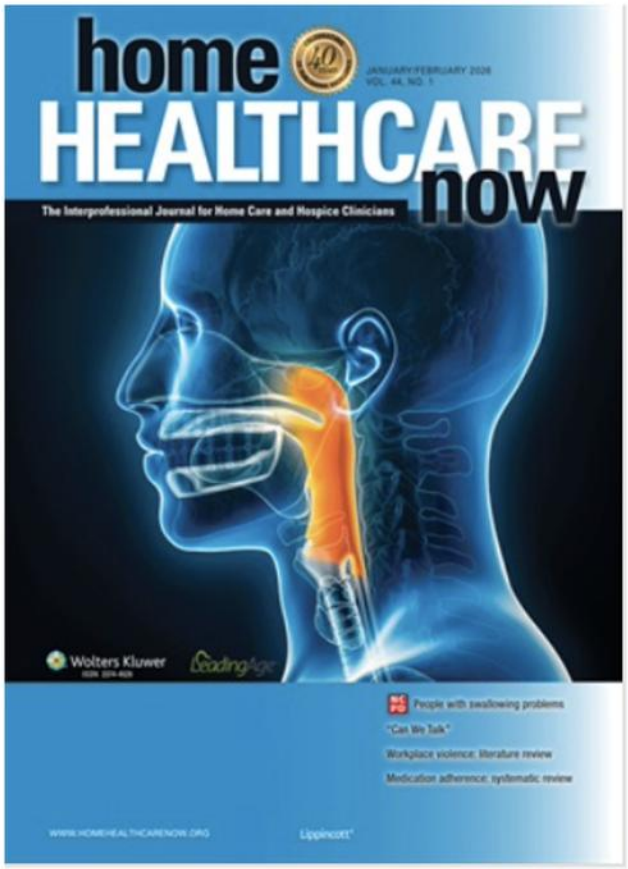

Earning Clinician Buy-in for AI in OASIS Coding and Plan of Care Development

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Home health clinicians are increasingly encountering artificial intelligence (AI) tools that transcribe or summarize visits, recommend OASIS responses, and prepopulate care plan elements. Despite potential gains in efficiency and cost reduction, the adoption of AI is being met with resistance by some home health clinicians and teams (Karnehed et al., 2025). This article summarizes common reasons for resistance among home health clinicians and offers practical strategies to earn clinician ownership while safeguarding accuracy and patient safety.

Clinicians that are more versed in AI will likely want to know what data the model was trained on, how it makes recommendations, and how to validate its output.

Why Resistance Is Rational

First, clinicians are appropriately wary of "automation bias"—an overreliance on machine suggestions that can dull clinician vigilance and perpetuate errors. Following a recent presentation I provided on AI in home health, I was approached by an experienced home health nurse who attended the conference. Her comment was, "I *want* to lean in, but AI goes against everything I learned in nursing school. It just feels *wrong* to let a machine do my job." Contemporary human-factors research shows that, particularly under high workload and time pressure (like that experienced by home health field clinicians), automated decision support can divert attention from independent verification, creating conditions for automation bias to flourish (Kupfer et al., 2023). Therefore, clinician reluctance and skepticism are to be expected when proposing the use of automated machines to carry out actions that clinicians have received extensive training to conduct.

Second, concerns about transparency and accountability abound. Clinicians may not have a great deal of experience in AI models, and therefore no context from which to offer any confidence in a machine taking over "their work." Clinicians that are more versed in AI will likely want to know what data the model was trained on, how it makes recommendations, and how to validate its output.

Third, the stakes in home health are high. OASIS recommendations drive quality measurement and reporting, impacting payment through the Patient-Driven Groupings Model (PDGM) and the Home Health Value-Based Purchasing (HHVBP) Model. Internally, agencies and clinicians may use the OASIS responses to identify patient needs or gaps, supporting development of the care plan. Suppose AI suggests an OASIS code based on an inappropriate look-back period or nudges a clinician toward an incorrect OASIS code without considering all necessary assessment details. In that case, agencies risk consequences related to quality, reimbursement, compliance, and appropriate patient care planning. CMS resources underscore that OASIS data submitted to CMS must be accurate, and that OASIS-based quality measures are calculated from defined quality episodes and are risk-adjusted using specific OASIS item responses, making data integrity nonnegotiable.

Finally, clinicians are unsure the *juice is worth the squeeze*. Although successful adoption of AI will likely involve investment in a learning curve, evidence that AI reduces documentation burden is growing, but remains mixed and setting-dependent (Olson et al., 2025).

Strategies to Earn Buy-in (Without Sacrificing Clinical Judgment)

1) **Adopt a "human-in-the-loop, verification-first" standard.** Mitigate automation bias with explicit countermeasures. Create policies that require clinicians to (a) review model recommendations AND rationales; (b) cross-check the model recommendation against source documentation; and (c) actively

accept, reject, or edit each AI-recommended OASIS response or care plan statement. Document trends for OASIS items or plan of care elements where AI recommendations are rejected by clinicians and share findings with the AI-solution developer to aid in ongoing model training. Clinician involvement in this approach will be valuable in not only improving the model, but the increased transparency in the process will provide a realistic perspective for the clinician and promote trust in the model and the necessary iterative process.

2) **Anchor the decision to use an AI tool to specific problems that affect clinicians and/or patients.** Frame AI adoption as the solution to one or more named problems that clinicians are already dealing with. For example, introducing the AI tool as a means of reducing documentation time, supporting plan of care development, or improving accuracy on high-impact OASIS items makes an immediate connection between an existing pain point and a possible resolution. Tying a specific AI tool or feature as a solution that benefits the clinician and/or patient directly will increase collaboration and adoption.
3) **Run short, well-designed pilots with internal champions**. Select two or three teams, determine a clear success criteria (e.g., time spent conducting a start of care assessment, time spent conducting a QA review on an AI-supported OASIS assessment, time spent documenting after hours, self-reported burnout, discrepancy rate in OASIS item coding, plan of care clarifications requested). Define how and when the targeted metric will be measured, as well as other pilot methodologies. Tracking and reporting objective and measurable metrics will provide a means to evaluate the effectiveness of the piloted process, allowing for refinements or scaling based on the findings.
4) **Provide comprehensive training and support, don't isolate AI as the magic bullet**. When implementing AI tools, blend policy and practice. When providing training on the technical steps for accepting or rejecting AI-generated OASIS coding recommendations, include training on the CMS guidance related to response-specific coding instructions for the item(s) being reviewed. Equip the clinicians with the clinical and guidance resources needed to code the items, to allow them to make informed decisions about accepting or rejecting the AI recommendations.

Although initially, these steps to review, validate, and accept or reject AI recommendations may still require significant involvement by the clinician, the opportunity for knowledgeable and experienced clinicians to be fully engaged in testing, refining, and validating the accuracy of the AI model is the price necessary for AI to earn the trust of perceptive clinicians.

Conclusion

Resistance to AI in home health is less a roadblock, and more a speedbump in the form of clinicians needing assurance that AI will lighten the load without diluting clinical judgment or replacing the clinician as the final decision maker in the OASIS coding and plan of care development processes. By insisting on transparency, rigorous verification by engaged clinicians, thoughtful piloting, and CMS-aligned education, leaders can convert AI skepticism into engaged, safety and accuracy-minded adoption. ■

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