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OT Professionals and Home Health 101

Build knowledge and confidence to work in the home health setting as an OT professional.
Excellent for therapists new to home health or seasoned therapists needing a refresher.

Krista Covell-Pierson OTR/L, BCB-PMD

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Learning Outcomes

1) Identify the stakeholders and their roles in home health

2) List five ways to incorporate caregivers into the OT treatment process

3) List three strategies to enhance home health documentation

2

CONTINUED

What is Home Health?

According to Wikipedia:

Home care is supportive care in the home. Care may be provided by licensed professionals who provide medical treatment needs or by professional caregivers who provide daily assistance to ensure the activities of daily living (ADLs) are met. In-home medical care is often and more accurately referred to as home health care or formal care. Often, the term home health care is used to distinguish it from non-medical care, custodial care, or private-duty care which refers to assistance and services provided by persons who are not nurses, doctors, or other licensed medical personnel.

According to Medicare.gov, home health care is a wide range of health care services that can be given in the home for a person experiencing an illness or injury. Home health care is usually less expensive, more convenient, and just as effective as care in a hospital or skilled nursing facility (SNF).

3

CONTINUED

Stakeholders

What is a stakeholder?

A person with an interest or concern in something, especially a business.

- Denoting a type of organization or system in which all the members or participants are seen as having an interest in its success.

Who are the stakeholders in home health?

- Client/Caregiver
- Agency
- The Public and Regulators
- Payers

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Clients and Caregivers

Clients and caregivers have a stake in the home health process because their health and well-being is affected. They expect care and services that will enhance their quality of life.

Because Medicare is the largest provider for HH services in the US, beneficiaries are typically over 65 or permanently disabled and unable to work.

- In 2013, 30% of clients receiving HH were 85 and older, 32% were between 75-84, 24% were between 65-74 and only 14% were under 65.

OTs working in HH can expect a majority of their clients to be older adults.

Data compilation allows us to know what the majority of HH clients may be dealing with medically. OTs will receive information on the client's primary diagnosis before the evaluation. The primary diagnosis best describes why home health services are medically required and is typically the most acute issue for a client at the time of referral.

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Clients and Caregivers

In 2013, the most common primary diagnoses of Medicare beneficiaries in HH included:

–Diabetes

–Heart failure

–Essential hypertension

–Chronic ulcer of the skin

–Osteoarthrosis and allied disorders

–Cardiac dysrhythmias

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Clients and Caregivers

These 6 diagnoses totaled 34.9% of the primary diagnoses in HH.

- However, HH clients typically experience more than one health diagnosis.
- Approximately 50% of clients enrolled in home health care were in an acute setting prior and
- 1 in 4 clients receiving home health care services are hospitalized during their care.

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CONTINUED

How does OT relate to this stakeholder?

OT professionals work with clients to improve their quality of life, facilitate engagement in meaningful occupations, improve safety for the clients and caregivers. OTs can provide support and guidance to caregivers in charge of managing chronic health care concerns and issues.

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CONTINUED

Agencies

Agencies have a stake in home health because they are in business and need to follow rules, regulations and need to provide interventions that are acceptable and beneficial to clients.

Agencies hire OTs to work full or part time or on a per-diem basis. OTs can also contract services with home health agencies.

Agencies expect OTs and other members of the healthcare team to follow regulations, policies and procedures in order to provide quality and appropriate care.

OTs should advocate for their role in the home health team to protect the hiring of OT..

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CONTINUED

Agencies

Regulations do not require agencies to have OT on staff as they do nursing, PT, and SLP. OT professionals must advocate for their important role in home care.

OTs can provide:

- Occupational profiles and performance assessments
- Activity analysis
- Can improve data accuracy
- Can improve outcome measures
- Specialists in occupations like ADL's, IADL's, rest and sleep, leisure, work, play, socialization, etc.

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CONTINUED

How does OT relate to this stakeholder?

OT professionals working with agencies are expected to know the regulations and payer requirements that inform the companies policies and procedures and must advocate for OT in the home health setting.

OTs have a similar stake in the home health care's success as the agencies.

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Public and Regulators

Public monies are used for Medicare and Medicaid therefore the public has a stake in the success of home health practices.

Regulators investigate the use of the public monies to ensure quality, appropriate services are being provided and are in place to protect the public at large.

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How does OT relate to this stakeholder?

OTs are expected to understand and adhere to rules and regulations as a minimum requirement for reimbursement and for the good of the public.

OT professionals may be expected to participate in a survey which is a process provided by regulators to ensure the home health agency is following the rules and regulations and upholding the good of the community at large.

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CONTINUED

Payers

Typically home health services are paid for via a third party. This may be Medicare, Medicaid or other insurance program.

Payers have a stake in the home health process to insure they are paying for services appropriately and that services provided are the most cost-effective options with expected good, clinical outcomes.

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CONTINUED

How does OT relate to this stakeholder?

OTs and their home health agencies can be affected by the payers in a positive or negative way. If an agency does not follow the regulations of a payer, the agency may jeopardize payment from the payer. This can impact the OTs employment and the sustainability of the agency. OT professionals must be accountable for knowledge of the rules and regulations of the payers.

There is not a large amount of research based on OT in the home and clinical outcomes so it is important for the OT to demonstrate in documentation the rationale for treatment interventions.

OT professionals are encouraged to participate in research on small or large scales to help support OTs involvement in home care.

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CONTINUED

Payers versus Regulators

OT professionals must understand the difference between the rules and regulations of the payers versus the regulators. They may, or may not, have the same directives.

OTs should feel empowered to ask for support from their agencies in the rules and regulations that must be followed. Agencies should be able to provide policies and procedures for OTs to follow. OTs can work with agencies to develop policies and procedures.

Always advocate for adherence to rules and regulations, ethical practice, and do not participate in unethical practices!

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CONTINUED

Recap of Stakeholders

Clients and Caregivers

Agencies

Payers

Public and Regulators

All entities should be seated at the table and every voice needs to be heard!

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CONTINUED

Important Discussion Points for OTs in Home Health

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CONTINUED

- Caregivers
- OTs and the OASIS
- OTs and opening a home health case
- Autonomy
- Supplies
- Documentation
- Primary diagnosis versus conditions
- Supervising COTA's and aides
- Homebound status
- Case conferences
- Communication
- Scheduling

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Caregivers are an important part of a treatment plan

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Caregivers are an important part of a treatment plan

- Develop problem solving skills
- Set up “formal” training with caregivers
- Respect relationships, cultures, spiritual needs, history, values and morals of the client/caregiver team
- Customize training to incorporate the person/context needs of clients and their caregiver(s)
- Focus on safety
- Reduce caregiver burden
- Increase efficiency for the client and caregiver
- Provide disease education
- Provide homework
- Provide handouts
- Demonstrate and ask for return demonstrations
- Listen to the client and the caregiver
- Report abuse!

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Aim to satisfy the client and caregiver

All home care agencies receiving payment from Medicare are required to use the Home Health Consumer Assessment of Healthcare Providers and Systems (HHCAHPS). This measures the client's and caregiver's perception of care.

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Aim to satisfy the client and caregiver

According to Medicare:

Experience is not the same as satisfaction

Patient experience surveys sometimes are mistaken for customer satisfaction surveys. Patient experience surveys focus on how patients experienced or perceived key aspects of their care, not how satisfied they were with their care. Patient experience surveys focus on asking patients whether or how often they experienced critical aspects of health care, including communication with their doctors, understanding their medication instructions, and the coordination of their healthcare needs.

CAHPS surveys follow scientific principles in survey design and development. The surveys are designed to reliably assess the experiences of a large sample of patients. They use standardized questions and data collection protocols to ensure that information can be compared across healthcare settings. CAHPS surveys are developed with broad stakeholder input, including a public solicitation of measures and a technical expert panel, and the opportunity for anyone to comment on the survey through multiple public comments period through the Federal Register. Finally, many CAHPS measures are statistically adjusted to correct for differences in the mix of patients across providers and the use of different survey modes.

https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/CAHPS/

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OASIS (Outcome and Assessment Information Set)

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OASIS (Outcome and Assessment Information Set)

- Required by all Medicare contracted home health agencies at certain times
  - Start of care
  - If a client transfers to inpatient
  - When care resumes after the patient was in inpatient care
  - Recertification
  - At change of condition
  - If the client dies during home care

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OASIS and OT

OTs can not establish eligibility for home health under Medicare Part A at the start of care

- OTs can establish eligibility for other payers at the start of care
- OTs can complete the OASIS at all other times it is required
- OTs are expected to collaborate on the OASIS with all disciplines throughout all clients' care

OASIS Manuals can be found online

- https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/HHQIOASISUserManual.html

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OASIS and OT

Some areas of the OASIS that an OT may participate in include:

- Pain
- Incontinence
- Dressing the upper body
- Dressing the lower body
- Vision
- Bathing
- Toileting
- And MORE
- OT's, PT's, RN's and SLP's look at things differently. OTs should be proactive to ensure documentation is consistent.

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CONTINUED

Autonomy is expected

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CONTINUED

Autonomy is expected

OTs will likely set much of their own schedule within agencies' expectations

- Evaluations and treatments will often be completed without another professional present
- Creativity is a must
- Communication is key to success
  - Healthcare team
    - PT's, RN, LCSW, SLP's, COTA's, OTR's, MSW's, CNA's, etc.
  - Outside of the agency
    - Physicians, hospitals, outpatient agencies, community resources
  - To management

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Autonomy is expected

(Communication Continued)

OTs should plan to communicate with physicians and other healthcare team members:

- After every evaluation
- For all updates in the plan of care
- Concerns
- Collaboration

More more more!

Document your efforts

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Supplies

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Supplies

- Device for documentation
- Phone
- GPS
- HIPPA compliant programs
- Blood pressure cuff
- Gloves
- Secure bag
- Treatment equipment
- Tape measure
- Adaptive equipment
- Durable medical equipment

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Supplies

Suggestions to request or provide:

- AE for people to trial
  - Reachers, walkers, etc.
    - Must be able to disinfect
- Markers
- Paper
- Colored tape
- Safety pins
- Paperclips
- Stapler
- Thumbtacks
- Puff paint
- Bump dots
- Goniometer
- Hand outs
- Plastic bags
- Scissors
- Assessments
- Hole punch
- Yarn
- Non-skid material
- Community resources
- Office on Aging guide
- Get creative!

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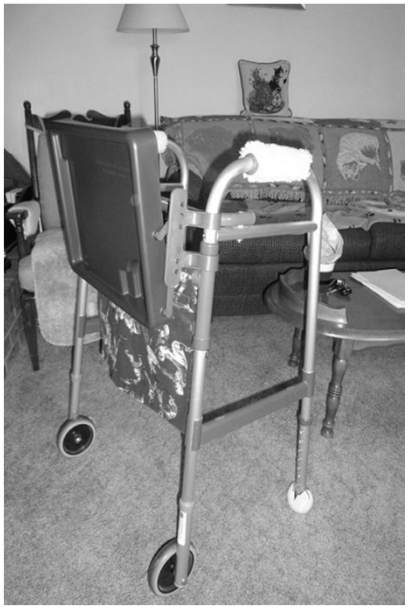

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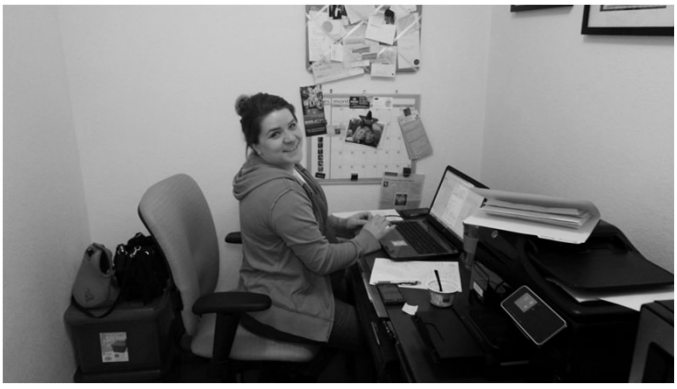
Documentation



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Documentation

- Electronic documentation systems are likely
- Evaluations
- Daily notes
- Recerts
- OASIS participation

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Evaluation

- Person and Caregiver
  - Cognition
  - Pain
  - Safety
  - Hearing
  - Reporting history
  - Patterns
  - Movement
  - Community access
  - Mood
  - Routine
  - Goals
  - Social support

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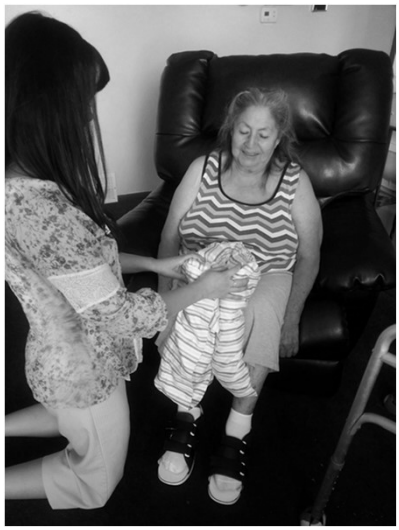

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Evaluation

- Context
  - Bathroom
  - Clutter
  - Food
  - Access
  - Safety concerns
  - Equipment
  - Clues!

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Evaluation

Performance

- Transfers
- Mobility
- Execution of ADL
- Initiation of ADL
- Awareness
- Fatigue
- Safety

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Evaluation: Diagnosis and Conditions

Both must be included in the OT evaluation and treatment plan.

Diagnosis: Client is an 84 year old male with Type 2 Diabetes.

Conditions:

- Macular degeneration
- Recent death of wife
- Two cats
- Lives above daughter's garage in apartment
- Does not drive
- Chronic back pain
- PTSD related to military experience
- History of R foot wound
- Arthritis
- Constipation
- Urinary incontinence
- Insomnia
- History of falls
- Neighbor checks on client daily
- Daughter travels a lot for work and can not help consistently
- Uses a walker
- Has a chair lift system to access his apartment

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CONTINUED

Diagnosis versus Condition

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CONTINUED

Evaluations and Goals

- Goal setting
  - Consider what improvements can be made
  - Analyze the amount of time to accomplish the improvements
  - Identify what occupations will be improved
  - Determine how to increase safety
- Select goals that will allow the client to be safe, maximize performance and live at home.
- Consider additional resources after home health ends. Outpatient, caregivers, community engagement.

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Evaluations and Goals

- Goals should be objective, functional and measurable
- Include an anticipated date the goal will be met
- Short-term and long-term goals are appropriate
- Treatment plan should explain the therapist's rationale
- Consider self-management of chronic conditions with goal-setting and treatment planning
- Analyze the sustainability of the interventions
- Include all assessments in the chart--not just the score
- Include all handouts in the chart that were given to the client

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Evaluations

Establish a realistic duration and frequency

- Understand your certification period
- Determine how many weeks are available for OT and do not recommend past that (if needed a recertification can be done)
- Set an appropriate amount of visits for the treatment plan
- Communicate the evaluation results to the physician and follow agency policy

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CONTINUED

Documentation

- Daily notes:
  - All visits require a daily note
  - Updating the plan of care can occur at any time
    - Contact the physician per agency policy
- Reassessments:
  - All plans of care must include a reassessment at least every 30 days
  - Does not require a complete re-evaluation

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CONTINUED

Discharge

- Discharge planning begins at evaluation
- Home health care is not intended to be long-term
- Criteria for discharge should be described
- Referrals are important!
- Know your community

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Supervisory Role

OTs may supervise aides and/or COTA's in a home health setting

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OTs and OT Assistants

OTR

- Completes evaluations
- Works with clients and caregivers
- Develops plan of care
- Completed reassessments
- Updates goals as needed
- Delegates, supervises and communicates to assistants and aides

COTA

- Completes standardized assessments as assigned by the OTR
- Communicates with OTR timely and regularly
- Works with clients and caregivers

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Supervising an Aide

- Primary role of an aide in home health is to assist with ADL's
- If a client is receiving RN services the aide will be supervised by the RN. If the client is not receiving RN services the aide can be supervised by a PT, SLP or OT.
- Frequency of the aide should coordinate with the changing performance of the patient in OT.
- Aide services discharging before OT will allow the OT to determine if goal status has been met.
- Communication is key

OTs can empower the aides and should listen to the aides, provide support and direction, can provide care together as appropriate.

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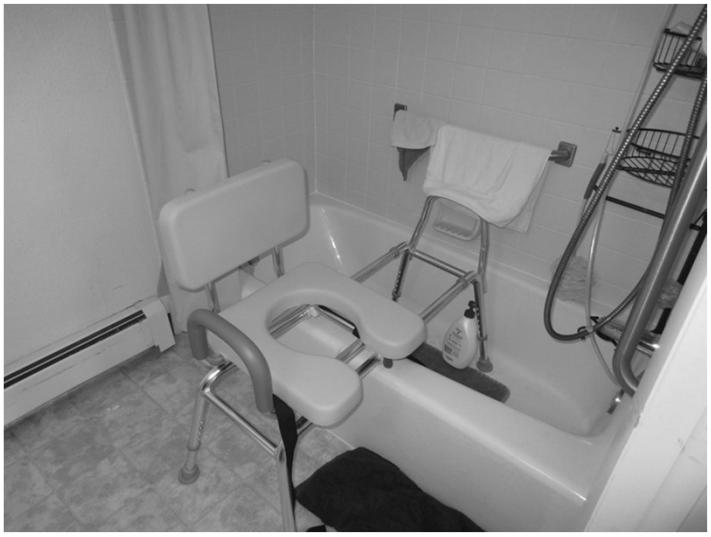

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Homebound Status

CMS's definition:

Normally unable to leave home unassisted. To be homebound means that leaving home takes considerable and taxing effort. A person may leave home for medical treatment or short, infrequent absences for non-medical reasons, such as a trip to the barber or to attend religious service. A need for adult day care doesn't keep you from getting home health care.

1.Criteria-One: The patient must either: - Because of illness or injury, need the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person in order to leave their place of residence OR - Have a condition such that leaving his or her home is medically contraindicated.

If the client meets Criteria-One, then the client must also meet two conditions in Criteria-Two.

2. Criteria-Two: - There must exist a normal inability to leave home; AND - Leaving home must require a considerable and taxing effort.

AND – Absences from the home are infrequent, of relatively short duration, or to receive medical care

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CONTINUED

Care Coordination Meetings

- Enhances communication
- Team members likely clinical and non-clinical
- Discuss clients performance and needs
- Promote OT to teammates
- Identify ways OT can help
- Problem solving

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CONTINUED

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Communication

- When in doubt, communicate it!
- Call the doctor, document it
- Call the nurse, document it
- Call teammates, document it
- Call family members, document it

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Scheduling

- Coordinating schedules can pose challenges for home health practitioners
- Organization
- Be prepared
- Front-load your week
- Avoid burn-out
- Build in breaks
- Communicate your needs to your managers
- Be creative
- Accommodate for your clients but establish boundaries
- Understand the agency's expectations and create realistic times for visits

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Questions?

- Krista@covellcare.com

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