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OASIS Alert

Industry Notes: NEW REPORT LAUDS OBQI DEMONSTRATION

Agencies choosing not to implement an outcome-based quality improvement program according to the **Centers for Medicare & Medicaid Services** game plan could be straying from the path to improved patient outcomes, a report suggests.

Hospitalization rates declined 22 percent in the national OBQI demonstration and 26 percent in the New York State demonstration, OASIS contractor **Center for Health Services Research** notes in a report recently posted to CMS Web site.

Rates of improvement for other target outcome measures from ambulation to improvement in urinary tract infections averaged between 5 and 7 percent per year in both trials, compared to 1 percent for non-targeted outcomes.

All of the demo agencies didnt take to OBQI right from the beginning, the report concedes. But those that stuck with it saw improvement as time marched on. "During the second year of OBQI, clinicians typically made the transition to an outcome-oriented mindset and better understood the need for OASIS data," the report says.

A major hurdle to OBQI success now is "a general lack of awareness of the rationale for and operational components of OBQI," CHSR warns. It urges CMS to continue training and disseminating information on OBQI.

The report and accompanying reports describing methodologies used for the development and calculation of OBQI indicators, as well as information on the studies on the validity and reliability of OASIS data, are at www.cms.hhs.gov/providers/hha/.

The General Accounting Office is calling for CMS to train a corps of super-surveyors to crack the whip on home health agencies, according to a new report.

The HHA survey system is rife with problems, the GAO insists in the report released July 19, "Medicare Home Health Agencies: Weaknesses in Federal and State Oversight Mask Potential Quality Issues" (GAO-02-382).

Many of the fixes the GAO proposes would result in more condition of participation-level deficiencies cited and more surveys conducted, potentially ushering in a whole new era of Operation Restore Trust-style survey tactics, observers fear.

One major problem: The number of COP-level deficiencies cited varies drastically among states, the GAO says. Another point of consternation for the watchdog agency is that state survey departments often are reluctant to terminate an agency from Medicare participation, instead letting it slip in and out of compliance with COPs, the report claims. To remedy this situation, CMS should implement a 13-year-old law mandating intermediate sanctions that surveyors could use to deal with noncompliance namely, civil monetary penalties, the GAO suggests.

Other perceived problems with the survey system include a discouraging complaint system, lack of surveys for branch offices, only a small number of records reviewed, and small sample sizes.

The report is at www.gao.gov/new.items/d02382.pdf.

If youve had trouble finding what youre looking for in the OASIS question-and-answer sets on the **Centers for Medicare & Medicaid Services** Web page, a recently added feature could bring a smile to your face.

At a frequently asked questions link on www.cms.hhs.gov/oasis/hhnew.asp, CMS allows users to search 281 FAQs by

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category or with a text search. CMS has eliminated duplicate questions as part of the new format, but the remaining questions have not changed, it says.

Public comparison of HHA outcomes already is capturing press attention. The South Bend Tribune Business Weekly has profiled the outcome-based quality improvement reports and highlighted the strengths and weaknesses of local HHA **Memorial Home Care**.

CMS has instructed Medicare contractors to establish a new process for reconsidering local medical review policies, according to July 10 program Transmittal No. 28. LMRP reconsideration requests must come from a beneficiary residing in or a contractor doing business in a contractors jurisdiction, only apply to final LMRPs, be in writing, and identify the language the requestor wants added to or deleted from the policy.

Contractors have 30 days from a request submission to decide if the request is valid. If not, hey must respond in writing to the requestor explaining why it is invalid. If so, the contractor must make a decision within 90 days and notify the requestor of the decision, including its rationale.

Contractors must post information about the new LMRP process on their Web sites, CMS adds.

CMS plans to instruct intermediaries to relent on a controversial foot care policy, CMS officials told industry representatives in a recent conference call. CMS will issue a clarification indicating that a recent coverage decision on foot care for patients with diabetes and vascular disease wouldnt prevent home care nurses who are trained to do so from providing foot care such as cutting nails for such patients, reps report. However, CMS has promised to issue other clarifications on the foot care policy in the past to no avail, observers note.

The Joint Commission on the Accreditation of Healthcare Organizations has unveiled another set of standards required of accredited home care providers.

"This first set of National Patient Safety Goals gives health care organizations focused, practical recommendations that will reduce specific health care errors," JCAHO said in announcing the goals July 24. "JCAHO will assess compliance with these recommendations during its onsite evaluations beginning January 1, 2003."

The goals are to:

1) Improve patient identification accuracy.
2) Improve the effectiveness of communication among caregivers.
3) Improve high-alert medication safety.
4) Eliminate wrong-site, wrong-patient, wrong-procedure surgery.
5) Improve infusion pump safety.
6) Improve the effectiveness of clinical alarm systems.

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