


Clinician's Connection To Documentation  
Tying Eligibility Assessments to Care  
Planning

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Subscriber Webinar  
April 2014



**HOSPICE FUNDAMENTALS**  
KNOWLEDGE • EXPERTISE • COMMON SENSE

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Today's Plan

- Consider the clinician's role in documentation
- Assist clinicians in making the connection of eligibility assessments to plans of care
- Review Actions of the Prudent Hospice™




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**Documentation: Areas of Focus**

<p><b>Medicare CoPs</b></p> <p><b>State Licensure Rules</b></p> <p>Assessment</p> <p>Plan of Care</p> <p>QAPI</p> <p>Professional Management</p>	<p><b>Medicare Coverage</b></p> <p>Eligibility</p> <p>Plan of Care</p> <p>Levels of Care</p>
<p><b>Interdisciplinary Group</b></p> <p>Assessments</p> <p>Care Provision</p> <p>Making a Difference</p>	<p><b>Professional Standards</b></p> <p><b>Licensure Requirements</b></p>

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### Why Should Clinicians Care?

- Professional responsibility
- Want to know that they make a difference
- Job security
- Good documentation is all you have if ever involved in legal action – supports the care which was appropriately provided
- Supports eligibility so eligible patients continue to receive uninterrupted

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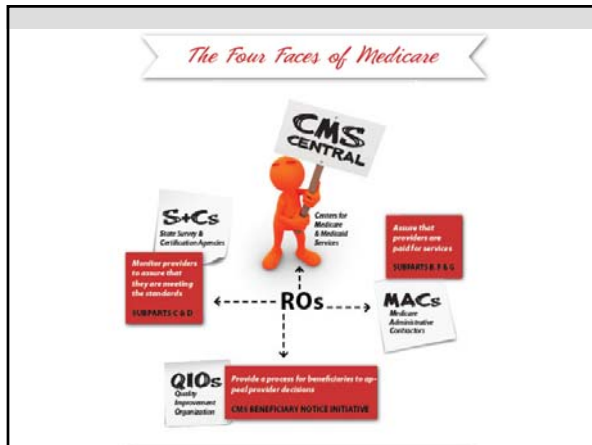
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### Medicare Coverage Requirements

- Medicare wants to know what they are paying for
- They review hospice records and decide whether to pay or not (or take money back)
- Report card
  - A get paid in full
  - C partial payment
  - F free care provided



**It's the evidence**

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### Subpart F – Covered Services §418.200

To be covered, hospice services must meet the following requirements.

1. They must be reasonable and necessary for the palliation or management of the terminal illness as well as related conditions.
2. The individual must elect hospice care in accordance with Sec. 418.24.
3. **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 Sec. 418.56.**
4. **The plan of care must be established before hospice care is provided.**
5. **The services provided must be consistent with the plan of care.**
6. A certification that the individuals terminally ill must be completed as set forth in Sec. 418.22.

Assure that providers are paid for services  
SUBPART F & G

MACs  
Medicare Administrative Contractors

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### The Condition and the 5 Standards

§418.56 IDG, Care Planning & Coordination of Services

- §418.56 (a) Approach to Service Delivery
- §418.56 (b) Plan of Care
- §418.56 (c) Content of the Plan of Care
- §418.56 (d) Review of the Plan of Care
- §418.56 (e) Coordination of Services

S+Cs  
State Survey & Certification Agencies  
Monitor providers to ensure that they are meeting the standards  
STANDARDS C & D

(c) Hospice Fundamentals 2013

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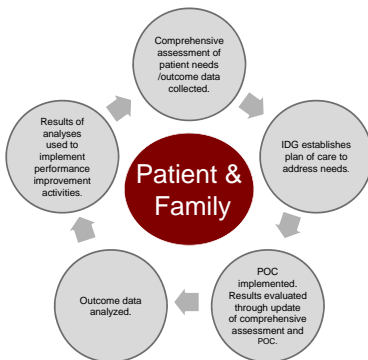
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### The Cycle of Care




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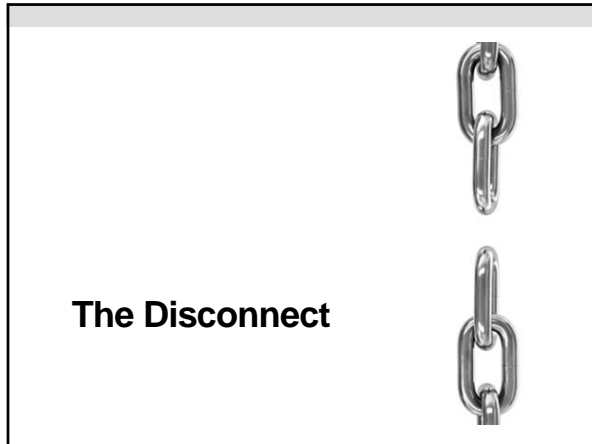
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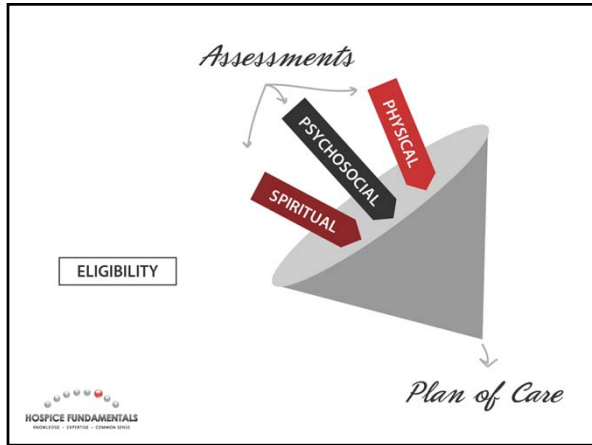
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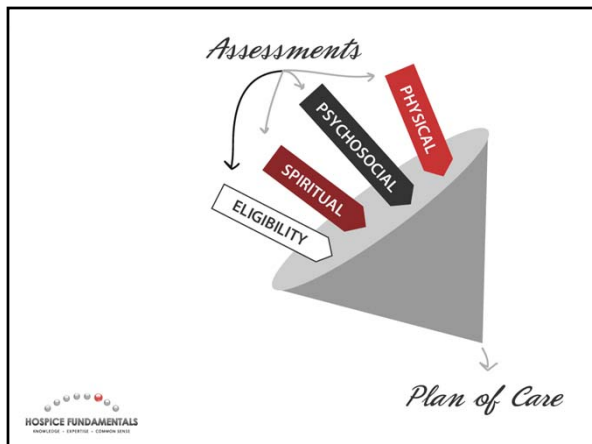
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### Assessments

- Patient symptoms and functional status
- Includes tools/scales
- Determine if care plan is effective
- Revise care plan
  - To meet current needs
- Anticipate future needs
  - Proactive care planning
  - Educate patient and family



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### Tool and Scales

PPS	Palliative Performance Scale
FAST	Functional Assessment Staging for Alzheimer's
NYHA	New York Heart Association PPS
ESAS	Edmonton Symptom Assessment Scale
HIS	Hospice Item Set

Weight/MAC/BMI      ADLs      Others



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### Why Do We Need Assessment Tools?

- Comprehensive assessments
- Care planning
  - Identification of problems
  - Goal setting: Are you making a difference?
- Eligibility determination
  - LCDs
  - 6 month prognosis
- Common language
- Descriptions
  - To improve the subjective description of an objective reality
- Clarification and standardization of documentation



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### Certification of Terminal Illness

- Hospice physician certifies based on the patient's terminal illness and related conditions
- Uses
  - current findings and medication and treatment orders
  - Information about the medical management of unrelated conditions
- Narrative should provide measurable parameters of the disease trajectory

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### LCDs and Care Planning

The identification of specific structural/functional impairments, together with any relevant activity limitations, should serve as the basis for palliative interventions and care-planning.

Palmetto GBA LCDs

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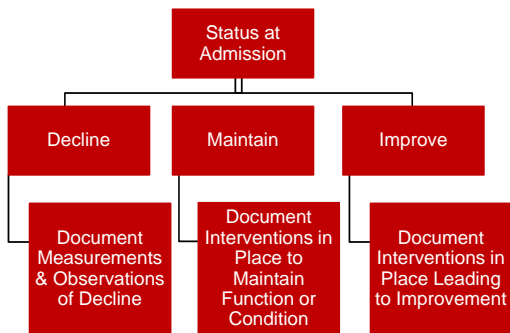
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### Admission Assessment as Documentation Reference Point



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**Care Planning**



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**General Decline**

- FAST, PPS
- Weight loss/decline in MAC/BMI
- Increasing dependence in ADLs
- Dysphagia
- Pocketing food
- Incontinence
- Skin breakdown
- Agitation
- Increased periods of sleeping
- Immobility
- Infections
- Medication changes

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**Connection to Care Planning**

- Weight loss
  - Nutritional assessments
  - Family and caregiver counseling and education food intake and end of life
  - Dietary changes
- Increasing incontinence
  - Skin care
  - Teach caregivers
  - Adult briefs
  - Bedside commode
  - Increase hospice aide visits to support caregiver



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### Activities of Daily Living Measurement Its about self care

ADLs	Describe amount of assistance required
Ambulation	
Continenence	• Independent
Transfers	• Minimal
Feeding	• Moderate
Bathing	• Completely dependent
Dressing	

- Document the level of assistance needed for each ADL
- Be descriptive-use narratives/comment boxes/summaries

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ADL Assistance Guidelines				
ADL	Independent	Minimal	Moderate	Complete
Ambulation	Ambulates without assistance.	Uses walker or cane for ambulation and/or needs standby assistance.	Physical assistance of another person required. Can propel self in wheelchair.	Non-ambulatory. Cannot propel own wheelchair.
Continenence/ Toileting	Goes to bathroom or uses bedside commode or urinal, cleans self and arranges clothes without assistance. Empies urinal or bedside commode. May use walker or wheelchair.	Receives assistance sometimes in going to bathroom or using bedside commode or urinal or in cleaning self and arranging clothes after elimination.	Receives assistance at all times in going to bathroom or using bedside commode or urinal or in cleaning self and arranging clothes after elimination. Incontinent of bowel and bladder occasionally.	Incontinent of bowel and bladder most or all of the time. Cannot go to bathroom or use urinal or bedside commode at all.
Transfer	Moves in and out of bed and chair without assistance.	Needs assistance of device or some assistance such as helping scoot to edge of chair/bed, or steadying chair or walker.	Requires physical assistance of one person who does some of the lifting and balancing.	Doesn't get out of bed unless lifted by person or device.
Dressing	Gets clothes from closets and drawers and gets dressed and undressed without assistance.	Gets clothes from closets and drawers gets dressed and undressed without assistance except for footwear and buttons.	Receives assistance in getting dressed or undressed or stays partly or completely undressed.	Unable to assist in any way.
Eating	Feeds self without assistance. Preparation of food may be by other person.	Feeds self after food is cut up or bread buttered.	Receives some assistance in getting food to mouth and is untidy.	Totally fed or receives tube feedings or IV fluids for nutritional support.
Bathing either sponge bath, shower or tub.	Receives no assistance (gets in and out of shower or tub by self).	Receives assistance in bathing only one part of the body (such as feet or back). Bath / shower or sponge water is prepared by another.	Receives assistance in bathing more than one body part. Bath / shower or sponge water is prepared by another.	Unable to assist in any way.

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### Activities of Daily Living Measurement

Example 1

Dependent in 6 of 6 ADLs at admission and at recertification




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### Activities of Daily Living Measurement

#### Example 2

##### Admission

- Minimum assistance
- Occasional incontinence
- Minimal assistance with transfers
- Moderate assistance with dressing
- Minimal feeding
- Moderate assistance with bathing

##### Recertification

- Moderate assistance with ambulation with rolling walker
- Incontinent bowel and bladder
- Complete assistance with transfers
- Moderate assistance with dressing
- Moderate in feeding
- Moderate assistance with bathing

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### Activities of Daily Living Measurement

#### Example 3

##### Recertification

Mr. Edwards has declined from needing standby assistance with ambulation to requiring the use of rolling walker along with someone to help steady him with a gait belt. He can no longer rise from his bed alone and he must be lifted to a standing position with use of gait belt. He is now completely incontinent bowel and bladder and requires adult briefs. He continues to require moderate assistance with bathing and dressing and gets more easily fatigued during these activities taking longer and having to rest afterwards. He can no longer use utensils, can only feed himself finger foods and has difficulty with getting fluids and takes at least 30 minutes to eat.

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### Connection to Care Planning

#### ADLs

- Equipment
- Increasing visits
- Family relationships/strengths/support
- Future planning for needs




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### End Stage Cardiopulmonary Disease

- NYHA Class
- ADLs/PPS
- Chest pain/tightness
- Dyspnea
- Oxygen usage
- O2 sats
- Productive cough
- Lung sounds
- Irregular rhythm/resting tachycardia
- Weight gain/loss
- Edema
- Hypotension
- Energy level
- Sleep disturbances
- Appetite
- Confusion/impaired memory/slowed
- Weight loss/cachexia
- Respiratory infections
- Medication changes

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### Connection to Care Planning

- Dyspnea
- Disabling
    - Affects on ADLs
    - Further loss of independence-psychosocial needs
  - Oxygen
    - Teach safety
    - Increased flow
  - SVN/Inhalers -
    - More frequent use
  - Advance care planning
  - Energy conservation
  - ADL assistance
  - Pain management
  - Increase hospice aide visits to support caregiver
  - Medication management and education



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### Connection to Care Planning

- Weight gain secondary to fluid retention
  - Fluid retention
  - Pulmonary congestion
  - Increase oxygen
  - Adjust medications
  - Increase visits



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### Pain

- Physical, spiritual and emotional pain
- Standardized scales
- Chest pain-use of NTG and effectiveness
- Increasing pain
- Increasing medication
- Nonpharmacological interventions
- Constipation
- Disease progression
  - Interpersonal relationships/family support
  - Advance care planning
- Effectiveness of plan of care



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### Effective Use of Tools Requires

- Determination of standard tools
- Definition of how it works in your documentation system
  - Consistent understanding of how it scores
  - Same place
  - Run reports



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### Actions of the Prudent Hospice™ Making the Connections

- Educate staff on importance of documentation
- Monitor and audit those most important areas
  - Prebilling
  - Report in usable manner
  - Connect results to what is important to clinicians
- Look at how well your ADL assessments are
  - documented,
  - connected to care planning and
  - support decline
- Accountability
- Performance appraisals



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### Summary

- Assessments drive care planning
- "Eligibility" assessments
  - Affect care planning
  - Support eligibility
- Connect all assessments to care planning
- The more comprehensive and descriptive the assessments the better care planning and ultimately the care of the patient

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### To Contact Us

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**HOSPICE FUNDAMENTALS**  
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# ADL Assistance Guidelines

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\*These are guidelines to provide a common descriptive language and will need to be modified for your documentation system/EHR. They are based on language using "Independent, Minimum, Moderate and Complete" and are adapted from *Katz Index of Independence in Activities of Daily Living (ADL)* and *Lawton and Brody Physical Self Maintenance Scale*".