REHAB ORIENTATION MANUAL

NOTE: Items referenced in *italics* are available at the subunits.

▪ Introduction to Homecare

Homecare is complex and requires that therapists have a working knowledge of the requirements and regulations associated with homecare in order to be successful and have a positive impact on patient outcomes in this specialty area. Medicare has set many of the standards for homecare. Because of this, therapists need a working baseline of knowledge related to how patients qualify for Medicare coverage, the rules related to the specific services, and other information that can assist the clinician, the organization and patients and their families when addressing Medicare questions. In January 1999, the Health Care Financing Administration (now called the Centers for Medicare and Medicaid Services or CMS) created a Condition of Participation (COP) for Home Health Agencies that required the use of a comprehensive assessment tool that identifies the patient's need for homecare and that meets the patient's medical, nursing, rehabilitative, social, and discharge planning needs. This condition required the use of a standard core data set – Outcome and Assessment Information Set or OASIS. It is believed that the use of OASIS for systematic patient assessment improves the quality of care and patient outcomes. By creating a COP for the assessment process, the importance of assessment in the establishment of a plan of care has been emphasized.

▪ Qualifying Criteria

The patient must meet all of the following "qualifying" criteria to be covered for homecare services by Medicare:

1. The patient is homebound as defined by Medicare;
2. The patient is an eligible Medicare beneficiary;
3. The homecare agency is Medicare-certified;
4. The services are coverable as defined in the *Home Health Provider Manual* and meet the specific coverage rules;
5. The services are medically reasonable and necessary based on the patient's unique condition;
6. A physician certifies and provides oversight of the patient's plan of care.

The *"Coverage of Services"* section related to skilled therapy services is described in the *Home Health Provider Manual* which is available on-line. Therapists are strongly encouraged to review this material and know these rules and the specific language for an understanding of therapy requirements under a Medicare Home Health plan of care.

▪ Admission/Service Requirement

Patients are admitted to the home health program when the qualifying criteria previously described are met. In addition, there must also be a reasonable expectation that the patient's medical, nursing, social and rehabilitation needs can be adequately met in the home by the agency's staff and the home environment is adequate and safe for patient care to be delivered. It is important to note again that all home health services provided to beneficiaries must be reasonable and necessary based upon clinical evidence regarding the patient's individual need for care. Coverage criteria vary between private insurance providers, however Medicare guidelines serve as an industry standard for the provision of home health services. The conditions which must be met and documented for a patient (beneficiary) to qualify for coverage of home health services and for continued qualification of these services are specified in the *Home Health Provider Manual* and are known as the *Conditions of Participation* (COPs). These are the rules that a home health agency must follow to participate in the Medicare program.

▪ Homebound Status

The Medicare definition of homebound and the Alabama Department of Public Health (ADPH) *Homebound Status* policy should be reviewed to improve understanding of how Medicare defines homebound. Homebound status is determined on an individual basis, looking at the patient as a whole. The patient's homebound status should be assessed during each therapy visit. If a patient's homebound status has changed or if a skilled provider is in doubt regarding a patient's homebound status, the Home Care Clinical Coordinator should be contacted immediately. It is Medicare fraud to knowingly continue to provide a patient home health care and to bill Medicare for services when it is known that the beneficiary is not homebound. If a patient is no longer homebound but continues to require rehabilitation services, the patient should be referred to an appropriate outpatient or rehabilitation program.

▪ Competency Assessment

Because of the uniqueness of homecare, competency assessment is an important process to ensure that clinicians are knowledgeable in this specialized area. This is not only an initial process but an ongoing process of reviewing knowledge and skills in order to provide the best homecare. You will be asked to provide evidence of *Competency Validation* to indicate your level of prior experience and ability with numerous therapeutic procedures as well as other skills. Components queried may include infection control, equipment use, communication skills, home visit activities, compliance with

Medicare rules, clinical documentation review, skilled therapy interventions, care coordination efforts, regulatory requirements, etc. This process of continually reviewing a therapist's knowledge and skills is key to the provision of the best home care. **A contractor is responsible for the validation of the skills of their care providers as a condition of their contract.**

▪ Care Management

Care management is a process the ADPH utilizes to provide quality services to patients by decreasing fragmentation of care and enhancing the patient's quality of life. This process is coordinated by the Home Care Clinical Coordinator. The Clinical Coordinator is the registered nurse who coordinates all care received by the patient and ensures that the needs of the patient are met in a consistent and timely manner. The goal of care management is quality patient care. All members of the team contribute to the care of patients. Remember that our patients are depending on us to make care decisions that are best for them.

We practice the concept of holistic assessment and care and consider all the patient's needs. Although you may be in a patient's home for a specific treatment or procedure, you should not close your eyes to other needs that arise. Assess the patient, notify the Clinical Coordinator and set into motion a plan to meet the patient's needs. Never ignore a symptom. Call and report the symptom to the Clinical Coordinator. Document this contact on the appropriate Therapy Clinical Note (*HBS-114 or 116 for PT, HBS-117 or 118 for OT or HBS 119 or 120 for ST*). It is then the Clinical Coordinator's responsibility to evaluate the symptom.

▪ Skilled Service

A patient must present with a need that makes skilled nursing, physical therapy or speech therapy services reasonable and necessary to be eligible for Medicare coverage of home health services. Once one of these qualifying services is involved, other secondary health services become reimbursable. These include Medical Social Services, Occupational Therapy, and Home Health Aide services. If a patient is discharged from all the qualifying services but has a continued need for occupational therapy, the occupational therapist should/can remain in the home. Like the qualifying services, a continuing need for occupational therapy will support Medical Social Services and the Home Health Aide. Medical Social Services and Home Health Aide services are not reimbursable without the presence of nursing, physical therapy, speech therapy, or occupational therapy services.

- **Reasonable and Necessary**

Documentation must reflect that skilled services are reasonable and necessary. Specific information that supports this requirement includes:

  - complexity of services should require a skilled practitioner to be provided safely and effectively (skilled services are necessary);
  - services are necessary to and consistent with the patient's unique needs, nature and severity of illness and practice standards (preventive services are not covered by Medicare);
  - services promote functional recovery or are necessary for establishing a safe and effective maintenance program.

- **Intermittent**

All home health services must be provided on an intermittent/part-time basis. Intermittent care requires that the patient have a recurring need for skilled treatment at least once every 60 days. Part-time means any number of days per week.

- **Under the Care of a Physician**

All services must be provided under a Plan of Care (POC). This must be reviewed, revised and continued by the physician every 60 days. All care provided to a patient requires a physician's order which must be in the medical record before Medicare or any other insurance can be billed.

▪ Receiving Patient Referrals

After determination of a need for rehabilitation services, the Clinical Coordinator will obtain verbal/written medical orders for the initial assessment visit by the rehabilitation provider(s). Upon receipt of the physician's orders requesting specific rehabilitation services, the Clinical Coordinator will call the appropriate rehabilitation specialist and relay verbal orders for the initial therapy evaluation visit. A request for therapy evaluation should be preceded or immediately followed by the provision of written information to the rehabilitation provider by FAX, mail or subunit office mail box, according to prearranged plans between the agency and the rehabilitation provider. These arrangements should be decided and agreed upon during a therapist's orientation and prior to provision of patient care.

Written referral information provided to the therapist should include: the patient's full name, an address, phone number and directions to the patient's home; medical diagnosis;

reason for referral; subunit name and telephone number; the agency start of care date; Clinical Coordinator's name; physician's name, address, and telephone number; a copy of the POC if available and the names and telephone numbers of other skilled professionals who will be involved in the case (if rehabilitation services are provided by multiple agencies); and any other information deemed necessary by the Clinical Coordinator (see *Referral/SOC form HBS-201* and *Referral Request HBS-291).* It is the responsibility of the Clinical Coordinator to have obtained verbal/written medical orders for the initial assessment visit by the rehabilitation provider.

Should a therapist receive a referral with a diagnosis unrelated to their specialty or the patient's care needs, the Clinical Coordinator is contracted. The therapist should ascertain whether the referral was received by the appropriate discipline. The therapist or Clinical Coordinator must be able to secure from the physician a diagnosis which supports medical necessity for therapy intervention.

▪ Visit Preparation

• Assemble Patient Information

The first step in preparing to make a home visit is to gather the necessary information for the patients on your schedule for the day. This will include a *Home Health Patient Encounter Form, HBS-286* to record visits made to ADPH patients, a Therapy Clinical Note for documentation of skilled services provided and directions to the patient's home and phone number.

• Verify Visit by Phone

To confirm your visit schedule, make a telephone call to the patient's home the day before or morning of the scheduled visit. Often this confirmation can be made at the time of a previous visit, but it is essential to call ahead to confirm the visit or to set up an agreed upon time of day. For daily or multiple visits each week, the phone call may become unnecessary because you have a set schedule with the patient. Valuable information can be obtained in the pre-visit phone call about changes in the patient's condition that can better prepare you for the home visit. In general, setting up an exact visit time is impossible and may cause concern if you are late or do not arrive at an exact time. Schedule an approximate time, such as mid morning, mid day, or early afternoon to avoid the issues associated with making a time-specific appointment and running late. If you have major schedule delays, attempt to call and reschedule or advise the patient of your changed schedule times. This conveys to the patient that you recognize they are partners in their care and that their time is valuable.

If you are visiting the patient for the first time or it has been some time since your last visit, use the phone call to confirm directions to the home. Ask about pets or other animals that may be at the home. If necessary, request that animals be secured before your visit. Some patients require notification prior to anyone visiting the home to restrain animals used for security purposes.

There are patients who do not have telephone service. In these cases there should be alternate telephone numbers in the medical record or it may be necessary to send a message by other members of the home care team.

• Review of Medical Record

When more medical information is needed regarding a patient, follow the procedure for obtaining the patient's medical record for review. There is a specific procedure in each subunit for obtaining medical records. All medical records taken out of the medical record area are to be signed out. You are responsible for returning all patient records checked out in your name. In preparing for a home visit, familiarize yourself with the patient's record and the purpose of the visit. Some visits need to be scheduled at specific times. Some visits take longer than others. You should also leave time for the unexpected. For example, if the purpose of the home visit is to teach family members to perform exercise and a return demonstration is to take place during the scheduled visit, the visit needs to be made at a time when the family member is available. The proximity of patient's houses to one another should be considered in scheduling your visits.

Become thoroughly familiar with the patient's history, current medical problems, medication regimen, and the plan of care, including specific interventions planned for the patient and teaching the plan. You need to know what the patient has been taught, what they have comprehended and what teaching is scheduled for the visit you are planning. If you are called to substitute for the regular therapist, that individual, the Clinical Coordinator or subunit supervisor will be able to brief you on a case. When you are the regular therapist and another therapist makes a visit, be sure to read their notes or contact them by phone for case conferencing on coordination of services, new problems and interventions.

Remember that all health care services must be consistent with the Plan of Care written for that discipline. Also, the plans of care written by different disciplines must not demonstrate an overlap of actual skilled services provided. For example, both physical and occupational therapy can not be providing the patient exercises for increasing ROM and strength in the right arm. From your multi-disciplinary contacts and chart reviews, you can prepare for your visit, make decisions about what you plan to accomplish and assist in providing coordinated services.

Many patients are visited several times a week. In these cases a thorough chart review may not be necessary after an initial review, especially if you are making the visits yourself. Your review of the medical record and/or contact with others providing the patient with care should help you to form realistic expectations for therapy progression, better understand the patient condition and better plan visit activities which coordinate and support other patient activities.

- **Gather Supplies**

After confirming your schedule and reviewing the patient medical record and/or contacting other patient care team members, gather all supplies needed to accomplish your planned interventions. Supply needs should be included in the Plan of Care. Not all supplies are covered by payment sources and the patient may have to obtain their own supplies. Some payment sources require pre-certification of supplies. It is the therapist's responsibility to inform the physician and instruct the patient on special supply needs. The cost of supplies not covered by patient insurance is the patient's responsibility. A Medical Social Worker may be able to provide assistance in these cases. Each visiting therapist will utilize a bag approved by the ADPH to carry therapy supplies as well as appropriate infection control supplies into the home and will adhere to proper bag technique. This is covered in the ADPH clinical *Bag Technique* policy.

- **Greet Patient**

The initial face to face meeting between the rehabilitation specialist and the patient and caregiver is very important because it sets the tone for the relationship to follow. If there are special considerations for entering the home, these should be documented in the visit file. Examples would be going to the back door, to knock loudly because patient is hard of hearing or to beware of dog. Ethnic considerations, such as removing shoes prior to entering the home so as not to be disrespectful, need to be noted. You are a guest in the patient's home and must show respect and consideration for the patient and their family and home. As a home care provider, you will encounter all types of weather and road conditions. Take care not to track elements from the outside into the home. When you enter the home, say "Hello Mrs. Jones, my name is _____ . I am your therapist from the _____ County Home Health." Wear your identification badge so that it is easily visible.

The first few minutes of the home visit will probably be spent in light conversation with the patient or in obtaining information on patient progress and answering questions about the patient's home program activities. This helps to put you and the patient at ease. During the initial visit, remind the patient that you can be contacted by calling the subunit at the number provided to them in their Patient Admission Booklet. The subunit will use the contact information you provide to them in order to reach you if needed.

▪ Initial Therapy Evaluation

The initial evaluation of the patient by the appropriate rehabilitation specialist should be completed within 24 hours of receipt of the written referral or as ordered by the physician. This requirement is covered in the ADPH policy titled *Rehabilitative Therapy*. The written referral is generally preceded by a telephone referral. In all cases possible, referrals should be relayed by FAX. If completion of the rehabilitation initial assessment is not possible within this time frame, the Clinical Coordinator should be informed

immediately. In this event, the Clinical Coordinator should either attempt to obtain the needed rehabilitation services from another provider or arrange for the initial assessment to be completed as early as possible, i.e., specific date/time. The Clinical Coordinator should record this information in the patient medical record.

All assessment information should be documented on the appropriate rehabilitation evaluation form (*HBS-114 for PT, HBS-117 for OT or HBS-119 for ST*). The assessment is comprised of many components which assist in eliciting needed information to determine the patient's needs for the therapy plan of care. The patient's medical/surgical history should be noted. This information includes the date(s) of the onset or exacerbation of the illness or injury, safety factors that place the patient at risk, the patient's functional status prior to the current condition, any history of prior therapy intervention(s) and outcomes, and the reason therapy is needed or initiated. Documentation should clearly illustrate an accurate reflection of the patient's condition and health status, including functional limitations. The assessment must describe the patient's homebound status and should reflect the impact of the patient's functional/medical limitations on their activity.

Following completion of the initial evaluation, orders for the recommended therapy POC must be obtained from the physician. Generally, orders are present only for the initial therapy evaluation which means that visits beyond the initial therapy evaluation are not covered until verbal orders are received from the physician. The following information should be called-in or faxed to the Clinical Coordinator no later than the next working day following the evaluation visit:

- Recommendations for therapy interventions
- Frequency for current certification period
- Estimated total duration of therapy services
- A brief explanation of the therapy goals
- Patient/caregiver response to therapy recommendations

If the Clinical Coordinator is not available, this information may be left as a voice mail message or relayed through a third party. Additionally, the completed Therapy Plan of Care page should be faxed to the subunit. As with all patient care communications, the therapist should document these communications.

If THERAPY ONLY is ordered, the RN and the therapist MUST visit on the same day to meet admission requirement guidelines from CMS. However, either clinician can make the initial visit to the patient's home but must be responsible for completing all admission information contained within the Patient Admission Booklet with the patient/caregiver. If the therapist has been in-serviced on the agency admission paperwork and related departmental policy, they may make the initial home visit to admit the patient and perform the therapy skills ordered by the physician. The admitting nurse should perform the OASIS SOC form/Comprehensive Assessment later that same day. It is important to note that no hands on care should be delivered until all admission paperwork is signed

and completed. The paperwork requirements for admission are specified in the *Admission* policy.

Original copies of discipline specific initial therapy evaluations and plans of care (*HBS-114 for PT, HBS-117 for OT or HBS-119 for ST*) should be forwarded to the subunit within 2 working days of completion of the initial rehabilitation evaluation. This requirement is specified in the *Medical Record: Documentation* policy.

▪ Therapy Plan of Care

Under the Prospective Payment System (PPS), the Therapy Plan of Care has to be established in conjunction with the total POC to establish payment criteria. The number of therapy visits determined to be necessary at the time of the initial therapy evaluation must be communicated to the subunit no later than the next working day following the evaluation visit. Communication with the subunit after every therapy evaluation is critical in determining the appropriateness of the therapy POC. Completion of a therapy "mini-OASIS" at the time of each therapy evaluation will allow the subunit to make a comparison with the functional OASIS M items as completed by skilled nursing at the time of the patient's comprehensive assessment. The therapist's assessment of 3 M items for PT and 4 M items for OT will provide a basis to compare specific functional items that will help the subunit determine if the projected therapy POC is supported by the OASIS assessment. A completed mini-OASIS form should be submitted with each PT and OT initial evaluation. Use the *PT Mini-OASIS* or the *OT Mini-OASIS* links to access these forms if reading this Manual electronically or request a copy of these forms if reading this Manual as a hard copy.

If the original physician order was for evaluation only, it is necessary to obtain verbal orders for the recommended therapy plan of care prior to proceeding with additional visits. If specific therapy orders (interventions, frequency and duration) were received upon referral and the evaluating therapist agrees with the recommendations, it is appropriate to contact the patient's physician to inform him/her that therapy has been initiated as ordered. This contact can be documented at the bottom of the Therapy Care Plan page of the Therapy Evaluation form. On the initial assessment visit, discuss the purpose of your visits with the patient and/or caregiver and determine what the patient and/or caregiver expect to gain from therapy intervention. The establishment of measurable goals at the onset of care is one of the therapist's most important responsibilities. The goals must be objective and measurable, include time-frames and should reflect what can be expected as a result of therapy intervention and the expected specific functional outcomes. The patient/caregiver must have input into the Therapy Plan of Care by assisting in the determination of therapy priorities and in setting the specific goals of intervention. If the patient/caregiver has unrealistic expectations for therapy outcomes, these should be documented and appropriate instruction and education in this area included as a therapy goal. The established Therapy Plan of Care as approved by the physician should include the following:

- primary diagnosis

- therapy diagnosis
- evidence of patient/caregiver participation
- short and long term goals that are functional in nature and are objective and measurable
- rehabilitation potential to achieve goals
- skilled interventions to be provided
- frequency of visits for the current certification period
- projected total duration of therapy services
- equipment recommendations
- functional limitations and justification for therapy services
- evidence of discharge planning and care coordination
- signature of evaluating therapist
- evidence of care coordination communication

Separate discipline-specific plans of care should be established, e.g., occupational, physical and/or speech therapy plans of care as indicated and appropriate. In all cases, therapy plans of care should address functional outcomes for the patient in terms of self care, social needs and increasing patient independence and safety. Discipline specific plans of care should be signed by the appropriate rehabilitation specialist.

All plans of care must be approved by the physician and include duration and frequency of services within a specific (re)certification period. The patient's total POC must be signed by a physician before a bill for services is submitted to the intermediary for payment of agency services. It is critical that submission of written documentation of service provision be done in a timely manner.

As your care for the patient progresses, the patient's ongoing needs are determined and new goals and objectives may be needed which would require modification of the original Therapy Plan of Care. This is done in consultation with the physician and new orders are written on a *Physician Orders Form* (*HBS-209*). A Therapy Plan of Care that includes long and short-term goals, the frequency and the duration of therapy and which is signed by the patient's physician serves as a medical order, is a legal document and must be followed exactly.

Orders for services on a Therapy Plan of Care must be specific and include:

- Professional discipline and frequency, e.g., PT: 3 wk 3; 2 wk 2 (physical therapy visits 3 times per week for 3 weeks; and 2 times per week for 2 weeks);
- Nature of specialized services, e.g., speech therapy to teach the patient and family strategies

to improve patient safety during oral intake of foods.

The total POC, including therapy plans for patient care, must be reviewed and signed by the physician at least every 60 days. Like the initial certification period, subsequent recertification periods may not exceed 60 days. All skilled services provided and billed for must be covered by a physician's order.

Therapy reassessments must be performed as required by regulation, including both timeliness of performance and content. Required reassessments should be documented on the **Therapy Reassessment** form (*HBS-122*) to make it easier for an external auditor to verify compliance with reassessment requirements.

Recommendations for a new or modified therapy plan of care must be accompanied by evidence of skilled re-assessment of patient functional levels utilizing the same methods of measurement used during the initial evaluation. The **Therapy Reassessment** form (*HBS-122*) can also be utilized for this purpose. The clinical record must contain progress notes that reflect patient progress (or lack of progress) toward long and short term goals/objectives as established in the therapy POC. Any changes in goals/objectives must be supported by documentation which reflects the need for changes based on the patient's functional status.

Recommendations for continuation of skilled therapy services must be provided to the Clinical Coordinator no later than two weeks prior to the end of the certification period. This should consist of a summary of the patient's progress, justification of continuing therapy needs, recommended medical orders including skilled therapy interventions, frequency and duration, and new functional goals.

▪ Physician Orders

The Clinical Coordinator is responsible for the review and facilitation of all medical orders written by the rehabilitation providers. The Clinical Coordinator should be contacted by telephone the same day the orders are initiated (initial visit) or that needed changes in the therapy plan of care are identified. This contact should be recorded by the therapist in the Care Coordination Section of the therapy documentation forms (*HBS-114 or HBS-116 for PT; HBS-117 or HBS-118 for OT; and HBS-119 or HBS-120 for ST*) or on a *Continuation/Conference Note (HBS-297).* Modifications to the original therapy plan of care are completed by utilizing the *Physician Orders Form (HBS-209)* in consultation with the Clinical Coordinator following physician contact related to the need to modify the therapy POC. A telephone conference with the Clinical Coordinator prior to modifying the plan of care will enhance coordination of care.

▪ Start of Care Date

The start of care date for nursing and each of the other skilled service providers that might be involved with a specific patient's care is defined as the first billable visit. To

enhance continuity and coordination of services, re-certification timetables will be synchronized by using the home health agency's start of care date as the benchmark across all skilled services rendering care to a specific patient. For example, if nursing admits the patient on 02/01/XX, then both nursing and PT will use the 02/01/XX start of care date and need to re-certify the patient before 04/01/XX which ends the certification period. In this manner, all skilled services will have the same recertification dates.

▪ Treatment Week

The ADPH treatment week begins on Sunday and ends on Saturday. The number of visits ordered per week must be completed between Sunday and Saturday. The number of visits included in a week for the first and last week of a (re)certification period should be based on the days remaining in the treatment week. For example, if a patient receives services beginning on Friday, the maximum number of visits the patient can receive during that treatment week is typically one – Friday – unless weekend services have been prearranged. This is covered in the *Treatment Week* policy.

▪ Direct Care

Direct care is the actual therapy intervention delivered by the health care provider during a home visit. Direct care includes skilled assessment and observation of the patient, teaching and training the patient and caregiver in home program activities and the use of strategies appropriate for patient improvement, and treatments and procedures which address the medical diagnosis and patient health care needs.

Direct care in the home integrates the patient, family and any other caregivers who might be involved in providing direct care. Home care needs cover a 24 hour period. Care provided by nurses and therapists is short term and intermittent. Since professional providers are not always present in the home, the patient and all other care persons must participate in direct care. When developing the plan of care and setting goals, consider the need to instruct the patient and family in procedures and other interventions so they can assume responsibility for all necessary and appropriate aspects of the patient's care when skilled services are no longer needed.

Payment sources expect health care professionals to identify competent care givers for the patient and instruct them about the patient's care. This ensures comprehensive coverage of the patient's needs, maintenance of skills acquired in therapy and cost-effective use of the patient's coverage benefits.

▪ Patient / Caregiver Education

Patient education is one of many roles assumed by the rehabilitation specialist. Educational activities include patient training and instruction. As managed care evolves in home care, visits are being limited by payment sources. The need to teach patients to

assess their ability for self care and to discharge them is even more central to health care delivery. Since the major responsibility for the care of the patient rests with someone other than the therapist, the primary goal of therapy must be self-care training and instruction of the patient and family. Our goals as educators are more important than ever. Efforts directed toward education of patients and caregivers are valued for their significance related to patient self-care or maintenance. It is also necessary to demonstrate progress toward goals or to provide an explanation if there is minimal or no progress. Teaching is a skilled service. In order to be reimbursed for instruction and education of patient and family, the skilled provider must document clearly and concisely the information being taught and the patient and family outcome, e.g., Did they understand the exercise you taught them? Could they show you they could do the exercise on their own? If not, how much assistance was required?

The goal of teaching is learning. Just because a patient is given information does not mean he/she has learned. A careful assessment of the patient's ability and readiness to learn, along with an assessment of your ability to teach, should be made before teaching begins. The degree of patient illness plays a role in the learning ability of patients. Factors such as pain, fear and depression influence ability and willingness to learn. A patient preoccupied with pain is unable to focus his attention on what a therapist is trying to teach. A patient who is clinically depressed will demonstrate impaired cognitive skills and ability to learn new information.

After assessing, planning is the next step. Set goals and objectives for your teaching that are patient centered and measurable. Develop a teaching plan which addresses these goals and objectives by identifying the material to be covered, the sequence of presentation and the method of presentation. The material you plan to teach has to be seen as needed by the patient. He or she has to understand why your information is necessary. Teaching follows graduated steps. Do not overload the patient with information. If teaching a procedure, teach it in the order the patient will perform the steps.

Research shows that much of the material published for use in patient education requires at least an eighth grade reading level. Most people with low literacy skills cope by agreeing with the instructor whether they understand the information or not. Before developing your plan, assess your patient's skill levels for those skills needed to learn the information you are presenting, e.g., reading, vision. Imagine your frustration if you base a plan on written materials only to discover that the patient does not read. Pictures and diagrams can be very helpful in enhancing verbal instruction.

Learning experiences require involvement of the patient and family. Learning is enhanced by active participation. Research shows that an individual remembers 10% of what is read, 20% of what is heard, 30% of what is seen and 50% of what is heard and seen.

Implement the teaching plan just like any other intervention. Gather all needed supplies. Be sure to include an environment conducive to learning. If you need access to a sink or

table, conduct the teaching where they are available and accessible. Be enthusiastic, confident and positive. Take your time, provide feedback, avoid the use of medical jargon, request patient, family and care giver participation and summarize frequently. Plan for future teaching sessions and let the patient know if he is making progress.

Evaluate the effectiveness of your teaching by examining the goals that were set. Determine what the patient has learned by return demonstration, verbal testing or change in behavior. Ask the patient to tell you what they have learned in their own words. If the goals have been met, the plan was successful. If the goals were not accomplished, reassess and revise the plan or develop a new plan.

Assessment of knowledge deficit and documentation of teaching are critical to reimbursement. Carefully and thoroughly document each step of the teaching plan. Medicare has specific criteria to determine whether a teaching visit is reimbursable.

First, who is conducting the teaching? Teaching that requires the expertise of a nurse, OT, PT or ST is considered reimbursable. If the services can be adequately performed without professional training, the services are not reimbursable. If you teach a family member to perform a skill, once the skill is mastered, the family member functions as the skilled provider and the nurse or therapist is no longer required.

Second, is the teaching reasonable and necessary? To be reasonable and necessary, the services must be consistent with the nature and severity of the illness, the patient's medical needs and accepted standard of practice.

Third, the teaching must be related to the patient's condition and not reinforcement of previous teaching. Reinforcement is generally not reimbursable, unless documented patient changes justify the teaching. When documenting teaching, avoid the words reinforced, reviewed or reminded. Do use words such as "instructed" or "educated" to describe teaching and document your method(s) of teaching. Also include the name of the person who received the instruction(s). Avoid using terms such as daughter or caregiver but state the name of the daughter or caregiver for clarity.

▪ Supervision / Coordination

Part of your responsibility during home visits may be to show coordination of care among all disciplines involved with provision of services to a specific patient. This can be documented on the date of the service on the *Therapy Clinical Note (HBS-116 for PT, HBS-118 for OT and HBS-120 for ST).* If more space is required, a *Continuation/Conference Note (HBS-297)* should be utilized.

The PTA and the OTA are supervised by a qualified therapist corresponding to that discipline. If the therapist determines that it is appropriate for a therapy assistant to carry out the therapy plan of care, there must be documentation that there has been communication from the therapist to the therapist assistant regarding the therapy plan of care. There must also be documentation in the clinical notes of ongoing communication

between the therapist and the therapist assistant as to the progression of the therapy goals and the status of the patient. Specific requirements for supervisory visits are determined by the therapist based on patient need except as required by insurance carriers or ADPH policy. Additional supervisory requirements are applicable when providing care for a patient with Blue Cross and Blue Shield as the provider. In these cases, the supervising therapist must co-sign each note written by the therapy assistant and must make at least every 6th visit to review, revise the plan of care, deliver the hands-on-treatment, and write and sign the treatment note for the visit date. These requirements are covered in the ADPH *Supervision of Patient Care* policy.

The ADPH requires supervision of therapists through direct on-site supervision at least annually to be coordinated by the subunit supervisor, area management team or Bureau Rehab Consultant. This requirement is covered in the ADPH *Supervision of Personnel* policy.

▪ Documentation

The ADPH *Medical Record: Documentation* policy relates to requirements for documentation in the clinical record. Complete and accurate documentation of patient services is critical to the coordination and continuity of a specific patient's care and to the agency being reimbursed for patient services. Each therapist is responsible for documenting all patient related activities and services in an accurate, detailed and timely manner. Remember, if you did not write it down, you did not do it. The accuracy of detail for patient care activities decreases across time. Efforts should be made to document the visit while you are in the home or in a safe location shortly after leaving the patient's home. Documentation should accurately reflect the condition of the patient. The need for therapy services is contingent upon the patient's unique problems and must be documented explicitly. Always write your notes knowing that you may have to prove why you saw the patient and ask yourself if you would authorize payment or reimbursement with this submitted note. Follow this checklist approach when assessing your documentation:

- ✓ Is the patient's homebound status stated in clear, concise, specific and measurable terms?
- ✓ Are all physician orders obtained prior to services being provided?
- ✓ Does the therapy baseline assessment/evaluation and other documentation state why the referral was made, the patient's functional or mobility changes/problems, medical history including prior level of function and current status?
- ✓ Are goals established that are measurable and functional in nature and do they state in clear terms what needs to be accomplished in a given period of time?

- ✓ Are there orders for all the therapy interventions or changes to the plan of care related to therapy services?
- ✓ Do the skilled therapy visit notes and re-evaluations use the same objective measurement tools as those of the initial evaluation to measure the patient's progress or lack of progress?
- ✓ Is there care coordination and communication documented for the therapy team members including those with nurses, physicians, social workers, therapists' assistants and others involved in the patient's care?
- ✓ Do notes reflect "skilled" interventions?

• Late Entry

Late entries may be made to the patient medical record as follows:

Indicate "Late Entry", then enter current date and time, reference to date when information should have been added, provide information to be added that was originally left out of the record, and sign entry.

• Corrections

Errors in entries to the medical record will be corrected as follows:

Make single line of black ink through the words to be corrected, write the initials of the individual correcting the record and record the date and time.

• Therapy Daily Visit Notes

Provision of skilled rehabilitation services will be documented daily on the *Therapy Clinical Note (HBS-116 for PT, HBS-118 for OT or HBS-112 for ST).* Daily visit notes should be initiated in the patient's home on the day of the therapy visit and signed by the patient/caregiver. The original Therapy Clinical Note should be forwarded to the home health agency within 2 working days of the date of the visit. This requirement is covered in the *Medical Record: Documentation* policy.

Access this link for instructions on how to complete the revised *Physical Therapy Clinical Note (HBS-116)* or request a printed copy of these instructions if reading this Manual as a hard copy. The clinical note for OT and ST is not in the same format as the PT Clinical Note. Instructions for completing the OT and ST clinical notes follow.

All service data regarding the patient's performance during skilled therapy will be recorded in the INTERVENTIONS, MEASURABLE OUTCOMES section, e.g., gait training with SW x 15 feet on a flat surface with mod ass't. Daily visit notes must reflect measurable progress in patient skills compared to notes which established a baseline for the skills being addressed. Only actual skilled activities should be documented in this section. These activities should address the short-term objectives and relate them directly to the long-term goals in the POC.

Therapy Clinical Notes should reflect the therapeutic exercises, training, education, instruction and ongoing assessment activities which must be performed or supervised by skilled therapists to ensure patient safety and therapy effectiveness or the restoration of specific loss of function. All therapeutic activities should be documented in clear, concise and measurable terms in this section or the Assessment section, e.g., patient/caregiver was able to correctly verbalize understanding of home program activity for strengthening LLE by verbalizing correctly 4/5 steps without assistance and 5/5 steps with minimal assistance.

The therapist's assessment of the patient's response to and understanding of the therapeutic activities should be documented under ASSESSMENT, GOAL PROGRESS or RESPONSE. If progress is not being demonstrated by the patient, measures which address this should be noted here. Progress in therapy and the relationship of progress in therapy to functional gains should be documented in this section. In addition, comments by the patient and caregiver which relate to patient progress in daily activities should be documented in this section. Patient/caregiver participation in therapy and home program activities can also be recorded in the Assessment section.

Written home program activities should be provided to the patient/caregiver on an as needed and ongoing basis. This information should be kept in one designated place in the home.

In the Plan section, the therapist should report plans for future therapy sessions. It is important that all contacts (verbal and written) and coordination efforts among members of the patient's health care team are evident in the clinical documentation. Patient status and coordination interactions should take place between providers of rehabilitation services and the clinical manager every two weeks at a minimum. Therapists are required to have input into scheduled case conferences which are held every two weeks. Prior to each scheduled conference, therapists will be provided with a list of the patients to be discussed at the conference. Therapists are required to contact the subunit prior to the conference and provide an update on those patients which they are following. In this way, current patient specific therapy information and plans can be utilized during the conference. This requirement is covered in the *Rehabilitative Therapy* policy. Evidence of care coordination and supervision can be documented on the *Therapy Clinical Notes (HBS-116 for PT, HBS-118 for OT or HBS-120 for ST)* or on a *Continuation/Conference Note (HBS-297)* as appropriate.

Notes submitted to the subunit that are not written legibly or are incomplete are not acceptable and will be returned to the therapist. These notes must be corrected and returned to the subunit within 1 working day. All sections on the forms used for documentation should be addressed.

▪ Case Conferences

The Conditions of Participation require documentation in the medial record that shows coordination of patient care. The Clinical Coordinator must have current information regarding all services being provided in the home. Case conferences are held at regularly scheduled intervals (every two weeks) and may be accomplished in person or by telephone contacts. The Clinical Coordinator, therapist and others involved in the patient's care discuss the patient's response to the treatment plan and develop modifications if necessary. Case conferences may take place in a formal or informal manner. Case conferences should support the goals and objectives outlined in the plan of care, report the patient's response and show evidence of coordinated care.

As referenced on the previous page, therapists are required to have input into scheduled case conference which are held every two weeks. Prior to each scheduled conference, therapists should be provided with a list of the patients to be discussed at the conference. Therapists are required to contact the subunit prior to the conference and provide an update on those patients which they are following. In this way, current specific patient related therapy information and plans can be utilized during the conference. This requirement can be found in the *Rehabilitative Therapy* policy.

Case conference activities (information gathering, collaboration, coordination contacts) can be documented on the appropriate therapy clinical note *(HBS-116 for PT, HBS-118 for OT or HBS-120 for ST)* in the designated section if the care coordination occurs on the date of skilled therapy provision. If more space is needed or the case conference activity does not coincide with a visit, a *Continuation/Conference Note (HBS-297)* should be utilized.

▪ Missed Visit

Coordination of care also involves the reporting of any missed visits. In the event that patient care is not delivered according to schedule, efforts should be taken to reschedule the missed visit(s) within the treatment week. This would include notifying the patient and/or caregiver, the Clinical Coordinator and/or the supervising therapist of a missed visit so that the visit can be rescheduled if at all possible. If it is not possible to reschedule a missed visit, the responsible therapist must notify the Clinical Coordinator of the reason the visit was missed and document this contact on a *Conference/Continuation Note (HBS-297).* The Clinical Coordinator will then notify the MD of the reason the visit was missed. If it becomes necessary to alter the original Therapy Plan of Care (i.e. the original treatment duration needs to be extended due to

missed visits), the responsible therapist will consult with the MD and the Clinical Coordinator to revise the Therapy Plan of Care with appropriate change orders which will be documented on a *Physician Orders Form (HBS-208).* The ADPH *Patient Care Delivery* policy describes this procedure.

▪ Patient Visit Schedule

Projected weekly schedules for the upcoming week should be submitted by each therapist to the agency every Friday by noon. Ask for the procedure used in the subunit. All schedules should reflect intermittent patient care. Corrected weekly schedules should be submitted to the agency as appropriate.

▪ Durable Medical Equipment (DME)

Durable Medical Equipment is an item that can withstand repeated use. DME is ordered by a physician. DME must be reasonable and necessary for treatment. Items such as hospital beds, walkers, wheelchairs and mechanical lifts are considered DME. The patient has the right to choose which DME supplier provides their equipment. Keep a list of suppliers with you and make their names available to the patient when a need arises. You are responsible in collaboration with the patient to assess the need for DME. The supplier provides instruction for DME use and you are to ensure that it is used properly. Equipment in the home and the name of the DME supplier is recorded in the medical record.

▪ Patient Discharge

The patient's health status and need for continuing care and services are assessed before discharge. The therapy discharge process should begin at the time of the initial therapy assessment at which time the patient/caregiver has input into their goals and anticipated discharge plans. Patients have the right to be fully informed and prepared for discharge. For patients requiring continuing care or service needs, the Clinical Coordinator assists the family in meeting the continuing care or service needs. Discharge planning identifies these needs and arranges for services as available. Therefore, it is essential that the agency be informed of the discharge plans of each discipline prior to discharge from that discipline. Discharge involves the patient, the family, the physician and all other members of the health care team.

Care for a patient is not arbitrarily terminated once the patient has been admitted for service. Patients are routinely discharged from home health services when: the patient has reached his maximum potential to a point where he can manage in the judgment of the physician and nurse or therapist without program assistance; the goals for services have been attained; maintenance of the patient's care can be assumed by the patient, family or others; the patient is no longer homebound; the requirement for skilled care is no longer met; or the patient dies.

• Initiation on Admission

The admission nurse actually begins the discharge planning process at the time of the patient's admission to home health services. The plan of care and goals are discussed with the patient, family or caregiver. The patient's plan of care also covers instructions for a timely discharge or referral to other programs for assistance. The admission nurse will explain during the admission visit that the patient will be discharged when he or she has reached his or her maximum potential, when goals are attained, maintenance of care can be assumed by the patient, family, or care persons, the patient is no longer homebound, skilled care is no longer required or the patient dies. The rehabilitation specialist is responsible for keeping the Clinical Coordinator informed regarding patient discharge status across the continuum of service provision.

• Patient/Caregiver Preparation

The patient and caregiver play an active part in preparing for discharge. The initial assessment visit is the time to begin setting goals and explain the purpose and frequency of the visits to be provided by the rehabilitation specialists. The time and anticipated length of care are important in planning patient discharge. The rehabilitation specialist documents that the above information is taught during the initial assessment visit, in part, by having the patient/caregiver sign the Therapy Evaluation Plan of Care form and by marking who received information concerning discharge in the designated section of the Therapy Plan of Care. If a caregiver receives this instruction, it is a good idea to specify this person by name. Preparation for discharge that begins at admission prevents misunderstanding when discharge time arrives.

• Other Discharge Reasons

Patients may be discharged from home health for other reasons than those previously stated. When the following situations occur, contact the Clinical Coordinator to initiate the appropriate action plan.

- ✓ Changes in the patient's condition, home situation, or medical supervision so that patient needs can no longer be met adequately at home may indicate the need for discharge. For example, the patient's condition may require continuous nursing care.
- ✓ The safety of staff is in jeopardy. The *Safety, Employee* policy guides you in appropriate measures to ensure your safety. If you feel you are in danger, leave the patient's home immediately, report the situation and complete appropriate documentation.
- ✓ If a patient refuses treatment, notify the physician and the Clinical Coordinator.

• Involuntary Termination

The situations just discussed may result in services being involuntarily terminated. The patient and the physician receive written notice before the date of termination that includes:

1. The date of service termination.
2. A statement of the reason for termination.
3. The inclusion of a suggested plan for continuing care.

• Discharge Order

An order by the physician is required for termination of home health therapy services PRIOR to completion of the Therapy Plan of Care. No order is required if the original Therapy Plan of Care is completed. Keep communication lines with physicians open so they are as prepared as the patient when it is time for patient discharge.

When care is subject to review from various sources that may result in denial of services, the Clinical Coordinator, therapist and organization make appropriate decisions regarding the provision of ongoing care or discharge based on the care required by the patient. These situations arise when a managed care provider, insurance company review or peer review does not agree with the agency and/or Clinical Coordinator's view of the patient. When this conflict arises, decisions are made in response to the care required by the patient and not solely on the external source.

• Patient Notification

The patient has the right to be fully informed and prepared for discharge. Verbal and/or written notification or instructions are given to the patient prior to discharge. If discharge planning is initiated on admission, the patient is more accepting when the time for discharge arrives.

• Notification of Intra-Disciplinary Team

Clinical Coordinators are responsible for coordination of care for all disciplines visiting the patient. Communicate changes in the Therapy Plan of Care to the Clinical Coordinator and document this care coordination on the *Therapy Clinical Note (HBS-116 for PT, HBS-118 for OT or HBS-120 for ST)* or *Conference/Continuation Note (HBS-297)* as appropriate. This communication is especially critical for patient discharge. If a predetermined discharge date is set, make sure all team members involved in the plan of care know the date. Discharges or transfers that happen suddenly, such as a result of hospital admission, require prompt notification of the Clinical Coordinator so that all team members can be notified as quickly as possible. It is your responsibility to participate in this notification process. Notification of unanticipated discharge is especially important if therapy is the only skilled service a patient is receiving in order to prevent unskilled visits from being made after the patient has been discharged from services.

• Discharge Date

The discharge date is the date of the last billable or covered service. Nursing (SN), physical therapy (PT), or speech therapy (ST) are qualifying services. Medical social services (MSS), home health aide (HHAide), and occupational therapy (OT) are dependent services. A continuing need for OT after the initial certification can be a qualifying service. A continued need for OT services will support the provision of MSS and HHAide services in the home, if appropriate and ordered by the physician. The rehabilitation therapist is responsible for coordinating discharge planning with the Clinical Coordinator and other services remaining in the home as appropriate.

The discharge date is the date of the last visit by the qualifying service, unless the patient is discharged for an unanticipated reason such as unexpected hospital admission or death of the patient. For example, a nurse visits Monday, HHAide visits Tuesday and Thursday, and the patient dies suddenly Friday. The dependent service visits (HHAide) are billable (covered) services and the discharge date is Thursday's date. The opposite occurs when therapy visits Monday and finds that the patient's goals are achieved, and the patient is discharged. If the Clinical Coordinator was not notified of the patient discharge and HHAides visit Tuesday and Thursday, the HHAide visits are not billable because the patient was discharged from skilled services on the preceding Monday.

• Therapy Discharge Summary

A discharge summary will be written at the time of the last therapy visit on the *Therapy Clinical Note (HBS-116 for PT, HBS-118 for OT or HBS-120 for ST)* for that date. This is done by marking the box labeled D/C VISIT/SUMMARY at the bottom of the Therapy Clinical Note form. The following information should be documented within the body of the note:

- status at time of referral as compared to status at time of discharge
- skilled care provided
- evidence of provision of instructions for continuation of recommendations following therapy discharge
- assessment of patient/caregiver response to instructions
- assessment of goal status with description of functional abilities
- evidence of care coordination concerning discharge.

It is best practice for the supervising therapist to perform the discharge visit and document the patient's status at the time of the discharge visit. In instances where this is not possible, i.e. discharge does not coincide with a visit or the last visit was made by an assistant, the supervising therapist can document a summary on a

Conference/Continuation Note (HBS-297) qualifying that the summary is based on the status of the patient at the time of the last therapy visit.

- **OASIS Discharge Documentation**

On occasion, the therapist may be required to complete the OASIS Discharge document at the time of their discharge visit. When this occurs, the information previously listed can be documented within the body of the OASIS Discharge form. It is recommended that the therapist be familiar with the OASIS assessment strategies provided in the Item-By-Item Tips found on the CMS OASIS web-based training site. Request assistance at the subunit to obtain this resource. Familiarity and practice will make this process much easier. It is important to emphasize that the OASIS items in the Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) section address the patient's functional status. Level of functioning is an important indicator of the patient's ability to remain in the home setting, as the goals of many home health interventions are to assist the patient to improve or maintain this capability as long as possible. It is very important that all clinicians answer these OASIS items correctly. These OASIS items are to be completed based on what the patient is ABLE to SAFELY do on the day of the assessment. Willingness and compliance are not the focus of these items. Direct observation is the preferred method for assessing a patient's ADL and IADL abilities and the patient must be viewed from a holistic perspective in assessing ability to safely perform ADLs and IADLs.

▪ Billing for Contract Services

No invoice for services may be processed until all necessary documentation is received by the Alabama Department of Public Health. Delays in completion of documentation will result in delays in payment for services rendered.