# Bringing Back the SOAP Note: Plan and Goals

***Practical Strategies for Defensible Home Health Documentation***

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## Series Objectives

- Define and apply the terms skilled, reasonable and necessary in the context of clinical documentation.
- Identify two strategies for collecting both subjective and objective information.
- Integrate "professional opinion" into initial assessments and routine visits to support clinical decision making.
- Formulate goals that meet the expectations of measureable and meaningful.

## Series Overview

- Subjective
- Objective
- Assessment
- Plan ✓

## Session Objectives

- Define planning care from the beginning and throughout an episode of care.
- Discuss the connection between subjective information, objective data, assessment and care planning.
- Examine specific documentation opportunities to confirm and update an active care plan.

# Dealing with Data

- Decision making is driven by data, now more than ever before…. and will only *increase* moving for
  - Regulations
  - Payment Methodc
  - Care Delivery Mc


# Data Driven Decision Making

Objective Data Analysis

Subjective Opinions

# Professional Opinion

- Collecting objective information in and of itself does not indicate a specific discipline skill set.
- The ability to interpret data gives it meaning and patient specific focus.


# Defining Key Concepts

**Skill** — Exclusive to the clinician

- proficiency, facility, or dexterity that is acquired or developed through training or experience; an art, trade, or technique

**Reasonable** — The amount makes sense

- governed by or being in accordance with reason or sound thinking; not excessive or extreme

**Necessary** — The care is indispensible

- Absolutely essential; needed to achieve a certain result or effect; requisite

## Conditions for Coverage of Therapy Services:

Skills of a therapist are needed to restore function

Patient's condition requires a qualified therapist to design or establish a maintenance program

Skills of a qualified therapist are required to perform maintenance therapy

Restorative | Maintenance | Maintenance

## Defining "Plan"

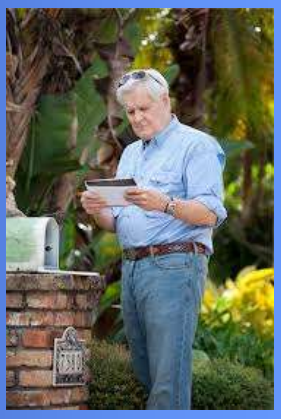
- World Dictionary: *"a detailed scheme, method, etc, for attaining an objective; a proposed, usually tentative idea for doing something"*
- Synonyms: *"plot, formula, system, project, design, scheme imply a formulated method of doing something."*
- Creates the roadmap for care delivery.

# Where Does the Plan Belong?


- Initial Assessments
- Subsequent Visits
- Functional Reassessments

# What the Notes Contain

- Plan:
  - Continue per plan of care
  - Tuesday
  - Plan for next visit = BLANK
- Goals:
  - Patient will be independent with wound management
  - Patient will bathe with verbal cues
  - Patient will amb 200 ft with walker and CGA to mailbox

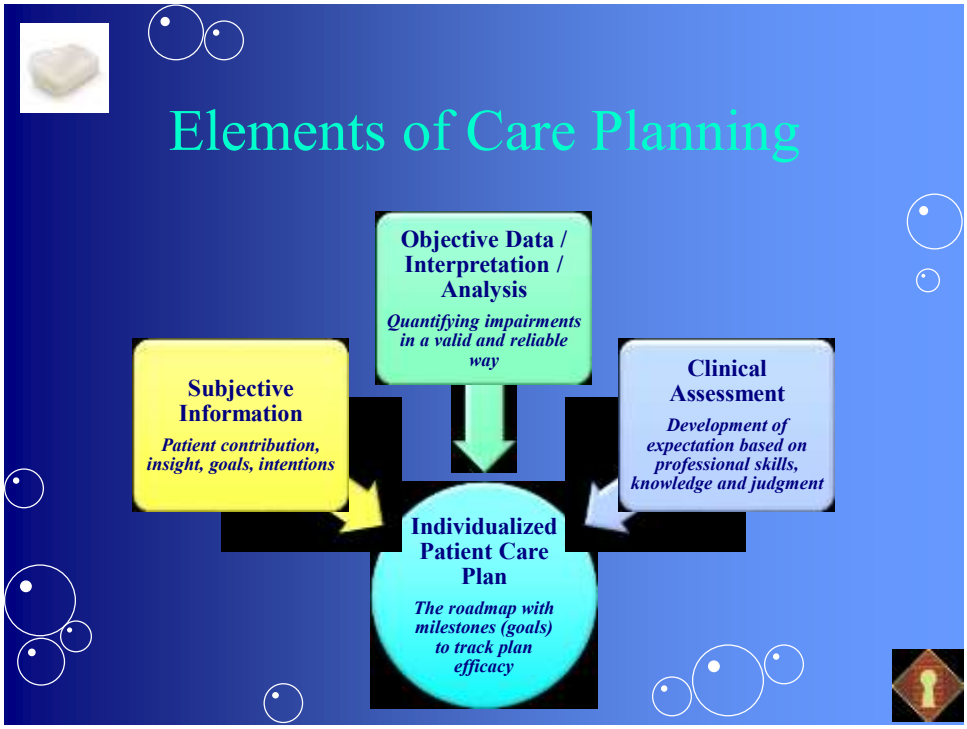


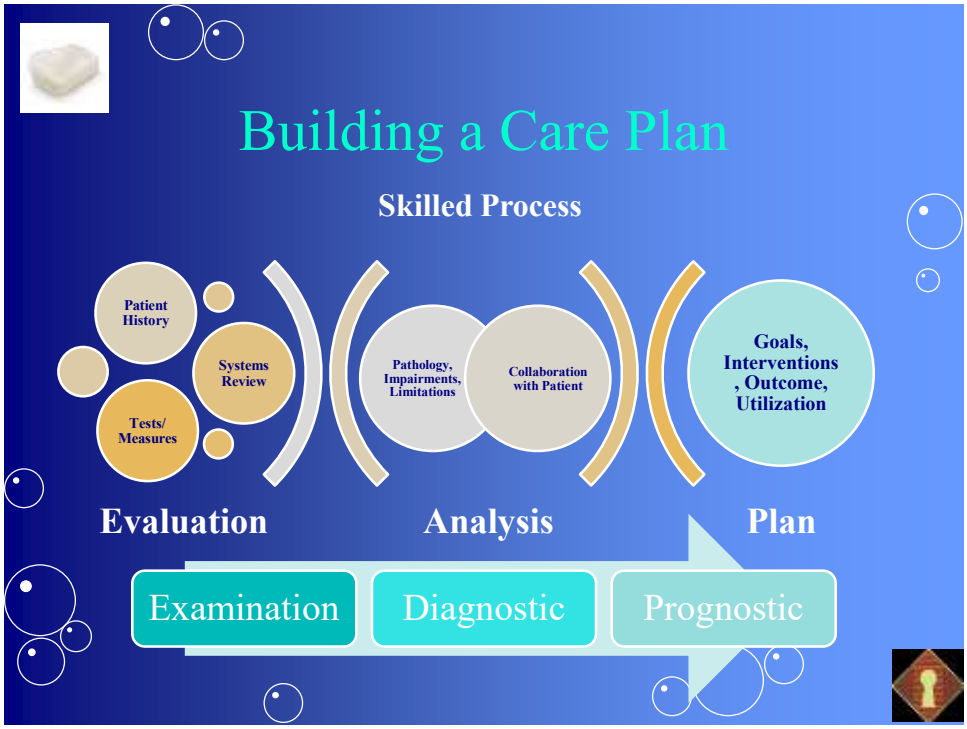
## Starting a Care Plan

- Development of the plan of care and goals requires the assessing clinician to envision the potential outcomes for the patient and choose the strategies to achieve them.
- Selection of interventions must correlate to the assessment findings.
- Both the plan and the goals must be specific to each individual patient.

## Demonstrating Skill

- Like an architect, the therapist constructs the plan per patient specifications (goals, abilities, environmental allowances/barriers, etc.) and identifies the materials ("interventions") needed to achieve the desired outcome.


Elements of Care Planning
Objective Data / Interpretation / Analysis
Quantifying impairments in a valid and reliable way
Subjective Information
Patient contribution, insight, goals, intentions
Clinical Assessment
Development of expectation based on professional skills, knowledge and judgment
Individualized Patient Care Plan
The roadmap with milestones (goals) to track plan efficacy


Building a Care Plan
Skilled Process
Patient History
Systems Review
Tests/ Measures
Pathology, Impairments, Limitations
Collaboration with Patient
Goals, Interventions, Outcome, Utilization
Evaluation
Analysis
Plan
Examination
Diagnostic
Prognostic

# Patient Specific Interventions?

- Medication Teaching
- Wound Care
- Gait Training
- Transfer Training
- Ther Ex
- ADL Retraining
- Cognitive Retraining
- Fall Reduction



# Choosing Interventions- Therapy

**WHAT**

- Patient transfers from sit to stand with moderate assistance.
- Patient requires minimal assistance to dress upper body.
- Patient ambulates 80 feet with a walker and CGA.

**WHY**

- ✓ Weakness
- ✓ Balance
- ✓ Pain
- ✓ Cognition
- ✓ Environment
- ✓ Fatigue
- ✓ Fall Risk

## Choosing Interventions- Nursing

WHAT

- Patient is taking her medication incorrectly
- Patient has fallen three times in the past week
- Patient's blood pressure has been elevated for two days.

WHY

- ✓ Knowledge
- ✓ Medications
- ✓ Weakness
- ✓ Balance
- ✓ Pain
- ✓ Cognition
- ✓ Environment
- ✓ Fatigue
- ✓ Fall Risk

## Managing Risk – Ther Ex

- WHY is that specific exercise important?
- WHY are changes made in the program?
- WHY is education necessary?
- WHY does a therapist need to be involved?

# Managing Risk – Med Teaching

- WHY is that specific medication important?
- WHY is education necessary?
- WHY is monitoring necessary?
- WHY does a nurse need to be involved?

# Defining "Goal"

- World Dictionary: *"the aim or object towards which an endeavour is directed; the terminal point of a journey or race"*
- Synonyms: *"target; purpose, object, objective, intent, intention."*
- Creates the anticipated outcome.

# What Does CMS Say?

- "The qualified therapist(s) determines if the **goals of the plan of care** have been achieved or if the plan of care may require updating. If needed, **changes to therapy goals** or an updated plan of care is sent to the physician for signature or discharge."
- "If the measurement results do not reveal progress toward **therapy goals** and/or do not indicate that therapy is effective, but therapy continues, the qualified therapist(s) must document why the physician and therapist have determined therapy should be continued."

Medicare Benefit Policy Manual – Chapter 7 Home Health Services 40.2.1 - General Principles Governing Reasonable and Necessary Physical Therapy, Speech-Language Pathology Services, and Occupational Therapy

# Are there LIMITS on Goals??

- "Any 'rules of thumb' that would declare a claim not covered solely on the basis of elements, such as lack of restoration potential, ability to walk a certain number of feet, or degree of stability, is unacceptable without individual review of all pertinent facts to determine if coverage may be justified. Medical denial decisions must be based on a detailed and thorough analysis of the beneficiary's total condition and individual need for care."

Medicare Program Integrity Manual: Transmittal 18
https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R18PIM.pdf

# How Many Goals?

- Focus should be on the quality of the goals and not the quantity.
- Key words:
  - **MEASURABLE**
  - **MEANINGFUL**


# "Measureable" Goals

**Consider:**

- Number of Meds
- ROM
- Distance
- Device
- Level of Assistance
- Functional Test Scores
- Lab Values

**Reconsider:**

- "fair/good/poor"
- "LRAD"
- "household"
- "community"
- "safe"
- "increase/improve"
- "Modified Independent"

# "Meaningful" Goals

- Connection to what is meaningful TO THE PATIENT
- Consider:
  - "to allow patient to"
  - "so patient can"
  - "to comply with"

# Summary of Key Points

- Should be ***observable***
- Should be ***measurable***
- Remediation of ***impairment***
- Intended to ***impact functioning*** *(that are* ***patient-specific****)*
  - Body structures/functions, activity limitations, participation restrictions
  - Those activities identified by an individual as essential to support physical, social, and psychological well-being and to create a personal sense of meaningful living
- For desired ***outcome***
- That are in defined ***time frame***

## Periodic Reassessments

- Mandatory Time Frames
  - Recertification
  - Resumption of Care
  - Therapy Functional Reassessments
- These are the MINIMUM expectations for assessing the patient AND the plan of care.

## Changing the Care Plan

- Making changes to the plan of care, inclusive of goal statements, based on the current presentation of the patient demonstrates MORE skill than cookie cutter care plan.
- One size should NOT fit all!

# Knowledge Application

- Mr. X is 77 years old hospitalized after a fall while letting his dog outside resulting in a pelvic fracture. He has been recently diagnosed with Type 2 Diabetic and is reporting trouble with managing his blood sugar. He lives with his grandson in a two story home with his bedroom and bathroom upstairs. Mr. X is refusing to go to a SNF and is being admitted to home health for nursing, PT, OT and HHA services.

# Data Analysis

| Assessment | Findings | Scoring Guide with Interpretation | Functional Relevance |
|---|---|---|---|
| 30 – sec CST | 8 reps | • Age/gender norms (11-17 reps)<br>(8/11 = 73% age/gender norms) | ***Mobility***<br>***Self Care***<br>***Medications*** |
| Timed Up & Go | 32 sec | • >30 secs: dependent for transfers, needed help to enter/ exit shower or tub, did not go out alone;<br>• (+) fall risk with score > 14 sec<br>(moderate mobility impairments and + fall risk) | ***Mobility***<br>***Self Care***<br>***Medications*** |
| Gait Velocity 4 Meter | 0.3m/sec | • **0.0-0.4m/sec = household amb.**<br>• 0.4-0.6m/sec = limited community amb<br>• **≤ 0.57m/sec = (+) falls risk**<br>• 0.6 – 1.0m/sec = lmtd /safe community amb<br>• > 1.0m/sec = functional community am<br>• > 1.2m/sec = safe to cross streets | ***Mobility***<br>***Self Care***<br>***Medications*** |
| MoCA | 24/30 | • WNL for age: >26<br>(minimal cognitive impairments) | ***Mobility***<br>***Self Care***<br>***Medication*** |

# Assessment in Action

***Which disciplines should be part of the plan?***

**Data Collected:**

- Subjective –
  - 3 falls managing dog
  - CG available only at night
  - Forgets medications
  - Can't work the glucometer
  - Wants to stay in the home
- Objective –
  - Blood sugar too high
  - LE weakness
  - + fall risk
  - Moderate mobility impairment
  - Mild cognitive impairment

**Assessments:**

- Medication management impacted by mild cognitive impairments and no access to CG during the day.
- Fine motor issues and mild cognitive impairments limit use of glucometer.
- LE weakness contributing to fall risk and pet management impacted by both issues.
- Caregiver access will impact overall plan

# So What Are We Going to Do?

| Plan | | |
|---|---|---|
| Interventions | Freq / Dur | Goals |

# In Closing

- No matter how documentation tools develop and evolve over time, the key elements of defensible documentation remain:
  - Patient specific SUBJECTIVE information
  - OBJECTIVE data that is analyzed by the professional
  - ASSESSMENT that reflects the skills of the therapist
  - A clear PLAN that is adjusted based on patient presentation

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