August 10, 2018

Fast Facts Friday

RehabCare

Documentation Tips – Evaluation (Part 1)

With the scrutiny that payers have on our documentation, understanding what constitutes a comprehensive therapy assessment, progress note, and discharge assessment is vital to support medical necessity and skilled services to our patients.

Consider the following to enhance your knowledge base and assist you with your rehab documentation skills to support the great care you deliver to your patients:

Evaluation

Tell the story/paint the picture of the patient's functional status needs with comprehensive, discipline specific documentation that leaves no? in the mind of the reader as to why your services are medically necessary to improve the quality of life for the patients you service.

- **Treatment Diagnosis** – is supported by a discipline specific, comprehensive assessment with a functional deficit section to compare PLOF and current level, underlying impairments with specialized tests, measurements and goals to address deficits/impairments identified and represents the medical condition or co-morbidities impacting rehab.

  Sample PT *– If choosing abnormality of gait as a tx dx, compete a gait analysis, balance assessment as well as document distance ambulated, AD required and amount of assist needed. Establish a gait goal that improves the pt's gait deviation(s) and why as well as decreasing assist with/without an AD, progressing from an AD, gait training on different surfaces & increasing distance.*

  Sample OT *– If choosing lack of coordination as a tx dx, fine and gross motor coordination must be evaluated, impairment(s) identified as well as a coordination goal established to improve function (be specific).*

  Sample SLP *– If choosing oropharyngeal dysphagia or cognitive communication deficit as tx dxs, a thorough bedside / clinical swallowing evaluation must be completed as well as swallowing goals established and a thorough assessment of cognition with cognitive goals.*

- **Reason for Referral** – details the reason(s)/events that led to the need for skilled rehab, inclusive of status post hospitalization, new admit, recent decline/improvement from baseline function, current medical status or co-morbidities impacting rehab and related to functional impairments, barriers with statement of risk(s) without skilled rehab intervention.

  Sample PT - *Pt. is a 75 y.o. female who was admitted to XYZ for short term rehab following a hospitalization for a left hip fracture from a fall at home slipping on a scatter rug. Pt. is s/p a hemiarthroplasty and is now PWB LLE. Pt. referred to PT from the MD secondary to LLE hip weakness and inability to transfer and ambulate without assist. Without skilled PT, pt. is at risk for further falls and re-hospitalization.*

  Sample OT *– This 67 year old female was admitted to XYZ for short term rehab following a 30 day hospitalization secondary to impulsive, aggressive and hostile behavior. Pt's medications were adjusted and she was diagnosed with dementia. OT was referred by the MD due to a severe decline in sitting and standing balance, ability to perform bathing, dressing, functional transfers and toilet tasks as well as a decrease in ability to follow simple instructions. Without skilled OT, pt. is at risk for further functional decline and possible re-hospitalization.*

  Sample SLP *– Patient is a 78 year old female who was referred to speech therapy services by nursing due to cognitive and communication changes with remembering when she last received medication, changes in expressing needs along with the physical therapist's report of patient exhibiting impulsive behaviors when performing transfers and difficulties sequencing ADLs. Without skilled SLP, pt. is at risk for further lack of communication to make basic needs known or pt. may be at risk of injury to self and/or others.*

- **Therapy Necessity** – justifies why the discipline specific skills are needed, identifies issues/problems to be addressed by the discipline, interventions with rationale and how these skilled services will improve function necessary for the return to PLOF, prior living setting and improvement in quality of life.

  Sample PT *– Skilled PT is necessary to improve dynamic standing balance, fall recovery skills, BLE strength and activity tolerance in order to perform transfers and ambulation with decreased risk for falls and assistance to achieve her prior level of function.*

  Sample OT *– Pt. requires skilled OT services to increase BUE strength, improve bed mobility, sitting and standing balance, functional transfers, toileting tasks, UB bathing and dressing and ability to perform meal prep and light housekeeping to decrease risk for falls, return to prior level of function and ensure a safe discharge home to independent living.*

  Sample SLP – Skilled SLP is necessary for cognitive-linguistic treatment to reduce adverse behaviors in order to improve sequencing of multi-step instructions for completion of ADL, safety awareness and for increased problem solving. Without therapy patient is at risk for falls and increased dependence on nursing staff with functional activities.

- **Functional Deficits** a MUST – details both prior and current level (IADLs, bed mobility, transfers balance – sitting and standing, gait, positioning, WC mobility and management, self-feeding, drinking, continence, hygiene, UB/LB dressing, grooming, bathing, functional transfers, shower/tub, functional transfers WC/bed, functional toilet transfers, swallowing, communication speech, etc.) that have an impact on rehab and relate to the goals established).

- **Underlying Impairments** required – includes objective information for all impairments to be addressed in the POC, i.e., strength, ROM, balance, pain, vision, coordination, sensation, activity tolerance, comprehension, expression, etc., to be addressed in the POC, and included in the goals that impact the patient's ability to perform a task at his/her highest level of function possible. Cognition should be addressed by all to paint a clear picture of what the pt. can do and how the pt. is able to engage with the therapist.

- **Standardized Tests** need to be appropriate, inclusive of score and rationale and initiated at the beginning of treatment, throughout the plan of care, as appropriate, to objectify, strengthen and help justify your therapeutic interventions.

- **Goals** are related to the disability/dysfunction, are objective, measurable, functional, patient focused, clear, concise, not bundled to avoid confusion and support the treatment diagnosis and deficits/impairments identified in the assessment with time frames to achieve. STGs should be dated for no greater than 2 weeks and LTGs for the entire POC.

- **Potential for achieving goals** – listed as Good or Excellent on the evaluation with prognostic statement supporting a positive expectation of improvement

- **Treatment plan** includes a reasonable intensity, frequency, duration, without ranges, with procedures, treatments and modalities that are consistent with the PLOF, objective findings and goals.

For further support of skilled therapy documentation, please refer to the following resources on Knect – Kindred Rehab Svcs → Clinical Services → Skilled Nursing (RHB):

- **Audits** – Rehab Chart Audit Guide
- **Clinical Practice Resources** – Clinical Program "At a Glance" Guides, On-The-Go Resources
- **Documentation, Forms** – PT/OT/SLP Evaluation, Specialty Forms
- **Documentation Tools** – Documentation Quick Tips, Indications for Evaluation & Treatments, Key Elements of an Evaluation, Quick Guides
- **Fast Fact Fridays**
- **Quality Assurance Materials** – Training PPTs, Competencies