The Cultural Aspects of Home Care Delivery

(cultural characteristics, human occupation, occupational therapy, task performance and analysis)

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This paper uses a patient example to demonstrate the pervasive influence of culture on an individual's values, goals, interests, roles, habits, and performance. Culture is a filter through which patients determine the direction and degree of their involvement in self-care, work, and leisure activities. Every occupational therapist intervention depends on an exchange of values. The constraints of home care practice accentuate the therapist's need to create a therapeutic environment that is understood and valued immediately. As a guest in the patient's home, the home care occupational therapist must quickly incorporate the patient's needs into the therapeutic program.

Home care occupational therapy began at the turn of the century; therapists were frequently employed by Visiting Nurse Associations, although the home was not a common site for most occupational therapists. Susan Tracy was the first home care therapist, and she described her experiences in one of the first occupational therapy textbooks (1). Hospital services expanded from the 1930s to the 1970s, and home care practice did not receive much attention. The number of home care therapists is expanding today as people realize the benefits of delivering occupational therapy in the patient's home. The need for home services will expand further as diagnostic related groups (DRGs) begin to influence the admission and discharge practices of hospital staffs.

Homebound occupational therapy requires a unique delivery model (2). Therapists must adapt to the following constraints: a) participating in a working team that is frequently led by a nurse; b) working independently without day-to-day supervision; c) delivering services in a home environment; d) working with minimal supplies and equipment; e) making decisions that must be consistent with the patient's and caretaker's value systems; f) changing one's therapeutic milieu with every patient; g) offering uninterrupted one-to-one therapy to the patient and the caretaker; h) interacting with the patient's social groups; and i) using documentation to justify retroactive payment for services.

The occupational therapy program begins with a request for service, which is initiated by a nurse, a physical therapist, a speech pathologist, or a physician. Thus, other professionals determine the need for occupational therapy services. The occupational therapist checks with the patient or caretaker, schedules a visit, and assesses the patient. Direct service must be evident in all programs so the assessment must be combined with direct care.

Medicare recognizes three reimbursable services: independence in activities of daily living (ADL), restoration of upper extremity function, or "other." Because the team works as a group, a primary concern is the therapist's ability to communicate with the patient, the caretakers, and the other professionals.

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The essence of an effective home program is the teaching and learning process. The patient and the caretakers must learn how to carry out the therapeutic programs. The home care team teaches family members how to adapt to chronic illness and patients how to function independently.

To qualify for reimbursement, therapists must demonstrate progress in a reasonable period of time. Home care therapists cannot maintain or support patients without offering evidence of progress in ADL, upper extremity retraining, or both areas. Splinting and environmental adaptations are considered also, but these services cannot be delivered without some link to independence training. Progress must be documented in the patient's medical record.

Therapists schedule visits two or three times per week; each visit is about 45 min. The visits continue from two months to more than six months, depending on the patient's progress.

The occupational therapy program must stimulate the patient's interest; an unmotivated patient probably will not participate in activities during the therapist's absence. Successful performance requires more than the three hours of therapy offered by the visiting therapist. The active involvement of the patient and caretakers must be enlisted. Therapy can continue during the therapist's absence.

Theoretical Background
The home care therapist must select relevant treatment programs to enlist the participation of the patient and the caretakers. A central concept in the selection process is the patient's culture. It is helpful to use the Model of Human Occupation developed by Kielhofner and Burke (3), which presents ideas originally introduced by Mary Reilly. Humans are viewed as open systems that influence and are influenced by the environment. The human system can therefore be analyzed in a threelayered hierarchy of subsystems. The layers are the volitional, habituation, and performance subsystems.

The volitional subsystem consists of values, personal causation, goals, and interests; the habituation subsystem consists of roles and habits; and the performance subsystem consists of skills (3). Therapists are usually concerned with all three subsystems. The home setting, however, requires an increased sensitivity to the importance of the patient's volitional and habituation subsystems because the therapist is a guest in the patient's home. The home therapist must quickly stimulate the patient's interest in the occupational therapy program. Patients who do not value their treatment programs frequently refuse to cooperate and carry out prescribed activities in the therapist's absence. Thus, the home care therapist must establish a good rapport on the first visit. This leaves little time to make important treatment decisions.

The home therapist will use human and nonhuman cues to make inferences about the patient's way of life. These inferences are based on the therapist's ability to understand the patient's culture.

Culture. Culture can be compared to a filter that colors the entire treatment process. Culture is defined as a common experience shared by a group of individuals. People design their own actions and interpret the behavior of others using cultural knowledge. Culture generates behavior, however culture is not the behavior itself (4). Individuals learn acceptable responses by making inferences based on a) what people do (cultural behavior), b) what people say (speech messages), and c) what people make and use (cultural artifacts) (5). Group members create

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a culture that consists of values, goals, interests, objects, and interaction and speech patterns.

Cultural experiences shape a person's volitional subsystem. Preferences emerge during infancy as caretakers reward, ignore, or punish selected behaviors, speech patterns, and objects that are used or made. Biological and genetic factors set an outer boundary, which also becomes part of the conditioning process. In short, culture influences personality development through an integrated learning process that emerges from formal and informal interactions. These patterns form networks, which can be as small as a peer group and as large as membership in a nation.

Culture also shapes values. Referring back to the Model of Human Occupation (3), values influence the formation of goals and interests. Values are an arbitrarily determined set of beliefs about what should be considered desirable. A value is a thought, emotion, or idea about a person, place, thing, or event. Everyone learns values; values are not genetic. On the other hand, values, once established, are not easily changed. If an individual was not taught as a child to floss teeth, he or she may not find this three-step activity a part of daily hygiene. Thus, culture serves as a conditioning agent for further experiences that guide other life choices (6).

Culture and the Model of Human Occupation. The Model of Human Occupation (3) helps the home care therapist in two ways. Primarily, it allows the therapist to select systematically goals and treatment that are meaningful to the patient and caretakers. If culture can be viewed as a filter through which the patient's volitional subsystem (values, goals, and interests) is reflected, then the model will also explain the relationship of the patient's roles and habits on performance. For example, if a patient believes that it is his wife's duty to dress him and she agrees, then a dressing program will not be valued. An alternative plan would be to introduce an activity to promote the patient's goal. Success might then lead to increased investment in self-care independence.

A second application of the Model of Human Occupation is in the establishment of rapport. As previously stated, the therapist uses human and nonhuman cues in the patient's environment to make inferences about his or her lifestyle. Later observations are compared with earlier ones so that the process becomes a small-scale search for the meaning of events and objects. The therapist tries to enter the lives of the patient and the caretaker as a participant observer. Appropriate interaction and intervention leads to the selection of relevant choices that fit the patient's and caretaker's needs.

Observations, astute questioning, and formal assessment tools are used to gather data. The therapist must constantly reevaluate the gathered information. Malinowski (7) claimed that the goal of cultural studies is to "grasp the native's point of view, his relation to life, to realize his (her) vision of his (her) world." In this basic exchange, the therapist learns from the patient, and the patient learns from the therapist.

The following example demonstrates the pervasive influence of culture on the volitional subsystem. This effect resonates through the other subsystems. The home care therapist must consider culture as a factor that affects the entire health care delivery process.

Case Study Analysis
DiMarcasi (fictitious name) is a 72-year-old man who sustained a left hemiplegia as a result of a cerebrovascular accident (CVA). DiMarcasi was born in Southern Italy. He was trained as a tailor and emigrated to America when he was 18 years old. He resides in a two-story row house in a lower middle-class urban neighborhood.

DiMarcasi was hospitalized for one week to stabilize his condition; he was then transferred to a rehabilitation center. He was so upset about staying away from his own home, that managing him became a problem for the staff. His physician decided to discharge him and order a home rehabilitation program.

DiMarcasi resides with his wife, a 70-year-old woman who suffers from elevated blood pressure. He has three grown sons; two sons are married and have moved away, and the 27-year-old son lives in the house.

Nonhuman Cues. The therapist entered a neat but shabby house and proceeded to examine all the
rooms. The furniture was from the 1940 era. The flowered wallpaper did not match the sofa and chairs. The worn rug covered the floors in the living and dining rooms, and continued up the 15 steps to the second floor. Upstairs, there were three bedrooms and a bath. The dining room seemed like it was reserved for special occasions because the surfaces of the table, server, and buffet were covered with elaborate doilies and china figurines.

In marked contrast, the kitchen was warm and cheery. The walls were freshly painted in white, red and white starched curtains decorated the windows. No cooking implements were visible, and all of the appliances seemed new. This room appeared to be the center of the family activities.

The patient was propped up in a rented hospital bed, which took half the breakfast room. The over-the-bed table, wheelchair, commode, four-point cane, and splints were crammed into a space behind the bed. The patient had been ambulatory in the rehabilitation center; however, this scene indicated that he may have regressed and was now bedridden. Values. DiMarcasi valued craftsmanship. He had definite ideas about acceptable behavior, and he was uncompromising. As a pragmatic craftsman, he disdained shortcuts and despised imperfection. His devotion to his family was obvious, but he and his wife bickered. His attitude was that the man of the house should make all of the cooking implements were lisible, obvious, but he and his wife bickered. His attitude was that the man of the house should make all of the

dishes. His values were fresh, and his circle of friends, his family, his garden, and opera.

**Influence of Culture in Other Subsystems**

Habitation Subsystem. Because his disability disrupted his patriarchal role, he is left only with the hollow ability to order his wife and son around. His previous behaviors— independent, aloof, and dignified actions—are in sharp contrast to those of his present. He has now assumed the role of a demanding child and even wears pajamas instead of street clothes as an outward symbol of his diminished status.

Daily Routine. DiMarcasi does not allow his wife to sleep through the night because he elicits her assistance for toileting himself, although he is physically and mentally capable of performing the task. After frequent interruptions in her sleep, Mrs. DiMarcasi begins her day by bathing, dressing, and feeding her husband; these activities take over 90 min.

DiMarcasi then watches television in bed for the rest of the day. He calls on his wife to address his every personal need. At 5:00 pm his son lifts him out of bed and shaves him. DiMarcasi refuses to see his friends because he is ashamed of “his condition.”

Performance Subsystem. The patient’s values shaped his goals and interests. His all-or-none approach to his left arm influenced his performance in self-care. By classifying himself as sick until his arm got better, he acted as he felt sick people should by wearing pajamas, staying in bed, and not participating in family or social activities. Participating in his own care made no sense to him, because in his culture, illness was regarded as an external event that happened to the helpless individual. He felt that visual symbols were needed to demonstrate the sick person’s dependent role, and that the person must wait for the recovery to come.

DiMarcasi experienced good return in his affected left arm and hand. He could shrug his shoulder and touch his right knee, using the flexion synergy pattern in the left upper extremity. Although his grasp was weak, he could still firmly hold 5-cm objects. His release of objects was slow but deliberate; however, he had no limitations in passive range of motion. Supination was intact. He could oppose the second and third digits in the left hand, but third digit opposition required a considerable effort.

He could assume responsibility for all aspects of his self-care when given occasional assistance such as fastening, brace donning, and food cutting. This fact was documented by the hospital rehabilitation staff. His transfers required minimal supervision, and his ambulation was also functional.

Perception and cognition were also intact. The patient’s regressed social interaction skills reflected
The therapist initially addressed DiMarcasi's daily activity needs. He claimed that he wanted to remain in bed. The therapist used his interest in his left upper extremity to motivate him, claiming that the most advantageous therapy program required his participation at the kitchen table. The therapist reviewed the skills he had presented at the rehabilitation center. With minimal instruction, DiMarcasi was guided out of bed, with his wife's help, and walked to the table, using his four-point cane. When the therapist returned, she noticed that he was fully dressed (including his vest) except for his pajama bottoms. This attire was prompted by his previous “sick” role. He was ashamed for the female therapist to see him in his bed clothing when he was seated at the kitchen table (somewhere he considered a “well” place). He remained unsure of his role and therefore required the pajama bottoms.

DiMarcasi became increasingly more critical of his wife's care. He said she was too slow or too quick, and was not capable of meeting his exacting standards. In short, he wanted to do things for himself. Within weeks, because of his strong will, his wife's work, and the therapist's guidance, DiMarcasi became independent in all aspects of his self-care except for bathing his right side, shaving himself, and cutting his meat. He also required minimal assistance during turns while ambulating.

The therapist was able to make these gains by using concrete activities that offered proof of the patient's gains, such as a weighted ball toss, construction of a tile trivet, polishing activities, and finally some ADL. For example, DiMarcasi became frustrated with his son's ability to shave him. He claimed that the son knew nothing about a proper shave. At first, DiMarcasi insisted on using a straightedge until he was shown an effective electric shaver. DiMarcasi decided that he would relinquish his straightedge for the opportunity to give himself a decent shave. Thus, the issue of control and power in his family role helped to promote functional gains.

The influence of his culture can be traced to the resonating influence of his values on goals, interests, roles, habits, and performance. The bossy, complaining, child-like DiMarcasi began to disappear as new roles and skills were merged with previous values, goals, and interests. Two weeks prior to discharge, the therapist noted that DiMarcasi was fully attired for the treatment session. He said that his friends had invited him to the opera, and he had decided to go. He stated that he could not go in pajamas so he got dressed. This was concrete evidence that he experienced a progressive shift in roles.

**Summary**

The home care therapist must create an occupational therapy program that stimulates the participation of the patient and the caretakers. This case study demonstrates the pervasive influence of culture on the patient's volitional, habitation, and performance subsystems. Careful analysis of human and nonhuman cues guide the therapist's goal and treatment decisions. As a participant observer, the therapist has the opportunity to enter the patient's world, adapt treatment to suit the patient's needs, and make occupational therapy a vital part of the recovery process.

**REFERENCES**