The Art of Home Health Documentation

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Learning Objectives

- Identify 3 important components of a clinical note
- Describe what components of a clinical note are necessary to make it skilled
- Define the parts of a clinical note that convey medical need
- List the required elements of a therapy evaluation visit note
CoP’s Regarding Documentation

484.60 Care Planning/Coordination of services and quality of care
484.75 Skilled professional services
484.110 Clinical record
484.55 Comprehensive assessment of patient
Specific Intervention Groups

- Observation and Assessment (O & A)
- Teaching and Training
- Performance of a Skill
- Management and Evaluation
Observation and Assessment

Where a patient was admitted to home health care for skilled observation because there was a reasonable potential of a complication or further acute episode, but did not develop a further acute episode or complication, the skilled observation services are still covered for 3 weeks or so long as there remains a reasonable potential for such a complication or further acute episode.
Teaching and Training

Re-teaching or retraining for an appropriate period may be considered reasonable and necessary where there is a change in the procedure or the patient's condition that requires re-teaching, or where the patient, family, or caregiver is not properly carrying out the task. The medical record should document the reason that the re-teaching or retraining is required and the patient/caregiver response to the education.

The reason why the training was unsuccessful should be documented in the record.

Quick Fact
Performance of a Skill

Wound care guidance/measurements/care

Injections/Infusion guidance

Ostomy Care guidance

Venipuncture guidance

Quick Fact

Medicare Home Health Benefit Manual 40.1.2.4 to 40.1.2.13
Management and Evaluation

For skilled nursing care to be reasonable and necessary for management and evaluation of the patient's plan of care, the complexity of the necessary unskilled services that are a necessary part of the medical treatment must require the involvement of skilled nursing personnel to promote the patient's recovery and medical safety in view of the patient's overall condition.
2 hrs post assessment

93%

79%

62%

45%
Start at the Beginning

The Narrative Note
A quality SOC/ROC narrative note contains:

- What was the circumstances that lead to the admission
- What is the living situation
- How is this patient getting around in the home using descriptive words
- Who is the caregiver and what is the extend of involvement
- What are the knowledge deficits and problems
- Education provided
- Call to MD to approve POC and include name
- Progress toward goals
- Plan for next visit
Patient seen today after rehab stay for reports of syncope but unknown of reason for it. Pt seen at ____ from 12/8 to 12/10 with all screenings/work up negative. Patient then sent to rehab for deconditioning. Pt found today in standard twin bed with right knee flexed with right hip abducted. When SN assessed LE's, asked for patient to straighten leg out and he could not. Felt pt leg behind knee and noted tendons shortened and right knee swollen. Family states he has been "dragging" that leg behind him with it flexed slightly for at least 2 years. Pt is noted to have chronic pain syndrome but currently on nothing more than ibuprofen for pain. Pt states this does help but due to pt with increase confusion could not rate his pain. It is obvious when anyone touches or attempts to straighten leg it causes severe pain by observing non verbal indicators. Assessed bottom due to patient bed/chair confined at this time since hospitalization and no noted sores but has 1 healed area in the gluteal cleft. Both heels were assessed with no red areas or skin breakdown. SN educated both sons on how to use draw sheet to turn pt without hurting themselves or pt. Also educated sons on how to transfer pt from bed to chair using good back safety. Son attempted to transfer pt before education and almost dropped him. Once SN demonstrated how to transfer, son was able to return demonstration but pt is max assist to transfer and attempts to "fight" against person due to rear of falling. Pt was holding on tight to sons clothes and also to the wheelchair and had to remind pt that son will not drop him. Once sitting in W/C pt had to be manually scooted to the back of the chair as he was sliding out. Had to tell pt to sit up straight which he did making it easier to assist him up in wheelchair. Pt appears to be very fearful of falling with hx of multiple falls in the past 3 months. Last fall resulted in facial fracture but required no surgery.

The rehab facility has ordered both a wheelchair and hospital bed but it has not arrived yet and the wheelchair that pt has belongs to the rehab and son to take back tomorrow. Pt has comorbid conditions of HTN, CAD, cervical spinal stenosis, BPH, anemia, peripheral neuropathy, COPD, gout, rt lower lobe mass, OA, chronic pain syndrome. Pt will need extensive education to the family in caring for patient to include skin care, care of bed/chairbound pt, transfer education, medication education as some of his medications have been changed. This will be the focus of care for the skilled nurse with need for contracture management of the right knee/hip joint and ADL care/management.
Recertification narrative note

- Summary of what has happened in past 60 days
- Plan for the next 60 days
- Justification/reason for recertification
- Specifics of continued need for any education
- Call MD to approve POC to include name
- Progress toward goals
- Plan for next visit
Patient seen today for recertification. Pt has had 2 urinary tract infections and seizure activity over the past month and need to complete hypertension education from hospitalization that occurred 45 days ago. Patient has comorbidities of Diabetes. Patient lives in apartment building with her daughter and son-in-law who assist with all of her care. Patient is ambulatory with a walker or holding on the walls and furniture as she was during the day of the assessment but she does use her walker. She had a number of medication changes while in the Hospital mainly surrounding her seizure medication. She and the son-in-law report that her seizure medication was not absorbing in her system at the time she was taking them because of dialysis three times a week. The MD rearranged a lot of her seizure medications to be taken at different times after dialysis so that it will be more effective. The patient and the son-in-law stated that she continues to have at least 1 seizure a week. She did have some episodes of hypertension but her blood sugar remained relatively stable. Skilled nurse watch the patient perform her glucometer check and the patient put in the strips the wrong way and also did not know how to use the Lancet system. Skilled nurse had to give her a verbal cues but she was able to accurately perform this with assistance. The son-in-law states that the daughter does manage her blood sugars in the home with the use of the glucometer. The daughter also manages all of her medications during skilled nurse visit. A call was made to the daughter to ensure that the medications were being accurately written down and verified. The skilled nurse focus of care for resumption of care will be assessment of her blood sugar along with her blood pressure and seizure activity. Assessment on new regimen of medications. Skilled nurse discuss with the daughter on the telephone about the seizure medications and the daughter appears to be very knowledgeable of this medication. She does have a follow-up appointment in two weeks with the neurologist along with her PCP. She goes to dialysis on Monday Wednesday and Friday.
The skilled note
What constitutes a quality note?

- Stands alone
- Homebound status
- More than just check boxes
- How, what, when, why, who
- Interventions with patient response
- Any adjustments in care
- Problem
- Plan for next visit
- Point of care charting
Special Considerations

How are goals being addressed?
Goals

All notes need to address progress toward goals.....

Example:

• Caregiver able to demonstrate how to administer pts IV Vancomycin
• Wound to the sacrum has decreased in size by 0.1cm with 100% granulation tissue in wound bed with no s/s infection noted.
• Pt able to verbalize when to take her Lasix but unable to state what medication is treating.
Documenting the actual performance of the intervention/skill or the "meat" of the note is always a focus.

This tells the payor source what was done in the home to help support medical need.

Don’t take short cuts or attempt to refer to another document to explain what was done during the visit.
Examples of documenting skill

SN seen today for education of Lasix due to new medication for patient. Pt placed on Lasix 2 days ago due to increase BP and swelling in LE’s. SN taught pt and daughter that medication is a “water” pill or diuretic that helps to remove excess fluid from the body through urination. Taught that this medication will cause her to void more and to take it early in the morning so she is not up to the bathroom all night.
Examples of documenting skill

SN seen today for assessment and care of the wound to the sacrum. SN removed soiled dressing, clean wound with normal saline, pack with calcium alginate to wound bed, cover with ABD pad, secure with tape.

Wound measures 4.2 x 8 x 1.7 cm with 100% granulation tissue in wound bed, undermine 1.2 cm from 9:00 to 12:00 with moderate amount of serosanguinous drainage with no odor.
Patient found sitting up in recliner, BBS=clear, BS x 4 quad, HR strong and regular, NAD. No pain noted. Will continue to monitor.
What do you think?

Complete assessment was done in patient and home environment. Vital signs taken and they are within normal limits. Patient with a traumatic wound in left leg, wound assessed and wound care performed as per MD order.
The skilled note
Therapy
Therapy documentation considerations

To be covered……..the skilled services must also be reasonable and necessary to the treatment of the patient's illness or injury or to the restoration or maintenance of function affected by the patient's illness or injury.
The Initial Evaluation

• Standardized tools to measure function
• Complexity of the treatment
• Limitations of environment
• More than just check boxes
• Prior level of function/current level of function
• Assessment/education of ability to follow through
• Any adjustments in care
• Problem/s
• Goals
• Plan for next visit
The Re-Evaluation

- Standardized tools to measure improvement (use same tool)
- Every 30 days
- Effectiveness of treatment to this point
- More than just check boxes
- Assessment/education of ability to follow through
- Any adjustments in care
- Problem/s
- Goals
- Plan for next visit
The Therapy Note

• Subjective/Objective information
• More than just check boxes
• NO COPY FORWARD!!!
• Assessment/education of ability to follow through
• Cues needed
• Any adjustments in care
• Problem/s
• Goals
• Plan for next visit
The Therapy Note Considerations

• Unique opportunity to train a patient within their own home environment
• Utilize patients environment in relation to:
  • level and terrain
  • obstacles
  • functional distance
  • handling load
• Tie the exercises chosen/taught to the functional deficit
Therapy Goals

Goals need to be/include:

• Quantifiable
• Relevant
• Clear
• Achievable
• Incorporations of standardized tools
• Time frame
What do you think?

Outcomes: "Signs of gain, just sure"

Plans: RF hot pack for carpal tunnel R
RF for carpal tunnel, PT TK, etc, etc, etc, etc.

PHYSICAL THERAPY
EVALUATION:

EVALUATION:

Outcomes: "Signs of gain, just sure"

Plans: RF hot pack for carpal tunnel R
Take Aways....

Keep it Simple.....

Focus on achievement of goals.....

Convey value.....