Developing A Functional Maintenance Program – A Therapy Perspective

Purpose: The purpose of this course is to offer both a rationale for therapy’s role in maintaining function and a system for designing functional maintenance programs for the geriatric client. This course will look at both the aging population and government regulations that provide both a social and an economic rationale for the importance of maintaining the function of the elderly population, even those that require nursing home services. In addition, this course will review a process for identifying individuals appropriate for maintenance programming and the essential elements for evaluation, treatment planning and functional maintenance program design, education and follow-up.

Learning Objectives:
1- Learners will understand the demographics of the aging population and it’s implications for therapy services
2- Learners will understand regulations that guide therapy services as they relate to maintenance programming
3- Learners will be able to identify when maintenance programs are indicated and for which populations
4- Learners will understand underlying factors that cause declines in function
5- Learners will have knowledge of resources to use for identifying candidates for functional maintenance programs
6- Learners will understand important elements to include on an evaluation when a functional maintenance program is indicated.
7- Learners will have knowledge of treatment planning for functional maintenance programs including goals and skilled treatment strategies
8- Learners will identify elements to include in designing a functional maintenance program including goals and general caregiver approaches.
9- Learners will have knowledge of three categories of people who can carry out a functional maintenance program
10 – Learners will understand the importance of both good set-up and follow-up of maintenance programs

Course Outline:
I. Purpose
II. Learning Objectives
III. Introduction – The Aging Population – This section deals with statistics and projections concerning the aging population as well as its impact on health services in the future, and includes the provision of therapy services.
IV. Avoidable Decline – This section defines avoidable decline in the long term care facility and the important mandate given to long term care providers to maintain the individual’s ability to function, even in the presence of chronic illness. This section also identifies the therapist’s role in prevention of decline.
V. What Does Medicare Say About Skilled Therapy and Maintenance Programs? – This section discusses Medicare regulations including the role of diagnosis in determining skilled services as well as the need for “significant change”. The challenges to therapists in determining what are “skilled” services are explored.
VI. When And For Whom Is A Maintenance Program Necessary? This section reviews specific Medicare guidelines concerning maintenance programming and delineates 3 occasions that maintenance programming may be necessary. In addition, 3 types of residents who would benefit from maintenance programming are identified.
VII. Identifying Residents Appropriate For Maintenance Programming – This section reviews the therapy screening process for maintenance program candidates. A review of the types of individuals that may need services are explored as well as examples of ways the therapist might intervene.
VIII. Additional Resources For Identifying Residents In Need Of Maintenance Programming – Other resources are identified that assist with therapy screening including the Minimum Data Set and Staff interviews.
IX. Evaluation And Treatment Planning For Maintenance Programs – This section reviews the essential elements of the evaluation including the documentation of medical complexities, objective measurements, reasons skilled intervention is needed and identifying appropriate levels of assistance. A detailed description of cognitive assistance is given for all therapy disciplines.
X. Treatment Progress Notes For Maintenance Programs – This section reviews the essential elements of therapy progress notes including specific language in how to better define our skilled services within progress notes.
XI. **Developing The Maintenance Program** – This section identifies how to write a maintenance program including problems/needs, goals, frequencies, approaches and special considerations. A sample program is provided.

XII. **Who Carries Out The Maintenance Program?** This section reviews three types of individuals that can carry out the program including restorative staff, STNA staff and other facility staff.

XIII. **Follow-up of Maintenance Programs** – This section reviews the responsibility for the maintenance program after discharge from therapy as well as other important aspects of follow-up including the quarterly screen.

XIV. **Setting Up Maintenance Programs In Your Facility** – This section stresses the importance of developing systems of communication with all departments in the long term care facility, in order to ensure proper carry over of the functional maintenance programs.

XV. **Summary**

---

**Introduction – The Aging Population**

Statistics as of July of 2004 showed that there were 36.3 million people over the age of 65 in the United States. Predictions are that by the year 2050, there will be 87.6 million people over the age of 65. This is an increase from 12% of the population to 21% of the population. As the population ages, even with alternatives present such as assisted living and home care, nursing home usage is still expected to increase. Those who live in nursing homes will have increased disability. This disability is most seen in impairment of activities of daily living such as walking, bathing, grooming, toileting, and other essential skills. One fourth of nursing home residents need assistance with one or two of these skills and three fourths require help with even more of these essential skills. Compounding these impairments are mental illnesses, problem behaviors, dementia and other complex conditions. Statistics show that 50 to 70% of nursing home residents have some type of dementia diagnosis. Additional statistics project that the actual number of dementia residents will double in the next 15 years. These types of compounding impairments magnify the disability already seen in the elderly population and cause a further loss of function. Over one half of these individuals who enter a long term care facility, will remain in long term care for a year or longer. Medicaid and Medicare bear the brunt of the cost of this care. Since the advent of the prospective payment system, payment for nursing home care is based on the actual amount of care required. Therefore, the more care that a person requires, ie the greater
the functional limitation, the greater the cost to Medicare and Medicaid. (AGS
Foundation 2005) Dorothy Dunlop, Ph.D. states,

“High economic, societal, and personal costs from functional limitation among older
adults, makes the prevention of functional problems an important public health issue."
(Dunlop, 2005, p. 1274)

The Centers for Medicare and Medicaid Services (CMS) must redefine the nature of
health care. With the population aging at a rapid pace, CMS must look at meeting all the
needs of their beneficiaries within a limited amount of resources. In the mid 90’s, CMS
instituted what is called the Medicare Health Outcomes Survey (HOS). This process was
initiated to look at ways to ensure not only quality of care but also efficiency of care.
The major goal was to look at how healthcare can not only improve, but also maintain the
quality of healthcare for Medicare/Medicaid beneficiaries and then to develop programs
to help older adults to maintain their function, even in the presence of chronic illness such
as arthritis, coronary artery disease, and diabetes. (Jones, 2004) While the information
from this study was mainly utilized for maintaining the health of individuals so they may
remain in the community, it has principles for those of us who are helping to manage the
care of residents who are in an inpatient setting. Therapists have the responsibility of
helping our clients, even in the face of chronic illness, maintain their functional abilities.

A study was published in 2006, which investigated the relationship between the loss and
decline of strength, balance, coordination, flexibility and other physical components of
individuals in long term care facilities, with the loss of independence and the loss of
quality of life. It is noted that although deterioration of physical skills are a normal part
of aging, those individuals who reside in long term care facilities are at increased risk for
this decline. The study looked at what physical components are essential for maintaining
independence in mobility and activities of daily living. The main purpose of the study
was to identify physical components that could be modified or changed and therefore
reduce the speed with which age related changes occur. This was then correlated with
the implementation of simple exercise programs that assisted in maintaining those skills.
The areas of physical function that were identified as “essential” to develop/maintain in a
long term care facility were coordination, muscle strength and flexibility. (Singh, 2006)
This is important information to those of us working in long term care facilities as a
decline in these essential elements of function will affect the individual’s ability to
participate in activities such as walking, bathing, toileting, eating, grooming and other
skills. The question remains, is this decline avoidable?

**Avoidable Decline**

An important piece of legislation that has implications for this topic is The Omnibus
Budget Reconciliation Act of 1987 (OBRA) which was born out of a national effort to
reform the quality of care in nursing homes. The overall message in this legislation hinges on the idea that a nursing home has the responsibility to care for residents in a way that promotes their quality of life by providing “services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident”. (D’Antonio-Nocera, p. 104) Even though 1 out of 5 deaths that occur in the United States occur in long-term care facilities, the modern nursing home should not be defined as a place to go to die. Regulations stemming from OBRA 1987 state that it is the responsibility of a nursing home to prevent “avoidable decline”. Surveyors are trained to hold long-term care facilities to the standard of not assuming that just because of age or even chronic illness, that decline is inevitable. One example given in an article contained in the journal the Annals of Long Term Care, is that of an individual with degenerative joint disease in the lower extremities. The nursing facility is not to assume that ambulation will decrease, i.e., that it is unavoidable, just because of the arthritis. One of the ways this is enforced is by the survey process. So how does the surveyor determine whether a decline is avoidable or not? They will ask questions such as, “Were appropriate assessments completed and risks identified?” Was this translated into a care plan and were risk factors addressed? Was the care plan followed by the staff? Was the care plan re-evaluated and modified as appropriate? It is the answer to these questions that determines whether the decline was avoidable or not. The expectation is that the facility should “aggressively” pursue all channels to maintain the resident’s status and avoid decline. It is only considered to be unavoidable, even in the case of a progressive illness, if all efforts were made to maintain the resident’s status. (Lawhorne, 1999)

This has significance for all healthcare providers in a nursing home including Nursing, Dietary, Activities, and yes, Therapy. Why does this have significance for therapists as we study the need and relevance of functional maintenance programming for our residents? Therapists have both an economic responsibility as well as a social responsibility to help the elderly individual maintain their functional independence as long as possible and to avoid decline. One of the ways to accomplish this is through developing maintenance programs for our residents. This course will give therapists a process for developing Functional Maintenance Programs for the clients they serve. The information that follows is based on clients seen in the long-term care facility, however, the principles can be adapted and applied to home care, assisted living, and other arenas where therapists serve the elderly population. Throughout the course, the Functional Maintenance Program will also be referred to as an “FMP”.

What Does Medicare Say About Skilled Therapy and Maintenance Programs?

We have seen some of the rationale for the importance of delivering services to our clients to assist them in maintaining their functional skills. Before we look at how to develop an FMP, we must first look at Medicare regulations and guidelines to see if this service would be considered a “skilled” service. Under section 220.2 of the Medicare Benefit Policy Manual (Reasonable and Necessary Outpatient Rehabilitation Therapy...
Services) which governs our practice in the long term care setting, the regulation states (words in bold print by this author);

“While a beneficiary’s particular medical condition is a valid factor in deciding if skilled therapy services are needed, a beneficiary’s **diagnosis or prognosis should never be the sole factor in deciding that a service is or is not skilled**. The key issue is whether the skills of a therapist are needed to treat the illness or injury, or **whether the services can be carried out by nonskilled personnel**. See item C for descriptions of skilled (rehabilitative) services.

There **must be an expectation that the patient’s condition will improve significantly in a reasonable (and generally predictable) period of time, or the services must be necessary for the establishment of a safe and effective maintenance program required in connection with a specific disease state**. In the case of a progressive degenerative disease, service may be intermittently necessary to determine the need for assistive equipment and/or establish a program to maximize function (see item D for descriptions of maintenance services);” (CMS Manual, p.167)

There are a few important items to note in this guideline. First, it is important to note that diagnosis alone should never be a stand alone factor in determining whether or not a client needs our services. For example, if a resident enters a long term care facility with a diagnosis of status post knee replacement and an order for therapy services, do they “automatically” need therapy services? Of course not. It is up to the therapist’s evaluation of the resident’s needs that determine whether the skills of a therapist are required (i.e., the services needed cannot be carried out by a non-skilled individual). By the same token, if a resident with Alzheimer’s Disease enters a long term care facility, the progressive degenerative diagnosis alone of AD should also not “rule out” the individual’s need for therapy services. Again, a screen/evaluation of the resident’s needs and whether they can be carried out only by the skills of a therapist or by non-skilled personnel is the basis for our decision regarding therapy services. (*Note that understanding what our skilled services are and documenting skilled services are an important aspect of the FMP treatment process and are dealt with later on in this course.)

The second important item to note in the above guideline is the condition of a significant improvement in a reasonable amount of time. Although what is defined as significant can be a somewhat “gray” area, Medicare does give some definition for therapists in how to document significant change, for example,

- A change in level of assistance required (includes both physical and cognitive assistance) – Example: change from mod to min assist in dressing
- A change in response to treatment within each assistance level (increased consistency, increased generalization, decreased refusals, decreased aggressive or destructive behaviors) – Example: resident remains at min assist with chair to bed transfers but with increased consistency in remembering safety instructions.
A change in accuracy – Example: resident increased from 50% to 75% on word naming (CORF Manual Section 502)

This definition of significant change challenges therapists in 2 ways: 1) During our evaluation we must make a prediction of the resident’s potential for improvement 2) We must make a prediction of whether that change will be “significant”. If our answer to both of those questions is “yes”, then skilled services are most likely indicated. But what happens if our answer to one or both of those questions is “no”? Does that indicate that no therapy services are required? If we continue to read in the above guidelines we will see that there is a provision for determining whether our skilled services are necessary to develop a maintenance program. So, the next question we must ask ourselves is 3) Are skilled therapy services necessary for the development of a safe and effective maintenance program? To begin to determine this we must look at when and for whom maintenance programs are necessary.

When and For Whom Is A Maintenance Program Necessary?

First, let’s look at what CMS regulations say concerning maintenance programs. They tell us something about both when a program is necessary and who they are necessary for. The CMS Benefit Policy Manual states,

“Maintenance Programs
During the last visits for rehabilitative treatment, the clinician may develop a maintenance program. The goals of a maintenance program would be, for example, to maintain functional status or to prevent decline in function. The specialized skill, knowledge and judgment of a therapist would be required, and services are covered, to design or establish the plan, assure patient safety, train the patient, family members and/or unskilled personnel and make infrequent but periodic reevaluations of the plan. The services of a qualified professional are not necessary to carry out a maintenance program, and are not covered under ordinary circumstances. The patient may perform such a program independently or with the assistance of unskilled personnel or family members.
Where a maintenance program is not established until after the rehabilitative therapy program has been completed (and the skills of a therapist are not necessary) development of a maintenance program would not be considered reasonable and necessary for the treatment of the patient’s condition. It would be excluded from coverage under §1862(a)(1) of the Act unless the patient’s safety was at risk (see below).” (CMS Manual, p. 170)

“Evaluation and Maintenance Plan without Rehabilitative Treatment. After the initial evaluation of the extent of the disorder, illness, or injury, if the treating qualified professional determines the potential for rehabilitation is insignificant, an appropriate
maintenance program may be established prior to discharge. Since the skills of a therapist are required for the development of the maintenance program and training the patient or caregivers, this service is covered.” (CMS Manual, p. 170)

In looking at these guidelines we should note 3 important things about the “When” of maintenance programming. A maintenance program may be established:

1) When a skilled rehabilitation program is nearing completion and your goal is to maintain the skills/function acquired during the skilled treatment and to prevent an avoidable decline. The program should be developed in conjunction with the last treatment sessions where progress is being made and not added on as an additional week of treatment at the end of skilled therapy.

2) When the resident has a screen/evaluation and it is determined that the potential for improvement (as defined above) is insignificant, then a maintenance program may be indicated.

3) When an existing FMP is no longer appropriate and adjustments need to be made.

In relation to Who may be appropriate, there are 3 types of persons for whom a maintenance program established by the therapist may be necessary:

1- The resident who is at risk for a functional decline and preventing that decline requires the specialized skill, knowledge and judgment of a therapist (As may be the case with progressive degenerative diseases such as Parkinson’s Disease, Huntington ’s Disease, etc…)

2- The resident for whom maintaining their functional status might require the specialized skill, knowledge and judgment of a therapist. (Instances might include residents with complexities such as dementia, mental illness, chronic arthritis, COPD, etc…)

3- The resident who has potential to improve, but that potential is anticipated to be slow or “insignificant”. (May be appropriate for either a Maintenance or Restorative program)

Now that we know when and for whom an FMP may be appropriate, we must develop systems for identifying those residents. The next section will address the identification process.

Identifying Residents Appropriate For Maintenance Programming

In following the above guidelines that CMS has outlined for maintenance programming,
let us look at different types of residents that we commonly see in the long term care setting that may require skilled services in the form of an FMP:

- **Resident with Progressive Degenerative Disease** (Includes: Alzheimer’s Disease, Lewey Body Disease, Multi-Infarct Dementia, Pick’s Disease, Huntington’s Disease, Parkinson’s Disease, ALS, Creutzfeldt-Jakob Disease, and others) – Residents in the long term care setting that have a progressive degenerative disease are at risk for decline due to the nature of their illness. For example, a resident with a long standing diagnosis of Multiple Sclerosis may have issues with fatigue, balance, coordination, incontinence, pain, and cognitive changes just to name a few. Typical occupational or physical therapy interventions may include mobility training or energy conservation principles. Because cognitive changes are also a part of the disease process, the individual may have difficulty remembering to continue using the energy conservation techniques during their ADL’s or the proper way to utilize the mobility aide. An FMP may be appropriate to teach/train the caregivers in the energy conservation and mobility techniques and how to cue the resident in their use. Another example might be a resident with Alzheimer’s disease. This resident may have issues with basic ADL care or utilizing a walker due to poor short term memory, sequencing difficulties, and communication problems (aphasia). An FMP might be indicated to train caregivers in how to lay out clothing, or where to place the walker, or how to gives cues to the resident for it’s use.

- **Other residents at risk for decline due to a specific disease state** (ex. Degenerative Joint Disease, Chronic Mental Illness, COPD/Emphysema, CHF, Diabetes etc...) In is not unusual for a resident in long term care to have complexities that may interfere with maximal function or the retention of skills. One study looked at the IADL skills and ADL skills of individuals with arthritis over a 2 year period. It was noted that there was a decline in functional abilities of these individuals. The greatest risk factor for this functional decline was a lack of regular physical activity. Arthritis is a very common occurrence in the elderly. Statistics show that 60% of people over 65 have some form of arthritis. The study concluded that engagement in regular physical activity reduced the risk of functional decline in ADL / IADL skills by over one third! The physical activity that was utilized in this study consisted of endurance and strengthening exercises. The study stated that since regular physical activity is something that can be changed or modified, and can make such a significant difference, it should be included in the plan of care for those we are serving. (Dunlop, 2005) Although there are some opportunities for physical exercise that are built into the life of a long term care facility (activity programming), these may not be individualized or complex enough to meet the needs of some residents at risk for decline. Therefore, in some cases, it may be appropriate to develop a specific exercise program to serve the needs of an individual with degenerative joint disease. Another example might be the resident with the complexity of a chronic mental
illness who may benefit from a structured schedule and adapted cueing strategies for ADL care. For example, the resident may need a daily and or weekly personal hygiene written schedule. In addition, he might benefit from environmental changes that cue him to utilize needed supplies.

- **Resident with a potential for Slow improvement** in ADL (Eating, Dressing, Bathing, Grooming, Toileting), Cognition/Orientation, Balance, Ambulation, ROM, Strength, Coordination, Endurance, Bed Mobility, Transfers, Communication Devices and techniques, Voice clarity, Ability to Understand, etc… In order to conserve resources, CMS states that progress must be made in a reasonable amount of time. For some resident’s there is a possibility that we may see slow improvement in skills with the right interventions and techniques. For example, a resident may experience some increase in ambulation with staff trained to ambulate the resident at various intervals throughout the day. Or communication skills might be somewhat improved if staff were trained to complete word finding drills during self care tasks with the resident. This could be incorporated into maintenance or possibly a restorative program which will eventually become a maintenance program.

- **Resident that has cognitive decline / impairment that interferes with function, safety and/or quality of life** and would benefit from modified cueing strategies, sensory modulation, environmental adaptation, adapted task structure, etc… There are many illnesses seen in the long term care setting that have a cognitive component of disability and may require specialized strategies in the form of an FMP. Some of these are listed above in the category of progressive degenerative disorders but there are other illnesses that may cause a type of dementia or cognitive impairment that interferes with function, safety and quality of life. Let’s take a moment to look at some of those diagnoses commonly seen and their particular cognitive impairment. These include but are not limited to:

  - **Parkinson’s Disease** (Brain disorder or central nervous system disorder) – The main effects of Parkinson’s Disease are seen in the motor realm but there are cognitive components to the disease such as problems with attention, impulse control, prioritizing, evaluating information, interpreting social cues, time awareness, slowing of thought, and short term memory disturbances.

  - **Cerebral Vascular Accident (CVA)** – During a stroke the blood flow to the brain is compromised, causing brain cells to die and cognitive changes can occur. Depending on where the damage occurs, the cognitive challenges are different. In left-sided hemiplegia cognitive challenges include judgment difficulties, impulsive style, and an unawareness of their own impairments which may lead to safety issues. In right sided hemiplegia (where we see aphasia) residents may exhibit slowed thought processes and therefore may need frequent instruction and feedback to complete tasks. Both right and left sided hemiplegia can show signs...
of memory difficulties such as shortened retention spans, difficulty in learning new information and problems in conceptualizing and generalizing.

**Transient Ischemic Attacks (TIA)** – A TIA is sometimes called a mini-stroke. In other words, it is a stroke that lasts for only a few seconds or minutes, but again, during those few moments the blood supply to the brain is compromised. A person who suffers multiple TIA’s can show signs of confusion and memory changes which can even lead to a type of dementia.

**Huntington’s Chorea** – Huntington’s Chorea is an inherited disorder which causes cell loss in the brain leading to physical, emotional and cognitive changes. Some of the cognitive changes include problems with attention, executive function, visual-spatial processing, abstract reasoning, and memory.

**Multiple Sclerosis (MS)** – MS is thought to be an autoimmune disorder where the body, in a sense, attacks itself. During this process, the myelin covering over the nerve cells are destroyed. Fifty percent of people with MS will develop some degree of cognitive dysfunction, which affects the individuals ability to think, reason, concentrate or remember.

**Alzheimer’s disease (AD)** – AD is a progressive brain disorder that research has shown to be related to plaques and tangled bundles of fibers in the brain. The result is a gradual deterioration of brain tissue. Cognitive decline is progressive with decreasing memory and ability to learn and reason, make judgments, communicate and carry out daily activities.

**Lewy Body Disease** – In this illness, proteins are found in an area of the brain stem where they diminish the neurotransmitter dopamine. The person will develop some Parkinson-like symptoms but also develops a type of dementia which is characterized by memory and language difficulties as well as problems with judgment and reason.

**Traumatic Brain Injury (TBI)** - A TBI occurs when there has been an injury to the head. It can be mild to severe and cause motor as well as cognitive impairments. Common cognitive impairments are difficulty with organization, concentration, impulse control, and memory.

**Alcoholism** - Brain damage is a common and potentially severe consequence of long-term, heavy alcohol consumption. It can lead to severe memory problems where information cannot be retained for more than a few seconds.

**Mental illnesses** such as Schizophrenia, Bipolar Disorder, Major Depression - In a mental illness there is a difficulty in how the brain works and processes
information (having nothing to do with intelligence), and therefore this presents some cognitive challenges for these individuals. For example in Schizophrenia there may be problems with attention, certain types of memory, and the executive functions that allow us to plan and organize. An individual with Bipolar Disorder may have difficulty concentrating, poor judgment, racing or slowed thought process and difficulty making decisions. And a resident with major depression may have difficulty with thinking, concentrating and remembering. (Leikin, 2003)

In cases where cognitive decline is occurring, it may be necessary for the therapist to look at the unique cognitive needs of that client and evaluate the impact that these deficits have on the ability to perform mobility tasks, ADL tasks and communication tasks. Then a determination would be made as to whether the individual would benefit from strategies such as modified cueing, sensory modulation, environmental adaptation, adapted task structure, or other strategies to assist in maintaining participation in these skills. Simple descriptions of some of these strategies are listed:

**Environmental analysis and adaptation**

**Decreasing distractions in the environment**

Analyzing - Looking at the various stimuli in an environment, all the things that are competing for your attention visually, auditory, even smells at times. In addition, looking at the frequency and intensity of the various stimuli and whether it is predictable or not. That could mean removing items that they don’t use from their sink top, or decreasing the number of overhead pages, or turning off the TV during self care.

**Increasing the number of clues in the environment**

Adapting - Examples would include putting objects in plain view (or even within 14 to 18 inches from eye level), putting striking visual cues in the environment such as labeling drawers, putting a sign up that reads to use the call light when needing help, putting yellow tape on the areas where hands are placed on a walker, marking things that may be safety hazards (putting red tape on the hot water knob for ex) writing out a shower or grooming schedule, hanging appropriate clothing together on the same hanger, or using a written schedule for daily living tasks (including leisure pursuits)

**Task analysis then design of task gradation, simplification and structuring**

This would include taking an activity and breaking it down into parts that the resident can accomplish. For some residents that might mean one step directions at a time, others can complete a larger part of the task at one time. Or it may mean changing the task to make it simpler – Deciding if the task / skill can be done a different way that would make the resident more successful. Or it could
mean structuring the task, for example, to do the task at a certain time every day or to define tasks/activities that are cognitively appropriate to the resident.

**Identify Modified Cueing Strategies** (Providing the appropriate level of assistance in cueing)

Does the individual needs cues to participate in the task / skill? What are the most appropriate cues for the individual - verbal, visual, tactile? Do they need to be given in combination? Do they need to be given constantly, consistently, intermittently? What are the communication techniques that work for the particular resident such as, speaking in short phrases, waiting 10-15 seconds for a response, or asking the resident if they need assistance instead of assuming they don’t require assistance if you don’t hear from them?

**Determine sensory processing patterns and implement modulation strategies**

Oftentimes these strategies can be used to effect a reduction in behaviors that are interfering with function and safety. Examples might include:
- Sit in a rocking chair or glider
- Listen to music (use headphones)
- Chew gum
- Provide fidgets/hold a weighted item
- Structured walking
- Abdominal breathing/relaxation tapes/guided imagery

Examples might include a resident with cognitive decline who can still participate in transfers with modified cueing and transfer strategies. Train the STNA to complete stand-pivot transfers on the count of three using “echo” counting and tactile cues before standing. Another example might be a resident with cognitive impairment who has difficulty scooping food, is distracted while eating and is a choking risk. This resident may still be able to participate in the feeding task by turning off music in the dining room, removing extra utensils from her tray, using adapted spoon and plate and then training staff in the set-up cueing for proper swallowing strategies. It is important to note that while many residents with cognitive decline will benefit from similar strategies, it may not be appropriate for all residents with cognitive decline and therefore a good screening process is necessary.

- **Resident that is experiencing behaviors that interfere with function and/or safety** and would benefit from modified cueing strategies, sensory modulation, environmental adaptation, adapted task structure, etc… Behavior problems are a common occurrence in long term care facilities. Behavior problems can affect both a resident’s functioning and their safety. An example of behavior affecting functioning might be a resident with COPD who experiences anxiety attacks during her shower because of the increased difficulty breathing in a humid environment. Therefore she resists her showers. Can her shower be structured to
occur first, before the shower room is too humid? Can the STNA be trained in appropriate breathing techniques and how to cue her in their proper use during her shower? Can the STNA be trained in energy conservation techniques and how to structure her morning routine to allow for rest breaks? An example of behavior affecting safety might be a dementia resident who is combative during care. Does the STNA need training in how to approach the resident, how to use validation communication techniques, how to give her something to hold during the task, to play soft music during the bath? The skills of the therapist may be necessary to determine the appropriate cueing strategies, environmental set-up, and sensory experiences to decrease the combative behavior and to maintain resident safety.

- **Resident with poor activity participation and has difficulty / inability to structure own leisure** – There are many residents with poor activity participation in a long term care facility that would not be appropriate for the development of an FMP. However, there are residents who may have poor participation due to lack of appropriate assistive equipment, lack of cognitive ability to structure own leisure, or in the case of a chronic mental illness, lack of motivation. This may be an area that the skills of a therapist may be necessary to train facility staff in activities appropriate to cognitive level, appropriate to physical level, or assisting a resident to identify and structure participation as may be necessary in the case of chronic mental illness.

- **Resident with limited ability / opportunity to interact with environment that is at risk for sensory deprivation and would benefit from structured opportunities to interact with environment** – This is generally the resident that is very low functioning and bedbound. For this reason a sensory program may be established to assist with eliciting movement, eliciting vocalizations, promoting relaxation or stimulating alerting responses, and increasing awareness of the environment. Sometimes a resident with severe vision and hearing loss is also a candidate for structured opportunities to interact with the environment that can be incorporated into a functional maintenance program.

- **Residents who exhibit excess disability (functioning lower than abilities) d/t complex medical conditions** (Dementia, Chronic Mental Illness, Pain, etc…)
  One author defines excess disabilities as “symptoms that are disproportionate to the underlying pathology so that the level of impairment is greater than one might expect given the person’s actual…disease. Things that contribute to excess disability might include caregiver expectations, the environment or task set-up or even physical variables such as pain or shortness of breath.” (Corcoran, 2001) For example, a resident with COPD that has difficulty breathing when performing morning ADL’s and therefore has the STNA complete her ADL’s for her, might benefit from an FMP where staff is trained in task segmentation and how to cue
for breathing techniques. Residents with cognitive disability are also at risk for excess disability. It is often difficult for staff to determine what the resident is able to do independently, and therefore it is not unusual for the STNA to “take over” in a care area that, with proper cueing and set-up, the resident may be able to do on their own. The University Hospitals of Cleveland state that in the treatment of Alzheimer’s Disease, “a major goal of the overall treatment plan should be the prevention of excess disability. This can be achieved by minimizing adverse drug effects and by maximizing caregiver skills and knowledge.” (University Memory and Aging Center, 2006) An FMP is one way for the therapist to determine and teach the proper strategies to the staff to prevent excess disability.

- **Resident at risk for skin breakdown / contractures due to reduced mobility or poor positioning** – This is the resident who is bedbound or the resident who is seated in a geri-chair, or wheelchair, or the resident with limited mobility in their extremities. Developing a plan / schedule for positioning, adaptive equipment and range of motion and training staff is crucial to these residents.

So let’s review, residents that may require the skills of a therapist to design an FMP would be:

- Resident with Progressive Degenerative Disease (Includes: Alzheimer’s Disease, Lewey Body Disease, Multi-Infarct Dementia, Pick’s Disease, Huntington’s Disease, Parkinson’s Disease, ALS, Creutzfeldt-Jakob Disease)
- Other residents at risk for decline due to a specific disease state (ex. Degenerative Joint Disease, Chronic Mental Illness, COPD/Emphysema, CHF, Diabetes etc...)
- Resident with a potential for Improvement (but it will be slow) in ADL(Eating, Dressing, Bathing, Grooming, Toileting), Cognition/Orientation, Balance, Ambulation, ROM, Strength, Coordination, Endurance, Bed Mobility, Transfers, Communication Devices and techniques, Voice clarity, Ability to Understand, etc…
- Resident that is experiencing behaviors that interfere with function and/or safety and would benefit from modified cueing strategies, sensory modulation, environmental adaptation, adapted task structure, etc…
- Resident that has cognitive decline / impairment that interferes with function, safety and/or quality of life and would benefit from modified cueing strategies, sensory modulation, environmental adaptation, adapted task structure, etc…
- Resident with poor activity participation and has difficulty / inability to structure own leisure
- Resident with limited ability / opportunity to interact with environment and is at risk for sensory deprivation and would benefit from structured opportunities to interact with environment
- Residents who exhibit excess disability (functioning lower than abilities) d/t complex medical conditions (Dementia, Chronic Mental Illness, etc…)
• Resident at risk for skin breakdown / contractures due to reduced mobility or poor positioning

This information can be organized into a screening tool to help with identification of appropriate candidates.

Additional Resources For Identifying Residents in Need of Maintenance Programming

1- The Minimum Data Set (MDS): The Minimum Data Set is a part of the comprehensive assessment process in the long term care setting. It is a tool for gathering information on the resident’s status in the following areas:

Identification and Background Information
Cognitive Patterns                  Health Conditions
Communication/Hearing Patterns     Nutritional Status
Vision Patterns                    Dental Status
Mood and Behavior Patterns         Skin Condition
Psychosocial Well-Being            Activity Pursuit Patterns
Physical Functioning and Structural Problems Medications
Continence Special Treatments and Procedures
Disease Diagnoses

Each of these areas has a listing of subtasks underneath which further define the resident’s function at any given point in time.

The MDS, therefore, becomes a “snapshot” of the resident’s status and it is completed at least quarterly. In this way, a resident’s status may be tracked and changes in status are noted. (Uniack, 1996) For this reason, it can be a useful tool for therapists in helping to identify residents who may benefit from maintenance programming. Here is a look at some of the sections and information that may be helpful to therapists:

MDS Section B. Cognitive Patterns

This section identifies whether the resident is comatose, if they have memory impairment, how cognition affects daily decisions, how their thinking processes vary and whether or not there has been a change in their cognition over the past 3 months. The therapist can ask, “Would this resident (if comatose) benefit from a structured program to increase sensory experiences/interaction with the environment?” “Does this resident have cognitive impairment that interferes with function, safety and/or quality of life and
would benefit from modified cueing strategies, sensory modulation, environmental adaptation, or adapted task structure?"

MDS Section C. Communication Patterns
   This section identifies hearing and vision difficulties / severity, devices used for communication and the resident’s ability to make them understood or to understand others. The therapist can ask “Is this resident at risk for decline or have the potential for slow improvement in communication techniques, clarity, and / or ability to understand?”

MDS Section E. Mood and Behavior Patterns
   This section identifies behaviors associated with anxiety or depression as well as behaviors that might impair safety such as verbal and physical aggression, wandering, disruptive behaviors and resistance to care. The therapist can ask, “Does this resident have behaviors that are interfering with their safety or their function and would modified cueing strategies, sensory modulation, environmental adaptation, or adapted task structure help the resident’s behaviors improve?”

MDS Section F Psychosocial Well-Being
   This section may assist in identifying individuals who have difficulty structuring their own involvement in individual and group activities as well as other involvement in facility life. The therapist can ask, “Is this resident unable to structure their own leisure and would benefit from assistance in structuring their day?”

MDS Section G Physical Functional and Structural Problems
   This section assists in identifying individuals requiring assistance with bed mobility, transfers, ambulation, dressing, eating, toileting, grooming, and bathing. In addition, some other important items contained in this section are balance, range of motion, and assistive equipment utilized. Finally, there is information that tells the therapist if the staff or the resident believes that the resident is capable of increased independence in Activities of Daily Living. The therapist may ask, “Is this resident at risk for decline or have the potential for slow improvement in areas of mobility or ADL function?” “Is this resident exhibiting excess disability?”

MDS Section I Disease Diagnoses
   This section notes diagnoses that have a relationship to, in part, ADL function, cognitive function, and mood and behavior function. The therapist can ask, “Does this resident have a progressive degenerative disease and does not have a functional maintenance program established?” Does this resident have another specific disease state (for example, degenerative joint disease) that would benefit from a program to maintain ADL, mobility or cognitive functioning?”

MDS Section J Health Conditions
   This section notes some important factors for the therapist. Dizziness, shortness of breath, pain and stability of conditions are all listed in this section. The therapist can
ask, “Does this resident have unstable health conditions in addition to pain / SOB and would benefit from a program to maintain their participation in mobility skills or ADL skills?”

2 - Staff Interviews as a Resource
Another resource that can assist the therapist in identifying residents who may benefit from maintenance programming is the long term care staff. The following is the list of questions that the therapist can ask. (These are not all inclusive of course, but just a few to get you started!)

Questions to ask Nursing/STNA’s when determining residents who may need your services:

In asking about Activities of Daily Living skills -
1- Do you have to help him/her more than you used to with their ADL’s?
2- Tell me how you have to help him/her to __________.
3- Do they get the items they need without assistance?
4- Do they have to be reminded to ________?
5- Are they resistant to care? (I.e.; are they combative/aggressive during care?)
6- Are they neglectful of their own care? (I.e.; do they refuse to bathe or get dressed?)
7- Do they ask for help when they need it?
8- Do they ask for the supplies they need?

In asking about balance/posture/ambulation/transfers-
1- Do they have more difficulty walking than they used to?
2- Do they walk down the center of the hallway without assistance?
3- Do they walk down the side of the hallway and hold on to the handrail?
4- Do they walk/sit in a stooped posture?
5- Do they have more difficulty getting up from chairs? Getting in and out of bed?
6- Do they use their walker correctly?

In asking about behaviors-
1- Do they receive prn’s frequently?
2- Do they have behaviors that cause them to lash out at others? That causes others to lash out at them?
3- Have their behaviors recently increased?
4- Do they wander into unsafe areas?

Questions to ask Activities:

1- Do you have residents with recent changes in their activity participation?
2- Do you have residents who have behaviors during your activity?
3- Do you notice any resident that is having difficulty participating in a favorite leisure activity? What is interfering with their function? (i.e. can’t pick up Bingo chips, can’t use the scissors)

4- Do you have a low functioning resident that you are having difficulty meeting their activity needs?

Again, this list of questions is not all-inclusive but can give you a start in identifying residents with possible therapy needs.

**Evaluation and Treatment Planning for Maintenance Programs**

Once you have identified residents that will benefit from an FMP, there are certain items to keep in mind as you complete the evaluation. In the Medicare Benefit Policy Manual, therapists are given guidelines as to what information is important to include in the evaluation and treatment planning. The evaluation should include:

1- Documentation supporting illness severity or complexity
2- Documentation supporting medical care prior to the current episode
3- Documentation required indicating beneficiary health related to quality of life
4- Documentation required indicating beneficiary social support
5- Documentation required indicating objective, measurable beneficiary physical function (Medicare Benefit Policy Manual, Chapter 15)

And,

“The plan of treatment must contain the diagnosis, the type, amount, frequency, and duration of skilled rehabilitation services to be performed, and the anticipated skilled rehabilitation goals. The plan of treatment should be sufficiently detailed to permit an independent evaluation of the patient’s specific need for the indicated skilled rehabilitation services and of the likelihood that the patient will derive meaningful benefit from them.” (CMS, Chap 12, p.7) Some tips for documentation on your evaluation would include:

- Relate Diagnosis/ICD-9 code to a specific disease state – Make sure that you are identifying the major illness that you are treating
• List all complexities, and where it is not obvious, describe the impact of those complexities on the resident’s functioning at someplace on the evaluation.

• Make clear the reason that skilled intervention is required. It should not be “to develop an FMP”. That is part of you treatment plan but it is not the reason that skilled intervention is required. Instead it should either refer to, for example:

  - a potential for slow improvement in function (mobility, ADL, Communication, etc…) or
  - risk for decline in ADL, Mobility, Communication, etc… or
  - decreased / impaired function and/or safety related to impaired cognition, behavioral episodes, limited ability to interact with environment, poor activity participation, or
  - exhibits excess disability due to complex medical conditions, or
  - at risk for skin breakdown / contractures, etc…

• During your assessment of Mobility / ADL / Communication related concerns, make sure your evaluation includes objective measurements as well as any information that affects the skill area you plan to address. Information that would be important to include would be pain, shortness of breath, cognitive issues that interfere, behavioral issues that interfere, etc…For example, if resident is exhibiting behavioral symptoms that interfere with bathing (i.e. verbal/physical aggression when pressed to perform, isolating/low motivation, resistance to care/non-compliance) be sure to include that in your evaluation including the amount of times it occurs – Multiple times daily, daily, 3-5 times a week, etc…. CMS is placing more emphasis on objective measures for comparison to show progress. (Medicare Benefit Policy Manual, Chapter 15) Even where progress is not the goal, as is the case with a maintenance program, objective measures are still important to establish the level of impairment affecting function. For example, if cognition is an issue, utilize a measurement tool that defines their cognitive performance. Or, if pain or SOB is interfering with function, utilize a tool that defines their level of pain or shortness of breath.

Examples of tools might include:
  Cognitive Scales-
  Allen Cognitive Battery including the Allen Cognitive Level Screen ACLS, Routine Task Inventory RTI, Allen Diagnostic Module ADM and the Cognitive Performance Test (Allen Cognitive Network, 2008)
  Global Deterioration Scale GDS (Reisberg, 1982)
  Functional Assessment Staging Tool FAST (Reisberg, 1988)
  Skin Integrity
  Braden Scale for Predicting Pressure Sore Risk (Society of Hospital Medicine 2004)
Endurance Scale
   Berg Perceived Exertion Scale (Centers for Disease Control, 2007)
   Shortness of Breath Visual Numeric (Stanford Patient Education Research Center)

Pain Scales
   Faces Pain Scale (Society of Hospital Medicine, 2004)
   Numeric Rating Scales (Society of Hospital Medicine, 2004)
   Visual Rating Scales (Society of Hospital Medicine, 2004)
   Verbal Descriptor Scale (Society of Hospital Medicine, 2004)

General Physical/ADL Scales
   Disability Rating Scale (Wright, 2000)
   Physical Self Maintenance Scale (Society of Hospital Medicine, 2004)
   Performance Oriented Mobility Assessment (Society of Hospital Medicine, 2004)
   Timed Get Up and Go Test (Society of Hospital Medicine, 2004)

Most of the above are simple scales and, along with other assessment tools, can be used to establish the level of impairment affecting function.

- Defining amount of assistance required: Most therapists are well aware of the need to document levels of assistance required. However, therapists must remember to document cognitive as well as physical assistance required during the evaluation. It is not uncommon to see a PT, for example, document the number of feet the resident ambulated using a walker with contact guard assist. What is sometimes left out of that measurement is that the therapist needed to tap the walker in the correct area that the hand needed placed and that the resident needed verbal directions throughout the task. In other words, what is left out of that measurement is the amount of cognitive assistance required. Cognitive assistance is most often documented by defining the number of cues given (min – mod – max), as well as the type of cue given (verbal – visual – tactile).

Assistance can therefore be described by OT/PT/ST as:
   Independent (no physical or cognitive assistance required)
   Standby physical assist to max physical assist with cognitive assist defined by one or a combination of the following type cues –

   Min-Mod-Max verbal cues
   Min-Mod-Max visual cues
   Min-Mod-Max tactile cues

   Total Assist (cognitively and physically dependent in task)
So, the finding may read, “Resident ambulates with walker 25 feet with contact guard physical assist, min tactile cues and max verbal cues.”

For the Occupational Therapist, Medicare has built the definitions of cognitive assistance into their documentation language as follows:

“If the goal for a patient is to increase functional abilities and to decrease the level of assistance needed, **the initial evaluation must measure the patient's starting functional abilities and level of assistance required.**

a. **Change in Level of Assistance.**--Document assistance levels by describing the relationship between functional activities and the need for assistance. Within the assistance levels of minimum, moderate, and maximum, there are intermediate gradations of improvement based on changes in behavior and response to assistance. Document improvements at each level. Compare the current cognitive and physical level achieved to that achieved previously. While the need for cognitive assistance often is the more severe and persistent disability, the requirement of physical assistance often is the major obstacle to successful outcomes and subsequent discharge. Document the levels as follows:

**Total Assistance.**--The need for 100 percent assistance by one or more persons to perform all physical activities and/or cognitive assistance to elicit a functional response to an external stimulation.

Total assistance is required if your documentation indicates the patient is only able to initiate minimal voluntary motor actions and that the skill of an occupational therapist is required to develop a therapeutic program or to implement a maintenance program to prevent or to minimize deterioration. A cognitively impaired patient requires total assistance when your documentation shows external stimuli are required to elicit automatic actions such as swallowing or responding to auditory stimuli. Document what OT skills are needed to identify and apply strategies for eliciting appropriate, consistent automatic responses to external stimuli.

**Maximum Assistance.**--The need for 75 percent assistance by one person to physically perform any part of a functional activity or cognitive assistance to perform gross motor actions in response to direction.

A patient requires maximum assistance if your documentation shows that maximum OT physical support and proprioceptive stimulation is needed for performance of each step of an activity every time it is performed. Document the specific need for OT proprioceptive stimulation or one-to-one demonstration by the occupational therapist due to lack of cognitive awareness of other people or objects in the environment.

**Moderate Assistance.**--The need for 50 percent assistance by one person to perform physical activities or constant cognitive assistance to sustain/complete simple, repetitive activities safely.
Document that your patient requires moderate assistance by indicating that moderate OT physical support and proprioceptive stimulation is needed for the patient to perform a functional activity, every time it is performed. Submit records that state how a cognitively impaired patient, at this level, requires intermittent one-to-one demonstration or intermittent cuing (physical or verbal) throughout the performance of the activity. Moderate assistance is needed when your documentation indicates that the therapist/caregiver needs to be in the immediate environment to assist the patient through a sequence to complete a functional activity. Document how this level of assistance requires a halt to continuing repetition of a task and to what extent assistance is needed to prevent unsafe, erratic or unpredictable actions that interfere with appropriate sequencing.

**Minimum Assistance.**--The need for 25 percent assistance by one person for physical activities and/or periodic, cognitive assistance to perform functional activities safely.

A physically impaired patient requires minimum assistance if your documentation indicates that activities can only be performed after physical setup by the therapist or caregiver, and if physical help is needed to initiate or sustain an activity. Document any review of alternate procedures, sequences and methods that may be required. A cognitively impaired patient requires minimal assistance if your documentation indicates the patient needs help in performing known activities to correct repeated mistakes, to check for compliance with established safety procedures, or to solve problems posed by unexpected hazards.

**Standby Assistance.**--Is the need for supervision by one person for the patient to perform new activity procedures that were adapted by the therapist for safe and effective performance.

A patient requires standby assistance when errors and the need for safety precautions are not always anticipated by the patient.

**Independent Status.**--No physical or cognitive assistance is required to perform functional activities.

Indicate in your documentation that patients at this level are able to implement the selected courses of action, consider potential errors, and anticipate safety hazards in familiar and new situations.

b. Change in Response to Treatment Within Each Level of Assistance.--Document significant improvement in a patient's condition. Indicate any change in one or more of the following categories of patient responses within any assistance level.

For the cognitively impaired patient, document refusal to perform that escalates into aggressive, destructive, or verbally abusive behavior if the patient is pressed by the therapist or caregiver to perform. In these cases, consider a reduction in these behaviors significant. However, you must still document these behaviors. Include the skilled OT provided to reduce the abnormal behavior.” (CORF, Section 503, pp.5-75 to 5-77)
Therefore an OT finding could read, “Resident able to dress self with min physical assist and mod physical and verbal cues to sequence.” Or “Resident can dress self with min physical assist and mod cognitive assist.”

Documentation of assistance levels is very important for our discussion of functional maintenance programs, for both the design and the carryover of the program. It is not uncommon to discharge someone from therapy, only to have the individual not be able to maintain the same level of function with the direct care staff. Sometimes that breakdown is in the details of the cueing strategies. What are the skilled strategies that we are using in therapy to enable that resident’s performance? In designing the program, the therapist must be able to identify the least amount of assistance required (cognitive and physical) in order to maintain resident independence and then they must be able to communicate how to implement that assistance (cognitive and physical) to the staff for proper carryover. This is of utmost importance in functional maintenance programs as staff education is the main component.

- In summarizing evaluation findings, make sure to indicate why your skilled services are necessary, for example, Resident will benefit from skilled services to maintain __________________ utilizing __________________ (compensatory strategies, modified environment, adapted task structure and modified cueing strategies, assisted exercise program, etc…)

- Estimated Duration of Treatment – Generally an FMP can be developed in 3 to 7 visits, of course this is based on the individual needs of the resident.

- Determination of Anticipated Goals – From your evaluation findings, you will need to develop anticipated goals. Since the duration of the treatment is very short, any long term goal established will indicate what general skill you hope to maintain. Short term goals will indicate the specific skill you will work on, the establishment of a functional maintenance program in relation to skill maintenance and the training of caregivers. Examples of evaluation goals might be:

  LTG:
  Resident will maintain current level of physical mobility and reduce complaints of pain

  STG:
  Resident will complete UE exercise program with set-up assist and intermittent verbal cues.
  Establish functional maintenance plan to maintain functional mobility and reduce complaints of pain
  Train resident/caregiver in safe/effective performance of FMP with 100% accuracy in return demonstration
LTG:
Resident will decrease resistance to ADL care that interferes with function and safe performance

STG:
Resident will bathe self with supervision assist and written / verbal reminders of schedule
Establish functional maintenance plan to facilitate max participation in bathing/grooming tasks and reduce behaviors
Resident/Caregivers will demonstrate 100% proficiency in carry out of FMP

Treatment Progress Notes For Maintenance Programs

The most important thing to remember when documenting treatment is to indicate the skilled service you are providing. That can be done in a daily note or in your weekly or discharge note (as this will occur about the same time).

- Make sure that your progress notes (whether daily or weekly) and your discharge notes include the “skilled” intervention provided. In looking at the Medicare Benefit Policy Manual’s description of skilled therapy, words such as evaluate, establish, design, identify, assess, analyze, implement, instruct, compensate, train, determine, develop, restore, and assure safety are used to describe a therapist's skilled service. (Medicare Benefit Policy Manual, Chapter 15) Although this only partly describes the skilled service you are providing, these would be important words to include in your documentation. For example, skilled treatment noted in your documentation may include things like:

  Development of exercise / ROM programs
  Training in Gait, Functional Mobility, Speech Production
  Instruction in safe transfer techniques, UE/LE Exercise techniques, Oral Motor Exercises, etc…
  Assure safe swallowing techniques, transfer techniques, bathing techniques, etc…
  Implementation of positioning strategies
  Identification of assistive equipment
  Teaching of Compensatory Strategies and Techniques
  Training of Caregivers (FMP, Restorative, Individual or Family instruction) – *Documentation should include caregiver competency demonstrated
  Analysis of environment
  Adaptation of environment
  Task analysis for feeding skill
  Assessment of task structure during dressing
  Design of task gradation, simplification and structuring
Developing the Maintenance Program

FMP Form/Delivery Record – There must be some type of form developed to contain the FMP goal, frequency of delivery, approaches and interventions, and any special considerations. The following is a breakdown of important aspects contained on the FMP form:

- FMP should state the problem or need. For example, the problem may be risk for decline in ADL function, or risk for decline in ambulation, or risk for decline in orientation.
- FMP should contain measurable goal. That goal would most likely be the goal that you had on your evaluation that is now carried over to the maintenance program. Sample goals might include:

  Resident will demo alerting response when presented with auditory/tactile stimuli ___% of time to promote interaction with the environment.

  Resident will remain alert with eyes open for 50% of structured activity with appropriate sensory strategies.

  Resident will sit appropriately positioned in supported sitting for ________ (period of time) ___ times per day.

  Resident will assist with rolling in bed (during self care) with consistent verbal, visual and tactile cues.

  Resident will receive PROM to LE daily to reduce risk of contractures.

  Resident will move arms/legs/trunk in response to cues to assist with dressing ___% of time with intermittent verbal and tactile cues.

  Resident will participate in UB dressing task with max verbal, visual and tactile cues.

  Resident will engage in structured activity/task for _____ minutes at regular intervals throughout the day.

  Resident will ambulate _____ feet with periodic cues to scan for obstacles
Resident will complete simple grooming task (comb hair, brush teeth, wash face) with set-up assist, environmental adaptation and intermittent verbal cues.

Resident will perform safe transfers from wheelchair to other surfaces with consistent verbal cues for safety sequences (locking wheelchair brakes, nose over toes, etc…)

Resident will participate in 2 structured activities daily to decrease wandering behavior and increase safety.

Resident will complete AROM for UE/LE with mod verbal cues to initiate and intermittent tactile cues to sustain motion.

Resident will reduce resistance to care/combative/agitated behaviors from daily to intermittent with adapted environment and cueing strategies.

Resident will demo ability to use lists/schedules with intermittent verbal cues to participate in ADL routines/HEP.

Resident will complete HEP with SBA and intermittent cues to start, stop and count.

Resident will effectively utilize memory aids to compensate for memory loss to complete self care tasks.

Resident will exhibit < 3 behavioral episodes per week with appropriate redirection and environmental and sensory modification to increase personal safety.

Remember, these are only sample goals and all goals should be specific to your resident and their particular needs.

- An FMP will contain frequency. The frequency may be anywhere from 1-7 days a week. Most programs will need to occur more than 1 or 2 days per week, but there may be times when a limited frequency is appropriate. The duration of the program is also variable. It may last only 5 minutes or as long as 30 minutes (especially in the case of a group program - groups should be no more than 4 residents to one staff).
- An FMP will contain clear approaches and interventions to achieve the desired goal. In addition to the actual task/performance skill you will teach the staff, you may need to include approaches that assist the resident in correct and safe performance. Some sample approaches:

To gain resident trust, begin your interaction socially
Get the resident’s attention before giving an instruction by ____________
Place only needed supplies out
Make sure items that you intend for them to use are placed directly in front of the resident
Place the item you want the resident to use in their hand
Lay out __________________ in visible location and position from left to right in order of use.
Give directions by giving only one step at a time
Provide min – mod - max verbal cues of _______________________________
Provide min – mod – max visual cues of _________________________________
Provide min – mod – max hands on (tactile) cues of ______________________
Allow 10-15 seconds to respond to instructions and cues before repeating
Limit the number of choices given
Allow 2 to 3 times the normal length to do task
Minimize distractions in the environment such as excess noise, excess supplies, etc…
Utilize specific environmental cue of __________________________________
Encourage a daily routine for __________ see attached routine and/or suggested activities
Exhibits poor safety awareness so provide regular safety checks to the environment to check for __________________
Place ________ supplies in a consistent place and in plain sight
Provide occasional verbal cues to _________________________________
Has difficulty remembering safety directions so remind the resident to _______
Provide supervision and verbal prompts to attend to details such as ____________
Check back _____ times during the performance of _________________ to ensure thoroughness/ask if they need help
Instruct _______________ using Demonstration / Slow pace and repetition
Refer resident to use memory aid: (specify) __________________________
Requires management of ________________ behaviors. Strategy that most often works ______________________________________
Signs of over stimulation may include _____________________________
Caregiver Instructions for Lower Level Residents:
Utilize the following sensory stimuli to promote awareness/interaction with the environment:
  Sight ________________________________
  Touch _______________________________
  Sound _______________________________
  Smell ________________________________
Hold visual items 12 to 18 inches from face
Place items in hand and assist resident to hold
Speak to resident in low, calm voice
Watch for signs that the resident is more alert (eyes open, facial movements, moving arms or legs, making sounds, head turn, etc…)
Watch for signs that the resident is more relaxed (decreased muscle tone, slower breathing patterns, relaxed facial muscles, etc…)
Positioning while in bed ____________________
Positioning while in supported sitting (geri chair or wheelchair) ______
Provide passive ranging to ____________ during ____________________
Help to initiate movement by: __________________
Provide hand over hand assistance to __________________
Cue to raise arms legs to assist with ______
Cue to “bridge” to assist in LE care/dressing
Encourage resident to “echo” counting to 3 during transfers
Give resident plenty of time to respond to directions
Break directions into very small parts, such as __________________
To assist resident to remain alert during activity/task ______________
Provide rest periods by ____________________

Remember, these are only samples and all interventions need to be individualized to the resident. Do not overwhelm the caregiving staff with too many instructions or interventions. Note special considerations for cueing/approaches in performing functional tasks. For example, resident might not like to be touched, so instruct staff to refrain from tactile cues. Or a resident may not like to be approached with a directive such as, “You need to take your bath now.” Instead, you might instruct the staff to begin the interaction socially, before offering the bath.

(Some goals/approaches formulated with information gained from Understanding Cognitive Performance Modes 1995)

- FMP should clearly state any special considerations or precautions staff should look for. Examples: SOB, behavioral patterns or concerns, edema to be watching for, physical changes such as reddened areas or other skin color changes.
- Signature of staff that have been trained
- Additionally, some FMP forms will contain a record of the delivery of the program. This is usually found in the form of a grid where days of service delivery can be initialed by the responsible staff.

In review, remember that the maintenance program should be resident centered, in other words, it is based on what the resident needs to maintain his or her ability level to function. It should clearly state what the problem or need is. Next, goals should be formulated to address the problem or need. The FMP will also state a frequency that is based on that particular resident. Then a detailed description of how to carry out the program should be defined. Include all the
specific approaches and interventions that will assist the resident in achieving his/her goal. Be sure to include any precautions or special considerations and have staff that you have trained sign the program.

A sample program might look something like this:

## Functional Maintenance Program

<table>
<thead>
<tr>
<th><strong>Resident Name:</strong></th>
<th>John Doe</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Problem:</strong></td>
<td>Resident has low UE muscle tone, consistent complaints of pain and is at risk for decreased mobility in UE’s.</td>
</tr>
<tr>
<td><strong>Goal:</strong></td>
<td>Resident will complete UE exercise program with set-up assist and intermittent verbal cues.</td>
</tr>
<tr>
<td><strong>Approaches and Interventions:</strong></td>
<td>Resident will complete the following exercises</td>
</tr>
<tr>
<td></td>
<td>Exercise 1 – XXXXXXXXXXXX</td>
</tr>
<tr>
<td></td>
<td>Exercise 2 – XXXXXXXXXXXX</td>
</tr>
<tr>
<td></td>
<td>Exercise 3 – XXXXXXXXXXXX</td>
</tr>
<tr>
<td></td>
<td>Encourage resident to count out loud to assist with focus and remembering number of repetitions</td>
</tr>
<tr>
<td></td>
<td>Watch for signs of exertion such as shortness of breath</td>
</tr>
<tr>
<td></td>
<td>Cue resident to take a rest break</td>
</tr>
<tr>
<td></td>
<td>Give verbal cues to stop if rating of pain is more than ___ on pain rating scale</td>
</tr>
<tr>
<td><strong>Frequency:</strong></td>
<td>3-5 times a week for 15 minutes</td>
</tr>
</tbody>
</table>

| **Staff Trained:**  | __________________________ |
|                     | __________________________ |
|                     | __________________________ |

| **Therapist Signature:** | __________________________ |
| **Date:** | ________________ |
Who Carries Out the Maintenance Program?

There are a few different options of who can carry out this type of a functional maintenance program:

**First**, the FMP can become a part of the regular Restorative Program. The Resident Assessment Instrument (RAI) Version 2.0 defines nursing rehabilitation/restorative care as “interventions that promote the resident’s ability to adapt and adjust to living as independently and safely as possible. This concept actively focuses on achieving and maintaining optimal physical, mental, and psychosocial functioning.” (RAI Manual, p. 3-191)

In order to be considered restorative care, the following must be incorporated into the plan:

- Measurable objectives and interventions must be documented in the care plan and in the clinical record.
- Evidence of periodic evaluation by licensed nurse must be present in the clinical record.
- Nurse assistants/aides must be trained in the techniques that promote resident involvement in the activity.
- These activities are carried out or supervised by members of the nursing staff. Sometimes, under licensed nurse supervision, other staff and volunteers will be assigned to work with specific residents.
- This category does not include groups with more than four residents per supervising helper or caregiver. “ (RAI Manual, p. 3-192)

Restorative can include both traditional restorative programs (where the goal is slow improvement) as well as maintenance programs (where the goal is to maintain function and/or prevent decline). The program can be administered by a restorative nursing aide or by other facility staff as appropriate. (see above guidelines) In order to actually code the minutes as restorative on the MDS, the program must be delivered for at least 15 minutes in a 24 hour period – this can be broken up into more than one session in that 24 hour time frame. (RAI Manual, Version 2.0)

**Secondly**, the maintenance program can be carried out by other members of the nursing staff. The direct care STNA can be trained to carry out the program. For example, the STNA could be trained in range of motion exercises to perform during the morning ADL routine. Another example might be training the resident’s STNA to ambulate the resident to the dining room for meals, similar to a walk to dine program. Or the STNA may be trained in swallowing techniques to be utilized / cued during a feeding program. A simple program such as this can be invaluable in maintaining a resident’s ability to walk, eat, or move their extremities to participate in dressing. Therapists must be careful to make the program simple and mindful of time constraints. In other words, the therapist
will not get good follow-through by facility staff if we are asking them to add an extra 30 minutes to the ADL routine of one resident.

**Thirdly**, other members of the facility staff can be trained to carry out a functional maintenance program. The most common use of other facility staff, are the activity staff. An FMP can be designed to train the activity personnel in a sensory stimulation program for a low functioning resident. Another example would be to develop and train staff to utilize cognitively appropriate normalization tasks for a dementia resident. When a program is designed, you will need to train the activity staff and have them demonstrate proficiency in the carry out of the program.

**Follow-up of Maintenance Programs**

Once a resident is discharged with an FMP, it becomes a nursing program. If it is discharged to a restorative program, the restorative nurse would oversee the program and make minor adjustments as necessary. If it is discharged to a direct care STNA, whatever nurse(s) oversee that aide’s resident assignments would have the responsibility of general supervision of the program. If it is discharged to activity or other LTC staff, someone would need to be assigned to oversee the program. That does not mean that therapy is not involved anymore. Therapy should have channels of communication set up so that any questions or concerns can be addressed. Formally, however, a routine quarterly screening by therapy of the patient should always involve a review of the current FMP measures in place. The screening should determine if the FMP is effective and if it is being complied with accurately. If there has been a decline in function or if the program is not meeting the needs of the resident then a re-evaluation may be necessary.

**Setting Up Maintenance Programs In Your Facility**

In speaking with many therapists, lack of follow through of a maintenance program is one of the major concerns. It is such a concern, that many therapists are hesitant to begin such a program. Unfortunately, if we take this attitude, it is the residents who will suffer by not receiving the needed care. There are a variety of reasons for lack of follow through, insufficient training, programs that are too complicated or too time consuming, but one of the main reasons is often a lack of communication. So, before you experience this frustration, talk with your facility team members who will be asked to carry out your plan:

**Administrator** – The Administrator should be aware of the program purpose and goals. Generally, they will not have any formal responsibility in regards to the program.
Director of Nursing – The DON is the most important person to get “buy in” from. You need to discuss the benefits of the program both to the residents and to the nursing staff. Emphasize that the goal of the program, which is to maintain resident’s functional abilities, will assist in reducing the burden of care for the direct care staff. Make sure he/she understands that the programs will be designed with the time constraints of the direct care staff in mind.

Restorative and Other Nursing Staff – Obviously, if the FMP’s are going to be under the restorative program, the restorative nurse will need a detailed description of the program and its goals. It will be their responsibility to oversee the programs once they are discharged from therapy. All nurses should be aware of the program and it’s goals as they will see their resident’s involved in various programs and will have a role in general overseeing of the program. If the direct care STNA’s are completing programs, the nurses would oversee that program as they do all other care given the resident.

STNA’s – Hopefully, therapy can have a role in the overall in-servicing of the direct care staff to describe the program and its goals. Again, make sure that you reassure the staff that the programs will be realistic and understandable and ultimately, benefit both the staff and the residents. Make sure that there is an avenue of communication established between nursing and therapy so that if there are any questions or concerns with the programs, they can be addressed quickly.

Other Staff – If you plan to utilize other LTC staff, such as activity staff, make sure that you communicate the purpose and goals of the program to them, as well as devise systems for on-going communication and dialogue.

MDS Nurse – It is important that the MDS nurse is aware of the programs so that they can be incorporated onto the resident care plan. Any resident who has a FMP should have that indicated on their care plan.

Therapy will need to be involved in both initial and ongoing in servicing!

Summary
The population is aging at a rapid pace and the actual number of people with disability, both physical and cognitive, is expected to increase. There is a high price tag to be paid for the care of those individuals with disability. The Center for Medicare and Medicaid Services is focusing on both quality and efficiency of care. They are looking for ways to both improve and maintain function in the elderly population. Therapists who serve the elderly population must look at their role in preventing and managing disability, even in the presence of chronic illness. Therapists have skills to determine what can be modified or changed in order to maintain mobility and activities of daily living skills for their clients. Also, therapists have skills to help maintain things such as strength, coordination and flexibility that aids in the retention of independence in function. Therapists then, through designing programs that address these areas, can teach others how to assist elderly clients in the maintenance of these skills. CMS recognizes the therapists’ role in designing maintenance programs and they have built into their regulations some guidelines for this type of skilled therapy. First, they have charged the long term care facility with the responsibility to prevent avoidable decline in the people that they care for. All efforts are to be made to maintain the resident’s status. One of the interventions that can be made is to involve therapy as indicated to assist in designing maintenance programming. Generally, “skilled” therapy must produce a “significant change” in the resident’s functional status, however, understanding the importance of assisting residents to maintain their functional status and avoid decline, CMS has made provision for the skilled service of designing maintenance programs for indicated resident’s and teaching caregivers how to carry out those programs. In addition, there are guidelines in place as to when a program can be developed and also who benefits from this type of programming. A variety of diagnoses and “at risk” individuals may be appropriate for an FMP but it is up to the therapist to design tools to identify those residents. In addition, other resources are available in the long term care setting that can assist in identifying residents that have difficulty maintaining skills and are at a high risk for decline. Two of those resources noted are the Minimum Data Set and the care giving staff. Once residents that will benefit from a maintenance program have been identified, the therapist must perform the evaluation. The evaluation should include some important information including diagnoses, complexities, reason for skilled intervention, and inclusion of objective assessments. In addition, it is very important to properly assess the amount of assistance needed, taking care to note the cognitive as well as the physical assistance required for each skill. This is critical for proper carryover of skills. Since progress in
treatment is not the goal, treatment progress notes will reflect the skilled service you are providing as well as the training given to caregivers. It is essential that you properly document the skilled services you are providing and the impact this has on the resident performance. When the actual program is developed, it should be placed on a form that specifies the problem, the goal(s), the frequency of the program, and approaches and interventions that are specific to the task performance. Three options were discussed for who can carry out the FMP program: the restorative staff, the STNA, or other facility staff as appropriate. Appropriate training and follow-up should also occur. If you are just beginning to develop and implement functional maintenance programs in your facility, you will need to work with all members of the interdisciplinary team to create a structure for the program before beginning. It is worth the effort, however, as the Functional Maintenance Program can become an integral part of the care of many of our clients.

Bibliography:


Corcoran, Mary, PhD, OTR/L, FAOTA. Occupational Therapy Practice Guidelines for Adults With Alzheimer’s Disease. American Occupational Therapy Association, Inc. 2001.

Dunlop, Dorothy D., Ph.D.,1,2 Pamela Semanik, Ph.D.,2,3 Jing Song, M.S.,2,4 Larry M. Manheim, Ph.D.,1,2 Vivian Shih, M.D.,4,6 and Rowland W. Chang, M.D., M.P.H. Risk Factors for Functional Decline in Older Adults with Arthritis. (2005). Arthritis and Rheumatism 2005 April; 52(4): 1274–1282. PubMed


