NHPCO GRAB & GO TOOLKIT

NHPCO Palliative Care Playbook for Hospices

Documentation

This toolkit is part of NHPCO's comprehensive Palliative Care Playbook that is available to members as a benefit of membership. Learn more about Community-Based Palliative Care Resources at www.nhpco.org/palliativecare.

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Leading Person-Centered Care

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There are multiple functions of documentation: communication, record of care (goals of care, care plan: assessment, interventions, response to treatment, etc.), reimbursement, quality assurance and process improvement. Effective documentation can improve the quality of care and patient safety. Effective documentation is comprehensive, accurate, timely, and accessible.

Electronic Health Record Evaluation

Most organizations use an electronic medical record to record documentation. There are a variety of vendors to choose from; some vendors focus solely on community-based services, such as home health and hospice care, others may focus on medical group practice documentation or hospital documentation. Single site focused electronic documentation software is typically called an electronic medical record. A few vendors have a comprehensive suite of products to cover care across the continuum, creating a multi-site electronic documentation software called an electronic health record which is more comprehensive. You are more apt to get program specific software from an EMR vendor; however, you get improved interoperability with an EHR.

Interoperability

The Centers for Medicare and Medicaid (CMS) are encouraging interoperability between electronic documentation software to ensure the provider and consumer have access to the most accurate up-to-date information when adjusting treatments and making care decisions. Proposed and new rules for various CMS reimbursed health care programs require software that meets 2015 CEHRT. For example, a medical group cannot participate in an advanced Alternative Payment Model unless their documentation software meets 2015 CERHT. The recently announced CMS/CMMI new care models require 2015 CEHRT to participate. Programs are allowed a one-year waiver. Incentives to achieve interoperability have been granted to software vendors for hospitals and medical groups, but not to community-based program software vendors. CMS/CMMI are now calling for penalties for providers and programs that do not meet the 2015 CEHRT across health care. It is recommended to select a vendor that meets or is working to meet the 2015 CEHRT requirements. If you are providing palliative care services to patients that are part of a health system or an ACO, check with them about interoperability between your EMR and theirs.

Registries

An EMR can provide functionality to create a panel of palliative care patients, often called a patient registry. Using a registry can help with case management and care coordination. Many palliative care programs operate as a population health management solution. Health management requires an ability to monitor the risk level of the population. Risks can include risk for disease progression, risk for symptom progression, risk for decline in function, risk for emergency room use and hospitalization, and risk for mortality. Some vendors have software programs that sit on top of the EMR to pull data out to inform the patient's risk level. Other applications allow for data extraction for quality reporting. Check with your vendor(s) about capabilities to use a registry for your panel of palliative care patients.

Practitioner Documentation

If your primary billing source will be Medicare B fee-for-service (FFS), it is best to think of your palliative care program as a medical practice. In FFS, the only members of the palliative care team that are billable are the physician and non-physician practitioners (NPPs), such as nurse practitioner, clinical nurse specialist, and physician assistant. These visits and services are billed under Evaluation and Management (E/M). Visits and services must be medically necessary and be provided by an eligible practitioner to be reimbursed. It is important to note that Medicare B does not have a mechanism to reimburse all members of an interdisciplinary team. There are no specific Conditions of Participation for the palliative care services. A medical practice follows the physician fee schedule rules.

There is an additional opportunity for mental health reimbursement if you have a licensed independent clinical social worker. You can also contract for these services. Billing for LICSW visits for individual or family psychotherapy must be based on a DSM V diagnosis code and local coverage determinations (LCDs) as defined by most Medicare Administrative Contractors.

Accurate coding is important to support the rational for services and treatments. Comprehensive documentation and coding paint a full picture of the patient. Palliative care physician and NPP documentation needs to be accurate to reflect the acuity of the patient, the utilization of resources, and ability to report quality. According to CMS, Physician and NPP documentation for E/M must include several elements:

- History*
- Physical examination*
- Medical decision making*
- Nature of the current problem
  - When documenting a specific condition include
    - Location
    - Laterality
    - Severity/stage
    - Type
    - Status: current/active or history/resolved
    - Causal relationships
- Counseling
- Coordination of care
- Time

**Considered the three key components of documentation.*

A couple other essential considerations that should be included in the physician/NPP documentation are

- Why the visit is medically necessary
- All acute and chronic diagnoses under treatment

For a comprehensive resource on physician/NPP documentation and coding, please see the resource creating by Jean Acevedo in collaboration with the California Health Care Foundation at https://www.chcf.org/wp-content/uploads/2019/05/DocumentationCodingHandbookPalliativeCare.pdf. This resource includes information on documentation for E/M coding, Advance Care Planning coding, Chronic Care Management coding, and risk avoidance. The hospice organization should not assume that physicians and NPPs have a thorough understanding of documentation and coding, even if they have practice experience. Quality assurance to review documentation and coding should be done on a regular basis, either weekly, monthly, or quarterly. Remedial education should be available for practitioners based on the quality of their documentation and coding. The hospice organization should have access to coding expertise either employed or via contract.

Documentation templates should reflect the elements necessary for accurate billing and coding. The templates can guide the behavior of the clinician to ensure completion of comprehensive assessments, diagnosis and treatment, advance care planning and goals of care discussions, symptom and medication management, caregiver assessment and support, care coordination, and development of a care plan.

Resource: Appendix A Samples of Electronic Documentation Templates for Physicians, NPPs, and Social Worker.

Z-Codes

Z-codes are used in conjunction with other diagnosis codes. Z codes replaced V codes in the ICD 10. Depending on the reason for the encounter some Z-codes can be used as the primary diagnoses while others may never be used as primary (e.g. Z51.5. should always be used as a secondary diagnosis code). Z51.5. should be used for all palliative care encounters as a secondary diagnosis code with a primary code for the condition requiring care. (Z51.5. replaces the ICD-9 code V66.7). Use of this code allows for identification of palliative care visits and could allow for reporting of prevalence of palliative care visits if everyone providing palliative care services used it consistently. Watch for ongoing guidance from the American Hospital Association on the use of Z51.5. as it may be allowed as a primary diagnosis for an inpatient stay in the future, depending on the reason for the admission. This could have implications for documentation requirements and claim submissions.

Per the ICD-10 Code book, there are two main reasons to use Z-codes: *"When a person who may or may not be sick encounters the health services for some specific purpose, such as to receive limited care or service for a current condition, to donate an organ or tissue, to receive prophylactic vaccination (immunization), or to discuss a problem which is in itself not a disease or injury."* OR *"When some circumstance or problem is present which influences the person's health status but is not in itself a current illness or injury."* Based on these reasons, you can see why use of the Z-codes in palliative care is appropriate and beneficial.

Resource: Appendix B Z-Codes for a breakdown of applicable Z-Codes and examples impacting reimbursement.

Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs)

The Center for Medicare and Medicaid Services (CMS) implemented the Quality Payment Program to reward value and outcomes through MIPS and APMs for professional services covered under the Medicare Physician Fee Schedule (PFS) based on the number of Medicare Part B patients served. Clinical performance is measured by data collected and reported in four areas: quality, improvement activities, promoting interoperability, and cost. Participation requirements are based on the volume of Medicare Part B patients or charges per year. Exempt clinicians include those in their first year of billing Medicare, clinicians with a low volume of Medicare Part B patients (< 200) or charges (< $90,000) or < 200 Medicare Part B services. Please note that clinicians that meet or exceed one or two, but not all, of the low volume threshold criteria can opt-in to participation. The low volume level is calculated at the participation level of the eligible clinician (either group or individual). Over time, the weight of the categories will evolve and shift. There are two hardship exceptions: one for the promoting interoperability category and the other for uncontrolled circumstances (e.g. natural disaster) applicable for the quality, cost, and improvement categories. There is technical assistance available to help rural and small provider practices to participate in MIPS. Reporting is done through claims, qualified clinical data registry, qualified registry, and electronic health records.

To learn more about MIPS and APMs and documentation considerations go to the following links:

- CMS Quality Payment Program
- AAFP MACRA Resources
- Certified Health IT Product List
- AMA Understanding MIPS
- SA/Ignite 10 FAQs about MIPS

Interdisciplinary Documentation

When a program is reimbursed for palliative care services by a health plan, they may use other codes to achieve payment. The plan may or may not direct staffing requirements. Staffing and payment methods are part of the contract negotiation. Some organizations negotiate for a per beneficiary per month reimbursement to cover the cost of the entire interdisciplinary team. The organization may negotiate an additional financial incentive for quality reporting and/or quality outcomes. Documentation templates for this type of reimbursement should include all the elements of services the organization has agreed to provide for the health plan beneficiaries. Ideally, these are the same services an organization provides to Medicare B beneficiaries; however, they may utilize other members of the interdisciplinary team to accomplish these tasks, with oversight from the program's medical director. The hospice may be able to use many of the templates already in use for hospice services to meet the documentation requirements for their palliative care program, but these templates need to be housed in a separate service within the EMR.

Depending on the type of program, all members of the interdisciplinary team need access to each other's notes. Check with your EMR vendor to see what functionality exists to achieve access in real time. It may be through a permission level for each individual clinician or an option to join the patient's care team. Find out if notifications can be received for all members of the care team when there are changes to the care plan (e.g. new orders, change in site of service or level of care, etc.). Check with the vendor to see if the patient has an option to have access to their record and if so, what level of access. For example, can they update their advance directives or care goals? Can the team set the level of access or the EMR view the patient has access to? Many vendors now have a patient portal and many health systems allow patients some level of access, including the ability to update portions of their records and ability to communicate directly with their practitioner.

Many programs see value in adding a registered nurse to case manage the panel of palliative care patients. Documentation for the RN should include holistic symptom and medication management activities and engagement activities. Symptom and medication management activities include all aspects of the nursing process: assessment, diagnosis, planning, implementation, and evaluation. Note, these activities should include a holistic approach, including physical, psycho-social, emotional, and spiritual. How else can the RN know when to trigger the need for intervention by other members of the interdisciplinary team? And the other members of the team benefit from the RN's documentation to understand what initiated the trigger. Engagement activities include care coordination, consultation, and collaboration with other members of

the health care team, as well as support, education, and coordination for the patient, family, and caregivers. You can use the same RN templates for your palliative care services that you use for your hospice program and modify to fit the expectations of the RN role within the palliative care model of care. Please refer to the Staffing chapter to review considerations regarding scope of practice and maintaining regulatory boundaries.

Standard assessment tools

A wise physician once said building templates in the EMR allows us to guide the behavior of the clinicians to ensure the quality of care provided. Incorporating evidence-based tools into the team's workflow is one way to accomplish this. Using a shared flowsheet has multiple values: standardizes best practice, creates efficiencies for physician and NPP documentation, ability to trend clinical information, and ease of data extraction for metrics. Ideally, the physician and NPPs on the team should be able to pull elements from the flowsheet into their progress note using a widget or shortcut. Furthermore, aligning the flowsheet rows across EMR modules allows the team to trend symptoms and other data elements across time and across the care continuum. Because the flowsheet is made up of discrete data elements, data can be pulled easily out of the record for quality measurement and reporting. Finally, consider which of these data elements might inform the care plan. Ask your EMR vendor and your IT build team about the ability to build the flowsheet, align it across modules (if applicable), provide a trending or synapsis function to view data over time and care settings, and how it may link to or pull certain discrete elements into the care plan.

Tip: The interdisciplinary team can help build the flowsheet. Start by researching evidence-based tools to identify which tools you want included in the flowsheet. One organization used an excel spreadsheet to list various tools. They divided the tools up to compile research, then came back together to determine which tools they would incorporate into the flowsheet based on several criteria (e.g. research to support validity, valid care settings, valid services/specialties, etc.). Here are some examples of tools you may want to consider:

- ESAS-r
- PPS
- Karnofsky Scale
- ECOG
- MME
- PHQ2 and PHQ9
- FAST
- Braden Scale
- Katz

Resource: Appendix C Copy of Assessment Tools Evaluation

When the tools have been identified, the flowsheet can be built. Ideally there is collaboration between the clinical team and the IT builder or developer. Once the flowsheet is built, testing can begin. Do not get discouraged if further refinement needs to occur. After all, that is the purpose of the testing phase. Testing needs to include all expectations for the flowsheet – alignment of rows across care settings, ability to pull data into physician and NPP progress note, synapsis or trending function, linkage to care plan, and ability extract data elements for reporting. When testing and refinement are completed and before implementation, the tool needs to be embedded in the workflow of various members of the team and a standard operating process or procedure needs to be written. The SOP will be part of the training and retraining phase for successful implementation of the flowsheet.

Resource: Appendix D Palliative Care Flowsheet

Example: UnityPoint Health developed a shared palliative care flowsheet in Epic. Members from the interdisciplinary team met with an informatics/build specialist and identified evidence-based tools to be incorporated into the flowsheet (see screenshot below). All members of the palliative care team should have access to the flowsheet. Physicians and NPPs had the ability to pulls data from the flowsheet into their progress note. This created an efficiency and improved team communication. The team developed standard operating procedures and workflows. They agreed on frequency

of completing the flowsheet and which team members were responsible. The team used the synapsis function to trend clinical information which was reviewed at the IDT meeting. The synapsis helped determine when a patient could be discharged from the palliative care service or when they should be moved to hospice (see second screen shot below). Metric definitions identified what data would be pulled when and why and how it would be reported. The team shared their flowsheet build with other Epic users and presented at the annual Epic conference.

Flowsheets

Summary · Chart Review · Results Review · Work List · Allergies · Immunizations · MAR · Flowsheets · Intake/Output · Notes · Education · Care Plan · Manage Orders · Charge Capture · Order Review · Prep for Proced... · InterDisciplinary · Palliative Care

File · Add Rows · Add LDA · Cascade · Add Col · Insert Col · Show Device Data · Last Filed · Reg Doc · Graph · Go to Date · Values By · Refresh · Legend · Cosign · Link Lines

Vital Signs · Adult Assessment · Infusion MAR · Intake/Output · Daily Cares/Safety · NICU D/C Checklist · Screenings · Core Measures · Oxygen · Post-Mortem · Palliative Care Asses...

Encounter Type · Encounter Type · Primary Palliative Diag... · Edmonton Symptom A... · Palliative Performance · FAST · MOCA · Mini Nutritional · MMSE · GDS · Patient Health Questio... · Non ICU Delirium Asse... · ICU Delirium Assessm... · Psychosocial · Stress Factors · Coping Responses · Spiritual & Cultural Scr... · Referrals Made · Decision to Forgo Trea... · Team Impact · Discharge Disposition

Encounter Type; Encounter Type; Primary Palliative Diagnosis; Primary Palliative Diagnosis; Edmonton Symptom Assessment System; Pain Score; Tiredness Score; Nausea Score; Depression Score; Anxiety Score; Drowsiness Score; Appetite Score; Wellbeing Score; Dyspnea Score; Other Problem Score; Palliative Performance Scale; Palliative Performance Scale Score; Functional Assessment Staging of Alzheimers Disease; FAST Stage Assessment; Visuospatial/Executive; Letters & Numbers; Cube Copy

08/13/15 1100 — Encounter Type — Select Single Option: (F5): Inpatient: ED; Inpatient: Hospital; Outpatient: Nursing Home Visit; Outpatient: Clinic; Outpatient: Home; Comment (F6)

Synopsis

Events By Time · Events By Type · Current Status · Palliative Care · Prenatal Profile · Ortho Profile · 6 Months · 07/06/15 – 01/02/16

Display: Days All

	7/9/2015	8/27/2015	Most Recent Value	
Encounter Type				
Encounter Type			Inpatient: Hospital	6/16/2015
Palliative Care Consult Type				
Palliative Care Consult Type				
Gestational Age				
Gestational Age				
Primary Palliative Diagnosis				
Primary Palliative Diagnosis				
Patient Goals				
Patient Goal(s)			test	1/12/2016
Advance Directives				
*Healthcare Directive		Yes AD	Yes AD	8/27/2015
(Calculated MU Data Element)		Met	Met	8/27/2015
Type of Healthcare Directive		Durable power of att...	Durable power of att...	8/27/2015
Information Provided on Healthcare Directives				
Healthcare Agent Appointed				
Power of Attorney for Healthcare Activated (WI Only)				
Healthcare Agent's Name				
Healthcare Agent's Phone Number				
Copy in Chart				
Patient has POST/POLST				
Date POST/POLST Initiated				
Pre-existing DNR/DNI Order				
Patient Requests Assistance				
Edmonton Symptom Assessment Symptom				
ESAS completed by			Patient	1/12/2016
Pain Score		3	3	8/27/2015
Tiredness Score			4	6/16/2015
Nausea Score			2	6/16/2015
Depression Score			4	6/16/2015
Anxiety Score			7	6/16/2015
Drowsiness Score			4	6/16/2015

The Care Plan

A care plan is broad, overarching, longitudinal blueprint that includes the patients' and the healthcare teams' concerns, goals, interventions, and outcomes. A plan of care is discipline specific with a focus on a set of related problems of health concerns. Several plans of care can be incorporated in a care plan. A treatment plan focuses on a specific health concern and is usually managed by one clinician. [1] We will focus on the care plan since it is the broadest plan and supports the care coordination value of a palliative care team. However, your palliative care service may only use the plan of care or treatment plan depending on the make up of your team and care model.

The care plan should include medical goals and treatment plan, as well as social determinants of health. You may be able to use the same care plan document for your palliative patients that you use for your hospice patients. Much of the care plan elements would be the same. Some things you may want to consider are whether there are elements of documentation elsewhere within the record that should link to the care plan or auto-populate the care plan. These functions allow the care plan to stay current and relevant. Does the patient have access to the care plan? Can they update portions of the care plan? Some EMR software allows access to the care plan through a patient portal. The organization can determine what elements of the care plan the patient can view and update. Another helpful function is automatic notification of members of the healthcare team when the care plan has been updated. Check with your vendor to see if these options are available.

Consider what information you want to be able to share with other members of the health care team (e.g. specialists, primary care physician, etc.). You can create a document for sharing through the state Health Information Exchange. Can the form be auto-populated? What other pieces of information need to be shared (e.g. medication lists)? What information do you need from others? How will you obtain this information? A key role and value of the palliative care team is care coordination and care management.

Here is an example of content in a Person-Centered Care Plan:[2]

Risk level: (High, Moderate, or Low) Risk is associated with severity of illness and other contributing factors. Work with your health care partners to define risk levels and identifiable factors

Last updated: (this function can be automatic whenever content related to Care Plan is updated elsewhere in the record, or when the Care Plan content is updated directly)

Medical History: (link)

Medications: (link)

Patient Care Team: (link) Some EMRs allow members of the care team to set notifications when Care Plans are updated

Personal Support Team: (Include community contacts, caseworkers, therapists, etc. here, primary caregiver/contact information)

Patient's Personal Goal(s):

Patient's Care Goal(s): (prevention and chronic)

Patient's Self-Management Tools: (include referrals, groups, DME, and education resources here)

Patient's Barriers to Care/Goals: (include any contributing risk factors here, e.g. social determinants of health, behavioral health, functional or cognitive barriers, etc.)

Advance Care Planning: (include link to advance directives, POST, etc.)

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1. Patricia C Dykes, Lipika Samal, Moreen Donahue, Jeffrey O Greenberg, Ann C Hurley, Omar Hasan, Terrance A O'Malley, Arjun K Venkatesh, Lynn A Volk, David W Bates, A patient-centered longitudinal care plan: vision versus reality, *Journal of the American Medical Informatics Association*, Volume 21, Issue 6, November 2014, Pages 1082–1090, https://doi.org/10.1136/amiajnl-2013-002454
2. Patient Centered Primary Care Institute. Examples of shared care plans. Retrieved from: http://www.pcpci.org/sites/default/files/resources/Shared%20Care%20Plans_0.pdf

Team Goals: (prevention and chronic)

For more information on developing a shared care plan go to https://integrationacademy.ahrq.gov/products/playbook/develop-shared-care-plan and https://www22.anthem.com/providertoolkit/SS3_UpdatedCarePlanPlaybook_EMPIRE.pdf and article by Dykes, et al. at https://academic.oup.com/jamia/article/21/6/1082/786980

Advance Care Planning, Advance Directives, and POST

Great work is done by the palliative care team to engage seriously ill individuals and their loved ones in goals of care and advance care planning conversations. However, patients, their families and even healthcare staff continue to misunderstand the purpose of advance care planning and other elements that support it.

Advance care planning is a process that should be initiated at the time of the initial encounter with the patient. Advance care planning is a communication process that allows the clinician and the patient, along with their family to discuss 'how they want their healthcare to go' based on their understanding of their disease process and their care goals. Advance care planning incorporates other activities, such as, goals of care discussions, advance directives and shared decision-making elements. It is an iterative process that must be established and reviewed at regular intervals. When this does not happen goals of care can become mis-matched with previously documented care goals as seen primarily with advance directive documents.

None of this great work matters if it is not documented and accessible to all the patient's health care partners. Be thoughtful about how your EMR provides opportunity to document these conversations and store Advance Directives and Physician Orders for Scope of Treatment (POST) documents. Many programs identify these conversations and directives as quality measures, so you'll need to have a way to extract them easily from the EMR. More importantly, the patient's wishes and the legal documents need to be readily accessible in the case of an emergent situation. Does your state participate in a cloud-based platform to store AD and POST documents? Do you have a policy and process for documenting ACP, AD, and POST? Do the patient's health partners have timely access to this information? Can your EMR prompt an auto-reminder to share updated information with the patient's healthcare partners?

Conclusion

There are multiple functions of documentation: communication, record of care (goals of care, care plan: assessment, interventions, response to treatment, etc.), reimbursement, quality assurance and process improvement. Effective documentation can improve the quality of care and patient safety. Effective documentation is comprehensive, accurate, timely, and accessible.

Appendix A: Samples of Electronic Documentation

The following are template examples of a variety of palliative care notes. Several of these examples are for inpatient but can easily be adapted for the clinic and home setting. Note the different short cuts and widgets are specific to the EMR software being used; however, these do provide examples of how functionality within the software can be used to optimize the software's capabilities and enhance the documentation tool.

Palliative Care Inpatient Note Examples – Medical provider

Palliative Care Initial Consult Note

Requesting Provider: ***
Unit Location at Time of Initial Consultation: {Select hospital:15267}
Primary diagnosis most pertinent to consult: {Select diagnosis:15268}
Reason for Consult: {Select reason(s):15264}

History Of Present Illness

Information for this consult was obtained from: {Select source(s):15269}
@HPI@
Pain Regimen: {Regimen?:15289}
Review: I have reviewed the {Reviewed:14835} in the electronic medical record and have made updates as needed.

Pertinent Review Of Systems

Pain: {Select Scale:15288}
Nausea / Vomiting: {N/V?:15270}
Dyspnea: {Dyspnea?:15271}
Additional @ROSBYAGE@

Social History / Spiritual

@HHSOCDOC@
Spiritual: { :11685}

Functional Status

@FUNCSTAT@

Physical Exam

Vitals: Temp Trend: @TMAX(24)@
Recent Vitals: @FLOW(6)@ | @FLOW(5)@ | @FLOW(8)@ | @FLOW(9)@ | @FLOW(10)@ | @FLOW(250026)@ | @FLOW(301030)@ | @FLOW(14)@
@PHYEXAMPAL@
Diagnostic Data: {Results Reviewed:13567}

Assessment / Prognosis

***

Recommendations

Goals of Care: ***
Symptom Management: ***
Psychosocial: ***
Intervention(s) made by team: {Select all that apply:15273}

Spent {Care Coord. Time:13938} out of {Total Time:13941} minutes in care coordination with the medical team and in education of {Patient family members:11427} on prognosis, disease process and symptom management.

{Select for prolonged service - otherwise DELETE:15272}

Palliative Care Follow-Up Note

Subjective

Subjective: ***
Current Medications Reviewed? {YES / NO:13732}
Pain: {Select Scale:15288}
Nausea / Vomiting: {N/V?:15270}
Dyspnea: {Dyspnea?:15271}
Other Symptoms: ***
Additional @ROSBYAGE@

Social History

@HHSOCDOC@

Physical Exam

Vitals:
Temp Trend: @TMAX(24)@
Recent Vitals: @FLOW(6)@ | @FLOW(5)@ | @FLOW(8)@ | @FLOW(9)@ | @FLOW(10)@ | @FLOW(250026)@ | @FLOW(301030)@ | @FLOW(14)@
@PHYEXAMPAL@
@FUNCSTAT@
Diagnostic Data: {Results Reviewed:13567}

Assessment / Prognosis

***

Recommendations

Goals of Care: ***
Symptom Management: ***
Psychosocial: ***
Intervention(s) made by team: {Select all that apply:15273}

Spent {Care Coord. Time:13938} out of {Total Time:13941} minutes in care coordination with the medical team and in education of {Patient family members:11427} on prognosis, disease process and symptom management.

{Select for prolonged service - otherwise DELETE:15272}

Palliative Medicine Consult

@NAME@
@MRN@

Attending Provider: @ATTPROV@
PCP: @PCP@
Palliative Medicine consult requested by @ATTPROV@ for @NAME@ who is a @AGE@ to:

Clarify patient/family goals of care
Provide symptom management recommendations
Clarify patient's long-term goals
Discuss patient's disease trajectory and overall prognosis
Discuss medical treatment options as it relates to patient/family goals of care

Impression

***
@RRPROBLIST@

Recommendations

Thank you for this consult and I agree with current interventions.
*** I suggest the following for as part of a Symptom Management Plan for @NAME@ and it includes:
***

*** Please complete and sign the colored Illinois DNAR form if patient is being discharged as the patient is currently @ CODESTATUS@

Subjective

HPI:
@NAME@ is @AGE@ and was admitted @ADMITDT@ with diagnoses of @ADMITDX@.
***

Review of Systems {ROS; COMPLETE:372162}
Palliative Care specific ROS:
Pain Assessment: (0=none, 1=mild, 2=moderate, 3=severe) ***

Location	
Intensity (0-10)	
Duration	
Description	
Radiates to	
Alleviated by	
Aggravated	
Current analgesic	
Is it working	
On softener/laxative	

Pain Management Interventions: see above
Symptom Assessment: (0=none, 1=mild, 2=moderate, 3=severe)

Dyspnea	***
Constipation	
Nausea	
Vomiting	
Depression	
Anorexia	
Cough	
Insomnia	
Diarrhea	
fatigue	
weakness	
confusion	

Treatment Side effects: ***
Symptom interventions: see above

History

@PMH@
@PSH@
@ALLERGY@
@MEDICATIONHOSP@
@MEDSPTA@
@SOC@
@FAMHX@

Objective:

Vital Signs: @VS@

Physcial Exam

General:
Ill appearing patient lying in bed
appropriate affect,
no apparent distress
Awake
Somnolent
Speech fluent

NEURO:
Mental status: Alert, oriented, thought content appropriate. No focal neurological deficits

HEENT:
Eyes: conjunctivae/corneas clear.
Ears: external ear w/o deformities b/l
Nose: Nares normal. No drainage, no discharge
Throat: Lips, Teeth and gums normal;
Neck: supple, symmetrical, trachea midline

Chest:
Expansion equal
Breath sounds vesicular b/l, no adventious sounds auscultated

CV:
No JVD noted, NoS3/S4 gallop, No rubs, Diastole clear
No Peripheral edema

Abdomen:
Soft, non tender, non-distended, Bowel sounds present

Extremities:
All extremities normal, atraumatic no cyanosis or edema, warm to touch

Skin:
turgor normal, no rashes or lesions, no jaundice or ulcerations

Lab And Diagostic Testing

Labs for 72 hrs
{FIND; LABS72:372210}

Palliative Care Assessment

Medical record reviewed and I spoke with patient's nurse and ***

1. **Process Of Care:**
   Goals of care clarified and include:
   Reduce unnecessary hospitalizations
   Maintain and/or increase quality of life
   Have symptoms well managed
   ***

Discussed treatment options risk and benefits: ***
Provided a copy of "Hard Choices for Loving People" to assist with decision making

Discussed discharge needs and realistic plan of care to meet these needs

*** Referred to Hospice - meets eligibility criteria for:

2. **Physical:**
   Physical exam performed on this patient (see finding).
   Symptom management plan established (see recommendations)

   Appears comfortable without short of breath or in pain at this time
   *** Appears to be in distress due to the following symptoms: ***

3. **Psychological:**

   Social and financial issues discussed.
   No Issues identified.
   *** Identified:
      Anticipatory grief
      Increased stress
      Decreased coping methods
   *** Low, Moderate, High Bereavement risk
   *** Negative/Positive Depression screening: "In the past two weeks, how often have you felt down, depressed, or

hopeless?"
Social worker consult ordered for ***

4. **Spiritual**:

*** No Issues identified.
Chaplain consult ordered for ***

5. **Social:**

Social and financial issues discussed.
*** No Issues identified.
*** Identified: work/home, financial, intimacy, and caregiver concerns

Lives at/with:
Family:

Social worker consult ordered for ***

Caregiver Distress: Caregiver needs discussed, including the need for respite, issues of guilt, and the intensity of family caregiving.
How to support caregiver and community resources discussed.

6. **Cultural:**

No Issues identified.
*** Identified:
  Language barrier
  Concerns about disclosure, truth telling, decision making
  An interpreter is needed.

7. **Care Of The Dying Patient:**

*** Patient not imminently dying at this time although sudden death would not be unexpected in someone with his/her health problems and age
*** Educated family of disease trajectory and signs/symptoms of approaching death
*** Discussed need for family to make funeral home arrangements
*** Funeral arrangements made by family; Funeral home of choice is:
*** Patient is displaying sign of approaching, imminent death.
*** Assessment includes: Apnea, irregular/labored respirations, cyanosis, mottling, unresponsiveness, no intake, decreased output, diminished pulses, agitation/terminal restlessness, and respiration secretions.
*** Emotional supported provided to family.

8. **Ethical And Legal:**

No Issues identified.
*** Patient has completed Advance Directives and it is on file
*** At time of exam @NAME@ is deemed decisional by this practitioner.
*** is patient's HCPOA Please include HCPOA and patient in any medical decision.

Facilitated discussion about patient's code status and provided literature about "what you should know about CPR"
The patient is @CODESTATUS@ and is so documented in EPIC chart.

Prognosis

Educated patient/family about patient's overall prognosis and disease trajectory (see prognosis)
Patient charted reviewed and based on physical assessment and patient/family interview, the following prognostication tool(s) were completed.

Karnofsky performance status scale

Value	Level of Functional Capacity
100	Normal, no complaints, no evidence of disease
90	Able to carry on normal activity, minor signs or symptoms of disease
80	Normal activity with effort, some signs or symptoms of disease
70	Cares for self, unable to carry on normal activity or to do active work
60	Requires occasional assistance, but is able to care for most needs
50	Requires considerable assistance and frequent medical care
40	Disabled, requires special care and assistance
30	Severely disabled, hospitalization is indicated although death is not imminent
20	Hospitalization is necessary, very sick, active supportive treatment necessary
10	Moribund, fatal processes progressing rapidly

Cancer Patients

Palliative Prognostic Index Score

Performance Score

10-20	4.0
30-50	2.5
>60	0

Oral Intake

Severely reduced	2.5
Moderately reduced	1.0
Normal	0
Edema	1.0
Dyspnea at rest	3.5
Delirium	4.0

TOTAL

Median Survival

90 days	< 2.0
61 days	2.1-4.0
12 days	>4,0

Recent Hospitalization in last 6 months
*** YES NO

Previous Palliative Medicine Service Consult:
*** YES NO

Summary

The following was achieved as a result of this Palliative Care encounter:
*** Patient/family verbalizes improved understanding of chronic illness and its trajectory.
Patient/family goals of care have been identified.
Distressing symptoms identified and recommendations made.
Treatment options and plan of care have been discussed and revised.
Advance directives completed
Code status was changed
Referral made to hospice

I have discussed recommendation with Palliative Care attending physician ***
and he concurs. Further, I have discussed my findings with patient's nurse, referring provider, social work and case management staff caring for this patient.

*** minutes were spent in total for this visit which consisted primarily of counseling and education dealing with the complex and emotionally intense issues of symptom management and palliative care in the setting of serious and potentially life-threatening illness. Patient/family had opportunity to ask questions.

Palliative Care IP Daily Progress Note

Date of Service:***
Primary Team and Attending: ***
Following for: Goals of care; pain; symptom management, family support, coping,***

History of Present Illness:

*** is a *** Y female with *** who is known to the palliative care team. ***

Review of Systems:

{ROS - COMPLETE:12658} Put palliative review of systems

Physical Exam:

Vitals: I personally reviewed the patient's vitals, relevant findings include:***

{PE PALLIATIVE CARE CC:50093112}

Karnofsky Performance Score
{KARNOFSKY SCALE:5010858}

Data Review / Labs:

Imaging/Labs: I personally reviewed the patient's labs/imaging and relevant results include: ***

____

____

Impression: ***

Recommendations:

1) ***

____

____

Counseling:

I spent a total of *** minutes unit floor time, of which *** minutes were spent in counseling and coordination of care.
{COUNSELING - PALLIATIVE CARE CC:50923112}

NICU Family Conference Note

Date and time of meeting: ***
Primary Team: ***
Attending MD: ***

Purpose: {IP PURPOSE:50150001}: (goal setting, clinical information sharing, resuscitation preferences, transition to comfort plan, disposition)

Location: patient's bedside, conference room, ***

Patient Participation: (would be in drop down)the patient participated in the discussion, the patient did not participate in the meeting due to ***

HPOA (activated/not-activated)

Family participation:
Family spokesperson and relationship:
Healthcare POA or guardian (if applicable):
Additional family/friends present for the discussion:

Clinical team participation:
Meeting was lead by:
Care team members present for the discussion: (drop down, critical care nurse, case management/social work, resident, fellow, attending, palliative care, primary physician, consulting medical team)

Meeting Summary:***

Patient/Family Goals of Care: (cure, life prolongation, rehabilitation, comfort, ***)

Prognosis:

Resuscitation Status: (full code, DNR, DNR/DNI, treatment limitations)

Next meeting if necessary: Date: *** Time:***

Faculty Attestation:
I participated in family conference along with *** (resident, nurse, fellow) as summarized above and spent *** minutes of face to face time in the unit of which greater than 50% of which was spent counseling, coordinating care and participating in conference.

Palliative Care IP Consult Note

Date of Service: @TD@
Date of Admission: @ADMITDT@

Attending Physician: @ATTPROV@
Primary Care Physician: @PCP@

Reason for Consult: To address pain management in the setting of ***.

Impression/Recommendations:

This is a @AGE@ old * with:**

1. Diagnosis: ***
   a. Estimated length of life: hours to days, days to weeks, weeks to months, less than 1 year, depends on goals, unknown, no life limiting condition,(Dropdown) ***
   b. Patient defined goals of care: cure, life prolongation, rehabilitation, comfort, deferred, deferred at primary teams request (Dropdown).

2. Nociceptive/Neuropathic Pain Syndrome secondary to ***:
   a. Recommend Starting ***
   b. Recommend Starting ***

3. Symptom (Dropdown):
   a. Recommend Starting ***
   b. Recommend Starting ***
   c.

4. Advanced Care Planning:
   a. Decision Making Capacity: {DECISION MAKING:50333112}
   b. POAHC: done, on file; done, not on file; not done; unknown status; deferred; deferred at primary teams request;***
   c. Limitations on life-sustaining treatments: None—Full Code; No escalation of care; No ICU transfer; No feeding tube, No antibiotics; DNR/DNI; *** (Dropdown)
   Community DNR Form/Bracelet: Present; Recommend completion (Dropdown)
   d. Date of last Family Meeting: None since admission; ***
   e. Attitude towards place of death: home, hospital, nursing home, Residential hospice, or other *** (Dropdown)
   f. Funeral arrangements/wishes: ***

5. Coping Style: ***
6. Stressors:
   a. ***
   b. ***

7.

History of Present Illness:

@M@ @LNAME@ is a @AGE@ old former *** with a PMH significant for *** and who was admitted to Froedtert Hospital on @ADMITDT@ with ***. The Palliative Medicine Team has been asked by Dr. @ATTPROV@ to see the patient to address ***.

Description of Symptom: ***

Oncological history: if relevant.

Patient's Understanding of the disease: ***

Family's Understanding of the disease: ***

Information Sharing Preferences: may share with

Patient preference for receiving information and decision making: Fully involved, Speak to family, Leave to MD, Unsure.***

Social History:

Spiritual History:
Religious Affiliation: {RELIGION/SPIRITUAL: 17029}
{SPIRITUAL HISTORY - PALLIATIVE CARE CC: 51373112}

Patient Support system: ***

Family Support system: ***

Family coping: ***

Education: ***

Work: ***

Hobbies/Joys: ***

Habits:
Tobacco: {YES NO UNSURE:50343112}
Alcohol: { YES NO UNSURE:50343112}
Recreational drugs: { YES NO UNSURE:50343112}
Patient {ADMITS TO/DENIES:50252007} any previous chemical dependency treatment.

Palliative Review of Symptoms:

(Dropdown – 1. I have completed a 14 point ROS and is negative except for the following; 2. Text below)

Pain Issues: ***

Constitutional:
Fevers/Chills: {YES NO UNSURE:50343112}
Weight Loss: {YES NO UNSURE:50343112}
Nutritional Status, including anorxia: {SEVERITY - EC:5653099}
Confusion: {SEVERITY - EC:5653099}

Eyes:
Vision changes: {YES NO UNSURE:50343112}

HEENT:
Headaches: {SEVERITY - EC:5653099}
Oral symptoms (oral pain, xerostomia, dysphagia, odynophagia): {YES NO UNSURE:50343112}

Respiratory
Dyspnea: {SEVERITY - EC:5653099}
Cough: {SEVERITY - EC:5653099}

Cardiovascular
Chest Pain:{YES NO UNSURE:50343112}

Gastrointestinal:

Abdominal Pain:{YES NO UNSURE:50343112}
Dyspepsia: {YES NO UNSURE:50343112}
Nausea/vomiting: {SEVERITY - EC:5653099}
Constipation: {YES NO UNSURE:50343112}
Diarrhea: {YES NO UNSURE:50343112}

Genitourinary:

Urinary Symptoms: {YES NO UNSURE:50343112}

Endocrine:

Fatigue: {SEVERITY - EC:5653099}

Neuro:

Sleep disturbance: {YES NO UNSURE:50343112}
Sedation: {SEVERITY - EC:5653099}
Myoclonus: {YES NO UNSURE:50343112}
Numbness/Weakness/Tingling: {SEVERITY - EC:5653099}

Musculoskeletal:

Muscle Weakness: {YES NO UNSURE:50343112}
Myalgias: {YES NO UNSURE:50343112}
Arthralgias: {YES NO UNSURE:50343112}

Psych:

Anxiety: {SEVERITY - EC:5653099}
Depression: {SEVERITY - EC:5653099}
Restlessness: {YES NO UNSURE:50343112}

Heme: Bleeding issues (epistaxis, hematuria): {YES NO UNSURE:50343112}

Skin: Rashs/pruritis: {YES NO UNSURE:50343112}

Other: ***

Past Medical:

I have personally reviewed the PMH as documented in the H&P; it is pertinent for ***.
@PMH@

Family History:

I have personally reviewed the family history as documented in the H&P; it is pertinent for ***.
@FAMHX@

Family history of alcohol/substance misuse: {Yes(relative 50033105)/No:50023105::"No"}

Allergies:

@ALLERGY@

Medications:

I have personally reviewed the medication list documented in the MAR and it is pertinent for:
***
@IPMEDLIST@

Physical Exam:

I have personally reviewed the vital signs for the last 24 hours and they are significant for:
@IPVITALSLAST@
@LAST3WT@

{PE PALLIATIVE CARE CC:50093112}

Delirium: {YES NO UNSURE:50343112}
Depression: {YES NO UNSURE:50343112}
Capacity for Decision-making: {YES NO UNSURE:50343112}

Karnofsky Performance Score
{KARNOFSKY SCALE:5010858}
ECOG Score:
{ECOG:50203112}

Data Review:

Laboratory: I personally reviewed the patient's labs and relevant results include:
***
@LAST1CR@
@LAST1LIVERFUNCTIONTESTS@

@LAST1CBC@

Imaging: I personally reviewed the patient's relevant imaging and results include:
***

Impression/Recommendations: Please refer to the assessment and recommendations documented at the top of the note.
The patient history and recommendations were discussed with ***.
@THANKYOUFORCONSULT@
@METIMESTAMP@

Counseling: (dropdown for inpatient/outpatient)

I spent a total of *** minutes unit floor (vs face to face) time today, of which >50% of minutes were spent in counseling and coordination of care. *** minutes were spent F2F.

{COUNSELING - PALLIATIVE CARE CC:50923112}

.**these are outpatient based **

I counseled the patient today about opioid use, side effects and toxicities. The patient was instructed to call our clinic immediately if having uncontrolled pain, constipation, sedation, frequent PRN use, or any other concern with their pain management.

I counseled the patient today about hospice care and its philosophy focusing on comfort, safety and family support. The general levels of service hospice can provide including the home, inpatient and respite settings were included in this discussion.

The patient was given instructions on how to contact our team during both regular hours and after hours; and was instructed to call at any time with new symptoms, questions or other issues

Palliative Care Assessment

Referring Physician:	***
Primary Physician:	@PCP@
Primary Diagnosis:	(Change to principal prob)
Secondary Diagnosis:	***

Reason for Consult: {Reason:20219}

Source Of Information: {INFORMATION SOURCE PALLIATIVE CARE:21032} ***

Patient Profile And Understanding Of Medical Condition:
Met with patient and family in conjunction with Palliative Care Provider, ***. Please refer to ***'s consultation note.

Living Situation/Support Services: ***
Home medical equipment: ***
Services in home: ***

Functional Assessment: {NUMBERS 0-100% (BY TEN %):21028}
Based on Palliative Performance Scale

(INSERT PPS SMARTLINK)

Advance Directives:
(INSERT SMARTLINK FOR SEC_MODEL_IP_DIRECTIVES)

Code status reviewed: {yes no:314532} Advance directive education provided: {Yes/No-Ex:120004}

Communication And Family Dynamics: ***

Cognition: {COGNITION PALLIATIVE CARE:21030}

Emotional Status / Psychological Symptoms: {PAL UPH EMOTIONAL STATUS/PSYCH SX PALLIATIVE CARE:30410001}
(INSERT PHQ2/4 AND PHQ9 SMARTLINK)

Anticipatory Grief: {yes no:314532}
***

Symptoms (INSERT SMARTLINK FOR ESAS - EACH ROW)

Spiritual-Cultural:
(INSERT SMARTLINK FROM DEMOG. FOR COMMUNITY OF FAITH)
(INSERT SMARTLINK FOR SPIRITUAL-CULTURAL SCREENING FS)
***

Patient and/or Family's Goals Of Care: ***

PLAN OF CARE based on patient's goals, values and preferences: ***

RECOMMENDATIONS for care, treatment and services: ***
Referral communicated to Patient Care Coordinator for: (INSERT SMARTLINK FOR REFERRALS MADE FLOWSHEET ROW)

Information regarding consult and plan of care communicated to: {PALLIATIVE CARE REFERRAL INFO COMMUNICATED TO:21034}- WITHIN LIST - CHANGE PHYSICIAN TO PROVIDER, ADD FAMILY ***

***

Palliative Care Team will follow during current hospitalization. ***

@ME@

@TD@ @NOW@

Palliative Care Consult

Name: @NAME@
Date of Birth: @DOB@
@ADMITDT@
@RRHLOS@
@ATTPROV@
MRN: @MRN@
CSN: @CSN@

Referring Physician:	***
Primary Physician:	@PCP@
Primary Diagnosis:	(Change to principal prob)

Reason for Consult: {Reason:20219}

Source of Information: {INFORMATION SOURCE PALLIATIVE CARE:21032} ***

History of Present Illness:
@NAME@ is a @AGE@ @SEX@ admitted ***
@PROBL@
@PMH@
@HXPSH@

Meds:
@CMED@

Social History: ***

Advance Directives:

(INSERT SMARTLINK FOR SEC_MODEL_IP_DIRECTIVES)
Code status reviewed: {yes no:314532}
Advance directive education provided: {Yes/No-Ex:120004}

***

ROS:
Review of Systems - {ros master:310782}

Symptoms: (INSERT SMARTLINK FOR ESAS - EACH ROW)

Exam:
@VSRANGES@
@LASTENCWT@

***

Emotional Status / Psychological Symptoms: {PAL UPH EMOTIONAL STATUS/PSYCH SX PALLIATIVE CARE:30410001
(INSERT PHQ2/4 AND PHQ9 SMARTLINK)

Labs/Diagnostics:

General:
{IP IHS GENERAL LABS:20242}

Heme:
{Hemelabs:304101015}

Pertinent Testing:

Functional Assessment: {NUMBERS 0-100% (BY TEN %):21028}
Based on Palliative Performance Scale
(INSERT PPS SMARTLINK)

Cognition: {COGNITION PALLIATIVE CARE:21030}

Assessment/Plan:
@HPROBL@

Plan: ***

Patient Profile and Understanding of Medical Condition:
Met with patient and family in conjunction with ***. Please refer to ***'s assessment note.

Thank you for the consult and opportunity to participate in the care of your patient.

@ME@

@TD@ @NOW@

Time: *** minutes in evaluation of patient with greater than 50% spent in counseling/discussing goals of care and care coordination.

Palliative Care Note

Encounter: {PALLIATIVE CARE ENCOUNTER:21021}

Purpose of this encounter: {PALLIATIVE CARE ENCOUNTER PURPOSE:21022}

Symptoms (rated on a scale of 0-10): {SYMPTOMS PALLIATIVE CARE:21023}

Emotional Needs: {EMOTIONAL NEEDS PALLIATIVE CARE:21024}

Referral made to: {PALLIATIVE CARE REFERRALS MADE TO:21025}

Spiritual Support: {SPIRITUAL SUPPORT PALLIATIVE CARE:21026}

Discharge Plan: {DISCHARGE PLAN PALLIATIVE CARE:21027}

Note: ***

Information regarding plan of care and recommendations communicated to: {PALLIATIVE CARE REFERRAL INFO COMMUNICATED TO:21034}

Palliative Sign Out Note

Code Status : @RRCODESTATUS@

Diagnosis: ***

Patient/Family Goal: ***

Symptom Management:***

Spiritual Care: ***

Disposition:***

Plan:***

Examples of PC Social Work Notes:

Palliative Care Initial Social Work Consult Note

Requesting Provider: @DBLINK(EPT,5610)@

Unit Location at Time of Initial Consultation: {Select hospital:15267}

Primary diagnosis most pertinent to consult: {Select diagnosis:15268}

Reason for Consult: {Select reason(s):15264}

Persons interviewed and their relationship to patient: {Select source(s):15269}

History of Present Illness

Information for this consult was obtained from: {Select source(s):15269}

Reason for hospital admission: ***

Course of hospital stay: ***

Pertinent Review Of Symptoms

Pain: {Select Scale:15288}

Nausea / Vomiting: {N/V?:15270}

Dyspnea: {Dyspnea?:15271}

Other Symptoms {Other symptoms:13940}

Social History / Spiritual

@HHSOCDOC@

Patient lives: {Living arrangements:60532}

Spiritual Considerations: { :11685}
@FUNCSTAT@

Palliative Performance Scale

{PPS:11426}

Prior PPS: {Prior PPS%:114261}

Assessment

Patient Mental Status: {MENTAL STATUS:30415512}

Patient Emotional Status: {EMOTIONAL STATUS:30415514}

Family Emotional Status: {EMOTIONAL STATUS:30415514}

Strengths related Coping: {COPING:30415513}

Confounding Factors: {Palliative Confounding Factors:109113}

Support System: {EXCELLENT/GOOD/FAIR/POOR:14807}

Needs: {NEEDS:30415515}

Patient person strength: {PATPERSTR:13638}

Sources of Support: {SourceofSupport:13644}

Reaction to Health Status: {HealthStatReaction:13646}

Understanding of Condition: {UnderstandCondition:13647}

Assessment / Problems Identified: ***

Recommendations

Advance Directives: {Palliative ADV DIR:10915104}

Intervention(s) Made by Team: {Select all that apply:15273}

Patient/Family Goals of Care: ***

Recommendations: ***

Anticipated disposition: {Living arrangements:60532}

Palliative Care Social Work Progress Note

Date of Admission: @ADMITDT@

Purpose of Visit: {VISIT PURPOSE:30415511}

Subjective

Person(s) interviewed and their relationship to patient: {Select source(s):15269}

Palliative Performance Scale

{PPS:11426}

Pertinent Review Of Symptoms

Pain: {Select Scale:15288}

Nausea / Vomiting: {N/V?:15270}

Dyspnea: {Dyspnea?:15271}

Other Symptoms {Other symptoms:13940}

Social History / Spiritual

@HHSOCDOC@

Assessment

Patient Mental Status: {MENTAL STATUS:30415512}

Patient Emotional Status: {EMOTIONAL STATUS:30415514}

Family Emotional Status: {EMOTIONAL STATUS:30415514}

Strengths related Coping: {COPING:30415513}

Narrative:

Recommendations

Advance Directives: {Palliative ADV DIR:10915104}

Intervention(s) Made by Team: {Select all that apply:15273}

Patient/Family Goals of Care: ***

Recommendations: ***

Anticipated disposition: {Living arrangements:60532}

Palliative Care Program Psychosocial Assessment Worksheet

Patient Name: @PNAME@
Room Number: @ROOMBED@

Patient Age: @AGE@
Sex: @SEX@
Marital Status:
# of Children:

Patient/Family Learning ability: {LEARNING BARRIERS:30411113}
Comments:

Patient/Family reported chief concern:
Patients Hopes/Goals:

Caregiving Assessment:

Patient lives: {Living arrangements:60532}
Primary caregiver/relationship/telephone:
Secondary caregiver/relationship/telephone:
Support System: {ADEQUATE INADEQUATE:30415506}
Financial issues/concerns:
Referral Made: {REFERRAL MADE:30415507}

Patient/Family Adaptive State:

Pt/Family aware of diagnosis/prognosis: {YES/NO/UNKNOWN:74}
Communication Pattern:{OPEN CLOSED:30415508}
Diagnosis/Prognosis: {PROGNOSIS:30415509}
Comments:

Legal Issues:

Living Will: {YES / NO:13732}
Carelink Indicates: {YES / NO:13732}
Living Will - Date: ***
Healthcare Surrogate: ***
Secondary Surrogate: ***
Life-prolonging treatment to be withheld: {YES / NO:13732}
Artificial nutrition/hydration to be withheld: {YES / NO:13732}

POA in Record: {YES / NO:13732}
Carelink Indicates: {YES / NO:13732}
Healthcare POA: {YES / NO:13732} Financial POA: {YES / NO:13732}
Date of POA: ****
POA Name:
Secondary POA:

Discharge Planning

Patient to return to: {RETURNING TO:30415510}

Additional Comments/Concerns:

@ME@ @TD@

Palliative Care Psychosocial Assessment

Purpose of Visit:{VISIT PURPOSE:30415511}
Diagnosis: @DIAG@
Mental Status: {MENTAL STATUS:30415512}

Ethnicity:
Marital Status:
Spiritual/Faith:

Patient Coping Status: {COPING:30415513}
Family Coping: {COPING:30415513}
Support System: {ADEQUATE/ INADEQUATE:12159}

Emotional Status: {EMOTIONAL STATUS:30415514}
Needs: {NEEDS:30415515}
Advance Directives: {advanced directive:12455}

Family Decision Maker:
Relationship:
Main Contact #

Code Status:

Living arrangements prior to hospitalization:

Anticipated disposition:
Veteran: {YES / NO:13732}
Branch:
Employment History:
History of abuse/habits:
Mental Health History:
Bereavement risk factors:
Other family/friends involved:
Interpreter needed: {YES / NO:13732}

Goals of Care:
@ME@

AdvancedCare Social Work Assessment Flow sheet

Informant Name:
Informant relationship to patient:

Patient's Primary Health Concern: (Open text)

Patient Perception of Illness: (Open Text)

Caregiver/family Perception of illness: (Open Text)

Language:

☐ English spoken/understood
☐ Interpreter needed ______________

Military History

☐ none
Branch of Service_________________ Combat ☐ Yes ☐No
Dates of Service__________________

Special Spiritual/cultural Needs related to treatment:

☐No ☐ Yes ____

Ability to Express thoughts/needs/Feelings

☐ Expresses thoughts/feeling/needs without difficulty
☐ Requires extra time or cuing
☐Speech limited to single words
☐ Uses only gestures (eyes blinking/eye or head movement/pointing)
☐ Unable to express thoughts/feeling/needs (speech unintelligible or inappropriate)

Living Arrangements:

☐ Patient's own home
☐ Home family member/friend
☐ Boarding home
☐ Assisted Living/retirement center
☐ Skilled nursing facility
☐ Long term care facility/nursing home
☐ shelter/homeless
☐ Other

Stability of current living situation:

☐ Permanent
☐ Stable
☐Temporary
☐ At risk
Notes: ____

Members of Household:

☐ Patient Lives Alone

Name:	Relationship:	Age:	Actively Involved:
______	______	______	☐ Yes ☐ No
______	______	______	☐ Yes ☐ No
______	______	______	☐ Yes ☐ No
______	______	______	☐ Yes ☐ No
______	______	______	☐ Yes ☐ No

Family Members/significant others not part of the household:

Name:	Relationship:	Age:	Actively Involved:
______	______	______	☐ Yes ☐ No
______	______	______	☐ Yes ☐ No
______	______	______	☐ Yes ☐ No
______	______	______	☐ Yes ☐ No

Relationship of Primary Caregiver:

☐ No primary caregiver
☐ Spouse/Significant other
☐ Natural child
☐ Step child
☐ Sibling
☐ Parent
☐ Friend/neighbor
☐ Community church/volunteer
☐ Paid help
☐ Other
Notes ______________________________

Caregiver limitations (potential or actual)

☐None
☐ Vision
☐ Hearing
☐ Speech/language
☐ Mobility/endurance
☐ Alcohol/substance abuse
☐ Conflict with patient
☐Concurrent treatment for own illness
☐ Limited coping skills
☐Difficulty with own ADLs
☐ Availability
☐ knowledge/understanding of illness/diagnosis
☐ Other
Notes: ______________________________

Support System

☐ Excellent - three or more willing family members/friends
☐ Good -two or less willing family members/friends
☐ Fair- one willing family member or friend
☐ Poor – no willing family members of friends

Knowledge of Disease Process:

☐ Excellent
☐ Good
☐ Fair
☐ Little
Education needs ____

Burden of Care

☐ None evident
☐ Physical caregiving responsibilities
☐ Emotional stress
☐ Financial strain
☐ Role conflict
☐ Change in family lifestyle
☐ Sleep disturbance
☐ Coping with Patient's behavior
☐ Other ____
Notes: ____

Abuse/Neglect(risk):

☐ history of abuse/neglect
☐ Lives alone or without concerned relatives
☐ Cognitive impairment
☐ Physical disability
☐ Intellectual disability
☐ Unsafe environment (ie guns/drug uses/history of violence in home)
Notes: ____

Abuse/Neglect (actual):

☐ No signs of abuse/neglect
☐ Physical
☐ Emotional
☐ Financial
☐ Sexual
☐ Inadequate or delayed medical care
☐ Other ____
Description ____
☐ Referral to protective services

Alertness

☐ Alert/oriented
☐ Lethargic
☐ Responds to verbal stimuli

☐ Responds to tactile stimuli
☐ Responds to Pain
☐ Unresponsive
Notes: ____

Sleep Pattern:

Hours per day _____ Time to onset of sleep _____
Perception of Sleep : ☐ Normal ☐Too much ☐too little

Ability to concentrate:

☐ No concern ☐ Difficulty concentrating

Energy Level:

☐ Low ☐ Average ☐ High

Memory:

☐ Intact ☐ Impaired
Notes:

Cognitive

☐ Negative for cognitive impairment
☐ Positive for cognitive impairment
Notes: ____

ADL's

I= Independent A=Assistance needed D=Dependent
Eating ____ Bathing ____ Dressing ____ Toileting ____ Transfers ____ Mobility ____

IADL's

Meal Prep ____ Money Mgmt ____ Medication Mgmt ____ Transportation ____
Telephone use ____ Housework ____ Shopping ____

Functional Impairments:

☐ Speech ☐ Hearing ☐ vision ☐ Ambulation ☐ SOB ☐ Endurance ☐ Amputation
☐ Other ____________________

Mood:

☐ Euthymic ☐ Depressed ☐ Anxious ☐Angry ☐ Euphoric ☐ Irritable

Affect:

☐ Congruent with mood ☐ Full ☐Constricted
☐ Flat ☐ Labile ☐Blunted ☐ Unable to assess

Thought Process:

☐ Logical/goal oriented ☐ Abstract ☐ Concrete ☐ Vague
☐ Tangential ☐ Perseverating ☐ Flight of Ideas

Mental Health History:

☐NA
Psychiatrist ______________________________
Therapist ______________________________
Diagnosis ______________________________
Hospitalization ______________________________
Notes: ______________________________

Substance Use/history

☐ None
☐ Alcohol Last used: _________ Frequency:_________
☐ Drugs Last used: _________ Frequency:_________
☐ Nicotine Last used: _________ Frequency:_________
☐ Other ______________________________

Sources of Stress in addition to Illness

☐ Financial☐ Employment change/job loss☐ Career/job change☐ Lifestyle change

☐ Child care
☐ death of a child
☐ death of a parent
☐ death of a spouse
☐ Housing
☐ Family/marital discord
☐ Marriage within last year
☐ Separation/divorce
☐ Legal Issues
☐ Transportation
☐ Moved
☐ Other ______________________________

Notes: ______________________________

Stress level reported:

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Financial:

Source of Income: ☐ Employed ☐Retirement ☐SSD ☐SSDI ☐SSI ☐medical disability/employer
Notes: ______________________________

Financial Concerns expressed: ______________________________

Leisure Activities:

____

What limits leisure activities: ______________________________
Identified Strengths: ______________________________
Unique Needs and Issues: ______________________________

Community Resources:

	Using	Needs
Home Health	☐	☐
Meal Assistance	☐	☐
Homemaker	☐	☐
Medicaid	☐	☐
SSI/SSDI	☐	☐
LTC Placement	☐	☐
ALF Placement	☐	☐
VA Benefits	☐	☐
Hospice	☐	☐
Respite	☐	☐
Adult Day Care	☐	☐
Emergency response system	☐	☐
Support Group	☐	☐
HME	☐	☐

Advanced Directives:

☐ Living Will ☐ Durable POA ☐ IPOLST/IPOST

Screening Tools Used:

☐ GAD-7 ☐ SAD ☐ SLUMS ☐ Mini Cog ☐ PHQ-9 ☐ ESAS

Assessment/Summary

____

Patient/ Family Expectations:

____

Interventions:

☐ Provide Crisis Intervention
☐ Assist with community Resource planning/Referral
☐ Counseling regarding need for short term problem solving
☐ Counseling regarding need for long-range planning and decision making
☐ Psychiatric referral
☐ Psychotherapy referral
☐ Education ____
☐ Other ____

Appendix B: Z-Codes

- Z-codes capture status or problem impacting the patient other than a disease or external cause, including socio-economic issues. However, a Z-code should not be used if an assigned ICD-10 code includes the status (such as a "complication of …")
  - Z00 – Z13 Health services for exams
  - Z14 – Z15 Genetic carrier and genetic susceptibility to disease
  - Z16 Resistance to antimicrobial drugs
  - Z17 Estrogen receptor status
  - Z18 Retained foreign body fragments
  - Z20 – Z28 Potential health hazards related to communicable diseases
  - Z30 – Z39 Health services in circumstances related to reproduction
  - Z40 – Z53 Encounters for other specific aftercare
  - Z55 – Z65 Potential health hazards related to socioeconomic and psychosocial circumstances
  - Z66 Do not resuscitate
  - Z67 Blood type
  - Z68 Body mass index
  - Z69 – Z76 Health services in other circumstances
  - Z77 – Z99 Potential health hazards related to family and personal history and certain conditions influencing health status
- o Z43 should be used when routine care, adjustment, or fitting is done to an artificial opening (e.g. tracheostomy, colostomy, fistula, etc.). This is not just about status of the opening, but about care. Documentation should indicate whether care was provided for the opening or if it is self-maintained.
  - Z43.0 - Encounter for attention to tracheostomy
  - Z43.1 - Encounter for attention to gastrostomy
  - Z43.2 - Encounter for attention to ileostomy
  - Z43.3 - for attention to colostomy
  - Z43.4 - Encounter for attention to other artificial openings of digestive tract
  - Z43.5 - Encounter for attention to cystostomy
  - Z43.6 - Encounter for attention to other artificial openings of urinary tract
  - Z43.7 - Encounter for attention to artificial vagina
  - Z43.8 - Encounter for attention to other artificial openings
  - Z43.9 - Encounter for attention to unspecified artificial opening
- Z55 – Z65 address potential health hazards related to socioeconomic and psychosocial issues. Links between the social determinants of health and disease management and prognostication continue to be explored and supported by research. Use of these codes continues to support research and explain issues related to the patient's disease process or treatment. For example, look at the proliferation of information on trauma-informed care. Below are Z-codes related to a history of abuse and neglect:
  - Z62.810 - Personal history of physical and sexual abuse in childhood
  - Z62.811 - Personal history of psychological abuse in childhood
  - Z62.812 - Personal history of neglect in childhood
  - Z62.819 - Personal history of unspecified abuse in childhood
- Family Issues:
  - Z62.820 - Parent-biological child conflict
  - Z62.821 - Parent-adopted child conflict
  - Z62.822 - Parent-foster child conflict
  - Z62.890 - Parent-child estrangement NEC
  - Z63.0 - Problems in relationship with spouse or partner
  - Z63.1- Problems in relationship with in-laws
  - Z63.31 - Absence of family member due to military deployment

  - Z63.32 - Other absence of family member
  - Z63.4 - Disappearance and death of family member
  - Z63.5 - Disruption of family by separation and divorce
  - Z63.6 - Dependent relative needing care at home
  - Z63.71 - Stress on family due to return of family member from military deployment
  - Z63.72 - Alcoholism and drug addiction in family
  - Z63.79 - Other stressful life events affecting family and household
- Housing and Resource Problems:
  - Z59.0 - Homelessness
  - Z59.1 - Inadequate housing
    - Lack of heating
    - Restriction of space
    - Technical defects in home preventing adequate care
    - Unsatisfactory surroundings
  - Z59.2 - Discord with neighbors, lodgers and landlord
  - Z59.4 - Lack of adequate food and safe drinking water
  - Z59.5 - Extreme poverty
  - Z59.6 - Low income
  - Z59.7 - Insufficient social insurance and welfare support
  - Z59.8 - Other problems related to housing and economic circumstances
    - Foreclosure on loan
    - Isolated dwelling
    - Problems with creditors
  - Z59.9 - Problem related to housing and economic circumstances, unspecified
  - Z60.2 - Problems related to living alone
- Z66 Do Not Resuscitate (DNR) may be used when it is documented by the physician or NPP that the patient has a DNR any time during the stay. Note: Each state has different regulations regarding the validity of a DNR outside of the hospital setting. If a POLST document is completed that includes a DNR order, this can suffice
- Z68 Body Mass can be used whenever weight is an issue, such as morbid obesity, cachexia, or malnutrition. The physician or NPP should document the diagnosis associated with a high or low BMI. The BMI can be obtained the documentation of other members of the interdisciplinary team (e.g. nurse or nutritionist).

  Obesity

  - –Z68.30-Body mass index (BMI) 30.0-30.9, adult
  - –Z68.31-Body mass index (BMI) 31.0-31.9, adult
  - –Z68.32-Body mass index (BMI) 32.0-32.9, adult
  - –Z68.33-Body mass index (BMI) 33.0-33.9, adult
  - –Z68.34-Body mass index (BMI) 34.0-34.9, adult
  - –Z68.35-Body mass index (BMI) 35.0-35.9, adult
  - –Z68.36-Body mass index (BMI) 36.0-36.9, adult
  - –Z68.37-Body mass index (BMI) 37.0-37.9, adult
  - –Z68.38-Body mass index (BMI) 38.0-38.9, adult
  - –Z68.39-Body mass index (BMI) 39.0-39.9, adult

  Morbid Obesity

  - Z68.41- Body mass index (BMI) 40.0-44.9, adult
  - –Z68.42 - Body mass index (BMI) 45.0-49.9, adult
  - –Z68.43 - Body mass index (BMI) 50-59.9 , adult
  - –Z68.44 - Body mass index (BMI) 60.0-69.9, adult

- –Z68.45 - Body mass index (BMI) 70 or greater, adult

Low weight issues: i.e. underweight, cachexia, malnutrition, anorexia

- –Z68.1 - Body mass index (BMI) 19 or less, adult
  - Use for BMI under 19 and from 19 – 19.9

Here is a comparison of reimbursement impacted by whether the Z code is used with ICD 10 codes. The first example does not include the Z code:

ICD-10-CM Diagnoses

#	GF	Code	POA	Description
1		J44.1	⚠	Chronic obstructive pulmonary disease with (acute) exacerbation

ICD-10-CM Diagnoses

#	GF	Code	POA	Description
1		J44.1	⚠	Chronic obstructive pulmonary disease with (acute) exacerbation
2	CC	Z68.1		Body mass index (BMI) 19 or less, adult
3		R63.4	⚠	Abnormal weight loss
4		Z51.5		Encounter for palliative care
5		I10	⚠	Essential (primary) hypertension
6		E03.9	⚠	Hypothyroidism, unspecified

ICD-10-PCS Procedures

#	GF	Code	Description	Episode	Provider	Date

CPT/HCPCS Procedures

#	Code	Description	Modifiers	Units	Ep	Provider	Date

DRG: **191 Chronic obstructive pulmonary disease w CC** MDC: **4** MS-DRG ver.33.0, Medicare IPPS/Medicare Managed Care

Weight: **0.9321** AMLOS: **4** GMLOS: **3.3** Cost Outlier: **N** Reimb: **$8,707.23**

- Opportunistic infections are fairly common in the seriously ill patient population. When an infection is resistant to antibiotic treatment a Z code can be used. First, code the infection. Then code the type of organism
  - MRSA and MSSA are combined into the organism code
  - B95.61 Methicillin susceptible staphylococcus aureus as the cause of diseases classified elsewhere
  - B95.62 Methicillin resistant Staphylococcus aureus infection as the cause of diseases classified elsewhere
- Resistance to other agents:

- Z16.2 Resistance to other antibiotics
  - Z16.20 Resistance to unspecified antibiotic / Resistance to antibiotics NOS
  - Z16.21 Resistance to vancomycin
  - Z16.22 Resistance to vancomycin related antibiotics
  - Z16.23 Resistance to quinolones and fluoroquinolones
  - 216.24 Resistance to multiple antibiotics
  - 216.29 Resistance to other single specified antibiotic
    - Resistance to aminoglycosides
    - Resistance to macroslides
    - Resistance to sulfonamides
    - Resistance to tetracyclines
  - Resistance to other antimicrobial drugs (excludes Z16.1-, Z16.2-)
    - Z16.30 Resistance to unspecified antimicrobial drugs / Drug resistance NOS
    - Z16.31 Resistance to antiparasitic drug(s) Resistance to quinine and related compounds
    - Z16.32 Resistance to antifungal drug(s)
    - Z16.33 Resistance to antiviral drug(s)
    - Z16.34 Resistance to antimycobacterial drug(s) Resistance to tuberculostatics
      - Z16.341 Resistance to single antimycobacterial drug / NOS
      - Z16.342 Resistance to multiple antimycobacterial drugs
    - Z16.35 Resistance to multiple antimicrobial drugs Excludes Resistance to multiple antibiotics only (Z16.24)
    - Z16.39 Resistance to other specified antimicrobial drug
- For example, a 83 year old woman diagnosed with a UTI with ESBL E> Coli would be assigned the following codes:
  - N39.0 urinary tract infection
  - B96.20 escherichia coli
  - Z16.12 extended spectrum beta lactamase (ESBL) resistance

- Health service in other circumstances Z69 – Z76 are used to describe confinement, difficulty accessing another level of care, or need for relief care.
  - Care Dependency Codes include
    - Z74.01 Bed confinement status
    - Z74.09 Other reduced mobility
    - Z74.1 Need for assistance with personal care
    - Z74.2 Need for assistance at home and no other household member is able to render care
    - Z74.3 Need for continuous supervision
    - Z74.8 Other problems related to care provider dependency
    - Z74.9 Problem related to care provider dependency, unspecified
    - Z75.0 Medical services not available in the home
    - Z75.1 Person awaiting admission to adequate facility elsewhere
    - Z75.2 Other waiting period for investigation and treatment
    - Z75.3 Unavailability and inaccessibility of health-care facilities
    - Z75.4 Unavailability and inaccessibility of other helping agencies
    - Z75.5 Holiday relief care
    - Z75.8 Other problems related to medical facilities and other health care
    - Z75.9 Unspecified problem related to medical facilities and other health care
  - Potential health hazards related to family and personal history and certain conditions influencing health status are covered by Z77 – Z99
    - For example, Z85 is used when a previous primary malignancy has been excised or eradicated from it site and there

is no further treatment and no evidence of any existing primary malignancy. An extension, invasion, or malignancy to another site is coded as a secondary neoplasm to that site. The secondary site can be listed first as the principal with the Z85 used as a secondary code. Personal history of malignancy codes includes the following:

- Z85.01 Personal history of malignant neoplasm of esophagus
- Z85.020 Personal history of malignant carcinoid tumor of stomach
- Z85.028 Personal history of other malignant neoplasm of stomach
- Z85.030 Personal history of malignant carcinoid tumor of large intestine
- Z85.038 Personal history of malignant neoplasm of large intestine

- A case example: A 55-year-old woman with history of breast cancer. Had mastectomy and chemotherapy with eradication of primary site. Now cancer has spread to intra-abdominal lymph nodes and bone. C77.2 secondary malignant neoplasm of intra-abdominal lymph nodes; C79.51 secondary malignant neoplasm of bone; Z85.3 personal history of malignant neoplasm of breast.

- Category Z95-Z97 include a multitude of codes for devices placed in a patient: cardiac, orthopedic, nervous system, etc. These codes are not used for complications related to devices.
  - Heart devices:
    - Z95.810 Presence of automatic (implantable) cardiac defibrillator
    - Z95.811 Presence of heart assist device
    - Z95.812 Presence of fully implantable artificial heart
    - Z95.818 Presence of other cardiac implants and grafts
    - Z95.820 Peripheral vascular angioplasty status with implants and grafts
    - Z95.828 Presence of other vascular implants and grafts
    - Z95.2 Presence of prosthetic heart valve
    - Z95.3 Presence of xenogenic heart valve
    - Z95.4 Presence of other heart-valve replacement
    - Z95.5 Presence of coronary angioplasty implant and graft
- Codes for dependence on external medical devices to manage a disease include:
  - Z99.0 Dependence on aspirator
  - Z99.11 Dependence on respirator (ventilator) status
  - Z99.12 Encounter for respirator (ventilator) dependence during power failure
  - Z99.2 Dependence on renal dialysis
  - Z99.3 Dependence on wheelchair
  - Z99.8 Dependence on other enabling machines and devices
  - Z99.81 Dependence on supplemental oxygen
  - Z99.89 Dependence on other enabling machines and devices

Here is an example comparing not using these Z codes:

ICD-10-CM Diagnoses

#	GF	Code	POA	Description
1	SP, RP	⚠ I50.33	⚠	Acute on chronic diastolic (congestive) heart failure
2	R2	J44.9	⚠	Chronic obstructive pulmonary disease, unspecified
3	S3, R2	J96.11	⚠	Chronic respiratory failure with hypoxia
4		Z51.5		Encounter for palliative care
5		I10	⚠	Essential (primary) hypertension

ICD-10-PCS Procedures

#	GF	Code	Description

CPT/HCPCS Procedures

#	Code	Description	Modifiers	Units	Ep

DRG: **194 Heart failure** MDC: **5** SOI: **2** ROM: **2** APR ver.32.0 (HAC), APR Weights and Trims (Simple Pricing)

Weight: **0.6127** Long Stay: **11** Short Stay: **1** AMLOS: **3.57** GMLOS: **3.03** Cost Outlier: **N** Reimb: **$4,103.25**

To using these Z codes (note the difference in reimbursement is an additional $2,319.84 with Z codes):

ICD-10-CM Diagnoses

#	GF	Code	POA	Description
1	SP, RP	⚠ I50.33	⚠	Acute on chronic diastolic (congestive) heart failure
2	S2	J44.9	⚠	Chronic obstructive pulmonary disease, unspecified
3	S3, R2	J96.11	⚠	Chronic respiratory failure with hypoxia
4	S2, R2	Z99.81		Dependence on supplemental oxygen
5		Z51.5		Encounter for palliative care
6		I10	⚠	Essential (primary) hypertension

ICD-10-PCS Procedures

#	GF	Code	Description

CPT/HCPCS Procedures

#	Code	Description	Modifiers	Units	Ep	P

DRG: **194 Heart failure** MDC: **5** SOI: **3** ROM: **2** APR ver.32.0 (HAC), APR Weights and Trims (Simple Pricing)

Weight: **0.9591** Long Stay: **17** Short Stay: **1** AMLOS: **5.36** GMLOS: **4.46** Cost Outlier: **N** Reimb: **$6,423.09**

- There are Z codes to describe organ status such as transplant or absence.
  - Z94.0 Kidney transplant status
  - Z94.1 Heart transplant status
  - Z94.2 Lung transplant status
  - Z94.3 Heart and lungs transplant status
  - Z94.4 Liver transplant status
  - Z94.5 Skin transplant status
  - Z94.6 Bone transplant status
  - Z94.7 Corneal transplant status
  - Z94.81 Bone marrow transplant status
  - Z94.82 Intestine transplant status
  - Z94.83 Pancreas transplant status
  - Z94.84 Stem cells transplant status
  - Z94.89 Other transplanted organ and tissue status
  - Z94.9 Transplanted organ and tissue status, unspecified

- Z codes used for the absence of an organ or body part include:
  - Z89.511 Acquired absence of right leg below knee
  - Z89.512 Acquired absence of left leg below knee
  - Z89.611 Acquired absence of right leg above knee
  - Z89.612 Acquired absence of left leg above knee
  - Z90.410 Acquired total absence of pancreas
  - Z90.411 Acquired partial absence of pancreas
  - Z90.49 Acquired absence of other specified parts of digestive tract
  - Z90.5 Acquired absence of kidney
- For presence of an artificial opening not requiring care use these Z codes:
  - Z93.0 Tracheostomy status
  - Z93.1 Gastrostomy status
  - Z93.2 Ileostomy status
  - Z93.3 Colostomy status
  - Z93.4 Other artificial openings of gastrointestinal tract status
  - Z93.50 Unspecified cystostomy status
  - Z93.51 Cutaneous-vesicostomy status
  - Z93.52 Appendico-vesicostomy status
  - Z93.59 Other cystostomy status
  - Z93.6 Other artificial openings of urinary tract status
  - Z93.8 Other artificial opening status
  - Z93.9 Artificial opening status, unspecified
- Category Z79 indicates the patient is being treated with medications on a long-term basis. Not to be used for toxic or adverse effects of a drug. Codes from this category should not be used for any medication being administered for a brief period of time to treat an acute illness or injury (e.g. course of antibiotics to treat an infection).
  - Z79.01 Long term (current) use of anticoagulants
  - Z79.02 Long term (current) use of antithrombotics/antiplatelets
  - Z79.1 Long term (current) use of non-steroidal anti-inflammatories (NSAID)
  - Z79.2 Long term (current) use of antibiotics
  - Z79.3 Long term (current) use of hormonal contraceptives
  - Z79.4 Long term (current) use of insulin
  - Z79.51 Long term (current) use of inhaled steroids
  - Z79.52 Long term (current) use of systemic steroids
- Non-compliant patients can increase resource use, including readmissions. Managing non-compliant patients can be difficult. There are Z codes that describe the reason for, or type of, non-compliance.
  - Z91.11 Patient's noncompliance with dietary regimen
  - Z91.120 Patient's intentional underdosing of medication regimen due to financial hardship
  - Z91.128 Patient's intentional underdosing of medication regimen for other reason
  - Z91.130 Patient's unintentional underdosing of medication regimen due to age-related debility.
  - Z91.138 Patient's unintentional underdosing of medication for other reason
  - Z91.14 Patient's other noncompliance with medication regimen
  - Z91.15 Patient's noncompliance with renal dialysis
  - Z91.19 Patient's noncompliance with other medical treatment and regimen
- Underdosing as defined by taking less of a medication than is prescribed by a provider or a manufacturer's instruction is a relatively new concept with ICD 10. Z-codes should be used if the reason for the hospitalization or service for the relapse of the condition under treatment is caused by underdosing or underdosing is a contributing factor. Supportive documentation provides a clear picture for readmissions/revisits. The physician or NPP must document the impact on the condition under

treatment or the condition that the underdosing caused; the fact that underdosing occurred; and the reason the underdosing happened.

- Intention Underdosing
  - Z91.12 Patient's intentional underdosing of medication regimen
    - Z91.120 Patient's intentional underdosing of medication regimen due to financial hardship
    - Z91.128 Patient's intentional underdosing of medication regimen for other reason
- Un-intentional Underdosing
  - Z91.13 Patient's unintentional underdosing of medication regimen
    - Z91.130 Patient's unintentional underdosing of medication regimen due to age-related debility
    - Z91.138 Patient's unintentional underdosing of medication regimen for other reason
- Unspecified Underdosing
  - Z91.14 Patient's other noncompliance with medication regimen
    - Patient's underdosing of medication NOS
- Example: A patient is being treated with prednisone for bone pain from metastatic bone cancer from the primary right lower lobe lung cancer. The patient stopped taking the medication due to forgetfulness from brain metastasis and developed secondary adrenal insufficiency.
  - E27.40 Adrenocortical insufficiency
  - T38.0X6A Underdosing of glucocorticoids and synthetic analogues
  - Z91.138 Patient's unintentional underdosing of medication regimen for other reason
  - Additional codes: lung cancer, secondary bone cancer, secondary brain cancer, neoplasm related pain
- Example: An elderly patient is admitted with acute on chronic diastolic CHF. The physician documents that the exacerbation occurred because the patient did not have enough money to buy the medications.
  - 150.33 Acute on chronic diastolic (congestive) heart failure
  - T50.1X6A Underdosing of loop (high-ceiling) diuretics, initial encounter
  - Z91.120 Patient's intentional underdosing of medication regimen due to financial hardship

Appendix C: Assessment Tools Evaluation

Assessment Tool	Evaluator Volunteers	Sites currently using	Domain	Presence of research that supports the validity of the tool	Valid in these care sites (aligned w research)	Valid with these Services / Specialties	Source of info?	Required by a VBC or regulation (payor source if Yes)	Informs Risk Stratification (currently used or being considered for inclusion in Risk Strat algorithm	Is integrated into EHR	Can be integrated into EHR	Access via portal	Data entry attributes / burden (minutes to complete)
				Yes	Hospital	Hospice	Patient		Yes	Yes	Yes	Yes	2
				No	Home	Pallitative Care	Family member		No	No	No	No	5
					Clinic	Behavioral Health	Physician						10
					SNF	Oncology	Other provider						30
					All	Pulmonary	Other staff						
					ICF	Cardiac							
						Pain Clinic							
						NA							
ACE - Adverse Childhood Experiences		1	Psychosocial										
Anxiety (PROMIS, GAD-7)		9	Psychosocial										
Borg Dyspnea Scale		5	Physical										
Braden Scale– Pressure Ulcer Risk Assessment		8	Physical										
Cognitive Assessment (Mini-Cog, Montreal Cognitive Assessment)		10	Psychosocial	Yes	All	All	Patient		Yes		Yes	No	3
Colorado Bereavement Risk Tool		0	Psychosocial										
Delirium Scale (CAM)		1	Psychosocial										
Distress Scale (Kessler Psychological Distress Scale, Subjective Units of Distress Scale)		1	Psychosocial										
ESAS-r - Edmonton Symptom Assessment System Revised		7	Comprehensive	Yes	All	All	Patient or PCG		No	Yes		Yes (pot)	2 or 5
FAST - Functional Assessment Screening Tool		6	Physical	Yes	All	Dementia only	Physician		Yes				
Ferrans & Power Quality of Life tool (assesses multiple domains)			Comprehensive										
Functional Status Questionnaire		10	Physical										
Hamilton Depression Scale			Psychosocial										
HRA - Health Risk Assessment		4	Comprehensive										
LCD - Local Coverage Determination guideline for Hospice		3	Comprehensive	Yes (old)	All	Hospice	Other provider & staff		No	No	?	NA	30+
MAHC-10 – Missouri Alliance for Home Care (fall risk)		3	Comprehensive	Yes	Home	HC, Hospice	Other staff		Yes	Yes			2
NCCN Distress scale			Psychosocial										
Pain Assessment / Scales (WILDA, PQAS, Wong-Baker, 1-10 numeric)		19	Physical										
PAM - Patient Activation Measure		0	Comprehensive										
Pediatric Population Ages and Stages		10	Comprehensive										

Assessment Tool	Evaluator Volunteers	Sites currently using	Domain	Presence of research that supports the validity of the tool	Valid in these care sites (aligned w research)	Valid with these Services / Specialties	Source of info?	Required by a VBC or regulation (payor source if Yes)	Informs Risk Stratification (currently used or being considered for inclusion in Risk Strat algorithm	Is integrated into EHR	Can be integrated into EHR	Access via portal	Data entry attributes / burden (minutes to complete)
PHQ2 - Component of the Patient Health Questionnaire for Depression		12	Psychosocial	Yes	All	All	Physician or other staff		Yes	Yes			2
PHQ4 - Component of the Patient Health Questionnaire for Depression and Anxiety		1	Psychosocial	Yes	All	All			Yes	?			2
PHQ9 - Component of the Patient Health Questionnaire for Depression		11	Psychosocial	Yes	All	All			Yes	Yes			2 or 5
PPS - Palliative Performance Scale		7	Physical	Yes	All	All	Physician or other staff		Yes	Yes		NA	2
SF12 - Quality of Life Survey		1	Comprehensive										
SF36 - Quality of Life Survey		1	Comprehensive										

Appendix D: Palliative Care Flowsheet

Current Request for Palliative Care Flowsheet Enhancement

Palliative Care Assessment Flowsheet:

Encounter Type	
Encounter Type	
Edmonton Symptom Assessment System	
Pain Score	
Tiredness Score	
Nausea Score	
Depression Score	
Anxiety Score	
Drowsiness Score	
Appetite Score	
Wellbeing Score	
Dyspnea Score	
Other Problem Score	
Palliative Performance Scale	
Palliative Performance Scale Score	
Functional Assessment Staging of Alzheimers Disease	
FAST Stage Assessment	

Orientation
What YEAR is it?
What SEASON is it?
What MONTH are we in?
What DAY of the week is it?
What is today's DATE
What COUNTRY are we in?
What STATE are we in?
What CITY are we in?
What building are you in?
What floor of the building are you?
Registration
Name these 3 objects - APPL E, PENNY, TABLE. 1 second to say each. Then ask the person to
Attention and Calculations:
Begin with 100 and count backward by 7 (Stop after 5 answers): 93, 86, 79, 72, 65. if the patient will

Recall
Ask for the names of all three objects given to remember in Q3. Score 1 point for each correct answer
Language:
Show the peson a "PENCIL" and a "WATCH". Have the person name them as you point. Score 1
Have the person repeat the phrase - "NO IFS, ANDS, or BUTS". Score 1 point for a correct repetition.
Have the person follow a 3 stage command. Take the paper in your right/left hand. Fold it in half once
Read and obey the message. CLOSE YOUR EYES Score 1 point if the person closes their eyes.
Ask the person to write a sentence of his/her own choice. The sentence should contain a subject and
Ask the person to copy the design. Score 1 point if all sides and angles are peserved and the
Total Score

Depression Screening	
Have you felt little interest or pleasure in	
Have you felt down, depressed or hopeless	
PHQ-2 Total Score	
Over the last 2 weeks, how often have you been bothered by any of thefollowing problems?	
Little interest or pleasure in doing things	
Feeling down, depressed, or hopeless	
Trouble falling or staying asleep, or sleeping	
Feeling tired or having little energy	
Poor appetite or overeating	
Feeling bad about yourself - or that you are	
Trouble concentrating on things, such as	
Moving or speaking so slowly that other	
Thoughts that you would be better off dead	
PHQ-9 Total Score	
If you checked offany problems. how	
Non ICU Delirium Assessment (CAM)	
1. Acute Onset or Flucuation Course	
2. Inattention	
3. LOC	
4. Disorganiz ed Thinking	
5. Delirium Suspected?	

ICU Delirium Assessment (CAM-ICU)
CNA Step 1: Acute onset or Fluctuating course
CNA Step 2: Inattention
CNA Step 3: Altered LOC

CNA Step 4: Disorganized Thinking
CNA Step 5: Delirium Present?

***Morse Fall Risk**
History of Falling
Secondary Diagnosis
Ambulatory Aids
Intra'IE!nous Therapy/Heparin/Saline Lock
Gait/rransferring
Mental Status
Score
Psychosocial
Psychosocial (WOL)
Stress Factors
Patient Stress Factors
Family Stress Factors
Coping Response
Patient Coping
Family

Spiritual-Culture:

8. Who are the significant people in your life: family, friends, community or faith, minister)
9. What are the most comforting spiritual practices in your life? (prayer, scripture, music , sacraments, nature)
10. How is your faith and/or support system affected by your illness?
11. What concerns, feelings or thoughts do you have about your illness?
12. Would you like spiritual care visits from a hospital chaplain while in the hospital? Yes/no
13. Would you like to contact your community or faith minister or spiritual care provider?

________Patient declines need for s piritual care supportatlhis time.

Referrals Made
Referrals Made
Decision to Forgo Treatment
Decision to Forgo Treatment
Team Impact
Team Impact
Discharge Disposition
Discharge Disposition

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