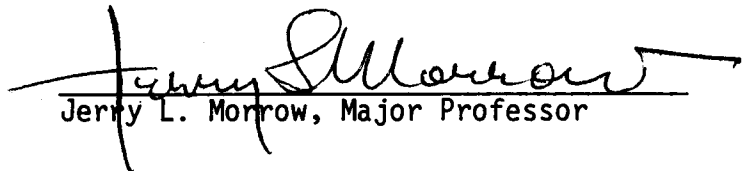
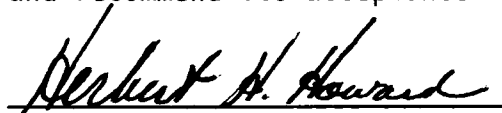


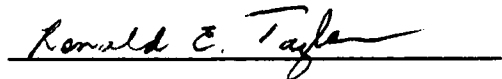
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COMMUNICATION TECHNIQUES AND PRACTICES OF HOME HEALTH AGENCIES OF
TENNESSEE ASSOCIATION FOR HOME HEALTH--REGION II

A Thesis
Presented for the
Master of Science
Degree
The University of Tennessee, Knoxville

Richard A. Ballenger

June 1985

DEDICATION

To my family which has supported me all-the-way!

To wife Barbara, who has not once complained about "supporting us" while I pursued educational goals.

To son Rick, who has shouldered responsibilities and "chores" so that I could have the time to study.

To daughter Wendy, whose pride and love have been evident and helped lift me over the barriers.

To God, who gave me the direction, talent, and desire. And, who has made this a wonderful family experience.

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David Baker--St. Mary's Home Health Care

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The author would especially like to thank Gayla Sasser, Executive Director of the Tennessee Association for Home Health, for her assistance and guidance. Appreciation also goes to Mary Mincey and Larry Boles of the Regional Public Health Office (Tennessee) for their contributions.

To Region II, Tennessee Association for Home Health Board of Directors, president, Linda Steele, and past-president,

Carolyn Connell, my sincere appreciation for their endorsement of the study.

ABSTRACT

This case study is an examination of the communication techniques and practices of the home health agencies in Region II, Tennessee Association for Home Health. Region II consists of 16 counties and is located in mid-eastern Tennessee--the greater Knoxville area--and the 15 surrounding counties.

The purpose of the study was to (1) identify the publics of the home health agencies, (2) examine the vehicles used in communication with these publics, and (3) seek the agency directors' opinions and attitudes concerning their publics and the communication efforts they are currently using. Because the home health care agencies sampled were diversely structured--hospital based, national chain branch offices and local proprietaries--it is believe that the findings of this study can be applied in all agencies of the Tennessee Association for Home Health. In addition, this study was intended as a benchmark for future, more comprehensive research in this area. Such an evaluative study might also be conducted of the communication efforts and/or effects from the agency to a specific public.

Information was gained through survey-interviews, of six agency directors. The agencies were selected to represent the categories noted above. Those selected represented the following: hospital based (3), national chain branches (2) and local proprietary (1). The directors indicated that they were concerned about the communication efforts (or lack of) being made to their publics.

This study was prompted by the observation that a lack of communication exists between various publics and the home health care agencies. In summary, the findings of this study are:

1. The publics of the agencies can be divided into two groups: internal and external publics.
2. Internal publics include: office staff, nursing services, mid-management and the advisory committee.
3. The external publics include: physicians, hospitals, consumers, government, public service agencies, answering services, pharmacists, nursing homes and other home health agencies and associations.
4. The communication vehicles that the agencies use with the skilled and Federally regulated areas, such as: nursing services, advisory committees, physicians (whose patients are under the agency's care) and the Medicare Intermediary are more developed than the ones in other areas.
5. There is a great lack of educational communication to the consumers and physicians who do not use the agency's services.
6. Little, if any, research is being done to define the agency's publics or to evaluate the agency's communications, or both.

7. Few, if any, agencies hire or employ staff members with professional communications training.
8. Few, if any, agencies employ full-time public relations or marketing staff.

This study suggests that the communication process needs to be addressed by both the home health care agency and the home health care association, either on the regional or state level. A different marketing and public relations effort may be appropriate for each.

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CHAPTER I

INTRODUCTION

During the 1970's, home health care emerged as a significant trend in the health care industry. This trend was precipitated by Federal and State legislative action of the 1960's. Prior to the 1970's, most home health care was delivered by the public health department or other public agencies, or both.

At the close of 1982, according to the U.S. Department of Health, Education and Welfare, there were 3,346 Medicare certified home health agencies in the United States. In 1984, the Tennessee Home Health Association reported that Tennessee had 277 Medicare certified home health agencies--more than any other state in our nation. The types of agencies included government (state, county, local), visiting nurse association, combined government/voluntary, hospital based, proprietary, private-nonprofit agency and others.

Obviously, there isn't a lack of home health care agencies. Yet, the questions that are frequently asked concerning home health care agencies include: "What do they do?" "How do you get them to come to the home?" and "Who pays for the services?" There is an apparent communication gap between the agencies and the general public. Indeed, an informal investigation (casual conversations with medical professionals, administrators, and an impromptu survey of a senior citizen group) revealed concern about a lack of

communication throughout the home health care industry. As a communications student, whose wife is employed by a home health care agency, my interest increased and this study was initiated.

At the outset of this study--communication techniques and practices of home health agencies--the nature and scope of the project were defined. The study was to be a case study, with interviews of selected directors of member agencies in the Tennessee Association for Home Health, Region II.

To ascertain what publics are identified by the home health care agencies and what communication vehicles are being used to reach these publics, directors of six selected agencies and the regional public health department will be interviewed by the author. The goal is to obtain both factual information and opinions of these health care specialists from in-depth interviews.

Specifically, this communication study assesses the effectiveness of the communication techniques and practices of the selected home health care agencies. Because effective dissemination of information is essential for growth in the market, this study was conducted in an attempt to provide useful data, to give new perspectives on known information and to evaluate some management assumptions through scientific research and evaluation. The information obtained will be disbursed to the Region II, Tennessee Association for Home Health.

Rationale and Significance

Home health care is an important segment of the total health industry and is also an important participant in enhancing the public's well-being.

In this study the following hypotheses are made: (1) that little communication is flowing between the agencies and their publics; (2) that few, if any, of the directors or staff have professional training in communications; and (3) that little research is being done to identify their publics.

If these hypotheses prove to be correct, this report will help the Region II agencies to recognize the problem. It should also provide a stimulus for these and other similar agencies to take action to better communicate with their publics.

Definition and Description of Home Health Care

Robert W. Buckingham, in his book The Complete Book of Home Health Care, describes home care as an alternative to costly and prolonged hospitalization or residence in a nursing home. He states that home care is one of the fastest growing movements in medicine today. It is used for patients with such illnesses as heart attacks, which involve a lengthy recovery period; for patients who are chronically and acutely ill, for example, disabled by a stroke; for patients who are terminally ill; for children for whom a long hospital stay can be extraordinarily stressful; and for the elderly who are too ill or disabled to function entirely on their own. This definition indicates that home health care is a humanitarian service that deals not only with the physical, but also with the psycho-social framework of our society.¹

¹Robert W. Buckingham, The Complete Book of Home Health Care (New York: Crossroad Publishing Co., 1984), p. 3.

Scientists tend to separate mankind's various states into physiological, psychological and sociological categories. They further divide these states into systems and mechanisms of systems. The purpose of this categorization is to simplify analysis and facilitate our understanding of ourselves and the environment in which we live and which we create for ourselves. In health care we find that, although the immediate problem may be manifest in a specific system, we must provide a more holistic philosophy to our care than is implied in the method by which we study ourselves. Home health care takes the holistic approach to client care. The philosophy of home care places the focus on the patient--his needs and well-being. He is the center of attention. The very arrangement implied in home care--that the patient receives treatment and comfort at home--is intended to produce a holistic response from the provider of care. The provider looks at the patient as a whole person existing within the social system of a family and a society.²

A more comprehensive definition of home health care is given in LaPorte and Rubin's Reform and Regulation in Long Term Care:

an array of services that may be brought into the home singly or in combination, in order to achieve and sustain the optimum state of health, activity, and independence for individuals requiring such services because of acute illness, exacerbations of chronic illness, or

²Helen M. F. Bartholomew, "Home Care Nursing: The Consumer's Perception" (M.A. thesis, University of Arizona, Tucson, 1976), p. 37.

long-term permanent limitations due to chronic illness and disability.³

Care in the home or a related non-institutional setting has as objectives three responses to patient care requirements:

- (1) improvement of functions to full independence, which ultimately permits the individual to remain at home and care for him or herself;
- (2) improve or maintain function and enable the individual to remain at home with family or community support; (3) enable a deteriorating person to remain at home as long as possible, when improvement and maintenance are no longer possible.⁴

There is no question that a need for home care exists. C. Carl Pegels, in an article appearing in the Journal of Health Politics, Policy and Law, reports that 25 to 40 percent of persons institutionalized in the United States today are placed there because of a lack of alternative home health care and community support services.⁵ Furthermore, the need for such services in the future is expected to increase dramatically. In 1975, between 6.8 and 11.8 percent of the population was estimated to be functionally disabled. The total potential demand for long-term care services

³LaPorte and Rubin, Reform and Regulation in Long Term Care (New York: Praeger Publishing, 1979), pp. 36-37.

⁴Joseph A. Papsidero, Sidney Katz, Sr., Mary Honora Kroger, and C. Amechi Alysom, eds., "Chance for change: Implications of a Chronic Disease Module Study" (Lansing, Michigan: Michigan State University Press, 1979), p. 103.

⁵C. Carl Pegels, "Institutional v. Noninstitutional Care for the Elderly," Journal of Health Politics, Policy and Law, 5, No. 2 (1980), 209.

is estimated to have increased from 5.5 to 9.9 million persons in 1975 to between 6.3 and 11.1 million in 1980, and will reach between 7.4 and 12.5 million in 1985.⁶

As the health delivery system evolves, and education of physicians, social workers and the public at large continues, the effectiveness and acceptance of home health care will continue to grow.

It could be said that the important part of "home care" is "care." As a response to a need for better services, the philosophy of home care is based on the notion that the quality of life is determined by the individual and those with whom he or she interacts closely. Home care is a support group of family, professionals and the community, which endeavors to provide for the needs of the ill and disabled and contribute to the quality of life for everyone involved in delivering or receiving care.⁷

It should be noted at this point that the word "health" was intentionally dropped in the utilization of the term "home health care" in the preceding paragraph. There is an argument within the health care family that says the word "health" should be dropped from the term "home health care" and be replaced with the less restrictive term "home care." Blum and Minkler, in an article for Journal of Social Issues, state: "for this reason [that home health

⁶Papsidero et al., p. 11.

⁷Buckingham, p. 11.

care agencies offer an array of services] we suggest the broader more encompassing term, 'home care' [be used] instead of the sometimes misleading designation "home health care."⁸ Our policies and programs should provide an array of services that foster not only health, but also activity and independence in one's normal environment. The term, "home health care," with its links to existing medical reimbursement patterns and regulations, needs to be broadened.⁹

Scholars and authors both agree and disagree with Blum and Minkler's suggestion. If we take this suggestion into our context, we then develop a definition of home health care that is broader and more straightforward: "home care is a general term referring to a combination of health care and social services to individual people and families in their homes or other community home-like settings."¹⁰ It is interesting to note that Blum and Minkler's rationale is published in a social science journal and not a medical journal.

History of Home Health Care

Home care, in its broadest sense and loosely defined, has always existed in the form of a family caring for an ill member.

⁸S. R. Blum and M. Minkler, "Toward a Continuation of Caring Alternatives: Community Based Care for the Elderly," Journal of Social Issues, 36, No. 2 (1980), 133

⁹Ibid., p. 133.

¹⁰Ibid., p. 134.

The earliest official home care program known to history was in Gheel, Belgium. Records indicate that this home care program was established in the 14th century for those suffering from emotional illness. Amazingly, this Belgian program is still in existence. It operates by selecting families in the community that provide care for the patients. One must consider that the Belgian people are unusually sensitive to the needs of their neighbors and, because of this, have kept this home care program alive through the centuries.¹¹

In the United States, the earliest home care program was established in 1796 at the Boston Dispensary.¹² The intent of the program was to provide medical care to the ill poor. The three reasons given for the development of this program were: (1) the sick may be attended without being separated from their families; (2) the sick can be assisted at less expense to the public than in a hospital; and (3) elderly patients could be comforted through charity without the public humiliation of being "institutionalized."¹³ This service offered home visits by physicians.

In the 19th century, most ill people were cared for at home. It was usually the mother or oldest female of the household who assumed full responsibility in caring for the ill member of the

¹¹Celia Moss Hailperin, "Twenty-Five Years of Home Care Services," Home Care: Living with Dying (1977), p. 137.

¹²C. R. Ryder, Changing Patterns in Home Care (Arlington, VA: Department of Health, Education and Welfare, 1976), p. 170.

¹³Hailperin, p. 137.

family.¹⁴ The only time a physician was brought in was when the illness was so serious that the patient's caretaker may not have known what to do. During this era, family friends and neighbors provided all the help they could--everything from "patient sitting" to moral support.

It must be kept in mind that, in this period of history, hospitals were generally thought of as "bad" places to be. They were considered places for dying, a last resort. They were also where homeless people and derelicts were treated.¹⁵

In 1875, the Boston University School of Medicine and the Massachusetts Homeopathic Hospital established a home care program that proved so successful it is still used today to instruct medical students in the aspects and techniques of home health care.¹⁶

Two years after the Boston University School of Medicine and the Massachusetts Homeopathic Hospital added home health care to their curricula, the women's branch of the New York City Mission was the first organization in the United States to employ a graduate nurse. This nurse was expected to provide nursing care to ill patients in their homes. Thus, 1877 marked the introduction of professional nursing care to home health care.

¹⁴Earland Cyrus, "A Historical Perspective on Home Health Care, " Home Care: Living with Dying, Elizabeth R. Prichard et al., eds. (New York: Columbia University Press, 1979), p. 13.

¹⁵Ibid.

¹⁶Hailperin, p. 138.

Other changes that occurred within the next decade (1880-1889) include the introduction of the first voluntary (nongovernmental) home health care agency in 1885. This agency, which was founded in Buffalo, New York, was to provide organized services to the ill at home. It utilized visiting nurses to teach families of the patients cleanliness and proper care to the patient while at home.

The success of voluntary home health services was so great that other agencies in Boston and Philadelphia were established in 1886. Soon an association was formed among voluntary agencies providing home health care in the northeastern states, the Visiting Nurse Association. Thus, another asset to the growth of home health care emerged.¹⁷

In 1898, the Los Angeles County Health Department became the first official health department to hire graduate nurses to provide visiting nurse care to the sick poor.

Unfortunately, the latter part of the century also showed a drastic change in the attitudes of people, particularly the wealthy, toward home health care. They felt that having a sick member of the family at home would stifle their social activities.¹⁸

During this time advances were made in medicine that encouraged the construction of hospitals. Because of the dislike of having sick people in their homes, the wealthy strongly supported and

¹⁷Catherine Tinkham and Eleanor F. Voorhies, Community Health Nursing: Evolution and Process (New York: Appleton-Century-Crofts, 1977), pp. 18-20.

¹⁸Cyrus, pp. 13-14.

financed hospital construction. Status was also obtained by "providing" for the sick. Soon after, the poor started demanding a better quality of home health care services, to somewhat equal that which was provided for the rich. This encouraged institutionalization over home health care as the medical personnel had better control of the facilities as compared to the patient's own home. It was also easier for the patients to gather at the facilities. Because of this attitude, held by both rich and poor, Americans entered the 20th century as an institution-oriented society.¹⁹

Additional home care programs, providing primarily nursing services, developed on a gradual and uneven basis throughout the country during the first half of the 20th century.

In the late 1930's, New York began using public funds to finance home care programs. Once again the incentive for home health care was strong. In 1940-42, a study was conducted by the Syracuse University College of Medicine, in which a home health care program was developed and a group of patients selected to participate after leaving the hospital. The results of the study indicated that a patient's quality of care was better at home than in an institution, and that home care led to quicker recovery.

Establishment of a hospital administered home care program by Montefiore Hospital, in New York City, in January 1947, is considered a turning point in the field of home care. It was the first hospital-based "coordinated home health care program" in the

¹⁹Ibid.

United States. This program is credited with reviving interest and focus on home care. The initial and continuing emphasis of this program is on providing home health services to the chronically ill population.

During the late 1950's and early 1960's more programs were established in response to community need in contrast to earlier programs that were often established to meet a specific need of the sponsor, such as to decrease the demand for hospital beds, to provide a resource for training medical students, or to reduce costs to welfare departments by providing an alternative to institutionalization of public assistance recipients. Because development of programs was increasingly responsive to community needs, services began to be extended to a broader segment of the population and sources of support were also broadened.²⁰

Scientific and social changes influenced the public's concern and led to enactment of Federal programs which contributed to the expansion of home care programs. Major influencing factors were:

- (1) The surfacing of chronic illness as a major health problem due to medical and technological advances, increase in life expectancy, and an overall population increase and an increase in the number and percentage of those 65 and over.
- (2) The increasing cost of hospital care which stimulated attention to less costly alternatives.

²⁰"Toward a Coordinated System for the Provision of Home Health Services," Report of the Metropolitan Health Planning Corporation Home Health Services Project (Cleveland, OH: Metropolitan Health Planning Corporation, 1975), p. 68.

- (3) The increasing availability of insurance and prepayment plans which contributed to an increased demand for health care, particularly hospital care and a full range of high quality services.
- (4) The aged population's need for health care coupled with its limited financial resources and access to insurance coverage.²¹

Medicare (the Health Insurance for the Aged Act, Title XVIII of the Social Security Act) was enacted in 1965 and became effective on July 1, 1966. Medicare, primarily for those 65 years and over, assists in meeting the costs of hospital, medical and other health care costs, including home health services. It contributed significantly to the growth of home health service programs and was instrumental in establishing the model for such services. To qualify for Medicare reimbursement, agencies must meet certain requirements and become certified. Medicaid was authorized by Title XIX of the Social Security Act and is a Federally funded, state-operated program of medical assistance, based on needs assessment for people with low incomes. Under broad Federal guidelines, the individual states determine benefits, eligibility, rates of payment and methods of administration. Medicaid has also contributed to the growth of home health service.

It should not surprise anyone that the growth of home care has followed the availability of the Federal money tree. Overall, Medicare is the major reimbursement mechanism for home health care visits.

²¹Ibid.

To keep the lid on soaring health care costs, in October 1983, Medicare started using a payment system entitled Diagnosis-Related-Groups system (DRG). In the past, hospital reimbursement for Medicare patients was based on a "per diem system"--the total cost of each patient's hospitalization divided by the number of days the patient was hospitalized. Now, however, a new prospective payment system was developed to reimburse hospitals according to a pre-set rate for a specific illness. This system is known as the Diagnosis-Related-Group (DRG). This has caused hospitals to aim for quicker discharge of their patients. With the trend toward early discharge to reduce the high cost of hospital care, and to meet reimbursement guidelines, home health care agencies are now seeing sicker patients--more oxygen tanks, tubes and complex treatments. This trend has again escalated and is profoundly affecting the growth and types of services offered by home health care providers.

Home Health Care in Tennessee

After Congress passed the Community Health Services and Facilities Act of 1961, which provided funds for the establishment of programs for nursing care of the sick at home, Tennessee initiated a pilot program (January 1962) in Marshall County for home health care. Two other local health departments joined the program later the same year: Chattanooga-Hamilton County and Knoxville-Knox County. By June 1966, 36 local health departments, covering over 70 percent of the population of the state, had initiated home nursing care programs.

In 1964, the U.S. Public Health Services loaned Tennessee a physical therapist. With his help in recruitment, a physical therapy service was instituted on a regional basis in the rural counties and on a full-time basis in the urban counties.

A third type of service became possible, in the home care program, through a federal grant in the spring of 1966. It was issued in preparation for the beginning of Medicare. With this money more nurses were employed to start the program in counties where it had not been possible previously because of the lack of the recommended ratio of nursing personnel to total population. In addition, a new category of worker, the home health aide, was employed and trained.

In December 1967, all 96 county health departments in Tennessee were giving some home care. Nursing personnel involved in home care included generalized public health nurses, licensed practical nurses and home health aides. Other personnel included physical therapists, nutritionists and occupational therapists.²²

Tennessee home health care continued to grow in the 1970's with proprietary agencies joining with the public health departments in providing home health care services to the public. On May 18, 1975, the Tennessee legislature passed regulatory guidelines that required that minimum standards and regulations be set for home health services. Such regulations were shortly thereafter adopted by the Board for Licensing Health Care Facilities.

²²"Home Health Care: A History of Service" (Bulletin),

Accelerated growth continued in the early 1980's. In fact, the growth rate was becoming a concern to the newly established Tennessee Association for Home Health (TAHH) and its membership. In a presentation to the governor's cost containment committee, October 2, 1984, Gayla M. Sasser (now executive director of TAHH) stated:

Statewide the growth, from 1981, of 113 licensed agencies to 277 in early 1984 represents a growth of 145 percent. A survey of the Tennessee Home Health Association Needs Assessment Committee found that Tennessee has more health agencies than any other state in our nation.²³

[However, according to Healthline, on December 31, 1984, Tennessee had 336 health agencies and Texas had 447. Author's note.]

In 1977, the Tennessee Association for Home Health was formed as a non-profit membership organization, incorporated under the laws of Tennessee. Its stated purposes included:

Serving the health needs of all the citizens of Tennessee by promoting the home health care concept.

Developing and promoting the highest standards of ethics for home health agencies.

Working toward integration of home health care as a vital component of comprehensive health care.

Providing a strong unified force to speak on matters of concern for home health agencies with intermediaries, legislators and regulatory bodies.

Tennessee Department of Health and Environment/Home Health Care, July, 1983, p. 6.

²³Gayla M. Sasser, "Presentation to the Governor's Cost Containment Committee," Tennessee Association for Home Health, October 2, 1984.

Promoting understanding and cooperation among home health agencies.

Developing and maintaining the use of standards that will enhance the quality of home health care.

Providing a mechanism for communication, planning, education and research in matters relevant to home health care needs.

Assembling information about home health care services and home health care problems and disseminating such information to the appropriate bodies and individuals throughout the state.²⁴

Regions were designated to develop continuity and to enhance the communication processes. Region II encompasses 16 counties and had 34 members as of 1984 (see Figure 1).

²⁴Home Health Care: A History of Service, p. 6.

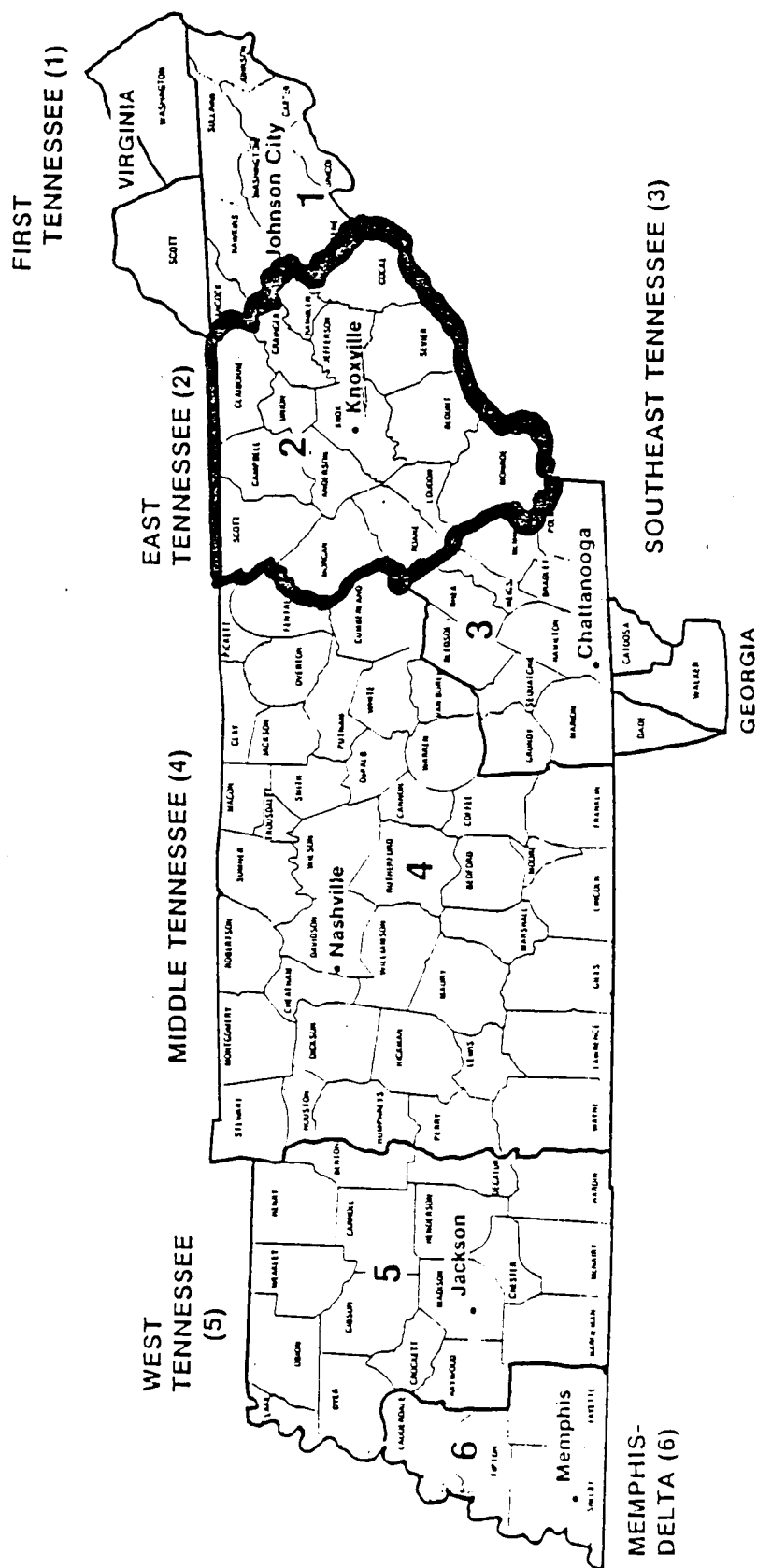


Figure 1. Health Service Areas in Tennessee

CHAPTER II

LITERATURE REVIEW

Home health care, as it is known today, is a relative newcomer to the modern medical profession. After the enactment of Title XVIII, Health Insurance for the Aged, of the Social Security Act (July 30, 1965), proprietors and entrepreneurs of the business world became interested in the potential income of home health care facilities. As this interest grew, and newcomers to the business tried to become established, numerous journals and periodicals published articles about the new "popular" topic--home health care.

Allen Spiegel, in his book Home Health Care, stated: "As this book evolved to fruition, I was struck with the volume of professional literature on the subject of home care."¹ Research shows that by far the majority of articles written deal with nursing techniques and their adaptation to home health care. Unfortunately for this study, there are few articles concerning administrative issues and fewer still that deal with communication in home health care.

Literature was reviewed in several libraries and a literature search was made in several indexes. The University of Tennessee's main library, East Tennessee Baptist Hospital's library, Fort Sanders

¹Allen D. Spiegel, Ph.D., M.P.H., Home Health Care: Home Birthing to Hospice Care (Owings Mills, MD: National Health Publishing, 1983), p. 1.

Regional Research Hospital's library, and the Saint Mary's Hospital library were utilized.

A "Healthline" computer search was initiated at The University of Tennessee main library in an effort to identify books and/or periodical articles that have been written on home health care and/or home health care communications. Subject headings consisted of: home health care, home care, visiting nurse services and home health care services. Communications, administration and organization, and marketing were the subheadings used in each category.

The computer search was confined to literature published after 1970. The search yielded a list of 25 journal articles and scholarly publications within the parameters of this study, as defined. Of the articles listed, a report to Cleveland's (Ohio) Metropolitan Health Planning Corporation and Federation for Community Planning was the most useful. Chapters on current problems in the delivery of home health care, factors affecting the market or use of home health care, the hospital's role in home health care, the role of community-based ambulatory health care centers, the historic development of home health care, referral practices, and various charts and statistics were useful in the preparation of this document.

Manual searches were initiated in indexes that related to the topic, such as: (1) National Library of Medicine's Index Medicus; (2) American Hospital Association's Hospital Literature Index; (3) Cumulative Index to Nursing & Allied Health; (4) New York Times Index; (5) Wall Street Journal Index; and (6) U.S. Government Publications Cumulative Index.

Robert W. Buckingham's The Complete Book of Home Health Care provided insight into areas such as: (1) introduction (definition) of home health care; (2) history of home health care; (3) legislation and home health care services--1935-1982; (4) economics of home health care; (5) the making of a home health agency; and (6) the marketing of home health care.

Spiegel's Home Health Care is a lengthy and comprehensive book. It is also well documented by chapter and notes. Spiegel stated that his goal in writing the book was "to aid people in gaining an awareness and sensitivity to the scope and diversity of home care. It [the book] should be suitable as a basic text for professional social and health schools."² Chapters cover subjects such as: (1) beginnings of home health care; (2) who needs home health care; (3) diseases/conditions suitable for home care; home care--what's it all about; and other topics are discussed in detail.

Paul Starr's The Social Transformation of American Medicine gives a historical survey of the development of American medicine. The book is divided into two parts: first, the rise of professional sovereignty; second, the transformation of medicine into an industry and the growing role of corporations and the state (government). Approximately 971 citations are noted for further reference.

Downs, Smeyak and Martin's Professional Interviewing was utilized to construct the interview instrument. The book addresses

²Ibid., p. 2.

specific questions such as: (1) what are the advantages of an interview versus survey? (2) What is an interview? (3) What are the different kinds of interviews to be considered? (4) What do you wish to accomplish with the interview? and (5) How do you construct an interview?

Several journals were found that addressed the subject of home health care. Most of the articles discuss specific issues such as: marketing, implications for nursing, choosing a medium for messages, communication--the anatomy of messages, the art of effective communication, organizational communication and others.

Carol A. Rudy discusses newsletters in her article "Communicating with Families Through a Pediatric Newsletter." "The newsletter is a service that keeps us in touch with our families and reinforces to them our commitment to their health care," she states.³

"The Art of Effective Communication," authored by Janet Worthington, discusses the "Peter Principle" and its relationship to health care. Published in the November, 1982 issue of Nursing Management, the article states that effective communication is the most important aspect of effective management.

Jeanette Lancaster's article for Nursing Management, "Communication: The Anatomy of Messages," discusses communication as a process, how communication operates within a climate and the

³Carol A. Rudy, "Communicating with Families Through a Pediatric Newsletter," Pediatric Nursing Magazine (September/October, 1982), p. 339.

channels of communication, and the author designs a communication model that greatly helped this author in his model design.

Other journal articles that were of use are: (1) "Home Health Care: Its Red Hot and Right Now," Nursing Life, 1983; (2) "Home Care Agencies and Health Care Competition," Home Healthcare, Nurse, 1985; (3) "Home Care Agency Adjusts to Competing Interest of Hospitals," Modern Healthcare, August 15, 1984; (4) "Commentary: Is Anybody Listening?" Canadian Nurse, March 1983; (5) "Hospital Change: Bridging the Gaps," Dimensions, February 1983; (6) "Motivating Staff-- Bridge Communication Gaps," Dimensions, December 1982; (7) "Home Care Today" (an interview), American Journal of Nursing, March 1984; and (8) "Health Fairs for Older Adults," Geriatric Nursing, May/June 1982.

Specific journal articles found to be very useful were:

Kathleen Daffara's article "The Future of Health Care Delivery" summarizes some of the problems facing this country's health care industry. "Professional ancillary services, such as I.V. therapy, nutritional support, respiratory and physical therapy have the capabilities of justifying their costs of their services to the home patients," she states.⁴

Peter Hill is a regular editorial writer for Dimensions magazine. In his monthly section, subtitled "Public Relations," he writes of issues that pertain to PR and marketing. Three articles: (1) "Public Relations: A Management Function" (June 1982); (2)

⁴Kathleen Daffara, R.N., "The Future of Health Care Delivery," NITA (July/August, 1984), 293-294.

"Marketing: A Four Letter Word" (February 1983); (3) "Choosing a Medium for Your Message" (December 1983) were found by the author to be very helpful for this study and are quoted herein.

"The Health Care Industry In the Marketplace: Implications for Nursing," by Donna Richards Sheridan, explores the economic theories of Milton Friedman (Regonomics are based on them) and how they apply to future nursing opportunities. She discusses threats to the free market system, availability (or lack of) government funding and how the removal of restraints will increase competition and provide impetus for innovations in health care delivery.⁵

Roger D'Aprix's article "Organizational Communication" discusses some emerging trends of the employee/organization communication process. He emphasizes the importance of the employee relationship with administration. He states, "The responsibility for communication leadership--and indeed ownership of the communication process and problem--rest with senior management."⁶

Periodicals that address the subject of home health care range from the "generalized" Family Circle, McCall's, Good Housekeeping, Reader's Digest and Modern Maturity to the more specific--medically oriented--magazines such as Caring, Hospital Topics, Geriatric Nursing, Gerontologist, Hospitals, Nurse Outlook,

⁵Donna Richards Sheridan, "The Health Care Industry in the Marketplace: Implications for Nursing," The Journal of Nursing Administration (September, 1983), 36-40.

⁶Roger D'Aprix, "Organizational Communication," Hospital Forum (May/June, 1984), 24-33.

Nursing Times, Nursing Mirror, Nurse Management, Lancet, Hospital Progress, Health Finance/Management, Dimension of Health Services, Canadian Nurse, and RN.

Three special publications by the National League of Nursing, each a collection of talks given at its annual meetings of 1970, 1973, and 1974, addressed various issues that pertain to home health care; none specifically addressed home health care communication.

A publication by the Tennessee Department of Health and Environment assisted in defining the history of home health care. It is entitled Home Health Care: A History of Service.

A paper which was a presentation to the governor's cost containment committee by the Tennessee Home Health Association's Executive Director, Gayla M. Sasser, contains informative material and useful statistics about the home health care industry in Tennessee.

The literature listed herein is by no means an inclusive listing of books, journals and periodicals about home health care or home health care communications. The quantity and diversity of literature do seem to indicate that a wide variety of people and organizations are interested in home care. Evident facts emerge from the literature reviewed: (1) that there is ample room for discussion of all aspects of the home care field, especially ethics, marketing, communications and education of the public; (2) that there do not appear to be clear-cut answers for all the issues at this time, partly due to the rapid growth of the industry; and (3) that communications in home health care is not an issue that has been addressed to any appreciable degree.

A literature search and review of articles that pertain specifically to communications in home health agencies turned up a great lack of discussion of the topic. Few articles dealt with home health communication, but the ones that deal with communication in the health industry as a whole can readily be adapted for the purposes of this study.

The study of communication in Region II home health care agencies has been endorsed by that association because no such study has been previously attempted and it deems the information to be of value. The state association is interested in the study and has been supportive by making publications available and offering advice and general counsel.

CHAPTER III

METHODOLOGY

Designing Research-Survey Instrument

An attempt to analyze the existing communication, communication vehicles, patterns and techniques that are now being used by home health agencies was planned. Specifically, the goal was to ascertain if there is a lack of communication between the home health agencies and their specific publics in the Region II area. The defining of publics and other pertinent information was obtained by interviewing directors of home health agencies of the Region II, State of Tennessee, Association of Home Health Agencies. The Board of Directors of Region II, by its president, Carolyn Connell, has endorsed the study and the use of the research-survey interview technique for obtaining the needed data and information.

An assumption was made that for the interview to be conducted in a professional manner, an interview instrument must be designed within established guidelines and that the interview be structured in such a manner that it will accomplish the desired goals.

The research-survey instrument was constructed to analyze current communication techniques and to bring out existing attitudes and opinions with regard to the agency's communication with both internal and external publics. This instrument was used to determine what communication needs and/or problems exist that need to be addressed by the home health agencies.

In the literature review, two books were found that pertained to the subject, and they discussed interviewing as a form of face-to-face, oral communication. These views closely fit those of the author and these books have been used extensively in the preparation of the interview instrument. The books are: Stanley Payne's The Art of Asking Questions and Downs, Smeyak and Martin's Professional Interviewing. The latter was particularly useful as it listed types of interviews to meet specific needs of the researcher.

The interview is relied upon in a variety of situations. Therefore, a variety of "types" of interviews have been developed to meet the needs of the researcher. Downs, Smeyak and Martin present 13 different types of interviews to be used in three broad discipline areas: management, mass media and research. The interview area that best serves the needs of this study is under the category of research; the type is listed as a survey interview. (Other choices: telephone interview, focus group and organizational diagnosis--the internal survey interviews). There are several advantages in using the research-survey interview that make it an attractive choice for this study. The RSI (research-survey interview) allows face-to-face contact, which increases rapport with an interviewee. Therefore, it is easier to gain cooperation and it also allows the interviewer to observe the irritations and difficulties that occur and to adjust accordingly. One of the major advantages of the RSI is that the interviewer may use visual aids to enhance communication and participation of the interview. It is also much more difficult to terminate

a RSI, because it is personal, as compared to a telephone interview or a written survey, both of which are less personal.

With the RSI interview, it was planned to accomplish the goal of obtaining useful information about the communication processes of the home health care agencies. It was also desired to obtain comments that will lead to a better understanding of the attitudes and opinions of the parties involved in the study.

Defining Communication

The study of the communication process is certainly not new to mankind. Even communication as a subject of scientific inquiry is not unique to any one field of study. Mass communicators, psychologists, political scientists, anthropologists, mathematicians, engineers, sociologists and health care specialists all study communication. We should not find this surprising since communication is the fundamental social process of humans. It is needed to build any form of social or group structure. Thus, disciplines concerned in any way with human societies, groups and behavior include the study of communication.

An obscure and astute philosopher made the statement that "communication is essential to the community. Indeed, without it the community would not exist." It may also be said that communication is essential to the existence of the health care agency.

E. Colin Cherry, in his book, On Human Communication, stated that "communication is that which links any organism together. When the communication ceases, the organism breaks up."

Another noted researcher and author, Harold Laswell, wrote what was to become one of the classical documents on communication, a paper entitled "The Structure and Function of Communication in Society." In this paper he made the following statement concerning communications: "A convenient way to describe an act of communication is to answer the following question--'Who Says What In Which Channel To Whom With What Effect?'"

Laswell's question indicates that communication is a process, not only with intermediate steps, but a process that utilizes "decision gates" to direct it. The questions--who, what, which and whom--indicate that choices must be made. These choices should be made by the evaluation process of data that have been gathered through scientific research. Otherwise, the communicator must realize less than desired communication effects, results, or both.

The communication process has been graphically depicted by various communication researchers in the form of models. Some of the better known models are: Shannon-Weaver's Mathematical Model, Newcomb's Social-Psychological Model and Tan's Transactional Model.

In this case study of the communication processes in home health agencies, it is desired that a simple view of the communications process be maintained. However, there are some truisms that should be understood pertaining to communication. Such as: (1) the sender of the communication has a unique set of psychosocial experiences and values that often differ from those of his intended audience. He should always approach his communication with this in mind; (2) the environment for each communication is unique and

should be observed, researched and understood before the message is created and the channel selected; (3) differing channels are perceived in different ways and have diverse values in the "eyes" of the receiver. These should be studied and evaluated before their selection; (4) each receiver will have a unique background from which he enters the process; and (5) that effects and/or feedback are not always visualized immediately.

It then becomes apparent that the "sender" of the communication should take into consideration the environment that the communication will enter, the barriers that may impede the process and how the message should be constructed. Also, he should always look for ways to improve this process so as to be more effective in their management of the communication process.

Jeannette Lancaster discusses the issue about the communication process and words it slightly differently. She states that

understanding the basic process of communication, looking at productive climates for communication, and examining both formal and informal channels of communication, including rumors and grapevines, can assist nurses (and administrators) to use the communication process more efficiently and productively. Further, barriers to communication must be considered as well as ways of improving communication.¹

Lancaster further quotes noted author and communications researcher S. I. Hayakawa in illustrating the difficulty of word selection. Hayakawa states: "The meanings of words are not in

¹Jeannette Lancaster, "Communication: The Anatomy of Messages," Nursing Management (September, 1983), p. 42.

the words: They are in us." Hayakawa thus emphasizes the critical nature of interpretation in the communication process.

Environment/climates, barriers, message construction, audience analysis, examining formal and informal channels of communication, and understanding the critical nature of word usage (due to varied interpretation) are all integral parts of the communication process. An understanding of this process will enhance the agency's ability to communicate effectively. It is then established that each person in the organization (health agency) has a key role in consistently sending and receiving clear, concise, honest messages. Time spent in analyzing and correcting one's own communication practices is time well spent. In the long run, it will enhance the communication process and save time--which saves money (see Figure 2).

Defining Publics

Communication is a process which is "aimed" at publics. The term "publics" is often used to simply refer to the opposite of "private." Others equate a public with the audience of a newspaper, magazine or television station. Still others broadly define publics as employees, communities or consumers, without realizing that there are different kinds of employee, community or consumer publics. Many practitioners believe publics have common demographic characteristics, such as age, sex, race or location of residence. They think, for example, of the elderly, women, blacks or urban dwellers as single publics when, in fact, these are social categories that may contain within them many publics. For example, an agency

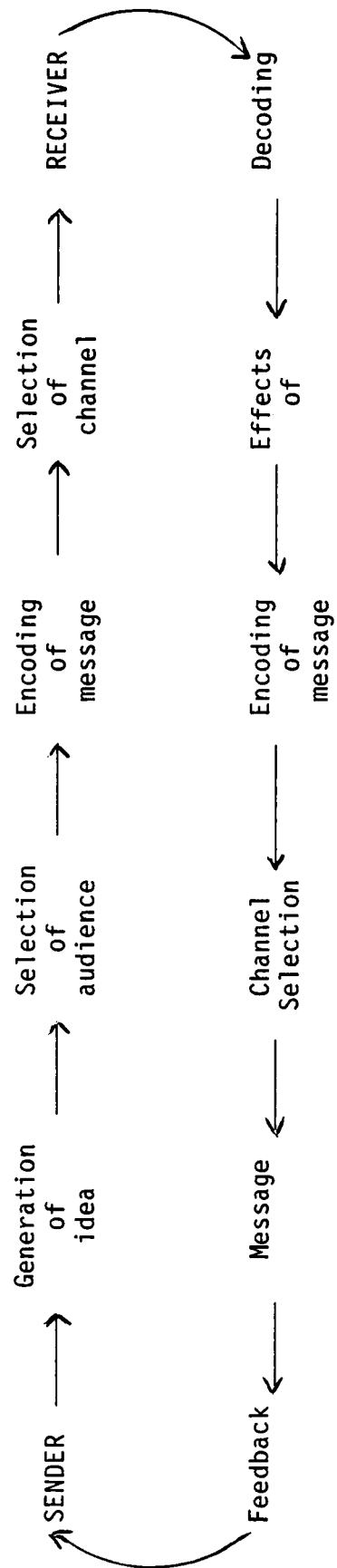


Figure 2. Communication Model

may have a broad group of employees, but within this group there may be several publics such as office staff, nursing staff, middle management and others. While all of these publics may share the common "being employed by the agency," they in fact have specific characteristics and share (within their group) concerns and problems that are specific to their experiences. It is thus essential that this group be communicated with and be able to respond to the communicators as an individual and/or specific public.

To clarify the definition of publics for this study, a public(s) will be defined as being any group that shares a common problem which creates and identifies that group. A public will usually be of some consequence to the organization and/or the organization will have some consequence on that group. Publics face a similar problem, recognize that the problem exists and organize to do something about that problem.

CHAPTER IV

SUMMARY OF FINDINGS

It was established through the research-survey-interviews that the Region II home health care agencies share several entities. It was predetermined before the survey that the publics of the agencies would be divided into internal and external categories. All directors interviewed readily accepted and agreed with this position.

The directors were asked oral questions from a master interview instrument (see Appendix A). Answers to those questions are listed in the order that they appear on the interview instrument. The numbers beside the question or statement indicate the number of agencies that replied in that respective category. It should be remembered that six agency directors were interviewed. In some instances the replies may not total six, as some directors did not answer all questions in like manner.

Defining the Publics

The existing internal publics, that home health agencies communicate with, were determined to be the categories shown in Table 1.

The internal publics varied, in size and organizational structure, but they served the same basic functions as publics for the home health agencies. Nursing staff, the largest internal public, and

Table 1. Existing Internal Publics

Category	Yes	No
<u>Office Staff</u>	5	1
Data Processor	4	2
Billing	6	0
Personnel	5	1
Acct./Fin.	3	3
Secretaries	6	0
Others		
Transcriptionists	1	
Health Planners	1	
<u>Mid-Management</u>	3	3
Branch Administrators	2	4
Public Relations	1	5
Marketing	0	6
Finance	0	6
Other		
Assistant Director	1	
Office Supervisor	1	
<u>Nursing Services</u>	6	0
Nurses	6	0
Social Workers	6	0
Physical Therapists	6	0
Aides	6	0
Nutrition	1	5
Pharmacy	1	0
Other		
Nutrition	1	
Occupational Therapist	1	
<u>Advisory Committee</u>	6	0
Other		
Medical Ex. Ct.	1	
Staff Physician	3	
Administrative Vice President	1	

the advisory committee are found in all agencies. Office staff varied greatly in size and as to detail in their responsibilities. Mid-management depended upon the organizational structure of the agency, the willingness of the director to delegate and budgetary considerations.

The existing primary external publics, with which home health agencies communicate, were determined to be those listed in Table 2.

External publics are varied and differ greatly as to their relationship with the agency. Physicians, hospitals and consumers, all referral sources, were the primary external publics.

In communicating with internal publics, the agencies used the following and/or answered the questions in the following manner:

- | | |
|--|-------------------------------|
| 1) Company/Employee newsletter | Yes: 5
No: 1 |
| 1a. Do you produce the newsletter in house? | Yes: 4
No: 2 |
| 1b. Who produces and designs the newsletter? | Staff: 5
Home
Office: 1 |
| 1c. Is the newsletter designed for employee response? | Yes: 1
No: 5 |
| 1d. How often is the newsletter printed? | Monthly: 5
Quarterly: 1 |
| 2) Do you have an employee council or committee that communicates to the administration employee concerns and ideas? | Yes: 1
No: 5 |

Table 2. Existing External Publics

Category	Yes	No
<u>Physicians</u>	6	0
<u>Hospitals</u>	6	0
Administration	1	5
Discharge Plan.	6	0
Nursing Services	1	
<u>Government</u>	2	4
Federal	1	5
State	6	0
County	1	5
Local	0	6
<u>Consumers</u>	6	0
General Public	6	0
Patients	6	0
Patients' Families	6	0
<u>Medicare</u>	6	0
<u>Medicaid</u>	6	0
<u>Home Health Agency</u>	6	0
<u>Home Health Association</u>	6	0
<u>Other</u>		
Civic Groups	6	
Pharmacists	2	
Region II	2	
Nursing Homes	1	
Senior Citizens	2	
Public Agencies	4	
Ambulance Auth.	1	
Senior Citizen Aide	1	
Answering Services	3	

3. Do you utilize a bulletin board for employee/adm. use? Yes: 6
4. Do you utilize focus group meetings to enhance communication with your internal publics? Yes: 6

Internal communications, in which the agency attempts to communicate with the internal publics, are the strongest communication efforts made by the agencies. Newsletters, bulletin boards and focus group discussions are all utilized in these efforts.

In communicating with external publics, the agencies used the following and/or answered the questions in the following manner:

- 1) Do you advertise? Yes: 6 No: 0
- | | | | |
|---------------|---|------------|---|
| Yellow Pages: | 6 | TV: | 0 |
| Specialty: | 0 | Newspapers | 1 |
| Billboard | 0 | Magazines | 2 |
| Radio | 1 | Other | 0 |

Is your advertising budgeted or do you divert other funds for this purpose? Budgeted: 5
Misc.: 1

- 2) Do you participate in public relations activities? Yes: 6
- | | |
|--------------------------|---|
| Operation Health Check: | 6 |
| Health Fairs: | 6 |
| Speak at club functions: | 6 |
| Blood pressure clinics: | 1 |
| Other | |
| Pharmacist education: | 1 |
| Older Amer. Meetings: | 1 |

- 2a. Do you employ a PR director or full-time person to carry out PR activities?
- | | |
|------|----|
| Yes: | 4* |
| No: | 2 |

(*three of four are "hospital employees--not agency employees)

- 2b. Are your PR activities budgeted or do you divert funds from other areas?
- | | |
|-----------|---|
| Budgeted: | 2 |
| Mis.: | 4 |

- 2c. How many man/hours/week are spent in PR work?
- | | |
|----------|-----|
| Average: | 22* |
|----------|-----|

(*one agency has a full-time person at 40 hours a week--others averaged 10 hours a week for the agency)

"I really think that if they understood what we do and what we're all about, more elderly people would benefit." This director's quote, about various publics, illustrates the findings of this study about the communication process of the home health care agencies. Little advertising, participation in mediocre public relations activities and only one agency employing a public relations (education) person leaves communication gaps between the agencies and these important publics.

- 3) In communicating with physicians, whose patients are under their care, agencies reported the following:

- 3a. Do you regularly communicate with these physicians?
- | | |
|------|---|
| Yes: | 6 |
| No: | 0 |

- 3b. What communication vehicle do you use?
- | | |
|----------|---|
| Phone: | 6 |
| Written: | 6 |

- 3c. After a team conference meeting, do you contact the patient's physician or send him a brief to keep him up to date?
- | | |
|------|---|
| Yes: | 2 |
| No: | 4 |

- | | | | |
|-----|--|-------------------|---|
| 3d. | How often is this done? | As needed: | 6 |
| | | After each mtg.: | 2 |
| 3e. | What communication vehicle do you use? | Written: | 6 |
| 3f. | What communication vehicle have you established to keep this physician up-to-date on the services that you offer? | Pre-printed form: | 1 |
| | | Letter: | 1 |
| | | Phone: | 2 |
| 4) | In communicating with physicians, whose patients are not under the agency's care, the agencies reported the following: | | |
| 4a. | Do you regularly communicate with these physicians? | Yes: | 2 |
| | | No: | 4 |
| 4b. | What communication vehicle do you use? | Agency Handbook: | 1 |
| | | PR: | 1 |
| 4c. | Do you regularly solicit referrals from them? | Yes: | 2 |
| | | No: | |

In answering generalized questions concerning physicians, the agencies responded as:

- 5) Do you feel physicians understand your agency's position in the health care market?
- | | |
|------|---|
| Yes: | 1 |
| No: | 5 |
- 6) In your opinion is there adequate communication between your health care association and physicians in the Region II area?
- | | |
|------|---|
| Yes: | 0 |
| No: | 6 |

Physicians, whose patients are under the care of the agency, are regularly communicated with as would be suspected. Regulations, ethics of the profession and basic need dictate that this public be communicated with regularly. However, it was found that some

agencies are making efforts to communicate in more detail and consistency than others.

Physicians whose patients are not under the agency's care are a public who is not being communicated with on a regular basis. A majority of directors felt that the physicians did not understand the home health care agency's position in the total health care market. All of the directors interviewed stated that, in their opinion, the Region II association was not adequately communicating with this important public.

- 7) Only limited information can be absorbed by parents and spouses of patients, during "official" visits. Do you utilize other communication means to reach, reinforce and educate your patients and/or families?

Written:	4
Phone:	2
Handbook:	1
- 8) What means do you use to communicate with area hospital discharge planners?

Person-to-person:	3
Phone:	1
- 9) What can be done to better implement communication between the discharge planning department and home health agencies?

Educating the social worker:	1
I don't know:	4

When asked questions concerning administrative issues, the agency directors answered as:

To increase profitability and/or to enhance your position in the home health care market (for 1985), do you plan to:

- a. Increase census through additional marketing efforts: 3
- b. Continue with your current program: 1
- c. Increase your cost efficiency: 2

Which communication vehicle that you presently use has proved the most effective?

One-on-one:	4
Word-of mouth:	1

Has anyone on your staff professional communications training:

Yes: 0

No: 6

What is your main source of referrals at present:

Physicians: 3

In-staff: 1

Varied: 1

Nursing Home: 1

Do you monitor "requested services":

Yes: 2

No: 4

Do you use this list in planning future services:

Yes: 2

Do you use formal or informal research to evaluate:

Publics: 1

Comm. Veh: 1

Marketing Pos: 1

Other Referrals: 2

A majority of agencies stated that they planned to increase their census through marketing efforts. One-on-one communication was the most often used communication vehicle. Little research is being done to define publics, evaluate communication vehicles, clarify marketing positions or in evaluating the referral channels. One director estimated that every fifth call was a referral from the general public. But, no records were being kept to validate this estimate.

CHAPTER V

ANALYSIS OF FINDINGS

Home health care agencies share common characteristics and pursuits; however, there are some distinct differences. It was revealed in the survey that there are three distinct types of home health agencies in the Region II area--hospital based, "independent" and national chain branches.

Hospital based agencies are an extension of the parent hospital and its programs directed toward the total health market. They are another "department" of the corporate institution. These agencies approach the marketing of home health and the designing of their organizational structure differently from any other type of agency. The hospital based agency makes use of several hospital internal departments, such as: data processing, accounting/finance, personnel, public relations and marketing. The agency does communicate with these publics, so it has been determined that they will be included as the agency's internal publics.

"Independent" or sole proprietary agencies are independent business men and women who must use several internal publics to function in the home health care market. Some of the more technical jobs such as data processing and accounting are contracted out to specialists of the respective areas.

The national branch agency is a part of a large corporation. It does minor billing and bookkeeping at the local level and then

sends the information to the "home office" for further processing. It was found that the home office provides most of the guidelines and administrative expertise that are needed to run the agency. Branch agencies also use home office departments such as public relations, data processing and marketing.

In an attempt to identify the internal publics, each administrator was asked to specifically state if she communicated with one or more of the following publics: (1) office staff; (2) mid-management; (3) nursing services; and (4) an advisory committee. It was found that all of the administrators communicated with two of the four publics--nursing services and an advisory committee. Communication with office staff and mid-management varied.

Nursing services is the agency's largest and most active public. The nursing services staff positions include: Registered Nurses, Licensed Practical Nurses, Social Workers, Physical and Speech Therapists, Aides and other specialists. The nursing services organization ranges from structured corporate style to the less structured "family" approach.

The advisory (board) committee has been established by Federal laws through the Medicare system. This committee is made up of local persons, agency staff, community leaders, and others who may be selected from the general public. It is also required that a physician be on the committee. The committee is required to meet at least twice a year.

Mid-management is not an internal public common to all agencies. The survey indicated a range from one assistant director to five assistant branch administrators being employed by agencies that did have mid-management. In most cases these assistant directors served in such capacities as director of nursing services, director of personnel, office manager, public relations representative and marketing director.

The office staff of the agencies varied in size and specific functioning. The duties of the individuals varied greatly, due to the agency's structure, as did the number employed in this group. All of the agencies interviewed employed a secretary or had someone to cover that position on a regular basis. They all also employed a billing clerk to send the proper documents to the home office or to do the actual billing. Other positions, such as data processing, personnel, accounting, transcriptionists and health planner were filled according to the organizational structure (type) of the agency.

In an attempt to define external publics, directors were asked to identify specific groups as publics with which they communicated. The external publics identified were: (1) physicians, (2) hospitals, (3) consumers, (4) government, (5) home health agencies, (6) home health associations, and (7) others--a category that included publics such as answering services, ambulance authorities, Mobile Meals, Senior Citizen Aide Services, nursing homes and pharmacists.

In an attempt to identify specific communication vehicles and methods used by the agencies, the agency directors were asked to identify the communication vehicles that they used to communicate with both their internal and external publics.

In communicating with their internal publics, the agencies use varied from the required team conference meetings to the much less formal personal interview. Communication vehicles such as bulletin boards and company/employee newsletters are used to enhance the communication process within the agency to the four defined publics: nursing staff, mid-management, office staff and advisory committee.

Team conference meetings (focus group discussions) are required by Medicare and held on a regular basis, ranging from weekly to monthly. They are the most effective and comprehensive channel of communication for both the administration and employees. Regardless of the agency's structure, the opportunity for communication is evident through these conference meetings. The purpose of the team conference meetings is to acquaint each member of the health care team with the current health status of each patient. Any significant change in the patient's health is noted and also reported to the patient's physician. In these meetings most agencies take the opportunity to discuss issues that affect their internal and external publics.

Two vehicles--the bulletin board and the company/employee newsletter--are popular channels that are utilized to communicate with the internal publics. Bulletin boards vary in size and shape,

but all serve the basic purpose of providing a designated area for communication. Company/employee newsletters come in two basic styles: (1) corporation produced vehicles and (2) photocopied pages of in-house bulletins, anecdotes and messages. The corporate newsletters range from national publications to locally produced publications. All directors interviewed, in this category, said that they have, and take, the opportunity to submit articles and messages to the corporate newsletters. The photocopied newsletter serves the basic purpose of communicating with the employees in a less grandiose style. Only one newsletter, corporate or photocopy, however, provided employees with an opportunity to respond to management.

The advisory committee is communicated with through a formal report at its required bi-annual meetings. Of course, phone and written communications flow back and forth as needed between this important (and required) public and the agency.

Only one of the six agencies interviewed has an employee council or committee that communicates to the administration the employees' concerns and/or ideas.

In communicating with the external publics of the agencies, several communication vehicles are used, such as personal contact, telephone, written messages, advertising and formal reports. The telephone, written messages and personal contact are the most often used vehicles. While all agencies reported that they advertise, these efforts are highly restricted and limited in scope. Basically, the Yellow Page advertising in the telephone directory constitutes the majority of effort in this area. Yellow Page advertising has

long been a popular "advertising" vehicle for professional people, organizations and groups. One of the main, if not the main, attractions of this type of advertising is that prices may not be published. The Yellow Pages prohibit price information in the ads. Legally, of course, the agencies may advertise price or any other feature that they select, but it is not "acceptable" to do so within their profession. Pricing would not be a major consideration in home health at this time, as Medicare dictates the charges for the services and 95 percent of the agency revenues are from Medicare. But, an agency may charge the patient more than Medicare dictates if they can collect the difference.

Only one agency (sole proprietary) uses radio and newspaper advertising. Two agencies use specialty magazine advertising. The magazine entitled The Waiting Room is distributed to physicians for use in their waiting rooms as reading material. Five agencies reported that their advertising funds were budgeted. Certainly, they must be speaking of the Yellow Page advertising as they do very little other advertising.

All agencies surveyed indicated that they participate in public relations activities such as Operation Health Check, Health Fairs, speaking at club functions and blood pressure clinics. Two other PR activities were listed by separate agencies--pharmacist education and attending Older American meetings. Four agencies reported that they employ full-time PR directors, but three of the four were hospital-based agencies that utilize the hospital's PR

personnel as needed. Only one agency employed a PR person for its exclusive use. The majority of the agencies reported that funding for PR activities came from miscellaneous budgeting categories. The average man-hours per week spent by the agency for PR functions was said to be approximately 22. This figure includes 40 hours spent by the full-time PR person, so the true average is closer to 10 hours a week spent for PR.

Two categories of physicians are communicated with by the home health agency--physicians who use the agency's services and physicians who have not used the agency's services.

In communicating with physicians whose patients are under the agency's care, the telephone, written message and formal report are the most prominent communication vehicles used. This group of physicians is regularly communicated with on mostly an "as-needed-indicates" basis. It was found that after the important team conference meetings, only two agencies sent briefs other than recertifications and supplemental orders, to the respective physicians concerning the patient's condition on a regular basis.

In communicating with physicians whose patients are not under the agency's care, the physicians are presented messages, primarily on a person-to-person basis, through marketing or public relations efforts. According to directors of hospital-based agencies, this group of physicians is not often contacted by its agencies. The hospital-based agencies are primarily concerned with only physicians who are "on staff" or use their parent corporation's services.

Hospitals constitute another prominent external public for all the agencies. The primary receiver of the agency communication is the discharge planner/social worker in the hospital. Very few agencies communicate directly with the hospital administration. Some communication is directed to floor nurses, staff physicians and nursing service directors.

Medicare, a very important external public, requires that a formal report, known as a recertification (recert), be sent to it every 60 days on all patients. Recertifications consist of a patient's history, his/her current status and his/her physician's orders. A recert is sent to the patient's physician for his signature, and then becomes a part of the patient's record (chart). This chart is used by the agency for the patient's Medicare billing. Recerts are, then, the most prominent formal communication vehicle between the agency and the physician. Medicare and Medicaid intermediaries are contacted regularly through formal reports, telephone and written communications, and on a personal basis during audits and meetings.

Consumers comprise the largest external public for home health agencies. A breakdown of this broad category indicates that there are three general areas of consumers: (1) general public, (2) patients and (3) patients' families. Various communication vehicles are used to communicate with these publics. Advertising (telephone directory-Yellow Page advertising) is the most utilized and most obvious. Public relations activities--Operation Health Check, health fairs, speaking to club and/or organizational meetings, hospice

associations and blood pressure clinics--are the main events where the public relations activities are represented.

Patients, of course, are contacted and communicated with through the delivery of the agency's services. Personal contact, written instructions and phone conversations are the primary communication vehicles used to communicate with the patients and the patients' families. Prepared brochures are also left with the families to describe treatments and additional services that are available from the agency.

Government, other home health agencies, the home health association and others are primarily communicated with, as needed, on a person-to-person basis. Some written communication is used for these publics also.

External publics comprise the largest group of publics for the home health agency. They are also the publics from which the agency's revenues are generated. Physicians, hospitals and consumer publics comprise the majority of the external publics. Communication vehicles utilized to communicate with these publics are primarily person-to-person communication, the telephone, written messages and reports, advertising and public relations marketing efforts.

Agency directors were asked if they felt that physicians understood their agency's position in the health care market--only one answered in the affirmative. All reported that in their opinion there is not adequate communication between the physicians and their home health association.

Written information comprises the bulk of communication to the patients and their families after the initial visit to the home. Many directors stated that the staff makes special efforts to write out special instructions to the patients or their family in an attempt to reach, reinforce and educate them about the patient's particular condition. This personal care is common in all of the agencies interviewed.

When the directors were asked about their plans to increase profitability and/or to enhance their position in the home health care market for 1985, they replied that they planned to increase market share with increased marketing efforts and to increase their cost efficiency. They stated that the communication vehicle that had proved the most effective so far was one-on-one communication. This may be reflected in the fact that no agency employs a person that has professional communications training.

Being nursing oriented, it was not surprising that the physician was listed as the number one referral source of the agencies. Hospital-based agencies have the strongest connection for referrals and seek them from staff physicians and their own corporate social worker/discharge planner.

When asked if they (the agencies) monitored "requested services" only two agencies reported that they did and that they further used the information to plan future services. One agency included this as informal research. Only one agency reported doing any formal research.

CHAPTER VI

CONCLUSIONS AND RECOMMENDATIONS

The home health care industry has propagated from Federal legislation and a seemingly endless supply of revenue from the Federal "money tree." Its growth has mushroomed the industry to a point where the revenues and returns on investment challenge the highly profitable computer industry.

Home health services are largely determined, as has been noted, by two factors: (1) the requirements of major funding resources and (2) the purpose and history of the administrative agency.

Along with the bonanza of Federal money comes the quagmire of paperwork that the respective Federal agencies require. A great deal of the administrator's time and energy is apparently spent in just keeping up with the numerous regulations and guidelines that are handed down through Medicare and its intermediaries. By spending the administrator's time with this paperwork, hiring and training staff and directing the implementation of the physicians' orders for their patients, the communication process has taken a back seat to other priorities. However, through improved technologies in communication equipment, the production implementation of the communication process has been simplified and is more readily accessible without extensive training. Modern equipment now makes it possible for the staff to have "time" to prepare communication

vehicles, that not so long ago were so time consuming that they were impractical.

Communicating and the Internal Publics

Communication with the agency's internal publics, consisting of team conference meetings, use of the bulletin board, personal interview and the company/employee newsletter is very positive.

The team conference meeting has the potential to be the strongest communication vehicle in use by the agency for its internal publics. Wine and Baird state,

health care in general, and nursing in particular, is experiencing dramatic changes in worker values, economic realities, and management theory. All three areas of change move toward actively involving employees in organizational decision making. Although nursing managers have implemented a variety of systems to gain employee participation, "Quality Circles" seem to be the most promising method currently available.¹

By practical application and administrative ingenuity, a section of the team conference meeting can become the agency's "Quality Circle"--time that employees and management talk openly and frankly about concerns and problems that are affecting both. There are advantages to discussing matters with staff. Salesmen have long realized this potential. They know they will receive an honest appraisal of their wares from staff users. No nurse is going to tell a salesman that the product or equipment he is trying to sell

¹J. A. Wine and J. E. Baird, Jr., "Improving Nursing Management and Practice Through Quality Circles," Journal of Nursing Administration (May, 1983), 5.

is great if it isn't because, if management purchases it, the nurse must use it. If salesmen can see the advantages of consulting staff, should not administrators consider the possibilities involved in discussing solutions to common or persistent problems with them?

A more open system of communication will permit greater staff participation and new programs will evolve more smoothly, with less resistance. By discussing ideas and plans before they are introduced, the necessity for "hard selling" will be reduced. Staff involvement can relieve the administrators of time-consuming duties and allow them to place their expertise where it can be better utilized to enhance the agency's position in the market and/or to increase its profitability.

Communicating Through Company/Employee Publications

Company publications, although they are time consuming to produce, can be effective communication tools. It is also realized that they can be a waste of time and a disaster for all involved. It seems that there is a stigma about company publications, particularly company/employee newsletters--anyone who is anybody must have one. There are some important questions that should be answered before an agency embarks upon the task of developing and publishing a company publication: (1) do I need one? (2) Have I evaluated my audience (demographics, age, can they read)? (3) Do I depend on repeat business--as with physicians? (4) Will this stretch my advertising budget? (5) Will it stimulate business if people are educated about my business? (6) Do I want to build or change my

image? (7) Who's going to get it--some agencies want their employee newsletter to reach publics other than just the employees. (8) Who is available to produce it?

The answers to these questions will enable administrators to make a mature and professional evaluation of their needs for a company publication.

There are several good reasons for producing a company publication: (1) it lets you make a deeper, longer-lasting impression; (2) it increases your flexibility; (3) it enhances your ability to gain control of who your market is; (4) it helps build traffic; (5) it can build image; (6) you may time your messages to various publics; and (7) it is free from competitors' messages.

The agencies surveyed did not employ a staff person(s) who had communications training. It is therefore apparent that they must rely upon outside expertise (corporate if it is available) in their approach to publications design or produce it themselves as time permits.

The company/employee newsletter can possibly serve several functions that will enhance the agency. But time, manpower, cost and benefits are four considerations to be evaluated before planning the newsletter.

Time can be drastically reduced with the addition of a word processor. The investment is now minimal as compared to the results accomplished and time saved.

Manpower certainly has to be considered and it may mean the addition of a part-time or full-time person. Again, this must be weighed against the expected benefits.

Carol Rudy reports that in her office the pediatric nurse associate solicits material from other members, physicians, a family counselor, a speech and hearing therapist and other nurses. Compiling, editing the newsletter, printing and envelope stuffing are all done in-house to cut the cost. Her newsletter has three sections: office news, community news, and feature articles. It is mailed to employees, physicians, patients and the patients' families.² The basic benefit, according to Rudy, is patient and patient-family education. "It keeps us in touch with our families and reinforces to them of our commitment to their health care," she states.³

Caring magazine's agency of the month (October 1984)--Boston Visiting Nurse Association--has a public relations director who utilizes a newsletter entitled "House Call." This publication began as a six-page newsletter in 1979. Now it is a twenty-eight page, three-color magazine that features consumer health education articles, articles on VNA patients and news about the agency. It is currently published twice a year and is circulated among community health professionals, community leaders and the public. It has become

²Carol A. Rudy, RN, MPH, CPNP, "Communicating with Families Through a Pediatric Newsletter," Pediatric Nursing, (September/October, 1982), 339.

³Ibid.

so well received that VNA is studying the possibility of marketing House Call's generic contents to outside agencies that do not employ full-time communications staff.

The Boston Visiting Nurse Association also publishes an internal, bi-monthly newsletter entitled "Inside/Out." It serves as the staff newsletter with goals to interpret key issues to the VNA; to foster a unified feeling among the four separate offices, to give management a forum for talking to staff; and to recognize staff achievements.

The success of the Boston VNA clearly indicates that a newsletter can be both effective and flexible in its use. It may be noted that no mention was made of the newsletter being a vehicle where employee response may be made to issues and concerns. One author approached this subject differently, yet simply: "a feeling of isolation is a symptom of inadequate lateral communication." If this is true, then it would seem that good lateral communication will abolish the feeling of isolation. Employees need identity and a feeling of belonging to a unit that is greater than their own efforts. The company/employee newsletter can help satisfy this need.

Communicating with External Publics

In communicating with the external publics, agencies are restricted by Federal Medicare guidelines that state that advertising and public relations activities are not reimbursable. Any funds for these activities must come out of the owner's pocket or from the parent corporation. Through the survey-interview, it was

ascertained that most of the agencies were listed in the Yellow Pages of local telephone books. Only two agencies indicated that they do any advertising other than Yellow Pages, and that is minimal--mostly in newspaper advertisements and in a local magazine entitled The Reception Room.

At present, 95 percent of the home health agency's patients are billed through Medicare. As new services are added to the agency, and more private-pay institutions (insurance) accept and provide for home care reimbursement, competition will become greater and advertising will play a greater role in the home health industry of the Region II area, as already reported in other areas of our nation, especially in the larger cities.

Communicating Through Public Relations

Public relations is a term that describes functions that embrace a broad spectrum of activities. Every agency, no matter how small, has a public relationship that has developed since its beginning. If no one in the agency has been delegated the responsibility for coordinating this public relationship, then it probably is being allowed to develop by chance.

Only one of the agencies interviewed employed a public relations director (community education director) full or part time. Very few of the agencies even budgeted for public relations activities. Most of the time expenses are covered if some member of the staff attends a special meeting, but unfortunately it was not indicated that anyone planned for public relations except the one

agency that employed the full-time employee for that purpose. No agency placed the public relations activities or the public relations function on the administrative level.

James E. Grunig lists characteristics of four models of public relations and in his narrative states,

The press agent/publicity model came first, in the period from 1850 to 1900; practitioners spread the faith of the organization involved, often through incomplete, distorted or half-true information.⁴

This was commonly known as propaganda.

Grunig then described what he called the public-information model.

It came first, beginning about 1900 and continuing as the major model of public relations until the 1920's. The purpose of this model is the dissemination of information. The public relations person functions essentially as a journalist in residence, whose job it is to report objectively information about his organization to the public.⁵

This is a one-way style of communication with no feedback.

The two-way asymmetric model of public relations developed in the 1920's.

Its practitioners have a function more like that of the press-agent/publicist, although their purpose can best be described as scientific persuasion. They utilize known

⁴James E. Grunig and Todd Hunt, Managing Public Relations (New York: CBS College Publishing, 1984), p. 21.

⁵Ibid.

statistical information and research their publics in an effort to persuade those publics to accept their organizations' point of view.⁶

The two-way symmetric model was developed in the 1960's and 1970's. In this role, public relations practitioners serve as mediators between organizations and their publics. Their goal is a mutual understanding between the two. These practitioners utilize formative and evaluative research and mostly theories of communication rather than theories of persuasion for planning and evaluation of public relations.

A quick study of the four models and a look at the data received in the interview-survey, which indicate only one agency is doing any research or evaluation of its communication or publics, show us that the public relations activities of the agencies of Region II are most similar to the public information model of the 1920's.

Peter Hill, public relations expert and author, put public relations and the home health agency into yet another perspective.

Every agency has a unique administrative structure, and the most important considerations when thinking of integrating public relations management into the system is which functions go together naturally, and what will be the relationship between them and other agency functions. One of the axioms of effective public relations is that the person charged with its administration reports directly to the C.E.O. Another is that he/she be recognized as part of the senior administration staff both by employees and by the community at large. This is not for the personal aggrandizement of the individual but because the media, in particular, will not want to communicate with simply a staff person.⁷

⁶Ibid., p. 22.

⁷Peter Hill, "Marketing: A Four Letter Word?" Dimensions

The inherent relationship of public relations and the administration can best be understood when the public relations position within the organization is defined. According to Grunig, public relations personnel perform what organization theorists call a "boundary" role. That means that they function at the edge of the agency, serving as a liaison between the organization and the external groups and individuals. They have one foot in the organization and one outside.⁸ Figure 3 shows the public relations function in an agency.

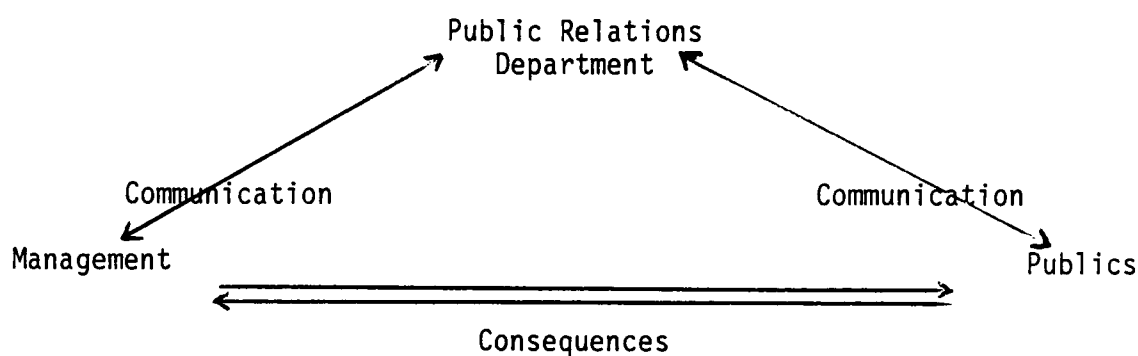


Figure 3. Public Relations Function Model

As the agency changes, new messages must be sent to new audiences with the expectation that new images will form in their minds. Both internal and external publics are defined and addressed. Public relations functions may include:

(February, 1983), 32.

⁸Grunig, p. 9.

1. The development of a speakers bureau to address community groups. Presentations could include slide shows, talks by staff on health topics, presentation of the overall agency program and services available, and literature and gifts for the audience.

2. The development of publications for both internal and external publics.

3. Making extensive use of community newspapers--call on the editors, ask for suggestions and seek their help as needed.

4. Designing of a public relations program, so that the staff will become involved--this enhances their feeling of belonging and of worth.

5. Educating the staff in elementary communication methods--speaking, writing and image building.

Boston VNA Public Relations Director Cindy Sperbeck states:

public relations director should spend a good deal of his/her time in one-to-one contact with staff, and in explaining public relations activities. It is time well-spent, because it has worked for us. We now have a pool of staff willing to participate in screenings, newspaper articles, television programs, speakers' bureau assignments, and any activity that the department creates.⁹

Sperbeck further stated that the staff of her agency has come to realize that public relations is not as scary as it sounds--that when they talk to an audience, they have learned that they

⁹"Agency of the Month--Visiting Nurse Association of Boston," Caring (October, 1984), 52.

are the experts, and that they have the background to field any questions that may be asked.¹⁰

Obviously, the public relations efforts of Region II agencies, as a group, have not reached the plateau of the preceding examples, in regard to penetration or expertise. But, there is no reason that they cannot. With conscientiously directed efforts, Region II agencies can become just as dynamic in their public relations efforts as Boston's VNA. It is also apparent that the agencies need to designate a person as their public relations director or community education director, if desired, and let that person implement a public relations program with similar guidelines and functions as previously outlined. The director and assistant director, if they are to maintain their other duties, cannot handle the job. As one director put it: "I can safely say that there is no way for a director to function in the public relations capacity on a full-time basis--you cannot do it--you can compromise by giving up your weekends and evenings and early mornings. I want to meet the person that can!"

Health Fairs, Operation Health Check and Blood Pressure Clinics should not be defined as public relations. They are events that an agency may attend, but public relations is an administrative function that is scientifically researched, planned and carried out to meet an agency's objectives. Public relations is the management of the agency's communications.

¹⁰Ibid., p. 53.

Communicating with Physicians

The home health care agency's communication with physicians is somewhat regulated. Agencies must have physicians' orders (signed) and a plan of treatment established before they can begin making home care visits. The physician is then "kept up-to-date" as needed through communication vehicles, such as: person-to-person contact, telephone conversations, written letters and formal reports. The communication frequency (except for the required 60-day recert) depends solely upon the patient's condition and/or requirements. If the agency needs to deviate from the existing nursing plan, then the physician is contacted and a new treatment plan must be authorized by him.

The agency's communication with a physician, where it has his patients under its care, is very positive and advanced. Basically, the fact that Federal regulations require it and also because of the nature of the situation, sometimes affecting the patient's life, this communication effort has priority over others.

Several directors said that they are planning to utilize data processing in the agency-physician communication effort. One director stated that one of the things they are going to do in regard to communicating with the physician, about the patient's condition, is put the patient history and treatment plan and visit records in data processing. A form can then be sent to the physician's office, after the team conference meeting. It will then be possible to send patient history and a basic outline of everything done for

that patient monthly. If the patient is seeing two or three different physicians, each will get a copy and then know what the other physicians have ordered (medication, procedures, etc.). They don't get that kind of information now.

By utilizing modern, advanced technology this agency is going to make an effort to enhance its communication process with physicians.

Improving communication with the physician was a topic every director was ready to discuss. Since this is an area that can "make or break" an agency, it is certainly an area where time, thought and planning are needed.

One director offered the statement that physicians' offices tend to be zoos. When physicians get a communication from an agency, they want to make sure it is something legitimate, that it is something meaningful and that it is something they need to be bothered with.

Most of the concerns expressed regarding physician-agency communication indicated a need for educating the physician about services available from home health care agencies. Also, the education process should include the generic--what home health care is all about. One interviewee stated that improving communication is not with the patients they have, but in letting the physician who uses their agency know more of what home health care offers. The real problem, he stated, is getting the physician to identify that there are more patients who could utilize home health care. The need is one of educating the physician on what home health care is!

When asked the question, "In your opinion is there adequate communication between your home health care association and the physicians of the Region II area?" all of the directors replied in the negative. Some replied with a resounding "NO!"

A more positive note was expressed by one director, when she responded: "I have seen a change--say in the last year--that the physicians are more willing to listen to what we have to say about home health. Due to the market being so competitive, everyone is waving a flag [to the physician particularly] and bragging that their's [agency] is the best." She continued: "Physicians are confused and then they also feel obligated to their respective hospitals, that have home health agencies."

Confusion, lack of education, lack of centralized information about home health, and directors' negative remarks about the association's lack of adequate communication to the physician public, all point toward the evident need for a planned educational effort to be put forth by the Region II association. One director went so far as to say that it is ridiculous that the regional association does not have a full-time public relations/education person hired to implement such educational programs for the physicians and also programs designed to educate the general public.

By reiterating a previous finding, that no agency interviewed has a staff member with professional communication training, it seems that this should be a prime concern to the Region II association and its membership.

Home health agencies' communication with physicians whose patients are not under their care is varigated. Most of the hospital-based home health agency directors stated frankly that they are concerned with providing services to staff physicians of their respective hospitals or ones that utilize that hospital only. They do not seek referrals from other physicians on any regular basis, if at all. In their communication efforts to these staff physicians, they utilize one-on-one communication primarily. Some mailing of information was used, especially if a new member joined the staff and/or if a new service was added.

Local proprietary, national chain offices, for-profit and non-profit agencies do seek referrals and enter into what we will term as marketing.

Marketing of Home Health Care

Hospital-based home health care agencies actually do very little formal marketing, as previously indicated. However, they do utilize some marketing techniques, such as:

1. Utilize a patient "check list," which is left in the patient's room and/or placed in the admission packet.
2. Place a section in the patient's handbook (which is given to him/her by the hospital) explaining home health care services that are offered by that agency.
3. Utilize discharge planning/social worker as a go-between. When the social worker sees a need for home health care he/she contacts the home health care director and notifies him/her of that need.

4. Meet physicians on the floor of the hospital and discuss their patients and/or "home health."

5. Attend hospital public relations functions and discuss "home health."

Non-hospital based agencies are more competitively oriented and enter into the "business phase" termed marketing. Marketing has several connotations--the one that best serves the home health industry is "education" or "educating" the public.

R. R. Alward defines marketing as

effectively managing exchange relationships with an organization's markets or constituencies. To apply a marketing approach to nursing administration, an awareness of all divisional relationships that involve the exchange of values must be developed. The interactions of the nursing division with the larger health care organization, patient population, medical staff, community, and other markets are very complex. Identifying markets with similar needs, preferences, perceptions, attitudes, and behaviors is essential because each segment requires different marketing strategies, tactics, and goals. A marketing information and research program can provide the data necessary to analyze the needs and preferences of the nursing markets as well as the nursing organization's capabilities and deficits.¹¹

Simply put, marketing, for the health care agency, is the delivery of health services to specific publics that have been defined through "history" or research. Marketing communication in the home health agency is the delivery of messages to publics, that have been defined, through channels of the communication process. In planning marketing strategies, the messages are aimed at one or more

¹¹R. R. Alward, "A Marketing Approach to Nursing Administration, Journal of Nursing Administrators (April, 1983), 18.

of the four aspects of standard marketing strategy: education, promotion, pricing, and channel selection. Alward does state, and it is noteworthy, that marketing information and research can provide useful data that are essential for directing the appropriate messages through the proper channels to the specific audience or public that will utilize the information in a positive manner.

Ten factors have been identified by the Metropolitan Health Planning Corporation of Cleveland, Ohio that affect the market or use of home health care:

- (1) The patient's condition and functional level, and whether it is amenable to treatment or care at home.
- (2) The availability of services needed for the treatment or care of the patient at home.
- (3) The availability of personnel.
- (4) The availability of financial subsidy or third party coverage of costs of the services provided to the patient at home.
- (5) The attitude of management and labor.
- (6) The physician's choice of home care.
- (7) The preference of the patient.
- (8) The preference and supporting character of the patient's family and the physical suitability of the household.
- (9) The referral sources and their knowledge about home care resources and referral procedures.
- (10) Factors that affect dispersion of services throughout the geographic area.¹²

A study of factors affecting the market or use of home health care will enable the agency to better design a marketing plan for their services. Whether the agency decides to use education, promotion or channel selection in its strategies (or all three), it will be better prepared to present its messages.

¹²"Toward a Coordinated System for the Provision of Home Health Services." Report of the Metropolitan Health Planning Corporation Home Health Services Project (Cleveland, OH: Metropolitan

The existing marketing techniques employed by the agencies interviewed range from the "they know we're here--that's about it!" to the agency that actively calls upon physicians and sees them as potential referral sources. Its activities are planned, but not based upon research. One agency director showed considerable knowledge about marketing and remarked that his agency plans their marketing which includes one-on-one, telephone and direct mail communication. This expertise was not the usual.

Marketing abilities can be taught and the association should discuss the possibility of educational opportunities in this area. This generic approach can be useful but, of course, specific training for a particular marketing technique or plan is going to be much more cost effective.

Marketing specialists predict that although there will always be shoddy products, quacks and con artists, on the whole the consumer is best protected by market competition--and the market competition is affecting the health care field.

Each agency is desirous of gaining its "share of market." In order for it to do so it is going to have to measure its performance. To do that each should consider the following, according to Peter Hill:

- (1) Who are the people you are serving and what services are you providing them?
- (2) What demand do you now have in each of those service areas?

- (3) How do you project demand growth over the short-term and the long-term?
- (4) How well are you equipped to meet current service demands and what priorities should be established for the future?
- (5) What proportion of your community are you expected to serve?
- (6) What do you know about service demands of other agencies?
- (7) What is your share of the total community requirements?¹³

Unless each agency has the answers to these questions, it will be difficult to chart a course for the development of its organization, through marketing or any other means.

Home health care has grown rapidly in the past fifteen years. Basically, the growth can be attributed to the availability of reimbursement funding through the Federal Medicare program. Approximately 95 percent of all home care is funded through this program. In the late 1970's the Federal government initiated a program to cut much of the "waste" in the Medicare program. The program initiated a procedure called "Diagnostic Related Groups," or DRGs. This said, essentially: "This is all that Medicare will pay for a specific illness, procedure, etc." Also in the DRGs, there is a time limit to the length of a patient's stay in the hospital for which the hospital may be reimbursed. By forcing the hospitals to restrict the length of a patient's stay, many patients who need additional care are sent home--a great boost for the home health care industry.

By far, the majority of home health care management personnel have come up through the ranks of nursing and social services.

¹³Hill, p. 32.

Few, if any, have management, marketing, public relations or communications training, which supersedes their position of management in the agency. Most approach marketing and communications by the "seat-of-the-pants" method, and some have done fairly well to this point.

Market competition is growing and is affecting the home health field. "Agencies are dropping like flies," stated one director. Why agencies are failing is not a question that this study is prepared to answer. But, why people are asking questions about home health care, such as, What do they do? How do you get them to come to the home? Who pays for the services? and Are they licensed? is what this study is designed to investigate.

Simply put, the problem is that there is a lack of communication. The word that the health field likes to use is education. Educating the physician, educating the public, and even educating themselves are topics of seminars and special events. But, unfortunately, the majority opinion is that there remains a great lack of education concerning the agency's publics.

Agency directors readily identified their publics and also identified the communication vehicles that may be used to reach these publics. The problem is that the use of these vehicles is not planned and utilized on a consistent basis, basically due to the lack of time that a director has to offer in this area. Most agencies are utilizing methods that may better be described as "hit-or-miss" and "putting-out-fires," when approaching public relations and "educating."

The objectives of this study were to define the internal and external publics, identify the communication vehicles used to reach these publics, and to make any recommendations that are deemed feasible.

The publics have been identified and may be found, as listed, in Appendix B. A listing of the publics and the communication vehicles that are predominately used to reach these publics may be found in Appendix C.

At the beginning of the study, three assumptions were made:

1. That little communication is flowing between the agencies and their publics. This assumption was incorrect. Certain publics of the agency are being communicated with quite effectively. Others are receiving no communication or at least no effective communication from the agency, either due to a lack of time or lack of expertise in the area of communications.

The second assumption was that few, if any, of the directors or staff have professional training in communications. This assumption proved to be correct as indicated in the survey findings.

The third assumption was that little research is being done to identify agency publics. This assumption proved to be correct, as indicated in the survey findings. Only one agency was doing any research at all.

One director may have put it all into perspective when he discussed the agency's position and its communication efforts: He stated that home health is a complicated business. In general, it is not very well understood and its position in the market place

is not understood. As a general rule, physicians do not understand the position of home health care in the total health care field. They are certainly highly capable of learning where home health fits in and what it has to offer. They just never sit down and listen. They see the agency as competition rather than support and that is not the case. An agency can really help a physician out if it is allowed to. It can mesh with the services the physician provides and not take business away from his office.

It thus is concluded that the agencies and the association need to implement education programs, directed to specific publics, through proven communication channels to facilitate a better understanding for all concerned..

Recommendations

Association

Invest in a full-time person, either on a state or regional basis, to implement public relations and "educational" programs for the home health care industry in general. These programs need to be based upon scientific research and proven communication techniques.

Agencies

Designate an individual, either full or part time, as the agency public relations representative. The public needs to see that such individuals are on the administrative level, for credibility of source, and they need to be consistent in their efforts to reach and communicate with various publics.

Instigate in-house research to ascertain your publics and how they are reacting to your communication efforts.

Research your referral origins (type of inquiry, where they learned of your agency, etc.), then communicate appropriately.

Develop a marketing--"educational"--plan and implement it. Then follow up to see that it is on schedule.

Provide a communication vehicle where your employees may respond to concerns, gripes, etc., either anonymously or in person.

Design all programs so that the employees have an input and become a part of the agency--not just workers for it.

Design an education program that will enhance your staff members' ability to communicate and/or understand their duties. Utilize outside expertise (The University of Tennessee, physicians, etc.) to bring important messages to these meetings--not just sales representatives showing off a new product.

This study has begun a process that should be continued and certainly taken into more depth. Specifics should be researched and evaluated by both agencies and the association. Evaluation should be an on-going process, whether pertaining to the communication process or to other specific areas.

The responsibility for communication leadership--and indeed the ownership of the communication process and problem--rests with senior management. What is required is that they actively address the process with the help of competent professionals. That is no more and no less than any other major organizational activity gets or deserves.

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APPENDICES

APPENDIX A

INTERVIEW SURVEY

DEFINING PUBLICS

I would like to define the publics that you communicate with. We will divide them into two groups for convenience sake--external and internal.

Concerning internal publics, which of these are existing internal publics that you communicate with?

____ Office Staff
____ Data Processing____
____ Billing____
____ Personnel____
____ Acct./Finance____
____ Secretaries____
____ Other____
____ Other____

____ Mid-Management
____ Branch Adm.____
____ Public Rel.____
____ Marketing____
____ Finance____
____ Other____
____ Other____

____ Nursing Services
____ Nurses____
____ Social Worker____
____ PT & ST____
____ Aides____
____ Nutrition____
____ Other____
____ Other____

____ Board of Directors____
OTHER____
OTHER____

Concerning external publics, which of these are existing external publics that you communicate with?

____ Physicians
____ Hospitals
____ Administration____
____ Discharge Pl.____
____ Other____
____ Other____

____ Government
____ Federal____
____ State____
____ County____
____ Local____
____ Other____

____ Medicare
____ Medicaid
____ Home health agencies
____ Home health associations
____ Other____
____ Other____
____ Other____

_____ Consumers
 _____ Gen. Pub. _____
 _____ Patients _____
 _____ Pat. Families _____
 _____ Other _____
 _____ Other _____

In communicating with internal publics--Do you use one or more of the following:

- 1) Company/Employee Newsletter Yes___ No___
 (NO....go to 2)
 - 1a. Do you produce the newsletter in house? Yes___ No___
 - 1b. Who produces and designs the newsletter? _____
 - 1c. Is the newsletter designed for employee response? Yes___ No___
 - 1d. How often is the newsletter printed?
 Weekly _____
 Monthly _____
 Quarterly _____
 Annually _____
- 2) Do you have an employee council or committee that communicates to the administration employee concerns and ideas? _____
- 3) Do you utilize a bulletin board for employee/adm. use? _____
- 4) Do you utilize focus group meetings to enhance communication with your internal publics? _____

In communicating with external publics--Do you use one or more of the following:

- 1) Do you advertise? Yes___ No___ (NO go to 2)
 - Yellow pages _____
 - Speciality (Pens, pencils etc.) _____
 - Billboard _____
 - Radio _____
 - TV _____
 - Newspaper _____
 - Magazine _____
 - Other _____
 - Other _____

Is your advertising budgeted or do you divert other funds for this purpose? _____

- 2) Do you participate in public relations activities? Yes___ No___
(NO go to 3)

Operation Health check_____
Health Fairs_____
Speak at club functions_____
Blood Pressure Clinics_____
Other_____
Other_____

2a. Do you employ a PR director or full-time person_____

2b. Are your PR activities budgeted or do you divert funds
from other areas_____

2c. How many man/hours/week are spent in PR work_____

- 3) In communicating with physicians whose patients are under
your care:

3a. Do you regularly communicate with these physicians?
Yes___ No___ (NO go to 4)

3b. What communication vehicle do you use?_____

3c. After a team conference meeting, do you contact the
patient's physician or send him a brief to keep him
up to date? Yes___ No___

3d. How often is this done? _____

3e. What communication do you use for this purpose?_____

3f. What communication have you established to keep this
physician up-to-date on the services that you offer?

- 4) In communicating with physicians whose patients are not under
your care:

4a. Do you regularly communicate with these physicians?
Yes___ No___ (NO go to 5)

4b. What communication vehicle do you use? _____

4c. Do you regularly solicit referrals from them? _____

- 5) Do you feel physicians understand your agency's position in the
health care market? _____

6) In your opinion is there adequate communication between your health care association and physicians of the region II area?

6a. What can be done different?

7) Only limited information can be absorbed by parents and spouses of patients during "official visits." Do you utilize other communication means to reach, reinforce and educate your patients and/or families? _____

8) What means do you use to communicate with area hospital discharge planners? _____

9) What can be done to better implement communication between the discharge planning department and home health agencies?

COMMUNICATION CONCERNING ADMINISTRATION ISSUES

To increase profitability and/or to enhance your position in the home health care market (for 1985) do you plan to:

- a. increase census through additional marketing efforts _____
- b. Continue with your current program _____
- c. Increase your cost efficiency _____

Which communication vehicle, that you presently use, has proved the most effective? _____

Has anyone on your staff professional communications training?

What is your main source of referrals at present _____

Do you monitor "requested services" (services that people ask for and you do not provide at the present) _____

Do you use this list in planning future services _____

Do you use formal or informal research to evaluate:

Publics _____
Communication vehicles _____
Marketing position _____
Other _____
Other _____

Are there any other comments that you would like to add concerning communications and/or home health care in general? _____

THANK YOU FOR YOUR TIME

APPENDIX B

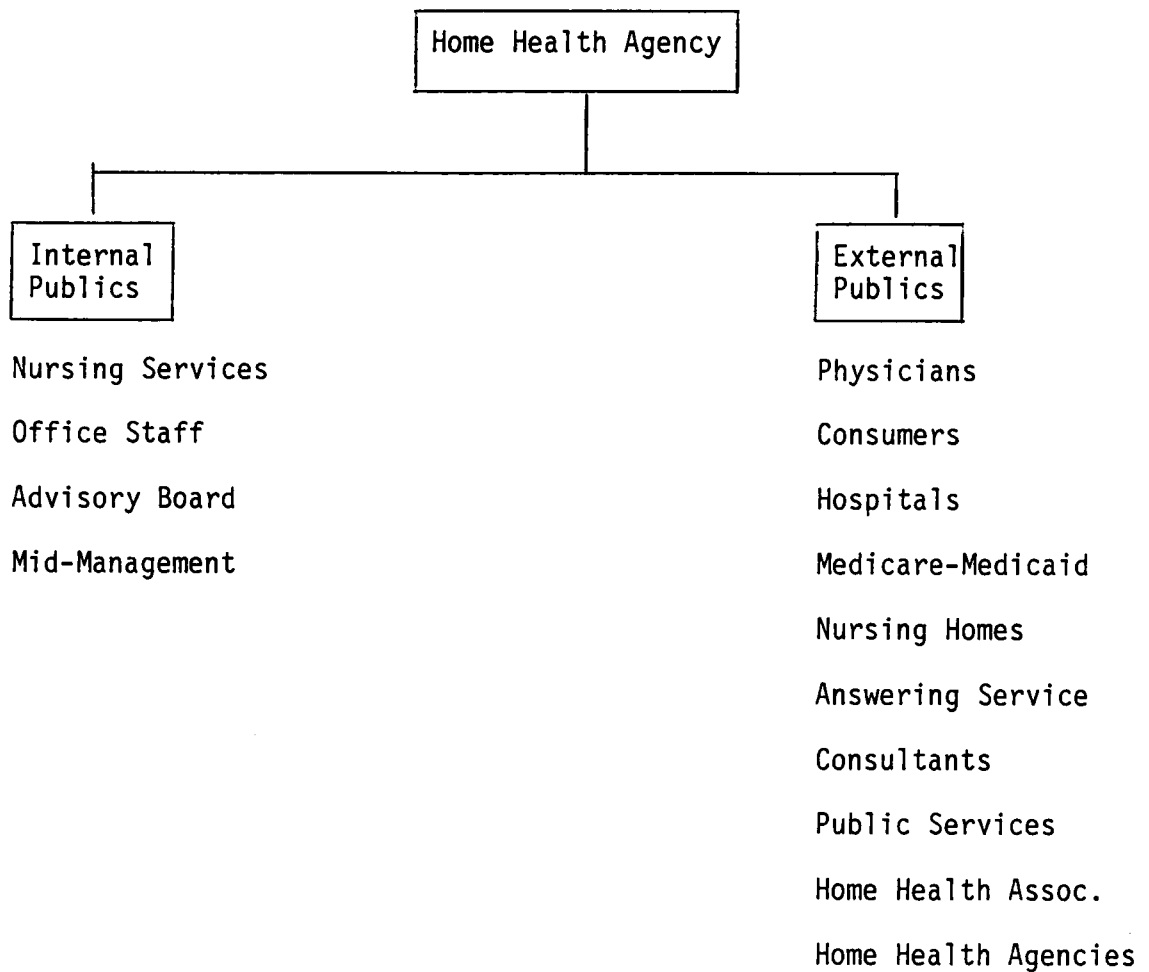


Figure 4. Home Health Agency Internal and External Publics as Identified by Survey

APPENDIX C

LISTING OF PUBLICS, DOMINATE COMMUNICATION VEHICLES AND FREQUENCY OF USE

PUBLIC	COMMUNICATION VEHICLE	FREQUENCY
<u>Internal Publics</u>		
Nursing Services	Newsletter Bulletin Board Person-to-person	Monthly-Quarterly --- As Needed
Office Staff	Team Conference Meeting Person-to-Person Person-to-Person Bulletin Board	Weekly-Monthly As Needed As Needed ---
Mid-Management	Team Conference Meeting Person-to-Person Phone/Notes	Weekly-Monthly As Needed "
Advisory Board	Newsletter Formal Mtg./Report Phone Letter	Monthly-Quarterly Bi-Annually As Needed "
<u>External Publics</u>		
Physicians	Newsletter Brochures Phone Formal Reports	Monthly-Quarterly As Needed " 60-days/ As Needed
Hospitals	Phone Reports (recerts/Summaries Person-to-Person Phone Person-to-Person	As Needed " "/60 days " As Needed "
Consumer	Advertising (Yellow Pages) Brochures Newsletters	Annually/Irregularly As Needed Monthly
Govt./Medicare	Formal Reports Phone	60-days/As Needed As Needed

APPENDIX D

October 31, 1984

Tennessee Association of
Home Health Care Agencies
5703 A N. Broadway
Knoxville, TN 37918

Dear Mrs. Connell:

In accordance with our phone conversation on Tuesday, October 30, I write you regarding the following request.

As a graduate student at the University of Tennessee, College of Communications, I seek endorsement, from the Region II council, Tennessee Association of Home Health Care Agencies, for a study/survey to be conducted for the purpose of studying the existing communication practices between the established medical community (physicians) and the relative newcomer to the medical field--home health care agencies.

I plan to prepare an agenda of interview questions. The answers to these questions may be used to aid interested parties in establishing a clearer understanding and/or determination of any communication needs and/or problems that may exist and need to be addressed.

The above study and survey will be conducted under the guidelines and supervision of a thesis committee, headed by Dr. Jerry Morrow, Public Relations Professor, College of Communications, University of Tennessee.

If you need any additional information, please contact me at your convenience.

Sincerely,

Richard A. Ballenger

cc Dr. Morrow
File

November 5, 1984

Region II Council
Tennessee Ass. of Home Health

Dear Board Member;

Please find enclosed a letter proposing a study/survey.

I will be contacting each of you by phone for your reactions and opinions.

Thank you;

Carolyn Connell

November 16, 1984

Richard A. Ballenger
5703 A. North Broadway
Knoxville, TN 37918

Dear Mr. Ballenger:

The Board of Directors of Region II Council of Home Health Agencies would like to endorse your study/survey on the existing communication practices between the medical community and home care agencies.

We are certainly interested in the results and hope we will have a chance to talk with you when you complete the study.

If we can be of assistance please feel free to call on us.

Sincerely,

Carolyn Connell
President,
Region II Council
Home Health Agencies



4711 Trousdale Drive - Nashville, TN 37220
Phones: 615 - 331-0463 & 615 - 331-0466

March 1, 1985

Mr. Richard Ballenger
Route 3, Box 83
Seymour, Tennessee 37865

Dear Richard:

Thank you again for your interest in the home health care industry. Your work will be helpful to us and I wish you much success.

The Tennessee Association for Home Health originated in 1977 by several home health agencies. Over the years, the association and activities grew and a staff was employed, (an Executive Director and Administrative Assistant.), and 193 members.

Enclosed is a directory which outlines the various association committees and goals. The list of members is outdated, but will give you an idea of our membership.

Also enclosed is a report I gave to the Governor's Cost Containment Committee in October, 1984 which has some pertinent data.

I hope this information is helpful.

Sincerely,

Gayla M. Sasser
Executive Director

GMS/psm

Enclosures

VITA

The author was born in Knoxville, Tennessee. He attended primary and secondary schools there, graduating from Young High School in 1962. He enrolled at The University of Tennessee and later transferred to East Tennessee State University. He entered the business world, without completing a degree, and established himself in the sales field.

In January, 1982 the author decided to return to school to broaden his educational and business opportunities and to gain a degree, and enrolled at Carson Newman College as a sophomore in the communications department. He received his degree two years later, and then enrolled in the College of Communications Master of Science degree program at The University of Tennessee, Knoxville.

Upon his return to school, he received national and regional recognition for his editing and publishing of school programs and magazine feature articles while a student.