Advocate Home Health Services - Therapy Guidelines

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Customer Service

Customer service is very important when partnering with Advocate. Contract therapy services companies are representing Advocate Home Health services out in the community. What contracting staff does is reflective of Advocate standards and the care that we bring to the patient. Our goal is to satisfy 100% of our customers. Contract companies that do not value customer service the way we do can no longer partner with Advocate. Areas of highest concern and repeated patient complaints are listed below.

1. **"When is my therapist coming?"** & **"My therapist never calls me"** All patients need to be called at least the day before a visit is made. Patients and families get very upset when staff "just show up" without calling, or call just hours before visits to say they are coming. Calendars should be used to document when you will be coming next, but a phone call must also be made to confirm the visit the night before. For the initial visit the branch agency staff will often let the patient know, based on the contract companies information, what day to expect the therapist, and when the patient does not hear from the therapist they are not happy.

2. **"My therapist came too late".** All visits must be made during normal visit hours. For Advocate those hours are 8:00am – 5:00pm. In general all visits should be completed by 5:30pm except for special patient request for a later or earlier visit. In addition visits should generally be scheduled when it is convenient to the patient and appropriate for their care. If a contract therapist has difficulty scheduling a patient they should contact the branch office.

3. **"My therapist stayed only 15min"**. All visits should be on average at least 40 min in length. We do recognize that some patients can not tolerate extensive hands on care. In those cases patient and caregiver teaching, additional skilled assessment, or other skilled intervention that is less taxing to the patient can be done.

4. "**My therapist did not work on what I needed"** & **" The therapist didn't do anything"**. Determine what the patient and families expectations or goals are for therapy and meet them. At times they may be unrealistic, but an attempt should be made to reach the goals and focus on what we are doing to accomplish them. ("we are doing this exercise so your leg gets stronger so you can climb the stairs"). If we can't meet the goals it is important to communicate to the family and patient why they were not able to be reached. (i.e. still too week in the leg muscles to climb the stairs; unresolved balance issues resulting in continuing to need the walker). Discuss what was accomplished by your service. (i.e. teaching, gain of new skills etc**).** Don't leave the client feeling they gained nothing from therapy just because they could not reach the goal they were hoping to.

Advocate Home Health Services - Therapy Guidelines

5. **"My therapist just stopped showing up"** & **"No one told me I was being discharged"**. Keep the patient and family aware of planned discharge. Begin this discussion at the first visit and continue it throughout the sessions. Alert the family and patient at least the visit before that they will be discharged from service or agency at the next visit. Mark it on the calendar "last visit" if you need to. Make sure that they know the follow up plan and have the information for the next step (i.e. go to outpatient, continue HEP etc). Communicate the planned D/C to the RN case manager or clinical manager so everyone is on the same page. (See Discharge for process). Don't forget about the HHABN if needed, and documentation to support your discussions and coordination of care.

6. **"My therapist did/does nothing with me"** Combat this compliant by constantly providing skilled service. Discuss with the patient what and why you are asking them to do something. Do not "just watch" them do their exercises each visit. Emphasis should be on teaching them the exercises and when reviewing the exercises provide feedback to the patient or caregiver on technique or upgrading the program independently. Provide education and reinforce reminding the patient that you are teaching them when providing feedback. (i.e. "remember I taught you the correct way to do stairs was… let's see how you are doing with that") Change it up. Use your skills to vary the program, provide hands on care, and safely challenge the patient.

Use objective equipment. Do not just eyeball the range for evaluation, measure the initial and progress with a goniometric measurement. Take vital signs, and let the patient know what the results are. Patients and families know quality skilled service when they experience it, and that is what Advocate strives to provide.

7. **"Your therapist never tells me what is going on with my patients."** Doctors are important customers as well and communication by the treating staff about their patients is vital. Repeated complaints by physicians of not knowing what is happening with their patients result in decreased referrals and therefore decreased business. Good communication results in repeat referrals and an increase in business. In addition, the patient talks to the doctor about the service they received. If they are not happy the MD is not happy and we jeopardize obtaining future referrals.

8. **"My therapist looked like they were ….. (a bum, going to the beach, just rolling out of bed)" "smelled like….."** Staff need to be dressed professionally. As a reminder; No jeans or tee shirts. Men should wear shirts with collars and "docker" style pants. Women should wear appropriately fitting clothes – not too tight or revealing. In the summer walking shorts may be worn or appropriate length culottes with sleeveless blouse or collared top. No tank tops may be worn. Socks must be worn with shoes, and it is suggested that no sandals be worn for safety reasons. Absolutely no flip flop sandals. Limit the amount of perfume or aftershave used and if the therapist smokes they should make sure that the smell is not overpowering. Identification badges should be worn at all times.

If a therapist anticipates a problem it is better to call the Clinical Manager or other branch personnel before problems escalate and we have a very unhappy patient or family.

Advocate: Process and Procedures Service Delivery

It is important that all contract therapy service companies (company) follow the process and procedures established by Advocate Home Health services (agency). It streamlines the flow of information and paperwork, allows for efficiency and accuracy in handling the business side of patient care, and allows for the agency to pay the company timely and completely. Untimely and incomplete submission of paperwork, invoices, and poor communication result in problems for all parties. Companies that have difficulty consistently meeting the business side of patient care will have a limited partnership with Advocate.

Referral Process

1. The contracting therapy services company (company) will receive a phone call/or fax from the scheduler or manager identifying a patient requiring services. This initial inquiry will include the what services are needed, location, and an anticipated SOC date (RN or PT). The company representative will confirm they can accept the referral as well as the anticipated therapy start date. If the company is uncertain as to staff availability if they must call the branch office within 2 hrs of the first call to let them know if they can cover the case, or the status of the referral.

2. Once the case is accepted by the company the referral (see sample Appendix C) will be faxed to the company and upon receiving the referral the company representative will confirm via phone call (or daily fax) that the referral has been received, confirm the name of the therapist that will be seeing the patient and the exact start date. It is expected that when the case is accepted the company will staff it and not turn it back to the agency saying it cannot service it.

3. If for some reason there is a delay in a therapy scheduled initial eval the scheduler must be notified by the company of the new anticipated start date.

4. On the faxed referral, besides patient information, will be payer information. If it is an insurance case and approval must be obtained for additional visits the name and number to call for further visits will also be listed. Other contact names and numbers including an RN Case Manager, Clinical Manager, and other therapists will also be listed.

5. The agency will notify the company of a patient's non-admit and no need for services as soon as that information is obtained by the agency.

Initial Visit/Evaluation Non Therapy Only Case

1. The patient should be called the day the referral is received to schedule the first therapy visit within 48 hours of the agency SOC or by the date stated in the initial referral call. If for some reason the patient can not be opened within that time frame (including the weekend) the scheduler must be informed. It is advisable that the therapist confirm that the patient has been seen by the RN prior to making initial visits as initial visits can be made only after the RN's SOC.

2. If the patient refuses initiation of services, a call should be made to the Clinical Manager stating any reasons for refusal and date and time of call. The Clinical Manager will confirm with patient their desire for no therapy and will notify MD and obtain additional instructions. Documentation of the patient's refusal (why, date & time) must be done on the narrative note by the company.

Advocate: Process and Procedures Service Delivery

3. On the initial visit complete the required paperwork. Objective findings and tests/measures should be used. (See Appendix A)

4. After the initial evaluation call in a report to the RN case manager (or if therapy only to the Clinical Manager). This is the main agency contact for the therapist once the case has been started. If the RN discharges the patient and therapy continues the Clinical Manager will be the contact.

> The verbal report should include the therapist's name, company name, patient's name, total number of visits planned, frequency/duration, (may not use ranges i.e. 1-2X/wk), brief assessment findings, therapy goals, and planned discharge date.
>
> If there are specific therapy orders the therapist will also identify any reasons the visit frequency and Plan of Care services vary from the specific orders on the referral.

(i.e. "Hi, this is Suzy Que of Best Therapy calling in a report for Jane Smith. She was seen for her initial physical therapy evaluation today April 25th. I will continue to see her 2 times per week for 2 weeks and 1X/week for 2 weeks for a total of 6 visits. Her main areas of difficulty are strength, safety and endurance. We will be working on gait training, transfer training and instruction in HEP, so that Mrs. Smith is safe and independent in use of a walker for 500ft level surfaces. We will also hope to make Mrs. Smith safe and independent in transfers sit to stand, and independent in performance of HEP with written copy. I am planning on discharging Mrs. Smith the week of May 16th. Should you have any questions please call me at 708-555-5555.)

5. After the initial visit the therapist should also call in a report to the primary MD regarding the anticipated POC. A message for the MD can be left regarding the POC with a contact number should they have any questions. (report example above).

6. All phone communications must be documented on the initial visit note.

Therapy Only Cases Initial SOC

1. Companies should be prepared to accept SOCs in areas they have identified they can service patients.

2. The patient should be called the day the referral is received to schedule the SOC on the requested date. If for some reason the patient can not be opened on this date the Clinical Manager and the physician must be informed.

3. For therapy only cases the Physical Therapist is responsible for completing all agency SOC paperwork, consents, comprehensive assessment, med review, and OASIS data collection. (see Appendix A).

4. All SOC paperwork and forms must be completed and turned in to the PBC per protocol for paper work submission.

5. All other communication and reporting following the SOC should follow the example in the Initial eval section.

Advocate: Process and Procedures Service Delivery

Managed Care Patients

1. For all insurance cases, a call must also be made to the agency insurance case management department (number on referral) like example above. Add to your report specific reasons as to why additional services are needed and that you are awaiting insurance approval. It is vital that a contact phone number for the therapist be left in the message for questions and notification of approval.
2. In addition, a completed evaluation form and a Rehabilitation Goals and Intervention form must be faxed to 847-318-1065 (temporary #). Authorization can not be processed without this information. If the eval is not complete additional information will be needed to obtain authorization, and may delay the approval process. Please note on cover sheet a contact phone number.

3. Conference with the agency insurance case manager for any authorization for continuing treatment beyond the initial authorization.

3. No visits can be made unless Insurance Authorization has been obtained or the therapist has the approval of the branch clinical manager.

4. Payment to the company is made for authorized visits only.

Subsequent/Routine Visits

1. All visits must be scheduled in advance with the patient /caregiver. The therapist should contact the patient the night before to confirm the visit previously scheduled.

2. Follow the documentation requirements for a routine visit located in Appendix B. If additional information is needed to be documented use a narrative note form.

3. If, after services have been initiated, the patient refuses further services, the patient has canceled or missed more than 3 visits, or the patient is no longer homebound you must contact the RN case manager/Clinical Manager. The MD should also be notified.

Conferencing

1. Report any significant changes in patient medical condition or other patient situations to the RN case manager/Clinical Manager.

2. Contact the RN case manager / Clinical Manager at least every 2 weeks to report patient progress toward goals, barriers to goals, and changes in POC.

3. Contact the RN case manager /Clinical Manager one week prior recertification and report plan.

4. Contact RN case manager at least 2 days prior to discharge (see D/C section).

5. Document all communication on the visit note or narrative note.

Advocate: Process and Procedures Service Delivery

MD Orders

1. Ordered frequencies and durations must be maintained. If visits are made beyond initial frequency or duration additional orders are needed to continue services.

2. A therapist is responsible to contact MD for all orders.
   Orders are required for:
   a. Initial POC and changes in the POC (frequency, and changes in patient status which require a change in POC (i.e. weight bearing status),
   b. When a patient is placed on hold from therapy
   c. When therapy is to be resumed (after a hold)
   d. When a patient is discharged prior to the Initial POC.

3. Once order is received the therapist may either write order and fax to the Clinical Manager or call the Clinical Manager to verbally give order. Do not send orders with regular paperwork to PBC as orders must be entered into system by branch agency.

Patient Canceled / Hold Visits and Resumed care

1. Patient Canceled Visit
   a. The agency will contact the company as soon as we are aware of a call to cancel a visit
   or patient hospitalization.
   b. The company has the responsibility of contacting the therapist about the cancellation.

2. If a patient repeatedly is canceling discuss need for continued service with RN case manager or Clinical manager.

3. Documentation is required for all missed/canceled visits that prevent completion of ordered weekly frequency. Included in documentation should be reason for cancellation, and effort made to reschedule visit**.**

4. Attempted visits.
   a. Scheduling protocol should limit the number of attempted visits. If a patient repeatedly is
   a no show discuss need for continued service with RN case manager or Clinical manager.
   b. Company will be notified if there is a higher proportion of attempted visits by particular
   staff and determination will be made if payment of attempted visits will be made.

5. Holds per Therapy
   a. Contact the clinical manager if a situation requires holding therapy.
   b. Contact the MD with rational for hold and obtain order for hold.
   c. Document the reasons for therapy hold, anticipated duration, and MD order.
   d. If there was a pre planned resume date on the MD order, the therapist must contact the Clinical manager prior to resuming care to confirm that the patient remained on service.

Advocate: Process and Procedures Service Delivery

e. If there was not a pre planned resume date the therapist must contact the clinical manager prior to resuming care to confirm that the patient remained on service, and then must contact MD and obtain new orders for therapy.

6. Hospital
   a. Company will be notified by the agency when "Resume orders" are received from the MD. They should not assume that just because a patient is out of the hospital they can start therapy again.
   b. For all patients just discharged from a re-hospitalization (even those that had therapy only services) the RN case manger will complete the ROC (resumption of care OASIS form) to determine if there is a nursing need.
   c. The therapist must complete an interim evaluation (same as initial eval form), establish new POC and perform all activities as if it were an initial eval.

7. A company can not resume therapy following a hospitalization or a call from a patient unless they have received a referral from the agency branch. This includes patient calls to therapist saying they have a new order from the doctor.

Written Home Exercise Program

1. Each patient serviced should receive a complete written HEP
   a. The program could be documented on a pre printed exercise form or written on a HEP form. It should include the patient's name, instructions for specific exercises, and the recommended number for repetitions and frequency per day/week. A copy or list of the program (including specific instructions) needs to be included with your documentation.

   b. Updates to the HEP (frequency, repetitions, and types of exercise) need to be documented.

   c. Document patient's/caregiver's understanding, response to program, and compliance.

Advocate: Process and Procedures Service Delivery

PTA/COTA Use and Supervision

A company may use a PTA/COTA as clinically appropriate but the following stipulations must be followed.

1. Branch agency must be notified when a PTA/COTA is placed on the case and who the supervising therapist is. The visits billed must indicate which visits were done by PT/OT and which were done by the assistant.

2. Eval and discharge must be done by the PT/OT.

3. Onsite supervisory visits must be made by the PT/OT at the minimum every 6th visit. Documentation must reflect supervision and communication with PTA/COTA.

4. All initial POCs, changes to the POC, MD communication, and MD orders must be done by the PT/OT.

DME Equipment

1. Make sure by checking with the patient or family, that equipment has not already been ordered by the hospital, RN, or that there is not a specific vendor or supplier that must be used due to insurance reasons. Confirm the patient wants the equipment.

2. Contact the MD and notify him of the patient's need for equipment and that order will be placed.

3. The therapist should contact Advocate DME at 1-800-564-2025 with specific equipment needed and confirm anticipated delivery for the family. DME will also call the patient prior to delivery.
No other DME company can be used by the therapist, however the patient may make their own arrangement for equipment using another DME provider if they wish.

4. Document in note equipment recommended, all orders placed, and companies used.

Recertification

1. Although it is rare a patient is recertified for an additional 60 days of care it can be done. If this is required for therapy the RN case manager / Clinical Manager must be contacted and the case discussed including rational for additional needs, goals / objectives for next period, and anticipated frequency and duration.

2. If therapy is the only discipline that will continue to visit the patient the therapist will be responsible for completing the recertification OASIS within re-certification 5 day window, interim evaluation, and complete the 60 day summary.

3. All post evaluation calls must be made as previously noted.

Advocate: Process and Procedures Service Delivery

Discharges

1. Begin discharge planning at the initial evaluation visit and document the discharge plan notification to the patient/family in the initial evaluation. Document ongoing discharge planning instructions to the patient, and to the caregivers in subsequent notes.

2. Company personnel (office or therapist) should contact the RN case manager (phone conference or message with return phone number) at least 2 days prior to a planned D/C and immediately if an unplanned D/C happens. At that time it should be determined who will be making the last visit.

> Example: "Hi, this is Susie the therapist seeing Mrs. Smith. I plan to have all goals accomplished by Thursday April 22 and plan to discharge the patient. If I need to complete the OASIS discharge please let me know by Wed.

3. If the RN discharges the patient prior to the therapist the RN will complete a D/C summary and this summary will be faxed to the company. It is the company's responsibility to get this summary to the therapist for OASIS–C completion and final agency discharge summary

4. If the RN is still on the case the therapist should complete a final visit note, and the discipline discharge summary (See Appendix B) and note on summary of service patient D/C.

5. The company/therapist will contact the MD prior to discharge and alert them to progress made, goals obtained, or obstacles to further gains or goals not met and why.

6. If outpatient therapy is recommended the therapist should refer the patient to the MD's preferred location or closest Advocate outpatient provider. At no time can a company therapist refer a patient to an outpatient center connected to their company or a center that they have a financial interest in.

7. If for some reason no visit was made at the time of DC, (care terminated prior to last planned visit) and the therapist was the clinician to make the last visit, complete the necessary paperwork and indicate the date of the last billable visit on the discharge summary, the reason no visit was made, and that the patient was discharged. The agency will notify the company if an OASIS needs to be completed and will send a service discharge summary form from the RN so the OASIS –C form can be correctly completed. (see Appendix B)

8. <u>All paperwork must be completed by the company therapist that saw the patient last, not an office person.</u>

Process and Procedures - Documentation Submission and Invoicing

1. Daily the therapist must fax to the agency branch office a completed "Summary of Service" form using correct codes, and completing per protocol (See Appendix B & C). Branch office personal will enter data into Allscripts system and provisonalize visits. This will initiate the process to pay the company timely. The original Summary of Service should be submitted with the notes and invoice to the PBC.

2. All original paperwork must be submitted with an invoice **to the PBC** at minimum 3X per week . CPT submits DAILY. This includes all SOC paperwork, evaluations, routine visits, recertification, discharge summaries, original summaries of service, OASIS paperwork and any other items to be placed in the chart. (routine Doctor's orders must be sent to Branch agency so they can be entered in Allscripts and visit calendar updated.)

3. It is vital that SOC and Initial Evaluations are submitted within 48-72 hrs of the visit so that the information can generate orders for the 485. Delay in submission prevents us from billing, and prevents us from being in compliance with having signed 485's and MD orders on the chart.

4. All visits invoiced must match those from the "daily summary of care form". This includes

a. correct patient name
b. patient number
c. type of visit (regular, eval, D/C)
d. class of therapist that provided the care (i.e. PT, PTA, OT, COTA, SPL)
e. time in/out

5. All visits on invoice must have complete documentation included with invoice for that visit type to be payable. Invoices may be held until missing documentation is sent. See Appendix A for required paperwork due for each type of visit.

6. Documentation missing will be requested by the agency and must be submitted to the PBC within 48 hrs with a new invoice to be considered for payment. We can not submit an invoice twice to accounts payable and items not payable on an invoice are crossed off. In order to be paid for that item it must be re listed on an invoice.

7. Documentation submitted later than within 1 week of service date will be subject to payment penalties.

8. At the end of the month any remaining documentation for the month must be submitted by the defined close date. The company will be notified by fax from the PBC of the date. Items that have not been submitted within 30 days of the date of visit will be considered non-existent and will not be paid.

9. Chart deficiencies (missing documentation, orders etc) should be at a minimum if procedures are followed. If deficiencies are found the company has 1 week to rectify them. Companies that disregard this request put their partnership with Advocate at risk. Any missing documentation should be sent to the location requesting it.

Advocate: Process and Procedures Documentation & Invoicing

10. All contract stipulated penalties and hold backs due to late or missing notes, visits without authorization, visits missing MD orders, and late invoices will be enforced.

11. Companies should expect payment of clean & complete invoices within 25-30 days. Invoices with missing items or questionable visits may be delayed until problems are resolved.

12. Any and all calls concerning invoices or payment should be directed to Kerrissa Pole at 630-572-6669. or kerrissa.pole@advocatehealthcare.com. At no time should calls be made to the Advocate Health Care accounts payable department, agency branch personnel, or administration.

Advocate: Appendix A FORMS

Advocate uses a mix of Briggs and their own documentation for all contract staff. You must use the agency documentation except for exercise sheets or other HEP. Advocate staff use Allscripts computer POC system for documentation, and company documentation information is keyed in with the original put in the patient's chart. All forms may be obtained through Branch offices. Completed samples of some of the forms are found in Appendix C. Only new and paperwork below will be accepted after 2/15/2010
Those items stared "***" must be submitted for visit to be paid.

SOC Visit : Initial start of care packet includes all the patient paperwork needed for a SOC. Folder to return all *** items to agency

Patient Information book and Appendix
*** Physical therapy SOC OASIS/Comprehensive assessment Form
***Homecare Patient Agreement,
***Notice of Privacy Practices
***Insurance Card Verification Form
***Medication Profile and Instructions
***Rehabilitation Intervention and Goals Sheet (new for 2010)
***Braden Assessment
***Tug Test
***Tinette (if needed for objective findings)
***Listing of visit on Daily Summary of Care form
Notification of Non-coverage Forms
Family Involvement Form
Patient Emergency Plan
***Home Health Aide assignment sheet (if Home Health Aide is needed)
***Doctors orders for MSW (if MSW is needed)
Patient service calendar

Initial Evaluation Visit

***Discipline specific evaluation form (2 pages PT; 1 page OT; 1 page ST)
***Rehabilitation Intervention and Goals Sheet (new for 2010)
***Tinette (if needed for objective findings)
***Listing of visit on Daily Summary of Care form

Routine /Revisits

***Discipline specific revisit form
***Listing of visit on Daily Summary of Care form
HEP sheets as appropriate

Discharge Discipline Only

***Discipline specific Discharge evaluation/visit form
*** Rehabilitation Intervention and Goals Sheet with resolution of goals (new for 2010)
(i.e. met / partially met / not met & why they were not met)
***Listing of visit on Daily Summary of Care form

Discharge Agency

***Therapy D/C OASIS/Comprehensive assessment Form

Advocate: Appendix A FORMS

*** Rehabilitation Intervention and Goals Sheet with resolution of goals (new for 2010)
(i.e. met / partially met / not met & why they were not met)
***Listing of visit on Daily Summary of Care form

Appendix B Therapy Documentation Standards

All company staff must be oriented by the company to Advocate forms and standards of documentation prior to being assigned an Advocate patient. See Appendix C for completed examples of some forms.

All documentation must be done in black ink and in legible handwriting. If it cannot be read, it was not documented.

It is very important that the patient name and number be correct and legible on each page submitted.

No abbreviations may be used that are not on the approved Advocate Health Services list.
Appendix D is a list of approved commonly used therapy abbreviations. A complete list may be obtained from the branch manager.

All documentation must be completed on an appropriate form, signed and dated. If the signature is not legible a printed name must be listed below the signature.

Throughout the documentation it should be clear at any point what is the condition of the patient, what we have done to improve or stabilize the patient medically or functionally, why we are continuing to service this patient, and with what skill, and finally what is our ongoing plan with this patient (discharge/ other treatments). If any piece of this is not clear we compromise our payment.

Summary of Service Form

1. Completed daily by each staff member. It is a daily listing for every patient encounter including the patient name, patient number (very important), Time in/Time out, and type of visit done.

2. For patients that have just received an evaluation, note on that patient's line the planned frequency and duration. (see Appendix C example) The agency scheduler will enter this information on the master patient calendar. This information must also match the frequency and duration on the eval form.

3. It is faxed daily by the therapist to the branch office for schedule / visit confirmation, entry in to Allscripts calendar of eval date and frequency and duration, and notation of discipline D/C in Allscripts.

Appendix B Therapy Documentation Standards

OASIS/Comprehensive Assessment for SOC & Agency Discharge

All staff should have passed/demonstrated OASIS-C competency prior to seeing any patient for SOC or discharge. If you have questions about this please contact the Rehab Services Manager.

1. All documentation must be completed by the clinician assessing or treating the patient. The company office staff can not complete a SOC or discharge OASIS based on staff notes.

2. CMS guidelines in Chapter 3 should be used in completing OASIS documentation, including WOCN wound guidelines.

3. To meet the CMS requirements for fall risk assessment a TUG (separate form) and Missouri Alliance (found in Briggs form) must be completed at SOC.

4. To meet the CMS requirements for skin breakdown risk a Braden assessment (separate form) must be completed at SOC.

5. Comprehensive assessment is inclusive of PT skilled items. Remember to document skilled intervention on page 18. No additional PT Evaluation form is needed.

Evaluation Forms

1. Used for all initial, and follow up assessments (post hospital, recerts and discharges) or anytime a complete assessment of patient is needed. (Note: OT has a separate Discharge Eval Form)

2. A complete evaluation should include the following information:

A. Advocate standard assessment items for all disciplines
- Vital Signs
  - HR - every visit – with cardiac diagnosis would accept to see resting and following activity
  - BP – every visit – may need to take sitting & standing, and at rest and following activity
  - Respiratory Rate- every visit- note if on O2 and liter rate
  - Pain – every visit – 10 point Scale
    - What kind, Where exactly,
    - When, Amount, What decreases it, or makes it worse
      - "Patient reports pain sharp stabbing pain in Lateral aspect of R Knee 5/10 when ambulating. Pain decreases to 2/10 when sitting"

B. Measurable objective data to document progress and set goals
- Safety / Environmental
  - Number of stairs and reason why need to climb them
  - Risk for falls and why
  - Other safety concerns in environment (rugs, heat/cold)

Appendix B — Therapy Documentation Standards

Availability and appropriateness of caregivers
Cognitive – level of alertness and orientation status
Balance – not just Fair/ Poor (is it dynamic, static, with device – without)
Use objective measure Tinetti, Get up and go, Forward reach, Berg
# of loss of balance in performance of a task
"Patient required contact guard 6 times to prevent fall when ambulation with her walker 100ft.
Fall risk
Timed Get up and go (TUG) and Missouri Alliance must be used with all SOC
Note in Initial eval fall risk factors
Other appropriate discipline specific assessments may be used as well
Endurance-
Perceived exertion (Borg scale)
RR or HR
rests in performance of task
Functional Activities- Ambulation, Transfers, ADLs
Assist –How much and for what
"Pt requires minimal manual assist for rising from chair due to weak quads"
"Pt requires CG assist for donning and doffing undergarments due to decreased sitting dynamic balance."

Gait analysis – deviations and unsafe behavior
Distance traveled using what device and how much assist
Stairs how many and how does patient handle them i.e. assist &device needed
Performance of skills needed to safely take care of self
BADL's & IADL's note limitations and why

Skin/Edema-
Circumference
Wound measurements
Advocate records uses a clock with 12/6 as vertical designation for length and perpendicular line for width. Tunneling is also recorded on clock. (2cm in length tunnel at 2 o'clock).

Tone / Sensation
Type of test (two point, sharp dull, propreoception, etc.)
Impact on safety, and performance of skills

ROM
Exact measurements if there is a goal to increase ROM (ie 0-45)

Strength
Exact measurements if there is a goal to increase strength (ie 3/5)

Appendix B Therapy Documentation Standards

Mental Status
Orientation, Memory, Judgment, Motivation, Cooperation

Equipment
Available, Condition, Needs

Other areas that might impact plan or attainment of goals
Previous functional status
Medication use
Functional deformities
Financial status

C. Documentation of skilled intervention should appear on all evaluations (i.e. what taught and patient's response,)

D. Documentation of discussion with the patient/caregiver of
Their therapy expectations
Appropriate goals and therapist's expectation of patient/caregiver participation in
goal achievement
Discharge plans

E. Problem list based on objective findings. (use "Rehabilitation Intervention and Goals" Form)
Include those that therapy will be addressing as well as those impacting care

F. Goals (use "Rehabilitation Intervention and Goals" Form)
Must link to the problems.
Should be attainable in time frame of POC, and should be linked to or improve function

G. Anticipated Frequency and duration
No ranges
Must be decreasing in nature (i.e. 3w1 2w1 1w2)
Must cover the period of planned treatment and appropriate to the goals/POC

H. Communication
With agency staff
With MD
With other caregivers/family

Appendix B Therapy Documentation Standards

Routine / Follow Up Visit Forms

1. Each visit must have a progress note using the correct paperwork.

2. The following items must be documented on each visit
    a. Vital signs (see Eval standard) must be taken and recorded
    b. Sufficient skilled intervention to justify continued therapy services.
        Teaching or training, patient response and level of understanding
        Skilled hands on techniques
            A list of exercises performed is not skilled; patient can do them on own - documentation must link to why therapist must be there.
    c. Progress toward goals should be recorded

3. Conferences with any team member should include topic and result.

4. Use Narrative form for any additional documentation that does not fit on the revisit form.

Discipline only Discharge

Prior to completing any paperwork confirm that this truly only a Discipline Discharge.

1. Therapy discharges documentation is a reassessment of the patient reflecting the improvement, stasis, or decline of the patient. All items from the initial eval that were assessed should be re assessed. (Please refer to evaluation section) it should also include:
    a. Condition at discharge
    b. Reason for Discharge
    c. Who the patient was discharged to/disposition
    d. Planned follow up

2. Using the “Rehabilitation Intervention and Goals” Form indicate status of the goals; met / partially met / not met. Document in note why goals were only partially met or not met and what is plan (i.e. to attain in outpatient; cognitively unable to be independent).

3. Documentation of appropriate discharge conferencing with patient and family and their response to discharge. Also include discharge conferencing with other care providers including MD and office staff.

4. On rare instances of an unplanned D/C and no visit was made to patient write “no visit” in the date section and complete the evaluation/documentation based on the patient status of the last visit. Document in the skilled intervention section the date of last visit. (Reminder check that therapy was not last visit made)

Appendix B Therapy Documentation Standards

Agency and Discipline Discharge

Prior to completing any paperwork confirm that the patient has no other service still providing care.

1. At this type of discharge the therapist is not only summarizing their care but the care of all providers in the agency. In order to do this the therapist should be aware of what services were provided by other disciplines including the nurse. They should make sure that they have a discipline discharge summary from the RN (via a fax) or have talked to the RN case manger regarding the status of nursing objectives.

2. The "Therapy D/C OASIS/Comprehensive assessment should be completed under the same parameters as the SOC Oasis.

a. Competent with completion of form
b. Following CMS, & WOCN guidelines
c. Only completed by the therapist that made the last visit.

3. In addition to the D/C Oasis the therapist must also complete the "Rehabilitation Intervention and Goals" Form, and note any conferencing as described above.

Appendix C Samples of Some Completed Documentation

SCAN IN HERE !!!!

Appendix D

Advocate Home Health Services
Approved Abbreviations and Symbols for Therapy Documentation

The following is a list of rehabilitation specific abbreviations. NO OTHER ABBREVIATIONS OTHER THAN APPROVED ABBREVIATIONS SHOULD BE USED IN DOCUMENTATION. For a complete list of abbreviations please contact your supervisor

R = right
L = left

UE = Upper Extremity
LE = Lower Extremity

N = Normal (used muscle testing)
G = Good (used muscle testing)
F = Fair (used muscle testing)
P = Poor (used muscle testing)
T = Trace (used muscle testing and tone)
WFL = Within Functional limits
WNL = Within Normal limits

MMT = manual muscle test
ROM = range of motion

HEP = Home Exercise Program
pt = patient

PT = Physical Therapy
OT = Occupational Therapy
ST or SLP = Speech therapy

ADL = Activities of Daily Living
IADL = Instrumental ADL (i.e. cooking, hobbies, housekeeping etc)
BADL = Basic ADL (i.e. Dressing, Bathing etc)

Min = Minimum
Mod = Moderate
Max = Maximum

SBA = Stand by Assist
CG = contact guard (not used for caregiver caregiver is cg)
I = Independent

WBAT = weight bearing as tolerated
TT = toe touch weight bearing
NWB = non weight bearing
PWB = partial weight bearing

Ex = exercise
rep = repetitions
flex = Flexion
ext = Extension
abd = abduction
add = adduction
IR = internal rotation
ER = external rotation

SLR = Straight leg raises
TKE = terminal knee extension
SAQ or SRQ = Short arch quads.

wks = weeks (as in 2x/3wks)

→← = to and from (in transfers sit →←stand)