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Integrating Occupational Therapy into Home-Based Primary Care Webinar Questions and Answers

Q: Any tips for integrating OT into a Palliative Program? Are there any specific goals that you would recommend for OT in palliative practice?

OT has been involved in hospice and palliative care. We as a profession – through our national association (American Occupational Therapy Association) – has a position paper on the goals. It ranges from anything having to do with caregiver education and continued engagement of patient in those activities that are most meaningful to them. Many of the goals are also similar to what we provide when deal with chronic disease management, managing fatigue, providing adaptive techniques and equipment for continued participation, as able. The primary goal is to empower the individual to be able to be engaged as much as possible in whatever activities are important to them. There have been effectiveness studies done where there has been a change in functional performance, patient satisfaction, and quality of life for people living with cancer, heart failure, respiratory diseases, neurodegenerative diseases, and even advanced dementia. In terms of integration, OT's are available through hospice and palliative care teams as out-patient or within the home.

Q: Where can we find more information about primary care OT for non-homebound patients?

There is a growing trend of private practitioners providing what they are now calling "Mobile Therapy." They are essentially Medicare Part B providers or are able to charge private insurance. Depending on what state you live in, there might be avenues for you to find out who those individuals are. As was mentioned during the presentation, there are primary care OTs who provides these services through the Patient Centered Medical Homes (PCMH) as an extended out-patient service in the home and there wouldn't be the homebound requirement for these patients.

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Q: What are the environmental characteristics to observe for patients for their functional potential?

It is driven by the activity that is expected by the patient, what might work well for one family member may not work well for the actual patient. It may begin with an assessment they have difficulties with their self-care tasks, look at the transfers that they are performing, addressing the toilet seat height, need for grab bars, safe access to tub, ability to reach food items etc. Assessing the physical environment alone will not provide the information on what the person's functional performance is within that environment. It is primarily to look at the environment being dependent on what they expect to be able to do. Examples might begin with determining how individuals are able to access necessary ADL and IADL items, making sure there are no obstructions, appropriate placement of necessary ADL items based on the patient's reaching height and balance, assessing for fall risks within the environment (need for handrails, low lighting) and risks for the individual patient (low BP/meds, vision, etc.). Very much the principles that I used to look at someone is similar to what ergonomics is in terms of looking at their anthropometric measurements and ensuring they "fit" within their home, that there is the proper person-environment fit.

Q: What is most helpful to include in an order for home-based occupational therapy orders?

As a practitioner, I would look for information about any medical contraindications and activity restrictions, and what the primary medical diagnosis is. It is helpful to know what the reason for the referral to OT is for, to assess for safety, determine functional abilities, whatever is a concern of the referral provider. It isn't uncommon that an order could just be about evaluate and treat. The amount of information on the orders would also be dependent upon whether the OT practitioner would have access to the patient's medical records. To summarize, it is helpful to have the diagnosis and if there are any specific functional or activity limitations and medical contra-indications.

Q: How many staff are employed by the program? How are savings tracked? For how long are patients tracked after an intervention? Are patients able to have another intervention later if this destabilize over time?

The staff usually have about 35 participants at once, and in a year about 90 to 105 in their caseload. Places tend to hire part time or full time based around a caseload. How the savings are tracked really depends on the organization. We had Medicare and Medicaid numbers as it was part of a research study. As insurance companies and other places are starting to do this, they can track through their own metrics. If you were part of Habitat for Humanity or a local home health agency, you would have to

work with the payers to track the utilization unless you were just to ask the people if they had been in a hospital or been in a nursing home.

For our research, we tracked up to 12 months, and the cost people did it for two years. If someone was to do it for their own practice, we let them decide what works for them. That is up to the implementing site. We have certain guidelines that we require, for example people can't drop out of OT for PT. Someone could get it the next year if they had a stroke or the next year, but again these are up to the implementing sites. We also have some sites that have set it up as a prehab if some is going to have a planned surgery like a hip or a heart valve or something. We can look at goals and fix up the house.

Q: How is a handyman repair person vetted to make sure that the work is done in a quality fashion?

Typically, what the CAPABLE sites do is they work with a separate organization that does its own licensing and bonding for the for the handy worker. Or, it is a Habitat for Humanity that starts the project and they have vetted everyone. It is important to work with reputable providers; we don't recommend getting bids for each job as it can be exhausting for the older adult. It is much better for the health place to hire their own handy workers or what's more usual is to contract with a nonprofit that either already exists with making older adult's house safer or an Ameri Corps site that trains people in carpentry. We do have lists and networks to hook people up with that, you don't just want to connect with someone who drives by with a hammer and looks handy.