Hospice Quality Reporting Program (HQRP) Guidance on Updating the Hospice Item Set (HIS) Admission Record

This fact sheet provides guidance on updating care process items in Sections F, J, and N of the HIS-Admission.

Background: As part of the HQRP, hospice providers will be required to submit a HIS-Admission and HIS-Discharge for each patient admission to their hospice on or after July 1, 2014. Hospice providers have from the time of admission until the completion date (which is defined as no later than the Admission Date +14 calendar days) to complete the HIS-Admission record.

General Conventions for HIS-Admission Care Process Item Completion: When responding to HIS care process items, providers may consider any care process documented in the clinical record that took place prior to the completion date (no later than the Admission Date + 14 calendar days); providers should **not** consider care process documented in the clinical record **after** the completion date.

- **Example 1:** patient admitted on 7/1/2014. Hospice has from 7/1/2014 until 7/15/2014 (admission date +14 calendar days) to complete the HIS-Admission record. When completing the HIS-Admission, providers may consider any care process documented in the clinical record prior to the completion date (7/15/2014); do not consider care processes documented in the clinical record **after** 7/15/2014.

Guidance on Updating Care Process Items in Section F: Preferences and Section J: Pain and Dyspnea/Shortness of Breath (SOB): Care process items in Sections F and J of the HIS-Admission ask about the **first** dated care process that is documented in the clinical record. For these items, responses should reflect documentation in the clinical record from the first dated care process; any subsequent changes in patient status/preferences for that particular care process are likely irrelevant for the purposes of HIS item completion.

- **Example 2:** Patient admitted on 7/1/2014. Clinical record shows first screen for SOB on 7/3/2014; this screening revealed the patient **did not** have SOB. Clinical record also shows that on 7/6/2014, patient was again screened for SOB; this screen revealed the patient **did** have SOB.
    - Complete Item J2030 based on the **first** dated screening for SOB, which happened on 7/3/2014. This means J2030A = "1, Yes" since the clinical record shows the patient was screened for SOB; J2030B = "07-03-2014"; J2030C = "0, No" since the patient did not have SOB **on the first screen**. Since Item J2030 asks about the first screening for SOB, the results of the second screening on 7/6/2014 are irrelevant for the purposes of HIS item completion. This logic applies to all of the pain, respiratory status, and preferences items since all of these items ask about the **first** dated care process.

Guidance on Updating Items in Section N: Medications (Opioid and Bowel): In contrast to the items in Sections F and J, items in Section N do not ask about the first dated care process. If the patient's status with respect to opioids or bowel regimen changes sometime after the hospice enters data on or fills out the HIS, but prior to the completion date, the hospice may **choose** to update the HIS to reflect the clinical documentation of the patient's most current status. To minimize burden on providers, CMS does not require that hospices update items in Section N to reflect that patient's most current status.

- **Example 3**: Patient admitted on 7/1/2014. Hospice fills out the HIS-Admission on 7/10/2014; as of 7/10, patient not on any opioids/bowel regimens. On 7/12/2014, patient is prescribed PRN opioid and bowel regimen.
    - In this situation, the hospice **may** update the previously completed Section N items to reflect the patient's new PRN opioid and bowel regimen prescriptions. Note that if the hospice had filled out the HIS-Admission on 7/10/2014 and the patient had been prescribed a new PRN opioid on 7/16/2014, the hospice **cannot** update the HIS since the patient was prescribed the opioid **after the completion date**.

Process for Updating HIS-Admission Records: CMS does not require that hospices update care process items on the HIS-Admission record. Should a hospice choose to update care process items in the HIS, the process for updating the HIS-Admission record depends on whether or not the record has already been submitted and accepted into the Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing (ASAP) System.

- If a record has **not** been submitted and accepted into the QIES ASAP system, no special process for updating the record is required.
- If a record has been submitted and accepted into the QIES ASAP system, the provider will need to use a modification request for the pertinent HIS-Admission record. More information about Modification Requests can be found in Chapter 3 of the HIS Manual, which can be found here. If a provider chooses to update the HIS-Admission record, only care processes that were documented in the clinical record up to the completion date (no later than the admission date + 14 days) should be considered.