



HOME HEALTH
& HOSPICE

Aveanna Home Health Therapy Orientation: Clinician Responsibilities and Home Visit Training



T H E F U T U R E O F H O M E C A R E

Therapy Orientation Agenda

In this segment, we will review the following items related to Clinician Responsibilities and Home Visit Training:

- The Aveanna Way
- HHCAHPS Survey
- Customer Service
- Working with your Branch and Clinical Expectations
- Aveanna Patient Booklet
- Discipline Specific Competencies



The Aveanna Way

Let's review principles of the Aveanna Way:



The brochure cover features a photograph of a healthcare professional in blue scrubs taking a patient's blood pressure. The Aveanna logo, "the aveanna way" with a stylized green and blue leaf icon, is in the top right. The tagline "Your satisfaction is everything to us. That's why we've built our care around you." is below the logo. The main text block reads: "No company is more dedicated to bringing the highest-quality care into your home, wherever home may be. We want to make sure your experience with us is exceptional. That's why we created our own program that's fully focused on your needs, goals, and satisfaction. We call it the Aveanna Way." A section titled "Better Care Begins with Better Service. Our Commitments to You." lists 8 principles. A small "www.aveanna.com" is at the bottom.

Better Care Begins with Better Service. Our Commitments to You.

- 1) We will notify you in advance of your scheduled visit or of any changes to your time.
- 2) We will be courteous and respectful.
- 3) We will take time to listen to your needs.
- 4) We will find out what is important to you, including your specific care goals.
- 5) We will explain your care goals in terms you can understand.
- 6) We will evaluate and address safety concerns in your home.
- 7) We will educate you on the purpose, side effects, and other relevant information related to your medications.
- 8) We will return your calls in a timely manner and answer all your questions to your satisfaction.



HHCAHPS Survey

- **HHCAHPS: Home Health Consumer Assessment of Healthcare Providers and Systems- Patients' Perspectives of Care Survey**
- Medicare requires Home Health agencies to be assessed on our customer service through surveys from a third-party vendor.
- It is important as therapists that we ask about new, changed, and/or updated medications, request the patient to rate their pain, and assess for home safety ***at every visit.***



HHCAHPS Survey

Be sure to demonstrate these following qualities during your home visit:

- **Listening**-Did we listen to the patient's concerns? Make good eye contact, speak at their eye level, perform teach back/return demonstration technique
- **Be respectful and courteous.**
- **Speak in easy-to-understand terms.** Avoid complicated explanations and medical jargon.
- **Treat the patient with care.** Assist the patient in moving safely. Ask them how they feel.
- **Answer questions timely.** It is important to address a patient's questions. If you do not know the answer, let the patient know that you will work on getting the answer. Follow up within 24 hours.



Customer Service

Let's review some important customer service tips:

- Best practice is to schedule all patient appointments 24 hours in advance. After multiple attempts to contact the patient, including emergency contact, clinician may be requested to travel to patient's home.
- Give patients an arrival time of up to 2 hours. If clinician is running late, please call the patient to update them on arrival time.
- Patients must be informed of anticipated treatment frequencies. Please document in admission booklet in the calendar section. This is not only a best practice, but also a Medicare requirement.
- Avoid using the patient's bathroom as it is a private residence.



Customer Service

- Always be careful in the home when others are present in discussing any patient information (HIPAA). Confirm with patient if you can speak in front of others regarding their personal health information.
- It is important to promote positive experiences with a patient. Greet the patient with a smile, address them by their preferred name, and ask them how they are doing. Refrain from complaining about items such as traffic delays, office issues, scheduling, etc.
- Closed toed shoes should be worn in the home. Also, shoes should never be removed in the home to prevent risk from a work-related injury. A patient may ask you to remove them due to various reasons but let them know that it is for safety.
- Pets-Verify if there are any animals in the home before arrival. Intake should be documenting this as a point care alert. However, for any clinician who does the SOC, it is always best for the clinician to ask patient if they have an animal in the home when calling to schedule appointments. When the clinician arrives at the front door, remind patient at that time as well.

Customer Service

- Never bring anyone to the home that is not cleared by the company.
- Never accept food, drinks, or gifts from a patient.
- All complaints are taken seriously. If you receive one, please bring it to the Executive Director's attention immediately.
- In the admission booklet, we have phone numbers that are anonymous hotlines for complaints. Complaints must be resolved within three working days.
- If you have concerns about a patient's homebound eligibility, please direct them to your clinical manager or executive director before discussing with the patient.
- Exceptions: Doctor appointments, church, hairdresser



Customer Service-Complaints

How to address Complaints:

- **What are complaints?**
- Complaints consist of treatment, or care, that is or fails to be furnished, is furnished inconsistently, or is furnished inappropriately.
- This includes mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and/or misappropriation of patient property, by anyone furnishing services on behalf of the Agency.
- Any Agency staff must report findings immediately to the Executive Director and appropriate authorities in accordance with state law.
- The timeframe for investigation is three working days after receipt of the complaint. Patient should receive a response upon completion of the investigation of the complaint.



Customer Service-Complaints

How to address Complaints:

- The individual designated to respond to the complaint is the Executive Director.
- Both the existence and resolution of the complaint will be documented.
- Investigative measures will be implemented based on the complaint, and intake information is obtained from the appropriate source.
- Appropriate authorities are informed if applicable.
- Corrective action is specific and directly related to the complaint.
- Patient and family rights are protected.
- Complaint management is incorporated into the QAPI (Quality Assessment and Performance Improvement) manual.



Working with your Branch and Clinical Expectations

Here are best practices for working with your branch:

- Home Care operates 24 hours a day, 7 days a week, 365 days a year. All staff are expected to support the branch by assisting with patient coverage as needed.
- For unplanned absences, contact your direct supervisor as soon as possible so that we can ensure patient coverage.
- Follow the Plan of Care/485 with regards to frequency and treatments. Plans of Care cannot be changed or updated by the clinician without receiving provider approval. If changes need to occur, please contact the provider's office to obtain new orders.
- Check supplies in between patient visits to ensure that you have an adequate amount. Also, make sure the supplies are not expired.



Working with your Branch and Clinical Expectations

- Please complete and sync your documentation within 24 hours.
- Perform a Selective Refresh once a week.
- We expect compliance with regulations when it comes to care provided and documentation of that care.
- Point of service documentation-document as much as you can in the home. At minimum, enter vitals and save as an incomplete note. This helps determine that the patient was seen for an actual visit when reviewing EMR.
- Involve and inform your patient-let them know you are tracking pertinent treatment details and functional progress.



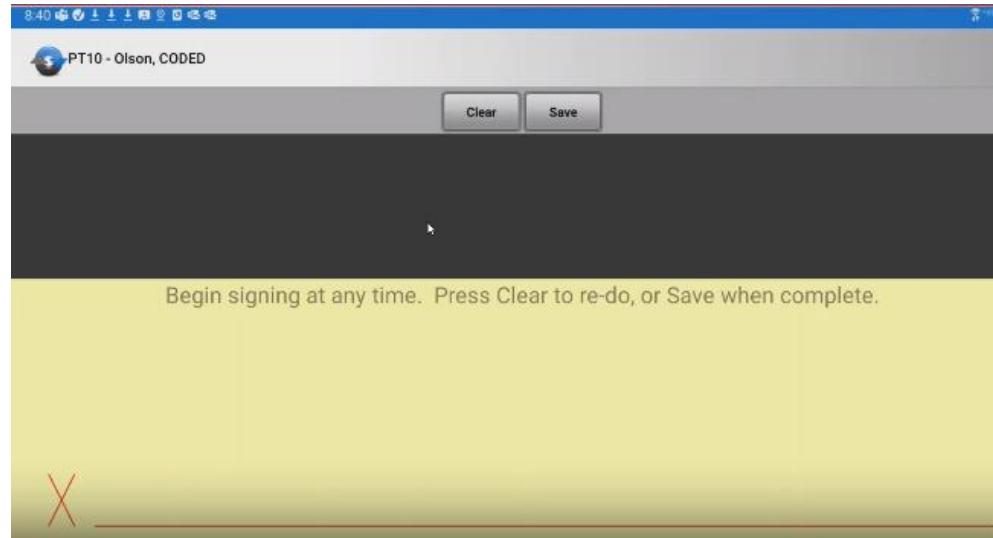
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Working with your Branch and Clinical Expectations

Obtaining Patient Signatures

- At the end of every visit, even if the visit is Incomplete, ensure that a patient signature is obtained at the completion of treatment under “Client Signature”.
- If the patient is cognitively and physically able to do so, ask them to sign for themselves.
- If the patient has a cognitive or physical disability, or a POA or patient representative who needs to sign for them, request a willing and able caregiver to sign for the patient.
- In the case of a patient who resides in an ALF, ask for the nursing director or staff to sign on behalf of the patient.



Working with your Branch and Clinical Expectations

Here are best practices for working with your branch:

- After completing an admission (SOC, ROC, Recert) and/or evaluation, the therapist may communicate any updates to the plan of care to branch leadership.
- Communicate regularly with the branch regarding patient needs or sharing of patient information. Do not ignore messages from branch sent via Teams, phone calls, or emails. It is understandable that you may not be able to respond right away as you may be involved with patient care, but please respond later in the day.
- The company regularly provides communications through email, and it is highly recommended to check the emails weekly as to not miss important company updates, communications from our benefits departments, and/or general education.
- Collaborate with other disciplines on the case-discuss visit frequency, focus of care, and patient needs and goals. You need to talk to other teammates, not just supervisors. We want to have patient centered care plans and prevent duplication of services.



Working with your Branch and Clinical Expectations

- Case conferences are an integral part of patient care coordination. If you cannot attend in person, communicate with branch to update patient status. Virtual meeting options on Teams are also available.
- Patient concerns - if you ever have any concerns regarding a patient e.g., vital sign parameters, patient presents with shortness of breath, and/or want to make recommendations, e.g., DME in home, contact the provider's office to discuss.
- If you are working in an ALF, do not treat a patient in a certified outpatient clinic space.



Working with your Branch and Clinical Expectations

- Protocols-Not all Orthopedic physicians follow the same approach with surgeries, so please review provider protocols in the referral attachments before you see a patient. If you do not see a protocol, contact the branch immediately, or speak to a fellow therapist that can help you. Always err on the side of caution if the protocol is not present until you have the information.
- Perform standardized tests that align with provider protocols and promote patient safety and well-being.
- Follow Treatment Orders as written. Provider approval is required to address appropriate care.



Working with your Branch and Clinical Expectations

- All non-visit activity pay will be reviewed by branch for approval.
- To get paid timely, all documentation must be completed and synched.
- All plans of care are reviewed. Estimated frequencies and durations will be assessed for medical necessity.
- All OASIS and Admissions will go through a quality review with recommendations. Please respond to the quality team in a timely manner.



Aveanna Patient Booklet

Let's review some important highlights in our Patient Admission Booklet:

Patient Booklet



Committed to comprehensive homecare,
quality, and innovation.



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Aveanna Patient Booklet-Consents

Let's review some important highlights in our Patient Admission Booklet:



Home Health Consent

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Patient Name: _____ DOB: _____ MR#: _____

Patient Rights and Responsibilities:

I acknowledge I have read and have received a verbal explanation and a written copy of the Client's Rights and Responsibilities under the State and Federal provisions in the Home Care Bill of Rights, and I understand them. I have received a copy of the Aveanna Home Health Admission Booklet containing information regarding its policies and Health Care Directives, the Outcome and Assessment Information Set ("OASIS") rights, agency Administrator's name, and contact information; Discharge, Transfer, and Referral policies; and how to contact local resources. The applicable state home health hotline number, its purpose, and hours of operation have been provided and explained to me. I understand that I have the right to choose my provider of services and acknowledge that I have chosen this agency as my provider of choice for my care. No employee of this agency has solicited or coerced my decision in selecting a home health agency.

Consent for Treatment:

I hereby give my permission for authorized personnel of Aveanna Home Health to perform all necessary assessments, procedures, and treatments as prescribed by my physician for the delivery of home health care, including telehealth services. I understand that services provided by telehealth will not replace needed in-person visits as ordered by my physician in my plan of care. I understand that the agency will supervise the services provided. I may refuse treatment or terminate services at any time, and the agency may terminate their services to me as outlined in the Admission Booklet.

I agree and consent to the home care plan and payment as outlined in the Admission Booklet. I understand my initial Plan of Care and subsequent Plans of Care may change based on medically necessary determinations made by my physician. I will be notified by the agency in advance of any change made to my plan of care.

Authorization for Payment:

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I consent to the release of all records required to act on this request. I request that payment of authorized benefits from Medicare, Medicaid, or other responsible payer be made on my behalf to Aveanna Home Health.

If I have Medicare Part A benefits, I understand that Medicare payments will be accepted as payment in full, and I have no financial liability. Should service(s) not be covered by Medicare and I wish to receive care or service, the Agency will notify me in writing. I understand that while I am under the agency's plan of care, the agency will coordinate all medically necessary therapy services and medical supplies for me. If I arrange for these services or supplies on my own, I understand that Medicare will not reimburse me, or my supplier and I will be responsible for the total cost.



Home Health Consent

Page 2 of 3

Patient Name: _____ DOB: _____ MR#: _____

Patient Financial Responsibility:

Selection	Description
<input type="checkbox"/>	1. Medicare will pay 100% of authorized visits.
<input type="checkbox"/>	2. Insurance/Medicare Advantage Plan/Government Plan <ul style="list-style-type: none">• Payer:• Estimated Financial Responsibility: Deductible: \$ _____ Out of Pocket Max: \$ _____ Deductible Remaining: \$ _____ Out of Pocket Remaining: \$ _____ Coinsurance/Copay: \$ _____
	Medicare Secondary Payer: <input type="checkbox"/> No, Patient does not have a Medicare Secondary plan. <input type="checkbox"/> Yes, Patient has a Medicare Secondary Plan. Primary insurance will be billed first. Any outstanding balance that remains will be billed to Medicare. Patient's estimated financial responsibility will be \$0.
<input type="checkbox"/>	3. Medicaid will pay 100% of authorized visits after spend-down. Spend down \$ _____/month
<input type="checkbox"/>	4. 100% Private Pay Services Estimated Financial Responsibility: \$ _____/month

Services	Proposed Frequency	Services	Proposed Frequency
<input type="checkbox"/> Skilled Nursing		<input type="checkbox"/> Home Health Aide	
<input type="checkbox"/> Physical Therapy		<input type="checkbox"/> Social Worker	
<input type="checkbox"/> Occupational Therapy		<input type="checkbox"/> Homemaker	
<input type="checkbox"/> Speech Therapy			

I understand that I am responsible for amounts not covered by my insurance, including deductibles, and any charges that my insurance will not cover. I will refer to my payer's explanation of benefits for maximum amount that I may be required to pay for services provided to me by Aveanna. I understand that I am responsible for amounts not paid by my insurance. If I am a Private Pay patient, I agree to pay for all services rendered by the agency at Aveanna's usual and customary rate at the time the service was provided to me.

Authorization for Release of Information:

I acknowledge receipt of the **Notice of Privacy Practices** and was given an opportunity to ask questions and voice concerns. I understand that the agency may use or disclose protected health information (PHI) about me to carry out treatment, payment, or health care operations. The agency may release information or receive information from insurance companies, health plans, Medicare, Medicaid, or any other person or entity that may be responsible for paying or processing for payment any portion of my bill for services; any person or entity affiliated with or representing for purposes of administration, billing, quality assurance, and risk management; any hospital, nursing home or other health care facility to which I may be/have been admitted; any assisted living or personal care facility of which I am a resident; any physician providing my care; family members and other caregivers who are part of my plan of care; licensing and accrediting bodies, and any other health care providers in order to initiate treatment.

I agree that the agency may share my PHI with emergency officials or others involved in my care to assist in disaster relief efforts.

Consent to Film or Record:

I hereby consent for the agency to record or film my care, treatment, and services and allow the agency to use the photographs/recordings for their internal use, for documenting my medical condition, or for insurance providers to document my condition for payment purposes. This consent includes the recording or filming of my image or voice.

Yes, I consent (default) Non-standard option: No, I do not consent

Advance Directives:

I have been made aware of my right to make health care decisions for myself in accordance with state law and that I may express my wishes in a document called an Advance Directive so that my wishes may be known when I am unable to speak for myself. I authorize Aveanna Home Health to receive a copy of my Advance Directive for their records. I understand if a copy of my Advance Directive is **not provided** to Aveanna Home Health within a reasonable period of time, the agency will continue to provide all care as ordered by my physician, which in the event of an adverse event and/or healthcare emergency, includes life sustaining and stabilizing measures consistent with standard and accepted medical practices.



Aveanna Patient Booklet-Individualized Emergency Plan

Let's review some important highlights in our Individualized Emergency Plan:



Patient Individualized Emergency Plan

Page 1 of 2

Patient Information		<input type="checkbox"/> Full Code <input type="checkbox"/> DNR <input type="checkbox"/> DNI
Patient Name: _____		DOB: _____
SOC Date: _____		Patient ID/MR#: _____
<input type="checkbox"/> Male	<input type="checkbox"/> Female	Height: _____
Weight: _____		
Home Phone Number: _____		Cell Phone Number: _____
Street Address: _____		
City: _____		State: _____
Zip: _____		
Physician: _____		Physician Phone Number: _____
Pharmacy Name, Address & Phone: _____		
Acuity Level Determination		
Acuity Rating: <input type="checkbox"/> 1 - 1-2 hours <input type="checkbox"/> 2 - same day <input type="checkbox"/> 3 - within a week		
Emergency Contact		Emergency Contact 2 <input type="checkbox"/> Not applicable
Name: _____	Relation: _____	Name: _____
Phone: _____	Alt: _____	Phone: _____
Address: _____		Address: _____

Patient Healthcare Information	
Primary Diagnosis: _____	Allergies: _____
Patient/caregiver Independent: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Patient/caregiver Independent with Self-Administered Medications: <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Patient has functional disability (check all that apply): <input type="checkbox"/> Walker/cane <input type="checkbox"/> Wheelchair <input type="checkbox"/> Bedbound	
<input type="checkbox"/> Hearing Impairment <input type="checkbox"/> Visual Impairment <input type="checkbox"/> Mental/Cognitive Impairment	
<input type="checkbox"/> Intellectual disability: _____	
<input type="checkbox"/> Ambulatory with assistance: <input type="checkbox"/> Maximum <input type="checkbox"/> Moderate <input type="checkbox"/> Minimum	
<input type="checkbox"/> Patient requires lifesaving treatments/equipment: (Select all that apply)	
<input type="checkbox"/> Life sustaining Infusion Describe: _____	
<input type="checkbox"/> Dialysis Describe: _____	
<input type="checkbox"/> Insulin requiring diabetic. Insulin administered by: <input type="checkbox"/> Injection <input type="checkbox"/> Pump (type: _____)	
Insulin type, dose and frequency: _____	
<input type="checkbox"/> Oxygen dependent: <input type="checkbox"/> Continuously <input type="checkbox"/> Intermittently: hours per day: _____	
<input type="checkbox"/> Oxygen at _____ liters/minute via: <input type="checkbox"/> Nasal cannula: <input type="checkbox"/> Mask <input type="checkbox"/> Tracheal <input type="checkbox"/> Liquid <input type="checkbox"/> Concentrator <input type="checkbox"/> Cylinder	
<input type="checkbox"/> Portable oxygen cylinder available <input type="checkbox"/> Portable battery-operated oxygen concentrator available	
<input type="checkbox"/> No portable oxygen available	
<input type="checkbox"/> CPAP: _____ cm H2O	
<input type="checkbox"/> BIPAP: _____ cm H2O EPAP: _____ cm H2O	
<input type="checkbox"/> BIPAP ST: IPAP: _____ cm H2O EPAP: _____ cm H2O Respiratory rate: _____	
<input type="checkbox"/> Ventilator Dependent (type: _____): <input type="checkbox"/> Portable with back-up battery <input type="checkbox"/> Not portable	
Ventilator settings: Respiratory rate: _____ Tidal volume: _____ FIO2: _____ PEEP: _____	
<input type="checkbox"/> Suction machine: <input type="checkbox"/> Portable with back-up battery <input type="checkbox"/> Not portable	
<input type="checkbox"/> Infusion pump: <input type="checkbox"/> Portable with back-up battery <input type="checkbox"/> Not portable	
<input type="checkbox"/> Enteral pump: <input type="checkbox"/> Portable with back-up battery <input type="checkbox"/> Not portable	

The Aveanna family of companies includes Aveanna Healthcare, LLC, its wholly-owned subsidiaries and affiliates, any other entity or organization in which Aveanna Healthcare or an affiliate owns a direct or indirect equity interest of greater than 50%, and any other healthcare entity in which an affiliate either manages or controls the day-to-day operations of the entity. Aveanna Healthcare, LLC does not discriminate on the basis of race, color, religion, national origin, age, sex, sexual orientation, gender identity or expression, disability, or any other basis prohibited by federal, state, or local law.

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Patient Individualized Emergency Plan

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<input type="checkbox"/> Other medical needs: <input type="checkbox"/> Wound care: _____
<input type="checkbox"/> Intravenous medications: _____
<input type="checkbox"/> Tube feeding: _____
<input type="checkbox"/> Extra supplies: _____
<input type="checkbox"/> Other: _____
<input type="checkbox"/> Other needs: <input type="checkbox"/> Communication barriers: _____ <input type="checkbox"/> Language barrier: _____
<input type="checkbox"/> Special diet: _____
<input type="checkbox"/> Other: _____

Patient Instructions: Identify a safe place and how to prepare the home to minimize damage. In the event of an emergency or disaster, take your emergency supply kit to your safe place and notify your out-of-home emergency contact of your location and condition. Contact the emergency officials by calling 911 if you are injured.

Safe space in home
<input type="checkbox"/> Tornado: _____
<input type="checkbox"/> Flood: _____
<input type="checkbox"/> Other: _____
Safe meeting place in neighborhood: <input type="checkbox"/> N/A or _____
Safe meeting place outside of neighborhood: <input type="checkbox"/> N/A or _____
Fire safety/exits: _____
Other: _____
Assisted Living? (ALF): <input type="checkbox"/> Yes <input type="checkbox"/> No Lives Alone? <input type="checkbox"/> Yes <input type="checkbox"/> No Above 1st Floor? <input type="checkbox"/> Yes <input type="checkbox"/> No

Evacuation
If evacuation is needed, notify Aveanna Home Health and see instructions below. To facilitate transportation, appropriate care and/or evacuation the patient plans to:
<input type="checkbox"/> Remain in the home
<input type="checkbox"/> Evacuate to home of family member or friend with assistance of family and/or caregiver. Name: _____ Phone: _____ Full Address: _____
<input type="checkbox"/> Hotel/Motel (Name/Phone Number): _____
<input type="checkbox"/> Shelter (Location): _____
<input type="checkbox"/> Special needs shelter: _____ Is patient registered for special needs shelter? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Evacuate with assistance. Aveanna Home Health may assist to arrange for non-emergency transportation, contact patient's out-of-home emergency contact and/or help to locate an available.
<input type="checkbox"/> Non-emergency Inpatient admission
<input type="checkbox"/> Evacuate with assistance of emergency officials. Call 911 for emergency transportation.

*When I am safe and able, I agree to contact Aveanna Home Health and let them know my status and whereabouts.
For more information, refer to the Community Emergency Guide.*

The above information was developed/reviewed with the patient and/or family:

Aveanna Representative Signature Printed Name Credentials Date Time



Discipline Specific Competencies

In this segment, we will review Initial and Annual Discipline Specific Competencies:

Occupational Therapist or Occupational Therapist Assistant (COTA)
Initial Skills Competency



Workday Learning Clinical

Occupational Therapist or COTA Name: _____

Clinician Self-Rating

A = I can perform well	B = I need to review	C = I have no experience
------------------------	----------------------	--------------------------

Verification Method

DOS= Direct Observation/ Skills Lab	O = Oral Question and Answer
-------------------------------------	------------------------------

Core Skill	Self-Rating	Verification Method	Completion Date	Observer Initials
Vital Signs (BP, HR, O2 Sat, RR, Temp.)	A, B, or C	DOS		
Lung Auscultation	A, B, or C	DOS		
ROM testing with goniometer	A, B, or C	DOS		
Manual muscle testing	A, B, or C	DOS		
ADL/ IADL training	A, B, or C			
Work simplification& energy conservation	A, B, or C			
Perceptual motor training	A, B, or C			
Cognitive skills development	A, B, or C			
Surgical Dressing Chg. / Sterile Tech.	A, B, or C	DOS		
Pain assessment	A, B, or C			
Transfer training	A, B, or C			
Therapeutic exercise/activities/Fine Motor	A, B, or C			
Application of gait belt	A, B, or C	DOS		
Timed Up and Go	A, B, or C	DOS		
Modified Barthel ADL Index	A, B, or C			
Katz ADL Index	A, B, or C			
Bag Technique	A, B, or C	DOS		
Hand Hygiene / Infection Control / PPE	A, B, or C	DOS		

* Compete separate skills competency for use of ultrasound and or neuromuscular electrical stimulation if provided at location and clinician will be required to use.

I understand I am responsible for seeking proper resources prior to performing skills for which competency has not been demonstrated.

Occupational Therapist or Occupational Therapist Assistant (COTA)
Annual Skills Competency



Workday Learning Clinical

Occupational Therapist or COTA Name: _____

Clinician Self Rating

A = I can perform well	B = I need to review	C = I have no experience
------------------------	----------------------	--------------------------

Verification Method

DOS = Direct Observation/ Skills Lab	O = Oral Question and Answer
--------------------------------------	------------------------------

Core Skill	Self-Rating	Verification Method	Completion Date	Observer Initials
Vital Signs (BP, HR, O2 Sat, RR, Temp.)	A, B, or C	DOS		
Lung Auscultation	A, B, or C	DOS		
Surgical Dressing Chg. / Sterile Tech.	A, B, or C	DOS		
Application of gait belt	A, B, or C	DOS		
Timed Up and Go	A, B, or C	DOS		
Modified Barthel ADL Index	A, B, or C			
Katz ADL Index	A, B, or C			
Bag Technique	A, B, or C	DOS		
Hand Hygiene	A, B, or C	DOS		

* Compete separate skills competency for use of ultrasound and or neuromuscular electrical stimulation if provided at location and clinician will be required to use.

I understand I am responsible for seeking proper resources prior to performing skills for which competency has not been demonstrated.

Therapist Name/Credentials (Print)

Therapist Signature

Date

Observer Name /Credentials (Print)

Observer Signature

Date



Discipline Specific Competencies

In this segment, we will review Discipline Specific Competencies:

- Prior to initiating patient visits, all therapists will be administered a competency by a Registered Therapist of the same discipline.
- Clinical competency includes core abilities that are required for fulfilling one's role as a clinician. The Company assesses staff competence in a systematic, measurable, and objective manner.
- Competency assessments measure an individual's professional judgement and knowledge skills, which demonstrate critical thinking skills appropriate to job responsibilities.
- Competency is evaluated through but not limited to direct observation, skills labs, return demonstration, review of process, review of documentation in medical records, testing, and/or verbal discussion.
- The competency process will be repeated annually.



