



# Excellence in Therapy Report

February 2011

## Table of Contents

Letter from Keith Crownover, Delta Health Technologies.....	1
The Changing Landscape for 2011 Related to Home Health Therapy Services .....	2
A National Response to a National Challenge .....	3
Steering Committee .....	3
Forum Participants .....	4
Forum Sponsors .....	5
Forum Methodology .....	6
Key Components of the Forum .....	6
Forum Group Work.....	6
Guidelines	
Group 1: Determining Which Therapy or Therapies to Order Based on OASIS Findings.....	7
Group 2: Involvement in the Completion of Specific Areas of the Comprehensive Assessment .....	25
Group 3: Ensuring an Accurate and Complete Therapy Assessment Process.....	35
Group 4: Ensuring Therapy Interventions Are Consistent with Assessment Findings .....	54
Group 5: Documentation Needed to Support Level of Care Provided Including Guidelines for Documentation Reviewers .....	77
Group 6: Appropriate Utilization of Therapy Assistants .....	85
Staffing Therapy Services .....	96
Therapy Recruitment Tips .....	96
Conclusion and Implications for Future Research .....	97
Appendix A – Reassessments.....	98
Tests and Measures References .....	101

Dear Homecare Professional:

It is with great pleasure that we enclose the ***Delta National Excellence in Therapy Report***. Delta Health Technologies has sponsored this first-of-its-kind, national effort to bring together homecare practitioners to develop tips and strategies to ensure that patients are receiving appropriate levels of therapy services.

One of the biggest surprises coming out of our forum was the fact that never before had Physical Therapists, Occupational Therapists, Speech-Language Pathologists, and Nurses gathered together to discuss how best to evaluate a patient's needs for home-based, rehabilitative services. More than 80 clinical experts from around the nation spent nearly 50 hours working collaboratively through six topics important to the proper and consistent documentation of the medical necessity of therapy services and the use of therapy assistants.

This is the second major, national effort that Delta has sponsored within the past year. We have underwritten this important work so that the output could be provided to all who are interested from within our industry, whether a provider, a consultant, or a vendor. Similarly, these guidelines are incorporated into a new software tool, ClinicalVirtuoso, that has been built collaboratively with *over 20* therapy organizations.

Delta Health Technologies offers your agency unparalleled expertise, customizable solutions and a fanatic commitment to your success. Thank you once again for your contributions to our industry.

Sincerely,



Keith R. Crossover  
President & CEO

P.S. The basic version of ClinicalVirtuoso is available at no charge for a limited time and can be accessed at [www.CinicalVirtuoso.com](http://www.CinicalVirtuoso.com).

## The Changing Landscape for 2011 Related to Home Health Therapy Services

Since the introduction of the Home Health Prospective Payment System (HH PPS) by the Centers for Medicaid & Medicare Services (CMS) in 2000, the industry has experienced an increase in the clinical and functional complexity of the patient population that it serves. Commensurate with growing patient population complexity and acuity has been the industry's need to advance interdisciplinary best practice clinical standards of care in which physical therapy, occupational therapy, and speech language pathology services have played a critical and expanding role. With the HH PPS system change in 2008, the role of Home Health Therapy services has continued to grow.

In the final HH PPS update for 2011, CMS has instituted significant changes intended to slow the rate of case-mix rate growth not attributable to patient acuity. As part of the update, CMS has clarified Therapy Service Coverage as well as the expectations related to documentation of medical necessity for these services. These updates have been driven by concerns over shifts in therapy practice since 2008 (26% increase in episodes with >14 visits) and include:

- Enhanced focus on specifics of documentation – new to the Coverage Requirements
  - Objective assessments done by qualified therapists.
  - Goals that are measureable and functional.
  - Accepted standards of clinical practice.
- Reassessment timeframes
  - Minimally at 30 days.
  - Every 13<sup>th</sup> and 19<sup>th</sup> visit.
  - Done by qualified therapist who directly participates in the assessment.
- Maintenance therapy
  - Reinforcement of coverage criteria for this specific area.
- Claims data
  - New G-Codes separating out therapist from therapist assistant visits.
  - New G-Codes relating to maintenance therapy and limited in their use to qualified therapist only.

Given these updates to the HH PPS system and the fundamental need that agencies have to implement standards of care, the industry is rapidly seeking information and strategies for success – a need that prompted the Delta National Excellence in Therapy Forum.

## **A National Response to a National Challenge**

The challenges that the home care agencies now face are real, they are serious, and they threaten the credibility of agencies everywhere. While the home care industry may sorely lack the definitive guidelines and transparent protocols needed, it does not lack in numbers of expert clinicians who have the expertise, passion, and commitment to develop these guidelines. Home care is blessed with clinical professionals (physical therapists, occupational therapists, speech therapists, social workers, and clinical nurses) at all levels who understand the problem and, more importantly, clearly understand what is fundamentally needed to create optimal guidelines. These experts are in every state. Many work for home care agencies, others for consulting firms and vendors who are equally concerned. All are committed to ensuring that every patient gets the right amount of rehab services at the right time and in the right manner.

What the industry lacks, however, is an organized effort to bring together these national experts to systematically address and develop rehab guidelines and protocols that ensure every patient receives the right number of quality services, services that respond to the needs of and protects the interest of each patient. The industry clearly needs protocols that include transparent documentation and substantiation that will stand up to any scrutiny or challenge by regulators, funders, and other oversight groups. While the industry may lack these resources, it clearly does not lack in the capacity to develop them. That is where the Delta National Excellence in Therapy comes in. The following is a brief outline containing some of the key descriptive logistics from the Forum.

**Goal:** To bring together national home care and rehab experts from every state to address the concerns being expressed by regulatory and oversight groups and to develop a set of national transparent guidelines and protocols that will serve as the foundation for the appropriate allocation of rehab services to patients in home care agencies throughout the country.

### **Steering Committee Members:**

Janet Brown, ASHA  
Keith Crownover, Delta Health Technologies  
Christine Gunderson, VNS of New York  
Jay Hudnall, Deaconess Home Care  
Cindy Krafft, Fazzi Associates  
Tonya Miller, Celtic Home Care  
Rudi Pijnnaken, Physical Therapy International  
Mary St. Pierre, NAHC  
Lisa Sholts, OSF Home Care Services  
Deb Williams, Sutter VNA and Hospice  
Bonnie Yingling, Delta Health Technologies  
Missi Zahoransky, AOTA

## Forum Participants:

### Region I

Catherine Cullen, VNA & Hospice of Vermont & New Hampshire, VT  
Katey Hawes, Androscoggin Home Care & Hospice, ME  
Kristen Mattson, Overlook VNA, MA  
Diane Miller, Visiting Nurse Services of Connecticut, CT  
Deb Mullen, Concord Regional VNA Association, NH  
Colleen Rose, VNA of Rhode Island, RI  
Jeanne Ryan, VNA & Hospice of Cooley Dickinson, MA

### Region II

Milagros Collazo, Condado Home Care Program, PR  
Roberta Geisenheimer, Promise Care, NJ  
Christine Gunderson, Visiting Nurse Service of New York, NY, Steering Committee  
Amie Martinelli, Bayada Nurses, NJ  
Kenneth Miller, Catholic Home Care/Tuoro College, NY  
Kenneth Schonbachler, VNA of Western, NY  
Patricia Soble, Lifetime Care Home Health & Hospice, NY  
Rae Szymanski, VNA of Hudson Valley, NY

### Region III

Mary Ann Conway, Bayada Nurses, VA  
Tonya Miller, Celtic Home Care, PA, Steering Committee  
Michelle Ralph, Jefferson Home Care, PA  
Judy Schank, Stella Maris Home Health & Hospice, MD  
Christopher Skrypski, Care Givers America Home Health Services, PA  
Linda Teodosio, Amedisys Home Health Services, MD  
Scott Wasserman, Medstar Health VNA, DC

### Region IV

Cindy Furlough, UNC/Rex Home Services, NC  
Sarah Gassman Schultz, PHC Home Health, SC  
Theresa Gates, Brooks Home Care Advantage, FL  
Jean-Michel Geoffriau, Sta-Home Health & Hospice, MS  
Jacqueline Gillis, Allcare Home Health & Hospice, AL  
Jay Hundall, Deaconess Home Care, MS, Steering Committee  
Scott Hutchinson, Carolina Home Health, SC  
Cynthia King, Baptist Trinity Homecare & Hospice, TN  
Beth Landry, Aegis at Home/Golden Living/Aseracare, GA  
Aimee Painter, Wellstar Home Health, GA  
Tammy Paulin, Deaconess Homecare, TN  
Joe Whitehurst, Senior Home Care, FL

### Region V

Iona Kaye Barton, Gundersen Lutheran at Home, WI  
Ruth Benjamin, Mid Michigan Home Care, MI  
Kris Bykerk, Community Physical Therapy & Associates, IL  
Mary Jane Fraser, Allina Home & Community Services, MN  
Arlynn Hansell, American Mercy Home Care, OH

Region V, continued

Liz Menges, VNA of Porter County, Inc., IN  
Jennifer Sandel, Lifespan, Inc., MI  
Lisa Sholts, OSF Home Care Services, IL, Steering Committee  
Kristen Sundgaard, Health East Home Care, MN  
Randal Tipton, Universal Home Care, OK

Region VI

Anna Lisa Lawton, Heritage Home Health Care & Hospice, NM  
Carlos Lopez, Jordan Health Services, TX  
Rudi Pijnaken, Physical Therapy International, TX, Steering Committee  
Jim Pittman, Baptist Health Home Network, AR  
Debra Richardson, Home Healthcare Partners, TX  
Nickie Wolfe, LHC Group, LA

Region VII

Valerie Bollinger, VNA of Southeast, MO  
Pam Eberspacher, Health Connect at Home, NE  
Melba Hale, BJC Home Care Services, MO  
Rita Schierer, Via Christi Home Health, KS  
Mike Shaw, Genesis Health System-VNA Division, IA

Region VIII

Mark Allen, Home Options, MT  
Ed Dieringer, Caregiver Support Network Home Health & Hospice, UT  
Susan Evans, Avera St. Luke's Home Health, SD  
Naida Lounsbury, Visiting Nurse Corporation, CO  
Stacy Plencner, Sanford Home Care, ND

Region IX

Lorna Beukema, Rehab at Home, Inc., CA  
Maile Collado, St. Francis Home Care Service, HI  
Deb Williams, Sutter VNA and Hospice, CA, Steering Committee

Region X

Bob Charves, Community Home Health & Hospice, WA  
Meda Jane Osbourne, Maxim Healthcare Services, AK  
Wayde Sondrup, Legacy Home Health Care, ID



*Keith R. Crownover, President & CEO  
Delta Health Technologies*

**Sponsors:** The Delta National Excellence in Therapy Forum was designed to be an open and highly interactive process. Sponsors include those who are recognized as key constituents in supporting either rehab services or the clinicians that provide those services. Sponsors include:

Delta Health Technologies  
Fazzi Associates  
National Association for Home Care & Hospice  
Home Health Section of the American Physical Therapy Association  
Home and Community Health Section of the American Occupational Therapy Association  
American Speech-Language-Hearing Association

**Forum Methodology:** The findings contained in this report are the result of an Expert Design Forum. This was a dynamic, highly involved process. National experts were recruited and asked to systematically address all areas of concern, identify existing resources and tools presently available, and develop best practice guidelines to ensure optimal use of rehabilitation services in home care agencies.

**The Key Components of the Delta National Excellence in Therapy Forum:** There were a number of key components of this national effort. They include:

1. Identification of the National Steering Committee to oversee the forum effort.
2. Involvement of National and State Associations: These Associations were key in identifying and recruiting experts to be involved in the project, engaging clinical leaders to provide input into the national survey, and providing support for broad-range dissemination of the findings.
3. Completion of the National Web-based Input Survey. This unique, open survey allowed anyone with knowledge or interest in the issue to provide input into the National Summit.
4. Holding of the Delta National Excellence in Therapy Forum in Chicago September 21 and 22, 2010. National experts came together at this two-day forum to develop the tips and guidelines contained in this report.
5. Preparation and distribution of the forum findings. This report has been created to distribute the findings, guidelines, and tips generated by the forum participants.

**Forum Group Work:** The work completed during the forum was done by forum participants assigned to specific content groups. The following is a list of the content areas each group completed.

Group 1: Guidelines for determining which therapy or therapies to order based on OASIS findings

Group 2: Guidelines for therapists' involvement in the completion of specific areas of the comprehensive assessment

Group 3: Guidelines for ensuring an accurate and complete therapy assessment process

Group 4: Guidelines for ensuring therapy interventions are consistent with assessment findings.

Group 5: Guidelines for documentation needed to support the level of care provided and including guidelines for documentation reviewers

Group 6: Appropriate utilization of therapy assistants

## Group 1

### Guidelines for Determining Which Therapy or Therapies to Order Based on OASIS Findings

The decision to include therapy services in a plan of care should be driven and supported by the findings of the comprehensive assessment inclusive of OASIS. The OASIS tool allows a clinician to identify the presence of a problem area for the patient but does not expand the responses to indicate *why* the problem exists. Determining the *why* requires the clinician to assess the patient further. The findings of that assessment assist in determining the appropriate services that should be provided in accordance with the needs of each individual patient. Although the functional questions seem to be the clear route to therapy, there are more items in other areas of the tool that should be considered in determining the need to make a referral to occupational, physical and/or speech therapy.

#### Guiding Principles

Be aware of what is within the scope of practice for each of the therapies and what is considered a skilled service for each discipline.

- Focus on triggers for referrals to another discipline. Do not pre-judge the need for another discipline.
- Remember that it's all about safety. If the clinician feels any need to intervene, this should not be overlooked even if the patient is currently living alone.
- Do not be influenced by the availability or lack thereof of a particular service; only consider the needs of the patient.
- Address safety first. It's OK to delay, stagger, and prioritize therapy entering care rather than overwhelming patients to the point where they refuse.
- Remember that OASIS Items do not stand alone. Consider the relationships between functional items as well as the impact of factors such as cognition, depression, anxiety, vision and ability to communicate.
- Observe actual demonstrated functional ability; do not rely only on patient reports.
- Evaluate the impact of cultural and religious beliefs on the ability of a patient to participate in certain tasks as well as the willingness to discuss and address particular problem areas.
- Assess patients against what is truly independent and safe. Compare their ability to same-age individuals who do not require skilled services. Do not simply compare one patient to another.
- Collaborate during the assessment phase. Although OASIS is required to be an assessment completed and signed by one clinician, there is still opportunity and need to collaborate and communicate between clinicians seeing the patient to ensure that the findings are as accurate as possible. Remember that there are five days to complete the Start of Care OASIS.
- Evaluate the effect that medications, strength, and balance have on the ability to do a functional task. These may need intervention before the mechanics of the task can be addressed.

**M1032** Risk for Hospitalization: Which of the following signs or symptoms characterize this patient as at risk for hospitalization? **(Mark all that apply.)**

- 1 - Recent decline in mental, emotional, or behavioral status
- 2 - Multiple hospitalizations (2 or more) in the past 12 months
- 3 - History of falls (2 or more falls – or any fall with an injury – in the past year)
- 4 - Taking five or more medications
- 5 - Frailty indicators, e.g., weight loss, self reported exhaustion
- 6 - Other
- 7 - None of the above

**Recommendations**

**Key Question to Consider:**

- How do the indentified risks for hospitalization impact functional status and safety in the home?

**Potential Referrals:**

- Occupational therapy and/or physical therapy as indicated by the assessment findings

**M1100** **Patient Living Situation:** Which of the following best describes the patient's residential circumstance and availability of assistance? **(Check one box only.)**

Living Arrangement	Availability of Assistance				
	Around the clock	Regular daytime	Regular nighttime	Occasional/short-term assistance	No assistance available
a. Patient lives alone	<input type="checkbox"/> 01	<input type="checkbox"/> 02	<input type="checkbox"/> 03	<input type="checkbox"/> 04	<input type="checkbox"/> 05
b. Patient lives with other person(s) in the home	<input type="checkbox"/> 06	<input type="checkbox"/> 07	<input type="checkbox"/> 08	<input type="checkbox"/> 09	<input type="checkbox"/> 10
c. Patient lives in congregate situation (e.g., assisted living)	<input type="checkbox"/> 11	<input type="checkbox"/> 12	<input type="checkbox"/> 13	<input type="checkbox"/> 14	<input type="checkbox"/> 15

**Recommendations**

**Key Questions to Consider:**

- Can the patient safely manage ADLs/IADLs with current level of assistance?
- Can the patient safely enter and exit the home with the current level of assistance?
- Can the patient activate emergency help if needed with available assistance?
- How do responses in the functional section and the cognitive/behavioral section impact the level of assistance the patient needs?

**Potential Referrals:**

- Occupational Therapy and/or Physical Therapy and/or Speech Therapy depending on assessment findings

**M1210 Ability to hear** (with hearing aid or hearing appliance if normally used):

- 0 - Adequate: hears normal conversation without difficulty.
- 1 - Mildly to Moderately Impaired: difficulty hearing in some environments or speaker may need to increase volume or speak distinctly.
- 2 - Severely Impaired: absence of useful hearing.
- UK - Unable to assess hearing.

**Recommendations**

**Key Questions to Consider:**

- How does the ability to hear affect the ability of the patient to learn and respond to safety alerts?
- Does the current level of ability suggest the need for adaptive equipment (like a different telephone)?
- Does the patient have the fine motor skills to manage hearing aids?

**Potential Referrals:**

- Occupational therapy – adaptive equipment, e.g. telephones, smoke alarm, doorbell
- Medical social work – outside resources as indicated
- Speech therapy – hearing screening

**M1220 Understanding of Verbal Content** in patient's own language (with hearing aid or device if used):

- 0 - Understands: clear comprehension without cues or repetitions.
- 1 - Usually Understands: understands most conversations, but misses some part/intent of message. Requires cues at times to understand.
- 2 - Sometimes Understands: understands only basic conversations or simple, direct phrases. Frequently requires cues to understand.
- 3 - Rarely/Never Understands.
- UK - Unable to assess understanding.

**Recommendations**

**Key Questions to Consider:**

- How does the patient's ability to understand verbal content impact the ability to effectively receive communication and follow through with directions?

**Potential Referrals:**

- Speech therapy

**M1230 Speech and Oral (Verbal) Expression of Language (in patient's own language):**

- 0 - Expresses complex ideas, feelings, and needs clearly, completely, and easily in all situations with no observable impairment.
- 1 - Minimal difficulty in expressing ideas and needs (may take extra time; makes occasional errors in word choice, grammar or speech intelligibility; needs minimal prompting or assistance).
- 2 - Expresses simple ideas or needs with moderate difficulty (needs prompting or assistance, errors in word choice, organization or speech intelligibility). Speaks in phrases or short sentences.
- 3 - Has severe difficulty expressing basic ideas or needs and requires maximal assistance or guessing by listener. Speech limited to single words or short phrases.
- 4 - Unable to express basic needs even with maximal prompting or assistance but is not comatose or unresponsive (e.g., speech is nonsensical or unintelligible).
- 5 - Patient nonresponsive or unable to speak.

**Recommendations**

**Key Questions to Consider:**

- How does the patient's ability to communicate verbally impact the ability to effectively communicate wants and needs and direct own care?
- How appropriate were the patient's verbal responses to interview questions throughout entire visit?
- Does this patient have a past diagnosis that might impact the ability to communicate verbally such as CVA, Parkinson's, ALS, head injury, etc.?
- Do any of the medications the patient is currently taking have any effects on the ability to communicate verbally?

**Potential Referrals:**

- Speech therapy



**M1242** Frequency of Pain Interfering with patient's activity or movement:

- 0 - Patient has no pain
- 1 - Patient has pain that does not interfere with activity or movement
- 2 - Less often than daily
- 3 - Daily, but not constantly
- 4 - All of the time

**Recommendations**

**Key Questions to Consider:**

- How does the patient's pain affect function and safety?
- Is the pain acute or chronic?
- Has the patient made changes in their routine activities due to pain?
- How does the environment impact the patient's pain?
- Can limitations be seen when observing the patient during movement?
- Ask patient – "Does pain interfere with anything you want or need to do?"

**Potential Referrals:**

- Occupational therapy and/or physical therapy as indicated by the nature of the impact on functional ability
- Psychiatric nurse or medical social worker for support as indicated.

**M1302** Does this patient have a Risk of Developing Pressure Ulcers?

- 0 – No
- 1 – Yes

**Recommendations**

**Key Questions to Consider:**

- What factors are present that increase risk of developing a pressure ulcer and/or are impairing the ability to heal a pressure ulcer?
  - Limited mobility
  - Decreased ability to transfer
  - Dysphagia impacting nutrition
  - Incontinence
  - Difficulty toileting
- Does the patient have the ability to self check for pressure ulcers?

**Potential Referrals:**

- Occupational therapy and/or physical therapy and/or speech therapy as indicated by the risk factors identified

**M1400** When is the patient dyspneic or noticeably **Short of Breath**?

- 0 - Patient is not short of breath
- 1 - When walking more than 20 feet, climbing stairs
- 2 - With moderate exertion (e.g., while dressing, using commode or bedpan, walking distances less than 20 feet)
- 3 - With minimal exertion (e.g., while eating, talking, or performing other ADLs) or with agitation
- 4 - At rest (during day or night)

**Recommendations**

**Key Questions to Consider:**

- How does the presence of dyspnea impact the patient's ability to effectively and safely function?
- If oxygen is being used by the patient, is it being effectively integrated into activities such as ambulation, self care, and household management?

**Potential Referrals:**

- Occupational therapy and/or physical therapy as indicated by the level of impact on the patient's functional ability

**M1615** When does **Urinary Incontinence** occur?

- 0 - Timed-voiding defers incontinence
- 1 - Occasional stress incontinence
- 2 - During the night only
- 3 - During the day only
- 4 - During the day and night

**Recommendations**

**Key Questions to Consider:**

- What are the contributing factors for incontinence?
  - Ability to safely ambulate
  - Ability to transfer
  - Clothing management issues
  - Set up of the home environment
  - Presence or absence of adaptive equipment
  - Effectiveness of the bladder program
  - Cognitive concerns

**Potential Referrals:**

- Occupational therapy and/or physical therapy as indicated by the contributing factors identified

**M1700 Cognitive Functioning:** Patient's current (day of assessment) level of alertness, orientation, comprehension, concentration, and immediate memory for simple commands.

- 0 - Alert/oriented, able to focus and shift attention, comprehends and recalls task directions independently.
- 1 - Requires prompting (cuing, repetition, reminders) only under stressful or unfamiliar conditions.
- 2 - Requires assistance and some direction in specific situations (e.g., on all tasks involving shifting of attention), or consistently requires low stimulus environment due to distractibility.
- 3 - Requires considerable assistance in routine situations. Is not alert and oriented or is unable to shift attention and recall directions more than half the time.
- 4 - Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state, or delirium.

#### Recommendations

#### Key Questions to Consider:

- How does the patient's level of cognitive functioning affect the safe performance of mobility, self care, and household management?
- How does the patient's level of cognitive functioning impact the plan of care with respect to retaining information and follow through?

#### Potential Referrals:

- Occupational therapy and/or speech therapy as indicated by the impact on the patient

**M1710 When Confused (Reported or Observed Within the Last 14 Days):**

- 0 - Never
- 1 - In new or complex situations only
- 2 - On awakening or at night only
- 3 - During the day and evening, but not constantly
- 4 - Constantly
- NA - Patient nonresponsive

#### Recommendations

#### Key Questions to Consider:

- How does the patient's level of confusion affect the safe performance of mobility, self care, and household management?
- How does the patient's level of confusion impact the plan of care with respect to retaining information and follow through?

#### Potential Referrals:

- Occupational therapy and/or speech therapy as indicated by the impact on the patient

**M1720 When Anxious (Reported or Observed Within the Last 14 Days):**

- 0 - None of the time
- 1 - Less often than daily
- 2 - Daily, but not constantly
- 3 - All of the time
- NA - Patient nonresponsive

**Recommendations****Key Questions to Consider:**

- How does the patient’s level of anxiety affect the safe performance of mobility, self care, and household management?
- How does the patient’s level of anxiety impact the plan of care with respect to retaining information and decision making?

**Potential Referrals:**

- Occupational therapy and/or physical therapy as indicated by the impact on the patient

**M1730 Depression Screening:** Has the patient been screened for depression, using a standardized depression screening tool?

- 0 - No
- 1 - Yes, patient was screened using the PHQ-2© scale. (Instructions for this two-question tool: Ask patient: “Over the last two weeks, how often have you been bothered by any of the following problems”)

PHQ-2©*	Not at all 0–1 day	Several days 2–6 days	More than half of the days 7–11 days	Nearly every day 12–14 days	N/A Unable to respond
a) Little interest or pleasure in doing things	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> na
b) Feeling down, depressed, or hopeless?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> na

- 2 - Yes, with a different standardized assessment-and the patient meets criteria for further evaluation for depression.
- 3 - Yes, patient was screened with a different standardized assessment-and the patient does not meet criteria for further evaluation for depression.

\*Copyright© Pfizer Inc. All rights reserved. Reproduced with permission.

**Recommendations****Key Questions to Consider:**

- How does the patient’s level of depression affect the safe performance of mobility, self care, and household management?
- Does current level of function increase the depression symptoms?
- How well are the medications for depression, if present, working?
- How does the patient’s level of depression impact the plan of care with respect to retaining information and decision making?

**Potential Referrals:**

- Occupational therapy and/or physical therapy as indicated by the impact on the patient

**M1740 Cognitive, behavioral, and psychiatric symptoms** that are demonstrated at least once a week (Reported or Observed): **(Mark all that apply.)**

- 1 - Memory deficit: failure to recognize familiar persons/places, inability to recall events of past 24 hours, significant memory loss so that supervision is required
- 2 - Impaired decision-making: failure to perform usual ADLs or IADLs, inability to appropriately stop activities, jeopardizes safety through actions
- 3 - Verbal disruption: yelling, threatening, excessive profanity, sexual references, etc.
- 4 - Physical aggression: aggressive or combative to self and others (e.g., hits self, throws objects, punches, dangerous maneuvers with wheelchair or other objects)
- 5 - Disruptive, infantile, or socially inappropriate behavior (**excludes** verbal actions)
- 6 - Delusional, hallucinatory, or paranoid behavior
- 7 - None of the above behaviors demonstrated

#### Recommendations

#### Key Questions to Consider:

- If selecting response 1 or response 2, how does it impact the patient's ability to manage functional activities safely?
- Does the caregiver need education on how to safely assist with the management of functional activities with this patient?

#### Potential Referrals:

- Occupational therapy and/or physical therapy and/or speech therapy as indicated by the impact on safety and function.

**M1745 Frequency of Disruptive Behavior Symptoms (Reported or Observed)** Any physical, verbal, or other disruptive/dangerous symptoms that are injurious to self or others or jeopardize personal safety.

- 0 - Never
- 1 - Less than once a month
- 2 - Once a month
- 3 - Several times each month
- 4 - Several times a week
- 5 - At least daily

#### Recommendations

#### Key Questions to Consider:

- How does the frequency of disruptive behavior impact safe functioning of the patient in the home?

#### Potential Referrals:

- Occupational therapy and/or physical therapy as indicated by the impact on safety and function and ability to participate effectively in therapy

- M1800 Grooming:** Current ability to tend safely to personal hygiene needs (i.e., washing face and hands, hair care, shaving or make up, teeth or denture care, fingernail care).
- 0 - Able to groom self unaided, with or without the use of assistive devices or adapted methods.
  - 1 - Grooming utensils must be placed within reach before able to complete grooming activities.
  - 2 - Someone must assist the patient to groom self.
  - 3 - Patient depends entirely upon someone else for grooming needs.

**Recommendations**

**Key Questions to Consider:**

- What factors may impact the ability to complete grooming tasks safely?
  - Environment
  - Ability to ambulate
  - Cognitive ability
  - Integration of equipment

**Potential Referrals:**

- Occupational therapy and/or physical therapy as indicated by the factor(s) impacting the patient's safety and ability

- M1810** Current **Ability to Dress Upper Body** safely (with or without dressing aids) including undergarments, pullovers, front-opening shirts and blouses, managing zippers, buttons, and snaps:
- 0 - Able to get clothes out of closets and drawers, put them on and remove them from the upper body without assistance.
  - 1 - Able to dress upper body without assistance if clothing is laid out or handed to the patient.
  - 2 - Someone must help the patient put on upper body clothing.
  - 3 - Patient depends entirely upon another person to dress the upper body

**Recommendations**

**Key Questions to Consider:**

- What factors may impact the ability to complete dressing tasks safely?
  - Environment
  - Ability to ambulate
  - Cognitive ability
  - Integration of equipment
  - Clothing style

**Potential Referrals:**

- Occupational therapy and/or physical therapy as indicated by the factor(s) impacting the patient's safety and ability

**M1820** Current **Ability to Dress Lower Body** safely (with or without dressing aids) including undergarments, slacks, socks or nylons, shoes:

- 0 - Able to obtain, put on, and remove clothing and shoes without assistance.
- 1 - Able to dress lower body without assistance if clothing and shoes are laid out or handed to the patient.
- 2 - Someone must help the patient put on undergarments, slacks, socks or nylons, and shoes.
- 3 - Patient depends entirely upon another person to dress lower body.

### Recommendations

#### Key Questions to Consider:

- What factors may impact the ability to complete dressing tasks safely?
  - Environment
  - Ability to ambulate
  - Cognitive ability
  - Integration of equipment
  - Clothing style

#### Potential Referrals:

- Occupational therapy and/or physical therapy as indicated by the factor(s) impacting the patient's safety and ability.



**M1830 Bathing:** Current ability to wash entire body safely. **Excludes grooming (washing face, washing hands, and shampooing hair).**

- 0 - Able to bathe self in shower or tub independently, including getting in and out of tub/shower.
- 1 - With the use of devices, is able to bathe self in shower or tub independently, including getting in and out of the tub/shower.
- 2 - Able to bathe in shower or tub with the intermittent assistance of another person:
  - (a) for intermittent supervision or encouragement or reminders, OR
  - (b) to get in and out of the shower or tub, OR
  - (c) for washing difficult to reach areas.
- 3 - Able to participate in bathing self in shower or tub, but requires presence of another person throughout the bath for assistance or supervision.
- 4 - Unable to use the shower or tub, but able to bathe self independently with or without the use of devices at the sink, in chair, or on commode.
- 5 - Unable to use the shower or tub, but able to participate in bathing self in bed, at the sink, in bedside chair, or on commode, with the assistance or supervision of another person throughout the bath.
- 6 - Unable to participate effectively in bathing and is bathed totally by another person.

**Recommendations**

**Key Questions to Consider:**

- Is the patient having issues with the transfer, the bathing itself, or both?
- Is a Home Health Aide part of the plan of care? If so, what bathing issue has been identified?
- What factors may impact the ability to complete bathing tasks safely?
  - Environment
  - Ability to ambulate
  - Cognitive ability
  - Integration of equipment

**Potential Referrals:**

- Occupational therapy and/or physical therapy as indicated by the factor(s) impacting the patient's safety and ability

**M1840 Toilet Transferring:** Current ability to get to and from the toilet or bedside commode safely and transfer on and off toilet/commode.

- 0 - Able to get to and from the toilet and transfer independently with or without a device.
- 1 - When reminded, assisted, or supervised by another person, able to get to and from the toilet and transfer.
- 2 - Unable to get to and from the toilet but is able to use a bedside commode (with or without assistance).
- 3 - Unable to get to and from the toilet or bedside commode but is able to use a bedpan/urinal independently.
- 4 - Is totally dependent in toileting.

#### Recommendations

#### Key Questions to Consider:

- What factors may impact the ability to complete the toilet transfer safely?
  - Environment
  - Ability to ambulate
  - Cognitive ability
  - Integration of equipment

#### Potential Referrals:

- Physical therapy

**M1845 Toileting Hygiene:** Current ability to maintain perineal hygiene safely, adjust clothes and/or incontinence pads before and after using toilet, commode, bedpan, urinal. If managing ostomy, includes cleaning area around stoma, but not managing equipment.

- 0 - Able to manage toileting hygiene and clothing management without assistance.
- 1 - Able to manage toileting hygiene and clothing management without assistance if supplies/implements are laid out for the patient.
- 2 - Someone must help the patient to maintain toileting hygiene and/or adjust clothing.
- 3 - Patient depends entirely upon another person to maintain toileting hygiene.

#### Recommendations

#### Key Questions to Consider:

- What factors may impact the ability to complete toileting hygiene safely?
  - Environment
  - Ability to ambulate
  - Cognitive ability
  - Integration of equipment
  - Clothing style

#### Potential Referrals:

- Occupational therapy

**M1850 Transferring:** Current ability to move safely from bed to chair, or ability to turn and position self in bed if patient is bedfast.

- 0 - Able to independently transfer.
- 1 - Able to transfer with minimal human assistance or with use of an assistive device.
- 2 - Able to bear weight and pivot during the transfer process but unable to transfer self.
- 3 - Unable to transfer self and is unable to bear weight or pivot when transferred by another person.
- 4 - Bedfast, unable to transfer but is able to turn and position self in bed.
- 5 - Bedfast, unable to transfer and is unable to turn and position self.

#### Recommendations

#### Key Questions to Consider:

- What factors may impact the ability to complete the bed to chair transfer safely?
  - Environment
  - Sleeping locations
  - Cognitive ability
  - Integration of equipment

#### Potential Referrals:

- Physical therapy

**M1860 Ambulation/Locomotion:** Current ability to walk safely, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces.

- 0 - Able to independently walk on even and uneven surfaces and negotiate stairs with or without railings (i.e., needs no human assistance or assistive device).
- 1 - With the use of a one-handed device (e.g. cane, single crutch, hemi-walker), able to independently walk on even and uneven surfaces and negotiate stairs with or without railings.
- 2 - Requires use of a two-handed device (e.g., walker or crutches) to walk alone on a level surface and/or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces.
- 3 - Able to walk only with the supervision or assistance of another person at all times.
- 4 - Chairfast, unable to ambulate but is able to wheel self independently.
- 5 - Chairfast, unable to ambulate and is unable to wheel self.
- 6 - Bedfast, unable to ambulate or be up in a chair.

#### Recommendations

#### Key Questions to Consider:

- What are all the possible surfaces in the patient's environment?
- How effectively in the patient using an assistive device?
- Does the patient need an assistive device and not have one?
- Should the patient be supervised when walking?
- What was the result of the Fall Risk Assessment?
- How does ability in this area impact other functional tasks?
- How do medications impact safety with ambulation?
- How does cognitive, mental or emotional status affect safe ambulation?

#### Potential Referrals:

- Physical therapy

**M1870 Feeding or Eating:** Current ability to feed self meals and snacks safely. Note: This refers only to the process of eating, chewing, and swallowing, not preparing the food to be eaten.

- 0 - Able to independently feed self.
- 1 - Able to feed self independently but requires:
  - (a) meal set-up; OR
  - (b) intermittent assistance or supervision from another person; OR
  - (c) a liquid, pureed or ground meat diet.
- 2 - Unable to feed self and must be assisted or supervised throughout the meal/snack.
- 3 - Able to take in nutrients orally and receives supplemental nutrients through a nasogastric tube or gastrostomy.
- 4 - Unable to take in nutrients orally and is fed nutrients through a nasogastric tube or gastrostomy
- 5 - Unable to take in nutrients orally or by tube feeding.

#### Recommendations

#### Key Questions to Consider:

- How does posture, positioning, and/or fine motor ability affect feeding and eating?
- What were the findings of the nutritional risk assessment?
- How do frailty indicators contribute to the ability to eat?

#### Potential Referrals:

- Occupational therapy and/or speech therapy as indicated by the factors impacting the patient's ability

**M1880 Current Ability to Plan and Prepare Light Meals** (e.g., cereal, sandwich) or reheat delivered meals safely:

- 0 - (a) Able to independently plan and prepare all light meals for self or reheat delivered meals; OR  
(b) Is physically, cognitively, and mentally able to prepare light meals on a regular basis but has not routinely performed light meal preparation in the past (i.e., prior to this home care admission).
- 1 - Unable to prepare light meals on a regular basis due to physical, cognitive, or mental limitations.
- 2 - Unable to prepare any light meals or reheat any delivered meals.

#### Recommendations

#### Key Question to Consider:

- What are the contributing factors that are impacting the patient's ability to plan and prepare light meals?
  - Cognitive status
  - Environment
  - Safe integration of assistive device
  - Outcome of Falls Risk Assessment
  - Standing tolerance/balance issues

#### Potential Referrals:

- Occupational therapy and/or physical therapy as indicated by the factors impacting the patient's ability to complete the task safely

**M1890**    **Ability to Use Telephone:** Current ability to answer the phone safely, including dialing numbers, and effectively using the telephone to communicate.

- 0 - Able to dial numbers and answer calls appropriately and as desired.
- 1 - Able to use a specially adapted telephone (i.e., large numbers on the dial, teletype phone for the deaf) and call essential numbers.
- 2 - Able to answer the telephone and carry on a normal conversation but has difficulty with placing calls.
- 3 - Able to answer the telephone only some of the time or is able to carry on only a limited conversation.
- 4 - Unable to answer the telephone at all but can listen if assisted with equipment.
- 5 - Totally unable to use the telephone.
- NA - Patient does not have a telephone.

#### Recommendations

#### Key Question to Consider:

- What are the contributing factors that are impacting the patient's ability to use the telephone effectively?
  - Fine motor skills
  - Visual issues
  - Cognitive status
  - Location of the phone and ability to access safely
  - Ability to hear and speak

#### Potential Referrals:

- Occupational therapy and/or speech therapy as indicated by the factors impacting the patient's ability to complete the task safely.

**M1910**    Has this patient had a multi-factor **Fall Risk Assessment** (such as falls history, use of multiple medications, mental impairment, toileting frequency, general mobility/transferring impairment, environmental hazards)?

- 0 - No multi-factor falls risk assessment conducted.
- 1 - Yes, and it does not indicate a risk for falls.
- 2 - Yes, and it indicates a risk for falls.

#### Recommendations

#### Key Question to Consider:

- Which specific risk factors were selected when completing the tool?
- Were safety concerns noted with any of the functionally driven questions?
- If the patient was unable to complete a validated tool, why not?

#### Potential Referrals:

- Occupational therapy and/or physical therapy and/or speech therapy as indicated by the factors contributing to the risk for falls or in inability to participate in a validated risk assessment

**M2000 Drug Regimen Review:** Does a complete drug regimen review indicate potential clinically significant medication issues, e.g., drug reactions, ineffective drug therapy, side effects, drug interactions, duplicate therapy, omissions, dosage errors, or noncompliance?

- 0 - Not assessed/reviewed [ *Go to M2010* ]
- 1 - No problems found during review [ *Go to M2010* ]
- 2 - Problems found during review
- NA - Patient is not taking any medications [ *Go to M2040* ]

#### Recommendations

#### Key Question to Consider:

- Are the problems identified on the Drug Regimen Review impacted by any or all of the following:
  - Cognitive status
  - Ability to swallow
  - Visual issues
  - Ability to access medications at correct times
  - Ability to open medication containers

#### Potential Referrals:

- Occupational therapy and/or physical therapy and/or speech therapy as indicated by the factors impacting the patient's ability to complete the task safely

**M2020 Management of Oral Medications:** Patient's current ability to prepare and take all oral medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals. **Excludes injectable and IV medications. (NOTE: This refers to ability, not compliance or willingness.)**

- 0 - Able to independently take the correct oral medication(s) and proper dosage(s) at the correct times.
- 1 - Able to take medication(s) at the correct times if:
  - (a) individual dosages are prepared in advance by another person; OR
  - (b) another person develops a drug diary or chart.
- 2 - Able to take medication(s) at the correct times if given reminders by another person at the appropriate times
- 3 - Unable to take medication unless administered by another person.
- NA - No oral medications prescribed.

#### Recommendations

#### Key Question to Consider:

- Are the issues identified that affect oral medication management impacted by any or all of the following:
  - Cognitive status
  - Swallowing issues
  - Visual issues
  - Fine motor skills
  - Ability to access medications at correct times
  - Ability to open medication containers

#### Potential Referrals:

- Occupational therapy and/or physical therapy and/or speech therapy as indicated by the factors impacting the patient's ability to complete the task safely

**M2030 Management of Injectable Medications:** Patient's current ability to prepare and take all prescribed injectable medications reliably and safely, including administration of correct dosage at the appropriate times/intervals. **Excludes IV medications.**

- 0 - Able to independently take the correct medication(s) and proper dosage(s) at the correct times.
- 1 - Able to take injectable medication(s) at the correct times if:
  - (a) individual syringes are prepared in advance by another person; OR
  - (b) another person develops a drug diary or chart.
- 2 - Able to take medication(s) at the correct times if given reminders by another person based on the frequency of the injection
- 3 - Unable to take injectable medication unless administered by another person.
- NA - No injectable medications prescribed.

### Recommendations

#### Key Question to Consider:

- Are the issues identified that affect injectable medication management impacted by any or all of the following:
  - Cognitive status
  - Fine motor skills
  - Visual issues
  - Ability to access medications at correct times
  - Ability to open medication containers

#### Potential Referrals:

- Occupational therapy and/or physical therapy and/or speech therapy as indicated by the factors impacting the patient's ability to complete the task safely

## Group 2

### Guidelines for Therapists' Involvement in the Completion of Specific Areas of the Comprehensive Assessment

Practicing in the home health setting requires a holistic approach to patient care for all clinicians. This can present a challenge as there are some areas that are perceived to be tied only to certain disciplines. Assessing and intervening in the area of function is seen as the role of the therapists while addressing wounds and vital signs is the role of the nurses. At times these perceptions can escalate to barriers that impact the agency's ability to deliver the highest level of care possible.

In order to build an effective interdisciplinary care management model, concerns raised by each discipline must be addressed. A fundamental point is that asking the therapist to be involved with wound measurements, depression screening and taking vital signs should be focused on the concept of "screening". The expectation is for therapists to be aware of a multitude of patient issues over the course of care in order to effectively communicate with any discipline that may be involved as part of follow up.



#### Guiding Principles

- Be clear, as an agency, as to the expectations and responsibilities of the therapists.
- Provide education to therapy staff at the time of hiring as well as throughout the course of the year as indicated.
- Assess competency annually at a minimum.
- Develop policies and procedures that are specific to each discipline involved.
- Be aware of the need for therapists to receive the most current information alongside the nurses.
- Allot time and support for effective collaboration and evaluation.
- Identify champions for specific areas of OASIS/Comprehensive Assessment.

With many of these assessment areas being questioned as to if they are within the scope of physical, occupational, and speech therapy, it is important to check a variety of resources to ensure that regulatory issues are cleared. This process is part of confirming any assertions by an individual therapist as to what can or cannot be done.

#### Necessary Resources

- Scope of Practice
  - Practice Acts for each discipline for their state(s)

- Licensing Boards
- Professional Associations
  - APTA, AOTA, and ASHA
- Standards of practice for each discipline
- Medicare Conditions of Participation
- OASIS Guidance Manual

Once all potential regulatory and practice issues have been reviewed, the training and competence of each individual therapist must be addressed. Simply because a therapist technically *can* do something does not mean he or she *should*. Initial assessment of skills, provision of education, and ongoing assessment of competence is of vital importance in ensuring that each therapist is providing the best possible level of care.

Topic	<b>Therapists Completing the OASIS Tool</b>
<b>Recommendations</b>	
<b>Impact on Therapy/Therapies</b>	
<ul style="list-style-type: none"> <li>a) Is it in the scope of practice? <ul style="list-style-type: none"> <li>• PT – all time points</li> <li>• OT – all time points except admissions for Medicare patients</li> <li>• ST – all time points</li> </ul> </li> <li>b) What are the perceived barriers to completing this area? <ul style="list-style-type: none"> <li>• Staffing levels</li> <li>• Time involved to complete the visit and the tool</li> <li>• Assumption that the OASIS requires the skill set of a nurse</li> <li>• State Practice Acts for therapy rarely address OASIS specifically</li> <li>• Staff resistance / discomfort with some areas of the assessment</li> </ul> </li> <li>c) What are the key supporting documents to support the above? <ul style="list-style-type: none"> <li>• APTA Guide to Physical Therapy Practice</li> <li>• AOTA Guide to Occupational Therapy Practice</li> <li>• Medicare Conditions of Participation</li> <li>• OASIS Guidance Manual</li> </ul> </li> </ul>	
<b>Key Tools (Evidence-Based or “Home-Grown”) That May Assist Therapists in This Area</b>	
<ul style="list-style-type: none"> <li>• OASIS Manual, Chapter 5</li> <li>• Standardized Assessments outlined in the OASIS Manual such as the Braden Scale to determine risk for pressure ulcers</li> </ul>	
<b>Tips to Assist Therapists in Completing This Area of the Comprehensive Assessment</b>	
<ul style="list-style-type: none"> <li>• Outline expectations as part of the hiring process</li> <li>• Set standards at orientation</li> <li>• Align policies and procedures to support therapist completing SOC/ROC</li> <li>• Formulate a skills competency checklist for OASIS related assessments for all disciplines that complete them</li> <li>• Select a therapy OASIS champion</li> </ul>	

Topic	<b>Medication Management</b>
<b>Recommendations</b>	
<b>Impact on Therapy/Therapies</b>	
<ul style="list-style-type: none"> <li>a) Is it in the scope of practice? <ul style="list-style-type: none"> <li>• PT: Yes</li> <li>• OT: Yes</li> <li>• ST: Yes</li> </ul> </li> <li>b) What are the perceived barriers to completing this area? <ul style="list-style-type: none"> <li>• Limited basic education for therapists depending upon when they were trained.</li> <li>• Lack of continuing education options for therapists in the area of medication management.</li> <li>• Resistance / discomfort of Therapy Staff to change in expectations.</li> <li>• Idea that medication management requires extensive detailed knowledge of all medications. and that management is all handled by one person.</li> <li>• Different level of involvement of contract therapists versus employed therapists.</li> <li>• Challenges of electronic versus paper documentation tools.</li> <li>• Challenge with availability of skilled staff (i.e. rural areas).</li> </ul> </li> <li>c) What are the key supporting documents to support the above? <ul style="list-style-type: none"> <li>• CoPs</li> <li>• State practice acts</li> <li>• Guide to practice (PT, OT, ST)</li> <li>• APTA specific statement issued 01/13/09 (link on CMS site)</li> </ul> </li> </ul>	
<b>Key Tools (Evidence-Based or “Home-Grown”) That May Assist Therapists in This Area</b>	
<ul style="list-style-type: none"> <li>• <i>Pharmacology in Rehabilitation</i> by Dr. Charles D. Ciccone</li> <li>• <a href="http://www.hhqi.org">www.hhqi.org</a></li> <li>• Beers Criteria</li> </ul>	
<b>Tips to Assist Therapists in Completing This Area of the Comprehensive Assessment</b>	
<ul style="list-style-type: none"> <li>• Integrate the concepts of medication management into the hiring process and orientation.</li> <li>• Acknowledge this is an uncomfortable area for rehab.</li> <li>• Provide education to therapy staff on medication issues. Local pharmacy schools may be willing to be available for questions.</li> <li>• Evaluate agency policy and procedures for alignment with agency expectations.</li> <li>• Evaluate or create competency (skills) checklist.</li> <li>• Utilize technology to increase effectiveness and efficiency (fax, scanner).</li> <li>• Create list of yes or no questions and what to do based on responses. (process flow sheet)</li> <li>• Clearly define expectations connected to specific time points such as the Start of Care and when nursing discharges prior to therapy.</li> </ul>	

Topic	<b>Wound Assessments</b>
<b>Recommendations</b>	
<b>Impact on Therapy/Therapies</b>	
<ul style="list-style-type: none"> <li>a) Is it in the scope of practice? <ul style="list-style-type: none"> <li>• Each HHA should check these documents to determine if it is in the therapist’s scope of practice: <ul style="list-style-type: none"> <li>○ Medicare Conditions of Participation</li> <li>○ State practice acts</li> <li>○ State licensure differences</li> </ul> </li> </ul> </li> <li>b) What are the perceived barriers to completing this area? <ul style="list-style-type: none"> <li>• Therapists stating that wound assessments are “out of scope”</li> <li>• Access to the appropriate information and resources to complete the task correctly</li> <li>• Amount and cost of training for limited use (i.e., ST)</li> </ul> </li> <li>c) What are the key supporting documents to support the above? <ul style="list-style-type: none"> <li>• Medicare Conditions of Participation</li> <li>• State Practice Acts</li> <li>• APTA comments 1/13/09</li> <li>• APTA OASIS-C comments 1/13/09</li> <li>• AOTA documents</li> <li>• ASHA documents</li> </ul> </li> </ul>	
<b>Key Tools (Evidence-Based or “Home-Grown”) That May Assist Therapists in This Area</b>	
<ul style="list-style-type: none"> <li>• OASIS Guidance Manual</li> <li>• Braden Scale</li> <li>• WOCN guidelines</li> <li>• Role of therapy services in pressure ulcer prevention and/or promoting healing</li> </ul>	
<b>Tips to Assist Therapists in Completing This Area of the Comprehensive Assessment</b>	
<ul style="list-style-type: none"> <li>• Educate therapy staff and confirm competency regularly</li> <li>• Provide the appropriate tools to complete the task.</li> <li>• Coordinate staff to best meet patient specific needs.</li> <li>• Assess productivity standards to allow support and collaboration/communication.</li> <li>• Utilize inexpensive technology such as digital cameras for wound photos</li> <li>• Identify a “champion” or resource person to whom staff can turn for direction.</li> </ul>	

Topic	<b>Cognitive Behavioral Issues</b>
<b>Recommendations</b>	
<b>Impact on Therapy/Therapies</b>	
<ul style="list-style-type: none"> <li>a) Is it in the scope of practice? <ul style="list-style-type: none"> <li>• PT: Yes</li> <li>• OT: Yes</li> <li>• ST: Yes</li> </ul> </li> <li>b) What are the perceived barriers to completing this area? <ul style="list-style-type: none"> <li>• Concern that something negative is being said about the patient</li> <li>• Lack of comfort assessing the patient and asking the appropriate questions</li> <li>• Reliability of the patient and/or family report (may under or over report)</li> <li>• Patient resistance to discuss issues and fear of impact on his or her life</li> <li>• Home health staff adapting their “normal” routine to incorporate these issues and the added time of doing so</li> </ul> </li> <li>c) What are the key supporting documents to support the above? <ul style="list-style-type: none"> <li>• Medicare Conditions of Participation</li> <li>• State Practice Act</li> <li>• OASIS Guidance Manual</li> </ul> </li> </ul>	
<b>Key Tools (Evidence-Based or “Home-Grown”) That May Assist Therapists in This Area</b>	
<ul style="list-style-type: none"> <li>• MMSE: Mini-Mental® State Examination</li> <li>• ACL: Allen Cognitive Level Screen</li> <li>• MoCA©: Montreal Cognitive Assessment</li> </ul>	
<b>Tips to Assist Therapists in Completing This Area of the Comprehensive Assessment</b>	
<ul style="list-style-type: none"> <li>• Educate staff on assessment skills, including how to ask the appropriate questions.</li> <li>• Communicate with team members on observed behaviors, including the time of day they appear or increase.</li> <li>• Collaborate with other disciplines on the management of patient issues in this area as consistency is a key element.</li> <li>• Review referral information for cognitive behavioral issues – past or present.</li> <li>• Review medications and diagnosis for relevant information and possible contributing factors.</li> <li>• Be aware that a treatment could have introduced a “change” and impacted how the patient is able to function.</li> </ul>	

Topic	<b>Interfering Pain</b>
<b>Recommendations</b>	
<b>Impact on Therapy/Therapies</b>	
<ul style="list-style-type: none"> <li>a) Is it in the scope of practice? <ul style="list-style-type: none"> <li>• PT: Yes</li> <li>• OT: Yes</li> <li>• ST: Yes</li> </ul> </li> <li>b) What are the perceived barriers to completing this area? <ul style="list-style-type: none"> <li>• Reliability of information provided by the patient and/or caregiver</li> <li>• Lack of standardized assessments for level of interference</li> <li>• Incorrectly linking the 0-10 pain scale findings to the level of interference</li> <li>• Patient understanding they may not even be aware of some of the modifications they have already made</li> <li>• Clinician inability to fully understand the scope and intent of this question</li> <li>• Inconsistency of data collection between disciplines</li> </ul> </li> <li>c) What are the key supporting documents to support the above? <ul style="list-style-type: none"> <li>• Medicare Conditions of Participation</li> <li>• State Practice Act</li> <li>• OASIS Guidance Manual</li> </ul> </li> </ul>	
<b>Key Tools (Evidence-Based or “Home-Grown”) That May Assist Therapists in This Area</b>	
<ul style="list-style-type: none"> <li>• Wong-Baker (faces)</li> <li>• Pain patient profile</li> <li>• Patient scale (PPS)</li> <li>• 0-10 scale</li> <li>• FLACC (nonverbal rating scale)</li> <li>• Visual Analog</li> </ul>	
<b>Tips to Assist Therapists in Completing This Area of the Comprehensive Assessment</b>	
<ul style="list-style-type: none"> <li>• Clearly link functional issues to interference of pain and efforts to improve the ability to manage.</li> <li>• Provide supporting documentation for patient’s perception versus observed behaviors.</li> <li>• Assess the etiology of pain.</li> <li>• Determine how pain affects function and if pain relief measures are effective.</li> <li>• Be consistent in how you ask the questions and assess the patient.</li> <li>• Assess pain before and after taking medication.</li> </ul>	

Topic	<b>Dyspnea on Exertion</b>
<b>Recommendations</b>	
<b>Impact on Therapy/Therapies</b>	
<p>a) Is it in the scope of practice?</p> <ul style="list-style-type: none"> <li>• PT – Yes</li> <li>• OT – Yes</li> <li>• ST – Yes</li> </ul> <p>b) What are the perceived barriers to completing this area?</p> <ul style="list-style-type: none"> <li>• Confusion that this question is related to the diagnosis alone.</li> <li>• Clarification of standardized tool</li> </ul> <p>c) What are the key supporting documents to support the above?</p> <ul style="list-style-type: none"> <li>• Medicare Conditions of Participation</li> <li>• State Practice Acts</li> </ul>	
<b>Key Tools (Evidence-Based or “Home-Grown”) That May Assist Therapists in This Area</b>	
<ul style="list-style-type: none"> <li>• TUG – Timed Up and Go</li> <li>• Pulse Oximetry – orders for this are required</li> <li>• Quality of life assessments of COPD/CHF population specifically</li> <li>• OASIS items related to functional activities</li> <li>• Assessment of self care, mobility and household management abilities</li> </ul>	
<b>Tips to Assist Therapists in Completing This Area of the Comprehensive Assessment</b>	
<ul style="list-style-type: none"> <li>• Specifically assess and address dyspnea issues when noted during functional activities.</li> <li>• Remember that using TUG for falls assessment can also provide information regarding dyspnea to 20 feet of ambulation.</li> <li>• Educate therapy staff on this specific issue at orientation.</li> <li>• Determine competency in ability to accurately assess for dyspnea.</li> <li>• Look at clues to possible respiratory issues such as diagnosis, medications, use of pillows when in bed, sleeping in a recliner, BiPAP or CPAP use.</li> <li>• Know that documentation regarding dyspnea issues can support homebound status.</li> </ul>	

Topic	<b>Depression Screening</b>
<b>Recommendations</b>	
<b>Impact on Therapy/Therapies</b>	
<ul style="list-style-type: none"> <li>a) Is it in the scope of practice? <ul style="list-style-type: none"> <li>• PT – Yes</li> <li>• OT – Yes</li> <li>• ST – Yes</li> </ul> </li> <li>b) What are the perceived barriers to completing this area? <ul style="list-style-type: none"> <li>• Therapist lack of clarity as to what is being asked of them (diagnosis vs. screening)</li> <li>• Lack of therapist experience in assessing this issue</li> <li>• Therapist and patient discomfort discussing depression</li> <li>• Patient avoidance of discussing/admitting to feelings that are indicators of depression</li> <li>• Uncertainty regarding what the clinician will do with the information <ul style="list-style-type: none"> <li>○ Is there an intervention on plan to address?</li> <li>○ What is the policy/procedure?</li> </ul> </li> </ul> </li> <li>c) What are the key supporting documents to support the above? <ul style="list-style-type: none"> <li>• OASIS Guidance Manual</li> <li>• Accreditation standards</li> <li>• Clinical practice standards</li> </ul> </li> </ul>	
<b>Key Tools (Evidence-Based or “Home-Grown”) That May Assist Therapists in This Area</b>	
<ul style="list-style-type: none"> <li>• PHQ-2</li> <li>• PHQ-9</li> <li>• Geriatric depression scale</li> <li>• Quality of life measure</li> </ul>	
<b>Tips to Assist Therapists in Completing This Area of the Comprehensive Assessment</b>	
<ul style="list-style-type: none"> <li>• Train staff in the correct use of the tools provided and determine competence.</li> <li>• Look at quality of life measures to determine how depression is impacting the patient.</li> <li>• Clearly identify how to handle follow up if screening indicates possibility of depression.</li> <li>• Educate staff on procedure.</li> </ul>	

Topic	<b>Vital Signs</b>
<b>Recommendations</b>	
<b>Impact on Therapy/Therapies</b>	
<ul style="list-style-type: none"> <li>a) Is it in the scope of practice? <ul style="list-style-type: none"> <li>• PT – Yes</li> <li>• OT – Yes</li> <li>• ST – Yes</li> </ul> </li> <li>b) What are the perceived barriers to completing this area? <ul style="list-style-type: none"> <li>• Staff perception of their scope of practice</li> <li>• Idea that the taking of vital signs is a nursing function</li> <li>• Therapists not knowing or understanding how to take vital signs correctly</li> </ul> </li> <li>c) What are the key supporting documents to support the above? <ul style="list-style-type: none"> <li>• APTA Guide to Practice</li> <li>• Multi-skilled Personnel document from ASHA</li> </ul> </li> </ul>	
<b>Key Tools (Evidence-Based or “Home-Grown”) That May Assist Therapists in This Area</b>	
<ul style="list-style-type: none"> <li>• American Heart Association teaching tools</li> </ul>	
<b>Tips to Assist Therapists in Completing This Area of the Comprehensive Assessment</b>	
<ul style="list-style-type: none"> <li>• Provide training in the proper way to collect and interpret vital sign information.</li> <li>• Provide appropriate equipment to the therapists and check regularly to ensure it is in working order.</li> <li>• Perform routine competency assessment of these skills for all staff involved in the process</li> <li>• Establish process for communication of patient specific vital sign parameters as indicated.</li> <li>• Provide access to agency established vital sign parameters, if available.</li> <li>• Determine responsibility and time frame for communication with the physician regarding vital sign findings.</li> </ul>	

## Group 3

### Guidelines for Ensuring an Accurate and Complete Therapy Assessment Process

The initial assessment is a foundation for the entire therapy plan of care. Selecting and administering tests and measures that are based on the individual patient's functional deficits will result in objective documentation that justifies the skilled service. Progress toward goals should be periodically evaluated over the course of care and final status documented at the time of discharge.



#### Guiding Principles for Evaluation Tools

- Use tools that are objective and measurable.
- Select tests and tools that are patient specific and functionally relevant.
- Perform tests and use tools in a standardized manner or document as modified.
- Document appropriately and relate findings to a functional goal.
- Tie findings to outcome measures as captured by OASIS.

Assessment Area	Strength
<b>Recommendations</b>	
<p><b>Importance of This Assessment Area Related To:</b></p> <p>Strength assessment and how it relates to</p> <ul style="list-style-type: none"> <li>• Function</li> <li>• Fall risk</li> <li>• Ability for self care</li> <li>• Safety and stability of gait</li> </ul> <p><b>Examples of Tools and Measurements</b></p> <ul style="list-style-type: none"> <li>• Manual Muscle Test – must be understood and completed correctly</li> <li>• Dynamometer</li> <li>• Relate muscle deficit to functional impairment (Nagi model)</li> <li>• 1 max rep</li> <li>• Static and dynamic strength</li> </ul> <p><b>Key Measurements and Approaches Needed to Support This Assessment Area</b></p> <ul style="list-style-type: none"> <li>• Consistency between isometric MMT and functional activities</li> <li>• Lowered strength documented in terms of functions that can't be completed</li> <li>• Evaluation of all groups of muscles involved in functional tasks (e.g., hip extension not in "break test" screen)</li> </ul> <p><b>Tips to Assist Therapists in Creating Meaningful Goals for This Assessment Area</b></p> <ul style="list-style-type: none"> <li>• Look at strength deficit as a missing component of a functional task.</li> <li>• Document strength-specific goals with both measurement and a meaningful functional tie-in.</li> </ul> <p><b>Special Considerations by Patient Populations</b></p> <ul style="list-style-type: none"> <li>• Use age-related norms of functional tasks in healthy population as a guideline for establishing the patient's baseline. For example, if a normal 60 year old can do 25 sit-to-stands in 30 seconds but your 60 year old patient can only do 0 or 2, there is now an objective baseline to measure against.</li> </ul>	

Assessment Area	ROM – Range of Motion
<b>Recommendations</b>	
<b>Importance of This Assessment Area Related To:</b>	
<ul style="list-style-type: none"> <li>• Functional abilities</li> <li>• Prior level of function and determination of goals</li> </ul>	
<b>Examples of Tools and Measurements</b>	
<ul style="list-style-type: none"> <li>• Goniometer – standardized landmarks</li> <li>• Range of Motion (ROM) measurements directly related to impact on patient function</li> <li>• Measurements of both ROM starts and ends</li> <li>• Information on end feel</li> <li>• Edema – girth measurements, standard landmarks</li> </ul>	
<b>Key Measurements and Approaches Needed to Support This Assessment Area</b>	
<ul style="list-style-type: none"> <li>• Goniometer measurements</li> </ul>	
<b>Tips to Assist Therapists in Creating Meaningful Goals for This Assessment Area</b>	
<ul style="list-style-type: none"> <li>• Do not forget that both active and passive ROM information is relevant</li> <li>• Test hip flexors – caution not to strengthen them when the patient already has hip flexor contractures</li> <li>• Think of lowered ROM as a missing component of skilled task/function</li> <li>• Increase ROM of the knee to 0-110° to allow for independent stair climbing</li> <li>• Avoid WNL or WFL on goals. Specify the functional impact of the ROM change.</li> <li>• Specify how the assessment was conducted when you do not use objective ROM measures.</li> </ul>	
<b>Special Considerations by Patient Population</b>	
<ul style="list-style-type: none"> <li>• Age-related norms</li> </ul>	

Assessment Area	Balance
<b>Recommendations</b>	
<b>Importance of This Assessment Area Related To:</b>	
<ul style="list-style-type: none"> <li>• Fall risk</li> <li>• Patient safety in the home</li> <li>• Ability to complete functional tasks</li> </ul>	
<b>Examples of Tools and Measures</b>	
<ul style="list-style-type: none"> <li>• Berg</li> <li>• Tinetti (POMA)</li> <li>• Activities Balance Confidence Scale</li> <li>• Functional Reach</li> <li>• DGI – Dynamic Gait Index</li> <li>• Romberg/Sharpened Romberg/Single Leg Stance (quick screen)</li> <li>• Modified Clinical Test of Sensory Integration in Balance</li> </ul>	
<b>Key Measurements and Approaches Needed to Support This Assessment Area</b>	
<ul style="list-style-type: none"> <li>• Avoid subjective reports (by therapist).</li> <li>• Document measurable and objective information.</li> <li>• Assess sitting, transition to stand, static stand (immediate vs. static), dynamic during function.</li> <li>• Define and measure specific limits of stability: ankle, hip, stopping strategies.</li> <li>• Assess impact of posture and postural control.</li> <li>• Rule out vestibular component.</li> </ul>	
<b>Tips to Assist Therapists in Creating Meaningful Goals for This Assessment Area</b>	
<ul style="list-style-type: none"> <li>• Relate goals to function – specific self care, mobility, and household management activities.</li> <li>• Know the psycho-metric properties of tests and tools, as well as normative data.</li> <li>• Connect objective measures to function</li> <li>• Assess impact of visual issues.</li> <li>• Link specific balance issues to functional activities.</li> </ul>	
<b>Special Considerations by Patient Population</b>	
<ul style="list-style-type: none"> <li>• Age-related norms</li> </ul>	

Assessment Area	Activity Tolerance
<b>Recommendations</b>	
<b>Importance of This Assessment Area Related To:</b>	
<ul style="list-style-type: none"> <li>• Ability to complete a functional activity in a timely manner</li> <li>• Endurance and dyspnea</li> <li>• How it affects progression of the therapy program</li> </ul>	
<b>Examples of Tools and Measurements</b>	
<ul style="list-style-type: none"> <li>• BORG Rate of Perceived Exertion Scale</li> <li>• Dyspnea scale – rebound times</li> <li>• Vitals – resp. HR, SPO2, lung sounds → rest, activity, recovery, symptomatic versus asymptomatic</li> <li>• OASIS M1400</li> </ul>	
<b>Key Measurements and Approaches Needed to Support This Assessment Area</b>	
<ul style="list-style-type: none"> <li>• Vital signs</li> <li>• Level of dyspnea</li> <li>• Prior level of function</li> <li>• Past medical history</li> <li>• A timed activity, including a baseline time measurement</li> </ul>	
<b>Tips to Assist Therapists in Creating Meaningful Goals for This Assessment Area</b>	
<ul style="list-style-type: none"> <li>• Monitor vitals during rest, activity, and recovery.</li> <li>• Incorporate endurance into functional activities.</li> <li>• Do not isolate endurance – include dyspnea, medication issues, etc.</li> </ul>	
<b>Special Considerations by Patient Population</b>	
<ul style="list-style-type: none"> <li>• COPD</li> <li>• CHF</li> <li>• Chronic disease</li> <li>• MS</li> <li>• Parkinson’s</li> <li>• Cognitive and/or communication impairments</li> </ul>	

Assessment Area	Cognitive/Behavioral
<b>Recommendations</b>	
<b>Importance of This Assessment Area Related To:</b>	
<ul style="list-style-type: none"> <li>• Ability to learn</li> <li>• Safe performance of self care, mobility, and household management</li> <li>• Patient decision making</li> <li>• Awareness of deficits</li> <li>• Assisting with determining best strategies for teaching</li> <li>• Triggering referrals for community or other services for assistance or follow up</li> <li>• Identifying acute changes in mental status (e.g., medication related)</li> <li>• Identifying need for caregiver coping skills and support</li> </ul>	
<b>Examples of Tools and Measurements</b>	
<ul style="list-style-type: none"> <li>• SLUMS – St. Louis U. Mental Status</li> <li>• ACLS – Allen Cognitive Level Screen</li> <li>• MMSE – Mini Mental Status Exam</li> <li>• ASHA National Outcomes Measurement System (problem solving attention, memory, pragmatics)</li> <li>• FAST (level of dementia)</li> </ul>	
<b>Key Measurements and Approaches Needed to Support This Assessment Area</b>	
<ul style="list-style-type: none"> <li>• Memory (short term/long term) – simple/complex commands</li> <li>• Attention to task</li> <li>• Problem solving</li> <li>• Awareness of deficits</li> <li>• Executive function (e.g., planning)</li> <li>• Sequencing</li> <li>• Orientation</li> <li>• Language comprehension</li> </ul>	
<b>Tips to Assist Therapists in Creating Meaningful Goals for This Assessment Area</b>	
<ul style="list-style-type: none"> <li>• Suggest compensation strategies/assistive devices for memory, attention (e.g., calendar, alarms, memory logs, environmental modification)</li> <li>• Assess safety Implications</li> <li>• Give caregiver training in compensatory strategies/assistive devices</li> <li>• Determine prior level of function</li> <li>• Identify patient/caregiver goals</li> <li>• Consider the impact of these possible Issues: <ul style="list-style-type: none"> <li>○ Cognitive impairments/dementia</li> <li>○ Respiratory impairment</li> <li>○ Neurological impairment</li> <li>○ Hearing impairment</li> <li>○ Vision impairment</li> <li>○ Multiple co-morbidities</li> <li>○ Medication effects</li> </ul> </li> </ul>	

Assessment Area	Safety/Fall Risk Assessment
<b>Recommendations</b>	
<p><b>Importance of This Assessment Area Related To:</b></p> <ul style="list-style-type: none"> <li>• Preventing rehospitalization</li> <li>• Keeping them in the home with the appropriate level of care</li> <li>• Injury prevention</li> <li>• Minimizing caregiver burden/need</li> <li>• Discharge planning</li> <li>• Identifying equipment needs</li> <li>• Identifying resource needs</li> <li>• Educating patient and/or caregiver</li> </ul> <p><b>Examples of Tools and Measurements</b></p> <ul style="list-style-type: none"> <li>• Functional tools (gait and balance assessment) <ul style="list-style-type: none"> <li>○ Objective measurable fall risks</li> </ul> </li> <li>• Cognitive tools (see behavioral/cognitive assessment)</li> <li>• Modified falls efficacy scale</li> <li>• OASIS (related results)</li> <li>• HAPS (home assessment)</li> </ul> <p><b>Key Measurements and Approaches Needed to Support This Assessment Area</b></p> <ul style="list-style-type: none"> <li>• History, frequency of falls</li> <li>• Environment (intrinsic/extrinsic factors)</li> <li>• Fear</li> <li>• Assistive devices</li> <li>• ROM, strength</li> <li>• Continence</li> <li>• Medication, high risk</li> <li>• Functional assessment (ADLs, IADLs, gait)</li> <li>• Special consideration given to: <ul style="list-style-type: none"> <li>○ Sensory deficits</li> <li>○ Cognition</li> <li>○ Vision</li> <li>○ O2 Tubing</li> <li>○ Balance/Vestibular</li> <li>○ Diagnoses</li> </ul> </li> </ul> <p><b>Tips to Assist Therapists in Creating Meaningful Goals for This Assessment Area</b></p> <ul style="list-style-type: none"> <li>• Consider home/environment modifications.</li> <li>• Determine patient/caregiver awareness of safety deficits/fall risk factors to prevent falls.</li> <li>• Verbalize comprehension of safety/fall risk prevention to prevent falls.</li> <li>• Incorporate awareness of patient's cognitive ability.</li> <li>• Teach appropriate use of adaptive equipment.</li> <li>• Demonstrate appropriate use of personal emergency response system.</li> <li>• Decrease risk of falls as evidenced by the function tool used.</li> </ul> <p><b>Special Considerations by Patient Population</b></p> <ul style="list-style-type: none"> <li>• Age-related norms</li> </ul>	

Assessment Area	Communication
<b>Recommendations</b>	
<p><b>Importance of This Assessment Area Related To:</b></p> <ul style="list-style-type: none"> <li>• Understanding verbal directions, safety precautions</li> <li>• Reading medication bottles, exercise program</li> <li>• Expressing needs, describing pain, asking for clarification of instructions and precautions</li> <li>• Communicating with caregivers</li> <li>• Emergency situations (dialing 911 and asking for help)</li> <li>• Taking phone messages from doctor’s office, therapists</li> </ul> <p><b>Examples of Tools and Measurements</b></p> <ul style="list-style-type: none"> <li>• ASHA Functional Assessment of Communication in Adults (ASHA FACS)</li> <li>• Western Aphasia Battery</li> <li>• ASHA National Outcomes Measurement System (15 functional communication scales)</li> </ul> <p><b>Key Measurements and Approaches Needed to Support This Assessment Area</b></p> <ul style="list-style-type: none"> <li>• Auditory comprehension (words, one/two and multi-step directions, conversation)</li> <li>• Reading (same as above)</li> <li>• Verbal expression</li> <li>• Writing</li> <li>• Speech intelligibility (slurring, excessive rate)</li> <li>• Voice (too soft, poor quality)</li> </ul> <p><b>Tips to Assist Therapists in Creating Meaningful Goals for This Assessment Area</b></p> <ul style="list-style-type: none"> <li>• Assess prior level of function.</li> <li>• Determine patient/caregiver goals.</li> <li>• Tie goals to safety (understanding precautions, following directions).</li> <li>• Train caregiver in cueing and use of assistive tools (communication board).</li> <li>• Assess use of telephone.</li> <li>• Train in self-cueing strategies (gestures, writing).</li> </ul> <p><b>Special Considerations by Patient Population</b></p> <ul style="list-style-type: none"> <li>• Cognitive impairment vs. dementia</li> <li>• Impact of respiratory status on cognition</li> <li>• Neurologic diagnosis: static vs. degenerative</li> <li>• Hearing impairment</li> <li>• Visual impairment</li> <li>• Impact of multiple co-morbidities</li> <li>• Impact of medication on cognition</li> <li>• Language barrier</li> </ul>	

Assessment Area	<b>Ambulation</b>
<b>Recommendations</b>	
<p><b>Importance of This Assessment Area Related To:</b></p> <ul style="list-style-type: none"> <li>• Ability to function in the home safely</li> <li>• Ability to enter and exit home</li> <li>• Fall prevention</li> </ul> <p><b>Examples of Tools and Measurements</b></p> <ul style="list-style-type: none"> <li>• DGI – Dynamic Gait Index</li> <li>• TUG – Timed Up and Go</li> <li>• Tinetti</li> <li>• Gait speed (NIH Toolbox) 8' &amp; 20'</li> <li>• Modified falls efficacy scale</li> <li>• Berg</li> <li>• APTA Guide to Practice Statement, page 6 – 44, home grown tools</li> <li>• Use norms when available</li> </ul> <p><b>Key Measurements and Approaches Needed to Support This Assessment Area</b></p> <ul style="list-style-type: none"> <li>• Most Important: Phases of gait cycle (step length, cadence, weight shift, velocity, stance, distance required to function in home/community)</li> <li>• Distance, assistive device, level of assistance</li> <li>• Limitations in ambulation tied to functional tasks</li> <li>• Level of exertion/fatigue</li> <li>• Footwear/surfaces</li> <li>• Fear of falls</li> <li>• Stairs</li> <li>• Cognition/comprehension</li> <li>• Prior level of function</li> </ul> <p><b>Tips to Assist Therapists in Creating Meaningful Goals for This Assessment Area</b></p> <ul style="list-style-type: none"> <li>• Connect results of standardized test to functional performance.</li> <li>• Set goals that are: functional, objective, measurable, and include the timeframe to reach the goals.</li> <li>• Consider community re-integration standards &amp; prior level of function.</li> <li>• Ask what the <u>patient's</u> goals are.</li> <li>• Remember caregiver involvement.</li> <li>• Pay particular attention to stairs – safety, adequate AD/rails, what is needed to negotiate versus how to exit the home.</li> <li>• Put safety first.</li> </ul> <p><b>Special Considerations by Patient Population</b></p> <ul style="list-style-type: none"> <li>• Age-related norms</li> <li>• Communication and/or cognitive impairments</li> </ul>	

Assessment Area	<b>Transfers</b>
<b>Recommendations</b>	
<b>Importance of This Assessment Area Related To:</b>	
<ul style="list-style-type: none"> <li>• Ability to function safely in the home</li> <li>• Amount of assistance needed from a caregiver</li> <li>• Fall prevention</li> </ul>	
<b>Examples of Tools and Measurements</b>	
<ul style="list-style-type: none"> <li>• TUG – Timed Up and Go</li> <li>• 30 second sit-to-stand</li> <li>• Components of the Tinetti</li> <li>• No home grown or specific evidence-based tools are recommended</li> </ul>	
<b>Key Measurements and Approaches Needed to Support This Assessment Area</b>	
<ul style="list-style-type: none"> <li>• Quality of movement</li> <li>• Functional limitations/specific components of task that limits function</li> <li>• Minimal/Moderate/Maximum assistance – <b>standardize</b> these distinctions</li> <li>• Primary surface from which they transfer</li> <li>• Comprehension of teaching</li> <li>• Remember to consider all factors of care and all factors in this case</li> </ul>	
<b>Tips to Assist Therapists in Creating Meaningful Goals for This Assessment Area</b>	
<ul style="list-style-type: none"> <li>• Functional issues</li> <li>• COG over base of support</li> <li>• Adequate ROM/strength</li> <li>• Ability to motor plan and sequence (cognitive)</li> <li>• Proper height of surfaces</li> <li>• Assistive devices, environmental modifications</li> </ul>	
<b>Special Considerations by Patient Population</b>	
<ul style="list-style-type: none"> <li>• Age-related norms</li> <li>• Cognitive and/or communication impairments</li> </ul>	

## Recommendations

**Importance of This Assessment Area Related To:**

- Independence
- Quality of life for the patient and/or caregiver
- Manage disease process
- Skin integrity preservation
- Falls predictor

**Examples of Tools and Measurements**

- Physical performance test
- AM-PAC (activity measures for post-acute care)
- Specific task analysis
- TUG (Timed Up and Go) cognitive and functional task aspects
- Balance measures
- TUG, Tinetti, DGI, Berg
- Modified FIM not recommended as a tool

**Key Measurements and Approaches Needed to Support This Assessment Area**

- Bathing
- Dressing
- Feeding/eating
- Grooming
- Continence
- Toileting
- Personal hygiene
- Transfers
- Functional mobility

**Tips to Assist Therapists in Creating Meaningful Goals for This Assessment Area**

- Break down tasks into specific components.
- Indicate whether goals are short term or long term.

**Special Considerations by Patient Population**

- Dementia/cognition problems
- Respiratory problems
- Hearing deficiency
- Visual deficiency
- Medication interference
- Co-morbidities
- Availability of caregiver
- Obesity
- Socialization

**Recommendations****Importance of This Assessment Area Related To:**

- Independence
- Quality of life for the patient and/or caregiver
- Disease process management
- Preservation of skin integrity
- Prediction of falls

**Examples of Tools and Measurements**

- Physical performance test
- AM-PAC (activity measures for post acute care)
- Specific task analysis
- TUG – cognitive/functional task aspects
- Balance measures: TUG, Tinetti, DGI, Berg

**Key Measurements and Approaches Needed to Support This Assessment Area**

- Housekeeping
- Meal preparation
- Medication management
- Shopping needs
- Telephone use
- Money management
- Care of pets/others
- Health management
- Emergency response/safety

**Tips to Assist Therapists in Creating Meaningful Goals for This Assessment Area**

- Break down tasks into specific components.
- Indicate whether goals are short term or long term.

**Special Considerations by Patient Population**

- Dementia/cognition
- Respiratory problems
- Hearing deficiencies
- Visual deficiencies
- Medical Interference
- Comorbidities
- Availability of caregiver
- Obesity
- Socialization

**Recommendations****Importance of This Assessment Area Related To:**

- Patient safety
- Reducing re-hospitalization
- Impact on patient's ability to function safely
- Impact of medications on patient quality of life and overall health status

**Examples of Tools and Measurements**

- Drug Regimen Review
- Beers Tool
- Medication profiles
- Drug reference handbooks

**Key Measurements and Approaches Needed to Support This Assessment Area**

- Components of the Drug Regimen Review as outlined in the Medicare Conditions of Participation
- Screening for and documentation of medication changes over the course of care
- Assessment of patient to determine impact of medications and possible side effects
- Gait assessment in relation to being able to access medications
- Swallowing and cognitive ability in relation to medication
- Fine motor skills in relation to opening and administering medication

**Tips to Assist Therapists in Creating Meaningful Goals for This Assessment Area**

- *Pharmacology in Rehabilitation* by Dr. Charles D. Ciccone
- Currently available drug reference books
- Online medication information
- Information provided by the pharmacy with the prescription
- Connection of mobility, swallowing, cognitive, and/or fine motor deficits to the ability to manage medications safely

**Special Considerations by Patient Population**

- Consider the impact of both cognitive and functional ability on the management of medication.

Assessment Area	Interfering Pain
<b>Recommendations</b>	
<p><b>Importance of This Assessment Area Related To:</b></p> <ul style="list-style-type: none"> <li>• 5<sup>th</sup> vital sign</li> <li>• How affects function</li> <li>• Right to have pain managed</li> <li>• How affects sleep/rest pattern</li> <li>• How affects quality of life</li> <li>• Impact on motivation</li> <li>• Ability of medications to effectively manage pain</li> <li>• Psychological impact</li> </ul> <p><b>Examples of Tools and Measurements</b></p> <ul style="list-style-type: none"> <li>• Analog scale</li> <li>• Wong-Baker scale</li> <li>• Pain Disability Index</li> <li>• Interference with Function</li> <li>• Vital signs</li> <li>• Non-verbal pain indicators (checklist)</li> <li>• FLACC – peds</li> </ul> <p><b>Key Measurements and Approaches Needed to Support This Assessment Area</b></p> <ul style="list-style-type: none"> <li>• Patient’s acceptable level of pain</li> <li>• Response to treatment</li> <li>• Joint integrity</li> <li>• Intensity, location, quality</li> <li>• Interventions and time-frame for using them</li> <li>• Factors that exacerbate pain</li> <li>• Factors that relieve pain</li> <li>• Time of day</li> <li>• Change in function related to pain</li> <li>• Acute versus chronic</li> <li>• Posture/posturing considerations</li> </ul> <p><b>Tips to Assist Therapists in Creating Meaningful Goals for This Assessment Area</b></p> <ul style="list-style-type: none"> <li>• Relate pain to function.</li> <li>• Focus on self-management.</li> <li>• Teach pain management to all patients to tolerate functional tasks.</li> <li>• Document when patient verbalizes satisfaction with pain management related to specific function (patient drivers determine the goal).</li> </ul>	

**Special Considerations by Patient Population**

- Culture/religion
- Substance abuse
- Side effects/adverse reactions
- Gender
- Age
- Psych - 2° gains
- Cognitive/communication
- Medication intolerance
- Etiology of pain
- Acute versus chronic pain
- Modalities (physical agents)
- Regulatory limitations
- Fear of addiction

Assessment Area	<b>Dyspnea</b>
<b>Recommendations</b>	
<b>Importance of This Assessment Area Related To:</b>	
<ul style="list-style-type: none"> <li>• Correlates to fall risk</li> <li>• Affects ability to function safely</li> <li>• Can limit ability to complete necessary tasks</li> </ul>	
<b>Examples of Tools and Measurements</b>	
<ul style="list-style-type: none"> <li>• Dyspnea scale</li> <li>• Borg Rate of Perceived Exertion</li> <li>• Related to M1400 on OASIS</li> <li>• Vitals – blood pressure, apical heart rate, lung sounds</li> <li>• Posture, use of respiratory muscle</li> </ul>	
<b>Key Measurements and Approaches Needed to Support This Assessment Area</b>	
<ul style="list-style-type: none"> <li>• Prior level of function.</li> <li>• Respiratory issues related to functional tasks.</li> <li>• Patient history and diagnoses – e.g., end-stage COPD, cardiac problems, MS.</li> <li>• SP02 (orders are required for this), heart rate, blood pressure, lung sounds.</li> </ul>	
<b>Tips to Assist Therapists in Creating Meaningful Goals for This Assessment Area</b>	
<ul style="list-style-type: none"> <li>• Set parameters for SP02 and blood pressure</li> <li>• Monitor vitals during activity, present and past</li> <li>• Correlate measurements to meaningful tasks</li> <li>• Document prior level and expectations</li> </ul>	
<b>Special Considerations by Patient Population</b>	
<ul style="list-style-type: none"> <li>• COPD</li> <li>• CHF</li> <li>• Pulmonary fibrosis</li> <li>• Lung cancer – stage of cancer</li> <li>• MS, chronic disease</li> </ul>	

**Recommendations****Importance of This Assessment Area Related To:**

- Prevention of skin breakdown
- Identification of any skin integrity issues
- Assessment of need for inclusion of additional services for the patient

**Examples of Tools and Measurements**

- Braden skin assessment
- OASIS items related to wounds
- Agency specific wound assessment tools
- WOCN

**Key Measurements and Approaches Needed to Support This Assessment Area**

- Visualization of pressure points considered at risk for skin breakdown. Cannot rely solely on patient report.
- Consistent measurements and assessment of wounds present on the patient at the time of the assessment.

**Tips to Assist Therapists in Creating Meaningful Goals for This Assessment Area**

- Connect contributing mobility, incontinence and cognitive/behavioral issues to the risk for skin breakdown as well as the promotion of wound healing as indicated.
- Consider contributing factors to skin breakdown such as immobility, incontinence, and cognitive/behavioral issue.

**Special Considerations by Patient Population**

- Patients with significantly compromised mobility regardless of reason should be considered at increased risk for skin breakdown.

**Recommendations****Importance of This Assessment Area Related To:**

- Nutrition
- Hydration
- Energy level
- Aspiration prevention
- Socialization
- Ability to take meds
- Weight loss

**Examples of Tools and Measurements**

- ASHA preferred practice patterns
- Clinical bedside evaluation
- Instrumental assessment
- Instrumental assessment (video fluoroscopy, endoscopy)

**Key Measurements and Approaches Needed to Support This Assessment Area**

- Stage of swallowing involved in impairment
- Oral (pocketing, weakness)
- Pharyngeal (coughing, choking, referral for video fluoroscopy, endoscopy)
- Cognitive and communication status
- Voice quality
- Oral motor exam
- Trial feeding with different textures

**Tips to Assist Therapists in Creating Meaningful Goals for This Assessment Area**

- Identify prior level of function
- Determine patient/caregiver goals
- Monitor progression of diet
- Evaluate length of time to consume meal (affects overall intake)
- Identify home exercise program for oral strength, range
- Evaluate for compensatory strategies/maneuvers/positioning
- Evaluate for caregiver training for cueing, environmental modification, diet modification

**Special Considerations by Patient Population**

- Cognitive impairments/dementia
- Respiratory
- Neurologic diagnosis: static vs. degenerative
- Hard of hearing
- Visual impairment
- Multiple co-morbidities
- Impact of medication regimen

Assessment Area	<b>Skin</b>
<b>Recommendations</b>	
<b>Importance of This Assessment Area Related To:</b>	
<ul style="list-style-type: none"> <li>• Prevention of skin breakdown</li> <li>• Identification of any skin integrity issues</li> <li>• Assessment of need for inclusion of additional services for the patient</li> </ul>	
<b>Examples of Tools and Measurements</b>	
<ul style="list-style-type: none"> <li>• Braden skin assessment</li> <li>• OASIS items related to wounds</li> <li>• Agency specific wound assessment tools</li> </ul>	
<b>Key Measurements and Approaches Needed to Support This Assessment Area</b>	
<ul style="list-style-type: none"> <li>• Visualization of key areas considered at risk for skin breakdown. Cannot rely solely on patient report.</li> <li>• Measurements and assessments of wound status present on the patient at the time of the assessment.</li> <li>• Contributing factors to skin breakdown such as immobility, incontinence, and cognitive/behavioral issues.</li> </ul>	
<b>Tips to Assist Therapists in Creating Meaningful Goals for This Assessment Area</b>	
<ul style="list-style-type: none"> <li>• Connect contributing mobility, incontinence, and cognitive/behavioral issues to the risk for skin breakdown as well as the promotion of wound healing as indicated.</li> </ul>	
<b>Special Considerations by Patient Population</b>	
<ul style="list-style-type: none"> <li>• Patients with significantly compromised mobility regardless of reason should be considered at increased risk for skin breakdown.</li> </ul>	

## Group 4

### Guidelines for Ensuring Therapy Interventions are Consistent with Assessment Findings

An intervention is the purposeful and skilled interaction with the patient/client using various techniques and methods to produce changes in the condition that are consistent with the evaluation, diagnosis, and prognosis. Decisions are contingent on response and progress to intervention. Concerns arise when therapy interventions appear to be selected from a limited list and repetitively used regardless of the condition of an individual patient. In order to support the medical necessity of the care provided, intervention must reflect the needs of the patient and clearly respond to both “so what?” and “for what?” questions.

**Intervention selection should reflect the ability of the therapist to understand and incorporate the following:**

- Root cause of problems
- Functional deficits
- Payer criteria
- Therapist skill, accountability, professional responsibility
- Statistics, evidenced – based practice and standards of practice
- Identifiable consequences of *not* doing an intervention

### Guiding Principles for Interventions

For interventions to reflect the specific needs of the patient, they must:

- Reflect functional goals.
- Include episode management (but doing triage or prioritizing the most impactful items).
- Address the root cause or deficit.
- Be tied to assessment findings.
- Include vital signs and pain assessment (including O2 saturation).
- Include a return demonstration by patient and caregiver, including verbalization/safety techniques.
- Challenge patient/caregivers (simply repeating what the caregiver does is NOT a skill).
- Include strategies that are evidence-based and follow standards of practice.
- Stand alone.
- Take into consideration co-morbidities, cognitive level, and communication.
- Include clinical observation and reasoning.
- Include assessment of response to intervention.
- Address discharge plans.
- Teach patient/caregiver how to manage the disease process.
- Include a functional, integrated approach to care.
- Use the therapist’s skill, accountability, and professional responsibility.
- Reflect understanding by each therapist of their clinical weakness or personal barriers, as well as understanding of when to get training or refer the patient out.

Intervention Area	Strength
<b>Recommendations</b>	
<b>Relevant Home Grown and/or Evidence-Based Intervention Assessments and Strategies</b>	
<ul style="list-style-type: none"> <li>• ACSM Guidelines</li> <li>• Multi-disciplinary and interdisciplinary treatment</li> <li>• Continual assessments as to why they are weak – looking for the root cause</li> <li>• Written HEP, VH1 Cards, software</li> <li>• Hands-on, manual treatments</li> <li>• Core strength training (pilates, ball, discs, sitting)</li> <li>• Transition open and closed chain</li> <li>• Open and closed kinetic change</li> </ul>	
<b>Ways to Think About Connecting Identified Needs/Issues to Specific Interventions for This Area While Emphasizing Function</b>	
<ul style="list-style-type: none"> <li>• Increase strength to increase function.</li> <li>• Define the patient’s responsibility relating to function or care.</li> <li>• Define or explain therapy skill.</li> <li>• Relate the intervention to goals and function.</li> <li>• Every visit counts.</li> <li>• Give exercise programs that can be done by the patient/caregiver.</li> <li>• Plan the next intervention, response, and any needed follow-through.</li> <li>• If performing X number of repetitions – know what function this is working toward.</li> <li>• Only address strength issues if warranted to improve function.</li> <li>• Do not define components as key to treatment (MMT, ROM); instead, define the function and specify components needed for success of functional task.</li> </ul>	
<b>Tips for Showing Skilled Care During Every Patient Encounter</b>	
<ul style="list-style-type: none"> <li>• Provide verbal cues.</li> <li>• Ask for a return demonstration by the patient/caregiver.</li> <li>• Advance HEP and modify as appropriate.</li> <li>• Focus on progress toward functional goals.</li> <li>• Consistently observe and review.</li> <li>• Explain the rationale for altering or progressing exercises.</li> <li>• Define the purpose of the intervention and why the skills of a therapist are needed</li> <li>• Teach patient to self manage or train caregiver to assist.</li> </ul>	
<b>Overall Considerations for This Patient Population</b>	
<ul style="list-style-type: none"> <li>• Distinguish carefully between weakness and strength deficits.</li> <li>• Be realistic about what a patient can perform. Teaching needs to reflect the patient’s ability level.</li> </ul>	

Intervention Area	Range of Motion
<b>Recommendations</b>	
<b>Relevant Home Grown and/or Evidence-Based Intervention Assessments and Strategies</b>	
<ul style="list-style-type: none"> <li>• Look at more than extremities.</li> <li>• Consider multiple planes of motion.</li> <li>• Do hands-on manual therapy. Specific manual therapy techniques can include: sustained stretching, PNF patterns, contract/relax techniques, joint mobilizations, splinting/positioning/dynamic splint.</li> <li>• Focus on functional activities.</li> <li>• Include appropriate modalities.</li> <li>• Do patient and family education.</li> <li>• Include tone management.</li> <li>• Know the published guidelines of what ROM is needed for functional tasks.</li> </ul>	
<b>Ways to Think About Connecting Identified Needs/Issues to Specific Interventions for This Area While Emphasizing Function</b>	
<ul style="list-style-type: none"> <li>• Assure therapist competencies (e.g., in manual techniques).</li> <li>• Know that home health isn't a barrier to treatment options.</li> <li>• Know that age of patient is not a barrier.</li> <li>• Remember that loss of ROM is not a normal part of aging.</li> <li>• Remember that lower ROM doesn't automatically mean lowered function.</li> <li>• Set functional improvement goals.</li> <li>• Ask whether range is achievable for that patient.</li> <li>• Know the published guidelines regarding ROM.</li> <li>• While measurements are important, they should be addressed in terms of functional gain.</li> <li>• Do not overtax patient.</li> </ul>	
<b>Tips for Showing Skilled Care During Every Patient Encounter</b>	
<ul style="list-style-type: none"> <li>• Focus on movement quality.</li> <li>• Focus on joint integrity.</li> <li>• Educate and coach on technique.</li> <li>• Perform objective measurements.</li> <li>• Set specific timeframes to achieve goals.</li> <li>• Document all the knowledge-based skills the therapists bring.</li> <li>• Explain why the therapist is doing "best practice" techniques for ROM exercise.</li> <li>• Document the true intervention – do not short-cut.</li> <li>• Talk with the patient to see what exercises were performed – know the patient's goals.</li> </ul>	
<b>Overall Considerations for This Patient Population</b>	
<ul style="list-style-type: none"> <li>• Co-morbidities and condition</li> <li>• Medications – e.g., those that may cause bruising from exercise</li> <li>• Environment</li> <li>• Team approach, follow up, and communication. Need to communicate what each discipline is working on.</li> <li>• Education of team</li> </ul>	

Intervention Area	Balance
<b>Recommendations</b>	
<b>Relevant Home Grown and/or Evidence-Based Intervention Assessments and Strategies</b>	
<ul style="list-style-type: none"> <li>• Doing some clinical education to delineate what problems are present</li> <li>• Repeating specific tests (Tinetti, Berg, Functional reach) during intervention to measure progress</li> <li>• Doing skilled functional task observation</li> <li>• Using evidence-based practice to define other complications (vestibular, etc.)</li> <li>• Using assessment techniques as treatment techniques but with a distinct difference in focus and activity of the therapist</li> <li>• Teaching compensatory strategies</li> <li>• Considering multiple surfaces</li> <li>• Doing cognitive assessments (mini-mental)</li> </ul>	
<b>Ways to Think About Connecting Identified Needs/Issues to Specific Interventions for This Area While Emphasizing Function</b>	
<ul style="list-style-type: none"> <li>• Develop a CE/educational tool for therapists to follow.</li> <li>• Communicate to the rest of the team what compensatory tech taught.</li> <li>• In doing episode management, ask - when the patient needs visits and who is primary.</li> <li>• Define functional balance and challenge the balance.</li> <li>• Define how increased balance changes functional abilities.</li> <li>• Assess for and demonstrate DME and adaptive equipment needs.</li> </ul>	
<b>Tips for Showing Skilled Care During Every Patient Encounter</b>	
<ul style="list-style-type: none"> <li>• Document progress and evidence-based practice tools.</li> <li>• Do intervention specific to assessment.</li> <li>• Remember the purpose is not to define the score of the tool, but to assess the cause of the score.</li> <li>• Define further needs and follow-ups.</li> <li>• Document every patient encounter.</li> </ul>	
<b>Overall Considerations for This Patient Population</b>	
<ul style="list-style-type: none"> <li>• Environmental challenges</li> <li>• How cognitive status impacts intervention – consider verbal cueing, written cueing</li> <li>• Working with other disciplines (i.e., aides, caregivers)</li> <li>• Addressing caregiver fear of patient falling</li> <li>• Co-morbidities</li> <li>• Medications</li> <li>• In home care –skill in challenging the patient without putting the patient at risk</li> </ul>	

Intervention Area	Activity Tolerance
<b>Recommendations</b>	
<b>Relevant Home Grown and/or Evidence-Based Intervention Assessments and Strategies</b>	
<ul style="list-style-type: none"> <li>• Distance, Time (6 minute walk test)</li> <li>• Perceived exertion (BORG)</li> <li>• Psychological component – motivation, overcoming fear of repeat event</li> <li>• Progressive activity plan – activity broken down to tasks that can be completed individually</li> <li>• Planned breaks – determining how many breaks and how long the breaks are during activity</li> <li>• Compliance with recommendations/program (including caregiver feedback)</li> <li>• Energy conservation/work simplification</li> <li>• Assess quality and impact of the following: <ul style="list-style-type: none"> <li>○ Aspiration</li> <li>○ Diet impact</li> <li>○ Sleep patterns</li> <li>○ Depression</li> </ul> </li> </ul>	
<b>Ways to Think About Connecting Identified Needs/Issues to Specific Interventions for This Area While Emphasizing Function</b>	
<ul style="list-style-type: none"> <li>• Determine the patient’s current activity level.</li> <li>• Find out what the patient’s goal is for speed and tolerance for activity.</li> <li>• Find out what the patient sees as the obstacle.</li> <li>• Use the assessment as the intervention.</li> <li>• Be realistic with expectations for the patient, caregiver, and therapists.</li> <li>• Recognize which endurance limitations require therapy and which require time to recover.</li> <li>• Understand disease management models to address rehospitalization issues.</li> <li>• Integrate the therapists into Telehealth.</li> </ul>	
<b>Tips for Showing Skilled Care During Every Patient Encounter</b>	
<ul style="list-style-type: none"> <li>• Link time/distance to function/goal.</li> <li>• Monitor vitals during activity - including eating.</li> <li>• Educate patient/caregiver on what to expect, when to push, and when to stop.</li> <li>• Document who was taught and what the response was; allow time for a return demonstration for patient/caregiver to teach back info.</li> <li>• Review the tracking sheet and assess for problems, modifying as required.</li> </ul>	
<b>Overall Considerations for This Patient Population</b>	
<ul style="list-style-type: none"> <li>• Co-morbidities</li> <li>• Medications</li> <li>• Humidity (from shower and also weather)</li> <li>• Pain</li> <li>• Cardiopulmonary versus muscular endurance</li> </ul>	

Intervention Area

**Cognitive/Behavioral**

**Recommendations**

**Relevant Home Grown and/or Evidence-Based Intervention Assessments and Strategies**

- Mini-mental® State Examination, SLMS and/or Mini-cognitive findings to drive intervention choice
- Areas of cognition to consider:
  - Abstract versus concrete thinking
  - Receptive and expressive communication
  - Self-awareness
  - Integration with sensory systems
  - Orientation
  - Safety Awareness
  - Short-term memory
  - Awareness of past, present, future
- Levels of education and job experience achieved
- Strategic focus on the functional application of cognition

**Ways to Think About Connecting Identified Needs/Issues to Specific Interventions for This Area While Emphasizing Function**

- Recognize when these deficits are creating an unsafe environment.
- Recognize caregiver burnout.
- Identify alternative living situations.
- Poly-pharmacy.
- Consider aspects for this patient that may be related to:
  - Depression
  - Hospitalization
  - Nutrition
  - Impact of diagnosis
- Apply adaptive education

**Tips for Showing Skilled Care During Every Patient Encounter**

- Assess the patient's:
  - Self awareness.
  - Ability to communicate basic wants and needs.
  - Ability to use compensatory strategies.
  - Ability to take on more of daily tasks.
  - Sequencing of activities (discussion versus performance).
  - Number and type of cues needed (physical, verbal, none).
  - Impulsivity level.
- Assess whether the patient is taking medications as prescribed.
- Recognize safety issues.
- Use teaching tools.
- Label items in environment.
- Assess adaptive equipment needs.
- Educate about referral sources for areas of impact.

**Overall Considerations for This Patient Population**

- Technology access
- Adaptive equipment
- Support groups
- Caregiver support
- Diagnosis
- Prior developmental issues

Intervention Area	<b>Safety</b>
<b>Recommendations</b>	
<b>Relevant Home Grown and/or Evidence-Based Intervention Assessments and Strategies</b>	
<ul style="list-style-type: none"> <li>• Home grown safety assessment</li> <li>• Environmental assessments/modifications/ adaptations</li> <li>• Compensatory techniques</li> <li>• Skilled observation of safety during intervention and clinical reasoning</li> <li>• Vital signs</li> <li>• Medications</li> <li>• Behavioral modifications</li> <li>• Proper use of medical equipment such as oxygen management</li> </ul>	
<b>Ways to Think About Connecting Identified Needs/Issues to Specific Interventions for This Area While Emphasizing Function</b>	
<ul style="list-style-type: none"> <li>• Create procedure for how a team intervenes on safety.</li> <li>• Delineate roles and needs of each patient specific to therapy intervention.</li> <li>• Communicate needs.</li> <li>• Triage the safety needs – determine what need immediate attention.</li> <li>• Remember that safety take precedence over other needs.</li> <li>• Establish vital sign parameters which may impact the interventions provided.</li> <li>• Determine environmental safety versus cognitive safety.</li> <li>• Determine whether they can call emergency services – have patient demonstrate a “911” call.</li> <li>• Consider an MSW referral.</li> </ul>	
<b>Tips for Showing Skilled Care During Every Patient Encounter</b>	
<ul style="list-style-type: none"> <li>• Determine how much assistance is required to perform a task safely.</li> <li>• Make sure risk factors are addressed and documented.</li> <li>• Educate on risks and implications.</li> <li>• Ensure patient/caregiver understand by using both verbalization and demonstration.</li> <li>• Ask for a return demonstration by the patient/caregiver.</li> </ul>	
<b>Overall Considerations for This Patient Population</b>	
<ul style="list-style-type: none"> <li>• Make sure the patient understands safety concerns.</li> <li>• Understand the patient’s values – the patient can choose to fall or be unsafe. Be aware we do not “trample on patients rights”.</li> <li>• Keep in mind possible factors relating to: <ul style="list-style-type: none"> <li>○ Culture</li> <li>○ Abuse/neglect</li> <li>○ Incontinence</li> <li>○ Environment</li> </ul> </li> <li>• Know community resources</li> </ul>	

### Recommendations

#### Relevant Home Grown and/or Evidence-Based Intervention Assessments and Strategies

- Evidence based tools to identify interventions, such as the “modified falls efficacy scale,” “CT collaboration for the prevention of falls,” and “Missouri Alliance for Home Care”
- “Lifeline” product
- “Wellcare” product
- Activity Based Confidence Scale (currently in validation process ), TUG, Tinetti, Berg
- Fall reports - patient report/responsibility
- Cognitive status assessment
- Communication of risk and implications of impairment to the patient
- Clinical observation and clinical reasoning
- Environmental/behavioral modifications
- Stabilization techniques
- Fall recovery techniques

#### Ways to Think About Connecting Identified Needs/Issues to Specific Interventions for This Area While Emphasizing Function

- Document fall prevention – learn to document using process measures terminology.
- Define “fall” and remember that falls are not just from standing.
- Understand the implications of medications.
- Understand the implications of impairments – e.g., balance, endurance, strength, ROM.
- Utilize a multi-disciplinary approach.
- Observe mobility.
- Embrace risk – push patient past their comfort zone to intervene successfully.
- Understand community and technology resources.
- Add value and expertise - repeating what the caregiver provides is not skilled.
- Ensure therapist competency – their competency is related to fall statistics, as well as the ability to educate patients on the seriousness of the issue.

#### Tips for Showing Skilled Care During Every Patient Encounter

- Link the intervention needs to specific, identified risk factors.
- Challenge patient outside the patient’s comfort zone – more than just progressing.
- Document using therapeutic terms, skilled observation, and clinical reasoning.
- Use process measure terminology, standardized tests.
- Assess and ensure home safety.
- Document environmental and behavioral modification, and follow through with recommendations.

#### Overall Considerations for This Patient Population

- Reference to age-group
- Patient values/patient rights
- Keep in mind possible factors relating to:
  - Abuse/neglect
  - Low vision
  - Sensory impairments
  - Incontinence

Intervention Area	<b>Communication</b>
<b>Recommendations</b>	
<b>Relevant Home Grown and/or Evidence-Based Intervention Assessments and Strategies</b>	
<ul style="list-style-type: none"> <li>• Informal conversation</li> <li>• Mini-mental® State Examination findings</li> <li>• Passy-Muir</li> <li>• SLMS findings</li> <li>• LSVT (Parkinson's)</li> <li>• Assess the patients: <ul style="list-style-type: none"> <li>○ Fluency</li> <li>○ Voice-breath support</li> <li>○ Ability to write name and address</li> <li>○ Auditory processing</li> <li>○ Motor planning</li> <li>○ Oral motor skills</li> <li>○ Prior communication abilities</li> <li>○ Ease in give and take of conversation</li> <li>○ Affect</li> <li>○ Hearing, vision, writing</li> <li>○ Ability to assess lateral environment and activities</li> <li>○ Expressive versus concrete thinking</li> </ul> </li> <li>• Medication effects</li> <li>• Augmentative/signing options</li> <li>• Electrolarynx</li> </ul>	
<b>Ways to Think About Connecting Identified Needs/Issues to Specific Interventions for This Area While Emphasizing Function</b>	
<ul style="list-style-type: none"> <li>• Train other therapists regarding scope of practice.</li> <li>• Train caregiver.</li> <li>• Understand how word usage can affect therapy compliance.</li> <li>• Assess hearing.</li> <li>• Document how they communicate – verbal, gestures, etc.</li> <li>• Ensure patient understands what they have to do for ADLs.</li> <li>• Consider what senses may be affecting the prognosis, based on diagnosis.</li> </ul>	
<b>Tips for Showing Skilled Care During Every Patient Encounter</b>	
<ul style="list-style-type: none"> <li>• Document limitations, cueing needs, patient's ability to follow direction or follow modified behavior.</li> <li>• Communication of basic needs – identify verbal versus augmentative.</li> <li>• Consider the relationship between breath support and posture.</li> <li>• Assess the value of oral motor exercises for improvement.</li> <li>• Observe tongue movement.</li> </ul>	

**Overall Considerations for This Patient Population**

- Social/cultural factors
- Willingness to communicate
- Address frustration for patient/caregiver, and suggest coping strategies
- Vision impairments
- Hearing impairments
- Community links for support
- Technology options
- Prior developmental issues

Intervention Area	<b>Ambulation</b>
<b>Recommendations</b>	
<b>Relevant Home Grown and/or Evidence-Based (linked to tests) Intervention Assessments and Strategies</b>	
<ul style="list-style-type: none"> <li>• Dynamic Gait Index</li> <li>• Guide to P.T. practice pg 1248</li> <li>• Tinetti gait components</li> <li>• TUG (Timed Up and Go)</li> <li>• GARS (Gait Abnormality Rating Scale)</li> <li>• Use of devices</li> <li>• Balance</li> <li>• Proprioception</li> <li>• Posture – scanning environment</li> <li>• Promotion of quality – e.g., tactile cues, physical assistance</li> <li>• Use of environment – e.g., surface changes, obstacles</li> <li>• Breaking down tasks – e.g., step length, base of support</li> </ul>	
<b>Ways to Think About Connecting Identified Needs/Issues to Specific Interventions for This Area While Emphasizing Function</b>	
<ul style="list-style-type: none"> <li>• Focus on quality components of gait; not just “people walkers.”</li> <li>• Assess patient’s awareness of deficits.</li> <li>• Focus on function that is patient-specific – e.g., observe the surfaces and distances specific to the patient.</li> <li>• Determine prior status – e.g., if non-ambulatory, document how long.</li> <li>• Provide guidelines for the patient, such as boundaries or hip precautions.</li> <li>• Consider breathing exercises.</li> <li>• Consider aerobic endurance activities.</li> </ul>	
<b>Tips for Showing Skilled Care During Every Patient Encounter</b>	
<ul style="list-style-type: none"> <li>• Distinguish between quality deficits and distance deficits.</li> <li>• Consider prescription of devices/equipment.</li> <li>• Incorporate strategies for deficits such as depth perception, severe posture deficits, and proprioception.</li> <li>• Do AFO/orthotic/prosthetic planning with orthotist.</li> <li>• Make shoe wear recommendations.</li> <li>• Ask for return demonstration by patient of what was taught.</li> </ul>	

### **Overall Considerations for This Patient Population**

- Keep it simple.
- Remember precautions (WB).
- Keep a cheat sheet for components (cadence, balance, assistive devices, assistance).
- Link with community resources to be successful after discharge.
- Consider the effects of:
  - Temporary gait deficits (NWB, carts)
  - Medications
  - Co-morbidities

Intervention Area	<b>Transfers</b>
<b>Recommendations</b>	
<p><b>Relevant Home Grown and/or Evidence-Based Intervention Assessments and Strategies</b></p> <ul style="list-style-type: none"> <li>• Reinforce learning through repetition.</li> <li>• Break down transfer into specific components and develop interventions for each component.</li> <li>• Utilize all/multiple surfaces which are specific to transfer – e.g., floor, bathroom.</li> <li>• Give caregiver instruction in technique and the parameters of what the agency staff will provide.</li> <li>• Instruct in equipment needs.</li> </ul> <p><b>Ways to Think About Connecting Identified Needs/Issues to Specific Interventions for This Area While Emphasizing Function</b></p> <ul style="list-style-type: none"> <li>• Contact SLP regarding sequencing issues.</li> <li>• Give therapy instruction to an aide for follow-through, which will require an overlap of aide and OT/PT/SLP visit.</li> <li>• Stay current on available technology and equipment.</li> </ul> <p><b>Tips for Showing Skilled Care During Every Patient Encounter</b></p> <ul style="list-style-type: none"> <li>• Address multiple interventions (e.g., repeated sit to stand) to provide therapy for transfers and fall prevention.</li> <li>• Consider patient response (vital signs) to activity.</li> <li>• Describe mobility with definition of quality.</li> <li>• Break down the different components of transfer.</li> </ul> <p><b>Overall Considerations for This Patient Population</b></p> <ul style="list-style-type: none"> <li>• Home environment</li> <li>• Home and furniture modifications with instruction regarding proper seating/equipment</li> <li>• Co-morbidities</li> <li>• Aide/therapist safety, if aide/therapist has lifting restrictions.</li> </ul>	

Intervention Area	Self Care (ADL's)
<b>Recommendations</b>	
<b>Relevant Home Grown and/or Evidence-Based Intervention Assessments and Strategies</b>	
<ul style="list-style-type: none"> <li>• Standardized tests/retests (with Bartnel Index, PASS)</li> <li>• Homegrown ADL assessments</li> <li>• DME/adaptive equipment</li> <li>• Bartnel index</li> <li>• Environmental modification</li> <li>• Co-education/return demonstration</li> <li>• Energy conservation/wake simplification/return demonstration</li> <li>• Assess the patient's:               <ul style="list-style-type: none"> <li>○ Balance</li> <li>○ Fall risk</li> <li>○ Functional mobility</li> <li>○ Activity tolerance/endurance</li> <li>○ Cognitive status</li> <li>○ Sleep patterns</li> <li>○ Performance skills</li> <li>○ Activity demands</li> <li>○ Depression (i.e., PHQ-2)</li> </ul> </li> </ul>	
<b>Ways to Think About Connecting Identified Needs/Issues to Specific Interventions for This Area While Emphasizing Function</b>	
<ul style="list-style-type: none"> <li>• Incorporate client centered goals and activities</li> <li>• Ask questions related to timing – does patient shower in AM or in PM</li> <li>• What is realistic – consider patient and caregiver</li> <li>• Awareness that even with OASIS changes, these areas are addressed</li> <li>• Awareness of actual cultural, physical, environmental, social, and spiritual contexts.</li> <li>• Incorporate multiple factors (e.g., balance, mobility, safety, fall risk, ROM, strength, cognition) into the area of self care.</li> </ul>	
<b>Tips for Showing Skilled Care During Every Patient Encounter</b>	
<ul style="list-style-type: none"> <li>• Document rationalization for choosing task – link the activity to improving specific components.</li> <li>• Document return demonstration by the patient and caregiver.</li> <li>• Document level of assistance required, type of assistance, and for what outcomes of occupational performance (i.e., Bartnel index).</li> <li>• Focus on improved health and wellness as well as quality of life.</li> <li>• Encourage increased participation in activities.</li> <li>• Plan ahead for prevention of further difficulties.</li> <li>• Instruct in using adaptive equipment/DME- instruction.</li> <li>• Support self-advocacy.</li> </ul>	
<b>Overall Considerations for This Patient Population</b>	
<ul style="list-style-type: none"> <li>• Patient goals</li> <li>• Providing guidelines for the patient, such as boundaries or hip precautions</li> <li>• Considering what is realistic for each patient and environment</li> <li>• Co-morbidities</li> <li>• Caregiver support/community resources</li> <li>• Discharge plan</li> </ul>	

Intervention Area	<b>Home Management (IADL's)</b>
<b>Recommendations</b>	
<b>Relevant Home Grown and/or Evidence-Based Intervention Assessments and Strategies</b>	
<ul style="list-style-type: none"> <li>• PASS – (Performance Assessment of Self-Care Skills)</li> <li>• Social participation</li> <li>• Work, play, leisure</li> <li>• Education</li> <li>• Body functions: neuro-muscular, visual, perceptual, sensory, cognitive, body structures.</li> <li>• Depression (i.e., PHQ-2)</li> <li>• Activity tolerance/endurance</li> <li>• Habits – routines, roles, behaviors</li> <li>• Performance skills – motor skills, processing</li> <li>• Adaptive equipment/technology/orthotics assessment</li> </ul>	
<b>Ways to Think About Connecting Identified Needs/Issues to Specific Interventions for This Area While Emphasizing Function</b>	
<ul style="list-style-type: none"> <li>• Incorporate client-centered goals and activities.</li> <li>• Determine what is realistic – consider both patient and caregiver.</li> <li>• Retain awareness that even with OASIS changes, these areas are addressed.</li> <li>• Retain awareness of actual cultural, physical, environmental, social, and spiritual contexts.</li> <li>• Incorporate multiple factors (e.g., balance, mobility, safety, fall risk, ROM, strength, cognition) into the area of home management.</li> </ul>	
<b>Tips for Showing Skilled Care During Every Patient Encounter</b>	
<ul style="list-style-type: none"> <li>• Document training in home management and community reintegration.</li> <li>• Coordinate care and case management transitional services.</li> <li>• Include environmental and behavioral modification.</li> <li>• Include energy conservation/work simplification suggestions.</li> <li>• Document rationalization for choosing task – link the activity to improving specific components.</li> <li>• Track outcomes (e.g., PASS).</li> </ul>	
<b>Overall Considerations for This Patient Population</b>	
<ul style="list-style-type: none"> <li>• Patient goals</li> <li>• Consider what is realistic for patient and environment</li> <li>• Cultural, spiritual, gender, psychosocial issues</li> <li>• Co-morbidities</li> <li>• Caregiver support/community resources</li> <li>• Discharge plan</li> </ul>	

Intervention Area	<b>Medication Management</b>
<b>Recommendations</b>	
<b>Relevant Home Grown and/or Evidence-Based Intervention Assessments and Strategies</b>	
<ul style="list-style-type: none"> <li>• Ask on every visit if there have been changes.</li> <li>• Diabetic – ask about blood sugars, what eaten when; use guidelines.</li> <li>• PT INR – when to exercise. Use guidelines.</li> <li>• Assess ability to open bottles, split pills.</li> <li>• Give strategies to remember to take medications – simplify directions.</li> <li>• Monitor and assess the patient based on their medication list (especially those for pain, BP, and blood sugar).</li> <li>• Find out whether patient can state what the medication is for.</li> </ul>	
<b>Ways to Think About Connecting Identified Needs/Issues to Specific Interventions for This Area While Emphasizing Function</b>	
<ul style="list-style-type: none"> <li>• Use of medication review program to identify duplication and interaction(s).</li> <li>• Utilize information sources such as Drugs.com or Epocrates.com.</li> <li>• Involve other disciplines such as OT/SLP/RN/dietician/social worker.</li> <li>• Distinguish between cognitive and physical inability to take medications.</li> <li>• Be aware of what medications the patient is on and their potential effects on treatment.</li> <li>• Be aware of when a nurse is necessary.</li> <li>• Be aware of when to contact the physician.</li> <li>• Understand scopes of practice and state practice acts.</li> <li>• Be aware of personal limitations.</li> <li>• Advocate for patients.</li> </ul>	
<b>Tips for Showing Skilled Care During Every Patient Encounter</b>	
<ul style="list-style-type: none"> <li>• Identify side effects.</li> <li>• Identify compliance.</li> <li>• Do medication reconciliation on every visit.</li> <li>• Notify physician of any issues.</li> <li>• Identify whether there are any fine motor or cognitive components that might affect their ability to ambulate to get their meals where they are located.</li> <li>• Monitor caregiver’s ability to provide if needed.</li> <li>• Because medication management is recognized as an Activity of Daily Living (ADL), document in that context.</li> </ul>	

**Overall Considerations for This Patient Population**

- Ongoing competency training (depending on graduation date may have zero background)
- Multiple prescribing physicians
- Know resources available (from other disciplines)
- Assess the possible effect of:
  - Herbals/OTC med
  - Oxygen
  - Eye drops
  - Food interactions
- Assessing possible issues of drug diversion
- Cultural concerns, religious, and gender issues

Intervention Area	<b>Interfering Pain</b>
<b>Recommendations</b>	
<p><b>Relevant Home Grown and/or Evidence-Based Intervention Assessments and Strategies</b></p> <ul style="list-style-type: none"> <li>• Use visual analog scale.</li> <li>• Address root cause; determine whether it is within your skill set/scope of practice.</li> <li>• Modalities – assess need prior to treatment and reassess effectiveness after treatment medications. <ul style="list-style-type: none"> <li>○ cold laser, ultrasound, E-stim, TENS, ice, heat, biofeedback</li> </ul> </li> <li>• Consider the psychological aspects of pain.</li> <li>• Manual techniques.</li> <li>• Edema management.</li> <li>• Relaxation techniques.</li> <li>• Breathing techniques.</li> <li>• Compensatory strategies</li> </ul> <p><b>Ways to Think About Connecting Identified Needs/Issues to Specific Interventions for This Area While Emphasizing Function</b></p> <ul style="list-style-type: none"> <li>• Have patient take medications before treatment.</li> <li>• Educate on timing of medications.</li> <li>• Understand that pain is a normal process and doesn't always require an intervention.</li> <li>• Standardize agency education on the subjectivity of pain.</li> <li>• Tie interfering pain into the patient's goals and expectations.</li> </ul> <p><b>Tips for Showing Skilled Care During Every Patient Encounter</b></p> <ul style="list-style-type: none"> <li>• Use visual analog scale.</li> <li>• Demonstrate skilled intervention and all parameters of intervention, and document the patient's response to your intervention.</li> <li>• Document where pain is interfering with functions.</li> <li>• Assess what patient can do now after your intervention.</li> </ul> <p><b>Special Considerations by Patient Population</b></p> <ul style="list-style-type: none"> <li>• Co-morbidities</li> <li>• Cognitive status</li> <li>• Pain tolerance, pain baseline</li> <li>• Possible inability to communicate pain</li> <li>• Allergies/contradictions to pain medications</li> </ul>	

Intervention Area

## Dyspnea

### Recommendations

#### Relevant Home Grown and/or Evidence Based Intervention Strategies

- BORG (perceived exertion)
- BORG Breathing scale
- Pulse ox as biofeedback (specific orders are required)
- Vital signs
- Assess the following:
  - Pulmonary hygiene
  - Inhalation/exhalation ratio
  - Diet
  - Anxiety/Relaxation
- Suggestions for energy conservation or work simplification
- Oxygen – conveying parameters/safety
- Positioning (to improve the mechanics of breathing)
- AD (assistive devices)

#### Ways to Think About Connecting Identified Needs/Issues to Specific Interventions for This Area While Emphasizing Function

- Assess cause (e.g., fluid overload, posture).
- Mobilize accessory muscles.
- Use diagnosis to predict prognosis.
- Identify personal barriers and gain necessary skills to address them.
- Assess diaphoretic excursion.

#### Tips for Showing Skilled Care During Every Patient Encounter

- Educate on the mechanics of breathing and the impact of positioning.
- DME – assist with positioning to promote chest expansion.
- Know the red flags for warning signs such as weight and the impact of swelling.
- Environment assessment – dust, dander, etc.
- Residual air is tidal – volume.
- Take vital signs before and after exertion.
- Consider use of the spirometer.

#### Overall Considerations for this Patient Population

- Medication compliance – consequences of non-compliance
- Coordination of disciplines to prevent duplication
- Environment
- Flu/pneumonia
- Don't assume based on diagnosis

Intervention Area	Skin
<b>Recommendations</b>	
<b>Relevant Home Grown and/or Evidence-Based Intervention assessments and Strategies</b>	
<ul style="list-style-type: none"> <li>• Braden scale plus specific interventions based on score</li> <li>• Nutritional risk assessment and teaching</li> <li>• Positioning/pressure relief strategies</li> <li>• Ability to move, including self-ROM and strength</li> <li>• Support surfaces</li> <li>• Adaptive equipment</li> <li>• Pictures (digital photos) via cell phones, memory cards to document</li> <li>• Instruction in skin parameters</li> <li>• Continence</li> <li>• Skin integrity assessment</li> <li>• Instruction in skin health, e.g., topical agents</li> <li>• Wound care when indicated and within the realm of the State Practice Act</li> <li>• Activity/mobility to prevent shear</li> </ul>	
<b>Ways to Think About Connecting Identified Needs/Issues to Specific Interventions for This Area While Emphasizing Function</b>	
<ul style="list-style-type: none"> <li>• Look to know if these are issues.</li> <li>• Assess cognition.</li> <li>• Do wound rounds and conferences.</li> </ul>	
<b>Tips for Showing Skilled Care During Every Patient Encounter</b>	
<ul style="list-style-type: none"> <li>• Assess the caregiver’s knowledge and ability to move patient safely.</li> <li>• Provide skilled wound care, when indicated and if it is within your training.</li> <li>• Document the patient’s progress towards goals.</li> <li>• Ask for a return demonstration by the patient/caregiver.</li> </ul>	
<b>Overall Considerations for This Patient Population</b>	
<ul style="list-style-type: none"> <li>• HIPAA transmission of photos</li> <li>• Impaired sensation</li> <li>• Co-morbidities – particularly diabetes</li> </ul>	

Intervention Area	<b>Maintenance Therapy</b>
<b>Recommendations</b>	
<b>Relevant Home Grown and/or Evidence-Based Intervention Assessments and Strategies</b>	
<ul style="list-style-type: none"> <li>• Skilled observation and assessment</li> <li>• Continuous evaluation, reevaluation, and modification of plan</li> <li>• What informs caregiver of change</li> <li>• Defined parameters to monitor and notify of need for a therapy reassessment or intervention</li> <li>• Identification of the issue and development of appropriate interventions</li> </ul>	
<b>Ways to Think About Connecting Identified Needs/Issues to Specific Interventions for This Area While Emphasizing Function</b>	
<ul style="list-style-type: none"> <li>• Educate agency regarding what the maintenance therapy is.</li> <li>• Understand that giving care is co-occupation, and needs to become a socially interactive routine; educate the caregiver.</li> <li>• Learn to allow for change.</li> </ul>	
<b>Tips for Showing Skilled Care During Every Patient Encounter</b>	
<ul style="list-style-type: none"> <li>• Ensure that an intervention demonstrates complexity and skill.</li> <li>• Identify the issue and why it requires therapists' skill.</li> </ul>	
<b>Overall Considerations for this Patient Population</b>	
<ul style="list-style-type: none"> <li>• Therapists' purpose is to prevent decline in – but not to improve – skills reassessment of caregiver's ability to carry out the program.</li> <li>• Revolving door patients.</li> <li>• See if issue can be resolved on the phone.</li> </ul>	

Intervention Area

**Incontinence**

**Recommendations**

**Relevant Home Grown and/or Evidence-Based Intervention Assessments and Strategies**

- Bio feedback Treatment
- Kegel exercises
- Timed voiding
- Environmental modification
- Behavioral modification
- Medications
- Skin integrity assessment
- DME
- Clothing modifications or adaptations
- Ability to access the bathroom safely – be alert to possible concerns with ambulation
- Speed of ambulation
- Caregiver education
- Observation and clinical reasoning skills

**Ways to Think About Connecting Identified Needs/Issues to Specific Interventions for This Area While Emphasizing Function**

- Need to be able to perform an accurate assessment.
- Not just patient response.
- Use a team approach.
- Identify the root cause.
- Know that incontinence should not be accepted as a normal part of aging.
- May be a leading cause for other areas of intervention (falls, safety, skin, ADLs, etc.).
- Know products that are available.
- Make a WOCN referral if able.
- Know your patient (dignity).
- Tips/guidelines on how to ask the questions.

**Tips for Showing Skilled Care During Every Patient Encounter**

- Ask for a return demonstration by the patient/caregiver.
- Teach self-skin assessment.
- Assess skin integrity and findings documented.
- Document instructions and response.
- Analysis of findings of recommended techniques and/or supplies.
- Document improvements related to other areas.

**Overall Considerations for This Patient Population**

- Respect and address quality of life.
- Address the stigma of incontinence.
- Address the patient and expectations – it is not the norm for this population to be incontinent.
- Address lack of skill in this area and lack of equipment/supplies at the agency level.
- Refer able patients as necessary to specialized interventions.
- Address use of a catheter and digital stimulation.

## Group 5

### Documentation Needed to Support the Level of Care Provided Including Guidelines for Documentation Reviewers

One of the largest areas of concern facing therapy services in home health is the quality of the content in the documentation. Regardless of the tools being used or if they are paper or electronic, there are key areas of content that must be present to support the medical necessity of the care.

Denials made by external reviewers are not because of one single error on one isolated visit. They are a result of a pattern of missing pieces. When the record is assessed in its entirety, there is not enough information to show skilled services were provided.



Evidence for medical necessity needs to flow from the first therapy visit to the last and be clear for each specific discipline involved in the care. Key elements include the following:

- Assessments that detail both the previous and current functional status of the patient and support why therapy is needed
- Goals that are patient specific, measurable, and tied to a functional outcome.
- Interventions that correlate to the goals
- Documentation of the need for each individual visit provided and clearly showing the skills of the therapist used at each encounter

Lack of evidence to support medical necessity is typically not a result of an isolated note or an omission in one of the above mentioned areas. It is seen when there is missing detail in various aspects of the documentation that leads a reviewer to conclude that the number of therapy visits provided to the patient were more than what was actually necessary.

Patient progress alone does not support medical necessity since patients can show improvement in functional activities without the involvement of therapy. To defend medical necessity, the clinician must clearly link how the skilled interventions performed by the therapist on each encounter were critical and/or instrumental in achieving progress and other changes that occur. This documented link between therapy and outcome should be clear to any reviewer regardless of individual clinical background.

## Recommendations

**Purpose of This Documentation Area**

- Assessments of the patient in a holistic manner must include the OASIS, therapy specific details, and agency defined assessments.
- Assessments may include but are not limited to: vital signs, wound assessments, and medication management.
- Assessments must include clear information on prior level of function.
- Identifies reasonable functional potential as well as potential barriers to progress.

**Tips for Documenting Skilled Care**

- Include consistency of information between the OASIS responses and the remainder of the assessment.
- Encourage communication and collaboration between disciplines to create consistent details between clinicians.
- Patient skills must be observed, not assessed through interview alone.
- Use the comprehensive assessment synopsis or narrative as an opportunity to highlight key issues for the patient and the need for specific disciplines to be involved in the plan of care.

**Samples of Well-Written Documentation Related to This Area**

- "Patient had decline in the following areas due to recent illness/surgery: \_\_\_\_\_"
- "Prior LOF was \_\_\_\_."
- "Currently presents w/ deficits in \_\_, \_\_, \_\_, requiring \_\_\_\_ assist and equip."
- "Struggles due to additional medical issues of \_\_, \_\_."
- "Pt lives [alone/w/caregivers]. He has good potential to return to PLF & meet goals as stated."
- "Pt/CG is motivated and in agreement w/tx plan & goals."
- "Skilled care will include \_\_\_\_\_."
- "Potential barriers to progress \_\_\_\_\_"

**Specific Strategies for Reviewers**

- Strategically connect diagnosis and co-morbidities to specific functional problems.
- Note barriers to progress.
- Note prior level of function.
- Note problems identified during the assessment that need to be addressed in the plan of care.
- Ensure that the OASIS and the remainder of the assessment are consistent.
- Provide objective, measurable goals.
- Make the specific activities of the therapist clear to demonstrate skill needed.
- Justify homebound status.
- Use measureable tools such as: TUG, Tinetti, Braden, Missouri Alliance, Berg, Circumferentials, Functional Reach, Cognition, and Rhomberg.
- Ensure that physical therapy documentation contains detailed assessments and goals for gait issues.
- Ensure that occupational therapy documentation contains qualitative details specific to the individual activities of daily living and household management.

## Recommendations

**Purpose of This Documentation Area**

- Use this specific opportunity for each discipline to identify what reasonable, relevant intervention is justified to keep the patient at home safe as long as possible.
- Establish treatment plans based on functionally driven objective measurements.
- Focus on deficits and how they affect function.
- Determine *why* a patient needs particular skills.
- Measure both quality and quantity of patient performance.

**Tips for Documenting Skilled Care**

- Focus on the crucial facts
- Highlight what a patient can't do, NOT can do relative to the patient's goals.

**Samples of Well Written Documentation Related to This Area**

- "Returned home w/dtr for temporary assistance until she returns to her independent prior level of function (PLOF) including driving."
- "Experienced cardiac incident post-op resulting in prolonged hospitalization."
- "Newly on O2, fearful of having a repeat incident, and c/o significant anxiety."
- "Cannot manage stairs to bedroom so is set-up in living room."
- "Patient has experienced a recent exacerbation of rheumatoid arthritis. Pain likely to slow recovery. Needs PT & OT to resume full ADL/IADL function."

**Specific Strategies for Reviewers**

- Homebound
- Identify skilled need
- Delineated, clear PLOF (prior level of function)
- Identify specific deficits
- Avoid "deferred" or "see nursing note" as part of the therapy assessment.
- Ensure that all problems identified are addressed in the plan of care.
- Complete overall plan of care with relevant goals and orders.

### Recommendations

#### Purpose of This Documentation Area

- Summarize progress toward goals or lack of progress and document why.
- Justify the need for continued care or discharge patient from care.
- Update the plan of treatment and outcome-driven goals.

#### Tips for Documenting Skilled Care

- Clearly state gradation of progress.
- Break down the goals in terms of progress made and need to change as indicated.
- State skilled interventions; each note should stand alone.
- Document what skills were used to get the progress you achieved.
- Revisit prognosis and functional deficits.
- Document quantifiable measurements of progress and current abilities.
- Note when patient has potential for further gains, items or keywords, or “has not reached maximum level of functional improvement.”
- Note barriers that may have affected the patient’s progress.
- Keep it simple

#### Samples of Well Written Documentation Related to This Area

- “This patient receive physical/occupational, and speech therapy for the past \_\_\_ weeks/days. PT treatment has consisted of balance training and reassessment using the Tinetti scale with improvements from 10/28 to 20/28. TUG score improve from 32 seconds to 20 seconds. Gait training addressing equal step length, increased hip flexion during swing, and functional speed. HEP was developed with instruction to patient and caregiver with good compliance of program. The patient continues to present with good potential to meet functional gains. Patient is not yet at maximum functional potential.”

#### Specific Strategies for Reviewers

- Document progress towards goals with specific details.
- Document goals that are measureable, specific, and functional.
- Document the skill required, stating clearly what the therapist was doing that could not have been done by another discipline or a caregiver.
- Can each note stand alone?
- Document barriers to progress and the need for continued care.
- Document objective testing (Berg, Tinetti, Borg perceived exertion, TUG) – repeat measures.
- Document plan on each visit.
- Avoid repetitive information, which loses meaning and impact over time and should be investigated further.

Documentation Area	<b>Plan of Care/Interventions</b>
<b>Recommendations</b>	
<p><b>Purpose of This Documentation Area</b></p> <ul style="list-style-type: none"> <li>• Guides intervention and create a roadmap to care.</li> <li>• Establish expectation for outcome.</li> <li>• Document functional goals.</li> <li>• Establish needed duration and frequency of treatment.</li> </ul> <p><b>Tips for Documenting Skilled Care</b></p> <ul style="list-style-type: none"> <li>• Treat the plan of care as a working document.</li> <li>• Assign an appropriate intervention for each.</li> <li>• Use skilled terminology in the interventions.</li> <li>• Use evidence based interventions.</li> <li>• Match each intervention to the identified functional limitation.</li> <li>• Remember to address pain, dyspnea, and cognition.</li> <li>• Document barriers to improvement.</li> <li>• Link the intervention with a specific goal or outcome.</li> </ul> <p><b>Sample of Well Written Documentation Related to This Area</b></p> <ul style="list-style-type: none"> <li>• “If goal is “patient will be a reduced fall risk as evident by Tinetti score of 24/28 or greater by ____, interventions on the plan of care would be balance training, therapeutic ex, gait training with emphasis on equal step length, speed and weight transference.”</li> </ul> <p><b>Specific Strategies for Reviewers</b></p> <ul style="list-style-type: none"> <li>• Try to avoid frequency ranges.</li> <li>• Make sure an intervention is linked to a deficit.</li> <li>• Make sure that goals documented frame the plan of care. If there is a goal for bathing, then interventions specific to that should be documented clearly in the plan.</li> <li>• Look for justification for higher frequency visits. Know what is more complex about this particular patient.</li> </ul>	

Documentation Area	Goals
<b>Recommendations</b>	
<b>Purpose of This Documentation Area</b>	
<ul style="list-style-type: none"> <li>• Communicate clearly the expectations for this patient and impact of the care provided.</li> <li>• Measure success objectively.</li> <li>• Track progress objectively.</li> <li>• Define the need for treatment.</li> <li>• Prepare the patient/caregiver for discharge.</li> </ul>	
<b>Tips for Documenting Skilled Care</b>	
Goals must be:	
<ul style="list-style-type: none"> <li>• <u>R</u>elevant/realistic within limitations of disease process</li> <li>• <u>U</u>nderstandable</li> <li>• <u>M</u>easurable (quantitative, validated, and reflective of norms)</li> <li>• <u>B</u>ehavioral (using the terminology “the patient will”)</li> <li>• <u>A</u>chievable</li> </ul>	
<b>Samples of Well Written Documentation Related to This Area</b>	
<ul style="list-style-type: none"> <li>• “Pt will exhibit improved upright stability and safety to ambulate independently with cane in home as evidenced by a score of 50/56 on Berg Balance scale. Target date _____”</li> <li>• “Pt will complete bathing in tub independently using adaptive equipment of _____ Target date _____”</li> </ul>	
<b>Specific Strategies for Reviewers</b>	
<ul style="list-style-type: none"> <li>• Ensure that goals must be patient specific, measurable, and meaningful with respect to functionally driven issues.</li> <li>• Look for documentation of progress towards goals.</li> </ul>	



**Recommendations****Purpose of This Documentation Area**

- Support appropriate payment for services.
- Justify the medical necessity of therapy treatment.
- Communicate the course of care to other disciplines.
- Support for good continuity of care from therapist to therapist.

**Tips for Documenting Skilled Care**

- Be specific as to the activities of both the patient and the therapist during each visit.
- Describe what type and amount of cueing is needed for the patient to complete a task safely and correctly.
- Use appropriate technical terms and approved abbreviations.
- Utilize relevant validated tests and measures.
- Describe what the therapist is doing to facilitate improvement.
- Clearly describe techniques the therapist is using for facilitation of patient performance.

**Samples of Well Written Documentation Related to This Area**

- "Gait training with patient emphasizing increased hip flexion during swing phase for proper foot clearance with physical cues provided at pelvis. Patient able to ambulate to 100 feet with walker and minimal assistance."
- "Patient performed small meal prep with verbal cues to obtain ¾ items from refrigerator."
- "Patient exhibited 120 degrees shoulder flexion following ultrasound treatment at 1.3 w/cm 2 x 10 minutes and hold/relax technique. Deep friction massage over biceps tendon."

**Specific Strategies for Reviewers**

- Each visit should be able to stand alone upon review, including a clear description of the activities of the therapist.
- Skills must reflect outcome driven goals as well as OASIS scores.
- Interventions must be accepted practices for deficits.
- "Training" and "teaching" must contain detail as to what specifics were addressed, as well as the patient's ability to retain information over the course of care.
- Therapeutic exercises must be more than names and repetitions. The level of therapist involvement should be evident.

## Recommendations

**Purpose of This Documentation Area**

- Identify patient progress and completion of goals.
- Substantiate that the patient is ready for discharge.
- Summarize the skilled care provided.
- Finalize list of available community resources and patient's knowledge of availability.
- Ensure that the patient's needs will be met post-discharge.
- Meet the requirements of third-party payers.

**Tips for Documenting Skilled Care**

- Make sure all items on the plan of care have been addressed.
- Utilize consistent tests and comparison measurements that were done throughout the course of treatment.
- Make sure all required notifications have been completed.
- Provide skilled care on the last visit.

**Sample of Well Written Documentation Related to This Area**

- "Patient has completed eight (8) visits of physical therapy that included gait training with the focus of increasing step length and foot clearance particularly when changing surfaces. Patient is now able to ambulate to 200 feet with his walker independently with no loss of balance and cannot safely access his bedroom and bathroom."

**Specific Strategies for Reviewers**

- Identify what skill was provided on the last visit.
- Ensure that goals were reconciled with comments of current level of function or reasons why the goal was not met.
- Make sure there is a summarization of skilled interventions and progress.
- Make sure that measurements and retests are clearly documented.

## Group 6

### Appropriate Utilization of Therapy Assistants

Therapy assistants are important members of the therapy team and an integral part of care delivery in many home health agencies. Questions arise about how to effectively and appropriately utilize assistants; considerable variation is evident throughout the country.

In order to ensure that an agency is able to include therapy assistants in their team, both regulatory and professional issues must be assessed first. These include:

- **State Practice Acts** – States range from very detailed information about use of assistants to no specific information at all. Some states clearly define the expectations of supervision and ratios of therapists to therapy assistants while others have no guidance in either of these areas. In order to be compliant with the regulations, agencies must be versed in the content of their State Practice Acts and review the most current versions at least annually as changes to them are made periodically. Compliance with the State Practice Act sets the minimum requirements. In states that lack clarity, agencies need to consider what expectations they set within their own policies and procedures.
- **Third Party Payers** – Agencies must clearly determine if visits provided by a therapy assistant will be reimbursed from any payer source. When entering in to any new agreements, the coverage of assistant visits must be clear in order to maintain appropriate reimbursement.
- **Professional Associations** – The American Physical Therapy Association (APTA)+ and the American Occupational Therapy Association (AOTA) have information available to support appropriate use of therapy assistants and are great resources to guide the development of policies and procedures.
- **Agency Policies and Procedures** – Providing clarity as to the expectations of a therapist and therapy assistant is a critical element to successful care delivery. Discussion of these issues should be part of the hiring and orientation processes. Compliance with policies and procedures should be a routine part of record review and the competency process.
- **Therapist and Assistant Competence** – Just because something *can* be done does not automatically mean it *should*. When use of assistants is allowed in a given state, it is important to have regular and consistent conversations with staff about issues and processes. It can be helpful to have some of these discussions with therapists and assistants separately to assess how communication, collaboration, and supervision are working.

**Recommendations****Reference Materials**

- State Practice Acts – individual to each state and specific for physical and occupational therapy
- Federation of State Boards
- American Physical Therapy Association
- American Occupational Therapy Association
- Medicare Conditions of Participation

**Key Considerations**

- Clarify any discrepancies between State Practice Acts, professional standards, and agency policy.
- Determine any specific payer restrictions.
- Review JCAHO/CHAP accreditation standards.
- Determine the cost to manage assistants.
- PT/OT commitment.
- PTA/COTA commitment.

**Tips for Effective Use of Therapy Assistants**

- Consider matching personality when matching up therapist/assistant teams.
- Set up expectations and protocols. E.g., that the PT/OT is to supervise PTAs/OTAs, and which decision tree tools will be used. Begin this during the interview process for therapist and assistants.
- Set up a different orientation structure for therapy assistants.
- Place priority on developing communication skills.
- Know that the quality of care plan is important to ensure that the assistants are directed appropriately.

**Strategies for Ensuring Compliance**

- Develop specific protocols or guidance for utilizing therapy assistants.
- Ensure the plan of care is clear and available to anyone seeing the patient.
- Structure supervisory visits.
- Clarify expectations regarding communication and documentation.

Focus Area	<b>OASIS Impact</b>
<b>Recommendations</b>	
<b>Reference Materials</b>	
<ul style="list-style-type: none"> <li>• OASIS Guidance Manual</li> </ul>	
<b>Key Considerations</b>	
<ul style="list-style-type: none"> <li>• Therapy assistants need a working knowledge of OASIS and outcome measurements in order to integrate that information into their visits and understand the impact on the plan of care.</li> </ul>	
<b>Tips for Effective Use of Therapy Assistants</b>	
<ul style="list-style-type: none"> <li>• Train assistants regarding OASIS and outcomes.</li> <li>• Integrate OASIS concepts into the supervisory process of the assistant.</li> <li>• Include assistants in relevant education on OASIS updates.</li> <li>• Include assistants in discussions of outcomes and efforts to improve agency performance.</li> </ul>	
<b>Strategies for Ensuring Compliance</b>	
<ul style="list-style-type: none"> <li>• Assess the content of therapy assistant documentation for consistency with OASIS findings and inclusion of outcome-focused strategies.</li> </ul>	



Focus Area	<b>Initiating Care</b>
<b>Recommendations</b>	
<b>Reference Materials</b>	
<ul style="list-style-type: none"> <li>• State Practice Acts</li> <li>• Medicare Conditions of Participation</li> <li>• American Physical Therapy Association</li> <li>• American Occupational Therapy Association</li> <li>• Agency policies and procedures</li> </ul>	
<b>Key Considerations</b>	
<ul style="list-style-type: none"> <li>• The therapist who evaluates the patient must determine whether the patient can appropriately be treated by a PTA/COTA.</li> <li>• The decision to utilize an assistant should be driven by the complexity of the patient and matched to the skill set of the assistant.</li> <li>• Therapist-to-assistants ratios and supervision requirements are both set by the State Practice Acts. This is the minimum level of compliance; if the therapist needs to see the patient more frequently based on complexity, then compliance with these requirements should occur.</li> <li>• The therapist should determine frequency and duration of PTA/COTA treatments.</li> </ul>	
<b>Tips for Effective Use of Therapy Assistants</b>	
<ul style="list-style-type: none"> <li>• Establish specific criteria regarding the inclusion of a therapy assistant in the plan of care to eliminate confusion and inconsistency.</li> </ul>	
<b>Strategies for Ensuring Compliance</b>	
<ul style="list-style-type: none"> <li>• Monitor patterns of inclusion of therapy assistants to ensure that clinical factors are the driving force and that the criteria are being followed consistently.</li> </ul>	

Focus Area	<b>Patient Management (medication issues, new symptoms, etc.)</b>
<b>Recommendations</b>	
<b>Reference Materials</b>	
<ul style="list-style-type: none"> <li>• State Practice Acts</li> <li>• Medicare Conditions of Participation</li> <li>• American Physical Therapy Association</li> <li>• American Occupational Therapy Association</li> <li>• Agency policies and procedures</li> </ul>	
<b>Key Considerations</b>	
<ul style="list-style-type: none"> <li>• Consider the complexity of the patient.</li> <li>• Provide access to the patient’s history and physical.</li> <li>• Assess all therapists’ ability to read history and physical.</li> <li>• Ensure that the plan of care specifically includes diagnosis-specific parameters for any identified issues.</li> <li>• Reconsider the frequency of supervisory visits.</li> <li>• Confirm the assistant has the appropriate level of clinical reasoning for the complexity of the patient.</li> </ul>	
<b>Tips for Effective Use of Therapy Assistants</b>	
<ul style="list-style-type: none"> <li>• Develop scripting for collecting accurate information related to issues such as medication management or new symptoms.</li> <li>• Document all changes in the medical record.</li> <li>• Communicate any changes in a timely fashion with the therapist and the team.</li> </ul>	
<b>Strategies for Ensuring Compliance</b>	
<ul style="list-style-type: none"> <li>• Perform documentation review</li> </ul>	

Focus Area      **Therapist – Assistant Communication**

**Recommendations**

**Reference Materials**

- State Practice Acts
- Medicare Conditions of Participation
- American Physical Therapy Association
- American Occupational Therapy Association
- Agency policies and procedures

**Key Considerations**

- The therapist is ultimately responsible for the care provided by the assistant and communication between both parties is critical to ensure that care is being directed and managed appropriately throughout the episode.

**Tips for Effective Use of Therapy Assistants**

- The training of therapist and assistants on communication expectations.
- Develop accountability and communication using a script, check, form, and/or guideline.
- Establish an effective communication style between the therapist and assistant.
- Document evidence of regular communication between therapist and assistant in the medical record, at least weekly.
- Train the assistants to initiate communication with therapist if needed, based on a change in the plan of care or patient’s status.

**Strategies for Ensuring Compliance**

- Systematize documentation and proof of communication.
- Incorporate documentation of communication in an audit tool.

Focus Area	<b>Assistant – Team Communication</b>
<b>Recommendations</b>	
<b>Reference Materials</b>	
<ul style="list-style-type: none"> <li>• State Practice Acts</li> <li>• Medicare Conditions of Participation</li> <li>• American Physical Therapy Association</li> <li>• American Occupational Therapy Association</li> <li>• Agency policies and procedures</li> </ul>	
<b>Key Considerations</b>	
<ul style="list-style-type: none"> <li>• Remember that assistants are valued members of the team.</li> <li>• Encourage assistants to communicate and document with other disciplines.</li> </ul>	
<b>Tips for Effective Use of Therapy Assistants</b>	
<ul style="list-style-type: none"> <li>• Educate therapist on the value of assistants.</li> <li>• Educate agency on the value/role of assistants.</li> <li>• Train assistants on OASIS.</li> </ul>	
<b>Strategies for Ensuring Compliance</b>	
<ul style="list-style-type: none"> <li>• Audit of communication records.</li> </ul>	



**Recommendations****Reference Materials**

- State Practice Acts
- Medicare Conditions of Participation
- American Physical Therapy Association
- American Occupational Therapy Association
- Agency policies and procedures

**Key Considerations**

- Define what supervision is, when it will occur and how it is to be documented.
- Determine staff availability: less for doing supervisory visits, but more toward for determining how many assistants a therapist can effectively supervise.

**Tips for Effective Use of Therapy Assistants**

- Evaluation must be performed by a PT/OT.
- Communicate both the plan of care and the goals to an assistant either by telephone or email before the first visit.
- Set up a supervisory visit that includes supervision of the assistant as well as supervision of the entire plan in accordance with state-specific regulations.
- Communication evident throughout the episode.

**Strategies for Ensuring Compliance**

- Record reviews to determine if supervision is being documented in sufficient detail.
- Schedule periodic discussion with assistants and therapists separately in order to assess how supervision and communication are really working.
- Empower the assistants to remind the therapist of the need of supervision.

**Recommendations****Reference Materials**

- State Practice Acts
- Medicare Conditions of Participation
- American Physical Therapy Association
- American Occupational Therapy Association
- Agency policies and procedures

**Key Considerations**

- Clearly define what a change in patient status is.

**Tips for Effective Use of Therapy Assistants**

- Consult the therapist about any changes in the plan of care (+ or -)
- Document any changes in the plan of care clearly and in detail, in both the therapist's and the assistant's notes.

**Strategies for Ensuring Compliance**

- Perform documentation review.
- Hold discussion groups with therapists separately from the assistants.
- Monitor outcomes.



Focus Area	<b>Discharge Planning</b>
<b>Recommendations</b>	
<b>Reference Materials</b>	
<ul style="list-style-type: none"><li>• State Practice Acts</li><li>• Medicare Conditions of Participation</li><li>• American Physical Therapy Association</li><li>• American Occupational Therapy Association</li><li>• Agency policies and procedures</li></ul>	
<b>Key Considerations</b>	
<ul style="list-style-type: none"><li>• Initiate at the time of the evaluation by the therapist and communicate to the assistant.</li></ul>	
<b>Tips for Effective Use of Therapy Assistants</b>	
<ul style="list-style-type: none"><li>• Review the discharge plan during weekly communication.</li><li>• Communicate about timely delivery of the notice of discharge.</li><li>• Have an assistant establish with the therapist the date of discharge.</li></ul>	
<b>Strategies for Ensuring Compliance</b>	
<ul style="list-style-type: none"><li>• Perform documentation review.</li><li>• Hold discussion groups with therapists separate from assistants.</li></ul>	

Focus Area	Documentation Considerations
<b>Recommendations</b>	
<p><b>Reference Materials</b></p> <ul style="list-style-type: none"> <li>• State Practice Acts</li> <li>• Medicare Conditions of Participation</li> <li>• American Physical Therapy Association</li> <li>• American Occupational Therapy Association</li> <li>• Agency policies and procedures</li> </ul> <p><b>Key Considerations</b></p> <ul style="list-style-type: none"> <li>• Be sure that the content aligns with the plan of care.</li> <li>• Establish a clear ability to see the activities of the assistant during the visits that support skilled care.</li> <li>• Document any communication with the therapist.</li> </ul> <p><b>Tips for Effective Use of Therapy Assistants</b></p> <ul style="list-style-type: none"> <li>• Establish expectations for the content and timeliness of assistant documentation.</li> <li>• Empower assistant to indicate to the therapist when a change in plan of care is needed.</li> <li>• Do homebound status documentation.</li> </ul> <p><b>Strategies for Ensuring Compliance</b></p> <ul style="list-style-type: none"> <li>• Do record review.</li> </ul>	

## Staffing Therapy Services

Therapy shortages for physical, occupational, and speech therapy services have become a way of life in many home health agencies. When looking at interdisciplinary care planning and the level of therapy involvement, it is clear that utilization is influenced directly by an agency's access to sufficient numbers of skilled therapists.

There is no easy solution, but the participants in the Delta Excellence in Therapy Forum shared an assortment of tips and ideas that they have used to fill open positions successfully. Some tips are more consistently successful than others, but all are listed below to provide approaches and ideas that may not been tried in an agency before.

### Therapy Recruitment Tips

- Highlight the ability for therapists to see one patient at a time, which is not possible in other settings, as well as the functional focus of home care.
- Compare your employment package within your market.
- Assess salaries to determine where you are in the market.
- Offer a free CEUs event for local therapists.
- Promote agency outcomes and the agency's focus on patient care aspects.
- Create a consultative model for "specialties" such as incontinence.
- Evaluate a staff recognition program.
- Consider an expanded per diem/PRN pool.
- Give employees referral bonuses.
- Present about home health care in other settings (such as a rehab department).
- Hold open houses.
- Be in touch with your staff and listen to suggestions.
- Establish a relationship with therapy schools.
- Other student programs.
- Offer flextime hours.

## Conclusion and Implications for Future Research

The Delta Excellence in Therapy Project proved to be an exceptional endeavor. It not only generated information, insights, and recommendations that have national implications for the improvement of the management and provision of therapy services, but also the process itself demonstrated the tremendous value of involving all disciplines in addressing challenging issues and in making best practice recommendations.

One of the biggest surprises that emerged from the Project were the comments by many of the participants that the Delta Project was the first time all of the therapies and nursing came together to address a shared concern in a truly collaborative effort. The strength of this collaborative effort is probably best substantiated by the value of the outcomes and the shared pride that people from all disciplines had in both the process and results.

It is clear by the amount of information in this report that much was learned and shared about what “medically necessary” therapy can look like, both in practice and in documentation. Attendees concluded that although much had been gained, more work could be done. This report, like clinical practice, must be periodically revisited and will continue to grow over time with further input from the industry. At this time, those who participated feel ready to share their findings with therapists, the home care team, and agency leadership to use as a foundation for continued work that clearly shows the value for all services provided to patients.

Similar events may be held to build on this momentum and move forward in interdisciplinary care delivery discussions. Therefore, this report is not an ending, but the beginning of a larger conversation, sharing ideas and strategies to enhance the overall quality of therapy involvement in the home care arena.

## APPENDIX A – REASSESSMENTS

### Who is responsible?

- Qualified therapists per Medicare, not the therapy assistants.
- Therapist makes a visit to the home with a treatment incorporated into the visit.
- Is not related to the supervisory visit for the therapy assistant.
- Must be done by any active discipline separately.

### Components of the reassessment

- The fundamental intent is to reevaluate the Plan of Care to confirm that the services continue to be warranted and to make changes as needed in the Plan of Care.
- Objective assessments:
  - Tests/measures completed at initial assessment should be retested.
  - Deficits need to be linked to a functional task.
- Expectation of progress:
  - Needs to be a clinically supported statement that the patient will continue to progress or will resume progress after a plateau or regression.
  - PPS 2011 reinforces that there must be a positive impact from therapy interventions, but also defines a skill that involves what the therapist is doing that will lead to progress at a later point.
- Effectiveness of therapy:
  - What was it that you, as a qualified therapist, did to “disrupt” the process and cause a change in the patient?
  - Therapists need to take credit for the complexity of care that only they can provide to impact the patient’s outcome.
- Plan to continue or discontinue:
  - Do the clinical findings and professional judgment support continued therapy or discharge?
  - Have goals been met or not, or do they need to be revised/upgraded?


### When are the reassessments required?

- Minimally every 30 days:
  - The count starts with each therapy evaluation.

- There is no definition or “time window” for the Minimally 30 Day Reassessment, so can be done at any time prior to 30 days.
- 13 and 19<sup>th</sup> therapy visits (please see tables below for details).
- Counting of the visits is always a cumulative number of completed PT, OT, and SLP visits within each 60 day episode.
- Only covered visits are counted visits. For example: if the 13<sup>th</sup> visit reassessment is not completed within the proper timeframe, the visits after the 13th including the reassessment visit would be considered “non-covered,” therefore would not be counted in the cumulative total.

## Counting Visits

<p><b>13 (before 14)</b></p> <ul style="list-style-type: none"> <li>• <b>Single Therapy</b> <ul style="list-style-type: none"> <li>– On literal 13<sup>th</sup></li> <li>– <i>Rural exception</i></li> <li>– Completion resets 30 days</li> <li>– Specific to each cert period</li> </ul> </li> <li>• <b>Multiple Therapy</b> <ul style="list-style-type: none"> <li>– “Close to”</li> <li>– <i>No Ranges</i></li> <li>– Completion resets 30 days</li> <li>– Specific to each cert period</li> </ul> </li> </ul>	<p><b>19 (before 20)</b></p> <ul style="list-style-type: none"> <li>• <b>Single Therapy</b> <ul style="list-style-type: none"> <li>– On literal 19<sup>th</sup></li> <li>– <i>Rural exception</i></li> <li>– Completion resets 30 days</li> <li>– Specific to each cert period</li> </ul> </li> <li>• <b>Multiple Therapy</b> <ul style="list-style-type: none"> <li>– “Close to”</li> <li>– <i>No Ranges</i></li> <li>– Completion resets 30 days</li> <li>– Specific to each cert period</li> </ul> </li> </ul>
---	---



## Tracking Every 30 Days



- **“Minimally”**
  - Starts with the first visit from therapy
  - Continues until discharge
  - May cross certification periods
  - **DON’T** wait until the last minute



### **Tips for documenting**

- Document progress towards goals.
- Document objective tests (Berg, Tinetti, MMT, ROM, Barthel Index, etc.) that were initially tested.
- Document what the therapist has done (effectiveness of therapy) to make the change/progress.
- Document barriers to progress, if any, and why the patient will continue to make progress.
- Link the deficit measured to a functional task that is affecting the patient.
- Avoid repetition in notes.
- Document any changes in the Plan of Care or revision of goals.

### **What if a reassessment is missed?**

- Do the reassessment at the next visit or as soon as possible.
- Remember, all disciplines need to do the reassessment within the proper timeframe, or visits will be non-covered.
- For example, if PT misses the 13 visit reassessment and OT does 3 more visits before PT does their reassessment on visit 16, those visits, along with visit 16, would be non-covered, even when OT has done their reassessment.
- In a single discipline case, if the reassessment is done early on visit 12 (if non-rural or other exception), it would be out of compliance.

## Tests and Measures References

30 Seconds Sit to Stand: [http://tle.tafevc.com.au/toolbox/items/9e9725d7-7d68-32a3-d545-718eb94b0c34/1/805\\_011\\_1.zip/fit011\\_1\\_l10/fit011\\_1\\_l10\\_1\\_1.htm](http://tle.tafevc.com.au/toolbox/items/9e9725d7-7d68-32a3-d545-718eb94b0c34/1/805_011_1.zip/fit011_1_l10/fit011_1_l10_1_1.htm)

6-Minute Walk Test: [http://www.chcr.brown.edu/geriatric\\_assessment\\_tool\\_kit.pdf](http://www.chcr.brown.edu/geriatric_assessment_tool_kit.pdf)

ACLS: <http://www.allen-cognitive-levels.com/levels.htm>

Activities Balance Confidence Scale: [http://www.chcr.brown.edu/geriatric\\_assessment\\_tool\\_kit.pdf](http://www.chcr.brown.edu/geriatric_assessment_tool_kit.pdf)

AM-PAC (Activity Measures for Post-Acute Care): <http://www.creare.com/downloads/AMPAC.CAT2.13.07.pdf>

ASHA National Outcomes Measurement System: <http://www.asha.org/members/research/noms/>

Barthel Index: <http://www.healthcare.uiowa.edu/igec/tools/function/barthelADLs.pdf>

Beers Criteria: <http://www.pharmacytimes.com/issue/pharmacy/2006/2006-06/2006-06-5624>

Berg Balance: [http://www.rnao.org/pda/copd/medical\\_research.html](http://www.rnao.org/pda/copd/medical_research.html)

Borg Scale: <http://www.cdc.gov/physicalactivity/everyone/measuring/exertion.html>

Braden Scale: <http://www.bradenscale.com/images/bschome.pdf>

DGI (Dynamic Gait Index): [http://www.chcr.brown.edu/geriatric\\_assessment\\_tool\\_kit.pdf](http://www.chcr.brown.edu/geriatric_assessment_tool_kit.pdf)

Dyspnea Scale: [http://www.rnao.org/pda/copd/medical\\_research.html](http://www.rnao.org/pda/copd/medical_research.html)

FACS (Functional Assessment of Communication): <http://www.asha.org/slp/>

FAST (Functional Assessment Staging Test for Dementia):  
[http://www.dementiaguide.com/aboutdementia/understanding/impaired\\_function/](http://www.dementiaguide.com/aboutdementia/understanding/impaired_function/)

FLACC (Face, Legs, Activity, Cry, Consolability Scale - Peds): [http://en.wikipedia.org/wiki/FLACC\\_scale](http://en.wikipedia.org/wiki/FLACC_scale)

Functional Reach: [http://www.chcr.brown.edu/geriatric\\_assessment\\_tool\\_kit.pdf](http://www.chcr.brown.edu/geriatric_assessment_tool_kit.pdf)

Gait Speed (10 Meter Walk Test): <http://faculty.washington.edu/cyndirob/10%20meter%20walk%20test.doc>

Gait speed: 8' and 20' (NIH Toolbox):  
<http://www.nihtoolbox.org/Articles%20About%20Toolbox/Make%20Sure%20You%20Measure%20Up.pdf>

GDS (Geriatric Depression Scale): [http://www.chcr.brown.edu/GDS\\_SHORT\\_FORM.PDF](http://www.chcr.brown.edu/GDS_SHORT_FORM.PDF)

LSVT—Parkinson's: <http://www.lsvtglobal.com/>

Missouri Alliance Falls Assessment: <http://www.homecaremissouri.org/documents/Fallriskassessmentform.pdf>

MMSE (Mini Mental State Examination): <http://www.isu.edu/nursing/opd/geriatric/MMSE.pdf>

Modified Clinical Test of Sensory Integration in Balance: <http://www.highbeam.com/doc/1G1-13937139.html>

Modified Fall Efficacy Test: <http://web.missouri.edu/~proste/tool/vest/Modified-Falls-Efficacy-Scale.pdf>

MoCa (Montreal Cognitive Assessment): <http://www.mocatest.org/>

Pain Disability Index: numerous scales for different pain - do a web search for "Pain Disability Index"

PASS (Performance Assessment of Self-Care Skills): [http://www.slackbooks.com/excerpts/37735\\_1.pdf](http://www.slackbooks.com/excerpts/37735_1.pdf)

PHQ2: [http://www.cqaimh.org/pdf/tool\\_phq2.pdf](http://www.cqaimh.org/pdf/tool_phq2.pdf)

Physical Performance Test: [http://www.chcr.brown.edu/geriatric\\_assessment\\_tool\\_kit.pdf](http://www.chcr.brown.edu/geriatric_assessment_tool_kit.pdf)

Romberg's Test: [http://en.wikipedia.org/wiki/romberg's\\_test](http://en.wikipedia.org/wiki/romberg's_test)

Single Leg Stance: <http://www.pitt.edu/~whitney/sls.html>

SLUMS (St. Louis University Mental Status Exam): [www.slu.edu/readstory/homepage/1294](http://www.slu.edu/readstory/homepage/1294)

POMA (Tinetti Performance Oriented Mobility Assessment):  
[http://www.chcr.brown.edu/geriatric\\_assessment\\_tool\\_kit.pdf](http://www.chcr.brown.edu/geriatric_assessment_tool_kit.pdf)

TUG (Timed Up and Go): [http://www.chcr.brown.edu/geriatric\\_assessment\\_tool\\_kit.pdf](http://www.chcr.brown.edu/geriatric_assessment_tool_kit.pdf)

Wong Baker Pain Scale: <http://www.geriu.org/uploads/painDVD/AdditionalMaterials/WongBakerPainScale.pdf>

---

The American Occupational Therapy Association: [www.aota.org](http://www.aota.org)

The American Speech-Language-Hearing Association: [www.asha.org](http://www.asha.org)

Delta Health Technologies: [www.deltahealthtech.com](http://www.deltahealthtech.com)

Fazzi Associates: [www.fazzi.com](http://www.fazzi.com)

The Home Health Section of the American Physical Therapy Association: [www.homehealthsection.org](http://www.homehealthsection.org)

National Association for Home Care & Hospice: [www.nahc.org](http://www.nahc.org)

Join in the ongoing discussions at [www.HomeCareCommunity.org](http://www.HomeCareCommunity.org), the only social network dedicated to the homecare, hospice, and private duty communities.