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| --- | --- | --- | --- | --- | --- |
| Functional Areas | Prior Level of Function(PLOF) | Current Level of Function(CLOF) | Goal | CLOF (minus) Goal | Scoring Key |
| **Transferring:** Current ability to move safely from bed to chair, or ability to turn and position self in bed if patient is bedfast. |  |  |  | *Multiply by 3* | 0 = Able to independently transfer. 1 = Able to transfer with minimal human assistance or with use of an assistive device. 2 = Able to bear weight and pivot during the transfer process but unable to transfer self. 3 = Unable to transfer self and is unable to bear weight or pivot when transferred by another person. 4 = Bedfast, unable to transfer but is able to turn and position self in bed. 5 = Bedfast, unable to transfer and is unable to turn and position self. |
| **Ambulation/Locomotion:** Current ability to walk safely, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces. |  |  |  | *Multiply by 3* | 0 = Able to independently walk on even and uneven surfaces and negotiate stairs with or without railings (specifically: needs no human assistance or assistive device). 1 = With the use of a one-handed device (for example, cane, single crutch, hemi-walker), able to independently walk on even and uneven surfaces and negotiate stairs with or without railings. 2 = Requires use of a two-handed device (for example, walker or crutches) to walk alone on a level surface and/or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces. 3 = Able to walk only with the supervision or assistance of another person at all times. 4 = Chairfast, unable to ambulate but is able to wheel self independently. 5 = Chairfast, unable to ambulate and is unable to wheel self. 6 = Bedfast, unable to ambulate or be up in a chair. |
| When is the patient dyspneic or noticeably **Short of Breath**? |  |  |  |  | 0 = Patient is not short of breath 1 = When walking more than 20 feet, climbing stairs 2 = With moderate exertion (for example, while dressing, using commode or bedpan, walking distances less than 20 feet) 3 = With minimal exertion (for example, while eating, talking, or performing other ADLs) or with agitation 4 = At rest (during day or night) |
| **Frequency of Pain** Interfering with patient's activity or movement: |  |  |  |  | 0 = Patient has no pain 1 = Patient has pain that does not interfere with activity or movement 2 = Less often than daily 3 = Daily, but not constantly 4 = All of the time |
| **Objective Measure** |  |  |  |  | Tinetti: **(2)** <18 (high fall risk) **(1)** 19-23 (moderate fall risk) **(0)** >24 (low fall risk)Berg: **(2)** 0-20 (wheelchair bound) **(1)** 21-40 (walking with assist) **(0)** 41-56 (independent) **Other:**  |
| Did patient receive acute or post-acute (skilled nursing facility, inpatient rehabilitation facility, long term care hospital, or inpatient psychiatric facility) **care in the 14 days prior to the HH admission** |  | Yes = 2No = 0 |
| **Risk for Hospitalization:** Which of the following signs or symptoms characterize this patient as at risk for hospitalization? **(Mark all that apply.)***INSTRUCTION: 1 POINT FOR EACH RISK IDENTIFIED* |  | ( ) - History of falls (2 or more falls – or any fall with an injury – in the past 12 months) ( ) - Multiple hospitalizations (2 or more) in the past 6 months( ) - Diagnosis of Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, or Diabetes Mellitus |
|  |  |  |  |  | 🡨Sum of column (ODCP Score) |

|  |  |  |
| --- | --- | --- |
| ***ODCP Score*** | ***Visit Range***  | ***Duration*** |
| ***0*** | ***1*** | ***Eval Only*** |
| ***1-4*** | ***2-5*** | ***2-5 weeks*** |
| ***5-7*** | ***6-7*** | ***5-6 weeks*** |
| ***8-11*** | ***8-9*** | ***6-7 weeks*** |
| ***12+*** | ***10*** | ***8 weeks*** |

**Frequency Recommendation:** **Frequencies of 2x/week to occur for no greater than 2 weeks. For example, 9 visits should have a frequency of 2w2, 1w5 or 1w1, 2w2, 1w4 or any similar variation.**

**(Therapy Evaluation is included in frequency written)**

*Note: This tool is to be used as a best practice and pathway for appropriate frequency and duration of therapy visits to best improve client outcomes. Therapists should always incorporate full evaluation findings and clinical decision-making skills to establish appropriate frequency, duration, and visit volume.*

Additional Considerations:

**Goal Writing** – At least one goal must be written for each Functional Area projected to improve in score.

**Division of functional areas** – When PT and OT are on services as a care team, treatment should be divided amongst disciplines. As a guideline, PT will assist with ambulation and functional transfers (with the exception of shower/bath and toilet transfers). OT will assist with shower/bath transfer, toilet transfer, upper/lower body dressing, grooming, and management of oral medications. Both disciplines will focus on shortness of breath and pain management.

**Dementia Patients** – Therapy should be scheduled with caregiver or facility staff with a focus on safe living environment, new equipment or assistive device training, and HEP instruction.

**Physician Prescribed Protocols** – A Physician’s protocol will always take precedent over Outcome Driven Care Plan Frequency and Duration.

**Clients on Hold** - Place clients on hold if not appropriate for skilled therapy due to restrictions. If client is non-weight bearing for lower extremity, spend a visit or two focusing on safe home environment, transfer safety, and establish a HEP. Place client on hold until cleared for weight-bearing to further progress towards functional outcomes such as ambulation, independent transfers, etc…

**Cognitive Impairment** – Occupational Therapy will evaluate and treat for cognitive impairment. Be sure that goals are written in a way to account for cognitive impairment and to demonstrate an improvement in functional outcomes.

**Therapy Exception Process** – If the therapist believes the ODCP recommended frequency and duration does not adequately account for the client’s need they can contact the Clinical Manager at their branch to collaborate on plan of care for patient prior to verbal orders.