The clinical and professional considerations of the occupational therapist in a Medicare-approved home health agency are discussed. These considerations include the effect of Medicare regulations on occupational therapy screening, evaluation, treatment, and discharge.

An occupational therapy chart review was conducted to determine the diagnoses of patients, the duration of treatment, and the outcome of interventions. The results show that the majority of patients referred to an occupational therapist have more than one treatable diagnosis. The average duration of treatment is 7.25 visits per patient. The outcome of intervention shows that 79% of patients treated by occupational therapy were able to remain safely at home either independently or with assistance.

The recent trend in health care is to provide alternatives to hospitalization and institutionalization. The constantly rising cost of a hospital stay and an increase in the elderly and disabled populations have created a large demand for other options.

The implementation of diagnostic related groups (DRGs), the classification system presently employed for hospital Medicare reimbursement, has further encouraged shorter hospital stays. As a result, the types of patients receiving health services in the home are changing dramatically, and referrals to home health agencies are skyrocketing. For example, one proprietary home health agency, located in Oakland, California, experienced a phenomenal 18% per month growth rate over a three-month period in 1983.

The purpose of this paper is to describe the role of occupational therapy in a specific Medicare-approved home health agency. The clinical and professional considerations of the occupational therapist in this setting are discussed along with the implications of third-party reimbursement and changes in the types of patient referrals. A six-month retrospective chart review was conducted at a home health agency located in Oakland, CA. Data gathered in diagnostic categories of patients being treated by occupational therapy along with information on the duration of treatment and outcome of intervention are discussed.

**Medicare and the Home Health Agency**

To be eligible for Medicare certification, an agency must do the following:

1. provide at least one therapeutic service in addition to skilled nursing;
2. have policies developed by at least one physician and one registered nurse;
3. maintain records and charts for all patients;
4. employ professional personnel that meet qualification standards by graduating from an approved program of study or by being eligible for appropriate certification examinations; and
5. provide for regular review of policies.

To receive individual treatment reimbursement, Medicare regula-

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tions require that a patient obtain a physician's orders along with a justification of the medical necessity and frequency of all provided services. Furthermore, the patient must be considered homebound and services must not be duplicated (1).

To comply with these regulations, coordination of all services and thorough documentation is essential. Whether or not a patient is receiving duplicate services from other sources should be determined during the screening process. This may be complicated if more than one primary physician is involved in the case, because referrals may have been made to more than one agency.

Duplication of services can also occur within just one agency. For example, an occupational therapist and a physical therapist may duplicate services by providing the same patient with an upper extremity range of motion program. In such a case, one of the services may be denied reimbursement. Team conferences, complete documentation, and definition of roles within the agency can minimize the duplication of services.

**Patient Population**

Because patients have short hospital stays today, home health agencies must now provide services to a more severely ill population; this population often has chronic illnesses and more than one diagnosed condition. Data collected on 68 home health patients from July through December 1983 showed that 65% of them had more than one treatable diagnosis (see Table 1).

**Screening**

In compliance with present Medicare regulations, occupational therapists may only begin treatment after a registered nurse, speech therapist, or a physical therapist has completed an initial assessment (1). Formerly, occupational therapy could only be provided in conjunction with one of these services. In 1981, Medicare regulations were changed to allow the continuance of occupational therapy services after the need for physical therapy, nursing, or speech therapy has ended. However, the need for occupational therapy alone does not qualify an individual for Medicare coverage (2).

This restriction, although liberalized, may still not be cost efficient. A patient's dependence in activities of daily living (ADL) is often the reason why he or she is homebound. The need for ADL training, equipment, and home modification can best be determined by an occupational therapist; in some cases, this may be the only service truly required to prevent a patient's institutionalization or ADL dependency.

In an agency that uses the team approach, the occupational therapist needs to take an active role in orienting other team members to occupational therapy philosophy, modalities, and services. Ongoing education within the team and referring physicians and maintenance of open lines of communication are essential for appropriate referrals to occupational therapy.

Part of the screening process of the Medicare-approved home health agency is to determine if the patient is homebound. This is not always a simple task, because the regulation is subject to interpretation. The regulation states that a normal inability to leave home, except for infrequent periods of relatively short duration such as a doctor's visit or "an occasional trip to the barber," is the guideline for considering an individual homebound. However, someone with two fractured shoulders who could not dress, bathe, or prepare meals independently could be denied homebound status because he or she is ambulatory. An ongoing reevaluation of a patient's homebound status is required during the course of treat-

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**Table 1**

Diagnostic Analysis of Occupational Therapy Patients

<table>
<thead>
<tr>
<th>Diagnosis (Reason for referral)</th>
<th>Number of Patients</th>
<th>Percentage with Multiple Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parkinson's disease</td>
<td>4</td>
<td>100</td>
</tr>
<tr>
<td>Cardiac</td>
<td>8</td>
<td>88</td>
</tr>
<tr>
<td>Other</td>
<td>6</td>
<td>83</td>
</tr>
<tr>
<td>Orthopedic</td>
<td>17</td>
<td>76</td>
</tr>
<tr>
<td>Arthritis</td>
<td>4</td>
<td>75</td>
</tr>
<tr>
<td>Postsurgical</td>
<td>4</td>
<td>75</td>
</tr>
<tr>
<td>Renal</td>
<td>2</td>
<td>50</td>
</tr>
<tr>
<td>Respiratory disease</td>
<td>10</td>
<td>50</td>
</tr>
<tr>
<td>Neurological (CVA and Brain Injury)</td>
<td>13</td>
<td>46</td>
</tr>
<tr>
<td>Total</td>
<td>68</td>
<td>65</td>
</tr>
</tbody>
</table>

Patients defined as having multiple diagnoses were those with additional disorders actually treated by occupational therapy. Neurological disorders category was the only one with less than 50% multiple diagnoses. A possible explanation for this variance is that the functional impairments caused by the neurological disorders can be so catastrophic that other conditions are either masked or treatment is not a priority.
ment. Using the team approach to make this judgment is helpful, because different observations, professional opinions, and data can be used to define a patient's status more clearly.

Evaluation
Medicare regulations require therapists to document treatment for every home visit. As a result, occupational therapy evaluation becomes an ongoing process that is integrated with the treatment.

The initial occupational therapy evaluation consists of functional assessments to determine a patient's upper extremity strength and range, coordination, balance, and his or her ability to perform independent ADLs. Information is also gathered concerning his or her avocational interests, mental status, support systems, and activity level. In-depth reflex and sensory testing along with perceptual dysfunction evaluation are conducted if necessary. Treatment begins with the first home visit and is recorded with the evaluation results.

Familiarity with the home environment is often comforting to the patients; this is especially important for those individuals having decreased sensory functions or mental status deficits. Many of the patients referred to home health agencies have experienced a recent hospitalization. Returning home allows them to regain a sense of control in their lives, which is often denied them in the hospital. Patients can then begin to assess their deficits more realistically and work with the therapist on appropriate treatment planning. To foster this renewed sense of autonomy, it is imperative that the occupational therapy evaluation focus on the patient's perceived needs and interests, and involve the patient in goal setting.

One obvious advantage to evaluation in the home setting is that home-modification and equipment needs can be directly assessed. Occupational therapists in hospital settings rarely have the opportunity to conduct a home visit with their patients and must rely on hospital observations and interviews for their home-modification recommendations.

Treatment
Modalities used in treatment will vary depending on the needs of the patient. However, certain facets of treatment require a different emphasis in a home setting.

Equipment. Occupational therapists in a home health agency often need to be creative in their equipment usage, because the storage and transporting of clinical tools is usually impractical. However, common household items can be used for a variety of activities; this provides the patient with greater involvement and familiarity with the tools. For example, a rolling pin used on surfaces of graded resistance can be used to increase upper extremity range and strength; a patient's golf balls and tees can be used to improve his or her coordination. This creative use of equipment presumes that the therapist has a thorough understanding of the goals, motivations, and desired results of the activity.

Approach. A primary emphasis of home treatment is to assist patients in reconstructing previous activity patterns, which were disrupted by accident or illness, and in developing new patterns, which are compatible with their present condition. The medical model commonly used in hospitals is often irrelevant in the home setting because of the large number of homebound patients having chronic disorders. The therapist must be aware not only of the patient's physical condition but also the environmental, social, and personal influences on the patient, which are often not addressed in the hospital. Using a holistic approach, an occupational therapist can facilitate a patient's reintegration into the community.

Prevention. Typical problems of home health care patients include decreased endurance, strength, and sensation, poor balance and mobility, and perceptual disorders and confusion; these problems increase the risk of accidents in the home. Therefore, prevention becomes an essential component of the home health treatment process. Every treatment plan is designed to increase the patient's safety awareness and knowledge of emergency procedures, create a safe environment, and provide the patient with programs and information on preventive health care. Home programs on how to prevent exacerbations of existing disorders are also available. Such programs include joint protection, energy conservation, and exercise.

Education. It is important to educate patients and their families on home programs and to prepare them for the responsibility of ongoing treatment and prevention. For occupational therapy to be successful, patients must incorporate occupational therapy concepts into their daily lives. Both the patients and their families are encouraged to solve problems with the therapist and question the modalities and techniques used. Important factors to assist patients and their families in adjustment and allow them to plan for the re-
Responsibility of continued care realistically include discussions of disease processes, expectations, and stress levels. Early in the treatment course, home programs are provided both verbally and in writing. This allows the therapist to adjust and reinforce the program as needed and ensures that everyone involved understands the program.

Duration. The duration of the treatment is determined by the patient's progress, his or her compliance with the programs, and the nature of the disorder itself.

The retrospective chart review (see Table 2) shows that each of the 68 patients treated by occupational therapy (from July through December 1983) received an average of 7.25 occupational therapist visits per patient over a four- to eight-week period is an indication of the cost-effectiveness of home health services. Cost comparisons between home health agencies, skilled nursing facilities, and hospitals are difficult because of varying treatment times, prices per unit of service, and different calculations of overhead expenses. However, the average cost of a hospital room is $250/day, and skilled nursing facilities cost an average of $70/day (3). A substantial savings for federal programs such as Medicare could be gained simply by eliminating the cost of 24-hour room and board.

Discharge
Medicare regulations require occupational therapists to discharge patients who fail to show continued progress toward stated goals within a reasonable amount of time, do not comply with the rehabilitation program, or have achieved maximum potential. A patient must be discharged from the agency when he or she no longer requires skilled intervention from either a therapist or a nurse or when he or she is no longer considered homebound.

Outcome of Occupational Therapy Intervention
One of the primary goals of occupational therapy in a home health agency is to alleviate functional impairments and enable a person to remain safely at home. A study of patients treated by occupational therapy over a six-month period showed 79% were able to remain at home either independently or with assistance (see Table 3). Patients having a single diagnosis were 6% more likely to remain at home either independently or with assistance (see Table 3). Patients having a single diagnosis were 6% more likely to remain at home with or without assistance than those having multiple diagnoses. Individuals with a single diagnosis were 14% more likely to remain at home without assistance than those with multiple diagnoses. Ten of the sixty-eight patients were placed in skilled or intermediate care facilities. It is not possible to determine from available data exactly how many of these patients might have been able to remain at home if assistance were available.

Professional Considerations
Home health care provides occu-
Table 3
Comparison of Intervention Outcomes of Single-Diagnosis and Multiple-Diagnoses Patients

<table>
<thead>
<tr>
<th>Classification</th>
<th>Independent</th>
<th>Assist</th>
<th>Placement</th>
<th>Expired</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of single-diagnosis patients</td>
<td>12</td>
<td>8</td>
<td>2</td>
<td>2</td>
<td>24</td>
</tr>
<tr>
<td>Percent of single-diagnosis patients</td>
<td>50</td>
<td>33</td>
<td>8</td>
<td>8</td>
<td>100</td>
</tr>
<tr>
<td>Number of multiple-diagnoses patients</td>
<td>16</td>
<td>18</td>
<td>8</td>
<td>2</td>
<td>44</td>
</tr>
<tr>
<td>Percent of multiple-diagnoses patients</td>
<td>36</td>
<td>41</td>
<td>18</td>
<td>5</td>
<td>100</td>
</tr>
<tr>
<td>Number of total patients</td>
<td>28</td>
<td>26</td>
<td>10</td>
<td>4</td>
<td>68</td>
</tr>
<tr>
<td>Percent of total patients</td>
<td>41</td>
<td>38</td>
<td>15</td>
<td>6</td>
<td>100</td>
</tr>
</tbody>
</table>

Patients designated as needing assistance at home are those individuals needing the help of another for at least one activity of daily living. These assistants include family members, significant others, or nonprofessional paid personnel such as attendants, aides, or homemakers.

Occupational therapists with a unique opportunity; using the medical model, they can employ the traditional values of activity and task-oriented therapy not often found in institutional settings. The sudden growth and rapidly changing status of home care also offer opportunities for program development, research, administration, and peer education.

Occupational therapists working in a home care setting are often isolated from other occupational therapists; thus, they must have excellent observation, diagnostic, and communication skills to deliver quality treatment. Occupational therapists in a home health agency rarely are able to use established treatment protocols or clinical tools specific to home care. However, these problems can be overcome by networking. Sharing ideas of treatment modalities, home programs, documentation, and research would be beneficial to the continued growth of occupational therapy in this area of practice.

Occupational therapy networking could also be the basis for political and educational involvement representing home care. Crucial areas for the future of occupational therapy in home care lie in the involvement of consulting and educating third-party payment sources and regulatory agencies.

Summary
Occupational therapists working within Medicare guidelines for a home health agency have limitations on the types and amounts of services they can provide. These therapists are also treating a growing number of severely ill patients, who might be institutionalized if home care services were not available.

The rapid changes in patient population and reimbursement patterns cause high levels of stress for professionals and patients alike. However, these changes also provide patients with a variety of choices for health care treatment and give health care professionals career development opportunities.

Occupational therapists have a valuable service to offer the home-bound patient; occupational therapy treatment has been successful in alleviating functional impairments, thus allowing patients to remain safely in their homes. Thus, the challenge to home care occupational therapists is to substantiate further the ability of occupational therapy to provide cost-effective quality home health care.

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