HOME HEALTH SECTION
AMERICAN PHYSICAL THERAPY ASSOCIATION

Providing PHYSICAL THERAPY *in the Home*

APTA
American Physical Therapy Association

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Special thanks to:

Third Edition Task Force Project Leaders:
Jonathan S. Talbot, PT, MS, COS-C

Kenneth L. Miller, PT, DPT, CEEAA

Chapter Authors:
Aban Singh, PT, LLB
Barbara Piper, PT, DPT
Debbie Becker, PT
Judy Schank, PT, MS
Kathy Medlin, PT, MS, GCS
Kelly Bailey, PT, DPT
Laurie Page, PT, DPT
Lisa Marie Naeger, PT
Lynn Kelly, PT, DPT, MS
Medha Bansode Ram, PT, MHS, GCS, COS-C
Patricia Crowl Yoder, PT, DPT
Paula Graul, PT, MS, GCS, CEEAA
Sharon Bezner, PT, PhD
Sheri Yarbray, PT, MS
Tim Dunn, PT, DPT, GCS, COS-C

Project Advisors:
Diana “Dee” Kornetti, PT
Arlynn Hansell, PT, HCS-D, HCS-O, COS-C

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PREFACE

Much has changed in the home health landscape since the second edition of *Guidelines for the Provision of Physical Therapy in the Home* was published in 2007. Since that time, the roles of physical therapists (PTs) and physical therapist assistants (PTAs) in the home health setting have expanded, reassessment requirements have changed, and public accountability has increased for the provision of best practices and the promotion of positive patient experiences. The American Physical Therapy Association's (APTA) revision of the *Code of Ethics for the Physical Therapist* and *Standards of Practice for the Physical Therapist Assistant* in 2010 resulted from a recognition of these evolving roles. Care coordination and interdisciplinary collaboration are now viewed as essential for producing a value-based experience for patients and their caregivers. The third edition, now titled *Providing Physical Therapy in the Home*, provides timely guidance to elevate the quality of physical therapist services in the home care setting to the highest levels, consistent with the Vision Statement of APTA.

Providing Physical Therapy in the Home includes several important revisions to its predecessor, *Guidelines for the Provision of Physical Therapy in the Home, second edition*. Perhaps most important, the model of the International Classification of Functioning, Disability, and Health (ICF), which was endorsed by APTA in 2008, has been integrated with Chapter 7, "Physical Therapy Admissions and Evaluation." This handbook also addresses new and relevant subjects. For instance, it adds an entire chapter, Chapter 9, dedicated to the role of physical therapists as case managers. Chapter 11, "Home Health Physical Therapy Supplies/Equipment and Infection Control," was derived from the "Tools of the Trade" resource found in the second edition. Chapter 13, "The Patient Experience," was deemed appropriate given that the Home Health Consumer Assessment of Healthcare Providers and Systems (HHCAHPS) was implemented in 2009 and is publically reported. The handbook adds Chapter 14, "Lifelong Learning and Continuing Competence," to inspire clinicians in home health to consider a formal career development pathway that brings value to both their patients and their personal ambitions. The final chapter, "Home Health Physical Therapist Practice References and Resources," was adapted from the "Online Resources" section in the second edition.

As currently organized, chapters 1 through 6 are written to be beneficial for PTs and PTAs working in the field, as well as for home health agency administrative personnel. Chapters 7 through 12 provide guidance specific to the actual provision of physical therapist services. Chapters 13 through 15 provide additional resource material for PTs and PTAs to improve quality of care for patients through continued competence and effective use of available resources.

This handbook provides a foundation for the provision of physical therapy to patients in their place of residence. The authors obtained input regarding the handbook from APTA staff members, Home Health Section members, committee chairs, and the Home Health Section Executive Committee. Consistent with APTA terminology, the handbook represents Home Health Section-approved, nonbinding statements of advice pertaining to the specifics of home health care.

The ongoing evolution of practice, research, and regulatory standards will influence home health physical therapist practice. The focus of practice remains on meeting the needs of patients and caregivers in their homes and communities. We recognize that this handbook does not reflect the entire scope of requirements associated specifically with home health physical therapy because of rules and regulations including, but not limited to:

- Federal rules and regulations such as Medicare Benefit Policy Manual Chapter 7, Medicare's conditions of participation, the prospective payment system, regional home health intermediary local coverage determinations, and the Health Insurance Portability and Accountability Act
- Individual state rules and regulations such as professional licensure requirements and public health regulations
- Municipal rules and regulations
- Referral relationships (APTA HOD P06-90-15-28)
- Accreditation bodies such as the Community Health Accreditation Program and The Joint Commission
- Applicable agency policies and procedures
- Reimbursement requirements of third-party payers
- Quality initiatives and advances in professional practice

This handbook represents statements of conditions that reflect **ideal performance criteria** for the administration of quality physical therapy in the home. These criteria may be used to assess compliance with best practices for therapy services provided by home health agencies. This book may be subject to changes and modifications to remain up-to-date with current home health rules and regulations.

The Home Health Section Practice Committee anticipates that this edition will be a valuable resource for home health agency leadership, physical therapists, and physical therapist assistants in providing the highest standards of care for patients and their caregivers.

Jonathan S. Talbot, PT, MS, COS-C
Kenneth L Miller, PT, DPT, CEEAA
Third Edition Task Force Leaders
Home Health Section of the American Physical Therapy Association

CHAPTER 1

ROLES OF THE PHYSICAL THERAPIST IN HOME HEALTH CARE

Introduction

Physical therapists working in the home health setting fulfill several valuable roles as they serve the needs of patients and caregivers. The roles and responsibilities of home health physical therapists have evolved over the years. The *Guide to Physical Therapist Practice*[1] and the American Physical Therapy Association (APTA) Code of Ethics for the Physical Therapist identify 5 roles[2,3] in which physical therapists may serve:

- Manager of patients and caregivers
- Consultant
- Educator
- Researcher (critical inquiry)
- Administrator

These roles pertain to the home health setting as follows.

The role of *manager of patients and caregivers* is well established in the home health setting at the basic level of providing physical therapy care. This role has evolved to include case management responsibilities. In the role of *consultant,* the physical therapist shares his or her expertise with patients and caregivers, peers, and organizations to promote optimal health and function. Physical therapists serve as *educators*, providing valuable training to patients and caregivers, and to peers via in-services. As *researchers*, physical therapists in home health care participate in the process of critical inquiry by using and interpreting standardized tests and measures to provide objective evidence about how their services benefit individuals. Some clinicians may also participate in research by contributing to the body of knowledge about how physical therapy benefits society at large. Finally, in the role of *administrator*, physical therapists serve as decision makers to guide a group of clinicians with the provision of quality and cost-effective care for the individuals served by their organization.

Physical therapists who fulfill their roles and responsibilities with professionalism[4] have the potential to positively impact the society in which they live. The APTA Vision Statement for the Profession[5] pursues a larger role for physical therapists of “transforming society by optimizing movement to improve the human experience.” This vision statement highlights the unique expertise of physical therapists as movement specialists and how they can affect societal health. Physical therapists serve in multiple roles in the home health setting, so they are well positioned to lead the way toward accomplishing this vision. The purpose of this chapter is to provide a guideline and criteria to help physical therapists succeed in their various roles.

GUIDELINE

In the pursuit of greater societal health, and in compliance with existing standards of care, policies, and regulations, physical therapists serve with professionalism in multiple roles and with multiple responsibilities in the home health setting, acting as patient care managers, consultants, educators, researchers, and administrators.

CRITERIA

1. The physical therapist (PT) serves as a *care manager* by:
    a. Admitting patients to home health services
    b. Completing a comprehensive patient history and examination according to current standards of best practice
    c. Reviewing medication profiles[6] for accuracy and identifying possible concerns or discrepancies for discussion with the physician and other members of the interdisciplinary team
    d. Developing and implementing appropriate plans of care based upon the following key components from the International Classification of Functioning, Disability, and Health (ICF)[7]:
        i. Prior level of function
        ii. Current and prior health condition(s)
        iii. Impairments of body function and structure
        iv. Activity limitations
        v. Participation restrictions
        vi. Environmental factors (eg, devices, medications, family support)
        vii. Personal factors (eg, race, education, lifestyle, habits)
    e. Submitting documentation that is timely, is accurate, and establishes the medical necessity for skilled physical therapy
    f. Collaborating regularly with the interdisciplinary team and recognizing the role of each member to help achieve patient-centered goals
    g. Supervising physical therapist assistants (PTAs) in compliance with all jurisdiction requirements, agency policies, and best practices[8-11]
    h. Making timely reassessments, including updating/modifying the plan of care as needed in response to patient condition
    i. Employing objective tests and measures at multiple time-points during the episode of care
    j. Accurately completing the Outcome and Assessment Information Set (OASIS)[12]
    k. Respecting cultural diversity and patient choice(s)[13]
    l. Advocating for patient safety by addressing concerns about his or her environment, social support, and emotional health
    m. Formulating a discharge plan and subsequently discharging patients from physical therapist services when skilled care is no longer indicated (see Chapter 12, "Discharge Planning," for explanation of the use of the term "discharge" throughout this publication)

2. The PT serves as a *consultant* in the home health setting by sharing his or her expertise and guidance with members of the interdisciplinary team and organizations regarding:
    a. Enhancement of clinical skills
    b. Promotion of value-based patient care
    c. Patient-centered care
    d. Improving the patient experience (eg, patient satisfaction)
    e. Risk-management strategies
3. The PT serves as an *educator* in the home health setting for patients and caregivers, students, community groups, and interdisciplinary teams by:
    a. Providing in-service training
    b. Serving as a mentor to students and clinicians
    c. Explaining the benefits of home health physical therapist services
    d. Planning for professional growth and continuing competence
4. The PT serves as a *researcher* by demonstrating critical inquiry in the home health setting by:
    a. Analyzing and applying research findings to physical therapist practice and education
    b. Disseminating the results of research
    c. Evaluating the efficacy of new and established interventions/technologies
    d. Participating in, planning, and conducting clinical, basic, or applied research
5. The PT serves as an *administrator* in the home health setting by being an organizational leader, which may include the following responsibilities:
    a. Serving in various leadership roles such as therapy director, agency administrator, regional therapy director, chief clinical officer, or chief executive officer
    b. Recruitment and retention of agency staff
    c. Promoting adherence to best practices and evidence-based care
    d. Ensuring regulatory compliance with the provision of home health services
    e. Participating in quality improvement activities, such as chart audits and peer reviews (home visits)
    f. Monitoring the quality of the patient experience (eg, patient satisfaction)
    g. Team building
    h. Supporting the establishment of student clinical affiliations
    i. Participating in community outreach events

CASE SCENARIO

Tom is a physical therapist with 10 years of experience. He began his career working 3 years in an outpatient setting, followed by 2 years in a hospital medical rehabilitation unit (MRU). He noticed patients were being sent home sooner than they used to be, prior to the completion of their MRU physical therapist plan of care, to receive home health services. A friend of his has been working for a home health agency and encouraged Tom to give it a try. He has now been doing home health during the past 5 years and has noticed a significant shift in his responsibilities during this time.

Initially, Tom didn't have to do start-of-care visits (ie, admissions) because his agency policy was to send nursing staff out to do all admissions. During the past 2 years, this policy has changed, and he has had to start admitting patients to home health. Fortunately, he has obtained extensive Outcome and Assessment Information Set (OASIS) and case management training, expanded his understanding of pharmacology, learned to document according to the model provided by the International Classification of Functioning, Disability, and Health (ICF), and increased use of evidence-based testing to more objectively quantify patient function. Consequently, he has improved his confidence with case managing patients with chronic diagnoses such as congestive heart failure (CHF) and chronic obstructive pulmonary disease (COPD), and he has used this knowledge to coordinate care to reduce re-hospitalization rates. His agency now boasts one of the lower re-hospitalization rates in the region.

Tom previously deferred the assessment of skin integrity, temperature, heart and lung sounds, and wound care to nursing staff, and routinely checked only blood pressure and pulse during visits. He weighs patients with CHF every visit to check for water retention. Having received additional training from his agency, he now routinely assesses all of these items with every patient, recognizing that this information makes him more instrumental in protecting the health and well-being of his patients. He plans reassessments carefully, and documents appropriately, to justify the ongoing need for skilled physical therapist services, if appropriate. His roles and responsibilities in home health care have changed, but he has proudly accepted these changes and it has challenged him to improve the quality of his care.

PRACTICAL APPLICATION

- Vision Statement and Guiding Principles for Physical Therapists
- Roles and Responsibilities of the Home Health Physical Therapist

Vision Statement and Guiding Principles for Physical Therapists[5]

(Adopted by the American Physical Therapy Association in June 2013)

APTA Vision Statement for the Physical Therapy Profession

Transforming society by optimizing movement to improve the human experience.

Guiding Principles

Identity. Physical therapists will be responsible for evaluating and managing an individual's movement system throughout his or her lifespan to improve the health of society. The movement system is the core of physical therapist practice, education, and research.

Quality. The physical therapy profession includes doctors of physical therapy who will commit to evidence-based practices in treatments, education, and research as they work to achieve functional outcomes while preventing adverse events to patient care and to society.

Collaboration. The physical therapy profession will collaborate with other health care providers, consumers, organizations, and disciplines to provide consumer-centered care. Evidence from research should translate to practice in order to help solve health-related challenges faced by society.

Value. The physical therapy profession will provide interventions that are safe, effective, patient centered, timely, efficient, and equitable. Outcomes will be cost effective, and value will be demonstrated in all settings. Accountability is an essential characteristic for demonstrating value.

Innovation. The physical therapy profession will offer creative and proactive solutions to enhance health services delivery and to increase the value of physical therapy to society. Innovation for value-based care will be assisted by new technology, care models, workforce needs, and delivery methods.

Consumer-centricity. The physical therapy profession will ensure that patient/client/consumer values and goals will be prioritized in all efforts and care settings. Physical therapists will embrace cultural competence as an important skill for ensuring that best practice is provided to all patients and clients.

Access/Equity. The physical therapy profession will recognize health inequities and disparities and seek to resolve them via creative models for service delivery. Physical therapists will seek improved access to health care for all members of society.

Advocacy. The physical therapy profession will advocate for health care systems based upon consumer-centered care. Physical therapists will advocate for appropriate care for patients, clients, and consumers both as individuals and as a population, in practice, education, and research settings.

Adapted with permission from the American Physical Therapy Association. Complete text may be found at http://www.apta.org/Vision/.

Table 1.1. Roles and Responsibilities of the Home Health Physical Therapist

Patient Care Manager	Consultant	Educator	Researcher	Administrator
Admission	Clinical skills	Continuing competence	Analysis	Best practice
Care plan development	Patient experience	In-services	Critical inquiry	Community outreach
Collaboration	Patient-centered care	Mentorship	Research participation	Leadership
Discharge planning	Risk management	Professional growth	Treatment efficacy	Patient experience
Documentation	Value-based care	Promotion of physical therapy		Quality improvement
Evaluation				Regulatory compliance
Medication review				Students
OASIS				Team building
Objective testing				
Patient safety				
PTA supervision				
Reassessments				
Regulatory compliance				
Respect				

Derived from roles of the physical therapist as defined in the Guide to Physical Therapist Practice.[1]

References

1. *Guide to Physical Therapist Practice 3.0*. American Physical Therapy Association; 2014. http://guidetoptpractice.apta.org/. Accessed August 20, 2014.

2. Swisher LL, Hiller P. The revised APTA code of ethics for the physical therapist and standards of ethical conduct for the physical therapist assistant: theory, purpose, process, and significance. *Phys Ther.* 2010;90:803-824.

3. American Physical Therapy Association House of Delegates. Code of ethics for the physical therapist (HOD S06-09-07-12). Alexandria, VA: American Physical Therapy Association; 2009. http://www.apta.org/uploadedFiles/APTAorg/About_Us/Policies/Ethics/CodeofEthics.pdf. Accessed December 9, 2013.

4. American Physical Therapy Association Ethics and Judicial Committee. Guide for professional conduct. Alexandria, VA: American Physical Therapy Association; 2010. http://www.apta.org/uploadedFiles/APTAorg/Practice_and_Patient_Care/Ethics/GuideforProfessionalConduct.pdf. Accessed December 9, 2013.

5. American Physical Therapy Association House of Delegates. Vision statement for the physical therapy profession (HOD P06-13-19-23). Alexandria, VA: American Physical Therapy Association; 2013. http://www.apta.org/Vision/. Accessed December 9, 2013.

6. The role of physical therapists in medication management. Official statement. Alexandria, VA: American Physical Therapy Association; 2010. http://www.apta.org/uploadedFiles/APTAorg/Payment/Medicare/Coding_and_Billing/Home_Health/Comments/Statement_MedicationManagement_102610.pdf. Accessed December 9, 2013.

7. ICF checklist, version 2.1a, clinician form for international classification of functioning, disability and health. Geneva, Switzerland: World Health Organization; 2003. http://www.who.int/classifications/icf/training/icfchecklist.pdf. Accessed December 16, 2013.

8. American Physical Therapy Association House of Delegates. Direction and supervision of the physical therapist assistant (HOD P06-05-18-26). Alexandria, VA: American Physical Therapy Association; 2005. http://www.apta.org/uploadedFiles/APTAorg/About_Us/Policies/HOD/Practice/Direction.pdf. Accessed December 9, 2013.

9. PTA Patient care & supervision. American Physical Therapy Association website. http://www.apta.org/PTA/PatientCare/. Updated February 20, 2013. Accessed December 9, 2013.

10. Practice acts by state. American Physical Therapy Association website. http://www.apta.org/Licensure/StatePracticeActs/. Updated April 20, 2014. Accessed May 30, 2014.

11. PT/PTA teamwork: models in delivering patient care. American Physical Therapy Association website. http://www.apta.org/SupervisionTeamwork/Models/. Updated June 20, 2013. Accessed December 9, 2013.

12. Outcome and assessment information set (OASIS). Centers for Medicare and Medicaid Services website. http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/OASIS/index.html. Updated April 5, 2012. Accessed December 28, 2013.

13. Policies & guidelines related to cultural competence and diversity. American Physical Therapy Association website. Updated September 12, 2013. http://www.apta.org/CulturalCompetence/Policies/. Accessed December 9, 2013.

CHAPTER 2

ROLES OF THE PHYSICAL THERAPIST ASSISTANT IN HOME HEALTH CARE

Introduction

Home health is a unique environment where the physical therapist assistant (PTA) may implement physical therapist plans of care in a patient's residence under the supervision of a physical therapist (PT). Physical therapist assistants are graduates of education programs accredited by the Commission on Accreditation in Physical Therapy Education (CAPTE).[1] The role of the PTA has been developing since the 1960s, when very few physical therapists were available to fill the growing demand for physical therapist services. Although PTAs may help expand access to home health physical therapy, the actual use of PTAs varies between jurisdictions due to licensure limitations.

In jurisdictions where PTAs are permitted to provide home health physical therapy, they fulfill several important roles.[2] Some of these roles include:

- Providing direct patient care under physical therapist supervision
- Documenting patient interventions and objective measurements
- Educating patients and caregivers to ensure safety
- Monitoring patient status and reporting changes
- Communicating and collaborating with the physical therapist and the interdisciplinary team

Physical therapist assistants serve in these roles to enhance quality, patient-centered care as contributing members of the home health interdisciplinary team.

GUIDELINE

Under the supervision of a physical therapist, and in compliance with existing standards of care, policies, and regulations, the physical therapist assistant provides patient care, documents services, educates patients and caregivers, monitors progress, and communicates with the interdisciplinary team.

CRITERIA

1. The physical therapist assistant (PTA) *provides patient care* by:
    a. Implementing the plan of care under the supervision[3,4] of the physical therapist
    b. Modifying interventions appropriately within the framework of the plan of care to progress patients toward goals
    c. Respecting cultural diversity and providing quality services to patients and caregivers in a nonjudgmental manner, regardless of the nature of their health problems[5,6]
    d. Maintaining confidentiality of patient information per state and federal regulations[7]
    e. Complying with the American Physical Therapy Association's (APTA) Standards of Practice for Physical Therapy[8]
    f. Complying with APTA's Standards of Ethical Conduct for the Physical Therapist Assistant[9-11]
2. The PTA *documents* skilled patient care by:
    a. Recording patient statements about functional difficulties and improvements noted during the course of care
    b. Describing teaching provided to patient and caregivers
    c. Describing specifically the interventions provided
    d. Recording patient and caregiver response to interventions
    e. Comparing patient performance with prior visits and/or goals
    f. Describing planned intervention modifications for the subsequent visit
    g. Submitting documentation to the agency in a timely manner
3. The PTA *educates* patients and caregivers by:
    a. Instructing in a home exercise program (HEP)
    b. Teaching safety principles
    c. Using appropriate modes of instruction (eg, verbal, demonstration) to facilitate optimal patient and caregiver understanding
    d. Providing preventive education regarding health and wellness
    e. Informing about care transition resources
    f. Participating in professional growth and continuing competence activities

4. The PTA *monitors* patient status by:
    a. Performing objective tests and documenting results
    b. Modifying interventions in response to patient progress, per direction of the supervising physical therapist
5. The PTA *communicates* with the interdisciplinary team by:
    a. Reporting the need for reassessment to the supervising physical therapist and preparing patients for discharge
    b. Conferencing with the supervising physical therapist regarding significant changes in the patient's condition
    c. Reporting observations of environmental issues and abusive situations to the supervising physical therapist and case manager
    d. Participating in multidisciplinary care conferences and quality improvement activities[12]

CASE SCENARIO

Jessica is a physical therapist assistant (PTA) who previously worked in a skilled nursing facility (SNF) for 6 years. She has begun working in the home health setting. She loves the geriatric population and enjoys home health because she gets to work 1-on-1 with patients. She is a self-starter and appreciates the ability to manage her patient schedule. During the past year, she has learned the importance of recording blood pressure, respiratory rate, pulse, and temperature every visit. On several occasions, she has reported to her supervising PT when vital signs were found to be outside parameters, enabling the team of therapists, nurses, and the patient's physician to coordinate an appropriate response to help prevent re-hospitalization. She also discusses her patient's pain level on every visit, and inquires about whether there are any changed medications or any side effects to medications. She reports any changes or problems to her supervising PT and other members of the interdisciplinary team.

Jessica effectively implements plan-of-care interventions within the scope of her license, using evidence-based techniques to optimize outcomes. For example, she uses the appropriate resistance for strengthening exercises, based on principles of safe overloading. She educates on a home exercise program effectively, requiring the patient and/or caregiver to teach back learning and provide return demonstration. She promptly contacts her supervising PT regarding any changes in patient condition to discuss an appropriate response. She and her supervising PT conference weekly to discuss each patient's status relative to the plan of care goals. They consider how many therapy disciplines are involved and verify timely scheduling of the next reassessment. She values her ability to make a difference in the lives of her patients and is honored by the high patient satisfaction scores that her agency receives.

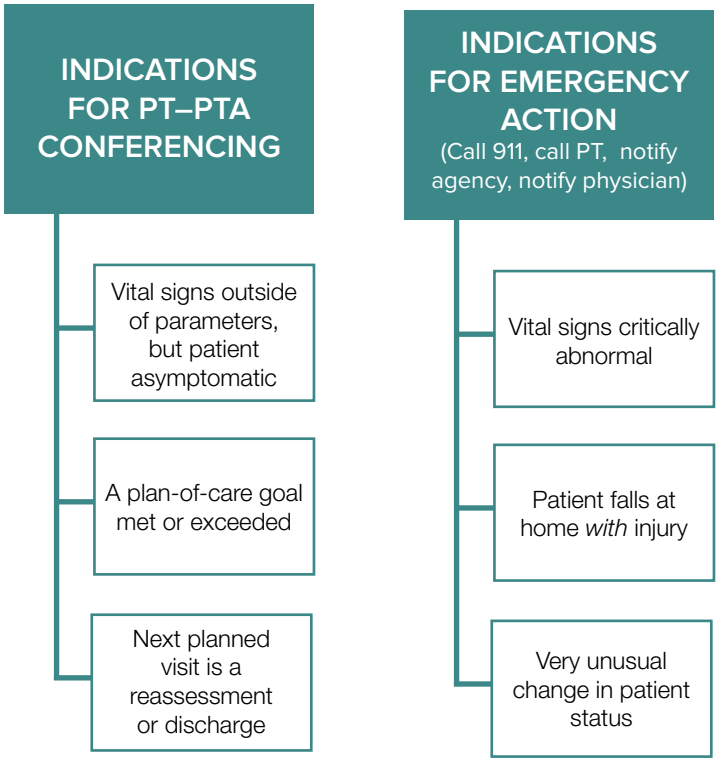
PRACTICAL APPLICATION

- Roles of the Physical Therapist Assistant in the Home Health Setting
- Appropriate PTA Responses to Changes in Patient Condition

Roles of the Physical Therapist Assistant in the Home Health Setting

- Provide patient care
- Document appropriately and timely
- Educate to ensure safety
- Monitor patient progress/changes
- Communicate patient status to supervising PT and collaborate with interdisciplinary team

Figure 2.1. Appropriate PTA responses to changes in patient condition.



References

1. Evaluative Criteria: PTA Programs. Alexandria, VA: Commission on Accreditation in Physical Therapy Education; 2013. http://www.capteonline.org/uploadedFiles/CAPTEorg/About_CAPTE/Resources/Accreditation_Handbook/EvaluativeCriteria_PTA.pdf. Accessed December 17, 2013.

2. Role of a physical therapist assistant (PTA). American Physical Therapy Association website. http://www.apta.org/PTACareers/RoleofaPTA/. Updated March 28, 2013. Accessed December 17, 2013.

3. American Physical Therapy Association House of Delegates. Levels of supervision (HOD P06-00-15). Alexandria, VA: American Physical Therapy Association; 2000. http://www.apta.org/uploadedFiles/APTAorg/About_Us/Policies/Terminology/LevelsSupervision.pdf. Accessed December 17, 2013.

4. PTA patient care & supervision. American Physical Therapy Association website. http://www.apta.org/PTA/PatientCare/. Updated February 20, 2013. Accessed December 17, 2013.

5. Policies & guidelines related to cultural competence and diversity. American Physical Therapy Association website. http://www.apta.org/CulturalCompetence/Policies/. Updated September 12, 2013. Accessed December 17, 2013.

6. American Physical Therapy Association House of Delegates. Nondiscrimination in the provision of physical therapy services (HOD P06-03-24-21). Alexandria, VA: American Physical Therapy Association; 2003. http://www.apta.org/uploadedFiles/APTAorg/About_Us/Policies/HOD/Health/Nondiscrimination.pdf. Accessed December 17, 2013.

7. Health information privacy. US Department of Health and Human Services website. http://www.hhs.gov/ocr/privacy/. Accessed December 17, 2013.

8. American Physical Therapy Association House of Delegates. Standards of practice for physical therapy (HOD P06-13-22-15). Alexandria, VA: American Physical Therapy Association; 2013. http://www.apta.org/uploadedFiles/APTAorg/About_Us/Policies/Practice/StandardsPractice.pdf. Accessed December 17, 2013.

9. American Physical Therapy Association House of Delegates. Standards of ethical conduct for the physical therapist assistant (HOD S06-09-20-18). Alexandria, VA: American Physical Therapy Association; 2009. http://www.apta.org/uploadedFiles/APTAorg/About_Us/Policies/Ethics/StandardsEthicalConductPTA.pdf. Accessed December 17, 2013.

10. American Physical Therapy Association Ethics and Judiciary Committee. Guide for conduct of the physical therapist assistant. Alexandria, VA: American Physical Therapy Association; 2010. http://www.apta.org/uploadedFiles/APTAorg/Practice_and_Patient_Care/Ethics/GuideforConductofthePTA.pdf. Accessed December 17, 2013.

11. American Physical Therapy Association Department of Physical Therapist Assistant Services and Department of Academic/Clinical Education Affairs. Values-based behaviors for the physical therapist assistant. Alexandria VA: American Physical Therapy Association; 2011. http://www.apta.org/uploadedFiles/APTAorg/PTAs/Careers/Values/ValuesBasedBehaviorsforPTA.pdf. Accessed December 17, 2013.

12. PT/PTA teamwork: models in delivering patient care. American Physical Therapy Association website. http://www.apta.org/SupervisionTeamwork/Models/. Updated June 20, 2013. Accessed December 9, 2013.

CHAPTER 3

QUALIFICATIONS

Introduction

The task of hiring and training a new physical therapist or physical therapist assistant can be challenging for home health agencies. It is imperative that therapists chosen to represent the agency or provider have the appropriate qualifications and skills to safely manage patients. Patients receiving home health physical therapy should benefit from a quality standard of care that inspires confidence in the ability of their therapist(s) to safely and effectively manage their health care needs.

Most agencies recognize the importance of finding therapists who are a "good fit" for their organizational goals for quality patient care. To this end, they may consider the mission of the organization and the unique needs of their patient population (eg, therapist compatibility with company culture, specialized training/qualifications, languages spoken). Meanwhile, the provision of home health services requires that a quality standard be maintained. The information in this chapter provides valuable guidance to agencies and clinicians to help ensure that the providers of home health services are adequately prepared prior to patient care, and that skills and knowledge are sufficiently maintained for quality care on an ongoing basis.

GUIDELINE

Appropriately qualified professionals provide home health physical therapist services in accordance with best practice standards.

CRITERIA

1. The physical therapist (PT) and physical therapist assistant (PTA) are health care professionals who have met the criteria for licensure as defined by federal guidelines.[1,2]
2. The PT and PTA are licensed to practice in the jurisdiction(s) in which the therapist provides care as required by law and, where applicable, meet all licensure requirements as defined by the jurisdiction.[3,4]
3. The PT and PTA comply with any jurisdiction-specific requirements for home health and, where applicable, reference and comply with the standards established by the jurisdiction's Department of Health.[5,6]
4. The PT and PTA are certified in basic life support (BLS)[7] in accordance with the certifying agency's guidelines and state regulations (eg, American Red Cross CPR/AED for Professional Rescuers and Health Care Providers[8] and American Heart Association Basic Life Support[9]).
5. The PT and PTA comply with applicable infection control guidelines developed by:
    a. The Centers for Disease Control and Prevention (eg, health care associated infections,[10] bloodborne pathogens[11])
    b. The Occupational Safety and Health Administration (eg, personal protective equipment,[12] respiratory protection,[13] exposure to tuberculosis[14])
    c. Agency policies and procedures
6. The PT and PTA are obligated to:
    a. Practice/work at or above the level determined to be the minimal acceptable standard that will ensure safe patient practice
    b. Participate in ongoing professional/career development that maintains the expected level of clinical practice/competency[15-19]
7. Related physical therapy experience is recommended for PTs and PTAs entering home health care to ensure that knowledge and skills are sufficient to safely provide physical therapist services to patients.[20] Agencies may promote ongoing therapist qualification for safe and appropriate patient care by:
    a. Performing pre-hire or pre-contract interviews with clinicians in which topics of clinical competency are discussed in detail specific to the needs of patients served by the home health agency
    b. Formally assessing clinical competencies post-hire or post-contract and prior to the provision of patient care
    c. Providing additional mentoring and training resources for clinicians new to home health care
    d. Supporting continuing competence and educational opportunities to promote lifelong learning
    e. Completing regularly scheduled clinician performance evaluations

CASE SCENARIO

Tom and Jessica were each interviewed by the home health agency. The interviews included discussions of the clinical needs of the patients served by the agency and a background check to ensure that both Tom and Jessica were properly licensed. During the interview process, the agency representative noted that both have the flexibility to provide home health services and determined that they have the organizational ability to manage patient schedules appropriately. From their respective conversations, Tom and Jessica made clear that they looked at patients holistically, considering all aspects of a patient's needs including their diagnoses, home safety, living situation, caregiver availability, social support network, and transportation needs. It was also evident that they were already in the habit of performing PT–PTA conferences regularly and coordinating care with the physician and with other disciplines when appropriate. They both verbalized understanding of how to identify problems with medication management and respond appropriately.

Tom has some experience and training with providing wound care and is certified for lymphedema management. The home health agency explained to Tom that they would require that he provide evidence of training and competency in these areas prior to treating patients with these conditions. Tom and Jessica reported being comfortable using the modalities that the agency has available (eg, electrical stimulation, ultrasound), but the agency plans to have a preceptor therapist meet with them to have them demonstrate competency. This preceptor will assist with orientation and discuss other competencies identified by the agency as important for safe patient care, and report back to agency leadership when Tom and Jessica are cleared for patient care.

PRACTICAL APPLICATION

- Home Health Qualifications for PTs and PTAs
- Home Health PTA Supervision Requirements by Jurisdiction

Table 3.1. Home Health Qualifications for PTs and PTAs

Criteria	Application for Home Health Agency	References
1. Licensure/Certification/ Registration The physical therapist (PT) and physical therapist assistant (PTA) are health care professionals who have met the criteria for licensure as defined by federal guidelines.	Agency verifies licensure as required in the jurisdictions within the area of coverage of the home health agency. Agency performs required background checks (eg, criminal, Medicare exclusion, disciplinary actions). Agency verifies other requirements as needed (eg, liability insurance, automobile insurance, driver's license).	US Government Printing Office. 42 CFR 484.4—Personnel qualifications.[1] American Physical Therapy Association House of Delegates. Consumer protection in the provision of physical therapist services: qualifications of persons providing physical therapist services (HOD P06-01-20-20).[2]
2. PT and PTA Licensure Requirements The PT and PTA are licensed to practice in the jurisdiction(s) in which the therapist provides care and meet all licensure requirements as defined by the jurisdiction.	Agency verifies that therapists meet requirements for active licensure, including continuing education.	Practice acts by state. American Physical Therapy Association.[3] Licensure reference guide. The Federation of State boards of Physical Therapy.[4]
3. PT and PTA Jurisdiction Requirements PT and PTA comply with any jurisdiction-specific requirements for home health and, where applicable, reference and comply with the standards established by the jurisdiction's Department of Health.	Agency verifies adequate PTA supervision by the PT according to the requirements of the state/ jurisdiction *and* the professional judgment of supervising PT. Agency determines if any payer restrictions are relevant to use of PTA services.	US Government Printing Office. 42 CFR 484.12—Condition of participation: compliance with federal, state, and local laws, disclosure and ownership information, and accepted professional standards and principles.[5] State health departments and services. State and Local Government on the Net.[6]

Table 3.1. (Continued)

4. Basic Life Support and Cardiopulmonary Resuscitation PT and PTA are certified in basic life support (BLS) in accordance with the certifying agency's guidelines and state regulations.	PT and PTA complete BLS training prior to providing patient care. Agency verifies that BLS training meets its requirements (eg, American Red Cross CPR/AED for Professional Rescuers and Health Care Providers, American Heart Association Basic Life Support, or equivalent).	American Physical Therapy Association House of Delegates. Cardiopulmonary resuscitation (HOD P06-06-12-09).[7] American Red Cross. First aid, CPR, and AED certification.[8*] American Heart Association. Basic life support.[9*] *Inclusion of these references should not be interpreted as endorsement by APTA or the Home Health Section.
5. Infection Control Guidelines The PT and PTA comply with applicable infection control guidelines developed by: a.) The Centers for Disease Control (CDC); b.) The Occupational Safety and Health Administration (OSHA); and c.) Agency-specific policies and procedures.	PT and PTA demonstrate compliance with standards of infection control, including bag technique and hand washing. PT and PTA to follow agency-specific infection control guidelines.	Centers for Disease Control and Prevention. Healthcare associated infections (HIAs).[10] US Dept of Labor. Bloodborne pathogens.[11] US Dept of Labor. Personal protective equipment.[12] US Dept of Labor. Respiratory protection.[13] US Dept of Labor. Enforcement procedures and scheduling for occupational exposure to tuberculosis.[14]

Table 3.1. (Continued)

6. PT and PTA Standards of Practice The PT and PTA are obligated to: a.) Practice/work at or above the level determined to be the minimal acceptable standard that will ensure safe and effective patient practice; and b.) Participate in ongoing professional/career development that maintains a level of clinical practice/ competence consistent with minimal acceptable standards.	PT and PTA provide care that is culturally sensitive, professional, and compassionate. PT and PTA provide care based upon evidence-based practice, including use of valid standardized tests and clinical practice guidelines (CPGs). PT and PTA demonstrate core values identified by APTA, including: 1. Accountability 2. Compassion/caring 3. Excellence 4. Integrity 5. Professional duty 6. Social responsibility PT and PTA demonstrate behaviors consistent with the Code of Ethics for the Physical Therapist and Standards of Ethical Conduct for the Physical Therapist Assistant.	American Physical Therapy Association Board of Directors. Professionalism in physical therapy: core values (BOD 05-04-02-03).[15] American Physical Therapy Association House of Delegates. Code of ethics for the physical therapist (HOD S06-09-07-12).[16] American Physical Therapy Association House of Delegates. Standards of ethical conduct for the physical therapist assistant (HOD-S06-09-20-18).[17] American Physical Therapy Association House of Delegates. Standards of practice for physical therapy (HOD-S06-13-22-15).[18] American Physical Therapy Association House of Delegates. Nondiscrimination in the provision of physical therapy services (HOD P06-03-24-21).[19]

Table 3.1. (Continued)

7. Knowledge and Skills Competency Related physical therapy experience is recommended for PTs and PTAs entering home health care to ensure that knowledge and skills are sufficient to safely provide physical therapist services to patients. Agencies may promote ongoing therapist qualification for safe and appropriate patient care by: a.) Performing pre-hire or pre-contract interviews with clinicians in which topics of clinical competency are discussed in detail specific to the needs of patients served by the home health agency b.) Formally assessing clinical competencies post-hire or post-contract and prior to the provision of patient care c.) Providing additional mentoring and training resources for clinicians new to home health care d.) Supporting continuing competence/educational opportunities to promote lifelong learning e.) Completing regularly scheduled clinician performance evaluations	Agency completes competency assessments prior to PT or PTA providing patient care. Agency provides further education or mentoring for any deficits noted. Agency provides mentoring resources to any new clinician in home health to ensure effective preparation for his or her role. Agency supports continuing competence/education opportunities to promote enhanced knowledge base among therapy staff. Agency completes performance evaluations that hold PT and PTA to standard of care consistent with safe patient care and timely and appropriate documentation.	Career management. American Physical Therapy Association website.[20]

Home Health PTA Supervision Requirements by Jurisdiction

The level of physical therapist assistant (PTA) supervision varies from one jurisdiction to another. Physical therapists (PTs), PTAs, and home health agencies need to know how the regulations for their jurisdiction affect PTA utilization in the home health setting. The Federation of State Boards of Physical Therapy and APTA provide valuable reference information for identifying PTA supervision requirements by jurisdiction. Reference information is provided below, but clinicians are responsible for recognizing that this reference material may not be updated as quickly as the various practice regulations around the country. Therefore, this reference material should not take precedence over having a good working knowledge of the most up-to-date practice regulations applicable to the jurisdiction where one is licensed to practice.

PTA Supervision Requirements by Jurisdiction
The Federation of State Boards of Physical Therapy
https://www.fsbpt.org/Portals/0/documents/free-resources/JLRGSupervisionRequirements_201006.pdf.

Physical Therapy Practice Acts by State
American Physical Therapy Association
http://www.apta.org/Licensure/StatePracticeActs/

References

1. US Government Printing Office. 42 CFR 484.4—Personnel qualifications. http://www.gpo.gov/fdsys/granule/CFR-2011-title42-vol5/CFR-2011-title42-vol5-sec484-4/content-detail.html. Accessed December 20, 2013.

2. American Physical Therapy Association House of Delegates. Consumer protection in the provision of physical therapy services: qualifications of persons providing physical therapy services (HOD P06-01-20-20). Alexandria, VA: American Physical Therapy Association; 2001. http://www.apta.org/uploadedFiles/APTAorg/About_Us/Policies/HOD/Practice/ConsumerProtection.pdf. Accessed December 20, 2013.

3. Practice acts by state. American Physical Therapy Association website. http://www.apta.org/Licensure/StatePracticeActs/. Updated April 20, 2014. Accessed May 30, 2014.

4. Licensure reference guide. The Federation of State Boards of Physical Therapy website. http://www.fsbpt.org/FreeResources/RegulatoryResources/LicensureReferenceGuide.aspx. Accessed December 28, 2013.

5. US Government Printing Office. 42 CFR 484.12—Condition of participation: compliance with federal, state, and local laws, disclosure and ownership information, and accepted professional standards and principles. http://www.gpo.gov/fdsys/granule/CFR-2011-title42-vol5/CFR-2011-title42-vol5-sec484-12/content-detail.html**.** Accessed December 20, 2013.

6. State health departments and services. State and Local Government on the Net website. http://www.statelocalgov.net/50states-health.cfm. Accessed December 28, 2013.

7. American Physical Therapy Association House of Delegates. Cardiopulmonary resuscitation (HOD P06-06-12-09). Alexandria, VA: American Physical Therapy Association; 2006. http://www.apta.org/uploadedFiles/APTAorg/About_Us/Policies/Health_Social_Environment/CardiopulmonaryResuscitation.pdf#search=%22cardiopulmonary_resuscitation%22. Accessed December 20, 2013.

8. First aid, CPR, and AED certification. American Red Cross website. http://www.redcross.org/CPR-Training. Accessed August 14, 2014.

9. Basic life support. American Heart Association website. http://www.heart.org/HEARTORG/CPRAndECC/HealthcareProviders/BasicLifeSupportBLS/Basic-Life-Support-BLS_UCM_001281_SubHomePage.jsp. Accessed August 14, 2014.

10. Healthcare associated infections (HIAs). Centers for Disease Control and Prevention website. http://www.cdc.gov/hai/prevent/prevent_pubs.html. Updated January 27, 2014. Accessed May 30, 2014.

11. Standards 29 CFR 1910.1030 Bloodborne pathogens. US Department of Labor website. https://www.osha.gov/SLTC/bloodbornepathogens/. Accessed April 30, 2014.

12. US Department of Labor. Personal protective equipment. Website. https://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=STANDARDS&p_id=9777. Accessed December 28, 2013.

13. US Department of Labor. Respiratory protection. Website. https://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=STANDARDS&p_id=9777 . Accessed December 28, 2013.

14. US Department of Labor. Enforcement procedures and scheduling for occupational exposure to tuberculosis. Website. https://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=DIRECTIVES&p_id=1586&p_text_version=FALSE. Accessed December 28, 2013.

15. American Physical Therapy Association Board of Directors. Professionalism in physical therapy: core values (BOD 05-04-02-03). Alexandria, VA: American Physical Therapy Association; 2004. http://www.apta.org/uploadedFiles/APTAorg/About_Us/Policies/BOD/Judicial/ProfessionalisminPT.pdf. Accessed December 28, 2013.

16. American Physical Therapy Association House of Delegates. Code of ethics for the physical therapist (HOD S06-09-07-12). Alexandria, VA: American Physical Therapy Association; 2009. http://www.apta.org/uploadedFiles/APTAorg/About_Us/Policies/Ethics/CodeofEthics.pdf. Accessed December 28, 2013.

17. American Physical Therapy Association House of Delegates. Standards of ethical conduct for the physical therapist assistant (HOD-S06-09-20-18). Alexandria, VA: American Physical Therapy Association; 2009. http://www.apta.org/uploadedFiles/APTAorg/About_Us/Policies/Ethics/StandardsEthicalConductPTA.pdf. Accessed December 28, 2013.

18. American Physical Therapy Association House of Delegates. Standards of practice for physical therapy (HOD-S06-13-22-15). Alexandria, VA: American Physical Therapy Association; 2013. http://www.apta.org/uploadedFiles/APTAorg/About_Us/Policies/Practice/StandardsPractice.pdf. Accessed December 28, 2013.

19. American Physical Therapy Association House of Delegates. Nondiscrimination in the provision of physical therapy services (HOD P06-03-24-21). Alexandria, VA: American Physical Therapy Association; 2003. http://www.apta.org/uploadedFiles/APTAorg/About_Us/Policies/Health_Social_Environment/NonDiscriminationProvisionPTServices.pdf. Accessed December 28, 2013.

20. Career management. American Physical Therapy Association website. http://www.apta.org/CareerManagement/. Updated December 30, 2013. Accessed May 30, 2014.

CHAPTER 4

ORIENTATION TO THE AGENCY

Introduction

The task of orienting and training a new physical therapist (PT) or physical therapist assistant (PTA) has become increasingly important as home health providers seek to improve the quality of therapy services. Training new clinicians is costly, and well-planned orientation can enhance retention. A comprehensive and organized orientation process is essential for building a strong therapy team and furthering the mission and objectives of the home health agency.

Although field therapists can learn from experience, they will make many mistakes that are unnecessary and potentially damaging to the agency's reputation. Agency orientation programs fail for several reasons:

- The orientation was not planned.
- The clinician was unaware of the home health job requirements and protocols.
- The therapist does not feel welcomed or supported with administrative issues.
- The field therapist hired does not meet qualification standards as set by APTA to practice in this setting.

Effective orientation should include familiarizing new PTs and PTAs with agency operations, with an overall design to inspire their support for the unique mission of the organization. Clinicians must also be oriented to regulatory requirements related to the provision of home health services. The orientation also should include training to facilitate direct patient care that is evidence based and implements best practices. Precepting/mentoring is an effective approach for assisting agencies with providing a quality orientation, which in turn may contribute to improved clinician retention.[1-3] The guideline and criteria in this chapter provide direction on how to customize a comprehensive orientation for therapy field staff.

GUIDELINE

The PT and PTA receive a comprehensive agency orientation that at a minimum includes training on policies and procedures involving agency administration and on the safe provision of direct patient care.

CRITERIA

1. The agency provides orientation regarding administrative policies and procedures that include, but are not limited to:
    a. Agency philosophy, which may include a statement of the company's mission, values, and/or vision
    b. Agency organizational structure, including:
        i. Hierarchy, including ownership
        ii. Reporting structure, including:
            1. Clinical reporting
            2. Administrative reporting
        iii. Corporate compliance, including:
            1. Regulatory compliance (eg, Health Insurance Portability and Accountability Act [HIPAA], Medicare Conditions of Participation)
            2. Ethical compliance
        iv. List of agency contact information
    c. Policy and procedure manual
        i. Physical therapist (PT) and physical therapist assistant (PTA) review and sign all appropriate forms of acknowledgment as required by agency
        ii. Employee handbook, if available, is issued to PT and PTA
    d. Risk management and quality improvement efforts, including:
        i. Occurrence reporting
        ii. Complaint response process
        iii. Quality improvement initiatives, including efforts to improve:
            1. Outcomes
            2. Patient experience
        iv. If applicable, accrediting agency requirements (eg, Joint Commission, Community Health Accreditation Program)
    e. Regulatory overview

i. Applicable municipal, state, and federal rules and regulations (eg, conditions of participation, prospective payment system, local coverage determinations)
ii. Patient privacy (HIPAA)
iii. Reimbursement source/third-party payer requirements
iv. Quality assurance, improvement programs, and public reporting
    1. Outcome-Based Quality Improvement (OBQI) / Outcome-Based Quality Monitoring (OBQM)
    2. OASIS Quality and Process Measures
    3. Home Health Compare
    4. HHCAHPS Survey

f. Services provided by the agency, including:
    i. Nursing
    ii. Physical therapy
    iii. Occupational therapy
    iv. Speech therapy
    v. Home health aide
    vi. Social work
    vii. Dietician
    viii. Care sitting
g. Hours of operation, including:
    i. Regular service hours
    ii. On-call service, including plans for staffing weekends and holidays (eg, on-call schedule)
h. Time-off/vacation requests
    i. Request policy/procedure and approval considerations
    ii. Coverage planning/expectations, including procedure for ensuring adequate PTA supervision is maintained (where applicable)
i. Payroll instructions/processes
j. Performance evaluations, including a review of key performance expectations and evaluation schedule/frequency
k. Professional responsibilities/expectations, which may include:
    i. Continuing competence
    ii. Professional growth/development
    iii. Mentoring clinicians new to home care
    iv. Mentoring students (if applicable)
l. Employee benefits information (per agency)

m. Job description, which may include:
    i. Required work hours
    ii. Productivity expectations
    iii. Physical job demands
    iv. In-home visit time expectations
    v. Documentation expectations
    vi. Required meeting attendance
    vii. Interdisciplinary communication
    viii. On-call expectations for weekends/holidays

n. Agency interdisciplinary communication processes (eg, team meetings, initial case report, status report, discharge notification, reassessment planning), including:
    i. Communication logistics (eg, onsite meeting, phone call, e-mail)
    ii. Documentation requirements
    iii. Meeting frequency and expected duration
    iv. Attendance and participation requirements and expectations
    v. Meeting preparation

2. The agency provides orientation regarding the safe provision of direct patient care following best practices and current evidence. Orientation may include education on:
    a. Patient care processes for:
        i. Timely management of new referrals
        ii. Appointment scheduling
        iii. Verification of appropriate visit types (eg, OASIS vs PT evaluation only)
        iv. Securing additional orders from the physician
    b. Patient admission/start-of-care forms, and policies and procedures, including:
        i. Home folder contents
        ii. Consent forms
        iii. Patient rights and responsibilities
        iv. Privacy
        v. Complaint procedure
    c. Chart review to include locating patient demographics, advance directives, physician orders, medication profile, diagnoses/coding, and homebound status
    d. Clinical competency/skills assessment, which may include:
        i. Clinician self-assessment of skills and certifications

ii. Competency ensured via written testing and/or demonstration of techniques for:
    1. Clinical skills
    2. Tests and measures
    3. OASIS
    4. Oxygen safety
    5. Infection control
iii. Training to recognize abuse and neglect, and reporting procedures
iv. Field observation
v. Competency testing
vi. Other requirements per agency policy

e. Basic life-support training requirements
f. Infection control
g. Dress code and personal appearance
h. Physician orders/communication, including:
    i. Organizing communication to physician using standardized method for efficiency (eg, Situation Background Assessment Recommendation [SBAR])
    ii. Obtaining and appropriately documenting receipt of verbal orders
    iii. Timely communication regarding sudden changes in patient status (eg, vital signs outside parameters, falls, emergency care)
    iv. Managing hold orders (eg, hospital hold, patient request)
i. Homebound status
j. OASIS instructions, time points, and management
k. Clinical documentation requirements:
    i. Types of forms/format required (eg, electronic record, paper forms)
    ii. Approved abbreviation list (including list of "do not use" abbreviations)
    iii. Physician orders
    iv. Expectations regarding content, including compliance with third-party payer requirements (eg, local coverage determination)
    v. Requirements for timely submission
    vi. Instructions for correct application of clinical instruments, and tests and measures (eg, OASIS, standardized tests, evidence-based measures)
    vii. Change of service/discharge notification (eg, patient notification)
    viii. Home logbook documentation
    ix. Agency policy regarding patient/clinician signatures on visit notes
    x. Other requirements per agency policy
l. Plan of care development and visit scheduling per evaluation findings, safety considerations, prior level of function, patient and caregiver goals, and recommended evidence-based interventions

m. Supervision requirements for PTs, including:
    i. PTA supervision
    ii. Home health aide supervision
n. Patient and caregiver safety, including:
    i. Protocol for requesting emergency care
    ii. Identification of home safety concerns
    iii. Falls prevention education
    iv. Medication profile management/reconciliation
    v. Procedures for minimizing re-hospitalization
    vi. Oxygen safety
o. Diagnoses coding
p. Discharge planning, including advance notification, forms, and procedures (eg, interdisciplinary coordination)
q. Emergency preparedness and disaster response plan, including priority codes and triaging process
r. Workplace safety, including:
    i. Driving safety
    ii. Auto insurance
    iii. Visit safety (eg, animals, weapons)
    iv. Community safety
    v. Personal protection equipment (PPE)
    vi. Hazardous materials and Safety Data Sheet (SDS) location
s. Therapy supplies and equipment, including:
    i. Description of therapy supplies issued by agency for clinician use during visits
    ii. Policies regarding issuance of supplies/equipment to patients or caregivers
    iii. Process for checking out and caring for therapy modalities (eg, ultrasound, neuromuscular electrical nerve stimulation [NMES])
    iv. Infection control with equipment use

CASE SCENARIO

The agency for which Tom and Jessica work has a 2-week orientation, an assigned preceptor, and a 3-month probation period. They received some initial training in the office and then were assigned to ride with their preceptor for field training. Competencies were discussed and rated, and the preceptor was instructed to follow up and verify competency. The preceptors determined the new clinicians' readiness for beginning to perform their own visits and provided training reports to the agency supervisor. The preceptors instructed the patient scheduler to follow a "ramp-up" scheduling plan to avoid overwhelming Tom and Jessica during their first 2 or 3 weeks of treating patients. The availability of the preceptors to answer many routine questions from Tom and Jessica lightened the burden on the agency supervisor while promoting a helpful and encouraging experience for these new clinicians. Tom and Jessica commented to one another that this was the best orientation they have ever had, and they are pleased with the support they have felt. Most important, they are satisfied with their decision to work for this agency and view this as a long-term decision. Agency management has noticed a 15% reduction in clinician turnover since implementing this comprehensive orientation plan 2 years ago, and their patient satisfaction scores have been climbing steadily.

PRACTICAL APPLICATION

- Home Health Agency PT/PTA Orientation: Administrative Policies and Procedures
- Home Health Agency PT/PTA Orientation: Direct Patient Care Policies and Procedures
- Orientation/Human Resources: Common Resources

Table 4.1. Home Health Agency PT/PTA Orientation: Administrative Policies and Procedures

Administrative Policies And Procedures		Description
☐	Agency philosophy	• Mission statement • Company values • Company's vision
☐	Agency organizational structure	• Hierarchy/ownership • Reporting structure for clinical and administrative issues • Corporate compliance with regulatory and ethical matters • List of agency contact information
☐	Policy and procedure manual	• Agency-specific forms for PT/PTA signature • Employee handbook
☐	Risk management and quality improvement efforts	• Occurrence reporting • Complaint response process • Quality improvement initiatives (eg, outcomes, patient experience) • Accrediting agency requirements (if applicable)
☐	Regulatory overview	• Municipal, state, and federal rules and regulations • HIPAA • Reimbursement source/third-party payer requirements • Quality assurance, improvement programs, and public reporting • (OBQI/OBQM, OASIS Quality/Process Measures, Home Health Compare, HHCAHPS)
☐	Services provided by the agency	• Nursing, PT, OT, SLP, social work, dietetics, care sitting, etc
☐	Hours of operation	• Regular service hours • On-call service, including plans for staffing weekends and holidays (eg, on-call schedule)
☐	Time-off/vacation requests	• Request policy/procedure and approval considerations • Coverage planning/expectations, including procedure for ensuring adequate PTA supervision is maintained (where applicable)
☐	Payroll instructions/processes	• Due dates, timesheets, and submission process
☐	Performance evaluations	• Key performance expectations • Evaluation schedule/frequency

Table 4.1. (Continued)

☐	Professional responsibilities/ expectations	• Continuing competence • Professional growth/development • Mentoring clinicians new to home care • Mentoring students
☐	Employee benefits information	• Per agency
☐	Job description	• Required work hours • Productivity expectations • Physical job demands • In-home visit time expectations • Documentation expectations • Required meeting attendance • Interdisciplinary communication • On-call expectations for weekends/holidays • Other agency-specific items
☐	Agency interdisciplinary communication processes	• Team meetings, initial case report, status report, discharge notification, and reassessment planning • Communication logistics (eg, onsite meeting, phone call, e-mail) • Documentation requirements • Meeting frequency and expected duration • Attendance/participation requirements and expectations • Meeting preparation

Table 4.2. Home Health Agency PT/PTA Orientation: Direct Patient Care Policies and Procedures

Direct Patient Care Policies and Procedures		Description
☐	Patient care processes	• Timely management of new referrals • Appointment scheduling • Verification of appropriate visit types • Securing additional orders from the physician • Patient admission information, including start-of-care contents, consent forms, home folder contents (eg, rights and responsibilities, privacy, complaint procedure)
☐	Patient admission/start-of-care forms and policies/ procedures	• Home folder contents • Consent forms • Patient rights and responsibilities • Privacy • Complaint procedure
☐	Chart review	• Locating patient demographics • Advance directives • Physician orders • Medication profile • Diagnoses/coding • Homebound status • Other
☐	Clinical competency/skills assessment	• Clinician self-assessment of skills and certifications • Competency verification by supervisor/preceptor, with regard to clinical skills, tests and measures, OASIS, oxygen safety, infection control, etc • Training to recognize abuse and neglect, and reporting procedures • Field observation • Competency testing • Other competency requirements per agency policy
☐	Basic life support training requirements	• Refer to APTA guidance • Specify requirements (hands-on vs online) for both initial certification and renewal
☐	Infection control	• Universal precautions • Hand washing • Bag technique • Equipment management/cleaning
☐	Dress code and appearance	• Per agency policy

Table 4.2. (Continued)

☐	Physician orders/ communication	• Organizing communication to physician with standardized method for efficiency (eg, SBAR) • Obtaining and appropriately documenting receipt of verbal orders • Timely communication regarding sudden changes in patient status (eg, vital signs outside parameters, falls, emergency care) • Managing hold orders (eg, hospital hold, patient request)
☐	Homebound status	• Per payer requirements for coverage
☐	OASIS instructions, time-points, and management	• Per CMS training materials regarding OASIS
☐	Clinical documentation requirements	• Types of forms/format required (eg, electronic record, paper forms) • Approved abbreviation list (including list of "do not use" abbreviations) • Physician orders • Expectations regarding content, including compliance with third-party payer requirements (eg, local coverage determinations) • Requirements for timely submission • Instructions for correct application of clinical instruments, and tests and measures (eg, OASIS, standardized tests, evidence-based measures) • Change of service/discharge notification (eg, patient notification) • Home logbook documentation • Agency policy regarding patient/clinician signatures on visit notes • Other requirements per agency policy
☐	Plan of care development and visit scheduling	• Per evaluation findings, safety considerations, prior level of function, patient and caregiver goals, and recommended evidence-based interventions
☐	Supervision requirements for PTs	• PTA supervision (if applicable) • Home health aide supervision (if applicable)
☐	Patient and caregiver safety	• Protocol for requesting emergency care • Identification of home safety concerns • Falls prevention education • Medication profile management/reconciliation • Procedures for minimizing re-hospitalization • Oxygen safety • Competency requirements (eg, field observation, competency testing)
☐	Diagnoses coding	• Per agency policy and training

Table 4.2. (Continued)

☐	Discharge planning	• Advance patient and caregiver notification • Discharge instruction forms • Discharge procedures (eg, interdisciplinary coordination)
☐	Emergency preparedness and disaster response plan	• Review priority codes and triaging process
☐	Workplace safety	• Driving safety • Visit safety (eg, animals, weapons) • Community safety • Personal protection devices (PPD) • Auto insurance • Hazardous materials and Safety Data Sheet (SDS) location • Emergency preparedness and disaster response plan
☐	Therapy supplies and equipment	• Description of therapy supplies issued by agency for clinician use during visits • Policy regarding issuance of supplies/equipment to patients/caregivers • Process for checking out/caring for therapy modality equipment (eg, ultrasound, NMES) • Infection control with equipment use

Orientation/Human Resources: Common Resources

Centers for Medicare and Medicaid Services (CMS)
Provides health coverage through Medicare, Medicaid, and the Children's Health Insurance Program
www.cms.gov, www.cms.gov/Medicare/Medicare.html (specific to Medicare, Medicare Advantage plans, home health quality initiatives, and home health agency centers)

US Department of Health and Human Services (HHS)
Principal federal agency for protecting Americans' health and providing essential human services, especially for those least able to help themselves
www.hhs.gov

The Joint Commission
An independent, not-for-profit organization that accredits and certifies health care organizations and programs in the United States that commit to meeting certain performance standards
www.jointcommission.org

Community Health Accreditation Program (CHAP)
Surveys agencies providing home health, hospice, and home medical equipment services, to determine if they meet the Medicare conditions of participation and CMS quality standards
www.chapinc.org

OASIS Answers
Includes questions and answers to guide completion of OASIS questions
www.oasisanswers.com

Home Health Compare
Quality of care ratings per OASIS and Medicare quality measures
www.medicare.gov/homehealthcompare

Consumer Assessment of Healthcare Providers and Systems (CAHPS)
Consumer survey to measure the experience of people receiving home health care from Medicare-certified home health agencies.
www.homehealthcahps.org

American Physical Therapy Association

Information relevant to physical therapist practice in home health, though APTA and its specialty sections

www.apta.org

www.homehealthsection.org

www.geriatricspt.org

www.neuropt.org (outcome measure recommendations for stroke, multiple sclerosis, spinal cord injury, traumatic brain injury)

www.ptnow.org (APTA resource for evidence-based practice)

Rehabilitation Measures Database

Identification and summaries of reliable and valid measurement instruments

www.rehabmeasures.org

NOTE: This is not a comprehensive list, but it includes several established resources to ensure that orientation material is accurate and appropriate.

References

1. Accountemps survey: one in three employers lacks orientation program for new hires [news release]. Menlo Park, CA: Accountemps, a division of Robert Half; March 20, 2012. http://accountemps.rhi.mediaroom.com/orientation. Accessed May 30, 2014.

2. Wallace K. Creating an effective new employee orientation program. *Library Leadership & Management*. 2009;23(4):168-176. http://journals.tdl.org/llm/index.php/llm/issue/view/116. Accessed May 30, 2014.

3. Lindo DK. New employee orientation is your job! *Supervision*. August 1999;60(8):6-9. .

CHAPTER 5

REFERRAL INFORMATION

Introduction

Referral information should provide the agency with diagnostic information to assist the physical therapist with the evaluation process and the development of an appropriate plan of care to address the patient's functional deficits. Referral information is received via diverse sources (eg, phone contact, e-mail, facsimile, databases, tablets). It is important for the agency to pursue a basic set of information upon receipt of the referral. The physical therapist plays an important role in this process.

The physical therapist should review the orders upon referral and seek clarification from and/or provide feedback to the physician as indicated. This communication influences the quality of the plan of care through order clarification. Furthermore, it enhances effective case management and encourages interdisciplinary dialogue. This chapter provides guidance for agencies and therapists about essential referral information.

GUIDELINE

The physical therapist has available pertinent and legible information from referral sources prior to the initial patient encounter/visit in order to provide effective case management, inclusive of comprehensive examination, evaluation, and ongoing intervention.

CRITERIA

1. The information received from the referral source should include:[1]
    a. Patient information:
        i. Name
        ii. Date of birth (DOB)
        iii. Address and phone number
        iv. Languages spoken
            1. Interpreter needs, and, if applicable, the name of the interpreter
        v. Diagnoses (eg, ICD code, date of onset or exacerbation)
        vi. Reason for physical therapy referral
        vii. Referral physician order
        viii. Date of referral
            1. If ordered by the physician, date for physical therapist evaluation
        ix. Medical/surgical history (including surgical procedures)
        x. Code status
        xi. Precautions/restrictions
            1. Weight-bearing status
            2. Infection control precautions
            3. Range of motion restrictions
            4. Other precautions/restrictions
        xii. Medication profile
        xiii. Durable medical equipment (DME) needs (if known)
        xiv. Home environment unusual issues
    b. Caregiver information
        i. Name
        ii. Phone numbers (at least 2, if possible)
        iii. Relationship to the patient
        iv. Availability

v. Health care proxy

1. Emergency contact
   a. Name
   b. Phone number

c. Payer source information from all payers
   i. Payer name(s)
   ii. Identification number(s)
d. Referral source/physician information
   i. Name (eg, name of the hospital, skilled nursing facility, or physician office)
   ii. Discharge date from skilled nursing facility or hospital
e. Duration of stay in the facility
f. Date of last face-to-face encounter, if applicable
g. Information of physician signing plan of care for physical therapy
   i. Name
   ii. Address
   iii. Phone number

CASE SCENARIO

A referral with the following information is received June 6 from the intake department of the home health agency. The agency director agrees to accept the patient and instructs the office patient scheduler to contact Tom to admit the patient to services with his physical therapy evaluation. Tom agrees to see this patient, and the information below is securely faxed to his agency office. He tries to contact the patient but does not get an answer. He then tries contacting the patient's daughter, Susan, who replies and tells him that her mother is hard of hearing and sometimes doesn't answer the phone. She indicates that Tom can stop by at 3:00 pm today to admit the patient to home health services. She says that her mother is looking forward to getting stronger.

Orders:	PT evaluate & treat, assess for home health aide, occupational therapist
Patient:	Mary Jones
MR#:	012345678910
Address:	37 Main Street
Phone:	xxx-283-4489
Emergency Contacts:	Patient's daughter, Susan, staying with mother for next week
Emergency Phone:	Susan, Home: xxx-609-1245; Mobile: xxx-609-9876
DOB:	1/22/1942 (age 72)
Hospital stay:	5/29/2013 – 5/31/2013
Subacute Rehab:	5/31/2013 – 6/7/2013
D/C home date:	6/7/2013
Dx:	s/p fall in home L hip fx ORIF, WBAT LLE
Comorbidities:	CHF, DM, HTN
Meds (current):	Metoprolol, Hydrocodone, Lisinopril, Lasix
Allergies:	NKA
Attending MD:	Dr Oz, 46 High St, Phone: 837-6733
Primary Insurance:	Medicare
Secondary Insurance:	None
Copay:	$0/visit
Comments:	Please call daughter to schedule

PRACTICAL APPLICATION

- Essential Referral Information

Essential Referral Information

The process of obtaining a history is a vital component of the examination process. If the referral information is unclear or illegible, the physical therapist is responsible for obtaining clarification directly from the referral source or via agency resources. The key is to ensure that the physical therapist has the required information to evaluate the patient and determine an appropriate plan of care for the patient.

Table 5.1. Essential Referral Information

Primary Information			
Patient Name/DOB	**Referral Source/ Physician**	**Payer Source Information**	
Address/Social Security #	Address	Insurance #	
Phone number	Phone number	Preauthorization required	
Diagnoses	Date of referral	Copay information	
Date of onset	SOC date	Other pertinent data from insurance	
Medical information	Requested date for PT consult	Multiple payers	
Medical/surgical procedures	Urgency of initial visit	Deductibles/copays	
Precautions	Physician orders		
	Evaluation and treat		
Secondary Information			
Emergency Contact	**Facility D/C**	**Home Environment**	**Medications**
Primary caregiver	Length of stay	Unusual circumstances	List
Contact designee	Diagnostic reports	Prior level of function	Frequency/ dosages
Power of attorney (POA)	Specific care	DME needs	Special instructions
Health care proxy (HCP)	Episode status		
	Weight-bearing status		

Reference

1. Medicare and home health care. Centers for Medicare and Medicaid Services, US Department of Health and Human Services. http://www.medicare.gov/pubs/pdf/10969.pdf. Updated May 2010. Accessed December 15, 2013.

CHAPTER 6

TIMELY SCHEDULING OF THE HOME VISITS

Introduction

Seeing patients in a timely manner is one of the hallmarks of clinical professionalism. It contributes to improved patient and caregiver experience,[1] improved compliance with regulations/policies,[2] and positive feedback from referral sources. Patients and caregivers quickly become concerned about the impact on outcomes when care is delayed, so it is important for agencies and clinicians to address this issue proactively and responsibly.

Delays in care have various causes. Home health agencies and their field clinicians need to analyze this issue and determine solutions for minimizing delays, and then implement those solutions. The seeds of a successful relationship with the patient and caregiver are planted when the patient recognizes that the physical therapist (PT) truly understands the patient's medical journey and values the patient's time. This level of compassion by the PT is associated with timely and appropriate care, which results in a positive patient experience. No one is surprised when positive outcomes occur under these circumstances.

GUIDELINE

The physical therapist performs the initial examination and evaluation, and conducts subsequent visits in a timely manner in coordination with the patient and caregiver.

CRITERIA

1. The physical therapist (PT) or agency managerial designee makes initial telephone contact with the patient within 24 hours of referral acceptance.
2. The PT contacts the patient and caregiver within 24 hours of being assigned responsibility for the patient's initial evaluation and schedules the initial evaluation and examination visit in a timely manner:
    a. In compliance with regulatory and payer requirements
    b. In compliance with agency requirements
    c. In compliance with physician orders
    d. In consideration of the needs of the patient and caregiver
3. If the initial examination and evaluation aren't provided within the expected timeframe, the PT contacts the referring physician to coordinate care.
4. Prior arrangements, exceptions, or expectations should be documented and communicated by the:
    a. Referral source
    b. Patient
    c. Patient's caregiver(s)
    d. Appropriate agency personnel
5. The PT thoroughly reviews referral information to ensure that involved caregivers are made aware of the appointment (eg, medical power of attorney, surrogate decision maker).

CASE SCENARIO

Tom is assigned by his home health agency to perform a physical therapy start of care (SOC) on a patient named Helen. The date of the referral is June 7, so Tom recognizes that the SOC visit must be performed within 48 hours of this referral in order to be compliant with the Medicare Conditions of Participation. Meanwhile, the designated office personnel responsible for referral intake verifies the accuracy of patient insurance, address, and phone number as provided with the referral. Tom contacts Helen on June 7 to schedule an appointment for 10:00 am on June 8. Tom explains that the visit will take approximately 1-2 hours and asks that the patient have all of her medications together for review so that the medication profile can be updated. The phone call is documented in the electronic medical record (EMR). Tom notes that Helen's daughter is the medical power of attorney, so he also calls her to inform her of the visit time and to invite her to attend the appointment.

On June 8, Tom runs a little behind with an earlier appointment, so he calls Helen and her daughter at 9:45 am to let them know he won't make it there until about 10:15 am. When Tom arrives at 10:15, Helen and her daughter are welcoming and appreciate him letting them know about the small delay. Tom completes the admission visit in 90 minutes and, before leaving, confirms the next visit for 10:00 am on June 10. He promises to call and remind Helen the evening before. After he leaves, Helen and her daughter comment to one another how professional Tom has been, and how glad they are that they selected his agency to provide home health services.

PRACTICAL APPLICATION

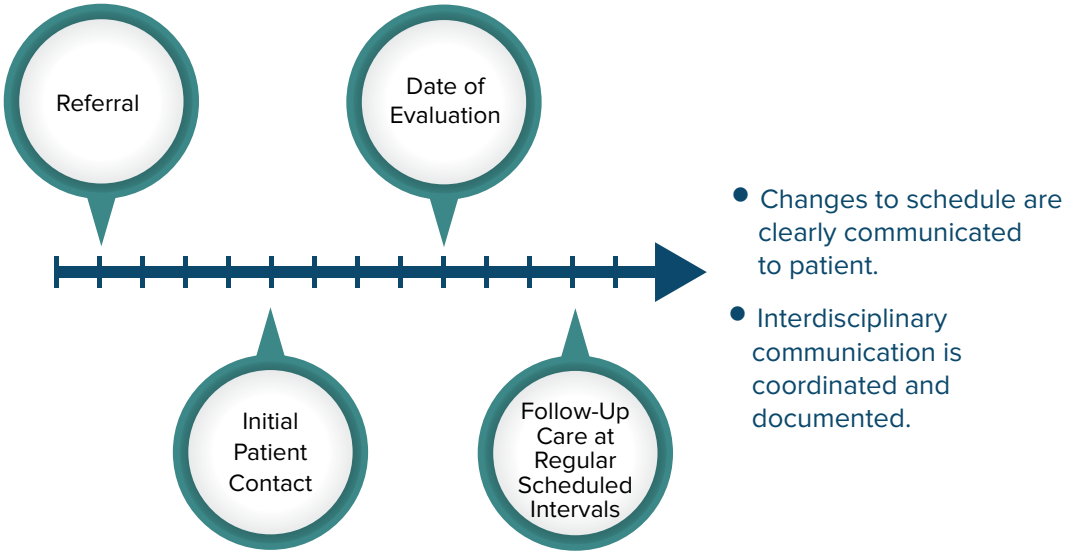
- Scheduling for Patient Satisfaction

Scheduling for Patient Satisfaction

In caring for patients within their homes, physical therapists (PTs) function as guests just as much as clinicians. Part of that privilege necessitates upholding the core values of altruism, compassion, and professional duty. PTs are to act in the best interests of patients. Three simple rules for scheduling home visits will assist the PT in being a successful home health clinician.

1. Call the patient to schedule the visit.
2. Set a time and date for the visit.
3. Arrive on time.

Figure 6.1. Patient scheduling timeline.



PTs can gain further insight into a patient's situation and preferences by examining the referral.

- Does the patient prefer to be addressed by a specific name?
- Is there a time of day that the PT should not call or schedule a visit?
- Should visit dates and times be scheduled with someone other than the patient?

Mindful attention to details will help the PT succeed as a home health clinician.

References

1. About home health care CAHPS survey. Centers for Medicare and Medicaid Services website. https://homehealthcahps.org/GeneralInformation/AboutHomeHealthCareCAHPSSurvey.aspx. Accessed December 16, 2013.

2. State operations manual, appendix B—guidance to surveyors: home health agencies. Centers for Medicare and Medicaid Services. http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/som107ap_b_hha.pdf. Updated August 12, 2005. Accessed December 15, 2013.

CHAPTER 7

PHYSICAL THERAPY ADMISSIONS AND EVALUATIONS

Introduction

The physical therapist (not the physical therapist assistant) is responsible for performing a comprehensive assessment of the home care patient. The *Guide to Physical Therapist Practice* provides insight into the evaluation process with the statement: "To establish the individual's specific diagnosis, prognosis, and plan of care through the evaluation process, physical therapists synthesize the collected examination data …"[1] Also, APTA has endorsed use of the International Classification of Functioning, Disability, and Health (ICF) as a valuable model for assessing patient function in a holistic manner.[2] This endorsement provides insight into how the physical therapist evaluation process continues to evolve toward standardizing and improving the quality of services for the patients served by our profession.

Clinicians not yet familiar with the ICF model and terminology should educate themselves about it and begin using it as a means to improve the quality of their evaluations and care planning. In the future, use of the ICF model and its terminology may be required.[3] The World Health Organization (WHO) has already prepared a checklist to help clinicians learn to apply the concepts of the ICF.[4] Some of the key terms associated with the ICF model include:

- Health condition(s)
- Body function and structure (impairments)
- Activity (limitations)
- Participation (restrictions)
- Environmental factors
- Personal factors

Full consideration of these elements, and use of standardized testing to objectively quantify them wherever possible, should be viewed as the standard for a quality physical therapist evaluation. This chapter will help physical therapists align their evaluations to this standard, and enhance their case management skills when they are tasked with admitting patients to home care services.

GUIDELINE

The physical therapist meets the needs of patients, caregivers, and referral sources during the initial examination and evaluation by applying principles of best practice consistent with the Guide to Physical Therapist Practice. This includes an evidence-based approach that involves an appropriate and adequate selection of standardized tests for objective measurement and a documented explanation of the patient's current functional status using terminology consistent with the ICF model.

CRITERIA

Physical therapists are prepared to address the following areas as appropriate, per the *Guide to Physical Therapist Practice*[1] by documenting patient status for any of the following items applicable to patient status:

1. Health Conditions
    a. History, to include relevant:
        i. Medical history
        ii. Surgical history
    b. Diagnoses
        i. Primary and secondary
        ii. Verify that coded diagnoses are accurate and support medical necessity for physical therapist services
2. Body Function and Structure
    a. Aerobic capacity and endurance
    b. Anthropometric measures
        i. Height, weight, girth/circumference, and limb length(s)
    c. Balance
        i. Use of standardized, evidence-based, and objective assessments
    d. Circulation
        i. Vital sign assessment of blood pressure, respiratory rate, pulse, and temperature
        ii. Oxygen saturation readings with patients requiring monitoring in response to activity
        iii. Use of standardized, evidence-based, and objective assessments (refer to Practical Application section of this chapter)
        iv. Assessment for signs and symptoms of embolus or deep vein thrombosis (DVT) for postoperative and sedentary patients
    e. Cranial and peripheral nerve testing and reflex integrity
        i. Auditory, visual, and vestibular function
        ii. Light touch, position sense
        iii. Deep tendon reflexes (DTR)

f. Gait and locomotion
    i. Gait analysis, including objective measures of walking speed and distance, as well as description of deviations
    ii. All applicable surfaces (eg, level, uneven, sloped, stairs)
    iii. Weight-bearing status
    iv. Assistive device(s)
    v. Human assistance needed
    vi. Footwear and other devices (eg, orthotics/prosthetics)
g. Integumentary integrity
    i. Skin color/pallor, temperature, turgor, nail beds, hair
    ii. Lesions/abnormalities
    iii. Wound assessment/measurement, including signs and symptoms of potential wound infection
    iv. Pressure ulcer risk assessment
h. Joint integrity and mobility testing, and range of motion
    i. Special testing as indicated
    ii. Active range of motion (AROM)
    iii. Passive range of motion (PROM)
i. Mental functions
    i. Ability to learn/process commands
    ii. Communication skills
    iii. Orientation to person, place, and time
    iv. Short-term and long-term memory
j. Motor function and muscle performance
    i. Dexterity
    ii. Muscle endurance
    iii. Fine and gross motor control
    iv. Manual muscle tests
    v. Muscle performance tests
    vi. Dynamometry
    vii. Physical capacity tests
k. Neuromotor development and sensory processing
    i. Babinski/clonus
    ii. Tone
    iii. Reflex integration/abnormal reflexes

l. Pain
    i. Use of a standardized measure of pain
    ii. Assessment of impact of pain on activity and participation
m. Posture/body mechanics
    i. Resting posture (supine, sitting, standing)
    ii. Posture during functional activities

3. Activities
    a. Learning and applying knowledge
    b. Communication
    c. Mobility
    d. Self-care, home management, and domestic life
        i. Activities of daily living (ADLs)
        ii. Instrumental activities of daily living (IADLs)

4. Participation
    a. Identification of roles for participation in:
        i. Community (eg, pharmacy, physician appointment, church)
        ii. Leisure integration (eg, shopping)
        iii. Social interaction (eg, family reunions)
        iv. Work/employment (eg, performing job duties, yard work)
        v. Educational pursuits (eg, attending school)

5. Environmental factors
    a. Products/technology
        i. Food/nutrition
        ii. Medication profile
        iii. Ability to use telephone
        iv. Assistive, adaptive, supportive, and protective devices
            1. Identification of durable medical equipment (DME) and assistive devices used
            2. Identification of DME and assistive devices needed for safe function, including orthotic/prosthetic requirements
        v. Presence of or need for ramps to help access home environment safely
    b. Home environment
        i. Adaptations (eg, bed, furniture risers, modifications, ergonomics)
        ii. Lighting
        iii. Room temperature
        iv. Safety hazards (eg, fire safety)
        v. Architectural barriers and falls risk factors

c. Social support and health services
    i. Home health agency staff
    ii. Family/caregivers
    iii. Sitters
d. Attitudes
    i. Family
    ii. Caregivers
    iii. Friends
e. Community services and transportation

6. Personal factors
    a. Lifestyle and habits
    b. Socioeconomic status and possible impact on care
    c. Education level and ability to comprehend instructions
    d. Effect of life events on function
    e. Race/ethnicity/sexual orientation
    f. Emotional state and depression
        i. Depression assessment per best practice (eg, OASIS)

CASE SCENARIO

Tom arrives at the home of the patient, Mary, introduces himself, and talks with Mary and her daughter to determine Mary's prior level of function (PLOF), the details of the fall, and her hospital and rehab stay. He takes vitals, does a functional assessment, and then focuses on specific neuromuscular areas. He reviews all the medications that Mary is taking. He also takes a photo of the surgical wound, assessing the wound and noting the wound care as prescribed by the physician.

During the assessment, Tom instructs Mary in the proper use of her walker. She was using it to stand and placing it too far in front of her during ambulation. He also adjusts it to the proper height and reverses the wheels so that it will fit through the doorways in her home. He instructs her in ankle pumps to help decrease the edema in her left foot and ankle. She is able to perform these correctly.

During the start of care (SOC) visit, Tom determines that Mary has medications in her home from before her hospitalization. The dosage for Lisinopril was different from what came home from the SAR, and Lasix had been added. Mary had some questions about that. The medication will be clarified by the primary care physician (PCP) and an order/referral made for the nurse.

Telehealth screen: With her diagnosis of congestive heart failure (CHF), Tom recommended telehealth, and Mary and her daughter were agreeable. Tom made a call to the telehealth nurse to begin setup.

Tom left Mary a folder with her patient rights, falls prevention precautions, agency contact numbers, and a calendar. He scheduled 2 more visits this week, explaining that he would be bringing Jessica, a PTA, to work with Mary on the next visit. He wrote both dates on Mary's calendar. He explained that the OT, nurse, and HHA office would be calling to schedule visits with her.

PRACTICAL APPLICATION

- Standardized Testing Considerations for Home Health Patients
- Using the ICF Model to Complete a Home Health Physical Therapist Evaluation

Table 7.1. Standardized Testing Considerations for Home Health Patients[5]

Category	Tests	References
Endurance Tests and Measures	6-Minute Walk Test	American Thoracic Society. Guidelines for the six-minute walk test. Am *J Respir Crit Care Med*. 2002;166:111-117. Lusardi MM, Pellecchia GL, Schulman M. Functional performance in community living older adults. *J Geriatr Phys Ther*. 2003;26(3):14-22.
	Borg Rating of Perceived Exertion Scale	Borg GAV. Psycho-physical bases of perceived exertion. *Med Sci Sports Exerc*. 1982;14:377–381.
	2-Minute Step Test	Jones CJ, Rikli RE. Measuring functional fitness of older adults. *J Active Aging*. March/April 2002:24-30.
Strength Tests	30-Second Chair Stand Test *and* 30-Second Arm Curl Test	Jones CJ, Rikli RE. Measuring functional fitness of older adults. *J Active Aging*. March/April 2002:24-30.

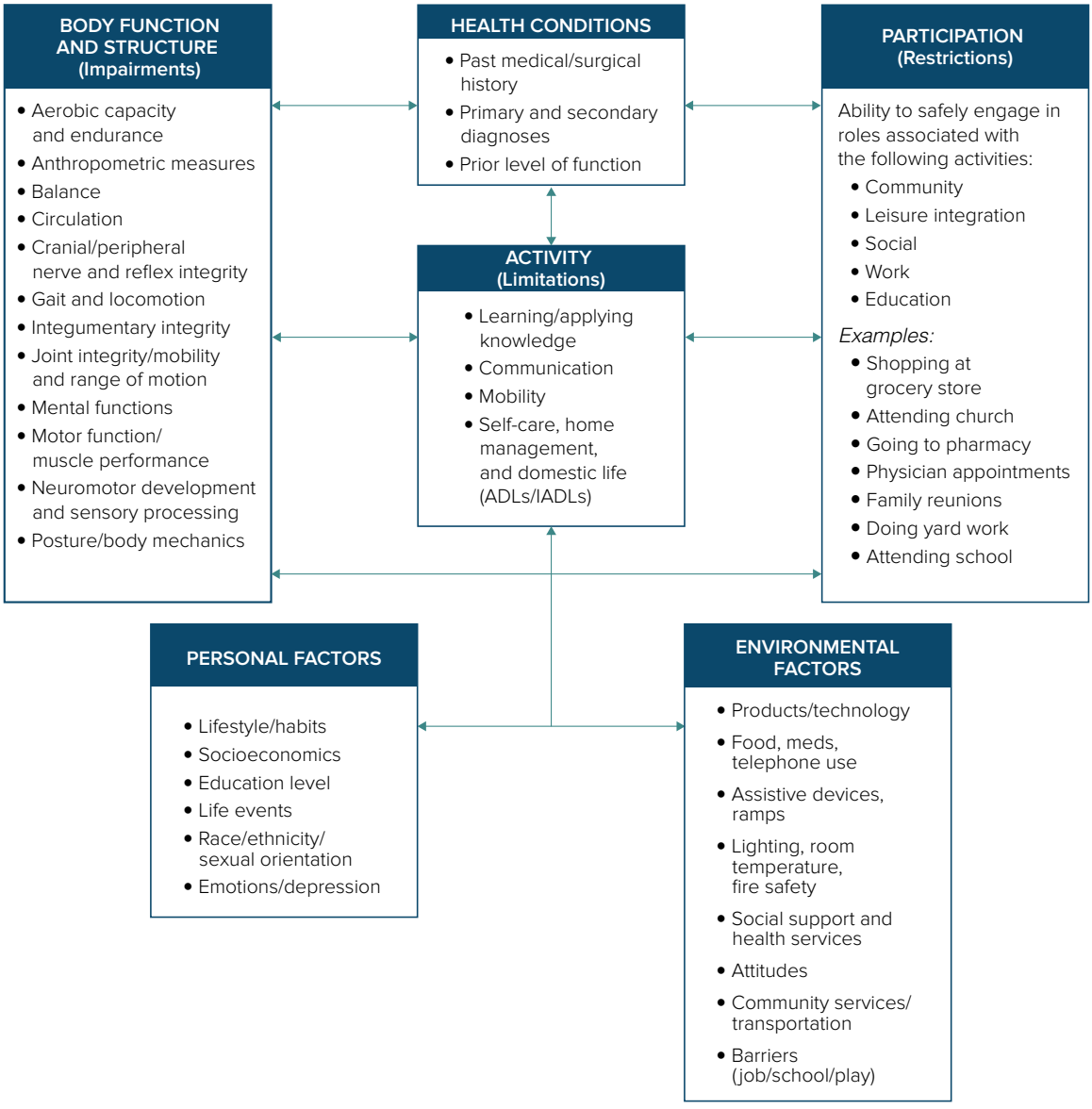
Table 7.1. (Continued)

Gait/Balance and Falls Risk	Walking Speed (also called Comfortable Gait Speed and Fast Gait Speed)	Fritz S, Lusardi M. White paper: walking speed: the sixth vital sign. *J Geriatr Phys Ther.* 2009;32(2):2-5.
	Berg Balance Scale	Muir S, Berg K, Chesworth B, et al. Use of the Berg Balance Scale for predicting multiple falls in community-dwelling elderly people: a prospective study. *Phys Ther.* 2008;88:449-459.
	Unipedal Stance Test (also called One-Leg Stance Test)	Springer BA, Marin R, Cyhan T, et al. Normative values for the unipedal stance test with eyes open and closed. *J Geriatr Phys Ther*. 2007;30(1):8-15.
	Timed Up and Go	Shumway-Cook A, Brauer S, Woollacott M. Predicting the probability for falls in community-dwelling older adults using the timed up & go test. *Phys Ther.* 2000;80(9):896-903.
	Functional Reach	Duncan PW, et al. Functional reach: a new clinical measure. *J Ger.* 1990;45:M192-197. Duncan PW, et al. Functional reach: predictive validity in a sample of elderly male veterans. *J Ger.* 1992;47:M93-98.
	Sitting Functional Reach (Forward/Lateral)	Thompson M, Medley A. Forward and lateral sitting functional reach in younger middle-aged and older adults. *J Geriatr Phys Ther.* 2007;30(2):43-48.
	Four-Square Step Test	Dite W, Temple VA. A clinical test of stepping and change of direction to identify multiple falling older adults. *Arch Phys Med Rehabil*. 2002;83:1566-1571.
	Modified Clinical Test of Sensory Integration on Balance	Shumway-Cook A, Horak FB. Assessing the influence of sensory interaction on balance: suggestion from the field. *Phys Ther.* 1986;66:1548-1550. Cohen H, Blatchly CA, Gombash LL. A study of the clinical test of sensory interaction and balance. *Phys Ther*. 1993;73:346-51.
	Missouri Alliance for Home Care Fall Risk Assessment Tool	Calys M, Gagnon K, Jernigan S. A validation study of the Missouri Alliance for Home Care fall risk assessment tool. *Home Health Care Management and Practice*. April 2013;25(2):39-44.

Table 7.1. (Continued)

Pain	Wong-Baker Faces Visual Analog Scale PAINAD	Hockenberry MJ, Wilson D, Winkelstein ML. *Wong's Essentials of Pediatric Nursing*. 7th Ed. St Louis, 2005:1259. Hjermstad MJ, Fayers PM, Haugen DF, et al. Studies comparing numerical rating scales, verbal rating scales, and visual analogue scales for assessment of pain intensity in adults. *J Pain and Symptom Management*. 2010;41(6):1073-1093. Jordan A, Hughes J, Pakresi M, et al. The utility of PAINAD in assessing pain in a UK population with severe dementia. *Int J Geriatr Psychiat.* 2011;26(2):118-126.
Vestibular	4-Item Dynamic Gait Index	Marcheti G, Whitney S. Construction and validation of the 4-item Dynamic Gait Index. *Phys Ther*. 2006; 86:1651-1660.

Figure 7.1. Using the ICF Model to complete a home health physical therapist evaluation.[6]



References

1. *Guide to Physical Therapist Practice 3.0*. American Physical Therapy Association; 2014. http://guidetoptpractice.apta.org/. Accessed August 20, 2014.

2. Bemis-Dougherty A. Practice matters: what is the ICF? *PT—Magazine of Physical Therapy*. 2009; 17(1):44-46. http://www.apta.org/PTinMotion/2009/2/Feature/PracticeMatters/ICF/. Accessed February 26, 2014.

3. Langham B. International classification of functioning: a common language for case management in a changing home health environment. *The Quarterly Report, Home Health Section of the American Physical Therapy Association*. 2013;48(3):15-18.2.

4. ICF checklist, version 2.1a, clinician form for international classification of functioning, disability and health. Geneva, Switzerland: World Health Organization; 2003. http://www.who.int/classifications/icf/training/icfchecklist.pdf. Accessed December 16, 2013.

5. The Home Health Section Toolbox of Standardized Tests and Measures. Home Health Section website. 2013. https://c.ymcdn.com/sites/hhsapta.site-ym.com/resource/resmgr/practice/toolbox_final_9-2013.pdf. Accessed May 22, 2014.

6. Towards a common language for functioning, disability and health: ICF—the international classification of functioning, disability and health. Geneva, Switzerland: World Health Organization; 2002. http://www.who.int/classifications/icf/training/icfbeginnersguide.pdf. Accessed December 16, 2013.

CHAPTER 8

PHYSICAL THERAPIST PLAN OF CARE

Introduction

"The development, implementation, management, and evaluation of a patient care plan based on the physician's orders constitute skilled therapy services when, because of the patient's condition, those activities require the skills of a qualified therapist to ensure the effectiveness of the treatment goals and ensure medical safety."

—Medicare Benefit Policy Manual, Chapter 7, Section 40.2.1[1]

After the initial examination and evaluation are completed, the physical therapist develops a plan of care (POC). The POC directs treatment throughout the home health episode. Returning a patient to his or her prior level of function or maximum functional status is the focus of the POC. During the initial physical therapist evaluation visit, the physical therapist should review the POC with the patient or an authorized representative to obtain informed consent. Collaborative care planning may positively impact patient and caregiver adherence, satisfaction, and outcomes. This chapter provides guidance for designing and implementing a quality plan of care.

GUIDELINE

Consistent with APTA's *Guide to Physical Therapist Practice*,[2] and in collaboration with the patient and caregiver, the physical therapist develops a plan of care (POC) that is based upon principles of evidence-based practice, that optimizes the functional needs, and that addresses the safety concerns of the patient and caregiver.

CRITERIA

1. The physical therapist (PT) develops the plan of care (POC), which includes:
    a. Specific, functional, and measurable goals developed in collaboration with the patient/family/caregiver
    b. Frequency and duration of physical therapist services
    c. Treatments or interventions to be provided to optimize patient participation in ADLs and IADLs
    d. Anticipated plans for discharge
    e. Prognosis/rehabilitation potential
2. The PT reviews the POC with the patient/caregiver.
3. The physician approves the POC with either written or verbal permission.
4. The PT provides appropriate supervision of POC treatments being provided by a PTA and/or home health aide, in compliance with APTA policy and state and federal regulations.
5. At each visit, the PT assesses and documents the skilled services provided and objectively measures the patient's response to the interventions provided. The PT implements program changes at each visit, as indicated by the inherent complexity of the patient/caregiver.
6. The PT reviews and updates the POC as determined by patient need and regulatory/payer/agency requirements.

CASE SCENARIO

Mary Jones
PT 3w1, 2w3
OT Eval 1w1
SN Assess medications/patient education 1w1
HHA 2w4 assist with personal care

Interventions: Transfer training, gait training, safety education, and therapeutic exercise for LE strengthening

Short-term goals (provide expected date or timeframe for achievement):

1. Improve bilateral lower extremity strength in the hips and knees to 4/5 to improve patient's ability to transfer safely and independently
2. Improve transfers from minimum assistance to independent to improve safety and independence in the home

Long-term goals (provide expected date or timeframe for achievement):

1. Patient to ambulate 200 ft independently using appropriate device to enable patient to access entire home
2. Improve patient's ability to ascend and descend 4 stairs using railing and cane, requiring supervision level assistance to enter/exit home safely
3. Improve patient's 30-Second Chair Stand score to 12 reps to reflect improved functional strength for safe transfers and reduce falls risk
4. Improve patient's walking speed to 2.5 ft/sec (within age/gender normal values) to decrease risk of falls and hospitalization

Rehab Potential: Good for the above goals

Discharge Plan: Outpatient therapy

Following the visit, Tom calls the attending physician for verbal approval of the POC. Tom writes the orders; he creates a 485 and sends it to the physician electronically or by fax. Tom provides the referrals for the other disciplines to the appropriate scheduler.

PRACTICAL APPLICATION

- Using the ICF to Construct an Appropriate Plan of Care

Using the ICF to Construct an Appropriate Plan of Care

The International Classification of Functioning, Disability, and Health (ICF) is the World Health Organization's framework for measuring health and disability. It emphasizes the functioning of individuals in their environment and the community. The framework can help determine an individual's health care and rehabilitative needs. The table below shows how identifying the functional deficits in terms of activity and participation is helpful for selecting appropriate plan of care interventions, objective measures, and goals.

Table 8.1. Using the ICF to Construct an Appropriate Plan of Care[3]

Activity/ Participation Problems	Intervention Considerations	Objective Measure(s)*	Short-Term (STG) and Long-Term (LTG) Goal(s)
Fatigue limits access to the bedroom and bathroom located on the second floor, which prevents the patient from showering/bathing.	• Gait/stair training • Transfer training • Strengthening • Home modifications/ DME	• 30-Second Chair Stand Test (30 SCST) • 2-Minute Step Test	**STG:** Patient to perform 30 SCST x 12 reps to achieve strength to perform stair-climbing with supervision by [DATE]. **LTG:** Patient to complete 50 reps of 2-Minute Step Test to increase endurance for safe access to bathroom by [DATE].
Caregiver doesn't know how to safely transport patient to a physician appointment because patient is unsteady.	• Car transfer training • Balance training	• Berg Balance Test	**STG:** Berg score to increase from 45/56 to 50/56 to reduce falls risk by [DATE]. **LTG:** Caregiver to demonstrate safe ability to assist patient with car transfers by [DATE].

Table 8.1. (Continued)

Patient is unable to use walker to get from the living room to the toilet safely and timely due to narrow doorways and multiple throw rugs.	• Gait training • Education regarding timing voiding • Home modification (eg, removal of throw rugs) • Device/DME training (eg, change walker wheels to inside)	• Timed Up and Go (TUG) • Walking Speed	**STG:** All throw rugs removed in 2 days. **STG:** TUG score to improve from 25 to 18 seconds to decrease falls risk by [DATE]. **LTG:** Walking speed to improve from 1.20 ft/sec to 2.00 ft/sec so patient can reach toilet safely and timely by [DATE].
Patient is unable to safely walk 800 feet from apartment to assisted living facility dining area due to fatigue, poor step clearance, and impaired balance.	• Cardiovascular endurance training/ conditioning • Balance training • Gait training • Strengthening	• 6-Minute Walk Test (6MWT) • 30-Second Chair Stand Test (30 SCST)	**LTG:** Patient to improve 6MWT distance from 200' to 800' to improve safe access to dining area by [DATE]. **LTG:** 30 SCST score to improve to 12 reps to reduce falls risk and improve step clearance by [DATE].

References

1. Chapter 7—home health services. In: Medicare Benefit Policy Manual, Rev 179. Washington DC: Centers for Medicare and Medicaid Services. http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c07.pdf. Updated January 14, 2014. Accessed May 30, 2014.

2. *Guide to Physical Therapist Practice 3.0*. American Physical Therapy Association; 2014. http://guidetoptpractice.apta.org/. Accessed August 20, 2014.

3. Towards a common language for functioning, disability and health: ICF—the international classification of functioning, disability and health. Geneva, Switzerland: World Health Organization; 2002. http://www.who.int/classifications/icf/training/icfbeginnersguide.pdf. Accessed December 16, 2013.

CHAPTER 9

PHYSICAL THERAPISTS AS CASE MANAGERS

Introduction

Physical therapists have sufficient knowledge and skills to serve as front line health care providers and are prepared to be case managers in the home health setting. They admit patients to home health care with a comprehensive evaluation and examination, performance of a medication review, coordination of needed services, and management of discharge planning/care transitions. According to an official statement of the American Physical Therapy Association (APTA) regarding the role of physical therapists with medication management, physical therapists should be proficient in "screening, evaluation, collection of information, identification of adverse events/reactions, and education."[1] Physical therapists also recognize that patients derive the greatest value from achieving safe and optimal function both at home and in the community. The purpose of this chapter is to support home health physical therapists with the guidance and criteria needed to better understand how to case manage high-quality home health services.

GUIDELINE

Home health physical therapists serve as holistic case managers by assuming full responsibility for each patient's needs via comprehensive assessments, medication reviews, coordination of services, education, and timely discharge planning.

CRITERIA

1. Physical therapists (PTs) initiate case management responsibilities via a comprehensive evaluation and examination consistent with the tenets of the International Classification of Functioning, Disability, and Health (ICF),[2] which includes consideration of:
    a. Health condition
    b. Body function and structure
    c. Safety with activities at home
    d. Safety with community participation outside the home
    e. Environmental factors
    f. Personal factors
2. PTs deemed competent to do so by their agency may enhance patient safety and prevent adverse consequences by performing medication reviews, as allowed by state and federal regulations, to assess for:
    a. Accuracy of the medication profile
    b. Allergies
    c. High-risk medications
    d. Medication adherence
    e. Medication dosage and frequency
    f. Medication interactions
    g. Medication knowledge deficit
    h. Medication purposes, action, and side effects
    i. Oxygen use
    j. Polypharmacy
    k. Prescription and nonprescription medications, including supplements and ointments/creams
    l. Need for coordination with the appropriate health care provider for resolving any concerns about medications

3. The PT coordinates care with the physician and the interdisciplinary team to provide best practices with:
    a. Risk management, including:
        i. Falls risk
        ii. Depression
        iii. Pressure ulcer risk
        iv. Wounds/infection
        v. Abuse (physical/emotional/drug)
        vi. Environmental hazards, including durable medical equipment (DME) needs
    b. Chronic illnesses such as diabetes, congestive heart failure (CHF), and chronic obstructive pulmonary disease (COPD), by providing:
        i. Education about disease management, including typical signs and symptoms
        ii. Protocols to follow when signs and symptoms are outside of predefined parameters (eg, call physician, emergency care)
        iii. Education regarding prescribed programs (eg, exercise, positioning, safety)
        iv. Coordination of alternative therapies/services
        v. Recommendations for equipment to improve safety and quality of life
        vi. Information about community resources
    c. Pain management
        i. Review of pharmacological and nonpharmacological interventions for managing pain
        ii. Instruction in relaxation techniques (eg, breathing exercises, tai chi)
        iii. Education to manage pain in coordination with therapy services to improve exercise tolerance
4. PTs coordinate discharge planning with the interdisciplinary team by:
    a. Initiating discharge planning at the time of patient admission
    b. Revising/updating goals as needed
    c. Avoiding underutilization and overutilization, consistent with the APTA Code of Ethics for the Physical Therapist[3]
    d. Arranging the most appropriate care transition after completion of home health services

CASE SCENARIO

Tom is the PT case manager for Mary, and Jessica, the PTA, will provide continuing care under Tom's supervision. They instruct Mary in transfers, exercises, and correct gait pattern using her rolling walker. Jessica will continue to progress Mary's program, adding more exercises, working on balance, gait, and the stairs. Tom will periodically assess Mary's progress. Mary is given a written home exercise program to be performed daily.

The occupational therapist (OT) evaluates the patient on June 11 and sets a frequency of 1w3 to get Mary a tub transfer bench, instruct her in using it safely, and obtain equipment for helping Mary to don and doff her own socks and shoes. Tom secures physician orders for home health aide (HHA) services 2w4 to assist with personal care.

A nurse comes in and assists with getting the proper medications and setting up a medi-planner to increase Mary's safety and independence. She helps Mary to understand the status of her disease and instructs her in the signs and symptoms that indicate the need to call a physician. Mary becomes proficient with the use of telehealth and is independent within 3 weeks.

Tom manages the case by ensuring that all of Mary's needs are met and that orders are up-to-date. Tom is required by his state regulations to assess the patient periodically. Jessica and Tom keep in touch weekly by e-mail or phone regarding progress and respond in a timely manner to any problems that arise.

During the third week of care, Jessica finds that Mary has a very low blood pressure and is complaining of feeling lightheaded and dizzy. Jessica calls the physician, who decreases the Lasix dosage. Jessica informs Tom about the change and Tom adjusts the medical record to reflect the change.

A PT reassessment is done after 4 weeks. Mary has made significant progress but is still in need of continued physical therapy and HHA services. The OT has met their goals and is discharged. Tom determines that skilled services will continue another 4 weeks until the end of the certification period.

Mary has made great progress at 7 weeks after SOC, which was the 19th visit reassessment. She is able to get in and out of bed, on and off the toilet, and shower independently. Mary still needs assistance with her IADLs and groceries. The HHA is discharged. Mary is walking with a single point cane independently in the home, but the physician does not approve driving yet. Mary's final goal is to be able to use the stairs independently with a single-point cane. Her wonderful neighbor is willing to drive her to outpatient physical therapy. On August 6, the PT explains the advance beneficiary notice of noncoverage form, which Mary signs, agreeing that she will be discharged on August 13.

PRACTICAL APPLICATION

- Medication Management
- OASIS Process Measures Reported to Home Health Compare
- Best Practice Assessments and Intervention Planning

Medication Management

Documentation of medications should always include:

- name of drug
- dose
- type (capsules, tablets, gelcaps)
- route
- frequency

Dose is the measure of drug taken at a time and should, at a minimum, include:

- weight (mg)
- volume (ml)
- number of dosage forms (unit, puff, vial, suppository)

Common medication routes include but are not limited to:

- drops
- inhaled (nebulizer, oxygen, inhaler device)
- injections
- intravenous (IV)
- oral
- parenteral
- rectal and vaginal (suppositories)
- sprays (nasal)
- topical (ointments, pastes, creams, lotions)
- transdermal (patches)

Frequency should be documented as follows, without abbreviations:

- daily
- __ times a day
- every __ hours
- in morning, at bedtime
- before meals, after meals, with meals
- as needed (PRN) for _____ (must state reason; eg, pain, shortness of breath, special instructions)
- sliding scales

NOTE: The role of physical therapists in medication management is regulated by state licensing boards. It is the responsibility of each therapist to review and comply with his or her state regulations.

OASIS Process Measures Reported to Home Health Compare

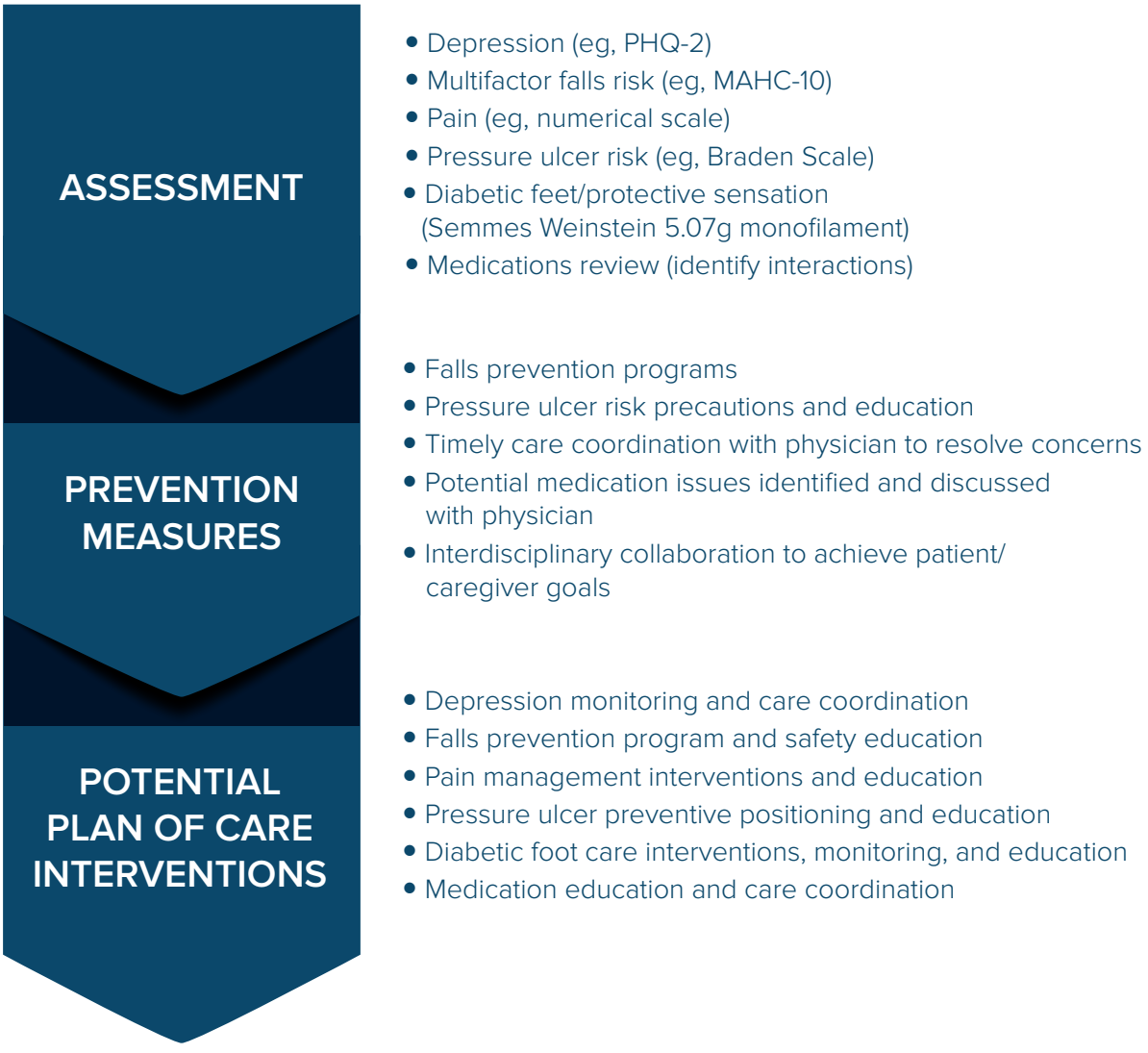
Table 9.1. Case Managerial Considerations for the Physical Therapist: OASIS Quality Process Measures[4]

Start of Care (SOC)/Resumption of Care (ROC) OASIS Visits*		
OASIS Item	**Description**	**Process Type**
(QM) MO102	Timely initiation of care	Timely care
(QM) M1240	Pain assessment conducted	Assessment
(QM) M1300	Pressure ulcer risk assessment conducted	Assessment
(QM) M1730	Depression assessment conducted	Assessment
(QM) M1910	Multifactor falls risk assessment conducted	Assessment
(QM) M2250(f)	Pressure ulcer prevention in plan of care	Care planning
Transfer to Inpatient Facility (TIF)/Discharge (DC) OASIS Visits*		
OASIS Item	**Description**	**Process Type**
(QM) M1500	Heart failure symptoms addressed	Care plan implementation
(QM) M2400(a)	Diabetic foot care and patient and caregiver education implemented	Care plan implementation
(QM) M2400(d)	Pain interventions implemented	Care plan implementation
(QM) M2015	Drug education on all medications provided to patient and caregiver	Education
(QM) M1040/45	Influenza immunization received (flu season)	Prevention
(QM) M1050/55	Pneumococcal polysaccharide vaccine received	Prevention
(QM) M2400(e)	Pressure ulcer prevention implemented	Prevention

Best Practice Assessments and Intervention Planning

Providing best practice under the current OASIS Quality Process Measures categories requires fulfillment of the physical therapist's role to perform best practice assessments on ***all*** patients. Following the assessment, appropriate interventions should be included in the physician-ordered plan of care, implemented as ordered within the required time frame, and clearly documented in the medical record. Note that OASIS item guidance allows for preventive interventions to be provided even if the formal assessment finds the patient not to be at risk for that item.

Figure 9.1. Best practice assessments and intervention planning.



References

1. The role of physical therapists in medication management. Official statement. Alexandria, VA: American Physical Therapy Association; 2010. http://www.apta.org/uploadedFiles/APTAorg/Payment/Medicare/Coding_and_Billing/Home_Health/Comments/Statement_MedicationManagement_102610.pdf. Accessed December 9, 2013.

2. Towards a common language for functioning, disability and health: ICF—the international classification of functioning, disability and health. Geneva, Switzerland: World Health Organization; 2002. http://www.who.int/classifications/icf/training/icfbeginnersguide.pdf. Accessed December 16, 2013.

3. American Physical Therapy Association House of Delegates. Code of ethics for the physical therapist (HOD S06-09-07-12). Alexandria, VA: American Physical Therapy Association; 2009. http://www.apta.org/uploadedFiles/APTAorg/About_Us/Policies/Ethics/CodeofEthics.pdf. Accessed December 9, 2013.

4. Home health quality measures – process [table]. Quality measures. Centers for Medicare and Medicaid Services website. http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/HHQIQualityMeasures.html. July 2013. Accessed December 17, 2013.

CHAPTER 10

DOCUMENTATION REQUIREMENTS IN HOME HEALTH CARE

Introduction

Documentation by home health physical therapists serves multiple purposes as a clinical record, a business document, a legal document, and a source of potential outcomes data for research and education.[1] In other words, physical therapists and physical therapist assistants are responsible for producing documentation that meets professional standards,[2] meets payer source requirements for reimbursement,[3] and complies with legal requirements for licensure within their jurisdiction.[4] The documentation of skilled services should clearly illustrate the clinical decision-making and problem-solving processes consistent with contemporary, evidence-based practice.

Given the time and travel constraints associated with home health care, producing documentation that consistently and efficiently satisfies these requirements can be challenging. Nevertheless, the standard for quality documentation has been established, and clinicians are obligated to continuously pursue achievement of that standard. Fortunately, many resources are available to assist clinicians with this pursuit. For instance, APTA's *Guide to Physical Therapist Practice*,[5] the APTA Code of Ethics,[6] Standards of Ethical Conduct,[7] APTA online resources,[2] and the ICF model[8] provide valuable guidance and instruction. The ICF model, in particular, assists clinicians with a method for consistently framing their documentation with information that is considered essential for the justification of skilled physical therapist services. This chapter provides a guideline and criteria for home health documentation that is general to all visit types, documentation that is unique to specific visit types (eg, evaluation, reassessments, discharges), and nonvisit documentation.

GUIDELINE

The physical therapist and physical therapist assistant complete timely documentation for each visit performed, providing clear justification for services rendered that is consistent with the essential requirements specified by APTA, state and federal regulations, home health agency policy, and payer sources.

CRITERIA

1. Physical therapists (PTs) and physical therapist assistants (PTAs) follow general principles of documentation,[2] which include but are not limited to:
    a. *Abbreviations*—minimal use, "do not use," per home health agency policy
    b. *Addendums/errors*—documentation errors must be corrected by drawing a single line through the error and initialing and dating the error or through the appropriate mechanism for electronic documentation
    c. *Functional progress*—document status regularly
    d. *Skilled care*—includes problem solving, clinical decision making, objectively measuring patient response, and standardized testing
    e. *Timeliness*—documentation should be completed the same day as the encounter/visit
    f. *Terms/phrases to avoid*—Avoid generalized statements such as "tolerated treatment well," "continue POC," and "as above"
2. Documentation required for all visits
    a. Name of patient
    b. Visit date and start/end times
    c. Objective tests and measures
    d. Vital signs
    e. Homebound status, if applicable
    f. Medication review (eg, changes, side effects, new medications)
    g. Physical therapist intervention(s), including:
        i. Rationale/explanation for intervention(s)
        ii. Education/cueing (eg, mobility training, body mechanics, safety, home exercise program, medication effects on exercise and physical activity)
        iii. Detailed description of treatment(s)
        iv. Objective measure of patient response (eg, Borg scale, vital signs)
        v. Assistance required
    h. Comparative statement(s) to identify patient progress or lack thereof
        i. Current visit vs prior visit
        ii. Current visit vs goals
        iii. Existing impairments/functional limitations vs prior level of function

i. Identification of barriers to progress, if applicable
j. Plan for next visit, to include specific modifications/progression of interventions for unmet goals
k. Modification/update of discharge plan as needed
l. Applicable physician/interdisciplinary communication
m. Appropriate signature(s) that include:
    i. Legible physical therapist/physical therapist assistant signature, with full name and designation[2]
    ii. If required by home health agency policy, signature of patient or caregiver/power of attorney

3. Additional documentation pertaining to evaluation visits
    a. Start of care/admission visits include:
        i. Signed consent forms
        ii. Explanation of services
        iii. Outcome Assessment Information Set (OASIS)
        iv. Acuity/priority status
        v. Education regarding advance directives and privacy rights (HIPAA)
    b. Initial evaluation/examination visits include:
        i. Medical history
        ii. Current medical status and diagnoses (eg, medical, rehab)
        iii. Medication review/allergies
        iv. Prior vs current level of function
        v. Impairments and functional limitations
        vi. Activity limitations/participation restrictions
        vii. Environment/equipment and personal factors
        viii. Interventions provided
        ix. Patient-centered goals with expected time frame for achievement
        x. Rehab potential to achieve plan-of-care goals
        xi. Planned interventions and frequency/duration of visits
        xii. Discharge plan
    c. Reassessment
        i. Reassessments performed by PTs in association with the following visits:
            1. Resumption of care (ROC)
            2. Follow-up to change of patient condition
            3. Recertification
            4. Functional reassessment required by state/federal regulations

ii. Reassessment documentation should include:
    1. Standardized testing with explanation of relevance to goals
    2. Summary of progress toward goals, or lack thereof
    3. Summary of barriers to progress toward goals
    4. Justification for why patient requires continued treatment
    5. Rationale for any plan of care modifications, including updated goals and visit frequency changes

d. Discharge visits should include the following components:
    i. OASIS assessment when needed
    ii. Current level of function with objective measures
    iii. Interventions received
    iv. Discharge disposition
    v. Discharge instructions/discharge notice provided per regulatory requirement
    vi. Medication reconciliation
    vii. Goals met
    viii. Explanation for any unmet goals
    ix. Communication with physician regarding recommendations for any ongoing care

4. Nonvisit documentation
    a. Supervision
        i. PTA supervision may be done with or without a visit per state requirements
        ii. Documentation of onsite observation of PTA visit or review and follow-up of PT plan of care of PTA notes
        iii. Ongoing PT and PTA communication regarding patient care and any medical issues that come up during visits made by PTA
    b. Care coordination
        i. Conferencing to include communication with physician, interdisciplinary team, and equipment companies
        ii. Missed visit/refusal, including date, time, reason, and physician notification
        iii. Patient visit scheduling
    c. Nonvisit OASIS
        i. Transfer to inpatient facility
        ii. Nonvisit discharge

CASE SCENARIO

The home health agency for which Tom works recently received an Additional Documentation Request (ADR) from Medicare. The agency needs to provide documentation to demonstrate the medical necessity for the physical therapist services provided. Fortunately, Tom has been documenting consistent with the ICF model. His documentation clearly identifies the reason for referral and contains a specific description of the patient's prior level of function. His documentation includes details about environmental factors such as devices/equipment being used, and the degree to which the patient could effectively participate in community functions prior to this episode. He clearly identifies the patient's goals, which are integrated into the goals of the physical therapist plan of care. He has objectively measured impairments of body functions and structures and detailed their impact on functional mobility/activity participation. He has selected appropriate standardized tests to provide a baseline status and to evidence progress or the lack thereof in response to the plan of care.

The rationale for selected interventions is based on principles of best practice and current evidence. Functional mobility training includes both a description of deviations and the teaching provided to correct them. Therapeutic exercises for strengthening include appropriate resistance based upon the overload principle. Tom has instructed the patient in a home exercise program, including details about safe and correct technique. Objective measures of patient response to interventions guide appropriate intensity and activity progression. Tom regularly documents patient progress toward goals and completes timely reassessments, updating the plan of care as indicated. He has clearly documented care coordination with other team members and the physician throughout the episode of care.

The agency finds that Tom's documentation makes it easy to prepare a response to this ADR. The elements of the ICF model are easily identified in the medical record. As a result, the agency successfully demonstrates that the care provided was skilled and medically necessary to address the patient's health condition. Medicare agrees to cover these services in their entirety.

PRACTICAL APPLICATION

- Checklist for Integrating ICF Model With Initial Physical Therapist Evaluation Documentation
- Home Health Physical Therapy Documentation Q&A
- Home Health Skilled Documentation Components by Visit Type
- Highlights From APTA's Defensible Documentation

Table 10.1. Checklist for Integrating ICF Model With Initial Physical Therapist Evaluation Documentation[8]

Checklist Categories	Examples
☐ Reason for referral (health condition) • Primary diagnoses ☐ Comorbidities • Secondary diagnoses • Medical/surgical history ☐ Prior level of function • Community access • Transportation method(s) • Mobility devices used • Human assistance needed • Status with ADLs/IADLs	*Patient referred for physical therapy s/p CVA with left hemiparesis in July 2013. Patient has hypertension and controls diabetes with his diet. Surgical history includes left total hip replacement in 2010. Prior to CVA, patient was independent with all community access using personal vehicle, using a single-point cane for ambulation. Managed all ADLs and IADLs independently.*
☐ Impaired body functions and structures • Specify involved body system(s) and structural deficits	*Left side of body with neurologic impairment involving abnormal tone, synergistic movement patterns, and musculoskeletal weakness. Musculoskeletal range of motion (ROM) deficit with 80 degrees of passive left shoulder flexion and abduction. Left shoulder joint subluxed and painful, rated 4/10 at rest. Impaired gait with deviations including short left foot stance time, left foot drop, and slow walking speed (1.20 ft/sec). Endocrine system with impaired insulin resistance. Cardiovascular impairment: right upper arm blood pressure 160/90.*
☐ Activity limitations • Deficits with ADLs/IADLs • Deficits with transfers • Deficits with gait • Home management ☐ Environmental factors • Medications, food • DME/devices used • Social support • Attitudes ☐ Participation restrictions • Community integration • Social involvement	*Patient requires moderate assistance with bathing and hygiene, and minimal assistance with bed mobility. Requires minimal assistance and a hemi-walker for safe ambulation. Fatigue limits ambulation distance to 20 feet. Requires moderate assistance to reach clothing or dress self.* *Patient unable to attend church services, and his daughter manages grocery shopping, medications, and finances. He is unable to safely access bathroom due to low toilet and narrow doorway, and doesn't have a bedside commode. Daughter plans to arrange for Meals on Wheels. Patient is agreeable to participate in therapy. Daughter states she doesn't have time to help patient with exercises.*

Table 10.1. (Continued)

☐ Personal factors • Patient goals • Medication profile	*Patient is frustrated with situation and depressed about lack of independence. He doesn't want to be a burden for his daughter.*
☐ Rehab potential (to meet goals) ☐ Plan of care • Frequency/duration • Interventions • Short- and long-term goals • Discharge plan	*Good rehab potential to meet stated goals of plan of care.* *Physical therapy 3w4, 2w4 effective week of [DATE] to provide training to address deficits with gait, transfers, bed mobility, home safety, falls risk, and neuromuscular function. Coordinate medication management with physician and with patient and caregiver. Order bedside commode. Request evaluations by OT and MSW and plan to discharge patient to independent function at home.* *(List objective short- and long-term goals with expected achievement dates.)*

Home Health Physical Therapy Documentation Q&A

Q. *Sometimes I am too busy and forget to perform any standardized testing during evaluation visits, and so I don't have any objective measures documented. Is that okay?*

A. Therapists must include objective measures to quantify impairments on evaluation to form a baseline. Without an objective baseline, it is difficult to substantiate any changes in patient status during subsequent reassessments. A documented explanation of the significance of these tests and measures provides valuable support to justify the physical therapist plan of care. If these tests aren't performed during the initial evaluation, the physical therapist should arrange to complete such testing during the next visit.

Q. *What are some examples of objective measures that I should use routinely?*

A. Objective measures should be selected carefully based upon their ability to provide a baseline of the patient's condition. The Centers for Medicare and Medicaid Services (CMS) recommends that clinicians seek guidance from their professional associations.[9] The American Physical Therapy Association has developed www.ptnow.org as a resource for this type of guidance.

Q. *My documentation shows that the patient performed more reps with exercises today compared with the prior visit. Isn't that enough to show skilled care?*

A. It is very important for the documentation to establish that the inherent complexity of the exercises is such that they could not be performed by a nonskilled caregiver. For example, documenting **why** the number of reps was appropriate helps to demonstrate client response (eg, Borg/RPE scale). Furthermore, skilled care is demonstrated by documenting the education required to ensure safe exercise performance, including instructions/guidance about when to rest.

Q. *If I modify performance of a standardized test due to patient difficulty (eg, has to use arms to stand up from a chair for 30-Second Chair Stand Test), may I still compare the results with normative values?*

A. No. The normative values should only be compared with tests performed exactly as described in the literature. However, if the modification is consistent from one test to another, you may compare the results between those tests to demonstrate progress. For example, a patient who uses her arms to complete the 30-Second Chair Stand Test can show progress if the number of reps changed from 4 to 7 between assessments.

Q. *If the patient achieves a goal prior to the end of the plan of care, is it okay to continue with that intervention without modifying the goal?*

A. In general, if the goal has been met, justifying the medical necessity for providing the same interventions with a restorative plan of care is difficult. If concerns exist about patient safety and/or the patient's ability to maintain that status, the evaluating clinician should determine whether a skilled maintenance plan of care is appropriate. In the absence of a skilled need for maintenance therapy, the goal should be updated or the intervention should be discontinued.

Q. *Does documenting improvements in ambulation distance demonstrate medical necessity for skilled therapy services?*

A. In general, medical necessity and skill may not be demonstrated if distance is the only factor documented. For example, the medical necessity and skill associated with gait training depends upon documentation of teaching being provided to correct gait deviations, the patient's ability to safely access his or her home environment/community (including human assistance needed), and the appropriateness of devices being used for ambulation. Goals for ambulation distance should reflect the documented needs of the patient's home environment and community participation.

Q. *My agency uses an electronic medical record, which allows me to copy and paste the same intervention text from one visit note to the next. This saves a lot of documentation time. Is this okay?*

A. This is very risky. Intervention documentation for each visit should stand alone with the unique documentation of services and teaching provided during that visit. Clinicians must be cautious to avoid duplicating documentation from one visit to another, which presents a "cookie-cutter" appearance that makes it difficult to substantiate ongoing skilled services. It is critical to refrain from copying and pasting any assessment information from one visit note to another. This is unprofessional and fails to denote that any ongoing skilled assessment is occurring. CMS is expected to scrutinize this further with the expanded use of electronic health records.[10]

Home Health Skilled Documentation Components by Visit Type

Comprehensive Assessments (Start of Care, Resumption of Care, Recertification)

Purpose: Design and individualize plan of care for payment episode

Qualified clinician: PT

Elements:

- Patient demographics
- Informed consent
- OASIS (if required)
- Medical history and comorbidities
- Vital signs
- Health condition, with reason for referral and diagnoses
- Prior level of function
- Personal factors, including medication review/allergies
- Impairment measures (eg, strength, ROM, balance)
- Standardized tests for functional mobility
- Environmental factors, including safety concerns and equipment used/needed
- Clinical judgment and interpretation
- Rationale for skilled interventions
- Objective measures of response to interventions (eg, Borg, pain, vital signs)
- Participation restrictions
- Care coordination
- Visit frequency/duration
- Discharge plan

Visit Note

Purpose: Document interventions, status, and progress toward goals

Qualified clinician(s): PT or PTA

Elements:

- Vital signs
- Pain: pre- and post-treatment
- Interventions designed to achieve functional goals; should include:
  - Skilled teaching (eg, technique, verbal cues)
  - Specific description (eg, reps, weights, distance)
  - Objective patient response (eg, Borg, pain, vital signs)
- Document evidence of progress toward goals or lack thereof

- Comparison of performance to prior visit(s)
- Description of residual impairments, functional limitations, and education needs
- Equipment training
- Environmental safety education
- Care coordination/conferencing
- Focus/plan for next visit

Reassessments

Purpose: Assess functional progress and modify plan of care as indicated

Qualified clinician(s): PT

Elements:

- Complete both regular visit note documentation and the reassessment
- Complete timely reassessments as required by regulations, payers, and patient need(s)
- Perform standardized testing and objectively quantify patient function
- Explain results of standardized testing, comparing with normative values as appropriate
- Document barriers to progress
- Document summary of progress supported by objective measurements
- Document status with regard to plan of care goals
- If not discharging patient, provide justification for why continued skilled care is indicated, including rehab potential if goals have changed
- Communicate plan of care changes to physician, including changes to frequency/duration and goals

Discharge Note

Purpose: Summarize patient's response to PT plan of care

Qualified clinician(s): PT

Elements

- Ensure patient was notified appropriately of discharge plan
- Complete regular visit note documentation and discharge reassessment
- Justify discharge visit with documentation of skilled interventions provided during that visit
- Coordinate with care team to determine if discharge OASIS is required
- Perform standardized testing and objectively quantify patient function
- Explain results of standardized testing, comparing with normative values as appropriate
- List goals met and explain any unmet goals
- Summarize interventions received
- Document discharge disposition
- Communicate discharge status to care team and physician

Table 10.2. Highlights From APTA's "Defensible Documentation"[2]

Tips for Documenting Progress	Tips for Documenting Evidence-Based Care	Top 10 Payer Complaints About Documentation	Avoid
• Update patient goals periodically • Highlight patient progress toward goals • Show comparisons from previous date to current date • Show a focus on function • Reassess when clinically indicated and according to regulatory requirements	• Keep up-to-date with research through journal articles and reviews, ArticleSearch on PTNow at PTNow.org • Include valid and reliable tests and measures as appropriate • Include standardized tests and measures in clinical documentation	• Poor legibility • Incomplete • Date of service not documented • Abbreviations—too many and/or can't understand • Documentation doesn't support billing (coding) • Skilled care not demonstrated • Medical necessity not demonstrated • Progress not demonstrated (restorative plan of care) • Repetitious daily notes without change in patient status • Interventions without clarification of time, frequency, or duration	• "Patient tolerated treatment well" • "Continue per plan" • "As above" • Unknown or confusing abbreviations • Adverbs such as slightly, likely • Adjectives such as good, fair, well • Words "minimal," "moderate," and "maximal"

Adapted with permission from the American Physical Therapy Association.

References

1. American Physical Therapy Association. Documentation: tips for improvement. *PT—Magazine of Physical Therapy*. January 2006. http://www.apta.org/PTinMotion/2006/1/Feature/GoodTipsDocumentation/. Accessed December 17, 2013.

2. Defensible documentation for patient/client management. American Physical Therapy Association website. http://www.apta.org/Documentation/DefensibleDocumentation/. Updated March 28, 2012. Accessed January 29, 2014.

3. Chapter 7—home health services. In: *Medicare Benefit Policy Manual, Rev 179*. Washington DC: Centers for Medicare and Medicaid Services. http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c07.pdf. Updated January 14, 2014. Accessed May 30, 2014.

4. Practice acts by state. American Physical Therapy Association website. http://www.apta.org/Licensure/StatePracticeActs/. Updated April 20, 2014. Accessed May 30, 2014.

5. *Guide to Physical Therapist Practice 3.0*. American Physical Therapy Association; 2014. http://guidetoptpractice.apta.org/. Accessed August 20, 2014.

6. American Physical Therapy Association House of Delegates. Code of ethics for the physical therapist (HOD S06-09-07-12). Alexandria, VA: American Physical Therapy Association; 2009. http://www.apta.org/uploadedFiles/APTAorg/About_Us/Policies/Ethics/CodeofEthics.pdf. Accessed December 9, 2013.

7. American Physical Therapy Association House of Delegates. Standards of ethical conduct for the physical therapist assistant (HOD S06-09-20-18). Alexandria, VA: American Physical Therapy Association; 2009. http://www.apta.org/uploadedFiles/APTAorg/About_Us/Policies/Ethics/StandardsEthicalConductPTA.pdf. Accessed December 17, 2013.

8. Towards a common language for functioning, disability and health: ICF—the international classification of functioning, disability and health. Geneva, Switzerland: World Health Organization; 2002. http://www.who.int/classifications/icf/training/icfbeginnersguide.pdf. Accessed December 16, 2013.

9. Therapy questions and answers (Q&A #15). Centers for Medicare and Medicaid Services. http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/downloads/therapy_questions_and_answers.pdf. Revised February 28, 2013. Accessed January 27, 2014.

10. Levinson D. CMS and its contractors have adopted few program integrity practices to address vulnerabilities in EHRs (OEI-01-11-00671). Department of Health and Human Services, Office of the Inspector General. January 2014. http://oig.hhs.gov/oei/reports/oei-01-11-00571.pdf. Accessed January 29, 2014.

HOME HEALTH PHYSICAL THERAPY SUPPLIES/EQUIPMENT AND INFECTION CONTROL

Introduction

Physical therapists and physical therapist assistants working in the home health setting need to be prepared with the necessary supplies and equipment for providing patient care. Many clinicians store supplies in their vehicles and use a bag to bring supplies into the patient's home. Some home health agencies provide supplies, but sometimes clinicians need to assemble their own collection of supplies and equipment for patient care.

In 2002, the United States saw an estimated 1.2 million infections involving 8 million adult and pediatric patients receiving home health services.[1] With the expected growth and prevalence of multiple-drug-resistant organisms, agencies and clinicians need to ensure that policies and procedures are in place to minimize risk for both themselves and the patients they serve.[2] Clinicians are responsible for ensuring that their equipment is safe for use with patients. This involves following infection control measures and ensuring that equipment is serviced appropriately and in a timely way. Clinicians should use proper bag technique in patients' homes.[3] Clinicians also should be prepared with all of the essential forms/documents that may be required during patient visits or encounters. This chapter provides guidance and criteria for achieving these objectives as part of providing a safe and valuable patient experience.

GUIDELINE

The home health physical therapist and physical therapist assistant prepare and organize their supplies and equipment, follow infection control procedures, and maintain patient safety.

CRITERIA

1. Physical therapists (PTs) and physical therapist assistants (PTAs) organize supplies and equipment in their vehicles and supply bags with “clean” and “dirty” areas.
2. PTs and PTAs carry supplies in the following categories (refer to Table 11.1 in the Practical Application section of this chapter):
    a. General
    b. Health assessment
    c. Quantitative measures
    d. Interventions
3. PTs and PTAs apply infection control measures by:
    a. Washing hands or using hand sanitizer
    b. Following universal precautions with potential contact with blood and other body fluids
    c. Maintaining supply bags in clean and orderly state
    d. Following appropriate bag technique by not placing supply bags on the floor and by using a barrier when placing the bag on other surfaces
    e. Cleaning/disinfecting reusable supplies and equipment after use
4. PTs and PTAs help to maintain patient safety by:
    a. Being prepared to use the following equipment as indicated:
        i. CPR pocket mask
        ii. Personal protective equipment (PPE), including gloves, gown, and mask
        iii. Wrench and screwdrivers (for equipment adjustment)
    b. Ensuring that electrical equipment is serviced and calibrated on a timely schedule

CASE SCENARIO

Tom and Jessica are provided some supplies and equipment by the home health agency that employs them. The agency educates them in infection control, including hand hygiene and bag technique. Prior to seeing patients, they are issued a supply bag containing:

- CPR pocket mask
- Dressing supplies (bandages, 4x4 gauze, tape)
- Goniometers (8" and 12" sizes)
- Gown, gloves, and mask
- Hand sanitizer and soap
- Oral thermometer and sheaths
- Pulse oximeter
- Sphygmanometer and stethoscope
- Stopwatch
- Elastic band
- Wax paper, drape, or paper towel to be used as a barrier

The supply bag is large enough to hold essential supplies and a laptop. The polyester covering is easy to sanitize with wipes. In addition to the agency-issued supplies, Tom and Jessica each purchase a balance pad for advanced balance training and a rolling tape measure to accurately measure distances and calculate walking speed. They purchase their own sets of adjustable ankle weights to provide resistance training during strengthening exercises.

Both clinicians perform hand hygiene before and after providing patient care, and prior to entering their home health bag's clean section. They also place a barrier between their supply bag and the couch where they set the bag. Sometimes they hang the bag from a door handle if no surface is suitable for resting the bag. They also use the barrier, such as wax paper, drape, or paper towel, between ankle weights and the patient's skin.

During every visit, they check patient temperature, blood pressure, pulse, respiratory rate, and pain levels. Tom occasionally checks out an ultrasound unit from the office and ensures that it has been serviced and calibrated annually. They are prepared to document occurrence reports, provide home exercise programs, complete Advance Beneficiary Notice of Noncoverage forms, and notes for physicians.

Tom and Jessica feel prepared with the supplies and equipment needed to provide optimal care for their patients.

PRACTICAL APPLICATION

- Supplies/Equipment Considerations for Home Health Physical Therapy
- Spaulding's Scheme for Infection Control

Table 11.1. Supplies/Equipment Considerations for Home Health Physical Therapy[4]

General	Health Assessment	Quantitative Measuring	Interventions

• Alcohol wipes
• Antibacterial wipes
• Barriers (eg, wax paper, paper towels, plastic wrap)
• CPR pocket mask
• Essential forms and/or equipment for documentation
• Garbage bags (for disposables)
• Hand sanitizer and antibacterial soap
• Personal protective equipment (PPE):
  ◦ Disposable gloves
  ◦ Goggles
  ◦ Gown
  ◦ Mask
  ◦ Shoe covers
• Spill kit
• Supply bag with "clean" and "dirty" compartments
• Wrench/screwdriver
	• 5.07 monofilament
	• Flashlight
	• Mirror
	• Pulse oximeter
	• Reflex hammer
	• Sharp/dull instruments
	• Sphygmanometer
	• Stethoscope
	• Thermometer (with disposable sheaths)
	• Tuning fork
		• Distance measuring wheel
		• Dynamometer
		• Goniometers (8" and 12")
		• Stopwatch
		• Tape measure (disposable)
			• Balance board
			• Cuff weights
			• Dumbbells
			• Elastic bands/tubing
			• Foam balance pad
			• Foldable step stool/riser
			• Gait belt
			• Home exercise programs
			• Modalities:
			  ◦ Electrical stimulator
			  ◦ Laser
			  ◦ TENS
			  ◦ Ultrasound
			• Pedal exerciser (pedaler)
			• Shoulder pulleys
			• Transfer board
			• Wound care:
			  ◦ Bandages
			  ◦ Scissors
			  ◦ Suture/staple removal kit

Table 11.2. Spaulding's Scheme for Infection Control[4]

Critical Items	Semi-Critical Items	Non-Critical Items
Devices that enter sterile tissue or spaces and must be sterile for use:	*Devices that contact mucous membranes and non-intact skin:*	*Equipment that contacts intact skin and thus should be clean for use or undergo low-level disinfection:*
• IV therapy catheters • Needles • Indwelling urinary catheters	• Oral suction catheters • Thermometers	• Stethoscopes • Blood pressure cuffs (sphygmanometers) • Pulse oximeters
How to manage infection control in home care:	*How to manage infection control in home care:*	*How to manage infection control in home care:*
• Sterilize by steam sterilization • If heat sensitive, ethylene oxide • Other liquid sterilants	• High-level disinfection • Chemical disinfectants (eg, chlorine, hydrogen peroxide)	• Wipe down with alcohol wipes/ swabs and allow to dry before use • Follow manufacturer's instructions

References

1. Association for Professionals in Infection Control and Epidemiology (APIC) and Healthcare Infection Control Practices Advisory Committee (HICPAC). APIC-HICPAC surveillance definitions for home health care and home hospice infections. *HICPAC*. February 2008. http://www.apic.org/resource_/tinymcefilemanager/practice_guidance/hh-surv-def.pdf. Accessed October 8, 2013.

2. Kenneley I. Infection control in home healthcare: an exploratory study of issues for patients and providers. *Home Healthc Nurse*. April 2012;30(4);235-245.

3. McGoldrick M. Bag technique: preventing and controlling infections in home care and hospice. *Home Healthc Nurse*. January 2014;32(1):39-45.

4. Rhinehart E, McGoldrick M. *Infection Control in Home Care and Hospice*. 2nd ed. Sudbury, MA: Jones and Bartlett; 2005:121-125.

CHAPTER 12

DISCHARGE PLANNING

Introduction

The dynamic process of discharge planning begins with the initial physical therapist evaluation and continues until physical therapist services are no longer indicated. The *Guide to Physical Therapist Practice,* 2nd edition, defines *discharge* as the "process of ending physical therapy services that have been provided during a single episode of care, when the anticipated goals and expected outcomes have been achieved."[1(678)] The *Guide* differentiates this from *discontinuation*, which is a situation when "termination of physical therapy service occurs *prior* to achievement of anticipated goals and expected outcomes."[1(678)] In June 2013, the American Physical Therapy Association (APTA) House of Delegates (House) voted to adopt the phrase "conclusion of the episode of care"[2] as a replacement for the terms *discharge* and *discontinuation*. (Language in versions of the *Guide to Physical Therapist Practice* published after 2013 follows the House policy, and "discharge" is not used.) However, to avoid confusion with the specific implications of the concept of ending an episode of care within home health care, *Providing Physical Therapy in the Home* uses the term "discharge" in reference to the above terminology.

A comprehensive discharge plan focuses on achieving patient and caregiver goals by adequately considering diagnoses, impairments, functional limitations, societal resources, environmental safety, risk reduction/prevention, community access, and care transition. Discharge planning involves a collaborative effort with an interdisciplinary team and leads to improved patient outcomes and satisfaction.[3] This chapter provides guidance and criteria for developing a patient-centered discharge plan.

GUIDELINE

The physical therapist coordinates an appropriate discharge plan to address patient and caregiver goals.

CRITERIA

1. The physical therapist (PT) considers the impact of the following factors and addresses them within the discharge plan:
    a. Patient diagnoses
    b. Physical impairments
    c. Functional limitations
    d. Societal resources
    e. Environmental safety
    f. Risk reduction/prevention
    g. Community access
    h. Care transition(s)
2. The PT evaluates the appropriateness for discharge based upon:
    a. Physician changes to the ordered services
    b. Patient refusal or change in homebound status
    c. Financial concerns
    d. Patient progress toward goals of the plan of care, or lack thereof
    e. Patient adherence to safety recommendations
3. The PT coordinates discharge planning with the patient and caregiver and the interdisciplinary team.
4. The PT ensures that the patient/caregiver receives adequate advance notice of planned discharge date, per regulatory requirements.
5. The PT documents a discharge summary that includes:
    a. The reason for referral
    b. The number of visits provided
    c. A list of therapeutic interventions and education provided
    d. Objective measures of the patient's initial status compared with discharge status
    e. Progress toward goals of the plan of care
    f. Explanation for unmet goals, including a summary of comorbidities
    g. Description of environmental and personal factors
    h. Discharge disposition (eg, care transition to other setting, self-care at home)

CASE SCENARIO

During the initial physical therapist evaluation with his patient, Mary, Tom reviews her diagnoses to identify any comorbidities that could affect her rehab potential. Tom evaluates Mary's physical impairments and functional limitations and explains to her what he feels would be a realistic outcome. Tom recommends that Mary have grab bars installed prior to the conclusion of therapy services so that he can work with her on using them to improve safety with bathroom transfers. Tom also recommends that they have the railing fixed by the 3 steps exiting the home. Her daughter Susan indicates that her husband will take care of that.

The goals of the plan of care were established in collaboration with Mary and her daughter Susan. The goals accounted for Mary's desire to be able to go out to eat with her friends twice a month, which would require some assistance from Susan for transportation since Mary doesn't drive. Susan plans to transport Mary to and from outpatient physical therapist services after she is discharged from home health care. In preparation for the conclusion of her home health plan of care, Tom verifies the outpatient clinic with Mary and reaches out to the physical therapist there to coordinate the care transition. Tom also ensures that Mary can safely demonstrate the ability to independently manage bathroom transfers with her new grab bars, and safely exit and enter the home with the new, sturdy railing.

PRACTICAL APPLICATION

- Considerations for Planning a Safe Patient Discharge
- Documenting an Appropriate Discharge Summary

Figure 12.1. Considerations for planning a safe patient discharge.

Documenting an Appropriate Discharge Summary

Discharge date: 8/20/2013

Patient was *referred for physical therapy*[a] s/p fall with resultant left hip fracture requiring ORIF. Patient received 12 *physical therapy visits*[b] beginning on 7/15/2013.

Skilled interventions/education[c] provided were therapeutic exercise, bed mobility training, transfer training, gait training, and home safety instructions. Patient is doing home exercise program as instructed.

Status of goals:

- 30-Second Chair Stand Test score improved from 3 to 12 reps, indicating improved functional lower extremity strength and safety during transfers.[d] *GOAL MET*[e]
- Walking speed improved from 1.20 ft/sec to 2.00 ft/sec, indicating reduced risk for falls and hospitalization. *GOAL MET*
- Ascending/descending 3 steps to egress house improved from unable to min assist. *GOAL UNMET (arthritic knee pain and poor safety awareness)*[f]

Patient has *good family support*[g] with daughter checking on her several times/week. Daughter will be transporting patient to/from *outpatient physical therapist services*[h] effective next week.

Key Elements of a Discharge Summary:

a. The reason for referral
b. The number of visits provided
c. A list of therapeutic interventions and education provided
d. Objective measures of the patient's initial status compared with discharge status
e. Progress toward goals of the plan of care
f. Explanation for unmet goals, including a summary of comorbidities
g. Description of environmental and personal factors
h. Discharge disposition (eg, care transition to other setting, self-care at home)

Note: *This is a guideline. Agencies, payers, and licensing bodies may have more or less stringent requirements for discharge documentation. Clinicians are responsible for knowing what is required. More comprehensive documentation may be required when the patient is being discharged from all home health agency services, to reflect appropriate case management.*

References

1. *Guide to Physical Therapist Practice*. Rev 2nd ed. Alexandria, VA: American Physical Therapy Association; 2003.

2. American Physical Therapy Association House of Delegates. Standards of practice for physical therapy (HOD P06-13-22-15). Alexandria, VA: American Physical Therapy Association; 2013. http://www.apta.org/uploadedFiles/APTAorg/About_Us/Policies/Practice/StandardsPractice.pdf. Accessed February 26, 2014.

3. Hearn J, Higginson IJ. Do specialist palliative care teams improve outcomes for cancer patients? A systematic literature review. *Pall Med*. 1998;12:317-332.

CHAPTER 13

THE PATIENT EXPERIENCE

Introduction

Receiving positive feedback from patients and caregivers is one of the most rewarding aspects of the physical therapy profession. In the home health setting, clinicians need to recognize that they are truly guests in the homes of patients and caregivers. The American Physical Therapy Association produced the Code of Ethics for the Physical Therapist[1] and the Standards of Ethical Conduct for the Physical Therapist Assistant[2] to inspire the highest standards of care. These documents obligate physical therapists and physical therapist assistants to act in a "respectful manner toward each person," employ "compassionate and caring behaviors," and collaborate with patients/caregivers about their health care decisions. Fulfillment of these obligations establishes the foundation for a positive patient experience.

Various methods exist for collecting, analyzing, and reporting patient satisfaction data. For example, the Home Health Consumer Assessment of Health Providers and Systems (HHCAHPS) was developed by the Centers for Medicare and Medicaid Services (CMS) to produce comparable patient satisfaction data, incentivize agencies to improve quality, and enhance public accountability by increasing the transparency of services being provided.[3] Another method for collecting information is for home health agencies to make follow-up phone calls to patients and caregivers. This chapter helps physical therapists and physical therapist assistants understand their role in helping their agency attain the highest levels of patient satisfaction.

GUIDELINE

The physical therapist and physical therapist assistant provide quality services to patients and caregivers in the home setting and accept responsibility for contributing to a positive patient experience.

CRITERIA

1. Physical therapists (PTs) and physical therapist assistants (PTAs) contribute to positive patient and caregiver satisfaction with home health services by:
    a. Providing compassionate care, including:
        i. Staying informed about all the care and treatment being provided via regular collaboration with other care providers
        ii. Treating patients as gently as possible
        iii. Treating patients/caregivers with courtesy and respect
        iv. Understanding and respecting cultural differences
        v. Promptly managing patient/caregiver concerns to minimize problems with care
    b. Communicating appropriately with patients/caregivers, including:
        i. Establishing informed consent for the services to be provided
        ii. Ensuring they are consistently aware of arrival times
        iii. Educating in easy-to-understand terms
        iv. Listening carefully
        v. Assisting office personnel with helpful and timely resolution of concerns
    c. Managing specific care issues, including but not limited to:
        i. Discussing safety in the home environment
        ii. Talking about pain, pain management, and its impact on function
        iii. Asking to see and then talking with patient/caregiver about all prescription and over-the-counter (OTC) medications
        iv. Inquiring about new/changed prescription and OTC medications and then providing instruction as indicated regarding:
            1. Purpose
            2. Timing/scheduling
            3. Side effects
        v. Following best practices for chronic conditions (eg, heart failure, chronic obstructive pulmonary disease, diabetes)
        vi. Preventive care to minimize pressure ulcer risk
        vii. Follow-up questions regarding immunizations (eg, influenza, pneumonia)

CASE SCENARIO

A few weeks after her discharge from home care services, Mary receives a survey asking about the care that she received from the home health agency. She was very happy and gives high marks for how she was treated by the staff. Everyone was respectful and treated her as gently as possible. She always knew when to expect a clinician, which made it easier for her to manage her day. When she had a problem or question she felt that the staff was very well informed, and she was confident in the answers provided. Mary was glad that the nurses and therapists took the time to discuss her medications, educate on disease processes, and make home safety recommendations. Jessica showed her pictures of her hip and provided education about the healing process.

Both Tom and Jessica prepared the patient for the expected muscle soreness associated with the rehabilitation process and regularly requested feedback about pain/soreness pre- and post-treatment sessions. Mary gives a glowing report to her friends and family about the quality of care she received. She reports that the agency was great and helped her get back to normal. Two months later, her neighbor asks her surgeon for services from this same agency based upon Mary's recommendation.

PRACTICAL APPLICATION

- How Physical Therapists Can Promote Better Patient Satisfaction Ratings on HHCAHPS Survey
- Understanding Patient Care Factors that Contribute to High Global Scores on the HHCAHPS Survey

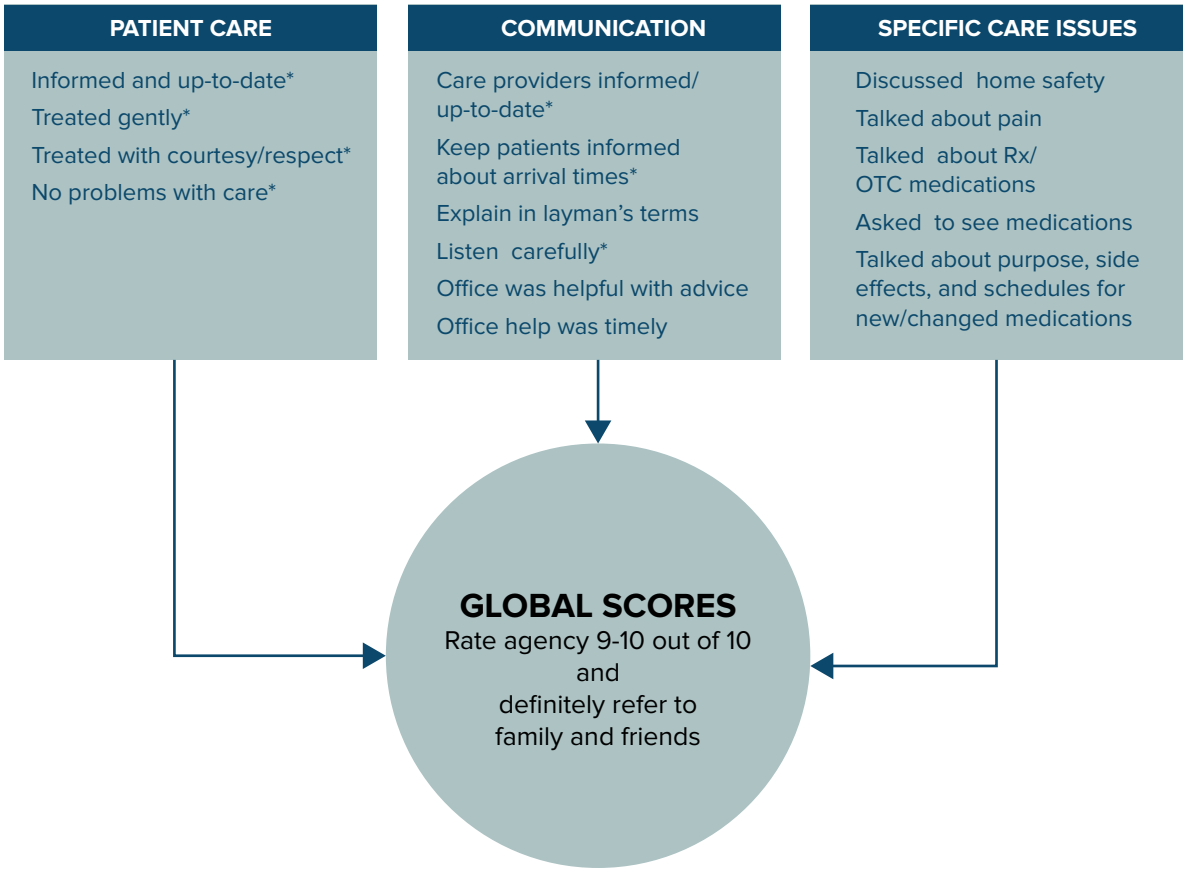
Table 13.1. How Physical Therapists Can Promote Better Patient Satisfaction Ratings on Home Health Consumers of Healthcare Providers and Services (HHCAHPS) Survey

Category: Care of Patients	Physical Therapist Actions
Were home health providers informed and up-to-date about the patient's care/ treatment? *(Question 9)*	• Communicate with other team members • Secure understanding of how each discipline contributes to patient goals • Collaborate weekly with other team members about ongoing plans and discharge planning
Was the patient treated as gently as possible? *(Question 16)*	• Explain what you are going to do • Instruct patients to take pain meds prior to therapy visits to reduce pain • Ask if they need anything prior to leaving the patient's home
Was the patient/caregiver treated with courtesy and respect? *(Question 19)*	• Treat patients and caregivers the way that you would like to be treated • Be respectful of cultural and personal preferences (eg, removal of shoes, greetings) • When leaving, replace all items as you found them
Did the patient have any problems with care received? *(Question 24)*	• Respond to concerns and implement solutions quickly
Category: Communications Between Providers and Patients/Caregivers	**Physical Therapist Actions**
Was the patient/caregiver informed about all care to be provided at the SOC? *(Question 2)*	• Explain rationale for services to be provided (eg, SN, OT, HHA, MSW, RD) to patient and caregiver during SOC visit
Was the patient/caregiver informed about arrival times? *(Question 15)*	• Schedule visits on the patient's calendar • Inform patients of timeframe for arrival; promptly notify if running late
Were explanations to patient and caregiver given in easy-to-understand terms? *(Question 17)*	• Use layman's terminology • Verify patient understanding
Did providers listen carefully to patient and caregiver? *(Question 18)*	• Verbalize understanding • Respond promptly to address concerns
Did office staff provide timely assistance and advice? *(Questions 22 & 23)*	• Build good communicative relationships with office staff • Promptly communicate changes of patient status, case manager assignments, scheduling changes, etc

Table 13.1. (Continued)

Category: Specific Care Issues	Physical Therapist Actions
Upon admission, did the provider discuss home safety with the patient/caregiver? *(Question 3)*	• Provide safety education (eg, falls prevention, devices) • Recommend environmental changes
Did the provider ask to see and then discuss prescription and over-the-counter (OTC) medications? *(Questions 4 & 5)*	• Ask to see all medications, ointments/creams, vitamins, and herbal remedies • Discuss schedule, purpose, action, and side effects of medications • Inquire about medication changes every visit
Did the provider(s) ask about any new or changed prescription medications and educate as indicated? *(Questions 12, 13, & 14)*	• Discuss schedule, purpose, action, and side effects of medications • Inquire about medication changes every visit • Review information/pharmacy handouts
Global Survey Questions	
How would the patient/caregiver rate the home health agency from 0-10? *(Question 20)* Would the patient/caregiver recommend this agency to family or friends for home health care? *(Question 25)*	HHCAHPS questions shown to most strongly influence positive global survey scores are: • Care of patients: 9, 16, 19, and 24 • Communication: 15, 17, and 18

Figure 13.1. Understanding patient care factors that contribute to high global scores on the HHCAHPS[3] survey.



*Identified as "key drivers" by Fazzi[4] for improving global scores involving agency rank and patient/caregiver sentiment for "definitely" recommending agency to family and friends.

References

1. American Physical Therapy Association House of Delegates. Code of ethics for the physical therapist (HOD S06-09-07-12). Alexandria, VA: American Physical Therapy Association; 2009. http://www.apta.org/uploadedFiles/APTAorg/About_Us/Policies/Ethics/CodeofEthics.pdf. Accessed December 9, 2013.

2. American Physical Therapy Association House of Delegates. Standards of ethical conduct for the physical therapist assistant (HOD S06-09-20-18). Alexandria, VA: American Physical Therapy Association; 2009. http://www.apta.org/uploadedFiles/APTAorg/About_Us/Policies/Ethics/StandardsEthicalConductPTA.pdf. Accessed December 17, 2013.

3. About home health care CAHPS survey. Centers for Medicare and Medicaid Services website. https://homehealthcahps.org/GeneralInformation/AboutHomeHealthCareCAHPSSurvey.aspx. Accessed December 16, 2013.

4. Mazza G. Key drivers for improving HHCAHPS results. Fazzi.com website. http://www.fazzi.com/Key_Drivers_for_Improving_HHCAHPS_Results.html. Accessed May 1, 2014.

CHAPTER 14

LIFELONG LEARNING AND CONTINUING COMPETENCE

Introduction

The health care arena is rapidly changing. Physical therapists and physical therapist assistants keep up with these changes by accepting the responsibility for lifelong learning and continued professional competence. In 2007, the American Physical Therapy Association defined *continuing competence* as "the ongoing possession and application of contemporary knowledge, skills, and abilities commensurate with an individual's (physical therapist or physical therapist assistant) role within the context of public health, welfare, and safety and defined by a scope of practice and practice setting."[1] APTA's Code of Ethics for the Physical Therapist[2] provides valuable guidance on how to fulfill this responsibility. It tasks physical therapists to "achieve and maintain professional competence" through "critical self-assessment," continued education, and following best practices by evaluating the "strength of evidence" for interventions provided.

Professional excellence and continued competence may involve several pathways.[3] For example, some may pursue clinical specialization and/or certification while others may pursue higher levels of education. Physical therapists also can take opportunities to participate in research or serve in positions of leadership that promote the profession of physical therapy. These various roles are important for demonstrating the role of physical therapists in promoting a healthy society. This chapter encourages physical therapists and physical therapist assistants to fulfill their obligation to society via a pathway of lifelong learning and continued competence.

GUIDELINE

The physical therapist and physical therapist assistant are committed to lifelong learning and continuing competence.

CRITERIA

1. Physical therapists (PTs) and physical therapist assistants (PTAs) demonstrate their commitment to lifelong learning and continuing competence by:
    a. Fulfilling their roles as health care professionals who promote quality health and wellbeing in society
    b. Complying with contemporary standards of best practice, including reliance on evidence for clinical decision-making
    c. Practicing autonomously in the home health setting, which minimally includes:
        i. Collaboration with the physician and the interdisciplinary team
        ii. Case management efforts centered on value-based care for patients, including:
            1. Supervision of medication management
            2. Monitoring emotional health of patients/caregivers
            3. Assessing environmental risks and needs for safety modifications
            4. Identifying the need for additional services
            5. Promotion of functional recovery and societal participation for patients and caregivers
            6. Active participation in care planning meetings
    d. Exhibiting the 7 core values of professionalism[4]:
        i. Accountability
        ii. Altruism
        iii. Compassion/caring
        iv. Excellence
        v. Integrity
        vi. Professional duty
        vii. Social responsibility
    e. Practicing in compliance with the following:
        i. *Guide to Physical Therapist Practice*[5]
        ii. Standards of Practice for Physical Therapy[6] and Guide for Conduct of the Physical Therapist Assistant[7]
        iii. Code of Ethics for the Physical Therapist[2] and Standards of Ethical Conduct for the Physical Therapist Assistant[8]

f. Integrating the APTA vision for the profession,[9] which includes the following principles:
    i. Identity
    ii. Quality
    iii. Collaboration
    iv. Value
    v. Innovation
    vi. Consumer-centricity
    vii. Access/equity
    viii. Advocacy
g. Participating in or supporting clinical research

2. PTs and PTAs regularly perform self-reflection as part of their professional development, which includes:
    a. Determining their current levels of competence
    b. Identifying opportunities for growth and development
    c. Pursuing higher levels of excellence within their scope of practice; obtaining enhanced knowledge and skills
    d. Participating in opportunities that promote and advance the physical therapy profession
    e. Collaborating with professional peers and interdisciplinary teams to optimize value-based care
    f. Establishing short-term and long-term professional goals as part of a lifelong learning pathway, which may include advanced degrees, specialization, and/or certification

CASE SCENARIO

Shortly after beginning to work in the home health setting, Tom recognizes that he needs some additional training to enhance his case management knowledge and skills. He is particularly interested in becoming more confident with reviewing the medication profile.

He identifies and completes a pharmacology course for physical therapists. A few months after completing this training, he determines that one of his patients has been taking both a generic and a brand name version of the same medication without realizing it. Tom contacts the physician to seek clarification, and the physician asks that the patient be instructed to discontinue one of those medications. The physician compliments Tom on his thorough assessment and says that this could have been hazardous for the patient if it had continued too long. This proves to be a valuable experience for understanding Tom's role as a case manager.

Tom subsequently pursues and completes OASIS certification, which he finds to be extremely helpful for accurately scoring OASIS items. He also completes some training on the use of standardized tests, which proves to be beneficial for completing reassessments that justify care with sound clinical evidence. He maintains his membership with the American Physical Therapy Association and the Home Health Section, which lead to volunteer opportunities and community education activities. Tom decides to continue on a career path in the home health setting, and plans to pursue further training to obtain specialization in geriatric care.

PRACTICAL APPLICATION

- Professional Development Pathways for Physical Therapists and Physical Therapist Assistants

Table 14.1. Professional Development Pathways for Physical Therapists and Physical Therapist Assistants[3]

Credentialed Clinical Instructor Program (CCIP)	The CCIP career development pathway is appropriate for PTs and PTAs working in a clinical setting who seek to develop their teaching skills. They learn to provide a challenging and educational clinical experience for students. *Obtain additional information at:* www.apta.org/CCIP/
Research	The Foundation for Physical Therapy provides funding for physical therapy research, supports evidence-based practice, enhances the value of patient services, and contributes to the development of the next generation of researchers. Funding supports areas of scientific, clinical, and health services research. Many of the sections within APTA also award grants that support research. *Obtain additional information at:* http://foundation4pt.org/
Board-Certified Clinical Specialization	Specialist certification enables a physical therapist to obtain advanced professional education and proficiency in a selected area of practice. Clinical specialization focuses on a specific field of practice, requiring additional knowledge, skill, and experience beyond that of an entry-level physical therapist. The American Board of Physical Therapy Specialties (ABPTS) recognizes clinicians who attain this level of advanced specialization. *Obtain additional information at:* www.abpts.org/home.aspx
Postprofessional Degree	There are multiple opportunities for postprofessional degrees, including postdoctoral, doctoral/graduate programs, transitional doctor of physical therapy (DPT), and PhD and ScD programs. *Obtain additional information at:* www.apta.org/PostprofessionalDegree/
Residency and Fellowship Programs	Residency and fellowship programs consist of clinical or nonclinical opportunities for postprofessional mentoring and training. Based on a foundation in scientific inquiry, they include written and live practical examinations and evidence-based practice. A physical therapist clinical fellowship program is similar to the medical model. Fellowship training is not appropriate for new physical therapist graduates. *Obtain additional information at:* www.abptrfe.org/home.aspx
Leadership Development	APTA offers multiple programs and opportunities to develop leadership skills. For example, a variety of leadership meetings take place at APTA Combined Sections Meeting (CSM) and NEXT Conference and Exposition. *Obtain additional information at:* www.apta.org/LeadershipDevelopment/

Table 14.1. (Continued)

PTA Recognition of Advanced Proficiency	Physical therapist assistants who meet minimum eligibility requirements may receive APTA's Recognition of Advanced Proficiency for the Physical Therapist Assistant. *Obtain additional information at:* www.apta.org/PTARecognition/
PTA Advanced Proficiency Pathways (APP)	PTAs can gain advanced proficiency knowledge and skill in a selected area of work. Participants take online core courses common to all of the APPs, take content-specific courses for the selected area of work, and have mentoring experiences with a qualified mentor of the participant's choosing. *Obtain additional information at:* www.apta.org/APP/

References

1. American Physical Therapy Association House of Delegates. Professional development, lifelong learning, and continuing competence in physical therapy (HOD P05-07-14-14). Alexandria, VA: American Physical Therapy Association; 2007. http://www.apta.org/uploadedFiles/APTAorg/About_Us/Policies/HOD/Professional_Development/ProfessionalDev.pdf. Accessed January 20, 2014.

2. American Physical Therapy Association House of Delegates. Code of ethics for the physical therapist (HOD S06-09-07-12). Alexandria, VA: American Physical Therapy Association; 2009. http://www.apta.org/uploadedFiles/APTAorg/About_Us/Policies/Ethics/CodeofEthics.pdf. Accessed December 9, 2013.

3. Career development. American Physical Therapy Association website. http://www.apta.org/CareerDevelopment/. Updated July 11, 2013. Accessed November 5, 2013.

4. American Physical Therapy Association House of Delegates. Core values (HOD P05-07-19-19). Alexandria, VA: American Physical Therapy Association; 2007. http://www.apta.org/uploadedFiles/APTAorg/About_Us/Policies/Ethics/CoreValuesEndorsement.pdf. Accessed December 28, 2013.

5. *Guide to Physical Therapist Practice 3.0.* American Physical Therapy Association; 2014. http://guidetoptpractice.apta.org/. Accessed August 20, 2014.

6. American Physical Therapy Association House of Delegates. Standards of practice for physical therapy (HOD P06-13-22-15). Alexandria, VA: American Physical Therapy Association; 2013. http://www.apta.org/uploadedFiles/APTAorg/About_Us/Policies/Practice/StandardsPractice.pdf. Accessed January 20, 2014.

7. American Physical Therapy Association Ethics and Judiciary Committee. Guide for conduct of the physical therapist assistant. Alexandria, VA: American Physical Therapy Association; 2010. http://www.apta.org/uploadedFiles/APTAorg/Practice_and_Patient_Care/Ethics/GuideforConductofthePTA.pdf. Accessed December 17, 2013.

8. American Physical Therapy Association House of Delegates. Standards of ethical conduct for the physical therapist assistant (HOD S06-09-20-18). Alexandria, VA: American Physical Therapy Association; 2009. http://www.apta.org/uploadedFiles/APTAorg/About_Us/Policies/Ethics/StandardsEthicalConductPTA.pdf. Accessed December 17, 2013.

9. American Physical Therapy Association House of Delegates. Vision statement for the physical therapy profession (HOD P06-13-19-23). Alexandria, VA: American Physical Therapy Association; 2013. http://www.apta.org/Vision/. Accessed January 20, 2014.

HOME HEALTH PHYSICAL THERAPIST PRACTICE RESOURCES AND REFERENCES

Introduction

In any setting, the physical therapist is responsible for keeping current with evidence-based practice and staying aware of rules and regulations affecting that practice. In home health, where the physical therapist practices autonomously, it is essential for the physical therapist to have the resources readily available to provide timely care for patients. As case manager, the physical therapist is responsible for identifying all needs of the patient. This includes medication reconciliation and obtaining referrals for other disciplines.

This chapter provides a list of online resources for physical therapy, rules and regulations affecting home health, and resources for community support for patients and their families. Also, for the modern smartphone user, this chapter lists a sampling of free apps available for quick reference to medications, anatomy, coding, and more.

Online Resources

Physical Therapy Resources

- APTA Advocacy: www.apta.org/advocacy/
- APTA Code of Ethics: www.apta.org/uploadedFiles/APTAorg/About_Us/Policies/Ethics/CodeofEthics.pdf
- APTA Guide to Physical Therapist Practice: http://guidetoptpractice.apta.org/
- APTA Policies and Bylaws: www.apta.org/policies/
- Federation of State Boards of Physical Therapy (FSBPT): www.fsbpt.org/index.asp
- FSBPT Licensing Authorities: www.fsbpt.org/licensingAuthorities/index.asp
- Home Health Section of APTA: www.homehealthsection.org/
- PTNow (Evidence-Based Practice): www.ptnow.org/
- State Physical Therapy Practice Acts: www.apta.org/Licensure/StatePracticeActs/

Regulatory Resources

- Accreditation for Health Care: www.achc.org/
- CMS Home Health Agency Center: www.cms.hhs.gov/center/hha.asp
- Community Health Accreditation Program: www.chapinc.org/
- CMS Conditions of Participation: http://www.gpo.gov/fdsys/pkg/FR-1997-03-10/pdf/97-5316.pdf
- Home Health PPS: www.cms.hhs.gov/HomeHealthPPS/
- Home Health Quality Initiatives: www.cms.hhs.gov/HomeHealthQualityInits/01_Overview.asp#TopOfPage
- The Joint Commission: www.jointcommission.org/accreditation/home_care_accreditation.aspx
- Occupational Safety and Health Administration (OSHA): www.osha.gov

Industry Resources

- Alzheimer's Association: www.alz.org/
- American Heart Association: http://www.heart.org/HEARTORG/
- American Stroke Association: www.strokeassociation.org/STROKEORG/
- Defensible Documentation: www.apta.org/Documentation/DefensibleDocumentation/
- Home Health Compare: http://www.medicare.gov/homehealthcompare/search.html
- National Association for Home Care and Hospice (NAHC): www.nahc.org/
- National Council on Aging: www.ncoa.org
- OASIS Answers Inc: http://www.oasisanswers.com/
- Outcome and Assessment Information Set (OASIS): www.cms.hhs.gov/oasis/
- Parkinson's Association: www.parkinson.org/ and www.apdaparkinson.org/
- Quality Improvement Organizations: www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityImprovementOrgs/index.html
- Services for Seniors—Eldercare Locator: www.eldercare.gov

Free Smartphone Apps

(Not all-inclusive, and listing does not imply endorsement by APTA or the Home Health Section)

- iPharmacy: Drug guide and pill identifier
- Micromedex: Drug information
- Epocrates: Drug, disease, and diagnostic information
- Medscape: Mobile WebMD
- iTriage: Health, doctor, symptoms, and health care search
- Visual Anatomy: Interactive reference and education tool
- Find-a-Code ICD10/ICD9+GEMS: Code sets and general equivalency mappings between ICD-10 and ICD-9
- Educus ICD-9 codes, Version 2011
- ICD 10 Lite 2012: ICD 10 codes

PROVIDING PHYSICAL THERAPY IN THE HOME

This comprehensive successor to the APTA Home Health Section's popular *Guidelines for the Provision of Physical Therapy in the Home* reflects the expanding roles of physical therapists and physical therapist assistants in the home health setting, changes in reassessment requirements, and increased public accountability for best practices and positive patient experiences.

Providing Physical Therapy in the Home provides timely guidance to elevate the quality of physical therapist services in the home care setting to the highest levels, consistent with the Vision Statement of APTA:

Transforming society by optimizing movement to improve the human experience.

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