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School of Occupational Therapy

Administration and Leadership Development within Skilled Nursing Facilities

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A Capstone Project Entitled

Administration and Leadership Development within Skilled Nursing Facilities

Submitted to the School of Occupational Therapy at University of Indianapolis in partial fulfillment for the requirements of the Doctor of Occupational Therapy degree.

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Abstract

The purpose of this doctoral capstone experience was to develop administration and leadership skills in regards to occupational therapy practices in the skilled nursing facility environment through literature review, mentorship, interdisciplinary collaboration and practical application. Through evaluation, concerns with skilled therapy documentation and group therapy utilization in the skilled nursing facility environment were revealed. Weaknesses in skilled therapy documentation were found to affect patient length of stay, reimbursement, and quality services provided. In response, a documentation manual, was created in order to increase proficiency and efficiency, as well as to promote veracity. Effectiveness will be measured via quarterly documentation review audits. A group therapy educational program was created and presented to increase competency and promote ethical client centered therapy practice. Outcomes of this program will be analyzed for efficacy and to identify areas of continuous program improvement. Group therapy percentage tracking will be used to screen for changes in utilization. Learning occurred via development and execution of educational programs and resources deemed necessary through program evaluation. Effective and professional communication was demonstrated and improved upon throughout this capstone experience. Advanced reasoning was employed to analyze, synthesize, and evaluate concerns related to occupational performance, participation, reimbursement and appropriate therapeutic service provision.

Keywords: Occupational therapy, skilled nursing facility, documentation, group therapy

Administration and Leadership Development within Skilled Nursing Facilities

Doctoral Capstone Experience

Background

Skilled Nursing Facilities

Skilled nursing facilities provide short term 24-hour skilled care to qualifying recipients, which primarily consist of older adults (Sollitto, 2017). Skilled services provided in this environment typically include nursing, social services, dietary, occupational therapy, physical therapy and speech therapy (Your Medicare Coverage, n.d.). Diagnoses frequently addressed in skilled nursing facilities consist of joint replacement, septicemia, pneumonia, congestive heart failure exacerbation, urinary tract infections, and acute renal failure (About Occupational Therapy, n.d.; Sollitto, 2017).

Occupational therapy. Occupational therapy is a key skilled service that is proven to increase functional independence with the common diagnoses treated in the skilled nursing facility environment (Jette, Warren & Wirtalla, 2005). Occupational therapists address factors necessary to complete activities that the clients may need, have and/or want to participate in (About Occupational Therapy, n.d.). Within the skilled nursing facility environment, occupations commonly addressed by occupational therapists include activities of daily living (ADLs), instrumental activities of daily living (IADL), rest and sleep, education, work, play, leisure, and social participation (American Occupational Therapy Association, 2014). Client factors, performance skills, performance patterns, context and environment are taken into consideration to address the activities above (AOTA, 2014). Occupational therapists collaborate with other key disciplines of skilled services providers such as nursing, speech and physical therapy in an effort to reach optimal patient outcomes (Sollitto, 2017). Increased spending on occupational therapy

has proven to reduce 30-day patient hospital readmissions, potentially due to occupational therapy's unique client centered focus with regards to functional and social needs (Rogers, Bai, Lavin & Anderson, 2017).

Reimbursement. There are several sources of reimbursement for skilled services provided to patients within the skilled nursing facility environment, such as occupational therapy. Medicare is the largest and most commonly billed reimbursement source for rehabilitative stays in a skilled nursing facilities. Currently, Medicare Part A covers a stay in a skilled nursing facility following a qualifying hospitalization and a referral for skilled rehabilitation (Your Medicare Coverage, n.d.). Other common payer sources include Medicaid, Medicare Part B, private insurance, and Medicare replacement plans. Each reimbursement source varies in the way that they disperse payment (levels, per diem reimbursement rate, resource utilization group based), qualifying days of therapy, admittance regulations, and skilled services documentation requirements. These sources can also determine the minutes, units, and/or current procedural terminology (CPT) codes that they deem reimbursable, which in turn affects therapeutic service provision.

Changes in reimbursement. There are several new reimbursement programs that have already been put in place for cost saving and increased continuity of care initiatives. These programs include Bundled Payments for Care Improvement (BPCI), Accountable Care Organizations (ACO), Next Generation Accountable Care Organizations (NGACO), Health Maintenance Organizations (HMO), and managed care (Innovation Models, 2017). These programs have affected reimbursement for skilled nursing facility stays as well as changed service provision. Among several commonalities between these programs, decreasing patient length of stay seems to be at the forefront of their initiatives.

Future changes in reimbursement. Drastic changes to Medicare reimbursement systems have been proposed to be implemented following October, 2018 at a currently undisclosed time (Centers for Medicare and Medicaid Services, 2018). Although the feasibility of the program has been brought into question, Resident Classification System, Version 1 (RCS-1) is the suggested program to be implemented. This program will shift skilled nursing facility reimbursement from a fee-for-service, resources utilization group based model, to value-based reimbursement model. In theory, this means that hospitals and skilled nursing facilities will be compensated based on the quality of the services provided instead of the merely the amount. The goal is for patients to receive better quality of care by rewarding effective interdisciplinary collaboration between hospitals and skilled nursing facilities. For therapists providing services to beneficiaries in skilled nursing facilities, it is proposed that patients will be clinically categorized, based on their primary diagnosis, into sections including major joint replacement or spinal surgery, other orthopedic, non-orthopedic surgery, medication management, and acute neurologic. The proposed program would reimburse skilled nursing facilities for 100% of the services provided for days 1-14 of the stay and then is reduced every 3 days by 1% (CMS, 2018). This program will potentially incentivize shorter length of stays, increased quality of services leading to better outcomes, and decreased hospital readmissions (Optima Health Solutions, 2018). RCS-1 will have major effects on therapeutic service provision in the hospital and skilled nursing facility setting (Optima Health Solutions, 2018).

Documentation. One factor that can affect reimbursement for skilled therapy in the skilled nursing facility setting, regardless of the payer source, is documentation of the skilled services provided. Clinical records are required to be maintained within professional standards and practices that are complete, accurately documented, readily accessible, and systematically

organized (Lewis, 2015). Occupational therapy practitioners have a duty to uphold veracity in their documentation practices by providing comprehensive, accurate, and objective patient information (AOTA, 2015). Required therapy documentation includes evaluations (plan of care), daily treatment notes addressing each CPT code billed, progress notes, updated plans of care and discharge summaries for each treatment episode (CMS, 2017). For proper reimbursement, therapist documentation must advocate that the unique skills of a therapist including but not limited to knowledge, clinical judgment, decision making skills, and expertise were absolutely required to conduct the therapeutic treatment (CMS, 2017). The necessity of the therapeutic services provided must be justified within the documentation as well (CMS, 2017).

Group Therapy. Group therapy is a therapeutic service provision method used to provide patient education and increase patient skills through group dynamics and social interaction (AOTA, 2014). The most used definition for group therapy is "the treatment of two or more patients simultaneously, who may or may not be performing the same/similar activity. One unit of group therapy per patient is appropriate if the therapist is dividing attention, providing only intermittent personal contact, or giving instructions to two or more patients" (RAI, 2017; LCD, 2015). This definition is used for Medicare Part B, accountable care organization, Medicaid, and managed care beneficiaries. Medicare Part A defines group therapy as, "the treatment of four patients who are performing the same or similar activities, and are supervised by a therapist or an assistant" (RAI, 2017). This definition maintains that the group must be planned in advance for exactly 4 patients and can only be 25% of patient's total therapy (RAI, 2017). Currently group and concurrent therapy are less than 1% of all modes of therapy reimbursed in skilled nursing facilities (Pickus, 2017). The evolving reimbursement systems, such as RCS-1, are projected to create an increase in group therapy provision within skilled

nursing facility therapy setting to offset the proposed compensation reduction for skilled services (Optima Health Solutions, 2018). Group therapy may also be a strategy used to increase productivity for therapists (Optima Health Solutions, 2018).

Theory

Theoretical paradigms and principles were used to guide this doctoral capstone experience, in an effort to ensure that core occupational therapy values were utilized to progress the profession, while meeting identified societal needs. The overall paradigm used for this doctoral capstone experience is the *American Occupational Therapy Association (AOTA) 2015 Code of Ethics,* which includes core values that direct the occupational therapy profession such as altruism, equality, freedom, justice, dignity, truth, and prudence (AOTA, 2015). Continuous quality improvement was also utilized as a leading principle for the actions completed throughout this doctoral capstone experience, as it aims to address practice with a focus on improving efficiency, patient care, or clinical outcomes (Basics of Quality improvement, 2014). The five pillars commonly addressed in quality improvement include establishing a culture of quality, identifying and prioritizing improvement, collect and analyze data, communicate results, and commit ongoing evaluations (Basics of Quality Improvement, 2014). While examining service provision through the code of ethics lens, societal needs were identified and prioritized for potential areas of improvement. The specific framework of continuous quality improvement was used to prioritize, develop and execute programs in an effort to perpetuate a culture of quality in this environment.

Purpose

The overall purpose of this doctoral capstone experience was to develop administration and leadership skills, with regards to occupational therapy in the skilled nursing facility

environment, through self-directed learning, review of evidence, supervised application, mentorship and interdisciplinary collaboration. Examination of reimbursement sources and their requirements will be completed to create a working knowledge base. Documentation will be assessed and guidelines will be developed to reach optimal reimbursement with increased time for quality patient care and to create continuity of care. Ethical client-centered group therapy practices will be examined with regards to provision of this service, optimal patient care and outcomes, value based reimbursement systems. Professional development within the context of the ever-changing insurance reimbursement systems in skilled nursing facilities will be completed.

Screening and Evaluation

Continuous Quality Improvement

Continuous quality improvement can provide direction in the enhancement of quality and safe patient care (Bonnel & Smith, 2018). The continuous quality improvement process can be used to sustain practical, ethical, appropriate, and evidence based interventions used in patient care (Lorch & Pollack, 2014). Skilled nursing facilities are regulated by several bodies that advocate for continuous service enhancement including Medicare, state agencies, accrediting bodies, accountable care organization partnerships, bundled payment systems, managed care programs, hospital partnerships, facility and company requirements. State operated skilled nursing facilities are surveyed by state and regional offices to determine if the facilities are eligible to participate in Medicare or Medicaid (Nursing homes, 2018). Measures are in place to assess performance such as the bundled payment systems that are responsible for patients 90 days postoperatively (Bonnel & Smith, 2018). Joint excellent certification through the joint commission assesses quality of care, continuous improvement outcomes, and good use of

resources (Bonnel & Smith, 2018). Five-star quality rating system which includes health inspections, staffing, and quality measures (Five-star quality rating system, 2018). CARF attempts to maintain quality standards for patients within the providers (CARF, 2018). OSHA strives to create safe working conditions for all workers by enforcing standards and providing training, outreach, education and assistance (Occupational Safety and Health Administration, n.d.).

Within the company that the doctoral capstone experience was completed, in-house continuous quality improvement strategies include interdisciplinary continuous quality review (CQR) meetings. These meetings are completed by the regional building managers, in an effort to ensure that quality standards and processes are being upheld as required by regulations in the best interest of the patients they serve. The meetings require administrators and a representative from each department including nursing, therapy, dietary, activities, the business office, admissions, and minimal data set (MDS) coordinators to attend at each individual facility. Patient care over the past quarter is examined extensively for areas of improvement. Patient data is compared to national, state, and similar facility data to screen for possible areas of concern as well. If there are concerns noted, collaborative action plans are developed to correct the issue. This is the step in the process that evidence based practices are incorporated into patient care to remediate issues and to continuously better patient care practices. A timeline to complete these changes as well as follow-up action plans to ensure changes have been made are developed and employed. All of these processes are used to monitor continuous quality improvement with regards to patient care or operations within skilled nursing facilities.

Needs Assessment

A needs assessment was performed in an effort to uncover further potential areas of continuous quality improvement. A SWOT analysis was then completed as a part of the needs assessment which focuses on the strengths, weaknesses, opportunities, and threats of the organization (Bonnel & Smith, 2018). Strengths of the internal organization included ethical practice, growing number of facility acquisitions, occupational therapist led company, several established skilled nursing facility therapy departments and usage of continuous quality improvement. Implementation of new programs before they are mandatory is a strength that allows therapists, facilities, and patients to adjust to the changes and address challenges earlier, as they arise. Established weaknesses included therapist resistance to providing group therapy, productivity demands, and documentation time. Identified opportunities from outside the organization included decreased readmission rates, length of stay, increased documentation skills, and increased group therapy for therapeutic benefit. With managed care and accountable care organization reimbursement programs on the rise, there is an opportunity to increase continuity of care from post-operation or hospital stay to discharge from skilled nursing facility for patients enrolled in these programs. A major threat included the proposed Medicare reformation, RCS-1, which presents opportunities to transforms service delivery models to continually strive for quality of care. Literature review and collaboration with knowledgeable mentors was completed to screen for areas of further potential continuous quality improvement needs specific to therapy within the skilled nursing facility.

Documentation guide. Site mentors identified skilled therapy documentation as a source of weakness for therapists, which can affect patient length of stay, reimbursement, and quality services provided. Backman, Kåwe, and Bjorklund (2008), showed that only 21% of occupational therapy documentation included in patient records is actually complete. Discussion

and observation with therapists revealed that they were feeling frustrated with documentation requirements taking up patient care time and were often unsure of how to adequately document skilled services to justify reimbursement. Review of current patient therapy documentation revealed several concerns, such as inability to discriminate between occupational and physical therapy documentation. Another concern identified in the documentation was that there was no mention of activities of daily living (ADL), occupational performance, or cognition in a troubling amount of patient documentation. It is good practice to analyze occupational performance, which includes client strengths and areas for improvement, and to document the results as a portion of the patient evaluation (AOTA, 2014). A lack of standardized and/or non-standardized tests to measure and demonstrate progress was identified in the documentation reviewed. According to AOTA (2014), standardized assessments are preferred, when appropriate and available, to provide objective data about factors that may affect engagement and performance in occupation. The culmination of these identified weaknesses determined the need for a skilled documentation guide and educational for therapists.

Group therapy. Group therapy was also identified as a factor that has affected therapy service provision in the skilled nursing facility setting. Group therapy has been projected to be the future of therapy in the skilled nursing facility environment and will also be used to increase and supplement productivity standards for therapists with changing reimbursement systems such as RCS-1 (Optima Health Solutions, 2018). Site mentors agreed with this statement, communicating that group therapy is becoming more prevalent as a mode of therapy and a way to increase profit. Therapy supervisors were emailed and asked to provide common questions, comments, and/or concerns they receive regarding the provision of group therapy. It was concluded that group therapy can be difficult to perform within the skilled nursing facility

environment through conversation and observation of therapists. Reasons such as, managing several patients at once and scheduling groups around several patient schedules were found to hinder the provision of group therapy. It was also identified that the definition of group therapy for certain payers and the confines of how group therapy can be performed and billed were widely misunderstood. Although frustrations regarding group therapy have been expressed, literature supports the use of group therapy for certain diagnoses often treated within the skilled nursing facility environment including hip or knee replacement, Parkinson's disease, cerebrovascular accident, knee osteoarthritis, post-cerebrovascular accident aphasia, back pain and urinary incontinence (Coulter, Weber, Scarvell, 2009; Gauthier, Dalziel, and Gauthier, 1987; Mehdizadehm, Mehraban, Zahediyannasab, 2017; Allen, et al., 2016, Layfield, Ballard, Robin 2013; Robertson & Harding, 2014). The push for increasing the provision of group therapy as a mode of therapy, and the frustrations conveyed by therapists and experts in the field, identified a need for the implementation of a group therapy educational program as well as helpful resources.

Practice Area

Skilled nursing facilities are a traditional and existing practice area for occupational therapists. Although it is a traditional area, practice is constantly evolving, creating the need for continuous needs assessments and quality practice improvements. An occupation based treatment approach is being promoted to increase quality of care, like many other existing and emerging areas of occupational therapy.

Value based reimbursement systems are affecting and will continue to affect occupational therapy services provided within the skilled nursing facility setting, but also other traditional areas of OT, such as acute care. Accountable care organizations are facilitated by the participating hospital, making it their responsibility to follow the patient and attempt to create

continuity of care (AOTA, 2012). D'Aunno, Broffman, Sparer, Kumar, and D'Aunno (2018) found that interdisciplinary and collaborative relationships between healthcare providers, including therapists, can distinguish high from low performing accountable care organizations. This puts more responsibility on doctors, nurses, therapists, and social workers to increase collaboration for patient care in the acute care setting as well as the skilled nursing facility setting. Resulting from the push to decreased length of stay from programs such as accountable care organizations, acute care occupational therapists will be asked to use their unique client centered holistic methods to increase patient independence faster, which is also the case in skilled nursing facilities (AOTA, 2012). Therapists in both settings are expected to be guided by altruism, equality, freedom, justice, dignity, truth, and prudence (AOTA, 2015). Although skilled nursing facilities and acute care occupational therapy differs in many ways, the common principles of practice such as the core values from *AOTA 2015 Code of Ethics* are the same.

Implementation

Administration and leadership skills were developed through research, planning, development and implementation of therapy staff education regarding group therapy and skilled documentation skills. Staff development regarding therapy documentation was implemented including plans of care, progress notes, daily notes, insurance updates and discharge summaries via dissemination of resource guides and virtual education. Group therapy education was disseminated via verbal presentation as well. These were implemented to increase effective quality service provision for identified societal needs. These educational programs and resources were executed in an effort to promote increased patient outcomes while simultaneously maximizing financial opportunity.

Documentation Manual

A comprehensive documentation manual, refer to Appendix A, was created to be utilized by occupational, physical, and speech therapy practitioners to increase proficiency and efficiency with patient documentation. This guide was developed in an effort to ensure veracity within therapy documentation practices. It can be referenced for guidance when documenting skilled therapy services within the skilled nursing facility environment and consequently increase the chances of proper reimbursement. Resources including Medicare guidelines, local determination coverage norms, insurance documentation guidelines, relevant literature, and the company documentation programs were used to modify the previous *Lifespan Documentation Guide* to meet the current needs of therapists.

These practices led to the first draft of the documentation guide that was then used to audit occupational, physical, and speech therapy documentation company-wide. This audit was completed to uncover further potential areas of improvement. Plans of care, daily notes, progress notes, and discharge summaries for patients throughout the company were included in this review process. Several repetitive discrepancies between the established guidelines and actual patient documentation were identified. An example of a variance was the inclusion of group therapy indicators. According to Accelerated Care Corporation (2015), a rationale for utilizing group therapy as a treatment modality must be indicated in the plan of care. This was not consistently identified in the plans of care for patients that participated in group therapy. Common discrepancies were investigated through staff and management collaboration, electronic medical record reporting via Casamba, and literature review. Information to remediate these inconsistencies was then included or clarified in the documentation guide.

Following these procedures, the guide was in its completed form and was reviewed for accuracy and flow by another occupational therapy doctoral capstone student with an abundant knowledge of the material. Final guidelines were presented to management and edited collaboratively for content. Once this was completed, a master documentation manual was produced. Resources referenced within the guidelines, such as *Wisconsin Physicians Service (WPS) Local Coverage Determination (LCD) Modalities in Depth,* were added as appendices to create a comprehensive documentation manual for therapists to utilize. Resources included in the manual included specific examples of how to document specific scenarios and current procedural terminology codes.

A documentation education session was provided to therapists via mandatory Skype meeting. Lead therapists were notified of the appointment, via company email, four days before the meeting. The session was scheduled for less than ten minutes. Attendance was taken at the beginning of the Skype session to ensure participation company-wide. The day before the educational session, the documentation manual was emailed to each therapy supervisor within the company to initiate implementation to staff. Due to the previous *Lifespan Documentation Guide* being widely known and accepted within the company, the presentation included mainly the highlights of the changes made to the documentation manual as well as the reasoning behind the change. This was to maintain the efficient use of therapist time throughout the day. Topics covered included precautions vs. contraindications, documentation of the *Evaluation of Potential Readmission Factors* outcome measure, inclusion of standardized tests, documentation of group therapy practices, consent to treat for Part B patients, documentation of modalities, skilled verbs for daily notes, red flag words, how to include function into documentation, and how to show functional progress or lack thereof with standardized tests. Examples of how to implement the

changes were also included in the education. Questions were taken and answered throughout the presentation to ensure understanding.

Following the education, supervisors were instructed to distribute the manual to therapists and to convey the importance of its implementation and compliance. The manual has been placed in the *Cyber Attack Plan Manual* located at each facility and also was placed in plain sight in the therapy office for therapists to reference. It was incorporated into the 'new hire' packet and mandatory orientation session in an attempt to increase documentation competency from the beginning of the orientation process. Further questions regarding the manual were directed to assigned regional managers.

Group Therapy Education

As another form of internal staff development to meet identified societal needs, group therapy education was created and presented to staff. This educational program was presented to staff including occupational, physical, and speech therapy practitioners to increase competency and promote ethical provision of this mode of therapy. The evidence-based staff education was developed after a thorough literature review as well as Medicare guidelines, local determination norms, and advice from therapists as well as management. Current prevalence, reimbursement, diagnoses, effectiveness, ethical considerations and outcomes were the focus of the literature review in preparation for this educational program. Health sciences databases were used to scour the evidence regarding group therapy information including; OT search tool, MEDline Plus with Full Text and CINAHL Plus with Full Text. MeSH (Medical subject headings) and CINAHL Plus with Full Text tutorials were utilized to maximize identification of evidence. This information was synthesized and used to create the educational PowerPoint presentation, refer to Appendix B.

Staff education was implemented via mandatory Skype sessions with all the lead therapists within the company. Lead therapists were notified of the appointment, via company email, one week before the session. This email also contains a handout, PDF of the PowerPoint presentation slides, to follow along with the session and to act as a resource for the future. The handout was emailed in advance to allow lead therapists time to review the material before the presentation and formulate questions, if appropriate. Sessions were scheduled based on availability and took no longer than ten minutes. Attendance was taken at the beginning of the Skype session to ensure participation company-wide.

The education began with an introduction of the presenter and a brief explanation of the occupational therapy doctoral capstone experience. The educator then presented the information, following the sequence of the provided PowerPoint presentation. The definition of group therapy was presented followed by a validation of identified challenges and an explanation of the increased need for group therapy as an intervention. Rationale for the infrequent use of group therapy used in the recent past within the skilled nursing facility setting was presented based on past laws and policies. Throughout the presentation, these former laws and guidelines were compared and contrasted with current laws and regulations to encourage understanding ethical usage of this mode of therapy.

Staff education then transitioned to the presentation of appropriate purposes of group therapy, populations, goals, diagnoses, and effective evidence based treatments. The effects of group therapy on reimbursement were included in the presentation to create a deeper understanding of the requested increase in group therapy. The education session concluded with the presentation of examples of appropriate group therapy usage and documentation of those services. Questions were taken via live messaging with regional managers.

Lead therapists were asked to educate their therapy team at mandatory weekly team meetings on group therapy based on the resources and presentation provided. All therapy practitioners within the company are unable to attend to the Skype call due to productivity standards and general feasibility. Lead therapists were encouraged to contact the presenter or assigned regional managers for any questions in the future.

Leadership

Professional leadership skills were developed through creation and dissemination of these educational resources and programs. To determine programmatic needs, appropriate communication and clinical reasoning were employed to investigate the professional abilities of therapy practitioners. Marketing skills were used to implement the education programs effectively and to create therapist buy-in. A leadership skill that was strengthened through the implementation of the group therapy educational program was advocacy for evidence-based patient care. Advocacy for patients and therapy practitioners is also evident in the development and implementation of these programs.

Discontinuation and Outcomes

The preceding section described strategies utilized for quality improvement throughout the developmental and implementation stages of the documentation manual and group therapy education. After implementation, continuous quality improvement remains essential to ensure that practices executed throughout this doctoral capstone experience remain best practice. For group therapy education and the documentation manual to remain sustainable; usefulness, ease of use, and improved participation need to be measured to identify effectiveness and to ensure that they continue to meet societal needs. The following is an explanation of ongoing strategies

for continuous improvement of the educational programs and resources, in an effort to advance patient outcomes while simultaneously maximizing financial opportunity.

Documentation Manual

Improvements of the documentation manual were made throughout the duration of the developmental process based on the needs of the therapists, relevant literature, and input from management. Following reveal of the documentation manual, staff comprehension and compliance will be measured via quarterly documentation review audits and then these will be compared to previous results. The company *Documentation Audit Form* will be used to complete this measure. These quarterly audits are completed at each building for all disciplines at the facility level by assigned regional managers. This documentation compliance audit will be compared to the first quarterly audit completed in 2018. The outcomes of these reports will be used to adapt the documentation manual for increased effectiveness and accuracy, if appropriate. Any concerns voiced by therapists following the reveal of the documentation manual will be addressed by clarification or modification of the document with regards to current laws and required procedures.

For continuation of quality improvement, these audits will continue to be compared for the next two audit cycles of 2018. In October 2018, after the commencement of a new Medicare reimbursement system, this manual will need to be revised based on the societal needs. In January of 2019, documentation compliance will be reassessed, which may reveal the need for another occupational therapy doctoral capstone student to update this guide.

Group Therapy Education

After the group therapy education has been disseminated, outcomes of the educational program will be analyzed for efficacy. These outcomes will be used to identify areas of possible

program improvement. Data to be analyzed will be collected three weeks after the education is presented by the doctoral student. It will be collected in this timeframe due to the weekly reporting schedule, in an effort to capture authentic and accurate results. This will also give lead therapists time to educate their staff appropriately and allow time for proper implementation.

Group therapy percentages for each facility are measured by a Casamba group therapy report each week. This report is based on the amount of group therapy that was provided compared to the amount of eligible group therapy minutes. Following the education, this report will be completed and percentages will be compared to the previous four weeks' percentages, to measure change. In January 2019, after the new Medicare reimbursement system has been in place for three months, group therapy protocols will be revisited by management. This may be proposed to a different occupational therapy doctoral capstone student as a potential project.

Continuous quality improvement measures must be sustained to ensure that the programs and resources put into place throughout this doctoral capstone experience, remain best practice. Furthermore, any questions, comments, and/or concerns identified following the implementation of the programs, will be addressed in a timely manner to ensure responsiveness. Regional management has been assigned these continuous quality improvement tasks, but the 2019 occupational therapy doctoral capstone experience student will also act as an an asset in this process.

Overall Learning

The purpose of this doctoral capstone experience was to cultivate advanced practice occupational therapy skills with regards to therapy administration and leadership in the skilled nursing facility environment. Learning occurred via development and execution of educational programs and resources deemed necessary through program evaluation. Programmatic needs

were identified through effective communication with therapists, analylization of societal needs, and interdisciplinary collaboration. Program evaluation and continuous quality improvement took place throughout the entire experience, which allowed for development of the skills required to complete these actions. Ethical client-centered practices, guided by professional standards, were promoted through the creation and implementation of the program and educational resources. After extensive evaluation of the site, the needs of therapists, and the needs of the patients, group therapy education and skilled documentation education emerged as potential areas of improvement to increase ethical provision of therapeutic services with regards to reimbursement.

Evaluation

Advanced professional reasoning was employed to analyze, synthesize, and evaluate concerns related to occupational performance, participation, reimbursement and appropriate therapeutic service provision in the skilled nursing facility environment. Literature review and collaboration with site mentors were completed to screen for areas of potential continuous quality improvement needs. Communication and clinical reasoning were required to determine programmatic needs through the investigation of professional abilities of the therapy practitioners. The evaluation process required further development of research skills to identify the most relevant evidence-based information.

Documentation manual. Site mentors identified skilled therapy documentation as a source of weakness for therapists, which can affect patient length of stay, reimbursement, and quality services provided. Therapists revealed that they were experiencing frustration with documentation requirements through effective communication. Skilled therapy documentation audit revealed several concerns, such as inability to discriminate between occupational and

physical therapy documentation. Abilities to effectively audit documentation required growth in that skill. The culmination of these identified weaknesses determined the need for a documentation guide for therapists.

Group therapy. Throughout extensive evaluation of relevant literature, appropriate provision of group therapy services was identified as a factor that is effecting therapy services in the skilled nursing facility setting. Communication with site mentors, as well as evaluation of evidence, revealed that group therapy is becoming more prevalent as a mode of therapy due to increased accountable care organization reimbursement sources and a way to increase profit. Ability to analyze financial impact of assorted therapeutic modes of therapy was employed to understand the full impact on total reimbursement. The push for increasing use of group therapy and the frustrations conveyed by therapists identified a need for group therapy education.

Implementation

Following the evaluation and identification of these concerns, the information was synthesized and an implementation plan to target these problems through continuous quality improvement was developed. After these plans were developed to meet the societal needs identified, they were implemented.

Documentation guide. A documentation guide was created to meet the need identified in the evaluation stage. It was created for therapists and students to increase proficiency and efficiency with documentation skills. The guide strives to ensure veracity within occupational therapy practices, which was found to be lacking in the evaluation phase. Literature review, effective communication with therapists and administrators, and skilled observation skills were all exercised throughout the development of the documentation guide. Skills to synthesize the needs identified in the evaluation stage and to develop long lasting strategies to address these

needs were used throughout this stage. After the guide was created, collaboration with therapists, site mentors, and another doctoral capstone experience student took place to allow for continuous quality improvements.

Group therapy. Group therapy education was developed to address the need for increased knowledge for appropriate service provision. This was in an effort to increase competency and promote ethical client centered occupational therapy service delivery. Evidenced based research skills were used to identify critical knowledge and factors required for effective and ethical group therapy practices. This information was synthesized and a comprehensive educational presentation was developed based off of these identified factors. Education on group documentation requirements, covered and non-covered group therapy modes, reimbursement and evidence based procedures were included to assist in increasing group therapy percentages. Ideas for conducting occupation based, diagnosis or functional impairment specific groups, were provided as well. Education was implemented through a skype session presented to therapy supervisors using effective marketing and communication methods. Information delivery was modified throughout the implementation of this program, based off of trials, increasing ability to successfully impact therapists as a leader. Presentation of this educational program developed the ability to advocate for evidence-based patient care.

Conclusion

Throughout this doctoral capstone experience the *AOTA 2015 Code of Ethics*, as well as continuous quality improvement, were used as guiding principles in program development to meet identified societal needs within the skilled nursing facility environment. These societal needs were identified by program evaluation and program develop was utilized to increase quality processes. Programs were implemented in an effort to increase ethical and evidenced

based patient care with regards to financial gain. A comprehensive documentation manual was created for occupational, physical, and speech therapy practitioners when documenting skilled therapy services. A group therapy educational program was created and presented to therapists to increase understanding and ethical implementation of this mode of therapy. Effective and professional communication was completed throughout this capstone experience. Advanced reasoning was employed to analyze, synthesize, and evaluate concerns related to occupational performance, participation, reimbursement and appropriate therapeutic service provision. Advanced occupational therapy knowledge was developed through exploration and utilization of administration and leadership skills throughout this innovative research application process.

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Appendix A

Lifespan Documentation Guidelines

Plan of Care:

1. **Demographic Information**: Guarantee all demographic information is entered in Casamba so it transfers to the POC. Ensure if Jr., SR. or middle initial is listed in Matrix under "Name" on the facesheet, it is also included in Casamba. If the name does not match exactly, the claim can be *denied*.

2. **Onset Date:** Must reflect the most recent documented incident, decline, and/or acute onset of a *functional deficit* or *an acute impairment* that warranted the current initiation of therapy services. The onset date is *NOT* the date that the resident was diagnosed with a disease or condition. The onset date is chosen for the primary and secondary diagnoses.

3. **Qualifying Hospital Stay**: These dates should match the dates listed in Matrix under "Qualifying Hospital Stay". If the hospital stay pulls over to the POC from a prior therapy episode and is not pertinent to the current therapy episode, *remove it*.

4. **Reason for Referral:** Be specific regarding who referred the resident for treatment, what occurred that prompted the need for therapy, the date that the referral was documented, and what functional deficit areas and/or underlying impairments were noted that created the need for the referral.

5. **Therapy Necessity:** Document necessity of skilled therapy services and examples of *negative outcomes* that may occur if the therapy services were not provided.

6. **Medications:** *Do NOT* write "see Matrix". Instead, list the current medications that the resident has been prescribed. Medications can have a huge impact on function and can cause extrapyramidal symptoms. Also, if the resident has recently had an increased dose of pain medications, anti-anxiety medications, psychotropic medications, or hypnotic medications ordered, it would be excellent to mention this. These types of medication changes can lead to falls, declines in function, changes in status, or increased behaviors.

7. **Precautions:** "Precautions reflect situations in which a patient is at a risk of experiencing adverse effects" (Bellew, Michlovitz & Nolan, 2016, p. 16). Include all physician ordered precautions.

    a. Examples include weight bearing restrictions, fall risk, special precautions (hip, spinal, sternal/cardiac, isolation), swallowing, hard of hearing, legally blind, brace/orthosis, thickened liquids, blood thinners, wounds, O2 requirements, SOB, endurance, diet restrictions, behaviors, required assistive devices, stats, and the stage of cognitive impairment should be listed.

8. **History/ Medical Complexities/ Patient Factors:** List all pertinent diagnoses that could be causing the acute symptoms or decline in function.

9. **Prior Residence and Living Arrangement:** This section should be very thorough. It is an opportunity to write a narrative prior level of function and should include: living environment (# of stairs, rails, grab bars, which level bed/bath is on), amount of assistance required and who provided the assistance, assistive devices and adaptive equipment utilized, and functional skills related to mobility, communication, ADLs, IADLs, community mobility, swallow, and/or cognitive status.

10. **Discharge Environmental Factors/Social Support:** Discuss the resident's support system (family, a hired caregiver, restorative nursing, home health, etc.) and the amount of assistance that the resident will receive after therapy services are discontinued.

11. **Contraindications:** Specific situation which makes treatments (specifically modalities) potentially harmful to patients (Bellew, Michlovitz & Nolan, 2016). Including but not limited to DVT, infection, pacemaker, aortic aneurysm, orthostatic hypotension, shortness of breath, abnormal potassium levels.

    a. **Example:** Heat modalities contraindicated on hands secondary to reduced sensation

12. **Previous Therapy:** The dates of the most recent episode of therapy *at this facility* should be listed. Goals, resident's response to intervention and the outcome of the prior episode of therapy should be documented.

13. **Discharge Plans:** List goals and outcomes the resident and/or caregiver is expecting from skilled therapy intervention.

14. **Informed Consent:** For the LTC residents, consent to treat must be documented in the daily note, *on the day of the evaluation*, under the evaluation CPT code. The information included in the daily note should contain 1) name of the person contacted, 2) relationship of the resident to the patient, 3) if the contact was made in person or over the phone, and 4) that consent to treat was given. This process is billable if completed when the therapist is with the resident. If the person is unable to be contacted after several attempts, document the attempts and if a message was left.

15. **Functional Deficits:** Identify the current functional deficits and enter the prior, current, and anticipated level of function. *Do NOT enter UNKNOWN*!

    a. **Section GG**

    b. **Pain Impacting**

    c. **Hospital Readmission Factors:** Scores indicate levels of safety impairment and are based on criteria for each item that measure how safely tasks are performed with or without a caregiver (reference *EPRF User's Manual*). Sections are listed below.

PT: Readmit Risk:

- **(Pre)Ambulatory Fall Risk** (Section 1.1a: Functional Mobility)

OR

- **Wheelchair Mobility Fall Risk** (Section 1.1b, Functional Mobility)
    - Only score ONE of the ambulation scores; (pre)ambulatory -OR- w/c mobility; whichever item is most appropriate for the patient. The other item that is not the most appropriate should be scored as '8' for all three scoring sections.
    - This is patient's safety impairment without caregiver
- **Safety in Transfers** (Section 1.2: Functional Mobility)
    - This is patient's safety impairment without caregiver
- **Caregiver-Mobility** (Section 5.1: Caregiver Return Demonstration)
    - Do not use '8' to score caregiver assistance at initial evaluation if the patient has a caregiver who is able to assist the patient.
    - A score of '8' should only be used if the patient does NOT require caregiver assistance.
    - If the patient requires assistance, but does not have a caregiver score the item as a '7'.

- If the patient DOES have a caregiver, the score should be acquired through information on the patient's medical chart; if no information can be acquired to score this item, score as a '7'.

OT: Readmit Risk:

- **Toileting Safety** (Section 2.1: Self Care)
  - Items scored based on the patient's safety impairment with or without caregiver assistance (if applicable)
- **Feeding & Eating** (Section 2.2: Self Care)
  - Items scored based on the patient's safety impairment with or without caregiver assistance (if applicable)
- **Fxnl Cognition** (Section 3.1: Functional Cognition)
- **Home Evaluation** (Section 4.1: Home Environment)
  - Do not use '8' to score the home assessment if the patient will return to a home environment. A score of '8' should only be used if the patient will remain in SNF or is homeless.
  - Items scored based on the patient's safety impairment with or without caregiver assistance (if applicable)
- **Caregiver-Self Care** (Section 5.2: Caregiver Return Demonstration)
  - Do not use '8' to score caregiver assistance at initial evaluation if the patient has a caregiver who is able to assist the patient.
  - A score of '8' is only used if the patient does NOT require caregiver assistance.
  - If the patient requires assistance, but does not have a caregiver score the item as a '7'.
  - If the patient DOES have a caregiver, the score should be acquired through information on the patient's medical chart; if no information can be acquired to score this item, score as a '7'.

*If the therapist is unable to determine if the patient has a caregiver who can provide safe

and appropriate assistance, score the item(s) without caregiver assistance.

*Scores are not affected by the time it takes to complete tasks or by the use of adaptive equipment/devices, unless specified otherwise. All test items must be scored.

* Items are scored on a scale of 1 to 7. Higher scores indicate greater safety impairment; a score of '1' indicates no safety concerns and a score of '7' indicates safety concerns for 100% of the activity. An additional score option of '8' is available for items that are not applicable to the patient.

*If more information on any of these factors would be beneficial, add a narrative section and include further clarification. Reference the *Evaluation of Potential Readmission Factors (EPRF) Manual* for further instruction.

16. **Underlying Impairments:** Identify all underlying impairments and add the level of current impairment. In the narrative box, please include, goniometric measurements, functional skills impacted by pain, safety awareness deficits, activity tolerance, cognitive impairments, ROM deficits, etc. Only impairments that are addressed by a goal need to be included, it is not necessary to indicate intact or normal.

    a. **PHQ9 Psychosocial Well being**

b. **Standardized Tests:** It is best practice to have at least 1, if not more, standardized tests on all evaluations. Make sure to include what the standardized test results *indicate* in this section or in the goals.

17. **Goals:** Please make sure that goals make sense and are as specific as possible. Goals must be patient centered, measurable and pertaining to *identified* functional impairments. Use percentages of cues (verbal, tactile, written) to show progress. Must be written with adequate baseline of functional documentation so change can be measured. The best practice is to make STGs Performance Skills / Underlying Deficits specific and make the LTGs Occupation / Functional Skills based. This helps to show progress.

18. **Rehab Potential:** This should always be "good" if the goals are written appropriately.

19. **CPT Codes- Requires skilled services to focus on:** Include CPT codes that will be billed and provided during intervention. *Do not* use cognitive retraining, this is very difficult to get reimbursed and is only appropriate in rare instances.

    a. **PAM:** If including a physical agent modality, only choose 1 and follow the ACP protocol. The chosen modality needs to be included in a short-term goal as well.

        - **The clarification order** for a modality *must* include: specific modality, body location, physiological impairment, function impacted, frequency, and duration.

    b. **Group Therapeutic Procedures CPT 97150/92508:** If appropriate, group therapy should be included as a CPT intervention code. "The rationale for utilizing group therapy should be documented in the POC. Some ability to self-initiate the tasks/activities in the group such that they don't need 1-on-1 assistance 100% of the time" (ACP).

20. **Treatment Diagnosis**: Refer to Appendix C, *ICD-10 Therapy TREATMENT Codes that Support Medical Necessity (are reimbursable)*, for more information.

21. **Frequency/Duration/Amount:** Duration is the number of days the patient will be seen, this can be no greater than 90 days. Frequency is the amount of times the patient will be seen per week. Amount is times per day (BID/QD).

Daily Note:

1. **Purpose:** Record skilled interventions and treatments provided to justify the billed codes on the claim. It must be conveyed that the unique skills of a therapist were absolutely necessary to provide the treatment. Refer to the Appendix A, *WPS CPT Documentation Tips Guide,* for specific examples per CPT code.

    a. **Modalities**: Only charge for the skilled part of modalities including choosing parameters electrode placement, skin checks, determining proper pulse frequency and duration, and simulation mode, etc. *Do NOT* charge for patients sitting and receiving a modality when the therapist is not actively engaged. Refer to Appendix B, *WPS LCD Modalities in Depth,* for more information and specific examples.

        - **Skilled documentation of modalities must include:** The specific modality, device used (what size US transducer, type of electrodes), body location treated, parameters (waveform for e-stim, frequency, intensity and measure i.e, 24 volts or 1.0 Watts/cm2), treatment duration, physiological effect resident response to treatment (descriptors such as muscle twitch), patient's tolerance to treatment, patient's

cooperation, patient comments regarding the modality, skin integrity prior to and after intervention, physiological impairment treated and functional improvements, rationale for continued use or discontinuing the modality.

b. **Group Therapeutic Procedures CPT 97150/92508:** "Include the purpose of the group and the number of participants. Group activities must address at least 1 of each participating patient's treatment goals. Group attendees should have similar levels of acuity/severity" (ACP). Therapeutic benefit from group dynamics and socialization should be documented. Skilled nature of group therapy needs to be described. For example, upgrading the difficulty of the activity for an individual could be included. For more information reference Appendix D, *Group Therapy.*

2. **Consent to treat upon evaluation:** For the LTC residents, consent to treat must be documented in the daily note, *on the day of the evaluation*, under the evaluation CPT code. The information included in the daily note should contain 1) name of the person contacted, 2) relationship of the resident to the patient, 3) if the contact was made in person or over the phone, and 4) that consent to treat was given. This process is billable if completed when the therapist is with the resident. If the person is unable to be contacted after several attempts, document the attempts and if a message was left.

3. **Skilled Verbs:** Evaluated, fabricated, analyzed, guided, corrected, adapted, instructed, modified, assessed, coordinated, facilitated, tailored, graded, developed, designed, optimized, stabilized, educated.

4. **Red flags:** Slight improvement, routine, monitor, maintain, making slow progress, no progress made, reviewed, unable to learn, overall generalized weakness, poor/fair rehab potential, poor participation, low motivation, poor prognosis

5. **Daily note on day of discharge:** Do not just write "see d/c". Include the skilled interventions that took place on the day of discharge.

Progress Note:

1. **Goals:** Enter the current level of the STGs. If the goal is achieved, upgrade or discharge the goal to show movement in the documentation. If no progress has been made for 2 progress notes in a row with a specific goal(s), downgrade or discharge the goal, then add new goals pertaining to long term goals. Remember, that the goal date is the date the therapist expects the goal will be met. This date should be no longer than *2 weeks* from day set.

2. **Analysis of functional Outcome/Clinical Impression:** Discuss the resident's response to intervention and modifications made to approaches when necessary. Also, discuss improvements in underlying impairments and functional skills. List barriers to progress, and why the skills of the therapist are required to provide the skilled intervention. Update standardized test scores and include narrative interpretations. This section should specifically describe the contributing factor(s) to the functional deficits, and the impact on their health/well-being.

3. **Remaining Functional Deficits/ Underlying Impairment:** Include deficits that are still present or newly identified and what the focus of intervention will be for the next 2 weeks, keeping long term goals in mind.

4. **Precautions**

5. **Updated Standardized Tests**

6. **Skilled Services Provided since Last Report:** Do not simply list the codes that were billed such as ther ex, neuro, ADL etc. Discuss the *skilled services* that were provided for *each code billed* since the last progress note or evaluation. This section should describe what therapy is doing with or teaching the patient that *no one else* has the skill to provide. Explain modifications to tasks, grading of tasks, compensatory and adaptive strategy education, skilled assessment of task performance, techniques used to improve functional performance, etc.

    a. **Skilled Services:** Therapeutic exercise is *NOT* a skilled service. CNAs, RNAs, rehab aides, and caregivers can all give a patient a 2 lb weight. However, graded resistance exercise with assessment of muscle fatigue is skilled. The Omnicycle is not skilled, however, it becomes skilled when the therapist provides continued assessment of the patient's cardiopulmonary function or vital signs. Refer to Appendix A, *WPS CPT Documentation Tips,* for more information.

    b. **Physical Agent Modality**: If a PAM was billed, discuss the physiological impairment treated, body location, parameters, skin integrity prior to and following the modality and functional improvements. Also include patient's tolerance, cooperation, and comments regarding the modality. Include the rationale for continued use of the modality. Refer to Appendix B, *WPS LCD Modalities in Depth,* for more information.

        - All of the following components should be addressed for each PN when a modality has been utilized in the progress reporting period including the specific modality, waveform for e-stim, frequency, intensity and measure (i.e, 24 volts or 1.0 Watts/cm2), descriptors such as muscle twitch, treatment duration, body location treated, device used (what size US transducer, type of electrodes), physiological effect, resident response to treatment, rationale for continued use or discontinuing the modality

7. **Updates to Treatment approach:** List changes in intensity of services, added treatment modalities, or changes in goals or discharge plans.

8. **Reason for Missed Treatments**

9. **Patient / Caregiver Training:** Therapists are teachers. This section should contain information on every note. Therapists educate and train not only the patient, but also CNAs, family members, caregivers, RNAs, and other interdisciplinary team members. Make sure that the answers to the questions listed below are all included in patient/caregiver education documentation.

    a. Who did I education? (patient, caregiver, restorative aide)
    b. What did I educate? Technique, strategy or exercise: (hip precautions, cardiac precautions, swallow strategies, adaptive equipment use, positioning device use)
    c. How did I educate? (verbal instructions, written instruction, demonstration of technique)
    d. Did the patient/caregiver understand?
    e. Did the patient/caregiver return demonstrate, and how accurate was the return demonstration?

10. **Impact on Burden of Care/ Daily Life:** The amount of assistance the resident requires and who will be or is providing the assistance. Burden of care is related to the resources (man power) it will take to help the resident in the current environment as well as the anticipated discharge environment.

11. **Prognosis for Further Progress:** Should be "good" if goals are appropriate. If it is not "good", then goals should be adjusted, as well as treatment approaches.

Discharge Summary:

1. **Goals:** Enter the current level of the STGs and LTGs.

2. **Analysis of Functional Outcome/Clinical Impression:** Discuss the resident's response to intervention and how approaches were modified if the resident responded negatively. Also, discuss improvements in underlying impairments and improvements in functional skills. List barriers to progress, and why the skills of the therapist are required to provide intervention.

3. **Impact on Burden of Care/Daily Life:** The amount of assistance the resident requires and who will be or is providing the assistance. Burden of care is related to the resources (man power) it will take to help the resident in the current environment and in the discharge environment.

4. **Skilled Services Provided since Last report:** Do not simply list the codes that were billed such as ther ex, neuro, ADL etc. Discuss *skilled services* that were provided for *each code billed* since the last progress note. The skilled services provided section should describe what therapy did with or taught the patient that *no one else* had the skill to provide. This section should explain modifications to tasks, grading of tasks, teaching of compensatory and adaptive strategies, skilled assessment of task performance, techniques used to improve functional perform, etc.

    a. **Skilled Services:** Therapeutic exercise is *NOT* a skilled service. CNAs, RNAs, rehab aides, and caregivers can all give a patient a 2 lb weight. However, graded resistance exercise with assessment of muscle fatigue is skilled. The Omnicycle is not skilled, however, It becomes skilled when the therapist provides continued assessment of the patient's cardiopulmonary function or vital signs. Refer to Appendix A, *WPS CPT Documentation Tips,* for more information.

    b. **Physical Agent Modality:** If a PAM was billed, discuss the physiological impairment treated, body location, parameters, skin integrity prior to and following the modality and functional improvements. Also include patient's tolerance, cooperation, and comments regarding the modality. Include the rationale for continued use of the modality. Refer to Appendix B, *WPS LCD Modalities in Depth*, for more information.

        - The specific modality, waveform for e-stim, frequency, intensity and measure (i.e, 24 volts or 1.0 Watts/cm2), descriptors such as muscle twitch, treatment duration, body location treated, device used (what size US transducer, type of electrodes), physiological effect, resident response to treatment, rationale for continued use or discontinuing the modality

5. **Summary of Skilled Services Provided since SOC:** Do not simply list the codes that were billed such as therapeutic exercise, neuro, ADL etc. Discuss what *skilled service* was provided for *each code billed for the entire duration of treatment.* Also, discuss the functional gains achieved by providing each billed code. The skilled services provided section should describe what therapy did with or taught the patient that *no one else* has the skill to provide. This section should explain modifications to tasks, grading of tasks, teaching of compensatory and adaptive strategies, skilled assessment of task performance, techniques used to improve functional perform, etc.

6. **Patient/ Caregiver Training since Last Report:** Therapists are teachers. This section should contain information on every note. Therapists educate and train not only the patient, but also CNAs, family members, caregivers, RNAs, and other interdisciplinary team members. Make sure that the answers to the questions listed below are all included in patient/caregiver education documentation.

    a. Who did I education? (patient, caregiver, restorative aide)

b. What did I educate? Technique, strategy or exercise: (hip precautions, cardiac precautions, swallow strategies, adaptive equipment use, positioning device use)
c. How did I educate? (verbal instructions, written instruction, demonstration of technique)
d. Did the patient/caregiver understand?
e. Did the patient/caregiver return demonstrate, and how accurate was the return demonstration?

7. **Precautions**

8. **Reason for Missed Treatments**

9. **Discharge Plans & Instructions:** List the discharge environment, caregiver instruction provided, home exercise program, restorative nursing program, and any follow up services that will be provided such as home health or outpatient services. Also, discuss equipment ordered or needed upon discharge. Patient and/or caregiver have acknowledged understanding of post-discharge plan from therapy.

10. **Updated Standardized Tests**: Complete standardized tests completed in the plan of care. Add a narrative of what the change in scores indicates.

11. **Contraindications**

12. **Patient/Caregiver is aware and reports understanding of the diagnosis and prognosis**

13. **Functional Deficits:** Enter the current level of the functional deficits listed. Do NOT enter UNKNOWN.
    a. **Section GG**
    b. **Pain Impacting**
    c. **Hospital Readmission Factors:** Scores indicate levels of safety impairment. Scores are based on criteria for each item that measure how safely tasks are performed with or without a caregiver upon evaluation and discharge (reference *EPRF User's Manual*).

PT: Readmit Risk:

- **(Pre)Ambulatory Fall Risk** (Section 1.1 a: Functional Mobility)

OR

- **Wheelchair Mobility Fall Risk** (Section 1.1b: Functional Mobility)
  - Only score ONE of the ambulation scores; (pre)ambulatory -OR- w/c mobility; whichever item is most appropriate for the patient. The other item that is not the most appropriate should be scored as '8' for all three scoring sections.
  - This is patient's safety impairment without caregiver
- **Safety in Transfers** (Section 1.2: Functional Mobility)
  - This is patient's safety impairment without caregiver
- **Caregiver-Mobility** (Section 5.1: Caregiver Return Demonstration)
  - Do not use '8' to score caregiver assistance at initial evaluation if the patient has a caregiver who is able to assist the patient.
  - A score of '8' should only be used if the patient does NOT require caregiver assistance.
  - If the patient requires assistance, but does not have a caregiver score the item as a '7'.
  - If the patient DOES have a caregiver, the score should be acquired through information on the patient's medical chart; if no information can be acquired to score this item, score as a '7'.

OT: Readmit Risk:

- **Toileting Safety** (Section 2.1: Self Care)
    - Items scored based on the patient's safety impairment with or without caregiver assistance (if applicable)
- **Feeding & Eating** (Section 2.2: Self Care)
    - Items scored based on the patient's safety impairment with or without caregiver assistance (if applicable)
- **Fxnl Cognitio**n (Section 3.1: Functional Cognition)
- **Home Evaluation** (Section 4.1: Home Environment)
    - Do not use '8' to score the home assessment if the patient will return to a home environment. A score of '8' should only be used if the patient will remain in SNF or is homeless.
    - Items scored based on the patient's safety impairment with or without caregiver assistance (if applicable)
- **Caregiver-Self Care** (Section 5.2: Caregiver Return Demonstration)
    - Do not use '8' to score caregiver assistance at initial evaluation if the patient has a caregiver who is able to assist the patient.
    - A score of '8' should only be used if the patient does NOT require caregiver assistance.
    - If the patient requires assistance, but does not have a caregiver score the item as a '7'.
    - If the patient DOES have a caregiver, the score should be acquired through information on the patient's medical chart; if no information can be acquired to score this item, score as a '7'.

d. If the therapist is unable to determine if the patient has a caregiver who can provide safe and appropriate assistance, score the item(s) without caregiver assistance.

e. Scores are not affected by the time it takes to complete tasks or by the use of adaptive equipment/devices, unless specified otherwise. All test items must be scored.

f. Items are scored on a scale of 1 to 7. Higher scores indicate greater safety impairment; a score of '1' indicates no safety concerns and a score of '7' indicates safety concerns for 100% of the activity. An additional score option of '8' is available for items that are not applicable to the patient.

g. If more information on any of these factors would be beneficial, add a narrative section and include further clarification. Reference the *Evaluation of Potential Readmission Factors (EPRF) Manual* for further instruction.

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Appendix B

Group Therapy in a Skilled Nursing Facility

Presented by: Darian Burchfield

Objectives

- To increase knowledge regarding service provision guidelines of group therapy
- To increase understanding of ethical billing and effective documentation of group therapy
- To increase knowledge regarding the benefits of ethical group therapy as evidenced by peer reviewed literature

Definition of Group Therapy

Non-RUG Based

- The treatment of 2 or more patients simultaneously, **who may or may not be** performing the same/similar activity.
- If the therapist is dividing attention, providing only intermittent personal contact, or giving instructions to 2 or more patients, one unit is appropriate per patient.

(RAI,2017; LCD, 2015)

Definition of Concurrent therapy

RUG Based

- The treatment of 2 patients, who are not performing the same or similar activities, at the same time, regardless of payer source, both of whom must be in the line-of-sight of the treating therapy practitioners
- Only exists for RUG-based payers

Definition of Group Therapy

RUG Based

- Treatment of 4 patients who are performing **the same or similar activities**, and are supervised by a therapist or an assistant.
  - Must be planned in advance for exactly 4 patients
  - Only 25% of total therapy

(RAI, 2017)

CPT Billing Codes

- CPT 97150– Therapeutic Procedure (s), group (2 or more individuals)
  - Occupational and Physical Therapy
  - Speech therapy**– Dysphagia only**
- CPT 92508– Group, two or more individuals
  - Speech therapy

(RAI, 2017; LCD, 2015)

Question?

You have two patients that come down to the therapy gym and participate in therapy, at the same time, for 30 minutes. One is Medicare Part A and one is Medicare Part B. How does the therapist bill those minutes?

Question?

All patients below have non–RUG based payers. The therapist treats 3 patients from 1:00pm–2:00pm providing brief intermittent instruction while monitoring all 3. How does the therapist bill these minutes?

Patient A= 1:00 pm – 2:00 pm (60 minutes)
Patient B= 1:00 pm– 1:30 pm (30 minutes)
Patient C= 1:30 pm– 2:00 pm (30 minutes)

Non-Covered Group Therapy

- Provided by students (without supervision), therapy aides, rehab techs, nursing aides, recreational therapists, exercise physiologists, or athletic trainers
- Previously taught exercise programs, independent exercise, or exercise on machines/equipment in the absence of skilled care
- Routine (i.e., supportive) groups such as maintenance programs, nursing rehabilitation programs, or recreational therapy programs

(LCD, 2015)

Session Participation

- Patients do not have to be at the same functional level to participate in group therapy
  - Reminder: Does NOT have to be the same or similar activity
- Inappropriate Patients
  - Isolation, extreme behaviors, requires constant 1-on-1 attention, patient preference

Relevant Literature

- THA/TKA
- Back pain
- Parkinson's Disease
- CVA
- Knee OA
- Post stroke aphasia

Unique Benefits of Group Therapy

- Motivating
- Carry-over
- Independence
- Change-of-pace
- Peer support
- Efficiency
- Unique treatment
- Fun!!!!!!!!!

(ACP, 2015)

Positive Impact on Productivity

- If a therapist spends 60 minutes with a singular client and 45 minutes of that time is billable then the therapist is 75% productive for that hour.
- If a therapist spends 60 minutes doing group for 2 patients then the therapist is 200% productive for that hour.

Question?

A therapist treats 3 patients from 1:00pm–2:00pm providing brief intermittent personal contact while monitoring all 3. What is the therapists productivity for this hour?

Patient A= 1:00 pm – 2:00 pm (60 minutes)
Patient B= 1:00 pm– 1:30 pm (30 minutes)
Patient C= 1:30 pm– 2:00 pm (30 minutes)

Gathering Patients

- Use this time as an opportunity for treatment
  - Address functional transfers, functional mobility, provide education, provide cueing for safety, etc.
  - These minutes count towards
    - Individual patient minutes
    - Therapist productivity

Productivity & Scheduling

- When possible, communicate therapy times
  - Patients, other therapists, nursing, family, etc.
- Flexible Scheduling
- Group Therapy Expectation
  - Number is skewed

Ethical Considerations

- Is group therapy an ethical mode of therapy?
  - Proper implementation
    - Using appropriate definition for payer
  - Proven benefits
  - Proper billing
    - Group Therapy CPT code, if appropriate

Therapy Students

Group therapy can be coded when

- The student provides group treatment and the supervising therapist/assistant is present throughout the session and is not engaged in any other activity or treatment
- Supervising therapist/assistant is provides group treatment and the therapy student is not providing any other treatment

(RAI, 2017)

Documentation Requirements

- CPT code on the POC
- Description in the daily treatment note
  - Purpose of group
  - Number of participants
  - Individualized patient performance
- Skilled service– Lifespan Documentation Manual

(ACP, 2015)

Thank you!

Further questions regarding group therapy should be directed to regional managers