“Health System Reform for Nursing Home Residents”

A Robert Wood Johnson Funded Grant Program
By Fairview Hospitals and HealthCare Services
Minneapolis, Minnesota

FINAL EVALUATION REPORT

EXECUTIVE SUMMARY

by

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EXECUTIVE SUMMARY
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The Project.

In 1995, the Fairview Foundation received a $644,212 grant from the Robert Wood Johnson Foundation to implement a three-year demonstration project that came to be known as “Fairview Partners (FP).” The purpose of the project was to better serve the needs of elderly nursing home residents by improving the quality of on-site primary care, reducing unnecessary hospital utilization, and lowering acute care costs. To achieve these goals, the project believed that a multifaceted change in the underlying financial and organizational models was needed to better support an integrated clinical care model.

With those goals in mind, the grantees worked with collaborating partner organizations to form an integrated health network. The original network was comprised of three hospitals (and related clinics and services), 14 long-term care facilities, and a physician organization. By early 1996, these partners had established a “virtual organization” via a contractual joint venture. Originally designed to deliver care for residents who were dually eligible for Medicare and Medicaid dollars, FP contracted with a health plan to implement a capitated-based, risk-sharing product. After three years, the FP network has:

- Expanded from 14 to 15 nursing homes;
- Entered into additional managed care contracts with two other third-party payers;
- Began serving community-dwelling seniors in addition to nursing home residents;
- Formalized its business structure within the Fairview system, while maintaining collaborative governance and active participation from partner organizations;
- Enrolled a total of 330 elderly members in one of several programs;
- Showed a financial surplus at the end of the grant period; and
- Developed some reproducible “lessons learned” for other, similar projects.

The External Evaluation.

A team of professionals from the University of Minnesota and Professional Data Analysts, Inc., was awarded a 26-month contract to evaluate the process and outcomes of this demonstration project. The team used a combination of qualitative and quantitative methods to investigate intended changes in the financial model, in organizational relationships, in clinical care, and in hospital utilization. In all, they produced seven interim reports and a 30-page Final Evaluation Report (see attached list of deliverables).

Evaluation Findings: Highlights and Recommendations.

Fairview Partners was developed in response to a fragmented system of care for elderly residents living in nursing homes. With the assistance of the Robert Wood Johnson Foundation and in-kind contributions from partnering organizations, the grantees were
able to fully develop an integrated health network (IHN) in three years. While this network consumed all of the grantees’ time (making it unrealistic to create two additional networks, or “risk pools,” as originally planned), the concept of an IHN changed over time. These changes stemmed partly from some lessons that were learned about network management (e.g., the importance of centralizing the enrollment function), and partly to events occurring in the marketplace (e.g., competition from other care systems). The current network is considerably broader and more ambitious in scope than the original vision. Rather than replicating separate networks for discrete populations, FP expanded the network to incorporate additional populations along a broader spectrum of care and to embrace new partners into the network. Although current member enrollment is less than desired (approximately 217 active members), this network is functioning successfully.

In designing the blueprint for the network, program planners assumed that a chain of intermediate objectives would have to be accomplished. These objectives were diagrammed by the evaluation team into a linear model with five phases. These phases now serve as a useful framework for summarizing the successes and challenges of FP.

1. Building the Network “Model”

The assumptions embedded in the “model building” phase of the program posited that:

“If organizational commitment is invested, and management structures and procedures are developed, and a contract uniting provider partners is achieved, in which financial incentives are realigned, and a philosophy of patient centered, integrated care can be supported . . .”

These elements represent the “job” the network partners faced at the beginning of the grant. Essentially, the job involved relationship building and organizational development for an entity that did not exist previously. While the work of maintaining a viable network is never done, these objectives were basically met. The structure of the network is in place. Governance remains stable despite turnover in key leadership. Agreement on shared principles of partnership and of care delivery remains high. Considerable forces still propel these organizations to work together and to resolve differences in mutually agreeable ways.

The management challenge for the coming year will be to keep the investment and commitment of partners high despite several factors:

- Network expansion (i.e., expansion in overall size, geographic area, patient populations, and number of provider organizations).
- Loss of grant dollars in 1998, and the need to increase member enrollment to maintain financial viability.
- Increased attention to criteria for network membership, partner accountability, and standards of network performance.
2. Managing External Contingencies

For the network model to succeed, certain external contingencies would have to be successfully negotiated. The assumptions posited here were that:

"If contracts with third-party payers are achieved, and sufficient enrollment of residents is accomplished, and federal legislation for Medicare and Medicaid remains reasonably stable and sufficient, and competition within the marketplace does not destabilize the network..."

These elements challenge network partners to continuously refine their goals and strategies in light of external events and pressures. Each of these contingencies proved challenging for Fairview Partners during all three years of the grant. Third-party contracts led, in some cases, to protracted and not always satisfactory negotiations. Member enrollment proved much more difficult than originally anticipated, partly due to the inefficiency of partner-driven enrollment as conceived in the "decentralized" organizational model, and partly due to the moratorium on new enrollment imposed by the third-party payer while the state's managed care program was being introduced. Competition between care systems was strong throughout the period and adversely affected member enrollment. The extent to which competition complicated, or even compromised the care of residents in homes where multiple systems operate is not known, but such a situation is possible. All of these factors represent ongoing challenges for the network. Although they were successfully negotiated—at least for the short term—in 1996 and 1997, it was not without cost, time, and energy.

With regard to managing external contingencies for the future, the challenges are to:

- Maximize the points of leverage in the web of factors influencing enrollment and optimal implementation of the care model in order to successfully compete with other care systems.
- Strategically align with third-party payers who support the care delivery principles of the network.
- Avoid dependence on one payer, and use the performance of the network's first two years to negotiate new and favorable contracts with other payers.
- Engage in public relations activity and participate in professional forums in order to communicate the successful features of the network.

3. Building the Support Systems

A demonstration project "goes away" once the funding is gone unless steps are taken to change the support systems that underlie new modes of operation. The assumptions embedded in the support system phase of network development posited that:
"If suitable GNP's and MDs are engaged in the network, and if consensus on a clear model of IHN care delivery is achieved, and data management systems are constructed to support financial integration, billing, and care delivery; and if resources and time are sufficient to allow for adequate training and team building to occur . . ."

In terms of building or enhancing the support structure needed, the network did exceptionally well with the first two objectives. While more improvements in the data management systems (especially at the nursing home facility level) would be ideal, the network is operating fairly efficiently with the systems in place. Information on residents is being routinely collected by GNP's and utilization data are being regularly examined. Financial information is now more readily available, organized and reported on a monthly basis. In terms of adequate orientation and training, early attempts to train administrative and nursing staff at the facility level concentrated on marketing and billing, and fell short in terms of communicating the care model. The network experienced greater success with teaching the network's care principles and procedures informally, through mentoring by GNP's, or specifically requested in-services.

The support system challenges of the future are to:

- Explore ways to regularly and efficiently orient new facility staff, given the high turnover experienced historically in the industry. This might be accomplished by a video tape presentation about the network, or a computer-assisted program that walks staff through "frequently asked questions," or even a web site.
- Encourage nursing homes to update their computer facilities, both hardware and software, and introduce software systems that could standardize data collection for quality assurance purposes.
- Continue to find ways to build family, resident, and staff feedback into the ongoing structure of the network. This could yield benefits beyond those of quality assessment [see the section on Outcomes (e.) below]. Specifically, it might help with further clarifying market niches and improving enrollment.

4. Implementing Care Delivery

The assumptions embedded in the actual delivery of the care model posited that:

"If case management protocols are followed, and extended care pathways are used, and periodic case reviews and ongoing staff development workshops are accomplished, and personal collaboration between care team providers and residents and their families occurs . . ."

These elements touch on the actual operation of the program. Site visit data suggest that implementation of the care model varied across sites and was dependent upon a number
of factors. Overall, however, the care model was being implemented well. Response to the GNPs by the physicians was very positive. Today, the model reportedly enjoys a growing positive reputation among providers in the area.

The implementation challenges of the future are to:

- Identify tools and resource materials needed to better support care at the point of service (e.g., a teaching module on common problems leading to hospitalization).
- Continue to investigate the extent to which clinical pathways are being used and their usefulness to staff and their impact on resident outcomes.
- Develop the “end-of-life” pathway. Such a pathway may have potential relevance to staff and their concerns for how to manage a “good death”—one that meets the needs of families. Evidence that the network helps families during this transition also may be valuable for quality assurance (see next section).

5. Intended Outcomes: Quality Care, Lower Utilization, Lower Costs

Taking all these elements together, these phases suggest that if (a) the network’s organizational structure is successfully designed and developed, if (b) external contingencies are successfully managed, if (c) the support systems required for the network are successfully developed or enhanced, and if (d) the care delivery model is implemented consistently and well, then the (e) quality of care would be optimal, utilization patterns would change, and utilization costs would be reduced.

In terms of outcomes, this evaluation team focused mainly on the effect of the network on changing utilization patterns. We noted that the network made money in its first two years and commented on why we believed this was so, but we did not independently measure costs, nor track actual changes in costs due to network variables. Neither did we collect an independent measure of quality of care. To support formative evaluation, we did use the network’s definitions of the intended characteristics of the care model as a yardstick for assessing implementation. The only additional data we have to support an assertion that the care delivered was “high quality care” is the interesting difference between Fairview Partner residents and non-enrollees in terms of their end-of-study status: fewer Fairview Partner residents had died compared to their matched controls (see Table 1, attached).

We have fairly dramatic evidence, however, that utilization patterns were affected by the introduction of the network. Utilization rates (as defined by number of hospital admissions and days per 1,000 members per year) were lower for Fairview Partner enrollees than for residents not enrolled in a managed care system (see attached Table 2). While lack of statistical significance for the more narrowly defined period of enrollment complicates the picture (see Table 3), as does the lack of difference between enrollment and non-enrollment periods for Fairview Partner residents alone (see Table 4), the trends
were still fairly strong. It's difficult to deny the very significant differences seen for the full study and the replication of the same pattern during the enrollment window. Given the highly successful matching of subjects with controls on selection variables such as case mix, gender, age, date of nursing home admission, and facility, no other real explanation for these differences exists that is not attributable, at least in part, to the presence of the network, its incentives, its providers, and the interactions that occurred.

The most likely explanation for the smaller effects on utilization seen during the enrollment window and for Fairview Partner residents alone during enrollment and non-enrollment periods is that the "intervention" was not confined to just the period of time during which the resident was actually enrolled. This is plausible, given the way in which demonstration projects are typically implemented in "real life," under uncontrolled (i.e., non-laboratory) conditions. Additionally, we know from first-year interviews with committee members that many facilities were "already moving in this direction" in terms of aligning with other provider organizations to change patterns of care. We know that physicians who were invited to be part of the network were those who were already inclined to practice principles of care articulated by the network's model; some of them had worked with the participating homes for years. We know that other variables believed to impact successful implementation, such as the presence of a medical director who is affiliated with Fairview or supportive of the network, were already in place before enrollment officially began. Thus, we feel the significant results seen in the larger study period are worthy of dissemination.

**In regards to documenting outcomes for the future, the challenges are to:**

- Develop a quality assessment program in order to document quality from a consumer or family point of view, if not from a health outcomes standpoint, rather than simply inferring quality from low utilization rates. Given the anxiety of the general public about managed care and its perceived propensity to cut back on services at the price of care, the network needs to consider how its very healthy profit margin in 1996-97 would be interpreted in the absence of additional data on quality. The projected surplus of 10% for 1998 is extremely positive for this industry. While this is good news for the network and its immediate audiences (i.e., administrators in the partnering organizations whose continued support is desired), the public relations challenge of explaining this profit in the absence of consumer satisfaction and other indicators of network quality should be considered. This is an important, contentious issue that is not likely to go away. Admittedly, it also is not easy to address and not unique to Fairview Partners; it should concern all of the provider organizations involved as they enter into managed care contracts.

**Summary**

In summary, Fairview Partners was a successful demonstration program. It demonstrated that partnership among organizations operating in a competitive environment is possible
when they share common goals, develop mutually agreed upon principles and procedures of interaction, and trust each other. It demonstrated that integrating primary and acute care management for the elderly can be accomplished within the nursing home setting. FP’s care model appeared to be clinically advantageous, according to participating physicians, GNPs, and nursing home staff—many of whom have had opportunities to compare this model with other working arrangements (past and current).

As with coalitions and partnerships in general, participants learned that an IHN evolves best from a history of previous working relationships, but is subject to economic and political forces beyond the group’s immediate control. Successful network implementation therefore requires strong leadership, time and effort from all partners, and commitment to invest in the common good as it supports best care for the elderly. Participants also attributed part of their success to inspired project direction, outside resources (in the form of the grant), and the benefits of formative as well as summative evaluation data. Future parties seeking to replicate a similar network may consider the importance of these and other supports as they embark on their own partnership journey.

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List of Deliverables
Prepared by the Evaluation Team


Table 1
Full Study Period Comparison:
End-of-Study Status of Fairview Partner and Non-Enrolled Residents
(N = 510)

<table>
<thead>
<tr>
<th>Status</th>
<th>Non-Enrolled Residents (n = 255)</th>
<th>Fairview Partner Residents (n = 255)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Still living in the nursing home</td>
<td>56.1 (%)</td>
<td>78.0 (%)</td>
</tr>
<tr>
<td>Living at home</td>
<td>11.4 (%)</td>
<td>0.8 (%)</td>
</tr>
<tr>
<td>Deceased</td>
<td>27.8 (%)</td>
<td>20.9 (%)</td>
</tr>
<tr>
<td>Other (hospital, other long-term care or assisted living facility)</td>
<td>4.7 (%)</td>
<td>0.4 (%)</td>
</tr>
<tr>
<td></td>
<td>100.0 (%)</td>
<td>100.0 (%)</td>
</tr>
</tbody>
</table>

Table 2
Full Study Comparison:
Utilization Findings for Fairview Partner and Non-Enrolled Residents
(N = 510)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Non-Enrolled Residents (n = 255)</th>
<th>Fairview Partner Residents (n = 255)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of hospital admissions/1,000/year</td>
<td>621</td>
<td>261*</td>
</tr>
<tr>
<td>Number of hospital days/1000/year</td>
<td>3,708</td>
<td>1,489*</td>
</tr>
<tr>
<td>Average length of hospital stay</td>
<td>5.7</td>
<td>5.5</td>
</tr>
<tr>
<td>Number of SNF days/1,000/year</td>
<td>25,246</td>
<td>9,495*</td>
</tr>
<tr>
<td>Number of nursing home days/year</td>
<td>344</td>
<td>363*</td>
</tr>
</tbody>
</table>

* = statistically significant

Table 2 shows statistically significant, and highly meaningful differences in four of the five indicators studied for this set of comparisons:

- Non-enrolled residents had 2.4 higher hospitalization admissions than FP residents.
- Non-enrolled residents had 2.5 times more hospital days than FP residents.
- Non-enrolled residents had 2.5 times higher SNF days than for FP residents.
- FP residents spent significantly more days in the nursing home than the non-enrolled residents.
### Table 3
Enrollment Window Only Comparison: Utilization Findings for Fairview Partner and Non-Enrolled Residents  
(N = 463)

<table>
<thead>
<tr>
<th></th>
<th>Non-Enrolled Residents</th>
<th>Fairview Partner Residents</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(n = 209)</td>
<td>(n = 254)</td>
</tr>
<tr>
<td>Number of hospital admissions/1,000/year</td>
<td>435</td>
<td>234</td>
</tr>
<tr>
<td>Number of hospital days/1,000/year</td>
<td>2,198</td>
<td>1,246</td>
</tr>
<tr>
<td>Average length of hospital stay</td>
<td>4.8</td>
<td>4.5</td>
</tr>
<tr>
<td>Number of SNF days/1,000/year</td>
<td>18,201</td>
<td>5,977*</td>
</tr>
<tr>
<td>Number of nursing home days/year</td>
<td>348</td>
<td>360</td>
</tr>
</tbody>
</table>

* = statistically significant

### Table 4
Fairview Partners Only Comparison: Utilization Findings During Periods of Enrollment and Non-Enrollment  
(N = 201)

<table>
<thead>
<tr>
<th></th>
<th>Fairview Partner Non-Enrolled Period of Time (mean = 5 mos.)</th>
<th>Fairview Partner Enrollment Period (mean = 10 months)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of hospital admissions/1,000/year</td>
<td>236</td>
<td>244</td>
</tr>
<tr>
<td>Number of hospital days/1,000/year</td>
<td>2,133</td>
<td>1,246</td>
</tr>
<tr>
<td>Average length of hospital stay</td>
<td>11</td>
<td>12</td>
</tr>
<tr>
<td>Number of SNF days/1,000/year</td>
<td>15,448</td>
<td>6,706*</td>
</tr>
<tr>
<td>Number of nursing home days/year</td>
<td>360</td>
<td>361</td>
</tr>
</tbody>
</table>

* = statistically significant