



OASIS Process Flow

It's important to note that the following processes are to be used as a guideline only and should be updated accordingly by each agency in order to comply with agency processes. Please visit the CMS website for information on rules and regulations around Home Health documentation.

Start of Care (SOC)

1. Intake enters the patient's chart (see handout in Database Readiness > Patient Management)
2. Clinician reviews and updates Tabs: Patient Chart (1st tab with patients name), Relationships, and Care Profile.
3. Clinician Starts and Completes the SN Start of Care/Resumption of Care C-2.00 Document. For the P page and orders process please see handout in Process Improvement > Scheduling Options. The Clinician will want to update one of the scheduled visits on week 9 as the recert visit.
4. On the Plan of Care Teaching page of the OASIS, click Create Order, this will create an initial order on the Orders Tab. Once the OASIS is completed, go to the orders tab and fill in the frequency and generate to the schedule.
 - a. If the patient has wounds, please click the create wound order on the wound page
 - b. If you do not want your frequency and narrative to be on 1 order (in case you need to d/c the order due to frequency change), you can create a separate order for the frequencies.
5. Clinician marks the OASIS as completed and clicks save on the Documents Tab in Document Status.
 - a. You can also have the Clinician lock the OASIS but if QA determines changes are needed the OASIS will need to be revised.
 - b. Until the OASIS is locked you cannot create the 485 and document flow will not occur (if the OASIS is created and the Clinician goes back out prior to locking the OASIS the T, CPS, and wound page will not fill in form the OASIS)
6. QA logs into Episode Master (agency needs to determine how many times a week) and reviews any OASIS in the report date from the last time QA was completed.
7. QA goes to the patient chart and sends an email from the patient's chart to the Clinician with corrections that need to be made (if you want a case communication to be created, open the OASIS and send the email).
8. Clinician unchecks complete (and lock, if the document is locked) and clicks save, then opens the document and makes corrections. Then she will go to the documents tab and in the document status check complete and save.
9. QA will review the OASIS and send an email to the Clinician with additional changes or lets the Clinician know it is ok to lock the OASIS.

10. Once the OASIS is locked, the QA staff will go to the chart and in the documents tab, update the document status that the OASIS has been certified.
11. Create the Homecare Certification (485), this step can be done once the Clinician locks the OASIS. The 485 should be reviewed and then saved. Once it is completed and locked, it can be sent to the physician for signature.
12. Create the OASIS Extract file under Tools > OASIS Extract (agency needs to determine how many times a week/month this task occurs). If there are any OASIS that are locked but not certified, whoever is pulling the OASIS Extract will contact QA to ensure it is ready to go to the state.

Recertification

1. The Clinician performing the Recert reviews and updates Tabs: Patient Chart (1st tab with patients name), Relationships, and Care Profile.
2. Clinician performing the Recert Starts and Completes the SN Follow-up/Recertification C-2.00 Document. The Recert has to be completed in the 5 day window or the system will not generate the new PPS episode.
3. On the Plan of Care Teaching page of the OASIS, click Create Order, this will create an initial order on the Orders Tab. Once the OASIS is completed, go to the orders tab and fill in the frequency and generate to the schedule. If the recert begins towards the end of the week and no visits the first week please see handout in Process Improvement > Scheduling Options.
 - a. If the patient has wounds, please click the create wound order on the wound page
 - b. If you do not want your frequency and narrative to be on 1 order (in case you need to d/c the order due to frequency change), you can create a separate order for the frequencies.
4. While in the Orders Tab, the Clinician will see the orders from the past cert period. If your agency is not using the projected end date (this will auto pull when using the initial or recert orders) when creating the order the Clinician must enter a Discontinue Date on all orders that shouldn't pull to the Recert 485. The system will automatically pull all orders with a start date on or before the PPS start date unless the order type is Assess/Eval or Discontinue. If the order is discontinued or a projected end date is entered the order will not pull.
5. Clinician marks the OASIS as completed and clicks save on the Documents Tab in Document Status.
 - a. You can also have the Clinician lock the OASIS but if QA determines changes are needed the OASIS will need to be revised.
 - b. Until the OASIS is locked you cannot create the 485 and document flow will not occur (if the OASIS is created and the Clinician goes back out prior to locking the OASIS the T, CPS, and wound page will not fill in form the OASIS)
6. QA logs into Episode Master (agency needs to determine how many times a week) and reviews any OASIS in the report date from the last time QA was completed.

7. QA goes to the patient chart and sends an email from the patient's chart to the Clinician with corrections that need to be made (if you want a case communication to be created, open the OASIS and send the email).
8. Clinician unchecks complete (and lock, if the document is locked) and clicks save, then opens the document and makes corrections. Then she will go to the documents tab and in the document status check complete and save.
9. QA will review the OASIS and send an email to the Clinician with additional changes or lets the Clinician know it is ok to lock the OASIS.
10. Once the OASIS is locked, the QA staff will go to the chart and in the documents tab, update the document status that the OASIS has been certified.
11. Create the Homecare Recertification (485), this step can be done once the Clinician locks the OASIS. The 485 should be reviewed and then saved. Once it is completed and locked, it can be sent to the physician for signature.
12. Create the OASIS Extract file under Tools > OASIS Extract (agency needs to determine how many times a week/month this task occurs). If there are any OASIS that are locked but not certified, whoever is pulling the OASIS Extract will contact QA to ensure it is ready to go to the state.

Transfers

1. Clinician performing the Transfer Starts and Completes the OASIS SN Transfer C-2.00 Document (located in the Documents with OASIS Questions Only folder in the document pick list).
 - a. If the transfer is tied to a visit in a patient's home, the clinician will use the SN Transfer C-2.00
2. Clinician marks the OASIS as completed, locked, and clicks save on the Documents Tab in Document Status.
3. Clinician goes to the Orders Tab and marks all active orders as discontinued by entering in a Discontinue Date and clicking save. This will turn all visits after the discontinue pink and remove them off of the Home Screen for Clinicians assigned to the visits.
4. (optional) Clinician or office staff will add Event Log under Menu > Patients > Admission/Discharge > Event Log. This allows office staff to pull a report under Reports > Admission > Event Log.
5. (optional): Clinician or office staff will send a system email that the patient has transferred.
6. QA logs into Episode Master (agency needs to determine how many times a week) and reviews any OASIS in the report date from the last time QA was completed.
7. QA goes to the patient chart and sends an email from the patient's chart to the Clinician with corrections that need to be made (if you want a case communication to be created, open the OASIS and send the email).
8. Clinician clicks revise and then opens the document and makes corrections. Then she will go to the documents tab and in the document status check complete and save.
9. QA will review the OASIS and send an email to the Clinician with additional changes.

10. Once the OASIS is locked, the QA staff will go to the chart and in the documents tab, update the document status that the OASIS has been certified.
11. Create the OASIS Extract file under Tools > OASIS Extract (agency needs to determine how many times a week/month this task occurs). If there are any OASIS that are locked but not certified, whoever is pulling the OASIS Extract will contact QA to ensure it is ready to go to the state.
12. If the patient comes back on service fill out the appropriate OASIS, entered an end date in the Event Log, and enter in orders for scheduling.
13. If the patient doesn't come back on service, fill out an OASIS SN Discharge C-2.00 and entered an end date in the Event Log.

Resumption of Care (ROC)

1. The Clinician performing the ROC reviews and updates Tabs: Patient Chart (1st tab with patients name), Relationships, and Care Profile.
2. Clinician Starts and Completes the SN Start of Care/Resumption of Care C-2.00 Document. For the P page and orders process please see handout in Process Improvement > Scheduling Options. The Clinician will want to update one of the scheduled visits on week 9 as the recert visit.
3. On the Plan of Care Teaching page of the OASIS, click Create Order, this will create an initial order on the Orders Tab. Once the OASIS is completed, go to the orders tab and fill in the frequency and generate to the schedule.
 - a. If the patient has wounds, please click the create wound order on the wound page
 - b. If you do not want your frequency and narrative to be on 1 order (in case you need to d/c the order due to frequency change), you can create a separate order for the frequencies.
4. Clinician marks the OASIS as completed and clicks save on the Documents Tab in Document Status.
 - a. You can also have the Clinician lock the OASIS but if QA determines changes are needed the OASIS will need to be revised.
5. (optional) Clinician or office staff will update the Event Log with an end date under Menu > Patients > Admission/Discharge > Event Log.
6. QA logs into Episode Master (agency needs to determine how many times a week) and reviews any OASIS in the report date from the last time QA was completed.
7. QA goes to the patient chart and sends an email from the patient's chart to the Clinician with corrections that need to be made (if you want a case communication to be created, open the OASIS and send the email).
8. Clinician unchecks complete (and lock, if the document is locked) and clicks save, then opens the document and makes corrections. Then she will go to the documents tab and in the document status check complete and save.
9. QA will review the OASIS and send an email to the Clinician with additional changes or lets the Clinician know it is ok to lock the OASIS.

10. Once the OASIS is locked, the QA staff will go to the chart and in the documents tab, update the document status that the OASIS has been certified.
11. Create Verbal Orders to resume the schedules on the calendar. Once the order(s) are completed and locked, it can be sent to the physician for signature.
12. Create the OASIS Extract file under Tools > OASIS Extract (agency needs to determine how many times a week/month this task occurs). If there are any OASIS that are locked but not certified, whoever is pulling the OASIS Extract will contact QA to ensure it is ready to go to the state.

Discharge

1. Clinician performing the Discharge Starts and Completes the SN Discharge – Death at Home C-2.00 or SN Discharge C-2.00.
 - a. If not tied to a visit use the Documents with OASIS Questions Only folder OASIS SN Discharge document.
2. Clinician marks the OASIS as completed, locked, and clicks save on the Documents Tab in Document Status.
3. QA logs into Episode Master (agency needs to determine how many times a week) and reviews any OASIS in the report date from the last time QA was completed.
4. QA goes to the patient chart and sends an email from the patient's chart to the Clinician with corrections that need to be made (if you want a case communication to be created, open the OASIS and send the email).
5. Clinician clicks revise and then opens the document and makes corrections. Then she will go to the documents tab and in the document status check complete and save.
6. QA will review the OASIS and send an email to the Clinician with additional changes or lets the Clinician know it is ok to lock the OASIS.
7. Once the OASIS is locked, the QA staff will go to the chart and in the documents tab, update the document status that the OASIS has been certified.
8. Create the OASIS Extract file under Tools > OASIS Extract (agency needs to determine how many times a week/month this task occurs). If there are any OASIS that are locked but not certified, whoever is pulling the OASIS Extract will contact QA to ensure it is ready to go to the state.
9. Clinician performing the Discharge Starts, Completes, and Locks the Discharge Summary Homecare
10. (optional): Clinician or office staff will send a system email that the patient has discharged.
11. Clinician or office staff will go to the 1st tab on the patient chart and click on Discharge, fill out the screen and click discharge. If your agency is using orders and scheduling, click on Discontinue & Cancel. If your agency is not using orders and scheduling, click on Discharge Only.
12. If the patient comes back on service, search for the discharged patient, click on Admission, click the readmit button, if you want the information to copy forward from the previous admission click Yes, if you do not want it to copy forward click No, and then following the readmission steps.

Daily Notes for Nurses

Enterprise Edition has several notes Nurses can use for daily visit notes. Please see view the following link > Blank HCF Forms > click on the documents and folders you wish to view:

<http://support.healthcarefirst.com/impdocs/>

Note	T	CPS	Sup Visit	Copy Forward	Summary of Sections	# of Pages
SN Routine Visit Note (found under disease specific routine notes)	Yes	Yes	Yes	No	Vital Signs, Pain, Goals Assessment, Process Measures, Wound Page, Assessment Summary, Update CPS Page	6
SN Clinical Progress Note (B) – has to be turn on in System Control by HEALTHCAREfirst	Yes	Yes	Yes	Yes	Vital Signs, Genitourinary/Reproductive, Mental Status, Respiratory, Cardiac, Gastrointestinal, Homebound Status, Infusion Therapy, Wound Page, Assessment Summary, Update CPS Page	4
Skilled Nursing Visit Note	Yes	Yes	Yes	No	Homebound Status, Cardiac, Pulmonary, Skin, Head, Vision, Hearing, Nose, Oral, Neurological, GI, GU, Emotional Status, Procedures during the visit, Instructions, Teaching	5
SN Clinical Evaluation C-2.00	Yes	Yes	Yes	Yes	Vitals, Body Systems, Wound Page, Fall Risk, Medications, Mental Status, Plan of Care, Assessment Summary, Update CPS Page	11
SN Daily Progress Note	No	No	No	Yes	Vitals, Pain, Large Comment Box	1

Disease Specific Routine Notes – used for specific diagnosis

Aides

Aide’s documentation should be done on the HHA Care Plan B and HHA Visit Note B

Therapy

Therapy also has several notes that can be used; each agency needs to determine which notes the therapy staff will use. Please see view the following link > Blank HCF Forms > click on the documents and folders you wish to view: <http://support.healthcarefirst.com/impdocs/>

Other Notes

The system has several other notes for patients, your agency will want to review the notes and determine your policy/procedures around the options. Please see view the following link > Blank HCF Forms > click on the documents and folders you wish to view:

<http://support.healthcarefirst.com/impdocs/>