Improving Compliance in Missed Visits Documentation

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Improving Compliance in Missed Visits Documentation

Ma Rosalie B. Felix

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Cathy Coleman, DNP, RN, PHN, CPHQ, CNL

July 19, 2024
Abstract

Problem: Within the South Bay Hospice Agency, documentation compliance for missed visits was 68% in the first quarter of 2024, when the national standard should be 100% according to the Centers for Medicare & Medicaid Services.

Context: Inadequate nurse documentation and communication between health professionals can lead to medical errors, poor team communication and suboptimal patient outcomes (Tasew et al., 2019). Therefore, the importance of documentation compliance is imperative. Hospice staff perform scheduled visits for terminally ill patients 1-2 times a week; however, a missed visit can occur when a patient declines it for a variety of reasons.

Interventions: The interdisciplinary team and volunteer leadership staff attended two trainings to reinforce agency policy; electronic smart phrase was created to standardize communication; supervisor responsibility was increased to include weekly Electronic Health Record audits.

Measures: The percentage of documented reasons for missed visits per month and the percentage of staff notifying a medical doctor (MD) of a missed visit were tracked through weekly audits.

Results: April was at a 96.55% compliance rate; May at 91.22%; and June at 100%.

Conclusions: The patient’s hospice journey must be completely and clearly documented to prevent negative patient experiences and regulatory non-compliance. A multi-faceted intervention including team education, standardized electronic workflow using a smart phrase, and weekly audits are recommended to ensure continuity of care and condition of participation compliance with regulatory agencies.

Keywords: documentation compliance, hospice, missed visits, audits, home care, communication
Introduction

Documentation within nursing is referred to as any recorded information regarding a patient’s status and any care or services that were provided by the nurse (Doody et al., 2018). Therefore, the South Bay Hospice Agency expects nurses and members of the interdisciplinary team to document all aspects of a patient’s visit in a timely manner, including any missed visits, within the electronic health record (EHR).

Personal Leadership Statement

Strength-based leadership is developing and building on one’s strengths to improve performance and achieve better outcomes (Wei & Horton-Deutsch, 2022). Nursing with strength-based leadership can lead to strength-based nursing care (Wei & Horton-Deutsch, 2022). To develop these strengths in nursing care, it is critical for a leader to create a healthy work environment where each team member is supported and valued, to support their development and continuous learning (Wei & Horston-Deutsch, 2022).

Working in hospice requires effective collaboration within a cross-functional team that includes doctors, registered nurses, medical social workers, spiritual counselors, volunteers, and home health aides. This author applies her strengths as a clinical nurse leader (CNL) by learning about individual patients’ needs, and then brainstorming ideas and strategizing with the team to create effective care plans, to achieve the best outcomes while expressing positivity and giving praise to the team. Utilizing these leadership strengths can help facilitate a healthy work environment and promote the team’s ongoing development and a culture of continuous individual and collective learning. Fostering both personal and team strengths leads to this author’s vision of strength-based nursing care delivery.
Sharing values as a CNL in learning and strategizing are apparent in this project as documentation compliance is vital due to its impact on clinical decision-making (Demsash et al., 2023). Therefore, this quality improvement project to improve documentation compliance of missed visits aims to ensure that all teams involved - registered nurses, medical social workers, spiritual counselors, volunteers, home health aides, and medical doctors - are informed of a missed visit.

**Problem Description**

Missed visits occur when the healthcare staff is unable to visit the patient due to patient or family declination. Nursing documentation, including missed visit documentation, should be performed to meet both professional and legal requirements (Tasew et al., 2019). The failure to document a missed visit, reason, and notify the physician resulted in a L435 deficiency from California Department of Public Health. An L435 deficiency is failure to comply to 42 CFR 418.56 Standard Plan of Care (Condition of participation: Interdisciplinary group, care planning, and coordination of services, 2008). Baseline data from quarter 4 2023 data showed that compliance in documenting missed visits was at 68%, when it should be at 100%. The gap analysis identified that the lack of compliance is due to inconsistent notifications from staff to physicians, lack of a standardized communication procedure regarding missed visits, and no established schedule for auditing EHR (See Appendix A).

**Specific Project Aim**

The aim of this project is to increase documentation compliance from a baseline of 68% to 90% by September 2024 in all three regional branches (Redwood City, Santa Clara, and San Jose) within the South Bay Hospice Agency.

**Available Knowledge**
**PICOT Question**

A PICOT (Problem, Intervention, Comparison, Outcome, and Timeframe) question was created to guide the search process. The PICOT question for this project and literature search was:

Compared to the current practice of no standardized documentation for missed visits, how can the standardization of missed visit documentation for hospice patients improve documentation compliance by hospice staff within 6 months?

**Search Strategy**

A systematic electronic search was conducted to identify articles from different databases including CINAHL, and PubMed. The search strategy focused on Systemic Reviews, Critically Appraised Research Studies, and Individual Research Studies that were related to nursing documentation and compliance of nursing staff with required documentation. The search terms used were the following: nursing documentation, quality documentation, documentation, home hospice, missed visits, home visits, palliative, and compliance. The search was further limited to articles from 2015 to the present in the English language. The top five articles were chosen from CINAHL after a thorough review. The five chosen articles as evidence were critically appraised using the John Hopkins Evidence Level and Quality Guide.

**Critique, Level, and Quality of Evidence**

Bunting & Klerk (2022) performed a systematic review of 76 articles published between 1991 to 2020 to identify the most effective strategies to improve clinical nursing documentation and concluded that auditing documents as well as providing personal feedback can improve quality of documentation. Strengths of this study were the number of studies reviewed and the
types of studies reviewed. A limitation was that only one person performed the review of the full text studies, which may have caused bias. Evidence rating was a Level II B (See Appendix B).

Doody et al. (2018) performed a systematic review of nursing documentation within palliative care. The study emphasized the importance of quality nursing documentation and concluded that the main reason for insufficient documentation is the lack of standardized terminology to provide an accurate account of the patient’s condition, care provided, and the response to care (Doody et al., 2018). A strength of this study was that the review included both qualitative and quantitative studies. However, a limitation was that only 5 studies were reviewed. Evidence rating was a Level II B. See Appendix B.

Edassery et al. (2021) performed a quality improvement project to determine the root causes of not documenting. An Ishikawa Diagram was used to identify the primary root cause - lack of standardized format for documentation (Edassery et al., 2021). Strengths identified with this quality improvement project included a clear timeline to implement interventions based on the root causes identified and a discussion related to sustainability of the project. A limitation identified was the inability to measure the outcome with respect to communication gaps (Edassery et al., 2021). Evidence rating was a Level V B (See Appendix B).

Molkdskred et al. (2021) performed an audit of the nursing documentation in a community care center in Norway to assess the quality of nursing documentation and implement a tool to help improve documentation practices. The audit identified knowledge gaps in nursing documentation and concluded that training and the use of standard terminologies and user-friendly formats were linked to quality nursing documentation (Molkdskred et al., 2021). A strength identified with this project was that it tailored interventions based on the identified
barriers. A limitation of the project was the lack of an improvement plan and timeframe. Evidence rating was a Level V B (See Appendix B).

Yang et al. (2019) performed a qualitative study, where 10 observations were made of home care agency admissions by 5 admission nurses. The study identified the potential causes for delay in documentation and the use of memory aids to ensure timely documentation is for each visit. A strength of this study was that the objective and methods to obtain data were clear. A limitation of this project was that only 5 nurses from a single home health agency using a single EHR system were observed (Yang et al., 2019). Evidence rating was Level III B (See Appendix B).

Summary of Themes and Applicability to Project

The theme presented in the five articles reviewed was the importance of quality nursing documentation and strategies that support improving compliance with documentation. These articles will help identify best practices and interventions to improve documentation compliance for missed visits.

Rationale

Documentation is understood to be an important communication tool but is often set to a lower priority as a nurse’s focus is on direct patient care (Doody, et al., 2018). Doody et al. (2018) also found that the nursing documentation focused on physical care and symptom management. This may explain why missed visits are not consistently documented within the South Bay Hospice Agency. The interventions created for this project were based on the studies performed by Doody et al. (2018), Moldskred et al. (2021), and Bunting & Klerk (2022). Standardizing a communication protocol for missed visits can help improve documentation compliance, as it can lessen the time spent on documentation while still providing an accurate
account of the patient’s journey (Doody, et al., 2018). Conducting a routine audit identified solutions to improve compliance (Bunting & Klerk, 2022; Moldskred et al., 2021).

**Context**

Hospice care is a microsystem that provides multidimensional care with the goal of reducing physical, psychological, social, and spiritual suffering (Koorn et al., 2020). South Bay Hospice provides hospice care services to individuals who are terminally ill during their final stages of life, as well as support for their caregivers (Kaiser Permanente, n.d.). Professional staff include registered nurses, medical social workers, spiritual counselors, hospice physician, home health aide, and hospice volunteers. Each healthcare staff performs 1-2 visits per week. Communications with the interprofessional teams are performed through daily and weekly team meetings.

**SWOT Analysis**

The SWOT analysis identified strengths, weaknesses, opportunities, and threats of this quality improvement project. (See Appendix C). Strengths include support from leaders and organization, while weaknesses include resistance from front line staff and challenges in streamlining the process. Opportunities include leveraging technological solutions and standardizing documentation to streamline and improve compliance in documentation. Potential threats may be changes in regulatory requirements and increases in workload burden amongst staff that may further prevent quality documentation.

**Stakeholder Power Grid**

The power grid analysis identified stakeholders that need to be kept satisfied, managed closely, monitored, and kept informed (See Appendix D). The analysis identified that the area manager, continuum administrator, service director, and director of quality should be kept
satisfied. Registered nurses, medical social workers, and spiritual counselors are directly involved with documentation and notification to physicians on missed visits, which is why they will be managed closely. Home health aides are required to inform the case manager of the missed visit but cannot notify physicians. Therefore, home health aides will be monitored by their supervisor. Quality coordinator and clinical supervisor need to be continuously informed.

**Intervention**

**Interventions and Rationale**

The following interventions will be implemented to increase documentation compliance for missed visits by hospice staff: staff training, standardization of new communication smart phrase workflow, and implementation of routine audits of electronic health record documentation. Documentation is understood to be an important communication tool but is often set to a lower priority as a nurse’s focus is on direct patient care (Doody et al., 2018). Doody et al. (2018) also found that the nursing documentation within this area focused on physical care and symptom management. The interventions created for this project were based on the studies performed by Doody et al. (2018), Moldskred et al. (2021), and Bunting & Klerk (2022).

Standardizing a communication protocol for missed visits can help improve documentation compliance, as it can lessen the time spent on documentation while still providing an accurate account of the patient’s journey (Doody et al., 2018). Implementing a routine audit identified solutions to improve compliance (Bunting & Klerk, 2022; Moldskred et al., 2021).

**Financial Model**

The average number of deficiencies per inspection is 1 (See Appendix E). With the estimated average cost of each deficiency being $8,500.00 (Enforcement remedies for hospice programs with deficiencies, 2021), this leads to an estimated annual total cost of $8,500.00 for the South
Bay Hospice Agency. The improved process to increase documentation compliance for missed visits should result in an estimated annual cost avoidance of $4,250.00 for this agency.

The cost of implementation considered the number of personnel needed, their hourly rate in addition to 30% benefits, the cost of a 1-hour training session for each personnel, and the required materials and supplies. The hospice agencies require quality coordinators, registered nurses, medical social workers, home health aides, clinical supervisors, volunteer coordinator, and spiritual counselors to document missed visits and audit the electronic health record documentations. Total implementation cost for the first year will be $3,788.00. For the second year, the budget considered replacement or updates to training materials or supplies, which resulted in a total cost of $150.00. The project saving return on investment is anticipated to be $462.00 and $4,100.00 by Year 1 and Year 2, respectively.

**Study of the Intervention**

**Measurement strategy**

The outcome measure will be percentage of documented missed visits per month, where the target is ≥ 90%. The process measure includes percentage of staff documenting the reason and notifying medical doctor (MD) of a missed visit, where the measure target is at 100%. The balancing measures include no negative impact to quality of documentation and no deficiency finding during triennial re-certification survey, where both measures target will be at 0%. The data sources for all measures will be through the electronic health record (See Appendix F).

**PDSA Cycles**

The Model for Improvement (MFI) framework - Plan, Do, Study, Act Cycles (PDSA) promoted by the Institute for Healthcare Improvement (IHI) can help to speed up the improvement process and ensure that improvements close any gaps discovered throughout the
cycles and small tests of change. The team moves back and forth between the three questions of the model: what we are trying to accomplish, how we know a change is an improvement, and what changes that can be made to improve. Learning from PDSA cycles results in potential, effective, sustainable, operational changes (Institute for Healthcare Improvement, n.d.).

The interventions and their measures have been established to answer the first question of what we are trying to do. The routine audits will help us understand if the changes that were implemented are an improvement and if additional interventions are needed to test and assess the level of improvement.

**Ethical Considerations**

The Jesuit value of cura personalis, “care for the whole person,” emphasizes recognizing and promoting an individual’s unique abilities and well-being (University of San Francisco, n.d.). To abide by this Jesuit value, it is imperative to improve the quality and compliance of nursing documentation. Additionally, the American Nurse Association (ANA) ethical standard provision 4 of accountability emphasizes that nurses are accountable for their practice and decisions (Haddad & Geiger, 2023). Ensuring that the patient’s journey is completely and clearly documented prevents negative patient outcomes caused by miscommunication amongst the patient, patient’s family, and healthcare staff (Doody et al., 2018). Improving quality and compliance documentation in nursing reinforces this responsibility of cura personalis and ANA provision 4, which promotes accountability and integrity in nursing practice.

In education, the Jesuit commitment in Mind to continuously learn is a value that encourages nurses to stay informed, seek new knowledge, and remain open to ideas and thoughts (University of San Francisco, n.d.). The SWOT analysis (See Appendix C) shows that there may be initial resistance from front-line staff of the proposed changes. As part of this project, staff’
training will be provided of the new changes and process, which will promote continuous learning. Furthermore, the ANA ethical standard provision 5 reinforces the Jesuit commitment in Mind as it emphasizes the importance of professional growth. By seeking to improve documentation practices, the project contributes to the advancement of nursing practice and the enhancement of care quality.

The University of San Francisco’s value of *People for Others* and the American Nurses Association Ethical Standards is reflective in this project because quality and compliant documentation are critical in healthcare to prevent negative patient outcomes and harm (Doody et al., 2018). This project has been approved as a quality improvement project by faculty using QI review guidelines and is exempt from IRB approval. The Research Determination Office (RDO) Committee for the South Bay Hospice Northern California region has determined the project does not meet the regulatory definition of research involving human subjects per 45 CFR 46.102(d) (See Appendix G).

**Outcome Measure Results**

The small test of change performed in April 2024 has shown improvements with documentation compliance. April 2024 was at a 96.55% compliance rate, May 2024 at 91.22%, and June 2024 at 100% (See Appendix H).

**Summary**

Review of the data (as seen in Appendix H) showed a decline of non-compliance by June 2024. However, after the small test of change performed in April 2024, compliance in May 2024 decreased slightly. To prevent increases in non-compliance, it is vital to understand the root cause of non-compliant documentation. Once the root cause has been identified, the solution should be implemented as an additional intervention or as a revision to a current intervention to
improve the process. Determining root cause of non-compliance should be considered once more data has been gathered.

**Conclusions**

Improving documentation compliance within the South Bay Hospice Agency is vital to comply professionally and legally. Quality and compliant nursing documentation can prevent negative patient outcomes (Doody et al., 2018). Because of the failure to document the reason for a missed visit and notify the physician, this resulted in a L435 deficiency, which is failure to comply to 42 CFR 418.56 Standard Plan of Care (Condition of participation: Interdisciplinary group, care planning, and coordination of services, 2008). Additionally, the office of Inspector general (OIG) has found instances where hospices failed to consistently provide required services to beneficiaries (U.S. Department of Health and Human Services, 2019). With increased government oversight of hospice providers, improving documentation compliance is critical; it serves as evidence of the specific care provided and adherence to the individualized plan of care. A multi-faceted change initiative to improve documentation of missed visits led to 100% compliance over 6 months. To prevent regulatory deficiencies and improve agency outcomes, implementation of an evidence-based, standardized communication procedure, staff trainings, and routine EHR audits, improved documentation compliance are recommended to reinforce the importance of data analysis and effective interdisciplinary team education.
References


42 CFR 488. (2024). Enforcement remedies for hospice programs with deficiencies.


https://doi.org/10.1097/CIN.0000000000000468
Appendices

Appendix – A

Gap Analysis

<table>
<thead>
<tr>
<th>Area under consideration: Baseline data obtained from electronic health record audits in 2023 showed an average of 67% compliance rate for missed visits documentation within the agency.</th>
<th>Desired State</th>
<th>Current State</th>
<th>Action Steps</th>
</tr>
</thead>
<tbody>
<tr>
<td>To increase compliance with missed visit documentation to 90%.</td>
<td>Inconsistencies among staff in notifying the physician regarding the missed visits and reasons.</td>
<td>Implement training sessions for staff proficiency.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lack of standardized communication procedures regarding missed visit notification between home health aides and registered nurse.</td>
<td>Establish standardized communication protocols for reporting missed visits.</td>
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</tr>
<tr>
<td></td>
<td>No established schedule for auditing electronic health records to ensure compliance with documenting missed visits.</td>
<td>Conduct routine audits of electronic health records.</td>
<td></td>
</tr>
</tbody>
</table>
Appendix – B

Evaluation Table

<table>
<thead>
<tr>
<th>Study</th>
<th>Design</th>
<th>Sample</th>
<th>Outcome/Feasibility</th>
<th>Evidence Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Summary of Findings: 76 articles, published between 1991 to 2020, were reviewed. 10 studies achieved a post intervention compliance of greater than or equal to 70%. The review concluded that documentation audit with personal feedback is a method to improve clinical nursing documentation.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Applicability: The systematic review conclusions may be applied to my QI project as it provided a strategy to improve clinical nursing documentation.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Strengths: There was a good amount of studies reviewed, that were a mixture quantitative, RCT, and qualitative studies.</td>
<td></td>
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</tr>
<tr>
<td></td>
<td></td>
<td>Limitations: Only one reviewed performed full text</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Study</td>
<td>Methodology</td>
<td>Sample</td>
<td>Findings</td>
<td>Applicability</td>
</tr>
<tr>
<td>-------</td>
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<td>--------</td>
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<td>---------------</td>
</tr>
<tr>
<td>Doody, O., Bailey, M. E., Moran, S., &amp; Stewart, K. (2018). Nursing documentation in palliative care: An integrative review. <em>Journal of Nursing</em>, 5(3).</td>
<td>Integrative Review (Systematic Review)</td>
<td>The study compiled literature from the following databases: Scopus, Medline, CINAHL, Web of Science and Academic Search Complete. Sample: N/A</td>
<td>Based on the systematic review, quality nursing documentation is vital in providing clear information, improving communication, and avoiding duplication. Summary of Findings: The systematic review conclusions may be applied to my QI project as it emphasized the importance of quality nursing documentation.</td>
<td>Applicability: The studies reviewed were a good mixture of qualitative and quantitative studies. Strengths: The studies reviewed were a good mixture of qualitative and quantitative studies. Limitations: Only 5 studies were reviewed.</td>
</tr>
<tr>
<td>Edassery, D. E., Chittezhathu, R. K., &amp; Warrier, J. J. (2021). Documentation of prognostication discussion. <em>Indian Journal of Palliative Care</em>, 27(2), 222–229.</td>
<td>Quality Improvement</td>
<td>Sample: 1 NGO Setting: NGO providing palliative and supportive care at outpatient, home visits and</td>
<td>The QI project used the Ishikawa Diagram to determine the root causes of not documenting. The main cause was there</td>
<td>Level V B</td>
</tr>
<tr>
<td>Moldskred, P. S., Snibsøer, A. K., &amp; Espehaug, B. (2021). Improving the quality of nursing documentation at a residential care home: a clinical audit. <em>BMC Nursing</em>, 20(1), 103. <a href="https://doi.org/10.1186/s12912-021-00629-9">https://doi.org/10.1186/s12912-021-00629-9</a></td>
<td>Quality Improvement Sample: 2 wards in a Norwegian community care center, organized as a residential care home for people with dementia needing 24 hour nursing care Setting: Norway</td>
<td><strong>Summary of Findings:</strong> The QI project performed a criteria-based clinical audit and identified knowledge gaps in electronic nursing documentation. They also identified that use of standard terminologies and user-friendly formats was linked to high-quality nursing documentation. The <strong>Applicability:</strong> The method used in this QI Project may be applied to my QI project to understand why we do not document missed visits consistently. <strong>Strengths:</strong> The QI project had a clear timeline of when to implement interventions based on the root causes identified. The QI project also discussed how to sustain the project. <strong>Limitations:</strong> The project was unable to measure the outcome with respect to communication gaps.</td>
<td>Level V B</td>
<td></td>
</tr>
</tbody>
</table>
Conclusion was that a criteria-based clinical audit could improve the quality of nursing documentation.

**Applicability:**
Performing audits of nursing documentation of missed visits may improve the quality of documentation as well as ensure the sustainability of my QI project.

**Strengths:**
The QI project tailored interventions based on the identified barriers

**Limitations:**
There was no clear aim statement in terms of what they plan to improve and within what timeframe.

<p>| Qualitative Study (Observation) | Sample: 10 observations of home care agency admissions with five admission nurses | Summary of Findings: The study identified the potential causes for delay in documentation and the strategy (i.e. use of memory aids) to ensure timely documentation is performed for each visit. | Level III B |
| Setting: Rural Pennsylvania | | <strong>Applicability:</strong> The identified strategies within the |</p>
<table>
<thead>
<tr>
<th>Paper may be implemented as a standardization of documentation for missed visits within Hospice.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strengths:</strong> The study showed that the use of memory aids supported staff in recalling the information that needed to be documented.</td>
</tr>
<tr>
<td><strong>Limitations:</strong> Only five nurses from a single home health agency using a single EHR system were observed. It would be best to increase the sample size for this study.</td>
</tr>
</tbody>
</table>
## Appendix – C

### SWOT Analysis

<table>
<thead>
<tr>
<th>Internal (attributes of the organization)</th>
<th>Favorable/Helpful</th>
<th>Unfavorable/Harmful</th>
</tr>
</thead>
</table>
| **Strengths**                            | • The project has strong support from senior leaders and organization.  
• The organization has a team focusing on improving compliance.  
• The organization has the necessary resources such as technology and training materials.  | **Weaknesses**  
• Initial resistance from front-line staff of the proposed changes.  
• Challenges in streamlining processes and ensuring accuracy.  |

<table>
<thead>
<tr>
<th>External (attributes of the organization)</th>
<th>Opportunities</th>
<th>Threats</th>
</tr>
</thead>
</table>
| **Opportunities**                       | • Leveraging technology solutions can streamline documentation processes, improve accuracy, and enhance compliance.  
• A standardized documentation templates and processes can simplify the documentation process and promote consistency.  | • Changes in regulatory requirement or compliance standards.  
• Potential increase workload burden due to change in documentation procedure.  
• Staff dissatisfaction leading to more inconsistency  |
Appendix – D

Power Interest Grid

- Keep Satisfied
  - Area Manager
  - Continuum Administrator
  - Service Director
  - Director of Quality

- Manage Closely
  - Registered Nurses
  - Medical Social Workers
  - Spiritual Counselors

- Monitor
  - Home Health Aides

- Keep Informed
  - Quality Coordinator
  - Clinical Supervisor
Appendix – E

Financial Model (Budget and ROI for the Project)

<table>
<thead>
<tr>
<th>Current State</th>
<th>Documentation compliance for missed visits by hospice staff is at 68%.</th>
<th>Average # of deficiency letters received per inspection</th>
<th>Estimated maximum cost of an L435 deficiency</th>
<th>Estimated annual total cost of addressing L435 deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>1</td>
<td>$8,500</td>
<td>$8,500</td>
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</table>

<table>
<thead>
<tr>
<th>Improved State</th>
<th>Documentation compliance for missed visits by hospice staff is at 90%</th>
<th>Estimated annual cost avoidance</th>
<th>$4,250</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

**Year 1 Improvement Cost (Cost Implementation)**

<table>
<thead>
<tr>
<th></th>
<th>Number</th>
<th>Hourly Rate + .3 Benefit</th>
<th>Annual Cost (1 hour class)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality Coordinator</td>
<td>2</td>
<td>$117</td>
<td>$234</td>
</tr>
<tr>
<td>Registered Nurse</td>
<td>18</td>
<td>$127</td>
<td>$2,293</td>
</tr>
<tr>
<td>Social Workers</td>
<td>5</td>
<td>$52</td>
<td>$260</td>
</tr>
<tr>
<td>Chaplains(Spiritual Counselor)</td>
<td>2</td>
<td>$46</td>
<td>$92</td>
</tr>
<tr>
<td>Home Health Aides (HHA)</td>
<td>9</td>
<td>$39</td>
<td>$351</td>
</tr>
<tr>
<td>Clinical Supervisors</td>
<td>2</td>
<td>$129</td>
<td>$258</td>
</tr>
<tr>
<td>Materials/Supplies</td>
<td></td>
<td>$300</td>
<td>$300</td>
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<tr>
<td><strong>Total Cost</strong></td>
<td></td>
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<td>$3,788</td>
</tr>
</tbody>
</table>

**Year 2 Improvement Cost (Cost Implementation)**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th>$150</th>
</tr>
</thead>
<tbody>
<tr>
<td>Materials/Supplies (For replacements/updates)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total Cost</strong></td>
<td></td>
<td></td>
<td>$150</td>
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<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th>Year 1</th>
<th>Year 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project Savings (ROI)</td>
<td></td>
<td></td>
<td>$462</td>
<td>$4,100</td>
</tr>
</tbody>
</table>
Appendix – F

Project Charter

**Project Charter**: Improving compliance with missed visits documentation in Hospice

**Global Aim**: Hospice agency will not have a deficiency during triennial recertification survey in missed visit documentation in 2025.

**Specific Aim**: To improve compliance of South Bay Hospice agency in documenting missed visits from 67% to 90% by September 2024

**Background**: Hospice care provides assistance to individuals with terminal illnesses and their families when curative treatment are no longer an option. Each hospice provider develops individualized plan of care designed to address specific patient needs (Centers for Medicare and Medicaid, 2024). According to the 2019 hospice survey deficiency data, missed direct-care visits is one of the most common deficiencies in plan of care implementation (Centers for Medicare and Medicaid, 2024).

The office of Inspector general (OIG) has found instances where hospices failed to consistently provide required services to beneficiaries (U.S. Department of Health and Human Services, 2019). With increased government oversight of hospice providers, a thorough documentation is vital and serves as evidence on the specific care provided and adherence to the individualized plan of care.

**Sponsors**

<table>
<thead>
<tr>
<th>Quality Department</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Director</td>
</tr>
<tr>
<td>Site Director</td>
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**Goals**: To reduce the percentage of non-compliance in missed visits documentation by:

1. Implementing a training session for staff proficiency.
2. Establishing a standardized communication protocol.

**Measures**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Data Source</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outcome</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of documented missed visits</td>
<td>EHR</td>
<td>≥90%</td>
</tr>
<tr>
<td><strong>Process</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% staff notifying MD of missed visits and the reason</td>
<td>EHR</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Balancing</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No negative impact on the overall quality of the documentation</td>
<td>EHR</td>
<td>0%</td>
</tr>
<tr>
<td>No deficiency finding during Triennial recertification survey</td>
<td>EHR</td>
<td>0%</td>
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</table>

**Team**

- Hospice RNs
- Medical Social Workers
- Spiritual Counselors
- Clinical Services Supervisors
- Home Health Aides
- Volunteers

**Measurement Strategy**

**Background (Global Aim)** Hospice agency will not have a deficiency during recertification survey in missed visit documentation in 2025.

**Population Criteria:** Hospice staff that perform visits (Hospice RNs, Medical Social Workers, Spiritual Counselors, Home Health Aides, Volunteers)

**Data Collection Method:** Missed visit documentation data will be collected through review of the EHRs.

**Data Definitions**
### Data Element Definition

<table>
<thead>
<tr>
<th>Data Element</th>
<th>Definition</th>
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<tbody>
<tr>
<td>Missed Visit</td>
<td>When the healthcare staff is unable to visit the patient due to patient declination, which is required to be communicated to physicians with the reason and documented in the EHR.</td>
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</table>

### Measure Description

<table>
<thead>
<tr>
<th>Measure</th>
<th>Measure Definition</th>
<th>Data Collection Source</th>
<th>Goal</th>
</tr>
</thead>
</table>
| % of documented missed visits | \[
\frac{\text{# of documented missed visits}}{\text{total # of missed visits}}
\] | EHR | ≥90% |
| % staff notifying MD of missed visits and the reason | \[
\frac{\text{# of documented notification to MD of missed visits and the reason}}{\text{total # of missed visits}}
\] | EHR | 100% |

### Driver Diagram

**SPECIFIC AIM**

To increase documentation compliance from a baseline of 68% to 90% by September 2024 within the South Bay Hospice Agency

**KEY DRIVERS**

Staff Adherence

**CHANGE IDEAS**

1. Standardizing communication procedure
2. Staff trainings on process of communication and documentation
3. Routine audits of EHRs ensuring adherence
# Project Timeline

<table>
<thead>
<tr>
<th>Task#</th>
<th>Description of Tasks and Communication Interventions</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Responsible Party/Stakeholder</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
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<td></td>
<td>Clinical Supervisor</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Data Collection</td>
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<td></td>
<td></td>
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<td>Clinical Supervisor</td>
<td>Ongoing</td>
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<tr>
<td>2</td>
<td>Interventions Established</td>
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<td>Clinical Supervisor</td>
<td>Completed</td>
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<tr>
<td>4</td>
<td>Small Test of Change</td>
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<td>Clinical Supervisor</td>
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</tr>
<tr>
<td>5</td>
<td>Implementation of Interventions</td>
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<td></td>
<td>Clinical Supervisor</td>
<td>Ongoing</td>
</tr>
<tr>
<td>6</td>
<td>Routine Audit of EHRs</td>
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<td></td>
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<td></td>
<td></td>
<td>Clinical Supervisor</td>
<td>Pending</td>
</tr>
</tbody>
</table>
Appendix - G

RDO

Dear Ms. Nguyen:

The Research Determination Committee for the Kaiser Permanente Northern California region has reviewed the documents submitted for the above referenced project to be used by Ma Felix, MSN student. The project does not meet the regulatory definition of research involving human subjects as noted here:

Not Research

The activity does not meet the regulatory definition of research per 45 CFR 46.102(d): Research means a systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalizable knowledge.

This determination is based on the information provided. If the scope or nature of the project changes in a manner that could impact this review, please resubmit for a new determination. The word “research” should not appear in any posters or publications resulting from this project. Further, if publications, presentations or posters are generated from this project the following wording must be used to reference to the project research determination outcome:

“The Research Determination Committee for the Kaiser Permanente Northern California region has determined the project does not meet the regulatory definition of research involving human subjects per 45 CFR 46.102(d)”

You are expected, however, to implement your study or project in a manner congruent with accepted professional standards and ethical guidelines as described in the Belmont Report (http://www.hhs.gov/ohrp/humansubjects/guidance/belmont.html).

Additionally, you are responsible for keeping a copy of this determination letter in your project files as it may be necessary to demonstrate that your project was properly reviewed. Provide this approval letter to the Physician in Charge (PIC), your Area Manager, and Chief of Service, to determine whether additional approvals are needed.

Finally, all manuscripts/case series/case studies must receive written approval prior to submission to a journal or book. The Principal Investigator (PI) or first author (if different) must request their PIC1, or the Division of Research (DOR) Director2, or the Research & Innovation Academy (RIA)3 or an equivalent level leader4 review and provide written approval for publication submission. The PI is responsible for retaining a copy of the approval.

Sincerely,

The Research Determination Committee
KPNC-RDO@kp.org

1PIC approval is required for all manuscripts/case series/case studies that do not include a DOR employee as an author; including but not limited to medical students, residents, and fellows.

2DOR Director approval is required for all manuscripts/case series/case studies that include DOR employees as authors.

3For all nurse-authored manuscripts/case series/case studies, approval by the Research & Innovation Academy is required.

4If you are not sure who this would be, please contact the Research Determination Office (KPNC-RDO@kp.org)
Appendix – H

Preliminary Results

Documentation Compliance

<table>
<thead>
<tr>
<th>Month</th>
<th>Target Compliance Rate</th>
<th>Actual Compliance Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>January</td>
<td>94%</td>
<td>74%</td>
</tr>
<tr>
<td>February</td>
<td>97%</td>
<td>96.55%</td>
</tr>
<tr>
<td>March</td>
<td>91.22%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Legend:
- **Blue** - Target Compliance Rate
- **Red** - Actual Compliance Rate