Clinical Documentation in Home Health Care

Stephanie Bivens, JD, CELA
Kelly J. McDonald RN, JD
Bivens & Associates, PLLC
5020 E. Shea Blvd., #100
Scottsdale, AZ 85254
(480)922-1010  www.bivenslaw.com
Goals of Clinical Documentation

- Quality and Continuity of Care
- Satisfy Regulatory Compliance
- Ensure payment (Medicare)
Quality and Continuity of Care

- Clinical documentation should begin with a **complete assessment** and evaluation of the patient. Clinicians must record all details of their evaluation, clearly establishing the patient's condition upon start of treatment. This is the benchmark for tracking treatment progress. Each clinician must develop a thorough **plan of care** delineating a clinical route for getting the patient from their starting point to a higher level of health and functionality. Plans of care should include goals, treatment types and specific measures for outcome. **Progress** notes should clearly denote the care rendered and how it relates to the patient's plan of care. Treatment notes should indicate the impact of the intervention or treatment on the patient's overall condition. Charting needs to be clear, specific, and measurable. Home health agency progress notes become part of the patient’s medical record.

- Overall, the **primary goal** of proper clinical documentation is to ensure the quality and continuity of care to the patient by allowing the next care provider to know what you did, why you did it, and the benefit to the patient.

- Appropriate documentation promotes:
  - a high standard of clinical care
  - continuity of care
  - improved communication and dissemination of information between and across service providers
  - an accurate contemporaneous account of treatment, intervention and care planning
  - improved goal setting and evaluation of care outcomes
  - improved early detection of problems and changes in health status
  - evidence of patient care
## Satisfy Regulatory Compliance

**AAC R9-10-1106. Plan of Care**

- A. Home health services shall be provided by the home health agency in accordance with a written plan of care established and authorized by a physician in consultation with the patient and other members of the home health care team.
- B. The plan of care shall be based on the patient's diagnosis and the assessment of the patient's immediate and long-term needs and shall include the following:
  - 1. Diagnosis;
  - 2. Surgery dates relevant to home health services;
  - 3. Mental status;
  - 4. Functional limitations;
  - 5. Rehabilitation potential;
  - 6. Type and frequency of services to be provided;
  - 7. Treatments, medications, and any drug allergies;
  - 8. Therapy and professional services, procedures, and modalities including the amount, frequency, and duration of service;
  - 9. Activities permitted;
  - 10. Nutritional requirements; and
  - 11. Safety measures to protect against injury.
- C. Staff shall document, in the medical record, any verbal order for either the initiation or modification to the plan of care and shall include in the record the physician's verifying signature which shall be obtained within 30 days of the order.
- D. The home health care team shall review the plan of care every 62 days or more often, as the patient's need or condition warrants. The review shall include the authorization by the physician for the continuation of the patient's plan of care or the revision thereof.
Satisfy Regulatory Compliance

<table>
<thead>
<tr>
<th><strong>AAC R9-10-1108. Medical Records</strong></th>
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<tr>
<td>A. The administrator shall ensure the maintenance of policies and procedures governing the protection and confidentiality of medical records.</td>
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<td>B. Each agency shall maintain a medical record for each patient which contains the following:</td>
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<td>1. Patient name and address, name of patient’s representative, caretaker, and physician;</td>
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<td>2. Written acknowledgment that the patient received a copy of patient rights prior to the beginning of care;</td>
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<td>3. Documentation concerning advance directives;</td>
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<td>4. Medical history, current diagnoses, and findings;</td>
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<td>5. Plan of care;</td>
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<td>6. Physician orders;</td>
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<td>7. Initial and periodic assessments and progress notes that are dated, signed by the person providing the service, and filed weekly;</td>
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<td>8. Documentation of each patient contact for care or services;</td>
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<td>9. Reports of patient home health service conferences;</td>
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<td>10. Reports of patient summaries sent to the physician;</td>
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<td>11. Reports of contacts with the physician by staff and the patient;</td>
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<td>12. Supervisory reports on home health aide and personal care services; and</td>
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<td>13. Patient transfer or discharge plan and discharge summary.</td>
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<td>C. Medical records shall be maintained for five years beyond the last date of service provided. If the patient is a minor, the medical record shall be retained for three years after the patient reaches 18 years of age.</td>
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Satisfy Regulatory Compliance

- **AAC R9-10-1105. Supportive Services**
  - A. Supportive services do not require a physician order and shall be provided in accordance with agency policies.
  - B. Supportive services may include a personal care attendant who is employed by the agency to provide personal care services only. A registered nurse shall assign personal care tasks, in writing, to the attendant and shall ensure that the attendant documents all care provided in the patient's medical record.
A. The supervising physician or registered nurse shall ensure that nursing services shall be managed in accordance with the following:
   a. The initial assessment shall be conducted within 72 hours of a patient’s acceptance into a home health program and shall include a review of advance directives;
   b. Reassessments shall be conducted within 62-day periods thereafter, according to the patient’s needs and as the patient’s condition warrants; and
   c. The assessments shall include:
      i. Patient needs, resources, family, and environment;
      ii. Goals of patient care;
      iii. Medications used by the patient, including the side effects and contraindications; and
      iv. A listing of required medical supplies and durable medical goods.

2. A registered nurse shall be responsible for the following:
   a. Implementing a patient’s plan of care;
   b. Coordinating patient care with other members of the home health care team;
   c. Assigning a licensed practical nurse to provide nursing services in accordance with home health agency policies;
   d. Supervising home health aides and assigning written patient care duties to individual home health aides;
   e. Informing the patient’s physician of changes in a patient’s condition and needs;
   f. Summarizing the patient’s status for submission to the physician, every 62 days or more often, as the patient’s condition warrants;
   g. Ensuring that the findings and ongoing services are documented in the medical record for each patient contact;
   h. Participating in the preparation of patient transfer, discharge plan, and discharge summary;
   i. Documenting verbal orders received from the physician in the medical record;
   j. Conducting supervisory visits to the patient who is receiving home health aide services to determine the quality of care being given by the home health aide, according to the following schedule:
      i. Every two weeks when home health aide services together with either nursing services or therapy services are being provided; or
      ii. Every 62 days while only home health aide services are being provided; and
   k. Evaluating, by direct observation of performance, the competency of the home health aide and personal care attendant.
Satisfy Regulatory Compliance

- **AAC R9-10-1104. Home Health Services**
  - B. The supervising physician or registered nurse shall ensure that home health aide services are provided under the supervision of a registered nurse as follows:
  - i. Home health aide services shall be provided by an individual who has completed a home health aide training program pursuant to R9-10-1103(D) or by an individual who is in good standing with the State Board of Nursing, Nurse Aide Register.
  - ii. Each home health aide shall:
    - a. Perform only those tasks assigned, in writing, by the registered nurse or a therapist pursuant to subsection (C)(4);
    - b. Report any observations of change in a patient's condition to the registered nurse; and
    - c. Document care provided in the patient's medical record.
  - C. The supervising physician or registered nurse shall ensure that providers of therapy and other professional services comply with the following:
    - i. The services shall be ordered by a physician and provided in accordance with the patient's plan of care.
    - ii. A therapist or individual providing professional services shall:
      - a. Assist the physician in evaluating the patient's needs;
      - b. Participate in developing, evaluating, and revising the plan of care and establishing goals;
      - c. Coordinate patient care with other members of the home health care team;
      - d. Ensure that the findings and ongoing services are documented in the medical record; and
      - e. Participate in the preparation of the patient transfer, discharge plan, and discharge summary.
    - iii. A therapist or provider of professional services shall document any physician orders received pertaining to their respective therapy or professional services.
    - iv. A therapist may supervise a home health aide when a physician orders home health aide and therapy services only. As a supervisor, the therapist shall:
      - a. Assign patient care duties, in writing, to the home health aide;
      - b. Comply with the assessment requirements in subsection (A)(1); and
Satisfy Regulatory Compliance

- **42 CFR § 484.48**  Medicare Home Health Services Condition of Participation: Clinical Records.
  
  A clinical record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every patient receiving home health services. In addition to the plan of care, the record contains appropriate identifying information; name of physician; drug, dietary, treatment, and activity orders; signed and dated clinical and progress notes; copies of summary reports sent to the attending physician; and a discharge summary. The HHA must inform the attending physician of the availability of a discharge summary. The discharge summary must be sent to the attending physician upon request and must include the patient’s medical and health status at discharge.

- (a) **Standards: Retention of records.** Clinical records are retained for 5 years after the month the cost report to which the records apply is filed with the intermediary, unless State law stipulates a longer period of time. Policies provide for retention even if the HHA discontinues operations. If a patient is transferred to another health facility, a copy of the record or abstract is sent with the patient.

- (b) **Standards: Protection of records.** Clinical record information is safeguarded against loss or unauthorized use. Written procedures govern use and removal of records and the conditions for release of information. Patient’s written consent is required for release of information not authorized by law.
Ensure Payment (Medicare)

- **42 CFR 424.22 - Requirements for home health services.**
  
  As a condition for payment of home health services under Medicare Part A or Medicare Part B, a physician must certify as follows:
  
  (i) The individual needs or needed intermittent skilled nursing care, or physical or speech therapy.
  
  (ii) Home health services were required because the individual was confined to the home except when receiving outpatient services.
  
  (iii) A plan for furnishing the services has been established and is periodically reviewed by a physician who is a doctor of medicine, osteopathy, or podiatric medicine, and who is not precluded from performing this function. (A doctor of podiatric medicine may perform only plan of treatment functions that are consistent with the functions he or she is authorized to perform under State law.)
  
  (iv) The services were furnished while the individual was under the care of a physician who is a doctor of medicine, osteopathy, or podiatric medicine.

**Home Health Face-to-Face Encounter – A New Home Health Certification Requirement.** Note, as a condition for payment, the Affordable Care Act mandates that prior to certifying a patient’s eligibility for the home health benefit, the certifying physician must document that he or she has had a face-to-face encounter with the patient. Documentation regarding these encounters must be present on certifications for patients with starts of care on and after 1/1/11. The physician or allowed NPP(non-physician practitioner) must document when the physician saw the patient, and document how the patient’s clinical condition as seen during that encounter supports the patients homebound status and need for skilled services. Physicians who attend patients in acute or sub-acute settings may now certify the need for home health care based on their face to face contact with the patient, initiate the orders, and then “hand-off” the patient to his or her community-based physician to sign off on the plan of care. The face to face encounter must occur within the 90 days prior to start of care, or within 30 days after start of care.

Recertification is required at least every 60 days, preferably at the time the plan is reviewed, and must be signed by the physician who reviews the plan of care. The recertification is required at least every 60 days when there is a (i) Beneficiary elected transfer; or (ii) Discharge and return to the same HHA during the 60-day episode. The recertification statement must indicate the continuing need for services and estimate how much longer the services will be required. Need for occupational therapy may be the basis for continuing services that were initiated because the individual needed skilled nursing care or physical or speech therapy.
Ensure Payment (Medicare)

- Clinical documentation is written not just for a clinician to remember a patient’s case or to share information with another clinician working on a patient, but also for Medicare or another insurance reviewer to understand the necessity and progression of the patient’s course of treatment. Medicare pays for a patient’s progress or at a minimum, maintenance. As care providers render services they should clearly denote (1) the care provided, (2) how that care relates to the patient’s plan of care, and (3) the impact of the care or treatment on the patient’s overall condition. Charting needs to be specific and measurable and contain significant detail to best ensure insurance/Medicare reimbursement. In addition, these type of notes are beneficial in the event you or your company are sued.

- Detailed documentation will better ensure Medicare will not deny payment due to “lack of medical necessity”, when the problem is really lack of documented medical necessity.
Ensure Payment (Medicare)

- Publication 100-02, Chapter 7, Home Health Services (effective 4/1/11) enacted stricter standards for documenting therapy services.
- The assessment, measurement and documentation of therapy services under Medicare rules were recently updated which, in part, that at defined points during a course of treatment for each therapy discipline for which services are provided, a qualified therapist (not an assistant) must assess the patient’s function using a method which objectively measure ADLs such as, but not limited to eating, swallowing, bathing, dressing, toileting, walking, climbing stairs, using assistive devices, and mental and cognitive factors. Measurements must be documented in the medical record which correspond to the therapist’s discipline and care plan goals. At least every 30 days, a qualified therapist from each discipline must provide the ordered therapy service, functionally reassess the patient, and compare the resultant measurement to prior assessment measurements. The therapist must document in the clinical record the measurement results along with a determination of the effectiveness of therapy. Reassessment is also required by the qualified therapist on the 13th and 19th visits.
Helpful Charting Hints

- If your company uses pre-printed forms or a checklist format be sure to complete forms accurately. If you need more space to include a narrative, add a sheet.
- Use “just the facts” approach, avoid adverbs, opinions, or adjectives. This may be helpful to you or your employer if there are allegations of wrongdoing.
- If you need to make changes to the documentation do not “cross out” or “white out” the error. Rather, initial it and add the correction to the record. If you need to add something later (on a different date) it is best to enter a separate “late entry” explaining it is a late entry (not necessarily why) and initial the same. Changes or additions should be minimized as they can lead to confusing records and perceptions of poor care and decision making practices.
- Make progress/chart notes the same day as services are rendered. Chronological entries generally are considered more reliable as a representation of care rendered.
- Do not forget to include date, name, professional designation, and initials to documentation entries.
- When charting patient’s progress, focus on his needs and plan to treat unresolved problems.
- Documentation must be patient focused and based on professional observation and assessment that does not have any basis in unfounded conclusions or personal judgments.
- Identify of source of information (including information provided by another health care professional or patient family member)
- Document each time you teach the patient, family, and/or caregivers.
- It should be assumed that any and all clinical documentation will be scrutinized at some point.
- Detailed documentation in relation to critical incidents such as patient falls, harm to patients, or medication errors.