

The Hospice benefit is provided to beneficiaries with clinical evidence and descriptive notes to show the beneficiary is terminally ill and progressing in a manner that a physician would reasonably conclude that the beneficiary's life expectancy is months or less.

## Importance of Descriptive Narratives in Clinical Records

Descriptive information completes the picture started with check-based assessments. Comparative information establishes longitudinal decline and may indicate decline suggestive of terminal status.

Each Clinical Note must be able to stand alone and show how the patient remains terminally ill or it may appear the patient has stabilized, becomes chronically ill and requires discharge planning to occur. Failure to document a distinct different will result in payment denial for a month, certification period or even an entire admission.

Surveyors appear to be focusing on severe, unrelenting symptoms as a basis for terminal status/medical necessity. Examples include: dyspnea at rest in patients with COPD or heart failure; and dysphagia with aspiration pneumonia in patients with dementia. Inconsistency decreases the clinical record's credibility in the eyes of reviewers and makes it harder for those trying to identify the patient's true clinical status and to defend your claims. Examples of inconsistency include:

- PPS assessments not supported by other assessment data in the clinical record
- Incorrectly applied FAST assessments and/or scores not supported by other assessment data
- Disparity between physician narratives and clinical information in the clinical record
- Lack of consistency in recording weights, anthropomorphic measurements, other objective data
- Absent or inconsistent data for a specific LCD has the appearance of disregard for or lack of awareness of the LCD which can also send up red flags.

Decline is inherent to the dying process in most diseases and most hospice staff are attuned to documenting the slightest signs. But decline is also associated with chronic conditions and advanced age. In denial statements, reviewers often state there is evidence of decline, but deny the claim because terminal status is not established.

Nursing narratives repeated verbatim across Clinical Notes, IDG Notes, and Plans of Care can have the effect of reducing credibility of documented assessments and narratives. This also may contribute to a clinical picture of stability for the patient. Documentation must support the patient's decline. Each Clinical Note must show evidence of signs and symptoms of decline despite optimal care.

Document using International Classification of Functioning: impairments in function, activity limitations, participation limitations, and communication impairment. Include in narrative documentation information about how so morbid conditions and secondary conditions affect the patient's decline. Consider ways to document which systems of the body are in a terminal condition.

Allow documentation to describe changes in a patient's health status. Compare historical assessment data with current assessment data and changes in the patient's functional status from the past to the most current assessment.

Clinical Notes from all disciplines should demonstrate a consistent picture of terminal. Avoid vague statements such as: "slow decline," "disease progressing." The more objective the documentation, the better. Remember: Hospice is for those needing true "skilled palliation of end of life symptomatology".

# How To Document Decline In Hospice Patients

**Zhe Xu**



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## **Table of Contents How To Document Decline In Hospice Patients**

1. Understanding the eBook How To Document Decline In Hospice Patients
  - The Rise of Digital Reading How To Document Decline In Hospice Patients
  - Advantages of eBooks Over Traditional Books
2. Identifying How To Document Decline In Hospice Patients
  - Exploring Different Genres
  - Considering Fiction vs. Non-Fiction
  - Determining Your Reading Goals
3. Choosing the Right eBook Platform
  - Popular eBook Platforms
  - Features to Look for in an How To Document Decline In Hospice Patients
  - User-Friendly Interface
4. Exploring eBook Recommendations from How To Document Decline In Hospice Patients
  - Personalized Recommendations
  - How To Document Decline In Hospice Patients User Reviews and Ratings
  - How To Document Decline In Hospice Patients and Bestseller Lists
5. Accessing How To Document Decline In Hospice Patients Free and Paid eBooks
  - How To Document Decline In Hospice Patients Public Domain eBooks
  - How To Document Decline In Hospice Patients eBook Subscription Services
  - How To Document Decline In Hospice Patients Budget-Friendly Options
6. Navigating How To Document Decline In Hospice Patients eBook Formats
  - ePub, PDF, MOBI, and More
  - How To Document Decline In Hospice Patients Compatibility with Devices
  - How To Document Decline In Hospice Patients Enhanced eBook Features
7. Enhancing Your Reading Experience
  - Adjustable Fonts and Text Sizes of How To Document Decline In Hospice Patients
  - Highlighting and Note-Taking How To Document Decline In Hospice Patients
  - Interactive Elements How To Document Decline In Hospice Patients
8. Staying Engaged with How To Document Decline In Hospice Patients

- Joining Online Reading Communities
- Participating in Virtual Book Clubs
- Following Authors and Publishers How To Document Decline In Hospice Patients
- 9. Balancing eBooks and Physical Books How To Document Decline In Hospice Patients
  - Benefits of a Digital Library
  - Creating a Diverse Reading Collection How To Document Decline In Hospice Patients
- 10. Overcoming Reading Challenges
  - Dealing with Digital Eye Strain
  - Minimizing Distractions
  - Managing Screen Time
- 11. Cultivating a Reading Routine How To Document Decline In Hospice Patients
  - Setting Reading Goals How To Document Decline In Hospice Patients
  - Carving Out Dedicated Reading Time
- 12. Sourcing Reliable Information of How To Document Decline In Hospice Patients
  - Fact-Checking eBook Content of How To Document Decline In Hospice Patients
  - Distinguishing Credible Sources
- 13. Promoting Lifelong Learning
  - Utilizing eBooks for Skill Development
  - Exploring Educational eBooks
- 14. Embracing eBook Trends
  - Integration of Multimedia Elements
  - Interactive and Gamified eBooks

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