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Evaluation of the Home Health Pay-for-Performance Demonstration

Contract # HHSM-500-2005-000221, Task Order 0001

Comparison of Treatment vs. Control Pay-for-Performance Participant Home Health Agencies on Care Practices, Policies, and Staffing during CY2009: Final Report

Deliverable Task 3b: Conduct Evaluation Survey

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1. Background

The quality of care received by home health patients has come under increasing scrutiny during the past several years, particularly since the advent of the prospective payment system in 2001, even as the number of patients served by this provider group continues to increase. The Medicare Payment Advisory Commission (MedPAC) report, "A Data Book: Healthcare Spending and the Medicare Program, June 2009," indicates that the number of beneficiaries using home health care services from 2002 to 2007 increased by approximately 25% and the number of episodes of care delivered increased by a similar percentage during the same time period. Similarly, the number of visits that are delivered by skilled staff (e.g., registered nurses, physical therapists) increased from 69% to 80%. The importance of the quality of care delivered by home health agencies is evidenced by the 2003 introduction of the Centers for Medicare and Medicaid Services (CMS) Web site entitled Home Health Compare where the consumer can compare home health agencies across multiple patient outcomes.

As part of the Medicare Pay-for-Performance Initiatives of 2005, CMS began an effort to test the effectiveness of a pay-for-performance (P4P) approach in a variety of health care settings. The Home Health Pay-for-Performance Demonstration (Demonstration) project sponsored by CMS and managed by its implementation contractor, Abt Associates, began in 2007. In the Demonstration volunteer home health agencies from seven states in four CMS regions were randomly assigned to either treatment or control groups using a matching algorithm to ensure that the two groups for each region were equivalent prior to the beginning of the Demonstration. Treatment agencies were eligible to share cost savings associated with the Demonstration based on either their absolute performance level on a quality measure or their substantial improvement on a quality measure. The evaluation of the Demonstration's effectiveness, also sponsored by CMS and conducted by the University of Colorado Denver, Anschutz Medical Center, includes both an analysis of the costs associated with improved performance and collection of qualitative data to explore what agencies did to achieve higher (or where appropriate, lower) rates on patient outcomes. A core issue to be addressed in the evaluation was whether the quality-related activities that Demonstration home health agencies engaged in, produce superior patient outcomes.

The effectiveness of pay-for-performance has been studied in a variety of health care delivery settings, but its study in the home health area has been extremely limited. Rosenthal and Frank (2006) reviewed five studies from research literature prior to 2004 involving the application of pay-for-performance in the health care setting, specifically physicians and physician groups. The number of physicians in these studies varied from 15 to 60, and only one study involved physician groups. The research showed that pay-for-performance produced only minimal effects on quality. Proposed reasons why there were limited or no quality effects included poorly focused incentives, small numbers of physicians involved, and challenges of the inherent imbalance of power between physician information and client knowledge commonly found in health care situations. Petersen et al. (2006) reviewed 17 studies on incentive payments. Thirteen of these studies focused on process of care (preventive care) measures. The majority of studies showed at least partial positive relationship between incentive payments and identified measures. Four studies displayed unintended (negative) effects of the incentive payments. Most of the studies involved personal care physicians, both individual and groups, with the remaining studies taking place in institutional settings (e.g., nursing homes).

What are the research literature findings with regard to pay-for-performance and home health agencies? Two studies provide empirical data on the topic. Boyce and Feldman (2007) evaluated the performance of 17 home health agencies (HHAs) that participated in the ReACH (Reduce Acute Care Hospitalization) demonstration project sponsored by CMS. To help HHAs, the demonstration used a set of targeted, instruction/information-based strategies from Quality Improvement Organizations (QIOs) and achieved a risk-adjusted acute care hospitalization rate of 23% or less—a rate comparable to the top 25% of all HHAs nationally. The general strategies used in the ReACH program include:

- 1. Instituting a quality improvement process to reduce acute care hospitalizations for patients at risk,
- 2. Establishing explicit criteria for admitting patients from the hospital and improving their transition to home care,
- 3. Increasing capacity to appropriately screen and intervene for patients at risk of hospitalization,
- 4. Implementing targeted strategies and systems to support effective care management, and
- 5. Enhancing communication and coordination with primary care physicians and specialists (Boyce and Feldman, pg. 107).

Boyce and Feldman also reported that successful reduction in acute care hospitalization was related to the availability of agency resources include staffing and time to devote to the project and the ability to make administrative changes including data management and transitioning to electronic-based systems. Making changes to these administrative, business, and clinical practices was facilitated by the availability of QIO support, ReACH resources, receipt of lessons learned and prior experience addressing acute care hospitalization, committed leadership, and buy-in from agency staff. In addition to using an assessment tool for identifying patients at risk for hospitalization, the 17 HHAs reported several specific strategies that they believed were most effective in reducing acute care hospitalization (ordered by frequency of responses) including:

- Instituting risk-appropriate care plans (6 respondents)
- Front-loading visits for high risk patients (6 respondents)
- Establishing patient emergency response plans (4 respondents)
- Introducing disease management tools (4 respondents)
- Using nurse-physician scripts and educational tools (3 respondents) (Boyce and Feldman, pg. 114).

Boyce and Feldman (2007) stated that HHAs found the benchmarking and timely feedback on their performance that was part of the ReACH intervention to be particularly useful in their improvement efforts. One benchmarking technique, front-loading visits for high-risk patients, was most often cited as the key to reducing acute care hospitalization rates. The researchers summarized their findings by reiterating the importance of embedding the performance improvement activities within the agency's formal structure with committed and active senior leadership, as well as an external support system utilizing technology (virtual communities) and QIO technical assistance.

Schade and colleagues (2009) compared 294 matched home health agencies (147 target HHAs and 147 matching HHAs) involved in an intervention program focused on reducing hospitalization rates. The interventions available to both target and matching HHAs included public events, provision of educational packages and technical assistance, quality measure

feedback, and program reminders. The intervention did succeed in reversing a negative trend in hospitalization rates for the HHAs in both groups that adopted the strategies provided in the educational packages. The researchers concluded that merely agreeing to participate in the campaign did not improve performance, but effective participation through adoption of campaign methods did make a difference.

Some authors have raised concerns about applying a pay-for-performance system on home health agencies. Twiss and Schwien (2008), writing in a journal sponsored by a national advocacy group for home health agencies and hospices, recognized that pay-for-performance probably will become a reality for home health agencies. Their expressed concerns included how pay-for-performance will transition from Demonstration to national implementation, whether current risk adjustment techniques are sufficiently robust to create an "equal playing field," whether the criteria for success will be both attainment of quality and quality improvement, as it is in the HHP4P Demonstration, and if (or when) the performance criteria will include process or patient satisfaction quality measures.

There are two core conclusions that can be derived from this brief review of research literature related to pay-for-performance as it relates to health care in general and home health agencies in particular:

- 1. Pay-for-performance systems can be effective in creating change in health care provider outcomes.
- 2. Pay-for-performance systems are most effective in creating and sustaining the necessary changes when support and assistance are available both internally from the health care provider (leadership and staff buy-in) and externally from national programs and organizations.

2. <u>Summary of Year 1 (CY2008) Findings</u>

Year 1 activities in the Home Health Pay-for-Performance (HHP4P) Demonstration Evaluation included the development and approval of the Home Health Pay-for-Performance Demonstration Evaluation Survey by the Office of Management and Budget (OMB), and administration of these instruments using a Web-based secure platform, and analyzing the results from 219 respondents to the survey.

Instrumentation: After several reviews, OMB approved two survey instruments, one for the treatment agencies and a parallel one for the control agencies. These instruments covered five areas of home health care activity: staffing, care practices, policies, external contingencies, and Demonstration impact. Survey questions were designed with multiple options to simplify the response demand on participants. One open-ended response question was added to the end of the survey. These questions were reviewed by research staff and experienced home health administrator/registered nurses to ensure the construct validity and reliability of the respondent answers to these questions. OMB requested, and the University of Colorado Denver complete cognitive testing of the survey items to identify the amount of cognitive burden imposed on the individual for each of the survey questions.

As a result of these instrument development activities, the final treatment survey contained a total of 19 questions from all 5 of the areas of home health care activity identified previously, while the final control survey contained 15 questions from all of the areas of home health care activity identified previously except HHP4P Demonstration impact. Participants accessed the

Web-based surveys that were housed on a secure University of Colorado Denver computer system, using their own computer system and Internet connection. Data (participant responses) were automatically transferred to a separate, secured computer server within the University of Colorado for analysis.

Administration: All 570 HHAs that were voluntary participants in the HHP4P Demonstration were invited multiple times via multiple modalities to complete the Web-based survey. These multiple contacts continued for more than a 30-day period that ended in January 2010. HHAs that completed the survey received a recognition certificate.

Findings: Based on a total of 219 completed surveys (116 treatment and 103 control HHAs) that focused on HHP4P Demonstration activities during calendar year 2008, the following differences or similarities between the treatment and control HHAs were identified:

- Respondents were primarily senior management personnel, with QI / PI Coordinators completing the large majority of the remaining surveys;
- There were no statistically significant differences for either increases or turnover in staffing;
- Registered nurses (RNs) had the highest percentage of personnel increase (40.2%) and turnover (63.0%) for these agencies;
- Control HHAs were generally more likely to add staff functions than treatment HHAs;
- HHAs appeared to focus on training the new employees to become productive and effective members of the organization;
- Most HHAs received support from either QIOs or corporate support groups during calendar year 2008;
- More than half of the responding HHAs are not part of a larger corporate group;
- Larger corporations focused on those outcomes that could generate the largest bonus amount in the Demonstration;
- Control HHAs were significantly more likely (31.1%) to report a new policy that focused on changes in productivity requirements for their staff than treatment agencies (18.1%);
- The majority of both groups (treatment = 55.2%; control = 53.4%) reported making changes to care practices, including front-loading patient visits;
- Treatment HHAs as compared with control HHAs were more likely to have initiated new staff education (42.2% vs. 32.0%) and additional record review activities (55.2% vs. 45.6%);
- Control HHAs were significantly more likely to use electronic information exchange with referral sources beginning in 2008 than treatment HHAs (19.4% vs. 8.6%);
- Treatment HHAs reported higher rates of changes in visit patterns, introduction of telemonitoring, increased MD communication, increased care team communication, implementation of screening assessments and falls prevention programs, and improved vaccination rates;
- Control HHAs reported higher rates of change in visit mix, and enhanced wound care protocols;
- Control HHAs generally reported higher rates of negative external influences on the number of home health agencies, availability of physical therapists locally, and availability of occupational therapists locally;

- Both the treatment and control groups (82.9% and 77.6%, respectively, of those HHAs providing comments) report that they had received no feedback from Abt Associates other than their assignment to either the treatment or control group;
- The large majority of treatment and control HHAs that provided comments identified the lack of feedback from Abt Associates during the first year of the HHP4P Demonstration as an issue worthy of comment; and
- Virtually all of the other comments from the treatment HHAs could be classified as positive, whereas virtually all of the remaining comments from the control HHAs were split between positive and negative comments (the latter primarily focused on the fairness of the comparison between agencies given case mix differences and data collection/analysis issues).

As stated previously, only the Treatment HHAs received questions regarding how the HHP4P Demonstration affected costs, quality, and their overall commitment to sustaining results beyond the end of the HHP4P Demonstration. The following are some highlights from their reports on the survey:

- The majority of HHAs (53.4%) reported that participation in the HHP4P Demonstration resulted in a less than 1% change in HHA costs, while 22.4% reported a 1% 5% increase in HHA costs attributable to the Demonstration;
- HHAs believed that the HHP4P Demonstration would have the greatest positive impact on acute care hospitalization (69.0%) and management of oral medications (72.4%);
- A substantial majority of the treatment HHAs believed that the demonstration would have a positive impact on the agency's patient outcomes (67.2%) and quality of care provided by the agency (61.2%);
- Treatment HHAs' self-report on commitment, readiness, and willingness to sustain the activities as very high (86.2%, 81.0%, and 85.3%, respectively);

Summary: A convenience sample of 219 HHAs representing approximately 40% of the HHP4P Demonstration HHAs from all seven participating states and with approximately equal numbers of both treatment and control HHAs provided a useful picture of what policies and practices were implemented during the first year of the HHP4P Demonstration. The policy and practices primarily emphasized reducing acute care hospitalization rates, which is both an emphasis of the HHP4P Demonstration based on the monetary rewards associated with this outcome and an on-going emphasis for both CMS and its QIO organizations. There were few statistically significant differences in the responses between the treatment and control HHAs. However, there were substantial differences within these groups in terms of clinical care practices and the focus of how technology was used. Policy differences also were noted between treatment and control HHAs.

3. Year 2 Methodology

Instrumentation changes: Prior to administering the Web-based surveys, several changes were made to the two survey instruments. The Treatment instrument was split into two forms: one for Winners during Year 1 (CY2008) and one for Non-Winners during Year 1. This allowed the inclusion of questions for how the Winners notified staff, their patient population, and the general community about their success, as well as how the monetary awards were used. Both

Treatment instrument forms requested the HHAs to predict how they would do in Year 2 of the demonstration. The Control instrument was expanded to include cost of implementation items and impact on performance items. The total number of questions in each instrument varied slightly: "Winners" = 22 items, "Non-Winners" = 20 items; and "Control" = 20 items.

For all forms of the survey instrument, one item was significantly revised and two new items were created. The "Staff Turnover" item was significantly revised to capture the amount of turnover using numerically-based, qualitative descriptions of the amount of turnover. For example, turnover that was "0 - 5%" described "No/Low" turnover, "6-20%" described "Small", "21-40%" described "Moderate," etc. A new multiple option item that identified several possible support activities for HHAs that participate in P4P (e.g., regular updates or reminders about the program, best practices newsletters, renewed QIO involvement with HHAs) were rated by the HHAs on their anticipated effectiveness. Additionally, all forms of the survey instrument added an open-ended item requesting the HHAs to share advice for other HHAs who will participate in P4P in the future. Copies of all three forms of the instrument can be found in Appendix A.

Methodological changes: As in Year 1, all HHAs participating in the Demonstration were invited via letter and email to participate in the Year 2. The survey was available to HHAs from October 2010 through the end of January 2011. Biweekly email reminders were sent to all HHAs that had not completed the survey. HHAs that completed the survey received a certificate of recognition and a copy of a summary of the findings from the Year 1 Report on the Evaluation of the Demonstration. Table 1 provides the distribution by region and state of the number of previous Winners, Non-Winners, and Control agencies that participated in the Year 2 Web-based survey. Interestingly, nearly 58% of the Year 1 respondents to the Web-based survey also submitted responses on the Year 2 surveys.

			Tre		
Region	State	Total	Yr1 Winners	Yr1 Non-Winners	Control
NE	СТ	10	8		2
NE	MA	12	4		8
SE	AL	13	6		7
SE	GA	8	4		4
SE	TN	12	7	1	4
MW	IL	36	16	6	14
W	CA	34	15	4	15
	·				
	Totals	125	60	11	54
				. –	

Table 1:Distribution by Region and State of Winners, Non-Winners, and Control Agencies that
Participated both in the Year 1 and Year 2 Web-based Survey.

Totals	125	60	11	54
Year 2 Totals	217	108	15	94
% Repeat	57.6%	55.6%	73.3%	57.4%

4. <u>Results</u>

4a. Regional Cross-tabulations

Overview: Cross-tabulations for each item, except for Survey Item #4, were computed for the three Treatment groups (Winners, Non-Winners, and Control), for four regions (Northeast, Southeast, Midwest, and West), and for the seven states (MA, CT, TN, AL, GA, IL, and CA). Cross-tabulations using multiple stratification variables (region by treatment) also were computed for each question. Chi-square analyses were computed on each of these cross-tabulations. Three levels of significance are reported on the accompanying tables: high (p<0.01); moderate (p<0.05); and slight (p<0.10). These cross-tabulations can be found in Appendix B.

The results are displayed by survey question, with the completed question and response options (where appropriate) presented as the title for the accompanying table. The number of statistically significant results differed by question. The lowest numbers of significant relationships were for Survey Items #3 (preparer) (two significant relationships) and Survey Item #8 (staff positions/functions) (three significant relationships). At the other end of the spectrum, several items had at least 10 statistically significant relationships identified:

- Survey Item #5 (CY2009 performance—17),
- Survey Item #6 (change in staff positions—10),
- Survey Item #14 (local/regional impact—14),
- Survey Item #18 (impact on QI/PI—10), and
- Survey Item #19 (impact on outcomes, cost/finances—31)

A few other survey items fell just below the 10 statistically significant values criterion.

Discussion of Selected Specific Results: <u>Survey Item #5</u> (CY2009 performance) produced a large number of statistically significant differences by treatment group. In general, Control HHAs viewed their CY2009 performance as better than their CY2008 performance while the Winning HHAs reported no change in performance, and Non-Winners reported either the same or worse performance. There were some differences by region/state with HHAs from GA and TN more likely to indicate substantial improvement in Acute Care Hospitalization and Any Emergent Care. Control HHAs in IL were more likely to report high performance in the improvement in Activities of Daily Living (ADL) outcomes than other treatment groups, while Winner HHAs in IL were more likely to report substantial improvement in these ADL outcomes.

<u>Survey Item #6</u> (Staff changes) showed strong regional and/or state differences. The notable disciplines, not surprisingly, are registered nurse (RN), licensed practical nurse (LPN), medical social worker (MSW), and home health aide (HH Aide). Typically, the states in the Southeast (SE) region reported a higher percentage of decreases or no changes in these positions, whereas the other regions notably the Northeast (NE) and West, reported increases in staff in these positions during CY2009.

<u>Survey Item #7</u> (Turnover rates) showed few differences across all of the comparisons. The Midwest (MW) and West regions reported slightly higher turnover rates for RNs than did the other two regions. Given that these two regions are single states, the differences were

specifically related to IL and CA. Approximately 20% of the HHAs from these states reported a moderate (<40%) turnover rate and between 30% and 40% of HHAs from these states report a small (<20%) turnover rate. For most regions the large majority of HHAs reported no/low (<5%) turnover rate for RNs.

For <u>Survey Item #8</u> (Staff positions/functions) only staff education produced statistically significant results. In the NE and West regions, Winner HHAs were more likely to already have this position and Control HHAs were more likely to add this position during CY2009.

Regional differences were also identified for <u>Survey Item #9</u> (Policy changes). Policies related to patient infection control, new clinical specialties, and on-call staff changes were more likely to occur in the West (CA) than for the other regions. Staff hiring practices produced multiple statistically significant differences. Again, the West (CA) was more likely as a region to implement hiring practice changes. However, in the NE region, Control and Non-Winner HHAs were more likely to implement this policy change than the Winner HHAs. Perhaps these latter HHAs already have the policy in place.

State and regional differences also were identified for <u>Survey Item #10</u> (Care provider/QI practices). Regions other than the SE were more likely to institute changes in staff competencies and staff evaluation criteria than the SE. Employee incentive and management practice changes were more likely to occur in the MW and West than in the other two regions involved in the Demonstration.

<u>Survey Item #11</u> (Technology innovations) produced mixed results. Electronic access to HHA policies resulted in statistically significant differences for treatment group (Non-Winners had the highest rates), with similar results within regions. Changes in the use and/or selection of wound care materials were more likely to occur in the MW and West regions.

Survey Item #13 (Corporate initiatives) differences were more likely to occur in the SE than in other regions. This is not surprising given the high percentage of HHAs under corporate sponsorship in this region. In general, Control HHAs from the SE region were more likely than their counterparts to modify an existing corporate program that focused on reducing Acute Care Hospitalization, Any Emergent Care, and the number of patient falls. Similarly, Control HHAs from the SE region also increased attention on staff training when compared with their counterparts from that region.

Regional differences for <u>Survey Item #14</u> (Local/regional issues) reached a level of statistical significance for several elements measured by this item. HHAs reported that the lack of available professional staff (RNs, physical therapists (PTs), occupational therapists (OTs) and HH Aides) had a negative impact. In particular, a higher percentage of HHAs in the NE region reported availability problems for RNs, HH Aides, and PTs, while HHAs in the MW region cited difficulty in obtaining PT services. The MW region also found the availability of OTs to be problematic—and to a slightly less extent, the West also found OT services difficult to obtain. HHAs in the SE region viewed other health care providers as a mixed bag. In some cases, Control HHAs viewed the number of hospitals as having both a positive and negative impact, while in other cases Winner HHAs viewed the number of urgent care facilities as either positive

or negative. The interpretation of these results is not clear, except that other health care providers in the SE region do have an effect (positive, negative, or both) on the different treatment groups from this region.

<u>Survey Item #17</u> (Estimated cost impact) produced some statistically significant results. Control HHAs estimated that their cost of delivering care either was much more costly or much less costly than before their P4P Demonstration when compared with the Winner HHAs. Of the Winner HHAs, 60% estimated that there was a less than 1% change (60%), and 31% estimated that there was a slight increase of 1-5% in the cost of delivering care due to the HHP4P Demonstration. Approximately 25% of the Control HHAs estimated that their costs had increased by more than 5% as a result of the HHP4P Demonstration. Perhaps the Winner HHAs were already spending more on the delivery of care and hence, did not identify any increase in costs to maintain their high level of performance.

The HHP4P Demonstration's perceived impact on target outcomes is captured in <u>Survey Item</u> <u>#18</u> (Target outcome impact). Winner HHAs are slightly more positive about the Demonstration's impact on Improvement in Management of Oral Medications than Control HHAs. State differences on this item are varied. All states, except AL, believe that the HHP4P Demonstration will result in at least modest reduction in Acute Care Hospitalization rates and an increase in Improvement in the Status of Surgical Wounds. IL, CT, and AL all have lower expectations regarding reducing Any Emergent Care than the other four states. Improvement in Management of Oral Medications is very likely to see at least a modest improvement according to nearly 80% of HHAs from TN. Winner and Control HHAs were both optimistic about Improvement in Management of Oral Medications, with Winner HHAs in the West (CA) Region reporting slightly more positive results than Control HHAs.

<u>Survey Item #19</u> (Demonstration impact on quality and finances) produced the largest number of statistically significant differences. Treatment group differences, 60% of Control HHAs and 80% of the Winner HHAs, indicate that the HHP4P Demonstration had a positive impact (slight or very) on the quality of care provided by the HHA, while no Non-Winner HHAs reported a positive impact (all reported "no impact"). Conversely, about 40% of the Control HHAs responded that the HHP4P Demonstration had a negative impact on statewide HHA solvency and profitability and profitability of their HHA, whereas only about 10% of the Winner HHAs responded in this manner. On a positive note, 40% of the Control HHAs and 60% of the Winner HHAs thought that the HHP4P Demonstration had a positive impact on referral source satisfaction with the quality of care.

There were also regional and state-to-state differences on Survey Item #19. Approximately 60% of the HHAs in the NE and MW reported a positive effect on the quality of care provided by the HHA, and a surprisingly high 80% of the HHAs from the SE and West also reported a positive effect. No agencies completing the survey expected a negative impact on the quality of care provided by the HHA. The SE region viewed the impact as spreading statewide (70%), whereas 40% of the HHAs in the NE viewed the demonstration as having a statewide effect on quality of care. The NE region was generally more positive about how the HHP4P Demonstration would impact financial solvency and the profitability of their HHA and HHAs in the state, especially compared with HHAs from the SE region that typically were much more negative on all four of

these elements. Patient satisfaction varied by region from MW $\approx 40\%$ to SE $\approx 70\%$; the MW was also lowest in its rating of staff satisfaction ($\approx 30\%$); whereas all other regions reported about 50% staff satisfaction. Perhaps the fact that the HHAs in the MW did not receive a monetary bonus would explain part of this difference in staff satisfaction.

Discussion of General Findings: These findings can be combined into two groups that are not necessarily mutually exclusive: regional differences and positive impact of the HHP4P Demonstration. Highlights of each set of findings will be presented separately.

There were clear regional differences among the 219 HHAs that participated in the Year 2 Webbased survey. In general, HHAs from the NE region were much more positive about their experiences and the expected impact than HHAs from the SE. HHAs from the MW were much more likely to report more negative about financial issues than HHAs from other regions. The HHAs from the MW and West reported higher turnover rates than other regions for skilled health care professionals. The SE did expect greater positive results from the HHP4P Demonstration in the areas of patient satisfaction and statewide improvement in patient care than the other regions.

The HHAs responding to the Year 2 Web-based survey were generally positive about the effect of the HHP4P Demonstration. This was highlighted by all HHAs reporting either neutral or positive effects on the quality of care provided to patients, and in the positive impacts on a number of patient outcomes including Acute Care Hospitalization, Any Emergent Care, and Improvement in Management in Oral Medications. Even the cost of impact of the HHP4P Demonstration was minimal as evidenced by more than 90% of the Winner HHAs reporting either no increase or less than a 5% increase in costs for providing care to patients.

Differences among treatment groups (Winners, Non-Winners, and Control HHAs) were largely restricted to perceptions about improvements or performance on the target outcomes and the impact on financial solvency and profitability. In general, Winner HHAs expressed more positive views than the Control HHAs on these measures.

Conclusion: The findings from the Year 2 Web-based survey were similar to the Year 1 results. There were a larger number of statistically significant differences in the Year 2 results than in the previous year. However, the findings of a generally positive view of effect of the HHP4P Demonstration across all treatment groups, and regional differences in staffing and perceptions of the financial impact of the HHP4P Demonstration are consistent with the Year 1 findings.

4b. Chi-Square Summaries

Appendix C provides a summarization of the statistically significant Chi-square result by item across each of the dimensions that were analyzed (region, state, treatment/control) for the Web-based survey items. These tables provide the statistically significant relationships discussed in detail in the previous section into single tables for each item.

4c. Winners, Non-Winner, and Control Comparisons

Appendix D provides cross-tabulation for selected items on the Web-based survey comparing Winner, Non-Winner, and Control HHA responses. No Chi-square values for these tables were computed as the number of Non-Winner participants is quite small, so the number of empty cells might contribute to false positive (or false negative) results. Interesting findings were that Control HHAs in the Southeast and Midwest were more likely to anticipate higher performance in Year 2 while Winner HHAs in these same regions characterized this change as "improved performance." There were few meaningful differences in staff turnover—most (>80%) rating the problem as "no/low" in all areas except for RNs where about 50% rated the turnover as "no/low" and 30% rated the problem as "small". About 54% of Winners and Control HHAs viewed virtually no change in costs ("less than a 1% change") while approximately 24% reported a slight (<5%) increase.

4d. Regression Models for Demonstration Target Outcomes

Background/Overview: "Regression Model Summaries" (Appendix E) contains several sets of tables that provide statistical information for prediction models on selected "outcome" items using the Year 2 Web-based Survey, computed for three groups of home health agencies: "All" HHAs, "Control" HHAs, and "Winner" HHAs. The "outcome" items are based on Survey Items #17 – 19 that ask the participating HHAs to rate what the expected impact of the Demonstration was on a variety of financial and patient outcome items. The independent variables used to develop the prediction models were response elements from Survey Items #7 – 12.

The tables for each set of prediction models "All" HHAs, "Control" HHAs, and "Winner" HHAs provide the following statistical information:

- Name of the independent variable,
- Bivariate correlation between the independent variable and the dependent variable,
- Regression coefficient for the independent variable in the prediction model,
- Statistical significance level of the independent variable in the prediction model,
- A model summary that includes:
 - o the multiple R value for the prediction equation,
 - o the R-squared value for the prediction equation,
 - ANOVA F value for model fit, and
 - the statistical significance of the F value for the model.

The three groups----"All" HHAs, "Control" HHAs, and "Winner" HHAs—are expected to have some overlap in the independent variables that are included in the prediction models. However, differences in the set of independent variables for the prediction models may point to differences in the strategies used by Control vs. Winner HHAs to address (create change in) particular health care outcomes. The differences in these independent variable groups may provide additional insight into how Control and Winner HHAs differ. The independent variables that are in common between Control and Winner HHAs—or found in all three models reflect the core set of prediction variables for the outcome (dependent measure).

Methodology: The methodology used to construct the prediction models was as follows:

- Create three data sets:
 - All HHAs that completed the Year 2 Web-based Survey;
 - All Control HHAs that completed the Year 2 Web-based Survey; and
 - All Winner HHAs that completed the Year 2 Web-based Survey.
- Identify "outcome" type survey items and options (elements) within these items. The following is a list of the "outcomes" for which prediction models were created:
 - Cost of Participating in Demonstration (Item #17)
 - QI Impact on Acute Care Hospitalization (Item #18 a)
 - QI Impact on Any Emergent Care (Item #18 b)
 - QI Impact on Improvement in Bathing (Item #18 c)
 - QI Impact on Improvement in Ambulation/Locomotion (Item #18 d)
 - QI Impact on Improvement in Transferring (Item #18 e)
 - QI Impact on Improvement in Status of Surgical Wounds (Item #18 f)
 - QI Impact on Improvement in Management of Oral Medications (Item #18 g)
 - Demonstration's Impact on Patient Outcomes (Item #19 a)
 - Demonstration's Impact on Quality of Care (Item #19 b)
 - Demonstration's Impact on HHA's Cost of Providing Care (Item #19 e)
 - Demonstration's Impact on HHA's Financial Solvency (Item #19 f)
 - Demonstration's Impact on HHA's Profitability (Item #19 i)
 - Demonstration's Impact on Patient Satisfaction (Item #19 j)
 - Demonstration's Impact on Staff Satisfaction (Item #19 k)
- Calculate bivariate correlations between the 65 independent variables taken from Survey Items #7 12 and the 15 dependent measures identified as "outcome" items.
- Select all independent variables that have a bivariate correlation where p<0.05 to use in a fixed Ordinary Least Squares (OLS) regression model.
- Compute a fixed OLS regression model using the selected independent variables associated with each dependent ("outcome") variable. Note: because there was no attempt to further reduce the number of independent variables in the final models based on the p-value of the coefficient, some redundancy of independent variables that are included in the models is expected.

Discussion of Individual Outcome Models: The tables Appendix E (pp. E.1 – E.27) use a coding system to assist the reader identifying which variables are in common for all three models (superscript 1), which are in common for the "All" and "Control" models (superscript 2), and which are in common for the "All" and "Winner" models (superscript 3). If there is no superscript value in the cell with the variable name, then the variable is unique to that model.

Cost of Participating in Demonstration: Only a small number of independent variables (five to seven) showed strong bivariate correlations with this dependent variable across the three data sets. There were no independent variables in common among all three models. The "All" and "Control" models shared two variables: Staff education and Wound care protocols (superscript 2). The "All" and "Winner" models shared two variables: Management practices and Hiring requirement (superscript 3). "Control" and "Winner" models share no variables. This suggests that Control and Winner HHAs differed greatly in how they approached dealing with costs associated with the P4P Demonstration. Control HHAs targeted specific activities (e.g., staff

education, care protocols, materials) whereas Winner HHAs used more global strategies (e.g., staff competencies, management practices, and hiring requirements). The R-squared values for the models ranged from 0.094 for "All" to 0.281 for "Control." Each model was statistically significant based on its F-value at p < 0.01.

Quality Improvement Impact on Acute Care Hospitalization: Reducing the need for home health patients to receive additional Acute Care Hospitalization was clearly a major goal for the Home Health P4P Demonstration project. The prediction models created included more independent variables than the "Cost of Participation" models and varied from 9 ("Control") to 15 ("All"). Three independent variables-Employee incentives, Clinical pathways, and Communication with the physician—were shared by all three models (superscript 1). Additionally, the "All" and "Control" models share three other variables-Plan of Care specific parameters, Vaccination focus, and Care plans—while "All" and "Winner" models share five different variables: Clinical team meetings, Disease management program, Patient teaching, Medication dispensing systems, and Disease management. As with the "Cost of Participation" models, the differences between the Control HHA approach and the Winner HHA approach can be characterized as "specific" (Control) versus "strategic" (Winner). The R-squared values for the models ranged from 0.130 for "Winner" to 0.258 for "Control." The "All" and "Control" models were statistically significant based on its F-value at p < 0.01. The "Winner" model was not statistically significant.

Quality Improvement Impact on Any Emergent Care: Reducing the need for Any Emergent Care for HHA patients is also an important goal of the HH P4P Demonstration as the use of emergency departments by home health patients leads to increased medical care costs for Medicare. The number of independent variables used in these three models varied from 14 ("Control") to 28 ("All"). As expected, the number of shared independent variables increased from the previous models to five: Staff evaluation criteria, Communication with physician, Plan of Care specific parameters, Physician communication, and Electronic access to policies. The "All" and "Control" models shared an additional five independent variables, while the "All" and "Winner" models shared a different, additional 15 independent variables. The additional variables for Control HHAs focused on care plans, record reviews, and changes to and faster visits. Conversely, the Winner HHAs focused on management practices (including employee incentives and business hours, supervision), both direct and telemonitoring, patient teaching, and disease and medication control programs. The Winner HHAs strategy seemed to be focused on activities that affect the patient care (e.g., education, disease and medication control programs) versus the Control HHAs' focus on record review and faster intervention. The R-squared values for the models ranged from 0.268 for "All" to 0.442 for "Control." The "All" and "Control" models were statistically significant based on its F-value at p < 0.01, while the "Winner" model was statistically significant at the p < 0.05 level.

Quality Improvement Impact on Improvement in Bathing: There were only three independent variables common to all three models for this dependent measure: Employee incentives, Patient infection control, and Hiring requirements. The number of independent measures for the three models varied from 17 ("Winners") to 32 ("All"). There were 11 uniquely shared variables between the "All" and "Control" models that focus on communication (e.g., clinical team meetings, patient teaching, communication with physician) and management (e.g., practices,

supervision of HH Aides, visit pattern changes). The "All" and "Winner" models shared a different 10 variables that focus on staff competencies and evaluation, as well as communication-related variables (e.g., patient and physician communication, and e-messaging with staff). The R-squared values for the models ranged from 0.237 for "All" to 0.427 for "Control." Each model was statistically significant based on its F-value at p < 0.01.

Quality Improvement Impact on Improvement in Ambulation / Locomotion: Five independent variables were shared among the three models: Staff competencies, Employee incentives, Care team communication, Patient infection control, and e-messaging with staff. The number of independent variables for the models ranged from 12 ("Winner") to 32 ("All"). The 14 uniquely shared variables between the "All" and "Control" models were a rather eclectic group including management practices such as record reviews, PI programs, visit pattern management, and hiring practices, as well as patient care related initiatives such as screening assessments, medication dispensing systems, disease management, and falls prevention. The "All" and "Winner" models shared seven unique variables including mentoring programs, staff evaluation, visit mix and clinical resources, as well as two business practices—on-call staff changes and expanded business hours. The R-squared values for the models ranged from 0.224 for "All" to 0.481 for "Control." The "Control" and "Winner" models were statistically significant at the p < 0.05 level.

Quality Improvement Impact on Improvement in Transferring: The number of independent variables for the models ranged from 12 ("Winner") to 32 ("All") with only 3 independent variables common to all three models: Reduced time from referral to admissions, Physician communication, and Disease management. Eighteen independent variables were in common between the "All" and "Control" models. These variables covered a myriad of areas including management practices (e.g., PI programs, record review, visit pattern changes, HH Aide supervision, hiring requirements), communication (with patients and physicians), and care practices (e.g., wound care protocols, medication dispensing, falls prevention, infection control). Eight variables were unique to the "All" and "Winner" models. The themes represented in these variables were programmatic (e.g., mentoring, evaluation criteria, visit mix) and business-related (e.g., on-call staff changes, expanded business hours). The R-squared values for the models ranged from 0.192 for "Winner" to 0.485 for "Control." The "All" and "Winner" models were statistically significant based on its F-value at p < 0.05, while only the "Control" model was statistically significant at the p < 0.01 level.

Quality Improvement Impact on Improvement in Status of Surgical Wounds: The number of independent variables that showed strong bivariate correlations with this dependent variable ranged from 9 ("Winner") to 23 ("All") for the three models. There were five independent variables in common among all three models: Communication with physician, Care team communication, Wound care protocols, Disease management, and Hiring practices. These five variables seem to be quite consistent with what would influence the outcome being predicted. The "All" and "Control" models shared eight variables. These variables appear to supplement or reinforce the five variables that are in common among the models. The "All" and "Winner" models shared three variables: Staff evaluation criteria, Patient teaching, and Medication checking software. This suggests that Control and Winner HHAs differed in their approach to

improving the status of surgical wounds. Control HHAs targeted specific activities (e.g., record review, wound materials) whereas Winner HHAs used more global strategies (e.g., patient teaching, staff evaluation criteria). The R-squared values for the models ranged from 0.190 for "All" to 0.318 for "Control." The "All" and "Winner" models were statistically significant based on its F-value at p < 0.01, while the "Control" model was significant at the p < 0.05 level.

Quality Improvement Impact on Improvement in Management of Oral Medications:

Given the number of medications taken by home health patients, this outcome is also an important goal for the Home Health P4P Demonstration project. As with the prediction models created for the "Cost of Participation" outcome, there were no independent variables share by all three models. The number of independent variables in the models varied from 8 ("Control") to 13 ("All"), which is one of the lower totals from among the models presented. The "All" and "Control" models share six variables, while the "All" and "Winner" models share seven different variables. As has been the pattern with the other models, the Control HHAs focused on specific interventions (e.g., Plan-of-Care specific parameters, Screening assessments, and Medication dispensing systems). Winner HHAs emphasized staff competencies and evaluations, patient teaching, and some unexpected variables (Falls prevention and expanded business hours). The R-squared values for the models ranged from 0.149 for "All" to 0.237 for "Control." Each of the models were statistically significant based on its F-value at p < 0.01.

Demonstration's Impact on Patient Outcomes: Unlike the preceding seven models that addressed each of the seven targeted and publicly-reported Outcome Based Quality Improvement (OBOI) outcomes, this outcome and the ones that follow are based on Survey Item #19. The responding agencies were ask to provide a more global assessment of the impact of the HH P4P Demonstration Project on a variety of patient care-related outcomes and institutional (home health agency) outcomes. The number of independent variables used in these three models varied from 9 ("Control") to 26 ("All"). The number of shared independent variables for all models was three: Communication with physician, Patient communication, and Patient infection control. The "All" and "Control" models shared an additional three independent variables, while the "All" and "Winner" models shared a different, additional 12 independent variables. The additional variables for Control HHAs were Change in visit mix, Screening assessment, and Pressure ulcer reduction equipment. Conversely, the Winner HHAs focused on management practices, including staff competencies and electronic access to policies, clinical staff meetings/communication, and attention to clinical pathways, and programmatic interventions (disease management, reducing time between referral and patient admission, and electronic medical records). Winner HHAs also focused on patient training. The R-squared values for the models ranged from 0.195 for "All" to 0.314 for "Winner." The "All" and "Winner" models were statistically significant based on its F-value at p < 0.05, while the "Control" model was statistically significant at the p < 0.01 level.

Demonstration's Impact on HHA's Quality of Care: There were only three independent variables common to all three models for this dependent measure: Communication with physician, Patient infection control, and Hiring requirements. The number of independent measures for the three models varied from 10 ("Control") to 25 ("All"). There were six uniquely shared variables between the "All" and "Control" models that focused primarily on management (e.g., screening assessment, visit pattern/mix changes, reducing referral to patient admission

time). The "All" and "Winner" models shared a different 10 variables that focus on patient teaching, care team coordination, and particular systems such as wound care and medications. The R-squared values for the models ranged from 0.186 for "All" to 0.276 for "Winner." Each model was statistically significant based on its F-value at p < 0.05.

Demonstration's Impact on HHA's Cost of Providing Care: This outcome produced the model with the fewest independent variables (three for "Control") for any of the models created in this analysis. The "All" model was the largest for this group and had 11 variables. Not unexpectedly given the topic and the few independent variables in the "Control" model, there were no shared variables among the three models. The "All" and "Control" models shared one variable: Process Improvement programs. The "All" and "Winner" models shared four unique variables: Patient teaching, Screening assessments, Wound care protocols, and Patient infection control. The R-squared values for the models ranged from 0.125 for "All" to 0.173 for "Winner." Interestingly, all three models were statistically significant based on its F-value at p < 0.01.

Demonstration's Impact on HHA's Financial Solvency: The number of independent variables for the models ranged from six ("Control") to 10 ("All") with only one independent variable common to all three models: Plan-of-Care specific parameters. Four independent variables were in common between the "All" and "Control" models, including Process Improvement programs, Communication with the physician, Other staff turnover, and Physician communication. How these four variables relate to the home health agency's financial solvency is not intuitively obvious. Only one of the remaining eight variables in the "Winner" model was also included in the "All" model: Patient teaching. Why so few of the other variables in the "Winner" model were in the "All" model was not explored. The R-squared values for the models ranged from 0.104 for "All" to 0.200 for "Winner." All three models were statistically significant based on its F-value at the p < 0.01 level.

Demonstration's Impact on HHA's Profitability: There were four independent variables common to all three models for this dependent measure: Communication with physician, Planof-Care specific parameters, Physician communication, and Emergency response. This was the only time that "Emergency response" was in any of the models computed for this analysis. The number of independent measures for the three models varied from seven ("Control") to 16 ("All"). There were three uniquely shared variables between the "All" and "Control" models: Change to visit mix, Other staff turnover, and Patient communication. The "All" and "Winner" models shared a different five variables that focused on patient teaching, care team coordination, screening, wound care, and hiring practices. The R-squared values for the models ranged from 0.165 for "All" to 0.284 for "Winner." Each model was statistically significant based on its F-value at p < 0.01.

Demonstration's Impact on HHA's Cost of Providing Care: This outcome produced the model with the fewest independent variables (three for "Control") for any of the models created in this analysis. The "All" model was the largest for this group and had 11 variables. Not unexpectedly given the topic and the few independent variables in the "Control" model, there were no shared variables among the three models. The "All" and "Control" models shared one variable: Process Improvement programs. The "All" and "Winner" models shared four unique

variables: Patient teaching, Screening assessments, Wound care protocols, and Patient infection control. The R-squared values for the models ranged from 0.125 for "All" to 0.173 for "Winner." Interestingly, all three models were statistically significant based on its F-value at p < 0.01.

Demonstration's Impact on HHA's Patient Satisfaction: Home health patient satisfaction will begin to be formally measured for all HHAs beginning in October 2011. HHAs are always acutely aware of how satisfied their patients are with the quality and timeliness of the services provided by the HHA. Because HHA patients often return to the same agency or refer their peers to a particular HHA, patient satisfaction is an important indicator of the quality of an HHA. The number of independent variables for the models ranged from 15 ("Control") to 33 ("All"), the most for any of the constructed models. There were eight variables that were common to all three models. These include many of the "in-common" variables previously identified, such as communication with physician and patient, reducing time between referral and patient admission, patient infection control, and hiring practices. Four independent variables were in common between the "All" and "Control" models: Clinical resources, Change in visit mix, Other staff turnover, and Screening assessments. Ten variables in the "Winner" model were also included in the "All" model. These included staff-related variables such as mentoring, team meetings, and record review, and management variables such as disease management and expanded business hours. The R-squared values for the models ranged from 0.291 for "Winner" to 0.352 for "Control." Only the "All" and "Control" models were statistically significant based on its F-value at the p < 0.01 level.

Demonstration's Impact on HHA's Staff Satisfaction: The culture of an organization plays an important role in the organization's ability to provide high quality services. This is especially true in home health agencies where staff satisfaction is a key indicator of a healthy culture. This outcome produced the model with the second fewest independent variables (four for "Control") for any of the models created in this analysis. The "Winner" model was the largest for this group and had 24 variables. This is the only case in these analyses where the "All" model did not contain the largest number of independent variables. Two independent variables, Reducing time between referral and patient admission and Patient communication, were common among the three models. The "All" and "Control" models shared two variables: Screening assessments and Physician communication. The "All" and "Winner" models shared 12 unique variables including patient-related (e.g., Patient teaching and Plan-of-Care specific parameters), clinicianrelated (e.g., mentoring, team meetings/communication, physician communication), and management-related (e.g., change in visit mix, productivity, hiring requirements). The Rsquared values for the models ranged from 0.125 for "Control" to 0.312 for "Winner." Interestingly, the "All" model was statistically significant based on its F-value at p < 0.01, while the "Control" model—using the F-value—was significant at the p < 0.05 level.

Summary of Models and Independent Variables: Several independent variables were found in multiple models including: Communication with physician (seven models), Patient infection control (five models), Hiring requirements and Patient communication (four models). There were four other variables that were in common on three models including Reducing the time from referral to patient admissions, Plan of Care specific parameters, and Employee incentives.

These would represent home health care core strategies for creating an effective and efficient organization that could provide quality care to its patients.

As noted previously, there are differences between the variables in the "Control" HHA models versus those more typically found in the "Winner" HHAs. Screening assessments (eight) and Change in visit patterns (seven) were most often unique to the "Control" HHAs. Other variables more commonly associated with "Control" HHAs were Medication dispensing systems and Process Improvement programs (five) and Record review (four). Conversely, "Winner" HHAs were strongly characterized by Patient teaching, which was unique to "Winner" HHAs in 11 models. Clinical team meetings and Staff evaluation criteria each occurred in five models, while Disease management program and Expanded business hours were unique in four models.

Conclusion: Reviewing these regression models in aggregate, there is a core set of variables/strategies used by home health agencies to address the needs of its patients while maintaining a fiscally viable organization. Similarly, while few differences were seen with the cross-tabulation comparison of Control versus Winner HHAs on an item-by-item basis, the regression analyses suggest that there are consistent differences between the two groups. The Control HHAs approach many of the outcomes using a structural solution, whereas Winner HHAs approach their outcomes using a patient and staff-centered approach.

5. <u>Discussion</u>

The findings for these four analyses have been presented in detail in the prior sections. They will be summarized here in outline form for ease of reference.

Regional Cross-tabulations (Appendix B)

- These comparisons focus on Regional and Experimental (Treatment Winners, Treatment Non-Winners, and Control HHAs) Group differences for Items 7, 8, 17, 18, and 19.
- Item #7 (Table B.2) focuses on Staff Turnover using a rating scale of Low/No (<5%), Small (6-20%), Moderate (21-40%), High (41-75%), and Very High (>75%).
- Table B.2 (Item #7) showed that across Regions and across Experimental groups the large majority (>70%) reported Low/No turnover in Senior Management, QI/PI Coordinator, Clinical Supervisor, Physical Therapist, Occupational Therapist, Medical Social Worker, RN with Specialty, Licensed Practical Nurse, Home Health Aide, Administrative Staff, and Other staff.
- For Registered Nurses, Item #7 showed that the turnover rate was reported as Low/No in about 50% of the Regions and across Experimental groups; about 30% reported Small turnover, and about 15% reported a Moderate turnover in this professional group.
- Item #8 (Table B.3, pp. B.6-7) focuses on added new positions due to the Demonstration with three options—already existed, added, and does not exist.
- For Item #8 the QI/PI Coordinator position was most likely to already exist (about 65%), whereas a combination position for improving quality was least likely to already exist (about 47%).
- As reported in Item #8, Control agencies were more likely than Treatment agencies to add the following positions: QI/PI Coordinator, Documentation Quality Assurance, Staff Education, Outcome Analysis, and Combination position.

- As reported in Item #8, the Midwest was most likely to add QI/PI Coordinator, Documentation Quality Assurance, Staff Education, and Utilization/Resource Review positions.
- As reported in Item #8, the Southeast was most likely to add an Outcome Analysis position, while the West was most likely to add a Combination position.
- Item #17 (Table B.4. p. B.8) asked the agencies to estimate the Demonstration's impact on the cost of providing care using a seven-option scale from >10% decrease to a >10% increase with "<1% change" as the midpoint in the scale.
- Nearly 54% of all HHAs reported <1% change (positive or negative) in the cost of providing care.
- About 24%, based on their Item #17 response, reported a 1-5% increase in the cost of providing care, while about 10% reported a 5-10% increase.
- About 5% reported a 1-5% decrease in their costs based on Item #17.
- Item #18 (Table B.5, pp. B.9-12) asked the agencies to estimate the impact of their QI activities on the seven target outcomes, rating the impact as no impact, modest, or substantial.
- Approximately 64 67% of agencies rated the impact as "Modest" or "Substantial" for three outcomes: Acute Care Hospitalization, Improvement in Ambulation/Locomotion, and Improvement in Management in Oral Medications.
- As reported on Item #18, only about 55% of agencies rated the impact as "Modest" or "Substantial" for Any Emergent Care and Improvement in Bathing.
- Treatment agencies reported a larger impact than Control agencies for Any Emergent Care and Improvement in Management of Oral Medications; whereas the reverse was true for Acute Care Hospitalization, Improvement in Bathing, and Improvement in Ambulation/Locomotion.
- As reported on Item #18, the West agencies reported a greater impact than the other regions on Acute Care Hospitalization, Improvement in Ambulation/Locomotion, and Improvement in Status of Surgical Wounds.
- The Northeast agencies reported a greater impact ("modest" or "substantial" combined) on Improvement in Management of Oral Medications, while the Southeast agencies reported a greater impact on Improvement in Transferring, and the Midwest agencies reported greater impact on Improvement in Bathing.
- Item #19 (Table 6, pp. B.13-17) requested assessments of the overall impact of the Demonstration on several patient and organization changes including Patient Outcomes, Quality of Care, and Cost of Care using a five-point scale Very Negative, Slightly Negative, No Impact, Slightly Positive, and Very Positive.
- Based on Item #19, most agencies rated the impact on Patient Outcomes as either Slightly Positive (44%) or Very Positive (26%) with virtually all of the remaining rating the Demonstration as having No Impact (30%).
- Treatment agencies were slightly more positive than Control agencies about Patient Outcomes, and the West agencies had the highest overall rating for this item when compared with the other regions.
- Based on Item #19, most agencies rated the impact on Quality of Care as either Slightly Positive (45%) or Very Positive (28%) with all of the remaining rating the Demonstration as having No Impact (27%).

- Treatment agencies were slightly more positive than Control agencies about Quality of Care, and the West agencies had the highest overall rating for this item when compared with the other regions.
- Based on Item #19, most agencies rated the impact on Cost of Care as either having No Impact (46%) or Slightly Negative (30%); approximately 21% rated the Cost of Care as either Slightly Positive (13%) or Very Positive (8%).

Chi-Square Summaries (Appendix C)

- This section provides a more complex analysis of both main effects (i.e., Regional or Experimental (Treatment Winners, Treatment Non-Winners, and Control HHAs) differences) as well as interactions between Regions and Experimental groups using a Chi-Square analysis to determine statistical significance between or among the stratification variables.
- The items reviewed in this section are #3, 5 14, and 17 20.
- There were some differences between the regions and across the states in who completed the survey answers by functional level (Item 3, Table C.1, p. C.1).
- Item #5 (Table C.2, p. C.1) focused on expected CY2009 performance levels (i.e., high performance or high improvement) across the seven target outcome measures.
- There were statistically significant differences among the Winners, Non-Winners, and Control agencies across all seven target outcome measures.
- There were differences among the states for Acute Care Hospitalization and Any Emergent Care.
- Regional differences by Experimental group interactions varied for two to four outcome measures in all regions except the West, where there were no differences between the Experimental groups for any of the outcome measures.
- Item #6 (Table C.3, p. C.2) focused on changes in the number of different professional personnel during CY2009 using the following options: increase, decrease, or no change.
- There were regional and state differences for Registered Nurses, Licensed Practical Nurses, Medical Social Worker, and Home Health Aide.
- Item #7 (Table C.4, p. C.2) focuses on Staff Turnover using a rating scale of Low/No (<5%), Small (6-20%), Moderate (21-40%), High (41-75%), and Very High (>75%).
- There were regional and state differences in turnover rates for Registered Nurses and both the Southeast and Midwest Experimental comparisons showed statistically significant differences in Senior Management turnover.
- Item #8 (Table C.5, p. C.3) focuses on added new positions due to the Demonstration with three options—already exists, added, and does not exist.
- Statistically significant differences in staff education were found among the Experimental groups, and specifically in the Northeast and West agencies.
- Item #9 (Table C.6, p. C.3) asks agencies to report any policy changes that occurred in CY2009.
- The Chi-Square analysis showed statistically significant differences across Regions for policies related to Patient Infection Control, New Clinical Specialties, On-Call Staff Changes, and Hiring Requirements.
- Hiring Requirements were also statistically different among states and between the Northeast Experimental groups based on Item 9 responses.

- Item #10 (Table C.7, p. C.4) asks agencies to report any activities intended to improve the quality of care that occurred in CY2009.
- The Chi-Square analysis showed statistically significant differences across Regions for activities intended to improve the quality of care that were related to Staff competencies, Management practices, Staff evaluation criteria, and Employee incentives, with the latter two activities also being statistically significant across the states.
- Item #11 (Table C.8, p. C.4) asks agencies to report any technology innovations intended to improve the quality of care that occurred in CY2009.
- There was little consensus across Regions, states, and Experimental groups.
- Regions and states did show statistically significant differences on the choice and use of wound care materials.
- Experimental groups showed differences regarding the electronic access to policies, especially in the Southeast and Midwest.
- Item #12 (Table C.9, p. C.5) asks agencies to report any care practices intended to improve the specific clinical outcomes that occurred in CY2009.
- There were only five statistically significant differences either by Experimental group, Region, among states, or within specific Regional-by-Experimental groups combinations, with no obvious pattern.
- Item #13 (Table C.10, p. C.6) focuses on corporate support for health care initiatives that occurred in CY2009.
- The Southeast agencies were most likely to show statistically significant differences across Experimental groups, notably for reducing hospitalization, reducing emergency department use, falls risk reduction, and staff training.
- Falls risk reduction was statistically significant for the Northeast region Experimental groups, and there were overall Regional differences for staff training.
- Item #14 (Table C.11, p. C.6) requests agencies to evaluate the impact of local and regional issues on their operations using a four-option scale (no impact, negative impact, both positive and negative impact, positive impact).
- Four staffing availability issues (i.e., Registered Nurses, Physical Therapists, Occupational Therapists, and Home Health Aides) showed Regional differences, and all except Physical Therapists show statistically significant differences at the state level.
- Four competitor or other health care provider issues (i.e., # hospitals, # of skilled nursing facilities, # urgent care facilities, and # of home health agencies) locally showed statistically significant differences between Experimental groups only in the Southeast region.
- Item #17 (Table C.12, p. C.7) asked the agencies to estimate the Demonstration's impact on the cost of providing care using a seven-option scale from >10% decrease to a >10% increase with "<1% change" as the midpoint in the scale.
- Statistically significant Experimental group and Regional differences were identified, especially for the Midwest and West regions.
- Item #18 (Table C.13, p. C.7) asked the agencies to estimate the impact of their QI activities on the seven target outcomes, rating the impact as no impact, modest, or substantial.

- The largest number of statistically significant differences were found among the states with Any Emergent Care also showing statistically significant differences between Experimental groups and in the Midwest agencies.
- Item #19 (Table C.14, p. C.8) requested assessments of the overall impact of the Demonstration on several patient and organization changes including Patient Outcomes, Quality of Care, and Cost of Care using a five-point scale Very Negative, Slightly Negative, No Impact, Slightly Positive, and Very Positive.
- This item produced a very large number (31) of statistically significant differences either among Regions, between Experimental groups, or between Experimental groups within specific Regions.
- Seven items:
 - Quality of Care provided by the home health agency
 - Quality of Care provide home health agencies in the state
 - Financial solvency of the home health agency
 - Financial solvency of home health agencies in the state
 - Profitability of the home health agency
 - Profitability of home health agencies in the state
 - Patient satisfaction with the home health agency

all showed statistically significant differences at the Regional and state levels.

- Five items:
 - Quality of Care provided by the home health agency
 - Financial solvency of home health agencies in the state
 - Profitability of the home health
 - Profitability of home health agencies in the state
 - Referral satisfaction

all showed statistically significant differences across Experimental groups.

- Each Region showed at least one statistically significant difference among its Experimental groups, with the Southeast identifying four—mostly financial-related issues.
- Item #20 (Table C.15, p. C.8) requested agency feedback on the utility of various support activities that might enhance the productivity of the P4P agencies.
- There was strong support for many support activities (i.e., high frequencies), but few statistical differences between Experimental groups or across Regions.

Winners, Non-Winners, and Control Comparisons (Appendix D)

- The tables in this section provide cross-tabulations for Treatment Winners, Treatment Non-Winners, and Control agencies across selected items.
- The number of Treatment Non-Winning agencies completing the survey (15) was much smaller than either of the other two groups (100 Treatment Winners; 94 Control).
- Item #3 (Table D.1, p. D.1) contains information about the position of the person in the agency who completed the Web-based survey.
- The majority of preparers were Senior Management (65%) with most of the remaining surveys completed by the QI/PI Coordinator (23%).
- Item #5 (Table D.2, pp. D.1-4) compares the three groups of agencies on expected CY2009 performance levels (i.e., high performance or high improvement) across the seven target outcome measures.

- Typically between 40 50% of the agencies reported that they expected no change in their performance between the first year and the second year of the P4P Demonstration.
- In general, between 30 34% of the agencies reported that they expected to win "High Performance" awards across each of the seven target outcome measures.
- Conversely, with the exception of Improvement in Management of Oral Medications that reported 30%, between 20—24% of agencies indicated that they expected to win a "Substantial Improvement" award for the target outcomes.
- Item #7 (Table D.3, p. D.4-8) focuses on Staff Turnover using a rating scale of Low/No (<5%), Small (6-20%), Moderate (21-40%), High (41-75%), and Very High (>75%).
- Most positions were reported as having No/Low turnover, and there were no obvious differences among the Treatment Winners, Treatment Non-Winners, and Control agencies responses.
- Registered Nurse turnover (p. D.5) was the highest among professional positions; Control agencies reported slightly higher turnover rates than either of the other two Experimental groups—except in the Southeast agencies.
- Item #15 (Table D.4, p. D.9) asked the agencies to estimate the Demonstration's impact on the cost of providing care using a seven-option scale from >10% decrease to a >10% increase with "<1% change" as the midpoint in the scale.
- Control agencies were more likely to report larger increases in costs due to the P4P Demonstration than either of the other groups in the Northeast, Southeast, and Midwest; West Control and Treatment Winners were equally likely to report higher costs of care.

Regression Models for Target Outcomes (Appendix E)

- Ordinary Least Square (OLS) regression models for key cost and patient outcome items were computed using the target item response as the dependent measure and all other survey item responses (the response option for the item was turned into a dichotomous variable).
- Three tables are provided for each model and are differentiated by the population included in the regression model—all Control and Treatment Winner agencies ("All HHAs") that responded to the survey; only Control agencies ("Control HHAs") that responded; and only Treatment Winner agencies ("Winning HHAs") that responded.
- The first two columns identify the bivariate correlation between the predictor variable and the dependent measure as well as the statistical significance for this correlation; typically all of the identified independent variables have a bivariate correlation of p<0.05.
- These prediction variables were included into the OLS equation and the coefficients for each prediction variable and the significance level in the regression equation are presented in the last two columns in the table.
- The model summary for each model is presented in the lines that follow the model and contain the R, R², F, and statistical significance.
- For the Cost of Participating in the Demonstration (Table E.1, p. E.1)—survey item #17, each of the three regression models were significant at p < 0.01, albeit for different independent variables in the Control and Treatment Winner models.
- For the Impact on Acute Care Hospitalization (Table E.2, pp. E.2-3)—survey item #18, two of the three regression models were significant at p < 0.01, albeit with three common independent variables in the Control and Treatment Winner models, but six (Control) or

seven (Treatment Winner) other independent variables used in each model to achieve the model quality.

- For the Impact on Any Emergent Care (Table E.3, pp. E.4-5)—survey item #18, two of the three regression models were significant at p < 0.01, albeit with five common independent variables in the Control and Treatment Winner models, but nine (Control) or sixteen (Treatment Winner) other independent variables used in each model to achieve the model quality.
- For the Impact on Improvement in Bathing (Table E.4, pp. E.6-7)—survey item #18, each of the three regression models were significant at p < 0.01, albeit with three common independent variables in the Control and Treatment Winner models, but sixteen (Control) or fourteen (Treatment Winner) other independent variables used in each model to achieve the model quality.
- For the Impact on Improvement in Ambulation/Locomotion (Table E.5, pp. E.8-9) survey item #18, two of the three regression models were significant at p < 0.01, albeit with five common independent variables in the Control and Treatment Winner models, but nineteen (Control) or seven (Treatment Winner) other independent variables used in each model to achieve the model quality.
- For the Impact on Improvement in Transferring (Table E.6, pp. E.10-11)—survey item #18, two of the three regression models were significant at p < 0.02, albeit with three common independent variables in the Control and Treatment Winner models, but twenty-two (Control) or nine (Treatment Winner) other independent variables used in each model to achieve the model quality.
- For the Impact on Improvement in Status of Surgical Wounds (Table E.7, pp. E.12-13) survey item #18, each of the three regression models were significant at p < 0.02, albeit with five common independent variables in the Control and Treatment Winner models, but twelve (Control) or four (Treatment Winner) other independent variables used in each model to achieve the model quality.
- For the Impact on Improvement in Management in Oral Medications (Table E.8, pp. E.14-15)—survey item #18, each of the three regression models were significant at p < 0.01, albeit for different independent variables in the Control and Treatment Winner models.
- For the survey item #19 impact globally on Patient Outcomes (Table E.9, pp. E.16-17), two of the three regression models were significant at p < 0.02, albeit with three common independent variables in the Control and Treatment Winner models, but six (Control) or nineteen (Treatment Winner) other independent variables used in each model to achieve the model quality.
- For the survey item #19 impact globally on HHA's Quality of Care (Table E.10, pp. E.18-19), two of the three regression models were significant at p < 0.02, albeit with three common independent variables in the Control and Treatment Winner models, but sixteen (Control) or nineteen (Treatment Winner) other independent variables used in each model to achieve the model quality.
- For the survey item #19 impact globally on HHA's Cost of Providing Care (Table E.11, pp. E.20), each of the three regression models were significant at p < 0.01, albeit for different independent variables in the Control and Treatment Winner models.
- For the survey item #19 impact globally on HHA's Financial Solvency (Table E.12, pp. E.21), each of the three regression models were significant at p < 0.01, albeit with one

common independent variable in the Control and Treatment Winner models, but five (Control) or eight (Treatment Winner) other independent variables used in each model to achieve the model quality.

- For the survey item #19 impact globally on HHA's Profitability (Table E.13, pp. E.22-23), each of the three regression models were significant at p < 0.02, albeit with four common independent variables in the Control and Treatment Winner models, but three (Control) or eleven (Treatment Winner) other independent variables used in each model to achieve the model quality.
- For the survey item #19 impact globally on HHA's Patient Satisfaction (Table E.14, pp. E.24-25), each of the three regression models were significant at p < 0.02, albeit with seven common independent variables in the Control and Treatment Winner models, but three (Control) or fourteen (Treatment Winner) other independent variables used in each model to achieve the model quality.
- For the survey item #19 impact globally on HHA's Staff Satisfaction (Table E.15, pp. E.26-27), each of the three regression models were significant at p < 0.02, albeit with two common independent variables in the Control and Treatment Winner models, but two (Control) or twenty-two (Treatment Winner) other independent variables used in each model to achieve the model quality.

6. <u>Conclusion</u>

Based on the Regional cross-tabulation, Chi-square Summary, and Winners/Non-Winners/ Control analyses, there were some differences by Region and by State. These were both the areas of perception of costs and the availability of professional staff. The Southeast was more likely to report financial concerns than the other areas. Among the Experimental groups, Control agencies were more likely to add staff, have slightly higher turnover rates among Registered Nurses, be concerned about financial issues, and be slightly more pessimistic than the Treatment agencies. Based on the Regression models, there were very distinct approaches how Treatment Winners vs. Control agencies addressed each of the desired outcomes. Some of these differences are also reflected in the tone and approaches to patient care that are found in the narrative comments for these two groups that are presented in Appendix F.

7. <u>References</u>

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Appendix A: Survey Instruments

[Note: This is a text version of the on-line survey, with no graphic elements such as radio buttons, check boxes, and text boxes. It is presented in this form for accessibility - rb indicates radio button; cb indicates checkbox.]

Treatment (Winner) Survey Instrument

Home Health Pay for Performance Demonstration Evaluation Survey

Thank you again for your willingness to complete the Year 2 Home Health Pay for Performance (P4P) Demonstration Survey. The purpose of this survey is to gather information from home health agencies participating in the (P4P) Demonstration that is generally not available via other data sources.

For this survey we would like you to focus your attention on what your agency did during Calendar Year (CY) 2009.

We estimate that the survey will take less than 15 minutes to complete.

Tracking Information:

1. Enter the Name of Agency: _____

1a. [OPTIONAL] Email address of Agency or Person completing survey:

2. Enter Agency's CMS Certification Number (formerly Provider Number):

3. Title of person completing form: [Pull down menu list = Senior Management (CEO, DON, etc.), QI / PI Coordinator; Administrative/Support; Clinical Supervisor Position; Other]

(*Name of Agency = 50 characters; [OPTIONAL] Email address = 50 characters; Provider Number = 6 characters; Title = per list*)

4. Congratulations on receiving recognition based on your Year 1 (CY2008) performance in the Home Health P4P Demonstration. Please indicate which of the following awards you received for Year 1.

If you do not know the outcome measures for which you received your award(s), check this box. [cb] **[indicates check box]**

Outcome Measure	N/A	High Performance	Substantial Improvement
Acute Care Hospitalization	rb	rb	rb
Any Emergent Care	rb	rb	rb
Improvement in Bathing	rb	rb	rb
Improvement in Ambulation/Locomotion	rb	rb	rb
Improvement in Transferring	rb	rb	rb
Improvement in Status of Surgical Wounds	rb	rb	rb
Improvement in Management of Oral Medications	rb	rb	rb

If known, check all that apply. (N/A is pre-filled) [Note: rb indicates radio button]

5. Based on your understanding of your agency's performance during Year 2 (CY2009), please indicate which of the following awards you think you might receive for Year 2 (CY2009). (check all that apply—maximum is seven awards) (*N/A is pre-filled*) [Note: rb indicates radio button]

Outcome Measure	N/A	High Performance	Substantial Improvement
Acute Care Hospitalization	rb	rb	rb
Any Emergent Care	rb	rb	rb
Improvement in Bathing	rb	rb	rb
Improvement in Ambulation/Locomotion	rb	rb	rb
Improvement in Transferring	rb	rb	rb
Improvement in Status of Surgical Wounds	rb	rb	rb
Improvement in Management of Oral Medications	rb	rb	rb

6. Which of the following describes any changes in the <u>number of your staff</u> (i.e., <u>increase</u> = the position was vacant, requested, or created and was filled, or additional (new) staff were hired; <u>decrease</u> = a position was filled, but now is vacant) that occurred during CY2009? Indicate change for each--if any. (*Radio button w/ "No Change" as default*) [Note: rb indicates radio button]

Job Category	Decreased Staffing	No Change	Increased Staffing
a. Senior management (CEO, DON, etc.)	rb	rb	rb
b. Quality improvement or performance improvement coordinator	rb	rb	rb
c. Clinical supervisory positions	rb	rb	rb
d. Registered nurse	rb	rb	rb
e. Registered nurse with specialty license/ certification (e.g., wound, psychiatric)	rb	rb	rb
f. Licensed practical nurse	rb	rb	rb
g. Physical therapist	rb	rb	rb
h. Occupational therapist	rb	rb	rb
i. Medical social worker	rb	rb	rb
j. Home health aide	rb	rb	rb
k. Administrative/support	rb	rb	rb
1. Other (specify25 characters)	rb	rb	rb

 Which of the following describes the <u>turnover in your staff</u> (e.g., a staff member left and was replaced by a new or another staff member in that position) that occurred during CY2009? (*Radio button w/ "No/Low" as default*) [Note: rb indicates radio button]

Job Category	No/Low (0-5%)	Small (6-20%)	Moderate (21-40%)	High (41-75%)	Very high (>75%)
a. Senior management (CEO, DON, etc.)	rb	rb	rb	rb	rb
b. Quality improvement or performance improvement coordinator	rb	rb	rb	rb	rb
c. Clinical supervisory positions	rb	rb	rb	rb	rb
d. Registered nurse	rb	rb	rb	rb	rb
e. Registered nurse with specialty license/ certification (e.g., wound, psychiatric)	rb	rb	rb	rb	rb
f. Licensed practical nurse	rb	rb	rb	rb	rb
g. Physical therapist	rb	rb	rb	rb	rb
h. Occupational therapist	rb	rb	rb	rb	rb
i. Medical social worker	rb	rb	rb	rb	rb
j. Home health aide	rb	rb	rb	rb	rb
k. Administrative/support	rb	rb	rb	rb	rb

8. Did you add any new positions/functions during CY2009 <u>specifically because of your participation in</u> <u>the demonstration</u>?

	Job Function	Already Existed	Added Position/Function	Does Not Exist
a.	Quality improvement (QI) or performance improvement (PI) coordination	rb	rb	rb
b.	Documentation quality assurance or OASIS accuracy	rb	rb	rb
c.	Staff education	rb	rb	rb
d.	Outcome analysis	rb	rb	rb
e.	Utilization/Resource review	rb	rb	rb
f.	"Combination" position(s) that includes two or more of the "a - e" functions	rb	rb	rb
g.	Other (specify)	rb	rb	rb

(Radio button w/ "Does Not Exist" as default) [Note: rb indicates radio button]

9. What <u>policy changes</u> did <u>your agency</u> implemented during CY2009? Policies related to...(Check all that apply)

(Check box; no pre-fill) [Note: cb indicates check box]

- [cb] a. Changes in care practices (e.g., "front-loading" visits, medicine reconciliation)
- [cb] b. Implementation of care pathways/standardized care plans
- [cb] c. Reduction in time between referral and admission visit
- [cb] d. Communication with patient (quantity and/or quality)
- [cb] e. Communication with physician (quantity and/or quality)
- [cb] f. Disease management programs
- [cb] g. Telehealth programs
- [cb] h. Falls prevention programs
- [cb] i. Patient infection control programs
- [cb] j. New clinical specialties programs (specify):
- [cb] k. Change in on-call staff for non-business hours
- [cb] 1. Expanded business hours
- [cb] m. Changes in productivity requirements for staff
- [cb] n. Changes in staff hiring requirements
- [cb] o. Other (specify):
- What <u>activities directed toward care providers</u> and intended to improve quality of care did <u>your</u> <u>agency</u> implemented during CY2009? (Check all that apply) (Check box; no pre-fill) [Note: cb indicates check box]
 - [cb] a. New staff education programs and/or changes in requirements for number of educational hours
 - [cb] b. Performance improvement programs
 - [cb] c. Mentoring programs
 - [cb] d. Additional clinical team meetings
 - [cb] e. Additional record review activities
 - [cb] f. New staff competencies
 - [cb] g. Changes in staff evaluation criteria
 - [cb] h. Employee incentives for performance improvement
 - [cb] i. Changes in staff management practices of nursing or therapy staff (e.g., increased oversight, etc.)
 - [cb] j. Changes in home health aide supervisory practices
 - [cb] k. Additional clinical resources for field staff (e.g., consultation; new specialty care staff; Web access to best practices, etc.)
 - [cb] l. Other (specify):
- 11. What <u>technological innovations</u> designed to improve the quality of patient care did <u>your agency</u> implemented during CY2009? (Check all that apply) (*Check box; no pre-fill*) [Note: cb indicates check box]
 - [cb] a. Telemonitoring equipment
 - [cb] b. Electronic health records
 - [cb] c. Electronic information exchange with referral sources other than physicians (e.g., hospital)
 - [cb] d. Electronic information exchange with physicians
 - [cb] e. Secure electronic messaging systems for agency care team members
 - [cb] f. New infusion devices or equipment
 - [cb] g. New respiratory equipment (e.g., ventilators, etc.)
 - [cb] h. Physiologic monitoring equipment (e.g., blood glucose monitors, prothrombin monitors, etc.)
 - [cb] i. Inflatable mattresses or similar equipment to reduce incidence of pressure ulcers
 - [cb] j. Special dressings or therapies for wound care
 - [cb] k. Medication reminder systems
 - [cb] 1. Medication dispensing systems
 - [cb] m. Implementation of medication checking/reconciliation software
 - [cb] n. Personal emergency response systems
 - [cb] o. Electronic access to policies, procedures, best practices, etc.
 - [cb] p. Other (specify):

- What <u>care practice changes</u> designed to improve the specific clinical outcomes did <u>your agency</u> implemented during CY2009? (Check all that apply) (Check box; no pre-fill) [Note: cb indicates check box]
 - [cb] a. Changes in visit patterns (e.g., front-loading; increased number of visits for specific diagnoses)
 - [cb] b. Introduction of telemonitoring
 - [cb] c. Changes in visit mix (e.g., increased use of PT, etc.)
 - [cb] d. Introduction of disease management programs
 - [cb] e. Introduction and/or increased use of clinical pathways
 - [cb] f. Changes in patient teaching plans
 - [cb] g. Increased communication with MD
 - [cb] h. Inclusion on POC of specific parameters for when to call physician (e.g., call MD for BS > 150)
 - [cb] i. Increased care team communication (e.g., team meetings, etc.)
 - [cb] j. Implementation of screening assessments (e.g., falls risk)
 - [cb] k. Implementation of falls prevention programs
 - [cb] 1. Enhanced wound care protocols
 - [cb] m. Increased efforts to improve vaccination rates (e.g., flu and pneumococcus)
 - [cb] n. Use of medication reminder or dispensing systems
 - [cb] o. Standards related to medication reconciliation or MD follow-up
 - [cb] p. Other (specify): _____
- 13. Identify any <u>corporate initiatives</u> that were implemented during CY2009. (Indicate change for each--if any) (*Radio button w/ "No Change" pre-filled*) [Note: rb indicates radio button]

[cb] NA, Not Part of Chain/Corporation

	Corporate Initiative Focus	No Change	Modified Existing Program	Implemented New Program
a.	Reducing potentially avoidable hospitalizations	rb	rb	rb
b.	Reducing potentially avoidable emergency care	rb	rb	rb
c.	Improving rehabilitation outcomes	rb	rb	rb
d.	Pressure ulcer treatment	rb	rb	rb
e.	Falls risk reduction programs	rb	rb	rb
f.	Medication management programs	rb	rb	rb
g.	Use of technology to support patient care	rb	rb	rb
h.	Staff training	rb	rb	rb
i.	Participation in QIO quality initiatives	rb	rb	rb
j.	Performance incentive program (monetary)	rb	rb	rb
k.	Enhanced corporate communications	rb	rb	rb
1.	Other (specify):	rb	rb	rb

14. Identify any <u>impact on your agency</u> that occurred during CY2009 that may have been the result of <u>local/regional issues or situations</u>. (Indicate impact for each--if any) (*Radio button w/ "No Impact" pre-filled*) [Note: rb indicates radio button]

		Type of Impact			
	Type of Local/Regional Change	No Impact	Negative	Both + / -	Positive
a.	# of community hospitals (or hospital beds)	rb	rb	rb	rb
b.	# of skilled nursing facilities (or SNF beds)	rb	rb	rb	rb
c.	# of urgent/emergency care facilities	rb	rb	rb	rb
d.	# of home health agencies	rb	rb	rb	rb
e.	Availability of nurses locally	rb	rb	rb	rb
f.	Availability of physical therapists locally	rb	rb	rb	rb
g.	Availability of occupational therapists locally	rb	rb	rb	rb
h.	Availability of home health aides locally	rb	rb	rb	rb
i.	Changes in population demographics locally	rb	rb	rb	rb
j.	Local physician care practice patterns	rb	rb	rb	rb
k.	Change in available community resources (e.g., Assisted living facilities, adult day care, transportation programs, meal programs, respite care providers, etc	rb	rb	rb	rb
1.	Natural disaster (e.g., flood, fire, etc.)	rb	rb	rb	rb
m.	State health care policy (e.g., Medicaid funding)	rb	rb	rb	rb

15. With whom did you share the news that you had received a P4P Award? (Check all that apply) (*Radio button w/ "Did not share" pre-filled*) [Note: rb indicates radio button]

	Communication		
Group	Did not share Shared		
a. Management Team	rb	rb	
b. Clinical Staff	rb	rb	
c. Administrative Staff	rb	rb	
d. Corporate board/parent company	rb	rb	
e. Local community	rb	rb	
f. Referral sources	rb	rb	
g. Other (specify):	rb	rb	

	Distribution		
Action	N/A	Yes	
a. Bonuses awarded to corporate staff	rb	rb	
b. Bonuses awarded to senior HHA staff	rb	rb	
c. Bonuses awarded across HHA staff	rb	rb	
d. Special event/celebration for HHA	rb	rb	
e. Purchased new equipment/materials	rb	rb	
f. Hired new staff	rb	rb	
g. Provided additional training for staff	rb	rb	
h. Other (specify):	rb	rb	

16. How was the Year 1 (CY2008) P4P Award money shared? (Check all that apply) (*Radio button w/ "N/A" pre-filled*) [Note: rb indicates radio button]

What is your <u>best estimate</u> of the effects of activities related to the pay for performance demonstration during Year 2 (CY2009) on the <u>cost of providing care</u> to your patients? (*Radio button w/ "Less than 1% change" pre-filled*) [Note: rb indicates radio button]

Ι	Decrease by > 10%	Decrease by $5-10\%$	Decrease by $1-5\%$	Less than 1% change	Increase by $1-5\%$	Increase by $5-10\%$	Increase by $> 10\%$
	rb	rb	rb	rb	rb	rb	rb

How much of an <u>impact</u> on your patients do you think <u>your quality improvement activities</u> have had on the outcomes targeted during Year 2 (CY2009) of the demonstration? (*Radio button w/ "No Impact" pre-filled*) [Note: rb indicates radio button]

	Probable impact of QI on outcomes			
		Modest	Substantial	
Outcome Measure	No Impact	Improvement	Improvement	
a. Incidence of Acute Care Hospitalization	rb	rb	rb	
b. Incidence of Any Emergent Care	rb	rb	rb	
c. Improvement in Bathing	rb	rb	rb	
d. Improvement in Ambulation/Locomotion	rb	rb	rb	
e. Improvement in Transferring	rb	rb	rb	
f. Improvement in Status of Surgical Wounds	rb	rb	rb	
g. Improvement in Management of Oral Medications	rb	rb	rb	

		Very	Slightly	No	Slightly	Very
	Focus of Effect	Negative	Negative	Impact	Positive	Positive
a.	My agency's patient outcomes	rb	rb	rb	rb	rb
b.	Quality of care at my agency	rb	rb	rb	rb	rb
c.	Quality of care statewide	rb	rb	rb	rb	rb
d.	Access to care for Medicare beneficiaries	rb	rb	rb	rb	rb
e.	Cost of providing home health care	rb	rb	rb	rb	rb
f.	Financial solvency of my agency	rb	rb	rb	rb	rb
g.	Financial solvency of home health agencies statewide	rb	rb	rb	rb	rb
h.	Profitability of my agency	rb	rb	rb	rb	rb
i.	Profitability of home health agencies statewide	rb	rb	rb	rb	rb
j.	Patient satisfaction w/ agency	rb	rb	rb	rb	rb
k.	Staff satisfaction at agency	rb	rb	rb	rb	rb
1.	Referral source satisfaction w/ agency	rb	rb	rb	rb	rb

19. What <u>effect</u> do you think <u>the demonstration</u> will have on the following? (*Radio button w/ "No Impact" pre-filled*) [Note: rb indicates radio button]

20. Rate each of the following actions/reports in terms of how useful they would be if Home Health P4P is implemented:

(Radio button w/ "N/A" pre-filled)	[Note: rb indicates radio button]
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		Not		Very	Extremely	N/A
	Report or Activity	Useful	Useful	Useful	Useful	
a.	Publish regular (monthly or quarterly)	rh	rh	rb	rb	rb
	updates or reminders about the P4P program	10	10	10	10	10
b.	Publish monthly "best practices" $(2 - 4)$	rh	rb	rh	rb	rb
	items) that are related to the target outcomes	10	10	10	10	10
c.	Make home health P4P support an element in	rb	rh	rb	rb	rb
	QIO Statement of Work	1D	ID	10	UD UT	10
d.	Identify available online workshops					
	sponsored by professional organizations that	rh	rh	rb	rb	rb
	have specific themes (e.g., implementation of	1D	ID	10	UD UT	10
	telehealth systems; wound care protocols)					
e.	Each month publish/highlight the activities of					
	one high performing HHA (each region	rb	rb	rb	rb	rb
	should have at least one annually)					
f.	Publish targeted, effective intervention					
	strategies for different HHA groups (e.g.,	rh	rh	rb	rb	rb
	rural vs. urban; large vs. small; non-profit vs.	ID.	ID	10	di	10
	for profit)					
g.	Provide certificates of recognition to high	rh	rh	rb	rb	rb
	performing HHAs	ŭ	ID	10	di	10
h.	Publish information on high performing					
	HHAs to the public (e.g., list agencies on	rb	rb	rb	rb	rb
	Home Health Compare)					

- 21. Please use the space below to provide any other comments what your agency learned by participating in the P4P Demonstration during Calendar Years 2008 and 2009. (optional) (*There will be a 500-word limit on this box with automatic word count*)
- 22. Please use the space below to provide <u>specific advice that you would share with other HHAs on how</u> to be successful if P4P becomes an implemented program in CY2012. (Optional) (*There will be a 500-word limit on this box with automatic word count*)

Thank you very much for providing your feedback. Please review your answers prior to pressing the "Send" button.

Treatment Non-Winners Instrument

Home Health Pay for Performance Demonstration Evaluation Survey

Thank you again for your willingness to complete the Year 2 Home Health Pay for Performance (P4P) Demonstration Survey. The purpose of this survey is to gather information from home health agencies participating in the (P4P) Demonstration that is generally not available via other data sources.

For this survey we would like you to focus your attention on what your agency did during Calendar Year (CY) 2009.

We estimate that the survey will take less than 15 minutes to complete.

Tracking Information:

- Enter the Name of Agency:
 1a. [OPTIONAL] Email address of Agency or Person completing survey:
- 2. Enter Agency's CMS Certification Number (formerly Provider Number):
- 3. Title of person completing form: [Pull down menu list = Senior Management (CEO, DON, etc.), QI / PI Coordinator; Administrative/Support; Clinical Supervisor Position; Other]

(*Name of Agency = 50 characters; [OPTIONAL] Email address = 50 characters; Provider Number = 6 characters; Title = per list*)

(Note: HHAs that received an award based on their Year 1 performance would receive the "Treatment winner" survey. HHAs that were in the "Treatment" group but did not receive any awards in Year 1 would receive the "Treatment non-winner" survey. HHAs that are part of the "Control" group will automatically receive the "Control" survey.)

4. Given that you did not win any performance awards in Year 1 (CY2008), please indicate if your agency focused on any of the following during Year 2 (CY2009) of the demonstration. (check all that apply) (*N/A is pre-filled*)) [Note: rb indicates radio button]

Outcome Measure	N/A	Changed HHA policies	Changed HHA practices	Increased training	Other
Acute Care Hospitalization	rb	rb	rb	rb	rb
Any Emergent Care	rb	rb	rb	rb	rb
Improvement in Bathing	rb	rb	rb	rb	rb
Improvement in Ambulation/Locomotion	rb	rb	rb	rb	rb
Improvement in Transferring	rb	rb	rb	rb	rb
Improvement in Status of Surgical Wounds	rb	rb	rb	rb	rb
Improvement in Management of Oral Medications	rb	rb	rb	rb	rb

5. Based on your understanding of your agency's performance during Year 2 (CY2009), please indicate which of the following awards you think you might receive for Year 2 (CY2009). (check all that apply—maximum is seven awards) (*N/A is pre-filled*) [Note: rb indicates radio button]

Outcome Measure	N/A	High Performance	Substantial Improvement
Acute Care Hospitalization	rb	rb	rb
Any Emergent Care	rb	rb	rb
Improvement in Bathing	rb	rb	rb
Improvement in Ambulation/Locomotion	rb	rb	rb
Improvement in Transferring	rb	rb	rb
Improvement in Status of Surgical Wounds	rb	rb	rb
Improvement in Management of Oral Medications	rb	rb	rb

6. Which of the following describes any changes in the <u>number of your staff</u> (i.e., <u>increase</u> = the position was vacant, requested, or created and was filled, or additional (new) staff were hired; <u>decrease</u> = a position was filled, but now is vacant) that occurred during CY2009? Indicate change for each--if any. (*Radio button w/ "No Change" as default*) [Note: rb indicates radio button]

Job Category	Decreased Staffing	No Change	Increased Staffing
a. Senior management (CEO, DON, etc.)	rb	rb	rb
b. Quality improvement or performance improvement coordinator	rb	rb	rb
c. Clinical supervisory positions	rb	rb	rb
d. Registered nurse	rb	rb	rb
e. Registered nurse with specialty license/ certification (e.g., wound, psychiatric)	rb	rb	rb
f. Licensed practical nurse	rb	rb	rb
g. Physical therapist	rb	rb	rb
h. Occupational therapist	rb	rb	rb
i. Medical social worker	rb	rb	rb
j. Home health aide	rb	rb	rb
k. Administrative/support	rb	rb	rb
1. Other (specify25 characters)	rb	rb	rb

7. Which of the following describes the <u>turnover in your staff</u> (e.g., a staff member left and was replaced by a new or another staff member in that position) that occurred during CY2009? (*Radio button w/ "No/Low"" as default*) [Note: rb indicates radio button]

Job Category	No/Low (0-5%)	Small (6-20%)	Moderate (21-40%)	High (41-75%)	Very high (>75%)
a. Senior management (CEO, DON,	rb	rb	rb	rb	rb
etc.)					
b. Quality improvement or	rb	rb	rb	rb	rb
coordinator					
c. Clinical supervisory positions	rb	rb	rb	rb	rb
d. Registered nurse	rb	rb	rb	rb	rb
e. Registered nurse with specialty	rb	rb	rb	rb	rb
license/ certification (e.g., wound, psychiatric)					
f. Licensed practical nurse	rb	rb	rb	rb	rb
g. Physical therapist	rb	rb	rb	rb	rb
h. Occupational therapist	rb	rb	rb	rb	rb
i. Medical social worker	rb	rb	rb	rb	rb
j. Home health aide	rb	rb	rb	rb	rb
k. Administrative/support	rb	rb	rb	rb	rb
1. Other (specify 25 characters)	rb	rb	rb	rb	rb

8.. Did you add any new positions/functions during CY2009 <u>specifically because of your participation in</u> <u>the demonstration</u>?

		Already	Added	Does Not
	Job Function	Existed	Position/Function	Exist
a.	Quality improvement (QI) or performance improvement (PI) coordination	rb	rb	rb
b.	Documentation quality assurance or OASIS accuracy	rb	rb	rb
c.	Staff education	rb	rb	rb
d.	Outcome analysis	rb	rb	rb
e.	Utilization/Resource review	rb	rb	rb
f.	"Combination" position(s) that includes two or more of the "a - e" functions	rb	rb	rb
g.	Other (specify)	rb	rb	rb

(Radio button w/ "Does Not Exist" as default) [Note: rb indicates radio button]

9. What <u>policy changes</u> did <u>your agency</u> implemented during CY2009? Policies related to...(Check all that apply)

(Check box; no pre-fill) [Note: cb indicates check box]

- [cb] a. Changes in care practices (e.g., "front-loading" visits, medicine reconciliation)
- [cb] b. Implementation of care pathways/standardized care plans
- [cb] c. Reduction in time between referral and admission visit
- [cb] d. Communication with patient (quantity and/or quality)
- [cb] e. Communication with physician (quantity and/or quality)
- [cb] f. Disease management programs
- [cb] g. Telehealth programs
- [cb] h. Falls prevention programs
- [cb] i. Patient infection control programs
- [cb] j. New clinical specialties programs (specify):
- [cb] k. Change in on-call staff for non-business hours
- [cb] 1. Expanded business hours
- [cb] m. Changes in productivity requirements for staff
- [cb] n. Changes in staff hiring requirements
- [cb] o. Other (specify):

- 10. What <u>activities directed toward care providers</u> and intended to improve quality of care did <u>your agency</u> implemented during CY2009? (Check all that apply) (*Check box; no pre-fill*)
 - [cb] a. New staff education programs and/or changes in requirements for number of educational hours
 - [cb] b. Performance improvement programs
 - [cb] c. Mentoring programs
 - [cb] d. Additional clinical team meetings
 - [cb] e. Additional record review activities
 - [cb] f. New staff competencies
 - [cb] g. Changes in staff evaluation criteria
 - [cb] h. Employee incentives for performance improvement
 - [cb] i. Changes in staff management practices of nursing or therapy staff (e.g., increased oversight, etc.)
 - [cb] j. Changes in home health aide supervisory practices
 - [cb] k. Additional clinical resources for field staff (e.g., consultation; new specialty care staff; Web access to best practices, etc.)
 - [cb] l. Other (specify):
- 11. What <u>technological innovations</u> designed to improve the quality of patient care did <u>your agency</u> implemented during CY2009? (Check all that apply) (*Check box; no pre-fill*) [Note: cb indicates check box]
 - [cb] a. Telemonitoring equipment
 - [cb] b. Electronic health records
 - [cb] c. Electronic information exchange with referral sources other than physicians (e.g., hospital)
 - [cb] d. Electronic information exchange with physicians
 - [cb] e. Secure electronic messaging systems for agency care team members
 - [cb] f. New infusion devices or equipment
 - [cb] g. New respiratory equipment (e.g., ventilators, etc.)
 - [cb] h. Physiologic monitoring equipment (e.g., blood glucose monitors, prothrombin monitors, etc.)
 - [cb] i. Inflatable mattresses or similar equipment to reduce incidence of pressure ulcers
 - [cb] j. Special dressings or therapies for wound care
 - [cb] k. Medication reminder systems
 - [cb] 1. Medication dispensing systems
 - [cb] m. Implementation of medication checking/reconciliation software
 - [cb] n. Personal emergency response systems
 - [cb] o. Electronic access to policies, procedures, best practices, etc.
 - [cb] p. Other (specify):

- What <u>care practice changes</u> designed to improve the specific clinical outcomes did <u>your agency</u> implemented during CY2009? (Check all that apply) (Check box; no pre-fill) [Note: cb indicates check box]
 - [cb] a. Changes in visit patterns (e.g., front-loading; increased number of visits for specific diagnoses)
 - [cb] b. Introduction of telemonitoring
 - [cb] c. Changes in visit mix (e.g., increased use of PT, etc.)
 - [cb] d. Introduction of disease management programs
 - [cb] e. Introduction and/or increased use of clinical pathways
 - [cb] f. Changes in patient teaching plans
 - [cb] g. Increased communication with MD
 - [cb] h. Inclusion on POC of specific parameters for when to call physician (e.g., call MD for BS > 150)
 - [cb] i. Increased care team communication (e.g., team meetings, etc.)
 - [cb] j. Implementation of screening assessments (e.g., falls risk)
 - [cb] k. Implementation of falls prevention programs
 - [cb] 1. Enhanced wound care protocols
 - [cb] m. Increased efforts to improve vaccination rates (e.g., flu and pneumococcus)
 - [cb] n. Use of medication reminder or dispensing systems
 - [cb] o. Standards related to medication reconciliation or MD follow-up
 - [cb] p. Other (specify):
- 13. Identify any <u>corporate initiatives</u> that were implemented during CY2009. (Indicate change for each--if any) (*Radio button w/ "No Change" pre-filled*) [Note: rb indicates radio button]

[cb] NA, Not Part of Chain/Corporation

Corporate Initiative Focus	No Change	Modified Existing Program	Implemented New Program
a. Reducing potentially avoidable hospitalizations	rb	rb	rb
b. Reducing potentially avoidable emergency care	rb	rb	rb
c. Improving rehabilitation outcomes	rb	rb	rb
d. Pressure ulcer treatment	rb	rb	rb
e. Falls risk reduction programs	rb	rb	rb
f. Medication management programs	rb	rb	rb
g. Use of technology to support patient care	rb	rb	rb
h. Staff training	rb	rb	rb
i. Participation in QIO quality initiatives	rb	rb	rb
j. Performance incentive program (monetary)	rb	rb	rb
k. Enhanced corporate communications	rb	rb	rb
1. Other (specify):	rb	rb	rb

Identify any impact on your agency that occurred during CY2009 that may have been the result of 14. local/regional issues or situations. (Indicate impact for each--if any) (*Radio button w/ "No Impact" pre-filled*) [Note: rb indicates radio button]

		Type of Impact			
		No		Both	
	Type of Local/Regional Change	Impact	Negative	+/-	Positive
a.	# of community hospitals (or hospital beds)	rb	rb	rb	rb
b.	# of skilled nursing facilities (or SNF beds)	rb	rb	rb	rb
c.	# of urgent/emergency care facilities	rb	rb	rb	rb
d.	# of home health agencies	rb	rb	rb	rb
e.	Availability of nurses locally	rb	rb	rb	rb
f.	Availability of physical therapists locally	rb	rb	rb	rb
g.	Availability of occupational therapists locally	rb	rb	rb	rb
h.	Availability of home health aides locally	rb	rb	rb	rb
i.	Changes in population demographics locally	rb	rb	rb	rb
j.	Local physician care practice patterns	rb	rb	rb	rb
k.	Change in available community resources (e.g., Assisted living facilities, adult day care, transporta- tion programs, meal programs, respite care providers)	rb	rb	rb	rb
1.	Natural disaster (e.g., flood, fire, etc.)	rb	rb	rb	rb
m.	State health care policy (e.g., Medicaid funding)	rb	rb	rb	rb

15. What is your best estimate of the effects of activities related to the pay for performance demonstration during Year 2 (CY2009) on the cost of providing care to your patients? (Radio button w/ "Less than 1% change" pre-filled) [Note: rb indicates radio button]

Decrease by > 10%	Decrease by $5-10\%$	Decrease by $1-5\%$	Less than 1% change	Increase by $1-5\%$	Increase by $5-10\%$	Increase by > 10%
rb	rb	rb	rb	rb	rb	rb

How much of an impact on your patients do you think your quality improvement activities have had on 16. the outcomes targeted during Year 2 (CY2009) of the demonstration? (R

adio button w/ "No	o Impact"	pre-filled)	[Note: rb	indicates	radio	button]
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	Probable impact of QI on outcomes				
Outcome Massure	No Impost	Modest	Substantial		
o Incidence of Acute Care Hegnitelization	No Impact	Improvement	Improvement		
a. Incluence of Acute Care Hospitalization	rb	rb	rb		
b. Incidence of Any Emergent Care	rb	rb	rb		
c. Improvement in Bathing	rb	rb	rb		
d. Improvement in Ambulation/Locomotion	rb	rb	rb		
e. Improvement in Transferring	rb	rb	rb		
f. Improvement in Status of Surgical Wounds	rb	rb	rb		
g. Improvement in Management of Oral Medications	rb	rb	rb		

	Focus of Effect	Very Negative	Slightly Negative	No Impact	Slightly Positive	Very Positive
a.	My agency's patient outcomes	rb	rb	rb	rb	rb
b.	Quality of care at my agency	rb	rb	rb	rb	rb
c.	Quality of care statewide	rb	rb	rb	rb	rb
d.	Access to care for Medicare beneficiaries	rb	rb	rb	rb	rb
e.	Cost of providing home health care	rb	rb	rb	rb	rb
f.	Financial solvency of my agency	rb	rb	rb	rb	rb
g.	Financial solvency of home health agencies statewide	rb	rb	rb	rb	rb
h.	Profitability of my agency	rb	rb	rb	rb	rb
i.	Profitability of home health agencies statewide	rb	rb	rb	rb	rb
j.	Patient satisfaction w/ agency	rb	rb	rb	rb	rb
k.	Staff satisfaction at agency	rb	rb	rb	rb	rb
1.	Referral source satisfaction w/ agency	rb	rb	rb	rb	rb

17. What <u>effect</u> do you think <u>the demonstration</u> will have on the following? (*Radio button w/ "No Impact" pre-filled*) [Note: rb indicates radio button]

18. Rate each of the following actions/reports in terms of how useful they would be if Home Health P4P is implemented:

(*Radio button w/ "N/A" pre-filled*) [Note: rb indicates radio button]

	Report or Activity	Not Useful	Useful	Very Useful	Extremely Useful	N/A
a.	Publish regular (monthly or quarterly) updates or reminders about the P4P program	rb	rb	rb	rb	rb
b.	Publish monthly "best practices" $(2 - 4 \text{ items})$ that are related to the target outcomes	rb	rb	rb	rb	rb
c.	Make home health P4P support an element in QIO Statement of Work	rb	rb	rb	rb	rb
d.	Identify available online workshops sponsored by professional organizations that have specific themes (e.g., implementation of telehealth systems; wound care protocols)	rb	rb	rb	rb	rb
e.	Each month publish/highlight the activities of one high performing HHA (each region should have at least one annually)	rb	rb	rb	rb	rb
f.	Publish targeted, effective intervention strategies for different HHA groups (e.g., rural vs. urban; large vs. small; non-profit vs. for profit)	rb	rb	rb	rb	rb
g.	Provide certificates of recognition to high performing HHAs	rb	rb	rb	rb	rb
h.	Publish information on high performing HHAs to the public (e.g., list agencies on Home Health Compare)	rb	rb	rb	rb	rb

- 19. Please use the space below to provide any other comments <u>what your agency learned by</u> <u>participating in the P4P Demonstration during Calendar Years 2008 and 2009</u>. (optional) *(There will be a 500-word limit on this box with automatic word count)*
- 20. Please use the space below to provide <u>specific advice that you would share with other HHAs on</u> <u>how to be successful if P4P becomes an implemented program in CY2012</u>. (Optional) *(There will be a 500-word limit on this box with automatic word count)*

Thank you very much for providing your feedback. Please review your answers prior to pressing the "Send" button.

Control Instrument

Home Health Pay for Performance Demonstration Evaluation Survey

Thank you again for your willingness to complete the Year 2 Home Health Pay for Performance (P4P) Demonstration Survey. The purpose of this survey is to gather information from home health agencies participating in the (P4P) Demonstration that is generally not available via other data sources.

For this survey we would like you to focus your attention on what your agency did during Calendar Year (CY) 2009.

We estimate that the survey will take less than 15 minutes to complete.

Tracking Information:

- 1. Enter the Name of Agency:
- 1a. [OPTIONAL] Email address of Agency or Person completing survey:
- _____
- 2. Enter Agency's CMS Certification Number (formerly Provider Number): _____
- 3. Title of person completing form: [Pull down menu list = Senior Management (CEO, DON, etc.), QI / PI Coordinator; Administrative/Support; Clinical Supervisor Position; Other]

(*Name of Agency = 50 characters; [OPTIONAL] Email address = 50 characters; Provider Number = 6 characters; Title = per list*)

(Note: HHAs that received an award based on their Year 1 performance would receive the "Treatment winner" survey. HHAs that were in the "Treatment" group but did not receive any awards in Year 1 would receive the "Treatment non-winner" survey. HHAs that are part of the "Control" group will automatically receive the "Control" survey.)

4. Please indicate if your agency focused on any of the following during Year 2 (CY2009) of the demonstration. (check all that apply) *(N/A is pre-filled)* [Note: rb indicates radio button]

Outcome Measure	N/A	Changed HHA policies	Changed HHA practices	Increased training	Other
Acute Care Hospitalization	rb	rb	rb	rb	rb
Any Emergent Care	rb	rb	rb	rb	rb
Improvement in Bathing	rb	rb	rb	rb	rb
Improvement in Ambulation/Locomotion	rb	rb	rb	rb	rb
Improvement in Transferring	rb	rb	rb	rb	rb
Improvement in Status of Surgical Wounds	rb	rb	rb	rb	rb
Improvement in Management of Oral Medications	rb	rb	rb	rb	rb

5. Based on your understanding of your agency's performance during Year 2 (CY2009), please indicate <u>how much you improved</u> on each of the following outcomes during Year 2 (CY2009). (check all that apply) *('None' is pre-filled)* **[Note: rb indicates radio button]**

Outcome Measure	None	Modest (1-2%)	Substantial (>2%)
Acute Care Hospitalization	rb	rb	rb
Any Emergent Care	rb	rb	rb
Improvement in Bathing	rb	rb	rb
Improvement in Ambulation/Locomotion	rb	rb	rb
Improvement in Transferring	rb	rb	rb
Improvement in Status of Surgical Wounds	rb	rb	rb
Improvement in Management of Oral Medications	rb	rb	rb

6. Which of the following describes any changes in the <u>number of your staff</u> (i.e., <u>increase</u> = the position was vacant, requested, or created and was filled, or additional (new) staff were hired; <u>decrease</u> = a position was filled, but now is vacant) that occurred during CY2009? Indicate change for each--if any.

Job Category	Decreased Staffing	No Change	Increased Staffing
a. Senior management (CEO, DON, etc.)	rb	rb	rb
b. Quality improvement or performance improvement coordinator	rb	rb	rb
c. Clinical supervisory positions	rb	rb	rb
d. Registered nurse	rb	rb	rb
e. Registered nurse with specialty license/ certification (e.g., wound, psychiatric)	rb	rb	rb
f. Licensed practical nurse	rb	rb	rb
g. Physical therapist	rb	rb	rb
h. Occupational therapist	rb	rb	rb
i. Medical social worker	rb	rb	rb
j. Home health aide	rb	rb	rb
k. Administrative/support	rb	rb	rb
1. Other (specify25 characters)	rb	rb	rb

(Radio button w/ "No Change" as default) [Note: rb indicates radio button]

 Which of the following describes the <u>turnover in your staff</u> (e.g., a staff member left and was replaced by a new or another staff member in that position) that occurred during CY2009? (*Radio button w/ "No/Low"* as default) [Note: rb indicates radio button]

Job Category	No/Low (0-5%)	Small (6-20%)	Moderate (21-40%)	High (41-75%)	Very high (>75%)
a. Senior management (CEO, DON, etc.)	rb	rb	rb	rb	rb
b. Quality improvement or performance improvement coordinator	rb	rb	rb	rb	rb
c. Clinical supervisory positions	rb	rb	rb	rb	rb
d. Registered nurse	rb	rb	rb	rb	rb
e. Registered nurse with specialty license/ certification (e.g., wound, psychiatric)	rb	rb	rb	rb	rb
f. Licensed practical nurse	rb	rb	rb	rb	rb
g. Physical therapist	rb	rb	rb	rb	rb
h. Occupational therapist	rb	rb	rb	rb	rb
i. Medical social worker	rb	rb	rb	rb	rb
j. Home health aide	rb	rb	rb	rb	rb
k. Administrative/support	rb	rb	rb	rb	rb
1. Other (specify 25 characters)	rb	rb	rb	rb	rb

8. Did you add any new positions/functions during CY2009 <u>specifically because of your participation in</u> <u>the demonstration</u>?

	Job Function	Already Existed	Added Position/Function	Does Not Exist
a.	Quality improvement (QI) or performance improvement (PI) coordination	rb	rb	rb
b.	Documentation quality assurance or OASIS accuracy	rb	rb	rb
c.	Staff education	rb	rb	rb
d.	Outcome analysis	rb	rb	rb
e.	Utilization/Resource review	rb	rb	rb
f.	"Combination" position(s) that includes two or more of the "a - e" functions	rb	rb	rb
g.	Other (specify)	rb	rb	rb

(Radio button w/ "Does Not Exist" as default) [Note: rb indicates radio button]

9. What <u>policy changes</u> did <u>your agency</u> implemented during CY2009? Policies related to...(Check all that apply)

(Check box; no pre-fill) [Note: cb indicates check box]

- [cb] a. Changes in care practices (e.g., "front-loading" visits, medicine reconciliation)
- [cb] b. Implementation of care pathways/standardized care plans
- [cb] c. Reduction in time between referral and admission visit
- [cb] d. Communication with patient (quantity and/or quality)
- [cb] e. Communication with physician (quantity and/or quality)
- [cb] f. Disease management programs
- [cb] g. Telehealth programs
- [cb] h. Falls prevention programs
- [cb] i. Patient infection control programs
- [cb] j. New clinical specialties programs (specify):
- [cb] k. Change in on-call staff for non-business hours
- [cb] 1. Expanded business hours
- [cb] m. Changes in productivity requirements for staff
- [cb] n. Changes in staff hiring requirements
- [cb] o. Other (specify):

- What <u>activities directed toward care providers</u> and intended to improve quality of care did <u>your</u> <u>agency</u> implemented during CY2009? (Check all that apply) (Check box; no pre-fill) [Note: cb indicates check box]
 - [cb] a. New staff education programs and/or changes in requirements for number of educational hours
 - [cb] b. Performance improvement programs
 - [cb] c. Mentoring programs
 - [cb] d. Additional clinical team meetings
 - [cb] e. Additional record review activities
 - [cb] f. New staff competencies
 - [cb] g. Changes in staff evaluation criteria
 - [cb] h. Employee incentives for performance improvement
 - [cb] i. Changes in staff management practices of nursing or therapy staff (e.g., increased oversight, etc.)
 - [cb] j. Changes in home health aide supervisory practices
 - [cb] k. Additional clinical resources for field staff (e.g., consultation; new specialty care staff; Web access to best practices, etc.)
 - [cb] l. Other (specify): _____
- 11. What <u>technological innovations</u> designed to improve the quality of patient care did <u>your agency</u> implemented during CY2009? (Check all that apply)
 (Check box; no pre-fill) [Note: cb indicates check box]
 - [cb] a. Telemonitoring equipment
 - [cb] b. Electronic health records
 - [cb] c. Electronic information exchange with referral sources other than physicians (e.g., hospital)
 - [cb] d. Electronic information exchange with physicians
 - [cb] e. Secure electronic messaging systems for agency care team members
 - [cb] f. New infusion devices or equipment
 - [cb] g. New respiratory equipment (e.g., ventilators, etc.)
 - [cb] h. Physiologic monitoring equipment (e.g., blood glucose monitors, prothrombin monitors, etc.)
 - [cb] i. Inflatable mattresses or similar equipment to reduce incidence of pressure ulcers
 - [cb] j. Special dressings or therapies for wound care
 - [cb] k. Medication reminder systems
 - [cb] 1. Medication dispensing systems
 - [cb] m. Implementation of medication checking/reconciliation software
 - [cb] n. Personal emergency response systems
 - [cb] o. Electronic access to policies, procedures, best practices, etc.
 - [cb] p. Other (specify):

- 12. What <u>care practice changes</u> designed to improve the specific clinical outcomes did <u>your agency</u> implemented during CY2009? (Check all that apply) (*Check box; no pre-fill*) [Note: cb indicates check box]
 - [cb] a. Changes in visit patterns (e.g., front-loading; increased number of visits for specific diagnoses)
 - [cb] b. Introduction of telemonitoring
 - [cb] c. Changes in visit mix (e.g., increased use of PT, etc.)
 - [cb] d. Introduction of disease management programs
 - [cb] e. Introduction and/or increased use of clinical pathways
 - [cb] f. Changes in patient teaching plans
 - [cb] g. Increased communication with MD
 - [cb] h. Inclusion on POC of specific parameters for when to call physician (e.g., call MD for BS > 150)
 - [cb] i. Increased care team communication (e.g., team meetings, etc.)
 - [cb] j. Implementation of screening assessments (e.g., falls risk)
 - [cb] k. Implementation of falls prevention programs
 - [cb] 1. Enhanced wound care protocols
 - [cb] m. Increased efforts to improve vaccination rates (e.g., flu and pneumococcus)
 - [cb] n. Use of medication reminder or dispensing systems
 - [cb] o. Standards related to medication reconciliation or MD follow-up
 - [cb] p. Other (specify):
- Identify any <u>corporate initiatives</u> that were implemented during CY2009. (Indicate change for each--if any) (*Radio button w/ "No Change" pre-filled*) [Note: rb indicates radio button]
 [cb] NA, Not Part of Chain/Corporation

	Corporate Initiative Focus	No Change	Modified Existing Program	Implemented New Program
a.	Reducing potentially avoidable hospitalizations	rb	rb	rb
b.	Reducing potentially avoidable emergency care	rb	rb	rb
c.	Improving rehabilitation outcomes	rb	rb	rb
d.	Pressure ulcer treatment	rb	rb	rb
e.	Falls risk reduction programs	rb	rb	rb
f.	Medication management programs	rb	rb	rb
g.	Use of technology to support patient care	rb	rb	rb
h.	Staff training	rb	rb	rb
i.	Participation in QIO quality initiatives	rb	rb	rb
j.	Performance incentive program (monetary)	rb	rb	rb
k.	Enhanced corporate communications	rb	rb	rb
1.	Other (specify):	rb	rb	rb

 Identify any <u>impact on your agency</u> that occurred during CY2009 that may have been the result of <u>local/regional issues or situations</u>. (Indicate impact for each--if any) (*Radio button w/ "No Impact" pre-filled*) [Note: rb indicates radio button]

			Type of	Impact	
		No		Both	
	Type of Local/Regional Change	Impact	Negative	+/-	Positive
a.	# of community hospitals (or hospital beds)	rb	rb	rb	rb
b.	# of skilled nursing facilities (or SNF beds)	rb	rb	rb	rb
c.	# of urgent/emergency care facilities	rb	rb	rb	rb
d.	# of home health agencies	rb	rb	rb	rb
e.	Availability of nurses locally	rb	rb	rb	rb
f.	Availability of physical therapists locally	rb	rb	rb	rb
g.	Availability of occupational therapists locally	rb	rb	rb	rb
h.	Availability of home health aides locally	rb	rb	rb	rb
i.	Changes in population demographics locally	rb	rb	rb	rb
j.	Local physician care practice patterns	rb	rb	rb	rb
k.	Change in available community resources (Assisted living facilities, adult day care, transportation programs, meal programs, respite care providers)	rb	rb	rb	rb
1.	Natural disaster (e.g., flood, fire, etc.)	rb	rb	rb	rb
m.	State health care policy (e.g., Medicaid funding)	rb	rb	rb	rb

15. What is your <u>best estimate</u> of the effects of activities related to the pay for performance demonstration during Year 2 (CY2009) on the <u>cost of providing care</u> to your patients? (*Radio button w/ "Less than 1% change" pre-filled*) [Note: rb indicates radio button]

Decre > 1	ase by E	Decrease by 5 – 10%	Decrease by $1-5\%$	Less than 1% change	Increase by $1-5\%$	Increase by $5-10\%$	Increase by $> 10\%$
r	b	rb	rb	rb	rb	rb	rb

16. How much of an <u>impact</u> on your patients do you think <u>your quality improvement activities</u> have had on the outcomes targeted during Year 2 (CY2009) of the demonstration?
 (*Radio button w/ "No Impact" pre-filled*) [Note: rb indicates radio button]

	Probable impact of QI on outcomes					
Outcome Measure	No Impact	Modest Improvement	Substantial Improvement			
a. Incidence of Acute Care Hospitalization	rb	rb	rb			
b. Incidence of Any Emergent Care	rb	rb	rb			
c. Improvement in Bathing	rb	rb	rb			
d. Improvement in Ambulation/Locomotion	rb	rb	rb			
e. Improvement in Transferring	rb	rb	rb			
f. Improvement in Status of Surgical Wounds	rb	rb	rb			
g. Improvement in Management of Oral Medications	rb	rb	rb			

	Focus of Effect	Very Negative	Slightly Negative	No Impact	Slightly Positive	Very Positive
a.	My agency's patient outcomes	rb	rb	rb	rb	rb
b.	Quality of care at my agency	rb	rb	rb	rb	rb
c.	Quality of care statewide	rb	rb	rb	rb	rb
d.	Access to care for Medicare beneficiaries	rb	rb	rb	rb	rb
e.	Cost of providing home health care	rb	rb	rb	rb	rb
f.	Financial solvency of my agency	rb	rb	rb	rb	rb
g.	Financial solvency of home health agencies statewide	rb	rb	rb	rb	rb
h.	Profitability of my agency	rb	rb	rb	rb	rb
i.	Profitability of home health agencies statewide	rb	rb	rb	rb	rb
j.	Patient satisfaction w/ agency	rb	rb	rb	rb	rb
k.	Staff satisfaction at agency	rb	rb	rb	rb	rb
1.	Referral source satisfaction w/ agency	rb	rb	rb	rb	rb

17. What <u>effect</u> do you think <u>the demonstration</u> will have on the following? (*Radio button w/ "No Impact" pre-filled*) [Note: rb indicates radio button]

18. Rate each of the following actions/reports in terms of how useful they would be if Home Health P4P is implemented:

(*Radio button w/ "N/A" pre-filled*) [Note: rb indicates radio button]

	Report or Activity	Not Useful	Useful	Very Useful	Extremely Useful	N/A
a.	Publish regular (monthly or quarterly) updates or reminders about the P4P program	rb	rb	rb	rb	rb
b.	Publish monthly "best practices" $(2 - 4 \text{ items})$ that are related to the target outcomes	rb	rb	rb	rb	rb
c.	Make home health P4P support an element in QIO Statement of Work	rb	rb	rb	rb	rb
d.	Identify available online workshops sponsored by professional organizations that have specific themes (e.g., implementation of telehealth systems; wound care protocols)	rb	rb	rb	rb	rb
e.	Each month publish/highlight the activities of one high performing HHA (each region should have at least one annually)	rb	rb	rb	rb	rb
f.	Publish targeted, effective intervention strategies for different HHA groups (e.g., rural vs. urban; large vs. small; non-profit vs. for profit)	rb	rb	rb	rb	rb
g.	Provide certificates of recognition to high performing HHAs	rb	rb	rb	rb	rb
h.	Publish information on high performing HHAs to the public (e.g., list agencies on Home Health Compare)	rb	rb	rb	rb	rb

- 19 Please use the space below to provide any other comments <u>what your agency learned by</u> participating in the P4P Demonstration during Calendar Years 2008 and 2009. (optional) (*There will be a 500-word limit on this box with automatic word count*)
- 20. Please use the space below to provide <u>specific advice that you would share with other HHAs on how</u> to be successful if P4P becomes an implemented program in CY2012. (Optional) *(There will be a 500-word limit on this box with automatic word count)*

Thank you very much for providing your feedback. Please review your answers prior to pressing the "Send" button.

Appendix B: Year 2 Intervention and Regional Cross-Tabulations

Table B.1: Year 2 Home Health P4P Demonstration Evaluation Survey Participants.

		Participa	Int Group		1	
	<u> </u>	No	Y	es	-1	
Group	Count	%	Count	%	Total	Signi
Control	40	42.6%	54	57.4%	94	ns
Treatment	53	42.4%	72	57.6%	125	
Total/Average	93	42.5%	126	57.5%	219	

Repeat Responder Survey Participants by Control and Treatment Group.

Survey Participants by Region, Control, and Treatment Group.

		Participa				
	Co	Control Treatment				
Regions	Count	%	Count	%	Total	Signif.
Northeast (MA, CT)	17	40.5%	25	59.5%	42	ns
Southeast (TN, AL, GA)	28	41.8%	39	58.2%	67	
Midwest (IL)	25	49.0%	26	51.0%	51	
West (CA)	24	40.7%	35	59.3%	59	
Total/Average	94	42.9%	125	57.1%	219	

Repeat Responder Survey Participants by Region, Control, and Treatment Group.

		Participa				
	1	No	Y	'es		
Regions	Count	%	Count	%	Total	Signif.
Northeast (MA, CT)	19	45.2%	23	54.8%	42	ns
Southeast (TN, AL, GA)	34	50.7%	33	49.3%	67	
Midwest (IL)	15	29.4%	36	70.6%	51	
West (CA)	25	42.4%	34	57.6%	59	
Total/Average	93	42.5%	126	57.5%	219	

Table B.2: Frequency Distributions by Treatment Group and by Region for Survey Item 7: ...turnover in your staff (e.g., a staff member left and was replaced by a new or another staff member in that position)

Turnover – Senior Management

Group	Low/No (<5%)	Small (6-20%)	Moderate (21-40%)	High (41-75%)	Very High (>75%)	Signif.
Control (n=94)	94.7%	2.1%	2.1%	1.1%	0.0%	ns
Treatment (n=125)	91.2%	5.6%	1.6%	0.8%	0.8%	
Total (n=219)	92.7%	4.1%	1.8%	0.9%	0.5%	

Region						Signif.
Northeast (MA, CT) (n=42)	95.2%	2.4%	2.4%	0.0%	0.0%	ns
Southeast (TN, AL, GA) (n=67)	89.6%	7.5%	1.5%	0.0%	1.5%	
Midwest (IL) (n=51)	96.1%	2.0%	2.0%	0.0%	0.0%	
West (CA) (n=59)	91.5%	3.4%	1.7%	3.4%	0.0%	
Total (n=219)	92.7%	4.1%	1.8%	0.9%	0.5%	

Turnover – QI/PI Coordinator

Group	Low/No (<5%)	Small (6-20%)	Moderate (21-40%)	High (41-75%)	Very High (>75%)	Signif.
Control (n=94)	92.6%	5.3%	1.1%	1.1%	0.0%	ns
Treatment (n=125)	84.8%	9.6%	1.6%	0.8%	3.2%	
Total (n=219)	88.1%	7.8%	1.4%	0.9%	1.8%	

Region						Signif.
Northeast (MA, CT) (n=42)	85.7%	7.1%	2.4%	0.0%	4.8%	ns
Southeast (TN, AL, GA) (n=67)	86.6%	10.4%	0.0%	1.5%	1.5%	
Midwest (IL) (n=51)	94.1%	3.9%	2.0%	0.0%	0.0%	
West (CA) (n=59)	86.4%	8.5%	1.7%	1.7%	1.7%	
Total (n=219)	88.1%	7.8%	1.4%	0.9%	1.8%	

Turnover – Clinical Supervisor

Group	Low/No (<5%)	Small (6-20%)	Moderate (21-40%)	High (41-75%)	Very High (>75%)	Signif.
Control (n=94)	76.6%	13.8%	7.4%	2.1%	0.0%	ns
Treatment (n=125)	84.8%	8.8%	4.0%	1.6%	0.8%	
Total (n=219)	81.3%	11.0%	5.5%	1.8%	0.5%	

Region						Signif.
Northeast (MA, CT) (n=42)	81.0%	11.9%	2.4%	2.4%	2.4%	ns
Southeast (TN, AL, GA) (n=67)	76.1%	13.4%	9.0%	1.5%	0.0%	
Midwest (IL) (n=51)	82.4%	11.8%	5.9%	0.0%	0.0%	
West (CA) (n=59)	86.4%	6.8%	3.4%	3.4%	0.0%	
Total (n=219)	81.3%	11.0%	5.5%	1.8%	0.5%	

Table B.2: Frequency Distributions by Treatment Group and by Region for Survey Item 7: ...turnover in your staff (e.g., a staff member left and was replaced by a new or another staff member in that position). (cont'd)

Group	Low/No (<5%)	Small (6-20%)	Moderate (21-40%)	High (41-75%)	Very High (>75%)	Signif.
Control (n=94)	52.1%	30.9%	13.8%	2.1%	1.1%	ns
Treatment (n=125)	49.6%	29.6%	16.0%	3.2%	1.6%	
Total (n=219)	50.7%	30.1%	15.1%	2.7%	1.4%	

Turnover – RN

Region						Signif.
Northeast (MA, CT) (n=42)	50.0%	42.9%	2.4%	2.4%	2.4%	0.028
Southeast (TN, AL, GA) (n=67)	41.8%	26.9%	23.9%	6.0%	1.5%	
Midwest (IL) (n=51)	66.7%	17.6%	13.7%	.0%	2.0%	
West (CA) (n=59)	47.5%	35.6%	15.3%	1.7%	.0%	
Total (n=219)	50.7%	30.1%	15.1%	2.7%	1.4%	

Turnover – RN with specialty license/certification

Group	Low/No (<5%)	Small (6-20%)	Moderate (21-40%)	High (41-75%)	Very High (>75%)	Signif.
Control (n=94)	93.6%	4.3%	2.1%	.0%	.0%	ns
Treatment (n=125)	95.2%	2.4%	.0%	.8%	1.6%	
Total (n=219)	94.5%	3.2%	.9%	.5%	.9%	

Region						Signif.
Northeast (MA, CT) (n=42)	95.2%	4.8%	0.0%	0.0%	0.0%	ns
Southeast (TN, AL, GA) (n=67)	92.5%	3.0%	1.5%	1.5%	1.5%	
Midwest (IL) (n=51)	100.0%	0.0%	.0%	0.0%	0.0%	
West (CA) (n=59)	91.5%	5.1%	1.7%	0.0%	1.7%	
Total (n=219)	94.5%	3.2%	0.9%	0.5%	0.9%	

Turnover – LPN

Group	Low/No (<5%)	Small (6-20%)	Moderate (21-40%)	High (41-75%)	Very High (>75%)	Signif.
Control (n=94)	81.9%	12.8%	4.3%	1.1%	.0%	ns
Treatment (n=125)	88.8%	6.4%	4.0%	.8%	.0%	
Total (n=219)	85.8%	9.1%	4.1%	.9%	.0%	

Region						Signif.
Northeast (MA, CT) (n=42)	90.5%	9.5%	0.0%	0.0%	0.0%	ns
Southeast (TN, AL, GA) (n=67)	76.1%	16.4%	6.0%	1.5%	0.0%	
Midwest (IL) (n=51)	94.1%	2.0%	3.9%	0.0%	0.0%	
West (CA) (n=59)	86.4%	6.8%	5.1%	1.7%	0.0%	
Total (n=219)	85.8%	9.1%	4.1%	0.9%	0.0%]

Table B.2: Frequency Distributions by Treatment Group and by Region for Survey Item 7: ...turnover in your staff (e.g., a staff member left and was replaced by a new or another staff member in that position). (cont'd)

Turnover – Physical Therapist

Group	Low/No (<5%)	Small (6-20%)	Moderate (21-40%)	High (41-75%)	Very High (>75%)	Signif.
Control (n=94)	78.7%	14.9%	4.3%	1.1%	1.1%	ns
Treatment (n=125)	79.2%	16.8%	3.2%	0.0%	0.8%	
Total (n=219)	79.0%	16.0%	3.7%	0.5%	0.9%	

Region						Signif.
Northeast (MA, CT) (n=42)	81.0%	16.7%	0.0%	2.4%	0.0%	ns
Southeast (TN, AL, GA) (n=67)	77.6%	14.9%	7.5%	0.0%	0.0%	
Midwest (IL) (n=51)	82.4%	15.7%	.0%	0.0%	2.0%	
West (CA) (n=59)	76.3%	16.9%	5.1%	0.0%	1.7%	
Total (n=219)	79.0%	16.0%	3.7%	0.5%	0.9%	

Turnover – Occupational Therapist

Group	Low/No (<5%)	Small (6-20%)	Moderate (21-40%)	High (41-75%)	Very High (>75%)	Signif.
Control (n=94)	80.9%	16.0%	2.1%	0.0%	1.1%	0.086
Treatment (n=125)	91.2%	5.6%	1.6%	0.0%	1.6%	
Total (n=219)	86.8%	10.0%	1.8%	0.0%	1.4%	

Region						Signif.
Northeast (MA, CT) (n=42)	85.7%	11.9%	2.4%	0.0%	0.0%	ns
Southeast (TN, AL, GA) (n=67)	82.1%	11.9%	4.5%	0.0%	1.5%	
Midwest (IL) (n=51)	90.2%	7.8%	.0%	0.0%	2.0%	
West (CA) (n=59)	89.8%	8.5%	.0%	0.0%	1.7%	
Total (n=219)	86.8%	10.0%	1.8%	0.0%	1.4%	

Turnover – Medical Social Worker

Group	Low/No (<5%)	Small (6-20%)	Moderate (21-40%)	High (41-75%)	Very High (>75%)	Signif.
Control (n=94)	91.5%	8.5%	0.0%	0.0%	0.0%	ns
Treatment (n=125)	94.4%	3.2%	0.8%	0.0%	1.6%	
Total (n=219)	93.2%	5.5%	0.5%	0.0%	0.9%	

Region						Signif.
Northeast (MA, CT) (n=42)	90.5%	9.5%	0.0%	0.0%	0.0%	ns
Southeast (TN, AL, GA) (n=67)	92.5%	4.5%	1.5%	0.0%	1.5%	
Midwest (IL) (n=51)	98.0%	2.0%	0.0%	0.0%	0.0%	
West (CA) (n=59)	91.5%	6.8%	0.0%	0.0%	1.7%	
Total (n=219)	93.2%	5.5%	0.5%	0.0%	0.9%	

Table B.2: Frequency Distributions by Treatment Group and by Region for Survey Item 7: ...turnover in your staff (e.g., a staff member left and was replaced by a new or another staff member in that position). (cont'd)

Turnover – Home Health Aide

Group	Low/No (<5%)	Small (6-20%)	Moderate (21-40%)	High (41-75%)	Very High (>75%)	Signif.
Control (n=94)	84.0%	10.6%	4.3%	1.1%	0.0%	ns
Treatment (n=125)	85.6%	10.4%	1.6%	2.4%	0.0%	
Total (n=219)	84.9%	10.5%	2.7%	1.8%	0.0%	

Region						Signif.
Northeast (MA, CT) (n=42)	73.8%	19.0%	7.1%	0.0%	0.0%	ns
Southeast (TN, AL, GA) (n=67)	86.6%	9.0%	1.5%	3.0%	0.0%	
Midwest (IL) (n=51)	88.2%	9.8%	2.0%	0.0%	0.0%	
West (CA) (n=59)	88.1%	6.8%	1.7%	3.4%	0.0%	
Total (n=219)	84.9%	10.5%	2.7%	1.8%	0.0%	

Turnover – Administrative Support

Group	Low/No (<5%)	Small (6-20%)	Moderate (21-40%)	High (41-75%)	Very High (>75%)	Signif.
Control (n=94)	86.2%	9.6%	4.3%	0.0%	0.0%	ns
Treatment (n=125)	83.2%	12.8%	4.0%	0.0%	0.0%	
Total (n=219)	84.5%	11.4%	4.1%	0.0%	0.0%	

Region						Signif.
Northeast (MA, CT) (n=42)	81.0%	16.7%	2.4%	0.0%	0.0%	ns
Southeast (TN, AL, GA) (n=67)	82.1%	10.4%	7.5%	0.0%	0.0%	
Midwest (IL) (n=51)	94.1%	5.9%	0.0%	0.0%	0.0%	
West (CA) (n=59)	81.4%	13.6%	5.1%	0.0%	0.0%	
Total (n=219)	84.5%	11.4%	4.1%	0.0%	0.0%	

Turnover – Other

Group	Low/No (<5%)	Small (6-20%)	Moderate (21-40%)	High (41-75%)	Very High (>75%)	Signif.
Control (n=94)	97.9%	1.1%	1.1%	0.0%	0.0%	ns
Treatment (n=125)	100.0%	0.0%	0.0%	0.0%	0.0%	
Total (n=219)	99.1%	0.5%	0.5%	0.0%	0.0%	

Region						Signif.
Northeast (MA, CT) (n=42)	100.0%	0.0%	0.0%	0.0%	0.0%	ns
Southeast (TN, AL, GA) (n=67)	98.5%	0.0%	1.5%	0.0%	0.0%	
Midwest (IL) (n=51)	100.0%	0.0%	0.0%	0.0%	0.0%	
West (CA) (n=59)	98.3%	1.7%	0.0%	0.0%	0.0%	
Total (n=219)	99.1%	0.5%	0.5%	0.0%	0.0%	

Table B.3: Frequency Distributions by Treatment Group and by Region for Survey Item 8: Did you add any new positions/functions during CY2009 specifically because of your participation in the demonstration?

QI/PI Coordinator

Group	Already Existed	Added	Does not Exist	Signif.
Control (n=94)	68.1%	10.6%	21.3%	ns
Treatment (n=125)	63.2%	8.8%	28.0%	
Total (n=219)	65.3%	9.6%	25.1%	

Region				Signif.
Northeast (MA, CT) (n=42)	73.8%	9.5%	16.7%	ns
Southeast (TN, AL, GA) (n=67)	68.7%	6.0%	25.4%	
Midwest (IL) (n=51)	54.9%	13.7%	31.4%	
West (CA) (n=59)	64.4%	10.2%	25.4%	
Total (n=219)	65.3%	9.6%	25.1%	

Documentation quality assurance or OASIS accuracy

Group	Already Existed	Added	Does not Exist	Signif.
Control (n=94)	52.1%	17.0%	30.9%	ns
Treatment (n=125)	54.4%	11.2%	34.4%	
Total (n=219)	53.4%	13.7%	32.9%	

			-	
Region				Signif.
Northeast (MA, CT) (n=42)	57.1%	9.5%	33.3%	ns
Southeast (TN, AL, GA) (n=67)	58.2%	10.4%	31.3%	
Midwest (IL) (n=51)	43.1%	19.6%	37.3%	
West (CA) (n=59)	54.2%	15.3%	30.5%	
Total (n=219)	53.4%	13.7%	32.9%	

Staff Education

Group	Already Existed	Added	Does not Exist	Signif.
Control (n=94)	55.3%	13.8%	30.9%	ns
Treatment (n=125)	56.0%	7.2%	36.8%	
Total (n=219)	55.7%	10.0%	34.2%	

Region				Signif.
Northeast (MA, CT) (n=42)	54.8%	9.5%	35.7%	ns
Southeast (TN, AL, GA) (n=67)	64.2%	6.0%	29.9%	
Midwest (IL) (n=51)	51.0%	15.7%	33.3%	
West (CA) (n=59)	50.8%	10.2%	39.0%	
Total (n=219)	55.7%	10.0%	34.2%	

Table B.3: Frequency Distributions by Treatment Group and by Region for Survey Item 8: Did you add any new positions/functions during CY2009 specifically because of your participation in the demonstration? (cont'd)

Outcome Analysis

Group	Already Existed	Added	Does not Exist	Signif.
Control (n=94)	51.1%	9.6%	39.4%	ns
Treatment (n=125)	48.8%	6.4%	44.8%	
Total (n=219)	49.8%	7.8%	42.5%	

Region				Signif.
Northeast (MA, CT) (n=42)	42.9%	7.1%	50.0%	ns
Southeast (TN, AL, GA) (n=67)	56.7%	9.0%	34.3%	
Midwest (IL) (n=51)	45.1%	7.8%	47.1%	
West (CA) (n=59)	50.8%	6.8%	42.4%	
Total (n=219)	49.8%	7.8%	42.5%	

Utilization/Resource Review

Group	Already Existed	Added	Does not Exist	Signif.
Control (n=94)	57.4%	2.1%	40.4%	ns
Treatment (n=125)	54.4%	2.4%	43.2%	
Total (n=219)	55.7%	2.3%	42.0%	

Region				Signif.
Northeast (MA, CT) (n=42)	52.4%	.0%	47.6%	ns
Southeast (TN, AL, GA) (n=67)	64.2%	1.5%	34.3%	
Midwest (IL) (n=51)	45.1%	3.9%	51.0%	
West (CA) (n=59)	57.6%	3.4%	39.0%	
Total (n=219)	55.7%	2.3%	42.0%	

"Combination" position(s) that includes two or more of the above position/functions

Group	Already Existed	Added	Does not Exist	Signif.
Control (n=94)	45.7%	11.7%	42.6%	ns
Treatment (n=125)	48.8%	8.0%	43.2%	
Total (n=219)	47.5%	9.6%	42.9%	

Region				Signif.
Northeast (MA, CT) (n=42)	38.1%	7.1%	54.8%	ns
Southeast (TN, AL, GA) (n=67)	49.3%	7.5%	43.3%	
Midwest (IL) (n=51)	60.8%	7.8%	31.4%	
West (CA) (n=59)	40.7%	15.3%	44.1%	
Total (n=219)	47.5%	9.6%	42.9%	

	>10% d	ecrease	5-10% d	ecrease	1-5% de	ecrease	<1% c	hange	1-5% ir	crease	5-10% i	ncrease	>10% ir	ncrease		
Group	Count	%	Count	%	Count	%	Count	%	Count	%	Count	%	Count	%	Total	Signif.
Control	1	1.1%	3	3.2%	7	7.4%	43	45.7%	17	18.1%	16	17.0%	7	7.4%	94	0.002
Treatment	0	0.0%	1	0.8%	4	3.2%	75	60.0%	36	28.8%	6	4.8%	3	2.4%	125	
Total/Average	1	0.5%	4	1.8%	11	5.0%	118	53.9%	53	24.2%	22	10.0%	10	4.6%	219	
	[I													-
	>10% d	ecrease	5-10% d	ecrease	1-5% de	ecrease	<1% c	hange	1-5% ir	icrease	5-10% i	ncrease	>10% ir	ncrease		
Region	Count	%	Count	%	Count	%	Count	%	Count	%	Count	%	Count	%	Total	Signif.
Northeast (MA, CT)	0	0.0%	0	0.0%	3	7.1%	27	64.3%	8	19.0%	3	7.1%	1	2.4%	42	0.045
Southeast (TN,AL,GA)	0	0.0%	3	4.5%	5	7.5%	36	53.7%	20	29.9%	2	3.0%	1	1.5%	67	
Midwest (IL)	0	0.0%	1	2.0%	3	5.9%	29	56.9%	10	19.6%	6	11.8%	2	3.9%	51	
West (CA)	1	1.7%	0	0.0%	0	0.0%	26	44.1%	15	25.4%	11	18.6%	6	10.2%	59	
Total/Average	1	0.5%	4	1.8%	11	5.0%	118	53.9%	53	24.2%	22	10.0%	10	4.6%	219]

Table B.4: Frequency Distributions by Treatment Group and by Region for Survey Item 17: What is your best estimate of the Demonstration's impact on cost of providing care?

Table B.5: Frequency Distributions by Treatment Group and by Region for Survey Item 18: What impact did your QI activities have on the outcomes targeted during Year 2 (CY2009)?

Acute Care Hospitalization?

	No li	mpact	Мо	dest	Substantial			
Group	Count	%	Count	%	Count	%	Total	Signif.
Control	35	37.2%	41	43.6%	18	19.1%	94	ns
Treatment	44	35.2%	65	52.0%	16	12.8%	125	
Total/Average	79	36.1%	106	48.4%	34	15.5%	219	

	No I	mpact	Modest		Substantial			
Region	Count	%	Count	%	Count	%	Total	Signif.
Northeast (MA, CT)	14	33.3%	21	50.0%	7	16.7%	42	ns
Southeast (TN,AL,GA)	26	38.8%	31	46.3%	10	14.9%	67	
Midwest (IL)	22	43.1%	22	43.1%	7	13.7%	51	
West (CA)	17	28.8%	32	54.2%	10	16.9%	59	
Total/Average	79	36.1%	106	48.4%	34	15.5%	219]

Any Emergent Care?

	No l	mpact	Мо	dest	Substantial			
Group	Count	%	Count	%	Count	%	Total	Signif.
Control	45	47.9%	38	40.4%	11	11.7%	94	ns
Treatment	54	43.2%	57	45.6%	14	11.2%	125	
Total/Average	99	45.2%	95	43.4%	25	11.4%	219	

	No li	mpact	Modest		Substantial			
Region	Count	%	Count	%	Count	%	Total	Signif.
Northeast (MA, CT)	20	47.6%	16	38.1%	6	14.3%	42	ns
Southeast (TN,AL,GA)	27	40.3%	34	50.7%	6	9.0%	67	
Midwest (IL)	28	54.9%	17	33.3%	6	11.8%	51	
West (CA)	24	40.7%	28	47.5%	7	11.9%	59	
Total/Average	99	45.2%	95	43.4%	25	11.4%	219	

Table B.5: Frequency Distributions by Treatment Group and by Region for Survey Item 18: What impact did your QI activities have on the outcomes targeted during Year 2 (CY2009)? (cont'd)

Improvement in Bathing?

			Improv	ement				
	No l	mpact	Мо	dest	Substantial			
Group	Count	%	Count	%	Count	%	Total	Signif.
Control	39	41.5%	45	47.9%	10	10.6%	94	ns
Treatment	60	48.0%	52	41.6%	13	10.4%	125	
Total/Average	99	45.2%	397	44.3%	23	10.5%	219	

	No Impact		Мо	dest	Subs	tantial		
Region	Count	%	Count	%	Count	%	Total	Signif.
Northeast (MA, CT)	21	50.0%	19	45.2%	2	4.8%	42	ns
Southeast (TN,AL,GA)	30	44.8%	29	43.3%	8	11.9%	67	
Midwest (IL)	21	41.2%	26	51.0%	4	7.8%	51	
West (CA)	27	45.8%	23	39.0%	9	15.3%	59	
Total/Average	99	45.2%	97	44.3%	23	10.5%	219	

Improvement in Ambulation/Locomotion?

	No li	mpact	Мо	dest	Substantial			
Group	Count	%	Count	%	Count	%	Total	Signif.
Control	29	30.9%	51	54.3%	14	14.9%	94	ns
Treatment	50	40.0%	51	40.8%	24	19.2%	125	
Total/Average	79	36.1%	102	46.6%	38	17.4%	219	

	No l	mpact	Modest		Substantial			
Region	Count	%	Count	%	Count	%	Total	Signif.
Northeast (MA, CT)	17	40.5%	17	40.0%	8	19.0%	42	ns
Southeast (TN,AL,GA)	27	40.3%	32	47.8%	8	11.9%	67	
Midwest (IL)	18	35.3%	26	51.0%	7	13.7%	51	
West (CA)	17	28.8%	27	45.8%	15	25.4%	59	
Total/Average	79	36.1%	102	46.6%	38	17.4%	219	

Table B.5: Frequency Distributions by Treatment Group and by Region for Survey Item 18: What impact did your QI activities have on the outcomes targeted during Year 2 (CY2009)? (cont'd)

Improvement in Transferring?

Improvement								
	No li	mpact	Мо	dest	Substantial			
Group	Count	%	Count	%	Count	%	Total	Signif.
Control	38	40.4%	43	45.7%	13	13.8%	94	ns
Treatment	51	40.8%	54	43.2%	20	16.0%	125	
Total/Average	89	40.6%	97	44.3%	33	15.1%	219	

	No I	mpact	t Modest		Substantial			
Region	Count	%	Count	%	Count	%	Total	Signif.
Northeast (MA, CT)	18	42.9%	18	42.9%	6	14.3%	42	ns
Southeast (TN,AL,GA)	23	34.3%	36	53.7%	8	11.9%	67	
Midwest (IL)	24	47.1%	22	43.1%	5	9.8%	51	
West (CA)	24	40.7%	21	35.6%	14	23.7%	59	
Total/Average	89	40.6%	97	44.3%	33	15.1%	219	

Improvement in Status of Surgical Wounds?

	No li	mpact	Мо	dest	Substantial			
Group	Count	%	Count	%	Count	%	Total	Signif.
Control	35	37.2%	41	43.6%	18	19.1%	94	ns
Treatment	46	36.8%	52	41.6%	27	21.6%	125	
Total/Average	81	37.0%	93	42.5%	45	20.5%	219	

	No I	mpact	Modest		Substantial			
Region	Count	%	Count	%	Count	%	Total	Signif.
Northeast (MA, CT)	13	31.0%	18	42.9%	11	26.2%	42	0.58
Southeast (TN,AL,GA)	33	49.3%	25	37.3%	9	13.4%	67	
Midwest (IL)	17	33.3%	27	52.9%	7	13.7%	51	
West (CA)	18	30.5%	23	39.0%	18	30.5%	59	
Total/Average	81	37.0%	93	42.5%	45	20.5%	219	

Table B.5: Frequency Distributions by Treatment Group and by Region for Survey Item 18: What impact did your QI activities have on the outcomes targeted during Year 2 (CY2009)? (cont'd)

	No Impact		Modest		Substantial			
Group	Count	%	Count	%	Count	%	Total	Signif.
Control	33	35.1%	47	50.0%	14	14.9%	94	ns
Treatment	39	31.2%	64	51.2%	22	17.6%	125	
Total/Average	72	32.9%	111	50.7%	36	16.4%	219	

Improvement in Management of Oral Medications?

	Improvement							
	No Impact		Modest		Substantial			
Region	Count	%	Count	%	Count	%	Total	Signif.
Northeast (MA, CT)	12	28.6%	22	52.4%	8	19.0%	42	Ns
Southeast (TN,AL,GA)	24	35.8%	34	50.7%	9	13.4%	67	
Midwest (IL)	17	33.3%	25	49.0%	9	17.6%	51	
West (CA)	19	32.2%	30	50.8%	10	16.9%	59	
Total/Average	72	32.9%	111	50.7%	36	16.4%	219	
Table B.6: Frequency Distributions by Treatment Group and by Region for Survey Item 19: What effect do you think the Demonstration will have on the following?

Patient Outcomes

	Very N	egative	Slightly	Negative	No In	npact	Slightly	Positive	Very P	ositive		
Group	Count	%	Count	%	Count	%	Count	%	Count	%	Total	Signif.
Control	0	0.0%	1	1.1%	31	33.0%	41	43.6%	21	22.3%	94	ns
Treatment	0	0.0%	0	0.0%	34	27.2%	56	44.8%	35	28.0%	125	
Total/Average	0	0.0%	1	0.5%	65	29.7%	97	44.3%	56	25.6%	219	

	Very N	legative	Slightly	Negative	No In	npact	Slightly	Positive	Very P	ositive		
Region	Count	%	Count	%	Count	%	Count	%	Count	%	Total	Signif.
Northeast (MA, CT)	0	0.0%	0	0.0%	16	38.1%	17	40.5%	9	21.4%	42	ns
Southeast (TN,AL,GA)	0	0.0%	1	1.5%	17	25.4%	32	47.8%	17	25.4%	67	
Midwest (IL)	0	0.0%	0	0.0%	19	37.3%	23	45.1%	9	17.6%	51	
West (CA)	0	0.0%	0	0.0%	13	22.0%	25	42.4%	21	35.6%	59	
Total/Average	0	0.0%	1	0.5%	65	29.7%	97	44.3%	56	25.6%	219	

Quality of Care?

	Very N	legative	Slightly	Negative	No In	npact	Slightly	Positive	Very P	ositive		
Group	Count	%	Count	%	Count	%	Count	%	Count	%	Total	Signif.
Control	0	0.0%	0	0.0%	30	31.9%	41	43.6%	23	24.5%	94	ns
Treatment	0	0.0%	0	0.0%	30	24.0%	57	45.6%	38	30.4%	125	
Total/Average	0	0.0%	0	0.0%	60	27.4%	98	44.7%	61	27.9%	219	

	Very N	legative	Slightly	Negative	No In	npact	Slightly	Positive	Very P	ositive		
Region	Count	%	Count	%	Count	%	Count	%	Count	%	Total	Signif.
Northeast (MA, CT)	0	0.0%	0	0.0%	17	40.5%	18	42.9%	7	16.7%	42	ns
Southeast (TN,AL,GA)	0	0.0%	0	0.0%	13	19.4%	32	47.9%	22	32.8%	67	
Midwest (IL)	0	0.0%	0	0.0%	18	35.3%	22	43.1%	11	21.6%	51	
West (CA)	0	0.0%	0	0.0%	12	20.3%	26	44.1%	21	35.6%	59	
Total/Average	0	0.0%	0	0.0%	60	27.4%	98	44.7%	61	27.9%	219	

Table B.6: Frequency Distributions by Treatment Group and by Region for Survey Item 19: What effect do you think the Demonstration will have on the following? (cont'd)

Cost of Care?

	Very N	legative	Slightly	Negative	No In	npact	Slightly	Positive	Very P	ositive		
Group	Count	%	Count	%	Count	%	Count	%	Count	%	Total	Signif.
Control	6	6.4%	32	34.0%	40	42.6%	8	8.5%	8	8.5%	94	0.051
Treatment	1	0.8%	33	26.4%	60	48.0%	21	16.8%	10	8.0%	125	
Total/Average	7	3.2%	65	29.7%	100	45.7%	29	13.2%	18	8.2%	219	

	Very N	legative	Slightly	Negative	No In	npact	Slightly	Positive	Very P	ositive		
Region	Count	%	Count	%	Count	%	Count	%	Count	%	Total	Signif.
Northeast (MA, CT)	1	2.4%	9	21.4%	22	52.4%	10	23.8%	0	0.0%	42	0.015
Southeast (TN,AL,GA)	1	1.5%	2	31.3%	27	40.3%	12	17.9%	6	9.0%	67	
Midwest (IL)	4	7.8%	13	25.5%	27	52.9%	4	7.8	3	5.9%	51	
West (CA)	1	1.7%	22	37.3%	24	40.7%	3	5.1%	9	15.3%	59	
Total/Average	7	3.2%	65	29.7%	100	45.7%	29	13.2%	18	8.2%	219	

HHA's Financial Solvency?

	Very N	legative	Slightly	Negative	No In	npact	Slightly	Positive	Very P	ositive		
Group	Count	%	Count	%	Count	%	Count	%	Count	%	Total	Signif.
Control	3	3.2%	25	26.6%	52	55.3%	6	6.4%	8	8.5%	94	0.004
Treatment	1	0.8%	16	12.8%	72	57.6%	27	21.6%	9	7.2%	125	
Total/Average	4	1.8%	41	18.7%	124	56.6%	33	15.1%	17	7.8%	219	

	Very N	egative	Slightly	Negative	No In	npact	Slightly	Positive	Very P	ositive		
Region	Count	%	Count	%	Count	%	Count	%	Count	%	Total	Signif.
Northeast (MA, CT)	1	2.4%	3	7.1%	32	76.2%	6	14.3%	0	0.0%	42	0.050
Southeast (TN,AL,GA)	1	1.5%	19	28.4%	28	41.8%	10	14.9%	9	13.4%	67	
Midwest (IL)	1	2.0%	10	19.6%	32	62.7%	6	11.8%	2	3.9%	51	
West (CA)	1	1.7%	9	15.3%	32	54.2%	11	18.6%	6	10.2%	59	
Total/Average	4	1.8%	41	18.7%	124	56.6%	33	15.1%	17	7.8%	219	

Table B.6: Frequency Distributions by Treatment Group and by Region for Survey Item 19: What effect do you think the Demonstration will have on the following? (cont'd)

HHA's Profitability?

	Very N	legative	Slightly	Negative	No In	npact	Slightly	Positive	Very P	ositive		
Group	Count	%	Count	%	Count	%	Count	%	Count	%	Total	Signif.
Control	5	5.3%	26	27.7%	43	45.7%	13	13.8%	7	7.4%	94	0.011
Treatment	1	0.8%	18	14.4%	62	49.6%	33	26.4%	11	8.8%	125	
Total/Average	6	2.7%	44	20.1%	105	47.9%	46	21.0%	18	8.2%	219	

	Very N	legative	Slightly	Negative	No In	npact	Slightly	Positive	Very P	ositive		
Region	Count	%	Count	%	Count	%	Count	%	Count	%	Total	Signif.
Northeast (MA, CT)	1	2.4%	5	11.9%	25	59.5%	11	26.2%	0	0.0%	42	0.012
Southeast (TN,AL,GA)	1	1.5%	19	28.4%	26	38.8%	13	19.4%	8	11.9%	67	
Midwest (IL)	4	7.8%	11	21.6%	28	54.9%	5	9.8%	3	5.9%	51	
West (CA)	0	0.0%	9	15.3%	26	44.1%	17	28.8%	7	11.9%	59	
Total/Average	6	2.7%	44	20.1%	105	47.9%	46	21.0%	18	8.2%	219	

HHA's Patient Satisfaction?

	Very N	egative	Slightly	Negative	No In	npact	Slightly	Positive	Very P	ositive		
Group	Count	%	Count	%	Count	%	Count	%	Count	%	Total	Signif.
Control	0	0.0%	3	3.2%	44	46.8%	26	27.7%	21	22.3%	94	0.042
Treatment	0	0.0%	0	0.0%	45	36.0%	51	40.8%	29	23.2%	125	
Total/Average	0	0.0%	3	1.4%	89	40.6%	77	35.2%	50	22.8%	219	

	Very N	legative	Slightly	Negative	No In	npact	Slightly	Positive	Very P	ositive		
Region	Count	%	Count	%	Count	%	Count	%	Count	%	Total	Signif.
Northeast (MA, CT)	0	0.0%	0	0.0%	21	50.0%	17	40.5%	4	9.5%	42	0.020
Southeast (TN,AL,GA)	0	0.0%	0	0.0%	22	32.8%	26	38.8%	19	28.4%	67	
Midwest (IL)	0	0.0%	1	2.0%	28	54.9%	15	29.4%	7	13.7%	51	
West (CA)	0	0.0%	1	3.4%	18	30.5%	19	32.2%	20	33.9%	59	
Total/Average	0	0.0%	3	1.4%	89	40.6%	77	35.2%	50	22.8%	219	

Table B.6: Frequency Distributions by Treatment Group and by Region for Survey Item 19: What effect do you think the Demonstration will have on the following? (cont'd)

HHA's Staff Satisfaction?

	Very N	egative	Slightly	Negative	No In	npact	Slightly	Positive	Very P	ositive		
Group	Count	%	Count	%	Count	%	Count	%	Count	%	Total	Signif.
Control	2	2.1%	8	8.5%	49	51.1%	21	22.3%	15	16.0%	94	0.031
Treatment	0	0.0%	3	2.4%	54	43.2%	44	35.2%	24	19.2%	125	
Total/Average	2	0.9%	11	5.0%	102	46.6%	65	29.7%	39	17.8%	219	

	Very N	legative	Slightly	Negative	No In	npact	Slightly	Positive	Very P	ositive		
Region	Count	%	Count	%	Count	%	Count	%	Count	%	Total	Signif.
Northeast (MA, CT)	0	0.0%	2	4.8%	20	47.6%	17	40.5%	3	7.1%	42	0.052
Southeast (TN,AL,GA)	0	0.0%	2	3.0%	31	46.3%	18	26.9%	16	23.9%	67	
Midwest (IL)	2	3.9%	2	3.9%	30	58.8%	10	19.6%	7	13.7%	51	
West (CA)	0	0.0%	5	8.5%	21	35.6%	20	33.9%	13	22.0%	59	
Total/Average	2	0.9%	11	5.0%	102	46.6%	65	29.7%	39	17.8%	219]

Appendix C: Summary Tables of Chi-Square Values from Cross-Tabulation

Table C.1: Cross tabulations (Chi-Square) Results for Year 2 Web Survey of Home Health P4P Participating HHAs by Treatment Group and Regions for Survey Item 3: Who completed the survey for the agency?

	Statistically Significant Differences Among									
Q3 Item Elements	Experimental Groups: Control / Winners / Non- Winners	Region (NE, SE, MW, W)	State (MA, CT, TN, AL, GA, IL, CA)	Region (NE) by Treatment Group	Region (SE) by Treatment Group	Region (MW) by Treatment Group	Region (W) by Treatment Group			
Who completed survey for the agency?		p< 0.01	p< 0.01							

Table C.2:Cross tabulations (Chi-Square) Results for Year 2 Web Survey of Home Health P4P
Participating HHAs by Treatment Group and Regions for Survey Item 5: Based on your
CY2009 performance, are you expecting to show higher performance, substantial
improvement, or no change for each of the following outcomes.

		Statistically Significant Differences Among										
Q5 Item Elements	Experimental Groups: Control / Winners / Non- Winners	Region (NE, SE, MW, W)	State (MA, CT, TN, AL, GA, IL, CA)	Region (NE) by Treatment Group	Region (SE) by Treatment Group	Region (MW) by Treatment Group	Region (W) by Treatment Group					
Acute Care Hospitalization	p< 0.05		p< 0.10		p< 0.10							
Any Emergent Care	p< 0.01		p< 0.10	p< 0.05	p< 0.01							
Improvement in Bathing	p< 0.01					p< 0.05						
Improvement in Ambulation/Locomotion	p< 0.01			p< 0.10		p< 0.05						
Improvement in Transferring	p< 0.05											
Improvement in Status of Surgical Wound	p< 0.01					p< 0.05						
Improvement in Manage- ment of Oral Medications	p< 0.05					p< 0.05						

Table C.3: Cross tabulations (Chi-Square) Results for Year 2 Web Survey of Home Health P4P Participating HHAs by Treatment Group and Regions for Survey Item 6: ... changes in the number of your staff (i.e., increased staffing, decreased staffing).

		Sta	atistically Sigr	nificant Differe	ences Among.		
Q6 Item Elements	Experimental Groups: Control / Winners / Non- Winners	Region (NE, SE, MW, W)	State (MA, CT, TN, AL, GA, IL, CA)	Region (NE) by Treatment Group	Region (SE) by Treatment Group	Region (MW) by Treatment Group	Region (W) by Treatment Group
Sr Management							
QI/PI Coord							
Clinical Suprv.	p< 0.05						p< 0.05
RN		p< 0.01	p< 0.01				
RN w/ specialty							
LPN		p< 0.01	p< 0.01				
PT							
ОТ							
MSW		p< 0.05	p< 0.10				
HH Aide		p< 0.05	p< 0.05				
Admin. Support							

Table C.4:Cross tabulations (Chi-Square) Results for Year 2 Web Survey of Home Health P4P
Participating HHAs by Treatment Group and Regions for Survey Item 7: ... turnover in your
staff (Options = No/Low (0-5%); Small (6-20%); Moderate (21-40%); High (41-75%); Very High
(>75%).

		Sta	atistically Sigr	ificant Differe	nces Among.		
Q7 Item Elements	Experimental Groups: Control / Winners / Non- Winners	Region (NE, SE, MW, W)	State (MA, CT, TN, AL, GA, IL, CA)	Region (NE) by Treatment Group	Region (SE) by Treatment Group	Region (MW) by Treatment Group	Region (W) by Treatment Group
Sr Management					p< 0.05	p< 0.10	
QI/PI Coord							p< 0.10
Clinical Suprv.							
RN		p< 0.05	p< 0.01				
RN w/ specialty							
LPN							
PT							
OT							
MSW							
HH Aide							
Admin. Support.							

Table C.5:Cross tabulations (Chi-Square) Results for Year 2 Web Survey of Home Health P4P
Participating HHAs by Treatment Group and Regions for Survey Item 8: Did you add any new
positions/functions during CY2009 specifically because of your participation in the
demonstration (Options = Already Existed, Added, Does Not Exist).

		Statistically Significant Differences Among										
Q8 Item Elements	Experimental Groups: Control / Winners / Non- Winners	Region (NE, SE, MW, W)	State (MA, CT, TN, AL, GA, IL, CA)	Region (NE) by Treatment Group	Region (SE) by Treatment Group	Region (MW) by Treatment Group	Region (W) by Treatment Group					
QI/PI Coord												
Doc quality/accuracy												
Staff Education	p< 0.05			p< 0.10			p< 0.05					
Outcome Analysis												
Resource Utilization												
Combination pos.												

Table C.6:Cross tabulations (Chi-Square) Results for Year 2 Web Survey of Home Health P4P
Participating HHAs by Treatment Group and Regions for Survey Item 9: What policy changes
did your agency implement during CY2009?

		Sta	atistically Sigr	nificant Differe	ences Among.		
Q9 Item Elements	Experimental Groups: Control / Winners / Non- Winners	Region (NE, SE, MW, W)	State (MA, CT, TN, AL, GA, IL, CA)	Region (NE) by Treatment Group	Region (SE) by Treatment Group	Region (MW) by Treatment Group	Region (W) by Treatment Group
Care practice							
Care plans							
Reduce time ref/adms				p< 0.05			
Pt communication							
Physician comm.							
Disease mgmt.							
Telehealth							
Falls prevention			p< 0.10				
Patient infection cntrl		p< 0.10					
New clinical splty.		p< 0.05					
On-call staff change		p< 0.05					
Expand business hrs							
Productivity requirements							
Hiring requirements		p< 0.01	p< 0.05	p< 0.05			

Table C.7: Cross tabulations (Chi-Square) Results for Year 2 Web Survey of Home Health P4P Participating HHAs by Treatment Group and Regions for Survey Item 10: What activities directed toward care providers and intended to improve quality of care did your agency implement during CY2009? Cross tabulations (Chi-Square) Results for Year 2 Web Survey of Home Health P4P

			Statistically Si	ignificant Differer	nces Among		
Q10 Item Elements	Experimental Groups: Control / Winners / Non- Winners	Region (NE, SE, MW, W)	State (MA, CT, TN, AL, GA, IL, CA)	Region (NE) by Treatment Group	Region (SE) by Treatment Group	Region (MW) by Treatment Group	Region (W) by Treatment Group
Staff education							
PI programs							
Mentoring programs							
Clinical team meetings							
Record review							
Staff competencies		p< 0.05					
Staff evaluation criteria		p< 0.05	p< 0.10				
Employee incentives		p< 0.05	p< 0.10				
Mgment practices		p< 0.10		p< 0.05			
HH Aide supervision							
Clinical resources							

Table C.8:Cross tabulations (Chi-Square) Results for Year 2 Web Survey of Home Health P4P
Participating HHAs by Treatment Group and Regions for Survey Item 11: What technological
innovations designed to improve the quality of care did your agency implement during
CY2009?

			Statistically Sig	nificant Difference	es Among		
Q11 Item Elements	Experimental Groups: Control / Winners / Non- Winners	Region (NE, SE, MW, W)	State (MA, CT, TN, AL, GA, IL, CA)	Region (NE) by Treatment Group	Region (SE) by Treatment Group	Region (MW) by Treatment Group	Region (W) by Treatment Group
Telemonitoring equip.							
EMRs							
E Info exchng referrals							
E Info exchng MDs							
E messaging staff						p< 0.05	
Infusion devices		p< 0.10					
Respiratory equip.							
Physiological monitor equip.					p< 0.05		
PU reduction equip.							
Wound care materials		p< 0.05	p< 0.05				
Med reminder sys							
Med dispense sys							
Med check software							
Emergency response						p< 0.05	
E access to policies	p< 0.05				p< 0.10	p< 0.05	

Table C.9:Cross tabulations (Chi-Square) Results for Year 2 Web Survey of Home Health P4P
Participating HHAs by Treatment Group and Regions for Survey Item 12: What care practice
changes designed to improve specific clinical outcomes did your agency implement during
CY2009?

			Statistically Sign	nificant Differenc	es Among		
Q12 Item Elements	Experimental Groups: Control / Winners / Non- Winners	Region (NE, SE, MW, W)	State (MA, CT, TN, AL, GA, IL, CA)	Region (NE) by Treatment Group	Region (SE) by Treatment Group	Region (MW) by Treatment Group	Region (W) by Treatment Group
Changing visit patterns	p< 0.10					p< 0.01	
Telemonitoring							
Changing visit mix							
Disease mgmt prog.							
Clinical pathways							
Patient teaching				p< 0.10			
Communication w/MD	p< 0.10						
POC specific parameters							
Care team comm.							
Screening assessment							
Falls prevention prog.							
Wound care protocols							
Vaccination focus		p< 0.10					
Med dispense sys					p< 0.01		

Table C.10:Cross tabulations (Chi-Square) Results for Year 2 Web Survey of Home Health P4P
Participating HHAs by Treatment Group and Regions for Survey Item 13: Identify any
corporate initiatives that were implemented during CY2009. (Note: if HHA was not part of a
chain, they skipped this item.)

			Statistically Sig	gnificant Differen	ces Among		
Q13 Item Elements	Experimental Groups: Control / Winners / Non- Winners	Region (NE, SE, MW, W)	State (MA, CT, TN, AL, GA, IL, CA)	Region (NE) by Treatment Group	Region (SE) by Treatment Group	Region (MW) by Treatment Group	Region (W) by Treatment Group
Part of Chain?	p< 0.10						
Reduce hospitalization					p< 0.01		
Reduce ER use					p< 0.05		
Rehab outcomes							
PU treatments							
Falls risk reduction				p< 0.05	p< 0.01		
Med mgmt program							
Tech. for patient							
Staff training		p< 0.10			p< 0.05		
QIO participation							
Performance incentive							
Corp communication							

Table C.11:Cross tabulations (Chi-Square) Results for Year 2 Web Survey of Home Health P4P
Participating HHAs by Treatment Group and Regions for Survey Item 14:Identify any impact
on your agency that occurred during CY2009 that may have been the result of local / regional
issues or situations.

		Sta	atistically Sigr	nificant Differe	nces Among.		
Q14 Item Elements	Experimental Groups: Control / Winners / Non- Winners	Region (NE, SE, MW, W)	State (MA, CT, TN, AL, GA, IL, CA)	Region (NE) by Treatment Group	Region (SE) by Treatment Group	Region (MW) by Treatment Group	Region (W) by Treatment Group
# hospitals					p< 0.01		
# SNFs					p< 0.01		
# Urgent Care					p< 0.01		
# HHAs					p< 0.01		
Availability RNs		p< 0.01	p< 0.05				
Availability PTs		p< 0.05					
Availability OTs		p< 0.05	p< 0.05				
Availability HH Aides		p< 0.01	p< 0.05				
Demographics							
Local care practices				p< 0.10			
Community resources					p< 0.01		
Natural disaster							
State health policies		p< 0.10					

Table C.12:Cross tabulations (Chi-Square) Results for Year 2 Web Survey of Home Health P4P
Participating HHAs by Treatment Group and Regions for Survey Item 17: What is your best
estimate of how changes related to the P4P Demo changed the cost of providing care to your
patients? (Options: >10% Decrease; 5-10% Decrease; 1-5% Decrease; Less than 1% Change;
1-5% Increase; 5-10% Increase).

	Statistically Significant Differences Among						
Q17 Item Elements	Experimental Groups: Control / Winners / Non- Winners	Region (NE, SE, MW, W)	State (MA, CT, TN, AL, GA, IL, CA)	Region (NE) by Treatment Group	Region (SE) by Treatment Group	Region (MW) by Treatment Group	Region (W) by Treatment Group
Cost impact	p< 0.01	p< 0.05				p< 0.10	p< 0.10

Table C.13:Cross tabulations (Chi-Square) Results for Year 2 Web Survey of Home Health P4P
Participating HHAs by Treatment Group and Regions for Survey Item 18: How much of an
impact on your patients do you think your quality improvement activities have had on the
outcomes targeted during Year 2 (CY2009)? (Options: No Impact; Modest Improvement;
Substantial Improvement)

	Statistically Significant Differences Among							
Q18 Item Elements	Experimental Groups: Control / Winners / Non- Winners	Region (NE, SE, MW, W)	State (MA, CT, TN, AL, GA, IL, CA)	Region (NE) by Treatment Group	Region (SE) by Treatment Group	Region (MW) by Treatment Group	Region (W) by Treatment Group	
Acute Care Hospitalization			p< 0.10					
Any Emergent Care	p< 0.05		p< 0.10			p< 0.05		
Improvement in Bathing								
Improvement in Ambulation/ Locomotion				p< 0.10				
Improvement in Transferring								
Improvement in Status of Surgical Wound		p< 0.10	p< 0.10					
Improvement in Manage- ment of Oral Medications	p< 0.01		p< 0.10				p< 0.01	

Table C.14:Cross tabulations (Chi-Square) Results for Year 2 Web Survey of Home Health P4P
Participating HHAs by Treatment Group and Regions for:Survey Item 19What effect do you
think the demonstration will have on the following?(Options: Very Negative; Slightly
Negative; No Impact; Slightly Positive; Very Positive)

			Statistically Sig	gnificant Differen	ces Among		
Q19 Item Elements	Experimental Groups: Control / Winners / Non- Winners	Region (NE, SE, MW, W)	State (MA, CT, TN, AL, GA, IL, CA)	Region (NE) by Treatment Group	Region (SE) by Treatment Group	Region (MW) by Treatment Group	Region (W) by Treatment Group
Patient outcomes			p< 0.10				
Quality of care HHA	p< 0.05	p< 0.10	p< 0.10				
Quality of carestate		p< 0.10	p< 0.05				
Access to care		p< 0.05					
Cost of care			p< 0.10				
Financial solvency		p< 0.05	p< 0.10				p< 0.10
Financial solvency HHAs-statewide	p< 0.05	p< 0.05	p< 0.10	p< 0.05	p< 0.10		
Profitability HHA	p< 0.05	p< 0.05	p< 0.05			p< 0.10	
Profitabilitystate	p< 0.10	p< 0.05	p< 0.05		p< 0.10	p< 0.10	
Patient satisfaction		p< 0.05	p< 0.05		p< 0.05		
Staff satisfaction		p< 0.10					
Referral satisfaction	p< 0.05				p< 0.01		

Table C.15:Cross tabulations (Chi-Square) Results for Year 2 Web Survey of Home Health P4P
Participating HHAs by Treatment Group and Regions for:Survey Item 20:Rate each of the
following actions/reports in terms of how useful it would be if Home Health P4P is
implemented. (Options: Not Useful; Useful; Very Useful; Extremely Useful; N/A)

		Statistically Significant Differences Among						
Q20 Item Elements	Experimental Groups: Control / Winners / Non- Winners	Region (NE, SE, MW, W)	State (MA, CT, TN, AL, GA, IL, CA)	Region (NE) by Treatment Group	Region (SE) by Treatment Group	Region (MW) by Treatment Group	Region (W) by Treatment Group	
Regular updates						p< 0.05		
Best practices						p< 0.05		
QIO SOW	p< 0.10							
Online workshops								
Highlight high performing HHA								
Intervention strategies								
Certificates of recognition								
Publicize high performance HHA								

Appendix D: Cross-Tabulation by Region and Winners, Non-Winner, and Control Comparisons

Table D.1: Selected Cross-Tabulation Results by Region and Treatment Group by Survey Item 3: Who completed the survey for the agency? (Options = Senior Management; QI/PI Coordinator; Other Staff).

REGION	GROUP	Total	Administrative/ Support	Clinical Supervisory Positions	Other	QI / PI Coordinator	Senior Mgmt (CEO, DON, etc)
Northeast	Control	17	1			6	10
	NonWin	2				1	1
	Winner	23			1	2	20
Southeast	Control	28			2	13	13
	NonWin	1				1	
	Winner	38	1	2	1	12	22
Midwest	Control	25		4	1	5	15
	NonWin	7				1	6
	Winner	19	1	1	1	3	13
West	Control	24	3			2	19
	NonWin	5	2				3
	Winner	30	2	1	1	5	21
		Percent of Total	4.6%	3.7%	3.2%	23.3%	65.3%

Table D.2: Selected Cross-Tabulation Results by Region and Treatment Group by Survey Item 5: Based on your CY2009 performance, are you expecting to show higher performance, substantial improvement, or no change for each of the following:

Acute Care Hospitalization

REGION	GROUP	Total	N/A	High Performance	Substantial Improvement
Northeast	Control	17	3	9	5
	NonWin	2	1		1
	Winner	23	10	7	6
Southeast	Control	28	9	14	5
	NonWin	1	1		
	Winner	38	17	7	14
Midwest	Control	25	11	6	8
	NonWin	7	5		2
	Winner	19	13	3	3
West	Control	24	8	9	7
	NonWin	5	3		2
	Winner	30	10	14	6
		Percent of Total	41.6%	31.5%	26.9%

Table D.2:Selected Cross-Tabulation Results by Region and Treatment Group for Survey Item 5: Based on
your CY2009 performance, are you expecting to show higher performance, substantial
improvement, or no change for each of the following: (cont'd)

REGION	GROUP	Total	N/A	High Performance	Substantial Improvement
Northeast	Control	17	2	11	4
	NonWin	2	1		1
	Winner	23	13	6	4
Southeast	Control	28	6	17	5
	NonWin	1	1		
	Winner	38	22	6	10
Midwest	Control	25	13	7	5
	NonWin	7	5		2
	Winner	19	10	4	5
West	Control	24	8	7	9
	NonWin	5	4		1
	Winner	30	14	9	7
		Percent of Total	45.2%	30.6%	24.2%

Any Emergent Care

Improvement in Bathing

REGION	GROUP	Total	N/A	High Performance	Substantial Improvement
Northeast	Control	17	6	8	3
	NonWin	2	2		
	Winner	23	15	3	5
Southeast	Control	28	11	13	4
	NonWin	1	1		
	Winner	38	19	8	11
Midwest	Control	25	6	14	5
	NonWin	7	5	1	1
	Winner	19	11	3	5
West	Control	24	11	6	7
	NonWin	5	3		2
	Winner	30	13	7	10
		Percent of Total	47.0%	28.8%	24.2%

Improvement in Ambulation/Locomotion

REGION	GROUP	Total	N/A	High Performance	Substantial Improvement
Northeast	Control	17	5	8	4
	NonWin	2	2		
	Winner	23	14	3	6
Southeast	Control	28	10	12	6
	NonWin	1	1		
	Winner	38	18	9	11
Midwest	Control	25	6	15	4
	NonWin	7	5	1	1
	Winner	19	11	3	5
West	Control	24	8	9	7
	NonWin	5	1	1	3
	Winner	30	12	12	6
		Percent of Total	42.5%	33.3%	24.2%

Table D.2:Selected Cross-Tabulation Results by Region and Treatment Group for Survey Item 5: Based on
your CY2009 performance, are you expecting to show higher performance, substantial
improvement, or no change for each of the following: (cont'd)

REGION	GROUP	Total	N/A	High Performance	Substantial Improvement
Northeast	Control	17	5	8	4
	NonWin	2	2		
	Winner	23	14	4	5
Southeast	Control	28	10	14	4
	NonWin	1	1		
	Winner	38	18	10	10
Midwest	Control	25	10	13	2
	NonWin	7	5	1	1
	Winner	19	13	3	3
West	Control	24	9	8	7
	NonWin	5	2	1	2
	Winner	30	11	11	8
		Percent of Total	45.7%	33.3%	21.0%

Improvement in Transferring

Improvement in Status of Surgical Wounds

REGION	GROUP	Total	N/A	High Performance	Substantial Improvement
Northeast	Control	17	4	9	4
	NonWin	2	2		
	Winner	23	10	5	8
Southeast	Control	28	11	13	4
	NonWin	1	1		
	Winner	38	16	9	13
Midwest	Control	25	6	13	6
	NonWin	7	4		3
	Winner	19	10	2	7
West	Control	24	8	7	9
	NonWin	5	2	1	2
	Winner	30	12	12	6
		Percent of Total	39.3%	32.4%	28.3%

Table D.2: Selected Cross-Tabulation Results by Region and Treatment Group for Survey Item 5: Based on your CY2009 performance, are you expecting to show higher performance, substantial improvement, or no change for each of the following: (cont'd)

REGION	GROUP	Total	N/A	High Performance	Substantial Improvement
Northeast	Control	17	3	9	5
	NonWin	2	1	1	
	Winner	23	10	6	7
Southeast	Control	28	10	9	9
	NonWin	1			1
	Winner	38	13	13	12
Midwest	Control	25	4	15	6
	NonWin	7	4	2	1
	Winner	19	9	3	7
West	Control	24	9	9	6
	NonWin	5	4		1
	Winner	30	12	7	11
		Percent of Total	36.1%	33.8%	30.1%

Improvement in Management of Oral Medications

Table D.3: Selected Cross-Tabulation Results by Region and Treatment Group for Survey Item 7: turnover in your staff (e.g., a staff member left and was replaced by a new or another staff member in that position)

REGION	GROUP	Total	No/Low (<=5%)	Small (6- 20%)	Moderate (21-40%)	High (41- 75%)	Very High (>75%)
Northeast	Control	17	17				
	NonWin	2	2				
	Winner	23	21	1	1		
Southeast	Control	28	26	1	1		
	NonWin	1		1			
	Winner	38	34	3			1
Midwest	Control	25	25				
	NonWin	7	6	1			
	Winner	19	18		1		
West	Control	24	21	1	1	1	
	NonWin	5	4	1			
	Winner	30	29			1	
		Percent of Total	92.7%	4.1%	1.8%	0.9%	0.5%

Staff Turnover--Senior Management

REGION	GROUP	Total	No/Low (<=5%)	Small (6- 20%)	Moderate (21-40%)	High (41- 75%)	Very High (>75%)
Northeast	Control	17	15	1	1		
	NonWin	2	2				
	Winner	23	19	2			2
Southeast	Control	28	26	2			
	NonWin	1	1				
	Winner	38	31	5		1	1
Midwest	Control	25	24	1			
	NonWin	7	7				
	Winner	19	17	1	1		
West	Control	24	22	1		1	
	NonWin	5	4		1		
	Winner	30	25	4			1
		Percent of Total	88.1%	7.8%	1.4%	0.9%	1.8%

Staff Turnover--QI / PI Coordinator

Staff Turnover--Clinical Supervisors

REGION	GROUP	Total	No/Low (<=5%)	Small (6- 20%)	Moderate (21-40%)	High (41- 75%)	Very High (>75%)
Northeast	Control	17	13	3	1		
	NonWin	2	2				
	Winner	23	19	2		1	1
Southeast	Control	28	20	4	4		
	NonWin	1	1				
	Winner	38	30	5	2	1	
Midwest	Control	25	21	3	1		
	NonWin	7	7				
	Winner	19	14	3	2		
West	Control	24	18	3	1	2	
	NonWin	5	5				
	Winner	30	28	1	1		
		Percent of Total	81.3%	11.0%	5.5%	1.8%	0.5%

Staff Turnover--RNs

REGION	GROUP	Total	No/Low (<=5%)	Small (6- 20%)	Moderate (21-40%)	High (41- 75%)	Very High (>75%)
Northeast	Control	17	9	7		1	
	NonWin	2		2			
	Winner	23	12	9	1		1
Southeast	Control	28	14	8	5	1	
	NonWin	1		1			
	Winner	38	14	9	11	3	1
Midwest	Control	25	17	4	3		1
	NonWin	7	5		2		
	Winner	19	12	5	2		
West	Control	24	9	10	5		
	NonWin	5	2	1	2		
	Winner	30	17	10	2	1	
		Percent of Total	50.7%	30.1%	15.1%	2.7%	1.4%

REGION	GROUP	Total	No/Low (<=5%)	Small (6- 20%)	Moderate (21-40%)	High (41- 75%)	Very High (>75%)
Northeast	Control	17	15	2			
	NonWin	2	2				
	Winner	23	23				
Southeast	Control	28	26	1	1		
	NonWin	1	1				
	Winner	38	35	1		1	1
Midwest	Control	25	25				
	NonWin	7	7				
	Winner	19	19				
West	Control	24	22	1	1		
	NonWin	5	5				
	Winner	30	27	2			1
		Percent of Total	94.5%	3.2%	0.9%	0.5%	0.9%

Staff Turnover--RNs with Specialty License

Staff Turnover--LPNs

REGION	GROUP	Total	No/Low (<=5%)	Small (6- 20%)	Moderate (21-40%)	High (41- 75%)	Very High (>75%)
Northeast	Control	17	15	2			
	NonWin	2	2				
	Winner	23	21	2			
Southeast	Control	28	19	7	1	1	
	NonWin	1	1				
	Winner	38	31	4	3		
Midwest	Control	25	24		1		
	NonWin	7	6		1		
	Winner	19	18	1			
West	Control	24	19	3	2		
	NonWin	5	5				
	Winner	30	27	1	1	1	
		Percent of Total	85.8%	9.1%	4.1%	0.9%	0.0%

Staff Turnover--PTs

REGION	GROUP	Total	No/Low (<=5%)	Small (6- 20%)	Moderate (21-40%)	High (41- 75%)	Very High (>75%)
Northeast	Control	17	13	3		1	
	NonWin	2	2				
	Winner	23	19	4			
Southeast	Control	28	22	4	2		
	NonWin	1	1				
	Winner	38	29	6	3		
Midwest	Control	25	20	4			1
	NonWin	7	6	1			
	Winner	19	16	3			
West	Control	24	19	3	2		
	NonWin	5	5				
	Winner	30	21	7	1		1
		Percent of Total	79.0%	16.0%	3.7%	0.5%	0.9%

REGION	GROUP	Total	No/Low (<=5%)	Small (6- 20%)	Moderate (21-40%)	High (41- 75%)	Very High (>75%)
Northeast	Control	17	12	4	1		
	NonWin	2	2				
	Winner	23	22	1			
Southeast	Control	28	21	6	1		
	NonWin	1	1				
	Winner	38	33	2	2		1
Midwest	Control	25	22	2			1
	NonWin	7	7				
	Winner	19	17	2			
West	Control	24	21	3			
	NonWin	5	5				
	Winner	30	27	2		_	1
		Percent of Total	86.8%	10.0%	1.8%	0.0%	1.4%

Staff Turnover--OTs

Staff Turnover--Medical Social Worker

REGION	GROUP	Total	No/Low (<=5%)	Small (6- 20%)	Moderate (21-40%)	High (41- 75%)	Very High (>75%)
Northeast	Control	17	14	3			
	NonWin	2	2				
	Winner	23	22	1			
Southeast	Control	28	26	2			
	NonWin	1	1				
	Winner	38	35	1	1		1
Midwest	Control	25	24	1			
	NonWin	7	7				
	Winner	19	19				
West	Control	24	22	2			
	NonWin	5	5				
	Winner	30	27	2			1
		Percent of Total	93.2%	5.5%	0.5%	0.0%	0.9%

Staff Turnover--Home Health Aide

REGION	GROUP	Total	No/Low (<=5%)	Small (6- 20%)	Moderate (21-40%)	High (41- 75%)	Very High (>75%)
Northeast	Control	17	12	4	1		
	NonWin	2	2				
	Winner	23	17	4	2		
Southeast	Control	28	25	2	1		
	NonWin	1	1				
	Winner	38	32	4		2	
Midwest	Control	25	22	2	1		
	NonWin	7	6	1			
	Winner	19	17	2			
West	Control	24	20	2	1	1	
	NonWin	5	5				
	Winner	30	27	2		1	
		Percent of Total	84.9%	10.5%	2.7%	1.8%	0.0%

REGION	GROUP	Total	No/Low (<=5%)	Small (6- 20%)	Moderate (21-40%)	High (41- 75%)	Very High (>75%)
Northeast	Control	17	13	3	1		
	NonWin	2	2				
	Winner	23	19	4			
Southeast	Control	28	24	2	2		
	NonWin	1	1				
	Winner	38	30	5	3		
Midwest	Control	25	23	2			
	NonWin	7	6	1			
	Winner	19	19				
West	Control	24	21	2	1		
	NonWin	5	4		1		
	Winner	30	23	6	1		
		Percent of Total	84.5%	11.4%	4.1%	0.0%	0.0%

Staff Turnover--Administrative Support

Staff Turnover--Other

REGION	GROUP	Total	No/Low (<=5%)	Small (6- 20%)	Moderate (21-40%)	High (41- 75%)	Very High (>75%)
Northeast	Control	17	17				
	NonWin	2	2				
	Winner	23	23				
Southeast	Control	28	27		1		
	NonWin	1	1				
	Winner	38	38				
Midwest	Control	25	25				
	NonWin	7	7				
	Winner	19	19				
West	Control	24	23	1			
	NonWin	5	5				
	Winner	30	30				
		Percent of Total	99.1%	0.5%	0.5%	0.0%	0.0%

REGION	GROUP	Total	Decreased >10%	Decreased 5- 10%	Decreased 1-5%	Less than 1% Change	Increased 1-5%	Increased 5-10%	Increased >10%
Northeast	Control	17			2	8	3	3	1
	NonWin	2				2			
	Winner	23			1	17	5		
Southeast	Control	28		3	3	14	6	1	1
	NonWin	1				1			
	Winner	38			2	21	14	1	
Midwest	Control	25			2	12	4	6	1
	NonWin	7			1	5			1
	Winner	19		1		12	6		
West	Control	24	1			9	4	6	4
	NonWin	5				2		3	
	Winner	30				15	11	2	2
		Percent of Total	0.5%	1.8%	5.0%	53.9%	24.2%	10.0%	4.6%

 Table D.4:
 Selected Cross-Tabulation Results by Region and Treatment Group for Survey Item 15: What is your best estimate of the effects of activities related to the pay for performance demonstration during Year 2 on the cost of providing care to your patients?

Appendix E: Regression Models for Demonstration Target Outcomes

Regression Models for Demonstration "Outcomes" for All, Control-only, and Winners-only HHAs Using Web Survey Items

Table E.1: Models for Cost of Participating in Demonstration.

Model for All HHAs

Independent Variables	Bivariate Correlation	Correlation p value	Model Coefficient	p value in Model
(Constant)			4.121	.000
Staff education ²	.146	.015	.138	.312
Wound care protocols ²	.172	.005	.100	.510
Wound care materials ²	.194	.002	.224	.156
Management practices ³	.228	.000	.325	.037
Hiring requirements ³	.168	.006	.139	.518
Patient teaching	.164	.008	.103	.496
Physiological monitor equip.	.135	.023	.070	.696
Model Summary	R	R Square	F	Sig.
	0.306	0.094	3.114	0.004

Model for Control HHAs

Independent Variables	Bivariate Correlation	Correlation p value	Model Coefficient	p value in Model
(Constant)			4.671	.000
Staff education ²	.237	.011	.596	.012
Wound care protocols ²	.232	.012	.382	.138
Wound care materials ²	.256	.006	.443	.112
RN w/ specialty turnover	240	.010	-1.254	.000
HH Aide turnover	.259	.006	.489	.016
Model Summary	R	R Square	F	Sig.
	0.531	0.281	6.895	0.000

Model for Winning HHAs

Independent Variables	Bivariate Correlation	Correlation p value	Model Coefficient	p value in Model
(Constant)			3.864	.000
Management practices ³	.279	.002	.320	.046
Hiring requirements ³	.211	.013	.064	.773
Staff competencies	.195	.021	.124	.392
Admin. Support Turnover	.261	.003	.299	.033
On-call staff change	.211	.013	.217	.311
Model Summary	R	R Square	F	Sig.
	0.390	0.152	3.736	0.004

¹ Common to "All", "Control", "Winners" ² Common to "All" & "Control" ³ Common to "All" & "Winners" ⁴ Common to "Control" & "Winners"

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Table E.2: Models for Quality Improvement Impact on Acute Care Hospitalization.

Model for All HHAs

Independent Variables	Bivariate Correlation	Correlation p value	Model Coefficient	p value in Model
(Constant)			1.526	.000
Employee incentives 1	.214	.001	.218	.143
Clinical pathways ¹	.241	.000	.164	.246
Communication w/ MD ¹	.216	.001	.194	.102
POC specific parameters ²	.154	.011	.051	.616
Vaccination focus ²	.135	.023	.041	.681
Care plans ²	.213	.001	.089	.489
Clinical team meetings ³	.170	.006	.028	.796
Disease management program ³	.215	.001	.091	.504
Patient teaching ³	.141	.018	021	.849
Med dispense sys ³	.130	.027	.025	.868
Disease management. ³	.213	.001	.049	.724
Staff evaluation criteria	.150	.013	.106	.397
Management practices	.141	.019	032	.784
Telemonitoring	.151	.013	.232	.105
Physician comm.	.143	.017	074	.530

Model Summary	R	R Square	F	Sig.
	0.371	0.137	2.156	0.009

Model for Control HHAs

Independent Variables	Bivariate Correlation	Correlation p value	Model Coefficient	p value in Model
(Constant)			1.903	.000
Employee incentives ¹	.275	.004	.449	.066
Clinical pathways ¹	.269	.004	.260	.253
Communication w/ MD ¹	.218	.017	.254	.114
POC specific parameters ²	.283	.003	.130	.448
Vaccination focus ²	.228	.014	.086	.607
Care plans ²	.271	.004	.063	.749
PT turnover	266	.005	222	.107
OT turnover	241	.010	107	.490
Physiological monitor equip.	.212	.020	.020	.914

Model Summary	R	R Square	F	Sig.
	0.508	0.258	3.243	0.002

¹ Common to "All", "Control", "Winners" ² Common to "All" & "Control"

³ Common to "All" & "Winners" ⁴ Common to "Control" & "Winners"

Table E.2: Models for Quality Improvement Impact on Acute Care Hospitalization. (cont'd)

Model for Winning HHAs

Independent Variables	Bivariate Correlation	Correlation p value	Model Coefficient	p value in Model
(Constant)			1.609	.000
Employee incentives ¹	.197	.019	.115	.559
Clinical pathways ¹	.203	.017	.086	.588
Communication w/ MD1	.199	.018	011	.943
Clinical team meetings3	.214	.013	.077	.610
Disease management program ³	.199	.018	.029	.871
Patient teaching ³	.195	.020	.023	.886
Med dispense sys ³	.193	.022	.168	.392
Disease management. ³	.292	.001	.267	.175
Patient communication	.195	.021	.046	.750
On-call staff change	.191	.023	.110	.592
Model Summary	R	R Square	F	Sig.
	0.360	0.130	1.474	0.160

³ Common to "All" & "Winners" ⁴ Common to "Control" & "Winners"

¹ Common to "All", "Control", "Winners" ² Common to "All" & "Control"

Table E.3: Models for Quality Improvement Impact on Any Emergent Care.

Model for All HHAs

Independent Variables	Bivariate Correlation	Correlation p value	Model Coefficient	p value in Model
(Constant)			1.304	.000
Staff evaluation criteria1	.269	.000	.194	.135
Communication w/ MD ¹	.294	.000	.245	.031
POC specific parameters ¹	.275	.000	.201	.042
Physician comm.1	.225	.000	037	.746
E access to policies ¹	.172	.005	.130	.278
Record review ²	.171	.006	015	.881
Changing visit patterns ²	.192	.002	.057	.582
Vaccination focus ²	.164	.007	.021	.820
Care plans ²	.216	.001	.103	.424
Reduce time ref/adms ²	.161	.009	.050	.656
Physiological monitor equip.2	.192	.002	.084	.470
Employee incentives ³	.256	.000	.207	.157
Management practices ³	.201	.001	.033	.765
HH Aide supervision ³	.141	.018	.131	.484
Telemonitoring ³	.163	.008	.107	.649
Disease management program ³	.176	.005	.013	.920
Clinical pathways ³	.257	.000	.121	.383
Patient teaching ³	.208	.001	.005	.964
Care team comm.3	.161	.009	028	.814
Med dispense sys ³	.205	.001	.211	.219
Disease management. ³	.186	.003	073	.591
Expand business hrs ³	.221	.001	.652	.074
Telemonitoring equip. ³	.159	.009	.205	.391
Med reminder sys ³	.150	.013	208	.287
Med dispense sys ³	.169	.006	.279	.305
Med check software ³	.155	.011	002	.994
Clinical team meetings	.143	.017	108	.355
Wound care protocols	.135	.023	116	.265
Model Summary	R	R Square	F	Sig.
	0.518	0.268	2.490	0.000

³ Common to "All" & "Winners" ⁴ Common to "Control" & "Winners"

¹ Common to "All", "Control", "Winners" ² Common to "All" & "Control"

Table E.3: Models for Quality Improvement Impact on Any Emergent Care. (cont'd)

Model for Control HHAs

Independent Variables	Bivariate Correlation	Correlation p value	Model Coefficient	p value in Model
(Constant)			1.535	.000
Staff evaluation criteria ¹	.314	.001	.215	.197
Communication w/ MD ¹	.278	.003	.262	.116
POC specific parameters ¹	.355	.000	.128	.415
Physician comm. ¹	.278	.003	.014	.935
E access to policies ¹	.240	.010	.412	.013
Record review ²	.218	.017	.054	.689
Changing visit patterns ²	.249	.008	.076	.598
Vaccination focus ²	.205	.024	.021	.890
Care plans ²	.348	.000	.144	.384
Reduce time ref/adms ²	.292	.002	001	.993
Physiological monitor equip. ²	.275	.004	.200	.181
PI programs	.256	.006	.232	.085
PT turnover	323	.001	343	.003
MSW turnover	230	.013	081	.763
Model Summary	R	R Square	F	Sig.
	0.665	0.442	4.467	0.000

Model for Winning HHAs

Independent Variables	Bivariate Correlation	Correlation p value	Model Coefficient	p value in Model	
(Constant)			1.420	.000	
Staff evaluation criteria ¹	.230	.008	110	.594	
Communication w/ MD ¹	.294	.001	.119	.486	
POC specific parameters ¹	.272	.002	.181	.227	
Physician comm.1	.212	.013	025	.894	
E access to policies ¹	.225	.009	.035	.850	
Employee incentives ³	.314	.000	.265	.231	
Management practices ³	.259	.003	.012	.950	
HH Aide supervision ³	.214	.012	296	.491	
Telemonitoring ³	.191	.023	074	.829	
Disease management program ³	.198	.019	.074	.702	
Clinical pathways ³	.264	.003	.123	.459	
Patient teaching ³	.266	.002	.020	.901	
Care team comm. ³	.204	.016	020	.896	
Med dispense sys ³	.271	.002	.264	.296	
Disease management. ³	.223	.010	.045	.837	
Expand business hrs ³	.293	.001	.742	.101	
Telemonitoring equip.3	.228	.008	.518	.159	
Med reminder sys ³	.263	.003	191	.550	
Med dispense sys ³	.220	.010	.612	.107	
Med check software ³	.263	.003	.182	.530	
Patient communication	.205	.016	002	.992	
Model Summary	R	R Square	F	Sig.	
	0.546	0.298	1.780	0.033	

¹ Common to "All", "Control", "Winners" ² Common to "All" & "Control"

³ Common to "All" & "Winners" ⁴ Common to "Control" & "Winners"

Table E.4: Models for Quality Improvement Impact on Improvement in Bathing.

Model for All HHAs

Independent Variables	Bivariate Correlation	Correlation p value	Model Coefficient	p value in Model
(Constant)			1.226	.000
Employee incentives ¹	.226	.000	.222	.130
Patient infection cntrl ¹	.328	.000	.339	.010
Hiring requirements.1	.229	.000	.074	.656
PI programs ²	.165	.007	.116	.267
Clinical team meetings ²	.144	.017	089	.451
Management practices ²	.214	.001	.170	.138
HH Aide supervision ²	.201	.001	.204	.282
Changing visit patterns ²	.142	.018	.033	.757
Patient teaching ²	.193	.002	024	.831
Communication w/ MD ²	.200	.002	.026	.824
POC specific parameters ²	.153	.012	.041	.681
Care team comm. ²	.177	.004	047	.688
Wound care protocols ²	.177	.004	101	.367
Med dispense sys ²	.235	.000	.223	.206
Disease management. ²	.154	.011	107	.377
Staff competencies ³	.177	.004	.042	.693
Staff evaluation criteria ³	.143	.017	059	.666
Clinical resources ³	.166	.007	.122	.261
Changing visit mix ³	.185	.003	.058	.571
Admin. Support Turnover ³	.140	.019	.122	.234
Reduce time ref/adms ³	.265	.000	.259	.026
Patient communication ³	.213	.001	.022	.850
Physician comm. ³	.172	.006	093	.468
On-call staff change ³	.140	.019	.044	.784
E messaging staff ³	.139	.020	.057	.670
Record review	.147	.015	048	.655
Clinical pathways	.154	.011	.106	.451
Care plans	.139	.020	032	.807
Falls prevention	.137	.021	041	.695
Wound care materials	.146	.015	.050	.647
Med reminder sys	.157	.010	144	.485
Med dispense sys	.135	.023	.269	.339

Model Summary	R	R Square	F	Sig.
	0.487	0.237	1.805	0.008

¹ Common to "All", "Control", "Winners" ² Common to "All" & "Control"

³ Common to "All" & "Winners" ⁴ Common to "Control" & "Winners"

Table E.4: Models for Quality Improvement Impact on Improvement in Bathing. (cont'd)

Model for Control HHAs

Independent Variables	Bivariate Correlation	Correlation p value	Model Coefficient	p value in Model
(Constant)			1.224	.000
Employee incentives ¹	.322	.001	.525	.021
Patient infection cntrl ¹	.383	.000	.342	.085
Hiring requirements.1	.230	.013	048	.834
PI programs ²	.265	.005	.153	.290
Clinical team meetings ²	.280	.003	.180	.247
Management practices ²	.313	.001	.211	.154
HH Aide supervision ²	.223	.015	.122	.575
Changing visit patterns ²	.204	.024	.050	.735
Patient teaching ²	.290	.002	.018	.903
Communication w/ MD ²	.284	.003	.145	.356
POC specific parameters ²	.255	.007	008	.954
Care team comm. ²	.244	.009	142	.395
Wound care protocols ²	.205	.024	043	.766
Med dispense sys ²	.427	.000	.523	.022
Disease management. ²	.263	.005	094	.542
Screening assessment	.267	.005	.046	.770
Falls prevention program	.234	.011	088	.603
Infusion devices	.216	.018	.379	.091
Physiological monitor equip.	.239	.010	.059	.714

Model Summary	R	R Square	F	Sig.
	0.653	0.427	2.903	0.001

Model for Winning HHAs

Independent Variables	Bivariate Correlation	Correlation p value	Model Coefficient	p value in Model
(Constant)			.838	.000
Employee incentives ¹	.216	.012	.100	.626
Patient infection cntrl ¹	.322	.000	.192	.296
Hiring requirements.1	.275	.002	.054	.818
Staff competencies ³	.240	.006	.015	.917
Staff evaluation criteria ³	.260	.003	.103	.584
Clinical resources ³	.302	.001	.266	.066
Changing visit mix ³	.192	.022	069	.637
Admin. Support Turnover ³	.217	.011	.329	.034
Reduce time ref/adms ³	.301	.001	.232	.201
Patient communication ³	.206	.015	.005	.975
Physician comm. ³	.187	.025	123	.472
On-call staff change ³	.234	.007	.156	.476
E messaging staff ³	.231	.008	.207	.232
Mentoring programs	.193	.022	028	.875
Clinical Supervision	.276	.002	.175	.065
LPN turnover	.247	.005	.181	.244
PT turnover	.192	.022	153	.303
	•	•	·	
Model Summary	R	R Square	F	Sig.
	0.550	0.302	2.343	0.005

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¹ Common to "All", "Control", "Winners" ² Common to "All" & "Control"

³ Common to "All" & "Winners" ⁴ Common to "Control" & "Winners"

Table E.5: Models for Quality Improvement Impact on Improvement in Ambulation/Locomotion.

Model for All HHAs

Independent Variables	Bivariate Correlation	Correlation p value	Model Coefficient	p value in Model
(Constant)			1.383	.000
Staff competencies1	.217	.001	.073	.524
Employee incentives ¹	.218	.001	.062	.688
Care team comm.1	.231	.000	.067	.574
Patient infection cntrl ¹	.250	.000	.175	.214
E messaging staff ¹	.219	.001	.230	.113
PI programs ²	.186	.003	.100	.378
Record review ²	.193	.002	021	.856
Management practices ²	.232	.000	.086	.482
Changing visit patterns ²	.183	.003	.073	.524
Patient teaching ²	.226	.000	.043	.711
Communication w/ MD ²	.162	.008	066	.593
Screening assessment ²	.137	.021	104	.379
Wound care protocols ²	.171	.006	083	.485
Med dispense sys ²	.137	.021	.090	.582
Reduce time ref/adms ²	.237	.000	.124	.316
Patient communication ²	.183	.003	004	.973
Disease management. ²	.204	.001	.096	.530
Falls prevention ²	.162	.008	014	.908
Hiring requirements. ²	.200	.002	.041	.806
Mentoring programs ³	.183	.003	.003	.979
Staff evaluation criteria ³	.294	.000	.316	.027
Clinical resources ³	.168	.006	.058	.613
Changing visit mix ³	.217	.001	.147	.182
LPN Turnover ³	.157	.010	.076	.423
On-call staff change ³	.176	.005	.032	.853
Expand business hrs ³	.181	.004	.250	.524
HH Aide supervision	.149	.014	.125	.548
Disease management program	.165	.007	040	.779
Clinical pathways	.160	.009	.033	.832
Care plans	.162	.008	.003	.985
Physician comm.	.169	.006	117	.396
Wound care materials	.150	.013	.016	.891
	-		•	

Model Summary	R	R Square	F	Sig.
	0.474	0.224	1.680	0.018

¹ Common to "All", "Control", "Winners" ² Common to "All" & "Control"

³ Common to "All" & "Winners" ⁴ Common to "Control" & "Winners"

Table E.5: Models for Quality Improvement Impact on Improvement in Ambulation/Locomotion. (cont'd)

Model for Control HHAs

Independent Variables	Bivariate Correlation	Correlation p value	Model Coefficient	p value in Model
(Constant)			1.310	.000
Staff competencies ¹	.260	.006	.158	.272
Employee incentives ¹	.241	.010	.386	.084
Care team comm.1	.243	.009	159	.344
Patient infection cntrl ¹	.364	.000	.223	.269
E messaging staff ¹	.239	.010	.436	.033
PI programs ²	.275	.004	.138	.362
Record review ²	.354	.000	.244	.117
Management practices ²	.348	.000	.275	.072
Changing visit patterns ²	.275	.004	.062	.693
Patient teaching ²	.332	.001	.085	.569
Communication w/ MD ²	.279	.003	012	.939
Screening assessment ²	.302	.002	047	.776
Wound care protocols ²	.223	.015	022	.880
Med dispense sys ²	.399	.000	.661	.005
Reduce time ref/adms ²	.280	.003	.212	.189
Patient communication ²	.205	.024	104	.502
Disease management. ²	.287	.002	056	.740
Falls prevention ²	.217	.018	051	.792
Hiring requirements. ²	.287	.003	.194	.392
Staff education	.211	.021	013	.921
Clinical team meetings	.228	.014	.071	.652
POC specific parameters	.216	.018	034	.815
Falls prevention program	.205	.024	159	.472
Physiological monitor equip.	.216	.018	.100	.522
Model Summary	R	R Square	F	Sig.
	0.693	0.481	2.660	0.001

Model for Winning HHAs

Independent Variables	Bivariate Correlation	Correlation p value	Model Coefficient	p value in Model
(Constant)			1.284	.000
Staff competencies ¹	.191	.023	071	.648
Employee incentives ¹	.195	.021	120	.595
Care team comm.1	.236	.006	.019	.904
Patient infection cntrl ¹	.201	.017	.040	.836
E messaging staff ¹	.197	.019	.141	.441
Mentoring programs ³	.203	.017	052	.782
Staff evaluation criteria ³	.413	.000	.648	.002
Clinical resources ³	.277	.002	.220	.164
Changing visit mix ³	.220	.011	.192	.212
LPN turnover ³	.237	.006	.244	.071
On-call staff change ³	.230	.008	065	.781
Expand business hrs ³	.238	.006	.437	.253
Model Summary	R	R Square	F	Sig.
	0.516	0.266	2.931	0.002

¹ Common to "All", "Control", "Winners" ² Common to "All" & "Control"

³ Common to "All" & "Winners" ⁴ Common to "Control" & "Winners"

 Table E.6:
 Models for Quality Improvement Impact on Improvement in Transferring.

Model for All HHAs

Independent Variables	Bivariate Correlation	Correlation p value	Model Coefficient	p value in Model
(Constant)			1.030	.000
Reduce time ref/adms1	.241	.000	.147	.232
Physician comm.1	.217	.001	007	.960
Disease management.1	.285	.000	.193	.208
PI programs ²	.225	.000	.154	.175
Record review ²	.221	.001	.046	.687
Staff competencies ²	.166	.007	035	.760
Management practices ²	.256	.000	.157	.190
HH Aide supervision ²	.177	.004	.254	.222
Changing visit patterns ²	.184	.003	.072	.611
Disease management program ²	.212	.001	034	.817
Clinical pathways ²	.183	.003	.192	.210
Patient teaching ²	.220	.001	033	.776
Communication w/ MD ²	.195	.002	025	.838
Screening assessment ²	.145	.016	032	.788
Wound care protocols ²	.143	.017	152	.193
Med dispense sys ²	.134	.024	.041	.799
Patient communication ²	.197	.002	078	.536
Falls prevention ²	.188	.003	.026	.824
Patient infection cntrl ²	.209	.001	.125	.370
Hiring requirements. ²	.202	.001	006	.972
Mentoring programs ³	.181	.004	.062	.602
Staff evaluation criteria ³	.215	.001	.216	.129
Clinical resources ³	.145	.016	.042	.715
Changing visit mix ³	.205	.001	.105	.342
Care team comm.3	.223	.000	.024	.838
LPN Turnover ³	.182	.003	.108	.256
On-call staff change ³	.149	.014	.036	.836
Expand business hrs3	.147	.015	080	.838
Employee incentives	.181	.004	.048	.756
Admin. Support Turnover	.173	.005	.195	.076
Care practice	.170	.006	.025	.856
Care plans	.143	.017	163	.261
	-		-	-

Model Summary	R	R Square	F	Sig.
	0.473	0.223	1.672	0.019

¹ Common to "All", "Control", "Winners" ² Common to "All" & "Control"

³ Common to "All" & "Winners" ⁴ Common to "Control" & "Winners"

Table E.6: Models for Quality Improvement Impact on Improvement in Transferring. (cont'd)

Model for Control HHAs

Independent Variables	Bivariate Correlation	Correlation p value	Model Coefficient	p value in Model
(Constant)			1.090	.000
Reduce time ref/adms1	.252	.007	.199	.264
Physician comm.1	.278	.003	- 265	.166
Disease management.1	.394	.000	.149	.507
PI programs ²	.332	.001	.182	.300
Record review ²	.397	.000	.328	.040
Staff competencies ²	.239	.010	.122	.407
Management practices ²	.350	.000	.067	.677
HH Aide supervision ²	.237	.011	.285	.251
Changing visit patterns ²	.233	.012	.006	.975
Disease management program ²	.298	.002	- 155	.469
Clinical pathways ²	.228	.014	.177	.379
Patient teaching ²	.287	.002	.038	.805
Communication w/ MD ²	.278	.003	.014	.936
Screening assessment ²	.255	.007	185	.290
Wound care protocols ²	.231	.012	110	.498
Med dispense sys ²	.284	.003	.505	.049
Care practice ²	.224	.015	.063	.702
Patient communication ²	.286	.003	.174	.311
Falls prevention ²	.262	.005	- 042	.800
Patient infection cntrl ²	.364	.000	.191	.357
Hiring requirements. ²	.287	.002	.112	.637
E messaging staff ⁴	.285	.003	.641	.004
Staff education	.253	.007	.006	.968
Telemonitoring	.229	.013	.616	.026
PU reduction equip.	.228	.014	.009	.974
Model Summary	R	R Square	F	Sig.
	0.697	0.485	2.566	0.001

Model for Winning HHAs

Independent Variables	Bivariate Correlation	Correlation p value	Model Coefficient	p value in Model
(Constant)			1.294	.000
Reduce time ref/adms1	.222	.010	.034	.862
Physician comm.1	.201	.018	007	.965
Disease management.1	.207	.015	.073	.693
Mentoring programs ³	.218	.011	.012	.950
Staff evaluation criteria ³	.312	.000	.349	.095
Clinical resources ³	.199	.019	.071	.657
Changing visit mix ³	.234	.007	.175	.257
Care team comm.3	.268	.002	.104	.535
LPN turnover ³	.223	.010	.184	.192
On-call staff change ³	.230	.008	009	.969
Expand business hrs3	.194	.021	.263	.490
E messaging staff ⁴	.206	.016	.168	.375
Model Summary	R	R Square	F	Sig.
	0.438	0.192	1.918	0.041

¹ Common to "All", "Control", "Winners" ² Common to "All" & "Control"

³ Common to "All" & "Winners" ⁴ Common to "Control" & "Winners"

 Table E.7:
 Models for Quality Improvement Impact on Improvement in Status of Surgical Wounds.

Model for All HHAs

Independent Variables	Bivariate Correlation	Correlation p value	Model Coefficient	p value in Model
(Constant)			.909	.012
Communication w/ MD1	.315	.000	.341	.008
Care team comm.1	.277	.000	.237	.076
Wound care protocols1	.240	.000	.072	.556
Disease management.1	.201	.001	.067	.596
Hiring requirements.1	.196	.002	.068	.691
Record review ²	.164	.008	034	.778
Management practices ²	.134	.024	004	.972
HH Aide supervision ²	.157	.010	.143	.495
Changing visit patterns ²	.209	.001	.190	.100
Screening assessment ²	.198	.002	005	.969
Reduce time ref/adms ²	.152	.012	011	.934
Physician comm.2	.171	.006	150	.247
Wound care materials ²	.199	.002	.151	.194
Staff evaluation criteria ³	.157	.010	.075	.600
Patient teaching ³	.192	.002	.045	.711
Med check software ³	.134	.024	.177	.440
PI programs	.140	.019	.050	.662
Clinical team meetings	.159	.009	136	.298
Changing visit mix	.133	.025	.023	.840
Med dispense sys	.139	.020	079	.636
Other Turnover	.143	.017	.500	.151
On-call staff change	.137	.021	044	.808
Productivity requirements.	.138	.020	004	.977

Model Summary	R	R Square	F	Sig.
	0.436	0.190	1.991	0.006

³ Common to "All" & "Winners" ⁴ Common to "Control" & "Winners"

¹ Common to "All", "Control", "Winners" ² Common to "All" & "Control"

Table E.7: Models for Quality Improvement Impact on Improvement in Status of Surgical Wounds. (cont'd)

Model for Control HHAs

Independent Variables	Bivariate Correlation	Correlation p value	Model Coefficient	p value in Model
(Constant)			.675	.074
Communication w/ MD1	.307	.001	.216	.276
Care team comm.1	.277	.003	.025	.892
Wound care protocols ¹	.286	.003	.198	.294
Disease management.1	.221	.016	090	.632
Hiring requirements.1	.314	.001	.145	.588
Record review ²	.354	.000	.285	.108
Management practices ²	.244	.009	.110	.544
HH Aide supervision ²	.227	.014	.144	.566
Changing visit patterns ²	.326	.001	.305	.118
Screening assessment ²	.301	.002	.116	.530
Reduce time ref/adms ²	.213	.020	109	.551
Physician comm.2	.218	.017	066	.756
Wound care materials ²	.244	.009	.065	.725
POC specific parameters	.224	.015	.014	.933
Other care change	.226	.014	.404	.248
Care practice	.208	.022	.119	.495
Patient communication	.214	.019	.022	.904

Model Summary	R	R Square	F	Sig.
	0.564	0.318	2.082	0.016

Model for Winning HHAs

Independent Variables	Bivariate Correlation	Correlation p value	Model Coefficient	p value in Model
(Constant)			1.779	.000
Communication w/ MD1	.302	.001	.160	.344
Care team comm.1	.284	.001	.258	.116
Wound care protocols ¹	.213	.013	.050	.764
Disease management.1	.235	.007	.150	.396
Hiring requirements.1	.190	.023	.160	.499
Staff evaluation criteria ³	.209	.014	.047	.813
Patient teaching ³	.263	.003	.176	.296
Staff education	223	.010	494	.000
Med check software	.211	.013	.295	.292
Model Summary	R	R Square	F	Sig.
	0.500	0.250	3.696	0.000

¹ Common to "All", "Control", "Winners" ² Common to "All" & "Control"

³ Common to "All" & "Winners" ⁴ Common to "Control" & "Winners"

Table E.8: Models for Quality Improvement Impact on Improvement in Management of Oral Medications.

Model for All HHAs

Independent Variables	Bivariate Correlation	Correlation p value	Model Coefficient	p value in Model
(Constant)			1.510	.000
Changing visit patterns ²	.184	.003	.150	.149
Communication w/ MD ²	.193	.002	.072	.497
POC specific parameters ²	.184	.003	.085	.383
Screening assessment ²	.215	.001	.094	.386
Med dispense sys ²	.171	.006	.160	.285
Patient infection cntrl ²	.208	.001	.125	.323
Staff competencies3	.184	.003	.062	.550
Staff evaluation criteria ³	.204	.001	.144	.241
Patient teaching ³	.181	.004	.029	.785
Care team comm.3	.166	.007	021	.847
Reduce time ref/adms ³	.135	.023	034	.762
Falls prevention ³	.159	.009	.008	.941
Expand business hrs ³	.233	.000	.888	.010

Model Summary	R	R Square	F	Sig.
	0.386	0.149	2.758	0.001

Model for Control HHAs

Independent Variables	Bivariate Correlation	Correlation p value	Model Coefficient	p value in Model
(Constant)			1.313	.000
Changing visit patterns ²	.296	.002	.319	.045
Communication w/ MD ²	.262	.005	.143	.370
POC specific parameters ²	.273	.004	.144	.326
Screening assessment ²	.292	.002	.117	.450
Med dispense sys ²	.358	.000	.513	.070
Patient infection cntrl ²	.206	.023	071	.715
Falls prevention program	.229	.013	.044	.798
Med dispense	.233	.012	.169	.701

Model Summary	R	R Square	F	Sig.
	0.486	0.237	3.292	0.003

¹ Common to "All", "Control", "Winners" ² Common to "All" & "Control"

³ Common to "All" & "Winners" ⁴ Common to "Control" & "Winners"

Table E.8: Models for Quality Improvement Impact on Improvement in Management of Oral Medications. (cont'd)

Model for Winning HHAs

Independent Variables	Bivariate Correlation	Correlation p value	Model Coefficient	p value in Model
(Constant)			1.536	.000
Staff competencies ³	.215	.012	.066	.637
Staff evaluation criteria ³	.251	.004	.171	.337
Patient teaching ³	.329	.000	.289	.049
Care team comm.3	.202	.017	003	.983
Reduce time ref/adms3	.216	.012	.090	.593
Falls prevention ³	.200	.018	.052	.705
Expand business hrs3	.311	.000	.689	.050
Employee incentives	.192	.022	065	.745
LPN turnover	.216	.012	.161	.187
	•			•
Model Summary	R	R Square	F	Sig.
	0.452	0.204	2.846	0.005

³ Common to "All" & "Winners" ⁴ Common to "Control" & "Winners"

¹ Common to "All", "Control", "Winners" ² Common to "All" & "Control"
Table E.9: Models for the Demonstration's Impact on Patient Outcomes.

Model for All HHAs

Independent Variables	Bivariate Correlation	Correlation p value	Model Coefficient	p value in Model
(Constant)			3.547	.000
Communication w/ MD1	.229	.000	.050	.703
Patient communication ¹	.281	.000	.218	.099
Patient infection cntrl ¹	.255	.000	.267	.068
Changing visit mix ²	.188	.003	.131	.251
Screening assessment ²	.176	.005	026	.828
PU reduction equip.2	.145	.016	.253	.288
Clinical team meetings ³	.157	.010	064	.638
Staff competencies ³	.129	.029	034	.769
Disease management program ³	.136	.022	050	.747
Clinical pathways ³	.181	.004	.102	.468
Patient teaching ³	.227	.000	.077	.529
Care team comm.3	.222	.000	.081	.570
Reduce time ref/adms ³	.204	.001	.040	.758
Physician comm.3	.230	.000	043	.765
Disease management.3	.176	.005	033	.840
Hiring requirements.3	.203	.001	.103	.549
EMRs ³	.189	.002	.175	.229
E access to policies ³	.169	.006	.095	.508
Management practices	.176	.005	001	.993
HH Aide supervision	.135	.023	.064	.768
Changing visit patterns	.210	.001	.149	.213
Wound care protocols	.153	.012	101	.431
Med dispense sys	.174	.005	.109	.529
Expand business hours	.145	.016	.146	.722
Wound care materials	.150	.013	010	.937
Med check software	.145	.016	.271	.263
Model Summary	R	R Square	F	Sig.

Model Summary	R	R Square	F	Sig.
	0.441	0.195	1.787	0.015

¹ Common to "All", "Control", "Winners" ² Common to "All" & "Control"

³ Common to "All" & "Winners" ⁴ Common to "Control" & "Winners"

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Table E.9: Models for the Demonstration's Impact on Patient Outcomes. (cont'd)

Model for Control HHAs

Independent Variables	Bivariate Correlation	Correlation p value	Model Coefficient	p value in Model
(Constant)			2.981	.000
Communication w/ MD1	.232	.012	027	.879
Patient communication ¹	.360	.000	.324	.068
Patient infection cntrl ¹	.225	.014	.124	.515
Changing visit mix ²	.203	.025	.151	.401
Screening assessment ²	.276	.004	.095	.581
PU reduction equip. ²	.207	.023	.338	.253
PI programs	.242	.009	.101	.556
POC specific parameters	.239	.010	.401	.101
Other staff turnover	.207	.023	.475	.169

Model Summary	R	R Square	F	Sig.
	0.482	0.232	2.823	0.006

Independent Variables	Bivariate Correlation	Correlation p value	Model Coefficient	p value in Model
(Constant)			3.597	.000
Communication w/ MD1	.259	.003	124	.504
Patient communication ¹	.236	.007	171	.367
Patient infection cntrl ¹	.339	.000	.205	.343
Clinical team meetings ³	.290	.001	019	.921
Staff competencies ³	.230	.008	.043	.788
Disease management program ³	.240	.006	045	.823
Clinical pathways ³	.236	.007	061	.734
Patient teaching ³	.402	.000	.281	.123
Care team comm.3	.304	.001	.152	.412
Reduce time ref/adms ³	.295	.001	.122	.544
Physician comm.3	.309	.001	.236	.240
Disease management. ³	.331	.000	.161	.493
Hiring requirements.3	.235	.007	111	.670
EMRs ³	.208	.015	.139	.470
E access to policies ³	.213	.013	.109	.593
Mentoring programs	.270	.002	.220	.277
Staff evaluation Criteria	.208	.015	217	.329
Employee incentives	.350	.000	.346	.157
Management practices	.240	.006	049	.812
LPN turnover	.217	.012	.104	.461
Med reminder sys	.195	.021	031	.909
Med check software	.252	.004	.393	.187
		1	1	
Model Summary	R	R Square	F	Sig.
	0.560	0.314	1.810	0.028

¹ Common to "All", "Control", "Winners" ² Common to "All" & "Control"

³ Common to "All" & "Winners" ⁴ Common to "Control" & "Winners"

 Table E.10:
 Models for the Demonstration's Impact on HHA's Quality of Care.

Model for All HHAs

Independent Variables	Bivariate Correlation	Correlation p value	Model Coefficient	p value in Model
(Constant)			3.416	.000
Communication w/ MD1	.281	.000	.194	.132
Patient infection cntrl ¹	.264	.000	.275	.052
Hiring requirements.1	.230	.000	.109	.531
Changing visit patterns ²	.161	.009	.097	.508
Changing visit mix ²	.177	.004	.073	.521
Screening assessment ²	.190	.002	.046	.697
Care practice ²	.105	.060	.006	.963
Reduce time ref/adms ²	.202	.001	.069	.595
Patient communication ²	.216	.001	.093	.481
Clinical team meetings ³	.205	.001	.001	.994
Management practices ³	.156	.010	011	.933
Patient teaching ³	.200	.001	.041	.739
Wound care protocols ³	.184	.003	020	.871
Sr Management Turnover ³	.133	.025	.179	.079
Physician comm.3	.230	.000	008	.954
Disease management.3	.169	.006	109	.423
Productivity requirements.3	.170	.006	.020	.882
Wound care materials ³	.190	.002	.085	.484
Med reminder sys ³	.177	.004	.071	.732
Record review	.178	.004	.000	1.000
Staff competencies	.108	.056	128	.268
Clinical resources	.145	.016	.080	.511
Clinical pathways	.202	.001	.211	.120
POC specific parameters	.168	.006	.022	.846
Care team comm.	.240	.000	.032	.811

Model Summary	R	R Square	F	Sig.
	0.431	0.186	1.765	0.018

¹ Common to "All", "Control", "Winners" ² Common to "All" & "Control"

Table E.10: Models for the Demonstration's Impact on HHA's Quality of Care. (cont'd)

Model for Control HHAs

Independent Variables	Bivariate Correlation	Correlation p value	Model Coefficient	p value in Model
(Constant)			3.356	.000
Communication w/ MD1	.317	.001	.216	.238
Patient infection cntrl ¹	.222	.016	052	.803
Hiring requirements.1	.251	.007	.231	.372
Changing visit patterns ²	.220	.017	.105	.586
Changing visit mix ²	.221	.016	.107	.549
Screening assessment ²	.297	.002	.131	.457
Care practice ²	.221	.016	.230	.196
Reduce time ref/adms ²	.282	.003	.131	.459
Patient communication ²	.297	.002	.143	.419
Med dispense sys	.219	.017	.218	.435
Model Summary	R	R Square	F	Sig.
	0.473	0.224	2.394	0.015

Independent Variables	Bivariate Correlation	Correlation p value	Model Coefficient	p value in Model
(Constant)			3.498	.000
Communication w/ MD1	.272	.002	.061	.732
Patient infection cntrl ¹	.356	.000	.262	.210
Hiring requirements.1	.199	.019	094	.711
Clinical team meetings3	.258	.003	.041	.832
Management practices ³	.211	.013	114	.579
Patient teaching ³	.309	.001	.090	.612
POC specific parameters ³	.227	.009	.118	.483
Care team comm.3	.286	.001	.120	.496
Physician comm.3	.246	.005	020	.908
Disease management.3	.275	.002	.075	.699
Productivity requirements.3	.229	.008	.053	.800
Wound care materials ³	.223	.010	.051	.757
Med reminder sys ³	.209	.014	062	.835
Staff evaluation criteria	.252	.004	.075	.727
Employee incentives	.381	.000	.432	.075
Clinical pathways	.262	.003	.108	.546
Wound care protocols	.218	.011	030	.862
LPN turnover	.259	.003	.273	.049
On-call staff change	.199	.019	098	.685
Model Summary	R	R Square	F	Sig.
	0.525	0.276	1.802	0.034

¹ Common to "All", "Control", "Winners" ² Common to "All" & "Control"

³ Common to "All" & "Winners" ⁴ Common to "Control" & "Winners"

Table E.11: Models for the Demonstration's Impact on HHA's Cost of Providing Care.

Model for All HHAs

Independent Variables	Bivariate Correlation	Correlation p value	Model Coefficient	p value in Model
(Constant)			1.699	.000
PI programs ²	.161	.009	.130	.337
Patient teaching ³	.152	.012	.154	.287
Screening assessment ³	.136	.022	.051	.719
Wound care protocols ³	.134	.024	.011	.942
Patient infection cntrl3	.212	.001	.326	.055
Telemonitoring	.160	.009	.397	.041
Communication w/ MD	.137	.021	.020	.888
Care team comm.	.134	.024	.005	.974
Med dispense sys	.145	.016	.086	.683
Sr Management Turnover	.171	.006	.231	.069
Other Turnover	.168	.006	.666	.119

Model Summary	R	R Square	F	Sig.
	0.354	0.125	2.690	0.003

Model for Control HHAs

Independent Variables	Bivariate Correlation	Correlation p value	Model Coefficient	p value in Model
(Constant)			1.430	.002
PI programs ²	.273	.004	.393	.070
Other staff turnover	.266	.005	.958	.027
Physician comm.	.255	.007	.289	.175

Model Summary	R	R Square	F	Sig.
	0.386	0.149	5.238	0.002

Model for Winning HHAs

Independent Variables	Bivariate Correlation	Correlation p value	Model Coefficient	p value in Model	
(Constant)			2.450	.000	
Patient teaching ³	.223	.010	.066	.738	
Screening assessment ³	.206	.015	.149	.390	
Wound care protocols ³	.196	.020	.087	.639	
Patient infection cntrl3	.255	.004	.294	.211	
Mentoring programs	.301	.001	.356	.110	
Employee incentives	.233	.007	.159	.532	
LPN turnover	.240	.006	.271	.087	
Model Summary	R	R Square	F	Sig.	
	0.416	0.173	3.057	0.006	

¹ Common to "All", "Control", "Winners" ² Common to "All" & "Control"

³ Common to "All" & "Winners" ⁴ Common to "Control" & "Winners"

Table E.12: Models for the Demonstration's Impact on HHA's Financial Solvency.

Model for All HHAs

Independent Variables	Bivariate Correlation	Correlation p value	Model Coefficient	p value in Model
(Constant)			2.062	.000
POC specific parameters ¹	.198	.002	.189	.127
PI programs ²	.136	.022	.082	.522
Communication w/ MD ²	.179	.004	.061	.666
Other staff turnover ²	.135	.023	.672	.076
Physician comm.2	.154	.012	.026	.870
Patient teaching ³	.163	.008	.094	.468
Changing visit mix	.182	.003	.228	.069
Screening assessment	.162	.008	.053	.676
Patient communication	.137	.022	.038	.794
PU reduction equip.	.136	.023	.277	.260
Model Summary	R	R Square	F	Sig.
	0.322	0.104	2.410	0.010

Model for Control HHAs

Independent Variables	Bivariate Correlation	Correlation p value	Model Coefficient	p value in Model
(Constant)			1.726	.000
POC specific parameters ¹	.230	.013	.214	.258
PI programs ²	.260	.006	.191	.343
Communication w/ MD ²	.216	.018	.166	.455
Other staff turnover ²	.225	.015	.747	.055
Physician comm.2	.216	.018	.045	.839
EMRs	.286	.003	.639	.018

Model Summary	R	R Square	F	Sig.
	0.441	0.194	3.499	0.004

Independent Variables	Bivariate Correlation	Correlation p value	Model Coefficient	p value in Model
(Constant)			2.623	.000
POC specific parameters ¹	.271	.002	.214	.179
Patient teaching ³	.294	.001	.211	.249
Clinical team meetings	.189	.024	.022	.907
Employee incentives	.247	.005	.222	.333
Care team comm.	.199	.019	002	.993
Wound care protocols	.302	.001	.274	.109
LPN turnover	.228	.008	.157	.391
OT turnover	.188	.025	.129	.390
Patient infection control	.216	.012	.040	.847
Model Summary	R	R Square	F	Sia.

Model Summary	R	R Square	F	Sig.
	0.447	0.200	2.776	0.006

¹ Common to "All", "Control", "Winners" ² Common to "All" & "Control"

³ Common to "All" & "Winners" ⁴ Common to "Control" & "Winners"

^{* &}amp; "Control" ⁴Ce

Table E.13: Models for the Demonstration's Impact on HHA's Profitability.

Model for All HHAs

Independent Variables	Bivariate Correlation	Correlation p value	Model Coefficient	p value in Model
(Constant)			1.801	.000
Communication w/ MD1	.252	.000	.147	.348
POC specific parameters ¹	.169	.006	.094	.474
Physician comm.1	.268	.000	.262	.116
Emergency response ¹	.176	.005	.448	.114
Changing visit mix ²	.192	.002	.226	.095
Other staff turnover ²	.154	.011	.923	.027
Patient communication ²	.169	.006	047	.754
Patient teaching ³	.204	.001	.200	.157
Care team comm.3	.144	.017	097	.507
Screening assessment ³	.179	.004	.086	.538
Wound care protocols ³	.132	.025	038	.788
Hiring reqrmnts. ³	.137	.021	063	.751
Staff competencies	.087	.099	020	.878
Med dispense sys	.138	.021	.002	.993
PU reduction equip.	.158	.010	.287	.287
E access to policies	.144	.016	.162	.307

Model Summary	R	R Square	F	Sig.
	0.406	0.165	2.487	0.002

Model for Control HHAs

Independent Variables	Bivariate Correlation	Correlation p value	Model Coefficient	p value in Model
(Constant)			1.512	.001
Communication w/ MD1	.312	.001	.045	.855
POC specific parameters ¹	.236	.011	.164	.410
Physician comm.1	.357	.000	.447	.070
Emergency response ¹	.241	.010	.865	.066
Changing visit mix ²	.211	.021	.300	.160
Other staff turnover ²	.257	.006	.945	.023
Patient communication ²	.231	.012	022	.920
	·	•	•	•
Model Summary	R	R Square	F	Sig.

Model Summary	R	R Square	F	Sig.
	0.490	0.240	3.881	0.001

¹ Common to "All", "Control", "Winners" ² Common to "All" & "Control"

Table E.13: Models for the Demonstration's Impact on HHA's Profitability. (cont'd)

Model for Winning HHAs

Independent Variables	Bivariate Correlation	Correlation p value	Model Coefficient	p value in Model
(Constant)			2.762	.000
Communication w/ MD1	.219	.011	092	.653
POC specific parameters ¹	.192	.022	.081	.650
Physician comm.1	.197	.019	045	.815
Emergency response ¹	.229	.008	.882	.022
Patient teaching ³	.381	.000	.446	.025
Care team comm.3	.219	.011	010	.962
Screening assessment ³	.235	.007	.090	.614
Wound care protocols ³	.293	.001	.197	.292
Hiring requirements ³	.277	.002	.205	.446
Mentoring programs	.257	.003	.178	.423
Clinical team meetings	.241	.006	047	.824
Employee incentives	.287	.001	.140	.581
Management practices	.264	.003	.102	.635
LPN turnover	.228	.008	.160	.303
Med check software	.242	.005	.150	.631
Model Summony	P	P Squara	E	Sia
would summary	0.533	0.284	2.487	0.004

¹ Common to "All", "Control", "Winners" ² Common to "All" & "Control"

Table E.14: Models for the Demonstration's Impact on HHA's Patient Satisfaction.

Model for All HHAs

Independent Variables	Bivariate Correlation	Bivariate Correlation Correlation p value		p value in Model
(Constant)			2.775	.000
HH Aide supervision ¹	.181	.004	.197	.387
Communication w/ MD1	.300	.000	.234	.083
Care team comm.1	.293	.000	.107	.453
Reduce time ref/adms1	.260	.000	.129	.334
Patient communication ¹	.307	.000	.192	.164
Physician comm.1	.283	.000	026	.861
Patient infection cntrl ¹	.273	.000	.327	.030
Hiring requirements ¹	.300	.000	.062	.756
Clinical resources ²	.175	.005	.127	.338
Changing visit mix ²	.218	.001	.174	.145
Screening assessment ²	.154	.011	032	.798
Med dispense sys ²	.146	.015	101	.623
Other staff turnover ²	.136	.022	.432	.256
Mentoring programs ³	.200	.001	.163	.210
Clinical team meetings ³	.249	.000	023	.872
Record review ³	.228 .000 .		.132	.294
Management practices ³	.207	.001	.043	.749
Disease management program ³	.159	.009	.021	.891
Clinical pathways ³	.179	.004	.161	.266
Patient teaching ³	.275	.000	.137	.292
Admin. Support Turnover ³	.195	.002	.179	.142
Disease management.3	.182	.003	188	.262
Expand business hrs ³	.162	.008	.100	.809
PI programs	.133	.025	056	.649
Staff competencies	.001	.494	366	.003
POC specific parameters	.155	.011	.023	.846
Wound care protocols	.168	.006	117	.368
Care practice	.059	.191	060	.615
Productivity requirements	.143	.018	166	.240
EMRs	.163	.008	.109	.472
Wound care materials	.184	.003	.068	.588
Med reminder sys	.159	.009	.037	.884
E access to policies	.186	.003	.166	.268
	•	•	-	-
Madal O	-		-	0'

Model Summary	R	R Square	F	Sig.
	0.549	0.301	2.417	0.000

¹ Common to "All", "Control", "Winners" ² Common to "All" & "Control"

³ Common to "All" & "Winners"

⁴ Common to "Control" & "Winners"

Model for Control HHAs

Independent Variables	Bivariate Correlation	Correlation p value	Model Coefficient	p value in Model
(Constant)			2.843	.000
HH Aide supervision ¹	.210	.021	.096	.731
Communication w/ MD1	.369	.000	.239	.290
Care team comm.1	.313 .001 .066		.731	
Reduce time ref/adms1	.345	.000	.393	.051
Patient communication ¹	.380	.000	.237	.253
Physician comm.1	.294	.002	096	.664
Patient infection cntrl ¹	.294	.002	.202	.417
Hiring requirements ¹	.326	.001	.247	.421
Clinical resources ²	.280	.003	.385	.054
Changing visit mix ²	.269	.004	.200	.309
Screening assessment ²	.305	.001	.076	.708
Other staff turnover ²	.215	.019	.282	.467
Employee incentives ⁴	.206	.023	.151	.599
Falls prevention program	.205	.024	239	.289
Med dispense sys	.206	.023	.102	.746
Model Summary	R	R Square	F	Sig.
	0.593	0.352	2.820	0.002

Independent Variables	Bivariate Correlation Correlation p val		Model Coefficient	p value in Model
(Constant)			3.085	.000
HH Aide supervision ¹	.200	.018	.063	.884
Communication w/ MD1	.287	.001	.069	.715
Care team comm.1	.270	.002	.018	.926
Reduce time ref/adms1	.243	.005	041	.855
Patient communication ¹	.238	.006	001	.997
Physician comm.1	.263	.003	011	.961
Patient infection cntrl ¹	.304	.001	.112	.617
Hiring requirements ¹	.265	.003	064	.824
Mentoring programs ³	.273	.002	.151	.471
Clinical team meetings ³	.306	.001	.101	.612
Record review ³	.253	.004	.005	.980
Management practices ³	.241	.006	049	.824
Disease management program ³	.241	.006	.090	.662
Clinical pathways ³	.214	.012	.024	.901
Patient teaching ³	.397	.000	.297	.122
Admin. Support Turnover ³	.227	.008	.270	.137
Disease management. ³	.296	.001	.104	.664
Expand business hrs ³	.217	.012	.034	.943
Employee incentives ⁴	.353	.000	.434	.095
LPN turnover	.227	.008	.158	.435
PT turnover	.195	.020	009	.960
On-call staff change	.193	.022	121	.628
Model Summary	R	R Square	F	Sig.
	0.540	0.291	1.625	0.059

¹ Common to "All", "Control", "Winners" ² Common to "All" & "Control"

³ Common to "All" & "Winners" ⁴ Common to "Control" & "Winners"

 Table E.15:
 Models for the Demonstration's Impact on HHA's Staff Satisfaction.

Model for All HHAs

Independent Variables	Bivariate Correlation	Correlation p value	Model Coefficient	p value in Model
(Constant)			3.149	.000
Reduce time ref/adms1	.203	.001	.068	.649
Patient communication ¹	.246	.000	.254	.093
Screening assessment ²	.165	.007	.037	.784
Physician comm. ²	.190	.002	045	.778
Mentoring programs ³	.168	.006	.190	.185
Clinical team meetings ³	.147	.015	127	.407
Record review ³	.175	.005	.087	.531
Changing visit mix ³	.231	.000	.300	.023
Patient teaching ³	.228	.000	.185	.183
Communication w/ MD ³	.198	.002	.091	.540
POC specific parameters ³	.132	.025	.072	.569
Care team comm.3	.200	.001	.098	.525
Wound care protocols ³	.154	.011	.073	.586
Patient infection cntrl3	.152	.012	.067	.678
Productivity requirements ³	.143	.017	.021	.886
Hiring requirements ³	.206	.001	.081	.697
Staff competencies	015	.411	317	.016
Management practices	.089	.094	152	.293
Admin. Support Turnover	.138	.021	.067	.611
Expand business hours	.144	.017	.594	.183

Model Summary	R	R Square	F	Sig.
	0.421	0.177	2.127	0.005

Model for Control HHAs

Independent Variables	Bivariate Correlation	Correlation p value	Model Coefficient	p value in Model
(Constant)			3.044	.000
Reduce time ref/adms1	.248	.008	.276	.208
Patient communication ¹	.319	.001	.460	.052
Screening assessment ²	.205	.024	.102	.624
Physician comm.2	.208	.022	002	.993

Model Summary	R	R Square	F	Sig.
	0.354	0.125	3.192	0.017

¹ Common to "All", "Control", "Winners" ² Common to "All" & "Control"

Table E.15: Models for the Demonstration's Impact on HHA's Staff Satisfaction. (cont'd)

Model for Winning HHAs

(Constant) 2.965 .000 Reduce time ref/adms ¹ .230 .008 .042 .864 Patient communication ¹ .209 .014 .050 .798 Mentoring programs ³ .335 .000 .330 .149 Clinical team meetings ³ .243 .005 .086 .708 Record review ³ .228 .008 .030 .879 Changing visit mix ³ .234 .007 .155 .395 Patient teaching ³ .350 .000 .237 .254 Communication w/ MD ³ .259 .003 .012 .950 POC specific parameters ³ .216 .012 .152 .424 Care team comm. ³ .299 .001 .119 .583	Independent Variables	Bivariate Correlation	Correlation p value	Model Coefficient	p value in Model
Reduce time ref/adms ¹ .230 .008 .042 .864 Patient communication ¹ .209 .014 .050 .798 Mentoring programs ³ .335 .000 .330 .149 Clinical team meetings ³ .243 .005 .086 .708 Record review ³ .228 .008 .030 .879 Changing visit mix ³ .234 .007 .155 .395 Patient teaching ³ .350 .000 .237 .254 Communication w/ MD ³ .259 .003 .012 .950 POC specific parameters ³ .216 .012 .152 .424 Care team comm. ³ .299 .001 .119 .583	(Constant)			2.965	.000
Patient communication1 .209 .014 .050 .798 Mentoring programs3 .335 .000 .330 .149 Clinical team meetings3 .243 .005 086 .708 Record review3 .228 .008 .030 .879 Changing visit mix3 .234 .007 .155 .395 Patient teaching3 .350 .000 .237 .254 Communication w/ MD3 .259 .003 .012 .950 POC specific parameters3 .216 .012 .152 .424 Care team comm.3 .299 .001 .119 .583	Reduce time ref/adms1	.230	.008	.042	.864
Mentoring programs ³ .335 .000 .330 .149 Clinical team meetings ³ .243 .005 086 .708 Record review ³ .228 .008 .030 .879 Changing visit mix ³ .234 .007 .155 .395 Patient teaching ³ .350 .000 .237 .254 Communication w/ MD ³ .259 .003 .012 .950 POC specific parameters ³ .216 .012 .152 .424 Care team comm. ³ .299 .001 .119 .583 Wound care protocols ³ .312 .000 .180 .368	Patient communication ¹	.209	.014	.050	.798
Clinical team meetings ³ .243 .005 086 .708 Record review ³ .228 .008 .030 .879 Changing visit mix ³ .234 .007 .155 .395 Patient teaching ³ .350 .000 .237 .254 Communication w/ MD ³ .259 .003 .012 .950 POC specific parameters ³ .216 .012 .152 .424 Care team comm. ³ .299 .001 .119 .583 Wound care protocols ³ .312 .000 .180 .368	Mentoring programs ³	.335	.000	.330	.149
Record review ³ .228 .008 .030 .879 Changing visit mix ³ .234 .007 .155 .395 Patient teaching ³ .350 .000 .237 .254 Communication w/ MD ³ .259 .003 .012 .950 POC specific parameters ³ .216 .012 .152 .424 Care team comm. ³ .299 .001 .119 .583 Wound care protocols ³ .312 .000 .180 .368	Clinical team meetings ³	.243	.005	086	.708
Changing visit mix ³ .234 .007 .155 .395 Patient teaching ³ .350 .000 .237 .254 Communication w/ MD ³ .259 .003 .012 .950 POC specific parameters ³ .216 .012 .152 .424 Care team comm. ³ .299 .001 .119 .583 Wound care protocols ³ .312 .000 .180 .368	Record review ³	.228	.008	.030	.879
Patient teaching ³ .350 .000 .237 .254 Communication w/ MD ³ .259 .003 .012 .950 POC specific parameters ³ .216 .012 .152 .424 Care team comm. ³ .299 .001 .119 .583 Wound care protocols ³ .312 .000 .180 .368	Changing visit mix ³	.234	.007	.155	.395
Communication w/ MD ³ .259 .003 .012 .950 POC specific parameters ³ .216 .012 .152 .424 Care team comm. ³ .299 .001 .119 .583 Wound care protocols ³ .312 .000 180 .368	Patient teaching ³	.350	.000	.237	.254
POC specific parameters ³ .216 .012 .152 .424 Care team comm. ³ .299 .001 .119 .583 Wound care protocols ³ .312 .000 180 .368	Communication w/ MD ³	.259	.003	.012	.950
Care team comm. ³ .299 .001 .119 .583 Wound care protocols ³ .312 .000 180 .368	POC specific parameters ³	.216	.012	.152	.424
Wound care protocols ³ 312 000 180 368	Care team comm.3	.299	.001	.119	.583
	Nound care protocols ³	.312	.000	.180	.368
Patient infection cntrl ³ .222 .010167 .500	Patient infection cntrl3	.222	.010	167	.500
Productivity requirements ³ .194 .021123 .613	Productivity requirements ³	.194	.021	123	.613
Hiring requirements ³ .260 .003 .085 .776	Hiring requirements ³	.260	.003	.085	.776
Communication w/ MD .308 .001 .116 .659	Communication w/ MD	.308	.001	.116	.659
POC specific parameters .357 .000 .538 .056	POC specific parameters	.357	.000	.538	.056
Care team comm224 .009245 .310	Care team comm.	.224	.009	245	.310
Clinical pathways .229 .008 .117 .580	Clinical pathways	.229	.008	.117	.580
LPN turnover .239 .006 .154 .447	_PN turnover	.239	.006	.154	.447
PT turnover .191 .023 .144 .425	PT turnover	.191	.023	.144	.425
Disease management220 .010130 .592	Disease management.	.220	.010	130	.592
On-call staff change .194 .021294 .314	On-call staff change	.194	.021	294	.314
Med check software .261 .003 .376 .252	Med check software	.261	.003	.376	.252
E access to policies .194 .021 .047 .840	E access to policies	.194	.021	.047	.840

Model Summary	R	R Square	F	Sig.
	0.559	0.312	1.608	0.059

¹ Common to "All", "Control", "Winners" ² Common to "All" & "Control"

	Comments		Su	ggestions
	#	% of Respondents	#	% of Respondents
Control	19	20.2%	15	16.0%
Non-Winners	2	13.3%	1	6.7%
Winners	41	37.3%	34	30.9%
Totals	62	28.3%	50	22.8%

Appendix F: Summary of Comments

All responses to Survey question: "Please use the space below to provide any other comments what your agency learned by participating in the P4P Demonstration during Calendar Years 2008 and 2009."

NOTE: If a comment exceeded the length of available characters in the "comment" item field, the comment was truncated and is designated by the following [truncated]. The comments below also contain minor editing of participant responses to correct grammatical errors and complete sentences.)

Control Comments

- Good home health services rendered prevents frequent re-hospitalizations.
 - Quality control improved staff documentations.
 - Regular staff meeting improved interdisciplinary communications; physician is regularly updated regarding patient status
- 2 We have put best practices into our daily routine and have identified them as Best Practices
- 3 Absolutely nothing since Illinois was not recognized as a State that received any bonus dollars. Nurses want to take care of their patients, I know that there has to be a balance, but really, the patients don't understand why they have to be asked [truncated]
- 4 As part of the control group we focused on best practices and readiness for Oasis C.
- 5 Continued need for focus on education on OASIS accuracy and monitoring of quality indicators for care planning trends.
- 6 Education of staff is key and OASIS competency is crucial. Continuous, on-going OASIS education is also needed to ensure accuracy.
- 7 First I must say that I was unaware that we were participating in this demonstration although I'm not sure that that would have made a difference. It would have been nice to have received updates as to what was being done in the participating group.
- 8 We learned how to teach, monitor & provide better (quality) patient care. There was much improvement to QIO data collection, analysis & strategic planning (including implementation & evaluation). We learned how to be better support clinicians.
- 9 Many of the activities implemented showed no improvement until 2010 when we began to see an improvement in several areas.
- 10 My Agency was one of the control group. There was not a lot of interaction.
- 11 Our agency just did what we had to do to improve our outcomes without really knowing how we are rated during the demonstration period as we had no contact or input from you. We basically went out and go about our business by consistently providing education.
- 12 Our agency was designated as a control group. We were more alert and in tuned to our documentation and our clinical care.

- 13 That without increased revenue that it will be impossible to study the results of information provided by P4P. Competing with large corporations is likely to impact our agency on a large scale.
- 14 There was no information received/obtained during the two year demonstration.
- 15 Unfortunately, we were the control group so we received no increase in guidelines or suggestions for improvement.
- 16 We had been working hard prior to this to get ready for P4P. There is not enough timely feedback to be able to use with the staff to make it current for them. P4P has been being discussed for over 10 years now and we still don't have good information.
- 17 We learned nothing since we were a control agency. We did what we would have done anyway despite participation in the demonstration.
- 18 We were part of the control group and so just responded to issues as we normally would.
- 19 We've worked on multiple processes that positively impacted patient care / outcomes. P4P demonstration project as well as our Casper reports started us on this journey. Staff has to be trained and have buy in on the importance of their role in P4P.

Non-Winner Comments

- 1 It appears that agencies that take on the more complex and high tech clients who are at greater risk for complications, rehospitalizations and poor outcomes will not do so well in the P4P arena. I am worried that those types of clients will find [truncated]
- 2 We changed computer software systems in 2008 and have had multiple issues, which took a lot of our time and ultimately had a negative outcome.

Winner Comments

- 1 Education of staff is key and OASIS competency is crucial. Continuous, on-going OASIS education is also needed to ensure accuracy.
- 2 a. Improved outcomes

b. Increased staff knowledge and awareness to agencies target goals

- 3 2008/2009 was a time of turmoil in my Agency. We have since been acquired by another Agency so it becomes difficult to comment on anything during this time period.
- 4 As stated during the site visit by Ms. Angela Richard.
- 5 BEING ONE OF THE PARTICIPANTS IN THE P4P DEMONSTRATION AND BECAME ONE OF THE TOP PERFORMER IN OUR REGION IS A BIG IMPACT TO OUR AGENCY. WE INCREASE OUR REFERRALS, COMPLIMENTS CALL FROM PATIENTS AND FAMILY ETC. WE ARE VERY PROUD TO SAY THAT WE HAVE....[truncated]
- 6 BPIP were very informative. Leadership would have been more involved if we had known at inception which group we were assigned to and the financial impact of our efforts.
- 7 Education and supportive structure are key elements to improvement.
- 8 I don't know as we learned anything as there was not communication throughout. We had to devise our own benchmarks and seek out our own best practices. We had no idea who else was participating and so could not collaborate on best practices.
- 9 Improved patient outcomes and patient and clinician satisfaction and see below.
- 10 Improving outcomes and performing in the top percentiles proved to be very cost intensive. Agencies need more directions in meeting and maintaining high standards with little or no cost inflation. In the beginning, it appears that the benefit does...[truncated]

- 11 It is how a nurse or therapist answers the questions on the OASIS for outcomes; even though they are instructed to assess the same, it is subjective in the end. Therefore, OASIS should not be set to pay for performance standards.
- 12 It is not easy, it takes time and resources, care plans/assessments must be aligned to support positive outcomes.
- 13 It is really hard for me to know because our company changed last year to a new ownership. The previous DON was updated on this information.
- 14 It is very satisfying to be involved in projects that increase a positive outcome results in patient care. It gives us added motivation as new concepts, theories and practices are shared with a common initiative to work toward. Also, being evaluated...[truncated]
- 15 It should not be the responsibility of Home Health Agency's alone to reduce Acute Care Hospitalization. We need to have specific guidelines for hospitals, MDs, SNFs and Home Care Agencies to work together to reduce rehospitilizations.
- 16 Keep close tabs on reported items.
- 17 [Agency wrote] No comments
- 18 [Agency wrote] No comments
- 19 Our agency benefited as we focused on reducing rehospitalizations. The staff were engaged in the process and the project expanded to the hospital and SNF settings. We collaborated through Qualidigm to reduce rehospitalization of CHF patients which had a very...[truncated]
- 20 Our agency must quickly identify the needs of each patient and communicate this information between caregiver, physician and clinical supervisors timely. This collaborative effort is imperative to ensure the patient is given the most appropriate care.
- 21 Our agency qualified for 7 P4P awards but didn't receive any money because of the methodology. We are an Illinois Agency. Very discouraging. You could see the improvement from 2008 to 2009, but we received no award.
- 22 Our agency realized that we provide a very high quality of care to our community compare to other providers.
- 23 Our participation YR1 was blind to our clinical staff. We had created best practice standards and that implementation impacted the findings with no link to P4P. YR2 staff obviously aware and we continued to strive for best practice standards with...[truncated]
- 24 P4P is a very useful tool to grade and reward top performing agencies nationwide. In this hard economic situation, it is very important for MEDICARE to try and save money to stay solvent. Our Agency has been integrating Home Health Compare and HHQI...[truncated]
- 25 Participation in the P4P helped us to evaluate our care delivery practices that impact patient care outcomes. Focusing on the patient care outcomes gave us the opportunity to change our care processes; forced us to develop specific programs.
- 26 Thank you for giving us the opportunity to participate in the survey and for rewarding us. We remain committed to providing quality care.
- 27 The agency was not informed of what kind of reward/s we had or did not have. The participation of the agency is quite helpful for us but we do need to know where, how and what we had accomplished to help us improve our services or better service to...[truncated]
- 28 The need for quality improvement measures directly affects patient outcomes and should serve as a springboard for future changes.
- 29 The prior Administrator indicated little impact, and I cannot locate documentation. In 2010, during the CMS blackout for HH Compare clinical outcomes, we have been using

SHP, Inc. to track our outcomes, including which items are expected to be P4P... [truncated]

- 30 We are an agency that conducts(ed) its practices without any changes due to our participation in the P4P program. Our practices remained the same before, during, and after the program. We evaluate our practices on a regular basis and since we ...[truncated]
- 31 We didn't receive extra help on improving our outcomes. We sent staff to educational workshops, read best practices, and worked to incorporate these practices into pt. care. We had staff turnover including the Quality coordinator/supervisor in 2009.
- 32 We found that staff education and team discussions made a significant difference. Our PI nurse had team meetings at which we would discuss patients that had frequent hospitalizations and the team identified what they could have done to prevent it.
- 33 We learned that the communication between ABT and Shay was essentially non-existent. We also learned that lack of recognition results in an "I don't care" attitude. Was made aware of results for year one from University of Colorado. No public recognition.
- 34 We learned that we needed to set a goal to achieve the outcome we want. We formed a team with all the disciplines. Our team received training in techniques and good customer services. The technique training is to maintain the program emphasizing ...[truncated]
- 35 We learned that you can have an impact on your patient outcomes if you put the focus on them. We had not consistently informed staff of our outcomes until 2008, at which time we began posting the CMS outcomes quarterly and explaining to staff what ...[truncated]
- 36 we really enjoyed the challenge. I feel like the nurses are more focused since then and I can tell a difference in the way we all think now.
- 37 We were bought out by a corporate company that came in and completely changes our practices. I cannot evaluate how change r/t to the survey has affected us, because our change did not come from the survey.
- 38 We were recognized as Homecare Elite and received a bonus for the P4P demonstration, but did not receive any information on what specifically we did to achieve the recognition or bonus. I would like to have this information to share with our staff and to know...[truncated]
- 39 We would want/need more timely information in order to develop lead measures to assure success.
- 40 With the challenges of rural healthcare:
 - a. Low education and economics of our clients
 - b. High incidence of multiple high risk comorbidities
 - c. Decreased reimbursement and visit authorizations from our payers
 - d. Patients being discharged from Acute ...[truncated]
- 41 You should provide reports of the outcomes with the P4P checks. We still have no idea in what areas we excelled or improved to receive the performance money.

All responses to Survey question: "Please use the space below to provide <u>specific advice that</u> <u>you would share with other HHAs on how to be successful if P4P becomes an implemented</u> <u>program in CY2012</u>."

(NOTE: The comments contain minor editing of participant responses to correct grammatical errors and complete sentences.)

Control Suggestions

- 1 Patient care comes first.
- 2 You have to keep moving and reach for the stars always let staff know this is a TEAM approach.
- 3 Educate, educate, educate on OASIS conventions, data items, why and how outcomes will impact the agency's status within the medical community, patients served, staff satisfaction and retention, and financial viability of the agency in the future.
- 4 Focus on patient outcomes, quality care, regulatory guidelines & patient satisfaction. Review every doc before filed in hard chart.
- 5 I will be interested to see the results of the participants in the active group. It's difficult to consistently get and keep improvement.
- 6 If patient needs an aide, probably the patient could benefit from a therapist. We focus on 'rehab'-ing the patient so that they are not dependent on an aide. ACH: We have started scheduling 4 clinician visits within the first 7 days after SOC or ROC if the patient is high risk. (NOTE: same comment as treatment agency from multi-agency group.)
- 7 Implement and maintain the highest quality standards for your agency's progress and overall patient care improvement.
- 8 Invest in quality care seminars by sending your top clinicians who are strong leaders and are able to provide in-service to your visiting staff.
- 9 Make sure you have the staff available to follow your outcomes related to P4P.
- 10 Multi factorial approach and oversight to quality indicators drilled down to clinician level. Clear thorough education for OASIS accuracy. Education to referral sources to build bridge for care transitions.
- 11 Must establish and maintain productive and effective relationships with physicians. We do this by utilizing an INTAKE nurse who meets face to face with physicians on a daily basis (M-F).
- 12 Our agency does not have the option of providing financial incentives for employees although I think that would be great. As management provide training often. Provide education at least monthly. Make it of short duration. Most important ...
- 13 Staff requires constant and continuous training and education in order to achieve CQI and higher performance in care and documentation.
- 14 We are moving toward value based / quality care systems. It is not only the right thing to do for patients, but future payment structures will be driven by outcomes and patient satisfaction. Start ASAP because it takes time, resources and many[truncated]

Non-Winner Suggestions

1 OASIS C has added a lot more time to documentation. My main concern with so much required documentation is the impact it has on patient care and the viability of home health agencies. Stay focused on patient care and satisfaction.

Winner Suggestions

- 1 Educate, educate, educate on OASIS conventions, data items, why and how outcomes will impact the agency's status within the medical community, patients served, staff satisfaction and retention, and financial viability of the agency in the future.
- 2 Designate a staff development coordinator.
- 3 a. strict compliance with the standards
 - b. strict review on oasis information before admission and discharge.
 - c. constant communication of the team
 - d. Use the best practices
 - e. Participate in seminars that could help agency improve and be updated...[truncated]
- 4 Accurate OASIS assessment is paramount. Processing of OASIS must include review with clinician to provide real time teaching regarding how to answer questions, consistency and supporting documentation
- 5 As stated during the site visit by Ms. Angela Richard.
- 6 Be patient oriented. Analysis of each patient needs and wants are very important to an efficient and effective plan of care. Front loading is beneficial only for certain patients. Quality of each visit is also very important. Listening more to the ...[truncated]
- 7 Communication is a key component to P4P: communication about P4P with staff, both field and management and finance, communication with patients about the agency on call system, agency role and purpose/goals of care, when to call the agency if there...[truncated]
- 8 Continuous oversight of QI initiatives. Keep your Eye on the Ball. Keep abreast of the best practices and implement as appropriate.
- 9 Do not wait until it is implemented. Plan ahead and implement best practices now.
- 10 Follow CMS OASIS guidance (and changes), train/retrain adult learners often, and provide timely QM oversight to question OASIS answers inconsistent with clinical documentation. Rushed clinicians can inadvertently lower scores by not reading a question....[truncated]
- 11 Front loading visits and using the telemonitors made a significant difference.
- 12 If patient needs an aide, probably the patient could benefit from a therapist. We focus on 'rehab'-ing the patient so that they are not dependent on an aide. ACH: We have started scheduling 4 clinician visits within the first 7 days after SOC or ROC if the patient is high risk. (NOTE: same comment as control agency from multi-agency group.)
- 13 Increase staff education on the importance of OASIS accuracy. Evaluate for disease management programs.
- 14 Involve staff at all levels. Keep staff informed throughout the process and of the overall results. By engaging all staff through the early process, the momentum will move forward to keep the initiatives of the program moving forward well past ...[truncated]
- 15 It takes work, but it is worth it
- 16 Keep your eye on the reason for the P4P program which is patient care. Do not become so form or another assessment challenged that you forget that the reason you are there is to provide excellent Home Health care to the patient.
- 17 Look at each element from a global perspective in order to identify structural opportunities.

- 18 Make sure staff know how they and the agency are being rated on each reported item.
- 19 Make sure you have knowledge of how and why you received the P4P money.
- 20 [Agency wrote] No comments
- 21 [Agency wrote] No comments
- 22 OASIS training is a must!!!!
- 23 QI staff needs to provide regular classes on interpretation of OASIS questions especially with OASIS-C. Staff needs to be sent to workshops on improving disease management. All management staff must work together to improve the quality and safety outcomes.
- 24 Regularly communicate with staff on strategies and actions, then communicate the same information twice more.
- 25 Staff participation and engagement is key. Once the staff understand the impact they can have on outcomes, it becomes much easier to achieve success.
- 26 TEAMWORK, DEDICATED STAFF AND CONTINUOUS EDUCATION PROGRAM TO ALL STAFF.
- 27 Technology, Technology, Technology
- 28 The philosophy of the organization trickles down to the team partners who are the front end of the care and services. The senior management must be willing to invest in our partners (staff, patient, referral sources) involved in the change process.
- 29 Need to form some sort of high risk calls on high risk patients. It has helped us in the past few years keeping patients out of the hospital. We call all of our high risk patients 2x a week regardless of what is going on and it has really showed a difference. We will continue...[truncated]
- 30 We have had a lot of success in the past 2 1/2 years with our outcomes. I attribute that to an increased awareness of the NEED to improve our outcomes. My agency allocated resources for SHP and an additional Quality Coordinator to put the focus on...[truncated]
- 31 We recommend to Clinicians to see the patient as soon as possible after hospital discharge, focus on medications, obtaining thorough history/physical, front-load visits for all patients as well as initiate rehab as soon as possible to implement fall risk...[truncated]
- 32 Weekly team conferences involving all disciplines involved in the patient care. Home supervisory visit with staff present (SN/CHHA/PT etc.). Provide frequent in-service and training. Extensive new employee orientation/training. Provide continuity in patient...[truncated]
- 33 Work to change the methodology so that all agencies receive incentives whether or not the control group showed improvement as well. How can you incentivize agencies if they don't get rewarded because of your payment methodology?
- 34 You need to determine your goal, how you plan to accomplish it and then track performance closely, communicate frequently your progress to goal and tie outcomes to individual performance goals.