“Documenting to Dazzle”
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Chaplain Core Curriculum
Track 2 Seminar
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Objectives:
The participant will

1. Increase knowledge of current CMS documentation standards.
2. Acquire practical strategies for effective, complete, and compliant documentation.
3. Effectively produce documentation that meets guidelines and exceeds expectations.
“More than half of chaplain visits did not focus specifically on spiritual issues, but were concerned instead with physical symptoms, existential and emotional matters, family concerns, life reviews, medical issues and advance directives.”

*PlainViews*, April 9, 2014, Volume 11, No. 6
“The Chaplain's Role Goes Beyond Spiritual Care When Testing the Seriously Ill”
§418.56  Condition of participation: Interdisciplinary group, care planning, and coordination of services.

The plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions, including the following:

1. **Interventions** to manage pain and symptoms.
2. A detailed statement of the **scope and frequency** of services necessary to meet the specific patient and family needs.
3. **Measurable outcomes** anticipated from implementing and coordinating the plan of care.
4. Drugs and treatment necessary to meet the needs of the patient.
5. Medical supplies and appliances necessary to meet the needs of the patient.
6. The interdisciplinary group's **documentation of the patient's or representative's level of understanding, involvement, and agreement with the plan of care**, in accordance with the hospice's own policies, in the clinical record.
Assessment: An Example

Based on Needs/Hopes/Resources model

• Pt expressed moderate spiritual, emotional and relational distress re feeling abandoned/punished by God through his illness and neglected by his faith community while hospitalized. (needs)
• Pt reported strong support from his wife of 30 years. However, he stated “we don’t talk about God stuff.” His two adult children live out of state. He identified no intimate friendships. (needs & resources)
• Pt expressed intermediate hope he will be well enough to attend his daughter’s wedding in June. Pt expressed little sense of ultimate hope at present. (hopes)
• Pt self-identified as an “old philosopher” and seems willing and able to explore issues as long as his pain is controlled. (resources)
• Pt is receptive to and would benefit from continued chaplaincy care to address providence, theodicy, grief, hope & reconciliation. (needs & resources)

Intervention Words and Phrases

- Directed
- Encouraged
- Identified
- Explored
- Facilitated
- Validated
- Reframed
- Normalized

- Educated
- Modeled
- Provided spiritual guidance
- Provided spiritual reading
- Engaged in life review
- Sang/played/listened to hymns
AEB  (As Evidenced By)
Outcomes

• “Some patients reached new self-awareness, found a deeper sense of purpose and meaning, or made important steps toward reconciling with important people in their lives.” UCSF study (PlainViews, April 2014)
Care Plan Forms, Trigger Sheets

What’s the big deal?

Frequent deficiency is the Care Plan not matching the assessment and the visit notes not following the Care Plan.

ALWAYS SEE the POC as a living document that informs the work.
Documentation

• Technically
  – Record goals, interventions, outcomes (needs, hopes, resources)
  – Use language and terms that are measurable (avoid “very”, “some,” “lots”)
Documentation

• Clinically
  – Consider continuity - Coordination of care, including continuity between disciplines, is essential
  – Chaplains are clinicians
  – Chaplains are notorious for charting too positively!
Documentation

• Towards DIAGNOSIS
  – Be familiar with LCD’s (Local Coverage Determinations, which are factors that determine medical necessity of hospice services for a particular terminal illness).
  – Note physical symptoms, pain, decline, etc, at every visit.
Hospice Local Coverage Determination (LCD)

- LCDs provide guidance in determining medical necessity of services.
- The LCD:
  - Allows for the *decline* of a beneficiary to be a factor in determining prognosis.
  - Consists of three parts, and a disease specific appendices:
    - Part I is related to the decline in a beneficiary predictive of a six month prognosis.
    - Part II is related to the functional limitations of a beneficiary, and is used in conjunction with the disease specific appendices. Part II does not stand alone in prediction of a limited prognosis.
    - Part III is co-morbidities that may be helpful in predicting and documenting a six-month prognosis.
Hospice Local Coverage Determination (LCD)

See handout:

“Coverage Indications, Limitations, and/or Medical Necessity”

Excerpts taken from: http://www.cms.gov/medicare-coverage-database
Value of Narrative

If you use EMR (Electronic Med Recs) and have the ability to add narrative, then do it. Don’t be lazy or afraid. **Your connection to the dx could save the chart in an audit!**

*Think of every note coming before a judge and having to defend the fact that the patient is on service.*
Chaplain made routine visit (PURPOSE) for spiritual and emotional support of pt. (GOAL) Patient has hospice dx of COPD. (NOTE DIAGNOSIS) CH spoke with charge nurse Lisa and reviewed pt’s chart to ensure continuity of care. (COORDINATION OF CARE)
Upon arrival, pt lying on back in bed, slightly inclined, with 02 on. Pt said, “I stay in bed because I’m so tired all the time.” Pt was up in wheelchair at previous visit 2 weeks ago. Pt reported discomfort related to increased swelling in legs. (SYMPTOMS and DECLINE RELATED TO DIAGNOSIS)

CH notified NF charge nurse Lisa, as well as hospice RN case manager, about pt’s report of discomfort. (COORDINATION OF CARE)
Pt reported feeling anxious about family’s well-being after pt’s death. CH provided active listening and validation of feelings for emotional support. (NEEDS and INTERVENTIONS)

Per pt request, and based on POC, CH facilitated prayers with pt for spiritual support. (NEED and INTERVENTION)

Upon CH’s offer, pt requested that CH provide communion for pt at next visit. (NEED)
Pt appeared comfortable and peaceful at end of visit AEB saying, “I feel so much better after your visits,” and expressing no verbal complaints or non-verbal sx of pain/discomfort. (OUTCOMES)

CH to provide communion for pt at next visit, and continue POC of 1-2 visits per month + 1 PRN visit for support. (SUMMARY OF PLANNED INTERVENTIONS)
Case #1 Mrs. P

- 92 y/o. Admitted 9/1/14, Alzheimer’s, debility, malnutrition, chronic constipation. Lives in grp home. Son is DPA, who requests that he be notified when patient is in pain. Son is hesitant to allow mom narcotic pain meds – fear of addiction.
Case #2, Mr. Y

- 62 y/o male admitted 1/24, Malignant melanoma with invasive tumor protruding from the nose, declined further treatment. Lives with wife in private home. Has hospital bed. 2/3/14 wife called, condition worse and started giving Morphine Sulfate.
Case #3, J.P.

- 15 y/o male. History of meningitis 3 years ago resulting in paraplegia. Non responsive to verbal stimuli. Total care. N/G tube and suprapubic catheter. Mother has full responsibility for care. Two other children in the home ages 8 and 5. Father works and is seldom available for providing support or assistance. Admitted 2/13 following hospital stay for pneumonia. His physician has told family that patient is eligible for hospice. Comfort and palliative care only.