



Adults in Health Care

Speech-Language Pathology User's Guide



AMERICAN
SPEECH-LANGUAGE-
HEARING
ASSOCIATION



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Dear NOMS Participant:

ASHA's National Center for Evidence-Based Practice in Communication Disorders is pleased that you have decided to participate in the Adult component of ASHA's National Outcomes Measurement System (NOMS) for Speech-Language Pathology (SLP). This is your copy of the NOMS: Adult User's Guide. Please carefully review this self-study-training program, practice scoring the sample scenarios, and continue to use it as a reference when completing NOMS data collection.

In order to begin data collection, you must first complete the NOMS: SLP User Registration Test included at the end of this guide and submit it to ASHA. Please consult your facility's Subscriber to obtain your Facility ID number(s) to be used when submitting your completed test. We will then send you and your Subscriber a pass/fail notification letter. If you do not pass the test, we will include a different version of the test along with your notification letter. Before retaking the test, we encourage you to reread the guide, paying particular attention to the guidelines in the Functional Communication Measures (FCMs) section, which explain the differences between each level of the seven-point FCM scales.

Once you have become a Registered NOMS User, you should contact your facility's Subscriber to obtain any materials needed to begin data collection. To ensure the credibility of the data, we encourage you to be accurate and timely in your data collection.

Thank you for your participation and the very active role you have taken in helping to shape the future of the profession. If you have any questions about NOMS data collection, please contact Tobi Frymark at 301-296-8736 or TFrymark@asha.org.

Sincerely,

Robert C. Mullen, MPH
Director
National Center for Evidence-Based Practice in Communication Disorders

Guidelines for Scoring and Interpretation

Admission

Any patient who is 16 years of age or older with a treatment plan recommending speech and language intervention for a minimum of *two sessions* is eligible for participation in NOMS data collection. Patients must receive speech and language intervention using one of the two following treatment models:

- a. **Individual and/or group treatment model:** The speech-language pathologist provides direct treatment to the patient on a one-on-one basis and/or in a group treatment format (two or more patients). Includes patients receiving co-treatment provided by two disciplines, as well as patients who are receiving services simultaneously, but working on different activities.
- b. **Training and/or consultation model:** Speech and language intervention is provided to the patient, family, caregiver, or other related health professional to establish/modify a home program and/or to complete patient/caregiver training. The patient must be present for a minimum of two sessions. Periodic training and/or consultation sessions may be provided in conjunction with the individual and/or group treatment model.

The patient is admitted to NOMS data collection on the first day of the speech and language treatment or when the training/consultation is initiated. In other words, the admission date is the date the Functional Communication Measure(s) (FCMs) are scored and may not necessarily be the date of the speech-language pathology evaluation.

When possible, NOMS data collection should not be initiated until the patient is medically stable and able to participate in the treatment program.

- The following patients *should not* be included in NOMS data collection:
 - Patients seen for evaluation only.
 - Adults with developmental disabilities.
- In addition, a few FCMs are not applicable to certain patient populations as outlined in the *Note* Section that appears at the top of each of the FCMs. For example, the Fluency FCM should not be used for patients with underlying neurological involvement, the Voice FCM should not be used for patients who have had a tracheostomy or laryngectomy, or for patients with a resonance disorder, and the Swallowing FCM should not be used for patients with swallowing difficulties as a result of poor dentition. Please become familiar with these as well as other exceptions outlined in each *Note* Section prior to selecting an FCM scale.

Admission Form

1. Clinician ID

This is your eight-digit ASHA membership number. If you are currently in your clinical fellowship year and do not yet have an eight-digit ASHA number, please contact the National Center for Evidence-Based Practice in Communication Disorders (N-CEP), and a clinician ID number will be assigned to you.

2. Patient ID/Medicare ID

This is the number assigned by your facility to identify each patient. It can be up to 11 alphanumeric characters and must be used consistently on all forms for each patient. ASHA will have no way of identifying individual patients and confidentiality of the data will be maintained at all times.

In the future, we hope to collect data across the continuum of care in health care settings and across treatment programs. In order to be able to do this, the patient ID number must be identical across all treatment settings. You may want to consider this as you begin to assign your patient ID numbers.

3. Age at Admission

Provide the patient's age at the time of admission to speech and language services.

4. Admission Date

Indicate the date the FCM(s) were scored. This date should be the day that speech and language services are initiated using either the individual/group treatment or training/consultation models.

5. Medical Diagnosis/es

Indicate the ICD-9-CM Code that corresponds to the *one* primary and *any* secondary (if applicable) medical diagnosis associated with the patient's communication and/or swallowing disorder for which he/she is currently being treated. For Cerebrovascular Disease also indicate right, left, or bilateral CVA, or unknown.

Listed on the data collection form are medical diagnoses that correspond to the ICD-9-CM groupings most commonly treated in healthcare settings. This is not an exhaustive list and only includes those diagnoses that typically result in a communication or swallowing disorder. If the patient's medical diagnosis is not listed, you may write in the appropriate diagnosis and ICD-9 CM Code. If you have questions about a diagnosis or which category it belongs in, refer to your ICD-9-CM manual, which should be available at your facility. Do not include the ICD-9-CM Codes for the communication disorder itself (e.g., aphasia, dysphagia, apraxia, etc.)

Medical Diagnoses

Neoplasm Lip/Pharynx (140.00–149.99)	Malignant cancers of the lip, oral cavity, and pharynx
Other Neoplasm (150.00–160.99 and 162.00–239.99)	Malignant and benign tumors. In particular, ones relating to communication disorders include brain tumors, cancers of the head and neck, digestive track, esophagus, nasal cavities, middle ear, accessory sinuses, neoplasms of uncertain behavior. Do not include cancers of the mouth or larynx.
Neoplasm Larynx (161.00–161.99)	Malignant cancer of the larynx (laryngectomy).
Mental Disorders (290.00–319.00)	Senile and presenile organic psychotic conditions, schizophrenia, amnesia, Korsakoff's syndrome (alcoholic or nonalcoholic induced), chronic psychotic conditions, mental retardation.
Anoxia (348.10)	Anoxia.
Encephalopathy (348.30)	Encephalopathy, unspecified.
CNS Diseases: Diseases of the Nervous System and Sense Organs (320.00–348.00 and 348.40–359.90)	Alzheimer's disease, Pick's disease, Parkinson's disease, Huntington's choreas, myoclonus, Friedreich's ataxia, cerebellar ataxias, multiple sclerosis, cerebral cysts, cerebral edema, myasthenia gravis, amyotrophic lateral sclerosis, pseudobulbar palsy, muscular dystrophies. Do not include anoxia or encephalopathy.
Cerebrovascular Disease (430.00–432.99 and 436.00–438.99)	Subarachnoid hemorrhage, intercerebral hemorrhage, CVA, Stroke, ill-defined cerebrovascular disease, non-ruptured cerebrovascular aneurysm, late effects of cerebrovascular disease involving speech and language deficits, dysphagia, apraxia.
Occlusion/TIA (433.00–435.90)	Cerebral thrombosis, cerebral embolism, unspecified cerebral artery occlusion, TIA.
Respiratory Diseases (460.00–519.99)	Bilateral or unilateral paralysis of the vocal cords or larynx, polyps, nodules, edema of the larynx, acute laryngitis and tracheitis.
Hemorrhage/Injury (852.00–852.99)	Subarachnoid, subdural, and extradural hemorrhage following injury from external causes.
Head Injury (854.00–854.99)	Intracranial injury of unspecified brain or head injury.

6. Onset of Primary Medical Diagnosis

Indicate the date of onset (mm/yyyy) for the primary medical diagnosis associated with the patient's communication and/or swallowing disorder for which he/she is currently being treated, or, select unknown.

7. Gender

Indicate the patient's gender.

8. Race/Ethnicity

Select the group/race of the patient. If unknown, consult documentation that clearly identifies the patient's personal selection, or indicate as "Unknown."

9. SLP Diagnosis/es

Select the communication and/or swallowing disorder(s) for which the patient is currently being treated. If the patient's SLP diagnosis isn't listed, you may write in the appropriate diagnosis.

10. Current Treatment Setting

Indicate the level of care in which the patient will actually receive speech and language treatment. For example, if you are in private practice and contract with a local hospital for outpatient services, you should code the treatment setting as "Outpatient Rehab." If the patient's current treatment setting is not listed, you may write in the appropriate setting.

The following are descriptors of treatment settings to be used for the purposes of NOMS:

Acute Hospital	Inpatient care provided in an acute care medical facility.
Inpatient Rehab	Free standing rehabilitation hospitals and rehabilitation units in acute care hospitals that are designed to support intensive, interdisciplinary rehabilitation of disabling conditions.
Subacute	Subacute care is comprehensive, inpatient care designed for someone who has an acute illness, injury, or exacerbation of a chronic disease process. The care is provided immediately following, or in place of, acute hospitalization to treat one or more specific active complex conditions as part of a specifically defined program, regardless of the site. Subacute care is typically provided in a hospital or skilled nursing facility. Subacute care (usually between one and three hours of treatment per week) requires the coordinated services of an interdisciplinary team and is generally more intensive than skilled nursing care. Daily to weekly patient assessments and treatment plan reviews are required for a limited period until a condition is stabilized. (Source: AHCA, JCAHO, and Association of Hospital-Based Skilled Nursing Facilities, 1996). Use this category if your program is specifically defined as a subacute program for marketing purposes.
Skilled Nursing	Skilled nursing, for purposes of NOMS, refers to both skilled nursing and intermediate or extended care units/facilities. Skilled nursing units are usually either hospital-based or exist in a long-term care facility and require skilled nursing care 24 hours a day. Rehab therapy services may be provided. Many of the patients may be reimbursed under Medicare, Part A (for the first 100 days) and then reimbursed under Medicaid or

	Medicare, Part B. Also refers to intermediate or extended care settings where 24-hour medical supervision is provided, but skilled nursing services are not required. Many of the patients may be reimbursed under Medicare, Part B.
Home Health	Speech and language services are provided in the home.
Outpatient Rehab	Outpatient services provided in a hospital.
Comprehensive Outpatient Rehab	Coordinated, comprehensive outpatient diagnostic, therapeutic and rehabilitative services provided in a single location for injuries, disabilities, and sicknesses.
Day Treatment	A non-residential interdisciplinary rehabilitation program centered on community and vocational re-integration. Services are primarily provided in a structure group setting.
Assisted Living	A residential living facility within which limited medical care as well as assistance with personal care and activities of daily living is provided.
Office-Based	Any freestanding speech and hearing clinic or office-based private practice clinic.
Other	

11. Setting Previous to Current Admission

Indicate the setting the patient was in prior to his/her admission into the current treatment setting. For example, if the patient was living at home and receiving outpatient services, you should code the setting previous to current admission as “Home.” If the patient’s previous treatment setting is not listed, you may write in the appropriate setting. If unknown, indicate as “Unknown.”

12. Did the Patient Receive SLP Services in the Previous Setting

Indicate whether the patient had received SLP services at another level of care prior to this treatment setting for the communication and/or swallowing disorder currently being treated. If unknown, consult documentation that clearly indicates whether previous speech and language services were provided, or indicate as “Unknown.”

13. Funding Source at Admission

Select the primary funding source providing the majority of reimbursement for the patient's SLP services. If funding is provided by multiple sources, select the funding source that is providing the majority of reimbursement. If the patient is a Medicare recipient who has a Medicare supplement policy, code as either Medicare Part A, Part B or Part C/Advantage.

Medicare Part A (Hospital Insurance)	Hospital insurance which covers inpatient care in hospitals and services provided in skilled nursing facilities, hospices, and home health care. Speech-language pathology services are covered in all of these settings.
Medicare Part B (Medical Insurance)	Medical insurance which covers doctors' services, outpatient care, and some home health care. Physician approved evaluation and treatment to regain and strengthen speech and language skills, including cognitive and swallowing skills, may be provided.
Medicare Part C/Advantage	Private insurance companies offer this insurance coverage which is a combination of Medicare Part A (hospital insurance) and Medicare Part B (medical insurance).
Medicaid (Fee-for-Service)	Services must be provided by any Medicaid-approved provider.
Medicaid (Managed Care)	Services must be provided only by provider(s) specified by the health plan(s) that have entered into a contract or subcontract arrangement with the state Medicaid agency.
Veteran's Administration	Services provided under the Veteran's Health Administration.
Commercial Fee-For-Service	The plan pays per visit or per procedure usually after a deductible has been met (e.g., Aetna, Blue Cross/Blue Shield, etc.)
Managed Care Plans (HMO, PPO, IPA)	Providers are specified by the health plan (e.g., HMO, PPO, IPA, etc.)
Self-Pay	The caregiver or responsible party pays the full amount. No known insurance coverage was provided.
Unknown	

14. Functional Communication Measures

Score only the FCM(s) that correspond to those aspects of the patient's swallowing and/or communication disorder(s) established in the current treatment plan. The FCMs should be scored before initiating any intervention and should be scored between a Level 1 and Level 6. You should not score any admission FCM at a Level 7 (most functional) because those aspects of communication and swallowing would be within normal limits and, therefore, not addressed in the defined treatment plan.

- *Complete descriptions of the fifteen sets of FCM levels and detailed scoring guidelines are provided in the FCM section of this guide. Please review them carefully before beginning to score any of the measures.*

Guidelines for Scoring and Interpretation

Add/Close FCM

The Add/Close FCM Form has been designed to keep track of any modification in the treatment plan that necessitates change to the FCMs during the course of intervention. The Add/Close FCM Form should be used any time a treatment program is modified within the same treatment setting. The FCM(s) you provide on this form indicate that you have either begun work in a new clinical area (added) or completely discontinued work in a clinical area (closed) prior to the final termination of treatment in this setting.

The addition of an FCM can be based on the identification of a new goal area as a result of the patient's progress and/or awareness of an additional communication or swallowing disorder. The closing of an FCM can be based on the termination or discontinuation of a specific goal area in a continued treatment plan.

You may rate more than one FCM on the same form as long as the changes occur on the same date. Use separate Add/Close FCM Forms if the changes occur on different dates. You may use as many Add/Close FCM Forms as needed during the course of treatment.

- *Do not use this form if there is a major change or decline in the patient's medical condition that has a significant impact on communication and/or swallowing abilities (e.g., if the patient suffers a second stroke). Instead, you will need to discharge and readmit the patient to NOMS.*

The following are examples for using the Add/Close FCM Form in NOMS data collection:

- You determine that a patient with jargon aphasia is also dysarthric when he/she begins to speak in real words. *You expand your treatment program to address the patient's dysarthria and the Motor Speech FCM is added.*
- You determine a patient with mixed aphasia was pre-morbidly illiterate with the exception of writing his/her name. Once achieved, you continue to work on other areas of language. *The Writing FCM is discontinued/closed with written expression returned to functional limits. (FCMs for Spoken Language Expression and Spoken Language Comprehension continue to be addressed in treatment.)*

Add/Close FCM Form

Re-enter the identifying information exactly as submitted on the Admission Form.

1. Clinician ID

2. Patient ID

3. Date of FCM Change

Indicate the date you scored the added or closed FCM(s).

4. Add Functional Communication Measures

Indicate the FCM(s) that are being added as of the date indicated above. Do not rescore FCMs entered on the Admission Form. *Leave this question blank if you are not adding any FCMs.*

5. Close Functional Communication Measures

Indicate the patient's level for the FCM(s) that are being closed as of the date indicated above. *Leave this question blank if you are not closing any FCM(s).*

6. Predominant Service Delivery Model for Closed FCM

Specify the *one* service delivery model used the majority of the time for each closed FCM. *Leave this question blank if you are not closing any FCM(s).*

Guidelines for Scoring and Interpretation

Discharge

The patient is discharged from NOMS data collection on the last day of the speech and language intervention in the current treatment setting. A patient is considered discharged from NOMS data collection when he/she is discharged from speech and language services according to your facility's guidelines or when any of the following occur:

- The communication and/or swallowing disorder being treated has been rehabilitated to within functional limits and speech and language services are no longer warranted.
- The patient's recovery has plateaued, and speech and language services are no longer indicated at that time.
- The patient is discharged to another level of care within the same or different health care facility. The patient is transferred from one treatment setting/program to another prior to the completion of speech and language goals, because the intervention can best be addressed at another level of care.
- The patient is discharged from the facility/program prior to the completion of SLP treatment due to any of the following reasons: lack of transportation, non-compliance with treatment program, AMA (against medical advice) discharge, family/patient request, patient would not pay (this applies only to self-pay patients), attendance (break in treatment for more than 5 consecutive treatment sessions). Treatment sessions are defined according to the patient's individualized treatment plan. *Rescheduled treatment sessions are not considered missed sessions and should not be counted.*
- There is a change or decline in the patient's medical condition that significantly impacts/alters the patient's functional communication and/or swallowing abilities.
- Health insurance or funding source has reached maximum coverage.

Discharge and Readmission Guidelines:

A patient should be discharged and readmitted to NOMS data collection when he/she is discharged from SLP services according to the discharge criteria outlined above and then treatment is reinitiated at a later time. Speech and language services can resume in the same treatment setting or at a different level of care. A new Admission Form must be completed to reflect all applicable changes, including new diagnosis, treatment setting, admission date, and FCM(s).

- *You must discharge and readmit a patient as he/she enters another level of care. It is not necessary to discharge and readmit a patient to NOMS data collection as a result of a change in clinician during the course of a patient's intervention program in the same treatment setting.*

The following are examples of when to discharge a patient from NOMS:

- The patient is being seen for SLP home health services and suffers a subsequent stroke. Although the patient was not hospitalized, he/she experiences a decline in communication skills. *The patient is discharged due to a change in medical condition.*
- The patient is scheduled for outpatient SLP treatment 2 times per week and misses 3 consecutive weeks due to transportation difficulties. *The patient is discharged from facility due to a break in treatment program for more than five consecutive sessions.*
- The patient is transferred from an inpatient rehabilitation program to an outpatient day treatment program prior to the completion of inpatient treatment goals. The patient is recommended for continued SLP services as part of the day treatment program. *The patient is discharged to another level of care, because the intervention can best be addressed at that level of care.*
- The patient is discharged from an acute hospital and is recommended for continued SLP services in an inpatient rehabilitation hospital. *The patient is discharged to another level of care.*

The following are examples of when not to discharge from NOMS Data Collection:

- The patient receives home health services 3 times per week and misses six of the regularly scheduled sessions due to illness. Two of these sessions are rescheduled to other days. *Treatment rescheduled. Only 4 sessions missed.*
- The patient is scheduled for inpatient services 5 times per week. After 2 weeks of treatment, there is a change in primary clinician. *Clinician is a Registered NOMS User. No interruption in treatment plan.*

Discharge Form

Re-enter the identifying information exactly as submitted on the Admission Form.

1. Clinician ID

2. Patient ID

3. Discharge Date

Indicate the date the patient is discharged from NOMS data collection. This may or may not coincide with the patient's discharge from the program or facility.

4. Where the Treatment Goals for this Level of Care Met?

Indicate whether all of the SLP treatment goals were met for the current treatment setting. *If yes, skip directly to Question #6. If no, indicate the primary reason for discharge in Question #5.*

5. Primary Reason for Discharge

Indicate the *one* primary reason the patient was discharged from the treatment program and NOMS data collection. If there is more than one contributing reason that the patient was discharged, use your best clinical judgment in selecting the primary reason. If the primary reason for discharging the patient is not listed, you may write in the appropriate reason.

Patient progress plateaued	Goals have not been met, but the patient is no longer making progress and does not appear to benefit from continued SLP intervention at this time.
Discharge from facility	The patient is discharged from the facility to another setting or level of care <i>prior to</i> the completion of SLP treatment goals for any of the following reasons: intervention can be better addressed at another level of care, lack of transportation, non-compliance with treatment program, AMA (against medical advice) discharge, family/patient request, patient would not pay (this applies only to self-pay patients), attendance (break in treatment for more than 5 consecutive sessions). <i>Rescheduled treatment sessions should not be counted.</i>
Change in medical condition	There is a change in medical condition impacting the patient's current communication and/or swallowing abilities. This generally requires a change in the existing treatment plan. <i>Use this category to indicate the death of a patient.</i>
Insurance declined coverage	Health insurance or funding source would not authorize additional funding.
Insurance benefits exhausted	Health insurance or funding source reached maximum benefits.
Discharged due to PPS	Funding reached maximum coverage under Prospective Payment System.
Other	

6. Are Continued SLP Services Recommended Upon Discharge

Indicate whether SLP services were recommended upon discharge from current treatment setting.

7. Funding Source at Discharge

Select the *one* primary funding source providing the majority of reimbursement for SLP services. If funding was provided by multiple sources or switched part way through treatment, select the funding source that provided the majority of reimbursement. If the patient is a Medicare recipient who has a Medicare supplement policy, code as either Medicare Part A, Part B or Part C/Advantage.

Medicare Part A (Hospital Insurance)	Hospital insurance which covers inpatient care in hospitals and services provided in skilled nursing facilities, hospices, and home health care. Speech-language pathology services are covered in all of these settings.
Medicare Part B (Medical Insurance)	Medical insurance which covers doctors' services, outpatient care, and some home health care. Physician approved evaluation and treatment to regain and strengthen speech and language skills, including cognitive and swallowing skills, may be provided.
Medicare Part C/Advantage	Private insurance companies offer this insurance coverage which is a combination of Medicare Part A (hospital insurance) and Medicare Part B (medical insurance).
Medicaid (Fee-for-Service)	Services must be provided by any Medicaid-approved provider.
Medicaid (Managed Care)	Services must be provided only by provider(s) specified by the health plan(s) that have entered into a contract or subcontract arrangement with the state Medicaid agency.
Veteran's Administration	Services provided under the Veteran's Health Administration.
Commercial Fee-For-Service	The plan pays per visit or per procedure usually after a deductible has been met (e.g., Aetna, Blue Cross/Blue Shield, etc.)
Managed Care Plans (HMO, PPO, IPA)	Providers are specified by the health plan (e.g., HMO, PPO, IPA, etc.)
Self-Pay	The caregiver or responsible party pays the full amount. No known insurance coverage was provided.
Unknown	

8. Patient Setting Subsequent to Discharge

Indicate the setting to which the patient is discharged. If the discharge setting is not listed, you may write in the appropriate setting, or indicate as “Unknown.”

9. Average Number of Sessions per Week

Indicate the average number of treatment sessions the patient typically received per week.

10. Length of Typical Session

Indicate the average length of the speech and language sessions.

11. Total Number of 15-Minute SLP Treatment Units

Indicate the total number of 15-minute units of speech-language pathology intervention that were provided to the patient. All direct billable services for which you were responsible should be included. (*e.g., A graduate extern or SLP assistance working with your patients should be included in total number of units. You are still responsible for those treatment sessions and, therefore, should be billing for those services.*)

Item #11 (“15-Minute Units”) refers to the total amount of treatment hours for a client. A few examples follow.

- A patient seen for 45 minutes for only one session has a total treatment time of 45 minutes. Then, $45 \text{ minutes} / 15 \text{ minutes} = 3 \text{ units}$. *Enter the number “3” in the box for item #11.*
- A patient seen for 30 minutes, twice a week, for four weeks = $30 \times 2 \times 4 = 240$ minutes (total treatment time). Then, $240 \text{ minutes} / 15 \text{ minutes} = 16 \text{ units}$. *Enter the number “16” in the box for item #11.*
- A patient seen for a 60 minute evaluation, one 15 minute session during the first week of therapy, two 30 minute sessions during the second week of therapy, and three 45 minute sessions during the last week (also the third week) of therapy = $15 + (30 * 2) + (45 * 3) = 210$ minutes (total treatment time). Then, $210 \text{ minutes} / 15 \text{ minutes} = 14 \text{ units}$. *Enter the number “14” in the box for item #11. Enter the number “4” in the box for item #12 (60 minutes of evaluation/15 minutes = 4).*

12. Total Number of 15-Minute SLP Evaluation Units

Indicate the total number of 15-minute units of speech-language evaluation that were provided to the patient. This includes units spent completing the initial evaluation and any new evaluation or re-assessment units that were conducted by the clinician during the current speech and language intervention program. Modified barium swallow studies should be included. *See 3rd bullet in number 11 for example.*

13. Functional Communication Measures

Score all of the FCMs that were initially scored on the Admission Form and/or added on the Add/Close FCM Form. If you previously closed any FCM(s) on the Add/Close FCM Form, it is not necessary to re-score the same FCM(s) on the Discharge Form.

Indicate the approximate percentage of treatment time that was allocated for each major clinical area corresponding to an FCM that was addressed as part of the treatment program. Percentages should be approximated in increments of ten. Please note that even though you should not rescore FCMs that were previously closed on the Add/Close FCM Form, you still must indicate the percentage of total treatment time spent on that FCM at the time of discharge. If you addressed any clinical area(s) as part of the treatment plan for which there is no FCM, you may write in the appropriate area and include percentage of treatment time spent addressing that area. *The percentage of treatment time for all of the FCMs must equal 100%.*

Indicate the predominant service delivery model used for the majority of the time for each FCM rated. You do not have to indicate the predominant service delivery model for any FCM that was previously closed using on an Add/Close FCM Form, unless you failed to do so at that time.

14. Is English the Primary Language of the Patient?

Indicate if English is the primary language of the patient. *Only complete Questions #15 and #16 if the answer to this question is "No."*

15. What Language(s) was/were Used in Treatment?

Indicate language(s) used in treatment.

16. Who Assisted the SLP in Communicating with this Patient?

If English is not the patient's primary language, indicate who assisted the SLP with providing speech and language services.

Functional Communication Measures

Introduction

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 in various speech-language pathology treatment settings. 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 Add/Close FCM Form.

Description of Seven-Level FCM scoring

Each level of the FCMs contain 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	50–79% of the time.
Occasionally	20–49% of the time.
Rarely	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 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. Both the amount and intensity of the cueing must be considered in scoring an FCM.

General FCM Scoring Guidelines

The following can be used as general guidelines with 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 non-verbal, 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 should be used as general guidelines when scoring the FCMs:

- Select the FCMs based on the goals of the patient’s individualized treatment plan.
- Carefully read the “Note” Section that accompanies each FCM.
- 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.
- Determine the level that best reflects the majority of the patient’s communication or swallowing abilities for the selected FCMs.
- Consider the amount and intensity of cueing, the complexity of information, and the environment in which the patient is able to communicate.
- Administration of specific formal or informal tests and assessments are not necessary to score the FCMs.
- Score the FCMs on the first day of the treatment intervention or when the treatment goals are introduced into the treatment program. The FCM scores should be indicated on either the Admission or Add/Close FCM data collection forms.
- Score the discharge FCMs when the goal(s) are discontinued from the treatment program, either on the Add/Close FCM or Discharge data collection forms.
- Do not use rating guidelines from any other outcomes measurement system.

In Section IV, there are some sample scenarios that you should use to practice scoring the FCMs. We encourage you to try them before you begin the NOMS User Registration Test. If you have any questions about how to score the FCMs, we encourage you to reread the FCM section of the User Guide, practice scoring the FCMs with some of your patients, and discuss your scores and rationales with your colleagues.

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 1 or more of the following alaryngeal communication methods: tracheo-esophageal 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.

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 is 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 maximum 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 maximum cueing.
- LEVEL 3:** Pragmatics are functional a majority of the time when the individual is given consistent and maximum 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 are 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 is 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 required.

LEVEL 3: Alternative method of feeding 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.

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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 tracheostomy, 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.

PRACTICE SCENARIOS

Scenario 1: At Admission

Mr. Grant, with a history of Parkinson's disease, was referred for a speech, language, and swallowing evaluation because of some choking incidents and deterioration in his medical condition. Speech and language evaluation revealed that language functioning was well within normal limits, as was cognitive functioning. Oral motor examination revealed mild weakness in lingual and labial strength and function. Bedside swallowing examination revealed the presence of dysphagia, characterized by pocketing, delayed initiation of the swallow, and weakness of the laryngeal mechanism. Patient is able to tolerate soft foods and syrup-thick liquids when using a chin-down technique. Patient is at risk for aspiration. Vocal volume was low, and pitch breaks were noted during conversational speech.

Treatment recommendation:

Swallowing treatment is recommended to increase the speed of initiation of the swallowing reflex and teach compensatory strategies for safe swallow. Intervention for the voice disorder should be considered once the swallowing goals have been addressed.

Which FCM(s) would you initially score on Admission and what level(s) would you score?

Scoring

- Score the Swallowing FCM. Mr. Grant is a Level 4.

Rationale

- Score a Level 4 because he has a moderate restriction in his diet level, as indicated by the soft diet and thick syrupy liquids (down one level in both solid *and* liquid consistency).
- Swallowing is the only FCM that should initially be scored because it is the only area initially addressed in the treatment program.
- You should not score the language or cognitive-communication FCMs because those aspects of communication were within normal limits and will not be addressed as part of the treatment program. The FCMs are not intended to reflect the entire evaluation.

Practice Scenario 1 continued on the next page

Scenario 1: Three Weeks into Treatment

Three weeks into treatment, the swallowing problem had improved, partly due to a change in medication. Mr. Grant was able to resume a regular diet with thin liquids and on the occasional instances when he encountered difficulty, he was able to independently use compensatory strategies. No further swallowing intervention was indicated. Voice goals were, however, added at that same time. He continues to complain that his voice sounds weak and he has considerable difficulty teaching his regularly scheduled two-hour classes because he is unable to project his voice and it tires quickly.

How would you score the Add/Close FCM Form?

Scoring

- Score (close) the Swallowing FCM. Mr. Grant is a Level 7.
- Add the Voice FCM. Mr. Grant is a Level 4.
- Make both changes on the same Add/Close FCM Form. Indicate the date the changes were made.

Rationale

- Close the Swallowing FCM because Mr. Grant has resumed a regular diet, is able to use compensatory strategies independently when needed, and is not dependent on any external assistance to make him independent.
- Score Level 4 on the Voice FCM because his voice is functional but is consistently affected in high-vocal demand situations (i.e., teaching his class). The pitch breaks are sometimes distracting.
- Use the same Add/Close FCM Form for both changes because the changes were made at the same time.

Practice Scenario 1 continued on the next page

Scenario 1: At Discharge

Voice treatment continued until the end of the semester, but was discontinued when Mr. Grant left for a summer vacation. He was able to maintain a normal sounding voice during treatment sessions, but pitch breaks were occasionally noted. He continued to complain that his voice was weak, and pitch breaks continued to be evident. He was able to teach about one hour of his class before his voice fatigued. He did use a microphone and reported that he sometimes remembered to use good vocal hygiene and therapy techniques.

How would you score Mr. Grant's Discharge Form?

Scoring

- Score the Voice FCM. Mr. Grant is a Level 5.
- Do not rescore the Swallowing FCM on the Discharge Form.
- Indicate on the Discharge Form the percentage of time spent addressing both the swallowing and the voice goals.

Rationale

- Mr. Grant is a Level 5 because voice production is still affected in high-vocal demand situations about half of the time, but he is beginning to use some compensatory strategies.
- Do not score the Swallowing FCM on the Discharge Form because swallowing was closed previously on the Add/Close FCM Form.
- Indicate the percentage of time spent addressing both the swallowing and the voice goals on the Discharge Form because percentage of time for each goal cannot be calculated until discharge.

Scenario 2:

As a result of a stroke, Mr. Baxter presents with severe expressive aphasia. Upon prodding by the clinician, he attempts to communicate by pointing his finger. However, he is not able to get his message across to staff or family even when they try to guess his meaning or help him communicate. Despite constant efforts on the part of his communication partner, communication is not achieved.

Treatment Recommendations:

Speech and language treatment is recommended in the acute inpatient setting to improve functional communication using a simple AAC system.

Which FCM(s) would you score?

At which level(s) would you score Mr. Baxter?

Scoring

- Score the Augmentative-Alternative Communication FCM. Mr. Baxter is a Level 1.

Rationale

- Mr. Baxter is unable to communicate any meaningful message even with maximum cueing; therefore, he is a Level 1.
- If he were able to convey some rote/automatic or simple messages using AAC, even if they were meaningful less than 20% of the time, he would be a Level 2 on the Augmentative-Alternative Communication FCM.
- Do not score the Spoken Language Expression FCM because it is not currently being addressed in the treatment setting.

Scenario 3

Some days when Ms. Nivens comes to the group treatment session, she says hello to other members of the group. She frequently gets out of her chair. With consistent help from the clinician (e.g., clinician tells her it's her turn to speak, motions to her to keep quiet when it's someone else's turn) she is able to participate in simple conversations.

Which FCM would you score?

At which level would you score Ms. Nivens?

Scoring

- Score the Pragmatics FCM. Ms. Nivens is a Level 3.

Rationale

- Ms. Nivens is a Level 3 because some days she says hello, engages in social greetings, and can participate in simple conversations with maximum cueing. She needs maximum cueing to engage in simple communications, but on rare occasions, initiates simple greetings without cues.
- She is not a Level 2 because her pragmatic skills are occasionally functional, exceeding “rare” (less than the 20%) functionality indicated in Level 2.
- She is not a Level 4 because of her dependency on the cues, her inability to adhere to the rules of social communication (e.g., turn taking, group participation, or interruptions), and her inability to monitor behavior based on subtle feedback from the environment.

Scenario 4

At discharge, Mr. Slaughter is eating a regular diet and drinking thin liquids. However, due to poor dentition, he is unable to manage meats well.

Which FCM would you score?

At which level would you score Mr. Slaughter?

Scoring

- Score the Swallowing FCM. Mr. Slaughter is a Level 7.

Rationale

- Mr. Slaughter is a Level 7 because he is able to eat a regular diet and does not exhibit any clinical signs of dysphagia.
- His difficulty eating meats is due to poor dentition and is not a result of any swallowing disorder. Patients who exhibit normal swallowing abilities, and would therefore not receive swallowing intervention, should not be penalized if their diet is modified because of food allergies or poor dentition (e.g., the absence of properly fitting dentures).

Scenario 5

Ms. Richards cannot answer yes/no questions about pain reliably, but often can respond appropriately if the clinician lightly touches her elbow and looks at her inquisitively while asking a question.

Which FCM would you score?

At which level would you score Ms. Richards?

Scoring

- Score the Spoken Language Comprehension FCM. Ms. Richards is a Level 2.

Rationale

- Although Ms. Richards is unable to respond reliably to yes/no questions, she responds to personal needs and indicates that she is in pain when given maximum cues.
- The fact that she is able to respond to a combination of both tactile and visual cues places her higher than a Level 1. (Level 1 would mean that she did not respond even with maximum cueing.)
- She is not a Level 3 because usually (at least 50-79% of the time) she cannot answer simple yes/no questions, and she is not able to understand simple directions, even with cues, unless the context is known.

Scenario 6

Ms. Lindstrom does not press the call bell when she needs to go to the bathroom. She attempts to get out of her wheelchair without locking her breaks, taking off her lap tray or unlatching the safety belt. Even when the nurse prompts her, she is unable to safely move herself from her wheelchair to the toilet, and needs assistance/supervision at all times.

Which FCM would you score?

At which level would you score Ms. Lindstrom?

Scoring

- Score the Problem Solving FCM. Ms. Lindstrom is a Level 1.

Rationale

- Ms. Lindstrom is a Level 1 because she is unable to recognize or solve problems regardless of cueing and needs 1:1 supervision.
- She is not a Level 2 because she is unable to solve rote or simple problems in structured settings even with assistance.

Scenario 7

Mr. Howard is learning to use esophageal speech as his primary means of communication. After learning an air injection technique, Mr. Howard is able to produce initial fricative and plosive words and short phrases. He regularly needs cues/assistance from his therapist (e.g. providing external pressure to the neck) to maintain adequate volume and respiratory control to produce 2-4 word phrases.

Which FCM would you score?

At which level would you score Mr. Howard?

Scoring

- Score the Alaryngeal Communication FCM. Mr. Howard is a Level 3.

Rationale

- Mr. Howard is a Level 3 because he is able to produce short words and phrases with cueing.
- He is not a Level 4 because he is unable to produce sentences/messages in structured conversations with familiar and unfamiliar partners.

Scenario 8

Ms. Morgenstern can't read signs in the environment (e.g., exit, women's room, parking) unless her partner helps her by giving the sound of the first letter and giving her other hints such as pointing out the picture on the restroom door that goes with Women's. Her partner has tried to help her read some other, longer words but she can't do it.

Which FCM would you score?

At which level would you score Ms. Morgenstern?

Scoring

- Score the Reading FCM. Ms. Morgenstern is a Level 2.

Rationale

- Ms. Morgenstern is a Level 2 because she is able to read single words when given a combination of phonetic and pictorial cues (maximum cues).
- Because she is able to identify some familiar words, with cueing, she is functioning at a higher level than indicated at Level 1.
- She is not able to read longer or more complex words even with assistance. Had she been able to read these, she would be a Level 3.

Scenario 9

Upon prodding by the clinician, Mr. Gerard attempts to respond. He produces consonant-vowel sequences but is not able to get the message across to staff or family even when they try to help him communicate or when they try guessing the meaning. Despite constant efforts on the part of the communication partner, meaningful spoken communication is not achieved.

Which FCM would you score?

At which level would you score Mr. Gerard?

Scoring

- Score the Spoken Language Expression FCM. Mr. Gerard is a Level 1.

Rationale

- Mr. Gerard is unable to communicate any message even with maximum cueing; therefore, he is a Level 1.
- If he were able to produce some automatic or imitative words or phrases, even if they were rarely spoken (i.e. meaningful less than 20% of the time), he would be a Level 2.



NOMS: ADULT SLP USER REGISTRATION TEST

The NOMS User Registration Test is administered online*. To access the test, go to <http://www.asha.org/members/research/noms/training/default/>. Once you have signed in, proceed to the “Practice Scenarios and Test” section of the training to complete the registration test.

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