All About NOMS: A Guide to Understanding and Applying Quality Data to Improve Patient Care

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Course Statement:

- Are you maximizing your use of NOMS? Are you unsure what to do with the data?
- This course will target how to identify the value of speech-language pathology services by incorporating NOMS data.
- We will analyze and interpret the predictive patterns of the NOMS outcomes, distinguish how we measure our care, and discuss how to apply the data for quality improvement with our patients.
Objectives:

- At the conclusion of this course, you will be able to:
  1.) Describe the benefits of the National Outcomes Measurement System (NOMS).
  2.) Identify how to use NOMS, interpret data, and recognize measurable change from admission to discharge.
  3.) Integrate NOMS outcomes data into daily documentation by reporting changes in FCM levels, analyzing and documenting practice patterns to ensure you maintain the highest level of care for your patients.

Introductions

- A bit about me
- A bit about you
  - Live Polling Warm-up!
    - How long have you been a speech therapist
    - What excites you about being a SLP
    - What company do you work for?
Thoughts about NOMS

- SLP Thoughts:
  - What do you like about NOMS
  - What do you find frustrating
  - What FCMs do you find you are choosing most frequently
  - Do your patients typically meet the projected FCM levels

NOMS

ASHA’s National Outcomes Measurement System
National Outcomes Measure (NOMS)

- History:
  - In 1993, ASHA formed a task force on Treatment Outcomes and Cost Effectiveness
  - The Task Force reviewed multiple existing data collections systems but decided they needed a system comprehensive and sensitive enough to meet the needs of ASHA
  - The Task Force worked for 2 years on the development of the national database system
  - In 1998 NOMS was launched
  - In 2013 a new and enhanced NOMS

What is NOMS?

- A voluntary data collection system created to illustrate the value of speech-language pathology services in healthcare or school settings
- NOMS uses ASHA’s Functional Communication Measures (FCMs).
  - a series of 15 disorders
  - a seven point rating scale
  - describes the change in an individual’s functional communication and/or swallowing ability
- SLPs submit clinical data to ASHA’s national registry in exchange for access to their data benchmarked by treatment setting and diagnosis and compared to the national data
- Who should receive NOMS training
Why Get Involved with NOMS?

- Provides data to support the effectiveness of skilled SLP services
- Outcomes data is an essential component of advocating for the services SLP provide
- Outcomes data is used to improve the quality of services and establish preferred practice patterns
- Opportunity to benchmark organizational performance with national outcomes
- Identify change & trends
- Provides answers to clinical questions

Path to Implementing NOMS

- NOMS participation begins at an organizational level
- An organization must meet and maintain requirements and participate in an agreement, in order to exchange data
  - Eligibility Criteria
- NOMS data collection begins when patient care and documentation begins
NOMS FAQs & Live Polling...

1. Which of the following are patients who should be included in NOMS data collection?
   a) Patients seen for evaluation only
   b) Patients with an established plan of care targeting at least one FCM
   c) Adults with developmental disabilities
   d) All of the above

- patients who are 16 years of age or older
- patients receiving skilled ST services at any level of care (e.g., acute, inpatient, SNF)
- patients receiving a minimum of two treatment sessions in an individual, group, or training/consultation format
2. What patients SHOULD NOT be included in NOMS data collection?
   a) Patients seen for evaluation only
   b) Patients over 65 years old
   c) Adults with developmental disabilities
   d) Both a & b

3. When should NOMS be completed?
   a) Evaluations
   b) Progress reports
   c) Discharges
   d) All of the above
Live Polling

4. How many Functional Communication Measures (FCMs) should the SLP score for a given patient?
   a) No more than three is recommended
   b) All that correspond to elements of the plan of care
   c) Start with one and add one on each progress report
   d) One from each category of intervention

Live Polling

5. When entering results within Optima Therapy documents, the SLP only needs to complete the red items in the ASHA’s NOMS Intake section pictured below.
   a) True
   b) False
NOMS FAQs...what sections do I complete on Evaluations?

- All sections of ASHA NOMs must be completed within Optima Therapy documents
  
  ✓ Sections must be fully completed in order to send the NOMS data to ASHA.

On the evaluation, complete the sections “ASHA NOMs - Intake” and then click on “next section” to complete the ASHA NOMs - FCM level.

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NOMS FAQs...Evaluations

When completing the FCM level on the evaluation, you will need to choose the current level and a projected level. See below:
NOMS FAQs...what sections do I complete on Progress Reports?

- Complete All Sections!

For a Progress Report – be certain to click “yes” if you need to add another FCM scale (e.g. perhaps you add a new goal for auditory comprehension). Otherwise, click on the current value for this Progress Report, as well as “no” if there are no FCMs being added. See below:

NOMS FAQ...what sections do I complete at Discharge?

- Complete All Sections!

For the Discharge complete the “ASHA’s NOMS- FCMs”. Click “next section” to complete the “ASHA NOMS- D/C Status”. See both examples below:
NOMS FAQs...

- Live Polling

6. NOMS should be completed for all appropriate patients regardless of payer source.
   a) True
   b) False

NOMS FAQs...

- Live Polling

7. FCMs replace my other standardized assessments?
   a) True
   b) False
8. Which of the following is the definition that matches the NOMS treatment setting option, **Home Health**?
   a) Service in a patient’s home, billed under Medicare part A or similar
   b) Community dwelling and Independent or assisted living patients who leave their home for services; billed under Medicare part B or similar
   c) Traditional SNF patients, primarily Part A or related payers, admitted for skilled care for a short-term stay
   d) Long Term Care patients that live in the facility and are not planning to discharge; typically billed under Part B, related payer, or Medicaid

9. Which of the following is the definition that matches the NOMS treatment setting option, **Subacute**?
   a) Service in a patient’s home, billed under Medicare part A or similar
   b) Community dwelling and Independent or assisted living patients who leave their home for services; billed under Medicare part B or similar
   c) Traditional SNF patients, primarily Part A or related payers, admitted for skilled care for a short-term stay
   d) Long Term Care patients that live in the facility and are not planning to discharge; typically billed under Part B, related payer, or Medicaid
10. Which of the following is the definition that matches the NOMS treatment setting option, **Skilled Nursing**?

a) Service in a patient’s home, billed under Medicare part A or similar

b) Community dwelling and independent or assisted living patients who leave their home for services; billed under Medicare part B or similar

c) Traditional SNF patients, primarily Part A or related payers, admitted for skilled care for a short-term stay

d) Long Term Care patients that live in the facility and are not planning to discharge; typically billed under Part B, related payer, or Medicaid
NOMS FAQs...treatment settings

What treatment setting should I be listing for my patients?

- **Home Health** - service in a patient’s home, billed under Medicare part A or similar
- **Outpatient Rehab** - community dwelling and Independent or assisted living patients who leave their home for services; billed under Medicare part B or similar
- **Subacute** - traditional SNF patients, primarily Part A or related payers, admitted for skilled care for a short-term stay
- **Skilled Nursing** - Long Term Care patients that live in the facility and are not planning to discharge; typically billed under Part B, related payer, or Medicaid (Remember to not include adults with developmental disabilities)

NOMS FAQ...

- Live Polling

11. Should FCMs correlate with G-codes?
   
a) True
   
b) False

<table>
<thead>
<tr>
<th>FCM Level</th>
<th>Corresponding G code level</th>
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<tbody>
<tr>
<td>Level 1</td>
<td>CN - 100 percent impaired, limited or restricted</td>
</tr>
<tr>
<td>Level 2</td>
<td>CM - At least 80 percent but less than 100 percent impaired, limited or restricted</td>
</tr>
<tr>
<td>Level 3</td>
<td>CL - At least 60 percent but less than 80 percent impaired, limited or restricted</td>
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<tr>
<td>Level 4</td>
<td>CK - At least 40 percent but less than 60 percent impaired, limited or restricted</td>
</tr>
<tr>
<td>Level 5</td>
<td>CJ - At least 20 percent but less than 40 percent impaired, limited or restricted</td>
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<tr>
<td>Level 6</td>
<td>CI - At least 1 percent but less than 20 percent impaired, limited or restricted</td>
</tr>
<tr>
<td>Level 7</td>
<td>CH - 0 percent impaired, limited or restricted</td>
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</table>
12. Which of the following is an indicator for a patient being discharged from NOMS?

a) On the last day of treatment, when the patient has met all goals and further treatment is not recommended.

b) If treatment goals have not been met and the patient discharged to another level of care.

c) If treatment goals have not been met and the patient’s progress has plateaued.

d) All of the above.

- Change in medical condition (or death of a patient).
- Insurance benefits exhausted or declined.
- Patient requested or noncompliance.
The following are the fifteen FCMs used with the Adult Healthcare component of NOMS:

- Alaryngeal Communication, Attention,
  - Augmentative-Alternative Communication,
  - Fluency, Memory, Motor Speech, Pragmatics,
  - Problem Solving, Reading, Spoken Language Comprehension, Spoken Language Expression,
  - Swallowing, Voice, Voice following
  - Tracheostomy, Writing
FCM Scoring Guidelines

- Administration of assessments is not needed to score the FCMs
- FCM(s) are chosen based on the goals targeted in the patient’s current plan of care
- Deciding on the FCM level - consider what the patient is able to do functionally as well as the amount and intensity of cueing required
- Review the descriptions of all seven levels before scoring the FCMs
- Read the Note section that accompanies each FCM as a few of the FCMs are not applicable to certain patient populations
  - All FCM levels has Notes except for the following: Pragmatics, Reading, Spoken Language Comprehension

Selecting & Scoring FCMs

<table>
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<tr>
<th>Frequency of Cueing</th>
<th>Required</th>
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<td>Consistent</td>
<td>80 - 100% of the time</td>
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<tr>
<td>Usually</td>
<td>50 - 79% of the time</td>
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<tr>
<td>Occasionally</td>
<td>20 - 49% of the time</td>
</tr>
<tr>
<td>Rarely</td>
<td>less than 20% of the time</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Intensity of Cueing</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximal</td>
<td>Multiple cues that are obvious to nonclinicians. Any combination of auditory, visual, pictorial, tactile, or written cues.</td>
</tr>
<tr>
<td>Moderate</td>
<td>Combination of cueing types, some of which may be intrusive.</td>
</tr>
<tr>
<td>Minimal</td>
<td>Subtle and only one type of cueing.</td>
</tr>
</tbody>
</table>
FCM Scoring

- A Level 5 on one scale likely is not comparable to a Level 5 on a different scale
- Below are some examples of treatment tasks

<table>
<thead>
<tr>
<th>Simple routine living activities</th>
<th>Complex living activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic self-care activities that most adults carry out every living activities day: following simple directions, eating a meal, and completing personal hygiene, dressing, etc.</td>
<td>Changing a flat tire; reading a book; planning and preparing a meal; and managing one’s own medical, financial, and personal affairs, etc.</td>
</tr>
</tbody>
</table>

Level 5: Attention versus Memory

- **Attention**

  **LEVEL 5:** The individual maintains attention within simple living activities with occasional minimal cues within distracting environments. The individual requires increased cueing to start, continue, and change attention during complex activities.

- **Memory**

  **LEVEL 5:** The individual consistently requires minimal cues to recall or use external memory aids for complex and novel information. The individual consistently requires minimal cues to plan and follow through on complex future events (e.g., menu planning and meal preparation, planning a party, etc.).
FCM Scoring Guidelines

- **Level 1**: the patient’s communication or swallowing abilities are nonfunctional. The patient is generally unable to respond to a task regardless of the amount of structure or cueing that is provided
  - Spoken Language Comprehension

  **LEVEL 1**: The individual is alert, but unable to follow simple directions or respond to yes/no questions, even with cues.

- **Level 2, 3, & 4**: the burden of care is placed on the communication partner to make the patient functional. As the patient improves they assume more responsibility; however there may be an increased need for structure and cueing as complexity increases
  - Spoken Language Comprehension-

  **LEVEL 2**: With consistent, maximal cues, the individual is able to follow simple directions, respond to simple yes/no questions in context, and respond to simple words or phrases related to personal needs.

  **LEVEL 3**: The individual usually responds accurately to simple yes/no questions. The individual is able to follow simple directions out of context, although moderate cueing is consistently needed. Accurate comprehension of more complex directions/messages is infrequent.

  **LEVEL 4**: The individual consistently responds accurately to simple yes/no questions and occasionally follows simple directions without cues. Moderate contextual support is usually needed to understand complex sentences/messages. The individual is able to understand limited conversations about routine daily activities with familiar communication partners.
FCM Scoring Guidelines

- **Level 5**: the transition to functionality, the patient assumes more responsibility for the communications and initiates some compensatory strategies
  - **Spoken Language Comprehension** - 

  **LEVEL 5**: The individual is able to understand communication in structured conversations with both familiar and unfamiliar communication partners. The individual occasionally requires minimal cueing to understand more complex sentences/messages. The individual occasionally initiates the use of compensatory strategies when encountering difficulty.

- **Level 6**: the patient may be fairly independent, but still dependent on the communication partner to provide some external cueing, structure, or direction

- **Level 7**: the patient is fully independent and may use some compensatory strategies; no longer relies on any external cues from the communication partner
  - **Spoken Language Comprehension** - 

  **LEVEL 6**: The individual is able to understand communication in most activities, but some limitations in comprehension are still apparent in vocational, avocational, and social activities. The individual rarely requires minimal cueing to understand complex sentences. The individual usually uses compensatory strategies when encountering difficulty.

  **LEVEL 7**: The individual’s ability to independently participate in vocational, avocational, and social activities is not limited by spoken language comprehension. When difficulty with comprehension occurs, the individual consistently uses a compensatory strategy.
FCM: Alaryngeal Communication

- **Note:**
  - ✓ “This FCM should be used for individuals who have had a total or near-total laryngectomy. Scoring on this FCM does not include ability to independently clean and manage prosthetic equipment. Application of this FCM assumes appropriate sizing and placement of prosthesis.”
  - ✓ “Communication can be achieved with one or more of the following alaryngeal communication methods: tracheoesophageal puncture (TEP), the use of an artificial larynx (AL) or esophageal speech production (ES). Primary type of alaryngeal communication must be indicated on Admission Form.”

FCM: Attention

- **Note:**
  - ✓ “The following are some examples of living activities as used with this FCM

  - **Simple living activities** following simple directions, reading environmental signs, eating a meal, completing personal hygiene, and dressing
  - **Complex living activities** watching a news program, reading a book, planning and preparing a meal, and managing one’s own medical, financial, and personal affairs.”
FCM: Augmentative-Alternative Communication

- **Note:**
  - “This FCM should be used when supplementing or replacing an individual’s natural speech with one or more aided or unaided augmentative-alternative communication (AAC) systems. Examples of augmentative-alternative communication include use of gestures, eye blink system, alphabet board, communication book, electronic device, etc.”
  - “Scoring on this FCM does not include ability to independently set up and manage AAC system.”
  - The following are examples of communication exchanges as used with this FCM:
    - Automatic: conveying basic and/or automatic information such as greetings, indicating pain, or bathroom
    - Simple: conveying personal wants/needs such as hunger, thirst, sleep, or personal-biographical information
    - Complex: conveying medical, financial, and/or vocational information

FCM: Fluency

- **Note:**
  - “This FCM should not be used for individuals who exhibit difficulty with rate and prosody as a result of a neurological impairment, cluttering, foreign dialect, or developmental disability.”
FCM: Memory

- **Note:**
  - The following should be used to guide this FCM:
    - **External Memory Aid** - calendars, schedules, communication/memory books, pictures, color coding.
    - **Memory Strategies** - silent rehearsals, word associations, chunking, mnemonic strategies

FCM: Motor Speech

- **Note:**
  - “Individuals who exhibit deficits in speech production may exhibit underlying deficits in respiration, phonation, articulation, prosody, and resonance. In some instances it may be beneficial to utilize additional FCMs focusing on voice if disordered phonation is a large component.”
FCM: Problem Solving

**Note:**

- “Individuals should be scored on this FCM based on their problem-solving ability during the completion of functional activities. Problem solving involves the ability to identify the problem, generate appropriate solutions, and evaluate the outcome in a reasonable/timely manner.”

- “Individuals must demonstrate sufficient attention and memory skills to be scored on this FCM (functioning at a minimum of Level 3 on the Attention and Memory FCMs).”

- Supervision is defined as follows:
  - **1:1 supervision**— for safety reasons, the individual requires monitoring at all times
  - **Close supervision**— individual requires someone standing by or within arm’s reach during problem-solving task
  - **Distant supervision**— individual requires someone checking in during problem-solving tasks.

FCM: Problem Solving Task Examples

- Examples of Problem-Solving tasks used with this FCM:
  - **Rote Problem-Solving Task**: picking up dropped item when knocked over, turning on/off television or light, and answering telephone
  - **Simple Problem-Solving Tasks**: following schedule, requesting assistance, using call bell, identifying basic wants/needs, cold meal preparation, and completing personal hygiene/dressing
  - **Complex Problem-Solving Tasks**: working on a computer; managing personal, medical, and financial affairs; preparing complex meal; grocery shopping; and route finding/map reading
**FCM: Spoken Language Expression**

- **Note:**
  - ✓ “This FCM should not be used for individuals using an augmentative/alternative communication system.”

**FCM: Swallowing**

- **Note:**
  - ✓ “In Levels 3–5, some patients may meet only one of the “and/or” criteria listed. If you have difficulty deciding on the most appropriate level for an individual, use dietary level as the most important criterion if the dietary level is the result of swallow function rather than dentition only. Dietary levels at FCM Levels 6 and 7 should be judged only on swallow function, and any influence of poor dentition should be disregarded.”
**FCM: Swallowing- Diet Levels**

- **Swallowing: Dietary Levels/Restrictions**
  - **Maximum restrictions:** Diet is two or more levels below a regular diet status in solid and liquid consistency.
  - **Moderate restrictions:** Diet is two or more levels below a regular diet status in either solid or liquid consistency (but not both), OR diet is one level below in both solid and liquid consistency.
  - **Minimum restrictions:** Diet is one level below a regular diet status in solid or liquid consistency.

**FCM: Swallowing- Solids**

- **Solids**
  - **Regular:** No restrictions (Level 4 or regular diet).
  - **Reduced one level:** Meats are cooked until soft, with no tough or stringy foods. Might include meats like meat loaf, baked fish, and soft chicken. Vegetables are cooked soft (Level 3 or mechanical soft).
  - **Reduced two levels:** Meats are chopped or ground. Vegetables are of one consistency (e.g., soufflé, baked potato) or are mashed with a fork (Level 2 or dysphagia mechanical soft).
  - **Reduced three levels:** Meats and vegetables are pureed (Level 1 or puree).
FCM: Swallowing - Liquids

- Liquids
  - Regular: Thin liquids; no restrictions
  - Reduced one level: Nectar, syrup; mildly thick
  - Reduced two levels: Honey; moderately thick
  - Reduced three levels: Pudding; extra thick

FCM: Voice

- Note:
  - “This FCM should not be used for individuals who have had a laryngectomy or tracheotomy or for individuals with resonance disorders.”
FCM: Voice Following Tracheostomy

- **Note:**
  - “This FCM should be used for individuals who have undergone tracheostomy tube placement as a result of a temporary or stable medical condition and are considered candidates for oral communication. Application of this FCM assumes appropriate sizing and placement of tracheostomy tube and includes individuals on mechanical ventilation.”
  - “Voicing can be achieved using digital occlusion of the tracheostomy tube, placement of a speaking valve, tracheostomy tube cap, or via a talking tracheostomy tube. Scoring on this FCM does not include ability to independently set up and manage equipment.”

FCM: Writing

- **Note:**
  - “This FCM should not be used for individuals using an augmentative-alternative communication system. References made here to the writing of words assume that the words are spelled correctly.”
FCM Thoughts

- Choosing FCM projected levels
  - Is the projected level realistic and reachable
    - What is the discharge plan
  - Is our judgement accurate based on our evaluation
  - If between two levels, maybe we choose the lower level
Interpreting FCMs in Documentation

**FCMs - Evaluation:**

**Assessment Summary**

- **Impressions:** Clinical Impressions: Pt. presents with moderate-severe cognitive impairment characterized by decreased problem solving secondary to reduced thought organization and alternating attention. Pt. also presents with severe memory impairment with delayed recall of new information, and reports this has declined since hospitalization. Pt. presents with minimal verbal expression impairment with instances of anoma and disfluencies. Pt. is moderately aware of impairments, but self-correction is limited at this point.

- **Skilled Justification:** Reason for Skilled Services: Pt. will benefit from skilled ST services to improve alternating attention, problem solving, thought organization, memory, and conversational verbal expression to improve pt. functional performance with complex ADLs and IADLs, and to improve quality of life.

- **Risk Factors:** Risk Factors: High Fall risk, MoCA 10/36, B knees pain when waking, impaired memory.

**ASHA's National Outcomes Measurement System (NOMS)**

- **Functional Communication Measures:**
  - Attention = 5/7, Projected Goal = 6/7
  - Memory = 4/7, Projected Goal = 5/7
  - Problem Solving = 4/7
  - Projected Goal = 5/7
FCMs - Evaluation:

**Assessment Summary**

**Impressions**
Clinical Impressions: Patient presents with symbolic dysfunctions following his recent CVA. Per assessment and patient report, problem solving deficits impact patient’s ability to perform routine tasks (i.e., dressing) independently. Patient also states concern for management of medications and ST plans to further assess medication management in further treatment. Patient reduced problem solving and cognitive deficits may impact his ability to return home to live independently. ST plans to address functional problem solving as well as executive functions and alternating attention to increase patient functional performance in tasks. ST plans to continue to assess patient safety awareness in environment and panning for tasks at home.

**Skilled Justification**
Reason for Skilled Services: Patient requires skilled SLP service for cognition to enhance cognitive skills, improve attention/concentration, increase verbal problem solving, improve executive functioning skills and improve visuospatial skills in order to enhance patient’s quality of life by improving ability to increase participation w/ADLs w/decreased (A), follow directions for activities and ADLs, decrease risk for falls and return to prior level of living.

**Risk Factors**
Risk Factors: Decreased ability to return to prior living environment, Decreased ability to return to prior level of assistance and Falls.

**ASHA’s National Outcomes Measurement System (NOMS)**

<table>
<thead>
<tr>
<th>Functional Communication Measures</th>
<th>Problem Solving = 3/7</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Projected Goal = 6/7</td>
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</tbody>
</table>

FCMs - Progress Report:

**Justification for Skilled Services**

**Rehab Potential**
Potential for Achieving Goals: Patient demonstrates good rehab potential as evidenced by Ability to follow 2-step directions, Supportive caregivers/staff, Strong family support and Active participation w/POT.

**Continued Skill**
Reasons for Continuing Treatment: Patient is able to read so plan to continue to use spaced retrieval treatment to recall referring to visual aids for information such as use of call button or orientation information. Patient has decreased memory and safety awareness which makes her a significant fall risk. Patient also continues to demonstrate inconsistent throat clearing or cough with thin liquids and plan to monitor safe tolerance.

**ASHA’s National Outcomes Measurement System (NOMS)**

<table>
<thead>
<tr>
<th>Functional Communication Measures</th>
<th>Memory = 2/7, Projected Goal = 4/7</th>
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<tbody>
<tr>
<td></td>
<td>Problem Solving = 2/7</td>
</tr>
<tr>
<td></td>
<td>Projected Goal = 4/7</td>
</tr>
<tr>
<td></td>
<td>Spoken Language Comprehension = 2/7, Projected Goal = 5/7</td>
</tr>
<tr>
<td></td>
<td>Spoken Language Expression = 4/7, Projected Goal = 6/7</td>
</tr>
<tr>
<td></td>
<td>Swallowing = 6/7, Projected Goal = 7/7</td>
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</tbody>
</table>
FCMs- Discharge:

Documentation Example: Problem Solving/Memory
Documentation Example: Dysphagia

**Patient Response**
Progress & Response to Tx: Patient has met LT/ST goals and Patient has reached PLOF as a result of skilled interventions. Pt was initially on a puree diet and HTL and has been upgraded slowly to a regular diet and thin liquids. The MASA was readministered and the pt improved from a 186 to a 196 from initial evaluation. This indicates improved swallow safety and function. Pt also improved on the ASHA DOM's for swallowing from a 4/7 to a 7/7, indicating pt's diet has been safely upgraded to regular and pt is independent with strategies.

Documentation Example: Spoken Language Comprehension

**Patient Response**
Progress & Response to Tx: Pt demonstrates progress with goals re verbal expression with carry over into functional conversation/communication, use of alternative means of communication including written and with AAC device, and functionally using ipod as communication device. Pt continues to demonstrate deficits re verbal and written expression and reading and auditory comprehension, impacting safety with communicating medical needs, safety concerns with use of w.c. and walking in apartment, participating in social activities, and needing increased (A) for all tasks of ADLs. Pt demonstrates functional progress dt skilled interventions and education facilitated by SLP as measured by ASHA FCMS (Functional Communication Measures), a national outcome measurement system that is a 7 pt rating scale describing a change in pts functional skills over time. Pt demonstrates progress in the category of spoken lang comp, with increased score from 3/7 to 4/7, with long term goal to function at level 5. This progress indicated increased functional performance level of initiation of communication with spoken lang in simple structured communication in ADLs with mod cuing.
Infinity’s Path to NOMS

- Infinity’s Initiative to systematically measure outcomes
  - Standard Outcomes PT, OT, ST
  - Infinity SLP Working Group identified NOMS
  - Initiated PT, OT, ST Outcomes
    - ST outcomes delayed due to waiting on collaboration between the EMR & ASHA
  - Determined duration required for training
    - Based on PT/OT experience ~ 2 months
    - Created “NOMS Training Information for Clinicians”
Infinity’s Path to NOMS

- Communication plan created to identify employees to complete training
  - Required employees - Full-time/Part-time employees
  - SLPs with previous NOMS training from past employers
    - Do not need to complete NOMS training again
  - NOMS training completed within the onboarding process
    - Includes all SLPs - full-time/part-time, PRN, Travelers
- NOMS Training
  - Summer to Fall Focus
    - How to get the training completed
    - Communicating/Implementing processes created for training
    - Communication with ASHA
    - Measuring success with training
- Set a training deadline
  - Drawing for an Apple TV
- SLPs & NOMS Adherence
  - Created tools to support NOMS training
    - NOMS FAQs
    - NOMS Adults in Healthcare Pocket Guide
    - Quick Reference Guide
    - Resource to find NOMS support tools
- ARD/DOR education
  - Report to measure adherence
Training

Adherence

Outcomes

NOMS Data Submitted?

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<th>Date</th>
<th>Description</th>
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<td>Export could not be sent due to incomplete NOMS data on one or more of the patient's Speech Therapy documents. Unable to find at least one Evaluation document with completed ASHA NOMS intake data for therapy track 'ST 1/16/2017 - 2/12/2017'. The following errors occurred for each EVAL document: Evaluation 1/16/2017 - 2/12/2017 error: intake data not complete or document Evaluation 1/16/2017 - 2/12/2017 missing 'ASHA NOMS_SettingPreviousCurrentAdmission'.</td>
</tr>
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<tr>
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<tr>
<td>03/01/2017</td>
<td>Receipt Acknowledged</td>
</tr>
<tr>
<td>03/02/2017</td>
<td>Receipt Acknowledged</td>
</tr>
</tbody>
</table>
NOMS Adherence: Infinity Rehab

- Incomplete NOMS Submissions:
  1.) Missing intake information
      - Not all sections of the NOMS data were completed on evaluation, even those items not indicated in red
  2.) No evaluation data completed
      - This includes intake data, as well as, identifying and marking FCM levels specific to patient’s deficits
  3.) No discharge data completed
      - NOMS was initiated and completed on evaluation and progress report; however, FCMs were not completed, discharge status was not completed, or both were “non-completed” or incomplete on the discharge document

Adherence: Infinity Rehab

- February 2017: 40.2%
- December 2016: 36.82%
NOMS: Infinity Rehab

- Sample Size for Swallowing
  - August 2016: N=158 (National N=4,161)
  - February 2017: N=398 (National 4,075)
- Sample Size for Memory
  - August 2016: N=138 (National=2,505)
  - February 2017: N=357 (National=2,596)
- Sample Size for Problem Solving
  - August 2016: N=110 (National=2,026)
  - February 2017: N=284 (National=2,119)
- Sample Size for Attention
  - August 2016: N=74 (National=838)
  - February 2017: N=141 (National=886)
- Sample Size for Spoken Language Expression
  - August 2016: N=29 (National=1,075)
  - February 2017: N=83 (National=963)

NOMS Data Reports

[Image of NOMS Data Reports]
NOMS Report Criteria

**SELECT REPORT CRITERIA**

- Select Component: ADULTS (Healthcare)
- Select Facility/Setting: ALL
- Select Time Period: 02/01/2017 - 02/28/2017
- Select Treatment Setting(s): 4 selected
- Select Motor/Dysphagia: ALL

**GENERATE REPORT**

---

Adult NOMS Data Report

**FUNCTIONAL COMMUNICATION MEASURES (FCMs)**

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Swallowing FCM</th>
<th>Memory FCM</th>
<th>Problem Solving FCM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local FCM</td>
<td>» Level 1: 36%</td>
<td>» Level 1: 37%</td>
<td>» Level 1: 32%</td>
</tr>
<tr>
<td>National (N=252)</td>
<td>29%</td>
<td>35%</td>
<td>30%</td>
</tr>
</tbody>
</table>

Statistics computed on sample sizes less than 15 are not considered meaningful.
### Adult NOMS Data Report

#### Patient and Treatment Characteristics

- **Age Category**: 65 or above: 54.7%
- **Gender**: Female: 56.4%
- **Race/Ethnicity**: White: 56.6%
- **Medical Diagnoses**: Other: 60.3%
- **Time Post Onset/Exacerbation**: 0 to < 3 months: 57.4%
- **SLP Diagnoses**: Cognitive - Communication Disorder: 64.0%
- **Funding**: Medicare - Part A: 54.4%
- **% of Patients who Received Previous SLP Services**: 40.2%
- **% of Patients with Treatment Goals Met**: 36.3%
- **Other Reasons for Discharge**: Patient discharged to another level of care: 40.6%
- **% of Patients with Further SLP Services Recommended**: 32.6%
- **Discharge Disposition**: Skilled Nursing: 32.6%

#### Discharge Disposition

- **Average Number of Sessions per Week**: Less than one: 62.0%
- **Length of Typical SLP Treatment Session**: 31 to 45 minutes: 56.0%
- **Average Number of SLP Treatment Sessions**: 12.5
- **Average Number of SLP Evaluation Sessions**: 1.0
- **Average Length of Stay (in days)**: 19.3
- **% of Patients with English as Primary Language**: 97.8%

---

### Adult NOMS Data Report continued

#### Average Number of Sessions per Week

<table>
<thead>
<tr>
<th>Comparison</th>
<th>Infinity Rehab</th>
<th>National</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than one</td>
<td>13</td>
<td>.5</td>
</tr>
<tr>
<td>One</td>
<td>22</td>
<td>.9</td>
</tr>
<tr>
<td>Two</td>
<td>102</td>
<td>4.1</td>
</tr>
<tr>
<td>Three</td>
<td>222</td>
<td>9.9</td>
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<td>Four</td>
<td>336</td>
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</tr>
<tr>
<td>Five</td>
<td>368</td>
<td>16.0</td>
</tr>
<tr>
<td>More than Five</td>
<td>1403</td>
<td>56.2</td>
</tr>
<tr>
<td>Total</td>
<td>2495</td>
<td>100.0</td>
</tr>
</tbody>
</table>
NOMS Data - What does it tell us?

Looking at Infinity’s NOMS Outcomes Data:

- Break out Groups
  - Looking at February 2017
  - What did we find:
    1.) Compare Infinity Data to National Data
    2.) What levels do we see progress
    3.) Compare Service Delivery Models
    4.) Compare number of treatment sessions
Outcomes Data & the Future

Future Directions
- Movement toward patient centered care
  - PROS (Patient-Reported Outcomes)
  - PROS supplement and enrich our current clinical assessment capability
  - PROs allow a more valid measurement of important outcomes

Goal: “Discovering what works for what patients under what conditions, what circumstances, to achieve what outcomes and at what cost.”

Final Thoughts/Questions: NOMS
References


PLEASE PRINT or SAVE this document in order to have access to the seven-point rating scales while taking the test and also while scoring your patients.

Adults in Health Care

Functional Communication Measures (FCMs)

Speech-Language Pathology
NOMS Functional Communication Measures

The Functional Communication Measures (FCMs) are a series of seven-point rating scales, ranging from least functional (Level 1) to most functional (Level 7). They have been developed by ASHA to describe the different aspects of a patient’s functional communication and swallowing abilities over the course of speech-language pathology intervention.

- The following are the fifteen FCMs used with the Adult Healthcare component of NOMS:
  - Alaryngeal Communication
  - Attention
  - Augmentative-Alternative Communication
  - Fluency
  - Memory
  - Motor Speech
  - Pragmatics
  - Problem Solving
  - Reading
  - Spoken Language Comprehension
  - Spoken Language Expression
  - Swallowing
  - Voice
  - Voice following Tracheostomy
  - Writing

These FCMs were designed to describe functional abilities over time from admission to discharge at a given level of care. They are not dependent upon administration of any particular formal or informal assessment measures, but are clinical observations provided by the speech-language pathologist of the patient’s communication and/or swallowing abilities addressed by an individualized treatment plan.

FCMs should only be scored if they specifically relate to the patient’s individualized treatment plan and goals. It is not anticipated that all of the FCMs will be scored for any one patient. On average, only a few FCMs per patient will be selected. FCMs can be modified throughout the course of intervention as a treatment plan changes by indicating any adjustments on the optional Update Form. Clinicians should always be blinded to previous FCM score(s).
Description of the Seven-Level FCM Scoring

Each level of the FCMs contains references to the intensity and frequency of the cueing method and use of compensatory strategies that are required to assist the patient in becoming functional and independent in various situations and activities. Both the amount and intensity of the cueing must be considered in scoring an FCM. Familiarize yourself with the following descriptors and refer to them when scoring the FCM scales.

Frequency of Cueing

- **Consistent**: Required 80 - 100% of the time.
- **Usually**: Required 50 - 79% of the time.
- **Occasionally**: Required 20 – 49% of the time.
- **Rarely**: Required less than 20% of the time.

Intensity of Cueing

- **Maximal**: Multiple cues that are obvious to nonclinicians. Any combination of auditory, visual, pictorial, tactile, or written cues.
- **Moderate**: Combination of cueing types, some of which may be intrusive.
- **Minimal**: Subtle and only one type of cueing.

You will notice that the intensity and frequency of the cueing may be modified from one FCM level to another as the complexity of the information/task or situation increases. Outlined below are some examples of general types of activities in which the patient may engage throughout the course of recovery. These are provided merely for illustration and are not intended as must-do activities for rating a patient at a particular FCM level.

- **Simple routine living activities**: Basic self-care activities that most adults carry out every living activities day: following simple directions; eating a meal; and completing personal hygiene, dressing, etc.
- **Complex living activities**: Changing a flat tire; reading a book; planning and preparing a meal; and managing one’s own medical, financial, and personal affairs, etc.

We tried as much as possible to ensure consistency among similar levels of performance on the various FCM scales; however, this was not always possible given the nature of the different aspects of communication and swallowing abilities. For example, do not assume that a Level 5 on one scale is comparable to a Level 5 on a different scale.
General Guidelines for FCM levels

The following can be used as general guidelines about the FCM levels:

- At level 1, the patient’s communication or swallowing abilities are nonfunctional, and the patient is generally unable to respond to a task regardless of the amount of structure or cueing that is provided. If, because of the patient’s condition, you are unable to elicit any response for a targeted behavior, do not score the FCM. For example, if a patient is nonverbal, and although you suspect that speech may be dysarthric, you are unable to evaluate or confirm this. Do not score the Motor Speech FCM until you actually initiate treatment in that area.

- At the lower levels, the burden of care is placed on the communication partner to make the patient functional. With improvement, the patient begins to assume more responsibility for the communications and begins to initiate some compensatory strategies. However, there may be an increased need for external structure or cueing as the complexity increases.

- Level 5 is typically the transition to functionality. There is a shift at this level as the patient begins to assume more responsibility for the communications and begins to initiate some compensatory strategies. Although the patient may continue to require cueing at the higher FCM levels, there is a decreasing dependency on the clinician and others to make the patient functional.

- At a Level 6, the patient may be fairly independent, but still depends on the communication partner to provide some external cueing, structure, or direction.

- At a Level 7, the patient is fully independent in all aspects of vocational, avocational, and social activities. Although the patient may self-initiate and independently use some compensatory strategies, he/she no longer relies on any external cues from the communication partner. Scoring at a Level 7 assumes independent functioning, but does not necessarily imply that the individual has returned to a premorbid level of “normal” functioning in a particular clinical area.
- The following can be used as general guidelines for scoring the FCM levels:

  - Select the FCM(s) based on the goals targeted in the patient’s current treatment plan of care.

  - When determining an FCM level, consider what the patient is able to do functionally as well as the amount and intensity of cueing needed.

  - Carefully review the descriptions of all seven levels before beginning to score the FCMs. Do not assume, for example, that a Level 3 on one scale is equivalent to a Level 3 on a different scale.

  - Carefully review the Note section that accompanies each FCM as a few of the FCMs are not applicable to certain patient populations. Exceptions are outlined in the Note Section that appears at the top of select FCMs. For example, the Voice FCM should not be used for patients who have a tracheostomy or laryngectomy, or for patients with resonance disorder, and the Swallowing FCM should not be used for patients with swallowing difficulties as a result of poor dentition. Please carefully review these as well as other exceptions prior to selecting an FCM scale.

  - Administration of specific formal or informal tests and assessments is not necessary to score the FCMs.

  - Score the admission FCMs upon completion of the evaluation and prior to the initiation of treatment.

  - Score the discharge FCMs when the goal(s) are discontinued in the current treatment setting.

  - Clinicians should not refer to the admission FCM score(s) when determining update FCM score(s) and/or discharge FCM score(s). Clinician should be blinded to previous FCM score(s).

  - Do not use rating guidelines from other outcome measurement systems to score the FCMs.
Alaryngeal Communication

Note: This FCM should be used for individuals who have had a total or near-total laryngectomy. Scoring on this FCM does not include ability to independently clean and manage prosthetic equipment. Application of this FCM assumes appropriate sizing and placement of prosthesis.

Communication can be achieved with one or more of the following alaryngeal communication methods: tracheoesophageal puncture (TEP), the use of an artificial larynx (AL) or esophageal speech production (ES). Primary type of alaryngeal communication must be indicated on Admission Form.

LEVEL 1: The individual is unable to vocalize as a result of total or near-total laryngectomy. Alternate means of communication (e.g., writing, gestures, mouthing, electronic device, etc.) are used all of the time. Individual cannot participate in vocational, avocational, and social activities requiring oral communication.

LEVEL 2: With consistent, maximal cueing, the individual can produce short consonant-vowel combinations and/or simple words in known contexts. However, intelligibility/accuracy may vary. Participation in vocational, avocational, and social activities requiring oral communication is significantly limited with alternate means of communication needed all of the time.

LEVEL 3: The individual usually requires moderate cueing to produce simple words and short phrases with familiar communication partners, although accuracy/intelligibility may vary. Participation in vocational, avocational, and social activities requiring oral communication is limited most of the time, and alternate means of communication may be needed.

LEVEL 4: The individual occasionally requires minimal cueing to produce sentences/messages during structured conversations with familiar communication partners and usually requires moderate cueing to produce sentences/messages with unfamiliar partners, although accuracy/intelligibility may vary. Spontaneous conversation is not consistent and the individual rarely produces complex sentences/messages that are understood by others. Participation in vocational, avocational, and social activities requiring oral communication is limited some of the time, and alternate means of communication may be needed.

LEVEL 5: The individual is successfully able to communicate using alaryngeal communication in simple structured conversations with both familiar and unfamiliar communication partners. The individual occasionally requires minimal cueing during spontaneous conversation to intelligibly produce more complex sentences/messages with unfamiliar partners. The individual occasionally self-monitors communication effectiveness and uses compensatory strategies when encountering difficulty.

LEVEL 6: The individual is successfully able to communicate using alaryngeal communication, but some limitations are still apparent in vocational, avocational, and social activities. The individual rarely requires minimal cueing during spontaneous conversation to intelligibly produce complex sentences/messages with unfamiliar communication partners and usually self-monitors communication effectiveness and uses compensatory strategies when encountering difficulty.

LEVEL 7: The individual’s ability to successfully and independently participate in vocational, avocational, and social activities is not limited by alaryngeal communication. The individual independently self-monitors communication effectiveness and uses compensatory strategies when encountering difficulty.
Attention

**Note:** The following are some examples of living activities as used with this FCM:

**Simple living activities** following simple directions, reading environmental signs, eating a meal, completing personal hygiene, and dressing.

**Complex living activities** watching a news program, reading a book, planning and preparing a meal, and managing one’s own medical, financial, and personal affairs.

**LEVEL 1:** Attention is nonfunctional. The individual is generally unresponsive to most stimuli.

**LEVEL 2:** The individual can briefly attend with consistent maximal stimulation, but not long enough to complete even simple living tasks.

**LEVEL 3:** The individual maintains attention over time to complete simple living tasks of short duration with consistent maximal cueing in the absence of distracting stimuli.

**LEVEL 4:** The individual maintains attention during simple living tasks of multiple steps and long duration within a minimally distracting environment with consistent minimal cueing.

**LEVEL 5:** The individual maintains attention within simple living activities with occasional minimal cues within distracting environments. The individual requires increased cueing to start, continue, and change attention during complex activities.

**LEVEL 6:** The individual maintains attention within complex activities and can attend simultaneously to multiple demands with rare minimal cues. The individual usually uses compensatory strategies when encountering difficulty. The individual has mild difficulty or takes more than a reasonable amount of time to attend to multiple tasks/stimuli.

**LEVEL 7:** The individual’s ability to participate in vocational, avocational, or social activities is not limited by attentional abilities. Independent functioning may occasionally include the use of compensatory strategies.
Augmentative-Alternative Communication

**Note:** This FCM should be used when supplementing or replacing an individual’s natural speech with one or more aided or unaided augmentative-alternative communication (AAC) systems. Examples of augmentative-alternative communication include use of gestures, eye blink system, alphabet board, communication book, electronic device, etc.

Scoring on this FCM does not include ability to independently set up and manage AAC system.

The following are examples of communication exchanges as used with this FCM:

- **Rote/automatic:** conveying basic and/or automatic information such as greetings, indicating pain, or need for elimination.

- **Simple:** conveying personal wants/needs such as hunger, thirst, sleep, or personal-biographical information.

- **Complex:** conveying medical, financial, and/or vocational information.

**LEVEL 1:** The individual attempts to communicate (e.g., gestures, pointing, communication board, electronic device, etc). However, communication using augmentative-alternative communication is not meaningful to familiar or unfamiliar listeners at any time regardless of amount of cueing or assistance.

**LEVEL 2:** The individual attempts to communicate rote/automatic messages (e.g., waving hello when greeted, responding to name). With consistent, maximal cueing and additional time, the individual can use augmentative-alternative communication to convey simple messages related to personal wants/needs with familiar communication partners. However, communication attempts are rarely accurate or meaningful, and the communication partner must assume responsibility for structuring all communication exchanges.

**LEVEL 3:** The individual usually requires moderate cueing and additional time to use augmentative-alternative communication to convey simple messages related to personal wants/needs with familiar communication partners, although accuracy may vary. The communication partner must assume responsibility for structuring most communication exchanges.

**LEVEL 4:** The individual occasionally requires minimal cueing and additional time to use augmentative-alternative communication to convey simple messages related to routine daily activities in structured conversations with familiar communication partners. He/she usually requires moderate cueing and additional time to convey simple messages to unfamiliar communication partners with varying accuracy.

(continued)
Augmentative-Alternative Communication FCM continued

**LEVEL 5:** The individual is successfully able to use augmentative-alternative communication in structured conversations with both familiar and unfamiliar communication partners. However, he/she may occasionally require minimal cueing and additional time in communication exchanges with unfamiliar communication partners. The individual occasionally requires moderate cueing and additional time to convey more complex thoughts/messages and occasionally self-monitors communication effectiveness when encountering difficulty.

**LEVEL 6:** The individual is successfully able to communicate using augmentative-alternative communication in most daily activities, but some limitations are still apparent in vocational, avocational, and social activities. The individual rarely requires minimal cueing and additional time to convey complex thoughts/messages and usually self-monitors communication effectiveness when encountering difficulty.

**LEVEL 7:** The individual’s ability to successfully and independently participate in vocational, avocational, and social activities is not limited by augmentative-alternative communication skills. The individual independently self-monitors communication effectiveness when encountering difficulty.
**Fluency**

*Note: This FCM should not be used for individuals who exhibit difficulty with rate and prosody as a result of a neurological impairment, cluttering, foreign dialect, or developmental disability.*

**LEVEL 1:** Fluency is so disrupted that speech is often not functional for communication. Attempts at speech communication are extremely labored in all situations, which renders the speaker virtually unintelligible. Alternative means of speaking are used most of the time. Listeners avoid spoken interaction with the individual.

**LEVEL 2:** Speech is functional most of the time, but labored in many day-to-day situations due to extended disruptions of speech flow, which sometimes render the individual difficult to understand. Participation in vocational, avocational, and social activities requiring speech is reduced overall. Listener discomfort is evident throughout conversational interactions.

**LEVEL 3:** Speech is functional. Dysfluencies are evident in all situations, but are particularly frequent in problem situations. Vocational, avocational, and social participation requiring speech is occasionally reduced overall and significantly reduced within what the individual perceives as problem situations. Some listener discomfort is evident throughout interactions.

**LEVEL 4:** Speech is functional for communication, but there is extreme situational variation. The frequency and severity of disruptions of speech flow within problem situations is distracting most but not all of the time. Vocational, avocational, and social participation requiring speech is limited most of the time in problem situations. Listeners are often aware of fluency difficulty.

**LEVEL 5:** Speech is functional for communication, and fluency can be maintained in some situations. Self-monitoring is inconsistent. The frequency and severity of disruptions of speech flow within problem situations is distracting some of the time. Speech difficulties are noticeable when they occur and sometimes limit vocational, avocational, and social activities requiring speech in problem situations. Listeners are occasionally aware of fluency difficulties relative to particular situations.

**LEVEL 6:** Speech is functional for communication, and fluency can be maintained most of the time. Self-monitoring is consistent. Vocational, avocational, and social activities requiring speech are not restricted most of the time. Listeners are infrequently aware of fluency difficulties even in problem situations.

**LEVEL 7:** Disruptions in speech flow do not call attention to the speaker, and participation in activities requiring speech is not limited. May include self-monitoring as needed.
**Memory**

*Note: The following terms are used with this FCM:*

- **External Memory Aid**: calendars, schedules, communication/memory books, pictures, color coding.

- **Memory Strategies**: silent rehearsals, word associations, chunking, mnemonic strategies.

**LEVEL 1**: The individual is unable to recall any information, regardless of cueing.

**LEVEL 2**: The individual consistently requires maximal verbal cues or uses external aids to recall personal information (e.g., family members, biographical information, physical location, etc.) in structured environments.

**LEVEL 3**: The individual usually requires maximal cues to recall or use external aids for simple routine and personal information (e.g., schedule, names of familiar staff, location of therapy areas, etc.) in structured environments.

**LEVEL 4**: The individual occasionally requires minimal cues to recall or use external memory aids for simple routine and personal information in structured environments. The individual requires consistent maximal cues to recall or use memory aids for complex and novel information (e.g., carry out multiple steps activities, accommodate schedule changes, anticipate meal times, etc.), plan and follow through on simple future events (e.g., use calendar to keep appointments, use log books to complete a single assignment/task, etc.) in structured environments.

**LEVEL 5**: The individual consistently requires minimal cues to recall or use external memory aids for complex and novel information. The individual consistently requires minimal cues to plan and follow through on complex future events (e.g., menu planning and meal preparation, planning a party, etc.).

**LEVEL 6**: The individual is able to recall or use external aids/memory strategies for complex information and planning complex future events most of the time. When there is a breakdown in the use of recall/memory strategies/external memory aids, the individual occasionally requires minimal cues. These breakdowns may occasionally interfere with the individual’s functioning in vocational, avocational, and social activities.

**LEVEL 7**: The individual is successful and independent in recalling or using external aids/memory strategies for complex information and planning future events in all vocational, avocational, and social activities.
**Motor Speech**

**Note:** Individuals who exhibit deficits in speech production may exhibit underlying deficits in respiration, phonation, articulation, prosody, and resonance. In some instances it may be beneficial to utilize additional FCMs focusing on voice if disordered phonation is a large component.

**LEVEL 1:** The individual attempts to speak, but speech cannot be understood by familiar or unfamiliar listeners at any time.

**LEVEL 2:** The individual attempts to speak. The communication partner must assume responsibility for interpreting the message, and with consistent and maximal cues, the patient can produce short consonant-vowel combinations or automatic words that are rarely intelligible in context.

**LEVEL 3:** The communication partner must assume primary responsibility for interpreting the communication exchange; however, the individual is able to produce short consonant–vowel combinations or automatic words intelligibly. With consistent and moderate cueing, the individual can produce simple words and phrases intelligibly, although accuracy may vary.

**LEVEL 4:** In simple structured conversation with familiar communication partners, the individual can produce simple words and phrases intelligibly. The individual usually requires moderate cueing in order to produce simple sentences intelligibly, although accuracy may vary.

**LEVEL 5:** The individual is able to speak intelligibly using simple sentences in daily routine activities with both familiar and unfamiliar communication partners. The individual occasionally requires minimal cueing to produce more complex sentences/messages in routine activities, although accuracy may vary and the individual may occasionally use compensatory strategies.

**LEVEL 6:** The individual is successfully able to communicate intelligibly in most activities, but some limitations in intelligibility are still apparent in vocational, avocational, and social activities. The individual rarely requires minimal cueing to produce complex sentences/messages intelligibly. The individual usually uses compensatory strategies when encountering difficulty.

**LEVEL 7:** The individual’s ability to successfully and independently participate in vocational, avocational, or social activities is not limited by speech production. Independent functioning may occasionally include the use of compensatory techniques.
Pragmatics

LEVEL 1: Pragmatics are nonfunctional in all situations or settings regardless of feedback and cueing. The individual cannot initiate appropriate responses to the environment and is unaware of the needs and feedback of the communication partner.

LEVEL 2: On rare occasions, pragmatics are functional in familiar and structured settings with familiar people and maximal cueing.

LEVEL 3: Pragmatics are functional a majority of the time when the individual is given consistent and maximal cueing in highly structured settings or situations with familiar partners. The individual rarely uses common and simple social communication without cues.

LEVEL 4: Pragmatics are functional a majority of the time without cues in structured settings or situations with familiar communication partners. With unfamiliar partners or in unstructured settings, the individual needs maximal cues. The individual uses and adheres to common and simple rules of social communication but is unaware of subtle feedback from the environment.

LEVEL 5: Pragmatics are functional in unfamiliar settings and with unfamiliar partners with consistent minimal cueing. The individual inconsistently responds to subtle feedback from the environment.

LEVEL 6: Pragmatics are functional in most settings or situations with occasional minimal cues. The majority of the time, the individual is able to modify behaviors in response to subtle feedback from the environment.

LEVEL 7: The individual’s ability to successfully and independently participate in vocational, avocational, and social activities is not limited by pragmatics. The individual rarely experiences pragmatic difficulties, but when this occurs, is consistently and independently able to modify behaviors in response to feedback from the environment.
Problem Solving

Note: Individuals should be scored on this FCM based on their problem-solving ability during the completion of functional activities. Problem solving involves the ability to identify the problem, generate appropriate solutions, and evaluate the outcome in a reasonable/timely manner.

Individuals must demonstrate sufficient attention and memory skills to be scored on this FCM (functioning at a minimum of Level 3 on the Attention and Memory FCMs).

For the purposes of this scale, supervision is defined as follows: 1:1 supervision—for safety reasons, the individual requires monitoring at all times; close supervision—individual requires someone standing by or within arm’s reach during problem-solving task; and distant supervision—individual requires someone checking in during problem-solving tasks.

The following are examples of problem-solving tasks as used with this FCM:

**Rote Problem-Solving Tasks:** picking up dropped item when knocked over, turning on/off television or light, and answering telephone.

**Simple Problem-Solving Tasks:** following schedule, requesting assistance, using call bell, identifying basic wants/needs, cold meal preparation, and completing personal hygiene/dressing.

**Complex Problem-Solving Tasks:** working on a computer; managing personal, medical, and financial affairs; preparing complex meal; grocery shopping; and route finding/map reading.

**LEVEL 1:** Problem solving skills are nonfunctional in all situations or settings regardless of cueing or additional time given. The individual does not recognize a problem given any level of cueing. 1:1 supervision is required.

**LEVEL 2:** The individual is able to solve rote problems (i.e., picking up a cup, if knocked over) in immediate environment. With consistent, maximal cues/assistance and additional time, the individual is able to recognize problems, generate appropriate solutions, and/or carry out steps to complete simple problem-solving tasks in structured environments. However, problem-solving attempts are rarely accurate, and 1:1 supervision is required.

**LEVEL 3:** The individual usually requires moderate cues/assistance and additional time to recognize problems, generate appropriate solutions, and/or carry out steps to complete simple problem-solving tasks in structured environments, although accuracy may vary. Close supervision is required.

**LEVEL 4:** The individual occasionally requires minimal cues/assistance to complete simple problem-solving tasks in structured environments. Additional time may be needed to recognize problems, generate appropriate solutions, and carry out steps to solve problems. Distant supervision may be required to complete simple problem-solving tasks.

The individual demonstrates emerging problem-solving skills for complex problem-solving tasks. With consistent, maximal cues/assistance and additional time, he/she is able to identify salient features of complex problems, but rarely provides appropriate solutions. The individual rarely self-monitors effectiveness of performance and/or uses strategies when encountering difficulty. Close supervision may be required during complex problem-solving tasks.

(continued)
Problem Solving FCM continued

**LEVEL 5:** The individual demonstrates functional problem-solving skills in routine daily activities. He/she rarely requires minimal cueing/assistance or additional time to recognize problems, identify various solutions, and carry out steps to complete simple problem-solving tasks.

The individual usually requires moderate cues/assistance to identify salient features of complex problems and occasionally provides appropriate solutions. He/she usually needs additional time to complete complex problem-solving tasks and occasionally self-monitors effectiveness of performance and uses strategies when encountering difficulty. Distant supervision may be required to complete complex problem-solving tasks.

**LEVEL 6:** Problem-solving skills are functional in most settings, but some limitations in problem solving are still apparent in vocational, avocational, and social activities. The individual rarely requires minimal cueing/assistance or additional time to generate multiple solutions and carry out steps to complete complex problem-solving tasks. He/she usually self-monitors effectiveness of performance and uses strategies when encountering difficulty.

**LEVEL 7:** The individual’s ability to successfully and independently participate in vocational, avocational, or social activities is not limited by problem-solving skills. Independent functioning rarely requires more than a reasonable time to complete complex problem-solving tasks. The individual independently self-monitors effectiveness of performance and uses strategies when needed.
**Reading**

**LEVEL 1:** The individual attends to printed material, but doesn’t recognize even single letters or common words.

**LEVEL 2:** The individual reads single letters and common words with consistent maximal cueing.

**LEVEL 3:** The individual reads single letters and common words, and with consistent moderate cueing, can read some words that are less familiar, longer, and more complex.

**LEVEL 4:** The individual reads words and phrases related to routine daily activities and words that are less familiar, longer, and more complex. The individual usually requires moderate cueing to read sentences of approximately 5–7 words.

**LEVEL 5:** The individual reads sentence-level material containing some complex words. The individual occasionally requires minimal cueing to read more complex sentences and paragraph-level material. The individual occasionally uses compensatory strategies.

**LEVEL 6:** The individual is successfully able to read most material but some limitations in reading are still apparent in vocational, avocational, and social activities. The individual rarely requires minimal cueing to read complex material. Although reading is successful, it may take the individual longer to read the material. The individual usually uses compensatory strategies when encountering difficulty.

**LEVEL 7:** The individual’s ability to successfully and independently participate in vocational, avocational, and social activities is not limited by reading skills. Independent functioning may occasionally include use of compensatory strategies.
**Spoken Language Comprehension**

**LEVEL 1:** The individual is alert, but unable to follow simple directions or respond to yes/no questions, even with cues.

**LEVEL 2:** With consistent, maximal cues, the individual is able to follow simple directions, respond to simple yes/no questions in context, and respond to simple words or phrases related to personal needs.

**LEVEL 3:** The individual usually responds accurately to simple yes/no questions. The individual is able to follow simple directions out of context, although moderate cueing is consistently needed. Accurate comprehension of more complex directions/messages is infrequent.

**LEVEL 4:** The individual consistently responds accurately to simple yes/no questions and occasionally follows simple directions without cues. Moderate contextual support is usually needed to understand complex sentences/messages. The individual is able to understand limited conversations about routine daily activities with familiar communication partners.

**LEVEL 5:** The individual is able to understand communication in structured conversations with both familiar and unfamiliar communication partners. The individual occasionally requires minimal cueing to understand more complex sentences/messages. The individual occasionally initiates the use of compensatory strategies when encountering difficulty.

**LEVEL 6:** The individual is able to understand communication in most activities, but some limitations in comprehension are still apparent in vocational, avocational, and social activities. The individual rarely requires minimal cueing to understand complex sentences. The individual usually uses compensatory strategies when encountering difficulty.

**LEVEL 7:** The individual’s ability to independently participate in vocational, avocational, and social activities is not limited by spoken language comprehension. When difficulty with comprehension occurs, the individual consistently uses a compensatory strategy.
Spoken Language Expression

Note: This FCM should not be used for individuals using an augmentative/alternative communication system.

LEVEL 1: The individual attempts to speak, but verbalizations are not meaningful to familiar or unfamiliar communication partners at any time.

LEVEL 2: The individual attempts to speak, although few attempts are accurate or appropriate. The communication partner must assume responsibility for structuring the communication exchange, and with consistent and maximal cueing, the individual can only occasionally produce automatic and/or imitative words and phrases that are rarely meaningful in context.

LEVEL 3: The communication partner must assume responsibility for structuring the communication exchange, and with consistent and moderate cueing, the individual can produce words and phrases that are appropriate and meaningful in context.

LEVEL 4: The individual is successfully able to initiate communication using spoken language in simple, structured conversations in routine daily activities with familiar communication partners. The individual usually requires moderate cueing, but is able to demonstrate use of simple sentences (i.e., semantics, syntax, and morphology) and rarely uses complex sentences/messages.

LEVEL 5: The individual is successfully able to initiate communication using spoken language in structured conversations with both familiar and unfamiliar communication partners. The individual occasionally requires minimal cueing to frame more complex sentences in messages. The individual occasionally self-cues when encountering difficulty.

LEVEL 6: The individual is successfully able to communicate in most activities, but some limitations in spoken language are still apparent in vocational, avocational, and social activities. The individual rarely requires minimal cueing to frame complex sentences. The individual usually self-cues when encountering difficulty.

LEVEL 7: The individual’s ability to successfully and independently participate in vocational, avocational, and social activities is not limited by spoken language skills. Independent functioning may occasionally include use of self-cueing.
Swallowing

Note: In Levels 3–5, some patients may meet only one of the “and/or” criteria listed. If you have difficulty deciding on the most appropriate level for an individual, use dietary level as the most important criterion if the dietary level is the result of swallow function rather than dentition only. Dietary levels at FCM Levels 6 and 7 should be judged only on swallow function, and any influence of poor dentition should be disregarded.

LEVEL 1: Individual is not able to swallow anything safely by mouth. All nutrition and hydration are received through non-oral means (e.g., nasogastric tube, PEG).

LEVEL 2: Individual is not able to swallow safely by mouth for nutrition and hydration, but may take some consistency with consistent maximal cues in therapy only. Alternative method of feeding is required.

LEVEL 3: Alternative method of feeding is required as individual takes less than 50% of nutrition and hydration by mouth, and/or swallowing is safe with consistent use of moderate cues to use compensatory strategies and/or requires maximum diet restriction.

LEVEL 4: Swallowing is safe, but usually requires moderate cues to use compensatory strategies, and/or the individual has moderate diet restrictions and/or still requires tube feeding and/or oral supplements.

LEVEL 5: Swallowing is safe with minimal diet restriction and/or occasionally requires minimal cueing to use compensatory strategies. The individual may occasionally self-cue. All nutrition and hydration needs are met by mouth at mealtime.

LEVEL 6: Swallowing is safe, and the individual eats and drinks independently and may rarely require minimal cueing. The individual usually self-cues when difficulty occurs. May need to avoid specific food items (e.g., popcorn and nuts) or require additional time (due to dysphagia).

LEVEL 7: The individual’s ability to eat independently is not limited by swallow function. Swallowing would be safe and efficient for all consistencies. Compensatory strategies are effectively used when needed.

Diet levels/restrictions are defined on the next page. Your facility’s levels may not exactly match these, but please use these levels as a guide in scoring this FCM.

(continued)
Swallowing FCM continued

Swallowing: Dietary Levels/Restrictions

**Maximum restrictions:** Diet is two or more levels below a regular diet status in solid and liquid consistency.

**Moderate restrictions:** Diet is two or more levels below a regular diet status in either solid or liquid consistency (but not both), OR diet is one level below in both solid and liquid consistency.

**Minimum restrictions:** Diet is one level below a regular diet status in solid or liquid consistency.

**Solids**

**Regular:** No restrictions.

**Reduced one level:** Meats are cooked until soft, with no tough or stringy foods. Might include meats like meat loaf, baked fish, and soft chicken. Vegetables are cooked soft.

**Reduced two levels:** Meats are chopped or ground. Vegetables are of one consistency (e.g., soufflé, baked potato) or are mashed with a fork.

**Reduced three levels:** Meats and vegetables are pureed.

**Liquids**

**Regular:** Thin liquids; no restrictions.

**Reduced one level:** Nectar, syrup; mildly thick.

**Reduced two levels:** Honey; moderately thick.

**Reduced three levels:** Pudding; extra thick.
**Voice**

*Note: This FCM should not be used for individuals who have had a laryngectomy or tracheotomy or for individuals with resonance disorders.*

**LEVEL 1:** The individual is unable to use voice to communicate. Alternative means for communicating are used all of the time. The individual cannot participate in vocational, avocational, and social activities requiring voice.

**LEVEL 2:** Voice is not functional for communication most of the time. Alternative means for communicating must be used most of the time. The individual’s participation in vocational, avocational, and social activities is significantly limited all of the time.

**LEVEL 3:** Voice is functional for communication, but is consistently distracting and interferes with communication by drawing attention to itself. Participation in vocational, avocational, and social activities is limited most of the time.

**LEVEL 4:** Voice is functional for communication, but sometimes distracting. The individual’s ability to participate in vocational, avocational, and social activities requiring voice is occasionally affected in low-vocal demand activities, but consistently affected in high-vocal demand activities.

**LEVEL 5:** Voice occasionally sounds normal with self-monitoring, but there is some situational variation. The individual’s ability to participate in vocational, avocational, and social activities requiring voice is rarely affected in low-vocal demand activities, but is occasionally affected in high-vocal demand activities.

**LEVEL 6:** Voice sounds normal most of the time across all settings and situations. Self-monitoring is consistent when needed. The individual’s ability to participate in vocational, avocational, and social activities requiring voice is not affected in low-vocal demand activities, but is rarely affected in high-vocal demand activities.

**LEVEL 7:** The individual’s ability to successfully and independently participate in vocational, avocational, and social activities requiring high-or low-vocal demands is not limited by voice. Self-monitoring is effectively used, but only occasionally needed.
**Voice Following Tracheostomy**

*Note:* This FCM should be used for individuals who have undergone tracheostomy tube placement as a result of a temporary or stable medical condition and are considered candidates for oral communication. Application of this FCM assumes appropriate sizing and placement of tracheostomy tube and includes individuals on mechanical ventilation.

Voicing can be achieved using digital occlusion of the tracheostomy tube, placement of a speaking valve, tracheostomy tube cap, or via a talking tracheostomy tube. Scoring on this FCM does not include ability to independently set up and manage equipment.

**LEVEL 1:** The individual cannot produce voice as a result of tracheostomy. Alternate means for communication (e.g., writing, mouthing, gestures, alphabet board, electronic device, etc.) are used all of the time. The individual cannot participate in vocational, avocational, and social activities requiring oral communication.

**LEVEL 2:** With consistent, maximal cueing/assistance, the individual can produce short intervals of phonation/vocalization and/or consonant–vowel combinations. However, voice is not functional for communication with alternate means for communication required all of the time. Participation in vocational, avocational, and social activities requiring oral communication is significantly limited all of the time.

**LEVEL 3:** The individual usually requires moderate cueing/assistance to produce simple words and short phrases, although accuracy may vary. Participation in vocational, avocational, and social activities requiring oral communication is limited most of the time and alternate means of communication may be needed.

**LEVEL 4:** The individual occasionally requires minimal cueing/assistance to produce simple sentences/messages during structured conversations with familiar communication partners and usually requires moderate cueing/assistance to produce simple sentences/messages with unfamiliar partners, although accuracy may vary. Spontaneous conversation is not consistent, and the individual rarely produces complex sentences/messages that are understood by others. Participation in vocational, avocational, and social activities requiring oral communication is limited some of the time and alternate means of communication may be needed.

**LEVEL 5:** The individual is successfully able to communicate using voice via the tracheostomy tube during structured conversations with familiar and unfamiliar partners. The individual occasionally requires minimal cueing/assistance to intelligibly produce more complex sentences/messages with unfamiliar partners. He/she occasionally self-monitors communication effectiveness when encountering difficulty.

**LEVEL 6:** The individual is successfully able to communicate using voice via the tracheostomy tube in most situations, but some limitations are still apparent in vocational, avocational, and social activities. The individual rarely requires minimal cueing/assistance to intelligibly produce complex sentences/messages and usually self-monitors communication effectiveness when encountering difficulty.

**LEVEL 7:** The individual’s ability to successfully and independently participate in vocational, avocational, and social activities is not limited by the tracheotomy or use of the tracheostomy tube. The individual independently self-monitors communication effectiveness when encountering difficulties.
Writing

Note: This FCM should not be used for individuals using an augmentative-alternative communication system. References made here to the writing of words assume that the words are spelled correctly.

LEVEL 1: The individual attempts to write, but doesn’t produce recognizable single letters or common words.

LEVEL 2: The individual writes single letters and common words with consistent maximal cueing.

LEVEL 3: The individual writes single letters and common words, and with consistent moderate cueing, can write some words that are less familiar, longer, and more complex.

LEVEL 4: The individual writes words and phrases related to routine daily activities and words that are less familiar, longer, and more complex. The individual usually requires moderate cueing to write sentences of approximately 5–7 words.

LEVEL 5: The individual writes sentence-level material containing some complex words. The individual occasionally requires minimal cueing to write more complex sentences and paragraph-level material. The individual occasionally uses compensatory strategies.

LEVEL 6: The individual is successfully able to write most material, but some limitations in writing are still apparent in vocational, avocational, and social activities. The individual rarely requires minimal cueing to write complex material. The individual usually uses compensatory strategies when encountering difficulty.

LEVEL 7: The individual’s ability to successfully and independently participate in vocational, avocational, and social activities is not limited by writing skills. Independent functioning may occasionally include use of compensatory strategies.
Click “Refresh” at the bottom of the left menu to activate the next section
FCM Scoring: Is it Accurate?

FCMs- Evaluation:

Assessment Summary

**Impressions**
Clinical Impressions: Pt. presents with moderate-severe cognitive impairment characterized by decreased problem solving secondary to reduced thought organization and alternating attention. Pt. also presents with severe memory impairment with delayed recall of new information, and reports this has declined since hospitalization. Pt. presents with minimal verbal expression impairment with instances of anomia and disfluencies. Pt. is moderately aware of impairments, but self-correction is limited at this point.

**Skilled Justification**
Reason for Skilled Services: Pt. will benefit from skilled ST services to improve alternating attention, problem solving, thought organization, memory, and conversational verbal expression to improve pt. functional performance with complex ADLs and IADLs, and to improve quality of life.

**Risk Factors**
Risk Factors: High fall risk, MoCA 10/30, B knees pain when walking, impaired memory.

**ASHA’s National Outcomes Measurement System (NOMS)**

**Functional Communication Measures**
- Attention = 5/7, Projected Goal = 6/7
- Memory = 4/7, Projected Goal = 5/7
- Problem Solving = 4/7
- Projected Goal = 5/7

Page 1 of 3

FCMs- Evaluation:

Assessment Summary

**Impressions**
Clinical Impressions: Patient presents with symbolic dysfunctions following his recent CVA. Per assessment and patient report, problem solving deficits impact patient’s ability to perform routine tasks (i.e. dressing) independently. Patient also states concern for management of medications and ST plans to further assess medication management in further treatment. Patient reduced problem solving and cognitive deficits may impact his ability to return home to live independently. ST plans to address functional problem solving as well as executive functions and alternating attention to increase patient functional performance in tasks. ST plans to continue to assess patient safety awareness in environment and planning for tasks at home.

**Skilled Justification**
Reason for Skilled Services: Patient requires skilled SLP service for cognition to enhance cognitive skills, improve attention/concentration, increase verbal problem solving, improve executive functioning skills and improve visuospatial skills in order to enhance patient’s quality of life by improving ability to increase participation w/ADLs w/decreased (A), follow directions for activities and ADLs, decrease risk for falls and return to prior level of living.

**Risk Factors**
Risk Factors: Decreased ability to return to prior living environment, Decreased ability to return to prior level of assistance and Falls.

**ASHA’s National Outcomes Measurement System (NOMS)**

**Functional Communication Measures**
- Problem Solving = 3/7
- Projected Goal = 6/7
**FCMs - Progress Report:**

<table>
<thead>
<tr>
<th>Justification for Skilled Services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Rehab Potential</strong></td>
</tr>
<tr>
<td><strong>Continued Skill</strong></td>
</tr>
</tbody>
</table>

**ASHA's National Outcomes Measurement System (NOMS)**

*Functional Communication Measures*

<table>
<thead>
<tr>
<th>Measure</th>
<th>Performance</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Memory</td>
<td>2/7</td>
<td>4/7</td>
</tr>
<tr>
<td>Problem Solving</td>
<td>2/7</td>
<td>4/7</td>
</tr>
<tr>
<td>Spoken Language Comprehension</td>
<td>2/7</td>
<td>5/7</td>
</tr>
<tr>
<td>Spoken Language Expression</td>
<td>4/7</td>
<td>6/7</td>
</tr>
<tr>
<td>Swallowing</td>
<td>6/7</td>
<td>7/7</td>
</tr>
</tbody>
</table>

**FCMs - Discharge:**

**Summary Since Last Progress Report**

<table>
<thead>
<tr>
<th>Skill</th>
<th>Interventions Provided: Therapist provided skilled dysphagia therapy focusing assessing and improving swallowing safety and performance at all phases with mechanical soft and thin liquid textures. Therapist trained pt. and caregivers on safe swallow strategies, and provided mod-max cueing to train strategies and provide feedback on performance. Therapist reduced cueing to occasional-min to provide feedback on performance and to assist with self-feeding tasks. Pt and Caregiver Training: Pt. and caregiver trained for effective cueing to reduce bolus size, rate of intake, and to increase use of liquid wash to improve oral clearance. Pt. and caregivers educated re: risks and s/sx of aspiration/penetration, including increased risk presented by oral residue.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Response</td>
<td>Progress &amp; Response to Tx: Pt. demonstrates improved swallowing performance and safety including improved use of trained safe swallow strategies with reduced cueing. Pt. demonstrates increased oral prep and clearance with increased oral motor function. Pt. demonstrates increased independent use of rate and bolus reduction, as well as liquid wash strategy. Pt. continues to require occasional-min cueing/assistance with fine motor and self-feeding tasks.</td>
</tr>
</tbody>
</table>

**Discharge Status and Recommendations**

<table>
<thead>
<tr>
<th>Location</th>
<th>DC Location = Patient discharged to reside in this LTC facility.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prognosis</td>
<td>Prognosis to Maintain CLOF = Good with consistent staff follow-through</td>
</tr>
<tr>
<td>Functional Outcomes</td>
<td>Swallowing Abilities = Disant Supervision</td>
</tr>
<tr>
<td>Diet / Liquids</td>
<td>Diet Recs - Solids = mechanical soft Diet Recs - Liquids = Thin Liquids</td>
</tr>
<tr>
<td>Intake Protocol</td>
<td>Swallow Strategies/Positions: To facilitate safety and efficiency, it is recommended the patient use the following strategies and/or maneuvers during oral intake: alteration of liquid/solid, rate modification, bolus size modifications, effortful swallow and general swallowing techniques/precautions and upright posture during meals and upright posture for 30 mins after meals. Supervision for Oral Intake = Distant supervision</td>
</tr>
</tbody>
</table>

**ASHA's National Outcomes Measurement System (NOMS)**

*Functional Communication Measures* | Swallowing | 7/7 | Projected Goal | 7/7 |