Characteristics and Resource Utilization of Patients of a Proprietary Home Health Agency in Rural South Central Kentucky

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CHARACTERISTICS AND RESOURCE UTILIZATION OF PATIENTS OF A PROPRIETARY HOME HEALTH AGENCY IN RURAL SOUTH CENTRAL KENTUCKY

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the Faculty of the Department of Nursing
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Master of Science in Nursing

by
Linda F. Sewell
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CHARACTERISTICS AND RESOURCE UTILIZATION OF PATIENTS OF A
PROPRIETARY HOME HEALTH AGENCY IN RURAL SOUTH CENTRAL
KENTUCKY

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The home health industry's introduction to managed care raises the prospect of reduced access to health care and poor outcomes for a vulnerable segment of our population--the rural elderly. Before effective intervention strategies can be accurately evaluated, a clearer picture of the sociodemographic features and home care service consumption is needed for this understudied group.

The study was intended to provide a basis for future research into the evaluation of alternative methods of delivering effective care in terms of outcome and decreased cost for this population. A retrospective descriptive analysis was made of the patient record for the first six months of care from a proprietary home health agency. Eighty-one charts were examined and features such as age, race, gender, socioeconomic level, functional limitations, family support and literacy were analyzed to provide a profile of the patient population. Resource consumption was measured in terms of the type and frequency of disciplines intervening in each case. Comparison was made between the characteristics of the sample and the resource use.

The study provided a composite view of the typical patient: Caucasian, literate, low income female, between 70-80 years of age, without family support. No clear linkage between specific characteristics and resource consumption was found; there was a broad range in the numbers of visits made to patients.
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CHAPTER I
INTRODUCTION

The advent of health care reform in this country has had a profound impact on the delivery of health care services to all members of our society--including the most vulnerable of our population, the very young and the elderly (Curtin, 1996). While home health care emerged from the reforms of the 1980s with cost-based reimbursement essentially intact, managed care and restricted reimbursement are anticipated to be the basis for funding of home care in the near future (Marelli, 1996). To meet the needs of their patient populations economically and effectively, home care agencies must develop strategies to provide quality care within financial limitations. The first step involved in forming cost effective interventions is understanding the characteristics and resource utilization of the patient population served by the agency. The purpose of this study was to examine the characteristics and resource utilization of a group of rural, elderly home health patients to provide a basis for cost containment and quality assurance strategies.

Current Policies

As the population of the country ages, the health care needs of the elderly and chronically ill are expected to increase. The present revenue structure will not be able to meet the financial burden of a large retired population dependent on a smaller number of tax-paying workers. Some authorities have predicted that Social Security and Medicare funds will be depleted by the end of the millennium (Curtin, 1996).
Reform of the delivery and reimbursement system of acute care providers began in 1983, with the introduction of diagnostic related groups (DRGs). In this system, patients are classified according to their primary diagnosis, as well as by other factors such as age, surgery, and the presence of a secondary diagnosis. The DRG is an indicator of resource consumption of the patient and, consequently, is used as the basis for reimbursement in the acute care setting (Churness & Kleffel, 1991).

The introduction of DRGs changed the way health care was delivered. Patients were discharged from the hospital "quicker and sicker." Lengthy stays in the acute care setting meant revenue loss to the hospitals; it was fiscally imperative that patients be discharged as soon as was feasible. The result of this policy was a large percentage of post hospital patients with continued needs for nursing or therapy interventions (Curtin, 1990). Attempts to address these patients' needs included teaching patients, while in the hospital, to manage their health problems. However, shortfalls in patient staffing ratios, higher acuity levels of in-hospital patients, and inadequate staff preparation and education led to inconsistent results in patient knowledge levels and self-care abilities (Curtin, 1990).

Cognitive deficits due to confusion in the acute phase of illness and lack of education or literacy skills were also factors that impaired the ability of vulnerable populations, such as the elderly, to be adequately prepared for discharge home (Marelli, 1996). Lack of support systems in the community setting, either from family or friends, had the potential to undo any benefit gained from treatment during the acute care phase of the patient's illness, with the prospect of rehospitalization due to an exacerbation or recurrence of the original problem. The elderly in particular were most susceptible to the prospect of inadequate support and care mechanisms on discharge home. If adequate care mechanisms were in place, the elderly have been shown to be most likely to thrive when allowed to remain in a home in familiar surroundings (Cookman, 1996).
Keeping the elderly and unwell at home while providing health services previously available in the acute care or nursing home setting was envisioned by health policy makers as a cost effective means to ensure quality of life for the patients while at the same time saving money by reducing the time spent in the acute care setting. It was expected that home care would also cut costs by reducing or eliminating rehospitalizations. (Dellasega, Dansky & King, 1994). While hospitals began to experience revenue losses and downsizing, home care agencies sprang up to fill the gap between the acute phase of illness and recovery (Curtin, 1990). Home care was seen as an efficient and cost effective alternative to prolonged hospital stays or placement in a long term care facility. Providing nursing, therapy, and personal care services, with a focus on rehabilitation to optimal levels of functioning, seemed to be a win-win situation in terms of quality of life for the population served and savings for society at large (Dellasega, Dansky & King, 1994). Elderly patients could remain in their home environment where they were most likely to recover optimally from illness, while at the same time reducing the cost to Medicare and Medicaid for lengthy stays in the acute care setting by offering many of the same nursing and ancillary services in the patient's home.

Problems with Current Policies

Reality has shown otherwise. Escalating costs for home care have brought about a review of the payment system. Until recently, home health reimbursement has been a retrospective payment system based on visits made to patients by the disciplines of the agency and authorized by the primary physician. Guidelines for frequency or intensity of services is given in the Medicare "bible"- the Homehealth Information Manual 11, which outlines those services deemed "reasonable and necessary" to ensure appropriate and safe care for a particular patient. Much leeway is allowed in the guidelines, and nurses and other health care providers have considerable freedom to make visits, as long as approval of the physician is obtained (Corbett, 1994). This system of payment is now being reviewed and the expectation is that reimbursement for all Medicare patients will be based
on a managed care system, with either a prescribed number of visits permitted to a patient or a certain amount of payment guaranteed to the agency. Both reimbursement systems will be based on patient acuity levels at the time of admission to the agency (Goodwin, 1992). At present, patients who have a private insurance payer source have a determination of the number and type of services made by a case manager of the insurance company at the time of admission to the agency.

Medicaid recipients in the state of Kentucky are already in the process of being placed in a managed care system. The program is presently being implemented and takes effect in November 1997 in selected districts of the state, with all of the state projected to be covered by 1998. Under the previous system of payment there was no specified limit on visits provided to a patient as long as they were deemed necessary; now strict restrictions of frequency and type of total visits are anticipated, as is a reduction in the amount of time allowed for the home health agency to rehabilitate the patient. Although guidelines are not yet clearly developed, administrators of home care agencies anticipate that the levels of reimbursement will be based on an acuity level scale, in which categories such as prior hospitalization within 120 days, medical diagnoses such as diabetes and heart disease, and need for wound care will be the primary factors considered in deciding the level of payment for a particular patient (Goodwin, 1992).

Other factors that may impact the recovery potential for a particular patient—family support, education levels, self-care abilities, and demographics—are not considered in the equation. Limited reimbursement for home care raises the very real prospect of reduced accessibility of health care services to medical assistance recipients. Rationing and reduction of care as a result of anticipated changes in Medicaid reimbursement may lead to increased rates of rehospitalizations and increased morbidity and mortality rates for those patients whose sole payer source is Medicaid, with the implication for less than optimal health care for an increasingly vulnerable segment of our society.
The Need for Further Study

Most home health care in this country is provided by proprietary or for-profit home health agencies, either free-standing or affiliated with a local hospital. To remain viable, an agency must be able to provide quality health care to its patients while remaining financially sound. Strategies to enable the most efficient delivery of care while maintaining the quality of life for the patients must be developed by home care agencies. Identifying those patients who are most likely to utilize high amounts of resources during their time of care by the agency will enable nurses and other caregivers to implement educational and outcome focused care plans (OCPs) from the time of admission (Churness & Kleffel, 1991).

Studies on the use of OCPs have shown that cost effective and high quality patient care can be achieved through such interventions. However, there is little data on the impact that sociodemographic factors have on the effectiveness of OCPs; rather, the emphasis has been on identifying patients with a particular medical diagnosis such as diabetes or heart disease and the effect a standardized outcome focused plan of care had on the patient. Factors other than medical diagnoses must be considered in order to effectively evaluate the needs of patients, and to make decisions regarding the interventions which will be both cost effective for the agency and satisfactory in terms of quality of life for the patients.

The rural elderly present a distinct problem in terms of availability and quality of care. This population is most likely to suffer from poverty, isolation, lack of transportation, poor access to healthcare, and a lack of both informal and formal support services (Ballard, 1983). Presently, there are few available studies that address the particular service needs or the characteristics of this group. Therefore, the need exists for a study that will identify the service needs of the rural elderly while accounting for characteristics such as age, race, gender, socioeconomic status, literacy, functional ability, and family support.
CHAPTER II
CRITICAL REVIEW OF RELEVANT LITERATURE

In this chapter, the literature pertinent to the study is reviewed. In the first section of the review the researcher examines some of the relevant theoretical writings; in the second section the researcher discusses studies that are relevant to practice.

Theoretical Literature

The concept of the patient as a multifaceted organism with multiple needs is used to develop a holistic approach in providing care. Specifically, systems theory as developed by Ludwig von Bertalanffy was used as the theoretical underpinning of the study in order to understand how factors other than medical problems can impact on the health or wellness of an individual.

Systems Theory

In his book, Introduction to Theoretical Biology, Von Bertalanffy (1957) wrote of wholeness, organization and teleology of the human organism at a time when a mathematical reductionism approach to science was the accepted norm. The human organism is seen as the prototype of an open, living system (Rizzo, 1976). Within its environment, the human system must cope with problems to sustain its viability. Some problems are seen as internal to the system while others are external (Hearn, 1976). When a problem such as illness or bereavement threatens to overwhelm an individual system's coping mechanisms, health and welfare professionals can assist by helping the individual deal with problems in the internal or external environment (Hearn, 1976). Interactions between two open systems (i.e., the patient and health care providers) must be considered
in addition to the patient's illness or disease. Family support, age, race and gender will all come to play a part in negotiating a successful strategy to optimize wellness.

Nursing Models

King's conceptual model proposes that there are three levels of functioning: the individual, the group, and society (King, 1981). These three dynamic and interacting systems exchange energy and information on a continuous basis. When making decisions on nursing interventions, the impact of the dynamics and interplay of all systems on the individual patient must be considered. King also proposes a health model as opposed to a disease model in reversing the trend of illness-focused health care delivery. A health model emphasizes factors which may enhance or detract from health. Instead of focusing on the pathology of disease, the health model looks for health norms, and at interactions between individuals, groups, and social systems that impact health status.

Likewise, Neuman's model focuses on the person as a holistic being or complete system whose parts are interrelated physical, social, psychological, and developmental factors (Neuman, 1982). Understanding the interplay of the various levels of factors is important in reaching decisions regarding interventions for the individual patient. If providers understand what level of input that will be required from the formal caregiving system as far as supplementing or replacing self-care abilities, then they may realistically make decisions regarding interventions that promote health seeking behaviors as opposed to treating the symptoms of illness. By evaluating the self care levels, educational level, and functional abilities of patients, a home care agency can anticipate and design plans of care that will most effectively promote optimal health levels in their patient population.

Factors Impacting Patient Care

This section of the literature review examines factors which may impact on the provision of care to patients. Categories include social and cultural factors such as family and community support, culturally relevant care and attachment behaviors; health care
reform and trends; health care needs of the elderly; managed care and its impact; and recent innovations in home care planning and delivery.

Social and Cultural Factors

In delivering health care service to the individual or community, the integration of the needs of the patient with the resources of the provider are essential. Effectiveness of the care process in satisfying health needs is influenced by the demographics of the groups; cultural, psychosocial, and economic attributes influence attitudes and behaviors (Meyer, 1971). Leininger has been a pioneer in recognizing the significance of culturally appropriate nursing action in the deliverance of effective health care (Barnum, 1994). The rural Appalachian culture of the population described in this study has been noted to have norms and beliefs that differ from that of the mainstream US culture, with a tradition of self-care and self-reliance as a result of centuries of isolation and poverty (Simon, 1987).

Social support systems and networks can impact the amount of health care sought by patients. Identifying the availability and willingness of family support is the first step in assessing the patient's needs. In a study of chronically ill patients, Mootz (1981) found that serious illness was not a factor in the number of healthcare provider contacts; social support members' attitudes and expectations were more influential in affecting utilization of resources than the patient's condition. Effective interventions by health care providers must therefore take into account the knowledge level of the caregivers and family and must include them in teaching strategies as part of the overall care plan for the patient.

Health Care Reform

Health care reform and its impact on home health care is discussed by White (1994). Although the specifics are as yet unclear, the consensus of home health agency administrators is that cuts in Medicare reimbursement and increased enrollment in managed care plans will curtail the growth experienced by the industry. After the enactment of Medicare's prospective payment system for acute care settings in 1983, demand for home health care rose 234% by 1985 (Twardon & Gartner, 1995).
Twardon and Gartner's study also found that population problems which encompassed age, complexity of care, and a changing society were increasing the demand placed on home care agencies.

The mean age and proportion of frail elderly in the population are increasing, while earlier hospital discharge and increased patient acuity, as well as a disintegrating expanded family, leave those at risk more likely to need an increase in availability of formal home based care. Rural elderly are seen as particularly vulnerable due to lack of access to preventive care, limited educational opportunities, and a greater incidence of poverty (Ballard, 1983). The needs of this vulnerable group must not be ignored; understanding the characteristics of the rural elderly and their particular requirements from the health care system is a critical step in meeting those needs.

Health Needs of the Elderly

Tartasky (1990) has studied coping strategies of elders with multiple chronic illnesses. She found no relationship among gender, ethnicity, or physical illness and illness outcome, while mental illness accounted for a 5% increase in needed services for the home based sample. Dellasega, Dansky, and King (1994) found a significant increase in the volume and type of services needed by the elderly with a cognitive impairment. Pasquale (1988) reports a correlation between the functional status and living arrangements and the consumption of home care resources in a group of home care Medicare clients. Pasquale (1988) also outlined the characteristics of Medicare home care patients with the findings that chronic health problems predominated and that over 50% of the sample had at least moderate functional impairment—with females being more impaired and older than males.

Fisher (1990) reported that community residing elderly, aged 80 and above, were less likely to have informal caregiving and support networks and were more dependent on formal home health care. This finding is a significant one in light of the fact that the population of those older than age eighty is one of the fastest growing demographic groups today. The US Census Bureau (1995) reports that the oldest old, those 85 and
older, rose 274% between 1960 and 1994. In contrast, the overall US population grew only 45%. It is anticipated that the oldest old will number 19 million in 2050, comprising 5% of all Americans. Frederiks and Wierek (1992) confirmed that users of professional home care are older, more often female, living alone, and with mental and financial problems. A Dutch study corroborated the findings that factors influencing the utilization of home care included female gender, living alone, and low income. However, no relationship between feelings of loneliness and depression were noted, although closer proximity of social network groups was reported to be characteristic of the non-user group (Kempen, 1991).

Factors which can impact the health status of the elderly also include the attachment to place and things (Cookman, 1996). Rather than focus on the safety of the environment as the only factor to be considered in evaluating the coping strategy of the home bound chronically ill, attachment to environmental objects provided important sources of security, belonging and self-identity. Guiliani's (1991) review of the literature on attachment to home by the elderly defined it as a state of psychological well-being as a result of the presence or accessibility of familiar places and objects, and contrasts this with the distress experienced when the place or objects are inaccessible (Guiliani, 1991). This study and similar studies (Cookman, 1996) on attachment reinforce the need to keep the elderly at home for as long as possible to maintain their quality of life.

Impact of Managed Care

Recent studies have focused on the utilization of home health services of patients enrolled in health maintenance organizations as opposed to those served by the traditional fee for service providers. In a study done by Adams and Kramer (1996), no significant difference was found in resource utilization patterns between the two groups. In another study, Adams and Biggerstaff (1995) compared quality outcomes between the traditional Medicare fee for service program and a health maintenance organization with a Medicare cost contract with the federal government. The research showed superior quality
outcomes for patients enrolled in the Medicare fee for service program. Managed care and its implications for home care are discussed by Brown (1995) in a study of a pilot program to coordinate financing and delivery of all health, medical and social services for a population of frail home care elderly. Emphasis was placed on care planning and evaluation of utilization data. This study provides a basis for designing effective intervention once an understanding of a population and its needs has been determined.

Innovations in Home Care Planning

Critical paths have been in use in acute care settings for several years in response to the introduction of Diagnosis Related Groups (DRGs). Recently, attention has been given to their use in a home care setting. They are seen as a method of maintaining quality care while controlling costs through coordination of services. A goal of home care is cost containment through the prevention of acute hospital care and nursing home admissions; this goal will require home care services for prolonged periods of time. Corbett (1994) believes that home care can benefit from the use of critical paths by demonstrating the link between patient characteristics, services provided, and outcomes. Distinction should be made between patients who will need short term or long term care. In spite of these obvious benefits, the author reports that critical paths have been given minimal attention in home care.

Adams and Biggerstaff (1995) conducted a study to compare patient outcomes and resource utilization in home care using traditional process focused care plans (PCPs) and outcome focused care plans (OCPs) as exemplified by critical paths. The authors reported significantly improved quality indicators and reduced nursing visit time with the use of OCPs. Adams and Wilson (1995) found in a different study that use of OCPs resulted in significantly better quality indicator scores for patients cared for by agency staff members than traditional PCPs. The caveat given by the authors is that tools are only as good as those who use them and that education and training of agency staff must be assessed before deciding to change to an OCP format. Martin, Scheet, and Stegman
(1993) surveyed 2403 patients in four states. Their study was one of the first to provide descriptive data about home health clients and measures of care outcome. The authors described the usefulness of a standard method, in this case the Omaha System, in describing and quantifying nursing practice in the community health setting.

Characteristics of home care patients at discharge are discussed by Helberg (1993), who found that 61% of patients could manage independently or with the help of family providers. The rest, 39%, required at least some help from community service providers, were institutionalized, or had died. Discharge status was more closely linked to nursing needs than to medical conditions or sociodemographic characteristics.

Summary

Human beings are complex open systems who are involved in a constant exchange of energy with surrounding systems to maintain a steady state. Any deficit in the internal support system of the individual will require a compensatory input from an external system. External systems include the organism's physical environment, family and informal caregivers, as well as professional health care providers.

The population of this country is aging, with the oldest age group being one of the fastest growing segments of society. This population is also the one most likely to need healthcare and the group least likely to have a social network and support system.

Most elders thrive better if they are allowed to remain in a home and surroundings with significant attachments. Home health care has increased dramatically as a result of Prospective Payment (PPS) and Diagnosis Related Group (DRG) systems instigated in the 1980s. Traditional fees for service programs, as now provided for by Medicare, are expected to be replaced by PPS and managed care in home health as in the acute care setting. To remain financially viable while providing quality care to its clients, home care agencies must develop strategies to improve outcome while limiting or reducing utilization of resources.
Critical paths are seen as a possible innovation to achieve this goal. More research into the characteristics of patients and the comparison of outcome versus process focused care plans is needed before agency administrators can make significant and effective changes in the way home care is delivered.

While there has been some research conducted on the home care population, there is a shortage of information relevant to the rural elderly and their specific needs. The home care industry is aware that drastic changes are imminent in the way they deliver care and how they will be reimbursed. However, agencies in this part of the country are unable to locate studies that are focused on the needs of the communities they serve or of the precise makeup of their patient populations. Before innovations in care delivery can be made, administrators and nurses need to have a clear picture of the population they serve. The researcher will attempt to provide that picture to allow for further research and development of cost effective, high quality care to the rural elderly.
CHAPTER III
FRAME OF REFERENCE

The framework of the study was based on a systems analysis approach to health care. The interactions of physical, social, and psychosocial systems interplay to impact the health of the individual as a holistic being. The focus of the medical model on illness and disease process is too limited to explain how patients will or will not recover from illness and regain optimal levels of functioning. The researcher examined the impact of other factors on the health of elderly home care patients and provided a demographic description of the patients served by a proprietary home health agency.

Systems theory as developed by Von Bertalanffy (1957), and expanded by King (1981), proposes that the human organism is an open living system, which must cope with problems within its internal and external environments to sustain viability. An individual's coping systems may be overwhelmed by stressors such as illness or bereavement; on the other hand, the coping system may be enhanced by assistance from family, social support systems, or by health care providers. Other factors, such as age, race, gender, educational levels and socioeconomic status, may impact coping skills. In order to provide effective health care, the provider must help the patient deal with problems in the internal and external environments, and must provide the care with consideration of the above factors not simply focus on the medical diagnosis or disease process.
Purpose of the Study

The purpose of this study was to identify the characteristics and resource utilization of a group of rural elderly home health patients in Kentucky and to prepare the way for studies in greater detail and depth for prediction and correlation of population characteristics and home care resource utilization—along with the effectiveness of innovative interventions such as outcome focused care plans—for this group. Before further analysis or changes in the approach to care delivery is undertaken, a basic description of the population served and its resource needs must be available. The researcher endeavored to provide that description. Thus, the objectives were (a) to provide a description of the characteristics of a group of elderly patients currently receiving home health care in rural Kentucky, (b) to identify the type and quantity of services of a proprietary home care agency utilized by the population described above, and (c) to compare the characteristics of the population with the services utilized.

Conceptual and Operational Definitions

Conceptual Definitions

Systems theory proposes that an individual is an open system in which various elements are in open and dynamic interaction. Within this interaction, stressors are tension creating factors which may cause disequilibrium and which create a demand for readjustment. Illness is seen as a reflection of unmet needs and as an interruption of negentropy, a process of energy utilization assisting the system's progression toward stability or wellness. The researcher examined the interplay of various systems as they impacted the population of the home care agency.

Definition of the Variables

Variables in the study were the demographic, social, and functional characteristics of the population; resource utilization was the frequency and type of services provided to the population by the home health agency. The above information was obtained from the patients' records, including the admission assessment form (Appendix A).
Demographic Variables

Age. The population was divided into three age groups consisting of adults aged less than 70, adults aged 70-80, and adults aged greater than 80.

Race. The categories were Caucasian or African American, the only racial groups served by the agency at the present time.

Education. Patients were classified as literate or illiterate as noted in the admission assessment. Literate patients are able to read, comprehend and sign the consent for care document included in the admission process.

Socioeconomic status. This consisted of two groups; those who were eligible for assistance through Medicaid, and those who qualified for Medicare only. Medicare provides health care coverage for all adults over age 65; Medicaid provides supplemental coverage for low income adults and children. Thus, those patients qualifying for Medicare only would have a higher socioeconomic status than Medicaid recipients.

Social Characteristics

Family support. This category was defined as the presence or absence of a willing caregiver in the home.

Functional Characteristics

Functional Ability. Functional ability was assessed by the scores obtained on the Barthel Index. This scale was designed as an evaluative instrument to measure rehabilitation potential, predict length of care, estimate prognosis, and anticipate discharge outcomes. The scale was completed in this study from information in the patient records. Ten activities were assessed. They were: (a) feeding, if food needs to be cut up, this equals help; (b) moving from wheelchair to bed and returning; (c) caring for personal toilet, washing face, combing hair, shaving and cleaning teeth; (d) getting on or off the toilet, handling clothes, wiping and flushing; (e) bathing self; (f) walking on level surfaces or propelling wheelchair; (g) ascending and descending stairs; (h) dressing, including tying
shoes and fastening fasteners; (i) controlling bowels; and (j) controlling bladder. Patients were designated as minimally, moderately or severely impaired based on the scoring of the Barthel Index. Patients were scored on the ten activities which were totaled to give a score of 0 (totally dependent) to 100 (totally independent). Instructions for scoring the Barthel Index are included in Appendix B. For the purpose of this study, patient scores of 60-100 were rated as minimal functional limitation, scores of 15-60 as moderate limitation, and scores of 0-15 as severe functional limitation.

Resource Utilization Characteristics

Population. A group of adults presently served by a proprietary, home health care agency which is approved by the Joint Commission of Accreditation of Healthcare Organizations (JCAHO). The patients had by Medicare definition at least one medical diagnosis which qualifies them for intermittent skilled nursing care.

Skilled Nursing Care. Nursing care given by an appropriately licensed nurse; either a licensed practical nurse or registered nurse.

Therapy. Speech, physical, or occupational therapy provided by licensed therapy personnel for the purpose of rehabilitating the patient.

Personal Care. Services necessary to maintain adequate personal hygiene to adults with functional limitations.

Outcome Measurement. Negative outcome was defined as rehospitalization, death, or admission to a long term care facility. Positive outcome was defined as discharge due to attainment of prior levels of functioning. Rehospitalization implied that the interventions undertaken by the home health agency in the treatment of the patient were not effective in preventing a recurrence or exacerbation of the patient's problem(s). Patients whose condition was designated terminal (i.e., projected to live less than six months) were excluded from the study.

At present, there is some dispute as to the exact role that home care plays in the health care system. While originally designed to rehabilitate and discharge patients who
were released from hospitals, agencies now find themselves in the position of maintenance of the frail elderly and chronically ill at home for as long as possible, with the goals of preventing admission to a nursing home, reducing the length and frequency of acute care stays, and reducing utilization of emergency departments (Rajacich & Cameron, 1995). This strategy not only is cost effective but also means an improved quality of life for the patients. A shortage of available nursing home beds places a burden of care on family members, a burden that can be alleviated through home health. The above definition of outcome measurement incorporates both areas of service provided by home care, incorporating both rehabilitation and prevention of admission to a long term care facility.

Assumptions

Three assumptions underlie the methodology of this study. The first assumption was that health is a desirable state of being for all people. The precise definition of health may vary; for the purpose of this study it was defined as the optimal level of functioning and the minimum of discomfort for the patients.

Since the study was one of home health care, the second assumption was that care provided to the patient in the home is preferable to care provided within an institution (Cookman, 1996). The third assumption was that the study would show significant linkage between characteristics and resource consumption.

The purpose and objectives of this study were discussed in the context of the theoretical framework and the operational definitions of terms and variables. Together, they provided the foundation for the methodology presented in the next chapter.
CHAPTER IV
METHODS AND PROCEDURES

The purpose of the study was to identify social and demographic characteristics of a group of elderly patients living in a rural area of Kentucky and to compare these characteristics with the type and quantity of services provided to them by a home health agency. There is little information in the literature on this particular population which will be especially vulnerable if health care reform mandates reduction of funding for home care for the elderly and disadvantaged. Factors that influence consumption of services were studied in a framework of general systems theory. Since the individual must be seen in a holistic context, examination of only the physical causes of illness are inadequate in understanding the patient's needs. The spheres of social support, educational levels, economic status, age, gender, race, as well as levels of function and activities of daily living, all interact to impact the health status of the whole person—with unmet needs in any of these areas leading to a lack of wellness and well-being. Consequently, any agency that provides care can anticipate demand in requested health care services to attempt to meet the expectation of wellness in the individual patient.

Methods

The sample studied was one of eighty-one adult patients being served by a proprietary, Joint Commission on Accreditation of Health Organizations certified home health agency in South Central Kentucky. The setting of the study was one county office of the home health agency in rural Kentucky. The sociodemographic and resource utilization information was taken from the admission assessment and charts of each patient.
and was analyzed using a descriptive statistic for the measures of central tendency for the sample.

The researcher had access to the patient records of all patients currently and previously served by the agency in the time period from October 1993 to March 1996 in this county.

**Sample Selection**

The sample was selected from a total patient population of 148 present and prior patients. Included in the study were adult patients who qualified for home health care under Medicare guidelines. These guidelines require that the patient be homebound; that the services are provided under a plan of care approved by a physician; that the services are on an intermittent basis; that the care is provided by a Medicare certified agency; and that the patient meets the qualifications of a Medicare beneficiary (Marelli, 1994).

Excluded from the study were patients with a terminal diagnosis (i.e., a life expectancy of less than six months) at time of admission to the agency, as were infants and children. These patients would be expected to require greater amounts of care due to their acuity levels. Patients whose payer source was private insurance were also excluded since services are decided by a case manager of the insurance company and the agency has little or no discretion in decisions regarding number of visits permitted. A total of 81 adult patients aged 50 or older served by the agency in a six month time period between October 1993 and March 1996 were selected for the study.

**Services**

The services utilized by the sample were skilled nursing, aides for personal care, and therapy, which included physical, speech, and occupational therapies.

**Instrumentation**

Several variables were measured in this study. Each will be discussed in the following section.

**Demographic Characteristics.** The sociodemographic characteristics and resource utilization information of the patients studied were taken from the admission assessment
and encounter notes of the disciplines under consideration as contained in the patients' charts (Appendix A.). The demographic characteristics age, gender, and race are self-explanatory.

*Family Support.* Family support was defined as the presence or absence of a caregiver willing to assist in the home, as noted on the family assessment portion of the admission record. While a caregiver was frequently a relative or spouse, the definition under Medicare stipulates only that a caregiver is someone who is "willing and able" to give care, regardless of marital or familial ties.

*Literacy.* Literacy status is also described in the admission assessment, and noted in the clinical encounter record, where patients are required to sign their names on each encounter sheet; those unable to sign are instructed to make a mark and is so designated as the patient's mark by the nurse making the visit. The admitting nurse must also evaluate the patient's ability to read and comprehend the consent for treatment form at the time of the first visit and must indicate literacy status on the admission tool (Appendix A). Since many interventions now approved and encouraged by Medicare and Medicaid focus on empowering patients to provide their own care, the assessment of the literacy status of newly admitted patients is an essential first step in planning an individualized and effective teaching strategy.

*Socioeconomic Status.* The socioeconomic status was defined as those eligible for Medicaid versus those who receive Medicare only. Since socioeconomic status and educational levels are frequently positively correlated, it may be assumed that Medicaid recipients i.e. low income patients, may require more intensive educational efforts than Medicare patients with otherwise similar characteristics. Medicare patients are also more likely to have financial resources which may be used in supplementing caregiving services such as personal care than are Medicaid patients.

*Functional Ability.* Functional ability was assessed by the scores obtained on the *Barthel Index.* This scale was designed as an evaluative instrument to measure rehabilitation
potential, predict length of care, estimate prognosis, and anticipate discharge outcomes. The scale was completed in this study from information in the patient records. Ten activities were assessed. They were comprised of: (a) feeding, if food needs to be cut up, this equals help; (b) moving from wheelchair to bed and returning; (c) caring for personal toilet, washing face, combing hair, shaving and cleaning teeth; (d) getting on or off the toilet, handling clothes, wiping and flushing; (e) bathing self; (f) walking on level surfaces or propelling wheelchair; (g) ascending and descending stairs; (h) dressing, including tying shoes and fastening fasteners; (i) controlling bowels; and (j) controlling bladder.

Scoring of the Index

Patients were scored on the ten activities which were totaled to give a score of 0 (totally dependent) to 100 (totally independent). Instructions for scoring the *Barthel Index* are included in Appendix B. For the purpose of the study, patient scores of 60-100 were rated with minimal functional limitation, scores of 15-60 with moderate limitation, and scores of 0-15 with severe functional limitation.

Validity and Reliability of the *Barthel Index*

The *Barthel Index* has been given a correlational validity with the PULSES Profile of Pearson coefficients ranging from -0.74 to -0.90 ($p < 0.001$). Hearn (1976) conducted a study in which 36% of patients who scored 0-15 on the *Barthel Index* improved significantly in functioning; while 77% of those scoring 60-100 had the same improvement. Bowling (1991) found similar results in four other studies, with a score of 60 being considered pivotal in the movement from dependency to assisted independence. The test has been given a test-retest reliability of 0.89 with an inter-rater agreement exceeding 0.95.

Consumption of Services

The consumption of services was taken from a tally of the encounter notes of the nursing, therapy and home health aide staff. The initial admission visit was excluded from the study.
Outcome Measurements

Outcome measurements were noted from the discharge and transfer records in the patients' charts. Negative outcome was defined as rehospitalization for an exacerbation of one of the health problems identified on admission, death, or admission to a long term care facility. Positive outcome was defined as discharge from the home health agency due to attainment of prior levels of functioning. These records are mandated to be included in the chart whenever a patient is discharged from the agency or transferred to a hospital for acute care. A copy of the agency's form is included in Appendix C.

Procedure

The study was a retrospective descriptive analysis of the pattern of services and patient characteristics. Eighty-one patients who met the criteria of being eligible for Medicare funded home health care were selected from a total of 148 previous and present patients served by a proprietary home care agency in one rural Kentucky county. The consumption of services was limited to the first six months of care from admission to the agency. The time frame of the study was between October 1993 and March 1996.

All data were obtained from the patients' charts; no direct patient contact was made for the study. Information was gathered from a review of the admission assessment conducted by an RN employee of the agency, by examination of the patients' discharge records, when applicable, and by an audit of the visit count by staff as recorded in the patients' charts in the sections covering nursing, therapy and home health aide visits. No distinction was made between chargeable and non chargeable visits for the purpose of this study. The evaluation of patient characteristics was taken from patient records; these included current and discharge charts kept in the county office where the study was conducted. No treatments or interventions were performed on the subjects.
Ethical Considerations

Application for approval of the study was made through the head of the Department of Nursing at Western Kentucky University. The proposal was then forwarded to the Human Subjects Review Board (HSRB) of the university, where it received an Expedited Review and subsequent approval (see Appendix D).

Since there was no direct patient contact for the study, no questions of harm to the patients' physical or psychosocial health were raised. All information was available in the patient record. As a provision of the consent for services form signed on admission to the agency by the patient, information regarding the patient is allowed to be made available to staff members of the agency. The major ethical consideration involved in this study was that of patient confidentiality. All patients were assigned randomly selected numbers as a means of identification by the researcher. The list of numbers was kept in the researcher's office in a locked box. All patient information was referred to by the assigned number; no names of patients were used on the collection tools. The information from the patient record was kept in a separate locked drawer in the agency's office; no individual outside the agency was privy to any of the information gathered for the study. Permission to use the patients' records was obtained from the administrator of the agency. A copy of the letter is included in Appendix D.

Retention of Materials

After the appropriate time period for retention of research materials, the researcher's data and information will be disposed of by shredding the documents as per agency protocol. The actual patient records remain the property of the agency and are kept in locked cabinets in the county office and in a secure storage facility at the company's central office.
Data Analysis

Descriptive statistics were used to analyze each characteristic of the patient and the services utilized. The data analysis was done with Simstat for Windows statistics program, Version 1.1, (Novartis), on a Compaq PC. The following demographic and social characteristics of the sample were compared to the consumption of services: age, race, gender, socioeconomic status, literacy, family support, and functional abilities. Positive or negative outcomes were noted in relation to the above data (See Results).

Methodological Limitations

The sample was one of convenience: this was regarded as a limitation since opportunity for bias exists (Burns & Grove, 1993). The sample was also of a particularly homogeneous nature, in that the regional and cultural attributes of the population are very similar. This may restrict generalization to a wider-based population, although most rural populations in this country have matching demographic backgrounds. The study was intended essentially to describe and explore the characteristics of patients in this region and to provide a basis for future investigation.

Advantages of this form of sampling were that the needs of the particular agency were addressed regarding the development of appropriate strategies to optimize care for the population served by the agency itself as well as similarly structured agencies in rural areas. Little research has been done on the population under study; it was unlikely that the researcher would be able to obtain any other form of sample than the one described.

Communication of Findings

Information obtained from the study was made available to the administration and management of the agency. The findings were also of interest to others in the home care field. A summary of the study was made available for staff of the agency where the study was conducted as well as others in the area involved in home care. Formal application for publication may be made to journals dedicated to the home health field as well as research publications. Journals of nursing management and administration may be interested in this
issue, particularly in light of the prospect of decreased reimbursement and funding for home health agencies.

Interest in the issues of quality care and cost containment are now going to be priorities in the field of home health care; therefore, basic descriptive research in the area of the care of the rural elderly would be a valuable tool to assist in the decision making not only of administrators and management in allocation of personnel and resources but also of the staff involved in the planning and execution of day to day care of their patients.

Summary

The recent climate of health care has resulted in budgetary restrictions and curtailing of services. Home health care had been viewed as a means to reduce health care costs by limiting stays in acute care facilities. Since 1985 the numbers of home care patients have increased dramatically, as has the cost to Medicare of providing their care.

Managed care has been used as one method of reducing health care costs and has been in force in the acute and primary care settings. Budget restrictions and capitation are in the process of being implemented in home care reimbursement in the state of Kentucky.

In order to design cost effective interventions while providing quality health care, home health administrators and nurses must have a clear overview of the nature of the population they serve and an understanding of the resource utilization of their patients. There is a shortage of research information on these subjects, particularly in the geographic region of rural Kentucky.

This study was undertaken to describe the sociodemographic and other characteristics of a population of elderly home health patients living in rural Kentucky. The purpose was to identify the characteristics and to compare them to the type and quantity of resources of a proprietary home care agency. The services included skilled nursing, therapy, and personal care by home health aides. Outcome measurements were evaluated either by attainment of prior level of functioning or by deterioration of health
resulting in death, rehospitalization, or admission to a nursing home. The study was limited to the first six months of care from initial admission.

The patients were selected from one county office of the agency. Admission criteria included eligibility to receive Medicare home health benefits; excluded were infants, children, and those with a terminal diagnosis at time of admission.

The study was approved by the head of the Nursing Department of Western Kentucky University and the university HSRB. No direct patient contact was made; all information for the study was obtained from the patients' charts kept in the county office. Confidentiality was assured by the assigning of random numbers to the patients' records when gathering information and by keeping all records securely locked in the agency's office. The material will be destroyed per agency protocol at the appropriate time.

The data were collected from the admission assessment, from the discharge and transfer records, and clinical encounter notes, all of which were contained within the patients' charts. Analysis of the data was done on a Compaq PC with Simstat for Windows program, version 1.1 (Novartis), using a descriptive statistic to elucidate the measures of central tendency of the sample.

The findings were made available to the administration and staff of the agency. They are also available for any health care provider in the area and may be submitted by the researcher for publication to journals of home care and nursing management and administration. A methodological limitation of the study is the relatively small size; however, this convenience sample is reflective of the population served in this area by this and other home care agencies.
CHAPTER V
RESULTS

The purpose of the study was to identify characteristics of the elderly home health patients served by a proprietary home health agency serving a rural community and the services utilized by the patients under Medicare and Medicaid's system of reimbursement in effect before October of 1996. The objectives were (a) to provide a description of the characteristics of the population studied, (b) to identify the type and quantity of home care services utilized by the population, and (c) to compare the characteristics of the population with the services utilized. The study was intended to serve as a basis for development of cost effective interventions and provision of high quality care in a time of changing reimbursement methods for the home care industry. To facilitate the presentation of the findings, results will be discussed as related to the actual objectives.

Sample Characteristics

The sample was selected from a total of 148 present and prior patients of a proprietary home health agency in rural Kentucky. The patients met the Medicare qualifications for home care, which include homebound status, the need for intermittent services under the supervision of a physician, and eligibility for Medicare benefits. Excluded were infants and adults with a terminal diagnosis at the time of admission. A total of 81 of the original pool of 148 met the eligibility requirements.

Analysis of the characteristics of the group of patients ($N=81$) was done by a measure of frequency of the variables under consideration. The sample was predominantly Caucasian (95.1%), female (65.4%), literate (67.9%), and receiving medical assistance
(60.5%). The majority were without family to assist (76%), were in the over 70 age range (75.3%), and had moderate functional limitation (53.1%). One patient had a positive outcome (1.2%), negative outcomes were found in 69.1%. The remainder had neither positive nor negative outcomes in the six month period under study.

Type and Quantity of Home Care Services Utilized by the Sample

The visit count of the group was analyzed by discipline and frequency (see Table 1) from information contained in the patients' charts in the first six months of admission to the agency. The time frame of the study was from October 1993 to March 1996. Home health aide visits were the most numerous, followed by skilled nursing. Home health aide services were defined as care to ensure adequate personal hygiene in adults with functional limitations and included bathing, grooming, assisting with dressing, and toileting. Nursing services included administering medications, wound care, intravenous therapy, assessment of patient needs, and teaching. Therapy visits were the least frequently occurring. Therapy was defined as physical, occupational or speech therapy designed to rehabilitate the patient to an optimal level of functioning. During the six months period an average of 127.3 visits per patient was made. The range was extremely wide, between 15- 456, with a standard deviation of 86.878.

Table 1

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
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<th>Std Dev</th>
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Table 2

Comparison of total visits by sociodemographic characteristics

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<td>&lt;70</td>
<td>133.03</td>
<td>91.97</td>
<td>15</td>
<td>456</td>
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<td>F=0.027</td>
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<td>70-80</td>
<td>114.22</td>
<td>85.36</td>
<td>25</td>
<td>428</td>
<td>32</td>
<td></td>
</tr>
<tr>
<td>&gt;80</td>
<td>139.95</td>
<td>83.19</td>
<td>18</td>
<td>378</td>
<td>29</td>
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<tr>
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<td></td>
<td></td>
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<td></td>
</tr>
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<td>African American</td>
<td>200.75</td>
<td>183.69</td>
<td>46</td>
<td>456</td>
<td>4</td>
<td>t=0.901</td>
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<td>Caucasian</td>
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<td>79.46</td>
<td>15</td>
<td>428</td>
<td>77</td>
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<td>Male</td>
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<td>86.35</td>
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<td>247</td>
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<td>125.41</td>
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<td>72.98</td>
<td>52</td>
<td>378</td>
<td>25</td>
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Note: no values were statistically significant at the alpha level of 0.05
Comparison of Characteristics of the Sample with Services Utilized.

A comparative breakdown analysis was done between the total number of visits and the characteristics of the group (see Table 2). There were no statistically significant differences in the amount of services used and the three age groups. The 70-80 age group was the largest ($N=32$). However, the oldest old, aged $>80$ years, was numerically the second largest in size ($N=29$). This group is the one least likely to have help from informal support groups and is also the fastest growing demographic group in the U.S. African Americans had more total visits than Caucasians, but comprised a small percentage of the total number of patients. Males and females had essentially the same resource consumption rates; females in the study outnumbered males almost 2:1 (males $N=28$, females $N=53$). This fact reflects the overall demographic pattern of the longer lifespan of females and the more frequent likelihood of older women being widowed and alone than is found in older men.

Medicaid patients had an overall higher resource consumption than those receiving Medicare only; again, there was no statistically significant difference. Medicaid patients were more likely than Medicare recipients to be unable to pay for out of pocket services and more reliant on state and federally funded formal care. Literacy status had no impact on the services used; there was a very broad range from a minimum of 15 visits to a maximum of 456. The frequency analysis indicated that three patients had over 350 visits each; 40 patients fell in the frequency range of 101-247 visits. The presence or absence of willing family members to assist made no difference in the visits made. Only one fourth of the patients had family to help, the remainder relied solely on the home care agency.

The degree of functional limitations correlated with the absolute number of visits made per patient, but again was not statistically significant. Most of the patients fell within the moderately limited category ($N=43$). Those in the minimally limited category
(N=24) still had an average of 82 visits in the six month period. Patients with negative outcome had more visits than those without. Only one patient had a positive outcome.

Summary of Results

The predominant socio-demographic characteristics of the group in the study were female gender, aged greater than 70, Caucasian, of low socioeconomic status, and literate. Most were without family members to assist with their care and had moderate to severe functional limitations. Home health aide services for personal care were the most frequently made visits, followed by skilled nursing and therapies. The greatest resource utilization was by females, the illiterate, those aged greater than 80, without family support, and with severe functional limitations. An unexpected finding was the extremely wide range of visits and the large standard deviation. There was not a statistically significant difference among the characteristics of the group to account for the type or quantity of resources utilized.
The purpose of this study was to identify sociodemographic characteristics of a group of elderly home health patients receiving care from a proprietary home care agency in a rural area of Kentucky in order to establish a basis for developing cost effective and high quality care in a time of shrinking resources and limited reimbursement for home care visits from private and public pay sources. The objectives were to describe the population served by the agency, to identify the type and quantity of services utilized by the patients, and to compare the characteristics of the population with the services utilized.

Patient Profile

In the group of patients studied, the typical home care recipient was female, low-income, Caucasian, literate, moderately limited in functional abilities, aged between 70 and 80, and living without family support. This finding confirms those of Pasquale (1989), Fisher (1990), and Fredericks and Wierek (1992), who found that females living alone, with limited financial resources, and moderate impairment in function, were most likely to be dependent on formal home health care.

Further corroboration for this profile of recipients of home care was provided in an editorial in the newsletter for The National Association for Home Care (1997). The author urged Congress to reject a provision in the current federal budget which would require a $5.00 copay for all home health visits. The main argument used was that the
largest group of home health care recipients was women older than 75 with an annual
budget of $8,000, and that this group would bear a heavy burden if the measure passed.

The type of services used by the patients most often was personal care, followed
by nursing services and therapy. Personal care services are more likely to be needed for
patients without a family support system and who have some functional limitations, which
were characteristics of the most frequently occurring group. This finding was also
confirmed by Pasquale (1989), and Fisher (1990).

Statistical Significance

The number of total visits and the age of the patients showed no statistically
relevant differences. In terms of numbers of the sample, the oldest old, i.e., those aged
greater than 80, were the second largest group (N=29) out of a total of 81 patients. This
demographic group is one of the fastest growing in the country as reported by the U.S.
Census Bureau in 1995. It is also the group least likely to have an informal support
group, either of family or friends, and most likely to depend on a home care agency for
help (Fisher, 1990). It follows that this most vulnerable population would be hardest hit
in terms of quality of life if substantial cuts were made in home care visits.

There was no significant relationship between the characteristics of the patients
and the type or number of resources consumed. African American patients had a higher
total number of visits than Caucasians, but totaled only 4 out of 81 patients. Males and
females had essentially the same number of total visits; females did outnumber males by
almost 2:1. Although the females did not have a significantly higher level of resource
consumption, they are more likely than males to live alone at the end of their lives and to
make up a larger percentage of the aged population (U.S. Census Bureau, 1995). This
finding is similar to that of Tartasky (1990), who found that neither gender nor ethnicity
had an impact on health outcomes in home care patients.

Socioeconomics did not have a statistically significant impact on the resources
consumed; however, the total number of visits for Medicaid patients, i.e., those with
limited financial resources, was higher than for Medicare patients \( (N=138.63 \text{ vs. } N=109.97) \). Medicaid patients are more likely to be dependent on federally and state funded programs and less able to pay for private care in the event of decreased allowable services from formal care systems such as home health. The mean difference between the two groups was almost 30 visits in the six month period of services studied; this greater number of visits which Medicaid recipients may need could deter some agencies from accepting low income patients.

Literacy had no real effect on the number of visits received; approximately one third of the patients were illiterate, this result will be discussed in the section dealing with the implications for practice. Similarly, the presence or absence of family members to assist with care had little effect on resource usage. In the event of limitations on visits or services, there is a need to teach family members and potential caregivers that the home health agency will not be able to provide for all the needs of the patient, that the family must take a more active role in helping with care. In the past, the fact that a family member was present in the home and capable of being taught to give care was not grounds to limit nursing or personal care services; the family member also had to be willing to help. In light of restrictions on the capability of home health agencies to provide services, families, neighbors and voluntary agencies must combine to fill the gaps in services and assist the patient to remain safely at home.

Differences in functional abilities also had no significant impact on numbers of total visits. This finding is in contrast to a study done by Pasquale (1988), who found that the number of services consumed by home care patients increased as functional limitations increased. The possibility may exist that those patients who were designated as minimally or moderately impaired were in fact being provided with more care than was actually needed. Implications of this finding may include provision for better education of patients at the time of admission, with an emphasis on teaching self care and avoiding the impression that home health care equals unlimited services. Referral to therapy disciplines
for evaluation of self-care abilities and rehabilitation potential would be an appropriate intervention in reducing the dependency on personal care services.

Range of Visits

The range of numbers of visits was extremely broad, from a minimum of 15 to a maximum of 456 ($SD=86.878$). Although certain demographic groups had a greater average number of visits, the wide variance in the frequency of visits negated any difference in resource utilization of one group over another. This finding could indicate that the medical diagnosis of the patient may impact the amount of care needed; diagnoses were not considered in the study as the researcher was interested in other factors which can impact health care needs of patients. This finding was confirmed by Mootz (1981), who found that the severity of illness was not a factor in the frequency of healthcare provider contacts. All of the patients in the present study had a minimum of two chronic illnesses, and increased severity of disease would have negatively impacted the functional ability of the patients. There was little difference in practical terms in the means of the three functional groups.

One variable not considered in the study is the pattern of visits ordered by individual nurses. The RN who admits the patient often has a great deal of autonomy in ordering the frequency and type of visits. The nurse establishes broad goals for the patient at the time of admission, but there is no standard procedure or guidelines within the agency for developing the plan of care. A recent report by the federal Government Accounting Office (GAO) found that proprietary agencies made a higher number of visits to home health patients than did nonprofit agencies, with no difference found in the medical or demographic variables of the populations served ("Homecare News," 1997). This report suggests that the corporate climate in for-profit agencies may encourage the staff to order more visits under a retrospective payment system than the staff in a comparable nonprofit agency.
Implications for Practice

The greatest number of home health patients in the group were elderly women without financial resources or family support. Since it is probable that there will be funding cuts and reduction of services available to this population, agencies and nurses must be aware that these patients have little other recourse for assistance other than the formal home care system. Given the low rate of positive outcome (i.e., rehabilitation and discharge from care within 6 months) many of these patients are going to need care on a long term basis. Referral to the Medicaid Waiver Program which is designed to provide home maintenance as an alternative to nursing home placement may be indicated for many of these patients rather than admission to home health, which requires that the care be intermittent and finite. Alternative strategies may include decreasing the frequency of visits but extending them over a longer period of time as one way to assure that the patient will not be prematurely discharged from home care. Health care providers must also look more closely at charitable and volunteer services in the community to take the place of reduced government funded services.

The wide range of visits ordered seems to indicate a lack of consistency in assessment of patient care needs among the agency staff. While complete standardization of care is not possible or necessarily desirable, care maps or pathways designed specifically for home health could be utilized agency wide to achieve a consensus among care providers. Use of care pathways in home health have been shown to reduce costs and prevent rehospitalizations (Corbett, 1994). Since a sociodemographic profile of patients is now available in this study, patients with similar backgrounds and medical diagnoses could be selected to implement care maps and to evaluate their efficacy in comparison to the established system of care delivery.

Implementing new methods of developing and delivering care gives the administration opportunities for staff education in the changing nature of home health. The emphasis must be on goals of rehabilitation and discharge from the agency, rather
than long-term maintenance. Nurses must learn effective teaching strategies to empower patients and their families to provide their own care and maintain health; staff must emphasize the finite amount of care that the agency will provide, and avoid complacency and lack of involvement in health care decisions by patients. A systematic approach through use of care maps as outlined by Corbett (1994), and Adams and Wilson (1995), would assist staff members in attaining continuity and consistency in their teaching plans.

Although the majority of the patient population was literate, a substantial percentage (32.1%) was not. Education of patients in self-care abilities is a priority intervention in rehabilitation; alternative teaching tools must be devised with this group in mind. Present practice involves oral teaching reinforced by patient information sheets. This strategy is of little value when literacy skills are lacking. It cannot be assumed that patients can retain adequate information from a few encounters with nurses, during which time teaching is mixed with skilled interventions. Other forms of non-written tools need to be developed; these could include audio-visual aides, VCR tapes and portable units to take to homes without technological devices, colorful charts, and instruction sheets with graphic illustrations in place of words. Identifying mutual goals with the patient and encouraging their active participation through informal "learning contracts" can help the patient attain the ability to manage their own health care (Rice, 1992).

If rehabilitation and discharge from care is accepted as a priority for patients, the agency must give some consideration to increasing utilization of the therapy disciplines as a means to that end. Under the present system, this third arm of the care team is used very little. There is a need to educate physicians, nursing staff, families, and patients in the role that the therapy disciplines can play in rehabilitating patients to optimal levels of functioning. Rice (1992) emphasizes that home health nurses can play an important role in that education process. While some functional limitations are a normal part of the aging process, distinction must be made between those that are inevitable and irreversible
and those that can be treated or accommodated; bias against the elderly should not play any part in determining treatment decisions.

Implications for Education

In the past, most home health agencies required that their employees have a minimum of one year's experience in the acute care setting to attain and refine assessment and clinical skills (Rice, 1992). Downsizing of staff numbers in hospitals has led to fewer new graduates being hired as medical-surgical nurses, while the growth in the home care sector has made it necessary for some agencies to hire new graduates or nurses with less than one year's hospital experience (Curtin, 1996).

As the job market has changed for nurses in the past ten years, so must the curriculum of nursing programs if they want to produce graduates who are prepared to enter the work force in a changing health care environment. There should be increased emphasis on delivering care out of the traditional hospital setting, the area in which most students are prepared by their academic programs. Teaching students about the varied opportunities for nursing in business, industry, and community settings is required to prepare future nurses for their expanding roles in the health care system (Curtin, 1996).

Present standards for nursing education of associate degree nurses make no provision for a community health component in their formal education. In the office in which the study was conducted, seven of the eight RNs had associate degrees. None had had any classroom instruction on home health care; one had spent one clinical day's rotation with a home care nurse in a medium sized city.

An important component of health care in the nineties and the millennium to come is cost containment and reimbursement. Few if any new graduates are aware of the restrictions and limitations placed on agencies and institutions in providing care for their patients. Most are not aware of DRGs, utilization review, ICD-9 coding, or what an agency charges for services and supplies.
While it is not expected that new graduates can be educationally prepared to be proficient in every and all sectors of the health care field, nor to be sophisticated in reimbursement and health care financing, there is a need to incorporate the realities of the present day health care system into academic programs. Perhaps the lack of education in the fields of home care and the managed care environment could have contributed to the lack of consistency in writing orders among the agency's nurses, resulting in the broad range of the number of visits revealed in the study. Of course, ultimately it is the responsibility of the home health agency to train its staff and nurses in the appropriate allocation of resources and cost effective care (Rice, 1992).

Implications for Research

A limitation of the study is the small sample size and the use of only one home care agency's patients. Further studies could be done within the agency to corroborate sociodemographic and utilization findings; the agency is presently licensed in eight counties within the state of Kentucky and expects to expand within and outside the state in the near future. Cooperation with other proprietary and community based agencies within the region could lead to evaluation of a wider based population in a larger study. As mentioned previously, comparative studies of care maps and traditional care plans could be done using patients with matched sociodemographic characteristics and medical diagnoses to evaluate means of making care more efficient and effective. Most of the studies presently existing in the literature have been done on populations on the West and East coasts of the United States. (Adams & Biggerstaff, 1995).

Within the group studied, other characteristics may be evaluated to determine if they have any effect on outcome or utilization. Cognitive abilities, mental illness diagnoses, locus of control, and health belief systems may well have more influence on dependence on formal health care systems than the variables in the study; or they may interact with the social and demographic elements to increase or decrease dependency. Tartasky (1990) found that mental illness accounted for a 5% increase in needed services
for a home health patient sample, while gender, ethnicity and physical illness had no effect on increased resource use. Dellasega, Dansky, and King (1994) reported a significant increase in the amount and type of services among the elderly with a cognitive impairment. More in-depth research on the group is needed to evaluate the effect of these other characteristics on the group's home health needs.

The lack of statistically significant differences in the characteristics of the patients and the resources consumed could lead to more investigation of the initial patient evaluation by the admitting RN and to whether or not the services ordered matched the actual needs of the patients. In this study, in contrast to what the researcher expected from the literature review, neither age, gender, family assistance nor functional limitations had any impact on the total numbers of visits. A comparison between this sample and comparably matched patients from other agencies may reveal a pattern of inappropriate and unnecessary visits unrelated to the actual requirements of the patients.

Further study of the pattern of services ordered by different RNs could shed some light on the broad range of visits. It may be possible to identify one or a group of nurses who will order a higher frequency of visits unrelated to the characteristics examined in this study. An example is that of the patients who did have family support, but who still had some of the highest numbers of visits by all disciplines. These patients had a range of 15 to 428 visits within the six months time period of the study, with a mean of 126.47 (SD=94.96). The group of patients without family support had a range of 23 to 456 visits, with a mean of 127.91 (SD=74.36).

A qualitative study on two or three members of the sample may give better insight into the expectations the population has of the health care system and what interventions are most likely to succeed within the cultural framework of this area. Culturally appropriate care provides the broadest and most important means to promote health and well-being (Rice, 1992). Investigating health beliefs and factors which trigger health care seeking behaviors that are relevant to the group may be elicited by a small in-depth study.
Given the relative homogeneity of the area's population, results could be extrapolated beyond the immediate circle of informants. The elders of this area have a great wealth of life experience and knowledge that has taken them from the primitive technology and isolation of the early part of this century to the present day globally interconnected society of high tech and the world wide web (Simon, 1987). Such knowledge could be invaluable to research now and in the future and could help providers develop interventions to assure optimal levels of health and function in a time of limited resources and funding.

Current Trends

A recent development in the home health field is that of allegations of overbilling to Medicare, especially by proprietary home care agencies. This material was not available at the time of the literature review of the study, but it is significant in affecting the public and political perceptions of home health care and may result in more stringent budget cuts and limitations of services. Researchers examining the variation in the number of visits provided by proprietary and voluntary or government agencies showed that for-profit agencies made an average of 78 visits per year, per beneficiary, whereas nonprofit organizations averaged 46 visits ("Homecare News," 1997). There was no difference due to region, demographics, diagnoses, qualifying conditions, or quality of care. In the shadow of allegations of fraud and abuse of the Medicare system, all levels and disciplines of home health staff must work diligently to assure that the care given to their patients remains of the highest quality while endeavoring to control and limit costs in a changing health care environment.
References


Appendix A

Admission Assessment
INITIAL ASSESSMENT PACKET

LAST NAME ___________________________________ FIRST NAME __________________________ SS # __________ / __________ / ______

DOB __________ / __________ / ______ SEX: □ M □ F MARITAL STATUS: □ Single □ Married □ Widowed □ Divorced □ Sep

PHONE ( ) __________ ____________________________

HOME ADDRESS

ADDRESS WHERE PATIENT IS TO BE SEEN

Branch:

Primary Language: □ English □ Spanish □ Other: ______________________ Need for Interpreter □ Y

RACE: □ Asian □ Black □ Hispanic □ American Indian □ Alaskan Native □ Pacific Islander □ Unknown □ White (Not Hispanic)

Religious Affiliation: ______________________ Spiritual Contact: ______________________ Phone: ______________________

Directions to Home ______________________

____________________________ ______________________ ______________________

____________________________ ______________________ ______________________

____________________________ ______________________ ______________________

____________________________

EMERGENCY CONTACTS:

DAYTIME: ______________________ Name: ______________________ Phone #: ______________________ Relationship: ______________________

NIGHTTIME: ______________________ Name: ______________________ Phone #: ______________________ Relationship: ______________________

Referral Source: ______________________ Contact: ______________________ Date: ______________________

(Specify Actual)

□ Payor Change □ Readmit

Start of Care / Certification Date: ______________________ Reason for Assessment: □ New Admission □ New Diagnosis

DNR □ Yes EMS DNR □ Yes Placement within home ______________________

Advance Directives □ Yes □ Living Will □ Durable Power of Attorney □ Health Care Surrogate

IV Patient? □ Yes Wound Care Patient? □ Yes Medicare Mix # (1-18) __________

Verbal Start of Care: ______________________ Admit Date: ______________________

Plan of Care V/O Date ________ By DR: ______________________ Assessment by: ______________________

Nurse Signature: ______________________ Date of Assessment: ______________________
Patient's Name: 

<table>
<thead>
<tr>
<th>PRIMARY INSURANCE</th>
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<tr>
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<td>□ Private Insurance</td>
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<tr>
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<td>□ Private Pay</td>
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<tr>
<td>Subscribed: □ Self □ Spouse □ Other</td>
<td>Subscribed: □ Self □ Spouse □ Other</td>
</tr>
<tr>
<td>HIC #:</td>
<td>HIC #:</td>
</tr>
</tbody>
</table>

FUNCTIONAL LIMITATIONS:

1. Amputation  □ Hearing  □ Ambulation  □ Dyspnea Minimal Exercise
2. Bowel/Bladder Incont.  □ Paralysis  □ Speech  □ Other
3. Contracture  □ Endurance  □ Legally Blind

ACTIVITIES PERMITTED:

1. Complete Bedrest  □ Transfer Bed/Chair  □ Independent at Home  □ Wheelchair
2. Bedrest, BIP  □ Exercises Prescribed  □ Couches  □ Walker
3. Up as Tolerated  □ Partial Weight Bearing  □ Cars  □ No Restrictions

FUNCTIONAL STATUS:

□ Independent Ambulation / Care  □ Independent with Ambulation Device
□ Needs Assistance - Ambulation / Care  □ Independent
□ Needs Assistance - Ambulation / Care  □ Wheelchair

PRIOR FUNCTIONAL STATUS:

□ Independent Ambulation / Care  □ Needs Assistance - Ambulation / Care
□ Independent with Ambulation Device  □ Dependent
□ Independent with Ambulation Device  □ Wheelchair

PAIN: How often does pain interfere with the patient's activity/movement?

☐ 0 None of the time (i.e., patient has pain, but it does not interfere with activity/movement)
☐ 1 Some of the time (i.e., less than daily)
☐ 2 Most of the time (i.e., daily)
☐ 3 All of the time
☐ 4 No pain

DYSPNEA: When is the patient noticeably short of breath?

☐ 0 Never, patient is not short of breath
☐ 1 When walking more than 20 feet, climbing stairs
☐ 2 With moderate exertion (e.g., while dressing, using commode/bedpan, walking distances less than 20 feet)
☐ 3 With minimal exertion (e.g., while eating, talking, or performing other ADLs or with agitation)
☐ 4 At rest (during day and/or night)

MENTAL STATUS:

□ Oriented
□ Confused
□ Forgetful
□ Disoriented
□ Agitated
□ Other

NUTRITION - IBW Calculation / Harris Benedict Equation

Net (Include enteral/supplements/TPN):

Nutritional Risk: □ Low □ Moderate □ High

Check any of the following that apply:

☐ Significant Weight Loss/Gain  □ Open Wound  □ GI Problems Impairing Nutrition
☐ Cancer  □ Chewing/Swallowing Problems  □ Nutritional Deficit
☐ Dependent on Other Person for Meals  □ Burns  □ Poor Appetite
☐ Receiving Meals on Wheels  □ Eat Few Fruits, Vegetables, or Milk Products

Any of the above are present, explain in narrative. Further nutritional evaluation/interventions may be indicated.

Activity Factors: □ Confined to Bed  □ Out Of Bed

Surgery: □ Minor  □ Major
Infection: □ Mild  □ Moderate
Trauma: □ Skeletal  □ Head injury (with Steroid Therapy)
Burn: □ 40% Body Area  □ 100% Body Area

Comments:
** Visual Verification of all Insurance Cards At Time Of Admission by Admitting Nurse is Mandatory **

### KENTUCKY MEDICAL ASSISTANCE IDENTIFICATION CARD (MAID)

<table>
<thead>
<tr>
<th>Eligible Member(s) Name(s) as Appears on Card</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 Digit Medical Assistance ID #</td>
</tr>
<tr>
<td>From:</td>
</tr>
</tbody>
</table>

Select Card Type:
- Regular Card - (White - No Restrictions)
- Qualified Medicare Beneficiary (QMB) / Maid Card - (White - No Restrictions)
- Ken Pac Maid Card - (Green) -
- Lock In Maid Card - (Pink) - No Restrictions (Services provided s/b reported to MD on card)
- QMB - (Red, White, & Blue w/State of KY) - ** Home Health Services/Walker Not Covered **

Nurse Signature: ___________________________ Date: ________________
Patient's Name: ____________________________

SUPPLIES:  □ Wound Care  □ IV  □ Diabetic  □ Ostomy  □ Urological  □ Venipuncture  □ Fleets Enema  □ Incontinence  □ Reachers  □ Stockinette  □ T.E.D. Hose  □ Tap Water Enema  □ Splints  □ Tube Feeding Supplies  □ Unna Boot

List Specific Supply Items in Box #21 (Orders for Discipline)

LIVING ARRANGEMENT:  □ Alone  □ Spouse  □ Child/Family member  □ Significant Other  □ Other __________
□ Owns Home  □ Rents  □ Lives @ Family Member’s Residence  □ Boarding Home or rented room  □ Personal Care Home  □ Specialized Housing for Elderly  □ Assisted Living Facility

SAFETY MEASURES:

□ Adhere to Diet  □ Oxygen Precautions  □ Keep Bed Rails up at All Times  □ Follow Diabetic Instructions  □ No Smoking  □ Reposition Every 1-2 Hours  □ Adhere to Medication Regime  □ Keep Dressing Clean and Dry  □ Pad Bed Rails  □ Keep Meds / Chem out of Reach  □ Report S&S of Disease  □ Fall Precautions  □ Proper of Meds / DVS  □ Use Planned Fire Escape Route  □ Keep Kitty or Bag Lowered  □ Discard Expired Medications  □ Obtain Smoke Detector  □ Use Hoyer Lift  □ Dispose of Sharps in Container  □ Obtain Carbon Monoxide Detector  □ Wear Shoes Outside  □ Seizure Precautions  □ Remove Loose Rugs  □ Use Car seat  □ Good Skin Care  □ Transfer with Assistance  □ Keep Area Clear & Uncluttered  □ Report S&S of Infection  □ Use Walker / Cane to Ambulate  □ Keep Head of Bed Elevated  □ Do Not Remove Dressing  □ Ambulate with Assistance  □ Keep Foot of Bed Elevated  □ Dispose of Dressings Appropriately  □ Use Night light  □ Keep Emergency Exit Accessible  □ Report S&S of Bleeding  □ Get into Tub with Assistance  □ Do Not Block Exit Fire Escape Routes

REASON HOMEBOUND

□ Anxiety  □ Req. Assist with Ambulating  □ Severe SOB / DOE on Exertion  □ Agitation  □ Poor Balance / Unsafe  □ Requires Oxygen  □ Agitated  □ Increased Pain on Ambulating  □ Req. Assist with ADL  □ Behavior Poses Risk  □ Bedbound  □ Obese  □ Fear / Refuse to Leave  □ Cannot Navigate Stairs  □ Poor Endurance  □ Paranoia  □ BKA  □ Frail  □ Judgment Impaired  □ AKA  □ Paraplegia  □ Confused  □ Req. Assist with Transfers  □ Hemiplegia  □ Agoraphobic  □ Chair Transfer Only  □ Paralytic  □ Disorder  □ Bed rest with BRP  □ Cardiac Restrictions  □ Unable to Ambulate  □ Unforewarned Dizziness  □ End Stage Disease  □ Unconscious  □ SOB at Rest  □ Impending Death  □ Unable to Walk or Stand  □ Respiratory Distress  □ N / A  □ Wheelchair Dependent  □ Impaired
Patient's Name: ________________________________

Product Lines and Programs: (Choose the most significant Service Program - ONLY 1)

- Respiratory
- Medical
- Surgical
- Acute
- Hip
- Chemo
- Infusion
- Well Baby
- Osmolies
- Oxygen
- Onset
- Chronic
- Knee
- Hydration
- Neonatal
- Wound Care
- Pulse Ox
- Exacerb.
- Transplant
- Shoulder
- Pain Mgmt
- Early Discharge
- Decubitus
- Nebulizers
- COPD
- Infusion
- ADL's
- Antibiotics
- Phototherapy
- Burns
- Ventilator Care
- CVA
- CABG
- Communications
- TPN
- Apnea Monit.
- HTN
- Exacerb
- Fine Motor Skills
- Line Maint.
- Neuro
- Psychiatric
- Adult
- Geriatrics
- Diabetes
- IDDM
- Onset
- Insulin Pump

Patient Hospitalization History:

<table>
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<tr>
<th>HOSPITAL / FACILITY (Most Recent First)</th>
<th>ADMIT</th>
<th>D/C</th>
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Reasons for Hospitalization / Inpatient Stay:

<table>
<thead>
<tr>
<th>ICD-9 Code</th>
<th>Order #</th>
<th>DIAGNOSIS Reflected in Plan of Treatment</th>
<th>Date</th>
<th>Disease State</th>
<th>Severity</th>
</tr>
</thead>
</table>

Severity Index: 0 = Asymptomatic 1 = Symptoms well controlled 2 = Symptoms controlled with difficulty, daily functioning affected, needs ongoing monitoring 3 = Symptoms poorly controlled, needs frequent treatment, medication changes 4 = Symptoms poorly controlled; history of re-hospitalization.

<table>
<thead>
<tr>
<th>ICD-9 Code</th>
<th>Surgical Procedure</th>
<th>Date</th>
<th>Diagnosis Necessitating Surgery</th>
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<tbody>
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Date Last Seen by MD ____________________________  KeaPac # ____________________________

Primary MD Last Name ____________________________  First Name ____________________________
Address ____________________________  Phone (____) ____________________________
Number & Street Name ____________________________  City/State/Zip ____________________________

Secondary MD Last Name ____________________________  First Name ____________________________
Address ____________________________  Phone (____) ____________________________
Number & Street Name ____________________________  City/State/Zip ____________________________
Other Providers

<table>
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**Patient's Name:**

---

**PHYSICAL ASSESSMENT**

*(Specify left, right or extremity, etc.)*

Identify other complaints, findings, etc. in comments section.

### EENT

- No Problems Noted
- Pain
- L. R.
- L. R.
- Poor Vision
- L. R.
- Toothache
- L. R.
- Dry Mouth
- L. R.
- Mouth Sores
- L. R.
- Sinus problems
- L. R.
- Snoring
- L. R.
- Excess mucous/secretions
- L. R.
- Sore tongue
- L. R.
- Earaches
- L. R.
- Dentures
- L. L.
- Frequent sore throat

### CARDIOVASCULAR/PULMONARY

- No Problems Noted
- Abnormal Heart Sounds
- Orthopnea
- Palpitations
- AOO
- Pacemaker Rate:
  - Insertion Date:
  - Checks done by:

### GASTROINTESTINAL

- No Problems Noted
- Nausea
- Abdominal Softness
- Vomiting
- Abdominal Rigidity
- Dysphagia
- Abdominal Distension / Bowel Sounds
- Heartburn
- Abdominal Tenderness
- Gallstones
- Abdominal Masses
- Constipation
- Hemorrhoids
- Abdominal Torsion / Hemorrhoids
- Bowel Obstruction
- Bowel-Tube/No-Tube
  - Type:
  - Size:
  - Date Changed:

### GENITOURINARY

- No Problems Noted
- Frequency
- Urgency
- Incontinence
- Retention
- Dysuria
- Hematuria
- Infection
- Prostate enlargement

### GYNECOLOGICAL

- No Problems Noted
- Hysterectomy
- Amenorrhea
- Menopausal Status
- Birth Control

### MUSCULOSKELETAL

- No Problems Noted
- Swollen Joints
- Weakness
- Painful Joints
- Limited R.O.M.
- Prostheses
- Amputations
- Fractures

---

**Comments:**
### PHYSICAL ASSESSMENT (continued)

#### NEUROLOGICAL

<table>
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<th>Comment</th>
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<tr>
<td>Pain</td>
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<td>Seizures</td>
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<tr>
<td>Confused</td>
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<tr>
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<td>Paroxysm</td>
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<td>Unsteady Gait</td>
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#### LYMPHATIC & HEMATOLOGIC

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#### ENDOCRINE

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<tr>
<td>Hirsutism</td>
<td></td>
</tr>
<tr>
<td>Thirst</td>
<td></td>
</tr>
<tr>
<td>Sweats</td>
<td></td>
</tr>
<tr>
<td>Moon Face</td>
<td></td>
</tr>
<tr>
<td>Hair Loss</td>
<td></td>
</tr>
<tr>
<td>Hormonal Replacement Therapy</td>
<td></td>
</tr>
</tbody>
</table>

#### PREVENTIVE HEALTH SCREENING

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast Exam</td>
<td></td>
</tr>
<tr>
<td>Hearing Test</td>
<td></td>
</tr>
<tr>
<td>Pap Smear/Genital Exam</td>
<td></td>
</tr>
<tr>
<td>Stool for Occult Blood</td>
<td></td>
</tr>
<tr>
<td>Thyroid Tests</td>
<td></td>
</tr>
<tr>
<td>Hepatitis Vaccine</td>
<td></td>
</tr>
<tr>
<td>Mammogram</td>
<td></td>
</tr>
<tr>
<td>Tonometer for Glaucoma</td>
<td></td>
</tr>
<tr>
<td>Tensionometry</td>
<td></td>
</tr>
<tr>
<td>Postmenopausal</td>
<td></td>
</tr>
<tr>
<td>Tuberculosis</td>
<td></td>
</tr>
</tbody>
</table>

#### PARENTERAL THERAPY

| Status of Vein:           | Good  | Fair | Poor |
| Access Type:             | Implanted Port | PICC | Midline | Peripheral | Epidural |
| Insertion Site:          |        |      |      |
| Clean/Drainage/Tenderness|        |      |      |
| Swelling/Erythema/Rash   |        |      |      |
| Lumen:                   | Single | Double | Triple |
| Catheter Size:           |        |      |      |
| Access Device Inserted:  |        |      |      |
| PICC Length:             |        |      |      |
| X-Ray Results:           |        |      |      |
| Should Be Obtained:      |        |      |      |
| Drug(s)/Dosage:          |        |      |      |
| Diluent/Amount:          |        |      |      |
| Rate of Infusion:        |        |      |      |
| Bolus Dose/Frequency:    |        |      |      |

#### Infusion Company

<table>
<thead>
<tr>
<th>Information</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Patient's Name:  

Instructions Provided On:  
- Disposal of Sharps  
- Disposal of Dressings  
- Emergency Preparedness  
- Advance Directives  
- Patient Rights/Responsibilities  
- Other Safety Measures:  

Emergency Numbers Provided:  
- Fire  
- Ambulance  
- Police  
- On Call Nurse  
- Hospital  

Patient/Family History  
(Circle all that apply: Self, M-Mother, F-Father, S-Sister, B-Brother)  

Anemia: Self M F B S  
Arthritis: Self M F B S  
Asthma: Self M F B S  
Alcoholism: Self M F B S  
Cancer: Self M F B S  
Diabetes: Self M F B S  
Epilepsy: Self M F B S  
Liver Disease: Self M F B S  
Phlebitis: Self M F B S  
Mental Illness: Self M F B S  
Rheumatic Fever: Self M F B S  
Sepsis: Self M F B S  
Stomach Ulcers: Self M F B S  
Tuberculosis: Self M F B S  

PHYSICAL ASSESSMENT  
(Specify left, right or extremity, etc.)  

SKIN  

- Lacerations  
- Abrasions  
- Pustules  
- Lesions  
- Drainage  

Does patient have a history of resolved pressure ulcers?  Y  

<table>
<thead>
<tr>
<th>Type</th>
<th>Location</th>
<th>L</th>
<th>W</th>
<th>D</th>
<th>Stage*</th>
<th>Drainage \ color</th>
<th>Tunneling</th>
<th>Granulation</th>
<th>Status</th>
<th>Eschar \ color</th>
<th>Condition of Surrounding Skin</th>
</tr>
</thead>
</table>

Type: P-Presure Ulcer  S-Stasis Ulcer  W-Surgical Wound  T-Skin Tear  L-Laceration  B-Burn  
Stage: 1-Non-blanchable erythema of intact skin; II-Partial thickness skin loss involving epidermis and/or dermis; III-Deep-tissue pressure ulcer with exposed muscle, tendons, or bone; IV-Deep-tissue pressure ulcer with exposed tendons, bone, or muscle; V-Deep-tissue pressure ulcer with exposed bone.  
Status: 1-Full granulating; 2-Early partial granulation; 3-Not healing; N/A-No observable ulcer/wound
### PSYCHOSOCIAL

**Patient's Name:**

**Primary Caregiver:**

**Phone:**

**Family Support (including ability/willingness to provide/assist with care):**

**Caregiver Health Status:**  
- [ ] Good
- [ ] Fair
- [ ] Poor

**Communication:**  
- [ ] Appropriate
- [ ] Inappropriate
- [ ] Non Communicative

**Patient Coping Skills:**  
- [ ] Good
- [ ] Poor

**Problems/Strength/Needs (Psychosocial, Financial, etc.):**

- [ ] 1-Unable to afford medicine / medical supplies
- [ ] 2-Unable to afford food
- [ ] 3-Unable to afford medical care not covered by insurance / Medicare
- [ ] 4-Unable to afford rent / utilities

**Recent life altering events (i.e. death in family):**

**Other Agencies Providing Care/Care Provided:**

**Length of time Patient is alone during the day:**

- [ ] 0 - Never
- [ ] 1 - About 1 Hr.
- [ ] 2 - Long periods of time
- [ ] 3 - All of the time

**Chronic Conditions:**

**Chief Complaint/Reason for Admission:**

**Education Needs:**

**Patient Able to Read:**

- [ ] Yes
- [ ] No

**Caregiver Able to Read:**

- [ ] Yes
- [ ] No

**Learning Ability/Impediments:**

**Comments/Instructions:**

### ENVIRONMENTAL SAFETY ASSESSMENT

*(Check all that apply)*

<table>
<thead>
<tr>
<th>Structural Barriers</th>
<th>Safety Hazards</th>
<th>Sanitation Hazards</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ 0 - None</td>
<td>□ 0 - None</td>
<td>□ 0 - None</td>
</tr>
<tr>
<td>□ 1 - Stairs inside home MUST be used by patient (to get to toilet, sleeping, eating area)</td>
<td>□ 1 - Inadequate floor, roof, windows</td>
<td>□ 1 - No running water</td>
</tr>
<tr>
<td>□ 2 - Stairs inside home to be used optionally (to get to laundry facilities, etc.)</td>
<td>□ 2 - Inadequate lighting</td>
<td>□ 2 - Contaminated water</td>
</tr>
<tr>
<td>□ 3 - Stairs leading from inside to outside</td>
<td>□ 3 - Unsafe gas/electric appliances</td>
<td>□ 3 - No toilet facilities</td>
</tr>
<tr>
<td>□ 4 - Narrow or obstructed doorways</td>
<td>□ 4 - Inadequate heating or wiring</td>
<td>□ 4 - Outdoor toilet facilities</td>
</tr>
</tbody>
</table>

**High Risk Factors:**

- □ 1 - Heavy smoking
- □ 2 - Obesity
- □ 3 - Alcoholism
- □ 4 - Drug dependency
- □ 5 - None of the above
- □ 6 - Other (specify)
### Patient's Name: ____________________

#### PLAN OF TREATMENT

<table>
<thead>
<tr>
<th>Skill</th>
<th>Orders / Frequency / Duration (Check all that apply &amp; add other needed orders - include Freq / Dur.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>SN</td>
<td><strong>da</strong>__  _<strong><strong>wk</strong></strong>  _<strong><strong>wk</strong></strong>  _<strong><strong>wk</strong></strong>  _<strong><strong>wk</strong></strong>  _<strong><strong>wk</strong></strong>  _<strong><strong>q</strong></strong>  _<strong><strong>q</strong></strong>  _<strong><strong>mo</strong></strong>  _<strong><strong>mo</strong></strong>  _<strong><strong>prn</strong></strong></td>
</tr>
<tr>
<td>POT1</td>
<td>☐ Assess for exacerbation of _____</td>
</tr>
<tr>
<td>POT2</td>
<td>☐ Instruct medication regimen, including correct administration, purpose, any contraindications, significant side effects / interactions, storage, etc.</td>
</tr>
<tr>
<td>POT3</td>
<td>☐ Instruct diet regimen &amp; evaluate compliance for _____ diet.</td>
</tr>
<tr>
<td>POT4</td>
<td>☐ Instruct on disease process related to _____ to include TX, symptom management, and emergency care.</td>
</tr>
<tr>
<td>POT5</td>
<td>☐ Instruct: Fall Prevention; Bladder Retraining; Safety Measures Care of Bedbound / immobile patient; Catheter Care</td>
</tr>
<tr>
<td>POT6</td>
<td>☐ Instruct: _____</td>
</tr>
<tr>
<td>POT7</td>
<td>☐ Administer insulin: _____</td>
</tr>
<tr>
<td>POT8</td>
<td>☐ Venipuncture for: _____</td>
</tr>
<tr>
<td>POT9</td>
<td>☐ F/C insertion: _____ Fr. _____ cc. Change prn _____ for complications</td>
</tr>
<tr>
<td>POT10</td>
<td>☐ Wound Care to (list areas): _____</td>
</tr>
<tr>
<td>POT11</td>
<td>☐ Call physician if fasting glucose above _____ or below _____ and/or if non fasting glucose above _____ or below _____</td>
</tr>
<tr>
<td>POT12</td>
<td>☐ May omit visits due to unpassable roads, patient refusing care, MD appointments, hospital stays, or temporarily out of area.</td>
</tr>
<tr>
<td>POT13</td>
<td>☐ DO NOT RESUSCITATE</td>
</tr>
<tr>
<td>POT14</td>
<td>☐ SN Other: _____</td>
</tr>
<tr>
<td>POT15</td>
<td>☐ AIDE: <strong>da</strong>__  _<strong><strong>wk</strong></strong>  _<strong><strong>wk</strong></strong>  _<strong><strong>wk</strong></strong></td>
</tr>
</tbody>
</table>

- Personal Care - POT 15
- Weights - POT 17
- Assist with exercises - POT 16
- Light Housekeeping - POT 18
MSS 1 da 1

Evaluate and assist with: 
- Housing/Environment (MSS1)
- Anxiety/coping (MSS2)
- LTC placement (MSS3)
- Financial/legal issues (MSS4)
- Depression (MSS5)
- Community Resources (MSS6)
- Transportation (MSS7)
- Compliance with Tx Plan (MSS8)
- Other (MSS9)

PT EVAL
Referral for evaluation and treatment with Plan of Care to follow. 1 da 1

OT EVAL
Referral for evaluation and treatment with Plan of Care to follow. 1 da 1

SLP EVAL
Referral for evaluation and treatment with Plan of Care to follow. 1 da 1

OTHER

PSYCH
Psychiatric Nurse to:

PT19

SN
Parenteral Therapy Administration:

<table>
<thead>
<tr>
<th>POT20</th>
<th>Medication / Solution</th>
<th>Dosage / Amt</th>
<th>Route</th>
<th>Diluent &amp; Amount</th>
<th>Frequency</th>
<th>Duration</th>
</tr>
</thead>
</table>

Administer via:  
- Peripheral line
- Central line
Type: [ ]

Flush:  
- [ ] Saline cc
- Hypertonic solution [ ] or [ ] or post infusion or blood draws, as needed.

Site change:  
- [ ] Extended peripheral dwell time; change pm s/s complications
- [ ] Other

Site dressing change every [ ]

Procedure:

Tubing change frequency:

[ ] Other

POT21
Anaphylaxis Protocol PRN as follows:

Adult: POT22
- [ ] 0.9% NaCl 500 @ 150 cc/hr or to maintain systolic BP of 90 mm Hg

POT23
- [ ] Epinephrine 0.3ml (1:1000) SC; may repeat once in 10 minutes

POT24
- [ ] Epinephrine 1:10,000 IV - dosage

POT25
- [ ] Decadron 1ml (4mg/ml) IM or IV
- [ ] Benadryl 50 mg IM or IV for itching
- [ ] Other:

Child: POT26
- [ ] Epinephrine 1:1000 SC - dosage

POT27
- [ ] Decadron 4 mg/ml 25cc IM or IV
- [ ] Benadryl IM for itching - dosage
- [ ] Other:

Signature: ___________________________  RN
Complete the following section on behavioral psychiatric referrals only.

Facial Expressions:  
- Smiling
- Flat
- Anxious
- Agitated
- Friendly
- Drewy
- Tense
- Facial Tics
- Happy
- Tearful
- Fearful
- Other
- Sad
- Calm
- Angry

Gestures:  
- None Observed
- Wrings Hands
- Talks with Hands
- Picks at Clothes
- Faces

Eye Contact:  
- Good
- Fair
- Poor
- Fleeting

Communication:  
- Speech Impairment:  
  - Thought Blocking
  - Illlogical
  - Loose Association
  - Inappropriate
  - Speech:  
  - Stuttering
  - Mumbling
  - Mush
  - Appropriate
  - Inappropriate

Judgment:
1. What should you do if you were in a crowded building and smelled smoke?

2. What would you do if a family member, friend, or someone important to you died?

3. What would you do if you inherited $10,000.00 tomorrow?

4. What would you wish for if you were given three wishes?
   1.
   2.
   3.

Other Questions to Ask:
1. Ask the patient what they would consider to be the best thing that has ever happened in their life.

2. Who can you depend on to help you?

3. What do they help you with?

4. Are they related to you? If yes, how?
Patient's Name: ________________________________

5. Who is the most important person in your life? ________________________________

6. Is God or religion important to you? If yes, how? ________________________________

7. Do you use prayer in your life? If yes, describe ________________________________

8. Have you ever thought about harming or killing yourself? ________________ If yes, how? ________________________________

9. Have you ever tried to kill yourself? ________________ If yes, how? ________________________________

10. Do you have a weapon (gun) in the house? ________________________________

11. Are you willing to turn the weapon over to a neighbor or relative? ________________ If yes, Who? ________________________________

Medication Issues:

1. Does patient understand reason for taking medications? ________________________________

2. Does patient understand schedule for taking medications ________________________________

3. Is patient confident with medication regimen? Complaint? ________________________________

4. What side effects, if any, is patient experiencing? ________________________________

5. Risk for Re-hospitalization: Low, Moderate, High ________________________________

6. Risk Assessment Based On (check all that apply):
   - History of frequent hospitalizations
   - No or limited support system
   - Little or no insight
   - Now compliant with medications and/or follow-up appointments
   - Denial of problem
## Goals / Rehabilitation / Discharge Plans

### GENERAL:

<table>
<thead>
<tr>
<th>Patient / Caregiver will:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>GEN001 Achieve optimal level of functioning</td>
<td>GEN009 Patient and / or family able to accept and understand care necessary related to disease process.</td>
</tr>
<tr>
<td>GEN002 Return to prior level of functioning by (Date)</td>
<td>GEN010 Patient / family able to explain disease and describe actions to take during any exacerbation by</td>
</tr>
<tr>
<td>GEN003 Patient able to function safely without skilled agency services by</td>
<td>GEN011 Demonstrate knowledge and skills to care for</td>
</tr>
<tr>
<td>GEN004 Or Family will access community resources by</td>
<td>GEN012 Identify emergency actions.</td>
</tr>
<tr>
<td>GEN005 Return to independence in ADL’s and personal hygiene.</td>
<td>GEN013 Identify measures to maintain safety.</td>
</tr>
<tr>
<td>GEN006 Demonstrate techniques to conserve energy.</td>
<td>GEN014 Clutter / safety hazards removed / corrected</td>
</tr>
<tr>
<td>GEN007 Identify when to contact physician</td>
<td>GEN015 Be medication compliant.</td>
</tr>
<tr>
<td>GEN008 Demonstrate daily compliance with</td>
<td>GEN016 Identify medications - schedule, dose, purpose, side effects.</td>
</tr>
</tbody>
</table>

### ANTICOAGULANT TX / HEMATOLOGICAL:

<table>
<thead>
<tr>
<th>Patient / Caregiver will:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>ANT001 Demonstrate compliance with anticoagulant therapy regimen.</td>
<td>ANT004 Caregiver will demonstrate techniques to protect patient from injury and infection.</td>
</tr>
<tr>
<td>ANT002 Avoid injury and infection.</td>
<td>ANT005 Self demonstrate iron administration as ordered.</td>
</tr>
<tr>
<td>ANT003 Identify signs and symptoms of bleeding and appropriate actions.</td>
<td>ANT006 Self demonstrate vitamin B12 administration.</td>
</tr>
</tbody>
</table>

### CARDIAC:

<table>
<thead>
<tr>
<th>Patient / Caregiver will:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>CAR001 Describe personal sx or &quot;signals&quot; of heart pain.</td>
<td>CAR005 Identify need and desire to quit use of tobacco.</td>
</tr>
<tr>
<td>CAR002 Demonstrate appropriate exercise and reports response to exercise</td>
<td>CAR006 Report angina or equivalent.</td>
</tr>
<tr>
<td>CAR003 Describe appropriate actions to take if sx recur (or similar sx in another anginal area).</td>
<td>CAR007 Reports angina remains stable in frequency, intensity, and duration.</td>
</tr>
<tr>
<td>CAR004 Self monitor weight and take appropriate action</td>
<td>CAR008 Lists specific foods indicated on diet and foods to avoid.</td>
</tr>
<tr>
<td>CAR005 Begin cardiac rehab program activity (outpatient).</td>
<td></td>
</tr>
</tbody>
</table>

### DIABETES / ENDOCRINE:

<table>
<thead>
<tr>
<th>Patient / Caregiver will:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>DIA001 Demonstrate knowledge of and compliance with insulin diet.</td>
<td>DIA004 Demonstrate knowledge and skills to administer insulin</td>
</tr>
<tr>
<td>DIA002 Be knowledgeable of sx/sx rt reaction and appropriate action</td>
<td>DIA005 Demonstrate increased activity tolerance, adequate nutritional intake, and absence of complications.</td>
</tr>
<tr>
<td>DIA003 Demonstrate compliance with diabetic regimen.</td>
<td>DIA006 Demonstrate skin care techniques.</td>
</tr>
</tbody>
</table>
### EENT

<table>
<thead>
<tr>
<th>EENT01</th>
<th>Patient / Caregiver will:</th>
<th>EENT03</th>
<th>Caregiver will demonstrate knowledge and skills to care for visually impaired patient.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Demonstrate compensatory measures for hearing loss.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>EENT02</td>
<td>Patient / Caregiver will:</td>
<td>EENT04</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Demonstrate compensatory measures for vision limitations or loss.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Gastrointestinal

<table>
<thead>
<tr>
<th>GAST01</th>
<th>Patient / Caregiver will:</th>
<th>GAST03</th>
<th>Implement measures to alleviate symptoms.</th>
</tr>
</thead>
<tbody>
<tr>
<td>GAST02</td>
<td>Maintain proper body weight.</td>
<td>GAST07</td>
<td>Verbalize prescribed diet and rationale.</td>
</tr>
<tr>
<td>GAST03</td>
<td>Implement measures to promote bowel continence.</td>
<td>GAST08</td>
<td>Demonstrate knowledge and skills to perform bowel routines.</td>
</tr>
<tr>
<td>GAST04</td>
<td>Maintain adequate nutrition and hydration.</td>
<td>GAST09</td>
<td>Take adequate nutrition and hydration.</td>
</tr>
</tbody>
</table>

### Genitourinary

<table>
<thead>
<tr>
<th>GENU01</th>
<th>Patient / Caregiver will:</th>
<th>GENU03</th>
<th>Implement measures to control (specific symptom).</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Establish regular patterns of urine output.</td>
<td></td>
<td>Demonstrate infection control.</td>
</tr>
<tr>
<td>GENU02</td>
<td>Implement measures to promote urinary continence.</td>
<td>GENU06</td>
<td>Demonstrate self-catheterization technique.</td>
</tr>
<tr>
<td>GENU03</td>
<td>Demonstrate compliance with bladder management regimen.</td>
<td>GENU07</td>
<td>Caregiver will demonstrate catheterization technique.</td>
</tr>
<tr>
<td>GENU04</td>
<td>Assume responsibility for care of catheter and appropriate fluid intake.</td>
<td>GENU09</td>
<td>Adequate urinary output through indwelling Foley catheter with absence of complications.</td>
</tr>
</tbody>
</table>

### Intravenous Therapy

<table>
<thead>
<tr>
<th>IV01</th>
<th>Patient / Caregiver will:</th>
<th>IV02</th>
<th>Verbalize correct infusion procedure, care of access device and disposal and storage of IV supplies and equipment.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Demonstrate knowledge and skills to self administer IV Therapy.</td>
<td>IV03</td>
<td>Have access device which will remain patent and without incidence of complications.</td>
</tr>
</tbody>
</table>

### Musculoskeletal / Rehab

<table>
<thead>
<tr>
<th>REH001</th>
<th>Patient / Caregiver will:</th>
<th>REH005</th>
<th>Demonstrate transfer technique.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Achieve optimal level of mobility.</td>
<td></td>
<td>Demonstrate measures to control pain.</td>
</tr>
<tr>
<td>REH002</td>
<td>Achieve optimal level of Ambulation.</td>
<td>REH007</td>
<td>Correctly demonstrates ordered exercises.</td>
</tr>
<tr>
<td>REH003</td>
<td>Achieve functional Ambulation with use of</td>
<td>REH008</td>
<td>Caregiver will assist patient with transfers, Ambulation, and exercises.</td>
</tr>
<tr>
<td></td>
<td>Ambulation, and exercises.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>REH004</td>
<td>Demonstrate increased mobility, coordination and strength.</td>
<td>REH009</td>
<td>Demonstrate knowledge of wheel chair propulsion/management.</td>
</tr>
</tbody>
</table>

### Fracture / Amputation

<table>
<thead>
<tr>
<th>FRAC01</th>
<th>Patient / Caregiver will:</th>
<th>FRAC05</th>
<th>Demonstrate conditioning techniques of residual limb in preparation for prosthesis.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Achieve maximum function of</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FRAC02</td>
<td>Will demonstrate transfer technique, positioning, and exercises.</td>
<td>FRAC06</td>
<td>Demonstrate techniques to control pain and swelling.</td>
</tr>
<tr>
<td>FRAC03</td>
<td>Achieve optimal level of Ambulation with prosthesis.</td>
<td>FRAC07</td>
<td>Caregiver will demonstrate knowledge and skills to care for patient with prosthesis.</td>
</tr>
<tr>
<td>FRAC04</td>
<td>Demonstrate care of prosthesis, residual limb.</td>
<td>FRAC08</td>
<td>Demonstrate care case.</td>
</tr>
</tbody>
</table>

**Goals / Rehabilitation / Discharge Plans - cont.**
**Goals / Rehabilitation / Discharge Plans - cont.**

### NEUROLOGICAL

<table>
<thead>
<tr>
<th>Patient / Caregiver will:</th>
<th>NEUR01</th>
<th>Achieve optimal level of independence in ADLs</th>
<th>NEUR02</th>
<th>Demonstrate improved coordination and functioning</th>
</tr>
</thead>
<tbody>
<tr>
<td>NEUR03</td>
<td>Demonstrate adequate communication skills</td>
<td>NEUR04</td>
<td>Demonstrate techniques to compensate for neurological limitations</td>
<td></td>
</tr>
</tbody>
</table>

### PAIN MANAGEMENT / ONCOLOGY / HOSPICE

<table>
<thead>
<tr>
<th>Patient / Caregiver will:</th>
<th>PAIN01</th>
<th>Modify routines to maintain self care and optimal level of functioning</th>
<th>PAIN04</th>
<th>Comfort and peace until death</th>
</tr>
</thead>
<tbody>
<tr>
<td>PAIN05</td>
<td>Caregiver will demonstrate knowledge and skills to care for patient undergoing</td>
<td>PAIN06</td>
<td>Caregiver will demonstrate knowledge and skills to maintain patient at home through death</td>
<td></td>
</tr>
<tr>
<td>PAIN07</td>
<td>Demonstrate measures to alleviate</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### OSTOMY

<table>
<thead>
<tr>
<th>Patient / Caregiver will:</th>
<th>OST01</th>
<th>Achieve independence in management of</th>
<th>OST03</th>
<th>Resume previous lifestyle</th>
</tr>
</thead>
<tbody>
<tr>
<td>OST02</td>
<td>Demonstrate colostomy irrigation</td>
<td>OST04</td>
<td>Maintain proper body weight</td>
<td></td>
</tr>
</tbody>
</table>

### OXYGEN

<table>
<thead>
<tr>
<th>Patient / Caregiver will:</th>
<th>OXY01</th>
<th>Demonstrate improved oxygen exchange</th>
<th>OXY02</th>
<th>Demonstrate safe and appropriate use of oxygen</th>
</tr>
</thead>
</table>

### PARENTERAL / ENTERAL NUTRITION

<table>
<thead>
<tr>
<th>Patient / Caregiver will:</th>
<th>NUTR01</th>
<th>Receive parenteral nutrition as ordered without complications</th>
<th>NUTR04</th>
<th>Receive enteral nutrition as ordered without complications</th>
</tr>
</thead>
<tbody>
<tr>
<td>NUTR05</td>
<td>Demonstrate knowledge and skills to administer TPN and related care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NUTR06</td>
<td>Demonstrate daily compliance with nutritional therapy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NUTR07</td>
<td>Achieve adequate nutrition and hydration</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### RESPIRATORY

<table>
<thead>
<tr>
<th>Patient / Caregiver will:</th>
<th>RESP01</th>
<th>Show improved respiratory function</th>
<th>RESP04</th>
<th>Demonstrate intervention techniques for respiratory distress</th>
</tr>
</thead>
<tbody>
<tr>
<td>RESP02</td>
<td>Modify lifestyle to achieve optimal level of respiratory functioning</td>
<td>RESP05</td>
<td>Control respiratory environment, practice breathing exercises, and adhere to therapeutic regimen</td>
<td></td>
</tr>
<tr>
<td>RESP03</td>
<td>Demonstrate decreased respiratory complications</td>
<td>RESP06</td>
<td>Perform respiratory therapy as ordered</td>
<td></td>
</tr>
</tbody>
</table>

### INFECTION CONTROL

<table>
<thead>
<tr>
<th>Patient / Caregiver will:</th>
<th>INF01</th>
<th>Demonstrates infection control measures</th>
<th>INF02</th>
<th>Describes how to maintain immune response</th>
</tr>
</thead>
<tbody>
<tr>
<td>INF03</td>
<td>Takes measures to protect self and others from disease</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## WOUND / INTEGUMENTARY

<table>
<thead>
<tr>
<th>Patient / Caregiver will:</th>
<th>WND05</th>
<th>Patient / Caregiver will:</th>
<th>WND06</th>
</tr>
</thead>
<tbody>
<tr>
<td>WND01</td>
<td>Demonstrate care and dressing of wound.</td>
<td>Demonstrate improved nutrition.</td>
<td></td>
</tr>
<tr>
<td>WND02</td>
<td>Implement measures to promote healing of wound.</td>
<td>Identify signs and symptoms of infection and interventions.</td>
<td></td>
</tr>
<tr>
<td>WND03</td>
<td>Implement measures to promote healing of decubitus.</td>
<td>Wound healed without incidence of complication by</td>
<td></td>
</tr>
<tr>
<td>WND04</td>
<td>Wound will decrease in size by ___cm by ___</td>
<td>WND09</td>
<td>SNV decrease to less than ___ days/week by ___</td>
</tr>
</tbody>
</table>

## BEHAVIORAL HEALTH

<table>
<thead>
<tr>
<th>Patient / Caregiver:</th>
<th>BEH019</th>
<th>Patient / Caregiver:</th>
<th>BEH020</th>
</tr>
</thead>
<tbody>
<tr>
<td>BEH001</td>
<td>Will be accessing community resources by</td>
<td>Verbalizes improved feelings of self-worth and self-esteem by</td>
<td></td>
</tr>
<tr>
<td>BEH002</td>
<td>Demonstrates independence following teaching in:</td>
<td>Verbalizes strengths, assets and accomplishments by</td>
<td></td>
</tr>
<tr>
<td>BEH003</td>
<td>Medication purpose, by ___</td>
<td>Expresses helpfulness and realistic future goals by</td>
<td></td>
</tr>
<tr>
<td>BEH004</td>
<td>Medication schedule, by ___</td>
<td>Maintains abstinence from illicit drug and alcohol use by</td>
<td></td>
</tr>
<tr>
<td>BEH005</td>
<td>Medication side effects, by ___</td>
<td>Demonstrates non-violent or physically aggressive behavior by</td>
<td></td>
</tr>
<tr>
<td>BEH006</td>
<td>Verbalizes emergency/support plan by</td>
<td>Expresses feelings appropriately by</td>
<td></td>
</tr>
<tr>
<td>BEH007</td>
<td>Demonstrates appropriate management of personal hygiene by</td>
<td>Caregiver demonstrates appropriate/consistent parenting by</td>
<td></td>
</tr>
<tr>
<td>BEH008</td>
<td>Accepts and understands care necessary related to disease process by</td>
<td>Demonstrates effective coping skills by</td>
<td></td>
</tr>
<tr>
<td>BEH009</td>
<td>Able to explain disease and describe actions to take during periods of exacerbation</td>
<td>Demonstrates increased insight and judgment</td>
<td></td>
</tr>
<tr>
<td>BEH010</td>
<td>Accepts and understands and participates in behavior modification plan/contracts/techniques by</td>
<td>Identifies stressors that may have negative influence by</td>
<td></td>
</tr>
<tr>
<td>BEH011</td>
<td>Understands discharge plan.</td>
<td>Takes action to reduce stressors by</td>
<td></td>
</tr>
<tr>
<td>BEH012</td>
<td>Demonstrates appropriate:</td>
<td>Demonstrates absence of delusions/hallucinations by</td>
<td></td>
</tr>
<tr>
<td>BEH013</td>
<td>Diet and hydration, by ___</td>
<td>Demonstrates reduced impulsivity by</td>
<td></td>
</tr>
<tr>
<td>BEH014</td>
<td>Sleep/restrict activity, by ___</td>
<td>Expresses logical, goal directed thoughts and ideas by</td>
<td></td>
</tr>
<tr>
<td>BEH015</td>
<td>Bladder/ bowel regimen, by ___</td>
<td>Exhibits socially appropriate behavior by</td>
<td></td>
</tr>
<tr>
<td>BEH016</td>
<td>Functions safely without agency services by</td>
<td>Verbalizes trust in others by</td>
<td></td>
</tr>
<tr>
<td>BEH017</td>
<td>Demonstrates appropriate interpersonal skills by</td>
<td>Exhibits reality-based thinking in verbal and non-verbal behavior by</td>
<td></td>
</tr>
<tr>
<td>BEH018</td>
<td>Demonstrates social interactions by</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Goals / Rehabilitation / Discharge Plans - cont.

| BEH037 | □ Appropriate parent/child interactions/relations are displayed by |
| BEH038 | □ Displays effective problem solving skills by |
| BEH039 | □ Patient distinguishes boundaries between self, others, and environment by |
| BEH040 | □ Effectively employs relaxation techniques by |
| BEH041 | □ Demonstrates an absence of suicidal ideation / gestures by |

PROGNOSIS:  
1  Poor - Little or no recovery is expected and/or further decline is imminent.  
2  Guarded - Minimal improvement in status is expected, decline is possible.  
3  Fair - Partial to full recovery is expected.  
4  Good - Marked improvement in status is expected.  
5  Excellent

Goals Other:  

Rehab Potential:  

Discharge Plans:  

DME Company:  

Equipment Supplied:  
**Patient Name: ________________________________**

**Assessment of Patient's ADL/IADL Abilities**

<table>
<thead>
<tr>
<th>Dates</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
</table>

**Bathing:** Refers to ability to wash his/her entire body. Excludes grooming (washing face and hands only).

<table>
<thead>
<tr>
<th>0 0 0 0</th>
<th>Is able to bathe self independently.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 1 1 1</td>
<td>Is able to bathe self in shower or tub independently with the use of devices such as grab rails, bath bench, hand-held shower, brushes.</td>
</tr>
</tbody>
</table>
| 2 2 2 2 | Is able to bathe in shower or tub with the assistance of another person:
|        | (a.) For intermittent supervision/encouragement/reminders, OR (b.) To get in and out of the shower/tub, OR (c.) For washing difficult to reach areas. |
| 3 3 3 3 | Is able to bathe in shower or tub and participates in bathing self, but requires presence of another person throughout the bath for assistance/supervision. |
| 4 4 4 4 | Is unable to use the shower or tub and is bathed in bed or bedside chair. (The patient may be independent in washing self or may participate in the process with help from another person.) |
| 5 5 5 5 | Is unable to effectively participate in the bathing process and is totally bathed by another person. |

**Dress Upper Body:**

<table>
<thead>
<tr>
<th>0 0 0 0</th>
<th>Patient is able to get clothes on and feed dressed and put them on and remove them from the upper body without assistance. (This includes underwear, pullovers, and front-opening shirts and blouses, as well as managing zippers, buttons, and snaps.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 1 1 1</td>
<td>Some assistance with dressing upper body is required. This can include help putting on a blouse/shirt or sweater, assistance with closures such as buttons, zippers, snaps or hooks, or use of dressing aids such as velcro, closures, button hooks, or zipper pulls.</td>
</tr>
<tr>
<td>2 2 2 2</td>
<td>Patient depends entirely upon another person to dress the upper body.</td>
</tr>
</tbody>
</table>

**Dress Lower Body:**

<table>
<thead>
<tr>
<th>0 0 0 0</th>
<th>Patient is able to get clothing on and feed dressed and put them on and remove them from the lower body.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 1 1 1</td>
<td>Patient is able to get clothing on and feed dressed and put them on and remove them from the lower body.</td>
</tr>
<tr>
<td>2 2 2 2</td>
<td>Someone must help the patient get on clothing.</td>
</tr>
<tr>
<td>3 3 3 3</td>
<td>Patient depends entirely upon another person to dress the lower body.</td>
</tr>
</tbody>
</table>

**Toileting:** Refers to ability to get to and from the toilet or bedside commode. Excludes elimination problems associated with catheters, incontinence, constipation.

<table>
<thead>
<tr>
<th>0 0 0 0</th>
<th>Is able to get to and from the toilet independently with or without a device (wheelchair, walker, cane, crutch).</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 1 1 1</td>
<td>Is able to get to and from the toilet only when reminded, assisted, or supervised by another person.</td>
</tr>
<tr>
<td>2 2 2 2</td>
<td>Is unable to get to and from the toilet but is able to use a bedside commode with or without assistance.</td>
</tr>
<tr>
<td>3 3 3 3</td>
<td>Is unable to get to and from the toilet or bedside commode but is able to use a bedside commode independently.</td>
</tr>
<tr>
<td>4 4 4 4</td>
<td>Is totally dependent in toileting.</td>
</tr>
</tbody>
</table>
Transferring: Refers to ability to move from bed to chair, on and off toilet or commode, onto and out of tub/shower, and turn and position self in bed if patient is bedfast.

1 2 3 4
0 0 0 0 Is able to transfer independently
1 1 1 1 Is able to transfer with minimal human assistance or with use of device (e.g., grab bars, sturdy furniture, slide board).
2 2 2 2 Is unable to transfer self but is able to bear weight and pivot during the transfer process.
3 3 3 3 Is unable to transfer self and is unable to bear weight or participate when transferred by another person (includes use of the Hoyer lift to transfer).
4 4 4 4 Bedfast, unable to transfer but is able to turn and position self in bed.
5 5 5 5 Bedfast, unable to transfer and is unable to turn and position self.

Ambulation/Locomotion: Refers to ability to safely ambulate in a variety of settings.

0 0 0 0 Is able to independently (i.e., without human assistance) walk on even and uneven surfaces without the use of a device (e.g., walker, cane) and climb stairs with or without railings.
1 1 1 1 Is able to walk alone only when using a device (e.g., negotiate stairs/steps or uneven surfaces).
2 2 2 2 Is able to walk only with the supervision/assistance of another person at all times.
3 3 3 3 Chairfast, unable to ambulate even with assistance but is able to wheel self independently.
4 4 4 4 Chairfast, unable to ambulate even with assistance and is unable to wheel self.
5 5 5 5 Bedfast, unable to ambulate or be up in a chair.

Grooming: Refers to ability to tend to personal hygiene needs.

0 0 0 0 Is able to comb and brush hair, shave or apply make-up, clean teeth or dentures, and manage routine fingernail care unaided, with or without the use of assistive devices or adapted (handled combs or brushes, suction brushes for cleaning nails or dentures, adapted shaving equipment or adapted key for rolling toothpaste tubes.)
1 1 1 1 Someone must place grooming utensils within reach before patient is able to complete grooming activities.
2 2 2 2 Someone must help the patient comb and brush hair, shave or apply make-up, clean teeth or dentures, or trim fingernails.
3 3 3 3 Patient depends upon someone else entirely for grooming needs.

Housekeeping: Refers to the patient's safe and effective performance of routine cleaning in the home, including light tasks (e.g., dusting, wiping kitchen counters) and heavier tasks (e.g., vacuuming, cleaning bathrooms).

1 2 3 4
0 0 0 0 Performs all housekeeping tasks independently or is physically, cognitively, and mentally able to perform all housekeeping tasks but has not routinely participated in housekeeping tasks in the past (i.e., prior to home care admission).
1 1 1 1 Is able to perform only light housekeeping (e.g., dusting, wiping kitchen counters) tasks independently.
2 2 2 2 Is able to perform housekeeping tasks with intermittent assistance/supervision from another person.
3 3 3 3 Is unable to consistently perform any housekeeping tasks unless assisted by another person throughout the process.
4 4 4 4 Is unable to effectively participate in any housekeeping tasks.

Ability to Use Telephone: Refers to ability to answer the phone, dial numbers, and effectively use the telephone to communicate. Excludes mobility problems which interfere with getting to and from the phone.

0 0 0 0 Is able to dial numbers and answer calls appropriately and as desired.
1 1 1 1 Is able to use a specially adapted telephone (i.e., large numbers on the dial, teletype phone for the deaf) and call essential numbers.
2 2 2 2 Is able to answer the telephone and carry on a normal conversation but has difficulty with placing calls.
3 3 3 3 Is able to answer the telephone only some of the time or is able to carry on only a limited conversation.
4 4 4 4 Is unable to answer the telephone at all but can listen if assisted with equipment.
5 5 5 5 Is totally unable to use the telephone.
6 6 6 6 Patient does not have a telephone.

Preparing Light Meals: Refers to the patient's ability to plan/prepare light meals (e.g., cereal, sandwich) or reheat delivered meals.

0 0 0 0 Plans and prepares all light meals for self/receives delivered meals or is physically, cognitively, and mentally able to prepare light meals on a regular basis but has not routinely done this in the past (i.e., prior to this home care admission).
1 1 1 1 Is unable to prepare light meals on a regular basis due to physical, cognitive, or mental limitations.
2 2 2 2 Is unable to prepare light meals or to reheat any delivered meals.
Laundry: Refers to ability to do own laundry - to carry to and from washing machine, to use washer and dryer, to wash small items by hand.

1.  Takes care of all laundry tasks; can access laundry facilities and perform all as physically, cognitively, and mentally able to do laundry and access facilities, but has not routinely performed laundry tasks in the past (i.e., prior to this home care admission).

2.  Is able to do only light laundry, such as minor hand wash or light washer loads. Due to physical, cognitive, and/or mental limitations, and/or off-site location of laundry facilities, needs assistance with heavy laundry such as accessing laundry facilities, carrying large loads of laundry.

3.  Is unable to do any laundry due to physical limitation or needs continual supervision and assistance with laundry due to cognitive and/or mental limitation.

Management of Oral Medications: Refers to the patient's ability to prepare and take all prescribed oral medications reliably and safety. Includes administration of all correct doses at the appropriate times/intervals. Excludes injectable and IV medications. (NOTE: This refers to ability, not compliance or willingness.)

1.  Is able to take the correct oral medication(s) and proper dosage(s) at the correct times independently.

2.  Is able to manage daily buying needs, but needs help managing checkbook, paying bills.

3.  Is unable to manage money.

Caregivers: Refers to ability, willingness, and availability of caregivers to safely and effectively care for patient.

1.  Caregivers are able, willing and available to provide supportive care to patient.

2.  Caregiver is willing or physically able but needs extensive instruction due to mental limitations to provide care.

3.  Caregiver is unable to safely and effectively provide care.
Appendix B

*Barthel Index*
Exhibit 3.2 The Barthel Index

Note: A score of zero is given where patients cannot meet the defined criterion.

<table>
<thead>
<tr>
<th>Activity</th>
<th>With help</th>
<th>Independent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Feeding (if food needs to be cut up = help)</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>2. Moving from wheelchair to bed and return (includes sitting up in bed)</td>
<td>5-10</td>
<td>15</td>
</tr>
<tr>
<td>3. Personal toilet (wash face, comb hair, shave, clean teeth)</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>4. Getting on and off toilet (handling clothes, wipe, flush)</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>5. Bathing self</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>6. Walking on level surface (or if unable to walk, propel wheelchair)</td>
<td>10</td>
<td>15</td>
</tr>
<tr>
<td>*score only if unable to walk</td>
<td>0*</td>
<td>5*</td>
</tr>
<tr>
<td>7. Ascend and descend stairs</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>8. Dressing (includes tying shoes, fastening fasteners)</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>9. Controlling bowels</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>10. Controlling bladder</td>
<td>5</td>
<td>10</td>
</tr>
</tbody>
</table>

Exhibit 3.3 Instructions for Scoring the Barthel Index

Note: A score of zero is given when the patient cannot meet the defined criterion.

1. Feeding
   10 = Independent. The patient can feed himself a meal from a tray or table when someone puts the food within his reach. He must use an assistive device if this is needed, cut up the food, use salt and pepper, spread butter, etc. He must accomplish this in a reasonable time.
   5 = Some help is necessary (when cutting up food, etc., as listed above).
   1 = Patient needs help because of imbalance or in handling clothes.

2. Moving from wheelchair to bed and return
   10 = Independent in all phases of this activity. Patient can safely approach the bed, lie down, come to a sitting position on the side of the bed, change the position of the wheelchair, if necessary, to transfer back into it safely, and return to the wheelchair.
   5 = Patient needs help because of imbalance or in handling clothes.

3. Doing personal toilet
   5 = Patient can wash hands and face, comb hair, clean teeth, and shave. He may use any kind of razor but must put it in the drawer or cabinet. Female patients must put on own make-up, if used, but need not braid or style hair.

4. Getting on and off toilet
   10 = Patient is able to get on and off toilet, fasten and unfasten clothes, prevent soiling of clothes, and use toilet paper without help. He may use a wall bar or other object of support if needed. If it is necessary to use a bed pan instead of a toilet, he must be able to place it on a chair, empty it, and clean it.
   5 = Patient needs help because of imbalance or in handling clothes or in using toilet paper.
Bathing self

5 = Patient may use a bathtub, a shower, or take a complete sponge bath. He must be able to do all the steps involved in whichever method is employed without another person being present.

Walking on a level surface

15 = Patient can walk at least 50 yards without help or supervision. He may wear braces or prostheses and use crutches, canes, or a walkerette but not a rolling walker. He must be able to lock and unlock braces if used, assume the standing position and sit down, get the necessary mechanical aids into position for use, and dispose of them when he sits. (Putting on and taking off braces is scored under dressing.)

10 = Patient needs help or supervision in any of the above but can walk at least 50 yards with a little help.

Propelling a wheelchair

5 = If a patient cannot ambulate but can propel a wheelchair independently. He must be able to go around corners, turn around, maneuver the chair to a table, bed, toilet, etc. He must be able to push a chair at least 50 yards. Do not score this item if the patient gets score for walking.

Ascending and descending stairs

10 = Patient is able to go up and down a flight of stairs safely without help or supervision. He may and should use handrails, canes, or crutches when needed. He must be able to carry canes or crutches as he ascends or descends stairs.

5 = Patient needs help with or supervision of any one of the above items.

Dressing and undressing

10 = Patient is able to put on and remove all clothing, and tie shoe laces (unless it is necessary to use adaptations for this). The activity includes putting on and removing and fastening corset or braces when these are prescribed. Special clothing as suspenders, loose shoes, dresses that open down the front may be used when necessary.

5 = Patient needs help in putting on or removing any clothing. He must do at least half the work himself. He must accomplish this in a reasonable time.

Women need not be scored on use of a brassiere or girdle unless these are prescribed garments.

Continence of bowels

10 = Patient is able to control his bowels and have no accidents. He can use a suppository or take an enema when necessary (as for spinal cord injury patients who have had bowel training).

5 = Patient needs help in using a suppository or taking an enema or has occasional accidents.

Controlling bladder

2 = Patient is able to control his bladder day and night. Spinal cord injury patients who wear an external device and leg bag must put them on independently, clean and empty bag, and stay dry day and night.

3 = Patient has occasional accidents or cannot wait for the bed pan or get to the toilet in time or needs help with an external device.

Appendix C

Discharge and Transfer Summary
TRANSFER DISCHARGE SUMMARY

Patient Name: M.R. # Start of Care:____________________

Date of Last Visit: ___________________ Transfer Date: ___________________ Discharge Date: ___________________

Services: □ SN □ PT □ SLP □ OT □ SW □ Aide □ Other ________________________

Primary Diagnosis at D/C: ________________________

Summary of Progress, Goals Achieved, Care Provided, Patient Response: ________________________

Vital Signs Last Visit: (T) ______ (R) ______ (P) ______ (R/P) ______ Allergies: ________________________

Diet/Fluid: ________________________ Skin Integrity: ________________________

Mental Status: □ Alert □ Cooperative □ Confused ________________________

Activity Level: □ Ambulates independently □ Out of bed with assistance □ Homebound
□ Ambulates with assistance □ Bedridden □ Other ________________________

Adaptation Equipment: □ Cane □ Walker □ Wheelchair □ Hospital Bed □ Oxygen □ Bedside Commode
□ Other ________________________

Advance Directives/DNR: □ Yes □ No □ Type: ________________________

Reason For Discharge/Transfer:
□ AO - Attained Goals □ BC - Transferred to BCP □ EX - Expired
□ HO - Hospitalized □ HP - Transferred to Hospice □ LT - Transferred to LTCP
□ NS - Not housebound □ NC - Non-compliant with POC □ NH - Not housebound
□ OA - Transferred to other agency □ OF - Transferred to other facility □ OS - Transferred to Outpt Care
□ PO - Physician's Order □ PR - Patient Request □ RF - Transferred to Rehab Facility
□ SS - Stalled care not Required □ TB - Threatening Behavior □ UH - Unsafe/Inapp. Home Envr.
□ VE - Visits Exhausted

Transfer/Discharge Health Care Provisions/Instructions Provided to:
□ Patient/Self-Care □ Nursing Home ________________________
□ Relative/Caregiver □ Hospital ________________________

Transfer/Discharge Instructions Provided: ________________________

Follow-up Health Care: PL/Family notified □ Yes □ No □ N/A
Appointment: ________________________ Receiving Agency notified □ Yes □ No □ N/A

Dr. ________________________ Notified: □ Yes □ No □ Ordered □ Transfer □ D/C ________ Date ________ Copy Sent 

Please call Family Home Health Care, Inc. for home health services at: ________________________

Signature: ________________________ Title: ________________________ Date: ________________________
Appendix D

HSRB Approval
January 21, 1997

Linda Sewell
C/o Dr. Kay Carr
Department of Nursing
Western Kentucky University

Dear Ms. Sewell:

Your research topic "Indicators of Resource Utilization by Home Health Patients in Rural Southern Kentucky," has undergone review by the Western Kentucky University IRB for human subjects of research and it has been determined that risks to subjects are: (1) minimized and reasonable; and that (2) research procedures are consistent with a sound research design and do not expose the subjects to unnecessary risk. Reviewers determined that: (1) benefits to subjects are considered along with the importance of the topic and that outcomes are reasonable; (2) selection of subjects is equitable; and (3) the purposes of the research and the research setting is amenable to subjects' welfare and producing desired outcomes; that indications of coercion or prejudice are absent, and that participation is clearly voluntary.

In addition, the IRB found that: (1) informed consent will be sought and documented from each prospective subject; (2) provision is made for collecting, using and storing data in a manner that protects the safety and privacy of the subjects and the confidentiality of the data; and (3) that appropriate safeguards are included to protect the rights and welfare of the subjects. Please store all data securely at an on campus location for a minimum of three years.

Your research therefore meets the criteria of Expedited review under the institutional human subjects protocol and is approved. Copies of your request for human subjects review, your application, and this approval, are maintained in the Office Sponsored Programs at the above address.

Kindest regards.

Sincerely,

Phillip Myers, Ph.D.
Director, Office of Sponsored Programs and Human Subjects Coordinator

c: Human Subjects File

HSApprovalLSewell
January 24, 1997

Ms. Linda F. Sewell
7201 Judio Road
Cattle, Kentucky 42752

Dear Linda:

Please be advised that the Governing Board has reviewed your research proposal to study characteristics and resource utilization of patients in Cumberland county.

I am happy to report that the Board has approved your request to access patient medical record information for this research project. Please be advised that the Board is concerned about patient confidentiality and will require that you report to them your destruction of final records after completion of data gathering and finalizing your research report. Also, please be advised that Admission Assessment forms, Clinical Notes, and other agency forms are considered to be proprietary information. They may be used within your research report but may not be reproduced or otherwise distributed without further agency approval.

Best wishes in your research endeavor.

Sincerely,

Administrator