Diagnosis Dementia: Goal Planning and Documentation in Home Health Care

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Objectives

As a result of this course, participants will be able to:

1. Describe the 3 important goal categories for a dementia patient.
2. Describe the basic necessities for reimbursable documentation of speech therapy services with the dementia patient.
3. List the 3 main criteria for eligibility of home care reimbursement by Medicare.
Introduction

- Medicare cannot deny a claim solely based on the diagnosis of dementia.
- We need to be good stewards of Medicare dollars and have a good plan in place to work with this population. We cannot AFFORD to waste precious time.
- As long as the intervention with the patient who has dementia is proven to be *skilled and necessary*, the service will be reimbursed.
- If it is not documented…it did NOT happen.
Three Goal Areas for the SLP (for patients with dementia)...

- Good questions to ask when developing goals for the dementia population:
  - Can the patient communicate his/her very basic wants and needs?
  - Can the patient take nutrition, hydration, and medication safely and in adequate amounts?
  - Is the patient safe in his/her living environment?
  - What kind of education/training is needed for patient, family, and/or care giver?
Establishing goals for dementia

- Goals for patients with dementia are not going to be any different than the goals that are established for any other patient population.
Questions to Answer Prior to Goal Writing

- What treatment areas will affect this person the most?
- What means the most to the patient to address?
- What are some abilities/strengths the patient exhibits that can help them to successfully reach their goals?
- How many therapy sessions will you need to achieve these goals and/or how many sessions has the patient’s insurance provider authorized you to have to treat this patient?
- Does the patient agree that they need therapy?
- What goals will help build patient success?
- Are the patients caregivers willing to participate in treatment/carryover?
Anatomy of A Goal

- A strongly written goal needs to be:
  - Measurable
  - Attainable
  - Explicit
  - Functional

- Also needs to include:
  - Conditions
  - Understandable Language
Anatomy of A Goal

- “Patient will utilize compensatory strategies, such as describing an item by function and/or attributes or stating the initial letter of an item, 8/10 trials with minimal verbal cueing to improve expression of wants and needs.”

- Measurable
- Attainable
- Explicit
- Functional
- Conditions
Long Term & Short Term Goals

- **Long-term goals**
  - cover an extended period of treatment intervention (e.g. a Medicare certification period, in-patient rehabilitation stay) and state what you would ultimately like to see the patient achieve during that time.

- **Short-term goals**
  - state the steps the patient will take to achieve the long-term goal and allow measurement of the patient’s response to intervention and prognosis for meeting the long-term goal.
The patient is a home health care client who has dementia and was recently provided with a walker for safe ambulation. Physical therapy reports that the patient often forgets that he has the walker and is often found walking around the house without it, increasing his fall risk and risk for injury. A speech therapy order was obtained to address memory and safety in using the walker.

**Long-Term Goal:**
- By the end of the Medicare certification period, patient will recall and demonstrate safe use of walker to ambulate independently in home and reduce fall risk.

**Short-Term Goals:**
- Patient will recall need for walker to safely ambulate at the initial trial of three consecutive therapy sessions using the Spaced Retrieval technique (technique to improve memory/recall in persons with cognitive impairments).
- Patient will recall and regularly utilize walker correctly when ambulating in home 8/10 trials independently.
Goal Development Worksheet

Patient
Name/Initials: ____________________________________________

Diagnoses: _______________________________________________

Payor/Insurance: __________________________________________

# of Sessions Authorized/Anticipated Length of Treatment:_____

Summary of Assessment Results:______________________________

Patient/Caregiver Feedback: _________________________________

__________________________________________________________

__________________________________________________________

__________________________________________________________

Does Patient Agree with Need for Treatment?  Y   N

Patient Strengths/Abilities:
1. _______________________________________________________

2. _______________________________________________________

3. _______________________________________________________

Patient Personal Goals:
1. _______________________________________________________

2. _______________________________________________________

3. _______________________________________________________

Family/Caregiver Goals:
1. _______________________________________________________

2. _______________________________________________________

3. _______________________________________________________

Is Patient Safe In Environment?  Y   N

Can Patient Communicate Wants/Needs?  Y   N

Is Patient Eating Safely?  Y   N

Priority Areas of Treatment:
1. _______________________________________________________

2. _______________________________________________________

3. _______________________________________________________

Goals that will likely lead to early success
1. _______________________________________________________

2. _______________________________________________________

3. _______________________________________________________

Goal Examples: Communication

- Patient will demonstrate increased word recall skills to improve overall expression of wants and needs by utilizing compensatory strategies, such as description and/or use of synonyms, 80% of trials with minimal verbal and visual cueing.

- Patient will locate and use target communication word cards, stating common wants/needs, to improve communication with facility staff 8/10 trials with minimal verbal cueing.

- Patient will correctly utilize pain assessment chart, depicting areas of body that are in pain and level of pain severity, 9/10 trials with minimal verbal cueing to assist caregivers in addressing pain management needs.

- Patient will correctly locate and read labeled items in room to improve word recall skills and increase participation in self-care 9/10 trials with minimal verbal cueing.

- Client will recall and demonstrate use of strategy of taking deeper breaths prior to speaking to promote increased volume and sub-glottal pressure and increase understanding by listeners 90% of trials with moderate verbal cues.
Goal Examples: Communication

- Client will recall and demonstrate proper placement of articulators (i.e. tongue, lips, teeth) to produce alveolar sounds (e.g. /t/, /d/, /n/, /s/ and /z/) at word level to increase communication abilities and intelligibility of speech 80% of trials with minimal verbal and visual cueing.

- Patient will demonstrate the ability to choose between 2 items on a written list to communicate wants/needs related to meal, self-care, and leisure 8/10 trials with minimal verbal cueing.

- Patient will correctly utilize established alternative communication device to express daily wants/needs 90% of trials with moderate verbal cueing and physical demonstration.

- Patient will read and follow written script to participate in telephone conversations to improve interaction with family and friends 8/10 trials with minimal verbal cueing.

- Patient will utilize picture board to identify needs related to ADL’s and social interaction 8/10 trials with moderate verbal cueing and physical demonstration.
Goal Examples: Swallowing

- Patient will recall and demonstrate use of chin tuck strategy when swallowing during meals 80% of trials to decrease risk of aspiration with use of visual cue and minimal verbal cueing.

- Patient will demonstrate use of reduced bite size 80% of trials during meals using adaptive equipment and minimal verbal cueing to reduce risk of choking.

- Patient will demonstrate decreased rate of eating during meals by placing utensil on plate between bites 90% of trials during meals using visual cue and minimal verbal cueing to reduce choking risk.

- Patient will recall and demonstrate use of double swallows following each bite of food 80% of trials during 5-minute intervals during meals to reduce risk of aspiration.

- Patient will demonstrate decreased pocketing of food in oral cavity by recalling to sweep oral cavity with tongue following each bite of food 80% of trials during meals using a visual cue and moderate verbal cueing and physical demonstration.
Goal Examples: Swallowing

- Patient will recall and demonstrate use liquid wash following every 2 bites of food to increase hydration and decrease choking risk 80% of trials with use of visual cue and minimal verbal cueing.

- Caregivers will demonstrate ability to teach-back elements of established aspiration prevention program with 90% accuracy.

- Caregivers will recall and demonstrate proper thickening of liquids to honey consistency 2/3 of trials over 3 consecutive sessions to decrease patient’s risk of aspiration.

- Caregivers will demonstrate proper cleaning of patient’s oral cavity to reduce colonization of bacteria in mouth and reduce aspiration risk over 3 consecutive therapy sessions.

- Caregivers will demonstrate proper meal set up of patient’s food, including types of food prepared, cutting to safe bite size, and positioning on plate to increase patient’s amount of oral intake and ability to self feed over 3 consecutive therapy sessions.
Goal Examples: Cognition

• Patient will recall times of medication administration using visual cue to increase medication adherence over 3 consecutive therapy sessions using the Spaced Retrieval technique (technique used to help persons recall information over progressively longer intervals of time).

• Patient will demonstrate proper self-administration of medications by taking medications at correct dosage times as evidenced by use of medication checklist and assessment of patient’s medication organizer to insure medication adherence over 3 consecutive therapy sessions.

• Patient will correctly recall facility room number to decrease wandering in facility and increase overall safety over 3 consecutive therapy sessions using the spaced retrieval technique (technique used to help persons recall information over progressively longer intervals of time).

• Patient will recall and demonstrate ability to read facility staff name badges in order to identify caregivers 8/10 trials with minimal verbal cueing.

• Patient will recall need to ambulate with walker at all times to decrease fall risk using visual cues at the initial trial of 3 consecutive therapy sessions using the spaced retrieval technique (technique used to help persons recall information over progressively longer intervals of time).
Goal Examples: Cognition

- Patient will recall and demonstrate recommended hip precautions to reduce risk of re-injury using a visual cue 8/10 trials.

- Patient will recall location of personal memory book and use book in order to better remember personal information and daily routines over 3 consecutive sessions using the spaced retrieval technique (technique used to help persons recall information over progressively longer intervals of time).

- Patient will recall location of emergency numbers in home and read list aloud in order to increase safety within home 8/10 trials.

- Patient will recall and utilize medication administration checklist in order to recall taking medications and decrease repetitive question asking behavior to facility staff over 3 consecutive therapy sessions using the spaced retrieval technique (technique used to help persons recall information over progressively longer intervals of time).

- Patient will utilize visual cue in order to recall telephone conversations with family to decrease agitation and frequency of calls to family 80% of trials.
Goal Examples: Teaching/training

- Caregiver will demonstrate knowledge of safe liquid administration by thickening liquids to recommended consistency independently.
- Family member will demonstrate knowledge of dementia resources by locating them in the education book provided.
- Caregiver will participate in training/education on using communication strategies.
- Family member will be instructed on signs/symptoms of aspiration.

Important Note!

If a caregiver or family member states that they do not want to participate in training, are unable or unwilling to learn, this MUST be documented. If a caregiver/family member is unable or unwilling to participate in education, DO NOT continue to document teaching and training. Medicare will not reimburse for teaching and training of somebody who has stated they do not want to learn.
Documentation Guidelines according to a local coverage determination for Medicare

- Include characterization of target behaviors (i.e. choking)
- The specific impairments and activity limitations identified for each beneficiary (i.e. Choking leads to an increase in respiratory infections)
- An evaluation of the ability of the family or caregiver to learn and implement the proposed interventions. (i.e. family is willing to follow through with providing modified diet)
- Environmental factors impacting the identified behaviors and resultant care plan (i.e. patient eats in a distracting environment affecting his ability to follow compensatory strategies)
- For unsuccessful teaching and training, the reasons why the training was unsuccessful should be documented.
Appropriate documentation promotes:

- A high standard of clinical care
- Continuity of care
- Improved communication and dissemination of information between and across service providers
- An accurate account of treatment, intervention and care planning.
- Improved goal setting and evaluation of care outcomes
- Improved early detection of problems and changes in health status
- Evidence of patient care.
The World Health Organization:

- A clinicians documentation should be able to demonstrate:
  - A full account of the clinicians assessment
  - Relevant information in relation to the patients condition at any given time
  - Evidence that the clinician met their duty of care and taken all reasonable decisions and actions to provide the highest standard of care.
  - Evidence that the clinician met their duty of care and that any actions or omissions did not compromise the patients safety or identified health outcomes
  - A record of all communications with other relevant others in relations to the patient
Look at it the W.H.O. way…

• Disease or disorder
  ◦ How does this affect body functions and structure?
  ◦ How does that then affect activity?
  ◦ How does that affect participation?

(example: Patient with Lewy Body disease suffers from dysarthria which affects his ability to effectively communicate limiting his ability to express his basic wants and needs.)
Documentation necessities

- Clear
- Concise
- Complete
- Consecutive
- Correct
- Contemporary
- Comprehensive
- Collaborative
- Patient Centered
- Confidential
John has early stage dementia and lives with his daughter, who works during the day. He has recently become more aware of his memory deficits, and his daughter worries about his safety when she is away from home at work.

John calls his daughter frequently during the day to ask where she is and when she is returning home, and about tasks that he can do around the house “to help out”. John’s daughter makes him lunch before she leaves for work and leaves it in the refrigerator for him to eat, but she often returns home to find the food untouched and still in the refrigerator, even though she reminds him to eat when he calls her.

John’s doctor recommended speech therapy via home health care to help address his memory deficits, to improve his safety, and to help his daughter better manage his care.
Review of Notes and Case Studies

- Patient will utilize a visual cue, such as a memo board, to recall daughter’s whereabouts during day and time returning home in order to improve recall and decrease multiple phone calls to daughter during day at the beginning of 3 consecutive therapy sessions using the spaced retrieval technique and confirmation of carryover of goal by caregiver.

- Patient will utilize a choice board and/or checklist to assist in choosing activities/tasks to complete during the day in order to increase engagement in activities and provide a meaningful role for patient 80% of trials.

- Patient will recall presence of meal in refrigerator for lunch and eat provided meal 3 out of 5 days using visual cues in order to increase nutrition and decrease risk of weight loss.

- Caregiver will be able to teach back to therapist use of visual/graphic cues to assist father in recall of important personal and safety information with 90% accuracy.
R.T. is an 82 year-old male living in an assisted living facility. Diagnoses include dementia, congestive heart failure, asthma and type 2 diabetes. R.T. is a former auto worker whose wife is deceased. He has four children who all live out of town.

Assessment results:
- 13/30 on the Mini Mental Status Evaluation (MMSE; Folstein & Folstein, 1975);
- able to read 48 pt. sized Arial font;
- Client passed Spaced Retrieval Screen (Bourgeois et. al. 2003).
- Patient stated in evaluation that he was open to receiving therapy, although he stated that he “didn’t think it would do much good.”
Client Input: Client wants to do more “on his own” and doesn’t enjoy being around “all of the sick people”. Feels “bored” and misses his family and old way of life.

Staff Input: Resident is often found napping in other residents’ rooms; often leaves cane in room; tends to take large bites of food when eating, leading to choking; wears cologne, sometimes in “excessive amounts”

Family Input: Satisfied with care; would like a way to communicate with their father and update him on family events beyond talking on the phone.
Goal Development Worksheet

Patient Name/Initials: R.T.
Diagnoses: dementia, CHF, asthma, type 2 diabetes
Payor/Insurance: Medicare

# of Sessions Authorized/Anticipated Length of Treatment: 3 times a week for 4 weeks

Does Patient Agree with Need for Treatment? _✓_ Y _✓_ N

Summary of Assessment Results: 13/30 MMSE; reads 48 pt. size Arial font; passed spaced retrieval screen

Patient/Caregiver Feedback:
Pt. wants to do more "on his own" and doesn’t enjoy being around "all of the sick people". Feels "bored" and misses his family

Staff: Pt. naps in other rooms; leaves cane in room; takes large bites of food (choking); wears lots of cologne.

Family: Satisfied with care; communicate with beyond talking on phone

Does Patient Agree with Need for Treatment? _✓_ Y _✓_ N

Patient Strengths/Abilities:
1. Likes to "help out"
2. Functional reading/writing skills
3. Friendly but shy

Patient Personal Goals:
1. Be less bored; feel needed
2. Not fall again
3. Recall personal info better

Family/Caregiver Goals:
1. Staff: Decrease behavior issues/increase safety
2. Family: feel closer to their dad

Is Patient Safe In Environment?
_✓_ Y _✓_ N

Fall Risk (not using cane); choking risk

Can Patient Communicate Wants/Needs? _✓_ Y _✓_ N

Is Patient Eating Safely? _✓_ Y _✓_ N

Choking risk; large bites of food

Priority Areas of Treatment:
1. Use of cane
2. Reduced bite size of food
3. Orientation (room location)

Goals that will likely lead to early success
1. Use of cane (fear of falling)
2. Finding room

3. Use of memory book for recall of patient info
Mr. C is a 75 year old male with a diagnosis of Alzheimer’s dementia. Despite his dementia, this patient lives in an assisted living facility with fairly high functioning residents. He was referred for ST for wandering behaviors which have placed him at risk for his own safety and has upset the other residents in the community. Mr. C was found to be a good candidate for using Spaced Retrieval technique using visual cues of homing pigeons in the facility (Mr. C used to raise pigeons). Mr. C was successful in learning his compensatory strategy with eliminating unsafe and disruptive wandering behaviors.

Pt was seen by SLP for 22 visits over 2 certification periods.

Pt was also seen by OT and SN during both certification periods.
Mr. C: Evaluation

- “Patient has a diagnosis of Alzheimer’s disease with behavioral disturbance.”
- “Patient lives in an assisted living facility beside a busy street…there are no locked exits.”
- “Patient was referred for ST services for a new onset of behavioral disturbance including increased confusion to time, place and circumstance.”
- “Patient demonstrated a score of 20/30 on the SLUMS.”
- “Patient presents with behaviors indicative of stage 4-5 on the Global Deterioration Scale.”
- “Patients behavior includes wandering into other resident’s apartments and exit doors leading into a busy roadway.”
- “Patient is now at risk for accidental injury to self as well as facing risk for eviction from the assisted living community.”
- “These behaviors are compromising patients ability to live in the least restrictive environment as well as compromising his current level of independent ADL function.”
- “Family/caregivers have expressed that they are willing to participate in and learn compensatory strategies for this patient.”
- “Discussed plan of care, including compensatory memory strategies with OT and SN.”
Mr. C: Long Term Goals

- Patient will use visual cues to locate his room independently 100% of the time.
- Family/caregivers will show return demonstration of compensatory strategies 100%.
Mr. C: Short Term Goals

- Patient will recall his memory strategy using spaced retrieval prompt ("When you need to find your way, what do you do?") 5/10 trials.
- Patient will locate visual cues in facility 8/10 trials.
- Patient will locate the dining room from his room using visual cues only 3/5 trials.
Mr. C: Progress

- “Patient able to recall strategy for locating his room 8 out of 10 trials with verbal prompting.”
- “Patient able to recall strategy for locating his room 10/10 trials with verbal prompting.”
- “Staff report patient able to independently locate the dining room using visual cues.”
- “Staff report patient continues to have trouble locating room from dining room without initial prompts.”
- “Patient’s son was informed via phone of compensatory strategy for environmental awareness including appropriate cue/response (“When you need to find your way, what do you do?”). Son verbalized return demonstration at 100%.”
Mr. C: Discharge

- “Pt was able to locate his apartment from the 1st floor with the use of visual cues and no other cues 100%.”
- “Patient is discharged from ST services as his goals are met and wandering behaviors have been resolved.”
- “Family and caregivers have demonstrated appropriate knowledge and use of strategies.”
Questions & Answers

Thank You!

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