An Introduction to Home Health with Career Advice to Help You Land Your First Job!

LAUNCH INTO HOME HEALTH PHYSICAL THERAPY

PETER B. SIMS, MS PT
FOREWORD BY ARNIE CISNEROS, PT

First Edition

Published in Evanston, Illinois by 0 Days Off, LLC.
ISBN: 978-0-9972991-0-6 – paperback
ISBN: 978-0-9972991-0-5 – ebook

Send all inquiries to peter@0daysoff.com
Discounts are offered on bulk orders for home health agencies and accredited physical therapy schools.

Cover Design by Ida Fia Sveningsson
Interior Book Design by Saravanan Ponnaiyan

Printed in the United States of America

I had two goals in mind when I set out to create this book:
1. introduce the practicing physical therapist and physical therapy student to the home health industry and work setting and
2. provide career advice to help the reader successfully prepare and land a job in home health.

May this book shorten and empower your journey.

Thank you for buying this book.

DEDICATION

To my mom, Barbara J. Frohardt. Thank you for teaching me unconditional love and compassion. I am forever grateful. You will always be remembered and loved.

To my wife, Lauren G. Cosby. Thank you for your motivating words, consistent love, and unconditional support. You make me a better man, husband, and father.

To my dad, Wendell Benjamin Sims. You have always been in my corner and a consistent positive force in my life. Thank you for always believing in me.

To my kiddos, Nasir and Vedah. Always strive to be the best at everything you do. I love you always and forever.

SPECIAL THANKS

Ayuda Therapists
Arnie Cisneros, PT
Allison Hilger, SLP
Brent Stuart, PT
Christopher Costello, PT
David M. Kelley, PT
Delali G. Goka, PT
Joyce Boin, PT
Julie Cook, PT
Karim G. Dure, MBA, JD
Lauren G. Cosby
Mara Rosen, OT
Mary K. Fritz, MBA
Nicholas Crosby, PT
Northeastern University PT Professors
Peter Engert, PT
Rodney Morgan, PT
Sean Sumner, PT

Free Companion Course

As a bonus for buying this book, the author has created a free online companion course to complement each chapter, which will help you gain a deeper understanding of the concepts and lessons discussed. The companion course includes interviews from home health professionals as well as bonus content not included in the book.

Inside the course you will find:

- The book's references
- Videos to walk you through high-frequency concepts
- Visual diagrams
- Downloadable sample and useful documents
- Resource links and content
- Video and audio interviews with home health professionals
- Bonus content beyond what I share in the book

I will be adding material and resources over time; so make sure you check back and stay engaged. Any feedback or ideas on ways to make the course better are welcome and appreciated.

Sign-up for the free Companion Course here:
www.learn.peterbsims.com

Disclaimer

This publication contains material designed to assist the reader in evaluating the home health setting and home health as a career choice and is for educational purposes only. While the publisher and author have made every attempt to verify that the information provided in this book is correct and up to date, the Publisher and Author assume no responsibility for any error, inaccuracy or omission.

The recommendations and content contained herein are not suitable for every situation. The materials contained herein are not intended to represent or guarantee you will achieve your desired result and the Publisher and Author make no such guarantee.

This book in not intended for use as a source of medical, business, legal or financial advice. You should always retain competent medical, business, legal and financial professionals. The views in this book should not be taken as expert instruction or command. Neither Author or Publisher assume any responsibility for any injury or loss and/or damage to persons or property arising out of or related to any use of material contained in this book. The reader is responsible for his or her own actions and is responsible for relaying on independent expertise and knowledge of the patient/client, to determine the best treatment and method of application for the patient/client.

FOREWORD

Healthcare has been in a state of reinvention over the past 50 years; many of us take for granted the care production and delivery model that we use to practice our skills. Most healthcare professionals enter a caring profession with a desire to improve the lives of suffering patients; it is this call that separates us from business, financial, or other professions. Rehabilitation therapists have traditionally held a unique place in the care model, as the functional identity of a patient is directly connected to their safety and wellness in the home. The introduction of Medicare in 1965 created the care model we all work in today, and ongoing and regular refinement of the system assures that we will continue to deliver quality care into the future.

The maturation of the Medicare model is taken for granted by many; it is responsible for the introduction and development of the Home Health program we know today. In the early 1980s, when I was licensed and began my practice, 85% of all rehab services were delivered through acute care hospitals. There were few services delivered in nursing homes (the Skilled Nursing Facility program was yet to be introduced) since patients were treated for rehab during seventeen day admissions. Home Health was effectively a pilot program, working under fee-for-service coverage that often included programs that ran for months to years. Effectively, the Care Continuum that today moves patients through a system of Providers addressing a specific patient profile didn't exist. Patient movement didn't follow the path we know today; Acute Hospital – Inpatient Rehabilitation Facility – Skilled Nursing Facility – Home Health –

Outpatient. When Medicare alone evolved past the fee-for-service model, where any service ordered by a physician and delivered to a patient was covered, healthcare developed the continuum we work in today.

The introduction of acuity into the medical model was another Medicare advancement as the Prospective Payment System was unveiled in 1984 with the DRG acute care program. An acronym for Diagnosis-Related Groupings, DRGs created a process where patients were classified, programmed, and reimbursed according to the level of severity of the patient's diagnosis. Patients who were sicker had a higher acuity DRG, which related to more coverage and payment to address the level of illness. This management of acute care hospitalizations by acuity was the basis of Length of Stay control in the hospital setting. As a direct result of DRG installation, hospital LOS stats decreased from 17 days (in 1984) to 3.8 days (today), creating the Post-Acute Care Continuum. This newly outlined continuum designated a series of Providers who addressed a specific patient profile to program a steadily improving Medicare beneficiary as they returned to health.

Post-discharge hospital patients requiring additional care were treated in Inpatient Rehab Facilities (or floors) if they needed significant rehab services of three or more hours per day. Patients who needed post-DC care but failed to qualify for an IRF may have been placed in a Skilled Nursing Facility (SNF); the SNF designation allowed for the post-dc treatment of step-down medical-surgical patients, as well as the Sub-Acute rehab patient. As patients improved and their ability to perform successfully in less restrictive environments that offered less support, they moved down the Care Continuum into the Home Health realm. Home Health, the Part A

Medicare Provider designated to deliver community-based services to the homebound client, primarily after discharge from an acute admission, treated these patients in their respective homes. This Care Continuum has provided the basic framework for patient movement throughout an acute episode as the client returns to their prior level of function. Further evolution of this model continued as the Prospective Payment System, relating payment and care volumes to an individual patient's acuity identity, swept across the Care Continuum.

The evolution of the Medicare PPS model in the Post-Acute sector further refined the acuity-based program as it pertained to post-discharge care. PPS introduction of the RUG system brought care redesign into the Skilled Nursing Facility model; RUGs (Resource Utilization Groupings) were to SNFs what DRGs were to acute care hospitals. Addressing Utilization, the combination of costs and care content, assured value was maintained in terms of compliance with Medicare programming regulations. By subdividing patient populations according to acuity measures, and managing those patients on a constant reassessment schedule to address progress due to delivered treatment to date, patients were improved at a faster rate for comparably less costs. It is important to note, however, that SNF patient volumes and costs were decreased while clinical outcomes improved through this progressive protocol. In the first six months after the introduction of the PPS RUG process in 1996, rehab billings decreased >35%.

This care redesign that occurred in the mid-90s for SNF Providers and patients had a direct and permanent effect on the subsequent Care Continuum site, Home Health. As patients emerged sooner from the SNF under the PPS process, they transitioned to the Home Health

phase. This marked the emergence of the Home Health Provider as the value-based determinant of the success of the entire acute episode, now measured in terms of returning the patient to their prior level of function. Ironically enough, at that point in time, Medicare had already begun piloting the version of the PPS model that would ultimately rewire Home Health to assume this role successfully. The involved effort to develop a similar acuity-based PPS version to apply to Home Health produced an assessment mechanism of determining an individual patient's identity. That assessment, the Outcome and Assessment Information Set (OASIS), developed a patient admission profile that identified programming and reimbursement on a per episode basis. The OASIS offered significant improvements in the Home Health model for all involved; Medicare, physicians, patients, and outcomes versus costs. Ultimately, the OASIS identified the patient in terms of a Home Health Resource Group, or HHRG score. HHRGs, which are a Home Health version of acute care DRGS, are the acuity/payment score created from the OASIS admission. They are the primary information vehicle for Medicare to determine patient and program compliance, and they offer Home Health the opportunity to uncover a patient's clinical needs not identified in the original referral. By promoting a multi-system, multi-disciplinary assessment of all patients admitted to Home Health, the OASIS can determine a value-based program inclusive of referral directives, global health, and functional performance.

This is the Home Health model we all work under today. We have become accustomed to specific elements of the model, and they define our care product in ways we often fail to realize. Working under certification periods, schedule habits, care delivery limitations, stressful caseloads, and an ever-changing system complicated by

healthcare reforms, it is easy to lose sight of the care component of what we do. The role and importance of rehab in the Home Health model continues to grow, and this care trend will undoubtedly affect our profession. Physical therapists, for example, have been educated along an inpatient dynamic as a result of the delivery system we have worked under for decades. Educational curriculums will need to adopt to care advances that lie ahead in response to a shift in focus to accommodate a more flexible delivery model.

As the Medicare delivery system continues to mature, we can expect care redesign to continue. Specifically, the care reform outlined by the Affordable Care Act will produce a deliberate and significant shift to community-based care delivery. By rewiring the Care Continuum in terms of value rather than volume, many sweeping changes will affect the model we reviewed above. Efficient care delivery models will replace the current acute episode in terms of Bundling programs that place care under the control of health systems or hospitals in the form of Accountable Care Organizations (ACOs). In the case of a Bundled acute care episode, the ACO will be clinically and financially responsible for all care delivered for a period up to 90 days after discharge from a hospital. Bundles primarily seek value as they rewire the episode, and the result will be to drive care downstream in terms of the Care Continuum.

As a result of the ACA reforms, Medicare predicts that over the next decade, up to 80% of total care delivered to beneficiaries will be in the form of either pre-acute or post-acute care, and that occurs in the home. This will be achieved by a steady emphasis on prevention and a concurrent de-emphasis on inpatient treatment. Through the evolution of the Home Health benefit, much of today's patient treatment will be delivered in the home; this is the care path

if the future. Episodic Bundling will deliver patients to Home health sicker and sooner, and care must shift to meet the demands of this caseload. In addition, ACO-based Population Health programs will manage the chronic care patient of the future entirely through community-based delivery. As the role of Home Health grows in the future ACO care landscape, the importance of therapists working in the home will continue to expand.

Throughout the history of Home Health, rehab therapists who entered the community care arena were often left to fend for themselves as they attempted to adapt to an un-structured delivery model. Historically, a majority of therapists worked inpatient jobs after graduation; this dovetailed with much of their educational and clinical affiliation experience. Whether delivering care to acute care, inpatient rehab patients, or sub-acute rehab clients, nearly all therapists initially develop and deliver care plans for programs focused on discharge to home. The dynamics of inpatient care are consistent and quite different from Home Health in nearly all aspects, as any therapist who has weathered the transition to homecare can attest. The environment varies from patient to patient, and every home represents a clinical, cultural, and social challenge for even the most charismatic and experienced therapist.

The reality of the Home Health model for rehab therapists is it presents a constant challenge to distill the essence of their care processes as a means of delivering value under a fluctuating delivery model. Every home, every floor plan, family dynamic, patient profile, DME requirement, etc., requires the rehab professional to improvise on the fly with an eye on producing desired results under a changing set of Medicare regulations. In addition, the individual therapist may

have taken numerous educational and working experience routes to arrive at the doorstep of a Home Health patient for their first visit.

This guidebook for the rehab professional speaks to many of the challenges and opportunities of community delivery from the most important perspective. That is the first-person perspective of a seasoned Physical Therapist and entrepreneur, voiced by Peter Sims. Having delivered quality community-based rehab services to countless clients over a storied career, he speaks to the rehab professional seeking a level of expertise in the Home Health sector. Rarely has a resource of this type been available for the therapist seeking a clearer path to success in Home Health in terms of patient outcomes and professional growth. I urge readers to employ the author's insight as a guidelight to an exciting future in home care.

Arnie Cisneros is a Physical Therapist who is a leading author and healthcare consultant; he is Founder and President of Home Health Strategic Management (HHSM). He is known for his adaptation of traditional care programming to address progressive reforms and philosophies. He can be reached at www.homehealthstrategicmanagement.com

CONTENTS

INTRODUCTION

Simply by opening this copy of *Launch into Home Health Physical Therapy: An Introduction to Home Health with Career Advice to Help You Land Your First Job*, you have taken an important step toward learning the fundamentals of home health. This book is for the practicing or student physical therapist who wants to learn about home health. By the end of the book, you will have the tools to land your first job as a home health physical therapist (HH PT)! I am certain that, by the end of this book, you will know as much about home health physical therapy as someone who has been working in the profession for over a year – all before you even see your first patient!

The Opportunity

Home health has become an extension of the hospital with high-tech medical services and equipment provided to patients in the comfort of their home. This is made possible by enhancements in medical technology and by highly skilled and trained clinicians who serve medically complex and vulnerable home health patients.

In addition, home health is the number-one, fastest-growing employment sector [1] in the U.S. economy and serves as a critical component in the health care system, since it has been proven to lower the cost of delivering care to those who need it. The surging demand in home health is due to a few key drivers, including: innovation in medical technology, changes in reimbursement models, shorter hospital stays, reduced costs for home health,

patient preference, and the upsurge in the number of Baby Boomers reaching age 65—the so-called "Silver Tsunami." [2]

According to an article in the Archives of Physical Medicine and Rehabilitation, "Access to Post-acute Rehabilitation," more than 10 million Medicare beneficiaries annually are discharged from acute care hospitals into post-acute care (PAC) settings, including inpatient rehabilitation facilities, skilled nursing facilities and home health service. [3] This number will continue to climb over the next few decades. The time has never been better for physical therapists to learn about home health with the goal of landing a job in this dynamic and rewarding setting. This book will help you do just that!

Home health clinicians enjoy relative autonomy and make their own schedules, so work hours can be flexible. Rather than being paid a salary regardless of how many hours you work or patients you see, as a home health physical therapist, you have a tremendous financial upside due to the pay-per-visit earnings model, which allows you to earn more when you perform more. Moreover, unlike most other work settings for the physical therapist, you have increased freedom and a change of scenery, since you move between patients' homes all day instead of being confined to one location.

Additionally, unlike in the outpatient setting, where you commonly are managing multiple patients at the same time, the HH PT provides only one-on-one, direct patient-care. Home health gives clinicians a unique and positive opportunity to provide patient-centered care with an emphasis on value creation, interdisciplinary collaboration, and providing high-quality patient care.

When I started as an HH PT, I had no roadmap in the form of a book, no mentor, and no guide. Looking back, I would have paid a

lot for a practical and straightforward resource like this, as it would have helped me understand home health, become a better clinician and teammate, avoid mistakes, earn more, and discover how best to find a top-tier home health agency to work for. As Toni Morrison once said, "If there's a book that you want to read, but it hasn't been written yet, then you must write it." [4] It took me a while, but that's just what I did.

The goal of this book is to prepare you—the practicing or student physical therapist—by offering practical lessons, personal case stories, tips and insights, as well as current home health trends and data, which I know will help you understand this dynamic, rewarding, and growing work setting for the physical therapist. Of course, I don't have all the answers, and certain things can only be learned by experience, but I'm happy to share what I've learned so far on my unique journey as a home health physical therapist and entrepreneur in this space.

I designed this book to be simple and easy to read. It's an introductory reference guide, broken down into chapters, sections, and then into individual lessons, so you can easily access the information most useful to you. Skip around as you like—read through the whole book in one sitting or read a lesson or two every day. I have made the content applicable to real-world home health, what you need to know to thrive, using case examples, research, and stories from my own career to illustrate and enliven the key points.

My Story

I started in home health more than a decade ago after quitting my physical therapy job in the outpatient setting due to severe burnout

and frustration. As an outpatient PT, I was expected to double- and triple-book my patients constantly, market to physicians to get new referrals on my "off hours," and work for a salary regardless of how many hours I put in each day. Professional development and patient care were secondary to profits. I knew there was a more fulfilling setting where I could earn more to feed my family, pay down my student loans, and, most importantly, make more of a positive impact in my patients' lives. Thankfully, I found home health, the setting where I am able to achieve all of my professional goals.

After a short stint as a HH PT working for a local home health agency (HHA), I decided to launch the Chicago-based home health therapy staffing company Ayuda Rehab & Wellness (Ayuda) to satisfy my entrepreneurial spirit, fulfill my mission to build a team of dedicated, compassionate, and professional home health therapists, and work to create solutions to the problems I witnessed in home health.

I was my company's first home health therapist; we now have over 15 therapists. Ayuda's revenue started at $0 and now it is over seven figures. We have traveled more than 500,000 miles to serve more than 8,000 home health patients. It was not easy building Ayuda to where it is now. There were multiple years where I worked literally every day. In rain, sleet, snow, and heat waves. I traveled everywhere. There were many times where I could not afford to pay myself. I persevered, focused on always providing quality care and hiring the best therapists I could find! It has been hard, but 100% worth every moment. I wouldn't change a thing and am thankful to all of those who helped me on the way.

I have had offers to sell Ayuda, but have turned them all down. I'm having too much fun! We have been chosen by the most respectable home health agencies (HHA) in the Chicagoland area to be their preferred provider of home health therapy services. Advocate at Home is one of them, to name the largest and most prestigious.

Ayuda has grown in breadth and depth since its inception, and I have had the pleasure of hiring, leading, and educating many passionate home health therapists. This book contains the essence of the home health training and curriculum I share with each Ayuda therapist.

I have been an American Association of Physical Therapists (APTA) member for more than 10 years, a member of the APTA's Geriatrics and Home Health sections, and am studying to sit for the exam to become a Geriatric Clinical Specialist. I continue to actively practicing as a HH PT because I love home health and patient care.

Why I Wrote This Book

There are three reasons why I wrote this book. First, I am totally passionate about home health and have dedicated my time, money, and life to learning and growing in this space. Second, I find that there is a shortage of home health information for physical therapists and physical therapist students who are interested in learning about this setting. Finally, I did not get an orientation or much of any training at my first two PT jobs. I was just thrown into patient care the day after I started. I think this book will be an excellent resource for anyone who had or is having the same experience as I had and wants to learn and grow, but currently lacks proper support and guidance.

After Reading This Book, You Will:

- Understand how home health works, the function of the home health agency, and characteristics of the home health patient.
- Learn how to make your home health patients safer, stronger, and happier in their homes.
- Understand the essence of the initial, routine, and discharge visits.
- Be familiarized with the home health clinical team and other stakeholders.
- Learn how to boost your day-to-day efficiency and productivity.
- Recognize how to spot and avoid common pitfalls.
- Understand basic clinical documentation and patient care expectations.
- Be familiarized with the OASIS and other home health specific concepts like homebound and face-to-face encounter.
- Know how to find top-tier home health agencies that will serve as potential employers.
- Understand how to prepare for and land a home health physical therapy job.
- Increase your earning potential!

We have a lot of ground to cover, so let's jump in and have some fun learning about the dynamic and rewarding setting of home health.

1 HOME HEALTH 101

I want you heading in the right direction on day one, so in this chapter, I will introduce you to the Centers for Medicare and Medicaid Service's role in home health, how home health works, compare home health to other work settings, share earnings potential data, discuss what it takes to be successful in home health, describe the role of a HH PT, and much more.

Post-Acute Care (PAC): Home Health

Post-acute care (PAC) provides specialized, follow-up medical care for the eligible patient (who still needs ongoing medical management) after he or she has been discharged from an inpatient, acute-care hospital stay. Home health is one of the five PAC settings. Here are the other four:

- Skilled Nursing Facilities (SNFs)
- Inpatient Rehabilitation Facilities (IRFs)
- Long-term Care Hospitals (LTCHs).
- Ongoing Outpatient Care

Patients who receive PAC following a major health episode see faster and greater clinical improvements compared to patients discharged to their homes without follow-up. [1]

In this book, "home health" refers to Medicare skilled, intermittent home health care, which is paid for under the Medicare home health benefit and is provided by Medicare-certified home health agencies (CHHA). You will learn more about the home health agency (HHA) in the next chapter.

Whomever Has the Gold Makes the Rules

Guess who the largest health insurance payer in the United States is? Yep, the Centers for Medicare and Medicaid Services (CMS) is the largest. [2] In 2014, Medicare and Medicaid represented 77% of the total home health spending. [3] In 2014, the total, national home health expenditures was $82.3 billion [3] and Medicare spent approximately $17.7 billion of this total. [4] CMS definitely has the gold and certainly make the rules.

In this book, you will witness and learn about the massive role CMS plays in the U.S. home health industry. When I use the word Medicare, I am also speaking about CMS as they are the ones who administer Medicare. CMS make the rules home health agencies, providers, and patients must follow.

Additionally, when I talk about third-party payers, I default to what CMS does, says, and requires as they establish the criteria, standards, and guidelines for home health care services. Many private and managed third-party payers also follow the rules CMS sets. The scenarios and examples used in this book will refer to the Medicare home health patient, unless otherwise stated.

The Best CMS Home Health Learning Resource:
www.cms.gov/center/hha.asp

How Home Health Works

A Medicare patient, Mr. Jordan, is seen by a physician, who then identifies that her patient needs home health services due to an exacerbation of his chronic medical condition, congestive heart failure. The physician calls a local Medicare-certified home health agency (CHHA) to order skilled, intermittent home health services for Mr. Jordan.

The home health agency obtains Mr. Jordan's home health orders, which are for skilled nursing, physical therapy (PT) and occupational therapy (OT). The HHA identifies who the treating clinicians will be, and immediately staffs them to evaluate and treat Mr. Jordan. Once the patient is home, the nurse sets up a time and date for the initial comprehensive assessment. The PT and OT schedule their visits to be performed following the nurses. All home health clinicians get in to perform their initial evaluations in a timely manner.

Skilled nursing, PT, and OT start care and end care within a three-week period. The nurse performs four visits, PT and OT both perform six visits. During the episode of care, all home health providers are communicating with each other and with the referring physician to promote and ensure safe, effective, and high-quality care.

The Mr. Jordan is discharged without an adverse event or a re-hospitalization. He is back to his prior level of function, safe in his home, and with a renewed and improved quality of life due to the home health care he just received.

Home Health vs. Other Settings

Home health is both different and similar to other work settings for the physical therapist. In this lesson, I will give a brief overview of the major differences and similarities between home health and the five common PT work settings:

1) Private practice, outpatient office or clinics:

Home health patients are too sick or injured to leave their homes. As one of the primary eligibility requirements for home health, all patients must be homebound to receive services. In the outpatient setting, patients are more medically stable, functionally independent, and may be slightly younger and healthier than the typical home health patient. From a payment standpoint, Medicare home health patients do NOT have an annual payment cap on services, but in the outpatient setting, Medicare patients do. PTs who work in outpatient clinics are allowed to provide and bill Medicare for group therapy. [5] In home health, group therapy is not approved. Medicare patients in the outpatient setting pay for services under Medicare part B. In outpatient you may have to treat multiple patients at the same time. In home health, patient care is always provided one-on-one. Similar to home health, the patient's medical records are fragmented, not centralized like in a hospital or inpatient setting. Multidisciplinary collaboration does not usually happen daily in the outpatient clinic setting.

2) Inpatient, acute care hospital:

Medicare patients in both settings pay for services under Medicare part A (Hospital Insurance). The hospital patient is most likely less medically stable than the home health patient. However,

the inpatient acute care setting, in my opinion, is the most similar setting to home health. Some physical therapy schools allow home health to serve as an inpatient hospital clinical affiliation. Unlike in home health, in this setting all health professionals are on premise and in relatively close contact. In home health, you can go days and even weeks before you run into a fellow home health teammate. PTs who work in inpatient, acute care hospitals are allowed to provide and bill for group therapy, which is not allowed in home health. [5] Patient in the hospital can be see twice per day, but in home health, this is not allowed. Most home health referrals come from patients who have been discharged from the hospital setting. Also different from home health, all medical records are centralized and can be accessed by all providers. Multidisciplinary collaboration happens daily and in person.

3) Skilled nursing facilities (SNF):

Patients who receive care at a skilled nursing facility must have had a three-day prior hospitalization. In home health, you do not need to have a prior hospitalization to initiate the home health benefit. In the SNF, after 20 days of care, Medicare patients must pay a co-pay. [6] Co-pays are currently NOT required in home health by Medicare. Patients who are in a skilled nursing facility most likely do not have the support and/or the infrastructure to be discharged home after their recent hospital stay. PTs working in such facilities are allowed to provide group therapy, which is not permissible in home health. [5] Patients in SNF may be treated by PTs 7 days a week, but that is not allowed in home health. Unlike in home health, all health care providers are on premise and in relatively close contact. Multidisciplinary collaboration happens daily and in person.

4) Inpatient rehab:

Patients in this setting must be medically stable and able to tolerate three hours per day of OT, PT, and Speech Language Pathology (SLP), on average. [7] Often times, patients who receive care in the Inpatient rehab setting receive therapy seven days per week. Inpatient rehab facilities are usually located in hospitals or have free-standing building where services are provided. Home health service is intermittent care (less than seven days per week) provided in the comfort of the patient's home. Inpatient rehab clinical providers regularly meet face-to-face to coordinate care, unlike in home health, where you may never meet a fellow clinician who shares the same patient. Again, all health professionals are on premise and in relatively close contact. Multidisciplinary collaboration happens daily and in person.

5) School systems:

The patient population is adolescents. In home health, it is primarily older adults. In schools, most patients receiving PT do not have acute illness or injury like you will encounter in home health. In home health, you will work with a patient, typically for three to four weeks, depending on medical condition and care needs, but in the school systems, you may work with your patients for a school year or more. Similarly, both settings require the PT to adapt the patient's environment (school and home). PT services for school systems are paid by Medicare under Part B [8], unlike in home health, which is paid under Part A. Both settings require a superior level of communication, coordination, and partnership with caregivers. Multidisciplinary collaboration does not happen daily.

In home health, expect to spend a small percentage of time at the home health agency office. In fact, there may be days or weeks during which you never set foot in the office. This was strange for me at my first home health job as a HH PT, but I quickly adjusted to getting things done before and after patient care – usually in the car or at my home office.

In addition to spending time on the road, you will also spend a good deal of time working from your home, so it's a good idea to create an office there. My recommendation is to set up a basic home office with reliable internet and a quality computer, printer, desk, and comfy chair. Planning, working, and preparation will happen here. Make your home office as comfortable and inspiring as possible.

Now that you have a deeper understanding of home health as well as other PT work environments and how they are similar and not, let's turn to money matters: how much do home health PTs make?

Earnings: The Home Health PT

Here are insightful facts about wage and earning potential as a home health physical therapist: According to the Bureau of Labor Statistics, home heath physical therapists are the most highly paid other than those in school systems at $99,740 and $96,560, respectively. [11] Additionally, APTA's 2013 report on median gross earned income also demonstrates excellent earnings for home health physical therapists at $87,000 with Acute Care Hospital at #1 with $92,000. [9-10] In 2015, the highest-paying metropolitan area for physical therapists was Las Vegas, Nevada at a whopping $135,390 per year. [11] This number

will continue to climb as expert's report that the demand for PTs will continue to outweigh the supply.

In the next lesson, you will discover if you have what it takes to be a successful home health physical therapist.

Market Fit: 10 Statements about the Successful HH PT

By now, you've seen that home health is not only a growing career option, but that it is also quite lucrative. Home health is not for everyone, but if you align with the 10 statements below, it might be the right choice for you.

#1. You have an affinity for older adults

#2. You don't like being in one place all day and like the freedom to change environments and move around

#3. You need a work setting where the patient to the therapist ratio is consistently 1:1

#4. You enjoy driving and are not the road-rage type

#5. You are comfortable with working with a diverse demographic of people, in other people's homes, and in neighborhoods than might be different than yours

#6. You feel confident in your clinical skills, even if you do not have exercise equipment, props, and the usual toys found in inpatient, outpatient, and other physical therapy work settings

#7. You have an affinity for and experience in the acute care setting and like the challenge of treating medically complex patients

#8. You are comfortable being alone and are comfortable with strangers in unfamiliar places

#9. You prefer to be paid based on your performance and not be locked into a salary

#10. You are comfortable outside in the elements

If these statements describe you, home health is definitely the work setting for you and I believe you will thrive! Next, I'll describe what the HH PT does to create value for the home health patient.

PT Role in Home Health

As a HH PT, using evidence-based interventions and up-to-date practices, where available, you will work to improve your patients':

- Knowledge and understanding of their Home Exercise Program (HEP) that you create for them
- Knowledge and understanding of how to obtain and maintain a safe home environment to promote health and recovery
- Gait and transitional movement skills (stairs, bed, toilet, chair, floor, car, etc.)
- Posture
- Balance
- Functional strength
- Range of motion/mobility
- Aerobic capacity/endurance
- Ability to transfer from different surfaces in the home

- Pain level and reduce edema through modalities and manual therapy
- Mobility in and out of the patient's home (curbs, car, stairs, etc.)
- Management and utilization of adaptive and durable medical equipment to promote safety, mobility, health, risk reduction, and increase efficiency
- Understanding of proper lifestyle management and breathing exercises
- Ability to stay safe by preventing falls, and learning strategies to stay out of the hospital

Does this type of patient-care and value creation sound attractive to you? As a home health physical therapist, you will consistently work with patients that need your help to regain health, mobility, and function. This is a very rewarding and fulfilling work setting.

To work as a HH PT, it is important to have a travel bag full of essential tools for the job. I'll teach you about the most crucial items you will need.

HH PT's Travel Bag and the Essentials

Every home health physical therapist will have a travel bag, issued and replenished by your employer. This is the bag that you use for storing and mobilizing your gear for home health visits.

Preparing for the day will ensure that you have the most vital gear with you so you can serve your patients properly. Before you leave your home or the office, double-check your bag to ensure you have all of your important gear.

iPad/smartphone/ laptop/tablet for clinical note documentation, and charger(s)	Tape measure for edema or girth measurement	House slippers (for when you take off your shoes and don't want to get your socks dirty)
Goniometer	Black ink pen with light	Thermometer
A box of disposable, non-latex gloves	Disposable covers (Chux)	BP cuff with paper protection covers
Hand soap	Stethoscope	Reflex hammer
Gait belt	Business cards	Pulse oximeter
Alcohol pads and disinfectant wipes	Disposable bags to store clean and dirty items	Paper copies of your home exercise program exercises
Band-Aids	Disposable CPR resuscitation mask	Mask, disposable gown
Plastic folder to hold paper documents	Masking and paper tape	A small multi-head screwdriver and pliers
Lint brush	Bandage scissors	Elastic resistance bands
Sphygmomanometer	Hand-held dynamometer	Eye chart

Travel as light as you can, and always double-check your travel pack before you head out each day. Strive to be super creative by using the items you have and those found in your patient's home.

Skilled Care Is the Only Option

As a HH PT, every session you must provide skilled care. Skilled care is known to be care provided that is complex in nature and only a qualified professional can thoughtfully, safely, and effectively perform this type of work. [12]

Examples of Skilled Physical Therapy

- Teaching a patient how to ambulate correctly after having a total knee replacement
- Teaching a patient how to safely and correctly get in and out of the bed after having lumbar spine surgery
- Teaching a patient on how to safely ascend and descend stairs with lower extremity weight-bearing restrictions and with an assistive device
- Developing and prescribing a home exercise program to address impairments and functional limitations to achieve specific functional goals within specific time frames
- Facilitating lower extremity strength and standing static and dynamic balance training to ensure safe ambulation
- Prescribing recommendations on how to reduce edema and pain secondary to a joint replacement surgery

If the physical therapy services you are providing are not skilled, the care will be denied and will not be reimbursed by third-party payers.

Unskilled Care Is Never an Option

Unskilled care is not reimbursable and cannot be provided by home health physical therapists. If unskilled care is provided and not deemed medically necessary, the HH PT will likely be vulnerable to audit recoupment and/or legal action by the third-party payer.

Examples of Unskilled Care

- Walking with the patient and having a chat

- Watching someone perform their written Home Exercise Program without teaching technique, progression options, or offering safety recommendations
- Services that reinforce previously learned skills that do not restore function in a reasonable amount of time
- Watching someone go up and down the stairs
- Repetitive activities, general in nature, that do not progress over time and lack focus and purpose (an example of this would be performing the same exercises visit after visit without adding, changing, modifying, or progressing the activity).

Remember, unskilled care is not what HH PTs do. Never lose focus of why you are working with your patient. When care is no longer skilled, reasonable, and medically necessary, you should discharge your patient. Create value for your patient with each and every skilled visit. Forget volume-based care and focus on value-based care! Welcome to home health in the 21st century.

Home health is always changing. In the next lesson, I want to share some knowledge to manage your expectations of things you can and cannot change in home health. I hope this knowledge will give you power and peace of mind.

"The Wisdom to Know the Difference"

> *"God, grant me the serenity to accept the things I cannot change. The courage to change the things I can. And, the wisdom to know the difference."*
>
> - Reinhold Niebuhr

You may have heard this quote before and it may resonate with you. In this lesson, I will share situations and conditions in home health that you CAN and CANNOT change. Understanding these items should lessen your stress, anxiety, and/or frustrations when working or as a student doing a clinical affiliation in home health. Those who recognize and acknowledge the inevitability of change, stand to benefit the most.

Things You CANNOT Change in Home Health

1. Weather
2. Where your patient lives
3. Traffic
4. Your patient's living environment
5. Your patient's experience and belief system
6. Your patient's preference for visit times and their daily schedule
7. Your patient's diagnosis and prognosis
8. How other people react to things
9. Your patient's change in medical status
10. If others are having a "bad day"
11. If your patient declines home health services, but you know that they need it and would benefit from it
12. Errors and mistakes in the back office/administration, i.e., incorrect address, phone number, and medical information
13. Illegible documentation

14. Colleagues who are not as professional or as self-motivated as you
15. Physicians and other stakeholders who do not return your important phone calls or messages
16. What time the RN will get in to see the patient to do the initial assessment to start the care

Things You CAN change in Home Health

1. Your mindset
2. Your attitude
3. Your knowledge
4. Your awareness
5. Your beliefs
6. Your work ethic
7. Your willingness to go above and beyond
8. Your effectiveness in getting your work done on time
9. Your organizational abilities
10. Your ability to add skills to your personal and professional portfolio

When you experience something you CANNOT change, take a deep breath in and a deep breath out, and let it go.

In the next chapter, you will enjoy an introduction to the home health agency. Let's go!

NOTES

2 THE HOME HEALTH AGENCY

In this chapter, I will introduce you to the home health agency: who they are, what they do, who they employ, the different ways you can help them win as well as review how they get paid. Also, I will share employment options, pay models, and tips to get you the best employment package possible for your first home health job.

What is a Home Health Agency?

The home health agency (HHA) is the company (for-profit or nonprofit) responsible for providing home health services to home health patients. The HHA can be part of a service delivery system like a hospital or be a freestanding, independent enterprise. They can be large and publicly traded or a small "mom-and-pop."

The HHA is open 24 hours a day and 7 days a week, 365 days a year. As a student PT (SPT) or aspiring home health physical therapist (HH PT), this is the organization you will work for. The physical therapist looking to obtain employment can work with one HHA or contract and work with a few. My company, Ayuda, works with over 10 HHAs as a sub-contractor. They all refer us home health patients who need skilled physical therapy (PT), occupational therapy (OT), and/or speech language pathology (SLP). Most home health agencies generally provide nursing (RN), home health aide, PT, OT, SLP, and medical social worker (MSW).

According to the Centers of Medicare & Medicaid Services (CMS), the federal agency responsible for administering Medicare and Medicaid, in 2014, there were over 12,400 Medicare-certified HHA in the United States. [1] To earn the Certified Home Health Agency (CHHA) status, the agency must meet specific CMS guidelines and criteria regarding patient care and quality standards as well as meet health and safety requirements. [2] CHHAs are able to bill Medicare, while home health agencies that are not certified cannot do so. Most HHAs are licensed and regulated by the state they reside in, but not all HHAs are Medicare-certified. [3] I recommend that you choose to work for a CHHA; if they are committed to investing time, energy, and resources like personnel and money to earn this certification, they are likely more committed to upholding a higher standard of excellence. In this book, we will use HHA and CHHA, interchangeably, but know that we are always referring to the Certified Home Health Agency.

Facts about the Home Health Agency

- Open 7 days a week
- Employ clinical and non-clinical personnel
- Must comply with CMS's Conditions of Participation
- Must have relationships with referral sources (physicians) to obtain patients
- Must comply with all state and federal regulations to operate
- The majority of home health agencies are "for-profit" [4]
- CHHAs are paid by Medicare in 60-day episodes [1]
- Home health services for the Medicare beneficiary is paid under Part A [5]

Weekend coverage is a pain point for most home health agencies. As an employed HH PT, weekend service is both an opportunity to help the HHA provide PT to patients and to build up a solid caseload for the coming week. Once you are hired and working as a HH PT, use the weekend to help your patients and company, as well as contribute to your productivity needs. As a SPT doing a clinical rotation, you may also have to work with your Clinical Instructor (CI) on the weekend. Go for it! Weekend home health is a little different due to less traffic, more family members at home, and few medical appointments so patients are more likely to be home and relaxed. At least, weekends have been like this for me, doing urban home health in Chicago.

How Medicare Pays the Home Health Agency

Home health agencies are reimbursed by Medicare through a system called the Home Health Prospective Payment System (HH PPS). Reimbursement in this model is of a fixed amount and is established in advance. A unit of payment under this system is a 60-day episode of care. [6] Medicare pays the HHAs twice. Fifty to sixty percent of the total payment at the start of care and the remaining percent at the end of care, after all documentation is submitted and deemed accurate. [7]

The amount paid by Medicare to the HHA is based on the patient's care needs, medical condition, diagnosis and geography. For example, a patient who is debilitated, has congestive heart failure, and needs skilled home health PT, OT, and nursing care will be reimbursed more than for a relatively healthy patient with hypertension who only needs minimal skilled nursing care.

Help the HHA Win

The HHA definitely needs you for your physical therapy skills. However, they most likely need you to help in other important areas, too, including those that aren't clinically-based. Home health is a team sport, so once you are hired or are on your clinical rotation as a SPT, there are several important areas where you can also help them win. With an awareness of these areas, you will soon become "the Irreplaceable HH PT."

Here is an overview of departments and functions of the typical home health agency where you can add value (non-clinical) to help them excel.

Sales – Find new referral sources to increase sales.

Marketing – Get the word out about the company and how awesome it is!

Recruitment – Find classmates, colleagues, and other smart and creative therapists, and get them to join the team.

Customer Service – Earn patient testimonials, get return patients, and have excellent survey scores.

Quality Assurance – Perform chart reviews, mentor new hires, and allow others to shadow you.

Clinical Provider – Take Continuing Education Unit (CEU) courses and present an in-service, be active in the APTA, do research, and take on a physical therapy student.

Home health agencies hire HH PTs as employees as well as independent contractors. In the next lesson, we will examine both employment options.

Independent Contractor or Employee

As a PT looking to land your first job in HH, you will certainly need to think about and commit to either being an employee or independent contractor. I will briefly introduce these options. You must meet the Internal Revenue Service (IRS) guidelines to be truly considered an independent contractor.

There are benefits to both, and some important differences. As an employee, your employer takes out taxes and pays a portion of your payroll taxes (Social Security, Medicare, etc.). As an independent contractor, you are responsible for paying your own taxes, which means you must manage your tax liabilities accordingly. Another major difference is that as an employee, you are most likely to get some form of benefits (health insurance, mileage, 401K, paid time off, etc). This is not likely as an independent contractor, where you'll be responsible for sourcing and paying those benefits yourself. Another possible difference is that the employee is usually paid every two weeks, but the independent contractor may be paid every month.

As an independent contractor, you will likely receive a higher per-visit rate than an employee. You can also incorporate yourself into a company and write-off certain IRS-eligible expenses. Independent contractors can have multiple referral sources (more than one HHA) while employees simply have one referral source for patients.

As an independent contractor, you will have to act and think more entrepreneurial than if you are an employee. For example, you will have to focus on getting paid for your work (account receivables), generating sales/new referrals, risk management, hiring, training, and managing and optimizing financial statements, and clinical-

related activities. It's a lot of work, but it's what I did and is what a lot of HH PTs are doing.

This book was written with the focus on the HH PT who plans to work for a home health agency as an employee. My next book will be for the entrepreneur HH PT who wants to be an independent contractor with the goal of building a home health staffing company with multiple therapists and multiple referral sources.

My advice for the novice HH PT is to deepen your learning, get some practical experience, build your network, and get your hands dirty for at least a year before you decide to become an entrepreneur in this space. You will be glad you got some experience first. That's what I did!

If you're really interested in being an independent contractor/entrepreneur in home health, apply for a free 20-minute phone consultation with me. I am happy to help you explore this option and answer any questions you may have.

Go here to apply: www.peterbsims.com/freeconsult/

Wage Options for the HH PT

I have seen three different wage models offered to HH PTs by HHAs. It is vital to understand which one best meets your personal needs.

Pay-Per-Visit (PPV)

In this option, you will be paid for each skilled and billable visit that you perform. Some HHAs will pay you different rates based on the type of visit. For example, a PT evaluation earns you $50, a routine

visit earns you $45, a PT start of care earns you $80, and so on. This is the most common wage model.

Salary

This option is usually reserved for full-time HH PTs. Full-time performance expectation at Ayuda is 60 visits per two-week pay period. As a full-time, salaried home health physical therapist, you should expect a minimum performance-visit-expectation each pay period.

Hybrid (salary + pay-per-visit)

This was the payment model I started with in 2006. The hybrid model is usually reserved for full-time HH PTs. This option is when you receive a base salary and every visit over a set threshold will be paid to you at a per-visit rate. If your potential employer does not offer this as an option, try to introduce it! For the novice home health physical therapist, this combines incentives and security all in one – a true win-win.

Perks and Home Health Agency Values

After you find a top-tier home health agency (HHA), win the interview and get an offer, you will learn what that company values. Are they willing to invest in their clinical staff (i.e., support the concept of continued competence, lifelong learning, and ongoing professional development), in addition to the salary or per-visit payment? If so, you might have found yourself a true top-tier winner. If not, there are other companies out there that are willing to nurture and cultivate their clinical staff. I would recommend waiting until you find the right one.

Here is a non-exhaustive list of perks from HHAs that I found most valuable and that may resonate with you.

- Continuing education stipend
- Mileage reimbursement for work-related travel and highway tolls
- Reimbursement for APTA membership
- Gym membership stipend
- Office expense stipend – printing paper and ink
- Mobile phone full or partial reimbursement
- Audible.com (audiobooks) subscription
- Foreign language course stipend
- Compensation for CPR course/test

Top Tip

The mileage reimbursement perk is essential for the HH PT. Make this perk a must as an employee or independent contractor. You need to be paid for all the miles you will travel.

In the next chapter, you will meet the home health patient: the person for whom you will help change weakness into strength!

NOTES

3 THE HOME HEALTH PATIENT

In this chapter I will provide an overview of the Medicare home health patient, including a review of home health eligibility, the meaning of "homebound" and a typical face-to-face encounter, the typical demographics, and the most common illnesses, injuries and challenges this population encounters. This chapter also discusses common out-of-pocket purchases made by home health patients and describes the most common patient complaints and positive words. Let's dive in.

Home Health Patient Eligibility

According to the Medicare Benefit Policy Manual, Chapter 7, all Medicare home health patients must meet each of the criteria specified below to qualify for the home health benefit. If they do, Medicare has agreed to pay for the skilled services provided. [1]

Here are the five eligibility criteria:

1. The patient must be confined to the home
2. The patient must be under the care of a physician
3. The patient must be receiving services under a plan of care established and periodically reviewed by a physician

4. The patient must be in need of skilled nursing care on an intermittent basis or physical therapy or speech-language pathology OR
5. The patient must have a continuing need for occupational therapy. [1]

Medicare uses the word "intermittent" to stress the fact that home health is not an everyday skilled service. Further, they define intermittent as skilled care that is either provided as needed, provided less than seven days each week or fewer than eight hours each day for periods of 21 days or fewer. Medicare does report that there are exceptions to this in special situations when more care is needed, but the care must be reasonable and medically necessary. [1]

The home health patient does not have a length of stay limit as long as ALL Medicare criteria a met. [1] In the next two lessons, I will review two eligibility requirements: homebound and under the care of a physician (the face-to-face encounter) to dig a little deeper into these home health eligibility requirements.

Companion Course

Access CMS's Home Health Conditions of Participation – See chapter 3.

Confined to the Home – Homebound

If your patient is not considered homebound, they are not eligible to receive the home health benefit. No ifs ands or buts about it. That said, I want to dig a little deeper into this eligibility requirement

as it is the most publicized of all of the five eligibility requirements. Homebound status must be documented in your physical evaluation and all subsequent clinical notes.

Medicare has developed two criteria that have to be met for the patient to be considered confined to the home (homebound).

According to the Medicare Benefit Policy, the law requires that a physician certify in all cases that the patient is confined to his/her home. For purposes of the statute, an individual shall be considered "confined to the home" (homebound) if the following TWO criteria are met:

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

If the patient meets one of the Criteria-One conditions, then the patient must ALSO meet the two additional requirements defined in Criteria-Two below.

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

The HH PT must be a homebound status expert because of the deep understanding they have of their patient's ability or lack thereof to safely and effectively leave their home. A patient's ability to safely enter and exit the home will often be a functional goal within the PT plan of care.

Two Homebound Statement Examples

The patient is unable to safely ambulate on even and uneven surfaces due to LEFT knee pain and decreased standing balance, left quad, and hamstring weakness (3-/5 per manual muscle test) secondary to a left total knee replacement. He is at high risk for falls per Timed Up and Go score. When walking, the patient requires the constant use of a rolling walker and assistance from another person for safety. The patient is homebound and it is a taxing effort to leave home.

The patient is short of breath when walking short distances and unsteady when walking on even and uneven surfaces due to decreased bilateral LE strength and standing balance. She requires the constant use of a standard walker and assistance from another person for safety when transfering and walking. She is at high risk for falls per Functional Reach score. Since returning home from the hospital, the patient is not safe or able to perform the stairs to exit her home and must be carried out in a wheelchair by two people.

Companion Course

Access additional homebound information and examples – See chapter 3.

Face-To-Face Encounter

Another one of the five eligibility requirements is that the home health patient must be under the care of a physician. A face-to-face encounter is the physician's verification or attestation that the home health patient is truly eligible for home health services and

is under their care. This encounter happens face-to-face between the physician and the patient. Most of the time, the physician who certifies that the patient is eligible for home health services is the physician who establishes and signs the plan of care. [1]

These face-to-face encounters must be with a physician (or allowed non-physician practitioner) who is prescribing home health services. [3] Implementation of the face-to-face requirement was effective April 1, 2011, and "is intended to be a tool for reducing fraud, waste, and abuse by assuring that physicians or other healthcare providers have actually met with potential home health patients to ascertain their specific care needs." [4]

CMS's current policy is that the "face-to-face" physician or allowed non-physician practitioner encounter must occur within 90 days prior to or within 30 days after the first visit of home health services, the Start of Care (SOC). [3] If your patient has not had a face-to-face in the timeframes just described, they will not be eligible for home health services. [1][5]

It is likely that by the time you receive the referral to treat your home health patient, they will have already had their face-to-face encounter with the referring physician or other eligible health profession and have been certified eligible.

Always communicate with your clinical manager if you are unsure of your patient's eligibility of any of the five Medicare eligibility requirements.

Companion Course

Access additional face-to-face encounter information to get a deeper understanding of this eligibility requirement – See chapter 3.

Basic Patient Characteristics/Demographics

Get to know your patients. Who are they? Where do they come from? What is their story? What are their needs, goals, and problems? The more you know about them and their needs, the better you will be able to help.

In the United States at the end of 2013, the Center of Disease Control and Prevention (CDC) estimated that more than 4,900,000 [6] patients received services from home health agencies. Medicare reports that, in the same year, about 3.5 million Medicare beneficiaries received home health services. [7]

In an article about long-term care, published by the CDC, more than 82% of ALL home health patients were age 65 years and over. The majority of home health patient were between the ages of 75 and 84 years old. Women utilize home health services more than men (62.1% vs. 37.9%), and 75.4% of home health patients are white, while 13.5% black, 7.7% Hispanic, and 3.3% other. [6] Among the oldest Americans, the Census predicts that the population age 85 and above will double by 2026 and triple by 2049. [8] As a HH PT, you must be prepared to care for people of all ages – as anyone who is eligible and needs the services, will receive it. However, the geriatric populace with chronic conditions and limitations in activities of daily

living (ADL) will be the primary users of the Medicare home health benefit over the next few decades.

Fast Fact

Medicare enrollment is projected to increase by more than 50% over the next 15 years from 57 million beneficiaries in 2015 to more than 80 million in 2030. [8]

Most Common Illnesses and Injuries

Physical therapists who are generalists and specialists all thrive in home health. Anyone who comes out of the hospital or healthcare facility might end up receiving home health services. Additionally, patients are referred to home health after having a medical appointment with an eligible physician or health professional who deems it medically necessary. Here are some of the most common illnesses, injuries, pathologies, and diagnoses that you will encounter in home health: amputation; balance fall disorders with injuries; cancer; CHF exacerbation; chronic ulcer of skin; dementia; diabetes exacerbation; musculoskeletal disorders/injury; stroke; COPD/emphysema/ pneumonia; developmental delay/disability; joint replacements; low back pain; multiple sclerosis; motor vehicle accident with injuries; osteoarthritis; and Parkinson's disease.

I am a true believer in providing patient-centered care. An essential component in this type of care is addressing the patient's specific needs and goals. According to the CDC, the 2013-2014 statistics of the percentage of home health patients that require assistance in the following functional areas are as follows:

- 96% need bathing assistance
- 94% need walking and locomotion assistance
- 88% need dressing assistance
- 88% need transferring in and out of bed assistance
- 73% need toileting assistance
- 57% need eating assistance [6]

This list encompasses issues address by both home health physical therapists and occupational therapists. Home health therapists truly have an opportunity to help improve a patient's functional abilities in all of the above stated areas.

In the next lesson, I will share the most common patient complaints so you will know how to avoid each one of them.

The 16 Most Common Patient Complaints

You might think you're doing everything you can to please the patient, and yet you find your relationship strained. Here are some common causes of patient dissatisfaction in home health:

1. Therapists consistently running late to appointments and not calling to let the patient know
2. Lack of empathy, compassion, or respect shown
3. Mis-communication
4. Lack of professionalism
5. Therapist is too aggressive
6. No show, no call

7. Surprise discharge
8. Therapists with strong odor or inappropriate dress
9. Therapist talks about personal problems to the patient
10. Short treatment session
11. No communication with referring physician or key family members/caregivers
12. Poor or limited explanation of interventions, goals, plan of care, and discharge plans
13. Inconsistencies and lack of progression with treatment plan
14. No recommendations or dissemination of a written home exercise program
15. Poor communication with other health care providers
16. Lack of advocacy when the opportunity presents itself

All of these complaints are avoidable. Treat your patients how you want to be treated or how you would treat your family members.

Common "Out-of-Pocket Purchases" for Your Patient

Here is a list of the most common items that my home health patients need but are not likely to be covered by third-party payers. I often recommend these items to help my patients reduce risk factors and pain as well as to help adapt their home environment in a safe and effective way.

Cold and heat packs	Foam roller/therapy bolster/wedges/ pillows	Nabber or gripper
Walker gliders/caps and walker bags	Rollators	Elastic resistance bands
Grab bars	Non-slip shower mat	Bed rails
Recliner lift chair	Sticky household socks	Lightweight transport chair
Foam rubber balance pad	Hand railings for stairs	Furniture risers

I commonly use Amazon.com to order these types of items for my patients because of Amazon's low cost, quick shipping, and huge inventory.

Companion Course

See a list of possibly useful items for your home health patient – See chapter 3.

In the next and final lesson of this chapter, you will get to hear words from satisfied patients. Strive to earn these words every visit.

What You Want to Hear From Your Patients

- I'm glad to see you.
- You are so patient with me.
- You are not too aggressive with me.
- Thank you for calling to let me know your plans.

- We did a lot today, but not too much.
- Thank you for listening to me.
- Thank you for explaining things to me.
- Thank you for waiting for me even though I was running late.
- I can tell you really love your job.

If you are tremendously creating value in their lives, you will consistently hear words like these. In the next chapter, I will introduce you to the Outcome and Assessment Information Set (OASIS). Let's dive in!

NOTES

4 THE OASIS

As a home health physical therapist (HH PT), you will quickly get familiar with a Medicare data collection tool called the *OASIS,* which stands for the *Outcome and Assessment Information Set*. In this chapter, you will find an overview of this unique home health specific data set that is intertwined into the care of each Medicare home health patient.

OASIS What?

The OASIS is essentially multiple questions that must be answered by a home health clinician based on the patient's assessment at a specific and determined point during the time they are receiving home health services. The OASIS questions/elements must be obtained for all Medicare patients and some agencies require them on all patients. The RN, OT, PT, and SLP are all home health providers eligible to answer OASIS questions based on the patient's status and/or ability.

The collection of a patient's OASIS data allows for measuring objective and systematic change in patient status from beginning of care to the time that the patient is discharged. The patient's OASIS data is also used for home health agency outcome monitoring, clinical assessment, care planning, internal agency-

level applications, and calculating several types of quality reports which are provided to home health agencies to help guide quality and performance improvement efforts. [1-2] Essentially, the OASIS elements are the foundation for the entire clinical, operational, quality and reimbursement process in home health care.

Specific training is recommended and, in my opinion, necessary for all home health physical therapists to accurately score the OASIS questions. Two important reasons for accurate scoring is that it 1. affects the home health agency's reimbursement from Medicare and 2. objectively demonstrates whether the home health patient got better, worse, or stayed the same after receiving home health services.

Enough talk about the OASIS, let me showcase four ADL-based OASIS questions that relate the home health patient's functional abilities, which are all are addressed by physical therapy services.

1. **M1820 – Lower Body Dressing**
2. **M1840 – Toilet Transferring**
3. **M1850 – Transferring**
4. **M1860 – Ambulation/Locomotion** [3]

To give you an example of a complete OASIS question, here is the OASIS question: **M1860 Ambulation/Locomotion.**

M1860 Ambulation/Locomotion: Current ability to walk safely, once in a standing position, or use a wheelchair, once in a seated position, and a variety of surfaces.
0 – Able to independently walk on even and uneven surfaces and negotiate stairs with or without railings (specifically: needs no human assistance or assistive device).
1 – With the use of a one-handed device (for example, cane, single crutch, hemi-walker), able to independently walk on even and uneven surfaces and negotiate stairs with or without railings.
2 – Requires the use of a two-handed device (for example, walker or crutches) to walk alone on a level surface and or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces.
3 – Able to walk only with the supervision or assistance of another person at all times.
4 – Chair fast, unable to ambulate but is able to wheel self independently.
5 – chair fast, unable to ambulate and is unable to wheel self.
6 – Bedfast, unable to ambulate or be up in a chair. [3]

As you can see, the higher the patient scores, the less mobile and independent they are in the M1860 Ambulation/Locomotion OASIS element.

For example, on the initial visit the patient scores a “3” on M1860; and, after seven skilled physical therapy visits, they may improve and score a “1.” This would be an excellent outcome and Medicare is happy to pay for this type of measurable, functional improvement. A primary goal, as a HH PT is to change a home health patient’s functional ability by the end of care.

Companion Course

Access more OASIS questions and learn more – See chapter 4.

Six Time Points to Document OASIS Data

Here is a basic overview of six specific times when OASIS data must be collected on the Medicare home health patient.

Start of Care OASIS Assessment

The start of care (SOC) OASIS data collection must be completed by the first eligible home health clinical provider to assess the home health patient. The SOC OASIS assessment data is collected at the initial visit. In my experience, about 80% of the time, the SOC comprehensive assessment visit is performed by an RN, but this varies depending on referral source, region, diagnosis, and other factors. The SOC OASIS assessment can also be carried out by a physical therapist or speech language pathologist, but not an occupational therapist. Medicare rules do not allow occupational therapists to perform the SOC OASIS. [4]

Top Tip

The SOC date is the first day from which the 60-day episode of home health starts. A 60-day episode is nine weeks and is considered a unit of payment by Medicare. [5]

Re-Certification OASIS Assessment

When a patient is re-certified, it is because one or more treating home health clinicians have decided that an additional 60- days of skilled care are medically necessary and reasonable. However, this decision to re-certify a patient will be made in the name of the home health agency. As home health reform continues to materialize the autonomy of HH clinicians, especially therapists, will change.

In my experience, the re-certification OASIS data is usually collected by a RN, but it can be collected by a PT, OT or SLP. [3]

Two Reasons for a HH PT to Re-Certify:

1. The patient was in and out the hospital for a portion of the 60-day episode and, therefore, missed care.
2. The patient started the plan of care, not at their prior level of function, and they are making some excellent functional gains; they are 100% compliant and motivated and skilled home health services remain medically necessary, reasonable; their prognosis is good to excellent.

DC OASIS (Discharge from Agency) Assessment

The Discharge (DC) OASIS data collection must be completed by the last clinical provider in the home and is dated for the last billable, skilled visit that was performed. This is the agency's discharge visit. Once completed, the DC OASIS data officially closes the case and the home health agency can submit for final payment.

Top Tip

The DC OASIS must be completed and submitted within 48 hours of the discharge visit for all Medicare patients. [6]

Transfer OASIS Assessment

The transfer OASIS data collection must be completed by an eligible home health clinician when a patient is transferred or admitted into an inpatient facility (hospital, rehab facility, nursing home, or inpatient hospice) for 24 hours or more for reasons other than diagnostic testing. [7] The transfer OASIS is required to be processed/completed within 48 hours of learning of the transfer into the inpatient facility. The patient may or may not be discharged from home health services; this will depend on the agency's policy and the reasons why the patient was transferred. [7] Please follow your agency's policies and procedures on completing the transfer OASIS. The patient is not available to be assessed in this type of OASIS, so you are going off of the patient's most recent assessment/visit data.

Resumption of Care (ROC) OASIS Assessment

The ROC OASIS data collection must be completed by the first home health provider who sees the patient for the first time after they were discharged from an inpatient facility, after being admitted. This OASIS document re-initiates home health services within the same 60-day episode, which started at the original SOC date. The ROC can be performed by an RN, PT, OT, or SLP. [7]

Death at Home OASIS Assessment

The Death at Home OASIS data collection happens when a home health patient dies when enrolled in home health services. In this case, the patient dies somewhere other than in a hospital/inpatient facility, outpatient facility, or an emergency room/department.

In a nutshell, those are the essential time points when OASIS data must be obtained. I am sure your new top-tier home health agency or Clinical Instructor will give you a thorough orientation on their policies and procedures in relation to their expectations and policies on OASIS data collection.

Top Tip

Access an awesome OASIS learning and consulting resource for the HH PT: www.oasisanswers.com.

I'll now introduce you to the home health interdisciplinary and caregiver team. These teammates are the essential people who are all working together to help the patient achieve the highest level of function, safety, and health possible.

NOTES

5 THE HOME HEALTH TEAM

In this chapter, I will introduce you to the home health interdisciplinary team, which is made up of six clinical providers and the caregiver who are all involved in helping optimize the home health patient's safety, health, mobility, and well-being. You must strive to build strong communication channels and solid working relationships with the home health team.

Caregivers

Caregivers can be family members, friends, or even neighbors. Their primary role is to assist the home health patient. Caregivers may or may not be paid by the patient. Medicare does not pay for care given by caregivers, but this could change in the future. Some caregivers do not even recognize themselves as caregivers. Their work can be rewarding as well as stressful and mentally and physically demanding. [1]

Caregivers usually assist patients with activities of daily living like bathing, dressing, grooming, transferring, and walking as well as instrumental activities of daily living like shopping, driving and cleaning. They also may act as legal representation, care for wounds, administer medication or IVs, and provide moral and psychological support. As a home health physical therapist (HH PT),

you will constantly be working with caregivers. You must teach them, listen to them, help them, and certainly incorporate them into the patient's plan of care. A few examples of this would be to teach the caregivers the patient's home exercise program, safe and effective lifting and transferring techniques as well as how to effectively care for the patient and make the home as safe as possible to reduce risks for falls and/or injury.

Top Tip

A patient's medical record should never be shared with a third-party (including family or non-family members) without explicit authorization from the patient.

Referring Physician

The home health patient may have multiple physicians. In this section, I will be discussing the referring home health physician only as this is the health care professional you will be communicating with because he/she is managing the patient's home health care plan.

The most common physicians I have encountered in home health are doctors of medicine (MDs) and doctors of osteopathy (DOs). These physicians initially certify that the patient is eligible for the home health benefit and there is medical necessity for skilled, intermittent home health care. Also, as previously discussed, they are responsible for the face-to-face encounter with the patient.

The referring physician also signs (at least every 60 days) and manages the home health care plan. You will likely be calling and

communicating with the referring physician at the beginning, during, and at the end of care to report clinical status and discharge plans.

Always contact the referring physician when necessary. They will return your call. They too care about the well-being and health of your shared patient. Work closely with them and your patients will benefit.

Registered Nurse (RN)

The registered nurse (RN) plays an extremely vital role in home health. He/she is considered the case manager (CM) of the home health clinical team. Beside the referring physician, the RN needs to be contacted routinely to coordinate care. The RN usually performs the initial comprehensive start of care assessment, which initiates the home health service. The RN provides skilled nursing services for the home health patient until completion of the nursing plan of care.

The RN's job is to assess the home health patient's health condition and medical nursing needs. They administer and manage medications as well as develop and implement nursing care plans. They teach health maintenance, safety, and disease prevention. Here are a couple other ways in which RNs provide skilled care for the home health patient: IVs, catheters, shots, Foley, J- and G-tubes, teaching about prescription drugs or diabetes care, wound care, and teaching and performing dressing changes.

You will care coordinate with at them at the beginning of care to report your frequency and duration and care plan, at discharge to inform them that your care is ending, and anytime during care with clinically relevant information. [2] RNs do have the ability to complete

start of care OASIS assessments. [3] The RN supervises the Licensed Practical Nurse's care. [4]

Licensed Practical Nurse (LPN)

The licensed practical nurse (LPN) is part of the nursing team, but is not allowed to perform functions like administer medication, perform diagnostic tests, or analyze results. [6] They work under the direction and supervision of the physician and RN. State licensing is required. LPNs are not allowed to answer OASIS items, [5] but are vital assets in home health. [4]

Home Health Aide

The home health aide provides routine individualized, unskilled healthcare, under the supervision of the RN or other health professional like a PT, OT, or SLP. According to the United States Department of Labor's Bureau of Labor Statistics, the home health aide monitors and reports changes in health status of the home health patient. They take vital signs and are able at take patients through their individualized, home exercise program. They also provide personal care such as bathing, dressing, and grooming of the home health patient. [7] The home health aide is not allowed to answer OASIS items [5] and is not allowed to work with home health patients who are NOT receiving skilled care from one or more providers (PT, OT, SLP or RN).

Fast Fact

The home health aide is the only member of the home health team that *is allowed to provide unskilled care.*

Speech Language Pathologist (SLP)

The Speech & Language Pathologist (SLP) works with patients who present with illness and/or injury of speech, language, cognitive, and swallowing deficits. The goal of HH Speech Therapy is to provide rehabilitation and support so that the patient can participate and communicate with the maximum independence that their capabilities will allow.

Speech and language treatment focuses on assisting the patient with communicating wants, needs, and thoughts. SLP's complete four types of therapy: speech, language, cognition, and swallowing. Often, therapies will be provided from more than one type according to the diversity of deficits for each patient. Speech therapy improves a patient's accuracy for speaking, for example, strengthening labial and lingual strength in dysarthria. Language therapy assists the patient with formulating sentences and recalling words. For example, an SLP assist a person with Broca's Aphasia to produce complex grammatical structures. In cognitive therapy, SLP's work on improving problem solving, memory, orientation, and safety awareness. This can include activities such as making a memory book to assist with memory of family names and personal information or improving safety awareness of fall risks with practice in problem solving scenarios. In swallowing therapy, SLP's use exercises and swallowing modifications to strengthen the swallow mechanisms to reduce the risk for aspiration-pneumonia.

SLP's work with OT's and PT's to assist with patient understanding and memory for completing home exercise programs. SLPs do have the ability to complete start of care OASIS assessments. [3]

Occupational Therapist (OT)

Occupational therapy (OT) is prescribed to home health patients who have upper extremity deficits and functional limitations in areas of occupational participation. This can include daily living skills like dressing, bathing, grooming, homemaking, meal preparation, self-care, the ability to care for others and carry out other important daily life activities. Importantly, they focus on impairments and functional limitations of the upper extremity [10] as well as address challenges with participation in valued daily life occupations through therapeutic exercise and activities, modifications and adaptations as well as education. OTs do not have the ability to complete start of care OASIS assessments. [3] The occupational therapist directs and supervises the certified occupational therapist assistant (COTA). OTs and PTs work closely together, but never should duplicate services. For example, both disciplines should never both focus on tub transfers or gait training.

Certified Occupational Therapist Assistant (COTA)

The certified occupational therapist assistant (COTA) carries out the plan of care of the occupational therapist, under the OT's direction and supervision. [11] In Illinois, the state I practice in, the OT is required to supervise the COTA and make a supervisory visit every four to six visits. The COTA is not allowed to complete OASIS documentation. [5] Review the state practice act for COTAs as they differ widely from one state to the another and must be followed.

Physical Therapist (PT)

The home health physical therapist's goals are to assist home health patients who have lower extremity impairments and functional

limitations in areas of self-care, activities of daily living (ADL), instrumental activities of daily living (IADL), and home management. Additionally, some of the core elements of the HH PT's interventions include manual therapy, therapeutic exercise and activity training, progressive strengthening, gait, posture and balance training, assistive devices prescription and management, home adaptations and modifications, HEP development and instruction, and patient and caregiver education. The HH PT will always perform a home safety assessment at the initial visit as well as subsequent visits to optimize the home health patient's safety, function, and efficiency.

Physical therapists with experience treating patients in the inpatient hospital or SNF setting will have a similar patient demographic in home health and may feel more prepared for home health than a PT who has only worked in schools or the private outpatient practice.

The physical therapist is responsible for the supervision of the physical therapy assistant (PTA).

Physical Therapy Assistant (PTA)

As in all other settings, the physical therapy assistant carries out the plan of care of the physical therapist, under the PT's direction and supervision. They do this in accordance with state laws and deliver physical therapy services within the scope of treatment plans established by a physical therapist. State practice acts differ widely from one state to the next and must be reviewed and assessed carefully. In Illinois, the physical therapy assistant needs a supervisory visit every sixth visit.

This position requires formal education in an accredited PTA school, which is currently an associate degree as well as

state licensure. [12-13] The PTA is not allowed to complete OASIS documentation per CMS. [5]

Medical Social Worker (MSW)

The medical social worker assesses social and emotional factors that could impede care, safety, and recovery related to the illness, injury, and/or home environment. They recommend and assist with financial and social services and community resource outlets, as well as perform brief in-home counseling services for patients, caregivers, and/or family members. MSWs "provide individuals, families, and groups with the psychosocial support needed to cope with chronic, acute, or terminal illnesses." [14] The MSWs are not allowed to perform OASIS documentation per CMS. [5]

Companion Course

Access interviews with home health providers and stakeholders - See bonus chapter.

In the next lesson, you will receive some essential information about care coordination. You must understand this concept in order to provide the best care possible to each and every home health patient.

Care Coordination

The home health team must consistently work together to anticipate and appropriately respond to any challenges, issues, or scenarios where help is needed for the patient. Care coordination is the exchanging of information between all stakeholders. It should

happen regularly and be documented in each clinical note when it does. Effective, timely, and detailed communication is the key to success and will help you and your patients thrive.

In home health, care coordination can occur when you exchange information with doctors, nurses, other therapy disciplines, caregivers, and other persons involved in the patient's care. Exchanges are of pertinent clinical findings, assessments, patient care activities, objective measurements, discoveries, and observations of importance.

Case Story

I had a patient status-post acute left total knee replacement. He told me that he could not afford the anti-coagulation medication prescribed, and, therefore, was not taking anything. I immediately called the orthopedic surgeon with this valuable information. A few hours later, the orthopedic surgeon prescribed something similar and affordable enough so he could start taking something to reduce the risk for blood clots. If I had not communicated with the physician, this patient may have had an adverse event. Effective communication means better care. That starts with listening and then understanding what you need to communicate and to whom.

In home health, unlike in most other PT work settings, care coordination usually happens over the phone, not in person. For some, this may be an added challenge because you are going to have to make the effort to call because you are not likely to run into the patient's physician and/or interdisciplinary clinicians like you would in an inpatient facility.

Care Coordination: Who, What, When and Why

Working with a team can be great, but only if you know your role and your responsibilities. In home health, it's crucial to understand what information needs to be reported and to whom.

Here is a non-exhaustive list of who, what, when and why care coordination happens in home health.

When to care coordinate to the RN:

- When the patient presents with medication question(s) or receives a new medication
- Patient is confused about when and how to take their prescribed medication(s)
- Abnormal clinical findings, like critically abnormal vital signs or extremely high pain levels
- Wound care questions or abnormal wound care observations like foul odor, increased drainage, signs of infection, or bandage abnormalities
- Functional or mental status changes, especially when there is a noticeable decline
- Discharge planning and extension requests
- Safety issues that affect staff and/or the patient
- Falls or any adverse events
- Right after the physical therapy evaluation and the day before or day of discharge visit

When to care coordinate to the physician:

- Any changes in the plan of care such as a request for a prescription to extend care, a missed visit, or a delay in care
- Severe exacerbation of pain, and/or abnormal clinically significant signs or symptoms: sign of infection, shortness of breath, blood clot, heart attack, or increased edema
- Questions about medical appointments, medications issues/questions, precautions or protocols
- Abnormal clinical events, like a fall or new injury
- Requests for a prescription to add a home health clinician to the care plan; i.e. OT, SLP, RN, home health aide or MSW
- Request to write a prescription for assistive device/durable medical equipment such as a cane, wheelchair, walker, crutches, or hospital bed
- Request for a prescription for outpatient services after home health services is complete
- Report patient noncompliant behavior
- Report when there is a delay (>48 hours from SOC) in performing your initial visit/evaluation

There are other times when you are going to have to care coordinate with other home health clinical providers and caregivers when you are working with a shared patient.

Here are a few more examples on care coordination with caregivers and the interdisciplinary team:

Your patient has increased pain or decreased tolerance during the treatment session. When this happens, report this to the other clinicians scheduled to visit on the same day to help them prepare and assess if there are any changes.

Caregivers disagree with or say that they will not comply with recommendations or teachings. When this happens, communicate with any other treating clinicians and to the referring physician to strategize on how to best promote adherence and assess additional options.

You may experience safety challenges. For example, an untrained dog that is dangerous. A family member who smokes. A home that is not fit to live in because the structure is unsound. When anything appears or is unsafe, care coordinate with other clinicians working with the patient, the referring physician, and your clinical manager to come to a solution.

Home modification recommendations. When I make a recommendation such as move furniture, install grab bars, or install stair rails to assist with stair negotiation, I recommend care coordinating with other colleagues to get their insight and thoughts on the home modification recommendation.

In home health, you will consistently work with the patient's caregiver(s). Here are a few common scenarios of when and what to care coordinate with them.

Durable Medical Equipment (DME)/Assistive Device (AD) ordering and teaching. If the patient's health insurance does not pay for a piece of DME/AD, you will have to show the caregiver what needs to be ordered and how to do it. Not all of your patients will be

able to perform this task so you will have to work directly with the caregiver. Additionally, with some DME /ADs including walkers with wheels, grab bars, commodes, hospital beds, Hoyer lifts, and the like that require explanation for assembly, management and usage, you will have to instruct and teach the caregiver.

Appointment scheduling. Many caregivers are the primary people who set up and manage the home health patient's appointments. That said, you will have to communicate with and through them to ensure you are able to obtain access to your home health patient.

Home exercise program instruction and implementation. Every home health patient must receive an individualized home exercise program. Due to cognitive and/or physical restrictions, not all patients will be able to independently perform them. If this is the case, you are responsible for teaching the caregiver, who is now responsible for instructing and implementing the HEP to the home health patient. Use the method, "Teach Back" to ensure independence with your teachings.

Safety and preventative education recommendations. Some patients forget to do what you have taught them. For example, always use your walker when up walking, elevate and ice throughout the day, use the commode at night, or always use the cane when you negotiate the stairs. Teach the caregivers everything you teach your patient to increase the likelihood that the recommendations will be followed.

Finally, **body mechanics and proper patient transferring techniques are critical.** There are caregivers who do not know how to correctly and safely transfer a person. This is your opportunity

to teach them the correct way to do it, which will reduce risk, and possibly prevent both patient and caregiver injury.

Companion Course

Access a short quiz to test your knowledge on when you should care coordinate as a home health physical therapist – See chapter 5.

You are now ready to jump into some important patient care information. It all begins at the initial home health visit. Let's dive in!

NOTES

6 THE INITIAL VISIT

In this chapter, I will introduce the most important things you must know and do to have success before, during, and after your initial home health visit. Armed with this knowledge, you are sure to provide high-quality patient care and do great!

Sense of Urgency... Get in the Same Day!

This lesson addresses the minimum time frames, after the start of care (SOC) date, in which you are expected to get in to perform the physical therapy initial visit. Medicare requires that home health agencies (HHAs) make an initial assessment visit within 48 hours of receiving the referral or the patient's return home from an inpatient facility or on the physician-ordered start of care. [1] That said, at a minimum, based on how I have practiced and lead my team of home health therapists, you need to get in within 48 hours of the SOC to perform your initial visit on patients with non-orthopedic surgical conditions.

As with orthopedic cases, specifically total joint replacements, you will most likely be required to get in on the same day or within 24 hours of the SOC. My recommendation and best practice is to perform your initial visit on the same day as the SOC.

If you are unable to get in within 48 hours of the SOC time frame, regardless of condition or diagnosis, there better be a really good reason (patient-specific). If you are unable to get in within 48 hours of the SOC, this is considered a "delay" in services. For a delay, you must document in the patient's medical record explaining why the delay occurred. In addition, you must call the referring physician, RN case manager, and your clinical manager to inform them of the delay and to discuss the strategy on how to proceed.

Check with your HHA to learn their policy on *when* they expect clinicians to get in and what to do when there is a delay in care. Again, in my opinion, the best practice is to get in to perform your initial visit on the same day as the SOC.

Top Tip

The faster you get in to assess your home health patient, the safer he/she will be.

The 8 Essential Principles of the Successful "Intro Call"

The "intro call" is when you call the patient for the first time to schedule the time and date of the initial visit. This is one of the most important pieces of the home health puzzle, so listen up.

The goal is to AVOID confusing or stressing out the patient. So just introduce yourself, set up the time and date, and ensure that the nurse has been in to perform the initial SOC assessment. Follow the below flow and you will achieve this goal.

Once you get the patient or caregiver on the phone, make sure you state and question the following:

1. Who you are (name and profession)
2. Who you represent (name of your home health agency)
3. Why you are calling (I am calling to initiate physical therapy services per physician orders)
4. Who the referring physician is
5. Confirm the best phone number to use to reach the patient and confirm the patient's address. Sometimes the patient's location changes and/or they have a preferred phone number to use.
6. Then, welcome your patient home!
7. After this, you will ask the MOST IMPORTANT question, "Has the nurse been in yet?" Sometimes there will not be nursing orders, so only ask this question when you know that there are.

You need to know if "the nurse has been in" because Medicare requires that the RN perform the initial comprehensive assessment/start of care (SOC) before any other clinician sees the Medicare patient. So if you go before the RN, you will not be paid, the visit will not be reimbursed nor count and you will be breaking a Medicare rule.

8. Finally, schedule and confirm the time and date of your initial evaluation.

That's it. If you follow this flow, your patient will be confident in you, know who and why you are coming to their home, and will be ready for you when you arrive. You will also know if you need to care

coordinate with any key stakeholder based on information gathered from the “intro call”.

In the next lesson, you are going to learn the most important questions to ask you home health patient at the initial visit.

Patient History “Must-Know Info” for the Initial Visit

One of the first things you’ll do in the initial visit is to systematically obtain information pertaining to the patient’s past and present health condition(s), risk factors, and main reason for the home health referral – also known as ‘patient history’. The goal is to obtain the patient’s detailed history, so you can design a patient-centered plan of care that consists of functional goals, outcomes, and interventions. Student physical therapists should plan to be active during this phase of the initial visit. Ask as many thoughtful questions as you can to hone your patient history skills.

The questions below relate to the examination elements of the Patient/Client Management Model from the Guide to Physical Therapy Practice. I ask every home health patient these questions at the initial visit:

- What was the recent event that initiated home health?
- If you were hospitalized, what are the admission and discharge dates?
- Have you had any hospitalizations or surgeries over the past one or two years?
- Have you ever had home health before? If so, when and why?
- Before the recent illness/injury, describe your prior level of function (PLOF)?

- Do you have any future physician appointment scheduled? If so, with who, where, when, and do you have transportation?
- Do you have plans to leave home in the near future? If so, for what reason(s)?
- What are your personal goals? What do you want to get back to doing that you were doing before your recent illness or injury?
- Have you fallen recently? If so, how many times? Where were you? Do you know why you fell?
- Are you afraid of falling (0 = no fear; 10 = greatest fear)
- Do you have a family member or caregiver to assist you if needed? If so, who are they, what is their name and when are they available to assist you?

This non-exhaustive list covers key information that will help you create a patient-centered physical therapy plan of care that optimizes success for all stakeholders. The data you obtain should make its way into your physical therapy initial evaluation note.

Companion Course

What are some other vital questions you think are important to ask at the initial visit? - See chapter 6.

Once you have obtained the essential patient history and reason for referral information, the next step is to take the patient's vital signs. Let discuss best practice with vital signs in home health.

Essential Vital Signs

During the initial visit and every subsequent visit, as part of the systems review, you must take the following vital signs. No excuses.

- Respiration rate (at rest and after activity)
- Blood pressure (at rest and during or after activity)
- Heart rate (at rest and during or after activity)
- Temperature (before treatment session starts)
- Pain (I like to include it as another vital sign)

If one or more vital sign is abnormal, you need to take action and care coordinate with the referring physician, the RN case manager, and/or any other stakeholder. The HHA you work for will have specific guidelines and parameters on what to do when you encounter abnormal vital signs.

It's extremely important to know when to stop or not begin your treatment session based on abnormal vital sign readings. You must memorize the contraindications and precautions related to activity to prevent injury or illness exacerbation. Additionally, be aware of any physician ordered, patient-specific parameters, ranges, or limitations that your patient may have. This is your responsibility.

In Chapter 10, "Special Scenarios," you will learn more about when to withhold and when to terminate activity based on abnormal vital signs and other factors.

Product Reccomendation

My favorite thermometer is the FDA-approved Innovo Forehead and Ear (Dual-Mode).

In the next lesson, I will share a very important document that all home health patients who have been discharge from a facility should have. If they do, obtain it and review it as it will help you in the process of creating a patient-centered physical therapy plan of care.

Find the Patient's Discharge Papers!

During your time with the patient at the initial visit, ask to them to give you their hospital/facility discharge papers. The discharge papers will show you the orders, medications, admission and discharge dates, and all other salient information to help you understand and design an excellent plan of care. Help your patient be organized and keep these papers in a safe place. A good place to keep them is in the home health agency folder along with your written home exercise program. Speaking of the home health agency folder...

Companion Course

Access sample hospital discharge papers - See chapter 6.

Find the Home Health Agency Folder

In each home, there should be a HHA folder, which is left by the first provider who performed the initial SOC assessment. Make sure you locate it early on in the initial visit and I recommend keeping your patient's home exercise program there. On the front of the HHA folder, sign your name and write your profession, and write the best way for the patient to contact you (phone number: personal or office).

This HHA folder may have multiple medical documents in it, such as:

- Patient's medication list
- Discharge papers
- Consent and privacy information
- Important company contact information
- Flow sheet to track clinical data and date and time of service

I work with HHAs that keep therapy visit tracking and an OASIS data collection sheets in the HHA folder. This is the "go-to" folder and is the best place to store all important documents about and for the patient.

Companion Course

Access a sample visit tracking sheet utilized by Ayuda therapists – See chapter 6.

At this point in the initial visit, you are ready to perform the home safety assessment. Let's learn about it now!

Home Safety Assessment – Be Empathetic, but Firm

At the initial visit, you must always perform a home safety assessment (HSA), which is designed to identify areas and items in the patient's home that are barriers, unsafe, and, if not modified or changed, may lead to an adverse event like a fall or injury. Ultimately, the purpose of the HSA is to reduce risk factors, optimize safety, and improve functional mobility within the patient's residence.

One important part of the HSA is the "walk through." This is when you literally walk through the patient's home, gathering information on the items, barriers, and safety hazards that can lead to falls, injury, and/or an adverse event. Environmental barriers that are commonly identified as safety issues and fall risk hazards are: deficient lighting; miscellaneous obstacles in the area such as electrical cords, clutter, rugs, pets, or toys; uneven or irregular surfaces; steps and stairs; lack of grab bars in the bathroom tub or shower; doorway thresholds; low toilet; lacking or faulty handrails at steps or stairs; lack of non-stick mats or strips in the shower/bathroom tub; chairs without armrests and/or an unstable base; and, importantly, the patient not having working or appropriate assistive device(s).

After completion of the HSA, you will kindly offer the patient and/or caregiver your written and/or verbal recommendations on how to implement the HSA recommendations –– providing support and resources. Importantly, in the initial PT evaluation note, you must also document that a formal home safety assessment was completed, including a summary of your recommendations.

Here is sample statement about a HSA that I used in one of my physical therapy evaluations.

"A formal home safety assessment was performed today. The physical therapist recommended: removing all clutter, throw rugs in living room, first floor bathroom and in the bedroom; and not to use the big red chair with faulty base and without armrests. Additionally, I instructed the patient and caregivers to rearrange all identified furniture to make transport paths safer and more open. Also, the patient and caregivers were given verbal and written recommendations/instructions on

purchasing grab bars for shower, handrails for stair to enter/ exit the front of the house, and rollator for in-home walking."

This is the type of language I use to document this important element of the physical therapy evaluation/initial visit. The home safety assessment does not end at the initial visit, it is ongoing as you will discover other areas where your expertise can reduce risk factors, optimize safety, and improve functional mobility within the patient's home.

Patient's Perspective: Be mindful of your recommendations on ways to modify and make your patient's home safer. Some people are very sensitive about their homes, especially changing and moving things around. Empathize with them and give them little doses at a time. Start with the most dangerous items that increase the risk for falls or injury. Be thorough, vigilant, and work hard to address every possible risk factor. Your patient's life and safety depends on you and it is your responsibility to help them make their home safer.

Companion Course

Access a short presentation on fall risk reduction and home safety modifications by Mara Rosen, OT – See chapter 6.

Find the Spot

During the initial visit, it is very important to find the best location(s) in your patient's home for you to provide care. I usually locate one or two spots during the home safety assessment when I'm doing the walk through. Depending on the home and the patient, this could be

the bed, couch, straight-backed chair with arm rests, countertop, and even the floor. Find your ideal space and start changing weakness to strength!

Top Tip

You must start treatment on the initial visit, don't wait. Here are a few essential interventions I address on the first visit: safe and proper mechanics with ADLs, locomotion, best footwear, assistive device management, HEP instruction and performancee, and ADLs teaching, performance, and safety recommendations.

In the next lesson, I will we will explore why each home health plan of care must have a standardized functional assessment tool documented.

Standardized Objective Measurement Tools (SOMT)

The fundamental goal is to return the patient to their prior level of function. This does not always happen, so the goal then becomes to get them to the highest level of function achievable. That said, a proven way to objectively measure and assess (at different points in time) if a patient is making observable gains or not is by utilizing a standardized objective measurement tool (SOMT).

There are many SOMTs to choose from. As a HH PT, you are required to choose the most appropriate one for your patient. At a minimum, the SOMT must be measured at the initial evaluation, at any reassessments (reevaluation), and at discharge.

Over time, this objective data will show you if your patient is making functional or objective gains or not. The patient's SOMT score is documented in their clinical notes each time you assess it.

Here are seven of my most commonly used standardized objective measurement tools for the low and high level, ambulatory and non-ambulatory home health patient.

1. Modified Functional Reach – Dynamic Sitting Balance [2]
2. Timed Up and Go (TUG) – Dynamic Standing Balance [3]
3. 2-Minute Step Test – Aerobic Capacity [4]
4. 30-Second Chair Stand Test – Bilateral Lower Extremity Functional Strength [5]
5. Four-Square Step Test – Assessing Agility [6]
6. Tinetti – Balance and Gait Ability [7]
7. 6-Minute Walk Test – A sub-maximal test of aerobic capacity/endurance [8]

At a minimum, you must choose one SOMT for each physical therapy plan of care and it must be a goal, usually a long-term one. Below are my "go-to" SOMTs:

Modified Functional Reach Test

For those patients who are non-ambulatory, my favorite SOMT for seated dynamic balance is the Modified Functional Reach Test. It is commonly used in research and clinically to assess balance ability and predict the risk of falling in people unable to stand. [2] It is quick, easy to perform, patients usually tolerate it well, and it has a proven track record within the healthcare community. Additionally, you do not need many items to complete it. [2]

Timed Up and Go – TUG

For those patients who are ambulatory, my favorite standing dynamic balance SOMT is the Timed Up and Go Test (TUG). The TUG test was found to be a sensitive and specific measure for identifying older adults who are prone to falls. [9-10] It is quick, easy to perform, patients usually like it, and has a proven track record within the healthcare community. Additionally, you do not need much equipment (tape measure, stop watch, chair) to complete it. [3]

Companion Course

Access other commonly utilized SOMTs – See chapter 12.

After you have completed the majority of the examination and evaluation, you must now start thinking about your patient's recovery trajectory. Meaning, how many visits will they need and for how long? Let's dive into care plan creation, specifically choosing frequency and duration for the home health patient.

Frequency and Duration – Get It Right!

As you create your physical therapy plan of care, you must include a frequency and duration. This is not easy, especially at first, but I'm going to help you get a perspective on what is important and offer you a few tips on how to design a frequency and duration best suited for your patient's safety, speed of recovery, and return to a high level of functioning. Some physicians will include a PT frequency and duration in their prescription. However, you must design an individualized, patient-centered plan of care, including a

frequency and duration that you decide the patient needs based on your evaluation, examination, assessment, diagnosis, prognosis and medical necessity.

Home health is an extension of the hospital. Patients are coming home quicker and sicker. In inpatient rehab, all patients are seen by PT, OT, and SLP daily for a minimum of three hours per day. In the skilled nursing facility and acute inpatient facilities, most patients are seen at least daily for PT. In home health, patients are seen on an intermittent basis, so daily visits are most often not allowed (in extreme cases, they may be). That said, three visits per week is an effective and reasonable option for the home health patient. Generally speaking, I think, three times a week for the first two weeks in home health is the optimized frequency that will allow you to truly make a positive impact in your patient's life. This is called front-loading (higher frequency early, transitioning to less frequency later). For example, 3w2 and 2w1. This strategy can lead to increased patient safety and improve activity participation and clinical outcomes.

Here are the most important characteristics I look at when making my decision on what frequency and duration will best serve my patient's needs and that will be reasonable and necessary.

- How unsafe are they in their home?
- Do they have any caregivers to assist them?
- Do they live alone?
- What was is the patient's prior level of function compared to their current level of function?
- Are they able to walk? If so, do they need supervision, an assistive device, or another person(s) for assistance?

- Is their illness or injury acute, sub-acute, or a chronic condition?
- Are they medically unstable or at high risk for re-hospitalization?
- Are you the only home health provider with orders or are there others like an RN, OT, and/or SLP to provide services?
- What is the patient's cognitive status?
- What is the patient's pain level. Is their pain managed well?

Based on the answers to these questions, you should gain an understanding of severity, acuity, and how much skilled PT care the patient will require. My advice is: the less safe, the higher the pain levels, the farther from PLOF, and the more assistance needed: three times a week is the best frequency to choose for the patient. Strive to get back in the next day with all high-risk patients.

Choosing the duration is a bit easier. I use the three-week duration as the maximum initial duration. Medicare uses the number 21 days to describe intermittent, [11] so I personally use that duration as my compass.

If the patient needs additional skilled physical therapy visits beyond the initial plan of care, you can process an extension request (learn about the extension request in Chapter 10) and fight for additional skilled PT visits.

Importantly, as a patient-centered, safety strategy, I strive to get right back in the next day if I find that the patient is unsafe, unstable, and at a HIGH fall risk per TUG or Tinetti performance. If you need to send a patient back to the hospital, don't be afraid to call 911 and send them back. Better safe than sorry. You are getting paid to help, so earn your money.

Giving a Report after the Initial Visit Is Complete

Once you have finished the initial visit and have all of the information needed to create your physical therapy plan of care (PT POC), you are officially ready to give a clinical report. HHAs that I work with require that this will be your first mandatory care coordination call to the referring physician and/or the RN case manager. Keep the report concise but descriptive, while focusing on the most important clinical, physical therapy-based assessments, and recommendations.

Most important information to share:

1. Summary of the PT plan of care, including the frequency and duration
2. Physical therapy prognosis
3. Any barriers or safety problems identified
4. Patient motivation and attitude toward home health services
5. Pain or medication problems or questions
6. Any pertinent OASIS data points scores (M1820, M1840, M1850, M1860)
7. Recommendation to prescribe other home health providers to evaluate and treat
8. Recommendation to prescribe assistive device(s) or medical equipment
9. Discharge plans

You are required to document this communication (who you spoke with, when it occurred, what was reported, and any outcomes) in your clinical note, the physical therapy evaluation document.

Companion Course

Access audio of a home health physical therapist giving a clinical report – See chapter 6.

In the next lesson, you will learn about a program that each home health patient must receive. I'm talking about the home exercise program.

Home Exercise Program (HEP)

Every patient and/or caregiver will receive a home exercise program, regardless of how many times they are seen for skilled home physical therapy. It will also be a functional goal in the PT plan of care. If the patient is not able to be independent with the HEP due to cognitive and/or physical reasons, the caregiver(s) must be trained and be independent with it by discharge.

It is important to set up your initial HEP in the safest and most effective manner, including the mode, exercise description, frequency, intensity, patient position, sets, repetitions, and how often it must be performed. I have seen novice HH PTs injure patients because they progress them too fast or start them off doing therapeutic exercises/activities that are too strenuous for them.

Tip for a user-friendly HEP: According to a research article, *Effect of Number of Home Exercises on Compliance and Performance in Adults Over 65 Years of Age*, "Subjects who were prescribed 2 exercises performed better than subjects who were prescribed 8 exercises." [12] I have found this to be true with my patients. That saod, I prescribe a few exercises for each HEP I design. Less is more.

There may be times when a patient is referred to home health physical therapy, but they really do not need it due to being at their PLOF or a high level of function where providing skilled home health care would not be reasonable or necessary. In the next lesson, I will showcase a strategy to identify a patient who fits this profile.

Top Tip

The HEP does not have to always be therapeutic exercises (squats, straight leg raises or seated marching). It could also be any type of functional activity, like a progressing walking program.

Hokey Pokey? If so, They May Not Need Home Health PT

If your home health patient can do the hokey pokey (> five rounds) at the initial visit with ease and without rest breaks, an assistive device, or loss of balance episodes, I would consider them a home health Olympic athlete! They may be better suited for outpatient physical therapy than home health, but I'll let you be the judge of that.

Keeping with the theme of assessing a patient's home health PT needs, I will give an overview of a patient who only needs limited skilled home PT services.

3-Visit Max to Teach a Maintenance HEP

From time to time, you may get patients who are eligible and need home health services, but from a physical therapy standpoint, all they really need is a couple skilled PT visits to teach them a progressed HEP. In my experience, and with success, I have been

able to justify performing three skilled home health PT visits to teach my ambulatory home health patient a "progressed, maintenance home exercise program."

This is my process of how to progress the maintenance HEP for the ambulatory patient, over a three-visit period. Visit one, the patient is taught and performs two essential therapeutic functional exercises, which are in supine. Visit two, the patient is taught and performs two seated therapeutic functional exercises. Visit three, the discharge visit, the patient is taught and performs two or standing therapeutic functional exercises. So by discharge, the patient has six exercises in all functional positions to do for the rest of their life to improve physical function, health status, and quality of life.

Be Aware

You must also provide additional skilled interventions, teachings, and procedures during these visits as HEP teaching by itself not enough.

You are off to a great start! Now you know a lot about how to successfully perform the initial visit. In the next chapter, I will introduce you to the most essential information about the routine visit so you can hit the ground running in home health as a HH PT.

NOTES

7 THE ROUTINE VISIT

In this chapter, I will introduce the most important things you must know and do to have success before, during, and after your initial home health visit. Armed with this knowledge, you are sure to provide high-quality patient care and do great!

Intro, Etiquette, and Visit Mechanics

Before you walk in, set a timer or alarm on your phone for 45 minutes. This will give you an objective time measurement to keep you on track, focused, and moving forward.

Once you arrive at your patient's door, ask them if you should take off your shoes before entering as this shows respect and character. You do not want to track in the "outside" or disrespect the patient or their property.

Make sure your patient knows and remembers your name and make sure you are calling them their preferred name. I don't know how many times I have had patients not remember the name of their health care provider – this is unacceptable. Wear your name tag above the waist so they can see it.

Once in, identify the best treatment site(s) in the home to do therapy (this can be multiple locations). Additionally, you must find

a safe place to leave your travel bag. Never place your bag on the floor because someone can trip over it and it is against home health "bag technique" protocol. My favorite location is on a non-important chair, sitting on top of a plastic cover or Chux pad.

Once the ideal treatment location is identified and all parties are present, you must perform the bag technique (see Chapter 11 "Being in the Patient's Home") and start the skilled home physical therapy treatment session.

Key Patient Questions to Ask at the Routine Visit

Here are a few important questions that I ask to get a pulse on how I can best help the patient.

- Have you been doing your HEP since our last visit?
- Have you been taking your medications as prescribed? Have you taken them today?
- Do you have any questions about your medications?
- Do you have any upcoming or changes in your medical appointments?
- Have you had any falls or injuries since the last visit?
- What are your pain levels today?
- What would you like to focus on today for your treatment session?
- Have you been outside of your residence since the last session?
- How did you feel after our last session?
- Have you been compliant with the safety recommendations?

After going through or during the above questions, you need to take your patient's vital signs at rest. Then make sure your patient is aware of the goals that they have met and that they are working to achieve to ensure that everyone is on the same page. Also, touch on the patient's discharge planning trajectory.

It is vital that your patient is making functional gains and progressing, ideally during each skilled treatment session. You will progress them by adding a new therapeutic exercise or functional activity (stairs, tub transfers, etc.), increasing sets or repetitions, progressing the distance for gait training with or without an assistive device, and/or adding important teachings to promote safety, mechanics, and/or posture. Our ultimate goal is to return our patient to the highest level of function achievable as well as reduce risk for unnecessary hospital readmissions.

8 Valuable Treatment Session Tips

1. After obtaining the subjective reporting and taking vital signs, I always start the treatment session with a warm-up. My favorite warm-up is to go through the patient's written home exercise program. Have them teach it back to you.
2. Inform your patient about what the focus of the day's session will be. I focus on one or two things only, i.e. stairs, knee extension, tub transfers, quad control during stance phase of gait, sit to stand, or single leg balance. Do not overwhelm your patient with too many activities in one session. Prioritize the most important functional tasks, goals, and focus on them for the session.
3. Focus patient teachings and interventions on how it will positively affect their safety, function, outcomes, and quality of life.

4. Again, please use your best judgment in choosing the intensity, duration, and frequency of your interventions. I have found that less is somtimes more, especially with the geriatric population. Avoid being too aggressive.
5. You should spend a minimum of 45 minutes with all of your patients. Sometimes the patient may need less or more time. If, for whatever reason, the patient needs less than 45 minutes, always document the reasons why in the clinical note.
6. It is a best practice to obtain the patient's signature and date of service, either on a digital device or paper. If you forget, get it on the next visit.
7. If you are doing manual therapy, make sure you are always draping the patient appropriately and explaining what and why you are doing it.
8. The best time to perform clinical charting is when your patient is taking rest breaks. Don't let documentation take away from engaging with your patient.

In this next lesson, we will cover progressing the patient's home exercise program, something that must be done to get your home health patient stronger and safer in his/her home.

HEP Progression (include progressive resistive exercise)

This is the most basic method I use to progress the medically complex, ambulatory home health patient. First, I start out with supine therapeutic exercises/activities. Then, I progress them to sitting. From sitting, the progression is to the standing. A progressive resistive exercise program recommends to start with a small number

of repetitions (8–12) until fatigued. Then make sure you give your patients enough time to take some rest between exercises for recovery. Over time and in a safe manner, based on your clinical expertise, add resistance as the ability to generate muscle force develops." [1] Importantly, review and strive to go through your patient's HEP each session and always add a safe and appropriate progression (add reps, sets, change position, etc.) as tolerated.

The routine visit is coming to an end. You are off to a great start so far. Here are a few key tips to close it out successfully.

Save the Best for Last!

Before finishing the session, I always ask the following questions or make comments to gauge patient satisfaction and attitude to their home health PT care plan:

1. Do you feel like you had a good session today?
2. Did I address all of your concerns and answer all of your questions?
3. Do you continue to commit to perform your HEP daily and to my recommendations on safety?
4. How do you feel right now? Are your symptoms worse, the same, or better than before you started?

These questions should give you insights into the therapy session, workload satisfaction, and response to treatment. If the patient said they had a good session and feels fulfilled, you will know that it is appropriate to stop the session and should trust that the patient is satisfied.

Some patients will be more candid than others, so listen more than you talk and don't be afraid to ask follow-up questions to clarify or learn more. If they say that they do not feel like today was a good session or they feel worse than before starting, try to figure out why, what needs to be addressed, and how you can help them.

Key Points to Remember with the Routine Visit

- Always let your patient know how many more visits they have left in their plan of care. NO SURPRISE DISCHARGES or SPONTANEOUS RECOVERIES! Discharge planning begins at the initial evaluation and continues up to the discharge day.
- Review and confirm with your patients the time and date of the next skilled treatment session. Make sure you are keeping track as well. I use my smartphone's calendar application with alarm notification enabled to stay organized with my patient schedule.
- Remind the patient to do their HEP as prescribed and have them verify by tallying the days and times when they do.
- Stay consistent in the treatment sessions. People like and are comfortable with consistency.
- Make sure you are progressing the patient each and every visit as tolerated.
- Always use your gait belt when you have your patients up and mobilizing. The gait belt has positive psychological effects and helps you to effectively manage fall risk.
- Always give the patient your undivided attention and be empathetic in your words and actions.

- Less is sometimes more in relation to things you *do* (interventions/procedures) with your patient during the treatment session. Build trust before you build muscle.
- Put your phone on silent or vibrate. No texting or taking non-emergency calls.
- Each visit, coordinate care with your home health interdisciplinary team in a timely and effective manner. Don't wait, do it now!

Now it's time to discharge. Let's talk about this special visit that can be a celebration and sometimes a sad departure, all in one.

NOTES

8 THE DISCHARGE VISIT

In this chapter, you will learn everything you need to know to avoid mistakes, increase patient satisfaction, and optimize the discharge visit to help you make it more of a celebration than a sad departure.

Verbal Cues = Not Independent

Don't discharge your patient too early or call them independent when they are not. First, we will address some situations when it appears like your patient is ready to be discharged or independent with certain functional activities, but in reality, they need more time and are truly not independent.

Some HH PTs think that their patient is independent when they really are not. If your patient needs any teaching, cueing, or supervision to perform any functional activity safely and correctly, you can't yet call them independent.

Here are some examples of a home health patient not being independent or ready to be discharged (while there is potential in the patient to reach independence).

Stairs:

Your patient can go up and down the stairs without physical assistance, but you need to constantly cue them verbally to ensure

safety (considering weight-bearing status or presence/absence of railings) and that they're using the correct technique. This patient is not yet independent.

Gait:

Your patient can walk with a single point cane without physical assistance, but the technique is not heel/toe, and their posture is abnormal. You need to supervise and cue them verbally throughout the gait cycle. This patient is not yet independent.

Sit to Stand Transfers:

Your patient can go from sit to stand and stand to sit without physical assistance of another. However, he needs verbal cues to remember to reach back to grab the chair when sitting, as well as verbal cues to scoot forward and pull their feet back before standing. The patient is not yet independent.

HEP:

If your patient cannot perform the HEP without you providing her with verbal cues for technique and alignment, she is not independent.

Don't call a patient independent or discharge too early when there is potential to achieve a higher level of function and safety. On the other hand, sometimes patients are ready for discharge, but they don't realize or want to be discharged.

"I'm Not Ready to Be Discharged."

Most patients enjoy home health physical therapy. Bonds between the patient and provider are real and they happen. This lesson is

about when patients are not ready, in their minds, to be discharged, but from a physical therapy prognosis and objective standpoint, they are ready. In this scenario, you will need to make sure your communication is excellent and that you explain why now is the appropriate time for the discharge.

We never want a patient to feel like they were abandoned. Secondly, we never want a patient to feel unheard. Third, we never want the patient to NOT know they have been discharged and think that you just stopped showing up. So plan, listen, and communicate well.

In the next lesson, the patient is ready and so are you. Let's review the essentials of the discharge visit for the HH PT.

Discharge Visit Essentials

If there is no evidence to support continuing skilled home physical therapy, it is time to discharge the patient – even if you have additional visits left in the physical therapy plan of care and/or other stakeholders are asking for you to continue.

When the time has come to discharge your patient, they need to be independent ("teach back") with their personalized, HEP, at a minimum. If they are not, you will have to get to the bottom of why that is and if they are ready for discharge. All patients and/or caregivers must be independent with their HEP at or before discharge. Some patients will improve and some will not; however, all must be independent with their HEP at discharge.

Goals should be met with the easier coming first, then the more challenging later, throughout the plan of care. I can't stress this enough: spontaneous recoveries will not be reimbursed and should

not happen. For reference, a spontaneous recovery is when the patient has not met any goals, but at the end of care, all of the goals are recorded as met.

You must document in the clinical discharge note who the patient will be discharged to by obtaining this information before or at the discharge visit. In home health, patients are discharged to self, family, and, sometimes, they are discharged to their physician for medical follow-up or to a power of attorney.

The patient must acknowledge (and hopefully, agree with) the discharge. This must be articulated in the clinical discharge note. In the clinical discharge note, you must include any recommendations that the home health patient or caregivers must continue to implement after discharge. An example statement is: The patient agrees to perform his HEP daily and to follow-up with his primary care physician as needed and to always use his rolling walker when up walking.

At discharge at Ayuda, we give our patients a magnet "gold medal." It says, "Congratulations! You have successfully completed home health therapy!" It costs less than a quarter, and allows us to turn the final session into a celebration.

At discharge, I tell all of my patients that they can call me anytime, if they have any physical therapy-related questions they need answered. I have received a few early morning and late night calls, but I strive to go above and beyond for my patients. I bet you do, too!

Finally, care coordination must happen as well. Inform your clinical manager, the referring physician, and RN case manager that you are discharging your patient.

Companion Course

Access Ayuda's goal medal that every patient receives at discharge – See chapter 8.

Top Reasons for Discharge

According to Medicare, the home health agency can only discharge patients for the following reasons:

- When the patient has met the maximum rehabilitation potential
- When the home health agency can no longer meet the patient's needs, based on the patient's health status and severity of condition
- When the patient or payer can no longer pay for the services provided by the HHA
- When the physician and home health agency decide that the patient no longer needs home health services because the patient's health and safety has improved or stabilized adequately or the patient is noncompliant
- When the patient and/or family refuse home health services or choose to be transferred or discharged
- When the patient moves out of a geographic area
- When the patient is not home/not found
- Failure to maintain the services of a referring physician
- No physician order to continue treatment/services
- When a patient dies [1]

There are patients referred to home health for physical therapy, however, they only need one skilled PT visit. In the next lesson, I will share tips on how to manage this scenario.

Valuable Tips for Safety and Success for the 1w1

The 1w1 is the evaluation and discharge, all-in-one. During this type of visit, you must provide skilled physical therapy care, even if they are 1w1. Remember: regardless of frequency and duration, you have to provide skilled care every time you perform a visit as a HH PT.

You must have strong objective data to support the 1w1. For example, the patient scores six seconds on the Timed Up and Go, which puts her at no fall risk measurement. Or you have a patient who has 5/5 lower extremity and upper extremity strength per manual muscle strength testing and does not have pain or use an assistive device to ambulate.

The patient must be independent with the HEP that you have prescribed and explained, even if they are 1w1. If they are not independent with the HEP, please continue to work with them until they are. Remember from the previous lesson, you have a maximum of three skilled PT visits to teach your patient a "progressed, maintenance HEP."

The patient must have at least one goal to meet, even if they are 1w1. You cannot create a plan of care without including a goal.

You must do everything in this visit as you would if you were planning to see them more than once. For instance, perform the home safety assessment and perform skilled teaching and interventions.

Make sure that the patient is aware that you will not be returning. It is an evaluation-only scenario. Make sure all safety and mobility recommendations are understood by the patient and/or caregiver. Ensure that the patient truly understands, by having them repeat to you, that they acknowledge that today is their last visit with you.

The 1w1 does happen, it's rare, but it is totally fine. Some people do not need more than one skilled home health physical therapy visit. Never let anyone make you see a patient longer than you believe skilled care is needed.

Last Clinician In – Do the DC OASIS!

With all Medicare patients, when you are the last home health clinician to perform the skilled, billable visit: you are responsible for the DC OASIS.

We have covered a lot so far. In the next chapter, I will introduce you to clinical documentation for the home health physical therapist.

NOTES

9 CLINICAL DOCUMENTATION

In this chapter, I will be covering everything related to clinical documentation for the home health physical therapist. This will help you avoid mistakes, save time, and demonstrate excellence in clinical note planning, creating, and reviewing.

Write Professionally

When you write, make sure to use correct grammar, punctuation, and spelling. Don't over use abbreviations. You are a professional and must think, speak, and act like one. Your documentation is a reflection of the service you provide, so it's important to take the time to do it right.

Document Well or Your Patient Will Suffer

Payers are always working to determine if money is well-spent. They perform frequent cost-benefit analyses – is the skilled care worth it? When a payer reads your notes and CAN NOT easily see that the patient is benefitting from your services (not skilled, patient is not progressing, care doesn't appear to remain reasonable and necessary, etc.), the payer will stop authorization and payment. During every visit, you must document well or your patient will suffer and the care provided may go uncompensated. You do your patient a disservice by creating subpar clinical notes.

Top Tip

After you have completed your clinical note, take two minutes to review it before you submit it. This will give you the opportunity to make modifications and improvements so each note is excellent, reimbursable, and defensible when it is audited.

Deposition and Witness

Over the years, I have had to give depositions and served as a witness in a trial relating to care I provided a patient. I was not at fault in any way, however, the primary evidence of my testimony came from my clinical notes. If they were full of errors or inconsistencies, something negative could have happened to me. Make sure you take the time to create excellent clinical documentation or you, too, could suffer.

Start Documenting in the Home

Start all clinical documentation in your patient's home. This will be key to your success. Work diligently to document as much as you can in the patient's home. If you cannot complete the note in the home, you have the opportunity to finish it in the car before you move on to the next patient. If you do any documentation in the car, be mindful of your safety and, of course, your posture.

If you do not get all or most of your clinical documentation done in the patient's home or in your car, you will have to do it once you get home. Some Ayuda teammates do all clinical notes at home. I never recommend this, because you end up feeling as though

you're always working. Strive to finish before you return home. This will improve your quality of life. Also, the information about the visit will be fresher and more likely accurate.

Get your mind focused and make a commitment at the start of the day by saying, "I will start and get all notes done before I get home today." Yes, you can!

Progression: Goals Must Be Achieved to Continue

Ideally, your home health patient should meet at least one goal every one or two skilled treatment sessions. This shows progression/improvement, which is a Medicare "Improvement Standard" requirement, and is then reimbursed by Medicare and other third-party payers.

If two visits have gone by without your patient meeting one goal, you may have set the goals too high, the patient may not be tolerating therapy well, or there may be a compliance issue. Third-party payers will not continue paying if there is a lack of progression or the patient is not compliant. If your patient is not tolerating therapy well and/or is plateauing, contact your clinical manager and the referring physician to discuss the plan of action and next steps.

Top Tip

If your patient is not progressing toward their established goals, your documentation must address the barrier(s)/change(s) and what you plan to do about it.

Documenting Frequency and Duration – Overview

Below is the format I use to write the home health frequency and duration. The frequency and duration is written in the PT evaluation note and is included in the patient home health plan of care. I find this to be the simplest method to write the frequency and duration.

1w1 – One visit per week for one week

2w2 – Two visits per week for two weeks

3w3 – Three visits per week for three weeks

1w1; 2w2 – One visit per week for one week and two visits per week for two weeks

3w3; 2w1 – Three visits per week for three weeks and two visits per week for one week

5w1; 3w1; 2w1 – Five visits per week for one week, three visits per week for one week and two visits per week for one week

Here is another, similar way (although a bit more complex) to write frequency and duration for the home health patient. You may see both.

3/wk. x 4 wks.; 2/wk. x 3 wks.; 2/wk. x 1 wk.

Companion Course

Test your skills to correctly identify frequency and duration in home health - See chapter 9.

Documenting Goals – Overview

Every home health patient should receive at least one to two goals, regardless of whether you see them once or multiple times. You will document the goals in the physical therapy evaluation, which will be added to the patient's plan of care. Ideally, the patient's goals should be met by discharge. The following are six key points to focus on when writing goals for the home health patient:

1. All goals must have an end date (for example, "To be met by [date].").
2. In your plan of care, always include a standardized objective measurement tool, such as "Timed Up and Go" or "Modified Functional Reach" (for example, the patient will score < 14 seconds on the TUG to reduce risk for falls by [date].).
3. If you discharge your patient on the initial visit, they still must have a goal, and it should be met on that date. Patients that refuse/decline care beyond the initial visit may not meet some or all goals.
4. Keep goal volume to a minimum. I recommend five to eight goals.
5. The gait distance in home health must relate specifically to each patient's unique functional needs. That said, if your patient needs to walk 50 feet to get to the bathroom or 250 feet to get down the stairs and to the curb to get into a vehicle to get to medical appointments, that should be the gait distance you choose.

6. All goals must be SMART:
    a. Specific/Person-Centered
    b. Measurable/Clear and Concise
    c. Achievable/Attainable (but challenging)
    d. Realistic
    e. Time Limited

Because Medicare expects functional progression/improvement (not including maintenance therapy) to occur throughout the plan of care, it is ideal for your patient to be meeting goals throughout the plan of care. There should never be spontaneous recoveries. You must use evidence-based care to drive successful outcomes.

Top Tip

Always include a patient-stated goal (exactly what they say to you) in your plan of care. For example, "I want to be able to walk up and down my stairs by myself so I can sleep in my own bed."

Best Clinical Documentation Tips

These important principles relate to creating clinical documentation in home health:

- Strive to complete and submit all clinical notes and clinical documents in a timely manner. Best practice is within 24 hours from when the visit was performed.

- The clinical note is considered a legal document. It is subject to all federal and state laws, and any and all medical record laws.
- Your clinical documentation must show your care is reasonable and necessary, and the evidence must justify a skilled need.
- Be concise, truthful, and tell a story about how you are adding value and providing skilled care to your patient and/or caregiver.
- Your interventions must connect to the patient's impairments and functional deficits, which then connect to the patient's outcomes and goals.
- The physical therapy evaluation, the most critical component of documentation, must support and justify the need for skilled PT services.
- In each clinical note, you must document the patient's homebound status.
- In each clinical note, you must capture your patient or authorized person's signature and date of service.
- In each clinical note, you must sign your complete name with your professional credentials and date of service.
- Your clinical documentation directly impacts the bottom line at your home health agency. Sloppiness could put the viability of the company in jeopardy and your license on the line.
- Document consistently for all patients regardless of third-party payer.

- Obtain and document that consent was obtained in the initial evaluation.
- You must document the "time in" and "time out" for each note.

Be Aware

I work with an agency that does not require signatures. I still obtain them and I recommend that you do, too. The signature is the confirmation and verification that you performed the skilled visit. Never leave a home without it.

In the next chapter, I will introduce you to being in the patient's home.

NOTES

10 BEING IN THE PATIENT'S HOME

Your patient's home is like their hospital room. It's the clinical setting for the patient and the home health physical therapist (HH PT), and therefore it's where you will create the most value in their life. But it's also the patient's personal, private space filled with their most treasured belongings. The goal of this chapter is to provide an overview of proven methods to make the home health experience for your patient exceptional and what to expect when in your patient's home. Additionally, you will find strategies on how to provide the most conscientious, effective, patient-centered care to your patient while in their home.

Not All Homes Are Equal

You are likely to work with people from a wide range of socioeconomic, cultural, and educational backgrounds. Every home will be different, and most homes are probably very different from your home. Expect the unexpected, be creative and industrious, and stay safe.

First, Serve Your Patient's Needs

Sometimes patients want to be seen at particular times and on particular days. Try to be accepting and accommodate this when possible. My experience has been that after you provide care on

their schedule, most patients become more flexible with scheduling future times and days. Essential Principle: The Law of Reciprocity. In social psychology, reciprocity is a social rule that says we should repay, in kind, what another person has provided us. [1] People give back the kind of treatment they have received from you. Take care of your patients first, and they'll take care of you.

Knock, Knock

Sometimes patients don't have working phones or doorbells. When I started, I quickly learned to knock on windows if I didn't get a response at the door or on the phone. If you're waiting more than one minute without success, knock on the window.

Patient Home Etiquette

Respect your patient's home. One proven way to do this is to offer to take off your shoes when you enter your patient's home. Bring house slippers if you do not want to walk around in your socks. Likewise, be respectful of their space and belongings; it is helpful to remember that you are a guest in someone else's home.

Companion Course

Access a short video on what I think is the best footwear for the home health clinician – See chapter 10.

The Bag Technique in 6 Steps

In this lesson, you will learn how to safely manage and handle your home health physical therapy bag with the primary aim of preventing the transfer of microorganisms that can potentially cause infection[2 & 3]

The bag technique is a step-by-step process that needs to be performed each and every treatment session. Some home health agencies teach it a little differently than others. Don't worry, the principles remain the same – use the "Bag" technique every treatment session. Follow these steps.

Step 1

At the beginning of the session, place your home health PT bag on disposable under-pads (Chux) on an elevated surface. This keeps the bag clean and not contaminated.

Step 2

Wash and dry your hands. This is the single most effective way to prevent infection.

Step 3

Place clean items needed to provide care on disposable under-pads (Chux) lining surface. This keeps clean items from becoming contaminated.

Step 4

Perform the skilled physical therapy care.

Step 5

After skilled care is over, clean all tools with disinfectant wipes that were in direct patient contact. Put cleaned items back into clean Ziploc baggies. Put anything that is dirty and that you will not clean in dirty plastic baggies. Fold up the disposable under-pads (Chux) and put it in the dirty section of your home health PT bag.

Step 6

Lastly, clean your hands. [2 & 3]

Mission complete!

Companion Course

Access a short, step-by-step visual presentation on how to perform the bag technique – See chapter 10.

Know Thy Name

Always confirm what the patient would like to be called: Mrs. Smith, Harriett, Mr. Washington, etc. This knowledge is vital in providing excellent customer service, being respectful, and building trust. It is equally important to make sure your patient knows your name! Use a mnemonic device to ensure that your patients never forget your name. I use a well-known nursery rhyme: "I'm Peter, Peter, Pumpkin Eater." Is there a mnemonic device for your name?

One Mouth and Two Ears

The famous philosopher Epictetus said, "We have two ears and one mouth so that we can listen twice as much as we speak." I believe that it is our responsibility and duty to listen more than we speak. The more we listen, the more we can help our patients.

Everyone Is Unique

Consider the patient's ability to understand and retain the information you are giving them. Whenever possible, include the caregiver(s)

in the PT care plan, and address different learning styles (auditory, visual, and kinesthetic). Understanding patient and caregiver learning preferences will give you greater potential to create value and be a more effective HH PT.

It's About Them, Not You

Focus on your patient's needs, goals, dreams, and quality of life. I have had patients describe clinical providers venting, complaining, and disclosing family and personal issues. This causes stress and discord during the treatment sessions. Leave your personal problems at home and bring helpful words, positive energy, enthusiasm, and useful teachings to your patients' lives. It's about the patient, not about you.

Be Careful in the Home

Be extremely careful when you are in your patient's home. If there are any strange odors like chemicals, pesticides, smoke, gas, or anything that you feel is hazardous to your health or any illegal activity going on in a patient's home, you need to let the patient know that you have to leave. Once you are in a safe environment, immediately contact your clinical manager to discuss next steps.

If you prefer to avoid pets like dogs or cats, please kindly ask your patients or family members to move them to another room. If they do not and you feel you are in harm's way, please leave and contact your clinical manager to discuss options.

Double check structures (chair, table, couch, bed, etc.) to make sure that they are reliable enough to use during the treatment session. Work hard not to damage your patient's personal property. Accidents happen, but are less likely when you stay focused and aware.

"Above and Beyond" Missions

A small percentage of patients will need help "above and beyond" what a home health PT normally provides due to lack of caregivers or family members to help. These are a few of the "above and beyond" tasks that I have performed to help my beloved patients out:

- Take out the garbage
- Change light bulbs
- Sweep clutter out of transportation path
- Move/rearrange furniture
- Wash dishes
- Bring a glass of water or food
- Empty the commode
- Bring in mail

I named my company Ayuda, which means "to help" in Spanish. Being a home health PT allows me to do this each and every day, and I'm thankful.

Hands into Fists

> *"The model for the application of your principles is the boxer rather than the gladiator. The gladiator puts down or takes up the sword he uses, but the boxer always has his hands and needs only to clinch them into fists."*
>
> - Marcus Aurelius

I believe that the home health physical therapist is more like the boxer than the gladiator. Some therapists become dependent on the use of therapeutic props, tools, and toys to perform care. But in home health, your hands, imagination, and creativity reign supreme. In home health, you do not have access to the commonly used accessories and equipment found in the clinic.

In my opinion, this keeps you astute, innovative, and adaptable. Every day, the HH PT is required to be creative for simple things like finding the best and safest surface to provide care or how to adapt a piece of furniture or living space to enhance safety and functional mobility. Every home is different.

Another reality for the HH PT is you must only carry the most essential props and tools into the patient's home. That said, you must use your imagination and creativity to find things in the patient's home to use to provide care. For example, I have used frozen veggies for cryotherapy, cans of soup for progressive resistance exercises, a broomstick for a cane, pillows for unstable surface balance training, and more.

Love: Weekends Are for Family

When you work weekends, expect more family members to be present in the home. Embrace this and get the family members involved in the patient's care. Plan to teach everyone in the home your patient's home exercise program and ways to help them thrive. Your patients will need all the help they can get and family are most often the best helpers!

Pain Management: Call Before You Go

With all patients who have significant pain challenges, I recommend that you give them a call 45-60 minutes before the skilled session. This warning is vital and allows them the extra time to take their pain medications before you bring the pain! They will appreciate you much more and be able to tolerate and progress more because of it.

Respect the Hours of Operation

Do not contact your patients too early or late. Think about a good cut-off time for contacting your patients in the morning and evening. My cut-off time is after 7 p.m. and before 8 a.m. Please be respectful of your patients' time and do your best to be a positive, motivating force in their lives. You are only in their lives for a short period of time, so always be a fresh dose of inspiration so they can continue to heal.

Positive Patient Testimonial

If your patient verbalizes that they are satisfied with your service and offers to call or write your manager, take them up on it.

Top three tools your patient can use to communicate their positive experience:

1. Phone call to your manager.
2. Email or written letter to your manager.
3. Written testimonial on a customer experience platform like Google +, Yelp, Twitter, or your company's Facebook page.

I would softly suggest that they can provide a review, if the patient initiates and says that they want to provide one. Make sure you have contact information and options ready so you can tell them where to send the testimonial.

In the next chapter, you will discover some special scenarios that happen in home health. This chapter will help you get more prepared to hit the ground running in your first job or clinical affiliation in home health.

NOTES

11 SPECIAL SCENARIOS

This chapter shares a variety of real-life home health scenarios. These lessons will help you identify and work through opportunities, problems, interruptions, and abnormal conditions that will occasionally pop up in home health.

Withhold Exercise!

Before you start working with your patient, if they have the following signs and symptoms, you must withhold treatment and immediately start care coordination to devise a course of action. It is inappropriate to treat a medically unstable patient. Exercise should be withheld when the following is present:

- Resting heart rate >100
- Hypertensive blood pressure (systolic >160 mm Hg, diastolic >90 mm Hg)
- Hypotensive resting blood pressure (systolic <80 mm Hg)
- MI or extension of infarction within the previous two days
- Ventricular ectopy at rest
- Atrial fibrillation with rapid ventricular response at rest (>100 bpm)

- Uncontrolled metabolic diseases like diabetes
- Psychosis or other unstable psychological condition. [1]

With the above signs, symptoms, and conditions, your patient is unstable and medical care must precede home health physical therapy. Follow your home health agency's policy and procedures, act swiftly, and get your patient the medical care that is needed. In addition, if one or more of the above symptoms are present in your patient, you are required to initiate a call to the RN case manager and referring physician to report abnormal findings.

Terminate Exercise!

When you are working with your patient, exercise should be terminated if the following occur:

- Increase in systolic pressure of 20 mm Hg or more
- Decrease in diastolic pressure of 20 mm Hg or more
- Heart rate increase or decrease by more than 20 beats per minute
- Severe dyspnea or paradoxical breathing
- Dizziness
- Excessive sweating
- Patient report of feeling faint. [2]

If your patient suffers from any of these abnormal clinical signs or symptoms when you are working with them, you must follow your home health agency's policy and procedures and act swiftly. If one or more of these signs are assessed, you are required to initiate

a call to the RN case manager and referring physician to report abnormal findings.

Always be prepared and willing to call 911. Stay aware and focused. Your patients are depending on you.

Patient Plateau

You and I got into this business to help our patients. We all want each one of our patients to reach their maximum level of function possible and get well again. This is the ideal world, but sometimes it does not happen. The expectation in home health is that throughout the physical therapy plan of care, our patients are steadily making functional gains and meeting their goals. When you identify that your patient has plateaued and is at his/her maximum physical therapy rehab potential in their home, you must discharge them.

3 Examples of What Patient Plateau May Look Like

- Two or more sessions, back-to-back, without making functional progression(s)
- The patient has returned to their prior level of function
- Majority of goals have been met; however, they will not be able to meet the others in a reasonable timeframe and working to achieve more advanced goals could put their safety at risk

For example, Mrs. Smith is an 88-year-old female who lives with her 92-year-old husband. Her prior level of function was ambulation with a single point cane. She has a history of falls. You have two gait goals for Mrs. Smith: one is independent with a rolling walker, and the other is independent with a single point cane. In eight visits, the

patient is now independent and safe with her rolling walker but has not started gait training with single point cane. It may take another eight visits to get her possibly safe and independent with a single point cane.

What would you recommend for this patient? 1. Continue with skilled physical therapy to work on progressing her to a single point cane? If so, why? 2. Discharge Mrs. Smith with the recommendation to continue using the rolling walker? If so, why?

Companion Course

Access data on what other PTs think is the right choice for Mrs. Smith – See chapter 11.

In the next lesson, we will move away from patient plateau and into learning about patient noncompliance and "not fully participating." Both are special scenarios that occur in home health.

Not Fully Participating and Noncompliance

Home health patients must be compliant with their physical therapy plan of care to continue to receive services. Not fully participating is different than noncompliance. Here is an example of an entry in a clinical note to demonstrate compliance: *The patient was cooperative, motivated, and participatory with all physical therapy functional activities in sitting and standing and during all gait training activities today. Additionally, she reports doing her HEP daily as prescribed and implementing all home safety recommendations.*

A patient might not be fully participating in the day's session due to having a bad night's sleep, high pain levels, nausea and vomiting,

or any other reason that can make someone not feel well. This happens and is okay. In this a, 'not fully participating' scenario, don't call or document patient noncompliance. Do as much as you can in that session with the goal of progression, but be compassionate and empathetic.

Conversely, when patients are consistently not motivated or refusing treatment, you must seriously consider revisiting the plan of care and make a care coordination call to the referring physician to put it on his/her radar.

Take all reasonable steps to resolve noncompliance issues prior to discharging a patient. For example: 1. describe why home health PT is medically necessary; 2. remind them that their physician ordered home health PT; 3. remind them of their goals; 4. explain what progress will look like for them; 5. talk with caregivers to see if they have any tips or strategies to promote compliance.

Your patients will have good days and bad. Don't overreact when they say they have not been able to do exactly as you prescribed (for example, a patient did not do his HEP three times but did it once or a patient declines the stairs one day because she is too fatigued).

Now you know what not fully participating and noncompliance look like and what to do when you experience either of these scenarios. In the next lesson, we will address the special scenario of when a patient is not available for a planned treatment session and what you must do.

Missed Visit Essentials

A missed visit is a clinical note that is part of the medical record. A missed visit is when a skilled home health visit does not occur within

a specific time, within a home health clinician's plan of care. A missed visit is a special scenario and should be very rare. Importantly, a missed visit is a patient-centered occurrence and cannot be due to a therapist's schedule or a therapist's personal needs.

Acceptable reasons for a missed visit:

- Not home/no answer for pre-scheduled skilled physical therapy session
- Patient hospitalized
- Patient has a medical appointment
- Family emergency/personal reasons of the patient
- Patient is ill/sick
- Other – specific, patient-centered circumstances

The home health industry is open seven days a week, and each home health agency must have the appropriate staff to service all patients each and every day. I say this to point out that if you are not available on a certain day, your patient should not suffer and still needs to receive care. A simple solution is for you or your employer to find a PT or PTA teammate to see your patient in your place.

Three "Must-Do" Tips When Processing a Missed Visit

1. Always document what happened (why the skilled visit did not happen; patient-centered circumstance)
2. Always call the RN case manager or home health agency representative to communicate the missed visit and document this communication in the missed visit note

3. Always notify the referring physician to communicate the missed visit and document this communication in the missed visit note

All of the above are essential in processing a missed visit. Get clarification from your HHA on their policies and procedures on how to further process a missed visit.

Companion Course

See a few sample missed visits notes – See chapter 11.

Too Many Missed Visits = Red Flag

If your patient starts having multiple missed visits (>1), this should raise a red flag. Every now and again, you may get patients who have valid reasons for a missed visit. You must know that all stakeholders are monitoring patient compliance and your productivity, and working to ensure that all care provided is skilled, reasonable, and necessary. If your patient starts having too many missed visits (>1), it puts each of these variables at risk.

During your interview, ask the top-tier HHA what their policy is on missed visits to gain insight on their expectations and learn what your responsibility would be as an employee.

Stick to the Plan of Care!

The plan of care must be followed, no exceptions. All visits requested and authorized in the physical therapy plan of care must be accounted for.

Case Story

Let's say your frequency and duration for Mrs. Newcomer is 3w3. This means that you plan to see her three times for three weeks. In the first week, you perform an evaluation and two routine visits. All is well. You have followed your physical therapy plan of care so far. But the following week you are only able to perform two routine skilled visits because she is not available any other day that week due to doctor's appointments.

In this scenario, to complete the plan of care, you must process a missed visit for this week to tally three visits (two routine and one missed visit). Not completing a missed visit would raise a red flag, and this patient's medical record would be out of compliance.

Companion Course

Access a few PT POCs and identify which one is correct.

In the next lesson, I will teach you the important steps you need to take when the home health patient is sent to the hospital.

The 5 Steps to Take When Your Patient is Hospitalized

Step 1

You must be like Sherlock Holmes and obtain as much information on what happened.

Get this info:

- Name of the person you spoke with who reported the hospitalization (patient's spouse, patient's caregiver, etc.).
- Which hospital did the patient go to?
- Why did the patient go to the hospital (fall, shortness of breath, pain, chest pain, etc.)?
- When did the patient go (today at 5 p.m., last night at 9 p.m., etc.)?
- How did the patient get there (ambulance, bus, taxi, family transport, etc.)?

Step 2:

Call your clinical manager, the RN case manager, and referring physician to report the hospitalization, including all of the data you gathered in Step 1.

Step 3

Document a missed visit or communication note in the medical record (depends on your home health agency's policy) including all of the data you gathered in Step 1.

Step 4

Remove all future visits from your schedule and consider this patient on "hospital hold." Your home health agency will have a specific protocol for hospitalized patients. Follow it and wait for the patient to return (as they sometimes do).

Step 5

If your Medicare patient is admitted to an inpatient facility, not returning to resume home health services and you were the last clinician to perform a skilled and billable visit, you are then responsible for completing the DC OASIS.

Accountability Activity:

Ask yourself these questions when your patient is hospitalized:

1. Was the patient's hospitalization avoidable/preventable?
2. Could I have done anything different?
3. What will I do differently next time?

Take time to reflect on these questions. Stay vigilant and remember that our home health patients are counting on us to help them. Let's never let them down. Now that you understand what to do in the event of a hospitalization, you will learn the difference between a patient being admitted to an inpatient facility and being in observation – and why this even matters.

Admitted to Inpatient or in Observation?

Our primary goal as home health physical therapists is to keep our patients out of the hospital. But sometimes, they do go back because of reasons out of our control (unfortunate, but necessary). When a patient goes into the hospital/inpatient facility, they are either "admitted" to an inpatient facility or "in observation" care (not admitted, emergency care). Let's examine both because they are different.

“Admitted” to an Inpatient Facility

This happens when your patient is:

- Admitted to the inpatient facility (not waiting in the ER being examined, not on observation bed in ER)
- Residing in an inpatient facility (admitted) for 24 hours or longer (does not include time spent in ER)
- Admitted for reasons other than diagnostic testing only and receiving treatment [3]

In “Observation” care (not admitted, emergency care)

This happens when your patient is:

- In observation care and not admitted
- In the ER, on observation bed in ER
- In observation care only (for as long as needed) receiving only diagnostic testing and no treatment. [3]

You must clarify and confirm if your patient was in observation or admitted to an inpatient facility. This is the crucial information you must obtain, because if your patient is admitted to an inpatient facility and they are discharged home, the HHA will have to obtain new home health orders and create a new plan of care (POC). If they are in observation only, and you have orders to get back in, you DO NOT have to create a new POC, but CAN proceed with your initial POC.

Case Misstep

I once had a patient who was in observation and not admitted. I mistakenly did a physical therapy evaluation, which was incorrect. I should have done a routine visit and continued with the initial POC. I had to delete the PT evaluation and do the correct routine visit note. I wasted precious time because I did not confirm the patient's hospitalization status before I completed the clinical note.

Companion Course

Access a short quiz to see if you can accurately answer if the patient was admitted or in observation – See chapter 11.

In the next two lessons, I will conclude the chapter by providing an introduction to the two different types of reassessment clinical notes required for home health and best practice tips to stay compliant.

30-Day Reassessment – Overview

This special type of visit and clinical note is called the 30-day reassessment. This reassessment is a requirement for all home health therapists (PT, OT, and SLP). The Centers for Medicare and Medicaid Services (CMS) require reassessment to be performed at least once every 30 days. [4] During the visit, you are reassessing the patient with the goal of showing evidence that the care up to this point has been skilled, reasonable, and necessary, and that the patient has shown skilled functional progression and achieved

some short and long-term goal(s). At this point in the care plan, you must also make the case for why skilled care remains reasonable and necessary beyond the reassessment date. Analyze what goals have and have not been achieved since the initial visit, and how you plan to get the patient to achieve them, and, finally describe the patient's PT prognosis and the interventions you plan to implement to continue progressing the patient.

The 30 days start counting from your initial visit [4] CMS clarifies: "at least every 30 days a qualified therapist (instead of an assistant) must provide the needed therapy service and functional reassessment of the patient." [4] I advise my team to perform the reassessment between the 21st and 28th day to prevent missing it.

Suppose that it is the 28th day, and you have a scheduled visit. On this visit, because it is the closest visit to the 30th day from the evaluation, you must perform the 30-day reassessment.

Extension: Request to Continue Skilled Care – Overview

This special scenario exists when the physical therapy plan of care comes to the last visit, the initially planned discharge visit date. However, at this time and in your opinion, the patient is not appropriate or ready for discharge due to the patient not responding to the PT interventions as expected and/or there has been an unanticipated change in the patient's status. So your plan is to extend care, by documenting a reassessment to request additional skilled home PT visits.

An example of this scenario is: you are at your patient's last visit, they are not yet safe in their home, remain a fall risk, and are not at their prior level of function. You identify that continued skilled home

physical therapy remains reasonable and necessary at this point and into the near future.

Your clinical documentation up to this point must show that your patient's PT prognosis is good to excellent, some goals have been met but not all, he/she is not yet safe in his/her home, and that the patient is 100% motivated and compliant and verbalizes a commitment to continue to work to make functional gains. When all of these variables are true, you have the option to request "an extension" to change/update the patient's PT POC with the goal of obtaining authorization (new prescription from the referring physician) for more skilled visits to getting them to their highest level of function and safety achievable.

Companion Course

Access step-by-step presentation on how to process an extension request – See chapter 11.

Now that you are aware of many special scenarios found in home health, I will share everything I know about how to increase your efficiency, productivity, and how to optimize your success as a HH PT.

NOTES

12 BEING THE BEST HOME HEALTH PT

In this chapter, you will discover some top productivity and efficiency hacks that I have learned over the years and that help me boost my performance to this day! Also, I will share a few proven tips on how to be an irreplaceable home health physical therapist and teammate. The goal of the chapter is to save you time, improve your efficiency and productivity, and introduce you to a few ideas and tools to help you optimize success in home health.

Start Early

I recommend starting your days off as early as possible for four simple reasons: 1. you will beat the morning rush; 2. most people are more productive in the mornings; 3. the home health patients I work with prefer morning and afternoon visits, not evening; 4. you will get home earlier.

If you can see three patients by noon, you are doing good. If you have seen four by noon, you are doing great. My goal is to try to complete four visits by noon, so I strive to start at 8 a.m. Remember, I'm doing urban home health (decreased travel times compared to rural home health). Most of my home health patients prefer to be seen between 10 a.m. and 2 p.m., so when you find patients willing to start early, get them scheduled.

Set a Timer When Completing Notes

When you are completing your clinical notes at home or in the car, I recommend setting a timer/stopwatch for 10 minutes. The timer will keep you focused and aware of how much time you're spending finishing your clinical notes. I believe that most people work more efficiently when there's a clock counting down to a deadline. Try it. It may help you.

One Proven Way to Help Your Team Win

Keep your manager aware of your availability to accept new patient referrals. Do this as far in advance as you can project – not on the day of. This will create a win-win for you and your employer. Staffing a new patient referral is one of the most challenging, important, and time-sensitive functions in the operation of a HHA. Letting your manager know when you do and don't have openings in your schedule helps them staff patients more efficiently. Sharing your availability prevents backlogs and delays for patient staffing. Increased efficiency also positively affects patient safety and wellbeing because home health clinicians get to them faster.

Clear and frequent communication with your manager also keeps you on track to hit your productivity targets. If you practice this strategy, I am certain that you will stay busy, your employer will appreciate you, and you will be able to help more patients. A win-win-win!

Staffing Inquiries: ASAP!

Respond to all inquiries about accepting new patient referrals immediately when it is safe and appropriate (obviously not in the

middle of gait or stair training). As stated in the last lesson, staffing new patient referrals is one of the most time-sensitive and important aspects of home health. If you take too long, the HHA could lose the referral and the patient may suffer.

Overview of Patient Scheduling

Effective patient scheduling is one of the most important ways to succeed as a home health physical therapist. When you schedule well, you increase your productivity and save valuable time, and your patients get the most out of the skilled physical therapy care you are providing. Effective patient scheduling is an art and science. In the next lesson, I will describe the top six patient-centered, best practice scheduling strategies for this industry.

Six Proven Scheduling Strategies That Work!

The following six tips will help you optimize success with patient scheduling:

1. **Effective patient scheduling involves prioritizing the patient's needs before your own.** If your patient needs a visit and it happens to be the weekend, put them on the weekend schedule. Skilled care must continue regardless of your personal schedule so that your patient's health does not suffer. Your employer should have the resources in place to provide home health services 7 days a week.
2. **When you are working with your patient to schedule a visit time, ask, "Is there a time that doesn't work for you to have PT?"** Once you know the times that "do work" and that "work well' with their schedule, you can select one. This will definitely help

schedule your visits in a patient-centered manner by focusing on the patient's needs first.

3. **Schedule your patient out until discharge.** For example, if you know you will see your patient 3w3 at the initial visit, schedule the days and times up to the discharge date. Then, make sure you immediately add the times and visit dates to your paper or cloud-based calendar so that you stay organized and do not double book or make an error. Most patients love to know the days and times of their treatment sessions in advance. This control over their schedule during this challenging time is a very important variable that promotes well-being and quality of life.
4. **Write down your scheduled visits (time and date) on paper and give it to your patient**. I attach a patient-scheduling calendar to each patient's written HEP to keep him/her aware of the scheduled visits.
5. **When you schedule, give your patients a minimum one-hour range to arrive.** For example, "I'll be there on Mondays, Wednesdays, and Fridays between noon and 1 p.m." This gives you a buffer for things that may slow you down during your commute. I like to explain that you need this one-hour range because of the nature of your job. I say, "I need to give this range because I work with very sick people and sometimes they need extra time and care." Once I make this factual statement, patients understand and accept the time range.
6. **Always call your patient before you go to their home.** I have saved so much time by doing this. There will be times when you have a visit scheduled but something changes. So when you call and then find out that they are now not available, you will not waste your time and can modify your schedule.

Stay committed to these proven strategies, and you will save time and optimize your success as a HH PT.

Your Vehicle Matters

I know home health therapists who take public transportation and/or ride their bikes to patient visits. Ayuda currently has a PT who rides his bike and an OT who takes only public transportation. They make it work! However, this option will be limiting for the vast majority of home health professionals, and completely restricting for rural HH PTs. As a SPT, your clinical instructor (CI) will be in a vehicle, not on a bike or public transportation, so don't worry.

For me, having a car in home health is a must, but I don't recommend rolling up to your patients' homes in a Porsche SUV or S class Mercedes Benz. The best car for home health is a reliable, non-flashy, fuel-efficient, compact car. In my opinion, the best overall car for both urban and rural home health, is the Toyota Prius, for value, safety, size, and fuel efficiency. You do not have to go out and buy a new car to work in home health, but make sure your car is reliable and not too flashy.

Doing a Circle

Here is one of my top strategies for success: Make the farthest-away patient your first patient of the day, and the last patient closest to home. In practice, by implementing what I call "doing a circle" throughout the day, you will be making your way back toward home and not zig-zagging back and forth. This isn't always possible because you do not control where your patients live, but when you are able to schedule and pull-off "doing a circle," be thankful and know you are working at the most efficient level possible.

Companion Course

Access a visual of how "doing a circle" looks in practice.

Check the Weather

Do this before you leave home. Prepare for what mother nature has in store and you will have a productive and safe day.

Lunch

Pack and bring your lunch with you every day and always have some water with you to stay hydrated. This will save you a ton of time and money as compared to someone who has to find and pay for food every day – you will also end up eating healthier. No, I'm not your dad, but I do care about your well-being. Pack your lunch!

Set Daily Goals and Achieve Them!

Setting daily goals is the single best way to boost your productivity and make your dreams become reality. Each morning, I like to write my top daily goals for the day on a notecard, which I carry around with me during the day. Throughout the day, I review it and make updates. If I do well, by the end of the day I have achieved all of my goals.

Here are my two favorite tips to help me achieve my productivity goals.

First, tell yourself, repeatedly, that you are going to hit your productivity goal. As Napoleon Hill famously said, "Whatever the

mind can conceive and believe, it can achieve." An example of this would be to start the day off by saying to yourself, "I will see all of my scheduled patients, provide them with excellent care, be a safe driver, and get home in time for dinner."

Second, schedule your patients out at least a day in advance. Minimize ad hoc. I use Google maps to plan my routes, I implement "doing a circle," and my patients know when our scheduled visit will occur so they are ready when I arrive.

Get Full and Build a Buffer

It is your responsibility to fill up your caseload and weekly schedule with skilled, billable visits. You should have the ability to tell your boss, manager, supervisor, or director whether you can accept a new case or not. Your manager should ask you if you have availability, not force you to take cases over your capacity.

Getting full is an art and a science, and it is the process of building up a caseload to where you have enough patients to satisfy your needs. Getting full can be challenging to the novice HH PT due to discharges, readmissions, volatility of scheduling, mother nature, and a host of other issues.

Full-time PTs at Ayuda average six visits per day or 30 visits per week. So at Ayuda, the active patient range to be considered "full" is between 12-16 active patients. If you are full time and you focus on obtaining and maintaining this active patient range, you are more likely to consistently hit your productivity goals.

Equally important, you must build up a buffer of active patients. For example, let's say you want to have six visits per day over the next

five days so you can finish the week with 30 total visits. I recommend that you schedule seven visits on a minimum of three out of those five days. Why, you may ask? It is not uncommon in home health to encounter unplanned schedule changes like hospitalizations, unplanned appointments, and missed visits. If you do not build up a buffer of additional patient visits, you are sure to consistently fall short of your visit performance goals.

Be First

If you make a mistake, be the first one to address it, before the other party does. For example, you realize you forgot to complete a clinical note and it is now two days later. Contact your manager and let her know you forgot and will get it done shortly. Another example: you forgot to call the RN to report your discharge. Call before they call you and apologize, then give the report. If you are running late, call your patient before they call you. Be proactive and address potential issues before they manifest. Be first, not last.

Conflict and Equanimity

You are bound to run into conflict. It is part of life. Your character shows in how you choose to respond to conflict. Stay calm, embrace equanimity, and take five deep breaths before you act. Sleeping on it can be a good idea, too! Remember, there are always two sides to every story.

Create "Contacts," Save Face.

Once you have the correct phone numbers for all of your new patients, add them and their home address to your smartphone

right away. When they call you, you will recognize them, and you will know how to get to their home quicker because it's mapped in.

But the Physician Said...

Never, put your license on the line for anyone, including a physician. Quick story: I have had physicians ask me to provide additional care to a patient after they had met their maximum home physical therapy rehab potential and were recently discharged. I had to say no because it was not medically necessary or reasonable. They were not happy, but I knew it was the right thing to do. Even if a physician has made an order for home health PT, it does not automatically justify the medical necessity of physical therapy services. Protect your license and reputation at all times. As Warren Buffet wisely said, "It takes 20 years to build a reputation and five minutes to ruin it. If you think about that, you'll do things differently."

Password Lock All Devices

Make sure that your work-related smartphone, laptop, computer, tablet, data, etc. is always password-protected to maintain patient confidentiality and privacy.

Patient-Centered Scheduling and Optimized Rest

Give your patient time to recover and rest between visits. Do what is best for your patient, not what is best for you and your schedule. I have known therapists who cram in successive visits or space the visits out too far because it is convenient for their personal schedules. This is unacceptable and must be avoided at all costs. If unexpected conflicts arise in your schedule, let your clinical manager

know and they can have a colleague step in and assist with patient care. Always do what is right for your patient's safety and wellbeing.

Companion Course

Access a visual of what cramming and patient-centered scheduling looks like – See chapter 12.

Always Leave a Message

Don't just call and hang up before leaving a message. A message or voicemail is the best way for your patient to know and verify that you called. Leave a detailed message with questions, comments, and/or instructions. Be an excellent communicator and professional in all that you do. This will help your patients heal and give them peace of mind.

When leaving a message, remember to speak slowly and clearly, stating your name, phone number, and reason for the call.

Top Tip

Keep all patient information private. This includes all verbal and written (like texting and email) patient data. Follow all local, state, and federal guidelines and regulations on patient privacy.

Keep Track of Your Business

Always count your visit totals, reimbursements, perks, mileage totals, and benefits. Sometimes, mistakes happen with billing and payroll.

I'll share two brief stories to showcase the importance of reviewing all business information from your employer to ensure accuracy.

When I started working, I decided that I didn't need to check my paystub. I trusted my employer and thought they would be able to manage my payroll and ensure its accuracy. How wrong I was! I was paid per visit and the company missed multiple visits that I completed. The company also failed to include my work-related mileage reimbursement.

A home health teammate didn't check his pay-stub for almost two years. Little did he know, he chose the incorrect State and Federal deductions. He eventually had to pay back two years of unpaid taxes.

Mistakes do happen, and they are most likely not intentional or malicious. Stay focused, keep good records, and trust but verify. Learn from my experience – always check your pay stub!

"I Didn't Know" Is Never an Excuse!

Right now there are PTs who worked in home health who are locked up in the federal prison system because they made bad decisions. They have lost their physical therapy licenses, damaged their personal reputations, owe a lot of money in restitution, and hurt a lot of people. "I didn't know" will not prevent you from getting in trouble. Learn the rules and never break the law.

Here are a few ways in which the law can be broken:

- Receive or pay bribes and kickbacks to obtain patient referrals
- Falsify medical records to make patients appear sicker than they actually are

- Present false statements
- Unnecessary treatment
- Submitting false claims
- Falsely sign medical documents
- Obstruct justice

You get the picture. Always do the right thing. Remember, we got into this profession to help people, not hurt them.

APTA's Integrity in Practice

As a physical therapist, I am proud to say that the APTA has launched a campaign called the Integrity in Practice. The APTA website calls it "a comprehensive campaign to promote high quality care." It does this by helping PTs navigate complex regulations and payment systems and by making tools and resources available for PTs to encourage and promote evidence-based practice, ethics, professionalism, prevention of fraud, abuse, waste, and more. [1]

I am thankful that the APTA is leading the charge on these issues. Check out this program and enroll in the free ethics, professionalism, defensible documentation, fraud, waste and abuse and other continuing education courses offered to all licensed physical therapists.

Additional Reading:
www.integrity.apta.org/AboutUs/Campaign

APTA's Free Reducing Risk Courses:
www.apta.org/ReducingRisk/Courses

Ways to Be a Great Teammate

We all need help every now and again. The following behaviors and activities are proven ways to help your fellow physical therapist teammates out when they need assistance. It is a non-exhaustive list, but it should get you thinking!

- Respond in a timely manner to all inquiries
- Cover patients for your teammates when they are away on vacation or sick
- Help colleagues facing a challenging time with encouragement and support
- Celebrate their birthdays
- If asked, participate in social events with your team. If you cannot, let them know and thank them for the invitation
- Be an enthusiastic and a positive person

What are some ways that you have helped support and assist fellow colleagues?

Lifelong Learner – Learn As You Drive

Use your driving travel time wisely. I love audiobooks through audible.com, podcasts, and foreign language learning tools like chinesepod.com to keep me growing and gaining knowledge. Additionally, companies like physicaltherapy.com, udemy.com and lynda.com enable you to learn about multiple topics via video lessons. Listen and learn while you drive, but always pay attention to the road.

Why not spend your time learning a new skill and increasing your knowledge while you work? One of the world's richest people,

Warren Buffett, says he reads 500 pages every day. [2] How many pages are your reading every day?

Right now, double down and make some substantial investments in yourself. Whether it means buying books, listening to educational podcasts, taking continuing education courses, hiring a coach, or attending conferences – you are the safest and wisest investment you can make. As Benjamin Franklin said, "an investment in knowledge pays the best interest."

APTA: Make That Investment

I have been a member of the American Physical Therapy Association (APTA) since I was a physical therapy student (I had a short lapse when finances were very tight, but have been active for more than eight years without disruption). I love being a member because the APTA fights to advance and strengthen our profession.

As a member, you have access to clinical research and resources, free and paid CEU courses, grant opportunities, discounts to conferences, social networking opportunities, current news and hot topics, and multiple ways to make an impact in our profession. Additionally, APTA has a Home Health section that focuses on the needs of SPTs, PTs and PTAs practicing in this space. I believe it is our duty to serve, and the APTA is doing just that. Please become a member.

APTA's website:
www.apta.org

APTA's Home Health Section website:
www.homehealthsection.org

A few PT, OT and SLP colleagues and I created the "Home Health Therapist" LinkedIn social network group to share best practices and network. If you are interested in joining the group of home health PTs, PTAs, OTs, COTAs, and SLPs, find us on LinkedIn by searching for the group, "Home Health Therapist."

In the next and final chapter, I will offer you my best career advice and get you prepared to land your first PT job in home health.

NOTES

13 CAREER ADVICE

I have introduced you to a lot of information to bring you up-to-speed on being a HH PT. Hopefully you now have a keen understanding of home health and on what it takes to thrive in this setting. In this chapter, I'm going to share with you the most valuable insights and advice I have learned as a practicing HH PT, an employer, and an entrepreneur. My goal is to prepare you to land a great job as a HH PT. To win a phenomenal job at a top-tier HHA, you are going to have to do your homework, ask tough questions, take some risks, and strive for win-win.

Do You Have What It Takes?

Not everybody is cut out to be a HH PT. I have seen clinicians come and go, succeed and fail. Those who thrive, in my opinion, have the following qualities and characteristics.

- Excellent communicator
- Physical and mental stamina
- A leader who can also be led
- Emotional resilience
- Resourceful and creative, "think outside of the box"

- Act with a sense of urgency and are passionately committed to help others regardless of race, religion, ethnicity, or gender
- Detail-oriented and supremely organized
- Empathetic
- Can-do/positive mental attitude
- Excellent interpersonal skills and comfortable in abnormal settings
- Conscientious listener
- High emotional intelligence with a growth mindset [8]
- Strong moral compass
- Customer-centric
- Self-motivated and a lifelong learner
- Self-aware and adaptable
- Team-oriented

Does this sound like you? I bet it does. Let's now do some self-assessment to help you figure out what you are looking for in a home health job. If you are a student physical therapist (SPT), your clinical rotation will be full-time for a set number of weeks depending on where you are in your program.

Full Time, Part Time, or PRN?

Before I teach you how to find the best HHA to work for, you need to decide whether you want to work full time, part time or per diem (PRN). In my experience, the most successful part-time HH PTs commit to working at least three days over a seven-day week. This

allows you to work with those patients (the majority) that need the intensity of care that requires at least three skilled visits per week. If you work less than three days, you will be sharing your patients with other colleague HH PTs to cover the third visit. This is not necessarily a bad thing, but it can sometimes adversely affect the continuity of care and be more disruptive than nurturing for the patient. I have hired PRN therapists who provide patient care on weekends and holidays only. So if you choose the per diem option, you are committing to helping out as you are available and as needed by the HHA. So what will it be: full time, part time or PRN?

Only the Best Home Health Agency!

So now you are thinking about or maybe even know how many days you can commit to working in home health.

I recommend that you find and select only top-tier HHAs, and strive to get multiple offers for employment. This will give you the opportunity to compare and contrast, and eventually choose the home health agency that best resonates with your core values and needs in a job.

For the SPT, your university will have already done the hard work of selecting the best site for you to participate in a home health clinical rotation.

In the next lesson, I'll share a variety of ways to search for and locate HHAs.

How to Find a Top-Tier Home Health Agency

As you know, HHAs are the primary employers in this industry, so it is important that you find synergy with the right organization. Described below are my top five best channels to find local HHAs.

Personal Connections

Start with friends, associates, classmates, and colleagues. Anyone who has worked in home health will know good and bad companies and have some connections to make an introduction. This should be the first place to start your research.

Benefit: Obtain insider information about the business; have a person to contact directly in the organization; easy access to key "shot callers."

Downside: The contact may lead you to where they work to get a referral bonus, but that company may not be top-tier. The referral may also be biased, and therefore overlook quality.

Home Health Compare

This is Medicare's platform to assess and report on the quality of all Medicare certified home health agencies in the United States. It was launched in 2015 and is an excellent resource to learn about how a home health agency is performing in relation to patient care, clinical outcomes, and patient satisfaction.[2] This is an excellent resource.

Benefit: User-friendly website. You just enter your local zip code and can find the 5-Star Rating of all local home health agencies. This online tool provides an agency rating based on quality measures. You can do research from the comfort of your home.

Downside: It's impersonal.

Google.com

As you know, Google is the world's largest search engine [3] and should be added to your search to locate top-tier home health agencies. I would use the keywords, "Home health agency, home health agency jobs, home health PT job, home care physical therapy job, employment for physical therapist home care." Then add the name of the city or town that you would like to work in. Google has worked for me and others.

Benefit: Google has downloaded the entire worldwide web and made it searchable. Enough said.

Downside: It's impersonal.

Yelp.com

Yelp is a pioneer in connecting people with local businesses and allowing customers to review businesses.

Benefit: Gain insights by examining past patient experiences with the company, testimonials, and reviews. You can also obtain company and contact information.

Downside: Not all home health companies are indexed; sometimes the validity and reliability of reviews may be questionable.

Glassdoor.com

Glassdoor is the online platform where people can find jobs and read reviews from past employees of most companies.

Benefit: Gain insights into company culture through reviews from past employee experiences and personal testimonials. Obtain company and contact information.

Downside: Not all businesses are indexed and the validity and reliability of past employee reviews may be questionable. Also, you have to sign up for a free account to get full access and enhanced company data.

Recruiting Firms

If you use this channel, go with an agent or firm that you or someone you know has successfully used to place them in a PT setting. A personal referral and recommendation is priceless with this option.

Benefit: Industry reputation and contacts; possibly higher wage due to recruiters negotiating on your behalf; incentivized to get you hired; more leads in less time than if you were looking alone.

Downside: May not have your best interests in mind. Recruiters might place you in a job that makes them more money, but is not best for you.

Utilize all of these channels and find others. Some searches may be more fruitful than others. Look for reviews, both negative and positive. Once you have done so, make a list of the top three choices that appear to have the best reputation and best fit with what you're looking for. I recommend creating a pros and cons list and/or strength, weakness, opportunities, threats (SWOT) analysis.

Then, contact each company and prepare yourself for the next phase: getting ready to earn the best HH PT position available to you!

With that in mind, let's move on to the next section, which focuses on how to create value for the HHA, so they will want to hire you on the spot.

Focus on What You Bring to the Table

A sure way to decrease the likelihood of getting hired is by thinking of *me, me, me*. Think about the company first, and then share your ideas on how YOU will help the company succeed, grow, and be better by hiring you. Remember, the interview comes before the offer, so focusing your questions and comments primarily on vacation hours, PTO, benefits, and salary is not going to impress the employer. Don't put the cart before the horse. You are working to influence and give your potential employer tangible ways that you can help the company win. The goal is to get an awesome offer and the job, and by thinking only of yourself, you are sure to not get anything.

Proven Ways to Win the Interview

This goes without saying, but I still have to address it here: dress professionally. You only get one chance to make a first impression and you want it to be an excellent one. So dress like you want to make an excellent first impression.

You will have to do your homework on the home health agency. Memorize some important data points, facts, milestones, core values, and other information about the company and its people. You will certainly impress the interviewer(s) and, in my experience, it is rare that people do their homework and prepare – you'll be memorable and will make an excellent first impression because of it.

Have a working knowledge of home health, even if you don't have any experience. Share what you know and have learned. This book will give you an optimal start so you can knock their socks off!

Have some stories from past work, clinical, and personal experiences. Think about times when you had to solve a problem, show leadership, overcome obstacles, and work well with your colleagues and patients. Be prepared to think and talk about some challenges and triumphs.

Be ready to articulate how you plan to help the company win. What are YOU bringing to the table that will make them want to hurry up and hire you before their competitors do?

Your potential employer is looking for you to add immediate value to what they are doing, even if this is your first job in home health.

Think about this beforehand and be able to articulate how you can add value and help the company achieve its goals. Be specific about the skills, experiences, and talents that make you a unique candidate for the position, but do not lie or overpromise things you can't deliver – you'll get caught.

Give an example of when you created something out of nothing and share what you learned in the process. This can include anything from starting a business, completing a challenging puzzle, studying a foreign language, learning to pitch a tent, or even writing a case study or article.

What you need to show as a PT and a SPT is that you are creative, self-motivated, and will finish what you start. As an entrepreneur and clinician, I look to hire people who are organized, self-starters, passionate about service, and team players.

If you were the boss, what would be significant to you in the hiring process? Think about this question and write out the primary three characteristics that most impress you in others. What would lead you to hire that person? How can you demonstrate those characteristics for the hiring manager through your own skills and experiences?

Must-Know Interview Questions

When you are interviewing for your new position, be prepared to answer the following questions. These are all of the basic questions I always ask candidates.

- What days and times will you be available to work?
- Are you available to work weekends? If so, which ones?
- Do you desire to work full time, part time, or per diem? W2 or as an independent contractor?
- When are you able to start?
- Do you have all of your HR personnel items up-to-date?
- Will you need health insurance or do you already have coverage?
- If you are looking for part-time work, what days and times will you be available?
- Do you speak any foreign languages?
- Do you have a dependable vehicle?

Muse over potential answers to these questions. Also, perform some practice interviews with friends or family to get you fired up and ready to win the interview!

Questions to Ask Your Potential New Employer

Questions during an interview shouldn't only come from the potential employer. You should also use the interview to find out more about the company and these questions will give you a basis to learn more.

1. Why are they hiring for your position?
2. Can you meet and speak with current therapists?
3. Who do they get their referrals from?
4. Do they have territory expectations?
5. What are the orientation and training protocols?
6. What are their core values, and how are these demonstrated?
7. Do physical therapists have control over clinical decision-making, like care plan creation?
8. Do they require a specific number of skilled, billable patient visits to receive full-time benefits?
9. What is their policy on determining when a therapist does not have the capacity to take more cases? For example, can you safely decline new referrals until you have more availability?
10. Who will you be reporting to (reporting relationship)? Can you meet that person?
11. How would they describe their company culture?
12. Are they a Medicare-certified home health agency?

This is a non-exhaustive list (and you don't have to ask every single question on the list); my goal is to get you thinking. Your homework is to come up with three to five more questions for your potential new employer.

Shadow to Learn

Before you accept a position, it's extremely important to take advantage of the opportunity to shadow. Job shadowing is a great way to learn culture and practices in a new company. You will literally be shadowing a HH PT or other home health clinician for a visit or two or even for a full day. This is not standard hiring practice, so you most likely will have to request it. We always encourage shadowing for potential new Ayuda hires. This allows our clinical team to meet the candidate, and the candidate can learn and experience the company and teammates in person.

During the shadowing experience, you will meet some of your potential colleagues and deepen your understanding of their morale, get answers to important questions, gain insights on the company culture, learn about in-the-field clinical documentation realities, and come away with a better understanding of the business. These factors will all influence your decision to sign on as an employee.

Get Paid a Premium

There have been four scenarios where I have paid a premium to hire a new therapist. This premium was not based on their experience as a practicing therapist. It was based on the human and social capital that they brought to the table.

These are the scenarios in which I have paid a premium to hire a therapist:

1. **Having foreign language skills:** A language that is useful and frequently used within the population you serve can add significant value to any home health agency.

2. **Having started and finished something,** such as:
   - ► Developed a training manual
   - ► Wrote a case report
   - ► Started a business
   - ► Designed and presented a research project
   - ► Published an article after completing some research
   - ► Created a website or blog
3. **Proven social networks that give access to recruiting new therapists and earning more patient referrals.**
4. **Studied or lived abroad.**

Unfortunately, I can't guarantee that having these skills, experiences, and/or connections necessarily means you will earn more. I personally place a high value on these attributes, and have found that people who possess them add value to our team, culture, and to the lives of the patients we serve.

What's your edge? What's your competitive advantage over your competition? What are you doing in addition to being an awesome clinician to elevate your game? Make sure you communicate that in the interview and hiring process.

As a SPT, are you getting to know your professors on a professional level? They have a wealth of knowledge and experience and they can and will help you during and after PT school if you build and cultivate that relationship now. They can also serve as great references when the time comes.

If You Don't Ask, You Don't Get!

When you get an offer for employment, I always recommend submitting a counteroffer. You never know and I obviously can't guarantee you will get more, however, I wish I would have known and practiced this early in my career. In multiple instances, I took the first offer and later figured out that I probably could have earned more or received additional perks if I had just asked. Frankly, most employers are assuming that you will counter their initial offer. I wrote this book because I want you to succeed and get everything you deserve in your career as a home health physical therapist. It never hurts to advocate for yourself. A counteroffer is doing just that.

Use your best judgment and think win-win when you counteroffer. Don't be greedy as you could potentially insult your employer.

Congratulations, You Got the Job!

You earned yourself a position as a home health physical therapist! You nailed the interview, impressed the employer, counter-offered without insulting, and created a win-win. You have already started building relationships with your new teammates and are working for (drum roll please)... a local top tier home health agency. I'm so proud of you! I knew you had it in you because you stuck around to read this far into the book!

Let's briefly move into what will be expected of you from a human resources (HR) perspective before you see your first home health patient. In the next few lessons in this chapter, you will learn a basic framework of what to expect for the orientation and training process

as well as advice to get you through those few challenging months as a beginner HH PT.

Be Prepared: "Must-Have HR Documents"

Your new employer will want various HR documents. Here's a summary of what you'll need:

- State Physical Therapy License
- Evidence of current auto insurance
- Current driver's license
- Current CPR certification
- Recent evidence of current physical/medical exam – "Fit to work full-duty as a home health physical therapist"
- Social Security card
- Form I-9 from Department of Homeland Security
- Annual TB test results
- Proof of Hepatitis B vaccination or immunity
- Proof of immunizations or immunity to MMR and Varicella
- Proof of influenza/flu shot or medical release signed by MD
- Criminal background check
- Ten-panel urine drug screen

Get prepared now and have your HR documents ready to go! As a SPT, your school will provide you with liability insurance, but research what is needed for a clinical affiliation in home health. If an HR item becomes expired, you cannot continue working until it is updated.

Be in the Know

It will take time and effort to get to know all of the players at your new company. Get a quick start on this. Knowing who to call and learning when and how to get access to people and information will help you thrive and excel. Start building your Rolodex of colleagues, clinical and non-clinical. In my experience, this is the single best way to start building your social networks, learning and engaging in the company culture, and optimizing success as a HH PT.

Do not rush through your orientation and training. Have paper and pencil or your tablet ready on day one and take meticulous notes. Start learning people's names and jot down all questions with the goal of getting them answered by your manager(s). During your orientation, you are certain to interact with multiple colleagues within the organization. Do your best to make an excellent first impression. Be positive and show enthusiasm!

Important Lessons for the Newbie

As we are essentially colleagues now, I want to offer you some advice and perspective for you to take for the first few days, weeks, and months.

Be patient with yourself. It is going to take you at least four to twelve months to get comfortable and in the "flow" with the entire home health lifestyle (patient care, scheduling, travel, care coordination, documentation, time commitment, etc.).

Get to know all of your colleagues on a personal basis, and learn about their roles within the company. You may also be working with contract personnel from other companies. Get to know them,

too. Your home health teammates are vital assets in your career, so build and strengthen those relationships.

Your primary focus from day one must be to provide excellent patient care. You will learn and improve on the other parts of home health gradually and over time.

Start your patient-care days off as early as possible. This will allow you to beat any morning traffic congestion and finish before the after-work rush. Also, most older adults do not like to be seen in the later afternoon or evening, but prefer morning and afternoon appointments.

Keep a journal and document all questions, comments, and ideas that come up during your day. Bring this journal to your manager and/or mentor and make sure you get the answers you need.

Obtain a home health physical therapy mentor. A mentor will guide and support you through the process of starting and building a career in home health.

I'm excited for you! Remember that you are not alone. You have an advantage and are more prepared than most by just reading this book and doing additional studying. If you ever need a coach or a mentor, contact me at peter@peterbsims.com. I would love to help you.

Please continue to read the conclusion of Launch into Home Health Physical Therapy. Thank you!

NOTES

IN CONCLUSION

Honestly, creating this book has been both a pleasure and an education. I have become a better home health physical therapist and entrepreneur simply by brainstorming, researching, organizing, and writing this book – it has given me the opportunity to focus on and share the most important aspects of this industry and share everything that I have learned so far. I have done my best to cover the most practical, essential, and high-frequency topics that you need to optimize success as a home health physical therapist and land yourself a job!

My hope is that, by now, you have a home health position lined up, a solid introductory foundation of home health, and a good grasp of some practical tools, proven tips, and success strategies so you will hit the ground running in this fundamentally rewarding setting.

I'm sure you have some unanswered questions. This is good. This book is an introduction and a non-exhaustive sharing of information and knowledge.

Additionally, I am very optimistic about the future of home health. I believe that, for home health to thrive in the 21st century, we need expert, professional, and empathetic physical therapists serving patients. Home health needs you!

Finally, live your core values, do the right thing, keep learning and adding skills to your resume, be a team player, stay up-to-date with industry trends and current research, and fully commit yourself to creating value to the lives of all of your patients. If you do, success will be all yours as a new home health physical therapist. Welcome to the club!

Thank you and let's stay connected!

Live well,

Peter B Sims, MS PT
CEO Ayuda Rehab & Wellness, Inc.
www.peterbsims.com