LONG TERM CARE HOSPITAL ASSESSMENT
SUBMISSION ENTRY & REPORTING TOOL
(LASER)
USER GUIDE

IN SUPPORT OF VERSION 1.3.0 (APRIL 2017)

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INTRODUCTION
The Long Term Care Hospital (LTCH) Quality Reporting Manual (QRP) and the LTCH Care Data Sets were developed by the Centers for Medicare & Medicaid Services (CMS).

The LTCH Assessment Submission Entry and Reporting tool (LASER) was developed by the Centers for Medicare & Medicaid Services (CMS). LASER is a free, Java based application which provides an option for Long Term Care Hospital providers to collect and maintain Facility, Patient, and LTCH Care Assessment information for subsequent submission to the appropriate national data repository. LASER displays the LTCH Care assessment instrument similar to the paper version of the form.

This User Guide will cover all of the user functionality found in LASER as well as the Help and Security features. The QIES Help Desk is also available for technical support and assistance if needed and may be contacted by phone at 877-201-4721 or by email to help@qtso.com.

INSTALLATION

INSTALLERS ACCESS RIGHTS
To install LASER the User must be logged into the PC as a Workstation Administrator.

Users of the application MUST have read/write access to the location where the database is installed.

HARDWARE/SOFTWARE SPECIFICATIONS
The Minimum and Recommended System Requirements may be found on the QIES Technical Support Office home page: https://www.qtso.com/index.php

SECURITY
Making information security one of your organizations core values ensures the prevention of unauthorized viewing of Personally Identifiable Information (PII) or Protected Health Information (PHI).

It is important that providers work with their Information Technology (IT) team or other resources to build a security-minded organizational culture which enforces strong authentication and access controls as well as limits physical access to devices (e.g., laptops, handholds, desktops, servers, thumb drives, CDs, backups) containing PII or PHI data.

CMS recommends that providers encrypt the hard drive of any electronic device which has access to data containing PII or PHI, such as exported assessment records. Once assessments have been exported from the LASER application the data will no longer be encrypted. It is also recommended that those electronic devices, which contain PII or PHI, be physically secured and locked (password protected) when not in use.

WINDOWS SETTINGS
In order to ensure the reliable operation of the LASER software application use of a supported Microsoft Windows operating system is imperative. The Font Size property must be set to “Small Fonts”. This property can be found under the Settings tab of desktop properties: Start\Control Panel\Appearance and Personalization\Display\.
SYSTEM CONFIGURATION/INSTALLATION TYPE

STANDALONE
The Standalone installation is self-contained on one workstation.

NETWORK CLIENT
The Network Client/Server installation uses a server to support one or more individual workstations, all accessing one database by multiple computers and users.

- Servers hold the central database and must utilize the Server installation file first.
- Network Clients are placed on the users individual workstations which then access the database on the Server. The Network Client is installed after the Server installation has been successfully completed.

Please refer to the LASER Installation Guide for assistance installing and setting up the LASER application. The QIES Help Desk is available for technical support and assistance if needed and may be contacted by phone at 877-201-4721 or by email to help@qtso.com.

VERSION VERIFICATION
Information about the version of LASER currently installed may be found by selecting ‘About Quality Management System’ from the ‘Help’ drop-down on the Menu Bar.

The following System Configuration information will be displayed in the lower left side of the screen:

- Installation Type
- Feature Label (LASER)
- Feature Version
- Feature ID
- Build ID
When the LASER application is accessed and the computer running LASER has an internet connection, the application will compare the version currently installed with the version available on the QIES Technical Support Office (QTSO) website. If a new version of LASER is available, a message will display directing the user to the QTSO website to download the latest version.

GENERAL OVERVIEW
LASER software provides the following functionality:

- Facility Setup/Maintenance
- User Setup/Maintenance
- Patient Setup/Maintenance
- Assessment Maintenance
- Import/Export
- Reporting

ACCESS
Once LASER has been installed, access the program using one of the following methods:

- Start Menu – Select the LASER icon from the Start Menu
- Desktop – Double click the LASER icon found on the desktop
- Directory – Navigate to the directory where LASER is installed, double click the LASER.exe
ACCESSIBILITY
Selecting the ‘Enable Accessibility Features’ checkbox at the bottom of the login screen will turn on accessibility features for users requiring assistive technology (e.g. screen readers). The box will remain checked or unchecked until changed by the user.

SCREEN LAYOUT

TITLE BAR
• Displays the name of the software application: LASER.

MENU BAR
• Located just below the Title, the Menu Bar consists of drop-down lists which contain command selections dependent on user role and the screen that is currently active.

• Pressing the Alt key on the keyboard will place the cursor in the menu bar. Using the arrow keys on the keyboard, users can navigate through the selections on the menu bar. For example: On the Assessment Search screen, if the cursor is on the File menu item, pressing the right directional arrow will move the cursor to the next menu item. Pressing the up and/or down directional arrows will provide navigation through the drop-down menu list.

TOOL BAR
• Located just below the Menu Bar, the Tool Bar contains screen specific buttons and icons to assist the user. Hover or “mouse over” the icons to display a description of the available functionality.

SCREEN TABS
• Located just below the Tool Bar, Screen Tabs will display the open screens (e.g. Facility, Patient, User, and Assessment). An asterisk (*) will display on the tab to the left of the tab title if there are screen changes which need to be saved.

SCREEN AND COLUMN SIZE CONTROL
The various screens available are divided into distinct functional sections. Search and Summary sections may be collapsed by a single click of the arrow located next to the section title. Clicking on the arrow a second time will expand the section.

Columns and sections may be resized if needed by hovering over the line which separates the sections or column headers. The cursor will create an arrow. Click and drag the “left-right arrow” icon to the desired width.
FIELD TYPES

TEXT
Text fields allow data to be entered manually. Data entered must adhere to the rules of the LTCH data specifications (length, use of special characters etc.). The following is an example of a text field.

<table>
<thead>
<tr>
<th>Field Name</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Last Name (A0500C)*</td>
<td>Insert Last Name</td>
</tr>
</tbody>
</table>

DATE
Date fields are formatted for the entry of a valid date (MM-DD-YYYY) where MM = 01-12, DD = 01-31, and YYYY = the four digit year. Some date fields allow other data to be entered, such as a (-) for ‘not assessed/no information’, these fields will be defined by the LTCH data specifications. The following is an example of a date field.

<table>
<thead>
<tr>
<th>Field Name</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth Date (A0900)*</td>
<td>Insert Date</td>
</tr>
</tbody>
</table>

Please Note: When the ‘Enable Accessibility Features’ checkbox is checked on the LASER Login Screen the calendar icon will NOT be displayed. When the ‘Enable Accessibility Features’ checkbox is unchecked on the LASER Login Screen there will be a calendar icon next to each date field that the user may utilize instead of manually entering in a date.

CHECKBOX
Checkboxes allow the selection of “yes” answers simply by clicking the box next to the appropriate value. Double clicking the check box will mark the response as ‘not assessed’ when this is a valid response according to the data specifications. Clicking the check box a third time will uncheck the box for a selection of “no”. The following is an example of a checkbox.

<table>
<thead>
<tr>
<th>Field Name</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Race/Ethnicity (A1000) Check all that apply*</td>
<td>Select Race/Ethnicity</td>
</tr>
</tbody>
</table>

DROP-DOWN LIST
Drop-down lists contain allowable answers to a specific field. To answer a drop-down question, tab to the field and use the arrow keys on the keyboard to navigate through the answer options. Once the appropriate answer is displayed, use the Tab key to move to the next question. A mouse may also be used to select an answer in a drop-down list. Click the arrow on the right side of the field to expand the list. Click the desired answer. Click the mouse on the next question. The ‘Delete’ key on the keyboard can be used to clear the field. The following is an example of a drop-down list.

<table>
<thead>
<tr>
<th>Field Name</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marital Status (A1200)*</td>
<td>Select Marital Status</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Never married</td>
<td></td>
</tr>
<tr>
<td>2. Married</td>
<td></td>
</tr>
<tr>
<td>3. Widowed</td>
<td></td>
</tr>
<tr>
<td>4. Separated</td>
<td></td>
</tr>
<tr>
<td>5. Divorced</td>
<td></td>
</tr>
<tr>
<td>- Not assessed/No information</td>
<td></td>
</tr>
<tr>
<td>*Voluntarily skipped</td>
<td></td>
</tr>
</tbody>
</table>
ICD CODE GRID

Grid buttons are used for the entry of ICD codes. Clicking on the grid button will open the ICD code display window. Please note this display window will be empty until ICD codes have been manually entered. All codes must be formatted correctly and should come from the appropriate ICD listing for the time of the assessment. For questions relating to ICD coding please visit the following CMS webpages as needed.

For questions relating to ICD-9 coding please visit the following CMS webpage: http://www.cms.gov/Medicare/Coding/ICD9ProviderDiagnosticCodes/codes.html

For questions relating to ICD-10 coding please visit the following CMS webpage: http://www.cms.gov/Medicare/Coding/ICD10/index.html
**EDITS**

Data integrity edits are applied as information is entered into LASER. These edits are unique messages put in place to assist users with the accurate completion of data entry. Some edits will present a pop-up message and must be addressed when displayed in order to proceed. Other edits may not appear until the assessment is saved and validated. The following types of edits may occur in LASER:

**ERRORS**
This type of edit lets the user know information is missing or invalid. It must be entered or corrected before the information will be saved.

**WARNINGS**
This type of edit indicates there is information entered that should be verified as accurate, or serve as a reminder of how some fields should be populated.

**INFORMATIONAL**
This type of edit gives the user general information about the assessment.

**DATA ENTRY TIPS**

- For optimization of the skip patterns and/or edits, it is recommended that assessment data be entered in the order the questions appear on the screen.

- Enter data in each field and use the ‘Tab’ key on the keyboard to navigate from field to field. This allows skip patterns and edits to be appropriately applied and helps ensure all fields are addressed.

- Some fields require use of additional keys. For example, checkbox fields use the ‘Tab’ and ‘Shift + Tab’ keys to scroll through the available responses. Once the desired response is highlighted, pressing the spacebar will make the selection. Press the ‘Tab’ key to move to the next field and ‘Shift + Tab’ to go to the previous selection. The mouse may also be used to move to a field and make a selection.

**ORDER OF DATA ENTRY:**

- Create a facility
- Create a user
- Create a patient
- Create an assessment
- Export the assessment
LOGIN

Please Note: The Default User account (laser) cannot be used to create patients or assessments. For detailed instructions regarding the initial login please consult the LASER Installation Guide.

Complete the following steps to login to LASER:

1. Launch the LASER application from the start menu, desktop or directory where installed.

2. The LASER splash screen containing the CMS logo displays momentarily.

3. The ‘Welcome to LASER’ screen will display while the program is loading. This may take a few minutes and requires no response from the user.
4. The ‘Login’ screen displays.

5. Enter the assigned User ID.

6. Enter the Password. When logging in for the first time enter your assigned User ID in both the ‘User ID’ and ‘Password’ fields; these are case sensitive.

7. Click ‘Login’.
8. When logging in for the first time, the ‘Change Password’ screen displays as follows:

- The new password and the confirm new password must match.
- The new password must be at least 8 characters long.
- The new password must be no more than 20 characters long.
- The new password must not contain any space.
- The new password must not contain the User ID, First Name, Last Name, or Email.
- The new password must not begin with a number.
- The new password can only contain a maximum of 3 repetitive characters.
- The new password must contain at least one for each of the following type of characters:
  - Upper-case Character: A-Z
  - Lower-case Character: a-z
  - Number: 0-9
  - Special Character: &~!@#$%^*()_+={}\[]|:;"'<>,.?/
- The new password must not match any of the user's most recent 6 passwords.
- The new password will be set to expire in 60 days.

![Password Change Screen]

9. Enter a new password in the ‘New Password’ and ‘Confirm New Password’ fields. The password is case sensitive and must match in both fields.

10. Select ‘Continue’ to complete the login process.

Please Note: Selecting ‘Cancel’ will display the following message: “You must change your password before accessing the system. If you do not change your password, you will be logged off the system.” Clicking ‘Cancel’ on this pop-up will take the User back to the previous ‘Change Password’ pop-up. Clicking ‘OK’ takes the User to the login screen where they must re-enter the assigned User ID in both the ‘User ID’ and ‘Password’ fields.
11. The ‘Security Questions’ screen displays the following questions:

- What city were you born in?
- What year did you graduate from high school?
- What is your favorite sport?
- What was the make of your first car?
- What was the color of your first car?
- What is your mother's maiden name?
- What was the name of your first pet?
- What size shoe do you wear?
- What is your favorite season of the year?
- What is your favorite movie?

12. Complete the answers to a minimum of six (6) questions.

13. Tab to the bottom of the list to enable the ‘OK’ button.

14. Click ‘OK’ to continue to the ‘Home’ screen.
The following ‘Welcome to LASER’ message will be displayed prior to the ‘Home’ screen only when ‘Enable Accessibility Features’ has been selected upon login.

Welcome to LASER.

This is the welcome message for LASER. After closing this dialog box, press the ALT key to enable the drop down menu to perform LASER administrative activities and assessment entry. Use CONTROL+Page Up and CONTROL+Page Down to switch between open screens. Press Alt+J to get additional information about that window.

Currently, the screen that is open is used to detail the various sections of LASER. It consists of multiple sections, each with a button to take the user to the section described.

---

**HOME SCREEN**

The options displayed on the ‘Home’ screen are dependent upon User Type. A System Administrator will have full access while a Data Entry User will have limited access. Please see the User Setup and Maintenance section for additional information regarding User Types. Below is an example of the System Administrator’s ‘Home’ screen.

---

[Diagram of the System Administrator’s ‘Home’ screen]
HOME SCREEN DEFAULT
By default, the ‘Home’ screen will be displayed upon each login. The screen may be closed by selecting the white “X” on the tab titled ‘Home’. This will close the ‘Home’ screen for the remainder of the user’s session.

To reactivate the ‘Home’ screen once it has been closed, select ‘Help’ from the Menu Bar at the upper right followed by ‘Home Screen’ OR use the short-cut, Ctrl+Alt+W.

If the user does not wish to see the ‘Home’ screen upon each login the default setting may be turned off by placing a checkmark into the box at the lower left corner of the screen next to the following statement: “Do not display this home screen after logging into the application”. Placing a checkmark into this box will only affect the user currently logged into the application. All other users will continue to see the ‘Home’ screen.

FACILITY SETUP AND MAINTENANCE
The Default User must create at least one Facility before being permitted to add any further data to the LASER application. Please consult the LASER Installation Guide for detailed instructions regarding the initial login and setup by the Default User.

The ‘Facility Information’ screen allows users, dependent upon their User Type, to setup and modify facilities. The term “facility” refers to a long term care hospital (LTCH).

The ‘Facility Information’ screen displays in two sections:

- Facility Summary (on the left)
- Facility Detail (on the right)
  - All facility data entry is done in this section

ADD A FACILITY
Complete the following steps to create a new facility:

1. Select ‘Facility’ from the Administration drop-down on the Menu Bar or ‘Go To Facility’ from the ‘Home’ screen.

2. The ‘Facility Information’ screen displays.
3. Enter the appropriate facility information into the Facility Detail section. Required fields display on the screen in bold type with an asterisk.

4. After facility information has been entered, click the ‘Save’ icon. Saved facility information will display in the Facility Summary section on the left side of the screen.

5. To add additional facilities, click the ‘New’ icon, enter data and click the ‘Save’ icon.

**MODIFY A FACILITY**

Complete the following steps to modify an existing facility:

1. Locate and highlight the facility in the Facility Summary section.
2. Make the appropriate changes in the Facility Detail section on the right side of the screen.
3. Click the ‘Save’ icon.

**DELETE A FACILITY**

Complete the following steps to delete a facility:

1. Locate and highlight the facility in the Facility Summary section.
2. Click the ‘Delete’ icon.
   - Only a System Administrator can delete a facility.
   - Deletions cannot be made if Users, Patients, or Assessments are currently associated to a facility.
USER SETUP AND MAINTENANCE

The Default User must create at least one System Administrator User before being permitted to add any further data to the LASER application. It is highly recommended to set up more than one System Administrator User. In the event the primary System Administrator User’s account becomes locked, the second System Administrator will have the ability to unlock the primary account. Please consult the LASER Installation Guide for detailed instructions regarding the initial login and setup by the Default User.

USER TYPES

To enhance the security of data there are four User Types available within the LASER application, each having a unique level of access. The following User Types are available:

- Default User
- System Administrator
- Data Entry
- View Only

Please Note: The Default User ID (laser) may only be used to add or modify facilities and users. After successfully creating at least one Facility and one System Administrator, the Default User should log out of the application. The newly created System Administrator User must login to display the full LASER menu. The table below provides a summary of the functions available to each User Type. An “X” denotes that a function will be available to that particular User Type, unless otherwise specified. Note, you will not see the Default User in this summary.

<table>
<thead>
<tr>
<th>Features/Functionality</th>
<th>System Administrator</th>
<th>Data Entry</th>
<th>View Only</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessments</td>
<td>Add/Edit/Delete</td>
<td>Add/Edit</td>
<td></td>
</tr>
<tr>
<td>Create Inactivation Requests</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Create Modification Requests</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Export Files</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Import Files</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maintain Facility Information</td>
<td>Add/Edit</td>
<td>Edit</td>
<td></td>
</tr>
<tr>
<td>Maintain Patient Information</td>
<td>Add/Edit/Hide/Delete</td>
<td>Add/Edit</td>
<td></td>
</tr>
<tr>
<td>Maintain User Information</td>
<td>Add/Edit/Delete*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Perform Data Entry for LTCH form</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Print Assesments (Report)</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>View Assessment Data Entry Report</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Data Comparison Report</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>View Event Tracking Report</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>View Hidden Patients/Assessments</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>View User List</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>View Assessments Entered by Any User</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

*System Administrators are not allowed to change their own User Type or enter a termination date for their own User ID.
**ADD A USER**

The ‘User Information’ screen allows users, dependent upon their User Type, to modify and setup new user accounts. The term ‘user’ refers to the individuals who will be viewing or entering data into the LASER application.

The ‘User Information’ screen displays in two sections:

- **User Summary (on the left)**
- **User Detail (on the right)**
  - All user data entry is done in this section.

Complete the following steps to add a new user:

1. Select ‘User’ from the Administration drop-down on the Menu Bar or ‘Go to User’ from the ‘Home’ screen.

2. The ‘User Information’ screen displays.

3. Enter the appropriate user information into the User Detail section. Required fields display on the screen in bold type with an asterisk.
4. After entering all required user information, click the ‘Save’ icon. Saved user information will display in the User Summary section on the left side of the screen.

5. To add additional users, click the ‘New’ icon, enter data and click the ‘Save’ icon.

**TERMINATION DATE**

A Termination Date should only be entered if an active user is no longer valid (e.g., no longer works for the facility). If a Termination Date is entered for a user with pending assessments, a Termination Date message box will display advising pending assessments should be reassigned to an active user.

If there is only one System Administrator and that person terminates his/her position, a new System Administrator must be set up prior to entering the Termination Date for the existing System Administrator.

**MODIFY A USER**

Complete the following steps to modify an existing user:

1. Locate and highlight the user in the User Summary section.
2. Make the appropriate changes in the User Detail section on the right side of the screen.
3. Click the ‘Save’ icon.

**DELETE A USER**

Complete the following steps to delete a user:

1. Locate and highlight the user in the User Summary section.
2. Click the ‘Delete’ icon.
   a. Deletions cannot be made if the user has created or modified facility, patient, or assessment data.
User passwords may be changed at any time.

Complete the following steps to change a password:

1. Login to LASER.
2. Select ‘Change Password’ from the Security drop-down on the Menu Bar.

3. The ‘Change Password’ screen displays along with the following rules:
   
   - The new password and the confirm new password must match.
   - The new password must be at least 8 characters long.
   - The new password must be no more than 20 characters long.
   - The new password must not contain any space.
   - The new password must not contain the User ID, First Name, Last Name, or Email.
   - The new password must not begin with a number.
   - The new password can only contain a maximum of 3 repetitive characters.
   - The new password must contain at least one for each of the following type of characters:
     - Upper-case Character: A-Z
     - Lower-case Character: a-z
     - Number: 0-9
     - Special Character: &~!@#$%^*()_+={}|:;"'<,.?/
   - The new password must not match any of the user's most recent 6 passwords.
   - The new password will be set to expire in 60 days.
4. Enter the current password in the ‘Password’ box.

5. Enter a new password in the ‘New Password’ and ‘Confirm New Password’ box.
6. Select ‘Change Password’. Selecting ‘Cancel’ will close the ‘Change Password’ screen and will not change the existing password.

FORGOT PASSWORD

Complete the following steps if you have forgotten your password:

1. Enter the User ID and select the ‘Forgot Password’ button.

2. The ‘Security Questions’ pop-up window displays with three (3) of the security questions which were answered during the initial setup of the given User ID.

3. Enter responses to the questions provided.

4. Select ‘OK’ to continue to the ‘Change Password’ screen. Selecting ‘Cancel’ will close the security questions and return to the login screen.
**LOCKED USER ACCOUNT**

LASER will allow three (3) login attempts prior to locking a user account and removing the ability to login. The following message will be displayed when a user account becomes locked: “Your account has been locked. Contact your System Administrator or click Forgot Password Alt+F to unlock your account.”

As stated in the error message there are two options when a user account has become locked. Click ‘OK’ to return to the ‘Login’ screen. Follow the instructions for **Forgot Password** to unlock the account.

The user may also contact a System Administrator who can reset the account using the following steps:

1. Select ‘User’ from the Administration drop-down on the Menu Bar.

![Menu Bar Screenshot]

2. Locate and highlight the locked user account in the User Summary section. Locked user accounts will display in bold type.

3. Check the ‘Reset Password/Unlock The Account’ checkbox in the User Detail section on the right side of the screen.

4. Click the ‘Save’ icon.

5. The user account is now unlocked. The password has been reset to match the User ID. Please note the password is case sensitive and must match in both the ‘User ID’ and ‘Password’ fields.

**Please Note:** In the event the primary System Administrator account becomes locked, a second System Administrator OR the Default User (User ID = laser) may log in and reset the account by following the steps defined above.

If the System Administrator account cannot be unlocked using the **Forgot Password** instructions or the **Locked User Account** instructions please contact the QIES Help Desk for further assistance. The Help Desk will reset the Default User account (User ID=laser) which may then be used to unlock the account or setup a new System Administrator.
PATIENT SETUP AND MAINTENANCE

The ‘Patient Information’ screen allows users, depending on user type, to add, edit, delete and search for patients.

The ‘Patient Information’ screen displays in 4 sections:

- Search Criteria (top of the screen)
- Patient Summary (on the left)
- Patient Detail (on the right)
  - All patient data entry is done in this section.
- Actions (on lower right)

ADD A PATIENT

Complete the following steps to add a new patient:

1. Select ‘Patient’ from the Administration drop-down on the Menu Bar.

2. The ‘Patient Information’ screen displays.
3. Enter the appropriate patient information into the Patient Detail section. Required fields display on the screen in bold type with an asterisk.

4. After entering the required patient information, click the ‘Save’ icon. Saved patient information will display in the Patient Summary section.

5. To add additional patients click the ‘New’ icon, or utilize the ‘Add Patient’ button located in the Actions section on the right side of the screen. Enter data and click the ‘Save’ icon.

HIDE A PATIENT RECORD

The ‘Hide Patient Record’ field located in the Patient Detail section allows users to hide records that no longer need to be accessed. For example, when a patient is no longer in the facility and all associated assessments have been exported; the user can hide the patient record. To hide a patient’s records, select the “Yes, hide record” option within the Patient Detail section.

PATIENT SEARCH

The ‘Search Criteria’ section is located at the top of the ‘Patient Information’ screen. To retrieve all existing patient records, leave the Search Criteria blank and click the ‘Search’ button.

Complete the following steps to retrieve one or more records based on Search Criteria:

1. Select criteria from the ‘Field Name’ and ‘Condition’ lists.
2. Enter a ‘Field Value’.
3. Select the box next to ‘Show Hidden’ to include records marked ‘Yes, hide record’ in the Patient Details section.
4. Click the ‘Search’ button.
5. Click the ‘Clear’ button to remove search criteria and begin a new patient search.

Please Note: A System Administrator will see duplicate patients listed in the Patient Summary section if a patient has been at multiple facilities and the System Administrator has access to all of those facilities within the LASER application.

It is also recommended that the user close any open tabs and begin with a new ‘Patient Information’ screen when conducting a search after updating or modifying patient or facility information.
**MODIFY A PATIENT**

Complete the following steps to modify an existing patient:

1. Locate and highlight the patient in the Patient Summary section.
2. Make the appropriate changes in the Patient Detail section on the right side of the screen.
3. Click the ‘Save’ icon.

The following message will display on the ‘Assessment Search’ screen when opening an existing assessment after patient information has been modified: “The patient information has changed, would you like to update the assessment to reflect these changes?”

The user will be shown the field name values currently in the assessment (Before Value) as well as the value after selecting ‘Yes’ on the Patient Data Updated pop-up window (After Value).

- Selecting ‘Yes’ will update the patient information within the selected assessment record to reflect what is in the Patient Detail section of the ‘Patient Information’ screen.
- Selecting ‘No’ will open the record without updating patient information within the selected assessment record.

**Please Note:** This message will continue to be displayed each time an assessment is opened after modifying the patient data until ‘Yes’ is selected.

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**DELETE A PATIENT**

Complete the following steps to delete a patient:

1. Locate and highlight the patient in the Patient Summary section.
2. Click the ‘Delete’ icon or the ‘Delete Patient’ button in the Actions section of the ‘Patient Information’ screen.
   - Deletions cannot be made if one or more assessments have been created for the patient.
**MOVE A PATIENT**

In the event a patient is moved from one LTCH facility to another within the same corporation, it is necessary to reassign the patient to the appropriate facility. Before reassigning a patient to a new facility ALL existing assessments must be in an ‘Exported’ or ‘Outdated’ status.

**Verify Assessment Status**

Complete the following steps to verify the status of a patient’s assessments:

1. Perform an assessment search by following the Assessment Search procedure. It is recommended that the ‘show hidden’ checkbox be applied to ensure all existing records are shown.

2. If all assessments found have an ‘Exported’ or ‘Outdated’ status, proceed to Assign a New Facility ID below.

3. If ‘Non-Exported’ assessments are found, enter any remaining applicable data to complete the assessment record. Required fields will appear in bold type in the ‘Navigator’ section of the ‘Assessment’ screen. You may also choose to delete an assessment if it has been entered in error.

4. Click the ‘Save and Validate’ icon.

5. If the assessment is complete you will have achieved a status of ‘Outdated’ or ‘Export Ready’. Close the assessment.

6. For ‘Export Ready’ assessments, follow the Export procedure to set the status appropriately.

**Assign a New Facility ID**

Complete the following steps to assign a patient to a new facility:

1. Select ‘Patient’ from the Administration drop-down on the Menu Bar.

2. The ‘Patient Information’ screen displays.

3. Perform a Patient Search for the patient you wish to move.

4. Locate and highlight the patient to be reassigned in the Patient Summary section.

5. Verify the patient information in the Patient Detail section on the right.

6. Select the new facility from the ‘Assigned Facility/Provider Submission ID (FAC_ID)’ drop-down.

7. Click the ‘Save’ icon.

8. The ‘Confirm Change Facility’ screen displays the following message: “Are you sure you want to change the facility for Patient (patient name)? The following assessments for this patient will remain in the original facility where they were created:”
9. Click ‘Finish’ to complete the patient move process and assign the new facility information.

10. Click ‘Cancel’ to return to the ‘Patient Information’ screen.

When a patient has been successfully moved the following confirmation message will be displayed: “(Patient Name) has been moved successfully.” Saved patient information will display in the Patient Summary section of the Patient Screen.

If assessments remain for a patient which are not ‘Exported’ or ‘Outdated’, the following error message will be displayed: “All assessments associated with this Patient must be in either an OUTDATED or EXPORTED status. Please review these assessments and set the status to a status mentioned previously.”
SCREEN TABS
Tabs for active screens (e.g. Home, Patient, Assessment Search, and Assessment) will display below the Toolbar at the top of the screen. The ‘Assessment’ tab will display the assessment type, patient name and assessment date.

When the assessment screen is open no other screens may be accessed.

If an attempt to view a subsequent screen tab such as ‘Assessment Search’ while the ‘Assessment’ screen is active, the user will receive an error message stating that this function is not allowed. Click ‘OK’ to close the error message and return to the ‘Assessment’ screen.

ASSESSMENT SCREEN TABS
When an assessment is opened three additional tabs will be displayed:

- Assessment
- Patient Details
- Assessment Determination
ASSESSMENT
The ‘Assessment’ tab displays the patient assessment; this is where all assessment data entry will be completed.

PATIENT DETAILS
The ‘Patient Details’ tab displays patient demographic data in a view only, non-editable, format.

ASSESSMENT DETERMINATION
The ‘Assessment Determination’ tab displays data previously entered on the ‘Add Assessment’ wizard in a view only, non-editable, format.

NAVIGATOR
The assessment ‘Navigator’ is located in the top left corner of the ‘Assessment’ screen and will display all assessment items in a collapsible tree format. Unanswered questions will appear in bold type.

As questions are answered, they are removed from the tree. To change the display of the tree to continue showing answered questions utilize the ‘Show/Hide’ icon in the Toolbar at the top of the screen.

TIP: Clicking on an item in the tree will move the cursor to the selected field within the assessment.
EDITS

Data integrity edits are applied as information is entered into LASER. These edits are unique messages put in place to assist users with the accurate completion of data entry. Some edits will present a pop-up message and must be addressed when displayed in order to proceed. Other edits may not appear until the assessment is saved and validated.

The assessment ‘Edits’ section is located in the bottom left corner of the ‘Assessment’ screen. This section displays applicable errors or warnings found within an assessment after selecting the ‘Save and Validate’ icon.

The following types of edits may occur in LASER:

ERRORS (!)
This type of edit informs the user that information is missing or invalid. Data must be entered or corrected before the assessment may be completed.

WARNINGS (#)
This type of edit indicates there is data entered that should be verified as accurate, or serves as a reminder regarding how certain fields should be completed.

INFORMATIONAL (?)
This type of edit gives the user general information about the assessment data entered.

TIP: Clicking on an edit message will move the cursor to the appropriate field within the assessment so it may be verified or corrected. An Assessment Error Report may be printed which will display all edits shown on the ‘Edits’ section of the ‘Assessment’ screen.
ADD AN ASSESSMENT

Complete the following steps to create an assessment:

1. Select ‘Patient’ from the Administration drop-down on the Menu Bar.

2. Complete a Patient Search or add a new patient.

3. In the Patient Summary section, double click on the patient you wish to add an assessment for, OR highlight the patient row by clicking on the patient and click the ‘Add Assessment’ button at the bottom of the Actions Section.

4. The ‘Add Assessment’ wizard displays.

5. Enter information into the fields as appropriate. Required fields display on the screen in bold type with an asterisk.

6. Click ‘Finish’ to display the ‘Assessment’ screen and continue entering assessment data OR click ‘Cancel’ to return to the ‘Patient Information’ screen.
Please Note: After clicking ‘Finish’ errors and/or warning messages, if applicable, will display in a pop-up window before opening the ‘Assessment’ screen. Below is an example of the ‘Assessment’ screen.

7. Enter data as appropriate on the ‘Assessment’ screen. Required fields will appear in bold type in the ‘Navigator’ section at the upper left. Clicking on an item in the ‘Navigator’ will move the cursor to the selected field within the assessment.

Please Note: For optimization of the skip patterns and/or edits, it is recommended that data be entered in the order the questions appear on the screen.

8. To save progress as data is entered, click the ‘Save’ icon or utilize the short-cut, Ctrl+S.

9. When data entry is complete click the ‘Save and Validate’ icon to validate the assessment for errors or warnings.
DUPLICATE ASSESSMENTS
In the event that the information entered on the ‘Add Assessment’ wizard duplicates an existing record within the assessment database, the ‘Next’ button will enable on the ‘Add Assessment’ wizard, instead of the ‘Finish’ button. The following screen will display with a list of duplicate assessments.

Complete the following steps to proceed in the event of a duplicate assessment:

1. Click to highlight the assessment.
2. Click the ‘Finish’ button to review and continue data entry of the existing assessment or select ‘Cancel’ to return to the ‘Patient’ screen.

If the assessment found to be a duplicate is already in an exported status, the following message will display: “Duplicate assessment found has a status of “EXPORTED” and cannot be opened from this window. Please use the assessment search screen.” The user will need to navigate to the Assessment Search screen to modify or remove the assessment before proceeding.
**ASSESSMENT SEARCH**

Complete the following steps to search for an assessment:

1. Select ‘Search’ from the Assessment drop-down on the Menu Bar.

2. The ‘Assessment Search’ screen displays.

3. To retrieve all existing assessment records leave the Search Criteria blank and click the ‘Search’ button.

4. To retrieve one or more assessment records based on Search Criteria:
   a) Select criteria from the Field Name and Condition lists.
   b) Enter a corresponding Field Value.
   c) Click the ‘Search’ button.
   d) Click the ‘Clear’ button to remove search criteria.

**Please Note:** Selecting the box next to ‘Show Hidden’ will include records for patients marked ‘Yes, Hide Record’ on the ‘Patient’ screen.

It is also recommended that the user close any open tabs and begin with a new ‘Assessment Search’ screen when conducting a search after updating or modifying patient or facility information.
VIEW ONLY
Occasionally it may be necessary to view previously entered information where there is not a need to modify or edit the data. To view assessment data without editing or resetting the assessment status (e.g. Exported assessment) users may utilize the ‘View Only’ checkbox.

Complete the following steps to open an assessment in ‘View Only’ mode:

1. Complete an Assessment Search to locate the desired assessment.
2. Click to place a checkmark into the ‘View Only’ checkbox at the bottom of the screen.
3. Highlight the desired assessment record and select the ‘View Assessment’ button at the bottom of the ‘Assessment Search’ screen, or double click to open the assessment for viewing.
4. The ‘Assessment’ screen opens in ‘View Only’ mode.

Please Note: Assessments may not be modified in ‘View Only’ mode. To make changes to this assessment OR subsequent assessment records the ‘View Only’ checkbox must be unchecked.

MODIFY AN ASSESSMENT
When modifying an assessment the user must first determine the assessment status. The assessment status may be viewed on the ‘Assessment Search’ screen as shown in the example below or on the Tool Bar once an assessment record has been opened. The following assessment statuses may occur within LASER:

- NEW
- IN_USE
- DATA_ENTRY
- EXPORT_READY
- EXPORTED
- OUTDATED (assessment record greater than 36 months old)
NEW, IN_USE, DATA_ENTRY, EXPORT READY or OUTDATED

Complete the following steps to modify an existing assessment with a status of NEW, IN_USE, DATA_ENTRY, EXPORT READY or OUTDATED:

1. Complete an Assessment Search to locate the desired assessment.

2. Highlight the assessment and select the ‘Edit Assessment’ button at the bottom of the ‘Assessment Search’ screen or double click to open the assessment for modification.

Please Note: When an OUTDATED assessment is opened the following decision message will be displayed: “(Target Date) is greater than 36 months old. Would you like to continue and open this assessment?” Select ‘Yes’ to continue.

3. The ‘Assessment’ screen will display.

TIP: Unanswered questions will appear in bold type in the Navigator section at the upper left corner of the ‘Assessment’ screen. Clicking on an item in the Navigator tree will move the cursor to the selected field within the assessment.

4. Modify the assessment as appropriate.

5. Select the ‘Save and Validate’ icon on the toolbar to display any applicable warnings or errors found within an assessment.

EXPORTED

Only a user with System Administrator access may modify an assessment that has been exported.

Complete the following steps to modify an existing assessment with a status of EXPORTED:

1. Complete an Assessment Search to locate the desired assessment.

2. Highlight the assessment and select the ‘Edit Assessment’ button at the bottom of the ‘Assessment Search’ screen or double click to open the assessment for modification.

3. The ‘Exported Assessment’ pop-up window displays with the following options:

   - Open this assessment in read only mode - Assessment opens and displays all previously selected answers in a view only format. This selection checks the ‘View Only’ checkbox at the bottom of the ‘Assessment Search’ screen. All other assessments will be view only until this box is unchecked.

   - Create a correction record – Assessment opens and displays all previously selected answers. All fields may be modified with the exception of the responses given on the ‘Add Assessment’ wizard. [Assessment Reference Date (A0210), Admission Date (A0220), Reason for Assessment (A0250) and Discharge Date (A0270)]

   - Create an inactivation record – Inactivation assessment opens. All fields are a view only, non-editable, format with the exception of Z0500B which will need to be answered. Once saved the assessment type will be changed to XX- Inactivation.
• **Reset Status and Edit** – Assessment opens and displays all previously selected answers in an editable format. All fields may be modified with the exception of the responses given on the ‘Add Assessment’ wizard. [Assessment Reference Date (A0210), Admission Date (A0220), Reason for Assessment (A0250), and Discharge Date (A0270)] The assessment status will be changed to IN_USE.

Please Note: Users who do not have System Administrator access will be shown an ‘Exported Assessment’ pop-up with only one option to “Open this assessment in read only mode.” Selecting ‘OK’ will open the assessment for viewing only, selecting ‘Cancel’ will return the user to the ‘Assessment Search’ screen.

4. Select one of the four options provided on the ‘Exported Assessment’ pop-up window.

5. Select ‘OK’ to continue.

6. Modify the assessment if applicable or enter the LTCH Care Data Set Completion Date (Z0500B) if creating an inactivation assessment.

7. Click the ‘Save and Validate’ icon on the toolbar.

**COPY AN INACTIVATED ASSESSMENT**

Occasionally it may be necessary to inactivate a record which subsequently needs to be modified for re-submission to the national data repository. For example, LTCH policy instructs the provider to submit an inactivation record when the first name, last name, SSN, gender and/or birthdate is to be corrected. A new record with the correct information is then submitted.

After updating the patient information (see **Modify a Patient**) a copy of the inactivated record can be made to avoid the need to re-enter all of the assessment data.

Please Note: If modifications need to be made to any fields contained within the ‘Add Assessment’ wizard. [Assessment Reference Date (A0210), Admission Date (A0220), Reason for Assessment (A0250), and Discharge Date (A0270)] a NEW assessment record must be added following an inactivation.

Complete the following steps to copy an inactivated assessment with a status of EXPORTED:
1. Complete an [Assessment Search](#) to locate the inactivated assessment. Note that the assessment type will be shown as XX-Inactivation on the ‘Assessment Search’ screen.

2. Highlight the assessment and select the ‘Edit Assessment’ button at the bottom of the ‘Assessment Search’ screen or double click to open the assessment.

3. The ‘Exported Assessment’ pop-up window displays with the following options:

   - **Open this assessment in read only mode** – Inactivation assessment opens and displays all previously selected answers in a view only format. This selection checks the ‘View Only’ checkbox at the bottom of the ‘Assessment Search’ screen. All other assessments will be view only until this box is unchecked.

   - **Create a copy** – Assessment opens and displays all previously selected answers in an editable format. All fields may be modified with the exception of the responses given on the ‘Add Assessment’ wizard. [Assessment Reference Date (A0210), Admission Date (A0220), Reason for Assessment (A0250), and Discharge Date (A0270)] Only one copy per inactivated assessment is allowed.

   - **Reset Status** – Inactivation Assessment opens and displays all applicable fields in a view only, non-editable format. The Assessment Status will be changed to IN_USE.

4. Select one of the three options provided on the ‘Exported Assessment’ pop-up window.

5. Select ‘OK’ to continue.

**Please Note:** The following message will display prior to opening the assessment if patient information has been modified: “The patient information has changed, would you like to update the assessment to reflect these changes?”

   - Select ‘Yes’ to update the assessment with the ‘After Value’.
   - Select ‘No’ to open the assessment without updating patient information.
6. The ‘Assessment’ screen opens.

7. Modify the assessment data if applicable.

8. Click the ‘Save and Validate’ icon on the toolbar.

9. Close the assessment.

**DELETE AN ASSESSMENT**

Only a user with System Administrator access may delete an assessment. Assessments with a status of EXPORTED cannot be deleted; the status of these records must be reset to complete the deletion.

Complete the following steps to delete an assessment:

1. Complete an Assessment Search to locate the desired assessment.

2. Click once to highlight the assessment.

3. Click the ‘Delete Assessment’ button at the bottom of the ‘Assessment Search’ screen to delete the selected assessment.

4. The ‘Confirm Assessment Delete’ pop-up window displays the following message: “Are you sure you want to delete assessment [patient last name, first name, admission/re-entry date (A0210)]?”

![Confirm Assessment Delete Pop-up Window]

5. Select ‘OK’ to delete the assessment. Select ‘Cancel’ to close the pop-up window. The assessment will not be deleted.

If an assessment with a current status of EXPORTED needs to be deleted the user should first verify that the assessment record has not been submitted to the national data repository.

Complete the following steps to delete an assessment that has been previously exported:

1. Complete an Assessment Search to locate the desired assessment.

2. Highlight the assessment and select the ‘Edit Assessment’ button at the bottom of the ‘Assessment Search’ screen or double click to open the assessment.
3. The ‘Exported Assessment’ pop-up window displays with the following options:

- Open this assessment in read only mode
- Create a correction record
- Create an inactivation record
- Reset Status and Edit

![Exported Assessment pop-up window]

4. Select the ‘Reset Status and Edit’ radio button.

5. Select ‘OK’.

6. The ‘Assessment’ screen will open setting the status to IN_USE.

7. Close the assessment.

8. Follow the instructions to [Delete an Assessment](#) to complete the removal of the assessment record.

**EXPORT**

The ‘Export Assessments’ screen allows the user to export records for subsequent submission to the appropriate national data repository.

Complete the following steps to export an assessment:

1. Select ‘Export’ from the Import/Export drop-down on the Menu Bar.

2. The ‘Export Assessments’ screen displays.
3. The export process will depend upon which Export Type is chosen. Select one of the following Export Types from the drop-down at the upper left corner of the ‘Export Assessments’ screen:

- New Export (Assessments marked as “Export Ready”)
- Previous Export (Assessments marked as “Export Ready” or “Exported”)

The process for each Export Type has been defined below.

**NEW EXPORT**
(Assessments marked as “Export Ready”)

Complete the following steps when selecting New Export:

1. Click the ‘Browse’ button to select the Export Path. This is the location where the exported files will be saved.

2. Enter a unique file name into the field labeled Export Name. The Export Name will serve as a reference to the user when submitting the file to the appropriate national data repository. An example of what a user may choose to enter here would be the date the export file is created.

3. Enter the Export Description. This is an optional field which may be used to document additional details regarding the export file.

4. Select the assessments to be included in the export file by placing a checkmark into the boxes next to the desired assessment records. A minimum of one selection is required.

   - The ‘Select All’ button will select all assessments displayed in the list to be included in the export file.
   - The ‘Clear Selection’ button will unselect all assessments previously selected.

5. If desired, select the ‘Print Assessment List’ button to print a list of all assessments selected to be included in the export file. Please note: This report does not have a preview option and will be sent directly to the printer of the user’s choice.

6. If desired, select the ‘Error Check’ button to validate all assessments selected for export. Warnings and/or Error results will display in a new screen.
7. Select the ‘Export’ button to complete the export process.

8. The ‘Export Complete’ pop-up window displays notifying the user that the export process is complete. The number of assessments which have been exported as well as the location of the exported files displays within this pop-up window.

**PREVIOUS EXPORT**

(Assessments marked as “Export Ready or “Exported”)

Complete the following steps when selecting Previous Export:

1. Begin by highlighting a previously exported file from the list in the Previous Exports section located in the center of the ‘Export Assessments’ screen.

2. A list of assessments included in the previous export will be displayed in the section titled Previously Exported Assessments located at the bottom of the ‘Export Assessments’ screen.

3. Select the assessments to be included in the export file by placing a checkmark into the boxes next to the desired assessment records. While all assessments included in the previous export will be displayed, ONLY assessments with a status of “Export Ready” or “Exported” may be selected for inclusion in a new export file. A minimum of one selection is required.

- The ‘Select All’ button will select all assessments displayed in the list to be included in the export file.
- The ‘Clear Selection’ button will unselect all assessments previously selected.
4. Click the ‘Browse’ button to select the Export Path. This is the location where the exported files will be saved.

5. Enter a unique file name into the field labeled Export Name. The Export Name will serve as a reference to the user when submitting the file to the appropriate national data repository. An example of what a user may choose to enter here would be the date the export file is created.

**Please Note:** By default the original Export Path and Export Name will be displayed. It is recommended to use the same Export Path for each export file; however the Export Name should be unique for each export file created. Failure to create a new Export Name may result in the following pop-up window: “The file you are attempting to export already exists, overwrite file?”

- Selecting ‘Yes’ will replace the original export file saved.
- Selecting ‘No’ will return the user to the ‘Export Assessments’ screen so they may select a new Export Name.

6. Enter the Export Description. This is an optional field which may be used to document additional details regarding the export file.

7. If desired, select the ‘Print Assessment List’ button to print a list of all assessments selected to be included in the export file. Please note: This report does not have a preview option and will be sent directly to the printer of the user’s choice.

8. If desired, select the ‘Error Check’ button to validate all assessments selected for export. Warnings and/or Error results will display in a new screen.

- Select the ‘Save to File’ button to save the error report.
- Select the ‘Close’ icon in the upper right corner to close the error report.

9. Select the ‘Export’ button to complete the export process.

10. The ‘Export Complete’ pop-up window displays notifying the user that the export process is complete. The number of assessments which have been exported as well as the location of the exported files displays within this pop-up window.
IMPORT

The ‘Import Assessments’ screen allows users to determine how data is imported into LASER.

Complete the following steps to import an assessment:

1. Select ‘Import’ from the Import/Export drop-down on the toolbar.

2. The ‘Import Assessments’ screen displays.

3. Click the ‘Browse’ button to navigate to the location of the files to be imported.

**Please Note:** There may be an increased wait time when importing a large number of assessment records due to database encryption.

4. Set the desired preferences. You may select preferences individually or click the ‘Select All Options’ button to check or uncheck all checkboxes.

**PREFERENCES**

**PATIENT DATA OPTIONS CHECKBOX**

Selecting this checkbox turns off the warning message displayed when a new patient is imported. “Do not give warning when new patient is added during import.”
MISCELLANEOUS DATA OPTIONS CHECKBOXES

- “Do not display warnings in error check results.” Selecting this checkbox removes warning messages from the error check results report that displays after importing data. Only fatal errors are included in the report.

- “Assign Exported status to assessments without errors (instead of Export Ready).” Selecting this checkbox sets the status of imported assessments to ‘Exported’ if the assessment record does not contain errors.

- “Associate assessments with a blank Fac ID field to the selected facility below.” Selecting this checkbox links import records which are missing a facility ID to the selected facility.

5. Select the ‘Error Check File’ button to validate all assessments to be imported. Error results will display in a new screen.
   a. Select the ‘Save to File’ button to save the error report (.txt).
   b. Click the ‘Close’ icon in the top right corner to close the report.

6. Click the ‘Import’ button to import the selected assessment records into LASER.

7. If the import file chosen contains assessment records for patients who have not previously been entered into LASER a ‘New Patient’ message will be displayed: “A new patient is being added to (Facility – FAC ID). Continue with the import of (Patient Name - SSN)?”
   a. Click ‘Yes’ to continue.
   b. Click ‘No’ or ‘Cancel’ to stop the import process.

Please Note: This message will NOT be shown if the Patient Data Options checkbox has been selected.
8. The ‘Import Complete’ message displays along with a Status Report for all assessments included in the import.

![Import Complete Message]

9. If none of the selected files are successfully imported, the ‘Import Failed’ message displays along with a Status Report.

![Import Failed Message]

10. Click the ‘OK’ button on the ‘Import Complete’ pop-up window to view the Status Report.

11. Click the ‘Save to File’ button on the bottom of the Status Report to save a copy. The Import Status report cannot be minimized.

12. Click ‘Close’ in the top right corner to close the Status Report.

REPORTS
LASER reports allow users to preview and print assessment information as well as detail and summary information for both facilities and patients.

The following reports are available within the LASER application:

- Print Assessment Report
- Assessment Error Report
- Event Tracking
- Assessment Data Entry – By Status
- Data Comparison
**PRINT ASSESSMENT REPORT**

The Print Assessment Report provides a listing of all data which has been entered into the assessment record. Complete the following steps to obtain the Print Assessment Report.

1. Begin generating the report using one of the three available methods.
   - Click the ‘Print Assessment Report’ icon on the Toolbar.
   - Utilize the short-cut, Ctrl+A.
   - Select ‘Print Assessment Report’ from the File drop-down on the Menu Bar.

2. The Print Assessment Report criteria selection window is displayed. This criteria selection window should be used to designate the number of signature lines shown on the printed report. The default number of signature lines will be 12.
   
   Selecting ‘Cancel’ will close the criteria selection window; the Print Assessment Report will not be generated.

3. Select the ‘OK’ button to generate the report.


5. To print the report, click the ‘Print’ icon on the Report Viewer screen.

6. To save the report as a PDF document, click the ‘Save’ icon on the Report Viewer screen.

7. To export and save the report using a different file type, click the arrow next to the ‘Save’ icon.

8. The following export type values are available:
   - Export as PDF
   - Export as RTF
   - Export as Jasper Reports
   - Export as HTML
   - Export as Single Sheet XLS
   - Export as Multi Sheet XLS
   - Export as CSV
   - Export as XML
   - Export as XML with Images
Assessment Error Report

The Assessment Error Report provides a printable listing of all edits received for an assessment and may be generated in one of the following ways:

- Click the ‘Print Error Report’ button located at the bottom of the ‘Edits’ section.
- Click the ‘Print Assessment Error Report’ icon on the Toolbar.
- Utilize the short-cut Ctrl+P.
- Select ‘Print Assessment Error Report’ from the File drop-down on the Menu Bar.

Assessment Error Report

Assessment Type: LP - LTCH Planned Discharge
Assessment Date: 09/17/2015
Last Name: Last Name
Admission Date: 09/17/2015

<table>
<thead>
<tr>
<th>Question</th>
<th>Severity</th>
<th>Error Number</th>
<th>Error Message</th>
</tr>
</thead>
<tbody>
<tr>
<td>ITM_SET_VRSNWarning</td>
<td>-1031</td>
<td></td>
<td>Invalid version code value.</td>
</tr>
<tr>
<td>SPEC_VRSN_C Warning</td>
<td>-1031</td>
<td></td>
<td>Invalid version code value.</td>
</tr>
</tbody>
</table>
EVENT TRACKING
The Event Tracking report is available ONLY to users with System Administrator access. This report may be used to track activity such as additions, deletions and/or modifications which are made to data within the Facility, User, Patient or Assessment screens.

Complete the following steps to run the Event Tracking report:

1. Select ‘Event Tracking’ from the Reports drop-down on the Menu Bar.

2. The ‘Event Tracking’ criteria selection window displays.

3. Complete the required fields. Required fields display on the screen in bold type with an asterisk.

4. Select the ‘OK’ button to generate the report. Selecting ‘Cancel’ will close the ‘Event Tracking’ criteria selection window.

5. To print the report, click the ‘Print’ icon on the Report Viewer screen.

6. To save the report as a PDF document, click the ‘Save’ icon on the Report Viewer screen.

7. To export and save the report using a different file type, click the arrow next to the ‘Save’ icon.

8. The following export type values display:
   - Export as PDF
   - Export as RTF
   - Export as Jasper Reports
   - Export as HTML
   - Export as Single Sheet XLS
   - Export as Multi Sheet XLS
   - Export as CSV
   - Export as XML
   - Export as XML with Images
**ASSESSMENT DATA ENTRY – BY STATUS**

The Assessment Data Entry – By Status report provides a listing of all assessment records for the chosen status. The following statuses are available in LASER:

- New
- In Use
- Data Entry
- Export Ready
- Exported
- Outdated

Complete the following steps to run the Assessment Data Entry – By Status report:

1. Select ‘Assessment Data Entry – By Status’ from the Reports drop-down on the Menu Bar.

2. The ‘Assessment Data Entry – By Status’ criteria selection window displays.

3. Complete the required fields. Required fields display on the screen in bold type with an asterisk. To select two or more statuses, hold the Ctrl OR the Shift button on your keyboard while you select or scroll through the list.

4. Select the ‘OK’ button to generate the report. Selecting ‘Cancel’ will close the ‘Assessment Data Entry – By Status’ criteria selection window.
5. The Report Viewer screen opens displaying the generated report.

6. To print the report, click the ‘Print’ icon on the Report Viewer screen.

7. To save the report, click the ‘Save’ icon on the Report Viewer screen.

8. To export and save the report using a different file type, click the arrow next to the ‘Save’ icon.

9. The following export type values display:
   - Export as PDF
   - Export as RTF
   - Export as Jasper Reports
   - Export as HTML
   - Export as Single Sheet XLS
   - Export as Multi Sheet XLS
   - Export as CSV
   - Export as XML
   - Export as XML with Images

DATA COMPARISON

The Data Comparison Report will compare facility and patient data within assessment records to data stored within the facility and patient administration screens. It will display the fields where data in the assessment no longer matches what is in the administration records.

Complete the following steps to pull a Data Comparison Report:


2. The ‘Data Comparison Report’ criteria selection window displays.

3. Complete the required fields. Required fields display on the screen in bold type with an asterisk.
4. Select the ‘OK’ button to generate the report. Selecting ‘Cancel’ will close the ‘Data Comparison Report’ criteria selection window.

5. To print the report, click the ‘Print’ icon on the Report Viewer screen.

6. To save the report, click the ‘Save’ icon on the Report Viewer screen.

7. To export and save the report using a different file type, click the arrow next to the ‘Save’ icon.

8. The following export type values display:
   - Export as PDF
   - Export as RTF
   - Export as Jasper Reports
   - Export as HTML
   - Export as Single Sheet XLS
   - Export as Multi Sheet XLS
   - Export as CSV
   - Export as XML
   - Export as XML with Images
CLOSE THE APPLICATION

To close the LASER application select ‘Exit’ from the File drop-down on the Menu Bar. LASER may also be closed by selecting the close icon in the upper right corner of the screen.

LOGOUT

To log out and return to the LASER ‘Login’ screen, select ‘Logout’ from the Security drop-down on the Menu Bar.

SESSION TIME OUT

To enhance the security of data stored within the LASER application the system will issue a timeout warning if there has been no activity by the user for ten (10) minutes. The following decision message will be displayed: “Do you wish to cancel the session time out?”

To continue with the session click ‘OK’. If the user does not cancel the session time out prior to 15 minutes of inactivity LASER will close the active screens and return the user to the ‘Login’ screen. If assessment data has been entered but not saved when a time out occurs the application will perform an auto save of the assessment data.
DATA BACKUP

When closing an active session of LASER the user will receive the following decision message along with a listing of the current backup location: “Would you like to backup the database?”

- Select ‘Yes’ to backup the database and close LASER.
- Select ‘No’ to decline the database backup and close the LASER application.

It is strongly recommended that users backup the database each time new data is entered. If a backup has not occurred in the last seven (7) days, LASER will automatically backup the database when the application is closed.

When a database backup is attempted and fails, the following message will be displayed: “The database backup procedure has failed. Please contact your System Administrator.” Users should contact the QIES Help Desk for additional assistance.

CHANGING THE BACKUP FILE LOCATION

The default location for the database backup is located in a database/backup folder where the application is installed. Only a System Administrator may change the location where the backup will be stored.

Complete the following steps to change the location where the backup will be stored:

1. Select ‘Change Backup File Location’ from the File drop-down on the Menu Bar.

2. The ‘Change Backup File Location’ pop-up window displays with the current backup location highlighted.
3. Select the desired backup location.

4. Select ‘OK’ to set the location and close the pop-up window.

5. Selecting ‘Cancel’ will close the pop-up window without changing the location of the backup files.

DATA RESTORE
A database restore requires the assistance of the QIES Help Desk. In the event of data loss, a System Administrator may perform a data restore using a prior database backup.

When attempting to restore a database using a backup which is older than that of the installed version of LASER the following error message will be displayed: “The version of the backup you selected is older than the current version of LASER. Please select a backup of the same version.” Select ‘OK’ to return to the ‘Login’ screen and restore using the appropriate backup file.

HELP
The LTCH Quality Reporting Manual (QRP) provides users with item-specific definitions, instructions and tips for completing LTCH assessments.

Complete the following steps to access help documentation via the Menu Bar:

The LASER ‘Get Help’ screen will be displayed which includes a direct link to the CMS webpage where the LTCH Quality Reporting Manual (QRP) will be found.

Please utilize the LTCH Quality Reporting Program (QRP) Manual for assistance completing the LTCH Care Data Set. For item-by-item guidance chapter three has been organized to correspond with each section of the LTCH Care Data Set.


For questions relating to ICD-9 coding please visit the following CMS webpage: http://www.cms.gov/Medicare/Coding/ICD9ProviderDiagnosticCodes/codes.html

For questions relating to ICD-10 coding please visit the following CMS webpage: http://www.cms.gov/Medicare/Coding/ICD10/index.html

**QIES Help Desk**
For additional technical support and assistance please contact the QIES Help Desk.

Hours: Monday - Friday 7AM – 7PM CST
Phone: 877-201-4721
Email: help@qtso.com
Website: https://www.qtso.com