Strategies for Increasing Referrals for Occupational Therapy in Home Health Care

Patricia A. Kelly, Michael J. Steinhauer

Key Words: home care services • professional productivity (of occupational therapists) • referral process, occupational therapy

Many occupational therapists in home health care complain that there are too few referrals to occupational therapy. While working in our administrative positions for home health care agencies, we were concerned about our finding that so few cases referred for rehabilitation were seen by occupational therapists. We made many inquiries to our intake coordinators, clinical directors, and others to determine the reasons for a lack of specific referrals for occupational therapy. Among the responses we received were that (a) patients had often not heard of occupational therapy and did not request it; (b) physicians believed that physical therapy could manage all of the patient's physical rehabilitation needs; (c) intake coordinators were unaware of the scope of occupational therapy services and did not encourage it, nor did they describe occupational therapy care in terms of functional enhancement of the patient's independence so as to give occupational therapy greater meaning; and (d) third-party payers had often limited the use of occupational therapy, thus preventing us from bringing our unique perspective to patient care.

With this initial understanding of the problem, we shared our concerns with other therapists in our respective state occupational therapy associations (i.e., Indiana and Illinois) who also work in home health care. This paper presents several strategies we have created to enhance occupational therapy referrals in home health care.

Strategies
We began our efforts by making rounds with some of the home health care nurses. By visiting with the patients, we were able to suggest ways to make each patient's life more functional. For example, we observed a patient with multiple sclerosis who was ready to be discharged from home health care. She was seated in an overstuffed chair that was too large for her, which placed her in a deformed posture that could cause scoliosis while crowding her lung space. By adapting the chair with pillows, we were able to allow the patient to sit more erectly. She could also transfer more easily, because the placement of newspapers stuffed in a pillowcase beneath her seat cushion elevated the seat. Both the nurse and the patient were delighted with the results. The nurse has since made other occupational therapy referrals at a much earlier stage in her patients' care.

A second strategy we developed is to provide in-service training to nursing field staff and intake coordinators through brief presentations at staff meetings, so as to alert these professionals to the advantages of occupational therapy for patients with specific diagnoses. We use the Health Care Financing Administration's (1990) designated treatment codes for occupational therapy as a clinical and documentation starting place and supplement this information with consumer and health professional information sheets (e.g., "Occupational Therapy Is Important..."
Cian have never turned down requests for occupational therapists, case managers, and Medicare reviewers. When our agency staff network. We engage in competency training of nursing aides, student orientations, and care planning meetings. Some home health care and occupational therapy state associations have developed holiday greeting cards for patients that include a short but meaningful message about the value of occupational therapy services.

Fifth, we encourage intake coordinators and field staff to explain in functional terms the patient's area of dysfunction at home to the physician, for example, memory loss following a stroke that may lead to difficulty in sequencing, sensory or balance loss, or other hurdles to proper functioning. This functional picture explains the role of occupational therapy in a specific case and how we would address the problem. One nurse said that physicians have never turned down requests for occupational therapy services when presented in this way.

Another strategy we employ is to take part in reviewing intake referrals and agency-required clinical record review activities to find potential clients. We look for reports of dependence in activities of daily living; a need for assistance from a home health aide; problems with balance, memory, or safety; difficulties in transferring; sensory losses; and other documented deficiencies.

We work toward clear and concise documentation of functional assessments, treatment plans, goals, and results of occupational therapy treatment. These notes can provide the basis for an educational program for physicians, case managers, and Medicare reviewers. When our progress notes reflect the measurable difference treatment has made in the patient’s daily functional ability, each note is a powerful marketing tool. For example, an occupational therapist in our network received a letter from Medicare complimenting her and her home health care team on their well-coordinated and documented care for a difficult case.

We also employ the unusual strategy of networking with hospital occupational therapists and discharge planners to provide continuity of care for the patient after discharge. We provide a home safety evaluation to check on the patient’s and family’s effective transition from hospital to home. Many patients are overwhelmed by this transition, and family members, already tired from daily hospital visits, may need support to facilitate the implementation of home care programs. Additionally, support may be needed to balance the patient’s needs with those of family members or caregivers. Transfer methods may need to be taught to caregivers for both safety and efficiency. Home health aides can be used to facilitate the follow-up home exercise programs set up by both physical and occupational therapy. Starting at the hospital site ensures a much smoother transition for all these issues.

We also anticipate sharing days with hospital occupational therapists, when possible. A home health occupational therapist can observe at the hospital clinic to refresh and update his or her clinical skills, while the hospital occupational therapists can spend a day with us in the field to see what problems and challenges the occupational therapist and patient face in a home situation.

Another successful strategy involves networking with local occupational therapists to set up a speaker’s bureau. We ask to be invited to speak at various support groups, for example, groups for persons with multiple sclerosis, arthritis, Parkinson disease, and stroke as well as support groups for caregivers. We speak to church groups, at nutrition sites (which are generally sponsored by area agencies on aging or by churches), and at senior citizens’ social clubs. We discuss adaptive equipment that will make life easier and more comfortable as well as movements and transfer methods that will increase safety and conserve energy. We then answer questions. Local TV and radio talk and informational shows are other avenues by which we have expanded occupational therapy awareness. We also participate in health fairs, because attendees of these events are always eager to learn new ways of managing their problems. At such events, agency brochures and adaptive equipment handouts, especially about arthritis and joint protection, are useful marketing tools.

We find two additional strategies successful as well. First, one can submit success stories relating to specific patient diagnostic groups to magazines, newspapers, and consumer health publications. For example, an occupational therapist in our group is writing a story for a union magazine describing her success with a disabled union member. She depicts the effect that occupational therapy has had on that worker and his eventual recovery and functional improvement. Other possible sources for publication include the American Association of Retired Persons; the Kiwanis, Lions, Exchange, and Rotary Clubs; and local or regional newspaper health sections. All can be used to increase the awareness of occupational therapy in the community.

Second, we have been successful in asking for appointments with nursing or case management staff at health maintenance organizations and insurance companies. We provide a slide presentation and AOTA handouts to explain occupational therapy’s role in returning the client to greater function. We stress the value of rehabili-
tation at home and its cost-effectiveness. Our audience is almost always receptive to our ideas and learns more about occupational therapy.

Summary

The paucity of home health care referrals for occupational therapy led us to develop an educational approach to increase both the referral sources and the number of referrals to occupational therapy. With a consistent effort to exercise clearly identified strategies, the occupational therapy referrals at the Visiting Nurse Association of Porter County, Indiana, increased threefold from the number of referrals at the same time last year. The greater staff awareness of the need for occupational therapy in home health care requires occupational therapists to continually prevent old nonreferring habits from reemerging and to orient and educate new staff members as they enter the home health care field.

Acknowledgments

We wish to thank the Illinois Occupational Therapy Association's Home Health Resource Group, Karen Cagen, OTR, and Susan Sandefur, OTR, for their valuable input.

Reference