Speech Language Pathologists
Progress Summaries, Discharge Summaries and Care Plans

Monthly Report Lists

The Report List is titled by the Month (e.g. "May Reports") It lists clients, which SLPA is responsible for creating the Progress Summary, and the due date by which the SLPA needs to have it done. If a client is shared, the list indicates both Clinicians and they decide who will do the report.

Patient Name	DOB	Auth#	CPT	Auth Start	Auth Thru	Due Date	Therapist(s)	Completed Date	Care Plan
LAST, FIRST	1/12/2009	20180129 71133140 0002	X4303	1/17/2018	5/2/2018	4/12/18	Name/Name		

SLPAs refer to/work off of a printed, hard-copy posted on the bulletin board by the printer.

SLPs have access to the shared Google Doc (using the Google Doc is *required*: so that we are all working, real-time, updating no matter who is using the doc). When a new Report List is published, review it. If your SLPA Supervisee has any reports due, you are the SLP responsible to review, consult, finalize the Progress Summary (or D/C) and the client's new Care Plan.

SLPAs create the PS (see examples of Progress Summaries)

Once they've added in comments and checked that the data reflects what's actually happening, they "sign" the PS. In Clinic Source, in the client's "Documentation" view, you see a little "pen" next to the PS. This lets you/SLP know that the summary is ready for you to check, edit, make final recommendations, etc.

Immediately after the SLPA has created the Progress Summary, they create a new Care Plan. Every time we report progress, we adjust, add, modify the goals. Even if the goals are not changing at all, we must still have a new CP - so that the data/progress we've just reported, is no longer "pulled" into the next reporting period. The only time we do NOT create a new Care Plan is if we are graduating or discharging the client.

When you check Clinic Source and see that the SLPA has finished her part - you should see two things:

1) A Summary - with a "pen" icon next to it
2) A new Care Plan (new date and goals)

SLP:

1) Open the **Progress Summary** and enter Edit mode
2) **Proofread everything**; correct spelling, grammar, change word usage, etc. Be sure to scroll down on any comments they may have made on individual goals - because the 'view' in Clinic Source sometimes doesn't show everything in the viewable space and it's easy to "miss" text that needs to be edited. Add any comments, observations you want to be included.
3) **Sign**/finalize the approved Progress Summary (click on the pen for Supervising SLP signature)
4) Open the **Care Plan** and do the same:
   a) proofread
   b) expand goals to be "SMART" goals, bump up target levels if/as needed
   c) add new goals and/or double-check goals SLPA may have added based on discussion with you

   The Care Plan is *NOT SIGNED*/locked

5) **New Care Plan** is the only "**active**" CP.
   In the client's "Documentation" view (e.g. his/her Clinic Source "chart") go into the previous Care Plan, edit view, and unclick the box marked "active." There can only be one (1) active Care Plan at a time. The "active" Care Plan is the one from which Clinic Source pulls goals and populates them into the session SOAP notes.

6) **Document PS and CP finalized in the Report List** (in the shared Google doc) -highlight the client row in yellow - adding information under the last two columns:

Last, First	11/17/2014	20180126711331400003	X4303	12/15/2017	5/1/2018	4/11/18	**ALICIA/ELIZABETH**	*ready to submit*	*CP done*

When this is highlighted, our Billing Department sees that the Progress Summary and Care Plan are complete. The Clinic Source Care Plan = a Prescription for the Physician to sign so that when he/she returns it, we can submit to insurance. (Note: when you see a client row is highlighted in blue, this indicates that Billing has submitted everything to insurance.)

Discharge Summaries

When we discharge or graduate a client, we must complete a record of final progress and documentation of reasons for discharge.

1) The SLPA (and sometimes SLP if d/c happens at a time outside of Authorization Expiration date) will **create a Progress Summary**.
2) In the top, right hand corner of the Progress Summary, there's a box that indicates "**Discharge**" - **click that box**. The PS turns into a D/C Summary and adds fields for *Reason for Discharge* and a place to indicate the *discharge date*/effective date.
3) Signing/Signatures apply

Discharge Summaries for long term TST Clients -

To the extent possible, we are attempting to review each Client's case individually prior to their next Progress Report/Authorization Expiration.

For many clients who began treatment at XYZ years ago, we review progress over time to determine whether the client is making measurable progress. SLP will do a file review: Initial Evaluation -levels of functioning, Re-Evaluations - levels of functioning, and review of Progress Reports (in the Shared Drive, CalOptima, Alphabetical files). If progress does not document clear, continued benefit from skilled, speech-language therapy, we must recommend discharge.

If measurable progress continues, is clear and documented, or if you are confident that a particular treatment approach/tool has not been provided and can be provided consistently and with fidelity, recommend continued treatment.

If a Client graduates or is discharged, there is no Care Plan.