Codify
BY AAPC

Eli's Rehab Report

HHAs: Is Your PTA and COTA Utilization Hurting Your Agency?

See where most HHAs go wrong when it comes to these valuable assistants.

A huge caseload of patients backlogged for therapy, staffing shortages, a high cost per visit, and less than optimal productivity -- sound similar to your home health agency's rehab situation? It's not a pretty picture for most HHAs in these crunched times. And if it's not about productivity, it's about producing better patient outcomes.

The good news: Most agencies can remedy these problems by making changes to their therapy assistant utilization. Here's what the experts have to say.

Consider Your State Practice Act First

You can't change your assistant utilization until you know what your state practice act allows in the home care setting. "Frequency, scope of practice, and type of supervision are state-dependent," says **Francine Wheelock, PT, MPA,** manager of clinical information systems for MaineGeneral Health in Augusta, Maine. Plus, states have their own rules on therapist-to-assistant ratios, she adds.

Careful: Some agencies consider their state practice act "the gold standard of care," which is not always clinically appropriate, says **Cindy Krafft, MS, PT, COSC,** Peoria, Ill.-based consultant with Fazzi Associates. For example, in Illinois, an assistant can see a patient after the therapist has done an evaluation, but the clinician needs to see the patient every six visits. But if you're dealing with a complex case, the therapist may need to go more often,Krafft says. So before you max out your assistants to the minimum standard in your state for productivity's sake, remember that it is a minimum.

Also, your outcomes are more important than ever with Medicare's Home Health Quality Reporting Initiative. "HHAs must report quality standards in 2009 or receive a 2 percent reduction in payment," said **Roshunda Drummond-Dye, Esq.,** associate director of payment policy and advocacy for the American Physical Therapy Association, in a presentation at APTA's Combined Sections Meeting in February 2009. Plus, there's the home health pay-for-performance demonstration going on too, she pointed out.

Good idea: Check your payer policies guidelines too. "Many insurance companies have limitations on coverage or no-coverage for assistant visits," Wheelock says. And "it's up to the therapist and the home health agency to get pre-approval for coverage of PTA/COTA visits."

Create a Communication Policy

Technology such as e-mail, cell phones, and pagers have been welcome additions to the days when a COTA, for example, had to find a pay phone or use a patient's land line to call her supervising OT with a question. "But now it's as if agencies have too many choices of communication," which can hurt productivity, Krafft says.

It's hard enough to track down a clinician when you have to try his e-mail, cell phone, voice mail, or other contact, and it gets even more complicated when each clinician has her own contact preference, Krafft says.

Solution: Get your therapists and assistants to agree on a standard communication policy. Perhaps you decide to always use cell phones only and require everyone to check their voicemail at 11 a.m. and 4 p.m. every day. If you don't have company phones and therapists don't want to use their personal minutes, perhaps an e-mail solution would be better. Whatever you decide, keep it simple and consistent.

Develop an Objective Handoff Procedure

CPT® 2023 American Medical Association. All rights reserved.

Codify BY AAPC

Another issue that can kill productivity -- and quality of care -- is inconsistent patient handoffs. "It's very interesting when I go into an agency and speak separately with the assistants," Krafft observes. The assistants speak up more -- and often about things that shouldn't be happening. For example, she's heard of clinicians handing off all the "stinky" (or less desirable) patients to the assistants. "I've also seen PTs hand off a patient to PTAs and then decide later to take the patient back because the patient's dog is nice, or an OT gives a patient to the COTA because the drive is too far," she recalls.

Bottom line: None of these reasons have a clinical basis. And the other extreme happens, too. "I've seen therapists with trust issues refuse to hand off their patients to assistants, and then assistants end up going home because there's no work -- yet there are patients still waiting for therapy and the physicians are wondering why," Krafft says.

Even if the therapist thinks she's doing the patient a favor, the agency's therapy productivity suffers, and the cost per visit goes up.

"But beyond that, eventually physicians won't tolerate their patients' waiting for therapy and will start looking for other providers," Kraft warns. "Remember that it's never the good news that keeps to the front of their minds," Krafft says.

Solution: Create an official handoff procedure based on clinical criteria, Krafft recommends. You might also get upper management to help develop the procedure. "A lot of HHAs, particularly because most of them are run by nurses, are hesitant to get into this process because they feel it is a 'therapy thing,' but sometimes we need a little guidance to make sure we're really using all our resources," Krafft adds.

CPT® 2023 American Medical Association. All rights reserved.