Documenting Homebound Status

by Stephanie Miller, PT, MS, CLT

Just a few days ago I was sitting at a red light. It changed to green yet still no one was moving. Then the horns started beeping. In a hurry myself, I leaned my head out the window to see what the hold-up was. Just then, I saw this elderly gentleman crossing the street with a front wheeled walker with the little tennis balls on the back. He seemed to be trying to cross as fast as he could, but it still wasn't fast enough to traverse the distance in the allotted time. My heart went out to him.

As I drove off, I couldn't stop thinking about that man. It snowballed into a number of thoughts, but I kept coming back to a few scenarios I had encountered over the last few years. It made me think of my patient that insurance considered no longer homebound because she was able to ambulate 35 feet, as well as a patient in an assisted living facility (ALF) who had a prior level of function of independence with transfers and ambulation, but because the ALF has staff on site to assist with these activities, her insurance company was going to stop approving home therapy after she reached a level of minimum assist. If I was a true community ambulator prior to an illness, 35 feet wouldn't be good enough for me to return to my previous lifestyle. And if I was toileting myself prior to a hospitalization, you better believe my final goal would not be using a call bell and waiting for someone to take me to the bathroom in my own apartment. Those aren't the final goals of our patients either.

In instances like those above, of course I fought the insurance companies. I submitted more and more information, and when necessary went to peer reviews through the physician to get continued coverage for much needed therapy. But no one wants to be jumping through red tape hoops when our patients are clearly homebound and without a doubt in need of home care services. So, what can we do?

Understanding what constitutes homebound status is the first step. The second, of course, is documentation. We need to paint the most accurate pictures of our patients from the start and throughout their episodes of care, describing their prior level of function (PLOF), their current limitations, and why they need us as skilled clinicians to get them from point A to point B.

Defining homebound status can be tricky. What about that patient who travels to the local superstore weekly, but with a horribly unsafe walking pattern, doesn't use his assistive device, and has had three falls in the last week? Or the patient who is independent ambulating without an assistive device on all terrain, but is so depressed or fearful of falling, that she doesn't leave the home. What about the insurance company that deems your patient non-homebound for ambulating a distance of 35 feet? Until I researched the true definitions for this article, I too felt it was gray territory. And to a degree, it still can be, but I plan to provide some clarity for you, along with resources to reference when it comes to defining if a patient is truly homebound.

The Home Health Insurance Manual put out by the Centers for Medicare and Medicaid Services (CMS) is a great resource. Chapter 7 is dedicated to defining homebound status. It states that an individual does not have to be bedridden to be considered confined to the home, but that it must be a considerable and taxing effort to leave. These outings should also be infrequent and for short durations, and/or are meant for receiving health care treatment. Examples of this include: adult day centers where medical care is received, outpatient dialysis services, and outpatient chemotherapy or radiation treatments. Religious services also fall under absences of infrequent or short durations, so patients may attend these events and still fall under homebound status. Other examples include family reunions, graduations, trips to the barber/beautician, weddings, and funerals.

As per CMS, "a patient will be considered to be homebound if they have a condition due to an illness or injury that restricts their ability to leave their place of residence except with the aid of: supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person; or if leaving home is medically contraindicated." Examples illustrating this include the following:

- a patient who requires assistance of another person to leave the home due to:
    - dementia
    - blindness

- lacks upper extremity strength to maneuver doors to exit the home
- inability to navigate stairs without assistance and there are stairs to exit the home

- a patient who has recently returned home from the hospital:
  - who has weakness/debility requiring the use of an assistive device who tolerates only short distances
  - who has increased pain limiting ability to ambulate for prolonged periods
  - with restrictions from the physician preventing leaving the home safely (weight bearing restrictions, only perform stair climbing once daily, limited specified time allowed out of bed)

- a patient with neurodegenerative conditions, typically during periods of exacerbation or late stages

- a patient with a psychiatric illness who refuses to leave the home or is unsafe to leave the home unattended despite physical ability to do so

The manual clearly states, "The aged person who does not often travel from home because of feebleness and insecurity brought on by advanced age would not be considered confined to the home for purposes of receiving home health services unless they meet…" (the conditions specified previously in the document, most of which I've paraphrased above). So, for your patient who doesn't leave the home because she wants you to keep coming as it is more convenient or because she just loves you; she is not homebound. The thing to keep in mind is that being homebound is not an active choice or cognitive decision, but the consequence of a physical or mental limitation.

Now that the definition of homebound status has been clarified, the next step is documenting it. Accurately documenting the criteria that make a given patient homebound and the skilled care you plan to provide to progress that patient to a higher level of function is of utmost importance. All too often I see documentation stating "Patient tolerated well" or "Patient showing good progress toward goals". I've seen visits documenting only distance of ambulation and therapeutic exercises performed, when two weeks prior, the clinician documented that the caregiver was independent in taking the patient safely through a home exercise program and walking program. I myself have made the same mistakes. For me, it wasn't until the first time an insurance company questioned the necessity of my visits that I realized the significance of what we put in our notes. I looked at my documentation and, per what was written, questioned the necessity myself. Of the charts I review, I know the clinicians are providing appropriate and necessary skilled care to truly homebound patients, as did I, but sometimes our documentation doesn't accurately reflect that.

When I was in school and learned the FIM standard, 46m (150ft) was considered the minimum to designate someone an independent ambulator. Studies have shown 62m (200ft) as the minimum necessary for community ambulation. With the advent of superstores, more recent studies have found 300-600m (984-1968ft) is the distance a person may travel when visiting one destination. And in reality, when we run errands, it's typically to more than one location. So it is with our patients if they plan to return to their true PLOF.

When documenting ambulation, it is important to document exactly what the patient will need to navigate to perform his/her typical ADLs. How many feet to the mailbox, or the garage, or the dining hall of and ALF? What type of terrain must be navigated to exit the home? Is there one step to enter the garage? Is there a handrail to exit the short flight of steps to get to the driveway? Is there a gravel or ramped driveway to get to the mailbox? The answers to these questions not only help us formulate our plan of treatment, but show the insurance company or auditor what the patient has to be able to do to be safely deemed non-homebound. And they justify our treatment plans on paper.

Once all of that has been documented on the evaluation, consistency of attention to detail must be documented throughout routine visits. What is the patient's gait pattern during ambulation? Are verbal or tactile cues necessary for improved safety with ambulation or transfers? Does the patient require an assistive device, and if so, is it a new device that they need continued training on? Does the person require standing or seated rest breaks during ambulation and if so, after what distance? What is the BORG or RPE rating after certain distances? And what change, if any, is there with pulse ox levels or blood pressures with household versus community distances? How well does the patient navigate around oxygen tubing? What is the quality of gait and safety on varied terrain or with stationary/moving obstacles?

Narratives are so important in showing a true picture of how the patient is performing in the home and out of the home. But at times, subjective data can be challenged. It is also important to use objective data to further support our narratives. Evidence based tools such as TUG, functional reach, and gait velocity can further quantify deficiencies and/or show progress. Depending on location of residence and type of street, studies have found that it's necessary to walk a speed of 0.8-1.2m/s to safely navigate a crosswalk. Gait velocity is a great and easy test to do to quantify this. Any patient scoring less than 0.8m/s isn't deemed safe or appropriate for meeting the criteria to cross most streets in the allotted time provided at stoplights. With that one test, you can obtain great objective data to support your patient's homebound status.

As I read through charts, and I have to admit sometimes my own, I see a supine HEP provided for the first week or two, then seated for the next week or two, then standing, then discharge. As my grad school professors warned against cookbook treatments, I vowed I would be above it…and then, I fell into it. I used to see the downfalls of the home setting because you don't always have a theraball accessible or weights or balance boards. But then I came to realize the injustice I was doing for my patients by simulating their home environments/challenges in the rehab or outpatient setting. You can't accurately reproduce a missing second step or wiggly banister. I started to see home care in a different light, as a unique opportunity to train the patient within his/her own environment. Instead of simulating their environment with equipment, I had all of the obstacles and challenges right in front of me. I just had to embrace and utilize them.

Perry et al found that in addition to walking function, patients must be able to adapt physically and cognitively to sudden disturbance in body movement when they encounter environmental barriers and unexpected events during community ambulation. Four variables were identified to classify walking ability: 1-changes in level and terrain irregularity, 2-obstacle avoidance, 3-increase in distance, and 4-manual handling of loads. Maybe we need to keep the dog in a separate room when we initially start treating someone, but Spot won't be locked up forever. Train your patient to navigate around him. It's a challenge he/she will face on a daily basis at home, as well as out at the local shopping mall while passersby are texting and walking around in their own worlds. Call the patient's phone during gait training to challenge balance through quick directional changes they would automatically make if they heard the phone ring. Instead of avoiding the broken sidewalk, train the patient how to safely navigate in the grass around it or how to safely step over it. Have the patient carry a bag of groceries to/from the car. We are in the perfect setting to prepare patients for safe return to their PLOF or highest level of independence in the community. We have every environmental challenge in front of us. We just need to see it, use it, and document it!

To further show skilled need, we need to give ourselves credit for all of the patient education we do. All too often I will do a supervisory visit with a clinician and hear him/her provide tons of education to a patient, but then see none of it documented. Educating on signs and symptoms of infection, the effects of therapeutic exercise/activity on blood sugar levels, diabetic foot care and proper footwear for falls prevention, signs and symptoms of urinary tract infection or deep vein thrombosis, and falls prevention are imperative to a patient's safe return to PLOF. We're constantly instructing patients to remove throw rugs or explaining the benefits of having grab bars in the bathroom. We just need make certain to consistently write it down. Those are some of the skill sets that we distinctly have. This is information that a patient's caregiver can't provide. And it's what justifies our visits.

Here are some examples of good versus not-so-good documentation related to homebound status. When precepting new clinicians, I often give two pieces of advice when reviewing notes: 1-Read it as if you are trying to justify why this visit should not be paid for. Did this visit need to be performed by a skilled clinician or could the caregiver have performed this same treatment? And 2-Read it as if you're trying to justify why this patient is appropriate to go to outpatient for continued treatment. Why is this patient not homebound? If you're documentation accurately supports the skilled need that you provided and that this patient is truly homebound, your note is complete!

An article from the *International Journal of Physical Medicine and Rehabilitation* states that walking function is critical in improving activity of daily living and quality of life post stroke. It goes on to discuss that the environmental set up of hospitals and rehab settings often accommodates those with impairments, rather than challenging them. And stresses the importance of reproducing obstacles that the patient may face in the community for safe return to PLOF. We are in the perfect field for that. We have cracked sidewalks, throw rugs, clutter, and pets running amidst living spaces in most every setting we go into. We train patients in these environments daily and make sure they are safe

GOOD	BETTER
Patient lives with spouse and has first floor set up. Patient ambulates with walker.	Patient lives with spouse in 2 floor home with 3 steps to enter home with handrail on the right going up and with bedroom and full bath on 2nd floor. Patient reports PLOF as independent with navigating full flight of stairs to 2nd floor without assistive device and able to safely exit home without assistance. Patient currently using first floor set up with hospital bed in living room and performing sink bath in ½ bath on first floor with assistance from spouse and ambulating with supervision with front wheeled walker. Patient reports goal is to return to PLOF of independently navigating both floors and exiting home without AD.
Patient ambulated 100 feet with walker with supervision with taxing effort.	Patient ambulated 100 feet with front wheeled walker with supervision and 1 standing rest break after 72 feet. Patient unable to hold a conversation with the last 5 feet and pulse ox dropped from 97% to 90% with this distance. Patient reports a BORG score of 15 after ambulating 100 feet.
Patient with partial understanding of hip precautions.	Patient able to correctly verbalize 2/3 hip precautions, but continues to require verbal cues to avoid breaking 90 degree rule. PT educated in the importance of keeping items such as remote control and toilet paper near to patient to avoid automatic reaching forward for these items and potentially breaking 90 degree rule. Patient will continue to require training on hip precautions.
Fall prevention reviewed.	PT educated patient/caregiver in the benefits of throw rug removal and in the falls risks of keeping these items in place. PT reviewed benefits of better securing handrail on full flight of stairs and on grab bar placement in the bathroom to reduce falls risk. Patient/caregiver verbalized understanding of all instructions.
Patient understands HEP.	Patient is able to correctly verbalize all seated therapeutic exercises as per written HEP and is able to correctly perform repeat demonstration 100% of the time with use of handout.
Patient will benefit from continued PT.	Patient continues to require verbal cues 25% of the time for heel toe gait pattern with ambulation without assistive device in the home. Due to inclement weather, outdoor ambulation has not yet been attempted. Patient requires skilled home PT to progress safety with ambulating on indoor terrain with goal of progressing to outdoor ambulation in future visits.
Patient progressing well.	Patient able to ambulate 172 feet with front wheeled walker independently on straight pathways and with supervision with turning and navigating around moving obstacles while maintaining O2 levels of 93-96%. Patient demonstrates upright posture 100% of the time without verbal cues this visit.

to navigate them. We are the key piece to transitioning our patients from being homebound to being safe community dwellers. We just need to give ourselves credit for everything we do by documenting it.

References

- http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c07.pdf
- Andrews AW, Chinworth SA, Bourassa M, Garvin M, Benton D, Tanner S (2010) Update on distance and velocity requirements for community ambulation. J Geriatr Phys Ther. 33(3):128-34.
- Perry J, Garrett M, Gronley JK, Mulroy SJ (1995) Classification of walking handicap in the stroke population. Stroke 26: 982-989.
- Oh DW (2013) Community Ambulation: Clinical Criteria for Therapists' Reasoning and Decision-making in Stroke Rehabilitation. Int J Phys Med Rehabil 1: 126. doi:10.4172/jpmr.1000126

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