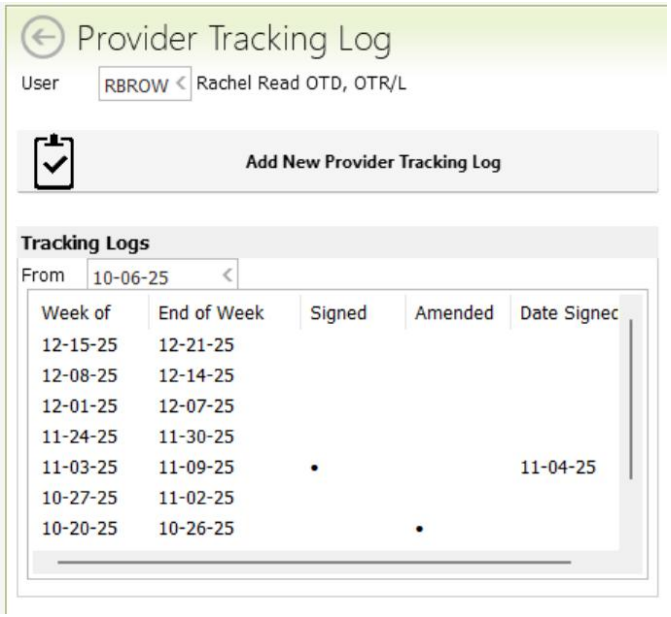
Tracking Log in RT Standard

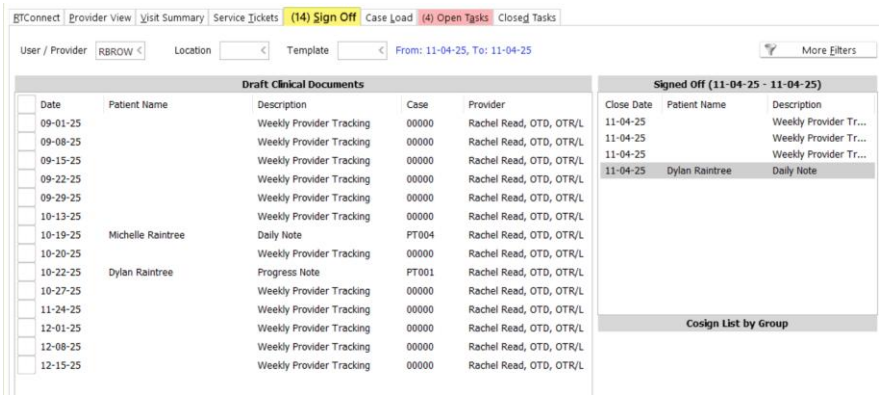
- Tracking Log
  - Will function and appear almost exactly as it does in RT Custom with those exceptions noted on slide 3



Tracking Log in RT Standard

- Unsigned Tracking Logs
  - Can be located from the Provide Tracking Log List
    - Will only display the last 4 weeks of tracking logs (same rules as RT Custom)
  - Sign Off Tab in Dashboard
    - Will display all created and unsigned logs in the event an amendment was requested by support beyond 4 weeks

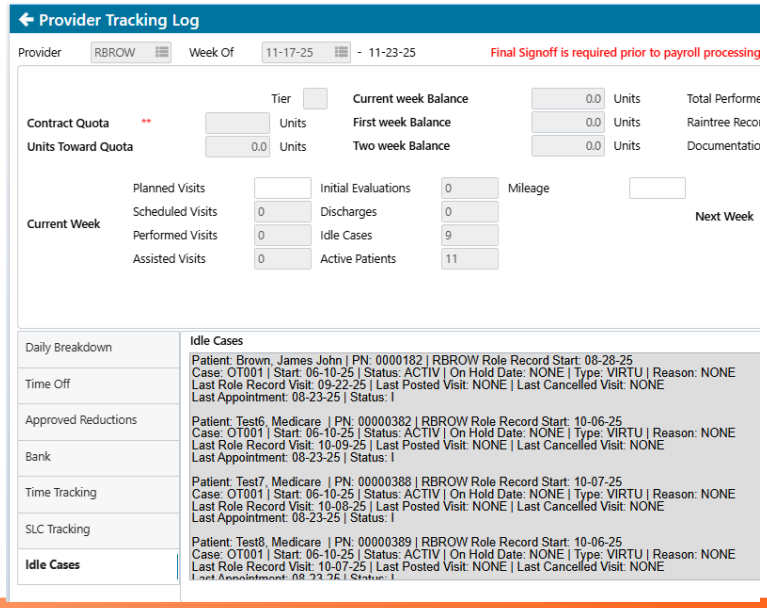




Tracking Log Idle Case Management

Idle case will display and block tracking log sign off if there is not activity in 2 weeks for each case.

- Satisfying Idle cases can be done by:
  - Discharging the case
  - Canceled appointments that were scheduled
  - Requesting the case be put on hold by emailing your practice liaison and providing an on-hold reason and date.



Tracking Log Reconciliation For Go-Live

Phase	States	Tracking Log Week at Go-Live
1	DE	2nd
2	MN, WI, FL, AR	1st
3	NC, SC, GA, AZ, CA, CO, NM, NV, OR, WA, AL	1st
4	MI, KY, OH, MA, NH, CT, RI	2nd
5	PA & TX	2nd
6	ME, VA, MD, MS, TN, LA	2nd
7	NY, NJ	2nd
8	IL, IA, KS, MO, IN	1st

For CQ clinicians Only: Depending on the payperiod week of your go-live, specific action will need to be taken to properly reconcile your tracking log(s) for the payperiod.

Tracking Log Reconciliation For Go-Live

Go Live Week in RT Standard: 1st Week of the Pay Period

Congratulations! The simplest way to manage your tracking log is to start fresh in RT Standard.

- Make sure your final tracking log in RT Custom is fully completed and signed off by the **blackout date**.
  - Do not make any changes or amendments to this log after the blackout date.
  - All PTO and bank balances will be imported into RT Standard exactly as they appear in your tracking log at the time of sign-off on the blackout date.

Tracking Log Reconciliation For Go-Live

Go-Live Week in RT Standard: 2nd Week of the Pay Period

This requires a little more attention and action in both:

- RT Custom for the 1st Week of the Pay Period (last week in RT Custom)
- RT Standard for the 2nd week of the Pay Period (go-live week)

Please treat week 1 as if you must reconcile your 1-week CQ

- Scenario 1: Hit CQ exactly Week 1 in RT Custom (includes use of PTO to reconcile)
  - Week 1 (RT Custom): sign tracking log by blackout date. Do not make any changes or amendments after sign off.
  - Week 2 (RT Standard): sign tracking log
- Scenario 2: Missed CQ for Week 1 in RT Custom
  - Week 1 (RT Custom):Take units from bank to reconcile (if reduction or PTO is not applicable and/or you plan to make up units in next week)
  - Week 2 (RT Standard): Plan to make up missed visits from week 1 and add those units to your bank
  - *Example for 100-unit CQ: Week 1 (RT Custom) hit 90 units and took 10 units from bank to reconcile to 100 CQ. Week 2 (RT Standard) plan to hit 110 to deposit back the 10 units taken from the week 1 bank in RT custom.*
- Scenario 3: Produce over your CQ
  - Week 1 (RT Custom): Document overage in general note section of tracking log and send task to RD (system restricts adding to bank or paying out bank in week 1
  - Week 2 (RT Standard): RD will apply your units over your week 1 CQ as a reduction so you receive credit for those units toward your 2-week CQ.
  - Example for 100-unit CQ: Week 1 (RT Custom) hit 110 units. Document 10 units in notes and send task to RD notifying them of your overage. Week 2 (RT Standard) RD will apply those 10 units as a reduction, so you receive those units toward your 2-week CQ.

Support Roadmap: Start Smart, Escalate Right

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