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DOCUMENTING IN SKILLED NURSING FACILITIES: PART II

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Course Description

This course will describe best practices for documenting skilled levels of care provided by an SLP including in depth review of goal creation, daily note documentation, and progress report writing.

In addition, case studies will be used in order to support documentation in real world settings

Course Objectives

1. **Participants will be able to identify methods for writing functional, measurable and realistic short term objectives and long term goals for restorative and maintenance-based levels of care.**
2. **Participants will be able to describe how to document skilled levels of care within daily notes.**
3. **Participants will be able to describe best practices for documenting functional gains made during SLP services in progress reports**

Know your REGULATIONS

- **Medicare Benefit Policy Manual Chapter 15 Section 220**
- **National Coverage Determinations**
- **Local Coverage Determinations**
  - **Regional Specific**

MEDICARE BENEFIT POLICY MANUAL
CHAPTER 15
"REASONABLE AND NECESSARY"

Indications for Speech Therapy Services

- *Speech-language pathology services are those services provided within the scope of practice of speech-language pathologists*
- *Necessary for the diagnosis and treatment of speech and language disorders, which result in communication disabilities and for the diagnosis and treatment of swallowing disorders (dysphagia)*
- ***Regardless of the presence of a communication disability*.**

(See CMS Publication 100-03, Medicare National Coverage Determinations (NCD) Manual, Part 3, Section 170.3) (CMS Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 15, Section 230.3(A))

"Reasonable and Necessary"

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))

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"Reasonable and Necessary"

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))

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"Reasonable and Necessary"

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 nonskilled 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))

"Reasonable and Necessary"

Determining Appropriate 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.*

Evaluation Defined

An EVALUATION is a separately payable comprehensive service provided by a clinician, as defined above, that requires professional skills to make clinical judgments about conditions for which services are indicated ***based on objective measurements and subjective evaluations of patient performance and functional abilities (BASELINES).***

An Evaluation is warranted e.g., for a ***new diagnosis (change from plof).***

These evaluative judgments are essential to development of the plan of care, including goals and the selection of interventions.

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Documentation 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**

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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:

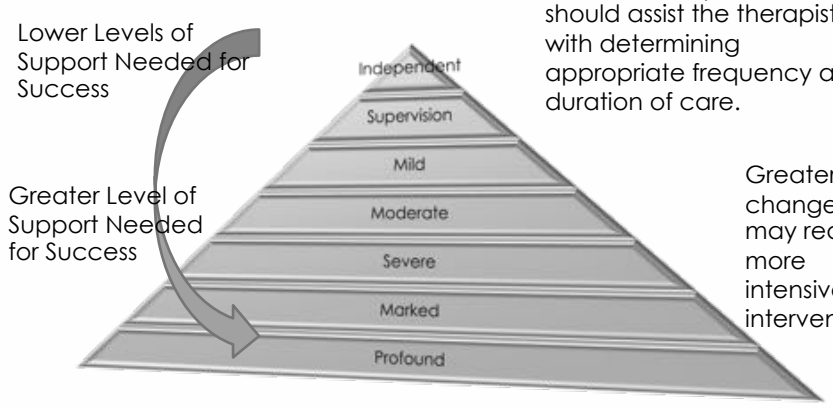
Will the plan be **restorative** or **maintenance** based in nature?

Prior Level of Function *Must be documented*

The residents' **prior level of function (PLOF)** refers to the 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.

Documented PLOF must reflect and align with skilled need.

Documenting Change from PLOF to Baseline



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

Rehab Therapy Defined

- *Rehabilitative/Restorative therapy includes services designed to address recovery or improvement in function and, when possible,* ***restoration to a previous level of health and well-being (i.e. PLOF)****.*
- *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.*

Maintenance Programs

- *MAINTENANCE PROGRAM (MP) means a program established by a therapist that consists of activities and/or mechanisms that will assist a beneficiary in maximizing or maintaining the progress he or she has made during therapy or to prevent or slow further deterioration due to a disease or illness.*
- The services of a maintenance program themselves are not covered. However, the development of a functional treatment plan for patient maintenance including evaluation, plan of treatment, and staff and family training, is covered, but it must require the skills of an SLP, and be a distinct and separate service which can only be done safely by a SLP

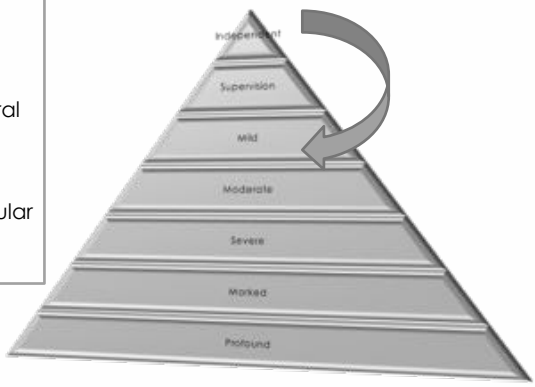
The Jimmo Affect…. Can't I treat anyone now?

Clarified with Jimmo versus Sebelius Final Ruling:

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

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

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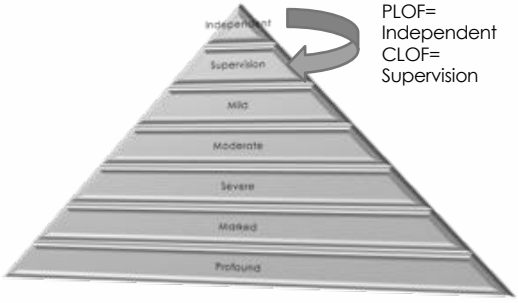
Rehab to Maintenance

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

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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.

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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.

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SNF Documentation Part II: SLP.COM

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.

GOAL BUILDING

Goals/Treatment Measures

- REALISTIC/LONG TERM/FUNCTIONAL
- There should be an expectation of **measurable functional** improvement.

- Measureable 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

S.M.A.R.T. GOALS

- Specific
- Measurable
- Attainable
- Realistic
- Timely

SPECIFIC

A specific goal has a much greater chance of being accomplished than a general goal. To set a specific goal you must answer the six "W" questions:

*Who:	Who is involved?
*What:	What do I want to accomplish?
*Where:	Identify a location.
*When:	Establish a time frame.
*Which:	Identify requirements and constraints.
*Why:	Specific reasons, purpose or benefits of accomplishing the goal.

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MEASURABLE

- There must be tangible criteria for measuring progress toward the attainment of each goal you set.
- To determine if a goal is measurable, ask questions such as……How much? How many? How will you know when it is accomplished?

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ATTAINABLE
(sometimes called ACTIONABLE or ACHIEVABLE)

- Goals must be set that can realistically be achieved

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REALISTIC

- A realistic goal is one that is attainable, but also one the patient or family agrees they are willing to work towards. Clients cannot achieve goals if they only work on them with the SLP during the treatment sessions.

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TIMELY or time-bound

- A goal should be grounded within a time frame.
  - Long term goals
  - Short term goals
- Frequency and Duration should be individualized and align with the time element.

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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

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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

Goals/Treatment Measures

- REALISTIC/LONG TERM/FUNCTIONAL
- There should be an expectation of **measurable functional** improvement.
- Measureable 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

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.

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Sample LONG TERM Goals

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

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SNF Documentation Part II: SLP.COM

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 MEASUREABLE COMPONENT **with 100% accuracy and no cues in**

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

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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

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Voice: LTG and STGs

- VOICE
- **Patient will be able to use voice in all vocational and avocational activities for periods of up to two hours without experiencing hoarseness or phonation breaks.**
  - Patient will reduce vocally abusive behaviors of coughing and throat clearing to less than one/hour so that the vocal folds can heal
  - Patient will reduce use of excess muscle tension in the vocal folds so that the voice sounds less hoarse
  - Patient will demonstrate adequate vocal intensity of 21-40 dB at 1-3 feet from conversational partner 100% of the time at the phrase level in order to increase functional communication skills.
  - Patient will decrease presence of aphonia 100% of the time at the sentence level in order to increase functional communication skills.

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Dysarthria: LTG and STGs

- DYSARTHRIA
- **Patient's speech will be understood by familiar and unfamiliar listeners 90% of the communication attempts with no repetitions or clarifications needed**.
  - Patient will increase use of breath support and control strategies to 100% accuracy during production of (choose level) simple/short sentences to increase (choose speech intelligibility, voice quality, vocal intensity).
  - Patient will articulate (choose, complex conversation, simple conversational tasks, paragraphs, complex/long sentences, simple/short sentences, phrases, polysyllabic words/phrases, multi-syllabic words/phrases, 10 functional words, words, automatics/chains, sounds/phonemes) with 100% intelligibility using (choose, decreased rate, increased volume, over-articulation, pacing, phrase monitoring, breath support and control, intonation patterns, intonation variances, phrase control with visual markers, environmental modifications, relaxation techniques, or easy onset techniques) using increased volume and over-articulation in order to participate in meaningful interactions

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Apraxia: LTG and STG

- APRAXIA
- **Patient's verbal message will be smooth and easy to understand, free of self-corrections and slow rate, by familiar listeners 95% of attempts**
  - Patient will improve ability to repeat words and phrases to 100% without errors to improve speech pattern.

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Receptive Language: LTG and STGs

- RECEPTIVE LANGUAGE
- **Patient will understand spoken language in simple 1:1 conversational settings by responding appropriately when no cues are provided.**
- 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 understand yes/no questions with 100% accuracy in order to communicate basic wants/needs.
- Objectives to achieve
  - Patient will understand the names of common objects so she can point to desired objects to make needs known
  - Patient will understand simple sentences related to daily activities so that she can participate in her care

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Expressive Language: LTG and STGs

- EXPRESSIVE LANGUAGE
- **Patient will improve verbal expression to Independence in order to participate in meaningful interactions**
- Patient will produce automatic speech (e.g. greetings, chains) with 100% of attempts to increase ability to communicate basic wants/needs
- Patient will repeat (choose, vowels, syllables, automatics, CVC stimuli, core functional, or fill in the blank) CVC stimuli with 100% to improve patient's ability to improve expressive communication.

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DYSPHAGIA

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Dysphagia per Medicare Manual

- *Dysphagia, or difficulty in swallowing, can cause food to enter the airway, resulting in coughing, choking, pulmonary problems, aspiration or inadequate nutrition and hydration with resultant weight loss, failure to thrive, pneumonia and death.*
- *Most often due to complex neurological and/or structural impairments including head and neck trauma, cerebrovascular accident, neuromuscular degenerative diseases, head and neck cancer, dementias, and encephalopathies.* ***For these reasons, it is important that only qualified professionals with specific training and experience in this disorder provide evaluation and treatment***. (MBPM, 2016)

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Specialized Dysphagia Care

Per the Medicare Benefit Policy Manual definition of SLP Scope:

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 (MBPM, 2016).*

How are you documenting competencies above?

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92526- Dysphagia Therapy

Patient/caregiver training in feeding/swallowing techniques

Proper head and body positioning

Amount of intake per swallow

Appropriate diet (determining) texture and viscosity

Means of facilitating the swallow

Feeding techniques and need for self help eating/feeding devices

Facilitation of more normal tone or oral facilitation techniques

Laryngeal elevation training

Compensatory Swallow techniques

Oral sensitivity training

Techniques to reduce shortness of breath of fatigue during duration of meal.

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How am I documenting unique skilled dysphagia care?

Verbal Understanding/Return Demo	How do you educate Patient/caregiver training in feeding/swallowing techniques?
SPECIFIC- tsp; tbsp; # of trials; goals related to PO diet/therapeutic portion	What changes are made to head & body positioning Amount of intake per swallow (specific) Appropriate diet (determining) texture and viscosity Means of facilitating the swallow
Relation to Instrumental	Feeding techniques and need for self help eating/feeding devices Facilitation of more normal tone or oral facilitation techniques Laryngeal elevation training
MEASURES: BORG, Pulse Ox, amount of time prior to, signs after.	Compensatory Swallow techniques Oral sensitivity training Techniques to reduce shortness of breath of fatigue during duration of meal

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Now… How am I Documenting this?

Daily Note Sample 1:
Patient seen with noon meal for skilled ST, likes mechanical meats, nursing fed 100% of the time, verbal cue to sit up straight

Daily Note Sample 2:
Patient received therapeutic PO trials of mechanical soft meats at noon meal, noted increased bolus formation when presented in 1 tbsp size bolus as evidenced by reduced oral stasis throughout oral cavity s/p swallow, education provided to CNA staff with noted verbal understanding and return demonstration of technique on 7/10 trials

Tips for Dysphagia Goals

- Create goals and objectives to target areas of noted impairment on evaluation that paint a clear picture of treatments that will be provided.
- Create goals and objectives to target various **impaired phases** of swallowing noted below along with use of **swallow strategies** .
- Create goals and objectives that measure **specific target textures and viscosities**
- When clinically appropriate measure progress with tolerance of **therapeutic trials** prior to full advance of diet
- **Utilize instrumental assessment to increase measurability for pharyngeal and upper 1/3rd esophageal phase**

Phase Breakdown & Measurability

- I. Oral Prep
- II. Oral
- III. Pharyngeal
-
- IV. Esophageal

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I. Oral Prep Phase

Patient will increase ability to initiate oral phase of swallow to WFL to enable patient to effectively consume highest level of oral intake.

Patient will increase oral prep abilities to Independent in response to verbal and/or tactile cueing from trained caregivers.

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II. Oral Phase

Patient will exhibit minimal pocketing/stasis as evidenced by clear oral cavity 100% of attempts while consuming puree consistencies and nectar thick liquids

Patient will increase oral motor control of swallow musculature to Independence to increase ability to safely swallow regular textures and thin liquids as evidenced by no s/s dysphagia

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III. Pharyngeal Phase

- DYSPHAGIA
- Patient will be able to eat and drink a regular diet with thin liquids with no compensatory techniques as determined by repeat instrumental exam.
- Objectives to achieve
  - Patient will improve laryngeal closure so that food and liquids do not enter the airway
  - Patient will hyolaryngeal elevation to reduce residue in the pyriform sinuses that might fall into the airway

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When do we need Instrumental for Measure?

- Instrumental assessment of swallowing may be indicated for the evaluation of a patient with dysphagia, who has a pharyngeal dysfunction or who is at risk for aspiration.

  Examples of clinical syndromes where instrumental assessment of swallowing may be indicated are:
- Stroke or other central nervous system (CNS) disorder with associated impairment of speech and swallowing;
  - Difficulty swallowing following surgical ablation, radiation, or chemotherapy for head and neck cancer;
  - Documented difficulty swallowing in patients without obvious CNS disorder
  - Generalized debilitation with difficulty swallowing;
  - Clinical history of aspiration or history of aspiration pneumonia; and
  - Head or neck injury.
- **Instrumental assessment of swallowing may be needed for clinical decisions whether to place feeding gastrostomy tubes, in the dietary management of the impaired patient, and to plan and evaluate appropriate therapy programs**.

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IV. "Treating" upper 1/3 esophagus

- The pharyngoesophageal phase of swallowing (upper one-third of the esophagus) involves the passage of a bolus through the upper esophageal sphincter, into the esophagus, and through the lower sphincter into the stomach. Esophageal dysphagia is primarily addressed through medical assessment and management. Speech-language pathologists and qualified occupational therapists may be involved in evaluation of the upper third of the esophagus for esophageal motility and gastroesophageal reflux and provide counseling and ***exercises.***

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"Treating" the upper 1/3 of esophagus

- Exercises that may address opening of the UES
- Shaker/Head-Lift
- Mendelsohn

You can comment on improvement in the performance of those exercises, but can't judge improved function without repeat instrumental

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PROGRESS REPORTS

Progress Note

- Document improvement and compare to status at beginning of treatment or at least to previous progress note
- If that note does not show progress, state why and explain why you still expect continued improvement.
- Timing- Medicare requires every 10 visits or every 30 days whichever comes first.

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Discharge Summary

- Summarizes the skilled services provided from start to end of care
- Clearly outlines progress towards goals
  - Clearly describe where the patient was at the beginning of treatment and where they are now
- Outlines recommendations for further therapy or other evaluations/services

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Questions?