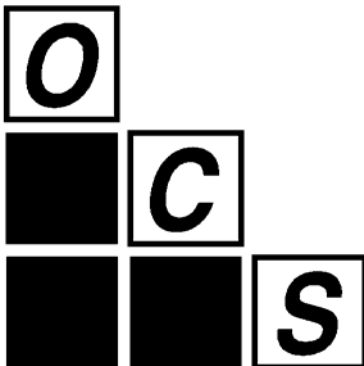


WHITE PAPER
02-002

**Benchmarking & Beyond—
Information Trends in the
Home Health Industry**



OUTCOME CONCEPT SYSTEMS®, INC

Contents

1.	Background & Introduction	Page 2
2.	Historical Perspective	Pages 2-3
3.	State of Home Health Benchmarking Today	Pages 3-4
4.	Dealing with Data Overload	Pages 4-8
5.	Conclusion	Page 8

Background & Introduction

In the last few years, agencies have grown increasingly adept at comparing their performance to that of other organizations. This management practice, called “benchmarking,” is particularly useful as a reference point for performance improvement activities. With its increase in popularity in recent years, benchmarking has undergone an evolution in both form and functionality. Agencies’ thirst for comparative data has led to the emergence of several distinct types of benchmarking—clinical, operational, patient satisfaction, and resource/cost—with each form representing a different but important aspect of agency management.

Because agencies are demanding more and better information, benchmark functionality has grown increasingly sophisticated, with the development of characteristic-based comparisons, flexible reporting options, and massive data warehouses for more detailed analyses. However, the evolution is not complete—agencies now require a new type of analysis, focused on high-level executive summaries while reducing the current “data overload”.

Historical Perspective

Performance Improvement (PI) is not new to home health. Agencies have engaged in activities to improve quality of care for as long as they have been in business. However, their ability to solidly ground PI efforts in data was historically limited due to the lack of available information—primarily the lack of a standardized data set. PI became a cumbersome process that was often based upon anecdotes and one-time snapshots.

The answer to this problem came in the form of the OASIS (Outcome and Assessment Information Set), a standardized assessment that all Medicare-certified HHAs must gather on patients at specific intervals during their tenure in home care. The OASIS was designed to be a patient outcome measurement tool, focused on tracking the change in patients’ status across certain clinical and functional areas. For the first time, with the CMS OASIS mandate, agencies had a uniform tool that would allow them to objectively analyze patient outcomes and benchmark performance. At the same time, the OASIS mandate presented significant challenges to the home care industry—paperwork, computer systems, clinician training, and billing systems all needed to be updated.

The difficulty of implementing OASIS was not the only challenge faced by the home health industry in the late 1990’s. Between 1997 and 2000, agencies experienced significant restrictions in their overall funding. This trend started with the Balanced Budget Act of 1997 (which drastically reduced Medicare spending), it was followed by the institution of the Interim Payment System

(IPS), and it ended with implementation of the Prospective Payment System (PPS) in October of 2000. Because of the energy and effort required to navigate these challenges, most agencies did not have the time or management focus to devote to benchmarking, outcomes analysis, and performance improvement—until recently.

Under PPS, patients are categorized into 1 of 80 groups called home health resource groups (HHRGs) based upon answers to the OASIS. Agencies are then paid a pre-determined fixed rate for each patient based on their HHRG, regardless of the actual costs incurred for the care of that patient. In this system, agencies have more incentive than ever to provide cost-effective care. Meanwhile, the goal—of both CMS and HHAs—is to ensure that quality and outcomes are not jeopardized as agencies become more cost conscious.

In the last few years, most home health agencies have successfully navigated through the implementation of PPS and have gained experience in this new reimbursement methodology. As the pain of PPS subsides, a new industry-wide thirst for comparative outcome information is emerging. Agency executives want to know: *What outcomes are achievable for certain types of patients? What is the ideal number of visits required to optimize outcomes? How does my agency's case mix compare to others? What about my hospital readmission rates? Costs? How can I improve my agency's performance? Where do I start?*

State of Home Health Benchmarking Today

This new thirst for benchmark information has not been entirely provider-driven. Throughout the implementation of PPS, CMS clearly indicated that they planned to use data derived from the OASIS as a means to measure and compare adverse events and patient outcomes. At the same time, accreditation bodies, such as the Joint Commission for Accreditation of Health Care Organizations (JCAHO) and the Community Health Accreditation Program (CHAP), have both included outcomes benchmarking as a component of their accreditation requirements.

In early 2000, CMS released their first OASIS-based reports—the Outcomes Based Quality Monitoring (OBQM) reports. These reports served two primary purposes: (1) The Case Mix Report compares an agency's patient population to national statistics, and (2) the Adverse Events Report compares an agency's incidence of adverse events against national averages. Along with the OBQM reports came the requirement that agencies use this information to investigate the occurrence of adverse events.

One year later, CMS released risk-adjusted Outcomes Based Quality Improvement (OBQI) reports. These new reports benchmark each agency's performance across 41 different outcomes

(only 29 of the outcomes are currently risk adjusted) against a national reference. Unlike the OBQM reports, the OBQI reports did not come hand-in-hand with a new compliance requirement. Even with no mandate in place, CMS announced that surveyors will have access to agencies' OBQI reports and will formally begin using them to target surveys in Fall of 2002.

Perhaps most concerning to the industry today is CMS' plan to publicly release agency-specific outcomes data by or before February 2003. CMS officials propose to identify a small number of measures that best reflect agency outcomes and quality of patient care, benchmark each agency's scores against national reference norms, and release this information to the home health consumer base via the Internet (and possibly even full-page ads in local newspapers).

With all of the above developments, one thing is certain—benchmarking is now an institutionalized component of home health. Agencies are expected to use benchmark information as a part of their PI activities, and surveyors will be using that very same benchmark information to evaluate agency performance. Furthermore, agencies themselves are embracing benchmarking as a tool to manage the cost/quality relationship, not just meet compliance requirements. As the industry evolves, payors and referral sources will want to know how specific agencies compare to others. Finally, with the publication of CMS' data, consumers will have questions, and agencies will need to educate the public about what the quality indicators reveal about each organization.

In this new market, information will be central to home health agency survival. It is therefore critical that all agencies use benchmarks to ensure that they understand their own data better than the regulators, surveyors, payors, patients, and public. Agencies need to understand the reasons why they might see certain trends in the data; they need to understand how unique aspects of their case mix drive outcomes information; and they need to be able to drill-down to discover the root of a quality issue or the reason for a particular success. The bottom line—they need more information than what CMS has made publicly available.

Dealing with Data Overload

Even the most astute of agencies are grappling with a new problem—the home health industry switched from “no data” to “too much data” in a very short time period. With this swing of the pendulum has come the problem of “data overload.” Agencies are now grappling with the need to examine multiple reports from multiple sources: OBQI reports, OBQM reports, operational benchmarks, JCAHO compare and control charts, and OASIS-based benchmark reporting, to name of few. At times, it can seem like too much, and many agencies simply cringe when they hear that they need access to even more information to be successful.

So, what is the answer for data overload? *The answer is more data.*

How can this be?

Agencies are dealing with different types of data coming at them from different directions (publicly available data from CMS, internally derived reports, vendor-generated benchmarks). While agencies must use all of the information that is available to them, they are left to discover ways to synthesize all of it into something meaningful. They must manually dig through the information, identify how it all works together, uncover trends, and embark on a labor-intensive PI process. It is easy to understand how agencies start to feel overloaded with information and it can be very difficult to understand how more data can help with this challenge.

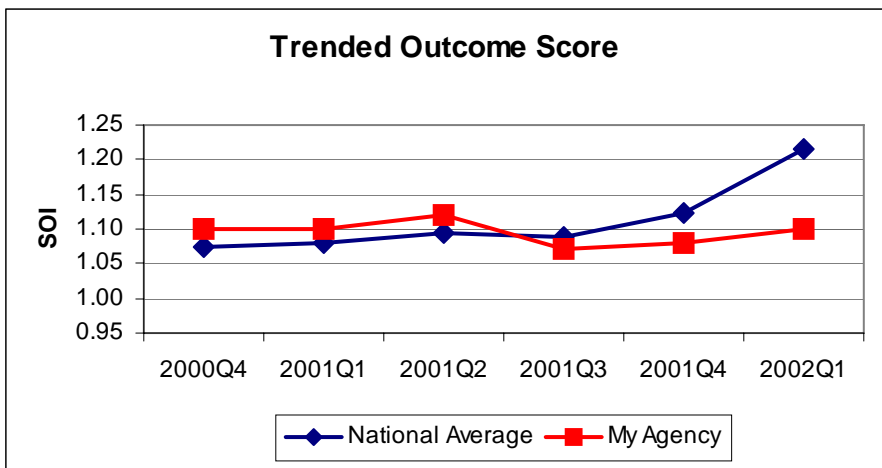
The answer does not lie purely in increasing the volume of reports and different types of data; rather, the key to success is more relevant and meaningful data. Agencies need access to the kind of information that *they* can control, rather than being controlled by the data itself. This data must provide a high-level depiction of overall performance while simultaneously enabling them to “drill-down” into more narrowly defined aspects of their agency.

Summary executive-level reports are the first key to success. While it is important to examine individual outcomes as a part of OBQI and PI activities, executives might want to understand how their agency performs overall in managing outcomes. Rather than trying to dig through multiple micro-level analyses to get at that answer, it would be useful to have a high-level portrait of performance. From there, executives can determine where to focus their time and attention.

But, how can one combine up to 50 different clinical and functional outcomes into one comprehensive picture?

One possible option—It is possible to create a single number or “score” that represents an agency’s overall performance in managing quality outcomes. One approach to developing this type of score involves looking at various outcome measures to assign a patient score at start of care and discharge, and then comparing the two scores to identify the change in patient status. Each patient would then receive an individual outcome score, which could be “rolled-up” to the agency level.

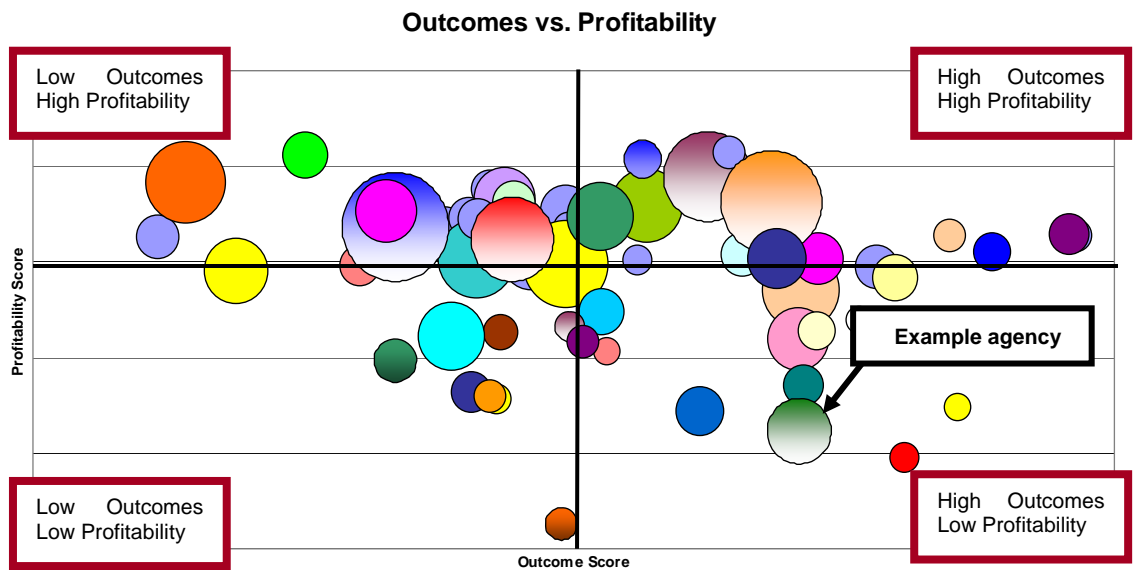
This resulting outcome score could be used in a couple of different ways. First, an agency could trend their outcome score over time to identify any changes in performance, as demonstrated in the following graph:



This trended analysis reveals that prior to the second quarter of 2001 (2001Q2), the example agency ("My Agency") was consistently above the national average. By the third quarter of 2001 (2001Q3), the agency had dropped below the national average, and it remained there in the subsequent quarters. If this were a real agency, they would most likely want to investigate any changes in agency practice or patient population between the second and third quarter that could have led to a decline in outcomes. They might also want to evaluate if this decline appeared across different groups of patients, or if it was isolated to a subset of patients.

Armed with this information, agency executives could then target their analysis in a more focused manner and determine whether they had a problem that needed "solving" or whether there was a certain group of patients that disproportionately contributed to this trend. In either case, it would be beneficial for agency management to understand this information before they faced questions by surveyors or the general public.

In addition to the trended analysis, a single outcome score can be used to easily synthesize and cross-analyze different types of data from different sources. In the following bubble graph, we plotted agency profitability against the above-mentioned outcome score in order to represent how well an agency is co-managing resources and quality of care.



In the above bubble graph, the example agency can quickly determine that they are located in the category of agencies with low profitability and high outcomes. This tells agency management that their outcomes are strong, but they are below average in terms of profitability.

An analysis such as this not only helps individual agencies assess their performance, but it can also be used to tell us more about the most successful home care organizations. Starting with a comparison like this, we can ask ourselves what is different about the organizations that fell into the “best practices” quadrant with high profitability and high outcomes. We can begin to solve this mystery by identifying the operational characteristics of the agencies in the upper right hand quadrant. This type of information could help agency management determine whether changes in their own practices might help them achieve better outcomes or higher profitability.

The second key to success is benchmark data drill-down. In addition to a summary perspective, agencies need to have better control over how they dig into the information to identify the root of a problem or the reason for a success. The concept of drill-down can be defined as the practice of narrowing the focus of outcomes analysis. Rather than looking at aggregated outcomes for your entire patient population, agencies need the ability to examine outcomes for a specific subset of patients. This subset can be identified by items such as diagnosis, referring physician, HHRG, case weight range, payor source, discharge disposition, or any combination of these. CMS does not provide sufficient detail to facilitate drill-down, but agencies can either use an outside vendor or rely on internally created databases and tools to get at this information—in either case, it is possible for agencies to conduct this type of analysis.

Unfortunately, too many agencies start with the drill-down concept and “get lost” in the details—and there are so many details. When this happens, PI programs and benchmarking analyses are sometimes abandoned because there’s just too much data and agencies don’t know where to start. This problem can be avoided if agencies use summary information to identify the problem or issue, and then focus drill-down activities on the specific areas that require further analysis.

Conclusion

With today’s benchmarking concepts and tools, agencies have the unprecedented opportunity to use information as a strategic advantage. First, they can better concentrate their valuable time and attention on the issues that really make a difference in their overall performance. Ultimately, this increases overall efficiency and effectiveness of agency practice. Second, they can better prepare for the onslaught of “outsiders” (surveyors, regulators, payors, and the general public) who have information about their specific outcomes and performance. Although agencies are concerned about being overwhelmed by more information, access to more of the right information will allow agencies to proactively address their critical strategic needs and position themselves for ongoing success.

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:

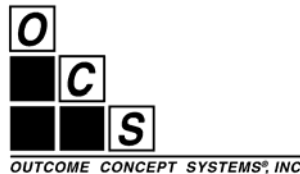
CMS OASIS Home Page: <http://www.hcfa.gov/medicaid/oasis/oasishmp.htm>

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