Home Health Care Revisited: Challenges for the Future

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Historical Perspective

Initially, the home was the site of most health care. Since the early 1920s, occupational therapy has been providing home health services through visiting nurse associations, public health agencies, and community- and hospital-based home care agencies (Punwar, 1988). After World War I, acute-care treatment of persons with short-term diseases and disabilities began to shift from the home to the hospital, due in part to new surgical techniques, more complicated and improved antiseptic procedures, and advanced medical technology (Ginzberg, Balinsky, & Ostrow, 1984).

Medicare and Medicaid were established in 1965 as fee-for-service programs. These reimbursement programs encouraged the expansion of hospital acute-care services, but little consideration was given to cost. While hospitals were expanding, the elderly population in the United States was increasing. Today, there are 26.5 million persons over the age of 65 years, and by 2020, this population will outnumber teenagers by 2 to 1 (Hasselkus & Kierrat, 1989). Elderly persons tend to enter the acute-care hospital system with multiple chronic conditions: 86% of all elderly persons suffer from one or more chronic conditions of varying degrees of severity, and 56% of those over 75 years of age are limited in activities of daily living due to chronic conditions (Brody & Rough, 1986).

The combination of fee-for-service reimbursement systems and an older, chronically ill patient population requiring multiple interventions has led to rapid increases in health care costs. In an attempt to control these hospital costs, the federal government enacted the Prospective Payment System for Medicare patients in...
was cerebrovascular accident (807%).

sponded, 87.8% were involved in di-

showed a somewhat slower growth

and 3.8% in supervision. The primary

caseloads will increase by 37%

uprates the therapists’ home care

services are real and frequent in all

segments of the health care industry.

Occupational therapy practitioners

be aware of the various reim-

bursements systems and work with in-

mediaries to resolve any denials

for occupational therapy services.

Anderson (1988) recommended that oc-

cupational therapists be encouraged to

use the Medicare appeals process

when problems cannot be resolved

and a denial seems inappropriate.

Recognition by federal and state

funding agencies represents positive

steps for the practice of occupational

therapy. However, as noted earlier,

fewer home health care agencies are

seeking Medicare certification. As a

profession, we must monitor funding
trends and continue to seek reim-

bursement from sources that include

health maintenance organizations,

private insurance companies, and

industry.

AOTA Efforts

On a national level, the AOTA has re-

sponded to home care industry de-

mands in several ways. In 1978, the

Representative Assembly approved

Standards of Practice for Occupa-

tional Therapy Services in Home

Health (AOTA, 1986c). In

November 1984, a special issue of the

American Journal of Occupational

Therapy (Steinhauer, 1984a) was de-

voted to home health care. In that

issue, Steinhauer (1984b) identified

a need for professional guidelines for

occupational therapy in home health

care.

In 1985, the AOTA Commission on

Practice identified home health care as

a growing practice area and a

Target for increased occupational ther-

apy activity. A task force was formed,

and Guidelines for Occupational

Therapy Services in Home Health

(AOTA, 1987a) was made available in

1987. The guidelines address issues

specific to home health care regard-

ing referral, documentation, reim-

bursement, employment, and con-

tracting, in addition to providing

numerous resources. In 1988, the

Joint Commission for Accreditation of

Healthcare Organizations responded
to the industry’s needs for standards

by developing Home Care Standards

for Accreditation, which provides a

voluntary accreditation process. AOTA

Growth of Home Health Care Services

The trend toward shorter hospital

stays has pushed home care practice

into the public arena. The home care

industry experienced a 100% growth

rate from 1975 to 1984 (AOTA, 1989).

Although the number of Medicare-
certified agencies has increased over-

all from 4,584 in 1984 to 5,676 in Jan-

uary 1989, there has been a slight
decline from a high of 5,887 agencies

in 1987 (AOTA, 1989). This leveling
effect is most likely due to (a) in-
creasing numbers of hospital-based

care agencies, joint ventures, and

consolidations; (b) some agencies

not seeking Medicare certification;

and (c) the inability of smaller

community-based agencies to survive

in a highly competitive marketplace.

According to the Health Care and Fi-
nancing Administration (U.S. Con-
egress, 1988), home health Medicare

benefits alone now total approxi-

mately $2.5 billion and are projected
to increase to $3.7 billion by 1993;

the average charge per visit is ex-
pected to increase from $63 to $82

over the same period.

According to AOTA’s 1986

Member Data Survey (AOTA, 1986b),

the number of occupational therapists

who named home health care as their

primary employment setting in-
creased from 0.9% in 1982 to 4.6% in

1986. The data for certified occupa-
tional therapy assistants in home care

showed a somewhat slower growth

rate, from 0.2% to 1.2% during the

same period. In 1986, 59.5% of the

home care agencies had occupational

therapy services (AOTA, 1989). Of all

the occupational therapists who re-

sponded, 87.8% were involved in di-

rect service, 5.2% in administration,

and 3.8% in supervision. The primary

health problem of the patients seen

was cerebrovascular accident (80.7%).
The 1986 Member Data Survey repre-

sented only those therapists who con-

sidered home health care to be their

primary area of practice. It did not

consider therapists who rotated

through hospital-based home care

agencies or who contracted for ser-

vices as a secondary area of practice.

The growth rate of the home health

care industry and its funding sources,

both of which promote the functional

independence of patients, indicates

that occupational therapy currently

represents a small percentage of the

potential home health care market.

Reimbursement

Parts A and B of Medicare will pay for

home health care that is considered

medically necessary. Specifically,

occupational therapy services are cov-

ered once the patient qualifies for

home health services on the basis of

an initial need for skilled nursing,

physical therapy, or speech-language

therapy services. Occupational

therapy services may then be ex-
tended solely on the basis of a con-
inuing need for the services. In addi-
tion, the recent extension of full

Medicare Part B coverage to occupa-
tional therapy services through the

Omnibus Budget Reconciliation Act

of 1986 (Public Law 99-509) allows

home agencies (as well as other certi-

fied providers) to provide occupa-
tional therapy services to patients in

their homes. In other words, the pa-

tient is no longer required to be

homebound to be eligible for occupa-
tional therapy services.

The Legislative and Political Af-
fairs Division of AOTA has targeted

home health reimbursement for occu-
pational therapy as a priority during

this 101st session of the U.S. Con-
egress. The main issue is the inclusion

of occupational therapists as the

fourth primary providers of skilled

home health care services along with

speech–language pathologists, phy-

sical therapists, and nurses. Practi-
tioners have estimated that when oc-
pupational therapists become primary

providers, the therapists’ home care

caseloads will increase by 37%

(AOTA, 1986a).

Increased coverage for occupa-
tional therapy services has not en-
sured reimbursement. Denials for ser-

vices are real and frequent in all
was represented on the joint commission's Professional Technical Advisory Committee. Previously, AOTA contributed to the development of the standards and their accompanying guidelines as a member of the joint commission's Home Care Task Force.

Current Roles and Opportunities for Occupational Therapists

Occupational therapy's emphasis on adaptation, individualization of environments to promote optimal functioning, and life satisfaction makes the home a natural setting for treatment. In the home, work simplification and energy conservation become practical realities, and practitioners have a unique opportunity to understand the importance of activities of daily living from the patient's and caregivers' perspectives. The challenge of working in an environment that may be constrained by architectural barriers, ineffective equipment, a lack of support systems, and a lack of the financial resources necessary for independence demands experienced therapists who are innovative, adaptable, flexible, and creative.

Without the supportive environment of the hospital or clinic, the home care practitioner must be able to work independently, be motivated to communicate with team members, and be able to organize schedules and the timely completion of documentation. Home care caseloads may include children with traumatic brain injury, quadriplegic patients who are ventilator-dependent, and stroke patients with multiple secondary diagnoses. Continuing education, therefore, is essential for home care practitioners to stay informed about various problems faced as well as the increasingly advanced levels of care that the home health care patient requires.

Additional direct service opportunities in home care exist in personal care and support services, with durable medical equipment companies, in hospice care, in pediatric care, and in case management.

Personal care and support services may be one of the fastest growing and highest volume segments of the home health care industry. Increasing amounts of private and Medicaid dollars are being diverted from institutions to alternative care programs that allow persons to remain at home with support services. In many states, these services are administered through Area Agencies on Aging. The Area Agencies may contract with occupational therapists to assess a person's ability to be cared for at home and to seek their recommendations for support services.

The earlier discharge of patients with acute care needs has led to the steady growth of home care durable medical equipment companies. These companies provide equipment that promotes functional independence, prevents disability, and promotes home safety. They hire skilled professionals, including occupational therapists, to assess a patient's need for functional equipment and to instruct the patient and caregiver in its installation and use.

Some home health care agencies provide hospice services, and occupational therapists are often members of the hospice team. As such, occupational therapy practitioners acknowledge individual patients' rights to autonomy, self-respect, and independence as they work to adapt self-care and leisure tasks to meet the patients' and caregivers' needs. Occupational therapists working in this area have access to the Guidelines for Occupational Therapy Services in Hospice (AOTA, 1987b).

Pediatrics is another area of home care that is developing in response to the increasing numbers of children who are released from neonatal intensive care units. Occupational therapy practitioners must gain an understanding of the services and reimbursement systems that are developing to meet the needs of families who are willing to care for their technology-dependent and seriously disabled children at home (AOTA, 1985).

Case management is an additional area of home health practice that represents opportunities for occupational therapy personnel. Traditionally, case managers have managed the resources associated with the care of persons with long-term disabilities resulting from catastrophic injuries. Within the home care industry, private case management companies are beginning to assist employers and employees in the selection of affordable and quality home health services. Case managers assess the needs of the patient and caregiver, assist them in obtaining needed services, and help them negotiate for reimbursement with third-party payers. Proposed long-term-care legislation and the Catastrophic Health Care Bill have provisions for alternative care programs that include personal care, support services, and case management.

Recommendations

Health care trends, demographics, proposed legislation, expanding reimbursement systems, and patients' preferences for autonomy and control all point to the continued growth and expansion of home health care services. To meet the challenge of home care expansion, the profession must provide qualified occupational therapy practitioners. The following points are also important:

- The specialty area of home health care should be integrated into the mainstream of occupational therapy education. Students need opportunities to observe skilled therapists in the home setting at both the preclinical and fieldwork levels. The Bay Valley Home Health Level I fieldwork experience is one example of such a setting (Burdick & Fox, 1986), but similar settings are few and need to be developed.

- As health care costs continue to rise, the profession needs to demonstrate the efficacy and cost-effectiveness of its services. Both routine outcome studies and research are needed to monitor and evaluate procedures and technologies as well as to weigh patient benefits against service costs. Occupational therapists need to establish and implement such methods on an ongoing basis before management and evaluation systems are imposed from the outside.
• Occupational therapy practitioners should submit manuscripts and case reports to peer review journals and publications to further expand the database for occupational therapy in home health care.
• Because service provision in an institutional setting differs greatly from that in a home health care setting, occupational therapy practitioners new to the home care field need continuing education opportunities as well as guidance from more experienced practitioners.

Summary
Home health care is a consumer-driven industry that will continue to grow in response to the patients' needs and the availability of payment sources that support their care. This is an opportune time for occupational therapy personnel to enter the home health care industry because of the many direct care, leadership, and administrative positions that are available. If individual practitioners wait too long to respond to the current personnel shortage in home health care, other professions will respond by developing and expanding their scope of practice to meet industry needs.

Perhaps 2 years hence, when AOTA returns to the National Association of Home Care conference, more occupational therapists will be practicing in home care or will be in leadership positions in home health care agencies throughout the country. Then, the most frequent comment to be heard may be, "Occupational therapy is the key service in our home care agency."

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References


