Clinicians Connection:
The Role of the IDG in Eligibility

August 2018
Subscriber Webinar

Today’s Session
• Importance of understanding and documenting eligibility
• The role of the IDG in supporting eligibility
• Eligibility and the IDG plan of care
• Assessments and documentation
• Effective IDG meetings for eligibility reviews
• Actions of the Prudent Hospice

Understanding and Documentation of Eligibility

Why It Counts
Top Denial Reasons

- Palmetto GBA: Not Hospice Appropriate
- CGS: Six-month terminal prognosis not supported
- NGS: According to Medicare hospice requirements, the information provided does not support a terminal prognosis of six months or less

It all means the same thing: the documentation does not tell the reviewer the story of why the patient has a prognosis of 6 months or less.

Eligibility Requirement

- Physician certification statement of 6 months or less supported by a narrative
  - At admission by the hospice physician and the attending physician, if they have one
  - At recertification by the hospice physician

Remember - At admission only 1 narrative is required

The Role of the IDG in Eligibility

Documentation
- Carefully documenting to terminal and secondary conditions and comorbidities
- Recognizing and documenting symptom changes heralding significant change in condition
- Connecting eligibility assessment findings to plan of care

Team Process
- Presenting and discussing findings at IDG meeting
- Capturing information from other team members
- Discussion when eligible and when not so sure
Assessments and Documentation

Eligibility Documentation
Even if the patient is absolutely clinically eligible:
- If the chart doesn’t document the eligibility
  - On admission
  - At recertification
  - Ongoing basis during the cert period
- If the staff don’t document eligibility in their notes
  - All the staff (Chaplains and Social Workers included)
- If we can’t prove they are/were eligible
  
  Medicare will say they are not eligible

Assessments and Documentation
Findings related to the impact of the terminal and related conditions on the
- Plan of care
- Patient
- Family
- Decline
Palmetto GBA & Decline

Since determination of decline presumes assessment of the patient's status over time, it is essential that both baseline and follow-up determinations be reported where appropriate. Since weight loss due to decreasing oral intake is often a good predictor of decline, it is essential that hospice staff document this information in the hospice medical record. Obtaining and recording objective data is instrumental in showing the continual decline of a patient when the weight loss and decreased appetite is not caused by other factors such as medication. Patients that have ceased to show on-going decline or who have plateaued from a trajectory of decline may no longer meet hospice eligibility guidelines despite a significant need for custodial care.

NGS & CGS & Decline

Part I. Decline in clinical status guidelines

Patients will be considered to have a life expectancy of six months or less if there is documented evidence of decline in clinical status based on the guidelines listed below. Since determination of decline presumes assessment of the patient's status over time, it is essential that both baseline and follow-up determinations be reported where appropriate. Baseline data may be established on admission to hospice or by using existing information from records. Other clinical variables not on this list may support a six-month or less life expectancy. These should be documented in the clinical record.

MACs & Decline

To show decline you need to document objective data over time
### General Decline - Everyone Helps Out

**Nutrition Status**
- Weight loss/decline in MAC/BMI
- Dysphagia
- Pocketing food
- Longer to eat
- Eating less/less interest in food

**Behavioral Status**
- Less interaction
- Agitation
- Increased periods of sleeping

**Functional Status**
- FAST, PPS
- Increasing dependence in ADLs
- Increased immobility
- Unable to sit unsupported
- Incontinence
- Skin breakdown

**Infections**

**IDG Documentation - Nurses**

- Objective measurable data
  - FAST
  - PPS
  - Weight/MAC
  - O2 sat
  - Edema
  - Dyspnea
  - Pain
  - Skin breakdown

- Increased symptoms
- Medication changes
- Increase in PRN medication use
- Increase in O2 hours and liters
- Effectiveness of interventions
- Hospice Aide assignment appropriate

### IDG Documentation - Nurses

**Recertification Summary**
- Age, reason for continued hospice eligibility, i.e., terminal, secondary and co-morbid conditions
- Why hospice, why still, i.e., what demonstrates person remains eligible
- Describe any decline over past 3 – 6 months
- Mental and functional status prior to admission or last 4 to 6 months compared to now
- Describe current status as compared to 4 – 6 months ago
- Medication changes
- Plan of care changes

Make sure the summary is consistent with data in the nursing assessment and LCDs/Clinical Indicators/Worksheets for Eligibility.
IDG Documentation

Social worker, chaplain and hospice aide
• Document as to how they were and how they are now
• Subtleties of decline
  – Can no longer come to the door
  – Unable to hold head up this visit as compared to last
  – Lack of focus, only able to carry on conversation for a few minutes
    compared to last month when was engaged for 15 minutes
  – No longer wearing dentures and when asked why, its because they are too loose
  – Sitting in a wheelchair with head hanging down and leaning to one side

Common Documentation Problems

• Using wrong tool(s) for patient or diagnosis or not using it at all
• Inconsistencies among clinicians
  – Scoring
  – Usage – some do, some don’t
  – Documentation placement (especially with EMRs)
• Clicking templates without actual data
• Not identifying scores that don’t make sense or are in conflict with others
• Scoring without reference to context
• No baseline measurements

Common Documentation Problems
• Using words like ... stable, unchanged, appears to be losing weight
  – Instead document abnormal findings consistently with objective assessment findings
  – Compare and contrast
• Failure to regularly weigh or measure
  – Make sure to obtain baseline measurements; actual weight and MAC at admission and monthly
• Medications are changed and no documentation why
  – Something in the assessments resulted in the medication change, so document why
  – Document the results/outcomes of the change
• Hospice Aide does not document patient response
  – Ensure process where how patient tolerates ADLs get documented
  – Reports to RN to change HA assignment
### Common Documentation Problems

- No document of consideration of intensity of care
  - Document to the caregiving environment
  - Example: 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
  - If its abnormal, document
  - All falls and injuries reported
- Generic documentation about ADLs
  - Document how much assistance is needed with each ADL that requires assistance (min, mod, total)

### Paint the Picture Through Your Documentation

- Use the comment boxes
- Use narratives
- Tell the story

Use the expertise of IDG assessments and power of EMR
‘As Evidenced by...’

- When you use descriptors like: cachectic, anorexic, non-ambulatory, dyspnea (at rest or on exertion), weight loss, poor appetite, fragile, failing, weaker...
- Always follow up with “as evidenced by...” to fully describe what you see

Narrative in Need of Improvement

96 years old with Alzheimer’s disease. Weight loss. Sleeping more. Expect her to decline more.

Good Narrative

This is a 99 year old female with a terminal diagnosis of end stage Alzheimer’s Disease and a Major Depressive Disorder. Her other significant comorbidities include: COPD with oxygen dependence, ASHD, Essential Hypertension, Syncope, Hypothyroidism, osteoarthritis, h/o vertebral compression fracture.

She is a resident in the memory care unit.

DNR. PPS 30%, Fast 7C. non-verbal with garbled words that are incomprehensible.

ADLs with total assist with bathing, dressing, grooming, toileting, transfers and preparation of meals. The patient is able to feed herself with each meal taking up to 2 hours till completion.

She is non-ambulatory and is either wheelchair bound or bedfast.
Incontinent of bowel and bladder. Appetite fair to poor per staff eating a mechanical soft diet due to dysphagia. She consumes approximately 50% of her meals. She remains a high risk for aspiration. She continues a slow progressive loss of weight due to her decreased appetite. Wt 146 lbs 3/2018; Wt 136 lbs 6/2018; Wt 133 lbs 8/2018. Total Wt loss of 13 lbs (-9.1%) since March 2018 and BMI was 21.3. She is O2 dependent due to her advanced COPD and is receiving O2 at 2.5 LPM via nasal cannula; O2 sat 89% on RA. The patient sleeps about 16-18 hours/24 hour day per staff. Palliation of anxiety with Ativan 0.25 mg po q4h prn at least daily. She receives Seroquel 50 mg po daily for psychosis and for mood stabilization.
Assessments

Should be individualized based on ongoing assessments
Should change with decline
Support eligibility based on identified needs
Identify scope and frequency of services needed and provided

Examples
- Hospice aide increased from 3 times per week to daily as wife can no longer manage the increased physical requirements
- HA assignment changed to bed bath as too difficult to transfer patient into shower
- Oxygen order now 3 liters continuous from PRN

Plan of Care
Updating the Plan of Care

Are problems identified in the comprehensive assessment and updates care planned?
What changed in the comprehensive assessment that should result in a change to the POC?
• Increased symptom management needs
• Increased weakness resulting in caregiver strain
• Family role changes

Connection to Care Planning-ADLs

• Decline in self care
• Increase need to for caregiver assistance
• Equipment
• Increasing visits
• Family relationships/strengths/support
• Future planning for needs

Activities of Daily Living Measurement

It’s about self care and how much help is needed
Document the level of assistance needed for each ADL
Be descriptive-use narratives/comment boxes/summaries
Describe amount of assistance required for each ADL separately
– Independent
– Minimal
– Moderate
– Completely
– Dependent
### ADL Assistance Guidelines

<table>
<thead>
<tr>
<th>ADL</th>
<th>Minimal Assistance</th>
<th>Moderate Assistance</th>
<th>Complete Assistance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulation</td>
<td>Does not require assistance.</td>
<td>Requires some assistance.</td>
<td>Requires full assistance.</td>
</tr>
<tr>
<td>Ambulation/Fooding</td>
<td>Assistance with eating or drinking, or assistance with feeding.</td>
<td>Requires assistance with eating or drinking, or assistance with feeding.</td>
<td>Requires full assistance with eating or drinking, or assistance with feeding.</td>
</tr>
<tr>
<td>Dressing</td>
<td>Does not require assistance.</td>
<td>Requires some assistance.</td>
<td>Requires full assistance.</td>
</tr>
<tr>
<td>Eating</td>
<td>Does not require assistance.</td>
<td>Requires some assistance.</td>
<td>Requires full assistance.</td>
</tr>
<tr>
<td>Bathing</td>
<td>Does not require assistance.</td>
<td>Requires some assistance.</td>
<td>Requires full assistance.</td>
</tr>
</tbody>
</table>

### Activities of Daily Living Measurement

**Example 1**
Dependent in 6 of 6 ADLs at admission and at recertification

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

**Example 2**

- Moderate assistance with ambulation with rolling walker
- Incontinence bowel and bladder
- Complete assistance with transfers
- Moderate assistance with dressing
- Moderate in feeding
- Moderate assistance with bathing
Connection to Care Planning

• Weight loss
  – 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

Connection to Care Planning-Dyspnea

• Disabling
  – Affects on ADLs
  – Further loss of independence—psychosocial needs

• Oxygen
  – Teach safety
  – Increased flow

• SVNs/Inhalers
  – More frequent use

• Advance care planning

• Energy conservation
• ADL assistance
• Increase hospice aide visits to support caregiver
• Medication management and education

Connection to Care Planning-Fluid Retention

• Weight gain secondary to fluid retention
• Edema
• Pulmonary congestion
• Increased dyspnea
• Increase oxygen
• Adjust medications
• Increase visits

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Connection to Care Planning - Pain

- All kinds: physical, spiritual and emotional
- Use of standardized scales
- Increasing pain
- Chest pain - use of NTG and effectiveness
- Increasing medication usage
- Constipation due to opioid use
- Pharmacological and non-pharmacological interventions
  - Disease progression
    - Interpersonal relationships/family support
    - Advance care planning

IDG Meeting

Where the Magic Happens
(or where it should)

An IDG Meeting Is a Process Which

- Utilizes the discipline specific skills and knowledge of each member of the IDG
- Includes an evaluation & review of the problems, goals and interventions to improve outcomes
- Lets the IDG know if the care is making a difference
- Addresses changes which might include new problems, changed goals and or new interventions such as, visit frequency, additional services, medications and DME, level of care
An IDG Meeting Is a Process Which

• Provides an opportunity to anticipate possible changes in the disease progression for proactive care planning
  – What do we expect might happen
  – How to plan for that
• Allows time to assess the eligibility of patients and their appropriate level of care
How’s the Balance?

IDG Meetings - The Balance

Enough time for responsible discussions
- Purpose of IDG Meetings
- Finding the balance
  - Care Planning
  - IDG update documentation
  - Eligibility discussions

IDG Meetings - The Balance

Standardize format
- DARE (Deaths/Discharges, Admissions, Recertifications, Everyone Else)
- Case presentation
Prior to Start of Benefit Period

• Review any trending data
• Determine need for any additional diagnostic studies
• F2F
• Narrative
• Look for any contradictory or inconsistent documentation
• IDG documentation and communication
• Consider a deeper review of those with LOS > 180 days

Prior to Start of Benefit Period

3 to 4 weeks
  — RN reassessment visit and summary
  — Discussion in IDG – Any concerns
2 – 4 weeks
  — F2F visit
  — Discussion in IDG – Any concerns
1 – 2 weeks
  — Final review and discussion in IDG
  — Writing of the physician narrative

Social Workers and Spiritual Care Coordinators

• Less frequent visits, should see more subtle or even overt changes
• Share any changes observed
• Clarify what a “good conversation” really means
Hospice Aide

Often not at the IDG meetings but can and often due have valuable information

- ADL decline
- Fatigue
- Intake

Case Presentation Format - Example

- Name, age, terminal illness, secondary conditions and co-morbid conditions, admission date, level of care and attending physician
- Review the problems on the current plan of care, one at a time and after each, report:
  - Is the goal measurable - do we know if we are making a difference?
  - Any changes to the interventions or goals since the last IDG review
  - Based on the comprehensive assessment data, are the goals met? Problems resolved. Have the outcomes been met? If not, discuss what needs to change?
  - Are the symptoms and other issues being controlled effectively with current interventions?
- Discuss any new problems identified through the comprehensive assessment. Develop goals and interventions
  - New orders
  - New services
  - Change to visit frequency
  - Change in interventions
- Any plans for this patient and family that have not been addressed yet?
- Review of eligibility - why hospice, why still? Reviewed at every IDG meeting. More in depth review anytime there is a concern for continued eligibility and prior to recertification

Presenting a Case for Eligibility

After general case presentation then

- Why hospice, why still. i.e., what demonstrates person remains eligible
  - Disease specific
  - Describe current status as compared to 3 to 6 months ago
  - Mental and functional status prior to admission or last 4 to 6 months compared to now
- Current status compared to past status
  - Weight or MAC changes
  - ADLs
  - Skin breakdown
  - Falls
  - Intake
  - Appropriate data from tools
- Medication changes and why
- Plan of care changes
Problems/Issues/Needs: Pain Control  
Goal: Pain will be managed at caregiver defined acceptable pain level of 3 or less using PainAd scale

Interventions:
• Assess pain each visit by each discipline - Notify CM if pain greater than 3 using PainAd
• SN to assess the effectiveness of pain medications and use of breakthrough
• SN to educate CG on use of medication and positioning
• Assess constipation related to increase in opioid use
• Medications (whatever is in the orders/ medication profile does not need to be repeated)

IDT update: Pain has been above 3 several times in past week as CG is not providing medication before wound care as ordered. Will provide further education and increase RN visits to 4 times a week (every other day) for reinforcement. Will reassess effectiveness of medication regimen.

Problems/Issues/Needs: No advance directive but family requests additional information. Not sure about future hospitalizations as he has become increasingly weaker

Goal: Advance directive discussions and information will be provided by August 6th

Interventions:
• SW & RN to educate and assist with advance directives
• SW to encourage family meeting to discuss advance directive
• IDT to explore the benefits of DNR status with patient and family and any future hospitalizations
• SW encourage execution of advance directives while patient is able
• SW frequencies – 1 x week until family decision made

IDT Update: Family meeting held on August 3rd. Family in agreement with patient wishes. Advance directive being completed by patient. Pt express desire to not return to hospital. Will make a follow up visit by August 10th to obtain copy of completed advance directive. SW frequency changed to 2 x month.

Problems/Issues/Needs: Daughter concerned about ability to continue to care for patient at home.

Goal: Develop a plan by August 25 to meet needs of patient and daughter as condition continues to deteriorate

Interventions:
• Increase hospice aide visits to daily to provide for ADLs
• SN assess ADL decline in patient
• SN obtain Hoyer lift and Geri-chair
• SN educate on transfer techniques
• Volunteer to come weekly, sit with patient so daughter can go out and get hair done & run errands
• SW explore financial resources for hired caregiver
• SW assist with Medicaid application for aide and attendant care
• SW to explore if alternate living arrangements would be acceptable (ALF, NH)
When Eligibility Is Not So Clear....

The Prudent Hospice Approach: Evaluating and Planning for Discharge

Link:  https://web.telspan.com/play/fundamentals/3499-oct
Handout: The Process Steps When Eligibility is Not So Clear

Actions of the Prudent Hospice™ IDG and Eligibility

• Ensure your IDG meetings have a balanced approach
• Require discussions and documentation to include “as evidenced by...”
• Put efforts into tying eligibility to care planning (because they really are!)
• Ensure all staff has eligibility competency appropriate to their position
• Monitor and audit those most important areas
  – Consistency
  – Correct use of scales/tools
  – Plans of care updated as patient / caregiver needs change
  – Report in usable manner
  – Connect results to what is important to clinicians

To Contact Us

Susan Balfour
919-491-0699
Susan@HospiceFundamentals.com

Roseanne Berry
480-650-5604
Roseanne@HospiceFundamentals.com

Charlene Rios
602-740-0783
Charlene@HospiceFundamentals.com

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### ADL Assistance Guidelines*

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

*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”. They are adapted from Katz Index of Independence in Activities of Daily Living (ADL) and Lawton and Brody Physical Self Maintenance Scale*.  

4/5/14
**Standardized Case Presentation***

1) Start with SW and Chaplain presentations

2) Name, age, sex, terminal illness, secondary conditions (related) and co-morbid conditions (related and unrelated), admission date, level of care and attending physician

3) Review the problems on the current plan of care, one at a time and after each, report:
   a) Is the goal measurable-do we know if we are making a difference?
   b) Any changes to the interventions of goals since the last IDG review
   c) Based on the comprehensive assessment data, are the goals met/problem resolved. Have the outcomes been met? If not, discuss what needs to change?
   d) Are the symptoms and other issues being controlled effectively with current interventions?

4) Discuss any new problems identified through the comprehensive assessment for the plan of care. Develop goals and interventions.
   a) New orders
   b) New services
   c) Change to visit frequency
   d) Change in interventions

5) Do any of the IDG members have any plans for this patient and family that have not been addressed yet?

6) Any changes in conditions which change ICD-10 reporting?

7) Review of eligibility-why hospice, why still i.e., what demonstrates person remains eligible?
   a) Reviewed at every IDG meeting
   b) More in depth review anytime there is a concern for continued eligibility and prior to recertification
   c) Disease specific
   d) Describe current status as compared to 3 to 6 months ago
   e) Weight or MAC changes
   f) ADLs
   g) Skin breakdown
   h) Falls
   i) Mental and functional status prior to admission or last 3 to 6 months compared to now
   j) Medication changes and why
   k) Plan of care changes and why

*These are basic guidelines to use as a starting point in improving case discussions at your IDG meeting through a consistent format. The flow will be impacted by your individual processes such as your electronic health record, individual make up of your hospice (inpatient facilities, length of stay, case mix).
The Process Steps
When Eligibility Is Not So Clear*

At least two weeks before recert or anytime there is the question of eligibility:

IDT Activities
1. Discuss possible discharge
2. Formulate plan to gather additional information

Make physician/ARNP visit (and include F2F if required)

IDT Discharge Planning
1. Begin to identify needs
   - Attending physician
   - DME
   - Medications
   - Referrals
   - Supplies
   - Education
2. Update POC as appropriate for change in needs or titration of services
3. Begin to coordinate possible discharge with pt/family/facility

IDT Activities
1. Obtain additional diagnostic information as indicated
2. Update comprehensive assessment including RN recertification summary

Review by a new set of eyes

IDT Discussion
1. Eligibility
2. Discharge Plan

Eligible > Recertify

No Longer Eligible
1. Implement discharge plan
2. Notify attending physician
3. Obtain discharge order from hospice physician
4. Issue NOMNC no less than two days before scheduled discharge.

*Suggested steps for The Prudent Hospice™

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