OASIS Alert

Assessment: Use Community Care To Cut Down On Chronic Transfers

Decrease OASIS paperwork and hospitalizations with this advice.

Just because your chronically ill patients are in and out of the hospital more quickly than you can keep track of doesn't mean you can 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 **Judy Adams, RN, BSN, HCS-D, COS-C,** a clinical consultant with **LarsonAllen** in Chapel Hill.

Challenge: When the patient returns home, agencies have another 48 hours to complete a Resumption of Care (ROC) OASIS, Adams clarifies. However, most 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.

Important: When completing the transfer OASIS, agencies should indicate whether they will discharge the patient with the transfer, Adams reminds providers. "If the HHA expects the patient to return to home health services, they should mark 'transfer, not discharged from the agency,'" she explains. "If they believe the patient will be permanently placed in another level of care and not return to home health, they should indicate 'transfer to an inpatient facility, patient discharged from agency.'"

Adams offers the following answers to other common "what if" scenarios agencies might encounter:

If the agency completes a transfer OASIS when the patient has not been discharged from the agency, and the patient does not return to the HHA, there is no requirement to do any further OASIS assessment. The agency simply would complete its own 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, the HHA can correct the previous OASIS and then complete a resumption of care assessment.

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

3 Tips To Troubleshoot Common Transfer Problems

Tip #1: Ask patients to call your first. Your agency should educate patients to call you before they are admitted to the hospital so that you can better track their care. And, if you teach patients to call you before they enter the acute setting, you may help them avoid hospitalization and address the issue within the community setting -- a cost benefit to everyone, Adams says.

Tip #2: Pay attention to the upcoming SOW. Unfortunately, rather than treat problems within the home, many physicians, local hospitals, patients and families are more comfortable turning to the emergency room for help. While your agency can't change this pattern, "the upcoming QIO 10th scope of work is targeted at more cooperation between physicians, acute care hospitals, skilled nursing facilities and home health agencies as a strategy to reduce costly hospitalizations," Adams points out.

Tip #3: Partner with the medical community. Though you might encounter some roadblocks, you should begin reaching out to your medical community to decrease your patients' transfers. For instance, you might team up with a leading physician "to develop protocols to treat patients in their homes at the first sign of changes in their conditions rather than immediately turn to the hospital," Adams suggests. You can spot common reasons for hospitalization and focus on

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developing cooperative approaches to those issues.

Example: Many home health patients are re-hospitalized for respiratory problems such as pneumonia or exacerbation of chronic obstructive pulmonary disease. The **New York Heart Association** developed a community-based protocol for congestive heart failure involving increased doses of lasix and low weight gain to decrease hospitalizations related to the respiratory problems, Adams points out.

Bottom line: Home health agencies should try to develop these types of early intervention protocols. "Even starting with one physician that refers a number of patients to the agency can be a start to developing a proven protocol that could eliminate or at least reduce hospitalization for even on condition," Adams stresses.

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