## 01 Interventions/Goals



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### Purpose:

To guide therapists on what to document in the Interventions/Goals section of an Evaluation visit.

#### Question Intent:

The Interventions/Goals section is intended to document the skilled interventions, techniques, strategies, and exercises that were addressed and instructed to patient/caregiver during the Assessment visit.

Per Medicare Benefit Policy Manual Chapter 7 - Home Health Services, the Interventions/Goals section highlights the importance "that the home health records for every visit will reflect the need for skilled medical care provided."

Additionally, this guidance states, "the clinical notes are expected to tell the story of the patient's achievements towards his/her goals as outlined in the Plan of Care".

This is essential in Restorative Therapy documentation.

**NOTE** - see the Maintenance Therapy article to see how Interventions/Goals should be utilized for Maintenance Therapy patients.

#### Response-Specific Instructions:

1. At SOC (00) and Evaluation (01) visits, the therapist will click on Interventions/Goals to document their skilled interventions and establish progress related to the functional goals.

1.		
		Visit Actions
	Mileage/Drive Time*	
	Demographics	
	Vital Signs & Measures*	
	Physical Assessment*	
	Patient Goals*	
	Diagnoses*	
	Procedures	
	Pathways*	
	Interventions/Goals*	

- 2. Review the various categories in Interventions/Goals and proceed to document the skilled details and specific tasks that were addressed during that day's Evaluation session. In this example, "Disease Process" is selected.
  - 1.

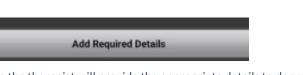
🗌 DISEASE PROCESS 🛛 🧲	
PSYCHOSOCIAL	
THERAPY TREATMENT	
	Complete Incomplete

3. To document that Interventions in this section were provided during the Evaluation, click on "Provided", which will turn the button green.



4. Then select "Add Required Details" to include specific details related to that category.

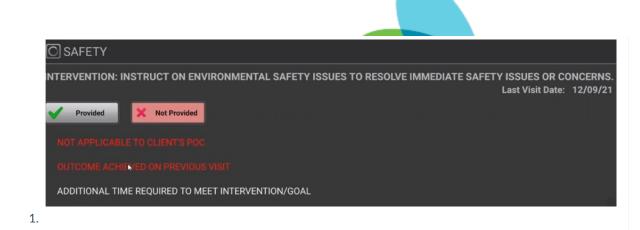
1		
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- 2. Here the therapist will provide the appropriate details to document skilled interventions performed or instructed during the assessment visit. Be sure to hit "Save" at the bottom tab so the documentation will not be lost.
- 5. Lastly, when an intervention is **Provided**, at assessment the therapist will ALWAYS choose the goal as **Met. This** follows a 'green - green' pattern to ensure that this intervention/goal falls off of the patient record and only future Interventions/Goals appear from 01 Pathways & New Order are documented to on future visits.

1.					
	INTERVENTION: INSTRUCT PATIENT / CAREGIVER ON NECESSARY PRECAUTIONS TO PREVENT FURTHER INJURY TO CURRENT STATUS.				
		Last Visit Date:			
	V Provided X Not Provided				
	DETAILS				
	INSTRUCTED IN SAFE FUNCTINOAL MOBILITY, ADHERING TO WBAT GUIDANCE.				
	GOAL: PATIENT / CAREGIVER VERBALIZE UNDERSTANDING OF THE INSTRUCTED PRECAUTIO THEIR SAFETY AND TO AVOID COMPROMISING THEIR REHABILITATION.	DNS IN ORDER TO MAXIMIZE			
	HAS THE GOAL BEEN MET?				

6. At the Evaluation Visit, if the task is "Not Provided" be sure to select an option in RED which will ensure a 'red - red' pattern is followed so that this intervention does not proceed forward, and only interventions from Pathways carry forward to future visits.



From article: 01 Interventions/Goals | Last Modified on 08/16/2024 11:24 am EDT

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