Using the SBAR Format to Decrease Rehospitalization Rates

by Paula DeLorm, PT, DPT, CEEAA, COS-C

As health care costs continue to place a burden on the federal budget, rehospitalization rates have gained significant attention as a contributing factor to total patient spending. Legislation was developed with provisions that make changes to Medicare including those designed to reduce rehospitalizations.

Recent studies have described rehospitalization rates. Stephen et al. reported that rehospitalization rates vary by hospital, geographic area, and disease type and severity. It was also reported that 19.6% of Medicare fee-for-service beneficiaries were rehospitalized within 30 days. The Medicare Payment Advisory Commission (MedPAC) found that 17.6% of hospital admissions resulted in rehospitalization within 30 days of discharge. MedPAC reported that these rehospitalizations accounted for $15 billion of Medicare spending.

The Centers for Medicare and Medicaid Services (CMS) are making more information publicly available, further increasing attention on the area of rehospitalizations. Thirty-day readmission rates for hospitals nationwide are published on the Hospital Compare website. Information shows rehospitalization rates for heart attack, heart failure, and pneumonia compared with U.S. national averages.

Consumers may use Home Health Compare, another publicly available Medicare website, to help in selecting a home care agency. Home health agency outcome information is available on the Home Health Compare website with comparison of agency, state, and national rates.

Outcomes reported to the public on the Home Health Compare website are divided into five categories.

- Managing Daily Activities - improvement in ambulation/locomotion, transfers, and bathing.
- Managing Pain and Treating Symptoms - frequency of monitoring pain, treating a patient’s pain, decrease in pain with moving around, of treating heart failure symptoms, and improvements in breathing.
- Treating Wounds and Preventing Pressure Sores - improvements in surgical wounds, frequency of assessing risk of pressure ulcers, inclusion of treatment to prevent pressure ulcers, and frequency of taking physician-ordered action to prevent pressure ulcers.
- Preventing Harm - timely initiation of care, medication education, improvement in medication management, assessing fall risk, depression screening, flu and pneumonia immunizations, and foot care for diabetic patients.
- Preventing Unplanned Hospital Care - urgent care received and rehospitalizations.

It is important to be aware of the differences between the information reported on rehospitalizations between the two websites. Rehospitalization rates on Hospital Compare report 30-day readmission rates for hospitals, whereas Home Care Compare information reports 60-day rehospitalization from initial start of care.
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The attention that rehospitalization is gaining related to acute and post-acute level is motivating many home health agencies to look at ways to decrease rehospitalization rates. In addition, agencies are looking for ways to communicate more effectively with physicians when is they anticipate that a client may have emergent care needs.

HomeCare of Holland Home is a locally-owned, Christian-based, non-profit organization serving over 1,400 people every year in the Grand Rapids Michigan area. Holland Home provides skilled nursing, psychiatric care, and rehabilitation with special programs such as telehealth and lymphedema. Understanding the health complexities of older adults, HomeCare of Holland Home has become involved with a community post-hospitalization group looking at ways to decrease rehospitalization rates. The SBAR (Situation, Background, Assessment, Recommendation) format has been introduced at Holland Home as a communication tool for best practice in reducing avoidable rehospitalizations.

The SBAR format, originally used in the military and aviation industries, was developed for use in the medical community at Kaiser Permanente. SBAR is a standardized way of communicating information. It promotes enhanced patient care because it supports health care professionals in communicating with each other in a concise and structured format. This concise format improves efficiency and accuracy.

SBAR stands for:

- **S** = Situation (a concise statement of the problem)
- **B** = Background (pertinent and brief information related to the situation)
- **A** = Assessment (analysis and considerations of options — what you found/think)
- **R** = Recommendation (action requested/recommended — what you want)

The SBAR format used by Holland Home is found in Figure 1. The note template is entered into the electronic medical record and the clinician completes the form following the prompts. The Institute for Healthcare Improvement website contains some SBAR formats that have been adapted for specific settings.

The SBAR format has been used in hospital emergency departments, physician offices, operating rooms, and interdisciplinary teams in residential care. In a study by Andreoli et al, SBAR was implemented and evaluated for use in fall prevention and management in an inpatient rehabilitation setting and was shown to be an effective way to communicate urgent and non-urgent issues.

The SBAR – Communication Tool and Progress Note

<table>
<thead>
<tr>
<th>Situation</th>
<th>The problem being reported is related to:</th>
</tr>
</thead>
</table>
| Background | • Primary diagnosis on admission:  
• Medical history includes:  
• Most recent findings:  
• Vital signs:  
• O2 saturation (on O2 or not, via NC or mask):  
• Allergies:  
• Changes in mental status, neuro:  
• Recent falls:  
• Medication changes recently:  
• Advance directives:  
• Details about reason for call: |
| Assessment | • I think that the patient is:  
• OR I am not sure what the problem is, but the patient’s status is deteriorating. |
| Recommendations | I suggest or request:  
• Schedule visit by MD, NP, other disciplines:  
• Visit change frequency:  
• New lab, x-ray, pulse oximetry, urinalysis, telemetry, EKG or other test:  
• Medication changes:  
• Nutrition or fluid restriction changes/IV fluids:  
• Wound care changes:  
• Observe for and report to physician (patient specific parameters):  
• Other: |

Communicated to (physician’s name):

The goal of using the SBAR tool is to ensure that clinicians gather pertinent information and deliver it to the physician in a format that will allow him/her to make a decision about which issues can be handled in the home setting or physician office, thus reducing rehospitalizations.

By the end of September all clinical teams will have been introduced to using the SBAR tool at Holland Home. Clinical teams include Med-Surg, Mental Health, and Therapy.

Reports from clinicians indicate that it takes less than one minute to collect information and deliver pertinent information to physicians. The concise yet comprehensive information has been well received. One physician shared a scenario where a clinician called to request a prescription for a client, but the clinician did not have sufficient information to allow the

continued on Page 4
physician to order the appropriate medication. The physician requested additional information which required a second phone call and a delay in obtaining the medication. This delay could have been avoided by using the SBAR format.

HomeCare of Holland Home works to continuously make improvements on performance. Agency staff are regularly provided with outcome information as individual staff members compared to agency, state, and national rates. Recent implementation of the SBAR format for physician communication when hospitalization is anticipated is part of HomeCare of Holland Home’s improvement on performance for achieving best practice for reducing avoidable rehospitalizations. To determine effectiveness of the tool, impact on rehospitalization rates, and appropriate patient care management prior to rehospitalization each hospitalization is reviewed by the agency and community post-hospitalization group. By using the SBAR to communicate and collaborate with members of the home care team and other care providers, clients will receive the appropriate care in the appropriate setting.

**REFERENCES**

2. On March 30, 2010, the President signed into law H.R. 4872, the Health Care and Education AffordabilityReconciliation Act of 2010 (the Reconciliation Act, or HCERA; P.L. 111-152). The Reconciliation Act makes changes to a number of Medicare-related provisions in PPACA and adds several new provisions.
5. Hospital Compare website: http://www.hospitalcompare.hhs.gov/?AspxAutoDetectCookieSupport=1

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**Examples of documentation using the SBAR tool:**

**Therapy-related example:**

- **Situation:** client demonstrating increased edema and pain with clinical characteristics suggestive of DVT
- **Background:** Primary diagnosis - left Total Knee Arthroplasty 6 weeks prior, History – Allergies – none known, Recent falls – none, Medication changes – none recently, Lovenox discontinued after 10 days, Advance directives – DNR
- **Assessment:** Vital signs – BP 136/72, P 86, PO 97, R 18. Details about reason for call – client demonstrated local calf tenderness, warmth and tenderness, and a greater than 3 cm increase in edema on symptomatic leg
- **Recommendation:** obtain diagnostic Ultrasound

The next example is one more typical of nursing:

- **Situation:** PT/INR inconsistent results, signs and symptoms of bleeding
- **Background:** admitted to home care for atrial fibrillation, Allergies – Sulfa drugs, Recent falls – none, Med changes recently – Coumadin dosage decreased 5 days ago, Advanced directives – DNR
- **Assessment:** - Vital signs – BP 130/78, P 88, PO 96, R 18. Details about reason for call –PT/INR today 3.2, signs and symptoms of bleeding (hematura and bruising) indicate that result is correct, another test performed with resulting PT/INR 6.0
- **Recommendation:** obtain a peripheral blood draw to confirm accurate results and medication dosage decrease
I have not included an editorial piece in the last few editions of The Quarterly Report as loyal readers of the section’s newsletter are aware. This has been due, in part, to increasing business responsibilities at my agency, as much as the home care industry not having a “major event” to draw me back from my ownership activities. Well, that certainly changed in early October with the release of the Missouri Alliance for Home Care (MAHC) Fall Risk Assessment Tool (MAHC-10) validation study!

Like many other section members, my phone and email have been bombarded with this nationally-recognized event. The National Association for Home Care and Hospice (NAHC) has heralded the study, as well as its findings, on their website, stating, “The validity of the MAHC-10 developed by the MAHC Fall Prevention Benchmarking Initiative has been tested. Home Health Agencies may now use this single tool for their Outcome and Assessment Information Set (OASIS)-required patient fall risk assessment.”

Ken Miller, PT, DPT, Publication Committee member and Practice Committee Co-Chair for the Home Health Section, and I felt it extremely important to reach out to membership on this issue as this study gathers a “head of steam” and shows early signs of altering industry-wide practice in a way we have not realized since the inception of PPS-2011 therapy refinements on April 1, 2011. Unfortunately, we are not of the opinion that publication of the MAHC-10 validation study is quite the seminal event that it appears to be at initial glance. And it may, in fact, present agencies with more questions than answers.

That said, we first would like to applaud the efforts of authors Mary Calys, PT, DPT, Kendra Gagnon, PT, PhD, and Stephen Jernigan, PT, PhD. Completing a validation study to the rigor required for publication in a peer-reviewed journal is to be commended.1 However, we are concerned about the almost instantaneous change in practice patterns it appears to be producing in its first week of availability to the home health industry at large. We do not believe this industry “buzz” is in any way the responsibility or intent of the authors, as there has been a continuous push from the industry for validation of this, or any, multi-factorial fall assessment tool since the inception of the fall risk assessment process measure itself.

This “push” has only been intensified with the desire of agencies to score in the highest percentile of this process measure [OASIS M1910] on publicly reported outcomes [Home Health Compare] by completing a standardized, objective instrument that provides a cut-off score for fall risk to patients that are bed-bound, non-ambulatory and unable to transfer without assistance. In essence, those patients who cannot complete an existing instrument, such as the Timed Up & Go (TUG).

We would like therapists and the agencies where they work to look more closely at the psychometrics of the MAHC-10 validation study, as well as the discussion section of the article presented by the authors themselves. We encourage members to adopt a more disciplined approach to review of the literature for informed decision-making, rather than simply reading a press release or noteworthy statement on a listserv or website related to using the MAHC-10 as the single tool to determine fall risk in the home care population.

Why do we say this? First, look at the sensitivity and specificity for the MAHC-10 for the fall risk cut-off scores presented in the Calys article. Using a cutoff score of > 4 to determine the risk of falling, the sensitivity of 96.9% is impressive, meaning that it is able to identify almost 97/100 people (out of a hypothetical sample of 100 people who actually have a fall risk) as having a risk of falls. However, the specificity of 13.3% is very low, meaning that only 13 of 100 without having a fall risk would be accurately identified.

In plain terms, the test is able to identify the majority of people with a fall risk as having such a risk, while at the same time, shows a large percentage (87%) without having a fall risk as appearing to in fact have a fall risk! Calys, Gagnon and Jernigan stated, “The disproportionate ratio of sensitivity and specificity associated with this tool may increase the cost, resources, and burden in home health care to provide services to those identified as having fall risk that perhaps do not need fall-related interventions.” Thus, using the MAHC-10 at a cut-off score of > 4 as the sole test for screening for falls may lead to over-utilization of resources for those that do not need services for fall risk at all.
Perhaps using the MAHC-10 with the proposed cut-off score of 6 would have greater specificity and be more useful. The Receiver Operating Characteristics (ROC) curve shows that the greater the cut-off score is, the greater the specificity is at the expense of a lower sensitivity. The higher cut-off score of 6 yields a specificity of 46.9% which is much improved from 13.3%. However, the sensitivity is decreased to 68.7%, which is now much less sensitive, meaning that it will identify only 69/100 people (out of a hypothetical sample of 100 people who actually have a falls risk). In plain language, the test will miss 31 of 100 people who have a risk of falling! Is this an acceptable number? Are home care agencies going to be comfortable with knowingly missing 31% of potential fallers?

Second, falls are multifactorial and many experts in the industry have concluded that there is no single test that can accurately predict falls when used in isolation. We agree with this conclusion and recommend using multiple assessment tools when screening for fall risk. Tools with both high sensitivity and specificity to minimize false positives and false negatives can more accurately capture those at risk for falling. Contrary to the MAHC-10, the TUG instrument (using a cut-off of 13.5 seconds) has a sensitivity of 87% and specificity of 87% as determined by Shumway-Cook. Both sensitivity and specificity for the TUG are excellent for use as a fall screen tool. In order to provide best practice and use the evidence appropriately, we recommend continued use of the TUG instrument (or other validated instrument with good sensitivity and specificity) in conjunction with the MAHC-10.

Since its recent validation [MAHC-10 instrument], many in the industry are happy that they can now answer the OASIS-C item M1910 process measure [Multifactor Fall Risk Assessment Conducted for Patients 65 and Over] 100% of the time (including the bedbound, non-ambulatory patient). We would now ask, what is the purpose of the process measure? Is the goal for home care agencies to obtain 100% compliance on M1910? Or is the goal to perform a standardized, multi-factorial and validated screen to identify those at risk [provide best practice] and use the OASIS process measure item responses to develop and implement an appropriate plan of care (POC) based on the patient’s individual needs?

The March 2010 Process-Based Quality Improvement (PBQI) Manual published by CMS provides a clear explanation of the purpose of the process measures. CMS’ purpose of creating the process measures is to evaluate the rate at which a home health agency (HHA) uses specific evidence-based processes of care. CMS is looking not at the rate of use in a vacuum, but in relation to the use of specific evidence-based processes of care. CMS has stated, “...clinicians are reminded and encouraged to use specific evidence-based care practices. In addition, process measures can be helpful in assisting HHAs to assess the degree to which clinicians are implementing specific evidence-based practices that can affect clinical outcomes.” It seems, then, the intent of the process measures is to improve practice, not find the quickest and potentially “easiest” way to meet requirements, or achieve a 100% on a publicly reported outcome.

Knowing what you now know about the MAHC-10 tool’s psychometric properties, would moving to use of this instrument alone, as a measure of fall risk in our patients, make clinical sense? Would it demonstrate the level of professional and ethical practice to which we aspire? We don’t think so.

REFERENCES


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Diana (Dee), a physical therapist for twenty-four years, is the administrator and co-owner of Integrity Home Health Care, Inc., a locally-owned and operated Medicare-certified home health agency in Central Florida. Dee is nationally recognized as a speaker in the areas of home care, standardized tests and measures in the field of physical therapy, therapy training and staff development in the home health arena. She is the current Editor of the Home Health Section publication, The Quarterly Report, and may be reached by email: dkornetti@homewithintegrity.com.

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INTRODUCTION
Falls in the elderly population are epidemic. Falls are the leading cause of injury among adults aged 65 years and older in the United States. 1 in 3 older adults over the age of 65 years falls each year, with less than half of these individuals talking to their health care providers about it. According to the Centers for Disease Control and Prevention (CDC), an older adult will be treated in a hospital emergency department for injuries related to a fall in the next 17 seconds. In the next 30 minutes, an older adult will die from injuries sustained in a fall (Figure 1). Many older adults, although they have never experienced a fall, develop a fear of falling that results in the self-imposed restriction of normal activities, ultimately compromising their quality of life. People age 75 and older who fall are four to five times more likely than those age 65 to 74 to be admitted to a long-term care facility for a year or longer. In 2000, falls among older adults cost the U.S. health care system over $19 billion, or $23.6 billion in 2005 dollars. In 2010, the overall rate of nonfatal fall injury episodes for which a health care professional was contacted was 43 per 1,000 population. Persons aged ≥75 years had the highest rate (Figure 2). Having information on the economic burden of older adult falls can help make the case for funding prevention programs and reducing overall health care costs. Inclusion of a falls risk assessment process measure in the OASIS-C document appropriately focuses on this high-risk, high-volume, problem-prone area in the home health care setting.

M1910 - FALL RISK ASSESSMENT
Clinicians in the home health setting assess the patient’s risk of falls through the completion of (M1910) Falls Risk Assessment: Has this patient had a multi-factor Fall Risk Assessment (such as falls history, use of multiple medications, mental impairment, toileting frequency, general mobility/transferring impairment, environmental hazards)?

☐ 0 - No multi-factor falls risk assessment conducted.
☐ 1 - Yes, and it does not indicate a risk for falls.
☐ 2 - Yes, and it indicates a risk for falls.

*Lifetime medical costs refer to the medical costs (treatment and rehabilitation) associated with the fatal injury event.

* Per 1,000 population. † Annualized rates of injury episodes for which a health-care professional was contacted either in person or by telephone for advice or treatment. An injury episode refers to a traumatic event in which the person experienced one or more injuries from an external cause.
The intent of M1910 is to determine if the agency has assessed the patient and home environment for characteristics that place the patient at risk for falls. It is used to capture the agency’s use of best practices following the completion of the comprehensive assessment. Patients under the age of 65 will be excluded from the denominator of the publicly reported measure. Completion of this item occurs on both start of care (SOC) and resumption of care (ROC) time points.

To answer M1910 correctly, the fall risk assessment must have been completed by the clinician completing the SOC or ROC Comprehensive Assessment. For many agencies, this clinician is a non-therapist (nurse). It is accurate to select Response 0 if:

- a multi-factor falls risk screening was not conducted by the home health agency,
- a multi-factor falls risk screening was conducted by the home health agency but NOT during the required assessment time frame,
- a multi-factor falls risk screening was conducted during the assessment time frame, but by someone other than the assessing clinician.

To accurately select Response 1 or 2, the item must be completed by the home health agency during the CMS-specified time frames for completion of the comprehensive assessment (5 days for SOC; 48 hours following inpatient facility discharge, or knowledge of patient’s return home for ROC), and the clinician must complete a multi-factorial assessment of falls. This may require the incorporation of several tools.

CMS states, “for M1910, the agency can use a multi-factor, standardized, validated fall risk assessment tool, or alternatively, a standardized, validated performance assessment, like the TUG (Timed Up and Go) or Functional Reach Assessment, combined with at least one other factor, e.g. fall history, polypharmacy, impaired vision, incontinence, etc. to meet the requirements of the multifactor, standardized validated fall risk assessment.”

A validated instrument is one that:

1) has been scientifically tested in a population with characteristics similar to that of the patient being assessed and shown to be effective in identifying people at risk for falls; and
2) includes a standard response scale. The standardized tool must be both appropriate for the patient based on their cognitive and physical status and appropriately administered as indicated in the instructions.”

Until recently, this required the incorporation of at least 2 tools (e.g. MAHC and TUG) to ensure that determination of fall risk is accurately completed, as there did not exist one instrument that was comprised of multiple factors and had been statistically validated. When completing multiple tools, the determination of fall risk is based on the score on the validated instrument (Reference: OASIS Fall Risk Assessment Tool).

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**Plan of Care Synopsis: (Check only one box in each row.)** Does the physician-ordered plan of care include the following:

<table>
<thead>
<tr>
<th>Plan / Intervention</th>
<th>No</th>
<th>Yes</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Patient-specific parameters for notifying physician of changes in vital signs or other clinical findings</td>
<td></td>
<td></td>
<td>Physician has chosen not to establish patient-specific parameters for this patient. Agency will use standardized clinical guidelines accessible for all care providers to reference</td>
</tr>
<tr>
<td>b. Diabetic foot care including monitoring for the presence of skin lesions on the lower extremities and patient/caregiver education on proper foot care</td>
<td></td>
<td></td>
<td>Patient is not diabetic or is bilateral amputee</td>
</tr>
<tr>
<td>c. Falls prevention interventions</td>
<td></td>
<td></td>
<td>Patient is not assessed to be at risk for falls</td>
</tr>
<tr>
<td>d. Depression intervention(s) such as medication, referral for other treatment, or a monitoring plan for current treatment</td>
<td></td>
<td></td>
<td>Patient has no diagnosis or symptoms of depression</td>
</tr>
<tr>
<td>e. Intervention(s) to monitor and mitigate pain</td>
<td></td>
<td></td>
<td>No pain identified</td>
</tr>
<tr>
<td>f. Intervention(s) to prevent pressure ulcers</td>
<td></td>
<td></td>
<td>Patient is not assessed to be at risk for pressure ulcers</td>
</tr>
<tr>
<td>g. Pressure ulcer treatment based on principles of moist wound healing OR order for treatment based on moist wound healing has been requested from physician</td>
<td></td>
<td></td>
<td>Patient has no pressure ulcers with need for moist wound healing</td>
</tr>
</tbody>
</table>
If a patient is unable to complete the validated instrument component of the multi-factorial fall risk assessment, it is appropriate to answer Response 0 on M1910. At times, patients have not been able to complete this component, due to being bed bound, non-ambulatory or unable to transfer without assistance. In this case, CMS Q & A’s of April 2010 state, “For an assessment tool to meet the criteria for a ‘yes’ response on M1910, the assessment would need to have been validated as a tool that specifically measures risk for falls. If the patient is not able to participate in tasks required to allow the completion and scoring of the assessment(s) that the agency chooses to utilize, ‘0 – No multi-factor fall risk assessment conducted’ should be reported.”

(M2400) Intervention Synopsis: (Check only one box in each row.) Since the previous OASIS assessment, were the following interventions BOTH included in the physician-ordered plan of care AND implemented?

<table>
<thead>
<tr>
<th>Plan / Intervention</th>
<th>No</th>
<th>Yes</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>b. Falls prevention interventions</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Item M2250 – Plan of Care Synopsis identifies if the physician-ordered home health plan of care incorporates specific best practices. The “physician ordered plan of care” means that the patient’s condition has been discussed and there is agreement as to the plan of care between the home health agency staff and the physician. Item M2250 is composed of all the OASIS-C process measures, and scoring of M2250c – Falls prevention interventions – should incorporate the findings from the fall risk assessment process measure, M1910.

M2250c – Falls prevention interventions can be answered “Yes” prior to the receipt of signed orders if the clinical record reflects evidence of communication with the physician to include specified best practice interventions in the plan of care. Assuming all other OASIS information is completed, the Date Assessment Completed (M0090) then becomes the date of the communication with the physician to establish the Plan of Care that includes interventions listed in M2250. If the assessing clinician chooses to wait to complete M2250 until after discussion with another discipline that has completed their assessment and care plan development, this does not violate the requirement that the comprehensive assessment be completed by one clinician within the required time frame (five days for SOC, two days for ROC). For example, if the RN identifies fall risk during the SOC comprehensive assessment, the RN can wait until the PT conducts his/her evaluation and develops the PT care plan to determine if the patient’s Plan of Care includes interventions to prevent fall risk. The M0090 date should reflect the last date that information was gathered that was necessary for completion of the assessment.

If the physician-ordered plan of care contains specific interventions to reduce the risk of falls, select “Yes.” Environmental changes and strengthening exercises are examples of possible fall prevention interventions. If the plan of care does not include interventions for fall prevention, mark “No” for the applicable line, whether or not an assessment for falls risk was conducted. Select “NA” if the patient was not assessed as being at risk for falls. Completion of M2250c is not automatically dictated by the scoring of M1910. If an individual is scored “1” - Yes, and it does not indicate a risk for falls – on M1910, it may still be appropriate to incorporate other fall prevention interventions based on findings on the multi-factorial assessment (e.g. medication reduction, vision, home environment modifications).

Item M2400 – Intervention Synopsis identifies if specific interventions focused on specific problems were both included on the physician-ordered home health plan of care AND implemented as part of care provided during the home health care episode (at the time of the previous OASIS assessment or since that time). This item is completed on transfer to inpatient facility (with or without agency discharge) and on agency discharge (not to an inpatient facility).

For response “Yes” to be selected, the clinical intervention must have been included in the plan of care AND implemented at the time of the previous OASIS assessment or since that time. If the intervention was in the plan of care but not implemented, or if the intervention was implemented but not in the plan of care, select Response “0 – No”. In this case, the care provider should document rationale in the clinical record. Interventions provided by home health agency staff, including the assessing clinician, may be reported by the assessing clinician in M2400. For example, if the RN finds a patient to be at risk for falls, and the physical therapist implements fall prevention interventions included in the plan of care prior to the end of the allowed assessment time frame, the RN may select “Yes” for row b of M2400. The M0090 Date Assessment Completed should report the date the last information was gathered to complete the Comprehensive Assessment.

If the physician-ordered plan of care contains specific interventions to reduce the risk of falls and the clinical record contains documentation that these interventions were performed at the time of the previous OASIS assessment or since that time, select “Yes.” Environmental changes, strengthening exercises, and consultation with the physician regarding medication concerns are examples of possible falls prevention interventions. If the plan of care does not include interventions for fall...
prevention, and/or the there is no documentation in the clinical record that these interventions were performed at the time of the previous OASIS assessment or since that time, mark “No,” whether or not an assessment for falls risk was conducted. Select “NA” if a formal multi-factor Fall Risk Assessment indicates the patient was not at risk for falls since the last OASIS assessment.13

IMPLICATIONS FOR THE PHYSICAL THERAPIST
Completion of the M1910 fall risk assessment process measure by the OASIS clinician should trigger interdisciplinary communication to ensure that care coordination occurs between nursing and therapy to ensure falls prevention interventions are consistent with patient presentation. Incorporation of evidence-based interventions, consistent with current standards of practice, must be clearly documented in the patient’s medical record to meet current documentation expectations as outlined in the regulations of PPS-2011 therapy refinements. Agency-specific validated instruments for measuring fall risk for the 65 years and older home care client should be incorporated into the physical therapy assessment and subsequent reassessments to objectively quantify progress achieved through skilled therapy intervention. Utilization of a variety of standardized, validated instruments is appropriate (e.g. balance, balance confidence) to reinforce findings of the OASIS fall risk assessment item (M1910) and support therapist clinical decision-making.

REFERENCES
7. Graphic source: MMWR Quickstats. 02/03/2012
10. CMS OCCB Q&A. January 2010, pp 4-5. www.oasiscertificate.org
11. CMS OCCB Q&A. April 2010, questions 22,23. www.oasiscertificate.org

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Fact Sheet for Documenting Therapy Services in the Home Health Setting
by Ken Miller, PT, DPT

INTRODUCTION
The Home Health Section (HHS) of the American Physical Therapy Association has been sought out by membership to provide resources to the home health industry regarding the need for compliance with documentation requirements as put forth by the Department of Health and Human Services pertaining to coverage requirements in the Centers for Medicare and Medicaid Services Prospective Payment System Final Rule 2011. The HHS executive leadership has heard the call to be a voice for the industry and accepts this role enthusiastically.

The following fact sheet is a draft that is currently available to members through the Section website. We expect this document to evolve into a position statement urging home health industry software developers and service providers toward resources that support agencies and therapists in complying with current CMS documentation requirements. Once a position statement is adopted by the HHS Board of Directors, members will be provided with an opportunity to review and comment on the document. Once the open comment period has closed, the comments will be compiled and a final position statement will be drafted, approved and available for the target audience as listed in the document to assist all parties involved in home health to perform their functions with a patient-centered focus.

TARGET AUDIENCE
Clinicians (Physical Therapists and Physical Therapist Assistants); Agency Owners/Administrators; Paper and Electronic Medical Record designers/vendors; third party insurance payers; governmental agencies such as Health and Human Services Agency, Centers for Medicare and Medicaid Services and national/state home health care associations.

PURPOSE
This document serves to highlight the Code of Ethics for the Physical Therapist [Adopted by the APTA House of Delegates, in 2009 and Effective in 2010]¹ and the Guide for Professional Conduct [Amended by the Ethics and Judicial Committee of the APTA, in 2010]² with regard to physical therapists’ documentation and compliance with Centers for Medicare and Medicaid Services’ (CMS) Prospective Payment System (PPS) 2011 Final Rule Therapy regulations in both paper and electronic medical records (EMR).

CMS PPS 2011 FINAL RULE (THERAPY REGULATIONS)
The Medicare Benefit Policy Manual Chapter 7 contains CMS’ coverage requirements and regulations for home health services.³ Section 40.2 pertains to the requirements for skilled therapy services. “As described in section 40.2.1(b), at defined points during a course of therapy, the qualified physical ther-

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) OF 1996
The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) called for the establishment of standards and requirements for transmitting certain health information to improve the efficiency and effectiveness of the health care system while protecting patient privacy.⁴ HIPAA requirements initiated movement towards establishment and standardization of an electronic medical health record and electronic transactions related to billing.

HEALTH INFORMATION TECHNOLOGY FOR ECONOMIC AND CLINICAL HEALTH ACT (HITECH ACT) OF 2009
The HITECH Act of 2009 provided for further promotion of the use of electronic medical record documentation with the establishment of incentive programs and included standardization of the EMR and the players involved in the process.⁵ The HITECH Act further clarifies the protection of health information that is addressed in the HIPAA Act. The Act defined the term, “Health Information Technology”⁶ which means hardware, software, integrated technologies or related licenses, intellectual property, upgrades, or packaged solutions sold as services that are designed for or support the use by health care entities or patients for the electronic creation, maintenance, access, or exchange of health information. The term “enterprise integration” means the electronic linkage of health care providers, health plans, the government, and other interested parties, to enable the electronic exchange and use of health information among all the components in the health care infrastructure in accordance with applicable law, and such term includes related application protocols and other related standards.

Section 3001 of the Act established within the Department of Health and Human Services an Office of the National Co-
ordinator for Health Information Technology. The National Coordinator performs the duties under subsection (c) in a manner consistent with the development of a nationwide health information technology infrastructure that allows for the electronic use and exchange of information and that—“(1) ensures that each patient’s health information is secure and protected, in accordance with applicable law; “(2) improves health care quality, reduces medical errors, reduces health disparities, and advances the delivery of patient-centered medical care; “(3) reduces health care costs resulting from inefficiency, medical errors, inappropriate care, duplicative care, and incomplete information; (4) provides appropriate information to help guide medical decisions at the time and place of care; (5) ensures the inclusion of meaningful public input in such development of such infrastructure; (6) improves the coordination of care and information among hospitals, laboratories, physician offices, and other entities through an effective infrastructure for the secure and authorized exchange of health care information; (7) improves public health activities and facilitates the early identification and rapid response to public health threats and emergencies, including bioterror events and infectious disease outbreaks; (8) facilitates health and clinical research and health care quality; (9) promotes early detection, prevention, and management of chronic diseases; (10) promotes a more effective marketplace, greater competition, greater systems analysis, increased consumer choice, and improved outcomes in health care services; and (11) improves efforts to reduce health disparities.”

Item #3 above regarding incomplete information; item #4 regarding the provision of appropriate information to help guide medical decisions, and items #8 -11 all pertain to the PPS 2011 requirement of objective measurements and use of these measurements to determine effectiveness or lack thereof of the plan of care in decision making.

CODE OF ETHICS FOR THE PHYSICAL THERAPIST AND THE APTA GUIDE FOR PROFESSIONAL CONDUCT

The APTA Guide for Professional Conduct states, “The Code and the Guide apply to all physical therapists.” Given this definitive statement, all physical therapists are mandated to abide by the ethical code that was adopted in 2009. The Code and Guide serve to provide a framework by which physical therapists may determine the propriety of their conduct. The Code of Ethics contains 8 principles physical therapists must adhere to however, principles 3, 4, 5, and 7 are applicable to proper documentation and conformance to the PPS 2011 regulations.¹ ²

Principle #3: Physical therapists shall be accountable for making sound professional judgments.

It is the ethical responsibility of physical therapists to follow principle #3 and use sound judgment when documenting in the clinical record. It is not reasonable to cite principle #3 in order to argue that physical therapists “do not need to comply with the inclusion of objective test measures and adherence to the multi-

ple reassessment time points and content” if the paper or electronic medical record system templates do not include these required elements. The purpose of using objective measurements successively through the home care episode is to determine the efficacy of the interventions being provided and assists for making sound professional judgments.

Principle #4: Physical therapists shall demonstrate integrity in their relationships with patients/clients, families, colleagues, students, research participants, other health care providers, employers, payers, and the public.

The Home Health Section realizes that CMS regulations may change annually and understands that all parties involved in the provision of home care have challenges to maintain compliance with regulatory changes. Physical therapists, home health agencies, and Paper/EMR designers/software vendors alike need to demonstrate integrity in their relationships between and amongst themselves. Integrity is paramount within the relationship in order to ensure regulatory compliance. Where physical therapists are bound by the Code of Ethics, home health agencies and paper/EMR designers/software vendors are bound by their respective mission/vision statements.

Principle #5: Physical therapists shall fulfill their legal and professional obligations.

The Home Health Section believes that physical therapists are mandated to comply with CMS PPS 2011 requirements to follow their legal and professional obligation to practice physical therapy.

Principle #7: Physical therapists shall promote organizational behaviors and business practices that benefit patients/clients and society.

The Home Health Section believes that physical therapists should work together with home health agencies and paper/EMR designers/software vendors and other organizations involved in the home health industry for the purpose of promoting practices that benefit patients/clients and society. Organizational behaviors and business practices that focus on the best care of patients/clients and society as a whole is congruent with and mandated by principle #7.

CONCLUSION

All entities involved in the delivery of home health services are mandated by federal law [HIPAA, HITECH Acts, CMS PPS 2011, etc.]; state law [State Health Department] and are obligated to follow their respective accreditation agencies [The Joint Commissions], the Code of Ethics and Mission/Vision Statements. The Home Health Section seeks to be a home health industry leader to assist physical therapists, home health agencies and paper/EMR designers/software vendors and others in regulatory compliance. Specifically, the Section strives to assist physical therapists in complying with the documen-
tation requirements of CMS’ Prospective Payment System (PPS) 2011 Final Rule with regard to both paper and electronic medical records (EMR). We believe that collaboration between physical therapists, agencies, and others is critical for best practice and in the best interest of our patients/clients and society as a whole.

REFERENCES

Kenneth L Miller, PT, DPT is the clinical educator for Catholic Home Care and Good Samaritan Home Care where he provides staff development, continuing education and training to the rehab staff using best practice and evidenced-based practice tools. Dr. Miller is a recipient of the Home Health Section Research Grant and is currently involved in a RCT involving management of chronic heart failure in the home environment. He can be reached at kenmpt@aol.com or Kenneth.miller@chsli.org.

Combined Sections Meeting (CSM) in San Diego

by Tonya Miller, PT, DPT, COS-C

San Diego, here we come! We will be kicking off 2013 like only over 10,000 PTs and PTA can do! This year’s CSM is scheduled for January 20th - 24th in sunny San Diego. The Home Health Section’s programming will bring something for everyone. Whether you are a hands-on home health clinician, an aspiring industry leader, or just getting started in home health, this CSM will provide you with new skills to take back to your practice.

The Home Health Section programming starts off early with a two day pre-conference course focused on home health industry leadership. The “Therapy Leadership in Home Health: Building Your Executive Portfolio” will provide you with the tools needed to be a successful leader in your agency, as well as the tools to educate others about therapy leadership in home health. If therapy leadership is not your focus, our pre-conference course on Monday January 21st entitled “Strengthening Your Exercise Intervention: Effectively Using Theraband®” is sure to provide you with a practical take-home approach to strength training in the home health setting.

Regular programming will be from Tuesday, January 22 until Thursday, January 24th and will provide a range of topics from a two-part vital signs and auscultation series to regulatory updates and ethical discussion around key industry issues. There will also be programming focused on other clinical areas such as intervention for individuals with vestibular issues. And of course, no Home Health Section programming would be complete without a few OASIS-focused educational courses.

As always, we have some fun-filled evenings planned, starting with our roundtables meet and greet series on Tuesday from 6 pm until 9 pm. This session provides members with a chance to network and discuss key issues facing home health therapists. It is a great way to reconnect with other members and a terrific way for new members to get to know others in the section. The Home Health Section business meeting, which meets on Wednesday evening from 6-8pm, provides members with an overview of the section’s strategic plan and accomplishments throughout the year. Additionally, awards are given to outstanding section members. This session is informative and a great way to find out how you can become a more active member of the section.

San Diego is a beautiful city with the average annual temperature of 70 degrees, a welcome January break for all of us in the eastern and northern parts of the country! Just the weather alone should be enough to bring you to CSM this year! If you add great programming, wonderful networking sessions, and an amazing city to explore, there is really only one option: register for CSM 2013!

See you in San Diego!!!

Tonya Miller is the Central PA/ Maryland Regional Director and the Director of Rehab Education and Program Development for Celtic Healthcare, administering both hospice and home health care divisions, and supervising a multi-state interdisciplinary team. She is also Vice President and Program Chair for the Home Health Section. She may be reached by email: miller@celtichealthcare.com.
Home Health Bad News: Are you Prepared to Respond?

by Bud Langham, PT, MBA

Have you seen home health in the news lately? Your patients and referral sources probably have, and you shouldn’t be surprised when they seem a bit suspicious of our industry generally or your agency specifically. Frankly, it is a very reasonable reaction to all the press releases from the Office of Inspector General (OIG) and the Department of Justice (DOJ) in the past year or two. See the table below for some of the alleged fraud in home health.

Just to be clear, this is a short list of recent Department of Justice activity surrounding the home health industry. I suppose if I were to include all the cases or press releases, my editor would be hard pressed to get it all in the publication! If you are inclined, try entering “home health” and “department of justice” into your Google search bar and read the troubling articles yourself.

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<th><strong>Home Care Yields Medicare Bounty – Wall Street Journal, April, 2010</strong></th>
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<td>This article appears to have elevated suspicion of home health agencies and paved the way to the therapy reassessment rule. The author questioned the therapy practices of the publicly traded home health companies. Specifically citing the shift in number of therapy visits per episode following the 2008 change in Medicare home health reimbursement policy.</td>
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<th><strong>Dallas Physician Accused of $375 Million in Medicare Fraud – February 2012</strong></th>
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<td>Dr. Jacques Roy, 54, and six associates have been accused of paying recruiters $50 for each Medicare beneficiary they signed up for home health services they never received. In some cases it appears they recruited homeless individuals for the scheme.</td>
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<th><strong>Home Health Care Administrator Sentenced to 20 Months in Federal Prison – Aug, 2012</strong></th>
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<td>The defendant admitted that from January 2007 through April 2010, she and her husband falsified documents in order to increase payments received from Medicare. The falsifications made patients appear to be sicker than they actually were and in need of greater care than they actually required. The defendant also admitted that she knowingly assisted her husband in paying cash kickbacks to a Chicago doctor. The kickbacks were paid in return for the doctor referring patients.</td>
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<th><strong>Four Individuals Charged in Detroit for Alleged Roles in Medicare Fraud Scheme – Sept, 2012</strong></th>
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<td>Four individuals were charged for their participation in a Medicare fraud scheme involving home health services. The scheme allegedly involved a total of more than $1.6 million in fraudulent claims submitted to Medicare for home health services that were medically unnecessary and/or never provided. All four defendants were arrested.</td>
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<th><strong>Owner of Miami Home Health Company Pleads Guilty in $60 Million Health Care Fraud Scheme – Aug, 2012</strong></th>
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<td>In a $60 million home health Medicare fraud scheme, the defendant pleaded guilty to one count of conspiracy to defraud the United States and to receive health care kickbacks.</td>
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<th><strong>Tennessee-Based Home Health Care Provider &amp; Related Entities Agree to Pay More Than $9 M to Resolve False Claims Act Lawsuit – Aug, 2012</strong></th>
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<td>The defendants agreed to pay $9.375 million to the federal government. This payment is to resolve the lawsuit that the United States filed in 2009 alleging that they violated the False Claims Act, caused Medicare to pay out money through mistake of fact, and were unjustly enriched by falsely concealing the home health agencies’ relationship with their management.</td>
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<tr>
<th><strong>OWNERS OF TWO CHICAGO HOME HEALTH CARE AGENCIES AND THREE DOCTORS AMONG 10 CHARGED IN ALLEGED MEDICARE KICKBACK SCHEMES – June, 2012</strong></th>
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<td>Ten defendants, including the owners of two Chicago home health care companies and three physicians were indicted for allegedly participating in two separate schemes to pay and receive cash kickbacks in exchange for the referral of Medicare patients for home health care services.</td>
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How are we to respond to these press clippings? You better have a response prepared because patients and referral sources want to be reassured that they are working with agencies that will not be subject to DOJ investigations. They want to know they are working with reputable home health businesses that are doing the right things for their patients and adhering to Medicare regulations.

Recently the Office of Inspector General (OIG) published a report entitled “Inappropriate and Questionable Billing by Medicare Home Health Agencies”. Due to the influx of information about the vulnerabilities of the Medicare home health benefit to fraud, waste, and abuse, the OIG felt it necessary to perform data analysis in an effort to identify inappropriate billing. They included claims from 2010 in their analysis. Findings included:
In addition to the five recommendations the OIG gave to CMS, the report also stated that the OIG would share the information from the report, as well as the names of the home health agencies with questionable billing, with MACs and RACs as they prioritize their work in the future in deciding what claims to review.

What does all this mean to you? Whether you are a field clinician, a supervisor, or an executive you must be aware of this information and the public perception of our industry. I suspect most of the agencies identified in this report as having questionable billing can absolutely justify their practices. I truly believe it is beneficial to shine a light on irregular practices in any industry. This places an additional burden on HHAs and home health professionals to defend the care we’ve provided or correct practices that are out of line.

Additionally, the OIG and CMS have been quite transparent in revealing at least some of the methodology they will use going forward to determine which HHAs merit increased scrutiny. This is highly actionable information. The day after the OIG report was released my organization had already utilized the document to do a complete analysis of our own agencies in an effort to determine whether or not we had any exposure to additional scrutiny. Your organization can and should do the same. HHAs must remain diligent in the process of self-examination. Operational audits, clinical audits, and compliance audits should be highly valued and closely reviewed. I highly recommend HHAs have internal discussions about the press releases mentioned in this article in addition to the OIG report. If you don’t see any momentum in your agency along these lines, reach out to your supervisors with the information and initiate the discussion. These are industry problems, as such they impact not only HHAs, physical therapists, and physical therapist assistants, but they eventually impact Medicare beneficiaries’ access to the home health benefit. Let’s all take proactive steps to protect this critically important and too often misrepresented Medicare benefit.

To read the entire OIG report on inappropriate and questionable billing enter the following address into your browser: http://oig.hhs.gov/oei/reports/oei-04-11-00240.asp

Bud Langham, PT, MBA, COS-C, is Chief Clinical Officer for Encompass Home Health, Inc. a leading provider of home health, hospice, and pediatric services in Texas, Oklahoma, Colorado, New Mexico, Utah, Idaho, and Oregon. Bud’s office is in Dallas, TX at the EHH home office. He welcomes comments and can be reached at blangham@ehhi.com.
Snake Oil:
When Advertising Claims Cross the Line

by Robin Childers, CAE

Cure-all elixirs, commonly known as “Snake Oil”, have been around since at least the 19th-Century when travelling medicine shows promoted remedies salesmen claimed could cure anything from hair loss to gun-shot wounds. Things haven’t changed much as many of today’s advertising claims test the boundaries not only of what is believable, but what is legal or ethical.

The physical therapy profession isn’t exempt from its share of Snake Oil charlatans as illustrated by a mid-September discussion on the Home Health Section listserv about the tactics used by some professionals to promote their services through advertisements and websites. 1 Problems arise when professionals make unfounded and unsupported claims about the benefits specific therapy interventions may provide patients or when the professional uses strategies designed to scare or threaten customers into compliance. In many of these cases, the professionals who stretch the truth about the benefits of their services or products, or who use questionable campaign methods to recruit customers, are also talented at skirting liability. They often know exactly where the boundaries lie. We can’t accuse them of anything more than bad taste, poor judgment, or a failure to distinguish between what is right and what is legal.

Fortunately, the Snake Oil promoter isn’t the only category for professionals who mislead clients and potential clients with questionable promotions. Some professionals may simply be uneducated, uninformed, or merely oblivious to the impressions they’ve left.

As an individual professional, you have some power to influence how physical therapy services are promoted. As a health care practitioner, you also bear some responsibility for protecting the public from fraud within your own profession.

When you encounter therapy promotions you feel are questionable, ask questions of the right people, and if warranted, take action. You may be disappointed by a lack of consequences if the advertisement doesn’t violate law or professional standards, but you might also be pleasantly rewarded by results with the quick disappearance of the offending ad or website.

Here are some action-oriented options for confronting physical therapy advertisements or promotions you believe are misleading or fraudulent:

CONTACT YOUR STATE LICENSING BOARD
The scope of practice for physical therapists and physical therapist assistants is defined in individual state practice acts; likewise what is allowed or not allowed in professional advertising, if addressed at all, is also covered by individual states (it may be part of the practice act or elsewhere in the state’s code). The state in which an individual professional practices empowers that individual to practice through the licensing process. As a consequence, when you have questions or concerns about the legality of how an individual professional is practicing (or advertising/promoting his or her practice), contacting the state licensing board for the state in which the professional practices is a good starting place.

It’s a good idea to be familiar with the physical therapy practice act and related rules in your state. You might be surprised by what’s included. Most state licensure regulations are available online. The Federation of State Boards of Physical Therapy (FSBPT) provides links for most state licensing entities: www.fsbpt.org

CONTACT YOUR STATE CHAPTER OF THE APTA
When Home Health Section members recently questioned the claims on a website owned by an Indiana-based physical therapist, my first call was to the Indiana Chapter of APTA. I provided the Chapter Executive Director with information about the site and my questions about it. Within a couple of hours, the Chapter had forwarded the issue to their legal advisor who had some immediate concerns related to the website and Indiana physical therapy advertising regulations. At the time of this writing, the website is being reviewed by the Indiana PT Committee (Indiana’s licensing entity).

State Chapters are generally intimately familiar with the state physical therapy act and related rules. They often play a critical role in bringing complaints forward to the state board and in monitoring complaints. They may also have legal resources at their disposal to investigate complaints. Your State Chapter may already have investigated the issue or advertiser in question and they can provide you with relevant information that may save you time and energy.

CONSUMER PROTECTION
Most state governments include an office of consumer protection although it may operate under a different name (consumer protection often falls under a state’s Department of Justice). When you don’t know where else to start with regard to questionable professional advertising, the consumer protection office may be able to offer you direction.

BEETTER BUSINESS BUREAUS
Although your area Better Business Bureau (BBB) is not the best place to start in registering a complaint related to a pro-
fessional’s advertisement or promotion, they can be good options for dissatisfied consumers. The BBB focuses on resolving complaints between consumers and businesses. It would be appropriate for you to refer a consumer to the BBB in a case where a consumer (patient) appears to be a victim of poor business practices rather than illegal or unethical behavior.

ETHICS & PROFESSIONALISM
When your questions about a physical therapy advertisement, promotion or website are more ethical in nature than legal, make use of APTA’s ethics decision-making tools. These tools assist members in determining when an ethical violation exists and provide you with steps to address it.

In addition to some of the options above, where local trends emerge in therapy advertising that harm the profession or pose risks to the public, it may be time to advocate for change through your State Chapter, state physical therapy licensing board, or in cooperation with your state legislators.

REFERENCES
1. Home Health Section listserv relevant message thread: http://finance.groups.yahoo.com/group/hhs-members/message/10406

RESOURCES
APTA Core Documents: http://www.apta.org/CoreDocuments/
- PT Code of Ethics:
- Guide for Professional Conduct
- Professionalism in Physical Therapy

APTA’s tools related to disputes or complaints (also provides information about APTA’s ethics process): http://www.apta.org/Ethics/Disputes/

Federation of State Boards of Physical Therapy > State licensing authorities, practice acts, and practice rules: https://www.fsbpt.org/LicensingAuthorities/index.asp

Better Business Bureau: www.bbb.org

Robin Childers is a certified association executive (CAE) with more than twenty-years of experience managing professional and trade associations. She is Executive Director of the Home Health Section and may be reached through the Home Health Section office.

TRUTH IN ADVERTISING HOT BUTTON: PHYSICAL THERAPY TERM & TITLE PROTECTION

With regard to truth in advertising, one of the greatest problems the profession of physical therapy faces is the use of the term “physical therapy” and the title “physical therapist” (including “PT”) by people who are not licensed physical therapists. In many states, only physical therapists may provide physical therapy and only physical therapists may refer to themselves as PTs. Some states allow billing for physical therapy only where the service has been provided directly by or under the direct supervision of a physical therapist.

Where does your state stand in term and title protection?

APTA Term & Title Protection Resources: http://www.apta.org/TermProtection/

NEW RESOURCE DOCUMENTS ON THE WEBSITE

The Home Health Section Practice Committee has provided a number of practical resource documents now available FREE to Section members and Partners on the Section website.

- Achieving OASIS-C Accuracy: Functional Scoring by Jonathan S. Talbot, PT, MS, COS-C; Diana Kornetti, PT, MA
- Goal Writing Guidelines for Home Health Therapists by Dee Kornetti, PT, MA, HCS-D, COS-C, Ken Miller, PT, DPT and Jonathan Talbot, PT, MS
- Fact Sheet for Documenting Therapy Services in the Home Health Setting by Ken Miller, PT, DPT (also published in this issue of The Quarterly Report on Pg. 11)
- Achieving Skilled Therapy Documentation during Routine Treatment Visits by Jonathan S. Talbot, PT, MS

Scan the QR code at left to go directly to the webpage for Practice Resource Documents. Members and Partners, you’ll need to login.

These documents are also available for purchase by non-members through the Section online store.
Medication Corner: by Stephanie Miller, PT

Medications & Falls

So, you walk into your patient’s home. What do you typically do first? You ask, “Is there anything new since my last visit? Any new falls? Any medication changes?” Does that sound about right? It’s not coincidence that we pair up these questions. Falls and medications or medication changes are all too commonly related, especially in the geriatric home care population.

Studies have shown that in community-dwelling older adults, falls occur 30-60% of the time. Five to 10% of falls in the elderly result in serious outcomes, such as fractures and head injuries, with 20% of patients suffering from hip fractures resulting in institutionalization or death. There are many factors influencing the prevalence of falls in the elderly. Some of the most common include visual deficits, increasing age, cognitive impairments, gait/balance deficits, and dizziness. Medications may also be a major factor in increasing falls risk in the geriatric home care population. Many medications can influence the prevalence of falls, but studies have narrowed down a few specific classifications of drugs that have the greatest impact. Of that list, I will be discussing the following three: benzodiazepines, antidepressants, and sedatives.

Benzodiazepines are commonly prescribed to treat anxiety, but may also be used for their sedative properties, as muscle relaxants, and as anticonvulsants. These medications function through enhancing the effect of gamma-aminobutyric acid (GABA), an inhibitory neurotransmitter in the central nervous system (CNS) regulating the excitability of the nervous system. Examples of benzodiazepines include: lorazepam (Ativan), clonazepam (Klonopin), alprazolam (Xanax), and diazepam (Valium).

Although there are definite benefits to the prescription of benzodiazepines, caution should be taken when prescribed to the elderly population. Older patients are more sensitive to the negative effects of these drugs, such as impaired memory and coordination, increased sedation, and therefore, are at an elevated risk for falls. If use of these medications is necessary, it is recommended that they be prescribed in low doses and for short durations. Alternative medications are recommended when appropriate.

Antidepressants are prescribed for mood disorders, like major depression, as well as anxiety and social disorders. They function through influencing how certain neurotransmitters affect the brain, primarily serotonin and norepinephrine. Common side effects noted in patients taking antidepressants are insomnia, nocturia, daytime drowsiness, and orthostatic hypotension, all of which can contribute to elevated falls risk in our patient population. There are a few major categories of antidepressants, each acting slightly differently. Two common ones are selective serotonin reuptake inhibitors and monoamine oxidase inhibitors.

Selective serotonin reuptake inhibitors (SSRIs) reduce the ability of neurons from taking back the released serotonin, making more serotonin available in the synapse, thereby reducing symptoms of depression. Examples include: citalopram (Celexa), escitalopram (Lexapro), paroxetine (Paxil), fluoxetine (Prozac), and sertraline (Zoloft).

Monoamine oxidase inhibitors (MAOIs) disrupt the action of the enzyme MAO, allowing increased amounts of neurotransmitter in the synapse, thereby increasing concentrations of serotonin, norepinephrine, and dopamine in the brain and reducing symptoms of depression. Examples of MAOIs include: phenelzine (Nardil), tranylcypromine (Parnate), isocarboxazid (Marplan), and selegiline (EMSAM). This category of antidepressants is less commonly prescribed due to their potential interactions with other medications and foods.

Sedatives are a third classification of medications that can increase the risk of falls in the geriatric home care population. Sedatives are prescribed commonly to treat panic attacks, pain, insomnia, and anxiety. They work by depressing the central nervous system; thereby slowing normal brain function. As mentioned previously during the discussion of benzodiazepines, sedatives also have an effect on the neurotransmitter GABA. A relaxing effect is produced by these medications through increasing GABA activity. Side effects can include feeling lightheaded or faint, blurred vision or double vision, confusion, and drowsiness and dizziness. Examples of common sedatives include: Barbiturates, such as phenobarbital (Luminal); benzodiazepines as mentioned previously; non-benzodiazepines, such as eszopiclone (Lunesta) and zolpidem (Ambien); and antihistamines, such as Phergan and diphenhydramine.

Diagnoses of anxiety, depression, insomnia and painful conditions in the geriatric home care population are very common. The drugs mentioned above will be seen consistently during medication reconciliation. We, as physical therapists and physical therapy assistants, are performing falls assessments...
on a regular basis and have great insight on the true falls risk of our patients. If we see these medications are part of a patient’s medication list and we also have assessed the patient to be at a high falls risk, there are a number of steps we can take. One is to consult the physician and express concern that the patient is at risk for falls and is also on medications that further predispose them to greater risk. If nursing is not on the case, a second option is to request a nursing referral for medication review and express your concerns to the nurse through interdisciplinary. The nurse may be able to discuss with the physician other options that can treat the patient’s diagnosis without putting the patient at increased risk for falls. A third step that is often forgotten is consulting the patient’s pharmacist. Pharmacists are often underutilized in their ability to assist us in the home setting. We can express our concern to them and they can also consult the physician with a level of expertise that cannot be overlooked when it comes to medication questions/concerns.

Other referrals that might benefit our patients in these situations include mental health nurses (MHRN) and medical social workers (MSW). An MHRN can assist by providing coping strategies and other techniques that may reduce the amount of medication a patient may require at a given time. MSWs can also assist with providing information on community resources, such as local counseling groups and assistance with household ADL’s that may relieve some feelings of being overwhelmed and improve organization or reduce stress in the patient’s life.

Our patients have often experienced loss at some point in their lives, have fears for the future, and have chronic conditions that may be quite painful and challenging. They will continue to have diagnoses that may be untreatable with anything other than the above medications. What we need to do is recognize which medications predispose our patients to falls, combine that information with outcomes of evidence-based falls assessment tools, and consult physicians, nurses, and/or pharmacists to express our concern. It is our specialty to provide education on home modifications to reduce falls risk, provide balance activities and home exercise programs to strengthen postural muscles, but it is sometimes challenging to discuss our concerns about medication side effects because medications are not our specialty as they are for other disciplines. I know this from firsthand experience. I do not claim in any way to know everything about medications; I don’t now and I never will. However, there are certain things I am capable and responsible to recognize and I am, first and foremost, my patient’s advocate. It is our job to be the best advocate we can be to keep our patients safe in their homes and I hope that you now feel more confident to do just that.

REFERENCES


Stephanie Miller, MSPT is a staff PT at Celtic Health Care and a member of the Home Health Section. She may be reached by email at millersm@celtichealthcare.com.

Home Health Section - APTA • Fall 2012 19
Meet the Candidates

Elections for Home Health Section offices will open on November 1st and close November 30th. The terms for newly-elected officers and the newest Nominating Committee member will begin following Combined Sections Meeting (CSM) in January. All terms are three years in length.

With the exception of students, all Home Health Section members are eligible to participate in the elections. Online voting takes just minutes and your participation is needed.

Please take a moment to get to know the candidates by reviewing the statements published below.

Election details, as well as candidate statements, are also available on the Home Health Section website.

FOR SECTION PRESIDENT

Cindy Krafft, PT
Peoria, Illinois

Biographical Statement
I have spent 17 of my 20 years as a physical therapist working in, with and for the home health industry. My current position as a consultant and educator has allowed me to interact with many levels with home health agencies as well as CMS as an advocate for physical therapy.

I live in central Illinois with my husband and 4 children. One of them recently decided to be a PT and is in his freshman year of college. My youngest, who is in 8th grade, has announced she wants to be a PT for dogs and has been researching that area of practice. I think this is related more to the recent addition of a beagle to our family than anything I may have said.

Candidate Statement
It has been my privilege to serve the Home Health Section in various capacities over the last 8 years. Each opportunity has helped me better understand issues within the profession as well as the industry. As your current President, I see that the vision of the future of therapy in home health has to take into consideration a wide variety of issues and concerns while maintaining our intense desire to serve patients who need us the most. The need for defined and consistent roles, responsibilities and process is imperative for long term viability and success and our recent strategic planning efforts are going to serve the Section well for years to come.

Leadership success requires members who are active and engaged and our Section and you have continued to step up to and at times over the plate in the areas of regulation, practice and advocacy. As we look ahead at health care reform and APTA Governance discussions, we need to stay “at the table” with a clear message while being open to consider new options.

My first term as President was not perfect but each new challenge creates an opportunity to grow. My commitment to serve each one of you has not wavered and I would be honored to continue in that role for another term. I welcome feedback.

FOR SECTION TREASURER

Beth Black, PT, GCS
Albuquerque, New Mexico

Biographical Statement
I have been a physical therapist for 19 years with a previous work history in business management and social work. I have worked as a homecare PT for the last 17 years. With my current company, I have had multiple roles including clinical work, quality assurance and audits, clinical informatics, documentation and program development, and staff training. My agency is a non-profit hospital-based homecare and hospice and one of the largest homecare agencies in the state.

Throughout my PT career I have been active in APTA, starting out with leadership positions in the New Mexico Chapter at District level, New Mexico Chapter Board of Directors, four years as Chapter Treasurer and most recently 7 years as chief and delegate to the House of Delegates. I have been a member of the Home Health Section the entire 17 years I’ve worked in homecare, becoming more active in the last seven years, including promoting section membership at New Mexico APTA chapter and state homecare association meetings, attending all CSMs and a few Annual Conferences. In addition, I have participated in the Home Health Section’s Finance Committee (2007-present) and Government Affairs committees (2009-present). I continue to be active in other APTA sections, the state homecare association and New Mexico Falls Coalition.
My primary areas of professional interest are fall prevention, hospice and palliative care, public health, and ethics.

Candidate Statement
My background in section, national APTA, and chapter leadership combined with my varied work experience has prepared me for the position of Home Health Section Treasurer. The Treasurer duties include being in charge of the Finance Committee and a member of the Executive Committee which are two very important but diverse responsibilities. With the APTA Governance Review in process and potential changes being discussed affecting our section, my participation last year as a member of the Governance Review on Sections Task Force has provided me with knowledge of the issues and the ability to assist in supporting the section and meeting members’ needs. As a previous New Mexico Chapter treasurer and current Home Health Section Finance Committee member, I am familiar with preparing and following budgets, the need to be organized and the importance in education of membership to be knowledgeable of our resources. My work experience in business management and social work before I became a physical therapist enhances my skills in clinical and business management. I am a strong advocate for our profession and for rehabilitation services in home health and hospice.

The Home Health Section is fortunate to have been financially sound for many years due to the exemplary work of previous leadership. We have increased membership and non-dues income, with a balanced budget. As a financially strong section we can continue to promote our leadership and expertise as leaders in home health.

Chris Chimenti, PT
Ontario, New York

Biographical Statement
I received my Bachelor of Science in Molecular Biology in 1994 from Grove City College in western Pennsylvania. In 1997, I earned my Master of Science in Physical Therapy from Slippery Rock University in the same region of Pennsylvania. Immediately following graduation, I accepted a position with Novacare Outpatient Rehabilitation in Crowley, Louisiana where I spent two years treating a variety of patients across a wide age span.

After meeting my wife who is also a P.T., we decided to relocate closer to home in the northeast to raise our family. I joined HCR Home Care in Rochester, New York in 1999 as a staff home health care Physical Therapist. In August 2002, I received a promotion to Therapeutic Services Program Manag-
er, and in May of 2006, was appointed Director of Therapeutic Services. My goal has always been to foster a culture of professional development with our organization, with a particular focus on best practice and skill development opportunities.

As a leader, my intent is always to promote autonomy, job satisfaction, and individual success. My research interests lie in the area of home health care practice, with a particular focus on using evidence to drive successful outcomes. I have conducted a number of studies throughout my career across a variety of special interest areas including falls prevention, Parkinson’s Disease management, and total knee replacement rehabilitation. I have presented on various research topics at both regional and national conferences.

In my personal time, I enjoy spending time with my wife Kelly, our 8 year-old son Brady, our 6 year-old daughter Allie, and our 13 year-old yellow lab Tahoe. Biking, fitness training, hiking, fishing, boating, and enjoying camp fires by our backyard pond are among our favorite things to do together.

Candidate Statement
Over the years, we have seen a number of changes occur within our industry. Mounting regulation, diminishing reimbursement, and growing documentation demands continue to bring unique challenges to our day-to-day work. If I were to be elected as Treasurer and join the Executive Committee, my intent would be to continue to advance our Section to a position of influence with CMS and other decision-making entities that impart control on our professional practice. We have many challenges ahead, but with strong, experienced leadership and a robust strategic plan, we can continue to represent our interests at the national level and serve as the go-to resource for those pursuing information about home care physical therapy practice.

I have served as Chair of the Research Committee for nearly 7 years now and have contributed to the Section in a number of different ways. I have personally witnessed tremendous growth in membership and unparalleled development of quality in member benefits. It is important to keep this momentum going and I feel well-equipped with the knowledge and experience to provide the necessary contributions. As Director of a large therapy team in a successful organization, I have many years of experience in managing budgets and allocating resources to key strategic initiatives. I am confident that the skills I have gained in financial management will create a seamless transition to the role of Treasurer and continue the Section along the path of sound financial health and accountability. As Chair of the Finance Committee, I will commit to timely financial reporting and assumption of any duties delegated by other members of the leadership team. The current and past members of the Executive Committee have established a solid framework for successful leadership. If elected, I will commit the necessary time and energy to ensure the Section continues to deliver optimum service to membership.
Biographical Statement
My physical therapy career began in 1999 after I graduated from Boston University. The majority of my career has been in the home health environment with experience in skilled nursing facilities and outpatient orthopedics.

When I am not working, I enjoy spending time with my wife Stefanie. Together, we are a puppy-raising family for The Seeing Eye. It is our great joy and privilege to be given a tiny puppy and return it to The Seeing Eye about a year later ready to be trained as a guide dog for a person with impaired vision.

I also am an active member of both the Pikesville Volunteer Fire Company and the Pleasant Hill Volunteer Fire Company. For both agencies, I assist in staffing the ambulance and hold certification as an emergency medical technician. From 2006 to 2011, I was treasurer for the Pikesville Volunteer Fire Company.

Candidate Statement
For the past five years, I have been a member of the Home Health Section’s Finance Committee. As a member of this small group, I have participated in forming the Section’s budget and contributed to investment decisions for HHS. Through the efforts of the current treasurer and the Finance Committee, the finances of the Home Health Section have been well managed for quite some time now.

It is my hope to leverage my experience on the Home Health Section’s Finance Committee as well as my outside experience as the treasurer of a not-for-profit corporation to continue the outstanding financial results that HHS has experienced. Specifically, my goals are to continue to adequately fund the programming and research initiatives of the Section, to work with the other leaders of the Section to continue to enhance non-dues revenue, to contribute to efforts to increase the Section’s membership and to make efforts to reduce administrative expenses while not reducing services provided to the Home Health Section’s members and leaders.

FOR SECTION NOMINATING COMMITTEE

Philip Goldsmith, PT
Hanover, Pennsylvania

Biographical Statement
My physical therapy career began in 1999 after I graduated from Boston University. The majority of my career has been in the home health environment with experience in skilled nursing facilities and outpatient orthopedics.

When I am not working, I enjoy spending time with my wife Stefanie. Together, we are a puppy-raising family for The Seeing Eye. It is our great joy and privilege to be given a tiny puppy and return it to The Seeing Eye about a year later ready to be trained as a guide dog for a person with impaired vision.

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Candidate Statement
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John M. DiCapo, PT, DPT, ATC
Chicago, Illinois

Biographical Statement
Through high school I worked as a pharmacy technician in a long term care pharmacy and had my first exposure to working with the geriatric client. I often would assist with deliveries and would get to meet the clients. I was intrigued by the complexity of their medical conditions and enjoyed the appreciation they showed for any help provided.

While studying at Marquette, I worked for 3 years as a research assistant working on method and mechanisms of exercise induced analgesia. I presented and co-authored studies on this topic. Following graduation, I worked in an outpatient orthopedics setting treating back and neck pain. I also worked part time in home health. After working 2 years in orthopedics I decided to try home health full time. I worked in the field full time for a year and then moved in to a part time field, part time leadership role. I currently have a full time leadership role but continue to practice as a home health physical therapist.

Candidate Statement
This past year at CSM, I took the Home Health Section’s pre conference course on Outcome Measures in Home Health. It was my first in person exposure to the section. I very much enjoyed the camaraderie that members of the section exhibited and how welcoming everyone was. At the section dinner I was lucky enough to sit at a table with our current section president and many other members of the section leadership. I had a great time talking with them and shared the same beliefs as they do. I saw first-hand how the section is trying to improve healthcare and I decided I wanted to become a part of it. Thus, I am running for a position on the nominating committee.
Andrew Morgan, PT, MBA
San Antonio, Texas

Biographical Statement
I was born in California, but I was primarily raised in Florida. I arrived in Texas to attend Baylor University. After graduating from Baylor with a Bachelor of Science in Education, I moved to San Antonio to attend physical therapy school. Upon graduation, I immediately entered home health, and I have been working in the industry since that time. I worked as a staff therapist, a lead therapist, and a director of rehabilitation in various agencies. In 2007, I used my knowledge of the local home health industry to start Petra Therapeutics, a contract therapy company that works with several agencies in the San Antonio area.

On a personal note, I am married with 2 children, and I enjoy competing in Triathlons.

Candidate Statement
I have been an APTA member since 1999, and I have been a Home Health Section member since 2002. Since I entered home health in 2002, I have been passionate about changing physician, patient, and community perceptions of what home health is by providing top quality, evidence-based care and by insisting that clinicians who work with me do the same. While this has served me well locally, I believe that I have more to offer the professional as a hole at the national level. In a competitive job market, I have continuously been successful at recruiting and retaining quality clinicians to work as part of my team. As a hiring manager, I am well-qualified at identifying leadership and other important skills in others and finding appropriate positions in which they can excel. I thank you for your consideration.

GET MORE INFORMATION ABOUT SECTION ELECTIONS ONLINE:
www.homehealthsection.org

The Home Health Section Partner Program

Overview & Eligibility
The Home Health Section is a specialty component of the American Physical Therapy Association (APTA), a professional association serving the physical therapy community. Only physical therapists, physical therapist assistants, and physical therapy students are eligible for membership in the APTA and its components.

The Home Health Section “Partner Program” provides individuals, organizations, and agencies who are ineligible for APTA membership with a means of staying informed of activities and developments in physical therapy relevant to the home health setting.

Partnership vs. Membership
The Section’s Partner Program is not a substitute for membership in APTA and the Section as membership provides individuals with significantly more information and resources to assist them in their careers as physical therapy professionals. Many of the benefits offered by both APTA and the Section are exclusive to members. If your organization employs physical therapists and/or physical therapist assistants, these professionals (and your organization) will benefit greatly from their membership in their professional association.

If your organization does not employ physical therapists, or if you wish simply to enhance and expand your access to information about the practice of physical therapy in the home health setting, the Section’s Partner Program is for you.

More information on this program is available from: http://tinyurl.com/hhspartner

Home Health Section - APTA • Fall 2012
Home Health Section CSM Pre-Conference Courses

January 20 – January 21, 2013 (2-day course)

Therapy Leadership in Home Health: Building Your Executive Portfolio
Speakers: Diana L. Kornetti, PT, MA; Sherry L. Teague, PTA, MS, ATC; Kenneth L. Miller, PT, DPT; Kristin Mattson, PT; Cynthia J. Krafft, PT, MS
Level: Intermediate
CEUs: 1.6 (16.0 contact hours/CCUs)
Preconference Pricing: Standard (2A) 2 Day

January 21, 2013 (1-day course)

Strengthening Your Exercise Intervention: Effectively Using Thera-Band®
Speakers: Wendy K. Anemaet, PT, PhD; Kate Nemetz, PT, DPT; Emily Neel, PT, DPT
Level: Multiple Level
CEUs: 0.8 (8.0 contact hours/CCUs)
Preconference Pricing: Standard (1A)

Register for either of the above pre-conference courses through APTA’s CSM registration.

www.apta.org/csm