

# Therapy Reassessment

Final Rule 2015

Home Health VNA  
Merrimack Valley Hospice  
HomeCare, Inc.



The Leaders in Home Health and Hospice Care

# Final Rule 2015

The 30 day reassessment is required for all patients with episodes beginning on/after January 1 2015.

As of March 2, 2015, all reassessments will be required only every 30 days.

# Scheduling Therapy Reassessment Visits using Visit Tags

- ▶ Clinician should look ahead to tag reassessment visits when doing:
  - Eval after SOC
  - Eval after ROC
  - At recert when creating new frequency/frequencies
  - ANY time you change your frequency
- ▶ CSC will check to confirm that reassessment visit is scheduled/tagged, but scheduling/tagging is the clinician's responsibility.

# Tagging a Therapy Reassessment Visit

- ▶ In the **Schedule screen** or in the **485, Visit Frequency Orders, Appointment** use the **Edit Appointment** button to check/add the Therapy Reassessment Visit Tag.

Notes  
Active  
D/C'd  
Appts

SN: Thu 1/22/15 Heart, Nurse, RN  
PT: Thu 1/22/15 <Unassigned>  
SN: Thu 1/29/15 Heart, Nurse, RN  
PT: Thu 1/29/15 <Unassigned>  
SN: Thu 2/5/15 Heart, Nurse, RN  
PT: Thu 2/5/15 <Unassigned>  
SN: Thu 2/12/15 Heart, Nurse, RN  
PT: Thu 2/12/15 <Unassigned>  
SN: Thu 2/19/15 Heart, Nurse, RN  
PT: Thu 2/19/15 <Unassigned>  
SN: Thu 2/26/15 Heart, Nurse, RN  
PT: Thu 2/26/15 <Unassigned>  
SN: Thu 3/5/15 Heart, Nurse, RN  
PT: Thu 3/5/15 <Unassigned>  
SN: Thu 3/12/15 Heart, Nurse, RN

DETAILS

Order - 1x/Wk x 10Wks

Patient Chart      D/C      Edit

Click to highlight a visit, then click Edit to add a visit tag.

# Tagging a Therapy Reassessment Visit

## Edit Appointment

Order

1-2x/Wk x 14Wks (1/15/15)

Type

<reason>

Clinician

Heart, Nurse, RN

Memo

When

01/15/15



4:24P

Est.Duration (minutes)

HCA Supervision

Labs

Therapy Assessment

OK

Cancel

# Viewing a Therapy Reassessment Visit Tag in the Schedule

Status	Name	Time	Admit Type
Visit	Doe, Jane		Certified/OASIS
	● Therapy Assessment		
Visit	Hospice , Harriet		Hospice

# Therapy Reassessment

- ▶ Perform reassessment every 30 days
- ▶ Update of goals/plan of care
- ▶ 30 Day Clock resets with each reassessment

# Documentation Requirements

- ▶ The therapist must assess the patient using a method which allows for objective measurement of function and successive comparison of measurements.



# Reassessment Requirements

- ▶ Assess the patient's functional status and objective measures. Document results (include Tinetti, TUG, distance ambulated etc).
- ▶ Assessments selected should correlate with plan of care (485).
- ▶ Compare measurements to prior reassessments – spell it out!
- ▶ Document the effectiveness of therapy, or lack thereof.
- ▶ Update care plan, goals and interventions, as appropriate.

# Review the Goals in the Plan of Care

- ▶ DC goals that have been achieved or are no longer appropriate. Add new goals as needed.
- ▶ Be sure to include measurable and functional goals.

# Reassessment Forms

- ▶ Use “PT/OT/ST Note Advanced” (regular note)
- ▶ Add “Addendum Advanced”
- ▶ Add “Narrative Note”
- ▶ Don’t double document in duplicate fields

The screenshot shows a software interface with a dropdown menu on the left and a list of items on the right. The dropdown menu is currently set to 'PT' and lists several options: Overview (red circle), Profile (yellow circle), Visits (green circle), Forms, 485 (yellow circle), Calls, Mtgs, Intake, and PT Today. The list on the right includes: PT Note Advanced (warning icon), PT Addendum Advanced (warning icon), Narrative Note (warning icon), Interim Orders (In Draft) (warning icon), Clinical Orders, PPS Groupers, Visit Frequency Orders (VFO), Facesheet, Insurance, Dx (warning icon), and Medications.

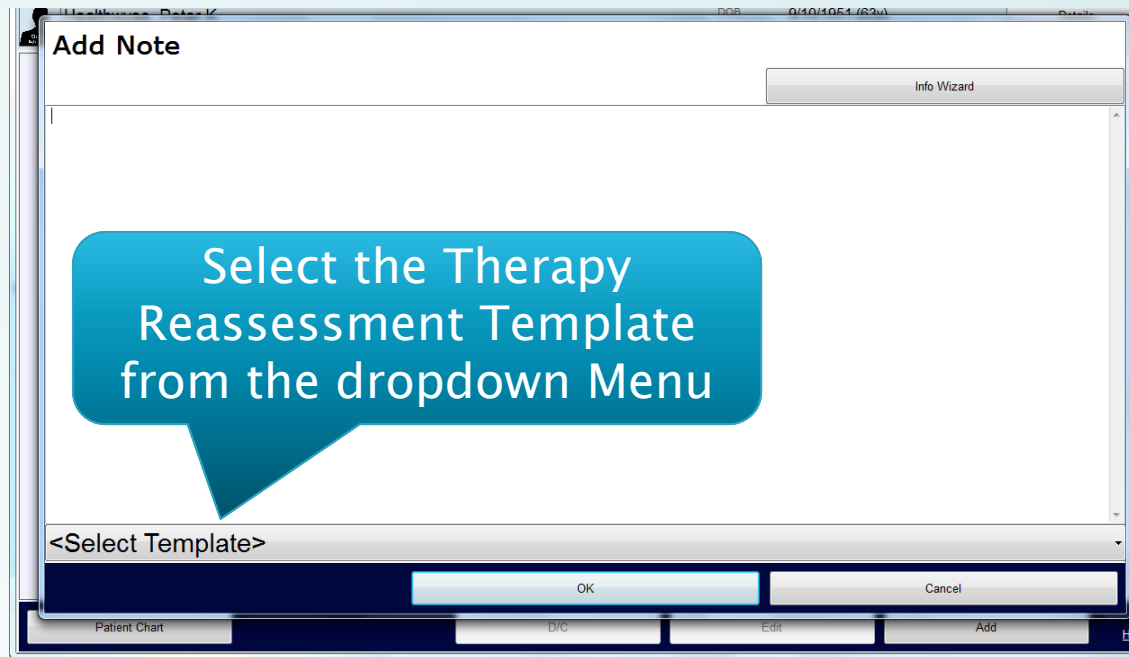
# Addendum Advanced

- ▶ Must document in Overview Tab indicating Assessment Reason.
- ▶ Complete remaining Tabs in Addendum as indicated.

🏠 Patient Chart | PT Addendum Advanced

Overview	ASSESSMENT REASON
Prior Function	<Select>
Current Function	
Tinetti	COMMENT
TUG	
Additional Tests	
Limitations	CURRENT DIAGNOSIS
Systems/Goals	<Diagnosis>
Equipment	
Assessment Summary	COMMENT
[Summary]	

# Complete the Narrative Note using the Template for Therapy Reassessment



The image shows a screenshot of a software interface for adding a note. The main window is titled "Add Note" and contains a large text area for entering the note. A blue callout box with white text points to a dropdown menu at the bottom of the text area, which currently displays "<Select Template>". The callout text reads: "Select the Therapy Reassessment Template from the dropdown Menu". Below the text area, there are two buttons: "OK" and "Cancel". At the bottom of the window, there is a navigation bar with buttons for "Patient Chart", "D/C", "Edit", "Add", and "Help".

Select the Therapy Reassessment Template from the dropdown Menu

<Select Template>

OK Cancel

Patient Chart D/C Edit Add Help

# Remember...

- ▶ Continually reassess patient
- ▶ Include objective measures to your notes at least every 2 weeks
- ▶ Document the effectiveness of therapy and progress towards goals
- ▶ Update care plan as appropriate

# Sample Reassessment Narrative (initial)

- ▶ 12/18/14 – Patient is an 80 year old female admitted s/p fall & sacral fractures 3 weeks ago. Has DM and newly diagnosed CHF. Weakness post hospital & SNF. Has pain 7/10 limiting mobility. MAHC 10 = 7. Tinetti = 14/28. Strength = 3/5 BLE. Plan HEP, gait training with walker → cane. Expected outcomes of increased mobility, strength & safety and decreased pain.

# Subsequent Reassessment – (compliant/measurable)

- ▶ 1/2/15 – Patient is an 80 year old female with dx s/p fall & sacral fractures 5 weeks ago. No new medical problems. Compliant with HEP & gait training program. Tinetti = 20/28 improved from 14/28. BLE strength is improved from 3/5 to 3+/5. Pain is improved from 7/10 to 3/10. Progressed to cane during day, walker at night still. Therapy is effective. Progressing toward goals. Will progress HEP. Pt is ambulating safely.



# Subsequent Reassessment – (not compliant, not measurable)

- ▶ 1/2/15 – Patient is an 80 year old female with dx s/p fall & sacral fractures 5 weeks ago. No new medical problems. Has been doing well, making steady gains. Has made progress with transfers, gait on level and stairs; she has also made progress with strength BLEs, balance and tolerance for activity. Patient will achieve independent transfers, gait on level with rolling walker, and assisted gait on stairs and uneven surfaces.