

From Data to Benchmarking to Best Practices: How Successful Agencies Get Better Financial and Quality Results

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What does it take to successfully manage a home care agency? Not just run it, but truly manage it? Better yet, what does it take to create an agency capable of posting some of the best quality and financial results in the field?

If we asked these questions of the most successful agencies in the country ten years ago, you would hear answer like: “Work harder,” “Be committed to quality,” “Increase productivity, particularly from your clinical staff,” and “Lower costs wherever you can.”

Their responses might lead you to ask a few logical questions. How do you know who the most successful agencies are? How do you know how successful you are compared to other agencies, both financially, and regarding quality? Are you competitive?

The problem ten years ago was that, other than two national patient satisfaction benchmark systems—one from Fazzi Associates and the other from Press Ganey Associates—there were few ways an agency could accurately compare themselves to their peers. But, for many providers, things are different today.

The Times, and Measures, are Changing

Ask the same questions today of the field’s most quality-conscious and financially successful agencies and you will get an entirely different, more organizationally sophisticated response. Agency leaders will say they know how they compare to their peers and how they intend to improve. They’ll tell you that start by comparing their agency to the most successful agencies in the country to learn what their successful peers do differently, specifically regarding practices, processes and structures that guide their progress.

Once they know, they follow the leader, adjusting their own practices, processes and structures to align themselves with the best performers. Most of these agency leaders will also report that they continually benchmark, monitor and compare their financial and quality performance with the best agencies to ensure they remain competitive.

“In the absence of benchmarking, you spend a lot of time trying to fix everything at once and trying to improve areas that aren’t necessarily in need of improvement,” says Chris Chesny, president of the MidMichigan Visiting Nurse Association, which serves more than 3,000 clients in nine counties around Saginaw and Midland. “You end up diluting the impact of what should be a very concerted effort in one particular area that could give you tremendous improvement. With a benchmarking report in front of you, you can see

where your efforts are going to make the most impact. There's a lot to do when you run a home health agency and you can't do everything at once or you're going to kill yourself trying."

Why such a dramatic change in home care's appreciation of benchmarking in such a short period of time? Partly, these changes reflect now realities that have emerged in home care. Some of these realities are the same natural evolution of management that has occurred in a broad range of industries. Others have to do with the reimbursement challenges that have been imposed on home care that have led to an embrace of new management models and approaches, particularly data-driven best practice management.

The move to new management models has been deliberate and sequential. In fewer than ten years, leading agencies have moved from simple data collection and internal comparisons to national benchmarking, aided by a number of benchmarking service companies. From here there has been the movement to the next generation of management: Best Practice Management! Examples of organizations that focus on best practice management include national chains such as Gentiva, Interim and Amedysis, along with hundreds of hospital-based and independent agencies that have joined national best practice management services. These organizations can readily attest that they know which practices work best. Furthermore, they now have the data to verify how insights gained from best practice management help justify changing practices, processes and structures, ultimately resulting in improvements in quality and financial results.

Three Generations of Management

Home care's shift to Best Practice Management follows a sequential, two-step process, common to other industries, including manufacturing, hospitals, retail and food service. Best Practice Management begins with internal data collection. Next comes industry benchmarking and the comparisons that lead to decisions about change. Let's look at how it applies in home care.

Throughout the nearly 125-year history of home care and up through the rapid growth period in the early and mid-1990s, agencies collected data individually and did internal comparisons. With the exception of national patient satisfaction benchmark systems, an agency had no way of knowing how its quality or financial outcomes or how its practices, processes and staffing ratios compared to others. Two specific external pressures, IPS/PPS in 1997, and Home Health Compare in 2003, suddenly and quickly increased the need for a more sophisticated, data-driven management style.

The first impetus toward broader benchmarking and later, best practices, occurred on August 6, 1997. In order to control costs, the Health Care Finance Administration, now known as the Centers for Medicare and Medicaid Services (CMS), began operating under the Balanced Budget Act of 1997. The centerpiece of this fundamental change was an Interim Payment System (IPS), which remained in effect for three years while a more permanent Prospective Pay System (PPS) was developed and tested. PPS was put in place in FY 2001 and remains in place today.

IPS turned the health care community upside down. Agencies were suddenly shifted from cost-reimbursement to non-standardized fixed reimbursements. Visits declined and regulations changed, prompting many agencies to slide quickly into deficits. Over 3,000 agencies—about 1/3 of the industry—were forced to close. Those that survived realized that the new payment system necessitated a new, more sophisticated form of management.

If agencies were to succeed, they needed to manage services more cost-effectively while simultaneously maintaining or enhancing quality. These were smart moves, given what happened three years later.

In November 2003, following a number of years of testing and beta testing of quality measurement and comparison reports, CMS introduced a second major driver toward comparative best practice management: Home Health Compare. Using a sub-set of each agency's OBQI scores, CMS used its Medicare website to publicize quality ratings of every home care agency in the country. Referral sources—physicians, potential patients, etc.—could simply view the CMS website to find out how one agency's quality scores compared to others in the area.

For many agencies, this public scrutiny was even more “public.” If the agency happened to be in one of dozens of urban areas, they might have had the distinct pleasure of finding their scores listed on a CMS-generated comparative chart in their local newspaper. The goal of using comparative data to encourage improved performance had become a reality.

Today, every home care leader in the country recognizes that his or her agency must be managed in a way that generates strong financial and quality results. Not one or the other, but both. To succeed, agencies must generate revenues to cover costs and score on par with or above national norms.

Best Practice: An Agency Perspective

When Christine Chesny took the reigns at MidMichigan in 2003, she brought with her an in-depth understanding of benchmarking's power. One of the first problems she identified, using our best practice management service, was that the agency was well below average case-mix benchmarks. Chesny turned to data analysis and additional benchmark measures to determine why. The information we provided helped Chesny piece the puzzle together.

“The same factors that drive our case-mix problem drive our clinical outcome viability,” says Chesny. “The benchmarking report helped us quantify it, and set budget targets for the next year that banked on us improving it. We had faith in the benchmarking data and we bought in.”

A Clinical Discovery

Through benchmarking, Chesny discovered that MidMichigan was not accurately representing its patients' acuity. Though acutely ill patients were being served, clinicians were not recording acuity in the proper place in patient charts. Consequently, agency bills

underreported acuity to OASIS, resulting in insufficient reimbursements. The fix resulted in an additional quarter million dollars in annual revenue.

“Now we’re going to the expense side,” Chesny reports. “This year we’ve said to managers, ‘Okay, we’ve done a good job with revenue. Let’s keep an eye on case mix while we work on productivity.’”

Establishing a Foundation for Best Practices

Home care leaders recognize that tracking their own data and their own performance is good, but that comparing themselves to other agencies, particularly high-performing agencies, is even better. Knowing how these high performance agencies do it, knowing which practices, processes, staffing ratios, etc. are leading to better quality and stronger financial results, is the best insights of all.

Such comparative insights give leaders the information crucial to strategic change. In fact, it is the need for these types of insights that have led to best practice management. Understanding what the right performance measures are can be gained through the use of benchmarking services. The service with which we’re most familiar is our own BestWorks Best Practice Management Service, though other products and services operate similarly. Starting in 2001, we began by asking 225 beta test agencies and, later, 500 initial users which outcome measures indicate an agency is successful.

What quickly emerged was that the field was concerned about the same two outcome measures with which CMS was concerned and already focusing on: quality and financial measures. What also emerged was the strong consensus on what were the specific outcomes measures needed for each of these two measures. We identified three for each measure.

For quality, the outcome measures with significant impact on an agency were identified as: the OBQI reports provided by CMS, the publicly available Home Health Compare results, and patient satisfaction percentile ranking. All three reflect an agency’s ability to provide beneficial health care to patients in their home, as well as indicate the public’s perception of care delivered.

On the financial side, the three reliable indicators of an agency’s financial status were Medicare profit or loss by episode, all home care profit or loss, and all agency (including non-home care) profit or loss. These measures are particularly effective because they give an organization a quick and clean overview of its financial status.

Once the outcome measures were defined and clarified, the question that needed to be answered, from a best practice perspective, was, “What are the practices, processes, structure, staffing ratios and other factors that affect the outcome measures?” In other words, what were all of the clinical, operational, and process measures that directly impacted the six identified outcome measure? The answer set in set in motion the development of a best practice service.

Using Best Practice

Medicare profit margins (or avoidance of loss) are commonly an issue of great concern to agency leaders. Reimbursement in this arena is driven by a clinician's OASIS assessment. Costs are driven by resource utilization and productivity-related issues.

If an agency's focus is Medicare profit margins, its logical question is, "How do we positively affect our Medicare revenue and our costs while maintaining high quality services? Among the key drivers of profit per episode are such obvious factors as case mix weight, visits per episode, therapy utilization, LUPA rate, clinical productivity, overhead and supply costs.

By comparing the practices and outcomes of agencies throughout the country, it became clear that there were marked differences in the practices and processes of those agencies with positive Medicare profit margins versus the practices and processes of those agencies that were struggling. Knowing which factors affect these outcomes, and then controlling them, provides the foundation for best practice management.

The same is true for utilizing best practice management to control quality results. By comparing the practices and processes of those agencies with exceptional outcomes to those agencies with mediocre outcomes, agencies were able to get data-driven insights in the best practices to get the best outcomes. Now, with the common expectation that Pay for Performance will eventually replace PPS, these insights are more valuable than ever.

Best Practice in Home Health Care: A Case Study

To understand how agencies might use benchmarks to develop best practice strategies, let's take a look at one agency. Briefly, the benchmarking service used in this case enables subscribers to monitor and analyze key outcome measures and compare their clinical, financial and operational practices against national norms that include many successful agencies.

Cathy Barr is the senior director for home health case HealthEast Home Care, a community-focused, non-profit health care agency that provides a full spectrum of health services to 4,300 individuals in a seven-county area in and around St. Paul, Minnesota. For the past three years, HealthEast has used data analysis to benchmark and incorporate best practices into its health delivery system.

"Utilizing the benchmarking data helps us focus our efforts. I don't know what we'd do without these tools, frankly," says Barr. One of the original participants in our benchmarking service, HealthEast already understood the power of data analysis. When the CMS comparisons were first published, HealthEast noticed that its pain management scores were below national average. The organization acted quickly to gather the data it needed to develop a quality improvement project to fix the problem. Last December, Stratis Health, a non-profit, independent, quality improvement organization, gave HealthEast its "Achievement Award for Superior Performance" in recognition of its success in implementing a quality measure, "Improvement in Pain Interfering with Activity."

HealthEast's leaders understood that defining what the agency wanted to change was only the first step. Determining what to measure to track progress toward positive change came next. Once the measurable goal was set, the project team assessed, at predetermined intervals, whether interventions put in place were effective until the goal was reached. The company's data, analysis programs, BestWorks critical comparison reports and on-demand data analysis website came together to provide the road map to improvement.

Barr admitted that there were some bumps in the road. In the initial benchmarking stages, the most difficult piece for Barr's team was to understand precisely what the definitions of a particular data set—or measure—should be in order that the agency might gather correct information for comparison with other members of the same data group.

Developing a list of priority measures with their drivers and tracking results on an on-going basis, and at specific, meaningful intervals, is crucial for leaders interested in best practice management. For example, a quality outcome indicator such as the overall OBQI might be evaluated on a biannual basis. These results could be shared with the executive leadership team and included in agency evaluations. But if the measures that drive this outcome are reported and shared with management and clinical teams on a weekly, monthly, or quarterly basis, an opportunity for truly continual improvement emerges.

Recently, HealthEast created a weekly “dashboard report” that takes benchmarking processes to the next level. This report gives managers and the clinical team a concise picture of census, admissions, discharges, cost per visitor hour, average length of stay and other key measures on a weekly basis. A monthly dashboard report provides a more analytical and in-depth perspective on the same data set as well as additional human resources figures.

“We do it all on one or two sheets. It's easy to digest and people can pick out important variances and then focus on those right away,” says Barr. “It allows managers and leaders to have information right at their fingertips.”

Benchmarking and Best Practice: Key to the Future

“At its most basic level, providing high quality health care is doing the right thing, at the right time, in the right way, for the right person. The challenge that health care providers and health system managers face everyday is knowing what the right thing is, when the time is right...”

- Agency for Healthcare Research and Quality
(Performance Plans for FY 2003 and 2004)

The need to benchmark is based on the simple—and fundamental- principle that an organization wishing to improve almost anything must first know where it stands among its peers, particularly its successful peers. In any field, an organization's level of success is directly tied to its ability to honestly assess its performance, then recognize lapses in service and, lastly, implement corrective measures.

Home care is moving into a new era, one where data, benchmarking, and certainly best practices will be essential for agency success and viability. Use the right practices,

processes, staffing patterns, etc. and you increase the likelihood that you will have a high-quality, financially viable agency. Do it wrong and you run the risk of poor quality scores and problematic cost and revenue figures. The good news? In an analysis of agencies who participate in our benchmarking service: the majority of agencies who score in the top 1/3 of quality also generated profit levels that exceeded MedPac's 2004 estimate of 16.9% Medicare profit per episode.

When you put it all together, one thing is clear: the tools and programmatic services and options needed to ensure success are now part of the new home care reality.

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