

## Clinical Documentation and Audits – The Clinician Connection

Ask the Experts  
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## What you will learn

- The purpose of documentation
- The role of the clinician in documentation
- Helping clinicians make the connection
- The use of monitoring and auditing processes to improve success in medical review audits and Medicare surveys



## Documentation is ...

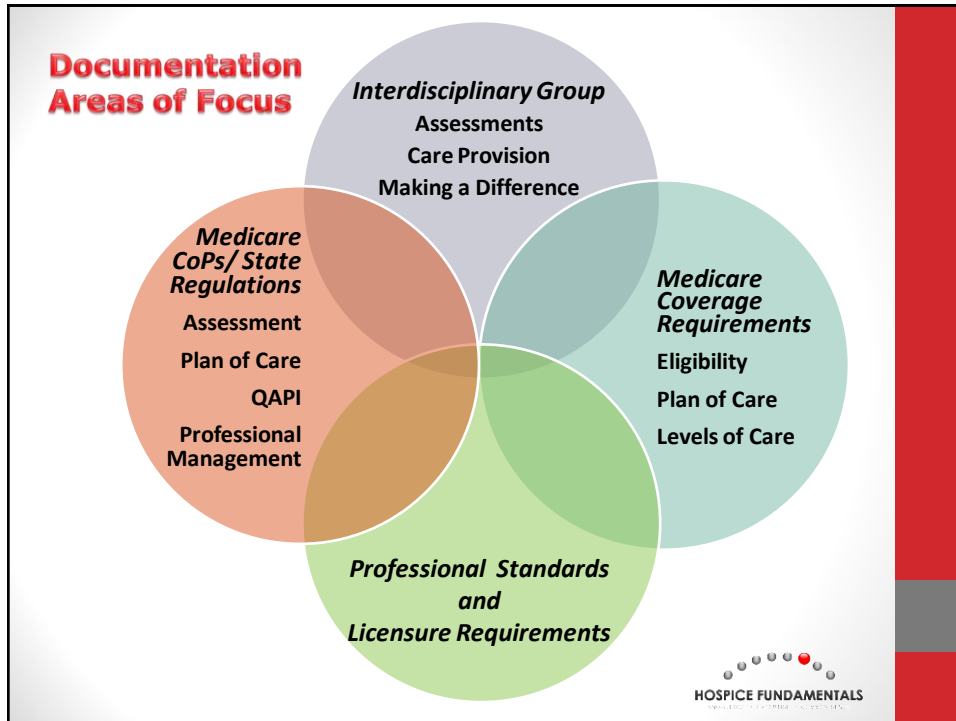
- Is to give written information that is proof or support of something that has been done or observed
- Documentation is communication
- Documentation of care is synonymous with care itself



## Documentation is not ...

- An afterthought
- Something I have to do that has nothing to do with the care of the patient and family
- Something to be done at 10 pm at night after the kids are in bed and...
- Ever heard (or said) this:
  - She's a really good nurse (substitute chaplain, social worker, physician) but her paperwork/documentation is poor (vague, illegible, disjointed, late, etc.)
  - Sure we wish we could read his/her notes





- ## Why Documentation is Important
- Legal document
    - Only document that chronicles patient's time in hospice
    - Assume it will be scrutinized by somebody at some point
  - Fundamental component of your practice - accountability
    - Assessment
    - Professional practice
    - Professional judgment
    - Critical thinking
- HOSPICE FUNDAMENTALS

## Why Documentation is Important

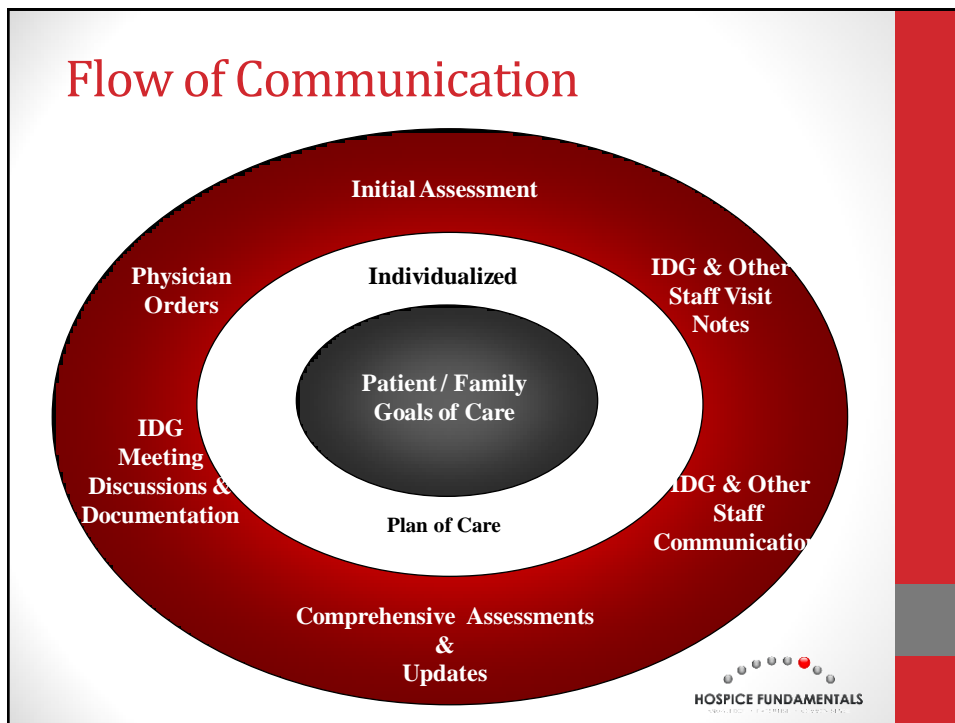
- Good compliance
  - Establishes and supports eligibility for the Medicare Hospice Benefit
  - Supports eligibility for the level of care
  - Determines proper reimbursement
  - Supports compliance with the Medicare CoPs, state licensure regulations and accreditation standards
  - And good compliance supports good care



## Why Documentation is Important

- Good care
  - The final chapter of the life story of a person
  - Subjective description of objective reality
  - How we communicate about the patients' and families' needs, goals and care
    - Accurate & detailed documentation reflects their most pressing needs, which in turn should foster good care
  - Provides a mechanism for understanding what is working and what still needs to be managed effectively
    - Effects care decisions
    - Communicates the patient and family needs and care provided to the IDG





- ## Why Documentation is Important
- Outcomes of care provided -progress towards goals
    - Validates that hospice makes a difference
    - Patient outcomes are valid indicators of the care provided
    - QAPI
  - Standardization of care
    - Assessments drive plan of care
    - Care provided in accordance with plan of care
    - Outcomes (progress or lack of progress towards goal) leads to changes to plan of care
- HOSPICE FUNDAMENTALS

## Documentation- Who is the Audience?

- IDG
- Quality reviews
- Surveyors (state, Medicare, accrediting bodies)
- Medicare (MACs, RACs, ZPICs, MICs)
- OIG
- Attorneys

**And what are they looking for?**



## Standards of care

- Documentation supports that you have:
  - Assessed, analyzed, and acted according to level of care needed by the patient
  - Identified patient needs and implemented appropriate POC
  - Determined the patient's wishes concerning self-determination
  - Communicated promptly any significant change in the patient's condition or response to care
  - Taken appropriate action
  - Protected patient privacy
  - Acted as patient advocate



## Medicare CoPs, state licensure requirements, accreditation standards

- Common Documentation Related Medicare Survey Deficiencies (keep in mind this is solely based on the documentation reviewed by the surveyor)
  - Care and services do not follow an individualized plan of care
  - Plan of care does not reflect patient and family goals and interventions based on the problems identified in the assessments and must include all services necessary for palliation
  - Comprehensive assessment not updated and plan of care not reviewed and revised as frequently as patient's condition requires but no less than every 15 days
  - Drug profiles incomplete
- Quality measures reporting



## 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**



## Medicare Coverage Requirements

- Eligibility-documentation that supports the patient has a prognosis of 6 months or less
- GIP and CHC-documentation that supports the higher level of care
- Certification/recertifications
- Plan of care-established before care provided and care provided according to POC



## Medicare Coverage Requirements- Why Care?

### It's the "New Reality"

- Increased scrutiny by the various entities
- Increased enforcement of documentation requirements
  - Administration pursuing initiative to cut improper payment rate for fee-for-service providers in half by 2012 (that's right now)  
[note – hospice is a FFS provider]
  - OIG recommended that CMS and its contractors focus on error prone providers [yes, hospice is part of this group also] and
  - CMS is increasingly tasking contractors to review medical records to prevent improper payments





## Why Should Clinicians Care?

- Want to know that they make a difference
- Professional responsibility
- Pride in care provided (outcomes)
- Supports eligibility so eligible patients continue to receive uninterrupted
- Job security
- Good documentation is all you have if ever taken to court /  
deposed – supports the care which was appropriately  
provided



## Eligibility Documentation Principles-Paint the Picture



## Painting the Picture

- Comparison charting
- Subjective writing
- Use of comment boxes
- Clear and detailed descriptions
- Specific discipline's documentation
- Illustrate why beneficiary is considered terminally ill
- Consistent understanding and use of assessment tools



## Assessment Tools in Hospice

- Functional performance measurement tools
  - Karnofsky Performance Scale (KPS)
  - Palliative Performance Scale (PPS)
  - Functional Assessment Staging (FAST)
  - Activities of daily living( ADLs)
  - New York Heart Association Classification (NYHA)
- Nutritional status measurement tools
  - Weight scales
  - Body Mass Index (BMI)
  - Mid Arm Circumference (MAC)



## Assessment Tools in Hospice

- Cognition measurement tools
  - Mini-Mental Exam
  - FAST
- Pain and Symptom Measurement Tools
  - Numeric (0-10)
  - Faces
  - Nonverbal (PainAd)
  - Edmonton Symptom Assessment Scale (ESAS)
  - The Missoula-VITAS Quality of Life Index (MVQOLI)
- Wound staging



## Common Documentation Challenges

- Admission documentation does not contain description of why hospice/why now and what patient “looked” like 3 to 6 months ago
- Inconsistent
  - FAST 7C but chaplain states patient told him about his Navy days
  - PPS 30% but documentation describes patient ambulating with a walker
  - Weights 121 pounds one month and 142 pounds the next
- Imprecise
  - “Assist with all ADLs”
  - “Weight loss” or “estimated weight”



## Common Documentation Challenges

- Using words like ... stable, unchanged
  - Document abnormal findings consistently
  - Need to have the associated contextual description
- Failure to regularly weigh or measure
  - Obtain baseline measurements
- No consideration of intensity of care
  - Plan of care
  - Patient has had no skin breakdown due to the 24 hour RTC attention provided by daughters turning ever 2 hours
- Failure to report injuries or falls, episodes of confusion or abnormal behaviors
  - Document them all in the record



## Connection to the EMR

- "Click and save"
  - Should use free text/comment/narrative options to avoid boiler plate information
- Overuse of cut and paste
- Recurring documentation
- Last visit documentation is starting point for next visit's documentation (cloning)



# Monitoring and Auditing-Making the Connections



## Purpose of Monitoring and Auditing

- Unmonitored key processes tend to decline over time
- Designed & implemented correctly
  - Provide information concerning effectiveness of key processes problems timely
  - Helps know where to focus education and process changes
  - Produce more accurate & reliable information for decision making
  - Prepare accurate & timely compliance reports
  - Supports an effective QAPI and compliance program



## The Basic Principles

1. The question to be answered is meaningful and is clearly, concisely and rationally formulated
2. The methodology is logical, appropriate, and passes the group wisdom test
3. The data collection process is feasible and provides valid, reliable, discriminatory and actionable data



## Principle 1: Formulating The Question

*The question to be answered is meaningful and is clearly, concisely and logically formulated*

- What is being audited?
- What exactly do you want to know?
- What makes it important to know?
- Will the question, as formulated, give you that information?
- How will you get the information?



## Examples-Does this question provide you what you need?

“Does the documentation support the patient’s eligibility?”

Apply the test questions

- What is being audited?
- What exactly do you want to know?
- What makes it important to know?
- Will the question, as formulated, give you that information?
- How will you get the information?



## A Better Way to Ask the Question

Which now becomes several questions to get at what you want...

- Is there a weight or MAC on admission?
- Is there a weight or MAC, at minimal, this recertification period?
- Are they consistent (do they make sense)?
- Do they show a decline?



## Example-Does this question provide you what you need?

Was patient's pain comfortable at 48 hours?

- What is being audited?
- What exactly do you want to know?
- What makes it important to know?
- Will the question, as formulated, give you that information?
- How will you get the information?



## A Better Way to Ask the Question

Which now becomes several questions to get at what you want...

- At the initial assessment did the patient self report they were uncomfortable due to pain?
- Did the patient self report he was no longer uncomfortable due to pain within 48 hours of admission?
- When did follow up screening occur?





## Principle 2: The Methodology

*The methodology is logical, appropriate, and passes the group wisdom test*

How will it be structured?

What is the plan?



## Plan

- Define the purpose
- What will be audited?
- How many?
- What period of time (focus on prebilling for payment requirements)
- Who will do the audits?
- How will they know how to use the tool?
- Will there be a test of the tool first?
- How will results be documented?
- How will results be reported?
- What will you do with results?



## Principle 3: The Data Collection

*The data collection process is feasible and provides valid, reliable, discriminatory and actionable data*

- What measurement tool will be used?



## Measurement Tools

- For a measurement to be meaningful, it must present data that can be acted upon
  - Valid – demonstrates that it measures what intended to
  - Reliable – results are consistent
  - Discriminatory – detects differences
  - Feasible – burden of measurement acceptable
  - Actionable – can do something about it
- What gets measured gets addressed
- Are a means to an end



## Qualities of Good Measurement Tools

- Affects lots of patients – high impact
- Simple, understandable, rational and repeatable – easy to interpret
- Shows a trend
- Clearly defined
- Is efficient to collect
- Is timely
- Measures the process/outcome want to know about
- Presents data that allows appropriate action to take place



## Unintended Consequences of Measurement Tools

- Burden & expense of measuring outcomes that may not be able to alter
- Results of poor audits may look as valid as the results of good audits
- Using resources assessing problems to the detriment of equally or more important problems not being assessed
- Doesn't measure what was intended yet use the results to make decisions



## Write Measurement Specifications

- Define the indicator to be measured
- Simple questions that will provide the needed information
  - Only one right answer (yes/no)
  - Be careful of the “not applicable”
- Decide on data source & data collection method



## Test the Tool

- Pilot test feasibility of measures & data collection method
  - Does it need to be more detailed
  - Is the data available
- Test reliability
  - If repeat the measure – will get the same results
- Test validity
  - Does it measure what it was meant to measure
- Revise tool based on what was learned



## Determine the Scoring

- Specify how measure will be scored
- Define acceptable performance
  - All stakeholders need to agree on what is acceptable
- Interpretation of test results
  - Must be presented in a meaningful way
  - How will it get communicated
  - Who needs the information



## Word About Thresholds

- How do you set thresholds?
- Should it always be 100%
- What is the organization's risk tolerance?



## The Most Common Audit Pitfalls

- Starting with an ill-formed question
- Trying to create one tool that measures everything
- Staff have not been adequately trained in the use of the tool
- Results based on too small number to make valid interpretation
- Constructing measurement tools designed to make everything look good rather than reality
- Assuming the answer
- Discounting the results
- Unwieldy data collection process
- Self monitoring & then using the scores/results as part of a bonus structure
- Stakeholders doing own auditing without checks and balances in place



Audit Tool			
Date: ___/___/___ Dates Reviewed: ___/___/___ through ___/___/___ DX: _____			
Patient: _____ Admission/Ongoing (Circle One) Location <input type="checkbox"/> Home <input type="checkbox"/> NF <input type="checkbox"/> GIP: _____			
1.	Weights (MACS is cannot weigh) are present	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	
2.	Weights support decline	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	
3.	Assistance with ADLs is descriptive	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	
4.	Assistance with ADLs supports decline	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	
5.	PPS is present	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	
6.	Documentation supports the PPS score	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	
7.	FAST is present	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	
8.	Documentation supports the FAST score	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	
9.	NHYA Class is present	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	
10.	Documentation supports the NHYA Class score	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	

## What documentation should you make sure is in really good shape?

- The picture of the patient as terminally ill
  - Nail the basics right now
- Certifications / recertifications
- Coordination of care especially with the nursing facility
- GIP and CHC levels of care-the crisis/symptoms you are treating and response to care
- Outcomes-Patient related



## Connections

- Educate staff on importance of documentation
- Monitor and audit those most important areas
  - Keep it focused
  - Peer reviews
  - Report in usable manner
  - Connect results to what is important to clinicians
- Maybe there is a PIP in the making!
- Celebrate improvements
- Team competition
- Accountability
- Performance appraisals



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