OASIS Alert

Assessment: 2 Step Process Can Cut Down Chronic Transfers

Decrease OASIS paperwork and hospitalizations with this advice.

Your chronically ill patients may zip in and out of the hospital more quickly than you can keep track of but you can't skip the transfer of care OASIS.

"Home health agencies must complete a transfer OASIS each time patients are admitted to an inpatient facility for 24 hours or more for anything other than diagnostic tests," says **Pat Jump,** with Rice Lake Wis-based **Acorn's End Training & Consulting**.

Challenge: When the patient returns home, agencies have another 48 hours to complete a Resumption of Care (ROC) OASIS, Jump says. However, many patients don't alert their home health providers when they are admitted to the hospital. This makes it difficult for agencies to stay on top of transfer and ROC paperwork.

Whether or not a client is discharged from the agency at the time of transfer to an inpatient facility depends primarily on the agency policy related to discharges, Jump says. Many providers have a policy stating that the client is not discharged from the agency upon admission to an inpatient facility unless the client remains in the facility beyond the end of the certification period. Other providers may have a policy stating that all clients are discharged from the agency upon an admission to an inpatient facility, she says. **The Centers for Medicare & Medicaid Services** does not dictate this discharge policy but rather leaves it as an agency decision.

Important: Whatever your agency policy, when completing the transfer OASIS, you should indicate whether you will discharge the patient with the transfer.

The OASIS Considerations for Medicare PPS Patients offers the following instructions for completing a transfer OASIS. If you expect the patient to return to home health services, mark "transfer, not discharged from the agency." If you believe the patient will be permanently placed in another level of care and not return to home health, indicate "transfer to an inpatient facility, patient discharged from agency."

Follow these Transfer Tips

If you complete a transfer OASIS when the patient has not been discharged from your agency, and the patient does not return to your care, there is no requirement to do any further OASIS assessment. You would simply complete a discharge summary.

If the agency marks the transfer OASIS with the patient being discharged but then the patient returns to home care within the 60-day episode, you can correct the previous OASIS to a transfer without discharge and then complete a resumption of care assessment.

If the patient returns to your agency after the 60-day episode, complete a new start of care OASIS and begin a whole new episode.

2 Steps To Troubleshoot Common Transfer Problems

Step #1: Ask patients to call you first. You can reduce the number of times a client fails to notify you about a hospitalization by discussing this scenario at the time of admission, Jump says. "Clinicians should routinely instruct patients and family members to notify the provider when a client is admitted to the hospital or has a clinic appointment for medical reasons," she says.

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A client is more likely to notify your agency if you provide him with a specific contact name and phone number, Jump says. For example, instruct the client to call "[phone number with area code] and ask for [staff first name] during business hours." Also list the correct phone number and contact person for after-hours calls.

Make sure this information is written in large font and posted in a place readily seen by the client such as on the refrigerator or near the phone, Jump suggests. Also, make sure the client knows why such notification is important.

Hint: State the importance in terms of why it is critical for the client to notify your agency, not in terms of why it is important to you, Jump suggests. Don't say, "We need to know so that we don't send an aide out when you are not home." Instead, say something like, "Notification makes it easier for you when you come back out of the hospital."

Step #2: Empower your patients. Hospitalizations are often reduced when clients and families receive information about the client's disease process, Jump says. Especially important is recognition of early symptoms of exacerbation and specific instructions regarding what to do when symptoms become apparent.

Some providers have specific instructions for each major disease process including a decision tree that explains what to do about various common symptoms of exacerbation, Jump says. Certain symptoms may require self-medication or self treatment while others may require notification of the provider and still others may require emergent treatment. It's important to go over the instructions periodically with the client and family, she says.

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