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Beyond the Fall: Integrating the Geriatric 5Ms into Home Health Plan of Care Development

Leah Verebes, PT, DPT, GCS

Introduction

Falls are a leading cause of injury, hospitalization, and loss of independence among older adults, accounting for a substantial proportion of unintentional injuries in individuals aged 65 years and older in the United States.¹ Falls are associated with significant morbidity, including fractures, functional decline, and increased mortality, and they contribute to a substantial burden on families and the healthcare system.² Home health physical therapists occupy a unique role in fall prevention because they are able to assess patients within their natural living environments and implement individualized interventions that address both physical and cognitive demands encountered during daily activities.

The literature consistently demonstrates that falls are rarely attributable to a single cause. Instead, fall risk is typically multifactorial and may involve a combination of musculoskeletal weakness, balance impairments, cognitive deficits, psychosocial stressors, and medication-related effects.³ Dual-task performance, defined as the ability to maintain mobility while simultaneously performing a cognitive task, has emerged as an important predictor of fall risk in older adults. Individuals with impaired dual-task performance are at greater risk of falling because real-world mobility commonly requires simultaneous cognitive processing, such as navigating environments while conversing or

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Did You Hear? Read All About It!



On July 11, during the APTA Leadership Congress in Portland, Oregon, APTA presented its annual honors and awards. Several APTA Home Health members were recognized for their outstanding contributions and career achievements in physical therapy:

- Zeeshan Bhimani, PT, BSPT, MHS, from Maryland, was recognized as the PT half of APTA's Outstanding PT/PTA Team.
- Rachel Burba, PTA, from Kentucky, received a Mary McMillan Scholarship.
- Gabe Freyaldenhoven, PT, DPT, from Arkansas, received the State Legislative Leadership Award.
- Brooke Hadley, PTA, from Kentucky, and Yousef Tamimi, PT, DPT, from Pennsylvania, both received Access and Opportunity scholarships.
- Kathleen Mangione, PT, PhD, FAPTA, from Pennsylvania, was honored with the Jules M. Rothstein Golden Pen Award for Scientific Writing.
- Kaegan Robertson, PTA, from Kentucky, received an Outstanding Student scholarship.
- Jeremy Foster, PTA, From Mississippi, received the Lucy Blair Service Award. Jeremy becomes only the third PTA to receive this prestigious recognition.
- Paras Goel, PT, DPT, MBA, PhD, from California, received both the Henry O. and Florence P. Kendall Practice Award and the Societal Impact Award.

Rachel, Brooke, Yousef, and Kaegan are all recently graduated new professionals! Zeeshan, Jeremy, and Paras are either currently involved with APTA Home Health committees or leadership or have been in the past.

Please join me in congratulating all our 2026 award winners!

Philip R. Goldsmith, PT, MSPT, DScPT, COS-C
President, APTA Home Health Academy

managing distractions.⁴ In addition, psychological factors such as depression and grief have been associated with cognitive decline, reduced functional performance, and increased fall risk in older populations.⁵ Medication-related factors may further compound these risks; polypharmacy and the use of psychotropic medications, including selective serotonin reuptake inhibitors (SSRIs), have been shown to impair executive function, balance, and postural stability, thereby increasing the likelihood of falls.⁶ This case report describes a patient with a complex fall history and highlights the interaction between musculoskeletal recovery, cognitive changes, medication management, and psychosocial influences within the context of home health physical therapy.

Case Description

"Jane" (pseudonym) is an older adult female living alone who was referred to home health physical therapy following a right hip fracture sustained during a fall at home. Within the preceding year, Jane had experienced two falls, first sustaining a distal radius fracture and subsequently a right hip fracture, both of which occurred following the death of her spouse in February of the previous year. This significant loss likely contributed to her psychosocial vulnerability, reduced social support, and changes in daily routines.

At the initial home visit following hip fracture repair, Jane presented with decreased lower extremity strength, particularly in the hip abductors and extensors, impaired balance, reduced gait speed, and limited endurance for household ambulation. She ambulated with a walker and demonstrated a high fear of falling. Cognitively, she was oriented to person, place, and time and was able to follow two- to three-step commands, though attention was occasionally inconsistent. She reported managing her own medications independently prior to the hip fracture.

Objective Measures

A comprehensive assessment using standardized outcome measures was performed:

- **Timed Up and Go (TUG):** 18 seconds, exceeding the commonly cited fall-risk threshold of 12 seconds for community-dwelling older adults, indicating elevated risk.
- **5 Times Sit to Stand (5xSTS):** 22 seconds, slower than age-matched norms (expected 12–14 seconds for women aged 70–79), consistent with lower extremity weakness and impaired functional mobility.
- **Gait speed:** 0.7 m/s, below the community ambulation threshold of 1.0 m/s, reflecting reduced walking endurance and higher fall risk.
- **Berg Balance Scale (BBS):** 42/56, indicating moderate fall risk.
- **Activities-specific Balance Confidence (ABC) scale:** 55%, suggesting low confidence in performing daily activities without losing balance.

Functional observation in her home environment included difficulty negotiating bathroom thresholds, limited ability to turn in narrow hallways, and hesitancy when reaching for objects on higher shelves. Jane also demonstrated reliance on compensatory strategies such as holding furniture for balance, indicating that mobility challenges extended beyond strength deficits.

Intervention and Clinical Reasoning

Intervention was designed with a holistic approach, integrating

physical, cognitive, and environmental strategies tailored to her home context. The home environment allowed for direct observation of real-life challenges, including furniture layout, uneven flooring, and clutter, informing treatment planning in ways that outpatient clinics cannot replicate.

Physical interventions included progressive lower extremity strengthening targeting hip abductors, extensors, quadriceps, and ankle dorsiflexors to improve support during weight-bearing tasks. Balance retraining incorporated static, dynamic, and functional tasks such as reaching, tandem standing, and stepping over obstacles. Gait training focused on symmetry, safe use of a walker, and endurance for household ambulation. Transfers were practiced repeatedly, with emphasis on sit-to-stand mechanics and safe bed and chair transitions.

Cognitive and dual-task interventions were integrated early to simulate real-life demands. Activities included ambulating while counting backward, carrying objects, or verbalizing categories, designed to challenge attention and executive function. Clinical reasoning for this approach was based on evidence demonstrating that dual-task deficits are highly predictive of falls, particularly in older adults recovering from fractures or with subtle cognitive decline.

Fall prevention education and environmental modifications were incorporated into each session. Recommendations included removing loose rugs, ensuring clear walking paths, adjusting lighting, and arranging frequently used items at accessible heights. Education also addressed pacing strategies, appropriate use of assistive devices, and recognition of fatigue as a fall risk factor.

This intervention approach also aligns with the **Geriatrics 5Ms framework**, an age-friendly model that emphasizes Mobility, Mind, Medications, Multicomplexity, and What Matters Most when caring for older adults. Mobility was addressed through strengthening, balance training, and gait retraining aimed at restoring safe household ambulation. Mind was incorporated through dual-task and cognitive engagement activities designed to challenge attention and executive function during mobility tasks. Medications were considered through ongoing monitoring of fatigue, dizziness, and potential medication-related fall risk factors, consistent with the need to optimize medication regimens in older adults. Multicomplexity was reflected in the integration of physical impairments, environmental barriers, and emerging cognitive changes into clinical decision-making. Finally, What Matters Most guided treatment goals by prioritizing the patient's ability to remain safely independent within her home environment. Incorporating the 5Ms framework supports a comprehensive, patient-centered approach to geriatric care and helps ensure that interventions address the multiple interacting factors that influence function and fall risk in older adults.⁷

Initially, Jane demonstrated steady progress. Gait symmetry improved, transfer independence increased, and she gained confidence with mobility. Her TUG improved to 16 seconds, 5xSTS decreased to 18 seconds, and gait speed increased modestly to 0.85 m/s. However, dual-task performance remained challenging, and subtle cognitive changes began to emerge.

Clinical Change and Reassessment

During subsequent visits, I observed subtle but important changes in Jane's behavior. She appeared increasingly forgetful, repeated questions, and occasionally struggled to recall exercise instructions previously mastered. Affect and behavior varied across sessions, sometimes showing flat mood, at other times mild irritability. These

changes were first identified due to the repeated, contextual nature of home health visits, which allow clinicians to see small day-to-day variations that might not be visible in outpatient or clinic settings.

Dual-task activities highlighted her emerging deficits. While walking and performing a cognitive task, Jane demonstrated decreased gait speed, increased variability, and occasional loss of balance. She also expressed difficulty remembering her medication schedule, raising concerns about medication adherence. Upon review, it became apparent that Jane was not taking her prescribed SSRI consistently. Missed or mistimed doses could contribute to fluctuations in mood, attention, and executive functioning, thereby increasing fall risk. Following discussion with her family, her grandson began preparing her weekly pill organizer, ensuring proper adherence and reducing cognitive load.

This scenario underscores a critical aspect of geriatric home health care: small deviations in day-to-day function, forgetfulness, variability in behavior, or inconsistent adherence to routines, can signal clinically significant changes in cognition, mood, or safety. In the outpatient clinic, such subtle changes may go unnoticed due to the controlled, less complex environment.

Discussion

This case highlights several key concepts in geriatric home health care. First, falls are inherently multifactorial. Jane’s injuries were not solely due to musculoskeletal weakness. Contributing factors included grief, depression, cognitive changes, dual-task interference, and medication mismanagement. Recognition of these overlapping contributors required both thorough assessment and repeated observation in her home environment.

Dual-task interference and executive function played a significant role in Jane’s functional decline. While her isolated physical measures indicated progress, tasks that combined cognitive and motor demands revealed deficits not captured in standard testing. This aligns with research demonstrating that dual-task deficits are predictive of falls and that executive dysfunction can impair sequencing, attention, and adaptability during everyday activities.

Medication management emerged as a critical factor. SSRIs, while commonly prescribed for depression in older adults, can contribute to dizziness, orthostatic hypotension, and impaired cognitive function if not taken appropriately. Jane’s inconsistent adherence likely exacerbated her forgetfulness, behavioral variability, and fall risk. Home health therapists are uniquely positioned to observe medication mismanagement and collaborate with family and primary care providers to mitigate risk.

Grief and functional decline must also be considered. The loss of a spouse can precipitate depression, cognitive slowing, and reduced self-care. In Jane’s case, bereavement compounded her vulnerability, influencing both mood and executive function. Such psychosocial factors are often invisible in outpatient settings, reinforcing the importance of home-based observation and intervention.

Interprofessional collaboration was essential in this case. By engaging Jane’s family and coordinating with her physician regarding SSRI adherence, we implemented practical strategies to enhance safety and independence. The combination of physical therapy, family support, and medical oversight exemplifies the multidisciplinary approach required in complex geriatric care.

Finally, home health practice emphasizes real-life problem solving. Unlike the controlled environment of an outpatient clinic, the home presents variable conditions, furniture placement, clutter, lighting,

and environmental hazards that influence functional performance. Therapists in the home are not just teaching exercises; they are integrating strength, balance, cognition, and environmental awareness into the patient’s daily context. This approach allows for early identification of subtle changes in cognition, affect, and safety, enabling timely intervention before falls or further decline occur.

Takeaway for Practice

Effective geriatric home health care requires attention to the whole person, including physical, cognitive, emotional, and environmental factors. Practitioners must observe small but meaningful changes in day-to-day performance, such as slight forgetfulness, mood variability, or difficulty managing medications. These changes can indicate significant underlying risks that are not apparent in standardized testing alone. Dual-task assessment and real-life scenario training are critical tools for uncovering hidden deficits. Home health physical therapists should engage family members in care planning, particularly for medication management and environmental safety, and maintain open communication with other healthcare providers to ensure coordinated care. This case demonstrates that physical recovery cannot be considered in isolation. By addressing the interplay of musculoskeletal strength, cognitive function, psychosocial health, and environmental context, clinicians can reduce fall risk and support aging in place. The home health setting uniquely allows therapists to integrate these elements into meaningful, functional interventions, while simultaneously monitoring early signs of decline. Future practice should continue to emphasize comprehensive, patient-centered approaches that incorporate dual-task training, medication management support, and psychosocial assessment as standard components of geriatric care.

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The CY 2027 HH Rule Finally Arrives: What Changes, What Matters

Ellen R. Strunk, PT, MS, GCS, FAPTA, ACEEAA, CHC, RACCT

On July 1, 2026, the Centers for Medicare and Medicaid Services (CMS) published its Calendar Year (CY) 2027 Home Health (HH) Prospective Payment System (PPS) proposed rule.¹ In addition to the proposals to update payment rates for CY 2027, CMS included a number of other proposals of interest to physical therapists. As with recent years, the proposal for 2027 does more than simply update payment rates: it refines case-mix calibration, adjusts outlier and wage index policies, and advances changes to the Home Health Quality Reporting Program (HH QRP) with an eye toward tighter alignment with the expanded Home Health Value-Based Purchasing (HHVBP) Model. For agencies, clinicians, and compliance teams, CY 2027 may be remembered as a “consolidation year” in which CMS uses several

years of Patient-Driven Grouper Model (PDGM) data to fine-tune how patient characteristics, comorbidities, and functional status translate into payment and performance.

Projections are HHAs Would See an Increase in Aggregated Payments of 2.4%

At the core of the proposed rule is the annual update to the national, standardized 30-day payment rate and associated per-visit rates under HH PPS. If finalized, HHAs would see an increase of 2.4%, or \$420 million in aggregate payments, representing a significant change from years past, which have included aggregate cuts to Medicare home health payments. This update incorporates the home

health market basket, productivity adjustments, and a recalibrated fixed-dollar loss ratio for outliers. It is layered on top of CMS’s ongoing “behavioral adjustment” work, in which the agency compares assumed versus actual provider behavior after PDGM implementation—such as changes in visit patterns, coding, and case-mix—and then applies permanent and temporary adjustments to keep aggregate spending aligned with statutory requirements. HH providers will welcome the fact that CMS did not propose an additional **permanent adjustment** to the CY 2027 30-day base payment rate. The agency said it will continue to analyze claims data through CY 2026, as required by law, to determine whether any future permanent adjustments are needed to account for the impact of the PDGM. However, even though they are not proposing a new permanent adjustment, CMS proposed a temporary adjustment of -3% to the 2027 national, standardized payment rate. Figure 1 illustrates the proposed change in national, standardized 30-day period payment amounts for CY 2027.

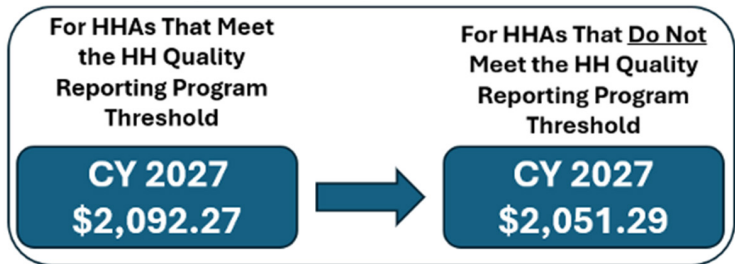


Figure 1. Proposed CY 2027 National, Standardized 30-day Period Payment Amount

In practical terms, HH agencies can expect some overall payment increase relative to 2026, but that increase will be partially offset by PDGM budget neutrality and behavior-related adjustments, reinforcing the need for operational efficiency and clinically appropriate utilization.

The proposed rule also revisits the PDGM case-mix structure itself. CMS proposes recalibration of PDGM case-mix weights, functional impairment levels, comorbidity subgroups, and low-utilization payment adjustment (LUPA) thresholds for CY 2027, using several years of actual data rather than the pre-implementation simulations that informed early PDGM design. These changes are intended to ensure that payment more accurately reflects current resource use and patient complexity. For HH agencies, this means that familiar clinical groups—such as musculoskeletal and neuro rehabilitation, complex nursing, and multiple chronic condition (MMTA) categories—may see shifts in relative weights, with corresponding implications for episode margins, discipline mix, and LUPA risk management.

Monitoring the Effects of the PDGM Implementation

CMS routinely analyzes Medicare home health benefit utilization and in the CY 2027 HH PPS proposed rule, there are a number of tables and figures that will be of interest to physical therapists (91 FR 41222 to 41234).

1. After initially dropping with PDGM, PT continues to be a driver of skilled service.

- Average PT visits per 30-day period dropped from about 3.3–3.33 in pre-PDGM simulated data (2018–2019) to about 2.7 in 2020 and have hovered around 2.7–2.77 through 2025, indicating a persistent reduction in PT intensity per period compared with the pre-PDGM therapy-threshold era.
- Total visits across all disciplines declined from 9.86 to 7.77 over

2018–2025, but PT has remained the second-largest discipline by volume after nursing, suggesting PT continues to be a central driver of skilled service delivery even with fewer visits.

2. PT is a small contributor to Low Utilization Payment Adjustment (LUPA) periods.

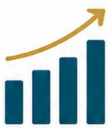
- The proportion of 30-day periods that are LUPAs has ranged roughly 6.6–8.7%, with a slight decrease by 2025.
- Within LUPA periods, PT averages only about 0.5–0.6 visits, compared with about 1.0–1.2 nursing visits. This means that when agencies fall into LUPA, PT is usually present but in very

Monitoring the Effects of PDGM

What the CY 2027 HH PPS Proposed Rule says about Physical Therapy



1



PT remains a core skilled service

- Average PT visits per 30-day period fell from about **3.3** before PDGM to about **2.7** in 2020 and then stayed stable through 2025.
- PT remains the **second-largest** discipline by visit volume after nursing.

2



PT plays a small but important role in LUPA periods

- LUPAs ranged from about **6.6%** to **8.7%** of periods.
- PT averages only about **0.5** to **0.6** visits in LUPA periods, so small scheduling changes can affect LUPA risk.

3



Therapy-only periods are growing

- Therapy-only periods increased from about **13.5%** in 2018 to **20.9%** in 2025.
- PT is now the defining service in a growing share of home health episodes.

4



MS Rehab remains highly PT-dependent

- MS Rehab rose from about **19.4%** of periods in 2020 to **21.5%** in 2025.
- MS Rehab and Neuro Rehab still have the highest therapy visit use, about **5** to **6** visits per period.

5



Comorbidity complexity is increasing

- Periods with no comorbidity adjustment fell from **55.6%** in simulated 2018 data to **24.1%** in 2025.
- PT caseloads increasingly include complex conditions that demand precise diagnosis coding.

6



Functional impairment remains high

- High functional impairment periods rose sharply with PDGM and remain around **38%** to **40%**.
- PTs are treating more impaired patients, but usually with only about **2.7** visits per period.

7



PT is managing more chronic community-based care

- Community-late periods now make up about **64.2%** of all periods, while institutional-early periods remain around **20%**.
- PT is increasingly managing chronic and longer-duration functional needs, not only post-hospital recovery.



Targeted Visits Matter More



Coding and OASIS accuracy affect payment



PT value is increasingly tied to complexity and function

Figure 2. Monitoring the Effects of PDGM

low doses, underscoring that small changes in PT scheduling can tip a period into or out of LUPA risk.

3. Therapy-only episodes have increased since 2018.

- The share of “therapy-only” periods (PT/OT/SLP only) has steadily increased from about 13.5% in 2018 to 20.9% in 2025. This suggests a growing cohort of patients whose home health care is driven purely by therapy, often musculoskeletal or neuro rehab cases where PT leads the plan of care.
- “Therapy + non-therapy” periods have remained relatively stable in the low-40% range, while “no therapy” periods have dropped from about 42.6% in 2020 to 36.6% in 2025. PT is therefore present in a majority of periods and increasingly defines the care for a sizable subset of patients.

4. MS Rehab remains the clinical group most dependent on PT.

- Musculoskeletal Rehab’s (MS) share of all periods has steadily risen, from about 19.4% in 2020 to 21.5% in 2025. PT is the primary discipline in this clinical group, so growth here represents increasing reliance on PT-driven episodes.
- Neuro Rehab has stabilized around 10–11% of periods and Wound care holds near 14%; both groups require substantial PT involvement in mobility, transfers, and positioning.
- Both MS Rehab and Neuro Rehab have the highest number of average therapy visits at 5–6 visits per period, and these have declined somewhat since pre-PDGM but then stabilized. This pattern implies PT is still concentrated where functional recovery needs are highest but under tighter visit budgets.

5. The proportion of periods with comorbidity complexity has increased.

- The proportion of periods with no comorbidity adjustment has fallen from a simulated 55.6% in 2018 to only 24.1% in 2025, while low and high comorbidity adjustments together now cover more than 75% of periods. This shows a marked increase in patients with complex multi-system disease receiving home health.
- Proposed low comorbidity subgroups and high-interaction groups include many conditions commonly seen in PT case-loads—diabetes (with neuropathy), heart failure, atherosclerosis, venous thrombosis, paraplegia/quadruplegia, stroke sequelae, pressure ulcers, and lymphedema. These categories reinforce the need for precise diagnosis coding.

6. Patients still present with a high functional impairment.

- High functional impairment periods rose sharply at PDGM implementation (from about 31–32% to over 41–44% in 2020–2021) and remain around 38–40%. This confirms that current home health patients are functionally more impaired and thus more likely to need intensive PT than pre-PDGM simulations suggested.
- Low impairment periods have declined compared with pre-PDGM, while medium impairment remains fairly stable.
- Therefore, PTs working in home health face a patient mix skewed toward moderate-to-high functional need, but generally have only 2.7 PT visits per period on average to address those needs.

7. PTs are seeing fewer patients post-hospital discharge and more patients with chronic conditions.

- Patients qualifying in the community-late admission period now make up about two-thirds of all periods (64.2% in 2025), whereas

institutional-early periods remain around 20% of all periods. PT increasingly manages longer sequences of care for community-based chronic conditions rather than just short post-acute transitions from institutional settings.

- Patients qualifying the institutional-early admission period, where PT often focuses on post-hospital functional recovery, have dipped slightly from 20% to about 18%, but remain a substantial segment requiring higher acuity rehab. **What does this mean for PT Practice?**
- PT is present in most home health periods and is increasingly the sole discipline in about one in five episodes, but average PT visits per period remain modest.
- Patients are more functionally impaired and more comorbid, especially in MS/Neuro Rehab and complex vascular/diabetic populations, making PT clinically more critical even as visit budgets remain tight.
- LUPA percentages are relatively stable but PT visit counts in LUPA periods are very low, meaning that small changes in PT scheduling and front-loading can have significant impacts to a HHA’s financial performance.

Proposed Updates to the HH Quality Report Program and the Expanded Value-Based Purchasing Program

On the quality side, CMS continues to refine the HH QRP, recognizing its growing role as both a pay-for-reporting mechanism and a foundation for value-based models. The CY 2027 rule proposes updates to the data submission timelines for the Outcomes and Assessment Instrument Set (OASIS) and moves OASIS and the HH Consumer Assessment of Healthcare Providers and Systems (CAHPS) reporting firmly into a calendar-year frame, which simplifies alignment with other quality programs but may require operational changes in internal audit and reporting cycles. CMS also outlines potential initiatives to better synchronize the HH QRP with the Expanded HH Value-Based Purchasing (VBP) Model, signaling that future measure selection and scoring will increasingly emphasize outcomes, patient experience, and avoidable utilization rather than process measures alone. Home health agencies that invest now in reliable data capture, outcome measurement, and cross-discipline care coordination will be better positioned as this alignment tightens.

Beyond payment and quality, the rule touches on several policy areas that shape the broader environment in which home health operates. CMS discusses the provision of palliative care services under the home health benefit, raising questions about how symptom-focused, interdisciplinary care for serious illness could be integrated into existing HH PPS structures. The proposed CY 2027 HH PPS rule does not create a new “palliative care benefit” in home health, but it uses several pages to clarify that community-based palliative care can and should be delivered under the existing Medicare home health benefit when patients meet current coverage criteria, and it signals CMS’s intent to expand and normalize this use going forward.

The agency also requests input on developing a home-health-specific wage index, an initiative that could eventually change how geographic labor cost differences are recognized in payment rates. Additional proposals clarify requirements for replacement of durable medical equipment, refine provider enrollment and Durable Medical Equipment, Prosthetic, Orthotics and Suppliers (DMEPOS) accreditation standards to combat fraud and abuse, and implement statutory changes expanding the DME benefit for certain external infusion pumps and associated drugs.

Taken together, the CY 2027 HH proposed rule reflects CMS’s intent to refine PDGM based on real-world experience, strengthen the link between payment and measurable quality, and ensure that program integrity keeps pace with evolving care models. For clinical leaders, compliance staff, and frontline therapists and nurses, it is less radical than proposed rules in recent years. Regardless, understanding these proposed changes—and their practical impact on visit planning, documentation, coding, and quality performance—is essential as agencies prepare comments, adjust strategies for 2027, and continue adapting to a home health landscape where clinical characteristics and outcomes, rather than service volume alone, drive success.📌

DISCLOSURE

This article was drafted with assistance from generative AI tools. All content was reviewed, edited, and verified by the author for accuracy and completeness.

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Ellen R. Strunk, PT, MS, GCS, FAPTA, ACEEAA, CHC, RACCT has worked in various roles & settings as both clinician, manager/director and policy expert. Ellen is an expert at helping customers understand the CMS prospective payment systems in the skilled nursing facility and home health setting, as well as outpatient therapy billing for all provider types. For over 15 years, Ellen has worked with dozens of clients as principal consultant and founder of Rehab Resources and Consulting, Inc. Her experience in both the home and community aspects of the post-acute care continuum gives her a unique perspective in finding solutions while ensuring a patient-centered approach is not lost in translation. As a policy expert, Ellen supports organizations in many areas including provider education, measure development, and regulatory compliance.

Frailty in Home Health

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Frailty is defined as a state in which there is an increase in an individual’s vulnerability for developing increased dependency and/or mortality when exposed to a physiological or psychological stressor, tipping the balance between reserve and insults, or positive and negative influences, leading to increased vulnerability. People living with frailty are more vulnerable to the effects of potential stressors, and to deterioration than others of the same chronological age. Frail individuals experience higher rates of adverse outcomes.¹ The World Health Organization (WHO) defines frailty as “a clinically recognizable state in which the ability of older people to cope with every day or acute stressors is compromised by an increased vulnerability brought by age-associated declines in physiological reserve and function across multiple organ systems.”²

There are several factors that contribute to frailty. Advanced age on its own does not necessarily mean vulnerability to negative health outcomes typical of frailty. Frailty is partly programmed in early life and is associated with lower socio-economic status in adulthood. Frailty is a state of decreased physiological reserve and compromised capacity to maintain homeostasis as a consequence of age-related, multiple, accumulated deficits. Frail older people are highly vulnerable to adverse health outcomes when exposed to an internal or external stressor. Frailty refers to instability and risk of loss of function and is clearly different and distinguishable from advanced age, disability, and comorbidity.³ Despite agreement on it being a multiply determined state of increased risk, consensus on a frailty definition has yet to be reached.¹

As the population ages, the concept of frailty becomes increasingly relevant in the provision of health care to the population. The population of older adults is expected to grow from 8.5% of people aged 65 and older to nearly 25% by 2050.¹ The prevalence of frailty among the community-dwelling population aged 65 years and older is ~10% but can range widely from 4.0% to 59.1% depending on the frailty criteria used. Advanced age is a significant risk factor for frailty and a quarter of those aged 80 years or older are frail. The prevalence of frailty gradually increases with age and is observed in selected populations with specific diseases or conditions, including cancer (42%), End-stage renal disease (37%), Heart failure (45%), Alzheimer disease (32%) and Nursing home residents (52%).³

The individual course of frailty varies, and the level of frailty can be reduced even in old age. Several longitudinal population-based studies have shown that 8.3%–17.9% of older adults improved their frailty status and some of them made frequent and dynamic transitions over time.³

The impact of frailty on the health care system is substantial. Frail individuals have increased risk of premature death, various negative health outcomes: falls, fractures, disability, dementia all of which could result in poor quality of life. Increased cost and use of health care resources: ER visits, hospitalization, and institutionalization. Health care costs of frail individuals are sometimes several-fold higher than those of non-frail counterparts. Older adults form the main users of medical and social care services. Current health care systems are mostly designed to address organ-specific and disease-specific problems one at a time and are not well prepared to deal with the chronic and complex medical needs of frail older patients and to provide seamless care for them in the long term. Older patients often receive suboptimal care due to this fragmented delivery of appropriate treatments and services.³

Assessing frailty early during care is essential to identify those patients who are most vulnerable. Frailty measurement is integral for guiding patient care, as it helps clinicians determine which interventions will be more likely to be beneficial and which may be more harmful to particular individuals.¹ There are nearly 70 frailty scales that have been developed to identify frailty with various aspects of physical, psychological, or social components. Each screening scale has its advantages in the disease setting for which it was developed, and the differences in the selection and application of debilitating scales are apparent and cannot be overlooked.⁴ There is no standard assessment instrument. The most widely used measures worldwide are the Frailty Phenotype (FP) and the Frailty Index (FI), Study of Osteoporotic Fracture Index (SOF), FRAIL Scale, Clinical Frailty Scale (CFS), Vulnerable Elder Survey-13 (VES-13), Tilburg Frailty Indicator (TFI), Groningen Frailty Indicator (GFI), and the Edmonton Frailty Scale (EFS) but these cannot be easily implemented in large-scale studies or busy clinics.^{4,5}

Frailty Phenotype (FP) assesses five physical domains: unintentional weight loss (4.5 kg or more in the last year), exhaustion (self-reported), low physical activity, weakness (low grip strength), and walking speed. An individual has frailty with ≥ 3 items; pre-frailty with 1-2 items and considered robust with 0 items.⁴

Groningen Frailty Indicator (GFI) has 9 physical, 1 cognitive, 3 social, and 2 psychological for a total of 4 dimensions. An individual is considered to have frailty with a score ≥ 4 . The GFI only assess frailty in home-dwelling older adults, does not contain a specialized and a self-assessed version, does not assess disability that could predict poor outcome, and does not identify grades of frailty.⁴

Frailty Index (FI) has 30-70 items in total including 8 frailty items and all the 3 domains (physical, psychological and social) are assessed. An individual has frailty with a score > 0.25 ; pre-frailty with a score of 0.12~0.25; and robust with a score < 0.12 . The Frailty Index can be used by clinicians in hospitals and in community settings but is used most often by researchers, as it's not easy to use because it involves mathematical calculations.⁴

Clinical Frailty Scale (CFS) has a total of 9 points: each point on its scale has a visual chart and a written description of frailty to assist the classification process. An individual is considered to have frailty with a score ≥ 5 . Score of 1 is considered very fit, 2 is fit, 3 managing well, 4 living with very mild frailty, 5 living with mild frailty, 6 living with moderate frailty, 7 living with severe frailty, 8 living with very severe frailty, 9 terminally ill.⁴ The CFS is widely favored for quick assessments in clinical settings. The CFS is commonly used to predict health outcomes in a variety of settings, mostly mortality, comorbidity, functional decline, mobility, and cognitive decline.⁴

Edmonton Frail Scale (EFS) is an 11-item scale, of which 9 items are self-reported. It assesses nine domains of frailty (cognition, general health status, functional independence, social support, medication usage, nutrition, mood, continence, functional performance). The following cut-offs are used to classify frailty severity: not frail (0-5), apparently vulnerable (6-7), mild frailty (8-9), moderate frailty (10-11) and severe frailty (12-17).⁴

Tilburg Frailty Indicator (TFI) is a self-reported scale composed of 2 parts: Part A about "determinants of frailty and diseases", and Part B about the "presence of frailty" that generates a final score. Part B includes three domains (physical, psychological, and social) and 15 items. An individual is considered to have frailty with a score ≥ 5 . The TFI Part B is a self-reported scale used in several countries, and it is associated with short-term disability, lower quality of life, hospitalization, and falls.⁴

Frail Scale is a recommended assessment as it's a simple tool consisting of five yes/no questions: Fatigue (How much of the time during the past 4 weeks did you feel tired? 1 = All of the time, 2 = Most of the time, 3 = Some of the time, 4 = A little of the time, 5 = None of the time. Responses of "1" or "2" are scored as 1 and all others as 0), Resistance (inability to climb 10 steps unassisted, 1 = Yes, 0 = No), Ambulation (inability to walk a few blocks without an assistive device unassisted, 1 = Yes, 0 = No), Illnesses (0-4 comorbidities = 0 and 5-11 comorbidities = 1), Loss of weight (5% loss of weight is scored as 1 and $< 5\%$ as 0). Frail scale scores range from 0-5: 1 point for each component; 0=best to 5=worst. An individual is considered Frail (3-5 points), Pre-frail (1-2 points), Robust (0 points). The Frail Scale Predicts mortality and incident ADL and IADL disabilities among community-dwelling older people and is recommended as one of the tools to detect frailty by the Joint Action ADVANTAGE, a EU co-funded initiative launched in 2017 involving 22 member states and over 40 organizations.^{6,7}

The Short Physical Performance Battery (SPPB) score has good diagnostic accuracy to discriminate between non-frail and frail older adults using a cut-off point of 9 or less for assessing frailty. SPPB's diagnostic accuracy measures for detecting prefrailty have low to moderate accuracy, this instrument can help in screening prefrail older adults from the cutoff point of 11 or less in the total SPPB score. Identification of prefrail older adults enables implementing early treatment in this target audience and can prevent their advance to frailty.⁸

The first physical component of frailty that manifests tends to be exhaustion, followed by slowness of gait, lowered physical activity, and

weakness. Weight loss tends to develop later than the other physical components of frailty. Functional decline associated with frailty is gradual, incessant, and begins several years before death. Frailty has the slowest rate of functional decline observable in the last year before death, and the most functional dependence in activities of daily living at 1 year before death.⁹

Once frailty is established and progresses in its natural course, other geriatric syndromes are more likely to emerge, including: falls, incontinence, rapid functional decline, pressure injuries, mild cognitive impairment, and delirium.⁹ A likely source of the fluctuations in frailty may be due to the highly dynamic character of ADL, IADL, and mobility disability. Characterized by a number of disability episodes, cycles of deterioration, recovery, and recurrence event over relative short time periods. Intra-individual variability in mobility limitations are also substantial among older adults, increase throughout late life and were higher among those who died. Frailty fluctuations increase with chronological age, are more likely in women, in those with low socioeconomic position (SEP), and those who died.¹⁰

Frailty in men versus women: Women tend to have poorer health status (i.e., they are frailer) but longer life expectancy (i.e., they are more resilient). Women tend to utilize healthcare more often and sooner have a longer life expectancy and are more socially vulnerable due to widowhood. While men have more risk-taking behaviors including smoking and alcohol consumption. Men also tend to have more lethal conditions: CVA, ischemic heart disease.¹¹

Management of frailty should include reversing (or slowing progression of) the features that characterize physical frailty: weakness (sarcopenia), slowness of gait, unintentional weight loss, fatigue, and low physical activity levels. Identifying and optimizing the management of comorbidities and their associated medications. Identifying and addressing other losses of intrinsic capacity (such as vision and hearing impairment, or low mood and affective problems) that contribute to the severity of frailty. Assessing an individual's priorities and psychosocial resources, which can affect social functioning and quality of life. Promoting the achievement of generic older adult physical activity recommendations coupled with targeted additions such as reducing sedentary behavior and improving strength and balance to prevent falls seems a reasonable approach, at least in people with pre-frailty.⁴ Consider the risks versus benefits of pharmacological and other treatments as they relate to each individual with frailty especially adequate protein intake of 30g/day for sarcopenia¹² and BP assessment as frail older adults tend to have lower BP which can be detrimental and lead to falls.¹³

Reversing mild frailty or preventing progression to worsening frailty may benefit individuals and lower health/social care costs. Health promotion behaviors to reverse mild frailty include the following:

- Mobility exercises, such as walking
- Specific exercises previously recommended by health-care professionals
- Avoiding long sedentary periods and for more robust participants, moderately intense exercise (e.g. dancing)
- Following a healthy diet (described by most participants as a variety of meat, fish, fruit, and vegetables), having a good meal at least once a day, avoiding weight gain and keeping energy up
- Follow lifetime habits rather than adjusting their diet to later life needs
- Social activities [e.g., meeting friends, shopping, attending social groups and using Skype™ (Microsoft Corporation, Redmond, WA, USA)]

- Employing strategies that improved memory, such as reading, crosswords, games, and watching quiz programs
- Developing ways to deal with low mood, including taking a philosophical attitude, waiting for it to pass, getting on with activities, talking to others, watching comedy
- Creating social or occupational behaviors, such as shopping and volunteering¹⁴

Strategies for successful reversal of mild frailty include service aimed at addressing a broad range of domains (socializing and mobility) at a low level, delivered over a sustained period through mechanisms such as providing information and psychological support. Older adults prefer a single non-specialist worker with effective communication skills to deliver the service, rather than a particular health-care professional after discharge from skilled services with a focus on independence.¹⁵

Successful implementation of frailty into clinical practice should include the following: taking care of age-related and frail older adults, to prevent rapid disability in our aging population; anticipate frailty to promote more efficient care; diagnose some age-related disease at an early stage (macular degeneration, glaucoma, hearing impairment, mild cognitive impairment, sarcopenia, or loss of mobility) and use specific tools to do the most accurate diagnosis of potential age related diseases. Assessment must include social, health, economic and psychosocial assessment, as well as the evaluation of the deficit accumulation.¹⁶ The role of PTs in achieving the Triple Aim for the frail older adult population is important to the future of healthcare: improving population health, optimizing the patient experience and reducing costs. Use of rehabilitative approaches to care for the frail older adult population has strong potential to improve functional status and quality of life, while concurrently reducing rates of disability, rehospitalization, institutionalization, and healthcare costs.¹⁷ Barriers to assessing frailty in home health include insufficient training, documentation burden, limited reimbursement, and high caseload.¹⁸

Home health intervention should include home-based exercise with a PT and nutrition interventions with a dietician and can help pre-frail or frail older adults to improve their frailty score and physical performance.¹⁹ Frailty advice on health behavior improvement has been found to improve physical functioning and modifying the home environment to facilitate health behavior change was found to improve both the physical functioning and health behavior of older people with frailty.²⁰

Home health physical therapists should also consider that chronic pain is independently associated with social frailty in community-dwelling older adults and simple assessments of chronic pain and subsequent pain management interventions might be beneficial for older people with social frailty.²¹ For community-dwelling older adults with frailty, chronic pain can negatively influence sensory, emotional and cognitive aspects of pain, leading to a decline in ADL and lower physical activity. A full pain assessment focused on sensory and emotional aspects of pain is important to identify frailty among older adults.²²

The needs of frail older adults receiving home health include receiving quality of care from experienced educated nurses/clinicians, information sharing, and continuity of care. Patient autonomy that allows for patient decision-making and self-sufficiency is also important. Frail older adults value relationships with professionals that care for them (someone they can talk to). The implications for practice therefore include that home health care is inherently highly specific to each individual cared for with the highest possible quality

of care that is safe, effective, timely, efficient and person-centered.²³ Home health physical therapists are in a unique position to reverse frailty that leads to social isolation by improving functional mobility so that older adults can return to the community.⁶

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Research Committee for the Home Health Section of the APTA 2012-2016 and 2024-present
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From Clinician to Contract Therapy Owner: The Back-Office Reality Nobody Prepares You For

Andrew Cisneros, PT, DPT, MS

Introduction

When most physical therapists (PT), occupational therapists (OT), and speech-language pathologists (SLP) consider moving into the home health space as independent contractors, they envision clinical freedom—meaningful one-on-one time with patients in their homes, flexible scheduling, and the financial upside of 1099 work. What they rarely envision is the labyrinthine world of running the business behind those visits.

I am a physical therapist who transitioned from traditional clinical settings into home health contracting. Over the course of building my contract therapy company—deploying PT, OT, and SLP contractors to home health agencies across the region—I discovered that the clinical training we receive prepares us extraordinarily well for the patient care side of this work, and almost not at all for the business side. The resources simply do not exist at the scale they should, and those already thriving in space are not always eager to share what they know.

This article is written for every therapist who has considered—or is currently navigating—the world of home health therapy contracting. My goal is to illuminate the challenges that rarely get discussed so that others do not have to learn everything the hard way, as I did.

The Knowledge Gap Is Real

One of the most striking realities of entering the home health therapy contracting space is how little formal guidance exists. Doctor

of Physical Therapy (DPT) and Master of Occupational Therapy (MOT) programs prepare us to evaluate, treat, and document—but how can a contract therapy owner navigate per-visit rate with an agency, structure an independent contractor agreement, manage payroll for a team of 1099 therapists, or reconcile billing discrepancies at the end of a payment cycle? In traditional healthcare settings, these concerns are handled by administrators, billing specialists, and HR departments. When you become the business owner, they all land on your desk.

I searched for mentors, communities, continuing ed — anything that would give me a real framework. What I found was noise: fragmented resources or guru programs promising six figures in 30 days. The broader physical therapy profession has made significant strides in entrepreneurship education, particularly for cash-based and outpatient practice models. But the contract therapy model, where a small company deploys therapists to multiple agencies under negotiated contracts, exists in a largely undiscussed corner of the industry.

Compounding this is a competitive culture of silence. Colleagues who have successfully navigated this space are often protective of their knowledge. The relationships they have built with agencies, the rates they have negotiated, and the operational systems they have developed are viewed as proprietary advantages rather than shared professional knowledge. This is understandable from a business perspective, but it leaves newcomers without the guidance they need and slows the overall maturation of the field.

Business Negotiation: The Skill PT School Does Not Teach

The foundation of a contract therapy business is the agreement between your company and the home health agencies you serve. These negotiations determine your per-visit rate, payment terms, scope of services, liability distribution, and often your company's survival. I entered my first-rate negotiation without any benchmarks. What is a fair per-visit rate for a PT evaluation versus a follow-up visit? What should that rate be in an urban market versus a rural one? What contractual terms protect my company if an agency delays payment by 60 or 90 days—which happens more often than anyone openly acknowledges? How do I negotiate from a position of strength when I am a new company with no track record? And if pay were delayed, when would I have a lawyer involved?

The answers to these questions exist in the collective experience of other contract therapy business owners, but accessing that knowledge is difficult. Unlike outpatient private practice, where organizations like the Private Practice Section of APTA provide networking, benchmarking data, and peer support, contract therapy business owners tend to operate in silos. Competition between companies serving the same regional agencies creates reluctance to share information, even among peers who might benefit from mutual transparency.

What I eventually learned—through trial, error, and occasional costly mistakes—is that contract negotiation in this space requires treating the relationship with each agency as a genuine partnership, not just a transaction. Agencies vary widely in their operational sophistication, payment reliability, and communication culture. Learning to assess these factors before signing a contract and building contingency clauses into agreements to address payment delays and scope changes are skills that took years to develop.

Contract therapy businesses largely build their legal and operational infrastructure from scratch — there are no standardized templates, no industry-wide rate benchmarks, and no formal mentorship pathways for emerging owners. This is a meaningful gap the profession could fill. Model agreements, rate benchmarking data, and structured mentorship programs would give new contract therapy owners the foundation they currently have to piece together on their own. A business attorney can help with contract drafting, but that expertise comes at a high cost that most early-stage owners aren't prepared for.

The Billing Reconciliation Problem

Perhaps no challenge consumed more of my time in the early years of my business than billing reconciliation. In a contract therapy model, the billing relationship is layered: the home health agency bills Medicare or the payer, receives reimbursement, and then pays my company for the visits our therapists completed. This creates a reconciliation challenge that most clinicians are entirely unprepared for.

The core problem is documentation tracking. At the end of each payment cycle, I must verify that every visit our therapists completed has been accurately captured, correctly billed by the agency, and properly paid to my company. In practice, this requires cross-referencing visit logs from my therapists, visit records held by the agency, and payment remittances—often across multiple agencies, each using different electronic health record systems and different payment schedules.

Discrepancies are common. A visit logged by a therapist may appear missing from an agency's records due to a documentation submission issue. A visit may have been billed under the incorrect code. Payment may have been held pending additional clinical

documentation. Each discrepancy requires follow-up communication, documentation review, and sometimes resubmission of clinical notes—all while the next payment cycle is already generating new visits to track.

For small contract therapy companies operating without dedicated billing staff, this administrative burden can consume hours each week. When multiplied across multiple agencies and multiple therapists, the potential for revenue loss due to missed or underpaid visits is substantial. Research on administrative burden in home health has documented that billing and documentation requirements represent a significant portion of non-clinical time for home health providers, with some analyses suggesting that home health agencies may spend upward of one-quarter of operational costs on administrative functions.¹

Managing 1099 Contractors: Compliance and Payroll Complexity

The decision to structure your therapy workforce as independent contractors rather than employees carries significant implications for both your company and the therapists you work with. While 1099 contractor arrangements offer flexibility and lower overhead compared to W-2 employment, they also come with compliance requirements and administrative complexity that are easy to underestimate.

The Internal Revenue Service (IRS) and the Department of Labor apply behavioral, financial, and relationship tests to determine whether a worker is truly an independent contractor or should be classified as an employee.² Maintaining contractor status requires careful attention to the degree of control your company exercises over how, when, and where therapists complete their work. For home health therapy contracting, where clinical autonomy is already central to the work, this distinction is often manageable—but it is not automatic. Contracts, onboarding materials, and day-to-day operational practices must all be structured with contractor compliance in mind.

Beyond compliance, the practical management of contractor payroll presents its own challenges. Unlike W-2 payroll processed through standard payroll systems with automatic tax withholding and reporting, 1099 payroll requires tracking payments across multiple therapists, ensuring IRS Form 1099-NEC filings are accurate and timely, and managing payment schedules that may not align neatly with the payment cycles of agency partners.

When cash flow is constrained—as it frequently is when agencies are slow to pay—managing contractor payroll becomes a genuine financial balancing act. Therapists expect to be paid for completed visits on a predictable schedule. Agency payment delays of 30, 60, or even 90 days can create a cash flow gap that small businesses struggle to bridge without established lines of credit or significant operating reserves. Early on, I learned that late-paying agencies rarely change. If an agency develops a pattern of late payment, that is a meaningful red flag — and the wisest move is to exit the partnership as quickly as possible while ensuring continuity of care for patients.

Visit Verification: The Foundation of Everything

Underlying the billing, payroll, and compliance challenges described above is a more fundamental problem: visit verification. To bill correctly, pay contractors accurately, reconcile accounts, and maintain compliance, a contract therapy company must have a reliable, accurate record of every visit completed by every therapist in its network.

This is harder than it sounds. Home health therapists work across geographically dispersed locations, often without consistent

internet connectivity. Visit documentation may be submitted through agency-specific Electronic Health Record (EHR) systems that the contracting company does not have direct access to. Therapists may document visits in the agency’s system but fail to submit parallel records to the contracting company’s tracking system. GPS verification of home visit locations—increasingly required by payers and agencies as a fraud prevention measure—adds another layer of technology and process management.

For companies relying on spreadsheets or informal communication to track visits, the risk of revenue loss and compliance gaps is significant. I spent the better part of two years managing visit verification through a combination of manual logs, shared spreadsheets, and email follow-up before acknowledging that this approach was not scalable and was leaving money on the table with each billing cycle.

Building Technology to Solve What No One Else Had Solved

The cumulative weight of these challenges—billing reconciliation, contractor payroll, visit verification, and general business administration—led me to a conclusion that I suspect many contract therapy business owners eventually reach: the tools available in the market are not built for us. Large home health agencies have enterprise billing systems and specialized EHR platforms. Outpatient private practices have practice management software designed for their model. But the contract therapy company—a small business deploying therapists to agencies under negotiated contracts—sits in a gap between these markets, underserved by existing technology.

I built HomeHealthSync (homehealthsync.com) to address this gap directly. The platform is designed specifically for home health therapy contract businesses and integrates visit submission and tracking, contractor payroll management, invoice generation for agency partners, and administrative reconciliation in one system. It is the tool I needed when I was building my business and could not find. The process of building it required learning software development alongside physical therapy—another domain where no formal pathway existed and where figuring things out independently was simply the reality. But the experience deepened my conviction that the contract therapy segment of the home health industry deserves dedicated resources, technology, and professional community support.

A Call for Greater Transparency and Support

The home health therapy contracting model creates meaningful access to skilled therapy services for patients who need them most—individuals who cannot travel to outpatient clinics and who depend on therapists coming to them. The value of this care is well-documented. Home health physical therapy has been associated with improved functional outcomes, reduced hospital readmissions, and greater patient satisfaction compared to alternative post-acute care settings.^{3,4}

The business owners who build and manage contract therapy companies make this access possible. They negotiate with agencies, manage compliance, handle payroll, and absorb the administrative burden that allows therapists to focus on clinical care. And they largely do this without a roadmap, without peer networks designed for their specific situation, and without the benchmarking data that would help them make better decisions.

The profession has an opportunity to change this. Greater transparency around rate benchmarking, model contract frameworks, and operational best practices for contract therapy businesses would lower the barriers to entry and reduce the costly trial-and-error that currently defines the learning curve. Peer networks and mentorship programs

specifically designed for contract therapy business owners would create the knowledge-sharing infrastructure that currently does not exist. The patients served by home health therapy deserve a strong, sustainable network of providers. Building that network requires supporting not just the clinical workforce, but the business owners who make the clinical work possible.

Conclusion

Running a home health therapy contract business requires mastering a set of skills that clinical training does not provide and that the profession has not yet fully supported. Business negotiation, billing reconciliation, contractor payroll management, and visit verification are not peripheral concerns—they are the operational core of a contract therapy company, and getting them wrong has direct consequences for therapists, agencies, and patients.

My hope in writing this article is to begin a conversation that is long overdue: a frank, transparent discussion of what it takes to build and sustain a contract therapy business in home health. I had to learn these lessons largely on my own, in an environment where resources were scarce and competitors were not eager to share what they knew. The next generation of contract therapy business owners should not have to start from the same place. The challenges are real. The resources to address them are insufficient. And the therapists and business owners doing this work deserve better from a profession that prides itself on evidence, education, and community.📍

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OASIS Tip Corner: M1850 Transferring

Brittany Czerw, PT, DPT
Penn Medicine at Home

M1850	Transferring: Current ability to move safely from bed to chair, or ability to turn and position self in bed if patient is bedfast.	
	0	Able to independently transfer.
	1	Able to transfer with minimal human assistance or with use of an assistive device.
	2	Able to bear weight and pivot during the transfer process but unable to transfer self.
	3	Unable to transfer self and is unable to bear weight or pivot when transferred by another person.
	4	Bedfast, unable to transfer but is able to turn and position self in bed.
	5	Bedfast, unable to transfer and is unable to turn and position self.

Did you know, the item intent is to determine a patient's level of assistance required to safely transfer? The preferred method for scoring M1850 is through direct observation of the patient's performance. The assessment should reflect the patient's ability to perform transfers safely under current conditions the day of the assessment (the 24 hours immediately preceding the visit and the time spent in the home). We can only score based upon the equipment that is available inside the home.

Tip: Score M1850 after you have assessed the patient's ability to move from the bed to a chair. If no chair is available or a patient does not routinely transfer into a chair, assess their ability to transfer from a supine position to the edge of the bed, stand or pivot to a chair that is applicable to their environment such as a bedside commode, toilet or a bench and their ability to return back into bed.

Are you surprised to learn that if a patient does not currently sleep in bed due to medical restrictions such as weight bearing or does not negotiate stairs to their bed, then you should still score based upon the patient's ability to transfer from a supine position to sitting at the edge of the current sleeping surface and their ability to stand and transfer to and from a chair?

Tip: As a rule of thumb, you must consider the patient's need for an assistive device and assistance of another person. If the patient can complete the transfer safely with an assistive device (such as a walker, cane, or sliding board), they would be considered to be a **Response 1**.

If the patient requires the use of an assistive device and minimal human assistance to safely transfer (helper is contributing less than 25% of the total effort which may include any combination of verbal cueing, environmental set-up, and/or actual hands-on assist), they

would be a **Response 2**. An example of **Response 2** would be appropriate for a patient who can safely transfer with the use of their walker and contact guard assistance.

If the patient is “bedfast” (see definition below), they would automatically be scored either a **Response 4** if able to turn and reposition themselves independently (no need for set-up, cueing or supervision) in bed or a **Response 5** if unable to turn or perform position changes while in bed without human assistance.

Were you aware, if the patient requires a **Hoyer lift** to transfer into a chair they are not considered to be bedfast? They would be scored as **Response 3**, unable to transfer self and bear weight or pivot when transferred by another person.

Tip: If a patient has weight bearing restrictions such as toe-touch, is non-weightbearing, or has an impairment that impedes their ability to bear weight (pain, weakness, etc.) and cannot transfer into a chair safely with an assistive device, they would be scored as **Response 3** due to being unable to bear weight when transferred by another person. The patient must be able to maintain weight bearing status during the transfer and safely stand and pivot to a chair. Interestingly, a patient can be scored a **Response 2** if they have weight-bearing restriction of their *upper extremities* and are able to transfer out of bed to another chair using a sliding board and with minimal human assistance safely.

Did you realize, a patient is considered to be “bedfast” if it is contraindicated to be out of bed either per physician orders or they are unable to tolerate being out of bed?

Tip: Clinicians should use their clinical judgement when determining if a patient is truly bedfast. For instance, if a patient can

tolerate being up in a chair for five minutes, then they are not bedfast. Alternatively, if a patient becomes severely hypotensive when transferred to the edge of the bed and the clinician determines it is not safe to transfer into a chair, then the patient can be scored a **Response 4 or 5** (see definitions above).

Do you routinely assess the patient’s gait impairment when scoring the transfer from the bed to their preferred sitting surface? If the patient’s bed is in their bedroom and their preferred sitting surface is down the hallway in the living room, their level of assistance for safe ambulation should be considered when determining the appropriate response.

Tip: These considerations should shed light on how to score the patient appropriately under various circumstances such as use of a transfer device, weight-bearing restrictions and sleeping in a recliner. The key is to score the patient based upon the equipment that is available currently in the home and the amount of assistance required to perform the transfer safely. If ability varies over time, score based on the patient’s ability >50% of the time during the preceding 24 hours and time of assessment.📌

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Have you checked out the APTA Home Health podcast, Home on the Go?

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Can ChatGPT be a Co-PT?

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ABSTRACT:

This article introduces ChatGPT as a new associate in Physical Therapy (PT). We examined how ChatGPT can assist in patient education, clinical decision-making, outcome measure administration, and treatment planning. The benefits of incorporating AI tools, such as ChatGPT, include enhanced accuracy, improved patient engagement, increased access to evidence-based practice, and potential for personalized interventions. It also discusses the limitations and challenges of adding this new technology to the PT practice. Ultimately, this paper argues that careful consideration of the benefits and limitations, along with the development of appropriate measures, is essential for successfully integrating ChatGPT into Physical Therapy practice and improving patient outcomes.

Artificial Intelligence (AI) tools such as ChatGPT in healthcare have demonstrated good potential for transforming PT clinical practice. ChatGPT offers promising applications in patient education, clinical decision-making, outcome measures, and treatment planning. This paper discusses the revolutionizing potential of ChatGPT in PT practices to improve patient outcomes and clinical planning, while highlighting the need for secure and ethical implementation.

Keywords: ChatGPT, Physical Therapy, Prompts, AI.

INTRODUCTION

Tools like Chat Generative Pretrained Transformer (ChatGPT) and AI have been gaining popularity in our day to day lives. In a field like Physical Therapy, which is very dynamic and deals directly with patient care, it is of utmost importance to embrace new technologies and apply them to the betterment of this profession.

AI technologies are rapidly evolving, and their applications have

benefited various sectors, including healthcare. In PT, where patient care is patient-centered and reliant on evidence-based practices, ChatGPT has the potential to improve patient outcomes and revolutionize clinical workflows. This paper discusses the applications, benefits, and challenges of integrating ChatGPT into PT practice and provides a comprehensive overview of its potential to advance the field.

Applications of ChatGPT in Physical Therapy:

1. Patient Education:

ChatGPT is an excellent source and tool for patient education. Studies assessing ChatGPT responses to common patient questions related to total ankle arthroplasty and Boxer's fracture have proven to be highly effective. This shows that the responses are accurate, accessible, and tailored to patient needs.^{1,2} By providing reliable information, the ChatGPT empowers patients to actively participate in their care, fostering better results.

2. Clinical Decision making:

ChatGPT serves as a valuable tool for PTs in decision-making by providing access to a vast repository of data from the literature, clinical guidelines, and evidence-based practices. This capability is particularly beneficial in complex cases where the synthesis of large volumes of information can be challenging. It helps clinicians make smarter and more informed choices, thereby enhancing patient outcomes.³

3. Outcome measure:

The use of patient-related outcome measures (PROM) is an integral part of PT practice as it enables a patient to assess

treatment efficiency and tailor interventions. Chat GPT assists in the accurate application and implementation of PROMs for optimal diagnosis and treatment.⁴

4. Formulating treatment plan:

With appropriate prompts from the Physical Therapist, ChatGPT can assist in formulating improved clinical decisions, leading to a superior therapy plan. By analyzing clinical data and synthesizing research findings, it offers recommendations that align with best practices, thereby improving the quality of care.⁵

Benefits of ChatGPT in PT

1. Accuracy:

ChatGPT can help reduce human error and provide more unbiased assessments, enhancing the precision of PT management planning.⁶

2. Enhanced patient engagement:

Tools such as ChatGPT are easily accessible, which can lead to improvement in patient knowledge and engagement, leading to better adherence to treatment plans and improved patient outcomes.⁷

3. Promotion of evidence-based practice:

With the vast amount of latest research and data available at our fingertips, ChatGPT can promote gold standards for PT practices.⁸

Challenges:

1. Ethics and Security:

One of the biggest challenges in using ChatGPT is the security of protected health information (PHI) under the Health Insurance Portability and Accountability Act (HIPAA). Ensuring the confidentiality and integrity of patient data is paramount because breaches can compromise patient privacy and trust.⁹

2. Confirmation bias:

Due to the vast amount of data available, there can be considerable confirmation bias, with clinicians selectively interpreting information that aligns with their preconceptions. This could result in suboptimal clinical decisions and hinder the delivery of effective care.¹⁰

DISCUSSION:

The integration of ChatGPT into PT practices offers numerous opportunities to improve clinical efficiency and patient care. Its application in patient education, clinical decision-making, outcome measures, and treatment planning demonstrates its potential to support evidence-based practice and improve outcomes. However, it is important to address the challenges associated with confirmation bias and data security for ethical and effective use.

Future research should focus on developing a robust framework for implementing ChatGPT in PT. Additionally, training programs focusing on AI literacy should be implemented to help clinicians become better equipped with this technology ethically and effectively.

CONCLUSION:

ChatGPT is a glimpse of an AI-driven world. It has great potential

to revolutionize Physical Therapy. It has the potential to improve clinical decision making, patient education, and outcome measures. While there are limitations, such as security and confirmation biases, the benefits of ChatGPT in PT are significant. As the healthcare landscape continues to evolve, it is essential to keep up with upcoming innovative solutions, such as ChatGPT, to improve patient care and outcomes.¹¹

Disclaimer: Usage of ChatGPT and AI tools in clinical practice should always abide by individual employer rules and institutional policies. Clinicians are responsible for maintaining professional standards and ensuring the security of patient data in accordance with local and federal regulations.

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Front-Loaded or Distributed? Supervision Timing in Smartphone-Guided, FES-Integrated Home Stroke Rehabilitation

Rudri Purohit, PT, and Tanvi Bhatt, PT, PhD

Clinicians managing chronic stroke in the home setting confront a persistent dosing problem. The literature supports a dose-response relationship in stroke rehabilitation,¹ and American Heart Association/American Stroke Association (AHA/ASA) guidelines call for intensive, repetitive, task-specific practice,² yet most patients fall well short of those volumes once outpatient services end.³ Functional electrical stimulation (FES) is a well-established neuromodulatory adjunct for motor relearning,^{4,5} and smartphone-based platforms now enable structured, FES-integrated programs to be delivered in the home.^{6,7} Because these programs are smartphone-guided, their success also depends in part on the patient's comfort with the technology (their digital literacy), which varies widely across stroke survivors and can influence how much independent home practice is feasible.⁸ At present, these programs are typically delivered in one of two ways, either with hands-on therapist supervision concentrated early in the episode (followed by independent home practice) or with intermittent supervision spread across the episode through periodic home visits or telerehabilitation. What remains unclear is how best to schedule that therapist contact, meaning its concentration and timing across the program, to optimize functional outcomes while balancing resource efficiency.

This question maps onto the motor-learning contrast between massed and distributed practice and feedback.⁹ Concentrating supervision early may support rapid initial skill acquisition, whereas spacing supervision across the episode aligns with evidence favoring distributed feedback for long-term skill retention¹⁰ and with self-determination theory, which emphasizes autonomy, competence, and relatedness.¹¹ In a recent study published in the *Journal of Physical Therapy Science*,¹² we compared two scheduling models, front-loaded supervision (concentrated early in the program) and distributed supervision (evenly spaced throughout), within a single, smartphone-guided, FES-integrated protocol. We summarized the key findings and clinical relevance here.

Study Design and Intervention

We studied 31 adults with chronic hemiparetic stroke (onset greater than 6 months) recruited across two sites (Chicago, USA; Santiago, Chile). All participants completed an identical 6-week, 18-session program consisting of three 1-hour sessions per week. The program was structured around dynamic balance, functional strength, gait, and stretching, with FES applied to four paretic lower-extremity

muscles involved in gait and postural control: the quadriceps, gluteus medius, tibialis anterior, and triceps surae. Rather than being activated simultaneously, these muscles were stimulated in task-specific sequences, timed to each exercise using the app's sequential and sensor-triggered algorithms, at frequencies of 25 to 45 pulses per second. Sessions were delivered through the TRAINFES ADVANCED® app (Biomedical Devices SpA, Santiago, Chile), which provided video instruction, automated reminders, and an in-app safety and form checklist with a lockout feature. Progression was governed by the rate of perceived exertion (RPE), advancing when RPE was 13/20 or lower for two consecutive sessions and holding or regressing at 16/20 or higher, or when the in-app form check was not passed.

The Front-Loaded Supervision Group (FSG; n=12) received supervised onboarding three times weekly for two weeks, then four weeks of independent home training. The Distributed Supervision Group (DSG; n=19) received one supervised and two independent sessions weekly across all six weeks. Total session count and total therapist contact were held constant between aims; only the temporal distribution of supervision differed.

Aim 1 was a prospective single-group feasibility study of the DSG. Aim 2 was a retrospective cohort comparison against our previously published FSG.¹³ The cohorts were assembled at different sites and timeframes and were not randomized, so the between-group analyses are exploratory and hypothesis-generating. Feasibility was the primary outcome for Aim 1, defined a priori as safety (the absence of adverse events) and adherence (the percentage of prescribed sessions completed). Functional performance was assessed before and after training with five measures: the Timed Up and Go (TUG), Berg Balance Scale (BBS), Mini-BESTest, Ten-Meter Walk Test (10MWT), and 30-Second Chair Stand Test (30STS). For the Aim 2 between-group contrasts, we also computed post-hoc achieved power for each outcome, so that each comparison could be weighted by the strength of its evidence rather than read as a simple significant-or-not result.

Results

Feasibility, our primary outcome for Aim 1, was established in both groups on its two pre-specified indices, safety and adherence. All 31 participants completed the program and post-assessment with no adverse events. Adherence was high in both arms (DSG 90.3 ± 10.2%; FSG 87.3 ± 8.7%), well above the sub-70% rates frequently reported for conventional post-stroke home programs.^{14,15} Session duration,

post-session RPE, and mean delivered FES intensity (FSG 38.4 ± 9.7 mA; DSG 40.1 ± 11.2 mA) were comparable between groups. Both groups also showed statistically significant within-group improvements on all five functional measures (TUG, BBS, Mini-BESTest, 10MWT, and 30STS), each exceeding the minimal clinically important difference (MCID) in both supervision models.

Contrasts for the BBS, Mini-BESTest, and 10MWT were non-significant, with low achieved power across all three (0.05 to 0.21). Given that power, these are reported as inconclusive rather than as evidence of equivalent response between the two models.

Limitations and Future Directions

Our results should be interpreted in light of several constraints of this study. The Aim 2 comparison is non-randomized and retrospective, and the cohorts differ by country, healthcare-system context, post-discharge access, and recruitment timeframe. The DSG was also younger on average (by 11.7 years) and differed in stroke etiology and lesion laterality. We cannot separate these factors from the supervision schedule, so we do not attribute the between-group differences, including the larger 30STS gain, to supervision timing alone. Granular within-session fidelity metrics were not exportable from the platform version available during data collection, and we did not conduct long-term follow-up. We therefore regard the between-group results as preliminary and hypothesis-generating, intended to motivate a randomized, adequately powered trial in the near future. Clinical PTs could make evidence-informed decisions about tailoring supervision strategies based on individual recovery profiles, resource availability, and adherence risks. Future PT researchers could examine the differential effects of supervision models on long-term retention outcomes, underlying neuroplastic mechanisms, cost-efficiency, and scalability on patient-centered programs.

Summary

In our cohort, a smartphone-guided, FES-integrated home program was feasible, safe, and highly adhered to in people with chronic stroke, producing clinically meaningful functional gains under both supervision schedules. The preliminary observation that distributed supervision may yield larger strength and mobility gains at equal total dose leads us to regard supervision timing as a modifiable variable worth testing prospectively, and one with direct relevance to how we structure home-based rehabilitation for people in chronic stages of stroke recovery.

Clinical Implications for Physical Therapists

The central implication is that the temporal distribution of supervision is something the clinician can control, independent of total visit count. When home health services are authorized, visits commonly default to early and clustered. These data raise the possibility that, for a chronic-stroke patient targeting lower-extremity strength and transfer goals specifically, distributing the same visits across the episode may outperform front-loading. Lower-extremity strength and transfer performance were the two domains in which the between-group difference appeared, on the 30STS and the TUG, whereas the balance and gait-speed contrasts were inconclusive. The rationale is grounded in motor learning: spaced therapist contact supports distributed feedback, self-regulated problem-solving, and operation near the challenge point,^{16,17} rather than a single concentrated acquisition phase followed by unsupported practice.

Whether to front-load or distribute supervision should be guided by the individual patient and by where they are in their recovery after stroke. A patient new to the program, lower in baseline function, or with lower digital literacy (less comfortable using the smartphone app) may require concentrated early supervision before independent sessions are appropriate. A patient who already grasps the program and needs reinforcement and accountability may benefit more from steady, spaced contact. Time since stroke also matters. Front-loaded supervision may better serve a patient in the subacute phase, when heightened neuroplasticity favors rapid skill acquisition, whereas distributed supervision may better suit a patient in the chronic phase, whose goal is to consolidate and maintain motor patterns.

Integrating FES with an app-guided program carries specific clinical responsibilities. The initial supervised session is where electrode placement, FES amplitude, and home setup are established and where contraindications and skin tolerance are verified. Amplitude is titrated to a visible, comfortable contraction of the target muscle without pain or unwanted joint motion, and progression is gated by perceived exertion rather than a fixed calendar. Establishing this foundation early is what makes intervening in independent sessions safe. For home health, a model that leverages app-guided independent work between fewer in-person visits may extend a limited authorization across a longer, more effective episode, provided the safety framework is set at the outset.

Practical Takeaways for Home Health

Consideration	What the Evidence Suggests
Is it feasible and safe?	A smartphone-guided, FES-integrated home program was feasible and safe in people with chronic stroke, with adherence near 90% and no adverse events.
Does it produce meaningful change?	Both supervision schedules produced significant within-group gains exceeding the MCID across mobility, balance, gait speed, and lower-extremity strength.
Does supervision timing matter?	At equal total dose, distributed supervision showed a stronger between-group difference on the 30STS ($d = 1.57$, power 0.98) and TUG ($d = 0.74$). Contrasts on the BBS, Mini-BESTest, and 10MWT were inconclusive due to low power.
How might I apply this?	Supervision timing is a modifiable scheduling variable, plausibly tailored to stroke chronicity, baseline function, and digital literacy.

Clinical Pearls

- Lower-extremity strength and sit-to-stand performance showed the clearest response to sustained therapist contact. For transfer- or strength-dominant goals, consider weighing supervision across the full episode rather than front-loading it.
- The 30STS and TUG are low-burden, repeatable measures that discriminate between schedules here; they serve well as interval progress markers between visits.
- Adherence appeared to depend more on the platform's video guidance, automated reminders, and safety lockouts than on visit frequency. Leverage the technology to sustain engagement between encounters.
- Titrate FES amplitude at the first supervised session to a visible, comfortable contraction without pain or unwanted joint motion, then re-verify as tolerance shifts.
- Gate progression with RPE: advance when RPE is at or below 13/20 for two consecutive sessions; hold or regress at 16/20 or higher, or when the in-app form check fails.
- The same total number of visits can lead to different results depending on when those visits occur, so plan the timing of supervision deliberately, not just the total amount.
- Match the schedule to the patient. Front-loading helps establish safe, correct technique early for patients who are subacute, new to the program, or lower in digital literacy. Many of these same patients, however, along with those who have cognitive concerns or limited caregiver support at home, may also need ongoing, distributed contact to sustain correct performance and engagement, so a hybrid (concentrated early visits followed by spaced check-ins) may suit them best. Distributed supervision is a reasonable default for the stable chronic patient who benefits from periodic reinforcement.📍

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World PT Day 2026



Celebrating our Global Impact: World PT day

Zeeshan Bhimani, PT, MHS-PT, CFPS

Did you know that World PT Day falls on September 8th every year? This annual global celebration is a powerful opportunity to recognize the profound impact our profession makes on individual lives and public health worldwide. Each year highlights a specific clinical focus, and this year, the global spotlight shines directly on promoting the physical therapist's vital role in cardiovascular and stroke rehabilitation.

For home health clinicians, this theme resonates deeply. The home environment represents the ultimate frontline for long-term recovery, lifestyle modification, and functional independence following a major cardiac event or cerebrovascular accident. In alignment with this global

focus, this issue of the *Quarterly* features a selection of compelling articles highlighting evidence-based home health physical therapy management for stroke and cardiovascular disease.

To access official toolkits, promotional posters, and advocacy materials to celebrate our day and elevate our profession, visit <https://world.physio/wptday>. Let's join clinicians across the globe in showcasing the unique value we bring to patient care. [#WorldPTDaycv](#)



Heart Failure and the Value We Deliver in Home Health Physical Therapy: Translating Evidence into Practice

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Editor's note: This article was adapted from an episode of *Home on the Go* Podcast originally aired April 15, 2026.

Heart failure (HF) remains one of the most complex, costly, and prevalent conditions managed in home health care. In this podcast episode, Chris Chimenti speaks with Dr. Konrad Dias—a cardiovascular and pulmonary clinical specialist with Emeritus status, educator, and co-author of the 2020 APTA Clinical Practice Guideline (CPG) for the physical therapy management of patients with heart failure—about how physical therapists (PTs) and physical therapist assistants (PTAs) can elevate care delivery for this population. Their discussion underscores a critical message: home health rehabilitation professionals are not peripheral contributors in heart failure management—they are central to improving outcomes, reducing readmissions, and delivering measurable value.

The Expanding Impact of Heart Failure

Heart failure prevalence continues to rise at an alarming rate, particularly among older adults, the primary population served in home health.¹ Dr. Dias highlights that the number of individuals living with

HF is expected to increase substantially by 2030 and beyond, placing increasing pressure on healthcare systems. In an effort to showcase the value of physical therapy in heart failure rehabilitation in homecare, Dr. Dias draws attention to four published papers including the 2022 American Heart Association/American College of Cardiology clinical practice guideline², the Physical Therapists HF CPG³, a HF knowledge translation paper⁴, and a recent perspective paper on using the Geriatric 5M model in HF rehabilitation.⁵

In the home health setting, HF is rarely an isolated diagnosis. It frequently coexists with conditions such as diabetes, hypertension, renal disease, and frailty.⁶ This clinical complexity increases the risk of hospital readmission, a key quality metric for agencies and a major burden for patients and caregivers. Importantly, research suggests that hospital readmissions are not solely driven by medical instability but are often linked to the post-discharge environment, functional limitations, and poor self-management.⁷ This distinction is essential. It highlights reason where PTs and PTAs can make the greatest

impact through purposeful interventions that address environmental constraints, medication compliance, mobility, strength, endurance, and patient education within the patient’s home.

Reframing the Role of Physical Therapy in Homecare

Traditionally, physical therapy in HF has been associated with aerobic exercise prescription. While aerobic and resistance training remains foundational, the conversation in this episode pushes beyond that narrow view. The 2020 APTA CPG makes it clear that PTs must take an active role in chronic disease management.³ Specifically, clinicians are expected to educate patients on:

- Daily weight monitoring
- Recognition of worsening symptoms
- Nutritional considerations
- Medication management

This emphasis reflects a paradigm shift. PTs are not simply providers of episodic care; they are facilitators of long-term behavior change. Effective HF management requires patients to understand their condition, recognize early warning signs, and take appropriate action. Without this knowledge, even the most well-designed exercise program will fall short.

The ABCDE Framework: Structuring Clinical Excellence

To operationalize these expectations, Dr. Dias delineates an innovative ABCDE framework—a practical model designed to guide clinical decision-making at every visit. This framework, published in a knowledge translation paper, provides structure while allowing flexibility based on patient presentation.⁴ A few considerations of the ABCDE framework are included below.

A – Assessment of Stability

Assessment goes beyond routine vital signs. While heart rate, blood pressure, oxygen saturation, and respiratory rate are essential, clinicians must also evaluate symptom trends. Changes in sleep position (e.g., needing more pillows), increased shortness of breath, new or worsening edema, and fatigue are critical indicators of instability. Importantly, stability should be assessed both from an absolute and relative perspective. Absolute stability refers to the assessment of the actual value of a hemodynamic parameter at a given point in time, whereas relative stability refers to changes in hemodynamic measurements or symptoms over time, such as from one day to the next or between clinical visits.⁴ This dual perspective helps clinicians identify early signs of decompensation that can be communicated with the interprofessional team in an effort to change medications and offset a potential hospital readmission. Through purposeful assessment of stability and communication with the team, physical therapists show value by potentially reducing unwarranted hospital readmissions.

B – Behavior Modification

Behavior change is often the most challenging component of care. Patients in home health often struggle with dietary restrictions, medication adherence, or activity recommendations. Identifying barriers, whether cognitive, emotional, or environmental, is essential in helping patients change their behavior. Through motivational interviewing and patient-centered communication strategies, physical therapists showcase value, support adherence, and empower patient self-management.

C – Cardiorespiratory Fitness Assessment

Objective outcome measures are critical for establishing baseline function and tracking progress. Tools such as gait speed, the Timed Up and Go (TUG), or functional endurance tests provide valuable data. In the absence of these measures, exercise prescription is less targeted. Through use of validated outcome measures physical therapists can show value by accurately quantifying improvements that guide exercise progression.

D – Dosage of Interventions

Exercise dosing in home health differs from traditional outpatient or cardiac rehabilitation settings. Patients in home health are not always in a state of stability as they may still be recovering from decompensation after recent hospital discharge. Despite being in this tenuous state, Dr. Dias relays the importance of prescribing various exercise interventions including aerobic exercise, strength training, interval training, and inspiratory muscle training for use in home health. Further, Dr. Dias emphasizes the value of the Borg 6–20 scale, which correlates with heart rate in healthy individuals and provides a practical method for gauging intensity—particularly in patients taking beta blockers.

E – Education

Education is not a one-time event but an ongoing process. Reinforcement on every visit ensures retention and promotes independence. Structured checklists available within the knowledge translation paper can help clinicians consistently address key topics without omission.⁴

Understanding Heart Failure Classification

A critical component of effective HF management in home health is understanding disease classification. The American Heart Association (AHA) staging system categorizes HF from Stage A through Stage D²:

- **Stage A:** At risk for HF (Patients with hypertension, obesity, diabetes, cardiotoxic agents, genetic variants for HF with no HF symptomatology).
- **Stage B:** Pre HF – Patients with structural heart disease or functional biomarkers of early HF, without any signs and symptoms of HF.
- **Stage C:** Overt HF – Patients with structural heart disease accompanied by signs and symptoms of HF.
- **Stage D:** Advanced, refractory heart failure with multiple readmissions and exacerbations despite optimal use of guideline directed medical treatment.

Unlike symptom-based classifications, this staging system is progressive and unidirectional. Once a patient reaches Stage C, they do not revert to earlier stages, even if symptoms improve. However, symptom severity can fluctuate. Assessment of symptoms can be objectively quantified using the New York Heart Association (NYHA) classification Class I-IV.³

For home health clinicians, this distinction is important. It reinforces the need for both including both prevention strategies for patients in (Stages A and B) and active management strategies for patients in (Stages C and D). A clear example is a patient being treated in home health following a knee replacement who may also have obesity, diabetes, and hypertension and therefore presents in Stage A HF. This patient will therefore benefit from education to prevent

progression to overt HF in addition to therapy aimed at improving knee function and mobility.

The Geriatric 5Ms: A Holistic Approach

Given the demographics of home health, integrating geriatric principles into HF care is essential. The Geriatric 5Ms framework provides a comprehensive, patient-centered lens in managing older adults with HF.⁵ The 5 M’s involve:

Mind: Cognitive impairments, depression, and delirium can significantly impact adherence and outcomes. Depression is often underdiagnosed and may hinder a patient’s ability to follow medical recommendations.

Mobility: Functional decline is both a cause and consequence of HF. Addressing strength, balance, and endurance is central to improving independence and reducing fall risk.

Medications: Polypharmacy is common. Patients may be managing complex regimens that include beta blockers, ACE inhibitors, diuretics, and other agents. PTs can showcase value by reinforcing adherence and identifying potential medication related issues.

Multicomplexity: Frailty and sarcopenia are prevalent in HF populations.⁶ Targeted strength training can help mitigate these conditions and improve overall function.

Matters Most: Patient-centered care requires understanding individual goals. For many, avoiding hospitalization and maintaining independence are top priorities.

Clinical Application of Evidence: A Case-Based Perspective

The episode culminates with a representative case of a 78-year-old male with Stage C HF, recent hospitalization, and multiple comorbidities. This scenario mirrors the typical home health patient.

Using the ABCDE framework:

- **Assessment** includes monitoring weight trends, symptoms, and physical findings such as lung sounds and edema.
- **Behavior modification** addresses diet, medication adherence, and activity levels.
- **Cardiorespiratory Fitness assessment** encourages use of outcome measures including the 2 minute walk test, 2 minute step test, timed up and go test, gait speed and others to establish a baseline that guides progression.
- **Dosage** relies on RPE and careful observation, especially given medication effects on heart rate for prescription of aerobic and interval training exercise. Further, strength training emerges as a particularly important intervention. The “muscle hypothesis” of HF suggests that peripheral muscle weakness contributes to decreased functional capacity and increased symptom burden. Addressing this impairment can break the cycle of deconditioning and improve overall outcomes.⁸
- **Education** using a checklist of items reinforces self-management strategies at every visit.

Recognizing and Responding to Exacerbation

A follow-up scenario illustrates clinical decision-making: the patient gains three pounds in 48 hours and reports increased fatigue. While weight gain is a key indicator, Dr. Dias emphasizes the importance

of a comprehensive assessment. Additional findings—such as worsening edema, changes in lung sounds, or increased dyspnea—provide a more complete picture of decompensation.⁹

Additionally, effective communication with the healthcare team is critical. Providing detailed, objective data strengthens clinical recommendations and can prevent unnecessary emergency department visits. This level of assessment demonstrates the value of physical therapy and reinforces the clinician’s role as a vital member of the care team.

Elevating Practice Through Skill Development

The discussion also highlights opportunities for professional growth. Skills such as auscultation of heart and lung sounds, once considered outside the traditional PT scope, are increasingly relevant in the home health setting. Incorporating these assessments enhances clinical reasoning and supports more accurate decision-making.

Similarly, using structured communication tools like SBAR (Situation, Background, Assessment, Recommendation) can improve collaboration with physicians and nurses, ensuring timely and appropriate interventions.

Key Takeaways for Home Health Clinicians

Dr. Dias concludes with three actionable strategies to optimize value. These include:

1. **Implement the ABCDE framework consistently** to guide assessment, intervention, and education.
2. **Recognize the full spectrum of heart failure**, including prevention in at-risk patients.
3. **Apply the Geriatric 5Ms** to address the complexity of older adults and align care with patient goals.

Conclusion

Heart failure management in home health is both challenging and deeply rewarding. As this episode illustrates, PTs and PTAs have the tools, knowledge, and clinical positioning to make a profound impact. By integrating evidence-based guidelines, structured frameworks, and patient-centered approaches, clinicians can reduce readmissions, improve functional outcomes, and enhance quality of life.

Ultimately, the value we deliver extends beyond individual interventions. It lies in our ability to synthesize complex information, empower patients, and advocate for optimal care. In doing so, we not only improve outcomes but also redefine the role of physical therapy in the evolving landscape of home health care.💡

Disclaimer: *This article was synthesized by AI using a summary of the Home on the Go podcast transcript and subsequently reviewed and edited by Dr. Dias for accuracy.*

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