A Hand-in-Hand Approach: Therapy & Home Health Aides

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October 6, 2004
As you can see, I will be discussing a therapy and HH aide relationship, and how HH agencies can improve outcomes & coordination of care for their clients through better collaboration between therapy and the aides. I don’t want to offend any of the nurses who may be receiving this information, as I fully support & recognize their influence & importance in this collaborative effort. However, for the sake of simplicity, I’m going to focus primarily on the therapy and aide relationship.
Lecture Objectives

- Discover how a team approach helps improve outcomes in home health clients.
- Distinguish the difference between PT, OT, and ST and recognize when their services are appropriate for the home health client.
- Outline the influence therapy plays on OASIS outcomes.
- Design a program that allows therapy & aides to maximize home health client potential.

It’s my hope that you will walk away from this lecture having learned at least one thing, or at least having had your minds triggered to consider something different or new. But if I do a really good job, I’m hoping we will have accomplished these four things: We will have Discovered . . . . Distinguished . . . . Outlined . . . . And designed . . . .
Before we head into the “How to” of the therapy/aide relationship, I’d like to explore what research there is that reinforces the “why” of the benefit of such a relationship. So let’s review some related studies and see what proof there is of its merit.
I come to you from South Dakota, where the agency I work with serves a largely rural area. With that in mind, there was an article in the Journal of Rural Health in 2002 that compared rural versus urban-based home care. This study showed that in rural home care, fewer overall visits were made, the cost of the care was less (due to fewer therapy visits), and the clients in the rural setting were more likely to have HH aide services provided, which isn’t necessarily bad except, fewer of these clients were discharged with their goals actually met, they had more readmissions to the hospital, and they received HH for a longer period of time. So you can see, providing home health in rural settings may cost less for the agency over time, but at the same time, the clients aren’t necessary getting the greatest benefit of the services.
The next study is one I found very interesting. This is information that was published in 2001 in the Journal of American Geriatric Society. It presented the order of onset of disability in activities of daily living as people age. Interestingly enough, it showed that the order of activity restriction consistently follows this pattern: Bathing is the first ADL that people lose the ability to do independently. That’s followed by loss of mobility, then toileting, dressing, and transfers, and finally, the ability to feed oneself. If you know anything about rehab, you’ll quickly notice these are all areas in which rehab gives focus. The study also showed that lower body strength needed for bathing, mobility, and toileting was lost before upper body strength necessary for dressing and feeding which is why you might see PT used more often than OT. Also, women had higher risks of disability in bathing and toileting activities. However, regardless of age or sex of the individual, the same order of onset of disability for ADLs was present. Keep this list in mind for the next slide.
So why is it important to address these ADL tasks through home health? According to an article published in the New England Journal of Medicine in October of 2002, it looks as though addressing ADLs helps in the long-term status of home health patients. The research demonstrated that there is an association between functional decline in the elderly and their morbidity. Furthermore, interventions provided in the home help to improve physical abilities and reduce the rate of functional decline for activities such as walking, bathing, dressing, transfers, toileting, eating, and grooming. Does this list sound familiar?
Benefit of Restorative Care

Restorative care provided by HH nursing, therapy, and HH aide staff associated with:

- Greater likelihood of remaining at home
- Reduced likelihood of ER visits
- Shorter home care episodes
- Lower number of PT, nursing, aide visits
- Improved scores in self-care, home management & mobility

Well now we know that having home health helps patients with these ADLs, but what happens if home health staff work together with common goals versus each discipline going in and working on their own separate goals? There was a study that looked at this. In the Journal of the American Medical Association, research sought to compare restorative care to usual care for older adults in home health. What it found was that when nursing, therapy, and aide services worked together collaboratively and provided extra training to the home health patient under restorative care, patients had a greater likelihood of remaining at home, there were fewer visits to the ER, shorter home care episodes, and improved outcomes in self-care, home management, and mobility. In the end, these outcomes reflect better quality of care, improved quality of life for the patients, improved outcomes for the community, and a better community image of the agency. In today’s world where Medicare is tracking outcomes through the OASIS assessments and then reporting those outcomes to the public, these improvements are important to the vitality of the home health agency. And a little good P.R. never hurts in these competitive home health markets.
There were four main characteristics found in the agency that provided this team effort restorative care:

1. Nurses, therapists, and aides were all trained in issues relevant to rehab, geriatric medicine, and goal attainment.
2. Reorganization of the staff had to take place in order to create a coordinated, interdisciplinary team approach with shared goals.
3. Staff had to transition from treating diseases and “taking care of” patients to working together to maximize function & patient comfort.
4. Goals were established through the effort of not only the HH staff, but also through patient and family input rather than dictated solely by each individual discipline.
Higher Therapy, Lower Aide Visits

- Shift in thinking from strictly nursing & aides in the home, to multidisciplinary approach
- Resulting in fewer nursing and aide visits, more therapy visits BUT fewer visits overall AND better outcomes

Of course this couldn’t occur without some shift in thinking from a strictly nursing and aide approach to home care, to a multidisciplinary approach involving nursing and therapy services. I believe ten years ago, this may have been a more difficult concept to grasp. But these days, home health is embracing rehab more and more as a vital component to patient care and improved outcomes.

If a home health agency now chooses to go a step further with this new restorative approach, it will create fewer visits for nursing and aides and even more use of therapy, BUT with fewer visits made overall, AND without sacrifice for improved outcomes.
Whether it’s that agencies are recognizing therapy more or are adopting a restorative model, the numbers show increased use of therapy and higher numbers of cases of high therapy utilization for home care. Outcome Concepts Systems of Seattle compared home care episodes from the 4th quarter of 2002 and 2003 and found that the percentage of episodes that expected high therapy went up 6%. Of those episodes expected to meet the high therapy threshold of 10 visits, 71% of them ended with high therapy. Of course that’s good news for many agencies, as meeting that 10 visit threshold often means doubling the money received for that episode.
OIG Doing Checks

- Office of Inspector General looking at number of therapy visits & length of visits
- Focus on episodes with 10 or 11 visits, close to threshold
- Visits should average 48 minutes

But beware—the Office of the Inspector General has also taken notice of this increase in the number of high therapy cases and they are looking more closely at those high utilization episodes. Their focus is on episodes with 10 or 11 therapy visits. They are often arguing whether those extra 1 or 2 visits are medically necessary, and whether there were several shortened visits that could have been combined into one visit. According to OIG standards, the average therapy visit is around 48 minutes in length. Careful supporting documentation regarding treatment provided, necessity of treatment, and progress towards goals is important for justifying high therapy need.
So far we’ve reviewed some studies that showed that home health interventions improve activities of daily living for many HH clients and their overall outcomes. We’ve seen how a team approach further helps to improve ADL outcomes. And we’ve discussed how a team approach influences therapy utilization.

Before we talk about how to implement this team approach, let’s take a quick step back and review just what therapy is all about. I’m sure most or all of you are familiar with the difference between PT, OT, and ST and just what sorts of things they work with, but I think it’s important to go over those things in relation to home health just one more time so that we’re all on the same page.
Let’s start with PT. I think PT is the most recognized therapy and the one most often utilized in the home setting. Everyone generally recognizes physical therapy for doing exercise and ambulating with patients, but there’s more to PT than that. PTs do fall assessments and help with balance through training or recommendation of assistive devices. They also have training in pulmonary and cardiac rehab issues, pain management, positioning, wound care, and home management.
PT’s Know Mobility

- Most qualified discipline to assess patient’s mobility and needs for assistive devices
- Able to assess patient safety with functional mobility issues & provide recommendation of appropriate interventions

Overall, PT is the one you want to go to in the home health setting for functional mobility and patient safety issues. They can recommend home modifications and assistive devices to aid in safe movement.
Much to the detriment of many patients, I strongly believe OT is all-too-often overlooked. While they also do some strengthening and assessment of home safety, they are the gurus of adaptive equipment, environmental adaptations, and energy conservation training. They address many of the self-care ADLs like grooming, dressing, bathing - things we all associate OT with. They also work with cognition related to home management and fine motor coordination necessary for the simplest task such as writing.
You’ll most often see OT ordered in home health for their expertise related to ADL/IADL deficits and adaptive equipment recommendation and teaching. I don’t know how many agencies are referring patients to OT, or to what extent, but I think you’re really missing out if you’re not realizing and capturing their potential to help the patients.
The hidden therapy in many agencies is Speech Therapy. Whether it’s because there is a shortage of speech therapists to fill open positions or that they are not fully understood, Speech Therapists can be a great asset to the home setting. Most people order speech therapy for swallowing problems or obvious speech impediments. Speech is under-utilized, however, for their work with cognitive processing.
ST’s Know Cognition

- Most qualified discipline to assess patient’s cognitive status & its impact on daily living
- Teach compensatory methods for cognitive, speech, or swallowing difficulties

If you have a speech therapist available, don’t forget to look to them for help with your patients who are cognitively impaired or who risk their safety through poor judgment. Of course, seek out a referral for speech therapy, too, for speech and swallowing-related difficulties.
In-depth assessment = Goals may be more realistic than those established by nursing (in terms of pt’s need for additional therapy and level of improvement to be expected)

No offense to any nurses, but because of the in-depth assessment therapies complete, their goals may be more realistic than those established by nursing in terms of a patient’s need for additional therapy and level of improvement to be expected. Therapies have also been shown to do a better job of accurately completing OASIS assessments.

If you’re in doubt about whether a PT, OT, or ST referral is appropriate, consider adding a therapy screening tool to your nursing admission packets. There may be an additional attachment to this powerpoint program of the screening tool that our agency currently uses. If you think it would be helpful to your agency, feel free to use it and tweak it however it fits your agency.
Well, I mentioned that dirty word “OASIS,” didn’t I? I’m not going to talk long on this subject, but I would like you to take a quick minute to consider all the things that I just mentioned that therapy can address in the home setting, as well as the list of ADLs from the previous studies we discussed. If you compare those lists to the questions on OASIS, you’re going to find that therapy can influence a great number of the outcomes looked at by OASIS. Use therapies and coordinate closely with nursing and aides, and you’ll soon find your OBQI reports showing fantastic changes. Let’s quickly review OASIS items that therapy influences. I’ve color-coded the M0 numbers. White is influenced by multiple therapies, gold by PT, blue by OT, and yellow by ST.
Therapy Influence on OASIS Outcomes$^{1,2,6}$

- M0370 (Frequency of caregiver assistance)
- M0380 (Type of caregiver assistance)
- M0400 (Hearing/Understanding Language)
- M0410 (Speech & Oral Expression)
- M0420 (Frequency of Pain)
- M0560 (Cognitive Function)
- M0570 (Confusion)
- M0590 (Depressive Feelings)

Just running through these quickly, there’s . . .
Therapy and OASIS, ADLs

- M0640 (Grooming)
- M0650 (Upper Body Dressing)
- M0660 (Lower Body Dressing)
- M0670 (Bathing)
- M0680 (Toileting)
- M0690 (Transferring)
- M0700 (Ambulation)

The more obvious ones...
Therapy & OASIS, ADLs

- M0710 (Feeding/Eating)
- M0720 (Planning/Preparing Light Meals)
- M0740 (Laundry)
- M0750 (Housekeeping)
- M0770 (Ability to use phone)
- M0825 (Therapy Need)

And then . . .
Answering OASIS Questions

- Complete OASIS items according to patient ability rather than willingness or compliance

  *Example: Patient able to bathe in shower with assist, but chooses to sponge bathe independently*

- Be honest about safety risk, supervision needs

Because therapy can influence so many items, it’s important to answer the questions correctly. Here are just a few tips, as a side note to the presentation:

- Complete the OASIS items based on patient ability rather than their willingness or compliance. So if a patient can bathe in the shower with some assistance, but chooses to independently sponge bathe at bedside, the patient should be marked as able to shower in the tub with assistance.

- Be honest about safety risk. Even if a patient doesn’t have supervision available, but really needs the supervision, mark the OASIS item as needing supervision.
• Sometimes the patient’s ability to complete a task varies. Check the OASIS answer that reflects what the patient is able to do the majority of the time.

• This next one is most important in my mind: Read the answers to OASIS items from the bottom up rather than the top down. You’ll find your answers are much different. We often only read the first one or two items and say, “Yep, that’s Mr. Jones, alright.” But had we read the next line, we might have found it more accurately described Mr. Jones.
• Don’t ask yes/no questions. “Are you ever short of breath?” Of course they’re not! Instead, use open-ended questions or comments: “Describe for me how . . .” or “Tell me when you have troubles catching your breath.”
• Compare your sick patient to a healthy patient in the same age group rather than comparing this patient to another sick patient. Avoid thinking, “Yeah, you have 5/10 pain, but Mrs. Anderson down the street has much worse pain than that and she’s doing this or that.”
• Observe the patient. Don’t just rely on the answers patients give you. Actually make them show you. Patients who just came from the hospital or just had surgery may be answering from their “old” body and reporting what they used to be able to do rather than what they’re capable of now.
Most importantly, instead of resenting the OASIS for the cumbersome document that it can be, use it to your advantage. Consider the answers and allow them to guide your plan of care. Think about how you can coordinate nursing needs, therapy needs, and aide services necessary to help the patients maximize their potential.
Okay, I’m done with OASIS and we’re finally down to the nitty gritty portion of this lecture: how to put it all together.

Because therapy assesses and treats many issues related to ADLs and because the aides’ primary responsibility in the home is often to assist with ADLs, it makes sense that there should be a strong relationship between therapy and aides. As we discovered earlier, we now even have research to prove this. As I said earlier, for the sake of explanation and time, I’m going to focus primarily on the therapist/aide relationship, but it’s not hard to extrapolate the same relationship to nursing, too.

Here’s how the relationship develops:
The PT, OT, or ST would go into the patient’s home and complete an evaluation and determine if an aide is appropriate. Likewise, if an aide is ordered, therapy may be needed to go in and do a preliminary screen (often done at no charge with physician approval). In this way, the nurse isn’t solely responsible for setting up the aide plan of care and the therapist may see adaptive equipment or therapy needs that may otherwise have been overlooked.
Involving therapy early-on allows the team to set expectations about a patient’s involvement at a time when both the patient and the caregivers are most receptive. This assessment is critical, as the aides are often thrust into a situation blindly and may not truly understand how much the patient can do or will be able to do for themselves.
Therapy/Aide Work Hand-in-Hand

- Necessary to achieve patient’s ADL goals
  
  Example: OT can’t work on bathing at every visit;
  Need to address other things (i.e. meal prep, cognitive issues, laundry, ROM, etc.)

- Aide can reinforce therapy plan of care and provide necessary assistance (vs. total care) for ADLs as outlined by therapist(s)

From that point, the therapist(s) and the aide need to work collaboratively to achieve ADL goals. For example: OT isn’t always able to work on bathing at every visit because there may be additional home issues they need to address such as laundry or meal preparation. So the aide may be able to complete bathing another time that week and reinforce the therapy plan of care and necessary assistance on the things that PT or OT can’t address at every visit.
The trick is learning how to “guide” patients to independence. Therapy can work with the patient and the aide so that the patient is firmly, but gently, guided to greater levels of independence. So the aide “guides” the patient rather than “doing” for the patient. Because the more the aide does to assist a patient that’s capable of doing more, the more likely the patient will become dependent on the aide’s care and the less likely the patient is to achieve goals and/or independence. With therapy actively involved in the aide POC, the aide is more aware of exactly where the patient needs help.
Use It or Lose It

- Aides struggle not to help patients
- Helping too much is disservice to patient
- Help patients *only* with things they can’t do
- Assist in small ways without compromising progress towards independence
- Causes care plan to be continuously evolving
- Day one care plan different from last day
- Communication between Therapy and Aide is key

At first, the aides struggle not to help patients, because it’s hard to stand by and wait for a patient to do something that could maybe be done quicker and/or easier if the aide were to assist. But this sort of “help” is doing a disservice to the patient. Aides have to learn to help patients only with the things the patient can’t do safely on their own. It’s possible to assist the patient in small ways without compromising progress towards independence. As the patient progresses, so will the plan of care. So it will be constantly evolving. What is on the aide care plan on day one really should be different from the last day. But for this to work, frequent and effective communication between therapy and the aide is necessary.
By Golly, It Works

- HHA’s with therapy-established aide care plans have better results with improving independence with ADLs
- Ultimate goal of patient, agency, and Medicare
- Improvements reflected on OASIS

And as expected, home health agencies with therapy-established aide care plans have better results with improving independence with ADLs, which is the ultimate goal of the patient, the agency, and of course, Medicare. And your OASIS outcomes should reflect that.
Keeping with Regulations

- Nursing responsible for supervision of aides if nursing is involved in care
- PT/OT/ST can develop/update plan of care and have nurse sign off on it = Need good collaboration between Therapy and Nurse
- Therapy supervises aide only if nursing not involved.

So far we’ve been talking about therapy guiding the aide care plan, but I wanted to remind you that, under Medicare, nursing is responsible for supervision of aides if there is nursing involved in the care. That doesn’t mean that therapy can’t give input into the aide plan of care and have the nurse sign off on it. Therapy is allowed to directly supervise the aide if/when nursing is not involved in the care.
Let’s explore how to develop this therapy/aide relationship.
Just as a general reference point, here are some typical diagnoses where therapy and aides are often involved, and where there is opportunity for collaboration between the two services, as well as nursing: CHF, strokes, fractures, total joint replacements, Parkinson’s, diabetes, lung conditions, and general weakness.
A Workable Approach

1. PT/OT/ST Assessment
2. Joint Therapy/Aide Visit
3. Ongoing Communication
4. Care Coordination
5. Aide Care Plan and Visit Note
6. Discharge

With that in mind, let’s outline an example of an ideal therapy/aide interaction. First, the therapist would complete their initial assessment. Then the therapist and aide would make a joint visit. From there, ongoing communication and care coordination is needed, along with updates to the aide care plan and review of the visit notes. Ultimately, goals are met and the patient is discharged from services.
To help explain this in better detail, I’m going to use an example that involves occupational therapy and an aide in relation to bathing assistance. As we learned at the beginning of this lecture, this is the ADL disability lost first in the order of onset. It’s also an area I see our aides being asked to assist with most frequently. It seems to be the area of care that patients are often resigned to being dependent.
First, the OT would complete his/her assessment, looking at all aspects of ADLs including grooming, bathing, household management, environment, etc. They would then recommend the necessary equipment needed for safe completion of the tasks.
At initial visit, or within 1-3 days

- OT takes note of all steps of bathing (doffing clothes, transfers, washing body/hair, drying, dressing, tidying bathroom)
- OT creates aide plan

At that visit, or within 1-3 days, the OT would then assess bathing—looking at all steps of bathing (getting clothes on and off, getting into and out of the tub, ability to wash the entire body, clean-up after the bath). If needed, the OT would then create the aide care plan.
Joint Shower Visit

- OT instructs aide how to assist patient
- Aides to use multiple verbal cues > physical assistance
- Both stress to patient the importance of full patient participation in treatment and that staff expect patient to do for themselves within the realm of safety and endurance

Once there is an order for the aide, the next step is the joint visit where the OT instructs the aide how to assist the patient, teaching when and how to give verbal cues rather than physical assistance where appropriate. This allows both the OT and the aide to stress to the patient the importance of full patient participation in treatment & reinforce that the staff expects the patient to do for him/herself as much as possible within the realm of safety and endurance. By doing a joint visit, it’s less likely that you’ll see the patient playing one staff member against the other, as both staff members are fully aware of what the other is expecting.
Ongoing communication could include several means, such as:

- Voice mail messages
- Post-it notes
- Email
- Documentation review
- Periodic joint visits
- But nothing beats the direct face-to-face communication

This allows the therapist to update the plan of care as necessary and lets the aide report progress and/or problems.
Case conference meetings are also prime opportunities for the team to get together to discuss goals related to patients. Allowing everyone to speak about the patient rather than just one discipline helps to foster better understanding. To further assist nursing and/or aides keep up with progress seen with therapy, therapists can put copies of their visit notes in the working files/mock charts of the nursing and aide staff.
Plan delegates exactly when aide should provide cueing and when to provide physical assistance

Plan also states patient responsibilities

Therapy reviews and adjusts aide care plan, decreases intervention as patient progresses

Of course, the aide care plan needs to be updated as patient progress is made, outlining which cues to use & when to use them, when & where to provide physical assistance, and the patient’s responsibilities. Then the plan of care is progressed with fewer necessary interventions as the patient improves.
**Discharge**

- Aide services discontinued when patient reaches maximum independence and safety
- Patient’s maximum will vary (does not mean patient is necessarily independent with all tasks)

When the patient reaches maximum independence & safety, therapy/aide services are discontinued. This doesn’t mean the outcome will always be complete bathing/ADL independence. A patient’s maximum will vary, and perhaps the aide may always be needed for some tasks, but hopefully they will be minimal.
In order for this nursing/therapy/aide relationship to be effective, your agency needs to properly equip your team.
Define Roles

- Educate staff on what services & interventions each member of the team can offer, “What’s My Line”
- Place a therapist in the role of rehab manager
- Include nursing & therapies in quality review
- Simultaneous competency assessments for nursing & therapy

• One such way is to educate your staff on what services and interventions each member of the team can offer. One article I read suggested giving the first fifteen minutes of case conference meetings to a staff member to explain their duties and expertise in a “What’s My Line” format.

• Another thing that may help is to put a therapist in the role of a case manager. I’m not just saying that because that happens to be my job. But from personal experience, I have seen a much better coordination of care between nursing and aides and the therapy staff since there was a therapist in a manager role.

• Consider having all disciplines should be involved in quality review.

• Complete competency assessments, involving issues related to both nursing and therapy.
As far as staff training:

• Therapy can provide inservices to the aides regarding specific ways to assist or verbally cue patients. For example: OTs can teach on how aides can help patients to dress themselves when patients have use of only one hand, how patients dress when adhering to hip precautions, or ways to encourage energy conservation for the compromised patient.

• If you can’t get all the group together at one time, consider videotaping the training sessions so those not in attendance are still able to benefit from the education.

• Maybe even consider making some of the more important topics part of a yearly competency.
Role-play scenarios to demonstrate assessment of bathroom equipment and arrangement, ambulation

Schedule practice sessions with demonstration/return demonstration of adaptive equipment/assistive devices for bathing

Review safety issues and principles to teach patients/caregivers related to ADLs

• Try role-playing scenarios to demonstrate special situations
• Schedule practice sessions with demonstration/return demonstration
• Review safety issues related to ADLs and how to teach patients and caregivers in such a way that they can understand and apply the learned knowledge.
This all sounds nice on paper, right? Well, I’m not going to lie to you and say that making these sorts of changes comes easily or is done overnight. The agency I work for has been gradually implementing some of these ideas over the past year or so, and it’s definitely a work in progress. No effort to change ever goes smoothly all of the time, but we are seeing some positive outcomes as a result of our efforts:
• There’s better communication in both directions, not just from therapists to aides, but also aides to the therapists or nurses. This is important, as it meets part of the Conditions of Participation for Home Health Agencies with Medicare patients.
• We started out trying a dictation format for communication, but found that it didn’t work. So we’ve switched to using email, which has worked out well for us.
• We’re seeing increased numbers of joint visits made and interactive inservices.
• Our case conference meetings are much different these days than a year ago. We’re seeing therapy speak up more.
• If nothing else, there’s been a great change in our thinking. For example, the agency I work for had previously more of a mindset that we would have OT address all ADLs and put the aide in only if OT wasn’t able to progress the patient towards expected goals. We’ve now realized that having an aide compliment OT goals can be beneficial for everyone, especially the patient.
• We’re considering making this restorative model a departmental performance improvement project.
I don’t want to neglect to recognize the resources I used for this lecture. I’d encourage you to review some of them. I won’t name each of them, as I know you all can read them for yourself. I’ll just quickly click through them.
References


These first two references are excellent.


The Home Health Publicly Reported Quality Measures Resource is also a good general reference.


And the research articles we discussed early in the presentation . . .


Home Health Line also has some very useful information.

18. “10 primary diagnoses that most often get 10+ therapy visits; HHAs more often underestimate,” Table, *Home Health Line*; June 4, 2004.


Questions

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It’s been a pleasure presenting to you today and I thank you for your interest in this topic. If you have additional comments or questions after today, don’t hesitate to contact me at a later date either via phone or email.