What Can Be Done About Home Health Fieldwork?

Debra Lindstrom-Hazel, MOT, OTR
Assistant Professor and Level I Coordinator of Occupational Therapy, Western Michigan University, Kalamazoo, Michigan 49008.

Mary Ann Bush, MA, OTR, FAOTA
Professor of Occupational Therapy, Western Michigan University, Kalamazoo, Michigan.

This article was accepted for publication January 13, 1997.

THE ISSUE IS

As we move into the 21st century, major changes in health care service delivery in the United States will affect fieldwork education. The location of service delivery is changing from institutions to community and home settings (Pew Health Professions Commission, 1995). As health care providers, occupational therapy practitioners must adapt to the changing environment and adapt skills and services to fit the evolving system (Phillips & Legaspi, 1995).

The Changing Health Care Environment

Home care is one of the fastest growing areas of practice for occupational therapists. From 1991 to 1995, the number of registered occupational therapists who considered home care as their primary area of practice increased by 106% (Health Policy Alternatives, Inc., 1996). In response to cost-containment procedures in the health care environment, patients are discharged from the hospital "quicker and sicker." Often, persons with acute conditions are discharged from the acute care hospital to their home, with necessary medical care occurring in the home. Medical services for persons with chronic illnesses are also moving from hospitals to the home where care can be managed more efficiently (Shortell, Gilleo, Anderson, Erickson, & Mitchell, 1996). Occupational therapy services in the home allow clients to function in familiar surroundings, doing activities that are part of their daily routine rather than those simulated in the clinic. The majority of home health recipients (75%) are Medicare enrollees; in the past 15 years, the number of Medicare enrollees who received home health care services rose 500% according to Hing's study, "Characteristics of Elderly Home Health Patients: Preliminary Data From the 1992 National Home and Hospice Survey" (as cited in Shortell et al., 1996). The home environment is not a new setting for occupational therapists (Levine, Corcoran, & Gitlin, 1993), and the trend of providing care in the home instead of the hospital is expected to increase in the 21st century (Pew Health Professions Commission, 1995).

Preparing Practitioners for Home Treatment

As the profession expands to meet the increased demand for occupational therapy services in the home, educational programs need to critically evaluate whether they are adequately preparing students for the changing health care environment. The Pew Health Professions Commission (1994) challenged programs that train health care professionals to define the general competencies that will be required of practitioners in the year 2005. These general competencies include the practitioner's ability to expand access to effective care, provide contemporary clinical care, participate in coordinated care, and ensure cost-effective and appropriate care. From these general competencies, specific competencies need to be defined for various practice settings within each health profession. In the area of home health, some of the competencies for occupational therapy practitioners include the ability to adjust to diverse cultural settings, use available equipment creatively, balance client and family member education with direct care, organize and manage time, and communicate effectively (Levine et al., 1993).

After the competencies have been defined, schools need to create opportunities for students to acquire skills to fulfill the competencies. To ensure that students have developed the competencies for their projected work environment, both didactic and clinical education components need to be considered. The academic classes provide the foundational knowledge and theoretical constructs upon which therapy is built (Hamlin, MacRae, & DeBrakke, 1995). There are opportunities for students to demonstrate some competencies in classroom, but many competencies are not developed until Level I fieldwork and are further developed or refined during Level II fieldwork. Therefore, fieldwork placements are a critical component of the student's education in which to develop competencies necessary to function in the work environment.
Fieldwork as Preparation for Practice

Historically, fieldwork has been the mechanism to acculturare students to the profession, providing the critical link between their academic preparation and the real world (Cohn & Crist, 1995). Because fieldwork is this “critical link,” it would make sense to provide a home health experience within either Level I or Level II placements in order to prepare students for the changing health care environment. Garbarini and Pearlman (1996) surveyed home health practitioners to determine why home health care is not used more extensively as a Level II fieldwork site. The return rate for their survey was low (25%), but more than half of the 127 respondents identified three “incentives” that would increase the therapists’ willingness to supervise students: (a) guidelines, (b) support, and (c) in-service training. This finding was consistent with Meyer’s (1995) conclusion that improved communication, structure, education, and support could effectively enhance clinical education and reduce stress for Level II fieldwork educators. Revenue production and decreased client load were two of the benefits that both students and supervisors identified in this study. These benefits are not available in home health Level II fieldwork settings where supervision in the home is required for legal and reimbursement reasons, which may vary from state to state and reimbursable to reimbursing. Therefore, there may be fewer incentives for supervisors to take Level II students if home health is their primary work setting. Successful Level II fieldwork models are in use (American Occupational Therapy Association [AOTA], 1997), but this literature was not available at the time this article was written.

According to the Pew Health Professions Commission (1995):

| Professional training and practice should place more emphasis on developing the qualities of a superb generalist, capable of comprehensive management of care, as opposed to the current orientation toward specialization. The next generation of health professionals must be prepared to practice in community- and ambulatory-based settings. This will require that dominance of the hospital as the training venue for most health professionals must end. (p. 17) |

As we strive to meet this challenge, home care settings are likely options to consider as potential training sites for generalists.

At Western Michigan University, we have never bypassed home health placements in favor of institutional settings, but we are now specifically seeking home health settings as a component of the students’ generalist education. Because of the fieldwork “crunch,” we are looking for “appropriate” sites wherever they may be, but we are increasing the dialogue with practitioners in our geographic area who provide home health care even if it is only a part of their service. In our geographic location, it is unrealistic that every student could be placed in a home care setting for at least one fieldwork placement, but the number of home health placements is growing each semester. We have found that the supervision recommended for our students on Level I placements fits nicely with agency legal and reimbursement requirements. The supervisor and student often travel together between homes or to a community agency. According to supervisors and students, the travel time between settings is valuable supervision time. In addition, carpooling allows students who do not have dependable transportation access to home experiences.

Level I Considerations

For more than 5 years, we have placed Level I students in home care settings. Most of the students are supervised by registered occupational therapists, yet a few are supervised by another professional. For example, we have consistently used a rural hospice setting where the student is supervised by a nurse, and student feedback about this experience has been generally positive. After the student is oriented to the agency policies and has gone on visits with other hospice professionals for a few weeks, he or she goes into the home unsupervised to provide hospice services as a volunteer (not a reimbursable occupational therapy service). Other students in home health care placements are closely supervised by occupational therapists.

Initially, we did not establish specific guidelines for home placements that were different from other Level I placements. Regardless of site or supervisor, all students were supervised by occupational therapy faculty members who were aware of the types of activities and programs that the students were performing. We realized that we needed some specific guidelines for students who are providing services in a client’s home. As in any facility, a student is expected to know and follow agency guidelines. It is even more critical that the student know and follow established guidelines when they go to a client’s home unsupervised. Suggestions to consider when developing these guidelines (with or without occupational therapist supervision) include, but are not limited to, the following: (a) whether a student is allowed to transfer clients, (b) procedures regarding home visits and client treatments in a supervisor’s absence, (c) emergency procedures, (d) documentation procedures when there is no occupational therapy supervisor, and (e) facility protocols for sharing student suggestions with clients (e.g., suggestions are approved by the supervisor first and then shared with clients).

As critical as fieldwork is for students’ education, it is only one component their professional preparation. The didactic component of education is not limited to classroom activities; nonetheless, the home environment has inherent size limitations for accommodating a group of students. Course assignments that require the student to go into a client’s home are often integral components of the didactic education. The assignment not only introduces students to the home health environment, but also is optimally followed by a processing discussion with the faculty member. Regularly working in a client’s home provides an opportunity to gain insight and sensitivity to issues that are only encountered when the therapist is the “guest” in a home rather than the “host” at a facility. Students who need to work in addition to taking classes are often encouraged to take a position as a home health aide or care provider. When students have home care experiences, they can enrich classroom learning by bringing concerns, problems, and successes from their home care work into the discussion (while maintaining confidentiality).

In striving to provide meaningful fieldwork experiences for our students,
The literature indicates that health care is specialization to the community and supervision. Because of the movement of the current scarcity of fieldwork sites, we have also found that placements with home health care as a component of their service need to be considered. As educators seek new sites, home health occupational therapy requires a practitioner to adopt a holistic perspective in order to assist clients to function optimally in their home environment. Because a large number of students work in addition to taking classes, they can be encouraged to find jobs as home health aides or chore providers as part-time employment before and during their didactic education. This work experience can help them to acculturate to the home setting. By encouraging students' participation in home health experiences, educators are helping to facilitate generalist competencies.

Acknowledgments
We thank Cindee Peterson, MA, OTR, Richard G. Cooper, EdD, OTR, FAOTA, Barbara Hooper, MS, OTR, and Jan Harbach for their assistance and contributions to the development and completion of this article.

References

The issue is provides a forum for debate and discussion of occupational therapy issues and related topics. Published articles are selected on the basis of interest to the profession and quality of the discussion. Readers are encouraged to submit manuscripts discussing opposite points of view or new topics. All manuscripts are subject to peer review. Submit three copies to Elaine Viseltear, Editor.

The opinions and positions expressed by the authors are their own and should not be construed as those of either the Editors or the American Occupational Therapy Association, Inc.