



Hospice Item Set

Presented By: CMS and RTI International
February 4-5, 2014



Welcome

- Introductions
- General Housekeeping

Slide 2

Day 1 Overview

- HQRP Background
- Section A: Administrative Information
- Section I: Active Diagnosis
- Section Z: Record Administrative
- Q&A for Sections A, I, Z
- Section J: Dyspnea

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Q&A Sessions

- In-Person: Submit one question per index card with
 - slide number and/or Chapter, Section, Item number if applicable.
 - Include your email address.
- Live-Streaming: E-mail Quality Help Desk at HospiceQualityQuestions@cms.hhs.gov
 - Put “HIS Training” in the subject line.
 - Include slide number and/or Chapter, Section, Item number if applicable.

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Unanswered Questions

- If your question is not answered during the training, please e-mail the Quality Help Desk at HospiceQualityQuestions@cms.hhs.gov
 - Put “HIS Training” in the subject line.
 - Include slide number and/or Chapter, Section, Item number if applicable.

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Hospice Quality Reporting Program (HQRP)

- Section 3004 of the Patient Protection and Affordable Care Act (ACA) establishes quality reporting program.
- Hospice Item Set (HIS) implemented as part of the FY 2014 Hospice Wage Index Final Rule.
- Office of Management and Budget (OMB) approval for HIS pending.

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FY 2016 Reporting Cycle

- Data collection beginning July 1, 2014
- Payment impact in FY 2016

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Applicable Hospices and Patients

- All Medicare-certified hospices must submit.
- Reporting eligibility for new Medicare-certified hospices will be communicated through provider outreach and rulemaking.
- Data is collected and submitted on **all** patient admissions.
- Quality measures will be calculated on patients 18 years and older.

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Item Set

- The HIS *is* an item set, a standardized tool for abstracting data from the clinical record.
- The HIS *is NOT* a patient assessment tool, and is not administered directly to the patient and/or family.

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Page 1-1

Implementation

- The HIS may be completed by any hospice staff member.
- HIS items should be completed based on information in the hospice record.

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Page 1-5

Implementation

- You may match or “cross walk” items from the clinical record to items in the HIS.
- You may add HIS items to your clinical record or patient assessment forms for a 1:1 abstraction.

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Completion and Submission Deadlines

Completion Deadlines:

- HIS-Admission: 14 days after admission
- HIS-Discharge: 7 days after discharge

Submission Deadlines:

- HIS-Admission: 30 days after admission
- HIS-Discharge: 30 days after discharge

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Sample Calendar

JULY/AUGUST						
Sun	Mon	Tues	Weds	Thur	Fri	Sat
		Admission 1	2	3	4	5
6	7	8	9	10	11	Discharge 12
13	14	Completion 15	16	17	18	Completion 19
20	21	22	23	24	25	26
27	28	29	30	Submission 31	1	2
3	4	5	6	7	8	9
10	Submission 11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30

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Submission

- The HIS-Admission Record must be submitted before the HIS-Discharge Record.
- Submit to CMS's Quality Improvement Evaluation System (QIES) Assessment Submission and Processing (ASAP) system.
- Additional details will be provided during technical training in May.

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Chapter 3

Maintenance of HIS Records

- It is recommended that hospices retain a copy of the HIS and any corrected versions.
- Hospices may want to retain the signature page in Section Z for potential future validation purposes.

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HIS Manual: Chapter 2 Item-Specific Instructions

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Pages 2A-1 to 2Z-2

Data captured by the HIS

Section of HIS	Care Process Items?	Corresponding QM
Section A: Administrative Information	No	-
Section F: Preferences	Yes	NQF #1641 – Treatment Preferences Modified NQF #1647 – Beliefs/Values Addressed (if desired by patient)
Section I: Active Diagnoses	No	-
Section J: Health Conditions (Pain and Dyspnea)	Yes	NQF #1634, NQF #1637 – Pain Screening and Assessment NQF #1639, NQF #1638 – Dyspnea Screening and Treatment
Section N: Medications	Yes	NQF #1617 – Patients on an Opioid who are Given a Bowel Regimen
Section Z: Record Administration	No	-

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Appendix C-2 to C-8

HIS-Admission vs. HIS-Discharge

HIS Admission
Section A: Administrative Information
Section F: Preferences
Section I: Active Diagnoses
Section J: Health Conditions (Pain and Dyspnea)
Section N: Medications
Section Z: Record Administration

Contains administrative items and care process items.

HIS Discharge
Section A: Administrative Information
Section Z: Record Administration

Contains a limited set of administrative items and 2 discharge items. No care process items.

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HIS Administrative Items: HIS Sections A, I, and Z

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Section A: Administrative Information

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Pages 2A-1 to 2A-11

Section A: Rationale

- This section obtains information that uniquely identifies each patient, the hospice, and the reason for the record.
- This information is needed to create records in the QIES ASAP system.

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Page 2A-1

Section A: Record Types

- Type of Record (A0050)
 - “Add new record”
 - “Modify existing record”
 - “Inactivate existing record”
- Reason for Record (A0250)
 - Must have an admission and discharge record for each patient admission.

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Pages 2A-1; 2A-4

Section A: Identification Numbers

- Facility Provider Numbers (A0100)
 - National Provider Identifier (NPI)
 - CMS Certification Number (CCN)
- Social Security and Medicare Number (A0600)
 - If no Medicare number, can use Railroad Retirement Board (RRB) number.
- Medicaid Number (A0700)
 - Enter “+” if pending; if patient later receives a number, include it on the next record.
 - A Modification Request is **not** required.
 - Enter “N” if not a Medicaid Recipient.

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Pages 2A-2; 2A-6; 2A-7

Section A: Patient Information

- Legal Name of Patient (A0500)
 - HIS-Admission, HIS-Discharge names should match.
- Gender (A0800)
- Birth Date (A0900)
 - If only year is known, leave “month” and “day” blank.
 - If only year and month are known, leave “day” blank.
- Race/Ethnicity (A1000)
 - Observer identification is permissible if there’s no clinical record documentation.

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Pages 2A-5; 2A-8

Section A: Dates

- Admission Date (A0220)
 - Medicare Patients: Same as hospice benefit election, which may be first day of hospice care.
- Date Initial Nursing Assessment Initiated (A0245)
 - First clinical screening and assessment of symptom needs, used to determine plan of care.

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Page 2A-4

Section A: Service Sites

- Site of Service at Admission (A0205)
 - May use information from Medicare claims to complete item.
- Admitted From (Immediately preceding this admission, where was the patient?) (A1802)

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Pages 2A-2; 2A-9

Section A: HIS-Discharge Only

- Discharge Date (A0270)
 - May be date of death, date the patient revoked the hospice benefit, or date the hospice discharged the patient.
- Reason for Discharge (A2115)
 - Review the clinical record, including the discharge plan and discharge order, to complete.

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Pages 2A-5; 2A-11

Section I: Active Diagnoses

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Page 2I-1

Section I: Rationale

- Disease processes can impact service delivery.

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I0010: Principal Diagnosis

- Select the condition that is chiefly responsible for the patient's admission (principal diagnosis):
 - Cancer
 - Dementia/Alzheimer's
 - None of the above

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Section Z: Record Administration

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Pages ZZ-1 to ZZ-2

Section Z: Rationale

- Signatures in Section Z are for use and retention by the hospice.
- Signatures indicate attestation that the abstracted information recorded in the HIS is complete and accurately reflects patient information.

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Page ZZ-1

Section Z: General

- Section Z should be retained in accordance with hospice policies regarding patient information.
- Staff completing the HIS record may or may not be the clinician(s) who completed the care processes.

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Pages 2Z-1 to 2Z-2

Z0400: Signature(s) of Person(s) Completing the Record

- All staff who complete any part of the HIS record must enter their information.
- Signatures are used to certify that the information the individual(s) provided is accurate.
- Not submitted as part of the HIS.
- Provided for hospice use.

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Page 2Z-1

Z0500: Signature of Person Verifying Record Completion

- One individual must verify that all items on the record have been completed.
- This signature does not certify the accuracy of the items that have been completed by other staff members.
- The completion date is used to document that the HIS record was completed in a timely manner.

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Page ZZ-2

Q&A – Sections A, I, Z

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HIS Care Process Items: HIS Sections F, J, and N

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Structure of Care Process Items

- The HIS abstracts data from the clinical record to capture if/when care processes took place.
- HIS care process items determine:
 - Did a care process take place?
 - When did the care process take place?
 - What were the results of the care process?

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Structure of Care Process Items

“Gateway” question
Did the care process take place?

Date
When did the care process take place?

Results
What were the results of the care process?

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

” to gateway ion, skip date results.

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Structure of Care Process Items

“Gateway” question
Did the care process take place?

Date
When did the care process take place?

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:

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Section J: Respiratory Status

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Pages 2J-10 to 2J-15

Section J: Respiratory Status – Rationale

- Shortness of breath (SOB) can be functionally limiting and distressing to patients and families.
 - Screening determines presence and severity of SOB, which informs treatment.
 - Treatment varies with SOB severity, etiology, and patient preferences.

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Page 2J-10

Section J: Respiratory Status

Corresponding HIS Items and QMs:

Care Process	Relevant HIS Item	Corresponding NQF Measure
Shortness of Breath (dyspnea) Screening	J2030	NQF #1639
Shortness of Breath (dyspnea) Treatment	J2040	NQF #1638

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Appendix C-6 to C-7

Section J: Respiratory Status – Corresponding QMs

- **NQF #1639 – Dyspnea Screening**
 - % of patients screened for dyspnea during initial nursing assessment
- **NQF #1638 – Dyspnea Treatment**
 - % of patients who screened positive for dyspnea who received treatment within 1 day of the screening
- **NQF #1639 and #1638 are “paired” measures.**

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Appendix C-6 to C-7

Item J2030: Screening for Shortness of Breath (Dyspnea)

- Looking for evidence of:
 - **J2030A:** Was the patient screened for SOB?
 - **J2030B:** Date the *first* SOB screening took place.
 - **J2030C:** Did the screening show the patient had SOB?

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Page 2J-10

J2030: Screening for SOB Tips

- Structured assessment for SOB is not well defined.
 - Screening may not include use of standardized scale.
 - Any documentation that the patient was screened is enough to select code “1, Yes” for J2030A.
- Evidence of a “positive” screen should consider clinical signs and patient/family report.

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J2030: Screening for SOB Examples

- Situation A:
 - In order to answer “Yes” to gateway question, must find evidence that SOB *as a specific symptom* was assessed in some manner.
- Situation B:
 - When interpreting results of dyspnea screen, consider patient/caregiver report as well as clinical signs.

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J2030: Screening for SOB Examples

- Situations C & D:
 - Select code for J2030 based on evidence in the clinical record.

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Item J2040: Treatment for SOB (Dyspnea)

- Looking for evidence of:
 - **J2040A:** Was treatment for SOB initiated?
 - **J2040B:** Date treatment for SOB initiated.
 - **J2040C:** Type(s) of treatment for SOB initiated.

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J2040: Treatment for SOB Tips

- Include PRN and regularly scheduled treatments.
- Include standing orders only if they are initiated.
- If a treatment has multiple uses (for example, opioids), only include it in J2040 if the clinical record indicates it was initiated to address symptoms of SOB.

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J2040: Treatment for SOB Examples

- Situation A:
 - If a treatment has multiple uses (for example, opioids), the clinical record must indicate that the treatment was initiated to treat symptoms of SOB.
- Situation B:
 - The date in J2040B should be the date that the *first* treatment for SOB was initiated.

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Wrap-Up and Day 2 Overview

- Section J: Pain
- Section N: Medications
- Q&A for Section J: Dyspnea (Day 1) and Pain and Section N: Medications
- Section F: Preferences
- Q&A for Section F: Preferences

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Section J: Pain

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Pages 2J-1 to 2J-9

Section J Pain: Rationale

- Pain is a prevalent and undertreated symptom.
- Pain management is a high priority for patients and caregivers.
- Pain screening and assessment are critical steps in pain management and treatment.

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Section J: Pain

Corresponding HIS Items and QMs:

Care Process	Relevant HIS Item	Corresponding NQF Measure
Pain Screening	J0900	NQF #1634
Pain Assessment	J0910	NQF #1637

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Appendix C-4 to C-5

Section J: Pain – Corresponding QMs

- **NQF #1634 – Pain Screening**
 - % of patients screened for pain during initial nursing assessment
- **NQF #1637 – Pain Assessment**
 - % of patients who screened positive for pain who received comprehensive pain assessment within 1 day of screening
- **NQF #1634 and #1637 are “paired” measures.**

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Appendix C-4 to C-5

Item J0900: Pain Screening

- Looking for evidence of:
 - **J0900A:** Was the patient screened for pain?
 - **J0900B:** Date the *first* pain screening took place.
 - **J0900C:** What was pain severity?
 - **J0900D:** Type of standardized pain tool used.

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Standardized Tool Definition

- Scientifically tested.
- Standard response scale.
- Appropriately administered.
- Relevant for the patient's ability to respond.

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J0900: Pain Screening Tips

- Pain screening includes evaluation of presence/absence of pain.
 - If pain is present, severity must be rated using a *standardized* pain tool.
- Select code for pain severity (J0900C) based on *highest* pain level recorded *at time of screening*.

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J0900: Pain Screening Examples

- Situations A and B:
 - No standardized pain tool was used.
 - Select “none” for Pain Severity (J0900C) and skip Type of Standardized Pain Tool (J0900D).

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J0900: Pain Screening Examples

- Situation C:
 - Select code “1, Mild” for J0900C based on severity rating *at the time of visit* (3/10).
- Situation D:
 - Select code “3, Severe” for J0900C based on the *highest* severity rating at the time of visit.

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Item J0910: Comprehensive Pain Assessment

- Looking for evidence of:
 - **J0910A:** Was a comprehensive pain assessment done?
 - Must be evidence of at least one element from J0910C to select “Yes” for J0910A.
 - **J0910B:** Date the *first* pain assessment took place.
 - **J0910C:** What elements did the pain assessment include?

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J0910: Pain Assessment Tips for Nonverbal Patients

Pain Assessment Characteristic	Nonverbal indicator
Location	Nonverbal pain cues <i>for a specific location</i> of the body
Severity	<i>Intensity</i> of nonverbal cues or nonverbal rating scale
Duration	<i>How long</i> patient exhibits nonverbal pain cues
Frequency	<i>How often</i> patient exhibits nonverbal pain cues
What relieves/worsens pain	Actions, activities, or positions that lead to more/fewer nonverbal pain cues
Effect on function or quality of life	Change in patient activity

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J0910: Pain Assessment Examples

- Situation A:
 - Select code for J0910C based on documentation of nonverbal indicators found in clinical record.
 - Include “6, What relieves/worsens pain” since clinician attempted to obtain the information from the caregiver.
- Situation B:
 - Select code for J0910 based on documentation in the clinical record.

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Section N: Medications

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Section N: Medications – Rationale

- Opioids are commonly used in pain management.
- Constipation is one of the most common opioid-related side effects.

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Section N: Medications

Corresponding HIS Items and QMs:

Care Process	Relevant HIS Item	Corresponding NQF Measure
Initiation/continuation of Scheduled Opioid	N0500	NQF #1617
Initiation/continuation of PRN Opioid	N0510	NQF #1617
Initiation/continuation of Bowel Regimen	N0520	NQF #1617

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Section N: Medications – Corresponding QM

- NQF #1617 – Patients Treated with an Opioid who are Given a Bowel Regimen
 - % of patients treated with an opioid who are prescribed a bowel regimen within 1 day of opioid prescription, or who have documentation why a bowel regimen is not needed.

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Appendix C-8

Item N0500: Scheduled Opioid

- Looking for evidence of:
 - **N0500A:** Was a scheduled opioid initiated or continued?
 - **N0500B:** Date scheduled opioid initiated or continued.

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N0500: Scheduled Opioid Tips

- Select code “1, Yes” if a regularly scheduled opioid was initiated for *any* reason, regardless of symptom.
- If patient received multiple scheduled opioids, enter date *first* opioid treatment was initiated.

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Item N0510: PRN Opioid

- Looking for evidence of:
 - **N0510A:** Was a PRN opioid initiated or continued?
 - **N0510B:** Date PRN opioid initiated or continued.

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N0510: PRN Opioid Tips

- Select code “1, Yes” if a PRN opioid was initiated for *any* reason, regardless of symptom.
- If patient received multiple opioids, enter date *first* opioid treatment was initiated.

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Item N0520: Bowel Regimen

- Complete only if patient is on an opioid (N0500A or N0510A = 1).
- Looking for evidence of:
 - **N0520A:** Was a bowel regimen initiated or continued?
 - **N0520B:** Date bowel regimen initiated or continued.

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N0520: Bowel Regimen Tips

- Bowel regimen includes, but is not limited to, laxatives, stool softeners, fiber supplements, enemas, suppositories.
- Documentation for why a bowel regimen was not initiated/continued could include clinical contraindication or patient refusal.

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Section N Examples

- Situation A:
 - Clinical record indicates the patient has a contraindication and should not be on a bowel regimen.
- Situation B:
 - Clinical record indicates patient on bowel regimen.

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Section N Examples

- Situation C:
 - Only complete N0520 if patient is on an opioid (scheduled and/or PRN).
 - Since patient is not on any opioid, do not complete N0520 even though a bowel regimen is documented in clinical record.

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Q&A – Section J: Dyspnea and Pain; Section N: Medications

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Section F: Preferences

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Section F: Rationale

- Giving patients opportunities to express their preferences and needs helps ensure:
 - Their care is consistent with their values.
 - Their needs are met.

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Section F: Preferences

Care Process	Relevant HIS Items	Corresponding NQF Measure
Treatment Preferences	F2000, F2100, F2200	NQF #1641
Beliefs/Values Addressed (if desired by the patient)	F3000	(Modified) NQF #1647

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Appendix C-2 to C-3

Section F: Corresponding QMs

- **NQF #1641 – Treatment Preferences**
 - % of patients with documentation of a discussion (or attempted discussion) about life-sustaining treatment preferences.
- **(Modified) NQF #1647 – Beliefs/Values Addressed (if desired by the patient)**
 - % of patients with documentation of a discussion (or attempted discussion) about spiritual/existential concerns.

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Appendix C-2 to C-3

Item F2000: CPR Preference

- **Looking for evidence of:**
 - F2000A: Discussion (or attempted discussion) regarding CPR preference
 - F2000B: Date of discussion (or attempted discussion)

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F2000: CPR Preference Tips

- Any hospice staff or IDG member can initiate discussion.
- Orders alone or short statements in the clinical record such as “DNR/DNI” or “full code” are insufficient evidence of a discussion.
- If the patient has an order or POLST form from a previous care setting, the hospice must re-affirm.

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F2000: CPR Preference Examples

- Situation A:
 - Use the first documented date of discussion.
- Situation B:
 - The patient had a recently dated DNR order, but it was signed in a prior care setting. There is no documentation that indicates the hospice re-confirmed the preferences.

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Item F2100: Other Life-Sustaining Treatment Preferences

- Looking for evidence of:
 - F2100A: Discussion (or attempted discussion) regarding other life-sustaining treatment preferences
 - F2100B: Date of discussion (or attempted discussion)

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F2100: Other Life-Sustaining Treatment Preferences Tips

- Any hospice staff or IDG member can initiate discussion.
- Orders alone are insufficient evidence of discussion.
- There is no comprehensive list of life-sustaining treatments.
- If the patient has an order or POLST form from a previous care setting, the hospice must re-affirm.

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F2100: Other Life- Sustaining Treatment Preference Examples

- Situation A:
 - Although the patient didn't state their preferences during the discussion, select the code based on evidence that a discussion occurred.
- Situation B:
 - A preexisting order alone is insufficient evidence of a discussion, even if the order was recently completed.

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Item F2200: Hospitalization Preference

- Looking for evidence of:
 - F2200A: Discussion (or attempted discussion) regarding hospitalization preference
 - F2200B: Date of discussion (or attempted discussion)

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F2200: Hospitalization Tips

- Any hospice staff or IDG member can initiate discussion.
- Orders alone are insufficient evidence of discussion.
- If the patient has an order or POLST form from a previous care setting, the hospice must re-affirm.

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F2200: Hospitalization Examples

- Situation A:
 - Although the patient didn't state their preferences during the discussion, select the code based on evidence that a discussion occurred.
- Situation B:
 - A preexisting order alone is insufficient evidence of a discussion, even if the order was recently completed.

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Item F3000: Beliefs/Values Addressed (if desired by the patient)

- Looking for evidence of:
 - F3000A: Discussion (or attempted discussion) regarding spiritual/existential concerns
 - F3000B: Date of discussion (or attempted discussion)

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Item F3000: Tips

- Any hospice staff or IDG member can initiate discussion.
- Brief statements or data in the clinical record denoting a patient's religious affiliation are insufficient evidence of discussion.
- This item does not capture whether interventions to address concerns were initiated.
- There is no comprehensive list of concerns related to beliefs and values.

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Item F3000: Examples

- Situation A:
 - A completed social worker questionnaire contained evidence of a discussion.
- Situation B:
 - Documentation of the patient's religious affiliation alone is insufficient evidence of a discussion.

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Q&A – Section F: Preferences

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Unanswered Questions

- If your question was not answered during the training, please e-mail the Quality Help Desk at HospiceQualityQuestions@cms.hhs.gov
 - Put “HIS Training” in the subject line.
 - Include slide number and/or Chapter, Section, Item number if applicable.

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Help Desks

- There are two Help Desks for Providers:
 - Quality Help Desk
 - HospiceQualityQuestions@cms.hhs.gov
 - Quality reporting requirement, quality measure, and reporting deadline questions
 - Technical Help Desk
 - help@qtso.com or 1-877-201-4721
 - Technical questions

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