OASIS...
CONTINUING THE JOURNEY

Laurie Otis, PT, MBA, MHA, GCS, COS-C
Pamela Teenier, RN, BSN, MBA, COS-C, HCS-D

Agenda

- AAA Initiative – Accurate Assessment Analysis
- Development Process and Results
- Best Practices and Lessons Learned
- OASIS C-1
Healthcare Quality Initiatives

IOM Report – Crossing the Quality Chasm 2001
- Six Aims for Improvement
  - Safe
  - Effective
  - Patient Centered
  - Timely
  - Efficient
  - Equitable

Triple Aim – IHI and CMS 2008
- Improving the experience of care
- Improving the health of populations
- Reducing per capita costs of health care

Collaboration Objectives

Keeping Pace in a Changing Landscape
OASIS Inter-rater Reliability

OASIS evaluations completed separately by a Registered Nurse and Physical Therapist for the same cohort yielded only 54% of identical responses.

Shew et al 2010

Continuous Improvement

Identify and eliminate factors causing variation

Standardize clinical management practices while promoting patient centered clinical decision making

Foster and leverage focused coaching and mentoring with a collaborative approach

Develop expertise in clinical assessment practices, QA, coaching and mentoring
Primary Activities – Systematic Approach

- **Input**
  - Comprehensive Patient Assessments
  - Information Transfer and Discussion – Case Conference and 1:1 Coaching
- **Throughput**
  - Ongoing conferencing and coaching
  - Monitor process adherence
- **Output**
  - Focus on patient centered outcomes
  - Alignment with regional and peer performance
  - Internalized behavior change

- Start Early
- Assure Competence
- Be Accountable
- Maximize the utility of science

Assessment Improvement Opportunities

- Retrospective review
- Nursing and Therapy
- Trending four months of performance
- Higher number of assessments
- Benchmark averages compared to regional performance
  - Comparing similar patient populations
Laser Focus Review / Identification

Identify outliers for specific M items
- Diabetes 2°
- Cardiac
- Vision
- Pain
- Dyspnea
- UB Dressing
- Bathing
- Toilet Transfer
- Transfers
- Ambulation

Pinpoint the knowledge gaps
- Regional
- Location
- Discipline
- Specialty Line

Determine potential causes
- Consider coverage areas
- Specialized skill sets

Assessment Report and Clinical Tools

- All assessments completed
- Four months of data
  - Updated monthly
- Ability to sort and compare by time point, discipline and specialty product line
- 10 OASIS items, C and F scores, CMW and M2200
- Roll up average of all assessments completed
  - Responses at individual patient level
- MCP Coaching Questions and Clinician Assessment Tips
- Monitoring Tool
AAA Report – Assessment Variances

Accurate Assessment Analysis

<table>
<thead>
<tr>
<th>By Assessing Clinician</th>
<th>Discipline</th>
<th>Episode</th>
<th>Region Averages</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Patients Assessed between 09/01/2014 and 12/31/2014</td>
<td>BN</td>
<td>0.25</td>
<td>1.5</td>
</tr>
<tr>
<td>Area</td>
<td>PT</td>
<td>0.27</td>
<td>1.5</td>
</tr>
<tr>
<td>Timpoint</td>
<td>SL/P/ST</td>
<td>0.20</td>
<td>1.5</td>
</tr>
<tr>
<td>Discipline</td>
<td>PT/SL/P/ST</td>
<td>0.20</td>
<td>1.5</td>
</tr>
</tbody>
</table>

- Clinical Manager and Divisional Leadership Team
  - Review data to identify opportunities
  - Clinicians trending significantly above or below branch or regional averages for each item
  - Select 2 clinicians per Clinical Manager and 1 or 2 OASIS items per clinician
  - Clinical Managers presented initiative to clinician(s) and reviewed performance data
  - Emphasis on quality improvement and assessment accuracy
    - In addition to QA process
  - 1:1 Face to Face Coaching and Mentoring
    - Ongoing review and coaching as needed
Coaching Sessions

Clinical Coaching Questions

M1810 – Current Ability to Dress Upper Body

- Safely (with or without dressing aids) including undergarments, pullovers, front-opening shirts and "long-sleeve" dressing, zippers, buttons, and snaps

Questions for a 1:1 Coaching Session with a Clinician

- What type of garment did the patient use to demonstrate UB dressing? What part of the activity did they have difficulty with if any? (Item retrieval, donning overhead, buttoning, etc.)
- Is your clinical opinion does the patient's performance match their current ability? (Not their "willingness" or "compliance")
- Did you recognize any difficulties with organizational capability — i.e. forgetfulness when retrieving items? If you identified limited ability to safely dress the upper body, tell me what you believe is causing the limitation(s)?
- Physical — limited ROM, balance deficits, dyspnea, fatigue
- Emotional / cognitive / behavioral — memory, deficits, impaired judgment, fear, organization; problem solving
- Sensory — vision deficits or pain
- Environmental factors — stairs, inaccessible closets, narrow doorways, clutter
- What is the most common type of upper body clothing the patient has in their closet or dresser? Where do they keep the clothing they typically wear each day?
- What time of day did you observe this activity and when during the assessment?
- Was the patient able to complete a conversation with you while performing the activity and if not would they be able to without jeopardizing their performance (safety concern)?
- Dyspnea endurance
- Attention to task — dual tasking: distractibility
- Is there potential for the patient to improve their ability and what did you observe to make you think they can or cannot improve?
- What did the caregiver report about the patient's ability to dress the upper body safely?
- Tell me how the patient's current problem has caused them to change how they get dressed or what they wear?

Clinician Assessment Tips

Pre-observation Questions:

- Do you have difficulty dressing?
- Have you recently changed what you wear to make it easier to get dressed? If so, is this because it was hard to get to the clothes or because it was difficult putting on that type of shirt?
- Where are your shirts located?
- Did you complete all your dressing and morning routine (grooming etc.) at the same time or do you need to rest in between activities?

Observation Strategies:

- Observe the patient's general appearance to determine if they are able to dress appropriately.
- Consider incorporating upper body dressing (taking shirt on and off) when assessing blood pressure.
- Ask the patient to show you where they keep their clothes and ask them to retrieve and replace a type of shirt they most often wear.
- Observe any dyspnea or restless breaks needed while performing the task.
- Observe need to go back and retrieve items (i.e. limited organizational ability).
- Observe time required completing the task and needing to stop and start due to inability to stay focused.
- Observe clothing orientation while performing the task — left arm in left sleeve etc.
- Observe their ability to transport the item, particularly if they use an assistive device.
- If upper body strength or presence is used, observe their ability to put on and take off (without assistance).

Response Instructions:

- Select response that best describes ability to perform the majority of upper body dressing tasks.
- If patient needs to go back and retrieve items, select “Limited organizational ability.”
- Select “Score level of ability” disregarding temporary environmental modifications that exist to facilitate access in response to a “bad day.”
- Evaluate need for OT or Aide services if score “2” or higher.
- If the patient requires standing assistance (a “helper” to dress safely or require verbal cues/reminders, select “Response “3”.

Definitions:

- Supervision = watching performance
- * “Verbal/Commm” = watching and talking through
- * Assistance = Physical contact
- * Minimal: 91-60% (teaching)
- * Moderate: 59-15% (guiding)
- * Severe: <14% (assisting)
Performance Improvement

- Consistent and timely focused item review
- Coaching, mentoring and monitoring
- Follow up calls with Divisional and Regional Leadership Teams
- On site shadow OASIS assessment
- Updates and performance review with clinicians
- Peer to peer presentations
- Celebrate successes and ability to sustain performance

Performance Results

Initial Episode SOCs - AVG M1860 Ambulation

780 Initial Assessment OASIS included in the AAA M1860 Focused Review
Testimonials and Implementation

Testimonials

• “The coaching questions helped me gain confidence in working with the clinicians"
• Clinicians stated they had better understanding of item intent
• “Seeing the snapshot of the individual assessments reinforces patient acuity levels and helps to reinforce resource needs – right disciplines at the right time”
• “I now review the OASIS guidance more often when I am not sure of which response to use”

Review and Implementation Time Points

• New employee orientation
• “Quarterly Pulse Check”
• Significant fluctuation in quality metrics

Best Practices and Lessons Learned

Stepping into the Future

• PI Methodology
• Stable Branch Leadership - Accountability
  • Branch owner and Regional / Divisional oversight
• >50% Focused Review
• Clinicians completing higher # of SOCs
• At least 3 months of Monitoring and Coaching as needed
• Clear definition of initiative and expectations
• Timely provision of coaching, mentoring and guidance
• Team problem solving with creative solutions
• Recognition of goal attainment and positive behavior change
OASIS-C1

- Minor wording changes
- Deletions
- Additions
- More significant change

<table>
<thead>
<tr>
<th>Minor wording changes</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>M1000 – Which inpatient facility</td>
<td>Changed “during” to “within” the past 14 days</td>
</tr>
<tr>
<td>M1040 (M1041) – Flu Vaccine</td>
<td>“Did the patient receive” to “Does this episode… include any dates”</td>
</tr>
<tr>
<td>M1045 (M1046)</td>
<td>“Reason not received” to “Did receive” with alternatives</td>
</tr>
<tr>
<td>M1050 (M1051) – PPV Vaccine</td>
<td>“Did patient receive” to “Has patient ever”</td>
</tr>
<tr>
<td>M1055 (M1056)</td>
<td>“State reason why” shortened</td>
</tr>
<tr>
<td>M1100 – Living situation</td>
<td>Added to response C – “residential care home”</td>
</tr>
<tr>
<td>M1240 – Pain</td>
<td>Added the word “validated” in question</td>
</tr>
</tbody>
</table>
### OASIS-C1

#### Minor wording changes

<table>
<thead>
<tr>
<th>Question</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>M1300 – Pressure ulcer assessment</td>
<td>Added validated to response 2</td>
</tr>
<tr>
<td>M1307 – Stage II Pressure ulcer at discharge</td>
<td>Added “excluding healed” to question</td>
</tr>
<tr>
<td>M1308 – Current number of pressure ulcers</td>
<td>SOC/Recert (only column only) Clarified instructions to exclude stage 1 and healed stage 2</td>
</tr>
<tr>
<td>M1320 – Status of pressure ulcer</td>
<td>Added language to question that excludes cannot be observed</td>
</tr>
<tr>
<td>M1324 – Most problematic pressure ulcer</td>
<td>Added language to question that excludes cannot be staged</td>
</tr>
<tr>
<td>M1334 – Most problematic stasis ulcer</td>
<td>Changed order of words</td>
</tr>
<tr>
<td>M1342 – Most problematic surgical wound</td>
<td>Changed order of words</td>
</tr>
</tbody>
</table>

---

### OASIS-C1

#### Minor wording changes

<table>
<thead>
<tr>
<th>Question</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>M1500 and M1510 – Heart failure</td>
<td>“at any point” to “at the time of or at any time” since…</td>
</tr>
<tr>
<td>M1730 – Depression screening</td>
<td>Added validated to question language</td>
</tr>
<tr>
<td>M1800 – Grooming</td>
<td>“i.e.” to “specifically” for examples</td>
</tr>
<tr>
<td>M1830 – Bathing</td>
<td>Removed “throughout the bath” from response 5</td>
</tr>
<tr>
<td>M1880 – Ability to plan means</td>
<td>Spelled out e.g. – for example</td>
</tr>
</tbody>
</table>
# OASIS-C1

## Minor wording changes

<table>
<thead>
<tr>
<th>Section</th>
<th>Changes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>M1900 – Prior functioning</strong></td>
<td>Changed question from “this current” to “most recent”&lt;br&gt;Changed examples in response a to “specifically: grooming, dressing, bathing, and toileting hygiene”&lt;br&gt;Changed examples in response b to “specifically: light meal preparation, laundry, shopping, and phone use”</td>
</tr>
<tr>
<td><strong>M1910 – Fall Risk assessment</strong></td>
<td>Added validated and shortened question language</td>
</tr>
<tr>
<td><strong>M2000 – Drug Review</strong></td>
<td>Spelled out e.g. and added [non-adherence] to clarify non-compliance&lt;br&gt;Added “adverse” before drug reactions and “significant” before side effects</td>
</tr>
<tr>
<td><strong>M2004 – Medication intervention</strong></td>
<td>Added “at the time of or at any time” before the word since</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Section</th>
<th>Changes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>M2015 – Drug Intervention</strong></td>
<td>Added “at the time of or at any time” before the word since&lt;br&gt;Added “adverse” before drug reactions and “significant” before side effects</td>
</tr>
<tr>
<td><strong>M2040 – Prior Medication Management</strong></td>
<td>Changed question from “this current” to “most recent”</td>
</tr>
<tr>
<td><strong>M2250 – Plan of Care Synopsis</strong></td>
<td>Diabetic foot care N/A: added “missing lower legs due to congenital or acquired condition”&lt;br&gt;Diabetic foot care N/A: added “missing lower legs due to congenital or acquired condition”&lt;br&gt;Fall N/A: Fall risk indicates instead of not assessed to be at risk&lt;br&gt;Pain N/A: Pain assessment does not indicate instead of no pain identified&lt;br&gt;Moist wound healing N/A: has no ulcers or none for which is indicated</td>
</tr>
</tbody>
</table>
## OASIS-C1

### Minor wording changes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>M2300</td>
<td>Emergent Care</td>
</tr>
<tr>
<td></td>
<td>&quot;At the time of or at any time&quot; added before the word since</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>M2400</td>
<td>Intervention Synopsis</td>
</tr>
<tr>
<td></td>
<td>&quot;At the time of or at any time&quot; added before the word since</td>
</tr>
</tbody>
</table>

### Deletions

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>M1012</td>
<td>Surgical Procedures</td>
</tr>
<tr>
<td>M1310/1312/1314</td>
<td>Pressure ulcer length, width, depth</td>
</tr>
<tr>
<td>M1350</td>
<td>Does this patient have an open wound</td>
</tr>
<tr>
<td>M1410</td>
<td>Respiratory treatments</td>
</tr>
<tr>
<td>M2440</td>
<td>Nursing home admission</td>
</tr>
</tbody>
</table>

- Deleted at recertification and discharge
- Deleted at discharge
- Deleted
### OASIS-C1 – Additions

*(M1309)* Worsening in Pressure Ulcer Status since SOC/ROC:

<table>
<thead>
<tr>
<th>Instructions for a – c: For Stage II, III and IV pressure ulcers, report the number that are new or have increased in numerical stage since the most recent SOC/ROC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enter Number</td>
</tr>
<tr>
<td>(Enter “0” if there are no current Stage II, III or IV pressure ulcers OR if all current Stage II, III or IV pressure ulcers existed at the same numerical stage at most recent SOC/ROC)</td>
</tr>
<tr>
<td>a. Stage II</td>
</tr>
<tr>
<td>b. Stage III</td>
</tr>
<tr>
<td>c. Stage IV</td>
</tr>
</tbody>
</table>

Instructions for d: For pressure ulcers that are Unstageable due to slough/eschar, report the number that are new or were a Stage I or II at the most recent SOC/ROC.

| Enter Number |
| (Enter “0” if there are no Unstageable pressure ulcers at discharge OR if all current Unstageable pressure ulcers were Stage III or IV or were Unstageable at most recent SOC/ROC) |
| d. Unstageable due to coverage of wound bed by slough or eschar | ___ |

### OASIS-C1 – Significant changes

*(M1302)* Types and Sources of Assistance: Determine the ability and willingness of non-agency caregivers (such as family members, friends, or privately paid caregivers) to provide assistance for the following activities, if assistance is needed. Excludes all care by your agency staff. (Check only one box in each row.)

<table>
<thead>
<tr>
<th>Type of Assistance</th>
<th>Non-agency caregiver(s) can independently provide assistance</th>
<th>Non-agency caregiver(s) need training/supportive services to provide assistance</th>
<th>Non-agency caregiver(s) are not likely to provide assistance OR it is unlikely they will provide assistance</th>
<th>Assistance needed, but no non-agency caregiver(s) available</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. ADL assistance (e.g., transfer, ambulation, bathing, dressing, toileting, eating/feeding)</td>
<td>☐ 0</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
</tr>
<tr>
<td>b. IADL assistance (e.g., meal preparation, housekeeping, laundry, telephone, shopping, financial)</td>
<td>☐ 0</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
</tr>
<tr>
<td>c. Medication administration (e.g., oral, inhalant or injectable)</td>
<td>☐ 0</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
</tr>
<tr>
<td>d. Medical procedures/treatments (e.g., changing wound dressing, home exercise program)</td>
<td>☐ 0</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
</tr>
</tbody>
</table>
OASIS-C1 – Significant changes

(M1033) Risk for Hospitalization: Which of the following signs or symptoms characterize this patient as at risk for hospitalization? (Mark all that apply.)

☐ 1 - History of falls (2 or more falls - or any fall with an injury - in the past 12 months)
☐ 2 - Unintentional weight loss of a total of 10 pounds or more in the past 12 months
☐ 3 - Multiple hospitalizations (2 or more) in the past 6 months
☐ 4 - Multiple emergency department visits (2 or more) in the past 6 months
☐ 5 - Decline in mental, emotional, or behavioral status in the past 3 months
☐ 6 - Reported or observed history of difficulty complying with any medical instructions (for example, medications, diet, exercise) in the past 3 months
☐ 7 - Currently taking 5 or more medications
☐ 8 - Currently reports exhaustion
☐ 9 - Other risk(s) not listed in 1-8
☐ 10 - None of the above

OASIS-C1 – Significant changes

(M2400) Intervention Synopsis: (Check only one box in each row.) At the time of or at any time since the previous OASIS assessment, were the following interventions BOTH included in the physician-ordered plan of care AND implemented?

<table>
<thead>
<tr>
<th>d. Depression intervention(s) such as medication, referral for other treatment, or a monitoring plan for current treatment and/or physician notified that patient screened positive for depression</th>
<th>☐ 0</th>
<th>☐ 1</th>
<th>☐ NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient has no diagnosis of depression AND depression screening indicates patient has: 1) no symptoms of depression; or 2) has some symptoms of depression but does not meet criteria for further evaluation of depression based on screening tool used.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Questions