EXHIBIT 103

INSTRUCTIONS FOR THE HOME HEALTH FUNCTIONAL ASSESSMENT INSTRUMENT (FAI)

This assessment instrument must be used for all patients selected for clinical record review with home visit, and for patients selected for clinical record review without home visits. It is your work sheet.

The form contains 5 modules:

- Clinical Record Review Modules A and B;
- Home Visit Module C;
- Patient Function and Care Summary Module D; and
- Agency Function and Care Summary Module E.

Write whatever notes you need in the Surveyor Notes section of each module. There are certain instances when you must write brief notes to explain your answers. Make every effort to be succinct in your responses.

Use the calendar work sheet attached to the FAI to determine whether the frequency and mix of visits was in compliance with the plan of care.

NOTE: Public reporting burden for this collection of information is estimated to average 1 hour per response. This includes time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to the Centers for Medicare & Medicaid Services, P.O. Box 26684, Baltimore, Maryland 21207, and to the Office of Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503. Paperwork Reduction Project (0938-0355).

Module A
Patient Condition and Anticipated Outcomes

Survey Date:	Enter the date on which you begin the record review of this patient.
Provider Medicare ID:	Enter the HHA's Medicare ID number in the upper right hand corner of Module A.
Patient HI Claim No.:	Enter the patient's Medicare Claim number. This is also referred to as an HI (Health Insurance) claim number. If patient does not have a Medicare number, enter N/A.

PATIENT INFORMATION

A1.	Patient Name:	Write in the name of the patient. This information will remain confidential. However, it is necessary for keeping track of your assessments.
A2.	Date of Birth/Age:	Enter patient's date of birth (DOB). Format should be month-day-year. If DOB not known, but age is, enter age. This should only be a two-digit (or perhaps three-digit) number. If six digits do not appear in this space, it will be assumed to be age.
A3.	Sex:	Check the appropriate box -- M = male; F = female.
A4.	Referral Date:	This is the date the HHA received a referral (either written or telephone) from the physician or hospital. This is not the date that the patient's family first called. (For Medicare patients, this date can typically be found on the Form CMS-485.)
	Hospital D/C Date:	Hospital discharge (d/c) date. This is the date that the patient was discharged from the hospital prior to this HHA admission. If patient was not hospitalized immediately prior to referral to HHA, enter N/A.
A5.	Start of Care:	The date of the first payable visit. (For Medicare patients, this date can typically be found on the patient's Form CMS-485.)
A6.	Admitted From:	Check appropriate box. This refers to the patient's last source of care.

A7.	Patient Risk Factors:	Check the patient risk factors that are related to medical diagnoses that apply. Chronic conditions refer to those conditions that the patient may have but which don't qualify as primary or other pertinent diagnoses. Check "None Known" if there is not evidence in the record that the patient has any factors or conditions that would impact on the problems for which the patient was admitted to home health.
A8.	Family Situation/ living Arrangement	Check only one. If the patient lives with a person other than a spouse, specify the relationship (e.g., son, daughter, friend, significant other). In some cases, the patient may live with a spouse and a child; if they live in the child's home, select child; if they live in the patient's home, select spouse.
A9.	Primary Informal Caretaker(s):	Check all that apply. The primary informal caregiver(s) is/are the person(s) the HHA has identified who will assume/share primary responsibility for looking after the patient.
A10.	Instructions:	The HHA should have ascertained whether or not the available primary informal caregiver(s) is/are able to receive instructions and provide patient care. It should not always be assumed that because there is a spouse or other person in the home that they are capable of providing care.
A11.	Living Environment:	Does the record indicate that there is reason to believe that the patient's living environment might detract from the HHA's ability to implement or complete the plan of care? (For example, bathroom does not have needed safety bars, therefore, patient will not be able to toilet self).

CONDITION/PROBLEM

A12.	Principal Diagnosis:	Enter the ICD-9-CM code and name of principal diagnosis for which patient is being treated. If known, give date of onset. (This information should be contained on the Form CMS-485. For non-Medicare patients, check the HHA initial assessment and/or hospital discharge notes/plan.)
A13.	Surgical Procedure:	List all recent surgical procedures performed. Give ICD-9-CM codes (V-codes, if applicable), name, and date procedure performed.

A14	Other Pertinent Diagnoses:	List the name, code, and date of onset of all other presenting conditions.
A15.	Impairments:	Check all that apply.
A16.	Medications:	Review the types of medications being taken by the patient. Enter the total number of different medications that the patient is taking. There are a number of things to look for when reviewing a patient's medications orders: known contraindications that the HHA may not be aware of; HHA awareness of allergies or drug sensitivities; prescription(s) for psychotropic or mood altering drugs. If there are other situations or problems with medications noted in the patient's record, include them here. Do not list medications.
A17	Prognosis:	This refers to the HHA/physician judgment as to the patient's prognosis at the start of care. For Medicare patients, this information can typically be found on the Form CMS-485. Check only one.
A18.	Medical Condition at Review:	Check the one that applies. "At review" refers to the survey review period. From reading the chart and talking with the HHA caregiver, you need to determine whether or not the patient's medical condition since admission to the HHA has improved, deteriorated, or is unchanged. You may need to wait until after the home visit to complete this assessment item.
A19	Visits/ Services:	Review the HHA's plan of care. Also, look for interim orders. Using the calendar work sheet provided, jot down the type and frequency of visits and services ordered. You may need to ask the HHA when their "treatment week" begins. As you go through the medical record, record the number and type of visits actually made. From the data you have gathered on the work sheet, determine whether or not HHA services were delivered as ordered. Check the appropriate answer.
A20	Anticipated Outcomes:	Another word for anticipated outcomes is goals. Request that a member of the clinical staff show you the places in the clinical record where anticipated outcomes for patient care are recorded. Include in your review Form CMS-485, "Home Health Certification and Plan of Care," and/or other records. Note any anticipated patient care outcomes that are related to the medical, nursing, and rehabilitative services ordered for this patient. These outcomes should be specific and measurable. For example,

	"Return to previous level of functioning" is inadequate if the medical record does not indicate what that level was, or how the HHA plans to measure its success. An adequate statement might be "Patient will return to full ambulation status, without ambulation aids, in 3 months." Since it is possible that outcomes could be revised during the course of care, include the date that the outcome was set. The HHA statute at §1891(c)(2)(C)(i)(II) of the Act requires that the standard survey include "A survey of the quality of care and services furnished by the agency as measured by indicators of medical, nursing, and rehabilitative care." Therefore, it is essential that you identify how the HHA defines, plans for, delivers and measures anticipated outcomes for patients.
Multiple Outcomes:	If there are more than 6 outcomes for a patient, continue to list these outcomes on the back of Module A.
Discharge Planning	From the record, determine if there is evidence that the HHA has begun planning toward discharge for this patient. Check the appropriate box.
Level of Achievement:	For each of the outcomes listed, check the level of achievement reached by the patient. Obtain information to answer this item from the medical record, the home visit, and conversations with the HHA caregiver.
	The term "Completely" implies that the patient has reached, at a minimum, the expected level of change (e.g., wound has healed, patient able to bear full weight, etc.).
	The term "Partially" implies that the patient did not reach the HHA's full expectation for improvement (for whatever reason). If you check this box, explain your choice (e.g., not enough time has elapsed, patient's condition changed such that outcome achievement is delayed, etc.) If you check "Partially" there should be some indication that the patient has made progress towards achieving the goal (e.g., Stage III/IV decubitus is now a Stage II).
	The term "Not at all" implies that no progress has been made toward outcome achievement. There are any number of reasons why this may be the case: "Outcome A" must be achieved before HHA can begin activities to achieve "Outcome B;" too early to determine/assess whether outcome has been met or whether measurable progress has been made. Explain your reasons for selecting this response.

Progress Notes: Does the patient's medical record contain written progress notes that describe and support the level of achievement for each of the anticipated patient care outcomes? Select the appropriate answer.

Module B

Activities of Daily Living (ADLs), Instrumental Activities of Daily Living (IADLs), Behavior, and Aids/Appliances

In this module, you will assess the patient's functioning level in the ADLs and the IADLs. USE MODULE TO REVIEW AND RECORD PERTINENT INFORMATION ONLY IF THE PATIENT'S ADMITTING DIAGNOSIS(ES) OR COMPLICATIONS OF THE SECONDARY DIAGNOSIS(ES) DIRECTLY AFFECT THE PATIENT'S POTENTIAL TO MEET HIS OR HER OWN ACTIVITIES OF DAILY LIVING OR INSTRUMENTAL ACTIVITIES OF DAILY LIVING, AND IF THERE IS RELEVANT INFORMATION THAT WOULD AFFECT THE HHA's PLANNING AND CARE OF THE PATIENT. You will also be asked to note any of the patient's behavioral or mental problems that are documented in the medical record.

The major objective of this module is to provide the surveyor with as complete a picture of the patient as possible. When preparing its plan of care, the HHA takes into consideration the patient's ability to perform certain functions for him/herself and the need for additional help; psychosocial factors, such as depression or disorientation, can also affect the patient's prognosis. In order for you to assess the appropriateness of the patient's plan of care and the anticipated outcomes, you should understand all of the factors that the HHA had to consider in dealing with this patient.

The HHA should have performed a thorough assessment on each patient at the time of admission to the agency. Review this assessment (and subsequent therapy assessments) to ascertain the patient's level of functioning at admission. Complete items B1-B6. Be sure to use the boxes marked "At Admission."

You should complete as much of Module B as possible given the information contained in the patient's medical record and what you learn from the HHA caregiver and the home visit. If the HHA is not treating one or more of these problem areas (ADLs, IADLs), it is quite possible that there will be no follow-up information about the patient's ability to perform these activities. You need only complete the "Record Review" and "Home Visit" portion of the patient and the reason(s) he/she is in home care.

NOTE: In the section that deals with IADLs, there are only two reference points -- "Record Review" and "Home Visit." Under "Record Review," include any and all information that you found in the medical record, whether it was recorded in the patient's initial assessment, or was documented subsequent to the start of care. Information that you obtained as a result of the home visit you make to the patient, record under "Home Visit."

In many instances, the HHA will have included changes in ADLs as part of the anticipated outcomes for a patient, e.g., post-stroke patients receiving physical therapy. Progress notes should indicate changes in the patient's functioning level. From your review of the clinical record, assess the patient's most current documented functioning

level and check the most appropriate box under the "Record Review" line. Information about patient progress should be found somewhere in the chart.

B1-B12 Responses

Needs no assistance -- this implies that the patient is capable of performing this activity by himself/herself, without the assistance of another person. If patient uses a mechanical device but performs the activity without the help of another, patient is considered to "need no assistance." For example, a patient uses a walker or cane and is capable of ambulating without the help of another; he/she is, therefore, considered to "need no assistance."

Helped by a person -- this implies that the patient is able to perform some major part of the activity, but requires the assistance of another person with some portion of the activity. For example, patient is capable of bringing food to his/her mouth, but he/she cannot cut meat or butter bread.

Unable to do -- this implies that the patient cannot carry out any significant portion of the activity--the entire function is performed for the patient by another person. For example, patient can walk to the bathroom but is neither able to transfer self to the toilet nor clean self afterwards, or patient uses bedpan that is emptied by another person.

If there is insufficient information to allow you to determine the functioning level of the patient, record this finding in the surveyor notes.

Needs More Help:

Check "yes" if there is evidence that the patient needs more help than he/she already has at "Record Review" time and "home visit". Use your own judgment as to whether or not more help is needed. Please remember that "needs more help" is not a wish list of services the patient "could use". If you indicate that the patient "needs more help," you must provide an explanation for your decision, and describe the kind of help you feel the patient needs. You must also note in your explanation whether or not the medical record documents indicate that the HHA is planning to provide additional help.

B1-B6 Summary

For the ADL, compare the patient's current functioning level with that at admission. Determine whether or not you think the patient has improved, is unchanged, or has deteriorated. If the patient has improved or deteriorated, provide a brief explanation. Check only one answer for each ADL.

B13. Behavioral/ Mental:

Write down all behavioral or mental conditions noted in the record (e.g., Alzheimer's disease, patient tends to wander, patient alert, etc.).

B14. Appliances:	Check the appropriate list of appliances and aids used by the patient. Note that there are two columns -- “Record” and “Home Visit.” Check under “Record” all of the appliances and aids noted in the medical record; check under “Home Visit” all of the aids or appliances used by the patient that you saw in the home.

Module C
Home Visit Module

This module must be used during the home visit. The purpose of the home visit is to allow the surveyor to see the patient, assess his/her understanding of the medical reasons that Medicare/Medicaid home care is being provided, assess the functioning level in ADLs and IADLs (if appropriate), and ascertain the presence of behavioral/mental problems. During this visit, the surveyor will also need to determine if there are environmental factors that could influence progress in the course of care. The home visit provides several sources of information--conversations with the HHA caregiver, conversations with the patient and the informal caregiver (if present), and direct observation. Good interviewing skills are a prerequisite to a successful home visit. You must not appear to be reading questions. You should try to establish a rapport with the patient/family. Try not to depend too heavily on the HHA caregiver. However, you should maximize your role as observer in an effort to minimize the need to ask a lot of questions.

FAMILY SITUATION

C1. Living Arrangement: Through conversation with the patient and/or the informal caregiver, verify the information contained in the medical record and recorded on Module A. Check the appropriate answer. If there is a discrepancy between the record and information obtained during the home visit, please explain. You may ask the HHA caregiver to explain. (For example, the daughter may have been living with the patient, but has since returned to her own home.)

C2. Primary Caregiver: Verify who the primary informal caregiver(s) is(are) for this patient. Refer back to information recorded on Module A. Explain any discrepancy.

C3. Instructions: Is(Are) the informal caregiver(s) able to receive instructions and provide the necessary care to the patient? You should determine this through conversation with and observation of the informal caregiver(s) who is(are) present during your home visit. Do not simply ask caregivers if they understand instructions. They should give you an example of what it is they do for the patient. You should include at least one example in your surveyor notes.

MEDICAL CONDITION PROBE

Through observation and conversations with the patient, the informal caregiver(s), and the HHA caregiver, determine the influence that the HHA has had in helping the patient/caregiver understand the patient's medical condition. There are seven things that you will focus on -- their understanding of the primary condition, how the care received

relates to the condition, how to report changes in the patient condition, their understanding of medication regime, diet, patient rights, and how to use the State home health hotline.

C4-C10 Responses:

Yes, Patient -- Yes, the patient has provided evidence that he/she understands.

Yes, Caregiver -- Yes, the caregiver has provided evidence that he/she understands.

Yes, Both -- Both the patient and the caregiver have provided evidence that they understand. Check this answer only if both have actually shown some understanding. Do not assume that because one understands, the other does too.

No -- Neither the patient nor the informal caregiver have demonstrated a sound understanding of the question.

Unknown -- Check this only if you were unable to ascertain the level of understanding. If "unknown," provide an explanation.

FUNCTIONAL CAPACITY PROBE

C11. ADLs: Determine the patient's functioning level in the relevant ADLs. You can do this through direct observation as well as through conversation with the patient and/or the informal caregiver. Record your responses on the ADL section of Module B.

C12. IADLs: Determine the patient's functioning level in the relevant IADLs. You can do this through conversation with the patient and/or the informal caregiver. Record your responses on the IADL section of Module B.

ENVIRONMENTAL PROBE

C13. Influence of Environmental Factors: Through conversation and observation, determine whether there is anything in the patient's living environment that could influence the plan of care and/or progress toward meeting anticipated outcomes. If you identify environmental factors, ascertain whether these influences have been discussed with the patient/caregiver by HHA staff and recorded in the clinical record, if appropriate. Explain in brief.

BEHAVIORAL/MENTAL PROBE

C14. Influence of Patient Behavior Problems/Mental Status:	Through conversation and observation, determine whether the patient exhibits any behavioral or mental problems that could influence the course of care and/or progress. You must also consider whether behavior problems or mental status could influence the patient's response to instructions about his/her rights. Explain in brief.

Module D
Patient Function and Care Summary

This module should be filled out for each patient after the home visit and record review have been completed. Use the Surveyor Notes section to explain your answers. This will prove extremely useful when completing the Agency Summary Form.

D1. Review Area: **Record Completeness** -- Check only one answer. Did your review of the record indicate that the required documentation was present in the record? Was the documentation informative? Are the records up-to-date? Possible responses include:

- **Substantially complete** -- All (or nearly all) of the required documentation was in the record and was up-to-date.
- **Partially complete** -- The patient's record was lacking some of the required documentation (even though the documentation was produced when the surveyor asked for it), or the documentation that was present was not informative or descriptive of patient condition/services provided.
- **Substantially incomplete** -- Major portions of the required documentation could not be found in the record.

Record Agreement with In-Home Observation -- Check only one answer. Does the patient's medical record accurately reflect what you observed during your home visit? (IF NO HOME VISIT MADE TO THIS PATIENT, NOTE THIS IN SURVEYOR NOTES SECTION AND PROCEED TO NEXT REVIEW AREA.) Possible responses include:

- **Substantially** -- For the most part, the record paints an accurate picture of the patient's medical condition,functioning level, and home environment (including ability of informal caregiver to provide care).
- **Partially** -- There are some discrepancies between what the record states and the patient's actual situation. Please explain your choice.
- **Not at all** -- There is very little resemblance between what the record states and what you observed during the home visit. Please explain your choice.

Adherence to Plan of Care -- Review the plan of care, and any subsequent change orders (the calendar work sheet should be useful for this). Determine whether or not the HHA followed the plan of care, in terms of number and type of visits made as well as the types of services delivered. The adherence to the plan of care for the medical condition should be viewed separately from the plan of care that deals with the ADLs. (If there is no care plan that deals with ADLs, check the appropriate box in the ADL line.) Possible responses include:

- **Complete Adherence** -- HHA was thorough in following the established plan of care. (Be careful to take into consideration the fact that the case may still be active.)

- **Partial adherence** -- HHA, in some cases, did not provide the prescribed number and type of services, and there is not a change order in the record to explain any diversion from the original plan of care. Explain the reasons for your choice.

- **No adherence** -- HHA has habitually disregarded the plan of care in providing services to this patient. Explain the reasons for your choice.

Patient Condition -- To complete this review area, you must consider what the patient looked like at admission, and what you know the patient to look like at the time of your review (based on record review and/or home visit).

The Patient Status for Medical Condition Should be Viewed Separately From That for ADLs -- If ADLs are not relevant to this case, check the appropriate box in the ADL line. Possible responses include:

- **Improved** -- The condition of the patient is better now than it was at the time of admission.

- **Unchanged** -- The condition of the patient has essentially not changed since he/she was first admitted to the HHA. (In many cases, change may not be expected, so don't view this necessarily as a negative judgment.) Briefly explain your choice.

- **Deteriorated** -- The condition of the patient has measurably deteriorated since the time of admission to the HHA for care. Briefly explain your choice.

SUMMARY EVALUATION OF PATIENT'S CARE

This section of the summary contains a set of eight questions that address your assessment of the appropriateness of the HHA's assessment, plan of care, and anticipated outcomes. Be sure to write surveyor notes to support your answers.

D2.	Assessment	Determine whether the assessments that the HHA made of the patient's medical ,nursing, and rehabilitative needs were appropriate at the start of care, and as care progressed. If you answer "No," provide an explanation under surveyor notes.
D3.	Plan of Care	Determine whether the types and frequencies of the services prescribed in the initial plan of care are appropriate. Consider such factors as the patient's condition at admission and the HHA's anticipated patient outcomes. If you answer "No," provide an explanation under surveyor notes.
D4.	Changes to the Plan of Care	Was the plan of care changed appropriately during the course of treatment to reflect any changes in the medical, nursing, and rehabilitative needs of the patient? Note that this refers to unanticipated changes in patient needs. For example: patient discharged sooner, or patient being treated for diabetes fell and broke a limb, additional home health aide services were ordered. If you answer "No," provide an explanation under surveyor notes.
D5.	Coordination of Services	Did you see evidence of coordination of services between (and among) the various disciplines treating this patient? If you do not find evidence in the medical record, it might be necessary to review HHA minutes of care planning meetings. If you answer "No," provide an explanation under surveyor notes.
D6	Therapy Services	Did the therapists treating this patient specify the procedures and modalities to be used, as well as the amount, frequency, and duration of these services? If you answer "No," provide an explanation under surveyor notes.
D7.	Patient Progress	Did the information you obtained through observation and conversation during your home visit lead you to conclude that the patient's progress (or lack of progress) was appropriate, given the patient's admitting and current medical and functional status? If you answer "No," provide an explanation under surveyor notes.

D8.	HHA Services Patient Status	Does the information you have reviewed on this case lead you to conclude that the HHA intervened appropriately and that the services provided to the patient made a difference in the patient's current medical and functional capacity? If you answer "No," provide an explanation under surveyor notes.
D9.	Additional Service Needs	In your judgment, could the HHA have done more to assist the patient in meeting medical, nursing, and/or rehabilitative needs within the range of usual HHA practice? If you answer "Yes," provide an explanation under surveyor notes and cite specific examples.

Module E
Agency Function and Care Summary

This module is to be completed only after you have reviewed the requisite number of records and conducted the required number of home visits.

Survey Dates:	Enter the dates that cover the period of time spent in this HHA's survey.
HHA Name:	Enter the name of the HHA. (If this is a chain, or multi-site HHA, enter the city/town of this particular agency.)
Medicare Provider ID:	Enter the HHA's Medicare Provider Number.
Service Area:	Check only one service area type. If you are unsure how to describe an HHA's service area, ask the administrator.
No. Records/Home Visits:	Number of records reviewed with home visits -- Enter the total number of patients for whom you conducted both a record review and made a home visit.
	Number of records reviewed, no home visit -- Enter the total number of patients for whom you conducted a record review only -- that is, you did not conduct a home visit.
	Number of home visits with no record review -- Enter the total number of patients for whom you conducted a home visit but did not complete a record review.
	Total number records reviewed.--Enter the total number of records reviewed during this survey, whether or not you conducted a home visit.
	Total number of home visits.--Enter the total number of patients for whom you conducted home visits, whether or not you completed a record review.

Summary Observation:

Check only one box for each of the review areas. These review areas are similar to those contained on the individual patient function and care summaries. Refer back to those when summarizing the HHA here. The responses include:

Favorable for most patients -- For the most part, the HHA receives high marks.

Favorable for some patients -- The HHA does not consistently receive

Unfavorable for most patients -- The HHA has demonstrated a pattern of inadequate marks in this review area. Explain your choice.

Review Areas:

Appropriateness of Assessments -- Determine whether the assessments that the HHA made of its patients' medical, nursing, and rehabilitative needs were appropriate at the start of care and as the care progressed.

Appropriateness of Care Plans and Services -- Determine whether the types and frequencies of the services prescribed in the initial plans of care were appropriate for the patients in this HHA.

Adherence to Plan of Care -- Determine whether the HHA followed the plans of care it established for the patients included in your review. This includes the frequency, type and duration of the services prescribed.

Coordination of Services Between Disciplines -- Determine whether there is evidence of coordination of services between (and among) the various disciplines treating patients in this HHA.

Completeness of Documentation -- Determine whether the medical records of the patients you reviewed were complete, that is, they contained all of the requisite documentation and that documentation was informative and up-to-date.

Treatment Contribution of HHA -- Determine whether the HHA intervened appropriately and whether the services provided to its patients made a difference in meeting their medical, nursing, and rehabilitative needs.

Surveyor

Summary: Before completing the surveyor summary, evaluate compliance with 42 CFR 484.12(a) and (b) and 42 CFR 484.36. (See §2204.) Read each of your 3 choices carefully before deciding whether there is evidence of a need for further action. Explain your decision.

Calendar Work Sheet

The last page of the FAI is the Calendar Work Sheet (CMS-1515F). Use it to determine whether the frequency and mix of visits is in compliance with the plan of care. This information is necessary to determine compliance with 42 CFR 484.18(a) and (b).

Before completing the work sheet, find out how the HHA defines its work week, that is, does its work week begin on a Sunday or the Start of Care (SOC) date? Also, find out from the HHA where the actual service dates are recorded in the patient's record.

To complete the work sheet, record the SOC date in the space provided. Complete the upper left-hand section which describes the planned frequency and duration of visits for each discipline. Put the calendar dates (June 1, June 2, etc.) for the period being evaluated in the upper left-hand corner of each box in the work sheet. Record the services actually provided in each day's box using the abbreviations for the disciplines. Use the most recent (re)certification period during which care was given to evaluate compliance with this regulatory requirement.

Determine whether the actual frequency of care delivered was in compliance with the frequency of care ordered by the physician. Circle any discrepancies.