Minimizing the Impact of Social Distancing for the Older Adult

Presenters: Emily Fleischman, Chris Childers, Carolina Zubiri and Diana Kornetti

ACADEMY OF ACUTE CARE PHYSICAL THERAPY

APTA Geriatrics

HOME HEALTH SECTION
AMERICAN PHYSICAL THERAPY ASSOCIATION

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Housekeeping

- All microphones are muted upon entrance
- Presenters will record questions and comments
- Audience questions and comments will be shared after all the speakers present
- Recording will be available by Monday April 6th
- Thank you:

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Social Distancing and Mental Health for the Geriatric Acute Care Patient

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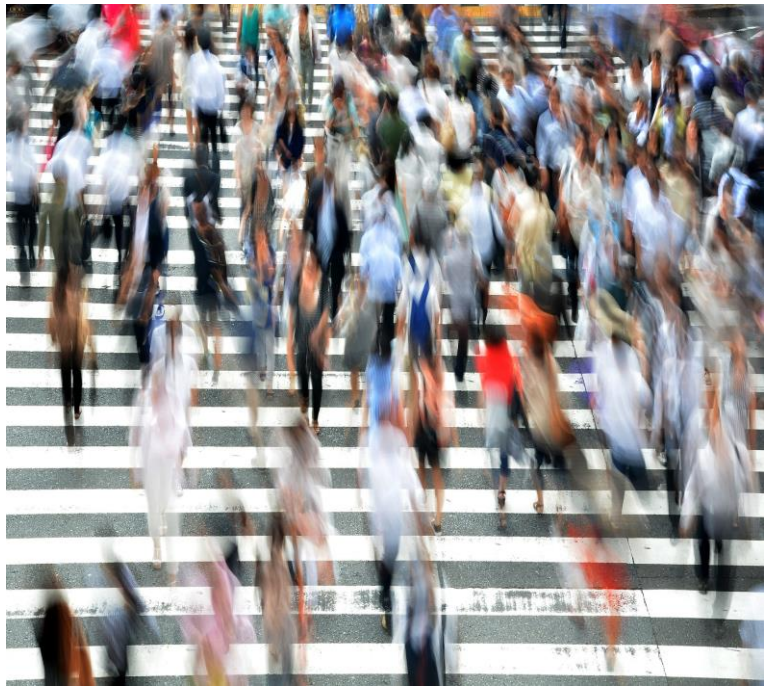
Demographics[1,2]



- Inpatient: 40% incidence of psychiatric comorbidity
  - General population: 18.9%
- Presence of a psychiatric comorbidity increases length of stay, medical costs, and rehospitalization

Effect of Social Distancing on Mental Health

- “From a psychological perspective, the consequences of social distancing are summed up in two words – isolation and uncertainty”[12]
- Social isolation negatively affects wellbeing[10]
  - Comparable to risk factors such as smoking
  - Loneliness positively correlated to anxiety, depression, panic attacks, and suicidal ideation[9]
  - Lessons learned from SARS in Toronto 2013[13]
- Voluntary self isolation results in less distress[11]
  - Involuntary in inpatient setting

Psychiatric Diagnoses

- Anxiety
- Depression
- Bipolar Disorder
- Borderline Personality Disorder

Anxiety[5]

- Most prevalent in any age category
- Highly comorbid with other disorders
- Common anxiety disorders
  - Specific Phobia
  - Social Anxiety Disorder
  - Panic Disorder
  - Generalized Anxiety

Depression[3,5]

- Major Depressive Disorder (MDD)
  - Lifetime prevalence of ~20%
  - Among the most debilitating diseases worldwide with highest reductions in disability adjusted years of life among all human diseases

Bipolar Disorder[5]

- Mood episodes
- Bipolar I
  - At least 1 manic episode
  - Not required depressive episode for diagnosis
- Bipolar II
  - At least 1 hypomanic episode
  - At least 1 major depressive episode
  - No manic episode
- Change with DSM-5 organization

Borderline Personality Disorder[4,6]

- Characterized by distressing disturbances in self-image, impulsivity, problems with emotional regulation, and pervasive problems with inter-personal relationships
- BPD common features:
  - Unstable and intense interpersonal relationships
  - Impulsivity leading to self-destructive behavior
  - Emotional instability with reactive mood
  - Difficulty controlling anger
  - Frantic efforts to avoid real or imagined abandonment

Practice You Can Apply Today

- Structure and communication with Borderline Personality Disorder
- Mindful movement practice
- Handling disruptive symptoms

Structure and Communication with BPD[6]

- Poorly regulated borderline personality disorder can quickly derail treatment sessions
- Key considerations for the clinician-patient relationship
  - Collaboration
  - Knowing yourself
  - Maintaining boundaries
  - Responsibility
  - Time and consistency

Mindful Movement Practice[7]

- Basic Mindfulness
  - Paying attention, on purpose, moment-by-moment without judgement
  - Typically stationary
    - For a patient that is highly anxious, this can be especially challenging
- By linking movement to a sense of calmness, we can help to make movement and exercise a safe space for patients

Mindful Movement Practice[7]

- Set up
  - Low arousal environment
  - Slow movement
  - Visual cues/mirror patient
- Options
  - Time breath to movement
  - Counting movements

Handling Disruptive Symptoms[8]

- Hallucinations
  - DO
    - Ask if they saw/heard something
    - Ask how they feel about the situation
    - Discuss the possibility that the experience is a symptom, hallucination, etc.
  - DON'T
    - Act shocked or alarmed
    - Tell them it is not real or casually dismiss it
    - Enter into a lengthy discussion about the hallucination

Handling Disruptive Symptoms[8]

- Delusions
  - DO
    - Listen neutrally, calmly, respectfully
    - Lead the conversation away from the delusional content
    - Explicitly tell them you want to change the subject
  - DON'T
    - Try to convince or argue someone out of a delusion
    - Question or discuss the delusion in detail

Handling Disruptive Symptoms[8]

- Bizarre Behavior

  - DO
    - Stay calm and nonjudgmental
    - Be concise and direct

  - DON'T
    - Focus on changing a harmless behavior
    - Discuss the behavior in greater detail

Key Points

- Social distancing's isolating effects on our geriatric population can be expected to negatively effect their mental health
- By making some small adjustments to practice, we as physical therapist can better serve this population

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The challenges for individuals with cognitive impairments

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Chair of the Cognitive and Mental Health Special Interest group

APTA Geriatrics

WHO Guidelines 2019 (1)

- Modifiable risk factors for developing dementia include social isolation and cognitive inactivity

The 3 Ds of the older adult population

Delirium

- Acute, sudden onset
- Acute illness
- Attention impaired
- Orientation impaired
- Hyper or hypo active
- Speech incoherent/slurred
- Hallucination and delusions

Depression

- Mood disturbance
- Sadness
- Crying
- Fatigue, weight loss
- Normal speech
- No memory loss

Dementia

- General decline in cognitive ability
- Delusion, irritability
- Normal speech but declining
- Memory loss
- Decreasing executive function

Treating or preventing the 3 Ds (2-5)

Delirium

- Early mobilization
- Frequent mobility

Depression

- Responds to Physical activity
- Had the best response to yoga

Dementia

WHO

PA reduces risk of cognitive decline where none is present

PA may reduce risk of further decline in those with MCI

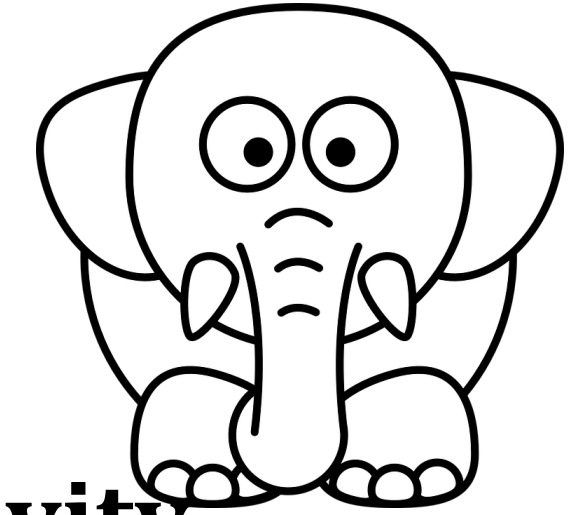
Social Distancing - challenges

The one thing that the 3Ds have in common is physical activity helps.

Social distancing – challenges:

- Group exercise is preferred as individuals with dementia are more engaged and show a more positive mood when involved with others in exercise [6]

Physical activity versus exercise



Exercise

- Structured and repetitive movements that fall within the more general term of physical activity

Physical Activity

- Any bodily movement that results in the expenditure of energy and can include household or occupational activities as well as sport and recreational

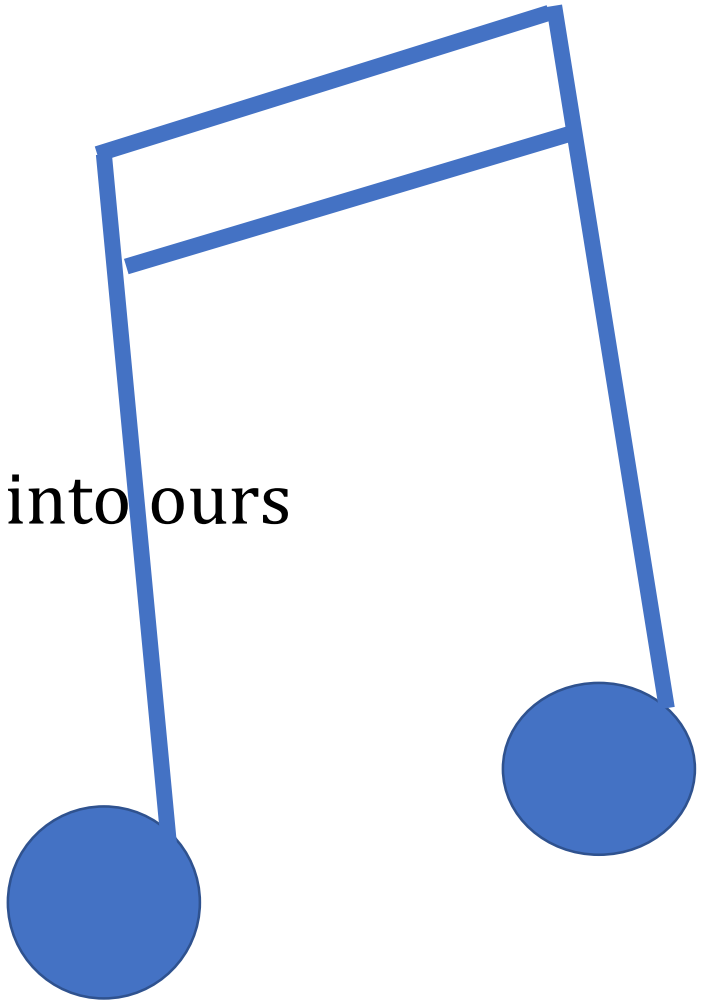
In home suggestions

What were they doing as a young adult?

Music – links to their past (7,8)

Step into their world, don't try to pull them into ours

Familiarize – engage - focus



Familiarize

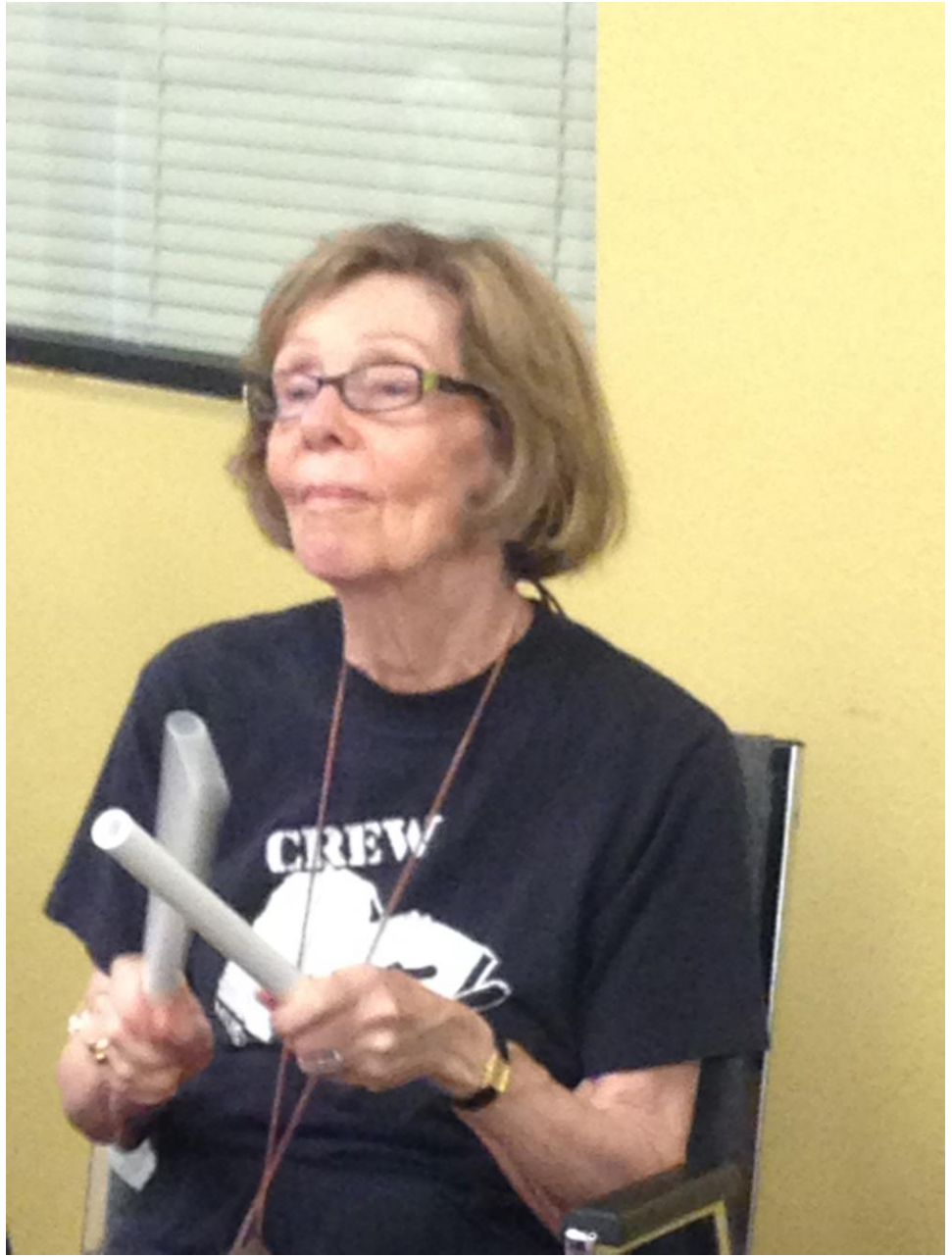
- Favorite piece of music and just “warm up” move extremities, 3 dimensional,
- You do it with them, everyone in the family/home, sitting or standing – safety is key

Engage

- Use techniques to incorporate them
- Tossing a ball – love and marriage
- Hand holding – jitterbug, waltz, meringue
- Boxing

Focus

- Specifics you want to address
- Sit – stand
- Turning
- Strengthening
- Cognitive component



Incorporate as much physical activity as they can manage

Some is better than none (4)

Routines

- Stick to similar routines as much as possible
- Build new things into the existing routine
  - Add activity after their nap, while waiting for lunch, after breakfast
  - Develop a new handwashing routine – increase frequency
  - Alexa – play our boxing music

Ensure adequate hydration and nutrition

Encourage novel ways of “visiting”

Social media, send videos, send cards and letters, photos, phone calls

Work to maintain their social wellness

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Stanford HEALTH CARE

Maximizing the Health of Patients with Chronic Lung Disease in a Time of Social Distancing

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Stanford | MEDICINE

Outline

- Introduction
- Chronic lung disease
- Effects of social isolation : a compounding factor
- Current challenges during Covid-19 pandemic
- Our role
  - Patient education
  - Setting a daily activity program
- Summary

Objectives

- By the end of this presentation, participants will be able to:
  - Educate patients with chronic lung disease on the basic principles and benefits of pulmonary rehab
  - Create a daily schedule that incorporates evidence-based interventions to maximize the health of patients with chronic lung disease at home during this time of social distancing

Chronic lung diseases

COPD

- **Emphysema**
- **Chronic bronchitis**

Asthma

Obstructive

Interstitial lung disease

Pulmonary fibrosis

Restrictive

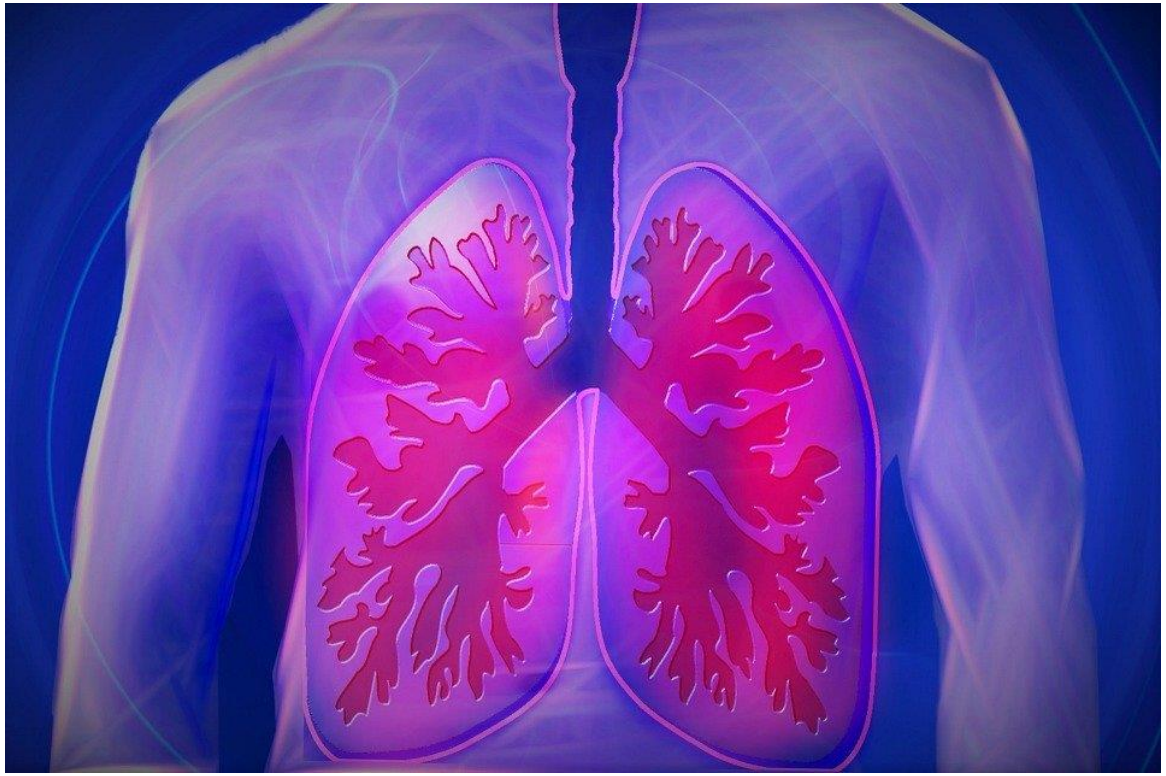
Others: Pulmonary hypertension

Obstructive lung disease

Prevalence in the world:
COPD: 20-30% of adults older than 70y.o
Asthma: 7% of adults older than 65y.o.

- Reduction in airflow
- Impaired EXHALATION
- Air remains in lung even after full exhalation

- Clinical presentation: wheezing, coughing, mucus production
- More severe: hypoxemia, unintended weight loss, significant decline in function



CDC.gov, Buist, 2007,Diaz-Guzman 2014

Chronic lung disease is associated with:

- Depression and anxiety
- Poor sleep quality
- Cognitive decline
- Physical deconditioning
- Immune system dysregulation

Effects of social isolation

- Depression
- Poor sleep quality
- Impaired executive function
- Accelerated cognitive decline
- Poor cardiovascular function
- Impaired immunity

Cleutjens 2016, Olaithe 2018, Hawkley,2015, Alcaraz 2018

COVID-19

Chronic lung disease = high risk category for increased illness severity

Anxiety and helplessness

Current challenge

- Patients unable to participate in pulmonary rehab
- Declining home health – fear of exposure
- Outpatient clinics: few taking new patients, if not closed completely
- Limited community resources: group activities cancelled, senior centers closed
- Limited family involvement/ younger family members isolating from older adults

Our role

- Empower our patients
- Give them tools to manage their disease and to cope with anxiety
- Minimize the effects of social isolation

Mitigating the problem

Extensive patient education

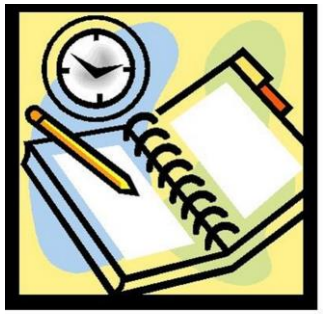
Basic education on lung anatomy and physiology

Benefits of exercise

Rate of perceived exertion

Energy conservation

Breathing exercises



Daily Schedule

Benefits of daily routines

Exercise prescription

Tips to increase adherence

Other considerations: sleep, nutrition, meds

Principles of pulmonary rehab

Multidisciplinary approach: pulmonologist, physiatrist, **PT**, OT, RT, nurse, nutritionist, social worker, psychologist

- Education: **lung disease, breathing techniques, energy conservation**, nutrition, medication, oxygen therapy, what to do in emergencies
- Exercise training: **appropriate frequency, intensity and specificity**
- Psychosocial/behavioral component: stress reduction, managing anxiety

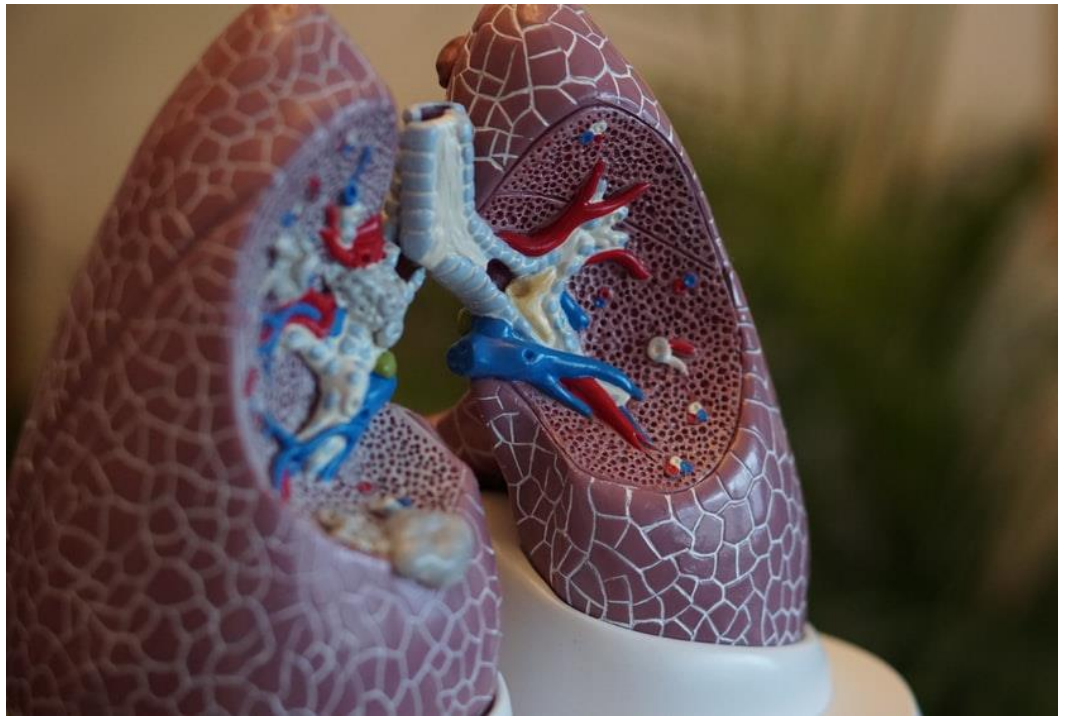
Goal: reduce disability and improve quality of life

American Thoracic Society, British Thoracic Society

Patient education: Lung health 101

General anatomy and physiology of the lungs:

- Bronchi and alveoli
- Gas exchange – oxygen to the tissues



Specific to their condition:
COPD: role of irritants, smoking cessation
Asthma: daily monitoring, asthma action plan, avoiding triggers

Patient education: Benefits of exercise

- **More energy** to do the things they love
- Improved strength
- Stronger bones
- More **resilient:** Improved ability to **fight off disease**
- **Better sleep** : Additional benefit if exercising early in the day and with natural light

Varrasse, 2015

Patient education: RPE

- Modified Borg scale
- Allows for individualization

- As therapists we can help patients with self-assessment
    - Eg: walking in the hallway, ask patient to self-rate RPE and give them feedback

Patient education: Energy conservation

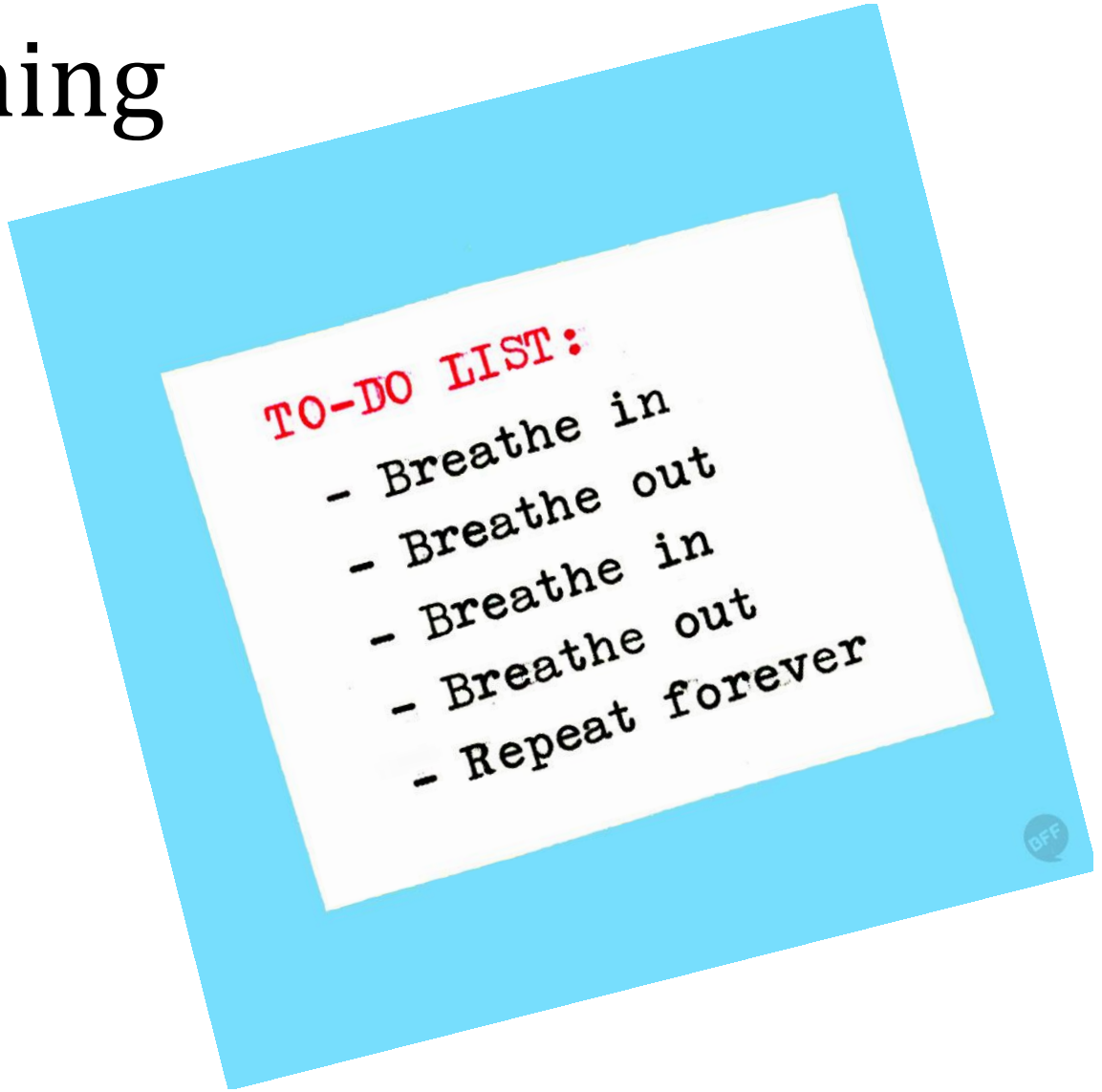
- Prioritizing activities
- Recognizing ADLs may constitute “exercise” depending on disease severity
    - Showering
    - Cooking
    - Laundry
- Scheduling breaks

Patient education: Breathing

Pursed lip breathing

Diaphragmatic breathing

Singing



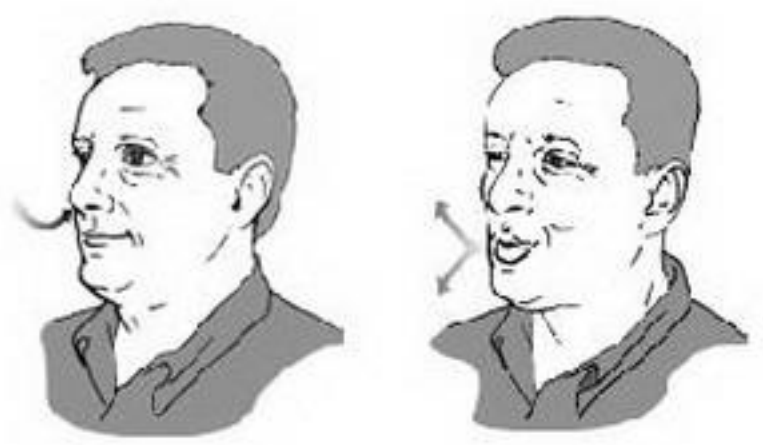
Patient education: Pursed lip breathing

Breathe in through the nose. Breathe out through pursed lips- try to breathe out **for twice as long** as breathing in

“Smell the roses, blow the candles”

Set goals: for example, breathe in for 4 seconds, let go for 8 seconds.

Making a sound “sss” or “thhhhh” can help control exhalation



Benefits:

Improves ventilation

Decreases work of breathing

Patient education: Diaphragmatic breathing

Hands on the belly

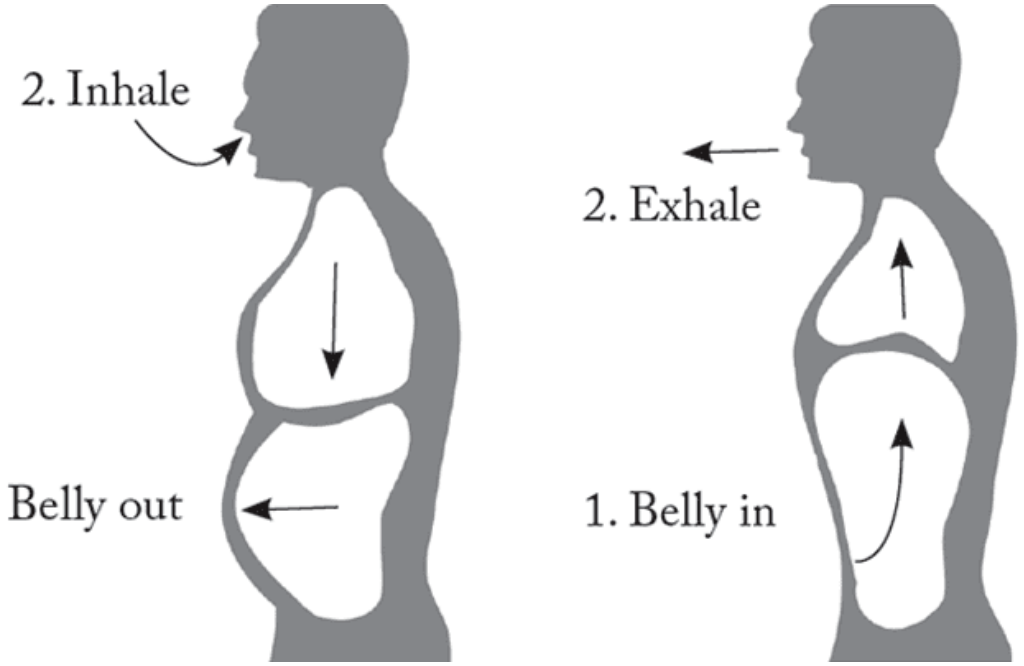
Inhale: hands rise

Exhale: Hands sink in

Goal: relaxing accessory breathing muscles – neck and chest

Strengthens the diaphragm

Slowing down the breath activates the parasympathetic response: rest and digest



Patient education: Singing

Singing requires active exhalation, controlled diaphragm contraction and good posture

Posture : straight back, relaxed shoulders, deep belly breaths

Warm up: lip trills

Good starting songs for controlled breathing: Silent night, Imagine, Can you Feel the love tonight

More advanced songs: Jingle Bell Rock, ABC, I’m still standing,

The training is in spacing out breaths: for an increased challenge, hold a note (for added pizzazz!), sing while standing, or try singing more lines without taking a break.

Mitigating the problem

Extensive patient education

Basic education on lung anatomy and physiology

Benefits of exercise

Rate of perceived exertion

Energy conservation

Breathing exercises

Daily Schedule

Benefits of daily routines

Exercise prescription

Tips to increase adherence

Other considerations: sleep, nutrition, meds

Benefits of a daily schedule : the evidence

Benefits of daily routines for older adults

- Reduced rate of insomnia and increased sleep quality – Zisberg 2010
- Increased medication adherence - Sanders 2013
- Daily routine increase adherence to exercise program- Hancox 2019

Individualized

Patient Centered

Set up in **collaboration** with that patient and their family

Designing a daily schedule: Exercise prescription

Aerobic exercise:

- Warm up and cool down
- Frequency: daily home sessions (ideally, 3- 4 home sessions and 2 additional supervised sessions/week at a pulmonary rehab)
- Intensity: moderate to high intensity 20-30 minutes. Moderate dyspnea: Refer to RPE 4-6
- Progression of activity: as exercise gets easier, increase duration and frequency of exercise, not intensity

Strength training: follow ACSM guidelines for older adults. Intensity determined by RPE 4-6 and SpO2 saturation. Specific to patient's goals and medical recommendation

American thoracic society journal British thoracic society

Exercises at home: some ideas

Ideally: perform 30min of exercise in the morning. Natural light.

Mild disease/ high level of function:
If able to go outside (backyard, quiet neighborhood): walking for 20-30minutes
Stationary bike

Moderate impairment:
Marching in place - high stepping with goal of continuous 2 min/break/2min for 20minutes
Gardening for 20-30min

Severe impairment:
Cooking a meal in standing, or 100 leg kicks over a period of 20minutes

Limitations of exercise at home

Difficult to safely challenge patients – moderate to high intensity exercise is safer in supervised environments

Outcome measures: 6minute walk test- difficult to administer pre and post to evaluate exercise capacity

Assumption that patient is receptive to education and able to follow instructions from a cognitive stand-point. Consider caregiver training if patient has cognitive impairment or decreased safety awareness

Adherence: Several studies reported high adherence, but adherence was generally higher in supervised programs compared to home programs

Pehlivan 2019 , Rivera-Torres 2019

How to increase adherence

- Include activities patient is already doing
- Include hobbies : example, reading – consider reading by a window
- If possible, include family
- Incorporate SMART goals
- Create room for progress and regression

Creating an effective schedule is challenging and highly individualized- no cookie-cutter programs!

Other considerations

- Sleep
- Nutrition
  - COPD and malnutrition -increased metabolic rate work of breathing
  - Foods rich in flavonoids and antioxidants slow down decline in lung function – Fruits and vegetables Garcia-Larsen 2017
- Social interactions

Sample Schedule for Annie: Has moderate asthma, able to go outside, likes lists

Morning:

- Wake up by 8am
- Morning meds
- Breakfast
- Exercise: Walk 20-30min outside
- Fun/Relax – read or knit by natural light!

Afternoon:

- Lunch – Afternoon meds
- Nap
- Social hour: Call family/friends
- Relax

Evening:

- Dinner – Evening meds
- Breathing exercises (singing 15-20min)
- Sleep goal: by 10pm

Sample Schedule for John: Has severe COPD, limited household mobility, does not like lists

Morning:

- Breakfast by 9am
- Exercise – 100 leg kicks and marching in place 15-20min by the window
- Rest/relax

Afternoon:

- Lunch
- Call family/friends
- Arm exercises 10-15min

Evening:

- Dinner
- Breathing exercises
- Sleep goal by 10pm

Application in acute care

Prior to discharge home, to SNF or LTAC

Work with patients and their families

Make it individualized

Collaborate with other providers: OT, SLP, dietician, respiratory therapist, psychologist, primary care team.

Chronic lung disease is associated with:

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- Cognitive decline
- Physical deconditioning
- Immune system dysregulation

Effects of social isolation

- Depression
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Cleutjens 2016, Olaithe 2018, Hawkley,2015, Alcaraz 2018

Take-away

As providers we are uniquely equipped to serve this vulnerable population through

- Patient education
- Setting a daily schedule
- Individualizing care and empowering our patients to maximize their health

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Considerations in Social Distancing for the Home Health Patient

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Overview of Home Health Presentation

- Medicare eligibility for coverage of home health care services
  - Homebound status
- Populations commonly receiving home health care services
- Focus of care delivery
  - Patient outcomes for home health therapy services
  - Data collection to establish patient baseline
- Early impact of social distancing on provision of home health therapy services
- Barriers to service delivery in the home health setting
- Preparing for care of the COVID-19 population in the home health setting

Eligibility for Home Health Services

Medicare Benefit Policy Manual – Chapter 7

Confined to home

Need skilled services

Under care of physician

Under a physician established POC

Have a face-to-face (F2F) encounter

Confined to Home Criteria

Patient Eligibility—Confined to Home

Section 1814(a) and Section 1835(a) of the Act specify that an individual is considered "confined to the home" (homebound) if the following two criteria are met:

First Criteria One of the Following must be met:	**Second Criteria** Both of the following must be met:
1. Because of illness or injury, the individual needs the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person to leave their place of residence.	1. There must exist a normal inability to leave home.
2. Have a condition such that leaving his or her home is medically contraindicated.	2. Leaving home must require a considerable and taxing effort.

Common Home Health Populations

- Following inpatient admission (ACH, with/without previous post-acute stay in LTHC, IRF, SNF) *or* referred from physician
  - Post-surgical conditions (i.e., joint replacement, surgery for neoplastic disease, organ transplant, amputation, CABG, colostomy training)
  - Acute exacerbation of chronic disease processes (i.e., COPD, CHF, MS, AMI)
  - Injury or infection (i.e., UTI, pneumonia, trauma due to fall)
  - Deterioration of existing condition (i.e., dehiscence of surgical incision, diabetes, chronic kidney disease, Alzheimer's disease)

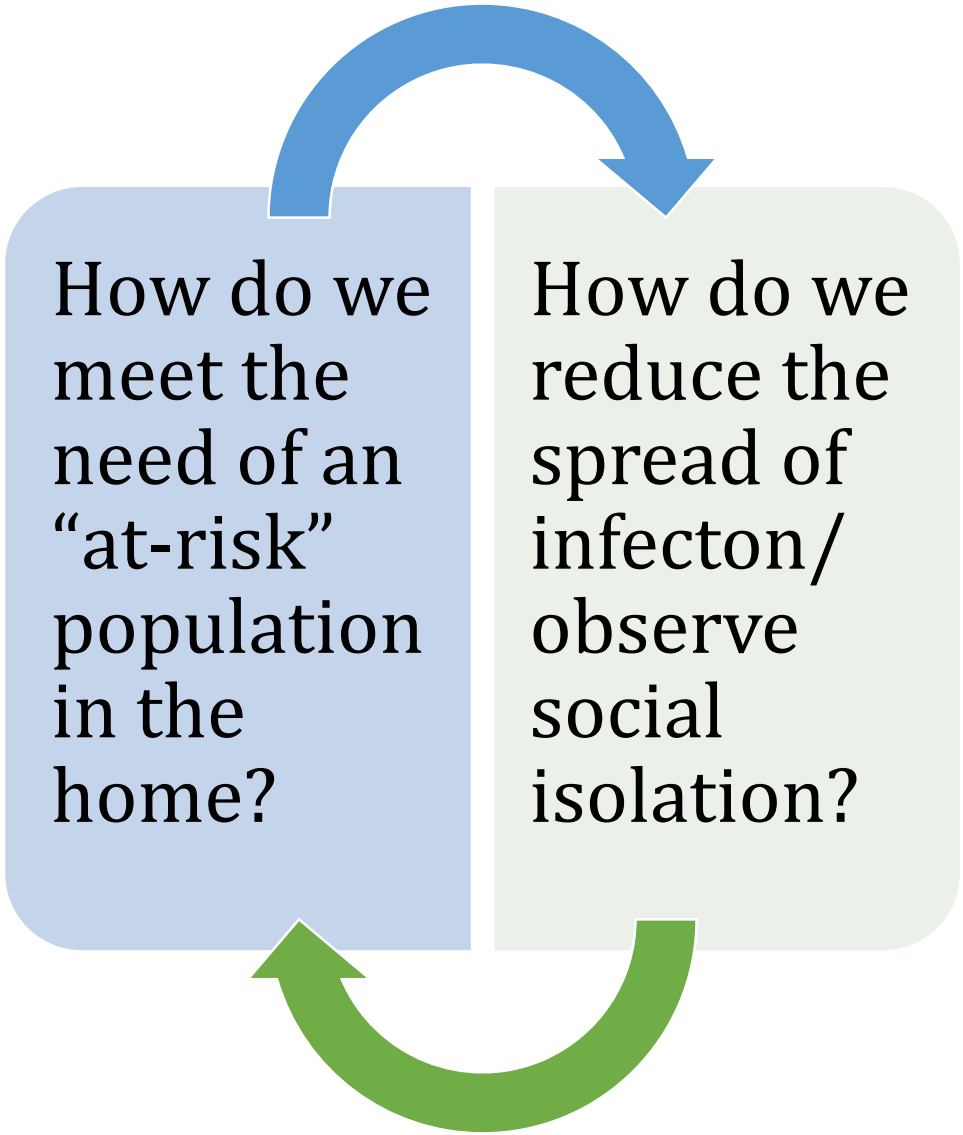
- Common patient presentation can include:
  - Change in functional status & abilities
  - Inability or lack of knowledge to carry out ongoing medical care
  - Compromised independence and/or support in home setting

Care Focus for Therapy in Home Health

- OPTIMIZE (improvement, stabilization) functional abilitites
  - Mobility (transfers, gait)
  - Self Care (ADLs, IADLs)
- PATIENT ACCOUNTABILITY for long-term management of medical conditions
- REDUCE (immediate and long-term) need for higher cost centers of care
  - Unplanned physician appointments
  - Urgent/emergent care
  - Acute care hospitalizations

Questions for Home Health Therapy Services

Challenges in COVID-19



Capturing Information for Decisioning - OASIS

OASIS ITEM

(M1033) Risk for Hospitalization: Which of the following signs or symptoms characterize this patient as at risk for hospitalization? **(Mark all that apply.)**

- ☐ 1 - History of falls (2 or more falls – or any fall with an injury – in the past 12 months)
- ☐ 2 - Unintentional weight loss of a total of 10 pounds or more in the past 12 months
- ☐ 3 - Multiple hospitalizations (2 or more) in the past 6 months
- ☐ 4 - Multiple emergency department visits (2 or more) in the past 6 months
- ☐ 5 - Decline in mental, emotional, or behavioral status in the past 3 months
- ☐ 6 - Reported or observed history of difficulty complying with any medical instructions (for example, medications, diet, exercise) in the past 3 months
- ☐ 7 - Currently taking 5 or more medications
- ☐ 8 - Currently reports exhaustion
- ☐ 9 - Other risk(s) not listed in 1 - 8
- ☐ 10 - None of the above

RESPONSE-SPECIFIC INSTRUCTIONS

- In Response 5, decline in mental, emotional, or behavioral status refers to significant changes occurring within the past 3 months that may impact the patient's ability to remain safely in the home and increase the likelihood of hospitalization.
- In Response 7, medications include OTC medications.
- Response 9 – Other risk(s), may be selected if the assessing clinician finds characteristics other than those listed in Responses 1-8 that may indicate risk for hospitalization (for example, slower movements during sit to stand and walking).

Capturing Information for Decisioning - OASIS

OASIS ITEM

(M1100) **Patient Living Situation:** Which of the following best describes the patient's residential circumstance and availability of assistance? **(Check one box only.)**

Living Arrangement	Availability of Assistance				
	Around the clock	Regular daytime	Regular nighttime	Occasional / short-term assistance	No assistance available
a. Patient lives alone	☐ 01	☐ 02	☐ 03	☐ 04	☐ 05
b. Patient lives with other person(s) in the home	☐ 06	☐ 07	☐ 08	☐ 09	☐ 10
c. Patient lives in congregate situation (for example, assisted living, residential care home)	☐ 11	☐ 12	☐ 13	☐ 14	☐ 15

RESPONSE-SPECIFIC INSTRUCTIONS

- **To answer this question:**
  - **First, determine living arrangement** – whether the patient normally lives alone, in a home with others, or in a congregate setting.
  - **Second, determine availability of assistance** – how frequently caregiver(s) are in the home and available to provide assistance if needed.

Capturing Information for Decisioning - OASIS

OASIS ITEM

(M1700)	**Cognitive Functioning:** Patient's current (day of assessment) level of alertness, orientation, comprehension, concentration, and immediate memory for simple commands.
Enter Code ☐	0 Alert/oriented, able to focus and shift attention, comprehends and recalls task directions independently. 1 Requires prompting (cuing, repetition, reminders) only under stressful or unfamiliar conditions. 2 Requires assistance and some direction in specific situations (for example, on all tasks involving shifting of attention) or consistently requires low stimulus environment due to distractibility. 3 Requires considerable assistance in routine situations. Is not alert and oriented or is unable to shift attention and recall directions more than half the time. 4 Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state, or delirium.

RESPONSE-SPECIFIC INSTRUCTIONS

- Responses progress from no impairment to severely impaired. Consider the degree of impairment.
- Consider the patient's signs/symptoms of cognitive dysfunction that have occurred over the past 24 hours.
- Consider the amount of supervision and care the patient has required due to cognitive deficits.
- Patients with diagnoses such as dementia, delirium, development delay disorders, mental retardation, etc., will have various degrees of cognitive dysfunction.
- Patients with neurological deficits related to stroke, mood/anxiety disorders, or who receive opioid therapy may have cognitive deficits.

Capturing Information for Decisioning - OASIS

OASIS ITEM

(M1720)	When Anxious (Reported or Observed Within the Last 14 Days):
Enter Code ☐	0 None of the time 1 Less often than daily 2 Daily, but not constantly 3 All of the time NA Patient nonresponsive

RESPONSE-SPECIFIC INSTRUCTIONS

- Anxiety includes:
  - Worry that interferes with learning and normal activities,
  - Feelings of being overwhelmed and having difficulty coping, or
  - Symptoms of anxiety disorders.

Capturing Information for Decisioning - OASIS

OASIS ITEM

(M1730) **Depression Screening:** Has the patient been screened for depression, using a standardized, validated depression screening tool?

Enter Code ☐

0 No

1 Yes, patient was screened using the PHQ-2©* scale.

Instructions for this two-question tool: Ask patient: "Over the last two weeks, how often have you been bothered by any of the following problems?"

PHQ-2©*	Not at all 0-1 day	Several days 2-6 days	More than half of the days 7-11 days	Nearly every day 12-14 days	NA Unable to respond
a) Little interest or pleasure in doing things	☐ 0	☐ 1	☐ 2	☐ 3	☐ NA
b) Feeling down, depressed, or hopeless?	☐ 0	☐ 1	☐ 2	☐ 3	☐ NA

2 Yes, patient was screened with a different standardized, validated assessment and the patient meets criteria for further evaluation for depression.

3 Yes, patient was screened with a different standardized, validated assessment and the patient does not meet criteria for further evaluation for depression.

Current Trends from the Home Health Front

- Early discharges from inpatient facilities  ıe
  - Triggered by patient/family request
  - Triggered by facility to increase bed access for increasingly acute population/reduce infection spread
- Redirection of outpatient clinic/office care  ıe-based care
  - HH nursing vs. physician office/specialty clinic
  - Home health therapy vs. outpatient therapy

- Resistance to admission of services into the home
  - Fear of infection
  - Observance of social distancing precautions

Barriers to Therapy Care Delivery in Home Health

- Restricted access in congregate living spaces to support limited exposure:
  - SN for “essential” activities on limited basis in ALFs/ILFs but denial of therapy services as “non-essential”
- Agency/clinician/patient mindset that therapy is not “essential” during pandemic response as outlined in regulatory guidance
  - Value of therapy in reduction of higher acuity care
- Reduction of elective procedures is correlated to a reduction in need for therapy services in post-surgical musculoskeletal population
- Lack of coverage of telehealth services in the home health setting
- Absence of a triage algorithm to support best patient outcomes

Access

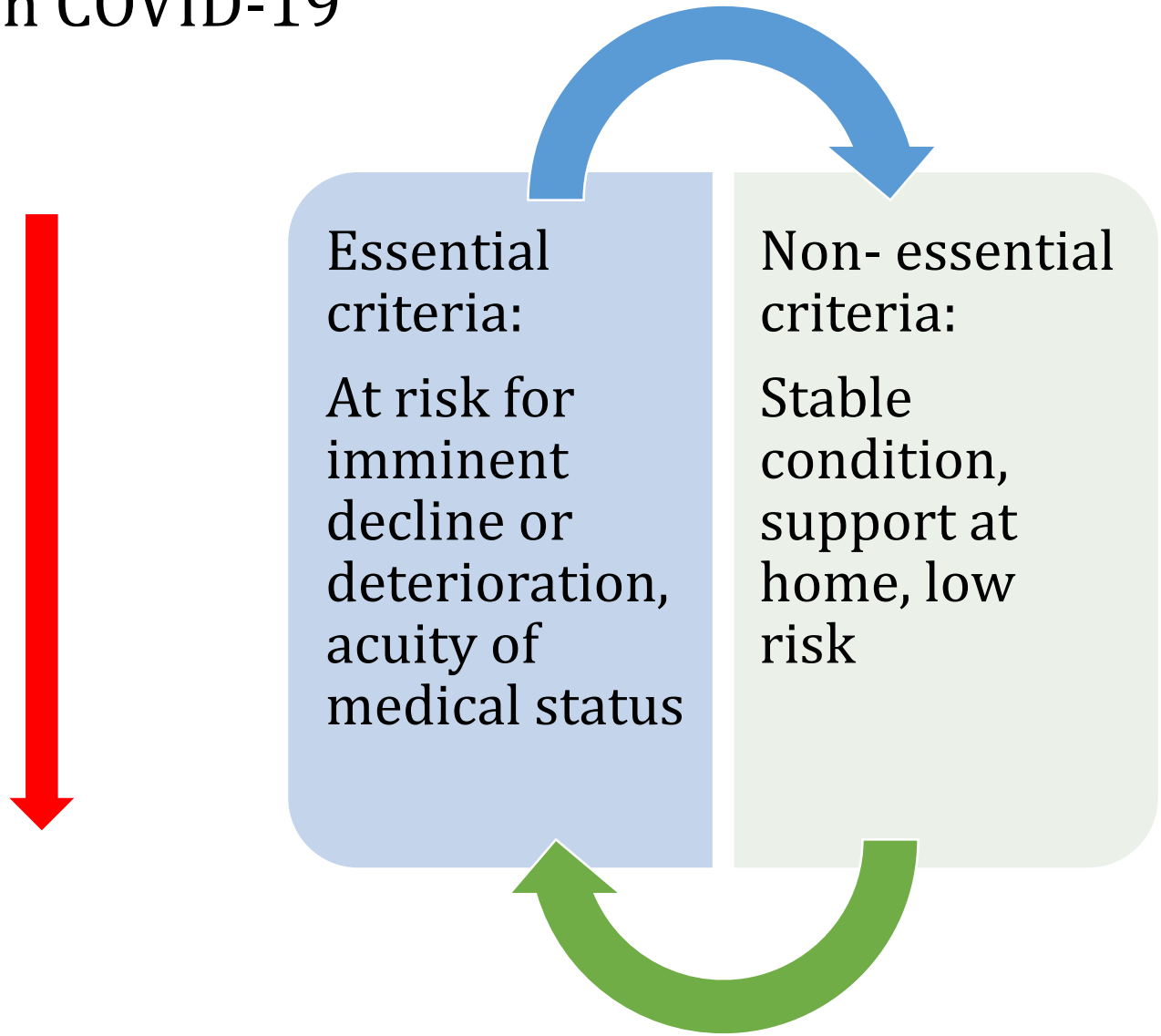
Restricted

Triaging of Home Health Therapy Services

Challenges in COVID-19

Need for in-home visit with appropriate PPE

Observation of social distancing parameters, use of equipment barriers/clean bag technique



Defer in-person care with follow –up plan, as indicated

Maintain social distancing through telehealth interactions

Support for Home Health Therapy Services

- Clear guidance on level of precaution use
  - standard, contact, airborne, droplet
- Facilitate agency interdisciplinary team collaboration to support best practice
  - Right clinician/service, right time, right patient
- Triage process to focus care delivery during pandemic
  - Treatment of non-COVID-19 patient population
  - Prepare for surge into home health of the COVID-19 patient population
- Exploration of viable telehealth delivery models in home health

Resource: CDC

Types of Transmission-Based Precautions

- Contact Precautions
- Droplet Precautions
- Airborne Infection Isolation

(CDC, Transmission-Based Precautions, https://www.cdc.gov/infectioncontrol/basics/transmission-based-precautions.html#anchor_1564058318)

CDC
Centers for Disease Control and Prevention

- Proper utilization of PPE vs. *over*- or *under*-utilization of available supply
- Maintenance of barriers in the home
- Handwashing
- Equipment cleaning
  - Medical devices
  - laptop

Resource: Evidence-based Literature

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Role of Physical Therapists in Reducing Hospital Readmissions: Optimizing Outcomes for Older Adults During Care Transitions From Hospital to Community

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Abstract

Hospital readmissions in older adult populations are an emerging quality indicator for acute care hospitals. Recent evidence has linked functional decline during and after hospitalization with an elevated risk of hospital readmission. However, models of care that have been developed to reduce hospital readmission rates do not adequately address functional deficits. Physical therapists, as experts in optimizing physical function, have a strong opportunity to contribute meaningfully to care transition models and demonstrate the value of physical therapy interventions in reducing readmissions. Thus, the purposes of this perspective article are: (1) to describe the need for physical therapist input during care transitions for older adults and (2) to outline strategies for expanding physical therapy participation in care transitions for older adults, with an overall goal of reducing avoidable 30-day hospital readmissions.

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Original Study

Inverse Dose-Response Relationship Between Home Health Care Services and Rehospitalization in Older Adults

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Do Elderly People at More Severe Activity of Daily Living Limitation Stages Fall More?

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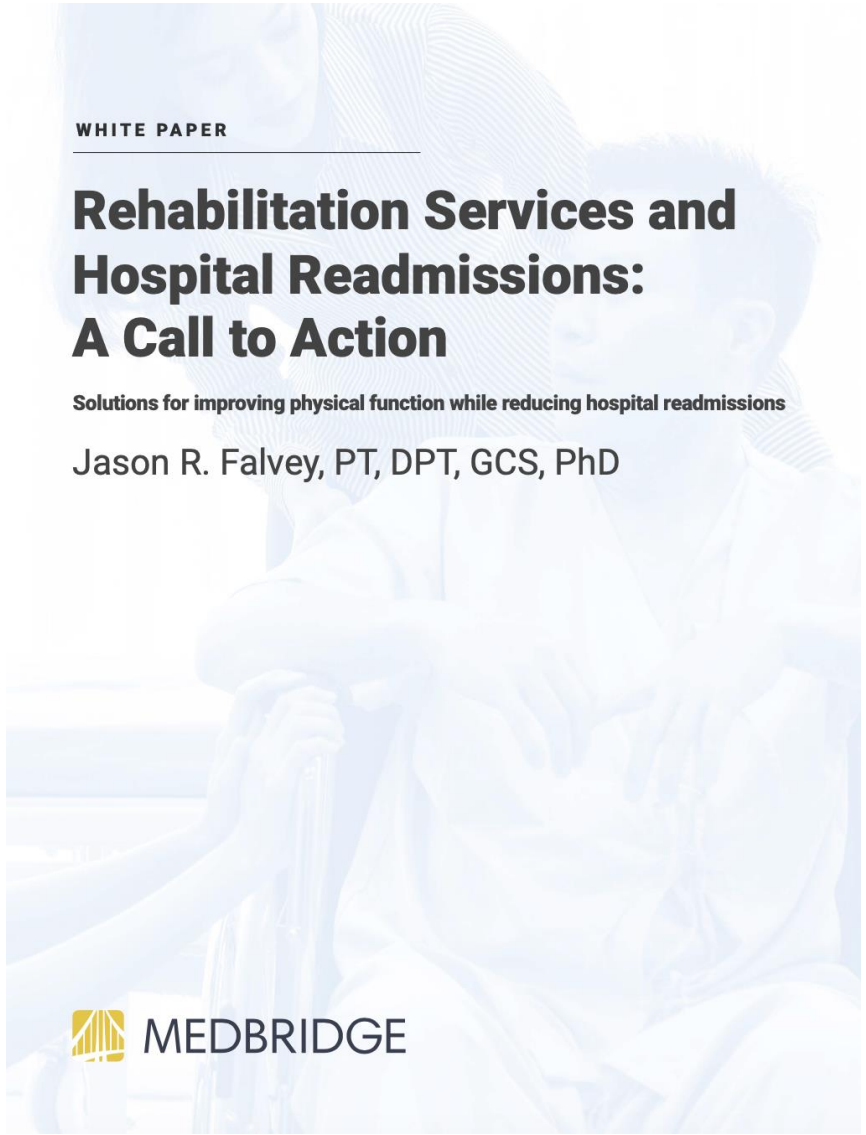
Additional Resources



VALUE STATEMENT FOR HOME HEALTH PHYSICAL THERAPY

This statement presents the value of home health physical therapy (HHPT) towards achieving the triple aim as defined by the Institute for Healthcare Improvement (IHI): improving population health, reducing healthcare costs and improving the patient experience.

HHPT enhances population health through comprehensive case management, use of evidence based examinations and interventions to promote better mobility and prevent deterioration at home and in the community. An evaluation of safe function at home and in the community is completed using a bio-psychosocial model framework from the International Classification of Functioning, Disability and Health (ICF) integrated into the Guide to Physical Therapist Practice 3.0. Examination factors include, but are not limited to: pain, medication management, movement patterns, range of motion, muscle power, nutrition/hydration status, systems review, activities of daily living, cognitive/emotional functioning, safety and fall risk. Physical therapy interventions seek to minimize the impact of various medical conditions on functional ability. Interventions may include therapeutic exercises, functional training activities, and specific education for patients and caregivers about strategies and resources to safely manage in their homes and communities. Ultimately, the effectiveness of physical therapy is demonstrated when patients age in place safely at home.

The American Physical Therapy Association (APTA) defines value as outcomes attained relative to the healthcare costs necessary to achieve those outcomes. HHPT strives to reduce healthcare costs by identifying risk levels for potentially avoidable events such as injurious falls, pressure ulcers, and re-hospitalization. Physical therapists assess risk levels via a variety of validated tests and objective measurements. Plans of care are then designed and implemented to optimize outcomes.

Outcome measures are used to determine quality in HHPT with individualized goals and publicly reported information on Medicare's Home Health Compare quality indicators with OASIS (Outcome and Assessment Information Set) data under the Part A benefit. Outcomes recorded include functional activities such as bathing, transferring, ambulation, and the management of pain and dyspnea. Additionally, the Centers for Medicare and Medicaid Services (CMS) Reports reveals that HHPT costs less than other post-acute care practice settings.

The scope of the patient experience in HHPT is measured via a satisfaction survey called HHCAHPS (Home Healthcare Consumer Assessment of Healthcare Providers and Systems). Survey data is utilized to improve patient-centered care, promote higher quality communication with patients and caregivers, and promote timely resolution of care-related concerns. Subsets of both OASIS outcomes and patient satisfaction survey data provide national benchmarks, allowing comparison in the "Quality of Care and Patient Satisfaction Star Ratings." Care-delivery that is patient-centered in an environment of high quality communication and care coordination yields higher patient satisfaction.

In summary, HHPT demonstrates value by reducing falls risk, decreasing re-hospitalization rates, improving function and promoting healthier lifestyle decisions. HHPT is well-positioned to partner with other healthcare providers in order to control healthcare costs, enhance patient satisfaction, and improve population health in America. The Home Health Section, a component of the APTA, is committed to advocating for the best evidence based practice of physical therapy in the home health setting.

HOME HEALTH SECTION
AMERICAN PHYSICAL THERAPY ASSOCIATION

Approved by the Home Health Section of the American Physical Therapy Association, September 30, 2017.

Questions?

Minimizing the Impact of Social Distancing for the Older Adult

Presenters: Emily Fleischman, Chris Childers, Carolina Zubiri and Diana Kornetti

ACADEMY OF ACUTE CARE PHYSICAL THERAPY

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