SPEECH PATHOLOGY PATIENT: _____

SPEECH PATHOLOGIST: _____

SPECIAL INSTRUCTIONS: _____

_____ DATE: _____

HANDOUT-ABLE: OP SLP Intake Guide

LEADING UP TO THE SLP EVALUATION:

___ Perform screening encounter & document (if applicable).
___ If indicated, recommend that the patient request orders directly from their medical provider.
___ Receive orders for SLP to "evaluate & treat as indicated."
___ Create a new patient record in the EMR.
___ Contact patient/family: state clearly the reason for the visit, per the referral.
___ Ask for the patient's and caregivers' preferred names for the clinician to utilize (relay this to the clinician as well).
___ Benefits determination (communicate with billing regarding pre-auth/deductibles, if needed).
___ Ask if there are special considerations or support needs for the process of onboarding services.
___ Communicate with the patient/family on "good faith estimate" details.
___ If the patient/caregivers desire to proceed, schedule the evaluation.
    ___ Inform the patient/family of any requirements for the new patient appointment:
        ___ For effective testing, we ask that please only have the patient and direct caregivers involved in the patient's care arrive for the visit.
        ___ Please arrive on time — as the amount of time designated for an evaluation is finite, to allow for overall practice scheduling needs.
        ___ Participants may arrive earlier than the time and utilize the waiting area if needed.
        ___ Following 15 minutes of missing an appointment, if the patient has not arrived, the visit will be rescheduled.
        ___ Please call or text for any visits -- as soon as possible if there is a risk of a delay so that troubleshooting & updated scheduling can occur.
        ___ All efforts need to be made to make up visits that are missed within the same week. Participants will be encouraged to make this a priority so that progress can occur.
        ___ Presence of the current medical insurance card is required at the date of visit.
        ___ Please bring related paperwork from other providers, instrumental tests, etc.
___ Coordinate availability of new patient paperwork, prepare for the patient/POA/parent to consent regarding:
    ___ Privacy policy forms.
    ___ Case history/medical history forms sharing.
    ___ Notification of special conditions of specific payor limitations (tele-practice for Medicare, if applicable, vs. if pre-authorizations/certifications are needed, etc.).
    ___ Financial policy forms.
    ___ Routine COVID-19 screening/questionnaire forms.

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___ Consent for in-person vs. tele-practice visits.
___ Practice information on availability/scheduling (method for making appointments).
___ Other related to the intake/consents: _____
___ Clinician: determine enough basic referral concerns/background information to establish a list of starting assessments for the initial evaluation.
___ Add the patient's birthday information to a cumulative calendar for tracking events related to the practice.
___ Add patient/provider information into the referral tracking database.
___ Upload referral information into the EMR.
___ Notify the referring provider that the referral was received, that contact was made, and that the evaluation has been scheduled (and when).

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EVALUATION APPOINTMENT:

AT VISIT:

___ Silence SLP/clinician electronics to avoid interruptions.
___ Introduce SLP to patient/family.
___ Reiterate the primary reason for the evaluation visit per the referral/gathering of preliminary data.
___ Obtain scanning/a photograph of the current medical insurance card.
___ Request/review the signing of consents/forms (if not already conducted prior to the visit).
___ Receive co-payment/payment for visit, if applicable.
___ Provide instruction on practice-specific information.
  ___ Where the restroom is located.
  ___ Where to fill out covid screener, moving forward, etc.
  ___ Provide the facility/SLP business card.
  ___ State clinician's preferred name.
  ___ Method of contact.
  ___ Presence of a confidential "input" box or feedback/suggestion mechanism from anyone involved in service delivery ("Your experience and thoughts on it matter").
___ Verify the address & contact information of the patient/family.
___ Ask that patient/family please silence electronics to avoid interruptions (unless expecting an urgent/emergency call; that this please be stated in advance).
___ Review/discuss the case history.
___ Conduct the evaluation.
  ___ Inquire about the over-arching goal of the patient/caregivers (follow-up questions).
  ___ Inquire about the general SLP-specific goal (perform follow-up questions).
  ___ Administer standardized measures, and related tasks.
  ___ Administer PROMs.
  ___ Administer informal tasks, as needed.
  ___ Perform point-of-service documentation as much as possible in the EMR, as clinically appropriate.
  ___ Ask if there are areas of concern that were not queried, asking open-ended questions and providing examples -- if needed.
  ___ State the positives the patient/caregiver has in place that will assist in reaching goals.
  ___ Discuss formal evaluation recommendations, plan of care, mechanisms to address areas of concern, starting goal areas, etc.
  ___ Receive information on preferences for patients in scheduling, if possible.
  ___ Determine willingness for a home practice program and document details.
  ___ Ask for any updates in insurance or contact information — that it be relayed promptly.
  ___ List the roles of the SLP and the roles of the patient/family for treatment.

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___ Discuss what to expect at future visits.
___ Provide opportunities for questions by the patient to be answered/concerns addressed.
___ Discuss/establish what the clinician will be responsible for, and what is asked of the patient – in order to make progress toward the patient's/caregivers' stated goals.
___ Schedule the follow-up treatment visit, if indicated.

FOLLOWING THE EVALUATION VISIT:

___ Scan in consents, COVID-19 questionnaire, and any documentation provided by the patient into the EMR.
___ Scan insurance cards into the EMR.
___ Notify the provider of the conducted evaluation, and state that the evaluation report is pending.
___ Score testing/assessment measures – add content to the full evaluation report.
___ Complete a daily note.
___ Complete the full evaluation report with POC/goals.
___ Enter CPT codes and ICD-10 codes into the EMR system/report.
___ Fax (and call) the referring provider, call to follow up to make sure it is received.
___ Confirm the first treatment visit via the automated system or another method.
___ Determine tasks for the first treatment visit.
___ Await/look for a signed POC document from the referring provider.
___ Communicate with billing regarding pre-auth, if needed.
___ Scan the signed copy of the evaluation/POC into the EMR.
___ Check to ensure delivered CPT codes are documented.

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"FIRST" FOLLOW-UP VISIT:

___ Silence SLP electronics to avoid interruptions.
___ Ask that patient/family please silence electronics to avoid interruptions (unless expecting an urgent/emergency call; that this please be stated in advance).
___ Administer COVID-19 screening/questionnaire.
___ Inquire if there are any new concerns since the last visit.
___ Facilitate in-depth discussion on evaluation results.
___ Provide an opportunity to discuss areas not covered at the intake visit.
___ Provide a copy of the full evaluation report if indicated after authorization has been obtained.
___ Conduct therapy tasks — directly or indirectly.
___ Perform point-of-service documentation as much as possible in the EMR.
___ Provide and discuss the rationales for any new recommendations.
___ Assign home practice tasks (reiterating the goals stated by the patient/caregivers at the time of evaluation as the "why" for performing a home program).
___ Create an opportunity for any questions to be asked/answered.
___ Schedule the next follow-up visit.

FOLLOWING THE VISIT:

___ Complete documentation of the daily note
___ Follow-up with the provider, as needed.
___ Plan tasks for the next visit, as well as collect materials for conducting activities.

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ROUTINE FOLLOW-UP VISITS:

___ Silence SLP electronics to avoid interruptions.
___ Ask that patient/family please silence electronics to avoid interruptions (unless expecting an urgent/emergency call; that this please be stated in advance).
___ Administer COVID-19 screening/questionnaire.
___ Inquire if there are any new concerns since the last visit.
___ Ask how the home practice program is turning out.
___ Conduct therapy tasks — directly or indirectly.
___ Perform point-of-service documentation as much as possible in the EMR.
___ Provide and discuss the rationales for any new recommendations.
___ Assign home practice tasks (reiterating the goals stated by the patient/caregivers at the time of evaluation as the "why" for performing a home program).
___ Create an opportunity for any questions to be asked/answered.
___ Schedule the next follow-up visit.

FOLLOWING THE VISIT:

___ Complete documentation of the daily note
___ Follow-up with the provider, as needed.
___ Plan tasks for the next visit, as well as collect materials for conducting activities.

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REASSESSMENT VISITS:

AT VISIT:

___ Silence SLP electronics to avoid interruptions.
___ Ask that patient/family please silence electronics to avoid interruptions (unless expecting an urgent/emergency call; that this please be stated in advance).
___ Administer COVID-19 screening/questionnaire.
___ State the nature of the need for a reassessment.
___ Inquire if there are any new concerns since the last visit.
___ Re-verify the patient's/caregivers' address/ contact information.
___ Conduct reassessment measures (receive an update of the goal of patient/ caregivers and establish the areas for improvement/interest.
___ State the positives the patient/caregiver has in place that will assist in reaching goals.
___ Check in all goals and provide updates.
___ Ask about new areas to address for the future.
___ Receive updated information on preferences for the patient in scheduling.
___ Determine willingness for a continued home practice program and document details, ask how it is going and adjust accordingly.
___ Re-visit older recommendations & provide/discuss the rationales for any new ones
___ Assign home practice tasks (reiterating the goals stated by the patient/caregivers at the time of evaluation as the "why" for performing a home program).
___ Create an opportunity for any questions to be asked/answered.
___ Schedule the next follow-up visit.

FOLLOWING THE VISIT:

___ Notify the provider, and state that the reassessment report is pending.
___ Score re-testing/re-assessment measures.
___ Complete the daily reassessment/encounter note.
___ Complete the re-assessment report with updated POC/goals, taking care to perform an in-depth analysis of the rationale to continue with services.
___ Update CPT codes and ICD-10 codes into the EMR system/report.
___ Fax (and call) the referring provider, call to follow up to make sure it is received.
___ Determine a plan for the next set of treatment tasks/activities.
___ Await/look for a signed POC document from the referring provider.
___ Communicate with billing regarding pre-auth, if needed.
___ Communicate with insurance on deductibles, etc., if needed.
___ Scan the signed copy of the reassessment into the EMR.
___ Check to ensure delivered CPT codes are documented.
___ Confirm the first treatment visit via the automated system or another method.
___ Plan tasks for the next visit, as well as collect materials for conducting activities.

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SLP DISCHARGE VISIT:

AT VISIT:

___ Silence SLP electronics to avoid interruptions.
___ Ask that patient/family please silence electronics to avoid interruptions (unless expecting an urgent/emergency call; that this please be stated in advance).
___ Administer COVID-19 screening/questionnaire.
___ State the rationale for the indicated discharge from SLP services.
___ Inquire if there are any final concerns.
___ Re-verify the patient's/caregivers' address/ contact information.
___ Conduct discharge reassessment measures & receive an update of the discharge status of goals.
___ Re-visit the original goals set by the patient, both general and SLP-specific.
___ Ask about new areas to address for referrals/recommendations.
___ Share information about conditions that may lead to re-starting SLP services again, in the future.
___ Follow up on any home program tasks for the patient to continue to implement into their regular schedule, if willing.
___ Re-visit older recommendations & provide/discuss the rationales for any new ones.
___ Reiterate the primary method of contact for the SLP in the future for any follow-up questions.
___ Create an opportunity for any questions to be asked/answered.
___ Thank the patient/caregivers for their hard work and wish them good luck on all endeavors.

FOLLOWING THE VISIT:

___ Notify the provider, and state that the discharge report is pending.
___ Score any re-testing/re-assessment measures.
___ Complete the daily reassessment/encounter note.
___ Complete the discharge report, summarizing care with the updated/discharge recommendations.
___ Fax (and call) the referring provider, call to follow up to make sure it is received.
___ Scan the signed copy of the reassessment into the EMR.
___ Check to ensure all delivered CPT codes during the scope of visits were accurately documented.
___ Change the status of the patient to an "inactive" status in the EMR.