OASIS Alert

Transfers: 2 Tips Keep Unexpected Transfers in Check

Education can prevent hospitalization.

Unplanned hospitalizations can really trip you up. But there are some things you can do to prevent them from breaking your stride. A little pre-planning can help smooth the way.

Rehospitalizations have a negative impact on your outcomes. And when patients are discharged from the hospital you risk losing them to other agencies. Take a pro-active approach to prevent these problems.

Transfer or Discharge?

The first step in handling your patient's hospitalization is completing a transfer OASIS.

Each time your patient is admitted to an inpatient facility for 24 hours or more for anything other than diagnostic tests, you must complete a transfer OASIS, says **Judy Adams, RN, BSN, HCS-D, HCS-O,** with **Adams Home Care Consulting** in Asheville, N.C.

Here's where things get tricky: When the patient returns home, you must complete a Resumption of Care (ROC) OASIS within 48 hours. Unfortunately, notifying the home health agency isn't a top priority for most patients when they are admitted to the hospital. This can make it tough to know when you need to complete transfer and ROC paperwork.

Follow Agency Discharge Policy

When completing a transfer OASIS, you should indicate whether you are discharging the patient with the transfer, Adams says. As a general rule, if you expect the patient to return to home health services, you should mark M0100 □ Reason for assessment "6 □ Transfer to inpatient facility, not discharged."

Remember that the **Centers for Medicare & Medicaid Services** treats the patient as a continuation within the same episode unless the patient was discharged with goals met or transferred to another home health agency, Adams says. So if the patient returns to your agency within the same 60 day period, the patient would not qualify for a Partial Episodic Payment Adjustment with a new SOC date and payment calculation, but continue under the current HHRG/HIPPS.

But if you expect the patient to move to another level of care permanently and not return to home health, you should choose M0100 response "7 □ Transfer to an inpatient facility □ discharged."

Before you rely on these general guidelines, be sure to review your agency's discharge policy to make certain you're in compliance. Many home health agencies have established policies that govern whether patients should be discharged at the time of transfer to an inpatient facility, says **Pat Jump,** with Rice Lake, Wis.-based **Acorn's End Training & Consulting**.

For example: Some discharge policies state that a patient is not automatically discharged from the agency upon admission to an inpatient facility unless the client remains in the facility beyond the end of the certification period, Jump says. Other agencies may have a policy requiring discharge of patients from the agency upon an admission to an inpatient facility. The **Centers for Medicare & Medicaid** does not dictate any one particular discharge policy □ it is an agency decision.

Whatever your agency policy, when completing the transfer OASIS, you will need to indicate whether you are discharging

the patient with the transfer.

Try these Transfer Tips

Not all transfers are the same, so you'll need to consider each unique situation when determining whether you need to complete a new OASIS after your patient has spent time as an inpatient. Here are some pointers for common transfer scenarios:

Situation: You completed a transfer OASIS for a patient who was admitted to the hospital, meeting Medicare's definition of an inpatient stay. The patient wasn't discharged from your agency, but he doesn't wish to return to your care.

Action: Complete a discharge summary. You don't need to complete an OASIS assessment for this patient.

Situation: You completed a transfer OASIS and discharged the patient. After returning home from the hospital, the patient returns to home care during the last five days of the 60-day episode after all.

Action: You could complete a new Start of Care OASIS to start a new episode of care for this patient. However, due to billing regulations requiring you to include services provided during a 60-day payment episode on one claim, CMS' preferred option would be for you to change the transfer with discharge to a transfer without discharge, and complete a Resumption of Care upon the patient's return to home care during the current payment episode.

Situation: You completed a transfer OASIS and discharged the patient. The patient returns home from the hospital and resumes home care after the 60-day episode.

Action: Complete a new start of care OASIS and begin a whole new episode.

Prevent Transfer Problems before they Start

Rushing around to complete transfer paperwork after the fact can be a hassle. Try these techniques to help streamline your processes.

Tip #1: Give patients your number. When patients call you before they are admitted to the hospital, you can do a better job of tracking their care.

You can begin educating patients at the time of admission about the importance of keeping you in the loop if they head to the hospital. And continue to give reminders throughout the episode. Routinely instruct the patient and his family members to notify you when he's admitted to the hospital or has a clinic appointment for medical reasons, Jump says.

Approach: Rather than telling the patient how inconvenient an unexpected hospitalization is for your agency, try explaining how it will benefit him, Jump suggests. Try saying something like "Letting us know what's going on can make it easier for you when you come home from the hospital."

Bonus: When patients call you before they visit the emergency department, you may be able to help them avoid hospitalization and address the issue within the community setting, Adams says. This is a cost benefit to everyone.

Giving your patient a card or refrigerator magnet that includes a specific contact name and phone number will help make it easy for him to contact you, Jump says. Make sure to include after-hours contact information as well. Write this information in a large font and post it in a convenient place such as on the refrigerator or near the phone.

Tip #2: Establish an Intervention Plan. For patients with chronic conditions, understanding disease processes and establishing protocols for dealing with the signs of exacerbation can help prevent unplanned hospitalizations.

Consider working with a physician who refers patients to your agency to develop protocols to treat patients in their homes at the first sign of changes in their conditions. This can help prevent them from immediately turning to the hospital, Adams suggests. Research your patients' common reasons for hospitalization and focus on developing preventative approaches to those issues.

Educating your patients and their families about the disease process will help reduce hospitalizations, Jump says. Knowing how to recognize early symptoms of exacerbation and what to do about them is especially helpful.

Try this: Create a decision tree with specific instructions for what to do about various common symptoms of exacerbation in major disease processes, Jump suggests. Knowing which symptoms can be addressed with self-medication or self treatment, which should be addressed with the home health agency or physician, and which warrant a trip to the hospital can help patients make a more informed choice about their care.

Repeat as needed: Remember to go over disease process instructions periodically with the patient and family.