Home Health OT

Introduction

Many occupational therapists provide treatment to different populations in home health care. Assessing and intervening with clients in their own homes is an excellent way to provide support in ADLs and IADLs. Therapists are able to address a wider range of interventions that they may be unable to in institutional settings. In addition, there is rarely the need for patients to simulate how they perform certain activities, as OTs can directly observe patients engaging in various occupations. Many theoretical foundations and approaches suggest doing therapy in the most normal, regular contexts possible for optimal results. While therapists must keep in mind that not every patient's living situation is ideal for therapy, the home is largely considered a naturalistic setting. This allows many people to experience functional gains and practice carrying over therapeutic skills where they will most often be used.

Section 1: Home Health OT Background

References: 1-14

Home health is just one place where occupational therapists can treat patients. However, this setting is not intended for patient convenience, as home health recipients must demonstrate medical necessity. Similar to patients in hospitals and skilled nursing facilities, individuals who are treated in this setting must possess a specific set of health needs. In order to receive Medicare reimbursement for home health service, someone must meet three homebound criteria. The first is that they have been advised by a healthcare provider to avoid leaving the home due to one or more medical conditions. Individuals who are homebound must also exert considerable effort to leave the home, which prevents them from doing so on a regular basis. Lastly, someone is viewed as homebound if they need

equipment (e.g. mobility devices such as crutches, a walker, a cane, or a wheelchair), assistance from another person, or modified methods of transportation due to an injury or illness.

As part of home health care, individuals are entitled to several services if they are deemed medically necessary. This includes:

- Skilled nursing care provided on no more than a part-time basis
- Rehabilitation services, including occupational therapy, physical therapy, and speech-language pathology
- Certain pieces of durable medical equipment and medical supplies to be used within the home
- Medical social services
- Home health aide services on no more than a part-time basis
    - A homebound individual can only receive these services if they are also receiving skilled nursing care or at least one rehabilitation service.
    - Aide services in this setting are intended to help with mobility tasks such as walking and transferring, ADLs (bathing, eating, grooming, hygiene, toileting, and dressing), and certain IADLs such as doing laundry.

Therapists must ensure the above criteria are met in order to establish medical necessity, which is a requirement for any level of care. This means that the patient not only medically requires the services being given, but also demonstrates that the services are not more appropriate for a different level of care. While those are considered the most important (and most relevant) stipulations to a therapist's scope of practice, the Centers for Medicare and Medicaid (CMS) has outlined

some additional requirements for home health patients. In order to reimburse for services, home health patients must also:

- Obtain an order from their doctor or another qualified healthcare provider
- Be treated by a home health agency with a Medicare certification
- Have received a visit from their doctor (or another healthcare provider if they gave the initial home health order) pertaining to the primary diagnoses that led them to receive home health services within the last 90 days
    - In order to fulfill this criteria, the visit must have been face-to-face.

Home Health Diagnoses & Outcomes

Home health services reach a great number of patients in the United States. According to the Centers for Disease Control and Prevention (CDC), 3 million patients received and were discharged from home health services in 2020. A more detailed CDC survey from the same year looked into the number of patients these agencies tend to serve. Results showed that 42.9% of home health agencies serve between 1 and 100 patients annually, 25.8% serve between 101 and 300 people, and 31.3% serve more than 301 individuals each year. The same survey found that 100% of home health agencies offer skilled nursing services and 95.7% of these organizations offer skilled therapy services. 79.2% of patients seen by home health providers were White. 94.9% of patients seen by home health providers required assistance with bathing and 67.9% of patients seen by these providers needed support for eating.

Because of the somewhat limited range of services provided within the home, there are certain diagnoses that home health therapists can expect to treat in this setting. Some of these conditions (such as diabetes) are considered common within the general public. Other health concerns, including post-surgical

diagnoses, are on this list because many people are discharged from hospitals or skilled nursing facilities to their home and require aftercare or related services. Below are the most frequently treated health conditions addressed in home health settings:

- Dementia (35.6%)
- Depression (42.5%)
- Diabetes mellitus (45%)
- Heart disease (54.5%)
- Hypertension (89.5%)

Research shows that home health service utilization was on the rise for individuals with dementia. Between 2010 and 2019, there was a 16.8% increase in the initiation of home care services for individuals with dementia. These numbers decreased between 2020 and 2022, perhaps spurred on by pandemic-related precautions and related industry changes. However, this still remains one of the most high-need diagnoses requiring home health services. This suggests that therapy administrators and health policy makers may need to more closely monitor outcomes for this population to ensure their needs are being met and best practices are being followed.

A 2024 survey conducted by the American Association of Retired Persons (AARP) showed that 75% of adults over the age of 50 reported wanting to stay in their current home for as long as they can. While a portion of the poll respondents are not yet considered older adults, this suggests there will likely be another increase in the demand for home health services (as well as home modifications) in the coming years.

Other health concerns that providers commonly address in this setting include:

- Chronic obstructive pulmonary disease (COPD)
- Cerebrovascular accident (CVA)
- Cancer
- Post-surgical care, most often for amputations or joint replacements
- Osteoarthritis (OA)
- Frequent falls
- Recurring dizziness
- Angina (chest pain)
- Traumatic brain injury (TBI)
- Parkinson's disease (PD)
- Amyotrophic lateral sclerosis (ALS)
- Multiple sclerosis (MS)
- Chronic renal failure
- Difficulty swallowing
- Aftercare for serious illnesses that are no longer contagious, such as pneumonia or influenza
- Multiple chronic conditions
    - This is especially common for individuals who may have recently been diagnosed with a chronic condition, are having difficulty managing multiple conditions, or have complex processes to follow in order to manage one or more conditions.

As you will notice, ‘frequent falls’ is included in this list. This phrase is enough to warrant rehabilitation services in most settings since this places individuals (especially older adults) at risk of serious injury and functional decline. Research shows that around 60% of all older adult falls take place within the home. In addition, between 30 and 50% of falls sustained by older adults pertain to environmental concerns; therefore, they can be remedied by occupational therapists making home modifications. This data demonstrates the importance of addressing falls at home.

However, home modifications are not impactful enough on their own to properly prevent falls. There are several evidence-based interventions that contribute to a multi-faceted approach, many of which fall under the scope of practice of a home health OT. There is a wide body of research supporting the combined provision of home modifications, exercise-based interventions, and clinical interventions to address the issue of falls in the home.

One study found that older adults tended to underestimate their personal risk of falling. Results showed that older adults identified an average of 5.1 risk factors pertaining to their situation while healthcare providers identified an average of 12.6. This study also showed that the bathroom and the kitchen were the highest risk areas within the home. This shows the need for skilled professionals such as OTs to address falls in this setting.

Research also shows the effectiveness of community-based programs in reducing fall rates within the home. Specifically, home hazard removal led to a 38% reduction in falls, though participants’ risk of falling remained the same after the intervention. Another study, though slightly dated, showed that OT can produce similar effects in the area of fall prevention. That piece of research found that, when delivered by occupational therapists, home modifications can potentially prevent 33% of older adult falls and save $442 million in direct medical costs as a

result of falls and fall-related injuries. Another study on the effects of OT home assessments yielded similar fall prevention rates (a reduction of 40%) for older adults identified as high risk.

In a similar vein, occupational therapy intervention in home health settings also has an impact on other outcomes, namely reducing hospital admissions and readmissions. Not all research studies detail specific readmission rates as a result of OT intervention, though one study did find a reduction in hospital readmissions in a two-year period, leading to a cost savings of $22,120 for each older adult who participated. Another set of investigators looked at how well a home care program for patients with advanced heart failure worked to reduce hospital length of stay and readmission rates. Results showed that both outcome measures decreased significantly after the program while these rates increased in the control group who did not receive any intervention.

Therapists should keep patients with certain diagnoses in mind when considering interventions to prevent readmission. For instance, CMS has identified specific 30-day protocols for diagnoses with some of the highest readmission rates, including heart failure, pneumonia, total hip arthroplasty (elective and primary), total knee arthroplasty (elective and primary), post-coronary artery bypass graft surgery, acute myocardial infarction, and chronic obstructive pulmonary disease.

OT's Role in Home Health

The American Occupational Therapy Association notes that the role of OTs in home health is to use a client-centered approach to thoroughly assess behavioral, physical, and environmental factors and address these areas to increase safety within the home setting, lower the risk of injury, and maximize function. While AOTA specifically identifies the importance of home health in assisting

independence of seniors, this setting proves beneficial to anyone with functional limitations as a result of disabilities or illnesses.

In particular, occupational therapists may perform any of the following functions in a home health setting:

- Recommending adaptive equipment for patients and training them (and their caregivers) in proper usage, device care, and applications
    - Adaptive equipment may include mobility devices, self-care aids, or cognitive aids, each of which should be used to improve a patient's functional performance and/or quality-of-life
- Training or retraining patients in activities of daily living
- Providing cognitive retraining in areas such as memory, safety awareness, planning, judgment, and attention, which are intended to assist with improving independence in functional areas
- Offering education on symptom management and medication management
- Providing strategies to assist with chronic disease management, including lifestyle changes, compensatory strategies, health monitoring, symptom tracking, and more
- Instructing patients on energy conservation, joint protection, and fatigue management to improve both safety and independence within the home

As you can imagine, caregivers are particularly essential in home health settings. Caregivers include anyone in a formal or informal capacity who helps the patient. This may mean neighbors and nearby friends who periodically assist with IADLs and home management or family and paid caregivers to provide constant care within the home. Therapists should be prepared to include caregivers as much as possible in the evaluation and treatment processes. This serves several purposes.

Firstly, working with the caregiver and patient in equal parts demonstrates a respect for the knowledge that many caregivers have of the people they work with, which is often in a long-term capacity. This means that therapists should ask caregivers to weigh in on many evaluation questions while still respecting the patient's dignity and allowing them to respond, if they are willing and able. Caregivers are also essential in some of the following ways:

- Assisting with or independently managing a patient's schedule and other 'background' duties that allow patients to attend and fully participate in sessions with less hassle
- Encouraging patients to carryover and reinforce the skills they have learned in therapy
- Providing valuable information as to patient behavior and challenges outside of sessions
- Offering motivation, encouragement, reassurance, and other forms of emotional support during the therapy process
- Helping communicate vital information to various healthcare providers, doctors, and family members to keep everyone up-to-date on the patient's status, progress, treatments, etc.

Section 1 Personal Reflection

What communication techniques might an occupational therapist use to ensure they are properly including both patients and their caregivers in the therapy process?

Section 1 Key Words

Daily living aids - Any devices (high- or low-tech) used to assist someone in daily living tasks such as meal preparation, participation in hobbies and leisure activities, grocery shopping, money management, medication management, and more

Durable medical equipment - Any type of medical equipment that is usually only helpful for those who are injured and/or sick, is used within the home, is reasonably predicted to last 3 years or more, and can withstand repeated use

Medical necessity - A factor that health insurers assess when determining coverage for medical, nursing, and rehabilitation services, equipment, and devices; medical necessity states that services, equipment, and devices must be administered to manage, relieve, cure, or diagnose a disease, condition, injury, or illness; should be appropriate and accepted as standard medical practice for the indicated diagnosis; and should not be exclusively provided to the patient or any related parties for the sake of convenience

Self-care aids - Any devices used to assist someone in performing any of the main self-care tasks; some examples include long-handled sponges, long-handled shoehorns, sock aids, button hooks, and more

Section 2: Occupational Therapy Evaluation and Goals in Home Health

References: 15-19

In order to properly assist individuals with the full range of concerns that can be addressed in this setting, occupational therapists must conduct thorough home health evaluations. While there is no protocol that outlines specifically what steps

to take when completing an evaluation, the following order tends to offer therapists a natural flow:

- Occupational profile
    - The basics of any occupational profile include a patient's presenting concern, meaningful occupations in the past, interests and values, relevant personal and environmental contexts, performance patterns, client factors, and patient- or caregiver-identified goals.
- Medical history
    - Prior level of function (namely in functional cognition, stair navigation, indoor mobility, and each self-care task)
    - Review of the patient's current medications (including their level of independence in taking those medications and any relevant routines or habits that pertain to medication management)
    - Previous plans of care for OT or other in-home services
- Tests of functional abilities
    - Therapists can gain a better understanding of their patients' functional abilities through a combination of formal and informal outcome measures. Informally, patients can observe how patients navigate their home environment, interact with caregivers, and go about basic tasks. Therapists can use a host of standardized assessments to supplement this information. Therapists should use both methods to explore several areas: ADL function, fall risk, vision, mobility, meal planning, emergency management, and cognition.
    - Therapists may prefer certain standardized assessments for use within the home due to their coverage of the above areas, ease of

use, and versatility. Many of these assessments don't require materials, which is a key consideration for home health since it can be difficult to transport equipment between homes. The most common and appropriate assessments for home health include:

- Mini-Mental Status Exam (MMSE)
- St. Louis University Mental Status (SLUMS) Examination
- Montreal Cognitive Assessment (MoCA)
- Allen Cognitive Level Screen (ACLS)
- Short Blessed Test
- Modified Barthel Index (MBI)
- Functional Independence Measure (FIM)
- Timed Up and Go (TUG)
- Functional reach
- Berg Balance Scale (BBS)
- Falls Efficacy Scale (FES)
- Tinetti Gait & Balance Test
- Activity-Specific Balance Confidence Scale (ABC Scale)
- 9-Hole Peg Test
- 2-Minute Step Test
- Test of Visual-Motor Integration
- In-Home Occupational Performance Evaluation (I-HOPE)

        - Safety Assessment of Function and the Environment for Rehabilitation - Health Outcome Measurement and Evaluation (SAFER HOME)
        - Home Safety Self Assessment Tool (HSSAT)
        - Home Falls and Accidents Screening Tool (Home FAST)
        - Falls Behavioral Scale (FaB)
        - Client-Clinician Assessment Protocol (C-CAP)
        - The Home Environment Assessment Protocol-Revised (HEAP-R)

Goal Setting

Home health OTs may set goals in some of the following areas. This list also provides sample goals in those areas that pertain to the home setting:

- Functional mobility (bed mobility, transfers, ambulation during ADLs)
    - The patient will independently adjust their position when in bed every 30 minutes to prevent pressure ulcers and maintain joint integrity within 4 weeks.
    - The patient will transfer from their bed to the bedside commode with minimum assistance using adaptive equipment to improve independence in toileting within 2 weeks.
    - The patient will complete a stand pivot transfer with stand-by assistance from their bed to their wheelchair to improve functional mobility during ADLs within 4 weeks.
- Improving home safety

    - This may include installing hand rails, grab bars, and similar tools to assist with home navigation and personal safety. Home health OTs may also identify larger home modifications patients need to successfully age-in-place. Many times, these warrant referrals to other agencies, though home health OTs can assist with smaller modifications as well as those that are organization-based (such as removing throw rugs, hiding cords and wires, etc.).

- Grooming and hygiene
    - The patient will independently brush their teeth while sitting at the edge of their bed 5 out of 7 days per week over a 4-week period.
    - With the use of a mobility aid and energy conservation strategies, the patient will stand at the sink and wash their hands for 2 minutes within 2 weeks.
    - While standing at the sink, the patient will independently comb their hair and wash their face within 5 minutes over a 4-week period.
- Dressing
    - The patient will independently don and doff their socks within 3 minutes using a sock aid within 6 weeks to improve participation in dressing.
    - The patient will don and doff a t-shirt with minimum assistance using one-handed techniques in 5 out of 7 days within 4 weeks.
    - The patient will don and doff elastic-waist pants while sitting at the edge of their bed 3 out of 7 days per week with stand-by assistance.
- Feeding

    - The patient will use eating utensils with built-up handles to independently self-feed 2 out of 3 meals per day across 4 weeks.
    - The patient will use a modified cup to independently drink liquids during mealtime across 7 consecutive meals without any spillage.
    - The patient will demonstrate independent use of a rocker knife to safely cut and eat their food for 5 out of 7 dinners across 2 weeks.
- Bathing
    - The patient will complete upper body bathing with minimum assistance while sitting at the edge of their bed in 7 out of 10 trials.
    - The patient will complete clothing management with minimum assistance while sitting on a tub bench within 8 out of 10 trials.
    - The patient will shower while standing with contact-guard assistance within 8 minutes every third day over a span of 4 weeks.
- Toileting
    - The patient will transfer on and off the raised toilet seat with minimal assistance to complete toileting 80% of the time.
    - The patient will independently manage clothing while seated on a bedside commode to use the toilet 80% of the time over the next 2 weeks.
    - The patient will complete perineal care with moderate assistance while seated on a regular toilet 80% of the time over the next 4 weeks.

Any of the above goals may include assistive devices and/or adaptive strategies, including joint protection strategies, energy conservation techniques, and task

modification or simplification. If any goals make mention of cognitive strategies (such as those used to enhance problem solving, memory, safety awareness, and similar skills), therapists should be sure to justify these by showing how they support independent living and occupational participation.

The same rationale applies to home exercise programs that focus on building or maintaining strength, balance, coordination, and range of motion. Therapists should be sure home exercise programs assist in improving some of these deficits **in order to** help them obtain or grow functional skills already outlined in their plan of care.

Section 2 Personal Reflection

How might a home health occupational therapist working on bed mobility with a patient differentiate their services from that of a home health physical therapist who may be addressing a similar skill?

Section 2 Key Words

Multi-morbidity - A term used to describe patients who have at least two chronic conditions with all conditions being around the same level of severity and none are considered the primary condition

Section 3: Best Practices in Home Health OT

References: 20-23

There are several considerations that home health therapists must keep in mind when treating in this setting. Firstly, it is essential that therapists **address their patients' primary conditions along with any co-occurring conditions** and other

factors that are present. Other factors that a therapist may address include contextual concerns that place the patient at risk of new or recurring injury. This may include hazards within the home, a lack of social support, affective changes, accessibility, and more. While this is best practice in many settings, it is even more essential that patients receive this type of comprehensive care within the home because patients are not monitored nearly as consistently as they are in residential settings. Therefore, the onus is on all providers to give this type of care during every encounter.

For example, a patient who is being seen in the home after undergoing a below-knee amputation should receive interventions such as therapeutic activities and exercises to assist with improving strength, range of motion, and endurance as well as education and training on maintaining skin integrity, caring for their residual limb and their prosthetic, if they have one. However, if the patient has secondary diagnoses of hypertension and osteoporosis, the patient should also be monitored for edema and should receive education to assist with modifying their diet, water intake, and activity levels to manage these conditions. If the therapist determines the patient has significant difficulty managing medications to control their hypertension and/or osteoporosis, it is their responsibility to make referrals to other relevant professionals. An OT should take these same steps if the patient demonstrates signs that these conditions are worsening.

In addition, **a team-based approach** is particularly essential in home healthcare because, many times, providers do not cross paths. This makes it so providers must be intentional and consistent about interprofessional communication, as this is integral to each patient's care. While some therapists may not initially think so, **caregivers are an important inclusion** in the "team" that we just referred to. Caregivers are even more essential in this setting than many people realize, so they should be a core part of the evaluation process. They may have more intimate knowledge of a patient's routines, habits, behaviors, and symptoms than

sometimes a patient may even have – though a patient's input is still quite valuable in its own right. The same goes for the treatment process, as caregivers should be trained on device use and maintenance, warning signs that point toward status changes, contact information for all relevant providers involved in the patient's care, home exercise programs, and task modifications as well as other strategies the patient learns during therapy. Caregivers are vital in ensuring a patient's adherence to and success with therapy.

Therapists must also **address case management** and disease management to provide effective care. They can do this by asking questions early in the care process and providing relevant interventions to address areas of need that were identified. Interventions may include addressing health literacy, giving patients summaries of their diagnoses, medications, and follow-up appointments, and the provision of appropriate community resources and referrals.

A therapist must also **be familiar with the Outcome and Assessment Information Set (OASIS)**, which is exclusive to home health. Some home health OTs may be tasked with OASIS-related duties, though all therapists should at least know the basics of OASIS to inform the care they provide. OASIS is used to give CMS vital information to assist with national quality efforts, though its main purpose is to help Medicare set reimbursement rates for all patient encounters.

It is well known that completing the OASIS can be a lengthy process, as the manual is 400 pages and many therapists report the assessment takes up to 90 minutes to complete. Because of its substantial nature, it is a common misconception that the OASIS itself allows therapists to remain compliant in a home health setting. However, many home health agencies must add other forms and documents to further ensure compliance, making the process even lengthier. It is required for certain home health professionals to complete OASIS at several pivotal points during a patient's plan of care. These include:

- Start of care (SOC)
- During the recertification period, which is completed every 60 days
- If and when a patient demonstrates a significant change in their medical status
- If and when a patient is admitted to a residential institution such as a skilled nursing facility (SNF) or a hospital
    - Depending on an agency's protocols, patients may or may not be discharged from home health at this time. The latter is especially likely if the patient is a recurring recipient of home health services and is known to be in and out of these facilities for various medical reasons. Regardless, admission to a residential facility for any amount of time requires the OASIS to be completed.
- Resumption of care (ROC)
- At the time of discharge

A clinician must complete the OASIS within 2 days of each of these events. The only exception to this is the start of care, which must be completed within 5 days of a patient first being evaluated or treated. It is best practice to have only one provider complete the OASIS, though they can receive information from other members of the team in order to ensure it is interprofessional in nature. For many years, registered nurses (RNs) were the only providers who could complete the OASIS, though physical therapists, occupational therapists, and speech-language pathologists are now able to take responsibility for completing this document. RNs still continue to take responsibility in many of the home health cases where nursing is provided alongside rehabilitation services, though PTs, OTs, and SLPs must complete the OASIS in the event they are the only provider treating the patient. It is important to note that occupational therapy alone doesn't qualify a

patient to receive home health services covered through Medicare. Therefore, OTs will only be responsible for the OASIS if a patient is receiving multiple rehabilitation and/or nursing services.

The OASIS sections a therapist must complete cover the following areas:

- Behavior
- Bladder and bowel function
- Cognitive patterns
- Health conditions
- Hearing, speech, and vision
- Medications
- Mood
- Participation in assessment and goal setting
- Preferences for customary routine activities
- Swallowing and nutritional status

The OASIS also contains a functional items section that requires providers to rate the patient on their participation in several activities, including grooming, upper body dressing, lower body dressing, bathing, toilet transfers, toilet hygiene, transferring, and ambulation/locomotion. The OASIS manual states that these ratings must be made based solely on the patient's ability rather than their real performance. The clinician must rate the patient on a scale of 0 to 3 (with 3 being total assistance and 0 being independent) at the time of their evaluation. They then set a numerical goal for each activity so the patient can work toward that. At

the time of the final OASIS (when the patient is discharged), the provider will score the same activity again to determine the progress the patient has made.

Section 3 Personal Reflection

If an OT discovers that a home health patient has some unaddressed mental health concerns that may need diagnosis and treatment, who should they make a referral to?

Section 3 Key Words

Resumption of care - The time when a patient resumes home health services after an inpatient stay

Section 4: Barriers & Facilitators in Home Health

References: 24-28

Dated research found five main categories of barriers that providers in home health settings faced. These included lacking the proper tools to educate patients, difficulties related to medical device usage, receiving varying degrees of involvement from families, feeling isolated and unsupported (especially regarding job duties that are physically demanding), and communication gaps between interprofessional providers. In many cases, tools assisted providers in overcoming these barriers, with the exception of family involvement, which was remedied through education and gaining a deeper knowledge of team dynamics.

Shahriari et al. (2024) found that many home health agencies experienced challenges related to infrastructure and the service provision process. Issues related to infrastructure included lack of contact with human resources,

difficulties related to the creation of home care-specific policies, economic struggles, and acculturalization concerns. Service provision issues were mostly attributed to providers experiencing obstacles in their attempts to increase the quality of services provided within the home. In addition, the state of a patients' home environment tended to create its own set of challenges for providers.

The home environment also posed its own ethical challenges for providers working in that setting. Knagenhjelm Hertzberg et al. (2023) found that clinicians had the most difficulty balancing risk in tension and autonomy. Specifically, these concerns presented themselves in patients either pushing back against or refusing care altogether, providers feeling pressure to educate patients on difficult topics such as the risks of continuing to live in an unaccommodating home environment, and blurred lines between encouragement and coaxing. This study also found that building long-term trust was difficult for providers to do within the home.

On the other hand, there are factors and tools that home health therapists can utilize to improve the work they do. Keyvanloo Shahrestanaki et al. (2023) found that healthcare members using foresight was one of the best ways to ensure patient safety and avoid any threats to their receipt of quality care. Sang et al. (2025) explored facilitators for home health patients who survived sepsis, though their findings can be applied to many home health diagnoses. Results showed that some of the most effective practices include moderating the role of technology in patient care (namely telehealth and messaging), proactively providing patient education, implementing programs built on the basis of population health, and leveraging community organization involvement to boost patient outcomes. These researchers also emphasized the importance of trust between patients and providers as well as specifically appointing two or more people in the interprofessional team to handle patient education and scheduling duties.

In terms of provider success from a more logistical standpoint, home health OTs should do some preparation before accepting a role in home health, as it can be helpful to calculate their hourly work requirements based on an agency's productivity demands. Therapists should clarify whether their productivity is measured on a weekly or daily basis. Some agencies utilize weighted systems, making it even more essential for therapists to ask their manager questions to understand how much time is factored into each day for non-clinical duties such as documentation, scheduling, and planning.

In addition, several strategies can assist home health OTs in this practice setting:

- Using daily and weekly planners to organize sessions
- Trialing timekeeping apps to keep you efficiently moving between sessions and days along with navigation apps to help you track mileage, alternative routes, etc.
- Practicing mindful point-of-service documentation while still giving proper supervision and attention to their patients
- Setting boundaries with patients and managers alike to keep sessions within their allotted time frames
- Grouping evaluations and reassessments together on one to two days per week
- Trying to schedule patients with similar zip codes together for maximum efficiency
- Creating pre-determined time slots for each day and offer those to patients for scheduling purposes

- Allowing time in your schedule for preparation, including refilling supplies, managing cases, making copies, returning or making phone calls, returning or sending emails and text messages
- Setting up your car with all the supplies you need to do your job, including personal protective equipment (PPE), a first aid kit, an emergency kit, equipment to take vital signs with, snacks, change of clothes or scrubs, phone and/or tablet chargers
- Getting a dashboard mount for your phone
- Programming hands-free talking so you can answer your phone (if needed) while driving without compromising your safety or timeliness
- Making documentation workflows, templates, and other pre-made documents to assist with notetaking and the overall flow of your session

Section 4 Personal Reflection

Which of the home health strategies for success can be used to help overcome some barriers experienced in this practice area?

Section 4 Key Words

Acculturalization - The interaction between individuals from various cultural backgrounds and groups, which leads to the sharing and adoption of new practices

Foresight - The ability to anticipate long-term consequences, events, and needs in a way that allows for sufficient planning and preparation

Point-of-service documentation - The act of completing patient documentation while treating a patient

Section 5: Case Study #1

A home health OT is treating a 69-year-old woman whose primary concern is a recent amputation of the left foot. This woman's secondary diagnoses include diabetes mellitus, hypertension, and a history of breast cancer. When the OT initially enters the home, she pinpoints several environmental factors that increase this woman's fall risk. The OT asks the woman about the assistance she has been receiving; she reports that a middle-aged neighbor brings her groceries and takes care of her yard for her, but that she does everything inside on her own. She mentioned several times how she appreciates the neighbor and also enjoys spending time with them. The OT asks the patient again if anyone helps her shower, get dressed, etc. Getting somewhat frustrated, the woman answers that she doesn't need any of that help and "won't need any of this [rehab] pretty soon either." The OT explains how these services can help with strengthening, avoiding falls, and make it generally easier for her to do the things (dressing, showering, etc.) that she is already doing for herself. The patient seemed somewhat more receptive after that, but did mention she will only do certain things during sessions.

1. With consideration given to both the patient's safety and building rapport, what might the therapist's first action step be?
2. What aspects of this patient's life might prove helpful as the therapist begins working with her?
3. Once it comes time to create the plan of care, what focus areas should the therapist include?

Section 6: Case Study #1 Review

This section will review the case studies that were previously presented. Responses will guide the clinician through a discussion of potential answers as well as encourage reflection.

1. With consideration given to both the patient's safety and building rapport, what might the therapist's first action step be?

   Since this patient is demonstrating some reluctance early on in the care process, it would be best for the therapist to take a more informal approach to the evaluation. The OT can tell the patient they can just "spend some time together" during their early visits. This gives the OT a chance to walk with the patient through her home as she completes her daily activities on her own and chat with her about likes, dislikes, and other aspects of the occupational profile. The OT can then see how the patient gets around and how she performs certain tasks with the potential for offering help here and there, as long as the patient seems more open to it.

2. What aspects of this patient's life might prove helpful as the therapist begins working with her?

   The help this patient receives from her neighbor is an important resource that appears to be helping with her recovery and will likely also continue to aid as she ages. As evidenced by her continual mention of the neighbor and her good deeds, the patient seems to recognize the role she is playing in her life. The therapist can ask the patient if she is open to inviting the neighbor over for coffee during her next therapy visit. If she agrees, this may soften the patient's demeanor and allow the OT to gain added insight into the patient's needs. In the best case scenario, this can potentially pave the way

to include the neighbor in future sessions (if the patient consents) and encourage the patient to participate.

3. Once it comes time to create the plan of care, what focus areas should the therapist include?

   The therapist should prioritize some simple home modifications to address fall prevention. This is important since she identified several obvious areas of concern immediately upon entering the house and the patient's presenting diagnosis further increases her risk of falling. The rest of the goals will be created based on whether the patient really is independent in ADLs as she claims to be. If the OT can verify that she is independent (and safe) while completing all ADLs, they can create goals surrounding functional mobility and strengthening. The patient would also likely benefit from goals addressing disease management since she has a few chronic conditions. If the patient displays a need for intervention related to some ADLs, then those should also be incorporated as goals.

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