Home Care 101

Objectives

- Understand the general payer requirements for eligibility for Home Health
- Understand the PT’s role in Home Care
- Discuss the truths and myths of Home Care
- Identify the benefits and challenges of working in Home Health
- Discuss the future of Home Care

Purpose of Home Health Care

- Patients can receive medically necessary and skilled intervention at their residence because it is a hardship for them to leave their home
- Patients can remain in their home in a safe manner with appropriate support

Why Home Health Care?

- Patients recover better at home
- Less incidence of nosocomial infection
- Shorter hospital stays – going home “sicker”
- Unwilling or absent caregivers
- Inability to function safely (ADLs/mobility/cognition)
- Hospitals not getting paid for re-hospitalizations within 30 days of d/c
- Inability to safely get to outpatient therapy—not related to transportation issues

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### General Medicare Regulations

- **Homebound Status**
  - "a normal inability to leave home and, consequently, leaving home would require a considerable taxing effort" *(cms.hhs.gov/manuals)*
  - **Short Duration**
  - **Infrequent**
  - **Taxing Effort**

  Homebound status is assessed on **every** visit.

### Medicare Regulations

Qualifying services include:

- **RN** ● **PT** ● **SLP**

Home Health services can only be provided if the patient exhibits RN, PT, or SLP needs upon referral and accepts at least one of the qualifying disciplines for them to establish continuing OT need.

### Medicare Regulations

**Therapy:**

- Treatment goals must be measurable

- Use objective measurement and successive comparison of measurements, *(CMS-1510-F, p. 95-96)*

- Reassessment visits are done within established Medicare guidelines

### Medicare: OASIS

- **Outcome and Assessment Information Set**

- Represents core items of a comprehensive "discipline-free" assessment

- Monitors the home health industry and outcomes

- Drives reimbursement

- Tool for setting up care plan

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Role of Home Health

Referrals may come from:
- Hospitals
- SNFs/TCUs
- Clinics / MDs
- Assisted Living Facilities
- Community Resources
- Family Members/Self
- Payers/Case Managers

Reason for Referral
- New diagnosis or exacerbation of chronic disease
- Recent hospitalization or surgical intervention
- Fall in the home
- Medication error
- Noted cognitive/functional decline
- Patient lives alone (no caregiver) and is struggling with taking care of self

Role of Physical Therapy

Focus on Assessing Function and Safety:
- Functional mobility throughout home (work with OT)
- Falls Risk (not just a PT problem)
- Medication Management—accessibility (work with nurse)
- Community Resources (work with MSW)
- General Home Safety (all disciplines)

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Role of PT

Focus on Assessing Function and Safety:
- Bed mobility/transfers  
  - variety of surfaces  
- Gait—levels and steps  
- Equipment  
- Pain management  
  (work with nursing)  
- Cardiopulmonary  
  (work with OT)  
- Continence  
  (work with OT and nursing)  
- Palliative Care & Hospice Programs

Role of PT

Focus on Safe and Realistic interventions:
- Simple Home Modifications  
- Compensatory Strategies  
- Patient / Caregiver Education  
- Assistance with Community Resources

Role of PT

Focus on problem solving and self-management for their conditions:
- New Diagnosis (Diabetes / CHF / Dementia)  
- Use of New Medical Equipment / Supplies  
  - Blood Pressure Cuff/CPMs  
  - Walkers/Bed Assist Rails/Grab Bars/Transfer Benches…  
  - Wound Dressings  
  - Exercise Programs

Typical Home Care PT Evaluation

- Focus on safety and independence with home mobility  
- Demonstration + Interview  
- Identify patient & family  
  (support system)  
  - Does the patient live alone?  
  - Who helps with what tasks?  
  - How available and willing are caregivers?

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Typical Home Care PT Evaluation

- Identify what a typical day is like for them
  - "How do you start your day?"
- Ask patient to describe what is especially difficult for them since becoming ill
- Ask what is important for them to get back to doing for themselves
- Ask for a "tour" of their home
  - "I'd like to see how you get around your home."

Typical Home Care PT Evaluation

The "Tour"
- Observe risks for potential falls
- Current DME—(adequate)?
- Lighting
- Accessibility to items
- Noise level / Distractions
- Family Dynamics

Typical Home Care PT Evaluation

- Bedroom/Bathroom
  - Demonstration:
    - Transfer in/out of bed
    - Transfer in/out of tub
    - Transfer on/off toilet
    - Observe use of existing DME
  - Discussion/Observation:
    - Challenges reported/seen in each setting and how they currently deal with them
    - Sleeping Habits / Getting up at night / Lighting

Typical Home Care PT Evaluation

- Any room where they spend most of their time
  - Demonstration:
    - Transfer in/out of chair, couch, recliner, lift chair
    - Observe use of existing adaptive equipment
  - Discussion / Observation:
    - How do they spend their day here?
    - What items are within their reach?

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Typical Home Care PT Evaluation

• Objective Measures
  – Demonstration:
    • Vitals: BP, HR, O2 Sats, Respirations, Temperature
    • AROM/MMT
    • Tinetti/Berg/TUG
  – Discussion / Observation:
    • Status of home—cleanliness, clutter
    • Physiological response to activity
    • Medication storage and accessibility

PT Initial Care Plan

• Develop Care Plan with the patient and family
• Home Health Goals should be “SMART:”
  – Specific
  – Measurable
  – Attainable
  – Relevant to the patient
  – Time-limited
• Start Discharge Planning at First Visit
  – Outpatient Therapy
  – Different Living Environment

Typical Home Care Visit

• Refer to Care Plan every visit
• Review Care Plan goals with patient every visit
• Plan for the unexpected!
  – Patient not feeling well
  – Patient has visitor
  – Another discipline present at your visit
• Typical visit: 45 minutes to 1 hour
• Typical frequency/duration: 2-3x/week, for 2 – 6 weeks (but it depends…)

Typical Home Care Visit

• Have patient demonstrate or teach back something they learned from last session
  – Assess follow through, compliance, cognition
• Other things to note
  – Changes to medication, pain levels, overall condition, falls?
  – Recent MD appointments
• Discuss the next appointment options

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PT Home Programs

- Exercises for weakness, Ortho, Parkinson’s, CVA, osteoporosis
- Falls Prevention
- Simple Home Modification
- Cardiopulmonary Management
- Incontinence Management
- Diabetic Management
- Palliative & Hospice Programs
- Caregiver Training
- And more…

Family Conferences

- Conducted in home with patient present
- Case Manager, RN, PT, OT, SLP, MSW

**Discussion:**
- Cognitive concerns and recommendations
- Transition to new, more supportive living environment
- Driving concerns
- Long term planning

Myths and Truths

<table>
<thead>
<tr>
<th>Myth</th>
<th>Truth</th>
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<tbody>
<tr>
<td>Patients are not allowed to leave their home.</td>
<td>Homebound is an ability status, not a choice.</td>
</tr>
<tr>
<td>My patients don’t need a lot of therapy.</td>
<td>My patient will receive whatever he needs to achieve his goals, just in a different setting.</td>
</tr>
<tr>
<td>Home Care therapy is not aggressive enough.</td>
<td>Home Care therapy will be as aggressive as needed to achieve functional goals.</td>
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Benefits

- Holistic care
- Large variety of PT care given—not rote PT
- Autonomy
- Flexible schedules
- Learn all the best restaurants, coffee houses, and bathrooms in your service area
- You won't need a GPS after two years!

Challenges

- This is their turf!
- Patients have many needs with limited resources
- Dysfunctional family dynamics
- Professional boundaries
- Working "alone"
- Minimal traditional therapy supplies
- Driving (weather)

Skills to be Successful in Home Health

- Strong time management skills
- Strong organizational skills
- Strong communication skills
- Clear sense of professional boundaries
- Comfortable with diversity
- Expect daily/last minute schedule changes
- Be willing to change the clinical approach
- Flexibility is a two way street....
- Enjoy change in general
- Bilingual??

Home Health Care Do's & Don'ts

DO:
- Stick as close to your time schedule as possible (time management)
- Address relevant and meaningful areas of function (ask the patient!)
- Communicate with the rest of the team regularly
- Have patients actually participate in tasks during visit and for homework

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Home Health Care Do's & Don'ts

DON'T:
- Just interview the patient for your assessment or visits
- Write orders that are the same for every patient
- Recommend sweeping changes all at once – remember you are still a guest in their home

Tips & Tricks

- Being Prepared:
  - Use trunk organizers
  - Kits for various ADLs / File bin
  - Empty Bin with Cover – infection control
  - GPS / Cell Phone
  - Phone Numbers
    - AAA / Towing company
    - City snow emergency alerts

Tips & Tricks (cont):
- Bag with Wheels
  - Gloves / BP Cuff / Waterless Sanitizer
  - Tape Measure / Extra forms
- Small Adapted Equipment
  - Theraband, Non-skid liners, bath bench
- Extra change for parking meters
- Febreze & Lint Remover

The Future of Home Health Care

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Future State….

- P4P—Pay for Performance
- ACO—Accountable Care Organizations
- Healthcare Reform
- Chronic Disease Management

Marked growth—lots of opportunity!!

Resources

- [www.cms.hhs.gov/manuals](http://www.cms.hhs.gov/manuals)
- CMS-Medicare Benefit Policy Manual, Chapter 3, Home Health Services
- CMS-Health Insurance Manual, Publication 11 (commonly known as HIM 11)
- Minnesota Home Care Association Rehab Team

Thank You

Questions

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