MEDBRIDGE

10 Steps to Consider When Creating An OASIS Training Solution For Your Staff

Introduction

Collecting accurate OASIS data in a timely manner has been a challenge for many agencies. Training staff is a process that does not end once orientation is completed. Insufficient training allows mistakes to become chronic, slowing down the review process and delaying the ability to bill. In PDGM, inaccurate assessment of functional impairments can reduce your average reimbursement by 15 percent.

OASIS data collection has wide ranging implications on outcomes and process measures, risk adjustment, and reimbursement. How familiar your team is with key concepts and terminology unique to OASIS will make or break accuracy. Agencies need an OASIS training solution that reduces costly errors, expedites the QA process, and is cost-effective.

With these important factors in mind, it may be time to take a fresh look at your organization's OASIS training program. We've partnered with Diana 'Dee' Kornetti, PT, MA, HCS-D, HCS-C, and Cindy Krafft, PT, MS, HCS-O, to create a comprehensive, engaging, and instantly applicable OASIS training series to address the key concepts home health frontline staff need to understand to correctly collect meaningful OASIS data.

Whether you're refreshing your training processes or starting anew, use this checklist to ensure you're getting the most out of the OASIS tool in your organization.

Meet the Instructors

Diana 'Dee' Kornetti
PT, MA, HCS-D, HCS-C

Dee, a physical therapist for more than 30 years, has experience as a co-owner, administrator, and clinician of a Medicare-certified home health agency. Dee is a nationally recognized educator in the areas of documentation, auditing, staff training, and education. Her focus is on operationalizing the skills and abilities essential to the post-acute continuum of care with an eye to regulatory requirements as established to meet individualized patient care needs.

Cindy Krafft
PT, MS, HCS-O

For the past 15 years, Cindy has been a nationally recognized educator in the areas of documentation, regulation, therapy utilization, and OASIS. She currently serves on multiple technical expert panels with CMS contractors, working on clinical and payment reforms and bundled payment care initiatives. Her focus is on providing the knowledge and tools critical to the post-acute continuum of care to operationalize external requirements while keeping the driver of care where it needs to be—the needs of each patient being cared for.

OASIS Assessment Checklist

- [ ] Introduce Key Concepts
- [ ] Understand the Fundamentals of Coding: ICD-10 Coding
- [ ] Collect Demographic and Care Planning Data
- [ ] Complete a System-by-System Assessment
- [ ] Conduct an Integumentary Assessment
- [ ] Assess Neuro-Emotional-Behavioral Status and the Ability to Manage Medications
- [ ] Connect Fall Risk and the Assessment of Functional Ability
- [ ] Evaluate Safe Completion of Self-Care Activities
- [ ] Determine Impact of Fall Risk on Mobility
- [ ] Address Data Collection Issues at Discharge

Introduce Key Concepts

Accurate OASIS data collection depends on a clear understanding of the rules that impact how data is collected and analyzed. Because OASIS data collection impacts both patient care and agency performance, it's important that your clinicians are introduced to the key concepts and terminology unique to the OASIS tool during their onboarding and continue to review any changes and updates annually.

Understand the Fundamentals of Coding: ICD-10 Coding

The coding process is integral to agency compliance. It's particularly important for clinicians, who are a critical element of the process, to fully understand the information required to support coding choices, its purpose, and the importance of clinical documentation as a whole. An improved understanding of these guidelines can not only help coders more efficiently complete OASIS coding tasks, but can also facilitate timely submission for reimbursement.

ICD-10 coding is one of the most difficult to master, so make sure that you have defined specific strategies for front line documentation to support coding compliance and that staff are able to articulate primary and secondary diagnoses as defined by OASIS guidance.

Collect Demographic and Care Planning Data

Demographic and clinical details gathered at the beginning of the assessment will set the stage for what needs to be done going forward and are crucial to establishing a comprehensive care plan. While some of this information may be provided as part of the referral, it's the clinician's duty to confirm that this information is current, accurate, and complete.

It is also important for the clinicians to understand how to fully address the patient's needs in the care plan itself and how to document appropriately to support the diagnosis, abilities, and goals determined in the assessment.

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Complete a System-by-System Assessment

Being able to identify common patient-specific risk factors such as sensory status, respiratory status, and elimination are vital for accurate assessment. For example, while something as seemingly simple as a visual assessment might seem like a quick box to tick, it can affect the patient's ability to safely maneuver in the home if there are compounding issues with posture or environment. A 'simple' oversight can quickly affect accurate data collection.

Conduct an Integumentary Assessment

Receiving post-operative wound care patients and treating those with compromised skin integrity is common in home health, so ensuring accurate collection of this data during the assessment is vital. In addition to its relatively recent boost in reimbursement status, there is even greater focus on the integumentary assessment, where pressure ulcer-specific terminology, healing status of stasis ulcers, and how to assess for and correctly document issues specific to primary and secondary intention surgical wounds comes into play.

Assess Neuro-Emotional-Behavioral Status and the Ability to Manage Medications

When assessing neuro-emotional-behavioral status, clinicians need to assess for and correctly document cognitive function, confusion, and anxiety, as well as cognitive, behavioral, and psychiatric symptoms. Depression, for example, can be captured and defined as a comorbidity that can affect the care plan.

The other important area impacting patient safety is medication management, where clinicians will need to assess for and correctly document considerations of the drug regimen review, as well as oral and injectable medication management.

Connect Fall Risk and the Assessment of Functional Ability

Falls are one of the most common and costly healthcare events, making the assessment and correct documentation of fall risk all the more important. Staff need to be able to articulate the guidance and definitions specific to assessing self-care and mobility and determining "safe and able."

Establishing these assessments within an integrated care plan will be crucial for preventing falls and ensuring the safety of the patient.

Evaluate Safe Completion of Self-Care Activities

To reduce risk of readmission, it's vital to assess the capacity for self-care. This includes grooming, oral hygiene, dressing, bathing, and toileting assessment. Bathing and toilet transfer are areas of heightened fall risk, and basic hygiene assessments are important for the patient's overall wellbeing and outlook. Under or overestimating the patient's ability to self-care can have significant impact on agency outcomes and reimbursement.

Determine Impact of Fall Risk on Mobility

Staff should be able to assess for and correctly document the ability to complete bed mobility, transfer, ambulate, successfully retrieve objects from the floor, and more. If relevant, the ability to utilize a wheelchair should also be assessed and documented.

When assessing mobility, it can be helpful to think of it as not necessarily assessing ability to perform an action—the patient may be physically capable—but rather if it's safe for the patient to perform this action alone, with assistance, or at all given their unique circumstances.

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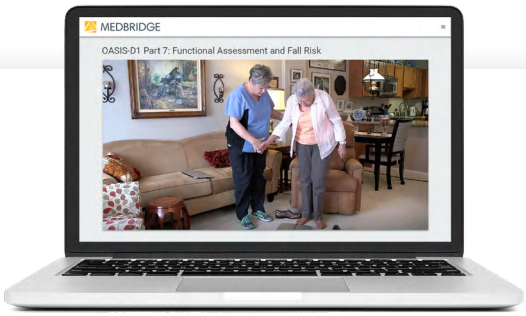
Address Data Collection Issues at Discharge

There are specific items at transfer and discharge that must be thoroughly understood by the clinician to ensure consistency of data collection. These can include documentation for wound assessment, intervention synopsis, any fall events, discharge disposition, and use of emergent and inpatient care.



Increase Assessment Accuracy and Expedite Training with Our OASIS Series

Ready to take the next step in your OASIS training? Expedite onboarding, provide annual refresher courses, and implement performance-based microtraining with our 10-part OASIS course series, hosted by Diana 'Dee' Kornetti and Cindy Krafft, to decrease the cost and time spent on documentation review and provide the appropriate level of reimbursement.

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