Hospice Documentation

April 2015

Home Health VNA
Merrimack Valley Hospice
HomeCare, Inc.

The Leaders in Home Health and Hospice Care

Objectives

- The participant will be able to discuss Hospice documentation best practices

Hospice Documentation

- Hospice documentation should provide an accurate visual presentation of patient status, describing the condition and symptoms supporting the terminal prognosis
- The clinician's documentation serves multiple purposes, most importantly coordination of care

Hospice Documentation

- The clinician's documentation also serves as a vehicle to assure the patient's status and care is appropriate for the Medicare Hospice Benefit and to meet other financial, quality or legal requirements

Hospice Documentation

- Clinician's documentation needs to substantiate the terminal prognosis with sufficient clinical information to support the patient's initial certification and any subsequent re-certifications

Hospice Documentation

- Since documentation is an accurate record of the patient's status and POC to meet their needs, documentation supporting the terminal prognosis should be consistent in all areas of the medical record, including assessments, progress notes, care planning goals, problems and interventions

Hospice Documentation

- Include documentation that reflects the patient's physical decline or structural/functional impairments over the period of care

- Good documentation (reflecting good assessments and care), intermittently compares the patient's status with baseline data collected upon admission

Hospice Documentation

- The clinician's documentation about the patient enables other healthcare providers providing services to understand the patient's medical history and provide informed care

Hospice Documentation

- **When documenting assessments and care, keep in mind the principles of good documentation:**
  - Accurate
  - Concise
  - Comprehensive
  - Patient centered
- **Do not include unfounded conclusions or personal judgments**

Hospice Documentation

- Medical records and the documentation therein, are legal documents
- They need to be maintained, accessed, and destroyed with a manner consistent with state and federal regulations

Hospice Documentation

- Documentation tells the patient's story
- Admission assessment data alerts the reader to problems, especially the terminal prognosis
- The plan of care outlines how these challenges will be addressed
- The visit notes and other documentation provide detail consistent with the plan of treatment and the patient/caregiver goals

418. 102 Clinical records

Content

Each patient's record must include the following:

1. The initial plan of care, updated plans of care, initial assessment, comprehensive assessment, updated comprehensive assessments, and clinical notes.

2. Signed copies of the notice of patient rights and election statement

3. Responses to medications, symptom management, treatments, and services.

418. 102 Clinical records

Content

Each patient's record must include the following:

4. Outcome measure data elements
5. Physician certification and recertification of terminal illness
6. Any advance directives as described in
7. Physician orders.

Documentation to Support Hospice Admission

- Change in condition to initiate Hospice referral
- Diagnostic documentation to support terminal illness
- Physician assessment and documentation
- Date of diagnosis and course of illness
- Patient has desire for palliative, non-curative treatment (signed election statement)

Documentation to Support Level of Care

- Patient needs or event (symptom control crisis for GIP or CHC, and caregiver need or crisis for Respite) which support higher level of care
- Interventions which were not effective at routine level of care prior to GIP or CHC care
- Continued higher level of care reasonable and medically necessary
- Start/stop time of higher level of care
- Services consistent with plan of treatment

Documentation to Support Hospice Services with Examples of Possible Quantifiable Values/Measures

- Documentation need only include that information that is specific to the patient being assessed

- Examples may include:
  - Change in patient's weight (pounds, kilograms)
  - Worsening diagnostic lab results (increase, decrease)

Documentation to Support Hospice Services with Examples of Possible Quantifiable Values/Measures

- **Examples may include:**
  - Change in pain
    - Type (ache, throb, sharp)
    - Intensity (Level 0–10)
    - Location (upper, lower)
    - Frequency (hourly, daily)
    - Medication usage (dosage, frequency)
  - Change in responsiveness (fading, alert, unresponsive)

Documentation to Support Hospice Services with Examples of Possible Quantifiable Values/Measures

- **Examples may include:**
  - Skin thickness/condition (fragile, intact, tears easily)
  - Dependence on ADLs
    - Occurrences of incontinence
    - Dress (assisted, unassisted)
    - Bathe (assisted, unassisted)
    - Ambulation ability (assisted, unassisted)
    - Ambulation distance (feet, steps)

Documentation to Support Hospice Services with Examples of Possible Quantifiable Values/Measures

- **Examples may include:**
  - Change in anthropomorphic measures
    - Upper arm measurements (inches, centimeters) – MAC consistent measurement BMI
    - Abdominal girth (inches, centimeters)
  - Change in signs
    - Respiratory rate (increased, decreased)
    - Oxygen flow rate (liters)
    - Hyper/hypotension
    - Radial/apical pulse (tachycardic, bradycardic, regular, irregular)
    - O2 Sats

Documentation to Support Hospice Services with Examples of Possible Quantifiable Values/Measures

- **Examples may include:**
  - Change in signs continued
    - Edema (level 1-4, pitting, non-pitting)
    - Turgor (slow, normal)
  - Change in strength/weakness (level 0-5)
  - Change in lucidity (oriented, confused)
  - Measurement/change in intake/output
    - Amount (cups, liters, ounces, teaspoons, mgs, ml, cc)
    - Percentage of meals eaten
    - Frequency
  - PPS decreasing
  - FAST decreasing

Documentation to Support Hospice Physician Services

- Physician is medical director, employee, volunteer, or consultant of Hospice
- Services were provided
- Services were reasonable and medically necessary

Prior to Claim Submission Ensure the Following

- Notice of Election (NOE) was signed and dated at start of care
- Certification/recertification (CTI) was signed and dated according to Medicare regulations
- Plan of Treatment (POT) signed and dated according to Medicare regulations
- The number of days/time and visits for each level of care is identified

Suggestions for Improved Documentation Fact Sheet

- Review “Suggestions for Improved Documentation” fact sheet