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Medicare Muscle 2

Good, Better, Best

Learning Objectives

After this course, participants will be able to:

- State the three key requirements for Medicare covered therapy services.
- Identify language that adequately describes skilled speech therapy services.
- Identify activities that adequately demonstrate the material impact of speech therapy services.

The Regulatory Environment

- The Medicare Benefit is overseen by the Center for Medicare and Medicaid Services, which is in turn overseen by the Department of Health and Human Services, which is in turn overseen by Congress. Congress has the authority to pass legislation that controls the benefits, how they are administered and how the are managed.
- CMS itself has minimal contact directly with providers – CMS retains the services of various Contractors to administer and audit the benefit.
  - CMS does publish documents that clarify coverage criteria for some services– these are called National Coverage Determinations (NCD's).
- Medicare Administrative Contractors (MACs, formerly FIs) administer the benefit.
  - The MAC can publish documents that put some controls on coverage and service delivery, although they cannot be more restrictive than NCD – these are called Local Coverage Determinations (LCD's).
- There are multiple contractors who are retained specifically to audit various aspects of the benefit and seek out overpayments.
  - While different auditors may be reviewing different uses or types of benefits, they are bound in interpreting the claim by the CMS requirements.

The Audit Landscape

- Many pieces of legislation have been passed over the last 15 years with the specific intention of seeking out overpayments in the Medicare system across all provider types.
- Therapy services in SNF and Outpatient have come under particular scrutiny in recent years, and audit activity in these venues has been climbing steadily.
- In some cases, the auditors are paid by virtue of a "finders fee," meaning their payment is a percent of what they recover in overpayments. This has caused some concern in the industry that CMS has (inadvertently) incentivized excessive findings. Congress and CMS have attempted to address some of these concerns with enhancements in contracts, but the avalanche of findings on claims has still deluged the appeals systems and there is currently a 1,000,000 claim (2.5 years) backlog in the Administration Law Judge pipeline.
- In almost all cases, a finding can be appealed. When faced with aggressive findings by auditors, more and more organizations are employing their appeal rights (hence the tremendous backlog for hearings).

Medicare Regulations for Coverage of Therapy Services

- From Chapter 15 of the Medicare Benefit Policy Manual, section 220.2:

  Reasonable and Necessary (and skilled!)
  - To be considered reasonable and necessary, each of the following conditions must be met:
    - The services shall be considered under accepted standards of medical practice to be a specific and effective treatment for the patient's condition.
      - CMS sources acceptable practice guidelines in the Medicare Manuals, LCD's, NCD's, and guidelines and literature of the professional therapy organizations.
    - The services shall be of such a level of complexity and sophistication or the condition of the patient shall be such that the services required can be safely and effectively performed only by a therapist.
- There are also multiple criteria for the delivery of therapy services as they relate to qualified personnel, contents of the plan of care, certification, etc.
- There are *additional* requirements for services to be provided under the part A benefit: the patient must require a skilled service daily, the service(s) must be related to a condition for which they received treatment during their qualifying hospital stay (or that arose while skilled), and on a practical matter the service(s) can only be provided in an inpatient setting.

Break It Down

- Medically necessary services: Services that are performed with the expectation that they will facilitate a good outcome or prevent a negative outcome.
  - You can make things better such that the patient is more independent or has better health
  - You can reduce the risk that the patient will lose independence or have a medical complication.
- Reasonable services: Services that are delivered in accordance with the nature and severity of the condition.
  - The intensity and frequency are supported by the number and severity of deficits
  - The services are in accordance with professional standards for the treatment of the condition.
- The services require the skills of a therapist.
  - There is an inherent complexity that requires knowledge only a therapist would have, or
  - The condition of the patient is so complicated that if others tried to do what a therapist is doing the activity would not have a therapeutic benefit or the patient might come to harm
  - If you can't explain why you need to do it and a CNA or well-trained family member can't or shouldn't do it, the service probably isn't skilled.

The (mythical) Improvement Standard

There is not – nor has there ever been – an *improvement* standard in order for therapy service to be covered by Medicare.

- **See Jimmo V. Sibelius**

CMS identifies two types of therapy:

Rehabilitative

- Rehabilitative therapy includes services designed to address recovery or improvement in function and, when possible, restoration to a previous level of health and well-being. Therefore, evaluation, re-evaluation and assessment documented in the Progress Report should describe objective measurements which, when compared, show improvements in function, decrease in severity or rationalization for an optimistic outlook to justify continued treatment

Note: There is no rule that says that a week without progress necessitates discharging a patient, even when the intent of the treatment is rehabilitative.

Maintenance

- Establishment or design of a maintenance program
- Delivery of a maintenance program

Material Impact

- Why does what we're doing matter?
- We need a way to think about the reason for our participation distinct from progress, even though *progress* might be the material impact we are having.
- In what other ways can we impact a patient?
  - Identifying safety, compensatory or adaptive strategies
  - Teaching those strategies to others
  - Assessing a new or changed condition
  - Preventing decline or deterioration
  - Analyzing a treatment plan for improved effectiveness

The "Just Right" Principle of Documentation

- The goal is to write just as much as you need to in order to show your services meet the requirements of CMS and other oversight entities.
- Not too little:
  - Minimalist documentation seldom sufficiently supports how the services are skilled, reasonable and necessary and can fail to convey acceptable standards of practice are being met.
- Not too much:
  - Over creation of documentation dilutes the content and is an ineffective use of time.
- A Caveat about Libraries and Build Features
  - EMR systems that include pre-fabricated libraries can be very helpful but should be viewed as a snack, not a meal.
    - The build feature can create entries that are grammatically awkward and clinically weak
    - Repeated use of the same library selections strips the skill out of the documentation – once the content become repetitive there is no evidence that the brain of a therapist was used to create it.

Evaluations - Diagnoses

- CMS requires that a diagnosis be present on an evaluation:
  - Medical and treatment diagnoses must meaningfully relate to each other
    - Conditions that do not correlate can undermined the case for medically necessary services
      - Hip fracture and dysphagia
      - UTI and cognitive linguistic impairment
      - GI Bleed and Aphasia
      - In each example, the conditions can co-exist, and an unrelated condition may be the precursor condition or create an environment in which another condition exacerbates, but it is the therapist's responsibility to identify the proper underling medical condition that cause the treatment condition that requires remediation.
    - Several diagnoses can be used for both medical and treatment if the components of both diagnosis type are present and the physician has identified the condition as a medical diagnosis, ie: R13.12, Oropharyngeal Dysphagia; 169.320, Aphasia following Cerebral Infarction
    - In a Part A benefit setting, there is no requirement that all disciplines are treating the same medical condition. The requirement is that the beneficiary is receiving services for a condition for which he or she received treatment during the three day qualifying stay (or that arose while he or she was skilled). There is no requirement that *all* services provided under the part A benefit meet this requirement.

Evaluations – Reason for Referral

Why do you need to evaluate the patient?

- Poor:
  - "Admitted to SNF with MD order for speech evaluation and treatment."
- Fair:
  - "Admitted to SNF with MD orders for dysphagia evaluation and treat after hospitalization for pneumonia."
- Best:
  - "Admitted to SNF after hospitalization for pneumonia, MD orders for dysphagia evaluation and treatment due to low intake and reports of coughing with thin liquids."

- What type of eval, how did you know?
- Just because a doctor orders a service does not mean it's covered by Medicare.

- Identified the clinical pathway for the services and related it to a new medical condition, but…
- Having pneumonia doesn't automatically necessitate a patient needing a dysphagia evaluation.

- This identifies the clinical pathway for services and what warranted the initial referral for the evaluation and treatment.

Evaluations – Reason for Referral

Why do you need to evaluate the patient?

- Poor:
  - Patient referred to speech therapy due to confusion.
- Fair:
  - "Patient referred to speech therapy by PT and OT due to recent onset of confusion."
- Best:
  - "Patient referred to Speech therapy by PT and OT due to recent onset of confusion that has not resolved and is impairing patients ability to advance with rehabilitation."

- Referred by whom? New confusion or old confusion? Are we sure it's not delirium? Why does it require speech therapy?

- Better – we could look for corroborating data somewhere, and we know it's new, but…
- How do we know it's not delirium and why do we want speech involved?

- This statement explains the rationale of referral, the impact of the impairment and clarifies that the condition is not transient and therefore likely to spontaneously recover.

Prior Level Of Function

The patient's prior level of function is a key element in supporting that the services are both reasonable and necessary. Without being able to describe what the patient was doing before the onset of the impairments, "recent onset" is not a meaningful prognostic indicator, nor is there a mechanism to tell when goals are met.

Poor:

- "Unable to determine prior level of function, patient poor historian."
- "Patient was independent with all ADL's."
- "Patient has baseline confusion."

Not having a prior level of function undermines your case right out the gate. If the PLOF is in un-available on evaluation, you must get it STAT and then analyze your goals and treatment plan in the context of that info and change/document accordingly.

How does this information support a speech/language, cognitive or dysphagia plan of care? ADL performance does not support the need for any ST interventions.

If the patient's current condition is unchanged, what is the purpose of your intervention? While there's no rule that says the condition must be new, that progress must be the reason for treatment, or that you cannot attempt to rehabilitation past a recent PLOF, you must still ensure that you are providing reasonable, necessary services. This requires careful consideration in a chronic condition.

Prior Level Of Function

The patient's prior level of function is a key element in supporting that the services are both reasonable and necessary. Without being able to describe what the patient was doing before the onset of the impairments, "recent onset" is not a meaningful prognostic indicator, nor is there a mechanism to tell when goals are met.

Fair:

- "Patient poor historian, chart says patient able to live alone."
- "Patient had Mild swallowing impairments."
- "Patient with fair communication abilities."

Living alone presupposes a certain level of capacity for cognitive function, but the dots are left for the reviewer(who won't be a therapist) to connect.

Includes an attempt at quantifying an impairment, but "mild" has no standardized level of impairment with ST, and swallowing has many components. This also suggests some degree of baseline impairment that needs detailing.

Again, "fair" is not a strong quantifier, and commination has many components. This suggests some degree of baseline impairment that needs clarification in order to ensure that the treatment plan can be assessed as reasonable and necessary.

Prior Level Of Function

The patient's prior level of function is a key element in supporting that the services are both reasonable and necessary. Without being able to describe what the patient was doing before the onset of the impairments, "recent onset" is not a meaningful prognostic indicator, nor is there a mechanism to tell when goals are met.

Best:

- "Patient unable to state PLOF, chart reports ability to live independently prior to hospitalization suggesting normal cognitive capacity. Will clarify with family at first opportunity and adjust goals/treatment plan as necessary."
- "Patient was able to tolerate thin liquids by cup and and straw, avoided coarse textures but ate mechanical soft items with normal intake and no reports of cough or other signs of airway compromise."
- "Patient able to express wants and needs and engage in social discourse in most settings, family reports word finding difficulties on the phone or during doctors appointments."

Not having a reliable PLOF must ultimately be addressed, but therapist draws a reasonable conclusion from available data and explains why. Indicates that follow-up for clarification will occur.

Detailed description of previous impairments creates a good foundation for goals and objectively identifies a functional target.

Assessment Data

Your assessment data is what you use to identify proper treatment interventions, assess rehab potential, set goals and measure progress. Data must be descriptive, as objective as possible and include all relevant areas.

- Poor Evaluations:
  - Use "Impaired" in many or most assessment areas.
  - Perform cursory assessments; i.e., provides an severity rating for oral phase of swallow without descriptors or distinctly identified impairments.
  - Reports multiple non-tested areas that are then included in goals or treatment approaches
- Fair Evaluations:
  - Provide severity ratings (min/mod/max) for most or all appropriate assessment areas but with minimal objective data or standardized tests.
- Best:
  - Backs up severity ratings with thorough narrative descriptions, percentages, or performance measures (successes out of 10, e.g., seconds of swallow initiation time)
  - Includes standardized testing or severity scales in as many assessment areas as is appropriate

Goal Writing

- Goals must be:
  - **Measurable** – the impact of your therapy must be able to be demonstrated, if it can't be measured it can't be a goal.
  - **Functional** – it must clearly correlate to the improved status of the patient receiving treatment; if there is no reason for the patient to perform the activity, or the improvement doesn't lead to improved health or decreased risk, how is treatment for the goal area reasonable and necessary?
- Goals must be supported by the data gathered in the assessment:
  - If there is no assessment for verbal output, there shouldn't be a goal for expression.
  - If there is no assessment for cognitive function, there shouldn't be a goal for reasoning, insight or orientation.
- Other considerations:
  - Goals cannot be written for caregivers, they must be patient based; but goal performance can include the support of trained caregivers.
  - If trained caregivers are a component of the goal, the training of the caregivers should be explicitly documented during the course of care.
  - Ensure that the goal is written such that you are measuring what you want to measure, and that it does not include so many variables that describing progress becomes complicated or impossible.
    - E.G: "Patient will tolerate 4 ounces thin liquids with mod swallowing impairment with 10 percent cues verbal and tactile cues"
      - Are you measuring progress with the number of ounces, the severity rating, the percent of verbal cues, percent of tactile cues, or some combination of all of the above?

Goal Samples:

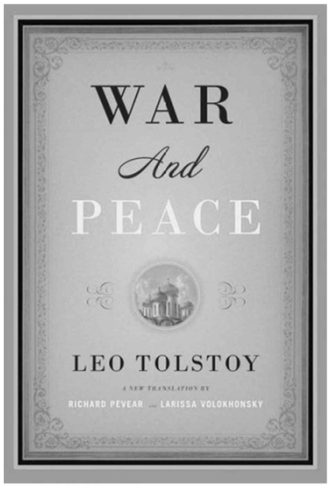
- Poor:
  - Patient will tolerate mechanical soft diet.
  - Patient will increase score on RIPA-G subtests to 25/30.
  - Patient will improve orientation.
  - Therapist will train caregivers in compensatory technique.
  - Patient will be able to repeat sequential numbers with 90% accuracy.
- Good:
  - Patient will complete labio-lingual exercises with visual model 5/5 times in order to increase oral strength and agility in preparation for textured food trials.
  - Patient will identify temporal and environmental information with 90% accuracy when cued to access memory board and calendar by trained caregivers.
  - Patient will utilize lingual sweep for oral clearing after every other swallow with occasional verbal cuing in CNA supervised dining environment.
  - Patient will tolerate 8 ounces of mechanical soft textures with cough on less than 5% of swallows.
  - Patient will demonstrate 75% intelligibility for short phrases with cueing for over-articulation 25% of the time.

- What constitutes "tolerance?"
- A score on a RIPA is not meaningful data to reviewers who are not therapists, additionally you cannot gather the data on a weekly basis.
- "Improve" is not measurable.
- Goals cannot be written for caregivers.
- Very few contexts where this ability would be meaningful (not *none*, just few).

- Goals in these examples all show a measurable component
- Activities are based in functional activity and/or risk reduction.
- The number of variables in the goal is controlled so that progress can be demonstrated/goals can be advanced.
- Examples show how to integrate an essential caregiver into a function while keeping the goal patient-based.

Progress Reports and Daily Notes

Don't Write This:



Isn't More Better?

- While entries that are too brief are likely to omit critical content that supports your services, ***more is not always better.***
- For example:
  Skilled services this week included lingual retraction exercises, labial strengthening and coordination exercises, tactile stimulation for increased oral response, deep pharyngeal stimulation for increased swallow response, deep pharyngeal stimulation for improved swallow initiation time, oral muscle exercises for strength, oral muscle exercises for coordination, oral motor exercises to improve oral transit time, oral motor exercises to improve mastication effort, training in compensatory techniques, training in use of chin tuck, training in use effortful of swallow, training in use of purposeful throat clear, training in use of airway protection strategies, training in use of pacing, training in use of controlled rate of swallow, trials of thin liquids by cup, trials of thin liquids by straw, trials of thin liquids with serial swallow presentation, trials of textured solids – single item, trials of textured solids – dry/coarse, education for texture management, education for swallow precautions, education for use of compensatory technique.

What should be in a progress report?

- Goal status updates:
  - What are you measuring and how are you measuring it?
    - Have you included too many variables to ever advance the goal?
    - Did you set the goal in percentages but are reporting in levels?
    - Was enough progress made that progress is primarily where you show material impact? If not, what impact did you have and where are you going to document it?
- Evidence of a skilled brain:
  - Build/Library documentation will stop looking skilled very quickly, there must be evidence that a brain was involved.
    - What issues predominated in the past treatment week? What things required the most of your bandwidth?
    - What was changed, progressed/advanced or re-worked based on how the patient responded to treatment?
      - **Be sure to include context.** Decisions that are not properly in context can look very odd at a later date.
- The reason more services are required:
  - You are using the activities and changes from last week to show how another week is reasonable: the patient's progress, the need for multiple changes to the plan or how the patient is cared for, the risk of the patient, the need to reach specific functional levels before discharge is viable – all these demonstrate why another period of therapy is reasonable and necessary.

Progress Report – Example, Dysphagia

Goals summary shows patient met 1/4 short term goals, and no measurable progression towards the long term goals.

In the assessment area:

- **Poor:** Patient show good response to treatment with progress to goals. Additional improvement is expected.
- **Better:** Patient improved in ability to sustain midline posture, and is showing better oral control of puree items in most sessions. However, often very sleepy this week, not safe to trial more advanced textures. Continue plan of care.
- **Best:** Patient showed ability to sustain midline posture 2 minutes before need for correction, and is able to maintain anterior control of pureed items on 80% of presentations. Noted increased sleepiness this week, trained caregivers in analysis of responsiveness prior to offering food or fluid as well as oral sweep/clear after meal. Nursing notified, advised that patient with UTI being treated which should allow resumption of challenge texture presentation. ST to focus on postural management and controlled trials of puree presentation to improve oral bolus formation and transit, and will progress to trials of more challenging textures as alertness improves.

Bonus Tip: Never document a barrier without documenting how you worked around it and how the patient responded. Documenting barrier after barrier undermines the case for services being reasonable!

This is not supported by the goal summary, and if no progress has been made so far why would progress be expected next week?

Attempted to capture progress outside of goal areas (should these areas be goals?) but descriptions are vague; explained why progress might have been limited (sleepiness) but without explaining why there is any assumption that this treatment will be effective in the upcoming week.

Reports progress that was noted outside of specific goal areas (should these areas be goals?), and quantifies them. Discusses the barrier as well as the risks it presents to the patient. Shows material impact distinct from progress to goals by reporting caregiver training. Identifies cause of barrier and explains why it is reasonable to think more progress will occur. Identifies treatment plan that is appropriate even in the presence of the barrier.

Progress Report – Example, Language

Goals summary shows patient met 3/4 short term goals, and 33% measurable progression towards the long term goals.

- **Poor:** Patient with progress to all goals, continue treatment.
- **Better:** Patient showing progress in the areas of word retrieval and fluency, with good response to treatment and excellent potential to make further progress. Patient is cooperative and motivated with all activity.
- **Best:** Patient has made excellent progress in response to therapy this week, see goal summary for details. Patient will benefit from increasing challenge for additional improvements in word retrieval, activities this week will increase linguistic demand and decreased contextual cues. Fluency is near functional for controlled, simple conversations so ongoing treatment will include structured/supported conversation with less familiar communicative partners in a higher distraction environments.

While the statement is true, and material impact is clearly in the progress being made, part of the skill is in the adaptation and analysis of treatment and none is shown here.

Uses past progress to justify expectation of future progress, and motivation and cooperate are good prognostic indicators. But there is still no true analysis or adaptation.

There is no need to restate documentation that already exists within the record, so no need to re-summarize goals. In a patient who is progressing well, it is important to link the recovery to the interventions. Demonstrating how the increase in challenge will further improve ability shows both skill and how the services are reasonable.

Daily Notes

- The CMS daily note requirement is met with what is recorded in a service log.
  - Some states have a daily narrative requirement (in some states the requirement is really for PT and OT, but ST daily notes end up turned on in the EMR systems.)
- It is critically important to remember that although daily narrative note is not required for Medicare, it is *always* required when anything occurs that warrants reporting. It is the mechanism whereby you demonstrate that your services routinely met acceptable standards of practice and where you demonstrate your appropriate real-time management of high-risk patients.
- Daily notes are also a very relevant place to capture the skilled nature of your services, since much of our skill is in the immediate adjustment, analysis and adaptation of our treatment delivery based on the patient we have in the moment.

*Bonus Tip: Avoid only documenting what the patient did, and document what **you** did in response to the presentation of the patient.*

The Secret to Showing Skill

- What did you do to make it *harder?*
  - Did you progress the texture, the pace, the bolus size, did you start to alternate solids and liquids?
  - Did you make the environment more distracting?
  - Did you increase the number of choices in the field? Did you eliminate gestural cues?
  - Did you increase the number of steps? Did you increase the latency? Did you require abstraction?
- What did you do to make it *safer?*
  - Did you downgrade the texture, slow the pace, cue for effortful swallow, cue for purposeful throat clear?
  - Did you decrease the distractions, reconfigure the postural support, or develop a cueing system?
  - Did you teach caregivers how to present the bolus, cue the patient, position the patient, or de-escalate the patient?
- What did you do to make it more *effective*?
  - Did you teach a strategy, an adaptation or compensation?
  - Did you develop or reconfigure a cueing system?
- How did you push the patient into a challenge state with tipping them into risk or resistance?
  - How did you know it was safe to present the next bite or try the more advanced texture?
  - How did you know it was safe to keep delivering the advanced texture?
  - How did you keep the patient with confusion from decompensating?
  - How did you get the resistant patient to participate?

Daily Notes - Examples

Poor:

- Gave patient lunch, oral care provided. Tolerated well. Educated on swallowing guidelines. Continue speech therapy.
- Patient seen for cognitive retraining. Patient with severe confusion and resistance to treatment. Spent 20 minutes calming patient down. Patient very distressed. Unable to complete problem solving exercises, completed reminiscing exercises.
- Talked with family about patient's aphasia, gave education on ways to engage patient in meaningful communication.
- Patient seen for swallowing treatment. Oriented patient to location and purpose of therapy, showed patient call light and reinforced how to use. Patient pleasant and cooperative.

Neither giving a meal nor providing oral care is a skilled service – a caregiver can do either of these will equal efficacy. Educated who about what? (Be cautious about educating patients who have documented confusion or dementia.) The skilled component is mostly missing.

This is a summary of barriers without evidence of adjustment, there is nothing that supports that anything meaningful could be accomplished during this session.

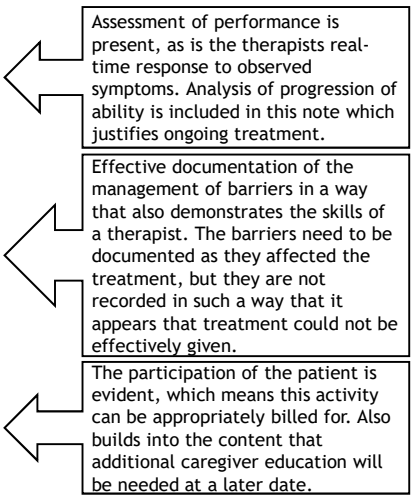
While this is an appropriate activity, this can only be a billable service if the patient is involved. If this education is provided without the participation of the patient, while important, it cannot be billed for.

No swallowing therapy appears to have occurred during this swallowing treatment session. If the patient needs cognitive-communication therapy also, a plan of care should be developed.

Daily Notes - Examples

Good:

- Saw patient during noon meal, presented with 2 varied mechanical soft items. Needed 66% cuing for portion size and 50% cuing for rotary chew pattern. Mild oral residue after approximately 20% of swallows, effectively cleared with small sip of thin liquids. No change to vocal quality. Not appropriate for diet advancement yet due to need for continuous cueing, continue speech therapy for progressive oral-pharyngeal retraining and texture trials.
- Patient seen for cognitive-communication retraining. Patient required de-escalation of agitation via sensory stimulus management at session onset, effective in facilitating transition to treatment activities. Treatment selections skewed to high-success opportunity recall items to facilitate sustained attention. Patient unable to complete abstract problem solving exercises today but was able to engage in low-mid complexity sequencing activities with 75% success.
- Spouse present during session today, able to provide education to both patient and spouse about aphasia. Demonstrated effective communication techniques with patient with good reverse demonstration by spouse. Will provide additional education for communication strategies throughout treatment course as patient's abilities progress.



Discharge Summaries

- Summary, (n.): *brief statement or account of the main points of something*.
- The discharge summary is way to explain the ultimate outcome, justify the termination of services, and briefly describe the course of care.
- Much like the progress report, **context is very important.** If the rationale behind treatment choices is not clear (especially the decision to terminate services before established goals were met) the case may not appear reasonable.
- The discharge summary should answer the following questions:
  - What was the patient able to do?
  - What was the patient unable to do?
  - Why was it time to stop?
  - Why was the decision made to stop remediation of remaining impairments?
  - What were the most important aspects of the course of treatment?
  - What is required/Who is responsible for maintaining the recovered function?
  - Where is the documentation that demonstrates training for those responsible for maintaining the recovered function?

Discharge Summary – Example, Dysphagia

Goals summary shows patient met 3/5 short term goals, and 50% of the components of the long term goal.

- **Poor:** Mr. J discharged from speech therapy, maximum progress attained. RNA training completed. Potential to maintain progress is good.
- **Better:** Mr. J is being discharged from speech therapy after successful progression from puree/NTL to mechanical soft textures and thin liquids. Patient unable to consistently tolerate whole meats without R-sided pocketing, RNA's trained in cueing techniques for effective oral clearing of mechanical soft with 100% effective response from patient. Patient has reached maximum at this time.
- **Best:** Mr. J is being discharged from speech therapy after a course of comprehensive oral and pharyngeal retraining to improve functional activity tolerance for sustained mastication and improved airway protection. Mr. J successfully advanced from puree solids/NTL to mechanical soft textures and thin liquids. Despite increased therapeutic intervention for oral strength and agility, Mr. J was unable to progress to regular textured meats without persistent R sided pocketing, so this texture is not appropriate at this time – patient without evidence of texture aversion. CNA/RNA training in verbal cuing for rotary chew pattern and alternating solids and liquids is 100% effective in facilitating oral clearing with mech soft textures and prognosis to maintain this level of function with the support of trained caregivers is excellent. Patient appears to have received maximum benefit from skilled speech therapy at this time.

No evidence of clinical analysis or explanation of why unmet goals no longer warrant treatment. No support for why potential to maintain function is good.

Summarizes response to treatment, but not what the treatment was about, mentions caregiver training but not what was trained. Mentions the reason for the unmet goals being stopped, but does not justify the treatment attempted.

Brief statement explaining the course of treatment and summary of response. Justification for discontinuing unmet goal present, as well as the intention of the treatment provided for the goal. Explicit documentation of who was trained and for what purpose. Addresses possible ongoing risk factors (texture aversion).
Note: If notes capturing caregiver training are present in daily notes, it is acceptable to refer to specific entries for details.

Discharge Summary – Example, Cognition

Goals summary shows patient met 4/5 short term goals, and 75% of the components of the long term goal.

- **Poor:** Mrs. M d/c'd from speech therapy, most goals met. Patient with ongoing confusion, needs 24 caregiver assist. Will receive home health speech therapy to address remaining deficits.
- **Better:** Mrs. M is being discharged home with husband who will be present 24 hrs. Good response to therapy, with most goals met. Patient with ongoing confusion, will need additional therapy to address remaining impairments. Memory board provided.
- **Best:** Mrs. M is being discharged home after receiving rehabilitation for her R sided CVA. Speech therapy consisted of cognitive-linguistic training focusing on insight and reasoning in daily household situations, recent and prospective memory, and sequencing for participation in self care activities. Mrs. M made good progress with speech therapy, meeting goals for simple problem solving and set-up assist use of journal for recall of daily events. Because of remaining impairments in insight, she will require 24 hour supervision. Mr. M's husband has been trained in cueing for use of her journal as well as safety management strategies for supervision and environmental management. Mrs. M has more potential to improve, and a home health referral has been made.

No summary of course of care. Going home with residual cognitive deficits, does anything need to happen to ensure the patient's safety?

Covers the basics, does not detail training provided by the therapist for safety in the home, does not analyze the impact of the remaining deficits.

Summarizes purpose and focus of treatment as well as overarching progress. Addresses impact of reaming impairment and details training provided.
Note: There is no need to restate individual functional performance areas summarized in a goal status update section.

In Summary

- Never assume that what you can see in your mind is evident on the paper – it is only clear when you make it clear.
- Remember that more is not always better – three power sentences are better than two fluffy paragraphs.
- No examples could ever properly capture the amazing variety of patients you will see, so they can only take you so far.
- The key is to remember the regulations and practice issues that drive the content:
  - Why is it necessary?
  - How is it reasonable?
  - Where are your skills showcased?

  Did you make a material impact?

- Remember the vital importance of what you do, and never let your documentation undermine the quality of your service and the power of your skills.