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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. 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. 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	Adjusted HCFA	Actual
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	Estimated Cost	Estimated Cost	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 underestimated 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.