OASIS-C Process Measures…What Is CMS Thinking?

OASIS-C has process measures! Industry responses to this fact include*…"where does CMS get off thinking they should put process measures into an assessment tool?*" and *"process measures belong in the plan of care – not in the assessment".* As a home care consultant and former surveyor with opportunity to visit many agencies, I can assure you – the OASIS-C process measures are a really good idea. There are many agencies that do not ensure adequate patient assessment and who do not include the use of evidence based best practices in their care planning. This occurs not because agency management does not intend to provide the best care to their patients but often because they have made assumptions about their clinicians' understanding of OASIS and care planning. Sometimes home care clinicians do not have a good grasp of Medicare requirements for home care and apply inpatient or outpatient care principles to the care planning for home care patients often resulting in a single diagnosis focus for care planning. A home care assessment and care plan as stated in the Conditions of Participation for Home Health Agencies, includes all diagnoses that will impact the patient's ability to respond to medical treatment and services. Incomplete or inadequate patient assessment and care planning results in poor patient outcomes and may result in lower PPS payments as well. Often home health agencies do not have checks and balances in place to ensure that assessment and care planning documentation omissions and errors are corrected and that appropriate patient care is actually delivered. Although I consistently hear "We provide high quality care" everywhere I go – few home health agencies are able to actually prove it. CMS will now require providers to prove that they are providing high quality care through standardized assessment and process.

The deficit reduction act of 2005 authorized the development of a health care *Value Based Purchasing* (VBP) plan. The VBP plan developed and presented in 2007 includes multiple measures for implementing a system that translates the actual **value** of healthcare services purchased by the government in terms of outcomes and cost. To know the value of the services provided means that CMS must be able to compare clinical and financial outcomes data among like providers. Comparison of data requires standardization; therefore data collection tools and clinical practice must be standardized. Clearly, all providers do not currently use the same assessment tools, protocols, processes or practice. Cost reports and outcomes data have demonstrated to CMS that all health care providers are not efficient and effective. Some home health providers appear to have provided few services and yet have very high costs and profits while others appear to provide many services and lose money. The clinical outcomes data have not shown definite relationships between cost and outcomes. With that in mind, CMS proceeded to pursue their attempt to level the playing field by standardizing more than just the patient assessment; CMS is including OASIS-C process measures, along with HHCAHPS and publically reported patient outcomes. These measurement systems are all a part of the CMS initiative for Value Based Purchasing (VBP). CMS intends to use an algorithm of the aggregation of scores from patient outcomes (Home Health Compare), patient satisfaction (HHCAHPS) and process measures (OASIS-C) to financially incentivize health care providers to become more effective and efficient in the delivery of health care. While hospitals currently will receive their annual payment update

based on the new algorithm (*RHQDAPU) home health care will not feel the full financial impact of VBP for another year or two.

**Reporting Hospital Quality Data for Annual Payment Update*

The stated goals for VBP include addressing underuse, overuse, and misuse of services, encouraging patient-centered care, reducing adverse events and improving patient safety and to stimulate investments in effective information technology, telehealth and the re-engineering of systems. CMS wants to avoid unnecessary costs in care while transforming Medicare from a passive payer to an active purchaser of high quality, efficient care. Current Medicare payment systems are based on resource consumption and quantity of care and NOT quality or efficiency. Health care providers traditionally have been paid based on the number and types of services delivered whether those services were always delivered as efficiently as possible, using the most effective treatment known whether the services were really necessary. The obvious connection between VBP and OASIS-C begins with the inclusion evidence based practice. *CMS states that they are *"committed to developing and publicly reporting process measures that support **evidence-based practices"*** and that they (CMS) *"will be **giving credit** to the agencies that adopt them. CMS has added process measures and CAHPS* (Consumer Assessment of Healthcare Providers) *to outcome measures to be as fair as possible and to give a well-rounded picture of overall agency quality. The new OASIS-C has been designed to also be able to measure improvement in processes."* The CMS response goes on to say, *"Information collected in the OASIS C data set on patient assessment, plan of treatment, and evidence-based practices will be used in the calculation of: 1) publicly-reported measures that recognize agencies that have incorporated evidence-based practices into their agency processes; 2) OBQI/OBQM quality reports that can provide guidance to agencies on how to improve care received by individual patients, prevent exacerbation of serious conditions and avoid adverse events; and 3) a Pay-for-Performance system that would link home health reimbursement to improvements in patient outcomes and/or adoption of evidence-based care processes and is under consideration for future implementation."*

The process measures in OASIS-C actually serve as "subliminal messages" encouraging providers to adopt best practices. The process measures include asking whether risk assessments for hospitalization, falls, heart failure, depression and pressure ulcers have been performed. Answering an OASIS question indicating that no risk assessments were done for any of the specific conditions or potential adverse events that CMS has single out – is guaranteed to raise a red flag. The fact that CMS is collecting data to determine whether or not an agency has implemented best practice guidelines **should** be an incentive to do so. Best practices encouraged by CMS include the provision of influenza vaccine, pneumococcal vaccine, for symptoms of heart failure, pain and depression, appropriate follow up for pressure ulcers and preventive diabetic foot care and patient and caregiver education and intervention regarding high risk drugs. OASIS-C is an excellent tool to introduce the best practice concept to home care providers who have not yet taken that step.

Additionally, OASIS-C includes questions to identify whether patients are at risk for multiple conditions and adverse events. If a patient is found to be at risk –the clinicians completing the assessment are asked to identify what (if anything) was done to **mitigate the risk**. This is a critical point: home health agencies must have the ability to "look back" into the episode to identify processes and interventions implemented.

Home health care agencies without electronic health records (EHR) may struggle to retrieve the "look back" information required without some type of outside data management assistance.

Check with your software vendors to see exactly how they intend to assist you with retrieving the required information. The future of home health care depends on having the ability as providers to respond quickly to change and prove our worth through risk adjusted outcomes and cost containment. The challenge for home health agency owners and senior management is to be able to make wise decisions as to where to spend the money – increasing your marketing budget to bring in more business without having appropriately educated clinical staff to take care of the patients referred will most certainly have poor financial results in addition to poor clinical outcomes. Outcomes will continue to become more transparent. Accurate clinical assessment and best practice implementation is crucial. Maintaining a clinical model that supports strong clinical management oversight of these processes is imperative. Inaccurate data results in inaccurate information. Since payment is dependent upon this data – you must make certain your information accurately reflects the severity of your patients.