



Home Health Section

Home Health Student Affiliations: Options and Opportunities

by Jennifer Walsh, PT, DPT

Clinical internships, or affiliations, are hands-on work experiences designed to help students integrate all the academic knowledge gained into performance concurrent with entry-level Physical Therapist practice. As the level of autonomy in Physical Therapy practice increases, new graduates in all settings must achieve a high standard of professionalism to perform as practitioners of choice and to achieve and maintain the respect of the medical community and the public. Nowhere is this more essential than in the profession of Home Health Physical Therapy.

Home health therapists practice independently in unsupervised environments. In order to effectively meet patient needs, they must understand and incorporate knowledge from other disciplines into their critical thinking processes. As the population continues to age and financial pressures shift patient care out of more costly inpatient centers, home health will continue to expand as an industry. We, as the current practitioners, need to evaluate how to provide qualified practitioners to meet the projected needs.

Traditionally, students were encouraged to get "a few years experience" in an inpatient or outpatient setting after graduation, and then perhaps "do a little home health on the side." In turn, many agencies have not been willing to consider a candidate who has less than 1-3 years work experience in an inpatient setting. Sadly, these images of home health still exist, and continue to be taught to students in schools today.

Employers may be hesitant about hiring new graduates in home health, fearing that the costs of the increased

up-front training and supervised practice time may just be too prohibitive. They may also worry that the new graduate's skill sets are just not broad enough to cover the many often emergent situations that a home health therapist may encounter. Clinical affiliations in home health provide a unique opportunity to provide appropriate students with the advanced critical thinking skills and some of the setting-specific training that is required for independent practice, thus reducing some of the new-hire investment. In addition, once a student has completed a positive affiliation in home care, and subsequently seeks employment as a new graduate, the employer can be more certain that the candidate is committed to the practice, reducing the risk of turnover and cost of rehire.

Another concern with home health clinical affiliations is staff willingness, given the independent nature of the profession. A therapist who might consider being a Clinical Instructor (CI) in a facility with other therapists to consult with may be less inclined to assume this task than in a setting where they practice completely independently. Staff may be concerned about productivity expectations, and the additional stress that may ensue. Creative solutions to these and the many other issues that arise do exist. In this edition of the newsletter, you will read an article written by a CI and by a student-turned-employee. Consider their perspectives as you think about the direction our profession is heading, and our responsibility to train the professionals who will meet the need.

Prior to initiating a student program, the home health agency should do a strengths and opportunities analy-

sis. Knowledge of the resources available will help guide decisions regarding the design or model the affiliation will follow. Staff availability, patient populations treated, geography, specialty programs, hospital resources if applicable, and community contacts are all vital resources to be considered when developing a program.

Learning objectives and instructional methods for a clinical affiliation in the home health setting need not be drastically different than those in traditional clinical settings. Students will learn by observation, guided instruction and practice, dialogue with the CI, journaling, reading materials, and completion of a case study or final project of some sort. Students also learn through teaching; including patient, peer, and community education. Larger agencies conducting research can utilize student input to enhance the learning experience.

For a traditional length affiliation (8-12 weeks), three basic clinical education designs lend themselves well to the home health setting. The Traditional Design pairs one CI to one student for the entire affiliation. That CI is responsible for planning and guiding the student's learning experiences. This is the model described in the companion article in this newsletter. In that article you will find the structure, strengths, and weaknesses of this model thoroughly summarized.

A less common design is the Interdisciplinary-Cooperative Design. This design offers the student two or more CI's, from the same or different disciplines. In this model, the student would spend at least 50% of his or her time with their primary CI (PT) learning to provide care for the general home

health population. The student would then follow his or her primary patients' care with all members of the interdisciplinary team, including nursing, occupational therapy, speech therapy, medical social services, and palliative care/hospice transitional services as appropriate. This affiliation design would be ideally suited for a larger agency with multiple staff on well defined geographic or medically-based teams, where the student would share common patients with the same practitioners from the other disciplines. The primary strength of this model is the strong focus on interdisciplinary education and communication, which is crucial for successful performance in today's home health environment. In addition, a tendency towards management of medically complex and diverse patients would occur as it is these patients who often require multidisciplinary care. One drawback to this model is that the student will practice physical therapy only when directly supervised by the CI. Interdisciplinary exposure is observational. The other disciplines involved can then be solicited for feedback on the student's interpersonal skills and ability to function as a member of the interdisciplinary team. An additional concern is that a large amount of initiative is required on the part of the student and the CI to coordinate the activities and observations. The Interdisciplinary-Cooperative Design also provides the opportunity for students to research, network, and observe available community resources (social service programs, DME's, community education programs, outpatient services, transportation options, etc). This knowledge can be invaluable to the new graduate beginning a career in home health PT.

The Specialty Design for clinical affiliations involves two CI's on different rotations to one student. These rotations could be geographic, medical, or based upon specialty programs available within the agency. An agency based in a city that covers outlying rural areas can provide a student with the full spectrum of experiences in a wide variety of socioeconomic climates. The student may spend half the affiliation with one CI providing care in the inner city, and a second in rural areas. Provision of services varies greatly from the city rural care where the homes may be far from hospitals and other basic necessities, teaching students the skill of using available resources and solving problems spontaneously. A specialty

design affiliation could be structured based on existing medical teams in the agency. For example, students could spend portions of their affiliations with PT's who focus on general medical care vs. orthopedics vs. cardiopulmonary vs. palliative/hospice care. Or the specialty design affiliation could be designed for a student who has an interest in a specific specialty program that is available at that agency. The student could spend half the affiliation learning general home care, and the other half learning cardiopulmonary, telemedicine, orthopedics, neurology, pediatrics, assistive technology and powered mobility, wound care, or whatever specialty programs and staff could provide. The advantages of the specialty design is that the student has the opportunity to gain in-depth knowledge about a patient population or technique of their interest, and that it is a flexible design that could be easily adapted by many sizes and types of home health agencies. One drawback to this design is that coordination is required between the two CI's to keep the student's experience cohesive, although not as much as the previous design.

One final consideration prior to initiating a home health student affiliation is the supplemental learning experiences that the agency may have to offer students. If the student is affiliated with a hospital, perhaps he/she can observe surgery, and follow a patient through the continuum of care. Or perhaps the student could spend a day with the hospital referral network, learning how discharge planning and placement occurs. As the student-CI pair in the matching article did, networking and observational settings can be arranged with organizations that home health therapists refer their patients to. The student could go to local outpatient clinics to learn about the services, or visit a Cardiac, Pulmonary, Vestibular Rehabilitation, or Aquatic Center. Site visits at Durable Medical Equipment companies or Orthotic and Prosthetic clinics can provide the student with valuable knowledge. The student may participate with the CI in community education settings, or could observe a visit with a social worker from the Area Agency on Aging.

A final component of a home health clinical affiliation can be student-to-student mentoring. Whether it is two students simultaneously at the same clinical site, prior students with incoming students, or students at two different sites, student mentoring can help guide

and enhance their clinical experiences. The June 2008 issue of *PT Magazine* presents an article on student-to-student mentoring programs and their benefits. If your agency has or is contemplating a student program, consider adding this component to the design.

Once foreign, student clinical affiliations in the home health setting are increasing in popularity. As the need for home health PT's continues to rise, agencies who seek to attract young, dynamic therapists would do well to consider the benefits of building a student program.

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Opportunities in Home Care for New Professionals and Physical Therapist Students

By Jennifer E. Wilson, PT, MBA

Decisions at Entry-Level

It is atypical for entry-level physical therapists to decide to work for a home care agency upon graduation. The very nature of home care requires PT's to be independent in managing and providing clinical services as well as managing their time, schedules, and community relationships. The level of independence needed on a day-to-day basis in home care requires therapists to be comfortable working alone and to be self-confident in a variety of skills including interpersonal communication, clinical, professionalism, marketing, networking, negotiation, critical thinking and problem-solving. Entry-level PT's may have some of these essential skills deemed at entry-level, close to entry-level, or developing during clinical education experiences. In addition, entry-level PT's may have limited work experience. The nature of home care also requires entry-level physical therapists to take initiative and be comfortable with applying creativity to solve clinical problems throughout the workday. New graduates should be interviewed carefully and receive solid mentoring to work through these issues.

Clinical Experiences in Home Care

Home care requires students to enter into a client's sacred space. Interacting in these environments can push students out of their more 'traditional clinical setting' comfort zones and require them to practice different adaptive clinical management skills. Physical therapist students in home care cannot rely on equipment and machines. Rather, they must figure out how to use the unique and varied resources to which they have access in each living situation. In this way, students gain valuable experience designing appropriate and authentic home exercise programs. Furthermore, clinical experiences in home care give physical therapist students an inside look at risk factors, barriers and social situations that can support or impede clinical outcomes.

Although entering into someone's home can be intimidating, it can lead to developing a profound connection. Despite initial discomfort, students master new ways to build rapport and develop a broader set of interpersonal

communication and professional skills. Additionally, PT students in home care have the chance to develop close mentoring relationships with their clinical instructors.

Physical therapist students in home care also learn how to navigate the health care system differently by experiencing a different point on the health care delivery continuum. This exposure can lead to developing new advocacy and promotional skills and invaluable community networks.

Building Broader Skills in PT Education

Learning experiences can prepare PT students and entry-level PT's for home care. Courses in professional issues, health care, and business management and leadership offer curricular portals to build broad business acumen and applied management skills, including relationship marketing and networking. By developing these skills early, new home care professionals will be more at ease and ready to access community, family and neighborhood resources right away.

Innovative Learning Experiences

Introducing professional issues such as healthcare reimbursement, leadership, and management in PT professional education can further augment the entry-level PT's preparation for practice in home care. For over five years, implementation of a variety of innovative learning experiences has yielded interesting results. Before discussing the application of these results to home care, it is important to highlight several key learning experiences and courses that contribute to building broader skills and increased self-confidence in entry level physical therapists.

Professional Issues Course

In the first professional issues course, physical therapist students design marketing plans that support the development of new services in a variety of settings. Accessing and building value for the consumer as well as developing a financially solvent program are key concepts emphasized in the development of these plans. Once plans are developed, based on student input, physi-

cal therapist students "sell" their programs to mock decision-makers who control the allocation of financial resources. It is noteworthy that these students develop their plans prior to starting their first clinical lab-based course. In completing this assignment, it was interesting to note how well the physical therapist students grasped the concepts of targeting consumers directly and building value from the onset. Additionally, they develop creative 'advertising and promotion' skills and practice how to 'sell' their idea to potential investors.

Health Care and Reimbursement Course

In the second course in the professional series, physical therapist students develop a comprehensive Reimbursement Resource Manual as a class assignment. They include information on Medicare, Managed Care and Medicaid (The 3 M's) and reimbursement in specific physical therapist practice settings including home care, SNFs, and IRFs. Students wrestle with discovering how difficult it is for physical therapists to be paid for providing services! Additionally, they sometimes become discouraged with how reimbursement and documentation vary so dramatically from one practice setting to another. Students are encouraged to take their completed resource manuals to their clinical experiences so they can integrate the concepts researched for the manual into everyday clinical practice.

Leadership Case Study

Physical therapist students complete a distance-learning case study in leadership in physical therapist practice while on clinical experiences. Students complete a literature review investigating the differences between leadership and management characteristics. They are required to interview the formal manager/leader in the department, practice, or home care agency. Physical therapist students gather and analyze real world data collected in order to complete an operations management/outcomes evaluation. Students determine how well the business/department is running and how effective the manager/leader is in managing the day-to-day operations of the business/

department. They assess how effective the identified manager/leader is in the following areas: communicating; evaluating performance of his/her staff; resolving conflict; building a team; marketing/selling; budgeting and forecasting; monitoring quality and reimbursement. Through this learning experience, students acquire knowledge about the differences between management and leadership characteristics, the impact of emotional intelligence on leadership effectiveness and how critical it is for a physical therapist practice to have an effective leader or a manager to ensure effective and successful administration in PT. Interestingly, students reported completing their own leadership self-assessment while completing their literature reviews.

Business of PT Course

For five consecutive years, physical therapist students joined one of several different student management committees (Operations, Marketing, Finance, Continuous Quality Improvement (CQI), Performance Management & Feedback and Business Development) for their entire final semester. Each committee supported the start-up and expansion of providing PT services at on-campus as well as off-campus practice settings. Each committee fulfilled a list of typical and unique tasks based on the committee's function (i.e., Marketing) and the needs of the PT setting and the community. PT students assumed the

role of Committee Chairs. Graduate Assistants were selected and assigned the role of Student Manager of Operations (SMO) for each site each year. Committee members/chairs reported to the SMOs who received continuous mentoring from the faculty course coordinator or management 'coach'. Student Management Teams (SMTs) comprised of Committee Chairs and the SMOs met weekly. The students participated in clinical care, fundraising, and business operations. In addition, students organized special events, such as Patient Appreciation Day, Continuing Education Workshops and a Community Think Tank. Students had opportunity to deal with local television media, and participate in committees. Peer and supervisory performance feedback was provided, and students had hands-on opportunity to learn about conflict resolution in a business setting.

Contemporary Physical Therapist Practice Keeps Changing

Physical Therapist practice continues to change at an accelerated pace. The ever-growing, aging population is determined to stay in their homes and be independent as long as possible. These demographic realities open up opportunities for physical therapists working in home care. Thus, diverse clinical management experiences continue to unfold for home care professionals as they respond to the ever-changing and

growing needs of their home care clients.

Discovering the Opportunities in Home Care

Designing innovative learning experiences for physical therapist students can be instrumental in building skills, such as leadership, teamwork, communication, marketing, finance, and conflict resolution. By implementing non-traditional methods of learning, entry level physical therapists can assume authentic management roles in physical therapy and practice non-clinical skills before they enter practice. These experiences help to develop more confident and creative health care professionals who think differently right when they enter practice.

Physical therapist students and new professionals who desire the chance to apply broader skills and different levels of thinking in a variety of situations are encouraged to consider home care. Home care physical therapists are in the community everyday. These encounters provide critical opportunities for home care professionals to add positively to the consumer and community perceptions of physical therapy and to the future of our profession.

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Clinical Affiliations in Home Health: A Shared Perspective

Introduction by Jennifer Walsh, PT, DPT

Clinical Instructor Perspective by Mary Flannery, PT, MSPT

Student/New Graduate Perspective by Jeanette Brown, PT, MSPT

Introduction

Home health practice has long been viewed as an arena solely for experienced clinicians. Historically, many agencies would not consider hiring a therapist with less than 1-3 years work experience in an inpatient setting. Thanks to the dedication and hard work of those who have promoted the advancement of Home Health Physical Therapy as a profession, and to the creativity of therapists who have a passion for working with students, the profession is now a valid and exciting career choice for the new graduate.

In this article, you will hear the personal perspectives of a CI-Student pair who successfully navigated through a

clinical affiliation, with a very positive outcome.

Clinical Instructor Perspective

Working in home health care can be very rewarding, yet challenging at the same time, even for a seasoned physical therapist. The home health care setting can be overwhelming for a new graduate and might even deter them from seeking employment in this setting. Offering to be a clinical instructor in home health provides an opportunity to alleviate any unfounded fears of a potential new hire. I assumed the clinical instructor role last year in home health and it was very fulfilling. I hope that by

sharing my journey with you that you are encouraged to consider taking students for affiliations.

Attending the APTA Clinical Instructor Credentialing Program helped to prepare me as a clinical instructor (CI). I already had the experiential knowledge required in home health, but appreciated the structure and tools the course offered to help facilitate the best learning environment for my student. This 15-hour course helped me create a student affiliation that was even more successful than I imagined.

A successful clinical affiliation is paramount to the student's professional development. Being a CI offers you the chance to make a difference and

positively impact that person's development. It allows you to give back to the profession that supports you and that you respect and honor. Being a CI is personally and professionally rewarding for me. It was impressive to observe my student, Jeanette Brown, grow considerably in her interpersonal and clinical skills during her home health affiliation.

The home health setting offers some ideal learning situations that can benefit both the student and CI, and improve the learning experience. Some of these benefits are inherent to the setting, and some can be enhanced by the agency's flexibility in working with the pair. My caseload was reduced for the first few weeks of the clinical affiliation. The hectic pace of a routine day was slowed down to acclimate Jeanette to the home care setting. She was able to ask questions and not feel hurried to see the next patient. My employer welcomes student affiliations and, within reason, allows the CI to adjust his/her schedule accordingly to facilitate the best learning environment for the student. The freedom to slowly increase our caseload helped reduce our stress levels and get our relationship off to a good start.

The flexibility of the home care setting offers learning opportunities that are not typically available in traditional clinic or hospital settings. We had the opportunity to analyze gait patterns in the community during our lunch breaks. We were able to visit physical therapy outpatient clinics in our coverage area in order to establish sound relationships between our agency and the outpatient clinics. My student was able to meet the staff, learn about their specialties, and tour the clinics. As a result, we were both better informed to make appropriate referrals for our patients.

Accepting a student affiliation can challenge the home health care therapist professionally. This benefits the CI as it keeps you in touch with the latest advancements in PT practice and education. It is challenging as a working professional to keep up with the large volume of new information that comes to us in journals, news trends, and continuing education courses with new treatment techniques. The student comes to us eager to share her contemporary, evidence-based treatment strategies gained from their academic curriculum. The experienced-based learning of the CI, coupled with the evidence-based preparation of the student, offers an opportunity for exchange that ben-

efits both parties. This results in more efficient and effective care for your patient.

Just as there are benefits to having a student affiliation in home health, there are some potential drawbacks as well. Home health clinicians spend a great deal of time driving from house to house. Traveling in the same vehicle with your student may potentially encroach upon your personal space and time that is often envied by persons in other clinical settings. You may experience a limitation in the privacy to make and take personal phone calls that you might otherwise entertain while in the car. Drive time, however, does afford for valuable clinical discussions between you and your student. The flexibility that is so highly valued by home health clinicians also temporarily diminished while having a student in home health. You may find it more challenging to schedule an impromptu doctor's appointment, stop in for an oil change, or run errands.

Lastly, if you have a difficult student or challenged learner, you may not have a readily available colleague in the next room that can provide immediate guidance for you. Fortunately, the Credentialed Clinical Instructor Program offers strategies to help with challenges that may arise. You can always consult with your Academic Coordinator/Director of Clinical Education (ACCE/DCE) and/or Center Coordinator of Clinical Education (CCCE) for assistance. They are able to offer support if you did encounter such a challenge.

Challenges faced in home health care are opportunities for growth for the CI and student, as well as the host organization. We should take a personal interest in the education of developing therapists following in our footsteps. With the elderly population rising, the demand for home health PT's will soar. Personally, remember that future generations of therapists could be treating us and/or our family members in our homes. Adequate staffing in the home health setting depends upon exposure of students to the benefits of home health PT practice. Perhaps you will consider taking a student for a home health affiliation. It might be as rewarding for you and your organization as it was for me and mine. In fact, my organization hired Jeanette Brown, MSPT just last year!

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The Student - New Graduate's Perspective

From the student perspective, I found my home health affiliation to be a greatly rewarding learning experience. As in any other setting, being a student in home care has both advantages and challenges.

Unlike other affiliations where I had little debriefing time with my Clinical Instructor (CI), I was able to discuss, plan, and critically think with my CI in the car between each visit. This provided me with immediate feedback regarding my patient care in a comfortable environment without the patient present.

Innate to the setting of home care is the consistent, 1-on-1 patient-therapist interaction. This allotted me a more closed learning environment with few distractions. There was no commotion of a busy hospital unit or high-traffic clinic. It was just the patient, the instructor, and myself. This was an ideal learning situation.

A common drawback to a home health affiliation is that there may be only one therapist to observe and learn from. My home care CI, Mary Flannery, addressed this issue by having me shadow other therapists and staff members. Observations allowed me to have days learning additional skill sets and to gain knowledge about the other disciplines involved in home health care (including Occupational Therapy, Medical Social Work, Skilled Nursing, Registered Dietician, and Hospital-to-Home Care Coordinator).

As an added benefit of these observations, Mary was able to address the primary challenge that a CI and student in home care will face: too much time together! Forty hours a week for 6, 8, or even 12 weeks is a very long time for anyone to spend with a co-worker, instructor or student. Calculated breaks for student observations are well appreciated by both the student and the CI.

In home care, the patient caseload is typically smaller (4-6 patients is average in my region) than in other settings. This allows the student to have more opportunity to develop a comprehensive plan of care for individual patients. Due to the inherent flexibility of home care, treatment times could be extended to reach learning objectives.

Although the patient caseload is relatively small compared to other settings, the population in home care is quite diverse. As a student, I gained experience with diagnoses including CVA, joint replacement, spinal cord in-

jury, chronic falls and debility, and much more. The age groups of my clients ranged from the early 20's to over 100. Diversity not only exists among patients, but in the work environment as well. This adds an interesting and challenging component to patient care. As a student learner, home care raises problem solving to the next level. The challenges I faced in patients' homes could not be taught in a classroom, lab, or clinic. Additionally, immersing myself in the living environment and family dynamics of individual patients gave me a firsthand, enhanced view of the patient picture as a whole.

One of the great skills a student develops in home care is the ability to be autonomous. It is essential for a therapist in home care to be independent and disciplined. I learned how to schedule a full caseload and to cope with sudden changes to my meticulously planned schedule. I can hear Mary's voice now, "Home care is all about being flexible." I had to develop my com-



munication skills through necessary phone calls to nurses, therapists, physicians, and other support staff. Additionally, as Mary reduced her level of assistance, I had to develop my ability to plan and treat independently. I was asked to work with patients as if I were the only therapist in the room. I was encouraged to act as if there was no one to provide an extra set of hands or to answer questions. I learned how to be resourceful with what supplies I had or information I could gather.

Mary is an APTA Credentialed Clinical Instructor. This was clearly evident during my clinical affiliation in home care. My learning was structured with homework assignments, such as researching diagnoses and surgical procedures. As mentioned previously, Mary set up observations with other staff members. She also arranged for us to attend both in-house and community-based continuing education courses. We observed gait in public places during our down time and lunch hours. Additionally, Mary facilitated outreach activities

where we toured several of the outpatient clinics that we made referrals to. Mary was able to show me that the role of the PT is greater than just treating patients. I can honestly say that Mary provided me with a fulfilling clinical experience, which prompted me to seek a career in home health immediately following graduation. I was hired as a full-time PT upon graduating in May 2007.

My exposure to home care as a student fostered my desire to work in this setting as a new graduate. Without this positive experience it is unlikely I would have chosen this path. Home care appeals to me because it exemplifies the autonomous practice that Physical Therapists strive for. Through my college and clinical education I have developed the ability to maximize my resources, move towards autonomous practice, and become a practitioner of choice.

Historically, it has been seen as non-traditional for a new graduate to take a job in home care. However, if given the right experience as a student in home care and a nurturing environment as a practicing PT, it can be very rewarding, for both the employer and the new graduate therapist.

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Supervision of Therapist Assistants and Home Health Aide: A New Graduate's Challenge

by *Cheryle Atwater, PT, MPH*

Supervision is a formidable task in any arena, but in the home health environment there are additional challenges posed by numerous regulations and the unique "off-site" delivery of care.

New graduates, and other therapists new to home care, may be surprised to learn their job responsibilities include supervision of therapy assistants and home health aides. To prevent any misunderstandings, these requirements should be discussed during the job interview along with other job expectations. Upon hire, core orientation items should include a review of agency policies for supervision and documentation requirements as well as scope of practice regulations and competency expectations.

I remember my first physical therapy role in a long-term care facility for mentally and developmentally disabled children and adults. I was well prepared for the clinical demands of the job, but unprepared for supervising the six therapy aides on my units.

Medicare acknowledges the role of physical therapist assistants, under the supervision of a licensed therapist, as a covered discipline under the home health benefit. However, Medicare Conditions of Participation (COP) are very broad regarding supervision of the assistant: "Services furnished by a qualified physical therapy assistant or qualified occupational therapy assistant may be furnished under the supervision of a qualified physical or occupational therapist. A physical therapy assistant

or occupational therapy assistant performs services planned, delegated, and supervised by the therapist; assists in preparing clinical notes and progress reports; and participates in educating the patient and family, and in in-service programs."¹

Therapy assistants cannot supervise home health aides nor complete the comprehensive assessment (OASIS), but otherwise the scope of PTA practice and the supervisory requirements by the licensed therapist are undefined. Medicare's broad definition of the role of PTAs is intentional; they defer to the state physical therapy licensing board. In some states, home care regulations may provide more guidance on supervision of home health personnel.

Each practicing therapist should be knowledgeable in their state practice guidelines and state home care regulations, if applicable, relevant to the use of assistants. Some states require joint supervisory visits, and others limit the number of assistants a therapist may supervise. Most practice acts define the length of time or number of visits the assistants can provide until a physical therapist must reevaluate the patient. In a few states, the physical therapy practice act requires direct on-site supervision of the PTA, therefore PTA's cannot be utilized in home health in these locations.

It is not uncommon for home health therapists to be supervised by a non-therapy manager. The PT and PTA should fully understand that administrative supervision may be performed by a non therapy manager; however, patient assignments and clinical supervision can only be performed by a physical therapist. Regardless of the state and practice setting, the therapist is ethically and legally required to provide clinical supervision including delegation of treatments or portions of treatment that are within the scope and skills of the assistant. Patient assignment is fully incumbent on the professional judgment of the supervising therapist.

The APTA's "PTA Licensure Pack" provides valuable information regarding the work and supervision of PTAs. The following position statement, from this resource, applies to assistants in the home care area:

"When supervising the physical therapist assistant in any off site setting, the following requirements must be observed:

1. A physical therapist must be accessible by telecommunications to the physical therapist assistant at all times while the physical therapist assistant is treating patients/clients.

2. There must be regularly scheduled and documented conferences with the physical therapist assistant regarding patients/clients, the frequency of which is determined by the needs of the patient/client and the needs of the physical therapist assistant.

3. In those situations in which a physical therapist assistant is involved in the care of a patient/client, a supervisory visit by the physical therapist will be made:

- a. Upon the physical therapist assistant's request for a reexamination, when a change in treatment plan of care is

needed, prior to any planned discharge, and in response to a change in the patient/client's medical status.

- b. At least once a month, or at a higher frequency when established by the physical therapist, in accordance with the needs of the patient.

- c. A supervisory visit should include:

1. An on-site reexamination of the patient/client.

2. On-site review of the plan of care with appropriate revision or termination.

3. Evaluation of need and recommendation for utilization of outside resources.²

The state regulation of physical therapy practice includes the practice of licensed physical therapist assistants. Home health aides, alternatively called personal care aides, nurse's aides or certified nursing assistants, are clinically supervised by nurses and their practice is usually regulated by the state's board of nursing. Home health aide services are a billable, covered Medicare service; however, aide services require specific orders for treatment, a detailed patient specific care plan and supervision by nursing or rehabilitation services.

Medicare COPs state: "The home health aide provides services that are ordered by the physician in the plan of care and that the aide is permitted to perform under State law" including "the provision of hands-on personal care, performance of simple procedures as an extension of therapy or nursing services, assistance in ambulation or exercises, and assistance in administering medications that are ordinarily self-administered..."¹ At the state level, regulation of aide services provides further definition of the aide scope of practice. While aide services may supplement therapy by assisting patients with exercises or ambulation and transfers, they cannot replace skilled therapy services.

Medicare regulations allow occupational therapists, physical therapists and speech language pathologists to supervise home health aides in therapy only cases. Aide supervision encompasses developing and communicating the aide care plan and an on-site visit to the patient's home, with no less fre-

quency than every two weeks to assess the aide's compliance with the care plan and to determine if the plan should be revised discontinued. There are no rules of "hierarchy" defining which rehabilitation discipline provides the aide supervision when multiple therapy disciplines are provided; however, this should be determined by the agency's policies and the patient's needs. For example, occupational therapists are the most appropriate supervisor of the aide care plan (for therapy only cases) when they are facilitating the patient's independence in activities of daily living.

Home health agencies, upon referencing all applicable regulations, should develop their own policies for supervision of assistants and home health aides. Agencies may choose to implement policies that are more stringent than the prevailing the state, federal, and professional regulations. In such cases, agencies will be held accountable to their own policies. For example, an agency whose policy requires assistant supervision every 14 days is expected to meet this standard although the state practice act requires supervision every 30 days.

While this article focuses on the Medicare regulations for PTA and home health aide supervision and practice, many insurers will not reimburse for therapy visits provided by a PTA. It is therefore incumbent on the agency to be knowledgeable in reimbursement criteria as it applies to both aide and assistant care.

Physical Therapist Assistants and Home Health Aides are valuable providers whose services can greatly enhance the rehabilitation plan of care. Agencies should consult with their state licensure boards regarding appropriate utilization of these providers. Those who utilize these staff can reap many positive patient care and financial benefits.

References

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2. American Physical Therapy Association, PTA Licensure Pack.

Cheryle is a member of the Publication Committee. She has more than 25 years of home health and hospice experience in a multitude of roles including visiting therapist, clinical manager, agency director and consultant. 

A Change in Direction Sparks Career Growth

by Melody Washington, PT, DPT

Upon completion of my Doctor of Physical Therapy Degree from Alabama State University in 2006, I was certain I would pursue a career in an outpatient orthopedic setting. The outpatient setting was my first exposure to the rewarding field of physical therapy. As a volunteer at an outpatient facility, I observed the physical therapist as she interacted with each patient, manually mobilized different joints of the body, and developed various exercise programs and plans of care for each patient. This positive experience is where I became very fascinated with this profession. Oblivious to the other clinical settings a physical therapist works in, I believed I was destined to work in an outpatient setting.

As I matriculated through the physical therapy program, I became aware of the other equally rewarding settings of physical therapy practice. I recall being presented with a case study in my Therapeutic Exercise class where I was to develop a plan of care for someone in the home with no equipment or pain-relieving modalities. This challenging introduction to home health physical therapy was an eye-opener to an alternative practice setting. Later, on a clinical internship, I was allowed to work in a home health setting for pediatrics. As a result of this clinical rotation, I was able to fully experience entering the home and providing care in order to gain an increase in functional mobility and developmental milestones with my patients.

In 2006, I graduated and became employed with a privately owned physical therapist practice. It was an

outpatient setting and I was ecstatic to be living my dream. However, the option of practicing in home health continued to be re-visited at national conferences, in the community and with colleagues. I began to inquire more and decided to begin working for a home health company.

This decision has been one of the best I have made in my career thus far. Being in home health has challenged me to think outside the box, become more creative in developing treatment options in the home and it has allowed me to become a better functional goal writer. Contrary to some common myths, home health physical therapists utilize manual therapy including joint mobilizations, proprioceptive neuromuscular techniques and neuro-development treatment techniques. This setting also provides an interdisciplinary approach to treatment, flexibility in scheduling, one on one treatment time and affords the therapist the opportunity to observe the patient in their natural habitat in order to fully assess any additional equipment the patient needs to function optimally in their home. Nevertheless, home health does have challenges as does any other setting. There can be an abundance of paperwork. Also, as you are treating in the field, you may face environmental challenges and pets. You practice independently, and must be prepared for any situation, because you are without any additional help for transfers or ambulation activities.

Being a young therapist, I have questions and face new situations on a daily basis. Being a member of a great

rehab team affords me the opportunity to seek new information from other therapists. I am also a member of the Home Health Section and Section on Geriatrics with the American Physical Therapy Association. This enables me to receive emails and additional publications that pertain directly to situations occurring in these populations. Moreover, I am able to stay abreast of current information as well as pose any questions or ideas to the group which is very helpful and often necessary.

Home health is often not promoted as strongly and may not be available as a clinical rotation option in many schools. I challenge all educators, physical therapists and physical therapist assistants and especially home health section members to continue to strive for excellence in the profession. This can be done through education and inservices conducted in the community and between professionals. Clinical education coordinators should also be urged to develop contracts with various home health agencies to allow students an opportunity to experience a clinical internship in the home health setting. If we as a profession begin to acknowledge the knowledge, skills and abilities of all therapists regardless of setting, we will be able to see better outcomes in our profession, careers and most importantly our patients.

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