Fact Sheet: The Hospice Item Set (HIS)

The purpose of this fact sheet is to provide general information about the Hospice Item Set (HIS).

Background and Introduction:

The HIS is a set of data elements that can be used to calculate 7 quality measures – 6 NQF-endorsed measures and 1 modified NQF-endorsed measure:

- NQF #1641 – Treatment Preferences
- Modified NQF #1647 – Beliefs/Values Addressed
- NQF #1634 & NQF #1637 – Pain Screening and Pain Assessment
- NQF #1639 & NQF #1638 – Dyspnea Screening and Dyspnea Treatment
- NQF #1617 – Patients Treated with an Opioid who are Given a Bowel Regimen

The HIS is not a patient assessment instrument and will not be administered to the patient and/or family or caregivers. In practical terms, there are several differences between an item set and a patient assessment instrument. Typically, assessments are administered at the patient level concurrent with regular patient care, and are intended to capture baseline information for use in developing the plan of care. In contrast, an item set is a standardized mechanism for abstracting data from the medical record.

Implementing the HIS in your hospice organization:

One method for implementing the HIS in your hospice organization is to map items currently in your clinical record to items in the HIS. In completing this mapping process, a provider may wish to add HIS items to their clinical records or patient assessment forms. Adding HIS items to your clinical record does not make the HIS a patient assessment – it merely allows for 1:1 abstraction from your clinical record to the HIS. CMS neither prohibits nor requires hospices to add HIS items to their clinical records or patient assessment forms.

Hospices will begin using the HIS for all patients beginning July 1, 2014. Hospices will be required to submit 2 HIS records for each patient admitted to their organization – a HIS-Admission record and a HIS-Discharge record. The HIS-Admission contains both administrative items for patient identification and clinical items for calculating the 7 quality measures. The HIS-Discharge is a limited set of administrative items also used for patient identification, as well as discharge information, which will be used primarily to determine patient exclusions for some of the 7 quality measures.

HIS completion and submission:

The HIS will be electronically completed and submitted to CMS on an ongoing basis. HIS completion timeframes vary by record: hospices will have 14 days from admission to complete HIS-Admission records and 7 days from discharge to complete HIS-Discharge records. After completing HIS records, hospices will electronically submit HIS records to CMS; hospices will have 30 days from a patient admission or discharge to submit the appropriate HIS record for that patient. Details on submission and completion processes will be addressed in a technical user manual, which will be made available on the https://www.qtso.com/ website.

HIS Training and Other Resources:

CMS will hold one HIS training in February 2014. Further details regarding dates and delivery method for the HIS training will be made available in coming months on the CMS HQRP website. Providers should regularly check this website in order to have the most up-to-date information regarding the HIS. In February 2014, CMS will also make available a HIS User Manual, which will also be posted on the CMS HQRP website.

For more information on the HIS, please review the FY 2014 Final Rule and the HIS PRA package. Also available are the Draft HIS Technical Specifications. If you have questions about the HIS or the HQRP in general, please contact the Quality Help Desk at HospiceQualityQuestions@cms.hhs.gov.