Administrator Program
Wednesday, November 16, 2022
12:00pm-1:00pm

H4. Hospice HOT Topics Part 2: Hospice Documentation Supporting Eligibility

Presented by:
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Hospice Documentation
Supporting Eligibility

Presenter: Leslie Heagy RN, COS-C

Objectives

- Review the Regulatory Requirements for creating and updating the hospice plan of care
- Learn the benefits of writing an effective plan of care with measurable patient centered goals
- Discuss the Role of the Hospice IDG in supporting eligibility
- Understand the importance of accurately documenting hospice eligibility to avoid claim denials under medical review.
HOSPICE DOCUMENTATION SUPPORTING ELIGIBILITY

- Documentation to support Hospice Eligibility Starts with the Hospice Intake/Referral
- The Initial RN assessment lays the foundation for Hospice Eligibility
- The RN is the first contact with the patient/family and completes the initial assessment. These findings are then communicated to the Hospice team.
- The Initial Comprehensive assessment builds on the foundation with input from the entire IDG
- Creating a Patient Care Plan from the hospice admission will set you up for success in documenting hospice eligibility every visit.
§418.54 Condition of Participation: Initial and Comprehensive Assessment of the Patient

- §418.54(a) Standard: Initial Assessment
- §418.54(b) Standard: Time Frame for Completion of the Comprehensive Assessment
- §418.54(c) Standard: Content of the Comprehensive Assessment
- §418.54(d) Standard: Update of the Comprehensive Assessment
- §418.54(e) Standard: Patient Outcome Measures

INITIAL ASSESSMENT

- The initial RN assessment must take place in the location where hospice services will be provided
- A Hospice Registered Nurse must complete within 48 hours of the effective date of election
- The RN initial Assessment findings are then communicated to the Hospice team.
- The purpose of the Initial RN Assessment is to identify immediate care needs: Physical, emotional, psychosocial status related to the terminal illness and co-morbid conditions
INITIAL ASSESSMENT

- The RN completes an initial assessment within 48 hours from the hospice date of election
- The admission is completed in the location where hospice services are going to be provided
- Identifies the patient/family’s immediate needs
- Determines the patient’s baseline status
- Begins the Problem List to be addressed in the POC (Plan of Care)
- Completion of the initial assessment lays the foundation for hospice eligibility
- Assessment Findings are communicated with the Hospice IDG (Interdisciplinary Team) including the attending physician when applicable.

TIMELY COMPLETION OF THE INITIAL COMPREHENSIVE ASSESSMENT

- The hospice interdisciplinary group, in consultation with the individual’s attending physician (if any), must complete the comprehensive assessment no later than 5 calendar days after the election of hospice care.
  - The patient may or may not have an attending physician.
  - If the attending physician is unavailable or unresponsive, the hospice physician assumes this role.
- If the patient does have an attending physician, one of the IDG should consult with this physician in completing the comprehensive assessment.
- All members of the IDG must be involved with completing the comprehensive assessment - regardless of visit status if patient refused social worker or chaplain.
CONTENT OF THE COMPREHENSIVE ASSESSMENT

(1) The nature and condition causing admission (including the presence or lack of objective data and subjective complaints).
(2) Complications and risk factors that affect care planning.
(3) Functional status, including the patient’s ability to understand and participate in his or her own care.
(4) Imminence of death.
(5) Severity of symptoms.
(6) Drug profile.
(7) Bereavement (risk assessment findings must be incorporated in the POC)
(8) The need for referrals and further evaluation by appropriate health professionals.

THE HOSPICE PLAN OF CARE
§ 418.56 Condition – Interdisciplinary Group, Care Planning, and Coordination of Services

The plan of care must specify the hospice care and services necessary to meet the patient and family-specific needs identified in the comprehensive assessment as such needs relate to the terminal illness and related conditions.

- § 418.56(b) Standard: Plan of Care
- § 418.56(c) Standard: Content of the plan of care
- §418.56(d) Standard: Review of the Plan of Care

418.56(b) Standard: Plan of Care

All hospice care and services furnished to patients and their families must follow an individualized written plan of care established by the hospice interdisciplinary group in collaboration with the attending physician (if any), the patient or representative, and the primary caregiver in accordance with the patient’s needs if any of them so desire.

Common problems
- Not providing care according to the care plan
- No orders for items on the care plan
- Not including the required individuals
- Not incorporating updated comprehensive assessment information into plan of care/information not individualized.
418.56(c) Standard: Content of the plan of care

The hospice must develop and individualized written plan of care for each patient. The plan of care must reflect patient and family goals and interventions based on the problems identified in the initial, comprehensive, and updated comprehensive assessments. The plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions.

Common problems:
- POC does not address all problems noted
- POC not individualized/patient specific
- POC does not reflect changes in the patient’s condition
- No documentation of POC development including IDG/attending physician

The Plan of Care MUST be:
- Individualized & Reflect the Patient/Family Goals
- Written and Established by the hospice IDG in consultation with
  - The attending physician (if any)
  - Patient or Patient Representative
  - Primary Caregiver and
  - In accordance with the patient’s needs if any of them so desire
- Provide All Services According to the Plan of Care
  - Patient and caregiver education and training for their responsibilities for the care and services identified in the plan of care
CONTENT OF THE HOSPICE PLAN OF CARE

The Plan of Care MUST:

- Include Interventions for Problems identified throughout the assessment process including:
  - Initial Assessment
  - Comprehensive Assessment
  - Updates to the Comprehensive Assessment
- Contain a list of medications, terminal diagnosis, and related conditions
- Include all items (including DME/supplies) and services necessary for palliation and management of the terminal illness and related conditions.

The POC must contain the following to be considered valid:

- Patient specific information
- Scope and frequency of services to meet the patient’s/family’s needs
- Services that are reasonable and necessary for the palliation and management of the patient’s terminal illness and any related conditions
- Measurable and realistic goals that are patient/family driven
- Interventions (Must be very specific)
- Evidence of IDG member involvement must be present
HOSPICE PLAN OF CARE

Common Problems seen with the hospice plan of care

- Missing interventions/goals for all disciplines providing care
- Missing visit frequencies
- Bereavement Risk Scores
- Misuse/overdependence on the EMR software
  - “Canned” documentation/not individualized
  - Check boxes – too many or not enough choices
  - Multiple interventions
  - Copy and Paste

The Hospice Plan of Care should:

- Be fluid meaning that it changes as the patient’s condition changes.
- Be developed by the IDG with the assessment findings from the initial and comprehensive assessments.
- Flow from patient assessments.
- Be reviewed, revised and updated by the IDG at least every 15 days or as often as the patient care needs change.
- Include interventions that are documented against at each visit.
Plan of Care Content should include
Measurable Outcomes
- Outcomes should specifically describe the desired behavior/result
- Measurable and Meaningful
- Attainable and Realistic
- Fluid – Change as the Patient’s Condition Changes
- Patient/Family Focused

DEVELOPING THE HOSPICE PLAN OF CARE

- **First**: Identifying Problems: Initial Assessment and Comprehensive Assessment
- **Second**: Setting Goals: What are the patient/family centered goals at the time of hospice admission?
- **Third**: Interventions
- **Fourth**: Evaluation
DEVELOPING THE HOSPICE PLAN OF CARE

First: Identifying Problems
- RN Initial Assessment-immediate needs
- Comprehensive assessment completed by the IDG, in consultation with the attending physician (if any)

Second: Set Goals
- What are the patient/family centered goals?
- What does the patient/family want?
  - Adequate pain/symptom control
  - Avoid inappropriate prolongation of dying
  - Achieve sense of control
  - Relieving burden
  - Strengthening relationships with loved ones
- Goals should be measurable and meaningful
- Goals should be attainable and realistic
PLAN OF CARE GOALS

POC goals are to be patient centered, specific, measurable and individualized to the patient/caregiver's goals or desired outcomes. Patient care plan interventions should include measurable goals to be able to show if the interventions are effective in meeting the patient's needs.

“Patient goal” is defined as a patient-specific objective, adapted to each patient based on the medical diagnosis, physician’s orders, comprehensive assessment, patient input, and the specific treatments provided by the agency.

“Measurable outcome” is a change in health status, functional status, or knowledge which occurs over time in response to a health care intervention.
WRITING PATIENT GOALS

**SMART** is an acronym for the guidelines nurses should use when setting their goals:

- **S** - Be specific. Setting broad nursing **goals** allows them to be open for interpretation. Clear, concise goal and answers **who** or **what** is involved.

- **M** - Keep it **measurable**. For **goals** to be effective, there must be some way to measure and record your progress.

- **A** - Keep it **attainable/achievable**. The goal is realistic, attainable and reasonable given the patient’s reality. Does the patient have the necessary knowledge, skills and ability necessary to achieve the goal?

- **R** - Be **realistic**. The goal addresses “**why**?” Is the goal relevant to the patient’s reality?

- **T** - Keep it **timely**. Clear-defined, specific time-line or target date. Does the goal answer **when**?

PROBLEMS IMPACTING PATIENT CARE GOALS

Problems Impacting Goals

- What is happening in their situation that is helping or hindering this patient and family from reaching their goals, wishes, needs?

- Are there knowledge deficits that need to be addressed?

- What kind of pain and suffering- medical, physical, emotional, spiritual and social is occurring?

- What changes have occurred that impact the patient’s day to day as a result of disease progression?
A Poor Care Plan Goal would be – “Patient will remain comfortable while on hospice services”

Comfortable is subjective and can be left open to interpretation by all clinicians.

Measurable goal – The patient’s pain level will be at a 4 or below with a regimen of oral opioids and non-pharmacological methods of ice and heat within 90 days.

The goal answers.....

✔ Who is involved
✔ Measurable with a timeframe
✔ Achievable based on the patient’s abilities
✔ Realistic and answers why based on the patient’s goal
✔ It answers when with a clearly defined target date.

GOAL EXAMPLE

- “Patient’s signs and symptoms will be well managed while on hospice.”
  - Patient’s anxiety will be decreased as evidenced by fewer episodes of crying with oral antianxiety medications within 9 weeks.

- “Patient’s UTI will resolve appropriately.”
  - The patient will be free of signs and symptoms of a UTI throughout 90 days of hospice care.

- “Cognitive and mobility decline will be monitored closely by hospice.” Intervention

- “The patient will be maintained in a safe environment and symptoms will be palliated during duration of services.” Intervention
Third: Interventions

- Steps towards achieving goals
- What interventions are necessary?
- Who will perform the interventions?
- How often?
- Monitoring IS okay
- Remember interventions will change as the patient/family situation changes to meet the overall goals.

Remember -

- The care plan goals are not necessarily designed to cure the patient’s issue, rather the goal is often to alleviate symptoms; to make the issues manageable within the philosophy of comfort and quality of life for terminal patients.
- Goals are not static and must be flexible and will change as the situation requires or patient declines.
Fourth: Evaluate Outcomes

- What is the patient’s progress towards goals?
- Are the interventions effective?
- Any new problems?
- Any needed changes to the plan of care?

HOSPICE PLAN OF CARE – HOSPICE ELIGIBILITY

When the Hospice POC is Patient Specific Continued Need for Hospice Care is Evident

The Plan of Care Supports Hospice Eligibility When...

- There is a Direct Link between the patient needs identified in the comprehensive assessment and the patient plan of care.
  - The assessment(s) produces a list of problems to be addressed for the patient/family.
  - The plan of care is then developed with interventions and goals for the list of problems identified within the patient assessment(s).
IDG MEETING...

UPDATING THE HOSPICE PLAN OF CARE

THE HOSPICE INTERDISCIPLINARY GROUP (IDG)

- What is the purpose of the IDG meeting?
- What is the Responsibilities of the Hospice IDG?
- What is the Role of the IDG in supporting hospice eligibility?
- How does the Plan of Care support continued need for hospice care?
- Does the patient assessment findings drive the patient’s individual plan of care?
- How does the IDG meeting documentation support hospice eligibility?
§418.56 Condition of participation: Interdisciplinary group, care planning, and coordination of services

- The hospice must designate an interdisciplinary group or groups as specified in paragraph (a) of this section which, in consultation with the patient’s attending physician, must prepare a written plan of care for each patient.

- The plan of care must specify the hospice care and services necessary to meet the patient and family-specific needs identified in the comprehensive assessment as such needs relate to the terminal illness and related conditions.

§418.56(d) Standard: Review of the plan of care - The hospice interdisciplinary group (in collaboration with the individual’s attending physician, if any) must review, revise and document the individualized plan as frequently as the patient’s condition requires, but no less frequently than every 15 calendar days.

418.56(e) Standard: Coordination of services - The Hospice must develop and maintain a system of communication and integration, in accordance with the hospice’s own policies and procedures, to ensure the IDG:

- Maintains responsibility for directing, coordinating, and supervising the care and services provided
- Care and services are provided in accordance with the plan of care
- The care and services provided are based on ALL assessments of the patient/family needs
- Ongoing sharing of information between all disciplines providing care and services in all settings and for other non-hospice healthcare providers furnishing services unrelated to the terminal illness and related conditions.
HOSPICE INTERDISCIPLINARY GROUP (IDG)

Core Services

- Physician Services
- Nursing Services
- Medical Social Services
- Counseling Services

DOES THE PATIENT ASSESSMENT FINDINGS DRIVE THE PATIENT’S INDIVIDUAL PLAN OF CARE?

Review the Plan of Care

- Review of the plan of care is typically completed during the IDG; however, this can be completed at anytime.
- What changed in the patient’s assessment that needs to reflect in the plan of care interventions or goals?
- Does a new problem need to be added or resolved?
- After reviewing the plan of care for updates, review the current care plans to ensure:
  - Current interventions are effective – If not, revise
  - Patient’s progress toward goals – If no progression, is the goal realistic and should it be revised?
DOES THE PATIENT ASSESSMENT FINDINGS DRIVE THE PATIENT’S INDIVIDUAL PLAN OF CARE?

Revised Plan of Care

Revise plan of care based on the patient’s ongoing assessments:

- Update when the patient’s condition changes, with medication changes, DME changes and services provided to further support symptoms of disease progression.
  - Increased long-acting morphine dose to 30mg 2 times a day due to the patient requiring an increase in short acting morphine PRN for breakthrough pain.
  - Oxygen order changed from PRN to 2L continuously to manage shortness of breath.
  - Hospice aide increased to 5 times a week as wife can no longer manage increase physical requirements for bathing.
  - Aide care plan update- change shower to bed bath with patient no longer able to transfer safely.

IDG MEETING DOCUMENTATION

Information to include on the IDG meeting note:

- Review of medication regimen and any new medications ordered or changed since last IDG
- Current status compared to 3, 6, 9 months ago. Weight changes, intake, appetite, skin, wounds and/or infections.
- Mental/Functional status from admission or in the last 3-6 months compared to now. New DME? Falls? Caregiver changes?
- Volunteer involvement and frequency
- Bereavement needs
- Progress toward goals
- All in agreement with Plan of Care
Avoid Documenting Generalized phrases such as:

- No Change
- Stable
- Slow Decline
- Eating less
- Sleeping more
- Appears to be losing weight
- Increase weakness

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**SCENARIO #1 IDG MEETING NOTE EXAMPLE**

- **Spiritual:** Mrs. Smith had difficulty walking from her bedroom to the kitchen during my visits since the last IDG due to trouble breathing and she is becoming more isolated from family and friends. Mrs. Smith reported anxiety just thinking about being alone at night and not being able to catch her breath, asking God why this is happening to her? Chaplain visits increased to weekly.

- **Psychosocial:** Mrs. Smith awaken her daughter several times at night when she gets anxious and feels short of breath, so the daughter is becoming exhausted. The daughter has quit her job to stay home and take care of her mother and reports feeling inadequate stating, “I just don’t know what else to do for her, sometimes I don’t feel like a very good caregiver.” Hospice Respite level of care may be needed soon.
SCENARIO #1 IDG MEETING NOTE EXAMPLE

Scenario #1 continued…

- **Nursing:** Mrs. Smith continues to have increased shortness of breath requiring increase doses of her sublingual morphine since the last IDG, weight on the last visit revealed a 3 lb. weight loss in a month. The daughter is writing down the number of PRN doses of morphine to determine if the long-acting needs to be increased. The daughter is showing s/s of caregiver exhaustion and discussed options with social worker following my last visit.

- **Volunteer:** Mrs. Smith continues to receive a volunteer one time a week for companionship while the daughter takes a break.

- **Bereavement:** Patient remains a low bereavement risk.

SCENARIO #2 IDG MEETING NOTE EXAMPLE

IDG meeting note documentation to support disease progression

- **Nursing:** Mr. Smith is a 78-year-old male with a hospice primary diagnosis of Lewy body dementia and continues to show consistent s/s of disease progression with dependence on paid caregivers for all ADLs, eating only 25% of meals from 50% and now requires total feed at mealtimes. He has a new skin tear to the right forearm that resulted from a fall a week ago. A low bed and floor pad was provided since the last IDG.

- **Chaplain:** Weekly spiritual support continues with prayer and presence requested by wife in dealing with war combat experiences.

- **MSW:** Continue to work with the patient’s son regarding nursing home placement verses 24-hour care in the home with patient’s decline.

- **Facilitator:** Discussed the family showing s/s of exhaustion in caring for the patient as the disease progresses. A family meeting is scheduled for Friday to assist with options to support both the patient and family during this time.
Hospice Documentation Supporting Eligibility

Local Coverage Determination (LCD)

- Created in 1996 as a Guide to be used in conjunction with clinical judgement and was never intended to be used as public policy, it was never validated and often ineffective at prognosis prediction. LCD does NOT = Prognosis.
- Recommend using the disease specific LCD guidelines only as a guide with patient specific findings when determining prognosis.
### LOCAL COVERAGE DETERMINATION (LCD)

<table>
<thead>
<tr>
<th>Non-Disease Specific Decline in Clinical Status LCD</th>
<th>Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Worsening Signs - Weakness</td>
<td>Unable to feed self</td>
</tr>
<tr>
<td>Decline in Palliative Performance Score (PPS) from &lt;70% due to Progression of Disease</td>
<td>The patient also has decreasing functional status (PPS was 60% six months ago currently 30%)</td>
</tr>
<tr>
<td>Progression to Dependence on Assistance for Two or More Activities of Daily Living (ADLs): Feeding, Ambulation, Continence, Transfer, Bathing, Dressing</td>
<td>Progressed from using a walker to chair/bedbound status in less than six months, requires a 1-person transfer.</td>
</tr>
<tr>
<td>Progressive Stage 3-4 Pressure Ulcers</td>
<td>Stage III pressure ulcer despite optimal wound prevention and treatment.</td>
</tr>
</tbody>
</table>

### LOCAL COVERAGE DETERMINATION (LCD)

<table>
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<tr>
<th>Non-Disease Specific Decline in Clinical Status LCD</th>
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</table>
| Progressive exhaustion caused by lack of nourishment as documented by:  
✓ Weight loss not due to reversible causes such as depression or use of diuretics  
✓ Decreasing serum albumen or cholesterol  
✓ Inadequate oral intake documented by decreasing food portion consumption | Weight loss (10% of body weight over last year), BMI of 18.6, all despite 1:1 feeding assistance.  
Malnutrition (Albumin of 2.5)  
Decreased oral intake (10% of meals) |
Documenting the Details is Important

- Knowing the questions to ask related to the disease process(s) will result in documentation to further support the terminal condition.
- Don’t just rely on the EMR software template
- Obtain objectively measurable data to support disease progression
- Compare changes over time to support disease progression
- Make sure the symptoms are correctly reflected in the documentation

If edema is present, are the interventions effective? Ask the patient if increase edema causes discomfort and when they notice the increase edema and discomfort to determine what intervention is needed.

- Patient continues to have 3+ pitting edema in the bilateral lower extremities despite optimal treatment of the disease process
- Instructed patient/caregiver to elevate bilateral lower extremities when out of bed to help decrease swelling and alleviate pain related to edema
**Respiratory Assessment**

- If the patient has shortness of breath, be specific on how the shortness of breath affects the patient on a daily basis and any new limitations that develop from the last visit because of the shortness of breath.
- Does the patient require periods of rest between activities? Are the recovery times getting longer?
- Is the patient short of breath with the use of supplemental oxygen?
- Has meal consumption decreased due to increased fatigue with eating? Increase sleeping after meals?
- Is conversational dyspnea present, requiring rest between words to catch breath?
- Avoid documenting within normal limits or at baseline for this patient, instead document what is present. Such as decreased air movement in bilateral bases, expiratory wheezing throughout, fine crackles in the right lower lobe.

**Medication Management**

- Does the patient follow medication regimen as prescribed?
  - Some patients may avoid certain medications at times such as diuretics and bowel stimulants due to their inability to get to the bathroom timely or needing to get up frequently through the night.
- If edema is present, are the interventions effective? Ask the patient if increased edema causes discomfort and when they notice the increase edema to determine if intervention is needed.
  - Patient continued to have 3+ pitting edema in the bilateral lower extremities despite optimal treatment.
  - Instructed patient/caregiver to elevate bilateral lower extremities when out of bed to help decrease swelling and alleviate pain related to edema.
- Each nursing assessment should include the patient’s response to interventions used to palliate symptoms.
Objective Measurable Data

- Documenting assessment findings with clinical objective measurements will clearly show decline with the ability to compare changes over time.
- The details matter and the changes over time matter. Avoid documenting WNL for the patient and just document what is present.
  - Decline in appetite with decreased intake from 75% to only consuming 25% in the last 3 weeks resulting in a decrease in the mid-arm circumference measurement from 22 cm to 21.5 cm in the last month.
  - The patient requires frequent cueing during mealtime, has trouble staying awake during mealtime, now requires care giver to feed all meals with much encouragement.
  - Increased daytime somnolence; sleeping 20 hours a day from 15 hours a day at the hospice start of care, only waking for meals, difficulty keeping eyes open during assessment, falling asleep during meals.
  - Significant functional decline with now bed to chair existence, loss of trunk support requiring pillows to prop up progressing to a PPS of 30% and FAST of 7D.

Weight Loss

- When weight loss is used to support the terminal condition, you MUST include the actual weight loss within the clinical record that shows the weight loss over a period of time, past and current nutritional status, current weight and any related interventions.
- If the patient record lacks objective clinical findings to support weight loss, then weight loss can not be used in determining ongoing hospice eligibility under medical review.
- Obtain both a weight in pounds and a mid-arm circumference measurement at the hospice start of care to establish the patient’s baseline.
- Consistently obtain patient weights and/or mid-arm circumference measurements throughout hospice care.
Consider When Documenting Weight:

- Is weight loss supported by visual observation and/or objective measurable data?
- Is weight loss due to decrease appetite/meal consumption or despite adequate intake?
- Weight in pounds, Mid-Arm Circumference Measurement, abdominal girth when ascites is present all need to include changes over time.
- If weight gain is present, include reason of weight gain such as, increased edema.
- Worsening functional status supports continued decline but may also stabilize weight due to decreased caloric expenditure.
- If the patient was able to self propel in a wheelchair and progresses to being bedbound and is no longer able to reposition self in the bed this would explain weight stabilization with a decrease in caloric expenditure.

Documenting Pain: Assessment should be consistent and include:

- Type of pain
- Intensity
- Location
- Character
- Duration
- Frequency
- Aggravating and alleviating factors
- Effect on function or quality of life
DOCUMENTATION SUGGESTIONS

Documenting Pain:
- Assessing pain in non-verbal or cognitively impaired
  - Non-verbal cues
  - Obtain feedback
  - Review history
- Assess patient’s knowledge and beliefs about pain
- Document if and when all pain medications are utilized and if they are controlling pain
  - If patient doesn’t have pain, is it because they are taking prescribed pain medications which are effective or does the patient ever have s/s of pain?
  - Documentation should include status of pain between assessments

DOCUMENTATION SUGGESTIONS

Documenting Strength and Weakness:
- Strength is usually tested against resistance
  - One side of the body is compared with the other
- Weakness may be subtle and could be:
  - A decrease in use of a limb
  - Slow movements
  - Impaired dexterity
**DOCUMENTATION SUGGESTIONS**

**Documenting Nutrition and Intake:**
- Assess at each visit
  - Patient’s appetite
  - Percentage of foods eaten or drank
  - What type of foods/drinks are being consumed
  - Ability to eat / drink
  - Any issues with eating
- Remember to compare changes over time

**DOCUMENTATION SUGGESTIONS**

**Documentation to Support Hospice Eligibility**
- Change in weight (loss, gain due to fluid retention, albumin < 2.5mg/L)
- Change in anthropomorphic measurements (Mid-arm circumference (MAC), abdominal girth) or loose-fitting clothes
- Worsening diagnostic lab results
- Change in pain
- Change in responsiveness
- Change in skin (turgor, fragile, excoriation, skin tears, wounds, edema)
- Worsening functional status, Dependence in ADLs
- Change in vital signs (RR, O2 saturation, BP, pulse)
Examples of Strong Documentation Supporting Eligibility

- The patient continues to require oxycodone 10 mg every 6 hours for pain with sublingual morphine (20mg/ml) 0.25ml/5mg every 4 hours as needed for breakthrough pain. (Remember to include number of PRN doses since the last visit)

- The patient has shown a decrease in anxiety with respiratory with increased use of nebulizer treatments and increased visits from the priest and social worker.

- Provided the patient briefs for incontinence as he is no longer able to make it to the bathroom.

- Daughter states: “My dad is gasping for breath even when he is just sitting and talking, and he did not do that last week” (Dyspnea at rest)

Examples of Strong Documentation Supporting Eligibility

- The patient continues to have increased shortness of breath despite optimal treatment with continuous supplemental oxygen, nebulizer treatments and use of inhalers requiring 2 doses of sublingual morphine since the last nursing visit.

- The patient is exhibiting symptoms of an upper respiratory infection with a productive cough, fine crackles throughout the lungs, 101.2 temperature and heart rate of 102. Obtained new order for antibiotic treatment during the visit. The patient continues to have reoccurring infections with last URI requiring antibiotic treatment 3 weeks ago supporting disease progression.

- The patient’s weight today is 120lbs. reflecting a weight loss of 5lbs. in the last 3 weeks and a total weight loss of 16lbs. in less than 2 months.

- The patient has progressed to a 7D requiring pillows to prop him up when in the wheelchair to keep from leaning/falling over.
COMMON PROBLEMS WITH DOCUMENTATION

Lack of consistent, objective date
Lack of comparison over time
Prognostic tools used (Karnofsky, PPS, FAST score) not supported by other documentation
Documentation supports a chronic condition vs a terminal condition
Documentation does not consistently show persistent and new symptoms of disease progression to support ongoing eligibility criteria.
LCD guidelines not supported

When Documentation No Longer supports the Terminal Prognosis...
- Unexplained weight gain
- Weight loss used to support a downward trajectory then weight loss STOPS
- No longer able to weigh patient
- No explanation for stable weight
- Documented FAST scores not supported in other documentation
- Documenting sleeping more without comparison over time
- Appetite poor, decrease meal consumption lacking measurable data to support
- Documentation lacks support for functional decline
- Inconsistent KPS/PPS scores
- The documentation does not support any exacerbation of symptoms
COMMON PROBLEMS WITH DOCUMENTATION

Consider when documenting in the patient chart, if the entry clearly supports the assessment findings?

- **Example:** Which of the entries below provides the level of detail needed to clearly describe the assessment findings regarding disease progression?
  - **Patient A** is sleeping more and continues to have a poor appetite.
  - **Patient B** continues to have a poor appetite despite frequent cueing during mealtime from the caregiver who reports he is now only consuming 25% of meals from greater than 75% 2 weeks ago. He is now sleeping 20 hours a day from 15 hours day at the hospice start of care and is now having a difficulty staying awake during meals.

COMMON PROBLEMS WITH DOCUMENTATION

DO NOT document the below phrases without elaborating in the documentation a detailed description:

- “Stable”
- “Slow progressive decline”
- “Appears to be losing weight”
- “Eating well”
- “Deteriorating”
DIFFERENCES IN DOCUMENTATION FOR HOSPICE CARE PROVIDED IN THE HOME & THE FACILITY

How does documentation for the patient who receives hospice care in a facility differ from the home patient? Which do you think will better support hospice eligibility?

DIFFERENCES IN DOCUMENTATION FOR HOSPICE CARE PROVIDED IN THE HOME & THE FACILITY

What are the factors that affect home vs. facility documentation?

- Who is the primary caregiver? 24-hour skilled care vs a spouse or child?
- What are the differences in the focus of care for facility & home patients?
- How many caregivers do you have reporting to you regarding the patient’s condition since your last visit?
- When do you see the patient in the nursing facility? Is the visit frequency different from a patient at home?
- Do you ask the same questions for a home patient as you do in the nursing home setting?
RECERTIFICATION DECISIONS

- Review baseline data collected on admission
- Review chronological IDG documentation
- Use baseline and ongoing documentation as a foundation that creates a picture of your patient over time
- Document current status with language and measurements consistent with diagnosis-specific LCD guidelines
- Making the case for recertification or need to discharge becomes less complicated with good data.

Every Visit Every Time
- Supports Hospice Eligibility
- Defines the terminal condition
- Contains objective measurable findings
- Supports disease specific LCD guidelines
- Visit note narratives include clinical findings to support the terminal condition
- Documentation shows the affects of end-stage disease on patient

IDG meeting notes
- Updates the hospice plan of care
- Documents changes since the last IDG meeting
- Includes input from the entire IDG including the attending physician (if any)
- Supports ongoing hospice eligibility

Recertification
- Review baseline data collected on admission
- Review chronological IDG documentation
- Review both persistent and new symptoms supporting the terminal condition
- Compare baseline data with current data to support ongoing eligibility
- Explain any symptom improvements
References


Thank You For Participating!

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