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ASSESSMENT OF PATIENTS WITH LOW-LEVEL COGNITIVE FUNCTION

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Course Description

- This course is part one of a two part series which will provide guidance on the assessment and treatment of individuals who present with low level cognitive functioning.
- Course one will examine methods for speech language pathologist on the evaluation of patients including methods for collecting baseline data and creation of functional, measureable, and timely goal targets based on analysis of clinical findings.

Learner Outcomes

- 1) Describe key assessment baseline areas for individuals who present with low level cognitive functioning.
- 2) Define methods for goal creation based on clinical findings examined during evaluation.
- 3) Explain best practices for documenting a comprehensive plan of care for individuals with low-level cognitive functioning

Regulatory Background- Medicare

Can I provide services to individuals who present with low level cognitive functioning?

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."

Source: Code of Federal Regulations [CFR] Title 42, Part 483.25

Regulatory Background- Medicare

Chronic Conditions- Can I assess and treat?

- *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 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.

Source: Medicare Benefit Policy Manual Chapter 15

CLINICAL CATEGORIES STROKE AND DEMENTIA

Guidelines

American Heart Association and American Stroke Association

- (1) **The Rehabilitation Program**, which includes system-level sections (eg, organization, levels of care)
- (2) **Prevention and Medical Management** of Comorbidities, in which reference is made to other published guidelines (eg, hypertension)
- (3) **Assessment**, focused on the body function/structure level of the *International Classification of Functioning, Disability, and Health (ICF)*
- (4) **Sensorimotor Impairments and Activities** (treatment/interventions), focused on the activity level of the *ICF*; and
- (5) **Transitions in Care and Community Rehabilitation**, focused primarily on the participation level of the *ICF*.

Stroke as a CHRONIC Condition

- Stroke is fundamentally a chronic condition
- The end of formal rehabilitation (commonly by 3–4 months after stroke) should not mean the end of the restorative process.
- Prior approaches have managed stroke medically as a temporary or transient condition instead of a chronic condition that warrants monitoring after the acute event.
- Currently, unmet needs persist in many domains, including social reintegration, health-related quality of life, maintenance of activity, and self-efficacy (i.e., belief in one's capability to carry out a behavior). Apathy is manifested in >50% of survivors at 1 year after stroke; fatigue is a common and debilitating symptom in chronic stroke; daily physical activity of community-living stroke survivors is low; and depressive symptomology is high.
- By 4 years after onset, >30% of stroke survivors report persistent participation restrictions (eg, difficulty with autonomy, engagement, or full filling societal roles)

Stroke: Cognition/Communication

◦ **Focus Assessment Areas:**

- Simple attention and complex attention ("working memory")
- Receptive, expressive, and repetition language abilities
- Praxis (performing skilled actions such as using a tool)
- Perceptual and constructional visual-spatial abilities, including issues related to visual fields and neglect
- Memory, including language-based memory and visual-spatial memory, and differentiating learning, recall, recognition, and forced-choice memory
- Executive functioning, including awareness of strengths and weaknesses, organization and prioritization of tasks, task maintenance and switching, reasoning and problem solving, error awareness and safety judgment, and emotional regulation.

Dementia: Medical History Work-Up

- Thorough medical and family history
- Recent cognitive & behavioral changes; memory and activities of daily living changes
- Polypharmacy/Medications- Review and be alert to drugs that can impair cognition, including some analgesics, psychotropics and sedative-hypnotics.
- Anticholinergics are also an issue because they target one of the chief neurotransmission systems affected by Alzheimer affected by Alzheimer's. Includes Antihistamines, over-the-counter allergy and cold preparations and sleeping aids.
- Prior to Testing Rule Out Depression/Delirium-One widely used screening tool is the **Geriatric Depression Scale Short Form**
- **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

How is dementia diagnosed?

Diagnosis of Dementia Guidelines: Not a specific disease but a **of symptoms** present for 6 months or longer

- Occurred from a higher level of function
- Severe enough to interfere with usual activities and daily life
- Affects **more than one** of the following four core cognitive domains:

Recent memory

Language - either comprehension or expression

Visuospatial ability

Executive function - abstract reasoning, problem solving and focus despite distractions

To Stage or not to Stage?

PROS

- Identify functional declines in order in early stages
 - Make appropriate referrals to members of IDT
 - Individualize POC
 - Determine appropriate level of care
- Increase awareness of natural progression of dementia disease progress

CONS

- Categorizes individuals into "groups" based on a sub-set of characteristics
- Can result in stigmas based on identified level of decline

Global Deterioration Scale

The **Global Deterioration Scale (GDS)**, developed by Dr. Barry Reisberg.

Provides caregivers an overview of the stages of cognitive function for those suffering from a primary degenerative dementia such as Alzheimer's disease.

Measurement of greater specificity can be achieved via use of additional assessments including the accompanying **Brief Cognitive Rating Scale (BCRS)** and the **Functional Assessment Staging (FAST)** measures.

Pre-Dementia Diagnosis: 1-2

Stage 1: No cognitive impairment.

- Unimpaired individuals experience no memory problems.

Stage 2: Very mild cognitive decline

- Individuals at this stage feel as if they have memory lapses, especially in forgetting familiar words or names or the location of keys, eyeglasses or other everyday objects
- Problems are not evident during a medical examination or apparent to friends, family, or co-workers.

Pre-Dementia Diagnosis: 3

Stage 3: Mild cognitive decline

- Friends, family, or co-workers begin to notice deficiencies.
 - Problems with memory or concentration may be measurable in clinical testing or discernible during a detailed medical interview.
- Common difficulties include:
- Word- or name-finding problems noticeable to family/friends
 - Decreased ability to recall names of new people
 - Performance issues in social or work settings noticeable to family, friends, or co-workers
 - Reading a passage and retaining little material
 - Losing or misplacing a valuable object
 - Decline in ability to plan or organize

Active Dementia: Stage 4

Stage 4: Moderate cognitive decline

- Medical interview detects clear-cut deficiencies:
- Decreased knowledge of recent occasions or events
- Impaired ability to perform challenging mental arithmetic; for example, to count backward from 100 by 7s
- Decreased capacity to perform complex tasks such as marketing, planning dinner for guests or paying bills and managing finances
- Reduced memory of personal history
- Individual may seem subdued and withdrawn, especially in socially or mentally challenging situations

Active Dementia: Stage 5

Stage 5: Moderately severe cognitive decline.

- Major gaps in memory and deficits in cognitive function emerge. Assistance with day-to-day activities becomes essential.

Deficits include:

- Unable to recall important details such as their current address, their telephone number, or the name of the college or high school from which they graduated
- Confusion about where they are or about the date, day of the week, or season
- Difficulty with less challenging mental arithmetic; for example, counting backward from 40 by 4s or from 20 by 2s
- Require assistance choosing proper clothing for the season or the occasion
- Usually retain substantial knowledge about themselves and know their own name and the names of their spouse and/or children
- Usually require no assistance with eating or using the toilet

Active Dementia: Stage 6

Stage 6: Severe cognitive decline.

- Memory difficulties continue to worsen, significant personality changes may emerge and affected individuals need extensive help with customary daily activities.

At this stage, individuals may:

- Lose most awareness of recent experiences and events as well as their surroundings
- Recollect their personal history imperfectly, although they generally recall their own name
- Occasionally forget the name of their spouse or primary caregiver but generally can distinguish familiar from unfamiliar faces
- Need help getting dressed properly; without supervision, may make such errors as putting pajamas over daytime clothes or shoes on the wrong feet
- Experience disruption of their normal sleep/waking cycle
- Need help with handling details of toileting (flushing toilet, wiping and disposing of tissue properly)
- Have increasing episodes of urinary and fecal incontinence
- Experience significant personality changes and behavioral symptoms, including suspiciousness and delusions; hallucinations (seeing or hearing things that are not really there); or compulsive, repetitive behaviors such as hand-wringing or tissue shredding
- Tend to wander and become lost

Active Dementia: Stage 7

Stage 7: Very severe cognitive decline

- This is the final stage of the disease when individuals lose the ability to respond to their environment, the ability to speak and, ultimately, the ability to control movement.
- Frequently individuals lose their capacity for recognizable speech, although words or phrases may occasionally be altered
- Individuals need help with eating and toileting and there is general incontinence of urine
- Individuals lose the ability to walk without assistance, then the ability to sit without support, the ability to smile, and the ability to hold their head up. Reflexes become abnormal and muscles grow rigid. Swallowing is impaired.

Functional Assessment Staging Tool (FAST)

FAST tool to determine if changes in a patient's condition are due to Alzheimer's disease or another condition. If the change is due to AD progression, then any changes on the FAST scale will be in sequence - **AD-related changes do not skip FAST stages. *see handout**

Example: a patient is mildly demented (FAST stage 4), and loses the ability to bathe (FAST 6b) but can still pick out their clothes (FAST 5) and dress themselves (FAST 6a), then they skipped FAST stages 5 and 6a and went directly to FAST stage 6b. These changes are not due to AD progression. It could be that the diagnosis of AD is wrong or that the patient has a second dementing disorder in addition to AD. Alternatively, a patient may have an exacerbation of an existing medical problem, developed a new medical problem, or had some other change in their care or living situation that caused the difficulty bathing.

ASSESSMENT: PLAN OF CARE REQUIREMENTS

STEPS

Step 1: Order Received

Step 2: Screen

Step 3: Evaluate and Determine if Skilled Intervention is Necessary

Step 4: Establish Plan of Care (POC): Collect Baseline and Prior Level of Function

Step 5: Write Clarification Order

Step 6: Have Plan of Care (POC) Certified

Step One: Order/Referral

- Needed for initial evaluation
 - SAMPLE: Speech Pathology to eval and treat as indicated secondary to noted declines in ability to respond to questions from caregivers and follow directions during activities of daily living
- 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.
 - Recertification of POC

Step Two: 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 Evaluate or Not Evaluate**
- **No Clinical Judgments or Skilled Recommendations Should be Made from Screen Alone**

Step Three: 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 and TYPE of SKILL

Documenting 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.
 - Samples:
 - Change in MDS Section C BIMS; MDS Section B Hearing Speech Vision; CAAs for Cognition
- Chronic Conditions: May not be the date of dx for condition, however related to exacerbation of dx process.

In conjunction current symptoms

- Provide correlation of why new onset has resulted in symptoms requiring your unique skilled services.
- Samples:
 - Reduced ability to participate in meal times due to increased distractions and reduced attention to task
 - Limited ability to participate in dual task interventions with PT and OT therefore limiting ability to complete negotiating obstacles and instrumental activities of daily living (IADLs).

✓ Medical History

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Documenting Prior Level of Function

The residents' **prior level of function** 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.

MUST BE INCLUDED IN DOCUMENTATION

FAQ- What if my patient is a poor historian due to dementia?

- Refer to family, prior Minimal Data Set (MDS) reports, contact the Primary Care Provider (as part of the Affordable Care Act ACA they are completing cognitive assessments as part of Medicare Annual Wellness visits)

Collecting Baseline Data

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.

FAQ- What if my patient suffers from mental fatigue due to dementia and I can not get all baselines day one?

Assess most appropriate areas day 1 which is often times language based via 92523, as clinically appropriate additional higher level areas can be assessed via 96125 at a later date.

Resident Assessment Index (RAI)

Section B: Hearing, Speech and Vision

B0700. Makes Self Understood	
Enter Code	Ability to express ideas and wants, consider both verbal and non-verbal expression 0. Understood 1. Usually understood - difficulty communicating some words or finishing thoughts but is able if prompted or given time 2. Sometimes understood - ability is limited to making concrete requests 3. Rarely/never understood
<input type="checkbox"/>	
B0800. Ability To Understand Others	
Enter Code	Understanding verbal content, however able (with hearing aid or device if used) 0. Understands - clear comprehension 1. Usually understands - misses some part/intent of message but comprehends most conversation 2. Sometimes understands - responds adequately to simple, direct communication only 3. Rarely/never understands
<input type="checkbox"/>	

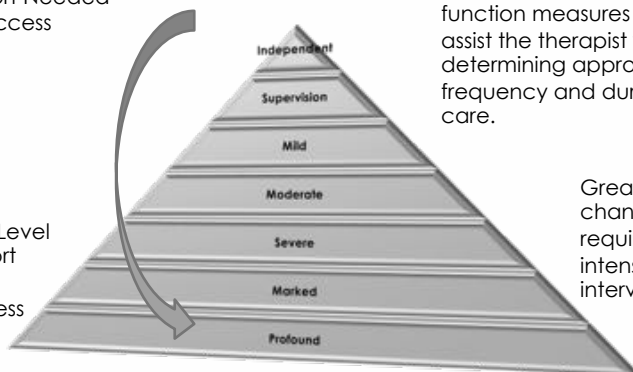
Section C: Cognitive Patterns

Brief Interview for Mental Status (BIMS)	
C0200. Repetition of Three Words	
Ask resident: "I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are: sock, blue, and bed. Now tell me the three words."	
Enter Code	Number of words repeated after first attempt
<input type="checkbox"/>	0. None
<input type="checkbox"/>	1. One
<input type="checkbox"/>	2. Two
<input type="checkbox"/>	3. Three
After the resident's first attempt, repeat the words using cues ("sock, something to wear; blue, a color; bed, a piece of furniture"). You may repeat the words up to two more times.	
C0300. Temporal Orientation (orientation to year, month, and day)	
Ask resident: "Please tell me what year it is right now."	
Enter Code	A. Able to report correct year
<input type="checkbox"/>	0. Missed by > 5 years or no answer
<input type="checkbox"/>	1. Missed by 2-5 years
<input type="checkbox"/>	2. Missed by 1 year
<input type="checkbox"/>	3. Correct
Ask resident: "What month are we in right now?"	
Enter Code	B. Able to report correct month
<input type="checkbox"/>	0. Missed by > 1 month or no answer
<input type="checkbox"/>	1. Missed by 6 days to 1 month
<input type="checkbox"/>	2. Accurate within 5 days
Ask resident: "What day of the week is today?"	
Enter Code	C. Able to report correct day of the week
<input type="checkbox"/>	0. Incorrect or no answer
<input type="checkbox"/>	1. Correct
C0400. Recall	
Ask resident: "Let's go back to an earlier question. What were those three words that I asked you to repeat?"	
If unable to remember a word, give cue (something to wear, a color, a piece of furniture) for that word.	
Enter Code	A. Able to recall "sock"
<input type="checkbox"/>	0. No - could not recall
<input type="checkbox"/>	1. Yes, after cueing ("something to wear")
<input type="checkbox"/>	2. Yes, no cue required
Enter Code	B. Able to recall "blue"
<input type="checkbox"/>	0. No - could not recall
<input type="checkbox"/>	1. Yes, after cueing ("a color")
<input type="checkbox"/>	2. Yes, no cue required
Enter Code	C. Able to recall "bed"
<input type="checkbox"/>	0. No - could not recall
<input type="checkbox"/>	1. Yes, after cueing ("a piece of furniture")
<input type="checkbox"/>	2. Yes, no cue required
C0500. Summary Score	
Enter Code	Add scores for questions C0200 C0300 and C0400 and fill in total score (00-150)
<input type="checkbox"/>	Enter 99 if the resident was unable to complete the interview

Baseline versus PLOF

Lower Levels of
Support Needed
for Success

Greater Level of
Support
Needed
for Success



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

Greater
changes may
require more
intensive
interventions

Diagnostic Testing

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

Determining Skilled Need

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

POC- Restoring Function

- 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)**.
- Plan should describe *objective measurements* which, when compared, show improvements in function, decrease in severity or rationalization for an optimistic outlook to justify continued treatment.
- Tip- Staging alone via GDS/FAST/BCRS will not be an adequate measure for showing improved function. Add additional measures to show improvement.

POC-Maintaining Function

- 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.
- Samples: Establishing POC to improve attention to task at meals with development of functional dining programs; establishing a POC for improved environmental awareness via use of signage

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

Anatomy of a GOAL*

Auditory Comprehension LTG:

Patient will improve auditory comprehension (target area) to Independent (measureable component) at the structured conversational level in order to improve receptive communication skills (functional aspect) (add time base- 30 days)

Auditory Comprehension STG:

Patient will improve ability to follow 3-steps commands (target area) on 9/10 trials (measureable component) in order to improve independence with ADL tasks (functional aspect) (2 weeks)

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

Frequency and Duration

- The **frequency** refers to the number of times in a week or # of visits over a specific time frame the type of treatment is provided.

- The **duration** is the number of weeks, or the number of treatment sessions, for THIS PLAN of care.

NO STATIC RULES- ALWAYS INDIVIDUALIZE

If the episode of care is anticipated to extend beyond the 90 calendar day limit for certification of a plan, it is desirable, although not required, that the clinician also estimate the duration of the entire episode of care in this setting.

Frequency and **Duration** should be patient specific, related to level of functional decline, and appropriate based on evidenced based practice patterns.

Step 5: Write Clarification Order

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

Sample: Mrs. Adams to receive skilled ST therapy 30 times over 60 days in order to target improved ability to participate in ADL tasks and reduce frustration and anxiety associated with transition from AL to SNF environment.

REMEMBER- Details are essential to carry over onto patient Care Plan

CASE STUDIES & GOAL WRITING

Mr. Smith: Cognition Impacting Meals

- Mr. Smith was noted to present with significant weight loss of 10% as triggered on MDS Section K. SLP evaluation reveals mildly impaired oral function. Additionally patient is increasing distracted at meals and nursing aides report this has worsened since daughter has taken a new job and is unable to attend noon meals with him.
- Evidence base
 - Strategy based intervention
 - Simulated presence therapy (SIMPRES) is an emotion-oriented approach aimed at reducing levels of anxiety and challenging behaviors by playing audio recordings of the voices of close relatives of the individual.

Mr. Smith Short Term Objectives

- Mr. Smith will increase ability to form and control bolus to WFL to enable safe consumption of mechanical soft textures and thin liquids 10/10 attempts and 50% cues in order to enhance his ability to meet primary nutrition/hydration needs.
- Mr. Smith will safely swallow mechanical soft textures and thin liquids using lingual sweep/re-swallow and alternation of liquids/solids with 50% verbal cues in order to decrease risks for malnutrition/weight loss

Mr. Smith Daily Note

- Mr. Smith was seen for skilled ST services at noon meal. ST implemented use of stimulated presence therapy incorporating daughters voice on recording for use of alternating bite and sip. Increase success noted with task from 10% use when directed by nursing assistants to 80% use when using daughters voice. Functional outcome of technique resulted in reduced oral stasis after swallow on 7/10 therapeutic PO trials of mechanical soft

Mr. Smith

- Mr. Smith was seen during am meal for skilled ST services.
- Interventions this date targeted promoting CNA carryover over compensatory swallow strategies. Nursing assistants demonstrated verbal understanding of need for lingual sweep/re-swallow and alternation of liquids and solids when patient presented with increased oral residues during meal. Competencies were further verified when CNAs were able to utilize stim press appropriately on 7/10 therapeutic trials resulting in patients ability to consume 80% of am meal with effective bolus control and absence of meal refusal or episodes of agitation.

Questions?