

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

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.