

# Bringing Back the SOAP Note: Subjective Information

*Practical Strategies for  
Defensible Home Health Documentation*



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## Series Objectives

- Define and apply the terms skilled, reasonable and necessary in the context of clinical documentation.
- Identify two strategies for collecting both subjective and objective information.
- Integrate “professional opinion” into initial assessments and routine visits to support clinical decision making.
- Formulate goals that meet the expectations of measurable and meaningful.




## Series Overview

- Subjective ✓
- Objective
- Assessment
- Plan



## Session Objectives

- Discuss key focus areas of subjective information
- Examine interview strategies that use open ended questions to gather critical pieces of information.
- Connect specific subjective information to content areas of routine documentation to increase support for medical necessity.





## Lay of the Land

- Healthcare costs continue to rise
  - Affordable Care Act
  - Post-Acute Care Reform
- Physician Fee Schedule broken
- SNF therapy utilization questioned
- HH therapy utilization scrutinized
  - Focus on Value and Quality



## CMS knows: PAC Matters!

**PAC Matters**  
**LTCH, IRF, HH, Nursing Homes**

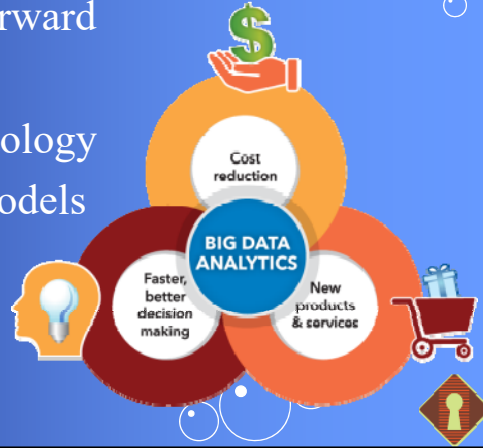
 <p><b>Long-Term Care Hospital (LTCH)</b>                      Services provided: Inpatient services include rehabilitation, respiratory therapy, pain management, and head trauma treatment.</p> <p>No. of Facilities: <b>420</b>                      Average length of stay: <b>26</b> days                      No. of Beneficiaries: <b>124k</b>  <a href="http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/index.html">http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/index.html</a></p>	 <p><b>Inpatient Rehabilitation Facility (IRF)</b>                      Services provided: Intensive rehabilitation therapy including physical, occupational, and speech therapy.</p> <p>No. of Facilities: <b>1,166</b>                      Average length of stay: <b>13</b> days                      No. of Beneficiaries: <b>373k</b>  <a href="http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/index.html">http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/index.html</a></p>
 <p><b>Home Health Agency (HHA)</b>                      Services provided: Skilled nursing or therapy services provided to Medicare beneficiaries who are homebound.</p> <p>No. of Facilities: <b>12,311</b>                      OASIS: Outcome and Assessment Information Set (OASIS) submissions: <b>35 million</b>                      Medicare spending: <b>\$18</b> billion  <a href="http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInfs/index.html">http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInfs/index.html</a></p>	 <p><b>Nursing Homes</b>                      Services provided: Short-term skilled nursing and rehabilitation services to individuals whose health problems are too severe or complicated for home care or assisted living.</p> <p>No. of Facilities: <b>15,000</b>                      Average length of stay: <b>30</b> days                      Beneficiaries: <b>1.7</b> million                      Medicare spending: <b>\$28.7</b> billion  <a href="http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInfs/index.html">http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInfs/index.html</a></p>



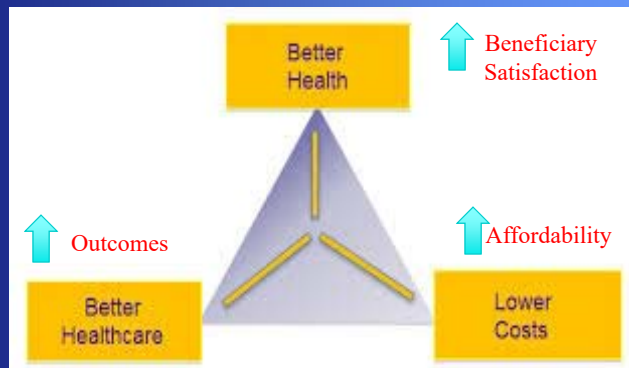


## Dealing with Data

- Decision making is driven by data, now more than ever before.... and will only *increase* moving forward
  - Regulations
  - Payment Methodology
  - Care Delivery Models



## CMS Triple Aim






## IMPACT Act and Assessments Data

- Goal: standardized patient assessment data to enable:
  - Data element uniformity
  - Quality care & improved outcomes
  - Data comparison across PAC setting
  - Improved DC process
  - Coordinated care



## Lessons Learned from PCR

- Documentation from physician encounter all the way through the clinical documentation from each professional must paint a clear consistent picture of the patients need for services
- Goals MUST be objective and measurable - evidenced based standardized measures improve affirmation
- Clear documentation is necessary - checking your EMR box for homebound puts you on the path to non-affirmation





## Data Driven Decision Making



Objective  
Data Analysis





Subjective  
Opinions

## State of Therapy Documentation





What we "do"	What we document
<ul style="list-style-type: none"> <li>• Prescribe individualized, exercise programs                             <ul style="list-style-type: none"> <li>– Progressive resistive</li> <li>– Progressive aerobic</li> </ul> </li> <li>• Educate on positioning, range of movement, substitution, delayed onset of muscle soreness</li> <li>• Monitor both patient &amp; program for appropriateness</li> </ul>	<ul style="list-style-type: none"> <li>• "3 x 10 toe tapping and seated marching"</li> <li>• "I had PT before. They walked me and did leg kicks."</li> <li>• 1lb weight x 30 reps</li> <li>• Yellow theraband resistance for all exercises/on all patients</li> <li>• Programs that never change . . . .</li> </ul>





## State of Nursing Documentation

What we “do”	What we document
<ul style="list-style-type: none"> <li>• Instruction in use, administration, s/s monitoring with specific medication(s) in use</li> <li>• Pressure ulcer assessment, monitoring of wound/peri-wound tissue, infection control</li> <li>• Instruction in dietary restrictions &amp; weight monitoring for self-mgmt of chronic disease</li> </ul>	<ul style="list-style-type: none"> <li>• “med teaching”</li> <li>• “pill box set up”</li> <li>• “wound care”</li> <li>• “SN for dressing change”</li> <li>• “disease process education”</li> </ul>

## More Than Writing “Better” Notes

- Systemic deficiencies:
  - ✓ Deficient internal quality audit findings
  - ✓ Limited ability to show progress/stabilization of patient
  - ✓ Lack of defensibility in external audit findings
    - ✓ Lack patient specificity
    - ✓ Do not support skilled care need
    - ✓ Reasonable & necessary questioned/services denied


**Evidence-based interventions**

**Patient-specific goal statements**


**Outcome expectations**

**Service Utilization**

CARE REDESIGN







## Defining Key Concepts

**Skill** ← Exclusive to the clinician

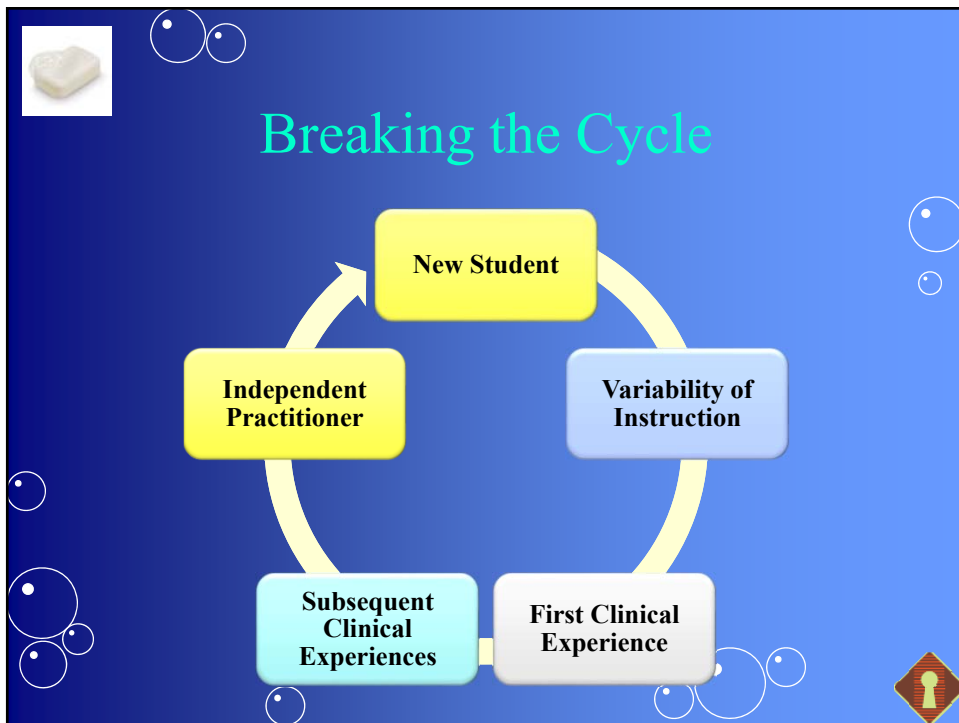
- proficiency, facility, or dexterity that is acquired or developed through training or experience; an art, trade, or technique

**Reasonable** ← The amount makes sense

- governed by or being in accordance with reason or sound thinking; not excessive or extreme

**Necessary** ← The care is indispensable

- Absolutely essential; needed to achieve a certain result or effect; requisite





## Defining “Subjective”

- World Dictionary: “*experienced only by the patient and incapable of being recognized or studied by anyone else*”
- Medical Dictionary: “*Of, relating to, or designating a symptom or condition perceived by the patient and not by the examiner*”
- Is a critical element for the “meaningful” components of documentation



## Does it Matter?

- Focus on objective information and specifically standardized assessment tools can overshadow the importance of subjective information.
- Regulations stress need for objective detail to support clinical decision making but this does NOT eliminate importance of the patient perception of the situation.





## Key Considerations

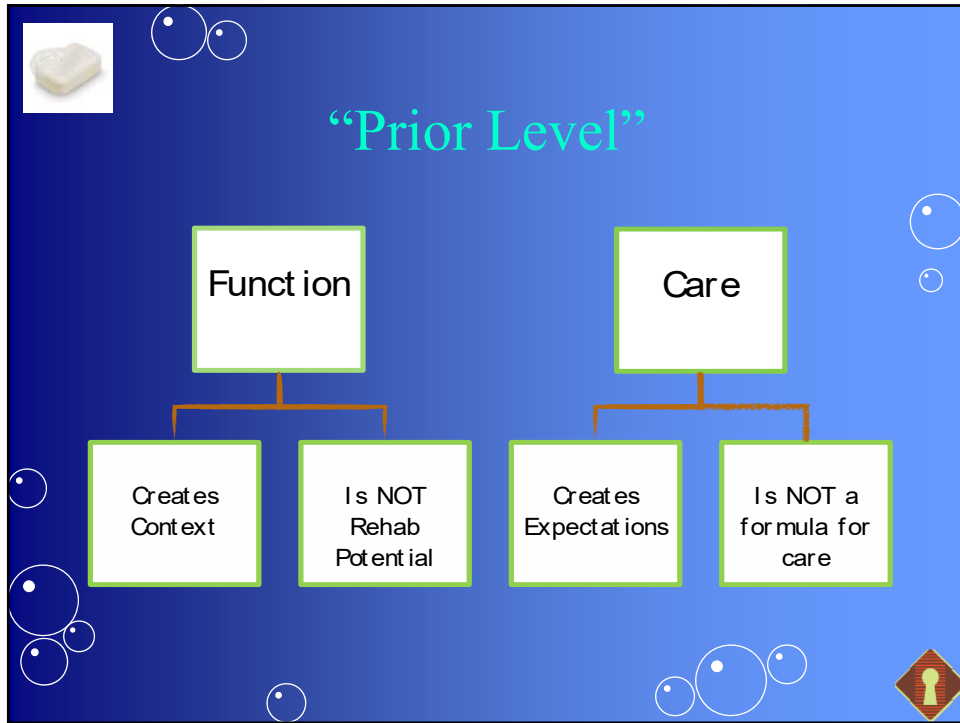
- Who are we getting the information from?
- What are we trying to learn?
- When did issues arise / resolve?
- Where are the obstacles in the environment?
- Why does the patient want services?




## Collecting Subjective Data



- Content shows patient / caregiver involvement in care planning.
- More than an area to document pain related issues.
- Positive information should be included as well.



- 
- Current Problem Areas**
- How comfortable would you be telling a stranger about...
  - Incontinence
  - Self Care Issues
  - Falls
  - Confusion
- 
- The slide features a blue background with decorative white circles and a small image of a heart in the top left. A keyhole icon is in the bottom right.



## How We Ask Matters

- Are you incontinent?
- Sometimes there are “accidents” when trying to get a walker through the bathroom door....
- Can you dress yourself?
- What makes it difficult to put your shoes and socks on?



## How We Ask Matters

- Are you confused?
- Do you ever forget where you have put something important?
- Can you rate your pain?
- How does pain effect what you are able to do?
- Do you fall often?
- Can you describe what happened when you fell?





## Conditions of Participation

- Revised § 484.50(c)(4)(i) to clarify that patients have the right to participate in and be informed about all assessments, rather than just the comprehensive assessment.



## § 484.50(c)(4)(i)

(4) Participate in, be informed about, and consent or refuse care in advance of and during treatment, where appropriate, with respect to--

- (i) Completion of all assessments;
- (ii) The care to be furnished, based on the comprehensive assessment;
- (iii) Establishing and revising the plan of care;



## § 484.50(c)(4)(i) continued

- (iv) The disciplines that will furnish the care;
- (v) The frequency of visits;
- (vi) Expected outcomes of care, including patient-identified goals, and anticipated risks and benefits;
- (vii) Any factors that could impact treatment effectiveness; and
- (viii) Any changes in the care to be furnished.



## Patient Specific Goals

- Has a patient ever said to a clinician:
  - “If I could walk 250 feet with my walker and supervision I would be happy”
  - “If I could get my keep my oxygen saturation above 95% my ADLs would be less taxing”





## Subsequent Visits



- A key component of confirming that interventions are effective involves subjective information throughout the course of care.
  - What is working with the home program?
  - What is NOT working with the home program?
  - What can you do now (alone, faster, easier...)?
  - Which activities give you the most trouble?
  - Pre and post treatment feedback



## Knowledge Application






- Mr. X is 77 years old hospitalized after a fall while letting his dog outside resulting in a pelvic fracture. He has been recently diagnosed with Type 2 Diabetic and is reporting trouble with managing his blood sugar. He lives with his grandson in a two story home with his bedroom and bathroom upstairs. Mr. X is refusing to go to a SNF and is being admitted to home health for nursing, PT, OT and HHA services.







## Subjective: What Do You Want To Know?

- Fall
- Caregiver
- Blood Sugar
- Pain
- Mobility
- Self Care
- Home Management
- Goals
- What Else?



## In Closing

- In order to clearly support that home health services are a vitally important part of the health care continuum, the patient's issues, concerns and goals must be captured and integrated into documentation throughout the care delivery process.





## Next Session

- Subjective
- Objective ✓
- Assessment
- Plan



## Be sure to Follow Us:



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