

SPEECH THERAPY OUTCOME DRIVEN CARE PLAN

Client Name: _____

Functional Areas	Prior Level of Function (PLOF)	Current Level of Function (CLOF)	GOAL	CLOF (minus) Goal	Scoring Key
Feeding or Eating Current ability to feed self meals and snack foods safely. Note: This refers only to the process of eating, chewing and swallowing and not to the food to be eaten.				<i>Multiply</i> x3	0 = Able to independently feed self. 1 = Able feed self independently but requires meal set up, intermittent assistance or supervision OR a liquid, pureed or ground meat diet. 2 = Unable to feed self and must be assisted or supervised throughout the meal /snack. 3 = Able to take nutrients orally and receives supplemental nutrients through a nasogastric tube or gastrostomy 4 = Unable to take in nutrients orally and is fed nutrients through a nasogastric tube or gastrostomy 5 = Unable to in nutrients orally or by tube feeding
Management of Oral Medications: Patient's <u>current ability</u> to prepare and take <u>all</u> oral medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals. Excludes injectable and IV medications. (NOTE: This refers to ability, not compliance or willingness.)					0 = Able to independently take the correct oral medication and proper dosage at the correct times. 1 = Able to take medication(s) at the correct times if: (a) individual dosages are prepared in advance by another person; <u>OR</u> (b) another person develops a drug diary or chart. 2 = Able to take medication(s) at the correct times if given reminders by another person at the appropriate times 3 = <u>Unable</u> to take medication unless administered by another person. NA = No oral medications prescribed.
Dysphagia- Speech therapy treatment to improve patient safety with swallowing in their home.					Yes = 3 No =0
Language / Communication Disorders- Speech Therapy to increase effective communication related to patient safety					Yes = 3 No =0
Did patient receive post-acute (skilled nursing facility, inpatient rehabilitation facility, long term care hospital, or inpatient psychiatric facility) care in the 14 days prior to the HH admission					Yes = 1 No = 0
Risk for Hospitalization: Which of the following signs or symptoms characterize this patient as at risk for hospitalization? (Mark all that apply.) <i>INSTRUCTION: 1 POINT FOR EACH RISK IDENTIFIED</i>					<input type="checkbox"/> - Multiple hospitalizations (2 or more) in the past 6 months <input type="checkbox"/> - Diagnosis of Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, or Diabetes Mellitus <input type="checkbox"/> -Unintentional weight loss of a total of 10 pounds or more in the past 12 months <input type="checkbox"/> Decline in mental, emotional, or behavioral status in the past 3 months
					← Sum of column (ODCP Score)

Employee Signature: _____ Date: _____