Course 1: Didactic Recorded Training Series

Part 2: Section A: Administrative Information

Introduction

Brenda Karkos:

Hello, and welcome to Course 1, the didactic portion of the training for HOPE, the new hospice data collection tool. This virtual training program is presented by CMS to prepare you for national implementation. Part 1 provided an overview of the training and an introduction to HOPE. Part 2 will now cover Section A, Administrative Information.

CMS Disclaimer

This disclaimer just explains that the information included was current at the time it was published or uploaded onto the web. Medicare policy changes frequently, so links to the source documents have been provided within this presentation for reference. These may include links to statutes, regulations, or other policy materials. The intent of this presentation is to be a general summary and does not take the place of either the written law or regulations. We encourage readers to review all of the materials related to HOPE in order to obtain a full and accurate statement of their contents.

Objectives

So here are the objectives for this lesson. At the end of Part 2, you should be able to list at least three items from Section A that are unchanged, describe some of the new items in Section A, and discuss the data collection for living arrangements and the availability of assistance.

Speaker

My name is Brenda Karkos. I am a senior associate at Abt Global. I'm also an RN with many years of clinical and administrative experience, including inpatient community health, hospice, and oncology. Since joining Abt in 2016, I've contributed mostly to CMS projects focused on hospice, oncology, home health, and other post-acute care settings. As a hospice subject matter expert, I've been fortunate to have been able to contribute to the development of HOPE.

Acronyms

There are many acronyms used throughout this presentation, including new ones related to HOPE. The link on this slide will bring you to a list of common acronyms used for the Hospice Quality Reporting Program.

Section A: Administrative Information

Now let's walk through all of the items in Section A, Administrative Information.

Section A: Items

On this slide, you will see a list of the items that are brand new for HOPE. There are only five. In the second column, the list contains those items that have been slightly revised from the original versions found in the Hospice Item Set, or the HIS.

Section A: Items (cont.)

And here are the rest of the items in Section A that may be familiar to you. These have not changed in any way. These same items are carried over from the HIS to HOPE.

Section A: Administrative Information Intent and Rationale

Let's discuss the intent and rationale for Section A, Administrative Information. The intent of Section A is to obtain key administrative information about the patient and hospice provider. The rationale is that these items help to uniquely identify each patient and hospice, as well as some of the potential patient care needs. Data collection in this section may be done by any of the assessing disciplines. While it will appear that some of these items are repeated with each

timepoint, many will be automatically populated during submission through your electronic health record system. Now let's walk through all of the items.

A0050. Type of Record and A0100. Facility Provider Numbers

These two, the Type of Record and Facility Provider Numbers, are unchanged. They will be included in each HOPE submission, all four timepoints. The first one just identifies the record that is being submitted, whether it is a new record, a modification to an existing record, or, perhaps, the inactivation of a record that needs to be withdrawn because of some error. The facility provider numbers will identify the national provider ID number and the CMS certification number to let CMS know which hospice this is.

A0215. Site of Service at Admission

A0215, Site of Service at Admission, identifies where the patient is at admission. There are nine choices. And if the patient is, perhaps, in a location that is not on the list, you would mark 99, Not listed. This item has been slightly revised.

A0215. Site of Service at Admission (cont.)

So just to be clear about what was revised from the original item, A0215 indicates the site where the patient is receiving hospice care at the time of admission. Revisions include removing repetitive words to simplify the item, such as "Hospice in" or "Hospice provided in." And "99, Not listed" replaced the phrase "Hospice provided in a place not otherwise specified," or NOS. The number was also changed due to these adjustments.

Section A: Date Items

Now let's look at some of Section A, Date Items. None of these have changed. First is the admission. Then the birthdate. These will both be submitted with any completed record, including both the HUVs. That is because these are used for record matching to be sure that all records identify the correct patient when submitted to CMS. The discharge date is also unchanged and will be submitted with any discharge record.

Date Items: Item-Specific Instructions

Now here are some specifics about these items. The admission date specifies the date on which the hospice becomes responsible for the patient's care, the birthdate is the birthdate of the patient, and the discharge date is the date the patient was discharged for any reason, including expired, revoked, or, perhaps, a live discharge.

A0250. Reason for Record

This item, Reason for Record, identifies the record that is being submitted, whether it is the admission, one of the HUVs, or the discharge. This is an item that is currently in use now but is marked "revised" only because the options for the two new HUV timepoints have been added.

A0500. Legal Name of Patient and A0550. Patient ZIP Code

And here are two more Section A items that are unchanged, the Legal Name of a Patient and the ZIP Code. The legal name is included in all of the records, admission, HUVs, and discharge. The ZIP code is only included on admission for that timepoint.

A0500 and A0550: Item-Specific Instructions

Let's look at some item-specific instructions. The legal name of the patient is the patient's name as it appears on their Medicare card. If the patient is not enrolled in the Medicare program, use the patient's name as it appears on a Medicaid card or another government-issued document. The patient's ZIP code is the ZIP code for the address where the patient is residing while receiving hospice services, even if this is not the patient's usual or legal address.

A0600. Social Security and Medicare Numbers

Now let's look at the item A0600, Social Security and Medicare Numbers. This item is marked "revised," and this is only because the old version had a reference to a real-world insurance number that was no longer being used. This item is included on each of the item sets since it is used for record matching.

A0700. Medicaid Number

And here is a screenshot of the Medicaid number. This one also has not been changed. And just like the last item, it would be included in all four of the HOPE timepoints.

A0810. Sex

So A0810, Sex, is the same familiar item you use now. The revision on this item is due to the name and number change. It asks for the same information, but it will replace A0800, Gender.

A1005. Ethnicity

Here is a screenshot of one of the brand-new items, Ethnicity. This is collected only on admission. There are seven choices here, and you check all that apply.

A1005: Item-Specific Instructions

Now let's review some item-specific instructions related to ethnicity. First, ask the patient to select the category or categories that most closely responds to their ethnicity from the list. Respondents should be offered the option of selecting one or more categories. Definitions may be provided only if requested in order to answer the item.

A1005: Item-Specific Instructions (cont.)

If a patient is unable to respond, you may use the response from a caregiver or responsible party. Only use medical record documentation to code this item if the patient is unable to respond and no caregiver or responsible party can provide a response. However, if a patient declines to respond, you would code Y, Patient declines to respond. In that case, you do not code based on other resources such as the caregiver or medical record documentation. If the patient can provide a response, you would check all that apply.

A1010. Race

A1010, Race, is also new. An older version used in the HIS is a combined item, A1000, Race/Ethnicity. This was removed for HOPE. As with the new ethnicity item, this is only collected on admission. Now let's look at some of the item-specific instructions.

A1010: Item-Specific Instructions

First, ask the patient to select the category or categories that most closely correspond to their race from the list. Respondents should be offered the option to select one or more categories. If a patient is unable to respond, the assessor may ask a caregiver or a responsible party.

A1010: Item-Specific Instructions (cont.)

Only use medical record documentation to code this item if the patient is unable to respond and no caregiver or responsible party is able to provide a response. As with the Ethnicity item, if the patient declines to respond, you will code Y, Patient declines to respond. In this case, you do not code based on a response from a caregiver, responsible party, or the medical record documentation. If the patient can provide a response, check the box or boxes indicating the race categories identified by the patient. Complete this item as close to the time of admission as possible.

A1110. Language

Here is another one of those new items. This one is asking about preferred language, and it is only asked on admission.

A1110: Item-Specific Instructions

And here are some of the item-specific instructions for language. First, ask the patient's preferred language. Then ask if the patient needs or wants an interpreter to communicate with a doctor or health care staff. There is a special note here on the slide, and it's telling you that it is acceptable for a caregiver and/or responsible party to be the interpreter if the patient is comfortable with it and if the caregiver or responsible party agrees to translate exactly what the patient says.

A1110: Item-Specific Instructions (cont.)

For this language item, if the patient, even with the assistance of an interpreter, is unable to respond, a caregiver or responsible party should be asked. If neither the patient nor caregiver is able to provide a response, then you may use medical record documentation.

A1400. Payer Information

Now let's look at another existing item. This is A1400, Payer Information. This item is currently in use, and the only revision made need here is that the word "Payer" was changed from "Payor" with an "o." This was done to align with the spelling used for the same item in the other post-acute care settings. This item has also been added to the new HUV item sets just in case there is a change to the payer that can be captured during those visits.

A1805. Admitted From

A1805, Admitted From, is another existing item. This will be familiar to some of you, but it has been slightly revised to align with the same item used in other settings. This item is collected only on admission.

A1805: Admitted From - Revisions

So here are the revisions that were made for this item. In the HIS, this is item number A1802. The response options, while very similar, have changed a bit, and one for critical access hospital was added. You'll want to review the list carefully to see the changes. There are also examples for you to review in the manual. The last response code, 99, is "Not listed." This was changed from "None of the above" to align with the other items in HOPE.

A1905. Living Arrangements

A1905, Living Arrangements, is the fourth of our five new items in Section A. It is asking about the patient's living arrangements at the time of the admission. Choices include living alone, living with others, or in a congregate home or a facility. There is also a response option for not having any permanent home, either unstable housing or someone who's experiencing homelessness.

A1905: Item-Specific Instructions

A variety of sources can be used to complete this item: patient and/or caregiver interview, the clinical record, the referral information, and your own observation. You would enter the code that best describes the patient's current living arrangements at the time of the assessment.

A1910. Availability of Assistance

A1910, Availability of Assistance, is our last of the new items for Section A. It is asking about the level of in-person assistance the patient has from available and willing caregivers at the time of the admission. This is excluding any hospice or facility staff. This item is collected only on admission, even if something was to change throughout the hospice stay.

A1910: Item-Specific Instructions

The patient and/or caregiver interview can be used to code this item. In the event that the patient cannot respond and no caregiver is present, the clinical record and referral information can be used to complete the item. If the patient lives in a facility, you can also use information from the facility staff.

A2115. Reason for Discharge

A2115, Reason for Discharge, is the last item in Section A. This has not changed and is collected at the time of discharge.

Key Takeaways

So here are the key takeaways from this lesson. Most items in Section A, Administrative Information, are unchanged. HOPE has added several new Section A items, a few items have been slightly revised for HOPE, and HOPE data collection will now include documenting both the living arrangements and the availability of assistance at the time of the admission. We do suggest you review the full HOPE Guidance Manual for much more detail about these items.

Submitting Questions

If you'd like to submit any questions based on this presentation, please use the link on this slide. During the Coding Workshop, select questions will be answered.

Thank You!

Thank you for your attention to Part 2 of this training. Please proceed to Part 3 to learn more about the HOPE data elements for Section F, Preferences, and I, Active Diagnoses.