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Jennifer Kernohan
University of San Francisco, sears.kernohan.rn@gmail.com

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Improvement of Outcome and Assessment Information Set (OASIS) Documentation in Home Care to Boost Medicare Star Rating

Jennifer Kernohan
University of San Francisco
MSN-CNL Program

Summer 2016

Abstract

The aim of this CNL Internship Project is to improve the admission and discharge assessments of a home care agency in order to boost agency's star ratings. The project is being carried out within a home care agency in Northern California. The multidisciplinary team provides services in the patients' place of residence, an ever-changing setting. The project follows a train-the trainer approach beginning with self-paced learning of the OASIS format. The trainee will conduct an admission, also known as start of care (SOC), assessment followed by trainer critique and advisement. Establishing a rapport early will aid the assessment process. Face-to-face assessment follows a review of systems that includes both interview and observation. This project has experienced many stopgaps due to scheduling constraints. An unexpected challenge has been the reluctance of staff to participate. This project is ongoing therefore no results are available to evaluate at this time. Given the many moving parts related to the star rating it will likely be at least a year before they reflect this projects' efforts. As an application in healthcare reform the OASIS is still relatively new. Research on its overall impact on the delivery of care is limited. CMS representatives state the implications star rating may have for future reimbursement and encourage OASIS training, however no evidence-based practice can be found on how home care agencies can best approach OASIS and its anticipated revisions.

Improvement of Outcome and Assessment Information Set (OASIS) Documentation in Home Care to Boost Medicare Star Rating

Clinical Leadership Theme

This project is established under the CNL function in *knowledge management*. My CNL role is that of *educator*. By utilizing concepts and critical thinking skills developed through the CNL curriculum the aim of this project is to improve the admission and discharge assessments in home care.

Statement of the Problem

The patient assessment is paramount is providing good care. Improper assessments lead to inaccurate patient profiles, under or over estimation of risk, and poor care plan development. As a result gaps appear in care delivery. Patients do not receive needed services while emphasis is placed on issues that are of lesser importance or are irrelevant. Clinical performance and patient satisfaction suffer translating into suboptimal ratings that affect the microsystems ability to thrive in a competitive industry. There are several factors that impact the assessment process, many of which are unique to home care. The challenges clinicians face in conducting home assessments can stem from the physical environment, patient-clinician dynamic, and/or the construct of the Outcome and Assessment Information Set (OASIS). Many find OASIS terminology vague and complex. (Marrelli, 2015) Confusion and apprehension tends to ensue when varying degrees of function have to be sequestered into four or five descriptive categories. The purpose of this project is to educate clinical staff on assessment strategies and how to apply observations to answer OASIS questions.

Rationale

The Patient Care Star Rating was developed by Centers for Medicare and Medicaid Services (CMS) to comply with The Affordable Care Act's call for transparency in consumer

reporting. In a competitive market star ratings provide consumers a snapshot of the quality of care provided by a home health agency. Most home health agencies tend to fall in the middle compared to the national average receiving 3- or 3.5-stars out of 5-stars.

In an effort to earn a higher star rating a root cause analysis (Appendix C) was conducted to identify areas for improvement. When OASIS responses from nursing assessments were compared with responses from physical therapy or occupational therapy assessments for the same patient inconsistencies were noted amongst several of the outcome measures used to calculate star ratings. Overall, the nurses tended to score patients as functioning better than the therapists did. As a result, when functional status at discharge was compared to that at admission there appeared to be little to no improvement and, in some cases, decline.

Through team discussion it was discovered that clinicians interpreted the OASIS responses differently. Clinicians expressed difficulty in selecting the most appropriate response due to "gray areas," as in, what was observed didn't seem to "fit" with the options available. Confusion and errors in interpreting OASIS responses was suspected in skewing the outcome measures thus reducing the agency's star rating.

Project Overview & Methodology

This projected is being implemented within a home care agency in northern California. The agency currently consists of four teams servicing a combination of rural and urban areas within a 70-mile radius of the office. Teams include two to three registered nurses and LVN's, at least one physical therapist, occupational therapist, speech therapist, medical social worker, and home health aide. Management follows a laissez faire style allowing clinicians autonomy in scheduling visits and structuring day-to-day tasks. Clinicians may see one to six patients per day depending on the type of visit and distance/travel time between patients. Bimonthly case

conferences, headed by the team manager, are an opportunity for face-to-face multidiscipline communication and collaboration. The majority of communication is through electronic forums and mobile devices. Assessments are conducted at the patients' residence, which may be any number of structures. Patient cognitive and physical status is highly variable and caregivers may or may not be present.

The project will follow a train-the-trainer approach and will begin with me, the trainer, completing self-paced learning modules comprised of webinar videos and review of the CMS OASIS Handbook. I will then conference with the data analysis manager and arrange an in-office training. Following this I will schedule one-on-one trainings with the newly hired nurses that will take place during actual admission and discharge visits. Ideally, time will be allotted after the visit for charting. This will also serve as an opportunity to discuss the appropriate OASIS responses. The goal is that OASIS data will depict a level of function consistent with the diagnoses and that the admission and discharge assessments will show the level of improvement expected based on the national benchmark. The home health agency's performance is demonstrated by how much the patients improve and is represented by star ratings: a system devised by CMS to compare home health agencies in United States. Currently my agency is rated 3.5 stars. The specific aim of the project is to improve the agency's star rating from 3.5 stars to 4 stars by January 2017.

This project targets the weakest modifiable link most directly related to the measures being captured: the competence and confidence of clinicians in OASIS documentation. Berenson and Rice (n.d.) astute that policy makers focus on financial incentives and performance measures, such as pay-for-performance systems and public reporting, to improve patient care. This implores both extrinsic (regulation and payment) and intrinsic (altruism) modes of

motivation. (Berenson & Rice, 2015) Star ratings are an overall score of individual performance. Feedback on performance, as shown through public reporting, is an effective motivator as it signals professionals' desire for self-improvement due to pride and reputation. (Berenson & Rice, n.d) Guided by social cognitive theory, the method of engagement for this project touches on individuals' self-efficacy; clinicians want to prove their competencies. The drive for personal and professional growth provides the incentive with which this change theory hinges upon. A successful program includes four processes: attentional processes, retention processes, motor reproduction processes, and reinforcement processes. (Kritsonis, 2005) Simply stated, behavioral modification is predominately motivation coupled with hands-on application and repetition.

Undoubtedly, there will be a steep learning curve that will level off as clinicians become more experienced. To track progress Strategic Healthcare Programs (SHP) software will be utilized. SHP is a web-based documentation management system that has several useful functions. The software "scrubs" the OASIS and highlights inconsistencies and alerts the user of high risk potential. SHP evaluates each clinician and provides a real-time scorecard similar to the agnecy's overall star rating report. This will help identify if training has been effective, where areas for improvement are, and provide direction as the project progresses.

Cost Analysis

Under the prospective payment system, home care agencies are reimbursed a standardized rate per 60-day episode per patient. This is roughly $3,000 based on data sheets from 2014. (CMS, 2014) Because patients' functionality, degree of illness, and care needs vary the reimbursement rate can be adjusted using a case-mix adjustment. On average Medicare pays roughly $5,000 per patient care episode. (Jones, 2014) There are 153 case-mix groups in which patients can be classified. The information obtained through the OASIS is how the home health

agency calculates the case-mix. Responses to OASIS questions are assigned a numerical score, which are grouped and coded to give the case-mix rate. Ideally, patients with more severe conditions and poorer functional status will generate a higher payment rate, however, as previously mentioned, this all depends on how the assessing clinician answers the OASIS questions at the start of care. The most common error with the OASIS is scoring a patient as being higher functioning than they actually are. Discrepancies, such as these, in the documentation can result in under billing. Additionally, downgrading the severity of the patients' status at admission can misrepresent the patients' progress at discharge and falsely display a poor outcome that can damage market ratings down the line. (Quintero, 2014)

The average wage for an assessing clinician is about $50/hr and there are about four assessing clinicians that would be involved in my project. The project would likely begin with an hour meeting ($250) then break-off into one-on-one training sessions. The trainee will be getting paid for the assessment regardless therefore does not factor into the expense. Assuming the trainer spends an eight-hour day with the trainee for four days, that's $1,600 plus the preceptor fee of $75/day. For a little over $2,000/week in wages this project brings the potential of thousands of dollars of adjusted reimbursement rates ongoing. This is a scenario in which the expected long-term gain outweighs the short-term expense.

Data Source/Literature Review

A PICO statement questioning if training clinicians on OASIS assessment will improve star ratings at the next quarterly report guided data search efforts. The Fusion database was used through Gleeson Library online services using a combination of search terms including keywords "OASIS", "training", "CMS", "Medicare", "home care", and "staff development". The Outcome and Assessment Information Set (OASIS) is a specialized form that that is relatively new and has

undergone numerous reforms since its initiation. Likewise, the star rating system has only been in affect since 2014. Speculation is that more changes to homecare documentation regulations are inevitable and agencies are encouraged to proactively train staff to remain in compliance. The financial implications related to home care data analytics found in the literature supports the proposed project and can be categorized by the demands of a growing industry, legislature and CMS regulations, better business models, and more synchronized patient care.

Homecare is a growing specialty due to an aging population, perceived cost-savings, and revised patient care models. Life expectancy is increasing thanks to a combination of medical advances and lifestyle changes. By 2050, one in five people will be 65 years or older. (Marquand & York, 2016) Five-percent of Medicare beneficiaries make up the majority of Medicare expenses and homecare utilization reduces those costs by 17%. (De Jong, 2014) Compared to the cost of an average inpatient or SNF admission homecare saves Medicare approximately $500 to $2,000 per day. (Jones, 2014) Furthermore, reports from The Joint Commission assert patients do better and are more satisfied with care at home. (Dilwali, 2013)

In 2012, Medicare spent $18 million in home health services for the over three million beneficiaries who received home care. (Marrelli, 2015) The number of Medicare-certified home health agencies has nearly doubled since 1990. (Howes, 2015) In 2014, The Bureau of Labor Statistics reported 93,000 jobs were created in home health sector and this trend is expected to continue. (Jones, 2014) With this growth comes concern over appropriate allocation of funds and increased susceptibility to fraud and abuse leading to stricter oversight of Medicare purse strings. (Jones, 2014)

It has been hypothesized that entrance of the prospective payment system (PPS) in home care accounted for increases in Medicare spending partly due to the emergence of more home

health agencies but also because agencies targeted visits with the highest reimbursement. (Kim & Jung, 2015) In a retrospective study, Kim and Jung (2015) examined the practice patterns of home health agencies entering the market between 2008-2010 and found that new agencies tailored their practices to earn the highest profit. Additional research reached the same conclusion noting that retrospective reimbursements increased when more visits were made to certain patients. (Kim & Norton, 2015)

In response to overutilization, therefore overspending, there have been ongoing efforts to establish value-based payment incentives that "reward good quality and penalize bad." (Kavangh et. al., 2012 pp 386) CMS's payment scheme has undergone several amendments over the years, for example, the ten percent cap on outlier payments and a 2% reduction in reimbursement for agencies that do not submit quality data. (Kim & Norton, 2015 and CMS, 2014) The pattern presented is one of a disjointed partnership in which both sides are struggling to optimize payments that will "align the principal's and agent's interests." (Conrad, 2015)

Payment reform has been explained through behavioral economics. Khuller and Safran (2016) outline the principles of behavioral economics as 1) delivering incentives, 2) targeting a range of performance, 3) bonuses for absolute performance, 4) focusing on quality, and 5) collecting data for peer comparisons. It is recognized that multidimensional outcome and process measures are related to quality improvement. This is why home care metrics are publicized as a composite score. (Gressel, 2013) In keeping with change theories that involve incentives, the prediction is that home care agencies with 4 or 5-star ratings will be rewarded with a quality bonus payment (QBP) like Medicare Advantage Plans currently are. (AMCP, 2011)

As stakeholders in the healthcare system, patients, providers, and payers are relying on data to make informed decisions. (Quintero, 2014 & Baier et. al., 2014) Appendix E provides the

stakeholder analysis. Public reporting is a Medicare mandate to increase transparency and facilitate the decision-making process. This information is available online. Home Health Compare lists all the Medicare-certified agencies in a given area and allows consumers to compare up to three home care agencies side-by-side. The majority of home health referrals come from hospital discharge planners; however, law stipulates that the patient has a choice in what agency they are discharged to. In a qualitative study, researchers conducted consumer focus groups and interviewed hospital case managers to determine the influence of public reporting in choosing a home health agency. It was found that the majority of patients and cases managers did not know information to help was available and decisions were based on non-quality measures such as location or 'word-of-mouth' recommendations. As the authors rightly predicted, this practice is changing now that Medicare is tightly tracking readmissions and holding hospitals liable for patient outcomes beyond their inpatient stay. (Baier et. al., 2014 & Dilwali, 2013) Therefore, the consequences of star ratings will become increasingly apparent as referral sources take greater notice of public reporting.

Timeline

This project has evolved since January 2016. It is expected that by mid-July I will have completed the self-paced learning modules. By this time I will have also conferenced with the data analysis manager and arranged a day for on-site SHP set-up and instruction. Following this I will conference with the agency branch manager and coordinate on-the-job training with the recently hired nurse(s). My goal is to have joined the nurse on three admission and two discharge visits by mid-August. Reviewing SHP data in November should provide adequate time to determine if training was effective at improving performance. Star ratings are published quarterly. Of note is that the way star ratings are analyzed causes a six-month delay in reporting.

Therefore the present score is based on data from last year and the rating associated with this projects implementation will not be reflected until at least 2018. Refer to Appendix A for timeline.

Expected Results

A hurdle in getting this project started has been establishing a relationship with individual(s) making up the outcomes management team. Scheduling and geographical constraints are challenges that have been and will continue to need to be overcome through each phase of the project. Delays partly ensue because even though this project is important it has not been made a priority. The fragmented fashion in which documentation is processed has produced a sense of urgency so much so that the focus is on how fast can one complete the OASIS, not on the accuracy of it.

The project's main objective is to improve the agency's star rating. However this cannot be accomplished without investing in the individual clinician. By taking an interest in the individual I expect this project will lead to more structure and organization within the microsystem. There are many steps between an agency's overall star rating an daily operations that goes beyond the scope of this paper though there is a correlation according to the structure-process-outcomes model. (Kavanagh et. al., 2012)

Nursing Relevance

The preceding sections have described healthcare in terms of economics using quality metrics to justify reform. The debate over financial incentives to improve quality and patient care is ongoing. It is possible that there is a pecuniary advantage in skewing quality metrics that might entice providers. Although, if studies on motivational technique have shown us anything it's that money is only part of the equation; to that end, there is a perceived obligation that nurse

leaders only apply practices that yield a return on investment. (Tucker, 2014) The emphasis placed on value-based care calls for a broadening of nursing knowledge and theory. This project is a step in that direction. Nickitas and Frederickson (2015) stated, "linking nursing knowledge and theory-based practice to a healthcare system's performance may help heighten the recognition of what is unique to nursing and awareness of nursing's value to cost." (pp. 239) Improvement of star ratings, which as previously mentioned is a measure of performance, begins with improvement of the assessment that will inevitably dictate the care that is received and the resulting outcomes. Home care continues to undergo major changes as CMS evolves to reach a broader clientele. An issue that has arisen in the care delivery model is fragmentation of care that is only expected to worsen for agencies that don't anticipate and prepare for future reforms. It is suggested that agencies "brush up" on OASIS documentation not only to recoup maximum payment but also to ensure patients receive high-level care. (HCPro, 2014)

Summary Report

The aim of this project is to improve the admission and discharge assessments in home care. This will specifically be represented by the agency star rating. Home health care encompasses a wide variety of patients with complex health alterations requiring nurses and other assessing clinicians to have a diverse skill set. The primary diagnoses for referral is vast, as are the secondary conditions that impact the plan of care. The care delivered is dependent upon a thorough and accurate assessment. However, because the care environment is continuously changing developing a standardized process for gathering information is challenging. Field staff is at a disadvantage because they are out of their elements when in patients homes. Home health professionals must be prepared for anything and be able to improvise. Structuring the admission assessment to obtain all the necessary information in a time-efficient manner takes practice.

Though time-consuming, the OASIS assessments are monumental in home health care. OASIS outcomes are the measure of the microsystem's value. Data collected from Home Health Compare provided the basis for this project. The microsystem's overall star rating is 3.5. Even though this is a half star better than the national average, the microsystem fell short when looking at specific categories, such as improvement in mobility (60% compared to 64%), bathing (65.6% compared to 69%), and pain (59.4% compared to 68.5%) to name a few. (Home Health Compare, 2016) It is hypothesized that error in gathering and scoring patient information at the start and end of care may account for the less than optimum results seen. Patients are improving yet the degree of improvement is not being captured with how information is presently entered. Focusing training efforts on how to answer OASIS items will likely close the gap currently seen between this microsystem and the national average benchmark.

The change process is summarized using the Plan-Do-Study-Act cycle (PDSA) (Appendix F). The first step of the project dealt with education. The OASIS Handbook was used as a guide to learn proper OASIS responses. OASIS contains an abundance of information that is not relevant to this projects outcome. Therefore it was decided to focus training on just the items calculated for star ratings. The second step of the project involved observation of assessment skills and application to OASIS items. After some delay and apprehension training took place and in-service instruction was provided. Key components of training included understanding the wording of OASIS items. Of particular importance is the qualifier of 'safety'. Appropriate responses must always relate to what the patient can safely do, not necessarily what they are doing. Second, excessive use of 'or' and 'and' confuse clinicians. These conjunctions broadly define varying degrees of functional status. Typically patients will not fit precisely into a particular category. Although, if the patient does not meet criteria for the first response then the

item must be marked up to the next level. Thirdly, the OASIS items do not follow a logical outline; it does not flow in a linear fashion. It jumps from system to system. Refer to Appendix G. The work around for this is to become familiar with the OASIS questions, conduct a head-to-toe-assessment, take notes, and transcribe onto the form later. This will stream line the assessment and help with time management as well as organization of information.

Step three is ongoing at this time. Due to unexpected delays and difficulties in aligning schedules the training process just recently began. The expectation going forward is for the new nurse/trainee to conduct solo admission visits, as she has previously been oriented per company protocol. Preliminary observation reveals additional coaching is needed in assessing patients' functional status and selecting most appropriate OASIS responses. SHP data will be reviewed in several months to determine if teaching was effective for this one individual. Future meetings with quality control managers are set to discuss ongoing project diffusion within the branch, though at its current rate it is highly suspect that the projects goal will be met in the anticipated timeframe.

Conclusion

The sustainability of this project lies in conveying the impact of the star rating as it relates to the individual. The microsystem depends on the buy-in of the staff that conducts the assessments. Currently, there is no incentive, or, at least, no perceived personal incentive behind the assessment methods. The benefit seems very one-sided; strongly favoring corporate's profit margin. Johnson et. al. (2004) expressed this as "adopter ownership;" personal desire and commitment to the plan.

Another factor that will need to be addressed is how assessments can be modified to yield the most accurate information. This is where the concept of standardization will be instrumental.

The assessment form itself is standardized. Where and how that information is obtained are not. The environment was briefly noted as probable hindrance in completing the OASIS form; often clinicians rely on inferences to complete documentation. This may be an area to explore once clinicians demonstrate stronger understanding, interpretation, and application of OASIS documentation.

Findings from this project will elicit a unique perspective on approaches to OASIS documentation. Home health care tends to wax and wane. Considering the trending economic climate, a home health surge is underway. Little evidence-based practice was found to support assessment techniques specific to the OASIS. This is perhaps due to the relative newness of the form and pending revisions. Home health as a whole appears to be underrepresented in nursing literature. As the demand for home health services grows the spotlight will shine on home health agencies that perform the best and the worst. By taking initiative with this project my agency will hopefully prove to be the former.

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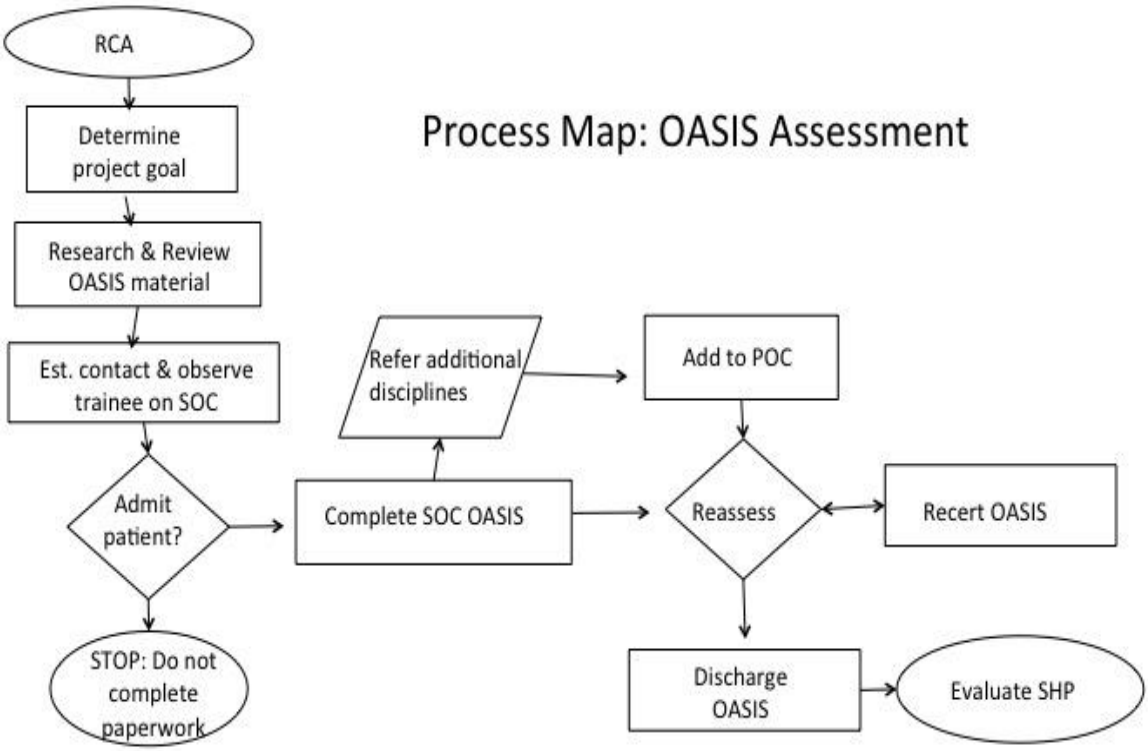
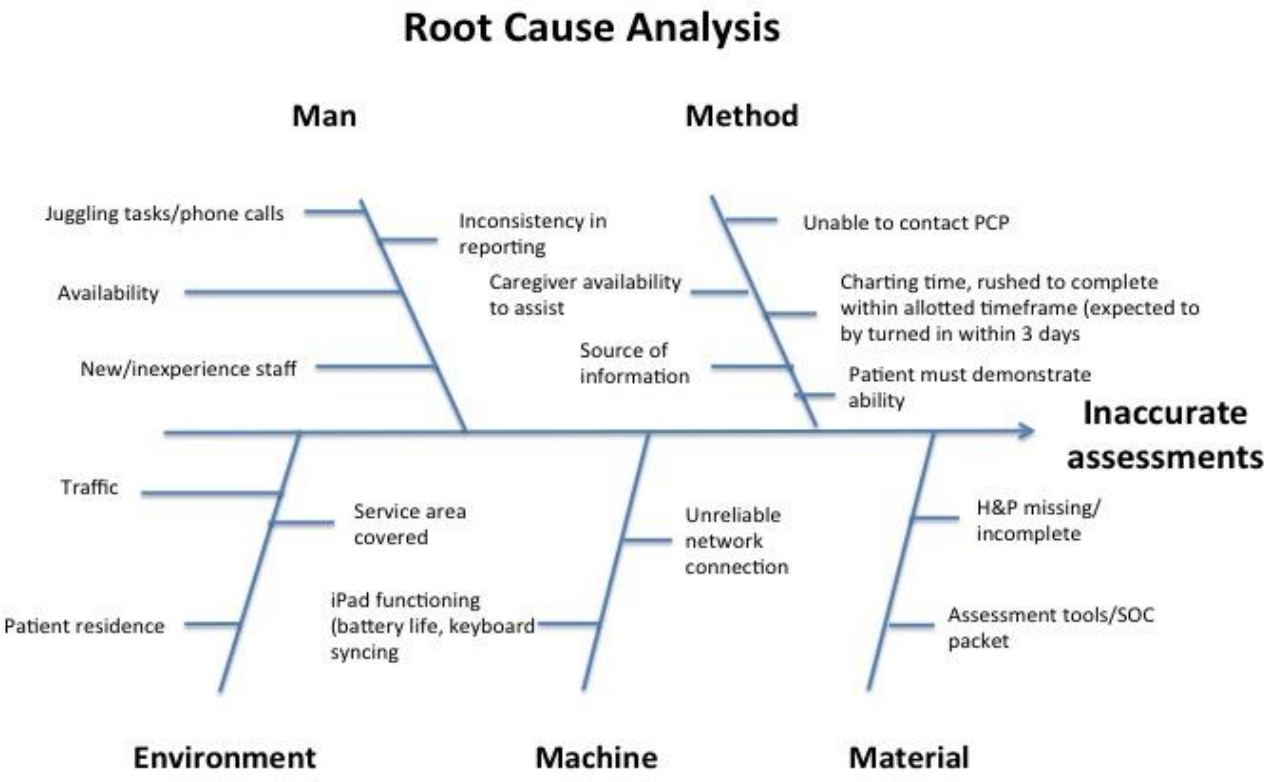
Appendix A

Project Timeline
Review OASIS Handbook
In-person training/set up SHP account
Review SHP data
January 2016
April
June
July
August
September
January 2017
Project discussion began
OASIS Training Modules Online
Work with new nurse
Star Ratings Published

Appendix B


Process Map: OASIS Assessment
RCA
Determine project goal
Research & Review OASIS material
Est. contact & observe trainee on SOC
Admit patient?
STOP: Do not complete paperwork
Complete SOC OASIS
Refer additional disciplines
Add to POC
Reassess
Recert OASIS
Discharge OASIS
Evaluate SHP

Appendix C


Root Cause Analysis
Man
Method
Juggling tasks/phone calls
Availability
New/inexperience staff
Inconsistency in reporting
Caregiver availability to assist
Source of information
Unable to contact PCP
Charting time, rushed to complete within allotted timeframe (expected to by turned in within 3 days
Patient must demonstrate ability
Inaccurate assessments
Traffic
Patient residence
Service area covered
iPad functioning (battery life, keyboard syncing
Unreliable network connection
H&P missing/ incomplete
Assessment tools/SOC packet
Environment
Machine
Material

Appendix D

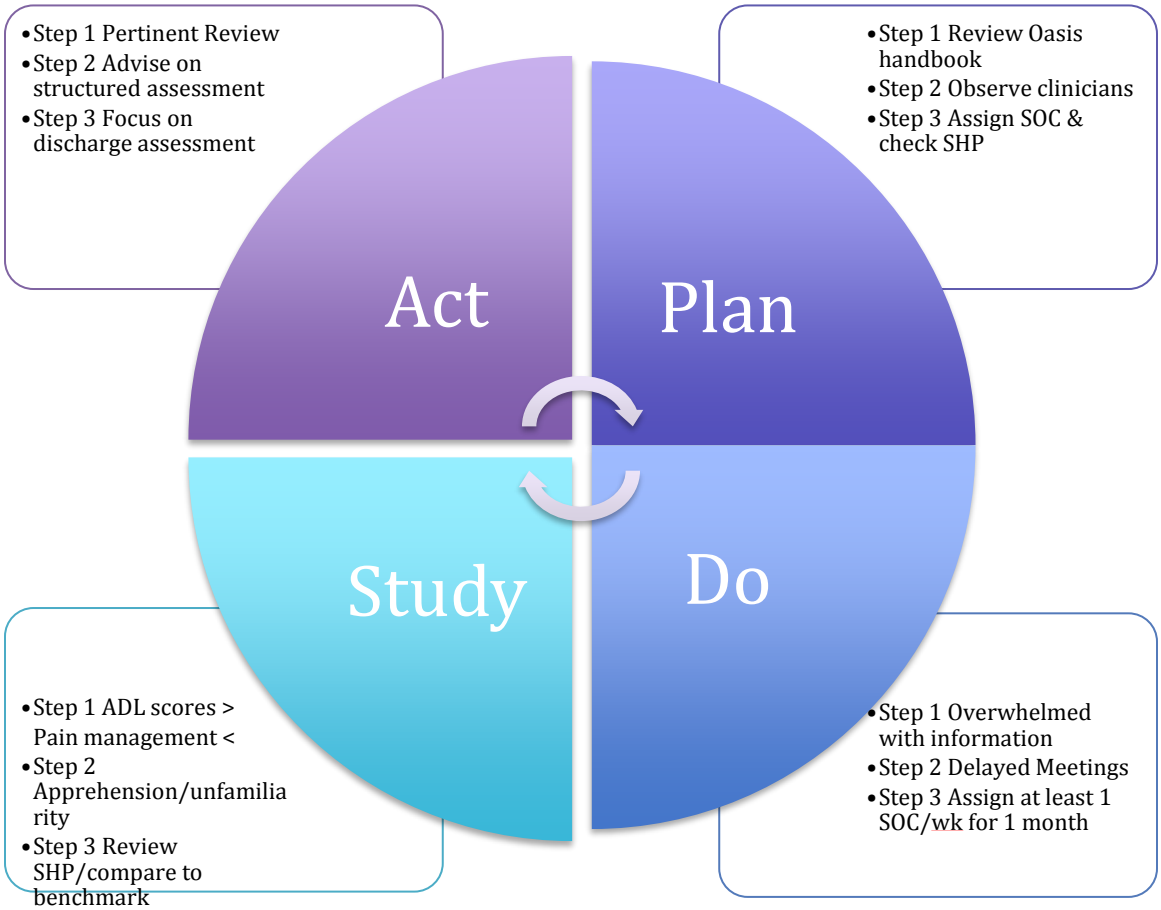
SWOT Analysis

Appendix E

Stakeholder Analysis

Stake-holder Names	How Important are they?	Level of Support	Barriers/ Block Efforts	Incentive	What's needed from stakeholders?
Payer	Medium	Low	Reforms New regulations	Better compliance Productivity Effectiveness	Clear expectations Adequate prior notice of changes
Patients	High	Medium	Functional status Motivation to improve/participation Higher acuity Expected decline r/t diagnosis	Improved quality of care Satisfaction	Cooperation
Clinician	High	Medium	Lack of knowledge Lack of experience Scheduling Travel distance and time Motivation	Gain knowledge Pride Professional growth Better performance	Desire to improve Cooperation Open-mind
Agency managers	High	High	Scheduling Staffing constraints Spending	Improved reputation Grow business Profitability Better outcome ratings	Access to training materials Time Coordination of coverage
Referral Sources	Medium	Low	Partnerships with agencies Inappropriate patient discharge status Lack of knowledge of services provided Communication deficits in planning care	Reduce readmission rates Reduce liability Better care coordination Better outcome ratings	Complete H&P information Complete referral information Accurate provider information Explain referral placement to patients

Appendix F


•Step 1 Pertinent Review
•Step 2 Advise on structured assessment
•Step 3 Focus on discharge assessment
•Step 1 Review Oasis handbook
•Step 2 Observe clinicians
•Step 3 Assign SOC & check SHP
Act
Plan
Study
Do
•Step 1 ADL scores > Pain management <
•Step 2 Apprehension/unfamiliarity
•Step 3 Review SHP/compare to benchmark
•Step 1 Overwhelmed with information
•Step 2 Delayed Meetings
•Step 3 Assign at least 1 SOC/wk for 1 month

Appendix G

OASIS Items

ADL / IADLs

OM (M1800) **Grooming:** Current ability to tend safely to personal hygiene needs (specifically: washing face and hands, hair care, shaving or make up, teeth or denture care, or fingernail care).

- 0 - Able to groom self unaided, with or without the use of assistive devices or adapted methods.
- 1 - Grooming utensils must be placed within reach before able to complete grooming activities.
- 2 - Someone must assist the patient to groom self.
- 3 - Patient depends entirely upon someone else for grooming needs. Clear

OM (M1810) Current **Ability to Dress Upper Body** safely (with or without dressing aids) including undergarments, pullovers, front-opening shirts and blouses, managing zippers, buttons, and snaps:

- 0 - Able to get clothes out of closets and drawers, put them on and remove them from the upper body without assistance.
- **1 - Able to dress upper body without assistance if clothing is laid out or handed to the patient.**
- **2 - Someone must help the patient put on upper body clothing.**
- **3 - Patient depends entirely upon another person to dress the upper body. Clear**

OM (M1820) Current **Ability to Dress Lower Body** safely (with or without dressing aids) including undergarments, slacks, socks or nylons, shoes:

- 0 - Able to obtain, put on, and remove clothing and shoes without assistance.
- **1 - Able to dress lower body without assistance if clothing and shoes are laid out or handed to the patient.**
- **2 - Someone must help the patient put on undergarments, slacks, socks or nylons, and shoes.**
- **3 - Patient depends entirely upon another person to dress lower body. Clear**

ADL / IADLs (continued)

OM (M1830) **Bathing:** Current ability to wash entire body safely. **Excludes grooming (washing face, washing hands, and shampooing hair).**

- 0 - Able to bathe self in shower or tub independently, including getting in and out of tub/shower.
- 1 - With the use of devices, is able to bathe self in shower or tub independently, including getting in and out of the tub/shower.
- **2 - Able to bathe in shower or tub with the intermittent assistance of another person:**
  (a) for intermittent supervision or encouragement or reminders, OR
  (b) to get in and out of the shower or tub, OR
  (c) for washing difficult to reach areas.
- **3 - Able to participate in bathing self in shower or tub, but requires presence of another person throughout the bath for assistance or supervision.**
- **4 - Unable to use the shower or tub, but able to bathe self independently with or without the use of devices at the sink, in chair, or on commode.**
- **5 - Unable to use the shower or tub, but able to participate in bathing self in bed, at the sink, in bedside chair, or on commode, with the assistance or supervision of another person.**
- **6 - Unable to participate effectively in bathing and is bathed totally by another person. Clear**

OM (M1840) **Toilet Transferring:** Current ability to get to and from the toilet or bedside commode safely and transfer on and off toilet/commode.

- 0 - Able to get to and from the toilet and transfer independently with or without a device.
- 1 - When reminded, assisted, or supervised by another person, able to get to and from the toilet and transfer.
- **2 - Unable to get to and from the toilet but is able to use a bedside commode (with or without assistance).**
- **3 - Unable to get to and from the toilet or bedside commode but is able to use a bedpan/urinal independently.**
- **4 - Is totally dependent in toileting. Clear**

OM (M1845) **Toileting Hygiene:** Current ability to maintain perineal hygiene safely, adjust clothes and/or incontinence pads before and after using toilet, commode, bedpan, urinal. If managing ostomy, includes cleaning area around stoma, but not managing equipment.

- 0 - Able to manage toileting hygiene and clothing management without assistance.
- 1 - Able to manage toileting hygiene and clothing management without assistance if supplies/implements are laid out for the patient.
- 2 - Someone must help the patient to maintain toileting hygiene and/or adjust clothing.
- 3 - Patient depends entirely upon another person to maintain toileting hygiene. Clear

OM (M1850) **Transferring:** Current ability to move safely from bed to chair, or ability to turn and position self in bed if patient is bedfast.

- 0 - Able to independently transfer.
- 1 - Able to transfer with minimal human assistance or with use of an assistive device.
- **2 - Able to bear weight and pivot during the transfer process but unable to transfer self.**
- **3 - Unable to transfer self and is unable to bear weight or pivot when transferred by another person.**
- **4 - Bedfast, unable to transfer but is able to turn and position self in bed.**
- **5 - Bedfast, unable to transfer and is unable to turn and position self. Clear**

ADL / IADLs (continued)

(M1860) Ambulation/Locomotion: Current ability to walk safely, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces.

- 0 - Able to independently walk on even and uneven surfaces and negotiate stairs with or without railings (specifically: needs no human assistance or assistive device).
- **1 - With the use of a one-handed device (for example, cane, single crutch, hemi-walker), able to independently walk on even and uneven surfaces and negotiate stairs with or without railings.**
- **2 - Requires use of a two-handed device (for example, walker or crutches) to walk alone on a level surface and/or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces.**
- **3 - Able to walk only with the supervision or assistance of another person at all times.**
- **4 - Chairfast, unable to ambulate but is able to wheel self independently.**
- **5 - Chairfast, unable to ambulate and is unable to wheel self.**
- **6 - Bedfast, unable to ambulate or be up in a chair. Clear**

(M1870) Feeding or Eating: Current ability to feed self meals and snacks safely. Note: This refers only to the process of eating, chewing, and swallowing, not preparing the food to be eaten.

- 0 - Able to independently feed self.
- 1 - Able to feed self independently but requires:
  (a) meal set-up; OR
  (b) intermittent assistance or supervision from another person; OR
  (c) a liquid, pureed or ground meat diet.
- 2 - Unable to feed self and must be assisted or supervised throughout the meal/snack.
- 3 - Able to take in nutrients orally and receives supplemental nutrients through a nasogastric tube or gastrostomy
- 4 - Unable to take in nutrients orally and is fed nutrients through a nasogastric tube or gastrostomy.
- 5 - Unable to take in nutrients orally or by tube feeding. Clear

(M1880) Current **Ability to Plan and Prepare Light Meals** (for example, cereal, sandwich) or reheat delivered meals safely:

- 0 - (a) Able to independently plan and prepare all light meals for self or reheat delivered meals; OR
  (b) Is physically, cognitively, and mentally able to prepare light meals on a regular basis but has not routinely performed light meal preparation in the past (specifically: prior to this home care admission).
- 1 - Unable to prepare light meals on a regular basis due to physical, cognitive, or mental limitations.
- 2 - Unable to prepare any light meals or reheat any delivered meals. Clear

(M1890) Ability to Use Telephone: Current ability to answer the phone safely, including dialing numbers, and effectively using the telephone to communicate.

- 0 - Able to dial numbers and answer calls appropriately and as desired.
- 1 - Able to use a specially adapted telephone (for example, large numbers on the dial, teletype phone for the deaf) and call essential numbers.
- 2 - Able to answer the telephone and carry on a normal conversation but has difficulty with placing calls.
- 3 - Able to answer the telephone only some of the time or is able to carry on only a limited conversation.
- 4 - Unable to answer the telephone at all but can listen if assisted with equipment.
- 5 - Totally unable to use the telephone.
- NA - Patient does not have a telephone. Clear