Home Health basics

How does the speech language pathologist fit in??

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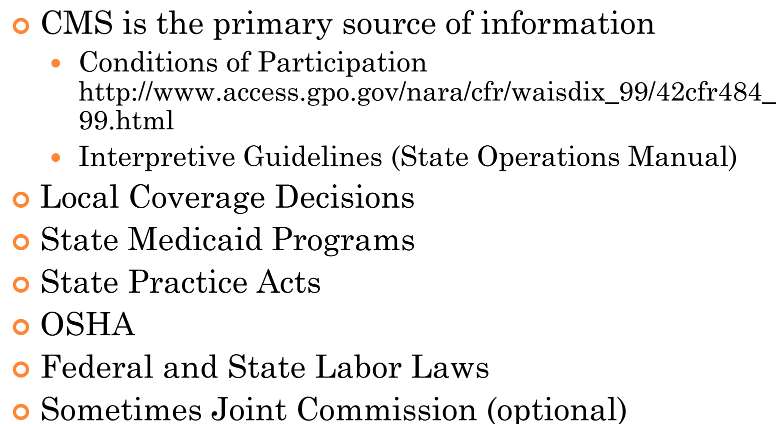
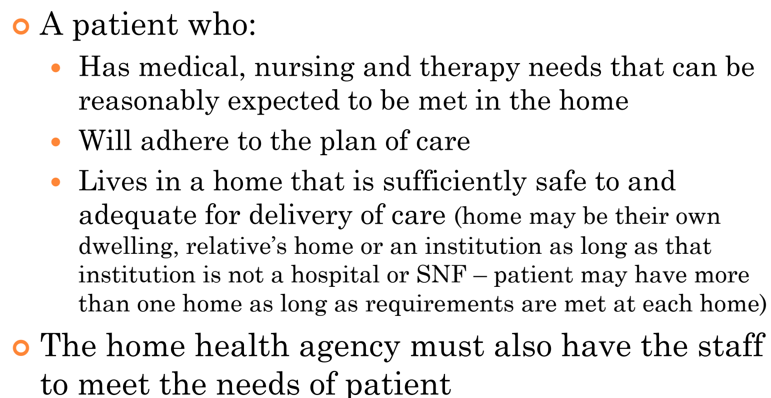
Home Health – What is it?

- Med A benefit
- Method of delivering intermittent skilled care
- Skilled Nursing Care
- Skilled PT and/or ST
- Once one of the above initiates the Home Health plan of care, OT, social services and home health aide can provide ongoing care.

- What does it take to allow patient to stay in their home and receive skilled services they need to avoid re-hospitalization?


HOME HEALTH – WHO REGULATES?
CMS is the primary source of information
Conditions of Participation http://www.access.gpo.gov/nara/cfr/waisdix_99/42cfr484_99.html
Interpretive Guidelines (State Operations Manual)
Local Coverage Decisions
State Medicaid Programs
State Practice Acts
OSHA
Federal and State Labor Laws
Sometimes Joint Commission (optional)


WHO QUALIFIES FOR HOME CARE?
A patient who:
Has medical, nursing and therapy needs that can be reasonably expected to be met in the home
Will adhere to the plan of care
Lives in a home that is sufficiently safe to and adequate for delivery of care (home may be their own dwelling, relative's home or an institution as long as that institution is not a hospital or SNF – patient may have more than one home as long as requirements are met at each home)
The home health agency must also have the staff to meet the needs of patient

A BENEFICIARY MUST MEET ALL

- Be confined to the home – homebound
- Under the care of a physician
- Receiving services under a plan of care established and periodically reviewed by the physician
- Be in need of skilled nursing, PT or ST on an intermittent basis, or have need for ongoing occupational therapy.

HOMEBOUND – WHAT IS IT?

- Criteria One – one or other must apply
  - Because of illness or injury, need the aid of supportive devices, the use of special transportation or the assistance of another person to leave their place of residence
  - Have a condition such that leaving the home is medically contraindicated.
- Criteria Two – both criteria must apply
  - Normal inability to leave the home
  - Going out cause a clear and taxing effort

  - CMS gives the following as examples of acceptable absences from home – beauty/barber shop, scenic drive/walk, church/religious services, family funeral/reunion/graduation – but must be clear and taxing effort and infrequent

Home Health episode – more details

- Each Home Health episode is 60 days and starts with a comprehensive assessment and POC written for a 60 day period.
  - Comprehensive Assessment includes details of current health status, establishes POC, and includes drug regime review
- Can recertify for additional 60 day episode as long as requirements for home continue to be met – there is no limit to the number of consecutive episodes.

OASIS

- Completed at key points
- Includes a clinical assessment and outcome measures determined through interview and observation
- At admission, can be completed by RN, PT or ST. All other time points, can be completed by OT as well.
- Must be updated and revised as often as patient's condition warrants but not less frequently than:
  - the last 5 days of every 60 day episode to recertify
  - within 48 hours of return from hospital stay
  - at discharge

How is the Home Health Agency paid?

- Comprehensive POC and OASIS generate a HHRG score
- Defines rate to be paid for all costs associated with care during 60 day episode, including all therapy costs
- Agency gets 60% once submitted and remaining 40% is paid upon discharge or end of episode if billed services match what was planned. (note: if you provide less, HHA will gets prorated amount which is less)
- Amount paid hits a "ceiling" at 20 combined therapy visits

Therapy portion of comprehensive POC

- Must include meaningful goals which pertain to the patient's illness or injury and resultant impairments
- Must include expected frequency and duration of services
- Must assess function with objective measures
- Should be completed within 48 hours of the agency SOC date so that information can be reflected in the admission OASIS.
- Verbal orders

Once plan of care is established…what's next??

- Visits are provided per plan at frequency and duration specified
- Functional Reassessment every 30 calendar days (determined by each discipline evaluation or recertification)
- Missed Visits
- Discharge Visits

Reminder: number of visits planned and provided is important for reimbursement and must be balanced with clinical needs of patient

Essentials of documentation

- Industry standards and our professional standards require quality documentation
  - Must convey medical necessity and skilled level of care provided
  - Reason for referral, medical necessity, skilled services, PLOF vs CLOF, underlying impairment measures are required, which is consistent with other settings
- Requirement for every visit:
  - Homebound status
  - Objective measures
  - Medication review
  - Assessment of vital signs
  - Assessment of pain
  - Plans for next visit

EXAMPLES – GOOD OR BAD??

- Reason for Referral: Patient X was recently hospitalized for 3rd pneumonia in 6 months with noted coughing and choking when swallowing. When discharged from SNF 6 weeks ago, patient was on altered diet and thickened liquids but has resumed regular diet on his own. High risk for aspiration and recurrent pneumonia.

- Reason for referral: Patient Y has memory deficits due to dementia.

EXAMPLES – GOOD OR BAD??

- Underlying Impairment Measures:
  - LTM intact, STM poor, Attention Span impaired
  - Immediate Memory for hip precautions 75%, delayed recall of hip precautions using spaced retrieval up to 2 minutes 60%. Family member able to provide verbal sequencing and cues during ADLs without compromising hip precautions.

Examples – Good or Bad??

- Skilled Services
  - Trail-making for executive functioning, Cues to use compensatory strategies for Swallowing, Memory Log
  - Utilized spaced retrieval and hierarchy of cueing to facilitate delayed recall of daughter's new work schedule and daily routine to improve safety in the home. Introduced use of clock alarm to trigger timing of blood glucose monitoring midday to avoid drops in blood sugar to reduce risk for falls.

Examples – Good or bad?

- Homebound: patient is homebound because he is no longer able to drive.
- Homebound: patient is homebound because she requires assistance of another to locate her destination and recall the purpose of her outing due to spatial orientation impairments and short term memory deficits.

Examples – Good or bad?

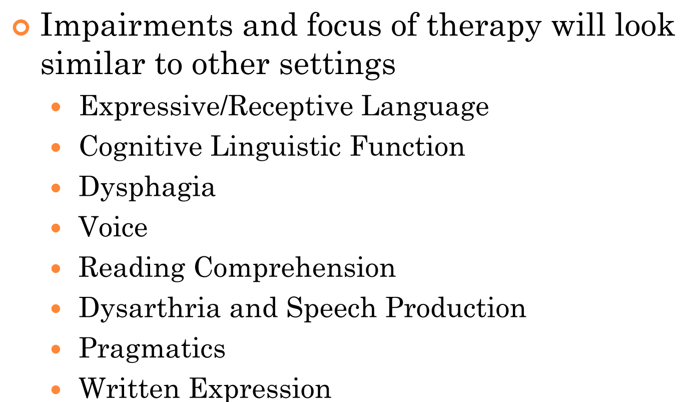
- Plan: Will review natural thickening agents and supply options for other commercial thickening agents due to aversion to current product. Will review options for menu items for upcoming church banquet to comply with diet restrictions.
- Plan: Continue plan of care
- Plan: Will add external alarm for timing glucose monitoring to augment written reminders. Will consult with nurse case manager regarding memory strategies and diabetic management needs. Additional approaches will be added as indicated.

Documentation Essentials

- Eval and POC
- Functional Reassessments
- Resumption of Care (ROC)
- Recertification
- Discharges

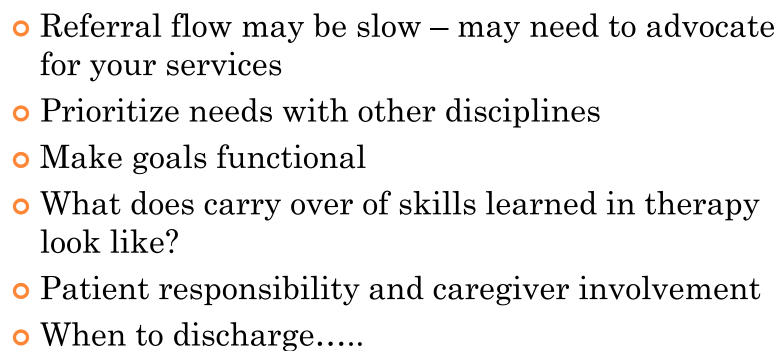
- What are these Medicare Forms – ABN, HHCCN and NOMNC??

Role of the speech language pathologist



- Impairments and focus of therapy will look similar to other settings
  - Expressive/Receptive Language
  - Cognitive Linguistic Function
  - Dysphagia
  - Voice
  - Reading Comprehension
  - Dysarthria and Speech Production
  - Pragmatics
  - Written Expression

ROLE OF SPEECH LANGUAGE PATHOLOGIST



- Referral flow may be slow – may need to advocate for your services
- Prioritize needs with other disciplines
- Make goals functional
- What does carry over of skills learned in therapy look like?
- Patient responsibility and caregiver involvement
- When to discharge…..

LET'S PRACTICE GOAL WRITING….

- Examples:
  - Dysphagia
  - Memory
  - Problem Solving
  - Voice or Speech Production
  - Spatial Orientation
  - Medication Management
  - Money Management

THERAPY MATERIALS

- Use what is in the patient's home
- Reasons by workbooks are not practical
  - Infection control considerations
  - Not as functional for home environment – not something patient would use in their home outside of therapy

How creative are you?

- Please get into small groups of 3-5
- Select one object from the bag of "Common Household Items"
- Brainstorm 3-5 creative ideas you have for use in therapy
- We will ask several groups to share their ideas

Now some of my ideas.....

APPS AND OTHER TECHNOLOGY RESOURCES....(2 OF MY FAVORITES)

- http://www.geekslp.com/
- http://www.spectronics.com.au/article/iphoneipad-Apps-for-aac

QUESTIONS???

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