MVH HOSPICE ORIENTATION
DOCUMENTATION: THE BUSINESS SIDE OF HOSPICE
2011

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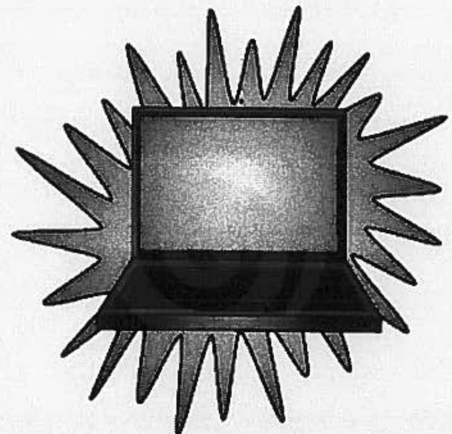

ELIGIBILITY FOR HOSPICE CARE

A person is eligible for hospice care if the prognosis is 6 months or less, if the disease runs its normal course. Upon referral, the diagnosis is verified to ensure it is a diagnosis that is appropriate for hospice.

HOSPICE DIAGNOSIS

Hospice requires a specific diagnosis. For example, we cannot use "history of lung cancer" or "history of recurrent pneumonia." "V" codes cannot be used.

Cancer Diagnosis

Always use the primary site as the principal hospice diagnosis (even if the primary site has been removed, e.g., breast cancer with mastectomy, lung cancer with lobectomy, osteosarcoma with amputation)
Metastases are a secondary diagnosis, unless the primary site is unknown, such as liver or brain lesions with unknown primary site. Secondary diagnoses are noted in the clinical summary.

Non-Cancer Diagnosis

Red flags are:

- Pneumonia/Sepsis (use only if the patient meets criteria for decline and has pneumonia/sepsis that is not responding to treatment, or further treatment is not pursued)
- Debility/Failure to Thrive (to be used as a "last resort" for the patient who has either multiple medical diagnoses, which, in their entirety constitute a terminal condition – e.g., IDDM, CRF, PVD with cellulitis, but none of which on its own is the terminal condition.)
- Be as specific as possible with heart disease, pulmonary disease, stroke/coma, liver disease, and renal disease, or other diagnosis.

Election of Medicare Benefit

All patients sign the general Hospice Election Form. For Medicare and MassHealth patients, the Election of Benefit/Informed Consent form is a basic requirement for coming on hospice. If a patient has MassHealth, they also must sign the MassHealth Hospice election form. If the patient is unable to sign because they are too ill, have dementia or are unresponsive, the patient's authorized representative may sign. The

reason the patient is not signing must be documented. A patient who is able to make his/her own decisions, but who has a physical impairment (blind, arm/hand limitations) can sign with an "X" with a note that the patient signed this as their legal signature.

It is not OK for the legal representative to sign for a competent patient, if the reason is to keep the patient from knowing they are on hospice. The Hospice Election Form is very specific about the patient being informed about the goals of hospice care. This has to be explained to families as part of the orientation to MVH.

Tip: If a patient is not eligible for Medicare or Medicaid on admission, but later becomes Medicare or Medicaid eligible, they must sign a new Hospice Election Form because there will be a new election date.

Certification

The attending physician must certify that the patient is eligible for hospice, based upon a prognosis of 6 months or less. Only a physician can certify for hospice, a nurse practitioner cannot. The Hospice Medical Director also certifies the hospice admission. Subsequent certifications (90-90-unlimited 60 days for Medicare & MassHealth) are signed by the Hospice Medical Director. The Hospice Medical Director is responsible for writing a short narrative that supports the need for hospice care, at the initial certification and at re-certification. For Medicare patients coming on hospice at their 3rd or greater certification period, a "face to face" visit by the medical director or nurse practitioner is required prior to admission.

Supporting Medical Information

Medicare requires that the medical record include information that supports the prognosis of 6 months or less. This may include hospital discharge summary, operative notes, history and physical, physician office notes, and test results. The HHVNA medical record printout or other VNA information is not sufficient.

Local Coverage Determination/LCD or "Unipolicy"

These are diagnosis-specific guidelines used to help determine hospice eligibility.
There are LCDs for:
Cancer
Pulmonary Disease
Liver Disease
Renal Disease
HIV
ALS
Heart Disease
Stroke/Coma
Decline in Health Status
Alzheimer's Disease & Related Disorders

- The "Unipolicy" form in the clinical record is completed by the admission nurse upon admission and by the primary nurse at recertification.

Medication Profile
All medications are listed on the profile. Each medication must include the following:

- Drug name (*Tip: use generic or brand name as ordered by physician*)
- Dose
- Route
- Frequency
- Indication
- Covered by MVH or not (*Tip: patient's with diagnosis of "debility" and "failure to thrive" have all medications, including diabetic medications, covered. There must be a really good reason not to cover medications for these diagnoses.*)

Over-the-counter, herbals and investigational drugs and medications not covered by hospice are included on the medication profile. Oxygen is also included on the medication profile.

Official "Do Not Use" List:
The following abbreviations and practices are associated with medication errors, and therefore may not be used in any part of the clinical record:
U (for unit)
IU (for international unit)
QD – once daily
QOD – every other day
Trailing zero
Lack of leading zero
The complete "Do Not Use List" is at the end of this document.

The medication profile is kept up to date with new medications, changes in current medications and discontinuance of medication.

ASSESSMENTS & PLAN OF CARE & DISCHARGE PLANNING

As part of the admission process, the Admission Nurse completes an assessment, This assessment forms the basis for the Plan of Care. This assessment includes initial psycho-social, spiritual and bereavement assessments.

The comprehensive assessment, which includes the full psycho-social, spiritual and bereavement assessments is required to be completed within 5 days. The admission nurse identifies patients and families with urgent needs as part of the admission assessment.

Consideration needs to be given to discharge planning at the time of admission. Unless the patient is near death at the time of admission, the possibility of stabilization and discharge needs to be addressed. Non-cancer diagnoses are at higher risk for stabilization and discharge. The following factors will have an impact on discharge planning:

- Where the patient lives – own home, apartment, assisted living, nursing home, family member home

- With whom the patient lives – presence/absence of actively involved care-giver
- Payment source – If long term care is even a remote possibility, the MassHealth application process should be started for patients who may meet eligibility criteria.

The primary nurse reviews the admission information when assuming care of the patient.

- Updates should be made to the Hospice Aide Care Plan if indicated, as more will be known about the patient's needs.
- The primary nurse should also review the hospice diagnosis and ensure that it is appropriate, review the supporting documentation, and ensure that the medication profile is accurate and complete.

All team members contribute to the development of the IDT Plan of Care

- Add/delete/modify problems and interventions based on that was learned from completing the discipline assessments.

If the patient/family would like the support of a volunteer, the volunteer referral process is initiated.

ONGOING DOCUMENTATION OF CARE AND SERVICES

Telling the Story

Documentation in the medical record must ***continuously support*** the need for hospice care. Each discipline has its own formatted visit note.

- **Prepare for the Visit**
    - Why is the patient on hospice?
    - Make sure you know what the patient's hospice diagnosis is.
    - What is the Plan of Care?
    - What symptoms and problems have been identified as priorities?
    - Review the visit notes for the most recent visits – your own, other nurses and other disciplines
    - What is the status of the priority problems per the POC?
    - Are there any new issues or concerns identified?
    - What are your goals for today's visit?
    - What issues are you going to address?

- **Documenting the visit**
    - Address each domain (section) on the visit note
    - Address the status of active problems, including interventions and response to interventions (e.g. increase in pain medication) and summarize changes in the patient's clinical condition.
    - Identify action items such as calls to physician, needed medications or supplies, referrals, etc.
    - Add a narrative only if there is additional information that cannot be addressed via the formatted note.

- Stay away from over-documenting minutiae. Unless it has some clinical relevance, where/what the patient was sitting, wearing, watching, or eating does not need to be mentioned.

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Non-Clinical Narrative:
Patient sitting in recliner, wearing Red Sox cap, watching TV. Wife says he's not eating much. Legs look good. Wife says that daughter is coming from California next week. They may go to Mohegan Sun for the weekend. Patient says he plans to win a million.

Patient sitting on porch when I arrived. Pleasantly confused and drinking a beer. Will talk to daughter about nursing home placement and private pay support.

Clinical Narrative:

Patient's daughter contacted me regarding her mother's increased confusion and inability to care for self. At this visit, the patient was clearly much more confused, and did not recall that we had met. Her confusion is such that she cannot be left alone in the home. Discussed further with daughter who greatly prefers to try private pay help rather than placement. Provided daughter with a list of agencies.

General Inpatient Level of Care

Appropriate reasons for the GIP level of care are pain and symptom management and care of the patient with skilled needs when there is a caregiver crisis. The GIP Learning Module is included in the Appendix of this manual.

Documentation for GIP:
For GIP patients in the hospital or nursing home, there must be a daily visit by a nurse. In all settings, GIP documentation must focus on target symptoms, and the reasons why GIP continues to be appropriate.

IDT FORMS AND DOCUMENTATION

Elements of IDT Documentation

IDT preparation note
Prior to the next IDT, review the patient's current problems and update as indicated.

- Add new problems and discontinue any problems that have been resolved.
- All active problems must be addressed in the IDT meeting note.
- Briefly note the current status of the problem – worse/same/better
- Describe the plan for addressing the problem over the next 2 weeks

IDT meeting notes need to be focused on things that can be measured.

RN Case Manager

- PPS score
- Weight loss (how much)
- Arm circumference

- % of time sleeping
- % of meals eaten
- Pain score & pain management – med increases, changes
- Infections
- Status of other S/S:
- For example:
    - Dyspnea
    - Ambulation
    - Swallowing
    - Elimination
    - Edema
    - Ascites
    - Wounds
    - Change in MS or mood
- If GIP, why appropriate
- If discharged is being considered, status of issues that support improvement or stabilization and support prognosis of greater than 6 months

<u>Social Work</u>

- Document current issues and problems being addressed:
    - EOL preparation
    - Bereavement needs
    - Financial concerns
    - Discharge planning for patients who may be discharged

<u>Chaplain</u>

- Document current issues and problems being addressed
    - EOL preparation
    - Bereavement needs

<u>Examples</u>

<u>IDT Preparation/Follow Up</u>
<u>RN</u>
#1
Dyspnea – a bit worse at rest – hot weather really bothers. Son to install AC this w/e. Encourage more frequent Roxanol use and O2 during the day.

#2
Dysphagia – more difficulty swallowing d/t tumor growth. Now eating only ice cream, pudding and a bit of baby food. Wt down 4 pounds in 2 weeks. Will review s/s of dying with spouse and response to choking episode.
Skin – Stage III pressure ulcer on coccyx – unchanged. Pt unable to tolerate being up in chair now. Continue wound care.

#3
Ascites – Increasing SOB d/t pressure. Abdominal girth up to 54 inches, refusing paracentesis.
Confusion – spouse reports less confusion with regular Lactulose dosing. Encourage and support regular medication schedule.

SW
#4
Anxiety – Pt. reports feeling panic re: impending death. Not sleeping more than 2-3 hours per night, can't eat d/t nausea. Massage/Reiki to be scheduled. Encourage use Lorazapam for anxiety, sips of ginger ale and dry crackers for N&V. Volunteer to start this week for companionship and errands.

#5
Preparation for death – Patient has yet to make plans for funeral or burial. Spouse refuses to discuss. SW will visit next week and try to begin to address planning with patient and spouse.

CHAPLAIN
#6
Alienation from church – Patient had been very active in local Catholic Church until her divorce 20 years ago. She now wishes to reconcile and has asked chaplain to contact priest for her.

UPDATING THE POC/POT BY ENDING OR ADDING PROBLEMS AND INTERVENTIONS

- POC will be changed when new problems are identified, problems are ended, interventions are added or ended
  - Examples of new problems:
    - Patient on service for 6 weeks has been in slow decline, now unable to sleep
    - Patient recently started on morphine develops constipation
    - Patient alleges her daughter slapped her
  - Examples of ended problems:
    - UTI successfully treated with antibiotic
    - Urinary incontinence relieved with Foley catheter
    - Nausea/vomiting relieved with Haldol
  - Examples of added interventions:
    - Medication changed to infusion pump
    - Wound consult for decubitus ulcer
    - O_2 added for respiratory distress
  - Examples of ended interventions are:
    - Use of wheelchair for patient now bed-bound
    - d/c monitoring of abdominal girth
  - Examples of things that are *not* new problems are:
    - Patient admitted who is already on a pain medication
    - "Alteration in comfort – ongoing pain management" is selected

- After a week on hospice, the patients been is no longer well-controlled, pain 8/10 on several days
- RN consults with medical director and attending physician and Roxanol dose is increased

  - This is not a change in the POC – "medication adjustment per physician order" was selected as an intervention
  - The reason for the medication change is documented in the nurse visit note via pain assessment and call to attending and medical director
  - The signed order from the attending physician documents his/her concurrence
  - The medication profile is updated to show the new dose

Ongoing visit notes document response.

Palliative Performance Scale (PPS)
This is a clinical assessment instrument developed at the Victoria Hospice that is used to assess the functional status of palliative care patients and to communicate their status among care provider team members.

The first PPS is done by the admission nurse . A subsequent PPS score is done for each IDT review. Over time, the expectation is that the score will go down, following the patient's declining status.

Score the PPS as a team, getting input from all members. Seeing the patient from different perspectives, at different times, and for varying reasons will have an impact on the score.

Tip: There are no "halfways" with the PPS – a score of "45" is not an acceptable PPS score.

THE RECERTIFICATION PROCESS

Based on the Medicare Conditions of Participation, patients are reviewed at intervals of 90/90/unlimited 60 day periods. The purpose of recertification is to ensure that the patient continues to meet hospice eligibility requirements.

Case managers are expected to keep track of their patients' recertification dates.

- Recertifications should be completed before the last day of the current certification period, and must be completed within 2 days after the certification period ends.
- Recerts may be completed up to 2 weeks in advance. If a recertification is not timely, the care cannot be billed.

Preparation for Recertification

The case manager has primary responsibility for the recertification. Each discipline is responsible for participation in the recertification process and must be prepared to contribute to the recertification discussion.

- Review documentation in medical record (nurse visit, social work, spiritual care, home health aide) to ensure that the need for continued hospice care is clearly documented.
- Prepare summary (notes to yourself, nothing formal) to present to IDT for consideration of recertification.
- If there is any doubt about continued eligibility, ensure the discharge plan is up to date.
- The medical director may make a visit to the patient to determine continued hospice eligibility. This is documented on the physician visit form. If the patient has Medicare and is in the 3rd or greater certification period, a face to face visit is required.
- Recertification cannot be for the purpose of discharge planning. The patient must either be discharged before the end of the current certification period, or the care cannot be billed.
- Confer with other team members prior to the recertification discussion at IDT.
- Complete Unipolicy
- Review and update the Hospice Aide Care Plan
- Review medication list and make sure it is updated
- Revise orders to be sent to attending physician
- The Medical Director will sign the recertification based upon the recommendation of the IDT.

Leaving Hospice – Death, Discharge, Revocation & Transfer

All patients leaving MVH get a Discharge Summary. The Discharge Summary is completed and sent to the attending physician, and filed in the medical record. Other forms may be required as explained below.

Death

The pronouncement form in the clinical record is completed by the nurse who pronounces death in accordance with an order from the physician. Massachusetts and New Hampshire have different state forms for pronouncement of death.

Transfer

If the patient is transferring to another hospice, the Change of Designated Hospice Form is completed. Pertinent medical information per policy MVH Policy 9064 is faxed to the receiving hospice.

Discharge

Patients may be discharge from hospice for several reasons:

- Moving out of the area

- No longer terminally ill (improvement in health status)
- Safety issues that cannot be resolved (extremely rare)

For Medicare patients, if the discharge is because the patient has been determined to no longer be terminally ill, the Medicare Notice of Provider Non-Coverage is issued to the patient/family. A member of IDT, usually the nurse or the social worker, will deliver the Notice. The family has the right to an expedited appeal through MassPro. The MVH Performance Improvement Coordinator will fax a copy of the medical record to MassPro upon notice that the patient/family is appealing the discharge. If an appeal is filed, the Detailed Notice of Non-Coverage explaining the reason for discharge is completed by MVH and given/mailed to the patient or family.

Revocation

The patient can revoke the hospice benefit at any time. The revocation must be in writing. We encourage that the MVH Revocation Form is used and the reason for revocation is stated. However, the patient/family does not have to use the MVH form, and a reason for revocation is not a requirement.

SPECIAL FORMS

Incident Report

A ***reportable incident*** may include any deviation from

- Law
- Regulation
- Foundation policy and procedure
- Patient care plan
- Patient or staff accident
- An unusual or unintended response to treatment
- Or a breach in patient privacy

The Home Health Foundation Incident Report Policy and form is included in the appendix of your notebook.

Unwitnessed Falls Report

An Unwitnessed Falls report is completed when there is a patient fall that is not observed by MVH staff.

The form and instructions is included in the appendix.

Complaint

A complaint form is completed whenever a patient or customer (physicians, discharge planners, community resources etc) and staff has a complaint or a concern. The form and policy are included in the appendix.

Clinical Record Documentation Housekeeping Tips

- Patient name and ID number goes on each page of any form/document that will be scanned and filed in the medical record.
  - Make sure patient name is correct and legible, this is vitally important!