OASIS Alert

Case Study: If Your Agency Is Sinking, OASIS Is Your Lifeboat

Focusing on OASIS basics erased this agency's million-dollar operating deficit in one year.

Viewing OASIS in an entirely different way solved one hospital-based home health agency's problems with low case-mix weights and a million-dollar deficit -- here's how you can do the same.

"OASIS is the key to a home care agency's entire well-being," Santa Rosa, CA-based **Lucy Andrews** told attendees at the recent 23rd National Policy Conference of the **National Association for Home Care & Hospice** in Washington, DC. Andrews is now president of **Creative Solutions Home Care Services**, after 15 years with a hospital-based HHA also in California.

Pointing to data released by NAHC, An-drews reminded the audience that 31 percent of HHAs had Medicare losses in 2003, and 36.5 percent are projected to have Medicare losses in 2004. Her agency was facing a loss of $1 million and she saw OASIS as the lifeline.

Dilemma: As she attempted to turn around her agency's continuing losses, Andrews saw several "disconnects" between the numbers affecting reimbursement and the types of patients her agency cared for. Although most of the agency's patients were referred directly after hospitalization and were sicker than average, the agency's case-mix weight was below 1.0. And clinicians often provided patients with many more medically necessary visits than the episode reimbursement paid for.

Planning: Lacking funds for expensive consultants or fancy software programs, Andrews focused on what the agency could do with what it already had -- OASIS. Looking back, she saw the agency had focused more on the mechanics of OASIS -- how to transmit data, how to meet the deadlines, how to get paid -- than on the content. And OASIS training had slowed down as Home Health Compare, outcomes and surveys took center stage.

This lack of knowledge left more interpretation to individual clinicians, resulting in inconsistency between what they put on the OASIS and what services they were providing and documenting in the record, Andrews told attendees. Outcomes also didn't show either how much had been done or the significant improvement the staff saw.

Tactic: "Unless you have consultants live with you ... you'll have to change your staff's mindset about the OASIS assessment," Andrews said. She decided to show the staff why OASIS data was important and how it could benefit them. One way to do this was to connect the Home Health Resource Group that resulted from the OASIS assessment with the number of visits clinicians felt were necessary because of the severity of a patient's illness.

Andrews thought this strategy would work for three reasons. First, clinicians focus on providing patients with the best possible care, so it was important that they see the connection between OASIS data and care planning. Next, clinicians wanted a measure of acuity like they had in the unionized hospital where the HHA was located. Finally, connecting the clerical and financial pieces would allow the staff to be part of the effort to turn around the agency's losses.

The first step: The agency started by looking at the areas of assessment that resulted in the HHRG. And they looked at it at the beginning of the episode rather than at the end. Andrews found that nurses tended to "project" where they saw the patient -- where they were going to be in the near future rather than now. So the agency focused on teaching staff to look at "the patient's usual condition at the time of the visit," she added.

The HHA encouraged observation rather than interviews, and emphasized using OASIS as a guide for the services

clinicians planned to provide. They discouraged clinicians from marking "NA" as an answer unless it was truly the correct answer. Clinicians often used "NA" when they felt rushed, and they didn't realize this response affected case-mix weight, Andrews said.

The HHA also made sure clinicians understood the clinical and functional domain questions thoroughly. "Chapter 8 of the OASIS Implementation Manual became our bible," Andrews noted. The agency taught staff about the connections between OASIS, the 485 and documentation in the record.

The next step: The agency then promoted the HHRG as a measure of the patients' acuity level (see "How To Translate The HHRG Into a REcommended Number of Visits"). They focused on whether the resulting HHRG and recommended number of visits really matched what clinicians saw in the patient assessment, Andrews explained. Clinicians were encouraged to ask: "Is this what I want for my patient?" If not, they were urged to "fix it now." Case managers learned to connect the financial piece with the clinical piece, focusing on getting accurately paid for the care provided.

Don't skip this part: Andrews and the case manager had a one-on-one conversation with each clinician to review at least half of her current case load. They went through the charts and related OASIS assessment to determine which issues each clinician needed help with. Clinicians began to see the discrepancies between the OASIS and the documentation. They also learned how to use the HHRG to estimate recommended number of visits and to double-check the OASIS. While this step was the most expensive, it was critical, Andrews said. The investment was well worth it.

Results: In the first 90 days of the program, **the agency's reimbursement increased by $300,000** even though the number of visits didn't decrease, Andrews cheered. They just better matched service with reimbursement, she said. And one year later the agency went from a million-dollar loss to break even, she added. The average case-mix weight increased to an appropriate level.

The staff understood OASIS and its benefits, she reported. This was reflected on the latest nurse satisfaction survey -- with 61 percent fewer staff members indicating paperwork as one of their top three concerns.