CLINICAL DOCUMENTATION: AUDIT READY AT ANY TIME

November 27, 2012

Objectives

- List 2 reasons why complying with regulations is so crucial to hospice providers.
- Articulate the difference between “technical” and “clinical” hospice eligibility.
- Cite the 5 elements that comprise technical eligibility.
- Provide 2 examples of documentation that supports clinical hospice eligibility (i.e., medical necessity).

Polling Question:

Do you have a written compliance plan?

Polling Question:

Has your hospice given active attention to the 60 day repayment rule?

CURRENT REGULATORY LANDSCAPE

WHY COMPLIANCE MATTERS
Current Regulatory Landscape: Why Compliance Matters
- Increased government scrutiny of health care providers
- Expanded audit activities
  - MACs
  - ZPICs
  - MICs
  - OIG
  - RACs

Why Compliance Matters (cont’d)
Examples of government scrutiny of hospice:
- Auditors sampling 30 hospice claims and extrapolating error rate to large universe resulting in multi-million dollar overpayment demands
- Government looking beyond hospice eligibility to levels of care billed and technical compliance
- State Medicaid agencies auditing hospices related to nursing home and board payments

Why Compliance Matters (cont’d)
Examples of recent allegations of whistleblowers:
- Billing for levels of care that are not medically necessary
- Pressure to admit ineligible patients
- Aggressive marketing to ineligible patients
- Backdating revocation forms to avoid payment for inpatient services
- Recertification of non-terminal patients

Why Compliance Matters (cont’d)
Legal obligations to identify and repay overpayments have changed
- FCA revised to expressly require providers to proactively investigate and repay overpayments; failing to do so can constitute a violation of the FCA

Why Compliance Matters (cont’d)
Whistleblowers are active in hospice:
- The False Claims Act ("FCA") allows private citizens to file private causes of action on behalf of the government ("qui tam" or "whistleblower" suits)
- Whistleblowers who bring a successful suit share in the award – typically 15-30%
- Ignored internal complaints are the #1 driver of whistleblower actions and tips to enforcement agencies

Why Documentation Is So Important From A Legal Standpoint
- False Claims Act
- Fraud Enforcement and Recovery Act
- Patient Protection and Affordable Care Act
- 60-Day Reporting and Repayment of Overpayments
False Claims Act: Knowingly

- Standard is “knowingly” – The FCA defines “knowingly” not only as actual knowledge, but also:
  - Deliberate ignorance of the truth or falsity of the information; or
  - Reckless disregard of the truth or falsity of the information

False Claims Act: FERA Amendments

- Enacted in 2009
- The Fraud Enforcement and Recovery Act (“FERA”) amended the FCA to expand liability for the retention of overpayments (“Reverse False Claim”)
  - FCA is violated if the provider knowingly conceals or knowingly avoids or decreases an obligation to pay or transmit money or property to the federal government
  - Applies even when there is no false statement or record or when claim was truthful based on information at the time submitted

False Claims Act: PPACA Amendments

- Enacted in 2010
- The Patient Protection and Affordable Care Act (“PPACA”) amended the FCA further to require providers to report and return overpayments within 60 days after the identification of the overpayment (“60-Day Repayment Requirement”)
- Failure to report may result in liability under the FCA and the Civil Monetary Penalties Law, and exclusion from federal health programs

False Claims Act: 60-Day Repayment Proposed Rules

What is an “overpayment”?
- Broadly defined as any money that a provider receives or retains under Medicare or Medicaid to which the person, after applicable reconciliation, is not entitled
- Examples (not all-inclusive) relating to documentation
  - Payments in excess of the Medicare allowable rate

False Claims Act: PPACA Amendments (cont’d)

- PPACA amended the federal Civil Monetary Penalties statute
- Any person that knows of an overpayment and does not report and return the overpayment is liable for up to $10,000 for each item or service, plus an assessment of up to three times the amount claimed for each such item or service
- Also may lead to exclusion from federal health care programs

False Claims Act: PPACA Amendments (cont’d)

- The 60-day Repayment Requirement has been in effect since March 2010
- Proposed implementing regulations released on February 16, 2012
False Claims Act: 60-Day Repayment Proposed Rules (cont’d)

- Duplicate payments
- Incorrectly coded payments
- Payments for non-covered services

Legal Framework and Documentation Concerns (cont’d.)

- A 2009 OIG Report found that 82% of hospice claims for patients in nursing homes did not meet at least one coverage requirement (OIG Report: Medicare Hospice Care for Beneficiaries in Nursing Facilities: Compliance with Medicare Coverage Requirements)

Key questions remain:

- What is a “reasonable inquiry”?
- What is the lookback period?
- When is an overpayment “identified”? 

Hospice Coverage Requirements: 1. Medical Necessity – Know

- Hospice services “must be reasonable and necessary for the palliation and management of the terminal illness as well as related conditions”

Hospice Coverage Requirements: 1. Medical Necessity – Do

- Ensure that all members of the IDG:
  - Have a copy of the current LCD guidelines
  - Know how to complete LCD-based assessments

  Ensure that IDG documentation:
  - Explains/supports eligibility – every discipline, every visit, every IDG meeting
  - Clearly reflects the palliative EOL needs of each patient (notes describing a chronically ill, caregiver-dependent, unchanging patient will not support a limited prognosis)
### Hospice Coverage Requirements: 1. Medical Necessity – Do (cont’d)
- Ensure that the POC:
  - Contains palliative interventions needed to manage EOL problems/issues
  - Reflects changes in the patient’s structural and functional status (including activities, relationships, level of caregiver dependence, time-to-task completion, etc.)

### Hospice Coverage Requirements: 2. Election – Do (cont’d)
- Ensure that patients/families understand the MHB and its limitations at admission
- Review high risk data and practice patterns for trends (e.g., frequent readmission after discharge or revocation, etc.)
- Assure POC management such that serial revocations & readmissions do not routinely occur for large numbers of patients

### Hospice Coverage Requirements: 2. Election – Do (cont’d)
- Identify & proactively manage patients (and contracted nursing facilities) who call 911 rather than the hospice
- Implement clear, team-oriented processes for related/unrelated decision-making and documentation
- Audit clinical records to ensure that a completed and accurately dated NOE is present prior to billing

### Hospice Coverage Requirements: 2. Election – Know
The individual must elect hospice care in accordance with 418.24, which includes:
- Identification of the particular hospice that will provide care to the individual
- Acknowledgement that patient has been given full understanding of the palliative rather than curative nature of hospice care
- Acknowledgement that Medicare payment for services that are related to the terminal illness are waived
- The effective date of the election, which may be the first day of hospice care or later, but not earlier than the date of the election statement
- The signature of the patient or representative

### Hospice Coverage Requirements: 3. Certification – Know
A certification that the individual is terminally ill must be completed as set forth in section 418.22, which includes:
- Verbal certification within two days of beginning of the benefit period; written certification before billing
- Certifications may be completed no more than 15 calendar days prior to the start of the benefit period
- Face-to-face visit must be conducted for the third and later benefit periods
- Face-to-face visits may occur no more than 30 days prior to the benefit period
- Physician must include a brief narrative explanation of the clinical findings that supports a life expectancy of six months or less
Hospice Coverage Requirements: 3. Certification – Do

- Develop a schedule and process to ensure that F3FEs are completed and documented in the appropriate timeframe (before recert)
- Ensure that no billing occurs if the F3FE was missed (communicate with MDS Coordinators at contracted nursing facilities, as needed)
- Ensure that all cert-related tools are “valid” (i.e., contains all required elements)
- Audit clinical records to ensure that valid cert-related forms are present prior to billing

Hospice Coverage Requirements: 4. Care Plan – Do

- Review care planning processes and tools to assure documentation of individualized problems, interventions, and goals
- Consider requiring SW and SC visits at least every 15 days to assure participation in assessment & POC updates
- Avoid using phrases like “no change in POC”, “stable”, “continue POC”, etc.
- Audit clinical records for POC compliance

Hospice Coverage Requirements: 4. Care Plan – Know

A plan of care must be established and periodically reviewed by the attending physician, the medical director, and the interdisciplinary group of the hospice program as set forth in 418.56, which includes:

- Individualized plan of care reflecting patient and family goals based on initial, comprehensive, and updated comprehensive assessments
- Include all services necessary for palliation and management of the terminal illness and related conditions

Technical Eligibility

Involves:

1. Notice of Election
2. Certification of Terminal Illness
3. Recertification
4. Physician Narrative Statements
5. Face-to-Face Encounters

Requires:

- Valid forms (containing all elements in proper format/lay-out)
- Timely completion (per regulations)
- Legibility (of dated signatures as well as content)

Hospice Coverage Requirements: 4. Care Plan – Know (cont’d)

- The plan of care must be established before hospice care is provided
- The services provided must be consistent with the plan of care
- Review, revise, and document the plan of care no less frequently than every 15 calendar days

Clinical Eligibility

Involves:

1. Admission (initial certification/eligibility)
2. Recertification
3. Level of care
4. Related/unrelated decision-making (secondary versus comorbid conditions, etc.)

Requires:

- Solid, ongoing, LCD-based documentation of eligibility
- IDG narrative in sync with selected scores
- Care is both needed & provided
- Documented rationale for unrelated care/RX
Eligibility & Documentation (cont’d)

When changing the hospice-qualifying diagnosis, also change (based on new diagnosis):
- Designation of all secondary and/or comorbid conditions
- Focus of clinical assessments, LCD-based worksheets, cert/recert tools, etc.
- Plan of Care
- Drug Profile
- Determinations of “related” versus “unrelated” status of all care, treatment, medications, etc.

Eligibility & Documentation

- IDG assessments and visit notes are required (checkboxes alone are insufficient), per minimum visit frequency ordered in POC
- All IDG narratives must support selected scores (KKP/PPS, FAST, NYHA, etc.)
- Need to differentiate between computer-generated and person-entered EHR content (especially when printing EHR documents for external audit/review)
- Disallow “copy & paste” and “auto-populating” features (with the exception of demographic info) as it is considered by OIG to be “cloning”

Eligibility & Documentation (cont’d)

- Higher levels of care must be supported by solid documentation justifying the higher billing
- Do the notes reflect the skilled care that was needed by the patient (and that could not be provided at a lower level of care or within the home setting)?
- Do the notes reflect that a higher level of care was actually provided by the hospice (and/or the staff of the contacted nursing facility or hospital)?

Be Audit Ready / Assure Clean Claims

Conduct random pre-billing audits to ensure that:
1. All technical eligibility requirements are met
   - This is a clerical audit and any staff member or volunteer can be trained to complete it

2. IDG narrative supports the patient’s limited prognosis / hospice eligibility / medical necessity as well as the level of care being billed
   - This audit requires clinical judgment and should be completed by specially trained staff (e.g., nurses or physicians)
NOE Audit
- Hospice provider's name
- Palliative care (not curative)
- Waiver language
- Specifies start of care (SOC) or effective date
- Patient/rep signature on, or prior to, SOC

Cert/Recert Audit (cont’d.)
- Written cert filed in clinical record prior to billing
- Oral cert/recert must identify:
  - Hospice staff member who obtained it
  - Physician it was obtained from
  - Date it was obtained

Cert/Recert Audit
- Executed within 2-day timeframe
- Contains physician's dated signature (no date stamps)
- Identifies benefit period start and end dates
- Initial cert completed by both the hospice and attending physicians

Physician Narrative Audit
- Does not contain checkboxes
- Is not comprised of standard language used for all patients
- Indicates whether the narrative was based on record review and/or patient exam
- Is written by physician
- Is legible
- Accurately reflects patient’s status and IDG assessments, scores, and narrative descriptions

Cert/Recert Audit (cont’d.)
- Specifies the prognosis is for a life expectancy of 6 months or less if the terminal illness runs its normal course
- Contains physician’s printed name (legible signature)
- Is accompanied by documentation of oral cert if written not obtained within 2 days

F2FE Audit
- Completed within specified timeframe
- Clearly titled
- Dated
- Signed with proper attestation location/language
- Legible
- Filed in the clinical record
- If completed by NP, findings were provided to recertifying physician
POC Audit

- Completed within specified timeframe
- Signed & dated by all IDG members
- Individualized (based on patient diagnosis, assessment, & level of care)
- Visit notes filed in the clinical record match the minimum frequency specified in the POC, do not exceed the maximum frequency, and are sufficient for patient/family needs

Clinical Eligibility Audit

- Develop LCD-based audit tools to ensure that MD & RN narrative supports limited prognosis
- Ensure that all IDG documentation in sync with patient assessments, scores, & descriptions
- All notes evidence the palliative EOL care needed by the patient & provided by the hospice
- Higher levels of care are well supported

MD / RN Do's and Don'ts

<table>
<thead>
<tr>
<th>Do</th>
<th>Don’t</th>
</tr>
</thead>
<tbody>
<tr>
<td>Write LCD-based narratives</td>
<td>Say “no change” or “stable”</td>
</tr>
<tr>
<td>Utilize measurable data (weights, MAC, BMI, VS, etc.)</td>
<td>Mistake simple data fluctuation for decline</td>
</tr>
<tr>
<td>Compare to admission baseline</td>
<td>Confuse “chronic” with “terminal”</td>
</tr>
<tr>
<td>Highlight all discernable decline</td>
<td>Copy &amp; paste other/older notes</td>
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Polling Question:

Has your hospice established a process for distinguishing secondary conditions from comorbidities?

Polling Question:

Are you confident that all palliative medications related to the terminal illness are covered by the hospice?

Real-World Example
When ADRs Turn Into FMR

- If there appears to be a pattern of questionable eligibility, a routine ADR process could trigger a Focused Medical Review (FMR)
- The MAC is focusing on a certain area such as a diagnosis (e.g., dementia or debility), a higher LOC, or longer LOS patients, among others
- FMR consumes a great deal of administrative resources and time
- Can lead to denial of payment or required paybacks for care already provided

Two-Fold Approach

- First, we devised a plan to provide education by disease type so SC staff could learn what to observe and document related to eligibility
- Second, we modified the narrative portion of our SC documentation in the EMR so they are required to document observations of eligibility
- We combined these into in-services presented to all SC staff by disease type on a monthly basis to keep the message going
- Dementia and CHF were our first two diagnoses addressed

FMR on Dementia

- In addition to opportunities for nursing and physician documentation, there is often an opportunity to improve supportive care (psychosocial, spiritual, and volunteers) documentation
- SC notes may not match the RN’s assessment documentation
- SC notes focus on the patient well being and not on terminality
- SC team members may not always recognize the terminal symptoms of a particular disease
- SC notes may not paint the picture of eligibility

SC Do’s and Don’ts

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Opportunities for Improvement

- We recognized that our SC staff didn’t always know what to observe in order to document hospice eligibility for their patients
- They were concerned that doing so would be outside their scope of practice and saw that doing so was the nurses’ responsibility
- When in fact, all members of the interdisciplinary group have the obligation of documenting eligibility per visit to paint the overall picture

From Reading All Notes...

...you should know:
- The patient’s hospice diagnosis
- Why the patient needs hospice care
- How the patient is eligible for hospice
- Why CMS should pay for the hospice care
**Narrative Note Format**

D = Data
- Write what you observed at the beginning of the session and relate it to the hospice diagnosis; write your assessment of need in this session

A = Action
- Write what you did in the session to address the needs you assessed

R = Results
- Write observable outcomes of your actions or interventions

O = Observations
- Write all observations of physical decline related to the diagnosis

P = PLAN
- Write how you will address care plan needs in the future

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**In-Services**

- What follows are the first two in-services we completed
- In this presentation, we will not review each slide in detail as they are provided for you as examples
- We will, however, focus on the new documentation format

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**DAROP and EMR**

- The DAROP format we created was designed to be utilized in the narrative summary of our Electronic Medical Record (EMR).
- Our EMR format includes the care plan being addressed as well as checklists for pain rating, PPE used, and communication to other professionals.
- For the note to be inclusive, it needs to address the care plan, pain, PPE, and communication to others.
- If adopting DAROP, please include the additional items if your EMR does not currently do so.

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**All IDG Observations Matter!**

- By adding the additional information that you observed in your session, you paint the picture of a patient who truly needs hospice care and is also benefitting from your professional interventions
- When you omit your observations, the patient doesn’t look like they need this intensive level of care
2 Common Hospice Diagnoses

- We will now look at two very common hospice diagnoses and provide you with a quick overview of the disease as well as tips on charting to support the terminal diagnosis
  - Dementia
  - Congestive Heart Failure

Overview of Dementia

- Common symptoms associated with End Stage Dementia are:
  - Cognitive impairment
  - Inability to perform self care
    - Eating
    - Bathing
    - Dressing
    - Toileting
  - Inability to ambulate independently
  - Inability to communicate

Dementia

- The next set of slides will provide:
  - A quick overview of the physical symptoms associated with Dementia/Alzheimer's
  - LCD indicators required for a patient with Dementia
  - How to incorporate these observations into your documentation

Overview of Dementia (cont'd)

- Hospice criteria for admission under Dementia
- FAST Score of a 7 or beyond
- Must have one of the following indicators present in the past 12 months:
  - Aspiration pneumonia
  - Pyelonephritis
  - Septicemia
  - Decubitus stage 3-4
  - Fever recurrent
  - Weight loss of 10%
  - Serum Albumin <2.5

Types of Dementia

- There are many different forms of dementia
- Some examples are:
  - Alzheimer's
  - Lewy Bodies
  - Vascular Dementia
  - OBS Dementia

Understanding the FAST Scale

- FAST score must be 7 or beyond
  - 7A Ability to speak limited
  - 7B Repetitive speech
  - 7C Non ambulatory
  - 7D Unable to sit up independently
  - 7E Unable to smile
  - 7F Unable to hold head up
Mini Mental Exam

- The Mini Mental Exam assess the patient's ability to show reason/cognitive processes.
- Some examples from the Mini Mental:
  - Have patient follow a series of commands
  - Have patient repeat multiple words from memory
  - Have patient do simple math problems
  - Have patient spell a word backwards
  - Have patient draw interlocking shapes

Observation of Patient’s Speech

- Nonsensical
- Responds to yes/no questions only
- Garbled
- Inappropriate responses
- Is speech repetitive?
- Sing-song
- MT = patients who cannot put words together to make sense in speech will often be able to sing song lyrics. You must document both!
  - E.g., “patient was able to sing the lyrics of her favorite song, but her spoken speech was garbled and she was not able to put words together that made sense.”

Documenting Increased Weakness

Previously...
- Was able to pivot
- Sleeps 12 of 24 hours
- Ambulated independently w/walker
- Able to sit upright in chair
- Able to self-propel w/c
- Able to engage in 30 minutes of singing favorite songs
- Was interested in activities (specify)

Now...
- Unable to bear weight
- Sleeps 18 of 24 hours
- Ambulates w/walker but now requires assistance
- Requires lateral arm support, support w/pillows, Geri-chair, foot rests, etc.
- Unable to self-propel w/c
- Only able to listen to songs; unable to sing along
- No longer able to participate in activities

Observations During Mealtimes

- 1:1 feed
- Unable to utilize silverware
- Requires prompting/encouragement to accept food, chew, swallow
- Prolonged chewing time/difficulty swallowing
- Pockets food
- Expresses no interest in food
- Plays with/throws food
- Takes food from others' plates

Mental Status – Is/Does the Patient:

- Able to make needs known?
- Recognize family members?
- Respond to name only?
- Wander aimlessly?
- Blank stare/stares off into space?
- Respond to tactile/auditory stimuli?
- Combative/Irritable/Paranoid?
- Maintain eye contact or visually track?
- Able to smile? Flat affect? Hold head upright?
- Drool?
- Laugh inappropriately?

Mealtime Observations (cont’d)

- Finger food only
- How much does the patient eat? Percentages are subjective. Be specific: “patient consumed 2 bites of sandwich and 4 teaspoons of Jell-O…” (100% of a piece of toast and 6 oz of tea cannot be compared to 100% of a steak dinner with potatoes, salad and dessert)
- Does the patient cough after eating or drinking?
- Is it taking longer to feed the patient?
- Is the patient refusing food?
Dyspnea and Dementia
- Respiratory issues are a consequence of the disease process
- Due to the abilities to swallow correctly, they have aspirations
- It is important for you to observe and document respiratory problems exhibited by the patient:
  - Does patient become SOB during session?
  - SOB or coughing with eating?
  - Wheezing sounds?
  - Gurgling sounds that are loud, raspy, sputtering
  - Family/caregiver education needed to prevent hospitalizations/911 calls

Observing Weight Loss
- Wt loss as evidenced by: loose fitting clothes? Belt is now too big? Extra skin folds?
- Are bony prominences evident?
- “Patient’s son can now lift and carry patient easily, whereas patient was too heavy two myths ago…”
- Does the patient look thinner when compared to a photo taken in healthier days (e.g., driver’s license)?
- Skeletal appearance

Observation of Ambulation/Transfers
- Requires standby, 1 or 2-person assist
- Requires Hoyer lift
- Does the patient lean to the side in w/c?
  - Relates to the FAST 7d and onward (Patient cannot maintain posture)
  - Has the patient lost the strength to lift feet off the ground when transported in a w/c?
  - Does the patient need a Geri chair or Broda chair?

Promoting Memory with Pictures
- We often try to facilitate moments of reality with our patients with dementia with memory albums, pictures on the wall, etc.
- How do we document that?
  - These events are not spontaneous by patient, and are guided directly by the staff member
  - "Patient was able to smile when social worker held the picture of her daughter and told her it was her daughter. She was not able to spontaneously recall who was in the picture."
- We need to note in the plan of care that we will use errorless discriminations to provide momentary reality experiences.
- We must still document the depth of confusion along with the positive outcomes!

Interventions
- We often provide successful experiences for the patient with end stage dementia by:
  - Using the patient’s name repeatedly
  - Identify self and others present in the room
  - Getting close and using touch as appropriate
  - Speaking slowly and clearly in their language
  - Using simple words and phrases

Interventions (cont’d)
- Entering their version of reality
- Do not ask questions regarding reasoning (post mini mental exam)
- Don’t talk about or over the patient
- Repeating the same message often
- Communicate by being with the person
- Foster comfort with music and tactile objects
### Documentation Do's and Don'ts

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### When in Reality

- Patient had a FAST Score rating of 7d, which means:
  - Cannot maintain posture without supports
  - Not able to maintain a reality-based conversation
- Even though patient was smiling upon arrival, be aware that as the disease progresses to 7e, the ability to smile is lost
- Patient was finishing being fed by aide upon chaplain’s arrival and patient was coughing after eating

### Sample Note

**Patient** smiled and greeted chaplain upon arrival in patient’s room. **Talked about her husband and family members while holding chaplain’s hand. Chaplain provided a ministry of presence, prayed with patient, and provided a follow up phone call to the daughter. Patient denied pain and appeared comfortable.**

### When in Reality (cont’d)

- Patient had support pillows and was leaning to side
- Patient was staring through Chaplain rather than actually “greeting” him

### From Reading this Note

- Do you know the hospice diagnosis?
- Do you know why this patient needs our care?
- Is the patient eligible for hospice services?
- Why would CMS pay for hospice care?

### New Narrative Note Format

- **D** = Data
  - Write what you observed at the beginning of the session and relate it to the hospice diagnosis; write your assessment of need in this session
- **A** = Action
  - Write what you did in the session to address the needs you assessed
- **R** = Results
  - Write observable outcomes of your actions or interventions
- **O** = Observations
  - Write all observations of physical decline related to the diagnosis
- **P** = PLAN
  - Write how you will address care plan needs in the future
Sample EFFECTIVE Note:

- **DATA** = patient was received in her wheelchair, leaning to her left side with support pillows as aide was completing feeding her lunch. Patient was coughing after eating and stared into space.
- **ACTION** = Chaplain greeted patient, held her hand, encouraged eye contact, read scripture and prayed with patient.
- **RESULTS** = When chaplain brought up husband’s name, patient began to talk about him as if he were still alive, although he has been deceased for years. Patient appeared comforted by prayers and scripture reading as evidenced by calm affect and closed eyes.
- **OBSERVATIONS** = patient coughed after mealtime, leaned to side, unable to engage in reality-based conversation.
- **PLAN** = Chaplain will phone patient's daughter to offer spiritual support and will visit patient in 2 weeks to comfort patient with scripture readings.

CHF (cont’d)

- Definition: CHF stands for Congestive Heart Failure
- Generally, Heart Failure is defined as the inability of the heart to supply sufficient blood flow to meet the body’s needs

Your Observations Matter!

- By adding the additional information that you observed in your session, you paint the picture of a patient who truly needs hospice care and is also benefitting from your professional interventions
- When you omit your observations, the patient doesn’t look like they need this intensive level of care

CHF (cont’d)

- Imagine a water pump that is no longer working at capacity, because it does not have the power, strength or new parts to push the water where it needs to go
- The heart is the body’s pump and when it begins to fail the entire body will become affected

Congestive Heart Failure – CHF

- The next set of slides will provide:
  - A quick overview of the physical symptoms associated with Congestive Heart Failure
  - LCD indicators required for a cardiac patient
  - How to incorporate these observations into your documentation

CHF (cont’d)

- Common symptoms that are associated with End Stage CHF are:
  - Shortness of breathe (SOB), also referred to at times as disabling dyspnea
  - Extreme fatigue with any activity
  - Edema in the Lower extremities (water retention)
  - Syncope (passing out)
NYHA Class IV

- The patient is classified as New York Heart Association (NYHA) Class IV
- Class IV patient with heart disease have an inability to carry on any physical activity without discomfort
- Symptoms of heart failure or angina (chest pain) may be present even at rest; if any physical activity is undertaken discomfort is increased

Hospice Criteria for CHF

- New York Heart Association Class IV
- Optimally treated means with diuretics and vasodilators or have angina pectoris at rest which is resistant to intensive medical therapy
- Ejection fraction of < 20% (see flip card)
- Supportive criteria (not required):
  - History of cardiac arrest or resuscitation
  - Treatment resistant arrhythmias
  - History of unexplained syncope

Documentation Supporting NYHA IV

- Patient unable to walk across room without seating down to rest
- Patient became SOB while talking
- Patient denies pain at moment but states last night he took 3 nitro pills before he got relief

Why Shortness of Breath (SOB)?

- The heart and lungs are very much intertwined; when the heart is not pumping correctly or below capacity, that means that the oxygen level in the blood stream is also below normal capacity
- When there is any physical demand placed on the body, the low level of oxygen will be used up quickly and the patient begins to become short of breath
- Usually applying oxygen will help reverse this condition, in some cases other treatments or medications may be needed

Supporting Documentation (cont’d)

- Patient without SOB while sitting, but once they get up they become SOB
- Nurse took patient’s o2 sat and it was 89%
- Hospice aide finished with bathing and patient is very fatigued and unable to participate in MT visit

Documenting SOB

- MT noted that patient became SOB after 5 mins of singing and had to stop
- SW noted that during our conversation that the patient became slightly SOB, she put on the oxygen and resumed conversation without incident
- Volunteer noted that the patient was using his walker when he opened the door and was breathing very heavy and had to sit down
- CH observed patient using walker and got tangled in the o2 tubing, patient became anxious and SOB and had to sit down. No fall witnessed
What is Syncope?

• Syncope is when a patient experiences dizziness, light headedness, passing out or blacking out
• This can be caused by low oxygen level and increased activity

How to Document When a Patient is on a Diuretic or has Edema

• Patient's legs are very swollen this visit, the ankles are overflowing the shoes
• When the Hospice Aide took off the patient's socks, the sock left very noticeable indentation in the skin
• Patient states that she can longer wear shoes since her feet are so big now
• The patient told the volunteer that she can't understand why she is gaining weight since she doesn't have any appetite any more

How to Document Syncope

• Patient had to hold on to the back of chair to steady herself due to feeling light headed
• CH visiting patient in ER, patient states she was going to the bedroom when she just blacked out and fell, patient will be discharged back to home this even per the ER nurse
• During SW visit, the patient's wife said that "Elmer got up out of bed a little while ago and fell right back into the bed. I thought he had died, but he woke up a few seconds later" SW notified RN case manager immediately, patient denies any pain during visit and using oxygen

Challenges Documenting CHF

• One thing you need to bear in mind when documenting on a CHF patient, is that the patient may not exhibit any signs of fatigue or discomfort during your visit because the are intentionally avoiding any activity that would cause them fatigue or discomfort

What is a Diuretic?

• A diuretic is commonly referred to as a water pill. Patients who have CHF are often placed on a diuretic to help with fluid retention. The diuretic helps to reduce swelling that commonly occurs in the lower extremities.
• Edema is the medical term for swelling. You may hear at times "patient has +4 pitting edema" this refers to taking a finger and pushing on a swollen ankle and by counting how many seconds it takes for the indentation made by the finger to return to normal.

Documentation Challenges (cont’d)

Some good examples:
• SW noted that the patient was sitting through visit without moving and voices no complaints, but once patient transferred from chair to bed, patient became SOB and needed oxygen
• MT noted that the patient sang in the beginning but by the end of the song, patient was only nodding their head, when MT asked why patient wasn’t singing, he said he was getting tired
Documentation Challenges (cont’d)
- Chaplain noted that the patient asked for prayer, when this chaplain asked what he wanted prayer for, the patient responded, “I need strength because I don’t have the strength to even brush my teeth any more!”
- Volunteer noted that the patient was happy to see her and asked if she could do a load of laundry. Patient stated that she gets dizzy when she stands up and now has to sit most of the day.

When in Reality
- The staff at the ALF reported the patient fell getting out of bed this morning and reported feeling “very dizzy”
- The patient avoided activities earlier in the morning because he was having increased SOB
- His feet and ankles were too swollen for his tennis shoes, so he was wearing house slippers that were cut in the back to provide more comfort

Sample IN EFFECTIVE Documentation
Social worker visited patient and his wife at the ALF. Patient reported no pain and said he was feeling “fine.” He was finishing his lunch while his wife visited him. She appeared concerned but coping well. SW provided emotional support and facilitated life review and reminiscence. SW available as needed.

New Narrative Note Format
D = Data
- Write what you observed at the beginning of the session and relate it to the hospice diagnosis; write your assessment of need in this session
A = Action
- Write what you did in the session to address the needs you assessed
R = Results
- Write observable outcomes of your actions or interventions
O = Observations
- Write all observations of physical decline related to the diagnosis
P = PLAN
- Write how you will address care plan needs in the future

From Reading this Note
- Do you know the hospice diagnosis?
- Do you know why this patient needs our care?
- Is the patient eligible for hospice services?
- Why would CMS pay for hospice care?

Your Observations Matter!
- By adding the additional information that you observed in your session, you paint the picture of a patient who truly needs hospice care and is also benefitting from your professional interventions
- When you omit your observations, the patient doesn’t look like they need this intensive level of care