Appendix A. Skill of the Week

Week	Topic
1	**Introduction:** Expectations, Site Orientation, Technology Privacy Review and System Registration, Supervision requirements for third-party payors, Logistics of clinical procedures
2	**Introduction Continued:** Billing System, Patient Scheduling, Medicare Standards and Procedures, Working files
3	**Basic Documentation:** Intro to EMR system, Flowchart/Timelines, Required Elements for Medicare, Writing strong SOAP notes
4	**Evaluation:** Case Hx/Interview, Review of EMR to obtain info, Assessment planning and procedures
5	**Evaluation Continued:** Analysis and Synthesis of Info, Treatment Planning, Goal Writing
6	**Evaluation-Putting it All Together:**
7	**Treatment Approaches:** EBP, Disorder-specific approaches
8	**Progress Reporting:** Dynamic Assessment, Diagnostic Treatment, Progress Report vs Recertification of Plan of Care MIDTERM REVIEW MEETING
9	**Building strong documentation skills:** Medical necessity, Need for skilled service, Goals and treatment match documented needs
10	**Continue to build strong documentation skills:**
11	**Patient Education/Counseling:** Reporting to Patient and Caregivers, Home Programming, Caregiver Training, Emotional Counseling/Active Listening
12	**Care Conferencing and Collaboration with other disciplines:** Reporting treatment planning and progress to patient and family, Reporting to other rehab professionals ("rounding"), Collaboration for functional outcomes
13	**Discharge Planning:** Training and Instruction, Collaboration with caregivers, Required documentation
14	**Review as needed:**
15	**Review as needed:** FINAL REVIEW MEETING

Appendix B. Required Elements in Documentation

Evaluation Report: (completed day of evaluation, conducted once a year if treatment has been continuous, or after any change in medical or functional status)

- Identifying information, ICD-9 Codes (medical and tx dx), Time In/Out
- *Assessment of hearing and vision status*
- *Level of functioning prior to incident*
- *Current level of functioning*
- *Anticipated benefits to functional ability*
- *Estimate of potential*
- E-Signature by SLP and Student (Dated)

Initial Plan of Care: (completed prior to initial treatment session, E-signature of MD required)

- Identifying information, ICD-9 codes (medical dx and treatment dx)
- *Long-term goals (measurable, functional, include anticipated duration, based on eval findings)*
- *Short-term goals (measurable, functional, include anticipated duration, based on eval findings)*
- *Type, amount, frequency and anticipated duration of tx*
- *Discharge and Generalization planning*
- E-Signature of SLP and Student (Dated)
- E-Signature of physician (Date)

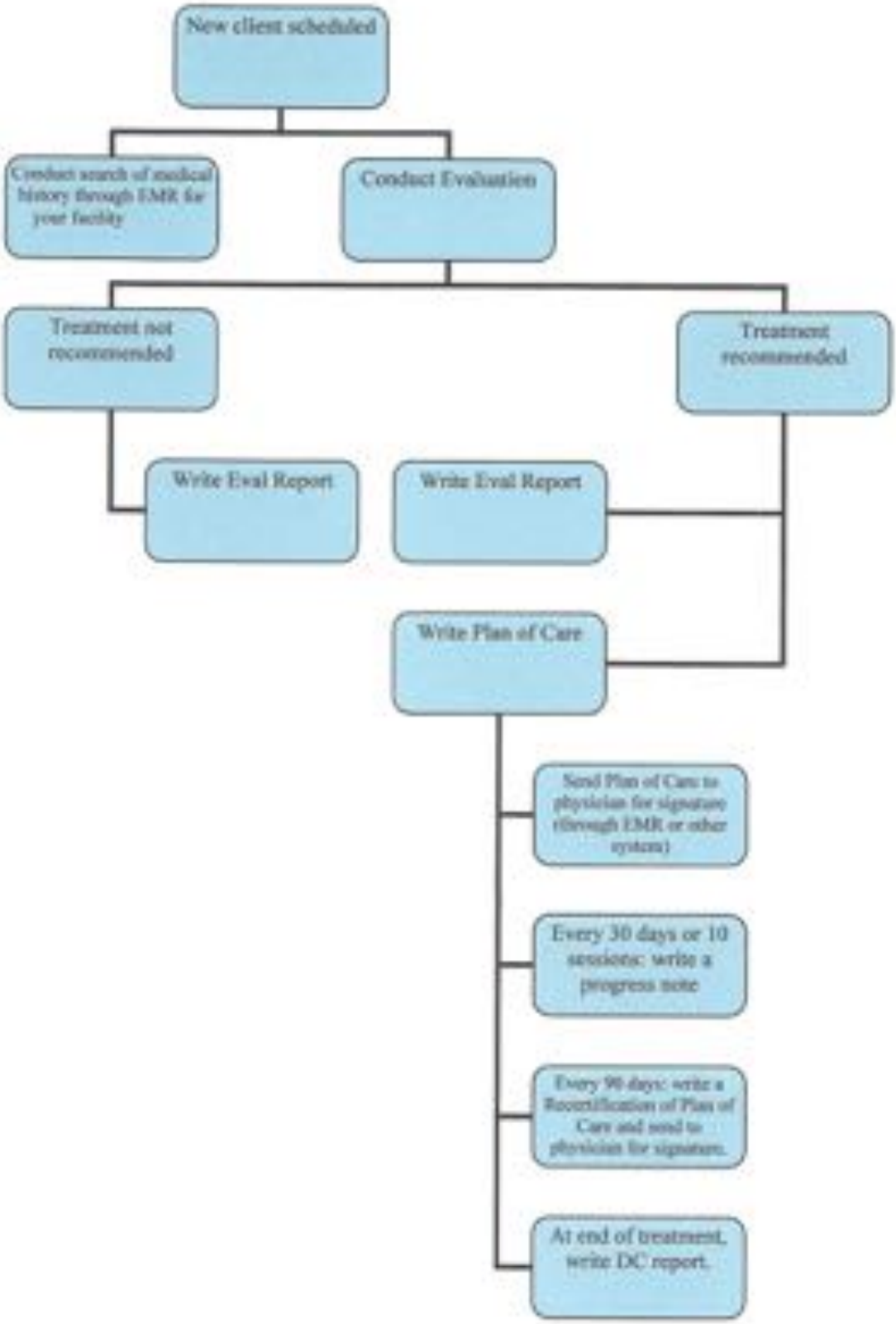
Progress Report/Recertification of Plan of Care: (PR completed every 30 calendar days, Recert of POC completed every 90 days)

- Identifying information, ICD-9 codes (medical dx and treatment dx)
- *Justification of Medical Necessity*
- *Statements of improvement/progress towards goals*
- *Any necessary modifications to long-term or short-term goals (measurable, functional, include anticipated duration, based on eval findings)*
- *Type, amount, frequency and anticipated duration of tx*
- *Discharge and Generalization planning*
- *Plans for continued tx*
- *Prognosis*
- E-Signature by SLP and Student (Dated)
- E-Signature of physician (Date)

Treatment Note: (completed after every tx session)

- Date, Time In/Time Out, Minutes of Service
- *SOAP*
- E-Signature by SLP and Student

Appendix C. Flowchart of Required Documentation



Appendix D. Documentation Worksheet

Client: use code until final version
DOB: blank until final version
Age: blank until final version
Date of Evaluation:
Date of Initial Treatment Session: Should not precede the date POC written
Date Plan of Care Written:
Primary Medical Diagnosis/ Treatment Diagnosis: should match ICD-9/10 codes
Primary/Referring Physician:
Reason for Referral: take from Eval Report

Long-term Goals for Duration of Treatment:
2-3 goals.
Think in terms of end of treatment (when these are met, they don't need treatment anymore).
Must be functional
Must be measurable in settings outside of therapy (involve caregivers in measurement if possible)

Short Term Goals for this Certification Period:
1-2 for each long-term goal
These would be the stepping stones toward reaching the long-term goals
Think in terms of 30-90 days (What can the client achieve in 30-90 days?)
Can be set to be reached in therapy sessions or outside of therapy
Must be measurable

Length/Frequency/Duration of Treatment:
How long will each session be?
How often will sessions occur?
How long do you think it will take to reach the long-term goals?

Prognosis:
How do you think they will do?
(Excellent, Good, Guarded, Poor)
(If you put Poor, should you really be doing therapy?)

Certification from : Date of initial tx session **through:** 90 calendar days later

Appendix E. Post Evaluation Treatment Planning Worksheet

Assessment Activity	Results	Areas of Strength	Areas of Need	Priority Level

Post Evaluation Treatment Planning Worksheet, Page 2

Area of Need (in order of priority)	**LT Goal**	**ST Goals**
1.		
2.		
3.		
4.		

**** LT Goals are written with the end-product in mind. Where will they be when treatment ends? Functional, generalized and measurable. Relay skills to be demonstrated in settings outside of treatment. Involve caregivers in the measurement as much as possible.*

**** ST Goals in outpatient medical settings target skills that can be achieved in 30 days. Functional, generalizable and measurable. These skills are the building blocks to achieving the long term goals. These skills begin in the treatment room and as the client progresses, transfer to other settings. Usually 1-2 ST goals for each LT Goal.*

*** Goals can be measured quantitatively and/or qualitatively for accuracy, level of assistance needed/level of independence or use of skills in all opportunities.*