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Hospice:

Documentation Toward Decline

Agenda

- Nursing Documentation
- Documentation per Body System
- Weights and Measurements
- Hospice Resources

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Nursing Documentation

- The Hospice Nurse is responsible for management of the patient as a whole. The nurse must know everything that is going on with the patient at any given time
- It is the responsibility of the nurse to ensure that he/she is aware of all aspects of the patients care especially in regard to improvement/decline.
- Each clinical note must be able to stand alone and show how the patient remains terminally ill or it may appear the patient has stabilized, become chronically ill and requires discharge planning to occur. Failure to document a distinct difference will result in payment denial for a month, certification period or even an entire admission.
- Decline is inherent to the dying process in most diseases and most hospice staff are attuned to documenting the slightest signs. But decline is also associated with chronic conditions and advanced age.
- Nursing narratives repeated verbatim across clinical notes, IDG notes, and plans of care can have the effect of reducing credibility of documented assessments and narratives. This also may contribute to a clinical picture for stability for the patient. Documentation must support the patient's decline. Each clinical note must show evidence of signs and symptoms of decline despite optimal care.

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01 Focus on patient deterioration and decline

02 Must support PCTI that a patient has a life expectancy

03 Good objective data

Custodial Comfort Care Vs. Terminal Care

Custodial Care: Slowly decline disease process, may require assistance with activities of daily living, can live several years as their body fails.

Terminal Care: Disease progression significantly declining, trajectory of progression provides prognosis of a life expectancy of less than six months.

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Document

Why Hospice? Why Now?

- Patient history
- Prior level of function
- Support physician’s certification of terminal illness
- Acuity
- Trajectory
- Six-month prognosis
- Hospitalizations
- Symptom exacerbations
- Changes in condition
- Need for additional care
- Comorbidities

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Document using International Classification of Functioning

	Activity limitations		Include a narrative documentation information about how co-morbid conditions and secondary conditions affect the patients decline	
Impairments in function		Participation limitations, and communication impairment		Consider ways to document which systems of the body are in a terminal condition

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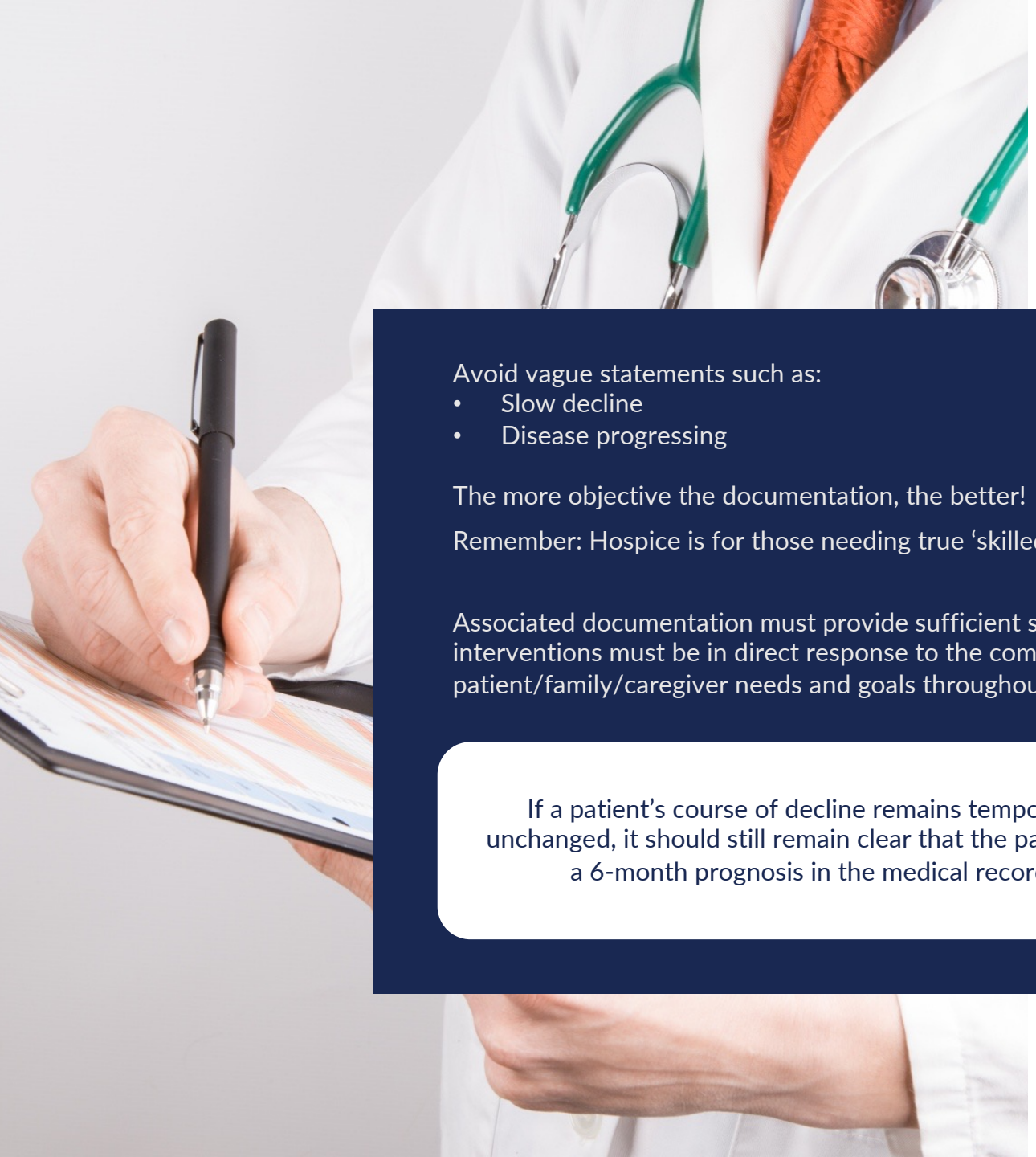

Clinical notes from all discipline should demonstrate a consistent picture of terminal

Avoid vague statements such as:

- Slow decline
- Disease progressing

The more objective the documentation, the better!

Remember: Hospice is for those needing true ‘skilled palliation of end-of-life symptomology’.

Associated documentation must provide sufficient support of the ongoing medical necessity of the services being provided. All interventions must be in direct response to the comprehensive assessment and the plan of care. Continual reassessment of patient/family/caregiver needs and goals throughout course of care must be completed no > every 15 days.

If a patient’s course of decline remains temporarily unchanged, it should still remain clear that the patient has a 6-month prognosis in the medical record.

If your documentation doesn’t reflect a 6-month or less prognosis (usually evidenced by clinical decline and medical necessity) you are at risk for payment denial.

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Document Measurable Objectives

- Weight/BMI
- Abdominal girth
- Mid arm circumference
- Labs (albumin, electrolytes, renal/liver function)
- Food and fluid intake
- Percent of meals completed
- Patient's signs and symptoms and how it has changed over time

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Weight Loss

- Document: ill-fitting dentures, eyeglasses, or jewelry; clothing size; sunken cheeks; prominent bones; skeletal appearance; and poor intake
- Every IDG member can, and should, describe the patient's physical appearance and how it's changing over time

Increasing dyspnea as evidenced by increased use of accessory muscles on inspiration and greater use of nebulizer, pursed-lip breathing, use of accessory muscles and use of medication to reduce the symptoms

Lack of appetite and associated weight loss as evidenced by 1-inch decrease in Mid Arm Circumference and ill-fitting clothes

Patient growing weaker over past 3 days as evidenced by now spending most of her time in bed (# of hours per 24 spent in bed/sleeping)

Make sure your narrative documentation clearly notes increased service utilization

Need more frequent or longer visits or greater involvement by members of IDG

- Changes in signs/symptoms
- Number of symptoms & degree of severity
- Medication changes to include the addition/discontinuation/titration/or route

Effective Documentation of Terminal Status

- Documentation must be legible
- Documentation is expected to show significant changes in the beneficiary's condition and plan of care
- Use measurable items such as weights, girth measurements

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Pain

- Type of pain
- Body language
- What odes pain mean to the patient
- What else does pain effect

Responsiveness

- Does the patient react to your presence?
- Is the patient frightened of you?
- Does the patient remember you from last visit?
- Does the patient remember why you're there?
- Unresponsive?
- Respond to touch? Smell? Light?
- Fades in and out of alertness?

ADLs

Levels of Activities of Daily Living (ADL) dependence

What can they do SAFELY?

- Getting in/out of shower
- Ambulate while carrying food
- Are they impulsive
- How does independence change
- What is the patient's reaction to loss of independence

Vital Signs

Respiration rate, blood pressure, pulse, temperature

- Graph easily shows change
- Does patient have a response to the procedure
- What are the specific vital signs for your patient

Strength

- Ask the patient to squeeze your hands
- Is there a difference from last visit?
- Can the patient raise their hands to yours?
- Is the patient able to stand?
- Assisted or unassisted, how long?
- Safely
- What are they no longer able to do because of loss of strength

Lucidity

- Can the patient carry on a lucid conversation?
- If you change the subject abruptly, can they still follow along?
- Can the patient make decisions?
- Simple or complex conversation?
- Current events knowledge?
- Inside or outside their world information?
- Does conversation frustrate your patient?

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I's and O's

Intake

- Make sure the serving size is appropriate and consistent
- Check for dehydration
- Is the patient offered food that they like and is appropriate for them?
- Appetite persistent or change?
- Have their tastes changed?
- Do they lose interest in food?
- Does increased weakness make it difficult to finish a meal?

Output

Patient requests a catheter or incontinence protection

- Too tired/weak to get up to the bathroom?
- Is there an odor in the home?
- Is there a system in place to measure output that is workable for the patient/family?
- Is your patient no longer embarrassed to ask for help?

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Fatigue

- Meet you at the door?
- Too tired to get out of chair?
- Recurrent?
- Too tired for self grooming?
- Too tired to prepare food or eat?
- No longer does favorite tasks?

Agitation

- Variable levels
- Unable to participate in conversation
- New?
- Increased?
- How easily is the patient agitated?
- Frustrated by what is happening to them?
- Does caregiver indicate frustration?

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Social Status

- Change in social support?
- Relationships?
- Quit going to church or favorite functions?

Pitfalls in Terminal Prognosis Documentation

- Paradigm shift for medical professionals, have been trained to show improvement – not decline

Amount and detail dependent upon the situation

- Chronic deteriorating condition vs. rapid profession
- Chronic, deteriorating condition may depend upon small details
- Rapid progression may be focused on only one symptom

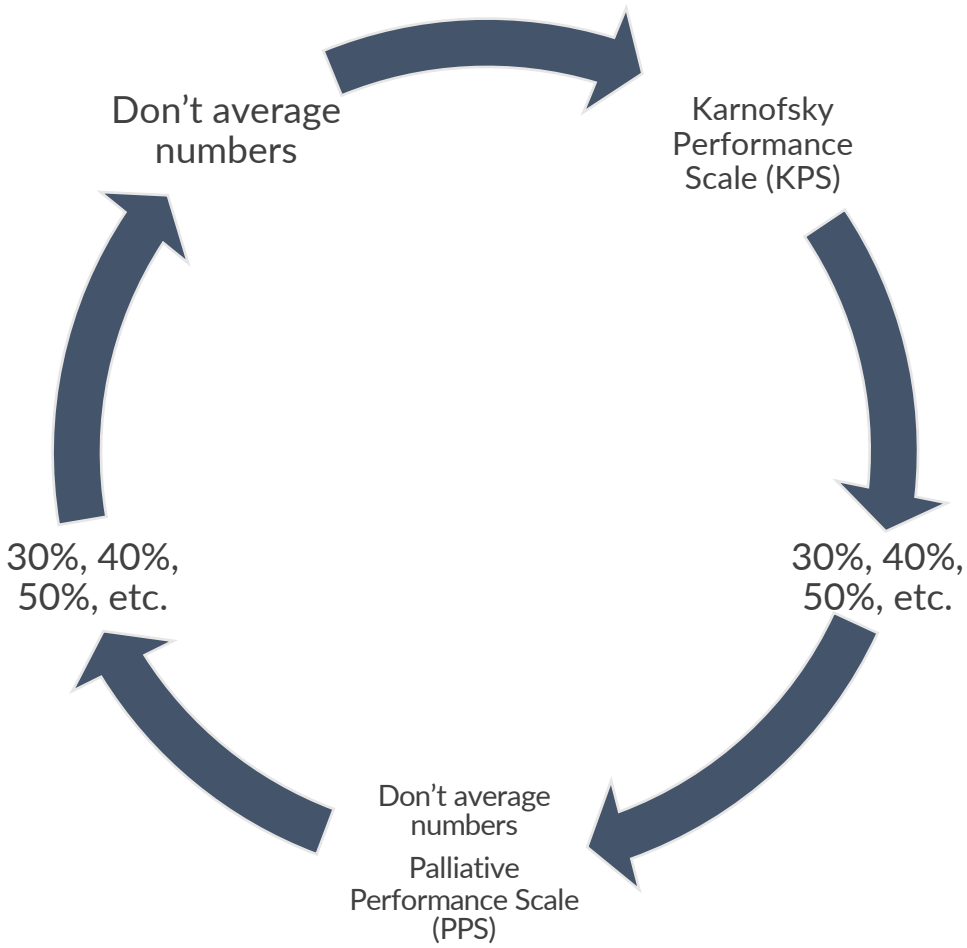
Obtain History and Physical Information

- May come from more than one source
    - Difference sources may have different focus
    - Dietician, emergency room staff
    - Recent hospital stay?
    - Lives or lived at facility?
    - What does caregiver notice?

Use functional scale, as appropriate and always tell what changed to make change in status

Functional Assessment Staging (FAST)
New York Heart Association (NYHA)

Should be determined by physician



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Don’t forget documentation from the interdisciplinary group (IDG) meetings

- Information form other staff members
- May have different perspectives
- Different staff members see patient at different times and in different circumstances
- Example – nurse compared with social worker or chaplain
- Aides have valuable information. See patient at most vulnerable.
- Visits at different times of day

Refer to Local Coverage Determination (LCD) for guidance

- Use numbers
- Use observations and data, not conclusions
- Clinical indicators of decline
    - Weight loss, infections, changes in mobility, etc.
- Review terminal admitting diagnosis – still appropriate?
- Reassessment is ongoing
- Remember quality versus quantity

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Documentation per Body System

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Neurological

- Orientation
- Lethargy
- Speech
- Follows commands/prompts
- Sleeping patterns
- Pain

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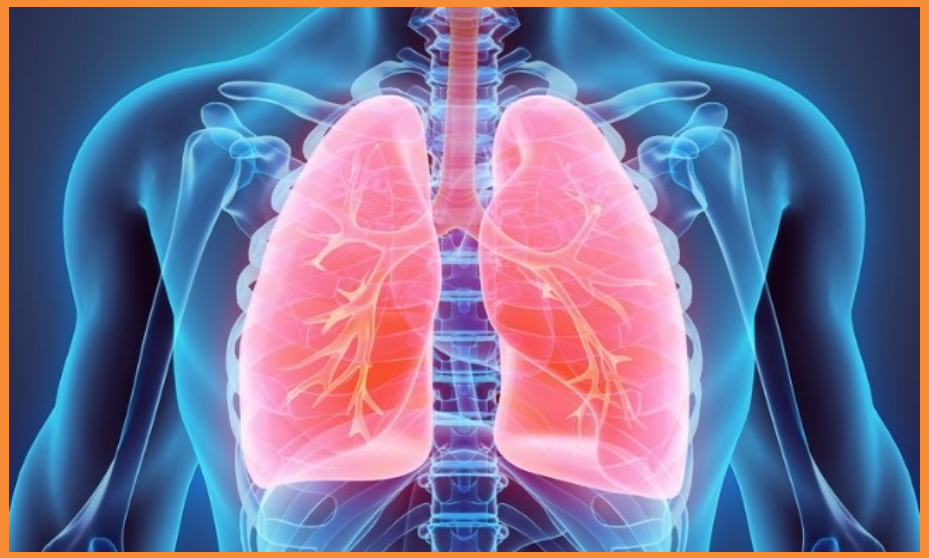
Respiratory

- Intractable Cough
- Oxygen Usage (what did they use prior?)
- Shortness of Breath (how far can they ambulate before getting SOB?)
- Lung Sounds
- Inspiratory Effort



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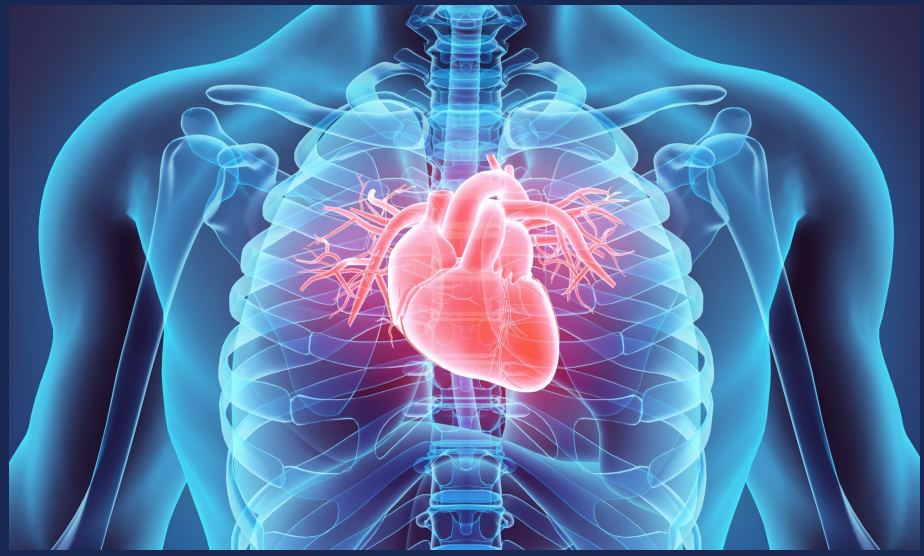
Cardiovascular

- Vital Signs
- Edema
- Heart Sounds
- Lasix Use
- Opioid Use
- Peripheral Pulses
- Circulation/Perfusion



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GI/GU

- Urine Output
- Incontinence
- Dependence on Continence Care
- Bowel Habits
- Foley
- Creatinine

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Skin

- Color, Temperature, Texture, Moisture, Integrity
- Skin Risk Tools (Braden/Norton Scale)
- Wounds
- Interventions

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Musculoskeletal

- ADL's
- Weakness/ROM
- Ambulation (PLOF)
- Trunk Control
- Devices (Cane, Walker, Hoyer, Wheelchair)
- KPS/PPS

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Nutrition

- Malnutrition
- BMI
- Diet
- N/V
- Dysphagia
- Weight
- Muscle Wasting
- Albumin
- Mid Arm Circumference
- Hydration
- Appetite

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Evidence Based Documentation

- Cachectic
- Anorexic
- Non-Ambulatory
- Dyspneic
- Weight Loss
- Poor Appetite
- Fragile
- Failing
- Weaker

As evidenced by…

Measurable Objectives

- Weights
- Mid-Arm Circumference
- Abdominal Girths
- Food and Fluid Intake
- Signs and Symptoms
- Diagnostic Studies
- Lab Values

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What's a 'Local Coverage Determination'?

LCDs are decisions made by a MAC whether to cover a particular item or service in MAC's jurisdiction (region) in accordance with section 1862(a)(1)(A) of the Social Security Act.

LCDs provide guidance in determining medical necessity of services. CGS has developed a hospice LCD, ID# L34538 titled Hospice Determining Terminal Status, using the National Hospice and Palliative Care Organization's (NHPCO) guidelines. Refer to the Medical Policies page to access the hospice LCD.

The LCD:

- Allows for the decline of a beneficiary to be a factor in determining prognosis.
- Consists of three parts, and disease specific appendices:
    - Part I is related to the **decline** in a beneficiary predictive of a six-month prognosis.
    - Part II is related to the **functional limitations of a beneficiary** and is used in conjunction with the disease specific appendices. Part II does not stand alone in prediction of a limited prognosis.
    - Part III discusses **co-morbidities** that may be helpful in predicting and documenting a six-month prognosis.
- Is used by CGS Medical Review staff as a guideline to aid in consistency of reviews.

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Common Errors Include

- No significant decline
- Documentation by various disciplines do not show same level of decline without explanation
- No measurable signs/symptoms presented for comparison
- Documentation does not support terminal status
- Documentation shows hospice benefit being utilized as long-term care benefit results in partial or full denial

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Weights and Measurements

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Example of Documentation

- Lying in bed, no eye contact or movement with occasional grunt and drooling. Doesn't respond to touch or voice. Very thin, no edema. Falls asleep while feeding.
- Patient is sitting in her w/c or lying in her bed 90% of the day. She tries to get up by herself and is too weak and unsteady which is leading to falls. Max assist with two to get from bed to wheelchair. Patient will ambulate behind w/c on occasion.
- 86 y/o patient with Alzheimer's. Patient frail with sunken temples, hollow cheeks, muscle wasting. Very sleepy during visit 0 rouses to voice and returns immediately to sleep. Staff reports patient sleeps 18-20 hours per 24 hours. Patient is completely dependent for 6/6 ADLs. Bed to chair existence with assist of 2 to pivot from chair to bed. Patient continues to lose weight – down 13 pounds in past 5 months.
- Patient sleeps 8 to 10 hours per day. He can feed himself but does better with finger foods. His appetite is fair. He has had a 6-pound weight loss over the past 3 months. He also had a 2cm decrease in the measure of his right upper arm from October to December. Episodes of low blood pressure. Increased pain meds. Ambulation unsteady.

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Example of Documentation

- Summary: 85 y/o Caucasian female dcd from SNF 5/22 then returned to hospital on 5/25. Pt had begun decline with confusion and memory loss, many falls and constant UTI's. Pt was dx'd with significant resp failure d/t asp pna. Dgtr/mpoa chose hospice for comfort care only. Family very supportive of patient and each other. Patient's spiritual needs have been met and faith is family's strength.
- Has new shower chair due to increased weakness. Requires assistance with showers, where 6 months ago patient was able to get into a regular shower/tub combination without assistance. Showers shortened to 5 minutes, where patient used to enjoy being in the warm water.

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Medical Chart Requests Tips

- Send in relevant documentation outside of period requested.
- Always send in admission assessments.
- Remember the reviewer can't see the person, chart the obvious.
- Decrease in appetite may mean the patient's dentures no longer fit or they don't like what is being served. Assess this for the reason.
- Should be able to identify person from the documentation without seeing the name.
- Review documentation prior to submitting to ensure guidelines are followed and you don't need to obtain further documentation from other sources to assist to show patient's eligible and appropriate for hospice.

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Hospice Resources

Medicare Benefit Policy Manual (cms.gov)

www.cgsmedicare.com/hhh/education/index.html

Hospice Documentation Checklist Tool (Home Health & Hospice)(cgsmedicare.com)

J15HH&H FAQs (cgsmedicare.com)

Hospice Quick Resource Tools (cgsmedicare.com)

Appropriate Clinical Factors to Consider During Recertification of Medicare Hospice Patients (cgsmedicare.com)

Suggestions for Improved Documentation to Support Medicare Hospice Services (cgsmedicare.com)

Hospice Documentation: Painting the Picture of the Terminal Patient (ngsmedicare.com)

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Thank You

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