MEDICARE'S OASIS: STANDARDIZED OUTCOME AND ASSESSMENT INFORMATION SET FOR HOME HEALTH CARE – July 1999

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The Outcome and Assessment Information Set (OASIS) that HCFA is requiring for purposes of outcome-based quality improvement under Medicare (as part of the new Conditions of Participation) has undergone several years of development and refinement. In addition to reviewing the purpose and evolution of the OASIS to date, this prologue provides information on selected operational issues.

Purpose, History, and Improvements

The data items that constitute the OASIS were developed largely for purposes of measuring patient outcomes in home health care. Nearly all of the items also are useful for assessing the care needs of patients, but no pretense is made that the OASIS constitutes a comprehensive assessment instrument. Since the vast majority of OASIS items are similar to those currently used by most home health agencies at start of care (often in less precise form), it is intended that home care agencies and others replace their current versions of these items with the actual OASIS items. Experience in various demonstration programs has shown that this enables home care providers to conduct more precise assessments of patient conditions for these items.

The OASIS has its genesis in 12 years of research, development, and demonstration programs to design and test outcome measures for home care (funded by HCFA and The Robert Wood Johnson Foundation). One of the important products from this program was a 73-item data set required to measure outcomes, first published in a 1994 report written by the Center for Health Services and Policy Research (the Research Center) at the University of Colorado. This was expanded to a 79-item data set as a result of recommendations from a HCFA-convened task force of home care experts who reviewed the data set from the perspective of items judged essential for assessment. The Research Center revised and rearranged the 79 items into a data set format termed OASIS-A in 1995.

The OASIS-A items that had been developed and tested in the national research program (along with those added by the expert panel) were then used operationally in two demonstration programs (summarized below) beginning in late 1995 and 1996. This experience suggested selected refinements, resulting in OASIS-B, which contained 79 items. Although a few items were dropped, a few were added, and wording changes were made to clarify items, the substance of OASIS-B was virtually the same as OASIS-A. The current (1998) release of OASIS, termed OASIS-B1, includes modifications to the patient identifiers (termed clinical record items) and one demographic item. These modifications are intended to assist HCFA in tracking and managing data. As the Medicare program moves forward with OASIS, it is clear such identifiers (also used for billing, care planning, etc., under Medicare) would naturally accompany the core OASIS items and be of value for agency-specific applications of OASIS.

Thus, OASIS-B was largely the result of applying and testing OASIS-A, beginning in 1996 in (1) the national demonstration of outcome-based quality improvement (OBQI) that HCFA is sponsoring and the University of Colorado Research Center is administering, and (2) an

analogous OBQI demonstration in New York State that the Department of Health is sponsoring and the University of Colorado Research Center is administering. The experience of the 50 national demonstration agencies and the 22 New York State demonstration agencies in using the OASIS for purposes of collecting outcome data, as well as selected experiences of other agencies throughout the country which have elected to use the OASIS data set, were taken into consideration in the modest set of revisions that initially resulted in OASIS-B.

Further experience in the demonstrations and in HCFA's needs for data management and administration subsequently were taken into consideration in refining OASIS-B to produce OASIS-B1. Reliability testing, programmatic applications, and provider suggestions to improve OASIS will continue with a view toward improving the data set. Nonetheless, OASIS is now regarded as a stable data set that can be used in the context of patient assessment and outcome monitoring. At the same time as home care practices, patient conditions, and policies change, it will be necessary to occasionally update and refine the data set. As other revisions are released, the suffixes "C," "D," etc. will be used.

One of the primary reasons OASIS has been deemed stable and useful for the home care field is its multiplicity of successful applications in the demonstration programs. Nearly all demonstration agencies have been extremely successful in effectively and precisely implementing and maintaining OASIS data collection. This in turn has resulted in accurate and useful outcome reports, case mix reports, and adverse event reports. Using the findings from the outcome reports and developing methods to evaluate the care that influences specific outcomes, a majority of agencies in the national demonstration changed care behaviors to produce improved outcomes in the areas they targeted for improvement.

It is our intent at the Research Center to provide the home care industry with regular updates on OBQI demonstrations, operational issues related to OBQI that are important to both individual agencies and Medicare, strengths and weaknesses associated with using the OASIS for various purposes, and other issues pertinent to smoothly and effectively implementing the OASIS data set in order to measure outcomes. We have used and will continue to use several different forums for these communications (including the HCFA website, since much of our home care research is sponsored by HCFA). Information related to operational features of the OASIS is summarized in subsequent paragraphs.

Operational Issues

With respect to understanding and using OASIS data items, several points are important to take into consideration. Since the OASIS is used for measuring outcomes defined as change in health status between two or more time points, most data items are obtained at start of care and follow-up time points (i.e., every two calendar months and discharge). Selected items are unique to either start of care or follow-up times. These are indicated as such on the OASIS. All OASIS items are intended to be completed through routine patient assessment approaches and collection of patient subjective and objective data. The items should not be used in the form of a patient interview for collecting data.

A number of software developers currently have software available or are developing software that incorporates the OASIS into their electronic clinical record systems.[1] In addition, stand-alone OASIS-specific software, not part of a more comprehensive electronic clinical record

[1] The OASIS data items have been copyrighted by the Center for Health Policy Research (now termed the Center for Health Services and Policy Research) and are in the public domain. They cannot be further copyrighted for exclusive use by a particular agent or organization.

system, has been developed for agencies that do not have or are not presently interested in a more comprehensive electronic clinical record system. This stand-alone software enables an agency to computerize or enter OASIS data that have been recorded by clinicians using forms that integrate the OASIS items into the agency's assessment instrument. HAVEN, which is distributed by HCFA at no charge, is an example of this type of software product. Regardless of whether an agency uses a comprehensive electronic clinical record system (possibly with laptops) or stand-alone software to specifically computerize OASIS items, it is important that the exact wording of OASIS items be directly incorporated into the clinical record. Agencies should be certain that their software (1) can be efficiently updated with occasional changes that might occur in OASIS, and (2) provides the capability to extract OASIS items for purposes of transmission to HCFA for outcome comparisons and benchmarking, as well as other agency internal applications that will naturally be of interest once OASIS data are computerized.

Care providers should not have the option to carry the same OASIS data from start of care to follow up in describing or assessing patient health status (this often results in inaccurate follow-up data because providers are tempted to minimize their time by carrying forward the data from the initial time point instead of properly reassessing and recording the information at follow up). This carry-forward approach should not be used in either paper or electronic documentation approaches. That is, assessment forms should not be designed with OASIS data from a prior time period on the same page as data for the current time period, and electronic clinical record software should not be designed so that OASIS data from a prior time period can simply be inserted into the current time period.

Completeness and accuracy of OASIS data are imperative. Not only are these attributes mandatory under HCFA requirements and surveillance policies, but most importantly, complete and accurate OASIS data are essential for individual home health agencies. With precise and comprehensive data, agencies will be able to systematically track case mix changes over time, compare agency-level case mix with a national reference sample, and most importantly, monitor patient outcomes from year to year and relative to national reference outcomes.

This means that agency CEOs, administrators, clinical managers, clinical staff, and fiscal staff should be aware of OASIS' purposes and, most critically, take all possible steps to ensure the accuracy and completeness of OASIS for every patient on whom such data are collected. If this is done, then the agency can derive full benefit from the multiplicity of uses of OASIS.

We wish to repeat that the OASIS was not developed as a comprehensive assessment instrument. It was developed primarily for purposes of measuring outcomes for adult home care patients. Agencies will find it necessary to supplement the OASIS in order to comprehensively assess health status and care needs of patients (for example, the OASIS does not include vital signs nor was it developed with pediatric patients in mind).

It is also important to note that the purpose of measuring patient outcomes through the OASIS is to assist home care agencies with quality improvement activities. In 1995, we authored a book published by the National Association for Home Care, *Outcome-Based Quality Improvement, A Manual for Home Care Agencies on How to Use Outcomes.*[2] This publication provides guidance to agencies on measuring and reporting outcomes and on using them to improve quality.

[2] For additional information on *Outcome-Based Quality Improvement*, call or write the National Association for Home Care, 228 Seventh St., SE, Washington, DC 20003, (202) 547-7424, fax: (202) 547-3540.