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Thriving in Skilled Nursing: Part II

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Session Description

Providing speech therapy services in skilled nursing facilities can be a daunting and rewarding experience.

This session will describe the roles of key interdisciplinary team members, discuss medical complexities affecting clinical decision making, and provide guidance on creation of treatment plans and goal building to support reimbursement of services

Objectives

1)Describe roles of key interdisciplinary team members in long term care settings

2)Explain effects of medical complexities which affect clinical decision making for residents in long term care settings

3)Describe how to develop treatment plans and develop functional, measurable goals which promote reimbursement of services

OBRA 1987

The Omnibus Budget Reconciliation Act of 1987 (OBRA '87) dramatically changed the way Skilled Nursing Facilities (SNFs) approached resident care, radically modifying nursing home regulations and the survey process.

- The federal government established a requirement for comprehensive assessment as the foundation for planning and delivering care to nursing home residents.

- Mandated that facilities "provide necessary care and services to help each resident attain or maintain their highest practicable physical, mental, and psychosocial well-being." and "ensure that the resident obtains optimal improvement or does not deteriorate within the limits of a resident's right to refuse treatment, and within the limits of recognized pathology and the normal aging process."
(Code of Federal Regulations [CFR] Title 42, Part 483.25.

What's going to Work? TEAMWORK

in·ter·dis·ci·pli·nar·y team (intĕr-disi-pli-nar-ē tēm): a group of health care professionals from diverse fields who work in a coordinated fashion toward a common goal for the patient.

Many hands make light work.

Alone we can do so little; together we can do so much"
- Helen Keller

Key Facility IDT Members

- Administrators, Owners. May be "in-house" or contract therapy
- Therapy Providers- PT,OT,ST; PTA and COTA, note that Medicare does not recognize SLPAs as providers
- Nursing- Director of Nursing, RN, LPN, CNAs
- Dietary- Registered Dietician, Dietary Manager, Dietary Assistants
- Social Worker

Residents. Family Members.

Speech Pathology- Reasons for Referral

- Coughing, throat clearing, watery eyes and/or runny nose at meals
- Decreased PO intake
- Weight loss/dehydration risks
- Increased time to complete meals/SOB at meals
- Refusal to eat/painful swallowing

- Decreased ability to respond to ?'s, ability to communicate needs, decreased vocal loudness, and/or ability to follow commands
- Increased forgetfulness
- Poor attention to task, problem solving and/or safety awareness

Physical Therapy- Reasons for Referral

- Shuffle Gait
- Unsteady Gait
- Frequent Falls
- Weakness
- Pain
- Open Wound
- Swelling
- Contractures

- Unable to get in/out of bed
- Needs help to walk or transfer
- Limited ROM
- Unable to maneuver w/c
- Leg splint causing redness
- Restraint needs

Occupational Therapy- Reasons for Referral

- Weakness
- Contractors
- Difficulty Dressing
- Vision Problems
- Restraint Needs
- Difficulty grooming
- Limited Range of motion
- Unable to follow directions
- Poor problem solving skills
- Unable to get on or off the toilet
- Unable to use hand in task
- Hand/wrist splint causing redness
- Memory problems

Individual Therapy

- Individual Therapy
  - Therapy provided on an individual basis
  - "One on one"

Individual Therapy Example

- Mr. Weary is receiving SLP services for dysphagia. He received one on one treatment time of 30 minutes.

- MDS Record:
  - Individual Therapy= 30 minutes
  - All 30 minutes are counted toward MDS

Concurrent Therapy

- Concurrent Therapy
  - Treatment of 2 residents at the same time, when the residents are not performing the same or similar activities, regardless of payor source, both of whom must be in line-of-sight of the treating therapist for Part A.
  - When a Part A resident receives therapy that meets this definition, it is defined as concurrent therapy for the Part A resident, regardless of the payor source of the second resident.

Concurrent Therapy Example

- Tammy Therapist is treating two Part A patients. She assists Mr. A with Therapeutic Exercises in order to improve Lower Extremity strength due to knee buckling during gait. She also performs interventions with Ms. B for balance activities. She goes back and forth between the two patients. Total treatment time is 20 minutes.
- MDS Record:
  - Concurrent for each patient is 20 minutes.
  - 10 minutes is counted toward RUG.

Group Therapy

- Part A as the treatment of 4 residents, regardless of payor source, who are performing the same or similar activities.
- Part B: treatment of two patients or more, regardless of payor source, at the same time.

Group Therapy Example

- Ollie, OT, is performing a Group activity with 4 patients for cooking. While in the activity, the patients work on fine motor skills for chopping and measuring, balance activities by reaching in cabinets and cognition by ability to follow directions. The treatment for all 4 patients lasts one hour.
- MDS Record:
  - Group Therapy: 60 minutes for all four patients
  - 15 minutes are counted toward RUG score

Co-Treatment

- Part A:
  - When two clinicians, each from a different discipline, treat one resident at the same time with different treatments, both disciplines may code the treatment session in full.
- Part B
  - Therapists, or therapy assistants, working together as a "team" to treat one or more patients.
  - Cannot bill separately for the same or different service provided at the same time to the same patient.

Co Treatment Example: ST/OT

- Speech and Occupational Therapy may provide co treatment to an individual during meal time in order to yield greater meal time functional outcomes for an individual with dysphagia in addition to self feeding deficits.

Co Treatment Example PT/ST

- Physical and Speech Therapy may provide co-treatment for an individual who presents with gait disturbance in addition to cognitive impairments affecting their abilities to negotiate obstacles in facility in order to yield greater functional outcomes for ability to ambulate throughout environment

Medical Complexities

Determining Need for Skill

- Evidenced Based Practice
- Complexity and Sophistication
- Medical Diagnoses
- Individualized Frequency and Duration

Evidenced Based Practice

- *The services shall be considered under **accepted standards of medical practice** to be a specific and effective treatment for the patient's condition. Acceptable practices for therapy services are found in:*
  - *Medicare manuals (such as this manual and Publications 100-03 and 100-04),*
  - *Contractors Local Coverage Determinations (LCDs and NCDs are available on the Medicare Coverage Database: http://www.cms.hhs.gov/mcd and*
  - *Guidelines and literature of the professions of physical therapy, occupational therapy and speech-language pathology.*

To be considered reasonable and necessary, the following conditions must be met: (CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 220.2(B))

Complexity and Sophistication

- *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 qualified therapist*
- *Services that do not require the performance or supervision of a therapist are not skilled and are not considered reasonable or necessary therapy services, even if they are performed or supervised by a qualified professional.*
- *If the contractor determines the services furnished were of a type that could have been safely and effectively performed only by or under the supervision of such a qualified professional, it shall presume that such services were properly supervised when required. However, this presumption is rebuttable, and, if in the course of processing claims it finds that services are not being furnished under proper supervision, it shall deny the claim and bring this matter to the attention of the Division of Survey and Certification of the Regional Office.*

To be considered reasonable and necessary, the following conditions must be met: (CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 220.2(B))

Medical Diagnoses

- *While a beneficiary's particular medical condition is a valid factor in deciding if skilled therapy services are needed, a* ***beneficiary's diagnosis or prognosis should never be the sole factor in deciding that a service is or is not skilled****. The key issue is whether the skills of a qualified therapist are needed to treat the illness or injury, or whether the services can be carried out by non-skilled personnel. See item C for descriptions of skilled (rehabilitative) services.*

To be considered reasonable and necessary, the following conditions must be met: (CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 220.2(B))

✓ Medical History

Onset or Exacerbation Date

- Onset/Exacerbation Date: the date of the functional change which as a result of dx indicated the need for skilled care
- Chronic Conditions: May not be the date of dx for condition, however related to exacerbation of dx process
- New Conditions: CVA/TBI will be date of new insult

In conjunction current symptoms

- Provide correlation of why new onset has resulted in symptoms requiring your unique skilled services.

Frequency and Duration

- *There must be an expectation that the patient's condition will improve significantly in a reasonable (and generally predictable) period of time, or the services must be necessary for the establishment of a safe and effective maintenance program required in connection with a specific disease state. In the case of a progressive degenerative disease, service may be intermittently necessary to determine the need for assistive equipment and/or establish a program to maximize function (see item D for descriptions of maintenance services); and*
- *The amount, frequency, and duration of the services must be reasonable under accepted standards of practice. The contractor shall consult local professionals or the state or national therapy associations in the development of any utilization guidelines.*

Reason for Referral

- Patient referred to ST due to decline of cognitive-communicative deficits and patient is now unable to perform executive function abilities secondary to lack of spontaneous recovery following hospitalization.
- Current Medical Hx: Current medical hx includes but not limited to: **UTI**, HTN, GERD, COPD, and **dementia, AMS**
- Past Medical History: PMH includes but not limited to: UTI, HTN, dementia, GERD, COPD,T12 compression fx, acute back **pain**, TIA, R wrist fx

Altered Mental Status

CAUTION:
Altered Mental Status
- Urinary Tract Infection
- Sepsis
- S/p Surgical Intervention; Anesthesia
- Depression
- Polypharmacy
- ETOH or Drug Withdrawal

Beware- Conditions which will spontaneously improve without skilled intervention

Delirium- DSM IV

Disturbance of Consciousness (i.e. reduced clarity of awareness of the environment) with reduced ability to focus, sustain, or shift attention
- Not due to a pre-existing, established, or evolving dementia
- **Disturbance develops over a short time (usually hours to days), and tends to fluctuate during the day**
- Evidence supports disturbance as caused by the direct physiological consequences of a general medical condition

UTIs and Dementia

Younger Adults with UTI	Older Adults with UTI
Experience distinct physical symptoms. Have painful urination, increased need to urinate, lower abdominal pain, back pain on one side, fever and chills.	Changes in the immune system related to reactions to infection occur as we age Seniors with a UTI may show increased signs of confusion, agitation or withdrawal. In individuals with dementia, UTIs can cause distressing behavior changes (delirium) which can develop in as little as one to two days. Symptoms of delirium can range from agitation and restlessness to hallucinations or delusions. UTIs can speed up the progression of dementia, making it crucial for caregivers to understand how to recognize and limit risks for UTIs in seniors.

Dementia and Depression

Assessment Tool- Geriatric Depression Scale
https://www.healthcare.uiowa.edu/igec/tools/depression/GDS.pdf

Prior to Testing Rule Out Depression/Delirium
One widely used screening tool is the Geriatric Depression Scale Short Form
A score of 5 suggests depression, while a score of 10 or more is highly suggestive of depression.

Rule out delirium
Acute disturbance of brain function, associated with physical illness
Results in disturbance of memory, language skills and orientation
Can develop in hours & days; dementia takes months and years

Confusion Assessment Method (CAM)

The Confusion Assessment Method (CAM) includes two parts. Part one is an assessment instrument that screens for overall cognitive impairment. Part two includes only those four features that were found to have the greatest ability to distinguish delirium or reversible confusion from other types of cognitive impairment.

Description

Approximately 15 - 60 % of elderly patients experience a delirium prior to or during a hospitalization but

the diagnosis is missed in up to 70% of cases. Delirium is associated with poor outcomes such as

prolonged hospitalization, functional decline, and increased use of chemical and physical restraints.

Delirium increases the risk of nursing home admission. Individuals at high risk for delirium should be assessed daily using a standardized tool to facilitate prompt identification and management. Risk factors for delirium include older age, prior cognitive impairment, presence of infection, severe illness or multiple co-morbidities, dehydration, psychotropic medication use, alcoholism, vision impairment and fractures.

Derived from:

http://consultgerirn.org/uploads/File/Confusion%20Assessment%20Method%20(CAM).pdf

When to screen for potential skilled need?

- UTI, repeat Urinary Analysis (UA) and completed course of Antibiotic Therapy (ABT)
- Surgical Intervention, Discharge from hospital >10 days after surgery/hip fracture.
- Polypharmacy, complete thorough chart review, speak with nursing regarding adjustment to new medications.

What about Chronic/Progressive Conditions?

- COPD/CHF
- Progressive Neurological Diagnoses
- Late Effects CVA

Individuals with Chronic Conditions

- *Rehabilitative* therapy may be needed, and improvement in a patient's condition may occur, even *when* a chronic, *progressive, degenerative,* or terminal condition exists.
- For example, a terminally ill patient may begin to exhibit self-care, mobility, and/or safety dependence requiring skilled therapy services. The fact that full **(full movement from baseline to plof)** or partial recovery is not possible does not necessarily mean that skilled therapy is not needed to improve the patient's condition *or to maximize his/her functional abilities.*
- The deciding factors are always whether the services are considered reasonable, effective treatments for the patient's condition and require the skills of a therapist, or whether they can be safely and effectively carried out by non-skilled personnel.

Treatment Planning Goal Writing

Can I skill/treat for?

- Treating a Medicare Part B 3x a week?
- Esophageal Phase Dysphagia?
- For completion of OMEs?
- For reduced intake/weight loss?
- Because the daughter wants an upgraded diet?
- For MCI? GDS Stage 4-5? Stage 6-7?
- Because the patient can't hear us?
- To treat cognitive dysfunction if OT is treating Cog?

Overview: Plan of Care (POC) Requirements

- ✓ **Order or Referral**
- ✓ Clear distinction for **Evaluation/Re-evaluation or Screening**
- ✓ Beneficiary's **History** and the **Onset or Exacerbation Date** of the current disorder.
- ✓ **History in conjunction current symptoms** must establish support for additional treatment.
- ✓ **Prior Level of Functioning** should be documented
- ✓ **Baseline** abilities should be documented
- ✓ PLOF + Baseline establish the basis for the therapeutic interventions.
- ✓ **Plan, Goals** (realistic, long-term, functional goals)
- ✓ **Duration** of therapy, **Frequency** of therapy, and definition of the **Type of Service.**
- ✓ **Diagnostic and assessment testing** services to ascertain the type, causal factor(s) should be identified during the evaluation.
- ✓ Clarify if plan is anticipated to be **rehabilitative/restorative or maintenance based**

Goals/Treatment Measures

- REALISTIC/LONG TERM/FUNCTIONAL
- There should be an expectation of **<u>measurable functional</u>** improvement.
- measurable component (percentile) needs to be attached to all short and long term goals
- Functional component (in order to…) needs to be attached to all short and long term goals.
- SUB-TASK functional impairment areas in order to measure more specific changes in function

Long Term versus Short Term Goals

- **LONG TERM GOALS** should reflect the highest level of desired function anticipated upon discharge. In most cases will be reflective of patient's prior level of function (PLOF)
- **SHORT TERM OBJECTIVES** are the stepping stones, targeted specific areas that are used to increase overall function in order to achieve LTGs

Sample LONG TERM

Auditory Comprehension	Patient will improve auditory comprehension to Independent in order to improve receptive communication skills
Cognition	Patient will increase cognitive skills to Independence to improve ability to participate in meaningful interactions
Cognitive Communicative	Patient will exhibit adequate cognitive-communicative skills for discharge home with No Supervision with environmental modifications as training to facilitate safety and independence
Motor Speech	Patient will increase speech intelligibility at the highest functional verbal expression level to 100% with familiar listeners, unfamiliar listeners and with groups

SHORT TERM: Auditory Comprehension

- Patient will demonstrate auditory comprehension of _____
- CHOOSE SPECIFIC LEVEL (biographical yes/no; environmental yes/no, simple yes/no, complex yes/no, common ADL objects, association objects/items, simple questions, simple instructions/commands, complex questions, simple conversation, complex conversation, various levels of functional communication, specific medications)

ADD measurable COMPONENT **with 100% accuracy and no cues in**

ADD FUNCTIONAL ASPECT **order to improve receptive communication skills**

SHORT TERM: Auditory Comprehension

Patient will follow 1-step commands with 100% accuracy in order to enhance patient's ability to follow directions for activities and ADLs

Patient will follow multi-step verbal commands with 100% accuracy and 25% verbal cues in order to enhance patient's ability to increase ability to participate in ADLs

Remember to SUB-TASK

- Expressive Language
  - Establish and advance goals across communication levels from automatics; word- conversation
- Receptive Language
  - Responding to yes/no, open ended versus closed ended ?'s
- Swallowing
  - Break down goals by phase of swallow- oral prep, oral, pharyngeal, upper 1/3rd esophageal
- Voice
  - Obtain baselines on specific areas- quality, pitch, intensity and create goals across these areas
- Cognition
  - Remember higher level executive function includes many areas- breakdown specifically for problem solving, sequencing and instrumental activities of daily living.

Considerations **Prior** to Creating Goals

Step One:

What is the gap between current baseline and the individuals prior level of function? What intensity of services are needed to return individual to PLOF?

Step Two:

What is the individuals desired long term outcome?

Step Three:

Will the plan be **restorative** or **maintenance** based in nature?

Can I use CUES in my GOALS?

- PROS
  - Can Assist at the Start of Care with Documenting stimulability for tasks and ability to learn
  - Can be beneficial for SHORT TERM maintenance based plans to reflect level of assist needed from caregivers at end of skilled care
  - Can be beneficial for showing increased "I" for patients when we are able to wean in conjunction with reflecting increased functional abilities

- CONS
  - If you use in goal you MUST measure consistently at all PRs and RECERTS
  - Once deemed repetitive in nature difficult to show skilled need
  - Clinician must show unique skilled need via increased overall function in conjunction with reduction of cues
  - Medicare will NOT ALLOW continued skilled need for cues alone

Baseline

The initial assessment establishes the **baseline** data necessary for evaluating expected rehabilitation potential, setting realistic goals, and measuring communication status at periodic intervals.

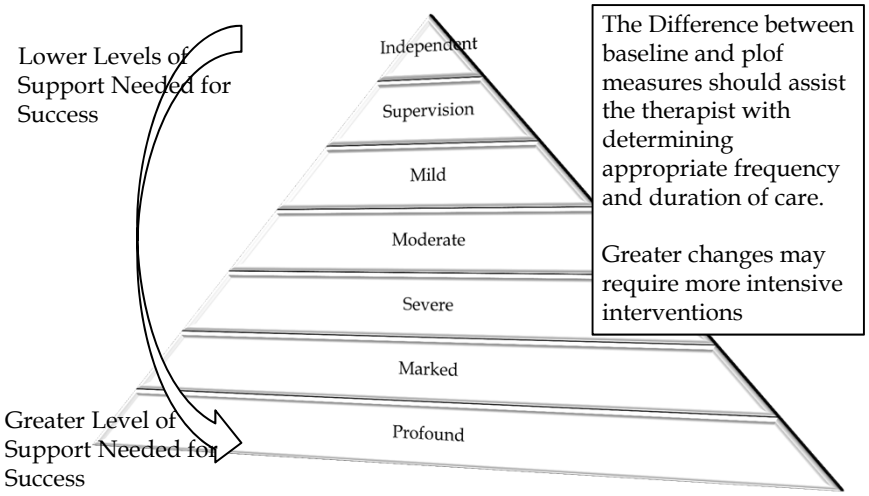
Methods for obtaining **baseline** function should include objective or subjective baseline diagnostic testing (standardized or non-standardized) followed by interpretation of test results, and clinical findings.

Goals should not be created for areas which do not have documented baseline measures, hence "DNT" or "Will not be addressed during POC" should not be used for target areas

Prior Level of Function

- The individuals' **prior level of function** refers to their functional level of independence prior to onset of decline which necessitated need for skilled therapy screening, and if deemed necessary, further evaluation and skilled intervention.

The Space Between

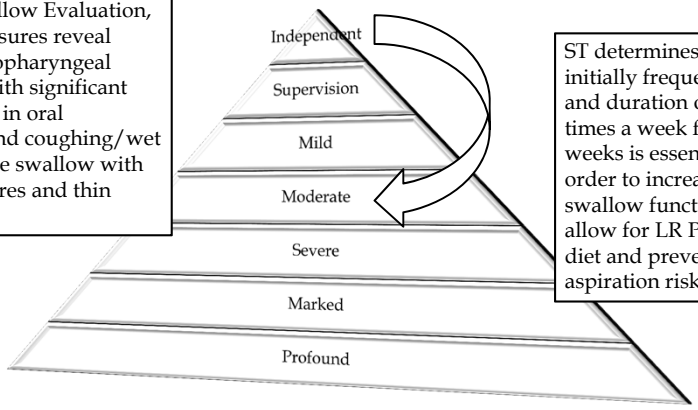


The Difference between baseline and plof measures should assist the therapist with determining appropriate frequency and duration of care.

Greater changes may require more intensive interventions

Case Study- "Rehab Therapy"

Ms. Jones is referred for Bedside Swallow Evaluation, baseline measures reveal moderate oropharyngeal dysphagia with significant impairments in oral processing and coughing/wet voice after the swallow with regular textures and thin liquids

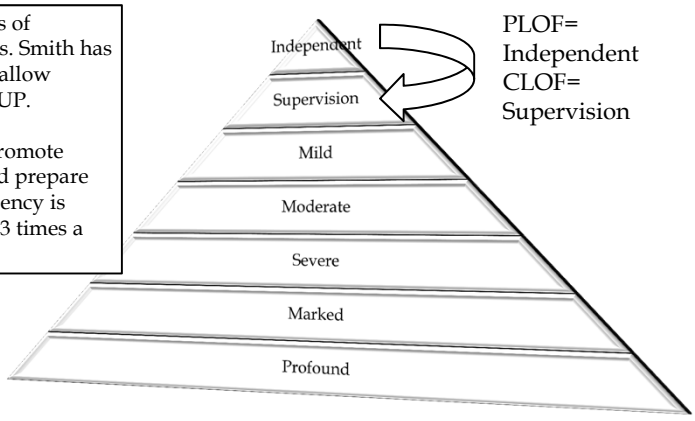


ST determines initially frequency and duration of 5 times a week for 4 weeks is essential in order to increase swallow function, allow for LR PO diet and prevent aspiration risks

Rehab to Maintenance

After 4 weeks of treatment, Ms. Smith has increased swallow function to SUP.

In order to promote carryover and prepare for d/c frequency is decreased to 3 times a week



PLOF= Independent
CLOF= Supervision

Dementia- Rehab & Maintenance

An individual with dementia of Alzheimer's type has noted difficulty following directions during ADL tasks

Maintenance Skilled therapy may be reasonable and necessary to increase ability to follow directions via use of external visual aides

Rehab/Restorative Skilled therapy may be reasonable and necessary for use of Spaced Retrieval Therapy to improve environmental orientation.

The Jimmo Affect… Can't I treat anyone now?

Clarified with Jimmo versus Sebelius Final Ruling:

- Establishment or Design of a Maintenance Program
- Delivery/Performance of a Maintenance Program
- Delivery of Rehabilitative/RestorativeTherapy

Maintenance Sample: VOICE

Motor Speech/Voice:
Skilled ST services may be deemed reasonable and necessary in order to maintain vocal clarity and intensity for an individual with Parkinson's Disease in order to continue training via use of Lee Silverman Voice Therapy (LSVT) techniques for maintenance. Note: transition from therapy services aimed at increasing function to maintenance therapy should occur following therapist/resident determination that max benefit has been achieved at a particular communication level (word, phase, sentence, structured conversation, or spontaneous conversation) with maintenance interventions being aimed at continued communication success (pending modifications which may be warranted secondary to typical declines with disease progression) at this level at a decreased intensity from prior services.

- Why can these services not be transitioned to a non-skilled professional such as a CNA or Nurse for restorative/maintenance?
- Due to the progressive nature of vocal and motor speech system changes, the skilled eye of an SLP is needed to develop and continue vocal function protocol and conduct differential diagnosis when changes occur across various systems of communication with disease progression.

Maintenance Sample: Cog-Language

Auditory Comprehension/Cognition:

Skilled ST services may be deemed reasonable and necessary in order to maintain auditory comprehension skills in the following instances:

An individual s/p new neurological insult following a period of intensive skilled ST interventions aimed at increasing abilities to comprehend language and perform cognitive tasks (sequencing, problem solving) at the highest level possible continued services for maintenance may be warranted to continue skilled therapeutic tasks for high level tasks in order to prevent functional declines in preparation for d/c to prior living environment while continued services are being provided by PT/OT. Interventions provided as maintenance versus rehabilitation in nature are to be provided at a decreased intensity from initial services.

Why can these services not be transitioned to a non-skilled professional?

Skilled interventions for high level auditory comprehension tasks including ability to follow multi-step ADL/IADL commands; comprehend conversational interactions; sequence during tasks and complete functional problem solving with others requires administration of tasks which cannot be performed or conducted by a non-skilled professional. In addition, tasks in the above instance will require periodic modification secondary to anticipated increased success with PT/OT sessions which will change task segmentation and progression of ADLs and IADLs. Remember- cases such as described may also move from rehabilitative in nature to maintenance to return to rehabilitative in nature secondary to increased physical abilities necessitating the need for higher level cognitive and language learning.

Maintenance Sample: Dysphagia

Skilled therapy services may be deemed reasonable and necessary in order to maintain adequate swallow functions for pleasure feeding regiment which is clearly defined and agreed upon by members of the interdisciplinary team in conjunction with the resident and family members.

Why can these services not be transitioned to a non-skilled professional?

Per the Medicare Benefit Policy Manual (2014):

Swallowing assessment and rehabilitation are highly specialized services. The professional rendering care must have education, experience and demonstrated competencies. Competencies include but are not limited to: identifying abnormal upper aerodigestive tract structure and function; conducting an oral, pharyngeal, laryngeal and respiratory function examination as it relates to the functional assessment of swallowing; recommending methods of oral intake and risk precautions; and developing a treatment plan employing appropriate compensations and therapy techniques.

Above competencies cannot be performed by a non-skilled professional in an individual presenting with dysphagia severity which would warrant pleasure feedings.

Note- need for pleasure feedings must be necessitated by a dysphagia secondary to oral, pharyngeal, and/or upper 1/3rd of the esophageal phase. Services for maintenance in end stage of dementia secondary to presence of tongue thrust as root cause or esophageal impairments/strictures/blockages in the lower 2/3rd of the esophagus would not warrant services as they are not covered for the Medicare Beneficiary.

Questions?