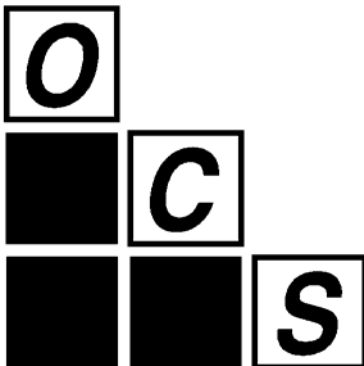


WHITE PAPER
02-001

**OBQI & The New Approach to
Performance Improvement
Part 1**



OUTCOME CONCEPT SYSTEMS®, INC

Contents

1.	Background & Introduction	Page 2
2.	OBQI—The Immediate Trend	Pages 2-3
3.	Performance Improvement—The New Approach	Page 4
	A. Indicators of Resource Use & Quality of Care	Pages 4-5
	B. Market Realities	Pages 5-6
4.	Looking to the Future	Pages 7-8
5.	Conclusion	Page 8

Background & Introduction

It is an understatement to say that the last few years have been challenging in home health. The evolving regulatory environment, combined with changes in accreditation requirements and the impact of recent economic forces, has been a hard-hitting reality. While HHAs are grappling with managing operations in the midst of these changes, they are also dealing with an increasingly competitive environment where marketing and referral source management are key. Within this context, many agency executives are embracing a new philosophy of performance improvement—one focused on finding and managing the optimal balance of resources and quality of care through an ongoing process of refinement.

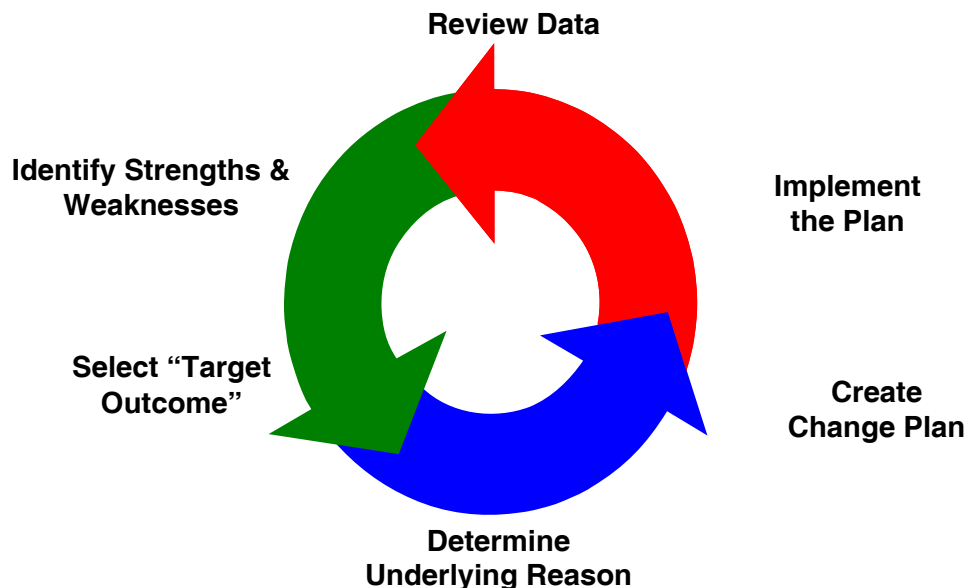
Most agencies recognize the importance of performance improvement (PI) and understand the value of comparative data; however, the historical lack of measurable benchmark metrics in this industry has forced many agencies to manage their PI activities around limited internal information and anecdotal external benchmarks. Without the ability to benchmark by diagnosis, perform regional analyses, compare by organization type, and truly marry outcome and utilization data, agencies have constructed their quality improvement initiatives around potentially incomplete information. Furthermore, the lack of “real time” statistics has hampered agencies’ abilities to monitor the impact of their PI efforts.

Organizations are increasingly aware of the need to step out of the data vacuum and take quality improvement the next step, because they recognize that they cannot rely on inferences and one-time snapshots to chart their course. While Outcomes Based Quality Improvement (OBQI) provides substantial support for the concept of a data-driven approach to PI, it is only one part of the larger picture. To achieve success, organizations must use information to improve patient outcomes in the context of resource availability and operational requirements.

OBQI—The Immediate Trend

The industry is buzzing with the concept of OBQI, or the philosophy that agencies should employ a systematic approach to improving quality of care. This involves actively reviewing outcomes data, using that data to identify both successes and opportunities for improvement, determining underlying reasons, selecting target outcomes, establishing and implementing a plan of action.

But the effort doesn’t stop there—As the diagram below depicts, OBQI is an ongoing process that requires consistent review of agency data to evaluate the efficacy of OBQI efforts and determine what other areas are in need of improvement.



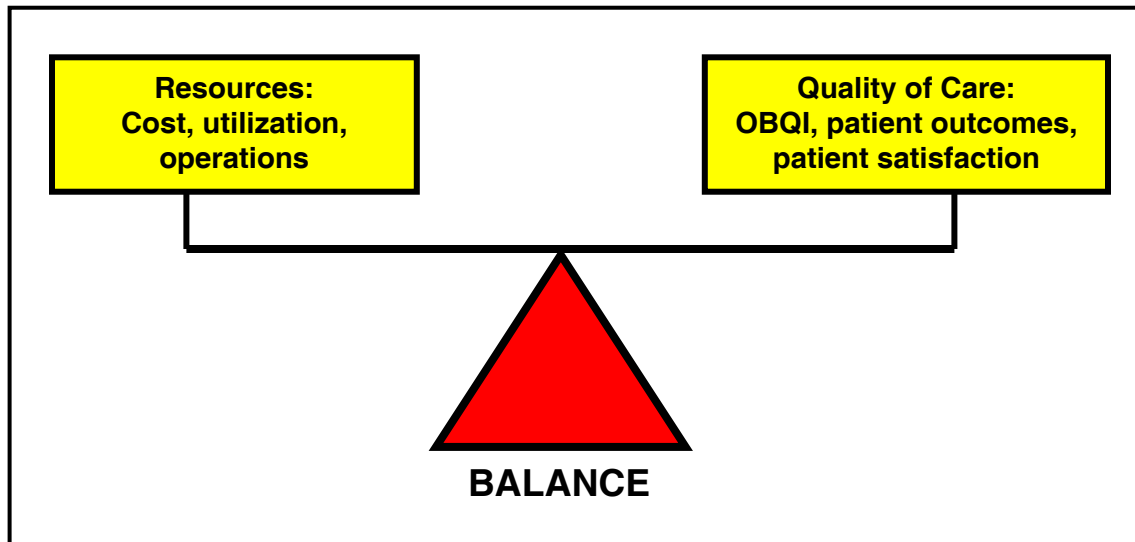
As the Center for Medicare and Medicaid Services (CMS) considers expanding OBQI beyond demonstration project participants and into the home health market as a mandated component of the Medicare home health Conditions of Participation (CoP), many agency executives are asking questions about how to implement this new process in their agencies. Where do I begin? *If I am already reviewing my outcomes, is that enough? How do I incorporate the OBQI process into my existing operations?*

It is important to recognize that some organizations understood the value of quality improvement early on and have already implemented the OBQI process, whether it is through participation in the OBQI demonstration project or by working with a vendor that offers access to outcomes data. Other organizations are only at the beginning stages of incorporating OBQI into their agency operations, and they may wonder what they need to do to get started.

To answer these questions, it is essential to broaden the focus beyond simply meeting another mandate. OBQI is not a uniform step-by-step methodology that must be implemented, and there is not only one right way to do it. Rather, it is a *philosophy* around improving outcomes that must become ingrained into an agency's day-to-day operations. OBQI requires that agencies demonstrate dedication to understanding and improving outcomes more for the survival of their agency in the reality of PPS than in direct response to a governmental requirement.

This is especially crucial in light of the differences that exist between agencies. In order to improve quality of care, organizations must customize their OBQI strategies to suit the unique needs of their patient populations and their agency characteristics.

OBQI is just one part of the larger picture. The realities of the home health market dictate that agencies focus their practices on the co-management of resources and quality of care. By only managing outcomes, in the absence of resource considerations, agencies risk long-term viability. Likewise, by only considering cost and neglecting patient outcomes, agencies fail to accomplish the most important mission of home care. Thus, successful organizations will carefully balance both aspects of the equation.

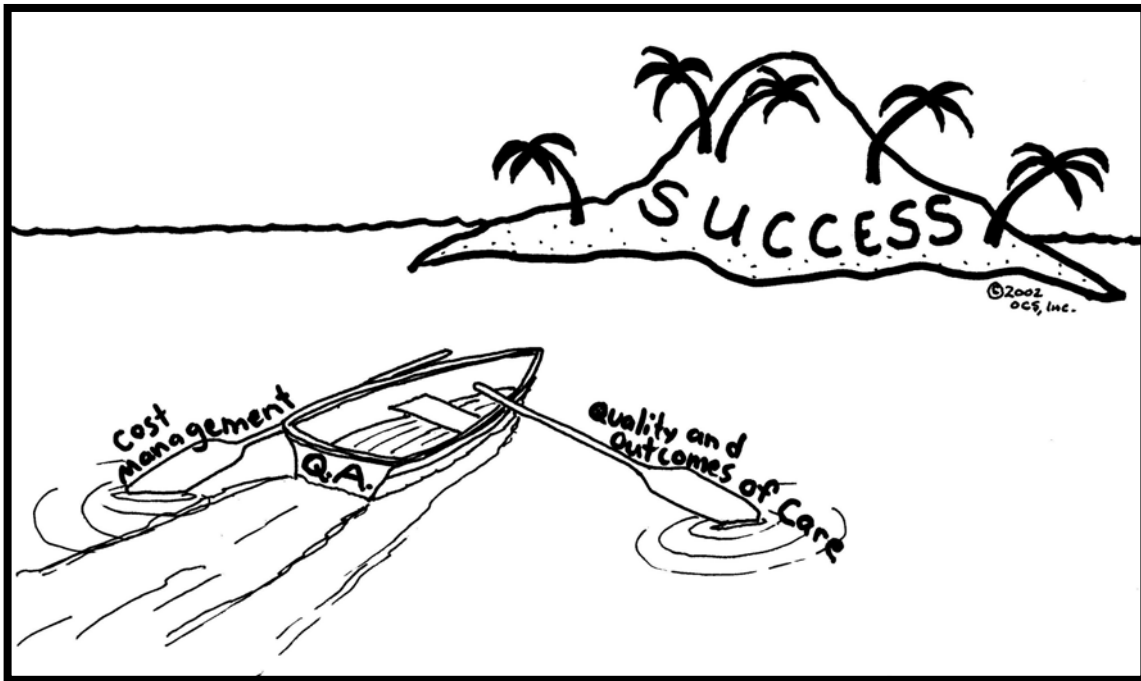


Performance Improvement —The New Approach

Most agency executives agree that ongoing performance improvement is key. But it is not the performance improvement philosophy that we have seen in previous years; rather, the new approach requires that organizations balance resource consumption and quality of care in the context of today's market realities. Successful agencies will go beyond reacting to accreditation and regulatory requirements—they will use their data to devise a customized strategy geared towards better managing all aspects of their organization.

Indicators of Resource Use & Quality of Care

Agency management can focus on a wide variety of measures to gauge their success or opportunities for improvement. In general, these measures fall into 3 categories: Quality Assurance (QA), Quality/Outcomes of Care, and Cost Management. The importance of each component in moving an agency toward success can be illustrated by using an analogy of a rowboat and an island.



Quality Assurance (The Boat): The most fundamental aspect of an agency's viability is Quality Assurance. In this context, QA refers to the very basics of agency operations—compliance with regulations, investigating adverse events, ensuring patient safety, and other mission critical activities. In the above analogy, QA forms the boat that keeps the agency above water. Without it, the organization will not survive—it is critical that agencies dedicate themselves to securing a firm foundation, eliminating “leaks” and making sure that the basics are met.

Quality and Outcomes of Care (Oar #1): More than just staying afloat, achieving success requires that organizations go beyond the minimum. They need to ensure that they achieve excellent outcomes and that the patients and their families are generally pleased with the services they receive. Through measuring and constantly enhancing a variety of outcomes, quality and satisfaction measures, agencies demonstrate a commitment to achieving the best for their patients. Striving for excellence in patient outcomes provides agencies with tools for marketing to

referral sources, demonstrating value to payors, thriving in a competitive environment, and satisfying the patients. Thus, quality and outcomes of care form one of our “oars.”

Cost Management (Oar #2): If an agency is only managing outcomes, however, they are rowing with a single oar and are greatly reducing their likelihood of achieving success. Financial viability requires that agencies remain conscious of resource use—thereby managing costs, the other “oar” in our boat analogy. Fiscal responsibility is a vital part of maintaining and growing any type of business.

Both of these areas of management are crucial for agency vitality. If agencies only use one oar (only manage resources without regard to quality of care, or vice versa), they will row in circles. By focusing on both “oars”—quality of care and cost management—agencies can propel themselves forward and reach success.

Market Realities

All home care organizations have certain absolute market realities with which they must contend. The longstanding effects of the Balanced Budget Act of 1997, the Prospective Payment System, Medicare home health Conditions of Participation, accreditation requirements and increasing competition between agencies are the most apparent forces working to define the home health market. National benchmarks provide a valuable context in which to evaluate agency outcomes and how they compare to the outcomes of other home care organizations also challenged by the same external forces.

Within this larger marketplace exists a great deal of diversity. Home health agencies operate under different state regulations, have a variety of business models, and function within unique geographic regions. These characteristics have an impact on the way organizations operate, and recent benchmark studies have demonstrated that variation in outcomes can be significant between different types of organizations. If an agency is to truly understand their information, and how it compares to their peers, they need to benchmark against similar organizations and not just the home health market as a whole.

Taking this one step further, one cannot discount the impact of different patient populations on agency processes and outcomes. Patient factors such as payment source, primary diagnosis, and the presence of wounds or pressure ulcers can lead to outcomes that are not necessarily representative solely of agency performance, but are influenced by the traits inherent in certain types of patients. Understanding differences between various patient groups can provide insight into how those groups impact agency outcomes. An agency with a patient population that differs significantly from the comparison group may expect outcomes data to vary according to those patient population differences. As such, it would be meaningful to compare how specific subsets of patients compare to other patients with the same characteristics in order to get a more accurate picture of performance.

To illustrate how patient-specific differences can impact agency-level outcomes, we performed a comparison of patients with the top three primary diagnoses at start of care (SOC) in home care for 3rd Quarter 2001:

- ❑ Osteoarthritis 715 (6% of all primary diagnoses nationally)
- ❑ Heart Failure 428 (5% of all primary diagnoses nationally)
- ❑ Diabetes 250 (5% of all primary diagnoses nationally)

Differences in Case Weight, LOS & Utilization: We first compared the average SOC case weight, length of stay (in days) and visits per patient for each of these three groups. We found dramatic differences when comparing patients within each diagnosis to each other and to the national norm for all patients. As the chart below demonstrates, average case weight ranges from 0.953 to 1.422 where the national average is 1.24. Visits range from 12.9 to 17.4 per patient where the national average is 17.5. The average LOS ranges from 27.3 to 51.4 days where the national average is 41.4.

Primary Diagnosis (ICD9)	Average SOC Case Weight	Average Total Visits	Average LOS
Osteoarthritis (715)	1.422	12.9	27.3
Heart Failure (428)	0.953	14.5	45.7
Diabetes (250)	1.222	17.4	51.4
National Norm	1.24	17.5	41.4

Source: 3^d Quarter 2001 data based on OCS proprietary national benchmark data warehouse of more than 3.5 million records

Differences in Outcomes: Do primary diagnosis and other patient-characteristics have an impact on outcomes? To answer this question we again used our groups of patients within each of the top three primary diagnoses and compared the outcomes of pain (M0420) and management of oral medications (M0780) as examples. Here, we saw significant differences in improvement and stabilization rates. Most notable is the difference in the improvement rate in both categories for patients with a primary diagnosis of osteoarthritis. We see a significantly lower rate of improvement in pain for these patients (51%) and a significantly higher rate of improvement in the management of oral medications (56%) as compared to heart failure patients (59% pain, 36% oral meds), diabetes patients (also 59% pain, 38% oral meds), and the national norm (57% pain, 37% oral meds).

Primary Diagnosis (ICD9)	Pain (M0420)		Management of Oral Meds (M0780)	
	Improved	Stabilized	Improved	Stabilized
Osteoarthritis (715)	51%	91%	56%	97%
Heart Failure (428)	59%	86%	36%	87%
Diabetes (250)	59%	88%	38%	89%
National Norm	57%	88%	37%	90%

Source: 3^d Quarter 2001 data based on OCS proprietary national benchmark data warehouse of more than 3.5 million records

Impact on Agency Outcomes: How are these differences relevant to performance improvement activities? Why are these differences important to consider when looking at agency-specific outcomes? Although statistics indicate that these top three primary diagnoses make up between 5% and 6% of the patients in home care on a national level, the concentration of these primary diagnoses within an individual agency can vary significantly. The chart below demonstrates that individual agencies may have up to 34% of their patient population with a primary diagnosis that is represented by only 5% of patients nationally.

Primary Diagnosis (ICD9)	National % of Primary Diagnosis at SOC	Low Agency Percentage	High Agency Percentage
Osteoarthritis (715)	6%	0%	31%
Heart Failure (428)	5%	0%	19%
Diabetes (250)	5%	0%	34%

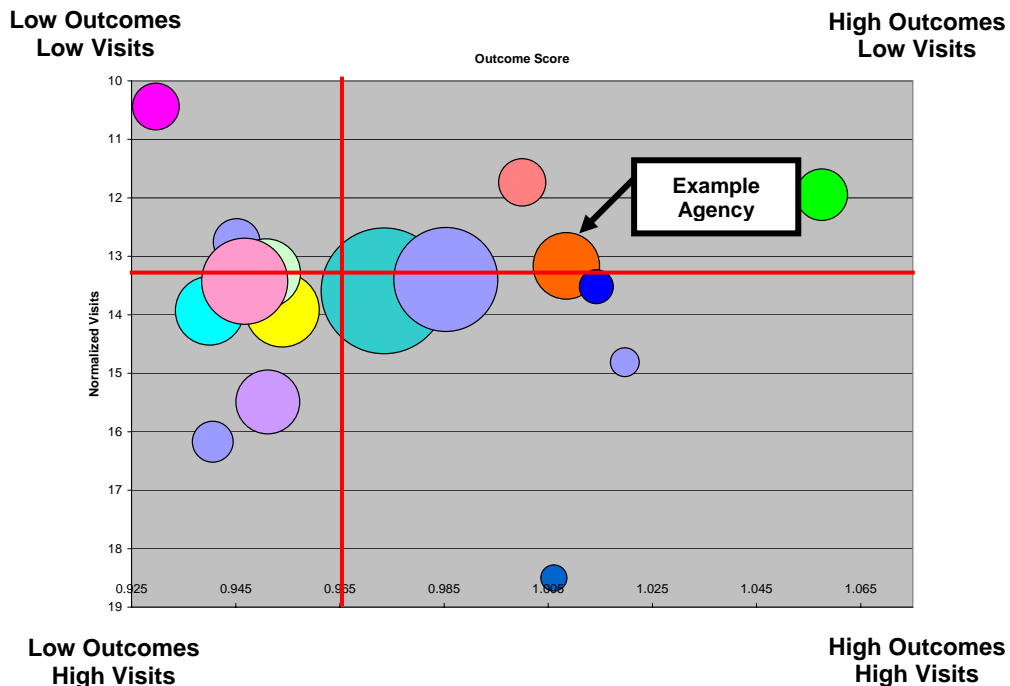
Source: 3^d Quarter 2001 data based on OCS proprietary national benchmark data warehouse of more than 3.5 million records

The variances that can be found in the outcomes for agencies or patients with particular characteristics highlight the importance of considering the market realities that are specific to individual organizations when using benchmark data for OBQI and PI efforts. Agencies must look to comparisons of like-organizations and similar patient populations to accurately identify both successes and opportunities for improvement. This “drill-down” should not be focused on creating excuses for poor outcomes; rather, this analysis should help organizations better target patient groups and identify more effective strategies for performance improvement.

Looking to the Future

For many agencies, this new approach to performance improvement may seem daunting—Where do I begin? How do I drill-down without a great deal of manual effort? How do I understand and evaluate the relationship between resource use and quality of care? Adopting this new performance improvement approach should not lead to information overload; rather, the future of performance improvement lies in establishing an easy-to-understand and high-level correlation between utilization and outcomes coupled with the kind of drill-down analysis that will facilitate more individualized comparisons. Using this as a starting point, agencies can identify successes and potential opportunities for improvement in the aggregate, followed by engaging a more detailed analysis of why they might see certain trends.

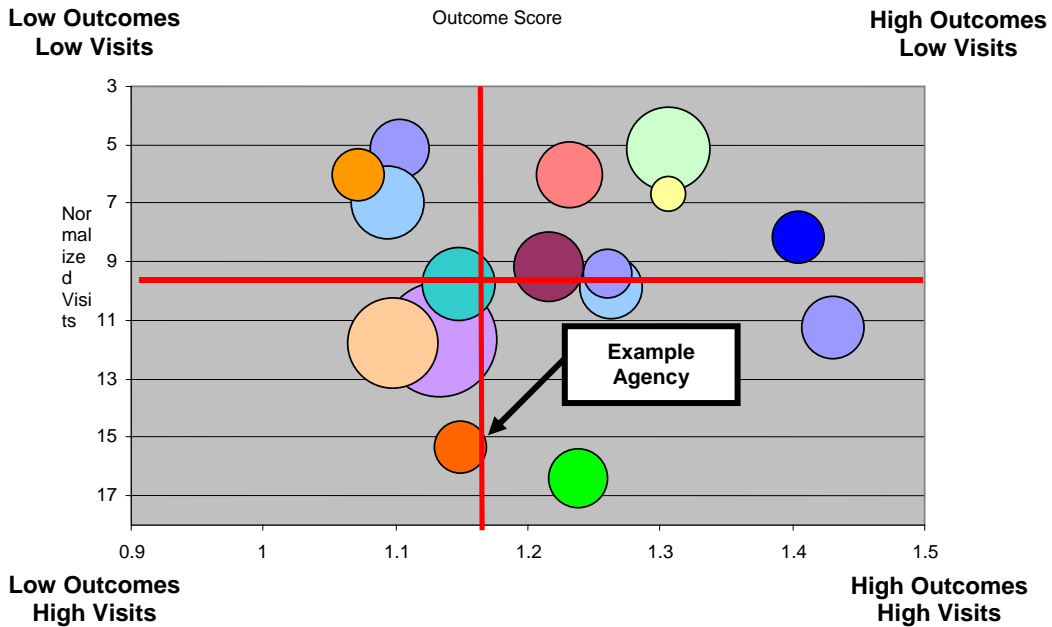
The following bubble graph may provide the initial high-level view necessary to begin this process. This graph depicts an agency's overall performance in managing outcomes and utilization as compared to industry norms. The horizontal axis represents the "outcomes score," or a measure of an agency's overall performance in managing outcomes. The vertical axis represents "normalized visits," or a risk adjusted measure of an agency's overall resource use. The bubbles represent individual agencies; the size of the bubbles represents agency size; and the cross hairs represent industry averages. According to this chart, the Example Agency is achieving higher than average outcomes through average resource expenditure, in terms of visits.



Includes patients discharged October 2000 – August 2001, with utilization data

This could be taken one step further to include only certain types of agencies in the comparison, in order to benchmark against like-agencies. Another method would be to restrict the patients included in the analysis to only those with certain characteristics, in order to understand how the agency's outcomes and resource management compare to others for specific subsets of patients.

The next bubble graph is an example of this approach, drilling-down to consider an agency's performance when looking only at their patients with a primary diagnosis of osteoarthritis (715), as compared to the performance of other agencies' osteoarthritis patients. In this analysis, while the Example Agency fared well in the overall management of cost and quality, they appear to be achieving slightly lower than average outcomes while expending higher than average resources, in terms of visits, for their osteoarthritis patients. Because osteoarthritis patients make up the largest percentage of primary diagnoses nationally, this may be a potential opportunity for improvement that deserves further investigation.



Includes patients discharged October 2000 – August 2001, with utilization data

Conclusion

With the challenges home care has experienced over the last several years, the thought of adopting a new approach to OBQI or performance improvement in response to a mandate can seem like too much. However, applying OBQI to agency management is a critical next step in maintaining viability in today's market. Organizations must incorporate OBQI into a larger performance improvement strategy focused on managing QA, quality of care, and cost in the context of an organization's individual market realities. It is through the application of this more comprehensive approach that agencies can position themselves strategically for the future.

About Outcome Concept Systems

Founded in 1992 by a team of home care professionals, OCS is a Seattle-based company focused on providing home care organizations with sophisticated, yet easy to use, information solutions. A market-driven organization, with a backbone of outstanding client support, OCS is the premier quality management vendor for home health, hospice, infusion, HME/DME and private duty organizations. Having amassed the nation's largest home health benchmark data warehouse and developed the market's only "drill-down" desktop reporting program, OCS is endorsed by trade associations throughout the country and recommended by major MIS vendors.

Suggested Reading:

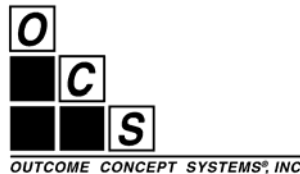
CMS OASIS Home Page: <http://www.hcfa.gov/medicaid/oasis/oasishmp.htm>

CMS Home Health Agency Manual: http://www.hcfa.gov/pubforms/11_hha/hh00.htm

University of Colorado Center for Health Policy & Research: <http://www.chspr.org>

OCS' White Paper Series: <http://www.ocsys.com/news/references.htm>

Home Health Line's Benchmark of the Week: <http://www.myhomehealth.com>



2719 East Madison Street, Suite 201
Seattle, WA 98112
206.325.3396 • www.ocsys.com