S. HRG. 106–289

TOO MUCH INFORMATION? THE IMPACT OF OASIS ON ACCESS TO HOME HEALTH CARE

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BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

ONE HUNDRED SIXTH CONGRESS

FIRST SESSION

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APPENDIX

TOO MUCH INFORMATION? THE IMPACT OF OASIS ON ACCESS TO HOME HEALTH CARE

MONDAY, MAY 24, 1999

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, DC.

The committee met, pursuant to notice, at 1 p.m., in room 366, Dirksen Senate Office Building, Hon. Charles Grassley (chairman of the committee) presiding.

Present: Senators Grassley, Craig, and Bryan.

OPENING STATEMENT OF SENATOR CHARLES GRASSLEY, CHAIRMAN

The CHAIRMAN. I am Senator Chuck Grassley, and I would like to call this meeting to order.

As chairman of the Special Committee on Aging, I want to welcome all of you who are here. We generally do get packed audiences, as we have again today, so some of you are probably pretty loyal in coming to a lot of committee hearings, and for those of you who come regularly, we welcome you back. For those of you who are here for the first time for a very important hearing, I want to thank everyone for being here, particularly our witnesses and those who have come from out of town, which is a good share of those of you who are here.

Before I make an opening comment—hello, Senator Craig—I was just about to say that Monday morning is a nice time to hold a hearing because we do not get interrupted by votes, but it also means that sometimes you do not get very good turnout. I owe Senator Craig an apology for mentioning that just as he walked in. But you will find on Mondays that people will be in and out, and I like to give my colleagues the opportunity to make opening statements, and if someone comes in and has to leave, I might break into your testimony.

Also, since people come and go, and all of us do not get a chance to ask all the questions we want to ask, I would suggest that you may receive some questions in writing from those of us who are here as well as those who might not be here. We will give you a 2-week window to answer those questions in writing, please, if you do have some submitted to you.

Let me mention why Medicare home health care is so important. I have never really met a citizen who wanted to wind up in a nursing home—and that is not to say anything denigrating about nursing homes; that is simply a fact. I think people want to stay in their own homes or with relatives for as long as they can.

The good news is that what we want is to also give them a quality of life and do something that is more cost-effective for the Government, because home care is so much more cost-effective for the Government than nursing home care.

In 1997, the Committee on Aging heard witnesses describe the fraud and abuse that some unscrupulous home health providers were involved in. Last year, we returned to home health but with a different focus—the new payment system and surety bond regulations that were turning the home care industry upside-down. Those hearings were two sides of the same coin. They were about making sure that our seniors and disabled citizens get the home health they are entitled to.

Today we turn to another related aspect of the Medicare home care program, the OASIS assessment. I am tempted to say it is the third side of the same coin, but maybe I should resist that temptation. My point is that OASIS is essential to Medicare beneficiaries who receive home care and that OASIS must be made to succeed.

Why do I feel so strongly about it? Because a key purpose of OASIS is to make the Medicare prospective payment system for home health care more accurate. The current payment scheme for home health care is a disaster, as we learned at last year's hearing. So we must meet the prospective payment system deadline of October 2000. Getting OASIS data on Medicare patients is essential for meeting that goal, and the sooner it is done, the better the prospective payment system will be.

In the worst case scenario, if the Health Care Financing Administration misses the deadline, there will be an automatic 15 percent cut in current payment levels that would drive the situation from bad to worse.

So I want to say clearly that abandoning OASIS is not an option. The issue for us today is making it work the right way so it gives us what we need without unduly burdening home health agencies and their patients.

To highlight some of the key issues, I will describe a few of the situations where I learned about OASIS. In January, I visited Greene County Medical Center in Jefferson, IA. There, I met one of our witnesses today, Cynthia Kail. When she and her colleagues showed me the length of the OASIS, I was shocked. I could believe their comments that it represented a paperwork burden that would strain agencies and take away valuable quality time from patients.

Today we will hear that point of view as well as the opposing perspective.

Several weeks later, I met with representatives of Lutheran Social Services of Des Moines and learned that all patients have to submit to OASIS whether the Federal Government is paying for their care or not. As a matter of principle, this bothered me. In general, I think that if the Government is not providing you with a benefit, it should not be imposing burdens on you.

Of course, I know there is an argument on the other side, and we are going to hear that as well today.

I also learned about another controversial aspect of OASIS the way many of you probably did—from the front page of The Washington Post. In March, the newspaper reported on concerns of privacy. OASIS requires information on some very private areas of life such as mental health and living situation. Some patients might object to that. HCFA also initially required that the information be transmitted to the Government in patient-identifiable form. It has subsequently said that the information is to be transmitted in this form only on Medicare and Medicaid patients.

But that does not answer all the questions in this area. Today we will hear a variety of views on this privacy issue.

Because we have six witnesses on our first panel, I am going to dispense with introductions and ask the witnesses to introduce themselves, but I do want to take a moment to greet my two constituents. I have already mentioned Cynthia Kail; the other one is Dr. Judy Conlin, the new director of the Iowa Department of Elder Affairs.

I welcome all of you. I will note for the audience that the written testimony of all witnesses is being posted on the Aging Committee internet site during the hearing.

Senator Breaux, my ranking minority member, and others may be coming in for comments. They participate on a very regular basis, particularly Senator Breaux, and the fact that he is absent only means that he has other things that are very important as he gets ready this week to participate in the Finance Committee's hearing on Medicare reform.

[The prepared statement of Senator Grassley follows:]

PREPARED STATEMENT OF SENATOR GRASSLEY

This hearing will come to order. As Chairman of the Special Committee on Aging it is my pleasure to welcome my colleagues, our witnesses, and members of the public to this important hearing. I want to thank everyone for being here.

First, let me mention why Medicare home health care so important. I've never met a citizen who wanted to end up in a nursing home.The good news is that what we want is also what's cheaper for the government, because home care is so much more cost-effective for the government than nursing home care.

In 1997, the Aging Committee heard witnesses describe the fraud and abuse that some unscrupulous home health providers were involved in. Last year, we returned to home health, but with a different focus: the new payment system and surety bond regulations that were turning the home care industry upside down. Those hearings were two sides of the same coin—they were both about making sure that our seniors and disabled people get the home care they're entitled to.

Well, today we turn to another related aspect of the Medicare home care program, the OASIS assessment. I'm tempted to say it's a third side of the same coin, but maybe I should just resist that temptation! My point is that OASIS is essential to Medicare beneficiaries who receive home care, and that OASIS must be made to succeed.

Why do I feel so strongly about it? Because a key purpose of OASIS is to make the Medicare prospective payment system (PPS) for home health care accurate. The current payment scheme for home health care is a disaster, as we learned at last year's hearing. So we must meet the PPS deadline of October, 2000. Getting OASIS data on Medicare patients is essential for that goal, and the sooner it's done, the better the PPS will be. In the worst case scenario, if HCFA misses the deadline, there'll be an automatic 15% cut in the current payment levels. That would drive the situation from bad to worse.

So I want to say clearly that abandoning OASIS is not an option. The issue for us today is making it work in the right way, so that it gives us what we need without unduly burdening home health agencies and their patients.

To highlight some of the key issues, I'll describe a few of the situations in which I learned about OASIS. In January, I visited Greene County Medical Center in Iowa, and there I met one of our witnesses today, Cindy Kail. When they showed me the length of OASIS, I was shocked. I could believe that it represented a paperwork burden that would strain agencies, and take time away from patients. Today, we'll hear that point of view, as well as the opposing perspective.

Several weeks later, I met with a representative of the Lutheran Social Services in Des Moines, and learned that all patients have to submit to OASIS, whether the federal government is paying for their care or not. This bothered me, on principle. In general, I think that if the government is not providing you with a benefit, then it shouldn't be imposing burdens on you. Of course, I know there's an argument on the other side, and we'll hear both sides today.

I learned about another controversial aspect of OASIS the same way many of you probably did: from the front page of the Washington Post. In March, the newspaper reported on concerns about privacy. OASIS requires information on some very private areas of life, such as mental health and living situation, and some patients might object to that. HCFA initially also required that the information be transmitted to the government in patient-identifiable form. It has subsequently said that information is to be transmitted in this form only on Medicare and Medicaid patients, but that doesn't answer all the questions in this area. Today we'll hear a variety of views on this privacy issue.

Because we have six witnesses on this first panel, I'm going to dispense with introductions and ask the witnesses to introduce themselves. But I do want to take a moment to greet my two constituents: Ms. Kail, and Dr. Judy Conlin, the new director of the Iowa Department of Elder Affairs. I welcome all of you, and ask Ms. Kail to begin.

Now I turn to my colleague Senator Craig from Idaho.

STATEMENT OF SENATOR LARRY CRAIG

Senator CRAIG. Thank you very much, Mr. Chairman, for holding the hearing to deal with the issue of the Outcome and Assessments Information Set requirements known as OASIS.

I also want to thank the witnesses for being here today. We appreciate your presence. I think this Senate and this Congress want to get to the base of the problem as we see it, or think we understand it, and that is why these hearings are very important.

While I support effective efforts to improve access to quality health care I am concerned about HCFA's proposed rules that would force some 9,000 home health care agencies to collect and report personal information on their patients.

Is the system as it currently exists an effective means of collecting the data necessary to improve patient outcomes, or is it a barrier to quality health care?

OASIS was developed to measure and evaluate patient outcomes in home health care. I am concerned that not all the information being collected is necessary, as the chairman has mentioned, for the proper performance of HCFA.

As the system evolves, I understand it will include a data set covering each patient's Social Security number, demographic characteristics, living arrangements and financial resources, as well as information on sensory, respiratory and elimination status, mental state, behavioral characteristics, range of activities, medication, productivity, and quality of life characteristics.

Data on health status that is accurate, competently collected and completely assessed would be useful to health care providers and the families of the elderly in the home health care system. However, gathering this sort of information to build a Government data base has me concerned about the implication for adequately protecting the privacy of individual patients.

In addition, Mr. Chairman, I wonder about the cost of actually implementing the system. In the Federal Register, HCFA states that the total startup cost for an average agency would be about $3,144. When you consider all that is required to keep the system intact—initial setup, data collection, transmission of OASIS data, and so on—I wonder if this estimate by HCFA is true for every home health care agency.

Again, Mr. Chairman, thank you for assembling this panel of witnesses today. It is important that we build a representative record on this issue so that we can have quality data by which to assess OASIS and recognize its costs.

All of us, or most of us, are committed to home health care. The unintended consequence of past congressional action is now well-known, and we want to make sure we do not create other unintended consequences or allow a Federal agency to do so without our knowledge.

So again, Mr. Chairman, I thank you.

[The prepared statement of Senator Craig follows along with prepared statements from Senator Hagel and Representative Jim Ryun:]

PREPARED STATEMENT OF SENATOR CRAIG

I'd like to thank the Chairman for holding this hearing today on the Outcome and Assessment Information Set requirements (OASIS). I would also like to thank each of the witnesses for taking the time to appear before the committee to testify.

While I support effective efforts to improve access to quality health care, I am a bit concerned about HCFA's proposed rule that would force 9,000 home health agencies (HHAs) to collect and report personal information on their patients. Is the system, as it currently exists, an effective means of collecting data necessary to improve patient outcomes or is it a barrier to quality health care?

OASIS was developed to measure and evaluate patient outcomes in home health care. I'm concerned that not all of the information being collected is necessary for the proper performance of HCFA. As the system evolves I understand it will include a data set covering each patient's Social Security number, demographic characteristics, living arrangements, and financial resources, as well as information on sensory, respiratory, and elimination status, mental state, behavioral characteristics, range of activities, medication, productivity, and "quality of life" characteristics. Data on health status that is accurate, competently collected, and competently assessed would be useful to health care providers and the families of the elderly in the home health care system. However, gathering this sort of information to build a government database has me concerned about the implications for adequately protecting the privacy of the individual patients.

In addition, I wonder about the costs of actually implementing this system. In the Federal Register, HCFA states that the total start-up cost for an average agency would be $3,144.00. When you consider all that is required to keep the system intact; initial start-up, data collection, transmission of OASIS data and so on, I wonder if this estimation by HCFA is true for every home health agency.

Again I would like to thank the Chairman and our panel of witnesses here today. This is a great opportunity to address concerns about OASIS, particularly privacy and cost issues, and move forward to improve the quality of home health care.

Thank you.

PREPARED STATEMENT OF SENATOR HAGEL

Good afternoon, Mr. Chairman. Thank you for calling this timely and important hearing on the Health Care Finance Administration's Outcome and Assessment Information Set (OASIS).

As the number of Americans over 65 continues to grow, home health care will play a significant role in providing services to meet their needs. Home health services allow seniors to receive personal care and assistance in the comfort of their own home, rather than in a nursing home or other institutional setting. In addition to offering seniors greater independence, home health is also a much less costly alternative to nursing home care.

The average cost of furnishing nursing home care is in excess of $40,000 per year. A figure made even more significant when one considers the fact that almost 40 percent of all nursing home care in this country is paid for by Medicaid. Home health assistance—which is provided under Part B of the Medicare program—only costs between $55 to $200 per visit. As we examine the extent to which OASIS imposes any additional administrative burdens and operational costs on the home health industry, it is important that we keep these figures in mind.

In accordance with the requirements of the 1997 Balanced Budget Act, HCFA was charged with creating a program that would monitor the quality of home health services provided to our nation's seniors. Their efforts resulted in OASIS. Although HCFA has indefinitely suspended the implementation of OASIS, in order to ensure compliance with the Paperwork Reduction and Privacy Acts, many home health providers are concerned.

Having had the opportunity to review OASIS, as well as the 19-page form that must be filled out for each patient, I can appreciate the depth of their discord. Not only are home health providers required to collect OASIS data from Medicare enrollees, but also from private payer and insurance patients. Some private pay and insurance patients have refused to participate, putting the provider in the difficult position of having to withhold services in order to comply with HCFA regulations. In addition, the start-up costs incurred by providers in implementing the OASIS requirements have far exceeded HCFA's initial projections. These costs are being imposed on home health agencies at the same time Medicare reimbursement rates for these services have been drastically reduced.

Home health providers are not the only ones who are unhappy with OASIS. Seniors themselves have expressed their frustration with the scope, frequency, and intrusiveness of the surveys. The information requested includes patient history, personal characteristics—such as race and ethnicity—living arrangements, and financial, behavioral, and psychological profiles. It is unclear how much of this information is helpful or necessary in order to monitor quality of care, implement prospective payment, or curb fraud and abuse.

It is crucial that the Health Care Financing Administration be given the tolls and the authority to obtain health data in order to ensure that our seniors are receiving the highest quality of care. By the same token, it is important that this information is obtained in such a manner that does not place an undue administrative and financial burden on home health providers, and takes into account the privacy and dignity of our seniors. It is my firm belief that such a balance can be reached.

I look forward to hearing more about the OASIS program from our panelists today, as well as any suggestions they may have on how this system can be improved.

Thank you Mr. Chairman.

PREPARED STATEMENT OF REPRESENTATIVE JIM RYUN

INTRODUCTION

I would like to thank Chairman Grassley for this opportunity to express my concerns about the Health Care Finance Administration's (HCFA) implementation of the Outcome and Assessment Information Set (OASIS).

Let me begin by applauding the efforts of HCFA to maintain an open dialogue with Congress and the home health industry during this delicate time of adjustment to the OASIS regulations. However, my colleagues and I remain concerned about several unintended consequences of OASIS, which have yet to be adequately addressed by HCFA. These unintended consequences pose a serious threat to home health care access in rural and medically underserved areas.

PROBLEM OF TIMING

I do not need to dispute the merits of the OASIS data set as a tool to measure the quality of care provided by home health agencies. After all, it was for this purpose that OASIS was developed in the first place. Many initial reactions tend to focus on only one aspect of OASIS (i.e. cost, privacy, paperwork burden etc.). As originally conceived, OASIS is not a bad thing. In fact, the OASIS data set is part of the solution. So what is the problem? Timing. The timing could not be worse for HCFA to link the home health agency quality of care assessment instrument mandated by Sec. 1891 (c) of the Social Security Act with the PPS data request provision afforded to the Secretary of Health and Human Services in Sec. 4602 of the 1997 Balanced Budget Act. Therefore, I believe we need to re-evaluate the current implementation of OASIS and focus on what needs to be done to get the prospective payment system (PPS) implemented as soon as possible.

KANSAS BACKGROUND

Before I get into my specific concerns with OASIS implementation, please allow me to describe the status of home care in Kansas. In rural Kansas, Medicare-certified home health agencies or certified home health departments are the primary source for providing in-home services needed by the most frail and vulnerable in our population. My personal interest in home health care and the OASIS regulations came as a direct result of numerous visits to home health providers in the Second District of Kansas. I have worked extensively with home health care agencies, Area Agencies on Aging, and other medical professionals in my district in order to fully understand the benefits and impacts of OASIS on the shaky infrastructure of rural health care. As the Representative of the Second District of Kansas, I must testify that HCFA has grossly underestimated the negative impact current OASIS regulations will have on my district.

We are all aware that more than 2200 home health agencies have closed down since the implementation of the interim payment system (IPS). Since January 1, 1998, 43 home health agencies in Kansas have closed. Although not all closures can be attributed to IPS or OASIS regulations, Kansas health providers face the legitimate concern that the compound effect ofOASIS compliance upon lower IPS reimbursement rates will accelerate the rate of agency closures.

HCFA's start-up cost and paperwork estimates were based on an "average-sized" home health agency of 18 nurses. Unfortunately, the vast majority of agencies in Kansas can only afford to maintain 1 to 5 nurses on staff. Even the largest home health agencies barely reach the lower revenue levels of a HCFA-defined "small-sized" home health agency. Because the resources available to treat patients are rapidly becoming more and more scarce, home health staff salaries have been greatly reduced. Regular employment benefits are being cut. The range of services is being reduced and therapists are being let go. There is a growing shortage of nurses. Home health agency administrators are now not only "administrating" the OASIS regulations for their home health agency, but they are now, themselves, making visits to the homes of patients to provide them with medical attention.

Unfortunately, this is the reality of home health care in Kansas right now. The many benefits of OASIS data as a measurement of quality care do not erase the fact that most of the home health agencies in my district are in financial trouble. We must be careful that our actions do not lend credibility to the sentiment that the policy makers in Washington, DC. are out-of-touch with the people their policy is intended to help. The numbers may easily work out on paper here in Washington; however, home health agency administrators across Kansas look at the same numbers and wonder how they can continue to provide the most vulnerable seniors with the services they desperately need. I am confident we can find a way to gather the necessary information to develop the PPS without the current all-inclusive, all-intrusive nature of the OASIS regulations.

NON-MEDICARE AND PRIVATE PAY PATIENTS

I believe our first priority should be the implementation of the PPS without any further delays. HCFA has already indicated that it has gathered enough information from the OASIS demonstration projects to be able to release the proposed regulations for the PPS later this fall. In a letter I sent to Secretary Shalala on May 20, 1999, thirty-three of my Congressional colleagues signed on to express our concern about the inclusion of non-Medicare and private pay patients in the development of the prospective payment system. We believe that HFCA can obtain the necessary information to finalize and implement the PPS on time without collecting personal and medical information from individuals outside of the Medicare program.

HCFA continues to underestimate the non-Medicare caseload borne by home health agencies, especially in Kansas. A recent survey conducted by the Kansas Home Care Association (KHCA) on all Kansas home health agencies found the average non-Medicare caseload to be fifty percent of the total home health agency caseload. This has occurred because most home health agencies have made an effort to balance the effects of IPS by diversifying their patient caseload. However, when agencies have to consider denying care to either non-Medicare or Medicare patients because of budgetary deficiencies, reimbursement caps, or a shortage of registered nurses to perform the lengthy comprehensive assessments, the patients are being placed in medical jeopardy. In these instances, which are now more common than HCFA appears to understand, the well-meaning desire for "quality care" begets a policy of abandonment or "no care."

HCFA has also underestimated how severely the OASIS regulations will affect the non-medical services provided by Area Agencies on Aging and home health agencies in rural and medically underserved areas. The Senior Care Act enacted by the Kansas Legislature in 1989 is a successful state program which provides services for people 60 years of age and older who face difficulties in maintaining self-care and independent living. The program has successfully met the daily living needs of Kansas seniors for over ten years while preventing the inappropriate orpremature institutionalization of older persons. The most common non-medical services provided by AAAs and home health agencies under the Senior Care Act include bathing, assistance with walking, dressing, laundry and housekeeping, transportation, and assistance with shopping.

However, the current OASIS regulations mandate that if non-medical, personal care services (that is, any service which requires touching) are being administered by a Medicare-certified home health agency, the unreimburseable and costly OASIS initial comprehensive assessment must be completed along with the follow-up assessments every two months. This means that if a son personally pays for care for his mother, the agency must still complete all the onerous paperwork for HCFA; just because a home health agency aide helped his mother take a bath. These non-medical services are necessary to keep senior citizens well and safe in their homes. Home health agencies in rural Kansas cannot afford to waste precious resources to fill out paperwork that does not directly benefit the patient nor the development of the PPS. These rural home health agencies will be forced to close down. If there are no home health agencies or care givers available to administer these vital services, many seniors in Kansas will be institutionalized, with the state and federal governments picking up the tab. These same non-medical services could have been provided at a lower cost to everyone had a home healthagency remained open to provide the services.

In 1998, the Kansas Social and Rehabilitative Services was charged $72.29 per day for nursing home stays. After the patient's share is factored out, the state's contribution is $23.15 per day with the federal government paying the remaining $34.27. For a year's worth of nursing home care, the total average cost is $26,400 with the state paying $8500 per patient and the federal government paying $12,500. By contrast, the average Senior Care Act plan in Central Kansas costs $189 a month ($2200 annually) with the state picking up two-thirds of the cost. Kansas saves approximately $66 per day per patient by keeping seniors out of institutions and by assisting them in their own homes.

Under the same section of the Social Security Act HCFA quotes to justify their oversight of non-Medicare patient quality, the Secretary is also charged with promoting the effective and efficient use of public moneys. However, HCFA's all-inclusive unfunded mandate will increase the pressure on Kansas health providers to stretch their dollars even further or close their doors forever. Let me reiterate that there is not a lot of room left for agencies to scale things back any further than they already have.

Agencies will continue to close down and seniors will instead be institutionalized. The Secretary cannot possibly promote the efficient use of public moneys if her unfunded mandates accelerate home health agency closures in underserved areas and increase the state and federal government's contribution to pay for institutionalized seniors. Many States have also expressed concern about the amount of the OASIS project they will be obligated to pay. I find it inappropriate for HCFA's unfunded mandates to force States and out-of-pocket payers to absorb unnecessary costs which HCFA ought to incur.

BURDEN ON AREA AGENCIES ON AGING

Finally, the inclusion of patients outside of the Medicare program in PPS research places an unjustified burden upon Area Agencies on Aging (AAA). AAAs are already subject to strict and adequate State and local assessment and reimbursement laws. HCFA has failed to recognize the impact its all-inclusive OASIS policies will have on health providers and facilitators who have been providing quality services with positive results for decades outside of the Medicare bureaucracy.

I'd like to tell you about one such agency in Kansas that has been meeting the needs of seniors in Kansas for many years. The North Central-Flint Hills Area Agency on Aging is a private, not-for-profit organization serving Kansans 60 and over in 18 counties. Under the capable and selfless leadership of Julie Walter, the Flint Hills Agency provides Kansas seniors with medical advice, legal assistance, friendship meals, transportation, recreational activities, volunteer opportunities, education, health agency location assistance. These programs are funded by the Senior Care Act, the Older Americans Act, Kansas Department on Aging, U.S. Department of Agriculture or mill levy taxes in all 18 counties served. The Flint Hills Agency is not a health facility and does not have doctors or nurses on staff. Julie and her staff work hard to find a home health agency willing to treat the senior citizen who needs personal assistance. However, under the OASIS regulations, Medicare-certified home health agencies that agree to take on a patient who needs bathing services will have to comply with all the OASIS assessments and timelines-even if bathing is the only service administered.

Medicare does not finance Julie's and her staff's hard work. She is financed primarily through the Older American's Act and Kansas funds-neither of which are under the jurisdiction of HCFA. Julie is now facing an additional strain on her agency's already tight resources because theOASIS regulations require OASIS assessments on all 1,237 patients she refers to the few remaining home health agencies in her area. With the additional costs from OASIS estimated at $188,385 and a budget for in-home services at only $113,000, she cannot afford to reimburse thehome health agencies with whom she contracts for all the additional visits. In fact, home health agency fiscal managers are advising them that it is not in their agencies' best interest to continue tocontract with Julie due to the added cost of the HCFA-required OASIS initial and follow-up assessments. Approximately 30 percent of the home health agencies with whom Julie has had a long-standing relationship have already indicated that they will be unable to continue their contract with her. This leaves Julie with the difficult choice of either denying care or placing those senior citizens on a waiting list.

CONCLUSION

If there is any one message I would like for you to take from this testimony it is this: HCFA's OASIS model completely ignores the real life hardships faced by rural America. As the Representative of the Second District of Kansas, the "real life" challenges presented to the home health agencies and Area Agencies on Aging from the OASIS regulations are of enormous concern to me. The nurses, administrators, and patients who contact me are concerned about the "real life" possibility that they may no longer be able to provide or receive home health care. I have listened to arguments for and against the way HCFA has chosen to implement OASIS. I find it disturbing that most of the arguments in support of OASIS fail to address the "real life" crisis in home health care today. Yes, if we could ignore the 43 home health agencies that have closed their doors in Kansas we could frame the debate around how effective we think OASIS will be in monitoring the quality of care provided. However, we cannot ignore these closings. We cannot ignore the realities that exist outside of HCFA's policy planning rooms. These realities include: 1) the home health industry is more valuable to Kansas than it is to Chicago or New York; 2) small agencies of two nurses are just as important to their seniors as large agencies with over fifty nurses; 3) rural home health agencies have been disproportionately affected by the 1997 Balanced Budget Act; and 4) rural home health agencies will be disproportionately affected by the OASIS regulations.

OASIS may be the perfect quality-of-care measuring tool. HCFA may even be able to find scientists and a few large health providers to testify that HCFA needs everything the way it is...all-inclusive, all-intrusive. But none of these academic arguments change the reality thatKansas home health agencies may not be able to afford OASIS. None of these academic excuses has changed my mind: non-Medicare patients should not be forced to participate in research projects for Medicare payment systems. HCFA's current excuse, "we don't understand why Kansas cannot afford OASIS" needs to change. HCFA needs to become as concerned about the shrinking access to home health care in rural and medically underserved areas as they are about making sure they get everything they want out of OASIS. HCFA owes Kansas a better explanation than "just grin and bear it!"

I wish the inclusion of non-Medicare patients was my only concern with OASIS. I am also concerned about the additional paperwork required, the vast subject area covered in the assessments, the short five-day window for follow-up assessments, the failure to obtain informed and written consent, and the invasions of patient privacy and records confidentiality. However, I believe that before we can even begin to explore the other policies of OASIS, we need to face the realities of today. HCFA needs a reality check. In Kansas, the reality is that OASIS is a good thing implemented in the wrong way at the wrong time. OASIS is part of the solution-until HCFA loses sight of the problem. I would encourage HCFA to take this time of delay to reexamine its OASIS policies and to get in touch with the people who live and work in a differentreality. Thank you for your time and attention.

The CHAIRMAN. Thank you, Senator Craig, not only for your statement but for participating in this committee meeting and being a valuable member of our Aging Committee.

We will start with Cynthia, and I will say to the witnesses that when the red light comes on, it is not a hard and fast 5-minute rule, but I would like to have you maybe finish your thought at that point. Also, as I indicated to all of you, please give us a little bit of your background as an introduction.

Cynthia, please.

STATEMENT OF CYNTHIA L. KAIL, ASSOCIATE ADMINISTRATOR, GREENE COUNTY MEDICAL CENTER, JEFFERSON, IA

Ms. KAIL. Hi. Senator Grassley, committee members and fellow panelists, my name is Cynthia Kail, and I am director of a small, rural, hospital-based home health agency in central Iowa.

Greene County, IA has the distinction of ranking No. 2 in the Nation for number of people over age 85 per capita. We take care of the oldest of the old, the most frail seniors in our Nation. Some of our patients range in age from 90 to 110 years of age, and their caregiving children range in age from 60 to 80 years old.

Many of the services that we provide to these patients are funded by sources other than Federal money. They are provided by sliding fee scales, private pay, local and State government tax money.

Our patients are old, they are frail; they tire easily. Our admission process is already very long by the time we go through a complete physical assessment, developing a plan of care, going over advance directives, the patients' bill of rights, the emergency plan, the on-call system, and other agency forms. That takes a lot of time, and it is tedious for those elderly patients.

In preparing my recommendations for today, I queried my home care colleagues across the Nation, and I received over 350 e-mail and fax responses in support of the recommendations I plan to present this afternoon.

As a whole, the industry is very supportive of the OASIS data collection tool in order to determine a prospective payment system and a quality agenda measuring quality outcomes. We have already spent valuable resources to determine and implement this system. Our biggest fear is that a prospective payment system will be based upon a medical diagnosis. Medical diagnoses do not tell us what the needs of the patient are in terms of nursing care and therapy care services.

We know that home health care resource utilization is based upon the patient's age, presence of a caregiver to do nonskilled things like meal preparation and shopping, skilled services like learning how to administer I.V. (intravaneous) medications, medication management, and wound care services.

Home health care resource utilization is also based on the patient's ability to do activities of daily living, dressing, toileting, eating, walking, and it is also dependent upon rural and urban services. There is some difference there. For example, if a patient cannot prepare meals for himself, and there is no Meals on Wheels service available, the agencies are responsible for providing that service as part of their care plan for the patient.

The recommendations that I would like to present are as follows: First that I think the OASIS data collection should be completed on admission and discharge, with perhaps an annual update to the patient's assessment. I would suggest the elimination of the every–2-month reassessment or change it. The changes, if we decide to keep the every–2-month reassessment, would include making sure the reassessment dates coincide with the certification dates for the physician's plan of treatment.

I believe that we do not necessarily need to have a home visit as a requirement for that reassessment. It could be based on the professional's knowledge. However, if it is required to have a home visit for that reassessment, there needs to be a 2-week window to allow for agencies to plan to complete the OASIS with other skilled services, and not have the administrative burden of extra visits to accomplish that.

I believe that the OASIS tool should be limited to Medicare-funded services that are skilled.

I believe we need to allow States the flexibility to determine if data collection methodology is needed for the state-administered Medicaid program.

We need to limit OASIS data collection initially to the twenty prospective payment data items. We need to make sure that HCFA can appropriately demonstrate their ability to utilize the data that is transmitted to develop a successful prospective payment system, and only then should we proceed to the quality management side of measuring outcomes, because I think that as an agency, we are not certain that that can be accomplished by HCFA by the time-frame that we need for the prospective payment system in the fall of 2000.

We need to protect our patients' privacy. I do not believe there is any place in a national data bank for identified private information. We need to have an assignment of a case number or some other system. Perhaps the agencies could collect the OASIS information and transmit all the information at once so the tracking would not have to be accomplished by sophisticated identifiers of the patient.

Finally, I think we need to require that HCFA follow the Paperwork Reduction and Privacy Acts. I think we need timely and consistent data from HCFA in order to implement OASIS requirements. I think we need to require that HCFA is Y2K-compatible for handling of the OASIS data as well as the prospective payment system and payment even in the interim. I would also suggest that we need an upward adjustment of the interim payment system for implementation and ongoing costs of the OASIS data collection system.

In summary, I would like to thank you for recognizing a large problem in the health care system for and being concerned about how Federal policy affects ethical home care providers in this country in their provision of services to the elderly population. You have the power to make HCFA comply with Federal legislation and regulation and to work with our industry in finding solutions to this problem.

Our elderly patients need to know that we are more concerned about the provision of quality services than we are about data collection. Home health care providers need your help because the Nation's elderly patients are depending upon us.

Thank you.

The CHAIRMAN. Thank you. We will wait until all the panelists have made their presentations, and then the members will ask questions. And there will also be an opportunity then for interaction among the panelists if you wish.

[The prepared statement of Ms. Kail follows:]

Comments made to US Senate Special Committee on Aging Re:

Outcome and Assessment Information Set (OASIS) for Home Health Care
5/24/99

By: **Cynthia L. Kall, MSN, RN, ARNP**
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INTRODUCTION:

Senator Grassley, Committee Members, and fellow panelists:

I want to thank you for the opportunity to address you with comments on OASIS this afternoon.

I come from a small community hospital based home care agency in central Iowa. But in essence, I represent all Iowa home care agencies and many across this great country. In preparing to come today, I queried my peers in Iowa and across the nation and found that their views are similar to mine. Therefore, I feel that I can adequately represent an agency perspective on the issue at hand.

It is imperative that the Senate Special Committee on Aging has a clear understanding of the effect of the OASIS data collection on the elderly in America. As you are probably aware, Iowa ranks number two in the nation for the number of people over the age of 65 per capita. Further, Iowa has the distinction of ranking number one for the number of elderly over the age of 85 per capita. Nestled in the heart of Iowa are two counties side by side - Calhoun and Greene counties - who have the distinction of ranking number one and two, respectively, in Iowa for the number of elderly over the age of 85 per capita. Therefore, it is fair to say that our agency takes care of the oldest of the elderly in the nation. In addition to the challenges of serving a large elderly population, fragmented family systems and the number of elderly living in poverty challenge us. I will attempt to help you understand the effects of the OASIS data collection system on your elderly constituents.

Our agency, and the nation's home care industry, has long supported the use of a uniform data set for collecting data, and measuring and ultimately improving patient outcomes in home care. Further, we are supportive of the Health Care Financing Administration's (HCFA's) efforts to develop a case-mix system for a home health prospective payment system (PPS). While many benefits may accrue from OASIS, we continue to believe that several actions must be taken before home care providers can adequately undertake OASIS data collection and assessment requirements. We are committed to collaboratively working through the bugs as opposed to eliminating a system that has already required a considerable amount of valuable resources to implement.

I will present information as statements of problems, followed by recommendations. This presentation will address nine (9) issues:

1. Effect of the OASIS on the Elderly
2. OASIS Data Collection for Medicare Patients Only
3. Privacy Rights of Patients Must Be Protected
4. Modification of OASIS Timeframes
5. Burdens on Agencies
6. PPS System that Truly Reflects Home Care Resource Consumption
7. Reimbursement of the Cost of OASIS Implementation
8. Adjustment of IPS if PPS Implementation Is Delayed
9. HCFA's Responsibilities to Providers

1. Effect of OASIS on the Elderly Patient

It appears that OASIS is more applicable to patients who have acute illnesses with rapid recovery. Most patients over the age of 85 do not make a full recovery after acute illnesses. Their advanced age, coupled with numerous health problems, lack of independence, lack of sophisticated service delivery in rural areas, and, often lack of a spouse or relative as a willing and able caregiver, lead to the provision of long term home care services. It is not uncommon to see little change in an elderly patient's condition, as reflected in OASIS, over the course of a year. Many of our elderly clients are maintained in their homes with a conservative number of visits, such as a skilled nursing visit every 1-2 months and aide visits 2-3 times a week (with the required, non-reimbursable every-two-week visit to supervise the aide). The current OASIS instructions require data collection every two months. That means that every visit or every other visit by the nurse requires extensive questioning of the patient and documentation by the nurse.

Patients become impatient, tired and/or annoyed with the OASIS data collection process. The home health admission process is already exhausting to the client. The required components are lengthy: completion of admission assessment including the OASIS data questions, complete physical assessment, explanation of rights, explanation of advance directives, explanations of agency policies and on-call system, determination of an emergency plan, determination of payment of services, and signing of agency forms for admission and release of information. Some clients are unable to complete the assessment process in one visit, necessitating repeated visits to the home. Our clients are worn out. They are frail and fragile. Our staff have encountered hostile caregivers, because we have "tired out Mom" or "delayed them from being able to get back to work timely" or "made dad decide he didn't want services".

When clients reach 80 years and beyond, they require more physical assistance from the home care aides and closer monitoring by the nurse. Frequently, they require assistance with setting up medications, grocery shopping, laundry, and environmental cleaning. Many of these services are not paid by Medicare because they do not constitute skilled services or personal care services. We provide these services through state grants, funding from the Iowa Department of Elder Affairs, and county taxes. The burden of OASIS on these non-Medicare funded services has the effect of reducing the number of individuals that can be served. We are using precious resources to collect data rather than care for our elderly.

RECOMMENDATIONS:

A. HCFA should modify OASIS requirements to reflect that completion of OASIS will only be required at admission and discharge to home health services, with an annual update of the OASIS for chronic care clients needing care longer than one year.

B. HCFA should modify the OASIS data collection system requirements as addressed in #2, #4 & #5 below.

2. OASIS Data Collection for Medicare & Medicaid Patients Only

HCFA has required OASIS data collection and reporting on all adult, non-maternity patients served by the Medicare or Medicaid certified agency. This includes private insurance patients, those paid by state and local governments, those paid by grants, and those paying for care out of their own pockets, regardless of payer or patient health status. It also includes terminally ill clients who have not elected to opt for the Medicare hospice benefit.

HCFA also requires OASIS data collection for clients who receive homemaker/home helper services, such as home cleaning and grocery shopping, not funded by Medicare or Medicaid. These services help elderly patients stay in their homes. To add in extra visits, time, and cost to these programs will limit agencies' ability to provide cost effective services; the net effect will be shrinkage of services due to an increase in administrative costs.

In addition, even though HCFA has specified that only twenty (20) specific OASIS data elements will be used for the case-mix system, the regulation requires that all seventy-nine (79) OASIS data elements be collected at least on admission and discharge for each patient. Many of the OASIS data items won't be used for prospective payment and are of questionable value for quality assurance.

Some private pay and insurance pay patients are refusing to answer OASIS questions, resulting in the agency notifying the client that they cannot provide services to them in order to remain in compliance with HCFA and state surveying agencies. Further, there is mistrust among the providers that HCFA will use the data from private-pay and insurance paid cases, distorting the case-mix adjusters that are critical to PPS. Since PPS is a Medicare reimbursement system, only Medicare patients should be involved in OASIS data collection.

RECOMMENDATIONS:

A. HCFA should modify the regulation to require OASIS data collection only on Medicare clients receiving intermittent skilled services that are funded by Medicare.

B. HCFA should modify the regulation to allow flexibility at the state level to administer Medicaid requirements for data collection to ensure requirements best-fit state designed programs.

C. HCFA should modify the regulation to clearly communicate the elimination of the OASIS requirement on private-pay, Medicare HMO, and private insurance clients; on care funded by state and local governments or other grants; and on private duty and homemaker/home helper services.

D. HCFA should mandate only the OASIS data collection items that are necessary for determination of a PPS system. HCFA should only consider implementing a quality agenda after successfully demonstrating their ability to manage the volume of data items necessary to deliver on a timely PPS system implementation.

E. No patient should be denied access to services based solely on his/her refusal to grant agency permission to transmit OASIS data to HCFA.

F. The PPS system must be based upon OASIS data for Medicare-funded care and information on the total number of Medicare reimbursed and non-reimbursed visits needed to maintain the client in their home. HCFA needs to have a full understanding of the total cost of care needed to care for a client to make policy determinations about a long-term home care benefit or cost-adjustments for patients whose care makes them an outlier in the current system.

G. HCFA should modify the regulation to eliminate the OASIS requirement for terminally ill Medicare and Medicaid beneficiaries who are served in traditional home care (not enrolled in Medicare certified *hospice* care).

3. Privacy Rights of Clients Must Be Protected

Many of the OASIS questions address the patient's health status and, as such, are protected as confidential medical information by the Federal Privacy Act of 1974. Some of the questions deal with especially sensitive areas such as whether the patient is able to afford food, reports feelings of hopelessness, or has attempted suicide. OASIS in its current form links personal information with identifying information, including patient name and social security numbers. The collection of OASIS patient information, if used inappropriately, could cause great harm to patients.

Identifying information, no matter how well encrypted, has no place in a national database. HCFA has not published a System of Records to protect this data as required by federal law.

RECOMMENDATIONS:

A. HCFA should modify OASIS requirements to allow for transmission of admission and discharge OASIS data to HCFA upon discharge of the patient. This would eliminate the need for patient identifiers attached to the data to track clients over time.

B. Assignment of a case number system, or agency assigned identifiers, for data submission could be incorporated to protect patient privacy without compromising outcome analysis activities.

C. No patient should be refused services on the basis of an unwillingness to consent to the transmission of confidential information.

4. Modification of OASIS Timeframes

The initial assessment is required within 48 hours of the referral, or within 48 hours of when the patient returns home, or on the physician-ordered start of care date. Agencies are required to implement a tracking system to monitor that the timeframes are met. It is not uncommon to receive referrals on patients when adult children are home for visits, with the request that services begin the following week after the visitor leaves. The agency should be able to schedule visits to meet the patient's needs.

HCFA regulation requires that the updated comprehensive assessment occur "as frequently as the patient's condition warrants due to major decline or improvement in the patient's health status....". The final rules do not define what constitutes a major decline or improvement in the patient's health status. This leaves a large gap of potential judgement on the part of Medicare State Surveyors to determine if the agency is in compliance on this requirement.

There is confusion about the need to obtain a physician's order for the visit to update the OASIS. There are times when the physician's orders do not coincide with the timeframes for OASIS assessments that must be updated by a home visit to interview the client. Section 204.2 E3 of the Medicare manual (HIM-11) reads, "any increase in the frequency of services or addition of new services must be authorized by the physician." An agency must obtain an order to increase visits to the patient. However, requiring the agency to obtain an order for these visits will require additional calls to the physician; this is likely to be undesirable for the supervising physician and a paperwork burden for the agency.

HCFA regulation requires that reassessments for OASIS occur every two calendar months from the start of care date and that the assessments must occur "no earlier than five (5) days before, and no later than one (1) day before the calendar day on which the certification period ends." This conflicts with the historical and traditional method for writing certification periods, as certification periods may be up to sixty-two (62) days, but may be shorter. It is possible for the certification periods to change over time, to not coincide with an every two calendar month date following the start of care date. Additionally, recertifications sometimes require additional non-reimbursed visits when an ordered and billable service does not coincide with the restrictive 5 days window requirement between days 57 and 62 since the start of care. Non-Medicare clients, with med box set-ups, insulin syringe fills, injections, etc., makes timing impossible. Elderly clients, some with declining cognitive status, don't understand the need to change the visit schedule to accommodate OASIS requirements. Customer service, as a quality initiative, implores agencies to allow the client to have input into the schedule of visits. Victimization of clients and agency staff to meet provider information collection systems should not occur.

RECOMMENDATIONS:

A. HCFA should modify the final rule to remove the requirement to collect reassessment OASIS data. Admission and discharge data should be sufficient to determine the case mix adjuster for PPS.

B. If elimination of reassessments is not agreed upon, HCFA should modify the final rule to:
  - remove the ambiguous and undefined language relating to administration of the comprehensive assessment for "major decline or improvement in the patient' health status."
  - clearly communicate that physician orders for the visits made to update assessments are not required.
  - base update assessments upon the patient's certification period rather than every two months based upon the start of care date.
  - allow update assessments to occur within a 2 week period prior to the recertification date to allow patients more control in determining their visit schedule, and agency staff more flexibility in meeting the requirements.

5. Burdens on Agencies

The complex and costly requirement to implement OASIS is being imposed upon home health agencies at the same time that we are being forced to drastically reduce our costs under the stringent limits of the Interim Payment System. The data requirements far exceed what is necessary to monitor quality and implement prospective payment. Further, there has been a lack of consistent guidance and answers about the new requirements, and there are continuing costs incurred each time HCFA makes more changes to the tool.

Our agency has spent approximately 100 nursing hours developing new assessment tools to incorporate OASIS questions into a complete assessment that would also meet Medicare Conditions of Participation and Joint Commission (JCAHO) standards. Our assessment tool increased from 3 pages to 26 pages in length. We have spent over 125 hours in staff education and training.

Our admission process has increased an average 1 hour for patient interview and data entry; it is now up to a 6 hour process including the home visit, travel, and documentation. The reassessments have increased visits by an average of 30 minutes each. Transfer assessments are relatively easy and only require 5-10 minutes. Discharge assessments take an average of 15 minutes.

During March and April, our nursing staff saw a dramatic increase in the size of the patient's records. When a patient was admitted to the hospital and came home again, extra nurse time was required to complete discharge OASIS items, and a readmission OASIS, thus adding thirteen (13) pages to the client's record within a week! This certainly does not meet our definition of paperwork reduction!

The need to visit patients for reassessments - when no visit has been ordered by the physician - to update the assessment has led to unreimbursable visits. During March and April, our agency staff made twenty-three (23) non-billable visits to collect OASIS data. The rigid timeframes imposed in reassessments and the requirement that a visit is necessary for reassessment cause an administrative burden on agencies. The nurse should be able to assimilate the data she knows about the client, augment it with a telephone call, and complete a reassessment.

We have a philosophy of teaching our patients to be self-sufficient and making a conservative number of visits. We have been "rewarded", for this prudent behavior, with Interim Payment System (IPS) per beneficiary limits of $900 - $2500 per year, while being required to implement costly data collection systems such as OASIS and the 15-minute billing increment reporting. An across the board IPS rate based on national norms, rather than penalizing the cost-effective agencies is needed. Why should a new agency just down the road be allowed a per beneficiary limit the amount of ours is just because they are new?

Finally, there is a morale issue brewing in home care. We begin each staff meeting with, "As of today, this is the reality we know....", and we close with, "Until we hear differently." Our staff is among the best. They have tried very hard to meet the intent of the requirements placed upon our agency. They face ethical dilemmas on a daily basis between what they believe is quality care and what we can afford to provide and still stay in business.

Our clients don't understand the need for OASIS or what IPS is all about. In fact, they are being told by Medicare that there is no change in payment for home care, and that it is their right to receive whatever care they need under their Medicare benefit from the accepting agency.

RECOMMENDATIONS:

A. HCFA must be required to operate under the *Paperwork Reduction Act*.
B. HCFA should modify OASIS requirements to eliminate the need for reassessment and transfer OASIS data collection.
C. If reassessments remain as a requirement, HCFA should modify the OASIS requirements to:
    - allow for reassessment to be based upon the professional nurse or therapist's knowledge about the client without requiring a home visit, **or**
    - allow the reassessment to occur within 2 calendar weeks prior to the recertification date.

6. PPS System that Truly Reflects Home Care Resource Consumption

Perhaps the greatest fear among my colleagues is that HCFA will enact a prospective payment system based solely upon a medical diagnosis. Senators, this would be a grave mistake. Home health care is primarily based upon nursing care. Nursing care is the care of human responses to diseases and conditions that are classified by medical diagnoses and further quantified into ICD-9 or DRG codes. Nursing care *is not* determined by medical diagnosis alone! Particularly in home care, the care plan is determined by the patient's age, ability to complete basic activities of daily living (ADLs), and the ability to learn self-care processes that are related to medical diagnoses. The care plan can also impacted in rural areas with limited community services (i.e. meals on wheels, local grocery stores, transportation services, etc.), as home care agency staff must make arrangements for services that their urban counterparts take for granted.

Lack of an able/willing caregiver continues to be a critical variable *dramatically* influencing the amount of services an agency needs to provide. Remember, some of our clients are 90-110 years old. That means that their children are aged 60-80 years old!! The caregiver is essential to safety issues, formation of an emergency plan, compliance with medications, transportation to medical appointments, etc. when the client is unable to manage these activities independently. When clients don't have someone available to assist them with ADLs, the agency may be the sole support system for the client. For example, if the client is unable to put on elastic support hose, bathe, or manage medications, the agency's care plan looks very different when there is not a capable support person or caregiver present to take on these duties. This translates into more visits by the agency.

There may be a caregiver present, but he/she may not be able or willing to provide the care that is needed by the client. For example, OASIS doesn't adequately take into account that the location of a wound might affect whether a patient is able to care for the wound independently. Not all caregivers are willing to take on extensive wound care, catheterization, inhalation treatments, IV administration, or other nursing skills. Even if the caregiver is willing to provide wound care, an ulcer on the buttocks, perineum, breast, or other private area of the body affects whether the patient wishes for a family member or friend to help them.

Nationwide, agencies agree that the caregiver variable is absolutely essential in predicting home care resource utilization. Iowa agencies know that the presence of an able and willing caregiver is perhaps the biggest variable in caring for the oldest of our elderly and frail clients. However, we are hearing rumors that HCFA believes that to be a source of fraud and abuse in home care reimbursement. Senators, there must be other ways of handling fraud and abuse through claims review processes rather than to blindly ignore the honest Iowa home care professionals' knowledge about what works for the nation's most elderly clients.

The data collection does not look at the number of visits required by various disciplines or the amount of case management/coordination of care required. Even if privacy concerns are ignored and HCFA has the ability to compare the OASIS data to the number of billed visits, this still doesn't give the full picture of needed care by the client because self-pay or other funded visits are not reported.

RECOMMENDATIONS:

A. HCFA must ensure that a home health PPS system is based upon the following variables:
    - functional status of the client (ability to complete activities of daily living)
    - co-morbidity (presence of numerous health problems)
    - client's age
    - barriers to learning self care (sensory deficits, psychiatric illnesses, willingness to learn, language barriers, cultural or religious barriers, level of education, etc.)
    - presence or absence of community support systems (meals on wheels, etc.)

B. HCFA must ensure that a home health PPS system is based upon the presence of an able and willing caregiver.

C. Limit the OASIS data elements to those necessary to implement the case-mix system for prospective payment.

D. The PPS system must be based upon OASIS data for Medicare-funded care and information on the total number of Medicare reimbursed and non-reimbursed visits needed to maintain the client in his/her home. HCFA needs to have a full understanding of the total cost of care needed to care for a client to make policy determinations about a long-term home care benefit or cost-adjustments for patients whose care makes them an outlier in the current system.

7. Reimbursement of the Cost of OASIS Implementation

The requirement for OASIS data collection and transmission has created an unfunded federal mandate for home health agencies. This mandate has that has manifested in the form of costs for computer hardware and software, staff training, revision of agency policies, new methods of tracking when assessments must be completed, new quality assurance audits of OASIS data, and other associated costs.

Two of the most frustrating events for agencies that have been trying to implement OASIS are the lack of final information in a timely manner and the many changes in the OASIS data set. Every change in the data set requires agency forms revisions and reprinting of forms. HCFA arrived at the conclusion that the OASIS data set would only add 3 pages to a start of care assessment form. Iowa agencies have experienced an increase in the assessment forms from 8 to 23 pages.

HCFA's cost estimates are erroneous. HCFA estimated printing at three (3) cents per page. This is exceptionally low. Most Iowa agencies are reporting minimum costs at ten (10) cents per page. HCFA did not calculate the every-second-calendar month update of the assessment resulting in a cost for non-billable visits.

There are hidden costs in the aggravation, frustration and number of mistakes caused by the lack of consistent, solid, and correct guidance. Agencies are willing to be compliant with HCFA's continued barrage of mandates, even at a time when our viability is at stake due to underfunding, but we need consistent and appropriate direction.

The Medicare program continues to shift the cost of care for the most elderly and frail beneficiaries to state and local governments. The needs have not changed; they still remain. So while Congress is congratulating itself on balancing a budget, it has come at the expense of the elderly and the providers who serve them. Less home care is being provided. More proud elderly are doing without care. More home care agencies and rural hospitals are closing. Access to care by rural elderly is just beginning to become problematic.

RECOMMENDATIONS:

A. HCFA should build in additional compensation for agencies, in terms of time, printing, and staff education, for each and every time it makes changes to the data sets after 2/24/99.
B. HCFA must fairly reimburse all start-up and ongoing costs of OASIS data collection and reporting on a pass-through basis.

8. Adjustment of IPS if PPS Implementation is Delayed

The very essence of home care is to prevent unnecessary, premature or inappropriate nursing home placements and hospitalizations. Home care agencies have responded to the challenge and increased capacity to care for the growing population of elderly in the nation. Just as we accomplished the goal set before us, we are being told that the increased capacity is due to fraud and abuse!

Iowa home care agencies provide cost-effective delivery of home care services, as evidenced by the 1996 data below:

National Ave. =	73.9 visits/client/year	$86/visit charge	$6355/client annual charges
Iowa Ave. =	49.4 visits/client/year	$63/visit charge	$3112/client annual charges

Make no mistake; the Balanced Budget Act (BBA) of 1997 made sweeping generalizations about home care providers. It continues to be far more detrimental to cost effective agencies. There is no fat to cut out.

Iowa agencies provided safe, effective services at half the cost of the national average. We didn't see HCFA trying to find out how Iowa home care agencies were able to provide cost-effective care to the most frail elderly in the nation. We didn't get the message that we were doing a good job of managing some of the most complex care for population who needed services the most. Instead, Iowa home care providers received the message that we were wasteful and fraudulent.

Payment for services should not be a mystery! No other industry is required to provide a service with no idea of how or what they will be paid. The IPS was implemented with full knowledge that a majority of agencies in the United States would in fact lose money. Part of the intent was a reduction in the number of home health agencies, which has occurred. Ten agencies have closed in Iowa to date as a result of BBA changes. This may not seem like a large number, unless you know that 90% of the Iowa home care providers have a fiscal year end coming up on 6/30/99. The full impact of IPS on Iowa providers can only be surveyed after FY 1999 cost reports are completed and filed.

The IPS cannot become a long-term payment strategy causing access barriers to home care for our nation's rural elderly. It needs adjustment beginning with the elimination of the automatic 15% reduction to become effective on 10/1/99.

RECOMMENDATIONS:

A. Elimination of the automatic 15% reduction in the IPS rate.
B. Adjustment of the per visit and the per beneficiary limits to fairly reimburse all start-up and ongoing costs of OASIS data collection and reporting on a pass-through basis.
C. Upward adjustment of the IPS if the PPS is delayed beyond 10/1/00.

9. HCFA's Responsibilities to Providers

There is wide spread distrust of HCFA by home care agencies due to the poor implementation and withdrawal of the surety bond and sequential billing (to end 7/1/99). OASIS data collection requirements is yet another example of failure in planning and implementing processes. HCFA has not clearly indicated their ability to make good use of data provided to them.

HCFA's conflicting statements about Y2K Compliance further undermine agencies' beliefs that HCFA will be able to receive and utilize OASIS data in a timely manner. Further, agencies are not even certain of HCFA's ability to continue to make timely payments for services rendered under a current system of payment, much less devise a better system. Finally, why should we believe that they will make good use of the fifteen-minute billing unit reporting requirement that is to become effective on 7/1/99?

HCFA has indicated their plan to provide agencies with *annual* reports and benchmarking data relative to OASIS data collection. This is unacceptable. In order to make quality performance improvements, agencies need timely data.

RECOMMENDATIONS:

A. HCFA must give a 90-day notice to re-implement OASIS data collection requirements, giving agencies adequate time to implement new systems.
B. HCFA must be required to fully utilize any data collected.
C. HCFA must be required to be Y2K complaint for data collection and service payment.
D. HCFA must be required to provide agencies with *quarterly* reports and benchmarking data, within 60 days of the end of each calendar quarter.
E. HCFA must establish a unified method of providing timely and consistent answers to providers' questions. These answers should be available on the OASIS web site, as well as through other mechanisms for agencies that do not have web access.

CONCLUSION:

Senators, thank you for your recognition of a huge national health care problem. Thank you for taking the time to be concerned about our elderly. You have the power to make HCFA comply with federal legislation and regulation. We are grateful for your efforts.

Iowa home health care providers, and a majority of the nation's providers, are very ethical. We are willing to comply with reasonable requests. We are willing to work with HCFA to find reasonable solutions to problems encountered. We are held accountable to the level of HCFA's highest standards. Mistakes on our part are not tolerated; they are construed as fraudulent. HCFA, on the other hand, is allowed serious lapses in good policy implementation. This affects our nation's elderly in terms of access to care.

Our elderly population needs to know that we are more interested in caring for them than we are in collecting data. The nation's home care providers need your help, but the nation's elderly depend upon you. I represent their silent voices today. Please listen; please help! Thank you!

The CHAIRMAN. I will now turn to Ms. Wright.

STATEMENT OF KRISTY WRIGHT, PRESIDENT AND CHIEF EXECUTIVE OFFICER, VISITING NURSES ASSOCIATION OF WESTERN PENNSYLVANIA, BUTLER, PA

Ms. WRIGHT. Thank you, Senator. Thank you for the opportunity to present testimony today.

I am the president and CEO of the Visiting Nurses Association of Western Pennsylvania. In the fall of 1995, we were accepted into the HCFA-funded outcome-based quality improvement demonstration project, commonly known as OASIS. Today I would like to share with you the experience that we have had in implementing and maintaining OASIS over the past 3 years, including the extremely positive results and the concerns that I have as a home care provider.

According to HCFA's own OASIS overview published on their web site, and I quote: "OASIS is a key component of Medicare's partnership with the home care industry to foster and monitor improved home health care outcomes. Overall, the OASIS items have utility for outcome monitoring, clinical assessment and care planning."

Having implemented OASIS and used the resulting reports, VNA is in the unique position to discuss the benefits of using OASIS as a quality improvement tool. We have had a structured, continuous quality improvement program for over 9 years, and this is the first comprehensive outcomes measurement tool that we have found.

OASIS information has allowed the VNA to actually evaluate the results of the care we give. After receiving the first year's outcome report, we chose improving ambulation and preventing re-hospitalization as improvement areas. We were able to increase our patients' ability to ambulate by 4 percent and decrease re-hospitalization by 10 percent. This translates into better care for our patients and significant savings of Medicare dollars.

The problem with OASIS is HCFA's planned implementation of the process, not only making it difficult or impossible for home health agencies to implement OASIS under IPS, but also threatening the validity of OASIS as a quality improvement tool.

First, HCFA has grossly underestimated startup and ongoing costs. When the estimated costs are adjusted for our larger-size agency, HCFA believes that it would cost us a little over $15,000 to implement. In actuality, it cost us over $77,000, and that does not include the hardware, the software and other infrastructure that we had in place.

HCFA also estimates that an agency our size would then spend a little over $11,000 annually. In reality, it has cost us over $30,000 annually to continue OASIS, and we are completely computerized, eliminating the need for data input. Not only is HCFA's estimate extremely low, but many agencies are unlikely to receive any reimbursement due to IPS.

Second, HCFA intends to use the data collected through OASIS for reimbursement purposes in addition to outcomes measurement. These uses are diametrically opposed and likely to invalidate the outcome results.

Third, HCFA has added items to OASIS such as patient and physician identifiers which appear to have more of an oversight and potentially punitive purpose than a "partnership." By using the OASIS data in this way, HCFA defeats the original goal of creating an outcomes measurement tool.

Fourth, HCFA is requiring that data be collected on patients receiving custodial and personal care services and on patients who are terminally ill. The research done was based on adult patients receiving home health care. Custodial and terminally ill patients were appropriately not included in the demonstration project.

Fifth, I share the concerns of confidentiality with transmitting patient-identifying information at public and national levels.

My final concern is that HCFA requires OASIS data be collected at a frequency not supported by research as being necessary for outcome measurement.

I strongly urge you to support the quality improvement benefits of OASIS but to reconsider its purpose and its implementation. If a tool is needed to determine reimbursement levels, HCFA should develop such a tool using the OASIS items specifically validated for that purpose and use it only for Medicare patients.

However, if HCFA is serious about quality improvement, several changes need to occur. First, the full OASIS tool should be utilized on all adult home health patients regardless of payer source, but that should be without patient-identifying information.

Nor is there a need for patient and physician-identifying information to be submitted for oversight purposes. If HCFA feels the need to monitor individual cases, there are already multiple oversight processes in place.

Second, additional assessments beyond the number validated in the demonstration project are unnecessary for outcomes measurement.

Finally, I urge you to reevaluate the cost of implementation. It is clear that HCFA has grossly underestimated the actual cost. I firmly believe that although the costs may be higher, it is money well-spent to ensure that our senior citizens receive quality home health care.

In conclusion, I believe this is a wonderful opportunity for HCFA and home health care providers to finally work as partners and not adversaries. Please do not allow this to become another area that is burdensome, punitive and fraught with suspicion. Our patients, the senior citizens of our country, are depending on us to do this right. With a few simple changes and a little compromise, we can make it the worthwhile project that it has the potential to be.

Thank you.

The CHAIRMAN. Thank you, Ms. Wright.

[The prepared statement of Ms. Wright follows:]

Testimony Before the Special Committee on Aging
US Senate
Hearing on OASIS
May 24, 1999

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Introduction

Thank you for the opportunity to present testimony today on issues related to OASIS and its impact on the home health care industry. I am the President and CEO of the Visiting Nurses Association (VNA), Western Pennsylvania. The VNA is a not-for-profit home health agency that has provided home health care to our community for 35 years. We serve a large rural area encompassing 5 counties north of Pittsburgh, PA. The VNA annually performs approximately 6000 admissions, provides skilled services to approximately 4000 patients, and makes a total of 120,000 visits. Approximately 90% of our services are provided to Medicare beneficiaries. We are Medicare and Medicaid certified and JCAHO accredited.

In 1994, the VNA began to investigate incorporating an outcome measurement system into our organization for the purposes of determining results of care, comparing achievements with others, and improving the definition of quality care for both internal and external review groups. In the fall of 1995, we were accepted into the Outcome Based Quality Improvement (OBQI) Demonstration Project (also known as the Medicare Quality Assurance Project) which the Health Care Financing Administration has funded for the purpose of measuring clinical and utilization outcomes.

Background

The VNA, Western Pennsylvania has a long history of identifying quality improvement as a top priority in all of its strategic plans. As such, quality is one of the organization's core values and is incorporated into all key decisions. We believe the measurement of outcomes is crucial to improving the services that we provide and to ensuring that the care we give is of the highest quality possible. When the Joint Commission on Accreditation of Healthcare Organizations produced a video on quality improvement in home care, they chose our organization and our quality improvement program as the example.

OASIS was initially conceived as a group of data elements that represent core items in a comprehensive assessment for an adult home care patient. It forms the basis for measuring patient outcomes for purposes of outcome-based quality improvement (OBQI). According to HCFA's own "OASIS Overview" published on their website, "OASIS is a key component of Medicare's partnership with the home care industry to foster and monitor improved home health care outcomes....The goal was not to produce a comprehensive assessment instrument, but to provide a set of data items [which are] necessary for measuring patient outcomes and essential for assessment - which home health agencies in turn could augment as they judge necessary. Overall, the OASIS items *have utility for outcome monitoring, clinical assessment, care planning, and other internal agency-level applications.*" (Emphasis added)

Research to determine the appropriate questions for the assessment tool and the validity of the outcomes data has spanned a period of nearly 10 years. Several revisions of the tool have occurred during that time, and the VNA has participated directly by providing input and field testing as a participant in the HCFA funded demonstration project.

Benefits of OASIS

Having implemented OASIS by integrating it into our nursing assessment process and using the data in various ways, the VNA is in the unique position to discuss the benefits that have resulted.

The benefits of using OASIS as a quality improvement tool are numerous. Information collected using the OASIS assessment tool, which was integrated into the VNA's previous assessment, is comprehensive and provides a thorough data base from which to identify patient problems. Nurses are also documenting in a more uniform and objective manner. The information and reports generated from the data have allowed the VNA to evaluate the results of home health care interventions against ourselves and other like agencies. By using a quality improvement process (OBQI), the VNA has seen measurable improvement in patient care outcomes since implementing OASIS. After the first year's Outcome Report was received and analyzed, our organization chose improving ambulation and preventing re-hospitalization as the two areas that we most needed to address. Using the OBQI process, we were able to increase our patient's ability to ambulate by 4% and decrease re-hospitalization of patients by 10%. This translates into better care for our patients and significant savings of Medicare dollars.

Other more generalized benefits include improving continuity of care when patients are seen by more than one nurse or by several skilled services (i.e. Nursing, Physical Therapy, Dietician, etc.), and identifying patient problems and care plan needs on admission and periodically throughout the course of care. There are also long term implications for using OASIS as a quality improvement tool. Measurable improvement in outcomes is an objective "report card" by which agencies themselves and outside reviewing bodies such as HCFA, JCAHO, managed care companies, etc. can use to compare the quality of services provided by various providers.

Areas of Concern

Costs

The problems with OASIS are really not with OASIS itself but with HCFA's planned implementation of the process.

A major concern is with HCFA's estimation of start-up and on-going costs for an agency to implement OASIS. HCFA's published data (Federal Register, January 25, 1999) states that the total start-up cost for an average agency would be $3144.00. The definition of an average agency is one with 18 clinicians and 486 admissions per year. There are several fallacies with HCFA's assumptions when calculating costs to individual agencies.

First, the amount of time by the OASIS coordinator, clinicians and other staff to integrate OASIS into existing forms and to educate staff is grossly underestimated. Refer to *Figure 1*. Second, the learning curve spanned 3 months and was closer to 5 hours (or 20 admissions) rather than 2 hours (or 8 admissions). Also, a factor not considered is the lower productivity of the staff during the learning curve. This not only affects expenses but also revenue. Third, HCFA has failed to recognize the on-going costs of OASIS. HCFA states that "OASIS data collection on an ongoing basis poses no additional burden above an HHA's routine patient assessment," and "implementation of later iterations of the OASIS will result in a very small one-time cost to HHA's." In a footnote, HCFA states that an expected 79 hours per year will be spent on an on-going basis to coordinate OASIS activities. In reality, the on-going cost of OASIS does have significant financial implications. Refer to *Figure 2*. Ongoing coordination, data input, and follow-up are considerable. Additionally, costs of making changes in the tool can be substantial. There are costs associated with making the necessary software changes, forms changes, and re-training staff.

Also in a footnote of the Federal Register (January 25, 1999), HCFA estimates that only 30% of the reasonable costs of implementing OASIS will be born by Medicare. There is no basis for this assumption. The majority of patients ill enough to need and qualify for home care are elderly or chronically disabled and are Medicare beneficiaries. Typically, well over 50% of an agency's patients are covered by Medicare and in some cases, as with our VNA, 90-95% of the patients are Medicare beneficiaries. More appropriately, HCFA's reimbursement estimate should be based on the percentage of patients receiving home care who are covered by Medicare.

Figures 1 and 2 summarize and compare HCFA's projected costs and the actual costs incurred by the VNA to implement OASIS. Since VNA has approximately 12 times the admissions and 5 times the clinicians of HCFA's "average agency," the HCFA amounts have been adjusted to reflect the larger numbers.

Figure 1
START-UP COSTS*

Activity	HCFA Estimated Cost	Adjusted HCFA Estimated Cost	Actual First Year VNA Costs
Form Development	$339	$339	$2592
Printing Costs	$280	$3360	$4756
Staff Training			
Coordinator	$360	$4320	$36,234
Clinicians	$1299	$6495	$12,909
Data Entry Staff	---	—	$8078
Learning Curve	$866	$4329	$10,823
Software/Hardware Revisions	—	—	$1680
TOTAL START-UP	$3144	$15,763	$77,072

Adjusted HCFA numbers have been inflated to reflect VNA agency size. These figures also do not reflect the costs of purchasing necessary hardware, software, and other infrastructure that the VNA already had in place prior to beginning the demonstration project. Agencies not having the necessary resources would have to purchase them at considerable cost.

Figure 2
ON-GOING COSTS*
Per Year

Activity	**HCFA Estimated Cost**	**Adjusted HCFA Estimated Cost**	**Actual VNA Costs**
Coordinator	$79	$948	$20,000
Training updates	---	—	$6480
Training new employees	---	—	
Training			$1924
Learning curve			$2405
TOTAL ON-GOING COSTS (per year)	$79	$948	$30,809

Adjusted HCFA numbers have been inflated to reflect the larger number of admissions done by the VNA. The VNA actual costs are stated with the assumption that the process is fully automated with the clinicians doing data input during their visit. If the process was first done on paper and needed to be input at a later time, costs would be significantly higher. Costs for quality improvement follow-up are also not included as this is a normal part of VNA operations.

Use of Data

Another significant concern is HCFA's intended use of the data collected through OASIS. Initially, according to HCFA's own information, OASIS was intended as a "partnership with home health agencies...for measuring patient outcomes." HCFA states that the OASIS items "have utility for outcome monitoring, clinical assessment, care planning, and other internal *agency-level* (emphasis added) applications. The OASIS data was not created nor was the research in the demonstration project done to substantiate reimbursement or set reimbursement levels. However, in order to fulfill the HHA [home health agency] provisions of the Balanced Budget Act of 1997, HCFA has chosen to utilize OASIS data to create Prospective Payment for HHA's. Although a separate project is underway to validate items in the data set to establish reimbursement levels per patient case (in preparation for Prospective Payment), it is unclear what the effect of this additional use will have on outcomes measurement.

In addition, HCFA has added items to OASIS which appear to have more oversight and potentially punitive purposes than a "partnership". New items include the patient's name, physician's identification number, the patient's Social Security and Medicaid numbers, and other patient identifying information. This type of data has no use and is not necessary in outcome measurement.

It is widely accepted that in order for quality improvement efforts to succeed, there must not be hidden agendas or punitive aspects associated with the process. By using the OASIS data in this way, HCFA has defeated their original goal of creating an outcomes measurement tool and subsequent improvement of the quality of home health care.

A final concern with the use of the data is HCFA's requirement that it be collected on patients receiving private duty (custodial and personal care) services and on patients who are terminally ill. The research done developing the tool was based on adult patients receiving home health care. Private duty and terminally ill patients receive an entirely different type of services with significantly variable expected outcomes.

Patient Privacy

The issue of patient privacy and confidentiality is certainly a concern. While we have not had any problems with confidentiality during the controlled demonstration project, I share the concerns of my colleagues and the home health care industry when sharing patient identifying information at a public and national level. Sharing with HCFA non-Medicare patient identifying information containing sensitive data is certainly an ethical issue and violates all confidentiality policies. While a complete assessment can not be done without gathering sensitive information regarding home environment and psycho-social status, the need for including patient identifying information for outcomes measurement purposes is not necessary. On the other hand, it seems futile to collect and aggregate data on only a portion of the patient population (i.e. only Medicare patients). A comprehensive outcomes measurement process should include the entire patient population. This issue is simply solved by deleting patient identifying information from all patients when submitting the data to HCFA.

Frequency and timing of data collection

Initially, OASIS data was to be collected on admission, at 60 day intervals, with hospitalization lasting longer than 48 hours and on discharge. The addition by HCFA requiring OASIS data be collected "with any significant change in patient status" is not supported by research as being necessary for outcome measurement. HCFA also does not define what is considered a "significant change." In reality, changes occur in patient status routinely in home care. This could result in multiple OASIS data collection being done at a high cost for no clear reason.

Research also does not support the absolute necessity of collecting data at follow-up time points within a 5 day window which is required by HCFA. During the demonstration project, these assessments were completed during the visit closest to the "window," but if doctor's orders and scheduling did not allow this level of precision, an extra "no charge" visit was not required. HCFA's rule would require adding a "no charge" visit when the 5 day window might be exceeded thus adding additional costs to the agency.

Real Life Perspective

The VNA is just completing its third year in the OASIS demonstration project. In all honesty, the start-up was as would be expected with any major change. The nursing staff felt burdened and resented the additional paperwork and time required. Over the three year period, the additional time to complete the assessments has not been significantly different than previously required since we had been collecting many of the data elements prior to implementing OASIS. We did, however, decide after six months to automate the entire process which has had a tremendous impact on time requirements and staff satisfaction. Fortunately, VNA had the infrastructure to make that change. We have also found that professional nurses do an excellent job of completing the assessment. The information is comprehensive and objective. We have frequently identified patient problems that had not been evident during hospitalization or previous professional assessments. Overall, the nursing staff supports the value of OASIS as a care planning and quality improvement tool and consider it an integral part of the patient's care.

The VNA has utilized OASIS data and outcomes reports in numerous ways including quality improvement activities on specific outcomes, diagnoses, and patient populations with like demographics. We have also utilized the data to share pertinent information with other health care professionals caring for the patient and are planning to implement a process in which we can share the data with the patient's physician.

Recommendations

While I completely empathize with my colleagues in home care and share their concerns as stated in my testimony, I would not recommend that OASIS be rejected. Instead, I urge you to reconsider its purpose and implementation.

First, OASIS should be utilized for its intended purposes of outcome monitoring, clinical assessment, care planning, and other internal agency-level applications. If a tool is needed to determine reimbursement levels, HCFA should utilize only the OASIS items specifically validated for that purpose. In addition, private duty patients and patients admitted to a program who's primary mission is caring for the terminally ill ought to be excluded from OASIS.

I also urge you to re-evaluate the costs of implementation. It is clear that HCFA has grossly under-estimated the actual costs of implementing OASIS, the on-going costs, and the portion that is Medicare's responsibility. I firmly believe that, although the costs are higher than projected, it is money well-spent to insure that our senior citizens receive quality home health care. It has been widely accepted that quality does not come cheaply but that it pays for itself in the long run.

If the OASIS tool is used appropriately, there is no need for patient identifying information to be submitted. As a tool that measures outcomes and drives quality improvement, aggregated data is sufficient. If HCFA feels the need to monitor individual cases, there are already multiple oversight processes in place. These include re-certification surveys and various audits by the fiscal intermediaries. By removing patient identifying information, the entire home health patient population could be used, all assessment data included, and patient privacy maintained.

Finally, the time intervals and frequency of data collection must be re-evaluated. Again, if the tool is appropriately utilized for outcomes measurement, the need for these additional assessments is not substantiated by research. If there is a need for re-evaluation of the case for reimbursement reasons, a separate methodology should be used.

Conclusion

This is such a wonderful opportunity for HCFA and home health care providers to finally work as partners and not adversaries. The original OASIS plan, conceptualized to measure outcomes and improve quality, is one that both "sides" can agree upon. Please don't allow this to become another area that is punitive and fraught with suspicion. Our patients, the Senior Citizens of our country, are depending on us to do this right. With a few simple changes and a little compromise we can make it the worthwhile project that it has the potential to be.

The CHAIRMAN. Dr. Conlin.

STATEMENT OF JUDITH A. CONLIN, DIRECTOR, IOWA DEPARTMENT OF ELDER AFFAIRS, DES MOINES, IA

Ms. CONLIN. Senator Grassley and committee members, I have been recently appointed the new director of the Iowa Department of Elder Affairs. Prior to that, I was executive director of the Alzheimer's Association in Iowa.

I could think of no better way to illustrate the concerns surrounding the implementation of the OASIS assessment than by taking you through the assessment process itself, and I will note prior to doing that that a new requirement effective January 1, 1999 requires that these assessments be completed only by a registered nurse. Previously, assessments could also be completed by social workers. We estimate in Iowa that this new requirement means that half or more of the people previously qualified to complete the assessments have effectively been eliminated. We begin this mandatory process, then, with half the staff that we had prior to January 1.

For the sake of illustration, let us assume I am a registered nurse, and I am qualified to do these assessments. I will begin by going out with the initial assessment tool, which is 19 pages in length. If I am extremely efficient in asking questions, and the person I am interviewing is extremely efficient at responding to my questions, we can manage to complete this initial assessment in 2 hours. If there is cognitive impairment or another reason that would slow the interview process, it will, of course, take longer than 2 hours.

In addition to this initial assessment, HCFA mandates that home health care agencies in each State have a comprehensive assessment that includes more than OASIS. In Iowa, that assessment tool is 14 pages in length.

Among other questions in the Iowa tool, there is the inclusion of a mental status questionnaire. To test cognitive ability, this part of the questionnaire necessarily takes more time and more patience, especially when there is cognitive impairment. In an attempt to be responsive to HCFA's requirements and also manage to collect all the data, I will merge the two assessment tools, the 19-page and the 14-page assessment, into one tool which is 26 pages. Still, this merged tool requires between 2½ and 3 hours to complete.

After this initial assessment, HCFA requires that there be a follow-up assessment every 60 days, specifically between day 57 and day 62. This is a 14-page tool, and it asks essentially the same questions. Moreover, every time I go out with a follow-up assessment, I am required to bring a brand new copy of the assessment. It is not a matter of checking to see if there is a change; it is a matter of beginning anew each time—60 days after 60 days after 60 days.

The next tool is triggered when there is an episode of some kind, such as a hospitalization after an episode. There is an assessment tool called the resumption of care tool, and it is 17 pages in length. Again, it is duplicative.

The resumption of care assessment is then followed each succeeding 60 days with a follow-up assessment, the same 14-page tool that we have prior to the assessment for the episode.

If the client is discharged from the system, there is yet another assessment tool, which is a 16-page assessment—and yes, again the questions are duplicative.

Clearly, the intent on HCFA's part is to provide services to clients. But what is the actual outcome? It is to have created an obstacle course with obstacles to elaborate, so expensive, so lengthy and so tedious that rather than facilitate services, by its very nature, it precludes services. What is achieved is precisely the opposite of what was intended—rather than strengthen the system to provide care in the home, this obstacle course undermines the ability to provide home care. Moreover, and very importantly, these assessments are unfunded Federal mandates. The health care providers charged with carrying out these mandates are unable to bear the costs of staffing for these assessments, nor are they equipped to enter the data collected from the assessments. As a result, alarming numbers of health care providers are going out of business. In Missouri, 80 health care providers have recently gone out of business; in Kansas, 40 providers have gone out of business; in Iowa, we are just beginning to count the bankruptcies.

The difficulties associated with HCFA's new mandates are compounded by a combination of events. There are increasing numbers of elderly in need of services as well as increasing numbers of what are described as the "old old." The math is deeply troubling. Because only registered nurses can complete the assessment, there is only half the staff, it takes quadruple the time, there are fewer health care providers, and inevitably the number of people who can possibly be reached or provided services is decreased dramatically.

This reversal of care from care in the home to institutional care will drive up the cost to the Government and drive down the care to the elderly. By any measure, it is the wrong outcome.

Ironically, all of this is happening at the very moment in time when home health care was demonstrating itself as a workable, preferable system of care for the client and as a cost-effective system of care for the taxpayer.

We are asking that you review and reconsider a system which places unfunded, unfair and unworkable obstacles in the path of home health care to the elderly.

Thank you.

The CHAIRMAN. Thank you, Dr. Conlin.

[The prepared statement of Ms. Conlin follows:]

Testimony of Judith A. Conlin
Director, Iowa Department of Elder Affairs
Senate Special Committee on Aging
May 24, 1999

I can think of no clearer way to illustrate the concerns surrounding the implementation of the OASIS assessment than by taking you through the assessment process itself. HCFA requires these assessments to be completed by all Medicare-certified home health agencies for all clients, both private pay clients and Medicare clients. A new requirement by HCFA, effective January 1, 1999, requires that these assessments can be completed only by a registered nurse. Previously, assessments could also be completed by social workers. We estimate this new requirement means that in Iowa half or more of the people previously qualified to complete the assessments have been effectively eliminated.

We begin this mandatory assessment process, then, with half the staff we had prior to January 1, 1999.

For the sake of illustration, let us assume I am a registered nurse and am qualified to do the assessments. I will begin by going out with the initial assessment tool. It is 19 pages in length. It asks such questions as: demographics and patient history; living arrangements; supportive assistance; sensory status; respiratory status; elimination status; neuro/emotional/behavioral status; etc. If I am extremely efficient at asking these questions and the person I am interviewing is also extremely efficient at responding to the questions, we can manage to complete this initial assessment in two hours. If there is cognitive impairment or other reasons that would slow the interview process, it will, of course, take longer than two hours.

In addition to this initial assessment, HCFA mandates that home health care agencies in each state have a comprehensive assessment that includes more than OASIS, a medical model, assessment. In Iowa, that assessment tool is 14 pages in length. Among other questions in the Iowa tool there is the inclusion of a mental status questionnaire. To test cognitive ability, this part of the questionnaire necessarily takes more time, more patience, especially when there is cognitive impairment, or even the fear of cognitive loss.

In an attempt to be responsive to HCFA's requirements and also manage to collect all of the data, Iowa merged the two assessment tools, the OASIS and the Iowa tool, the 19 page and the 14 page assessments, into one tool, which is 26 pages.
Still this merged tool requires between 2-1/2 and 3 hours to complete. Again, this is a conservative estimate.

After this initial assessment, HCFA requires there be a follow-up assessment every 60 days, specifically between days 55 and 60. This is a 14-page assessment tool and it asks questions which include demographics and patient history; living arrangements; supportive assistance; sensory status; respiratory status; elimination status; neuro/emotional/behavioral status; etc. If that sounds duplicative of the initial assessment, it is. Moreover, every time I go out with a follow-up assessment I am required to bring a brand new copy of the assessment. It is not a matter of checking to see if there is a change; it is a matter of beginning anew each time, 60 days after 60 days, after 60 days.

The next assessment tool is triggered when there is an episode of some kind, such as a hospitalization. After an episode there an assessment tool called the "Resumption of Care" tool, and it is 17 pages in length. It asks to assess demographics and patient history; living arrangements; supportive assistance; sensory status; respiratory status; elimination status; neuro/emotional/behavioral status; etc. Yes, again, it is duplication. The "Resumption of Care" assessment is then followed every succeeding 60 days with the follow-up assessment, the same 14 page tool we had been using prior to the episode.

If the client is to be discharged from the system, there is another assessment tool. This a 16 page assessment, and yes, again, the questions are duplicative.

Clearly the intent on HCFA's part is to provide services to clients, but what is the actual outcome? It is to have created an obstacle course -- obstacles so elaborate, so expensive, so lengthy and so tedious -- that rather than facilitate services, by its very nature, it precludes service. What is achieved is precisely the opposite of what was intended. Rather than strengthen the system to provide care in the home, this obstacle course undermines the ability to provide home care.

Moreover, and very importantly, these assessments are unfunded federal mandates. The health care providers who are charged with carrying out these mandates are unable to bear the costs of staffing for these assessments, nor are they equipped to enter the data collected from the assessments. As a result, alarming numbers of health care providers are going out of business. In Missouri, 80 health care providers have recently gone out of business; in Kansas 40 providers have gone out of business; in Iowa, we are just beginning to count the bankruptcies.

The difficulties associated with HCFA's new mandates are compounded by a combination of events:

- There are increasing numbers of elderly in need of services and also increasing numbers of what are described as the "old" old, those elderly who are the most frail.

- The math is deeply troubling: Because only registered nurses can complete the assessment, there is only half of the staff available to do assessments. It takes at least quadruple the time to complete the assessments. There are fewer health care providers able to stay in business. Inevitably, the number of people who can possibly be reached or provided services is decreased dramatically.

- The list of those needing services will grow and grow.

- Without services, increasing numbers of people will require nursing home care or hospitalization.

This reversal of care -- from care in the home to institutional care -- will drive up the costs to the government and drive down the care to the elderly. By any measure, this is the wrong outcome.

Ironically, all of this is happening at the very moment in time when home health care was demonstrating itself as a workable, preferable system of care for the client and as a cost-effective system of care for the taxpayer.

We are asking that you review and reconsider a system which places unfunded, unfair, and unworkable obstacles in the path of home care to the elderly.

The CHAIRMAN. Dr. Shaughnessy.

STATEMENT OF PETER W. SHAUGHNESSY, DIRECTOR, CENTER FOR HEALTH SERVICES AND POLICY RESEARCH, UNIVERSITY OF COLORADO HEALTH SCIENCES CENTER, DENVER, CO

Dr. SHAUGHNESSY. I am Peter Shaughnessy from the University of Colorado. Our research center has been doing research for a number of years that has resulted in OASIS.

I appreciate the opportunity to testify at today's hearing on OASIS. The primary purpose of OASIS is to enhance outcomes on behalf of home care patients. Extensive testing in hundreds of home care agencies has shown that it works.

OASIS is the result of a large national research program we conducted over the past 15 years at the University of Colorado, with input from clinicians, researchers, home care providers and managers.

OASIS contains the minimum number and types of data items needed for an effective outcome enhancement system for home care agencies and for HCFA.

In 1995, 54 demonstration agencies from 26 States embarked upon outcome improvement using the OASIS data and reporting system. Each agency investigated hospitalization as one of two targets for outcome enhancement. As shown in the first chart, in demonstration year one, the hospitalization rate before enhancement was 31.4 percent, compared with a significantly lower year two hospitalization rate of 28.3 percent after outcome enhancement. This translates into a $6.8 million savings in reduced hospitalization for these patients alone over just 1 year.

If all agencies in the U.S. conducted OASIS-based quality improvement and were but half as successful, this would save half a billion dollars in the first year just by using of OASIS for outcome enhancement.

Demonstration agencies were equally successful in improving their other target outcomes. A New York State demonstration validated the national results. These two separate demonstration programs indicate a pervasive and powerful impact of OASIS-based quality improvement on patient outcomes and hospital expenses.

A significant misconception about OASIS is that of a ponderous data set of over 80 new items. Most OASIS items are already part of an agency's clinical record for a patient, but the OASIS items are stated in more precise form. OASIS items are integrated into the clinical record, replacing similar items.

As shown in the next chart, a time study demonstrated that after agency staff had acclimated to OASIS, assessment time, including OASIS items at start of care, was about the same as assessment time without OASIS items. Nonetheless, it is appropriate to further assess whether specific types of startup and ongoing costs are adequately covered under IPS.

To be fully effective, OASIS-based quality improvement was designed to mesh with the total operations of agencies—not just patients of specific payers. Further, HCFA as the dominant payer for home health care, must ensure that Federal payment practices do not adversely impact either Medicare or non-Medicare patients.

Therefore, HCFA must have precise patient-level data to measure whether care is effective for Medicare and non-Medicare patients.

Under the prospective payment system, very strong incentives will exist to cut back on services. This can result in inferior care for Medicare patients and reduced access for non-Medicare patients. Without OASIS data on both Medicare and non-Medicare patients, PPS may create a two-class system of public and private pay patients. Because home care serves a highly vulnerable population, the homebound, ill elderly, this could have tragic consequences without OASIS.

Patient privacy must be protected, with safeguards to limit access to personally identifiable data, but this can be done without discarding or dismantling OASIS.

The interim payment system for home care has cast a dark shadow over receptivity to change and innovation in the home care field. Paradoxically, OASIS is a significant part of the solution to IPS. It is of immense value in determining how to provide cost-effective care.

In conclusion, the question is not whether we can afford to implement OASIS, for the costs of not implementing OASIS are far greater in both dollars and health of people. Rather, the question is how can we best implement the full OASIS data set and then guide its evolution and refinement on behalf of all who receive home care.

The CHAIRMAN. Thank you, Dr. Shaughnessy.

[The prepared statement of Dr. Shaughnessy follows:]

UNITED STATES SENATE
SPECIAL COMMITTEE ON AGING
Hearing on OASIS
May 24, 1999

Testimony of Peter W. Shaughnessy, Ph.D.
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The boldfaced material in this written statement highlights the main points of this testimony. Supporting information for the bolded points is found in the text and in Supplement A (starting on page 12), which contains comments from a number of individuals who are experienced with OASIS.

EVIDENCE ON THE VALUE OF OASIS TO EFFICIENTLY RAISE HOME CARE TO A NEW LEVEL OF QUALITY AND PATIENT WELL-BEING

During the past several months, the mandated use of the Outcome and ASsessment Information Set (OASIS) for home care has been criticized on the grounds that it will raise cost and, of more concern, reduce the quality of care and negatively affect the health of home care patients. It has been argued that OASIS is an unneeded, ponderous data set which because of its size (89 health-related items and selected additional items needed as identifiers), will increase time to assess patients with no positive return. Some have argued that only those OASIS items required for prospective payment should be required for Medicare patients and that there is no compelling reason to collect data for non-Medicare patients. Selected data items dealing with mental health and emotional status of individuals have been singled out as needlessly invasive of patient privacy, and it has been argued that these items should not appear in the OASIS data set or be transmitted to a central source.

The purpose of this testimony is to address these criticisms by discussing the evolution of OASIS, its value and effectiveness in improving quality of care, the efficiencies and improved patient outcomes it brings to home care, and its considerable promise for solving both short- and long-run problems in the home care field. In doing so, it will be clear not only that the aforementioned allegations and concerns are unfounded, but in most instances they are diametrically opposite the true attributes and circumstances that characterize OASIS. Except as indicated otherwise, all evidence, conclusions, and principles discussed in this testimony derive from the two-decade home health research and analysis program of the Center for Health Services and Policy Research at the University of Colorado Health Sciences Center. This program has entailed a multidisciplinary group of 50-60 faculty and staff, as well as many outside clinicians and researchers, devoted to conducting over 16 multi-year national research studies and demonstration projects in home care, the majority of which have involved different versions of OASIS and its various applications during the past 15 years. The funders of this program have been HCFA, the Robert Wood Johnson Foundation, the State of New York, and to a lesser extent, other foundations and state and federal governmental agencies.

OASIS: ITS SCIENTIFIC ORIGIN, PURPOSE, AND IMPACTS ON PATIENT OUTCOMES

Overview

The purpose of OASIS rests with the primary reason why (home) health care is provided. Stripping away issues such as regulation, payment, cost, utilization, and staffing, we provide health care to benefit people. Since outcomes are basically changes in health status between two time points (such as start of care and discharge from care), the fundamental purpose of health care is to positively influence patient outcomes. OASIS was carefully designed for the purpose of, and has a scientific history in, (cost-effectively) enhancing patient outcomes.

OASIS was developed to measure and evaluate patient outcomes of home care. All elements of OASIS were derived by first specifying a set of patient outcomes considered critical by home care experts (e.g., nurses, physicians, therapists, social workers, administrators) for purposes of evaluating the effectiveness of care. These outcomes were chosen from the most important domains of health status addressed by home care providers. **All data items in OASIS were developed, tested in hundreds of agencies, and refined for purposes of measuring outcomes in order to evaluate and enhance the effectiveness of home care. This has been and remains the fundamental purpose of OASIS: to enhance health outcomes on behalf of home care patients.**

The general categories of data and health status items in OASIS include demographics and patient history, living arrangements, supportive assistance, sensory status, integumentary (skin) status, respiratory status, elimination status, neuro/emotional/behavioral status, activities of daily living, medications, equipment management, and information collected at inpatient facility admission or agency discharge. Each of these general categories of data items was deemed necessary to properly measure and evaluate those patient outcomes judged to be most pivotal in examining the effectiveness of home care. To properly measure outcomes as change in patient health status over time, most OASIS data items are collected at start of care and every two months thereafter until and including time of discharge.

Not only were several multidisciplinary clinical panels convened to substantively review and revise sets of the most important outcome measures for home care, but OASIS data items and measurement methods were also reviewed by multidisciplinary panels of research methodologists, clinicians, home care managers, and policy analysts. As OASIS data items were employed in research projects and subsequently in demonstration projects, reliability and validity testing was undertaken with a view toward enhancing the accuracy and utility of the data items.

OASIS is the only major data set ever developed for a large component of our health care delivery system that has been focused first and foremost on measuring and improving outcomes on behalf of patients. This is the primary principle that has guided the evolution of OASIS over its 15-year history.

A set of seven additional operating principles was established to guide the development of the OASIS data set and its several applications. These principles evolved iteratively during the early stages of the OASIS developmental period, and thereafter "settled in" and became well established as basic tenets of the OASIS developmental process and its various applications. These seven guiding principles (secondary to the above guiding principle of outcome enhancement) are:

1. Develop a concise, uniform data set tailored to the unique features of home care. This data set should be an integral part of the comprehensive assessments providers conduct in their daily operations.
2. Employ scientific methods and standards.

3. Construct and revise a conceptually sound applications framework, later termed Outcome-(or OASIS-) Based Quality Improvement.
4. Develop a system of outcomes, OASIS data items, and reports that is useful and understandable for clinicians, managers, and home care agencies in general.
5. Design a system that fosters self-improvement, evolution, and provider ownership.
6. Limit the burden imposed on providers, while maximizing utility and practicality.
7. Anticipate that the OASIS data system will be used for multiple applications (such as informing consumers, agency marketing, monitoring and remedying fraud and abuse, facilitating voluntary accreditation, case mix adjustment for payment, increasing efficiency and effectiveness of survey and certification, detecting discrimination and access barriers to home care, determining impacts of payment policies, and monitoring the needs of recipients of home care — in addition to the primary objective of enhancing outcomes of home care).

These principles were used in guiding research and operational activities that entailed empirically testing several versions of OASIS data items and outcomes in more than 400 home care agencies, with the input of more than 1200 home care providers, managers, and administrators. Input also was received from Medicare and Medicaid officials, policy analysts, consumer representatives, and representatives from other governmental and nongovernmental organizations with interests in (possible) OASIS applications. The final OASIS data items represent the minimum number and types of items required to implement an effective outcome enhancement and quality assurance system at the home health agency level and at the national level.

OASIS Demonstration Programs

After the initial 10 years of research and development, in the mid-1990s the National Outcome-(or OASIS-)Based Quality Improvement (OBQI) Demonstration program involving 54 home health agencies from 26 states was implemented to serve as a prototype for a national program. This program included small, medium, and large agencies, both rural and urban agencies, and home care agencies representing a variety of ownership types from around the country. **Patterned after this national demonstration sponsored by HCFA, the New York State Department of Health implemented an OBQI demonstration to assess the utility of using OASIS-derived outcomes for agency-specific and regulatory applications.** This program was eventually expanded to include 65 home care agencies (both certified and noncertified). **The more than 100 agencies participating in the two demonstration programs successfully integrated into their day-to-day operations all facets of OASIS outcome data collection monitoring, data processing, and data transmission. OASIS data were collected on adult, nonmaternity patients regardless of payer. The OASIS implementation process typically required only a few months at each agency to run smoothly in day-to-day operations.**

The OBQI applications framework entails two components: outcome analysis and outcome enhancement. The outcome analysis component begins with collecting, computerizing, and transmitting OASIS data to a central source (the University of Colorado in the case of the demonstrations). Several types of reports are returned to each agency. The most important of these is an outcome report that permits agency staff to analyze their patient outcomes aggregated to the agency level. These reports provide a comparison of agency performance (1) relative to a national reference or benchmark sample and (2) from one year to the next. Performance is reflected by a variety of outcomes such as improvement in ambulation/locomotion, stabilization in speech or language, improvement in status of surgical wounds, stabilization in anxiety, and acute care hospitalization.

The second component of OBQI, outcome enhancement, involves home care agency staff conducting process-of-care investigations that lead to plans of action specifying how care behavior will be changed in order to enhance specific outcomes. After the first round of outcome reports, two plans of action were developed by every demonstration agency, one for each of two target outcomes chosen for enhancement. (All agencies were asked to choose hospitalization as one of their target outcomes for purposes of evaluation.)

For the national demonstration, pooling all patients from Year 1 and then from Year 2, the Year 1 hospitalization rate was 31.4%, compared with a Year 2 hospitalization rate of 28.3%. This statistically significant, case mix-adjusted difference translates into a rate of decrease from Year 1 to Year 2 of 10%. Examining secondary data from Medicare claims revealed no trends over this period of time that would suggest a national decline in hospitalization rates for home care patients.

The total percent improvement across all national demonstration agencies in the nonhospitalization target outcomes from Year 1 to Year 2 was 7.8%. The analogous improvement for comparison outcomes (not correlated with the target outcomes) was approximately 1% (0.9%). The difference between these two rates was also case mix adjusted and statistically significant.

Findings related to OBQI impacts for the national demonstration were validated by the results from the New York State demonstration. The overall rate of decline for risk-adjusted hospitalization rates in the New York State demonstration was 9% (compared with the aforementioned 10% in the national demonstration). The percentage improvement from Year 1 to Year 2 in other target outcomes relative to comparison outcomes was approximately the same as in the national demonstration.

Conclusions: Pervasive, Positive Impact of OASIS on Patient Outcomes and Strong Endorsement from Agency Staff

The findings from these two entirely separate demonstration programs indicate a pervasive, positive impact of OASIS-based quality improvement on patient outcomes. As agency staff become more expert in conducting process-of-care investigations, developing plans of action for outcome enhancement, and implementing and monitoring care behavior change as a result of such plans, it is likely that OASIS-based quality improvement will be conducted even more efficiently and effectively at the agency level. Further, as this approach is implemented nationally and as agencies disseminate and publish their methods for enhancing outcomes, a growing body of knowledge is likely to provide a foundation for continued improvements in the effectiveness of home care in the United States.

Reactions of home care agency management and staff to OASIS and OBQI are particularly informative in that they demonstrate the value and multiplicity of uses of OASIS to home care agency staff — as well as the strong sense of ownership of OASIS manifest in home care agencies experienced with this data set. Quotations from articles authored by demonstration agency staff as well as others close to the demonstration program experience are presented in Supplement A. (This supplement is highly informative — even if skimmed or read selectively.)

OASIS BURDEN AND PRIVACY ISSUES

Computer Expense

In implementing and maintaining the OASIS data system at a home care agency, several changes are necessary. The vast majority of agencies, including all larger agencies, have the computer capacity to encode and transmit OASIS data. For a smaller agency the cost of purchasing a computer with the needed capacity is between $900 and $1200. All agencies are currently required to bill HCFA electronically, so computer capabilities already exist unless an agency contracts its billing to another organization. Most personal computers used for word processing are sufficient to encode (computerize) and transmit OASIS data with free software available from HCFA.

In implementing OASIS, some agencies have chosen to upgrade their computer systems considerably, to make sweeping changes in their comprehensive assessments, and to invest considerably in staff training and orientation. This is certainly understandable and acceptable. On the one hand, it is a good time to be making such changes. On the other hand, it is not appropriate to attribute such investments to the implementation costs of OASIS.

Data Collection Burden

Regional train-the-trainer programs for implementing OASIS have been conducted so that state government and state home care association staff could attend sessions on how to conduct OASIS training for home care agency staff at the state level. Free or low-cost training and OASIS operations manuals on implementing and maintaining the OASIS data system are available to all agencies in the United States. These training programs and manuals instruct agency staff how to properly embed OASIS items in the agency's current assessment, replacing similar items with OASIS items. In this regard, the OASIS data set does not constitute a separate "instrument" unto itself that is "added onto" current agency assessment forms. The training manuals also include sample agency assessment forms with OASIS items integrated, that agencies are free to use.

A significant misconception about OASIS is that it is a ponderous data set that includes over 80 new items that substantially increase the time home care providers spend assessing patients. In fact, OASIS contains very few new items that are not already part of an agency's clinical record on a patient. It simply contains the same items in a more precise form that enhances the accuracy of assessment, improves care planning, and permits uniform evaluation of patient outcomes. OASIS items require more space on paper than the analogs that they replace in clinical records, but as a group, they typically require no more time for data collection. That is, once a provider is familiar with the items, it is only necessary for a particular option (e.g., level on a health status scale) to be checked, without any narrative notes regarding the patient's condition.

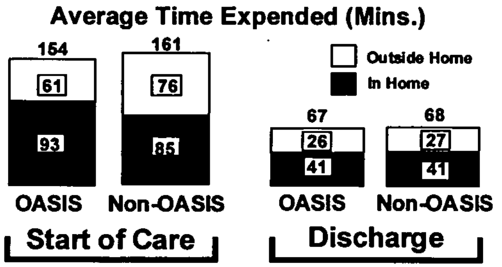
Hence, it is imperative to be aware that OASIS data elements replace, not augment, items in agencies' current clinical records. **A typical clinical record resulting from a patient assessment includes over 200 items if it is a valid comprehensive assessment. Replacing extant items with OASIS items, therefore, means that about half (or fewer) of the items in an agency's clinical record are replaced by OASIS items.** Although more paper is usually added to the agency's comprehensive assessment with OASIS, the total number of items is basically unchanged. The sample assessment form in the agency manual that incorporates OASIS and many other items needed for assessment actually requires fewer pages than the printed OASIS data set because it is formatted to take less space.

In an earlier prospective payment demonstration program, OASIS items were simply added to current agency assessments and therefore increased the time required to do an assessment. Further, selected additional agencies implementing OASIS or OASIS-like data items have not integrated these items into their assessment but added them on to the current assessment. This approach substantially increases the burden and time required to complete the assessment. These times have been invalidly cited as the added burden of OASIS for assessment.

In fact, as shown in the accompanying figure, a time study demonstrated that after agency staff had acclimated to OASIS, assessment time including OASIS items was no different

from assessment time not including OASIS data. In all, the start of care visit during which OASIS data are collected required a total of 154 minutes (including both in-home and out-of-home time, where out-of-home time refers to documentation, form completion, and care coordination activities not necessary to undertake in the patient's home). This was about the same as the total time for non-OASIS assessments — 161 total minutes. There was a difference in in-home time, with OASIS requiring 8 minutes more in-home time, and 15 minutes less out-of-home time. This is because the more objective and systematic checklist format of OASIS eliminates the need for a considerable amount of narrative documentation and thus, despite the fact that the OASIS items occupy more space on paper, they actually reduce total provider time spent in completing and documenting an assessment while at the same time rendering the assessment more precise. Total time at discharge was 67 minutes for OASIS users and 68 minutes for non-OASIS users. Because the number of OASIS items required at two-month intervals is approximately the same as those required at discharge (8 fewer items are required at two-month intervals than at discharge), the average time expended at the follow-up assessment should be similar to the discharge assessment.

OASIS TIME STUDY



In general, most agencies that have had at least one year of experience with OASIS are not surprised with the findings from the OASIS time study. In fact, one agency conducted its own time study that confirmed the above findings. **The results presented in the time study are averages, with some agencies experiencing more time and others less time than cited here.** Some agencies experienced considerably more assessment time after implementing OASIS. For the most part, this was because their original assessments required less time than was the case for the vast majority of agencies throughout the country. Various agency staff encountering this circumstance admitted that their original assessments were inadequate. Again, these results pertain to OASIS time requirements after clinical staff have had adequate orientation and experience in using OASIS items in an assessment. The learning curve for some clinical staff is considerably more accelerated than for others. Across the clinical staff in a typical agency, sufficient skill to reach the point where these results pertain is usually acquired within three months, and for the most part, sufficient skill is acquired considerably sooner.

Some Reasons for Burden Complaints and Valid Burden Concerns

Not one single agency in the aforementioned demonstration programs (in which agencies received no financial assistance to implement and maintain the OASIS data system) dropped from the program because of OASIS-related burden or costs. This also has been true with 97-98% of the agencies we are familiar with that have voluntarily implemented OASIS before the federal mandate. However, agencies that do not properly implement OASIS from the perspective of (1) integration of data items into the current assessment, (2) adequate training and orientation, (3) adequate communication with staff regarding the purposes and value of OASIS, and (4) not anticipating the natural resistance that occurs on the part of clinical staff to any change of this nature, will naturally struggle and, in many instances, complain that this is an extremely costly or difficult task to undertake.

The Medicare Conditions of Participation have long included the requirement that care provided by a home health agency follow a plan of care, which must have the following attributes:

> (a) Standard: Plan of Care. The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items (Source: CFR 42 - 484.18, revision effective August 1991).

In order to establish a plan of care with all of the attributes listed above, a clinician must complete the equivalent of what is now referred to as a comprehensive assessment. The recent HCFA regulation clarifies this responsibility and makes it more specific and uniform by requiring that a comprehensive assessment include OASIS. The new comprehensive assessment requirement extends the comprehensive assessment time points to include two-month follow-up points and discharge as well as start of care. It is important to note that this is not an OASIS requirement, rather it is a new comprehensive assessment requirement by HCFA.

Thus, many of the criticisms regarding OASIS-related burden are unfounded. Yet there are valid start-up costs related to training, forms development and integration, and a learning process that is real. These costs should (and may currently) be adequately covered. Also, time required to computerize OASIS data, which might be in the range of 10 minutes per form using the free HCFA software, is a new cost incurred by most agencies. As noted above, although not an OASIS-driven cost, the requirement that comprehensive assessments be done at follow-up time points may increase staff time for many agencies. **Although many burden-related concerns are unfounded, clarifying whether particular start-up costs, data entry or encoding costs, and (non-OASIS) assessment costs at follow-up time points are adequately covered under the current payment approach would only be fair to home care providers.**

Privacy Considerations

With respect to the issue of privacy, current concerns center on certain portions of OASIS which seem to be personal in nature, such as mental health and emotional status items in OASIS. There is consensus among home care clinicians that such items are needed in a comprehensive home care assessment in order to properly assess the needs of patients and determine mitigating factors that could influence how service should be provided or whether certain types of outcomes can be attained. In order to properly develop a plan of care, it is important to assess the patient's mental health and emotional status. To fail to do so would be to neglect a crucial element of care planning with possible serious consequences for patient health status. As noted earlier, the current Conditions of Participation for Medicare-certified agencies in Section 484.18(a) note that "the plan of care...covers all pertinent diagnoses, including mental status, ..." **From a clinical perspective, the main issue is not whether these items are needed, since they certainly are, but whether the information recorded on a given patient can be kept sufficiently private or confidential so that no one else (other than those who properly need access to such information) has access to the specific information on a named individual.**

That is, the challenge is whether such information can be transmitted to a third party (e.g., HCFA) for purposes such as quality improvement and still protect the privacy of the individual patient. There are two dimensions to this challenge. The first dimension involves the safeguards necessary to ensure that individuals authorized to have access to such data fulfill their responsibilities to prevent unauthorized or inappropriate use of the information. The second dimension is a technical issue which involves the encryption of identifying information. This applies to those instances where it is necessary to have individual patient data but in a form where patient identity is concealed. It deals with encryption of patient data to maintain security within the home care agency and during the data submission process.

Procedures already exist for safeguarding patient data against unauthorized use. Further, sanctions for inappropriate use of data have been established, and these systems will continue to evolve over time. The technical issues certainly can be solved. They require carefully designing a sound approach to protecting privacy through encryption — which also can be progressively improved over time. Addressing patient privacy need not prevent establishing a data collection system for the purposes of analyses to improve quality and refine payment methodologies.

Clearly, data on patient health status (e.g., OASIS data) and services are needed by payers to ensure that (1) services being provided are needed and (2) services are being effectively provided (in terms of their impacts on patients). Thus, payers obviously must have access to patient-level data for these purposes. In addition, if data on the health status and related information in OASIS were not available for purposes of refining outcome measurement and case mix adjustment for outcome evaluation, as well as case mix adjustment for prospective payment, it would seriously curtail the capacity to continually improve Medicare's approaches to quality enhancement and payment. **The challenge, which can be overcome, is therefore to use the best available methods for adequately protecting privacy at the present time and continually improve upon the privacy safeguards over the course of time.**

WHY COLLECT DATA ON INDIVIDUALS OTHER THAN MEDICARE AND MEDICAID PATIENTS?

As the OASIS and OBQI research program evolved, it became clear that to systematically monitor and improve patient outcomes, clinical staff of home care agencies wanted and needed outcome reports for all patients regardless of payer source. OASIS-based quality improvement and related reports were therefore designed to mesh with the "total operations" of agencies, not just part of their business (e.g., patients with specific payers). All the home care agencies with which we have worked in implementing OASIS and OASIS-based quality improvement have collected data on patients regardless of payer source. One of the primary advantages in doing so, from an agency's perspective, is that it receives outcome and related reports on its entire caseload. This permits managers to make more rational decisions in terms of resource management on behalf of their agency's patients, taking its total cost structure and total utilization picture into consideration. In addition, from a clinical perspective, agency staff are not required to use different forms for different types of patients. This uniformity helps in designing agency-wide approaches to care planning, care coordination, and the provision and monitoring of care.

In addition, the responsibility of HCFA to monitor the quality of care provided by home health agencies certified by Medicare is well established within the Social Security Act (Sec. 1861(o)(6) and Sec. 1891(b)). Furthermore, this responsibility is not limited to patients for whom the payer is Medicare or Medicaid.

Thus, on issues related to quality of care, Medicare's purview extends to all patients under the care of an agency that seeks Medicare certification and payment. The rationale for this, in part, rests with the principle that **the Federal government, as the dominant payer in this field, takes on the responsibility to certify home health agencies that provide care to Medicare enrollees and to ensure that HCFA payment practices and other policies and procedures do not adversely impact Medicare or non-Medicare patients.** Since Medicare is by far the largest payer in the home health care field, its payment and related practices have powerful impacts on what happens to both Medicare and non-Medicare patients.

Under the current payment environment (the Interim Payment System) there is little doubt that patterns of care have changed in the vast majority of home care agencies across the country. For the most part, such patterns seem to have been characterized by reductions in total number of visits and various types of services. What has happened to patients, both Medicare and non-Medicare patients, is relatively unknown. Are more patients being discharged without meeting their goals? Are elderly and chronic care patients receiving fewer services resulting in more complications that accelerate impairments and acute exacerbations of chronic problems? Is this more true for Medicare patients than non-Medicare patients?

Under the future payment environment (i.e., the Prospective Payment System [PPS]), very strong incentives will exist to cut back on services. Since a home care agency will be paid on the basis of an episode of care for each patient, regardless of how many visits are provided, the fiscal incentives to reduce visits will be pronounced. This can result in inferior care for Medicare patients, although we will not know whether this is the case unless we are able to measure what happens to patients, i.e., patient outcomes. Thus, on the one hand, it is likely that these incentives may result in a number of agencies providing inferior care to Medicare patients. On the other hand, agencies interested primarily in profit maximization will have the incentive to admit as many Medicare patients as possible and minimize services provided so as to maximize profit under PPS. **This can result not only in inferior outcomes for Medicare patients, but it can result in reduced access for non-Medicare patients since profits may not be as substantial for non-Medicare patients.**

Under any of these scenarios, **if OASIS data are collected on both Medicare and non-Medicare patients under PPS, it will be possible to determine which agencies have inferior outcomes for Medicare (or non-Medicare) patients and whether case mix or numbers of non-Medicare patients are changing substantially over time, reflecting decreasing access for non-Medicare patients. Thus, collecting data on all adult, nonmaternity patients admitted to certified home health agencies permits the Medicare program to meet its responsibilities to all patients.** In this regard, by requiring that OASIS data be available on all such patients, outcome reports can be produced for individual agencies that permit both individual home care providers and Medicare to assess impacts (on patients) of care behaviors in response to payment system changes. Thus, OASIS-derived outcome, case mix, and adverse event reports will help individual agencies in assessing the impacts of their internal changes (in response to payment) on patients. They also will help HCFA in assessing the system-wide impacts of such changes not only on Medicare patients, but also on other patients for which the government has the aforementioned responsibilities.

Without OASIS data collected on Medicare and non-Medicare patients alike, PPS may create a two-class home care delivery system for public- vs. nonpublic-pay patients, and we may not learn definitively of this system and how to fix it until it has caused many years of damage. Because home care serves a population that many describe as one of our most vulnerable (the homebound, ill elderly), this is an extremely serious concern.

POLICY CLIMATE CONDUCIVE TO OVERLOOKING THE VALUE OF OASIS

The Interim Payment System (IPS) for Medicare-certified home health agencies was implemented under the Balanced Budget Act of 1997. As is well known, IPS has had a powerful impact on the home care industry in the United States. By most estimates, at least 1000 certified agencies have closed. The financial status of many agencies is weak, and closures are continuing. Unfortunately, it does not appear that IPS has succeeded in eliminating the "bad apples." Many good agencies appear to have gone under. It is not possible to definitively assess whether we have lost predominantly good agencies because we do not have adequate data to determine how they were performing in terms of patient outcomes. Nevertheless, most individuals familiar with home care quality, payment issues, and public policy seem to agree that IPS has taken a serious toll on home care in the United States. While some of this is warranted, it appears to have gone beyond what might be considered in the best interest of home care from a public policy perspective.

Also unfortunate is the coincidence that HCFA's announcement mandating the OASIS data system, appearing in January of this year, has been coterminous with IPS. **In view of the strong backlash and preoccupation with IPS-related issues, it has been understandable that many in the industry have reached the conclusion that OASIS is essentially a designed accompaniment of IPS.**

In addition, because HCFA has been mandated to develop a prospective payment system (PPS) for home health care in the near future, it was necessary to announce an extremely ambitious schedule for certified home health agencies to implement OASIS data collection and transmission. That is, among the many purposes to be served by OASIS is to yield case mix data that will be used in revising and finalizing a case mix-adjustment methodology for conditioning payment on case mix under PPS. This application understandably forced an unusually tight implementation time frame.

These two factors, the implementation of IPS concurrent with the announcement of the OASIS mandate and the ambitious implementation schedule for OASIS released in the January 1999 regulations, have led to far more concern about OASIS than would otherwise be the case. In fact, three versions of OASIS have been released for public review and reaction over the past four years. None was negatively received until the implementation of IPS. In addition, many agencies voluntarily implemented OASIS and OASIS-based quality improvement without any mandate from HCFA. As discussed earlier, nearly all agencies that have implemented and maintained OASIS for at least a year are staunch advocates of OASIS and OASIS-based quality improvement. Before the shift to IPS took place, the home health industry was generally supportive of OASIS and felt a sense of ownership about this data set that was developed specifically with the needs of home care agencies in mind. This support was evidenced by the statements and activities of both individual agencies and by state and national provider associations (such as the National Association for Home Care).

Currently, there seems to be a tendency to examine the OASIS data set simply as a set of items that require a given amount of space on paper and have a given number of boxes that can be checked. There is also a tendency to examine the data items and question why certain ones are being collected. **Unfortunately, in the face of IPS, there has been little effort on the part of many in the home care field to understand how and why OASIS has evolved, what this data set is going to be used for, its significant value to home care agencies and their patients, and its merits.**

OASIS is incorrectly considered part of the IPS problem. In fact, OASIS represents a significant solution to several problems, including problems caused by IPS. As noted earlier, it was developed primarily for home care providers. One of the guiding principles in its development was that OASIS and its applications as they relate to outcome enhancement must be of practical value and mesh with the day-to-day operations of home care agencies. It must yield reports and tools that agency staff can use to evaluate their own effectiveness in terms of how they are investing resources on behalf of their patients. It was required that the reports be sufficiently practical and understandable so that agencies can change and reallocate staffing and other resources both to produce better outcomes and to control or minimize costs in doing so. That this is possible has been shown clearly under the OASIS OBQI demonstration programs.

OASIS can also be used by agency staff to monitor case mix, including potential changes in case mix so that approaches to care can be altered systematically in accord with the changing needs of patients. Beyond this, and in addition to outcome reports, agencies receive adverse event reports reflecting the frequency with which a variety of untoward events (such as emergent care for wound infection or deteriorating wound status, development of a urinary tract infection, or substantial decline in management of oral medications) occur. These types of events can be monitored efficiently through OASIS, providing agencies with critical information in order to investigate why they occur for individual patients.

As has been discussed, OASIS not only results in enhanced outcomes and management decisions on how best to invest limited resources in patient care, but it also can contribute to reducing total health system costs through enhanced outcomes such as reductions in hospitalization rates for home care patients. Much of this simply has been lost due to the preoccupation with IPS and the accelerated implementation schedule. **The main point, however, is that OASIS is not part of the problem. It is a significant component of the solution. The fact that it is extremely popular with those who have implemented and used it for a reasonable period of time is a testament to its utility. The solution works.**

FINAL STATEMENT

OASIS is a data set with a considerable history in enhancing the health outcomes of home care patients. It is far from what some have called a ponderous data set. Each of its well-studied data elements are precise and, when properly inserted into an agency's comprehensive assessment, replacing like items with OASIS items, it yields a highly useful information set that has been shown to:

- Increase the accuracy of patient assessments,
- Improve care planning,
- On average, require no additional assessment time after an initial learning curve,
- Yield outcome reports permitting an agency to monitor its own performance,
- Provide the basis for improving care when patient outcomes are poor, and
- Enable agency staff to allocate resources to minimize cost and maximize patient outcomes.

This, in turn, results in an overall program of continually improving cost effectiveness that evolves and improves as agency staff become progressively more familiar with OASIS applications.

From a public policy perspective, OASIS data can assist not only in enhancing patient outcomes, but also in refining the case mix-adjustment approach to prospective payment, evaluating the effects of prospective payment on Medicare and non-Medicare patients, and increasing the efficiency of the Medicare survey and certification program. In all, the fact that OASIS has been successfully applied and is of practical value at the home care agency level means it has utility for the individual patient receiving care, the home health agency, and the public oversight of care provision.

Supplement A

QUOTATIONS FROM HOME CARE AGENCY STAFF ABOUT THE VALUE OF OASIS

Selected quotations from articles authored by demonstration agency staff as well as articles authored by media reporters or others based on interviews with demonstration agency staff are reproduced below. These quotations demonstrate that, in a number of contexts and not just in a few instances, OASIS data collection and outcome- (or OASIS-) based quality improvement (OBQI) have proven beneficial to home care agencies and have contributed to enhanced quality of care for individual patients.

General Comments on the Advantages of OASIS and OBQI

Wide Ranging Positive Effect:

> "Implementation of OASIS data collection not only has far-reaching impact on operating procedures, it also has a wide ranging positive effect on patient care management and the organization's approach to QI. Clinicians express enthusiastic support of OASIS as a tool that has multiple benefits for patient care and staff development, including:
>
> - More objective and consistent patient assessment,
> - Improved staff assessment skills,
> - Systematic reassessment,
> - Better problem identification, care planning, and care delivery,
> - Universal measure of outcomes and goal achievement which facilitates an OBQI approach to process of care evaluation and continuous improvement of patient services."

Hulley D; K Scribner; and H Siegel. "OASIS: A case study by the Home and Health Care Association of Massachusetts" *The Remington Report*, September-October 1997, p. 55.

Increased Efficiency and Effectiveness:

> "As a result of implementation, our staff has become a more efficient and effective care team with an increased focus on patients' health status. Members of all disciplines were forced to 'speak the same language' and we were motivated to improve our documentation and delivery systems."

Rexrode A, et al. "OASIS: South Carolina's Experiences" *Home Health FOCUS*, August 1998, p. 19 & 21.

New QI Approach Benefits Patients and Clinicians, Demonstrates Effectiveness:

> "OASIS marks the first time we have focused on clinical quality improvement efforts as opposed to agency processes and procedures."
>
> "OASIS brought a decrease in both length of service and number of visits per client."
>
> "OASIS gave us outcome measures that demonstrate the value and effectiveness of home care. Nurses have had little data that truly demonstrate to the health care system that we can make a positive difference."
>
> "OASIS helps us identify patient problems more rapidly."
>
> "OASIS has brought quality improvement to the clinicians. It used to be 'the QI nurse's job'."

"Lessons from the OBQI demonstration sites" *Caring*, September 1997, p. 49-50.

Examples of Patient Well-Being and Performance Improvement

Improving Assessment and Teaching - Reducing Hospitalization:

"Since looking at the [OBQI outcome] report's bar graphs, St. Mary's Home Care has been able to improve patient education and assessment by coming up with new flowcharts and teaching forms that help the nursing staff deliver the best possible care to approximately 1000 clients annually."

"The amount of information we get out of it [OASIS] is great. It's great because it makes sure you are comparing apples to apples, not apples to oranges."

"There is a dollar cost to this, in terms of training staff to collect the data and getting up to speed. But if we can prevent one hospital admission, then it all balances out."

"Comparing apples to apples yields a healthy crop of QI action plans" *Homecare Quality Management*, July 1997, p. 86 & 89.

Reduction of Hospitalization Related to Diabetes:

"With the OASIS project...the patients are being readmitted to the hospital less than they were before...since the program began in January 1995, there hasn't been a single case of a diabetic patient being readmitted to the hospital for problems relating to the disease within 45 days of discharge. Previously... patients were constantly being readmitted for problems related to their diabetes."

"Give diabetic patients an attitude adjustment" *Homecare Quality Management*, October 1997, p. 141.

Improvement is Not Restricted to Poor Performers:

"The quality manager of Lee (MA) Visiting Nurse Association had no complaints with how the agency did on its first annual outcomes report using data collected as part of an Outcome and Assessment Information Set (OASIS) demonstration project."

"'We didn't do badly; some of our outcomes were slightly poorer than the national average, and some were better,' says Suzanne Hatch, BSN, MEd, CPHQ, quality manager and staff development coordinator for the Lee VNA."

"Because no glaring problems cropped up on the report, Hatch decided to make a quality improvement project out of one of the agency's more positive outcomes. 'This was going to be a learning experience, and I wanted it to be positive and to engage our nurses so they would be interested in participating in this quality project,' Hatch says." (Reference below)

Improvement in Dyspnea, "Like Discovering Gold":

"Hatch decided to focus on dyspnea, or breathing difficulties. The agency had done well in this area when compared to the national reference group, which was part of the demonstration project."

"'One of the bright spots of the year was our work with improving dyspnea outcomes,' Hatch adds. The staff was excited to think they had done this well, and the potential was there to do better."

"'It was like we discovered gold,' Hatch says. 'For all the patients who improved, this constellation of behavior was there,' Hatch says. 'We thought this was a good thing, but while we were better than the reference group, we saw we had room for improvement internally'."

"QI project makes good program even better" *Homecare Quality Management*, September 1998, p.134-136.

Better Outcomes, Precise Patient Assessment, and Managing Costs

Reduced Hospitalization - Linking Outcomes to Utilization:

"Anyone who thinks OASIS data won't be an indispensable survival tool for HHAs in this era of Medicare payment limits and prospective payments should consider the experience of one agency in HFCA's demonstration project."

"Advocate Home Health Service, Oak Brook, Ill., reduced its rehospitalizations 5% last year after analysis of its OASIS information showed it above average in 1996 patient returns to inpatient care."

"At Advocate, for example, patient symptoms that could lead to hospital admission, such as shortness of breath and edema-caused weight increases -- both of them heart failure indicators -- now are a priority, says Cheryl Meyer, Advocate's OASIS coordinator."

"For Advocate, OASIS-derived information also has made its nurses 'more aware of the need to document their interventions' during home visits, notes OASIS coordinator Meyer. In the past, incomplete documentation left the HHA uncertain about why some patients had been rehospitalized, she adds. But in the future Advocate hopes to tie clinical outcomes to resources, helping it to reduce average visits per episode of care in line with Medicare's new payment limits." (Reference below)

Precise Assessment Achieves Specific Determination of Patient Care Needs:

"A 75-year-old Medicare beneficiary was admitted by VNA Healthcare, Waterbury, Conn., with second degree burns of the left foot, insulin-dependent diabetes, hypertension, nerve damage causing numbness in the hands and feet and osteoarthritis."

"The patient's inability to bathe himself, use the toilet on his own or carry out any of the other activities of daily living (ADLs), as confirmed by his OASIS assessment, qualified him for seven days a week of nurse aide visits. But guided by OASIS, the VNA reduced that in stages to only two visits and ultimately discharged the patient after two months, says Nancy Culos, the VNA's VP for visiting nurse and home care." (Reference below)

Reduced Hospitalization Rates for Cardiac Patients:

"Visiting Nurse Service of New York, the nation's largest freestanding, nonprofit HHA, learned from trial collection of OASIS data by two of its 52 nurse teams that a number of patients should have been on ACE inhibitors to increase their cardiac output, but weren't. In addition, it discovered that many patients lacked scales to detect weight increases caused by fluid accumulation."

"Compared with the bare-bones information normally collected on patients, such as primary diagnosis and residence address, OASIS disclosed additional rehospitalization factors -- whether the patient was living alone, illness severity and ADL status. Alerted to those findings, nurses involved in the test have reduced the rehospitalization rate for their approximately 600 patients to 40.6% from 42.9%." (Reference below)

Fostering Functional Independence Rather than Dependence:

"OASIS information also showed patients weren't making the progress in grooming, dressing and bathing the HHA wants. One factor: Nurses weren't using the same definitions to describe a patient's ability to do bed-to-chair, standing-to-sitting and other 'transfers.' Another: Home health aides were keeping patients dependent in order to assure themselves of jobs, the VNS suspects.

"Guided by OASIS, the HHA now is readying new protocols designed to avoid rehospitalization and speed independence from home care, says Sylvia Koerner, director of quality management services. To encourage ADL progress, it also will be sharing its OASIS information with the 20 home health aide suppliers it contracts with throughout New York City, Koerner adds."

"OASIS data puts some HHAs ahead of IPS curve" ...*home health line*, June 22, 1998, p. 3-5.

More Thorough Assessment Results in More Efficient Care:

"Humboldt Home Health Services was one of the 50 [agencies] selected for participation in this project. The staff has been living and working with the OASIS data set for a year and a half and has gained some valuable insights about the provision of cost-effective quality service delivery and care practices through this experience."

"As the agency staff became more familiar with the use of the OASIS-based tool at the required intervals the nurses began to realize the potential impacts for improvement in both clinical care and in cost savings over the entire course of a patient's service delivery. Although the initial assessment process is longer than the previous one (10 to 20 minutes), the nursing staff's attitude about the overall effectiveness of care provision seems to have improved. This improvement was due to a more accurate assessment of patient needs and influencing factors, thereby facilitating utilization of appropriate resources at the right time to the correctly targeted patient need." (Reference below)

Measuring Outcomes Enhances Effectiveness of Care:

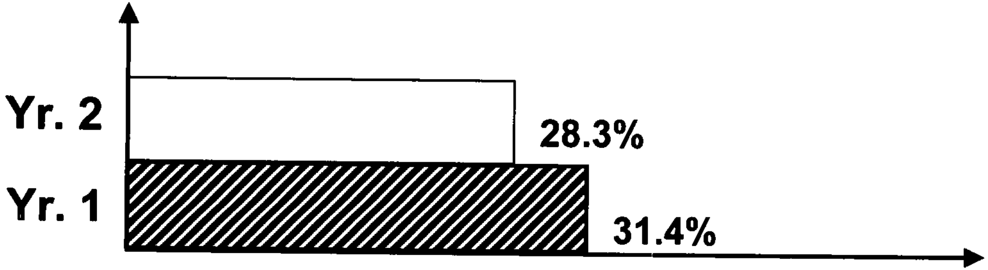
"The elements of successful care delivery entail the ability to measure clinical outcomes, to assess the effectiveness of actions, to measure the resources that were necessary to achieve those outcomes, and to measure patients' satisfaction with the care they received. How does an OASIS-based tool assist in this process? It provides an agency with the ability to plan care effectively, measure clinical outcomes in an objective standardized manner, and accurately evaluate the effectiveness of the care delivery."

"Using an OASIS-based tool has begun to assist Humboldt Home Health's staff in 'doing the right thing, the right way, at the right time'."

Starr T and L Anderson. "OASIS: Friend----Not Enemy" *Home Health Care Management and Practice*, June 1998, p. 111-113.

OBQI IMPACT: HOSPITALIZATION

Risk-Adjusted Hospitalization Rates



Net Decrease = 3.1%

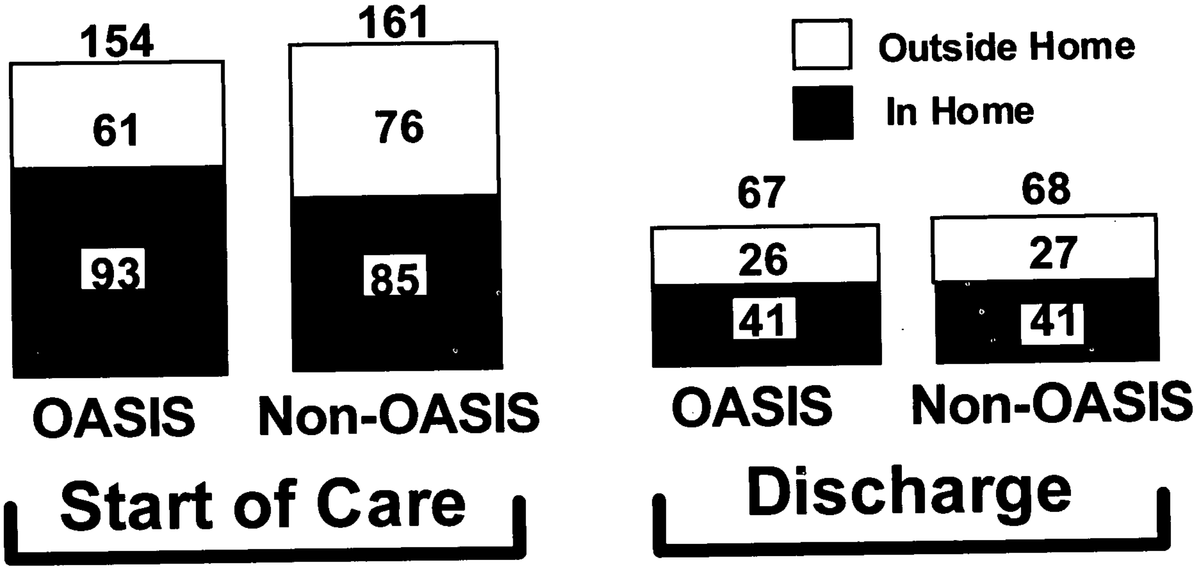
N_1 = 42,209

Rate of Decrease = 10%

N_2 = 32,373

OASIS TIME STUDY

Average Time Expended (Mins.)



The CHAIRMAN. Mr. Pyles.

STATEMENT OF JAMES C. PYLES, ON BEHALF OF THE HOME HEALTH SERVICES AND STAFFING ASSOCIATION AND AMERICAN PSYCHOANALYTIC ASSOCIATION, WASHINGTON, DC

Mr. PYLES. Thank you, Mr. Chairman.

My name is James Pyles. I represent the American Psychoanalytic Association and the Home Health Services and Staffing Association, and we appreciate this opportunity to talk about patient care concerns regarding OASIS.

First, let me make absolutely clear that the American Psychoanalytic Association and the Home Health Services and Staffing Association support well-thought-out measures that are likely to improve access to quality care. It is in fact, however, that very interest which is the basis for our concern about the manner in which HCFA has sought to implement OASIS.

The data collection requirements of OASIS went into effect on February the 24th and were suspended on April the 27th as a result of privacy and patient care concerns expressed by members of this committee as well as by other Members of Congress and by the White House.

HCFA has indicated, however, that it plans to resume implementation of OASIS as soon as it receives clearance from OMB. The 2-month experience with OASIS illustrates what happens when identifiable patient data is collected without adequate privacy protections and funding.

Specifically, we found that patients refused to provide some of the information required by OASIS, either because it was too voluminous or too personal. The caregivers then felt compelled to make up responses to the data collection tool in order to preserve access to medically necessary services for patients, and critically necessary funds and staff time were diverted from caring for the sickest, most frail patients to meet the additional administrative burden imposed by OASIS.

I would like to show the committee what we are talking about when we refer to the OASIS data collection instrument, if I could have my assistant unroll it down the aisle for you here. You will see that it measures nearly 30 feet long. It calls for the collection of more than 450 pieces of highly personal information, including sensitive information about a patient's emotions, family situation and finances. Home health agencies are required to collect this information every 60 days, upon admission, at discharge, and after each hospitalization of 48 hours or more. The information is then to be reported in a fully identifiable form to the State and Federal Governments, where it is to remain on file for 3 years.

We believe OASIS is being implemented in a manner that will eliminate rather than enhance access to quality care for the following reasons. No. 1, HCFA has indicated to us that all patients, even non-Medicare patients, will have to have their care terminated unless they consent to the collection and reporting of all OASIS data. Medicare patients will be compelled to sacrifice their right to privacy in order to obtain the health care coverage they have paid for with a lifetime of taxes.

We know from our experience and the findings of the OASIS contractors that many patients will refuse to consent. The nearly 30-foot-long document and more than 450 data items will have to be collected from patients who simply seek a bed bath or a surgical dressing change that they are willing to pay for with their own money.

Number two, the OASIS data must be collected on every patient regardless of whether it is essential for the particular patient's diagnosis and treatment. HCFA thereby appears to be substituting its medical judgment for that of the treating physician and the caregiver with respect to the information that is essential for safe and effective services.

Number three, HCFA has indicated that patients will have an opportunity to provide consent, but no consent or notice forms have ever been provided despite the fact that the data collection requirements were in effect for 2 months, and the data reporting was required as early as March 26th.

Number four, OASIS requires the reporting of the very facts, emotions and fears which the Supreme Court found in 1996 decision must remain private in order for counseling by medical social workers to be effective.

HCFA issued an opinion as recently as March of this year concurring that Federal and State common law require such communications to remain confidential.

Number five, implementing OASIS on the scale required by HCFA would divert a minimum, according to HCFA, of $45 million from patient care in the first year and $110 million over 5 years. HCFA estimates that the vast majority of agencies will receive little or no Medicare reimbursement for these additional costs. In effect, home health agencies are being put in the position of having to tell their patients: If you indicate to us that you are depressed, we will have to report you to the State and Federal Government. And similarly, if you live alone, we will have to report that as well, along with your State of residence and your ZIP Code.

We believe that the sick and particularly the aged sick of this country deserve better treatment. Even more importantly, OASIS in its current form violates one of this country's most fundamental founding principles—that citizens have a right to keep the Federal Government out of their homes as long as they obey the law. OASIS is being implemented in a manner that affords the sick with less privacy protection than someone accused of a crime. Needing health care should not be treated as a crime.

According, we urge the following, (1) suspend collection of OASIS data from non-Medicare patients. (2) provide patients with adequate notice and an opportunity for informed consent. Narrow the OASIS data set down to the core items essential for establishment of a case mix adjuster under PPS. Collect the information in a non-identifiable form, and reimburse agencies for the cost of collecting the information and reporting it.

I would just add one final note, that as we consider the privacy intrusion that OASIS has made on patients in their very homes, we are on the very threshold of a markup of the privacy bill tomorrow before the Labor Committee, which will establish new standards for medical privacy information in this country. The OASIS data collection tool violates many provisions of the bill that is in the chairman's mark that is scheduled to be marked up tomorrow.

Thank you.

The CHAIRMAN. Thank you.

[The prepared statement of Mr. Pyles follows:]

Statement

of the

Home Health Services and Staffing Association

and the

American Psychoanalytic Association

on the

Outcome and Assessment Information Set (OASIS)

before the

Senate Special Committee on Aging

presented by

James C. Pyles

May 24, 1999

Mr. Chairman and Members of the Committee, thank you for the opportunity to present testimony today on behalf of the American Psychoanalytic Association (the "American") and the Home Health Services and Staffing Association ("HHSSA") with respect to patient care concerns arising from the Health Care Financing Administration's attempted implementation of the "Outcome and Assessment Information Set" or "OASIS".

At the outset, let me make absolutely clear that the American and HHSSA support legitimate and effective efforts to improve access to quality health care. It is for that very reason that we have serious concerns about the manner in which HCFA has sought to implement OASIS. OASIS implementation was suspended by HCFA on April 27, but in the two months that the data collection requirement was in effect, we found that it was acting as a barrier to quality health care services rather than enhancing access to quality care.

The two-month experience with OASIS offers an excellent example of what happens when identifiable patient data is collected without adequate payment and privacy protections. Specifically, we have found that:

- patients will refuse to provide certain sensitive medical information in an identifiable form even if it means that the services cannot be provided;
- the caregivers will "make up" the data in order to avoid terminating medically necessary services; and
- funds must be diverted from caring for the sickest, most costly patients to pay for the significant additional administrative costs.

Thus, a poorly planned and implemented data collection effort reduces or eliminates access to quality health care and produces corrupted data which leads to poor health planning and policy.

The Status of OASIS

Effective February 24, 1999, HCFA began requiring home health agencies to collect OASIS data on all patients, both Medicare and private pay, as a condition of participation in the Medicare program. 64 Fed. Reg. 3764 (January 25, 1999). The OASIS data collection instrument contained more than 450 data elements and had to be collected from the patients (1) upon admission, (2) upon discharge, (3) after any 48-hour hospitalization, and (4) every 60 days. 64 Fed. Reg. at 3784.

The data to be collected included the following information related to the patient's mental health, family situation and financial information.

Mental health information

The OASIS data includes extremely sensitive mental health information, including whether the patient:

1. is in a "depressed mood (e.g., feeling sad, tearful)";
2. has a "sense of failure or self reproach";
3. has a feeling of "hopelessness";
4. has "recurrent thoughts of death"; and
5. has "thoughts of suicide". (62 Fed. Reg. 11052)

Family information

Other invasive questions include whether the patient lives:

1. alone;
2. with their spouse or a "significant other";
3. with another family member;
4. with paid help; or
5. with someone else. (62 Fed. Reg. 11048)

Financial information

The patients must also disclose certain financial information including:

1. whether they are unable to afford medical expenses that are not covered by Medicare;
2. whether they are unable to afford to pay their rent or utility bills;
3. whether they are unable to afford food;
4. whether they own or rent their residence or if it is owned by a "couple" or "significant other"; and
5. whether a family member owns their residence. (62 Fed. Reg. 11046, 11048)

This information was to be collected and reported to the state and federal governments in a fully identifiable form that included the patient's name, "ID number", Medicare number, state of residence, zip code and birth date. 62 Fed. Reg.11045. All of the information was to be collected on every patient regardless of whether the information was necessary for that patient's diagnosis and treatment. It was to remain on file with state and federal officials for at least three years. The regulations did not provide for notice to the patients or for a process to obtain their consent.

We raised the following legal and policy defects in the OASIS regulations in meetings with HCFA, members of Congress and the White House:

1. There is no indication of how HCFA plans to comply with the Privacy Act, 5 U.S.C. 552a. For example, the regulations do not indicate how HCFA plans to inform "each individual it asks to supply information" of (a) the authority for the requirement, (b) the principal purposes to which the information will be put, (c) the routine uses that will be made of the information, and (d) the effect on the individual of not providing the information.

2. The OASIS regulations would appear to violate several provisions of the Paperwork Reduction Act because:

   A. they authorize HCFA to "conduct or sponsor the collection of information" in advance of taking action to "reduce to the extent practicable and appropriate the burden on persons who will provide information to the agency"; and

   B. the information collection, as currently designed, is not "necessary for the proper performance of the functions of the agency".

44 U.S.C. secs. 3507(a) and 3508.

3. The OASIS regulations are in conflict with the rationale and the holding by the Supreme Court in <u>Jaffee v. Redmond</u>, 518 U.S. 1 (1996), which found that effective psychotherapy or counseling by a medical social worker cannot be performed unless the patient can have the "trust and confidence" that disclosures to a care giver will not be communicated further.

4. The OASIS regulations are in conflict with the laws of all 50 states and the District of Columbia which offer a psychotherapy privilege. See <u>Jaffee v. Redmond</u>.

5. The OASIS regulations are in conflict with the opinion rendered by HCFA on March 22, 1999, that the federal government may not gain access to the mental health records of non-Medicare patients because, "[f]irmly rooted in state case law, and established in federal law by the U.S. Supreme Court in <u>Jaffee v. Redmond</u>, 518 U.S. 1 (1996), the psychotherapist-patient privilege protects 'confidential communications between a licensed psychotherapist [or licensed social worker in the course of psychotherapy] and her patients in the course of diagnosis or treatment'. "

6. The OASIS regulations are in conflict with the representation, which the President made to mental health consumers in 1995 where he stated that he "supports the right of patients to receive [mental health] services without being compelled to disclose clinical records to. . . the government." See letter from President Clinton (July 31, 1995).

7. The OASIS regulations are in conflict with the recommendations for medical information privacy standards issued by Secretary of Health and Human Services, Donna Shalala on September 11, 1997.

8. Contrary to HCFA's assertions, many patients resisted providing the more than 450 data items, and home health agencies found that it imposed significant additional costs and burdens on staff. See "Case-mix Adjustment for a National Home Health Prospective Payment System", Abt Associates Inc., p. viii (December 1998).

9. In the final rule, HCFA does not explain why it is necessary to collect and report detailed personal information from non-Medicare patients. In fact, HCFA officials have informed us that they do not plan to use the data from non-Medicare patients in developing the case mix adjuster for the home health prospective payment system.

10. In the final rule, HCFA asserts that the OASIS information will allow the Secretary to assure that the conditions of participation are "adequate to protect the health and safety of individuals under the care of a home health agency." 64 Fed. Reg. 3764. The rule, however, sets forth no finding or data to show that the conditions of participation which have been in effect under Medicare for 35 years have been inadequate to protect the health and safety of individuals treated by home health agencies. Nor is any evidence cited to show that the quality of home health services is deficient in any way.

11. The OASIS regulations will impose a devastating financial burden on the home health industry, which was hit in fiscal 1998 with the largest percentage cut in reimbursement of any service in the history of the Medicare program (-15% growth rate according to recent CBO estimates).

In addition to the above concerns raised by health care providers, consumer groups, and patient advocacy organizations, several members of Congress also expressed concerns about HCFA's implementation of OASIS. Furthermore, several articles appeared in major newspapers around the country including:

1. "U.S. to Start Gathering Patient Data: Care Survey Draws Privacy Objections", The Washington Post, A1,March 11, 1999;

2. "U.S. to Amass More Data on Patients", The Los Angeles Times, March 11, 1999;

3. "More Data to Be Sought on Home Care", The New York Times, March 11, 1999;

4. "Data Sought on Home Care", The Boston Globe, A3, March 11, 1999;

5. "Home Health: HCFA to Start Gathering Personal Data", American Health Line, March 11, 1999;
6. "Under Fire, U.S. Amends Plan to Collect Health Care Data", The Washington Post, A5, April 1, 1999; and
7. "U.S. Puts off Collecting Medical Data", The Washington Post, A10, April 11, 1999.

In addition, both the American Civil Liberties Union (ACLU) and the Heritage Foundation strongly criticized the data collection effort. See "Home Nurses are Compelled To Do What Police Are Not Permitted To Do", The ACLU Massachusetts Medical Privacy Forum, and "HCFA's Latest Assault on Patient Privacy", The Heritage Foundation Executive Memorandum, March 22, 1999.

Finally, HCFA issued a notice dated April 27, 1999 announcing that they were delaying the "mandatory collection, use, encoding and transmission of OASIS" but only until clearances are obtained under the Paperwork Reduction Act.

HCFA's implementation of OASIS reduces access to quality home health services both because of the failure to protect patient privacy and because of the additional, uncompensated burden on home health agencies.

Privacy concerns

The American has been concerned for some years that access to effective psychotherapy will be eliminated unless the patient is permitted to communicate in private with a therapist. The United States Supreme Court reached a similar conclusion in the 1996 decision in Jaffee v. Redmond, in which it reviewed federal and state laws as well as canons of medical ethics and found that effective counseling by a medical social worker depends upon the patient having the trust and confidence that disclosures made to the social worker will not be further disclosed. 116 S.Ct. 1928.

Based on that finding, the Court recognized a "patient-therapist privilege" under federal law which, like the attorney-client privilege, cannot be waived without uncoerced patient consent. Accordingly, OASIS compels the routine disclosure of precisely the kind of information which the federal and state governments would be precluded from obtaining even under a court order in litigation. HCFA appears to agree since it issued an opinion on March 22 stating that the protection of such communications from disclosure is "firmly rooted" in both federal and state common law.

Thus, patients who agreed to provide the OASIS data were likely to cease making the kinds of disclosures that are essential for effective psychotherapy, including counseling by medical social workers.

HCFA officials also informed us that patients who refused to provide the information would have to have their services terminated. Accordingly, OASIS would eliminate access to services from Medicare certified home health agencies for these patients.

HCFA officials also informed us as recently as February 25 that during the collection of OASIS data in a 90-agency pilot project, "not a single patient objected to the collection of the data." A December 1998 interim report on the pilot project by the HCFA contractor, however, notes that one of the most "common implementation issues" was "gaining patient cooperation". The report states the following:

> Sometimes it is not the staff who resists the OASIS form but the patients. Several patients tired of the long assessment quickly and refused to answer any remaining questions. Some patients were also reluctant to answer background questions, such as finances, schooling, etc.

See "Case-Mix Adjustment for a National Home Health Prospective Payment System", First Interim Report, Abt. Associates Inc., p. viii.

Feedback from home health agencies that tried to collect the OASIS data between February 25 and April 27 showed that many patients refused to furnish the information and that the caregivers simply supplied the responses that were necessary to preserve access to the services. This scenario poses a significant threat to the reliability of the data that HCFA intends to use to develop a prospective payment system. Accurate data is important, otherwise the quality of care will be further eroded by an inaccurate prospective payment reimbursement system.

In addition, home health agencies have found that the OASIS requirements are intrusive and threatening and restrict the relationship building activities so necessary to effective care planning, intervention and treatment. Patients become "guarded" and tend not to share their feelings and needs for fear of further intrusion and loss of privacy.

This experience is similar to that observed in a recent survey by the California HealthCare Foundation which noted that increasingly patients and caregivers are withholding or distorting clinical data in order to protect the privacy of sensitive medical information. According to a recent editorial discussing this survey, "privacy of medical records is not only a moral priority but a medical necessity." See "Medical Privacy Cannot Wait", The Los Angeles Times, May 10, 1999.

Diversion of funds to administrative costs

HCFA also seems to grossly underestimate the operational and financial burden that OASIS imposes on home health agencies that participate in the Medicare program. In the preamble to the final regulation, HCFA states that, "after the initial learning curve, OASIS data collection on an ongoing basis poses no additional burden above an HHA's routine patient assessment." 64 Fed. Reg. 3782. It defies belief that a 30-foot form with 450 pieces of information to collect, computerize and report would not pose a significant burden for patients and home health agencies.

In fact, that is precisely what the HCFA contractor administering the pilot program found. Two other "common implementation issues" noted by the contractor were:

1. "Incorporating the OASIS+ items into day to day operations was a major challenge for many HHAs."
2. "Finding the time for the OASIS+ assessment was an important staff concern. The range of additional time reported to complete an initial OASIS+ ranged from a low of 20 minutes to a high of 60 minutes."

See Abt Interim Report at viii.

Further, HCFA concludes that Medicare certified agencies will incur a one time "start up cost" for collecting OASIS data of $33 million in fiscal years 1999 and 2000 as well as start up costs of $11.4 million for data reporting. 64 Fed. Reg. 3760, 3782. HHAs will incur additional ongoing costs of data reporting of $22 million per year or $110 million over the next five years. 64 Fed. Reg. 3760. HCFA also estimates that 70% of home health agencies will receive no Medicare reimbursement for these additional costs because they are at or above their per beneficiary limit under the interim payment system. 64 Fed. Reg. 3776.

Information released by the Congressional Budget Office on March 12, 1999 shows that Medicare spending on home health services declined an incredible 15% in fiscal year 1998 alone. Accordingly, many home health agencies no longer have the funds or staff to implement OASIS. In addition, the funding and resources necessary to implement OASIS will be diverted from direct patient care.

Home health agencies that participate in Medicare will be placed at a further disadvantage because they will be forced to incur unreimburseable costs that non-Medicare agencies will not have to incur. Non-Medicare patients will find it more desirable to be treated by agencies that do not participate in Medicare because they will not have to relinquish their medical privacy to receive services from such agencies.

This problem will become much worse by October 1, 2000 when Medicare reimbursement to certified agencies is due to be reduced another 15% under section 4601(e) of BBA '97.

Conclusion

We do not oppose the implementation of OASIS to the extent that it is needed for quality care improvement or to develop a prospective payment system. However, we do oppose any data collection effort that reduces or eliminates the effectiveness of necessary medical services. Accordingly, we urge HCFA to:

1. suspend collection of OASIS data from non-Medicare patients;
2. narrow the OASIS data set down to just the core data that are absolutely essential for the establishment of a case mix adjuster for prospective payment; and
3. collect this narrowed scope of data in a non-identifiable form or in some other manner that does not force patients to choose between necessary health care and their right to medical privacy.
4. reimburse home health agencies for the costs associated with OASIS implementation.

Such an approach should be in the best interest of HCFA as well as the public for the following reasons:

1. it will enhance HCFA's ability to meet the "ambitious" statutory schedule for implementation of prospective payment by October 1, 2000.
2. it will minimize the Y2K computer problems that are likely to arise for HCFA and the health care industry on January 1, 2000.
3. It will give Congress a chance to establish statutory privacy standards which it is required to do by August 21, 1999, and it will minimize the cost and disruption that may occur if OASIS data reporting requirements are inconsistent with the new statutory privacy standards.

Thank you for your interest in working to protect patient privacy and preserve quality care in home health services. I appreciate this opportunity to testify, and I will be happy to answer any questions the committee may have.

Attachment

HOME HEALTH SERVICES & STAFFING ASSOCIATION

HHS&SA
Established in 1978

May 17, 1999

Ms. Allison Eydt
Office of Information and Regulatory Affairs
Office of Management and Budget
Room 10235
New Executive Office Building
Washington D.C. 20503

Dear Allison:

Thank you for meeting with members from the Home Health Services & Staffing Association on Wednesday, April 28, to discuss the OASIS project for home health services. As requested, the following information provides further details of the impact on both patients and providers.

The Home Health Services and Staffing Association, a national trade association representing over 1,500 home health providers in 48 states, appreciates this opportunity to work with you to modify the current OASIS project. HHSSA strongly supports the development of an outcomes measurement tool for all Medicare home health patients. The association urges OMB, HCFA and Congress to carefully review the current OASIS regulations and work with our association to ensure confidentiality of personal patient information. The new regulations should also address the burden placed on home health agencies to comply with the new requirements. As home health agencies place financial funding and valuable staff resources towards the OASIS project, it should be noted that this is funding and resources taken from direct patient care. Therefore, it is crucial that the new requirements require valuable and needed data collection while at the same time preserving quality home health services.

OPERATIONAL ISSUES:

Operational issues related to the multiple aspects of the OASIS implementation requirements have been several, affecting multiple facets of home health agency functions and day-to-day operations. These regulations severely impact personnel efficiencies and retention, patient and provider caregiver relationships, and administrative functions relative to the data collection and reporting of the required information. Additionally, the actual costs of implementation have been highly underestimated and there are no validation activities initiated by HCFA to verify the actual cost impact of the regulations.

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Of major concern to agencies are the issues of the complexity of the collection of nonessential data, data entry/encoding demands, time constraints and restrictions, and a lack of adequate reimbursement for associated costs. Additional costs for OASIS implementation impact all home health agencies, regardless of size, and may provide additional, non-reimbursed costs anywhere from tens of thousands to hundreds of thousands annually. Agencies also have significant start-up costs. These additional costs have been placed on an industry severely crippled by the drastic Medicare cuts from 1997. Every dollar and staff time devoted to new regulations and paperwork are important resources taken directly from patient care.

In comments provided by HCFA, the governmental agency predicted that approximately $33 million would be required in start-up costs for OASIS by all home health agencies. HHSSA strongly believes that this estimate is underestimated. HCFA continues to state that 70% of all home health agencies will not be reimbursed by Medicare because the agencies will be over their per-beneficiary limit. As a result, few - if any - home health agencies will receive additional funding for the costs associated with OASIS. Again, financial funding for this project diverts revenue to serve the sickest Medicare beneficiaries. These objections are in no way to be construed as an industry opposition toward collection of outcome data, but as an attempt to assure meaningful data collection, reporting and outcome evaluation that exist within an environment of efficiency and reasonableness in relation to care planning and patient rights of privacy and confidentiality.

PRIVACY CONCERNS:

OASIS collection was required of home health agencies from February, 1999 to April, 1999 and has provided home health agencies with patient input for two months. The concerns expressed by numerous patients relate to privacy issues. Most patients feel that there are certain OASIS questions that are irrelevant to the planning of the care. They question and reject vehemently to the transmission of such information to the federal government for collection in a national data base. The collection and disclosure of some of this information in a fully identifiable form has been viewed as an invasion of privacy. Because patients are compelled to provide this information in order that they may receive necessary care and service, they are faced with dilemmas of refusing to provide information and obtain no care or relinquish their rights of privacy in order to secure care and treatment. The mandated assessment, in essence, now supercedes any medical judgement by a physician for the need of care to a patient. By requiring that all information is provided or the patient should not be treated, the OASIS tool supercedes the physician's assessment of needed home health services.

The OASIS tool has over 79 questions that must be answered prior to the patient receiving medical treatment. The numerous questions are asked regardless of the relevance to the assessment for the patient in a Medicare-certified agency. One of the primary goals of the OASIS project is data-collection to help modify a prospective payment system for Medicare home health services. A core group of questions - approximately twenty questions - are essential for the prospective payment system. Some of the codes that are most important include: grooming (M0640); dressing upper and lower body (M0650,0660); bathing (M0670); toileting (M0680); transferring (M0690); ambulation (M0700); pain during activity (M420); status of surgical wounds (M488); dyspnea (M0490); urinary incontinence (M0420); bowel incontenance (M0540); patient receiving parenteral therapy; and, particular diagnoses. The over seventy questions should be modified to the questions most needed by HCFA for a prospective payment system.

In order for patients to receive care from a home health agency, they are compelled to answer all questions or provide information for the RN or other appropriate health professional to make an assessment for a response. In situations where the patient refuses to answer certain questions, there is a great potential for the assessing professional to be tempted to enter data on their own to assure that the patient does not go without care. This scenario poses significant threat that the integrity of the data with which HCFA intends to evaluate outcomes will be skewed. In fact, for the two months that OASIS collection was required, nurses stated that they would answer questions for the patients to ensure proper medical treatment More importantly, data submitted will skew HCFA's ability to tweak the home health prospective payment system. It is critical that information provided to the federal government be as accurate as possible.

Home health care organizations have, for years, conducted comprehensive assessments to assist them in developing effective care plans for intervention. If a patient objects to answering certain questions or offering information, the patient is not compelled to provide the data in order to receive care, as long as the information is not critical to the care and treatment of the patient's condition. The OASIS requirement precludes agencies and health care professionals from using their expertise and judgement in determining the critical nature of information for the patient's overall care plan.

Non-Medicare patients (e.g., those receiving hourly/shift care, or visits for skilled or non-skilled care which are reimbursed by private funds, insurance of other third party payors) strongly object to the requirement of mandatory data collection and reporting to the federal government. This requirement then places an additional obstacle to the Medicare Certified agency as the "private pay" patient chooses to go to another "non-certified" agency where the OASIS requirements do not apply to them.

The assessment is a critical part of the establishment of the "nurse-patient" relationship. It enables the clinician to formulate a plan with the physician to treat and manage a condition. Assessment allows for the planning for maintenance care and management and evaluation of the care plan for custodial patients. In all settings, member agencies have found that the OASIS requirements are intrusive and threatening and restrict the relationship building activities so necessary to effective care planning, intervention and treatment. Patients become "guarded" and tend not to share their feelings and needs for fear of further intrusion and loss of privacy.

Member agencies have identified other significant operational challenges associated with the OASIS regulations and subsequent implementation. These relate to time spent performing the integrated comprehensive assessment which includes the OASIS data elements and the other additional assessments at specific time points for reassessment, transfer to an inpatient facility, resumption of care and discharge from service. Major difficulties have been encountered securing assessment information within the mandated time frames for reassessment (5 days before the 2-month anniversary of the certification period). Because of the time constraints, agencies have found that additional nursing visits must be performed without reimbursement possibility in order to meet time requirements. Agencies report that additional time of ½ to 1 hour is required for completion of the OASIS integrated assessments. Additional time burdens are experienced on reassessments and "resumption of care" assessments.

Member agencies cite the standard by managed care organizations who authorize social workers and others to assess the patient psychologically and the context of the home environment on the patient. However, the current OASIS project requires a nurse to perform this evaluation--an evaluation that the nurse can only surmise for a physician's diagnosis but cannot, nor should not, be used as a diagnosis of the patient. This includes questions regarding whether or not the patient has been suicidal - a question not needed for Medicare home health service treatment. These nurse visits are additional and are required without any additional reimbursement.

The OASIS project has so thoroughly reorganized an agency's schedule and that of its staff. One example has been the new requirement for the seven-day lock. Prior to OASIS, nurses had the ability to visit patients and, in most states, only go to the agency once a week. Documentation would be provided at that time and would meet the requirement for the doctor's orders. Due to the seven-day lock, nurses are now required to be at the office every two days to meet the requirement. Additional time spent away from the direct care to the patient which begs the question: will additional and burdensome requirements and paperwork increase or significantly decrease the quality of care to the patients?

Since the implementation of the OASIS project, member agencies have documented a significant trend by home health nurses and physical therapists to exit the home health program. Nurses and physical therapists cite as their number one reason the additional time spent on documentation and the lack of interaction with the patients. Home health services have been highly regarded for the personal and direct patient care by caring professional staff.

Home health services should be preserved for its cost-effective and personal service provided to patients in their own homes.

TECHNOLOGICAL ISSUES:

Problems with the HAVEN software have arisen relative to the time for data entering within the time frames allowed. In larger agencies, data entry access is limited to one person per agency at a time. This poses a problem for meeting the volume demands. Additionally, the HAVEN software precludes data entry of the same patient twice under two payor sources (e.g., Managed care—skilled care and private pay home health aide with different beginning and ending dates and some overlap.) The agencies must discharge and readmit in order to accommodate the "software." The data collection and encoding guidelines do not frequently allow for long time agency operations which meet individual state "waiver" program compliance requirements. Agencies are having to alter previously approved processes for Medicaid waiver programs to meet Medicare requirements.

A significant concern of many agencies revolves around the anticipated data analysis of their agency "outcomes." Certified agencies that perform a large amount of "continuous or hourly" care to the chronically ill or custodial patients believe that "outcomes" will be skewed when compared with the data for "intermittent visit" patient related care. This is especially true for patients who may be quadriplegic or ventilator dependent and whose ADLs and IADLs will never improve because of their inability due to injury/condition. Agencies believe that this type of data analysis will result in a situation of "comparing apples to oranges." Likewise, collection of information on hourly private duty nurses and home health aide services <u>only</u> should not be collected. These services do not relate to the Medicare program and will compromise the data collection.

A related and important concern has been the various interpretations by the fifty states. One example was a State Agency representative in North Carolina who informed home health agencies that no OASIS data should be collected on private pay patients. Different interpretations of the regulations provide a different requirement in every state, and result in further confusion by agencies. Even HCFA central staffers have differed on their understanding of the OASIS project. Agencies are left with a lot of unanswered questions and no clear guidelines to follow.

HCFA has not provided a clear indication as to when home health agencies will receive the first reports back regarding their own agency's information or a comparison report of their agency compared to other agencies in their area. The earliest time that has been stated is as long as one year until feedback is provided to a home health agency on its own data.

Agencies have experienced major increases in overall costs attributable to training and education of staff, design of integrated assessment tools that incorporate the OASIS data sets, printing of voluminous quantities of forms never before used, hardware and software costs, and costs for data entry staff to assure timeliness and encoding of data. Other expenses incurred are for additional time and mileage for nurses to come into the office to drop off paperwork for meeting tight data entry deadlines; additional staff to monitor and "QA" forms before data entry and to monitor reports after encoding; additional storage space for forms and records; phone costs for transmission time; and administrative time for trouble shooting and answering questions. Once again, no additional Medicare dollars have been provided for the increase in expenditures by agencies—negatively impacting home health care to the patients.

It is the consensus of the home health industry that while "outcomes evaluation" is important, more than adequate information can be obtained if the following modifications were made in relation to the OASIS initiative:

1. **OASIS data collection and reporting should apply to Medicare patients only.**
2. **All patient data should be reported with no patient identifiers attached (privacy issues must be respected).**
3. **Reduce the "data set" to the core group of questions that will be critical in establishing a prospective payment system.**

The Home Health Services & Staffing Association will be pleased to provide you with additional information upon request. Thank you for your interest in working to protect the patient's privacy and preserving quality care in home health services.

Sincerely,

Pam Wendt
Chair, HHSSA's Special Clinical Committee

Mara Benner
HHSSA's Executive Director

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The CHAIRMAN. Dr. Taler.

STATEMENT OF DR. GEORGE TALER, PRESIDENT, AMERICAN ACADEMY OF HOME CARE PHYSICIANS, BALTIMORE, MD

Dr. TALER. Good afternoon. I am Dr. George Taler. Senator Grassley, members of the committee and panel, thank you for the opportunity to share with you the thoughts and opinions of the American Academy of Home Care Physicians. We are a not-for-profit organization of over 600 physicians and other health care professionals dedicated to promoting the art, science and practice of medicine in the home.

I would like to present our support for the implementation of OASIS from three perspectives—that of a primary care physician, a physician executive, and as a researcher in health services delivery.

As a practicing physician, I have both immediate and long range concerns. I want to be sure that all the issues likely to affect the outcome of my patients' care have been identified and that the plan of care addresses each concern. I want to have information that I can use to tell if I am on the right track, that my patient is getting better, or especially, to alert me if he or she is getting worse. OASIS is designed to do just that.

Second, I want some objective way to judge how well the home health agency is doing its job. IPS has created a very strong incentive to cut services, and not all home care agencies are good at everything—unlike we physicians. However, OASIS provides a means for benchmarking agency performance that would be very helpful for the practicing physician.

Third—and here, I will be quite candid—I do what I do and the agencies do what they do largely because we think it is the right thing to do. There is very little if any science. There is currently no measure of quality. By that, I mean that what we do actually improves the rate of recuperation, relieves symptoms, restores functional independence, and promotes happiness and well-being faster than without these things. OASIS gives me the opportunity through outcomes-based research to learn what are the best approaches when using medications, nursing care, therapies, counseling, assistive equipment and supportive services in the care of the homebound patient.

Before I segue into research, let me talk a little bit about the administrative concerns. I have three points here as well. First, nurses perform a comprehensive assessment with each case. The domains are similar, but the questions are highly idiosyncratic, have not been tested for inter- and intra-rater reliability, and there is no readily available way to compare information among agencies. If OASIS elements were to be incorporated as the backbone of every agency's forms, there would be better reliability, greater consistency of information across agencies, less variability among home care agency assessments, a framework for comparing and amassing data, and far less training costs for agency personnel in the long run.

Second, the Academy fully appreciates the privacy issues. However, I must say that issues of mental health, caregiver support and living arrangements are crucial to our understanding of providing care at home. We have been assured that HCFA can satisfy the dictates of this law.

Third, we are concerned that the interim payment system has not been good for the home care industry as a whole. The payment criteria are capricious, and the patient limits have affected services to beneficiaries in an arbitrary manner. The prospective payment system proposed for implementation in October 2000 will level the field.

However, we have been very disturbed to hear of a proposal to use only those items from OASIS that have been found in the preliminary study to correlate best with the 80 reimbursement categories under PPS. We vehemently oppose this recommendation. Such a decision would totally eviscerate the outcomes analysis potential of OASIS and merely promote gaming of the data. Also, since our knowledge of what is important in defining the payment categories is likely to change with additional experience, using just a limited data set could eventually short-change the industry.

Now to the research perspective. As I mentioned earlier, OASIS is an outcomes assessment instrument and has tremendous potential for use in both clinical and operations research. It is also a very powerful tool for highlighting and decreasing regional variability in health services delivery, which will more readily expose fraud and abuse.

An issue important to the study of population health is the exclusion of non-Medicare patients. To my mind, the more data, the better your information, although I can envision some wiggle room on this topic.

Finally, although we are strongly in favor of implementing OASIS, the Academy is sensitive to the clinical and financial turmoil caused by IPS. Agencies face significant expenses when updating forms, increasing computer capacity, purchasing and revising software, and especially in staff training. There is no way to pass these costs on to the consumer, and IPS has left many agencies reeling.

On the other hand, IPS has created a windfall for the Government. I believe that you should find a way to give some of the money back to the agencies to cover the implementation costs of OASIS as a one-time payment.

In summary, OASIS gives me important feedback on my patients' progress and provides a means for recognizing the various strengths of agencies in the community. It allows researchers to use data from all agencies in the country for vital clinical and operations studies to advance the science of health care in the home. I think we need to strive to find a way to help home health agencies pay for the implementation of OASIS.

Thank you for your time and attention.

[The prepared statement of Dr. Taler follows:]

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United States Senate
Special Committee on Aging
May 24, 1999

Senator Charles Grassley, Chairman
Senator John Breaux, Ranking Member

G31 Dirksen Senate Office Building
Washington, DC 20510

Thank you for the opportunity to share with you the opinions of the American Academy of Home Care Physicians on the impending implementation of OASIS in the home care arena. Let me first tell you about the Academy. We are a not-for-profit organization of over 600 physicians and health care professionals dedicated to the art, science and practice of medicine in the home. Our membership includes primary care physicians and specialists, Medical Directors of home care agencies, teaching physicians, some forward-looking Directors of home care agencies, and others who see the value of physician participation in home care. A few of our members have been involved in the development of OASIS, which has given us a close-up view of the project, and many have been active in the practice of medicine in the nursing home where we experienced the implementation of the Minimum Data Set (MDS). From all of these perspectives, I can emphatically state that we have been awaiting OASIS with great anticipation, and strongly support this program as a fundamental step towards the future of health care delivery in this country.

The Clinical Perspective:

Let me begin from the viewpoint of a practicing physician. OASIS incorporates a broad array of factors essential to the understanding of the management of patients in this setting. The elements of the evaluation helps us assure that many important aspects of care have been addressed. In addition, there is a review of the functional status and supportive environment. This information is not likely to be a part of our office and hospital records, but is critical to the success of developing a global home-based medical care plan. Finally, data from OASIS provides a framework on which to "benchmark" our treatment strategies, both in terms of symptom control and health resource use.

However, two aspects of the clinical evaluation have emerged as controversial. First, OASIS gathers data on mental capacity, affective status and disruptive behaviors. Extrapolating from epidemiological studies in nursing homes, it is estimated that over half of our homebound patients have psychiatric disturbances that affect their daily lives and that exacerbate the burdens of caregiving. Exclusion of this information wrongfully discriminates against the homebound patient, by undermining our ability to have reliable information on which to judge the effectiveness of our treatment for these conditions, merely because of setting. It is extremely helpful to be alerted to potential problems with decision making, should we be faced with bioethical dilemmas and issues of end-of-life care. The second aspect is gathering data concerning the home and family. Information about the environs helps to guide the prescription for durable medical equipment and assistive devices. An assessment of the abilities and willingness of the caregiver, directs the educational component of the medical care plan and the referral for community-based supportive care. These components of OASIS are pivotal to our understanding of the entire enterprise of providing and coordinating services in the home.

We agree that the recently raised issues about patient privacy have legitimacy, especially when obtaining, compiling and transmitting data of a psychiatric nature, and about the family and home. Our residual concerns are with the security and the potential for unintended use of this information. We urge HCFA to promptly address and resolve any remaining problems so as to minimally delay the timetable toward implementation. In the interim, home care agencies should be strongly encouraged to collect OASIS data and begin the development of internal quality assurance processes.

The Administrative Perspective:

OASIS provides the first opportunity for industry-wide accountability in the home health arena, providing a means for investigating regional variability in medical care plans, and establishing a foundation for an equitable reimbursement system, as mandated by the Balanced Budget Amendment of 1997. The Interim Payment System (IPS) is broadly acknowledged as unfair. The Academy supports the establishment of a level field of competition as proposed through the implementation of the Prospective Payment System (PPS), which is dependent on OASIS data. The earlier that OASIS can be put into effect, the earlier we can move to a stable marketplace.

The fundamental purpose of OASIS is to provide a unified approach to quality improvement. Several Outcome-Based Quality Improvement (OBQI) studies in home care agencies under the auspices of the University of Colorado have demonstrated that OASIS data can be used to significantly affect the outcomes of care. In two large studies including over 100 agencies in 26 states, agencies were able to significantly reduce hospitalization rates among their patients. Individual agencies have also been able to improved outcomes on a variety of parameters, including functional, clinical and mental health measures. When eventually combined with cost data, the OBQI process is expected to have a profound effect on our ability to define cost effective clinical strategies that are unique to this setting. When care migrates towards a center of accepted clinical approaches, it is easier to recognize advances in our methods of health care delivery, to plan for future expenditures, and to identify fraud and abuse.

There are two administrative challenges that must be addressed before the full advantage of OASIS can be realized. The first is the costs to the agencies of implementing the OASIS program. Although there are 89 elements (which may seem a lot on cursory view), nearly all of the OASIS data items can replace analogous but less precise information that is already gathered, and can be readily incorporated into agency assessment forms. However, there is a considerable "learning curve" if the data is to be gathered reliably and completely, and the training costs are likely to be substantial. In addition, few agencies are positioned to absorb the costs for information system revision, and staff work associated with data collection, tracking, editing, computerization, and transmission of patient-level OASIS data. Creating a data management infrastructure is crucial on several levels. If agencies endure the cost of gathering OASIS data and HCFA cannot receive and process the data, there will follow a rapid loss of commitment and a decline in data quality. Finally, selected OASIS items are to be used to drive reimbursements, so efficient handling of OASIS data must be fully operational before the PPS can go into effect as planned in 2001.

The bottom line is that agencies truly need and would benefit from help with the cost of implementing OASIS. Major start-up and some steady-state expenses occur with any major transition like OASIS implementation. The proposed reimbursement is likely to be well below the initial costs to the agencies — and possibly below sustaining costs. We strongly recommend that HCFA consider a higher rate of remuneration in the first year of implementation, with adjustment to a base rate reflective of independently conducted time-analysis studies done in the field. Congress and HCFA could return some of the unexpectedly large savings already gained from the profound dampening effects of the IPS on home health care to help the agencies support the transition to OASIS and PPS. Removing the planned 15 percent reduction currently scheduled for 2000 and initiating some form of cash-flow support for implementation of PPS would also be a welcome respite.

The Academic Perspective:

We anticipate that OASIS data will also provide a basis for improving patient care and defining "best practices" in the community, by helping us discover what are the most cost-effective and efficient approaches to restoring health, or helping patients and their family cope with illness and disability. Much important information is emerging from the nursing home industry as the result of the implementation of the Minimum Data Set. Similarly, we expect that care for the homebound will improve through clinical trials using the OASIS as the standard tool for measuring change over time and across agencies throughout the country. In addition, the components included in OASIS have been carefully selected to sample the essential elements and relationships that are not only unique to care in the home, but also pertain to long term care in general. This information allows research comparing the various settings for care, and ultimately to more informed choices for patients, their families and health care professionals.

One of the proposed solutions to the costs of implementation is to limit data collection to only those items needed for PPS. This recommendation should be vehemently opposed. First, OASIS is the result of years of study, distilling only those items that contribute to the evaluation of clinical outcomes and resource utilization. Its power is not in its parts, but in the ability of the whole to accurately measure change over time. Disassembled, the entire effort to improve the care of the homebound is rendered useless. This would be a grave disservice to Medicare beneficiaries everywhere. Furthermore, the 20-25 items identified at this time as delineating approximately 80 PPS groups for reimbursement were derived from a limited study, and experience is more than likely to expand the range of parameters on which payments are based. Focusing on a few items begs for gaming the system, and thereby undermines the value of these items for outcomes analysis. This option is a destructive short-term solution, very shortsighted, and should be abandoned.

In order to obtain the best information for guiding the future of health care delivery, it is important that we raise the issue of privacy for non-Medicare and non-Medicaid patients served by Medicare and Medicaid agencies. From a national health policy perspective, the more consolidated data that we have about health care needs and health care delivery the better we will be able to plan for the future. Many of the "non-Medicare patients are members of managed care organizations funded through Medicare, and these beneficiaries should not be excluded. The remaining should be allowed access to OASIS assessment, if not encouraged to participate, as a means for assuring that they are receiving appropriate care. There is also a regulatory issue in that the Medicare Conditions of Participation require that quality standards be met for all patients served by Medicare certified agencies. In a closely related example, these privacy concerns have not been an issue in nursing homes where MDS data is collected on all patients. Information drives decision-making. It would be ironic that we would have better information from a setting that all of us dread, than from the home and community that we all hope to be the setting for our own long term care. Moreover, it is important to know whether changes in the Medicare reimbursement system will affect the quality of care for patients in other programs. There is value in having case-mix and outcome data that cuts across payer categories, even for short stay patients. In fact, such analyses have already revealed possible quality problems as the number of visits drops.

Conclusions:

The American Academy of Home Care Physicians strongly encourages Congress to support the immediate implementation of OASIS throughout the home care industry. Once the privacy concerns and issues of data collection, transmission and processing have been addressed, data should be shared with the government oversight entities. In addition, we are sensitive to the costs of start-up, especially staff training and information services upgrades. These expenses should be borne by HCFA as a one-time administrative expense over the course of the first year, funded by the unexpected windfall from IPS. Finally, payments for ongoing expenses related to OASIS should be included in the reimbursement structure for home health agencies both through the current IPS, and subsequently through PPS.

George Taler, MD
President, American Academy of Home Care Physicians

The CHAIRMAN. Thank you, Dr. Taler, and I thank all of the panelists for being so timely in their statements. I appreciate it very much.

I am going to turn first to Senator Craig.

Senator CRAIG. Mr. Chairman, thank you, and to all the panelists, thank you very much for your insight, or at least for your observations.

Ms. Kail, you mentioned the effects of OASIS on State-funded services not paid by Medicare, such as homemaker services. Is your agency curtailing such services due to OASIS burdens?

Ms. KAIL. Yes. The effect of OASIS on those privately paid services, State-funded services, and locally funded services, is that as the administrative costs go up, the amount of money available for services is shrinking. We have not denied anyone from services yet, but we have had to curtail some services and try to ration, if you will, the amount of care that we provide to those who would seek out our agency for services.

We are a sole community provider in that there are no other agencies within a 30-mile radius of our agency.

Senator CRAIG. Thank you.

Ms. Wright, you have been living with OASIS for several years, and you made it clear that it has benefited your agency. But you also argue that HCFA has badly underestimated the costs of OASIS for agencies. During the time of the demonstration, have you made HCFA aware of this, and if so, how did they respond?

Ms. WRIGHT. We have not made them directly aware of it. We were fortunate enough to implement this before IPS, so it was not so much of an issue for us. But if we had to implement OASIS now under IPS, we would not be able to have spent the $77,000 it cost us to do that.

Senator CRAIG. Dr. Conlin, I thank you for your comments.

Let me turn to Dr. Shaughnessy. I will tell you, Doctor, that my first reaction to your remarks was the creator of the system defending the system—and I do not mean that critically; that is just how I reacted. "This is my baby, and I am not going to say it is doing anything wrong; we just have to have this information."

You explained why the home health care agency can benefit from the OASIS data, but why does HCFA need patient-identifiable information on Medicare and Medicaid patients?

Dr. SHAUGHNESSY. Patient-identifiable information on Medicare patients is one issue. Non-Medicare is another. Patient-identifiable information on Medicare patients is needed because, simply as a payer, HCFA has to make certain that the services that it is paying for, number one, are provided, and, number two, are appropriate. Any payer whatsoever, including any commercial insurer, requires the same information. And——

Senator CRAIG. Ms. Kail has suggested tracking numbers, or numbers to track by, instead of all of this. Why couldn't we do that? Why wouldn't that make sense?

Dr. SHAUGHNESSY. In the case of HCFA, you also have claims data. The claims data constitute one set of information reflecting the dollars that are paid for services, and OASIS is another set of information on patient characteristics. It often is necessary to link patient characteristics with dollars paid, and right now, the only way to do that is with patient-identifiable information. Again, I know of no insurance companies that do anything other than this to link such data.

In terms of non-Medicare/non-Medicaid patients, HCFA has several applications of these data. One important application is the generation of outcome reports for home care agencies. This would not necessarily require patient-identifiable information on non-Medicare patients. Data on non-Medicare patients, as I was discussing earlier, is needed to assess the impacts of prospective payment on such patients. This is important. HCFA need not have patient names transmitted with such data to the national level. There are various ways this can be done for non-Medicare/non-Medicaid patients.

I do want to say something, though, on your first comment if I might, that I am here defending OASIS, if you will, as its creator or the father. If this had not worked, if this were not worth it over the past 15 years, and it had not become better and better on behalf of health care and on behalf of patients, I would not be here today.

Senator CRAIG. I appreciate you saying that. I am only telling you about my personal reaction. I cannot argue with the numbers, but I can argue with is there a better or a different way of getting at those numbers or causing that kind of an impact to the system created.

Dr. SHAUGHNESSY. If there is, it exceeds what we have spent 15 years trying to develop as best we could for home care. Our staff has studied home care from multiple perspectives for a considerable period of time. In much of what we did over the course of time, there were false starts, and then we would go another way. So this has been an interative process that has really reached the point where we feel it is extremely useful. And as you know, the agencies that have participated in this demonstration program—I would refer to Attachment A of my written testimony in that regard—are extremely supportive.

Could I just say one more thing about forms, 30 feet of them, and 450 items and so on?

Senator CRAIG. You start doing that, and I will start talking about the Paperwork Reduction Act by Congress.

Dr. SHAUGHNESSY. All right.

The CHAIRMAN. You may proceed.

Dr. SHAUGHNESSY. Thank you. I have one form in my hand which is approximately 10 pages that incorporates OASIS items into it. This is a comprehensive assessment form used by many homecare agencies, and it includes not only OASIS items but many others needed for assessment. For all this talk about multiple forms, when people integrate them the way they should be integrated—the time spent is illustrated in chart 2, and this was a fairly comprehensive time study—it is nowhere near the problem that we are hearing here today. For the most part, those people who are voicing concerns about burden of data collection and forms are people who have not used OASIS for several months or a year. They are people who are looking at it and giving us their gut reactions. When OASIS items are properly integrated into an assessment, these kinds of problems are minimized.

The CHAIRMAN. Are you telling us that you have what started out as an 18-page form down to a 10-page form that will give the information to HCFA?

Dr. SHAUGHNESSY. Yes, and it contains many items in addition to OASIS.

The CHAIRMAN. Well, then, why isn't HCFA using a 10-page form?

Dr. SHAUGHNESSY. It is simply a case of how you format it. *The Federal Register* we presented OASIS items in large type and an easy-to-read format that you rarely see in clinical records. This was for the benefit of people to incorporate these items into their word processing systems, change their agency forms and so on, and then condense them down.

The CHAIRMAN. I will give you more time, but can I follow up on that—are you talking just about the initial form, or all the follow-up forms?

Dr. SHAUGHNESSY. Well, the follow-up forms are exactly the same as the first form, with very, very minor changes. That is important to know.

There is a data requirement to collect the data at follow-up for two reasons. One, it is part of the comprehensive assessment that HCFA has required. The judgment has been made that comprehensive assessments are needed every so often. From clinical and quality perspectives this is worthwhile. The other reason to collect follow up data is that in order to measure outcomes, you have to measure change at multiple points in time, and therefore you need such information.

Again, experienced agencies have not found it to be any more excessive, typically, than what they have done at start of care and at discharge. I believe there is considerable confusion surrounding this on the part of people who have not implemented OASIS not integrated it or not used it properly.

Senator CRAIG. That is why we are here today, because there is confusion.

Can I ask two quick questions, Mr. Chairman?

The CHAIRMAN. Yes, you may, and while you are asking those questions, I am going to ask anyone else who wishes to respond to this, but I want to give Senator Craig time, because he has to leave at 2 o'clock.

So please go ahead.

Senator CRAIG. Thank you, Mr. Chairman.

I want to go to Dr. Taler, who used two terms that might reflect on shortening the form, or shaping the form. You used the phrase "wiggle room" pertaining to non-Medicare users of home care services. In the context of responding to that, would you also respond to what you mean by benchmarking agency performance measures?

Dr. TALER. On "wiggle room"—

Senator CRAIG. If we can find enough, we can get it down to 5 pages.

Dr. TALER. Actually, by "wiggle room," I mean the scope of the patient population that is assessed, not the assessment itself.

Senator CRAIG. I appreciate that. I thought that that was what you were after.

Dr. TALER. I think there are probably three categories of non-Medicare patients that we need to look at. One is the group of Medicare patients who are covered by "other" insurance, specifically, HMOs. I think that those are still Medicare dollars, and those patients are still Medicare patients even though there is a veil of the intermediary in there. There is also other medical insurance that is non-Medicare, such as CHAMPUS, but those patients also are under a health insurance format, and the thing that they have in common is that they have been referred to home care by a health care professional. I think that under those circumstances, we really need to look at are they getting the services that they need, and are those services effective.

There is a large group of patients who have taken their own initiative for purchasing services that they feel they want, and those patients are not referred by health care practitioners. Under those circumstances, I do not think that that data is of very much value, and I would propose that those people be excluded from having to complete the OASIS forms and that the services be provided to them as they are willing to purchase them.

On the second issue of benchmarking, when we look at our success in decreasing resource utilization and in improving function, that information sets a level of expectation, and we can look around the country at which agencies have performed the best and then look at what those agencies have done in terms of the processes and staffing, and those become in essence the targets for all other agencies to use. It allows us to look at different ways of providing these services using different personnel and approaches to find the best, most cost-effective means. Unless we use outcomes data, we really do not know what works best.

Senator CRAIG. Thank you all.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Craig, and I thank Senator Bryan for coming as well, if only briefly.

Senator Bryan. Thank you, Mr. Chairman.

The CHAIRMAN. I would like to go back to the point that I just made and get any or all of your reaction to Dr. Shaughnessy's response to Senator Craig's and my question.

Ms. Kail.

Ms. KAIL. As I look at the 10-page questionnaire—and I am looking at it down the table—it looks like it is about a size 8 font. Most of the nurses in my agency are at bifocal stage, and I am not sure of the practicality of that.

HCFA does not provide the forms. HCFA tells us we cannot change the structure of the data items in terms of changing a comma, a period, or anything like that. We can incorporate the data items into paper systems or computer systems. However, as Ms. Wright indicated earlier, if those systems were not in place before the interim payment system took effect, the agencies are feeling that they are not able to afford for that kind of software and hardware implementation to make the job a little easier.

So we are correct in saying that the interim payment system has compounded the issue. In addition to the data items that are needed for the OASIS tool, there are other things that we have to assess as professionals that need to be in our startup care or our assessment process. Those of us who are JCAHO-accredited have to ensure that all the JCAHO pieces for assessment are incorporated into that tool.

In addition, in Iowa, as Dr. Conlin mentioned, we have been trying very hard to put two tools together—the OASIS and the tool that we use in our elderly case management project, or Title 19 elderly waiver project. We tried to integrate those documents and I do not see, even with a size 8 font, that we are going to be able to limit that to under 15 pages.

The CHAIRMAN. Ms. Wright. I will just go across from left to right.

Ms. WRIGHT. I have a couple of comments. The first is the actual time required to do the assessment. We did find out, once we were through the learning curve for the nurse, that our assessment time did not significantly increase.

The difference is, again, we were under regular cost-based reimbursement, and we were able to take a much longer time to get that integrated into our system. We have several different branch offices, and we started out with just a few at a time and got them up to speed, and then we brought a few more on and brought them up to speed, and it took us quite a bit longer than HCFA is estimating. They are saying it takes about five admissions for the nurse. We are finding that it takes more like 20 admissions per nurse before they have gotten through the tool and they know the tool well enough to get through it in about the same amount of time. So it takes much longer than HCFA is estimating it will take.

I would also like to comment on the length of the form. We did integrate our assessment into the form, and it is somewhat longer with the pieces that we needed to put in that are not included in the OASIS tool.

I think the point that makes it so much longer for us is that we were used to more of a narrative, so it asked a question, and we jotted down a few notes about the assessment. The OASIS tool is more of a check-off box, and again, once the nurses learn and get through that learning curve, they are much more able to get through those check-offs quickly, as opposed to writing things down, but it does make the form a lot longer.

We completely computerized our forms. I do not know how we would possibly be able to do the same system on paper and then have to turn around and have somebody input the data. We did that for about 6 months at the beginning of the demonstration project and decided at that point that we could not bring on the rest of our offices doing it that way; it would have taken several full-time people just to sit down and put the data in our computer. So we computerized it, which again is an additional cost to be able to do that.

The CHAIRMAN. Dr. Conlin, do you want to speak to this point?

Ms. CONLIN. I think it has been spoken to very well. Thank you.

The CHAIRMAN. Mr. Pyles.

Mr. PYLES. Yes, if I could, since I made the reference to the 30 feet of documents. The 30-foot-long document is the one that was published by HCFA in the Federal Register and is the one that was being used by most home health agencies around the country at the time the data collection requirement went into effect.

I did not bring the data collection document that one of my clients sent me, which as the lady down the table said, incorporated other information that the agency had to have—that is 40 feet long and probably would not fit in this room. So I tried to keep this really just to the minimum that was in the Federal Register.

But I think there is an important point here. One thing I have learned in the privacy debate is that often what the patient wants gets lost. I think we have to remember who this program is for. It is not for HCFA, it is not for home health agencies. It is for patients.

What we have seen in the 2 months that this data collection effort was underway is that patients really object to this. They do not like it. They do not want to give out this kind of information. They are sick, they are tired, and they do not want to give this information.

I think one of the biggest problems we saw with it was that the patients were being presented with the choice of give up your right to privacy or give up your care. And that was happening even for non-Medicare patients who could only obtain services under an HMO from a Medicare-certified home health agency. They were being deprived of their right to privacy as well. They had to give up their coverage or give up their right to privacy.

I guess I would also point out that the experience we had over the 2-month period was not isolated. Abt Associates did a review of an OASIS pilot project, as I understand it, and they said, and I quote: "It is sometimes not the staff who resist the OASIS form but the patients. Several patients tired of the long assessment quickly and refused to answer any remaining questions. Some patients were also reluctant to answer background questions on finances, schooling, and so on."

This was a report that was given to HCFA in December of last year. We also find the Abt Associates noting that "Incorporating OASIS into the day-to-day operation was a major challenge for many home health agencies. Finding the time for OASIS assessment was an important staff concern. The range of additional time reported to complete an initial OASIS ranged from a low of 20 minutes to a high of 60 minutes."

We may be talking about forms of different lengths, we may be talking about different kinds of information, but the net effect here is that this was implemented in a way that deprived patients of access and even deprived the Government of reliable information.

The CHAIRMAN. Ms. Kail—and I am going to direct these questions to specific panelists, but if anyone else wants to respond or rebut, that is OK as well—what has HCFA told you to do with non-Medicare patients who refuse to answer OASIS questions? Is it your understanding that these people would be barred from home health services, and how would you explain this situation to people who are paying on their own?

Ms. KAIL. Our instructions were that if a patient did not participate in the OASIS data collection system, we were not to provide services to that patient. We have only had one patient to date who has refused care due to the OASIS data collection, and we referred him to some private people in our community to provide services for him. Those were nonskilled services, but they were able to get some shopping, home maintenance, laundry and those kinds of services in the community.

The CHAIRMAN. Under the rules, if you were not to ask the questions of a private-pay person, then the club that HCFA has is that you would not be certified to give any Medicare services—is that the leverage that they have on you?

Ms. KAIL. The leverage comes through our conditions of participation, and when they do the Medicare surveys, we would be cited with deficiencies.

The CHAIRMAN. You said you only had one person who refused. What was the reaction of that person?

Ms. KAIL. The person was an elderly person, and there was not as much reaction from him as from his children, who were very upset about not being able to get services. And again, we are the only agency in town, so for medical needs, they were looking at getting some wound care services through the emergency room.

The CHAIRMAN. Are there any other comments from anybody else?

Yes, Dr. Shaughnessy.

Dr. SHAUGHNESSY. In terms of patient refusal, it is important to step back and take a look at what the clinical aspects of this are. A care provider is responsible for obtaining information during a patient assessment not necessarily by interview, but by observation, examination, perhaps by assessing the home environment and the like—in order to plan for and provide care that is beneficial to the patient. Therefore, if information cannot be obtained from a patient or through other means, and if the patient refuses to provide certain critical information, a provider really does not have much choice but to refuse care if the information is essential to properly plan and provide care to the patient. For the most part, providers can, through gentle and considerate discussion or other means, obtain the needed information. So it is important to step back and understand the clinical side of this issue, and be aware that refusals rarely occur.

If I might, you mentioned rebuttals, and I would very much like to go back one question if I could, because there are a few other issues here. First of all, when one is talking about what is right and what is wrong with OASIS, you can glean a certain amount from reading through the items. But in terms of estimating the burden of time to collect data, and in terms of determining what is right and wrong with OASIS at the agency level, it is important that an agency have at least 3 or 4 months' experience. A lot of what we have heard in the form of complaints and what we are hearing here is from folks who have not had that much time.

In the demonstration programs and other voluntary programs we have been associated with, over 200,000 patients have participated in outcome enhancement using OASIS, and we have had virtually no patient refusals, no patient concerns of the type we are hearing about here, with some minor exceptions.

In terms of the Abt study that Mr. Pyles was talking about, that is an invalid study to cite, because they did not integrate OASIS into their clinical records. They simply added it on, and there was duplication of items. Therefore, you would expect more time to be spent. That was a study that was not a demonstration study for OASIS. It was for other purposes.

There is reference to OASIS as an instrument. OASIS is not an instrument. It is a data set of items to integrate into a clinical record. This unformatted data set of 17 to 19 pages, when integrated into a clinical record, is reformatted, and accompanied by and interspersed with other items such as additional assessment items. The 10 page form, or its equivalent, I held up previously has been used by literally hundreds of agencies. It has all OASIS items and the items needed for the Joint Commission oryx program. It is a standard assessment form that is used by many agencies.

One thing I should clarify—we have not talked about the end result of all of this as much as we have talked about OASIS. What an agency gets back after one year is called an "outcome report," which Dr. Taler referred to as a benchmark report. It is a report that has 41 different patient outcomes on it so a home care agency can compare its outcomes to the outcomes of other agencies across the country. It includes outcomes, such as improvement in ambulation, stabilization in anxiety, and hospitalization rates. An agency can thus assess where it stands relative to other home care agencies. That is No. 1, but No. 2, most importantly, it can determine where it stands relative to itself last year. So if my agency made improvements for key outcomes, I succeeded in changing care behaviors in areas on which I targeted.

For the most part, what we have seen when agencies actually use the data in this way with outcome reports and target on specific outcomes is that probably about 80 percent of the time, they improve. And what does that mean? They improve on behalf of their patients. All in all, the primary beneficiaries here are the millions of patients receiving home care.

Again, it is so easy to get tangled up on that one form that was published, which must be incorporated into clinical records and yields so many other useful things for agencies, that we forget to step back and look at the big picture.

The CHAIRMAN. Mr. Pyles, I think you indicated you wished to respond to my question to Ms. Kail.

Mr. PYLES. Yes. If you would not mind refreshing my memory, I am afraid I have forgotten what the question was.

The CHAIRMAN. It will be less disjointed if you would respond to Dr. Shaughnessy.

Mr. PYLES. OK, I will respond to the last comment, if I may; I guess that is freshest in my mind.

We have heard that in some of the OASIS applications that very few patients objected, and HCFA has said repeatedly that this is not to be viewed as a questionnaire.

I frankly was somewhat disturbed by that, because the net effect of that is that the patients will not know that this information is being mined from them, and information is being obtained that is not absolutely needed for that particular patient's diagnosis and treatment.

We are doing something different here, very different than we have done in the past. Throughout the 100-year history of home care in this country, doctors and nurses have had the ability and the opportunity to exercise their medical discretion, their medical judgment, to determine whether, if a patient did not want to provide some information on his or her background, that care could continue to be provided safely and effectively.

Under OASIS, at least the way HCFA was planning on implementing it, if the patient refused to provide even a single one of the more than 450 data items, the care could not be provided. That is a barrier to quality care.

Now, we have heard a lot of comment about how this will improve outcomes and improve quality care. Perhaps it will. But we also have a tradition in this country that patients must consent even to care that is going to benefit them. It is one of the most fundamental elements of the practice of medicine in this country. Even though Dr. Shaughnessy or others may have something they can do for me that will certainly benefit me, I have the right to say no thank you. But under OASIS, if you do not even know the information is being collected—there is no notice, no consent being obtained—the patients are deprived of that opportunity. It certainly should be a fundamental right of every patient to be informed of what information is being requested and how it is being used and have an opportunity to say no thanks.

The CHAIRMAN. Dr. Conlin, could you explain the additional costs that OASIS has improved upon Iowa State Government? Are the same costs being borne by other States as well, or is Iowa kind of a situation different from others, and how are those costs affecting the State's ability to serve its needy citizens?

Ms. CONLIN. You have in my written testimony the estimated startup costs to provide thorough OASIS documentation, and we estimate—and I know this is a very wide range, but our staff was using a number of different items—the initial startup costs to be between $5.5 million and $15.5 million. We have neither the staff nor the computers in place, or the training to train people, to do the input in the 99 counties now with case management.

In Kansas, where I was meeting with Kansas, Missouri, and Nebraska people in early April, Kansas estimated their initial startup costs at $4.3 million.

The CHAIRMAN. Thank you.

Dr. Shaughnessy, you mentioned that the current home health care climate is a big part of the problem that providers are having with OASIS and obviously, we have heard from a lot of people at this committee hearing as well as others that that is a crisis situation.

Would it make sense for the next year or two to mandate OASIS only for Medicare and Medicaid patients, and then, when the prospective payment system is in place, to consider extending it at that point to private pay patients?

Dr. SHAUGHNESSY. On the surface, that seems reasonable. The difficulty is when an agency has one approach for one type of patient, one set of forms and so on for a given type of patient and another set of forms for another type of patient—and we have encountered this and experimented with it—it is very, very difficult operationally at the agency level. Second, OASIS was designed, as I mentioned, to fit the total operations of a home care agency, and the information that is fed back to agencies using the OASIS data on the total operations helps them make determinations regarding cost-effectiveness and so on.

I truly understand what IPS has done to this industry. I understand the temptation to restrict OASIS to Medicare and Medicaid patients. But I think it would probably raise the cost and increase the problems with implementation if we put it in place in one way now and try to phase it in for other patients later.

If it were my agency, as long as I was phasing it in now, I would just as soon phase it in uniformly with all my clinical staff for all patients to do it that way. The advantage of that for me is that then I receive the outcome/case mix/adverse event reports on my total case load. I really do not think eliminating private pay patients would decrease costs that much and it would increase complexity.

Now, it would be nice—and I believe we are all saying this—if agencies could get some relief from IPS in one way or another. I am not even going to suggest or prescribe what way. But if OASIS had been implemented under another climate without IPS, I doubt that much of the resistance we are encountering now would in fact exist.

The CHAIRMAN. Mr. Pyles.

Mr. PYLES. Yes, if I could address that, in terms of efficiency, we know that the principal reason for moving ahead with some haste right now with the OASIS data collection tool is because HCFA is facing a tight time deadline of October 1, 2000 to develop a prospective payment system. It has been our suggestion that we should focus down on the things we need to do first—not that we do not ever do OASIS, or we do not ever do it in a particular way. But let us do the things we need to do first. Let us go after the information, collect the information from Medicare patients that HCFA needs to meet their deadline. We believe that that will actually enhance their ability to meet their deadline, because they and the agencies will not be having to collect such a high volume of information.

Also, it appears that the Senate is going to meet their August 21 deadline for new privacy standards. If they come up with new privacy standards that are completely inconsistent or even partially inconsistent with the OASIS data collection requirements, we are going to have yet another retooling that agencies and HCFA will have to go through to comply with that. And as a matter of fact, at least as far as the mental health information is concerned, there would have to be some major changes in OASIS in order to comply with the direction the Senate is moving in on privacy standards.

The CHAIRMAN. Ms. Wright.

Ms. WRIGHT. I would have to agree that if you implemented it incrementally, I do not believe that it would save costs. You still have to do all the forms adjustment, and you still have to do the training. It does not really make that big of a difference whether you are doing it for a portion of your patients, and it probably would complicate the system if you were doing two different types of assessments.

But I also agree with Mr. Pyles that we need to look at it more realistically, get the data that HCFA needs to do prospective pay and implement OASIS in a timeframe and with the cost considerations that will make it work instead of doing it the way we are trying to do it now and having the whole system fail.

The CHAIRMAN. That is my last question. I want to thank all of you for participating. We had a good discussion not only between Members but between panelists as well, so thank you very much for making it a very worthwhile discussion and contributing to this information, and in the process I hope helping HCFA.

I now call our final panel which consists of Dr. Jeffrey Kang, who is Director of the Office of Clinical Standards and Quality at the Health Care Financing Administration, and he is also that agency's chief clinical officer. The purpose of having him follow other witnesses is to give him a chance to respond to their views, and I hope the value of proceeding in this order is apparent to everyone. I think it is just a matter of common sense.

I welcome Dr. Kang and ask him to give whatever presentation he has as well as the extent to which he wants to respond to the first panel, and I will ask questions after he concludes.

Dr. Kang.

STATEMENT OF DR. JEFFREY KANG, DIRECTOR, OFFICE OF CLINICAL STANDARDS AND QUALITY, HEALTH CARE FINANCING ADMINISTRATION, WASHINGTON, DC

Dr. KANG. Chairman Grassley, Senator Breaux, distinguished members of the committee, thank you very much for this opportunity and for inviting me to discuss our efforts to improve home health agency care through the Outcome and Assessment Information Set.

OASIS represents a significant advance in home health care. It improves the quality of care by helping to accurately determine what each patient needs and then to assess their care over the course of treatment. Providers and surveyors can then monitor the outcomes of that care and learn how to improve.

This is very important, because I believe home health patients are the most vulnerable Medicare and Medicaid beneficiaries. They tend to have more health problems, and the fact that care is delivered in the home actually makes monitoring the quality of care much more challenging than any of the institutional settings where home care is provided—all the more reason to ask for accountability and measurement.

HCFA will be using OASIS data to monitor quality and to develop a performance report for each home health agency. We will show how well the home health agency is doing and how much it is improving and how it compares to agencies around the State and the country.

In the demonstration project, we have actually developed performance reports for home health agencies that were participating. As Dr. Shaughnessy mentioned, there are 41 some-odd parameters, and I have picked out six of them.

As you can see here—let us look at three outcomes—this is an actual home health agency in blue. We looked at their current performance against their previous performance the year before, and against the national average.

As you can see, this home health agency in this demonstration actually took this information and ended up significantly improving the pain interfering with activities scale patients' pain control; it helped improve patients' cognitive functioning, from 33 percent up to 48 percent, and it also helped improve the management of oral medications.

That is the quality side of the equation. What is very important here also is that good quality care is cost-effective. What we showed here, with the same agency in the same period of time, is that we had a decrease in emergency care services, more patients were actually discharged to the community, and we had a decrease in acute care hospitalization.

This is quite important, and I think it shows the value of this information, and OASIS will allow us to feed this information back to every, single home health agency in this country and allow HCFA to monitor the care that is being delivered.

Eventually, we hope we will be able to share these performance reports with the public. This ultimately will allow consumers to make informed choices with regard to their home health agency and I believe that consumers have a vested interest at stake here in knowing they are going to get good quality care from a home health agency, that their individual care is going to be good, and that they actually can get information to guide their choices of home health agencies.

OASIS also will help us make accurate payment under prospective payment. As you have already mentioned, we are going to start PPS in October of 2000, so it is very important that we collect this data.

We believe that using OASIS will both determine how accurate the payment is, but also assess and make sure that the quality is maintained at the highest possible levels. I think it is important to note that the administration proposed home health prospective payment with the understanding that we have the safeguards already built in against underutilization.

Our experience in other programs where we have moved to prospective payment, for example with DRGs is that if we had not done that, you end up with decreased utilization, dumping, and so on. Quite frankly, in OASIS by doing both, monitoring for quality at the same time as capitating payments helps us make sure that even under prospective payment, we will maintain and assure the level of quality of care that is being delivered.

One thing that came up in the previous panel, and I just wanted to make sure you understand OASIS does not require more effort by these agencies than the traditional assessment. It simply provides a standardized format. As a clinical provider, as a doctor who has delivered home health care in the past, these are comprehensive assessments that we have always done. So under traditional, care without OASIS, Home Health Agencies were spending about 161 minutes in total on this entire assessment. Then, with OASIS, what we discovered is that the time that the home health provider can spend with the patient increased from 85 to 93 minutes, the time of documentation actually decreased from 76 to 67 minutes. We believe this is an efficiency that is an appropriate direction to go in, with more time for patient care and less time for documentation. That is the advantage of standardization of this instrument.

Finally, let me talk a little bit about privacy issues. We are taking great pains to protect the privacy of OASIS data, and as you are aware, we did delay implementation of OASIS. The Vice President and the President have asked us to review all of our procedures.

Senator, I know I am running out of time——

The CHAIRMAN. Please continue. The reaction of your agency to what we have heard is very important.

Dr. KANG. Thank you.

Because of the privacy issues, we are limiting the use and transmission of personally identifiable data. Personally identifiable data, for example, as a matter of routine use, will not be going to private accrediting organizations. The previous confidentiality rules allow that. Data on private pay patients will be transmitted anonymously, or the other term is with "masked identifiers." We do not need private pay patients' information in an identifiable form to accomplish our quality oversight.

The data on patient financial factors, we also do not need for our quality purposes and payment purposes, so we will not ask for that to be transmitted.

Furthermore, we are accelerating our efforts to encrypt data during transmission, to provide yet another level of protection.

Finally, we are drafting a notice which will inform patients of their privacy rights. These rights currently exist under the 1974 Privacy Act. In brief, patients have five privacy rights, and all beneficiaries will be notified of these rights. We have actually tested in focus groups, and it is in plain, simple English and is very understandable.

The five privacy rights are: (1) beneficiaries have a right to know why the data is being collected; (2) they have a right to know that the data will be secure; (3) they have a right to know that the data will be confidential and what the procedures are for that; (4) they have a right to refuse to answer specific questions and still get care, so even if they refuse to answer a specific question, they can still get care; and (5) they have a right to see the data and requested changes or request corrections if they believe it is indicated.

These strong privacy protections will help ensure that patient information is kept confidential, but at the same time allow us to reap the many benefits that OASIS will give us in terms of high-quality care, correct payment and these performance reports and improving the quality of care.

Thank you very much.

[The prepared statement of Dr. Kang follows:]

Testimony of

JEFFREY KANG, M.D., M.P.H., DIRECTOR

OFFICE OF CLINICAL STANDARDS & QUALITY

HEALTH CARE FINANCING ADMINISTRATION

on the

HOME HEALTH CARE

OUTCOME AND ASSESSMENT INFORMATION SET (OASIS)

before the

SENATE SPECIAL COMMITTEE ON AGING

MAY 24, 1999

HCFA
MEDICARE • MEDICAID
Health Care Financing Administration

TESTIMONY
JEFF KANG, M.D., M.P.H., DIRECTOR
OFFICE OF CLINICAL STANDARDS AND QUALITY
HEALTH CARE FINANCING ADMINISTRATION
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Chairman Grassley, Senator Breaux, distinguished committee members, thank you for inviting us to discuss our efforts to improve home health care quality through better patient assessment and measurement of the outcomes of care. We are required by law to monitor the quality of home health care with a "standardized, reproducible assessment instrument." To improve care and comply with the law, we will be using the Outcome and Assessment Information Set (OASIS).

OASIS helps home health agencies determine what patients need, develop the right plan for their care, assess that care over the course of treatment, and learn how to improve the quality of that care. It incorporates all the information about patients' health and functional status, health service use, living conditions, and social support that are needed to support all the home health agencies' responsibilities. In addition to monitoring quality, OASIS also is essential for accurate payment under the new home health prospective payment system that the law requires us to use beginning October 1, 2000. We will be requiring use of OASIS by home health agencies as a Condition of Participation in the Medicare and Medicaid programs this year.

The important benefits of OASIS must be implemented in a way that protects personal privacy. At HCFA, we have an excellent historical record of safeguarding sensitive beneficiary information. Our agency provides greater protection for personal medical information than generally exists in the private sector, and we are actively participating in the Administration's inter-agency process to make Secretary Shalala's recommendations for medical privacy work on the operational level.

In recent months, we have come to realize that stronger privacy protections must be built into the structure of our new operations. President Clinton and Vice President Gore have both spoken about the paramount importance they attach to medical records privacy. This is why the Administration has been a consistent advocate for effective medical records privacy legislation. I am pleased to announce some new steps we are taking to assure the privacy of patients while maintaining the legitimate focus of the OASIS program, such as:

- Careful drafting of a notice that Medicare and Medicaid patients will receive. The notice will explain why OASIS data is collected, and inform patients of their right to see and request corrections of the data.
- Limitations on "routine uses" of data under the Privacy Act, so that personally identifiable data will only be used where statistical information is not sufficient. Among other changes, personally identifiable data will no longer go to accrediting organizations such as the Joint Commission for Accreditation of Health Organizations.
- Major changes in the treatment of private-pay patients under OASIS. We have decided that information on non-Medicare and non-Medicaid patients will *not* be transmitted to the States or the agency in personally identifiable form.
- After careful attention to each question in OASIS, virtually all questions were retained on grounds of assuring quality of care and appropriate reimbursement. We did identify a sensitive question on patient financial factors that we consider less critical to achieving program goals, and this information will not be reported to HCFA or the States.
- Acceleration of efforts to encrypt data during transmission, to provide yet another level of protection. We expect to complete these efforts within a year.

We are also making special efforts to help home health agencies learn how to use this valuable tool. We have learned through a demonstration of OASIS that, once home health care providers learn how to use OASIS, it actually slightly reduces the total time it takes to conduct a thorough patient assessment. Home health care professionals who have used OASIS in the demonstration agree that it takes no longer to use than their previous assessment methods. Because OASIS is structured in a checklist format, home health staff using it spend less of the total evaluation time writing out a narrative of their assessment findings and more time with the patient. A chart comparing average patient assessment times with and without OASIS is attached to my testimony.

More than 8,000 of the approximately 9,500 home health agencies participating in Medicare across the country have now received official OASIS training. Efforts to help providers through the OASIS learning curve include:

- a satellite broadcast training session on August 20, 1998 to sites across the country reaching approximately 30,000 home health care professionals (tapes of this session are also available);
- numerous presentations at industry trade association meetings;
- distribution of a free, detailed manual on how to collect OASIS data, use the software, and report the data;
- manuals, software, updates, and other additional assistance that can be downloaded from the Internet at *hcfa.gov/medicare/hsqb/oasis/oasishmp.htm*;
- answers to questions on installing OASIS software via a toll-free telephone line at 1-877-201-4721 and via E-mail *haven_help@ifmc.org*;
- establishing OASIS Educational Coordinators in all States;
- a week long conference last September to teach State personnel about OASIS; and
- a "train the trainer" program last October for all State OASIS Educational Coordinators to provide materials and detailed information on how to teach home health care professionals in their State how to use OASIS.

Background

Home health patients are among the most vulnerable Medicare and Medicaid beneficiaries. They tend to have more health problems, and the fact that care is delivered in the home makes monitoring the quality of that care more challenging. The Omnibus Budget Reconciliation Act of 1987 mandated that Medicare monitor the quality of home health care and services with a "standardized, reproducible" assessment instrument. The following year we contracted with University of Colorado researchers and clinicians to develop such an instrument. We have been working ever since to refine and validate what has become OASIS.

OASIS has been used by 162 home health agencies in various demonstration projects around the country. It has been tested in a national Outcome-Based Quality Improvement demonstration involving 50 home health agencies of all sizes, and in a single-State demonstration project involving 22 agencies. OASIS questions also have been used in the national Medicare home health prospective payment demonstration, which includes 90 agencies in five States.

OASIS provides a standardized format for the patient assessments that home health agencies have been doing all along. It does not require additional effort for agencies that have been conducting the thorough patient assessments that are needed in order to provide appropriate care. OASIS incorporates only information needed to support concrete indicators of patient need and quality of care.

The 79 data elements in OASIS were developed by clinicians and are valid, reliable, and risk adjusted, taking into account all characteristics of patient populations. This ensures that assessments done by different health care professionals with OASIS consistently yield the same results. It also ensures that quality measurement takes into account whether agencies are caring for sicker patients and therefore might have what otherwise would appear to be poorer care or outcomes.

OASIS is supported by the American Academy of Home Care Physicians, the National Alliance for the Mentally Ill, and many home health care providers who are voluntarily using OASIS because of its unprecedented value in promoting high quality care and comprehensive, accurate, clinical record-keeping. Home health care professionals using OASIS report that it is helping them to be more focused on the needs of individual patients, and to provide better care in fewer visits and with fewer subsequent hospitalizations.

Implementation

We first published a proposed rule for requiring use of OASIS by all home health agencies participating in the Medicare and Medicaid program in the *Federal Register* on March 10, 1997. Many comments on the proposed regulation suggested adding additional questions. However, to keep OASIS at a reasonable length, we instead will allow agencies flexibility to expand OASIS for their own patient population. For example, an agency that provides a larger share of mental health services can add extra questions related to mental health if it so chooses; however, these data will not be transmitted.

On January 25, 1999, we published a final regulation requiring use of OASIS and an interim final rule requiring that home health agencies encode and transmit the data to us. We had planned for home health agencies to begin mandatory reporting of OASIS data on April 26, 1999. However, on April 7 we announced that we would postpone the requirement in order to conduct a thorough evaluation of privacy concerns and to complete the review of OASIS pursuant to the Paperwork Reduction Act of 1995. Once these concerns are addressed, we expect to publish a new date for the start of mandatory collection and will report it in the *Federal Register*.

Once reporting begins, home health agencies will transmit computerized, coded OASIS data to State survey agencies using a private network with a direct phone connection. The State will compile the data and send it to the Health Care Financing Administration. OASIS system users must enter an ID and password at three different checkpoints before access is permitted. And, the data transmitted to the States and to HCFA is fully protected under the federal Privacy Act. The Privacy Act has been effective in ensuring confidentiality of Medicare data.

We will develop a performance report for each home health agency based on its OASIS reports, including a comparison of its performance to the State and national average. These performance reports will allow home health agencies to identify their own weaknesses and improve the quality of care they provide. They also will allow us to compare the quality of care among agencies and thereby increase scrutiny for those that need more oversight and assistance in improving quality.

Eventually, we will share these agency performance reports with the public so consumers can make informed choices among home health agencies based on the quality of care they provide. Examples of the information these reports will provide is attached to my testimony.

Data that can identify individual Medicare and Medicaid patients are critical to ensuring that we pay accurately for care and that we can monitor the quality of care. It allows evaluators to assess whether a home health patient's later admission to a hospital or nursing home might be related to gaps or problems with the care provided by the home health agency and identify potential areas for improvement. It is also essential for ensuring accurate payment under the prospective payment system. In particular, it links the OASIS data to actual claims data in order to create the proper weightings for reimbursement.

As I stated earlier, all information that could be used to identify private pay patients will be removed by the home health agencies before OASIS data is reported to HCFA and the State.

OASIS and Prospective Payment

OASIS data are critical to development, implementation, and accurate payment under the home health prospective payment system that Congress has required we implement in October 2000. We need to collect OASIS data as soon as possible in order to develop prospective payment rates and estimate their impact based on comprehensive national data. Doing so based on the limited OASIS research data available to us now could jeopardize our ability to pay accurately and to understand in advance how different types of agencies across the country will be affected.

The comprehensive information in OASIS is necessary to accurately determine the appropriate amount of care, and therefore the appropriate amount of payment for that care. This is particularly important in the home health environment, which is complicated by confounding factors such as patient behavior. Patient diagnosis alone, which is the basis for inpatient hospital prospective payment, predicts less than 10 percent of home health patients' need for service.

Using OASIS to both determine accurate payment and assess quality helps to minimize the burden on home health agencies. It also helps fight fraud and abuse, which has been a substantial problem in home health care, because it balances incentives. While prospective payment creates an incentive to "upcode" and say patients are sicker in order to receive higher payment, doing so with OASIS would result in poor quality indicators. That could trigger an investigation, as well as result in a competitive disadvantage when home health agency profiles based on OASIS data are eventually shared with the public.

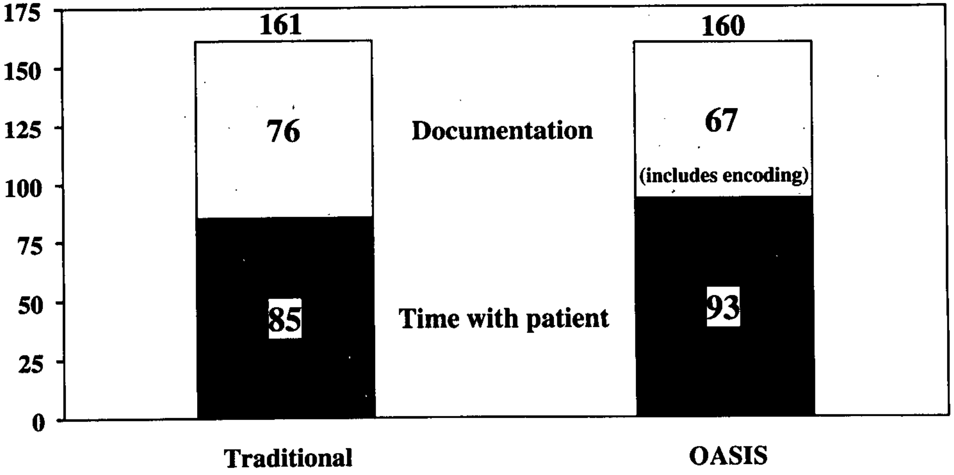
Using OASIS to monitor quality is even more essential under a prospective payment system. As mentioned above, prospective payment creates highly effective incentives to provide care efficiently, but those incentives must not be allowed to reduce appropriate care. OASIS will help providers accurately assess what the proper level of care is, and it will help us monitor that care to ensure that patients are getting all the care they need.

CONCLUSION

OASIS represents a significant advance in home health care. It is proven in rigorous testing to help improve the quality of patient care and the outcomes of that care. It allows home health care professionals to spend more time with patients and less time writing up assessments. It will help ensure accurate payment under the new prospective payment system. It will help ensure that beneficiaries receive high quality care. And it will help protect taxpayer dollars and the integrity of the Medicare and Medicaid programs. We are taking extra precautions, beyond our already stringent privacy protections for Medicare and Medicaid data, to ensure the confidentiality of OASIS information, and we are communicating these precautions to all (Medicare, Medicaid, and private pay) patients before they receive home health care. In addition, we are working to help home health care professionals learn how to use this important new clinical advance. I thank you for holding this hearing, and I am happy to answer your questions.

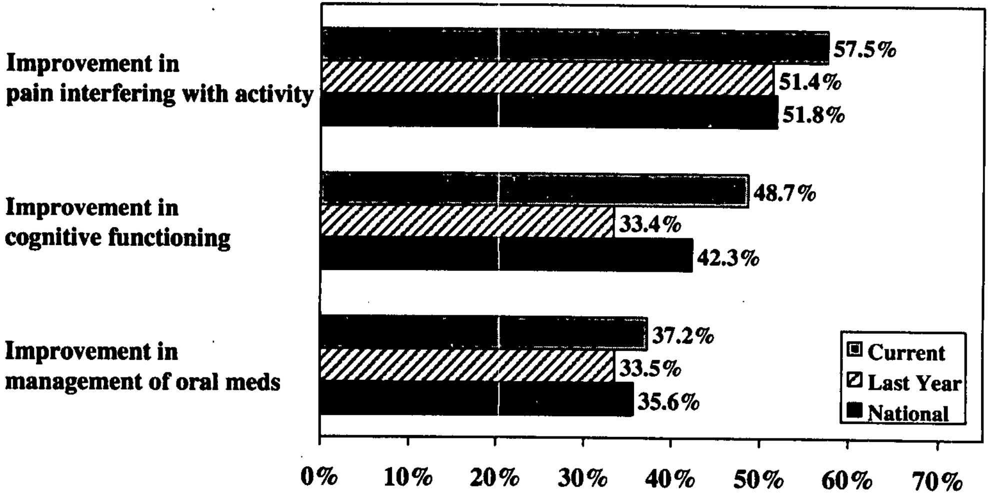
# # #

Average Assessment Time in Minutes for a New Patient



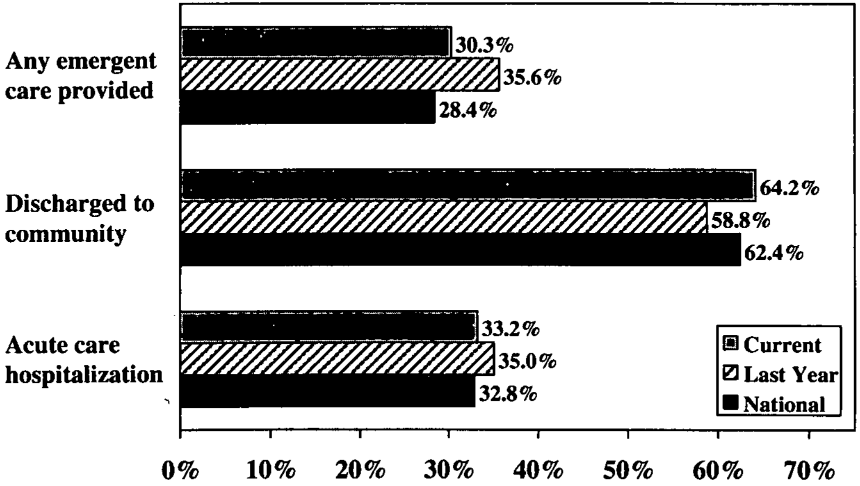
OASIS Outcome Report

End Results Outcomes



OASIS Outcome Report

Utilization Outcomes



The CHAIRMAN. Thank you very much for your testimony and for representing your agency here at this very important hearing.

I want to read one of Ms. Kail's recommendations and ask for your response. Quote: "HCFA should mandate only OASIS data collection items that are necessary for determination of the prospective payment system. HCFA should only consider implementing a quality agenda after successfully demonstrating their ability to manage the volume of data items necessary to deliver on a timely prospective payment system implementation." I would like you to comment on that.

Dr. KANG. First, actually, OASIS was developed in response to OBRA 1987, 12 years ago, saying that quality was really what we were after. As I mentioned, I think it is important to understand that under prospective payment or capitated payment, the incentives are completely reversed to lowering delivery of services.

So we actually feel that it is very important to do both—that the instruments should be kept intact so that we can monitor for quality, recognizing simultaneously while prospective payment goes in, that we need to safeguard against the perverse incentives.

If we just took the payment questions by themselves, we would actually totally undermine the ability to ensure that beneficiaries under prospective payment continue to get good quality of care. So I think we would have a hard time suggesting that we just do the payment questions by themselves.

The other thing I want to point out, as a previous home care clinician for 10 years, is that these questions are questions that we are taught to ask and assess patients on in part of our medical training or nursing training or PT training. That explains why the timing is not really changing a lot. These are things that we are doing already as part of good care, and I would have a hard time suggesting that we just do an instrument like this for payment purposes. This really was all about clinical care and clinical improvement and outcomes.

The CHAIRMAN. Let me follow up—how about the idea of proceeding with a full OASIS collection but only on Medicare patients and then, once the prospective payment system is in place, deciding whether and in what way to expand it to the private pay patients? Wouldn't that help HCFA focus on a top priority right now, which of course is getting that system in place—and I still take into consideration your statement that it was implemented in the first place for quality control under OBRA.

Dr. KANG. I think that is a good question, and we have considered that. I think it is important to remember that HCFA wears two hats. The first hat is as a payer or as an insurer. Under that hat, for the Medicare and Medicaid patient population, we are interested in accurate payment, and we are interested in knowing that we are getting quality services for that payment.

The second hat we wear, though, is our regulatory hat; this is the Medicare conditions of participation—and the statute actually tells us that our conditions of participation should apply for all beneficiaries taken care of by the home health agency irrespective of payment source.

So I think that from our perspective as a regulator, we believe that private pay patients are entitled to know that they are getting good quality services from their home health agency.

The one thing, though, is that it turns out in order to fill that regulatory hat for private pay patients, it turns out that we do not need that in an identifiable form. That is why we are changing our transmission so that it will be done anonymously, or encrypted, which would mean that we, HCFA, would not know who the identity of that private pay patient is.

The CHAIRMAN. You understand, though, that we have been regulating Medicare for a long time. How does that fit in with the goal of regulation, or the responsibility that you have for regulation? You have that responsibility anyway.

Dr. KANG. You are right that we have that responsibility, and we have had a longstanding tradition of not trying to create a two-tier system where certain beneficiaries get the OASIS instrument and others do not. I am a little concerned about the public perception and public policy implications that we would end up with a situation where Medicare and Medicaid people are getting these quality protections while private pay patients in the same home health agencies, would not. There is a specific statutory mandate, actually, that says Medicare conditions of participation apply to all the other patients served by the agency.

The CHAIRMAN. OASIS is currently on hold so that HCFA can get its privacy issues cleared away, but how long will it be on hold, and how will the delay affect the development of the prospective payment system by that October 2000 deadline?

Dr. KANG. We are currently still on time for meeting that October 2000 deadline. We would end up publishing a regulation sometime this fall based on the information from the demonstration projects, the some 150 agencies that participate in demonstration. We do need the OASIS data, though, before we go final in October of 2000 to really perfect and refine the system to do impact analyses and so on, so we do need this information for that.

In terms of the delay, what we are really at the point of is, after many discussions and hearings like this, considering all the privacy and burden issues, we do have to get clearance from the Office of Management and Budget and the Paperwork Reduction Act and also publish a notice with regard to disclosure and confidentiality. That would be the vehicle where we would actually publish a standard notification to beneficiaries around their privacy right that has to be served on all beneficiaries at the time of admission.

Once we have actually done those publications and get the appropriate clearance, our hope would be that we could start having OASIS collected and transmitted in time for us to do prospective payment by October 2000.

The CHAIRMAN. But isn't the bureaucratic delay in the final analysis holding up PPS?

Dr. KANG. As I said, we could publish the proposal regulation without this data. I do think, though, that we need this data for purposes of the final. So in the proposed rule, we could give a rough sense of what our methodology is, but in terms of refining that and doing an impact analysis on the home health agencies by

States or regions or by home health delivery type, we would need this data in order to have a final by October 2000.

The CHAIRMAN. Can you clarify the confusion over what happens to patients who decline to submit to the OASIS assessment? Is it really true that those patients will be denied service, and if so, is that the case even if they are paying their own way?

Dr. KANG. I think I need to answer that in two places. The first is with regard to Medicare and Medicaid patients. There is a clear right that patients have with regard to specific questions—the right to refuse to answer. That is something that we have not been terribly clear about, and we will be making that quite clear in the notification.

With regard to private pay patients, we actually think the issue here, the privacy issue in particular, is that if we have decided that the information is going to be sent to the Government anonymously, in other words, with masked identifiers, where HCFA or the Federal Government would not know who the patient is, if we actually explain that to the beneficiaries that the issues that you have heard with regard to privacy will dramatically be reduced.

Part of the problem in the last 2 months is that it has been presented that private pay information is going to be submitted with identifiers. With this change, we are going to be saying in a non-identifiable way or an anonymous way, in which case, we believe that private pay beneficiaries will have less of a problem with that.

The CHAIRMAN. Is it HCFA's position that it is required by law to mandate OASIS for all patients, even if they are private pay—and I would include private insurance as private pay as well. If so, I am not sure I agree with the interpretation of the law, but would HCFA support making the law more flexible?

Dr. KANG. Again, this gets us back to the conditions of participation. The statute is fairly clear here. Section 1981 says that the Medicare conditions of participation apply to all patients. I think that we, again in our regulatory hat, are very interested in making sure that all patients have similar protections and quality monitoring. Since we are not paying the bill, though, we do not need the information in an identifiable way.

As to whether we would support change in the law, particularly that Section 1981, which says that Medicare COPs really should apply to all patients, I would have to get back to you on that. That is such a basic tenet of the Medicare program, and that statute has been in place for many, many years, so I would have to get back to you on that.

The CHAIRMAN. We are talking about only changing it for private pay patients for OASIS, not for any other aspect of the law, so I will invite your response to me in writing on that.

Area agencies on aging provide quality care to a large—and I want to say that the questions that I am asking now are for Senator Roberts, who asked me to ask these questions of you, so if there is any follow-up in writing, it would be for our record, but also to his attention as well—Area Agencies on Aging provide quality care to a large number of seniors who receive non-Medicare services. Did you intend to apply OASIS requirements to these providers, and if so, was there any communication with the Administration on Aging, State Units on Aging, or leaders of the National

Association of Area Agencies on Aging as you developed the regulations for OASIS?

Dr. KANG. This is a very good question, and actually, I believe it bears on some of the issues that both Ms. Kail and Ms. Conlin were having in the State of Iowa.

The OASIS collection specifically excludes patients who are maternity, pediatrics, or people who are getting nonpersonal services—so homemaker services, for example, like cooking or shopping. So we do believe that the instrument really should be used for people who are getting personal or skilled services. The problem really comes in States like your own, where the area agencies have a program with their own information collection going on, which also has a certain skill level or skill mix, a case mix of patients receiving the service. We are very aware of this issue, and we are actually working with the Administration on Aging to try to sort through this.

It is very difficult, largely because there is tremendous variation from State to State. There are other area agencies and home and community-based waiver programs which are actually requiring OASIS themselves as their own monitoring tool because they have a very complex population. There are other agencies—and I am going to assume this is Iowa also, although I have not had a chance to speak directly to the witnesses, and I would certainly be happy to afterward—I think some of the rub is that they have their own measurement system, and it really turns out that OASIS is duplicative or is brand new, such that the actual times and resources that they are spending are much greater than a traditional home health agency that is already doing comprehensive assessments.

So it is an issue which we are actively exploring.

The CHAIRMAN. To this point, then, they have not been involved in the regulation writing.

Dr. KANG. We have had some early discussions, and we continue to have ongoing discussions.

The CHAIRMAN. Oh, there have been—OK. Thank you for clarifying what I thought was a "No" answer.

Dr. KANG. Sorry.

The CHAIRMAN. States already have operative methods and standards that assure quality of non-Medicare in-home and long-term care services. How will HCFA reconcile OASIS requirements with those that already exist without causing an unnecessary burden on providers?

Dr. KANG. I am sorry, Senator, could you repeat the question?

The CHAIRMAN. Yes. States already have operative methods and standards that assure quality of non-Medicare in-home and long-term care services. How will HCFA reconcile OASIS requirements with those that already exist without causing an unnecessary burden on providers?

Dr. KANG. Again, this really, I believe, is many of the homemaker services, area agencies, or home and community-based waiver programs, and we are actively working on this issue. There is tremendous State variability here.

Our interests are to make sure that we get appropriate accountability, and at the same time, we want to minimize duplications, and we are anxious to work with a variety of States on this issue.

The CHAIRMAN. Those are all of my oral questions for you. I want to thank you as well as all of our witnesses today for shedding so much light on this difficult situation. It occurs to me, as some of you have noted, that a big part of the problem with OASIS is the timing. It is hitting the agencies at the same time that they are trying to work through the interim payment system—it is kind of giving them a double whammy—and unfortunately, when the agencies have a problem, it is often the patients who feel the consequences. But I think we have to remember that OASIS is part of the solution to the payment problem, and if we can find a way to make it work now, it will help these agencies move forward into prospective payment, and they will be rewarded for being cost-effective and not punished, as they are now.

This committee will continue discussing OASIS, and particularly as chairman, I should do it with my colleagues, not only those on the committee but those are not on the committee, and of course, I will continue my talks with you, Dr. Kang, and your director, Nancy Ann, and with constituents and examine whether legislative changes are needed. Otherwise, we would have to conclude—and maybe we will—that HCFA is now basically on the right track.

It is not an easy issue, as I think we have heard from people who have been working on it for years and other people who are experiencing it this year for the first time, but we have to make it work, and I believe that this hearing will contribute to that effort.

I thank you all, and the committee will stand adjourned.

[Whereupon, at 2:50 p.m., the committee was adjourned]

APPENDIX

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STATEMENT

OF THE

AMERICAN PSYCHIATRIC ASSOCIATION

on

HOME HEALTH CARE ASSESSMENT

before the

SPECIAL AGING COMMITTEE

U.S. SENATE

May 24, 1999

The American Psychiatric Association, on behalf of more than 42,000 psychiatric physicians, is pleased to provide the Committee with our views on HCFA's home health care regulation, (OASIS). If this initiative is implemented, it would be a major, inappropriate expansion of government access to identifiable patient medical records that would undermine the quality of health care provided to patients.

We support HCFA's goal of improving quality, reducing fraud, and implementing a more effective payment system. However, we are deeply concerned because the regulation requires the disclosure of tens of thousands of patients' most sensitive medical record information to state and local governments.

Under the regulation, home health care agencies are required to report extensive medical records information, including highly sensitive personal, financial, and medical (including psychiatric) information to the government as a condition of their participation in the Medicare program and to receive payment. Worse yet, patients would not be asked for their fully voluntary, informed consent before this information is disclosed to the state and federal governments.

Patients must be free to protect their privacy by having the opportunity to exercise their fully voluntary, informed consent to disclosures of identifiable medical information outside of the home health care agency. In fact, since health care professionals are expected to fill out this assessment through observation without asking the patient questions, patients are unlikely to be aware that certain highly detailed and intrusive information will be reported to the federal and state governments. While patients will receive some type of notice, there is nothing in the regulations that yet indicates they will be specifically notified of what type of highly personal information will be disclosed.

The scope of the questionnaire is also troublesome. Home health care agencies participating in Medicare would be required to obtain this information even from non-Medicare patients and subsequently disclose the individually identifiable information to the state and federal governments.

Even if one accepts HCFA's rationale that the fully voluntary and informed consent of the patient should not be required before disclosure, we are still highly skeptical that their approach adequately protects patient privacy. HCFA has not presented a convincing case that the only way to achieve their goals is to routinely report identifiable medical information on every patient to the federal government and for the federal government to retain such information. Routinely using identifiable information for these purposes unnecessarily violates personal privacy thus undermining patient trust in the health care system and the quality of care. We also are concerned because this identifiable information could be routinely shared outside of HCFA.

Unfortunately, OASIS is just part of a more disturbing pattern of federal regulatory actions. In the past year we have already seen three other federal regulatory actions which endanger patient privacy and ultimately the quality of health care, including the Medicare + Choice regulations. These actions, allowing for extensive use and disclosure of medical records, demonstrate the need for a broad review of these federal regulatory actions, the Federal Privacy Act, and the "routine use disclosures" that are allowable under the Act. Unless these issues raised by the OASIS and the Privacy Act are resolved promptly, we fear that the same rationale could be used to justify future regulations affecting other groups of Medicare patients and even non-Medicare patients served by providers participating in Medicare.

We look forward to discussing this issue with you further.

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April 1, 1999

The Honorable Nancy-Ann Min DeParle
Administrator
Health Care Financing Administration
200 Independence Avenue SW, Rm 314G
Washington, DC 20201

Dear Ms. DeParle,

I am writing to express concern about the reporting requirements imposed by HCFA on home health agencies. Home health care providers in my state have some of the lowest average number of visits and lowest costs per Medicare beneficiary in the nation, while still providing quality, necessary, important care. Unfortunately, however, it's becoming more and more of a struggle for these providers, in part because of several issues dramatically affecting the delivery of home health services to beneficiaries in rural states like North Dakota.

The first issue relates to the requirement that home health agencies will collect Outcome and Assessment Information Set (OASIS) data on all patients (age 18 or over) receiving health services or personal care from the home health agency, except for prepartum and postpartum patients. Medicaid patients and personal care patients should not be mandated to participate in this assessment. Agencies that offer these personal care services would have to drastically change the way they do business, which would greatly increase the cost of providing these services to patients. Medicaid will not be reimbursing agencies for these additional services, and access to care in our rural state will become a critical issue. What is HCFA's rationale for requiring OASIS assessment on all patients, not just Medicare patients?

I'd also like to second the concerns raised by Congressman Ed Markey and others that the collection of this information could jeopardize the privacy of patients. I appreciate HCFA's recent announcement that you will be reviewing the privacy implications of OASIS. I strongly encourage you to make the appropriate changes to address these privacy concerns.

In addition, the time lines that these agencies are expected to meet are sometimes impossible. For instance, if a patient must be reassessed 48 hours after being discharged from a hospital, what will some of our rural agencies do to meet this standard? Calendar day deadlines should at least be changed to working day deadlines. The 48-hour after discharge rule should be changed to meet the same standard as the initial assessment to include "or as the physician orders."

The second issue that will dramatically affect these agencies is the 15-minute increment reporting, scheduled to be implemented July 1. The timing of this change is difficult for home health agencies that are already struggling to keep serving their patients. I encourage HCFA to take steps to minimize the burden of this reporting requirement on home health agencies.

I appreciate your attention to the concerns I've raised and hope to see that changes might be made in the near future to assist the home health care providers in North Dakota and throughout the nation.

Sincerely,

Byron

Byron L. Dorgan
U.S. Senator

BLD:smm

Thank you!

MeritCare®
Home Care

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May 6, 1999

The Honorable Senator Byron Dorgan
713 Hart Office Building
Washington, DC, 20510

Dear Senator Dorgan,

I just wanted to thank you for the letter that you forwarded to Nancy-Ann Min DeParle of HCFA. I truly appreciate your support of home care in North Dakota and the time you have committed to supporting our services.

Most of us in North Dakota do not have a problem with IPS at this time. PPS is expected for home health by October 1, 2000. The new OASIS functional assessment tool is directly tied to PPS and, as you may be aware, is currently on hold due to privacy and paper work reduction issues.

We continue to support a form of PPS for home health care reimbursement but feel that the OASIS tool, when it returns, should only be mandated for Medicare patients. It continues to make no sense to have this tool used on patients that Medicare does not reimburse or have any involvement in. If you had home care services today and OASIS was not on hold, we would have to ask you the 70+ questions, even though you may have a private insurance carrier. The same situation applies to someone who may only need assistance with medication administration, a bath or personal care that is paid for privately. The mandate to complete this tool on all patients could force us not to offer much needed services or make the cost of providing these services prohibitive. Access will be limited once agencies begin to experience these problems and no longer offer services.

My concerns about the OASIS tool and the looming mandate to record a home health visit in 15-minute increments remain the same as in my previous correspondence and conversations with you and Stephanie in March.

Thank you again for your effort related to these issues. We all appreciate your willingness to assist the home health care providers in North Dakota.

Sincerely,

Jo

Jo Burdick, RN, MSN
Executive Director
MeritCare Home Care
joburdick@meritcare.com

Thanks again for your support on these matters!

May 12, 1999

Nancy-Ann DeParle
Administrator
Health Care Financing Administration
200 Independence Avenue, S.W., Room 309G
Washington, D.C. 20201

Dear Ms. DeParle:

The American Hospital Association (AHA) represents nearly 5,000 hospitals, health systems and networks, about half of which operate home health agencies (HHAs). On behalf of these home health agencies, we would like to express our concern regarding the recent hold put on OASIS, the home health data collection system, and how this delay may affect the timing for implementation of the prospective payment system (PPS).

You stated in your January 25, 1999 rule that OASIS will be integral to the development of a reliable case mix system and our members are very anxious to move to a PPS that will recognize case mix with adequate adjustments.

The majority of our members are losing money under the interim payment system (IPS) and reassessing their ability to continue to serve Medicare patients. Fortunately, many are being supported in the short term by their parent hospital or system and are endeavoring to persevere until the PPS is implemented on October 1, 2000. However, as this date already reflects the one-year delay included in last year's Omnibus bill, *any* further delay could have devastating consequences on HHA viability and beneficiary access.

Further, most of AHA's members serve patient populations with complex needs that follow an acute care hospitalization. In the past year, as a significant number of freestanding agencies have closed, hospital-based HHAs have absorbed additional resource-intensive patients who were abandoned by other agencies. In some areas of the country, hospital-based HHAs are now sole community providers.

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Nancy-Ann DeParle
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May 12, 1999

While we are sympathetic to privacy issues and other concerns generated in response to the extensive data collection effort required by OASIS, we are just as concerned with the administrative burden it poses on providers, especially since Health Care Financing Administration (HCFA) has never made clear that all of these data elements are crucial for PPS and quality monitoring purposes. Collection of this extensive data set is administratively burdensome and expensive, and its startup and ongoing costs have been grossly underestimated by HCFA. We urge HCFA to review the OASIS instrument critically to determine if it can be streamlined. At the same time, *AHA urges HCFA to maintain the PPS startup date of October 1, 2000.*

Thank you for your consideration of this request, and hope your staff will contact us to discuss PPS timing. Please contact either me, Carmela Coyle, senior vice president for policy, at (202) 626-2266, or Barbara Tomar Marone at (202) 626-2344.

Sincerely,

Rick Pollack

Rick Pollack
Executive Vice President

HCA

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A voluntary association to foster and strengthen home health and related support services.

SENATE SPECIAL COMMITTEE ON AGING

HEARING ON

"TOO MUCH INFORMATION? THE IMPACT OF OASIS ON ACCESS TO HOME HEALTH CARE"

MAY 24, 1999

TESTIMONY OF

THE HOME CARE ASSOCIATION OF NEW YORK STATE, INC.

The Home Care Association of New York State, Inc., (HCA), is a statewide association representing some 300 providers of home and community-based services throughout the state of New York. HCA is a partner with the New York State Department of Health and the University of Colorado's Center for Health Services and Policy Research in our state's Outcome Based Quality Improvement Demonstration. A majority of the participants in both Phase I and Phase II of the New York State demonstration are members of HCA. Three of our members are participants in the national demonstration. It is from the experience of our provider members that we offer this testimony. We believe that the experiences of those in the home health community of New York offer the Senate Special Committee on Aging with a unique opportunity to evaluate the import of outcome measurement in general, and the OASIS tool in particular.

HCA Supports the Continued Implementation of the Outcome-Based Measurement Tool, OASIS

After careful consideration, the Board of the Home Care Association of New York State, Inc. supports the continued implementation of the outcome-based measurement tool, OASIS, for the following reasons:

- Information of this type is critical to the overall examination of care and leads to vast opportunities for improvement in the delivery of services;
- Information of the type provided by the OASIS tool is necessary if an appropriate and fair system of prospective payment is to be implemented for Medicare payment for home health services;
- The government and other payors, including individuals purchasing services, need information if they are to make sound purchasing decisions;
- Outcome measurement is part of an investigative process that offers savings across the board; when tied to resource consumption, it offers provider the maximum opportunity to manage effectively and efficiently;
- A uniform assessment tool will assist in evaluating the wide variation in home care utilization in this country;
- Although there are appropriate and very legitimate concerns for the costs of OASIS and the protection of patient information, HCA believes these issues can be addressed and are insufficient cause for the entire process to be eliminated.

The New York State Experience

After participating in the Health Care Financing Administration's Home Health Initiative, which led to the national demonstration of outcome measurement in home care known as the "Medicare Quality Assurance and Improvement Demonstration," New York State decided to undertake its own demonstration. As a result, the Center for Health Services and Policy Research (CHSR), at the University of Colorado, received funding under New York's Health Services Quality Improvement Grant Program. The New York demonstration, known as Outcome-Based Quality Improvement (OBQI), used the Outcomes and Assessment Information Set (OASIS) to collect outcomes data, develop outcome reports for participating providers. The CHSR worked with home health providers to use the data for improvement in two targeted areas, one of which was re-hospitalizations.

Phase I of the New York OBQI started with 22 Certified Home Health Agencies (CHHAs). The agencies were trained in the use of the OASIS tool and began collecting data in July of 1996 with agencies receiving their first set of outcome reports in July of 1997. Data was collected for two years and participants have recently begun collection for the third year of the demonstration, now known as Phase II. The Phase II demonstration was designed to expand the number of participating agencies by including more Licensed Home Care Services Agencies (LHCSAs) and Long Term Home Health Care Programs, New York's Medicaid waiver program that is also known as the "Nursing Home Without Walls." Through Phase II, 40 more providers, in 45 sites, were added to the demonstration. Data collection for Phase II began in November of 1998 and will continue through 2000. Phase II includes the testing of 10 additional indicators designed to assist in outcome measurement for the population needing personal care services. In New York, the LHCSAs provide the bulk of our personal care services either through contract with counties, as subcontractors to CHHAs or the LTHHCP, or to private pay clientele.

The Results of the OBQI in New York

The participants in Phase I of the OBQI Demonstration chose two indicators on which to focus investigation and then develop plans for improvement. Although the number of patients in home care for whom data was collected dropped between years one and two (July of 1996 to July of 1998), from 170,000 to 120,000, there had been a statistically significant reduction of 9% in re-hospitalizations. The state of New York estimates that this result has saved some $6 to $12 million in expenditures. The Medicaid and Medicare patients in this population provide a direct savings to both the state and federal government.

Participating agencies were also required to choose a second "target outcome" for improvement. Many of the outcomes selected were in the area of activities of daily living such as ambulation. There was a 6.5% rate of improvement on average.

Elements Critical to New York's Success With OBQI

Given that the overall New York experience can be termed a success, it is perhaps useful to highlight those components of our process which we believe were instrumental to securing a positive outcome. By doing so, we hope that the federal and state governments can learn from our experience and perhaps give some consideration to them as we go forward in this policy dialogue.

- **Training** – The project of data collection began only after there was a firm educational foundation provided. Participating agencies had the opportunity to work with CHSR staff directly to fully understand the definitions of the terms and how the data was to be collected and reported.
- **Support** – The University of Colorado's Center for Health Services and Policy Research staff provided ongoing technical support to the participating agencies. At the end of the first year, "mentors" were selected to give information specific to how they solved implementation issues in their agencies. With Phase II, mentors were selected to help guide and support the new participants. The training sessions helped construct a community of professionals dedicated to the study of outcomes for performance improvement.
- **Commitment** – The OBQI demonstrated how essential it is for an agency's leaders to be committed to the process. Only through full support could agency personnel understand that the sometimes difficult and intensive front-end work would lead to value for the patients and the agency.
- **Feedback** - The presentation of Outcome Measure Reports at the annual statewide conference was a milestone in the project. Once participants saw the results of the data collection from the previous year they entered the realm of curiosity and investigation. They celebrated those areas of performance in which they did well; they turned their investigative and clinical skills on those areas which they deemed needing of improvement. The overall attitude was one of excitement and creativity as agencies were finally able to quantify the value of their day to day efforts – both in patient care and in data collection.
- **Research First, Surveillance Second** – New York's OBQI demonstration is a research project. The results have been encrypted and have not been used as a regulatory tool to penalize agencies. At this point in time, state surveyors have been trained in quantitative measurement principles and the use of the OASIS tool. This information has not, however, been integrated into the state surveillance process. It may, however, have made the surveillance process run more smoothly as use of the tool has streamlined and focused the operations of the agencies.

Consideration of the Criticisms of HCFA's Implementation of OASIS

Since there have been several specific criticisms leveled at either the OASIS tool or HCFA's implementation of the use of the tool, it is important to address these in the context of our three years of experience in New York.

Patient Privacy

There has never been an instance reported to HCA of a patient refusing to allow the OASIS data to be collected. We support the passage of strong legislation for the protection of all patient specific data and its transmission. In fact, New York has a long history of paying particular attention to these issues as it has utilized a Data Protection Review Board to regulate and oversee the use of its hospital discharge data known as the Statewide Planning and Research Cooperative System (SPARCS.) Everyone who gets data from SPARCS must sign an affidavit that they will adhere to procedural safeguards to maintain the security of the information that includes keeping it physically secure and it includes restrictions on secondary release. The key threshold for obtaining this data is the explanation of what the data will be used for and the specific elements you request must relate to your purpose which must be deemed legitimate. There is a subset of data that are "administratively releasable," which are a set of variables that by themselves are by themselves difficult if not impossible to use in order to identify an individual and compromise their privacy.

Concern has also been voiced over "the forced collection and reporting of personal information," particularly information related to income and mental health. We point out that a patient's cognitive status is a critical factor in planning for and predicting the outcomes of care. Patient income relates to ability to fully adhere to the plan of care, including the filling of prescriptions. Most of the information targeted by the critics is in the patient record. We believe that these concerns can be addressed by additional measures if this committee believes that patient privacy and protection legislation or regulations are insufficient. For example, these elements can both be excised from the tool and secured in the record only.

Costs

Because the state of New York supported the training for OASIS, the costs of implementation for our demonstration was to some degree underwritten. The demonstration did not, however, support the costs of implementation in the agency. HCA has undertaken a careful evaluation of the costs and finds that HCFA has dramatically understated the costs. First of all, the average number of admissions in New York's agencies is five times that suggested by HCFA. In part this is because we have limited the market through our Certificate of Need process, thereby concentrating admissions in a smaller number of providers.

Start-up costs in New York were estimated to fall between $1300 and $3200 to incorporate the OASIS items into the assessment form; $600 to $1800 for printing of new forms; and training costs which vary greatly depending upon the size of the agency, the need to fill in with per diem staff while training is taking place, and the ongoing costs of training and retraining necessitated by staff turnover. Some of our largest New York City providers have told us that the ongoing costs of collection and transmission are around $100,000. These costs are calculated as including environmental costs (space for additional data entry people), extra utility costs, ongoing printing, and record storage. In upstate New York, the ongoing costs are around $50,000 in a moderate to large size agency.

Perhaps the most important contribution the federal government could and should make to the implementation of outcome measurement would be the recognition of reasonable hardware and software costs. These tools of the modern age minimize the time needed to process and transmit the data and can allow agencies to utilize the data on a concurrent basis to benchmark their progress. Once prospective payment is presented in its proposed form, it will be important for Congress to step forward and ensure that the infrastructure necessary to do this work is in place and appropriately reimbursed.

While HCA believes that an accurate assessment of the implementation and support costs is important, we hasten to point out that there are costs associated with having no information on outcomes and thereby making mistakes. The participants in the New York demonstration have utilized their outcome reports to make sure that they were providing appropriate care while saving money. As the Interim Payment System forced reductions in visits, agencies were able to judge whether or not there had been an attendant diminution in the care. In several instances, shortages of physical therapists had led to the use of occupational therapists in certain cases. The outcome reports demonstrated that patients with certain conditions who used occupational therapists had done not only as well, but also better than those with the physical therapists, and at less cost. In the last analysis, while it may be costly to collect data and convert it to outcome reports and changes in the process of care, it is costly to make mistakes and to waste resources.

Collection of Data On All Patients

Questions have been raised as to the appropriateness of the government to collect information on patients for whom it does not pay. We make the following observations about this contention:

1. The Conditions of Participation which are the guiding set of regulations for the Medicare program utilize a very sound public policy principle: that those providers who serve the Medicare population must adhere to standards that will be used throughout their operations, thereby applying a uniform standard of expectations to all who are allowed to receive the Medicare operating certificate. We think this is a sound policy from which the federal government should not retreat. By limiting the collection of data only to the Medicare population, the government is implicitly retreating from this high standard.

2. The federal and state governments have an interest in how care is delivered to the Medicaid population as well since there is federal financial participation. New York is currently testing several indicators for the "Medicaid-only" or personal care population. These should be considered at the very least before excluding a large portion of the home care population from outcome improvement efforts.

3. Without a database with which to compare Medicare outcomes, evaluation of how Medicare dollars are being spent will be limited at best. At worst, we could find that we are still in the dark with respect to the value of Medicare's home health benefit.

4. The designation of populations as static is inappropriate. A significant number of the patients who are now private pay will be either Medicare or Medicaid at some point in the future. In New York, at least 18% of our home care population are dually eligible for Medicare and Medicaid. There is substantial crossover in the populations.

5. Over time, we will be able to measure the value of services across sites of care. There is already overlap in the indicators used in the MDS and OASIS. New York's United Hospital Fund has recently undertaken a project to evaluate the MDS-Home Care (which includes a cross-walk with OASIS), that will hopefully facilitate the measurement of performance across the continuum of long term care. Halting OASIS only impedes and delays our progress towards new capitated systems of care.

6. Providers in New York who have good outcomes data have used the data to secure authorization of additional visits from managed care organizations.

7. Consumers need information if they are to be able to make sound choices about the plans and the providers they choose to deliver their care, regardless of who pays.

8. Home health agencies will find it easier to implement a tool on all patients since to separate the various payers will also be labor intensive and may over time lead to less value placed on the data collection and the resulting information.

Conclusion

Home health care costs have spiraled over the last few years. We have been the focus of fraud and abuse charges and increased surveillance and auditing efforts. Unlike other areas of the health care delivery system, however, we have been the first group of providers to step forward and endorse a tool that was uniform and consistent. While other areas of the health care delivery system in the U.S. do outcomes analysis, it is often via competing tools that minimize the ability of observers to compare one institution or provider entity to another. HCA has been proud of the efforts of the home care community in New York and elsewhere that have stepped forward and shouldered this effort with the help and support of researchers and policy-makers. The HCFA national demonstration and New York's OBQI may go down in history as one of the outstanding efforts of a provider community being willing and open to personal and public examination of its efforts and outcomes. We hope this committee and others in Congress will not be deterred from this important effort by those who appear to have an interest in minimizing the evaluation of home care that is justified. The real agenda of the critics may be to ensure that current patterns of utilization and payment continue for as long as possible. Only through information and examination, however, can sound payment and practice for home health be preserved and improved.

VisitingNurseService OF NEW YORK

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STATEMENT OF THE
VISITING NURSE SERVICE OF NY
PRESENTED TO THE
SENATE COMMITTEE ON AGING
HEARING ON
OASIS

May 24, 1999

Contact:

Judith Duhl, Director of Government Affairs
Visiting Nurse Service of NY
107 East 70 Street
New York, N.Y. 10021
212-794-6309

The Visiting Nurse Service of New York (VNSNY) is the nation's largest not-for-profit home health care agency. VNSNY has over one hundred years of experience in serving the diverse populations of New York City. VNSNY currently employs over 6,000 workers who care for 22,000 medically needy New Yorkers every day, including patients with both acute and chronic illnesses, the frail elderly, AIDS patients, and at-risk pregnant women and children.

VNSNY instituted OASIS (Outcomes Assessment Information Set) data collection in 1995 as part of our participation in a HCFA-sponsored national demonstration with the University of Colorado Center for Health Policy Research. We voluntarily expanded the use of OASIS to our entire adult care patient population in early 1998 because, based on our experience, we concluded that OASIS had great value for VNSNY for the reasons described more fully below. We have decided to continue to collect OASIS data despite the recent HCFA decision to suspend the reporting requirements. We have committed significant resources to implement OASIS, and have invested much time and energy to incorporate OASIS data collection into our information and clinical systems and to use the outcomes data to improve our care delivery.

Most significantly, we continue to use OASIS throughout our agency because we recognize the intrinsic benefits of OASIS. OASIS represents a first-ever attempt within the home care industry to develop a broad knowledge base about the clients we serve and the impact of our care, based on standardized, reliable and valid data collection and analysis. It has become the key means by which we at VNSNY are learning about and better understanding the patient population we serve. It is helping us to develop new programs, support our quality improvement efforts, and better manage clinical care to produce improved patient outcomes.

Based upon our extensive experience in collecting and analyzing OASIS data, VNSNY believes it is crucial that OASIS, in its entirety, be reinstated as soon as possible. We believe that OASIS information should be collected for all patients served by an agency, regardless of payor, for the reasons outlined below.

Background

Historically, the home care industry has grappled with the challenge of building an objective knowledge base about its patients and the impact of the care provided. In fact, there is little information available to providers, payors, policy-makers, or regulators which describes and compares beneficiary populations or benchmarks performance within the industry. Because of such a lack of data, there has been widespread misunderstanding about the overall value of home care to the health care system. This has been exacerbated in recent years by significant growth in the Medicare home health benefit and by widespread allegations of fraud and abuse by some providers. The absence of objective comparable performance data, combined with confusion and skepticism about the cost, quality, and effectiveness of home care service is particularly troubling as we approach a prospective payment system. The current and emerging environment make it critically important that home health providers individually and the industry as a whole be able to demonstrate, in an objective and reliable way the needs of our patient populations and how those needs affect utilization, the cost of care, and the effectiveness of care delivery.

As a result of over three years of experience, collecting, using, and analyzing the data from OASIS, we at the VNSNY believe OASIS, while not a perfect instrument, has significantly advanced our knowledge and understanding of these issues.

OASIS is useful for care planning

OASIS provides reliable and valid information to assist an agency to know who its patients are. This unique patient-specific information enables an agency to develop plans of care to meet patients' needs. Home care agencies have always collected information similar to OASIS data for assessment and care planning purposes. However, the major value of the OASIS instrument is the standardization of the content and the information collection process. This enables reliable and valid comparability of patients over time, both within an agency and across home care agencies. This comparability is critical to understanding how patient differences and similarities influence outcomes, evaluating which interventions impact care results, ensuring "best practices", and developing standards of care delivery.

OASIS allows us to build a knowledge base about the effectiveness of home care

There has always been some question, particularly with those unfamiliar with what home care really is, about its value. OASIS is helping VNSNY to understand better and quantify the effectiveness and real value of home care to individual patients as well as the potential impact on the health care system.

For example, OASIS has led to reduction in unplanned re-hospitalizations

As an example, as part of the National Outcomes Based Quality Improvement Project (OBQI), VNSNY and 49 other demonstration agencies used outcome reports generated from OASIS data to focus on developing strategies to reduce the incidence of unplanned re-hospitalization among our patients. As we implemented our improvement plans, we continued to collect and report OASIS data to the University of Colorado Center for Health Policy Research. Within six months, VNSNY as well as the demonstration agencies overall, effected a statistically significant reduction in the occurrence of patient re-hospitalization.

Hospitalization of Medicare beneficiaries represents significant cost to the Medicare Program. Clearly, an instrument such as OASIS, which has an impact on this and other outcomes (such as ambulation and other functional improvements and safe medication administration) through measurement and focused improvement activities, has great potential to reduce the overall cost of care within the health care system.

OASIS should be used in its entirety

Historically, the characteristics and severity of the home health patient population have changed over time, as have the concerns of policy makers. Therefore, it is critical to collect all the information from OASIS (not just 20+ questions) so that as changes occur in the patient population or new policy issues arise, the necessary data will be available. Furthermore, 20+ questions will not be sufficient to provide necessary case mix adjustment to allow for valid comparisons of patient outcomes to assure that patient outcomes are not being compromised as a result of payment incentives. Therefore it is critical to collect all of the data captured by OASIS, not just the items necessary for implementing prospective payment in the short run.

For example, we support the inclusion of the data items related to mental status and depression. VNSNY, in the design of its automated patient records, had identified the need to conduct a thorough and structured screening for depression as part of our regular assessment of home care patients. This was based upon our findings, supported by clinical research, that depression among the elderly is a common and often unrecognized problem that can negatively impact a patient's healing. In an effort to assure more regular recognition and appropriate intervention, it is important that this type of data be included in the collection of information through OASIS to identify problems and issues that impact care planning.

OASIS data collection should apply to all patients

The collection and analysis of outcomes information on all patients will allow us to identify and compare best practices across all patients and all payment sources; it will help inform us whether outcomes vary among different payors, and, in particular, will help us compare how patterns of care and care results may vary between fee-for-service and managed care payors. Historically, Medicare Conditions of Participation mandate that all rules apply to all patients served by a certified home health agency. The vision of the original design of the Medicare home health program was to assure that the same standards of care and patient protections available to Medicare beneficiaries were applied to patients covered by other insurance plans and vice versa, thus safeguarding against the development of a two-tiered system of care for government versus private payors. The same safeguards are necessary in assuring that outcomes of care are consistent regardless of payment source.

Privacy concerns about OASIS

We recognize that many in Congress and the Administration have legitimate concerns about the confidentiality of the electronic transmission of the OASIS data. We believe that this can be addressed by adopting "state of the art" technology to protect the identity of individual patients in order that unauthorized persons do not have access to confidential information about patients.

However, it is significant to note that the information being collected through OASIS has always been collected as part of the assessment and care planning process. The experience of VNSNY is that while OASIS is more structured, it includes no content which is not already collected and recorded in some form on our patients' records. In response to OASIS, we have simply eliminated areas where our own information has duplicated OASIS content and now use the OASIS instrument as a primary source of data collection for our home care records. These patient records have always been, as required by regulation, available to HCFA and other payors and regulators. We acknowledge, however, that patient record data has not been as broadly or easily accessible as it would become with electronic transmission of OASIS. We therefore support efforts to assure appropriate use of the data and to safeguard access to it.

VNSNY has not experienced any problems with confidentiality, or concerns about privacy during any use of OASIS in the past three years. VNSNY has a "Patient Acknowledgement" form that all patients sign. The form alerts patients to the fact that VNSNY must and will provide their medical record information to payors or regulators for purposes of payment review, regulatory audits, and other purposes.

OASIS implementation is costly

We recognize that there are costs associated with implementing OASIS. These include staff training and data entry costs and investment in computer hardware to accommodate the increased volume of data entry and electronic transmission of information, and finally reduced staff productivity during initial implementation. The home health care industry cannot reasonably be expected to absorb these costs as they struggle to adapt to the profound financial impacts of the Interim Payment System, to the prospect of 15-minute billing increments, and an additional 15% reduction in reimbursement. At a minimum, reimbursement should be made to agencies to cover the costs of initial implementation of the OASIS data collection and transmission program.

In conclusion, though we recognize the high unreimburseable costs of OASIS, and acknowledge the concerns about the electronic transmission of OASIS, the Visiting Nurse Service of New York urges Congress to work closely with HCFA and the provider community to get OASIS back on a timely track. Without OASIS there will be no PPS. Without OASIS the industry continues to lack the knowledge it needs about the value of home health care to patients and how these services help to improve clinical and social outcomes, and contribute to the health care industry as a whole.

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