CLINICAL MAPPING TOOL

Therapy Clinical Care Pathway

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Clinical Mapping Tool Procedure

To ensure the delivery of elite therapy, Functional Pathways' Clinical Mapping Tool serves as a care pathway to enhance the quality of care and consistently achieve optimal outcomes. The outcomes determined by the Clinical Mapping Tool align with Functional Pathways' communication software RightTrack™ -- which provides community staff, physicians, and family members the ability to track patients' progress.

The Clinical Mapping Tool follows a **seven-step process** that serves as a framework for determining the most clinically appropriate pathway for the patient.

THE SEVEN STEPS

1) Diagnosis	**Identify the primary diagnosis** impacting functional performance and refer to the diagnosis specific Clinical Care Pathway.
2) Outcomes	**Include the outcomes** listed for each diagnosis in RightTrack™ on the initial evaluation.
3) Therapy Goals	**Review the general goals for the diagnosis** specific Clinical Care Pathway to assist with setting goals based on prior level of function, current deficits, underlying impairments, and discharge disposition.
4) Recommended Pathways	**Select the appropriate Pathway to Success** and the supporting clinical programs.
5) Interventions	**Select medically necessary treatment** interventions and billing codes.
6) Re-Evaluation	**Re-evaluation may be necessary** if the patient does not follow an expected path to recovery. If re-evaluation is indicated, refer back to Steps 3 and 4 in the Clinical Mapping procedure.
7) Discharge	**Safe Transition Planning** should begin with the initial evaluation by utilizing Functional Pathways' Safe Transition Planning Tool.

Safe Transition Planning Tool

Name: _____ Discipline(s): PT ☐ OT ☐ ST ☐

Anticipated Transition Date: / /

Considerations for the interdisciplinary team to ensure a safe transition:

Yes ☐	No ☐	Have environmental barriers been identified and addressed to ensure a safe transition? (stairs, narrow hallways, lack of transportation, lack of caregiver support, etc.)
Yes ☐	No ☐	Does the resident have the ability to obtain, self-administer, and manage their medication(s)? If no, have arrangements been made for assistance?
Yes ☐	No ☐	Does the patient require a home visit to ensure optimal safety and independent function in the potential discharge environment?
Yes ☐	No ☐	Is the patient safe from self-harm or injury to others in the performance of functional activities in the potential discharge environment?
Yes ☐	No ☐	Have all short/long term goals been met? If not, have they been modified to address barriers to progress?
Yes ☐	No ☐	Has the interdisciplinary team met with the patient/caregiver to establish a transition plan, including discussion of equipment and follow up care needs in order to allow adequate time to prepare for the transition?
Yes ☐	No ☐	If caregiver support will be required at the discharge location, has this been discussed with the patient/family and arrangements made for the necessary level of caregiver assist?
Yes ☐	No ☐	Has the appropriate team member scheduled follow up appointments and aftercare arrangements (sitter, home health, etc.)?
Yes ☐	No ☐	Has all necessary patient/caregiver teaching and training been completed with return demonstration indicating understanding and independence in all areas?
Yes ☐	No ☐	Have psychosocial needs been addressed?
Yes ☐	No ☐	If patient is returning to an independent living setting, has training been provided in case of natural disasters? This can include patient exiting home in case of a fire, adverse weather, power outages, etc. Does the patient have a method to contact help in case of an emergency?
Yes ☐	No ☐	Has a home exercise program been provided with appropriate training to patient and caregivers to facilitate follow through?
Yes ☐	No ☐	Does the patient need a restorative program for continued maintenance and monitoring safety, if remaining in the SNF?
Yes ☐	No ☐	Has the activities department been apprised of appropriate activities/tasks, if patient to remain in the SNF?
Yes ☐	No ☐	Has the dietary department been notified of any final changes in diet, food presentation, or adaptive equipment?
Yes ☐	No ☐	Has the care plan team been notified and the care plan modified to reflect current needs?

Safe Transition Planning Tool

Anticipated Destination:

Private Home/Apt. ☐ ALF ☐ SNF ☐ Other ☐ _____

Support:

Alone ☐ With Family ☐ With Sitter ☐ Other ☐ _____ Caregiver (hrs/day) _____

Checklist for Discharge Destination

Stairs:

Inside _____ # Outside _____ Handrail(s): Right ☐ Left ☐ Both ☐ None ☐

Floors:

Carpet ☐ Rugs ☐ Wood ☐ Tile ☐ Other ☐ _____

Bedroom:

Main Level ☐ Upstairs ☐

Sleeps On:

Bed ☐ Hospital Bed ☐ Recliner ☐ Couch ☐

Bathroom:

Tub ☐ Tub / Shower ☐ Walk-In Shower ☐ Raised Toilet ☐ Tub Bench ☐

Recommendations

Home Evaluation:

Home Eval Needed: Yes ☐ No ☐ Date Completed: _____

If no, indicate reason: _____

Family/Patient/Caregiver education completed? PT ☐ OT ☐ ST ☐

Therapy Equipment:

Currently Owns: _____

Additional Equipment Needs: _____

Therapy Needs:

Outpatient:	PT ☐	OT ☐	ST ☐
Home Health:	PT ☐	OT ☐	ST ☐
Restorative Nursing:	PT ☐	OT ☐	ST ☐
Home Exercise Program:	PT ☐	OT ☐	ST ☐

Diet Texture and Liquid Viscosity: _____

Additional Comments:

_____

_____

_____

_____

Safe Transition Planning Tool

PHYSICAL THERAPY	OCCUPATIONAL THERAPY	SPEECH THERAPY
Ambulation:	**ADLs/IADLs:**	**Dysphagia:**
☐ Uneven Surfaces	☐ Oral Hygiene	☐ Eats Least Restrictive Diet
☐ Even Surfaces	☐ Grooming	☐ Drinks Least Restrictive Fluids
☐ Curbs	☐ Shaving	☐ Dysphagia Compensatory Strat.
☐ Ramps	☐ Personal Hygiene	☐ Preparation of Altered Diet
☐ Community Distance	☐ Toileting	**Functional Cognition:**
☐ Stairs	☐ Personal Nail Care	☐ Medication Management
☐ Ambulate with LRAD	☐ Retrieve Clothing	☐ Memory
Bed Mobility:	☐ Self Feeding	☐ Money Management
☐ Rolling	☐ Community Transportation	☐ Organization
☐ Scooting	☐ Cooking-Stove/Microwave/Oven	☐ Orientation
☐ Supine ⟷ Sit	☐ Energy Conservation	☐ Reasoning
Transfers:	☐ Food Preparation	☐ Safety Awareness
☐ Bed ⟷ Chair Transfers	☐ Housekeeping	☐ Sequencing
☐ Car Transfers	☐ Judgment/Memory	**Communication:**
☐ Fall Recovery Transfer	☐ Laundry	☐ Able to Communicate Needs
☐ Functional Activity Tolerance	☐ Managing Medication	☐ Able to Follow Commands
☐ Functional Safety Awareness	☐ Money Management	☐ Patient/Caregiver Education
☐ Home Exercise Program	☐ Organization/Sequencing	☐ Reading Comprehension
☐ Restorative Nursing Program	☐ Outdoor Activities/Leisure Skills	☐ Speech is Clear
☐ W/C Management/Mobility	☐ Personal Safety during ADL's	☐ Use of Compensatory Strat.
☐ Wound Management	☐ Using Phone	☐ Written Communication
	☐ Home Exercise Program	☐ Patient/Caregiver Education
	☐ Restorative Nursing Program	☐ Home Exercise Program
		☐ Restorative Nursing Program

Staff in Agreement that:	PT	OT	ST
Patient's individual wants/needs/goals were addressed?	☐	☐	☐
All applicable areas of function have been addressed?	☐	☐	☐
All goals met or all avenues have been exhausted to reach goals?	☐	☐	☐
Patient has reached the highest level of independence needed for the discharge setting?	☐	☐	☐
Patient/Caregiver(s) educated and understand discharge instructions?	☐	☐	☐

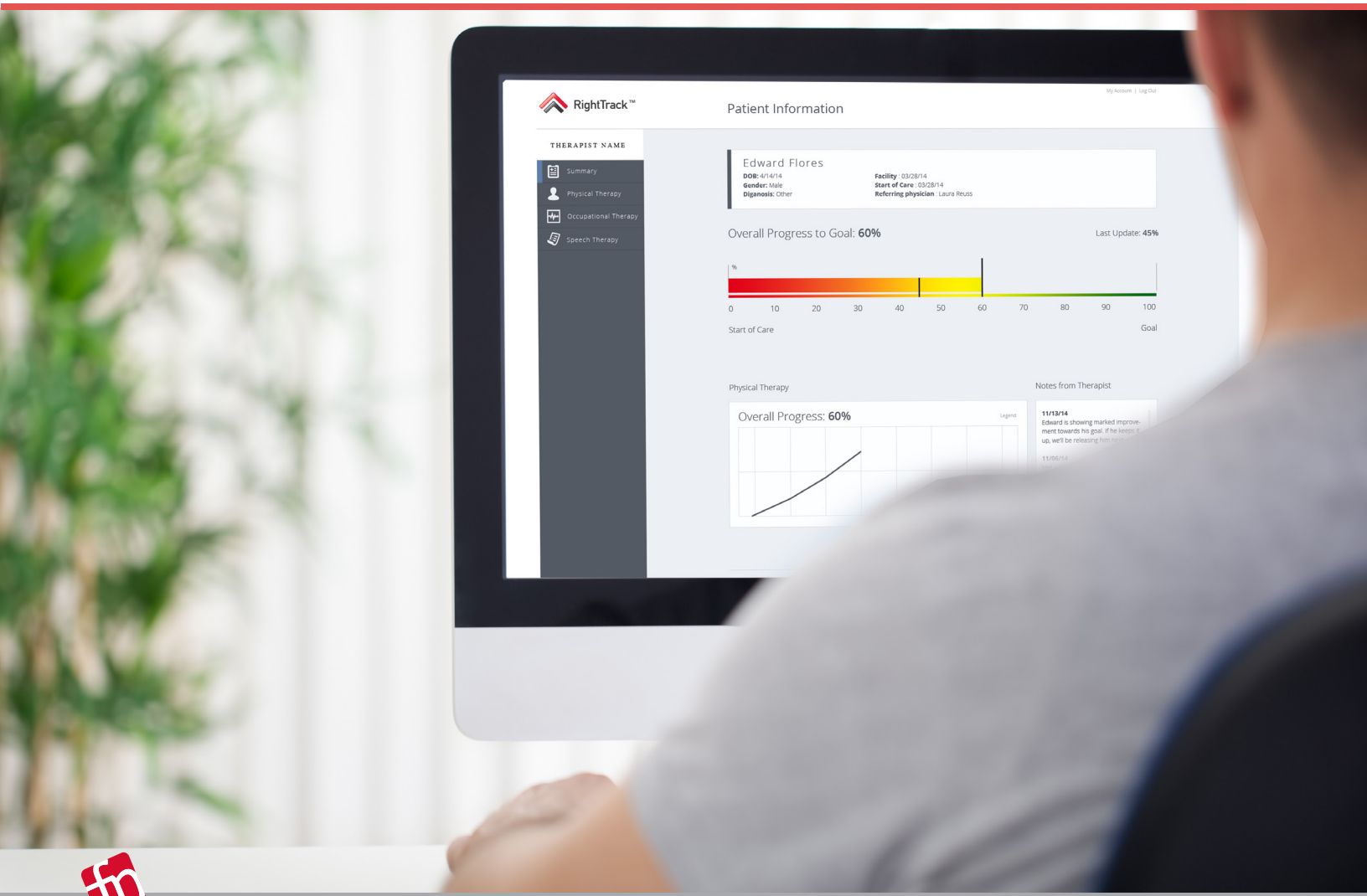
Benchmarking

RightTrack™ outcomes will be generated throughout the episode of care and upon discharge.

Reports generated from this information can be used during care plan meetings, Medicare meetings, and rehab team meetings to ensure appropriate progression of treatment plans.

Upon discharge:

- Compare ***Overall Progress to Goal*** achieved per discipline to Functional Pathways' identified benchmark. (Consult Regional Manager for specific benchmark.)
    - If patient's ***Overall Progress to Goal*** is below benchmark, determine why goals were not achieved.
    - If patient's ***Overall Progress to Goal*** exceeds 100%, determine if goals were set appropriately or adjusted accordingly.
- If patterns of inaccuracy or clinical program development needs are identified, provide individual or group training as appropriate.



Clinical Outcome Tracking Form

Date Reviewed:

	Progress to Goal		Reasons Not Met	Action Plan
Patient Name	Overall			
	PT			
Diagnosis	OT			
	ST			

	Progress to Goal		Reasons Not Met	Action Plan
Patient Name	Overall			
	PT			
Diagnosis	OT			
	ST			

	Progress to Goal		Reasons Not Met	Action Plan
Patient Name	Overall			
	PT			
Diagnosis	OT			
	ST			

	Progress to Goal		Reasons Not Met	Action Plan
Patient Name	Overall			
	PT			
Diagnosis	OT			
	ST			

	Progress to Goal		Reasons Not Met	Action Plan
Patient Name	Overall			
	PT			
Diagnosis	OT			
	ST			

	Progress to Goal		Reasons Not Met	Action Plan
Patient Name	Overall			
	PT			
Diagnosis	OT			
	ST			

	Progress to Goal		Reasons Not Met	Action Plan
Patient Name	Overall			
	PT			
Diagnosis	OT			
	ST			

Pathways to SUCCESS

Independence Pathway

For many patients, the ability to resume independent living is a primary goal.

Our **Independence Pathway** concentrates on rehabilitation to speed up this process. Once a patient achieves independence, we can continue programs that improve quality of life. The **Independence Pathway** programs focus on the components of function that comprise the patient's ability to perform personal self-care tasks with the least amount of assistance and with optimal safety.

Programs

- ADLs, Strength, Endurance, and Functional Mobility
- Aquatic Therapy
- Fall Prevention and Balance
- Lymphedema Management
- Pain Management
- Pre-Operative Hip and Knee Joint Replacement
- Urinary Continence
- Wellness

GOALS

To realize the patient's capabilities to maintain independence in areas of self-care and functional mobility to enhance overall quality of life

To maintain the patient's dignity and ability to positively interact with their environment

To monitor and proactively address changes in functional performance to prevent loss of independence

Safety Pathway

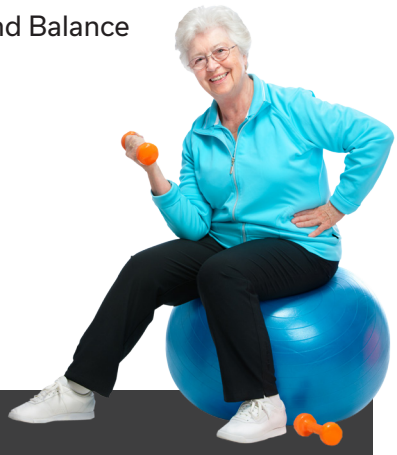
Our **Safety Pathway** assesses the abilities of each individual, creates a personalized plan for each, focuses on issues such as mobility, balance, eating, and communication

It also focuses on the ability to live and function safely, whether in a facility or in a private residence.

Safety Pathway comprehensive programs focus on assessing the patient's safety in several key areas including falls, oral intake, and safe discharge to home or assisted living. The maximization of a patient's safety and wellbeing post therapy services, will positively impact and decrease unnecessary re-hospitalization and avoidable accidents.

Programs

- Cognitive Linguistic Management
- Dementia Management and Cognitive Care
- Safe Transition Planning Tool
- Fall Prevention and Balance
- Safe Swallowing
- Restorative Care



GOALS

To provide a skilled assessment of the patients balance and strength to prevent falls in the home or community as well as the long term living environment

To provide a home evaluation to determine home safety and make key recommendations for adaptive equipment and/or suggest environmental modifications

Recovery Pathway

The **Recovery Pathway** programs focus on rehabilitation to allow patients to recover to pre-event status. Based on specific clinical events (such as a stroke or joint replacement), they are designed to provide maximum success in flexible, but efficient time frames.

Recovery Pathway programs provide a valid and reliable process to accurately measure functional performance.

Programs

- ADLs, Strength, Endurance, and Functional Mobility
- Aquatic Therapy
- Cardiac Recovery
- Joint Replacement Recovery
- Lymphedema Management
- Pain Management
- Pulmonary Rehabilitation
- Stroke Recovery
- Wound Care

GOALS

To demonstrate functional improvement and effectiveness of the individual treatment plan

To identify targets for overall quality improvement

To support marketing efforts with physician, hospitals, and other healthcare entities

To provide a comparison against national standards

Quality Pathway

Our **Quality Pathway** focuses on maximizing quality of life and underwriting facility quality standards. This program reduces the risk of re-hospitalization for complicated cases or patients in co-morbidity situations.

Quality Pathway programs focus on the use of evidence-based practice recommendations. This program will enable a facility to effectively manage the care of patients at high-risk for re-hospitalization and provides direction on integrating management of unplanned hospital transfers into a community's quality improvement program.

Programs

- Clinically Complex Care
- Dementia Management and Cognitive Care
- Pain Management
- Palliative and Comfort Care
- Restorative Care
- Safe Swallowing
- Seating and Positioning
- Wound Care

GOALS

To identify patients with the highest risk for developing acute change of condition

To provide best practice recommendations that will enable a facility to effectively manage the care of patients identified as high risk for re-hospitalization

To assist in the integration of ongoing quality improvement with the community's management of unplanned hospital transfers

Acute Respiratory Failure

OUTCOMES

Physical	*Occupational*	*Speech*
Bed Mobility Car Transfers Gait – Level Surfaces Stairs Transfers Dynamic Sitting Standing Balance Static Sitting and Standing Balance Pain Lower Extremity Strength	Bathing Dressing Hygiene/Grooming Housekeeping Self-Feeding Toileting Balance during ADLs Pain Upper Extremity Strength Memory	Motor Speech (Intelligibility) Verbal Expression Auditory Comprehension Memory Problem Solving Reading Comprehension Cognition Swallowing Abilities

GENERAL THERAPY GOALS

- Improve strength and functional activity tolerance to maximize independence in self-care, safe mobility, and functional task performance.
- Provide health education and training in use of breathing techniques, energy conservation strategies, task simplification & teaching of compensatory skills.
- Balance, transfer, and bed mobility assessment to maximize independence.
- Positioning strategies that promote the highest level of independent function and maintain open airway.
- Provide strategies to decrease anxiety related to impaired breathing, tracheostomy placement, ventilator use & improve mechanisms for managing shortness of breath & diminished control of their environment.
- Assess the impact of disease process on cognition, safety, and swallowing.

Acute Respiratory Failure

PATHWAYS TO SUCCESS

Independence Pathway

- ADLs, Strength, Endurance, and Mobility
- Fall Prevention and Balance
- Pain Management

Recovery Pathway

- ADLs, Strength, Endurance, and Mobility
- Pain Management
- Pulmonary Rehabilitation

Quality Pathway

- Clinically Complex Care
- Dementia Management & Cognitive Care
- Pain Management
- Palliative and Comfort Care
- Restorative Care
- Safe Swallowing
- Seating and Positioning

Safety Pathway

- Cognitive Linguistic Management
- Dementia Management and Cognitive Care
- Fall Prevention and Balance
- Restorative Care
- Safe Swallowing
- Safe Transition Planning Tool

INTERVENTIONS

Comprehensive evaluation of speech-language (92521, 92522, 92523, or 92524), swallowing evaluation (92610), PT evaluation (97001), and/or OT evaluation (97003).

Acute care strategies for the patient with co-morbidities, tracheostomy, and ventilators: gradual functional activity tolerance and strengthening activities that do not tax the respiratory system should be prioritized. Refer to Pulmonary and Clinically Complex Care Programs.

Therapy interventions should focus on functional deficits and potential for improvement based on prior level of function. Primary needs with this diagnosis are: functional communication, comfort, pain management, nutrition, non-labored breathing, mobility for pressure relief, and toileting with ongoing caregiver education and training.

Teaching and training in proper breathing techniques (pursed lips, diaphragmatic, deep breathing exercises), task simplification, energy conservation (97530), or code the activity addressed.

Acute Respiratory Failure

INTERVENTIONS CONTINUED

- Pain management techniques utilizing interventions for Acute Respiratory Failure; observe contraindications of modality use (code to appropriate activity).
- During treatment sessions, monitor oxygen saturation, heart rate, and vent alarm for signs and symptoms of distress (code the activity addressed).
- Balance (97112), mobility (97530), and transfer training (97530) to maximize functional mobility and safety, progressing to gait training as able (97116).
- Instruction in strategies for decreasing anxiety (guided imagery, relaxation, meditation), teaching coping mechanisms for managing shortness of breath, pacing activity or alternating rest and activity (97530), or code the activity addressed during ADL tasks (97535).
- Graded strengthening (97110) & functional activity tolerance (97530) as determined by the severity of Acute Respiratory Failure.
- Assessment and training in use of assistive and adaptive devices to promote safe mobility (97116) and independent self-care (97535) with emphasis on environmental modification and task simplification.
- Functional positioning (particularly if patient consumes meals in bed and/or has a tracheostomy/ventilator dependent); body mechanics to simplify tasks and promote functional posture while in bed, when seated, and during ambulating to allow lung expansion and to maintain open airway (code to appropriate activity).
- Chest physical therapy: postural drainage techniques, vibration & percussion, rhythmic breathing & coughing
- Swallowing assessment & treatment as indicated. Determine safest and least restrictive diet, compensatory strategies for safe swallowing, improve laryngeal control, breath support & positioning during meals (92526).
- Home assessment as needed to ensure safe transition to home or lesser level of care (code to activity addressed).
- Assessment and retraining in ADLs, functional transfers, and toileting (97535).
- Assessment and retraining in components of cognitive loss resulting in functional deficits related to oxygen loss, difficulty breathing, and/or excess secretions: OT (97532) or code the activity addressed, ST (92507) for cognitive deficits related to language, breath support strategies for functional communication, ST (92526) for cognitive deficits related to swallowing.
- Instruction in a home exercise program (97110) if transitioning to home or lessor level of care. Instruction in a restorative nursing program if remaining in long-term care setting.

Congestive Heart Failure (CHF)

OUTCOMES

Physical	*Occupational*	*Speech*
Bed Mobility Car Transfers Gait – Level Surfaces Stairs Transfers Dynamic Sitting Standing Balance Static Sitting and Standing Balance Pain Lower Extremity Strength	Bathing Dressing Hygiene/Grooming Housekeeping Self-Feeding Toileting Balance during ADLs Pain Upper Extremity Strength Memory	Motor Speech (Intelligibility) Verbal Expression Auditory Comprehension Memory Problem Solving Reading Comprehension Cognition Swallowing Abilities

GENERAL THERAPY GOALS

- Improve strength and functional activity tolerance to maximize independence in self-care, safe mobility, and functional task performance.
- Provide health education on disease process and training in use of appropriate breathing techniques, energy conservation strategies, and task simplification.
- Provide strategies for decreasing stress, anxiety, and improve the patient's coping mechanisms for managing shortness of breath and related symptom.
- Assess impact of disease process on cognition, safety, and swallowing.
- Balance and gait assessment to determine impact of CHF symptomology on safe mobility.

Congestive Heart Failure (CHF)

PATHWAYS TO SUCCESS

Independence Pathway

- ADLs, Strength, Endurance, and Mobility
- Aquatic Therapy
- Fall Prevention and Balance
- Pain Management
- Wellness

Recovery Pathway

- ADLs, Strength, Endurance, and Mobility
- Aquatic Therapy
- Pain Management
- Pulmonary Rehabilitation

Quality Pathway

- Clinically Complex Care
- Pain Management
- Palliative and Comfort Care
- Restorative Care
- Safe Swallowing
- Seating and Positioning

Safety Pathway

- Cognitive Linguistic Management
- Fall Prevention and Balance
- Restorative Care
- Safe Swallowing

INTERVENTIONS

- Comprehensive evaluation of speech-language (92521, 92522, 92523, or 92524), swallowing evaluation (92610), PT evaluation (97001), and/or OT evaluation (97003).
- Pain management techniques utilizing appropriate interventions for the CHF patient; observe contraindications of modality use (code to appropriate activity).
- During treatment sessions, monitor blood pressure, heart rate, and oxygen saturation (code to appropriate activity).
- Teaching and training in proper breathing techniques, task simplification and energy conservation (97530) or code the activity addressed.
- Instruction in strategies for decreasing anxiety, managing shortness of breath (97530), or code the activity addressed.
- Graded strengthening (97110) and functional activity tolerance (97530) as determined by severity of CHF.
- Balance (97112), gait (97116), and transfer training (97530) to maximize functional mobility and safety.
- Assessment and retraining in ADL deficits related to CHF (97535).

Congestive Heart Failure (CHF)

INTERVENTIONS CONTINUED

- Assessment and training in use of assistive and adaptive devices to promote safe mobility (97116) and independent self-care (97535) with emphasis on environmental modifications and task simplification.
- Assessment and retraining in components of cognitive loss resulting in functional deficits related to oxygen loss: OT (97532) or code the activity addressed, ST (92507) for cognitive deficits related to language, ST (92526) for cognitive deficits related to swallowing.
- Home assessment as needed to ensure safe transition to home or lesser level of care (code to activity addressed).
- Instruction in a home exercise program (97110) if transitioning to home or lessor level of care. Instruction in a restorative nursing program if remaining in long-term care setting.

Chronic Obstructive Pulmonary Disease

OUTCOMES

Physical	*Occupational*	*Speech*
Bed Mobility Car Transfers Gait – Level Surfaces Stairs Transfers Dynamic Sitting Standing Balance Static Sitting and Standing Balance Pain Lower Extremity Strength	Bathing Dressing Hygiene/Grooming Housekeeping Self-Feeding Toileting Balance during ADLs Pain Upper Extremity Strength Memory	Motor Speech (Intelligibility) Verbal Expression Auditory Comprehension Memory Problem Solving Reading Comprehension Cognition Swallowing Abilities

GENERAL THERAPY GOALS

- Improve strength and functional activity tolerance to maximize independence in self-care, safe mobility, and functional task performance.
- Provide health education and training in use of breathing techniques, energy conservation strategies, and task simplification.
- Provide strategies for decreasing stress, anxiety, improving coping mechanisms for managing shortness of breath, and techniques to mobilize secretions.
- Balance and gait assessment to determine impact of COPD symptomology on safe mobility.
- Assess impact of disease process on cognition, safety, and swallowing.

Chronic Obstructive Pulmonary Disease

PATHWAYS TO SUCCESS

Independence Pathway

- ADLs, Strength, Endurance, and Mobility
- Aquatic Therapy
- Fall Prevention and Balance
- Pain Management
- Urinary Continence
- Wellness

Recovery Pathway

- ADLs, Strength, Endurance, and Mobility
- Aquatic Therapy
- Pain Management
- Pulmonary Rehabilitation

Quality Pathway

- Clinically Complex Care
- Dementia Management and Cognitive Care
- Pain Management
- Palliative and Comfort Care
- Restorative Care
- Safe Swallowing

Safety Pathway

- Cognitive Linguistic Management
- Dementia Management and Cognitive Care
- Fall Prevention and Balance
- Restorative Care
- Safe Swallowing

INTERVENTIONS

- Comprehensive evaluation of speech-language (92521, 92522, 92523, or 92524), swallowing evaluation (92610), PT evaluation (97001), and/or OT evaluation (97003).
- Pain management techniques utilizing appropriate interventions for the patient with a COPD diagnosis, observe contraindications of modality use.
- During treatment sessions monitor oxygen saturation (code the activity addressed).
- Teaching and training in proper breathing techniques (pursed lip, diaphragmatic), task simplification, energy conservation, prioritizing daily activities (97530), or the code the activity addressed.
- Instruction in strategies for decreasing anxiety, managing shortness of breath, and pacing/prioritizing daily activities (97530), or the code activity addressed.
- Graded strengthening (97110) and functional activity tolerance (97530) as determined by the severity of COPD.
- Balance (97112), gait (97116), and transfer training (97530) to maximize functional mobility and safety.

Chronic Obstructive Pulmonary Disease

INTERVENTIONS CONTINUED

- Functional positioning while in bed (slightly elevated for easier breathing); body mechanics to simplify tasks and promote postural stability while seated and ambulating to allow lung expansion and facilitate open airway. If focus is improved ADL performance (97535); for all other activities (97350).
- Utilization of postural drainage techniques, productive cough, vibration, and percussion (97124), edema management (97140).
- Assessment and retraining in ADL deficits related to COPD (97535).
- Assessment and training in use of assistive and adaptive devices to promote safe mobility (97116) and independent self-care (97535) with emphasis on environmental modifications and task simplification.
- Assessment and retraining in components of cognitive loss resulting in functional deficits related to oxygen loss, difficulty breathing, excess secretions OT (97532), or code the activity addressed, ST (92507) for cognitive deficits related to language, ST (92526) for cognitive deficits related to swallowing.
- Home assessment as needed to ensure safe transition to home or lesser level of care (code the activity addressed).
- Instruction in a home exercise program (97110) if transitioning to home or lessor level of care. Instruction in a restorative nursing program if remaining in long-term care setting.

Medically Complex

OUTCOMES

Physical	*Occupational*	*Speech*
Bed Mobility Car Transfers Gait – Level Surfaces Stairs Transfers Dynamic Sitting Standing Balance Static Sitting and Standing Balance Pain Lower Extremity Strength	Bathing Dressing Hygiene/Grooming Housekeeping Self-Feeding Toileting Balance during ADLs Pain Upper Extremity Strength Memory	Motor Speech (Intelligibility) Verbal Expression Auditory Comprehension Memory Problem Solving Reading Comprehension Cognition Swallowing Abilities

GENERAL THERAPY GOALS

- Improve strength and functional activity tolerance to maximize independence in self-care, safe mobility, and functional task performance.
- Balance, transfer, gait, and mobility assessment to maximize independence.
- Assess impact of metabolic and acute mental status change on cognition and safety.
- Assess safety and effectiveness of swallow.

Medically Complex

PATHWAYS TO SUCCESS

Independence Pathway

- ADLs, Strength, Endurance, and Mobility
- Aquatic Therapy
- Fall Prevention and Balance
- Lymphedema Management
- Pain Management
- Urinary Continence

Recovery Pathway

- ADLs, Strength, Endurance, and Mobility
- Aquatic Therapy
- Pain Management
- Pulmonary Rehabilitation
- Wound Care

Quality Pathway

- Clinically Complex Care
- Dementia Management and Cognitive Care
- Pain Management
- Palliative and Comfort Care
- Restorative Care
- Safe Swallowing
- Seating and Positioning
- Wound Care

Safety Pathway

- Cognitive Linguistic Management
- Dementia Management and Cognitive Care
- Fall Prevention and Balance
- Restorative Care
- Safe Swallowing
- Safe Transition Planning Tool

INTERVENTIONS

Comprehensive evaluation of speech-language (92521, 92522, 92523, or 92524), evaluation of swallow (92610), physical therapy evaluation (97001), and/or occupational therapy evaluation (97003).

Therapy should not begin until medical intervention for dehydration or course of antibiotics have been completed in the presence of septic infection; unless, there is a life threatening functional deficit that can be specifically addressed through skilled therapy (dysphasia, high fall risk). The therapist must use sound clinical judgment to determine if the patient requires skilled therapy services or if they will spontaneously improve without skilled services resulting in referral to the restorative program.

Medically Complex

INTERVENTIONS CONTINUED

- Interventions should focus on functional deficits and potential for improvement based on prior level of function. Primary needs for the medically complex patient are communication, nutrition and hydration, and mobility for pressure relief and toileting. Acute care strategies for the patient with co-morbidities, including gradual functional activity tolerance, strengthening activities, and self-care retraining should be prioritized. Refer to the Clinically Complex Care Program.
- Pain and edema management utilizing physical agent modalities including electrical stimulation (G0283), ultrasound (97035), diathermy (97024), TENS (97032), and hot and cold pack application (97010-not billable under Medicare), observe contraindications of modality use.
- Graded strengthening (97110) and functional activity tolerance (97530).
- Balance (97112), mobility (97530), and transfer training (97530) to maximize functional mobility and safety, progressing to gait training (97116).
- Assessment and retraining in ADLs: upper/lower body dressing, bathing, functional transfers, and toileting (97535).
- Assessment and training the use of assistive and adaptive devices to promote safe mobility (97116) and independent self-care (97535).
- Assessment and retraining for cognitive loss/confusion that has resulted in functional deficits that do not spontaneously improve with medical intervention OT (97532), or code the activity addressed, ST (92507) for cognitive deficits related to language, ST (92526) for cognitive deficits related to swallowing.
- Swallowing assessment and treatment to determine safest/least restrictive diet, identify compensatory strategies for safe swallowing, adequate nutrient and hydration, and caregiver training (92526).
- Home assessment as needed to ensure safe transition to home or lesser level of care (bill under the primary activity provided during the assessment for self-care activity (97535) or gait (97116).
- Instruction in a home exercise program (97110) if transitioning to home or lessor level of care. Instruction in a restorative nursing program if remaining in long-term care setting.

Myocardial Infarction (MI)

OUTCOMES

Physical	*Occupational*	*Speech*
Bed Mobility Car Transfers Gait – Level Surfaces Stairs Transfers Dynamic Sitting Standing Balance Static Sitting and Standing Balance Pain Lower Extremity Strength	Bathing Dressing Hygiene/Grooming Housekeeping Self-Feeding Toileting Balance during ADLs Pain Upper Extremity Strength Memory	Motor Speech (Intelligibility) Verbal Expression Auditory Comprehension Memory Problem Solving Reading Comprehension Cognition Swallowing Abilities

GENERAL THERAPY GOALS

- Improve strength and functional activity tolerance to maximize independence in self-care, safe mobility, and functional task performance.
- Balance assessment and gait analysis to determine impact of MI on safe mobility.
- Assess impact of cardiac event on cognition and safety.
- Provide health education and strategies for lifestyle modification: use of breathing techniques, energy conservation strategies, and task simplification.
- Provide strategies for decreasing stress, anxiety, and for managing shortness of breath and fatigue.

Myocardial Infarction (MI)

PATHWAYS TO SUCCESS

Independence Pathway	*Recovery Pathway*
• ADLs, Strength, Endurance, and Mobility • Aquatic Therapy • Fall Prevention and Balance • Pain Management • Wellness	• ADLs, Strength, Endurance, and Mobility • Aquatic Therapy • Cardiac Recovery • Pain Management
Quality Pathway	***Safety Pathway***
• Clinically Complex Care • Pain Management • Palliative and Comfort Care • Restorative Care	• Fall Prevention and Balance • Restorative Care • Safe Swallowing

INTERVENTIONS

- Comprehensive evaluation of speech-language (92521, 92522, 92523, or 92524), swallowing evaluation (92610), PT evaluation (97001), and/or OT evaluation (97003).
- During treatment sessions monitor blood pressure, heart rate, and oxygen saturation (code to appropriate activity).
- Pain management techniques utilizing appropriate interventions for the MI patient; observe contraindications of modality use (code to appropriate activity).
- Teaching and training in proper breathing techniques, task simplification and energy conservation (97530), or code the activity addressed.
- Instruction in strategies for decreasing anxiety and managing shortness of breath (97530) or code the activity addressed.
- Graded strengthening (97110) and functional activity tolerance (97530) as determined by the recovery phase of the myocardial event.
- Balance (97112), gait (97116), and transfer training (97530) to maximize functional mobility and safety.

Myocardial Infarction (MI)

INTERVENTIONS CONTINUED

- Assessment and retraining in ADL deficits related to MI (97535).
- Assessment and training in use of assistive and adaptive devices to promote safe mobility (97116) and independent self-care (97535) with emphasis on environmental modifications and task simplification.
- Assessment and retraining/compensatory strategies for cognitive deficits resulting in functional deficits related to oxygen loss: OT (97532) or code activity addressed, ST (92507) for cognitive deficits related to language, ST (92526) for cognitive deficits related to swallowing.
- Provide health care education and teach lifestyle modification to promote wellness (97530).
- Home assessment as needed to ensure safe transition to home or lesser level of care (code to activity addressed).
- Instruction in a home exercise program (97110) if transitioning to home or lessor level of care. Instruction in a restorative nursing program if remaining in long-term care setting.

Cardiac

OUTCOMES

Physical	*Occupational*	*Speech*
Bed Mobility Car Transfers Gait – Level Surfaces Stairs Transfers Dynamic Sitting Standing Balance Static Sitting and Standing Balance Pain Lower Extremity Strength	Bathing Dressing Hygiene/Grooming Housekeeping Self-Feeding Toileting Balance during ADLs Pain Upper Extremity Strength Memory	Motor Speech (Intelligibility) Verbal Expression Auditory Comprehension Memory Problem Solving Reading Comprehension Cognition Swallowing Abilities

GENERAL THERAPY GOALS

- Improve strength and functional activity tolerance to maximize independence in self-care, safe mobility, and functional task performance.
- Balance assessment and gait analysis to determine impact of cardiac condition on safe mobility.
- Assess impact of cardiac event on cognition and safety.
- Provide health education and strategies for lifestyle modification, use of breathing techniques, energy conservation strategies, and task simplification.
- Provide strategies for decreasing stress, anxiety, and improve coping mechanisms for managing shortness of breath and fatigue.

Cardiac

PATHWAYS TO SUCCESS

Independence Pathway

- ADLs, Strength, Endurance, and Mobility
- Aquatic Therapy
- Fall Prevention and Balance
- Pain Management
- Wellness

Recovery Pathway

- ADLs, Strength, Endurance, and Mobility
- Aquatic Therapy
- Cardiac Recovery
- Pain Management

Quality Pathway

- Clinically Complex Care
- Pain Management
- Palliative and Comfort Care
- Restorative Care

Safety Pathway

- Fall Prevention and Balance
- Restorative Care
- Safe Transition Planning Tool

INTERVENTIONS

- Comprehensive evaluation of speech-language (92521, 92522, 92523, or 92524), evaluation of swallow (92610), PT evaluation (97001), and/or OT evaluation (97003).
- During treatment sessions monitor blood pressure, heart rate, and oxygen saturation (code the activity addressed).
- Pain management techniques utilizing appropriate interventions for the cardiac patient; observe contraindications of modality use (coded to the activity provided).
- Teaching and training in proper breathing techniques, task simplification, sternal precautions, and energy conservation (97530) or the code activity addressed.
- Instruction in strategies for decreasing anxiety (guided imagery, relaxation), coping mechanisms for managing shortness of breath (97530) or code the activity addressed.
- Graded strengthening (97110) and functional activity tolerance (97530) as determined by the recovery phase of the myocardial event. For post-surgical patients, ensure treatment plan is in accordance with physician's precautions and limitations.

Cardiac

INTERVENTIONS CONTINUED

- Balance (97112), gait (97116), and transfer training (97530) to maximize functional mobility and safety.
- Assessment and retraining in ADL deficits related to cardiac: upper/lower body dressing, bathing, functional transfers, and toileting (97535).
- Assessment and training in use of assistive and adaptive devices to promote safe mobility (97116) and independent self-care (97535) with emphasis on environmental modifications and task simplification.
- Assessment and retraining or compensatory strategies for cognitive deficits related to oxygen loss, OT (97532) or code the activity addressed, ST (92507) for cognitive deficits related to language, ST (92526) for cognitive deficits related to swallowing.
- Provide health care education and teach lifestyle modification to promote wellness (97530).
- Home assessment as needed, to ensure safe transition to home or lesser level of care (bill under the primary activity provided during the assessment self-care activity (97535) or gait (97116).
- Instruction in a home exercise program (97110) if transitioning to home or lessor level of care. Instruction in a restorative nursing program if remaining in long-term care setting.

Cerebrovascular Accident (CVA)

OUTCOMES

Physical	*Occupational*	*Speech*
Bed Mobility Car Transfers Gait – Level Surfaces Stairs Transfers Dynamic Sitting Standing Balance Static Sitting and Standing Balance Pain Lower Extremity Strength	Bathing Dressing Hygiene/Grooming Housekeeping Self-Feeding Toileting Balance during ADLs Pain Upper Extremity Strength Memory	Motor Speech (Intelligibility) Verbal Expression Auditory Comprehension Memory Problem Solving Reading Comprehension Cognition Swallowing Abilities

GENERAL THERAPY GOALS

- Improve strength and functional activity tolerance to maximize independence in self-care, safe mobility, and functional task performance.
- Provide health education and training in the management of impact of CVA on lifestyle, self-care independence, and daily activity.
- Balance assessment and gait analysis to determine deviations from normal gait patterns relating to CVA. Transfer and bed mobility assessment to maximize independence and safety.
- Assess impact of the CVA on sensation, visual perception, cognition, language, and swallowing and develop a comprehensive plan of care.
- Positioning strategies to promote highest level of independent mobility and function.

Cerebrovascular Accident (CVA)

PATHWAYS TO SUCCESS

Independence Pathway

- ADLs, Strength, Endurance, and Mobility
- Aquatic Therapy
- Fall Prevention and Balance
- Pain Management
- Urinary Continence

Recovery Pathway

- ADLs, Strength, Endurance, and Mobility
- Aquatic Therapy
- Pain Management
- Stroke Recovery

Quality Pathway

- Clinically Complex Care
- Dementia Management and Cognitive Care
- Pain Management
- Palliative and Comfort Care
- Restorative Care
- Safe Swallowing
- Seating and Positioning

Safety Pathway

- Cognitive Linguistic Management
- Dementia Management and Cognitive Care
- Fall Prevention and Balance
- Restorative Care
- Safe Swallowing
- Safe Transition Planning Tool

INTERVENTIONS

Comprehensive evaluation of speech-language (92521, 92522, 92523, or 92524), evaluation of swallow (92610), PT evaluation (97001), and/or OT evaluation (97003).

Neurodevelopmental treatment techniques to address abnormal muscle tone, motor deficits, postural control, proprioception and coordination (97112).

Joint mobilization techniques (97112), range of motion (97110) and soft tissue stretching, inhibitory techniques to facilitate normal movement and minimize pain (97112).

Gross motor activities (97530 or 97112) to normalize movement and facilitate postural righting reactions, stability, protective extension, and trunk control.

Pain management techniques utilizing interventions including electrical stimulation (G0283), ultrasound (97035), TENS (97032), hot and cold pack application (97010- not billable under Medicare). Observe contraindications of modality use. Coordinate with nursing staff for pain medications prior to therapy treatments.

Graded strengthening (97110) and functional activity tolerance (97530).

Cerebrovascular Accident (CVA)

INTERVENTIONS CONTINUED

- Balance (97112), mobility (97530), and transfer training (97530) to maximize functional mobility and safety. Progressive gait training (97116).
- Functional positioning for independent mobility and proper posture for swallowing: wheelchair mobility and management (97542), body mechanics, tasks simplification, and postural stability while seated and transferring (97535 or 97530).
- Caregiver instruction on proper transfer techniques, joint protection, support of flaccid extremities, progressive gait training, safety precautions, bed positioning to prevent development of increased muscle tone, contractures and foot drop (coded to activity addressed).
- Assessment and retraining in ADLs: upper/lower body dressing, bathing, functional transfers, self-feeding, and toileting. Independent Activities of Daily Living (IADL) if returning home or to a lesser level of care (97535).
- Assessment and training in use of assistive and adaptive devices to promote safe mobility (97116) and independent self-care (97535) with emphasis on environmental modifications and task simplification.
- Assessment of orthotic devices (97760).
- Assessment, retraining, and compensation for visual perceptual deficits (hemianospsia, visual field cuts) and/or cognitive loss OT (97532) or code activity addressed, ST (92507) for cognitive deficits related to language, for cognitive deficits related to swallowing (92526).
- Treatment of communication deficits (aphasia), provision of communication devices and strategies, and training to caregivers for carryover (92507).
- Swallowing assessment and treatment to determine safety of swallow, recommend least restrictive diet, teach compensatory strategies for swallow safety and prevention of aspiration, oral motor exercises (92526), and swallow study if clinically indicated.
- Home assessment as needed to ensure safe transition to home or lesser level of care (bill under activity provided during the assessment, self-care activity (97535) or gait (97116).
- Instruction in a home exercise program (97110) if transitioning to home or lessor level of care. Instruction in a restorative nursing program if remaining in long-term care setting.

Neuro - Degenerative

OUTCOMES

Physical	*Occupational*	*Speech*
Bed Mobility	Bathing	Motor Speech (Intelligibility)
Car Transfers	Dressing	Verbal Expression
Gait – Level Surfaces	Hygiene/Grooming	Auditory Comprehension
Stairs	Housekeeping	Memory
Transfers	Self-Feeding	Problem Solving
Dynamic Sitting Standing Balance	Toileting	Reading Comprehension
Static Sitting and Standing Balance	Balance during ADLs	Cognition
Pain	Pain	Swallowing Abilities
Lower Extremity Strength	Upper Extremity Strength	
	Memory	

GENERAL THERAPY GOALS

- Improve strength and functional activity tolerance to maximize independence in self-care, safe mobility, and functional task performance.
- Assess need for staff/caregiver training and development of restorative programs to minimize negative outcomes during the recovery process.
- Evaluation of seating and positioning needs, including skin protection strategies.
- Provide skilled assessment of cognition and stage dementia to determine impact on communication, safety, and swallowing.
- Balance, transfer, gait, and mobility assessment to maximize independence.

Neuro - Degenerative

PATHWAYS TO SUCCESS

Independence Pathway

- ADLs, Strength, Endurance, and Mobility
- Aquatic Therapy
- Fall Prevention and Balance
- Pain Management
- Urinary Continence

Recovery Pathway

- ADLs, Strength, Endurance, and Mobility
- Aquatic Therapy
- Pain Management
- Stroke Recovery

Quality Pathway

- Clinically Complex Care
- Dementia Management and Cognitive Care
- Pain Management
- Palliative and Comfort Care
- Restorative Care
- Safe Swallowing
- Seating and Positioning

Safety Pathway

- Cognitive Linguistic Management
- Dementia Management and Cognitive Care
- Fall Prevention and Balance
- Restorative Care
- Safe Swallowing

INTERVENTIONS

Comprehensive evaluation of speech-language (92521, 92522, 92523, or 92524), evaluation of swallow (92610), PT evaluation (97001), and/or OT evaluation (97003).

Therapy intervention should be focused on functional deficits and potential for improvement based on prior level of function and skilled cognitive assessment. Primary needs for patients with degenerative neuro conditions include quality of life and adaptive techniques to ensure functional communication addressing specific cognitive deficits, pain management, safe mobility and scheduled toileting to prevent loss of skin integrity and to preserve dignity. Provide compensatory strategies for functional activity tolerance, strengthening activities, and ADL retraining.

Pain management techniques utilizing appropriate modalities including electrical stimulation (G0283), ultrasound (97035), TENS (97032), diathermy (97024), hot and cold pack application (97010-not billable under Medicare) observe contraindications of modality use. Coordinate with nursing staff for appropriate pain medications prior to therapy treatments.

Neuro - Degenerative

INTERVENTIONS CONTINUED

- Graded strengthening (97110) and functional activity tolerance (97530).
- Balance (97112), mobility (97530), and transfer training (97530) to maximize functional mobility and safety, progressive gait training (97116).
- Evaluation of seating and positioning needs: wheelchair, gerichair, and bed positioning devices to decrease potential for contractures and maximize independence with self-care tasks, especially self-feeding (97535).
- Assessment and retraining in ADLs: upper/lower body dressing, bathing, self-feeding, functional transfers, and toileting (97535).
- Assessment and training in use of assistive and adaptive devices to promote safe mobility (97116) and independent self-care (97535).
- Assessment and treatment in components of cognitive decline resulting in functional and safety deficits according to the resident's current stage of dementia, OT (97532) or code activity addressed, ST (92507) for cognitive deficits related to language, strategies for functional communication, ST (92526) for cognitive deficits related to swallowing.
- If the resident will remain in long term care, development and implementation of a functional maintenance program to ensure highest level of independent function and quality of life (code the activity addressed).
- Caregiver/staff/family instruction and training in use of compensatory strategies, environmental modifications, communication tools/approach, and level of assistance required to complete tasks with appropriate verbal/tactile cues (code to the activity addressed).
- Home assessment as needed, to ensure safe transition to home or lesser level of care (bill under the primary activity provided during the assessment self-care activity (97535) or gait (97116).
- Instruction in a home exercise program (97110) if transitioning to home or lessor level of care. Instruction in a restorative nursing program if remaining in long-term care setting.

Spinal Cord / Brain Injury

OUTCOMES

Physical	*Occupational*	*Speech*
Bed Mobility Car Transfers Gait – Level Surfaces Stairs Transfers Dynamic Sitting Standing Balance Static Sitting and Standing Balance Pain Lower Extremity Strength	Bathing Dressing Hygiene/Grooming Housekeeping Self-Feeding Toileting Balance during ADLs Pain Upper Extremity Strength Memory	Motor Speech (Intelligibility) Verbal Expression Auditory Comprehension Memory Problem Solving Reading Comprehension Cognition Swallowing Abilities

GENERAL THERAPY GOALS

- Improve strength, functional activity tolerance and endurance to maximize independence in self-care, safe mobility, and functional task performance.
- Provide skilled assessment of cognition to determine impact on communication, safety, and swallowing.
- Assess need for staff/caregiver training and development of restorative programs to minimize negative outcomes during the recovery process.
- Evaluation of seating and positioning needs, including skin protection strategies.
- Balance, transfer, gait, and mobility assessment to maximize independence.

Spinal Cord / Brain Injury

PATHWAYS TO SUCCESS

Independence Pathway

- ADLs, Strength, Endurance, and Mobility
- Aquatic Therapy
- Fall Prevention and Balance
- Pain Management
- Urinary Continence

Recovery Pathway

- ADLs, Strength, Endurance, and Mobility
- Aquatic Therapy
- Pain Management
- Stroke Recovery

Quality Pathway

- Clinically Complex Care
- Dementia Management and Cognitive Care
- Pain Management
- Palliative and Comfort Care
- Restorative Care
- Safe Swallowing
- Seating and Positioning

Safety Pathway

- Cognitive Linguistic Management
- Dementia Management and Cognitive Care
- Fall Prevention and Balance
- Restorative Care
- Safe Swallowing
- Safe Transition Planning Tool

INTERVENTIONS

- Comprehensive evaluation of speech-language (92521, 92522, 92523, or 92524), evaluation of swallow (92610), PT evaluation (97001), and/or OT evaluation (97003).
- Therapy intervention should be focused on functional deficits and ability to maintain alertness and follow commands.
- Pain management techniques utilizing appropriate modalities including electrical stimulation (G0283), ultrasound (97035), TENS (97032), diathermy (97024), hot and cold pack application (97010-not billable under Medicare) observe contraindications of modality use. Coordinate with nursing staff for appropriate pain medications prior to therapy treatments.
- Graded strengthening (97110) and functional activity tolerance (97530).
- Balance (97112), mobility (97530), and transfer training (97530) to maximize functional mobility and safety, progressive gait training (97116).

Spinal Cord / Brain Injury

INTERVENTIONS CONTINUED

- Evaluation of seating and positioning needs: wheelchair, gerichair, and bed positioning devices to decrease potential for contractures and maximize independence with self-care tasks, especially self-feeding (97535).
- Assessment and retraining in ADLs: upper/lower body dressing, bathing, self-feeding, functional transfers, and toileting (97535).
- Assessment and training in use of assistive and adaptive devices to promote safe mobility (97116) and independent self-care (97535).
- Assessment and treatment in components of cognitive decline resulting in functional and safety deficits, OT (97532) or code activity addressed, ST (92507) for cognitive deficits related to language, strategies for functional communication, ST (92526) for cognitive deficits related to swallowing.
- If the resident will remain in long term care, development and implementation of a functional maintenance program to ensure highest level of independent function and quality of life (code the activity addressed).
- Caregiver/staff/family instruction and training in use of compensatory strategies, environmental modifications, communication tools/approach, and level of assistance required to complete tasks with appropriate verbal/tactile cues (code to the activity addressed).
- Home assessment as needed, to ensure safe transition to home or lesser level of care (bill under the primary activity provided during the assessment self-care activity (97535) or gait (97116).
- Instruction in a home exercise program (97110) if transitioning to home or lessor level of care. Instruction in a restorative nursing program if remaining in long-term care setting.

Hip

OUTCOMES

Physical	*Occupational*	*Speech*
Bed Mobility Car Transfers Gait – Level Surfaces Stairs Transfers Dynamic Sitting Standing Balance Static Sitting and Standing Balance Pain Lower Extremity Strength	Bathing Dressing Hygiene/Grooming Housekeeping Self-Feeding Toileting Balance during ADLs Pain Upper Extremity Strength Memory	Motor Speech (Intelligibility) Verbal Expression Auditory Comprehension Memory Problem Solving Reading Comprehension Cognition Swallowing Abilities

GENERAL THERAPY GOALS

- Normalize function and restore proper mechanics of the hip through range of motion, strengthening, and stability exercises.
- Facilitate highest level of independence in self-care and functional mobility.
- Facilitate highest level of independence in self-care and functional mobility.
- Balance assessment to determine impact on self-care and functional taskperformance.
- Gait analysis to determine deficits in gait pattern and need for assistive device.
- Decrease hip pain to regain functional mobility.

Hip

PATHWAYS TO SUCCESS

Independence Pathway

- ADLs, Strength, Endurance, and Mobility
- Aquatic Therapy
- Fall Prevention and Balance
- Pre-Operative Hip and Knee Joint Re-placement
- Lymphedema Management
- Pain Management
- Urinary Continence
- Wellness

Recovery Pathway

- ADLs, Strength, Endurance, and Mobility
- Aquatic Therapy
- Joint Replacement Recovery
- Lymphedema Management
- Pain Management
- Wound Care

Quality Pathway

- Clinically Complex Care
- Pain Management
- Restorative Care
- Seating and Positioning
- Wound Care

Safety Pathway

- Fall Prevention and Balance
- Restorative Care
- Safe Transition Planning Tool

INTERVENTIONS

- PT evaluation (97001) and OT evaluation (97003).
- Pain management techniques utilizing appropriate physical agent modalities including electrical stimulation (G0283), ultrasound (97035), TENS (97032), diathermy (97024), hot and cold pack application (97010-not billable under Medicare) observe contraindications of modality use. Coordinate with nursing staff for appropriate pain medications prior to therapy treatments.
- Joint and soft tissue mobilization to decrease hip pain, promote joint movement and prevent stiffness (97140).
- Range of motion, strengthening (97110), and functional activity tolerance (97530).
- Balance (97112) and gait training (97116) to promote weight bearing, minimize pain, and decrease risk for falls.

INTERVENTIONS CONTINUED

- Instruction and training in transfers (97530) to/from various surfaces: bed, chair, toilet, and car.
- Ensure hip precautions are followed according to physician protocol. See Functional Pathways Hip Precautions Handout for general guidelines.
- Training in body mechanics and positioning in bed, chair, and car while maintaining physician ordered precautions (weight bearing and anterior or posterior total hip precautions).
- Assessment of ADL deficits: lower body dressing, bathing, functional transfers, and toileting (97535).
- Assessment of assistive and adaptive devices to promote safe mobility (97116) and independent self-care, enabling hip precautions to be followed during the recovery process (97535).
- Home assessment as needed to ensure safe transition to home or lesser level of care (code to activity addressed).
- Instruction in a home exercise program (97110) if transitioning to home or lessor level of care. Instruction in a restorative nursing program if remaining in long-term care setting.

Knee

OUTCOMES

Physical	*Occupational*	*Speech*
Bed Mobility Car Transfers Gait – Level Surfaces Stairs Transfers Dynamic Sitting Standing Balance Static Sitting and Standing Balance Pain Lower Extremity Strength	Bathing Dressing Hygiene/Grooming Housekeeping Self-Feeding Toileting Balance during ADLs Pain Upper Extremity Strength Memory	Motor Speech (Intelligibility) Verbal Expression Auditory Comprehension Memory Problem Solving Reading Comprehension Cognition Swallowing Abilities

GENERAL THERAPY GOALS

- Normalize function of involved knee to facilitate highest level of independence in self-care and functional mobility.
- Restore proper mechanics of knee function through quad and hip strengthening, joint mobilization, and soft tissue mobilization.
- Gait analysis to determine deficits in gait pattern and balance related to knee pathology.
- Decrease pain and edema in order to regain active range of motion and functional strength.
- Balance assessment to determine impact of knee pathology on self-care and functional task performance.

Knee

PATHWAYS TO SUCCESS

Independence Pathway

- ADLs, Strength, Endurance, and Mobility
- Aquatic Therapy
- Fall Prevention and Balance
- Pre-Operative Hip and Knee Joint Re-placement
- Lymphedema Management
- Pain Management
- Wellness

Recovery Pathway

- ADLs, Strength, Endurance, and Mobility
- Aquatic Therapy
- Joint Replacement Recovery
- Lymphedema Management
- Pain Management
- Wound Care

Quality Pathway

- Pain Management
- Restorative Care
- Seating and Positioning
- Wound Care

Safety Pathway

- Fall Prevention and Balance
- Restorative Care
- Safe Transition Planning Tool

INTERVENTIONS

- PT evaluation (97001) and OT evaluation (97003).
- Pain and edema management utilizing physical agent modalities including electrical stimulation (G0283), ultrasound (97035), diathermy (97024), TENS (97032), hot and cold pack application (97010-not billable under Medicare), observe contraindications of modality use.
- Soft tissue mobilization and stretching techniques (97140).
- Range of motion, strengthening (97110), and functional activity tolerance (97530).
- Manual techniques for patellar mobilization/glide (97140). Balance (97112) and gait training (97116) to decrease fall risks and minimize functional impact relating to knee instability & pain.
- Instruction and training in transfers (97530) to/from various surfaces: bed, chair, toilet, and car.
- Assessment of ADL deficits related to knee pathology: lower body dressing, bathing, functional transfers & toileting (97535).
- Assessment of assistive and adaptive devices to promote safe mobility (97116) and independent self-care with environmental modification (97535).
- Home assessment as needed to ensure safe transition to home or lesser level of care (code to activity addressed).
- Instruction in a home exercise program (97110) if transitioning to home or lessor level of care. Instruction in a restorative nursing program if remaining in long-term care setting.

Shoulder

OUTCOMES

Physical	*Occupational*	*Speech*
Bed Mobility Car Transfers Gait – Level Surfaces Stairs Transfers Dynamic Sitting Standing Balance Static Sitting and Standing Balance Pain Lower Extremity Strength	Bathing Dressing Hygiene/Grooming Housekeeping Self-Feeding Toileting Balance during ADLs Pain Upper Extremity Strength Memory	Motor Speech (Intelligibility) Verbal Expression Auditory Comprehension Memory Problem Solving Reading Comprehension Cognition Swallowing Abilities

GENERAL THERAPY GOALS

- Normalize function of shoulder joint and surrounding musculature to facilitate highest level of independence with self-care and functional activity.
- Therapeutically manage and treat shoulder pain and inflammation using various modalities to minimize functional limitations.
- Strengthen rotator cuff and scapular stabilizers to ensure stability needed for proper scapulohumeral rhythm.

Shoulder

PATHWAYS TO SUCCESS

Independence Pathway

- ADLs, Strength, Endurance, and Mobility
- Aquatic Therapy
- Fall Prevention and Balance
- Pain Management
- Wellness

Recovery Pathway

- ADLs, Strength, Endurance, and Mobility
- Aquatic Therapy
- Joint Replacement Recovery
- Pain Management

Quality Pathway

- Pain Management
- Restorative Care
- Seating and Positioning

Safety Pathway

- Fall Prevention and Balance
- Restorative Care
- Safe Transition Planning Tool

INTERVENTIONS

- PT evaluation (97001) and OT evaluation (97003).
- Pain and edema management utilizing physical agent modalities including electrical stimulation (G0283), ultrasound (97035), diathermy (97024), TENS (97032), hot and cold pack application (97010-not billable under Medicare), observe contraindications of modality use.
- Joint mobilization and manual therapy techniques (97140) and myofacial release (97140) to improve joint mobility.
- Range of motion, strengthening (97110), and functional activity tolerance (97530).
- Balance (97112) and gait (97116) activities to minimize the functional impact of shoulder injury, pain, or disease process on daily activities and task performance.
- Instruction in transfers (97530) to/from various surfaces: bed, chair, toilet, and car.
- Assessment of ADL deficits related to shoulder pain & shoulder joint involvement: self-feeding, dressing, bathing & grooming (97535).
- Self-care retraining (97535) utilizing compensatory strategies during the healing process.
- Educating and teaching patient and caregivers compensatory skills for completion of daily tasks (97535).
- Assessment of adaptive equipment needs for independent self-care (97535) or assistive device for safe ambulation (97116).
- Home assessment as needed to ensure safe transition to home or lesser level of care (bill under the primary activity provided during assessment, (97535) for self-care activity).
- Instruction in a home exercise program (97110) if transitioning to home or lessor level of care. Instruction in a restorative nursing program if remaining in long-term care setting.

Ortho - Other

OUTCOMES

Physical	*Occupational*	*Speech*
Bed Mobility Car Transfers Gait – Level Surfaces Stairs Transfers Dynamic Sitting Standing Balance Static Sitting and Standing Balance Pain Lower Extremity Strength	Bathing Dressing Hygiene/Grooming Housekeeping Self-Feeding Toileting Balance during ADLs Pain Upper Extremity Strength Memory	Motor Speech (Intelligibility) Verbal Expression Auditory Comprehension Memory Problem Solving Reading Comprehension Cognition Swallowing Abilities

GENERAL THERAPY GOALS

- Normalized function and restore proper joint mechanics, range of motion, strengthening and stability exercises.
- Facilitate highest level of independence in self-care and functional mobility.
- Decrease pain to regain functional mobility.
- Gait analysis to determine deficits in gait pattern and need for assistive device.
- Balance assessment to determine impact on self-care and functional task performance.

Ortho - Other

PATHWAYS TO SUCCESS

Independence Pathway

- ADLs, Strength, Endurance, and Mobility
- Aquatic Therapy
- Fall Prevention and Balance
- Pre-Operative Hip and Knee Joint Replacement
- Lymphedema Management
- Pain Management
- Wellness

Recovery Pathway

- ADLs, Strength, Endurance, and Mobility
- Aquatic Therapy
- Joint Replacement Recovery
- Lymphedema Management
- Pain Management
- Wound Care

Quality Pathway

- Pain Management
- Restorative Care
- Seating and Positioning
- Wound Care

Safety Pathway

- Fall Prevention and Balance
- Restorative Care
- Safe Transition Planning Tool

INTERVENTIONS

- PT evaluation (97001) and OT evaluation (97003).
- Pain management techniques utilizing appropriate physical agent modalities including electrical stimulation (G0283), ultrasound (97035), TENS (97032), diathermy (97024), hot and cold pack application (97010-not billable under Medicare) observe contraindications of modality use. Coordinate with nursing staff for appropriate pain medications prior to therapy treatments.
- Joint and soft tissue mobilization to decrease pain, promote joint movement, and prevent stiffness (97140).
- Range of motion, strengthening (97110), and functional activity tolerance (97530).
- Balance (97112) and gait training (97116) to promote weight bearing, minimize pain, and decrease risk for falls.
- Educating and teaching patient and caregiver compensatory skills for completion of daily tasks (97535).
- Instruction and training in transfers (97530) to/from various surfaces: bed, chair, toilet, and car.

Ortho - Other

INTERVENTIONS CONTINUED

- Ensure precautions are followed according to physician protocol. See Functional Pathways Joint Replacement Recovery Program general guidelines.
- Training in body mechanics and positioning in bed, chair, and car while maintaining physician ordered precautions (weight bearing, lifting precautions, range of motion restrictions).
- Assessment of ADL deficits: dressing, bathing, functional transfers, hygiene, self-feeding, and toileting (97535).
- Assessment of assistive and adaptive devices to promote safe mobility (97116) and independent self-care, enabling precautions to be followed during the recovery process (97535).
- Home assessment as needed to ensure safe transition to home or lesser level of care (code to activity addressed).
- Instruction in a home exercise program (97110) if transitioning to home or lessor level of care. Instruction in a restorative nursing program if remaining in long-term care setting.

Pneumonia

OUTCOMES

Physical	*Occupational*	*Speech*
Bed Mobility Car Transfers Gait – Level Surfaces Stairs Transfers Dynamic Sitting Standing Balance Static Sitting and Standing Balance Pain Lower Extremity Strength	Bathing Dressing Hygiene/Grooming Housekeeping Self-Feeding Toileting Balance during ADLs Pain Upper Extremity Strength Memory	Motor Speech (Intelligibility) Verbal Expression Auditory Comprehension Memory Problem Solving Reading Comprehension Cognition Swallowing Abilities

GENERAL THERAPY GOALS

- Improve strength, functional activity tolerance and endurance to maximize independence in self-care, safe mobility, and functional task performance.
- Balance and gait assessment to determine impact of pneumonia symptomology on safe mobility.
- Provide strategies for decreasing stress and anxiety related to impaired breathing and improve coping mechanisms for managing shortness of breath and techniques to mobilize secretions.
- Provide health education and training in use of breathing techniques, energy conservation strategies, and task simplification.
- Assess impact of disease process on cognition, safety, and swallowing.

Pneumonia

PATHWAYS TO SUCCESS

Independence Pathway

- ADLs, Strength, Endurance, and Mobility
- Aquatic Therapy
- Fall Prevention and Balance
- Pain Management
- Wellness

Recovery Pathway

- ADLs, Strength, Endurance, and Mobility
- Aquatic Therapy
- Pain Management
- Pulmonary Rehabilitation

Quality Pathway

- Clinically Complex Care
- Pain Management
- Palliative and Comfort Care
- Restorative Care
- Safe Swallowing
- Seating and Positioning

Safety Pathway

- Cognitive Linguistic Management
- Fall Prevention and Balance
- Restorative Care
- Safe Swallowing
- Safe Transition Planning Tool

INTERVENTIONS

- Comprehensive evaluation of speech-language (92521, 92522, 92523, or 92524), swallowing evaluation (92610), PT evaluation (97001), and/or OT evaluation (97003).
- Pain management techniques utilizing appropriate interventions for the patient with a pneumonia diagnosis, observe contraindications of modality use.
- During treatment sessions monitor blood pressure, heart rate, and oxygen saturation for signs and symptoms of distress (code to appropriate activity).
- Teaching and training in proper breathing techniques (pursed lips, diaphragmatic, deep breathing exercises), task simplification, energy conservation, prioritizing daily activities (97530) or code the activity addressed.
- Instruction in strategies for decreasing anxiety, managing shortness of breath, and pacing/prioritizing daily activities (97530) or the code activity addressed.
- Graded strengthening (97110) and functional activity tolerance (97530) as determined by type (aspiration, viral, and bacterial) and severity of pneumonia.

Pneumonia

INTERVENTIONS CONTINUED

- Balance (97112), gait (97116), and transfer training (97530) to maximize functional mobility and safety.
- Functional positioning (particularly if patient consumes meals in bed); body mechanics to simplify tasks and promote functional posture while in bed, when seated, and during ambulating to allow lung expansion (code to appropriate activity).
- Chest physical therapy: postural drainage techniques, vibration and percussion, rhythmic breathing and coughing techniques (97124).
- Assessment and retraining in ADLs (97535).
- Assessment and training in use of assistive and adaptive devices to promote safe mobility (97116) and independent self-care (97535) with emphasis on environmental modification and task simplification.
- Assessment and retraining in components of cognitive loss resulting in functional deficits related to oxygen loss, difficulty breathing and/or excess secretions: OT (97532) or the code the activity addressed, ST (92507) for cognitive deficits related to language, breath support strategies for functional communication, and ST (92526) for cognitive deficits related to swallowing.
- Swallowing assessment and treatment for aspiration pneumonia, if suspected. Determine safest/least restrictive diet, compensatory strategies for safe swallowing, improve expiratory and laryngeal control, oral motor exercises, and positioning during meals (92526).
- Home assessment as needed to ensure safe transition to home or lesser level of care (code to activity addressed).
- Instruction in a home exercise program (97110)

Renal / Urinary

OUTCOMES

Physical	*Occupational*	*Speech*
Bed Mobility Car Transfers Gait – Level Surfaces Stairs Transfers Dynamic Sitting Standing Balance Static Sitting and Standing Balance Pain Lower Extremity Strength	Bathing Dressing Hygiene/Grooming Housekeeping Self-Feeding Toileting Balance during ADLs Pain Upper Extremity Strength Memory	Motor Speech (Intelligibility) Verbal Expression Auditory Comprehension Memory Problem Solving Reading Comprehension Cognition Swallowing Abilities

GENERAL THERAPY GOALS

- Improve strength, functional activity tolerance and endurance to maximize independence in self-care, safe mobility, and functional task performance.
- Balance, transfer, gait, and mobility assessment to maximize independence.
- Assess need for ongoing restorative urinary continence/toileting program.
- Provide health education and training in use of breathing techniques, energy conservation strategies, and task simplification.
- Assess impact of UTI on cognition and safety following antibiotic treatment.

Renal / Urinary

PATHWAYS TO SUCCESS

Independence Pathway

- ADLs, Strength, Endurance, and Mobility
- Aquatic Therapy
- Fall Prevention and Balance
- Pain Management
- Urinary Continence
- Wellness

Recovery Pathway

- ADLs, Strength, Endurance, and Mobility
- Aquatic Therapy
- Pain Management

Quality Pathway

- Clinically Complex Care
- Dementia Management and Cognitive Care
- Pain Management
- Palliative and Comfort Care
- Restorative Care
- Safe Swallowing

Safety Pathway

- Cognitive Linguistic Management
- Dementia Management and Cognitive Care
- Fall Prevention and Balance
- Restorative Care
- Safe Swallowing
- Safe Transition Planning Tool

INTERVENTIONS

Comprehensive evaluation of speech-language (92521, 92522, 92523, or 92524), evaluation of swallow (92610), PT evaluation (97001), and/or OT evaluation (97003).

For UTI, therapy should not begin until the prescribed course of antibiotics and medical treatment has been completed; unless, there is a life threatening functional deficit that can be specifically addressed through skilled therapy (dysphasia, high fall risk). The therapist must use sound clinical judgment to determine if the patient requires skilled therapy services or if they will spontaneously improve without skilled services resulting in referral to the restorative program.

Therapy interventions should be focused on functional deficits and potential for improvement based on prior level of function. Primary needs for this diagnostic category are adequate functional communication, quality of life and pain management, mobility for pressure relief and scheduled toileting to prevent loss of skin integrity.

Provide acute care strategies for the patient with co-morbidities, including gradual functional activity tolerance (97530), strengthening activities (97110), and ADL re-training (97535).

Renal / Urinary

INTERVENTIONS CONTINUED

- Pain and edema management utilizing physical agent modalities including electrical stimulation (G0283), ultrasound (97035), diathermy (97024), TENS (97032), hot and cold pack application (97010-not billable under Medicare), observe contraindications of modality use.
- Graded strengthening (97110) and functional activity tolerance (97530).
- Balance (97112), mobility (97530), and transfer training (97530) to maximize functional mobility and safety, progressing to gait training as able.
- Assess the need for a skilled urinary continence program (97535 or 97110).
- Assessment and retraining in ADLs: upper/lower body dressing, bathing, functional transfers, and toileting (97535).
- Assessment and training in use of assistive and adaptive devices to promote safe mobility (97116) and independent self-care (97535).
- Assessment and retraining in components of cognitive loss/confusion resulting in functional deficits that remain after the infection has cleared, OT (97532) or code the activity addressed, ST (92507) for cognitive deficits related to language, strategies for functional communication, ST (92526) for cognitive deficits related to swallowing.
- Home assessment as needed to ensure safe transition to home or lesser level of care (bill under the primary activity provided to the patient during this assessment, for self-care activity (97535) or for gait (97116)).
- Instruction in a home exercise program (97110) if transitioning to home or lessor level of care. Instruction in a restorative nursing program if remaining in long-term care setting.

Grand Rounds Policy

PURPOSE

The purpose of the **Grand Rounds Policy** is to ensure the elite delivery of therapy services through focused clinical screening and assessment of the resident's rehabilitation needs throughout the continuum of care.

THE FACILITY INTERDISCIPLINARY TEAM WILL:

- *Identify residents experiencing a decline in prior level of function.*
- Incorporate communication and feedback from the interdisciplinary care team regarding individual residents to accurately and timely screen for deficits related to quality of life and independence in all areas of daily activity.
- Utilize a person-centered care approach to the screening and identification process in determining the need for skilled therapy services.
- Facilitate communication and education for all caregivers regarding resident care approaches as they relate to therapy intervention and quality of life.
- Provide a visible and cohesive presence within the community.

POLICY AND PROCEDURE

It is the policy of Functional Pathways that each individual communities' therapy team will ensure that residents are screened and assessed through an interdisciplinary Grand Round Process. This will ensure accurate completion of the MDS and consistent communication and identification of the resident's skilled therapy needs. Procedure is as below:

1. An interdisciplinary team review will be conducted at least 14 days prior to the MDS due date. This may include walking rounds, chart review, and resident interviews.
2. The facility will establish a day and time for team rounds. It is recommended that these occur weekly but at a minimum, bi-monthly.
3. Members of the team will be appointed by the community's Administrator, teams typically include, RNAC, Dietary, Social Services, and Activities Director, as well as the Wound Care Nurse, Restorative Nursing, Therapy, and the assigned Nursing Assistant, RN, LPN.
4. An interdisciplinary review sheet will be used by the team to track residents discussed and screened during the Grand Round Process.
5. Therapists will utilize ScreenRight™ or carry blank screening forms and nursing referral sheets to be utilized during the Grand Round.
6. The clinical record, care plan, care/cue cards, task lists, or whatever the facility uses to communicate resident care will be utilized during the rounds.
7. A decision will be made regarding the type of MDS to be completed.
8. A decision will be made regarding skilled therapy intervention and documented on the therapy screen.
9. Documentation of results of the Grand Rounds will be completed by the designated Grand Round member (preferably the RNAC or MDS Coordinator) on the review sheet and signed by each participating discipline and placed in the clinical record.

Interdisciplinary Review Sheet

Interdisciplinary Quarterly MDS Review

Functional Pathways™ Excellence in Rehabilitation

Facility Name: _____

Resident Name: _____ Room: _____ Date: _____

Psychosocial Needs:

Cognition in past quarter:

Behavior in past quarter:

Psychoactive Medications:

Diagnosis for meds present in orders? ___ Yes ___ No

Comments: _____

Dietary Needs:

Weight changes in the past 30 - 180 days? ___ Gain ___ Loss ___ No Significant Change

Significant weight loss/gain? ___ Yes ___ No Present weight: _____ lbs

Swallowing difficulty? ___Yes ___ No Texture diet: _____ Liquids: _____

Comments: _____

ADL, Performance	Previous Quarter	Current Status	Change?	
			Yes	No
Bed Mobility				
Transfers				
Ambulation				
Dressing				
Eating				
Toileting				

Therapy referral sent? ___ Yes ___ No Comments: _____

Current Programs:

Active ROM _____

Passive ROM _____

Splint/brace _____

Bed Mobility _____

Transfers _____

Walking _____

Dressing _____

Grooming _____

Prosthesis Care _____

Communication _____

Self Feeding _____

Safe Swallowing _____

Wheelchair Mobility _____

Wheelchair Positioning _____

Rehabilitation:

On therapy caseload now?

___ PT ___ OT ___ ST

Comments: _____

_____

Bowel/Bladder Function:

Continent _____

Scheduled Toileting _____

Incontinence Care _____

Programs appropriate? ___ Yes ___ No Comments: _____

Interdisciplinary Review Sheet

Interdisciplinary Quarterly MDS Review, cont'd

Functional Pathways™ Excellence in Rehabilitation

Therapy Referral sent? ___ Yes ___ No

Pressure Ulcers: ___ Yes ___ No
Location and Stage: _____
Treatment: _____

Restraints, Safety Devices:
Side rails: ___ half bilateral ___ left half ___ right half ___ bilateral enablers ___ None
Used for positioning? ___ Yes ___ No Comment: _____
Chairs: ___ Recliner ___ Wheelchair ___ Merry Walker ___ Broda Chair ___ Other: _____
Other devices: ___ Half lap tray _____ full lap tray ___ lap buddy ___ Pommel Cushion
___ L Wedge cusion ___ R Wedge cushion ___ RRSB ___ FRSB ___ Velcro belt ___ Other:_____
Alarms: ___ Personal ___ Under cushion __ Bed alarm ___ Other: _____

Transfers: ___ Independent ___ Assist of 1 ___ Assist of 2 ___ SARA Lift ___ Mechanical Lift

Positioning Devices:
Chair: ___ Tray ___ Foot rest ___ Soft footboard ___ Wedge cushion ___ Lateral supports ___ Seat insert
Bed: ___ Trapeze ___ L wedge ___ R wedge ___ Lateral supports ___ L floor mat ___ R floor mat
Other: _____

Adaptive Equipment:
Feeding: ___ Plate guard ___ Sippy cup ___ Coated spoon __ Weighted utensils ___ Nosey cup
___ Kennedy cup ___ R curved spoon ___ L curved spoon
Dressing: ___ Sock aid ___ Long-handled shoehorn ___ Dressing stick ___ Reacher
Ambulation/Transfers: ___ Walker ___ Cane ___ Slide board
Other: _____

Pressure-Relieving Devices:
Mattress: ___ Pressure reducing ___ Pressure reducing with Wings ___ APM
Wheelchair cushion: ___ Gel ___ Gel overlay ___ Pommel ___ Other: _____
Other: ___ Protective boot ___ Heel protectors ___ Bunny boots ___ Arm tubes ___ Leg tubes
___ Geri sleeves ___ Geri legs ___ Palm guard ___ L ___ R ___ Other: _____

Medications/Pain Control:
___ Nine or more medications
Communications with physcian for nine or more meds and diagnosis is done by pharmacy.
Current pain medications: ___ Acetaminophen ___ Vicodin ___ Percocet ___ Ultram ___ Roxanol
Other: _____
Medication effective? ___ Yes ___ No Comments: _____

Team Members: _____ _____ _____
_____ _____ _____

Team Comments: _____

Nursing to Therapy Referral Form

Resident Name (Last, First, Middle Initial):	Date:
Type of Therapy (check all that apply): _____ All _____ PT _____ OT _____ ST	
Nursing Documentation notes recent decline _____ Yes _____ No (if no, please add nursing note to resident's chart)	Room #:

Reason for referral (check the area(s) of decline observed:

Cardiopulmonary
- ☐ Increased shortness of breath during routine activities
- ☐ Difficulty breathing during self-care
- ☐ Poor endurance and decreased strength
- ☐ Decreased walking
- ☐ Increased swelling/edema

☐ Declined ☐ Improved ☐ Same

Swallowing
- ☐ Coughing/clearing throat during meals
- ☐ Food left in mouth after swallowing
- ☐ "Pocketing" food in mouth
- ☐ Watering eyes/runny nose when eating or drinking
- ☐ Voice sounds wet or gurgly when eating or drinking
- ☐ Decreased intake during meals
- ☐ Significant weight loss
- ☐ Food spilling from mouth
- ☐ Having difficulty with food texture
- ☐ Change in Lung Status / Chest X-Ray
- ☐ Prolonged Chewing, Spitting Food

☐ Declined ☐ Improved ☐ Same

Range of Motion / Splints
- ☐ Decreased range of motion
- ☐ Current device not fitting properly
- ☐ Current splint causing swelling/redness
- ☐ Splint(s) need to be re-assessed
- ☐ Skin breakdown related to splint/prosthetic

☐ Declined ☐ Improved ☐ Same

Seating / Positioning
- ☐ Poor postural control during daily activities
- ☐ Leaning or sliding down in W/C or Geri-Chair
- ☐ Skin breakdown
- ☐ Contractures developing or worsening
- ☐ Difficulty repositioning self

☐ Declined ☐ Improved ☐ Same

Falls
- ☐ Recent fall(s)
- ☐ Decreased balance during routine tasks
- ☐ Decreased ability to recover from loss of balance
- ☐ Decreased safety awareness
- ☐ Needs environmental assessment
- ☐ Decreased walking distance with fatigue
- ☐ Decreased transfer status

☐ Declined ☐ Improved ☐ Same

Self-Care
- ☐ Increased assistance needed to complete dressing/grooming
- ☐ Increased assistance with toileting hygiene
- ☐ Increased assistance with bathing activity
- ☐ Increased time to complete activity
- ☐ Needs adaptive equipment
- ☐ Decreased ability to manipulate clothing fasteners i.e. buttons, zippers, snaps

☐ Declined ☐ Improved ☐ Same

Mobility
- ☐ Difficulty propelling wheelchair
- ☐ Needs electric wheelchair safety assessment
- ☐ Needs adaptive devices placed in/on wheelchair
- ☐ Decreased bed mobility
- ☐ Change in walking ability or distance
- ☐ Needs walking device assessed i.e. walker, cane, etc.

☐ Declined ☐ Improved ☐ Same

Dementia / Cognition
- ☐ Decreased socialization with behaviors
- ☐ Poor safety awareness
- ☐ Inability to follow simple 2-step instructions
- ☐ Memory loss/increased confusion
- ☐ Poor problem solving skills

☐ Declined ☐ Improved ☐ Same

Communication
- ☐ Decreased communication of needs/wants
- ☐ Delayed response to questions/conversation
- ☐ Difficulty speaking

☐ Declined ☐ Improved ☐ Same

Pain
- ☐ Increased pain
- ☐ Chronic pain not managed
- ☐ Pain interfering with routine tasks

☐ Declined ☐ Improved ☐ Same

Feeding / Eating
- ☐ Decreased ability to feed self
- ☐ Needs adaptive feeding devices
- ☐ Needs feeding program
- ☐ Needs modification of environment
- ☐ Needs increased cueing to finish meals

☐ Declined ☐ Improved ☐ Same

Incontinence
- ☐ Increased incontinence episodes
- ☐ Increased use of incontinence supplies (pads, diapers)
- ☐ Loss of urine during coughing/sneezing
- ☐ Decreased socialization and withdrawal from activities
- ☐ Sudden change in bowel and bladder routine

☐ Declined ☐ Improved ☐ Same

OTHER
- ☐ New onset diagnoses
- ☐ Wounds
- ☐ Decreased participation in activities
- ☐ Levels of assist vary throughout the day
- ☐ Needs instruction in car/activity bus transfers

☐ Declined ☐ Improved ☐ Same

Additional Comments: _____

_____

_____

_____

Signature: _____ **Credentials:** _____

Date: _____

Therapy Screen Form

Resident Name:	DOB:	Room #:

Current Level of Function

Bed Mobility:		Pain:	
Gait:		Cognition:	
Transfers:		Communication:	
Self-Feeding:		Diet Texture:	
Toileting:		Liquid Viscosity:	

Reason for referral (check the area(s) of decline observed:

Cardiopulmonary
- ☐ Increased shortness of breath during routine activities
- ☐ Increase difficulty breathing during self-care
- ☐ Decreased endurance and strength
- ☐ Decreased walking
- ☐ Increased swelling/edema
- ☐ No Change

ADL / Activities
- ☐ Increased assistance needed to complete dressing/ grooming
- ☐ Increased assistance with toileting transfers
- ☐ Increased assistance with toileting hygiene
- ☐ Increased assistance with bathing activity
- ☐ Increased time to complete ADL / leisure activities
- ☐ Needs adaptive equipment
- ☐ Decreased ability to manipulate clothing fasteners i.e. buttons, zippers, snaps
- ☐ Decreased socialization and withdrawal from activities
- ☐ No Change

Cognition
- ☐ Decreased socialization
- ☐ Decreased safety awareness
- ☐ Decreased ability to follow instructions / cues
- ☐ Increase memory loss / confusion
- ☐ Declined problem solving ability
- ☐ No Change

Mobility
- ☐ Decreased bed mobility
- ☐ Change in walking ability or distance
- ☐ Decreased trasfer status
- ☐ Unsteady gait
- ☐ Needs walking device assessed i.e. walker, cane, etc.
- ☐ No Change

Falls
- ☐ Recent fall(s)
- ☐ Decreased balance during routine tasks
- ☐ Decreased ability to recover from loss of balance
- ☐ Decreased safety awareness
- ☐ Needs environmental assessment
- ☐ Decreased walking distance with fatigue
- ☐ No Change

Swallowing
- ☐ Coughing/clearing throat during meals
- ☐ Food left in mouth after swallowing
- ☐ "Pocketing" food in mouth
- ☐ Watering eyes/runny nose when eating or drinking
- ☐ Voice sounds wet or gurgly when eating or drinking
- ☐ Decreased intake during meals
- ☐ Significant weight loss
- ☐ Food spilling from mouth
- ☐ Having difficulty with food texture
- ☐ Change in lung status / chest x-ray
- ☐ Prolonged chewing, spitting food
- ☐ No Change

Seating / Positioning
- ☐ Poor postural control during daily activities
- ☐ Leaning or sliding down in W/C or Geri-Chair
- ☐ Wounds: new, non-healing, and/or worsening
- ☐ Contractures developing or worsening
- ☐ Difficulty repositioning self
- ☐ Difficulty propelling wheelchair
- ☐ Needs electric wheelchair safety assessment
- ☐ Needs adaptive devices placed in/on wheelchair
- ☐ No Change

Other
- ☐ Other -- see notes for details
- ☐ No Change

Range of Motion / Splints
- ☐ Decrease in range of motion
- ☐ Increased joint stiffness / pain with joint movement
- ☐ Current device not fitting properly
- ☐ Current splint causing swelling/redness
- ☐ Splint(s) need to be re-assessed
- ☐ Skin breakdown related to splint/prosthetic
- ☐ No Change

Feeding / Eating
- ☐ Decreased ability to feed self
- ☐ Needs adaptive feeding devices
- ☐ Needs feeding program
- ☐ Increased spillage during meals
- ☐ Needs increased cueing to finish meals
- ☐ No Change

Incontinence
- ☐ Increased episodes of incontinence
- ☐ Increased use of incontinence supplies
- ☐ Loss of urine during coughing / sneezing
- ☐ Sudden change in bowel and bladder routine
- ☐ No Change

Pain
- ☐ Increased pain
- ☐ Exacerbation of chronic pain
- ☐ Pain interfering with routine tasks
- ☐ No Change

Communication
- ☐ Decreased communication of needs/wants
- ☐ Delayed response to questions/conversation
- ☐ Decrease in speech intelligibility
- ☐ No Change

Notes: _____

_____

_____

EVALUATION INDICATED	☐ PT ☐ OT ☐ ST ☐ None	Therapist Signature:	Date:

If eval(s) indicated, does nursing documentation support the change in function? _____ Yes _____ No *(If no, request it be added)*

Short Term Goal Bank

Energy Conservation / Compensatory Strategies:

- Patient will demonstrate ability to recall 2 energy conservation techniques in order to complete ADL dressing and grooming tasks with minimum assistance.
- Patient will utilize pacing/work simplification techniques 80% of time to complete IADL food preparation task with SBA.
- Patient will utilize energy conservation techniques during verbal communication/conversation without cueing 60% of time during 3/4 speech treatment sessions.
- Patient will recall and use 2 energy conservation techniques independently during meals to decrease shortness of breath while eating.

Breathing / Relaxation Techniques:

- Resident will demonstrate independence with use of relaxation techniques to decrease anxiety and slow respiratory rate during episodes of shortness of breath in order to increase independence in ADL task performance (functional mobility or ambulation).
- Patient will perform 10 minutes of standing exercise with 2 rest breaks and SpO2 > 90%.
- Patient will demonstrate ability to use pursed lip (diaphragmatic) breathing technique 80% time during toileting transfers to manage shortness of breath and decrease anxiety.

Environmental Modifications:

- Patient will demonstrate ability to safely navigate (ambulate) within room post repositioning of bed, recliner, and other furniture, 100% of time.
- Patient will demonstrate ability to properly utilize raised toilet seat and grab bar for toileting task with CGA.

Health Care and Lifestyle Education:

- Patient will demonstrate ability to recall 2-3 signs/symptoms of distress related to diagnoses in order to seek immediate assistance from caregivers.
- Patient will identify 3 positive lifestyle habits to utilize in order to prevent and/or delay disease process.
- Patient will identify and demonstrate correct use of an emergency communication system to request help post discharge to home.

NOTE: Additional goal sets may be found in each pathways program manual.