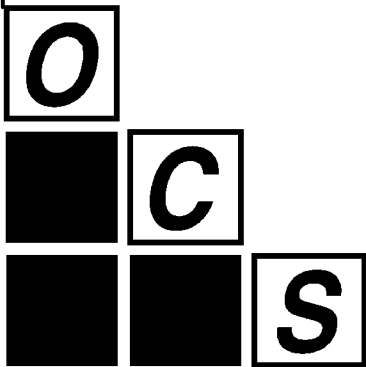


WHITE PAPER
99-001

PARTNERSHIPS IN MANAGED CARE
**Improving Quality and Satisfaction with Home
Health Services**



OUTCOME CONCEPT SYSTEMS®, INC

PARTNERSHIPS IN MANAGED CARE

Improving Quality and Satisfaction with Home Health Services

Alexis Wilson PhD, RN and Michele Quirolo, MS, RN, CHCE

Introduction

Price is not the only thing to consider when shopping for a managed care service provider. Due to the watchful eye of consumer organizations, including trying to tunnel out of negative public attention, managed care organizations (MCOs) are finally beginning to see that staying in business requires more than finding the lowest bidder for services. Increasingly, they are discovering that quality and value of services is what ultimately keeps the contracts—and the patients—coming.

Only 49 percent of HMOs were profitable in 1997, compared with nearly 90 percent in 1994 (Degenfelder, 1999). Still, managed care appears to be the method preferred to control medical expenditures—but it is evolving. Winning health plans will need to focus increasingly on customer service, large-scale operations, and significant patient enrollments. Medicare is requiring that health plans meet several new requirements (e.g., minimum enrollments, access and quality assurance) in order to enjoy participation in the multiple Medicare + Choice payment options now available to seniors.

Protection of patient's rights, and physician rights to act as patient advocates are important indicators to consumers when selecting a health care provider through employer plans or public programs. Because of the large number of enrollees, Medicare and Medicaid may offer more managed care choices than private employers (Davis and Schoen, 1998). Even so, while "consumer choice" is emphasized, managed care in fact places limits on choices of physicians, hospitals, and other health care providers. Today, selection of a managed care plan and selection of a physician are linked decisions, with important implications for patient satisfaction, continuity of care, and quality.

While accreditation by the National Committee for Quality Assurance (NCQA) or some other private organization suggests adherence to minimal quality standards, consumers still are faced with a difficult choice when they search for quality in managed care providers. This suggests that more direct data linking the outcomes of care with care processes will become increasingly

important in decision making. For consumers, outcomes are an indicator of care quality that lends security in the health plan they select. For health plans, accessing data that goes beyond the minimal standards of quality indicates voluntary participation to demonstrate quality of care on a higher level. This leads to real value in the marketplace, and the opportunity to stay ahead of competing plans.

A recent article in *Business and Health* (1999) cites a concept called “vendor management.” Vendor management links annual rate increases to performance. For health plans, a shift in strategy means no longer competing in the race to the bottom in terms of cost, but rather on the basis of quality and service. Incremental improvement on mutually agreed upon performance objectives is a concept that may still take years to accomplish, but it supports partnering with providers for a period of multiple years, in order to actually improve health care value.

Still, managed care plans are demanding and getting higher rates from employers to counteract higher medical costs, soaring pharmaceutical expenses, and plunging bottom lines. Hospitals, which contend they face more pressures from government payers, believe commercial managed care contracts represent the only area where they may be able to bargain for a better deal. Some hospitals and medical groups are negotiating contracts with health plans that will share directly in premium increases. Conversely, for hospitals to remain financially secure, they must find post-acute settings where patients can continue their treatment. For that, home health care is the most cost-effective option.

Home Health Care

Because of a mutual need to keep overall costs down, alliances between hospitals and home care agencies will grow. Right now, due to constraints imposed on home care by reductions in payment, some home care companies have adapted their clinical programs to meet the needs of certain patient populations with specific treatment plans. If patients who fall outside those plans are forced to remain in the hospital, they increase the hospital’s costs as well as the MCO’s. Working more closely, home care companies can adapt their clinical programs to meet the needs of the hospital, increase their own referrals, and decrease expensive inpatient care costs.

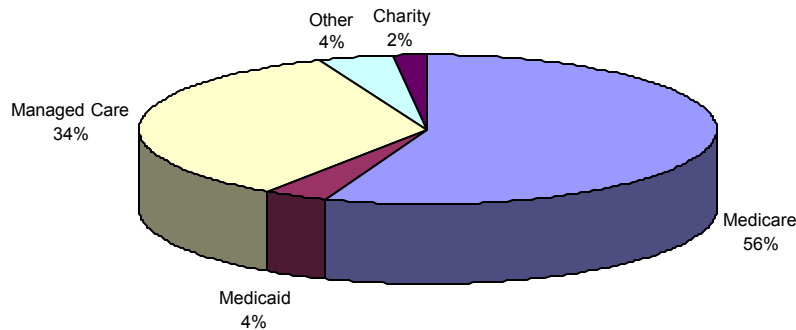
A recent study published in *JAMA* (Naylor, et al, 1999) bolsters arguments in favor of home health care utilization, including discharge planning before the patient leaves the hospital. The study demonstrates the potential of home care in promoting positive outcomes for hospitalized elders at high risk for re-hospitalization, while reducing the overall cost of care. The study examined the effectiveness of an advanced practice nurse (APN) planning the hospital discharge and providing home follow-up intervention for patients over 65 years old, and at risk for readmission to the hospital. The control (comparison) group received discharge planning that was routine for adult patients at study hospitals but with no APN intervention. If control group patients were referred for home care, they would receive only the standard care consistent with Medicare regulations. The results were that the intervention (test) group had fewer inpatient readmissions and fewer hospital days per patient. While many more studies such as this are necessary, the results suggest that if nurses are involved in the patient's discharge planning, with subsequent visits when they are sent home, better outcomes will typically occur and the health care system saves money.

A Case in Point

The Visiting Nurse Association of Hudson Valley (VNAHV) has been using patient outcomes to document quality and cost for nearly ten years. VNAHV recently celebrated its 100th anniversary of providing quality home care services to residents of Westchester County in New York State. Among the agency's many strategies for long-term success include its decisions made based on outcomes. The process began when the agency implemented an outcome-oriented patient documentation system and trained staff how to use selected measures in the day to day practice of home health care. The VNA negotiated contracts with local hospitals and physician groups to gain access to patients for discharge planning pre-discharge from the hospital.

Historically, the majority of home health agency revenues have been from Medicare. In recent years that has changed, as managed care becomes more prevalent (**Figure 1**). VNAHV is also located in an area with a heavy managed care penetration. Among the major payers are Oxford, Aetna, US Healthcare and Physicians Health Service. However, just as importantly, several groups of physicians are present, many with close ties to the local hospitals and community.

Figure 1
VNAHV Payers 1998



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VNAHV used outcome information to achieve success in three primary areas:

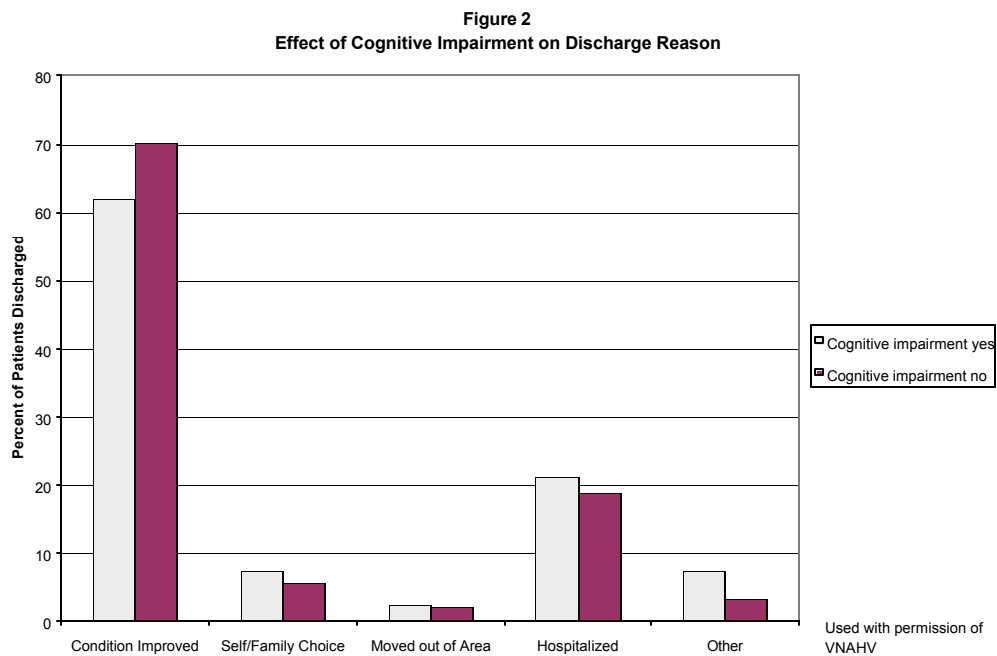
- 1) Internal operational efficiency;
- 2) Increased physician referrals; and
- 3) Managed care contract negotiation.

Internal Operations: A rapid advantage VNAHV observed from implementation of an outcome-oriented documentation system was the ability to stabilize staffing patterns based on the patient outcomes it observed. Because it had implemented outcome tracking systems early on, the organization did not have to make any major changes to staff during budget cutbacks as a result of the 1997 Balanced Budget Act (BBA). They had already adjusted utilization patterns downward based on the outcomes they achieved. Therefore, no radical changes in home visiting patterns became necessary, and no staff layoffs were required. Based on the outcome experience they already had, transition to the Outcomes Assessment and Information Set (OASIS) was also much easier.

Outcomes made the clinicians more aware of the results of the services they provided, which in turn helped them to understand the immediate (and longer term) impact their care had on patients. Care patterns emerged and so did feedback loops to improve care. At its most recent JCAHO survey, the organization received accreditation with commendation.

Increased Physician Referrals: Using physicians as the basic unit of data analysis, the VNAHV began a systematic analysis of the individual MDs making referrals and the patients they provided care to. Typically, in home health care, physicians complain that although they certify a plan of care that is updated periodically, they lose a sense of care continuity, or a clear picture of the complete care episode. VNAHV found that by receiving outcome data on all patients referred to home care, closer relationships with physicians were developed, which helped to decrease the reticence many physicians felt toward making home care referrals.

Initially, VNAHV worked closely with a prominent physician group in its community to develop reports based on the outcome data the nurses were collecting to help physicians see patient progress as well as potential problems. There was great concern on the part of the physicians as they were preparing to enter into a capitated provider agreement with a major insurer about who would be in control of patient care. However, it was clear that a critical factor in the existing health care environment was to reduce utilization of high cost care choices, avoid hospital readmission, and still assure quality. Using its data, VNAHV was able to demonstrate the effect of how co-morbidities, including cognitive impairment, impacted whether or not a patient was re-hospitalized, or discharged for other reasons (**Figure 2**).



Other examples of data presented to doctors were emergent care visits while receiving home health, the patient's ability to take medications independently, and much more. By discussing this information with the doctors involved, VNAHV was able to encourage more referrals because the benefits of home care were clear. When actual benefits were not evident, or there appeared to be problems with the patient care provided, data was presented to document the sequence of events. This provided the opportunity to forage a closer partnership with local doctors, instead of suffering potential negative effects when adverse patient outcomes occurred. Sometimes, the physicians provided input to disease and wound management protocols to benefit all parties concerned—especially the patient.

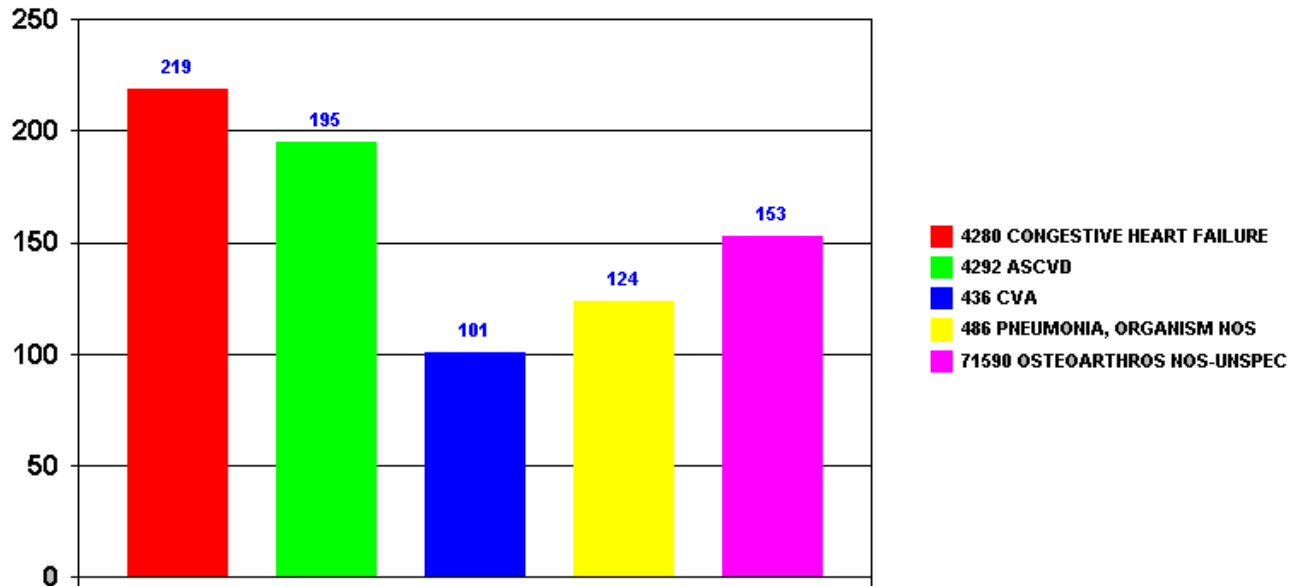
Managed Care Contracts: Contract negotiations between home care providers and managed care companies are often “bumpy” at best. The outlook for upcoming contract negotiations between managed-care plans and providers is not likely to improve in the coming years unless the providers are able to demonstrate the value of the services they provide. Value can be defined in a patient care equation that translates into the cost of care, utilization of services, and patient outcomes. The basic unit for consideration in the contract negotiation process is managed care's demands for lower rates from service providers and higher rates from employers, to counteract higher medical costs and declining bottom lines.

VNAHV was able to demonstrate the value-added benefits of its services to the managed care payers because they had the outcomes to back up home care use. For example, during contract negotiations with a payer, VNAHV provided a graph depicting the five major diagnoses of high service users by ICD9 code (**Figure 3**).

In the case of pneumonia where the readmission rate back into the hospital after discharge was high, the agency could demonstrate a lower cost per patient episode (even though they had a higher cost per visit) than some competing home care agencies. Primarily, this was because VNAHV could maintain a lower number of visits than its competitors, demonstrate good patient outcomes, and decrease readmits to hospital care after discharge. They also had the data to demonstrate lower inpatient lengths of stay than their competitors. Using the information described, VNAHV set up a solid foundation for partnerships with MCOs, including care management and joint planning of care.

Figure 3

Top 5 Primary ICD-9 Of Client Admitted Since 1998



Cases: 792 Admission date => 1998

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Ensuring Quality, Information, and Choice

Managed care plans have a strong financial incentive to lower costs at the expense of quality. So far, home health care has lacked the data necessary to make a legitimate argument against basing contract negotiation on anything but cost. However, as the consumer movement marches forward, managed care companies will be forced to become more responsive to patient concerns. Ask any patient and they will say, given the choice, that care at home is preferable to being in the hospital. To provide visiting nurse services simply “brings home” the caring attitude that health plans like to advertise. The competition between managed care plans must move beyond strictly lowering costs and into achieving a greater value, which includes patient satisfaction and positive outcomes. As comparable information on plan performance becomes more widely available, home health care has an opportunity to establish itself as a critical element in the continuum of managed care services, including cost containment.

VNAHV has served as a pioneer to demonstrate to MCOs that high quality home health care can be the best vehicle to save money and improve patient satisfaction with services. Protection to the public will remain mandatory, but perhaps with more home care, managed care plans can begin to realize the intent of their promise.

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Key Benefits to MCOs Working with Home Health Care

Working with home health agencies, winning health care plans can focus strategically on several marketplace advantages. Managed care appears to be the method preferred to control medical expenditures, which continues to evolve as more MCOs (and consumers) see the benefits of home care. Health plans will need to focus increasingly on:

1. Customer Service
2. Large Scale Operations
3. High Patient Enrollments

Meanwhile, consumers are still faced with a difficult choice when they search for quality in managed care providers. This suggests that more direct data linking the outcomes of care with care processes are necessary. Health plans that want to lend security to consumers will demonstrate:

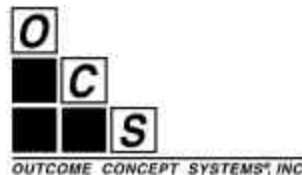
4. Outcome Data
5. Patient Care Management
6. Patient Satisfaction

Health plans that shift strategy to increasing home health use on the basis of quality and services will see rapid improvements in:

7. Competitive Position
8. Value and Quality
9. Physician Relations
10. Decreased Inpatient Stays

About Outcome Concept Systems

Outcome Concept Systems, Inc. is the pioneer in home care outcomes and benchmarking. The company produces clinical documentation and software technologies to assess and quantify the effects, or outcomes, of home health services. OCS provides computer programs to capture and graph the outcome information and assess the costs associated with the outcomes achieved. OCS also has a national reference database and produces performance benchmarking reports for participating agencies. The OCS performance measurement systems have met all initial requirements for approval by the JCAHO.



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