CLINICAL AND FINANCIAL EVALUATION OF A HOSPITAL BASED HOME HEALTH CARE DEPARTMENT

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Home health care agencies are currently under major scrutiny by the federal government to detect fradulent practices against Medicare. In order for agencies to be certified for Medicare reimbursement, they must meet Medicare Condtions of Participation. The purpose of this evaluation was to conduct the annual review of the M&M Home Health Care Agency.

Overall, the agency was found to be in compliance with Medicare regulations. Great strengths of the agency are its clinical care givers who provide services to home bound patients, its tight financial controls, and its integrity and focus on compliance with federal and state regulations. However, there were areas the agency must improve upon, especially in light of the dramatic changes in reimbursement, to remain financially viable. Areas for improvement include human resource functions, implementation of a clinical documentation information system, and improved admininistrative functions with customers and staff.

A special area of emphasis in this evaluation was the development of a patient satisfaction survey for the agency which will replace its existing measurement tool. This pilot project identified the need to incorporate a variety of methods to evaluate patient satisfaction other than a written survey such as telephone surveys and focus groups. Areas that offer potential for improvement include the answering service, administrative processes, and service delivery to patients who live with family members.

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Abstract

Home health care agencies are currently under major scrutiny by the federal government under Operation Restore Trust (ORT) and other government initiatives to detect fraudulent practices against Medicare. In order for agencies to be certified for Medicare reimbursement they must meet Medicare Conditions of Participation. Hospital-based home health care agencies are also required to be accredited by the Joint Commission Accreditation of Healthcare Organizations (JCAHO), if their parent hospital is accredited. The purpose of this Graduate Management Project (GMP) was to conduct the annual evaluation of the M&M Home Health Care Agency required for Medicare Certification and reimbursement and of JCAHO requirements.

Overall, the M&M agency was found to be in compliance with Medicare Conditions of Participation. Great strengths of the agency are its clinical caregivers who provide services to patients, tight financial controls, and its integrity and focus on compliance with federal and state regulations. However, there were areas that the agency must improve upon, especially in light of the dramatic changes in reimbursement, to remain a financially viable operation. These areas include improvement in its human resource functions, implementation of a clinical documentation system and effective information management, and improved administrative functions with customers and staff.

A special area of emphasis in this evaluation was the development of a patient satisfaction survey for the agency, to replace the existing measurement tool. This pilot project identified the need to incorporate a variety of methods to evaluate patient satisfaction other than a written survey such as telephone surveys and focus groups. Areas that should be targeted for agency improvement include the answering service, administrative processes and service delivery to patients who live with family members.

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Introduction

Home health care agencies have found themselves experiencing a paradigm leap rather than the paradigm shift that many industries accomplished in the early 1990's. Home health care is one of health care's cottage industries with approximately 18,000 agencies (almost 10,000 certified to treat Medicare patients). This is an increase from 11,000 agencies in 1990. The rapid proliferation in home health care is due to the passage by Congress of the hospital-based prospective payment system and continued growth of managed care that has pushed hospitals to cut costs to remain competitive. Hospitals rushed into the home care industry as the prospective payment system forced them to discharge patients earlier, Medicare coverage expanded, more sophisticated care could be delivered in the home, and cost-based payments became lucrative. Benchmarking, outcome management, and critical pathways are now important components of patient care planning. A prospective payment system looms on the horizon for home care in 1999. The state and federal governments are imposing new regulations. In order for a home health care agency to qualify for reimbursement through Medicare, they must meet Medicare Conditions of Participation. Certification is imperative because Medicare is the biggest single payer of home health care, accounting for thirty-eight percent of all home care spending in 1992. Once certified, the Medicare-certified home health agency (HHA) is required to conduct an operational evaluation of the agency's program at least once a year. The evaluation consists of a complete policy review, administrative review, and a clinical record review. The evaluation process assesses the extent to which the agency's program is appropriate, adequate, effective, and efficient. A major issue facing HHAs is the tougher anti-fraud and -abuse measures currently being directed by the federal government for Medicare under Operation Restore Trust (ORT). The federal government decided to spotlight the home care industry because of its rapid growth

and the perception of widespread fraud in the industry. The likelihood of Medicare fraud investigators auditing HHAs has increased dramatically. Hospital-based home health care agencies are also required to be accredited by the Joint Commission Accreditation of Healthcare Organizations (JCAHO), if their parent hospital is accredited. This research project will evaluate a hospital-based HHA, M&M Home Health Care Agency, to ensure that Medicare and JCAHO regulations are being met, and that the HHA is in compliance with appropriate billing requirements.

Background

M&M Home Health Care Agency (M&M) is an integrated home health care organization, hospital-based in a southeastern Virginia hospital. Several large cities, multiple military facilities, and a diverse population of multidisciplinary-cultural and multiple socioeconomic levels surround M&M. The agency delivers 34,000 patient visits annually. The organizational mission is "to be the premier provider of home care services and to be responsible to its community and changing needs." The core competencies of M&M are:

Infusion Therapy
Hospice
Maternal Child Home Health
Private Nursing
Rehabilitative Services

See Appendix A to review the organization chart for the M&M Home Health Agency.

Conditions Prompting the Study

By law, Medicare regulations require certified home health agencies to evaluate their programs annually. Such an evaluation process tests the researcher's skills in an area with increasing importance in the health care market as the population ages. In August 1996, M&M's hospital implemented performance improvement (PI) teams as part of its strategic plan. The

plan, known as "Vision 2000," focused improvement efforts on high cost diagnosis-related groups (DRGs). Respiratory, Oncology, Cardiology, Stroke, and Joint Replacement teams were formed. Consultants recommended that PI teams target patient discharge disposition pre-operatively, evaluating and increasing utilization of home care services to decrease average length of stay (ALOS). JCAHO is interested in the patient continuum of care from the acute setting to the subacute setting to assure patient continuity and quality of care. M&M strategically instituted a method to measure patient functional status improvement two years ago, called the functional independence measure (FIM), on all patients by all disciplines. Unfortunately, FIM's are not available on patients discharged from the acute hospital setting to M&M. Accordingly, patient functional status improvement cannot be measured across the continuum of care. Furthermore, standardization of training or Credentialing for all professionals measuring FIM's has not occurred. The validation of the FIM's in this agency is necessary if it is to be used as an outcome measurement. The parent hospital of M&M is currently evaluating two outcome measurement databases for purchase that will provide patient outcome data on the continuum. Once a system is chosen, it will provide an objective evaluation and opportunities to benchmark with other health care systems.

M&M has been fortunate to have the opportunity to enroll in two benchmarking projects by Premier Health Alliance (Premier). Premier is the largest health care alliance enterprise in the United States with over 230 owner systems. Premier resulted from a merger of Premier Health Alliance and SunHealth Alliance of Charlotte, North Carolina. The 1995-1996 project was the first home care benchmarking project conducted by Premier.

In September 1995, Premier initiated the benchmark process with twenty-three agencies in thirteen states, focusing on the admission and discharge process. The direction of the first project was to define benchmarking as a tool for the home care data collector to determine the

critical success factors which contribute to a well-run agency. The survey included the following: approximate visit time; average number of visits per patient; approximate ratio of staff to visits; control of mileage; control of supply usage; staff appropriately following orders and minimum amount of time to follow the standards of care for the admission process; accurate data in the medical record; and minimum amount of time to initiate patient care. After several meetings and a review of the survey results, the steering committee determined the "best practices" as identified by the participating agencies. Best practices included the following:

1) Using dedicated staff to handle admissions.

2) Obtaining as much demographic and admissions information as possible prior to the admission.

3) Minimizing the number of forms required.

4) Randomly conducting audits of the medical and financial records.

5) Using one person to negotiate and track visits for each payer.

Of the twenty-eight practices identified, M&M was already actively following seventeen practices. Of the remaining eleven practices, two were deemed not appropriate for implementation due to the agency size and staffing (Zell, 1997).

Feedback from the first project, as well as the enormous interest in the continuing benchmark activities, resulted in the development of a second benchmarking project that focused on best operational and clinical practices in home care programs. The project scope was to determine the cost and outcome of providing home care to patients with any of the following International Classification of Diseases, 9th Revision (ICD9), Clinical Modification codes as their primary diagnosis: 401, 402, 410, 411, 412, 413, 414, 416, 420, 421, 422, 424, 425, 426, 427, 428, and 429. These diagnosis codes are from the major diagnostic category "circulatory diseases." Because home care does not have the sophisticated patient severity adjustment

methodologies that health systems have developed, using the ICD9 codes was an attempt to control for patient severity. The goals of the second project included:

1) Identification of clinical and operational information technology, and identification of staffing practices that are critical to a successful home care operation.

2) Discerning the best practices that will lower cost and increase patient quality of care while reducing time spent on each patient encounter.

At the completion of the second project, a benchmark summary was compiled and an implementation conference was held to present benchmark activities and exchange ideas. M&M was selected as one of six agencies to present "best practices," and was identified as having the best demonstrated practices for: total labor cost per patient; average number of visits per patient; percentage of patients with an emergency room visit; percentage of patients discharged to self; and percentage of patients who met goals. M&M was recognized as a lower cost, high quality operation.

This project created a pool of potential benchmark partners for the M&M agency to continue the performance improvement process. Data were collected from twenty-three agencies on the following criteria:

1) Age of agency
2) Hospital affiliation
3) Accreditation status
4) Services provided by the agency
5) Number of visits
6) Staff mix
7) Gross revenue.

With this demographic information, agencies could be selected that were similar so further benchmarking could be accomplished.

Patient and provider satisfaction was an area not addressed in the benchmarking projects. Each agency had different satisfaction surveys to measure customer satisfaction; therefore meaningful comparisons were precluded between agencies. The director of M&M was not satisfied with the home care surveys being utilized to measure patient and physician satisfaction, and she expressed a desire for enhanced surveys. After contacting similar HHAs and obtaining their patient satisfaction surveys, the director of M&M was not receptive to using any of their surveys either. Therefore, the patient and physician satisfaction surveys were to be revised with experts from M&M.

Statement of the Problem

M&M and its hospital were recently accredited by JCAHO for three years. As of July 1993, Joint Commission began to conduct unannounced mid-cycle surveys of a five-percent sample of accredited organizations. This evaluation will also serve to document M&M's ongoing efforts to continuously improve performance in the event of an unannounced survey, and to fulfill the annual Medicare certification requirement for program evaluation. This evaluation will establish patient and provider satisfaction measurement tools to identify problems for the agency. Patient and provider satisfaction data can be used in marketing initiatives for both payers and other purchasers of health care services. Little data are available on patient and provider satisfaction in the home care arena.

Review of the Literature

Program evaluation measures effectiveness of operations, which is a major concern of home health agencies. It is used to measure the status quo and to project future changes and anticipated agency responses. Evaluation areas are copious and can be unending. However, investigative areas must be chosen according to their effect on patients, home health care agency management staff, and the community served by the agency (Harris and Yuan, 1987).

In general, program evaluation is designed to assess appropriateness, effectiveness, and efficiency of an agency. Frequently, forces that are outside their control affect the agency. These forces may include the climate of the industry, the population served by the agency, rules and regulations, and third party payers (Ruane and Ruane, 1997).

The climate of the home care industry is affected by numerous factors. Because home health care agencies have proliferated rapidly since the 1970's, this has placed home care agencies in adversarial relationships with each other. This climate strongly encourages agencies to complete the evaluation process. Evaluation becomes a necessity due to the increasing requirement for this information in managed care contracting, and the ever-changing economic forecast and future trends of the industry (Ruane and Ruane, 1997).

Compliance Issues

As the fastest growing segment of the Medicare program, the home health industry has been targeted for fraud and abuse. A recent report by the Health & Human Services (HHS) Inspector General (IG) on home health agencies revealed that, in four of the five states reviewed by the IG as part of Operation Restore Trust (ORT), forty percent of Medicare payments for home health should not have been remitted. Stamping out fraud and abuse has been a top

priority of the Clinton Administration. President Clinton assigned HHS to investigate the industry.

California, as part of an Operation Restore Trust state-wide outreach, designed a method to target Medicare certified agencies using 1994 and 1995 reimbursement data (Dymon, 1998). The forty-four agencies targeted for Medicare certification compliance audit were those that had the most rapid growth in dollar-per-patient reimbursement and overall Medicare dollars reimbursed. The study identified an overwhelming number of agencies that delivered substandard care. Eighty-one percent of the agencies surveyed had at least one Medicare Condition of Participation not within standards of compliance. Fourteen percent of these agencies were terminated with "Immediate Jeopardy" identified and with multiple Conditions of Participation not within standards of compliance. Some of the areas of non-compliance identified were:

- Thirty agencies failed to maintain a clinical record in accordance with accepted standards of participation.
- Seven agencies operated branch offices without formal notice to the state or HCFA.
- Fourteen agencies failed to designate a group of professional personnel that met compliance standards for the professional discipline component.

The study showed a correlation between the quality of care and the amount of Medicare dollars reimbursed per patient. Eight of the top agencies in the twenty-five percent highest average reimbursement per patient were terminated for substandard care. The California study found that using cost per patient reimbursement was a reliable indicator for questioning the quality of care delivery.

According to experts, several key areas should be addressed in HHA's Corporate Compliance Programs (CCPs):

- Policies for patient referrals-if the HHA is owned by the hospital, there is a written commitment to comply with anti-self-referral laws.
- Training and support for nurses to identify the truly homebound patient.
- Written policies to monitor frequency of treatment, duration of care, and plans of care.
- Claims submissions and cost reporting.
- Quality of care: establish and monitor procedures to check all levels of care; examine procedures for documenting and reporting missed visits.

As part of the anti-fraud efforts, HHS's Office of the Inspector General plans to release a model compliance plan for HHAs in 1998 (Corporate Compliance for Home Care: A Special Report, 1997). The term "compliance" refers to an organization's record of complying with statutes and regulations. Compliance programs are designed to demonstrate to government authorities that HHAs have made a commitment to adhere to all relevant laws as a matter of practice. HHAs can look to the Federal Sentencing Guidelines as the basis for corporate compliance programs. A CCP that conforms to the criteria in the United States Sentencing Guidelines for Organizations establishes a strong basis for minimizing any penalties, should a violation occur (Health Law Update, 1998). There are seven guideline components for Compliance Models:

- Compliance standards and procedures: written policies and procedures are developed regarding the submission of Medicare claims to ensure the agency is meeting regulatory requirements of The False Claims Act, The Stark self-referral laws, and Medicare's Conditions of Participation.

- Corporate Compliance Officer: this position will have oversight responsibility for the training of employees and correction of compliance problems.
- Human Resource functions: Insuring that background checks are accomplished during the hiring process.
- Employee training: teaching employees standards and procedures of relevant laws and the organization's CCP.
- Monitoring: auditing the CCP regularly to ensure it is effective.
- Enforcement and discipline: Policies are written defining how the organization will handle breaches in compliance policy.
- Response and prevention: develop a program to respond to violations and to prevent similar offenses from occurring.

Interim Payment System

The Balanced Budget Act of 1997 (BBA) dramatically reshaped the reimbursement structure of the Medicare home health care benefit (Suther, 1997). This legislation retained the cost-based reimbursement for agencies, but changed the way they are reimbursed. The interim payment system (IPS) will remain in effect until a new prospective payment system (PPS) is implemented for cost reporting, on or after October 1999. Under IPS, home health will be paid the lowest of: (1) their actual, reasonable costs; (2) the per-visit cost limits; or (3) a new blended agency-specific per-beneficiary annual limit, applied in the aggregate to the agency's unduplicated census count of Medicare patients.

The IPS reduces cost limits in two ways. Cost limits will be calculated based on 105% of the median per visit costs of freestanding home health agencies, rather than the previous method of 112% of the mean. Furthermore, the new cost limits will not take into account the "market

basket price increases" that occurred between July 1, 1994 and June 30, 1996. The combined effect of these two provisions results in cost limits that are 15% lower than otherwise expected. The reductions in skilled nursing and home health aide reimbursement limits are projected to decrease by 14% in both urban and rural locations.

HHAs will have to drastically modify their behavior to survive under the new reimbursement environment. The National Association for Home Care estimates that seventy-five percent of HHAs in operation will exceed the new cost limits if their operating practices remain unchanged. To be viable under IPS, HHAs will need to lower both unit costs and the utilization of services per patient.

The BBA also contained a number of anti-fraud provisions directed specifically at home health providers:

1. Payment of services will be based on where the service is provided, i.e., at the patient's home, not where the agency is located.
2. Surety bonds and disclosure of ownership interest: this provision requires HHAs to post a minimum bond of $50,000 to participate in the Medicare program.
3. Normative standards for home health claims: this provision authorizes Health and Human Services to establish guidelines for the frequency and duration of home health services.
4. Venipuncture: this provision revises the definition of skilled home health services to exclude venipuncture from the eligibility requirement for intermittent skilled nursing services.

Evaluation Models

An evaluation model is selected to assure a well-organized assessment plan. Most agencies use summative evaluations. Summative evaluations focus on assessing the achievement of goals and objectives of the program. There are four models commonly used in the evaluation of home health agencies: Systems model; Structure-Process-Outcome model; Goal Attainment model; and Planned versus Actual Performance model (Ruane and Ruane, 1997). Donabedian's (1978) Structure-Process-Outcome model was designed primarily for medical care and is one of the most popular methods for evaluation (Ruane and Ruane, 1997). It is sufficiently broad in nature to be applicable to home health care. Outcome in this case primarily refers to the attainment of a goal for patient recovery.

Due to the increasing focus on the importance of the evaluation process, many agencies have gone beyond the minimum requirements dictated by Medicare. Many agencies utilize the accreditation services of the National League for Nursing through its Community Health Accreditation Program (CHAP) or the Joint Commission on Accreditation of Healthcare Organizations (Ruane and Ruane, 1997). M&M is a hospital-based home health agency and is Joint Commission-accredited. Therefore, this project focuses on Joint Commission requirements (Comprehensive Accreditation Manual for Home Care, 1997-1998) and Medicare mandates (Department of Health and Human Services, August 1989, July 1991, September 1991). Medicare criteria for program evaluation require the assessment of organizational structure and process. Joint Commission has expanded its scope of evaluation to include standards that include patient satisfaction on the patient continuum of care from the acute to the subacute setting. "Hospitals are no longer looking at home health care as moneymaking, but rather as

providing that continuum of care that is critical," according to Carol Schaffer, CEO of Health Care Ventures, a wholly owned subsidiary of the Cleveland Clinic Foundation (Cerne, 1993).

The survey and accreditation decision processes are based on an organization's demonstration of compliance with the standards in the 1997-1998 Comprehensive Accreditation Manual for Home Care (CAMHC, Joint Commission, 1996). The standards manual is divided into two sections. Section One consists of five chapters that center on an organization's important patient focused functions. Section Two focuses on important organizational functions that support how patient care is delivered. The key areas of importance include:

- Rights and Ethics
- Patient Assessment
- Patient Care, Treatment, and Service
- Patient and Family Education
- Continuum of Care
- Improving Organizational Performance
- Leadership
- Environmental Safety and Equipment
- Management of Human Resources
- Management of Information
- Surveillance, Prevention, and Control of Infection

According to the most recent JCAHO statistics for surveys (Briefings on JCAHO--October 1997) conducted during the first six-months of 1997 at 534 home health agencies, the most serious deficiencies (type I listing) were:

1) The organization obtains, reviews, and revises a physician's or other authorized individual's orders, when applicable.

2) The organization identifies patients who are at nutritional risk.

3) The patient has a right to make informed decisions regarding care or services.

4) The organization implements actions and interventions as identified in the care planning process.

5) The patient has a right to create an advanced directive.

6) Caregivers safely and accurately administer medications, blood, and blood components.

7) The patient is involved in decisions to forgo or withdraw life-sustaining care.

8) The organization controls and accounts for the use of medications in the clinical staff's possession, when law and regulation permit dispersion.

9) The organization's policy and procedures address the physicians' responsibilities to manage medical care and services for their patients.

10) The organization informs physicians of these policies and procedures.

The agency's performance and services provided are affected by a number of factors (Clement, Wan, Stegall, 1995). First, the population served directs the types of services to be provided. The demographics, health status, health needs, and socioeconomic status of the people served will all influence the type and amount of services required by the community. Second, rules and regulations mandated by legislation and third party payers have the greatest influence on program evaluation. These standards are used to determine the agency's acceptability for reimbursement. Third, internal influences that result from the agency's philosophy and goals, the quality of its staff, management expertise, and its system of managing all patient information within the agency, have a definite effect on agency performance (Ruane and Ruane, 1997).

In order to successfully market home health care to physicians, managed care companies, payers, and consumers, the "deal is in the data" (Managed Home Care, April 1997). It is not only imperative to have a program that works, but it is also necessary to be able to generate statistics that support assertions that the agency will generate overall savings for the payer. Impressive outcome data collection and marketing prowess work together to ensure the success of a home care agency. To accomplish this goal, many agencies are developing disease management programs. These programs can be targeted for cost reductions, enhanced patient outcomes, and then marketed to payers.

Patient Satisfaction Data

Studies have shown that ninety-six percent of dissatisfied customers never voluntarily complain. Many companies, from small operations to Fortune 100 companies, however, rely on satisfaction surveys to measure customer satisfaction. Compounding the problems are the questionable reliability of the customer satisfaction tools (Duket, 1997). One suggested scale that provides relevant meaning and gives information to the organization on the possible impact upon customer loyalty is:

TABLE 1. Customer Satisfaction Scale

Grade	Name	Definition
A	Outstanding	Highest achievement
B	Good	Making an effort
C	Marginal	Barely getting by
D	Poor	Falling short
F	Failing	Totally lacking

Companies should realize that customer satisfaction ratings can be easily biased (Duket, 1997). Patient satisfaction is a measure in quality of patient care. Though difficult to quantify, patient satisfaction is an aspect of care that is evaluated by the Joint Commission of Accreditation of Health Care Organizations (Pelech, 1998).

The American Hospital Association (AHA) and the Picker Institute have joined forces to gather information about consumer satisfaction with health care (American Hospital Association and the Picker Institute, 1996). The Picker Institute analyzed focus groups and surveys conducted by the AHA to explore public perceptions of health care. Several consistent themes emerged from their research:

- The public has serious concerns about the future of health care; these concerns are centered in their personal experiences.
- Patients' experiences reveal important problems with the methodology of the health system and the decision process regarding matters of their care.

Patients gave high marks to health care systems when doctors, nurses, and medical staff treated them courteously, when they were treated with respect, and when their basic needs were met. Patients gave low marks to health systems that were difficult to navigate, when caregivers did not provide enough information, when they were not involved in decision-making, and when caregivers were not emotionally supportive. AHA focus groups revealed that patients wanted to be involved in their care. Among the Picker survey questions that correlated most strongly with patients' overall rating for care were those focusing on patients' involvement in the decision-making process.

Patient Outcome Data

Patient outcome data is an increasingly important component of the evaluation of the HHA. The Health Care Financing Organization (HCFA) is developing quality indicators (QI) for home health care that will mirror changes in functional and health status. In preliminary surveys, HCFA will use the quality indicators to direct the frequency of agency surveys and to focus on the areas in need of the greatest amount of improvement. After the indicators have been used in program evaluation for sufficient time to demonstrate reliability and validity, HCFA will be able to give agencies objective data on how their performance compares to other agencies. HCFA is refocusing from the structures and processes of health care to patient outcomes and strategies to improve them (Gagel, 1995). Shaughnessy and Crisler (1995) define patient outcomes as a change in patient health status between two or more time points. They describe three types of outcomes:

1) End-Result Outcome is a change in patient health status between two or more time points.

2) Intermediate-Result Outcome is a change in a patient's or caregiver's behavior, emotions, or knowledge that can influence the patient's end-result outcomes.

3) Utilization Outcome is a type of health care utilization that reflects a change in health status over time.

Examples of this type of data include admissions to emergency care, skilled nursing facility, or the hospital. These authors refer to global outcomes that pertain to all patients (analysis of hospitalization rates for all patients admitted to a home care agency for a given year) or a functional assessment outcome such as change in ambulation ability for orthopedic patients. Sophisticated purchasers of health care are beginning to ask hospitals and health plans to provide measures of patients' physical and emotional health status following treatment (Hansen, 1997).

Patient Classification Outcome Criteria System

Administrators of home care were interested in identifying and developing patient classification surveys as early as the 1970's (Daubert, 1997). With increasing frequency, consumers, federal and state legislators, and third party payers are asking for reliable data that home care makes a difference in a patient's health status. This need resulted in the development of an outcome measurement module. Designing this system was difficult because of two problems identified by Aydelotte (1973). First, it is difficult to describe the effects of care that the agency hopes to achieve, and there are problems identifying the specific populations that the agency serves. Second, five of the six traditional providers in home care services are independent disciplines that function autonomously in the patient situation. Measures of each of these disciplines are separate and distinct. The sixth provider of home care, the home health aide, is neither independent nor autonomous because these aides serve as an extension of nursing, physical therapy, or other therapies. This causes the final goal of outcome measurement and the actual functioning of the patient at discharge to be more difficult to measure. For this reason, it is not feasible for an agency to use outcome criteria according to each discipline employed.

It is also ineffective and impractical to use patient diagnosis for developing outcome criteria (Daubert, 1997). Patients referred to home care agencies have multiple diagnoses, and this makes diagnosis criteria for outcome measurement unwieldy. Following such a system would require that multiple sets of outcome criteria be applied for each individual patient situation. Aggregate data would be unattainable.

Benchmarking

Spendolini (1992) defined benchmarking as a "continuous systematic process for evaluating the products, services and work processes of organizations that are recognized as representing best practices for the purpose of organizational improvement." Health care organizations can benchmark locally, nationally, or through networks such as a formal system or alliance. Many health systems' home care agencies have implemented benchmarking programs as a means of developing services that are more effective and cost-efficient (HCIA Report, October 1996). Benchmarking data for home care are often recorded manually. Criteria benchmarked include the following: mileage per patient; number of visits per patient; revenue per patient; and services provided. According to HCIA, home health agencies have yet to institute major changes due to benchmarking. Instead, the information obtained has been used to focus on areas in need of performance improvement. The need to obtain data that reveal discrete costs and correlate those costs with functional outcome measurement increases on a daily basis in home care (Managed Home Care, May 1997). While hospitals have developed sophisticated, disciplined data capture systems, home care agencies have not. According to Davis Baker, Corporate Director of Home Care services for St. Frances, Inc., Columbus, Ohio, there is no standard format for comparing one agency with other agencies. Baker further laments that one of the greatest barriers to data comparison is the variety of ways systems capture costs in their accounting systems. Another roadblock is the reluctance of agencies to share data. Baker is developing a scientific, credible data base that will have meaningful data submitted by a cross-section of the industry. The development of this database is a collaborative effort between the participating agencies and the Healthcare Management Council (HMC). The goal of the HMC is to help health care agencies examine "apple-to-apple" comparisons so they can improve performance.

Much work is still needed in this area defining operational definitions. Benchmarking in home health care is still in its infancy. It is crucial that benchmarking initiatives be well planned to isolate best practices. The steps outlined by the benchmarking network include: developing senior management commitment; developing a mission statement; performing research; identifying benchmark partners; developing measures; developing and administering questionnaires; scrubbing and analyzing data; isolating best practices; conducting site interviews; and presenting findings and monitoring results (Czarnecki, 1995). The Medical Quality Management Source Book (1998) recommends possible benchmarking partners be identified with an alliance or corporation of which the hospital is a member. This route may lower resistance to sharing ideas and provide a less expensive source of benchmark data than using consultants. Once the network is established, increased communication between agencies may facilitate further benchmarking and organization performance improvement.

Because home health care services have proliferated so rapidly, it is especially important for HHAs in the same market to develop strategies to retain and increase market share. Access to comparison data on patient satisfaction and patient outcome measurements from HHA is difficult to obtain (Managed Home Care, February 1998). MR&A is a local market research company, and it has contracts with two of M&M's competitors that are currently benchmarking patient satisfaction. Through an agreement between the two organizations, MR&A is able to provide these agencies with comparative data regarding patient satisfaction. M&M's health system is currently engaging MR&A's services to provide telephonic patient satisfaction surveys to a representative sample of hospital patient discharges. An agreement has been reached between the health systems in this market to benchmark patient satisfaction (Pelech, 1998).

Purpose

The purpose of this Graduate Management Project is to complete an annual financial and clinical program evaluation of M&M, and to assess the extent to which the program provides patient care that is appropriate, adequate, efficient, and cost-effective, and to identify areas requiring improvement. This evaluation will be accomplished by assessing the Joint Commission accreditation report of January 1997 to determine what areas were targeted for improvement. Next, a determination will be made of progress toward continuous quality improvement in identified problem areas. Further, M&M's policies and procedures will be evaluated for compliance with Medicare Conditions of Participation. With agency experts determined by the Director of M&M, the researcher will design a provider satisfaction measurement tool to survey customer satisfaction for 1997. The next step will involve the development of a written patient satisfaction survey to be administered during the first quarter of 1998. The goal of the new survey is to determine whether or not the agency is receiving feedback from a representative sample of home health patients. Measurement tools for patient and provider satisfaction for hospice services are already in place.

Methods and Procedures

The evaluation of M&M will include four areas of concern: organization structure, activities, outcomes, and costs. The organization structure will delineate the administrative organization, facilities and equipment, scope of services, qualifications and profiles of professional personnel, characteristics of the patient population, and the policies and procedures governing patient care. Activities involve the processes that are planned to occur in the program. Outcomes refer to the program or patient objectives in relation to their attainment. The fiscal area focuses on cost and cost accountability. Evaluation of Joint Commission compliance will be

accomplished using the Joint Commission 1997-98 Comprehensive Accreditation Manual for Home Care.

The sources of information for the M&M evaluation are the patient and family including "significant other," the patient's clinical record, analysis of patient statistics, the agency's performance improvement plan (See Appendix B), community statistics, and financial records and reports. The opinions of patients will be evaluated by the measurement instruments already in place at the agency and the survey tool developed by the researcher and M&M experts. The Home Healthcare Management Information System will provide reasons for admission and discharge, amount and type of services, number of visits, and patient diagnosis. The documents related to the administration and organization of the agency will provide information on M&M's philosophy and patient care specific objectives. The statistics that describe the community served by M&M will provide the basis for recommendations. Financial documents and reports from M&M's corporate office will assist in the documentation of cost-effectiveness. The major methods and strategies to be utilized for collection of information are as follows:

1) Critical review of administrative philosophy, goals, objectives, and documents.
2) Clinical record review for quality and utilization of services (the quality and utilization review committee reports will be used).
3) Patient care policies and procedures review, and evaluation using the Joint Commission 1997-98 Comprehensive Accreditation Manual for Home Care.
4) Critical review of personnel policies, job descriptions and professional qualifications.
5) Reports of the Medicare survey, state licensing consultants, and JCAHO.
6) Recommendations from the M&M committees.

6) Recommendations from the M&M committees.

7) Results of patient opinion surveys and patient letters of appreciation and complaint.

8) Compilation of any relevant patient statistics that can be acquired from the agency information system.

9) Vertical and horizontal financial analysis of the agency for the years 1994, 1995, 1996, and 1997.

The data collected will include number of patients receiving each service offered, sources of referrals, number of patient visits, criteria for admissions, reasons for discharge, total staff days for each service offered, and number of patients not accepted with reasons.

Patient Satisfaction Survey Design

The patient satisfaction tool will include the appropriate demographic information including age, sex, primary diagnosis, and living arrangements. The tool will be designed with a panel of experts at M&M.

Once the survey tool has been developed, all patients from the first quarter of 1998 will be selected and categorized according to their major diagnostic category: 1) circulatory diseases; 2) respiratory diseases; 3) accidents, poisoning, and violence; 4) musculoskeletal systems; and 5) neoplasms, endocrine, nutritional, and metabolic disorders, etc. Analyses of the results will be completed using the statistical package of SPSS. Frequency distributions and standard deviation, standard error of the mean, mean, median, and mode will be computed.

Subjects

Surveys were sent to three hundred and twelve patients during the first quarter of 1998. Thirty-seven percent of patients were male and sixty-three percent were female. One hundred fifteen were males and one hundred ninety seven were females. Mailing lists were generated from the Home Healthcare Management Information System. The following table gives a breakdown of major diagnostic group by sex.

TABLE 2. Breakdown of Major Diagnostic Category by Sex

Major Diagnostic Category	**Percentage of Males 37%**	**Percentage of Females 63%**
Infective and Parasitic Diseases	.05%	2%
Neoplasms	1%	5%
Endocrine, Nutritional, and Metabolic Disease	1.5%	3%
Blood and Blood-Forming Disease	.005%	1%
Mental Disorders	2%	3%
Nervous System and Sense Organs	.05%	1.5%
Circulatory System	15%	3%
Respiratory System	5%	7%
Digestive System	.05%	2%
Complications of Pregnancy	0%	4%
Skin and Subcutaneous Tissue	1%	2%
Musculoskeletal System	3%	14%
Congenital Anomalies	0%	.6%
Symptoms of Ill-Defined Conditions	1.5%	1.5%
Accidents, poisonings, and Violence	4%	8%
Procedures	3%	5%

Of the three hundred and twelve surveys mailed, one hundred and eighteen were returned for a thirty-eight percent response rate. The following table gives the response rate by sex and major diagnostic category. Four surveys were eliminated because two patients were deceased

and family members completed the surveys, one respondent sent in two surveys, and a mother of a one-week-old child completed the survey for her infant. Of the remaining one hundred fourteen surveys, forty-two were received from males and seventy-two from females or thirty-seven percent and sixty-three percent, respectively. The survey response rate after the elimination of the four surveys was thirty seven percent.

TABLE 3. Breakdown of Survey Response Rate by Sex

Major Diagnostic Category	Percentage of Males Returning Surveys	Percentage of Females Returning Surveys
Infective and Parasitic Diseases	5%	4.2%
Neoplasms	5%	4.2%
Endocrine, Nutritional, and Metabolic Disease	5%	7%
Blood and Blood-Forming Disease	5%	0%
Mental Disorders	2.4%	4.2%
Nervous System and Sense Organs	0%	3%
Circulatory System	36%	21%
Respiratory System	19%	14%
Digestive System	0%	3%
Complications of Pregnancy	0%	4.2%
Skin and Subcutaneous Tissue	0%	3%
Musculoskeletal System	17%	19.0%
Congenital Anomalies	0%	0%
Symptoms of Ill-Defined Conditions	5%	3%
Accidents, poisonings, and Violence	2.4%	6%
Procedures	7%	6%

Due to the small percentages of patients in the diagnostic categories other than Circulatory, Respiratory, and musculoskeletal, categories were collapsed as shown in the following table.

TABLE 4. Breakdown of Survey Response Rate by Sex (Collapsed Categories)

	Male	Female
Circulatory System	36%	**21%**
Respiratory System	19%	14%
Musculoskeletal System	17%	19%
Other	28%	46%

The respondents' living arrangements were as follows: thirty-two lived alone (28%); fifty-nine lived with their spouses (52%); twenty-one lived with family members (18%); one lived with paid help (.9%); and one respondent specified "other" for a living arrangement (.9%). Because the response rate was so low for the categories "lived with family members," "lived with paid help," "lived with significant other," and "other," these categories were collapsed into the "other" category for the analysis. Ninety-five respondents (83%) correctly identified the medical condition that resulted in their home health care referral, while nineteen (17%) did not know why they had been referred to home health care. The descriptive statistics for survey questions one through fourteen are displayed in Appendix C.

When asked if expectations had been met, eighty percent of the respondents answered that their expectations had always been met; fifteen percent responded that expectations had been met most of the time; three percent stated that expectations had sometimes been met; while only three percent did not respond to the question. One hundred percent of those who responded said that telephone contact at the agency had been courteous. When asked about the answering service courtesy, ninety-six percent who responded rated that the answering service had responded courteously, while two percent responded negatively to the question. Ninety percent of the participants who responded indicated the agency had helped them achieve their goals, while two percent responded negatively to this question. One hundred percent of the

respondents would recommend services to others and would use the agency again for home health services, if necessary.

The grading scale for office personnel is outlined in the following table. Thirty-two percent of the respondents recorded that office personnel courteousness and willingness to help did not apply to them. Fifty-five percent graded office personnel with an A for outstanding service, while thirteen percent graded them with a B for making an effort. There were no comments or suggestions for improvement directed to office personnel in the open-ended comment question number twelve.

TABLE 5. Grading of Office Personnel on Service

Qo1101 Office Personnel	Grades	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	4 B	15	13.2	19.2	19.2
	5 A	63	55.3	80.8	100
	Total	78	68.4	100	
Missing	9 Does not Apply	36	31.6		
	Total	36	31.6		
Total		114	100		

The section of the survey directed to the M&M Caregivers sent to the home had a higher response rate. The following table gives the grade delineation for each of components that respondents were asked to rate.

TABLE 6. Grade Delineation by Component

Care Component Question Number	Percent A	Percent B	Percent C	Percent D
1102A Was knowledgeable	93	6	1	0
1102B Was dependable	88	10	2	0
1102C Was comforting	89	10	1	0
1102D Treated with dignity	92	7	1	0
1102E Taught about illness	85	13	2	0
1102F Gave clear instructions	93	7	0	0
1102G Was professional in appearance	91	9	0	0

Because responses were so overwhelmingly favorable, with no poor or failing grades, the seven variables were incorporated into a grading scale. To determine if the scale had internal consistency for reliability in measurement, a reliability coefficient was produced using Cronbach's Alpha reliability test. Cronbach's Alpha test measures consensus of opinion regarding each of the components in a scale. Each of the seven items was combined to develop an overall grade for caregivers. The reliability analysis of caregiver grading scale is found in the following table.

TABLE 7. Reliability Analysis of Caregiver Grading Scale

Caregiver Grade	Mean	Standard Deviation	Cases
1102A Was knowledgeable	4.9072	.3254	97
1102B Was dependable	4.8763	.3611	97
1102C Was comforting	4.8866	.3499	97
1102D Treated with dignity	4.9072	.3254	97
1102E Taught about illness	4.8351	.4253	97
1102F Gave clear instructions	4.9485	.2223	97
1102G Was professional in appearance	4.9175	.2765	97

The statistics for the caregiver grading scale were a mean 34.2784 with a standard deviation of 1.72 for the seven variables. An analysis was then completed to determine if the caregiver grading scale would have greater reliability if any of the seven variables were deleted. The following table gives the corrected item total correlation and the corresponding alpha if the item was deleted.

TABLE 8. Caregiver Grading Scale Corrected for Deleted Variables

Item	Scale mean if item deleted	Scale variance if item deleted	Corrected item total Correlation	Alpha if item deleted
Q1102A	29.37	2.28	.5799	.8494
Q1102B	29.39	2.10	.6938	.8333
Q1102C	29.04	2.09	.7263	.8283
Q1102D	29.37	2.15	.7275	.8291
Q1102E	29.44	2.06	.5816	.8564
Q1102F	29. 33	2.45	.6479	.8468
Q1102G	29.36	2.39	.5566	.8526

The reliability coefficients for N = 97 with seven items evaluated produced an alpha of .8620. This value indicates that each item in the scale is reliable in terms of measuring critical attributes of the grade given to a caregiver. Therefore, all seven items were considered in the caregiver grading scale.

A grade average was computed by summing all seven variables and dividing by seven. Missing data were recoded as 999 and excluded from the analysis. Frequencies revealed that there were ninety-seven valid and seventeen missing statistics. The mean value for the grade statistic was 4.9 with a standard deviation of .25. The minimum statistic was four or B and the maximum was five or A according to the survey scoring.

A one-way analysis of variance was then completed looking for differences between the mean grade statistic for caregivers and the four major diagnostic categories circulatory diseases, respiratory diseases, musculoskeletal diseases, and the other category. The test revealed no

significant differences between groups or within groups F=.402 and significance .752. The results of the one-way analysis of variance are presented in the table below.

TABLE 9. One-Way Analysis of Variance

		Sum of Squares	df	Mean Square	F	Sig.
Grade Average	Between Groups	7.407E-02	3	2.469E-02	.402	.752
	Within groups	5.711	93	6.141E-02		
	Total	5.785	96			

The next area of analysis was to investigate if there were overall performance grade differences given to the agency by sex, living arrangements, and major diagnostic disease category (See Appendix C for statistical analysis). For the purposes of this analysis, living arrangements were re-coded. Categories 3 (with significant other) zero responses, 4 (with family) twenty-one responses, 5 (with paid help) one response, and 6 (other) one response were grouped together as "other" because of the small numbers in these categories. Grades for over-all agency performance were nominally re-coded into a performance grade 0 = the lowest score through 4.999 and top scores of 5 were re-coded as one. Chi-square data analysis was completed by gender males = 0 and females = 1. There were no significant differences found by gender and the overall performance rating given to agency, Pearson chi-square value .3695 (df=1) α levels .05 = 3.84 and .001 = 6.64. There appear to be differences; 79.5% of the males rated the agency at the A level while only 74.1% of females rated the agency at the A level, but the differences were not significant. There were no significant differences found between patient living arrangements and over agency performance scores Pearson chi-square value 6.735[1] (df=4) α levels .05 = 9.49 and .001 = 13.28. There appear to be differences; 83.3% living alone, 79.2% with spouse, 61.1% with family, or 100% other situations rated the agency at the A level or

outstanding, but they were not significant. There were no significant differences found between Major Diagnostic Category and the over-all performance grade given to the agency, Pearson chi-square value .258[1] (df=3) α levels .05 = 7.82 and .001 = 16.27.

Physician and Office Staff Customer Evaluation

A survey was developed to evaluate referring physician and physician office staff satisfaction with M&M. Referring physician names were obtained from the Home Health Management Information System used by the agency. An incentive drawing of a gift certificate for a $25 lunch was used to entice the return rate of surveys for both physicians and office management staff.

Limitations

The Medicare evaluation of M&M is descriptive in nature and its results cannot be generalized to other agencies. The evaluation results are appropriate for performance improvement strategies for M&M only. Because the patient and provider satisfaction tools will be developed for use in the M&M agency, they may not be valid or reliable for other agencies.

Expected Findings and Utility of Results

This evaluation will fulfill the Medicare regulations that require certified home health agencies to evaluate their programs annually. M&M is also required by its parent corporation to produce an annual report demonstrating its accountability to financial, clinical and community parameters. This report will fulfill that requirement as well. In addition, this evaluation will serve to document M&M's ongoing efforts to continuously improve performance in the event of an unannounced Joint Commission survey. The method designed to report home care patient satisfaction will enable the agency to determine if M&M is receiving feedback from a

representative sample of its patient population and if alternative strategies should be evaluated to obtain more comprehensive feedback.

The M&M evaluation will provide the necessary information for the leadership and staff of M&M to facilitate improvements in clinical and financial systems to meet federal and state government, governing body, third party payer, and stakeholder expectations. This report will be retained as a part of the administrative records of the organization.

Results - Joint Commission on Accreditation of Healthcare Organizations

In the first step of the evaluation process, the researcher reviewed the M&M agency's January 1997 JCAHO survey results. The following deficiencies were noted for Home Health and/or Personal Care/Support: Partial Compliance for Rights and Ethics and Significant Compliance for Preparation and Dispensing and Environmental Safety.

For Home Health Rights and Ethics RI.1.3, M&M's Grid Element Score was 3, indicating "Partial Compliance" with the standard. The element focus is on the organization addressing patient rights in providing patient care or services (RI.1). The patient has the right to confidentiality (RI.3). During the inspection, JCAHO found M&M respected and protected the confidentiality of patient information with appropriate policies and practices. But on two home visits, there were patient record sheets visible in caregivers' unattended vehicles. In one case, only the patient's name was on the sheet. In the other case, the patient's name and other information (such as diagnosis) were visible.

M&M reviewed all aspects of maintaining clients' right to confidentiality after the inspection. Policy and practices to safeguard confidentiality included:

- Client confidentiality in employee orientation.
- Record maintenance: storage of, access to, and releasing of patient information.

- Passwords required for computer information.
- Limiting visitors to sensitive office areas.
- Interoffice paging.

The main focus of the M&M agency has been staff education to rectify deficiencies cited by JCAHO. Mandatory employee meetings were held to discuss these survey results. The agency implemented use of an aluminum form holder to safeguard patient confidentiality. This clipboard device has an enclosed metal box for storage of papers. The device holds papers safely out of sight, yet offers a convenient writing surface for charting documentation. Supervisory staff emphasized and observed patient confidentiality during on-site supervisory visits. The agency supervisory visit forms were revised to include a specific category to document that the staff is maintaining patient confidentiality. All employee and case manager team care meetings held since the inspection have emphasized the necessity of ensuring patient confidentiality. Supervisory staffs are performing frequent, unannounced vehicle inspections to verify client documents are not visible.

Supplemental recommendations or consultative recommendations are guidance for which standards were scored to indicate less than substantial compliance. If not acted upon, these recommendations may adversely affect a future accreditation decision. The recommendations are discussed below.

Standard: Home Health Preparation and Dispensing, specifically TX.6.8 (The organization has an inventory of medications readily available in the pharmacy for prescribing or ordering). (TX.6)

Medications and supplies are delivered to the appropriate patient. Registered nurses occasionally picked up medications at the hospital pharmacy and delivered them to the hospice

patient. There is a system for verifying these deliveries of any narcotics. However, there was no system to show that other drugs and products were delivered to the appropriate patients.

Standard: Home Health- Environmental Safety: EC.1.5

The organization maintains its plan for managing hazardous materials and wastes. On one home visit, the home health aide was not carrying a CPR mask. The home health aide was a hospice employee who stated she did not need the mask for hospice patients. Still, the home health aide said she occasionally visits home health patients. On another home visit, a registered nurse did not have a hard-sided container for transporting lab specimens. It was not needed during the visit. Nonetheless, the nurse stated that if she were to draw blood, she would transport it in a plastic bag marked "Biohazard."

Standard: Human Resources Management: HR.6.2:

The organization assesses, maintains, and improves the competence of all care and service staff members. The organization assesses each staff member's abilities to meet the performance expectations stated in his or her job description. On four of thirty-four personnel records reviewed (all four were volunteers), there was no written evidence/documentation of performance evaluation. The volunteer coordinator clearly described a process for evaluating volunteers, yet there was no documentation. M&M has developed a performance appraisal system for hospice volunteers and performance is monitored closely.

M&M received a grid score of 97 for the January 1997 JCAHO inspection. The next step in the evaluation process was for the researcher to conduct an inspection in November and December 1997 of the M&M Home Health Care Agency. To complete this evaluation, agency policies and procedures were reviewed, home visits were made with all disciplines, staff were

interviewed, and charts were audited. See Appendix G for the Resident Inspection using JCAHO Home Care Accreditation guidelines. A composite summary grid score was not derived because the agency is a department of the hospital and, as such, would not be scored as a freestanding agency. Results of this inspection are presented below.

Rights and Ethics: RI.1 - RI.7

The goal of rights and ethics is to improve patient outcomes by recognizing and respecting each patient's rights during the provision of care or services and conducting business relationships with patients and the public in an ethical manner. M&M is in substantial compliance with this standard, as evidenced by written policies and procedures, chart reviews, and observations during home visits. The M&M Home Health Care Agency appears to meet all major provisions of the standard and its intent.

Assessment: PE.1 - PE.8

The goal of the assessment function is to determine the care or services to be provided by the organization to meet the patient's needs. The assessment function of the agency is monitored closely during supervisory visits of the skilled nursing staff. The Improving Organizational Performance Plan (IOP) coordinator reviews one hundred percent of the clinical documentation of new professional staff members. Further, random review of staff that have been employed for longer periods is conducted unless discrepancies arise, in which case monitoring frequency is increased. The staff member corrects deficiencies discovered during this review. Any pertinent incident reports, medication variance reports, and analysis of service reports are reviewed with staff members as they are identified. Adverse trends are monitored and appropriate education is

conducted individually and collectively in case management meetings. The M&M Home Health Care Agency appears to meet all major provisions of the standard and its intent.

Care, Treatment, and Service: TX.1 - TX.11.4.2

The goal of the care, treatment, and service function is to provide individualized, planned, and appropriate care in settings suitable to the patient's care or service goals and needs. The staff of M&M completed Multidisciplinary-disciplinary chart audits of the Care Planning Process under the direction of the Improving Organizational Performance Coordinator in home health, private duty, and hospice. Documentation of the results of the audits revealed that discrepancies found during this process were incorporated as training in weekly staff meetings, case management meetings, and individual counseling sessions. Monitoring and feedback were provided to those individuals until deficiencies were corrected.

Nutritional Assessment Standard: TX.9

Interdisciplinary nutrition care planning is performed, as appropriate, as part of the patient's care." The intent of TX.9 is that a nutritional assessment be completed by a qualified health care professional, and that the patient be reassessed at specified intervals. A registered dietitian at the contract Durable Medical Equipment(DME) company assesses patients at M&M who are on enteral or parenteral nutrition. However, on review of five charts, documentation of the nutritional assessments was not in the charts nor were reassessments documented. Staff interviews with M&M case managers revealed they did not know the name of the registered dietitian who assessed these patients. Further, no written policy was available for staff to follow for patients identified to be at nutritional risk or for those requiring reassessment because they were at risk of nutrition complications. A written policy is not a requirement of Joint

Commission however it would be beneficial in the training of M&M staff. M&M does not have a registered dietitian or qualified nutritional expert to train staff or to be available for consultation with staff. The hospital dietitians are not consulted on patients, though most referrals to the agency are from the hospital and the hospital dietitians have completed inpatient nutritional assessment on referred patients. This is an area of concern and should be incorporated in the M&M Performance Improvement Plan for 1998.

Improving Organizational Performance: PI.3-PI.3.6.

This standard requires that data be collected related to:

- important processes and outcomes
- priority issues chosen for improvement
- patients' and families' needs, expectations and satisfaction.

M&M has a superb Organizational Performance Improvement Plan and continuously strives to improve. An integrated agency requires a comprehensive performance improvement program to be in compliance with Joint Commission Accreditation of Healthcare Organizations, and federal and state mandates. To accomplish this goal, an all-inclusive Improving Organizational Performance Plan (IOP) was developed. The IOP provided an opportunity for the agency leadership and staff to monitor and improve activities that impact on clinical, financial and compliance practices. Because so many of the activities in the agency overlap, it was decided that performance improvement activities would be identified that crossed all three areas. Processes were prioritized and teams created to examine current work practices and institute changes that would maximize overall agency effectiveness and efficiency. Utilizing the *Focus: Plan Do Check Act* system, processes in need of improvement were identified and addressed.

However, review of the current data collection systems revealed patient satisfaction data had not been analyzed as per agency policy for two quarters. The patient and family complaints had not been addressed in these surveys. Once this problem was identified, the director and the IOP coordinator developed a process to include the results of the satisfaction surveys as part of their weekly corporate operations meetings. Issues were discussed and resolved as they occurred. The M&M agency maintained a telephone complaint log, which had documentation of complaints and resolutions. The Performance Improvement Coordinator at the hospital monitoring M&M's complaint log reported that patient complaints did not arise at a higher than expected level for the agency. The coordinator revealed that complaint comparison data for home health were not available. The M&M Home Health Care Agency appears to meet all major provisions of the standard and its intent.

Education: PF.1 - PF.4.13.3

The goal of educating the patient and family is to improve patient health outcomes by promoting recovery, facilitating patient comfort, accelerating return of function, promoting healthy behavior, and appropriately involving the patient in his or her care. Observations made on home visits with physical therapists, registered nurses, and certified nursing assistants revealed an outstanding rapport with patients and family members. Home health patient progress notes reviewed with the IOP coordinator revealed the agency carefully scrutinizes all progress notes from new employees to insure appropriate and adequate documentation of care. A strong organizational code of ethics prevails to ensure patients are educated to the extent they and their family members can assume more of their own care. The home safety and disaster instructions after the home health employee assessed the home environments were comprehensive in nature.

Grid Score: Score 1 or substantial compliance. The M&M Home Health Care Agency meets all major provisions of the standard and its intent.

Continuum of Care and Services CC.1 - CC.6

The goal of the continuum of care and services is to define, shape, and sequence processes and activities to maximize coordination of care and services within a continuum of care. M&M employs a nurse liaison at its hospital that makes the initial assessment after the patient has been referred. All necessary data are manually collected from the medical records and are transferred to the appropriate case manager at the agency. The nurse liaison meets with discharge planners at the hospital daily, so she is aware of any discharges to the agency. The community education liaison nurse performs her rounds at referring skilled nursing facilities, psychiatric hospitals, and other referring hospitals to ease the patients' and families' transition to home health care. The community health nurse also ensures medical necessity criteria are met for durable medical equipment, and that those patients are truly homebound and require intermittent care. M&M is closely involved with its Hospital Performance Improvement Teams: Neuro-Rehabilitation, Joint Replacement, Respiratory, Congestive Heart Failure, and Oncology. Their involvement is designed to ensure a seamless continuum of care. The M&M Home Health Care Agency appears to meet all major provisions of the standard and its intent.

Environmental Safety and Equipment Management: EC.1 - EC.14

The goal of the environmental safety and equipment management function is to promote safe, effective patient and organization environments and equipment use. The agency maintains a file of incident reports on any adverse actions and follows specified preventive maintenance plans coordinated by the hospital facilities management department. The agency has had no

Worker's Compensation claims in the last four years. No discrepancies were noted. The M&M Home Health Care Agency appears to meet all major provisions of the standard and its intent.

Management of Human Resources HR.1 - HR.7

JCAHO requires home health organizations to provide adequate and appropriate staff to perform both organizational and patient care functions. The M&M human resource (HR) function was to be accomplished by a registered nurse with an advanced degree. She was to dedicate twenty-four hours per week to the HR function. Although there is much debate according to Robert Tortorici (1997) on the size of the personnel department, the standard in the home health care field is one full time, forty hour HR employee per one hundred employees. M&M has approximately one hundred thirty employees in home health, maternal child services, private duty, and hospice. This capable employee was attempting to develop the home health Registered Nurse Preceptor Program, coordinate education and training, interview, orient, and hire new employees, while simultaneously handling other administrative activities and providing clinical field staff support to the maternal child program. Consequently, this function in a human resource intensive business did not meet standards set by JCAHO. Furthermore, the agency did not have a published education program to provide ongoing staff education. The orientation and preceptor program used by the agency to provide on-the-job training to new home health nurses had not been written. Especially important to this process was the preceptor-training plan that would ensure consistency in new employee training. Because of the lack of staff dedicated to the human resource function, education resources such as videotapes and audiotapes were not effectively communicated to the staff. While the agency had excellent clinical staff resources, video presentations geared toward M&M policies should be developed and shown with greater frequency due to the erratic work schedules of staff who were not always available for meetings.

Recruitment to a home health agency is difficult in a scarce labor market, especially in southeastern Virginia. Many positions at the agency were occupied with part time, irregular employees. These employees do not have benefits, i.e., vacation and sick pay. It was difficult to schedule these employees during weekends and holidays. Through the 1997 Christmas holiday season, the management staff was plagued with staffing shortages. Scheduling was exceedingly difficult. Human Resources Management is an area of concern and should be incorporated in the M&M Performance Improvement Plan for 1998.

Management of Information: IM.1 - IM.9.25.1

IM.1 Information-Management Planning: The organization plans and designs information management processes to meet its internal and external needs.

The goal of management information is to obtain, manage, and use information to improve patient outcomes and individual and organization performance in patient care, governance, management, and support processes. M&M uses the Home Care Agency Management System (HAMS) for its billing system. M&M does not have a computerized system that goes beyond the billing process. Additionally, the capability to enter more extensive clinical information on patients is not available at this time. M&M is disadvantaged because the agency is not able to capture data on patient outcomes via its information system. Without an integrated computer system, it is beyond burdensome to attempt to capture the necessary data from the care provided in order to collect outcome measurement data. Accordingly, outcome measurement data are not available for internal or external use. Data were collected on patients with hip replacement but, because of the onerous nature of the task and the collection, it was discontinued. Separate patient records are maintained for each division of the agency. The agency has budgeted for a clinical documentation system, but capital is not available to install

the $260,000 system. The agency performs exceptionally well without a clinical documentation information system. However, a significant problem exists in the agency coordinating the flow of paper work. A universal complaint heard in staff interviews was that paperwork mysteriously disappeared and had to be resubmitted. Whenever information is requested from external agencies, major efforts are required to ensure that documentation is complete. Information Management is an area of concern and should be incorporated in the M&M Performance Improvement Plan for 1998.

Surveillance, Prevention, and Control of Infection: IC.1 - IC.5

The goal of surveillance, prevention, and control of infection is to improve patient health outcomes by identifying and reducing the risks of infection with patients and organization staff. M&M continues to monitor monthly all infections acquired by clients. No trends or correlation were found showing a direct cause-effect relationship between the client and staff. M&M Home Health Care Agency appears to meet all major provisions of the standard and its intent.

Medicare Conditions of Participation

The next step in the evaluation is evaluation of the agency's compliance with the Medicare Conditions of Participation.

Patient Rights Standards: Notice of rights and exercise of rights and respect for property.

The patients at M&M are informed of their rights. Written notification is given in advance of furnishing care to all patients at their initial evaluation. Documentation is maintained in the patient's chart. Patients are given the right to voice grievances against any provider working for M&M. The agency maintains a complaint log with the onset of the complaint and the resolution of the problem. All grievances have been resolved. Reprisal against patients is not

tolerated at M&M. Compliance was documented in the patient record during home visits with M&M providers and in the complaint log maintained at the agency.

Standard: Right to be informed and to participate in planning care and treatment

Patients are educated on advance directives. The agency has written policies and procedures delineating staff protocol with advance directives. Major components of treatment observed during home visits and case manager meetings were the emphasis on patient and family involvement in care. Full compliance was noted with this standard.

Standard: Confidentiality of medical records

This area was noted as a deficiency in the Joint Commission Accreditation of Health Care Organizations inspection of 1997. Policies and procedures were in place to ensure patient confidentiality during that inspection, however they were not being fully implemented by the M&M staff. Education and ongoing training have alleviated deficiencies. Compliance was noted on home visits and in the handling of patient information on the telephone and at the M&M offices.

Standard: Patient liability for payment

Patients have a right to be advised prior to the initiation of care regarding the extent to which payment is expected from Medicare or other sources. M&M informs patients verbally and in writing. Patients sign a "Permission to Treat" that discloses any co-payments or private pay responsibilities (home health, private duty, and hospice). Compliance with this standard was observed during patient home visits, skilled nursing facility visits, and hospital visits.

Standard: Home Health Hotline

M&M informs patients in writing of the state toll-free hotline, its hours of operation and the purpose of the hotline. Compliance was observed at home visits and in written policies and procedures.

Standard: Compliance with federal, state, and local laws.

M&M is in full compliance with all applicable federal, state, and local laws. The management team has developed a compliance plan and a compliance committee. Medicare and state Medicaid inspections completed in 1997 revealed no discrepancies. Selected members of the billing staff attended workshops sponsored by the Fiscal Intermediary (FI) in 1997. FI policies and procedures have been written and are closely followed. The agency has a long history of "zero" claim denials.

Standard: Disclosure of ownership and management information

M&M is a department of a not-for-profit hospital owned by a not-for-profit corporation. Full disclosure of the ownership and governing body is made available. All correspondence and

marketing materials have the parent corporation's name and logo displayed. Full disclosure is corporation policy.

Standard: Accepted Professional Standards and Principles

M&M has written professional standards of practice followed by its staff. Compliance is confirmed through staff charting audits and supervisory visits of staff. The agency has a code of ethics. Violations can result in employee termination. Evidence of current licensure for employees requiring licensure is maintained in personnel records by the medical record technicians for each of the case managers' teams at the agency. Personnel records and competencies were reviewed during the Joint Commission inspection, Medicare certification, and state Medicaid inspections. No discrepancies were noted.

Condition of Participation: Organization, Services, and Administration

M&M's services have reliable administrative controls, and line of authority for the delegation of responsibility is clearly set forth in writing. Administrative and supervisory functions are not delegated to another agency or organization. The corporation has sub-units to include private duty, hospice, and home health. All maintain their appropriate administrative records. As mentioned in the JCAHO review, administrative files and "paper" management is an area that is in need of improvement.

Standard: Administrator

The administrator is a registered nurse who organizes and directs the agency's continuing liaison with the parent hospital and the corporation of which it is a part. She employs qualified staff and ensures adequate staff education and evaluations, ensures the accuracy of public information materials and activities, and implements an effective budgeting and accounting system. The director of the corporation authorizes a qualified person to act in her absence.

Standard: Supervising Physician Standard Supervising Physician Standard Supervising Physician Standard Supervising Physician

The skilled nursing and other therapeutic services furnished at M&M are under the supervision and direction of a qualified physician. This physician is available at all times during operating hours, and the physician participates in all activities relevant to the professional services furnished.

Standard: Personnel policies

Appropriate written personnel records support M&M personnel practices and patient care. M&M's personnel records include qualifications and licensure that are kept current.

Standard: Personnel under hourly or per visit contracts.

M&M has personnel under per visit contracts. The agency has written contracts with those personnel that specify the following:

- That only M&M accepts patients for care.
- The services to be furnished.
- The necessity to conform to all applicable M&M policies and procedures.
- The responsibility for participating in standards of care.
- The manner in which the services will be controlled, coordinated and evaluated by
- The procedures for submitting clinical and progress notes, scheduling visits, and periodic
- patient evaluation.
- The payment for services furnished under the contract.

Standard: Coordination of patient services

Personnel furnishing services to the corporation are required to attend monthly case managers' meetings, maintain liaison with their case managers to coordinate effectively, and support the objectives in the plan of care. Clinical records and minutes of care conferences established that effective interchange and coordination of patient care occurs. Written summary reports are sent to attending physicians at least every sixty-two days. Documentation of the success of these efforts is available as part of M&M's progressive organizational performance improvement efforts. The corporation has access to a dietitian at the hospital, and the Clinical Manager of Nutrition is on their Professional Advisory Board. Problems were cited in the chart audits by agency's IOP coordinator for lack of follow-up with patients identified as requiring further nutritional evaluation.

Standard: Institutional Planning

M&M is required by its parent corporation to produce an operating plan, an operating budget, and a capital budget. The annual operating budget includes all anticipated income and expenses related to items that are considered income and expense items according to generally accepted accounting principles (GAAP) by the American Institute of Certified Public Accountants (AICPA).

Condition of Participation: Advisory Group of Professional Personnel

The M&M agency has an established professional advisory board that includes a physician and appropriate representation of other professional disciplines. These include a physical therapist, registered dietitian, and a consumer from the community. This advisory council meets twice a year to review M&M's policies governing the scope of services offered,

admission and discharge policies, medical supervision and plans of care, emergency care, clinical records, personnel qualifications, and program evaluation. This group is chartered to advise the corporation of professional issues, to participate in the evaluation of the agency's program, and to assist M&M in maintaining liaison with other health care providers in the community and in the agency's community information program. The group could be more involved with agency improvement initiatives. It is recommended the group meet as often as necessary to address pertinent issues rather than just twice per year. The minutes of the meetings are formally documented. The majority of the agency's council and advice is solicited from the Vice President of Operations, the Corporation's Risk Manager, and its Physician Advisor.

Condition of Participation: Acceptance of Patients, Plan of Care, Medical Supervision

Standard: Plan of Care

Patients are accepted for treatment at M&M on the basis of reasonable expectations that the patient's medical, nursing, and social needs can be met adequately in the patient's residence. The plan of care is developed in consultation with the agency staff and covers all pertinent diagnoses. This includes mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, safety measures to protect against injury, instructions for timely discharge or referral, and other appropriate information. The physical therapists, nurses, social workers, and other agency personnel participate in developing the plan of care.

Standard: Periodic review of plan of care

As required by Medicare, the attending physician and appropriate personnel at M&M review the total plan of care. The plan of care must be reviewed every sixty-two days. The

agency closely monitors plans of care to ensure this evaluation occurs as often as required. Professional staff at the agency must promptly alert the physician to any changes in patient conditions.

Standard: Conformance with the physician's orders

M&M conforms to physician's orders and this process is closely monitored. Verbal physician orders are immediately recorded and countersignatures are obtained from the physician. Monitoring and evaluation reveals close compliance with this standard.

Condition of Participation: Skilled Nursing Services

M&M has written policies that clearly designate: the scope of skilled nursing services offered; the manner in which those services are provided, supervised and evaluated; and the mechanisms for ensuring that skilled nursing service is furnished in accordance with the plan of care and corporate policy. Position descriptions and procedures delineate the duties and performance expectations for the registered nurse. These duties are consistent with the state practice acts and reflect current standards for nursing practice. The clinical records document the provision of skilled care and corporate policies and procedures. M&M clinical records document communication with the nursing staff and other providers to ensure there is continuity of care among the nursing staff and other disciplines involved with the patient. Improving Organizational Performance Coordinators monitor clinical documentation closely.

Condition of Participation: Therapy Services

Physical therapists, occupational therapists, speech therapists, and medical social service workers have clearly delineated scopes of practice, qualifications, and policies and procedures

that meet Medicare requirements. Documentation is closely monitored to ensure compliance with the plan of care. These disciplines are also involved in clinical record audits and peer review. Identified deficiencies are then translated into M&M's training plan and into an individual professional training plan. Progress is carefully observed.

Condition of Participation: Home Health Aide Services

Standard: Home health aide training

Home health aide training at the corporation has specific areas that are addressed in the classroom and in supervised practical training to meet Medicare certification standards.

(1) Communication skills.

(2) Observation, reporting, and documentation of patient status and the care or services provided.

(3) Reading and recording temperature, pulse, and respiration.

(4) Basic infection control procedures.

(5) Basic elements of body functioning and changes in body functioning that must be reported to an aides supervisor.

(6) Maintenance of a clean, safe, and healthy environment.

(7) Recognizing emergencies and knowledge of emergency procedures.

(8) The physical, emotional, and developmental needs and ways to work with the populations served by the HHA.

(9) Appropriate and safe techniques in personal hygiene and grooming that include:

(a) Bed bath

(b) Sponge, tub, or shower bath

(c) Shampoo

(d) Nail and skin care

(e) Oral hygiene

(f) Toileting and elimination

(10) Safe transfer techniques and ambulation.

(11) Normal range of motion and positioning.

(12) Adequate nutrition and fluid intake.

(13) Any other tasks the HHA aide performs.

The training and supervision of home health aides during the supervised practical portion of their indoctrination is performed by or under the general supervision of a registered nurse who possesses a minimum of two years of experience per Medicare certification regulations. Training is documented in personnel records.

Standard: Competency evaluation and in-service training

M&M's registered nurse, who is responsible for supervising the aides, uses self-study materials and inservice education to meet Medicare certification requirements. HHA aides are not permitted to complete any tasks that they have not been judged competent to complete, unless they are under the supervision of a registered nurse.

Standard: Supervision

The home health aide is assigned to a particular patient by a registered nurse and provided written duties to be accomplished. A registered nurse is required to make supervisory visits every sixty days. Supervisory visits must occur when the aide is providing care. This standard is carefully monitored at the corporation and compliance is good.

Personal Care Attendant: Evaluation Requirements

M&M employs personal care attendants to provide personal care services under the Medicaid personal care benefit provision. The education, evaluation, supervision, and competency requirements are similar to the requirements of the home health aides. The M&M registered nurse who supervises the agency's private duty division is successfully meeting these requirements.

M&M demonstrated compliance with the standards of participation on a continuous basis. The agency is prepared for a Medicare inspection at all times. M&M's administrator acts consistently to ensure policies, procedures, standards of practice, protocols, and other materials meet the conditions of participation.

Home Health Demographics

Analysis of the Home Healthcare Management Information System revealed that M&M's current patient population in home health is typical of that which has been seen over the past several years. The majority of patients are Caucasian females, age 65 and older, and on Medicare with the diagnosis of fracture. Seventy-five percent of patients admitted to M&M are referred from its parent hospital. The two other primary referral sources are Blue Cross Blue Shield and a health maintenance organization in which the parent corporation owns twenty percent. Patients are granted freedom of choice to select M&M, once the physician writes a referral for home care services. If a patient requests M&M, the patient is required to sign a "freedom of choice" so that documentation is available to demonstrate the patient was granted a choice. The majority of patients are from ZIP Codes in M&M's primary service area. Seventy-eight percent of M&M's revenue is from Medicare. The principal reason for patient discharge from home health was that patients' goals had been met. The 1997 average visits per patient in

home health were: 9.72 registered nurse visits; 3.49 physical therapy visits; .41 occupational therapist visits; .23 speech therapist; 4.66 home health aide visits; and .06 medical social worker visits. Fifty-three patients were not accepted for service because they did not meet the Medicare eligibility requirements for intermittent skilled care.

Changes have occurred from 1996 to 1997 in the admissions by diagnosis-related groups. The top five admission diagnostic categories in 1996 and 1997 are outlined in the following table.

TABLE 10. Top Five Admissions by Diagnostic Category - 1996 and 1997

1996 Major Diagnostic Categories (920)	**1997 Major Diagnostic Categories** (838)
Circulatory Diseases 322 (35%)	Circulatory Diseases 281 (34%)
Accidents, Poisoning, and Violence 229 (25%)	Accidents, Poisoning, and Violence 180 (21%)
Musculoskeletal System 181 (20%)	Respiratory System 149 (18%)
Respiratory System & Endocrine, Nutritional, and Metabolic Disease 106 (11%)	Musculoskeletal System 135 (16%)
Neoplasms 82 (9%)	Neoplasms 93 (11%)

These admitting diagnoses validate M&M's involvement with the Hospital Performance Improvement Teams: Neuro-Rehabilitation, Joint Replacement, Respiratory, Congestive Heart Failure, and Oncology. There were 1,668 admissions in home health during 1997. The average length of stay for these admissions was forty days. Twenty-one percent of admissions were male and seventy-six percent were female. Three percent of admissions were not coded by gender in the Home Healthcare Management Information System. The following table outlines admissions to the home health agency by age group.

TABLE 11. Admissions by Age Group

Age Range	Admits	Percentage
1 through 20	95	3.7%
21 through 59	1,245	48.4%
60 through 64	86	3.3%
65 through 69	121	4.7%
70 through 74	200	7.8%
75 through 79	249	10.0%
80 through 99	574	19.3%
Age not given	79	3.1%
Total	**2,570**	**100.0%**

The comprehensive statistics for the three integrated programs of M&M are as follows:

TABLE 12. M&M Program Statistics

1997	Days/Hours Visits	Admissions/Average Length of Stay	Productivity
Hospice	5,358 Days	112 / 34 days	124%
Private Duty	63,489 Hours	229 / 28 days	98%
Home Health	36,220 Visits	1,668 / 40 days	109%

The current staffing patterns for the agency are outlined in the following table:

TABLE 13. Staffing For the Agency

1997	RN	LPN	PT	OT	MSW	SP	CNA/ HHA	Support	SUPV
Home Health	25	1	5 Staff 23 Contract	2	2 PRN	1 PRN	8	9	7
Private Duty	0	0	0	0	0	0	57	2.25	1
Hospice	3	0	0	0	1	0	2	2	2

Private Duty

Private Duty continued to grow and offer vital community services. This division provided private pay services on an hourly basis, Medicaid personal care and respite services, hospital and nursing home staff relief, and supplemental support for the M&M hospice. Approximately half of the private duty patients are Medicaid patients requiring assistance with at least six activities of daily living and requiring approximately four hours of care several times per week. The remainder of private duty patients are self-pay patients who may or may not require assistance with personal care activities. The average length of stay for private duty patients who were discharged in 1997 was twenty-eight days, with the typical patient being a female over the age of seventy-five years.

Hospice

Hospice patients' average length of stay over the past year was thirty-four days and required 6.72 RN visits, 1.15 MSW visits, 4.14 volunteer hours, and 4.22 hospice aide visits. The most frequent diagnoses for hospice admissions were Neoplasms, followed by End-Stage CHF and End-Stage Cardiomyopathy. The hospice program had 112 admissions in 1997. The

Annual Hospice Memorial Service sponsored by M&M was held in October 1997, with fifty family members attending. During this family outreach program, butterfly bushes were planted in memory of past hospice patients.

1997 Patient Satisfaction Data

Patient satisfaction with the quality of care provided by the staff of M&M remained high in 1997. It was not possible to determine if the sample was representative of the agency population because demographic information, patient major diagnostic categories, and severity adjustment of the patients' disease conditions were not included in the survey. The surveys were mailed to 100% of the patients admitted to the agency. Admitted patients received only one survey per admittance, but received another survey if they were readmitted. The survey return rate was thirty-six percent.

Physician and Office Manager Satisfaction with M&M Home Health Care Agency

The annual review of physician satisfaction with M&M revealed physicians who use services are overwhelmingly pleased with services provided. One hundred percent of the physicians who responded: were satisfied their plans of care were carried out; indicated that changes in patient conditions were communicated in a timely manner; that staff were available for communication; that they received regular written and verbal communication on patients; and their patients were satisfied with treatment. A major customer service concern identified by both office managers and physicians was the slow access to case managers by telephone. See Appendices H through L for the survey instruments and letters directed to the office managers and physicians.

The following table reveals a financial breakdown for each of the areas of the agency.

TABLE 14. Financial Evaluation

1997	Gross Revenue $	Net Revenue $	Salary Expense $	Non-salary Expense $	Net Margin $	Net Margin Percentage
Hospice	**528,570**	**495,899**	**329,167**	**115,228**	**51,504**	**10.4%**
Private Duty	**627,190**	**618,281**	**492,950**	**33,854**	**91,477**	**14.7%**
Home Health	**3,701,794**	**2,577,927**	**1,739,379**	**306,000**	**532,548**	**21%**

All programs increased units of service and produced a positive bottom line in 1997.

Comparative data between M&M and the Premier benchmark are delineated in the following table.

TABLE 15. Comparative Data Between M&M and Premier

1997	M&M	Benchmark Study
Average normalized* administrative cost/patient	$ 346.68	Average: $ 475.98 Minimum: $ 155.52 Maximum: $ 919.00
Average normalized* clinical cost/patient	$ 429.45	Average: $ 855.07 Minimum: $ 188.44 Maximum: $1951.14
Average number of visits per patient per episode of care	RN: 10.60 PT: 4.70 Aide: 4.12	Avg. 18.4; Min. 7.80; Max. 40 Avg. 2.6; Min. .15; Max. 6.8 Avg. 11; Min. 4.12; Max. 25
Average length of stay	34.5 days	Average: 77.8 days Minimum: 26.9 days Maximum: 206.9 days
Average Percentage patients with emergency room visits	2%	Average: 13.2% Minimum: 2% Maximum: 32%
Average emergency room visits per patient	1	Average: 1.4 Minimum: 1.0 Maximum: 4.4
% Hospitalizations	16%	Average: 13.2% Minimum: 6% Maximum: 56%

* ***Takes into account cost of living/salary differences due to geographic location.***

Vertical & Horizontal Analysis

See Appendix M for the complete vertical and horizontal analysis and financial history for 1994 through 1997. During 1997, the percentage change in group health insurance was fifty one percent, mirroring the increasing cost trend for the nation. Monies spent on marketing and advertising decreased ninety one percent, because these expenses were consolidated with the parent hospital. Printing decreased twenty eight percent for similar reasons. These figures conform to the corporation's revised policy for marketing at the corporate level to managed care organizations and payer groups. Total salaries and operating expenses increased .9% from 1996

to 1997. Office rent declined by seven percent from 1996 to 1997 due to the agency's relocation to less expensive offices.

1998 Patient Satisfaction Revision Results

The revised patient satisfaction survey tool developed with a panel of experts from the agency provided excellent feedback on the agency processes. While the survey results were not representative of the agency population, valuable information was generated that requires further investigation. The overall scores provided on the home caregivers were very high but the office personnel rating appears to indicate that issues with the administrative structure should be explored further. Perhaps the next survey developed could hone in on the administrative process and be developed in conjunction with office personnel staff at the agency. Another area, which warrants investigation, is the overall performance ratings given the agency based on patient living situation. While differences were not significant, patients living with family members appear to rate the overall performance of the agency lower than patients living alone or with spouses do. Probing this area further with home caregivers and these patients may point to areas that could be improved for patients living with family members.

Of 312 surveys mailed, major diagnostic survey categories coded but not returned were: Diseases of the Blood and Blood-Forming Organs; Diseases of the Genitourinary System; Congenital Anomalies; and certain causes of Perinatal Morbidity. The sample of returned surveys was not representative of the agency population. The survey return rate of thirty eight percent is not abnormally low. However, because the patients could not be "severity adjusted" for their disease process, definitive conclusions are not possible. Since the agency did not have a clinical documentation information system, there were too many variables that could not be

quantified. It appears that healthier patients were able to respond to the survey while less healthy patients were not.

Discussion

1997 proved to be a record-breaking year for M&M. All agency programs expanded services above what had been projected, and a positive bottom line was realized. This is remarkable in light of a JCAHO inspection in January, staff shortages, agency relocation, and the intense focus required to ensure that Medicare fraud had not been committed. A further labor intensive project was the agency's continued participation in another bench marking activity with Premier, Inc. This second benchmarking project focused on best operational and clinical practices in home care programs. As a result of the second project, completed in April 1997, Premier selected M&M as the hospital-based home health care program model for seven of thirteen benchmarks for evaluating home health programs. An added benefit to this project was the pool of benchmarking partners identified.

The year 1997 marked continued support and participation in M&M's hospital Performance Improvement committees, i.e., Neuro-Rehab, Joint Replacement, Respiratory, Congestive Heart Failure, and Maternal Child Health. The achievement of these endeavors was demonstrated by the increasing numbers of these patients cared for by the staff of M&M, and through enhanced coordination with the hospital discharge planning and M&M hospital liaison position. With the involvement of the Maternal Child Health Team, the case manager at the corporation was able to establish the agency as the only CHAMPUS-certified pediatric home health and hospice agency in the market area. The success of this endeavor was recently verbalized by the supervisor of CHAMPUS Home Health Care Referrals at a meeting of the Department of Defense Exceptional Family Member Case Management Meeting held at a local

Army installation. Critical pathways and care maps for patients with congestive heart failure (CHF) were developed and implemented in conjunction with a Cardiac Nurse Specialist at M&M's hospital. A value-added benefit to this initiative was the invitation of M&M's nurses to participate in specialized training with the cardiac staff at the hospital. Also in 1997, the Hospice Clinical Services Coordinator was invited to be a member of the hospital Oncology PI Team. Moreover, the director of the M&M agency now has membership on the PI Communications Committee where further inroads can be gained in the health care continuum of care.

During the completion of this evaluation, the parent corporation of M&M signed a Letter of Intent and submitted a proposal to the United States Justice Department to merge with a major competitor in the market. This competitor also has a large home health department. Until the merger is approved, both organizations must operate as competitors with no sharing of information. Thus, comparisons with the other home health agency were not possible. However, recommendations will be geared toward the subsequent merger of the two agencies.

The researcher's review of JCAHO standards to ensure success in the event of an unannounced survey revealed one major problem area that could possibly result in a Type One recommendation from the Commission. During the review of the policy and procedure manual and clinical records, it was discovered that there was no written policy and procedure for staff to follow for patients identified at nutritional risk. Once a patient was identified at nutritional risk, no further documentation was noted in several charts or there was no evidence of reevaluation. Those patients on enteral and total parenteral nutrition being followed by the registered dietitian at the durable medical equipment (DME) company did not have documentation in their medical records of nutritional assessments. Follow-up nutritional evaluation regarding the effectiveness of therapy was also not part of the patients' medical records. The agency has a registered dietitian on their professional advisory council, but she has no involvement other than to come to

the advisory meeting once a year. Medicare does not reimburse for nutrition consultative services and to minimize costs, consultative services have to be minimized. The agency should, however, contract with a consulting dietitian who has home health nutrition competency to provide ongoing education and work with the agency to ensure this potential type one recommendation is rectified.

M&M monitors all Medicare certification requirements proactively. They are prepared for a Medicare Certification Inspection at any time. An area that could be improved would involve more interactions between the agency and its Professional Advisory Committee. The Improving Organizational Performance Coordinator is to be commended for her perseverance and dedication in carefully monitoring Medicare and JCAHO requirements. These efforts are especially noteworthy because the agency does not have a clinical documentation information management system, and the audits must be done manually.

Of significant note were the corporation's initiatives to combat fraud and abuse. A clinical integrity program was initiated to protect against false claims processing. This program requires a match of all billed charges with clinical notes. Monthly information system reports identify charges that fall outside the scope of the Plan of Treatment and, therefore, are not billed. No bills are sent electronically unless there are physician orders to cover all clinical visits. The corporation created a performance improvement team with clinical and administrative staff to focus on delayed claims. The team reduced past due Medicare accounts receivable from fourteen percent to less than ten percent in one hundred twenty days, and they also improved non-Medicare accounts receivable. Premier recognized the agency for this accomplishment in the recent benchmarking project. The Monthly Billing Process Improvement Team documents billing questions and issues to reach closure on related problems. For problem resolution, corporate guidance was sought from the Vice President of Corporate Operations, the Head of

Risk Management, and the hospital Ethics Committee. Additionally, the agency has established and maintained effective communication with their new Fiscal Intermediary (FI), Wellmark, Inc. This will continue to be an area of emphasis at M&M with the establishment of a Compliance Committee in 1998.

The success of M&M's Performance Improvement Plan was further validated in several ways. Financial audits regarding billing and collection practices revealed minor recommendations for improvement regarding deposits of checks. No billing problems were noted. Licensure and certification of May 1996 records revealed no discrepancies. There have been no challenges to any home health cost reports filed to date.

M&M experienced two major events in July 1997 that have had significant impact on operations. First, the office manager/billing coordinator resigned from Home Health and, shortly afterward, the agency relocated its offices. With the loss of the office manager, several lengthy staff illnesses and the relocation, the agency did not have the opportunity to organize its personnel and administrative files. Throughout the evaluation process, the Home Healthcare Management Information System files and personnel information were difficult to access. The former office manager was the only in-house expert on HAMS and was consulted by phone regularly. The trainers for HAMS were not engaged because of expensive consulting fees.

Due to the lack of M&M administrative support, agency meetings are fraught with frequent interruptions of phone calls for case managers and staff deviations from the stated meeting purpose. Another issue is "waiting times" for meetings to begin. The nurse liaison between M&M's hospital and the agency has waited up to an hour for weekend patient status reports to be received on Monday mornings. Improvements could be made by developing meeting management rules and developing a better system for handling phone calls during

meetings. Staff, posted and enforced should agree upon meeting rules. Improvements should be made immediately in this area.

The human resource function is weak at the agency. The director of the agency employed a maternal child field nurse in the human resources function for twenty-four hours per week. Because of staffing shortages, increased patient and administrative demands, this employee was overwhelmed and unable to complete her duties. Consequently, interviewing of potential new employees was fragmented. Communications were difficult because the human resources employee was frequently out of the office on clinical visits. This delayed hiring of new staff.

During the Christmas and New Year holiday season, the agency experienced numerous skilled field nursing and physical therapy scheduling difficulties because part time employees who have irregular schedules ("prn" employees) and contract employees were not obligated to provide holiday coverage. There were written policies and procedures regarding scheduling but they were not effective. Because all managers and supervisors were empowered to grant holiday leave, they did so liberally. Consequently, so many employees were off duty that adequate coverage was difficult. After the holidays, a new policy was developed and disseminated. This policy required that all employees be scheduled for either a summer or winter holiday, but not both. All holiday scheduling was to be coordinated through the clinical service manager, and employees would no longer be able to schedule time off for a holiday a year in advance. This new policy should alleviate the confusion experienced during the 1997 winter holiday season.

An additional problem was that the orientation and preceptor programs used by the agency to provide on-the-job training to new home health nurses had not been written. Especially important to this process was the preceptor-training plan that would ensure consistency in new employee training. The human resource function was also responsible for developing the continuing staff education and training program for skilled nurses. An on-going

training program for skilled professional employees, to include registered nurses, physical therapists, occupational therapists, medical social workers, and speech therapists, had not been developed for the entire calendar year. The diverse staff of the agency have broad education needs that exceed just training of problem issues that occur in the agency. Case managers schedule case conferences twice a month with skilled professionals and para-professionals (certified nursing assistants and home health aides). The case managers plan these meetings to focus on patient case presentations, concerns identified in chart reviews, and try to cover Medicare and JCAHO training requirements. All field staff members are required to attend one case conference per month. Training involving the entire agency was scheduled whenever it was deemed necessary and was usually the result of concerns identified by the organizational performance improvement program. Training schedules are difficult in home health care because of the nature of the work. This problem is worse for prn employees and contract staff. Attendance at M&M's training was lacking due to patient scheduling and other conflicting requirements for contract and prn employees. Training sessions were not videotaped even though the agency has the equipment. This suggestion, when offered, was not met with a favorable response by the agency director due to higher priority issues. She explained that the staff trainers did not want to be videotaped. She also felt it was not a good idea to have a video library of home health professional tapes for the skilled staff to view because staff were not available to maintain the library. It would be difficult to require staff to view these tapes. An example of a continuing education training session that could have been more effective was observed when experts at the company provided durable medical equipment (DME) training to new and seasoned field staff skilled nurses. This training covered the complex topic of administration of intravenous therapy (IV) so quickly that is was ineffective. This training was particularly ineffective for new and inexperienced employee according to researcher staff

interviews. Regarding taping, the IV topic could have been expanded and would have been an excellent session for a videotape presentation and further staff review. Development of a series of patient assessment and clinical documentation videotapes would be beneficial to the agency. Perhaps by doing so, the amount of time spent by the Improving Organizational Performance nurse to monitor clinical documentation could be decreased. This requirement is completed to ensure compliance with Medicare documentation standards. Refresher training updates would also be beneficial for nurses working prn. Possibly, these classes could be offered at the hospital and shared with critical care nurses there.

Case managers do not have continuing education and development sessions collectively due to patient needs and staffing requirements. Case managers coordinate patients' care with their field staff. This process requires supervisory visits of professional and para-professionals, coordinating patient care with physicians, physicians' office staff, patients, patients' family members, other case managers, and agency office personnel. The case managers at the agency have diverse backgrounds, including training in communications, handling difficult personalities and service recovery, and problem-solving techniques would be beneficial. Because the case managers are involved in such important roles more training would benefit the agency.

A problem area identified by the physician customer satisfaction survey was the difficulty of reaching the case managers by phone regarding patient concerns. A process improvement strategy should be prioritized between office receptionists and case managers. The current phone system and use of voice mail to communicate between providers, patients, and staff is outdated and does not meet the demands of the agency. The entire phone system failed once during the year, and messages left on voice mail were lost. The phones are a frequent complaint of staff, especially the field staff who travel to visit patients. Training in communications should be prioritized and presented to all staff because communication in patient care is crucial to the

success of the organization. Most of the staff does not have access to electronic mail communications or laptop computers for entry of patient documentation. Therefore, documentation is written manually and later entered into final format by medical records technicians for billing purposes. This process is lengthy and tedious. The pending merger should offer an opportunity to computerize this entire process. As Medicare reimbursement shrinks with the interim payment and, ultimately, to a prospective payment system, elimination of duplication-of-effort and labor intensive tasks is crucial to survival.

The 1997 patient satisfaction survey provided valuable feedback on patient concerns. However, the surveys were not reviewed in a timely manner. This precluded information from being conveyed to the staff in a sufficiently timely manner to rectify issues. The 1997 survey did not collect demographic information on patients. The revision of the survey and the incorporation of results in weekly operations meetings alleviated these two problems. However, the inability to benchmark results with competitors in the local market is a decided disadvantage. The proposal by MR&A to work with M&M toward development of a randomized representative sample telephone survey would offer this advantage. Patient dissatisfaction issues would be identified more rapidly than waiting for the slower communication through the mail system. If enacted, service recovery could begin in a timelier manner. Another advantage would be the communication with family members of the patients who are too ill to respond to a written survey. M&M does not have the staffing to organize a telephone survey. The objectivity of having a third party evaluate the agency patient satisfaction would also be of interest to payers that contract with M&M for home health services. Comparative objective patient satisfaction information in the local market with other home health organizations could also be used in marketing to acquire contracts with other payers. If the approaching merger is successful, however, this venture will not be necessary because the merging company is already

benchmarking patient satisfaction with other home health agencies through MR&A. The new company will have additional leverage to offer more competitive bids to managed care organizations.

The revised patient satisfaction survey revealed that most patients were satisfied with the agency. They were especially satisfied to be treated with respect, dignity, and be involved in their own care. Two quotes from surveys are typical of the responses: "The care far exceeded any expectations that I may have had. I especially commend my nurse, who was professional, comforting, and caring. I felt as though I had a doctor with me. She is a credit to anything or anyone she is associated with." Another patient responded, "They helped me a lot, gave me a lot of information and support. Taught me how to take care of myself. Helped me get on a schedule and control my pain. They helped me through a very difficult time. Thank you so much." As these quotes demonstrate, along with the survey results, a great strength of the agency is the personnel who are employed as caregivers.

The survey also identifies areas requiring improvement. The administrative functions in the office and the answering service after hours appear to be areas that require further investigation. One patient wrote that, on two occasions, the answering service did not forward her message to her caregivers that she had been hospitalized. The comment section of the survey had few areas of suggested improvement. One patient reported she had not been given a folder for agency papers, and that she would have also liked to have cards with her caregivers' names and phone numbers. Another patient expressed that he could have benefited from more physical therapy. One anonymous response reported that it appeared to take too long to get everything started after contact had been made with the agency. Perhaps this patient was admitted during the Christmas and New Year holidays when scheduling difficulties were apparent. Another patient expressed dissatisfaction when the ultrasound machine malfunctioned and she discovered

the agency did not have another machine in reserve. The patient felt her progress had been impeded due to the lack of treatments. Finally, a patient expressed that she would have preferred a female nurse rather than a male because she had stomach surgery.

A major weakness in the agency is the lack of a clinical documentation information system and an organized program to measure patient outcomes. Money has been budgeted to purchase a clinical documentation system, but expenditure of funds has not been approved. The latest technology places handheld computers and laptops into the hands of field staff so that patient visit documentation can be typed and electronically mailed to the agency. The technology available, however, may not meet current and future requirements for Outcomes Assessment Information Set (OASIS) or the Medicare required outcome measurement system that is still in beta test site development. With the amount of time required to manually assure that documentation meets Medicare current regulations and to ensure claims integrity, there is neither staff nor resources at M&M to organize an outcome measurement system. An outcome measurement plan was suggested to the director of M&M, but with numerous other priorities at the agency, resources could not be dedicated to this project. The capital for a clinical documentation program is not available at this time. Without computerization, outcome measurement would be time and cost prohibitive. The new organization that will evolve from the merger will have more capital and manpower to develop an outcome measurement system. The merger is crucial to the success of M&M because, without an outcome measurement system, new contracts with third party payers would be difficult to negotiate. As competition for managed care contracts (MCO) continues to intensify, payers expect, if not demand, that home care providers use field data collection. Field data collection will not only enhance efficiency, but also will reduce cost-per-visit fees and provide outcome measurement. This will integrate

agency data into the payer organization's information system. Outcome measurement will also soon be required for Medicare certification and JCAHO accreditation.

The organizational climate at M&M is proactive in handling issues that arise. However, because many of the managerial and supervisory staff have been employed at the agency for many years, the researcher observed a tendency for these individuals to collectively discount ideas from staff members who were new to the agency. The researcher observed many situations when the agency managers and supervisors did not act as a cohesive team. Team building and communications training would do much to improve morale at the agency. These types of training exercises would also facilitate the behavior necessary in the agency for merger and consolidation. The acceptance of new ideas at the agency is limited, perhaps due to the labor-intensive requirements to ensure compliance with Medicare regulations.

The agency's financial management is excellent. The horizontal and vertical trend analysis reveals no unusual variances. All programs continued to grow in 1997 and produced a favorable bottom line. A concern that is currently being addressed by the director of M&M is the comparatively low salaries for professional and paraprofessional staff. Because of the very competitive labor market, staffing the agency would become even more difficult if this issue is not addressed. Because of the heavy reliance on Medicare reimbursement, the uncertainty of the future Medicare reimbursement structure and the necessity to increase salaries, future financial viability may be difficult. The new reimbursement process under the interim payment system in 1998 and the changes that will occur in 1999 with the incorporation of the prospective payment system are issues that must be resolved. The administrative structure of the M&M agency currently is so lean that it will be difficult for the agency to make further cuts. This is especially the case without a clinical documentation system that can be integrated with the current billing system.

Conclusions

M&M is a superb example of a well-run home health agency. The staff is energetic and has already incorporated many of the researcher's suggestions into their organizational performance improvement plan for 1998. The current Premier comparative data place the agency above the benchmark for many of the financial and clinical benchmarks. This is especially remarkable in light of the lack of a clinical documentation information system that requires multiple handling and processing of agency paperwork.

The revised patient satisfaction survey points to areas in the agency administrative structure that are in need of improvement. The survey return rate was above expectations, but it was not representative of the population served. Perhaps more comprehensive information could be gathered with the use of periodic patient telephone surveys and a focus group on patient satisfaction with the agency.

M&M does not have a formal outcome measurement program. The determined leadership of M&M, however, was able to generate comparative data among twenty-two other agencies that can be used in marketing and payer contract information. This testifies to the high caliber of the administrative staff working at the agency. The elevated levels of patient satisfaction, the patient average length of stay being well below the benchmark average, and low patient use of the emergency room and re-hospitalization all serve to demonstrate the excellent quality of care provided to patients. The predominant reason for discharge from the agency was that patients had met their treatment goals. Coordination is under investigation between the agency and its parent hospital to see if a connection can be made with the outcome measurement program being developed by the hospital.

The agency must develop a performance improvement team to enhance access to case managers by the referring physicians. The agency has outgrown its phone system, and the

reliance on voice mail for vital communication is outdated. Perhaps now that the agency has a new office manager on staff, this area, as well as many of the administrative concerns, can be prioritized. Customer service training and service recovery should be added to the training schedule. Professional staff development training should be incorporated for the case managers. Their vital link with the customers cannot be minimized. The enhancement of communication skills and management competency skills is vital to the organization.

The commitment from management and staff at all levels of the agency is evident in their quest for the continuous improvement required by the Joint Commission Accreditation of Healthcare Organizations and for Medicare participation and certification. The problems identified in the agency with patient nutritional assessment are compounded by the exclusion of the dietitian services from Medicare reimbursement for home health patients or staff consultation. Solving the problems identified in the human resource area is crucial to the long-term viability of the agency, as is an effective personnel recruitment and retention program. The lack of M&M administrative support to complete filing and maintenance of records is an issue that should be resolved to enhance agency efficiency. In the pursuit of quality and cost-effective care in an era of dwindling reimbursement, agencies are forced to prioritize expenditures. As the reimbursement structure shifts to the interim payment system and, ultimately, to a prospective payment system in 1999, many agencies will not be able to remain in business. The increased government regulation and new laws will necessitate increased administrative overhead costs to ensure compliance. Home health care may become a segment of our health care system that can only be accessed by patients who are able to pay for this service. In its quest to eliminate fraud and abuse in the home health industry, Congress may eliminate it entirely. According to Vicki Gottlich, staff attorney for the National Senior Citizens Law Center, a Washington advocacy, evidence is beginning to mount that some Medicare enrollees are losing some or all of this home

health care benefit due to the changing reimbursement structure. According to Gottlich, the problem is becoming widespread and issues are arising in every state. M&M has done much to restore the community trust in home health care and has provided an outstanding service to its community. It is hoped the forthcoming merger will provide adequate capital to install a clinical documentation system and place more emphasis on the administrative functions of the agency. This will enable the agency to enhance efficiency and effectiveness to prepare for the future. It will also allow M&M to further streamline operations so it can continue to provide its well-received services to its community.

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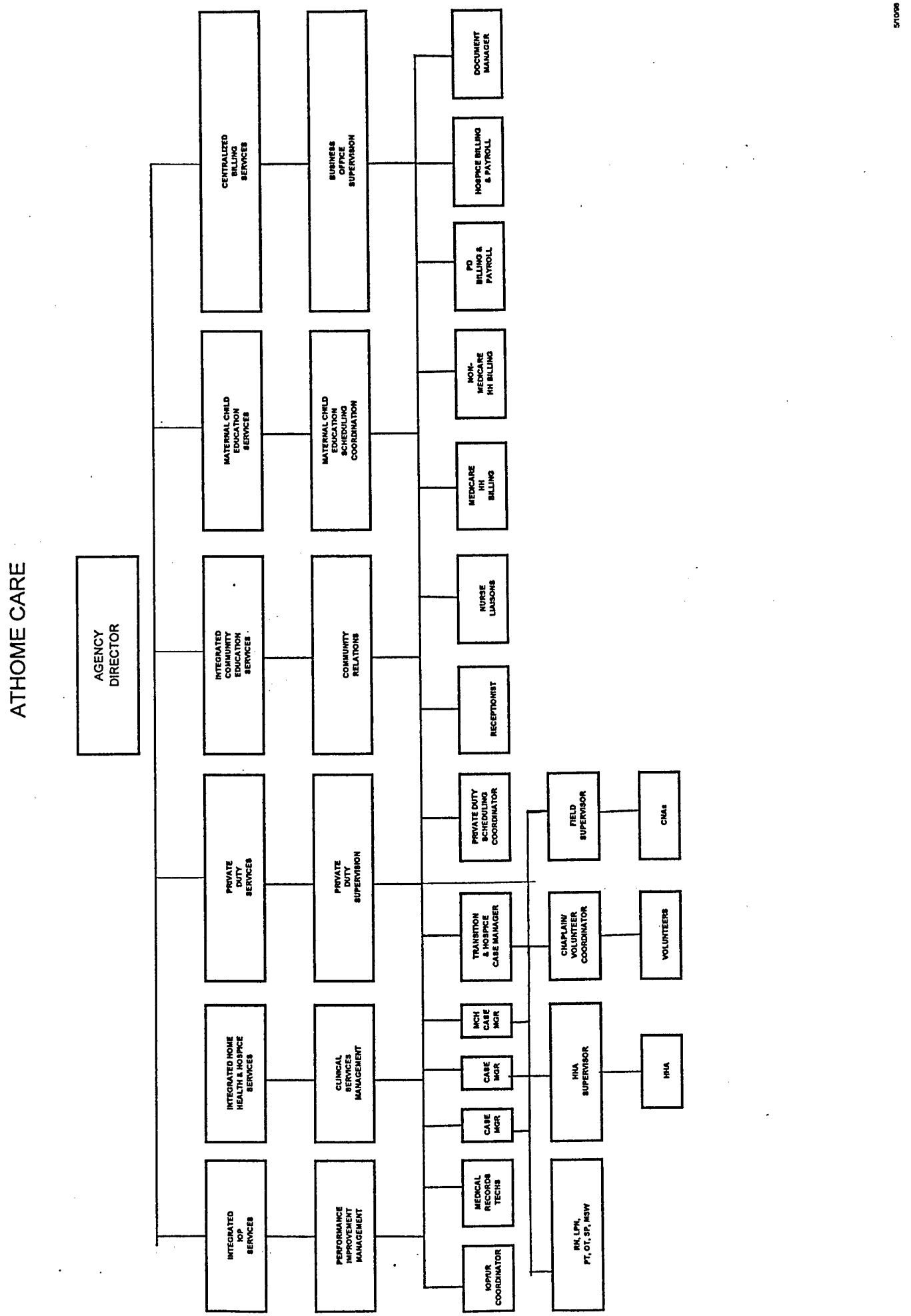
ATHOME CARE
AGENCY DIRECTOR
CENTRALIZED BILLING SERVICES
BUSINESS OFFICE SUPERVISION
DOCUMENT MANAGER
HOSPICE BILLING & PAYROLL
PD BILLING & PAYROLL
MATERNAL CHILD EDUCATION SERVICES
MATERNAL CHILD EDUCATION SCHEDULING COORDINATION
NON-MEDICARE HH BILLING
MEDICARE HH BILLING
INTEGRATED COMMUNITY EDUCATION SERVICES
COMMUNITY RELATIONS
NURSE LIAISONS
RECEPTIONIST
PRIVATE DUTY SERVICES
PRIVATE DUTY SUPERVISION
PRIVATE DUTY SCHEDULING COORDINATOR
FIELD SUPERVISOR
CNAs
TRANSITION & HOSPICE CASE MANAGER
CHAPLAIN/ VOLUNTEER COORDINATOR
VOLUNTEERS
INTEGRATED HOME HEALTH & HOSPICE SERVICES
CLINICAL SERVICES MANAGEMENT
MCH CASE MGR
CASE MGR
CASE MGR
HHA SUPERVISOR
HHA
INTEGRATED IOP SERVICES
PERFORMANCE IMPROVEMENT MANAGEMENT
MEDICAL RECORDS TECHS
IOPUR COORDINATOR
RN, LPN, PT, OT, SP, MSW
5/10/98

M&M Home Care Agency
1997 IMPROVING OPERATIONAL PERFORMANCE PROGRAM

Functions (FC): Rights/Ethics (RI); Assessment (PE); Care/Treatment/Services (TX); Education (PF); Continuum of care (CC); Improving Organizational Performance (PI); Leadership (LD); Mgt of Information (IM); Surveillance/ Prevention/Control of Infection (IC), Mgt of Human Resources (HR) Environmental Safety/Equipment Mgt (EC)

Reason:(RE): High risk (HR); Problem prone (PP), High volume (HV)

Dimensions of Performance (PD): Efficacy (EC); Availability (AV); Timeliness (TI); Effectiveness (EF); Safety (SA); Appropriateness (AP); Efficiency (EY); Respect/Caring (RC); Continuity (CO);

Outcome (OC): Quality (QU); Community Service (CS); Facilities (FS); Financial Resources (FR); Patient Outcomes (PO); Employee Development (ED). Hospital/physician Relationship (HP);

PRIORITY IMPROVEMENT ACTIVITY	COST CTR	FC	PD	RE	GOALS	OC	DATA COLLECTION	IMPROVEMENT PROCESS
Care planning process	HHS HOS PDS	PE, TX, PF, CC, PI, IM, HR	EC, AP, SA, TI, EF, EY, RC, CO	PP HV	The care plan will be a functional tool and reflect ongoing needs and services provided 100% of the time.	QU PO ED	HHS: Data will be collected from a quarterly review of 10% of cases. PDS: Data will be collected from supervisory visits & a quarterly review of at least 5 charts. HOS: Data will be collected utilizing the Hospice QA tool.	Following data review an appropriate improvement plan of action will be established as needed
Orientation	HHS HOS PDS	RI, PE, TX, PF, CC, PI, LD, EC, HR, IM, IC	EC, AP, AV, TI, EF, SA. EY, RC, CO	PP	HHS/HOS: Staff will score at least 80% on the post orientation test. PDS: Staff will follow the Plan of Care appropriately 100% of the time.	QU PO ED FR	HHS/HOS: Data will be collected from results of tests and reported quarterly. PDS: Data will be collected from the weekly documentation review by the PDS Supervisor and by information obtained during supervisory visits.	Following data review an appropriate improvement plan of action will be established as needed
Staffing Aides for Private Duty and Hospice clients, unfilled hours of service.	PDS HOS	TX, CC, LD, HR, IM, PI	AP, AV, TI, CO, SA	PP	Clients' staffing needs for Aide services will be met 100% of the time.	QI FR PO	Data will be collected from Private Duty & Hospice records of unfilled hours. To include unfilled shifts & also clients unable to admit. The **Performance Improvement Committee** will evaluate and recommend actions.	Following data review an appropriate improvement plan of action will be established as needed
Technical support staffing	HHS HOS	RI, PE, TX, PF, CC, PI, LD, EC, HR, IM, IC	EC, AP, AV, TI, EF, SA. EY, RC, CO	HR PP	The Agency will assess and define the role of the technical support position as appropriate by June 1997.	QU FR PO ED	RN preceptor will be assigned to all LPN's. LPN's will receive an RN supervisory visit at least monthly. Any pertinent Incident Reports, Medication Variance Reports, & Analysis of Service Reports will be reviewed. A **Performance Improvement Committee** consisting of Supervisory staff, Preceptors & IOP/UR staff will evaluate data and recommend actions.	Following data review an appropriate improvement plan of action will be established as needed
Claims Processing	HHS PDS	LD, RI, TX, HR	TI, EY	HV PP	HHS: At time of monthly billing, there will be no more than 5 claims which require a delay in processing due to lack of returned signed orders. PDS: At time of monthly billing, there will be no more than 3 cases which require a delay in processing due to incomplete paperwork.	FR ED	HHS: Data will be collected by the book-keeper & reviewed monthly by the Billing **Performance Improvement Committee** Follow up to be done by Case Managers with input from the IOP/UR staff. PDS: Data will be collected, reviewed and followed up monthly by the Private Duty Program or her designee.	Following data review an appropriate improvement plan of action will be established as needed

CONTINUOUS IMPROVEMENT ACTIVITY	COST CTR	FC	PD	RE	GOALS	OC	DATA COLLECTION	IMPROVEMENT PROCESS
Customer Satisfaction / Service Excellence	HHS PDS HOS	LD, RI, PF, TX, PI, HR	AP, RC	HV	Customer complaints will be addressed per agency policy with documented action taken and resolution 100% of the time.	QU CS HP FS FR PO ED	Data will be collected from (but not limited to): Incident Reports, Analysis of Service Reports, client satisfaction surveys, and IOP monitors and reported monthly. 100% of complaints received will be reviewed.	Continually monitor for trends or opportunities to improve processes and initiate changes as needed.
Physician Satisfaction / Service Excellence	HHS HOS	RI, TX, PF, CC, LD, HR, IM, PI	EC, AP, AV, TI, EF, CO, SA, EY, RC	HV	Utilize the physician as a process improvement team member. Identify areas in need of improvement which will enhance service excellence.	QU CS HP FS FR PO ED	Data will continually be collected and evaluated from the physician satisfactions surveys. Hospice Services will continue to use their own survey tool.	Continually monitor for trends or opportunities to improve processes and initiate changes as needed.
Plan of Care Processing	HHS	LD, PF, IM, PI,	TI, CO, EY	HV PP	All new charts and all charts for recertification will be processed with as much efficiency as possible.	QU FR PO ED	Data will be studied on a continuing basis by the Medical Records staff and the IOP/UR staff at the **Performance Improvement Committee** meetings.	Continually monitor for trends or opportunities to improve processes and initiate changes as needed.
Acquired client infections	HHS PDS HOS	PE, TX, PF, CC, IC, IM, IC,	EC, AP, EF, SA	HR	Identify possible correlation between client acquired infection(s) and specific employee(s).	QU PO ED	Data will be collected from IOP indicators and reported monthly.	Continually monitor for trends or opportunities to improve processes and initiate changes as needed.
Use of Quantifiable Outcome Measurements for Rehabilitative Services	HHS	TX, PE, CC, PF, IM, PI	EC, AP, EF, CO, EY	HV	Through the appropriate utilization of a functional measurement tool, data collected will assist with establishing Agency standards and support reimbursement capitation.	QU PO ED	Data will be collected from the initial therapy evaluation, 60 day summary report and discharge summary in the clinical record of clients with the primary diagnosis Total Hip Replacement.	Continually monitor for trends or opportunities to improve processes and initiate changes as needed.
Use of Quantifiable Measurements (FIMS) for Skilled Nursing outcomes studies	HHS	PE, TX, PF, CC, PI, EC, IM	EC, AP, EF, EY,	HV	Through the appropriate utilization of a functional measurement tool, data collected will assist with establishing Agency standards and support reimbursement capitation.	QU PO ED	Data will be collected from the Nursing FIMS which are utilized on the Discharge Summary and 60 Day Progress Note.	Continually monitor for trends or opportunities to improve processes and initiate changes as needed.
Pain Management of Hospice Clients	HOS	RI, PE, TX, PF, CC, IC, IM	EC, AP, AV, TI, EF, CO, EY, RC	HR	A measurable pain assessment will be performed on the initial visit. Client will demonstrate improvement in pain within 24 hours and achieve pain control according to the clients expectations within 48-72 hours.	QU PO ED FS	Data will be collected by the Hospice Program Supervisor from the medical records on an ongoing basis and reported quarterly. Sample size will include 100% of Hospice clients.	Continually monitor for trends or opportunities to improve processes and initiate changes as needed.

CONTINUOUS IMPROVEMENT ACTIVITY	COST CTR	FC	PD	RE	GOALS	OC	DATA COLLECTION	IMPROVEMENT PROCESS
Management of Wounds	HHS HOS	TX, PF, PE, IC, CC, IM, PI, IM	AP, TI, EC, EF, CO	HR	All wounds will show evidence of healing within 3 weeks or MD will be notified of lack of progress and appropriate orders obtained as needed.	QU PO ED FS	Data will be collected from the IOP indicators and reported monthly. Sample size will include 10% (or no less than 5) of clients with primary diagnosis open wound or decubitus.	Continually monitor for trends or opportunities to improve processes and initiate changes as needed.
Management of Surgical Wound Infections	HHS	TX, PF, PE, IC, CC, IM, PI, IM	AP, TI, EC, EF, CO, SA	HR	100% of clients acquiring surgical site infections within 30 days of surgery will have documentation of notification of the infection to the hospital where the surgery was performed.	QU PO ED FS	Data will be collected from the IOP indicators and reported monthly. Sample size will include 100% of reported surgical site infections.	Continually monitor for trends or opportunities to improve processes and initiate changes as needed.
DRG Outcome Studies	HHS	TX, CC, PI, IM,	AP, AV, TI, CO, EY	HV	To provide supporting data to prevent recidivism.	QU CS HP FR PO	Data will be collected from the VBGH Patient Discharge Disposition Report, M&M Agency's admissions & reported monthly for the DRGs: 79-Respiratory Infections & Inflammations; 88-COPD; 89-Simple pneumonia & pleurisy; 127-Heart Failure & Shock; 209-Joint Replacement, & S/P CABG.	Continually monitor for trends or opportunities to improve processes and initiate changes as needed.
Maternal Child High Risk Pregnancy Case Management Outcome Studies.	HHS	RI, PE, TX, PF, CC, EC, IM, IC, PI	EC, AP, AV, TI, EF, CO, SA, EY, RC	HR	Clients who receive High Risk Pregnancy case management will have higher potential for positive pregnancy outcomes. Pre-term labor will be minimized.	QU CS HP FR PO	Data will be collected from Maternal Child Health clinical documentation.	Continually monitor for trends or opportunities to improve processes and initiate changes as needed.
Benchmarking Studies	HHS	PE, TX, PF, CC, LD, IC, HR, IM, PI	EC, AP, TI, EF, CO, SA, EY	HV	Participate in the SunHealth Alliance Benchmarking Survey to assist with development of standards of "best practices" in home care.	QU CS HP FS FR PO ED	Data will be collected as required by SunHealth Alliance.	Continually monitor for trends or opportunities to improve processes and initiate changes as needed.
Family Satisfaction	HOS	RI, RX, PE PF,IC CC, IM PI IM, LD, PI,	EY, AP AV, EF CO ,SA EC , RC	HV	Provide supporting data to the National Hospice Organization Standards and Accreditation Committee to develop national outcomes studies.	QU CS PO ED	Data will be collected utilizing the National Hospice Organization Standards and Accreditation Committee Family Satisfaction Survey Data Collection Tool every 6 months.	We will continue to monitor for trends and opportunities to improve care.

Appendix C M&M Agency Patient Satisfaction Survey

Thank you for selecting M&M Agency for your Home Health needs. So that we may continue to provide excellent service, please answer these brief questions. If a question is not applicable, indicate "Does Not Apply." Please return this form at your earliest convenience in the self-addressed, stamped envelope. Contact us at 757-000-0000, if you have questions about this survey.

Name: (optional) _____ Age:_____

Please circle the appropriate response or answer the question.

1. Male Female

2. How do you live? By yourself With your spouse With a significant other
   With a Family Member With paid help Other

3. What medical condition or conditions resulted in your being referred to **M&M Agency**?

4. Were your expectations met by the staff of **M&M Agency**?
   Always Most of the time Sometimes Never

5. During telephone contact was our staff courteous and informative?
   Yes No Does Not Apply

6. If contacting our answering services after hours, did you find services prompt and satisfactory?
   Yes No Does Not Apply

7. Do you feel that care provided by the **M&M Agency** staff respected your wishes, beliefs and values?
   Yes No Does not Apply

8. Did the **M&M Agency** staff help you achieve your health care goals?
   Yes No Does Not Apply

9. Would you recommend **M&M Agency** Home Health Services to others?
   Yes No Does Not Apply

10. Would you use **M&M Agency** Home Health Services again?
    Yes No Does Not Apply

11. Please rate the following **M&M Agency** services using the grading system described below. Circle the appropriate letter grade for your response.

Grade	Name	Definition
A	**Outstanding**	**Highest achievement**
B	**Good**	**Making an effort**
C	**Average**	**Not out of the ordinary**
D	**Poor**	**Falling short**
F	**Failing**	**Totally lacking**

The **M&M Agency** Office Personnel (e.g., courteous on phone, willingness to help, etc.)

A B C D F Does Not Apply

The **M&M Agency** Caregiver sent to your home:

a.	Was knowledgeable of the job:	A	B	C	D	F Does Not Apply
b.	Was dependable:	A	B	C	D	F Does Not Apply
c.	Was comforting:	A	B	C	D	F Does Not Apply
d.	Treated me with dignity:	A	B	C	D	F Does Not Apply
e.	Taught me about my illness:	A	B	C	D	F Does Not Apply
f.	Gave me clear instructions :	A	B	C	D	F Does Not Apply
g.	Was Professional in appearance:	A	B	C	D	F Does Not Apply

Overall, how would you rate the services you received from **M&M Agency?**

A B C D F Does Not Apply

12. Please use the space below to make comments, suggestions, or bring to our attention any problems you may have had while using our services.

Thank you for helping us evaluate and improve our care.
If you would like to be contacted by an M&M Agency representative to discuss any aspect of your Home Health Care, please include your name, a daytime phone number and the most convenient time for us to call.

Name _____ Daytime phone number_____

Time _____

Appendix D
Descriptive Statistics for the Questionnaire

Question	Valid Statistic	Missing Statistic	Mean Statistic	Mean Std. Error	Median Statistic	Mode Statistic	Standard Deviation
Age	114	0	70.86	1.34	72	71	14.27
Q01 Sex	114	0	.63	4.54E-02	1.00	1	.48
Q02 Living Arrang.	114	0	2.15	.10	2.00	2	1.11
Q03 Knew Condition	114	0	.83	3.51E-02	1.00	1	.37
Q04 Expect	114	0	2.96	.10	3.00	3	1.10
Q05 Phone	107	7	1.00	.00		1	.00
Q06 Answer	52	62	.96	2.69E-02	1.00	1	.19
Q07 Respect	112	2	1.00	.00		1	.00
Q08 Achieve	100	14	.98	1.41E-02	1.00	1	.14
Q09 Services	112	2	1.00	.00		1	.00
Q010 Use Services	114	0	1.00	.00		1	.00
Q1101 Office	78	36	4.81	4.49E-02	5.00	5	.40
Q1102A	112	2	4.92	2.88E-02	5.00	5	.30
Q1102B	109	5	4.86	3.79E-02	5.00	5	.40
Q1102C Know	107	7	4.88	3.44E-02	5.00	5	.36
Q1102D Depend	110	4	4.91	3.04E-02	5.00	5	.32
Q110E Comfort	102	12	4.83	4.20E-02	5.00	5	.42
Q1102F Dignity	104	10	4.93	2.47E-02	5.00	5	.25
Q1102G Taught	110	4	4.91	2.75E-02	5.00	5	.29
Q1103 Overall	113	1	4.85	4.02E-02	5.00	5	.43
Overall							

Appendix E HOME HEALTH SERVICES M&M AGENCY PATIENT SATISFACTION SURVEY

Thank you for selecting M&M Agency for your Home Health needs. So that we may continue to provide excellent service, please answer these brief questions. If a question is not applicable, indicate "Does Not Apply." Please return this form at your earliest convenience in the self-addressed, stamped envelope. Contact us at 757-000-0000, if you have questions about this survey.

Name: (optional)_____ Age:_____

Please circle the appropriate response or answer the question.

Q01. Male (0) Female (1)

QO2. How do you live? By yourself (1) With your spouse (2) With a significant other (3) With a Family Member (4) With paid help (5) Other (6)

Q03. What medical condition or conditions resulted in your being referred to **M&M Agency**?

Yes (1)_____

No (2)_____

Q04. Were your expectations met by the staff of **M&M Agency**?
Always (3) Most of the time (2) Sometimes (1) Never (0)

Q05. During telephone contact was our staff courteous and informative?
Yes (1) No (0) Does Not Apply (9)

Q06. If contacting our answering services after hours, did you find services prompt and satisfactory?
Yes (1) No (0) Does Not Apply (9)

Q07. Do you feel that care provided by the **M&M Agency** staff respected your wishes, beliefs and values?
Yes (1) No (0) Does Not Apply (9)

Q08. Did the **M&M Agency** staff help you achieve your health care goals?
Yes (1) No (0) Does Not Apply (9)

Q09. Would you recommend **M&M Agency** Home Health Services to others?
Yes (1) No (0) Does Not Apply (9)

Q010. Would you use **M&M Agency** Home Health Services again?
Yes (1) No (0) Does Not Apply (9)

11. Please rate the following **M&M Agency** services using the grading system described below. Circle the appropriate letter grade for your response.

Grade	Name	Definition
A = (5)	**Outstanding**	**Highest achievement**
B = (4)	**Good**	**Making an effort**
C = (3)	**Average**	**Not out of the ordinary**
D = (2)	**Poor**	**Falling short**
F = (1)	**Failing**	**Totally lacking**
Does Not Apply = 9		

Q1101 Were **M&M Agency** Office Personnel (e.g., courteous on phone, willingness to help, etc.)
A B C D F Does Not Apply (9)

The M&M Agency Caregiver sent to your home:

Q1102a. Was knowledgeable of the job:	A	B	C	D	F	Does Not Apply
Q1102b. Was dependable	A	B	C	D	F	Does Not Apply
Q1102c. Was comforting:	A	B	C	D	F	Does Not Apply
Q1102d. Treated me with dignity:	A	B	C	D	F	Does Not Apply
Q1102e. Taught me about my illness:	A	B	C	D	F	Does Not Apply
Q1102f. Gave me clear instructions :	A	B	C	D	F	Does Not Apply
Q1102g. Was Professional in appearance:	A	B	C	D	F	Does Not Apply

Overall, how would you rate the services you received from **M&M Agency?**
A B C D F Does Not Apply

12. Please use the space below to make comments, suggestions, or bring to our attention any problems you may have had while using our services.

Thank you for helping us evaluate and improve our care.
If you would like to be contacted by an M&M Agency representative to discuss any aspect of your Home Health Care, please include your name, a daytime phone number and the most convenient time for us to call.

Name _____ Daytime phone number_____ Time _____

Responses to Question 12 on the Survey

1. Susie is the most caring person. I cannot begin to express my praise for her. She was so professional and stayed on top of my complications and worked hard to try and get me the help I needed. She even came to the hospital when I was operated on for a second time. Thank you for a wonderful caregiver.

2. Your staff was wonderful.

3. I appreciate the good service and help I received.

4. Susie is the most compassionate person. She has gone way beyond her duties to care for me.

5. Immediate service was most appreciated by the family.

6. The speech therapist was very professional, caring, never felt rushed, very patient, and thorough; I would highly recommend her to anyone in need of her services.

7. Maryann took my husband's blood pressure at his request the first day at my home. She said my husband needed to go to the hospital immediately. He went and was suffering from a bad heart attack that was imminent. His surgery was a few days later. He had home care also. She saved his life.

8. Had no problems. Velum was wonderful and John was a super therapist.

9. Had no problems with home health care.

10. I only had home health care a few days. I was treated with real respect and kindness.

11. They do not cut my toenails.

12. I highly recommend our nurse Debbie and I am so thankful to have her as a nurse. She is indeed outstanding.

13. Theresa is very good and goes beyond service to help you any way she can. Theresa is an excellent nurse.

14. Lynn was an excellent physical therapist.

15. Everyone did a great job.

16. Problem with the expectations of 78 year old wife to help spouse when the agency was not at home.

17. Please keep customers informed of insurance date for your service.

18. The care I received was excellent.

19. I was extremely satisfied with my care. They were very professional.

20. I'm really going to miss them. They were really a lot of help and company.

21. You provide an outstanding service.

22. I was really pleased with Carole. She was extremely helpful in getting me adjusted after my hospital stay. You definitely have an outstanding person working for you.

23. I can only answer this with one answer. Your service was always nice, considerate; you always do the work with tender care.

24. No problems! Theresa, our assigned nurse was so kind, considerate and gave such wonderful professional care. It was comforting to know that we could call at any time and receive help. This happened to me one Sunday night--Theresa was out of town, but help came immediately. Wonderful response time. Thank you for all you're doing.

25. Everyone was very nice and loving--could not be any better. Thanks a lot. God Bless all of you.

26. I loved Karen very much and I miss her too. She was very good to me.

27. Physical therapy was excellent.

28. Not any comments--all very good. I learned a great deal from the nurses.

29. Linda and Katherine were absolutely great and made the whole experience a lot more tolerable than I ever expected. My husband and I both will miss their daily visits!

30. No problems; your staff has been excellent in all their separate jobs.

31. The nurse who came to me was very pleasant and caring and since both our husbands were Navy we could chitchat and relax.

32. The answer to the above question is my comments to you and I could not ask for a nurse to be any better or any nicer.

33. Fred deserves "outstanding employee" award and Velma, the "home aide award" for outstanding services.

34. No problems--very dependable.

35. I have the highest regard for the nurses and staff in your organization. Please extend my "Thanks" to all.

36. Outstanding. Was recommended by my doctor. Shirley is the best. She is a credit to her profession. She can't do enough for her patients. Carol is also the best.

37. My only problem was my doctor. I since last week got a different doctor set up. I try to go out more but next time I need home care I will definitely suggest your agency. I was very happy with you and liked the way Dan treated me.

38. Had no problems - thank you for coming to my rescue.

39. No problems.

40. Theresa is a wonderful nurse.

41. No problems.

42. Nurse, physical therapist, and caregiver were all excellent.

43. I had no problems my therapy was outstanding, wonderful person. Jean Marie and Emily, this is the second time they help me. Couldn't ask for better ladies. You keep up the good work with the employees you sent me; you've never had any trouble. I forgot one of the beautiful ladies that checked on me, she was beautiful inside and out. I would like to tell you that I recommended you to Dr. Herbert Brewer. He called and talked about your company. I could not have said anything different than what I have said in this letter. He is a heart specialist.

44. Susie is the most caring person. I cannot begin to express my praise for her. She was so professional and stayed on top of my complications and worked hard to try and get me the help I needed. She even came to the hospital when I was operated on for a second time. Thank you for a wonderful caregiver.

45. Your staff was wonderful.

46. I appreciate the good service & help I received.

47. Susie is the most compassionate person. She has gone way beyond her duties to care for me.

48. The "RN" was outstanding

49. All who helped me were outstanding.

50. Nurse, Physical Therapist and caregiver were all excellent. Thank you.

51. I was extremely pleased with the care I received. PT was very patient and helpful to me. The health aides were confident in their responsibilities--kind and professional. They were all more than I expected. You can be proud of them.

52. Your agency was wonderful and helped me in every way. Why he even helped my wife carry in the groceries. Just can't say enough about him.

53. I took a wonderful turn for the better and we discontinued services. We were all very satisfied for the short time.

Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
Q01 sex * PERFGRAD	97	85.1%	17	14.9%	114	100.0%
Q02 Living Arrangements * PERFGRAD	97	85.1%	17	14.9%	114	100.0%
Q1104CAT major diagnostic category * PERFGRAD	97	85.1%	17	14.9%	114	100.0%

Q01 sex * PERFGRAD

Crosstab

			PERFGRAD		Total
			0	1	
Q01 sex	0 male	Count	8	31	39
		% within Q01 sex	20.5%	79.5%	100.0%
		% within PERFGRAD	34.8%	41.9%	40.2%
		% of Total	8.2%	32.0%	40.2%
	1 female	Count	15	43	58
		% within Q01 sex	25.9%	74.1%	100.0%
		% within PERFGRAD	65.2%	58.1%	59.8%
		% of Total	15.5%	44.3%	59.8%
Total		Count	23	74	97
		% within Q01 sex	23.7%	76.3%	100.0%
		% within PERFGRAD	100.0%	100.0%	100.0%
		% of Total	23.7%	76.3%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-tailed)	Exact Sig. (2-tailed)	Exact Sig. (1-tailed)
Pearson Chi-Square	.369[2]	1	.544		
Continuity Correction[1]	.132	1	.716		
Likelihood Ratio	.373	1	.541		
Fisher's Exact Test				.631	.361
Linear-by-Linear Association	.365	1	.546		
N of Valid Cases	97				

1. Computed only for a 2x2 table
2. 0 cells (.0%) have expected count less than 5. The minimum expected count is 9.25.

Q02 Living Arrangements * PERFGRAD

Crosstab

			PERFGRAD		Total
			0	1	
Q02 Living Arrangements	1 alone	Count	4	20	24
		% within Q02 Living Arrangements	16.7%	83.3%	100.0%
		% within PERFGRAD	17.4%	27.0%	24.7%
		% of Total	4.1%	20.6%	24.7%
	2 with your spouse	Count	11	42	53
		% within Q02 Living Arrangements	20.8%	79.2%	100.0%
		% within PERFGRAD	47.8%	56.8%	54.6%
		% of Total	11.3%	43.3%	54.6%
	4 with family	Count	7	11	18
		% within Q02 Living Arrangements	38.9%	61.1%	100.0%
		% within PERFGRAD	30.4%	14.9%	18.6%
		% of Total	7.2%	11.3%	18.6%
	5 paid help	Count		1	1
		% within Q02 Living Arrangements		100.0%	100.0%
		% within PERFGRAD		1.4%	1.0%
		% of Total		1.0%	1.0%
	6	Count	1		1
		% within Q02 Living Arrangements	100.0%		100.0%
		% within PERFGRAD	4.3%		1.0%
		% of Total	1.0%		1.0%
Total		Count	23	74	97
		% within Q02 Living Arrangements	23.7%	76.3%	100.0%
		% within PERFGRAD	100.0%	100.0%	100.0%
		% of Total	23.7%	76.3%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-tailed)
Pearson Chi-Square	6.735[1]	4	.151
Likelihood Ratio	6.443	4	.168
Linear-by-Linear Association	4.206	1	.040
N of Valid Cases	97		

1. 5 cells (50.0%) have expected count less than 5. The minimum expected count is .24.

Q1104CAT major diagnostic category * PERFGRAD

Crosstab

			PERFGRAD		Total
			0	1	
Q1104CAT major diagnostic category	7 circulatory	Count	5	19	24
		% within Q1104CAT major diagnostic category	20.8%	79.2%	100.0%
		% within PERFGRAD	21.7%	25.7%	24.7%
		% of Total	5.2%	19.6%	24.7%
	8 respiratory	Count	3	11	14
		% within Q1104CAT major diagnostic category	21.4%	78.6%	100.0%
		% within PERFGRAD	13.0%	14.9%	14.4%
		% of Total	3.1%	11.3%	14.4%
	13 Musculosskeletal system	Count	5	14	19
		% within Q1104CAT major diagnostic category	26.3%	73.7%	100.0%
		% within PERFGRAD	21.7%	18.9%	19.6%
		% of Total	5.2%	14.4%	19.6%
	16 ill defined conditions	Count	10	30	40
		% within Q1104CAT major diagnostic category	25.0%	75.0%	100.0%
		% within PERFGRAD	43.5%	40.5%	41.2%
		% of Total	10.3%	30.9%	41.2%
Total		Count	23	74	97
		% within Q1104CAT major diagnostic category	23.7%	76.3%	100.0%
		% within PERFGRAD	100.0%	100.0%	100.0%
		% of Total	23.7%	76.3%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-tailed)
Pearson Chi-Square	.258[1]	3	.968
Likelihood Ratio	.260	3	.967
Linear-by-Linear Association	.196	1	.658
N of Valid Cases	97		

1. 2 cells (25.0%) have expected count less than 5. The minimum expected count is 3.32.

Crosstabs

Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
Q01 sex * PERFGRAD	97	85.1%	17	14.9%	114	100.0%
Q02A * PERFGRAD	97	85.1%	17	14.9%	114	100.0%
Q1104CAT major diagnostic category * PERFGRAD	97	85.1%	17	14.9%	114	100.0%

Q01 sex * PERFGRAD

Appendix F

Crosstab

			PERFGRAD		Total
			0	1	
Q01 sex	0 male	Count	8	31	39
		% within Q01 sex	20.5%	79.5%	100.0%
		% within PERFGRAD	34.8%	41.9%	40.2%
		% of Total	8.2%	32.0%	40.2%
	1 female	Count	15	43	58
		% within Q01 sex	25.9%	74.1%	100.0%
		% within PERFGRAD	65.2%	58.1%	59.8%
		% of Total	15.5%	44.3%	59.8%
Total		Count	23	74	97
		% within Q01 sex	23.7%	76.3%	100.0%
		% within PERFGRAD	100.0%	100.0%	100.0%
		% of Total	23.7%	76.3%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-tailed)	Exact Sig. (2-tailed)	Exact Sig. (1-tailed)
Pearson Chi-Square	.369[2]	1	.544		
Continuity Correction[1]	.132	1	.716		
Likelihood Ratio	.373	1	.541		
Fisher's Exact Test				.631	.361
Linear-by-Linear Association	.365	1	.546		
N of Valid Cases	97				

1. Computed only for a 2x2 table
2. 0 cells (.0%) have expected count less than 5. The minimum expected count is 9.25.

Q02A * PERFGRAD

Crosstab

			PERFGRAD		Total
			0	1	
Q02A	1	Count	4	20	24
		% within Q02A	16.7%	83.3%	100.0%
		% within PERFGRAD	17.4%	27.0%	24.7%
		% of Total	4.1%	20.6%	24.7%
	2	Count	11	42	53
		% within Q02A	20.8%	79.2%	100.0%
		% within PERFGRAD	47.8%	56.8%	54.6%
		% of Total	11.3%	43.3%	54.6%
	3	Count	8	12	20
		% within Q02A	40.0%	60.0%	100.0%
		% within PERFGRAD	34.8%	16.2%	20.6%
		% of Total	8.2%	12.4%	20.6%
Total		Count	23	74	97
		% within Q02A	23.7%	76.3%	100.0%
		% within PERFGRAD	100.0%	100.0%	100.0%
		% of Total	23.7%	76.3%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-tailed)
Pearson Chi-Square	3.848[1]	2	.146
Likelihood Ratio	3.579	2	.167
Linear-by-Linear Association	3.056	1	.080
N of Valid Cases	97		

1. 1 cells (16.7%) have expected count less than 5. The minimum expected count is 4.74.

Q1104CAT major diagnostic category * PERFGRAD

Appendix F

Crosstab

			PERFGRAD		Total
			0	1	
Q1104CAT major diagnostic category	7 circulatory	Count	5	19	24
		% within Q1104CAT major diagnostic category	20.8%	79.2%	100.0%
		% within PERFGRAD	21.7%	25.7%	24.7%
		% of Total	5.2%	19.6%	24.7%
	8 respiratory	Count	3	11	14
		% within Q1104CAT major diagnostic category	21.4%	78.6%	100.0%
		% within PERFGRAD	13.0%	14.9%	14.4%
		% of Total	3.1%	11.3%	14.4%
	13 Musculosskeletal system	Count	5	14	19
		% within Q1104CAT major diagnostic category	26.3%	73.7%	100.0%
		% within PERFGRAD	21.7%	18.9%	19.6%
		% of Total	5.2%	14.4%	19.6%
	16 ill defined conditions	Count	10	30	40
		% within Q1104CAT major diagnostic category	25.0%	75.0%	100.0%
		% within PERFGRAD	43.5%	40.5%	41.2%
		% of Total	10.3%	30.9%	41.2%
Total		Count	23	74	97
		% within Q1104CAT major diagnostic category	23.7%	76.3%	100.0%
		% within PERFGRAD	100.0%	100.0%	100.0%
		% of Total	23.7%	76.3%	100.0%

Appendix F

Chi-Square Tests

	Value	df	Asymp. Sig. (2-tailed)
Pearson Chi-Square	.258[1]	3	.968
Likelihood Ratio	.260	3	.967
Linear-by-Linear Association	.196	1	.658
N of Valid Cases	97		

1. 2 cells (25.0%) have expected count less than 5. The minimum expected count is 3.32.

Appendix G
Resident Inspection Using
JCAHO Accreditation Guidelines

Organization: M&M Home Health Care Agency Survey Date: December 1997

Patient-Focused Functions	Organization Functions
Rights and Ethics	**Improving Organizational Performance**
Rights and Ethics: Appears to be in compliance	Improving Organizational Performance: Appears to be in compliance
Assessment	**Leadership**
Patient Assessment: Appears to be in compliance*	Governance: Appears to be in compliance
Assessment of Specific Populations: Appears to be in compliance	Operations: Appears to be in compliance
Care, Treatment, and Service	Role in Improving Performance: Appears to be in compliance
Care-planning Process: Appears to be in compliance	**Environmental Safety and Equipment Management**
Medication Administration: Appears to be in compliance	Environmental Safety: Appears to be in compliance
Patient Medication Monitoring: Appears to be in compliance	Equipment Management: Appears to be in compliance
Nutrition Care: Should be incorporated in PI activities	**Management of Human Resources**
Education	Management of Human Resources: Should be incorporated in PI activities
Education Program Management: Should be incorporated in PI activities	**Management of Information**
Patient Education: Appears to be in compliance	Information-Management Planning: Appears to be in compliance
Education about Specific Care: Appears to be in compliance	Patient Specific Data and Information: Should be incorporated in PI activities
Continuum of Care and Services	**Surveillance, Prevention, and Control of Infection**
Continuum of Care and Services: Appears to be in compliance	Surveillance, Prevention, and Control of Infection: Appears to be in compliance
* Nutritional Assessment and re-evaluation should be incorporated in PI activities	

Appendix H

January 13, 1998

Dear Office Manager,

Happy New Year. As we close out 1997, **M&M Agency** Home Health services would like your office to provide feedback on how well we are meeting your needs and the needs of your patients. We value your opinion of our services as well as the opinions of the physicians who work with you. Please complete your portion of the survey. If another person in your office is a better evaluator of our services, please pass the survey to them for completion.

Please ask the physician(s) to complete his or her portion of the enclosed surveys. Surveys should be returned in the stamped self-addressed enclosed envelopes. If forms are returned by the 31st of January, Office Managers are eligible for a drawing of a $25 gift certificate for a restaurant of the recipient's choice. Your name will be placed into the drawing for the return of your survey and for each of the physicians returning a survey. The winner will be chosen on February 2, 1998.

Thank you for your time. We look forward to hearing from you by January 31st.

Director of M&M Agency

Appendix I

M&M AGENCY

HOME HEALTH SERVICES
PHYSICIAN OFFICE STAFF
SATISFACTION SURVEY

So that we may continue to provide excellent service, please answer these brief questions. If a question is not applicable, indicate "Does Not Apply." Please return this form **on or before February 2, 1998** in the self-addressed, stamped envelope. If you have questions about this survey, please contact us at 757-467-3975.

1. Case managers deal effectively with problems or concerns.
   Strongly agree Agree No opinion Disagree Strongly disagree
   Does Not Apply
2. Phone personnel are helpful.
   Strongly agree Agree No opinion Disagree Strongly disagree
   Does Not Apply
3. Would you recommend **M&M Agency** to others?
   Strongly agree Agree No opinion Disagree Strongly disagree
   Does Not Apply
4. Do you have any feedback on **M&M Agency** Case Managers?_____
   _____
5. What can we do to make it easier for you to work with **M&M Agency?**_____
   _____
6. How can **M&M Agency** improve services to you and your patients? (Please use the back of page, if needed).
7. Do you have a problem or concern that you would like to discuss with someone? If yes, the director of **M&M Agency** will contact you. 1 Yes 1 No

Who is answering the survey? Name: (optional)_____

Position:_____Phone:_____

Appendix J
1997 Home Health Services Physician Office Staff Satisfaction Survey Results

1. Case Managers deal effectively:
   Strongly Agree 2 (18%) Agree 9 (82%)

2. Phone Personnel are helpful:
   Strongly Agree 2 (18%) Agree 8 (73%) Disagree 1 (9%)

3. Recommend M&M to others?
   Strongly Agree 3 (17%) Agree 8 (73%)

4. Comments

5. Feedback on AtHome Care Case Managers

The Case Managers have always been very helpful with case management and follow-up.

a. Our patients haven't had any problems and have stated that they get excellent care.
b. No.
c. No.
d. JoAnne is the best. Elizabeth--excellent Hospice Coordinator. Susie is the best home health nurse.
e. Have Home Health Care nurses be more available and not so unable to be reached after certain times. Anonymous
g. None

What can we do to make it easier for you to work with M&M?

The plastic laminated schedules of Lamaze classes, prenatal info, breast-feeding were extremely helpful in directing our patients in the office. I wonder if you couldn't print a smaller schedule for patients' use. I find myself copying it to give to them, as they are unsure in the office when they will attend. Cheryl, Nurse Manager for Perinatal Clinic

Have forms available for standing orders.

I think the patient evaluation process works very smoothly. Wendy

Nothing. Cathy

Nothing. Pat

Nothing--Keep as you are. Just keep up the good service we receive now. Bonnie Rae

Appendix K

HOME HEALTH SERVICES

M&M AGENCY PHYSICIAN SATISFACTION SURVEY

Thank you for selecting M&M Agency for your Home Health needs. So that we may continue to provide excellent service, please answer these brief questions. If a question is not applicable, indicate "Does Not Apply". Please return this form at your earliest convenience **on or before February 2, 1998** in the self-addressed, stamped envelope. If you have questions about this survey, please contact us at 757- 467- 3975.

1. Are your Plans of Care and instructions being carried out to your satisfaction by the staff of **M&M Agency**?
   Yes 1 No* *If no, please elaborate in question # 8
2. Are changes in your patient's condition reported in a timely manner by the staff of **M&M Agency**?
   Yes 1 No* *If no, please elaborate in question # 8
3. Is the staff of **M&M Agency** available for communication about your patients?
   Yes 1 No* *If no, please elaborate in question # 8
4. Do you receive regular verbal or written summaries of your patient's condition and progress from the staff of **M&M Agency**?
   Yes 1 No
5. Are your patients satisfied with the home care services of **M&M Agency**?
   Yes 1 No
6. Are you satisfied with the following **M&M Agency** services?

Nursing	1 Yes	1 No	1 Does Not Apply
Therapy	1 Yes	1 No	1 Does Not Apply
Social Work	1 Yes	1 No	1 Does Not Apply
Infusion Services	1 Yes	1 No	1 Does Not Apply
Office Receptionist	1 Yes	1 No	1 Does Not Apply
Office Case Managers	1 Yes	1 No	1 Does Not Apply

7. How would you like **M&M Agency** to communicate with you? Please specify all media.
   Telephone 1 Fax 1 Written 1 E-mail 1 Other
8. How can **M&M Agency** improve our services to you and your patients? (Please use the back of page, if needed)._____
9. What has been the most satisfying aspect of working with **M&M Agency?**_____
10. Do you have a problem or concern that you would like to discuss with someone? If yes, the director of **M&M Agency** will contact you. 1 Yes 1 No

Who is answering the survey? Name: (optional)_____
Position:_____ Phone:_____

Appendix L
1997 Home Health Physician Satisfaction Survey Results

Are your plans of care being carried out to your satisfaction? 100%
Yes 18 No

Changes in patients reported in a timely manner? 100%
Yes 18 No

Staff available for communication? 100%
Yes 18 No

Regular written and verbal communications? 100%
Yes 18 No

Patients satisfied? 100%
Yes 18 No

Satisfied with Services:

Nursing	yes 18 100%	
Therapy	yes 14 (78%)	N/A 4 (12%)
Social Work	yes 13 (72%)	N/A 5 (18%)
Infusion Services	yes 14 (78%)	N/A 5 (12%)
Office Receptionist	yes 12 (67%)	N/A 6 (33%)
Office Case Manager	Yes 13 (72%)	N/A 6 (28%)

How would you like communication?

Get a decent answering service--get rid of long waits to get a specific person on the phone.

Improve telephone service - too long on hold; would like a direct line to case managers

The majority of physicians requested communication via telephone and fax.

Home Health Service

Vertical and Horizontal Analysis

Revenue Statements

For the Years Ended 1997 And 1996

			Vertical Analysis		*Horizontal Analysis*	
					$	%
	1997	1996	1997	1996	Change	Change
Gross Revenue	3,701,794	3,518,460	100.00%	100.00%	183,334	5.21%
Less Revenue Deductions	(1,123,867)	(1,089,995)	30.36%	30.98%	(33,872)	3.11%
Net Operating Revenue	2,577,927	2,428,465	69.64%	69.02%	149,462	6.15%
Operating Expenses - Salaries						
Regular Salaries & Wages	1,036,198	1,020,999	27.99%	29.02%	15,199	1.49%
Field Regular Salaries & Wages	-	-	0.00%	0.00%	-	n/a
Overtime Salaries & Wages	5,800	6,389	0.16%	0.18%	(589)	-9.22%
Field Overtime Salaries & Wages	-	-	0.00%	0.00%	-	n/a
Vacation Salaries & Wages	64,337	62,635	1.74%	1.78%	1,702	2.72%
Sick Salaries & Wages	2,982	5,139	0.08%	0.15%	(2,157)	-41.97%
Special Pay	174,568	166,222	4.72%	4.72%	8,346	5.02%
Field Special Pay	-	-	0%	0.00%	-	n/a
Total Operating Exp - Salaries	1,283,885	1,261,384	34.68%	35.85%	22,501	1.78%
Operating Expenses - Other						
FICA Taxes	96,255	95,121	2.60%	2.70%	1,134	1.19%
Group Health Insurance	40,127	26,534	1.08%	0.75%	13,593	51.23%
Employee Ins LTD & LIFE	5,331	4,392	0.14%	0.12%	939	21.38%
Retirement	35,061	30,659	0.95%	0.87%	4,402	14.36%
State Unemployment	1,033	1,384	0.03%	0.04%	(351)	-25.36%
Tuition Reimbursement	212	(140)	0.01%	0.00%	352	-251.43%
Legal Fees	-	-	0.00%	0.00%	-	n/a
Risk Mgmt Fees	15,600	15,288	0.42%	0.43%	312	2.04%
Medical Specialist Fee	(5,620)	5,000	-0.15%	0.14%	(10,620)	-212.40%
Therapy Contract	277,475	313,111	7.50%	8.90%	(35,636)	-11.38%
Med/Surg Supplies-Chargeable	38,740	31,242	1.05%	0.89%	7,498	24.00%
Med/Surg Non-Chargeable	6,320	4,603	0.17%	0.13%	1,717	37.30%
Drugs	2,537	2,408	0.07%	0.07%	129	5.36%
Gen'l Supply& Min EQ	12,662	14,252	0.34%	0.41%	(1,590)	-11.16%
Telephone	9,520	7,814	0.26%	0.22%	1,706	21.83%
Purchased Maintenance	14,591	11,117	0.39%	0.32%	3,474	31.25%
Postage	674	1,432	0.02%	0.04%	(758)	-52.93%
Dues & Licenses-Facility	14,163	-	0.38%	0.00%	14,163	n/a
Dues & Licenses-Staff	150	286	0.00%	0.01%	(136)	n/a
Publications & Subscriptions	399	371	0.01%	0.01%	28	7.55%
Travel & Education	7,178	5,616	0.19%	0.16%	1,562	27.81%

Appendix M

			Vertical Analysis		*Horizontal Analysis*	
					$	%
	1997	1996	1997	1996	Change	Change
Educator Fees	100	-	0.00%	0.00%	100	n/a
Field Staff Travel and Education	89,094	84,841	2.41%	2.41%	4,253	5.01%
Equipment rental	1,576	1,271	0.04%	0.04%	305	24.00%
Office Rent	67,904	73,189	1.83%	2.08%	(5,285)	-7.22%
Recruitment	4,585	3,582	0.12%	0.10%	1,003	28.00%
Advertising & Marketing	1,133	12,161	0.03%	0.35%	(11,028)	-90.68%
Purchased Labor	731	262	0.02%	0.01%	469	179.01%
Special Outside services	3,490	280	0.09%	0.01%	3,210	1146.43%
Internal Dietary	-	64	0.00%	0.00%	(64)	n/a
Printing	11,742	16,227	0.32%	0.46%	(4,485)	-27.64%
Miscellaneous Expense	5,721	1,285	0.15%	0.04%	4,436	345.21%
Pager Rental	3,010	2,384	0.08%	0.07%	626	26.26%
Rebill Credits - Exernal A	-	(220)	0.00%	-0.01%	220	n/a
Total Operating Exp - Other	763,491	767,812	20.62%	21.82%	(4,321)	-0.56%
Total Salaries & Operating Exp	2,047,376	2,029,196	55.31%	57.67%	18,180	0.90%
NET INCOME (LOSS)	1,654,418	1,489,264	44.69%	42.33%	165,154	11.09%

Appendix M

Home Health Service

Vertical and Horizontal Analysis

Revenue Statements

For the Years Ended 1997 And 1994

			Vertical Analysis		*Horizontal Analysis*	
					$	%
	1997	1994	1997	1994	Change	Change
Gross Revenue	3,701,794	2,540,864	100.00%	100.00%	1,160,930	45.69%
Less Revenue Deductions	(1,123,867)	(755,436)	30.36%	29.73%	(368,431)	48.77%
Net Operating Revenue	2,577,927	1,785,428	69.64%	70.27%	792,499	44.39%
Operating Expenses - Salaries						
Regular Salaries & Wages	1,036,198	358,279	27.99%	14.10%	677,919	189.22%
Field Regular Salaries & Wages	-	422,601	0.00%	16.63%	(422,601)	-100.00%
Overtime Salaries & Wages	5,800	519	0.16%	0.02%	5,281	1017.53%
Field Overtime Salaries & Wages	-	2,617	0.00%	0.10%	(2,617)	-100.00%
Vacation Salaries & Wages	64,337	41,714	1.74%	1.64%	22,623	54.23%
Sick Salaries & Wages	2,982	5,248	0.08%	0.21%	(2,266)	-43.18%
Special Pay	174,568	88,421	4.72%	3.48%	86,147	97.43%
Field Special Pay	-	16,655	0.00%	0.66%	(16,655)	-100.00%
Total Operating Exp - Salaries	1,283,885	936,054	34.68%	36.84%	347,831	37.16%
Operating Expenses - Other						
FICA Taxes	96,255	70,273	2.60%	2.77%	25,982	36.97%
Group Health Insurance	40,127	21,950	1.08%	0.86%	18,177	82.81%
Employee Ins LTD & LIFE	5,331	2,328	0.14%	0.09%	3,003	128.99%
Retirement	35,061	16,123	0.95%	0.63%	18,938	117.46%
State Unemployment	1,033	354	0.03%	0.01%	679	191.81%
Tuition Reimbursement	212	-	0.01%	0.00%	212	n/a
Legal Fees	-	960	0.00%	0.04%	(960)	-100.00%
Risk Mgmt Fees	15,600	12,000	0.42%	0.47%	3,600	30.00%
Medical Specialist Fee	(5,620)	7,500	-0.15%	0.30%	(13,120)	-174.93%
Therapy Contract	277,475	204,670	7.50%	8.06%	72,805	35.57%
Med/Surg Supplies-Chargeable	38,740	46,304	1.05%	1.82%	(7,564)	-16.34%
Med/Surg Non-Chargeable	6,320	923	0.17%	0.04%	5,397	584.72%
Drugs	2,537	839	0.07%	0.03%	1,698	202.38%
Gen'l Supply& Min EQ	12,662	6,975	0.34%	0.27%	5,687	81.53%
Telephone	9,520	6,200	0.26%	0.24%	3,320	53.55%
Purchased Maintenance	14,591	7,126	0.39%	0.28%	7,465	104.76%
Postage	674	325	0.02%	0.01%	349	107.38%
Dues & Licenses-Facility	14,163	9,868	0.38%	0.39%	4,295	43.52%
Dues & Licenses-Staff	150	1,096	0.00%	0.04%	(946)	-86.31%
Publications & Subscriptions	399	3,017	0.01%	0.12%	(2,618)	-86.77%
Travel & Education	7,178	2,648	0.19%	0.10%	4,530	171.07%

Appendix M

			Vertical Analysis		*Horizontal Analysis*	
					$	%
	1997	1994	1997	1994	Change	Change
Educator Fees	100	-	0.00%	0.00%	100	n/a
Field Staff Travel and Education	89,094	68,692	2.41%	2.70%	20,402	29.70%
Equipment rental	1,576	3,915	0.04%	0.15%	(2,339)	-59.74%
Office Rent	67,904	71,300	1.83%	2.81%	(3,396)	-4.76%
Recruitment	4,585	-	0.12%	0.00%	4,585	n/a
Advertising & Marketing	1,133	1,191	0.03%	0.05%	(58)	-4.87%
Purchased Labor	731	474	0.02%	0.02%	257	54.22%
Special Outside services	3,490	3,485	0.09%	0.14%	5	0.14%
Internal Dietary	-	160	0.00%	0.01%	(160)	-100.00%
Printing	11,742	8,590	0.32%	0.34%	3,152	36.69%
Miscellaneous Expense	5,721	54,986	0.15%	2.16%	(49,265)	-89.60%
Pager Rental	3,010	3,758	0.08%	0.15%	(748)	-19.90%
Rebill Credits - Exernal A	-	(150,496)	0.00%	-5.92%	150,496	-100.00%
Total Operating Exp - Other	763,491	489,528	20.62%	19.27%	273,963	55.96%
Total Salaries & Operating Exp	2,047,376	1,425,582	55.31%	56.11%	621,794	43.62%
NET INCOME (LOSS)	1,654,418	359,846	44.69%	14.16%	1,294,572	359.76%

Appendix M

HOME HEALTH SERVICE

Vertical and Horizontal Analysis

Revenue Statements

For the Years ended 1995 and 1994

			Vertical Analysis		*Horizontal Analysis*	
					$	%
	1995	1994	1995	1994	Change	Change
Gross Revenue	3,370,000	2,540,864	100.00%	100.00%	829,136	32.63%
Less Revenue Deductions	(981,440)	(755,436)	29.12%	29.73%	(226,004)	29.92%
Net Operating Revenue	2,388,560	1,785,428	70.88%	70.27%	603,132	33.78%
Operating Expenses - Salaries						
Regular Salaries & Wages	731,106	358,279	21.69%	14.10%	372,827	104.06%
Field Regular Salaries & Wages	236,421	422,601	7.02%	16.63%	(186,180)	-44.06%
Overtime Salaries & Wages	3,292	519	0.10%	0.02%	2,773	534.30%
Field Overtime Salaries & Wages	352	2,617	0.01%	0.10%	(2,265)	-86.55%
Vacation Salaries & Wages	52,636	41,714	1.56%	1.64%	10,922	26.18%
Sick Salaries & Wages	3,566	5,248	0.11%	0.21%	(1,682)	-32.05%
Special Pay	114,518	88,421	3.40%	3.48%	26,097	29.51%
Field Special Pay	27,116	16,655	0.80%	1.07%	10,461	62.81%
Total Operating Exp - Salaries	1,169,007	936,054	34.69%	36.84%	232,953	24.89%
Operating Expenses - Other						
FICA Taxes	87,905	70,273	2.61%	2.77%	17,632	25.09%
Group Health Insurance	21,044	21,950	0.62%	0.86%	(906)	-4.13%
Employee Ins LTD & LIFE	2,996	2,328	0.09%	0.09%	668	28.69%
Retirement	23,144	16,123	0.69%	0.63%	7,021	43.55%
State Unemployment	411	354	0.01%	0.01%	57	16.10%
Tuition Reimbursement	685	-	0.02%	0.00%	685	n/a
Legal fees	-	960	0.00%	0.04%	(960)	-100.00%
Risk Mgmt Fees	15,624	12,000	0.46%	0.47%	3,624	30.20%
Medical Specialist Fee	5,000	7,500	0.15%	0.30%	(2,500)	-33.33%
Therapy Contract	318,670	204,670	9.46%	8.06%	114,000	55.70%
Med/Surg Supplies-Chargeable	57,691	46,304	1.71%	1.82%	11,387	24.59%
Med/Surg Non-Chargeable	832	923	0.02%	0.04%	(91)	-9.86%
Drugs	2,196	839	0.07%	0.03%	1,357	161.74%
Gen'l Supply& Min EQ	10,890	6,975	0.32%	0.27%	3,915	56.13%
Telephone	7,133	6,200	0.21%	0.24%	933	15.05%
Purchased Maintenance	8,432	7,126	0.25%	0.28%	1,306	18.33%
Postage	379	325	0.01%	0.01%	54	16.62%
Dues & Licenses-Facility	50	9,868	0.00%	0.39%	(9,818)	-99.49%
Dues & Licenses-Staff	666	1,096	0.02%	0.04%	(430)	-39.23%
Publications & Subscriptions	163	3,017	0.00%	0.12%	(2,854)	-94.60%
Travel & Education	4,299	2,648	0.13%	0.10%	1,651	62.35%

Appendix M

			Vertical Analysis		*Horizontal Analysis*	
					$	%
	1995	1994	1995	1994	Change	Change
Educator Fees	-	-	0.00%	0.00%	-	n/a
Field Staff Travel and Education	81,030	68,692	2.40%	2.70%	12,338	17.96%
Equipment rental	2,625	3,915	0.08%	0.15%	(1,290)	-32.95%
Office Rent	66,763	71,300	1.98%	2.81%	(4,537)	-6.36%
Recruitment	-	-	0.00%	0.00%	-	n/a
Advertising & Marketing	6,472	1,191	0.19%	0.05%	5,281	443.41%
Purchased Labor	445	474	0.01%	0.02%	(29)	-6.12%
Special Outside services	-	3,485	0.00%	0.14%	(3,485)	-100.00%
Internal Dietary	336	160	0.01%	0.01%	176	110.00%
Printing	12,913	8,590	0.01%	0.34%	4,323	50.33%
Miscellaneous Expense	3,740	54,986	0.38%	2.16%	(51,246)	-93.20%
Pager Rental	4,317	3,758	0.13%	0.15%	559	14.87%
Rebill Credits - Exernal A	(78,546)	(150,496)	-2.33%	-5.92%	71,950	-47.81%
Total Operating Exp - Other	670,300	489,528	19.89%	19.27%	180,772	36.93%
Total Salaries & Operating Exp	1,839,307	1,425,582	54.58%	56.11%	413,725	29.02%
NET INCOME (LOSS)	549,253	359,846	16.30%	14.16%	189,407	52.64%

Appendix M

HOME HEALTH SERVICE
Four Year Income History
For Years Ended 1994 through 1997

	1997	1996	1995	1994
Gross Revenue	3,701,794	3,518,460	3,370,000	2,540,864
Less Revenue Deductions	(1,123,867)	(1,089,995)	(981,440)	(755,436)
Net Operating Revenue	2,577,927	2,428,465	2,388,560	1,785,428
Operating Expenses - Salaries				
Regular Salaries & Wages	1,036,198	1,020,999	731,106	358,279
Field Regular Salaries & Wages	-	-	236,421	422,601
Overtime Salaries & Wages	5,800	6,389	3,292	519
Field Overtime Salaries & Wages	-	-	352	2,617
Vacation Salaries & Wages	64,337	62,635	52,636	41,714
Sick Salaries & Wages	2,982	5,139	3,566	5,248
Special Pay	174,568	166,222	114,518	88,421
Field Special Pay	-	-	27,116	16,655
Total Operating Exp - Salaries	1,283,885	1,261,384	1,169,007	936,054
Operating Expenses - Other				
FICA Taxes	96,255	95,121	87,905	70,273
Group Health Insurance	40,127	26,534	21,044	21,950
Employee Ins LTD & LIFE	5,331	4,392	2,996	2,328
Retirement	35,061	30,659	23,144	16,123
State Unemployment	1,033	1,384	411	354
Tuition Reimbursement	212	(140)	685	-
Legal Fees	-	-	-	960
Risk Mgmt Fees	15,600	15,288	15,624	12,000
Medical Specialist Fee	(5,620)	5,000	5,000	7,500
Therapy Contract	277,475	313,111	318,670	204,670
Med/Surg Supplies-Chargeable	38,740	31,242	57,691	46,304
Med/Surg Non-Chargeable	6,320	4,603	832	923
Drugs	2,537	2,408	2,196	839
Gen'l Supply& Min EQ	12,662	14,252	10,890	6,975
Telephone	9,520	7,814	7,133	6,200
Purchased Maintenance	14,591	11,117	8,432	7,126
Postage	674	1,432	379	325
Dues & Licenses-Facility	14,163	-	50	9,868
Dues & Licenses-Staff	150	286	666	1,096
Publications & Subscriptions	399	371	163	3,017
Travel & Education	7,178	5,616	4,299	2,648

Appendix M

	1997	1996	1995	1994
Educator Fees	100	-	-	-
Field Staff Travel and Education	89,094	84,841	81,030	68,692
Equipment rental	1,576	1,271	2,625	3,915
Office Rent	67,904	73,189	66,763	71,300
Recruitment	4,585	3,582	-	-
Advertising & Marketing	1,133	12,161	6,472	1,191
Purchased Labor	731	262	445	474
Special Outside services	3,490	280	-	3,485
Internal Dietary	-	64	336	160
Printing	11,742	16,227	12,913	8,590
Miscellaneous Expense	5,721	1,285	3,740	54,986
Pager Rental	3,010	2,384	4,317	3,758
Rebill Credits - Exernal A	-	(220)	(78,546)	(150,496)
Total Operating Exp - Other	763,491	767,812	670,300	489,528
Total Salaries & Operating Exp	2,047,376	2,029,196	1,839,307	1,425,582
NET INCOME (LOSS)	1,654,418	1,489,264	549,253	359,846