

# DOCUMENTING IN SKILLED NURSING FACILITIES: PART I

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## Course Description

- **Providing quality documentation for skilled services provided to Medicare beneficiaries begins with having an adequate understanding of regulations in the Medicare Benefit Policy Manual and Local Coverage Determinations (LCDs). This course will provide guidance on documenting plan of care requirements to support skilled speech pathology needs to Medicare beneficiaries including guidance for collecting baseline and prior level of function data and writing functional, measurable short term objectives and long term goals.**

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## Course Objectives

- **Create functional goal targets to promote reimbursement of services and evidence outcomes.**
- **Identify key areas for documenting reasonable and necessary services.**
- **Describe procedures which support skilled care.**

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## Know your REGULATIONS

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

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MEDICARE BENEFIT POLICY MANUAL  
CHAPTER 15  
“REASONABLE AND NECESSARY”

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## 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))

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## “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))

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## “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.

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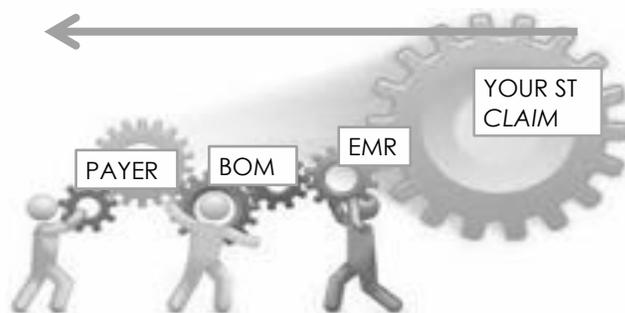
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# CODING: YOUR FIRST DEFENSE

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## Coding- Keeping Control



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## Documentation: Evaluation CPT Codes

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### 92610: Evaluation of Oral & Pharyngeal Swallowing Function

Medicare Benefit Policy Manual (MBPM), Dysphagia Defined:

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. It is 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 (1).

MBPM, Swallowing Assessment Inclusions:

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
- Developing a treatment plan employing appropriate compensations and therapy techniques (2).

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## 2014 Evaluation Codes Defined

- ❖ **92521** Evaluation of speech fluency (e.g., stuttering, cluttering)
- ❖ **92522** Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria)
- ❖ **92523** Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (e.g., receptive and expressive language)
- ❖ **92524** Behavioral and qualitative analysis of voice and resonance

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## Can new codes be billed together same day?

- ❖ The *CPT Handbook* does not include language to restrict an SLP's ability to bill these codes together because there are circumstances when it is appropriate for a patient to be evaluated for multiple disorders on the same day.
- ❖ Note- In those cases, **documentation** should **clearly reflect a complete and distinct evaluation for each disorder.**

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## One Hour *Time Based* Eval Codes

- ❖ 92626- Evaluation of Auditory Rehabilitation Status; First Hour
  - 92627 Evaluation of Auditory Rehabilitation Status; Each addition 15 minutes
- ❖ 96125- Standardized cognitive performance testing (e.g., Ross Information Processing Assessment) per hour of a qualified health care professional's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report. Per Hour.
- ❖ 96105- Assessment of Aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling and/or writing ex. by BDAE) with interpretation and report- Per Hour
- ❖ 92607 Evaluation for prescription for speech-generating AAC device face to face with the patient- First Hour.
  - 92608 Evaluation for prescription for speech-generating AAC device face to face with the patient- Each additional 30 minutes.

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## Is my documentation time included?

- Medicare Part A
  - MDS Section O: Rules for Recording Treatment Minutes
    - (*RAI Manual, Chapter 3, Section O*; directly-quoted text is in italics)
    - ***The therapist's time spent on documentation or on initial evaluation is not included*** (Page O 17)
    - *The therapist's time spent on subsequent reevaluations, conducted as part of the treatment process, should be counted* (Page O 17)
  - <http://www.asha.org/Practice/reimbursement/medicare/Medicare-Guidance-for-SLP-Services-in-Skilled-Nursing-Facilities/>
- Medicare Part B
  - 96105 and 96125 billing for Medicare Part B beneficiaries follows the definition of codes set forth per LCD definitions therefore allowing ST to account for interpretation time in assessment.

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## Case Studies

Mr. Smith is admitted to SNF following acute onset of RCVA requiring standardized measure of language and cognitive functions

- ❖ 96105- Assessment of Aphasia AND/OR
- ❖ 96125- Standardized Cognitive Performance Testing
- \*\* Think about clinical appropriateness when selecting evaluation type\*\* Will I mentally fatigue if I assess all areas day one?

- ❖ After 6 weeks of intensive treatment you determine he will require speech generating AAC device to meet communicative needs. Use 92607- Evaluation for prescription for speech generating AAC Device

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## Case Studies

Mr. Smith is referred for evaluation due to stuttering. He presents with Advanced Dementia.

- ❖ Remember- Dysfluency services are not typically covered by Medicare, nor would interventions aimed at fluency be supported by Evidenced Based Practice Patterns.
- ❖ Use 92523 Eval of Speech Sound Production with Eval of Language Comprehension and Expression **AND/OR**
- ❖ 96105- Assessment of Aphasia if patterns follow diagnostic criteria for Primary Progressive Aphasia associated with Dementia **OR**
- ❖ 96125- Standardized Cognitive Performance Testing inclusive of Dementia Staging Tools when disease process follows AD type Dementia.

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# DOCUMENTING: PLAN OF CARE REQUIREMENTS

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## 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 pof)**.

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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## STEPS

- Step 1: Order Received
- Step 2: Screen
- Step 3: Evaluate and Determine if Skilled Intervention is Necessary
- Step 4: Establish POC
- Step 5: Write Clarification Order
- Step 6: Get POC Certified
- Step 7: Re Eval as appropriate
- Step 8: Recertify when necessary

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## STEP 1: Order/Referral

- Needed for initial evaluation
- MD signature on POC acts as certification/clarification of services after evaluation
- New signature/certification needed for:
  - Any significant updates to POC affecting LTG (will require re-eval or recertification)
  - Addition of new interventions not included on initial plan.
    - Example-ST begins services for dysphagia alone, as resident progresses with laryngeal function further eval is warranted for voice and motor speech
    - PT completes initial POC for wound care and progresses patient to point where standard PT eval is reasonable and necessary
- Recertification of POC

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## STEP 2: "Screening"

- Screening assessments are non-covered and should not be billed.
- The initial screening assessments of patients or regular routine reassessments of patients are not covered.

**Think..... Screening Tells you Eval or Not Eval  
No Clinical Judgments or Skilled Recommendations Should be  
Made  
from Screen Alone**

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## STEP 3: Evaluation

- The order or referral for the evaluation and any specific testing in areas of concern should be designated by the referring physician in consultation with the therapist.
- The **documentation** of the evaluation or re-evaluation by the therapist should demonstrate that an **actual hands-on assessment** occurred to support the medical necessity for reimbursement of the evaluation or re-evaluation.

DETERMINES NEED FOR SKILL

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## Diagnostic Testing

- Diagnostic and assessment testing services to ascertain the type, causal factor(s) should be identified during the evaluation.
- Includes **documentation of standardized and non-standardized functional assessment tools.**

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## Documenting “ability to learn”

- Documentation is expected to support the ability of the beneficiary to learn and retain instruction.
- Absence of such documentation may result in a denial of services.
- If the patient has questionable cognitive skills, a brief cognitive-communication assessment should be performed in order to establish the patient's learning ability. The brief cognitive assessment may also determine the need for more comprehensive cognitive performance testing.

## Baseline \*Must be documented\*

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

**\*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.

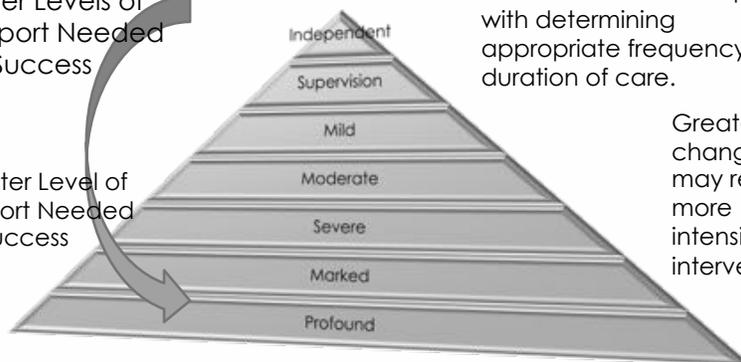
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## Documenting Change from PLOF to Baseline

Lower Levels of Support Needed for Success

Greater Level of Support Needed for Success



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

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## Step 4: Establish POC

Establish POC :

- Goals
- Frequency
- Duration
- Comparison of PLOF and Evaluation Baseline
- Deficits that require skilled care MUST have goals
- No Goal = No Treatment Can Occur
- State whether the plan is REHAB/RESTORATIVE or MAINTENANCE BASED

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## ✓ 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.

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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 or fatigue during duration of meal.

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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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How am I documenting unique skilled dysphagia care?

Verbal  
Understanding/Return  
Demo

SPECIFIC- tsp; tbsp; # of  
trials; goals related to PO  
diet/therapeutic portion

Relation to Instrumental

MEASURES: BORG, Pulse  
Ox, amount of time prior  
to, signs after.

How do you educate Patient/caregiver training in feeding/swallowing techniques?  
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  
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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## 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

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## 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.*

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## Maintenance Programs Defined

- *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.*

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## Maintenance Programs

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

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## 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/Restorative Therapy

## 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, phrase, 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.

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## Maintenance Sample: Dysphagia

Skilled therapy services may be deemed reasonable and necessary in order to maintain adequate swallow functions for pleasure feeding regimen 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.

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## 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 ptof)** 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.

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## 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

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## Step 5: Write Clarification Order

Patient to receive skilled (insert discipline) (insert frequency)  
(insert duration) in order to (insert reason)

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## Step 6: Certification of Eval/POC

- CERTIFICATION is the Physician's/Non Physician Practitioner's (NPP) approval of the plan of care (evaluation).
- Certification requires
  - Signature must be from the physician or NPP
  - **Timely certification occurs within 30 days**
  - A dated signature on the plan of care or some other document that indicates approval of the plan of care
  - When initial cert expires, a recert must then be completed certified within 30 days (needs MD signature and date which can be added as receipt date).

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# GOAL BUILDING

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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?

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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

## 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

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## Sample LONG TERM

<b>Auditory Comprehension</b>	Patient will improve auditory comprehension to Independent in order to improve receptive communication skills
<b>Cognition</b>	Patient will increase cognitive skills to Independence to improve ability to participate in meaningful interactions
<b>Cognitive Communicative</b>	Patient will exhibit adequate cognitive-communicative skills for discharge home with No Supervision with environmental modifications as training to facilitate safety and independence
<b>Motor Speech</b>	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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## 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**

## 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 1/3<sup>rd</sup> 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.

Questions?