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Exploring Family-Centered Care from the Perspectives of Home-Health Physical Therapists

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Abstract

Background and Purpose: Older adults often need caregivers to help them age in place successfully while maximizing their quality of life. These caregivers have the highest rates of burnout, injury, and turnover. Family-centered care (FCC) involves collaboration between the healthcare practitioner and the patient, family members, and caregivers. There is a paucity of evidence on how FCC is applied to older adults and their caregivers. The purpose of this general qualitative study was to explore how a group of home health physical therapists (HHPTS) deliver FCC to care-dependent older adults.

Methods: This general qualitative study used individual, semi-structured interviews with a purposeful sample of 14 HHPTs working for a variety of home health agencies in San Diego County. The interview responses were hand transcribed, hand coded, thematically analyzed, and conceptualized in the International Classification of Functioning, Disability, and Health model (ICF model). The coding table and interview guide were modified based on reviews by experts in home health physical therapy. A proprietary coding software program called NVivo was used to triangulate the results.

Results and Discussion: The 3 main themes that emerged were: (a) "FCC is Complex"; (b) "FCC Impacts Older Adults' Health Factors"; and (c) FCC is Impacted by Contextual Factors". Eleven subthemes also emerged. The themese and subthemes were conceptualized within the ICF Model. The first theme demonstrated that the HHPTs had a variety of understandings of, training on, and applications with FCC. The HHTP was conceptualized as an environmental factor that could impact the patient's health based on their knowledge and skills with FCC. The second theme demonstrated that FCC was utilized to address every ICF health factor by the HHPTs. This theme was conceptualized around the entire ICF Model. Neurological conditions and motivated families were seen as large factors in performing FCC. The third theme demonstrated that a wide variety of contextual factors impacted the HHPTs ability, time, and resources to perform FCC. This was conceptualized in ICF Model as personal and environmental factors that could facilitate or inhibit ("+/-") FCC approaches by the HHPTs.

Conclusions: This study closed some of the gaps in the literature on how FCC is delivered to older adult clients, their caregivers, and their family members. This knowledge may help to foster changes in FCC approaches and research. Changes like these could lead to improved health outcomes for older adults through reduced hospital readmissions and improved caregiver satisfaction with care as seen in pediatrics.

Key Words: Family-centered care, home health physical therapist, caregiver satisfaction, burnout, and International Classification of Functioning, Disability, and Health model.

Author Bio(s)

Dr. James Mathews, PT, DPT, PhD, is the author, and lead researcher, of the dissertation, “Exploring Family-Centered Care from the Perspectives of Home-Health Physical Therapists”. This dissertation was available for open access in ProQuest as of November 2020. The original Walden University Institutional Review Board (IRB) approval number is IRB# 04-13-0661874. Dr. Mathews is the Associate Program Director of an entry-level Doctor of Physical Therapy Program, a teaching faculty member, and a treating physical therapist in an adult day healthcare center. He is a novel researcher and a Board-Certified Clinical Specialist in Geriatric Physical Therapy. Dr. Mathews has been a licensed California Physical Therapist (PT-24087) since 1999. From 2003 to 2011, Dr. Mathews worked full-time in skilled nursing facilities. Since 2012, Dr. Mathews has worked full-time in academia. His inspiration for this study came from witnessing poor care transitions to home with family members and from the 2017 article by Dr. Alan Jette, PT, PhD, FAPTA, titled,

"From Person-Centered to Family-Centered Health Care".

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ABSTRACT

Background and Purpose: Older adults often need caregivers to help them age in place successfully while maximizing their quality of life. These caregivers have the highest rates of burnout, injury, and turnover. Family-centered care (FCC) involves collaboration between the healthcare practitioner and the patient, family members, and caregivers. There is a paucity of evidence on how FCC is applied to older adults and their caregivers. The purpose of this general qualitative study was to explore how a group of home health physical therapists (HHPTS) deliver FCC to care-dependent older adults. **Methods:** This general qualitative study used individual, semi-structured interviews with a purposeful sample of 14 HHPTs working for a variety of home health agencies in San Diego County. The interview responses were hand transcribed, hand coded, thematically analyzed, and conceptualized in the International Classification of Functioning, Disability, and Health model (ICF model). The coding table and interview guide were modified based on reviews by experts in home health physical therapy. A proprietary coding software program called NVivo was used to triangulate the results. **Results:** The 3 main themes that emerged were: 1) "FCC is Complex"; 2) "FCC Impacts Older Adults' Health Factors"; and 3) FCC is Impacted by Contextual Factors". Eleven subthemes also emerged. **Discussion:** The themes and subthemes were conceptualized within the ICF Model. The first theme demonstrated that the HHPTs had a variety of understandings of training on, and applications with, FCC. The HHTP was conceptualized as an environmental factor that could impact the patient's health based on their knowledge and skills with FCC. The second theme demonstrated that FCC was utilized to address every ICF health factor by the HHPTs. This theme was conceptualized around the entire ICF Model. Neurological conditions and motivated families were seen as large factors in performing FCC. The third theme demonstrated that a wide variety of contextual factors impacted the HHPTs ability, time, and resources to perform FCC. This was conceptualized in ICF Model as personal and environmental factors that could facilitate or inhibit ("+/-") FCC approaches by the HHPTs. **Conclusions**: This study closed some of the gaps in the literature on how FCC is delivered to older adult clients, their caregivers, and their family members. This knowledge may help to foster changes in FCC approaches and research. Changes like these could lead to improved health outcomes for older adults through reduced hospital readmissions and improved caregiver satisfaction with care as seen in pediatrics.

Keywords: age in place, family-centered care, home health physical therapist, caregiver satisfaction, burnout, and International Classification of Functioning, Disability, and Health model.

INTRODUCTION

Family-centered care (FCC) is a collaborative care[1] approach between the patient, the patient's family and caregivers, and the health professional.[2,3] This collaborative care approach aligns FCC with the systems theory[4] and the servant leadership model.[5] In pediatric care, FCC has resulted in improved health outcomes of reduced hospitalizations and readmissions[6], improved health and mortality[7], and improved satisfaction (patients and caregivers).[8,9] Care-dependent older adults need these improved health outcomes through FCC.

Prolonged hospitalizations cause a significant number of older adults to have post-acute states of deconditioning, confusion, and weakness.[10] These older adults lose their intrinsic capacity[11] to function safely alone and become care-dependent, institutionalized, or readmitted to a hospital – all at a great cost to society.[12,13] By 2060, the number of care-dependent older adults is expected to double.[14] In addition, the caregivers of care-dependent, older adults have the highest rates of injury, lost income, burnout, and turnover.[15]

Family-centered care may prevent this poor health outcome with care-dependent older adults, and their caregivers, when used by home health professionals. Home health physical therapists (HHPTs) are often the only health professionals to care for older adults in their homes after a hospitalization.[2,16] The main research problem is that there is paucity of evidence on how FCC is understood and applied by HHPTs.

OBJECTIVES

The purpose of this general qualitative study was to fill in some of the gap in understanding on how home health physical therapists (HHPTs) use FCC with older adults at home. The first objective of this study was to gain a deeper understanding of these perspectives through open-ended interview questioning. The second objective was to synthesize these understanding into themes and conceptualize these themes within the International Classification of Functioning Disability and Health Model (ICF Model) – a widely accepted conceptual model for physical therapy practice.[17]

DESIGN

This study is a condensed manuscript of a Walden University Institutional Review Board (IRB) approved dissertation (IRB# 04-13-0661874).[18] The research design was that of the general qualitative design.[19] This design allowed for social constructivism[19] by the HHPTs on their perspectives with FCC through interviews with them by the lead researcher. The main data collection tool used was a semi-structured, one-hour long (on average), individual interview using an expert-reviewed interview guide as recommended Rubin and Rubin.[20] The guide contained demographic and open-ended questions referred to as "key questions" (KQs).

The interviews were done virtually, audio recorded, and transcribed by hand. The transcriptions were member-checked by each HHPT. A coding table was constructed to code the responses to the 8 key questions (KQs) for each HHPT interviewed. Multiple coding procedures were used to code within a KQ response and across the HHPT responses. An expert reviewed: (a) the entire coding table through the formation holistic codes[21]; (b) the entire coding table through the formation of pattern codes[21]; (c) the entire coding table through the final stage of thematic analysis; and (d) the conceptualizations of the themes and subthemes from the coding table within the ICF model. A proprietary coding software (NVivo®) was used to triangulate the themes generated by the coding table that used a computer-generated word count process to code the member-checked transcripts.

METHODS

Participants

The inclusion criteria for participants in this study were: (a) a minimum of 12 months experience as a fulltime HHPT; (b) a caseload that included at least 50% older adults; (c) a valid California Physical Therapist license; (d) access to a computer with internet; and (e) working for a home health agency in San Diego County. Twenty HHPTs consented to be in the study, 14 were interviewed. Thematic saturation occurred at the 12th interview. The remaining 6 HHPTS that consented, but were not interviewed, were thanked for their interest to participate, and excused from the study. Of the 14 HHPTs interviewed, 2 identified as being male and 12 as female. On average, the HHPTs worked 5.5 years in home health, maintained a caseload of over 90% older adults, and reported seeing 80% of their older adults under Medicare Part A benefits. Each HHPT had a valid California PT license at the time of interviewing. Twelve of the 14 HHPTs were employed by for-profit, private home health agencies (HHAs). Two HHPTs were employed by not-for-profit, private HHAs. None of the HHPTs interviewed worked for the same HHA. Of the 14 interviewed, 2 HHPTs worked in urban parts of San Diego exclusively, 9 in a mix of urban-suburban parts of the county, and 3 identified with working in rural parts of the county. Three HHPTs reported receiving formal education on FCC, while 9 reported being familiar with the ICF model. One HHPT was an American Board of Physical Therapy Specialization (ABPTS) Board-Certified Geriatric Clinical Specialist, a.k.a. GCS and 2 were ABPTS Board-Certified Orthopedic Clinical Specialists, a.k.a. OCS.

Instrumentation

The lead researcher used instrumentation techniques on the interview guide and the coding table to conduct this study. Prior to the interviews, the draft interview guide was reviewed for accuracy and appropriateness by two expert HHPTs. The qualifications to be an expert included working as a home health physical therapist (HHPT) for at least 5 years in San Diego County and having a valid GCS. One of these experts, Expert 1, was the owner of their own for-profit home health agency (HHA) and the other, Expert 2, was a manager for a private for-profit HHA. Expert 1 suggested breaking up the key question 7 (KQ7) into 2 different questions and providing a definition of FCC later in the interview. Expert 2 recommended an additional demographic question about FCC on-the-job training. The feedback received from both experts was accepted into the final interview guide. Appendix A contains the guide. The coding table was reviewed by Expert 1 at: (a) the end of first main phase of coding (holistic coding); (b) the second main phase of coding (pattern coding); and (c) the end of thematic analysis.[21] Multiple changes were made to the coding table based on this expert feedback and discussion with the lead researcher by phone and email.

Procedures

Twenty participants were voluntarily recruited to participate in this study through snowball sampling[19] (a form of chain sampling), and through an e-flyer posted on a local physical therapy webpage. Each prospective HHPT received a formal, IRB approved consent email. HHPTs who consented were selected on a first come, first-serve basis. The interviews took place between June and August of 2020. Each interview was one-hour long (on average) and each was done virtually due to Covid-19 pandemic restrictions. The researcher had their camera on during the virtual interviews, but it was required by the IRB to have the participants keep their camera off for privacy. The virtual platform used was called RingCentral®.

The interviews were audio recorded and the recordings were transcribed by hand onto a Microsoft® Word document. The transcripts were emailed to each HHPT for member-checking. The member-checked transcripts, with their suggested edits, were returned by the end of September 2020 and transferred to the coding table. The coding table was a 92-page Microsoft Word® document. The first coding phase involved taking each of the 8 KQs and reducing them into paraphrases. These paraphrases were coded on the coding table into 1-2 word, "pre-codes".[21] The pre-codes were coded into holistic codes. The holistic codes were then sent to Expert 1.

Feedback from Expert 1 resulted in the elimination of holistic codes and the addition of new holistic codes. For example, draft code "Team Based" was eliminated. In addition, the holistic codes of "Cancer", "Trusting the HHPT", "Needing a Break", and "Interdisciplinary Team" were added. Figure 1 provides a sample of this from the original coding table.

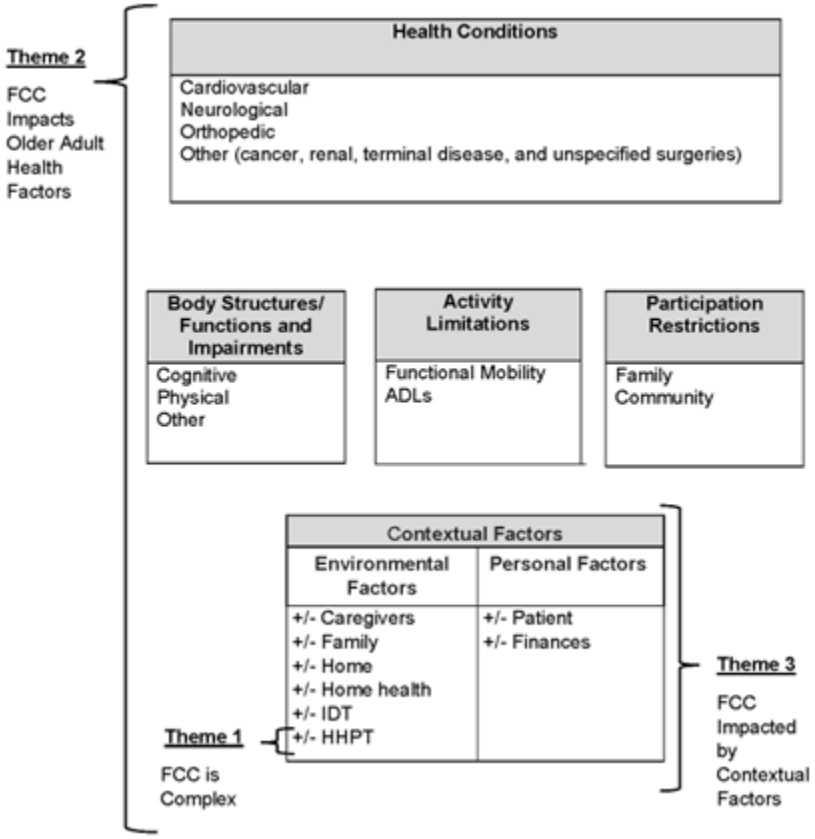
Figure 1. Pre-codes to code-mapping sample from coding table. Peer-debriefing occurred after first cycle coding and before code-mapping. This debriefing resulted in edits to the original list of holistic codes.

Pre-Codes	Holistic Codes (First Cycle)	Code-Mapping (After-First Cycle)
- Active caregiver - 1, 2, 8, 3, 9 - Active Listening - 10 - Adapts to type of home settings - 1 - Adapts to a type of assistance needed -1 - Adjusting PT agenda – 8, 1 - Balancing how and when PT communicates with the family -10, 8 - Based on patient and family goals - 8, 9 - Based on the conglomerate goals - 2, 12 - Build rapport -10 - Cannot decide for themselves - 2, 9, 3 - Caregiver education - 4 - Caregiver training - 4	**FCC Defined (1-13)** *Holistic Codes* 1. Adaptable 2. Coordinated / Collaborative 3. Inclusive 4. Family/ Caregiver Training/ Education 5. Interdisciplinary Team 6. Novel 7. Qualifying Criteria 8. Respectful to Individual Needs 9. Shared-Decision Making 10. Skilled Communication ~~11. Team-based~~ 12. Therapeutic 13. Timebound _____ Peer Debriefing:	**Category 1: Team focus on patient, family, caregivers.** *Related codes:* - Family/ Caregiver Training/ Education - Interdisciplinary Team - Shared-decision making - Inclusive - Referral to community services **Category 2: Situational** ***Related codes*** - Adaptable - COVID-19 Effects - Qualifying Criteria - Respectful to Individual Needs - Re-evaluation and extend if rapid progression - Timebound **Category 3: Skilled** ***Related codes:***

- Coaching families to participate in care 4, 8, 10 - Cognitive declines 4, 17 - Cognitive level 4, 17 - Collaboration with patient and family -2 … (full list on the coding table)	- "Q1 – I wonder if your codes 5 and 11 are similar and could be combined." – done	- Coordinated / Collaborative - Customer satisfaction sought - Documentation Styles Vary - Electronic Documentation - Family and caregiver goals are set and measured too - Novel - Psychology of being a therapist - Skilled Communication - Therapeutic

At the conclusion of the first coding phase, the holistic codes were re-arranged across interviews to form code-maps.[21] Code-mapping helped the researchers to organize the plethora of holistic codes from the 8 KQs into categories. The code-mapped codes went through a second coding phase called pattern coding. Pattern coding allowed the researcher to create codes that represented patterns amongst the code-mapped holistic codes and cross interviews and key questions to generate deeper connections between participant responses and concepts. Figure 2 provides a sample of the code-mapped holistic codes and resulting pattern codes.

Figure 2. Themes in the context of the ICF Model.



Theme 1 demonstrates that FCC is complex and depends on the HHPTs' reports of: 1) their FCC training, 2) their relationship with their interdisciplinary team, 3) their perception of situational needs, and 4) their levels of reported skilled services. Theme 2 demonstrates that FCC is used by the HHPTs in this study to address all 5 ICF health factors; each lists the main subthemes reported within the 5 health factors. Theme 3 demonstrates that the ability of the HHPT to deliver FCC is dependent on the impact of multiple other (+/-) contextual factors besides the HHPT (Theme 1). Note: This figure is an adaptation of original work, "International Classification of Functioning, Disability and Health. Geneva: World Health Organization (WHO); [2001]. License: CC BY-NC_SA 3.0 IG."

The pattern codes were sent back Expert 1. This expert review process resulted in new pattern codes being added to the coding table. For example, “Caregiver Attitudes”, “Poor Follow Through”, and “Unrealistic Expectations” were added. The pattern codes were then thematically analyzed to create themes and subthemes. The themes and subthemes went through another review with Expert 1, and the subtheme “Understanding” was changed to “Developing”. The final list of reviewed themes and subthemes were conceptualized within the ICF model and sent for a final review by Expert 1. No changes were recommended at this final stage.

To triangulate the themes from the coding table, another coding procedure was used. The member-checked transcripts were loaded all at once into a proprietary computer program (NVivo) for data analysis. This program utilized a complex word count function to analyze the responses. The 12 computer-generated themes were “Caregiver”, “Documentation”, “Support”, “Situations”, “System”, “Needs”, “Mobility”, “Injury”, “Side”, “Present”, “Native Speaker”, and “Culture” – see Appendix B. Although the computer-generated themes had different names, each was contained withing the 3 main themes of this study.

Data Analysis

The first cycle of coding began with paraphrasing answers to the questions, turning the paraphrases in to pre-codes, and then seeking to create holistic codes from the pre-codes. This process produced 108 holistic codes. The second cycle of coding produced 12 pattern codes with 55 related sub-codes from the code-maps. Thematically analysis of the pattern codes produced 3 main themes and 11 subthemes. These themes and subthemes were then conceptualized with the ICF model. Reflective note taking by the author did not lead to new themes or codes. Based on analysis of the interview responses by the 12th interview, thematic saturation was suspected. This was verified with 2 additional interviews that did not produce new understandings.

RESULTS

This study resulted in the creation 3 themes and 11 subthemes on how FCC used by HHPTs with care-dependent older adults. These understandings were able to be conceptualized within the ICF model.

ICF Conceptualization – “Theme 1: FCC is Complex”

The first theme, “Theme 1: FCC is Complex”, was synthesized from its four subthemes: 1) “Developing”, 2) “Interdisciplinary”, 3) “Situational”, and 4) “Skilled”. This theme was centered on the impact the HHPTs’ may have had on the patient’s health. It was conceptualized in the ICF Model under environmental factors and within the HHPT responsibilities (see Figure 1).

The first the subtheme, “Developing”, came from HHPT responses such as: “I have found that the training in home health is lacking significantly, and a lot of it you just have to kind of figure out as you go into it. I feel like there should be more exposure probably while they're in their degree programs, and then also there should just be a better training system in place.”

When the HHPTs were asked about treating others (families or caregivers) at home, most were hesitant to do so. For example, one HHPT reported, “I have not done that… I have given someone direct access in the past, but not to a caregiver”. Another said, “I would want to have a prescription before I treat a caregiver with the patient… I really don't know that I am covered insurance-wise with my malpractice insurance to do something like that.” One HHPT said that they would likely be, “…too overwhelmed to focus on anyone besides the patient.” In this sense, the use of direct access, and point of service care for the family at home was not developed. Two of the HHPTs would ask for a referral on the spouse of the patient to start after the episode of care with the original patient ended. The remainder reported they would educate the family or caregiver needing to seek a referral from a doctor. All 14 HHPTs had developed some strategy to cope with families needing care. These different strategies and the barriers to direct access in home health add to the theme that FCC is complex.

With the subtheme “Interdisciplinary”, 1 HHPT stated, “the primary care doctor does not return my phone calls making it hard for me to coordinate with them.” Many other HHPTs had difficulties with interdisciplinary communication timing. One HHPT stated, “I don’t communicate a lot with the home health nurse or the social worker because I cannot find the time to always coordinate with them to do that.” Another reported, “the amount of time that it takes to coordinate the care to get doctor's orders signed and make sure that everyone is on the same page inter-disciplinary is very challenging.” Four HHPTs reported that good relations with the primary doctor was making a difference in the quality of care with their patients. Other HHPTs reported no issues with interdisciplinary care, and that this form of care had led to better health outcomes for their patients. Given that interdisciplinary care was reported very differently amongst the HHPTs, it too adds to the complexity of FCC.

The subtheme “Situational” was multifaceted. The HHPTs faced different situations at home that either helped or hindered their FCC approaches. One HHPT reported that, “some cultures and families want to see everything that's going on and really want to be involved with all visits, this can be challenging to do as my time gets spent less on the patient and more on the family.” None of

the HHPTs reported bringing with them materials in other languages. Most of the HHPTs relied on families or the patient to translate for them. Professional phone-in translators were reported as, "too cumbersome" by 5 of the HHPTs, and 3 of the HHPTs reported relying on nonverbal communication alone. One HHPT reported that he needed to, "the great-grandchildren [because the patient] … preferred to work with them versus their adult child." The great-grandchild was a teenager and that challenged the HHPT both professionally and ethically. Situations like these, and how the HHPT responded, added to the complexity of FCC.

In terms of the fourth subtheme, "Skilled", reflected how the levels of skilled services differed significantly between the HHTPs. One HHPT reported that with skilled communication, "you must know how to treat the family members and how to include them." Another HHPT said that they did not include families much in their questioning. Some of the HHPTs reported working with all parties to get the consent forms signed on the plan of care, others worked the patient alone on this. One HHPT reported, "I often have to teach the family how to help the patient with their activities of daily living, but sometimes it's the opposite, I have to teach them not to totally enable the patient." This idea was echoed in another HHPT who reported the need to have caregivers be, "pseudo-therapists" and not maintenance workers alone. When asked about documentation, 8 of the 14 HHPTs struggled with it. For example, one HHPT reported, "the time that it takes to do the documentation is huge and cumbersome." Furthermore, 8 of the HHPTs reported documenting FCC under the heading of caregiver training, while the others managed to document in available free space in the electronic chart.

ICF Conceptualization – "Theme 2: FCC Impacts Older Adults' Health Factors"

Since each HHPT reported using FCC with all 5 of the ICF health factors, these health factors became the subthemes of the second theme "FCC Impacts Older Adult Health Factors". The five subthemes were named after the ICF health factors of: (a) health conditions; (b) impairments; (c) activity limitations; (d) participation restrictions; and (e) contextual factors. The entire ICF model in Figure 3 is contained within the second theme.

In terms of health conditions, the HHPTs reported a multitude of conditions for which they used FCC with. Neurological conditions were consistently reported as needing FCC by every HHPT. One HHPT stated, "I've used a lot of family-centered approaches with my SCI (spinal cord injury) and CVA (cerebral vascular accident) patients". Another stated, "I need to work with caregivers of neurologically involved patients, because the patient is at a point of function where the focus needs to be on safe management at home." Other health conditions commonly reported were cancer, cardio-pulmonary conditions, and orthopedic conditions. Only 1 HHPT reported using FCC with wounds and 2 with amputations.

Many impairments were reported too as befitting from FCC approaches. These impairments were largely related to the musculoskeletal and neuromuscular systems (flexibility, strength, balance, range of motion, motor control, etc.). One HHPT reported, "I work with all the caregivers to ensure they know to do range of motion and address the patient's postures in bed and in a chair". One HHPT, however, also reported using FCC to impact a patient's constipation, and another HHPT with addressing fears and anxieties with movement.

Activity limitations and participation restrictions were also reported as being addressed by each HHPT through FCC. For example, 1 HHPT stated, "it is important for [the caregiver] to be there to learn various things like how to assist with a stand-pivot transfer to a wheelchair." Others discussed the loss of familial roles as being fundamentally challenging. Older adult patients were often resistant to burden their loved ones with their care. Twelve of the HHPTs reported helping families at differing levels to find solutions to reducing their roles as caregivers.

Contextual factors were addressed with FCC as well. Both environmental and personal factors, were reported. Ten of the 14 HHPTs used FCC approaches to help motivate and educate caregivers and family members. In addition, all 14 of the HHPTs reported using FCC to help facilitate home modifications, obtain consents to care, and to schedule therapy visits.

ICF Conceptualization – "Theme 3: FCC Impacted by Contextual Factors

The final theme of "FCC Impacted by Contextual Factors" was represented by the subthemes "Environmental Factors" (not including the HHPT or IDT), and by the subtheme "Personal Factors" of the patient (income, education, attitudes, etc.). Although the second theme included contextual factors, this was done to represent how the HHPT used FCC to overcome contextual factors (like a home modifications). In this third theme, certain contextual factors were seen as impacting the use of FCC by the HHPT.

The contextual factor of family dynamics was consistently seen as a factor that impacts the use of FCC. For example, one HHPT reported, "family dynamics get in the way a lot." Another stated, "when there is buy-in, whether it's from the patient or from the family or the caregiver… just getting everyone present… sometimes is a challenge to figure out when everyone can work together." One HHPT stated, "I have seen situations where the caregivers neglecting their loved ones and they're just trying to get the money

from IHSS (in-home support services), or they're living in the home because they're living off the Social Security checks… and I know they don't care about the older adult". Another barrier to FCC was reported under the contextual factor of the Patient-Driven Groupings Model (PDGM). The was reported by 4 of the HHPTs. One of the HHPTs stated, "welcome to the wonderful world of PDGM… it's really challenging for the home health agencies and it's challenging for us as clinicians because we're having less and less time to be able to treat patients and train caregivers".

Other home health barriers included limitations on visit times by the home health agency (HHA), long commutes, and obtaining essential information prior to initiating HHPT care. One HHPT reported that they were, "limited on the actual amount of equipment I can bring into the patient's home." Another HHPT stated, "we have houses that are just so dirty or small that you can't or don't want to sit down". Another HHPT reported that patients with families with lower educational levels and poorer finances made it challenging to use FCC approaches. This same HHPT stated that these things limited what they could or would recommend in terms of home modifications and durable medical equipment. On a more positive side, 11 of the HHPTs reported that supportive caregivers allowed for more effective use of FCC. As one HHPT put it, "when there is the same family member or the same caregiver caring for that patient, then the follow through with my training is much easier and goes much better."

The main personal factors that affected the delivery of FCC by the HHPT included the patient's self-motivation and the patient's personal finances. For example, one HHPT stated, "sometimes you just come at a point where, you know, the older adults are just biding their time… they lack the self-motivation… you can try to draw on that, but if it's not really there, it's not there". Another HHPT reported that their patients with good finances could, "afford more expensive home modifications", private caregivers, and "ongoing therapy when Medicare benefits expire". One HHPT stated that, "if a patient doesn't have enough resources to continue care, that often becomes a problem with caregiver training."

DISCUSSION

The first theme "FCC is Complex" provided the research with a greater understanding of the different levels of FCC skills and knowledge between the HHPTs. This included the HHPTs' abilities to navigate interdisciplinary challenges and respond to different situations. This study echoes the literature for the need for FCC in the practice of FCC.[2,22,23] Family medicine was also explored in this study, and it was clear that no HHPT practiced direct access to others at home besides the patient. For rural areas, family medicine is recommended in the literature[24] and may improve efficiencies in home settings. [2,22] The second theme demonstrated that FCC approaches were used with every health factor in the ICF model. This study provides some evidence for the need to educate on how to best to apply FCC in practice. The third theme demonstrated that multiple contextual factors, like the Patient-Driven Groupings Model (PDGM), insurance authorization, and caregiver motivation have an impact on the effectiveness of FCC.

Limitations

This study was limited to a small group of HHPTs in one geographic area. In this regard, this study has limitations on generalizability (external validity). Still, according to the San Diego County Health and Human Services agency, San Diego County is diverse with ethnic groups, languages, income levels, and geography; it is the 5th most populous county.[25] Since the HHPTs were not visible to the lead researcher, this limited the lead researcher's ability to study their non-verbal communication. The lead researcher did not practice in home health but was a practicing physical therapist (PT). Five of the HHPTs had previous encounters with the lead researcher, as did the two expert reviewers. This may have influenced their responses despite efforts to mitigate this in the consent letter. Last, this study was limited in scope to HHPTs' perspectives and the home care setting.

CONCLUSIONS

This general qualitative inquiry provided deep understandings of how a group of HHPTs from San Diego County reported their knowledge and application of FCC with older adults and caregivers. This approach seemed that it may be most needed with neurological conditions and be most effective in the presence of positive contextual factors, such as, caregiver presence, financial support, and a positive attitude. In addition, this study provided insights into the many barriers that HHPTs may face when visiting the home of a patient and their family. These new understandings provided preliminary evidence for: (a) the need for additional visits with caregivers of care-dependent older adults; (b) the development of FCC best practices in home health physical therapy; and (c) additional research on the themes and subthemes described in this study.

REFERENCES

1. Capko J. The patient-centered movement. *J Med Pract Manage*. 2014;29(4):238.
2. Harvath TA, Mongoven JM, Bidwell JT, et al. Research priorities in family caregiving: process and outcomes of a conference on family-centered care across the trajectory of serious illness. *The Gerontologist.* 2020;60(Supplement_1):S5-S13.

3. Jette AM. From person-centered to family-centered health care. *Phys Ther*. 2017;97(2):157-158.
4. Petula S. Can applying systems theory improve quality in healthcare systems. *Journal for Healthcare Quality Web Exclusive.* 2005;27(6):W6-2.
5. Anderson BR. Improving health care by embracing systems theory. *J Thorac Cardiovasc Sur*g. 2016;152(2):593-594.
6. Flippo R, NeSmith E, Stark N, Joshua T, Hoehn M. Reduction of 30-day preventable pediatric readmission rates with post discharge phone calls utilizing a patient-and family-centered care approach. *J Pediatr Health Care*. 2015;29(6):492-500.
7. Russell LT, Beckmeyer JJ, Su-Russell C. Family-centered care and positive developmental outcomes for youth with special health care needs: Variations across family structures. *J Fam Nurs*. 2018;24(1):29-59.
8. Bastani F, Abadi TA, Haghani H. Effect of family-centered care on improving parental satisfaction and reducing readmission among premature infants: A randomized controlled trial. *J Clin Diagn Res*. 2015;9(1):SC04.
9. Zajicek-Farber ML, Lotrecchiano GR, Long TM, Farber JM. Parental perceptions of family centered care in medical homes of children with neurodevelopmental disabilities. *Matern Child Health J*. 2015;19(8):1744-1755.
10. Burke RE, Cumbler E, Coleman EA, Levy C. Post–acute care reform: implications and opportunities for hospitalists. *Journal of hospital medicine.* 2017;12(1):46-51.
11. Wang J, Boehm L, Mion LC. Intrinsic capacity in older hospitalized adults: implications for nursing practice. Geriatric nursing (New York, NY). 2017;38(4):359.
12. Jencks SF, Williams MV, Coleman EA. Rehospitalizations among patients in the Medicare fee-for-service program. *N Engl J Med*. 2009;360(14):1418-1428.
13. Fisher SR, Graham JE, Krishnan S, Ottenbacher KJ. Predictors of 30-Day Readmission Following Inpatient Rehabilitation for Patients at High Risk for Hospital Readmission. *Phys Ther*. 2016;96(1):62-70.
14. Wolff JL, Mulcahy J, Huang J, Roth DL, Covinsky K, Kasper JD. Family caregivers of older adults, 1999–2015: Trends in characteristics, circumstances, and role-related appraisal. *Gerontologist.* 2018;58(6):1021-103
15. Ankuda CK, Maust DT, Kabeto MU, McCammon RJ, Langa KM, Levine DA. Association between spousal caregiver well-being and care recipient healthcare expenditures. *J Am Geriatr Soc*. 2017;65(10):2220-2226.
16. Moore CL, Kaplan SL. A framework and resources for shared decision making: Opportunities for improved physical therapy outcomes. *Phys Ther*. 2018;98(12):1022-1036.
17. Steiner WA, Ryser L, Huber E, Uebelhart D, Aeschlimann A, Stucki G. Use of the ICF model as a clinical problem-solving tool in physical therapy and rehabilitation medicine. *Physical therapy.* 2002;82(11):1098-1107.
18. Mathews J. *Exploring Family-Centered Care from the Perspectives of Home-Health Physical Therapists*, Walden University; 2020.
19. Patton MQ. *Qualitative research & evaluation methods: Integrating theory and practice.* Sage; 2014.
20. Rubin HJ, Rubin IS. *Qualitative interviewing: The art of hearing data.* Sage; 2011.
21. Saldaña J. *The coding manual for qualitative researchers.* Sage; 2015.
22. Haines KJ. Engaging Families in Rehabilitation of People Who Are Critically Ill: An Underutilized Resource. Physical therapy. 2018;98(9):737-744.
23. Warner G, Stadnyk R. What is the Evidence and Context for Implementing Family-Centered Care for Older Adults? Physical & Occupational Therapy In Geriatrics. 2014;32(3):255-270.
24. Kumar P, Kumar R. Rural health scenario–role of family medicine: Academy of Family Physicians of India position paper. *Journal of family medicine and primary care.* 2018;7(6):1157.
25. County of San Diego, Health & Human Services Agency. Demographics. Accessed on October 6, 2022, from https://www.sandiegocounty.gov/hhsa/statistics_demographics.html

Appendix A: Interview Guide

Opening Phase
Hello and thank you for your willingness to participate in today's interview with me, Jim Mathews, a Ph.D. student at Walden University and a physical therapist. Thank you for agreeing to do this interview today and returning the informed consent. The information gathered today will be recorded and transcribed in confidence for the purposes of my dissertation alone. Your name and company will not be identified in this study and every effort will be made to keep your responses in complete confidence. This is a safe, private place and your responses will not be judged in any manner. Do I have your permission to proceed?
Introduction Phase

Purpose Statement
I would like to restate the purpose of this study. The purpose of this single-case study was to explore the perspectives of HHPTs on the delivery of FCC to older adults using a purposeful sample of HHPTs. This study will be used in my dissertation toward obtaining a Ph.D. in Health Care Administration with Walden University. Your participation is voluntary, and you may stop at any time. I will be recording the audio during today's meeting. Do you have any further questions before we proceed? I will start recording now. Now that we are recording, for the record, do you consent to participate in this study as previously explained? If so, please state, "I consent". Thank you!

Transition Phase
Demographic and Ice-Breaker Questions
I'd like to get to know a little bit about you before we plunge into the main questions.

1. How many years have you worked fulltime in home-health?
2. If you know, is your current home health agency for-profit or not-for-profit?
3. Are you currently working fulltime in home-health?
4. What percent of your workload is with older adults, i.e., adults over the age of 64?
5. Have you ever attended any training related to family-centered care delivery?
6. Do you have a GCS?
7. Are you familiar with the International Classification of Functioning, Disability, and Health Model, also known as the ICF model?
8. Do you have any questions?

Are you ready to proceed to the main questions related to FCC and older adults?

The Main Phase
KQ1: How would you define family-centered care with older-adults at home?
FCC Definition After HHPT Response
I would like to take a moment to define family-centered care as it relates to physical therapy services. Family-centered care, unlike patient-centered care, involves collaborating with families and caregivers. This collaboration occurs during the encounter with the older adults and includes family and caregivers training, family and caregiver PT interventions through direct access, family or caregiver's participation in interventions, and engaging in shared decision making with physical therapy services. Shared decision-making means that care decisions are shared between the patient and their family and the role of the PT is to provide informed choices.

Probe1: Do you have any questions about family-centered care with older adults?

KQ2: Can you please describe what situations and diagnoses would need family-centered care with older adults and their families at home? Family can mean caregivers, friends, and neighbors too.
KQ3: Can you think of who would want, or who would prefer family-centered approaches to care with older adult patients at home?
KQ4: Can you please describe a time when you have engaged in family-centered care with older adults and their families at home?
KQ5: Where in your plan-of-care or documentation can you address family-centered care approaches and interventions?
KQ6: Have you ever, or would you ever, treat a care-dependent older adult patient and treat a family member in pain simultaneously? If so, describe what you did or why you would. If not, why would you not treat someone simultaneously with their family?
KQ7: What factors, if any, would you describe as barriers, or challenges, to providing family-centered care to older adults at home?
KQ8: What factors would you describe as facilitators that allow you to provide family-centered care to older adults at home?

Closing Phase
That concludes my main questions, thank you. Do you have any questions or anything you would like to say now before we end?

I will be transcribing the audio recordings of these interviews to define some common themes related to delivering FCC with older adults at home. Please review the transcript for accuracy and send me any edits, and any additional information you would like to include. I will notify you in the next 2 weeks if any further action is needed beyond this. Do you have any questions?

Thank you for helping, feel free to contact me if you need any assistance.

Appendix B. NVivo Generated Themes