Certificate

Of

Need

Response to Questions III

Application

For

Hospice

Prince George's County

Submitted by:

P-B HEALTH

Home Health Care, Inc.

March 3, 2017

Preface

We, at **P-B Health** have structured this document to be responsive and organized for easy reference. **The Certificate of Need Response to Questions for Prince Georges County documents is as follow:**

Table of Contents

Project Budget

Part III – Consistency with Review Criteria at COMAR 10.24.01.08G (3)

Part IV –, Authorization and Signature

Hospice Application: Charts and Tables Supplement

References

Appendix H - **Exhibits 3 & 6 (previous exhibits)** and 1

Appendix I - Exhibits 2 & 4

While reading this document, you will find that **P-B Health's Response** is in **bold.** This indicates that the answer to the question posed will follow.

Table of Contents 3
Project Budget 4
Application Tables 4
Quality 5
Need 5
Viability 8
Hospice Application: Charts and Tables Supplement 10
Hospice Application Revised Charts and Tables Supplements 10
Table 2B: Statistical Projections-Proposed Project 10
Table 4: Revenue and Expenses-Proposed Project 10
Table 5: Manpower Information 10
TABLE 2B: STATISTICAL PROJECTIONS - PROPOSED PROJECT 15
TABLE 4: REVENUES AND EXPENSES - PROPOSED PROJECT 16
TABLE 5: MANPOWER INFORMATION 19
REFERENCES 21
APPENDIX H 22
APPENDIX I 32

MARYLAND HEALTH CARE COMMISSION

16-16-2385

MATTER/DOCKET NO

DATE DOCKETED

APPLICATION FOR CERTIFICATE OF NEED Responses to Prince Georges County, Maryland Questions: HOSPICE SERVICES

Project Budget

1. The re-submitted Table 1 showed a corrected Total Sources of Funds that equaled the Total Uses of Funds; however, the source of those funds was not shown. Please submit a corrected Table 1.

   P-B Health's Response:

   The total source of funds has been corrected as the Owner of P-B Health. **See Table 1 under number 9 (Owner). Hospice Charts and Tables.**

Application Tables

2. In response to staff's question about the impact the current hospice programs already in existence in Prince George's County if and when P-B Health entered the market (serving a projected 50, 150, 450, and 600 patients in the first four years), P-B Health reduced those projections to 50, 75, 113, and 169 for those four years, and called any impact that might cause "nominal." Because of these revised volume projections, P-B Health submitted revised application Tables. However, those resubmitted tables carried some apparently inconsistent projections, i.e.:
   - Despite the reduced hospice admissions, the modified projected average daily hospice census was the same in each of the original and modified tables (2B);

     P-B Health's Response:

P-B Health has made the modifications for projected average daily hospice census in Table 2B. Please see Hospice Charts and Tables.

- Similarly, the *visits by discipline* were the same in each of the original and modified tables;

  P-B Health's Response:

  P-B Health has made the modifications for *visits by discipline* in Table 2B. Please see Hospice Charts and Tables.

- The nursing staff in the original Table 5 was 14; in the resubmitted Table 5 it was 2…there were other differences between the respective staffing tables that do not seem logical. Please explain and correct and resubmit any tables that need correction.

  P-B Health Response:

  P-B Health has made the modifications in Table 5 Manpower and Table 4: Revenues and Expenses-Proposed Project along with explanation. Please see Hospice Charts and Tables.

Quality

3. Following up on your response to question 18 -- regarding P-B Health's ability to build a QAPI that meets the requirements of COMAR 10.07.21.09 – staff has adapted the survey tool used by the Office of Health Care Quality to make such an assessment and created a form that will facilitate your ability to show that your policy will conform. That form is attached. As its instructions direct, cite the section of your QAPI and specific language that addresses the required QAPI content.

   P-B Health Response:

   See attached QAPI Policy Appendix (H) exhibit (1)

Need

4. Part b of question 20 from our initial completeness letter stated: *The response lists a variety of facts and statistics but does not weave them into a theme or main point. Please restate the points being made regarding demographic and other statistics that are mentioned. As another example, Exhibits 3 and 6 are included, but not spoken about or*

referenced in the text, leaving staff to have to infer their purpose and/or significance. You have still not made the point you are hoping to make, and we are offering another opportunity to state what conclusion you draw from the statistics being quoted. Similarly, part d of that question asked for a restatement of the point you were driving at; your response still leaves that unclear.

P-B Health Response:

b. The projected need for 2018 is 662 patients. Prince Georges County is the second largest county in MD divided into five sub regions. Exhibit 3 indicates hospices that have the authorization in the jurisdictions but were not able to keep up with the growing population/and or was not able to service in the jurisdictions due to demographics. Socioeconomic, uninsured, underserved communities, and patients and family not aware of Hospice programs and its benefits.

The following Table shows that the residents of Prince George's County have a substantially lower use rate for hospice care than the aggregate use rate for residents of all the counties in Maryland.

Table A
Population by Age
Hospice Patients by Age
Use Rates/1,000
Prince George's County and All Counties
2014

	Age 0 to34	Age 35-64	Age 65-74	Age 75-84	Age 85+	Total
Prince George's County						
2014 Hospice Clients	23	402	384	493	601	1,903
2014 Population	441,814	351,626	61,770	26,677	9,868	891,755
2014 Use Rate/1,000	0.05	1.14	6.22	18.48	60.91	2.13
All Counties						
2014 Hospice Clients	184	3,306	3,540	5,362	8,596	20,988
2014 Population	2,739,895	2,406,664	468,977	230,404	109,592	5,955,532
2014 Use Rate/1,000	0.07	1.37	7.55	23.27	78.44	3.52

Source: Population: Maryland Department of Planning, (http://www.mdp.state.md.us/msdc/popproj/TotalPop_Cntr0514V2_W0714RaceShares_Selected.xls), Accessed on 2/28/17. 2014 population was calculated using the CAGI between MDP projections for 2010 and 2015.
Hospice Client: MHCC Public Use Data, 2014, Patient_Demographics_Age

These data are consistent with the studies cited in P-B's response to the original Completeness question 20b, which demonstrate that significantly more focus must be placed on educating and reaching out to the African-American community. This is

particularly true in Prince George's County, where, according to Maryland Department of Planning population data show that the 2015 non-"White Alone" population makes up approximately 86% of the population. (900,348 Total Population - 127,413 Total White Alone = 772,935 Total All Other; 772,935/900,348 = 0.8585)[1] Given both the findings in the studies cited in the original Completeness response and the demographics of Prince George's County, it is not surprising that the hospice use rate in Prince George's County trails the rest of the state.

The State Health Plan section on Hospice recognizes this disparity. On page 4 of COMAR 10.24.13, it states:

> The use of hospice services nationally and within Maryland varies by population groups. It has been shown that some individuals and groups are reluctant to access hospice services based on religious, ethnic, cultural and other factors.

These outcomes play a major part in the growing need for additional healthcare interventions and services in Prince Georges County.

In addition, the Maryland Department of Planning projects that the non-White population in Prince George's County will grow considerably more than the White population between 2015 and 2020.

Table B
Population Age 65+
By Race
Prince George's County
2015 and 2020

	2015	2020	% Change '15-'20
Total	103,364	123,807	19.8%
Total White Alone	27,605	29,547	7.0%
Total All Other	75,759	94,260	24.4%

Source: Population: Maryland Department of Planning, (http://www.mdp.state.md.us/msdc/popproj/TotalPop_Cntr0514V2_W0714RaceShares_Selected.xls), Accessed on 2/28/17.

Therefore it is critically important to address the disparities in use of hospice care by African American and other populations, as evidenced by the citations P-B Health provided. Otherwise, the disparity will only increase over the years.

[1] http://www.mdp.state.md.us/msdc/popproj/TotalPop_Cntr0514V2_W0714RaceShares_Selected.xls

Table B shows the population within Prince Georges County, Maryland. P-B Health Hospice role as a community health organization is to educate, teach, and serve these communities by working with church organizations, HBCU, Sororities, Hispanic and Latino Community Centers, and the NHPCO (National Hospice and Palliative Care Organization, Social Service Centers, Veteran Administration, and Radio Stations to continuously help support and meet these needs. As a minority owned health care provider that has experience working with the African American community in Baltimore, P-B Health's focus on addressing this disparity and will outreach to the African American and other minority communities in Prince George's county.

d. Exhibit 6 "How Does Hospice Use Vary by Urban/Rural Location?" is based on the Medicare Payment Report to Congress March 2016. This report indicated from 2000 to 2014 urban locations which included Prince George's County amongst other counties in the state of Maryland increased in hospice services from 24.3% to 48.6% which doubled in hospice beneficiaries under Medicare. These data indicate the need for additional Hospice Programs in Prince Georges County.

Viability

5. Question 22a) in our first completeness letter requested audited financial statements, which P-B has indicated it does not have. The Viability criterion in the CON application offers applicants an alternative, which P-B should provide: *In the absence of audited financial statements, provide documentation of the adequacy of financial resources to fund this project signed by a Certified Public Accountant who is not directly employed by the applicant.*

   P-B Health's Response:

   Please see letter of adequacy of financial resources to fund this project signed by a Certified Public Accountant who is not directly employed by the applicant. **Appendix I, exhibit 4**

6. Given P-B Health's marginal financial performance shown in 2014 and 2015, please submit financial statements for 2016. As you chose to do for 2014 and 2015, you may also provide a copy of tax form 1120 if/when it is available if you feel that that provides a more accurate or favorable picture.

   P-B Health's Response:

   As the 2014 and 2015 tax material that was previously submitted show, P-B Health operates on a calendar year basis. Hence, the 2016 calendar year ended only two months ago. P-B Health has submitted all of its 2016 financial records to its accountant, and the 2016 financial statements are not yet available. P-B Health respectfully suggests that no health care facility

could provide financial statements only two months following the end of its fiscal year. **P-B Health is willing to provide its financial statements for 2016 as soon as they are available,** which, according to our accountant, will be around **April 15, 2017**

However, please see the letter from Ron Katzen, CPA attesting that P-B Health has the financial resources to implement this project which is responding to Completeness **question 5**.

Further, P-B Health opened in 1987 providing home care services and expanded as a Medicare and Medicaid certified home health agency in Baltimore City in 1994 operating for approximately 30 years in serving Baltimore City residents (and particularly the African American community). It is owned by the Bailey family, who provide the care that is needed without looking to maximize profit. Notwithstanding, P-B Health has an established 30 year record of being a stable, financially viable provider.

Hospice Application Revised: Charts and Tables Supplement

TABLE 1 - PROJECT BUDGET

TABLE 2B: STATISTICAL PROJECTIONS – PROPOSED PROJECT

TABLE 4: REVENUES AND EXPENSES - PROPOSED PROJECT

TABLE 5: MANPOWER INFORMATION

TABLE 1: PROJECT BUDGET

P-B HEALTH'S RESPONSE:

INSTRUCTIONS: All estimates for 1.a.-d., 2.a.-j., and 3 are for current costs as of the date of application submission and should include the costs for all intended construction and renovations to be undertaken. (DO NOT CHANGE THIS FORM OR ITS LINE ITEMS. IF ADDITIONAL DETAIL OR CLARIFICATION IS NEEDED, ATTACH ADDITIONAL SHEET.)

A. Use of Funds

1. Capital Costs (if applicable):

a.	New Construction **(N/A)**	$_____
(1)	Building	_____
(2)	Fixed Equipment (not included in construction)	_____
(3)	Land Purchase	_____
(4)	Site Preparation	_____
(5)	Architect/Engineering Fees	_____
(6)	Permits, (Building, Utilities, Etc)	_____

SUBTOTAL $_____

b. Renovations **(N/A)**

(1) Building $_____

(2) Fixed Equipment (not included in construction) _____

(3) Architect/Engineering Fees _____

(4) Permits, (Building, Utilities, Etc.) _____

SUBTOTAL $_____

c. Other Capital Costs **(N/A)**

(1) Major Movable Equipment _____

(2) Minor Movable Equipment _____

(3) Contingencies _____

(4) Other (Specify) _____

TOTAL CURRENT CAPITAL COSTS $_____

(a - c)

d. Non Current Capital Cost **(N/A)**

(1) Interest (Gross) $_____

(2) Inflation (state all assumptions, Including time period and rate) $_____

TOTAL PROPOSED CAPITAL COSTS (a - d) $_____

2. Financing Cost and Other Cash Requirements:

a. Loan Placement Fees $ 0

	b.	Bond Discount	0	
	c.	Legal Fees (CON Related)	2,500.00	
	e.	Printing **(in house)**	0	
	f.	Consultant Fees		
		CON Application Assistance	5,000.00	
		Other (Specify)	0	
	g.	Liquidation of Existing Debt	0	
	h.	Debt Service Reserve Fund	0	
	i.	Principal Amortization		
		Reserve Fund	0	
	j.	Other (Specify)	0	
		TOTAL (a - j)	$7,500.00	
3.		Working Capital Startup Costs	$0	
		TOTAL USES OF FUNDS (1 - 3)		$7,500.00

B. Sources of Funds for Project:

1.	Cash	0
2.	Pledges: Gross _____, less allowance for uncollectables _____ = Net	0
3.	Gifts, bequests	0
4.	Interest income (gross)	0
5.	Authorized Bonds	0
6.	Mortgage	0

7.	Working capital loans	0
8.	Grants or Appropriation	
	(a) Federal	0
	(b) State	0
	(c) Local	0
9.	Other (Specify)	0

TOTAL SOURCES OF FUNDS (1-9) (Owner) $ 7,500.00

Lease Costs:

a. Land	$_____ x _____	= $ 0
b. Building	$_____ x _____	= $ 0
c. Major Movable Equipment	$_____ x _____	= $ 0
d. Minor Movable Equipment	$_____ x _____	= $ 0
e. Other (Specify)	$_____ x _____	= $

TABLE 2B: STATISTICAL PROJECTIONS – PROPOSED PROJECT

P-B HEALTH'S RESPONSE:

	Projected years – ending with first year at full utilization			
CY or FY (circle)	2018__	2019__	2020__	2021__
Admissions	50	75	113	169
Deaths	40	60	90	135
Non-death discharges	4	6	9	14
Patients served	46	69	104	155
Patient days	960	1412	2061	2944
Average length of stay	20.9	20.5	19.9	19.0
Average daily hospice census	8	12	18	27
Visits by discipline				
Skilled nursing	1137	1705	2556	3837
Social work	91	136	205	307
Hospice aides	168	252	378	567
Physicians - paid	0	0	0	0
Physicians - volunteer	5	8	12	18
Chaplain	79	119	178	267
Other clinical	204	306	459	713
Licensed beds				
Number of licensed GIP beds	0	0	0	0
Number of licensed Hospice House beds	0	0	0	0
Occupancy %	0	0	0	0
GIP(inpatient unit)	0	0	0	0
Hospice House	0	0	0	0

TABLE 4: REVENUES AND EXPENSES - PROPOSED PROJECT

P-B HEALTH'S RESPONSE:

(INSTRUCTIONS: Each applicant should complete this table for the proposed project only)

	Projected Years (ending with first full year at full utilization)			
CY or FY (Circle)	2018___	2019___	2020___	2021___
1. Revenue				
a. Inpatient services **(Respite)**	25,000	37,500	56,250	84,375
b. Hospice House services	0	0	0	0
c. Home care services	235,000	352,500	528,750	793,125
d. Gross Patient Service Revenue	310,000	465,000	697,500	1,046,250
e. Allowance for Bad Debt	(2,350)	(3,525)	(5,288)	(7,931)
f. Contractual Allowance	(50,000)	(75,000)	(112,500)	(168,750))
g. Charity Care	(7,650)	(11,475)	(17,213)	(25,819)
h. Net Patient Services Revenue	250,000	375,000	562,500	843,750
i. Other Operating Revenues (Specify)	0	0	0	0
j. Net Operating Revenue	250,000	375,000	562,500	843,750
2. Expenses				
a. Salaries, Wages, and Professional Fees, (including fringe benefits)	200,400	300,600	450,900	676,350
b. Contractual Services	20,000	30,000	45,000	67,500
c. Interest on Current Debt	0	0	0	0
d. Interest on Project Debt	4,630	6,945	10,418	15,626
e. Current Depreciation	0	0	0	0

f. Project Depreciation	0	0	0	0
g. Current Amortization	0	0	0	0
h. Project Amortization	1,500	2,250	3,375	5,063
i. Supplies	10,000	15,000	22,500	33,750
j. Other Expenses (Specify)**rent, comm.,ins., and taxes**	22,500	33,750	50,625	75,938
k. Total Operating Expenses	259,030	388,545	582,818	874,226
3. Income				
a. Income from Operation	(9,030)	13,545	20,318	30,476
b. Non-Operating Income	0	0	0	0
c. Subtotal	(9,030)	13,545	20,318	30,476
d. Income Taxes	0	(3,386)	(5,079)	(7,619)
e. Net Income (Loss)	(9,030)	10,159	15,238	22,857

Table 4 Cont.	**Projected Years (ending with first full year at full utilization)**			
CY or FY (Circle)	2018___	2019___	2020___	2021
4. Patient Mix				
A. As Percent of Total Revenue				
1. Medicare	70%	73%	75%	76%
2. Medicaid	10%	10%	12%	12%
3. Blue Cross	5%	4%	4%	3%
4. Other Commercial Insurance	13%	11%	7%	7%

6. Other (Specify)	2%	2%	2%	2%
7. TOTAL	100%	100%	100%	100%
B. As Percent of Patient Days/Visits/Procedures (as applicable)				
1. Medicare	60%	62%	64%	65%
2. Medicaid	18%	18%	20%	20%
3. Blue Cross	5%	4%	4%	3%
4. Other Commercial Insurance	14%	13%	9%	9%
5. Self-Pay	3%	3%	3%	3%
6. Other (Specify)	0	0	0	0
7. TOTAL	100%	100%	100%	100%

TABLE 5. MANPOWER INFORMATION

INSTRUCTIONS: List by service the staffing changes (specifying additions and/or deletions and distinguishing between employee and contractual services) required by this project. FTE data shall be calculated as 2,080 paid hours per year. Indicate the factor to be used in converting paid hours to worked hours

Position Title	Current No. FTEs	Change in FTEs (+/-)	Average Salary	Employee/ Contractual	TOTAL COST
Administration					
Administration	.2	.5	45,000	Employees	24,300
Direct Care					
Nursing	0	.8	60,000	Employees	43,008
Social work/services	0	.4	50,000	Employees	18,000
Hospice aides	0	1.2	30,000	Employees	32,400
Physicians-paid	0	0	0	Contractual	0
Physicians-volunteer	0	.04	300,000	Contractual	5,781
Chaplains	0	.2	45,000	Contractual	8,671
Bereavement staff	0	.6	45,000	Employees	34,400
Other clinical	0	.3	0	Both E/C	28,800/1,927
Support					
Other support	0	.04	188,000	Contractual	3,621
				Benefits*	**21,492**
				TOTAL	**220,400**

* Indicate method of calculating benefits cost

Based on current Home Health payroll for staff as listed above using Quickbooks. Benefits represent an Additional 12% added cost. (All employee's payroll taxes plus PTO and Health Benefits)Other Clinical represents Therapy Services. The Therapies are Physical, Occupational, And Speech Therapy. Speech Therapy is provided by a non-employee or contractor. The Therapy services provided by employees is costed at $28,800 and the Therapy service by the Contractor is $1,927. The total cost associated with employees and contractors is $200,400 Where $178,908 is salary and $21,492 is benefits. The Total cost associated with contractors Is $20,000.

Updated June 2016.

REFERENCES

Source: Population: Maryland Department of Planning, (http://www.mdp.state.md.us/msdc/popproj/TotalPop_Cntr0514V2_W0714RaceShares_Selected.xls), Accessed on 2/28/17. 2014 population was calculated using the CAGI between MDP projections for 2010 and 2015.

Source: Population: Maryland Department of Planning, (http://www.mdp.state.md.us/msdc/popproj/TotalPop_Cntr0514V2_W0714RaceShares_Selected.xls), Accessed on 2/28/17.

The State Health Plan section on Hospice recognizes this disparity. On page 4 of COMAR 10.24.13

Hospice Client: MHCC Public Use Data, 2014, Patient_Demographics_Age

Maryland Health Care Commission (presentation on hospice Linda Cole)

APPENDIX H

Appendix H

Exhibit 1 – QA/IP

Exhibit 3 - Where do Hospices Provide Care?

Exhibit 6 - How Does Hospice Use Vary By Urban/Rural Location?

Appendix I

Exhibit 2 – signed affirmations

Exhibit 4 - Letter of financial viability

Exhibit 3 (previous exhibit)

Where do Hospices Provide Care?

- 7 hospices provided services to less than 10 clients in authorized jurisdictions

- 17 instances where jurisdictions have at least one authorized provider with no substantial level of service provided

- One hospice served 2 out of 8 jurisdictions authorized; one served 2 out of 7 jurisdictions authorized

Exhibit 6 (previous exhibit)

How Does Hospice Use Vary by Urban/Rural Location?

Variable	2000	2011	2012	2013	2014
All Beneficiaries	22.9%	45.2%	46.7%	47.3%	47.8%
Location					
Urban	24.3%	46.6%	48.0%	48.5%	48.6%
Micropolitan	18.5%	41.4%	43.4%	44.3%	44.7%
Rural Adjacent to Urban	17.6%	40.2%	42.2%	42.9%	43.2%
Rural, nonadjacent to urban	15.8%	35.9%	37.7%	38.0%	38.7%

Source: Report to Congress: Medicare Payment Policy, March 2016
Note: Allegany, Anne Arundel, Baltimore, Baltimore City, Calvert, Carroll, Cecil, Charles, Frederick, Harford, Howard, Montgomery, Prince George's, Queen Anne's, St. Mary's, Somerset, Washington, Wicomico, Worcester are classified as urban. Dorchester and Talbot are classified as micropolitan. Caroline, Garrett, and Kent are classified as rural adjacent to urban.

Exhibit 1

Quality Intervention Improvement Plan

Policy

Quality Intervention Improvement Plan

Procedure

Program Objectives (COMAR 10.07.21.09C (1-6)

1. To provide high quality hospice services which meet Medicare Conditions of Participation, State licensure and JCACO home care standards.
2. To improve internal and external communication systems among the staff of the agency, with clients, and with referral sources.
3. To establish and maintain a program of monitoring, implementation, and evaluation in anticipation of continual improvement.
4. To monitor the provision of patient care and patient outcomes, provided by Registered Nurses, Licensed Practical Nurses, and Hospice Health Aides, Physical, Occupational and Speech Therapist, and Medical Social Workers to ensure that high quality, efficient services are provided, with minimal risk to the client.
5. To identify deficiency/problem areas in the delivery of patient care services, and to develop appropriate strategies to improve or resolve them.
6. To monitor client satisfaction with services to ensure that needs are being met.
7. To monitor continuity of care between disciplines (i.e. full-time, part-time, and contract staff) and to monitor continuity of care among care providers, so that there are no gaps or delays in care provision.
8. To monitor personnel hired by P-B Health and to evaluate their performance in the provision of patient care.

Program Goals **(COMAR 10.07.21.09 C,D,(2,3)**

1. To ensure compliance with regulatory and accreditation agencies with minimal areas of deficiency in service delivery.
2. To improve communication systems among staff, through the quality intervention process and specific action taken.
3. To ensure continual improvement in all aspects of care delivery.
4. To foster the provision of high quality, efficient home/hospice care services by all disciplines, with few deficient areas.
5. To provide opportunities that will take specific action to improve areas of deficiency in the delivery of high quality services to clients.
6. To show high patient satisfaction with services provided and to identify areas where improvement is needed.
7. To keep unusual occurrences, incidents, and events at a minimum.
8. To make recommendations and take action related to improved safety; educational programs for staff and or clients, and improve delivery of client services. This is a result of quality intervention and improvement activities.
9. To make recommendation and take actions which result in improved continuity of care among all disciplines and providers.
10. To improve monitoring of personnel and provide opportunities to identify areas that need improvement in terms of performance of job responsibilities.

Responsibility and Authority COMAR 10.07.21.09 D (4)

The participation of the management staff (Agency Administrator), the clinical staff (Clinical Managers of Clinical Service), and support staff is essential to the successful implementation of an effective quality improvement system. Each level of staff is included in some aspect of comprehensive (QA/PI) Quality Assurance and Performance Improvement program. Clinical and management staff participates in the identification of Important Aspects of Care, Indicator Development and Monitoring, Internal Clinical Record Reviews, and Issue Improvement Plans. **The Quality Assurance and Performance Improvement Staff Nurse, is responsible for assessing, planning, implementing, and evaluating the Quality Intervention/Performance Improvement program.** The Quality Assurance and Performance Improvement Staff Nurse is also responsible for arranging QA/PI Committee Meetings, preparing QA/PI Reports, and ensuring that

appropriate actions are taken, based on recommendations and findings of the QA/PI program activities. Additionally, the Quality Assurance and Performance Improvement Manager is responsible for educating all staff members about the QA/PI program, and their roles and responsibilities related to QA/PI. Non-clinical staff is responsible to participate in data collection, issue improvement plans, preparation of Quality Assurance Committee minute, reports, projects and tools.

COMAR 10.07.21.09 A & B & COMAR 10.07.21.09 E

The Board of Directors has the final authority and responsibility for the ongoing, comprehensive and integrated Hospice Quality Intervention Program. Quality Assurance and Performance Improvement Reports will be presented to the Board annually. All Quality Interventions and Improvement activities are summarized in this report, as well as results of all monitoring activities. The Board delegates authority of the implementation of the QA/PI Program through the Quality Assurance and Performance Improvement Manager, who ultimately is responsible to the Administrator.

The Quality Assurance and Performance Improvement Committee meets at least quarterly to review all QA/PI findings; have outcomes and results that are measurable and which may be incorporated into complete changes in the programs operation, and to make recommendations regarding all quality interventions and improvement activities.

Follow-up reports and recommendations from the QA/PI Committee are made available to all staff members, through memos and monthly staff meetings. Specific recommendations regarding deficient service areas will go directly to the Clinical Managers.

Quality Assurance and Performance Improvement Committee Quality Assurance and performance Improvement Committee

The Quality Assurance and performance improvement Committee has been established for the purpose of reviewing all of the QA/PI activities of the agency, and participating in monitoring activities, as previously outlined.

The Committee consists of representatives from the management and clinical staff, with input from all disciplines, and departments as appropriate.

The Quality Assurance Nurse is chairperson for this committee, and is designated by the Agency Administrator (AA). Meetings are held at least quarterly, where results of QA/PI activities are reported. Minutes for these meetings are kept on file in the office.

Committee Members (COMAR 10.07.21.09D(4)

CEO or her designee

QA/PI Nurses

Clinical Managers

Agency Administrator

Other Agency Representatives as needed

Monitoring of Important Aspects of Hospice Care (COMAR 10.07.21.09C (2) (3)

Monitoring of Important Aspects of Care is a major component of the Quality Assurance and Performance Improvement Program. The following important aspects of care have been identified, and have been prioritized. They have been chosen based on the fact that they are important aspects of Hospice Care.

Service Specific Aspects of Care

1. High Quality Patient Care Planning/Skilled Hospice Nursing Service
2. Provision of Comprehensive Personal Care Service for palliative/hospice
3. Provision of Comprehensive Rehabilitation Services, with adequate and appropriate patient care planning when needed (high volume)
4. Wound Care Management (high volume)
5. Safety Management in the Home by the Hospice Care Personnel

Other Areas:

1. Patient Satisfaction (high volume)
2. Patient Incident & Complaint issue (high volume)
3. HIS
4. CAHPS

Other Important aspects of care to be monitored:

1. Compliance with Infection Control Procedure
2. Interdisciplinary Communication
3. Medication Administration PROCEDURES
4. Skin Care Management

Indicator Development COMAR 10.07.21.09D (3)

The evaluation and monitoring of activity P-B Health Hospice Quality assurance Performance and Improvement Plans begin with the development of indicators from the Important Aspects of Care. (See Monitoring and Evaluation of Important Aspects of Care). We have identified a number of important aspects of care and will focus on each area as indicated above. Indicators, and other Quality Intervention and Improvement Activities that are monitored regularly are done so according to a continuous evaluation time line.

When an area is identified as needing improvement, an Issue Improvement Plan is developed. These problematic issues are identified through indicator analysis, quarterly utilization review findings, and through clinical record reviews, and other related Quality Assurance Intervention and Improvement Activities. However, issues may also be identified through other committee meetings, management or staff meetings. Issue improvement plans may lead to the development of other Important Aspects of Care, with subsequent indicator development. The Quality Assurance Intervention and Performance Improvement Issue Tracking Sheet identify areas of improvement, actions to be taken, responsible parties and follow-up as stated.

The Quality Assurance Intervention and Performance Improvement Committee receive a Report of Issue identification, progress, and resolution at their quarterly meetings. Quality Intervention and Improvement reports are presented to the

Professional Advisory Committee quarterly. In addition, The Board of Directors will receive a report at least annually of the Quality Assurance Intervention and Performance Improvement findings, action taken, and follow-up of actions taken.

Sources for evaluation include:

- Retrospective and concurrent chart reviews
- Patient Satisfaction Surveys
- Information collected on home hospice visits and on home hospice aide supervisory visits
- Incident Reports

Internal Clinical Record Review Audits:

Admission Audits

The admissions audit consists of a thorough review of all initial paperwork submitted by the admitting discipline. The purpose of this audit is to determine if the admission is appropriate to fit the level of hospice care being provided and if the admission has been done according to agency policy. This audit also focuses on the adequate completion of the Physicians Plan of Treatment. The POT/worksheet, the OASIS SOC Assessment Tool, and the Medication Record. An Admission Audit Review tool is used for this purpose, with findings reported back to the primary nurse on the case. The Clinical Manager ensures that all deficiency areas are corrected within 48-72 hours, and notes correction dates on the audit tool. The QA nurse will review the completed admission review tools and work with the Clinical Managers to provide documentation in-services as needed.

APPENDIX I

I hereby declare and affirm under the penalties of perjury that the facts stated in this application and its attachments are true and correct to the best of my knowledge, information and belief.

_____

Signature of Owner or Authorized Agent of the Applicant

_____

Print name and title

Date:_____

RONALD M. KATZEN, CPA

101 Schilling Road, Suite 30 • Hunt Valley, Maryland 21031 • Direct Line 410-852-1861

March 2, 2017

Mr. Kevin McDonald, Chief
Certificate of Needs Division
Center for Health Care Facilities
Planning & Development
Maryland Health Commission

Cc: Mr. Andrew L. Solberg
A.L.S. Health Care Consultant Services
5612 Thicket Lane
Columbia, MD 21044

Dear Mr. McDonald,

My name is Ronald Katzen. I am a CPA that has done consulting for P-B Health Home Care Agency for over 20 years. I am a member of a very special committee at P-B Health called the Professional Advisory Committee. They meet quarterly and discuss the important issues that are going on in the home health care industry. After the group introduces themselves and overviews are given about the state of company, the head of the Nursing Division gives a detailed analysis of the company's survey response in comparison to all other home health care agencies. This is taken very seriously and compared from one meeting to the next if there have been improvements. The biggest part of the meeting deals with the number of patients that have fallen down. This is an important discussion at every meeting. At the last meeting on February 10th, there was a list a 10 items that rank the persons chance of falling. It was very informative to the group of medical and accounting people that were in the meeting. After the health part of the meeting, we split into 2 groups, accounting and medical. The member of the Finance Committee reviews the budget and actual income statements that are prepared by Mr. Bailey. Questions about the budget are discussed and all of my questions are answered about payroll taxes and interest expense, etc.

Mr. Bailey is a hands-on CFO. He is very open with his accounting information. A gentile man with a wealth of knowledge, financially and legally. The company is very paper oriented, with a large paper trial. I remember at a recent Finance Committee meeting we tried to eliminate paper. Every employee put their agenda on the overhead projector. That did not last long and it was back to paper right after that.

The Baileys treat you like family and have a very special group of employees. In their history they have needed some help with bookkeeping as Mr. Bailey takes a lot of responsibility and is maxed out by his work load. He is a very straight shooter that never loses his temper. On the accounting side, I have assisted the company over the years verifying all of the bank statements and continue to do so. My main focus is reviewing monthly bank statements and comparing the direct deposit reports to the general ledger. My

other focus is reviewing the company's expenses from month to month along with year end expense analysis. I have compiled financial statements before the CPA firm of Moses Alade and Company came on board around 6 years ago. This was a great move when the outside CPA firm came on board. They have taken a lot of pressure off of the rather small accounting staff. The Medicare Cost Report is maintained and done in a timely manner. They also post the deposits and help maintain the payroll and operating accounts. P-B Health is very fast in paying all of their vendors.

As we move down the road with P-B Health, this company has the second generation involved in the business as well. Donald Green, Mrs. Bailey's son, is heavily involved in the business. He has been in the company for many years and has taken over many of the leadership roles.

In concluding I would like to say that the company has grown slowly over the years and has been financially sound. They are now ready to take the next step.

Sincerely,
Ronald Katzen CPA

Ronald Katzen CPA

Ronald Katzen
101 Schilling Rd. Suite # 30
Hunt Valley, Md. 21031
ronkatzen@hhladv.com
410-852-1861