Public Comment Summary Report

Project Title

Quality measures to satisfy the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) domain of: Home Health Application of the Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function Measure

Dates

- The Call for Public Comment was open from November 10, 2016 to December 09, 2016.
- The Public Comment Summary Report was finalized on February 23, 2017

Project Overview

The Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 was signed into law on October 6, 2014[1] . This Act requires Post-Acute Care (PAC) providers to report standardized patient assessment data and quality measure data to the Secretary.

The Centers for Medicare & Medicaid Services (CMS) is aligning quality measurement with PAC assessment instruments. Current federal assessment instruments are setting-specific and contain assessment items with varying concepts, definitions, and measurement scales. The move towards standardized assessment data elements facilitates cross-setting data collection, quality measurement, outcome comparison, and interoperable data exchange.

The Centers for Medicare & Medicaid Services (CMS) has contracted with Abt Associates to develop a cross-setting post-acute care measure for the quality measure domain – Function Status, Cognitive Function and Changes in Function and Cognitive Function. The contract name is Outcome and Assessment Information Set (OASIS) Quality Measure Development and Maintenance Project (contract number HHSM -500-2013-13001I, Task Order HHSM-500T0002). As part of its measure development process, CMS requests interested parties to submit comments on the candidate or concept measures that may be suitable for this project.

In this measure, Percent of Home Health Episodes with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function is outlined in the following description:

The cross-setting function quality measure is a process measure that is an application of the quality measure Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function (NQF #2631). This quality measure reports the percent of patients with a start of care/resumption of care and a discharge functional assessment and a treatment goal that addresses function. The treatment goal provides evidence that a care plan with a goal has been established for the patient.

Project Objectives

To obtain public input on the application of the quality measure Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function (NQF #2631) for Home Health.

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[1] https://www.govtrack.us/congress/bills/113/hr4994

Information About the Comments Received

- Web site used: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/CallforPublicComment.html
- Public comments were solicited by the following methods:
    - Posting on the CMS Public Comment website
    - Email notification to relevant stakeholders and stakeholder organizations
- Volume of responses received: CMS received 16 comments during the comment period

Stakeholder Comments – General Summary

This report provides a summary of public comments received for the Public Comment Period of November 10, 2016 to December 9, 2016, the close of the comment period. Abt Associates received a total of 17 comment letters and, of these; 15 comments are relevant to this project. One comment was out-of-scope and addressed the NPUAP proposed pressure ulcer staging terminology changes, including replacing "pressure ulcer" with "pressure injury." A second out of scope-comment addressed items to be included in the transfer of health measures. The Abt team also previously solicited comments on behalf of CMS regarding the *Refinement of Percent of Residents or Patients with Pressure Ulcers that are New or Worsened (Short-Stay) (NQF #0678) and Language Modifications Being Explored with the Term "Pressure Injury" and the "Transfer of Health Information and Care Preferences When an Individual Transitions" measures*, whose public comment periods overlapped with that of the functional status public comment period. That comment period is now closed. CMS thanks all commenters for providing comments, concerns, and suggestions in response to the request for public comment.

Several commenters expressed support for standardizing functional status data collection and for the overall measure construct. One commenter hypothesized that this process measure will increase awareness and compliance with collections of complete functional data across PAC providers. Another commenter noted that this process measure is useful for treatment but less for patient prognosis. Finally, one commenter concurred that variation in data collection across PAC providers makes communication about patient functional status at discharge challenging.

1. Burden

Summary: Four commenters expressed significant concern with the addition of new function items to the items that are currently included on the OASIS-C2 assessment. One commenter did not support the addition of new assessment items due to the added burden that would result from this addition. Three commenters suggested that extant OASIS items that would be duplicative with section GG items should be removed from the OASIS assessment to limit the additional burden to providers and patients. One of these commenters further noted that existing OASIS functional items are used for multiple measures, for risk-adjustment and for calculating case mix and recommended CMS use the new section GG assessment items for these purposes instead. Two commenters additionally requested CMS consider the additional resources needed by providers to accommodate item set changes, while another encouraged ongoing education efforts for new data elements. Finally, one commenter raised a general concern about the burden of all OASIS data collection for patients with very short episodes that end in death or transfer.

Response: CMS appreciates the feedback from commenters concerned with additional burden that could be introduced with new OASIS items for this functional status measure. CMS is sensitive to the issues of burden that could arise with new measures and will be mindful of factors of burden throughout the measure development process. CMS will review current OASIS functional items for their usage in current

measures, case-mix calculations, and risk adjustment and take into consideration the best ways to address burden for providers and patients.

2. Reversal of scales

Summary: Five commenters expressed concern that the scale on the section GG items and the current OASIS functional items are reversed, which could affect the reliability and validity of the items. They suggested the need for guidance to clarify how the section GG items should be scored. This commenter also noted that codes 07, 09 and 88 did not follow the order of the other coding. In addition, one commenter suggested standardizing all scales in the OASIS.

Response: CMS acknowledges that the scale for the items in the Section GG is reversed from the current OASIS C2 items and their associated scales. The Section GG item use an independence rating scale (higher score indicates independence). Should the new items be added to the OASIS C2, guidance will share how section GG items should be scored. There will also be clear guidance and training for the appropriate use of the "activity not attempted" codes "07","09", "88" with respect to the new Section GG items. The interrater reliability of the items in the Section GG has been tested and the results have been favorable with items' kappa scores between .59 and .80. Additional testing of the Section GG items with the OASIS functional items is ongoing to help develop guidance to support providers effectively managing the differences in the item scales.

3. Exclusions

Summary: Two commenters suggested exclusions for the function process measure. One commenter suggested excluding patients with cognitive impairments or who were enrolled in hospice care. Both commenters advocated for excluding patients who are likely to experience functional decline or who have diagnoses that specifically limit their function.

Response: CMS appreciates feedback from commenters with respect to exclusions for the functional process quality measure. This quality measure requires that a functional assessment be conducted at admission and discharge and that at least one function goal is reported. An assessment of a patient's functional status is relevant for a person with cognitive limitations and patients enrolled in hospice. Codes indicating that the activity was not attempted due to medical conditions or safety conditions or due to patient refusal may be used as part of the functional assessment. As a process measure, there are no denominator exclusions anticipated for this measure at this time. If this measure is finalized, guidance will be provided to assist providers in determining how best to assess patients with cognitive impairments or other clinical challenges that may serve as barriers in completing a functional assessment at start of care, resumption of care, or discharge.

4. Infeasible Items

Summary: Three commenters suggested that some items would not be appropriate for the home health setting and meaningful data couldn't be collected. Two such items mentioned specifically were the mobility items which assess the ability of the patient to walk or wheel 150 feet.

Response: We thank commenters who have raised concerns about items that may not be feasible to collect in the home health setting. CMS is aware that the assessment of some functional status items from Section GG items may not be practicable in the home health setting. CMS is investigating the best process for addressing scenarios in which an item cannot be feasibly assessed. Please note that there will be guidance that outlines how to use appropriately the "activity not attempted" codes "07","09", "88" with respect to the new Section GG items should these be adopted in the OASIS C2.

5. Goals

Summary: Two commenters addressed the issue of goals. One commenter outlined the need for guidance on the appropriate completion of the goals items and the usage of assistive devices. They noted that there currently is guidance related to the OASIS for existing functional items and emphasized that providers would need guidance to appropriately complete the assessment items needed for the function process measure. Another commenter expressed that setting goals at the beginning of care may result in unreasonable expectations and asked about the flexibility and process to reassess the goals.

Response: CMS thanks the commenters for the input on usage of assistive devices and assessing functional status goals with Section GG items and their concern about appropriate goal-setting. Determining the nature of the use of an assistive device is an important component of a patient's functional assessment. Should these items be added to OASIS C2, CMS will share provider guidance for the completion of functional assessment goals with assistive devices in a similar manner to guidance for the functional assessment items currently in the OASIS. With respect to appropriate goals, CMS expects that goals established will serve as the basis for providing quality care to patients and as a component of ongoing assessment of the patient's capabilities and needs. A HHA may decide to monitor patients' achievement of goals; however, the measure does not include monitoring the percent of patients who meet or exceed goals.

6. Workflow

One commenter noted that functional assessment is a multi-disciplinary process and should include all members of the rehabilitation team, adding that limiting this task to one clinician was not appropriate. This commenter also suggested other standardized screening tools or methods for quickly assessing patient functioning, such as the Timed Up and Go (TUG) tool.

Response: CMS appreciates feedback on appropriate workflow consideration for the functional status process measure. CMS will consider further the appropriateness and impact of multiple members of a rehabilitation team contributing to the completion of this process measure. CMS will also review the use of tools such as TUG in the development and refinement of any functional status measure.

7. Timing of Completing Functional Assessment

One commenter recommended CMS specify the timeline for completing the functional assessment.

Response: CMS appreciates the commenters request for additional information. With respect to the timeline for completion of the functional assessment, just as with OASIS assessent items, the expected timing for this measure is at start of care, resumption of care, or at discharge.

8. Additional items for assessment (cognitive function, self-care)

One commenter suggested the measure should include assessment of cognitive/executive function. Two commenters recommended adding bathing and dressing; one additionally noted these activities were more important than oral hygiene for assessing self-care.

Response: CMS thanks commenters for their input on additional items for consideration with respect to functional assessment. Items included in this measure represent the set of items that may be included across the four PAC providers that seek to standardize this process measure for functional status. These measures represent key areas of functional status, self-care and mobility of a patient, and key areas for establishing function goals with each patient. While the Section GG items focus primarily on motor function, patients requiring supervision due to cognitive limitations are coded as requiring supervision;

they are not considered independent. Additional items focused specifically on cognitive function and executive function are being tested for use in PAC in response to the IMPACT Act. CMS will take all new item suggestions into consideration in the measure development process.

9. Ambulation

Two commenters noted that while screening item GG0170 H1 instructs clinicians to continue to GG0170I ("Walk 10 feet") for patients that walk, this item was not included in the item specifications. One commenter recommending including "Walk 10 feet" as this is an appropriate task for some home health patients. Another cited a concern that walking does not take into account use of an assistive device.

Response: CMS thanks the respondents for their feedback with respect to ambulation. CMS will consider the suggestions for additional ambulation items. With respect to assistive devices, the assessment of each activity is conducted with an assistive, if appropriate.

10. Measure population

Summary: One commenter expressed concern with the lack of standardization in the population to be measure across PAC settings, e.g. Medicare only versus Medicare and Medicaid.

Response: CMS appreciates the commenter's attention to the issue of standardization in population across PAC settings. CMS is working to standardize the IMPACT Act measures and will consider population characteristics to best compare outcomes across varied payer populations. Characteristics of the population for this measure are defined by the population requirements of the Home Health setting's assessment tool, OASIS. The requirements of the OASIS determine the population characteristics for this potential measure.

11. Item Wording

Summary: One commenter suggested adding "safely" to the coding descriptions, to read "Patient safely completes . . ."

Response: CMS appreciates the commenter's emphasis on patient safety when considering coding descriptions for functional status measure items. Patient safety is a top priority as outlined in the National Quality Strategy and CMS anticipates that patient safety is carefully considered when evaluating a patient's functional ability and goals. Any guidance presented with respect to functional status items will emphasize that appropriate assessment of patient functional ability will be grounded in the concern for patient safety.

12. Intended measure use

One commenter asked for clarification with respect to CMS' intended use of the measure, asking whether it would be publicly-reported to facilitate consumer choice or if it would be used for making value-based payment decisions.

Response: This measure is being developed to satisfy a domain of the IMPACT Act as mandated by this law. If finalized, it will be publicly reported as part of the Home Health Quality Reporting Program as mandated by the IIMPACT Act.

Public Comment Verbatim Report

The following table details the verbatim comments received. We did not make any changes or edits to the content. However, we did exclude comments that were irrelevant to measure development.

ID	Date Posted	Text of Comments	Name, Credentials, and Organization of Commenter	E-Mail Address	Type of Organization
1	11/10/16	Hello One of the most confusing things with the addition of the first GG item to OASIS, is the fact that it uses a totally different scale of measurement than other OASIS functional items. While I have no personal or professional objections to the items added, I would like to recommend that if the other functional items within the home Health OASIS are to remain (dressing for example) that they go to the same consistent measurement scale. When one item scores 1 as best 5 as worst and the next scores 6 as best 1 at worst, it is confusing to field clinicians everywhere. I would also like to point out that in the home setting, the likelihood of a 150 ft corridor or somewhere you can wheel a wheelchair 50 feet with 2 turns is slim. It's a unusual home that has a 150 foot space that someone can walk in. Thank you for listening	Susan Johnsen, RN, MSN, COS-C Loma Linda University Medical Center Home Health Care	Johnsen, Susan <SJohnsen@llu.edu>	HHA Provider
2	11/11/2016	I would not include diet/nutritional measures which should be ordered by Physician, or discharge instructions in the measures. Patient preferences for advance directives must be confirmed by law with each transfer to a new facility, to assess patient rights to determination and change in preferences. Therefore providing this information is redundant and must be duplicated and confirmed with Physician orders. Patients with impaired cognitive status should be excluded and patients with end of life prognosis or transfer/discharge to hospice excluded. Patients with medical restrictions or contradictions should be excluded such as patients with surgical precautions, weight bearing limitations for mobility. If the redundant/duplicate oasis questions are eliminated for items of performance such as toileting hygiene, bed transfers, toilet transfers: then the functional abilities and discharge goals would be suitable. Additional time in data collection for oasis GG0170 and GG 0130 would be required and up to additional 30 minutes in observation for these activities.	Nina Kaiser, RN, BSN PHN MBA COS-C, Sutter Health	kaisern@sutterhealth.org	HHA

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		The coding does not provide enough guidance in the instructions (whether it is on the day of assessment ability and last 24 hours or 50% of usual ability and with or without assistive devices esp.). Types of assistive devices required should be included same as in the current oasis data set. Data does not appear suitable to be provided to patients/caregivers as it would lack meaningful and easily understood or health literacy standards for patient education. My comments reflect my views as an individual and not of any organization			
3	11/11/2016	I would not include diet/nutritional measures which should be ordered by Physician, or discharge instructions in the measures. Patient preferences for advance directives must be confirmed by law with each transfer to a new facility, to assess patient rights to determination and change in preferences. Therefore providing this information is redundant and must be duplicated and confirmed with Physician orders. Patients with impaired cognitive status should be excluded and patients with end of life prognosis or transfer/discharge to hospice excluded. Patients with medical restrictions or contradictions should be excluded such as patients with surgical precautions, weight bearing limitations for mobility. If the redundant/duplicate oasis questions are eliminated for items of performance such as toileting hygiene, bed transfers, toilet transfers: then the functional abilities and discharge goals would be suitable. Additional time in data collection for oasis GG0170 and GG 0130 would be required and up to additional 30 minutes in observation for these activities. The coding does not provide enough guidance in the instructions (whether it is on the day of assessment ability and last 24 hours or 50% of usual ability and with or without assistive devices esp.) Types of assistive devices required should be included same as in the current oasis data set. Data does not appear suitable to be provided to patients/caregivers as it would lack meaningful and easily understood or health literacy standards for patient education. My comments reflect my views as an individual and not of any organization.	Nina Kaiser, RN, BSN PHN MBA COS-C, Sutter Health	kaisern@sutterhealth.org	HHA

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4	11/15/2016	Folks, This metric requires a care plan to address the functional limitations reported at admission. Implicit in this requirement is a plan which aims to improve or maintain the current level of functional performance. In the case, where the patient is frail and elderly and may be at home instead in institutional care, there may be no prospect of functional improvement or maintenance. The patient's downward decline may be impossible to arrest and to determine how much the care plan slowed is very challenging. Therefore, the quality metric should exclude those patients whose functional level is not likely to improve.	Rich Chesney, Healthcare Market Resources, Inc.	rchesney@healthmr.com	HHA Advocacy
5	11/17/2016	The home health care industry is both interested in and committed to quality improvement. However CMS has continued unabated in its insatiable demand for more and more data. Instead of refining an already burdensome OASIS tool, CMS insists on piling on, year after year, additional data collection burden. The Home Health industry has been required to operate under an onslaught of regulations coupled with year over year cuts to reimbursement and then is asked to add on ever increasing administrative burden to collect ever more data. CMS would be better served by vastly reducing the unnecessary data collection and data collection points to create an efficient but more importantly effective methodology and tool to collect critically important cross setting data that would actually provide valid useful information. Accurate, valid information could then lead to real tangible quality improvement.	Judith Flynn MBA BSN RN CHC Vice President Patient Care Quality, Compliance Officer Partners HealthCare at Home	JBFlynn@partners.org	HHA
6	12/1/2016	The greatest impact to homecare re: changes in the functional assessment (OASIS) is: 1. For several of the questions CMS has reversed some of the scoring scales, which will lead to increased potential for errors/inconsistencies. For example: Currently all of the functional scoring scales---0 = independent (scales are usually 0-4 or 5, with increasing assistance needed (ie 5= maximum dependence), but with OASIS C2, some of the scales have been reversed 0=maximum dependence, and 5 is independent.	Jennifer A. Powell (Tenorio) BS, MSW, MBA-HCM Director of Continuing Care Trinity Health	Jennifer.a.powell@trinity-health.org	HHA
7	12/08/2016	Hello, The American Geriatrics Society (AGS) appreciates the opportunity to comment on the draft specifications for the development of the process measure: "Percent of Home Health Episodes with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function." The AGS is a not-for-profit organization comprised of nearly 6,000 professionals dedicated to improving the health, independence, and quality-of-life of all older adults. We have the following comments:	Anna Mikhailovich Senior Coordinator, Public Affairs and Advocacy The American Geriatrics Society	AMikhailovich@americangeriatrics.org	Advocacy

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		• Overall, the AGS believes that the measure is a good starting point for improving function in the post-acute care population. • We are seeking clarification regarding how the measure will be used. Will it be posted on the CMS website so that Medicare beneficiaries as consumers can make informed choices when choosing a home health agency? Or will it be used by CMS as a means to either reward "high performing" agencies and/or withhold payment to "low performing" agencies? • We suggest adding a specific timeframe to make the measure more impactful, e.g. requiring that the functional assessment be completed within one week of the start of home care services. • We also suggest adding "dressing" and "bathing" to the list of functional status items. • In the Section GG item set for mobility, we note that the "walking" assessment does not take into account if the patient uses an assistive device. For example, while several patients at baseline do not use a walker, they are discharged from the hospital with a walker due to balance issues or weakness from their acute illness. In these cases, the appropriate home health or skilled nursing facility goal would be to have the patient return to (near) baseline ambulating with less than walker, either with a cane or without any device. Thank you again for the opportunity to provide feedback. Should you have any questions, please don't hesitate to get in touch. Best regards, Anna			
8	12/09/2016	To Whom It May Concern: On behalf of the Association of Rehabilitation Nurses (ARN) – representing more than 5,400 rehabilitation nurses and more than 13,000 Certified Registered Rehabilitation Nurses (CRRN) that work to enhance the quality of life for those affected by physical disability and/or chronic illness – we appreciate the opportunity to comment on the development of a cross-setting post-acute quality measure on the Percent of Home Health Episodes with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function. Rehabilitation nursing is a philosophy of care, not a work setting or a phase of treatment. We base our practice on rehabilitative and restorative principles by: (1) managing complex medical issues; (2) collaborating with other specialists; (3) providing ongoing patient/caregiver	Jordan Wildermuth, MSW Manager, Health Policy & Advocacy Association of Rehabilitation Nurses (ARN)	jwildermuth@connect2amc.com	Advocacy

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		education; (4) setting goals for maximum independence; and (5) establishing plans of care to maintain optimal wellness. Rehabilitation nurses practice in all settings, including freestanding rehabilitation facilities, hospitals, long-term subacute care facilities/skilled nursing facilities (SNFs), long-term acute care facilities, comprehensive outpatient rehabilitation facilities (CORFs), home health agencies (HHAs), and private practices, to name a few. Rehabilitation nurses take a holistic approach to meeting patients' nursing and medical, vocational, educational, environmental, and spiritual needs. Rehabilitation nurses begin to work with individuals and their families soon after the onset of a disabling injury or chronic illness. We continue to provide support and care, including patient and family education, which empowers these individuals when they return home, to work, or to school. Rehabilitation nurses often teach patients and their caregivers how to access systems and resources. Identify setting-specific needs/concerns/barriers for capturing functional assessment and goal setting information using the data elements. Understanding the functional improvement of the patients our nurses treat is critical to ensuring these patients receive quality care. We concur with the statement in the Public Comment Document that the variation in data collection makes communication about patient/resident functioning challenging when patients/residents transition from one type of provider to another.[1] Another challenge presents itself as a result of the evolution of health care and increased specialization. During a patient's transition to a new setting, frequently, the discharging institution fails to transmit the patient's comprehensive medical information. This creates gaps in a patient's medical record, which can negatively impact patient care, including medication errors, wrong-site surgery, and death.[2] Transfer of information is particularly impacted by the time of day in which the discharge occurs. Weekend, late-afternoon, and holiday discharges can put patients at risk for readmission due to lack of available support services.[3] Gather feedback on importance, feasibility, usability and potential impact of adding functional assessment data elements for quality measurement as new items to the OASIS item set. Developing a care plan to address function is imperative to assure patient safety and return to optimal health. The collection of functional assessment data is not burdensome, as the items are being assessed at home; addressing functional assessment, however, is a multidisciplinary process and must include all members of the rehabilitation team. While the collection of functional assessment data is feasible, the expectation that solely one person can complete the OASIS assessment at the start of services and also report on new			

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		functional assessment items in a time-efficient manner is mistaken. The additional specifications outlined in the measure, particularly in regards to duplicative types of transfers and other walking and activities of daily living (ADL) functional assessments are extensive, time intensive, and require significant training. Generally, the majority of initial OASIS assessments are completed by registered nurses who must complete comprehensive physical and symptom assessments, as well as rigorous medication reconciliation. The first visit also requires significant time devoted to coordination of care. In total, the first visit in the patient's home takes approximately 90 minutes, which allows little to no time for reporting functional assessment items to the degree proposed within the measure. As a means to address the limited amount of time to assess function, ARN recommends that function be assessed by the completion of standardized screening tools, such as the timed up and go tool, a commonly used screening tool to assist clinicians in assessing a patient's functional level. Another method to determine function without requiring a labor intensive assessment could involve asking a patient to take off his shoes and socks. A positive screening then results in a more thorough, extensive, and specific assessment. CONCLUSION ARN very much appreciates the opportunity to provide comments to Abt Associates on the development of a cross-setting post-acute quality measure on the Percent of Home Health Episodes with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function. We are available to work with you, your colleagues, the rehabilitation community, and other stakeholders to develop and implement payment policy changes that ensure access to quality care for Medicare beneficiaries with physical disabilities and/or chronic disease. Should you have any questions, please do not hesitate to contact me or our Health Policy Associate, Kara Gainer (kara.gainer@dbr.com /202-230-5649). We thank you for your consideration of our concerns, recommendations, and requests. Respectfully submitted, Stephanie Vaughn, PhD RN CRRN President [1]Abt Associates. (2016). Development of the process measure: Percent of home health episodes with an admission and discharge functional assessment and a care plan that addresses function: Public comment document. Retrieved from www. cms.gov. [2]Friesen, M., White, S., and Byers, J. Handoffs: Implication for Nurses. https://www.ncbi.nlm.nih.gov/books/NBK2649/ [3]Nelson, J.M., Pulley, A.L. (2015). Transitional care can reduce hospital readmissions. American Nurse Today, 10 (4).			

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9	12/9/2016	Re: IMPACT Act of 2014 Cross-Setting Quality Measure: Percent of Home Health Episodes with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function. The metric itself seems to be useful and appropriate generally. I am concerned that very short stays in home health – e.g., death within a day or two, or transition to a different setting in the same time frame. Should the patient and the agency have to have completed an OASIS at all? I am impressed that a patient cannot generally be enrolled in home health in less than a couple of days because care cannot start until OASIS is complete. This limits rapid response which might avoid hospitalization. (see, for example, http://medicaring.org/2015/05/19/just-how-dysfunctional-is-frail-elder-care-in-the-u-s/) This is not peculiar to this metric, but this metric adds weight to the requirement to get all those questions answered before doing anything useful for the patient. A minor point – the items under section 4.2.3 are misnumbered, which makes the fourth item challenging, since it refers to the correct numbers. Thanks for the opportunity to comment	Joanne Lynn, MD Director Center for Elder Care and Advanced Illness Altarum Institute	joanne.lynn@altarum.org	Healthcare research
10	12/9/2016	IMPACT Act of 2014 Cross-Setting Quality Measure: Percent of Home Health Episodes with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function On behalf of our 93,000 member physical therapists, physical therapist assistants, and students of physical therapy, the American Physical Therapy Association (APTA) submits the following comments on the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 Cross-Setting Quality Measure: Percent of Home Health Episodes with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function. Physical therapy is an integral service provided to Medicare beneficiaries in all post-acute care settings. Physical therapists furnish medically necessary services to patients to improve their overall health and function, and to optimize their quality of life. Across the post-acute care settings, physical therapists provide services to patients through a plan of care that engages and optimizes the patient's participation in achieving shared goals of improved functional performance, reduced risk of injurious falls, and reduced risk of acute hospitalization, thereby promoting long-term health and wellness.	Heather Smith, PT, MPH Director of Quality American Physical Therapy Association	heathersmith@apta.org	Advocacy

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		Physical therapists perform an examination that includes the patient's history, a systems review, and tests and measures to determine the patient's therapeutic, rehabilitative, and functional status and any environmental factors that may limit the patient's activity and/or restrict participation. Through the evaluative process, the physical therapist develops a comprehensive plan of care to achieve the goals and outcomes of improved function. The physical therapist also instructs patients and caregivers in areas that will help to address specific impairments, activity limitations, participation restrictions, and environmental factors. This may include instruction in the use and performance of therapeutic exercises, functional activities, and assistive or adaptive devices, including prostheses and orthoses. As essential members of the health care team, physical therapists play an integral role in the transition of patients to the community. COMMENTS ON THE FUNCTIONAL MEASURE APTA supports the goal of improving quality of health care. Physical therapists are committed to providing high-quality, timely care and to the promotion of evidence-based and patient-centered practice. Furthermore, APTA believes it is essential that we move toward a core set of functional items to assess patients across the continuum of care. APTA is pleased to see that this process measure on patient function is being proposed for the home health setting as it is already being reported in other post-acute care settings. We believe this is an important process measure that will increase awareness and compliance with the collection of complete functional data across all post-acute care settings. APTA believes that provider education is important as new data elements are introduced into the post-acute care settings through the implementation of the IMPACT Act. We encourage ongoing education efforts for these new elements in the home health setting. CONCLUSION APTA thanks CMS for the opportunity to comment on the IMPACT Act of 2014 Cross-Setting Quality Measure: Percent of Home Health Episodes with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function, and we look forward to working with the agency and Abt Associates on these and other quality measures. If you have any questions regarding our comments, please contact Heather Smith, PT, MPH, director of quality, at 703/706-3140 or heathersmith@apta.org. Sincerely, Sharon L. Dunn, PT, PhD President			

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11	12/9/2016	RE: Project Title: IMPACT Act of 2014 Cross-Setting Quality Measure: Percent of Home Health Episodes with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function The National Association for Home Care & Hospice (NAHC) is the largest trade association in the country representing home health care agencies. NAHC members represent the entire spectrum of home care agencies, including Visiting Nurse Associations, government-based agencies, multi-state corporate organizations, health system affiliated providers, and freestanding, proprietary home health agencies. NAHC members serve several million Medicare home health care beneficiaries each year. In general, NAHC supports the intent and goals of the IMPACT Act to develop cross setting measures among post-acute care (PAC) providers. However, NAHC continues to be concerned with the potential for duplication and/or overlap with current OASIS assessment items when new items are added to the assessment instrument. The requirements of the IMPACT Act could result in a lengthy assessment tool that will become very burdensome for agencies to administer if redundant assessment items are not removed. Additionally, NAHC urges CMS and the measure developers to consider the various applications the OASIS assessment tool has for home health agencies (i.e. payment, quality measures, Star Rating and home health value based purchasing) when developing new assessment items. Almost all of the OASIS items impact one or more of these applications either directly or through risk adjustment for the quality measures. If GG 0130-Self-Care and GG 0170–Mobility are adopted into the OASIS data set, NAHC recommends that OASIS items M01840-ToiletTransfer, M01845–Toileting Hygiene, M01850–Transferring and M1860–Ambulation be removed from the assessment tool to avoid duplication. Since theses OASIS items are required to measure functional outcomes in the HHQI and HHQRP and to calculate the case mix for the home health prospective payment system, NAHC also recommends adapting assessment items GG 0130 and GG170 to serve these functions.	Mary K. Carr Vice President for Regulatory Affairs The National Association for Home Care & Hospice (NAHC)	mkc@nahc.org	HHA Advocacy

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		Further, NAHC urges CMS and the measure developers to take into consideration the financial and opportunity costs associated with incorporating the proposed functional assessment items into the OASIS assessment. Costs include staff training and the learning curve associated with achieving competence in completing new assessment items. Until agencies become competent, there is potential for negative impacts on the various applications affected by the OASIS assessment tool. Thank you for the opportunity to submit comments. If you need further information, please do not hesitate to contact me. Very truly yours, Mary K. Carr Vice President for Regulatory Affairs			
12	12/9/2016	Dear Sir or Madam: On behalf of our 39 hospitals in Arizona, California and Nevada, Dignity Health appreciates the opportunity to comment on the : IMPACT Act of 2014 Cross- Setting Quality Measure: Percent of Home Health Episodes with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function. The fifth-largest hospital system in the nation, Dignity Health is proud of our commitment to our mission to provide quality, affordable care to all, especially the poor and disenfranchised. Post-acute care (PAC) providers deliver patient interventions to the most frail, and often within a care team setting, creating treatment plans in concert with a number of specialists to address complex healthcare needs. Dignity Health has a robust Home Health program that provided 306,119 home care visits to approximately 24,655 patients annually in California and Nevada in fiscal year 2016, and operates 11 Inpatient Rehab Facilities (IRFs) and 5 Skilled Nursing Facilities (SNFs) across the system. Dignity Health is proud of our partnership with the government. Approximately 70% of the patients Dignity Health serves are enrolled in a government program, primarily either Medicare or Medicaid, but only 50% of our revenue is from the government. This dynamic makes Dignity Health particularly sensitive to increased reporting requirements and changes in reimbursement policies. Dignity Health believes humanity is the very core of health care and encourages the development of measures that truly measure quality and create opportunities to improve care across the spectrum, not just to simply “check the box.” As CMS works to implement standardized data sets, and moves toward bringing PAC into value based care, Dignity Health urges CMS to consider the additional resources required to implement assessment tools and	Paul Giles, Director Home Health Finance	Paul.Giles@DignityHealth.org	HHA

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		submit data. While we agree with the standardization of data elements, PAC providers are underfunded and have limited capital for additional investment. CMS should consider including risk adjustments for providers that serve the most vulnerable communities and continue working with providers to establish a vision for PAC and the important role they play in the spectrum of care. To provide appropriate feedback, Dignity Health convened home health staff to review the assessment tool and gathered the feedback below: 1) The coding for GG0130 and GG0170 items are very new to Home Health and just now being introduced into OASIS C2 item set, via the GG0170 new item effective 1/1/2017. We note there is an inconsistency in the coding between MM coding and now the GG coding, which will cause confusion among the Home Health staff members and suggest that current OASIS items be made consistent in the future with these items. 2) In as much as the codes are new to Home Health, the order of these codes seems odd, starting with 06 down to 01 and then exceptions 07, 09 and 88. These may be consistent with other similar coding schemes, but do not seem to be in a logical progression. 3) Suggest adding "safely" to the coding descriptions, i.e. "Patient safely completes…." 4) For GG0130 Self-Care, our team wonders why oral hygiene is selected as a measure, rather than bathing or dressing. It would seem either or both of these are more important than oral hygiene as a measure for goals. 5) In review of the form for GG0170 Mobility, we foresee problems with assessing the walking and/or wheeling 150 feet in the home health setting. In most cases, this will not be practical or applicable, due to limitations in the typical patient's home. Instead, it may likely be more practical to conduct this outside of the home, but then would be much more time consuming for the SOC/ROC assessment. We suspect the items with 150 feet measurement will not typically be feasible and suggest a different measure or a refined one that is feasible in the Home Health setting. 6) We have noted that for the GG0170 Mobility process measure for H1, item 2, Yes, refers to continue to GG0170I: Walk 10 feet. The proposed form, however, does not include the GG0170I item for walking 10 feet. Possibly either this narrative needs to be eliminated or add the section for GG0170I. 7) We have general concern over possible expectations in setting discharge goals at the time of Start of Care/ Resumption of Care (SOC/ROC), but become unrealistic during the course			

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		of the Home Health episodes of care. While Home Health clinicians can reasonably estimate what the discharge goals may be in normal cases, we would be concerned that these measurements can set unreasonable expectations, and therefore would subject Home Health Agencies to penalties. There is mentioned in the narrative for comments that there is a reassessment of the goals at the time of discharge, however, we are not familiar with how that would be accomplished. We would appreciate additional information in this area. CONCLUSION Dignity Health appreciates the opportunity to respond to this request for comments and hopes our input is helpful. If you have any questions, please feel free to reach out to Clara Evans, Director of Public Policy & Fiscal Advocacy at Clara.Evans@DignityHealth.org or at (916) 851.2007. Sincerely, Paul Giles, Director Home Health Finance			
13	12/9/2016	To Whom It May Concern: On behalf of the Visiting Nurse Associations of America (VNAA), thank you for the opportunity to comment on the Percent of Home Health Episodes with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function. VNAA advances quality, value and innovation in home-based care and represents mission-driven providers of home and community-based health care, including hospice, across the United States. VNAA members provide high-quality, patient-centered care at home, as well as offer support for family caregivers. They primarily serve the most clinically complex and vulnerable patients , who are by definition homebound and who will benefit from having closely integrated health exchange between all members of the care team—regardless of the severity of their illness—and serve a mixture of Medicare, Medicaid, privately-insured and uninsured patients. Home health providers continue to provide value and innovation in home-based care and care coordination. Home-based care providers work to improve the management of patients with chronic conditions, thus addressing some of the greatest challenges in health care today, including medication management, uncoordinated transitions of care and high rates of unnecessary hospital and emergency department utilization. In addition, home health provides medically	Joy M. Cameron Vice President Policy and Innovation Visiting Nurse Associations of America	jcameron@vnaa.org	Advocacy

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		necessary, skilled services in an incredibly efficient manner, providing care at a fraction of the cost of institutional care. We appreciate the work that is being undertaken to ensure that the IMPACT measures done in a way that while appropriate for each setting considers the location of Overall Comments on Percent of Home Health Episodes with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function On the whole, VNAA agrees with the quality process measure as suggested. However, there is a concern with the calculation algorithm. There is an inconsistency as to what population is used; some are Medicare only and some include Medicaid, as well. VNAA asks that there is consistency. VNAA appreciates the opportunity to comment on the Percent of Home Health Episodes with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function) proposed process measure. Please contact Danielle Pierotti, Vice President of Quality and Performance Improvement ion at dpierotti@vnaa.org or 571-527-1529 with any questions or concerns. Sincerely, Danielle Pierotti, RN, PhD, CENP, AOCN, CHPN Vice President, Quality and Performance Improvement			
14	12/9/2016	Re: Development of the of Process Measure: Percent of Home Health Episodes with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function The American Occupational Therapy Association (AOTA) is the national professional association representing the interests of more than 213,000 occupational therapists, occupational therapy assistants, and students of occupational therapy. The science-driven, evidence based practice of occupational therapy enables people of all ages to live life to its fullest by promoting health and minimizing the functional effects of illness, injury, and disability. Many occupational therapy practitioners serve Medicaid and dual eligible (Medicare and Medicaid) beneficiaries in community based settings, outpatient settings, and post-acute care (PAC) settings. Occupational therapy practitioners provide medically necessary and skilled intervention to empower beneficiaries of Medicare post-acute care (PAC) services to live their lives to the fullest. The practitioners we represent are very active in home health, working to ensure that beneficiaries are able to safely and successfully participate in meaningful everyday activities.	Jeremy Furniss, OTD, OTR/L, BCG, CDP Director of Quality Division of Academic & Scientific Affairs American Occupational Therapy Association, Inc.	jfurniss@aota.org	Advocacy

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		INTRODUCTION AOTA appreciates the opportunity to comment on the "Development of the Process Measure: Percent of Home Health Episodes with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function" document. AOTA supports the use of the CARE tool to standardize data collection of functional status and change in functional status. This proposal mirrors section GG implemented in the Minimum Data Set (MDS) this past year. AOTA appreciates the incremental approach of including the basic self-care and mobility items initially. However, we continue to be concerned with the duplication of information collected on the OASIS during transition. Our concerns are twofold: (1) measuring the same construct using two measurement tools and scales produces significant opportunity for measurement error and confusion resulting in decreased utility of either scale and (2) requiring practitioners to collect data on the same construct using two tools and scales is unnecessarily burdensome. AOTA highly encourages CMS to weight the benefit of collecting information with dual tools with the burden on practitioners and the utility of the information. AOTA also provides recommendations related to the mobility data elements included in the proposal AOTA Comments on Quality Measure Development and Maintenance for MLTSS Decreased utility of dual measurement tools The OASIS currently collects self-care and mobility information. Adding the CARE tool to collect self-care and mobility items in addition to the current items may create the potential for measurement error. The CARE tool items utilize a different rating scale to describe the ability of the beneficiary in key areas. Collecting information with two tools and two scales can be confusing and has the potential to impact the accuracy of either scale. Furthermore, because the two tools utilize different underlying measurement scales and questions, practitioners may not consistency differentiate when completing each individual element. The addition of Section GG to the OASIS also creates additional burden for the providers. We understand the need to maintain data collection on current elements as the new elements are added; however, we recommend that CMS work to provide a potential timeline on the possible alignment of data elements and removal of duplicate elements. MOBILITY AOTA recommends clarification on the "Section GG Sample" document provided. GG0170 H1 asks "Does the patient walk?" An answer of yes (2) refers the person complete the section to "Continue to GG0170I. Walk 10 feet". However, neither the proposal by Abt associates nor the			

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		"Section GG Sample" include an item GG01170I or Walk 10 feet. The proposal includes the item "Walk 50 feet with 2 turns." AOTA recommends including Walk 10 feet in the proposed Section GG. For some beneficiaries walking 10 feet may be functional and appropriate. Beneficiaries may not need to Walk 50 feet to remain safe in the home and participate in basic and instrumental activities of daily living (BADL/IADL). CONCLUSION AOTA appreciates the opportunity to comment on the proposal. We are eager to participate in ongoing discussions with CMS and contractors related to the implementation of IMPACT and the advancement of quality measurement in all settings.			
15	12/09/16	Dear Sir or Madam: The American Academy of Home Care Medicine is pleased at the efforts of CMS as it continues its work to implement the requirements of the IMPACT Act. The Academy represents the many physicians, nurse practitioners, physician assistants and others who are bringing home care medicine to those who need it across the country. A nonprofit professional society, the Academy has been in existence since 1988. We have two observations regarding the Function Measure. One is a recommendation that the measure provide the opportunity as in the Care Tool to assess sublevels of other levels of cognitive status such as executive function. The other observation is that the Measure presents treatment utility and on the other hand the Measure provides less utility in terms of a prognostic benefit. This said, we appreciate the work of CMS and its contractors to standardize measures across settings and assessment tools. We look forward to commenting on other measures and on further assisting CMS in ways that contribute to improved care and smarter spending for Medicare beneficiaries including the home limited. Sincerely, Gary Swartz	Gary Swartz, JD, MPA Associate Executive Director, Senior Public Policy Advisor American Academy of Home Care Medicine	Gary.Swartz@aahcm.org	Advocacy