Why goal writing is important

• Goals guide treatment
• Helps the therapist and patient measure progress
• Helps with discharge planning
• Reimbursement – goals help to distinguish skilled intervention vs. non-skilled

What is a goal

• A goal is a statement of intended changes in baseline performance components which are expected to occur as a result of planned treatment interventions to produce functional outcomes.

Establishing a Baseline

• Baseline performance components are established during the evaluation or in the first week of treatment so comparisons can be made objectively.
• The therapist should document a baseline status for every goal written and a PLOF. (ex: standing tolerance, cadence, attention span, ROM measurements, fine motor coordination, posture, balance)
• These baselines can be measured through skilled observation and/or formal testing (9 hole peg test, REEDCO, Tinetti,...)
• May write a STG for formal testing: Pt. will participate in a full fall prevention analysis assessment to guide mobility interventions.

Short term goal vs. long term goal

• Your short term goals must have a direct relation to your long term goals.
• STG: Pt. will improve BUE strength seen by pulling pants over hips independently during toileting task.
• LTG: Pt. will perform toileting independently.

What are performance components

• Performance components are the skills and abilities required to perform a specific oddslot task.
• Performance components help to distinguish skilled intervention vs. non-skilled.
• Performance component = Why the patient can’t perform the specific task, the underlying factors that are impeding the pt.’s ability to perform desired tasks.
• Example: Why can’t the patient ambulate safely? Due to his narrow BOS of 2” compared to the norm of 3” and his slow cadence of 60 steps/minute compared to norm of 81-125 steps/minute.
**PT Goal**
- Less-Skilled – Pt. will ambulate 250 feet with min assist using a rolling walker.
- Skilled – Pt. will improve BOS from 2” to 3” for increased stability and safety during ambulation.
- Skilled – Pt. will improve cadence from 60 steps/minute to 80 steps/minute to decrease fall risk during ambulation.

**Performance Components**
- Why can’t the patient perform dressing? Due to having difficulty sequencing multiple steps when compared to his ability to sequence 2 steps and demonstrating poor safety awareness by requiring several verbal cues during dressing to prevent harm compared to previously requiring no verbal cues.

**OT Goal**
- Less-Skilled – Pt. will perform dressing with min. assist.
- Skilled – Pt. will sequence through a 5 step dressing task with set-up assist (clothing placed on bed from left to right.)
- Skilled – Caregiver will be educated and demonstrate appropriate verbal cues to use during lower body dressing to prevent falls.

**Performance Components**
- Why does the patient have difficulty with swallowing? Difficulty with lingual sweep technique seen by pocketing food and poor lip closure causing excessive drooling which was not present prior to the evaluation.

**ST Goal**
- Less-Skilled – Pt. will swallow with no signs or symptoms of aspiration.
- Skilled – Pt. will use lingual sweep technique to search and remove pocketed food from cheeks with 90% accuracy with no verbal cues.
- Skilled – Through labial exercises, pt. will maintain labial seal to sip from cup with 90% accuracy with min verbal cues.

**Reimbursement**
- Unless treatment results in improved performance of a functional task, an improvement in a performance component alone may not be considered significant enough for reimbursement.
- Example: (less-skilled)Pt. will ambulate 150 feet with min assist using a rolling walker.
- A restorative aide could perform this goal.
- Must contain both a performance component and a functional task.
- Example: (skilled)Pt. will ambulate 150 feet demonstrating equal step length to allow normal gait pattern with min assist to safely ambulate to and from dining room for meals.
Characteristics of a Goal

• 1. Relevant
• 2. Understandable
• 3. Measurable
• 4. Meaningful
• 5. Achievable

Goals must contain the following:

• 1. Participant – The person performing the desired task.
• 2. Performance Component – The skills and abilities required to perform the task.
• 3. Task – Functional activity
• 4. Measure – Objective criteria for measuring progress

4 goal items

Patient will dress self independently in 15 minutes or less showing good activity tolerance.

• 1. Patient
• 2. Activity tolerance
• 3. Dressing
• 4. 15 minutes

4 goal items

Patient will improve bilateral hip flexion from 15 degrees to 30 degrees during swing phase of gait cycle to improve step height to decrease tripping.

• 1. Patient
• 2. Range of Motion
• 3. Gait/ambulation
• 4. 30 degrees

4 goal items

• Patient will demonstrate increased decision making ability by completing a daily menu request with moderate independence seen by utilizing an adapted food choice list and requiring 1 verbal cue for initiation.

• 1. Patient
• 2. Decision making
• 3. 1 verbal cue and adapted list
• 4. Menu request

How many goals???

• Try to have 3-4 short term goals; address each goal in your weekly progress report. Pick the 3 most important hierarchical goals. (must be able to don socks before shoes)
• Evaluating therapists may want to write all goals they plan to use so COTA's and PTA's may pick and choose new goals to add as treatment progresses
• Assistants may modify goals by breaking them down into smaller components, but it is ideal for the evaluating therapist to set goals that are achievable in 1 week.
Progress Reports

- This weekly report should objectively state the pt.'s progress toward goal achievement to allow comparison to initial findings and what skilled technique was used during treatment intervention.
- Each short term goal should be addressed.
- Document what the pt. can do and can’t do

Progress Report

- Example: Pt. met 2/4 short term goals this week and is now able to perform heel strike 100% of the time and exhibits a 3” base of support while ambulating which helps prevent falls. Pt. participated in a standardized assessment (Tinetti) scoring 23/28 which means pt. is at a moderate risk for falls. Pt. requires skilled PT intervention with a focus on weight shifting through graded challenging activities and progressive therapeutic exercises targeting plantar flexion muscles (gastrocnemius/soleus) to aide in push-off during swing cycle of gait.

Questions?

- Thank you!!
- Please fax your sign in sheets to April Gaedtke at HT corporate office: (317) 886-5026
Audit scoring definitions

Technically compliant:
enter 1 if all relevant fields are complete or marked n/a, signatures, dates and timeliness of entry is compliant

PLOF for goal areas:
enter 1 if there is an objective measure of PLOF for each short and long term goal

Objective Baselines:
Enter 1 if adequate baseline measures are established at eval and/or week 1 of therapy to provide sufficient opportunity for proving progress in all deficit areas to be addressed under this plan of care

Formal tests:
enter one if at least one formal test is completed with in the first week of therapy (Tinetti, ACL, BERG, etc.)

Goals measurable:
Enter 1 if each long and short term goal has an objective measure

Goals functional:
Enter 1 if each short and long term goal is functional (examples of functional goals include those for improved pain, ROM, transfers, ambulation quality, ambulation distance to a specific destination, bed mobility, self care, communication, swallow safety are acceptable)

Goals met weekly:
at least 2 goals are met each week

Reasonable expectation of progress:
based on the documented condition and interventions, reasonable expectation for further progress is proven at eval and in each progress note through the period reviewed

Skilled service justified:
Skilled need is clearly proven at eval and skilled services are documented in detail at each progress note. Skilled services=beyond the scope of a restorative aide

Duration supported:
The full duration of services from evaluation to last treatment reviewed meets coverage standards for payment
# Standardized Tests Reference

Refer to the HTS recommend clinical tests and scales for more detail

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<td>Routine Task Inventory</td>
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<td>Geriatric Patterns Test Card</td>
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<td>HHIS</td>
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<td>RTI – comprehension section</td>
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<tr>
<td>Dementia/Cognition</td>
<td>ACL leather lacing screen</td>
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<td>Adapted FAST scale</td>
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<td>Clock Drawing Test</td>
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<td>COPD</td>
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<td>6 min walk test/BORG perceived exertion rating scale</td>
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<td>Driving</td>
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<td>Dysphagia</td>
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<td>REEDCO posture score</td>
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<td>Gait</td>
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<td>Functional Ambulation Profile</td>
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<td>GARS – Gait Assessment Rating Scale</td>
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<td>Checklist of nonverbal pain indicators</td>
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<td>Pain-AD</td>
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<td>Visual pain intensity scale/Faces pain scale</td>
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<td>Fahn-Marsden Dystonia scale</td>
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<td>Columbian Rating Scale</td>
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<td>Pressure</td>
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<td>Visual-Perceptual Deficits</td>
<td>Lighthouse-functional Visions Questionnaire</td>
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*This chart is cross-referenced for the discipline(s) most likely to use the test for evaluations.*
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<tr>
<td><strong>Barthel Index</strong></td>
<td>Total functional performance for self care and mobility tasks. Good tool to demonstrate improvement from assist required at SOC to total independence in some areas after rehab.</td>
<td>AD and mobility devices if used; stairs.</td>
<td>0-100 (higher score indicates greater level of independence)</td>
</tr>
<tr>
<td><strong>RTI (Routine Task Inventory) – physical performance version</strong></td>
<td>Performance of “routine” self care tasks (grooming, dressing, bathing, toileting) are measured using a scale following several days of self care performance observation and/or caregiver interview</td>
<td>Generally used ADL items</td>
<td>Score 1-5 in each of 4 categories. Average of these scores should be corroborated with the ACLS score to determine cognitive level. Use <strong>Understanding Performance Modes</strong> in cognitive performance manual to guide interventions based on scoring.</td>
</tr>
<tr>
<td><strong>RIPA-G (Ross Information Processing Assessment-Geriatric)</strong></td>
<td>Cognitive Linguistic Deficits with subtests for immediate &amp; recent memory, temporal &amp; spatial orientation, environmental orientation, general recall, problem solving, abstract reasoning, organization of information, auditory processing &amp; comprehension, problem solving &amp; concrete reasoning, naming, oral reading,</td>
<td>RIPA-G manual</td>
<td>Sum 3 or 10 subtests is converted to quotient for final score calculation. Quotient is compared to percentile ranking table to determine level of cognitive linguistic impairment.</td>
</tr>
<tr>
<td><strong>MOCA (Montreal Cognitive Assessment)</strong></td>
<td>Attention/concentration, executive function, memory, language, visuoconstructional skill, conceptual thinking, calculations &amp; orientation</td>
<td>Moca score sheet, pencil</td>
<td>Total possible score is 30. 26 or above is normal. 19-25=mild cog. impairment 21-11=Alzheimers Disease</td>
</tr>
<tr>
<td><strong>Geriatric Patterns Test Card</strong></td>
<td>Ability to read printed material.</td>
<td>Geriatric patterns test card.</td>
<td>Scored 0 (adequate to read newsprint) up to 4 (highly impaired to read printed material)</td>
</tr>
<tr>
<td><strong>HHIS (Hearing Handicap Inventory Screening)</strong></td>
<td>Degree of hearing impairment handicap</td>
<td>HHIS screen form</td>
<td>0 – 8 = 13% probability of hearing impairment (no handicap/no referral) 10-24 = 50% probability of hearing impairment (mild-moderate handicap/refer) 26-40 = 84% probability of hearing impairment (severe handicap/refer)</td>
</tr>
<tr>
<td><strong>RTI (Routine Task Inventory)-Communication version</strong></td>
<td>Listening/comprehension, Talking/expression, Reading comprehension, Writing expression</td>
<td>Sample reading material, pencil/paper</td>
<td>Score 1-5 in each of the 4 categories. Average of these scores should be corroborated with the ACLS score to determine cognitive level. Use <strong>Understanding Performance Modes</strong> in cognitive performance manual to guide interventions based on scoring.</td>
</tr>
<tr>
<td><strong>Communication</strong></td>
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*Also refer to KELS (DC planning & I-ADL) & AdrS (driving) assessments below*
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<tr>
<th>Test</th>
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<tr>
<td><strong>Allen Cognitive Level Screen</strong> <em>(leather lacing or placemat test)</em></td>
<td>Cognitive performance as it relates to the ability to perform unfamiliar tasks. Strong correlation between test performance and daily functional performance. Valuable tool to guide rehab approaches to self care/mobility training, falls prevention and safe DC destination planning in the presence of cognitive decline.</td>
<td>Leather lacing kit or Placemat kit HTS cog. level determination worksheet</td>
<td>Scores cognitive level 3-6. Results should be corroborated with one of the RTI scales listed above. Use Understanding Performance Modes in cognitive performance manual to guide interventions based on scoring.</td>
</tr>
<tr>
<td><strong>Adapted FAST scale</strong></td>
<td>Dementia staging tool based on observations of general functional performance for tasks such as dressing, locating room, speech and toileting.</td>
<td>Adapted FAST scale worksheet</td>
<td>Stages dementia from stage 1-7b with interpretation range of no functional decline to early, late, middle and end stage dementia.</td>
</tr>
<tr>
<td><strong>Cognitive Performance Test</strong> <em>(based on Allen theory)</em></td>
<td>uses 7 subtasks (sorting meds, shopping for clothing, washing hands, preparing toast, using phone, traveling, dressing) that measure performance of common ADL tasks, for which the information-processing requirements can be systematically varied to assess ordinal levels of functional capacity. For each task, standard equipment, set-up and methods of administration are required</td>
<td>CPT kit</td>
<td>A gross level score is determined for each of the six tasks; these scores are then added for a total score and averaged (divided by 6) to determine the functional level and mode.</td>
</tr>
</tbody>
</table>
| **Clock Test** | Screen of executive functioning. Poor performance indicative of difficulty planning, problem solving, and functioning in situations requiring divided attention (e.g. driving.) Recommended even for seemingly high level residents as it is quick screen to identify early cognitive changes. | HTS cognitive level determination worksheet; pencil | Score 0-4 points (lower score indicates greater executive functioning deficits )
1-draws closed circle
1-includes all 12 correct #s
1-places #s in correct position
1-places hands in correct position (11:10) |
| **Spaced Retrieval Screen** | Memory screening tool to determine potential to benefit from spaced retrieval intervention focused on recalling information over progressively longer intervals of time. The goal of SR is to enable individuals to remember important information for clinically meaningful periods of time. | SR screen tool Verbal response cards Watch with second hand | Record number of correct recall responses with and without verbal response cards(cues) in the time periods listed. Divide correct responses by the number of trials to calculate a % of accuracy. Use this measure to show progressively longer intervals of accurate recall |

See MOCA, RIPA-G, & RTI info in sections above
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<td><strong>KELS (Kohlman Evaluation of Living Skills)</strong></td>
<td>Reading/writing, household safety situations, shopping/managing money, budgeting, check writing/bill paying, telephone use, transportation, work/leisure. Useful to identify critical areas of potential problems prior to DC home</td>
<td>KELS kit</td>
<td>Graded as independent or needs assistance in areas of self care, safety/health, money management, transportation/telephone, and work/leisure</td>
</tr>
<tr>
<td><strong>AdrS (Assessment of Driving Related Skills)</strong></td>
<td>Vision, cognition and motor function –key variables in safe driving. Provides useful information to physician to assist in their decision re: driving recommendations.</td>
<td>AdrS packet Snellen eye chart 10 ft marked path</td>
<td>Visual acuity, visual field, cognition and motor ability scores are calculated using subtests and summarized on a physician report as WFL or needing further intervention</td>
</tr>
<tr>
<td><strong>MASA (Mann Assessment of Swallowing Ability)</strong></td>
<td>Alertness, cooperation, auditory comprehension, respiration, respiratory rate for swallow, dysphasia,dyspraxia, dysarthria, saliva/oral secretion control, lip seal, tongue movement-strength-coordination, oral prep, gag, palate, bolus prep, oral transit, cough reflex, voluntary cough, voice, trache, pharyngeal response , &amp; diet</td>
<td>MASA instruction sheet and score guide</td>
<td>Circle the observed response on the MASA form, each of which is associated with a numeric score. Total all scores. 139-167=moderate dysphagia 168-177=mild dysphagia ≤ 148= moderate aspiration risk 149-169=mild aspiration risk</td>
</tr>
<tr>
<td><strong>ABC (Activities Specific Balance Confidence Scale)</strong></td>
<td>Self report measure (or based on interview) of self confidence performing various mobility/physical function tasks. Used as an indicator of fear of falls—a geriatric fall risk variable.</td>
<td>ABC scale</td>
<td>Each of 16 questions is rated from 0-100% confidence. Total ratings &amp; divide by 16 to determine % score. &gt;80%=high level physical functioning 50-80=moderate physical functioning &lt;50=low functioning &lt;67=predictive of future fall</td>
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<tr>
<td><strong>BERG balance scale</strong></td>
<td>Series of functional mobility task/transitional movement tests (e.g. sit to stand, stand unsupported, sitting with back unsupported, stand on one leg, turning 360° , pick up object from floor, reaching forward, turning to look behind, etc) scored individually 0-4 points based on observed performance. Used to measure safety with mobility tasks and fall risk.</td>
<td>BERG score sheet Ruler, 2 standard chairs (one w/arm rests, one without), Footstool or step, Stopwatch, 15 ft walkway</td>
<td>Sum all test items for possible 56 point maximum. 45=safe independent ambulation 41-56 = low fall risk 21-40 = medium fall risk 0 –20 = high fall risk</td>
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<tr>
<td><strong>Falls</strong></td>
<td>**HTS recommended clinical tests and scales</td>
<td>2011-2012**</td>
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<td><strong>Four Square Step Test (FSST)</strong></td>
<td>Dynamic balance during stepping and change of direction to identify multiple falling older adults. Test involves measuring performance and time required to step over canes laid in a cross pattern on the floor in a specific sequence.</td>
<td>Stop watch&lt;br&gt;4 canes&lt;br&gt;Gait belt&lt;br&gt;Scored based on time required to complete sequence (with notations on LOB episodes)</td>
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<tr>
<td><strong>Functional reach test (item 8 on BERG)</strong></td>
<td>Ability to maintain dynamic balance during reaching from standing positioned is measured in inches using a yardstick. (May be modified to sitting position if noted in documentation—e.g. Resident who has fallen forward from w/c while reaching for items would potentially benefit from test)</td>
<td>Yardstick&lt;br&gt;Scores less than 6 or 7 inches indicate limited functional balance. Most health individuals with adequate functional balance can reach 10 inches or more.</td>
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<tr>
<td><strong>Get up and Go Test</strong></td>
<td>Measure of safety during transitional movements and fall risk. Measures ability to rise from a sitting position, stand without using arms, walk 10 ft, turn, return to chair, sit back in chair without using arms for support.</td>
<td>Stop watch&lt;br&gt;Chair&lt;br&gt;10 ft walkway&lt;br&gt;Normal: completes task in &lt; 10 seconds. Abnormal: completes task in &gt;20 seconds Low scores correlate w/ good functional independence; high scores correlate w/poor functional independence &amp; higher fall risk.</td>
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<td><strong>Modified Physical Performance Test</strong></td>
<td>Physical functioning/mobility &amp; frailty. Series of 9 subtests that measure balance, chair rise, lifting book to a shelf, putting on a jacket, pick penny up from floor, turn 360°, walk 50 ft., stair climbing</td>
<td>Stopwatch, Straight back chair, book, shelf above shoulder ht., jacket, penny, 50ft walkway, 9-12 stairs&lt;br&gt;9 items scored 0-4 points each.&lt;br&gt;32/36 - 36/36 = not frail&lt;br&gt;25/36 - 31/36 = mild frailty&lt;br&gt;17/36 - 24/36 = moderate frailty&lt;br&gt;&amp; &lt; 17 = unlikely to be functional in community</td>
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<tr>
<td><strong>REEDCO posture score</strong></td>
<td>Rating of 4 posture conditions (forward head, dorsal kyphosis, trunk inclination and lumbar lordosis) Posture is measured using picture scale to rate position of head, shoulders, spine, hips, ankles, neck, upper back, trunk, lower back, abdomen on scale 0 poor, 5 fair, 10 good</td>
<td>REEDCO score sheet&lt;br&gt;Total 10 sub-scores for maximum of 100 points, to determine extent of postural deficit. Show postural improvement over time with improving REEDCO score.</td>
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<tr>
<td><strong>TUG (Timed Up and Go)</strong></td>
<td>Measures in seconds, the time taken to stand up from a standard arm chair (approximate seat height of 18in, walk a distance of 10 feet, turn, walk back to the chair, and sit down. The subject wears their regular footwear and uses their customary walking aid (none, cane, walker). No physical assistance is given. Optional addendum test includes carrying glass of water to assess division of attention during TUG.</td>
<td>Stopwatch&lt;br&gt;Straight chair&lt;br&gt;10 ft walkway&lt;br&gt;AD as needed&lt;br&gt;Older adults who take longer than 13.5 seconds to complete the TUG have a high risk for falls. Norms: age 60-69 = 7.0secs; age 70-79= 7.7 secs; age 80-89=11.0 secs without AD &amp; 19.9 w/AD; Age 90-91=14.7 secs without AD and 19.9 with AD</td>
<td></td>
</tr>
</tbody>
</table>
## HTS recommended clinical tests and scales 2011-2012

<table>
<thead>
<tr>
<th>Fall Assessment</th>
<th>Description</th>
<th>Risk Categories</th>
<th>Tools</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Tinetti</strong></td>
<td>Balance, gait and fall risk. Series of balance tests (sitting in chair, rising, balance upon immediate standing, stand balance, sternal nudge, eyes closed/feet together, turning 360˚, sitting down) and gait tests (initiation, step length, foot clearance, step symmetry, step continuity, path, trunk sway and base of support)</td>
<td>Chair walkway</td>
<td>Sum Balance &amp; Gait scores for possible score of up to 28. 26-28= very low risk of falls 20-25= moderate risk of falls 1-19= high risk of falls</td>
</tr>
<tr>
<td><strong>Dizziness Handicap Inventory</strong></td>
<td>Patient perception of handicap related to symptoms of dizziness is measured via interview responses to 25 questions. Answers yes, no, sometimes</td>
<td></td>
<td>Sum score responses using worksheet scale. 100-70= severe perception of handicap 69-40= moderate perception of handicap 39-0= low perception of handicap</td>
</tr>
<tr>
<td><strong>Fukuda Step Test</strong></td>
<td>Vestibular impairment screen—helps distinguish central from peripheral lesion. Subject is blindfolded and asked to step in place 50 times with arms raised to 90˚; reviewer observes marked movement from original position. Peripheral lesions tend to deviate to one side. Central lesions show side to side excursions. This test assists in the clinical picture but is not always reliable. See HTS vestibular assessment for other recommended tests.</td>
<td>Blindfold</td>
<td>Up to 30˚ movement to right or left is normal. Backward movement is rarely seen in those without disease.</td>
</tr>
</tbody>
</table>

See HTS falls prevention analysis tool and falls program manual (chess board on cover) for additional measurement options.

<table>
<thead>
<tr>
<th>Gait Test</th>
<th>Description</th>
<th>Score Interpretation</th>
<th>Tools</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dynamic Gait Index</strong></td>
<td>Tests 8 facets of gait and likelihood of falls. Tests in include gait on level surface, changing speed, head turns, pivot turn, step over obstacle, &amp; steps</td>
<td>&lt; 19/24 predictive of falls in the elderly.</td>
<td>Shoebox, 2 cones, steps, stopwatch, 20 ft walkway</td>
</tr>
<tr>
<td><strong>Functional Ambulation Profile</strong></td>
<td>Locomotor skill in subjects with neuromuscular or musculoskeletal disorders through analysis of static weight bearing, dynamic weight transfer and gait efficiency</td>
<td></td>
<td>Stopwatch, parallel bars</td>
</tr>
<tr>
<td><strong>Gait Assessment Rating Score (GARS)</strong></td>
<td>Relationship of gait abnormalities to falls in the elderly though tests of variability/rhythmicity of limb movements, guardedness, weaving, waddling, staggering, time in swing, foot contact, hip/knee ROM, UE/trunk/head position, &amp; arm/heelstrike synchrony</td>
<td></td>
<td>Walkway</td>
</tr>
</tbody>
</table>

See HTS falls prevention analysis tool and falls program manual (chess board on cover) for additional measurement options.
<table>
<thead>
<tr>
<th>Test</th>
<th>Measures</th>
<th>Supplies</th>
<th>Scoring</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Checklist of nonverbal pain indicators</strong></td>
<td>Pain in nonverbal patients via observations</td>
<td>Nonverbal pain indicator worksheet</td>
<td>6 criterion are scored 0 (not observed) or 1 (observed) for total pain score with and without movement</td>
</tr>
<tr>
<td><strong>Oswestry Disability Questionnaire</strong></td>
<td>Disability due to back and leg pain on a self report scale. Focus is on measure of impact on daily life (sleeping, lifting, walking, personal care, social activities etc.)</td>
<td>Oswestry questionnaire</td>
<td>0-5 score possible for each of 10 questions. Sum score __<strong>/50 x 100=</strong>_% disability</td>
</tr>
<tr>
<td><strong>Pain-AD</strong></td>
<td>Pain in patients with advanced dementia via observations</td>
<td>Pain-AD tool</td>
<td>5 Items are scored on observational tool on 0-2 point scale for a maximum possible total of 10. Higher score indicative of &gt;discomfort.</td>
</tr>
<tr>
<td><strong>Visual pain intensity scale/Faces pain scale</strong></td>
<td>Pain using picture scale of faces to indicate varying levels of comfort to discomfort. Faces correlate to 0-10 pain scale.</td>
<td>Visual pain intensity scale tool</td>
<td>Pain is rated 0-10. Higher score indicative of &gt; discomfort.</td>
</tr>
<tr>
<td><strong>9 hole peg test</strong></td>
<td>Fine motor coordination</td>
<td>Peg test board</td>
<td>no</td>
</tr>
<tr>
<td><strong>Ashworth scale</strong></td>
<td>Abnormal muscle tone</td>
<td></td>
<td>Scored on a scale 1 (no abnormal tone) to 5 (rigid in flexion or extension)</td>
</tr>
<tr>
<td><strong>Fahn-Marsden Dystonia scale</strong></td>
<td>Dystonia &amp; disability resulting from dystonia</td>
<td></td>
<td>Scored on a scale of 0-20 for a series of movement and functional tasks</td>
</tr>
<tr>
<td><strong>Columbian Rating Scale</strong></td>
<td>Parkinsons-severity of symptoms in categories of tremor, rigidity, bradykinesia, gait disturbance, posture, postural stability, rising from chair, finger dexterity, succession movements, foot tapping, facial expression, seborrhea, sialorrhea, facial expression</td>
<td></td>
<td>Scored on a 0-4 point defined scale for each variable. Total score sum to grade severity of symptoms. May use sub test scores as well (e.g. to measure tremor severity over time)</td>
</tr>
<tr>
<td><strong>Motor Assessment Scale</strong></td>
<td>Degree of motor impairment following stroke or neurological event. Examines muscle tone and the ability to move in synergistic patterns &amp; finally out of that pattern into normal movement patterns over time. Includes sub tests for motor/mobility tasks and UE movement/function</td>
<td></td>
<td>Score 0-54 on defined scale. Higher score indicates higher functioning on the affected side.</td>
</tr>
<tr>
<td><strong>Braden risk assessment</strong></td>
<td>Risk of developing pressure ulcer based on rating for observations of sensory perception, presence of moisture, activity level, mobility, nutrition, friction/shear,</td>
<td>Braden scale tool</td>
<td>Patients with a total score of 16 or less are considered to be at risk of developing pressure ulcers. 15 or 16 = low risk; 13 or 14 = moderate risk; 12 or less = high risk</td>
</tr>
</tbody>
</table>

HTS pressure ulcer prevention checklist and assessment tool recommended. Monofilament available for sensory testing—see pressure ulcer section of falls manual.
## HTS recommended clinical tests and scales 2011-2012

Please note that this listing is only a guide and not a complete list of tests/scales that are appropriate for use. Score sheets for tests, further instructions and other treatment tools are available to HTS employees on the website under clinical resources at [www.htstherapy.com](http://www.htstherapy.com). You may contact HTS for the above testing items if they are not currently available in your department.

<table>
<thead>
<tr>
<th>Test</th>
<th>Measures</th>
<th>Supplies</th>
<th>Scoring</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Lightouse-Functional Vision Questionnaire</strong></td>
<td>Visual deficits impact on function based on self report/interview</td>
<td>Questionnaire</td>
<td>15 point questionnaire with scoring scale &gt;9 score = requires vision referral</td>
</tr>
<tr>
<td><strong>Visual Functioning Questionnaire</strong></td>
<td>Visual health and impact of visual deficits on daily activities. Interview format.</td>
<td>Questionnaire</td>
<td>25 question objective interview tool with responses valuable to identify task difficulty and plan accommodations</td>
</tr>
<tr>
<td><strong>MVPT (Motor free visual perceptual test)</strong></td>
<td>Visual perception with subtests for visual discrimination, visual matching, visual memory, gestalt perception</td>
<td>MVPT manual (stopwatch-optional)</td>
<td>See manual for detailed scoring guidelines. For clinical use, may score each subtests and determine % accuracy to measure severity of deficit &amp; improvement over time.</td>
</tr>
<tr>
<td><strong>Snellen Eye chart</strong></td>
<td>Visual acuity</td>
<td>Eye chart Floor marked at 20 ft Eye cover (cup)</td>
<td>Distance standing Last row read legibly Example: at 20 ft, you can read the letters on the row marked “40”, this means you have visual acuity of 20/40 or better: 1/2 normal. From 10 feet, if the smallest letters you could read were on the “40” line, this would give you an acuity of 10/40: 1/4 normal. (referral for &lt; 20/40 or disparity &gt; 1 line on eye chart</td>
</tr>
<tr>
<td><strong>Amsler Grid</strong></td>
<td>Central visual field. Useful to detect early changes in vision in macular diseases and also for monitoring changes over time</td>
<td>Amsler grid</td>
<td>Positive report of lines appearing crooked, wavy, misshapen, discolored etc. is positive test. Referral necessary if this is new.</td>
</tr>
</tbody>
</table>

HTS vision assessment tool recommended for comprehensive review & guidance for complete vision evaluation.
Physical Therapy Components

1. Cardiovascular/pulmonary
   a. Heart rate
   b. Respiratory rate
   c. Edema
   d. Blood pressure

2. Integumentary
   a. Pliability
   b. Presence of scar tissue
   c. Skin color
   d. Skin integrity

3. Musculoskeletal
   a. Strength
   b. Range of Motion
   c. Joint Alignment
   d. Joint stability
   e. Weight bearing
   f. Weight shift
   g. Spatial Awareness
   h. Posture
   i. Endurance

4. Neuromotor
   a. Reflexes
   b. Tone
   c. Motor planning
   d. Motor control
      1. Coordination
      2. Kinesthesia
   e. Somatosensory
      1. Pain
   f. Balance
      1. Vestibular system
      2. Visual system
      3. Proprioceptive system

Gait Components:
- Base of support
- Cadence/velocity
- Balance
- Step length
- Step height
- Step width
- Step angle
- Step symmetry
- Arm/heel strike synchrony
- Heel strike
- Toe off
- Posture
- Safety awareness
- Foot swing

Gait Phases
1. Stance – heel strike, mid stance, toe off
2. Swing – acceleration, deceleration
3. Double Support
4. Gait Cycle – time between heel strike of same leg
Occupational Therapy Performance Components

A. Sensorimotor Component
1. Sensory
   a. Sensory Awareness
   b. Sensory Processing
      1. Tactile
      2. Proprioceptive
      3. Vestibular
      4. Visual
      5. Auditory
      6. Gustatory
      7. Olfactory
   c. Perceptual Processing
      1. Stereognosis
      2. Kinesthesia
      3. Pain Response
      4. Body Scheme
      5. Right-Left Discrimination
      6. Form Constancy
      7. Position in Space
      8. Visual-Closure
      9. Figure Ground
      10. Depth Perception
      11. Spatial Relations
      12. Topographical Orientation
2. Neuromusculoskeletal
   a. Reflex
   b. Range of Motion
   c. Muscle Tone
   d. Strength
   e. Endurance
   f. Postural Control
   g. Postural Alignment
   h. Soft Tissue Integrity
3. Motor
   a. Gross Coordination
   b. Crossing the Midline
   c. Laterality
   d. Bilateral Integration
   e. Motor Control
   f. Praxis
   g. Fine Coordination/Dexterity
   h. Visual-Motor Integration
   i. Oral-Motor Control

B. Cognitive Integration and Cognitive Components
1. Level of Arousal
2. Orientation
3. Recognition
4. Attention Span
5. Initiation of Activity
6. Termination of Activity
7. Memory
8. Sequencing
9. Categorization
10. Concept Formation
11. Spatial Operations
12. Problem Solving

C. Psychosocial Skills and Psychological Components
1. Psychological
   a. Values
   b. Interests
   c. Self-Concept
2. Social
   a. Role Performance
   b. Social Conduct
   c. Interpersonal Skills
   d. Self-Expression
3. Self-Management
   a. Coping Skills
   b. Time Management
   c. Self-Control
**Speech Therapy Components**

A. Auditory Comprehension
   1. Word discrimination/perception
   2. Response to phrases (Y/N, Wh-, personal ?’s, commands)
   3. Response to sentences
   4. Comprehension of paragraph length materials
   5. Response to conversation

B. Speech Reading
   1. Visual discrimination: sounds, words, phrases, sentences
   2. Auditory discrimination: sounds, words, phrases, sentences
   3. Auditory closure

C. Cognitive Communication
   1. Attention: sustained, selective, divided, alternating
   2. Orientation: person, spatial, temporal, situation
   3. Memory: restrospective, incidental, prospective
   4. Sequencing: simple to complex
   5. Problem solving: math, money, time, verbal/visual
   6. Reasoning: deductive, inductive
   7. Judgment/safety awareness
   8. Executive function: initiation, organization, integration
   9. Error awareness
   10. Self-correction of errors

D. Pragmatics
   1. Initiation
   2. Turn-taking
   3. Topic maintenance
   4. Interpretation of tone of voice, facial expression, gestures
   5. Appropriateness

E. Reading Comprehension
   1. Visual tracking
   2. Matching forms, letters
   3. Word-object-picture matching
   4. Word/phrase comprehension
   5. Sentence/paragraph comprehension
   6. Multiple paragraph comprehension
   7. Functional reading (schedule, phone book, directions, etc.)

F. Graphic Expression
   1. Mechanics, imitation, copying
   2. Drawing
   3. Recall of written symbols
      a. Serial writing
      b. Dictation: letters, words, sentences
   4. Phrases/sentence formulation
   5. Paragraph formulation
   6. Functional correspondence (personal, business)

G. Oral and Non-oral Expression
   1. Imitation (sounds, words, phrases)
   2. Automatic/serial output
   3. Single word production
   4. Phrase production
   5. Sentence production
   6. Conversational production

H. Articulation/Speech/Voice
   1. Oral motor strength, ROM, coordination
   2. Vocal quality (normal, nasal, breathy, harsh, hoarse)
   3. Rate, prosody, rhythm
   4. Pitch
   5. Volume
   6. Intelligibility: word, phrase, sentence, conversation
   7. Breath support: respiration/phonation coordination
   8. Initiation of speech

I. Swallowing
   1. Oral muscular strength, ROM, and coordination
   2. Sensation: lips/oral cavity
   3. Sensation: oral pharynx
   4. Bolus Manipulation
      a. Bolus formation
      b. A-P propulsion of bolus
      c. Tolerates varied textures
      d. Tolerates hot/cold temperatures
   5. Swallow response: reflexive, volitional
   6. Appropriate posture
   7. Airway protection
Choosing the best words and phrases to accurately document progress:

<table>
<thead>
<tr>
<th>Say and Use:</th>
<th>Don’t Say or Use:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specifics: what pt can/can’t do</td>
<td>Generalized weakness</td>
</tr>
<tr>
<td>Acute</td>
<td>Chronic</td>
</tr>
<tr>
<td>Beginning to respond</td>
<td>Stabilized</td>
</tr>
<tr>
<td>Objective measure of balance</td>
<td>Good, fair, poor</td>
</tr>
<tr>
<td>Assessed</td>
<td>Monitored</td>
</tr>
<tr>
<td>Continues to require</td>
<td>Slight improvement</td>
</tr>
<tr>
<td>Continues to progress</td>
<td>Has progressed</td>
</tr>
<tr>
<td>Analyzing</td>
<td>Looking at</td>
</tr>
<tr>
<td>Skilled teaching</td>
<td>Practice</td>
</tr>
<tr>
<td>Compensatory skills</td>
<td>Unable to learn</td>
</tr>
<tr>
<td>Adapted procedures</td>
<td>Reinstruct</td>
</tr>
<tr>
<td>Significant improvement</td>
<td>Little Improvement made</td>
</tr>
<tr>
<td>Objective measure</td>
<td>Little, much, slight, scant</td>
</tr>
<tr>
<td>Skilled activities</td>
<td>Played cards, bounced ball</td>
</tr>
<tr>
<td>Specific technique/strategy</td>
<td>Thera ex, act, neuro</td>
</tr>
<tr>
<td>Pressure redistribution</td>
<td>Pressure reduction</td>
</tr>
<tr>
<td>Activity Tolerance</td>
<td>Endurance</td>
</tr>
<tr>
<td>Techniques to motivate</td>
<td>Not motivated</td>
</tr>
<tr>
<td>Focus on the positive/how you’re going to modify your approach</td>
<td>Not Progressing/improving</td>
</tr>
</tbody>
</table>