Uniform Data System
Now part of Netsmart

The RehabConnect™ System

The RehabConnect™ System is designed specifically for inpatient acute rehabilitation. It seamlessly combines patient assessment documentation and coding of the IRF-PAI's quality indicators (QI) into one task, ensuring thorough narrative documentation that supports accurate QI codes and CMGs. The software can be interfaced with other clinical platforms to facilitate efficiencies and eliminate redundancies and errors, and it is capable of warehousing as much clinical data as your facility desires. When interfaced with a hospital's electronic medical record (EMR) system, the result is a dynamic workflow for your program's processes.

Benefits

The RehabConnect™ System's many clinical templates are built according to the documentation guidelines and logic in *The IRF-PAI Manual*, as well as the requirements in the *Medicare Benefit Policy Manual*. This integrated logic improves compliance and makes cases **more likely to stand up to a review or an audit**.

The clinician-friendly software **supports interdisciplinary documentation**, thus making it easier for your entire rehab team—nurses, therapists, and physicians—to work together.

The tasks of documenting patient care and supporting IRF-PAI coding are combined into one, thereby **increasing efficiency and improving accuracy**.

The **QI Manager** compiles all relevant IRF-PAI documentation throughout the system into one module whose built-in proprietary logic eases the burden of supporting IRF-PAI codes.

The software automatically extracts therapy treatment times and modes from the various therapy documentation and **eliminates the tedious burden of calculating total therapy values and recording them on the IRF-PAI**.

The software's optional **HL7® interfacing** optimizes efficiency and reduces data-entry duplication and errors.

Intuitive flags, views, and reports throughout the system **increase compliance with regulatory requirements** and **provide more efficient workflow and real-time administrative oversight**.

The software allows facilities to define and manage their own required fields, discipline-specific expectations within documents, task lists, user privileges, and more!

Features

Facesheet: This module combines patient data from your facility's hospital information system with the IRF-PAI.

Clinical Summary: This module provides a snapshot of pertinent patient information collected from multiple interdisciplinary documents.

Plan of Care: The POC module displays the physician's individualized overall plan of care and automatically pulls interventions, problems, focus areas, and goals together from admission assessments for easy access and tracking.

Clinical Documents: These comprehensive and customizable documentation templates support medical necessity, generate accurate section GG codes, provide documentation that supports all the quality indicator data elements, and demonstrate interdisciplinary team communication.

QI Manager: This module, which is built according to CMS's technical specifications, consolidates all IRF-specific regulatory documentation from various sources into one central location, with direct integration with the UDS-PROi® software and the IRF-PAI.

CareTrend PRO™ Module: This module includes therapy treatment time logs, section GG coding trends, pain ratings and interventions, and interdisciplinary education for user-defined time frames.

Patient Summary: This customizable interdisciplinary electronic sticky note facilitates real-time communication among team members about important patient care information.

Task List: This set of system flags helps facilities manage regulatory and facility-defined time frames related to clinical documentation requirements.

Required Fields: Administrators can define facility-specific expectations for areas in each clinical document that must be addressed before the document is completed to ensure compliance.

Reports: Multiple baseline reports, including reports on therapy treatment time, clinical document completion status, and interim functional QI documentation, help facilities improve their regulatory compliance.

Health Record Integration Tool: This optional module allows your facility to automate the transfer of clinical documents from the RehabConnect™ System to your facility's full EMR.

User Setup: This module allows administrators to set up RehabConnect™ user accounts with a customizable and unique set of permissions for each user.

Audit Log: This logging system tracks changes made to the entire documentation system, including user access, data changes, and module access.

Online Help: This series of documents provides complete and comprehensive online documentation for the entire software system. The documentation is specific to each module and screen, providing users with the quick and easy access to the specific help they need.