

Interdisciplinary PT Models in Home Care: A Collaborative Review

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Abstract: The shift toward providing physical therapy (PT) in home care settings has driven the development of interdisciplinary care models. These are models that coordinate various healthcare providers in taking care of the multiple needs of aging populations and chronic illness patients outside of any institutional setting. The review assesses the design, performance, and implementation issues of the interdisciplinary framework of physical therapy in the setting of home care. The article, using the current research literature, presents collaborative practices of physical therapists, occupational therapists, nurses, social workers, and speech-language pathologists. It has a focus on coordination of care, patient-centered outcomes, regulatory compliance, and evidence-based interventions. Further telehealth and other technological facilitators, like remote monitoring, which are facilitators of interdisciplinary delivery, are mentioned in the review. There are obstacles, such as role conflict, communication failures, and reimbursement discrepancies, that are mentioned. The article ends by stating the approaches that can be used to optimize collaborative PT models to improve patient outcomes and operating efficiency in the healthcare system.

Keywords: Interdisciplinary care, home health, physical therapy, collaborative models, geriatrics, chronic disease, integrated health.

INTRODUCTION

The importance of home-based physical therapy is growing among the aging and disabled populations and those people with mobility problems, who have a reduced ability to access outpatient rehabilitation. This is particularly crucial to people making a switch between the hospital and home environments. In this respect, interdisciplinary care models, which involve certain cooperation of professionals from diverse health practices, are becoming prominent due to the efficiency of such methods in facilitating rehabilitation. In contrast to the multidisciplinary models, where parallel, but independent, roles are concurrently present, interdisciplinary care stresses undifferentiated planning as well as shared decision-making. Physical therapists frequently work with nurses, occupational therapists, physical therapists, social workers, speech-language pathologists, and physicians in order to develop individual and goal-directed care plans (McElfish, P. A. *et al.*, 2018). Increased longevity and an increase in the number of chronic diseases result in the demand, which is also influenced by a demographic positive trend. The studies note the positive aspects such as reduced readmission, better patient satisfaction, and higher levels of functional autonomy (Kim, J. H. *et al.*, 2023). Despite the variety of home care systems between regions, some of the common needs are to have increased communication, protocol of care that is standardized and shared records. The attraction to decreasing healthcare costs with coordinated care has been further reinforced by such policies as the Medicare Home Health Prospective Payment System (Landers, S. *et al.*, 2016). Technology also has a great impact.

Technologies and tools such as electronic health records (EHRs), tele-rehabilitation platforms, and remote monitoring enable these teams to cooperate over long distances, thereby increasing continuity of care (Toussaint, P. J., & Coiera, E. 2005)

But it is not all smooth sailing. These are ambiguities in professional boundaries, unwieldy reimbursement, legal issues, and inadequate training of team practices. With a growing surge in value-based care providers, this becomes a more crucial issue to address. This review investigates the literature of interdisciplinary physical therapy in home care, including how teams are composed, care approaches, patient outcomes, increases in technology, and impediments to implementation. It can establish a direction to policymakers and practitioners so that more effective home rehabilitation services can be designed.

TEAM COMPOSITION AND PROFESSIONAL ROLES IN INTERDISCIPLINARY HOME CARE

Home care interdisciplinary physical therapy (PT) consists of the cooperation of different professionals of different specialties who work on common rehabilitation objectives. Physical therapists, occupational therapists, speech-language pathologists, nurses, social workers, and (in certain cases) psychologists or nutritionists make up the core team members. In physical therapists, mobility factors such as their strength, balance, and gait are examined to develop personalized strategies that foster functional independence (Resnik, L. J., & Allen, S. M. 2005). Occupational therapists work on activities of daily

living (ADL), which include grooming, meal prep, and home safety, and usually make recommendations on tools and adjustments (Wolf, T. J., Baum, C., & Connor, L. T. 2009). Speech-language pathologists become involved when there is a cognitive impairment or communication problems, as is often the case in the aftermath of strokes or neurodegenerative disorders, to address any speech problems, memory, and swallowing (Murray, L. L. 2012). The nurses observe vital signs, administer medicines, and reduce early signs of deterioration, whereas the nurse practitioners coordinate the medication (Williams, K. *et al.*, 2003). Social workers assess patients with psychosocial problems and refer them to resources that can resolve financial difficulty, caregiver stress, and lack of social interactions (Gaugler, J. E. *et al.*, 2005). Such professionals work on shared governance models that encourage joint decision-making, better coordination of care, and job satisfaction (Orchard, C. A. *et al.*, 2005). Such tools as unified care plans, team meetings, and interprofessional handoffs contribute to the clarification of the roles and facilitate collaboration. The directives concerning interprofessional education (IPE) have become a part of allied health education, developing understanding and respect among disciplines, communication, and problem-solving (Darlow, B. *et al.*, 2015). It has been proven that interdisciplinary teams at the home care level can reduce falls, improve mobility, and improve patient satisfaction. A special point to note is that these models have also been associated with a reduction in rehospitalization of medically complex older adults (Hughes, S. L. *et al.*, 2000; Conway, A. *et al.*, 2019).

CARE COORDINATION AND COMMUNICATION STRATEGIES

Interdisciplinary physical therapy (PT) requires coordination of care within the domiciliary setups. In the absence of structured communication and clear work processes, the multi-disciplinary input may be seen as disjointed, and the resulting duplication of work, failure to intervene, or differing results may prove detrimental, especially at home, where patients frequently have shifting needs along many specialties. The very first step of coordination starts with a thorough intake assessment in the initial visit to a home. Physical status, cognition, home environment, and caregiver support are regarded as an integrated appraisal to formulate one-set of treatment plan with aligned goals, interventions, and follow-up plans to all

participating disciplines (Dellefield, M. E. 2006). The advantage of Electronic Health Records (EHRs) is the way they improve communication, as they enable updates in real-time, shared notes, and risk alerts available to all providers. Common systems, such as Epic Home Health, where patients and providers use the same system, allow synchronizing care delivery, avoiding duplication of services, and helping make adjustments on time. Studies associate EHR-based coordination with a reduction in adverse events as well as increased clinician satisfaction (Kruse, C. S. *et al.*, 2018; O'Malley, A. S. *et al.*, 2010). Team huddles and case conferences are formats to reassess the progress of patients and to make changes. Official meetings can gather PTs, nurses, and care coordinators, whilst the handling of urgent cases is done through concise conversations, making the overall decision-making responsive and collective (Van Dongen, J. J. J. *et al.*, 2016). The use of standardized handoff tools such as SBAR and I-PASS can make transitions safer, particularly when a patient leaves a hospital, where failure of communication and delays in treatments decrease (Starmer, A. J. *et al.*, 2014). Telehealth provides on-time planning in the form of secure video conferencing and joint evaluations in environments with minimal physical access. PTs may work with other specialists remotely, e.g., during group assessment of post-stroke patients, and implement timely and synchronized changes that affect patient treatment (Wosik, J. *et al.*, 2020).

Documentation, scheduling, and service alignment are handled by a care coordinator who is a nurse in most cases. This role secures a chain of visitation of treatment, taking medication, and consistency of treatment. Coordination is associated with low rates of readmissions and a better functional outcome (Naylor, M. D. *et al.*, 2021; Albert, N. M. *et al.*, 2015). An important part of home care is family caregivers. They help out with the day-to-day activities and therapeutic exercises, and should be keenly aware. Oral verification in written form, visual presentation, and follow-up are crucial since the level of education of caregivers will strongly influence the safety and, hence, successful results of the rehabilitation of patients (Reinhard, S. C. *et al.*, 2008). However, those still exist, and these include inconsistent documentation, the unavailability of interoperable systems, poor training, and provider dispersion. Resolving such problems requires investments in shared technologies, continuing education, and promotion of collaborative care approaches.

CLINICAL EFFECTIVENESS AND OUTCOMES OF INTERDISCIPLINARY PT MODELS IN HOME CARE

There have been high levels of clinical efficacy in interdisciplinary physical therapy (PT) in home-based care models among varied patient populations. Unlike discipline-specific methods, integrated models have better results in terms of mobility, management of chronic conditions, cognitive responses, and health care usage. The first advantage is that there is improved functional recovery. The group efforts between PTs, occupational therapists, nurses, and speech-language pathologists led to an improvement in mobility more extensively and expeditiously. As an example, older adults who were receiving combined PT and nursing sessions improved on Timed Up and Go (TUG) tests by 20 percent faster than PT-only groups (Boland, L. *et al.*, 2017). The gait, balance, and fall risk are also enhanced by the use of such models that achieve uncoordinated intervention, such as strength training, environmental alteration, and medication evaluation (Sherrington, C. *et al.*, 2017). These models are of vital importance in the management of chronic disease in matters dealing with heart failure, COPD, Parkinson's disease, and diabetes. The PTs can improve endurance and mobility, whereas nurses can deal with medication and track the symptoms. In the care of Parkinson's, the combined collaboration of PTs, neurologists, and speech therapists minimizes the strain on the caregivers and helps the patients to last longer before they can live on their own (van der Marck, M. A. *et al.*, 2013). On the same note, patients with heart failure have achieved positive effects through concomitant PT-nurse contribution, such that there is improved control over fluid levels, an increase in the six-minute walk test results, and a reduction in readmission rates (Fonarow, G. C. *et*

al., 2007). There is improvement in cognitive and psychosocial outcomes, too. When dementia and stroke are involved, the combination of PT and cognitive therapy is a successful intervention that enhances memory, motor dysfunction, and integration of tasks (Cumming, T.B. *et al.*, 2013). The care given by mental health workers with PTs facilitates psychosocial health through strategies such as motivational interviewing and physical activation findings, decreasing depressive symptoms in homebound persons (Gitlin, L. N. *et al.*, 2010). Readmissions and emergency visits within hospitals are also reduced with the help of interdisciplinary monitoring. Earlier diagnosis and subsequent treatment lead to a lower 30-day readmission when compared to normal care rates of 17.8% and 23.4%, respectively (Coleman, E. A. *et al.*, 2005). The cooperation of PTs and nurses, which includes, e.g., blood pressure monitoring of dizziness-flagged patients, prevents emergency visits. Some groups gain impressively. Combined early wound care and early mobilization benefits post-surgery patients by increasing the speed of discharge and re-entry into the community. PTs who specialize in positioning and comfort collaborate with nurses dealing with symptoms, helping to increase dignity and minimize distress in palliative care (Casarett, D. 2008). The interdisciplinary PT models are more economical since they curtail the redundancy of services provided, enhance adherence, as well as shorten the length of hospital stay. Research indicates as much as \$1,500 dollars savings per care episode; a significant portion of those savings occurred due to a reduction in admission and higher recovery rates (Grabowski, D. C. *et al.*, 2007). The model favors not only clinical outcomes but also the sustainability of financial matters, in particular in aging groups with complex care.

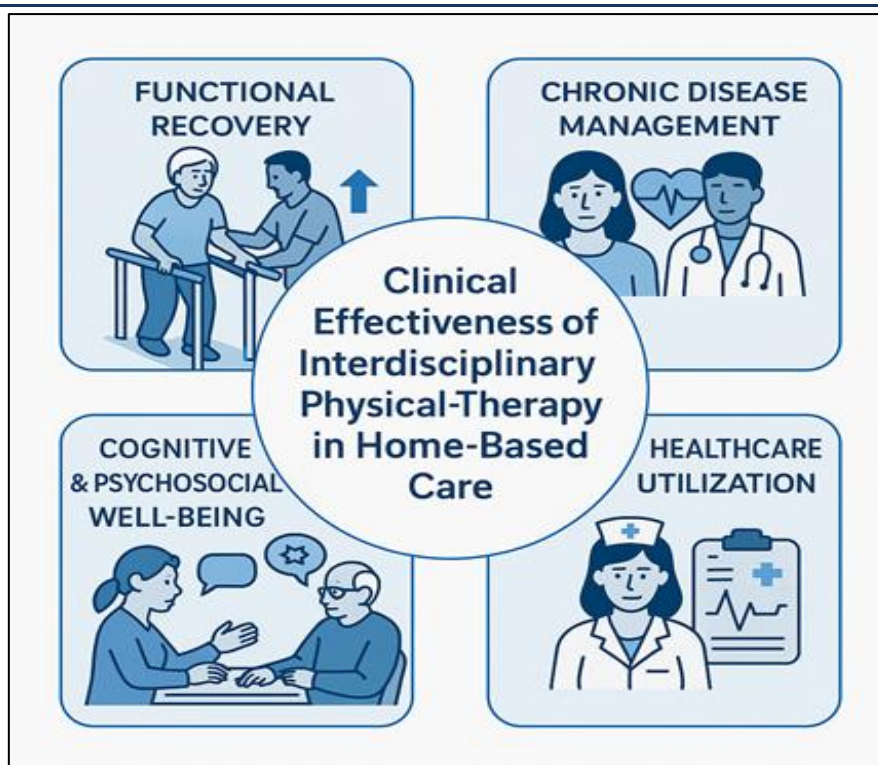


Figure 1: Clinical Impact Areas of Interdisciplinary Physical Therapy in Home-Based Care

Highlights key outcome domains: functional recovery, chronic disease management, psychosocial well-being, and reduced healthcare utilization achieved through collaborative home-based PT interventions.

TECHNOLOGY AND DIGITAL INTEGRATION IN INTERDISCIPLINARY MODELS

Interdisciplinary physical therapy (PT) in home care would transform due to digital technologies that will promote communication, remote monitoring, and data exchange, which increases patient engagement and the continuity of care. A healthy level of digital infrastructure has become the key to successful cooperation between medical workers. Integrated care relies on electronic health records (EHRs) so that PTs, physicians, and nurses can share treatment goals and edit care plans in real-time. EHRs diminish redundancy, enhance shared decision-making, and have proven to decrease medication mismatches by 28 percent and improve treatment planning by 35 percent (Yu, D. T. *et al.*, 2010). Telehealth also facilitates interdisciplinary care since it allows joint virtual sessions. As an example, mobility can be checked by therapists, adequate wound healing checked by nurses, and care delivered faster. Studies indicate that these models could produce similar results to

those of in-person therapy but without putting a burden on logistics (Totten, A. M. *et al.*, 2016). Remote patient monitoring (RPM) can improve hospital and patient safety and compliance via the transmission of real-time clinical data by such devices as accelerometers and glucose monitors. These aid in modifying the therapy about the variation in the status of the patient. According to one of the studies, coordinated RPM resulted in a 40 percent reduction of falls in people aged 65+ (Suthimon, M. T. *et al.*, 2021). CDSS enhances interdisciplinary care through issuing alerts and recommendations to resolve complex health issues that improve the consistency and safety of the treatment plan. Mobile applications and secure messaging tools also allow addressing team coordination, as all tools give a chance to communicate in real-time. Another app enhanced the experience of care and resolution of issues in the teams consisting of PTs, nurses, and case managers (Tan, J. *et al.*, 2020). Nevertheless, issues, such as interoperability gaps, digitally illiterate older adults, and mismatched platform design, continue to persist despite progress being made. Customization, training, and inclusivity design are vital when optimizing digital insertion in home-based interdisciplinary PT.

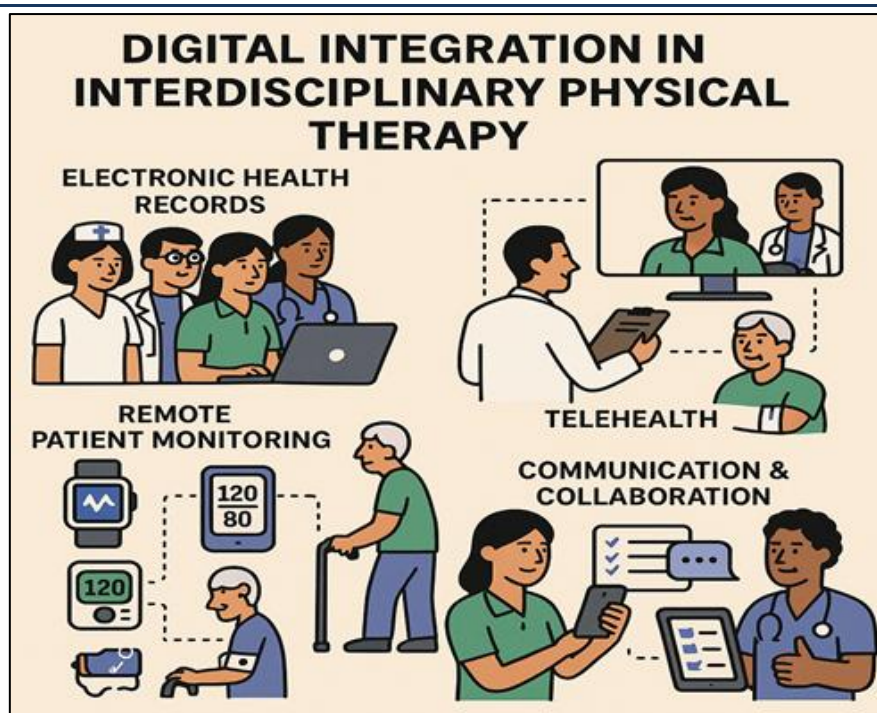


Figure 2: Digital Tools in Interdisciplinary Home-Based Physical Therapy

BARRIERS AND IMPLEMENTATION CHALLENGES IN INTERDISCIPLINARY PT MODELS

There are a number of systemic and operational issues during the implementation of interdisciplinary physical therapy (PT) models within home care. They are the discontinuity of service structure, professional role confusion, poor interdisciplinary training, financial and regulatory obstacles, technological inertia, cultural gaps, and issues of workforce sustainability. Some of the impediments include the fragmented pattern of home care, where bits and pieces of services are normally offered by uncoordinated agencies. That causes ineffective communication, unreliable documentation, and unnecessary redundancy, which, eventually, influences the overall quality of care and patient outcomes, especially during transitions between home and the hospital (Dellefield, M. E. *et al.*, 2015). Unless the roles are differentiated, role confusion or duplication of care is possible among the providers, especially between the PTs and occupational therapists, due to role ambiguity. Mutual respect and clearly defined responsibilities have to be considered to form valuable PT input in care planning, since hierarchical dynamics or the absence of mutual understanding can also result in a reduction of PT input in care planning.

Traditional education tends to isolate disciplines, and therefore, many clinicians do not get

interdisciplinary work training. Interprofessional simulations, shared clinical placements, and other programmes are useful in developing teamwork, communication, and shared decision-making capabilities (Reeves, S. *et al.*, 2011). Another obstacle is the financial structures. The existing types of reimbursement are predisposed to individual as opposed to unitary interventions; hence, there is a need to promote the incentive to integrated care provision, such as co-visits or coordination planning. Conversion into value-based payment may also help align collaborative practice incentives (Hussey, P. S. *et al.*, 2009). Collaborative practice is further hindered by regulatory constraints (such as different laws regarding licensing and privacy regulations, including HIPAA or GDPR). Laws tend to limit the way the information can be shared and which duties are assigned, which is why clearer policies and secure digital infrastructure are necessary. There is also the technological constraint. The home care industry has become very slow in adapting to modern technologies, and the patchy connection or lack of digital literacy, particularly among the older population groups, impedes virtual working. This is a concern that is worsened in low-resource or rural areas (Archambault, P. M. *et al.*, 2013). Resistance to change is widespread, and in most cases, staff may be against the adoption of team-based models because they fear the increased workload, loss of autonomy, or disbelief. Such frameworks as the Consolidated

Framework for Implementation Research (CFIR) may help manage change effectively and deal with resistance (Damschroder, L. J. *et al.*, 2009). Lastly, workforce capacity and leadership are conditions under which the sustainability of interdisciplinary care models is based. And shortages of PTs and other medical workers, not to mention turnover and burnout, could compromise long-term sustainability. To handle this, there is a need to

invest strategically to include training, flexibility in staffing, and assistance to healthcare workers.

To contextualize these challenges comprehensively, the following table outlines the core systemic and operational barriers faced in implementing interdisciplinary PT models in home care, along with their implications for patient-centered delivery.

Table 1: Systemic and Operational Challenges in Implementing Interdisciplinary PT Models in Home Care

Challenge Category	Underlying Issues	Implications for Home Care
Structural Fragmentation	Disparate service providers, siloed documentation systems	Delays in care transitions, poor continuity of therapy, and inefficiencies in service delivery
Role Ambiguity	Undefined scopes between PTs, OTs, and other disciplines	Overlapping responsibilities, reduced clarity in task delegation, and provider dissatisfaction
Educational Deficiencies	Limited exposure to interprofessional training during academic preparation	Reduced team effectiveness; lower collaborative confidence; skill gaps in joint decision-making
Financial Disincentives	Fee-for-service models that discourage joint activities and meetings	Underutilization of team visits, skewed reimbursement, and inequitable resource allocation
Regulatory Constraints	Varied licensing, data sharing restrictions, and jurisdictional rules	Legal barriers to role flexibility; limitations in shared electronic records; cross-provider misalignment
Technological Limitations	Obsolete software, inconsistent connectivity, and poor user training	Inhibited virtual coordination; reduced telehealth uptake; increased admin burden
Cultural Resistance	Organizational inertia, staff reluctance, perceived role threats	Hesitation to implement changes; perceived inefficiency of teamwork; resistance to interdisciplinary norms
Workforce Sustainability	Staff shortages, burnout, and turnover across home care disciplines	Disruption in team continuity; high onboarding costs; instability in long-term care planning

FUTURE DIRECTIONS AND INNOVATIONS IN INTERDISCIPLINARY PT HOME CARE

Digital innovation, transformations in roles, and in policy are transforming interdisciplinary physical therapy (PT) in home care in major ways. Technology is improving the way a team works and the patients, as aging populations continue to rely on home care. Mobile technology with video conferencing, secure messaging, shared electronic care plans, etc., now facilitates a wide range of communication between health professionals, increasing adherence and facilitating care (Bashshur, R. L. *et al.*, 2014). AI and machine learning are making their marks on care optimization through predictive data that indicates at-risk patients and refines the process of scheduling, leading to a shorter recovery period and more time-efficient rehabilitation (Jiang, X. *et al.*, 2020). Real-time and personalized therapy is also possible as wearables, smart sensors, and

activity trackers make it possible through constant monitoring of the same and input by caregivers, leading to the prevention of under- and over-treatment (Patel, M. S. *et al.*, 2015). There is an expansion in the role of the workforce, and more responsibility in assessment and coordination is addressed by the use of advanced practice providers. This will solve the shortage of providers and enhance continuity. One of the studies demonstrated that non-physician professionals who performed the role of leaders improved the care delivery at home (Bodenheimer, T., & Bauer, L. 2016). The financial models are changing to value-based and bundled care, where patient satisfaction and lower hospital readmissions are aligned to payer incentives. Such payment reforms are found to be effective in enhancing rehabilitation, proven by programs such as the CJR of Medicare (Navathe, A. S. *et al.*, 2017). Social prescribing has also become significant, connecting patients with community and access to such opportunities as exercise groups and

transportation, and helping to define the social determinants and engage in recovery (Bickerdike, L. *et al.*, 2017). Finally, standardised care models, such as role definitions and outcome measures, are progressing to aid in consistency, evaluation, and comparisons to international benchmarks, such as with the aid of tools, such as the InterRAI assessment, to compare quality (Foebel, A. D. *et al.*, 2015).

CONCLUSION

The models of interdisciplinary physical therapy in home care are a paradigm shift to more coordinated, responsive, and patient-centered rehabilitation. These models provide a more efficient way to approach the complex needs of patients in their familiar settings by integrating physical therapists, nurses, sociologists, and occupational therapists with other health professionals. Even as such challenges as structural fragmentation, role ambiguity, and constraints on reimbursement still prevail, developments in digital health, artificial intelligence, policy, and training are preparing the ground toward scalable and sustainable interdisciplinary models. What Home Rehabilitation of the Future holds is the eventual acceptance of these collaboration-viewpoints; the development of systems that do not merely bring back levels of mobility, but those that maintain independence, dignity, and quality of life among aging citizenry.

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Source of support: Nil; **Conflict of interest:** Nil.

Cite this article as:

Nathani, P. "Interdisciplinary PT Models in Home Care: A Collaborative Review." *Sarcouncil journal of Medical sciences* 4.10 (2025): pp 53-61.