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Referral patterns to occupational therapy in home health care

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**REFERRAL PATTERNS TO OCCUPATIONAL THERAPY
IN HOME HEALTH CARE**

A Thesis

Presented to

**The Faculty of the Department
of Occupational Therapy
San Jose State University**

**In Partial Fulfillment
of the Requirements for the Degree
Master of Science**

By

Erelah Maisun Gafni

December, 1997

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ABSTRACT

REFERRAL PATTERNS TO OCCUPATIONAL THERAPY IN HOME HEALTH CARE

by Erelah M. Gafni

Referral for home health care is the means by which treatment for patients who are returning home from other care institutions is initiated. Referrals are an essential aspect to the survival of a home health agency and to each discipline within the agency. The rate or frequency of referrals to occupational therapy in home health is the subject of this study.

Two home health agencies participated in the study. Nine hundred and seventy-three referrals were reviewed, from which 125 referrals were selected as having occupational therapy appropriate treatment needs. These needs were: Activities of Daily Living (ADL), Safety, and Mobility.

Findings did not indicate a shortage of primary referrals for occupational therapy as was anticipated. There were indications, however, that physicians and discharge planners are much more likely to refer patients with the above problem areas to physical therapy than to occupational therapy. Another finding was that occupational therapy received more referrals from outside sources than from within the agency. This finding was also different from what was expected.

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Chapter 1

INTRODUCTION

Purpose of The Study

The purpose of this study was to determine the level of utilization of occupational therapy as indicated by referrals for home health care through area home health agencies.

The percentage of primary referrals directed to occupational therapy was compared with the percentage of referrals directed to other disciplines within the home health agency. In addition, the frequency with which primary referrals were made to occupational therapy was compared with the frequency with which secondary referrals or interdisciplinary cross referrals were made to occupational therapy in home health care.

Statement of the Problem

Although occupational therapy services are offered through the majority of existing home health agencies today, they are often overlooked by physicians and discharge planners who refer patients to those agencies. This oversight is believed to result in patients being overlooked for occupational therapy or, if later referral is made, the timeliness may be questionable. There are times when members of other disciplines in the home health agency attempt to fill the gap by addressing issues which the occupational therapist would have addressed had a referral been made. While their efforts are well intended, they may lack the expertise needed to fully address the problem and

therefore fail to achieve optimal results in terms of patient's compliance and follow through.

As reality points to an emergence of business philosophy in the health care system, it is important for the value of each discipline within the home health agency to be accurately reflected in the number of referrals that it receives. A slow rate of referrals to occupational therapy may decrease the status of occupational therapy as a revenue generating service within the agency. In today's health care climate that is reimbursement driven and in which concern for the "bottom line" ranks high, the economic viability of a service is an important aspect in the assurance of the presence of a profession to provide services required by the patients.

Occupational therapists who are practicing in home health care settings at the present time perceive the number of referrals to occupational therapy services to be limited. In most rehabilitation facilities patients receive occupational therapy automatically. In home health care, however, patients receive occupational therapy only if a referral is made. Therefore, occupational therapy utilization occurs in direct proportion to the frequency with which referrals are made. The question of whether occupational therapy services are generally underutilized in home health care has not previously been studied.

Research Questions

The research questions generated for this study were:

1. What is the frequency with which primary referrals are made to occupational therapy in home health care for patients with identified activities of daily living (ADL), safety, and mobility needs?

2. Will the frequency of primary referrals to occupational therapy in home health care for patients with identified activities of daily living (ADL), safety, and mobility needs, be similar to the frequency of primary referrals to physical therapy or nursing services for patients with the same identified needs?

3. Will the frequency of secondary referrals to occupational therapy services in home health care be similar to the frequency of primary referrals to occupational therapy in home health care?

The three problem areas of ADL, safety, and mobility were chosen for three reasons: 1) they are appropriate for occupational therapy from the standpoint of the profession's theoretical and clinical base; 2) they were identified by Medicare Guidelines for Home Health as areas indicating the need for occupational therapy intervention; and 3) they represent commonly used terminology for home health referrals.

Definitions

Definitions for terms used in this study are:

Activities of daily living (ADL) are occupational performance tasks required for achieving competence in life roles (Pedretti & Zoltan, 1990). They include tasks of self-maintenance, communication, and home management. Self-maintenance includes dressing, feeding, toileting, bathing, and grooming. Communication skills include the ability to write, operate a personal computer, read, type, use the telephone, tape recorder or special communication device. Home management includes marketing, meal planning and preparation, cleaning, laundry, child care, and operating household appliances such as

vacuum cleaner, can opener, range, refrigerator, electric mixer, and hand operated utensils, as well as manipulating keys, faucets, light switches, windows, doors, scissors (Pedretti & Zoltan, 1990).

Home health agency is a facility that offers skilled professional services such as nursing, physical, occupational, and speech therapy, medical social service, and home health aide services which include assistance in personal care and light house keeping. Home health agencies are reimbursed for their services by Medicare, Medicaid, and private insurance (Corkery, 1989).

Home health care can be defined as a spectrum of services provided for patients and their families in their place of residence. Its aim is to promote, maintain, or restore health, or minimize the effects of illness and disability (Corkey, 1989). Home care uses a holistic approach for the provision of therapeutic services in the patient's home, which takes into account the patient's ethnic/cultural background, psychological response to illness and disability, psychosocial dynamics and availability of support systems (Willard & Spackman, 1988).

Level of utilization in this study is the frequency with which a particular service is requested through a referral. The number of individual patients who are seen by a specific discipline indicates the level of utilization of this discipline.

Mobility is the means by which a patient moves himself/herself from one position to another, or from one area to another. Mobility includes bed

mobility (rolling from side to side, scooting up and down, bridging, supine to sit), wheel chair mobility (wheel chair propulsion on level and uneven surface, indoors and outdoors, ramps, curbs), transfer training (sit to stand, bed transfer, wheel chair transfer, toilet transfer, tub transfer, shower transfer, car transfer, floor transfer), and functional ambulation with assistive devices: single point cane, quad cane, walker (Pedretti & Zoltan, 1990).

Primary referral is a referral that is generated outside the home health agency. It comes to the home health agency from acute care settings, outpatient clinics, or other health care settings. The referring professional is most often the physician or the discharge planner who is usually a nurse or a medical social worker (Guidelines for OT services in home health, American Occupational Therapy Association).

Frequency of referrals is the percentage of referrals with specific problem area(s) designated for a particular discipline in the agency.

Referral is the channel of communication through which cases are directed to a home health agency. Referral initiates home health service. Referrals are an essential aspect of the survival of a home health agency, without referrals the agency would not continue to exist (Harris, 1994).

Safety is any aspect of the patient's life that is concerned with risk of injury. It includes, but is not limited to the patient's cognitive status including safety judgment, safety awareness, impulsivity, concentration and attention, which

comprises the intrinsic risk for falls; the patient's physical status including balance, coordination and sensorimotor status, which comprises the extrinsic risk for falls; psychosocial situation including appropriateness of the level of care, which can range from independent living to 24 hour care; and environmental safety including architectural barriers, need for adaptive equipment, environmental adaptations, architectural modifications of the physical environment of the patient (Pedretti & Zoltan, 1990).

Secondary referral (interdisciplinary cross referral) is a referral that is generated inside the home health agency. When a primary referral does not include a request for occupational therapy but there appears to be a need for occupational therapy, the intake coordinator or the rehabilitation director who screens all incoming referrals may add occupational therapy service or convert the referral for occupational therapy, after obtaining additional orders from the physician to cover an occupational therapy visit (Guidelines for occupational therapy services for home health, American Occupational Therapy Association).

Significance of The Study

The primary aim of a health care system should be to provide the highest quality of care possible for its constituents. The level of occupational therapy utilization in home health care as reflected by the frequency of referrals, is one of the components that impacts the quality of patient care.

This study provides occupational therapists, home health personnel, physicians and discharge planners with data about the level of occupational

therapy utilization in home health care, as evidenced by the frequency of primary referrals for occupational therapy in home health.

Research conducted in this fast growing area of occupational therapy has been scarce. This study will attempt to fill a portion of this gap.

Assumptions

Assumptions held by the researcher are:

1. Referrals that are appropriate for occupational therapy are routinely addressed to other disciplines in home health agencies.
2. The occupational therapy service in the home health agency receives more referrals from within the agency than from sources outside the agency.

Limitations

Limitations of the study are:

1. The two agencies participating in the study form a sample of convenience rather than a random sample. They were chosen due to the researcher's familiarity with them via present or past employment.
2. Both agencies used in this study are Health Maintenance Organization (HMO) based agencies and are part of the same HMO organization.

CHAPTER 2

LITERATURE REVIEW

Introduction

The review of the literature is organized into two major sections. The first section presents a background of home health care within the health care system including the development of home health care in the past twenty years. The second section describes occupational therapy and home health care including the conceptual frames of reference that guided the study. The review is then summarized.

Development of Home Health Delivery System

"The most glamorous and fastest growing health delivery system today is home health care" (Hightower-Vandamm, 1985, p. 787). Home health care experienced phenomenal growth in the 1980's. It was predicted that between 1980 and 1990 money spent on home health services would have increased by 600% (Hightower-Vandamm, 1985). The total cost of home health services and products in 1983 was 6.3 billion, and was projected to reach 24.8 billion in 1995 according to Predicasts Inc., a marketing firm located in Cleveland, Ohio (American Occupational Therapy Association, Part II, 1985).

The home care industry experienced a 100% growth rate from 1975 to 1984 (American Occupational Therapy Association, 1989). According to the American Hospital Association the number of community hospitals with home health departments more than doubled between 1977 and 1984 (American Occupational Therapy Association, Part I, 1985). In 1985, according to the

Health Care Financing Administration (HCFA) Medicare-certified home health agencies were growing nationally at a rate of approximately 100 agencies every two months. On June 1985, there were 5,632 such agencies, an increase of 2,000 in less than three years. It is estimated that there were more than 7,000 certified and non-certified home health agencies nationwide in 1985 (American Occupational Therapy Association, Part I, 1985). In the late 80's, however, this fast growth seemed to peak, and a leveling effect began to emerge. Medicare-certified agencies increased from 4,684 in 1984 to 5,887 in 1987 and declined slightly to 5,676 in 1989 (Stoffel & Gwin, 1989).

Similar changes were taking place that affected occupational therapy as the profession was adapting itself to the general changes in the health care system of which it is a part. In 1984 almost half (49.3%) of the 4000 home health agencies nation wide provided occupational therapy. This was more than double the percentage from 1975 (American Occupational Therapy Association, Part I, 1985). Predicasts, Inc. indicated that primary services including nursing and therapies would increase from 2.6 billion in 1983 to 5.2 billion in 1988, and would exceed 10 billion in 1995 (American Occupational Therapy Association, Part II, 1985).

According to the American Occupational Therapy Association member data survey for 1986, the number of occupational therapists who named home health as their primary employment increased from 0.9% in 1973 to 4.6% in 1986 (Stoffel & Gwin, 1989). This number dropped to 3.6% in 1990 (American Occupational Therapy Association, 1990).

The reasons for these dramatic increases were anchored in the changing trends of the national health care system. Since the implementation of the Prospective Payment System and its diagnostic related groups (DRGs), the

classification system used for hospital Medicare reimbursement, hospitalization periods have gradually become shorter. In an effort to cut cost patients have been discharged home more quickly and more sickly, a situation that has increased the demand for home health care (American Occupational Therapy Association, Part I, 1985; MacRae, 1984; Stoffel & Gwin, 1989; Viseltar, 1984). In addition, the demographics of the American population point to an increase in the aging and chronically disabled population which requires medical and rehabilitation services after discharge from the hospital. (Jackson, 1984; MacRae, 1984).

It may appear that due to the phenomenal growth of the home health care sector, the level of prosperity would be equally unlimited. Alas, home health agencies indicate that because of severe competition and due to governmental intervention with capping reimbursement this is not the case (Hightower-Vandamm, 1985).

As "for profit" providers enter into the health care market, the patient-oriented environment is changing into a product-oriented environment. The focus on issues such as "quality of care" and "patient satisfaction" is shifting to focus on "products" and "profits" (Hightower-Vandamm, 1985).

Background on Home Health Care

The practice of occupational therapy in home health care focuses on quality of life issues and dates back to the early years of the profession. There are written accounts of home based treatment of occupational therapy from the early 1920's (Jackson, 1992). Although the scope of practice has changed since that time, the basic premise remains the same: occupation used as a

curative measure and a treatment that involves the patient and his or her environment (Jackson, 1992).

Occupational therapy is a function oriented treatment. At its core is a holistic view of a person within his or her natural environment and with an individual life style; its aim is to maximize functional independence in this context. The home is one's most natural and realistic environment, that is the reason occupational therapy lends itself so well to home health care.

The key to a smooth transition from hospital to home is a well organized discharge plan. Discharge planning is a process designed to prepare the patient for the next phase of care and to assist in making any necessary arrangements for that phase of care (Farren, 1991). Continuity of care can be defined as an organized movement of a patient through all phases of his or her medical care process (Frasca & Christy, 1986). Traditionally, the staff nurse had been the responsible professional for patient discharge planning; however, more recently hospital social workers have been sharing this responsibility due to an increasing complexity of needs against a background of decreasing community resources (Farren, 1991).

The discharge planner occupies a pivotal position regarding home health care referrals. Her/his understanding of the occupational therapist's role in home health care may be an important factor in the frequency with which referrals are made to occupational therapy. The literature regarding discharge planning reports on the role of therapy and the importance of gaining information from therapists for the discharge planning process. An interdisciplinary approach to discharge planning that involves the entire therapy team is important for the formulation of an effective discharge plan (Corkery, 1989). Physical, speech, and occupational therapists assess the

patient's level of function, implement a rehabilitation program that prepares the patient for a safe discharge home, instructs family members in the appropriate level of care, and if a need for continued therapy is identified, refers for therapy at home (Corkery, 1989). The various professionals are better able to recognize subtle deficits and construct a more complete and accurate picture of the patient's condition than would one professional preparing a discharge plan alone (Frasca & Christy, 1986).

Every home health referral is ultimately ordered by a physician; that is, only a physician can approve or reject a home health referral. However, the involvement of physicians in the discharge planning process varies greatly from facility to facility. In some settings the physician's involvement may be limited to endorsement (Runner-Heidt, 1984), while in other settings the physician may control the flow of referrals much more closely.

A hospital home health agency that functions as an integral part of a hospital system has an advantage regarding continuity of care. This type of home care agency incorporates and expands hospital services into a comprehensive and coordinated package. The home health team has direct access to patients' records, hospital staff, and hospital resources. Patients and families feel less apprehension knowing that there is a direct link between their providers of acute care and home health care (Frasca & Christy, 1986).

Prospective Payment System

The Prospective Payment System (PPS) was initiated by Medicare, the federal health program for seniors 65 years and older, in the early 1980's. The system reimburses hospitals for services provided to patients at a fixed rate. The rates for the various services had been established based on previous

institutional, regional, and national payment patterns of an assigned diagnostic group. The difference between the established rates of reimbursement and the actual cost of the service provided becomes the hospital's profit or loss. Prior to the PPS, fee for service was the norm by which hospitals billed for services provided. Following the implementation of the PPS, other third party payers such as public and private health insurance companies, and health maintenance organizations (HMOs), soon followed suit and instituted similar systems of reimbursement. Consequently, it became crucial to a hospital's survival for each service offered to a patient to be financially justified as well as medically justified. Length of hospital stay is one important variable by which the longer stay generates higher cost (Farren, 1991).

Research into the effects of discharge planning found that the Prospective Payment System helps to reduce hospital length of stay. Unnecessary hospitalization had been attributed to much of the rise in hospital expenditures (Cables & Mayers, 1983).

Impact of the Prospective Payment System on Home Health Care and Occupational Therapy

The effects of the Prospective Payment System (PPS) on home health care have been enormous. Prior to the implementation of the PPS by the federal government, home health care was relative unknown in the health care system. With a strong financial incentive to shorten hospital length of stay, home health care emerged as one of the preferred alternatives, and became a significant link in the patient care continuum (Runner-Heidt, 1984).

Studies

The American Occupational Therapy Association (AOTA) conducted a survey in 1985 to determine the impact of the PPS on the occupational therapy profession. Over 1000 directors of occupational therapy departments responded to the survey. General results showed that the profession was adapting well to the changes in the health care system. Relevant to this study are the following findings: 55.9% of respondents reported an increase in the number of patients referred to home health occupational therapy. Thirty-two percent of respondents indicated an increase in occupational therapy referrals, and 30.4% reported a decrease in occupational therapy referrals. From respondents' comments one learns that the increase was in out-patient referrals, while the decrease was in in-patient referrals. In addition to the structured survey questions, an open ended comment question was asked. One of the most frequently cited concerns was that patients were being discharged home when they could barely understand their medication orders or other treatments that were to be followed at home (American Occupational Therapy Association, 1985).

Medicare Guidelines for Occupational Therapy Practice

The Medicare Home Health Agency Manual is a document written by the Health Care Financing Administration (HCFA) in order to give guidelines and set standards of practice for home health care provided to Medicare patients. From the above document in a section titled "Billing for part B intermediary outpatient OT services" Medicare indicates the need for occupational therapy

when, for example, a patient may begin to exhibit ADL, mobility, and/or safety dependence (HCFA, 1989). Under a sub-heading "therapeutic programs," the authors of Medicare guidelines stated that the goals should generally be to increase functional abilities in ADL, mobility or patient safety. An example of a safety problem is described as when a patient without skilled occupational therapy intervention cannot function in a manner that is physically and/or cognitively safe (HCFA, 1989).

ADL, safety, and mobility are not the only problem areas that indicate the need for OT intervention as reported in the Medicare manual; however, upon reading this document they emerge as important areas.

Medicare and Occupational Therapy

The Medicare program that provides medical care for the aged and disabled reimburses health care services only when the service is deemed medically necessary (Steinhauer, 1984; Stoffel & Gwin, 1989). Medicare guidelines specify that primary skilled services include skilled nursing, physical therapy and speech therapy (Trossman, 1984). Occupational therapy is considered a "modified skilled" service. This means that occupational therapy can be provided in conjunction with the three previously mentioned services, or may continue after these services have discharged the patient, but the need for occupational therapy alone will not qualify occupational therapy personnel for reimbursement (Steinhauer, 1984). To summarize, occupational therapy cannot initiate treatment, cannot be the only discipline involved in a case, and cannot be the case manager.

The impact of this policy on the rate of occupational therapy referrals has not been measured; however, practitioners have estimated that when

occupational therapy becomes a primary skill, the therapist's case load will increase by 37% (American Occupational Therapy Association, 1986).

Occupational therapy enjoyed skilled status for a short time from 1980 to 1981, but Congress changed this policy for reasons that are still unclear (Steinhauer, 1984). Since 1981 when occupational therapy was eliminated as a primary skilled service, the AOTA has attempted annually to reverse the legislation and to reinstate occupational therapy status (AOTA, 1994). Thus far the Association has been unsuccessful in its efforts.

Theoretical Frames of Reference

The two frames of reference used in this research were the occupational adaptation frame of reference and the occupational performance frame of reference. The occupational adaptation frame of reference is relatively new. It originated from a need for a conceptual construct that would adequately address the specific requirements for the practice of occupational therapy in nontraditional settings. The expansion of occupational therapy services into the school system, and now into the home health care arena, were the impetus for the creation of this model (Schultz & Schkade, 1994).

Occupational adaptation is viewed as an internal process used throughout the life span as the person faces occupational challenges (Schultz & Schkade, 1992). Schultz and Schkade (1994), who are the authors of this frame of reference, wrote that:

the occupational adaptation practice model leads the therapist into a new layer of intervention, that is, treatment directed at affecting the patient's internal ability to generate, evaluate, and integrate adaptive responses in which relative mastery is experienced... We

suggest that the most beneficial effect of occupational therapy may occur when the occupational therapist focuses on the internal workings of the patient's occupational adaptation process, because that leads to the patient's ability to adapt and to approach each occupational challenge with greater success and satisfaction (1992, Part 2, p. 917).

Treatment with the occupational adaptation model focuses on strengthening the inner workings of the process by which the patient is empowered to face his or her own occupational challenges. The therapist becomes a facilitator rather than the agent of change (p. 918).

When patients complete their in-patient rehabilitation course and return home, they often discard techniques that were learned and assistive devices that they received in favor of self-generated methods and designs that best suit their personal life styles and choices. Therapists who are practicing in home health agencies and respect the patient's choices will be more effective in their therapeutic relationships with their patients. Overfocus on the patient's functional skills (e.g., self-care, home management, and adaptive equipment), may sometimes limit the contribution of occupational therapy and deny patients the opportunity to make vital changes in their occupational adaptation process (Schultz & Schkade, 1992). However, when the therapist encourages occupational adaptation (e.g., self-initiation, generalization of knowledge, problem solving, and responsibility), the internal adaptive process of the patient is awakened. This is not to say that one disregards the necessity of functional skills, but the focus shifts from acquisition of skills to occupational functioning (Schultz & Schkade, 1992). The goal is always patient satisfaction via relative mastery.

Occupational therapists who work in home health care report that the occupational adaptation framework provides a means to better explain to patients, family members, and other health professionals the unique role of

occupational therapy. Similarities and differences between occupational therapy and other health professions become clearer and sometimes may results in an increased rate of referrals to occupational therapy (Schultz & Schkade, 1994).

While the occupational adaptation frame of reference focuses on internal processes for mastery, the occupational performance frame of reference encompasses the three treatment areas of concern in this study, namely activities of daily living (ADL), safety, and mobility. The main building blocks of the occupational performance frame of reference are self-care, work and play/leisure. They are termed performance skills by Pedretti and Zoltan (1990). The substructures that make it possible to achieve competency in self-care, work, and play/leisure are called performance components. They are motor functioning, sensory-integrative functioning, cognitive functioning, psychological functioning, and social functioning.

Occupational performance requires learning and practice experiences with the role and developmental state-specific tasks and the utilization of all performance components. Deficits in task-learning experiences, performance components, and life space may result in limitation in occupational performance (AOTA cited in Pedretti & Zoltan, 1990, p. 1).

Activities of daily living (ADL) refer to the various tasks of self-care, work, and play/leisure that one is required to perform daily according to one's life role and developmental stage. Safety and mobility are two aspects that enable one to successfully achieve these tasks.

Summary

Home health care has grown significantly in the past two decades as a result of changes in the national health care system. The shortening of hospital length of stay and early discharge have been the main contributors in this trend. The gradual shift from focusing on quality of care to focusing on the economics in the health care system has made cost effectiveness a more immediate reality for all health professions.

Occupational therapy in home health care has grown as well in the past few years; however, it appears that the rate of referrals to occupational therapy in home health care has not yet reached optimal levels. This impacts both the quality of patient care as well as the economics of the occupational therapy profession.

CHAPTER 3

DESIGN AND METHODOLOGY

Objective

The objective of the study was to determine the level of occupational therapy utilization in home health care as indicated by the frequency with which primary referrals were made for occupational therapy services from physicians and discharge planners in home health agencies, and the frequency with which secondary referrals were made for occupational therapy services from other health care professionals within the home health agencies. This study used descriptive methodology. *Ex post facto* reviewing of patients charts yielded the data for analysis.

Research Questions

1. What is the frequency with which primary referrals to occupational therapy in home health care for patients with identified activities of daily living (ADL), safety, and mobility needs are made?
2. Will the frequency of primary referrals to occupational therapy in home health care for patients with identified activities of daily living (ADL), safety, and mobility needs, be similar to the frequency of primary referrals to physical therapy or nursing services for patients with the same identified needs?

3. Will the frequency of secondary referrals to occupational therapy services in home health care be similar to the frequency of primary referrals to occupational therapy in home health care?

Data Collection

Two home health agencies participated in the study; both are part of the Kaiser Permanente health organization, one of the largest HMO in the United States. The agencies are located in the Northern California region. One is located in Oakland, California, the other in Vallejo, California.

The majority of referrals to these home health agencies are made by hospitals, clinics, skilled nursing facilities (SNF) and the regional rehabilitation center located in Vallejo.

The data were extracted from original home health referrals that arrived at the two home health agencies in a three month period of time. The three months were February, March, and April, 1996 in Oakland, and August, September, and October, 1996 in Vallejo. The specific months were arbitrarily chosen by the researcher, and are viewed as an objective presentation of any three months period. A sample, approximately a third, of the referrals received by the intake desk at the home health agency within this specified time frame were reviewed. Most of the referrals that listed ADL, safety, and mobility as problem areas were selected. However, when the clinical picture in the referral clearly indicated that the referral would not be appropriate for occupational therapy, because the diagnosis is of a strictly medical nature, like wound care for example, the referral was excluded (Appendices A and B).

Frequency of primary referrals to the following disciplines were documented: occupational therapy, physical therapy, nursing services, medical social worker, and non-specific discipline (Appendix C).

In addition, secondary referrals to occupational therapy from the following disciplines were documented: physical therapy, nursing services, medical social worker, intake desk, and other.

Subjects

The inclusion criteria for the selection of the referrals were the existence of at least one problem area from the areas activities of daily living (ADL), safety and/or mobility. The referrals were reviewed to identify the disciplines that were being requested to address these problems during the home visit, e.g., nursing services, physical therapy, occupational therapy.

The three problem areas (ADL, safety, mobility) were chosen for three reasons: 1) They are appropriate for occupational therapy intervention from the stand point of the profession's theoretical and clinical base; 2) They were identified by Medicare Guidelines for Home Health as areas indicating the need for occupational therapy intervention; and 3) They often appear on referrals to the home health agencies.

Instrument and Procedures

A sample of about a third of the total referrals received at the two agencies were reviewed by the researcher. Referrals received during the three month period of time that indicated treatment needs in one or more of the problem areas described above (ADL, safety, mobility) were selected and the data from each individual referral were charted on the data collection sheet (Appendix

C). When all of the individual referral data were charted, they were totaled and tabulated on a second worksheet (Appendix D). The data were analyzed using descriptive statistics.

CHAPTER 4

DATA AND RESULTS

This chapter presents a description of the sample and the procedure that was used in the study, the data, the results, and reports the findings.

Description of the Sample

The total number of referrals reviewed was 973. In Oakland 427 referrals were reviewed, and in Vallejo 546 referrals were reviewed. These referrals were reviewed because they arrived in the agencies within the specified three months period of time that was chosen for each agency. These referrals represented a sample of just over a third of the total number of referrals that the agencies received. The two agencies have a volume of approximately 400-450 referrals per month per agency. Of the total referrals that were reviewed, 125 were selected for use in this study because they contained one or more of the problem areas of ADL, safety, or mobility, and were clearly appropriate for occupational therapy.

The referrals that were selected for the study were inspected to determine which discipline in the home health agency was asked to make the home visit. It must be noted that often more than one discipline was asked to perform the home health visit. In the case that more than one discipline was asked, each one was counted and tabulated as a primary referral for that specific discipline.

Although the three areas are appropriate for occupational therapy, due to role overlap among the disciplines of nursing, physical therapy, and speech pathology, the request may not have been exclusively appropriate for

occupational therapy. For example, a request for safety evaluation may be appropriate for a registered nurse, physical therapy, or occupational therapy, depending on various aspects, such as the diagnosis, the medical status of the patient, or the physical status of the patient. It was not uncommon to find a referral that included a request for safety evaluation by more than one discipline. Each discipline would then evaluate the patient's safety from its specific clinical perspective (see Appendix E for an example of multidiscipline referral). So, while an attempt was made to exclude those referrals that were blatantly inappropriate for occupational therapy, it should not be assumed that a primary referral to physical therapy for a safety check was considered an inappropriate referral, even though it may have been appropriate to have been referred to occupational therapy instead or as well. In other words, the main intent of the study was to find out whether appropriate occupational therapy referrals are routinely referred to other disciplines, and not to judge those referrals appropriate or inappropriate to other disciplines.

Presentation of the Data

The information gleaned from the referrals that were used in the study included: the discipline(s) on the primary referral, the discipline that made a secondary referral to OT (if one was made), the source of the primary referral (i.e. the referring professional and the facility), the problem area(s), the primary diagnosis (and secondary diagnosis if relevant), and the patient's age. The data were recorded on a Data Collection Sheet (Appendix A).

Figures 1, 2, and 3 illustrate the frequency of referrals by problem area. Mobility problems, presented in Figure 1, were referred to physical therapy 69.5% of the time, to occupational therapy 22.5% of the time, and to nursing services 8% of the time. This shows that when a patient has a mobility problem physicians and discharge planners are three times as likely to refer them to physical therapy as they would to occupational therapy.

Safety problems, shown in Figure 2, were referred to physical therapy 49.5% of the time, to nursing 34% of the time, and to occupational therapy 16.5% of the time. This shows that patients are three times as likely to be referred to physical therapy, and twice as likely to be referred to nursing services if the problem area is safety.

ADL problems, illustrated in Figure 3, were referred to physical therapy 29% of the time, to nursing 18.5% of the time, and occupational therapy 52.5% of the time. ADL is the most characteristic an occupational therapy problem area of the three. This shows that patients with ADL problem area are almost twice as likely to be referred to occupational therapy as compared with physical therapy, and almost three times as compared with nursing.

The referring professionals that made the referrals to the home health agency were physicians in 67% of the time, discharge planners (usually RN's) 28% of the time, and in very few cases the referrals came from durable medical equipment clerks and medical social workers.

The facilities that the referrals came from were hospitals 49% of the time, clinics 18.5% of the time, rehabilitation center 14% of the time, skilled nursing facilities 10% of the time, and emergency rooms 8.6% of the time.

Figure 1
Primary Referrals for Mobility Area

Figure 2
Primary Referrals for Safety

Figure 3
Primary Referrals for ADL

The primary diagnosis on the referrals that were reviewed were CVA 40% of the time, upper or lower extremities fractures resulting from falls 12% of the time, and chronic obstructive pulmonary disease, multiple sclerosis, and coronary artery bypass graft 4.8% of the time each. There were a number of other diagnoses that occurred only once or twice; therefore, no percentage calculation was made for them. The average age of the patients was 76 years.

Results

1. What is the frequency with which primary referrals to occupational therapy in home health care for patients with identified activities of daily living (ADL), safety, and mobility needs are made?

The mean frequency of primary referrals made to occupational therapy was 37%.

2. Will the frequency of primary referrals to occupational therapy in home health care for patients with identified ADL, safety, and mobility needs be similar to the rate of primary referrals to physical therapy or nursing services for patients with the same identified needs?

The frequency of primary referrals to occupational therapy was 37%. The frequency of primary referrals to physical therapy was 72%. The frequency of primary referrals to nursing was 40%, as shown in Figure 4.

3. Will the frequency of secondary referrals for occupational therapy services in home health care be similar to the rate of primary referrals to occupational therapy in home health care?

Figure 4
Primary Referrals by Discipline

Due to an error in data collection in the Vallejo agency relevant to this question, only data from the Oakland agency are available for analysis.

The frequency of secondary referrals was 29%. The frequency of primary referrals was 54%, as illustrated in Figure 5.

Findings

Primary referrals to occupational therapy at a frequency of 37% are higher than anticipated by the researcher, based on field experience and informal preparatory calculations that were done prior to the beginning of the study. When viewed in isolation, it does not seem to indicate that there is a problem of limited flow of referrals to occupational therapy in home health care. However, when it is viewed in the context of frequency of referrals to other home health disciplines, the picture changes.

Primary referrals to physical therapy occurred 72% of the time. Primary referrals to nursing service occurred 40% of the time (see Figure 4). This means that physicians and discharge planners are almost twice as likely to refer patients with the above problem areas to physical therapy as they are to occupational therapy. In addition, although the problem areas are rehabilitation oriented, physicians and discharge planners are just as likely to refer them to nursing services as they are to occupational therapy. In this context it appears that the flow of primary referrals to occupational therapy falls short.

Primary occupational therapy referrals at 54% (in Oakland only), were considerably higher than the secondary referrals to occupational therapy at 29% (see Figure 5). This indicates that the rate of primary referrals to occupational therapy (from outside sources) is greater than the rate of

Figure 5
Primary vs Secondary Referrals-Oakland

secondary referrals (from within the agency).

The difference between the mean rate of 37% primary referrals, and the Oakland agency alone rate of 54% primary referrals was noted. Possible explanation for this would be the different referral forms used in the two agencies. The referral form used in Vallejo specified ADL and swallowing as occupational therapy areas of treatment (Appendix D). The form used in Oakland did not give any specifications for occupational therapy areas of treatment, possibly leaving it more open for referrals to other problem areas (Appendix E). However, from practical experience of this researcher in the field of home health care, the rate of 54% primary referrals does seem unusually high, and should be retested in future studies.

CHAPTER 5

IMPLICATIONS, RECOMMENDATIONS AND SUMMARY

In this chapter, findings are discussed and implications for the profession, recommendations and summary are presented.

Purpose of The Study

The purpose of this study was to determine the level of utilization of occupational therapy as indicated by referrals for home health care through area home health agencies.

The percentage of primary referrals directed to occupational therapy was compared with the percentage of referrals directed to other disciplines within the home health agency. In addition, the frequency with which primary referrals were made to occupational therapy was compared with the frequency with which secondary referrals or interdisciplinary cross referrals were made to occupational therapy in home health care.

Discussion of Findings

The findings indicate that occupational therapy is primarily associated with the problem area of ADL. When the problem areas are safety or mobility, occupational therapy is much less likely to receive the referral. This points to a possible lack of understanding and a narrow view of the role of occupational therapy held by physicians and discharge planners. It may also point to confusion or role blurring between occupational therapy and other disciplines in the home health agency.

Summary

This research was designed to study the level of utilization of occupational therapy as indicated by referrals for home health care through area home health agencies. It was believed that occupational therapy services are sometimes overlooked by physicians and discharge planners who refer patients to those agencies. The frequency with which primary referrals to occupational therapy in home health care particularly in the areas of activities of daily living (ADL), safety, and mobility needs was the focus of the study. One hundred and twenty-five selected referrals containing one or more of these problem areas were reviewed. A mean frequency of 37% was found for primary referrals to occupational therapy, 72% for physical therapy, and 40% for nursing. The frequency of 37% was higher than anticipated by the researcher. While this frequency does not indicate a problem of limited referrals, when viewed in the context of the study, there are implications for change in procedures and the articulation of theory to better explain occupational therapy to other disciplines involved. Recommendations for further study are indicated.

Implications for the Profession

The occupational adaptation frame of reference interprets the unique role of occupational therapy as enhancing or facilitating the patient's internal process of adaptation. That is, the person's ability to adapt to new occupations (tasks), or to adapt to old occupations which must be performed differently due to new limitations. This practice model shifts the therapy focus from acquisition of skills to a focus on the internal workings of the patient's occupational adaptation process. This means that the therapy would focus on

facilitating the patient's ability to problem-solve, ability to increase self-initiation, and to generalize skills to a variety of tasks, all of which results in the patient's greater sense of accomplishment and satisfaction. This practice model suggests integration of the physical with the cognitive and emotional aspects of rehabilitation. It is a holistic approach to rehabilitation which has been a strong characteristic of the occupational therapy profession from its inception.

This frame of reference supports a different and unique approach to therapy that can help distinguish the role of occupational therapy from other disciplines, and thus assist other health professionals in knowing when to refer to occupational therapy. The literature supports the notion that explaining occupational therapy to other professionals with this frame of reference in mind has resulted in increased frequency of referrals.

This research suggests that incorporation of this frame of reference to explain the role of occupational therapy could make a difference in how other professionals view occupational therapy.

Impact of the Limitations

In addition to the limitations that were anticipated, the following limitations impacted the data collection and analysis phase.

1. Finding data and tracing referrals.

The main difficulty occurred during the data collection phase. The process of tracing referrals in both facilities proved difficult for a few reasons. First, the referrals were not filed in a manner that supported the needs of the study.

Secondly, the process of initiating secondary referrals (in the Oakland

facility) was conducted in a manner that at times left no traceable paper trail, and at other times left a trail so complex and convoluted that it was next to impossible to trace. This limitation may have significantly impacted question number three, which indicated greater frequency of primary referrals over secondary referrals. It was noted earlier that this finding does not support the researcher's experience in the field and should be retested.

2. Type of agencies.

The two agencies that participated in the study, although somewhat different in the internal organization of materials and secondary referral procedures, are essentially similar as they are a part of the same health organization. This may have weakened the generalizing ability of the study to non- Kaiser, non-HMO, home health agencies.

3. Problem areas.

The three problem areas of ADL, safety, and mobility were lumped together in the main body of the study. This may have distorted the results somewhat. It could have been more beneficial to study each problem area separately.

Recommendations

Further research in the area of home health care referrals to occupational therapy is recommended in the following areas:

- 1. Study of a greater variety of home health agencies such as free standing agencies, contract agencies, privately owned agencies, publicly funded agencies.**

- 2. Study of a greater variety of problem areas, and study of each problem area separately, to increase the understanding of how referring professionals are viewing the role of occupational therapy.**

3. Study of the effects of educating health professionals by conducting a before and after study to determine the effects of inservice sessions, shadowing, or other means of education on the frequency of referrals to occupational therapy.
4. Clarification through research of the issue of role overlap and role delineation. Role blurring among the various home health care disciplines, and more specific to this study between occupational therapy and physical therapy, is felt to be one of the main barriers to optimum frequency of referrals to occupational therapy. Although in reality there is some overlap between the two professions, there are also differences that need to be better understood.
5. Study and possible modification of home health care referral forms for maximum clarity and accuracy in order to assist the referring professional in directing his or her referral to the appropriate discipline. It was noted during the data collection that the form used in the Vallejo facility listed each home health discipline with its problem area. Occupational therapy had two problem areas listed under it. The first was ADL Training, and the second was Swallowing (Appendix D). A different form was used in the Oakland facility that had three slots for the referring person to indicate the patient's needs. The first slot was titled Equipment and Special Supplies, the second Physical Therapy Requirements, and the third Special Instructions (Appendix E). These forms are incomplete at best and misleading at worst. A physician or a discharge planner who would use them to make his or her referral for home health service would be hindered in making an appropriate referral.

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APPENDIX A
Data Collection Worksheet

Data Collection Worksheet

Primary referral to:

Secondary referral to occupational therapy from:

Source of referral:

Referring professional:

The facility:

Problem area(s):

Primary diagnosis:

Secondary (related) diagnosis:

Patient's age:

APPENDIX B
Tabulation Worksheet

Primary referrals to: | OT | PT | RN | MSW | None

In Oakland: | | | | |

In Vallejo: | | | | |

Total: | | | | |

Secondary referrals

to OT from: | PT | RN | MSW | Intake | Other

In Oakland: | | | | |

In Vallejo: | | | | |

Total: | | | | |

Key: OT = Occupational Therapy.

 PT = Physical Therapy.

 RN = Registered Nurse.

 MSW = Medical Social Worker.

 Intake = Intake desk at the home health agency.

Appendix C
Example of Multidiscipline Referral

HOME HEALTH REFERRAL

PATIENT'S LAST NAME		FIRST NAME		M.I.		MEDICARE #		EFFECTIVE DATE	
PATIENT'S HOME ADDRESS (INCLUDE ZIP CODE)		CITY		STATE		ZIP		DATE VERIFIED	
CLIA NO.		CITY		STATE		ZIP		DATE OF BIRTH	
GOT. & GP		DUE COV.		RESPONSIBLE PERSON OR RELATIVE		PHONE OF RESP. PERSON		SEX	
HOSPITAL ADMISSION DATE		HOSPITAL DISCHARGE DATE		HOSPITAL		CONTACT PERSON		PHONE	
TRANSFERRED TO		CONTACT PERSON		PHONE		ADMIT DATE		DISCHARGE DATE	
TRANSFERRING PHYSICIAN		PHONE		PRIMARY PHYSICIAN		PHONE			

Patient Data		M.D. Appointments	
ASSISTIVE DEVICE	MENTAL STATUS	CURRENT DIAGNOSIS AND SURGICAL PROCEDURE (AND DATE)	
☐ CANE	☒ ALERT - <i>some</i>	Hx C.V.F.	
☐ CRUTCH	☐ DEPRESSED		
☐ WALKER	☐ CONFUSED		
☒ WHEEL CHAIR	☐ AGITATED		
☐ INDEPENDENT	☐ ANGRY	ALLERGIES:	

RN		PT		OT		MSW		ACTIVITIES PERMITTED		BOWEL/BLADDER	
☒ SAFETY CHECK	☒ EVALUATION	☐ ADL TRAINING	☐ COUNSELING	☐ BR	☐ WB AS TOL	☐ COLOSTOMY					
☐ EVALUATION	☒ SAFETY CHECK	☐ SWALLOWING	☒ PLACEMENT	☐ BRP	☐ PWB	☐ CATHETER					
☐ INJECTIONS	☐ THERAPY		☐ RESOURCES	☐ CHAIR	☐ ACTIVE ROM	☐ SIZE					
☐ BLOOD WORK	☐ EQUIPMENT			☐ AS TOL	☐ PASSIVE ROM	☐ LAST CHANGED					
☐ DRSG. CHANGES	☐ ORDER/EVAL			☐ NWB	☐ ACTIVE EX.	☐ INCONTINENT					
☐ INSTRUCTION											
☐ FOLEY CHANGE											
☐ IV THERAPY											

DIET ☐ REG ☐ 2 GM NA ☐ OTHER (SPECIFY) _____

ACTIVITY RESTRICTIONS:

WRITE ALL MEDICATIONS/DRESSING CHANGE ORDERS/BLOOD WORK

Pt. not Managing well at home - declined SNF. Per wife & pt: pt. can manage his own toileting, needs 100% assistance for bathing, needs help for transfers to/from wheelchair.

Home health safety evaluation and HSA to discuss placement options

MD SIGNATURE	PRINTED NAME	DATE
<i>[Signature]</i>	<i>[Name]</i>	7/31/96

REVISION 7/95 (2.0)

DISTRIBUTION: HHS - HHS C.E. - CHAIR - CASE MANAGER - PHN - SECRETARY - GOLDENROD - HHS OPTION

Appendix D
Home Health Referral Form
(Form used in the Vallejo agency)

HOME HEALTH REFERRAL

PATIENT'S LAST NAME		FIRST NAME		M.I.		MEDICARE #		EFFECTIVE DATE		A		B					
PATIENT'S HOME ADDRESS (INCLUDE ZIP CODE)										HOME PHONE		DATE OF BIRTH		SEX		MARITAL STATUS	
M.R. NO.		COV. & GP		USE COV.		RESP. PERSON OR RELATIVE		PHONE OF RESP. PERSON		NAME							
HOSPITAL ADMISSION DATE		HOSPITAL DISCHARGE DATE		HOSPITAL		CONTACT PERSON		PHONE		MEDICAL #							
TRANSFERRED TO		HOME		CONTACT PERSON		PHONE		ADMIT DATE		DISCHARGE DATE							
TRANSFERRING PHYSICIAN		PHONE		PRIMARY PHYSICIAN		PHONE											

Patient Data

M.D. Appointments

ASSISTIVE DEVICE	MENTAL STATUS	CURRENT DIAGNOSIS AND SURGICAL PROCEDURE (AND DATE)
☐ CANE	☐ ALERT	PT for ↑ ADL, ↑ gait, ↑ strength
☐ CRUTCH	☐ DEPRESSED	
☐ WALKER	☐ CONFUSED	
☐ WHEEL CHAIR	☐ AGITATED	
☐ INDEPENDENT	☐ ANGRY	
ALLERGIES:		

M.D. ORDERS

RN	PT	OT	MSW	ACTIVITIES PERMITTED	BOWEL/BLADDER
☐ SAFETY CHECK	☐ EVALUATION	☐ ADL TRAINING	☐ COUNSELING	☐ BR	☐ WB AS TOL
☐ EVALUATION	☐ SAFETY CHECK	☐ SWALLOWING	☐ PLACEMENT	☐ BRP	☐ PWB
☐ INJECTIONS	☒ THERAPY		☐ RESOURCES	☐ CHAIR	☐ ACTIVE ROM
☐ BLOOD WORK	☐ EQUIPMENT ORDER/EVAL	☐ COMMUNICATION		☒ AS TOL	☐ PASSIVE ROM
☐ DRSG. CHANGES		☐ SWALLOWING		☐ NWB	☐ ACTIVE EX.
☐ INSTRUCTION					☐ INCONTINENT
☐ FOLEY CHANGE					
☐ IV THERAPY					
CODE PATIENT: ☐ YES ☐ NO					

DIET ☐ REG ☐ 2 GM NA ☐ OTHER (SPECIFY) _____

ACTIVITY RESTRICTIONS:

WRITE ALL MEDICATIONS/DRESSING CHANGE ORDERS/BLOOD WORK

PT for ↑ ADL, ↑ gait, ↑ strength

M.D. SIGNATURE

PRINTED M.D. NAME

DATE 7/5/94

OSHO-1 (REV. 2-93)

DISTRIBUTION: WHITE - HMA FILE • CANARY - CASE MANAGER • PINK - SECRETARY • GOLDENROD - HMA OPTION

Appendix E
Home Health Referral Form
(Form used in the Oakland agency)

040296

DISCHARGE ORDER: PATIENT CARE SUMMARY

ANTICIPATED DISCHARGE DATE

4/5

* dictate stat
summary #3831

TEMPORARY USE ONLY

☒ Home ☐ SNF* ☐ Other☒ Home Health Referral for ☒ RN ☐ MSW ☒ PT ☐ OT ☐ ST

INPATIENT TEAM

SSU

ATTENDING

RESIDENT/DEEPER

INTERN/DEEPER

REPRINT AREA

Principle Dx: Small intestine infarct in 2nd and 3rd loops

Major Secondary Dx's: Hip hip fracture

PATIENT CONDITION UPON DISCHARGE:

Mental Status: ☒ Clear ☐ Confused ☐ Withdrawn ☐ Aggressive ☐ OtherSpeech: ☒ Normal ☐ Unable ☐ Foreign (What language?)Mobility: ☐ Normal ☐ Cane ☒ Walker ☐ Wheelchair ☐ Bed only ☐ Side rail ☐ ParalysisSkin: ☒ Normal ☐ Decubiti/Location:Bowel: ☒ Continent ☐ IncontinentBladder: ☐ Continent ☐ Incontinent

DISCHARGE INSTRUCTIONS

ACTIVITY:

Sexual relations: ☐ Yes ☐ No ☐ When _____Driving car: ☐ Yes ☐ No ☐ When _____Bathing: ☐ Tub ☐ Shower ☐ SpongeLifting: ☐ Yes ☐ No ☐ Weight allowed: _____ lbs.Stairs: ☐ Yes ☐ No ☐ When _____ How many flights: _____

WEIGHT BEARING STATUS:

Right: _____

Left: _____

Return to work on: _____
Medications: See discharge order
sheet attached, including instructionsDiet: ☒ Regular ☐ 2 gm Na ☐ Diabetic _____ calories ☐ Other:

Equipment/Special Supplies:

Physical Therapy Requirements: - 100% in home

Special Instructions: (Including wound care & dressing change)

In to assess home safety and other equipment

APPOINTMENTS & TESTS

Provider	Date	Time	Tests	Date	Time
[Redacted] 3-4	4/29/96	9:00 AM	Howe St. East entrance	3:15 PM	

Further advice is available from your physician, or the Advice Nurse. If you need assistance in reaching your physician or the Advice Nurse, call 596-1000. You can reach the Emergency Department at 596-7600.

I have received and understand my instructions for care after discharge from the hospital.

SIGNATURE OF PATIENT OR RESPONSIBLE FAMILY MEMBER OR FRIEND

DATE

SIGNATURE OF PHYSICIAN

DATE/TIME

SIGNATURE OF NURSE

DATE

02381 (REV 5-94)

DISTRIBUTION: WHITE - CHART - CANARY - RN OR SNF - PINK - PATIENT - GOLDENROD - RMD