Documentation

Train Staff to Support Coverage
(including the newly proposed CoPs)

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Why Are We Here Today?

Documentation affects:

- Compliance with CoPs, state regulations, etc.
- Reimbursement
- Accreditation status
- Legal liability
- QAPI efforts
Why Are We Here Today?

Documentation should:

- Tell the patient’s unique story
- Enable communication/care coordination
- Facilitate care planning process
- Support standards & evidence-based practice
- Provide legal liability protection
- Support need for covered care

Objectives

1. Identify emerging trends that affect documentation standards.

2. Apply the principles of the care planning process to documentation.

3. Document to show adherence to the CoPs, including the new ones.
Trends Affecting Documentation

- Triple Aim Goals of Care
  - Quality, effective, cost-efficient
- Patient-centered – patient’s experience
- Data driven healthcare
  - QAPI – Quality Assurance & Performance Improvement
  - Outcomes & their link to interventions
  - Standardized terminologies
- Safety & quality initiatives
- New COPs: multiple implications
- Competition & growth

Safety & Quality Initiatives

- National Patient Safety Goals initiative
- Institute of Medicine (IOM) goals
- National Healthcare Safety Network (NHSN)
- OSHA Quick Takes
- Medication-Related Safety Initiatives
- Preventable occurrences: Falls, UTIs, Med-related errors
- Hand-overs – Transition / Risk Points on the continuum
- Medicare non-payment “never events” (e.g. UTI, VAP, pressure ulcers, etc.)
New Proposed COPs

- Care planning, coordination of care, & quality of care
- Quality Assurance-Performance Improvement (QAPI)
- Patient rights expanded
- Infection prevention
- Others

Number of Agencies & Costs Rising: Why More Scrutiny in Our Documentation?

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<tbody>
<tr>
<td>Number of Home Health Agencies</td>
<td>10,917</td>
<td>7,528</td>
<td>12,311</td>
<td>64%</td>
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<td>Total Spending in Billions</td>
<td>$17.7</td>
<td>$8.5</td>
<td>$18.0</td>
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Medpac (2014). Report to Congress: Medicare Payment Policy
Integrity 101

- Know the Medicare Home Care or Hospice Benefit Rules.
- These are federal monies belonging to all of us as taxpayers.
- Refer to 42 CFR 409 Medicare Coverage of Home Health Agencies (CoPs)
- Consult your state associations – the experts on local/state/Medicaid/waiver & other state based programs.

Integrity 101

- If it seems duplicative—it probably is—
- Trust your judgment – your license may depend upon it!
- Visit the Office of Inspector General’s website— oig.hhs.gov.
- If you see things that you do not seem “congruent” with the regs...or are asked to do something that is not right--you might want to consider other employment.
**Integrity 101**

- Areas of suspected fraud, waste and abuse:
  - Documenting homebound for patient who is not.
  - Altering records to obtain a higher payment amount
  - Soliciting, offering or receiving payment for referrals
  - Documenting/billing for visits not made.
  - Billing Medicare that don’t require skills of a nurse or therapist.

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**Documentation: Why So Valued?**

- Changing headsets: Only quality care gets paid for
- The questions become:
  - What did I do on this visit that improved patient outcomes?
  - Did I document this value?
- Home Care Compare –One measure of quality
- Patient/referral source experience!
- No sentinel events, no adverse events
- Tracking of incidents, infections, etc. with trending & analysis for prevention.
- Home Health Quality Initiative:
  - www.homehealthquality.org
The Ugly and True

- “Pain feeling fine post-surgery, except pain in right lower leg.” (No further assessment. No FU. Patient died of PE.)
- “Lab reported INR > 9.” No F/U. (Patient died of intracranial bleed overnight.)
- “Pt states pain level of 4/10, tolerable. Pt rates today’s pain as 8/10. Pt doing well. Plan: SNV next week as per POC.”
- “Pain is not well managed. Morphine dose increased from 15mg q4 hrs to 30mg q 4 hours. Plan: SNV next week.”
- “Pt somnolent, non-arouseable. Pt doing well.”

The Ugly and True

- “No BM x 3 days.” Next week: “No BM x 7 days.” No COC, no POC change documented.
- “Missed visit because patient has no skilled need.”
- “Patient returned home from grocery store.” Patient is homebound.”
- Reviewer’s report: “Inappropriate reliance on just checking drop down menus. Each note reads the same and does not create a picture of the patient, or show why/how patient needs care.”
Care Planning Process

...since this is your first day you'll be needing these...
Care Planning Process

Assess -> Identify Problems -> Identify Goals -> Develop Plan -> Implement Plan -> Evaluate

Planning & Providing Care

- Nursing Process
  - Assessment
  - Nursing diagnosis
  - Expected outcome
  - Plan
  - Intervention
  - Evaluation

- Therapy Process
  - Assessment
  - Problem
  - Goal
  - Plan
  - Intervention
  - Evaluation
Documenting Care Planning Process

- Assessment SOC/ROC/Recert OASIS
- Identify problems
- Identify goals Plan of Care (485)
- Plan the care
- Implement POC Follow POC, Visit Notes
- Evaluate Discharge/Transfer OASIS

The POC Drives the Care

SOC Assessment
- Discipline-specific assessment
- OASIS assessment
- Home health specific assessment

Plan of Care (485)
- Diagnoses/Problems
- Goals
- Orders
- Supplemental Orders

Visit Votes
- Assessments
- Interventions performed
- Response to interventions
Assess

- Status at SOC, ROC or Recert
- Assess deficits and needs
  - Risk for hospitalization
  - Medication problems
  - Dyspnea
  - Wounds
  - Depression
  - Functional deficits
  - Incontinence
  - Risk for falls/injury
  - Caregiver problems
  - Knowledge deficits
  - Pain/Other symptoms
  - Palliative/EOL Care

Identify Problems

- Every OASIS assessment item that identifies a deficit is a problem.
  - Not all problems are identified by the OASIS
- All problems deserve care planning
  - Or explain why the patient does not need care for this deficit.
- All problems are related to diagnoses
  - Capture diagnoses in M1020/1022/1024
Identify Goals

- Identify – with the patient – achievable goals.
- Goals patients want include:
  - Less pain
  - Healed wounds
  - Less dyspnea (better CHF/COPD management)
  - Effective nutrition with weight gain
  - Less anxiety & depression
  - Enhanced functional ability (ADLs & IADLs)
  - Good self-management of meds & treatments
  - Less ED visits and hospitalizations

Plan the Care

- Determine strategies to move the patient from current status to improved status & desired outcomes.
- List strategies on the POC.
- Provide specificity in all areas (allergies, DME, etc.)
Implement the POC

- Assess and observe patient’s status
- Teach recovery & self-management strategies
- Perform procedures & treatments
- Manage and evaluate the care plan

Follow the POC!
And document against POC!

Evaluate – on every visit!

- Is the POC working to progress patient towards desired outcomes?

- If not, revise the POC with Interim/Sup Orders.

- Discharge OASIS
  - Were the goals met?
  - What are the outcomes of our care?
The POC Drives the Care

- **SOC Assessment**
  - OASIS assessment
  - Discipline-specific assessment
  - Home health specific assessment

- **Plan of Care (485)**
  - Diagnoses/Problems
  - Goals
  - Orders

- **Visit Votes**
  - Assessments
  - Interventions performed
  - Response to interventions

Documenting Care Planning Process

- Assessment
- Identify problems
- Identify goals
- Plan the care
- Implement POC
- Evaluate

SOC /ROC/Recert OASIS
Plan of Care (485)
Follow POC, Visit Notes
Discharge/Transfer OASIS
Documentation Standards

ANA’s Principles for Documentation

- Reflect nursing process
- Accurate
- Concise
- Complete
- Contemporaneous
- Relevant
Who Is Reading Your Documentation?

- Physicians & team members
- Patients & caregivers (New CoPs)
- QAPI team members working to improve care
- Accreditation & Medicare/Medicaid Surveyors
- Reimbursement reviewers
  - CMS, RHHI, MACs, ZPICs
- Attorneys & juries

What Do the Readers Want from YOU?

- Assessed patient comprehensively ➔
- Identified the patient’s problems ➔
- Determined the achievable goals ➔
- Good care planning (POC) ➔
- Strictly implemented the POC ➔
- Achieved goals & discharged ➔ Terrific outcomes!
How Do the Readers Know?

- How does Medicare/Others know if you are doing what they are paying for?
- How does the jury know if you provided the Standard of Care?
- What is the “value” of your care?

YOUR documentation!

Clinical Record = A Good Story

- Admission Assessment/Evals = Set the scene, engage the reader in patient’s problems
- Diagnoses/Problems = Open major plot & subplots
- Goals = Foreshadow the end of the story
- Plan = Plot line for each diagnosis
- Implementation = Tell the story; Each Visit Note pulls the plot lines through
- Discharge Summary/OASIS = “...And the patient lived happily ever after.”
Documentation that Supports Coverage

- Only way to prove good care was provided (and payer’s rules for getting paid were followed) is to demonstrate it with care & documentation!
- Clinicians/managers/owners need to know/ follow the rules.
- Documentation tells the story.
- Documentation determines a claim’s destiny!
Medicare Criteria for Home Care

- Under care of a physician
- Homebound
- Medically reasonable and necessary care
- Skilled intermittent care
- Communication & coordination of care

All home care criteria must be met in documentation or do not bill Medicare/payer for services!!!
Under Care of a Physician

Must have orders for:
- All services
- Add or delete a discipline
- Change the frequency or duration of any discipline
- Exact and detailed orders for what you do
  - Exact wound care – any changes, need new orders!
    - Sterile water vs. saline (use of evidence-based care?)
    - Op-site vs. tegaderm
  - Apply ice pack or heating pad
  - Pulse ox, blood glucose testing
- EVERYTHING and ANYTHING!!!!

Who does Medicare say is a physician?

Under Care of a Physician

Must do EVERYTHING as ordered:
- Check POC at start of each visit
- Do what is ordered! Or document why not!
- Do only what is ordered – or get a new order!

Signed orders need to be in the chart before billing Medicare/payer.
Homebound

1. Criteria 1: Either-Or
   • Because of illness or injury, to leave home, needs:
     • Assistive device
     • Special transportation
     • Assistance of another person
     OR
   • Leaving home is medically contraindicated

2. Criteria 2: And—BOTH
   • Normally patient is unable to leave home
   • Leaving home requires considerable and taxing effort

Still can be homebound if leaves home...

- Frequently for ...
  - Doctor’s appointments or medical care
  - Certified adult day care

- Infrequently and for short duration for...
  - Faith-based services
  - Haircuts/beauty parlor

Document “considerable & taxing effort” for the patient to get in/out of the home.
Common reasons for homebound...

- Functional deficits
  - Difficulty ambulating, transferring
  - Vision deficit
  - Fraility with assistive devices
- Dyspnea, SOB on ambulation
- Post-op restrictions
- Pain restricting activities
- Cognitive problems
- Patient-environmental considerations
  - Stairs in/out of house

Medicare Reviews Our Documentation for....

- What considerable effort does it take to enable this patient to leave the home?
- What taxing effect does leaving the home have on the patient?

If they don’t see it, they can decide:
The patient isn’t homebound!!!
Documenting Homebound

- SOC documentation needs to paint a clear picture of a patient who requires considerable and taxing effort to leave the home.

  - “Severe DOE, SOB walking across room despite oxygen therapy. Unable to tolerate most ADLs without frequent rests.”

  - “L leg paralysis post recent stroke; unable to bear weight; relies on a wheelchair for movement within his home; home only accessible via stairs.”

- Your homebound examples?

Documenting Homebound...

- Activity restriction: no weight-bearing on left leg; becomes exhausted using crutches.

- Severe osteoarthritis both knees; requires two-person assistance to leave home.

- Stairs into home do not have handrail; patient does not leave home for fear of falling.

- Weight >300 pounds; limits activities to home due to difficulty ambulating & SOB.

- Severe weakness and fatigue, becomes exhausted with minimal activity.
Medically Reasonable & Necessary

- **Reasonable**
  - Services address reasonable goals.

- **Necessary**
  - Services are necessary for the patient’s diagnoses and assessed needs.
  - Each visit is necessary to meet the patient’s goals.

Discipline-Specific Documentation
Requires “Skilled” Nursing Care

1. Observation and Assessment
   • Generally, observation & assessment are reasonable if:
     • Patient’s condition is likely to change; Reasonable potential for complications, further acute episodes
     • Changes in status require change in treatment plan
     • If no changes in status/treatments for 3 weeks, O/A may no longer be “reasonable.”
   • Document:
     • Assessment strategies & parameters appropriate for patients’ diagnoses on POC.
     • All communication with MD about status changes.

Requires “Skilled” Nursing Care

2. Management & Evaluation of Care Plan
   • Skills of RN required to monitor non-skilled care:
     • Involvement of skilled nursing needed to promote recovery and ensure safety with underlying conditions.
     • Complex patients; high-potential for relapse, multiple co-morbidities, re-admissions, safety concerns, etc.
     • Encourage always reviewing care/documentation with clinical supervisor.
   • Document:
     • Pt’s clinical complex needs & caregiver challenges
     • Communication and coordination of care interventions
3. Teaching and Training

- Goal of teaching is effective self-care
- Skilled required to teach vs. nature of what is being taught.
- Teaching & topics to be taught must be on POC
- Teaching is reasonable if pt/cg willing and able to learn.
- Continued teaching when not willing/able is not reasonable.
- Initial instruction reinforcement (e.g. new for patient, why the teaching is needed, etc.)
- Document reasons for re-teaching or re-training (new caregiver, new problem)

3. Teaching and Training (continued)

- Document in patient record:
  - Assessment of factors affecting learning: fatigue, pain, language, literacy, etc.
  - Topic of teaching and who taught (pt, cg, etc.)
  - Document reasons for re-teaching or re-training (new caregiver, new problem)
  - Evaluation method used to determine learning - teach back, return demonstration, behavioral charts/journals
  - Teaching plan for next visit & areas needing reinforcement
Requires “Skilled” Nursing Care

4. Performing Procedures – Med Administration

- Administration of Medications (IV, IM, SQ)
  - Appropriate to diagnosis and Medicare standards
  - Vitamin B12, only for certain diagnoses, only monthly (except in initial treatment period)
  - Insulin: covered when patient physically or mentally unable and no other person willing/able
  - Non-skilled med administration:
    - Oral meds, drops and ointments
    - Pre-filling syringes (others can usually be taught)

Requires “Skilled” Nursing Care

4. Performing Procedures – Wound Care

- Only wounds requiring skilled assessment and intervention are covered
- POC must include exact wound care orders & wound care documentation must match orders exactly
- Document wound assessment – regularly
  - Length, width, depth, undermining, tunneling
  - Drainage: amount, color, consistency, odor
  - Wound edges: attached, rolled, epithelized
  - Wound bed: % granulating, slough, necrotic
  - Periwound skin: intact, macerated, infected, etc.
  - Pain level
Requires “Skilled” Nursing Care

4. Performing Procedures – Urinary Catheter
- Documentation of Urinary Catheter Replacement
  - Patient’s/catheter’s condition pre-procedure
  - Perineal prep performed
  - Catheter type, French size and balloon size
  - Amount of fluid used to fill balloon
  - Color and amount of urine post catheterization
  - Patient’s condition post procedure


Requires “Skilled” Nursing Care

4. Performing Procedures – Many procedures!
- Documentation includes:
  - Patient’s condition prior to procedure
  - What exactly was done, by who, how was it done
  - If products used, exactly what were they, how much was used
  - What were the results: how much was obtained, instilled, etc.
  - Patient’s condition after the procedure
  - Any teaching provided or follow-up taken
  - Any communication or coordination of care needed

Requires “Skilled” Therapy

- Service may be reasonable if:
  - Service is complex, requiring knowledge & skills of clinician
  - Consistent with severity of illness/injury
  - Considered specific, safe, and effective for the pt's condition
  - Provided with the expectation that the condition will improve in a reasonable, predictable period of time
  - Teaching exercises, techniques, precautions based on pt's illness or injury
  - Should have rehab/neuromuscular Dx and if focused on goals which are achievable and working toward is the patient making progress?

Requires “Skilled” Therapy

- Documentation guidelines:
  - Comprehensive assessment utilizing measurable tests (e.g., TUG, Tinetti, etc.)
  - Specific goals stated
  - Functional capacity and deficits: safety, range of motion, ADLs, mobility, strength, balance
  - Changes in functional capacity – describe the clinical condition and status
  - Evidence of care coordination with physician, other team members
  - Support homebound status and medical necessity
  - Describe home exercise program – describe type of exercise, number of repetitions, pounds/weights of each type of exercise
  - Plans for follow-up past discharge
Requires “Skilled” Social Services

o Interventions include:
  o Obtaining community and financial resources
  o Obtaining alternative living arrangements
  o Review of financial status
  o Arrange for meal service, home-delivered medications, etc.
  o Protective concerns
  o Other items where there are impediments to the POC being successfully implemented (e.g., cannot afford medications, no food in the home, safety issues, etc.)

Requires “Skilled” Social Services

o Documentation:
  o Support medical necessity
  o Communication coordination with physician, other team members
  o Intervention/resolution supporting POC being successfully implemented
  o Pt’s problems and goals for SW intervention are clearly stated
  o Unusual home/social environment is documented/identified
  o Clinical findings/developments that impact pt’s ability to participate/follow POC
  o Physician orders describing specifically the need for SW
  o All other clinician team member visit notes are congruent with SW documentation (e.g., infestation, pets, financial problems, etc.)
**Home Health Aides**

**Services May Be Reasonable If:**
- Services meet definition of covered aide services
- Specific physician’s orders for services
- Clear and specific documentation
- SN, PT, ST needed on intermittent basis
- Where there is a continued need for OT alone (in subsequent recertification periods) the patient meets the requirement for the need of a qualifying discipline and home health aide services can be provided

**Reasonable and Necessary:**
- Incidental services can be provided during the course of the visit as long as the primary purpose of the visit is to provide personal care
- Incidental services: light cleaning, shopping, taking out trash, etc.
- The frequency of visits must be reasonable, depending on patient’s condition
- Documentation in the skilled notes must be able to support the frequency of aide services – this is especially important with daily visits
- Note: Aide care & documentation must adhere to the patient’s Aide POC
Home Health Aides

- May be appropriate if:
  - SN, PT, ST needed on intermittent basis
  - Continued need for OT (in subsequent recertification periods)

- Services needed to
  - Facilitate treatment
  - Prevent deterioration
  - Maintain health

- Assessment & OASIS describes patient's functional limitations & inability to perform ADLs

- POC Orders include visit frequency, duration and care (personal care, ADL assistance)

Documenting Recertification

- Review patient admission criteria (e.g. meet criteria, safety, etc.)
- Is the patient homebound?
- Can family members provide needed care?
- Is the patient improving/changing?
- Evidence of care coordination/communication
- Response to medications, new treatments
- Interdisciplinary referrals timely and documentation supports
- MD orders obtained (complete, timely, specific)
- Lab results and coordination communication
- Progress toward goal/discharge
- Caregiver response coping/support
Documenting the New CoPs

Major Influences on New COPs

- Outcomes-driven care
  - Need for documented data
- Patient engagement and participation in care
  - Patient-centered care initiatives
- Interdisciplinary care to improve quality, efficiency, and cost-effectiveness of care
- Documentation as a way to improve care
  - Enables QAPI efforts
COPs & Clinical Records Standards

- Defined as written notation of a contact with a patient which describes S/S, interventions, meds, patients’ reaction & response, physical & emotional changes
- Clear, legible, complete, author identified & credentialed, date and time
- Readily accessible to patient
- Diagnosis, POC, Interventions match
- Patient goals identified – & progress towards goals
- Discharge/Transfer Summary

New COPs & Documentation

- QAPI: Need for standardized terminology
- Team-based care
  - Patient (CG, Rep) as team member
  - Shared decision-making model (patient, home care team, physician)
- Communication and coordination
  - Shared POC, no care silos
  - With patient, representative, and CG
Communication & Coordination of Care

- Notify physician, team members & caregivers of:
  - Changes in patient’s status
  - Changes in POC

- Document:
  - All communication & coordination of care!
  - Telephone calls and voice mails
  - Unexpected joint visits
  - Care conferences: Formal & informal

New COPs & Comprehensive Assessment

- Physical, psychosocial, cognitive, functional status
- Social determinants of health
- Caregivers and support systems
- Patient strengths & goals
- Medication review
- Discharge needs
New COPs & the POC

- Discussed in preferred language of patient and/or representative.
- Improvement, maintenance & prevention goals
- Education & training they will receive
- Copy to the patient

In summary.....
Documentation Processes: What to Avoid

- Information is missing
- Data not complete
- Delayed transmission/submission for billing, regulatory reports for OASIS
- Plan of Care (the “driver”) not being followed
- May reflect poor patient care (from a reviewer perspective)
- Poor communication/no evidence of care coordination
- Increased opportunity for errors
- Notes from different clinicians looks like they are caring for different patients (no congruency)
- Other problems such as accreditation concerns, complaint surveys, increased ADRs, denials, etc.
- Notes give appearance that patient received poor/substandard care
- Illegible writing!!!

Documentation Processes: The Goal!

- When documentation processes/systems work – IT LOOKS EASY!
- All information is aligned, legible, complete and congruent
- Care is coordinated and communicated among/across disciplines, is timely and planned, etc.
- Team members have information needed to coordinate care, review notes, make care decisions, bill, etc.
- When e-documentation is used, information is accessible, timely, and complete
- Problems are “closed out” (e.g. evidence of pain reduction, closing the loop on problems)
Documentation’s 10 Roles

1. Describes patient’s clinical status and needs.
2. Reflects care provided to patient
3. Shows standard of care provided
4. Supports communication, coordination, and handovers.
5. Serves as sole document chronicling care from admission to discharge.

6. Acts as basis for QAPI initiatives.
7. Provides organization with information for data collection and benchmarking
8. Provides basis for coverage & reimbursement.
9. Protects clinician/organization from alleged practice/fraud complaints
10. Recognizes that quality IS IN THE DETAILS.
The Fundamentals Remain

- Telling the story of the patient and the care
- Receiving appropriate reimbursement for quality care (e.g. outcomes)
- The source for communication, coordination, and evaluation
- Key to avoiding in-depth reviews, etc.
- The basis for payment or denial
- The documentation should show the story of “careful” case management
Want an Editable Powerpoint?

Send an e-mail labeled “Powerpoint Request”
to Mary.Narayan@cox.net.

Thank you!!!

References

References


Resources

- [www.marrelli.com/books](http://www.marrelli.com/books)
- [www.vnna.org](http://www.vnna.org)