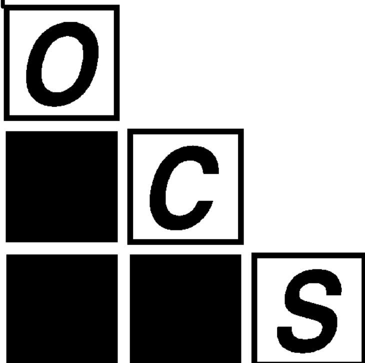
WHITE PAPER
98-003

Using Outcomes and OASIS as Strategic Tools



Using Outcomes and OASIS as Strategic Tools

Alexis Wilson, PhD, RN and Amanda Twiss

Introduction

Outcome data will soon be used in home health care to determine the value of clinical services from a new strategic perspective. Increasingly, outcome data and comparative benchmarking will become the norm for successful businesses--used to scrutinize and distinguish between home care service providers. Until now, the topic of outcomes has piqued the interest of providers and researchers, but the actual available information has had little utility on a larger scale. To date, there has not been enough uniform data to be of real interest to the clinical skeptics. Perhaps more importantly, outcome data is not typically used to fuel business negotiations or as part of the strategic financial and marketing planning process.

Outcomes are finally "coming into their own," and their potential to significantly impact the home health industry is starting to unfold. As health care becomes increasingly competitive, the need to demonstrate the value of services to consumers and payers is more compelling. So far, home care has lagged behind the hospital industry in its ability to demonstrate impact on the health and functioning of patients served. However, the data contained in the Outcomes Assessment and Information Set (OASIS) will drastically improve the availability of data because all Medicare certified agencies will be required to collect the 79+ items it contains.

OASIS data will help demonstrate the outcomes, or effects, of patient care and it will play a critical role in the case-mix methodology that will be used in defining prospective payment for home care. Presently, the multi-million dollar questions that exist in home care are: 1) How do the number of visits impact patient outcomes; and 2) How can costs be decreased without sacrificing quality? This paper will discuss how outcome data can answer these questions, and present competitive strategies utilizing the OASIS data.

There are several reasons that OASIS and other outcome data have not traditionally been used as a strategic tool in day-to-day business planning and operations. First, some in the industry believe that case-mix and risk-adjustment methods are still too imprecise to accurately predict resource consumption. However, the most significant reason why these tools have not been adopted as a management planning resource is a general lack of knowledge within the industry

about how to interpret, use, and present outcome information. Organizations that master these skills will have a key strategic advantage over the next several years.

Industry Background

Currently, tremendous variation exists across different geographic regions in the number of visits per patient during an episode of home care. This discrepancy has attracted the attention of policy makers, who have assumed that the variation is caused by over-utilization. In addition, with the number of visits per case increasing by over 30% in five years, and Medicare expenditures rising from $3.9 billion to an estimated $20.5 billion for the period 1990-1997, home care has become a principle target for cost cutting measures by the federal government. (HOMECARE News, Vol. XII, February 1998, p. 67).

The Balanced Budget Act of 1997 (BBA) has created a new operating environment for home care because of the recent reimbursement limits imposed by the BBA's Interim Payment System (IPS). In an attempt to control the rapid growth (and costs) of home care, the IPS will use utilization data from 1993 and 1994 (depending on cost reporting periods) to determine what Medicare will pay for visits. In addition, per beneficiary caps will be instituted as another mechanism to control costs by capping the amount Medicare will pay for a particular patient's care in the course of a year. Currently, it is estimated that seventy-five (75%) of Medicare certified agencies will have costs that exceed the new reimbursement limits. Most home health agencies will need to decrease their costs by at least 15-25%. As a result, a significant opportunity exists for home health care providers to use outcome data for competitive and strategic advantage. Furthermore, to justify the benefits of the services provided, home care must continually address issues of utilization and cost-benefit to customers. The power of outcome information needs to be harnessed decisively to enhance the understanding of consumers, payers, and policy-makers about the value of home health services.

The OASIS

In order to understand the clinical and the financial implications of using outcome data, some distinctions need to be made about the nature of the term "outcomes" and how various types of outcomes can be used to improve patient care and to maximize financial efficiency. The Outcomes Assessment and Information Set (OASIS), developed under contract for the Health Care Financing Administration (HCFA) by the Center for Health Services and Policy Research at

the University of Colorado, was originally designed to be used in the quality improvement process. While that is still a long-term goal, the current implementation plan is intended to provide the data needed for development of the case-mix methodology necessary for a home health care Prospective Payment System (PPS).

Since a PPS system is to be in place by October of 1999, HCFA has made public its intention to mandate the collection of OASIS data by all Medicare certified agencies during the summer of 1998, with electronic submission to State Agencies beginning in early 1999. Similar to the Minimum Data Set (MDS) in long term care, the OASIS data set will become the primary source of information for establishing payment for home health care and eventually to monitor quality. The OASIS items are collected/recorded by clinicians at (a minimum of) admission and discharge from care.

While some home care leaders question HCFA and Congress about the validity of using the OASIS for case-mix adjustment, they are beginning to recognize the potential benefits of collecting the data. The use of OASIS places a high degree of trust in the clinicians, mostly nurses, who will ultimately drive the case-mix data with clinical assessments. If those assessments are accurate, complete, and timely, the revenue to a home care agency can be maximized. Contrary to current feelings held by some home care leaders, if it is used properly OASIS can build a powerful body of evidence to support that home care provides clinical and financial advantages to the nation's health care system.

At the same time, on a somewhat parallel but quite different course, the Joint Commission for Accreditation of Healthcare Organizations (JCAHO) is requiring that all accredited home care agencies select a minimum of two outcome indicators from an "accepted" performance measurement system vendor by the end of 1998. Starting in March of the year 2000, data will have to be submitted from the measurement systems to the JCAHO in the form of benchmark reports.

With OASIS there will be a standardized database to facilitate comparative reports and "apples to apples" analyses. However, at present, two key elements are missing from the standard OASIS data collection process: 1) The link between outcomes and utilization and cost data; and

2) Tools to facilitate “real time” reporting of the information for use in an agency’s day-to-day operations.

Agencies that are able to clearly analyze the number of visits and other resource use indicators in light of shifts in patient outcomes will be well positioned to negotiate with referral sources and payers. However, they will need to be able to access different “slices” of information quickly and easily to respond to these outside parties—as well as to identify areas within the agencies that are in need of focused performance improvement efforts.

Presently, most home care organizations are leaving the task of data collection up to their nurses and management information systems. This may solve the data collection problem, but it does not solve the need to use all of the information. Until this issue is resolved, the wealth of data that could be used by organizations to improve, streamline, and demonstrate the value of their services will be lost.

Strategy #1 – Merge OASIS data with other key utilization and financial statistics for a balanced picture of an agency's performance.

Strategy #2 – Create or purchase tools to facilitate easy reporting of many different "slices" of OASIS data.

Outcomes: What are they?

The industry’s understanding of outcomes has increased significantly over the last five years. Most people are now familiar with the concepts and have accepted the importance of outcomes in determining organizational efficiency and value. Typically, outcomes are referred to in relation to the terms "outcomes management" and "outcome measurement."

Outcomes management documents the processes of patient care as a guide to more positive outcomes, and as a management tool to control the end results of medical interventions.

Simply put, outcomes management refers to standardized care processes that will, hopefully, create a positive patient response. The concept has been quite successful in hospitals and has now moved to a more sophisticated level of disease management (DM). Oftentimes, DM is based on the data provided by clinical guidelines that are, to a large degree, based upon outcomes management activities. This is much more difficult to master in home health care because of the variations in patient environments and in the caregiving ability within individual homes. However, the concept has staying power, and as the data improve, so will the ability of outcomes management programs to predict resource requirements.

Outcome measurement, on the other hand, examines the relationship between patient care processes and outcomes to quantify cost effectiveness and to classify changes in patient status between two points in time. The key is *two*. Patients must be assessed at a minimum of two time points using the same measurement tool to quantify changes in patient status. For example, dependence in bathing can be assessed on a scale of independence to dependence at admission and discharge, to determine the improvement, stabilization or decline during the time period that services were provided.

The goal of analyzing outcomes is to seek out and understand differences (variances) between the outcome data and the "norm." Norms (also referred to as "benchmarks") can be agency-specific, or they can be external, using some type of regional or national benchmark database. Regardless, when outcomes are much higher or lower than the norm, it is important to understand the reasons why, and either correct the process of care that lead to a negative outcome, or repeat the process of care that leads to a positive outcome. It is at this point that outcome measurement (identifying the outcome problem or opportunity) and outcome management (dictating a process of care) can work effectively in tandem.

As an aside, agency executives may also choose to promote (market) areas within their organization that vary from the norm in a beneficial way. For example, if an agency can demonstrate that its heart failure patients are less likely to be readmitted to the hospital than the "norm," this may be a useful piece of information to include in its marketing efforts with referral sources.

Strategy #3 – When using outcome data for performance improvement, focus first on areas with significant variance from the norm and examine the process(es) of care associated with these areas.

Strategy #4 – Use data derived from outcome measurement for both marketing and performance improvement.

Types of Outcomes

To comprehensively demonstrate the value of the services that are provided, a mix of outcome types is necessary—and all of them are valid. As soon as the industry becomes aware of the many types of outcome measures that can be collected, and how to use them, the art and science of outcome information will advance significantly. Several types of outcomes to consider are:

Clinical Outcomes: Clinical outcomes are designed to evaluate the process or outcomes of care associated with the delivery of clinical services. Clinical measures include things like medication use, infection control, or items from the patient assessment. Clinical measures focus on the appropriateness of clinical decision making and the processes for implementing those decisions. They are also useful in comparisons across different health care organizations.

Health Status Outcomes: Health status, in its broadest aspect, includes all of the manifestations of health, including functional status. Health measures address the functional well being of specific populations, both in general and in relation to specific conditions, preferably demonstrating positive change over time. The functional status of patients is often reflected in rehabilitation. For example, a change from dependence to independence in an activity of daily living (ADL) such as walking or bathing, could be called a functional status measure under the health status rubric.

Satisfaction Outcomes: Satisfaction is concerned with the patient perception of care services. An important development in health care has been recognition of the patient's point of view as a

legitimate measure of quality. Satisfaction measures focus on the delivery of care from the patient's/family's/caregiver's perspective. Some believe that satisfaction is not a valid outcome measure because it is subjective; others believe it is the only valid measure because if the patient is happy with the care they received, nothing else really matters.

Utilization Outcomes: Utilization outcomes are the easiest to gather. Utilization has to do with demographics, lengths of stay, re-hospitalization rates, and the number of cases admitted during a specified time period. While they do not measure the effects of care on patients per se, they are a source of good information about service trends within an organization such as the types of patients served, the most prevalent diagnoses, trends in the numbers of cases, etc.

Financial Outcomes: Financial outcomes reflect the costs of providing home care services. They include things such as the cost per case for a particular diagnostic category, the cost per visit or per episode, and the total costs of providing home health care services in any given time period.

This is by no means an exhaustive list of all possible types of outcomes, but it does encompass the major types that need to be examined by any organization to understand the relationships between many variables and to achieve a comprehensive picture of the care that has been provided.

Tools to Collect Outcomes

To maximize your organization's ability to see and understand the information that it has collected, a decision needs to be made about the type of tools that will be used in the collection process. Fortunately, the OASIS data set will provide a common set of data definitions, a critical tool to the outcome assessment process. Next, a data collection mechanism needs to be decided upon. From paper and pencil to pen-based or palmtop computers, this decision will be dependent upon an organization's resources and technological management ability. Next, to realize any advantage to collecting outcome data, there will need to be some type of reporting mechanism. Ideally, this will be available at the desktop personal computer (PC), to facilitate easy access by anyone that is interested. Reports and graphs are important tools for aggregating individual patient assessments, or to pinpoint other types of outcome information such as discharge disposition and the percentage of patients who improved in activities of daily

living (ADLs). PCs are generally much more flexible in their ability to produce reports than those that must be obtained from a larger main or mini frame system. PCs are also quicker to manipulate data, for example in Excel or Lotus programs, especially when combining clinical and financial outcome information.

Believe it or not, statistics are also an important management tool. This is not to say that the average administrator is going to care very much about correlation coefficients, or numbers of standard deviations away from the mean. But, statistics can be as simple as counts, percentages, etc., of data such as ethnicity, age mix, change in the number of referrals from one month to the next, or the average length of stay for a particular diagnosis.

Probably the most critical tool of all in the outcome measurement and reporting process is staff training and commitment. Staff will be critical when it comes to data integrity and the ability to trust that the data you are collecting is valid. Garbage in, garbage out, is the adage most appropriate to the organization that does not take the time to adequately train personnel in the data entry and collection process. It is well worth the investment to educate staff about the importance of outcomes to the future viability of the organization.

Bottom line, in any business you tend to manage what you measure. Thus, if you want to focus on managing utilization you need to track utilization as a part of your outcomes plan. If you want to manage patient satisfaction, you need to have a mechanism to measure patient satisfaction. If you want to promote a center of excellence in a specific clinical area, you need to carefully evaluate the clinical outcomes in that area.

Strategy #5 – You can manage what you measure. Agency management should understand the different types of available outcome data and consciously determine which outcomes they want to track over time.

Benchmarking

As noted earlier, benchmarking will be the tool that is most widely used in outcome measurement and reporting. Benchmarking is a continuous process of comparison, projection and implementation. It involves comparing your organization with others, discovering and

projecting best trends in practices, and meeting and exceeding the expectations of those who watch your performance. Done correctly, benchmarking will help you to learn from the experiences of others, and it will show you how you are performing in comparison to the “best in class.” It will identify your strengths and weaknesses, and help you to prioritize your improvement activities.

Many industries use external benchmarking to measure and evaluate their performance. Companies ranging from manufacturing firms, to restaurants, to consumer goods—focus on industry-wide analyses to help them fine-tune their business practices. Over the past 10 years, leaders within the hospital industry have begun using outcome and utilization benchmarking tools as competitive strategies.

While benchmarking within the home care industry is still a relatively new concept, a key benefit of the standard set of definitions provided by the OASIS is that it provides the ability to easily benchmark between organizations. Because every agency is collecting the same data in the same manner, agencies can compare themselves to relevant “norms”—as well as to other specific agencies (if appropriate). These standard definitions will allow the home care industry to begin to identify and measure progress toward “best practices.”

If systematically applied to your operations, the data obtained from benchmarking will also provide you with a corrective action plan. In other words, the data can be used to find where your organization excels and where the problems are that need to be fixed. Benchmark data is also invaluable for its “shock ability.” It readily points out areas where performance is lacking—which may surprise agency management and staff. Benchmarking allows you to set standards, and then to continuously measure performance based on an established reference point.

Strategy #6 – Benchmark your OASIS data (and other utilization and outcome information) against other organizations to identify your agency's strengths and opportunities for improvement.

Strategy #7 - Systematically use information derived from benchmarking to identify best practices and devise strategies to improve overall organizational performance.

Using Outcomes as a Financial Strategy

Financial outcomes, associated with clinical or other types of outcomes, become a powerful tool in proving the value of home care. Too often, agencies are hesitant to discuss finances and resource use in the same context as "outcomes." However, as the industry evolves, many are recognizing that these concepts are inextricably linked. The key to long term success for any organization is to determine the optimal mix of resources necessary to achieve the desired outcome(s).

Initially, focus on areas with high cost or utilization variation or extremes at one end or the other. If, for example, you determine that one clinician is able to get positive outcomes for diabetic patients in half the visits that it is taking the rest of the team, try to identify her/his practice patterns and determine whether certain methods of practice should be duplicated by other clinicians.

Once you are able to isolate financial outcomes, you have an excellent tool for beginning to compare data internally for cost related to satisfaction, clinical outcomes, utilization patterns, or service lines such as intravenous therapy, psychiatric programs, rehabilitation, etc. Using different types of outcome information will allow you to see a complete picture of your services and what is efficient and what is not. This data can then be used to highlight challenges for the management and staff. The use of this information will allow the organization to make informed choices about the services that are financially sound and positive for the patients. On the other hand, programs that are not achieving the results deemed necessary can be changed or eliminated based on solid data (evidence) instead of on hunches.

In the past, home health agencies have complained that their costs were higher because their patients were sicker than their neighboring organizations. Until an industry norm for case-mix adjustment is settled upon, or at least until more data are available for agency comparisons, be careful not to make blanket statements about the severity level of the patients you serve.

However, the data contained in the OASIS can be stratified (grouped) by agencies to begin to prove or disprove trends. For example, data can be grouped by age to determine if increased age is a factor in re-hospitalization rates, or death. Or, data can be grouped by patients who consistently improve in activities of daily living (ADLs) to determine the type of diagnoses that seem to have the most positive outcomes.

Strategy #8 – Use outcomes and benchmarks to determine the optimal mix of resources necessary to achieve the desired outcome(s).

Using Outcomes for Performance Improvement

The key to changing behavior within an organization is to provide ongoing and consistent feedback to staff. Remember to use benchmark data "shock ability" to get your points across about areas that need to change. Staff at the clinical and managerial levels will typically predict that their performance is at a higher level than the data may show. Use cost and outcome information to identify the areas of high variation in practice patterns, and watch the results that take place. Staff will respond to feedback that demonstrates they are somehow "different" in the way they practice, and most staff will want to fall into line with the norm at the organization, or within the industry. Providing reports on programs that are draining resources from the organization and are not producing tangible or positive outcomes for patients is an excellent method to foster communication, and to ensure that staff will understand why decisions to cut back or eliminate a particular program may be necessary.

At the same time, be prepared for and welcome opportunities for staff to question the validity of the information that you provide to them. Train staff about the use and interpretation of the data that is being used. This will be an excellent opportunity to reiterate the importance of completing accurate and timely assessments, and to allow staff to see that you are paying attention to variations in the data they collect.

Examples of questions to raise and investigate in a typical agency may be:

1. How frequently are diabetic patients re-hospitalized, and how much does that cost us?

2. At what expense (in skilled nursing visits) are we achieving superior improvement in the ADL ambulation for our hip fracture patients? Could we achieve the same results using different staff?
3. Does the absence or presence of a primary caregiver in the home make a difference in the number of visits necessary before discharge? If so, for which diagnoses?

Strategy #9 – The key to changing behavior is ongoing feedback. Provide agency staff with outcome reports illustrating their performance on a regular basis.

Strategy #10 – Involve staff in identifying opportunities for improvement by providing training on the use an interpretation of data.

Strategy #11 – Welcome opportunities for staff to question validity of information. It means they are "engaged" and paying attention.

Future Outlook

As the type and volume of outcome data become more sophisticated, standards will increase for detailed reporting. The organizations that master the data collection and reporting process will have a significant lead competitively and as the “bar” on outcome data is raised higher in the future. Increasingly, organizations will become experts at tracking their own processes and outcomes, and using the information as a vehicle for ongoing performance improvement, and more efficient operations.

Senior staff will look to outcome data to make decisions about new programs and to justify the elimination of programs deemed ineffective. Soon, a cost-benefit analysis that includes utilization, financial, clinical and patient satisfaction outcomes can help to make decisions. This will improve your ability to make the tough ethical choices you may face during budget cutbacks, or at least to paint a clearer picture about the complexity of dilemmas.

Soon, external benchmarking, which compares practices with other companies, will evolve into a strategic tool to examine how to compete more effectively. Down the line, strategic benchmarking, which seeks to identify winning strategies that have enabled high-performing companies to be successful in their respective marketplaces, will also become widely used in home care. Strategic benchmarking drives the longer-term competitive patterns of a company, and will enable home care companies to find tips on how to improve service and systems for better patterns of practice and customer satisfaction. Many additional uses of outcome information and benchmarks will become available as your organization becomes more proficient in data collection and analysis. Demonstrating the value of agency services through cost, clinical, satisfaction outcomes, etc., you gain the ability to negotiate successfully with outside organizations for new business and beneficial contracts.

As your ability to market services locally and nationally improves, you will also create an organizational image around your attention to quality, data, and operating efficiencies. What was once the long-range ideal of outcome measurement has become the short-range recipe to corporate success and the future of home care. To thrive in the new home care marketplace, leadership will increasingly see the strategic value of using outcome and OASIS information.

Strategy #12 – Agency leadership must view OASIS and other outcome information as more than just complying with a government mandate. They must view outcome information as a key strategic advantage.

Further Reading

Crisler, K.S., Campbell, B.M., Shaughnessy, P.W. 1997. OASIS BASICS: Beginning to use the Outcome and Assessment Information Set. Center for Health Services Research, Denver, CO.

Joint Commission for Accreditation of Healthcare Organizations (JCAHO). 1997. 1997-1998 Comprehensive Accreditation Manual for Home Care.

Joint Commission for Accreditation of Healthcare Organizations (JCAHO). 1998. A Guide to Establishing Programs for Assessing Outcomes in Clinical Settings.

Nathan, L. and Hartnett, M. 1998. “Implementing OASIS, Part 1.” OCS White Paper (Pub. #98-001).

Nathan, L. and Hartnett, M. 1998. “Implementing OASIS, Part 2.” OCS White Paper (Pub. #98-002).

Shaughnessy, P.W. and Crisler, K.S. 1995. Outcome-Based Quality Improvement. Center for Health Policy Research, Denver, CO (Prepared by National Association for Homecare).

Wilson, A.A. 1997. Home Care Outcomes and OASIS. Wilson and Associates, Gig Harbor, WA.

Wilson, A. and Nathan, L. 1997. “Understanding Benchmarks.” OCS White Paper (Pub. #97-001).

KEY STRATEGIES TO SUCCESS WITH OUTCOMES AND OASIS

Strategy #1 – Merge OASIS data with other key utilization and financial statistics for a balanced picture of an agency's performance.

Strategy #2 – Create or purchase tools to facilitate easy reporting of many different "slices" of OASIS data.

Strategy #3 – When using outcome data for performance improvement, focus first on areas with significant variance from the norm and examine the process(es) of care associated with these areas.

Strategy #4 – Use data derived from outcome measurement for both marketing and performance improvement.

Strategy #5 – You can manage what you measure. Agency management should understand the different types of available outcome data and consciously determine which outcomes they want to track over time.

Strategy #6 – Benchmark your OASIS data (and other utilization and outcome information against other organizations to identify your agency's strengths and opportunities for improvement.

Strategy #7 – Systematically use information derived from benchmarking to identify best practices and devise strategies to improve overall organizational performance.

Strategy #8 – Use outcomes and benchmarks to determine the optimal mix of resources necessary to achieve the desired outcome(s).

Strategy #9 – The key to changing behavior is ongoing feedback. Provide agency staff with outcome reports illustrating their performance on a regular basis.

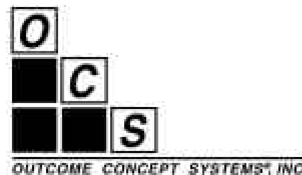
Strategy #10 – Involve staff in identifying opportunities for improvement by providing training on the use an interpretation of data.

Strategy #11 – Welcome opportunities for staff to question validity of information. It means they are "engaged" and paying attention.

Strategy #12 – Agency leadership must view OASIS and other outcome information as more than just complying with a government mandate. They must view outcome information as a key strategic advantage.

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.



2719 East Madison Street, Suite 201
Seattle, WA 98112
(206) 325-3396 / www.ocsys.com

© 1999 Outcome Concept Systems, Inc.