Minimizing the Impact of Social Distancing for the Older Adult

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

• All microphones are muted upon entrance
• Presenters will record questions and comments
• Audience questions and comments will be shared after all the speakers present
• Recording will be available by Monday April 6th
• Thank you:
Social Distancing and Mental Health for the Geriatric Acute Care Patient

Emily Fleischman, PT, DPT, GCS
Stanford Hospital, Palo Alto, CA
Demographics$^{1,2}$

- Inpatient: 40% incidence of psychiatric comorbidity
  - General population: 18.9%
- Presence of a psychiatric comorbidity increases length of stay, medical costs, and rehospitalization
Effect of Social Distancing on Mental Health

• “From a psychological perspective, the consequences of social distancing are summed up in two words – isolation and uncertainty”\(^\text{12}\)

• Social isolation negatively affects wellbeing\(^\text{10}\)
  - Comparable to risk factors such as smoking
  - Loneliness positively correlated to anxiety, depression, panic attacks, and suicidal ideation\(^\text{9}\)
  - Lessons learned from SARS in Toronto 2013\(^\text{13}\)

• Voluntary self isolation results in less distress\(^\text{11}\)
  - Involuntary in inpatient setting
Psychiatric Diagnoses

- Anxiety
- Depression
- Bipolar Disorder
- Borderline Personality Disorder
Anxiety

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

Depression

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

• Mood episodes
• Bipolar I
  • At least 1 manic episode
  • Not required depressive episode for diagnosis
• Bipolar II
  • At least 1 hypomanic episode
  • At least 1 major depressive episode
  • No manic episode
• Change with DSM-5 organization
Borderline Personality Disorder$^4,6$

- Characterized by distressing disturbances in self-image, impulsivity, problems with emotional regulation, and pervasive problems with inter-personal relationships

- BPD common features:
  - Unstable and intense interpersonal relationships
  - Impulsivity leading to self-destructive behavior
  - Emotional instability with reactive mood
  - Difficulty controlling anger
  - Frantic efforts to avoid real or imagined abandonment
Practice You Can Apply Today

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

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

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

• Set up
  • Low arousal environment
  • Slow movement
  • Visual cues/mirror patient

• Options
  • Time breath to movement
  • Counting movements
Handling Disruptive Symptoms

• Hallucinations

• **DO**
  - Ask if they saw/heard something
  - Ask how they feel about the situation
  - Discuss the possibility that the experience is a symptom, hallucination, etc.

• **DON’T**
  - Act shocked or alarmed
  - Tell them it is not real or casually dismiss it
  - Enter into a lengthy discussion about the hallucination
Handling Disruptive Symptoms

• Delusions

• DO
  • Listen neutrally, calmly, respectfully
  • Lead the conversation away from the delusional content
  • Explicitly tell them you want to change the subject

• DON’T
  • Try to convince or argue someone out of a delusion
  • Question or discuss the delusion in detail
Handling Disruptive Symptoms

• Bizarre Behavior

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

  • DON’T
    • Focus on changing a harmless behavior
    • Discuss the behavior in greater detail
Key Points

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


References


The challenges for individuals with cognitive impairments

Chris Childers PT, BSc (Hons), MS, PhD
Chair of the Cognitive and Mental Health Special Interest group
WHO Guidelines 2019 (1)

• Modifiable risk factors for developing dementia include social isolation and cognitive inactivity
The 3 Ds of the older adult population

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

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

Dementia
- General decline in cognitive ability
- Delusion, irritability
- Normal speech but declining
- Memory loss
- Decreasing executive function
Treating or preventing the 3 Ds (2-5)

Delirium
- Early mobilization
- Frequent mobility

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

Dementia
WHO
PA reduces risk of cognitive decline where none is present
PA may reduce risk of further decline in those with MCI
Social Distancing - challenges

The one thing that the 3Ds have in common is physical activity helps.
Social distancing – challenges:

• Group exercise is preferred as individuals with dementia are more engaged and show a more positive mood when involved with others in exercise (6)
Physical activity versus exercise

**Exercise**

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

**Physical Activity**

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

What were they doing as a young adult?
Music – links to their past (7,8)
Step into their world, don’t try to pull them into ours
Familiarize – engage - focus
Familiarize

• Favorite piece of music and just “warm up” move extremities, 3 dimensional,

• You do it with them, everyone in the family/home, sitting or standing – safety is key
Engage

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

• Specifics you want to address
• Sit – stand
• Turning
• Strengthening
• Cognitive component
Incorporate as much physical activity as they can manage

Some is better than none (4)
Routines

• Stick to similar routines as much as possible
• Build new things into the existing routine
  • Add activity after their nap, while waiting for lunch, after breakfast
  • Develop a new handwashing routine – increase frequency
  • Alexa – play our boxing music
Ensure adequate hydration and nutrition
Encourage novel ways of “visiting”

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

Work to maintain their social wellness
References


9. Beirne M. Listening wins again: Music therapy for dementia care. McKnight’s Long-Term Care News 2018;39(9):6-6
Maximizing the Health of Patients with Chronic Lung Disease in a Time of Social Distancing

Carolina Zubiri, DPT, GCS
Stanford Hospital, Critical Care team
Outline

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

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

**COPD**
- Emphysema
- Chronic bronchitis

**Asthma**

Interstitial lung disease

Pulmonary fibrosis

Others: Pulmonary hypertension

Obstructive

Restrictive
Obstructive lung disease

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

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

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

CDC.gov, Buist, 2007, Diaz-Guzman 2014
Chronic lung disease is associated with:

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

Effects of social isolation:

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

Cleutjens 2016, Olaithe 2018, Hawkley, 2015, Alcaraz 2018
COVID-19

Chronic lung disease = high risk category for increased illness severity
Anxiety and helplessness
Current challenge

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

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

**Extensive patient education**

- Basic education on lung anatomy and physiology
- Benefits of exercise
- Rate of perceived exertion
- Energy conservation
- Breathing exercises

**Daily Schedule**

- Benefits of daily routines
- Exercise prescription
- Tips to increase adherence
- Other considerations: sleep, nutrition, meds
Principles of pulmonary rehab

Multidisciplinary approach: pulmonologist, physiatrist, PT, OT, RT, nurse, nutritionist, social worker, psychologist
- Education: lung disease, breathing techniques, energy conservation, nutrition, medication, oxygen therapy, what to do in emergencies
- Exercise training: appropriate frequency, intensity and specificity
- Psychosocial/behavioral component: stress reduction, managing anxiety

Goal: reduce disability and improve quality of life

American Thoracic Society, British Thoracic Society
Patient education: Lung health 101

General anatomy and physiology of the lungs:
- Bronchi and alveoli
- Gas exchange – oxygen to the tissues

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

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

Varrasse, 2015
Patient education: RPE

- Modified Borg scale
- Allows for individualization

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

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

- Pursed lip breathing
- Diaphragmatic breathing
- Singing

TO-DO LIST:
- Breathe in
- Breathe out
- Breathe in
- Breathe out
- Repeat forever
Patient education: Pursed lip breathing

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

“Smell the roses, blow the candles”

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

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

Benefits:

Improves ventilation

Decreases work of breathing
Patient education: Diaphragmatic breathing

Hands on the belly
Inhale: hands rise
Exhale: Hands sink in
Goal: relaxing accessory breathing muscles – neck and chest
Strengthens the diaphragm
Slowling down the breath activates the parasympathetic response: rest and digest
Patient education: Singing

Singing requires active exhalation, controlled diaphragm contraction and good posture

Posture: straight back, relaxed shoulders, deep belly breaths

Warm up: lip trills

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

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

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

Extensive patient education

- Basic education on lung anatomy and physiology
- Benefits of exercise
- Rate of perceived exertion
- Energy conservation
- Breathing exercises

Daily Schedule

- Benefits of daily routines
- Exercise prescription
- Tips to increase adherence
- Other considerations: sleep, nutrition, meds
Benefits of a daily schedule: the evidence

Benefits of daily routines for older adults

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

Individualized

Patient Centered

Set up in collaboration with that patient and their family
Designing a daily schedule: Exercise prescription

**Aerobic exercise:**

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

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

American thoracic society journal British thoracic society
Exercises at home: some ideas


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

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

**Severe impairment:**
Cooking a meal in standing, or 100 leg kicks over a period of 20minutes
Limitations of exercise at home

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

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

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

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

Pehlivan 2019, Rivera-Torres 2019
How to increase adherence

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

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

- Sleep

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

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

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

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

Evening:
- Dinner – Evening meds
- Breathing exercises (singing 15-20min)
- Sleep goal: by 10pm
Sample Schedule for John: Has severe COPD, limited household mobility, does not like lists

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

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

Evening:
- Dinner
- Breathing exercises
- Sleep goal by 10pm
Application in acute care

Prior to discharge home, to SNF or LTAC
Work with patients and their families
Make it individualized
Collaborate with other providers: OT, SLP, dietician, respiratory therapist, psychologist, primary care team.
Chronic lung disease is associated with:
- Depression and anxiety
- Poor sleep quality
- Cognitive decline
- Physical deconditioning
- Immune system dysregulation

Effects of social isolation
- Depression
- Poor sleep quality
- Impaired executive function
- Accelerated cognitive decline
- Poor cardiovascular function
- Impaired immunity

Cleutjens 2016, Olathe 2018, Hawkley 2015, Alcaraz 2018
Take-away

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

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

Z et. 510 Contribution of Routine to Sleep Quality in Community Elderly.


Considerations in Social Distancing for the Home Health Patient

Diana (Dee) Kornetti, PT, MA, HCS-D, HCS-C
President, Home Health Section, APTA
Overview of Home Health Presentation

- Medicare eligibility for coverage of home health care services
  - Homebound status
- Populations commonly receiving home health care services
- Focus of care delivery
  - Patient outcomes for home health therapy services
  - Data collection to establish patient baseline
- Early impact of social distancing on provision of home health therapy services
- Barriers to service delivery in the home health setting
- Preparing for care of the COVID-19 population in the home health setting
Eligibility for Home Health Services
Medicare Benefit Policy Manual – Chapter 7

- Confined to home
- Need skilled services
- Under care of physician
- Under a physician established POC
- Have a face-to-face (F2F) encounter
## Confined to Home Criteria

### Patient Eligibility—Confined to Home

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

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

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

• Common patient presentation can include:
  • Change in functional status & abilities
  • Inability or lack of knowledge to carry out ongoing medical care
  • Compromised independence and/or support in home setting
Care Focus for Therapy in Home Health

• OPTIMIZE (improvement, stabilization) functional abilities
  • Mobility (transfers, gait)
  • Self Care (ADLs, IADLs)

• PATIENT ACCOUNTABILITY for long-term management of medical conditions

• REDUCE (immediate and long-term) need for higher cost centers of care
  • Unplanned physician appointments
  • Urgent/emergent care
  • Acute care hospitalizations
Questions for Home Health Therapy Services
Challenges in COVID-19

How do we meet the need of an “at-risk” population in the home?

How do we reduce the spread of infection/observe social isolation?
Capturing Information for Decisioning - OASIS

OASIS ITEM

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

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

RESPONSE-SPECIFIC INSTRUCTIONS

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

OASIS ITEM

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

<table>
<thead>
<tr>
<th>Living Arrangement</th>
<th>Availability of Assistance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Around the clock</td>
</tr>
<tr>
<td>a. Patient lives alone</td>
<td>□ 01</td>
</tr>
<tr>
<td>b. Patient lives with other person(s) in the home</td>
<td>□ 06</td>
</tr>
<tr>
<td>c. Patient lives in congregate situation (for example, assisted living, residential care home)</td>
<td>□ 11</td>
</tr>
</tbody>
</table>

**RESPONSE-SPECIFIC INSTRUCTIONS**

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

OASIS ITEM

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

RESPONSE-SPECIFIC INSTRUCTIONS

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

### OASIS ITEM

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>When Anxious (Reported or Observed Within the Last 14 Days):</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>None of the time</td>
</tr>
<tr>
<td>1</td>
<td>Less often than daily</td>
</tr>
<tr>
<td>2</td>
<td>Daily, but not constantly</td>
</tr>
<tr>
<td>3</td>
<td>All of the time</td>
</tr>
<tr>
<td>NA</td>
<td>Patient nonresponsive</td>
</tr>
</tbody>
</table>

### RESPONSE-SPECIFIC INSTRUCTIONS

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

**OASIS ITEM**

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>0</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Yes, patient was screened using the PHQ-2@* scale.</td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>PHQ-2@*</th>
<th>Not at all 0-1 day</th>
<th>Several days 2-6 days</th>
<th>More than half of the days 7-11 days</th>
<th>Nearly every day 12-14 days</th>
<th>NA Unable to respond</th>
</tr>
</thead>
<tbody>
<tr>
<td>a)</td>
<td>Little interest or pleasure in doing things</td>
<td>□ 0</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
</tr>
<tr>
<td>b)</td>
<td>Feeling down, depressed, or hopeless?</td>
<td>□ 0</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
</tr>
</tbody>
</table>

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

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

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Current Trends from the Home Health Front

• Early discharges from inpatient facilities
  • Triggered by patient/family request
  • Triggered by facility to increase bed access for increasingly acute population/reduce infection spread

• Redirection of outpatient clinic/office care to home-based care
  • HH nursing vs. physician office/specialty clinic
  • Home health therapy vs. outpatient therapy

• Resistance to admission of services into the home
  • Fear of infection
  • Observance of social distancing precautions
Barriers to Therapy Care Delivery in Home Health

- Restricted access in congregate living spaces to support limited exposure:
  - SN for “essential” activities on limited basis in ALFs/ILFs but denial of therapy services as “non-essential”
- Agency/clinician/patient mindset that therapy is not “essential” during pandemic response as outlined in regulatory guidance
  - Value of therapy in reduction of higher acuity care
- Reduction of elective procedures is correlated to a reduction in need for therapy services in post-surgical musculoskeletal population
- Lack of coverage of telehealth services in the home health setting
- Absence of a triage algorithm to support best patient outcomes
Triaging of Home Health Therapy Services
Challenges in COVID-19

Essential criteria:
At risk for imminent decline or deterioration, acuity of medical status

Non-essential criteria:
Stable condition, support at home, low risk

Need for in-home visit with appropriate PPE
Observation of social distancing parameters, use of equipment barriers/clean bag technique

Defer in-person care with follow-up plan, as indicated
Maintain social distancing through telehealth interactions
Support for Home Health Therapy Services

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

Types of Transmission-Based Precautions

• Contact Precautions
• Droplet Precautions
• Airborne Infection Isolation

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

(CDC, Transmission-Based Precautions, https://www.cdc.gov/infectioncontrol/basics/transmission-based-precautions.html#anchor_1564058318)
Role of Physical Therapists in Reducing Hospital Readmissions: Optimizing Outcomes for Older Adults During Care Transitions from Hospital to Community

Jason R. Fabel, PT, Robert E. Burke, MD, Marlene J. Rodgers, Beth M. McManus, Jennifer E. Stevens-Lapayev


Resource: Evidence-based Literature

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

Jing Liu Wang PhD, RN, RN-BC, Danne V. Liebel PhD, MSED, RN, Fang Yu PhD, RN, CNP-BC, FGSA, FANM, Thomas V. Caprio MD, LE, Jing Liu Shang PhD, RN

NIH Public Access
Author Manuscript
Am J Phys Med Rehabil. Author manuscript; available in PMC 2012 August 17.

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

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Rehabilitation Services and Hospital Readmissions: A Call to Action
Solutions for improving physical function while reducing hospital readmissions

Jason R. Falvey, PT, DPT, GCS, PhD

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

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

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

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

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

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

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