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Home Health for Speech-Language Pathologists: Understanding Home Health Care

Megan L. Malone, MA, CCC-SLP
Jennifer Loehr, MA, CCC-SLP

Moderated by:
Amy Hansen, MA, CCC-SLP, Managing Editor, SpeechPathology.com

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Learning Outcomes

- As a result of this course, participants will be able to:
  - Summarize key aspects of the home care setting with adults, including history, inclusion criteria, caseload characteristics, payment, and assessment and treatment structure.
  - Provide 2 possible strategies to overcome identified obstacles to practicing in home health care.
  - Describe key elements to consider when counseling and educating the older adult patient and his/her caregiver(s).
Home Health Statistics

- Home Care is in the top five industries for Speech Language Pathology
- Home Care offers the fifth highest wage for SLP’s (behind Management of Companies, Physician’s offices, Skilled Nursing Facilities, and Continuing Care Retirement Communities)
- Home Care is in the top 5 of the highest concentration of SLP’s

(U.S. Department of Labor – Bureau of Labor and Statistics; 2017)

Home Health Statistics for SLP

- According to the 2017 SLP Healthcare Survey (Practice Issues), SLP’s working in home care reported:
  - Percentage of facilities with productivity requirement: 36%
  - Mean productivity level for home care: 73%
    - SNF 85%; Rehab Hospital 78%
  - Daily “off the clock” work hours: 47%

American Speech and Hearing Association (1); (2017)
Home Health Statistics for SLP

- According to the 2017 SLP Healthcare Survey (Caseload Characteristics):
  - “SLPs in home health care settings spent most of their clinical services time (at least 60%) with children, especially infants and toddlers.”
  - “SLPs in home health care settings spent most of their pediatric clinical services time treating children with language and literacy disorders (at least 23%), speech sound disorders (at least 19%), and autism spectrum disorder (at least 15%).”
  - Primary diagnosis treated by SLP’s working with adults:
    - Swallowing (35%)
    - Aphasia 16%
    - Dementia 11%

  - American Speech and Hearing Association (2); 2017

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Home Health Statistics for SLP

- According to the 2017 SLP Healthcare Survey (Hourly and Per Home Visit Wage Report):
  - SLPs in home health agencies and clients’ homes (50%) were more likely to receive a per home-visit wage than an annual salary or hourly wage.
  - Median wage reported $68.27 with highest per visit rates reported in the West (median $80/visit); Midwest ($66/visit); South($65/visit); Northeast ($64/visit)

  - American Speech and Hearing Association (3); 2017
History of Home Health

Timeline

- Historically medical care was delivered to the home
- 1790’s organizations were developed to deliver care
- 1900’s increased concern for public health and welfare
- 1950’s increased organization for care in the home with addition of social work and rehabilitation services
- Home health agencies were funded by charitable contributions until 1965 with the introduction of the Medicare Act

- Omnibus Reconciliation Act of 1980 liberalized restrictions on home health care
  - Hospital PPS system is introduced
  - Earlier discharges from hospital to home
  - Medicare reimbursement for home care increased 33% per year from 1989 to 1986
  - No post acute hospitalization required. No limits to the amount of care reimbursed.

- Balanced Budget Act of 1987 curtailed Medicare Home Health care
  - Set limits of Medicare spending
  - Restrictions set for homebound status
  - Set focus on post acute care and episodic care
  - Cut increased services that were available in the 1980’s and early 1990’s

A Brief History of Home Health Care

- Prospective Payment System (PPS)
  - Home health agencies would be paid a set amount for each 60 day episode regardless of the amount of care provided
  - Balanced Budget Act (BBA) required home health agencies to report outcome data on all Medicare and Medicaid patients using the Outcome and Assessment Information Set (OASIS)

- By 2001 1/3 of all home health agencies closed. Medicare spending for home health care was reduced 5% in 5 years.
Triple Aim

- A framework initially conceived by the Institute for Healthcare Improvement and now is universally accepted in healthcare policy and delivery
- The Triple Aim declares that to improve the U.S. health care system, it is vital to pursue three goals simultaneously:
  - Improving the patient experience (including quality and satisfaction)
  - Improving the health of populations
  - Reducing the per capita cost of health care

Recent Past and Current Model (for now…)

- Medicare pays for care in the home providing skilled nursing, physical therapy, occupational therapy, speech-language pathology, home health aide care, and visits by medical social worker.
- A physician must make the referral and oversee the plan of care
- Patients must be temporarily or permanently homebound
- Patients must require skilled need and have medical necessity
- With Medicare Part A benefits home health services are covered 100% without a co-pay
In order to be considered homebound and qualify for Home Health services, an individual must meet the following criteria:

**Criteria One (one standard must be met):**
- “Because of illness or injury, need the aid of supportive devices such as crutches, canes, wheelchairs and walkers; the use of special transportation; or the assistance of another person to leave their place of residence”
- OR
- “a condition such that leaving his or her is medically contraindicated”.

**Criteria Two (both standards must be met):**
- “There must exist a normal inability to leave home”.
- AND
- “Leaving home must require a considerable and taxing effort”.

A patient may leave the home and still be considered homebound, if the absences are infrequent, short, or are related to health care needs. These could include:

- Attending religious services
- Occasional absences for non-medical events (hair dresser, funeral, etc.)
- Ongoing medical services

Absences should not indicate that the patient has the capacity to obtain the health care provided outside rather than in the home.

Remember: “Leaving home must require a considerable and taxing effort” (if a patient is driving his/herself, must determine that it meets these criteria and that the patient cannot obtain health care other than in the home).
Recent Past and Current Model (for now…)

- OASIS drives the reimbursement with regard to functional scoring
  - 80 separate payment categories
- Traditional Fee for Service
- 60 day episodes (9 week certification period)
- Prospective payment system
  - Given partial payment up front
  - If patient is discharged early, the HHA may have to return payment

What is OASIS-C2?

- Outcome and Assessment Information Set (OASIS-C)
  - Data collection that is discipline neutral
  - Head to toe observation of patient including physical, social, mental, emotional, environmental and socioeconomic barriers.
  - Data is used to determine level of care
  - Level of care determines reimbursement
  - If there are nursing orders, RN must do a Start of Care OASIS (SOC)
  - If there are no nursing orders, PT or ST can do SOC
  - Under Medicare regulations, OT can not stand alone
  - Discharge OASIS can be completed by RN, PT, OT, SLP

(CMS, 2017)
Treatment in Home Health

- Follows 60 day Medicare certification period
- Following evaluation, SLP must determine number of visits needed in order for patient to meet goals.
  - Follows frequency and duration structure for number of visits; number of visits/week for how many weeks for up to 9 weeks (e.g. 2w4, 1w2 (2 visits per week for 4 weeks, 1 visit per week for 2 weeks=total visits 10)
  - If patient requires additional visits, may recertify patient for additional 60 day periods until goals are met or until patient is no longer homebound.

SLP Role in Home Care

- Case Manager
- Clinical Specialist
- Marketer to Referral Sources
- Educator
  - Families, Referral Sources, Clinical Team Members
- Collaborator
- Advocate
- Auditor of Documentation
- Coordinator of Care
- “Translator”
  - Communication Experts; Modify materials to increase patient/caregiver understanding;
Pros of Home Care

- Pros
  - Autonomy
  - Flexibility of Schedule
  - Functionality
  - Pay
  - Some ability to have say in type of patients you see/locations you will serve
  - Ability to do PRN

Cons of Home Care

- Cons
  - Schedule changes/working around other disciplines, patient schedule
  - Lack of predictability of day
  - Distance between patients
  - Driving in difficult weather conditions
  - Documentation demands
  - Lack of regular in-person interaction with other disciplines/colleagues
  - Safety of areas/homes
  - Lack of supervision (tough to do as first job in field)
  - Must be comfortable with possibly being patient’s only point of contact on a given day
  - Performance of health monitoring procedures (blood pressure, temperature, etc.)
  - Lack of materials
Survival Strategies

Survival Guide: Documentation

- Stay organized!!
- Document during sessions as much as possible
- Use ICF Model to focus on function and skilled need for SLP services
- Create “cheat sheets” to help you complete forms more quickly
- Take advantage of any “down time” between patients to document
- Use time in car to make care coordination calls (orders to doctor, discussions with other disciplines, office, etc.)
- Schedule your day to include documentation time (early in day or end of day so you feel you can stay on top of documentation demands)
Survival Guide: Schedule

- Plot your visits by location
  - Map out your week and allow adequate time for driving
- See swallowing patients at meal times (most functional as well as no overlap with other disciplines)
  - Breakfast is a great time to schedule sessions so you can free up rest of day for clients
- Be flexible and ready for daily schedule changes
  - Pt. illness, other discipline visits, new evaluations
- Schedule as soon as possible with patients and use in house calendar so that pt. and other disciplines are aware of your schedule.
  - are arriving
  - Use and update electronic calendar if your agency uses one
- Know that will get it all done!
  - Sometimes seems impossible but it does end up working out!
  - Keep patients updated on schedule (top patient complaint is reporting not knowing when services are arriving)

Survival Guide: Collaboration

- Talk to your colleagues!
  - Hard to see other disciplines in person on daily basis so use Case Communication forms and secure email to discuss case.
  - Document these discussions!!
- Get the most out of interdisciplinary meetings
  - Write down questions for other disciplines in advance of meetings so you can be as effective and efficient as possible when you have face time with other team members
- If you’re the only SLP at your agency, find a network of other SLPS in your area or through state organization or ASHA to reach out and connect with for questions and support.
Survival Guide: Self Advocacy/Referrals

- Continuous education to agency and colleagues regarding scope of practice
- Volunteer to present at interdisciplinary meetings regarding SLP methods and strategies for communication
- Get involved in marketing to physicians and facilities like assisted living to help generate referrals and show necessity for SLP services
  - Can sometimes be considered part of your productivity to act in this capacity
- Stay on the radar…in a good way!
  - Encourage patients and families to complete agency satisfaction surveys and be clear about the impact home health has had on patient and the progress patient has demonstrated from your services and involvement

Survival Guide: Other Tips

- Be mindful of your own safety
  - Know the areas you are going; plan visits for time of day
  - Avoid bringing unnecessary attention to yourself (keep jewelry, electronics to a minimum)
  - Plan visits that can allow you to interface with other team members
  - Don’t share personal cell phone number; use agency number for all correspondence
  - Share schedule with agency (use electronic schedule so agency knows where you are and when)
  - Make sure your vehicle is in good shape and always has enough gas

- Minimize materials you take into home
  - Will make sessions more functional to use what patient already has in home
  - Advocate for agency to purchase necessary tests or materials you need to keep personal expenses down (can write off on taxes personal money spent)
Promoting Generalization

Counseling is Crucial!

- Timely and effective counseling increases the likelihood of optimal outcomes for all involved.
- Should occur throughout patient care.

What counseling in SLP *ISN’T*:

- The following are outside our scope of practice. We are not omniscient or all-powerful. Therefore we *cannot*:
  - always make definitive statements about what caused certain problems
  - predict the future (we might make some reasonable guesses)
  - assume the role of other professionals (e.g., doctors, vocational counselors, social workers)
  - be family or marriage counselors

*When in doubt... DEFER or COLLABORATE*
Encouraging Generalization

- Generalization includes skills/strategies addressed in treatment to maintain progress & counseling information to encourage retention of information shared.
- Document strategies and recommendations while in home in easy to understand language and in print that is visible to patient and family.
- Accounts for:
  - Memory issues
  - Health literacy
    - Degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.
    - Short Assessment of Health Literacy—Spanish and English (SAHL-S&E)
    - Rapid Estimate of Adult Literacy in Medicine—Short Form (REALM-SF); Available in Spanish
    - Both can be completed in about 5 minutes

Encouraging Generalization

- Modify materials to account for patient/family's health literacy skills.
- The more informed the patient and family, the better the decisions and outcomes.
- Can influence ability to maintain progress demonstrated from treatment and care & possibly reduce rehospitalization rates or need for patient's to require multiple certification periods or recurring need for home care.

- If they can't remember it, understand it or see it...THEY CAN'T USE IT!!
Can you go

We are here

Where is it

One and only

Not now

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Thank You!

meganmalone1025@gmail.com
jennyloehr65@gmail.com

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Menorah Park Center, for Senior Living, 2007
References

Home Health for Speech-Language Pathologists: Introduction to OASIS

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Learn Outcomes

1. Participants will be able to define the OASIS and its purpose.

2. Participants will be able to state and define three of the OASIS conventions.

3. Participants will be able to describe how and why speech-language pathologists are qualified to assess patients using the OASIS.
What is OASIS C-2?

- Outcome and Assessment Information Set
- Data collection that is discipline neutral
- Head to toe observation of patient including physical, social, mental, emotional, environmental and socioeconomic barriers.
- Data is collected through direct patient observation and discussion with patient caregivers
- Data is used to determine level of care
- Level of care determines reimbursement

What is OASIS C-2 (Continued)

- There is no time limit to the assessment (can be a lengthy process!)
- The information has to be collected and sent to CMS within 5 days
- There are multiple OASIS assessments that can be completed:
  - Start of Care
  - Resumption of Care
  - Recertification
  - Discharge
What is OASIS C-2? (Continued)

- If there are nursing orders, the RN must do a start of care OASIS (SOC)
- If there are no orders, PT or SLP can do SOC
- Under Medicare guidelines, OT cannot stand alone (therefore cannot complete a SOC)
- Subsequent OASIS (Recertification or Discharge) can be complete by all disciplines.

Why should the SLP complete the OASIS?

- Changes in the home health industry
- Conditions of Participation for Home Health
- Value based reimbursement vs. fee for service
- Star ratings (Home Health Compare)
- All clinicians should work at the top of their license
- SLP’S know how to use observation skills
- If the SLP is unwilling to do everything they are allowed, these privileges may disappear!
ASHA says…

Whether providing professional level services or basic patient-care skills, certified SLPs are ethically bound to "...provide all services competently." (ASHA Code of Ethics, Principle I, Rule A). SLPs must be adequately trained so that they can demonstrate competence in performing the activity.

(American Speech Language Hearing Association; 2008)

ASHA Scope of Practice

“Cross-training of basic patient care skills (routine, frequently provided, easily trainable, low-risk procedures such as suctioning patients, monitoring vital signs, and transferring and positioning patient) professional nonclinical skills, and/or administrative skills is a reasonable option that clinical practitioners may need to consider depending on the service delivery setting, geographic location, patient/client population and clinical workforce resources.”

(American Speech-Language and Hearing Association Scope of Practice; 2007)
Contents of the OASIS-C2

OASIS-C2 Contents

- Clinical Record Items: SOC date, discipline, payor sources, etc.
- Demographics and Patient History: Recent hospitalizations, diagnosis, risk status, medical history
- Living Arrangements: Determining prior and current need for assistance/level of care
- Sensory Status: Vision, hearing, communication
- Pain Assessment: Previous and current levels of pain with and without activity.
OASIS C-2 Contents (Continued)

- Integumentary Status: Condition of the skin (wounds, lesions, ulcers, etc.)
- Respiratory Status: Shortness of breath, O2 use
- Cardiac Status: Symptoms of heart failure or risks
- Genitourinary Status: Incontinence, UTI, catheter
- Gastrointestinal Status: Bowel incontinence, ostomy

OASIS C-2 Contents (Continued)

- Neuro/Emotional/Behavioral Status: Cognitive functioning, confusion, anxiety, depression, etc.
- ADL's: Prior and current level of functioning for grooming, dressing, bathing, toileting, ambulation, meal prep. etc.
- IADL’s: prior and current level of higher level functioning like medication management
- Medications: Medication review, reconciliation, management of medications
- Care Management: If patient is in need of assistance how much care is provided? Is the caregiver willing and able? How much teaching will be needed?
- Therapy Need/Plan of Care: What other services will be needed to care for the patient? RN, PT, OT, SLP, Home Health Aide, MSW
OASIS C-2 Contents (Continued)

- Additional areas of data collection:
  - Nutritional screening
  - DME/Supplies
  - Physical environment
  - Physician orders for frequency/duration of services
  - Significant findings

Rules to Follow (per CMS)
Twelve Basic Rules (Conventions)

- Know the time period for the question
- “Usual status” means 50% of the time or greater
- Understand the meaning between UK and NA
- No referencing prior assessments
- One clinician
- Understand what tasks are included and excluded
- Medical restriction infer ability
- Safety infers ability
- Understand what “assistance” means (verbal cues? Hands on?)
- Know the difference between “for example” and “specifically”
- Follow item by item guidance
- Stay current with any changes to the OASIS or the Conditions of Participation

Tips for Success
Tips for Success

- Describe speech-language pathology as a discipline and include pertinent areas regarding scope of practice to patient when setting up the visit before you arrive
- Utilize an electronic BP cuff and temporal-scanner thermometer if your agency allow
- Be observant! Look for discrepancies in patient reporting
- Find opportunities to assess skills in functional context
  - Reviewing medications with patient involvement
  - Assess patient’s cognition through conversation and recall during your visit

Tips for Success

- Bring blank paper and pen to write down recommendations, results of the assessment that will need to be documented later
- For ADL items, have the patient show you their bathroom, kitchen, etc. This allows you to assess ambulation, transfers, and safety
- If you observe something in your assessment that you are unsure about, work with your agency to bring in another discipline (i.e. wounds, questionable ambulation or transfers)
Tips for Success

- If time doesn’t allow for you to fully assess a certain domain, return again to complete (you have 5 days!)
- Understand your value and how you can assist in treatment of areas beyond traditional speech-language pathology
  - Medication management
  - Fall prevention
  - Patient safety
  - Patient/caregiver education

Tips for Success

- Use your resources!
  - Collaborate with others! (OASIS in tandem)
  - Clinical OASIS Specialist certification (COS-C)
Thank You!

jennyloehr65@gmail.com
meganmalone1025@gmail.com

References


American Speech Language and Hearing Association-Ethics
http://www.asha.org/policy/ET2008-00285.htm

American Speech Language and Hearing Association-Scope of Practice
https://www.asha.org/policy/SP2007-00283.htm
Home Health for Speech-Language Pathologists: Assessment, Treatment & Documentation

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Amy Natho, MS, CCC-SLP, CEU Administrator, SpeechPathology.com

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Learning Outcomes

- As a result of this course, participants will be able to:
  - Describe 2 recommended considerations to care planning in home health care.
  - Provide 3 assessment ideas for home health care.
  - Define the ICF model for documentation and its 6 components
Care Planning: Patient Eligibility

- To be eligible for Medicare home health services, a patient must have Medicare Part A and/or Part B AND:
  - 1. Be confined to the home
  - 2. Need skilled services
  - 3. Be under the care of a physician
  - 4. Receive services under a plan of care established and reviewed by a physician
    - 5. Have had a face-to-face encounter with a physician or allowed non-physician practitioner (NPP). Care must be furnished by or under arrangements made by a Medicare-participating Home Health Agency (HHA).

CMS (2015)
Care Planning: Certification Periods

- Patients deemed eligible for home health care are certified for services via a home health agency for a 60 day period (9 weeks).
- The certifying physician must certify that the patient needs skilled service, is home bound, that there is a plan of care established which the physician will periodically review & that services will be provided while under the care of the physician.
- A patient must have a face to face visit with the certifying physician within 90 days prior to the home care start of care date or within 30 days of the start of care.
- Patients can be seen for the entirety of the certification period or for a portion of it depending on the patient need, attainment of goals, etc.

CMS (2015)

Care Planning: Recertification

- A patient may be recertified to continue to receive care at the end of 60 day period.
  - If patient has not met goals during certification period, still meets eligibility criteria and still has good potential for improvement, recertification is recommended.
- There is no limit at this time to the number of continuous episodes a patient can be seen.
- Recertification requires completion of a comprehensive patient assessment, a recertification OASIS that includes limited data elements, a new plan of care, and a physician certifying how much longer the skilled services are required.

Home Care Institute (2015)
Care Planning: Frequency and Duration

- Each discipline seeing a patient must project the amount and frequency of visits needed during a certification period in order for the patient to meet his/her goals (i.e. visit pattern).
  - Example: Patient being seen by skilled nursing, PT, and SLP would have 3 separate frequencies and durations determined by each of those disciplines.
  - Frequency and duration is typically written to represent number of visits per week for how many weeks the patient will be seen by a discipline.
    - Example: 1w2, 2w4, 1w3 would represent a frequency and duration of 1 visit a week for 2 weeks, 2 visits a week for 4 weeks, and 1 visit a week for 3 weeks.
- Determining frequency and duration is dependent upon a number of factors:
  - Severity level of the patient’s impairment(s)
  - Patient’s risk for rehospitalization related to the areas of treatment focus (how safe is the patient related to treatment area?)
  - Number of disciplines involved and amount of visits ordered by those disciplines.
  - Patient and family schedule (patient scheduled for several medical visits outside of home, e.g. dialysis).
  - Level of caregiver burnout.

Coordination of Care and communication amongst disciplines is pivotal at when determining visit pattern (frequency and duration of skilled service) when the patient is first certified for care, when care is resumed due to an inpatient stay (hospital, skilled nursing, etc.) of greater than 24 hours or when the patient is recertified in order to provide the best and most needed care to the patient while not overwhelming the patient or family.
Care Planning: Visit Patterns

- Strategies for Determining Visit Patterns (Frequency and Duration):
  - Divide and Conquer
    - Stagger introduction of disciplines
      - Evaluating discipline should evaluate at Start of Care the patient’s level of severity, examine disciplines ordered by physician and make recommendations to physician if all disciplines ordered are required to see patient at beginning of certification period or if staggering disciplines would be more beneficial.
      - Evaluating discipline may identify need for other disciplines to be involved in plan of care but should discuss when orders for additional disciplines should be sought and/or request start dates from physician for those evaluations to be further into certification period.
      - Each discipline can complete evaluation visit and determine level of severity and discuss which disciplines are priorities to begin services.
      - If patient is overwhelmed at time of Start of Care with number of visits, physician can be notified and orders to reschedule evaluations to a later date or to initiate other disciplines later in the certification period can be requested.
    - Discuss with team number of visits projected and if that number is feasible for the patient factoring in patient schedule, patient fatigue, and level of caregiver support or burnout.

Care Planning: Frequency & Duration

- Visit patterns can follow any combination of frequency and duration that makes the most sense for the patient and for the disorder being treated.
- No set visit pattern to follow for a particular disorder
- Determine visit pattern based on level of intervention needed, along with other factors like number of other disciplines involved, patient fatigue, etc.
- Consider frontloading visits if speech is primary concern for patient
- Begin with more frequent visits if appropriate (2-3 visits a week) and then taper to less visits (1 visit per week) to increase generalization of skills.
Care Planning: Scheduling Visits

- Requires regular communication amongst disciplines for which days a common patient is being seen and at what time.
- Use in home calendar to communicate next visit
- Use electronic scheduler as part of EMR to schedule and/or view when other disciplines are scheduled. Note when several sessions are scheduled in one day and work with team to determine which visits should be prioritized or ones that could be moved. Be sure to account for patient and caregiver fatigue.
- Scheduling speech sessions during meals can be ideal! Can address swallowing goals or work on cognition and/or speech goals as well.

Assessment & Treatment in Home Health
Assessment Considerations

- Assessment areas should most strongly relate to reason for referral but additional areas of need may become apparent during evaluation which should be further assessed and considered for treatment.
- Assessment is ongoing and should occur each visit to determine patient progress as well as to identify new issues.
- Get the most bang for your buck! The SLP has a lot to look at during a short period of time, especially if also completing OASIS
  - The SLP completing OASIS data collection (Start of Care, Recertification, etc.) still has to complete a separate evaluation focused on speech-related areas
  - Responses during testing, evaluation tasks or during OASIS data collection that focus on another area can be used as data for impressions for other areas (e.g. verbal responses to cognitive testing questions can be used to assess motor speech, intelligibility, fluency, etc.
- Balance use of formal measures with use of informal and functional tasks to gain the clearest picture of the patient’s level of functioning.
- Possible standardized measures to use in home health assessment:
  - St. Louis Mental Status Examination (SLUMS) (Tariq & Morley, 2006)
  - The Cognitive Linguistic Quick Test (CLQT) (Helm-Estabrooks, 2001)
  - Allen Cognitive Levels (Allen, 1991)
  - Ross Information Processing Assessment: Geriatric (2) (RIPA-G) (Ross-Swain & Fogle, 2012)
  - Repeatable Battery for the Assessment of Neuropsychological Status (RBANS) (Randolph, 1998)
  - Spaced Retrieval Screen (Brush & Camp, 1998)
  - Vision or Reading Screening (Rapid Estimate of Adult Literacy in Medicine (REALM) (Arozullah, 2007)
  - Boston Naming Test (Kaplan, Goodglass & Weintraub, 2001)
  - 3-oz Water Swallow Test (DePippo, Holas, & Reding, 1992)
  - Consensus Auditory-Perceptual Evaluation of Voice (CAPE-V) (ASHA, 2009)
  - Voice Handicap Index (Jacobson, et al., 1997)
  - Oral Mechanism Exam
  - Cranial Nerve Examination
Assessment Considerations

- Non-standardized assessment measures:
  - Sustained reading or speaking (2-4 minutes) to evaluate fatigue, respiration, stress, intelligibility, prosody, pitch, etc.
  - Reading comprehension tasks
  - Sentence level tasks to evaluate areas listed above and ability to recall and repeat given information (working memory)
  - Vowel prolongation
  - Percentage correct on structured tasks (i.e., naming items in categories, recalling lists of given words, etc.)
  - Alternating and Sequential Motion Rates or diadochokinetec rates (examining jaw, lip, and tongue movement and articulation)
  - Response to visual cues and supports to determine response to compensatory strategies
  - Patient and caregiver goals!!! (what do they want to address in treatment??)

- Preparation of evaluation materials is important (copies of tests, having a stopwatch or phone to use as a timer, etc.) but also important to use items within the person's environment to assess skills to be as functional and meaningful as possible.
  - Use medication bottles or medication list to assess reading ability, comprehension
  - Use newspaper, mail, magazines in the home to find interesting content to read, discuss, assess recall, etc.
  - Assess barriers to success in the environment and work with patient and family toward reasonable solutions (distance between chair and table, amount of clutter on dining table where patient eats, ability to read cues from patient's vantage point,
  - Evaluate typical meal set up to allow patient greatest amount of independence to feed self, take recommended bite or sip size, check patient or caregiver's ability to properly thicken liquids, etc.
  - Use items around the house to work on confrontation naming, description, categorization, etc.
Treatment Considerations

- Use American Speech, Language and Hearing Association's (ASHA) Practice Portals for considerations for assessment and treatment options for a variety of disorders.
  - https://www.asha.org/Practice-Portal/Speech-Language-Pathologists/
- Keep treatment as functional as possible
  - Spaced Retrieval Technique to target recall of important information
  - Reminiscence Therapy
  - Use of visual/graphic cues and memory books
  - Validation therapy
  - Montessori-based programming
  - Practice of targeted skills at meals or at facility activities
  - Creation of grocery lists, sequencing and recall of use of technology (phone, television, computer, medical alert system, correct use of adaptive equipment)

Assessment Considerations

- Tools of the Trade:
  - Index cards (lined or unlined)
  - Permanent and dry erase markers
  - Highlighter marker
  - Adhesive notes
  - Blank notepaper
  - Scissors and tape
  - Dry erase board
  - Additional lighting
  - Prepared handouts on different disorders, recommendations, cues, etc.
  - Colored tape
  - Velcro or magnets
  - Clear picture frames
  - Clear packing tape, laminating pouches or plastic storage bags
  - Stopwatch
  - Smart phone or iPad to access websites for education or for use of timer or recording application
Documentation in Home Health

What are we asked to do?

- Per CMS, home health agencies and their care providers must show evidence of the following:
  - Homebound status
  - Medical necessity
  - Skilled service is provided AND is reasonable and necessary
  - Care coordination is demonstrated frequently
  - Preventing potentially avoidable events (i.e. ER visits, re-hospitalization)
    - Medication management
    - Reducing fall risk
    - Preventing skin break down
    - Mitigating decline due to depression
What is the ICF?

- International Classification of Functioning, Disability and Health
- Created by the World Health Organization (W.H.O)
  - WHO is the directing and coordinating authority on health for the world
  - Part of the United Nations
  - Developed the ICF in 1980 with revision and renaming in 2001
  - Has recently been adopted by professional organizations in the U.S.

WHO (2001)

What is the ICF?

- A holistic approach to care planning
- Focuses on patient centered care
- Helps illustrate “value” to the plan of care
- Helps to easily identify the medical necessity and skilled care within the documentation
- Justifies the amount and type of services provided
- Compliments the ICD-10 system of coding

 Allows us to get a **BIG PICTURE** of the patient and plan of care!
Documenting in the “olden days”

Mr. Black:
- 80 year old man
- L CVA on 10/1/17
- Aphasia and Dysphagia
- Admitted to acute care 10/1/17
- Discharged to HH on 10/7/17

Mr. White:
- 80 year old man
- L CVA on 10/1/17
- Aphasia and Dysphagia
- Admitted to acute care 10/1/17
- Discharged to HH on 10/7/17

They are NOT the same!

Mr. Black
- Lives on a dirt road in a very rural area
- No running water or electricity in the house
- Lives by himself
- Very motivated to participate in speech therapy
- Hoards bunny rabbits in his house
They are NOT the same!

Mr. White
• Retired physician
• Lives with his wife and children live nearby
• Resides in an independent living community
• Very stubborn. Doesn’t want to have anything to do with speech therapy!

6 Components of the ICF

- Health Condition
- Body Function and Structure Impairment
- Activity or Functional Impairment
- Participation Restriction
- Environmental Factors
- Personal Factors
Health Condition

- Overlying health conditions and co-morbidities that will impact the plan of care
  - Examples:
    - Dementia
    - HTN
    - CVA
      - Aphasia
      - Dysphagia
      - Hemiparesis

Body Function and Structural Impairment

- As a result of the overall health condition, what part of the body or body system is affected?
  - Nervous System (brain)
  - Cardiovascular System (heart)
  - Musculoskeletal System (muscles of the oral cavity, throat, limbs)
  - Digestive system (reduced oral intake)
  - Integumentary System (healing of the skin due to poor oral intake)
  - Genitourinary System (increased bladder infections due to dehydration)
Activity or Functional Impairment

- As a result of the body function/structural impairment, what is the activity or functional impairment?
  - Cognition
  - Communication
  - Swallowing

Participation Restriction

- As a result of the activity or functional impairment, what are the LIFE ACTIVITIES that the patient is restricted from participating?
  - Self management of medications
  - Home management
  - Using the telephone
  - Continuing active involvement with his church
  - Eating or drinking meals with family/friends
Environmental Restrictions

- Consider what environmental factors may be a barrier (or help facilitate) goal attainment. (physical or attitudinal barriers)
  - Patient lives in an independent living facility that will not provide altered diets
  - Patient’s apartment is 300 feet from the dining room (no benches)
  - Patient does not believe he has trouble swallowing and does not follow recommendations for compensatory strategies
  - Patient’s wife is afraid to upset her husband
  - Patient is exhibiting signs and symptoms of depression
  - Patient has numerous close and supportive family

Personal factors

- Consider what other factors that should be considered when building a plan of care.
  - Education level
  - Religious beliefs
  - Race
  - Gender
  - Age
  - Fitness level
  - Coping style
  - Social preferences
  - Upbringing
Once again…What is the connection to Home Health?

- Per CMS, home health agencies and their care providers must show evidence of the following:
  - Homebound status
  - Medical necessity
  - Skilled service is provided AND is reasonable and necessary
  - Care coordination is demonstrated frequently
  - Preventing potentially avoidable events (i.e. ER visits, re-hospitalization)
    - Medication management
    - Reducing fall risk
    - Preventing skin breakdown
    - Mitigating decline due to depression

If the ICF model is used in developing a plan of care…all of the above will be addressed!

Documenting in the ICF language:
(sample template)

- Health Condition (Reason for referral, recent history of illness or hospitalizations)
- PLOF: (more specific is better, i.e. pt. was able to obtain meds from pharmacy, drive on a daily basis, accurately take meds, dress self, prepare all meals, do laundry. Specify equipment and assistance needed.)
- Body structure/ body function impairments: (What body systems are involved and how does this impact function? Primary and secondary diagnoses, co-morbidities. Be specific and include objective measures.)
  - Neurological
  - Neuromuscular
  - Musculoskeletal
  - Cardiovascular
  - Digestive
  - Genitourinary
  - Respiratory
- Activity limitations and participation restrictions: (What activities specific to this person’s lifestyle are they unable to perform? Be specific and include objective measures.)
- Environmental factors: (What is the physical, social, and attitudinal environment surrounding the person? Include both positive and negative factors.)
- Rehab potential
- Patient/ caregiver goals:
  - Immediate focus of care: Goals of care for next 1-2 weeks.
  - Long term focus of care: Goals for part or all of cert period (specify timeframe).
- Plan: (Frequency/ duration, specific interventions/ modalities/ techniques. Patient/ caregiver education with teach-back, spaced retrieval, use of assistive technology as with automated med box, etc.)
Case Study

- Pt. is an 81-year old male discharged to home from hospital due to "mini stroke" ten days prior. Other diagnoses include HTN, Psoriasis, Osteoarthritis, Diabetes. No significant prior surgeries.
- Pt. is a retired mechanic who lives in two story home with wife and 2 dogs. Prior to stroke, pt. was driving (wife stopped driving several years ago). Prior to stroke, Pt. was setting up medications in pill organizer and taking them regularly without assistance (5 medications taken once per day in morning; 1 medication taken at bedtime) and was independently checking blood glucose level.
- Occasional assistance from daughter who is a nurse in meal preparation and grocery shopping, especially since stroke. Daughter is also currently setting up medication organizer and monitoring dosage as well as making reminder calls to pt. prior to bedtime to take nighttime med (Lipitor).
- Pt. reports unsteady gate and dizziness and short term memory deficits and word finding difficulties since stroke. Pt. would like to return to driving and managing his own health as well as to "feel less forgetful and not search for words when I talk".

Medical Necessity & Homebound Status

- Pt. Medical Necessity: Pt. requires skilled interventions due to deficits related to recent events including: hospitalization and related functional decline, increased dependence on caregiver for ADLs and mobility, recent complaints of dizziness, unsteadiness and/or pain. Pt had a CVA approx. 2 weeks ago, was admitted to hospital for 2 days and d/c home. Had follow up with Dr. X who recommended home health PT, OT, and ST. Pt is at increased fall risk especially with eyes closed and with turning, mild impulsivity is noted, mild word finding difficulties, and a decline in short term memory. Per the daughter, pt. is experiencing increased frequency of urinary incontinence since CVA. For these reasons, the mentioned therapies are necessary to assist this pt. to recovery as quickly and feasibly as possible.
- Homebound Status: Pt. has a condition that restricts his/her ability to leave their place of residence except with the aid of supportive devices, such as a cane, the assistance of another person. Due to decreased cognition/safety decision making and being a high fall risk, it is presently challenging for this pt. to leave the home. Since the CVA, the pt. is not to drive and the spouse stopped driving several years ago.
Case Study

- Health Condition (Reason for referral, recent history of illness or hospitalizations)
  - Speech Therapy Documentation (“Reason for Referral”)
  - “Recent mild CVA resulting in mild expressive language and memory deficits”
  - Referred to ST due to persisting deficits from mild CVA two weeks prior. Pt. admitted to hospital for two days and discharged home with orders for speech therapy services via home health to address short term memory deficits, word finding difficulties and mild impulsivity affecting communication with family and completion of daily tasks which pt. was independently completing prior to CVA.

Case Study

- Prior Level Of Functioning: more specific is better (i.e., pt was able to obtain meds from pharmacy, drive on a daily basis, accurately take meds, dress self, prepare all meals, do laundry. Specify equipment and assistance needed.)
  - Speech Therapy Documentation (“Prior Level of Functioning”)
  - “Pt. lived at home with wife and was independent and able to drive self.”

  - Pt. lived at home with wife and two dogs in two story home with intermittent assistance from daughter for grocery shopping and meal preparation. Prior to recent CVA, pt. was driving on a daily basis and was able to manage medications and monitor blood glucose level to manage diabetes. Pt. able to dress self and perform ADLs without reported difficulty. Pt. reports tolerance of regular diet prior to stroke with no swallowing difficulties reported. No prior use of equipment for ambulation or to complete ADLs. Pt. report of prior functioning confirmed by daughter.
Case Study

- Body structure/body function impairments: (What body systems are involved and how does this impact function? Primary and secondary diagnoses, co-morbidities. Be specific and include objective measures.)

  - Neurological: Speech Therapy Documentation “Areas addressed in ST eval”:
    - Cognition: St. Louis University Mental Status Exam (SLUMS) 18/30 with deficits noted in memory, following directions, and verbal fluency. Able to correctly answer incorrect responses following completion of test with min phonemic and semantic cueing. Passed Spaced Retrieval screen."
    - Language: “Non-standardized measures for expressive language: Word finding deficits noted (confrontational naming 70%; category naming: 60%; naming by description: 68%; during 5-minute conversation: 6 instances of word finding difficulty noted)”

  - Known etiology of deficits identified: “Deficits related to recent CVA; possible premorbid cognitive decline suspected”

  - Identified Impairments: Performance Areas to be Addressed
    - Memory Moderate 50-79%
    - Expressive Language Moderate 50-79%

Case Study (continued)

- Body Structure/Function (continued) (ICF)
  - Assessed cognitive deficits via standardized and non-standardized measures due to persisting deficits from recent CVA. Reported deficits in memory affecting pt's ability to recall steps to complete daily tasks (taking of meds; testing of blood glucose), recall events of day/recent past (family report frequent episodes of repetitive question asking & subsequent anxiety and frustration).
    - St. Louis Examination University Mental Status Exam (SLUMS) 18/30 with deficits noted in memory (recall of 5 objects @ 5 minute delay 2/5; recall of short story details 2/4), following directions (2 step (complex) 50%), and verbal fluency (12 items in category in 1 minute). Able to correctly answer incorrect responses following completion of test with min phonemic and semantic cueing. Passed Spaced Retrieval screen (measure assessing recall of new information over progressively longer time intervals).

  - Language: Assessed cognitive deficits via non-standardized measures due to persisting deficits from recent CVA. Reported deficits in language affecting pt's ability to participate in conversation with family and fluently express thoughts. Word finding deficits noted (confrontational naming 70%; category naming: 60%; naming by description: 68%; verbal fluency during SLUMS testing 12 items/1 min); during 5-minute conversation: 6 instances of word finding difficulty noted

  - Known etiology of deficits identified: Deficits related to recent CVA; possible premorbid cognitive decline suspected

  - Identified Impairments: Performance Areas to be Addressed
    - Memory Moderate 50-79%
    - Expressive Language Moderate 50-79%
Case Study

- Activity limitations and participation restrictions: (What activities specific to this person's lifestyle are they unable to perform? Be specific and include objective measures.)
  - Medical Necessity/Activity and Participation Restrictions:
    - "Pt. experienced recent mild CVA that have impacted functional communication skills and memory. Pt. and family motivated to participate in intervention. Treatment will focus on improving expressive language skills and cognitive retraining."
    - Due to recent CVA, deficits noted in memory skills that are currently impacting ability to perform daily tasks, such as preparing and taking medications per prescribed schedule and monitoring of blood glucose level and recall of daily events (repetitive question asking reported by family occurring regularly resulting in pt. and caregiver frustration). Pt unable to fully participate in conversation with family and fluently express thoughts resulting in pt. feeling socially isolated.

Case Study

- Environmental factors: (What is the physical, social, and attitudinal environment surrounding the person? Include both positive and negative factors.)
  - Positive prognostic factors:
    - Understanding of condition
    - Motivation to participate
    - Support of family friends
    - Availability of family/friends to provide assistance
    - High prior level of functioning
  - Barriers: None
Case Study

- Rehab potential:
  - Rehab Potential
  - *Good for improved cognitive function and expression, given pt.'s motivation, prior status and assistance of family.*

- Patient/ caregiver goals:
  - Patient Centered Goal
  - *Pt. will demonstrate improved overall memory and language skills to improve functional communication.*
  - *Pt. wishes to return to prior level of functioning by demonstrating improved memory skills to complete ADLs and manage medications, reduced impulsivity to return to driving and improved language expression to communicate with family.*

Case Study

- Immediate focus of care: Goals of care for next 1-2 weeks.
  - Education:
    - *Pt will accurately and safely demonstrate the home exercise program without caregiver assistance via return demonstration.*
  - Expressive Communication/Language:
    - STGs: (at end of 2 weeks of treatment)
      - *Pt. will express thoughts/ideas within a functional context with his primary communication partner with min cues at the sentence/conversation level.*
      - *Pt. will recall daily events with 80% accuracy on 3 consecutive sessions with compensatory strategies.*
  - Long term focus of care: Goals for part or all of cert period (specify timeframe).
    - *Pt will prepare, initiate, and arrange time and space to complete a complex task or activity (filing pill box) in the home with min assistance for 3 consecutive sessions.*
    - *Pt will use compensatory strategies to recall information for ADLs 2 out of 3 consecutive trials for 3 consecutive sessions.*
Case Study

- Plan: (Frequency/ duration, specific interventions/ modalities/ techniques. Patient/ caregiver education with teach-back, spaced retrieval, use of assistive technology as with automated med box, etc.)
  - Frequency/Duration
  - 2w3, 1w2
  - 2w3, 1w2; focus on use of compensatory strategies for memory including visual cueing and use of spaced retrieval method, structured tasks to improve word finding deficits & executive functioning strategies and repetition to improve task completion. Individualized cognitive communication home exercise program will be developed to promote progress and generalization of skills with caregiver education to assist patient.

Case Study

- Daily Treatment Note
- Describe Today’s Interventions/Response to Treatment (Discuss Procedural interventions, HEP, cues, required changes in performance, safety, fatigue, carryover with education provided, etc.)
  - Pt. and wife report continued improvement in memory and communication skills. Some confusion noted in orientation in day/date and recall of upcoming appointments. Discussed use of calendar, spaced retrieval technique, and continued practice of attention tasks to increase focus for recall. Pt. in agreement with recommendations. New cognitive and communication exercises assigned for HEP due to completion of previously assigned exercises. Pt. responsive to reduced cueing during word finding tasks. Pt. able to organize kitchen table to correctly organize medications in pill box for next 3 days with mod assist. Pt. and wife report improved communication between them since initiation of treatment and wife reports reduction in repetitive question asking behaviors.
- Ongoing skilled need/New problems identified/Plan for next visit:
  - Continue current plan: Pt. demonstrating reduced orientation so will initiate regular practice with calendar in order to assist with recall of upcoming appointments. Next visit will focus on reduced support for medication organization & increase of organization to 5 days in pill organizer.
ICF Resource

- ICF Webinars and Functional Goal Writing for Different Disorders
- https://www.asha.org/slp/icf/

Thank You!
jennyloehr65@gmail.com
meganmalone1025@gmail.com
References:

- World Health Organization; International Classification of Functioning, Disability and Health (ICF); Retrieved February 2, 2017 from https://www.who.int/classifications/icf/icf_more/en/
Need assistance or technical support?

- Call 800-242-5183
- Email customerservice@SpeechPathology.com
- Use the Q&A pod
How to earn CEUs

- Must be logged in for full time requirement
- Log in to your account and go to Pending Courses
- Must pass 10-question multiple-choice exam with a score of 80% or higher
  - Within 7 days for live webinar; within 30 days of registration for recorded/text/podcast formats
- Two opportunities to pass the exam

Home Health for Speech-Language Pathologists: Key Considerations and Requirements for the Home Health SLP

Jennifer Loehr M.A. CCC
COS-C
Encompass Health - Home Health and Hospice

Megan Malone M.A. CCC
Kent State University; Kindred at Home
Disclosures

Jennifer Loehr, M.A. CCC-SLP, employed by Encompass Health-Home Health and Hospice

Disclosures:
Financial — Author of Here’s How to Treat Dementia (2013); Plural Publishing
Nonfinancial — No relevant nonfinancial relationship exists.

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Learning Outcomes

Participants will be able to define the origin and purpose of the Conditions of Participation (COP).

Participants will be able to identify the SLPs role in Medication Management for the home health patient.

Participants will be able to identify three major parameters for implementing Maintenance Therapy for home health patients.
No More Silos!

The home health care industry is rapidly changing...forcing us to step outside of our silos!

Home Health Facts

• Home Care is in the top five industries for Speech-Language Pathology

• Home Care offers the fifth highest wage for SLP’s (behind Management of Companies, Physician’s offices, Skilled Nursing Facilities, and Continuing Care Retirement Communities)

(U.S. Department of Labor; Bureau of Labor and Statistics; 2017)
Home Health Facts

- Home health agencies were funded by charitable contributions until 1965 with the introduction of the Medicare Act.
- Omnibus Reconciliation Act of 1980 liberalized restrictions on home health care.
  - Hospital PPS system is introduced.
  - Earlier discharges from hospital to home.
  - Medicare reimbursement for home care increased 33% per year from 1989 to 1986.
  - No post acute hospitalization required. No limits to the amount of care reimbursed.
  - Set limits of Medicare spending.
  - Restrictions set for homebound status.
  - Set focus on post acute care and episodic care.
- Triple Aim framework initially conceived by the Institute for Healthcare Improvement and now is universally accepted in healthcare policy and delivery.
  - The Triple Aim declares that to improve the U.S. health care system, it is vital to pursue three goals simultaneously:
    - Improving the patient experience (including quality and satisfaction).
    - Improving the health of populations.
    - Reducing the per capita cost of health care.

12,400 home health agencies in the U.S. (CDC; 2014)

80% of home health agencies are for-profit providers.

All are Medicare certified (this is not a requirement if the HHA does not want to receive Medicare funding).

- In order to accept reimbursement from Medicare:
  - HHA’s must adhere to the Conditions of Participation.
Conditions of Participation

- Ensures that HHA's are all reading the same playbook
- Objective is to keep patient safe, aging in place and out of the hospital
  - Comprehensive Assessment
  - Care planning and adjustments
  - Communication/education with patients/caregivers
  - Team collaboration
  - Agency policies and processes
COP Subsections

- General Provisions: Definitions of the HHA's participation
  - Basis and Scope of a HHA's participation in Medicare programing with an emphasis on patient welfare and safety
  - Patient Care: Specific requirements to mitigate patient decline, optimize patient potential and avoid hospitalization
  - Patient rights
  - Transfers and Discharges
  - Care Planning
  - Infection Control
  - Coordination of Care
  - Compliance with Physician Orders
  - Skilled Services and Aide Supervision
  - Quality Improvement Program
  - Electronic Medical Records
- Organizational Environment: How the business operates
  - Licensing
  - Emergency preparedness
  - Governing body
  - Clinical documentation

COP’s and the SLP’s

- Comprehensive assessment: May be completed by SLP if necessary (SLP’s can perform the initial OASIS)
- Transfer and discharge: Patient must be informed of transfer or discharge in advance
- Compliance with physician orders: Must be evidence that communication occurred with the physician or qualified professional
- Care planning: Evidence that a care plan was established and adhered to during the course of care. Updates to the plan of care and evidence of communication with patient, caregiver, physician and team should be present in the medical record
- Communication and collaboration: Home health care is no longer autonomous! SLP’s must demonstrate frequent communication with other care providers
- Aide supervision: Multiple additions to the current COP outline home health aide programming and plan of care including regulations regarding supervision. Depending on state licensing for SLP’s, the SLP may be called upon to supervise a home health aide.
- Infection control: HHA must maintain an infection control program which includes monitoring of infections, education of patients/family/staff and take action to improve quality of infection control through a mandatory quality improvement program
- Emergency preparedness: All HHAs must have a process in place for patient specific emergency preparedness
- Patient/Caregiver/Family education: All education/training provided must be documented including the content of the training as well as the patient/caregiver/family members RESPONSE to training.
Medication Management

- Medication errors/adverse reactions account for 700,000 Emergency Room visits and 100,000 hospital admission for the elderly. (U.S. Department of Health and Human Services; 2018)
- Medicare defines medication reconciliation and instruction as part of the Conditions of Participation
- Home health care providers have to reconcile medications (prescription and over the counter drugs) during the initial visit
- Home health care providers need to include in their assessment the patient's ability to follow their drug regimen, identify possible barriers that promote risk for an adverse event, and include follow up in the patients plan of care
  - Confusion (patient unable to take medications as directed)
  - Physical inability (unable to open containers; unable to access a glass of water to take medications)
  - Environmental barrier (unable to reach medications; unable to get to the pharmacy)
  - Financial barrier (unable to afford medications)
  - Attitudinal barrier (patient chooses not to take medications; caregiver is unwilling to assist)
SLP’s Role in Medication Management

- SLP’s can help identify barriers to effective self medication management through assessment and clinical observation
- SLP’s can develop patient specific compensatory strategies for safe, effective medication management
- SLP’s can provide training and education on medications as part of the medication management program

Examples of SLP/Medication Management

- Cognitive Barriers:
  - Develop a simple calendar/schedule for patient to follow
  - Assist patient in finding the optimal medication planner
  - Assist with alternate labeling that is easier for patient to understand
  - Engage family/caregiver to provide daily telephone call/reminder for patient
  - Teach patient to identify specific medications and/or side effects
  - Train patient how to order refills via phone or computer
  - Assist patient in obtaining automatic pill dispenser

Don’t exclude patients who have cognitive dysfunction from medication management interventions. The COPs do not discriminate between diagnoses. Not ALL patients on a Med Management program need to be independent with taking medications!
Examples of SLP Medication Management

- Physical Inability
  - Improve swallow functions or promote compensatory strategies for safe intake of medications
  - Assist patient in learning how to use electronic blood pressure cuff
  - Assist patient in obtaining easy to open pill containers
  - Use of AAC equipment or strategies to refill prescriptions

Examples of SLP/Medication Management

- Environment challenges:
  - Safe storage and access to medications
  - Collaborate with OT and PT to promote safe mobility in taking medications
  - Assist patient in learning how to access transportation to the pharmacy or, how to get medications delivered
Additional Tips

- Per ASHA’s scope of practice, the speech-language pathologist should feel COMPETENT in the service being provided. If you don’t feel competent, reach out to your HHA for additional education and resources.
- Ensure that your state licensing board to ensure that it is within the scope of your state to instruct on medications
- COLLABORATE with the experts! Nurses, physicians and local pharmacists are great resources
- Thorough and detailed Documentation is NON-NEGOTIABLE! Per the COPs, we must not only document what we educated on, but we must also include the patient/caregiver/family RESPONSE. This will ensure reimbursement and serve to protect YOU.

Home Health Maintenance Therapy
History of Maintenance Therapy

- Historically, home health services are rehabilitative in nature with patients discharging from services when reaching a goal plateau.
- For patients with chronic conditions there is often a cycle of admission and discharge which creates risks for serious adverse events during the period of decline which can leading to injury and re-hospitalization.
- 2013 Jimmo v. Sebelius
- Medicare contractors can no longer apply the “improvement standard” when reviewing claims
- This case did not serve to expand coverage, but rather, served to clarify existing policy so that Medicare claims will be adjudicated consistently and appropriately. (CMS; 2017)

Regulatory Parameters

- Guidelines for provision of home health services by CMS
  - Patient is homebound
  - Patient must have medical necessity
  - Services are skilled in nature
  - Services are reasonable and necessary with regard to frequency and duration
    - There is no limit to the amount of home health care for beneficiaries as long as the above parameters are met.
Regulatory Guidelines for Maintenance Therapy

- Therapy provided must be offered by a qualified and licensed speech language pathologist (or other discipline as indicated).
- Maintenance Therapy cannot be provided by assistants
- The Speech-language pathologist must continue to follow all of the other guidelines stated by CMS:
  - Follow the Conditions of Participation
  - Complete and update the patient plan of care (including goals)
  - 30 day re-assessments (using standardized, validated, assessment tools)
  - accurate documentation of services provided.

(CMS; 2017)

Is Maintenance Therapy Right for the Patient?

- Special medical complications are identified and documented that clearly explains why there is a need for skilled speech-language pathology services
- The level of complexity of the needed procedures requires the skills of a qualified therapist to perform them
- The services provided will ensure patient safety (reduce risk for illness, injury, or an adverse event such as hospitalization or death)
Implementation

- Appropriate patients: Typically chronic or terminal neurological conditions including Parkinson’s disease, Alzheimer’s disease, ALS
- Appropriate treatment diagnosis: Relating to dysphagia, voice, speech expression
- Apply the following to your plan of care:
  - P- Prepare: Utilize the care team to coordinate and prepare goals and objectives
  - R-Rationale: Document safety concerns and complexity of services needed
  - O-Objectivity: Always use objective data and measures
  - V-Validate: Reassess often to reaffirm rationale and modify plan as needed
  - E-Educate: Provide teaching and training to patient, caregiver and family (Talbot; 2015)

Documentation

- Good documentation is the means for ensuring appropriate reimbursement for services provided
- Poor documentation can trigger audits by Medicare leading to possible denials, risking premature discharge of patients in need of services.
- Key elements:
  - Evidence that the services were skilled in nature
  - Evidence that the patient has medical necessity and ongoing needs of the patient
  - Evidence that training/education occurs with the patient/caregiver
  - Evidence that the patient is homebound
  - Goals established that will prevent or slow further deterioration
Maintenance Therapy Examples

- Patient with Parkinson’s disease who requires weekly SLP visits to maintain volume levels of voice (using compensatory strategies) so he will be able to express his basic wants and needs.
- Skilled Intervention: SLP will use clinical observation and assessment skills each visit to determine the efficacy of the interventions and make adaptations as necessary due to fluctuating status
- Goals:
  - Patient will maintain DB levels at 50 using compensatory strategies
  - Patient will demonstrate knowledge of self cuing strategies by demonstration during each treatment session
  - Patient will be able to use voice strategies to communicate via telephone to communicate wants and needs to facility caregivers

- Patient with dysphagia (due to Parkinson’s) who requires weekly SLP visits to provide e-stimulation and monitor/update exercise program as patient’s endurance fluctuates. Patient wants to remain on a regular diet so that he can remain in his assisted living apartment
- Skilled Intervention: SLP will perform e-stim to patient twice weekly to maintain swallow functioning. SLP will provide ongoing teaching and training of compensatory strategies and techniques including signs and symptoms of aspiration to patient and visiting family members. SLP will provide ongoing assessment and observation of patient each visit to determine level of functioning, decline in swallow functions and make adaptations as necessary.
- Goals:
  - Patient will demonstrate safe swallowing of liquids, solids and medications using compensatory strategies tolerating a regular diet and thin liquids.
  - Patient will demonstrate adherence to swallow strategies and diet modifications per caregiver report
  - Patient will demonstrate knowledge of swallow precautions and strategies via teach back each visit
Update: Medicare Proposed Changes to Home Health Payment

Thank You!
Jennifer Loehr
jennyloehr65@gmail.com
Megan Malone
meganmalone1025@gmail.com
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