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Changes in Wound Care Outcomes Analysis—New Home Health Compare Measures



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Changes in Wound Care Outcomes Analysis - New Home Health Compare Measures

INTRODUCTION

Like most in home health, you've likely been focused for the last six or nine months on a little thing known as PPS 2008. In the meantime, you may have missed another change that CMS implemented in November 2007 – two new measures added to Home Health Compare. Did you catch that? If so, bravo! If not, you aren't alone.

These two added measures are now available online for the public to see how your agency is performing:

- Percentage of patients who need unplanned medical care related to a wound that is new, is worse, or has become infected
(Otherwise known as Emergent Care for Wound-Related Problems)
- Percentage of patients whose wounds improved or healed after an operation
(Otherwise known as Improvement in the Status of Surgical Wound)

These are not new measures to homecare – the emergent care measure has been a part of the Outcomes Based Quality Measurement (OBQM) requirement since 2001, and the improvement measure available via CMS Outcomes Based Quality Improvement (OBQI) reports since the same year. But they are new to the set of publicly-reported measures available on Medicare's consumer-focused web site Medicare.gov as part of Home Health Compare.

Worth noting is that this move to publish outcomes on these two measures is part of a larger trend of Medicare directing more attention to wounds and wound care in home health. For instance, improvement in the status of surgical wounds is one of the measures included in the current home health pay-for-performance (P4P) demonstration project, and wound items on the OASIS have a greater contribution to reimbursement in PPS 2008 than previously. In addition, wound care was named by MedPAC as one of the prime considerations for new process measurements in the home health industry (see Chapter 5 – Adding quality measures in home health – of the June 2006 MedPAC report to Congress).

THE IMPETUS - \$\$\$

In 2005, Medicare spent almost \$2.4 billion on hospital stays for infections of surgical and traumatic wounds and disruption of surgical wounds (primary diagnoses of ICD-9s 958.3 [posttraumatic wound infection], 998.3 [disruption of operation wound], and 998.5 [postoperative infection]), according to the

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AHRQ HCUP database (see **Chart 1**). That number is more than double the amount they spent on hospital stays for the same conditions only five years earlier in 2000 (see **Chart 2**). The hospital care for pressure ulcers offers a very similar story, with the cost of caring for patients in the hospital with a primary diagnosis of pressure ulcer (ICD-9 code 707) nearly doubling from \$956 million in 2000 to just under \$1.9 billion in 2005.

Chart 1*

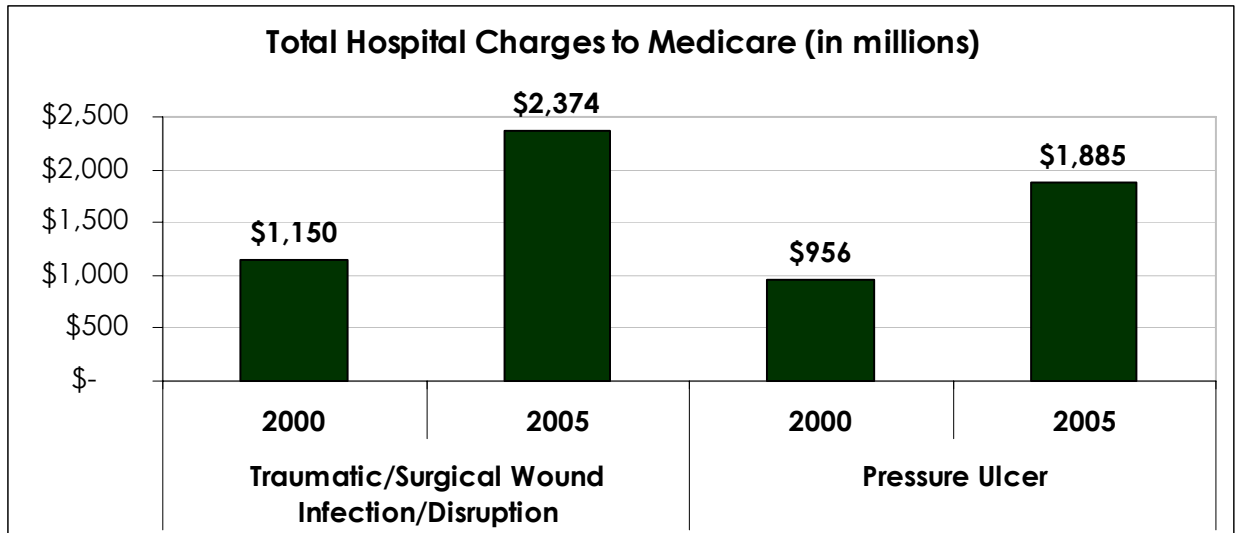
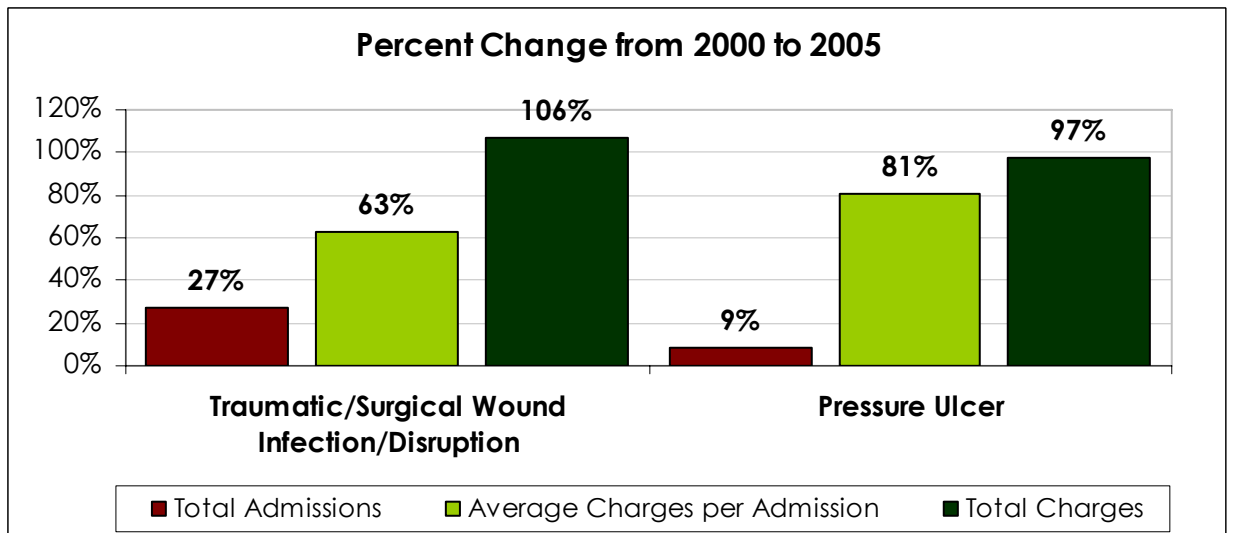


Chart 2*



* Data source: Agency for Health Research and Quality, HCUPnet on-line database.

- "Traumatic/Surgical Wound Infection/Disruption" represents Medicare hospital admissions with a primary diagnosis of 958.3 (post-traumatic wound infection), 998.3 (disruption of operation wound), and 998.5 (postoperative infection)
- "Pressure Ulcer" data represents Medicare hospital admissions with a primary diagnosis of 707 (chronic ulcer of skin)

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The increase in overall cost is due to both a rise in the number of Medicare hospital admissions for these wound-related problems and a higher per admission charge. Wound infection admission rates increased 27% during that window, from 50,200 to 63,610 while pressure ulcer admission rates increased a modest 9%, from 47,239 to 51,442 (see **Chart 3**). Average charges per admission witnessed a much more dramatic increase: 63%, from \$22,916 to \$37,317, for wound infection and a whopping 81%, from \$20,241 to \$36,652, for pressure ulcers (see **Chart 4**).

Chart 3*

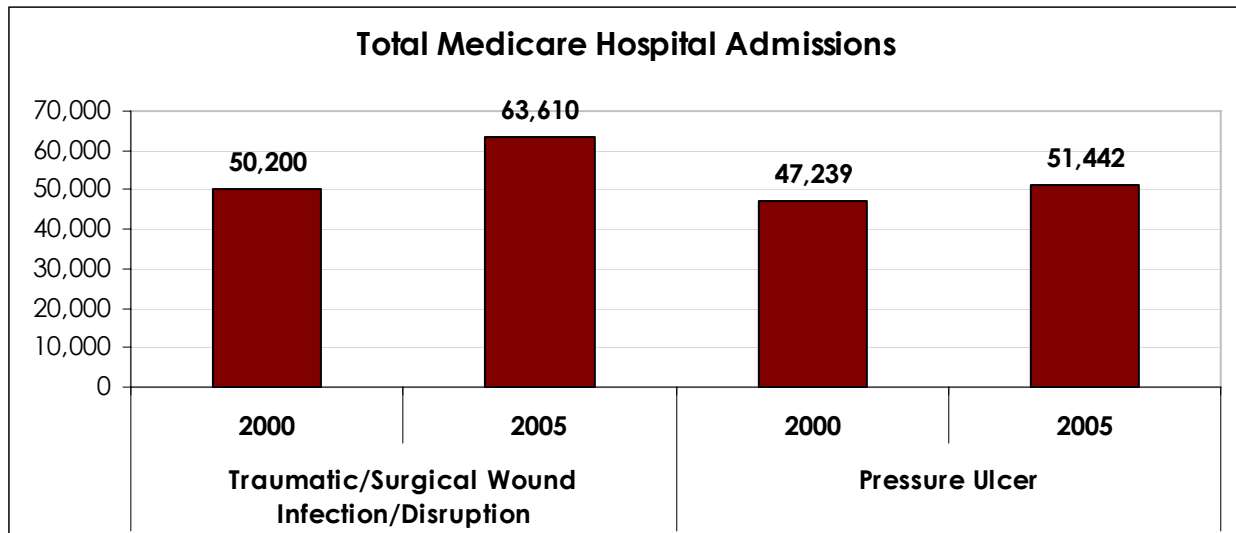
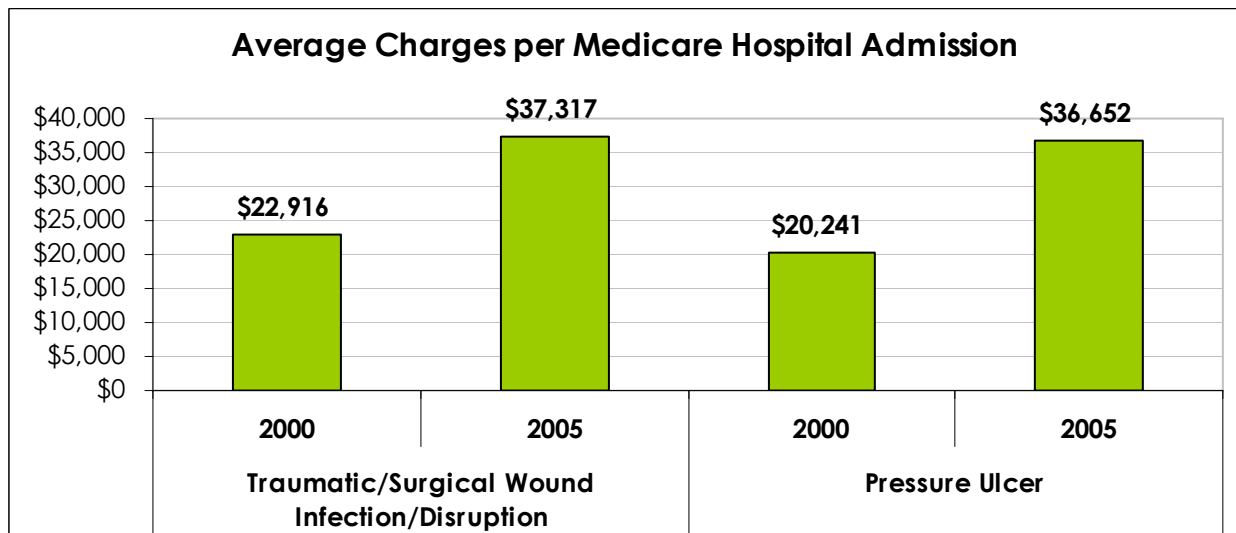


Chart 4*



* Data source: Agency for Health Research and Quality, HCUPnet on-line database.

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The grand total for these two types of hospital-based wound care comes in at just under \$4.3 billion. While this feels like a drop in the bucket of the almost \$411 billion that Medicare paid to hospitals in 2005, wound care is still an expensive undertaking. These statistics don't even reflect the full cost of wounds for Medicare. It excludes charges paid to doctors, wound care clinics, home health agencies, or nursing homes, or the hospital costs of caring for pressure ulcers or wound infections as a secondary diagnosis.

Another perspective is that this big drop in the very large bucket, which is actually more than 1% of overall hospital charges, is money spent on care for conditions that can arguably be prevented in many (although, not all) cases. The Agency for Healthcare Research and Quality (AHRQ) identified preventable hospitalizations as a focus for both cost containment and quality improvement (Agency for Healthcare Research and Quality, HCUP Fact Book No. 5). According to the AHRQ analysis, in 2000, nearly five million admissions to U.S. hospitals involved the treatment of preventable conditions, costing more than \$26.5 billion. The AHRQ suggests that a five percent reduction in preventable hospitalizations could result in savings of more than \$1.3 billion. A reduction in the number of instances of wound infection and new pressure ulcers that require hospitalization, and the corresponding reduction in the \$4.3 billion being spent on those hospitalizations, could be part of that overall reduction in preventable hospitalizations and costs.

Regardless of your perspective, the overall dollars spent on wound care are growing, and the healthcare industry, payors, and legislators are all well-aware of the impending demographic shift that will cause these numbers to keep increasing at a potentially unmanageable rate, at least for the foreseeable future. The logical next question is how to best manage wound care and its associated costs.

How do we get this trend under control?

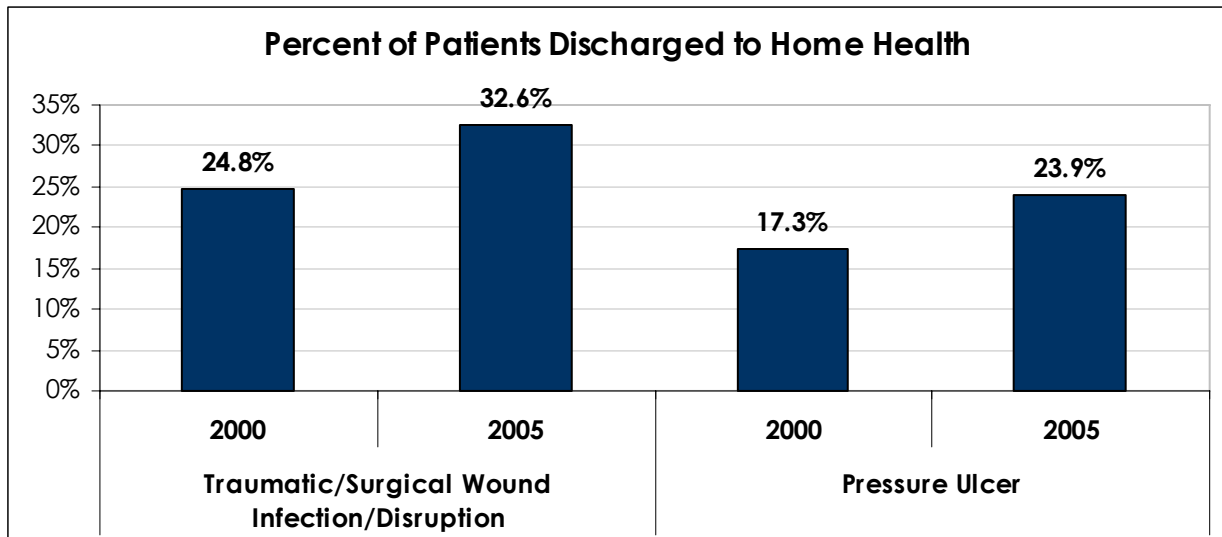
HOME HEALTH'S ROLE IN WOUND CARE

Home health provides an effective and efficient option for caring for many patients with wounds – helping patients to heal, preventing infection and wound deterioration, and contributing to the overall health, well-being and recovery of post-operative and wound-ridden patients. Advancements in wound treatment technology and options and the growing use in home health of wound-care specialists and wound, ostomy and continence nurses (WOCNs) all contribute to the attractiveness of home health services for wound care.

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The healthcare industry is already recognizing the value of home health as an important part of the wound care equation. The rate of hospital discharges to home health for patients with wound infection has increased from less than 25% in 2000 to almost 33% in 2005 (see **Chart 5**). For patients with pressure ulcers, the rate has increased from 17% to 24%. These increased rates, combined with the increased volume of admissions, have resulted in a total rise of 60% in the number of patients discharged from the hospital to home health.

Chart 5*



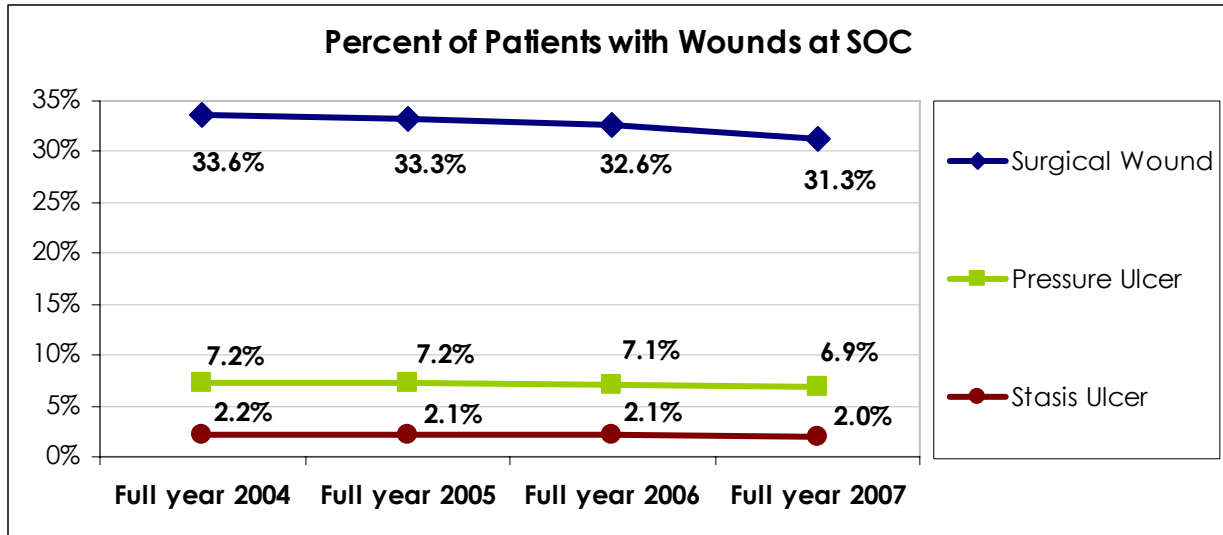
* Data source: Agency for Health Research and Quality, HCUPnet on-line database.

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Taking a look at some more recent trends (data source OCS, Inc.), wound patients as a percent of the overall home health population has stayed relatively steady over the past few years, showing just a slight decrease between 2004 and 2007 (see **Chart 6**). Today, surgical wound patients represent almost one-third of the home health patient population, pressure ulcer patients about 7%, and stasis ulcer patients about 2%.

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Chart 6**



**Data source: OCS, Inc. Representative of more than 2,000 provider locations and 1 million cases of care per year

THE NEW HOME HEALTH COMPARE MEASURES

As mentioned above, the two wound measures that are new to Home Health Compare (HHC) are not new to the industry. The calculations for these measures have not changed with their new, elevated status in the outcome analysis world. Somewhat surprisingly, they are still not risk adjusted, the only two out of the HHC bunch not to be adjusted based on an agency's patient population.

Measure Calculations

Emergent Care for Wound-Related Problem	Transfer assessments (RFA 06 and 07) where the response to M0840 (reason for emergent care) is 5 (Wound infection, deteriorating wound status, new lesion/ulcer)	All patients with a SOC and an end of care (either transferred or discharged) during the analysis window
Improvement in the Status of Surgical Wound	Status of most problematic surgical wound (M0488) is better at discharge than at SOC OR surgical wound is fully healed at discharge (M0488 is unanswered)	All patients with an observable surgical wound at SOC AND a SOC and a Discharge during the analysis window

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In the inaugural publication of these outcomes on HHC in November of 2007, the national rates for these measures were 79% for improvement in the status of surgical wounds and 1% for emergent care due to wound-related problems. Taking a look at recent trends (**Chart 7** and **Chart 8**), these outcomes have not changed much year-to-year at an industry level.

Chart 7**

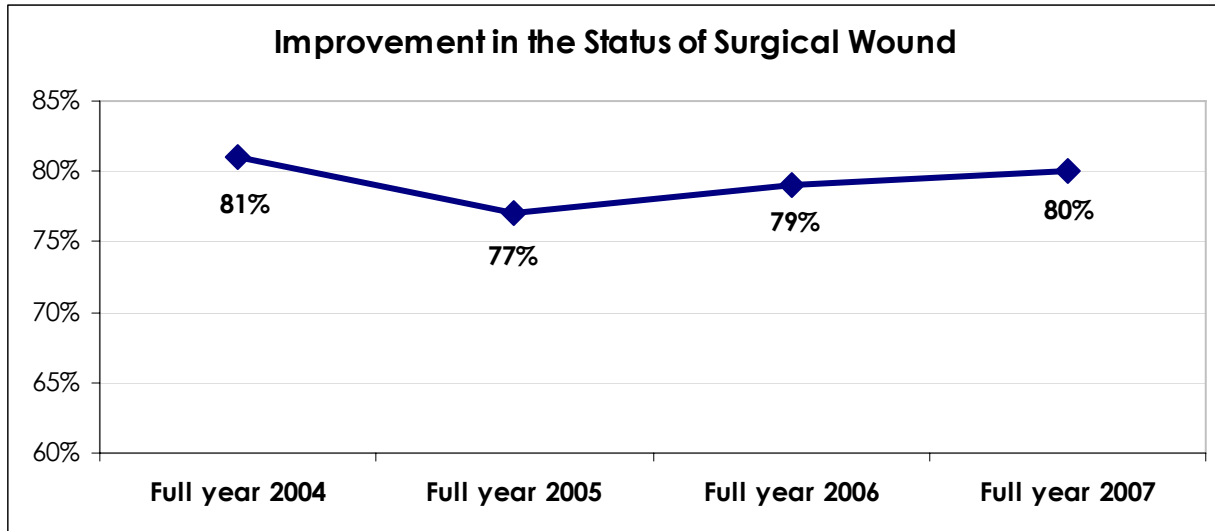
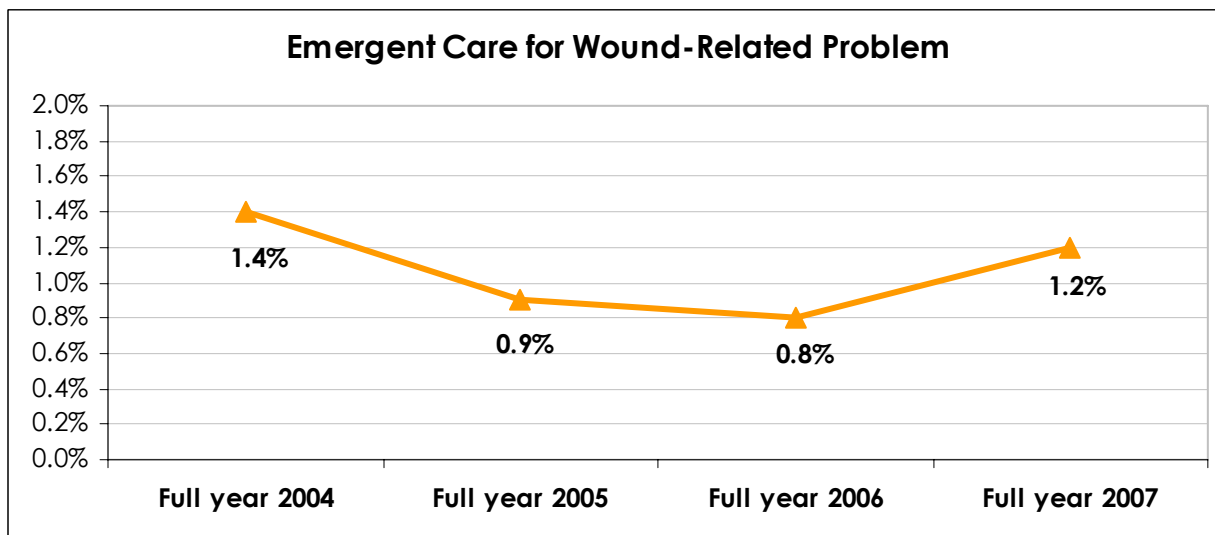


Chart 8**

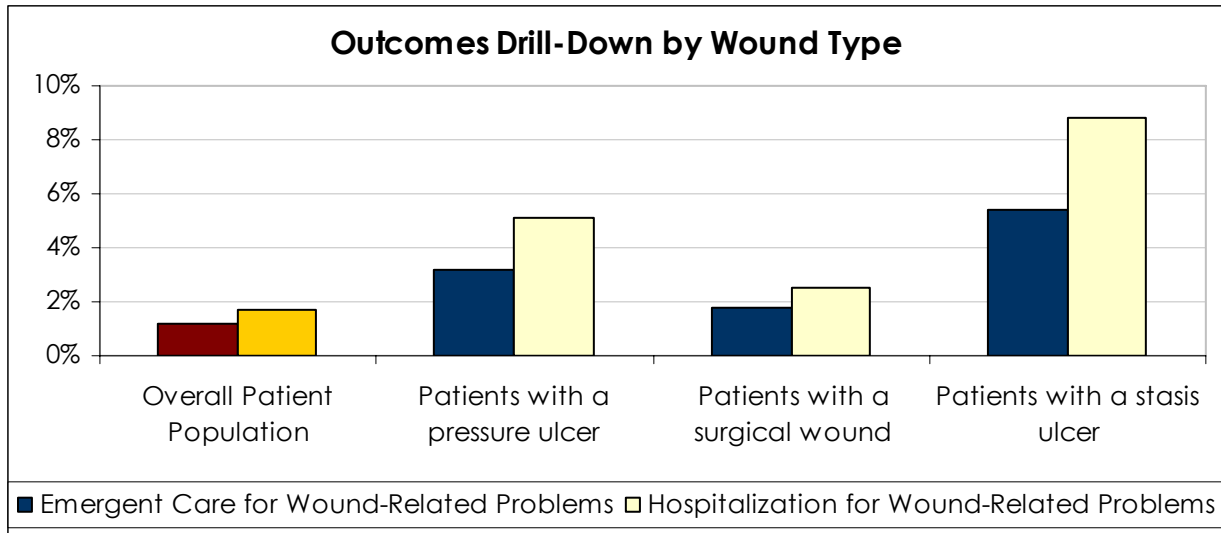


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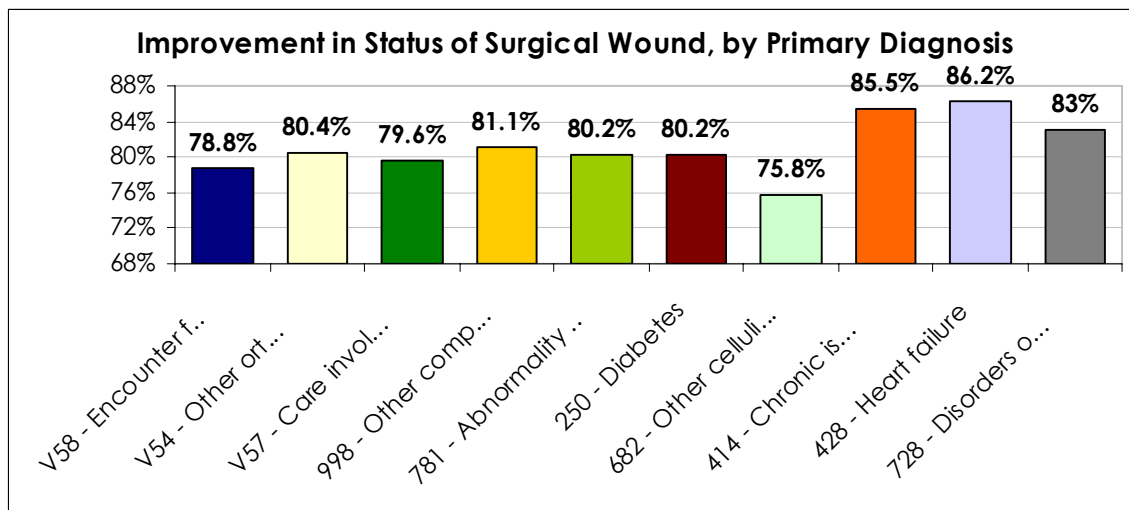
A closer look at the data does give us considerable insight into what drives these rates. For example, while the overall rate of emergent care due to wound-related problem is relatively low, at just over 1%, the rate of this adverse event is over 5% among patients with a stasis ulcer. That compares to 3% of patients with a pressure ulcer and just under 2% of patients with a surgical wound (see **Chart 9**).

Chart 9**



We see a similar pattern of differences in the drill-down data for improvement in the status of surgical wounds (see Chart 10). Among the ten most common primary diagnoses for patients with surgical wounds, the rate of improvement ranges from 76% (patients with a primary diagnosis of 682 – abscess and cellulitis) to 86% (patients with a primary diagnosis of 428 – heart failure).

Chart 10**



**Data source: OCS, Inc. Representative of more than 2,000 provider locations and 1 million cases of care per year

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CONCLUSION

What does this heightened focus on wound-related measures mean to your home care agency? Clearly, some types of wounds and some patients are intrinsically more or less likely to heal or to deteriorate to the point of requiring emergent care services. Understanding the distribution or mix of your patients and the care required for special cases can contribute greatly to an agency's ability to manage and improve upon these outcomes.

Furthermore, by improving your agency's performance in these and other wound outcomes, you may be able to reduce costs associated with caring for these patients. Traditionally money losers under the PPS system, you may be able to break even or come out slightly ahead on these episodes. In addition, it is likely that any future P4P program in home health would provide some sort of bonus for high or improving performance in wound measures. So, you'll have a combined incentive to work toward the best possible results, both for the health and happiness of your patients and your agency's bottom line.

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