Ensuring Clinical Documentation Reflects Care and Meets Requirements

Presenters

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Goals for Today’s Program

• Discuss documentation to meet the Medicare CoPs for comprehensive assessment and care planning
• Describe tips to enhance documentation to meet the Local Coverage Determinations (LCDs) and illustrate eligibility
• Explain eligibility and documentation requirements for the different levels of care under the Medicare Hospice Benefit

Assessment & Care Planning: Compliance with CoPs
Admission, Assessments, and Care Planning

- Election & consent
- Conduct & document initial assessment
- Conduct & document first comprehensive assessment
- Establish plan of care
- Update comprehensive assessment
- Update care plan
- Conduct IDG meetings & coordinate care

Initial Assessment

§ 418.54 Condition of participation: Initial and comprehensive assessment of the patient.
- IA must address immediate needs of the patient and family
- IA forms the foundation of documentation to guide care
- Determines involvement of other disciplines in completing the Comprehensive Assessment
Comprehensive Assessment

• Must assess the following:
  – Physical, psychosocial, emotional & spiritual needs
  – Nature & condition causing admission
  – Functional status
  – Imminence of death
  – Medications
  – Bereavement needs

• Assessment is a continuous process that drives updates to the plan of care

Updates to the Comprehensive Assessment

• Update CA every 15 days and as needed with significant changes in condition or level of care
• Address interventions in plan of care
• Disciplines must visit during the 15-day timeframe based on need
• Policies must describe what form(s) make up the CA and how updates are completed and documented
From Comprehensive Assessment to Plan of Care

§ 418.56 Condition of Participation:
Interdisciplinary group, care planning, coordination of services.

- CMS considers the plan of care the most important document in hospice care
- Using data from assessments, develop & update the plan of care.
- Must be interdisciplinary

Plan of Care

- Plan of care must address:
  - Interventions to address symptoms
  - Scope and frequency of services
  - Measurable outcomes
  - Drugs, treatments, supplies and DME
  - Patient or representative’s level of understanding, involvement, and agreement with the plan of care
Plan of Care

• IDG should use the plan of care as a tool
  – RN begins documentation of plan of care based on findings from the Initial Assessment & consults with others
  – IDG members add to and update as the Comprehensive Assessment is completed
  – Base plan of care on patient-specific needs
    • No “cookie cutter” documentation.
    • If using electronic records, free text on each note to individualize documentation

Updates to the Plan of Care

• IDG must review and revise the plan of care at least every 15 days
• Updates are necessary as conditions and needs change
• Must address progress toward goals
• Should guide interventions at each visit
Documentation:
Important Points

Documentation should be:
• Authentic
• Concise (more is not always better)
• Objective
• Comprehensive, but pertinent
• Consistent
• Timely

Strategies for Success

• Ensure that there are no blanks in pertinent areas of forms
• Ensure problems are addressed timely
• Document communication among IDG and with attending physician
• Show ongoing coordination of care with outside agencies
Strategies for Success

• Using goals from plan of care, document outcomes in assessments
• Ensure physician orders are updated timely
• Consistently update medication profile
• Show patient and family involvement in planning care
• Ensure that adequate discharge planning has occurred and is documented
  – Referrals, communication, transfer of information

Documentation of Prognosis
Admitted for end stage cardiac disease.

Poor response to standard treatment.
Desires palliative care.
Admitted for end stage cardiac disease. Poor response to standard treatment. Desires palliative care. Is NYHA Class IV with significant symptoms of angina at rest & inability to carry on any physical activity w/o discomfort. Ejection fraction of \( \leq 20\% \), significant ventricular arrhythmias, & unexplained syncope episodes.

Documentation Using LCDs

- **Documentation needs to address:**
  - Impairments in function & structure
  - Activity limitations
  - Participation restrictions
  - Secondary diagnoses
  - Co morbid conditions
Documentation Using LCDs

- Address the patient’s activity level, self care, communication, and mobility.
- Give a historical perspective of what the patient’s ability was in the previous time period and then document current status.
- BUT REMEMBER…
  - Decline ≠ eligibility.
  - Decline ≠ necessary or sufficient.

Documentation Using LCDs

- Use specifics to show the extent of the symptoms and limitations.
- Use the term “as evidenced by” to link prognosis to specific findings.
- Include symptoms such as wt loss, decubitus ulcers, and edema.
- Explain unusual or potentially misleading findings.
- Co morbid conditions such as CHF, COPD and diabetes affect prognosis.
Functional Assessment Tools

• **PPS**
  – Validated in palliative care
  – Be sure to use correctly

• **ECOG**
  – Cancer

• **Karnofsky**
  – Cancer

• **FAST**
  – Dementia

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Functional Assessment Tools

• **Mortality Risk Index Score and the Flacker-Kiely Mortality Assessment**
  – NH residents with advanced dementia
  – Retrospective cohort studies
  – Minimum Data Set (MDS) information

• **Critical: Must use tools correctly!**
  • [http://www.aacn.nche.edu/ELNEC/pdf/PalliativeCareAJN15.pdf](http://www.aacn.nche.edu/ELNEC/pdf/PalliativeCareAJN15.pdf)
Focused Quality Documentation

Examples of focused quality documentation:

• Documenting limits to daily activities of living for a patient with end-stage heart disease.
• Describing the extent of oxygen for a patient COPD and shortness of breath.
• Stating facts with objective information:
  – “Clothing no longer fits due to weight loss”
  – “Sleeping XX number of hours of day”
  – “Pain is severely limiting activities of daily living”

Comparative Documentation

• Comparative documentation:
  – Contrasts the patient’s present condition to his/her prior condition
  – Individualizes patients by focusing on their trajectory of decline
  – Presents specific information, not generalizations
    • One week ago, pt was eating ½ - ¾ of 2 meals per day. Now eating only ¼ of 1 meal each day.
Weak Documentation Syndrome

• Does not paint a picture of the patient.
• Weak documentation uses words/phrases like:
  – Stable
  – No change
  – Doing well
  – Slow, progressive decline
  – Appears to be losing weight
• It is all in the detail!

Documentation to Paint the Picture

Functional Decline
• “Inability to ambulate independently” could mean:
  – Needs help of one caregiver (supervision, guidance, support)
  – Needs assistance of two caregivers
  – Needs assistance of two caregivers and assistive devises
  – Ambulates 30 steps
  – Ambulates 2 steps to get over to the chair
Documentation to Paint the Picture

**Example - Functional Decline**

<table>
<thead>
<tr>
<th>Weak documentation example</th>
<th>“Impaired gait and mobility”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strong documentation example</td>
<td>“Requires a walker to ambulate due to leg weakness and unsteadiness. Maximum distance is 10-15 feet.”</td>
</tr>
</tbody>
</table>

Functional Status Changes

- “Inability to dress self” is vague and could mean:
  - Patient is physically unable to dress self
  - Patient may be able to assist dressing self
  - Patient is physically capable, but is behaviorally unable to comply with dressing activity
  - Patient is bedbound and cannot dress self
  - Patient refuses to dress self
**Example - Functional Status Changes**

<table>
<thead>
<tr>
<th>Weak documentation example</th>
<th>“Patient unable to dress self”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strong documentation example</td>
<td>“Patient agitated today and refused to assist with dressing self. Patient usually able to assist with shirt when provided verbal cues.”</td>
</tr>
</tbody>
</table>

**Weight Loss**

- “Patient losing weight” could mean:
  - Patient is eating less than before.
  - Patient is not eating at all.
  - Patient has lost two pounds.
  - Patient has lost twenty pounds.
  - Patient appears cachectic
Documentation to Paint the Picture

Example – Weight Loss

<table>
<thead>
<tr>
<th>Weak documentation example</th>
<th>“Patient is losing weight”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strong documentation example</td>
<td>“Patient’s clothes appear looser. Food intake decreased by 50% in the last week and he has lost interest in his favorite foods. MAC decreased by ¾ inches.”</td>
</tr>
</tbody>
</table>

Vague Statements
- “Continues slow decline”
- “Remains hospice appropriate”
- “Needs more care”

Inconsistent Documentation
- Nursing notes state: non-ambulatory  Chaplain notes state: walked around hall
- Admission for pain management without documentation of interventions
- “First-line” documentation (nurse, aide, SW, volunteer) does not match “second-line” documentation (IDG notes, summaries)
• Documentation must support level of care billed or payment can be reduced to Routine Home Care
• Reason for higher level of care must be noted – what prompted the change?
• All levels require ongoing documentation to show the patient is appropriate for hospice care.
Documentation: Routine Home Care

- Must document continued eligibility to support recertification
- Need to explain symptom management versus resolution of symptoms – give credit
- Document all interventions required to maintain comfort – medications, spiritual support, other non-pharmacologic measures

Levels of Care – Inpatient Respite

§ 418.204 Special coverage requirements.
- (b) Respite care.
  - (1) Respite care is short-term inpatient care provided to the individual only when necessary to relieve the family members or other persons caring for the individual.
  - (2) Respite care may be provided only on an occasional basis and may not be reimbursed for more than five consecutive days at a time.
Levels of Care – Inpatient Respite

- No regulation on frequency of use
- Be sure reason for respite care is noted
- Frequent use may send red flags to RHHI/MAC
- Scheduled (same time every month) can also raise concern

Levels of Care – Continuous Care

§ 418.204 Special coverage requirements.

- Nursing care may be covered on a continuous basis up to 24 hours a day during periods of crisis as necessary to maintain an individual at home.
- May use homemaker and/or hospice aide services to supplement, but nursing care must be provided for more than half of the period of care
- A period of crisis is a period in which the individual requires continuous care to achieve palliation or management of acute medical symptoms.
Levels of Care – Continuous Care

Documentation for Continuous Care:

- Describe the crisis in detail and the patient/family’s desire to remain at home
- All staff should document their time on a 24-hour log to show a minimum of 8 hours of care in a 24-hour period in order to bill for CHC.
- Hourly staff notes are preferred to best document crisis.
- Establish a new POC detailing the problems, interventions and expected outcomes. Staff visit notes should include the issues identified in the POC.

Provide details in documentation

- Document all previous attempts to relieve symptoms
  - Example: Pain unrelieved despite increase in scheduled dose and multiple breakthrough doses of pain medication
- Describe frequency, severity, intensity and associated symptoms
  - Example: Grimacing with frequent chest pain; shortness of breath more pronounced with coughing
- Document all interventions utilized to relieve patient’s discomfort
  - Example: Medications, oxygen, positioning, massage, bathing, music, lighting, verbal support, nebulizers, fans, suctioning, etc.
Levels of Care – Continuous Care

- Record all teaching to the patient, family or caregiver
- Document coordination with attending physician
- Physician order for CHC must be in place
- Show collaboration among team members

Levels of Care – General Inpatient

- General Inpatient (GIP) may be appropriate for pain control and symptom management
- Not to be used for caregiver breakdown
- Must require an intensity of care directed towards pain control and symptom management that cannot be managed in any other setting
- Imminent death does not require GIP if the patient is comfortable & needs are met
Levels of Care – General Inpatient

Documentation for GIP:

- Describe the patient's condition and the patient/family problems in detail.
- Explain clearly why the issues cannot be managed in the home setting, or at routine level of care if in a facility.
- Daily staff visits are appropriate in all settings so the hospice can maintain professional management of the patient.
- Document the coordination of care between the hospice and the facility providing GIP.

POC should be revised detailing the problems, interventions and expected outcomes.

The staff progress notes should include the issues identified in the POC.

A physician order for GIP must be in place.
Strategies for Success

Continuous home care and GIP

• Ensure that documentation addresses the symptoms that led to the crisis and the need for a higher level of care.
• Provide & document discharge planning from the beginning of the level of care change.
• When the patient stabilizes, move the patient to routine home care level.
• Conduct medical record review at specified times to ensure criteria are met.

➤ Remember: Caregiver breakdown is not a reason for GIP (Final Rule of the 2008 Hospice Wage Index)

CASE STUDIES
Case Study #1

- 84 year old male
- Diagnosis: Alzheimer’s Dementia
- Co morbidities: Renal insufficiency, Irritable bowel syndrome, Delirium
- Difficulty swallowing
- Wife reports 30 lb loss in the last 6 months
- Pant size changed from an XL to Medium
- Holds food and medications in his mouth
- 6/24/09 Wife reports change in diet to softer foods because of his dysphagia
- 7/2/09 MD note states Mr. Doe is high risk for aspiration

Case Study #1 (Cont.)

- Incontinent bowel and bladder
- Requires max assistance with dressing, bathing, toileting, and grooming
- Requires up to three showers/day to manage incontinence and diarrhea
- Having hallucinations and restlessness
- “Getting meaner” per wife
- Yelling out during the night
- Safety risk
- MD discontinued Coumadin because of “given life expectancy” and safety concerns with potential falls
- DNR, Does not want a feeding tube
Case Study #2

- 83 year old female
- Diagnosis: Cerebrovascular Accident (CVA)
- Co morbidities: COPD, Chronic bronchitis, Depression, Anemia
- Dependent on facility staff for all ADLs
- Increased agitation and pain – meds titrated
- Increased difficulty taking liquids and food
- Lethargic at times, refusing medications, and combative
- 6/6/09 Congested, aspiration suspected, more wheezing, mouth droop, right hand weakness

Case Study #2 (Cont.)

- 6/08/09 O2 Sat 82% on 2.5 lpm, rate increased
- 6/24/09 Hospice medical director consulted due to unmanaged pain
  - Roxanol increased to 15 mg q 2 hours prn
- 6/30/09 periods of apnea and gurgling
  - Lethargic, increased congestion, rales bilaterally
  - Fever of 101.4 degrees
  - Changed to GIP level of care
  - Ativan and Atropine drops ordered
  - Oxygen increased due to decreased sats
- Died 7/06/09
Documentation Examples

• **Summary Note in Medical Record**
  – Alert w/confusion. Fair appetite with recent wt loss. Recent falls. Dyspnea at rest. Changes in activities.

• **Stronger Note**
  – Alert. Confused, oriented to person only. Fair appetite. Recent wt. loss. Current wt. 104, previous wt. 107 one month ago. Recent falls due to unsteady gait and OOB w/o assist. Dyspnea at rest, 02 prn. Withdrawing from activities, refuses to go to dining room.

More Documentation Examples

• **Note on Physician’s Plan of Care:**

• **Important Data Omitted:**
  – PRN pain med increased recently. Had increased N/V necessitating change in diet and increased use of antiemetic. Decreased intake to less than 2 meals/day
Please, Sir, I want some more.

- More cases
- More examples
- More questions

Documentation Pearls

- Gather a comprehensive, useful history
- Assess the patient
  - Overall and based on the diagnoses
- Describe the patient
  - Overall and based on the diagnoses
- Use prognostic tools accurately
  - Population, diagnosis, within limitations
Documentation Pearls

- Ensure the Plan of Care is more than “report”
  - In IDT and in documentation
- Train SWs, chaplains, and aides to document pt appearance on every visit
  - Especially differences and changes
- Ensure that information in summaries and worksheets is supported by visit documentation.

Hospice Documentation Mantra

Documentation to support the terminal illness is an every day, every note practice.
NHPCO’s Regulatory Team

- **Judi Lund Person**
  - Vice President, Compliance and Regulatory Leadership
- **Jennifer Kennedy**
  - Regulatory & Compliance Director
- **NHPCO Regulatory Committee**
  - Members are from all over the country with a wide variety of experience

Regulatory Assistance

**Contact NHPCO’s Regulatory Department:**

- Regulatory Assistance Line: 703-647-8516
- Email: regulatory@nhpco.org
- Web: www.nhpco.org
  - Click on the NHPCO Regulatory & Compliance Center.
  - Click the BLUE BOX to send an email.
Resources


Bibliography

Bibliography