Documenting Progress in Home Care

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The home is an ideal environment for the practice of occupational therapy. However, the tumultuous health care environment of the late 1990s requires practitioners to take special care not only in delivering effective services, but also in documenting the delivery of skilled care. Documentation is the bridge between the delivery of occupational therapy services in the home and the approval for reimbursement of services by third-party payers. This article presents principles for writing reimbursable progress notes for home care that are based on Medicare documents related to occupational therapy. Application of these principles can improve efficiency and excellence in practitioners' documentation skills.

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The home environment is a virtual paradise for the practice of occupational therapy. Therapeutically selected, adapted, and graded involvement in familiar activities of daily living (ADL) provide a natural form of exercise that can restore health-producing cycles of involvement in self-care, work, play and leisure, and sleep. According to MacRae (1984), “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” (p. 723). The “real” environment of the home provides the ideal context in which to practice habit training, facilitate healthy patterns of temporal adaptation and functional performance, and observe and foster occupational adaptation as described by leaders throughout the history of the occupational therapy profession (Kielhofner, 1985; Meyer, 1922; Reed, 1984; Schkade & Schultz, 1992; Schultz & Schkade, 1992). In contrast to the home atmosphere, which is conducive to the practice of occupational therapy, is the tumult in health care service delivery surrounding the transition from fee-for-service to managed care models. The current atmosphere, which appears threatening, may actually exact from practitioners a purer practice of occupational therapy.

Today, the need for home-based occupational therapy services in the American culture is so real that if the discipline did not currently exist, the pressures of the current health care system would have to create a discipline to provide the services offered by occupational therapy. Since 1983, when the prospective payment system was legislated, increased numbers of persons have been released from hospitals and returned to their homes with needs for professional assistance to enable a return to functional independence. Shorter lengths of stay in the hospital have resulted in greater health care needs in the home. Professional services are needed to adapt the environment or the demands of activities for safety and function; to train caregivers and family members in compensatory methods, the use of adaptive equipment, special handling techniques, and the use and maintenance of personal care devices; to prevent medical complications; to reduce pain; and to maintain function. Occupational therapy practitioners are prepared to provide these skilled services. One of the major challenges facing home care practitioners is the documentation of the delivery of these services so that third-party payers recognize them as skilled and medically necessary and agree to pay for them.

Documentation

Many books, articles, and official documents cover the
essentials of documentation (Allen, Foto, Moon-Sperling, & Wilson, 1989; American Occupational Therapy Association [AOTA], 1992, 1995; DePaoli & Zenk-Jones, 1984). The purpose of this article is to clarify documentation principles that occupational therapy practitioners can apply to increase efficiency and the potential for reimbursement. It is primarily written to assist practitioners in writing the daily, brief progress notes that must follow each home visit; however, these same principles can be applied in the documentation of occupational therapy services delivered in any setting.

The Target Audience

According to Robertson (1992), the content an occupational therapy practitioner selects for documentation in the medical record depends on the target audience. The target audience may be the treatment team, the client, third-party payers, or others. A key to keeping documentation concise and brief is the identification of the target audience. In home health, progress notes are typically written for the practitioner (i.e., to keep track of the intervention plan, to guide plans for the next visit), for the treatment team (i.e., to document communication within and between disciplines, to prevent overlap), for accrediting agencies (i.e., to maintain accreditation status), and for third-party payers (i.e., to receive reimbursement).

Kunstaetter (1988) revealed that there was a discrepancy between the treatment provided by home care occupational therapy practitioners and what they documented in the medical record. The surveyed practitioners documented what was reimbursable in areas where they could easily show progress. Kunstaetter warned: “By allowing reimbursement regulations to determine our treatment and documentation needs, we may be gradually diverging from the essence of occupational therapy” (p. 518). As we enter the 21st century, occupational therapy must not permit the changing trends of the health care delivery system to define what the profession has to offer persons with disabilities who are homebound. In understanding current reimbursement guidelines, practitioners must grow in their ability to articulate the importance of occupational therapy services in enabling clients to achieve valued functional outcomes. The application of information related to reimbursement guidelines is intended to assure the delivery of the full scope and potential of occupational therapy services in the home by assisting practitioners in documenting in a manner acceptable to medical reviewers. The concept that documentation of services must be in accordance with reimbursement guidelines should presume only that the content selected for third-party payers, as a target audience, is a critical issue.

Third-Party Payers

Medicare is the largest third-party payer in the United States (Scott & Somers, 1992); private health insurance companies tend to copy the practice of government (Steinhauer, 1984). Because Medicare guidelines continue today to be the dominating standard that private insurance companies use in establishing coverage and medical review criteria, an analysis of the philosophy that underlies the federal documents may help occupational therapy practitioners to document in a manner that meets third-party payer standards. To this end, I analyzed the coverage guidelines in the Medicare Home Health Agency Manual (Health Care Financing Administration [HCFA], 1996) and Medical Review of Part B Intermediary Outpatient Occupational Therapy Bills (HCFA, 1989) guidelines and synthesized basic assumptions that appear to underlie these documents (see Appendix). I also identified principles to assist practitioners in understanding how to write progress notes that comply with these assumptions. Without exception, these principles also reflect excellent standards for occupational therapy documentation in all settings:

- Focus on function
- Focus on underlying causes
- Focus on progress
- Focus on safety
- State expectations for progress
- Explain slow progress or lack of progress
- Summarize skilled services delivered

Principles for Reimbursement

Focus on Function

Prior level of function. One of the most critical components of any initial home care occupational therapy evaluation is documentation of the prior level of function. A statement that incorporates environmental clues can connote a level of function beyond simple independence. For example: “Before hospitalization, the client was living independently in a three-story home, was independent in all self-care and homemaking, and used bathroom facilities on the second floor and laundry facilities in the basement.”

Identify and focus on meaningful activities. Probing interview skills are essential for identifying meaningful activities that the client was previously able to perform, that he or she is able or able to currently perform, and that he or she can be expected to resume. The Uniform Terminology (AOTA, 1994b) provides a careful breakdown of performance areas that can be used to establish long-term or short-term functional goals.

Long-term versus short-term goals. The classification of goals as long term or short term is determined according to the needs of each client. A long-term goal for one client may be a short-term goal for another.
TABLE 1  
Example of Establishing Short-Term Goals

<table>
<thead>
<tr>
<th>Short-Term Goals Based on Performance Component Deficits Could Be:</th>
<th>Short-Term Goals Based on Task Analysis Could Be:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trunk flexion and BUE forward reach adequate for LE dressing</td>
<td>Client will be able to properly place trousers over feet for donning.</td>
</tr>
<tr>
<td>Cognitive-perceptual skills adequate for positioning clothing for LE dressing</td>
<td>Client will be able to spontaneously dress LLE before RLE.</td>
</tr>
<tr>
<td>Endurance adequate for safety and independence in LE dressing</td>
<td>Client will be able to pull up trousers from a supported standing position.</td>
</tr>
<tr>
<td>Demonstrate compensatory methods and appropriate use of adaptive equipment for safe, independent LE dressing</td>
<td>Client will be able to demonstrate proper use of sock donor and long-handled shoe horn and complete LE dressing in 5 min without becoming SOB.</td>
</tr>
</tbody>
</table>

Note. BUE = both upper extremities; LE = lower extremity; LLE = left lower extremity; RLE = right lower extremity; SOB = shortness of breath.
eral Principles Governing Reasonable and Necessary Physical Therapy, Speech-Language Pathology Services, and Occupational Therapy," states that services are skilled if they "are necessary to the establishment of a safe and effective maintenance program" (§ 205.2, A.5.c.) or are "needed to manage and periodically reevaluate the appropriateness of a maintenance program" (§ 205.2, A.2.). Although the administration of periodic reevaluations is not uniformly practiced (often to the detriment of the person who needs this type of follow-up), functional maintenance programs are commonly a part of home health care.

Functional maintenance programs are similar to what is often termed a discharge program, a home program, or a home exercise program. The basic purpose of a functional maintenance program is to assure that the client, family member, or permanent caregiver will perform activities in a health-producing manner after skilled services are terminated. If a practitioner expects the client to use adaptive equipment or orthotic devices or the family members or caregivers to perform therapeutic handling or assistance during ADL, then a functional maintenance program should be documented. An example of goals and plans designed as part of a maintenance program includes the following:

**Goal:** Caregiver to provide safe, return demonstration of the following:
1. Donning and doffing the hand splint.
2. Safely using and adjusting wearing schedule.
3. Identifying a need for OT reevaluation, reasons for professional evaluation, and need for splint modification.
4. Therapeutically handling RUE during active-assistive ROM.
5. Demonstrating the proper type, timing, and frequency of verbal cues and physical assistance for client to maintain minimal assistance level of UE and LE dressing.

**Plan:** Instruct caregiver in therapeutic techniques related to functional maintenance program (as outlined in goals).

Note that the goals of a functional maintenance program can identify a family member or caregiver as the person receiving instruction. Practitioners should instruct to a level that will assure that family members, caregivers, or both understand the functional maintenance goals, the benefits of doing the program, and the potential consequences if the program is not followed and that they have the skills and confidence to carry out the maintenance program. The more specific occupational therapists can be in goal setting, the easier it will be to compute and justify the number of visits needed to accomplish the goals. Additionally, specific goals will support effective follow-through by occupational therapy assistants in carrying out the program.

**Focus on Underlying Factors**

Skilled evaluations document the relationship between medical problems and function. More specifically, occupational therapy practitioners identify specific physical or cognitive impairments that interfere with independence or safety in performance areas. Allen et al. (1989) stated: "When reimbursement is denied or delayed, it is often due to insufficient documentation—either the documentation lacks technical accuracy or lacks details supporting medical necessity [italics added]" (p. 798). (Note that these experts do not say that the documentation lacks details about media or methods used in occupational therapy.)

The key in this principle is to combine medical knowledge with observation and task analysis to identify the specific impairments that restrict or limit occupational function. This principle challenges practitioners to document the clinical reasoning that underlies the establishment of goals (e.g., Why should we be reimbursed for involving the client in activities to increase fine motor coordination?). For example: "Fine motor incoordination in the client's dominant right hand prevents independence in UE dressing," or "Weak mass grasp in the client's dominant right hand makes meal preparation dangerous."

The medical review guidelines related to skilled occupational therapy (HCFA, 1989) states that to be considered skilled, "The documentation must indicate that the severity of the physical/emotional/perceptual/cognitive disability requires complex and sophisticated knowledge to identify current and potential capabilities." (§ 3906.5a). Documenting the severity of the client's disability requires occupational therapy practitioners' full use of their strong medical background as well as integration of their occupational analysis skills. This principle challenges practitioners to concisely articulate the relationships that are identified and that underlie dysfunction. For example:

- Poor error awareness prevents this client from being independent in grooming and hygiene skills.
- Visual scanning and attention deficits contribute to the client's inability to feed herself independently.
- RUE and placement deficits and awkward grasp patterns prevent independence in LE dressing.
- Client's poor standing tolerance is preventing her from returning to independence in homemaking.
- Poor postural adjustment mechanisms (fear of trunk rotation and weight bearing on ULE [left lower extremity]) contribute to unsafe functional mobility skills. Unsafe functional mobility skills contribute to a lack of independence in toileting, hygiene, bathing, and dressing skills.

In these examples, documenting the relationship supports the need for the occupational therapy practitioner to involve the client in activities to increase error awareness,
improve visual scanning and attention skills, develop RUE motor control, and develop postural control in a standing position (functional mobility skills). Although the examples are not at a level of specificity typically seen in "treatment-oriented" documentation, they demonstrate statements of analysis that are important for practitioners to include in medical records in order to enable medical reviewers to agree to approve reimbursement of services.

In situations where the client is progressing slowly, application of this principle can be a strong tool for writing documentation that leads to reimbursement. Instead of focusing on the slowness, practitioners can document specifics about the impairments that are causing the functional disability. Practitioners must not become desensitized to the gravity and weight of suffering that clients are experiencing (e.g., the paralysis, the pain, the weakness and fatigue that accompanies use of compensatory methods and adaptive equipment). Their words must open the medical reviewer's eyes to the severity and complexity of the dysfunction observed during therapy. When practitioners are in the midst of an ADL retraining program, and the client is making steady, but slow, progress, it would be wise to document underlying causes and to avoid benign statements such as "client is progressing well." Uninformative rhetoric fills the medical records with "weeds" that the reviewer must ignore or uproot in order to discern the client's status and progress. Good documentation concisely communicates critical relationships between impairment and function.

Focus on Progress

A progress statement is more than that of current status; it should include a comparative analysis that informs the reader of change. The medical review guidelines (HCFA, 1989) provide clear descriptions of six levels of assistance that occupational therapy practitioners can be expected to use in evaluating progress. Although practitioners are free to use whatever scale they prefer, it is certainly an advantage to be aware of, if not use, the scale that HCFA has acknowledged. The following descriptors have been selected from this document to portray the various levels of assistance:

1. Total Assistance—initiates minimal voluntary motor actions, 100% assistance by one or more helpers
2. Maximum Assistance—75% assistance by one person, physical support needed each step, one-to-one demonstration
3. Moderate Assistance—50% assistance by one person, assistance needed every time, intermittent demonstration; occupational therapy practitioner or caregiver must be in the immediate area
4. Minimum Assistance—25% assistance by one person; requires setup; needs help to initiate or sustain an activity; needs help to review alternate procedures, sequences, and methods; needs help to correct repeated mistakes; needs periodic cognitive assistance to check safety compliance; needs assistance to solve problems posed by unexpected hazards.
5. Standby Assistance—supervision needed for safe, effective performance of adapted methods, safety precautions
6. Independent Status

The six levels provide much room for demonstrating progress. Practitioners must accurately establish a baseline to enable progress to be demonstrated. In most cases when adaptive equipment is initially issued to a client, one-to-one demonstration is provided (i.e., maximum assistance). If on the next visit, the client requires only intermittent demonstration, he or she has progressed from maximum to moderate assistance. The client who then requires only instruction or reminders in using alternate methods has progressed from moderate to minimal assistance. A client who lacks only the confidence to perform the task without supervision (e.g., fears falling or failure) has progressed from minimal to standby assistance. Clients progress from standby assistance to independent status when they do not need setup or safety supervision in performing a task.

The medical review guidelines (HCFA, 1989, § 3906.4b) also clearly inform reviewers that clients may experience progress within each level of assistance, if the occupational therapy practitioner documents a change in response to treatment, as evidenced by one of the following:

1. Decreased refusals
2. Increased consistency
3. Increased generalization

These concepts direct practitioners to document progress when a client is not moving rapidly from maximum, to moderate, to minimal assistance. Most home care practitioners have experienced the plight of arriving at a home treatment session to find that the client has, during the practitioner's absence, attempted (or mastered) the very skill that the practitioner had planned to evaluate, adapt,
or retrain. The good news is that there is no need for frustration: The practitioner has unearthed clear evidence of progress. The evaluation skills of the home care occupational therapist are a skilled service. Practitioners may document a client’s progress by noting generalization of the adaptation process from one skill to another, even if the progress occurred between visits. Such progress does not indicate that recovery is occurring spontaneously (i.e., that it would occur without the occupational therapy program in place), only that it is occurring between visits. An effective occupational therapy program may facilitate progress between visits, and practitioners should document such generalization as progress.

In addition to progress being demonstrated by changes in levels of assistance and changes within an assistance level, medical review guidelines state that progress in occupational therapy is evidenced when “a new skilled functional activity is initiated” (HCFA, 1989, § 3906.4c) or “a new skilled compensatory technique is added” (§ 3906.4d). Therefore, practitioners would be wise to sequence and organize intervention plans so that visits clearly document when a new actual performance evaluation of an area is completed or when a new technique or compensatory method is attempted. Instead of providing three pieces of adaptive equipment in one visit and documenting all three during three subsequent visits, it may be clearer to focus each visit on the skilled training that occurred with one piece of equipment (or compensatory method).

Focus on Safety

Third-party payers recognize the critical importance of safety in the home. The professional skills of occupational therapy practitioners play an extremely important role in evaluating and intervening in safety issues. The medical review guidelines describe in detail occupational therapy’s role in evaluating safety dependence and secondary complications (HCFA, 1989). For example, the guidelines recognize the potential for skin breakdown as a safety concern, going on to state:

Safety dependence may be demonstrated by high probability of falling, lack of environmental safety awareness, swallowing difficulties, abnormal aggressive/destructive behavior, severe pain, loss of skin sensation, progressive joint contracture, and joint protection/preservation requiring skilled occupational therapy intervention to protect the patient from further medical complication. (§ 3906.2)

Focusing on the evaluation and treatment of these safety issues in a progress note provides a clear view of the medical necessity for occupational therapy services.

State Expectations for Progress

Occupational therapy practitioners should carefully document expectations for progress related to independence and safety. The medical review guidelines state:

Occupational therapy services are covered only to the time that no further significant practical improvement can be expected. Progress reports or status summaries must document a continued expectation that the patient’s condition will continue to improve in a reasonable and generally predictable period of time [italics added]. (HCFA, 1989, § 3906.4)

The question is: Whose expectations? The answer cannot be “the medical reviewer who has never seen the client.” The occupational therapy practitioner’s professional judgment must be clearly stated: if there are expectations that the client will improve, then the progress note should include a concise statement of those expectations. Again, this is an important principle to apply if a practitioner is attempting to retrain a client in the safe, functional performance of a self-care task, and the client is not progressing quickly from one assistance level to another. The practitioner’s professional judgment that the client will achieve a higher level of independence or safety is key information to be included in a progress note.

Explain Slow Progress or Lack of Progress

The home health coverage guidelines (HCFA, 1996) use the terms reasonable and necessary to describe the amount, frequency, and duration of skilled therapy services that are covered. Although these terms may seem too vague to set clear limits, they provide the leniency needed to justify service delivery in special cases when progress is delayed by unique medical or life circumstances. The occupational therapy practitioner is responsible for documenting the aspects of the client’s condition or situation that has delayed progress. In an attempt to prepare reviewers for the potential delays that occur in rehabilitation, the medical review guidelines modify the guideline calling for “significant practical improvement” by stating: “Do not interpret the term ‘significant’ so stringently that you deny a claim simply because of a temporary setback in the patient’s progress” (HCFA, 1989, § 3906.4). Temporary setbacks are commonly caused by pain; medication changes; medical complications; and external circumstances, such as a death in the family. Practitioners should clearly document temporary setbacks that will delay progress toward goals. Appropriate use of the term temporary setback in the medical record could assist the medical reviewer in understanding the circumstances.

More commonly, progress may be slowed by difficulties practitioners encounter during the therapeutic process. Does Medicare cover a practice period to evaluate consistency of task performance? If a new compensatory method had been demonstrated to a client, would Medicare cover a practice session to evaluate whether the method actually improved function? The answer to both questions is yes.
In a section devoted to describing skilled occupational therapy, Medicare’s medical review guidelines describe the importance of granting time for effective training: “A period of practice may be approved for the patient and/or patient’s caregivers to learn the steps of the task, to verify the task’s effectiveness in improving function, and to check for safe and consistent task performance” (HCFA, 1989, § 3906.5a). The key to reimbursement in these situations is appropriate documentation. Practitioners do not “monitor performance” or simply “observe client perform” a task; the skilled evaluation purposes of the session must be clearly stated. For example:

Dressing: OT [occupational therapy] evaluated the effectiveness of compensatory methods demonstrated last session. Methods were modified to increase safety. Client demonstrated inconsistency in her ability to remember the proper movement sequence needed in donning her blouse.

*Summarize Skilled Services Delivered*

The *Elements of Clinical Documentation* (AOTA, 1995) states that when writing a contact, treatment, or visit note that activities, techniques, and modalities used may be indicated by checklist or brief statement. This directs practitioners away from the “blow-by-blow” reporting of the treatment provided. Reviewers do not have the time to wade through lengthy descriptions of every action taken during each session. For reimbursement purposes, it is vital that each visit reflect the delivery of skilled services. However, this information should be a brief, summary-type statement of what occurred. Evaluations are skilled services (HCFA, 1996); therefore, any actual performance evaluation of an ADL skill should be documented. Other skilled services can be categorized as direct intervention (e.g., ADL retraining; involvement in activities selected or adapted to challenge the development of performance components or areas; orthotic design, fabrication, fitting) or as instruction related to the maintenance program.

*Evaluations.* Because evaluations are considered skilled services, the documentation of plans for actual performance evaluations clarifies that skilled services are still needed. Plans to evaluate a client’s ability to perform an ADL skill or ability to integrate energy conservation methods (or other health-reinforcing principles) during the performance of a specific ADL skill demonstrate the continued need for occupational therapy.

*Direct intervention.* Occupational therapy practitioners spend a lot of time on ADL retraining. A simple statement informing the reviewer that ADL retraining is occurring in a specific area can be followed by statements that relate to one or more of the principles listed previously. For example:

*Grooming:* Client was instructed in compensatory methods to overcome visual attention problems during shaving. He has progressed from requiring moderate assistance to needing minimal assistance. He is expected to progress to independence.

Practitioners should document recommendations for adaptive equipment, regardless of the client’s decision to follow the recommendation. (This can protect the practitioner from litigation directed toward the absence of equipment that could have protected a client from injury.) If equipment is issued, or if a client is trained in the safe, appropriate use of equipment, this should also be documented.

Practitioners must decide for whom they are writing. If the target audience is a supervisor concerned with service competency in a specific area, then treatment-oriented information should be included. Or, if a registered occupational therapist conducts a supervisory visit and wants to communicate more information to a certified occupational therapy assistant, then specific treatment-oriented information should be included in the medical record. However, if a practitioner is writing a visit note with the third-party payer as the target audience, specifics of treatment related to media and strategies may be brief. For certified occupational therapy assistants who have already demonstrated service competency, or for registered occupational therapists who are providing continuous direct care to a client, the details of treatment may be greatly reduced in the medical record. Reducing the amount of treatment-oriented information in the medical record will enable reviewers to quickly identify important information about medical necessity and the critical role of occupational therapy in facilitating independence and safety in the home. (Practitioners should also recall that specific treatment information may be recorded in an abbreviated fashion in departmental records.)

*Instruction.* In the field of occupational therapy, instruction is commonly considered a part of intervention; after all, ADL retraining is often a matter of instructing clients in alternative methods. However, home care occupational therapy forms are often designed from a nursing perspective in which client instruction is separated from direct nursing. Practitioners must either accept this seemingly artificial division or develop forms that are more clearly aligned with occupational therapy models of practice. If practitioners must use forms that separate direct care from teaching and education (e.g., a checklist to indicate that instruction has been provided in a specific area), they should not feel compelled to duplicate information in the narrative section of the note.

Regardless of the format used, when occupational therapy practitioners provide any type of instruction, it is imperative that the client’s (or caregiver’s) response to the instruction be documented. This is especially important in cases where the learner may need more instruction
than is commonly needed (e.g., because of fear, pain, memory deficits). The practitioner's expectations for the learner to understand and demonstrate the skill being addressed may also be documented, similar to expectation for progress. Any maintenance program (i.e., home exercise, discharge) should be provided in writing to the client and should be included in the medical record. In some cases, when a specific protocol is commonly followed and is on file in the departmental records, practitioners may provide a written copy to the client and state the title of the protocol or instructional material in the medical record.

**Coordination with other disciplines.** In addition to making concise statements about the skilled services provided, practitioners may also make statements about the coordination of these services with other disciplines. Some home care agencies have developed progress note forms with special sections for the documentation of interdisciplinary communication and cooperation. If no special section exists, practitioners are encouraged to write the statement in the functional section to which the communication most closely relates. For instance, if an occupational therapy practitioner discussed transfer methods with the physical therapy practitioner and was working on the development of transfer skills for bathing, then a statement about the interdisciplinary communication could be placed in the bathing section of the note. Recording interdisciplinary communication will provide the reviewer with concrete evidence of cooperation and emphasize that overlap is not occurring.

**Summary: Case Example**

The selection of content for documentation in the medical record is an important skill home health practitioners use after every treatment session. Although not all of the principles are expected to be applied to every progress note, they can be used to examine the "reimbursement potential" of each note. Figure 1 is a case example that illustrates the application, and lack of application, of the principles. The context is set with a few brief highlights. A poor example illustrates common errors found in occupational therapy records, and a good example illustrates many of the principles described in this article.

**Conclusion**

Home-based occupational therapy practice enables practitioners to apply the core concepts on which the discipline was founded. Therapist-designed exercises that use newly purchased materials give way to real-life activities that clients want to resume and that, echoing the essence of our profession, provide "occupation therapy." There is no time and not much reason or financial support for involving clients in exercises or drills that focus on performance components that do not directly affect functional outcomes. The documentation of home care occupational therapy must stress the functional focus of our discipline. We cannot afford to have progress notes emphasize repetitive routines or small gains in the learning of home exercise programs that focus on performance components (e.g., upper-extremity strengthening) if there is no significant improvement expected in a meaningful performance area. The principles described in this article are meant to enable practitioners to maintain a view of the large, meaningful picture of what home care occupational therapy is about and to be able to document these services appropriately. The analysis of the third-party payer as a target audience should encourage practitioners to stay focused on the essential concepts of function, safety, and underlying factors that interfere with function and safety; progress toward goals; and expectations of progress. This analysis also encourages a progress-oriented (or outcome-oriented) rather than a treatment-oriented approach to documentation. Occupational therapy has the potential to lead the home health team in focusing on the real needs of the client who is homebound. Occupational therapy services, and the documentation of these services, must stay true to the core values of the discipline for the sake of our clients and the future of our profession. ▲

**Appendix**

**Assumptions for Reimbursement**

Occupational therapy will be reimbursed if:

1. The client has functional limitations that can be decreased.
2. The client's physical or cognitive impairments are interfering with function or safety, and
3. The client either is showing progress, has a good acute reason for not showing progress, or is expected to show progress.
4. The services delivered by the practitioner are skilled care, documented as evaluation or reevaluation; therapeutic intervention; or client, family member, caregiver instruction or training.
5. The practitioner has "skilled plans" that will significantly affect the client's level of independence or safety in performance areas or will design and implement a functional maintenance plan to be carried out by family members or caregivers.

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**References**

Figure 1. Poor and good case examples of progress note documentation. In the 4th week of the certification period, a practitioner is developing safety and independence in bathing using a tub-transfer bench. The first session established that the client required maximum assistance for transfers. During the second session, the client progressed from needing maximum assistance during transfers to needing moderate assistance. During the third training session, the practitioner’s note focused on performance of bathing and the performance components that interfered with safety and independence. This is the fourth bathing training session; it went much the same as the third, although the client’s potential for improving became clearer. Note. ADL = activities of daily living; LLE = left lower extremity; OT = occupational therapist; POC = plan of care.


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