# Course 1: Didactic Recorded Training Series

# Part 3: Section F: Preferences and Section I: Active Diagnoses

## Introduction

**Teresa Mota:**

Hello, and welcome to Course 1, the didactic portion of the training series for the Hospice Outcomes and Patient Evaluation, or HOPE, hospice's new data collection tool. This virtual training program is presented by CMS to prepare you for HOPE national implementation. Part 3 includes information regarding Section F, Preferences, and Section I, Active Diagnoses.

## CMS Disclaimer

This disclaimer explains that the information included in this presentation 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 implementation in order to obtain a full and accurate understanding of their contents.

## Objectives

Here are the objectives for the lesson. At the end of Part 3, you should be able to discuss the intent of the Section F, Preferences, items; describe changes in Section I, Active Diagnoses; and recall at least five of the new options to choose from in the principal diagnosis list.

## Speaker

My name is Teresa Mota. I am an associate at Abt Global. I'm also an RN with 32 years of clinical, administrative, and quality improvement experience in skilled nursing facilities, assisted living, self-acute care, and geriatric nursing. Prior to joining Abt, I worked for the Centers for Medicare & Medicaid Services as a

post-acute care subject matter nurse expert in quality measure and standardized patient resident assessment, data element development, and maintenance across post-acute care settings, assisting with the implementation of the Improving Medicare Post-Acute Care Transformation, or IMPACT, Act of 2014 and helped to stand up the Skilled Nursing Facility Quality Reporting Program.

Since joining Abt in 2017, I have focused mostly on CMS projects in skilled nursing facilities, long-term care, hospice, opioid and substance use disorders, and in other post-acute care settings. Having worked many years on CMS contracts related to the development and maintenance of patient assessment instruments, I've been fortunate to have been able to not only contribute to the instruments used in all post-acute care settings but also in the development of HOPE.

## Acronyms

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

## Section F: Preferences

Let's begin with Section F, Preferences.

## Section F: Items

Here are the items in Section F. For those who are familiar with this section, these items should look familiar to you as they've not changed. They include F2000, CPR Preference; F2100, Other Life-Sustaining Treatment Preferences; F2200, Hospitalization Preference; and F3000, Spiritual/Existential Concerns.

## Section F: Preferences Intent

The intent of the items in this section pertain to the hospice patient's preferences related to life-sustaining treatments and spiritual care. The best way to learn about these preferences are to elicit them directly from the patient or the caregiver/responsible party if the patient is unable to self-report this information. Know that the items in this section don't represent an exhaustive

list of patient preferences, so hospices should consider the patient may have more preferences than these. When completing this section, hospices should understand that this does not replace a thorough and ongoing discussion of the patient's preferences throughout their stay in hospice.

## Section F: Preferences Rationale

These data are collected because seriously ill and dying patients who express their preferences regarding life-sustaining treatments and spiritual existential concerns are more likely to receive care that is consistent with their values, which improves patient and family outcomes and satisfaction with their care. Another reason is that patients may come into the hospice with preferences for life-sustaining treatment and spiritual existential concerns, but this information may not reflect what the patient's current preferences or concerns are since they can change, particularly as their condition changes.

## Section F: Preferences Rationale (cont. 1)

Additionally, providing care for spiritual needs is a critical element of quality of life at the end of life. Patients and/or their caregivers should be allowed to express their needs for spiritual care, and hospice providers should help to ensure that these needs are met. One of the unique aspects of hospice care is its interdisciplinary approach to meeting the physical, psychosocial, and spiritual needs of the patient and caregivers. Discussing these spiritual concerns is the core of a rigorous assessment of spiritual care needs and is essential to making sure that these needs are met.

## Section F: Preferences Rationale (cont. 2)

The items in this section are intended to capture the process of eliciting the patient's preferences and capture the evidence of this discussion and/or communication about these preferences. It is not sufficient to code "Yes" to these preference items if there are only orders without evidence of a discussion or involvement of the patient and/or responsible party. Discussion and communication with the patient and/or responsible party about preferences has to occur or attempts to be made to accurately complete these items.

## F2000. CPR Preference

The next four slides depict the four different preference items found in this section. The first snapshot from the HOPE tool is the first preference item F2000, CPR Preference. Again, this item is unchanged and collected on admission.

## F2100. Other Life-Sustaining Treatment Preferences

Here is the second preference item, F2100, Other Life-Sustaining Treatment Preferences. Again, this item is unchanged and collected on admission.

## F2200. Hospitalization Preference

The next preference item is F2200, Hospitalization Preference, which is also unchanged and collected on admission.

## F3000. Spiritual/Existential Concerns

The final item in this section is F3000, Spiritual/Existential Concerns. Again, this item is unchanged and collected on admission.

The consistent thread across the four items in this section is that the hospice discussed or attempted to discuss the specific preference with the patient and/or caregiver, the hospice documents whether the discussion occurred or was attempted, or if the patient caregiver refused to discuss the particular preference. Code 0, No, is chosen if there is no documentation that the hospice discussed or attempted to discuss the particular preference. This could happen if the patient was unable to discuss and/or the responsible party was unavailable.

Code 1, Yes, and discussion occurred, is chosen if there is documentation that the hospice discussed the particular preference and engaged and/or had a conversation with the patient and/or responsible party. The conversation that occurs doesn't mean that the patient has to choose for or against a particular preference.

Code 2, Yes, but the patient/responsible party refused to discuss, is chosen if there's documentation that the hospice asked about the particular preference, but the patient or responsible party refused to discuss or was unable to discuss.

And finally, the date that is entered here is the date that the hospice first discussed or attempted to discuss the patient's preference. Multiple discussions

regarding the patient's preference may be documented in the clinical record, but the date entered here is based on the first date of discussion about the patient's preference.

## For all Section F Items: Item-Specific Instructions

For all Section F items, the item's completion should be based on a discussion of the patient's preferences and what's included in the clinical record. As a reminder, these preferences are related to CPR, hospitalization, life-sustaining treatment other than CPR, and spiritual/existential concerns.

## For all Section F Items: Item-Specific Instructions (cont.)

In coding these items, you should consider care processes and discussions documented in the clinical record that took place during preadmission, educational visits, and those that took place during the admission assessment. Be sure to review all the response options before making a selection. Remember that the date entered for these items is the date on which the discussion first occurred. Regardless of your familiarity with these items, I encourage you to review the information in Section F of the HOPE manual for further instructions and tips for completing these items.

## Section I: Active Diagnoses

OK, let's move on to Section I, Active Diagnoses.

## Section I: Active Diagnoses Intent and Rationale

While the item discussed in this section is not new, there have been some revisions to the item itself, so the section intent and rationale have also been revised. The revision to the section intent is that the item pertains not only to the principal diagnosis of the patient but now includes a list of comorbidities and coexisting conditions. Note that the rationale for why these data are collected is still for the disease processes and conditions listed in this item can impact service delivery, but the list was expanded from two to nine to reflect the most common principal diagnoses among hospice patients, as well as to document any comorbidities and coexisting conditions.

## I0010. Principal Diagnosis

So here's what the full item I0010, Principal Diagnosis, looks like. But we'll review each portion of the item more closely. This item is collected on admission, and, as noted previously, this item was revised.

## I0010. Principal Diagnosis (cont. 1)

Let's look closer at the principal diagnoses listed here. For those familiar with this item, you'll notice that there have been seven diagnoses added to this item, numbers 03 through 09, which include neurological conditions, stroke, chronic obstructive pulmonary disease, cardiovascular (excluding heart failure), heart failure, liver disease, and renal disease.

## I0010. Principal Diagnosis (cont. 2)

And this is a comorbidities and coexisting conditions list that was added to this item. I won't go over every single one of these, but you'll notice that there are quite a few choices here. To complete this portion of the item, review the medical record for comorbidities and/or coexisting conditions at the time of admission to the hospice. Check all comorbid and/or coexisting diseases or medical conditions that are addressed in the plan of care or that have the potential to impact the plan of care. Because there are different types of cancer, if the patient has the principal diagnosis of cancer and you've coded I0010 as 01, but the patient has a secondary cancer, you would check I0100, Cancer, in the comorbidities/coexisting conditions list. Otherwise, do not include the principal diagnosis when considering comorbidities or coexisting conditions. Remember that this is part of the principal diagnosis item, not a separate item.

## I0010: Item-Specific Instructions

Here are some specifics regarding this revised and expanded item. The principal diagnosis is the diagnosis that is chiefly responsible for the patient's admission, which is established after reviewing all available information and is the diagnosis that most contributes to the patient's life expectancy of six months or less. This item should be completed based on the patient's principal diagnosis at the time of admission to the hospice.

## I0010: Item-Specific Instructions (cont.)

To complete this item, you should review the clinical record for information regarding the principal diagnosis because the principal diagnosis should be based on what is indicated in the clinical record. Do not use sources external to the clinical record to complete this item. Be sure to review all of the response options before making a selection. Code 99, None of the above, is used if the patient's clinical diagnosis is not in the list provided.

## Key Takeaways

So here are the key takeaways from this session. Section F, Preferences, is unchanged from the information that hospices currently collect. The preferences items in HOPE are collected based on the first discussion of these preferences that occurred, including discussions that took place during admission or educational visits. In Section I, Principal Diagnosis, item I0010 has been expanded to include more options for the principal diagnosis and now includes a list of comorbidities and coexisting conditions.

## Submitting Questions

If you have any questions based on the information presented, please submit them using the link on this slide: CMSPostAcuteCareTraning@RainmakersSolutions.com. For the questions received, a select number will be answered in the upcoming coding workshop, so please do submit any questions you have.

## Thank You!

I want to thank you for your attention and participation today. You can now proceed to Part 4 to learn about Section J, Health Conditions.