































- 1  **OASIS D – What is Changing**
- 2  **Major Changes with OASIS D**
  - 28 Deleted Items
  - 6 New items with multiple responses
  - 16 Revised Items
  - 
  - Goal is more standardization across the healthcare setting
- 3  **How does accuracy of OASIS answers effect VNA HEALTH SYSTEM**
  - Home Health Compare Results
  - Quality of Patient Care Star Rating
  - IMPACT Act Quality Measures
  - Potentially Avoidable Events
  - Payment/Case Mix Weight
  - Outcome Based Quality Improvement
  - Outcome Based Quality Monitoring
  - Process Quality Measures
  - Home Health Value Based Purchasing Model
- 4  **What questions/answers are counted on our star ratings**
  - Timely Initiation of Care
  - Improvement in Management of Oral Med (NEW)
  - Improvement in bathing/transferring/ambulation
  - Improvement in Dyspnea
  - Improvement in Pain interfering with activity
  - Hospitalization (both admission and ER)
- 5  **Quality Episodes**
  - The time periods of when outcomes are reportable to CMS for home health compare and star ratings.
  - 1. SOC to Discharge
  - 2. SOC to Transfer
  - 3. ROC to Discharge
  - 4. ROC to Transfer
  - Recerts do NOT factor in to quality episodes
- 6  **Reviewing Assistance with ADL/IADL**
  - Assistance means assistance of another person
  - Not limited to physical contact
  - Can include necessary verbal cues and/or supervision
- 7  **DASH Response**
  - The DASH response continues to be allowed for particular questions
  - VNA Health System discourages the use of the dash response as this is stating did not review/assess.
- 8  **Review Death at Home**
  - The Death at Home OASIS is completed as follows:
  - Patient dies at home
  - Patient dies at church
  - Patient dies in the ambulance
  - Patient is pronounced DOA in ER
- 9  **TRANSFER – DISCHARGE FROM SERVICES**
  - COMPLETED WHEN:

- Patient Dies in the ER (while being treated)
  - Patient Dies in outpatient surgery/recovery room
  - Patient Dies while under observation status
  - Patient Dies within 24 hours of admission to an inpatient facility
- 10  **Unplanned Discharge from Agency**
- If you are asked to complete the Discharge OASIS related to being the last qualifying discipline to see this patient, you may use collaboration and may supplement discharge OASIS questions with information from patient visits by other agency staff that occurred within the last 5 calendar days the patient received visits.
  - This means go to the last visit made, you may use information from that visit and any visits within the 5 days from that visit back.
- 11  **Episode Timing**
- With OASIS D – January 1, 2019
  - Early is the first and second 60 day period.
  - Late is the third episode period or later.
- 12  **Changes in Pressure Ulcer**
- They have added Pressure Injury as this is reflective of State 1 Pressure Ulcer/Injuries.
  - They have removed the M question asking the status of the pressure ulcer
  - Please continue to be careful with staging the correct stage of the PU/PI
  - Remember if the PU is closed with epithelial tissue it is then considered healed and no longer reported on any future OASIS document
- 13  **NEW with UNSTAGEABLE**
- Any numerically stageable pressure ulcer/injury at SOC/ROC that is unstageable due to slough/eschar at discharge is considered new *and not considered present at the most recent SOC/ROC.*
  - *Therefore, at discharge, if you have an unstageable PU that was stageable on SOC/ROC it is now considered a NEW PU*
- 14  **Stage 4 Pressure Ulcer**
- If you are assessing a pressure ulcer and you see bone, tendon, muscle, you will stage this as a Stage 4, even if there is more than 25% slough/necrotic tissue.
- 15  **Reminder on PU/SW**
- A PU treated surgically with any kind of graft or flap is considered a surgical wound until 30 days after re-epithelialized. It is no longer a PU.
  - Examples: Muscle Flap; Skin Advancement Flap; Rotational Flap; Skin Flap; Skin Substitute Graft
  - DEBRIDEMENT: A PU that has been debrided REMAINS a PU
- 16  **Height and Weight**
- Height and Weight is expected to be measured at time of assessment. Using stated weight is not acceptable.
  - If unable to weigh due to safety issues, etc, then the dash response can be used.
  - There are several scales in each office to be used for this question.
  - Consistent dashes by a clinician will be monitored and reviewed
  - You may use a previous weight by our own staff within 30 days (this may be with a ROC)
- 17  **Surgical wound with particular procedures**
- Procedures that go beyond simple debridement, simple I&D or simple sutured traumatized lacerations would be a SW

- Examples: excision of a mass, structure, mesh, or surgical repair of trauma induced injuries like ruptured organs, fractures, tendons
  - Incisions created for the purpose of laparoscopic surgery, arthroscopy and other minimally invasive surgery/procedure
  - NOT SW: Simple debridement; I&D, Sutured Trauma lacerations and removal of toenail/callus
- 18  **SW status when needle access always in place**
- Cannot fully granulate and may remain "non-healing" while line or needle is in place
- 19  **Frequency of pain interfering with activity or movement**
- Not just a measurement of the presence of pain
  - Not just a measurement of frequency of pain
  - One part of a comprehensive pain assessment
  - Time: Day of assessment and recent pertinent past
  - Observation and Interview – Assess patient when moving. Don't overlook activities such as sleeping, eating, hobbies.
- 20  **Freq. of pain continued**
- Patient restricts activity to avoid pain
  - Pain does not have to totally prevent an activity, it may:
  - Cause activity to take longer to complete
  - Result in activity being performed less often than desired
  - Require patient to have additional help
- 21  **Dyspnea**
- Report what is true on the day of assessment (day of assessment is at that time and 24 hours prior)
  - Observe if patient is noticeably SOB; Interview.
  - Refer to examples included in response
  - Need to get patient walking around to assess
  - Assessment based on patient's use of oxygen, not physician's order. Patient does not use per physician order.
  - If oxygen only used at night report level of exertion that causes dyspnea without oxygen
- 22  **Therapies at Home**
- IV - For this OASIS question, if the patient has orders for PRN IV at SOC/ROC but the patient does not meet assessment parameters for administration at this time or within the 5 day window, then the answer would be NO.
  - TUBE FEED – Do NOT mark Response 3 if tube feed is PRN and patient did not receive feeding in prior 24 hours or as result of your assessment, or patient refused.
- 23  **Impairment or Personal Choice**
- Please be careful when answering the ADL questions regarding the patient impairment to be safe or personal choice.
  - Example: Patient has walker and cognitive impairment has the patient forgetting to use his walker vs patient has walker but cognitively decides he does not want to use it.
- 24  **Bedfast with ADL**
- On day of assessment, patient is either:
  - Medically restricted to bed OR

- Unable to tolerate being out of bed
  - Not required out of bed for any specific length of time
  - Use clinical judgment to determine if patient can tolerate being out of bed
  - Unable to tolerate being out of bed examples:
    - Has multiple system atrophy, becomes severely hypotensive within short time moving from supine to sitting position
  - Not Bedfast: Deconditioned after hospitalization only able to sit in chair for a few minutes.
- 25  **Plan of Care vs Intervention Synopsis**
- The POC synopsis has been discontinued for OASIS D (YAY!). Therefore, we will no longer have the matching issues with SOC to DC
  - The intervention synopsis remains at Transfer and DC and works as it has before. You are able to check the 485 to see what process measures were used and on the plan of care.
- 26  **Patient Living Situation**
- Row A Lives Alone for the following situations:
    - Lives alone in home, apartment, own room in boarding home
    - Lives with live-in paid help
    - Caregiver temporarily staying to provide care
- 27  **Depression Screen**
- Enter Response 1 – Yes N/A Unable to Respond
    - Clinician determines the patient has cognitive and physical ability to respond to the PHQ-2 questions but is unable to answer the specific question.
    - Example: I can't really say how many days I've felt hopeless.
- 28  **Bedfast**
- On day of assessment patient is either:
    - Medically restricted to bed or unable to tolerate being out of bed
  - Unable to tolerate out of bed examples:
    - has multiple system atrophy, becomes severely hypotensive within one minute of moving from supine to sitting position
  - NOT BEDFAST – deconditioned after hospitalization, only able to sit in chair for a few minutes
- 29  **Types and Sources of Assistance**
- NOTE: TED hose, prosthetic devices, orthotic devices or other supports with a medical/therapeutic impact are addressed in row d and NOT as ADL dressing items in row a.
  - Row F – Supervision and Safety – Includes needs related to the ability of the patient to safely remain in the home. Such assistance may range from calls to remind the forgetful patient to take medications to in-person visits, to assuring patient does not wander and related to cognitive/mental health concerns.
- 30  **Drug Regimen Review**
- The drug regimen review in post-acute care settings is to include medication reconciliation, a review of all medications a patient is currently using and review of the drug regimen to identify, and if possible, prevent potential clinically significant medication issues.

OAI Surgical Wound Quick Reference Source: OASIS Guidance Manual, OASIS Q&A*	
M1340 Surgical Wounds	
Includes	Excludes
Many, not all, surgical wounds/incisions of the <b>Integumentary System</b>	Surgical wounds/incisions <b>not</b> of the integumentary system: <ul style="list-style-type: none"> <li>- surgery to the mucosal membrane</li> <li>- cataract surgery of the eye</li> <li>- gynecological surgery via vaginal approach</li> </ul>
<b>Surgical site</b> primarily closed with staples, sutures, chemical bonding agents, etc., until completely re-epithelialized for about 30 days and healed	<ul style="list-style-type: none"> <li>- Old surgical wound with scar or keloid formation.</li> <li>- Staple sites</li> <li>- Retention sutures utilizing a button</li> <li>- Simple debridement of an existing wound (traumatic, pressure ulcer, etc.)</li> <li>- Enterocutaneous fistula</li> </ul>
A surgical "take down" or reversal of a previous ostomy	<ul style="list-style-type: none"> <li>- <b>All "ostomies" (openings that end in "ostomy")</b></li> <li>- <i>Examples:</i> thoracostomy/chest tube, gastrostomy, cystostomy, urostomy, colostomy, cholecystostomy, jejunostomy, tracheostomy, ileostomy, etc.</li> <li>- Ostomies with or without a drain</li> <li>- Surgical line around a fresh ostomy (peristomal or mucocutaneous suture line)</li> <li>- Bowel ostomy or gastrostomy closing on its own</li> <li>- Pleurx catheter inserted as a chest tube (thoracostomy)</li> </ul>
	<b>Simple debridement</b> of a burn, pressure ulcer, stasis ulcer, traumatic wound, etc.
<b>Repair</b> of a traumatic wound/injury <ul style="list-style-type: none"> <li>- <i>Examples:</i> surgery to repair ruptured organs, torn tendons, ligaments or muscles or fractures</li> </ul>	<b>Simple closure</b> of a traumatic laceration by sutures or stitches
<b>Procedures beyond a simple I&amp;D:</b> <ul style="list-style-type: none"> <li>- <i>Examples:</i> Excisions of a mass, abscess, mesh, other appliances or structures, etc.</li> </ul>	<b>Simple I&amp;D</b> of an abscess
<b>I&amp;D and other wounds with a drain placement even:</b> <ul style="list-style-type: none"> <li>- After the drain is removed</li> <li>- The drain opening was created percutaneously</li> <li>- Drain inserted into a puncture site</li> <li>- <i>Examples:</i> paracentesis, stab wound, Pleurx catheter draining an abdominal cavity</li> </ul>	<ul style="list-style-type: none"> <li>- Needle puncture sites without a drain</li> <li>- Needle aspiration of fluid without drain placement</li> <li>- Ostomies with a drain</li> <li>- I&amp;D with bone biopsy within a diabetic foot ulcer</li> </ul>
<b>Pressure ulcer treated with any kind of graft or flap even if it fails</b> <ul style="list-style-type: none"> <li>- Muscle <b>flap</b>, skin advancement <b>flap</b>, or rotational <b>flap</b> to surgically replace a pressure ulcer</li> <li>- <b>Total surgical excision</b> of pressure ulcer damage</li> <li>- <b>Skin graft</b> applied to a pressure ulcer (including skin substitutes)</li> </ul>	<ul style="list-style-type: none"> <li>- <b>Debridement</b> of a pressure ulcer</li> <li>- Closure of a pressure ulcer with sutures</li> </ul>
<ul style="list-style-type: none"> <li>- Skin graft <b>donor</b> sites</li> <li>- Skin graft applied to a burn</li> </ul>	

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OAI Surgical Wound Quick Reference Source: OASIS Guidance Manual, OASIS Q&A*	
M1340 Surgical Wounds	
Includes	Excludes
<ul style="list-style-type: none"> <li>- Incision site until healed to:               <ul style="list-style-type: none"> <li>- Implant a VP shunt, pacemaker, internal defibrillator</li> <li>- Insert a balloon catheter, MammoSite® device</li> <li>- Perform a procedure per femoral sheath via "cut down"</li> </ul> </li> <li>- Exit site for Left Ventricular Assist Device (LVAD)/HeartMate</li> <li>- Burr holes</li> <li>- Site resulting from:               <ul style="list-style-type: none"> <li>- Surgical procedure performed via arthroscopy, laparoscopy</li> <li>- Kyphoplasty procedure with open approach and surgical incision</li> </ul> </li> </ul>	<p><b>Needle puncture sites</b> resulting from:</p> <ul style="list-style-type: none"> <li>- Kyphoplasty</li> <li>- Arthrocentesis</li> <li>- Thoracentesis</li> <li>- Paracentesis</li> <li>- Cardiac catheterization</li> </ul>
<p><b>Central lines, implanted infusion devices, implanted venous access devices</b> while devices are in place and regardless of functionality or frequency of access</p> <ul style="list-style-type: none"> <li>- Examples: Mediports and portacath sites</li> <li>- On-Q pump/Q ball</li> <li>- AV shunt, AV graft, AV fistula</li> <li>- Peritoneal dialysis exit site</li> <li>- Vantas® device</li> </ul>	<ul style="list-style-type: none"> <li>- Peripheral IV sites</li> <li>- Peripherally inserted lines (PICC)</li> <li>- External device infusing medications SQ</li> <li>- Implanted pacemaker after the incision heals</li> <li>- Implanted internal defibrillator after the incision heals</li> </ul>
<p>Site of a centrally inserted <b>catheter type</b> typically intended for peripheral use</p> <ul style="list-style-type: none"> <li>- Example: a PICC catheter inserted into the central venous system</li> </ul>	<p>PICC catheter (tunneled and non-tunneled) inserted peripherally even if insertion required fluoroscopy or sutured in place</p>
Orthopedic pin sites	
<ul style="list-style-type: none"> <li>- Shave, punch or excisional biopsy to remove or diagnose skin lesions</li> <li>- Electrodesiccation and curettage site</li> </ul>	<p>Lesion resulting from cryosurgery</p>
Procedure beyond simple excision of a toenail	<ul style="list-style-type: none"> <li>- Removal/simple excision of a toenail</li> <li>- Callus removal sites</li> </ul>

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