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A Business Plan for a Case Management and Home Health Agency

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An Abstract Presented to the Faculty of the Graduate School of Lindenwood University in Partial Fulfillment of the Requirements for the Degree of Master of Science in Health Management

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ABSTRACT

This thesis will focus on the changes in health care delivery in the United States and how case management and home health care agencies have impacted upon it. The quality and cost-effectiveness of case management and home health care delivery will also be explored.

As we approach the twenty-first century, the focus of health care delivery is changing rapidly. The health care delivery system has undergone major changes and has had a tremendous impact on the development of case management and home health care agencies. These changes are affecting, and will affect health care consumers and the delivery of home care services. In general, research attributes those changes as including: the evolution of rapidly advancing technology, scientific breakthroughs, the implementation of governmentally-imposed policies, changes in the economy, and altered lifestyles of health care consumers. In addition, research has indicated that there is

a significant rise in the costs of health care today. Because of the multitudinous changes within our health care delivery system and the rising costs of health care, enormous interest has been created. Health care professionals, the federal government, insurance companies, and consumers are primarily interested in the establishment of comprehensive programs and methods designed to facilitate the improved delivery of cost-effective health care. The quest for finding solutions to the delivery of quality health care while simultaneously containing cost has also extended to Wall Street investors, independent providers, and health care consumers. Similarly, health care consumers are searching for new alternatives for regaining, restoring and maintaining health, or minimizing the effects of illness.

Based upon research and consumer health needs, the necessity becomes evident of: developing a structural and educational framework for establishing a case management and home health care agency; designing programs to target special health problems and high risk populations; discussing the

elements of program or service expenses which can be considered; illustration of the magnitude of cost savings which can be achieved; provision of an ongoing system for monitoring the economic and quality impacts of a case management and home health care agency; and, the offering of a methodology for reproducing the cost savings data in other case management and home care settings.

The purpose of this study is to develop a business plan for a case management and home health care agency positioned within a large city in a metropolitan area. It is anticipated that the business plan will illustrate the requirements for operating a case management and home health care agency while epitomizing quality, cost-effective health care services. Journal articles and published studies were the primary source of secondary data. Guidelines from the United States Small Business Administration and Missouri Department of Home Health Licensing and Certification requirements were utilized.

It is hoped that those who utilize the case management and

home health care agency will benefit from its services.

A BUSINESS PLAN FOR A CASE MANAGEMENT AND HOME HEALTH AGENCY

Zeporah A. Dunbar, R.N., B.S.N.

A Culminating Project Presented to the Faculty of the Graduate School of Lindenwood University in Partial Fulfillment of the Requirements for the Degree of Master of Science in Health Management

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DEDICATION

To my dear son, Donald J. Dunbar who has continuously given me an abundance of love and support throughout my research project. Donald, this thesis is dedicated to you, in hopes and prayers that it will serve as an inspiration for achieving your future goals. May the windows of Heaven pour you out continuous blessings. I love you, son. Thanking you throughout eternity for believing in me, I am,

Very truly yours,

Mommy

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Preface

As we enter into the next millennium, the focus of health care delivery in the United States is changing. Likewise, the manner in which care is delivered is changing. Health care is a vital service that will be utilized during ones' lifetime to prevent disease, maintain health, and/or minimize the effects of illness. The changes in the delivery of this vital service have become more apparent within the past decade. There have been dramatic shifts in health care delivery. Today, the focus is on maintaining wellness for the community at large. Similarly, the changes in the focus of the health care delivery system are receiving a large amount of deliberation. Many contend that changes in the health care delivery system are creating unstable conditions. Research also indicates that the cost of health care is rising significantly. The United States economic changes have had a colossal effect within the health care delivery system, particularly in terms of accessibility and affordability of health

care. In response to the economic changes, the federal government is attempting to implement health care reforms which can be used as an economic device to improve and deliver high quality health care services. Additionally, individuals are searching for solutions to the unstable conditions which have resulted from changes in the health care delivery system. Health care consumers are currently demanding improved health care delivery; and, many health care professionals are searching for methods designed to facilitate the improved delivery of quality, cost-effective health care services.

Simply put, the health care delivery system in the United States has reached a new era. Numerous transformations are occurring within the health care delivery system. According to Greenlick:

> "The focus of the health care system will be on preventing disease and maintaining function. The success of the system will be measured by how cost-effective it is and how well it works to maintain the mental, social, and physical functions of its participants" (181).

Numerous health care institutions in the United States are responding to the changes in the focus of the health care delivery system by establishing comprehensive case management and home health care services.

Case management is a dynamic and collaborative process. Many contend that case management and home health services offer a viable solution to quality, accessible, and cost-effective health care, particularly during this new era of health care delivery.

Following a recount of the evolution of the health care delivery system, home health and case management services and the effects of economic changes relative to health care will be explored.

One agency located in the Midwest has responded to the need for providing quality, accessible, and cost-effective health care services by establishing a Case Management and Home Health Care Agency for the clients it serves. An in-depth explanation of the success and cost-effectiveness of case

management home health programs will be explored in Chapter III.

Chapter I

INTRODUCTION

The United States' health care delivery system is continuously evolving. The continuous evolution is attributed to several factors including: steadily increasing health care costs; inaccessibility to quality health care; advancing medical technology; scientific breakthroughs; changes in the economy; governmentally-imposed healthcare reforms; and altered lifestyles of healthcare consumers. Another prevalent factor is that thirty seven million Americans are uninsured and many millions more are underinsured (DePorter 24).

The aforementioned factors have caused the health care industry to receive increased recognition from policy makers, those responsible for the financing and delivery of health care, and health care consumers. Moreover, in recent years health care, particularly its medical or curative aspect has captured the interest of the public, political leaders, and a more attentive media as never before (Sultz and Young 2).

Currently, when one listens to news programs on the television and

radio, reads the newspaper, or review major magazines, the topic of escalating health care costs is recognized. It is undoubtedly apparent that a cost-efficient method for delivering quality health care must be established. Additionally, the demand for quality health care at affordable prices is rapidly increasing. Health care consumers have been, and are presently requesting highly sophisticated and advanced technological healthcare systems which treat patients as customers at significantly lower costs. Health care consumers are also demanding greater access to quality health care. Likewise, the federal government is requesting a healthcare system that can deliver a higher quality of health care with a decreased revenue plan. The federal government is attempting to maintain some balance among cost, quality, and access, with the primary goal focusing on cost containment.

At present there is increasing recognition that health care is a growing business that consumes greater than 14 percent of the United States' gross domestic product and is soon expected to exceed over $1 trillion in spiraling costs (Sultz and Young 2). In many respects the health care delivery system has done an excellent job. There has been

significant progress in medical science and technology that is often attributed to measurable improvements in the quality of life. The paradox however, is that as our technology continues to improve and become more expensive, many more people are being deprived of its benefits (Sultz and Young 19). Research indicates that a large number of community-based hospitals, health care providers, and investors are recognizing this disparity by redesigning the current health care delivery system in order to improve quality, access, and the cost of health. Nevertheless, "the community hospital with its independent physicians, cost-based reimbursement, and voluntary board is dead. It lived about 100 years, evolving steadily with changes in technology, national wealth, and politics, but it will not dominate the 21st century" (Griffith 82). These changes are affecting, and will continue to affect health care consumers and the delivery of case management home health services.

In essence, the focus of health care delivery in the United States has changed tremendously. There has been "paradigm shifts from institutional care to home care. The primary focus of care has moved

from the institutional setting to a continuum of care in the community" (Quinn 233). Similarly, the focus has moved from a specialty care focus to a primary care base: "from treating illness to maintaining wellness; from caring for individuals to improving health status for populations" (Quinn 233). Some individuals consider this shift/change in the focus of our health care delivery system as creating unstable conditions, even to the point of turmoil. As Quinn states, "These dramatic shifts have resulted in a very unstable acute care medical system in which home and community-based care and case management will achieve new emphasis, importance and use" (234).

Today, health care consumers look to doctors, nurse practitioners, hospitals, case management and home health agencies, and extended care facilities to meet health care needs. Moreover, case management and home health care agencies are becoming increasingly popular with health care consumers in general, as people are taking a greater interest in their health and control of it. The aging population is also becoming more knowledgeable and aware of health care delivery options available to them. Fitness centers, health stores, and self-care

books have saturated the market, and are more popular than ever. Likewise, health care consumers have become more involved in preventive health, wellness and health maintenance programs. Literature suggests that health care consumers are seeking new alternatives for regaining or maintaining their health and minimizing the effects of illnesses. Case management and home health care services facilitate the delivery of quality, cost-effective health care; and appears to have emerged as a viable solution for many people.

In order to comprehend the complexity of the United States' health care delivery system and understand the evolution of case management and home health care, one must have a broad understanding of historical data over the past century. In addition, one must be cognizant of the unique interplay of advancing technology, research findings, financing, health care legislation, professional behaviors, and consumer values that drive what, how, why, where, and at what costs, quality health care is delivered in the United States.

Much of the mystique about the evolution of the United States' health care delivery system was fostered by its early practices. From

its earliest history, the focus of health care delivery, or more accurately medical care, had been centered around diseases in patients and the location of health care services. In essence, the health care delivery system had been fragmented. There are more than 6,300 hospitals in the United States operated by organizations ranging from federal agencies such as the Veterans Administration, to universities, churches, non-profit groups, for-profit managed care companies, and local community and municipal groups (Zweig White & Associates, Inc. 1). Although fragmented, the evolution of the health care delivery system can be traced to home health care and early American hospitals. Simply stated, home and community-based care is not a new phenomenon. "When England enacted its first formal social legislation in 1601, it contained home health provisions" (Quinn 235). In regard to case management's' relationship to home health, "case management has long been a part of community and home-based nursing care" (Quinn 235). Health care for childbirth, the sick, and the injured was either provided in the home or what is known today as hospitals. Moreover, before modern health care in the United States became so

technologically advanced, people began and ended their life at home, from childbirth to death. Healthcare from the late 1800's through the 1930's was relatively modest. Family, friends and physicians provided care for the sick, infirm, and injured in their homes. In the mid 1900's, most people continued to receive health care at home, and physicians were rendering medical care and services by making house calls. In the 19th and early 20th centuries, generally what occurred between physicians and patients in terms of diagnosis, treatment, and payment for services was treated as confidential between the patient and physician. Medical practice at best was considerably simple, and typically involved long-term relationships with patients. The medical practice also frequently involved long-standing relationships with several generations of the patient's family (Sultz and Young 27).

Individual physicians had complete autonomy over where, when, what, and how they delivered medical care, just as the physicians preferred. Physicians usually adjusted their fees according to their estimates of the patients' ability to pay for services, and generally collected their own fees. "That in essence, was the intimate physician-

patient relationship that the profession held sacred" (Sultz and Young 27). Patients also valued the medical opinions and services provided by their physicians.

Hospitals in early America served altogether disparate purposes from those of today. Likewise, relationships between patients and hospital personnel were ostensibly strained in the yesteryears of health care delivery. "The often strained relationship between patients and hospital personnel such as doctors, nurses, aides, technicians, and therapist dates back to the earliest history of health care in the United States" (Sultz and Young 50). Research indicates that the "indifference to patients' needs for information, comfort, and humane contact that is today a common complaint about hospital care is rooted not only in the history of medical care, but especially in the history of hospitals" (Sultz and Young 50).

In 1660 the first almshouse (home for the care of the poor) was established in Massachusetts. The almshouses were frequently called county poor farms, and were typically used for the aged poor. The almshouses were established as a result of the "Old Poor Law". "Poor

law is a term formerly used in Great Britain and in the United States for laws concerning assistance to the poor" (Downey, et. al P-477). Two forms of relief developed from the "Old Poor Law". The two forms of relief are as follows: "outdoor relief", or "home relief", to the poor in their homes, and "indoor relief" to individuals in almshouses. In the early American colonies, relief was also administered locally - by townships, counties or cities. Local administration of relief was the impelling force associated with various forms of patient abuses (Downey, et. al P-477) - a more detailed discussion in the pages to follow.

It was not until the 18th century that hospitals were created; they existed primarily for indigent or dying people. Similarly, hospitals And, hospitals were founded to "shelter the aged, dying, orphans, and vagrants, and to protect the inhabitants of a community from the contagious sick and dangerously insane" (Sultz and Young 50). The hospitals were funded by churches or volunteer organizations. Fees for the health care services rendered were obtained from those patients who could afford to pay their bills or from wealthy humanitarians

(Anderson 14). Howbeit, medical care during the 18th century was generally provided in the home. It was necessary however, in towns such as Boston, the largest city in the new democracy and other seaport towns to provide refuge for sailors and other shipboard individuals who were infected with contagious diseases. As a result of their contagious disease, sailors and other shipboard individuals were frequently "unceremoniously" left ashore when the ships set sail. Many towns "responded by organizing pesthouses, quarantine stations, or isolation hospitals to segregate the sick from the town inhabitants and prevent the spread of disease. Because these facilities were not intended to be used by local citizenry, they were located well outside the city limits" (Sultz and Young 50). Although the towns attempted to prevent the spread of disease, the hospitals were thought of as pesthouses and it was a common feeling that when you went in on two feet, you came out in a casket (Spiegel 1).

As populations increased, mental illness was seen as an additional problem to many of the townspeople. If ones behavior frightened the townspeople or became repugnant, they were referred to the town

townspeople or became repugnant, they were referred to the town board. It was a common practice during the 18th century for the town board to order the mentally ill person's relative or friends to construct a small stronghouse or cell on their property to harbor the mentally ill (Sultz and Young 50). However, if the mentally ill person had neither relatives nor friends, it was not uncommon for the town to lease him or her at a town auction to the person with the lowest bid. The bidder, or owner of the mentally ill person became responsible for confining the mentally ill individual for one year, normally in exchange for labor (Sultz and Young 50).

The pesthouses and isolation hospitals also provided the town with what appeared to be a perfect solution for dealing with other persons whose presence was a potential risk, or an offense to its denizens. Over a period of time, persons with mental illness, the homeless, the infirm, and petty criminals were all joined with the contagiously ill who occupied the pesthouses and isolation hospitals (Sultz and Young 50).

Throughout the 18th century, pesthouses continued to be established for the sick and the indigent. Bellevue Hospital was

originally the Poor House of New York City, and was established in 1736 to house the "poor, aged, insane, and disreputable" (Sultz and Young 50). The Public Hospital of Baltimore was established for the poor sick, insane, and seafaring of Maryland in 1789. "One hundred years later, in 1889, it became the now prestigious Johns Hopkins Hospital" (Sultz and Young 51).

Soon, nearly every city in America had established a pesthouse for isolating patients during disease outbreaks or epidemics. In 1835, Eloise Hospital in Wayne County, Michigan was created to provide care to the blind, old, young deaf, dumb insane, and destitute. Eloise Hospital increased in size to 6,000 beds for the purpose of rendering care for acute and chronic illness, mental diseases, and domiciliary services for the indigent (Sultz and Young 51). Similar examples of Eloise Hospital included the following hospitals: The Kings County Hospital in Brooklyn, Philadelphia General Hospital and Cleveland City Hospital. Despite the growth in hospitals, most of the hospitals in America during the 18th and early 19th centuries were viewed as disgraceful, and "the antithesis of what their patients needed.

They were dirty, unventilated, and contaminated with infections. They were overcrowded and offered little or no medical care. The only nurses available were former inmates or women who could get no other work" (Sultz and Young 51). Subsequently, the previously mentioned conditions further accelerated the spread of disease. In addition, visitation was restricted which alienated patients from the outside world.

Religious nursing groups played a significant role in the evolution of hospital care for the sick, infirm, and poor. "Catholic religious orders were the first groups responsible for kind and humane nursing performed by fairly well educated, sincere, and devoted disciples" (Sultz and Young 51).

Religious nursing groups brought about a new era in the evolution of the health care delivery system. In 1809, Mother Elizabeth Seton founded the American branch of St. Vincent de Paul Sisters of Charity, which established hospitals that still stand in major cities across the United States (Sultz and Young 51). In 1850, the Protestant nursing movement was brought to Pennsylvania from Germany and was based

on formal training in three major areas from nurse teachers, also called deaconesses. The areas included: religion, nursing, and nursing education (51).

Additionally, the civil war of the 1860s brought about a positive appreciation of the work of women in the nursing field. When sick or injured soldiers returned to their hometowns, they received health care treatment from devoted and capable nurses. For many, it was the first time that the soldier's family and relatives had experienced receiving health care from women outside of the home. The image of nursing became increasingly positive, and came to be viewed as a favorable career option.

The early American concept of charity and public responsibility requiring that provisions be made for the sick, poor, vagrants, mentally ill and criminals primarily dominated the 18th and 19th centuries. Two major influences in the early 1900s changed the way hospitals were viewed. The influences included the following: (1) antisepsis was discovered as an effective method to kill germs and could be used during surgery and, (2) the use of x-ray equipment led to more accurate

diagnoses. Both of these events helped to change the image of charity hospitals and assisted in the trend to deliver health care to patients in the hospital setting (Baulch 18). It was during this era that hospitals began to grow in numbers and size. In addition, changes in perspective occurred by which hospitals became a place not of dying but one of healing (Baulch 18). Later, physicians realized the efficacy of isolating the sick from the rest of the needy and putting them in facilities that were more properly called hospitals (Sultz and Young 52). Physicians were able to obtain citizen funding and founded the following charitable hospitals: Pennsylvania Hospital in Philadelphia; the New York Hospital in New York City; and, the Massachusetts General Hospital in Boston. Their motives, however, were not entirely in the sole interest of patients. "They wanted a place to practice surgery and obstetrics, to obtain patients to serve for the instruction of medical students, and to protect the sick from the insane" (Sultz and Young 52).

After 1860 nearly every state had set up a board of charity, or department of social welfare to supervise the local authorities who

were providing relief. "Such laws laid down standards to be followed. Special institutions were founded for the mentally ill, poor and neglected children, the sick, the mentally retarded, and the epileptic" (Downey, et. al. P-477).

Even though this system established standards for health care delivery to the poor and sick, this system of local relief was found to be inadequate during the Great Depression of the 1930s. The Great Depression caused concern over income security. Oftentimes, paying health care expenses could be financially ravaging to a family. The federal government intervened by stepping in with direct financial relief and with work relief, in which individuals were paid to work on public projects (Downey, et. al. P-477). Other government interventions included President Theodore Roosevelt's appointment of the Committee on Economic Security in 1934 to investigate income security and regulate legislation (Anderson 112).

One particular issue being examined during this period was the "problem of personal health services" (Anderson 112). During this time, a Medical Advisory Committee was established to explore health

insurance. Anderson asserts:

> The investigation of policy problems regarding health insurance did not get far. Witte reported Roosevelt was not interested in health insurance at that time, being more concerned with income transfer programs such as unemployment and old age pensions. Further, the members of the section on insurance gave health insurance a low priority. Public health measures dealing with maternal and child health programs, aid to the blind and to crippled children were given high priority. (113)

> ...Witte reported that the mention of health insurance in the Social Security Bill was meant only as a recommendation that the problem be studied. No legislation was proposed. Health insurance received only brief mention in the report on the Committee on Economic Security. (113)

The implementation of a universal health insurance plan is a subject of much debate at all levels of government in the United States, and continues to be a significant concern for all.

Following the establishment of the Medical Advisory Committee to explore health insurance, the government then set up a national system for the care of the poor and needy under the social welfare provisions

of the Social Security Act of 1935 and later amendments. Under these provisions, aid is given to five categories of individuals - the needy aged, dependent children, the blind, the disabled, and impoverished persons in need of medical aid. After the passage of the Social Security Act in 1935, the government also established special programs to assist certain low-income groups who needed health services; albeit, many of the programs were short-lived (Anderson 12). Despite the short life span of the programs, many of today's county or municipal hospitals were originally combinations of almshouses and infirmaries (Sultz and Young 51). Nevertheless, the relief and services provided by early almshouses and infirmaries remained inadequate (51).

People living in the early 20th century came to the realization that ones general health and overall well-being were positively affected by proper hygiene and sanitation practices. "The number of hospitals in the United States increased from 178 in 1873 to 4,300 in 1909. In 1946, at the close of World War II, there were 6,000 American hospitals, with 3.2 beds available for every 1,000 persons" (Sultz and Young 53). Also during that year, "Congress passed the Hill-

Burton Hospital Construction Act to fund expansion of the hospital system to achieve the goal of 4.5 beds per 1,000 persons. The system grew thereafter to reach a high of approximately 7,200 acute care hospitals" (Sultz and Young 53).

The advent of the third party payer was well stimulated by the Great Depression of the 1930's. Anderson asserts: early Blue Cross plans were initiated prior to when compulsory national health insurance legislation was being promoted in Congress (125). The general purpose for establishing the Blue Cross and Blue Shield medical plans was to assist self-pay patients who had little money and hospitals whose income revenues were decreasing significantly. Both plans positively impacted the general public by meeting the need for "some form of insurance to help pay for the unpredictable and occasionally high costs of personal health services" (Anderson 126). According to Anderson:

> In response to the success of Blue Cross, Blue Shield and other private insurance companies, Congress decreed that health insurance (and pensions) were fringe benefits and thus exempt from wartime freeze on wages. (17)

In 1965, Medicare and Medicaid were designed to provide assistance with the reimbursement of health care services for the aged and poor. Both, Medicaid and Medicare are government-oriented programs. Medicare is managed on a federal level and Medicaid operates on both, a federal and state level (Anderson 19).

After the implementation of Blue Cross, Blue Shield, Medicare and Medicaid programs, physicians and hospitals were not regulated in regard to the fees they could charge for health care services. According to Anderson, "the health service enterprise had become accustomed to being paid what it asked" (20). Hospital expenditures were increasing at a rate of 15 percent annually, and physicians' charges were not lagging far behind. In an attempt to control the aforementioned costs, Congress passed a law in 1972 which required utilization review of both hospital care and standards of physicians. Anderson describes Congress' efforts to control cost as follows:

> It was apparently Congress' intent to put a planning apparatus in place before the enactment of some form of national health

> insurance in order to have a handle on cost and to direct the development of personal health services. Certificates of need and rate control, although functions of the states, became part of the health services agencies' decisions and therefore a concern of the federal government, which can withhold payment from hospitals that do not comply. Even so, the current planning apparatus does not seem to have a firm place in national policy and continues to exist on sufferance. (22-23)

Healthcare costs continues to escalate although there is a concentrated effort to contain costs by payers and providers. In 1990 the annual percentage of the Gross National Product (GNP) dedicated to healthcare expenditures was over 12 percent for an estimated $676 Billion and increasing (Source Book 11). Today, a common statistic accepted throughout the media is that 14 percent of the Gross National Product (GNP) in the United States is spent on healthcare. Currently, there are more stringent government-based control mechanisms in place to address the issue of escalating health care costs. (This will be discussed in more detail in Chapter Two). Some feel that the only effort that will be successful in decreasing the percentage of the GNP spent on healthcare is by significantly decreasing the demand for

services (Source Book 11). This is proving to be extremely difficult because of the increasing number of aged in the population and the availability of more advanced technology to these consumers.

When discussing the present state of the health care delivery system in the United States, the author feels it is imperative to recapitulate how the system evolved into its current form. The foundation of healthcare delivery and modern medicine as it is known today can be summed-up as follows: During the 1930's many individuals served in the military service and were seeing physicians for the very first time in their lives. Physicians practiced alone, and their primary function was to treat the sick. During this era, the most common site of health care delivery was in the home and in the physician's office. Greenlick states, " the healthcare system and the practitioners of this era were evaluated on the basis of how "nice" the system or practitioner was " (180).

As previously mentioned, two major advances in modern medicine occurred after World War II causing a major impact on the growth of the health care industry. In the 1930's, the advent of antimicrobial

therapies provided remedies and cures to diseases that were historically looked upon as being untreatable and/or incurable. Since the 1940's there have been numerous technological advances in the field of health care. Diseases that once plagued in epidemic proportions have virtually been eradicated. Progress has been made in multiple radiological procedures allowing health care providers to diagnose and treat illnesses more efficiently and effectively. Advances in surgery have occurred to the point where procedures which formerly required lengthy hospitalizations are now being performed on an outpatient basis. Similarly, the late 1980's to early 1990's brought about a shift to outpatient surgery which has decreased the need for many inpatient beds in hospitals. Even with this shift to less than twenty four hour hospitalizations, the average length of stay has decreased to only approximately six days and the average cost per hospitalization is over $7,000. This merely indicates that patients requiring hospitalizations are more acutely ill than in previous years (Hall 12).

Greenlick recounts that in 1985 one of the major functions of the medical system was to cure diseases or interfere with the disease

process, and the main site of health care was the hospital. The whole medical system was measured by how technical it was and whether all appropriate and/or probable test were ordered in any given situation. A physician's primary obligations to his or her patient was becoming increasingly ambiguous (180).

During the past decade there has been increasing recognition that the focus of health care delivery has shifted from hospital based care to home based care. Home health care has long been in existence and, has continued to evolve as the number of hospital in the United States increased. In addition, although case management has long been a part of home-based nursing care, case management and home health care have two distinct connotations and, are frequently used in combination to improve quality, access, and cost of health care. Typically, one may think of familiar surroundings, comfort, security, and family or loved ones when they hear the word home. More importantly, many patients may think of autonomy in their home environment. They may select the hours they prefer to sleep and the clothing they prefer to wear. It is clear that, once hospitalized, a patient loses a certain degree of

his or her autonomy, if not most of it. For instance, he or she is no longer able to sleep in their own bed, choose their hours of sleep, or even wear their own clothing. Clearly there are many advantages to home health care. One advantage of home health care is that the comfort of ones surroundings can often provide the patient with strength and hasten their recovery. Moreover, research indicates that there is strong evidence that ones recovery is apt to occur more quickly when the patient is at home. Also, the patient's quality of life improves. Being able to participate in decisions about health care imparts to the patient a general sense of independence and well-being (Mullahy 325).

According to one health care professional from the Midwest, there are numerous treatments such as intravenous, respiratory and physical therapy, home dialysis, and comprehensive case management services that research has shown to be more cost-effective than the same treatment in a hospital setting (anonymous interview #1). This source also asserts that, if given a preference, many people generally prefer to receive health care services in their homes because it provides

convenience, privacy, and is less disruptive to their lifestyles. In addition, as touched on earlier, it allows the patient to remain more autonomous. For example, many patients no longer have to rely on family, neighbors, and friends for providing transportation to attend hospital based procedures that are now performed in the home (anonymous interview #1). Similarly, physicians today have the capability to perform many more procedures in their offices than in a hospital setting. Other benefits of home health care include the decreased risk of contracting an illness from a hospital borne infection (nosocomial infection), particularly with patients who are receiving chemotherapy or one that is immuno-compromised. Although hospitals are, indubitably, a place of advanced medical technology and medical care, they also can be repositories of infection.

As noted earlier, home health care is not a new phenomenon, having long been in existence. Home health care in the United States is a diverse and rapidly growing service industry. According to health care experts, "health care in the home is something nearly everyone will experience in some fashion in their lifetimes" (Kelly 3). Currently,

over 17,000 health care providers deliver home care services to more than nine million individuals who require such services (The National Council on Aging 1). Although diverse, home care is most simply defined as "community-based care provided to patients, more often referred to as 'clients' in their own residences" (Sultz and Young 218). As one of the fastest growing sectors of today's health care industry, home health reinforces the care being supplied by family and friends while maintaining the recipient's independence and dignity. Home health care professionals deliver community-based care, or home care services to persons with acute illness, long-term health conditions, permanent disabilities, or terminal illness.

The length of time that a client receives home care varies. For instance, "home care can either be a long-term provision of supportive care to avoid institutionalization, or short term intermittent care of clients following acute illness and hospitalization until the clients are sufficiently able to return to an independent level of functioning" (Sultz and Young 218). Home care can be provided through either a formal system which is composed of paid professionals and consists of

the following: case managers; registered nurses; licensed practical nurses; home health aides or personal care assistants; specialty care providers such as physical therapists, respiratory therapists and licensed medical social workers; or, through the informal system of caregivers which consist of family, relatives, neighbors, and friends.

In defining home health care, it is imperative to emphasize that the services to be provided should focus on the needs of the patient, and the provisions of that care are rendered in the patients' home. The term home health denotes much more than simply going into ones home to visit the sick and the shut in. Home health is further defined as the provision of care for an individual who is sick or disabled. This individual cannot independently function in society as a "healthy normal" person whether it is for a short period of time, or an extended period of time. The American Medical Association provided the following definition of home health care:

> ...therapies (such as diet, occupational, physical, psychological, and speech), vocational and social services may be included as basic components of home health care. The provision

> of these needed services to the patient at home constitutes a logical extension of the physician's therapeutic responsibility. At the physician's request and under his medical direction, personnel who provide these home care services operate as a team in assessing and developing the home health care plan. (Friedman 28)

It is apparent in the previous definition that explicit criteria exist to ensure that patients receive health care equivalent to the care provided in an acute setting. A more in-depth definition of home care is provided by the American Hospital Association. The definition provides an enumeration of appropriate services that may be offered such as respiratory therapy and nutritional guidance (Friedman 28). Other services include the following: medical care and supervision; nursing care and supervision; medical technician services; pharmaceutical services; social work services; respiratory/inhalation therapy; physical therapy; speech therapy; occupational therapy; durable medical equipment (appliance, equipment and sterile supplies) services; nutritional guidance; availability of hospital inpatient services; laboratory and radiology services; homemaker, health-aide and personal care services (Friedman 28).

The history of home care can surely be traced to earliest times, when in order to survive, people provided basic health care for one another in their own homes. However, in the late 1800s, home nursing services were organized. The home nursing agencies educated the ill and their families on skilled nursing care and cleanliness. In 1855, the Women's Branch of the New York City Mission was the first organization to employ a graduate nurse to provide home health care for the sick. Also, during this same year, New York is credited with establishing a voluntary agency for the purpose of providing home nursing care. Other such agencies soon followed in Boston and Philadelphia, and these later became the Visiting Nurse Association (Spiegel 2).

In the early 1900s, insurance companies became involved with home health. In 1909 the Metropolitan Life Insurance Company was first to offer home nursing services to its policy holders. These services quickly gained in popularity, and by 1928 the company was affiliated with 953 organizations that provided nursing services. Soon, other insurance companies became interested in home nursing services

and began to place an emphasis on health promotion rather than curing the sick (Spiegel 3).

In 1941 the University of Syracuse implemented a program that would provide medical care for patients discharge from the hospital (Spiegel 3). This was one of the first programs to illustrate the vital importance of medical care in the home after hospitalization. A nationwide committee called the National Organization of Public Health Nursing was established by 1946. One of its main goals was to determine the most desirable method of delivering home nursing care. Spiegel relates the three patterns of nursing that were recommended:

> 1. All public health nursing service, including care of the sick at home, administered and supported by the health department. This is the most satisfactory pattern for rural communities.
>
> 2. Preventative services carried by the health department, with one voluntary agency working beside nursing and some special fields. At present this type of organization is the most usually one in large cities.
>
> 3. A combination service jointly admin-

> istered voluntary agencies with all field services rendered by a single group of public health nurses. Such a combination of services is most desirable in smaller cities because it provides more and better service for each family. (4)

In June 1958 the Chronic Disease Program of the United States Public Health Services conducted a conference on organized health in Virginia. During the conference, there were four major elements discussed as being vital for a successful home care program: (1) administration, (2) personnel, (3) community resources, and (4) evaluation. Funding was also addressed, as well as areas of research that would assist insurance companies to gain data for the purpose of establishing appropriate premiums (Spiegel 9).

In 1961 public grants to both, public and nonpublic agencies became available to assist in developing health services outside of the hospital. The Surgeon General was authorized by the Community Health Services and Facilities Act to support services such as nursing care, homemaker services, physical therapy, occupational therapy, nutritional services, and social services. During 1962-1967, $42 million dollars was spent; 15 percent of these funds were used

for home health care. Numerous home care projects and services evolved after this period and became eligible for Medicare reimbursement.

The development of Medicare has had a major influence on the growth and expansion of home health care. Federal laws mandated that home care agencies provided other additional services in addition to nursing; these services could be a wide array of therapies or social services. Because many nursing agencies were not providing this minimal service, the federal government intervened by providing funds to assist home care agencies increase and improve their levels of care. It was during this time that private agencies primarily funded with Medicare monies significantly increased in number (Spiegel 10).

An estimated nine to eleven million people in the United States require some type of home health service, although many of these people receive their needed care through the informal system of home care, or from family members, friends and neighbors. In 1987, approximately six million people received formal home health services; and over three million of these people were elderly. In general, the

amount of home care that is needed rises with age with both functional disability and age being likely determinants of the need for home health care services (Basic Statistics 5).

At present millions of people are utilizing home health care; albeit, these services will be needed to an even greater degree with the rising percentage of elderly in our population. Simply stated, the American population is getting older and increasing in numbers. The 1983 Census Bureau indicated that in the past 20 years the number of people over age 65 has grown twice as fast compared to the rest of the population. In 1990, one out of every five persons was over age 65, in comparison to one in 16 at the turn of the century. It is anticipated that by 2025 the numbers are expected to be as high as one out of three. These numbers indicate that persons over the age of 65 are the fastest growing portion of the population in America (Nassif 25).

As the elderly population continues to grow, so does the demand for home care services. In today's market, the competition among home health care centers and agencies has intensified. The National

Association for Home Care identified 13,951 home care agencies in the United States in February 1993. These agencies are a combination of Medicare-certified agencies and hospices, home health agencies, home care aide organizations, and other hospices (Basic Statistics 1). In addition, many states mandate that insurance companies offer home care benefits. Interestingly, insurance companies found that they could save a significant amount of money when they utilized home care services. According to a study in 1981 on home care savings, the State of Colorado saved $163,000 by supplementing its employee benefit package with home care. Kodak also revealed that it saved $160,000 each year by adding a similar program (Nassif 28).

The vastly growing home health market has triggered a tremendous interest among many individuals and companies who want to be part of this growing trend. These individuals and/or agencies include case management agencies, medical equipment companies, doctors, and even pharmacists. Hospitals, which at one time had no interest in home care, are also seeing home care services as one way to increase their revenues. With the advent of Diagnostic Related Groups (DRGs)

in 1983, hospitals were finding their patients' length of stay shorter and an increased number of empty beds. Instead of discharging the patients from the hospital and perhaps not seeing them again, many were offered hospital-based home health care centers. Hospitals could continue to meet patient care needs by offering home health care services (Sultz and Young 67).

As mentioned earlier, there is still much debate in government pertaining to a national health insurance plan. When elected in 1992, President Bill Clinton placed health care reform on the foremost section of his domestic policy agenda. According to Health Policy Jargon, members of the Congress and other national leaders have agreed and rallied around the concept of reform. However, this is the only common area of agreement that is shared (21).

Hastings continues on with the reality that health care reform is indicated. He asserts:

> White House aides articulated the need for health care reform: lack of universal access to affordable health insurance; lack of security in existing insurance policies; rising health care costs;

> growing complexity of the health care system;
> declining choice of insurance plans and providers; and
> threatened quality of care. (152)

President Clinton's discussion of health care reform was initiated by several perceived problems in the health care delivery system which include:

> Growing numbers of uninsured Americans; health care costs rising twice as fast as wages; distortions in the health insurance market caused by under-riting practices designed solely to minimize rather than spread financial risk; maldistribution of resources, particularly primary care practitioners; medical malpractice, contributing to defensive medicine; and, the unsatisfactory health status of the U.S. population. (52)

On occasion intense debates ensued over the previously mentioned issues; however no resolutions were made. How can worthwhile change be brought about in this area of vast disagreement. Most concede that the system is so enormous and impaired by conflicting expectations that any applicable solution will be nearly impossible (21). Thus the issue of reform has decreased in importance and other issues facing the country have come to the fore. According to

Hastings:

> The problems in our health care system were not addressed legislatively, and they still exist despite many state and private sector attempts to control cost while increasing access. The public was seldom exposed to widespread discussion of the complex and interrelated problems in the current health care system, and consequently did not understand the need for reform, the various strategies being proposed, or the language of reform. It was easy for special groups to scare an untrusting public into believing that the status quo was safer than change.
>
> Despite the massive U.S. spending on health care, the population's health status does not appear to justify the investment. Prevention may be the single most effective long-term cost containment strategy available. Nurses can play a vital role in shaping health policy by engaging and educating the public, helping to educate state and federal legislators. (52)

Despite much debate, it is evident that President Clinton supports home health services as it is included in the Health Security Act of 1993. Additionally, the National Association for Home Care (NAHC) supports several key elements pertaining to the plan. Val J.

Halamandaris, president of NAHC, stated:

> I commend President Clinton and First Lady Hillary Rodham Clinton for the aggressive and historic efforts directed towards health care reform. I commend their leadership, their goals, and their basic approach. They have taken us a long way toward the establishment of the fundamental goal of creating a national health care system, including long-term care as a basic right for all Americans. ("Health Care" 2)

The Health Security Act contains a key provision which directly relates to home health. One function of the Health Security Act is to take the initial step towards developing a national, long-term home care program. Once established, this program would guarantee long-term care to the sick and disabled in their home. In regard to long-term care, President Clinton wants to develop a $15-20 billion long-term care program which would reach close to eight million people who are disabled and living at home. Among the eight million people, this program would include the elderly, severe or profound mentally retarded children under six years of age, and depend on specific types of technology ("Health Care" 3). Additionally, a portion of the Health

Security Act would recognize home health as a major component of the health care system and guarantee this coverage of care.

Even if the Clinton administration had not made healthcare reform its priority, it appears that health care providers and others in the industry would begin making changes of their own. It may also appear that the primary reason the government will have difficulty changing the current system of delivering a more cost-effective product, is the government. There are numerous regulatory agencies, federal, state, local and multiple private auditors, sanctioned by the government. An example illustrating ineffective conflicting government is pointed out in the article "Cross Train cautiously to assure legal, regulatory problems do not derail Patient Focused Care Plans". According to the article, some states allow hospitals to credential staff or validate their competencies under their medical staff bylaws; other states prohibit this practice. National organizations of various professional groups are allowed to validate competencies of their professionals for state licensing. However, some states do not sanction this practice (Patient-Focused Care 1 Sept. 1993: 1).

Considering the proposed government changes, economical changes, and with all the changes that are occurring with health care and specifically with home health care, it is apparent that the demand for home health care is significantly increasing. If cost-effectiveness is a given component of home health care services, one may anticipate an even faster growing trend toward increased utilization of home health care and other services such as case management.

Case management is not synonymous with home health care, although frequently used in combination to deliver quality health care services. Likewise, "managed care and case management are not interchangeable concepts. Managed care is a system of cost-containment programs; case management is a process" (Mullahy 5). More specifically, case management is a dynamic and collaborative process. It involves critical planning, developing, implementing and evaluating comprehensive programs. The ultimate goal of a case management program is to provide quality, cost-effective health care. Lumsdon acknowledges that the definition or meaning of case management may differ among individuals or agencies. Lumsdon

asserts: "case management means different things to different people - and perspective has everything to do with it. Insurers for example, typically view case management as utilization review, but hospitals typically use case management to link various inpatients activities" (44). A standardized definition of case management is an imperative source of data. This data can serve as a significant tool to equip case managers, health care providers, home health care agencies, insurance companies, and consumers with the knowledge needed to practice, conceptualize and utilize case management services.

According to Mullahy, by definition, "case management is a collaborative process which assesses, plans, implements, coordinates, monitors and evaluates the options and services to meet an individual's health needs, using communication and available resources to promote quality, cost-effective outcomes" (9). An analogy of case management might be that it is the very fabric by which a collaborative effort is sewn together using the availability of appropriate resources to create a holistic approach in meeting an individual's health needs.

"Case management is a cost-effective and care management tool.

Case management addresses the quality of care as well as offers opportunities for cost savings" (Warren, Puls, and Fogelstorm-DeZeeuw 173). Various model case management programs have been developed and used primarily as a process and strategy for restructuring our health care delivery system. To facilitate a clearer understanding of how case management is used as a process, one must be aware of the fact that "case management is a systematic process coordinated by one person to assess, plan, coordinate, evaluate and monitor multiple, interdisciplinary services to meet the needs of a client" (Hilgendorf 32Q). In addition to being a systematic process, case management utilizes a multidisciplinary and professional team approach to coordinate the delivery of quality, cost-effective services conducive to the provider, payer, and consumer. As a result of the coordination and utilization of appropriate resources, measurable outcomes for quality and cost- effectiveness of services are achieved. This will be discussed in more detail in Chapter Two.

Case management services can be utilized in a variety of settings. They include, but certainly are not limited to: independent case

management practices, hospitals, insurance companies and home healthcare agencies. In addition, "case management, in conjunction with such programs as pre-admission review, claims administration, and health care education for individuals and their families can smooth the path for health care delivery" (Mullahy xvi). This simply suggests that patients and their families do not have to become overwhelmed with the feeling that they are being abandoned or neglected in the middle of a vast health care system that is perhaps controlled by inaccessible authorities.

Generally, case management services are provided by case managers. "Case managers serve as the primary link between patients and their physicians, in addition to providing ongoing care education and assessment" (Lumsdon 44). The case manager acts an advocate for both the client and the health care system by coordinating utilization of appropriate, available cost-effective resources to meet the client's needs. "Case managers are coordinators, facilitators, impartial advocates, and educators. Their role is as varied as the site where they are employed and the job tittles that designated their position in the

past" (Mullahy 4). For instance, just a few years ago, the case manager in a home health care agency may have been given the job title of "Supervisor, Home Health Services". Simply stated, the case manager may be employed by the home health care agency, hospital, insurance company, or he or she may be an independent case manager or entrepreneur. A more general example of the role of the case manager can easily be reflected in Appendix A which features the case manager as a "keyworker" for coordinating services for the elderly. With the increase in the elderly population and their oftentimes frail, and or debilitated states secondary to the aging process, the case manager serves as a vital link or "keyworker" in coordinating accessibility to cost-effective health care. Serving in the role of a "keyworker" allows the case manager to target clients who are most at risk of nursing home placement in an attempt to prevent inappropriate institutionalization. For example, "case management in conjunction with adequate community-based long-term services can prevent premature institutionalization. Through pre-admission screening, case managers can often divert individuals to community-based services"

(Quinn 238).

Although cost-effectiveness is not the single strategic goal of case management programs and would be ethically scrutinized by many if it were, numerous professionals are dedicated to the belief that comprehensive case management programs justify the need for budget allocation, administrative support of case management programs, and widespread recognition for case management services. The establishment of a case management and home healthcare agency can serve as a bridge between institutional and community based systems or acute, sub-acute and community care systems through coordination and appropriate utilization of community resources for meeting consumer needs.

In keeping with this line of thinking, one case management and home healthcare agency is currently developing a comprehensive business plan for delivering health care, while simultaneously epitomizing quality, accessible and cost-effective healthcare services. According to the agency's chief executive officer, the program is:

> ...designed to provide the most appropriate level of care in order to ensure the delivery of quality, cost-effective health care services. The case management and home healthcare agency neither sleeps nor slumber; but, is open 24 hours a day, seven days a week when most physician offices closed. The incorporation address concerns regarding the growing number of "home bound" health care consumers who are experiencing difficulties accessing quality and cost-effective health care. Patient care plans are professionally customized to meet the client's individual needs. The incorporation's' commitment is to prevent the duplication and/or over-utilization of services (anonymous interview #2).

A case manager, who is also a registered nurse and home health clinical specialist will oversee the general operations. However, a physician will oversee operations in its entirety while simultaneously serving as the medical director. Plans are being made for the case management and home healthcare agency to be opened in August 1998 and will be staffed by licensed and unlicensed nursing personnel, administrative personnel, finance and accounting personnel, allied health personnel, nursing students, and health care management students of all levels of education (i.e., - diploma, associate degree, bachelor of science, master of science, and master of business

administration).

It is anticipated that the nurses, nursing students, and health care management students will gain significantly from this experience by learning more about case management, patient teaching, and the coordination and appropriate utilization of resources to meet patient needs. By providing these services to the community, the case management and home healthcare agency hopes to increase customer satisfaction by facilitating the improved delivery of quality, accessible, and cost-effective home health care.

Chapter II

LITERATURE REVIEW

Starting with the introduction of case management and home health care services and ending with the use of advanced medical technology to deliver health care, the human race has introduced important modifications into the health care delivery system. Undoubtedly, additional methods will be implemented in the future. Although those modifications have brought a wide array of advances in medical technology, patients, families and health care professionals sometimes face difficult decisions about medical treatments and the type of health service that is most advantageous for the patient. While case management and home health care services have become a more common health care alternative, many health care consumers remain concerned about quality, access, and the cost-effectiveness of health care. Oftentimes, the specification of responsibility for obtaining health care services is placed solely on the health care consumer. However, since society has an interest in deciding who is responsible

for what, some contend that health care consumers should not have to assume total responsibility for accessing the health care delivery system. All parties involved in health care delivery, including: case management and home health entrepreneurs, other health care providers, the federal government, insurance companies, investors, and consumers, all must play an equally important role in decisions that govern health care delivery, quality, access, and cost containment. In this chapter the author will endeavor to concentrate on issues related to quality, access, and the cost-effectiveness of case management and home health care services.

Case Management and Home Care Usage

Healthcare today is now one of the largest and most complex industries in the United States. "Over 17,000 providers deliver home care services to some 7 million individuals who require such services because of acute illness, long-term health conditions, permanent disability, or terminal illness" (The National Council on Aging 1). Simply stated, the health industry is a large enterprise. According to the National Council on Aging, "annual expenditures for home care

exceeded $27 billion in 1995" (1). It appears very evident from the statistics that there is a large consumer demand for case management and home health care services.

Many case management and home healthcare agencies design their programs based upon a humanistic approach of philosophy. Dr. Cherkasy, a designer of numerous home health care programs, believes strongly in the humanistic approach. He feels that it is crucial that the patient be viewed as an organic and spiritual whole, and as a whole in society. Elements such as the patient's family, where they reside, food preferences, preferred clothing, entertainment preferences, and occupation are all vitally important in understanding the patient as an individual and as a physically ill individual (Spiegel 160).

The humanistic approach is often used by the case management and home healthcare agency when determining which patients are most suited for home care and/or case management. Fundamentally, a case management and home healthcare agency is not for everyone. "Home health care is regarded as an alternative to extended hospital

stays or nursing home care by government and/or private insurers" (The National Council on the Aging 1-2). Each agency adheres to rules and regulations governing to whom they can administer case management and home services. For instance, individuals with severe disabilities who live alone and require 24-hour care, would not be suitable for home care, as this case would require more than home health care is capable of providing, or is designed to provide. However, the patient is a suitable candidate for case management services, and would benefit tremendously from appropriate utilization of resources. Similarly, an individual in a deep coma would need advanced, continuous care that is offered in a hospital setting or long-care facility, but would not be an appropriate candidate for home health care services. Again, this patient would be an appropriate candidate for case management services. The example also illustrate how case management and home health care services are frequently intertwined in order to deliver quality, accessible and cost-effective health care.

A common statistic agreed upon by many in the literature states that as many as nine to eleven million people need home care and/or case

management services. A vast number of these people will receive care from informal caregivers --friends or family members. "The broad definition of 'family' includes individuals with whom the patient has a consistent relationship. Close friends or relatives often become the primary caregivers" (The National Council on the Aging 1). In 1989 approximately three-quarters of severely disabled elderly persons who received home care services relied solely on family or unpaid help (Basic Statistics 5). In 1987 the National Expenditure Survey revealed that 5.9 million individuals in the United States received formal home care services (5). This is approximately 2.5 percent population of the United States; an estimated 50 percent of these recipient were over age 65. The formal caregiver includes those professionals who provide in-home health care, case management, and personal care services (The National Council on theAging 1). Table I illustrates complete demographics (inclusive of all ages) for health care recipients who use home care (Basic Statistics About Home Care 5). In addition, Table I illustrates the average number of home visits per home healthcare recipient according to ones' age. Table I is provided on the next page.

Table 1

National Home Care Usage, by Client Age

Characteristics (age in years)	US Population (thousands)	Home Care Recipients Number (thousands)	Home Care Recipients Percent of US Population	Average Number of Visits Per Recipient
All ages	239,393	5,878	2.5	44.0
Under 65	212,872	2,912	5.4	24.4
Under 6	24,838	621	2.5	4.3
6-17	41,950	251	0.6	14.9
18-39	86,340	863	1.0	22.8
40-64	59,744	1,183	2.0	37.9
65 and older	26,521	2,966	11.2	63.3
65-74	16,387	1,165	7.1	55.7
75-84	8,111	1,173	14.5	66.9
85 and older	2.032	628	30.9	70.6

SOURCE: Basic Statistics About Home Care 1993 (5).

There are many patients who are considered perfect candidates for case management and home health care services. Some of these perfect candidates include: the elderly, poor, children, handicapped,

chronically ill, mentally ill, terminally ill, disabled, and persons living in rural areas. Additionally, personal preference is a significant factor for candidates, or health care connoisseurs who are considering the case management and home health care option of health care delivery. Other considerations include: willing family members or friends who are capable of assisting, safe and available home technology, and the physical layout of the home must be adaptable to accommodate the patient's needs. Simply put, even though a patient may be suitable for case management and home health care, their home must also be suitable for home health care. Several questions must be asked in order to determine if ones' care at home would be successful or, if changes will need to be implemented. According to Spiegel, these questions may include the following:

1. Is the home quiet?
2. Does the home have stairs that could create barriers to rooms such as the bedroom or bathroom?
3. Is there a private room available for the patient? Does it have a bath?

4. Do the doors and hallways accommodate wheelchairs?
5. Are there small children in the household?
6. Is there an adult nearby?
7. Is there access to a telephone?
8. Is a television and radio available? (163)

If there are problems arising from any of these questions, arrangements would be indicated in order to accommodate the patient. For instance, the patient's bedroom can be relocated to the ground level, and perhaps some construction can widen doors or hallways for walker and/or wheelchair accessibility. Additionally, it may be necessary to equip the home with adaptive devices such as wheelchair ramps.

Case Management and Home Health Industry

Healthcare today is now one of the largest and most complex industries in the United States in both cost and employment. "Americans spent over $800 billion last year on health care. In 1995 alone, over $16 billion worth of new construction or renovation of health care facilities was in the design phase" (Zweig White &

Associates, Inc. 1). It appears very evident from these statistics that the health care industry in the United States is an enormous enterprise. From today's headlines to a firm's bottom line, the impact of the health care industry is continuously growing. However, overall the direction of this enormous business has never been more uncertain. At present, case management and home health are the fastest growing sectors of the health care industry. Although case management and home health are rapidly growing within the industry, the agency must meet certain local, state, and federal requirements for demonstrating quality, access, and cost-effectiveness. Licensure, certification, accreditation, authorization, and supervision are all essential components of an agency to ensure quality. For an agency to obtain licensure, it must have legal permission to operate, which is granted by public authority. This regulatory stipulation serves to protect the interests of the patient, and the community at large. To obtain certification, an agency must meet state licensing requirements and federal conditions for participation in the Medicare program. Once state and federal requirements are met, the certified agency's intention is recognized

nationwide, and the agency would be authorized to receive payment, or reimbursement for Medicare home health services. In addition, there are several requirements that must be met for patients to be considered eligible for case management and home health benefits under Medicare. According to the National Council on Aging, the beneficiary requirements include:

1. Must be homebound (to leave home would require considerable effort or put the patient's health at risk)

2. Must need one or more of the following services: skilled nursing care, physical therapy, and speech therapy

3. Must need another qualifying service for occupational therapy to be provided, however once begun it can be continued even if it remains the sole service. (3)

Additionally, a case management and home healthcare agency must meet state and federal requirements in order to be recognized for Medicaid certification, and to receive payments for health care services. "Medicaid is designed to help provide home care services for existing recipients and other people whose incomes are higher than

public aid eligibility limits, but who meet other criteria and cannot pay medical services" (The National Council on the Aging 3). The Medicaid program is jointly funded by the federal and state governments. Benefits awarded to health care recipients differ from state to state (The National Council on the Aging 3). The case management and home healthcare agency is also monitored by state health departments on behalf of the federal government, which assist in ensuring quality. Thus, a certified case management and home healthcare agency is very essential for elderly, disabled, and ill persons who rely on Medicare and Medicaid. Some agencies "also apply to be accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or other state, national or recognition authority" (The National Council on the Aging 1). An accredited home healthcare agency is meticulously evaluated and judged against stringent professional standards that are set by non-governmental organizations that work to boost excellence (Spiegel 421).

A case management and home healthcare agency may operate as a nonprofit organization or as a proprietary one. A nonprofit

organization may be either voluntary or private, a community service-oriented agency with a board of directors, or a privately operated agency run by an individual or a family who are business partners (Nassif 51). According to one emergency room registered nurse in the Midwest, it is illegal for a not-for-profit hospital located within the state of Missouri to deny emergency treatment to any person, regardless of whether their symptoms constitute an emergency situation or a crisis situation (anonymous interview #3). Additionally, a hospital cannot legally deny an individual treatment based on their ability to pay for services. Currently, the case management and home healthcare agencies working diligently to appropriately utilize resources in order to prevent patients from being denied access to needed services. Conversely, a case management and home healthcare agency that operates as a proprietary agency is concerned with profit-making; these agencies now comprise greater than one-third of all certified agencies (Basic Statistics 1).

Case management and home healthcare agencies provide a wide variety of personalized and technologically advanced health care

services to clientele who need it. In addition to the services provided, many contend that healing at home is the ideal solution for many health care connoisseurs. Home health is an industry and it is run as such. In keeping with this line of thinking, this indicates that there may be some poorly or inadequately run agencies, or agencies that are accustomed to utilizing unethical practices. For instance, Spiegel asserts that it is not uncommon for an agency to bill twice for the same service rendered. The agency may also intentionally bill more than one program for the same service, such as billing to both Medicare and Medicaid. Another example would include billing programs for services that were never provided by extending the level of care over what was indeed provided; this is undoubtedly an unethical and illegal practice. Some companies seem to spend monies lavishly, such as purchasing luxury cars to make home visits (330). Although these agencies may be few in number, they create a blemish on the entire industry. The intention of licensing, certification, and accreditation of the case management and home healthcare agencies is to offer these guidelines to a more dependable and trustworthy organization, one that is

capable of providing quality, accessible, and cost-effective health care to its patients. Additionally, case management and home healthcare agencies must provide the most appropriate level of care.

Home care is composed of three main levels: (1) intensive, (2) intermediate, and (3) maintenance. Intensive home care is utilized for a serious illness, in which the patient may be unstable and require intense physician and nursing care. Ordinarily the patient would be in a hospital setting or long-term care facility, but because the services can be provided in the home, the patient can receive treatment there. Intermediate home care is used when it is anticipated that a patient's medical condition or prognosis will not change a great deal, as rehabilitation is achieved or as their disease progresses. This particular patient may require personal care from professional health services. The last level of care is the maintenance level. The maintenance level is utilized when the patient's primary needs are for personal care or additional supportive environmental services. The patient's condition is relatively stable, although he or she may require periodic monitoring (Spiegel 174).

The various characteristics that the author has discussed can assist in determining an effective case management and home health system. In regards to home health, Spiegel provides a list of the previous characteristics: (1) coordination by a professional nurse; (2) complete medical records; (3) central administration; (4) contractual agreements; (5) no restrictions by age, sex, or source of payment; (6) standards for quality of care; (7) patient care planning; (8) utilization review; (9) data collection and analysis; (10) flexible, but standard administrative and professional policies (173).

Home care with the incorporation of case management is a desirable option for individuals who wish to remain in their homes to receive a form of health services, either on a temporary basis or for an extended length of time. "Individuals who can be rehabilitated following an accident or illness tend to recuperate sooner among comfortable, familiar surroundings. Staying at home may enhance his or her sense of independence and dignity" (The National Council on the Aging 3-4). However, one cannot arbitrarily opt to receive case management and home health care services. Case management and home health

care must be prescribed by a physician in the same manner in which medication is prescribed. Persons requiring case management and home health care are frequently referred for services after hospitalization, although prior hospitalization is neither a prerequisite nor requirement (The National Council on the Aging 2). If hospitalized, the treatment team generally consist of a physician, nurse, social worker, case manager, discharge planner, and occasionally family members who decide that home care services will hasten discharge, facilitate ones' recuperation, and prevent premature nursing home admission. Following the determination that case management and home health care are necessary, a specified process must be followed. When the physician recommends or prescribes case management and home health care services, an agency that provides appropriate services for treating the patient's condition is selected. Oftentimes, "physicians and hospital discharge planners refer the patient to home care agencies that are known to them and preferred by them. It is often more comfortable to follow the lead of the health care team in selection of a home care agency based on their knowledge and

familiarity" (The National Council on the Aging 4). Discharge planners and case managers in particular can often serve as a tremendous source of help to patients and families. They are knowledgeable about community agencies that offer case management and home healthcare services, sources of payment for services, have access to appropriate forms, and can assist patients in understanding their insurance by deciphering information contained within their insurance forms. Even persons have a right to select or change a case management and home health care agency just as they have the right to select and change their doctor. One always has the right to change providers. According to the National Council on the Aging, there are several Guidelines for selecting an agency:

1. Accreditation by state or other regulatory organization
2. Ability to supply the required services in a timely and professional manner
3. Acceptability to insurer
4. Employee screening for abuse and criminal backgrounds

5. Reference check with Better Business Bureau, friends, and/or neighbors

6. Manner of billing and reporting of on-going care costs to patient. (4)

Once selected, the agency obtains a detailed evaluation on each patient from the physician, and an individualized plan of care is customized or tailored to meet the specific needs of that particular patient. "The evaluation for home care should be comprehensive, including assessment of functional ability, mental status, psychological needs, nutritional status, and medication use and compliance" (The National Council on the Aging 2). The evaluation should include other pertinent considerations such as the patient's home environment, family participation, and community resources. One must then complete all fundamental paperwork ranging from consent to health care treatment, to signing payment obligations. In terms of payment obligations, coverage for case management and home health care is available through Medicare, Medicaid, private health insurance, and self pay. "Managed care organizations (MCO) or Health

Maintenance Organizations (HMOs) contract with specific home care agencies and other providers that may or may not be certified. Keep in mind that the choice of an agency is limited to those agencies that are contracted by the MCO or HMO" (The National Council on the Aging 3). When all of the paperwork is completed the case management and home healthcare agency selects the most appropriate personnel and arranges for the delivery of any durable medical equipment that may be required. Routinely scheduled in-home visits begin and the physician is kept abreast of the patient's status. Additionally, once a patient qualifies for Medicare-covered home care benefits, ancillary services provided by nursing assistants become available, if so required.

According to the National Council on the Aging, the service requirements include:

1. Must be reasonable and necessary
2. Must be offered in the patient's resident
3. Must be ordered by the physician
4. Must be provided on an intermittent basis. (3)

After the case management and home care is set up, the patient can

enjoy all the comforts of home while still receiving the needed care. The agency then submits a bill to the insurance company and/or patient. Lastly, home care treatment is terminated once specified goals are reached (Nassif 40).

A patient's physician plays a significant role in case management and home care because they must write orders prior to the start of health care services. The physician should be knowledgeable about where home care is available and how to refer patients for case management and home care services. The American Medical Association asserts:

> Appropriate physician participation and leadership is indispensable to the delivery of high-quality home care. Care that patients receive must be prescribed by a physician. Where there is insufficient physician participation, the quality of care can suffer. (Spiegel 470)

Although patients are not seen by a physician during each case management and home health care visit, the medical attention is projected through professionally trained and qualified personnel who

are responsible for carrying out the physician's orders. Simply stated, the physician oversees all care provided, and is ultimately responsible for the care given to each patient. In other words, the physician is a major stakeholder in the case management and home health industry.

In terms of theory, managed care has become a buzzword/byword for health care professionals, the federal government, insurance companies, provider hospitals, Wall Street investors, health maintenance organizations and consumers. There is a great interest among those mentioned to find solutions with measurable outcomes to the dilemmas and ethical issues associated with "managed care", "managing" care, finding methods to improve accessibility/availability of health care resources and providing quality cost-effective health care to consumers. The quest for finding these solutions has even taken a position within certain disciplines/professions. Nursing as a discipline, for example, has reviewed the use of nursing theory in nursing case management practice as a solution for providing quality health care while containing cost. According to author Betty Smith Williams, "managed care and case management models for patient care delivery

have ignited hope in the health care delivery system as powerful solutions to the mounting problems stemming from scarce resources" (60). The significance of nursing case management models (NCMM) in terms of outcome for patient care delivery, is they "are highly positive with the new system being credited with reduction in hospital lengths of stay" (Williams 60). Theories and concepts when applied to the establishment of a comprehensive case management and home healthcare agency, serve as a significant educational tool for clarifying, directing and methodizing the uniqueness of the contributions for improving health care delivery.

So, what exactly are NCMMs? "NCMMs are structures that direct the nurse service delivery on the basis of client type through an episode of client problems. These models shift the focus of nursing practice from plans to management, from tasks to case accountability, and from tasks to outcomes" (60). More specifically NCMMs "specify the system design, its parts, and its dynamics for the broader organizational goals" (60). To accomplish this, there is a need for the utilization of actual case management practice and the use of management theory

and concepts. In essence, when establishing a case management and home healthcare agency, it is imperative to continue to attempt to obtain a level of theoretical growth commensurable with case management practice. This theoretical growth will allow the case management and home healthcare agency to provide, methodize, and affirm the uniqueness of their contributions as a professional organization to health care delivery. In other words, from an educational perspective, continuous attention must be devoted to the collaboration of theory, as theory and practice go hand-in-hand (60).

Now that a standardized definition, theory/concepts, structural framework for the education/methodology, and a historical and current overview of case management have been provided, a brief historical overview of the advantages of home-based case management will be explored. In addition, the overall contributions of home health care agencies as an alternative way of providing quality, cost-effective health care services relevant to the health care delivery system will be addressed.

As previously mentioned, home and community-based care is not a

new phenomenon. Statistics acknowledge the incorporation of case management in home care and that there will be an increase in the utilization of home care as an alternative way of providing quality, cost-effective health care. For example, "The Health Care Financing Administration (HCFA) has projected that $60 billion will be spent on home care by the year 2000, an increase of 328% from the $14 billion spent in 1986" (Hilgendorf 32Q). This shift will continue to facilitate the increase in the utilization of home health care services as an alternative to receiving community-based resources and services. Simply put, there has been a major shift in the health care delivery system from institutional care to home care. Greater emphasis is being placed on providing a continuum of care in the community. This continuum of care is expanding greatly and there are multiple reasons for this expansion. For instance, "within the last 30 years, such care has expanded greatly, fueled by growth in the number of elderly, the rising cost of Medicare, Medicaid, and Title III of the Older American Act" (Quinn 235). In addition to the growing number of elderly clients in the community, many stakeholders in health care are finally

seeing advantages to providing quality, cost-effective case management services in the home environment.

Home-based case management services have numerous and significant advantages. "It frequently reduces the length and cost of hospitalization by making early discharge possible. It often prevents premature admission to a hospital, nursing home or other alternative care setting" (St. Joseph. Home Health Pamphlet N.d: N.p.). Additionally, professional health care services are extended into the home environment to provide a continuation of care such as when discharged from a hospital, or as an alternative to nursing home placement . "And perhaps most importantly, it enables patients to remain in their homes where family support and familiar surroundings enhance recovery and rehabilitation" (St. Joseph. Home Health Pamphlet N.d: N.p.). Many are recognizing the above advantages of home-based case management services which have contributed to the growth of case management and home health care agencies.

Numerous factors are attributed to the growth of case management and home health industry. To name a few, more patients are being

discharged from hospitals prior to their full recovery, and many more patients are in need of case management and/or home health care services. Hospital-based home care programs are also rapidly growing particularly because of inflationary costs associated with increasing medical expenses (Spiegel 40). There are multiple reasons for this growth. First, an early discharge from a high-cost hospital bed to a more economical bed is fiscally sensible; follow-up care at home can assist in reducing the potential for re-hospitalization which ultimately saves money. Nassif attests that approximately seven percent of all hospitalized patients on any particular day could be treated at home (6). Statistically, this percentage appears to indicate a high demand for home health care, and somewhat justify early discharges. Finally, rehabilitation in the home can include family members, or informal caregivers which also contributes to lowering costs.

Hospitals have become increasingly aware of the rising costs of medical care and the number of early discharges. In addition, they are also aware of decreasing figures in their patient census, particularly in smaller rural hospitals. Therefore, one solution to keeping patients

affiliated with the hospital is to discharge them, when appropriate, to the hospital-based home care program. Hospital-based home care programs must also meet all federal, state, and locally governed regulations and certification requirements, just as the independent case management and home healthcare agency. They should also provide professional nursing and other therapeutic home care services in order to meet various patient need (Spiegel 430).

In 1982 the Joint Commission on the Accreditation of Hospitals (JCAHO), nonprofit organization, developed a manual for hospitals that contained a detailed section on home care services. The manual listed five standards essential to home health. The standards are as follows:

1. The scope of the program should be specific and documented with clearly stated objectives.

2. There should be adequate personnel to deliver home care and meet the program's objective. Authority and duties of the director should be in writing.

3. Home care programs must be guided by appropriate written policies and procedures.

5. The quality of care should be reviewed and evaluated regularly. (Spiegel 430)

JCAH promotes "the attainment of uniformly high standards of institutionalized care" (Spiegel 430).

Cost-effectiveness

One of the main reasons that case management and home health care will be "the wave of the future" is largely attributed to cost-effectiveness. With the changes that are expected to occur in the United States health care delivery system, cost will undoubtedly remain a very high priority. When comparing costs between various methods of health care, it is imperative to be aware of the fact that figures are being meticulously examined. Cost-effectiveness is "a technique for assessing and comparing the costs and effectiveness of a program" (Spiegel 347). The significance of cost-effectiveness is numerous, and helps decision makers maker choices. Cost-effectiveness can also be considered as the ratio of net increase of health care costs to net effectiveness in terms enhanced of life expectancy and the quality of

life. Net costs are most simply defined as the medical, health, and social services cost of care, minus costs saved due to prevention, plus cost of care for disease that would not have occurred if the patient had not lived. Net effectiveness and net costs are not interchangeable. Net effectiveness is the savings in years plus life years saved by prevention minus years lost from side effects. Following the determination of these figures, the cost-effectiveness of the program may be evaluated (Spiegel 347).

In 1981, the Government Accounting Office asserted: "Home health is generally recognized as a beneficial and cost-effective alternative to prolonged hospital and nursing home care" (Spiegel 205). Hospitals charge patients a day rate based on all general services that the facility must provide in order to operate. Patients must also pay for administrative and building costs. Conversely, case management and home health patients are charged only for the health service s or personnel service they require. Case management and home health incorporations have lower administrative costs and patients may obtain their own pharmaceutical products or medications

by ordering the products and medications themselves at bulk rate. The cost of case management and home care provided over a period of time, such as a few weeks, can come closely to what the patient would most likely pay for a single day of hospital care (Nassif 13).

There are many cases of persons saving a significant amount of money by electing to use case management and home health care. The evidence of some savings can be traced as early as 20 years ago. For instance, in 1977 an elderly man was involved in an automobile accident and sustained severe injuries. His insurance company opted to provide home care for his recovery and discovered a tremendous savings. Following two months of home care, his bill was $3,200. The hospital stay would have cost $200 per day, with an estimated total of $12,500 for that same two month period. By using home care, the cost savings for the man and his insurance company was $9,300. In 1980 Bloom and Kissick conducted a study that illustrate another example of possible savings through the use of home health (Spiegel 380). According to the study, 19 terminally ill patients received health care in their home, and 19 terminally ill patients received health care in a

hospital. Both cases reflect charges in the last two weeks of life. Statistical financial reports revealed the following: the mean charges for home care were $586 whereas the hospital's mean charges were $6,280. In comparison to charges, the hospital charges were 10.5 times greater than the home (380).

Although these examples illustrate a significant amount of costs savings between hospital and home based care, there is much debate concerning the question of heroics and humanity in the care of the terminally ill. The general philosophy of physicians in a hospital and the hospital itself may attempt to save the patient's life in their final days of a terminal illness at all costs, even to the extent of employing heroic measures. But the patient may desire to spend the final days of their terminal illness in the privacy and comfort of their home. While many people choose to go to hospitals in order to receive medical care, it is also a place where many people spend the remaining days of their life. With the growing recognition and acceptance of case management and home health, there is also a significant increase in the number of persons who prefer to die in their home environment. In addition,

many persons choose to use hospice in their final days of life.

Hospice can be provided in the client's home or in the institutional setting. At present, in-home hospice care predominates in the United States. There are over 1,900 hospices nationwide, serving more than 240,000 people a year (Sultz and Young 211). Authors Sultz and Young define hospice as follows:

> Hospice is a philosophy that supports a coordinated program of care that is available as an option to the terminally ill. The most frequently encountered criterion for admission into hospice is that the applicant must have a terminal illness with a life expectancy, usually anticipated to be of six months duration or less. Aggressive medical treatment of the patient's disease may no longer be feasible or personally desirable.
>
> ...Hospice treatment is directed toward maintaining the comfort of the patient and the enhancement of of the patient's quality of life and sense of independence for however long that life may last. (210)

Funding

Currently, reimbursement for health care services provided by hospitals, case management and home healthcare agencies, physicians, and other health care providers comes primarily from private insurance

plans and Medicare or Medicaid. In other words, case management and home health care are funded in numerous ways. Most of the government funding for home health care comes from Medicare, Medicaid, Title XX, the Older Americans Act, the Veteran's Administration, and Champus (Basic Statistics 3). Private funding frequently comes from commercial insurance companies and constitute a small portion of home care payments. Other agencies and organizations such as the United Way frequently contribute money to fund home health care. Personal out-of-pocket payments are a large source of payment for home health care services (see Table 2).

Table 2

1992 Sources of Payment for Home Care

Source of Payment	Percent
Total	100.0
Medicare	37.8
Medicaid	24.7
Private Insurance	5.5
Out-of Pocket	31.4
Other	0.6

SOURCE: Basic Statistics about Home Care 1993 (3).

However, since the cost of health care services are so expensive, very few individuals pay for their health care entirely out-of-pocket. Additionally, the United States' current economical situation is a driving force for many new situations and practices. Some case management and home healthcare providers have chosen to incorporate capitation as a strategy for controlling costs. Nonetheless, a large share of government funding comes from Medicaid which was passed in 1965 as Title XIX of the Social Security Act. As previously mentioned, Medicaid is "designed to help provide home care services for existing recipients and other people whose incomes are higher than public aid eligibility limits, but who meet other criteria and cannot pay medical services" (The National Council on the Aging 3). In short, Medicaid finances health care for low-income people. Medicaid is jointly funded by the state and federal government. Specifically, it is state-administered with federal regulations and its eligibility criteria is mandated by each state (Spiegel 309). Medicaid meticulously specifies what it will cover. For instance, Medicaid will cover hospital or skilled nursing facility care, home health, physician services,

laboratory, radiology, family planning services, early and periodic screening, diagnosis and treatment to persons under 21 years of age, and rural clinic services (Spiegel 309).

In addition to Medicaid, a significant amount of case management and home health care funding comes from Medicare. Medicare became effective for home health funding on July 1, 1986, and passes as Title XVIII of the Social Security Act. Since the enactment of Medicare, the home health industry has tremendously accelerated (Basic Statistics 1). Similar to Medicaid, one must also be eligible for Medicare. Medicare is a nationwide insurance plan for persons 65 years or older, individuals who are eligible for social security disability payments over two years, and those with specific kidney transplants or dialysis. Medicare is composed of two parts: part A and part B. Part A is a hospital insurance and part B is supplementary medical insurance. As mentioned earlier, to be covered by Medicare, the case management and home healthcare agency must meet specific requirements. For instance patients must be homebound (confined to his or her residence), services must be prescribed by the physician, and

require part-time nursing and other therapies. In terms of home health payments, Medicare pays for the following: skilled nursing, physical therapy, speech therapy, medical social services, and home health aids. Medicare does not pay for services that do not receive hospital coverage. These services include such things as television, Meals-on-Wheels, housekeeping chores non-related to patient care, or transportation (Spiegel 295).

The advent of Medicare has made home health services available to the elderly and some disabled persons since 1973. According to statistics, in 1980 the number of certified Medicare agencies soared to 2,924 and doubled in 1985 to 5,983 (Basic Statistics 1). Similar to many other government-affiliated agencies, the number of Medicare-certified home health agencies began to even out in part because of the enormous amount of required paperwork and unreliable methods of payment. Subsequently, these problems led to a lawsuit brought against the Healthcare Financing Administration (HCFA) by several different organizations and groups in 1987. The lawsuit brought about a major impact which enabled the NAHC to rewrite numerous payment

policies for Medicare home health agencies. Following the lawsuit, the number of Medicare agencies began to grow once more, and reached a high of 6,902 in August 1993 (Basic Statistics 1).

The fiscal dilemma of steadily increasing health care costs has driven many providers to utilize capitation as a strategy for attempting to contain and control health care costs. One solution to this fiscal dilemma would be applying case management services in a capitated environment in accordance with CMSA's Standards of Practice. According to Birmingham, "capitation is an idea whose time has come. It provides a venue in which case managers can influence the use of resources to ensure access to and quality of care" (9). Case managers and some providers generally agree that "case management has already demonstrated efficiency and increased patient satisfaction in fee-for-service environments; integrating cases management standards of practice into capitated environments will improve access to care, quality of care and cost of care" (Birmingham 22). Knowledge of how to apply CMSA Standards of Practice for case management in a capitated environment can serve as a valuable tool to assist case

managers in utilizing appropriate resources and maintain high quality care resulting in cost efficiency for the provider. In essence, using CMSA's Standards of Practice can equip case managers with a strategic protocol for systematically managing health care delivery and resource referrals. In addition, it allows case managers to act entirely as advocates for both the patient and the health care delivery system by ensuring that client health care needs will be met. It also serves as a tool for obtaining measurable outcomes through evaluating the experiences of each client as well as the type, quality and amount of services delivered on a case-by-case basis. As a result, the client receives a holistic approach in meeting their needs through the use of case management in an established capitated environment. This holistic approach may be beneficial to the client, the provider and the community at large. Unlike fee-for-service, a form of reimbursement in which physicians, practitioners and hospitals are paid "reasonable or customary" fees for particular services rendered, "capitation is an arrangement by which a payer contracts with a provider for specific services and then pays that provider based on the number of enrolled

members in the payer's organization. Typically payment terms consist of a set amount of money per member per month (pmpm) that is paid to the provider regardless of how many services are delivered (9). In fee-for -service, the equation is "more service means more income" (9). However in capitation the specific number of services provided does not affect the amount of income a provider receives as do the costs associated with delivering care and making appropriate referrals. Subsequently, the risk of decreased profits shifts from the payer to the provider. Payers often choose capitation because it enables them to better predict cost, pass on financial risk to providers, and "it serves as a strategy for gaining exclusive contracts which adds a certain degree of predictability to their revenue stream" (9). Lastly, capitation provides a means for allowing providers to "monitor themselves, thereby avoiding external payer-based controls on utilization" (9).

Appendix B provides an illustration of the eight step plan based on CMSA Standards of Practice for Case Management. This plan can be utilized as a strategic tool for improving the case management process

which subsequently improves the quality of care. One case management and home healthcare agency located within a large metropolitan area in the Midwest has elected to apply this eight step plan and provide case management services in a capitated environment, chiefly as a tool to ensure high quality care. Secondly, and certainly not most importantly, it will be used as an element to add predictability to the agency's revenue. Finally, using this eight step plan will provide the agency's case managers with a "How To" guide for adhering to the goals of case management as defined by CMSA's Standards of Practice for Case Management. For example, by simply adding the term "appropriate" to the term "utilization", a goal of case management is defined as follows: "the case manager should encourage appropriate use of medical facilities and services, improve quality of care and maintain cost-effectiveness on a case-by-case basis" (10). The Standards go on to state that one purpose of case management is to maximize efficiency in the utilization of available resources. One consequence of capitation is that health care providers have financial incentives to keep patients healthy and treat them in an

effective manner. However as capitation becomes more widespread, more health care providers will embrace the concept of health promotion as the "wave of the future". Similarly, more health care providers will need to gain a wider understanding of how Medicare, Medicaid, Health Maintenance Organizations (HMOs), PPOs, "capitated" costs, managed care, hospital mergers, and privatization all affect funding for case management and home health care services.

Utilization

Although case management and home health care are widely available, it would appear that these services are still highly underutilized. Some contend that urbanization may play a significant role in this underutilization. Increased mobility and the development of many new social institutions are considered to have combined and disbanded the extended family. In many cases there is no longer a "traditional " family, and social institutions have assumed the role and have taken over some of the traditional functions of the family (Spiegel 74). A large number of individuals also select hospitals or other institutions over the home because of advanced medicine, science and more sophisticated technology, and frequently equate them with the acute hospital as opposed to case management and home health care (74).

Despite the many positive attributes inherent in case management and home health care, there are a few drawbacks. For instance the tools that are frequently used to measure and determine the quality of home health care are oftentimes more subjective than objective. This is indicative of the fact that the data received is largely obtained from verbal expressions and observations of the case management and home health care employee. Another drawback many individuals perceive and fear is that of being unable to get emergency assistance if and when they need it. This in particular is a major concern for the elderly and those who live alone. However there are other alternatives that are currently available. One such alternative on the market is called Lifeline. Lifeline is an electronic device that automatically dials a 24-hour telephone number by the single push of a button. This device serves to identify the caller and the type of emergency (Spiegel 386). There are also other devices on the market. An example would include the 9-1-1 system for reporting emergencies. When a person dials 9-1-1, a computer screen assists the dispatcher in tracing the location of the caller. The dispatcher can then send the appropriate type of assistance to the location of the caller.

Many times when people think of case management and home health agencies, they think of the elderly. Although it is true that a significant number of elderly people receive some type of home care service, an estimated 70 percent of all elderly persons receive home care services from family or friends, and not from institutions (22). Additionally only approximately 5 percent of those over 65 years of

age, or 1.3 million individuals reside in nursing homes, and 22 percent of those over 85 years of age reside in nursing homes (Spiegel 22).

These figures indicate that there are relatively few elderly in institutionalized settings. In view of the fact that there are fewer numbers of elderly individuals than one may expect in institutionalized settings, it would appear that these individuals are receiving case management and home health care services in their homes.

One of the most difficult tasks for anyone to face is the loss of their independence and dignity. Dr. Phillip W. Brickner, pioneer of hospital-based home services asserts: "People say they'd rather die at home than go to a nursing home. They're desperate to remain independent despite all risks" (Spiegel 17). Many elderly have an even harder time leaving their home because home is where they feel comfort, familiarity, and control. Val J. Halamandaris states, "There is significant evidence that people heal more quickly at home" (10). Institutionalized care to some degree may pose significant drawbacks. For instance, institutionalized care can quickly take away ones' independence. Another drawback that may occur when people are placed in institutions is the potential for depression occurring. Additionally, if the patient is not mobile, they may lose their autonomy (Spiegel 203). Furthermore, patients may experience increased physical and mental deterioration as a result of the shock of leaving family, friends, and familiar surroundings. Statistics indicate that 25 percent of the elderly who move into a nursing home die within the first year of residence (Nassiff 11). Many elderly can never return to the

community after entering a nursing home because their financial resources have been depleted and community ties are often severed.

Access

Accessibility to quality, cost-effective health care services remains a major concern for many. It would seem that a large number of patients can maintain more independence in their home with social, psychological, medical, and financial benefits. In the 1980s, Representative James Abnor of South Dakota testified in a congressional hearing regarding long-term care for the decade. Representative Abnor felt that there were several critical issues pertaining to care for the elderly. First, the elderly are in need of a single access point where they could go to find out about health care services. Second, existing services and programs must be coordinated with patient needs; and if appropriate services are non-existent, they must be developed. Lastly, family support must be encouraged and rewarded (Spiegel 242). Currently, not all of these conceptions have been accomplished within the past decade or so. Many of the elderly remain unaware about where to go or who to question about case management and home health care services or even that the services exist. In addition many do not know how to access this growing health care system.

In keeping with this line of thinking, one function of a case management and home healthcare agency is to serve as a single access point for elderly clients. The agency provides health care information

regarding preventative measures that can prevent illness and/or reduce further deterioration associated with disease processes. For instance, The Center for Disease Control (CDC) conducted a Behavioral Risk Factor Surveillance System survey in which the health habits of more than 100,000 Americans in all states were examined. The data analyzed from the study revealed some "alarming data". Research from the study indicated that "nearly half of the elderly are going without important preventative vaccine and medical tests" (Coley 4). The study further revealed that "Medicare covers many vaccines and tests, but clear health insurance coverage is not the only factor affecting the use of these services. Data from more than 22,500 Medicare patients shows only half are receiving a flu shot, which can be obtained free of charge" (4). The significance of receiving a flu vaccine is that "This is a one-time vaccination encouraged for all older people. It prevents a pneumonia that can become serious in the elderly" (4). Likewise, the study revealed that "women over the age of 65 should have a Pap smear once every 36 months, but just 55 to 88 percent of these women met these guidelines" (4). Preventative measures such as obtaining a Pap smear can help to detect early cancers. As a result of these alarming statistics, the CDC: "currently exploring programs to help older adults take advantage of these health measures" (4).

Generally, health care providers such as physicians, case management and home healthcare agencies, and hospitals are supposed to educate health care consumers and do what is medically indicated,

given the informed consent of the patient. Some feel that the question of access becomes one of proportionality, that is whether more good than harm will be done from a medical perspective. Seemingly there will be particular doubts about medical indications if the treatment includes provisions for denying health care to those who are unable to afford the services, in regard to meeting ones' basic health care needs. This chapter goes a step further to point out that although medicine and health care providers have generally and correctly concentrated on the good of the patient, the good of society or the community at large needs particular attention in terms of quality, access and the cost-effectiveness of health care services (Garrett, Baillie and Garrett 237). Ones' ability to access quality and cost-effective case management and home health care services is more serious than merely a question of medical indication versus convenience. It is imperative to remain aware that in all cases, medical indication for health care services must far and foremost outweigh convenience. Additionally, with spiraling health care costs and scarce health care resources, it is imperative to address issues concerning the distribution of case management and home health care services not only to those who are economically comfortable. Health care distribution is an area of much debate for many. Authors Garrett, Baillie and Garrett raise the question of social or distributive justice in terms of accessibility to health care. Although the authors question pertain to accessing the health care delivery system for the purpose of obtaining new modes of reproduction, the line of questioning is also pertinent to central issues concerning ones'

ability to access quality case management and home health care services. Thus, the applicability of the conclusions are as follows:

> First, the central task of health care is to meet the needs of human dignity, such as maintaining and restoring health and alleviating pain. Second, society has a duty to provide its members with access to an adequate level of health care that fulfills basic needs. Third, in the interests of social contributions, society must permit individuals to purchase more than the care adequate for basic needs. Ideally, the additional care should be purchased only when the basic needs have been met. (239)

In view of these conclusions, many argue that ideally no resources should be diverted to medical services such as new modes of reproduction until basic health care needs have all been met. However, the underlying problem remains the same. How can the quality, access, and cost-effectiveness of health care be improved for a population and community at large?

The use of public monies or insurance to pay for "medically indicated" health care is undoubtedly an area of grave concern. Estimated expenditures for national spending for personal care were expected to exceed $800 billion in 1993. Two-thirds of this amount is allocated for hospital care and physician services and only a small portion of these expenditures concern home health care. Despite the expenditures, the home care market grew 10 percent between 1986 and

1991, and 12 percent between 1991 and 1996. Expenditures for home care were estimated at $21 billion in 1993. Even though these figure seemingly appear to indicate that a great deal of money is being spent on home care, it is still only 2.6 percent of national health care spending (Basic Statistics 3). Appendix C illustrates national health expenditures for 1993.

Despite the numerous benefits of case management and home health care, these services remain underutilized. There are many reasons associated with the underutilization of case management and home health care services. These reasons include, but are not limited to, the following: (1) lack of consumer knowledge pertaining to the availability of case management and home health care services. Val Halamandaris, NAHC president asserts: "Consumers still don't know that home care exists" (Nassif 15); (2) some contend that there appears to be reluctance of the part of physicians to prescribe case management and home health care services. Simply put, physicians do not utilize home care as they might do so (Spiegel 495); and, (3) geographical barriers, such as those patients living in rural areas experience difficulty in obtaining these services.

Although case management and home health care services remain underutilized, the paradox remains, of the increased need for the utilization of case management and home health care services. In the Wall Street Journal on April 4, 1975, Dr. Robert Morris of Brandeis University discussed a combination of factors that collectively make the yesteryears-and-now the time for home health care (Spiegel 203).

A few of these factors include: (1) financial abuses of billions of dollars in the nursing home industry; (2) attempts to control inflationary costs; and (3) the move towards holistic concepts in medicine. These factors have increased the need for the home care movement and increasing recognition. Even though these statements were made over 20 years ago, they are still significantly valid today. According to one family physician from Wisconsin:

> "We've hardly scratched the surface as far as exploiting health care at home as a cost-saving device. Home visits directed by a physician/ nurse team can save dollars and provide good care in a good setting. What's required is for physicians to support this activity more widely than they do at present. (Spiegel 345)

Some health care consumers believe that good medical care is only possible in a hospital or institutional setting. In addition some feel that the more complex the diagnostic procedures and measures are, the better care they are receiving. These factors do not always constitute excellent medical care nor do they guarantee a high quality of care (Spiegel 17). According to a study conducted by the United States Department of Health and Human Services, home health was recognized as follows:

> The quality is typically quite high, primarily

> because of the service ethic and professionalism of the nurses. The fact that as home health nurses they can function in a much more independent manner than is customary for nurses (especially compared with hospital settings) seems to bring out the best in them. (Spiegel 9)

As case management and home health care continues to evolve, more consumers are finding personal satisfaction and contentment. Similarly, home health care is generally preferred over institutionalized care. Several other benefits of home care such as the normalcy of the patient's home environment and increased autonomy indicate the need for home health care. (See appendix D).

Component of Health Care System

Case management and home health care should be recognized as a major and vital component of the health care delivery system. Undoubtedly it is a rapidly growing industry in the United States. The National Association for Home Care reported a total of 13, 951 home care agencies in 1993 (Basic Statistics 1). Additionally, hospital-based home care agencies are expected to significantly increase and flourish within the next decade. According to a report titled, "Growth Trends in Hospital Home Care, 1980-1990," the American Hospital Association revealed that 35.6 percent of all hospitals in 1990 operated a home health care agency (Anderson 62). Additionally, many colleges and universities across the country are

beginning to incorporate case management and home health care as part of their curriculum. At present 20 Colleges of Pharmacy offer students a specific course in home health care and 29 other classes include home health care in over-the-counter and nonprescription pharmaceutical courses.

Trends

The health care market is evolving rapidly. Similarly, the case management and home health care market are evolving at a rapid pace. Large acute-care facilities are closing, yet numerous small, primary-care facilities are opening. Additionally, the consolidations of health care systems and the rise of managed care have given birth to a new focus of health care. The focus of care has shifted from treating individuals to treating the community at large. Some health care providers desiring to strengthen the industry will form partnerships and collaborate with other health care providers to look at ways to increase health consumers' awareness of and interest in selecting alternative methods of health care delivery. The alternative methods of health care delivery include, but are not limited to, the increased utilization of case management and home health care services. As we enter into the next

millennium, the trend in health care in the United States will indubitably focus on health promotion, prevention, health maintenance, and comprehensive case management and home health care services. The current challenge involves moving our health care delivery system from "managed care" to "managing" care. There is increased recognition of the need for placing greater emphasis on meeting standards to provide quality and fiscal accountability. Future trends acknowledge that changes in our health care delivery system must be accompanied by medical accountability to society (community at large); in other words, being accessible through the availability of home health care services, providing fiscal accountability, improving accessibility and availability to health care. In terms of fiscal and societal accountability, historically there has been some dissatisfaction among providers, consumers and payers. There is a need to acknowledge that "the lack of both social and fiscal accountability in our health care system is no longer acceptable, there is a need for the emergence of physician-patient-society- relationships as opposed to the traditional physician patient relationship as a solution to 'managing'

care in our community" (Romeo 11). Future trends acknowledging the need for social and fiscal accountability can serve as a stepping stone for actually providing accountability from our society in the reform of our health care delivery systems.

The establishment of a case management and home healthcare agency can facilitate fiscal and social accountability when the focus is maintained on the collaboration of quality, cost-effective services for consumers as opposed to looking solely at the revenue that can be generated. The case management process can serve to simplify access to the health care delivery system through the coordination of appropriate and available resources for services specific to the needs of the client. "The health and social systems have become more complex as they have evolved and multiplied, and have caused users of care to be confused about how to access, use, and pay for services that these systems deliver" (Quinn 234). Unfortunately, "the situation has become even more confusing for older persons with multiple complex diagnoses and functional disabilities who may meet some but not all criteria of each program" (234). Similarly, with increasing incidents of

HIV/AIDS (Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome), drug and alcoholism addiction, and growth in the elderly population, it is evident that future trends will include an increased demand for comprehensive case management and home health care services.

The establishment of comprehensive case management programs has been explicitly identified as producing quality health care with substantial savings. In essence, effective case management services provide opportunities for significant cost containment and improved quality of care in managed organizations. For example, "effective, multifaceted, and short-term case management services can result in significant cost savings for managed Medicaid, Medicare, and other health care programs. Such savings clearly offset the administrative cost of support for case managers, social service departments, and utilization management" (Warren, Puls, and Fogelstorm-DeZeeuw 173). These services can help to significantly improve the quality of life, and health care services for our clients.

Research has indicated that with the increasing elderly population,

the "annual revenue base of assisted-living facilities could grow form $12 billion to $30 billion by the year 2000" (Zweig White & Associates 2). It is equally, and sometimes more important to recognize that the rapidly changing health care environment will also demand different skills and experiences for health care professionals who will be challenged to become more responsible for wellness education and prevention of disease in the population it serves, and the community at large. One case management and home healthcare agency in the area is attempting to meet those changes by promoting wellness in the community it serves. By emphasizing disease prevention, they are making efforts to get health care consumers to develop healthier attitudes and lifestyles.

Although future trends indicate a shift towards increased utilization of case management and home health care services, the paradox however, is that there are potential problems. According to an article in The St. Louis Business Journal on December 29, 1997, "Home may be where the heart is, but it will be tougher for home to be where some health-care services are provided as of January 1, 1998 (1). More

specifically, "that's when many home health providers are expected to start feeling the punch of regulations included in the Federal Balanced-Budget Act approved earlier this year" (1). The significance of the Federal Balanced-Budget Act is as follows:

> Those new regulations cut Medicare reimbursements for home health providers anywhere from 10 percent to 50 percent. They also require home health firms to meet more stringent operating requirements, including posting a hefty surety bond. Those in the industry expect a major shakeout as a result.
>
> ...The difficulties stem from a provision in the 1997 Balanced Budget Act, which cut $115 billion in Medicare spending, including $16.2 billion for home health care. (2)

Allan Larson, manager of the St. Louis office of the health-care consulting firm of Larson, Allen, Weishair & Co. LLP, asserts, "one of the goals of Congress and the Health Care Financing Administration (HCFA), the federal agency responsible for administering Medicare, was to reduce the number of home health agencies, which have grown dramatically in the past decade (2). Larson further stated that Congress and HCFA "feel they will get more controlled and economic

care by having fewer numbers of providers" (2). To help control cost, it is anticipated that some agencies will drop the treatment of the sickest patients, those requiring many visits and expensive services. According to Larsons, many of the "patients could end up in long-term institutions, with state Medicaid programs picking up the bill for their health care. Home care was supposed to be a cheaper healthcare alternative. Now we're reversing the process" (2). Presently, statistics have shown that although home care represents only 9 percent of the entire Medicare budget, the Medicare home health benefit cut accounted for 15 percent of the total spending reduction (2).

Currently no one is certain if there will be a national health care reform, and if so what impact it will have on case management and home health care services. However, as humorist James Thurber states, "It is better to know some of the questions than to know all of the answers" (Leeds 27). It is certain, however, that future trends in the United States health care delivery system indicate change, and health care professionals must be fiscally and ethically accountable to health care consumers, payers, investors, and the community at large.

With the current turmoil in the health care delivery system, future trends also indicate that some case management and home health care agencies may be forced to reengineer their current structure. "To help cut costs, some agencies are expected to drop treatment of the sickest patients, those requiring many visits and expensive services. The bottom line is, patients will suffer" (St. Louis Business Journal 29 Dec. 1997. 2), said Ken Marx a partner at Baird Kurtz & Dobson, an accounting firm with several local health-care clients. Other home health care agencies have had to downsize. For instance, "The Southwestern Illinois Visiting Nurse Association will downsize its staff, said executive Michael Bader, although he did not know how many people he would have to lay off. The agency posted $2.3 million in total revenue last year" (2). Still, other agencies are attempting to accommodate increasing health care costs by relocating. To illustrate, "LAB Home Health Inc. has moved from Chesterfield to smaller quarters in Brentwood to save on rent, according to executive director Robert Pritts. LAB had $8.5 million in revenue in 1996" (2). The bottom line is: although future trends reveal an increased demand for

the utilization of case management and home health care services, one must be cognizant of the need for strategic business planning in order to remain viable in today's market.

To recapitulate: Competition is keener, medical advances and scientific breakthroughs have significantly increased, technology has become more sophisticated, and the health care delivery system has become more complex. As technology permeates every facet of the business world today, significant changes are occurring in health care delivery. "We are smack in the middle of what futurist John Naisbitt calls the 'high-tech high-touch society', when to get the most out of our machines we have to pay more attention than ever to people" (Leeds 1). These people are demanding changes in the health care delivery system. They want improved quality, greater access, and a more cost-effective system of health care delivery. Case management and home healthcare agencies offer an alternative method of health care delivery, and facilitate the improved delivery of quality, accessible, and cost-effective health care services. Likewise, case management and home health care services have undeniably become a most valuable

commodity within the health care industry; future trends indicate that they are "the wave of the future".

Chapter III

BUSINESS PLAN FOR A CASE MANAGEMENT AND HOME HEALTH AGENCY

In establishing a case management and home health agency, "creating a business plan should be the first move. Just as in case management, the strategy is to gather all the necessary information, evaluate the situation, and identify the steps that will ensure a successful outcome" (Mullahy 288). A case management and home healthcare agency's business plan holds the secret to success the way a hieroglyph holds the key to a prehistoric civilization; once you understand the symbols, the story unfolds before you. A thorough business plan can provide insight on how to break the code. Similarly, a carefully thought out agenda can turn into a formidable business tool. The purpose of the business plan is to serve as a guidance tool for providing clear cut directions for the implementation of immediate, short and long term goals. In essence it serves as a checklist to indicate what needs to be done to actually start the case management and home healthcare agency. In addition, it allows the entrepreneur to monitor progress, identify problems/obstacles, and modify the plan as needed on an on-going basis.

The business plan should include several essential elements

pertinent to the establishment of the case management and home healthcare agency. These elements include the following: a description of services provided by the case management and home healthcare agency; goals, i.e., short-term versus long-term case management or both; the population served, inclusive of age specifications and whether frail older, disabled and/or medically complex, i.e., AIDS/HIV populations who will be served. In addition, it should include the location/geographical area to be served and the actual building/setting for the case management and home healthcare agency. In terms of financing the case management and home healthcare agency, careful attention must be given to the anticipated start-up costs and the source of funding for start-up. Many entrepreneurs consider applying for a small business loan at this time to help defray the cost of start up for several reasons. These reasons include: securing real estate property to serve as an office setting, purchasing office equipment/supplies, hiring staff, and compensating the staff until financially stable. Financial stability will be achieved when the Case Management and Home Healthcare Agency begins to receive reimbursement for the actual case management and home healthcare services provided. One would also need a financial plan for years one through five showing anticipated revenues and expenses.

Appendix E illustrates an example of the necessary information required in an application for an actual small business loan. Additional

consideration must also be given to the overall type of funding anticipated, i.e., for-profit versus not-for-profit, or publicly-funded versus privately-funded. Appendix F illustrates an example of one case management and home healthcare agency's Business Plan Worksheet. Equally important, the case management and home healthcare agency must identify customer values. In other words, the entrepreneur must ask the following questions: "Who is my customer? What does my customer value?" (Silverio). Similarly, the case management and home healthcare entrepreneur "must find a need and fill it" (Silverio).

When the author was in the process of establishing the case management and home healthcare agency careful consideration was given to the type of ownership that it would have as a business, i.e., sole proprietorship, partnership, or incorporation. In order to make an intelligent decision on the type of ownership, several key aspects were considered, i.e., short and long term goals, the number/type of staff members needed to provide effective case management and home healthcare services. The overall plan to provide high quality, state of the art and cost-effective health care was the key factor in determining the type of ownership best suited for the Case Management and Home Healthcare Agency. It is imperative to recognize the distinct differences in the type of ownership of a business. The type of ownership may play a significant role in determining the efficiency and effectiveness of case management and home healthcare services delivered. A sole proprietorship is the least complicated and least

costly way to establish a case management and home healthcare agency. With sole proprietorship, the company is totally dependent upon the owner for ideas, growth, progress and delivery of case management and home healthcare services. A partnership occurs when there are two or more entrepreneurs forming the case management and home healthcare agency. The legal fees are more expensive for setting up a partnership but are less expensive than being under sole proprietorship. Advantages of a partnership include peer/colleague support, more capital for growth, and more ideas regarding how to make the case management and home healthcare deliver quality cost-effective services. In addition there is more of a knowledge base for forming a reference pool to provide increased information on the accessibility of appropriate and available resources. Lastly, the ability to serve as a catalyst and advocate for more clients is enhanced, allowing for an overall increase in contributions to the delivery of quality, cost-effective health care.

A corporation is more complicated and more costly than the other two previously mentioned types of ownership options. Corporations have boards, shareholders, and shared responsibility for the case management and home health incorporation. The advantages of being a corporation are the same as with having a partnership. As Gwen Ellis emphatically points out: "the greatest advantage is that the shareholders can avoid double taxation at both corporate and shareholder levels" (33). The disadvantages include, more individuals to participate in the decision/policy making process and to keep

informed of decisions/policies, more schedules to coordinate with for business/board meetings and the case management and home healthcare agency's financial status.

The state of Missouri mandates two distinct licensing requirements for operating a case management and home healthcare agency. Appendix G provides an example of a Merchant's Licensing Application and Business Personal Property Registration. This application can be obtained from ones' city/county's Department of Revenue - Division of Assessment. The entrepreneur must also complete an application which provides the name of the business and type of ownership, it is called the "Registration of Fictitious Name". Appendix H illustrates an example of this particular application and can be obtained from the Secretary of State, Corporate Division. In addition, the entrepreneur must contact the Missouri Department of Social Services Division of Aging to obtain an application and specific licensing requirements for operating a home healthcare agency as mandated by the state of Missouri.

Advice is a commodity seldom in short supply. The challenge however, lies in identifying appropriate sources who are capable of offering business advice that is worthwhile to the successful operation of a case management and home healthcare agency. "It is wise to seek the advice of a tax attorney in the beginning of establishing ones' case management and home healthcare agency. An attorney will guide ones' decision about what legal form his or her company should take" (Ellis 33).

The case management and home healthcare agency frequently referred to in this culminating project was best suited for a corporate structure. The decision was based upon the number and type of professionals who expressed a sincere interest in ownership as a means of providing high quality, cost-effective health care as a solution to the current shift of focus in health care delivery. Currently, the professionals interested in forming a corporation for ownership in the Case Management and Home Healthcare Agency include one registered nurse, one professional accountant, one administrative secretary, one marketing expert/real estate agent and one physician. In addition to the registered nurse interested in ownership, three additional registered nurses have expressed a profound desire to be employed by the Case Management and Home Healthcare Agency as case managers. The confirmation of the type of ownership was established in its' first official board meeting conducted in July, 1996. In addition, the Case Management and Home Healthcare Agency's real estate property was secured. Appendix I illustrates a sample indicating Articles of Incorporation for a case management and home healthcare agency. It depicts the individuals who are appointed to act as the initial directors of the agency and the total number of shares authorized to be issued.

In addition to a tax attorney, the establishment of a case management and home healthcare agency calls for health care professionals to have their own legal counsel in matters pertaining to its daily operations. Serious problems can result when there are no legal

provisions to address the establishment and operation of a case management and home healthcare agency. A vast majority of these problems can be mitigated if not solved by clarifications of the law. Indeed, there are laws governing the establishment of a case management and home healthcare agency. Laws on the establishment of a case management and home healthcare agency and related matters such as the legal requirements for establishing a healthcare agency enacted by the government, the site of much research in this area, are informative. The law provides that the aforementioned requirements for licensing are met prior to operating any type of case management and home healthcare business. As discussed in Chapter Two, one must also adhere to governmentally-imposed regulations for receiving Medicare and Medicaid reimbursement.

Common pitfalls/mistakes to avoid in ones' business plan are succinctly pointed out as follow: (1) "failure to plan your work - you need a business plan - a *road map* - as you integrate all the little bits and pieces of your ideas, aspirations and dreams" (Ellis 40). More importantly, "a plan helps you put the puzzle pieces together. Without a plan, you have no direction and you probably won't achieve what you set out to do...just remember, some people spend more time planning their vacation than they do their business " (40); (2) failure to implement the plan that one has developed for establishing the case management and home healthcare agency; (3) failure to organize ones' financial records with their board members/accountant; (4) failure to seek professional help, i.e. tax attorney and professional colleagues

for advice, guidance or successfully alleviating barriers/obstacles; and, (5) "failure to acknowledge and implement regulatory requirements" (Mark).

It is good to have an excellent and thorough business plan. "You will never be sorry you took the time to think through a plan carefully for your business" (Ellis 40). In addition, "this plan will become a beacon in dark times and a milestone in good times. If you think you're ready to plunge into a business without giving it much thought, slow down, count the cost, estimate the profit and then go forward" (40).

The success of the case management and home health business plan will be demonstrated by feasible and cost-effective business plan components. The business plan components are the actual constructs being examined and are identified as follows: marketing, management, operations, human resource, and financial/accounting plan. The scientific method will be used to empirically test the constructs through evaluation by three subject matter experts. Each of the business plan components will be explored in the pages to follow.

Executive Summary

--Vision/Mission

In 1996, the Case Management and Home Healthcare Agency was established to fill the needs of the community by providing a variety of case management and home healthcare services. Similarly, the agency is established to offer clientele a solution to quality, accessible, and cost-effective health care. The founders also recognized the

advantages of combining a case management and home healthcare agency in a state of the art facility, under one governing body. The agency's goal and mission is to be the leader in case management and home healthcare services and the home health industry. The Case Management and Home Healthcare Agency will achieve its goal and mission by providing the optimum and appropriate level of care for ensuring the delivery of quality, accessible, and cost-effective health care services.

--Present Situation

The Case Management and Home Healthcare Agency is in the formative stages of development. At present the agency plans to provide case management and home healthcare services to clients beginning 3 August 1998, and is currently encouraged by numerous home healthcare requests and six pending referral contracts for the 1999 fiscal year. Once capital is obtained from small business loans, investments, and pending grant money, the Case Management and Home Healthcare Agency will move forward with full scale operations to accommodate larger numbers of case management and home healthcare clientele. Meanwhile, the agency will continue to provide case management and home healthcare services to the aforementioned clients and continue actively pursuing the capital necessary to meet company goals.

--Company

The Case Management and Home Healthcare Agency was founded in 1996 based on the recognition that there is a need for comprehensive, quality, accessible, and cost-effective case management and home healthcare services in the Midwestern region. Whether case management and home healthcare services are being provided to health care consumers, the ultimate goal is to provide the most optimum and appropriate level of care in order to ensure the delivery of quality, accessible, and cost-effective health care services. In addition, the Agency's goal is to provide patient and physician satisfaction. The Case Management and Home Healthcare Agency is dedicated to the health, welfare, education, and good of the public. Through training, seminars, and home healthcare visits, the Case Management and Home Healthcare Agency will help perpetuate the wellness of the community.

--Management

One of the strongest assets of the Case Management and Home Healthcare Agency is the depth of experience and education of its management team. The Case Management and Home Healthcare Agency has recruited recognized experts in the areas of case management and home healthcare, to guide and direct the programs for maximum benefit to the public and the company.

--Products and Services

The Case management and Home Healthcare Agency will provide health care services in three primary areas:

1. Case management and home healthcare services for the general public.

2. Provide clinical (on-site) training for schools, colleges and universities.

3. Provide continuing healthcare education for case management home healthcare professionals.

--Market Environment

The marketplace is undergoing rapid change to keep up with escalating health care costs and decreasing government expenditures for case management and home healthcare services. The Agency is poised to meet the governments' fiscal restructuring by combining a case management and home healthcare agency into one facility and providing private management for them. With a superior healthcare management staff, it is believed that the Case Management and Home Healthcare Agency is in a position to garner a large segment of the market in a metropolitan area of the Midwestern region. Additionally, the Case Management and Home Healthcare Agency believes it offers seminars which are appropriate for everyone over the age of twelve. Specifically, this would include the elderly, the health compromised, family members, and anyone who feels they currently or in the future may meet criteria for case management and home healthcare services.

--Pricing and Profitability

Many current providers of case management and home healthcare services have increased pricing due to limited access, federal budget cuts, and high demand for these services. The condition for case management and home healthcare services in one large Midwestern metropolitan area is fragmented and largely unstructured. Most case management and home healthcare services currently being provided are either funded by private investors or by federal, state, or local tax dollars administered through public entities. This Case Management and Home Healthcare Agency enters the market in a position to offer low to moderate competitive pricing. Prices will vary depending upon the specific product or service rendered. Table 3 illustrates common prices for case management and home healthcare services.

Table 3

Home Health Rates

Discipline	Charge Per Visit
Skilled Nursing	$105.00
Physical Therapy	$105.00
Occupational Therapy	$105.00
Speech Therapy	$105.00
Medical Social Worker	$145.00
Home Health Aide	$ 60.00

SOURCE: Hassler, Denny. "Charges for SSM-Operated Home Care Agencies." 3 Nov. 1995.

Presently case management and home healthcare services for the general public are available on a widespread basis; the paradox however, is that numerous health care consumers are unable to access quality and cost-effective healthcare services. Many case management and home healthcare services are provided as a sideline, i.e., hospitals that offer programs not only to increase their revenue but to public relations. In fact, the government is decreasing its funding for some healthcare services while attempting to generate interest among private organizations to continue with the services. Some hospitals and other privately run agencies are finding it difficult to provide case management and home healthcare services as a marketing tool due to the increase in health care costs and decreased revenues. With the Case Management and Home Healthcare Agency's expanded range of services, both the general-public and government alike will benefit from the agency's expertise and flexibility.

--Customers

Customers using the Case Management and Home Healthcare agency receive a full range of services. All of the clientele, due to the nature of their illness, require comprehensive case management home healthcare services which the agency provides. Not only does this indicate that a great number of the clientele will become long-lasting customers, but they too may recommend the agency to others within the community. The current customers are targeted to begin receiving

services on 3 August 1998 and are an excellent target group for new services offered by the case management and home healthcare agency.

--Distribution

The Case Management and Home Healthcare Agency is very flexible in its ability to meet the clients' needs. Currently the staff is able to take a comprehensive program and provide case management home healthcare services in the clients' home. Upon receipt of capital from a small business loan, investments, and pending grants the Case Management and Home Healthcare Agency will be able to offer services to a wider community.

--Financial Plan

The case management and home healthcare agency's objective, at this time is to propel the agency into a permanent market position. The agency feels that within 5 years the case management and home healthcare agency will be in a position to permanently endow itself so that the company can continue to provide service to the community into perpetuity (a more detailed discussion in the pages to follow).

--Capital Requirements

According to the opportunities and requirements for the Case Management and Home Healthcare Agency and based on what the Agency feels are sound business assumptions, the agency's initial capital requirements are for $150,000 by August 1998.

The agency anticipates a one time grant of $250,000 for initial funding, and revenues exceeding $1,000,000 per year over the next five years to permanently endow the agency for all fixed expenses and to maintain the services offered. All of the original funds would be for a state of the art facility, initial promotion, and day-to-day expenses.

Vision and Mission

--Vision

By 2000, the Case Management and Home Healthcare Agency will be a highly visible company known as one of the top public service case management and home healthcare agencies in the industry. The Case Management and Home Healthcare Agency will have developed a variety of new services with a successful marketing approach. The Case Management and Home Healthcare Agency anticipates sales exceeding $1,000,000 and actively promoting its programs into the local, bi-state (Missouri and Illinois), and international marketplace. With this innovative approach to case management and home healthcare service, the agency will be a trend setter, commended and admired as a model company for all others in the industry.

--Mission Statement

The mission of the case management and home healthcare agency is to provide quality, cost-effective case management services to individuals (clients) and families for the primary purpose of promoting,

maintaining or restoring health, or minimizing the effects of illness and disability in a home environment.

The Agency's Home Care Case Managers are dedicated to providing high quality case management services in multiple settings within the community such as an individual's residence, a hospital, a nursing home, and even an adult care center. However, the primary goal is maintenance of care in the home setting. The Case Management and Home Healthcare Agency recognizes that each new client comes to the agency with unique health care needs, and it is the responsibility of the agency to provide individualized services for each client honestly, accurately, and with integrity. The Case Management and Home Healthcare Agency is committed to providing quality and state of the art case management, consultation, consumer health education, and home health services in the community setting in accordance with high moral and ethical practice standards.

With unending commitment to this mission, the Case Management and Home Healthcare Agency will be known as a company that provides the healthcare services and training necessary to make this a healthier world and provide a service that will benefit the community at large. The Case Management and Home Healthcare Agency maintains that the promotion of health and wellness of the community, as well as caring for the sick, injured and disabled is the top priority. The population served will not be discriminated against on the basis of race, creed, religion, national origin, age, sex, physical or mental handicap, political belief, veteran status, or inability to pay for health services.

--Goals

In order for the Case Management and Home Health to meet its mission, the following primary strategic goals must be achieved:

1. Market: By January, 2000 the Case Management and Home Healthcare Agency will reach all of the Metropolitan market. The agency will have an active customer base of over 250 clients. To reach these customers the Agency will employ a full-time marketing and public relations manager. The Agency will expand marketing efforts to include a bi-state client base generating additional revenue.
2. Sales: By January, 2000 the Case Management and Home Healthcare Agency will be a leader in the case management and home healthcare fields.
3. With physicians, nurse practitioners and consultants being knowledgeable and supportive of the agency's products and company, the case management and home healthcare agency will continue to capture more of the market.

For 1999 total sales will exceed $1,000,000.

For 2000 total sales will exceed $2,000,000.

For 2001 total sales will exceed $2,500,000.

For 2002 total sales will exceed $3,000,000.

For 2003 total sales will exceed $3,500,000.

By the year 2003, the Case Management and Home Healthcare Agency will:

1. Be fully endowed for all operational expenses.
2. Have case management and home healthcare services paid for by endowed healthcare insurers.
3. Have 33.3% of all private case management and home healthcare service market in the St. Louis region.
4. Be an industry leader for case management and home health care services in the metropolitan area.
5. Market its case management and home healthcare services to the Bi-state area (Missouri and Illinois).
6. Have added cohesiveness to all case management and home healthcare service in the area through shared training and resources.
7. Employ 50 full time employees, as well as 75 part-time employees, giving the area an economic boost.
8. Employ the leading experts in their fields, and be recognized as such.
9. Compensate staff appropriately to retain them through retirement.

The management team of the Case Management and Home Healthcare Agency feel confident that the aforementioned goals can be reached. It is felt that the team approach along with the esprit de corps that is found in the Case Management and Home Healthcare Agency's

management team will enable the agency to meet and exceed the goals set.

Company Overview

--Company Name

The legal name of the corporation will be the surname of the original founder.

--Legal Form of the business

The legal form of the Case Management and Home Healthcare agency is a Not-For-Profit Corporation. The corporation was formed to perpetuate the health, welfare, education and good of the public.

--Business Location

The business office will be located (positioned) in a high consumer traffic area, and away from similar competitors. The agency will also be located on the main level which can be quickly assessed. The nature of the business allows the agency to provide case management and home healthcare services on-site, whether it is the client's home or a nursing home. Persons working on the implementation of the Case Management and Home Healthcare Agency business plan will work closely with referring physicians and nurse practitioners to educate all interested healthcare providers who may want to utilize the agency as part of their education program. Additionally, the Case Management and Home Healthcare Agency will work closely with schools, colleges,

and universities who may also desire to use the corporation as part of their education program.

--Government Regulations

Because the Case Management and Home Healthcare Agency is operating in the home healthcare industry, it is under the regulation of multiple licenser boards and governing bodies.

The case management and home healthcare services are all regulated by both federal and state authorities. The agency has obtained, or is working to obtain all federal and state permits, licenses, and bonds to operate its facilities. There can be no assurance that the Case Management and Home Healthcare Agency operation and profitability will not be subject to restrictive regulation, or increased taxation by federal, state, and local agencies; however, past trends in the industry allude to future changes.

All of the case management and home healthcare case managers are professional registered nurses licensed by the State of Missouri, with many of them having recognition in the nursing field. The Case Management and Home Healthcare Agency relishes a good working relationship with all government agencies with whom it interacts with.

--Management team

The Case Management and Home Healthcare Agency's management team consists of three persons whose backgrounds total forty-four years of marketing experience and thirty years of corporate

development with various healthcare agencies. The strength of the Case Management and Home Healthcare management team lies in their combined expertise in education, management skills, and clinical experience. It is anticipated that this combination will produce outstanding results in the forthcoming months. The three elected board officers maintain various positions. The positions are as follows: (1) President, who also serves as the secretary and a member of the Board of Directors; (2) Vice President, who also serves as the treasurer and member of the Board of Directors; and, (3) Controller, who is also a member of the Board of Directors. Appendix J illustrates a more detailed description of the controllers activities within the Case Management and Home Healthcare Agency.

In terms of responsibilities, the president performs the following tasks: (1) develops and maintains the vision of the corporation; (2) oversees marketing, new program development, finance, and customer service; (3) approves all financial obligations; seeks business opportunities and strategic alliances with other companies and organizations in accordance with board directives and the company charter; and, (4) directs and coordinates financial programs to provide funding for new or continuing operations in order to maximize return, and increase productivity.

The vice president is responsible for the following: (1) managing marketing planning, advertising, public relations, sales promotion, and facilitation of staff services; (2) identifies all new markets and market research; (3) oversees market research and analysis as well as

evaluation of competition; and, (4) identifies and sets strategies for reaching local and international markets.

The controller's responsibilities include the following: (1) directs financial affairs of the organization; (2) prepares financial analysis of operations for guidance of management; (3) prepares reports which outline the corporation's financial position in areas of income, expenses, and earnings, based on past, present, and future operations; (4) directs preparation of budgets and financial forecasts; (5) arranges for audits of corporate accounts; and, (6) oversees the day-to-day operations of the case management and home healthcare facility and its proper utilization.

The management team also provides tremendous support for management decisions and program creativity. The leadership and alignment characteristics of the management team have resulted in the establishment of broad and flexible goals designed to meet the ever-changing demands of the rapidly moving marketplace requiring the Agency's products. This is evident when the team responds to situations requiring new and innovative capabilities such as advanced medical technology. All of the areas within which the Agency operates are extremely dynamic and require a management team that can not only deliver quality, accessible, and cost-effective healthcare services, but have the ability to predict trends and act to treat them. The Case Management and Home Healthcare Agency has that team.

--Board of Directors

The Case Management and Home Healthcare Agency's Board of Directors which will include highly qualified business and industry professionals, will assist the management team in making appropriate decisions and taking the most appropriate action when guiding the future of the agency. However, the Board of Directors will not be responsible for management decisions that are made on a day-to-day basis.

Appendix K illustrates the organizational chart for the Case Management and Home Healthcare Agency. The organizational chart provides a brief overview of the Agency's organizational structure in terms of reporting relationships, working relationships, and the communication channels among departments. It also represents the chain of command for managerial decision making and problem solving techniques. The organizational structure for the Case Management and Home Healthcare Agency represents the traditional view of a hierarchy. The Board of Directors and the Medical Director reside at the top of the structure, with increasing numbers at each successive layer. "Employees at the lowest levels of the structure perform the actual day-to-day operations of the enterprise and report to supervisors. The supervisors oversee the activities of the low-level employees, reporting in turn to mid-level managers" (Cats-Baril and Thompson 87). The managers report to the administrative level. The administrative level is responsible for reporting to the Board of Directors. The Board of Directors is also called the Advisory Board.

Management Plan

The management plan includes the four essential elements of management. The elements are as follows: planning, organizing, control, and leadership. Additionally, the management plan includes the following: short and long term goals, proposed administrative salaries and bonuses, profit sharing plans, and other compensation arrangements (i.e. deferred compensation in terms of stock options). The management plan explicitly identifies the following: description of management (administrative) duties and responsibilities; management peer review; team building; policies and procedures guidelines; and professional support and resources outside the Case Management and Home Healthcare Agency (i.e., attorneys, field experts, and technical advisors).

As previously mentioned, the management process of the Case Management and Home Healthcare Agency will include the four basic functions of management, namely: planning, executing (or coordinating), controlling and decision making. In terms of managerial planning, the Agency's managers are given the task of creating department documents known as "management by objective". The management by objective involves drawing up strategic plans to assist in achieving the overall objectives of the agency. The managerial planning also involves "forecasting future events and conditions by which it will be affected and budgeting for each of its activities" (Granof, Bell and Neumann 717-18). For instance, forecasting future events includes budget planning for health fairs to target the geriatric

population during the "flu season" and administration of flu vaccines. The managers are responsible for ensuring that plans are executed when department plans are approved by administration. Managers ensure that plans are executed in the day-to-day operations for the purpose of meeting the Agency's objectives. The agency utilizes a combination of the rational and administrative model for decision making and problem solving. Although this may sound complex, the combination works very well. In terms of the rational approach, there is "centralized power, harmony and consistency of goals across boundaries, and members who are objective, fully informed, and inclined to choose alternatives that maximize the good of the organization" (Cats-Baril and Thompson 85). The Case Management and Home Healthcare Agency uses the administrative model of decision making for various reasons. For example, "when a decision has been reached and the solution to the problem implemented and found to be acceptable, then the organization institutionalizes the procedure used to solve the problem into a standard operating procedure (SOP) (Cats-Baril and Thompson 85). The SOPs serve as a standardized set of rules and routines that are to be executed for various situations and/or problems. The SOPs are advantageous because they allow more time for managers to complete job tasks without having to start from the very beginning each time a situation or problem arise. In addition, the agency's administrative written policy is given to each new employee when they are hired. The employees are

encouraged to request to receive an appointment with the administrator for problems that can not be solved at the mid-management level.

--Strategic Alliances

The Case Management and Home Healthcare Agency is forming essential relationships with current industry leaders in the case management and home healthcare fields. These relationships will continue to be positively reinforced over the next few years. With the uniqueness of the comprehensive services provided by the Case Management and Home Healthcare Agency, these relationships will grow and improve in each specific area of endeavor.

--Joint Marketing Ventures

Joint marketing with established companies will produce additional revenues, creditability, and market presence. The Case Management and Home Healthcare Agency will pursue joint marketing ventures with other organizations to further the name of the Case Management and Home Healthcare Agency's product/services in the local and state market.

Product Strategy

Proprietary information is available to investors upon signature of a Non-Disclosure Agreement. The Agency's principle product is comprehensive case management and home healthcare. The Case Management and Home Healthcare Agency currently offers, or will

soon offer a diverse product mix consisting of eighteen case management and/or home health care services and seventeen health care specialties. Development of new products or spin-off products are planned for the future. A complete list of services includes, but is not limited to: comprehensive case management, home visits, free home healthcare assessments, AIDS/HIV care, cancer/oncology care, cardiac care, diabetic care, geriatric care, high-risk pregnancy services, home nursing care for the hearing/speech impaired, hospice care, pain management, pediatric care, renal care, respite care, ostomy management, and wound management. Health care specialties include, but are not limited to: registered nurses, case managers, licensed practical nurses, medical social worker, sign language interpreter, speech/language pathologist, respiratory therapists, physical therapists, occupational therapists, nursing assistants, certified home health/home care aides, personal care aides, homemakers, live-ins, companions, health education for clients and families, and CPR (Cardiopulmonary Resuscitation) for clients and families in the home setting. CPR training is provided through our affiliation and pending partnership with a locally established corporation. In addition to above services, there will be a weight and blood pressure machine available in the main lobby at no cost for consumer use (anonymous interview #1).

It is anticipated that the "cash cows" (substantial revenue) for the Case Management and Home Healthcare Agency will come from case management and home healthcare services provided to geriatric patients and AIDS/HIV patients.

--Proprietary Technology

Many of the case management and home healthcare services and opportunities include information that is not proprietary in nature, rather it is the agency's unique approach in the comprehensive delivery of the services that sets the agency apart. By combining different health care services and its entities into one facility, the Case Management and Home Healthcare Agency has created a unique organization that will be a trend setter in the coming years.

--Product Life Cycles

Case management and home healthcare employees are a unique group of individuals who participate in a thorough education to acquire licensing and certification to deliver healthcare services. However, this is just the beginning as all of these professionals require ongoing education whether it be re-certification every few years or continuing case management and home healthcare education. The Case Management and Home Healthcare Agency's commitment to education and the delivery of quality, accessible, and cost-effective health care results in endless opportunities to continue teaching these professionals, and the delivery of health care services to the community at large.

The case management and home healthcare portion of the business is a community necessity. There will always be sick, injured and disabled clients, and an ongoing need for trained personnel who can treat those persons. The role of the case management and home

healthcare provider has grown over the past few years; and, with health care trends leaning toward more community-based medical care systems, the case management and home healthcare providers' role will only continue to expand.

Overall, the Case Management and Home Healthcare Agency concludes that case management and home healthcare will continue to be viable in the marketplace. The Case Management and Home Healthcare Agency's future planning and activities will seek to ensure a strong market presence. The uniqueness of the comprehensive services, exceptional management, and the best employees will assure the Case Management and Home Healthcare Agency major share of a market that will continue to expand.

--Research and Development

The Case Management and Home Healthcare Agency has expended a tremendous amount of time and effort these past fourteen months on research and development. During the first nine months, the Case Management and Home Healthcare Agency spent most of its time putting together comprehensive programs, consultants, and resources that have made the company possible. The plans for 1998 and beyond call for an increase in research and development. The purpose is to identify and develop new and related services in order to increase the Case Management and Home Healthcare Agency's market share.

--Customers Return on Investment

For most customers, the Case Management and Home Healthcare Agency's products will pay for itself in terms of returned investment within the first one to two months. The aforementioned returned investments are attributed to the inexpensive and competitive pricing of the case management and home healthcare services, and assistance in the prevention of premature or extended hospital stays.

Regarding cost savings, the Case Management and Home Healthcare Agency will offer services at reduced pricing in part due to reduced overhead. By combining case management, home healthcare, and education entities, the cost savings will be multiplied. As a not-for-profit organization that is endowed, part of the fixed cost of overhead is absorbed in the initial grant capital and future grants.

--Useful Features/Benefits

All products/services offered by the Case Management and Home Healthcare Agency have unique characteristics that are not enjoyed by other organizations that provide similar services. The Case Management and Home Healthcare Agency utilizes the best healthcare professionals in each of the service fields offered. The capability of the healthcare professionals to reach a varied and diverse community is a particularly unique feature enjoyed by the Case Management and Home Healthcare Agency and its customers. Because the healthcare professionals and paraprofessionals have years of clinical as well as practical experience, the clients receive quality, accessible, and cost-

effective case management and home healthcare services, not just health care.

The Case Management and Home Healthcare Agency regularly examines roles that new products and services will play in the growth of the company. In order to promote the speed and effectiveness of future new product development efforts, the Case Management and Home Healthcare Agency is committed to the following: (1) exploring the continually changing roles of the case management and home healthcare industry; (2) leading the industry by offering comprehensive case management and home healthcare services that are innovative and trend setting; and, (3) utilizing all possible new technology to aid in teaching healthcare personnel, clients, and family members; and, most important - quality, cost-effective treatment of clients.

These commitments will span over the longevity of the corporation and will allow the Case Management and Home Healthcare Agency to remain on the leading edge of the industry, which is vital to continued success.

--Testing

Case management and home healthcare products/services, both pre-existing and new markets will continuously be tested and evaluated to determine their viability and cost-effectiveness.

--Product Selection Criteria

Because marketing is a vital component of the Case Management and Home Healthcare Agency, focus on the customer is extremely essential. By continuously offering current customers new products and services, it is believed longer customer retention can be achieved, in return reducing the cost of new advertising. Wise product and service selection is therefore critical to the Case Management and Home Healthcare Agency.

The Case Management and Home Healthcare Agency recognizes that the cost of new products and service development is expensive. To assure the best possible product decisions, the Case Management and Home Healthcare Agency will implement the following criteria for evaluating and selecting products: (1) the Case Management and Home Healthcare Agency will provide products and services to assist customers by promoting, maintaining or restoring health or minimizing the effects of illness and disability in a home environment. It is anticipated that these services will reduce time, effort, and expense for the customer, and help to maintain wellness for the community at large; (2) an estimation of the potential market, how they can be reached, and the possible benefits to the customer and to the Case Management and Home Healthcare Agency; (3) benefits versus profitability of case management and home healthcare seminars; (4) review of new and existing government programs and laws to determine the impact on new products; and, (5) requests for service and products by the customer.

The Case Management and Home Healthcare Agency believes in its philosophy that products and services must be constantly improved in order to maintain its competitive position, market value, and price point. The Case Management and Home Healthcare Agency must maintain the ability to adapt as the environment, customer needs, and agency capabilities change.

--Costs

In comparison to other companies, the Case Management and Home Healthcare Agency products/services are economical, and exceed the quality of many competitors.

--Product Fulfillment

Product fulfillment is an essential component of customer satisfaction. The Case Management and Home Healthcare Agency will utilize a quality assurance program to monitor and manage the delivery of services to ensure customer satisfaction and repeated sales.

Marketing Research-Marketing Analysis

--Industry Analysis

The case management and home healthcare market is growing at a rapid rate. The Health Care Financing Administration (HCFA) has projected that the market for these products/services will be $60 billion in 2000 representing a 328% growth from the $14 billion in 1986 (Hilgendorf 32Q).

Referenced sources contend that the major trend is for continued expansion of this industry. The area of greatest growth in the case management and home healthcare market is in the area of expanded and consolidated services demonstrating cost-effectiveness.

--Market Segment

A key factor in defining the market segment for case management and home healthcare is understanding the competition and the geographical boundaries that come into play in the case management and home health care industry. Currently, the marketplace is shared by 138 case management and home healthcare agencies in the metropolitan area (anonymous interview #).

Users of case management and home healthcare services are looking for quality and productivity improvements. Current developments in the industry have resulted in the need to change the way health care is delivered. This innovative new approach of delivering case management and home healthcare involves combining several comprehensive programs as a unique concept that will save thousands of dollars, which then can be passed on to the consumer.

The stability of the case management and home health care market is solid, based on the history of the industry and performance over the past two years. In the next two years and beyond, the industry will continue to grow.

Over the past ten years similar service provider companies have proven that meaningful markets exist for case management and home

healthcare products/services. These companies have primarily focused on the use of marketing to improve the bottom line on their balance sheets. These products have been successful in many areas of the country. Competitive products in this market are provided by major hospitals in the case management and home healthcare market. Additional competitive products/services stem from privately owned organizations.

Approximately 100% of homebound healthcare customers will need and purchase case management and home healthcare services following an illness, injury, or disability. At present a vast number of companies in this area are seeing an increase in the number of customers who require services.

--Strengths

In terms of strength, the Case Management and Home Healthcare Agency has several distinct advantages over competition. First, is its cost savings over other services being offered in the area. In the case management arena, the strength will be the agency's ability to capture the market with a higher quality of service at an equal or lower cost than the competitors.

By utilizing the highest caliber of healthcare professionals and compensating them accordingly, it is anticipated that Case Management and Home Healthcare Agency will have one of the finest organizations in the area. The strategy is to employ only experienced healthcare professionals with a proven track record and compensate

them appropriately. In addition, these healthcare professionals will be given a work environment that will facilitate pride in the company.

In marketing, the most powerful asset are the Case Management and Home Healthcare Agency's staff. The management team is professional and possesses years of expertise. The healthcare professionals are second to none. The overall work environment is one of utmost professionalism.

In terms of the corporate arena, the Case Management and Home Healthcare Agency will be supported by a strong financial base, including an excellent facility. The Case Management and Home Healthcare Agency will also be supported by a Board of Directors that can assist the agency to continue to be a leader in the industry well into the twenty-first century. The reputation that will be maintained in the business will be one of total professionalism. The Case Management and Home Healthcare Agency recognizes that its customers will always have the choice, and the only way the agency will be selected over those competitors is by catering to the individualized needs of each of those consumers.

--Weaknesses

The only notable marketplace disadvantage is that the Case Management and Home Healthcare Agency is a new corporation in the midst of keen competition. It will require some aggressive marketing and an explicit marketing plan to capture the market share that is felt to exist for the agency. Corporate weaknesses, at this time, consist only

of the need for several major corporate contributors. However, steps are being taken to address this problem.

--Opportunities

The potential for the Case Management and Home Healthcare Agency and its products in the market over the next two years is staggering. Based on existing conditions introduced in the Product Strategy section in the analysis above, it would appear that the market is wide open for a professionally run case management and home healthcare agency. A healthcare institution such as the Case Management and Home Healthcare Agency should easily capture the market in this area and will be looking at local and bi-state expansion toward the end of its first five years.

--Unexploited Opportunities

An altogether new application for this product would be entering the international market. At this time no one is addressing the need of case management and home healthcare services for third world countries. The Case Management and Home Healthcare Agency will be in the perfect position to provide both case management and home healthcare services to these third world countries. The cost to begin marketing in this new area should be minimal in relation to the large amount of income that may be generated by this new area.

--Customer Profile

The typical customer for case management and home healthcare services is someone who is homebound as a result of an illness, injury, or disability. Examples are the geriatric and/or AIDS/HIV clients. Quite frequently these would be individuals living in the community, senior citizen/retirement centers, and those without an informal caregiver system. The general public and industry will be part of the market.

The potential segment includes all users of home healthcare services. This is evidenced by the increased demand seen. As mentioned earlier, some nine to eleven million persons are in need of home healthcare. The strategic plan for meeting this increased demand will be achieved through advertisement strategies, and by establishing a reputation of providing quality, accessible, and cost-effective healthcare services. It is likely that potential customers are going to be familiar with similar products, and that they will readily accept the new service, provided that the Case Management and Home Healthcare Agency educates them on the advantages and cost savings that are offered.

The demographic segment consist of any citizen and population within the following geographical areas: Saint Louis City, Saint Louis County and Saint Charles County. The population density is greater in the inner city or metropolitan area. Future demographics will include the aforementioned geographical areas, and the bi-state (Missouri and Illinois) area as well.

An example of weaknesses perceived by some include competitors who appear rushed for time when making home visits, and high healthcare costs. Cost containment and the finest healthcare personnel can put us far ahead of the competitors.

--Observations and Conclusions

It would appear from the aforementioned information, that the Case Management and Home Healthcare Agency can become an industry leader. Much of the resources and data that has been utilized for comparison have come from competitors and their clients.

Marketing Plan

The Case Management and Home Healthcare Agency's marketing strategy is to enhance, promote and support the fact that the agency offers products that are the highest quality available in the industry. Additionally, the Agency's product/services are priced lower than competitors, and simultaneously offer a higher level of patient-physician satisfaction.

The overall marketing plan is based on the following fundamentals:

- That the Case Management and Home Healthcare Agency is in the health service and health education business.
- That the Case Management and Home Healthcare Agency plans to reach all case management and home healthcare clients and future clients in the area.

- Distribution channels to be used to reach the market segment include: professional client representatives, mailers, trade journals, extensive area advertising, and word of mouth among the area clients that are served.

To prove the value of each of the products offered, the Case Management and Home Healthcare Agency can show what services puts the Agency ahead of competition.

--Sales Strategy

The case management and home healthcare product should be treated as a long-term product. The home healthcare industry is an ever-expanding field. With much of the emphasis being placed on little or no hospital stay, case management and home health is the area where growth will continue at a dizzying pace. The trends are for patients to be treated in the home environment and significantly shorten hospital lengths of stay if possible. The population is currently living longer and increasing in numbers. There will always be a need for a professionally operated case management and home healthcare agency that can stay ahead of trends, and service its clientele appropriately.

Likewise, industrial education is essential to staying within OSHA (Occupational Safety and Health Administration) code. OSHA requirements for operating a Case Management and Home Healthcare Agency mandate that employees adhere to federal regulations governing the safety and health standards of the job. For instance, proper techniques for handling body fluids are addressed in OSHA regulations. Additionally, continuing case management and home

healthcare education is essential to the continued certification of those professionals, as well as staying abreast of new trends in the industry.

As such, the target market segments to focus on initially are the increasing elderly population, high-risks populations such as AIDS/HIV patients, high-risk pregnancies, and those patients with catastrophic illnesses. The target market will expand rapidly to include the industry and general public. Because of the product's special market characteristics as mentioned in the Market Analysis, the sales strategy includes the following:

- Providing health care consumers an easy way of meeting their case management and home healthcare needs and market it to them personally.
- Customer service representatives who will target customers to market products directly to the customer, i.e., senior citizen/retirement communities. The flexibility to market not only home healthcare services to them, but to also meet all of their needs for minimizing the effects of illness will assist the agency in becoming a leader in the industry.
- Entering the industry with a new approach. By packaging comprehensive programs for case management and home healthcare and health education together, the Case Management and Home Healthcare Agency can effectively lower the cost and provide more quality services for the same services if they were provided separately.
- Increase public awareness of the need for not only case management and home healthcare services, but emphasize the need for quality, accessible and cost-effective health care services. Additionally, the Case Management and Home Healthcare Agency

plans to make the public more aware of many other services that the agency offers, such as preventative and wellness programs.

--Positioning

A large number of consumers view the competition's product as being profit oriented due to the vast numbers of corners cut. With the agency's focus being on quality, accessibility, and cost-effectiveness not profit, the agency will be able to outperform the competition - not only in the competitive arena but also on the balance sheet as well. This unique advantage can be exploited to arrive at a winning position in the healthcare consumer's mind.

Perceptions regarding the Case Management and Home Healthcare Agency can be looked at from a three-fold perspective. There are internal corporate perceptions, external perceptions and consumer perceptions regarding the agency. The internal perceptions include: there is currently much debate over issues concerning the increasing incidents of Medicare fraud in the home health industry. In an attempt to reduce Medicare fraud, President Clinton's fiscal policy includes a proposal for a six-month moratorium on certifying new home healthcare agencies. In addition, the incidence of "me too" products within the industry are significantly increasing. The high incidence of "me too" products are frequently viewed as an external threat and lead to keener competition (anonymous interview #1). Secondly, case management and home health care industry critics are not thoroughly convinced that health care professionals, providers, insurance companies, and investors are providing fiscal, ethical and social

responsibility. Thirdly, case management and home healthcare services are receiving increasing recognition from health care consumers. Based on these perceptions, it is evident that change is indicated. The Case Management and Home Healthcare Agency will allocate resources within the agency specifically for consumer health education programs. These programs include, but are not limited to: disease prevention, wellness, and the physiological impacts of disease processes. Each program will based on a holistic approach. The explicit marketing plan will serve as a tool to address keen competition.

The general decision process is that consumers are demanding improved quality, accessibility, and cost-effective health care services. Similarly, some are basing their purchasing decision on quality, accessibility, and cost-effectiveness. However four major influences are identified. They include: (1) economic difficulties are leading to a decline in health care. For instance, thirty seven million Americans are uninsured and many millions more are underinsured; (2) physicians are sometimes reluctant to prescribe case management and home health care services; (3) a vast number of health care consumers rely on the health care professional for recommendations for case management and home health care services. Therefore, it may appear that health care professionals have the most influence regarding consumer access to quality and cost-effective case management and home health services; and, (4) although hospitals and other health care providers offer case management and home health care services to their clientele, many are

frequently overworked, understaffed, and have had to downsize or reengineer their organizations as a result of federal budget cuts and escalating health care costs.

It is easy to understand why the people are motivated to purchase the case management and home healthcare services because they are needed to maintain health; or, in many cases - prolong life. In the home healthcare industry, people will be motivated to utilize the services offered over competition because of the professionalism, cost savings, individualized treatment plans; and all of the home healthcare entities staffed by a professional home healthcare registered nurse.

The resulting Selling Basis for the agency's product then, is that the Case Management and Home Healthcare Agency has superior products that will be offered at a substantial savings over the competitors.

--Pricing

The prices for the case management and home healthcare services are determined first and foremost by the Case Management and Home Healthcare Agency's fixed cost and the cost of any shared overhead. Additionally it is imperative to know that competitive pricing is essential to the Case Management and Home Healthcare Agency's market profile. Compared to the competition the Case Management and Home Healthcare Agency prices are much lower in most product areas and at least fifteen to twenty percent lower in other areas where it is difficult to price the products any lower and still maintain the quality that the agency demands.

The Case Management and Home Healthcare Agency plans to review the pricing and marketing strategy at least every six months to help ensure the agency's share of the market as well as to make adjustments based on the continually changing trends of the business.

--Current Selling Methods

The Case Management and Home Healthcare Agency currently uses informational literature, word of mouth and direct calling as the primary forms of selling products. A brochure has also been produced. A mailing list is being generated to target each of the specific areas to which the agency offer services. Print ads will be addressed as the agency expand its services, as well as the various radio and television advertising that is available for a not-for-profit corporation such as the case management and home health care agency.

The Case Management and Home Healthcare Agency also plans to market (promote) the case management and health care services through information packets consisting of letters and pamphlets to physicians, nurse practitioners, schools, and health care consumers. The Case Management and Home Healthcare Agency plans to reach healthcare consumers through community mailings, bulletins, flyers, and health fairs. In addition, the Case Management and Home Healthcare Agency plans to market its grand opening by way of an open house in August 1998.

--Marketing Responsibilities

The original marketing will be conducted by a Marketing and Public Relations Manager. This person will be responsible for the continuing marketing and advertising aspects of the company. This will include budgets for the marketing department and its continued corporate growth.

--Next Steps

Based on the strategic plan, present decisions that must be made include how much to budget for each of the areas that the Case Management and Home Healthcare Agency is currently concentrating on.

The information needed to make those decisions is the market analysis that has already been done and the research that has been completed. The completed research include portions of the market into which it will be the easiest to move. The key decisions to be made in the near term or next six months are to evaluate how much of the market share the agency has acquired and what needs to be done to increase that share. The information needed to make both of these decisions with confidence includes research that has already been done, as well as future market analysis.

--Distribution Channels

The marketing department of the Case Management and Home Healthcare Agency plans to sell its products through several channels.

The determining factor in selecting these channels is the customer profiles that have been developed for each of the services that the agency provides. The Case Management and Home Healthcare Agency look forward to serving the metropolitan area and adjacent counties for case management and home healthcare services.

Key competition uses the same distribution channels. The Case Management and Home Healthcare Agency's mix of distribution channels will give the agency the advantages over competition. A partial list of the Case Management and Home Healthcare Agency's major customers include: physicians, nurse practitioners, discharge planners, three community colleges, two universities, and five senior citizen/retirement centers.

--Direct sales

The majority of the Case Management and Home Healthcare Agency sales will be handled internally through direct sales by the agency's staff. The Case Management and Home Healthcare Agency anticipates hiring two additional sales representative to market its services. The Case Management and Home Healthcare Agency has chosen to utilize a direct sales force because its products require considerable individualized consumer health care. The Case Management and Home Healthcare Agency's price point, pricing structure, and profits are such that its costs of sales warrants "person-to-person" selling strategy.

--Direct Response Mail

The Case Management and Home Healthcare Agency will be exploring the benefits of incremental, coordinated direct mail programs in the first quarter of 1999. The Case Management and Home Healthcare Agency anticipates a strong profit potential as it strengthens its direct caregiving capabilities. The Case Management and Home Healthcare Agency will be approaching this scientifically, as it improves its customer targeting ability. The agency proposes two 10,000 piece campaigns, each preceded by a 500 piece test.

--International Market

It is imperative to consider worldwide opportunities from the start. In the third year, the Case Management and Home Healthcare Agency goal will be to market internationally. The target will be primarily third world countries who have little to no case management and home healthcare services. By targeting these countries prospective clients can be brought into the country and put through several areas of the agency's training, such as with the training offered to health care management students at one local university. By using this approach the Case Management and Home Healthcare Agency can offer these countries the ability to increase the level of care. By cross training each of the students, they will have the ability to leave as certified home healthcare aides, case managers and home healthcare personnel.

--Customer Service

The case management and home healthcare customers emphasize that service and support are their major concerns. They are constantly impressed with the support that the agency provides. Service is currently available to all customers enrolled in the Case Management and Home Healthcare Agency. One major purpose of this service is to assure customer satisfaction and loyalty, thus allowing the Case Management and Home Healthcare Agency to increase sales as well as maintain a high profile within its service area.

Another service which adds value is to provide a full list of future case management and home healthcare services to clients and if requested, keep track of their healthcare service hours and how many more are predicted prior to being discharged from needed services.

Technical support to marketing and sales functions will be strengthened. Pre- and post-sales situations involving the application, delivery, and demonstration of services will be supported by the sales staff. It is the agency's goal that all of its sales personnel be certified in the services they are selling.

--Advertising and Promotion

The Case Management and Home Healthcare Agency recognizes the key to success at this time requires extensive promotion. This must be done aggressively on a wide scale. To accomplish its sales goals, the Case Management and Home Healthcare Agency requires an extremely capable advertising and public relations person. The Case

Management and Home Healthcare Agency plans to advertise in local and community newspapers, and later in major healthcare magazines such as The American Journal of Nursing, RN, and HT: The Magazine for Healthcare Travel Professionals.

--Objectives for Advertising and Promotion

The Case Management and Home Healthcare Agency has the following objectives:

- Position the Case Management and Home Healthcare Agency as the leader in the market.
- Increase company awareness and name recognition among healthcare professionals and customers.
- Generate qualified sales leads and potential new areas for field sales.
- Develop through market research significant information to create immediate and long-term marketing plans.
- Create product advertising programs supporting the quality of the agency's programs as well as its pricing.
- Coordinates sales literature, healthcare delivery materials, telemarketing programs, and direct response promotions in order to strengthen its share of the market.

--Media Objectives

Media objectives for the Case Management and Home Healthcare Agency include the following:

- Gain awareness of company among industry groups, case management and home healthcare buyers, and customers.
- Establish an image of the Case Management and Home Healthcare Agency as an organization that is professional, completely reliable, and highly positioned in the market.
- Maximize efficiency in selection and scheduling of published ads in publications to cover all of the markets the agency are attempting to reach.

--Media Strategy

The following elements are included in the Case Management and Home Healthcare Agency's media strategy:

- Select primary business publications with high market penetration.
- Schedule adequate frequency of ads to impact market with corporate image and product messages.
- Where possible, position advertising in or near articles on industry, and appropriate editorials.
- Utilize U.S. editions of trade publications.
- Take advantage of special high-interest issues of major publications when possible.

- Maximize ad life with monthly and weekly publications like the Journal publications. The Case Management and Home Healthcare Agency will develop an advertising campaign built around competitive advantages and professionalism, beginning with a "who we are" statement and supporting it with ads that reinforce the quality and economy message. Additionally, the Case Management and home healthcare agency will develop a consistent and frequent reach for health care consumers and healthcare professionals throughout the year.

--Advertising Campaign

The best way to reach potential case management and home healthcare customers is to develop an exquisite advertising campaign promoting the agency's basic premise - "quality and professionalism need not be cost forbidden". To establish the Case Management and Home Healthcare Agency's image, the delivery and tone of the Case Management and Home Healthcare Agency's statements will be excellence in quality healthcare delivery at a reasonable cost.

Ads will convey the appearance and feel of a company committed to its clientele. Research has shown that television, radio, and newspaper ads have been used by competitors. Therefore, it is imperative to convey the uniqueness of the Case Management and Home Healthcare Agency's commitment to healthcare consumers. The consumer mindset, as described in Marketing Strategies is one that is looking for the highest level of quality services without increasing the cost. Ideally, after becoming familiar with the agency's products, the consumer will be able to call on a local telephone number or 800 number to obtain additional information about services. Once that

initial contact is made, these persons will be added to the agency's data base or updated based upon that request and followed by the Case Management and Home Healthcare Agency sales staff.

Accordingly, the Case Management and Home Healthcare Agency has created a system of research and response to insure the maximum benefit from advertising dollars.

--Promotion

In addition to standard advertising practices, the Case Management and Home Healthcare Agency will gain considerable recognition through press releases. Many of these releases will be with prominent political figures and healthcare professionals. Many of the areas of services the agency are involved in and the nature of its commitment to the public will make it easy for the company to obtain press.

The number of trade shows attended will be increased from 0 to 2 or 3 each year. These shows will be attended independently with companies with which the Case Management and Home Healthcare Agency has joint marketing agreements. Reports and papers will be published for trade journals and all professional conferences. Health care consumers will be encouraged to call the Case Management and Home Healthcare Age 800 number.

--Direct Mail

In addition to using direct mail to distribute case management and home healthcare services, the Case Management and Home Healthcare

Agency will exercise direct customer communications through information updates, and the development of a quarterly newsletter for the staff and health care consumers.

--List Management

Given the growth potential of the Case Management and Home Healthcare Agency's potential customer pool, the Case Management and Home Healthcare Agency is currently building capabilities in database marketing. The Case Management and Home Healthcare Agency's registration files and periodic customer surveys will assist the Case Management and Home Healthcare Agency in understanding consumers, and measuring the success of the Case Management and Home Healthcare Agency's marketing, sales and product activities. Profile overlays or other lists that the agency purchases will fill in company awareness gaps. This in-house presence will provide the Case Management and Home Healthcare Agency's sales and technological support teams with tools that streamline operations, while they update the Case Management and Home Healthcare Agency's customer knowledge on a daily basis. The agency plans to develop a customer information system that will aid the Case Management and Home Healthcare agency in making sound decisions by providing historical answers to the marketing questions the agency pose. The agency will implement multiple critical components relating to the Case Management and Home Healthcare Agency's information management and technology systems. These components include, but

are not limited to: network configuration, hardware, software, and global communication, i.e., the world wide web and desktop conferencing. When computer accessibility to other remote sites is established, the company's initial plan is to extend the case management and home healthcare services to clients in the bi-state area.

The Case Management and Home Healthcare Agency will implement several programs to address the health care needs of indigent patients. The Case Management and Home Healthcare Agency will utilize a telephone triage system as one way to meet these needs. When the patient who is already within the system calls with a health concern, they are guided to assistance from a case manager who is also a registered nurse and home health clinical specialist. The case manager provides the patient with the most appropriate health care information, and/or the patient is given the appropriate resource referral. The patient is also scheduled for a home health follow-up visit from his or her regularly assigned case manager based upon the determination of need. Likewise, the patient's case manager is given a written account of the call. It is anticipated that this service will decrease the number of inappropriate emergency room visits, thereby decreasing health care costs (anonymous interview #1).

--Advertising Budget

For the next two years advertising and promotion will require $50,000. On an ongoing basis, the case management and home

healthcare agency will budget its advertisement investment as approximately 5% of total sales. This amount is necessary because of the need to capture a large percentage of the market and keep that portion of the market on an increase each year.

--Case Management and Home Health Care Spending

Compared to the industry average, the Case Management and Home Healthcare Agency is spending more in Consumer promotion. In order to capture the bulk of the market, the Case Management and Home Healthcare Agency must educate healthcare consumers that it is the logical choice for quality, accessible, and cost-effective health care.

--Public Relations

The Case Management and Home Healthcare Agency publicity efforts focus on accomplishing the following:

- Position the Case Management and Home Healthcare Agency at the leading edge in providing case management and home healthcare services.
- Increase the Case Management and Home Healthcare Agency's name and reputation among customers in prospective markets.
- Communicate on a regular basis with three target publics:
    1. Future users of the case management and home healthcare services.

2. Current consumers for one or more of the healthcare services.

3. All currently licensed case managers and home healthcare personnel.

Operations

The Case Management and Home Healthcare Agency will implement an operations plan to facilitate the successful day to day operations of the corporation. The operations plan include, but is not limited to the following: facilities (square footage, acquisition, future needs); location (accessibility to health care consumers, supplies, labor force); operating costs (heat, electric, telephone, water, general maintenance); manufacturing capability (equipment, materials, personnel, office and supply space); processes (inspection, inventory); labor (skilled, unskilled, special requirements/certification); research (not yet created) and development (improving on existing case management and home health care services); and, quality control (Total Quality Management/Quality Assurance). The operations plan also includes guidelines pertaining to the following: OSHA (Occupational Safety and Health Administration) and infection control plans; policy and procedures guideline for complying with government regulations (Medicare/Medicaid) and home health licensing requirements, and adequate insurance coverage.

At a minimum, the Case Management and Home Healthcare Agency will require the following equipment in order to begin operations in August 1998: telephones, an answering machine device,

eight pagers, three computer systems (includes monitor, hard drive and printer), computer software, one television/VCR combination, health-related videos, educational pamphlets, display cases, supply shelves, five file cabinets, cubicles and/or desks for each staff persons. In addition, two desks are required for students, at least six chairs for consumers, and twenty-five chairs for the training/conference room.

The square footage of the Case Management and Home Healthcare facility is large enough to accommodate current and future employees. Twelve full time employees and three part-time employees have been selected to begin employment on August 3, 1998. Future projections indicate that by the year 2000 the Case Management and Home Healthcare Agency will need to accommodate 25 full time employees and 50 part-time employees, inclusive of a state of the art training/conference room, cubicles and/or desks.

In addition to the initial funds needed for procuring the aforementioned items, persons working on the Case Management and Home Healthcare Agency's development anticipate an annual allocation of funds for updating case management and home healthcare reference material (anonymous interview #1). Appendix L illustrates the general administrative budget which includes operations costs on a day-to-day basis.

The Case Management and Home Healthcare Agency will be adequately staffed to ensure that it is accessible to clients, family members and physicians 24 hours per day, 7 days per week. The administrator, director of nursing and case managers will be

responsible for addressing all client/physician related issues by way of communication through company pagers. There is also a case manager/clinical home health specialist "on-call" to receive telephone calls during after duty hours. Additionally, the Case Management and Home Healthcare Agency will have an answering service for non-urgent calls. However, the Case Management and Home Healthcare office will be opened to the general public on Monday through Friday from 8:00 a.m. until 5:00 p.m.

The development of guidelines for the Case Management Home Healthcare Agency's standard operating procedures should be established in addition to creating a business plan, securing real estate property for the agency, and applying for a small business loan (unless, one is independently wealthy), and licensing. The guidelines/standard include the development of templates used as critical paths (pathways). Critical paths are often developed for a patient's admitting diagnosis to improve the quality and cost-effective of care delivered. In addition, it increases the case manager's effectiveness in coordinating appropriate resources available to the consumer and it serves to improve the quality of life. The care manager attempts to keep the client as close as possible to time lines designed as specified on the clinical paths. By keeping a close watch on any variances in patient care as well as examining the cause of any variances, early identification of problems are reviewed and aid in keeping wasted resources to a minimum.

In addition to the critical pathways developed, client/family education is provided throughout the entire individualized case

management process/relationship to increase autonomy in patients regarding decision making. Client education also serves as a strategic tool to ensure that patient and family needs were identified and that they were given appropriate preparation for their hospitalization and health services prior to hospitalizations. Client education also serves as a strategic tool during hospitalization when contracts for case management and home health care services are being secured prior to, and at discharge. In addition, student involvement is solicited because care managers help educate physicians and students to understand the case management system and importance of proper utilization of quality, cost-effective services. For this reason, a plan is currently being developed for case management and home healthcare agency to emphasize to provide administrative support for continuing education and training for its home care case managers.

Human Resource Plan

The human resource plan contains the following components: organizational structure; selection system criteria (personnel selection and related job descriptions); compensation and benefits (i.e., internal and external compensation, to include: wage and salaries, overtime, vacation, sick leave, and personal leave), performance appraisals (based on job analyses and performance standards; training and development (internal and external); employee assistant programs; and, policy procedure guidelines for grievances.

As previously mentioned, Appendix K illustrates the organizational structure for the Case Management and Home Healthcare Agency. In brief, the selection system criteria for the Case Management and Home Healthcare Agency personnel is based on ones' credentials, expertise, years of experience and related job descriptions. Employees must demonstrate a proven track record in their field of expertise as well as in their employment history. Performance appraisals are primarily based on job analyses and performance standards. Students will be supervised by the Education Coordinator who is also a home health clinical specialist, registered nurse and case manager. Compensation for home healthcare personnel at the case management and home healthcare agency will vary. The Case Management and Home Healthcare agency will compensate employees according to their job classification and years of experience. Many competitors do not provide substantial employee benefits packages. The Case Management and Home Healthcare Agency employees will be equitably compensated in order to facilitate the retention of employees and reduced turnover rates. Many competitors currently do not offer equitable employee benefits Employee benefit packages will include, but is not limited to: two weeks paid vacation upon completion of one year of employment; twelve sick days per year and one personal day; personnel, maternity, and paternity leave as the need arise; and, equitable compensation for overtime, i.e., employees will earn time-and-a-half for all hours above their full time schedule. The employees will also have access to a dental, prescription and health

health insurance plan. It is anticipated that the internal and external employee benefits packages will give the Case Management and Home Healthcare Agency a leading edge over competitors and help to retain qualified staff.

The Case Management and Home Healthcare Agency has developed policy and procedure guidelines for addressing grievances. An employee assistance program will also be implemented. The Case management and Home Healthcare Agency will contract with an established corporation to enhance its employee assistance program.

Financial Plan

The financial/accounting plan include the following areas: costs of capital required for start-up and, capital budget for operations. Additionally, the financial plan include the following: financial management of income and expenses, dividends, risks, retained earnings, and profit margins. The financial plan explicitly identifies the financial ratio analysis used for relating the elements of the Balance Sheet to the Income and Expense Statement (profit and loss), and Cash Flow Statement (Appendixes M and N). Financial projections (an estimation of future financial earnings and expense) which are broken down into monthly projections for the first two years, and annually thereafter, up to and including year 5 are illustrated in Appendix (O). Lastly, the finance and accounting manager will be responsible for maintaining accurate financial data in all other financial measures, to include market share, sales, and inventory management.

As stated earlier, cost-effectiveness is not the single strategic goal of case management programs, however there is a significant increase in the utilization of home care services and a growing population of elders who are apt to need multiple medical services. Thus, issues of reimbursement continuously surface to the forefront. In other words, "there is a dramatic population shift from a very young society to an old-old society, where increasingly significant numbers of older adults are living well into their 80s, these very old adults often are living in the community with or without formal assistance" (Quinn 234 - 35). Oftentimes family caregivers are approaching older age, i.e. 60-65 years old and may also be experiencing health problems. This adds a certain degree of complication to their ability to assume caregiving responsibilities to perhaps their 80-year-old mother, father or sibling. One may even see the 80 year old providing care to the 60 year old, or even to the 25 year old who is infected with AIDS/HIV. The examples given here indicate a significant need for case management and home care services. The case management and home healthcare agency has indubitably addressed this population by developing a plan to implement a goal for providing comprehensive case management home health care services for AIDS/HIV and geriatric clients. The plan is based upon the significant number of these particular clients within the community who are in need of dedicated case managers committed to coordinating services and navigating the health care delivery system. It is felt that dedicated case managers will enable clients to receive high quality, consistent and cost-effective services. This decision was

reached based upon information obtained through research and statistics on case management and home health care. For example, "in 1993, data from a national home and hospice survey published by the Department of Health and Human Services reported that people over age 65 comprise 74.5% of those receiving home health care and 71.5% of those were receiving home hospice care" (Quinn 235). These statistics are quite alarming. "Such staggering figures create both challenges and opportunities for home care providers and case management organizations and individuals (National Association for Home Care, 1993)" (235). Again, the goal of the case management and home healthcare agency is to provide quality, cost-effective services to the home health care population. However, the case management and home healthcare agency must receive appropriate funding on an on-going basis to remain viable. It is imperative to emphasize that compliance with regulatory requirements for reimbursement as well as educating appropriate staff members (i.e., professional case managers and nurses, and finance/accounting personnel) regarding the varied forms of reimbursement is a vital necessity in operating a case management and home healthcare agency.

Most services are covered by Medicare, Medicaid, and a large number of private insurance and managed care plans. In addition to home healthcare services, "Medicare funds are earmarked for acute care prescribed by a physician with the expectation that the individual will be rehabilitated within a short period. Medicaid funds pay for both

acute and long term care when certain eligibility criteria are met, namely income and medical necessity" (Quinn 235).

Although consumers do not generally have to pay out of pocket for home care services, depending upon the type of home services received there may be a fee-for-service if the particular service(s) rendered do not meet reimbursement criteria. Generally, and as previously mentioned, the consumer does not have to pay for receiving home services out of pocket. These services are provided 24 hours a day, 7 days a week and are tailored on a case-by-case basis to ensure the coordination and delivery of high quality home health case management services. Providing optimum quality and cost-effective home health case management services in the comfort of the client's home is the mission of our case management and home healthcare agency - not revenue.

Chapter IV

EVALUATION

The success of the case management and home healthcare business plan will be evaluated by the feasibility of its business plan components. As discussed in the former chapter, the business plan components are the actual constructs being examined, and are identified as follows: marketing, operations, management, human resources, and finance/accounting plan. The population that is addressed in this business plan is the case management and home healthcare consumers within a large city in a metropolitan area. Three individuals (subject matter experts) were asked to evaluate this project in terms of the subject matter, research methods, and appropriateness of content. The subject matter experts are identified as follows: one home healthcare agency owner, one case management and home healthcare registered nurse, and one home healthcare registered nurse. The demographic data used to describe the subject matter experts is based on the following: education, occupation, and tenure. A description of the subject matter experts are as follows:

--Subject Matter Expert One

- The home healthcare owner established her agency in 1994

- The agency is positioned in a large metropolitan area
- The owner has been a registered nurse for thirty seven years
- Along with being the owner of a home healthcare agency, the entrepreneur is a Clinical Nurse Specialist in Psychiatric Mental Health (A.P.N., M.S.N.), and has served in private practice for the past decade

The author selected this subject matter expert because of her extensive experience in the field of home health care and her intensive knowledge of the case management and home healthcare business plan as described in this project. In serving in different capacities as a registered nurse and entrepreneur, the home healthcare owner is recognized for having extensive knowledge of mandatory requirements for establishing and operating a case management and home healthcare agency.

--Subject Matter Expert Two

- The case management and home healthcare nurse has been a registered nurse for eighteen years, and has twelve years of home healthcare experience
- Along with serving as a case management and home health nurse, the nurse is an instructor for a certified nurse assistant program

- The nurse has also served as the Director of Nursing for a large hospital in the metropolitan area

The author chose this subject matter expert because of her extensive knowledge and experience in case management and home healthcare services. Likewise, the individual has a significant amount of expertise in managing and educating healthcare personnel.

--Subject Matter Expert Three

- The home healthcare nurse has been a registered nurse for fourteen years, and has five years of managerial experience

- Along with a Bachelor of Science Degree in Nursing, the nurse is a candidate for a Master of Science Degree in the nurse practitioner program at a local university

The author selected this subject matter expert because the nurse has a wealth of knowledge in the operation and management of a home healthcare agency. This individual was also chosen because of her candidacy in becoming a healthcare provider. As a nurse practitioner, this individual has a vision to refer patients for case management and home healthcare services.

The Case Management and Home Healthcare Agency has expended a tremendous amount of time and effort these past fourteen months on research and development of the business plan. During these past

fourteen months, the author collaborated with the aforementioned subject matter experts and others who were directly and indirectly involved with the various facets of research, planning, development, and implementation of the Case Management and Home Healthcare Agency.

Upon completion of the project, the subject matter experts evaluated the project in its entirety. The method used to examine the feasibility of the business plan was a survey which was completed by the subject matter experts. The survey consists of statements evaluating the business plan (for specific guidelines see Appendix P). Each of the subject matter experts agreed that the literature was very thorough. In addition, the subject matter experts contended that there was a good balance between the use of historical data and the information contained within each of the business plan components. They all felt that they were able to gain a broader perspective about the subject matter. Overall, the subject matter experts unanimously agreed that the business plan is feasible.

Subject matter expert one indicated that the case management and home healthcare business plan provides a realistic view of a company that provides many professional home healthcare services. Her comments indicated that the business plan will undoubtedly benefit the community it serves. In addition, she felt that the business plan accurately reflected the requirements for establishing and operating a case management and home healthcare agency. She further indicated that the business plan is feasible and would be successful in the

competitive market. Overall, she believed that the project was extremely interesting, well-researched, and an accurate reflection of todays' case management and home healthcare industry.

Subject matter expert two has also indicated that the case management and home healthcare business plan is feasible. She agrees that in view of the rapidly changing healthcare industry, a quality case management and home healthcare agency offers a viable solution in restructuring our healthcare delivery system. The subject matter expert felt that the business plan, when implemented would be successful. Additionally, she felt that the business plan would contribute significantly to the cost-effectiveness of healthcare as well as avoid the duplication of services. According to the subject matter expert, one must obtain a solid educational base for comprehending the benefits of implementing a case management and home healthcare agency. Similarly, she felt that healthcare professionals, investors and consumers must receive ongoing education in case management and home healthcare services. Her feelings pertaining to ongoing education are attributed to her strong belief that education is needed in order to accomplish the following: (1) perfect the discipline of case management and home health; (2) facilitate the improved delivery of quality, accessible, and cost-effective case management and home healthcare services; (3) increase public awareness regarding the advantages of case management and home healthcare services; and (4) keep all case management and home healthcare stakeholders abreast of changes affecting the industry. She felt that this project did an

exemplary job in discussing the aforementioned, and the effort spent was obvious. Her final comment was, "this is an excellent and feasible business plan. One should be commended at such an effort to contribute to the quality, accessibility, and cost-effectiveness of health care services. This business plan will undoubtedly contribute to that effort" (anonymous interview # 5)

Subject matter expert three also felt that the business plan was interesting, well-researched and feasible. Based on the case management and home healthcare business plan she feels that there is no doubt that the Case Management and Home Health Care Agency will prosper. More importantly, she felt that the case management and home healthcare business plan would provide much needed services within the communities.

Each of the subject matter experts strongly believed that the United States healthcare delivery system is in need of a drastic change in order to improve the quality, access, and cost of health care. These individuals concur that this project is a true reflection of the type of change that is indicated. These individuals also contend that health care professionals and the general public must become educated about the benefits of case management and home healthcare services. The three subject matter experts agreed that expert case management and home healthcare services facilitate the improved delivery of quality, accessible, and cost-effective healthcare services.

Chapter V

DISCUSSION

As we enter the 21st century, the traditional community hospital will no longer dominate the healthcare delivery system. The focus of healthcare delivery in the United States has changed, and is continuing to change. In response to these changes, numerous model programs are being developed to replace traditional community hospitals, and a predictable path is emanating. The vision of healthcare delivery in the United States is focusing more on community-based medical care systems. Case management and home healthcare agencies will be one major organizations within the medical care system. These organization will embrace health rather than healthcare, and cost reduction for a community at large. Additionally, the case management and home health care agencies will facilitate the improved delivery of quality, accessible, and cost-effective healthcare services. The previous chapters have examined the structure and design of a case management and home healthcare agency. A successful effort at the design of a case management and home healthcare agency would include five major components. Those components are the marketing, operations, management, human resources, and finance/accounting plan. The case management and home healthcare agency should prosper into the future if these components are properly designed to

certain specifications. The specific design of each component was presented in chapter three with an outline of the structure. In addition, chapter four supplied data to support the feasibility of the components. After careful examination of the components, the author found it imperative to expand on two of the aforementioned components to ensure future survival of the Case Management and Home Healthcare Agency. The author will examine internal and external satisfaction and employee relations.

The marketing plan of a case management and home healthcare agency is a new area to the standard healthcare facility. If the community at large can embrace the concept of taking responsibility for their health care, then the author believes that this can be a marketing tool within itself. However, case management and home healthcare agencies are having to develop new ways to promote their products/services in order to compete in today's marketplace. The two problems recognized with the current marketing efforts within the case management and home healthcare agency are the inability to efficiently reach the person before competitors, and what new products to market to the public. Developing product lines is crucial for survival. Health care consumers are seeking alternatives to the traditional ways of health care delivery. Excellent examples include: the increased use of birthing rooms, "rooming-in" for mothers and infants, and same day surgeries. Table 4 highlights a guide for adapting a marketing program that suits a healthcare institution. This table illustrates several steps to

obtain the maximum level of performance from one hospital's marketing department.

Table 4

Epidemiology of Marketing Plan

- Develop a tool to better equate resources and services with the population's health needs
- Develop a framework for a more global understanding of the health of the patient
- Develop a guide to the development and provision of comprehensive community services
- Develop an objective basis for communication between management and employees
- Develop a method for reconciling organizational interests with the community's growing needs for change

SOURCE: Epidemiology in Health Services Management. Exhibit by A. Denver (1984). Management of Hospitals and Health Services. Exhibit by Rockwell Schultz and Alton C. Johnson (1990).

Table 4 provides marketing policies that should be considered in the design of a case management and home health care agency. It is essential for the marketing plan to address customer needs and values. As Joe Silverio emphatically points out: "Who is my customer? What does my customer value?" (Interview. Class Discussion July 1997). To answer these questions it is imperative that the case management

and home healthcare agency identify the customer, the product, customer values. Once identified, these entities must be addressed in a proper fashion. In essence, the case management and home healthcare agency must, "find a need and fill it" (Silverio). These issues, when implemented, will increase profits and add stability in the years to come. An innovative design plan will encompass marketing strategies for a case management and home healthcare agency well into the future.

The next component in a successful business plan is the financial/accounting plan. As alluded to in previous chapters, cost-effectiveness is not the single strategic goal of case management programs, for it would be ethically scrutinized if it were. The case management and home healthcare agency is extremely important for the future. The case management and home healthcare agency must generate as much cash as possible. Additionally, the cash generated must be monitored correctly. The problem with financial management is attributed to escalating healthcare costs and scarce resources.

In addition to financial management, cost containment requires attention in any design project. This factor is the driving force that gained the attention of the federal government, investors, and other established agencies. Currently methods of reimbursement include, but are not limited to, private insurers, capitation, and the government. Fewer consumers are paying out of pocket for health care services. Similarly, fewer are able to afford health care services. This alarming fact is evidenced by the high number of individuals who are uninsured

or underinsured. Many more organizations are using capitation as a source of reimbursement. Capitation, or bulk payment per month per member, will cause changes. It will be extremely vital that the Case Management and Home Healthcare Agency's management monitor the cost factor for each department due to the reduction in revenue that capitation will bring. Therefore it is even more important to have a solid financial picture. Table 5 illustrates the division of a typical dollar within certain departments of a healthcare facility and the estimated division under capitation. These divisions are before and after capitation for each department listed. Similar divisions are apparent in the case management and home healthcare industry. The Case Management and Home Healthcare Agency must attempt to cut costs to exist and remain viable under capitation. However cutting costs does not imply cutting the quality and accessibility of healthcare services. Although cutting costs may denote potential problems, one advantage is that cutting costs often leads to the eradication of some services being duplicated. Table 5, again reveals that capitation will most likely change the structure of the organization.

Simply put, the case management and home healthcare agency is a business. In keeping with this line of thinking, the Case Management and Home Healthcare Agency must make profits in order to survive in the marketplace. Likewise, the author believes that the Case Management and Home Healthcare Agency must attempt to contain cost with all services offered. The ability to contain cost is a definite

asset. In conclusion, both cost containment and financial management are extremely vital in any design project.

Table 5

Dividing Up the Premium Dollar

Department	Current	Capitation
Hospital Inpatient and Outpatient Services	41 cents	30 cents
Physician Services	33	37
Outpatient Drugs	8	9
Nursing home care	1	5
Administration	14	12

SOURCE: As cited by Stanford University Hospital; J.P. Morgan; Source Book of Health Insurance Data (1992). Modern Healthcare. Exhibit from "Gatekeepers of Capitation," Karen Pallarito (1994).

Physicians have a crucial role in the healthcare structure. Case management and home healthcare agencies depend upon physicians to refer patients to them. The case management and home healthcare agency must maintain a good working relationship with physicians. Physicians must also increase their level of cooperation with case management and home healthcare agencies. The Case Management and Home Healthcare Agency needs both internal and external

customers, to be satisfied in order to stay in business. This concept has evolved from certain factors such as increased competition and reductions in healthcare payments. Table 6 examines the physician satisfaction rate before and after redesign of one institution.

Table 6

Physician Satisfaction Ratings

	Before Redesign	After Redesign
Nurse Relations	5.1%	6.4%
Finding Information	2.8	5.6
Information Quality	4.3	5.6
Care Processes	3.3	5.3
Quality of Care	3.6	6.2

SOURCE: As cited by a survey from The Sibson, Inc. (1988). Reengineering Healthcare. Exhibit from "Benchmarking and Performance Tracking", by David Zimmeran and John Skalko (1994).

Historically, healthcare facilities were able to function due to the nature of their business. However, now it is imperative to satisfy both the internal and external customers (Greene 30).

Lastly, the Case Management and Home Healthcare Agency needs to continue to seek creative avenues to strengthen the employee structure within the corporation. It is the employees, not executive management, that has the most contact with the client. Therefore it is essential to retain and motivate positive employees through a comprehensive training program.

The author plans to check with persons at the Case Management and Home Health care Agency in one year to assess the operation of the Case Management and Home Healthcare Agency. It is hoped that the author will be able to publish positive findings related to quality, accessibility and the cost-effectiveness of services at that time.

Due to the complexity of the healthcare delivery system, many changes have occurred in health care. Some of these changes are having immediate detrimental effects on individuals as well as on corporate America. Some concur that with so many different stakeholders in the healthcare system and with so many powerful political lobbies, it is understandable that the government has been unable to effectively address the problems of cost, access, and quality (Gerschefske). It is undoubtedly apparent that a cost-effective method for delivering health care must be established. The author agrees that case management and home healthcare services offer a viable solution to new and improved health care delivery. No one is certain what the future holds for any business but the author believes that entrepreneurs who adopt and live this philosophy will have a greater chance of enduring and prevailing in the industry.

It will be interesting to see how well the healthcare delivery system is functioning in the near or not so near future. Meanwhile this business plan, when properly implemented, can serve as a stepping stone for developing comprehensive case management and home health care agencies. The ultimate goal, of course, is to facilitate the improved delivery of quality, accessible, and cost-effective healthcare services.

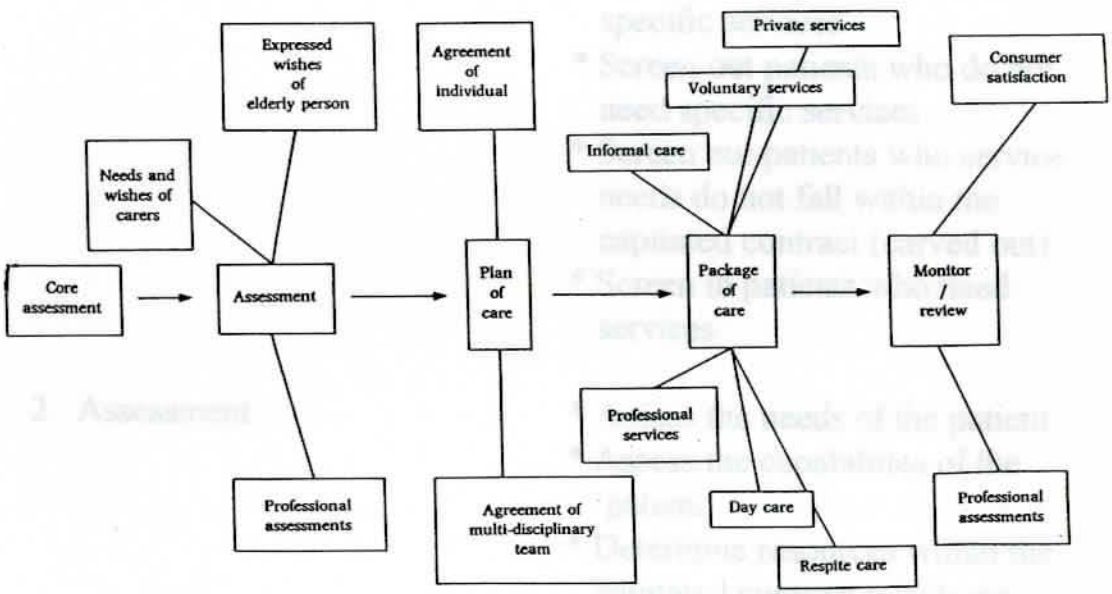
Appendices

Appendix A

Home Care Case Manager: "The Keyworker"

Case Managers can serve as a vital link or "keyworker" for coordinating services for the elderly (see diagram). With the increase in the elderly population, many may have some degree of debilitation secondary to the aging process.

Fundamentally, "case managers serve as the primary link between patients and their physicians, in addition to providing on-going care, education and assessment" (Lumsdon 44).



SOURCE: Dant, Tim and Brian Gearing. "Keyworker for Elderly People in the Community: Case Managers and Care Co-ordinators." Journal of Social Policy, 19.3, (1990): 337.

Appendix B

The Case Management Process Within Capitation

(*Page One of Three Pages*)

Steps in the Process	Features and Case Manager Functions in a Capitated Environment
1. Case Finding and screening	* All members are eligible for all services covered in the contract * Identify only patients who need specific services * Screen out patients who do not need specific services * Screen out patients who service needs do not fall within the capitated contract (carved out) * Screen in patients who need services
2. Assessment	* Assess the needs of the patient * Assess the capabilities of the patient * Determine resources within the capitated contract which are needed to meet those needs * Assess the resources of other providers in the network

Appendix B

The Case Management Process Within Capitation

(*Page Two of Three Pages*)

3. Problem identification	* Identify the problems which need intervention by the provider * Identify those problems which do not belong to the provider
4. Planning	* Plan strategies to meet the diagnostic, therapeutic, monitoring, and educational needs of the patient * Select the established guide-line(s) which will be used to monitor care * Find the least restrictive level of care * Plan to be efficient in the use of services
5. Implementation	* Make decisions about care needs * Match the needs of the patient with the resources available Use as few services as possible

Appendix B

The Case Management Process Within Capitation

(*Page Three of Three Pages*)

6. Monitoring	* Follow the progress of the patient closely using the guidelines selected * Change the level of care only when there is evidence that a change is needed * Maintain patient satisfaction * Avoid malpractice liability * Monitor for overutilization of services * Be vigilant for evidence of underutilization of services especially if it will cause use of more services later
7. Evaluation	* Use data collected to evaluate the individual's care and guidelines used
8. Documentation and collection	* Collect utilization data * Collect outcome data * Compare all data in relation to cost, quality, and access

SOURCE: Birmingham, Jacqueline. "How to Apply CMSA *Standards of Practice* for Case Management in a Capitated Environment" The Journal of Care Management 2.4. (1996): 9-22.

Appendix C

National Health Care Expenditures, 1993

	Percent
Total personal care	100
Hospital care	45
Physician's services	21
Nursing home care	9
Drugs and other medical nondurables	9
Other professional services	5
Dentists' services	5
Home care	3
Other personal Health care	2
Vision products and other medical durables	2

SOURCE: Basic Statistics About Home Care 1993 (3).

Appendix D

Benefits of Home Health Care

1. Patients prefer care in the normalcy of their home environment.

2. Homebound people can be taught to live in a relatively independent status.

3. The need for initial admission or readmission to inpatient institutions can be diminished.

4. For the necessary institutional admission, unnecessary days can be can be eliminated through early discharge to home care.

5. Unnecessary capital construction costs for inpatient facilities can be decreased.

6. The efficiency of the practicing physician can be increased can increased by expanding the team approach.

7. The physician can care for a greater number of patients through a home care program because he does not have to assemble and coordinate individually the services needed for patients in their home settings.

8. Home care staff can identify day-to-day problems and thus reduce the possibility of emergency situations arising. (Spiegel 162)

Appendix E

U.S. Small Business Administration
Application for Business Loan (Up to $100,000)

(Page One of Three Pages)

SBA Form 4-L (6/94)

U.S. SMALL BUSINESS ADMINISTRATION
APPLICATION FOR BUSINESS LOAN (UP TO $100,000)
It is not necessary to hire outside assistance for preparation of the application.

OMB Approval No. 3245-0016
Expiration Date: 9/30/97

Corporate Name (If any)
Trade Name & Street Address _____ Home Phone (___) _____
_____ Bus. Phone (___) _____

City _____ County _____ State ____ Zip _____

Mailing Address (if different) _____
Type of Business Date Established

Ownership in any other business? Yes ___ No ___
#Employees (Including Subsidiaries & Affiliates)
Include Owners & Managers

Before Loan _____ After Loan _____
Bank of Business Account:

IRS Tax ID #

MANAGEMENT (Proprietor, partners, officers, directors owning 20% or more of the company)--Must account for 100% of ownership of the business.

Name	SOCIAL SECURITY #	Complete Address	% Owned	*Military Service Y/N	From	To	*Race	*Sex

*This data is collected for statistical purposes only. It has no bearing on the credit decision to approve or decline this application. Disclosure is voluntary.

U.S. Citizen? Yes ___ No ___ If no, include a copy of Alien Registration Card (Form I 151 or I 551) Alien Registration #_____

Are any of the above individuals (a) presently under indictment, on parole or probation, or have they ever been (b) charged for any criminal offense other than a minor vehicle violation, or (c) convicted, placed on pretrial diversion, or placed on any form of probation including adjudication withheld pending probation for any criminal offense other than a minor vehicle violation? Yes ___ No ___ If yes, loan request must be submitted under regular 7(a) loan program.

Have you employed anyone to prepare this application? Yes ___ No ___ If yes, how much have you paid? $_____ How much do you owe? $_____

Have you or any officer of your company ever been involved in bankruptcy or insolvency proceedings? Yes ___ No ___ If yes, provide details to bank.
Are you or your business involved in any pending lawsuits? Yes ___ No ___ If yes, provide details to bank.

Appendix E

U.S. Small Business Administration
Application for Business Loan (Up to $100,000)

(Page Two of Three Pages)

DESCRIBE YOUR BUSINESS OPERATION:

IS BUSINESS ENGAGED IN EXPORT TRADE? Yes __ No __ DO YOU INTEND TO BEGIN EXPORTING AS A RESULT OF THIS LOAN? Yes __ No __

SUMMARY OF MANAGEMENT'S BUSINESS EXPERIENCE, EDUCATION, AND TRAINING:

LOAN REQUEST: HOW MUCH, FOR WHAT, WHY IT IS NEEDED

INDEBTEDNESS: Furnish information on ALL BUSINESS debts, contracts, notes, and mortgages payable. Indicate by an (*) items to be paid with loan proceeds.

To Whom Payable	Original Amount	Original Date	Present Balance	Rate of Interest	Maturity Date	Monthly Payment	Collateral	Current or Past Due
	$		$			$		
	$		$			$		
	$		$			$		
	$		$			$		

Appendix E

U.S. Small Business Administration
Application for Business Loan (Up to $100,000)

(Page Three of Three Pages)

PREVIOUS SBA OR OTHER GOVERNMENT FINANCING: If you or any principals or affiliates have ever requested Government Financing complete the following:

Name of Agency	Loan Number	Date Approved	$ Amount	Loan Balance	Status

If you knowingly make a false statement or overvalue a security to obtain a guaranteed loan from SBA you can be fined up to $10,000 or imprisoned for not more than five years or both under 18 USC 1001.

I hereby certify that all information contained in this document and any attachments is true and correct to the best of my knowledge.

If applicant is a proprietor or general partner, sign here: By: _____ Title _____ Date _____

If corporation sign below: Corporate Name _____

By: _____ Date: _____ Attested By: _____

Signature of President Signature of Corporate Secretary

Federal Recycling Program Printed on Recycled Paper

SOURCE: U.S. Small Business Administration. "Application for Business Loan (Up to $100,000)." SBA FORM 4-1. 1994.

Appendix F

Business Plan Worksheet

(*Page One of Three Pages*)

1. Describe the business in detail:

Company Name:_____

Address:_____

_____

Owner:_____

Business Partners:_____

_____

_____

Legal Structure:_____

(Attach copies of legal documents to your business plan.)

2. State the major goals and objectives of the business:

_____

_____

3. State the Mission of the business:
(Attach copies if more space is needed.)

_____

_____

4. State the Philosophy of the Business:

_____

_____

Appendix F

Business Plan Worksheet

(*Page Two of Three Pages*)

5. Discuss the special skills and experiences you bring to the company. Describe your qualifications. (Attach a resume to your business plan.)

_____

_____

6. Describe the products or services offered.

_____

_____

7. What advantages do your products or services have over those already on the market?

_____

_____

8. Describe your market (those people most likely to buy your product or service.)

_____

_____

9. List current customers, if any.

_____

_____

Appendix F

Business Plan Worksheet

(*Page Three of Three Pages*)

10. Indicate when, where and how you plan to advertise and publicize your business.

_____

_____

11. List all equipment and supplies you will require to get started.

_____

_____

12. Indicate how much money you will need to start. Beside these figures, project how you will obtain it. (Attach a copy of your start-up and first-year budgets.)

_____

_____

SOURCE: "Business Plan Worksheet" Anonymous Case Management and Home Healthcare Agency. (1996): 1-3.

Appendix G

Application for Merchant License

(Page One of Two Pages)

Merchant or Manufacturer Property
(314) 889-2220

St. Louis County, Missouri
Department of Revenue - Division of Assessment
41 South Central Avenue
Clayton, Missouri 63105

Business Personal Property
(314) 889-2141

APPLICATION FOR MERCHANT LICENSE, MANUFACTURER LICENSE AND BUSINESS PERSONAL PROPERTY REGISTRATION

A merchant license or a manufacturers license may not be necessary, however, all businesses are required to file a Business Personal Property Declaration each year. This application is available for public inspection. Fill out this application and mail to the address above.

PLEASE PRINT OR TYPE

☐ New Business ☐ Purchase of Existing Business ☐ Reinstating Old Business

Date Started in St. Louis County: _____

☐ Federal ID _____ ☐ State ID _____ ☐ Mo Sales Tax # _____

What name will business operate under (DBA)?
Name _____ Phone _____
Corporate Name _____
Physical Business location (Do Not use PO Box or Rural Route):
Street _____
City _____ State _____ Zip _____

Mailing address (Where you want tax forms mailed):
Name _____ Phone _____
Street _____
City _____ State _____ Zip _____

Appendix G

Application for Merchant License

(Page Two of Two Pages)

Primary Business Activity:

☐ Retail ☐ Manufacturing ☐ Service ☐ Wholesale ☐ Other _____

Will you be selling any type of alcoholic beverages? ☐ Yes ☐ No

Type of Ownership:

☐ Sole Owner ☐ Corporation ☐ Partnership Other _____

Name of Individual to Contact :

Name _____ Phone _____

Street _____ Title _____

City _____ State _____ Zip _____

Will the business operate under any other name(s) (ex. Franchise, Trade Name) ?

Describe the Business activity.

WORKER'S COMPENSATION COVERAGE

(SEE EXPLANATION ON REVERSE SIDE OF THIS FORM)

____ I Do hereby certify that I have Worker's Compensation Coverage as required by Chapter 287 Revised Statutes of Missouri 1986, as amended 1993.

This coverage is with _____

(Name of Insurance Company)

____ I Do hereby certify that I am not required to have Worker's Compensation Coverage under the provisions of Chapter 287 Revised Statutes of Missouri 1986, as amended 1993.

Signature _____ Date _____

LICAPP1 11/93

Appendix H

State of Missouri
Registration of Fictitious Name

(Page One of Four Pages)

State of Missouri

No. X _____

Rebecca McDowell Cook, Secretary of State

Corporation Division

Registration of Fictitious Name

(Submit in duplicate with a filing fee of $7)

This information is for the use of the public and gives no protection to the name. There is no provision in this Chapter to keep another company or corporation from adopting and using the same name. (RSMo 417)

We, the undersigned, are doing business under the following name, and at the following address:

Name to be registered: _____

Missouri Business Address: _____
(P.O. Boxes not accepted)

City, State and Zip Code: _____

The parties having an interest in the business, and the percentage they own are (if a corporation is owner, indicate corporation name and percentage owned). If all parties are jointly and severally liable, percentage of ownership need not be listed:

Appendix H

State of Missouri
Registration of Fictitious Name

(Page Two of Four Pages)

Name of Owners, Individual or Corporate	Street and Number	City	State and Zip Code	If listed, Percentage of ownership must equal 100%

(Must be typed or printed)

Return to: Secretary of State
Corporation Division
P.O. Box 778
Jefferson City, Mo. 65102

(Over)

Corp. #56 (12-94)

Appendix H

State of Missouri
Registration of Fictitious Name

(Page Three of Four Pages)

The undersigned, being all the parties owning interest in the above company, being duly sworn, upon their oaths each did say that the statements and matters set forth herein are true.

Individual Owners Sign Here

X _____ X _____

X _____ X _____

X _____ X _____

The undersigned corporation has caused this application to be executed in its name by its President or Vice-President and its Secretary or Assistant Secretary, this _____ day of _____, 19____.

If Corporation is Owner, Corporate Officers Execute Here

_____
(Exact Corporate Title)

By _____
Its President or Vice-President

By _____
Its Secretary or Assistant Secretary

Appendix H

State of Missouri
Registration of Fictitious Name

(Page Four of Four Pages)

(Corporate Seal)
If no seal, state "none".

State of Missouri

County of _____ } **ss**

I, _____, A Notary Public, do hereby certify that on the _____ day of _____, 19 _____, personally appeared before me _____, and being first duly sworn by me, acknowledged that _____ he signed as his own free act and deed the foregoing document in the capacity therein set forth and declared that the statements therein contained are true.

IN WITNESS WHEREOF, I have hereunto set my hand and seal the day and year before written.

(Notarial Seal)

_____
Notary Public

My commission expires _____

SOURCE: Secretary of State. "State of Missouri Registration of Fictitious Name." Corp. #56 1994.

Appendix I
Articles of Incorporation

ARTICLES OF INCORPORATION OF **Anonymous Case Management and Home Healthcare Agency**

ONE: The name of this corporation is **Anonymous Case Management and Home Healthcare Agency**.

TWO: The purpose of this corporation is to engage in any lawful act or activity for which a corporation may be organized under the General Corporation Law of California other than the banking business, the trust company business or the practice of a profession permitted to be incorporated by the California Corporation Code.

THREE: The name and address in this state of the corporation's initial agent for the service of process is:
Z.A.D., R.N., M.S. Health Management
Address - anonymous
City, State - a large metropolitan area in a Midwestern State

FOUR: This corporation is authorized to issue only one class of shares of stock which shall be designated common stock. The total number of shares it is authorized to issue is **10,000** shares.

FIVE: The names and address of the persons who are appointed to act as the initial directors of this corporation are:

Name	Address
Z.A.D.	**Anonymous**
J.C.V.	**Anonymous**
Dr. K.	**Anonymous**

SIX: The liability of the directors of the corporation for monetary damages shall be eliminated to the fullest extent permissible under California law.

SEVEN: The corporation is authorized to indemnify the directors and officers of the corporation to the fullest extent permissible under California law.

IN WITNESS WHEREOF, the undersigned, being all the persons named above as the initial directors, have executed these Articles of Incorporation.
Dated: ____**July 1998**

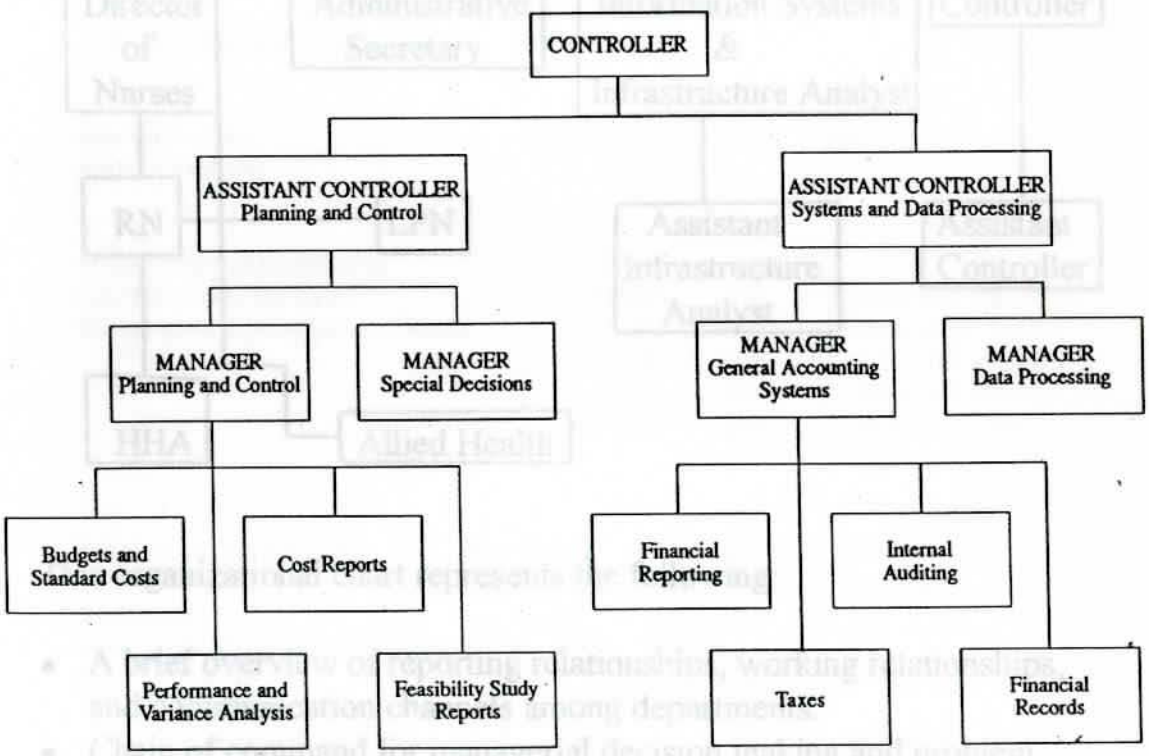
_____
_____
_____

SOURCE: "Articles of Incorporation." Anonymous Case Management and Home Healthcare Agency. 1996.

Appendix J

Controller's Activity

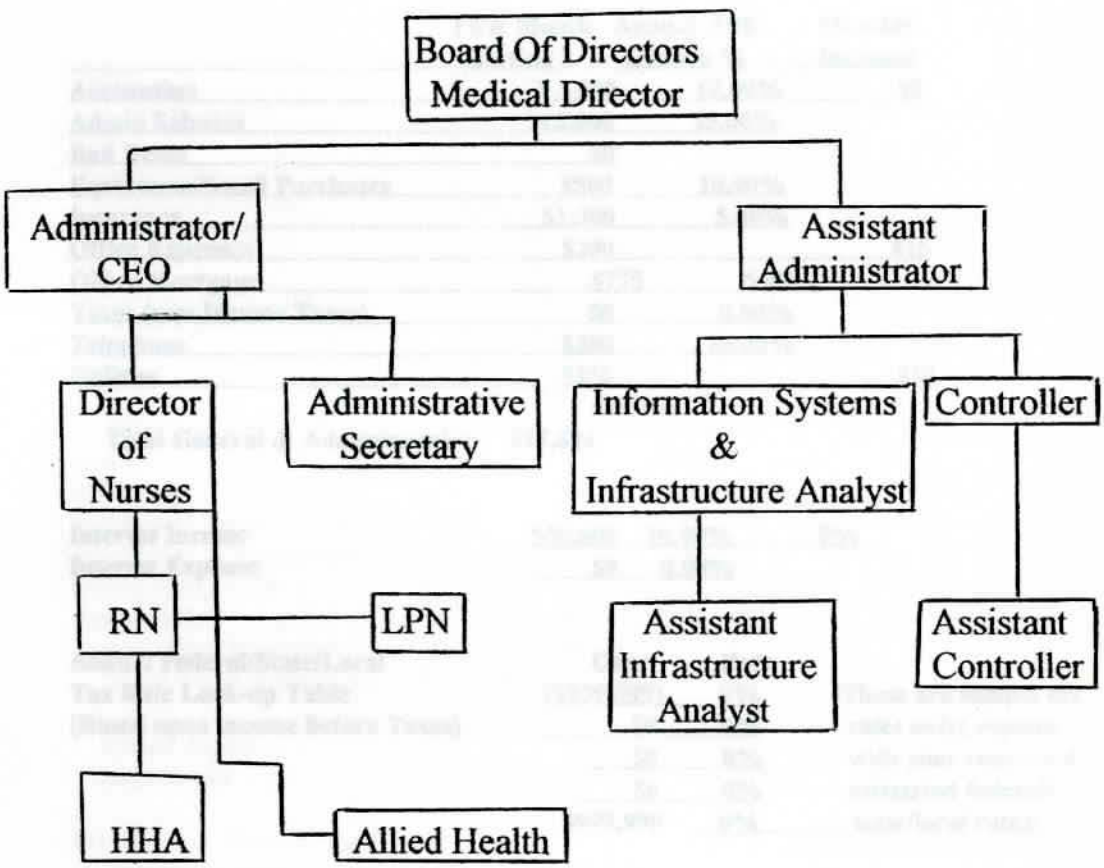
This diagram illustrates the controller's activities in the managerial department of a case management and home healthcare agency located in the Midwest. "The chief management accountant or the chief accounting executive of an organization is called the controller. The controller is in charge of the accounting department office and gives advice and services to other departments" (Minars, Shim, and Siegel 141).



SOURCE: Minars, Shim, and Joel Siegel. Introduction to Accounting II. New York: HarperCollins Pub., Inc. 1993.

Appendix K

Organizational Chart



This organizational chart represents the following:

- A brief overview of reporting relationships, working relationships, and communication channels among departments.
- Chain of command for managerial decision making and problem solving.

SOURCE: "Organizational Chart." Anonymous Case Management and Home Healthcare Agency. (1996): 1.

Appendix L

General Administrative Budget

BUDGET ASSUMPTIONS

	First Month Starting $	Annual -OR- Growth %	Monthly Increase
Accounting	$ 2,000	10.00%	$0
Admin Salaries	$12,000	25.00%	
Bad Debts	$0		
Equipment/Small Purchases	$500	10.00%	
Insurance	$1,500	5.00%	
Office Expenses	$200		$15
Office Mortgage	$775	5.00%	
Taxes (non-Income Taxes)	$0	0.00%	
Telephone	$300	20.00%	
Utilities	$350		$10
Total General & Administrative	$17,624		

Interest Income	$50,000	10.00%	0%
Interest Expense	$0	0.00%	

Annual Federal/State/Local Tax Rate Look-up Table (Based upon income before Taxes)	Over	Rate	
	($999,999)	0%	(These are sample tax rates only; replace with your combined estimated federal/ state/local rates)
	$0	0%	
	$0	0%	
	$0	0%	
	$999,999	0%	

Research & Development	First Month Starting $	Annual -OR- Growth %	Monthly Increase
Consulting	$0		$0
Equipment (Expensed Purchases)	$0	0.00%	
R & D Materials	$100	10.00%	$0
Total Research & Development	$100		

SOURCE: "General Administrative Budget." Anonymous Case Management and Home Healthcare Agency. (1997): 1.

Appendix M

Balance Sheet as of 30 Sept. 1998

BALANCE SHEET ASSUMPTIONS

	Year 0 - Beginning Balances
Assets	
Current Assets	
Cash	$300,000
Investments	$0
Accounts Receivable	$30,250
Notes Receivable	$0
Inventory	$0
Other Current Assets	$0
Total Current Assets	$330,250

Plant & Equipment		Asset Lives To Be Used For Depreciation (in Years)
Land	$0	N/A
Buildings	$0	40
Buildings/Leasehold Improvements	$0	10
Machinery & Equipment	$10,000	5
Office Equipment	$0	5
Automobiles	$0	3
Accumulated Depreciation	$0	
Total Net & Equipment	$10,000	
Other Assets	0	
Total Assets	$340,250	

Liabilities & Owners' Equity		***Owner/Stockholder Equity***	
Current Liabilities			
Short Term Debt	$0	**Common Stock**	$50,000
Accounts Payable	$0	**Retained Earnings**	$290,250
Other Payables	$0	**Dividends Payable**	$0
Accrued Liabilities	$0	**Total Owners' Equity**	$340,250
Total Current Liabilities	$0		
Long Term Debt	$0		
Total Liabilities	$0	**Total Liabilities & Equity**	$340,000

SOURCE: "Balance Sheet." Anonymous Case Management and Home Healthcare Agency. (1997): 1.

Appendix N

Cash Flow Assumptions (Year 1 by month)

Working Capital Assumptions(In Days)	Oct-98	Nov-98	Dec-98	Jan-99	Feb-99	Mar-99	Apr-99	May-99	Jun-99	Jul-99	Aug-99	Sept-99
Accounts Receivable	30	30	30	30	30	30	30	30	30	30	30	30
Inventory	0	0	0	0	0	0	0	0	0	0	0	0
Accounts Payable	30	30	30	30	30	30	30	30	30	30	30	30

Fixed Asset Purchases (In Dollars)	Oct-98	Nov-98	Dec-98	Jan-99	Feb-99	Mar-99	Apr-99	May-99	Jun-99	Jul-99	Aug-99	Sept-99
Land	$0	$0	$0	$1,000,000	$0	$0	$0	$0	$0	$0	$0	$0
Buildings	$0	$0	$0	$4,000,000	$0	$0	$0	$0	$0	$0	$0	$0
Building/Leasehold Improvements	$0	$0	$0	$0	$0	$200,000	$0	$0	$0	$0	$0	$0
Machinery & Equipment	$0	$0	$350,000	$0	$0	$0	$300,000	$0	$0	$0	$0	$0
Office Equipment	$0	$0	$0	$0	$0	$0	$40,000	$0	$0	$0	$0	$0
Automobiles	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Total Fixed Asset Purchases	$0	$0	$350,000	$5,000,000	$0	$200,000	$340,000	$0	$0	$0	$0	$0

Financing (In Dollars)	Oct-98	Nov-98	Dec-98	Jan-99	Feb-99	Mar-99	Apr-99	May-99	Jun-99	Jul-99	Aug-99	Sept-99
Sale of Stock	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Cash Dividends Declared	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Proceeds from Short Term Loans	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Repayment of Short Term Loans	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Proceeds from Long Term Loans	$0	$7,500,000	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Repayment of Long Term Loans	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0

Other Balance Sheet Accounts (In $)	Oct-98	Nov-98	Dec-98	Jan-99	Feb-99	Mar-99	Apr-99	May-99	Jun-99	Jul-99	Aug-99	Sept-99
Purchase of Investments	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Sale of Investments	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Increase in Notes Receivable	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Collection of Notes Receivable	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Increase in Other Current Assets	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Reduction of Other Current Assets	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Increase in Other Assets	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Reduction of Other Assets	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Increase in Other Payables	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Decrease in Other Payables	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Increase in Accrued Liabilities	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Decrease in Accrued Liabilities	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0

Appendix O

Forecasted Statements of Revenues and Expenses

(*Page One Of Two Pages*)

Sales Projection Method	Charge Per Visit
Skilled Nursing Visits (RN & LPN)	$105.00
Case Management Services	$105.00
Physical Therapy	$105.00
Occupational Therapy	$105.00
Speech Therapy	$105.00
Medical Social Worker	$145.00
Home Health Aide	$105.00

	Years ending 30 September (Thousands)				
Gross Operating Revenue:	1999	2000	2001	2002	2003
Nursing and routine care services	6,353	7,343	9,297	25,373	28,985
Ancillary Services	9,381	11,027	13,354	18,400	20,898
	15,734	18,370	22,651	43,773	49,883
Less contractual allowances, free services and other allowances	3,987	4,791	5,518	7,331	8,687
Net patient service revenue	11,747	13,579	17133	36442	55,195
Other operating revenue	155	185	230	425	650
Operating revenue, net	11,902	13,764	17,363	36,867	55,845

	Years ending 30 September (Thousands)				
	1999	2000	2001	2002	2003
Operating expenses:					
Office Mortgage	93	93	93	93	93
Salaries and wages	6,693	7,508	8,548	10,805	22,805
Licensing Fees	100	125	150	175	200
Utilities	350	425	550	600	625
Employee Benefits	485	600	745	1,050	1,250
Insurance	150	180	200	225	250
Supplies	1,500	1,750	2,000	2,100	2,500
Equipment	1,000	1,000	1,150	1,300	2,000
	10,371	11,681	13,436	16,348	29,723

Appendix O

Forecasted Statements of Revenues and Expenses

(*Page Two Of Two Pages*)

	1999	2000	2001	2002	2003
Excess of revenues over expenses before fixed charges, nonoperating revenue	**1,531**	**2,083**	**3,927**	**20,519**	**26,122**
Fixed charges:					
Interest	**275**	**718**	**1,564**	**3,257**	**3,256**
Depreciation	**310**	**305**	**485**	**781**	**756**
Amortization	**12**	**12**	**12**	**61**	**61**
Excess of revenues over expenses	**9,676**	**10,539**	**11,262**	**12,151**	**25,551**

SOURCE: "Forecasted Statements of Revenues and Expenses" Anonymous Case Management and Home Healthcare Agency. (1997): 1.

Appendix P

Cover Letter

Dear_____:

You have been chosen to participate in research that evaluates the enclosed business plan because of your enormous amount of expertise on the subject matter.

After reviewing the business plan, please complete the enclosed survey. The twenty questions on the survey are structured to evaluate the feasibility of the business plan. After each statement select the response that reflects your opinion about the statement. Indicate your agreement or disagreement by checking the appropriate response:

5 - Strongly Agree
4 - Agree
3 - Neither Agree/Disagree
2 - Disagree
1 - Strongly Disagree

The information in this survey is intended solely for research purposes only. The information will be handled as anonymous and, will be maintained in strict confidentiality unless your permission is granted for other use.

Please complete the survey and return it in the self-addressed, stamped envelop no later than 3 January 1998. I will contact you to discuss your comments and answer questions. Your participation is sincerely appreciated. I look forward to your comments. I am,

Respectfully yours,
Zeporah A. Dunbar, R.N., B.S.N.

Appendix Q
(*Page One of Six Pages*)

Evaluation Survey for Critiquing Research Paper

Proposed Title: A Business Plan for a Case Management and Home Health Agency

Check the response that best describes your feelings about the statements in reference to the business plan. Check only **one** response for each statement given.

1. The marketing section of the business plan clearly identifies the case management and home health products/services.

Strongly Agree	Agree	Neither Agree/Disagree	Disagree	Strongly Disagree
( )	( )	( )	( )	( )

2. The case management and home healthcare agency's marketing mix (which includes product, price, promotion, and place) shows a feasible plan for the coming year with projections of 3 to 5 years.

Strongly Agree	Agree	Neither Agree/Disagree	Disagree	Strongly Disagree
( )	( )	( )	( )	( )

Appendix Q
(*Page Two of Six Pages*)

3. The target marketing strategy (plan) for the case management and home healthcare agency, (i.e, the target market includes high risks populations, special populations, special health care needs, and AIDS/ HIV clients).

Strongly Agree	Agree	Neither Agree/Disagree	Disagree	Strongly Disagree
( )	( )	( )	( )	( )

4. The market positioning strategy is feasible. (i.e., the case management and home healthcare agency is located in high consumer traffic areas, and away from similar competitors.

Strongly Agree	Agree	Neither Agree/Disagree	Disagree	Strongly Disagree
( )	( )	( )	( )	( )

Indicate your response to the following statements in the blank spaces that been provided. If you need additional space, use the back of the survey.

5. Based on the information provided, do you foresee any problems in implementing the marketing plan?

_____

_____

_____

Appendix Q
(*Page Three of Six Pages*)

6. Based on the information provided, is the marketing plan feasible?

_____

_____

_____

7. The case management and home healthcare agency has thorough guidelines for daily operations (i.e, the office is open Monday through Friday, 0800 to 1700 hours; the nursing staff is available 7 days a week, 24 hours a day).

Strongly Agree	Agree	Neither Agree/Disagree	Disagree	Strongly Disagree
( )	( )	( )	( )	( )

8. Based on the information provided, do you have any suggestion for improving the operations section of the business plan?

_____

_____

_____

9. Based on the information provided, is the operations plan feasible?

_____

_____

_____

Appendix Q
(*Page Four of Six Pages*)

10. The management section of the business plan thoroughly address the four essential elements of management, i.e., planning, organization, control and leadership.

Strongly Agree	Agree	Neither Agree/Disagree	Disagree	Strongly Disagree
( )	( )	( )	( )	( )

11. The description of the management (administrative) duties responsibilities in the management section of the business plan is thorough.

Strongly Agree	Agree	Neither Agree/Disagree	Disagree	Strongly Disagree
( )	( )	( )	( )	( )

12. Based on the information provided, is the management plan feasible?

_____

_____

_____

13. In the human resource section, the organizational structure is feasible.

Strongly Agree	Agree	Neither Agree/Disagree	Disagree	Strongly Disagree
( )	( )	( )	( )	( )

Appendix Q
(*Page Five of Six Pages*)

14. Based on the information provided, is the human resource section of the business plan feasible?

_____

_____

_____

15. Do you have any suggestions for improving the human resource section of the business plan?

_____

_____

_____

16. The financial data concerning the capital (costs) required for start-up is justifiable.

_____

_____

_____

17. The accounting method used in the Income and Expense Statement (profit and loss) is thorough.

Strongly Agree	Agree	Neither Agree/Disagree	Disagree	Strongly Disagree
( )	( )	( )	( )	( )

Appendix Q
(*Page Six of Six Pages*)

18. The financial projections (an estimation of future financial earnings and expenses) shows feasible financial monthly projections for the first two years, and annually thereafter, up to and including year 5.

Strongly Agree	Agree	Neither Agree/Disagree	Disagree	Strongly Disagree
( )	( )	( )	( )	( )

19. Based on the information provided, is the financial/accounting plan feasible.

_____
_____
_____

20. Based on the information in the business plan, is the plan feasible?

_____
_____
_____

Works Cited

Anderson, Odin W. Health Services as a Growth Enterprise out on the United States Since 1875. 2nd ed. Ann Arbor: Health Administration Press, 1990.

Anonymous "Business Plan Worksheet for a Case Management and Home Healthcare Agency in a Large Midwestern City." (1996): 1-3.

Anonymous personal interview #1, 1 July 1996

Anonymous personal interview #2, 9 Aug. 1996

Anonymous personal interview #3, 21 Mar. 1997

Anonymous personal interview #4, 7 June 1997

Anonymous personal interview #5, 2 Mar. 1998

Basic Statistics About Home Care 1993. Washington, D.C.: National Association for Home Care, 1993.

Baulch, Evelyn M. Extended Health Care At Home: A Complete and Practical Guide. Berkeley, Calif: Celestial Arts, 1988.

Birmingham, Jacqueline. "How to Apply CMSA *Standards of Practice* for Case Management in a Capitated Environment." The Journal of Care Management 2.4. (1996): 9-22.

Cats-Baril, William and Ronald Thompson. Information Technology and Management. Chicago: Times Mirror Higher Education Group, Inc., 1997.

Coley, Rebecca. "Many Older People Come Up Short on Tests, Vaccinations." North County Journal 4 Feb. 1997. N.p.

"Cross Train Cautiously to Assure Legal, Regulatory Problems do not Derail PFC Plans." Patient-Focused Care 1 September 1993: 1- 11.

Dant, Tim and Brian Gearing. "Keyworkers for Elderly People in the Community: Case Managers and Care Co-ordinators." Journal of Social Policy 19.3 (1990): 331-360.

"Decoding Health Policy Jargon." Health Policy Jargon September 15, 1993: 21-28.

DePorter, D. "Does Dental Coverage Fit into the Health Care Reform?" Journal of Health Care Benefits September-October August 1992: 54-57.

Downey, Douglas W., et al. New Standard Encyclopedia Volume 13. Chicago: Standard Educational Corporation, 1993: P-477.

Ellis, Gwen. 101 Ways to Make Money at Home. Michigan: Servant Publications, 1996.

Friedman, Jo-Ann. A Complete Guide for Patients and Their Families. New York: W. W. Norton & Company, 1986.

Gannon, Kathi. "Colleges Opening Curriculums to Home Health-Care Courses." Drug Topics 19 Nov. 1990: 27.

Garrett, Baillie, and Rosellen M. Garrett. Health Care Ethics: Principles and Problems, Third Edition. New Jersey: Prentice-Hall Inc., 1998.

Gerschefske, Lynnette. Interview: Health Care Management 502, Class Discussion. 3 January 1998.

Granof, Bell, and Bruce R. Neumann. Accounting for Managers and Investors. New Jersey: Prentice Hall Inc., 1993.

Greene, Jay. "Competition for Patients Spurs Hospitals' Concern for Serving the Customer." Modern Healthcare 18 July 1994: 30-31.

Greenlick, Merwyn R. "Educating Physicians for the Twenty-First Century." Academic Medicine 70.3 (1995): 179-185.

Griffith, John R. "The Strategic Agenda for Community Health Care Organizations." Health Care Management Review 22.3 (1997): 82-91.

Halamandaris, Val. J. "Twenty Reasons for Health Care." Caring Magazine Oct. 1985: 10.

Hall, M.J. "Long-stay Patients in Short-stay Hospitals." Advanced Data 11 March 1993: 1-16.

Hastings, Kathleen E. "Health Care Reform: We Need It, But Do We Have the National Will to Shape Our Future?" Nurse Practitioner 20.1 (1995): 52-57.

"Health Care Reform Update." The National Association for Home Care 1 (24 Sept. 1993): 1-6.

Health Security Act. Washington, D.C.: U.S. Government Printing Office, 1993.

Hilgendorf, Patrice M. "Profile of the Successful Home Health Case Manager." Nursing Management 27.10 (1996): 32Q-32V.

Leeds, Dorothy. Smart Questions: A New Strategy for Successful Managers. McGraw Hill, New York: 1987.

Lumsdon, Kevin. "Case Management Evolves into Management of a Continuum of Care." Hospital & Health Networks 68.5 (1994): 44-45.

Manning, Margie. "Home Health Taking a Hit." The St. Louis Business Journal 29 Dec. 1997: 1-4.

Mark, Lynn. Interview: Case Management 515, Class Discussion. 4 Mar. 1997.

Minars, Shim, and Joel Siegel. Introduction to Accounting II. New York: HarperCollins Pub., Inc. 1993.

Mullahy, Catherine M. The Case Manager's Handbook. Aspen Publishers, Inc., 1995.

Nassif, Janet Zhun. The Home Health Care Solution. New York: Harper and Row, 1985.

Pallarito, Karen. "Managed-care Markets Teach CFOs the Secrets of Capitation." Modern Healthcare 27 June 1994: 94.

Romeo, Sam J. W. "Community Health and Managing the Care of a Population." MGM 11 (1996): 11-12.

Schulz, Rockwell, and Alton C. Johnson. Management of Hospitals and Health Services Strategic Issues and Performances. St. Louis: C.V. Mosby, 1990.

Secretary of State. "State of Missouri Registration of Fictitious Name." Corp. #56 1994.

Silverio, Joseph. Interview: Marketing Concept 550, Class Discussion 28 July 1997.

Source Book of Health Insurance Data 1986-1987. Washington, D.C.: Public Relations Division of the Health Insurance Association of America, 1987.

Spiegel, Allen D. Home Healthcare: Home Birthing to Hospice Care. Maryland: National Health Publishing, 1983.

St. Joseph Health Center. Home Health Pamphlet. N.d.: N.p.

Sultz, Harry A. and Kristina M. Young. Health Care USA: Understanding Its Organization and Delivery. Maryland: Aspen Publisher, Inc., 1995.

"Home Health Care." The National Council on the Aging. (16 Sept. 1997): 1-5.

Quinn, Joan. Case Management in Home and Community Care. New York: The Haworth Press, Inc., 1995. 233-48.

U.S. Small Business Administration. "Application for Business Loan (Up to $100,000)." SBA Form 4-1. 1994.

Warren, Puls, and Pamela Fogelstorm-DeZeeuw. "Cost-Effectiveness of Case Management: Experiences of a University Managed Health Organization." American Journal of Medical Quality 11.4 (1996): 173-78.

Williams, Betty Smith. "The Utility of Nursing Theory in Nursing Case Management Practice." Nursing Administration Quarterly 15.3 (1991) 60-65.

Zimmerman, David and John J. Skalko. Reengineering Healthcare: A Vision for the Future. Wisconsin: Eagle Press, 1994.

Zweig White and Associates, Inc. "The Health Care Market for A/E/P Environmental Consulting Services." ISBN 1-885002-23-8, July 1996.