



A Qualitative Study of Choosing Home Health Care After Hospitalization: The Unintended Consequences of 'Patient Choice' Requirements

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BACKGROUND: Although hospitals are increasingly held accountable for patients' post-discharge outcomes, giving them incentive to help patients choose high-performing home health agencies, little is known about how quality reports inform decision making.

OBJECTIVE: We aimed to learn how quality reports are used when choosing home care in one northeast state (Rhode Island).

DESIGN: The study consisted of focus groups with home health consumers and structured interviews with hospital case managers.

PARTICIPANTS: Thirteen consumers and 28 case managers from five hospitals participated in the study.

APPROACH: We identified key themes and illustrative quotes by audiotaping each session, and then three independent reviewers conducted repeated examination and content analysis.

KEY RESULTS: No participants were aware of existing state or Medicare home health agency public reports. Case managers provided agency lists to consumers, who routinely asked case managers to tell them which agencies to choose or which were best; but case managers felt unable to directly respond to consumers' requests for help in making the choice, because they did not have additional information to provide and because they feared violating federal laws requiring freedom of patient choice. Case managers also felt that there was little difference in agency quality, although they acknowledged they might not be aware of problems related to post-hospital care.

CONCLUSIONS: Home health consumers and hospital case managers were unaware of public reports about home health quality, which limited consumers' ability to make informed decisions and case managers' ability to assist them in that decision-making process. Case managers were otherwise prohibited from recommending specific providers to patients and viewed the 'patient choice' laws as restricting their ability to respond to patients' requests for help in choosing home health agencies.

Public reports can be marketed as tools that case managers can use to help patients differentiate among providers, while supporting patient autonomy.

KEY WORDS: decision making; home care; hospital administration; Medicare; patient decision report.

J Gen Intern Med 30(5):634-40

DOI: 10.1007/s11606-014-3164-7

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INTRODUCTION

Public reporting programs run by state departments of health and Medicare operate under the assumption that the public release of healthcare quality information increases transparency,^{1,2} accountability, and consumer choice,³ thus helping to improve overall healthcare quality;^{4,5} e.g., by reducing healthcare variation^{6,7} and eliminating disparities for at-risk populations.⁸ Medicare publishes quality data for individual providers on websites for home health agencies, hospitals, nursing homes, and physicians. Consumers can access this information to inform their healthcare decision making.

While public reporting may stimulate improvement through changes in provider⁹⁻¹¹ or purchaser behavior,¹² studies assessing the impact on overall quality are mixed,¹³ and evidence that healthcare consumers routinely use these data to make decisions remains scant.^{5,13-15} On the other hand, surveys indicate an increase in consumers' use of public reports,¹⁶ and consumers express a desire to have access to information that helps to make or affirm healthcare decisions.^{17,18}

Increasing awareness and use of public reports is especially timely for home health agencies, given state and national policies that encourage providers and payers to ensure that patients receive care in the least-restrictive setting possible.¹⁹⁻²¹ This includes shifting patients from acute and long-term care facilities to home-based and community-based services,²⁰ including home care, while simultaneously implementing programs designed to reduce unnecessary healthcare utilization and lower expenditures.²²⁻²⁵

Consumers often start receiving home care after a hospital stay. Because patients who require continuing care cannot be

Electronic supplementary material The online version of this article (doi:10.1007/s11606-014-3164-7) contains supplementary material, which is available to authorized users.

Received August 14, 2014

Accepted December 12, 2014

Published online January 9, 2015

discharged until there is a care plan in place,²⁶ hospital case managers ask them to choose a home health agency. Our aim was to learn how home health consumers and hospital case managers use existing public reports^{27,28} for patients needing home care. This was the first aim of a three-part study to develop and test a tool for consumers making the choice of a home health agency.

METHODS

We conducted consumer focus groups and case manager structured interviews in one northeast state (Rhode Island). Two 90-min focus groups were held in May 2013 and July 2013, respectively, and 28 30-min structured interviews were held from May 2013 through August 2013. Focus group participants were English-speaking consumers aged 21 years or older who either received home care within the previous 3 years or had cared for a family member who received services within the previous 3 years. We chose a 3-year period because we felt that consumers in this window would be able to recall the home health selection process. Structured interview participants were hospital case managers aged 21 years or older who worked at one of five hospitals throughout the state and whose professional responsibilities included discharge planning. For both the focus groups and structured interviews, participants were a convenience sample who responded to advertisements for study volunteers; they were not systematically selected as key informants.

The study's investigators developed interview guides (available in the electronic supplementary material) *de novo*, based on prior subject matter expertise and knowledge about public reporting and qualitative research methods to elicit participants' thoughts and ideas about a particular topic. The interview guides were not tested prior to implementation, but were intended to be modified, as needed, by the facilitator during the iterative process of conducting focus groups with consumers and interviews with hospital case managers.

The facilitator (M. Clark) is a female PhD-trained epidemiologist whose academic teaching and research expertise centers on qualitative healthcare research, including survey design, interviews, and focus groups. She is not a healthcare provider, does not have expertise in home health or public reporting, and met participants for the first time during each focus group and interview. She asked participants to describe the home health agency selection process (the focus of this paper), review an existing state home health public report, and describe what consumers would find helpful when choosing home care or what case managers would find helpful when guiding patients and families in their decision. The facilitator encouraged focus group participants to talk with one another, to further explore experiences and shared perspectives. One or two additional members of the research team observed each focus group or interview to record notes.

We audiotaped each session, and then three of the authors independently conducted repeated examination and content analysis to derive themes from the data,^{29,30} using observers' notes and data manually coded by two research assistants from the audiotapes. The three authors then met to reach agreement and settle any divergence in analysis. When identifying major themes, we considered the words, tone, context, nonverbal cues, internal consistency, frequency, intensity, and specificity of responses.

The study was approved by the Institutional Review Board of one of the local hospitals.

RESULTS

We conducted two focus groups with a total of 13 home health consumers (Table 1) and 28 structured interviews with individual hospital case managers (Table 2). The case managers were employed at five of the state's 11 acute-care hospitals. Table 3 presents major themes.

Process for Choosing Home Health Agencies at Hospital Discharge

All case managers reported routinely asking patients and family members to choose a home health agency from a list of agencies maintained separately by the case management department of each hospital or health system. Most, but not all, consumers recalled receiving these lists. Each list included agencies' names, addresses and phone numbers; some also had information about insurance accepted by each agency.

"We received a list from the hospital to choose from."
(Family member, participant PF01)

"We always give them choices, you know, a sheet with the names and addresses and phone numbers."
(Case manager, participant CM01)

Table 1 Consumer Characteristics (N=13)

Characteristic	Focus group participants
Type of consumer, n (%)	
Patient	1 (7.7 %)
Family member	10 (76.9 %)
Both patient and family member	2 (16.7 %)
Receipt of home health services, n (%)	
<12 months	9 (69.2 %)
12 + months	3 (23.1 %)
Don't know	1 (7.7 %)
Gender, n (%)	
Male	2 (15.4 %)
Female	11 (84.6 %)
Ethnicity, n (%)	
Non-Hispanic, white	10 (76.9 %)
Non-Hispanic, black	3 (23.1 %)
Hispanic	0 (0.0 %)
Other	0 (0.0 %)
Correctly answer health literacy screen, n (%)	13 (100.0 %)

The health literacy screen is a single question asking patients to answer a question based on a medication label

Table 2 Case Manager Characteristics (N=28)

Characteristic	Interview subjects
Gender, n (%)	
Male	0 (0.0 %)
Female	28 (100.0 %)
Ethnicity, n (%)	
Non-Hispanic, white	27 (96.4 %)
Non-Hispanic, black	0 (0.0 %)
Hispanic	0 (0.0 %)
Other	1 (3.6 %)
Employed at one of three hospitals with affiliated agency, n (%)	9 (32.1 %)
Years of experience helping patients choose home care, mean (median)	10.1 (7.0)

The five hospitals included two academic teaching hospitals (in one health system) and three community hospitals (in two health systems). Each of the three community hospitals had an affiliated home health agency.

Both case managers and consumers expressed an interest in having the ability to allow the patient to choose from the subset of agencies that could meet the patient's most basic needs: those that accept the patient's insurance, provide all needed services and could serve the patient's home area.

“[Insurance] is a big part of it; [they want] to be sure [the agency] accepts [their] insurance. Otherwise, you can't use that [agency].” (Case manager, participant CM02)
 “You call [the agency] and they just ask you about the healthcare [insurance]...” (Family member, participant PF02)

Many case managers volunteered that the lists they provided were not informative and did not provide the information patients needed to make an informed choice; but they seemed resigned to the fact that they had no additional information readily available to provide.

“It doesn't have much on it. It's not the best. But it's something that at least we can give them.” (Case manager, participant CM03)

Although the Rhode Island Department of Health and Medicare each publish public reports with information about individual home health agencies' quality of care, none of the participants (consumers or case managers) were familiar with these existing reports. Some consumers and case managers did, however, volunteer that they had used Department of Health or Medicare nursing home public reports.

“I don't think I've ever used a home care rating tool.” (Case manager, participant CM04)
 “[There are reports for nursing homes, but] I haven't seen anything from home health care.” (Family member, participant PF03)

'Patient Choice' Implications

All case managers spoke about using the list of agencies as a tool to uphold the Social Security and Medicare laws requiring Medicare patients to have the freedom to choose among providers.^{27,31} They referred to these laws frequently and called them 'patient choice' or simply 'choice.'

“It's really so that you can say you gave them choice. That is really why you're giving it to them.” (Case manager, participant CM05)

When probed about laws governing patient choice, case managers' responses varied, although no one cited the Social Security Act.

Table 3 Major Themes from Focus Groups and Interviews

Theme (s)	Discharge planning process	Illustrative quotes	
		Case managers	Consumers
Lack of awareness of home health public reports	Case managers ask patients to choose home health agencies from a list	“We always give them choices, you know, a sheet with the names and addresses and phone numbers.” (Case manager, participant CM01)	“[There are reports for nursing homes, but] I haven't seen anything from home health care.” (Family member, participant PF03)
Desire for actionable information	Patients don't know how to interpret the list, so they ask for help	“They [patients] will say, 'Who do you recommend?'" (Case manager, participant CM13)	“I'd be interested in the subjective quality rating from [other] patients.” (Family member, participant PF08)
Perception that 'patient choice' prohibits providing additional information	Case managers feel unable to further inform patients' decisions	“I can't tell you what everybody does and I can't make decisions for you [...] I can't help you choose.” (Case manager, participant CM07)	—
Differing beliefs on the importance or risk of the decision	Very little guidance or information provided	“You can't compare [nursing homes and agencies] because they [home health agencies] come do their thing and they're gone.” (Case manager, participant CM17)	“There's no quality control out of the hospital. You hate to see somebody harmed for things to get better.” (Family member, participant PF07)
Inability to ascertain quality	Choices are made without considering quality	“I tell them that most of the agencies are the same.” (Case manager, participant CM15)	“I wasn't familiar with any of them, so I chose [agency] because [they were] the closest.” (Family member, participant PF06)

“It’s hospital policy here that we don’t recommend [...] that’s against the bylaws.” (Case manager, participant CM03)

“It’s [Medicare] Conditions of Participation that choice is offered.” (Case manager, participant CM04)

“That’s all part of the Stark Laws. You can’t be perceived that we are giving business to a particular home health agency for a kick-back or anything like that.” (Case manager, participant CM06)

Nearly all case managers spoke about patient choice implications in the negative, focusing on what they were prohibited from doing as exemplified by the following.

“I can’t tell you what everybody does and I can’t make decisions for you [...] I can’t help you choose.” (Case manager, participant CM07)

Patient Decision Making with Limited Information

Absent any information about services or quality, consumers reported not knowing how to make a decision.

“I was in an accident...I broke eight bones. You don’t have a lot of time for planning or researching, or for anything, under those circumstances.” (Patient, participant PF04)

“I wish I had had advance warning—like, tomorrow we’re going to think about discharging her. Then I would have called and researched [before making the decision.]” (Family member, participant PF05)

Some chose an agency in the patient’s city or town, despite the fact that home health providers travel to the patient’s home, i.e., services are not provided at the agency’s physical address.

“I wasn’t familiar with any of them, so I chose [agency] because [they were] the closest to where my mother lives.” (Family member, participant PF06)

If consumers had previous home care experience, they often defaulted to choosing the same agency. This often came as a response to the case manager asking or reminding the patient about their past experience. If consumers did *not* have home care experience, case managers generally reported that they disregarded the list entirely (e.g., “I don’t care”) or asked for help.

“A lot of [patients] ask who’s good or who’s not. And we can’t answer that question.” (Case manager, participant CM08)

“They [patients] will say, ‘Who do you recommend?’” (Case manager, participant CM09)

Because consumers frequently phrased their request for help using the word ‘recommend,’ case managers responded by invoking the patient choice restrictions.

“We are not allowed to give specific recommendations.” (Case manager, participant CM10)

A subset of case managers, however, realized that a request for a ‘recommendation’ was really a request for help figuring out how to make the decision.

“We say, ‘I can’t recommend, but I can inform you.’” (Case manager, participant CM06)

“It’s by word of mouth kind of referral. Talk to your family. Talk to your doctors’ office if you are that unsure about what to do.” (Case manager, participant CM11)

If a patient did not express a preference and the hospital did not have an affiliated agency, case managers selected an agency based on the patient’s insurance and needed services.

“[If I pick,] I just randomly pick and just utilize and go through them. I don’t like to stick with the same agency, ‘cause I like to rotate.” (Case manager, participant CM12)

Nearly all case managers mentioned that they maintain a running mental inventory of information about agencies, e.g., that a certain agency provides cardiac monitoring or accepts a certain type of insurance, or that their department manager tries to keep track of information centrally.

Differences at Hospitals with Affiliated Agencies

The nine case managers (32.1 %) who worked for hospitals with an affiliated agency described the same decision-making process as the other case managers, with patients receiving a list of agencies, although some lists placed the hospital’s agency first (out of alphabetical order). When patients asked for help, these case managers disclosed their hospital’s relationship with that specific agency and asked them to sign a form attesting to the disclosure and the fact that they were given choices. They viewed these actions as ensuring that they upheld ‘patient choice.’

“They will say to us, ‘Who do you recommend?’ And we do say, ‘We do have a preferred provider...’” (Case manager, participant CM13)

“[I ask,] ‘Can I call the visiting nurses that are associated with [this hospital]?’ And they say yes or no, and I have them sign a form that says, I have chosen [agency].” (Case manager, participant CM14)

Perception of Importance of the Home Health Agency Decision

Nearly all of the case managers felt that agencies were of similar quality, although they acknowledged that there is no feedback loop once patients are discharged; i.e., they may not be aware of quality of care concerns after patients leave the hospital.

“I tell them that most of the agencies are the same.”
(Case manager, participant CM15)

“I always say that I’ve never heard anything bad about the ones that the hospital uses. You really don’t [hear anything bad].” (Case manager, participant CM16)

As a result of these beliefs, case managers perceived choosing an agency as relatively low risk compared to other discharge planning decisions. Some explicitly contrasted choosing home care against choosing skilled nursing or long-term care services, which involve residential care in a facility.

“There’s a lot of different factors that play into the skilled facility [choice] that you can’t compare to a home care [agency choice] because they [home health agencies] come do their thing and they’re gone.” (Case manager, participant CM17)

In contrast to the case managers’ perception of agencies as similar and unlikely to have poor quality, consumers in both focus groups described highly variable experiences with different agencies, including quality concerns.

“My mom had a couple of experiences and I’m not a complainer, but they were pretty egregious.” (Family member, participant PF07)

Although they mentioned clinical concerns, consumers focused more on their experiences with the people caring for them at home. Themes included wanting clear communication and expectations, consistent assignment of individual home health providers, reliability from those providers, and coordination of different services by the agency.

Emergence of Preferred Provider Networks

At the time of our discussions (May–August 2013), preferred provider relationships were beginning to appear; for example, with some physician offices asking their practices’ patients to choose specific agencies.

“The [physician office] care manager goes in and says, “Oh, no, we are affiliated with so-and-so [agency] and do you mind if we switch you?” [...] That’s the new reality of the world in the last few months.” (Case manager, participant CM06)

DISCUSSION

Despite the fact that state home health agency quality reports exist,³² we found that hospital case managers were unaware of them: they reported routinely asking patients to choose agencies from internally created lists that included agency names, addresses, and phone numbers. Because consumers did not know how to interpret these lists, they often asked for help. However, case managers felt unable to inform consumers’ decisions, both because they did not have information about agency quality (they were genuinely unaware of post-acute care experiences) and as a result of their interpretation of ‘patient choice’ laws. Absent any information to ascertain quality, consumers generally reported choosing agencies based on criteria unrelated to health care, such as location.

Over the last decade or more, state and federal programs have invested significant time and resources to publish quality and satisfaction ratings designed to assist consumers in choosing among providers, including home health agencies.^{28,29} However, the utility of this information depends upon numerous assumptions, including its availability at the point in time when consumers make decisions. And its availability to consumers depends largely on case managers’ awareness of the information, since they are guiding patients through hospital discharge. Several factors influenced case managers’ general reluctance to help. First, as noted above, they were unaware of the available reports. Second, although they admitted that there was no reliable feedback loop about patients’ home care experiences, they also felt that agencies were similar and that the decision was less consequential than, for example, residential placement in a nursing home. Finally, many case managers felt that ‘patient choice’ laws constrained their conversations with consumers. Even those who clearly distinguished between *informing* a decision (allowed) and *recommending* an agency (not allowed) expressed reservations about responding to consumers’ requests for information about which agencies are ‘best’; they feared breaking federal laws or hospital bylaws.

Public reports can support the intent of ‘patient choice’—patient autonomy—by providing case managers with unbiased information that they feel comfortable sharing as part of usual discharge. Such reports should be marketed directly to case managers, so that they are aware of available information and can incorporate it into discharge planning discussions. It is equally important that hospital leaders accurately educate case managers about ‘patient choice’ laws, so that case managers understand what is permissible—including how they can help patients make informed decisions, without restricting their freedom to choose. This requires changing both training and culture, as perceptions of ‘patient choice’ restrictions are shared among colleagues. Case managers can be a reliable conduit to share information directly with consumers during discharge planning, but only if they are aware of existing resources and feel able to use them.

While traditional fee-for-service payment structures provide hospitals with little incentive to be concerned about post-acute care outcomes and costs, new policies and programs being implemented by Medicare, including readmission penalties and bundled payment programs,^{23–25,32} are holding hospitals accountable for patients after discharge. As a result, we found it surprising that case managers continued to ask consumers to choose home care without information about quality or input from their care team. As hospitals' financial incentives and responsibilities for health outcomes reach beyond inpatient care, their commitment to ensuring high-quality post-acute care will need to change. Hospital leaders are likely to implement contractual relationships and discharge processes that encourage patients to choose high-performing providers. These new incentives will also change 'patient choice' dynamics.

We note several limitations. First, our results reflect participants' perceptions. We did not observe hospital discharge or the home health selection process, and reality may differ from perception. Second, only three home health patients participated in the focus groups. More than three-quarters of the focus group participants were family members. Although this may accurately reflect what case managers told us (that family members make most of the decisions about home health care), it means that we can offer limited insight into patients' perceptions and needs. Third, although case managers' participation was voluntary and we kept their comments confidential, their responses may be biased by a conscious or unconscious desire to present their hospital and personal role in a positive light. This could result from fear of describing processes that diverge from hospital policy and management direction, or from fear of being perceived negatively by our research team. Fourth, we asked consumers to reflect on home care experience within the prior 3 years. There may have been a recall bias surrounding their choice of an agency if a significant amount of time had elapsed between the experience and the focus group. Finally, our findings are based on research conducted in a single state, Rhode Island. Discharge processes and discussion may differ elsewhere, although the results of an informal survey that we conducted with a convenience sample of 40 case managers in five other states affirm our belief that most case managers (87.5%) use similar, basic lists of agencies. (We emailed colleagues in several states and asked them to share an electronic survey with any case managers they knew.)

In summary, we aimed to learn how home health consumers and hospital case managers use existing public reports for patients needing home care. We found that both home health consumers and hospital case managers were unaware of public reports about home health quality, which limited consumers' ability to make informed decisions and case managers' ability to assist them in that decision-making process. Case managers reported feeling otherwise prohibited from recommending specific providers to patients and viewed the 'patient choice' laws as restricting their ability to respond to patients' requests

for help in choosing home health agencies. Public reports can be marketed as tools that case managers can use to help patients differentiate among providers while supporting patient autonomy. Marketing reports to case managers will likely increase consumer awareness of these resources, as consumers often request information from a case manager during discharge planning discussions. Better informing both consumers and case managers about the availability of agency ratings, the variance in agency quality, and the importance of using this information has the potential to help improve patients' experience, outcomes, and costs.

Acknowledgements:

Conflict of Interest: The authors declare that they do not have a conflict of interest.

Contributors: The authors thank Liz Babalola, MPH, formerly of Healthcentric Advisors, for program coordination during the study's first year; Ann Messier, from Healthcentric Advisors, for administrative support and assistance coding the audio transcripts; Kimberly Pelland, from Healthcentric Advisors and the Brown University School of Public Health, for assistance coding the audio transcripts; the consumers who participated in focus groups; and the hospital case managers who volunteered for interviews and continue to support this ongoing study.

Funders: This study was funded by Agency for Healthcare Research and Quality Grant #1R21HS021879-01.

Prior Presentations: AcademyHealth Annual Research Meeting, San Diego, CA, June 2014.

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REFERENCES

1. **Leape LL.** Transparency and public reporting are essential for a safe health care system. *The Commonwealth Fund*. 2010.
2. **Ginsburg PB, Kemper NM.** Health care quality transparency: If you build it, will patients come? *Center for Studying Health System Change*. Commentary No. 4. July 2009. Available at: <http://www.hschange.com/CONTENT/1072/>. Accessed December 15, 2014.
3. **Shaller DV, Sofaer S, Findlay S, Hibbard JH, Lansky D, Delbanco S.** Consumers and quality-driven health care: a call to action. *Health Aff*. 2003;22(2):95–101.
4. **Totten A, Wagner J, Tiwari A, et al.** Closing the quality gap: Revisiting the state of the science (Vol. 5: Public reporting as a quality improvement strategy). 2012 Jul. December 2011. Rockville, MD: Agency for Healthcare Research and Quality. Available at: http://effectivehealthcare.ahrq.gov/ehc/products/343/1199/EvidReport208_CQGPublicReporting_FinalReport_20120724.pdf. Accessed December 15, 2014.
5. **Marshall MN, Shekelle PG, Leatherman S, Brook RH.** The public release of performance data: What do we expect to gain? A review of the evidence. *JAMA*. 2000;283:1866–1874.
6. **McGlynn EA, Asch SM, Adams J, et al.** The quality of health care delivered to adults in the United States. *N Engl J Med*. 2003;348(26):2635–45.
7. **Kohn LT, Corrigan JM, Donaldson MS., eds.** *To err is human: building a safer health system*. Committee on Quality of Health Care in America, Institute of Medicine. Washington DC: National Academy Press; 1999.
8. **Davies HT, Washington AE, Bindman AB.** Health care report cards: implications for vulnerable patient groups and the organizations providing them care. *J Health Polit Policy Law*. 2002;27:379–99.
9. **Hibbard JH, Stockard J, Tusler M.** Does publicizing hospital performance stimulate QI efforts? *Health Aff (Millwood)*. 2003;22(2):84–94.
10. **Hibbard JH, Stockard J, Tusler M.** Hospital performance reports: impact on quality, market share, and reputation. *Health Aff (Millwood)*. 2005;24(4):1150–60.

11. **Laschober M, Maxfield M, Felt-Lisk S, Miranda DJ.** Hospital response to public reporting of quality indicators. *Health Care Finance Rev.* 2007;28(3):61–76.
12. **Chernew M, Gowrisankaran G, McLaughlin C, Gibson T.** Quality and employers' choice of health plans. *J Health Econ May.* 2004;23:471–92.
13. **Fung CH, Lim YW, Mattke S, Damberg C, Shekelle PG.** Systematic review: the evidence that publishing patient care performance data improves quality of care. *Ann Intern Med.* 2008;148:111–23.
14. Canadian Health Services Research Foundation. Myth: People use health system report cards to make decisions about their healthcare. 2006. Available at: http://www.chi-fcass.ca/Migrated/PDF/myth23_e.pdf. Accessed December 15, 2014.
15. **Schauffler HH, Mordavsky JK.** Consumer reports in health care: do they make a difference? *Annu Rev Public Health.* 2001;22:69–89.
16. Kaiser Family Foundation. 2008 update on consumers' views of patient safety and quality information. 2008. Available at: www.kff.org/kaiserpolls/posr101508pkg.cfm. Accessed December 15, 2014.
17. **Sofaer S, Crofton C, Goldstein E, Hoy E, Crabb J.** What do consumers want to know about the quality of care in hospitals? *Health Serv Res Dec.* 2005;40(6 Pt 2):2018–36.
18. **Fotaki M, Roland M, Boyd A.** What benefits will choice bring to patients? Literature review and assessment of implications. *Journal of Health Services Research & Policy.* 2008;13(3):178–84.
19. Medicaid.gov. Money follows the person. Available at: <http://www.medic-aid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Balancing/Money-Follows-the-Person.html>. Accessed December 15, 2014.
20. United States Department of Justice, Civil Rights Division. Olmstead: Community integration for everyone. Available at: http://www.ada.gov/olmstead/olmstead_about.htm. Accessed December 15, 2014.
21. **Saucier P, Kasten J, Burwell B, Gold L.** The growth of managed long-term services and supports (MLTSS) programs: A 2012 update. http://www.medic-aid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/MLTSSP_White_paper_combined.pdf. Accessed December 15, 2014.
22. Centers for Medicare & Medicaid Innovations. Accountable care organizations. Available at: <http://innovation.cms.gov/initiatives/aco/>. Accessed December 15, 2014.
23. **Ginsburg PB.** Achieving health care cost containment through provider payment reform that engages patients and providers. *Health Aff (Millwood).* 2013;32(5):929–34.
24. Centers for Medicare & Medicaid Services. Medicare demonstrations: Community-based care transitions program. www.cms.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?itemID=CMS1239313. Accessed December 15, 2014.
25. **Delbanco S.** The payment reform landscape: Bundled payment. Available at: <http://healthaffairs.org/blog/2014/07/02/the-payment-reform-landscape-bundled-payment/>. Accessed December 15, 2014.
26. Centers for Medicare & Medicaid Services. 42 CFR 482.43 - Condition of participation: Discharge planning. Available at: <http://www.gpo.gov/fdsys/pkg/CFR-2011-title42-vol5/pdf/CFR-2011-title42-vol5-sec482-43.pdf>. Accessed December 15, 2014.
27. Rhode Island Department of Health. Quality information about home health agencies. Available at: <http://www.health.ri.gov/healthcare/providers/homehealthagencies/about/quality/>. Accessed December 15, 2014.
28. Medicare.gov. Home health compare. Available at: <http://www.medicare.gov/homehealthcompare/search.html>. Accessed December 15, 2014.
29. **Tong A, Sainsbury P, Craig J.** Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care.* 2007;19(6):349–357.
30. **Kohlbacher F.** The use of qualitative content analysis in case study research. *Forum Qualitative Social Research.* 2006;7(1):Art 21.
31. Social Security Act. SSA 1802(a): Free choice by patient guaranteed. Available at: http://www.ssa.gov/OP_Home/ssact/title18/1802.htm. Accessed December 15, 2014.
32. **Delbanco S.** The payment reform landscape: Bundled payment. Available at: <http://healthaffairs.org/blog/2014/07/02/the-payment-reform-landscape-bundled-payment/>. Accessed December 15, 2014.