

When Worldviews Collide: Home Health Care Case-Mix and Research on Patient Outcomes Reveal Different Worldviews of Health Care

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The Complex World of Health Care Policy.

Researchers in the world of health care often assume that contributions to the literature find their way into health policy. Recent developments in the means by which home health care agencies will be able to plan and charge for visits show how need for fiscal management in health care field may have marginal relation to optimal patient outcomes as determined by research, training, and experience. In this article we will show how the worldviews of fiscal management and patient outcome when merged may result in unexpected outcomes. For the interested reader a succinct yet telling perspective on health care policy in the United States (U.S.) can be had by reading Hendricks, Hatch and Stephen Cutler (1999). These authors note that the quality of life for the elderly is related to a nation's economic models and domestic policies. The Hendrick's et al (1999) article and an accompanying article by Binstock (1999) reveals the history and complexity of funding for health care programs in the United States. It comes as no surprise that the cost of health care in the U. S. continues to rise and runs ahead of the Consumer Price Index (Hendricks et al, 1999). Public health care expenditures for the elderly are four times that for younger persons (Hendricks et al, 1999). Medicare alone accounts for half this cost (Hendricks et al., 1999). Cost-containment measures are reflected in the Omnibus Budget Reconciliation Act of 1993 (Congressional Budget Office, 1993) and the Balanced Budget Act of 1997(Binstock, 1999). These Act's have resulted in fixed budget strategies for health care programs such as Medicare and cutbacks for provider reimbursement. The development of cost containment measures for health care is necessary to contain spiraling costs, but as consumers and researchers we assume that there are efforts to maintain with equal fervor concern for patient outcome.

The PPS Model: A Collision of Cost-containment and Quality of Care.

As suggested, a collision of the world of cost-containment and the world of quality of care can be envisioned with the enactment of the proposed Medicare home health services case-mix model. On October 1, 2000, the Health Care Financing Administration (HCFA) plans to install a payment system for home health agencies that will alter the previous

retrospective cost-based care-reimbursement system used since 1965 (St. Pierre & Dombi, 2000). The prospective payment system (PPS) when instituted will allow a reimbursement rate to be set for service that is estimated prior to service being provided. The case-mix model is designed to support a per-episode prospective payment system for health care costs. An episode of health care is set at 60 days. The formula for figuring the cost of reimbursement is reflected in the case-mix. In the case-mix system a patient is assigned to one of 80 patient groups based on a matrix of the 80 possible combinations developed from formula that has weights for 20 variables that reflect home health resource costs (Goldberg & Delargy, 2000; St. Pierre & Dombi, 2000). The 20 items have severity levels assigned of minimum low moderate or high (Goldberg & Delargy, 2000). Payments per an “episode” (defined in 60 day units) are calculated by multiplying the case-mix weight by the national standard payment rate (St. Pierre & Dombi, 2000).

The PPS system is designed to estimate with less variance from provider to provider the resources that patients will need for their care. This is not a treatment outcomes model but an estimate of resources model designed to predict care-time in the home. The case-mix from the PPS model developed from a Medicare-mandated study of care-based outcomes referred to as the Outcome and Assessment Information Set (OASIS). The original 80-item OASIS data set contained items designed to measure and document changes in adult clients health status (Sperling, 1998). Shortly after the introduction of the OASIS assessment it became apparent that uniform use of the OASIS across agencies would take some time to develop (Adams, Wilson, Haney, & Short, 1998; Goldberg & Delargy, 2000). An examination of the OASIS data set finds that most of the variables represented were those deemed important by clinicians and researchers for predicting health outcomes. A shift by HCFA toward an estimated use of resources model shortly after the introduction of the more care-based OASIS model not only requires learning of a new assessment technique, but does not eliminate the need for patient outcome assessments of potential patients. The OASIS model, perhaps unwieldy for estimation of cost-reimbursement, was an attempt to codify what care providers must do at initial interviews, i.e., estimate patient care outcomes.

A Case History Analysis.

A case history analysis illustrates this issue from the home health perspective.

A Responsible HCFA.

HCFA can be seen as acting responsibly to reduce the cost of home health care and to try to reduce the prevalence of overpayment in the system. The new case-mix is designed to: eliminate items that would create incentive for providers to distort patterns of good care, maximize reliability of reporting, reduce time of data collection, and exclude items considered policy inappropriate such as race (Goldberg & Delargy, 2000).

The Worldview of Health Care Research Use and Health Care Providers.

Why should any of this be of concern to researchers in the field of aging and health care as consumers in the health care system or as contributors to the literature? Because millions of dollars have been spent and will continue to be spent on state and federally-sponsored research programs designed to develop knowledge of the variables that predict care

outcomes. These outcomes would include, for example, risk of disability, efficacy of health care options, probability of hospitalization and/or nursing home use, suitability of housing, and mortality. The recent rearrangement of the National Institutes of Health study sections reflects a growing emphasis on research in the area of risk prevention and health behaviors. The PPS case-mix model does provide for estimates of functional status to include dressing the upper and lower body, bathing, toileting, transferring, and locomotion. However, other than these items there is no direct reflection in the model of such variables as: depression, executive or memory impairment, ability to perform higher order activities of daily living such as social and communication management, financial management, medication management, wound care management, transportation management, meal-preparation management, or presence of a viable caregiver. Beyond diagnostic categories and estimate of basic activities of daily living there is no estimation of excess disability allowable in the case-mix. The attempt to be politically correct with respect to race issues eliminates the use of funded research regarding race differences in health care use and outcomes (Whitfield, 2000). By example, at least one article has found that African Americans are less likely to use nursing homes than comparable whites (Fitzpatrick & Van Tran, 1997). This reduced use of nursing homes is offset by a greater use of paid home care, informal-only care, and no care (Fitzpatrick & Van Tran, 1997). It seems certain that any case-mix that does not allow for estimation of the “extraneous disability” factors that characterize use of home health care, is guaranteed to under serve some element of the population.

Millions of tax dollars are spent on health care training programs. The clinical health care provider in any arena of health care must be trained ethically and practically to deliver services designed to estimate and/or improve patient outcome. Research has impact through training, and training is designed to understand and improve patient outcome. Ethically the provider must do what is expected to improve patient outcomes and in some cases that may include stabilizing the patient prior to planning improvement in outcome. The PPS case-mix formula represents a shift in the power to treat the patient. Power has been removed from the provider, the educator and the researcher and has been placed in the hands of the accountant. Nevertheless, the responsibility remains with the provider. Experienced providers in the home health care system will still estimate the excess disability factors that contribute to number of home health care visits. Ethics and training are directed toward such estimates. While HCFA envisions a world where under and over estimations of care will average out cost-wise, in reality it is quite likely that health care providers may use their training and experience to calculate likely patient outcomes and avoid providing service to those patients who are at risk for more visits than can be paid for. That is, fiscal modeling is not the sole purview of HCFA. Patients may not be abandoned once under care, but need not be accepted for services a healthcare agency feels they cannot provide, or provide and remain fiscally viable.

It's Time to Fuse Healthcare Resource Policy with Health Care Outcome Research.

In the home health care arena the worlds of treatment outcome and treatment resources are about to collide head on. The number of home health care agencies is estimated to have grown 18-fold in the past two decades with a projected growth average of 13 percent per

year from the years 1996 to 2005 (Zink,1998). Clearly home health care can be considered as part of the first-line of defense against more expensive health care treatment options. Ironically, the dollars expended for health care research and training within a treatment outcome model likely will be used within the home health care reform resources model to estimate financial risk for care rather than patient outcomes. Hendricks et al. (1999) noted that there has been a retrenchment in programs for the elderly. The PPS system highlights the subtlety and complexity of the retrenchment process. In the case of health care fraud many of us would agree with policies designed to reduce the possibilities of overpayment. In this effort patient care cannot take second place. Those of us who live in the health care research world need to turn our attention toward assessing the interaction between policy, research, and training. It is time to be direct our research efforts toward an equitable fusion of health care resources policy and health care outcome. It will be a major challenge to health care research in the twenty-first century to forge a singular worldview perspective on this issue.

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