Patient Advocacy Methods for Optimal Outcomes Form

Patient Name: _____ Facility: _____ Date:_____

Clinicians: use this form to guide clinical practice throughout the patient's rehabilitation stay.
Aim: To enhance a patient's quality of life and optimize outcomes, to the fullest extent possible, at their chosen transition destination.

Patient Focused Approach to Care:

OPN
___ Obtain the pt's concerns / goals and write them in quotes in the weekly note.
____Modify treatment to address those concerns/goals.
____Obtain consensus on goals that need to be achieved with the patient / family / other health care team members prior to transition.
____ Modify the plan of care to meet any new concerns and goals that the patient / family wants to achieve.

Systems Approach
_____ Identify deficits using the APTA systems approach (Cardiovascular, Pulmonary, Musculoskeletal, Neuromuscular, and Integumentary) to provide skilled care for the whole pt and modify as necessary.
_____Identified the true prior level of function – functional level prior to the diagnosis that led to their current situation – and set goals based on that true prior level of function

Functional Assessments
____ Use a variety of Functional Assessment tests to uncover deficits, verify safety, confirm balance risk level, pain, function, obtain the patient's perceptions of their abilities.
_____Choose other tests if a ceiling effect occurs, other concerns/goals are identified
Document skilled interventions used to address deficits found on FATs on weekly note.

Scope of Practice
_____ PT / OT / ST scope reviewed

__
Complete Transition Forms
_____Home Safety Assessment (if going home)
_____ Pre-Transition Checklist _____ Transition Communication Form

Verify Equipment Needs:
____ Obtain / Upgrade all the necessary adaptive and DME equipment for optimizing function (including orthotics, AFOs, ex bands, etc.)
____ Instruct the patient / family with how to use, manage, maintain equipment. Observe repeat demonstration

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Provide Skilled Interventions / Instructions:

____ Give/upgrade ex program/safety instructions that the patient can use when not in therapy, when going home
_____Verify that the patient can use and repeat demonstrate the exercises / instructions
_____Provide CNAs, RNs, caregivers with instructions/training. Observe repeat demonstration.
_____Make sure that the patient is performing functions consistently throughout all shifts.
_____Use a modality to address deficits, impairments, improve outcomes
_____Achieve optimal rehab targets (gaining muscle strength via PREs, 1 rep max, gaining improved extremity motion/control w PNF, time/distance improvements for function)

Room/Wheelchair Safety:

____ Identify/address environmental factors affecting the patient's quality of life (call light in reach, ability to use call light, bed railings in optimal position, able to reach / use phone, etc.)
_____Clear path to washroom
_____Ability to use equipment: bed, slings, immobilizers, braces,
_____ Completed and make adjustments on W/C

Safety Targets and Community Integration Targets:

Provide skilled interventions for task appropriate to community integration/more challenging targets. Can the patient safely….

Medically Complex

_____ Rolls from side to side
_____Performs pressure relief
_____Utilizes bed rails to assist with movement
_____Adjusts self in bed
_____Positions self for eating, ADLs
_____Adjusts sheets, pillows, etc in bed
_____Completes ADL and IADL tasks that are important
_____Uses call light
_____Sits up in bed, on edge of bed
_____Transfers to chair/toilet/W/C, gerichair
_____Feeds self Can complete exercise program
_____Address skin integrity
_____Contracture prevention / management
_____Optimize breathing
_____Provide sensory stimulation

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Safely Adapt to Transition Location-

_____ Change speeds and maintain balance
_____ Negotiate safely: stairs, ramps, obstacles or curbs
_____ Multi-task while walking: walk & talk, walk& look from side to side or up & down
_____Walk safely on uneven surfaces such as grass, uneven pavement, thick carpets
_____Turn around quickly to face the opposite direction
_____Carry a drink while walking
_____Retrieve objects from the floor
_____Enter/exit car, SUV
_____Rise from low surfaces, soft surfaces, seats w/o armrests
_____Get up from the floor

ADL Targets beyond the basics:

_____Sweep/vacuum/mop the floor, rake leaves (simulated)
_____Cook a meal
_____Spill/Trash management
_____Pet management
_____Retrieve mail, open, read, understand, respond, sort
_____Do laundry, carry laundry basket, load and unload, sort, iron, fold, put away clothes
_____ Lift winter coat from closet, donn doff several layers of clothes
_____Donn doff boots, tie shoes, etc.
_____Complete cleaning tasks (bathroom, kitchen, wash dishes, etc)
_____Change linens, Make bed
_____Dressing (including zippers, buttons,) Bathing/Showering, hygiene, grooming, etc.

IADL Targets:

_____ Balance a checkbook
_____ Manage money
_____ Follow a map
_____Write a to do list, write a grocery list
_____Medication management
_____Meal plan / Follow a recipe
_____Emergency response preparedness
_____Driving readiness and safety (remembers road signs, rules of the road, has the mobility, flexibility, and strength to look behind them, operate the steering wheel, brakes, change pedals from gas to brakes, etc.)
_____Is aware of and complies with safety warnings on cleaning products/meds
_____Able to organize and complete shopping tasks

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Community Integration Targets (consider all of the above as well as)

_____ Carry a 5 pound weight for >1000 feet
_____ Complete 3 errands of 1,000 feet each
_____ Change speeds multiple times and maintain balance
_____ Carry a package up and down the stairs
_____ Walk at 4 feet per second for at least 1 minute to cross a street

Cognitive:

_____Language barrier – adaptations for therapy made
_____Language barrier – find an interpreter
_____Determine if difficulty mastering new tasks is physical or cognitive
_____Complete Cognitive Assessment (MOCA, Allen Cognitive, BCAT, SLUMS) to assess cognitive level and ability to make needs know, learn new tasks, exhibit safe judgement
_____Modify treatment to achieve best ability to function
_____ Take the time to assess what the patient enjoys and incorporate it into the treatment session
_____ Determine the Cause of the Cognitive Decline – any chance for improvement (UTI, TIA, traumatic brain injury, CVA, etc)
_____Discussed changes in cognition with other health professionals for assessment/work up

Emotional Status:

_____Consider what the patient's spirits are like
_____ What is the patient's emotional status
_____Work on gaining the patient's trust
_____Assess emotional status with several self assessments/questionnaires if in question
_____Suggest a consult from another MD or health professional

***ST: Communication / Swallowing:* Has the patient/family received…**

_____Proper diet texture / liquid consistency information/training and demonstrated understanding over time
_____Aspiration/swallowing precautions and follow thru demonstrated at all times assessed over time
_____Home program with handouts provided with Ind return demo
_____Communication strategies and adequate return demo of use over time
_____Suggested video swallow when appropriate
_____Tried new techniques to reach goals

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Clinical Treatment Options:
_____Seek the clinical expertise / advice of another discipline / health care professional.
_____Change therapists
_____Tried another approach / technique / to impact outcomes.
_____ Add PT ST OT MD Consult Other
_____changed Treatment Time / Location

Discussed with the entire Alden Team:
_____ Brought concerns/barriers to progress to your supervisor so they can be discussed at the Medicare meeting

***Medication Management:* Have you……..**
_____Taken into consideration how a new / altered med may be affecting the pt.
_____Assessed new/current med effectiveness on function.

_____ Given a new med enough time to become effective. (such as a Parkinson med to decrease tone)
_____Made sure pain meds are coordinated with therapy times.

***Co-morbidities:* Have you……..**
_____ Considered other underlying medical conditions which need to be addressed in order for goals to be achieved

***Obtain Consult with an MD:* Have you……..**
____Suggested further work-up by a specialist or follow up with their primary.

***Unmet Needs:* Have you……..**
____Ruled out/addressed unmet needs such as: a tooth ache, UTI, pain, feeling too hot, cold, hungry, fearful, unanswered questions, etc

***Family Resources:* Have you……..**
____Spoken with a family member to find out about their concerns / goals.
____ Found out if the family can impact on the patient's outcomes
by participating in therapy sessions
_____ refraining from too much interference
_____Invited the family to participate in care plan meetings to address their concerns utilizing a team approach.
_____ Found out from the family what was important to the patient if the patient has communication / cognitive difficulties.
_____Discussed barriers the family may have about caring for the patient