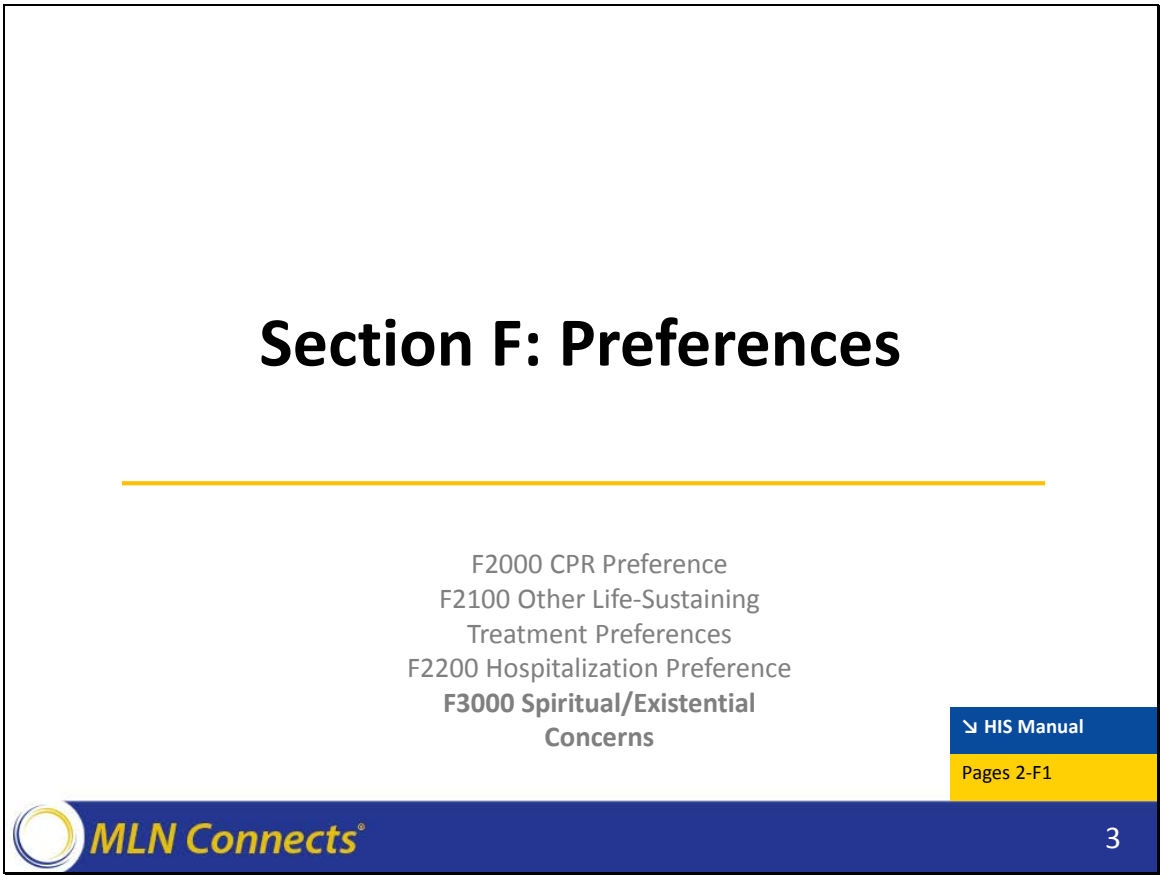
Welcome to the Centers for Medicare & Medicaid Services training presentation, “Updates to the Hospice Item Set Manual Version 1.02”.

This is the fourth of four modules. This module covers updates made to the care process sections of Chapter 2 of V1.02 of the HIS Manual.

Chapter 2: Care Process Items Sections F, J, and N

Franzi Rokoske, RTI International

Thank you. My name is Franzi Rokoske, and I'll be leading the last portion of this presentation, which will cover updates to the Care Process Items in V1.02 of the Hospice Item Set (or "HIS") Manual. This portion of the presentation will cover updates to guidance for completing HIS Items in Sections F: Preferences, Section J: Pain and Dyspnea, and Section N: Medications.



We'll begin with updates made to guidance in Section F the HIS Manual. In your manual, that section begins on page 2F-1.

Preferences reflect one of the tenets of hospice care. It is important for the patient and caregiver to be involved in decision-making and establishing goals for care.

There are 4 items in Section F that relate to patient's preferences regarding life-sustaining treatments and spiritual care. In this presentation, we will focus on Item F3000. Spiritual and Existential Concerns, since V1.02 of the HIS Manual includes a significant change in data collection guidance related to Item F3000.

F3000. Spiritual/Existential Concerns

F3000. Spiritual/Existential Concerns	
Enter Code ☐	**A. Was the patient and/or caregiver asked about spiritual/existential concerns?** Select the most accurate response. 0. **No** → Skip to I0010, Principal Diagnosis 1. **Yes, and discussion occurred** 2. **Yes, but the patient and/or caregiver refused to discuss** **B. Date the patient and/or caregiver was first asked about spiritual/existential concerns:** ☐☐ Month ☐☐ Day ☐☐☐☐ Year

- Permissible to consider care processes documented in the clinical record that may have taken place at pre-admission or educational visits.
  - This change makes the HIS guidance for F3000 consistent with Items F2000-2200.

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Item F3000 reports whether or not the patient and/or caregiver were asked about spiritual or existential concerns, and if so, the date this discussion took place or was attempted.

New guidance in the item-specific instructions for Item F3000 changes the date range providers can consider when completing F3000B, "Date patient and/or caregiver was first asked about spiritual/existential concerns". New guidance indicates that it is now permissible to consider discussions that took place prior to admission, either at pre-admission or educational visits. This means that **when completing Item F3000B, providers can now list dates that precede the Admission Date**. This newly refined guidance provides consistency across all Section F items – now it is permissible to consider discussions that took place at a pre-admission or educational visit for all items in Section F: F2000, F2100, F2200, and now also F3000.

An example of a pre-admission discussion of spiritual or existential concerns could be that during an educational or pre-admission visit, the hospice clinician discusses treatment preferences and spiritual/existential concerns.

F3000: Item-Specific Tips

- There is no comprehensive list of spiritual/existential concerns.
- Examples of a discussion regarding spiritual/existential concerns might include:
  - asking the patient/caregiver about need for spiritual or religious support
  - questions about cause or meaning of illness or death
  - discussion of a higher power related to illness
  - offer of a spiritual resource (such as a chaplain)

↘ HIS Manual

Pages 2F-13

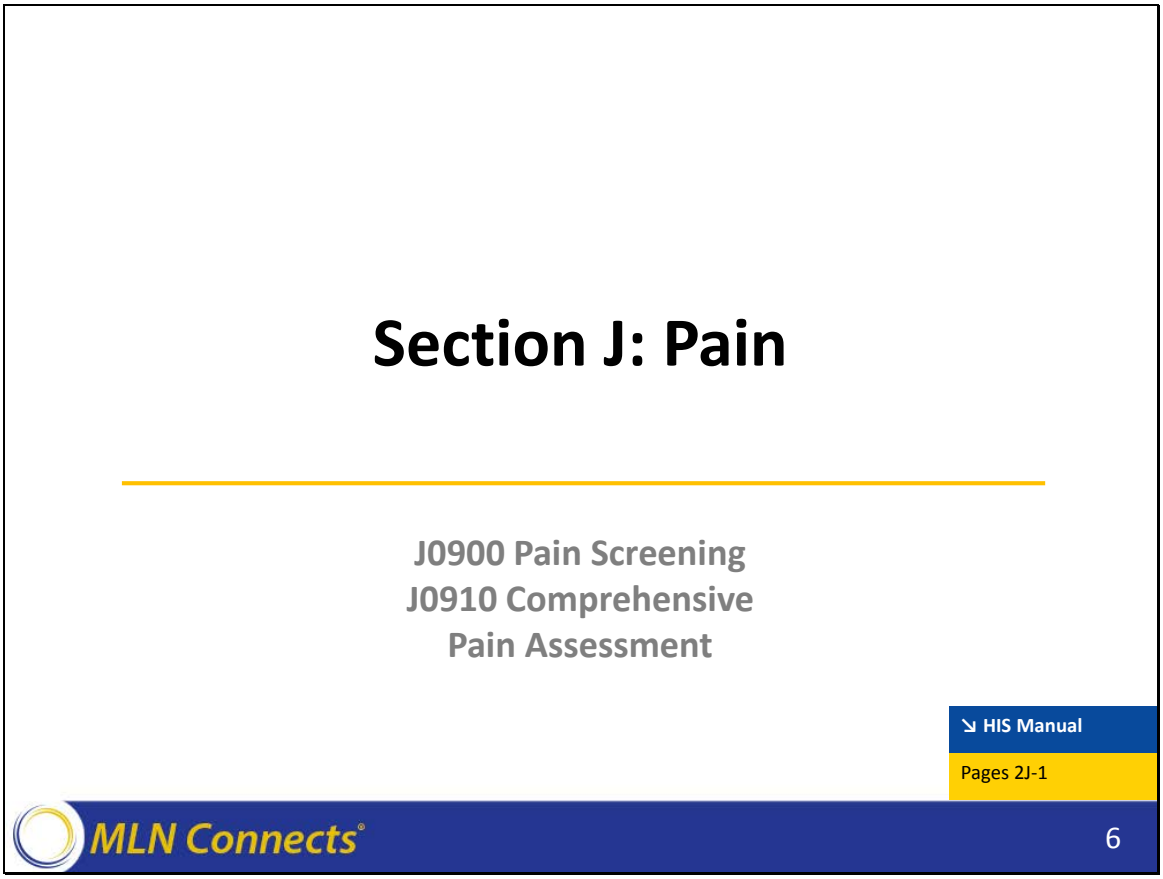
A discussion with the patient or caregiver about spiritual or existential concerns can be initiated by any member of the hospice staff or interdisciplinary group.

There is no comprehensive list of spiritual or existential concerns, although new guidance in V1.02 of the HIS Manual lists some examples. Discussion of spiritual or existential concerns might include asking the family about needs for spiritual support; asking the patient about the meaning of death; or offering the patient a spiritual resource, such as a chaplain.

Remember, the patient and family have the right to refuse to discuss these items. In these instances, the data collector would select response option 2, "Yes, but the patient and/or caregiver refused to discuss" for Item F3000A.

Also keep in mind that brief statements in the clinical record denoting a patient's religious affiliation are not sufficient to select response "Yes" for F3000A.

Additional details about items in Section F, including clinical examples can be found in the HIS Manual. Because this presentation focuses on updated guidance only, we recommend providers review the complete HIS Manual for instructions on completing all HIS items.



Now, we'll turn our attention to Section J. In your manual, that section begins on page 2J-1. Items in Section J pertain to physical symptom management for hospice patients.

Specifically, Section J reports on two physical symptoms: pain, and shortness of breath or dyspnea. Pain items include a pain screening and comprehensive pain assessment item; shortness of breath items include a screening and treatment item.

Pain and SOB screening, assessment, and treatment are fundamental elements of hospice care. Patients and families frequently worry if they or their loved one will experience pain or SOB. Managing physical symptoms is central to high quality hospice care.

First we'll go over Section J pain items.

V1.02 of the HIS Manual contains updated guidance for both of the pain items.

J0900. Pain Screening

J0900. Pain Screening

Enter Code ☐

A. Was the patient screened for pain?

0. **No** → Skip to J2030, Screening for Shortness of Breath
1. **Yes**

B. Date of first screening for pain:

☐☐ Month ☐☐ Day ☐☐☐☐ Year

Enter Code ☐

C. The patient's pain severity was:

0. **None** → Skip to J2030, Screening for Shortness of Breath
1. **Mild**
2. **Moderate**
3. **Severe**
9. **Pain not rated**

Enter Code ☐

D. Type of standardized pain tool used:

1. **Numeric**
2. **Verbal descriptor**
3. **Patient visual**
4. **Staff observation**
9. **No standardized tool used**

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Item J0900 reports whether the patient was screened for pain, and if so, what the date of the first pain screen was, what the severity of the patient's pain was, and what type of standardized pain tool was used for the screening.

J0900: Item-Specific Instructions

- J0900A – Was the patient screened for pain?
- J0900B – Date of first screening for pain
- J0900C – What was the patient's pain severity?
  - Scale has been modified to reflect the scale used by the National Comprehensive Cancer Network Pain Management Guidelines
  - www.nccn.org
  - 4-6 on a 10-point numeric scale is moderate
  - 7-10 on a 10-point numeric scale is severe
- J0900D – What kind of Standardized Pain Scale was used?

↘ HIS Manual

Pages 2J-2

Let's briefly review the Item Specific Instructions for J0900, highlighting some new guidance that appears in V1.02 of the HIS Manual. Item-specific instructions for J0900 begin on Page 2J-2 of the HIS Manual.

J0900A is the gateway question, and asks whether or not the patient was screened for pain.

J0900B is the date item and reports the date on which the patient was **first** screened for pain.

J0900C reports the severity of the patient's pain. Pain severity levels for J0900C have been modified in V1.02 of the HIS Manual to align with the National Comprehensive Cancer Network Guidelines. This means that response option 2, "moderate" now includes a pain severity score of 4-6 using a 10-point numeric scale. Response option 3, "severe" now includes a score of 7-10 using a 10-point numeric scale.

J0900D reports the type of standardized, evidence-based pain tool used to conduct the pain screen. The type of standardized tool used should be documented in the clinical record. If no description or detail regarding the type of pain tool used is found in the record, then providers should use response option "09, no standardized tool used" for J0900D. Do **not** use a dash.

J0900: Pain Screening Example

Situation E:

- Current pain at time of visit: 0/10
- History of pain, at its worst: 6/10
  - Dull, aching pain in lower abdomen
  - Pain is worse when walking
  - Pain is better when lying down

↘ HIS Manual

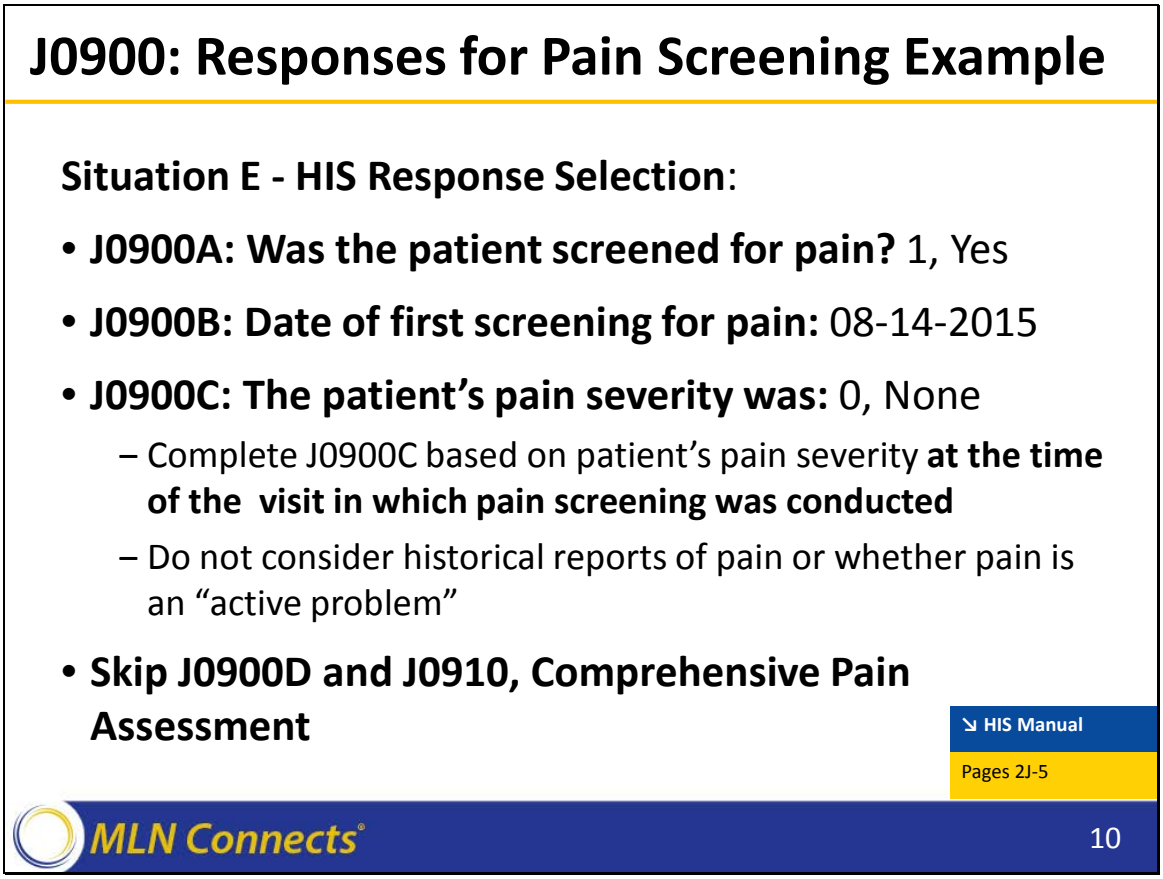
Pages 2J-5

We often receive questions on the Quality Help Desk about what to do in situations where the patient doesn't report current pain, but the patient does have a history of pain, and pain is an active problem for the patient.

A new example – Situation E – was added to V1.02 of the HIS Manual to illustrates how to complete J0900 in this situation.

Situation E begins on Page 2J-5 of V1.02 of the HIS Manual and reads: "patient's initial assessment form dated August 14, 2015 states: 'patient reports he has recently taken a dose of his pain medication, and his current pain is zero on a 0 to 10 pain scale. The patient states he has a history of pain. At its worst, pain is 6 out of 10 and is a dull, aching pain in the lower abdomen. Historically, pain is worse when the patient walks and pain is better when lying down'".

This is a situation where the patient reports no pain at the time of the visit, but clinical record documentation clearly shows that pain is an active problem for the patient.



Let's review how to complete Item J0900 in this situation.

In this example, "J0900A. Was the patient screened for pain?" would be completed using response option "1, yes". The date of the screening, August 14th, 2015, would be reported in J0900B. For J0900C, the data collector should respond "0, none" since J0900C should be completed based on the patient's pain severity **at the time of the visit in which the screening for pain was conducted.** Note that when you select "0, None" for J0900C, HIS instructions direct you to skip J0900D and skip Item J0910, which is the comprehensive pain assessment item.

The question we most often receive on the Help Desk is about the skip pattern in the situation where a patient doesn't report pain at the visit, but it is clear that pain is an active problem for the patient. Providers ask why they must skip J0900D and J0910 in this situation -- especially in instances like Situation E, where it is clear based on clinical record documentation that the assessing clinician completed a more comprehensive assessment of the patient's pain. Providers often write the Help Desk wondering why the HIS directs you to skip over J0910, the comprehensive pain assessment item, since it is good clinical practice to conduct a comprehensive pain assessment for patients where pain is an active problem.

Item completion instructions for J0900 reflect the current quality measure specifications for the corresponding quality measure, NQF #1634. That being said, HIS item completion instructions and corresponding quality measure specifications should not replace or supersede clinical best practice. In an instance like Situation E, it is appropriate for the clinician to carry out whatever assessment is clinically appropriate for the patient's situation. Best practice indicates if a patient is screened and is found to be in pain, **or if pain is an active clinical problem for the patient**, a comprehensive assessment should be completed to determine pain location, severity, character, duration, frequency, effect on function or quality of life, and what relieves and/or worsens the patient's pain. The assessing clinician can and should carry out this comprehensive assessment; however, in situations like the example presented here, information about the comprehensive assessment would not be captured by the HIS in Item J0910.

Thus, in Situation E, although there is clinical record documentation that the nurse further assessed the patient's pain (including historical rating, location, character, what makes pain better/worse), since the patient's pain rating **at the time of the screening** was "0, None," providers should follow skip patterns as indicated on the HIS, skipping J0900D and J0910. **Skipping J0910 in these instances will not negatively affect hospices' scores on the pain quality measures**.

CMS is considering future changes to the HIS items and the quality measure specifications; these changes would more closely align HIS data collection and quality measure calculation with clinical practice in situations like Situation E.

J0910. Comprehensive Pain Assessment

J0910. Comprehensive Pain Assessment	
Enter Code ☐	**A. Was a comprehensive pain assessment done?** 0. **No** → Skip to J2030, Screening for Shortness of Breath 1. **Yes** **B. Date of comprehensive pain assessment:** ☐☐ Month ☐☐ Day ☐☐☐☐ Year **C. Comprehensive pain assessment included:**
↓ **Check all that apply**	
☐	1. Location
☐	2. Severity
☐	3. Character
☐	4. Duration
☐	5. Frequency
☐	6. What relieves/worsens pain
☐	7. Effect on function or quality of life
☐	9. None of the Above

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Item J0910 reports whether a Comprehensive Pain Assessment was done, the date of the first comprehensive pain assessment, and which specific assessment elements were included in the comprehensive pain assessment.

J0910 begins on page 2J-6 of the HIS Manual.

J0910: Item-Specific Tips

- A comprehensive pain assessment should address multiple aspects of pain, beyond a determination of presence of pain and its severity.
- There are seven characteristics included in a comprehensive pain assessment.
- A comprehensive assessment can be conducted on comatose/unresponsive patients as well.
  - Use clinical observation or family report

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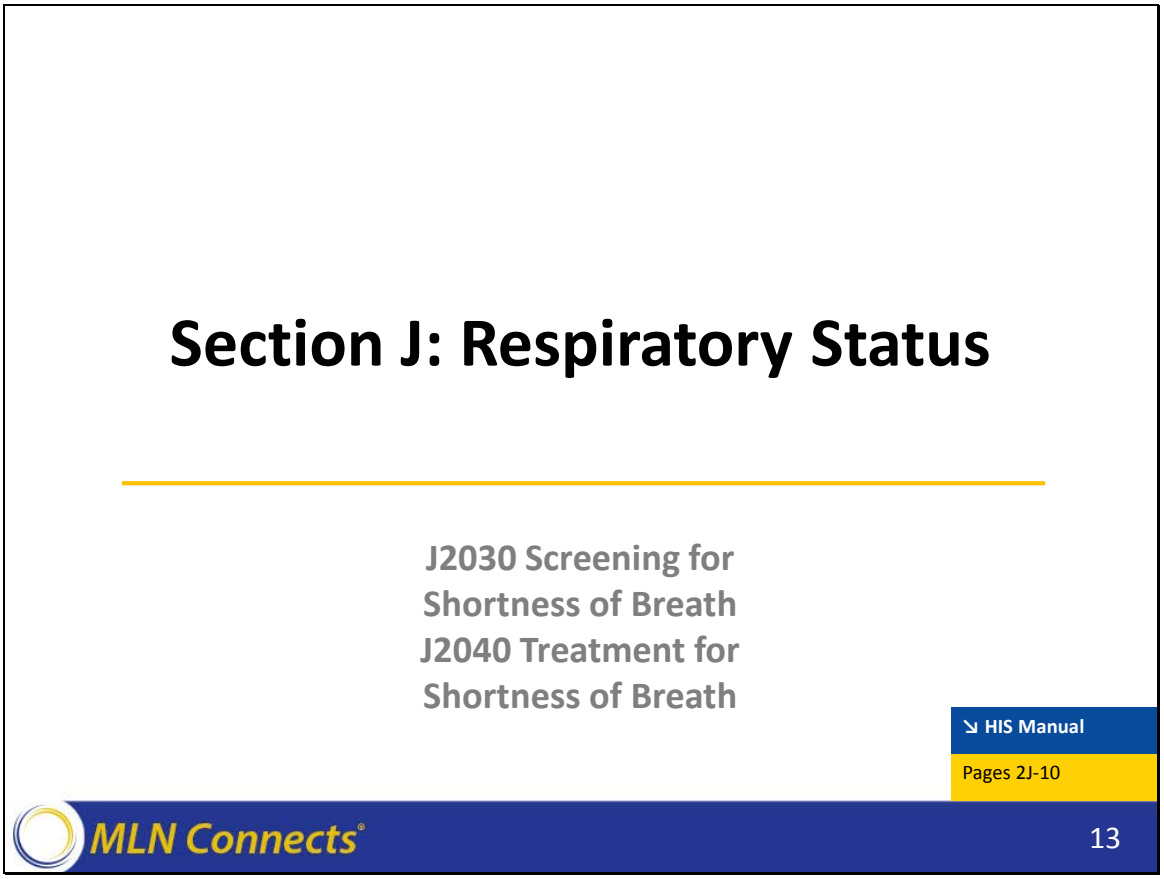
Pages 2J-8

By definition, a comprehensive pain assessment should address multiple aspects of pain, beyond presence of pain and its severity.

There are seven characteristics or elements of a comprehensive pain assessment that are reportable in the HIS. These seven characteristics include: pain location, severity, character, duration, frequency, what relieves or worsens the pain, and the pain's effect on function or quality of life.

A comprehensive pain assessment can be completed on unresponsive patients. For unresponsive patients, the hospice can elicit this information from staff observation, or family/caregiver report. For instance, the assessing clinician might observe a patient demonstrating nonverbal indicators of pain when changing position, or a caregiver might tell the clinician that the patient grimaces and pulls away when her arm is touched. Documentation in the clinical record that states something to the effect of "the location, severity, and character can not be assessed due to patient non-responsiveness" does not qualify to report a comprehensive pain assessment was completed.

Additional details regarding assessing pain for non-responsive patients are provided in the HIS Manual.



Now we'll focus on the shortness of breath items that appear in Section J of the HIS. There are two items in this section – J2030 and J2040. These items note whether the patient was screened for shortness of breath and whether treatment for shortness of breath was initiated.

Dyspnea or shortness of breath can be a symptom of the terminal disease (such as lung cancer) or of the terminal process. It can also be a symptom of underlying disease.

Shortness of breath can be distressing not only to the patient, but also to caregivers and families.

J2030. Screening for Shortness of Breath

J2030. Screening for Shortness of Breath	
Enter Code ☐	**A. Was the patient screened for shortness of breath?** 0. **No** → Skip to N0500, Scheduled Opioid 1. **Yes**
	B. Date of first screening for shortness of breath: ☐☐ Month ☐☐ Day ☐☐☐☐ Year
Enter Code ☐	**C. Did the screening indicate the patient had shortness of breath?** 0. **No** → Skip to N0500, Scheduled Opioid 1. **Yes**

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Item J2030 reports whether there was a screening for shortness of breath, the date of the screening, and whether the patient screened positive for shortness of breath.

J2030: Item-Specific Tips

- Evidence of a "positive" screen for shortness of breath
  - Consider whether shortness of breath (SOB) is an **active problem** for the patient at the time of the screening
  - Clinician may determine that SOB is an active problem, **even if SOB does not occur during the assessment visit**
  - If the patient is receiving treatment for SOB, that indicates SOB is an active problem.
  - This is different than determining severity of pain in J0900C (which is determined **at the time of the visit**)

↘ HIS Manual

Pages 2J-11

New guidance for completing J2030C can be found on page 2J-11 of V1.02 of the HIS Manual. Item-specific tips for J2030 state that evidence of a "positive" screen for shortness of breath should consider whether at the time of the screening clinical encounter, shortness of breath was an **active problem** for the patient.

Based on reports of recent symptoms or current treatment, the assessing clinician may determine that shortness of breath is an active problem, even if shortness of breath does not occur during the assessment visit.

Documentation of current treatment for shortness of breath, like oxygen use, indicates that shortness of breath is an active problem, even if the patient does not report current shortness of breath during the visit.

The guidance for providers to consider whether shortness of breath was an "active problem" for the patient differs from the guidance for determining pain severity in J0900C. Remember, in J0900C, you do not consider any historical report of pain or whether pain is an active problem for the patient.

J2030: Screening for SOB Example

Situation E:

- **Patient's initial assessment contains the following information:**
  - Patient currently not experiencing any SOB
  - Patient reports experiencing SOB when walking from the bed to the bathroom
  - SOB is mild to moderate, depending on activity level

↘ HIS Manual

Pages 2J-13

Let's look at a new example that has been added to the V1.02 of the HIS manual. This new scenario, Situation E, demonstrates an example of determining whether shortness of breath is an "active problem" for the patient. In Situation E, the clinical note dated August 15, 2015 reads: "patient reports he is currently not experiencing any shortness of breath. Patient reports that he does become short of breath when walking from the bed to the bathroom. Patient reports that when he is short of breath, shortness of breath is mild to moderate, depending on activity level."

J2030: Response for Screening for SOB Example

Situation E - HIS Response Selection:

- **J2030A: Was the patient screened for SOB?** 1, Yes
- **J2030B: Date of first screening for SOB:** 08-15-2015
- **J2030C: Did the screening indicate the patient had shortness of breath?** 1, Yes
  - Based on documentation indicating SOB was an "active problem" for the patient, even though the patient was not experiencing SOB at the time of the visit

↘ HIS Manual

Pages 2J-13

Let's work through selecting responses for J2030 based on the information presented in Situation E.

For **J2030A: Was the patient screened for shortness of breath?, select response** "1, Yes."

For **J2030B: Date of first screening for shortness of breath,** enter "08-15-2015".

For **J2030C: Did the screening indicate the patient had shortness of breath?,** select response "1, Yes."

In this scenario, it is evident the clinician evaluated the patient for presence and severity of shortness of breath. So you select response "1, Yes" for J2030A, and continue to J2030B, entering the date of the screening. J2030C should be completed based on whether shortness of breath **was an active problem for the patient.** So, select response "1, Yes" for J2030C to indicate the patient screened positive for shortness of breath.

Again, remember that the guidance about determining whether shortness of breath is an active problem for the patient differs from the guidance about determining pain severity for J0900C. For J0900C, only consider the patient's pain severity at the time of the screening.

J2040. Treatment for Shortness of Breath

J2040. Treatment for Shortness of Breath	
Enter Code ☐	**A. Was treatment for shortness of breath initiated?** Select the most accurate response 0. **No** → Skip to N0500, Scheduled Opioid 1. **No, patient declined treatment** → Skip to N0500, Scheduled Opioid 2. **Yes** **B. Date treatment for shortness of breath initiated:** ☐☐ Month ☐☐ Day ☐☐☐☐ Year **C. Type(s) of treatment for shortness of breath initiated:**
↓ **Check all that apply**	
☐	1. Opioids
☐	2. Other medication
☐	3. Oxygen
☐	4. Non-medication

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Item J2040, Treatment for Shortness of Breath, which appears on Page 2J-14 of V1.02 of the HIS Manual. This item reports whether treatment for shortness of breath was initiated, the date of treatment initiation, and what types of treatments for shortness of breath were initiated, including opioids, other non-opioid medications, oxygen, or non-medication treatments for shortness of breath.

J2040: Item-Specific Instructions

- For **comfort kits or pre-printed admission orders**, treatment is "initiated" when the hospice has received the order and there is documentation that the patient/caregiver was instructed to begin use of the medication or treatment for the relevant symptom.
  - Proactive education is not considered "initiation."
- For **non-medication interventions,** providers can use the date on which the hospice first discussed the intervention with the patient/caregiver.

↘ HIS Manual

Page 2J-14

New guidance in V1.02 of the HIS Manual provides additional clarification on the definition of treatment initiation for comfort kits or pre-printed admission orders.

Many hospices use comfort kits or pre-printed admission orders, which are a set of medications or treatments reviewed and approved by medical staff, and are routinely ordered for patients upon admission. Medications in the comfort kit or on pre-printed orders are initiated once the symptom profile of the patient changes and need for the treatment arises.

For **comfort kits or pre-printed admission orders**, treatment is considered to be "initiated" when the hospice has received the order **and** there is documentation that the patient or caregiver was instructed to begin use of the medication or treatment for the relevant symptom of shortness of breath.

If the date the hospice received the order is different from the date the hospice instructed the patient/caregiver to begin using the treatment/medication, "date treatment initiated" would be the later date, when both conditions were met (the hospice received the order AND instructed patient or caregiver to begin its use). Proactive education on medications in a comfort kit in anticipation of symptoms is not considered treatment "initiation."

For **non-medication interventions** like the use of fans, positioning, or patient education efforts there may not be specific physician orders. In this case, use the date on which the hospice first discussed the intervention with the patient or caregiver.

J2040C: Item-Specific Instructions and Tips

- Examples of some non-opioid medications that *might be used* for dyspnea include:
  - inhaled bronchodilators
  - steroids
  - diuretics
  - benzodiazepines
- These medication examples have multiple uses, so the order must indicate these are intended to address the patient's Shortness of Breath.

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Pages 2J-15

In reporting the types of treatment initiated for shortness of breath, J2040C includes the opportunity to report non-opioid medications in response option two. V1.02 of the HIS Manual provides examples of non-opioid medications that could be used for dyspnea, including inhaled bronchodilators, steroids, diuretics and benzodiazepines. Some of these treatments – including steroids and diuretics – have multiple uses. Since these medications have multiple uses, the order must indicate these treatments were initiated to address the patient's Shortness of Breath.

J2040C: Item-Specific Tip

- For J2040C, only include treatments that were initiated on the date listed in J2040B
  - If additional treatments are initiated on a later date, do not include these in J2040C

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Pages 2J-16

For J2040C, only report treatments for shortness of breath that were initiated on the date listed in J02040B. If additional treatments for shortness of breath are initiated at a later date, do not include those treatments in J2040C.

J2040: Treatment for SOB Example

Situation B:

- **Patient's initial assessment contains the following information:**
  - 9/15/15: Dyspnea/shortness of breath at rest. Instructed family to keep patient's head elevated on pillows while patient is in bed
  - 9/16/15: Oxygen ordered and scopolamine to dry respiratory secretions

↘ HIS Manual

Pages 2J-17

The example presented in Situation B on page 2J-17 of V1.02 of the HIS Manual has been updated to reflect current guidance about treatments for shortness of breath that are initiated on different dates.

In Situation B, the patient's initial assessment shows that treatment for shortness of breath was initiated on two dates: September 15, 2015 and September 16, 2015. On September 15th the hospice instructed the family to keep the patient's head elevated on pillows while the patient is in bed. The following day, September 16th, the hospice ordered oxygen and scopolamine to dry respiratory secretions.

J2040: Response Selection for Treatment for SOB Example

Situation B HIS Response Selection:

- **J2040A: Was treatment for SOB initiated?** 2, Yes
- **J2040B: Date treatment for SOB initiated:** 09-15-2015
- **J2040C: Type(s) of treatment for shortness of breath initiated:** 4, Non-medication.
  - Clinical record documentation indicates that the patient was short of breath and that more than one treatment was initiated for shortness of breath. However, only the treatment initiated on the date in J2040B should be listed in J2040C.

↘ HIS Manual

Pages 2J-17

Let's work through selecting responses for J2040 based on the information presented in Situation B.

For J2040A, select response "2, Yes" to indicate that treatment for SOB was initiated.

For J2040B, enter the date that the first treatment for SOB was initiated, which was September 15th, 2015.

For J2040C, select only those treatments that were initiated on the first date, September 15th. This means that although there were additional treatments initiated on September 16th, we would not include those in J2040C. J2040C should reflect only the treatments initiated on the date in J2040B.

J2040: Treatment for SOB Example

Situation D:

- **Patient's initial assessment contains the following information:**
  - Comfort pack in patient's home and on stand-by.
  - Patient and family are educated about medications in comfort pack, relevant symptoms, and where to store the comfort pack
  - Patient and family told not to use medications in pack unless advised to do so

↘ HIS Manual

Pages 2J-18

A new example for the Treatment for Shortness of Breath Item was added to V1.02 of the HIS Manual. This new example, Situation D, begins on Page 2J-18 of the HIS Manual. This example illustrates how to define treatment initiation for comfort packs.

As stated in Situation D, documentation in the clinical record indicates that a comfort pack was in the patient's home and on stand-by. The comfort pack included treatments that could be used for shortness of breath, and that the nurse provided proactive education to the patient and caregiver about the availability of these treatments. Documentation also shows that the nurse instructed the patient and family not to use the medications in the comfort kit until specifically advised to do so.

J2040: HIS Response Selection for Treatment for SOB Example

Situation D HIS Response Selection:

- **J2040A: Was treatment for SOB initiated?** 0, No
  - Clinical record documentation indicates that the comfort pack included treatments that could be used for SOB and that the nurse provided proactive education about these treatments. However, the clinical record contains no documentation that the nurse instructed the patient/family to begin using any of the treatments for SOB.
- **Skip J2040B and J2040C**

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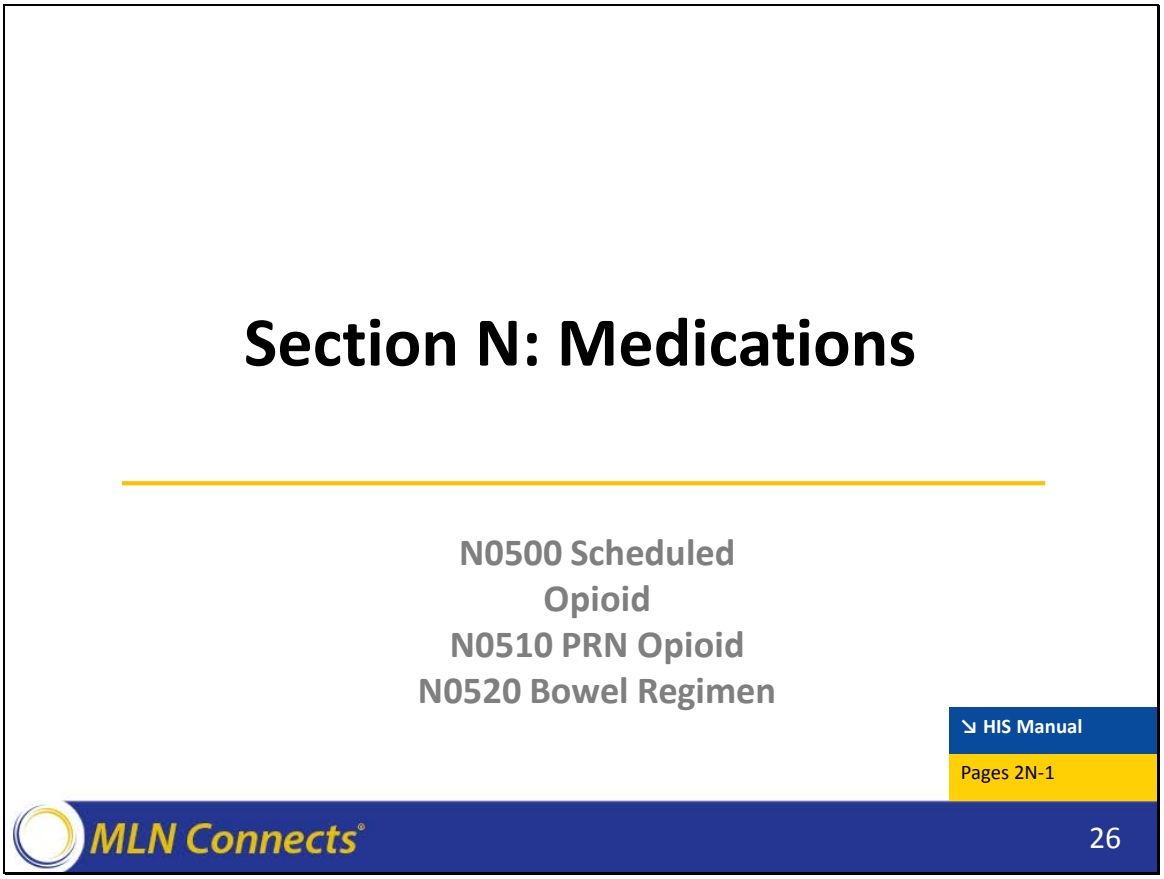
Pages 2J-18

Let's review the proper HIS response selection for Situation D.

In Situation D, the proper course of action is to select "0, No" for J2040A, which asks whether treatment for SOB was initiated. In Situation D, although there is documentation that a comfort pack was in the patient's home and the nurse provided proactive education about treatments in the comfort pack, there is no documentation that the nurse instructed the patient or family to begin using any of the treatments for shortness of breath. So, for the purposes of completing Item J2040, treatment for shortness of breath should be considered as not initiated. In this example, you would respond "0, No" to J2040A and skip J2040B and C.



The last section we will discuss is Section N, Medications, which includes items for reporting initiation of opioids and bowel regimens.

Section N includes 3 HIS items, N0500 Scheduled Opioids, N0510 PRN Opioids, and N0520 Bowel Regimen.

V1.02 of the HIS Manual contains updates guidance for all 3 of the items in Section N.

Section N begins on page 2N-1 of V1.02 of the HIS Manual

N0500. Scheduled Opioid, N0510. PRN Opioid Item-Specific Tips

- An “opioid” includes Schedule II – Schedule IV opioids, including hydrocodone and tramadol
- This is based on the side effect profile for these medications, which includes constipation.

↘ HIS Manual

Pages 2N-2, 2N-4

Items N0500 and N0510 report whether and when scheduled and PRN opioids were initiated.

For the purposes of completing Item N0500 and N0510, an “opioid” includes Schedule II – Schedule IV opioids, including hydrocodone and tramadol, based on the side effect profile, which includes constipation. Remember, Items in Section N are related to the NQF measure #1617, which reports the percentage of patients treated with an opioid who are also given a bowel regimen within 1 day. The intent of this quality measure is prevent opioid-induced constipation; since the side effect profile of Schedule II – IV opioids includes constipation, reporting Schedule II – IV opioids in Items N0500 and N0510 meets the intent of the quality measure.

N0500 & N0510: Item-Specific Instructions

- For **comfort kits or pre-printed admission orders**, treatment is considered "initiated" when the hospice has received the order and there is documentation that the patient/caregiver was instructed to begin use of the medication or treatment for the relevant symptom.
  - Proactive education is not considered "initiation"

↘ HIS Manual

Pages 2N-2, 2N-5

As with treatments for shortness of breath, hospices using comfort kits or pre-printed admission orders should follow new guidance in V1.02 of the HIS Manual. Guidance for defining "treatment initiation" in the case of comfort kits or pre-printed admission orders can be found on Pages 2N-2 and 2N-5 for these two HIS items.

Remember, that for **comfort kits or pre-printed admission orders**, treatment is considered to be "initiated" when the hospice has received the order **and** there is documentation that the patient or caregiver were instructed to begin using the medication or treatment. Proactive education alone is not considered "initiation".

N0520. Bowel Regimen

N0520. Bowel Regimen
Complete only if N0500A or N0510A = 1

Enter Code ☐

A. Was a bowel regimen initiated or continued? Select the most accurate response.

0. **No** → Skip to Z0400, Signature(s) of Person(s) Completing the Record
1. **No, but there is documentation of why a bowel regimen was not initiated or continued** → Skip to Z0400, Signature(s) of Person(s) Completing the Record
2. **Yes**

B. Date bowel regimen initiated or continued:

☐☐ Month ☐☐ Day ☐☐☐☐ Year

Manual
-5

N0520 reports if a bowel regimen was initiated or continued, and if so, the date the bowel regimen was initiated or continued.

Remember, only complete Item N0520 if the patient received an opioid. If the patient is not receiving any opioids, skip N0520, even if the patient is on a bowel regimen. This skip pattern mirrors the intent of the related quality measure, NQF #1617. This quality measure is about preventing **opioid-induced** constipation, so only complete N0520, the bowel regimen item, if the patient is receiving an opioid.

N0520: Item-Specific Tip

- The bowel regimen order **need not** explicitly state it is for the management of opioid induced constipation.
- For Example:
  - Order received on 8/12/15 for Milk of Magnesia 30 ccs daily for constipation.
  - Although order does not state specifically this is constipation related to opioid use, can still respond "yes" to N0520A
- Date bowel regimen initiated can precede date opioid(s) initiated

↘ HIS Manual

Pages 2N-6

Let's discuss two item-specific tips for N0520.

First, following the skip pattern discussed on the previous slide, Item N0520 is only completed if the patient is taking a PRN or scheduled opioid. That being said, in order to respond "Yes" to N0520A, the bowel regimen order in the clinical record does not need to explicitly state that it is for the management of opioid-induced constipation.

For example, suppose there was an order in a patient's clinical record dated August 12th, 2015 for 30 ccs of Milk of Magnesia daily for constipation. The order and clinical record do not specifically state that the constipation is opioid-induced. In the scenario on this slide, the HIS data collector could still respond "yes" to N0520 even though the order in the patient's clinical record does not state that the Milk of Magnesia was specifically ordered to prevent **opioid-induced** constipation.

The second item-specific tip for N0520 states that the date on which the bowel regimen was initiated can precede the date on which opioid(s) were initiated.

Section N Example

- **Situation D: Patient's initial assessment contains the following information:**
  - 7/23/2015: comfort pack in patient's home and on stand-by. Patient/family instructed on what medications are in comfort pack.
  - 7/23/2015: Order for Polyethylene glycol 17 g PO with full glass of water once daily.
  - 7/25/2015: Caregiver called and reported patient in moderate pain; instructed caregiver to open comfort pack and begin oxycodone every 4 hours as needed.

↘ HIS Manual

Pages 2N-9

To illustrate treatment initiation in the case of comfort packs and pre-printed admission orders, a new example – Situation D -- has been added to Section N of the HIS Manual. Situation D begins on page 2N-9 of the HIS Manual.

In Situation D, the patient's initial assessment contains documentation that on July 23rd, a comfort pack was in the patient's home and on stand-by. The patient and family were instructed on what medications were available in the comfort pack. Documentation from July 23rd also shows that there was an order for Polyethylene glycol to prevent constipation.

On July 25th, the caregiver called the hospice and reported the patient was experiencing moderate pain. The hospice staff instructed the patient to open the comfort pack and begin to take the oxycodone every 4 hours as needed for pain.

Response Selection for Section N Example

Situation D HIS Response Selection:

- **N0500A: Was a scheduled opioid initiated or continued?** 0, No
- **N0500B:** Skip
- **N0510A: Was a PRN opioid initiated or continued?** 1, Yes
- **N0510B: Date PRN opioid initiated or continued:** 07-25-2015
  - PRN oxycodone part of comfort pack; medication considered initiated on date the nurse instructed the patient/family to begin using the treatment
- **N0520A: Was a bowel regimen initiated or continued:** 2, Yes
- **N0520B: Date bowel regimen initiated or continued:** 07-23-2015
  - Date in N0520B can precede date in N0500B and/or N0510B
  - Order does not need to specifically state bowel regimen to prevent **opioid-induced** constipation

↘ HIS Manual

Pages 2N-9

Let's review HIS response selections for Situation D.

For the scheduled opioid item, N0500, since no scheduled opioid was initiated, select "0, No" for N0500A, skipping N0500B.

For N0510A, the clinical record documentation shows that a PRN opioid – oxycodone 10 mg – was initiated. For N0510B, date PRN opioid initiated, review the clinical record documentation carefully since the PRN opioid was part of a comfort pack. For "date PRN opioid initiated" list the date the nurse instructed the patient/family to begin using the oxycodone from the comfort pack, which was July 25th.

For N0520, the bowel regimen item, list the date on which the bowel regimen was initiated. In this example, bowel regimen initiation on July 23rd **preceded** the PRN opioid initiation on July 25th. This is acceptable. Also, note that the bowel regimen order **does not** need to state the bowel regimen was initiated specifically to prevent opioid-induced constipation.

Resources

The following slides present some resources hospice providers can use to stay up-to-date on HQRP and HIS requirements.

Staying Informed

- **CMS HQRP website:** http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/index.html
  - See "Hospice Item Set (HIS)" Section
- **Listservs:**
  - *MLN Connects eNews*
    - https://public.govdelivery.com/accounts/USCMS/subscriber/new?pop=t&topic_id=USCMS_7819
  - ODF listserv
    - http://www.cms.gov/Outreach-and-education/Outreach/OpenDoorForums/ODF_HHHDME.html
- **Federal Register:** http://www.federalregister.gov
  - Review proposed and final rules

Providers should regularly check the CMS HQRP website for updates and announcements. CMS recommends providers bookmark this website and visit the webpage regularly. The "Hospice Item Set (HIS)" portion of the webpage contains HIS-specific information.

There are two listservs providers can sign up for to stay informed of CMS requirements. Providers can sign up for the MLN Connects eNews listserv at the second webaddress listed on this slide; providers can also sign up for the Open Door Forum (ODF) listserv at the third webaddress listed on this slide.

Finally, providers should review proposed and final rules that are published by CMS. Proposed and final rules can be accessed at the Federal Register website listed on this slide.

Help Desks

- **Quality Help Desk**: HospiceQualityQuestions@cms.hhs.gov
  - Providers can email the Quality Help Desk if they have general questions about the Hospice Quality Reporting Program (HQRP) including, but not limited to: which hospices are required to report, general questions about reporting requirements, questions about quality measures, and reporting deadlines.
- **Technical Help Desk:** help@qtso.com
  - Phone: 1-877-201-4721 (Monday-Friday 7:00 a.m. - 7:00 p.m. Central Time)
  - Use for questions related to the HART tool, QIES ASAP, or other technical assistance information, including error messages or record rejections.
- **Reconsideration Help Desk**: HospiceQRPReconsiderations@cms.hhs.gov.
  - Use to submit a reconsideration request or to ask other questions related to reconsideration.

Finally, there are also 3 Help Desks available to assist providers with HQRP-related questions. Contact information for each of the help desks is listed on this slide.