OASIS Alert

Outcomes: Reframe The Episode For Better Outcomes

Remember: Your language sets expectations for patients and clinicians.

If you're focusing mainly on what happens during home visits, you're wasting two-thirds of the episode.

The major difference in home care, now that the prospective payment system controls reimbursement, is the switch in focus from visits to outcomes, occupational therapist and consultant **Karen Vance** told attendees at an educational session of the October annual meeting of the **National Association for Homecare & Hospice** in Phoenix.

As agencies shift their focus from providing and documenting a skilled service to setting and meeting goals for patient outcomes, they need to change where most of their efforts go, says Vance, with **BKD** in Springfield, MO.

Old way: Many agencies are still living in the past, Vance contends. Management often focuses on how many visits clinicians make, despite the fact that agencies are no longer paid by the visit. Clinicians consider an assessment something done only at the beginning of care. Visit frequency often remains unchanged throughout the episode. Team members care for the patient on parallel pathways with very little communication.

New way: Successful agencies focus on outcomes, Vance maintains. Team members are encouraged to communicate and contribute their expertise. Patients are involved in developing the plan of care. Patient independence is encouraged. And fewer visits can still lead to improved outcomes.

Reframe the way you think about home care to make the most of the 60-day episode, says occupational therapist **Carol Siebert** with the **University of North Carolina** in Chapel Hill, speaking in the session with Vance. And make every one of those days count.

A typical visit pattern may be twice a week for nine weeks, she suggests. So if you visit on 18 days of a 60-day episode, you are not visiting on two-thirds of the available days. Your challenge is to move the patient forward toward the outcomes you've chosen on those days as well as on visit days.

Examples: Making a phone call to the patient or caregiver after a visit helps ensure that the patient remembers to complete exercises or activities you asked them to do between visits. This call also allows you to clarify or reinforce something you taught the patient during the visit. This simple action improves your chances of reaching the goals you're working toward, Siebert explains.

Or a phone call may help you discover a problem that will interfere with a planned visit. Rearranging the visit lets you get the most out of this intensive use of resources, she notes.

To focus efforts on providing excellent care, while enhancing the agency's financial performance, Siebert and Vance suggest you:

Start your assessment in the right place. OASIS answers are an important part of the comprehensive assessment, but the most important piece of information is the patient's goal, Vance says. You need to know what is important to the patient and what he thinks you will be doing. Then your initial assessment helps you decide what is realistic.

If the family is involved, they can make or break the results, so their perspective is important as well, Siebert says. Set expectations at the beginning about what they can expect from your agency and what you expect from the patient and family.

Keep the big picture in mind. You are just a small part of the timeline of your patient's life, Vance points out. Each patient bringssomething different to the episode and these difference present opportunities for the clinician. When you answer M0 items, keep asking yourself where the patient is in relation to where he wants to go, Vance suggests.

Language matters. Use language that conveys shared responsibility both with the patient and among the team members. Describe how things you do with or for the patient at the beginning of an episode will later be done with the caregiver - and perhaps eventually by the patient alone. Include an expectation of increasing independence.

Involve the team. Assessment is an ongoing process. Continue to check progress against expectations. All staff can contribute information that will give you the big picture for the patient. Then draw on each team member's expertise. Don't forget how important the home health aide is in understanding the patient, Siebert says.

Develop one plan of care. You need a single "roadmap" for the journey, Siebert advises, and then you can allocate resources based on the plan. You may find you don't need all the people the referral requested at the beginning of the episode, she suggests. Or you may find you need to bring in another discipline. Having a single plan also helps patients understand the transitional nature of home care, and helps them plan ahead, she adds.

Care paths are only part of the picture. Care paths alone are not enough, Seibert says. Personalize the care path or canned guidelines to reflect the individual patient. To decide what outcomes are realistic for the patient, you also need to consider the expertise and resources of your agency and what the patient and her caregivers bring to the journey.

Optimize the value of every visit. The visit is just a "pit stop" that allows you to pause, reassess the situation, make sure you're still on course and examine the progress you (and/or the patient and caregiver) are making. During the visit, help the patient develop a shared plan about what comes next. Ask yourself what difference you made today with the patient, Vance suggests.

Editor's Note: For more ways to develop "Full Episode Thinking," you can order a tape of the presentation at www.nahc.org - click on "conference."