

## **NAHC's Response to The National Quality Forum's Draft National Voluntary Consensus Standards for Home Health Care**

October 1, 2004

The National Quality Forum  
Member Council Chair  
Attn: Home Health Care Project  
601 Thirteenth Street, NW  
Suite 500 North  
Washington, DC 20005

Dear Sir or Madame:

The National Association for Home Care & Hospice (NAHC) is the largest association representing home health, hospice and home medical equipment providers. NAHC appreciates the opportunity to comment on the draft *National Voluntary Consensus Standards for Home Health Care*. We support the concept of public reporting of quality measures. We believe that this information is vital to consumers' ability to make informed decisions in their selection of providers of home health services.

NAHC would like to take this opportunity to express its concerns about the proposed measures. We believe that many of these concerns are supported by the National Quality Forum as demonstrated by draft report references, the Centers for Medicare & Medicaid Services' (CMS) ongoing work on OASIS, and RAND's acknowledgement of the need for further refinement of ACOVE measures. Before further steps are taken to require these measures for public reporting, refinement efforts should be geared toward resolving these shortcomings, specifically those related to the intended purpose of OASIS and ACOVE measures, i.e. quality improvement versus public reporting.

### **OBQM Not Intended for Public Reporting**

We recommend that OASIS OBQM measures, including all emergent care and acute care hospitalization measures, not be used for public reporting. The NQF draft report acknowledges that OASIS OBQM measures were never intended for public reporting. This is based on the fact that the developers of OASIS specifically cautioned against such use (Centers for Medicare & Medicaid Services, *Implementing Outcome-Based Quality Improvement in Home Health Agencies*).

According to the developers, OBQM measures “serve as markers for *potential* problems in care because of their extremely low frequency negative ...” However, the developers emphasize “potential” and further state that “whether or not an individual patient situation results from inadequate care provision can only be determined through investigation of the care actually provided to specific patients. For example, as the developer further explains, when an agency investigates “ ‘emergent care for wound infections, deteriorating wound’ ... they may find situations where the patient appropriately went or was sent to the emergency room or physicians office at the very first sign of deteriorating wound status. This would be an example of appropriate care.”

Since OBQM measures are merely indicators of potential quality problems, rather than factual identifiers of deficits in care, it would be inappropriate for consumers to rely on these measures by themselves to determine quality. According to the advice to home health agency surveyors in the CMS *State Operations Manual, Chapter II*, “do not use adverse event reports in a vacuum... review these reports in light of the actual circumstances surrounding the delivery of care to the specific patients.”

Additionally, OBQM reports should not be used for public reporting because they are not adjusted to reflect the acuity level of patients served by an individual agency (i.e. they are not risk adjusted). NQF’s “Criteria for Evaluation and Selection” of measures bases suitability of measures on several criteria, one being that “an adequate and specified risk-adjustment strategy exists.” Without risk adjustment home health agencies that serve the poorest, oldest, and sickest patients will have higher rates of adverse events for reasons beyond their control.

The goal of home health services when caring for chronically ill individuals under payers such as Medicaid is to maintain them in their homes by providing supportive care services until they decline to the point where they must be transferred to an inpatient facility or die. Since OASIS is collected at the end of episodes of care (discharge, transfer or death), the only data collected for these chronic long-stay patients is at the time of these adverse, but inevitable events. We believe that this is another important reason why OBQM measures should be eliminated from the draft quality measures since agencies that care for large populations of chronically ill individuals (i.e. those having no potential for improvement or rehabilitation) will have inordinately high rates of adverse events that do not accurately reflect the quality of care.

#### ACOVE MEASURES

We recommend that ACOVE measures be eliminated from the recommended publicly- reported quality measures for several reasons, including questionable applicability, burden and cost. Furthermore, we believe that recommendation of ACOVE measures is contrary to the requirements of the CMS contract with NQF.

According to the footnote in the draft, NQF reported: "Under the contract for this project, CMS specified that consensus standards transmitted to CMS must "be based on data that are currently reported such that it is feasible for home health agencies to collect the data consistently and with not added burden."

According to RAND, the developers of the ACOVE measures, they were developed and tested in managed care organizations, rather than specific practice settings such as home health care. RAND further stated that the ACOVE measures were developed to evaluate health care at the system (or plan) level...by their health care plans or medical groups." To extend their application to home health care would not be appropriate at this time as they have never been examined and tested in this settings.

Although we agree with RAND that all caregivers must be prepared to identify and address the various health care issues found in the ACOVE measures, there is no consistent method for collecting this information in the home health setting. Furthermore, a primary responsibility of managed care organizations is to assess and diagnose. Although assessment is part of the responsibility of home health providers, to impose assessment requirements of the same magnitude as those for health systems is overly burdensome and inappropriate.

Furthermore, we do not agree that ACOVE measures would add only minimal additional burden as suggested in the draft reports. It takes home health agency clinicians 1 1/2 to 2 hour to complete the start of care OASIS assessment. To add ACOVE measures on top of OASIS requirements would be excessively burdensome. Attachment A provides a side-by-side comparison of data collection requirements of ACOVE as compared to those already collected for OASIS.

In addition to burden (as well as cost) to home health agencies, cost to CMS is a barrier to the ACOVE measures. According to RAND, "to implement the quality indicators in care settings, we developed instruments to abstract medical records, interview patients or proxies, and evaluate administrative data." It would be costly for CMS to develop and implement similar tools and processes in order to collect the information needed to use ACOVE measures as intended by its developers.

#### OASIS OBQI Measures

Finally, we suggest that each of the OBQI measures recommended for public reporting be carefully reviewed. The opinions of NQF and others about the acceptability of OBQI measures are based upon reliability studies conducted by the developers of OASIS and the OBQI process in 1997. Their determination of reliability was based upon the assessment of 66 home health patients by two specially trained clinicians. The clinicians both conducted assessments of the patients within 24-48 hours of each other. Use of OASIS was voluntary at the time. We believe that new reliability studies are indicated in light of the fact that

OASIS is now mandatory, with millions of OASIS data sets on file conducted by tens of thousands of clinicians. We believe that further review is essential in order to ensure that the OASIS reliability is applicable to the “real world” since the study assessments were performed by specially trained clinicians under optimal conditions, whose sole responsibility was to conduct the assessments.

In addition, concerns about OBQI measures are related to shortcoming of the OASIS data set. See Attachment B for specific information.

We thank you again for the opportunity to comment. If you have any questions please feel free to contact me at (202) 547-7424 or by e-mail at [mts@nahc.org](mailto:mts@nahc.org).

Sincerely,

Mary St.Pierre  
Vice President for Regulatory Affairs

## ATTACHMENT A

### COMPARISON OF ACOVE MEASURES AGAINST CURRENTLY COLLECTED DATA

The following table lists the elements of the recommended ACOVE measures that are not currently collected in a common data set used by home health agencies, hospices, etc. Although providers commonly collect this information as part of their comprehensive assessment and documentation of interventions, there is no single collection and reporting mechanism.

<b>ACOVE Measures</b>	<b>Not Documented in OASIS or Other Home Health Data Collection Forms</b>
<b>Vulnerable Elder Determination:</b> age, self rated health, physical and functional limitations Need help or unable to do any five IADL/ADL activities Physical: stooping, crouching or kneeling; lifting or carrying objects; reaching or extending arms; writing or handling and grasping small objects; walking a quarter of a mile, heavy	1. Self-rated health status 2. Physical function limitation: none with exception of heavy housework (M0750) Note: OASIS measure of distance walking limited to 20 feet to identify dyspnea. 3. Functional disability: managing money

<p>housework Functional: shopping, managing money, walking across the room, doing light housework, bathing or showering.</p>	
<p><b>Comprehensive Geriatric Assessment:</b> Medications: List of current medications (prescription and over-the-counter), or Documentation that patient takes no medications</p> <p>Functional status: ADL s/IADLs are noted: bathing, transfer, telephone use, housework, taking medications, dressing, continence, grocery shopping, laundry, managing money, toileting, feeding, meal preparation, mobility/ambulation, handyman work, transportation beyond walking</p> <p>Cognition: Mini Mental State Exam (MMSE), or Assessment of ALL of the following: Memory (e.g., object recall, "memory okay") Orientation (e.g., orientation to person, place and time, O x 3, O x 2, O x 1, "oriented") Attention (e.g., serial 7s or 3s, spell "world" backward, "attention wanders," "alert")</p> <p>Affect: Tested with depression screening instrument [e.g., Geriatric Depression Screen (GDS), Hamilton Depression Scale, etc.], or Documented 3 or more of the following: Mood Level of interest/pleasure in daily activities</p>	<p>Cognition: Mini Mental State Exam (MMSE), or Assessment of ALL of the following: Memory (e.g., object recall, "memory okay") Orientation (e.g., orientation to person, place and time, O x 3, O x 2, O x 1, "oriented") Attention (e.g., serial 7s or 3s, spell "world" backward, "attention wanders," "alert")</p>

<p>Decrease/increase in appetite/weight                  Presence/absence of sleep problems                  Psychomotor hyperactivity/retardation                  Energy level                  Presence/absence of guilt/worthlessness                  Clarity of thinking/concentration                  Presence/absence recurrent thoughts of death/suicide</p> <p>Gait and balance:                  Formal evaluation (usually timed) of both balance and gait while sitting, getting up, standing, and walking (e.g., Tinetti, Get-Up-and-Go, Timed-Up-and-Go, etc., or Description of balance (i.e., stability when sitting/walking/rising, resistance to nudge) or gait (i.e., initiation of gait, step length/height/symmetry/continuity/pat h, trunk, walking stance)</p> <p>Nutrition:                  24-hour dietary intake, or Information about usual type/quantity of food ingested, or Information about factors affecting food intake (e.g., ability to prepare meals, factors affecting appetite)</p> <p>Social support:                  Screened with social support survey instrument (e.g., MOS, Duke Social Support Index, DSSI, etc.) or referral to/consult with social worker, or Documented 3 or more of the following:                  Living situation (e.g., alone/with others, pets)                  Someone to call on for help, if needed (noted to be living with someone or a person outside the home identified)</p>	<p>Balance:                  Formal evaluation (usually timed) of both balance and gait while sitting, getting up, standing, and walking (e.g., Tinetti, Get-Up-and-Go, Timed-Up-and-Go, etc., or Description of balance (i.e., stability when sitting/walking/rising, resistance to nudge) or gait (i.e., initiation of gait, step length/height/symmetry/continuity/pat h, trunk, walking stance)</p> <p>Nutrition (ability to prepare meals and feed self only covered in OASIS):                  24-hour dietary intake, or Information about usual type/quantity of food ingested, or Information about factors affecting food intake</p> <p>Social support:                  Screened with social support survey instrument (e.g., MOS, Duke Social Support Index, DSSI, etc.) or referral to/consult with social worker, or Documented 3 or more of the following:                  Someone to call on for help, if needed (noted to be living with someone or a person outside the home identified)                  Family/social contacts/activities (i.e., level of isolation)                  Economic circumstances</p>
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<p>Family/social contacts/activities (i.e., level of isolation) Economic circumstances</p> <p>Hearing: HHIE-S (or other tool), audioscope, audiogram, or ENT referral, or Tested by whisper, ticking watch, Rinne/Weber, or tympanometry, or Description of hearing status with impact on function</p> <p>Vision: Referral to/consult with ophthalmologist/optometrist, or Tested visual acuity (e.g., Snellen, J-Test, pinhole), or Description of vision status with impact on function</p>	
<p><b>Evaluation of Pressure Ulcers:</b> location, depth/stage, size, presence or absence of necrotic tissue or eschar</p>	<ol style="list-style-type: none"> <li>1. Location</li> <li>2. Size</li> <li>3. Presence or absence of necrotic tissue or eschar</li> </ol>
<p><b>Risk Assessment for Pressure Ulcers:</b> formal assessment of pressure ulcer risk with a standardized tool (e.g. Braden, Norton, etc) OR documentation of an assessment that includes ALL aspects of pressure ulcer risk (i.e. Sensory perception, moisture, activity, mobility, nutrition, and friction/shear.</p>	<ol style="list-style-type: none"> <li>1. Formal scales, e.g. Braden, Norton</li> <li>2. Pressure ulcer risk factors:             <ol style="list-style-type: none"> <li>a. sensory perception</li> <li>b. moisture</li> <li>c. activity</li> <li>d. nutrition</li> <li>e. friction/shear</li> </ol> </li> </ol>
<p><b>Evaluation of Reversible Causes of Malnutrition:</b> admitted with diagnosis of malnutrition, cachexia, inadequate oral intake, hypoalbuminemia includes documentation of nutrition status by a dietitian/nutritionist (or referral made) OR assessment of: dental status (e.g. reference to chewing or referral to dentist); food security (e.g. financial status, referral to social worker);</p>	<ol style="list-style-type: none"> <li>1. Dietian/nutritionist referral</li> <li>2. Dental status</li> <li>3. Food security</li> <li>4. Appetite/dietary intake</li> </ol>

<p>appetite/dietary intake (e.g. nutrition assessment , 72-hour calorie count); swallowing ability (e.g. reference to swallowing, referral for swallowing study or video fluoroscopy); disease-related dietary restrictions(e.g. low salt, low protein)</p>	
<p><b>Evaluation of falls</b> (asking about falls)</p>	<p>Asking about falls</p>
<p><b>Caregiver Support and Patient Safety for Dementia Patients:</b> diagnosis of dementia, Alzheimers disease, OR chronic cognitive impairment whose records document counseling about 2 or more of the following: patient safety, conflict resolution, community resources, general/unspecified/other dementia education</p>	<p>Documentation of counseling about patient safety, conflict resolution, community resources, general/unspecified/other dementia education</p>
<p><b>Documentation of Advance Directive, Surrogate or Preferences:</b> advance directive or durable power of attorney or living will, OR, note describing patient treatment preferences or name of surrogate OR note of discussion attempting to elicit patient treatment preferences or name of surrogate</p>	<p>Documentation of Advance Directive, Surrogate or Preferences</p>

## Attachment B

### Home Health Care Performance Measures

The National Association for Home Care (NAHC) is the largest trade association representing home health agencies in this country. NAHC has long supported the development of performance measures for home health services. Our efforts in this area include development and presentation of OASIS educational programs

and materials, beginning in the early 1990s. We have also supported and promoted the Quality Improvement Organizations' (QIO) educational efforts.

The OASIS data set and resultant outcome reports are the only standardized tools available for measurement of home health quality at this time. However, NAHC has serious concerns about the accuracy and precision of some of the OASIS outcome measures. These concerns are based on reports from numerous clinicians and quality improvement experts since the advent of OASIS data collection. Many of these concerns are under review by the Center for Health Services and Policy Research at the University of Colorado's Technical Expert Panel, which consists of representatives from the provider and research community.

Ideally, OASIS should serve as the data source for home health performance measures since home health agencies have had nearly five years of experience with OASIS data collection. However, the problems identified below should be addressed and corrected before any of the outcomes listed are selected. Therefore, NACH requests that the National Quality Forum, and its home health care steering committee, carefully consider the following list of problems that we have identified with OASIS and the outcomes produced.

#### TRANSFERRING

The outcome measures for improvement and stabilization in grooming, dressing, and transferring include lists of specific tasks that must be assessed in order to determine a patient's ability to perform those activities of daily living (ADL). The Centers for Medicare and Medicaid Services (CMS) instructs home health clinicians that, if a patient demonstrates variability in the capacity to perform the tasks included in the ADL, the clinician should choose the response that describes the patient's ability more than 50% of the time.

We believe that requiring clinicians to measure frequency of performance results in subjectivity. We feel that this subjectivity adversely impacts the validity of the ADL outcome measures. In addition, use of the "more than 50%" rule causes the outcome measures to be insensitive to improvement under certain circumstances. For example, the requirement to rate patients as independent when they are able to perform ADLs or transfer more than 50% of the time, or more than 50% of the task in that ADL, at a given time results in failure to measure improved functioning.

#### BATHING

Many elderly individuals are admitted to home care unable to bathe without assistance. However, after receiving home health services, patients frequently improve to the point of being independent in bathing themselves at a sink. This is the maximum level of improvement that will be achieved by many elderly individuals because they will never be deemed to be safe using a shower or tub.

However, the OASIS outcome for bathing fails recognize progression from dependent to independence in bathing at the sink as improvement.

#### **AMBULATION**

The ambulation outcome fails to measure improvement in walking with a walker to a cane, and from walking with a quad cane to a straight cane. Additionally, this outcome fails to measure improvement in the distance an individual can ambulate, an important goal of therapy services since it demonstrates increased endurance.

#### **SURGICAL WOUNDS**

The outcome for status of surgical wounds is insensitive to measurements of improvement that takes place during many post-surgical episodes of care. Older surgical wounds must often be coded as a “fully granulating” upon admission. Although these wounds continue to heal in response to home health services, they can only be coded as “fully granulating” upon discharge since fully granulating is the best score available. However, unlike all other OASIS items that are excluded from the outcome calculations when patients cannot show improvement because they are at the maximum level on admission, patients with fully granulating surgical wounds are included, thus negatively impacting agencies’ outcomes.

#### **MEDICATION MANAGEMENT**

The impact of care is not measured despite improvements if, on admission, patients are able to manage more than 50% of their oral medications or manage oral medications more than 50% of the time. The effects of care cannot be measured for these patients because they are not included in outcome reports since their ability is scored at the highest level (independent) despite the fact that there are deficits in their ability.

#### **ADVERSE EVENTS**

Discharge to the community needing wound care or medication assistance is calculated based upon the following OASIS items: discharge to the community, presence of confusion, inability to manage medications, status or pressure ulcers and surgical wounds. This adverse event does not include identification of the presence of caregivers who could perform these functions for dependent patients, an important consideration when determining whether the discharge was appropriate or inappropriate.