Course 1: Didactic Recorded Training Series

Part 4: Section J: Health Conditions

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Introduction

Hello, and welcome to Part 4 of 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 4 will review Section J, Health Conditions.

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 the materials related to HOPE implementation to obtain a full and accurate statement of their contents.

Objectives

Here are the objectives for this lesson. At the end of Part 4, you should be able to name at least three of the six new items from Section J, summarize the intent of the symptom impact item, and describe the symptom follow-up (SFV) items and when they need to be completed.

Speaker

My name is Therese Rodda. I'm a senior associate at Abt Global. I am also a physical therapist with many years of clinical and administrative experience, including inpatient, outpatient, and home health and hospice. Since joining Abt in 2019, I have contributed to many federal health care initiatives across acute and post-acute care settings. It has been a privilege to be part of HOPE development, and I am excited about implementation.

Acronyms

There are many acronyms used throughout this presentation, including the 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 J: Health Conditions

So let's jump in and look at the items in Section J.

Section J: Items

On this slide, you will see six data elements that are brand new for HOPE. The second column lists the items that have not changed. These data elements were carried over directly from the Hospice Item Set, or HIS. Finally, the third column lists the one data element that was revised slightly from the original version found in the HIS. "Unknown about terminology," "data element," and "item" will be used interchangeably throughout the presentation.

Section J: Health Conditions Intent

Let's discuss the intent of the items in Section J. Section J items are intended to document the physical symptoms and the impact of pain and non-pain symptoms for hospice patients. They include an assessment of imminent death, screening for pain, a comprehensive pain assessment (if warranted), and screening for dyspnea. They are intended to incorporate information from patient, family, or caregiver interviews, as well as the clinical assessment and judgment of the assessing nurse if the patient is unable to participate.

Section J: Health Conditions Rationale

Pain and non-pain symptoms, such as shortness of breath, are prevalent and undertreated for many populations of seriously ill patients, including those nearing the end of life. This forms the foundation for the rationale for the data elements found in Section J. Pain management is also a high priority for patients, family, and caregivers.

Section J: Health Conditions Rationale (cont.)

The rationale is also based on knowing that other non-pain symptoms, for example, nausea and vomiting, can be functionally limiting and distressing to patients, as well as to their families and caregivers. Screening for pain and non-pain symptoms and their impact on the patient will assist the hospice team with care planning. Further, effective treatment is available to alleviate and lessen the impact of most pain and non-pain symptoms. Now I will start to walk through the individual items in Section J.

J0050. Death is Imminent

First up is J0050, Death is Imminent. This is a new data element for HOPE. It is collected on admission at HUV1 and HUV2. It asks the clinician, "At the time of this assessment and based on your clinical assessment, does the patient appear to have a life expectancy of 3 days or less?"

J0050: Item-Specific Instructions

For J0050, Death is Imminent, the clinician decides the patient's status based on the assessment at the time of the visit. The important takeaway is highlighted in red. The response to this item does not indicate a statement of the actual prognosis but, rather, the likelihood that death is imminent based on the symptoms the clinician is observing. And just a reminder: When counting days, the day of the assessment is considered Day 0.

J0900. Pain Screening

The next item is J0900, Pain Screening, which is collected on admission and is the first of four items related to the assessment of pain. This item was carried over from the HIS and has not changed.

J0900: Item-Specific Instructions

To code this item, the clinician needs to assess the patient for the presence of pain or the absence of pain. Responses should be based on what is determined during the assessment visit and/or included in the clinical record. You should not use sources external to the clinical record. When preparing to respond, the clinician should consider results of a standardized pain screening tool and any other screening approaches the clinician might use, including asking the patient

about their pain comfort. The clinician should review all response choices before selecting a response.

J0905. Pain Active Problem

The next data element for pain is J0905, Pain Active Problem. Again, this item was carried over from the HIS and remains unchanged. This item is also collected on admission. Based on the assessment, the clinician determines if pain is an active problem. Remember: Pain can be an active problem even if the patient is not experiencing pain at the time of the assessment. If the clinician determines pain is not an active problem, the remaining pain items are skipped and the clinician moves to the shortness of breath items.

J0910. Comprehensive Pain Assessment

For those where pain is an active problem, the clinician moves to the third pain item, J0910, Comprehensive Pain Assessment. This item remains unchanged and continues to be collected on admission. This item asks the clinician if a comprehensive assessment was performed and the date. Additionally, I want to call your attention to the list of pain characteristics, which are included in the comprehensive pain assessment. They are location of pain, severity of pain, character of pain, duration of pain, frequency of pain, what relieves or worsens the pain, and the effect of the pain on function or quality. These are the characteristics the clinician should include in their assessment.

J0910: Item-Specific Instructions

For this data element, a comprehensive pain Assessment should assess multiple aspects of pain, as just mentioned, beyond the presence and severity of pain. For any of the seven characteristics listed in the pain assessment item, the clinician should select responses based on the assessment of the patient and also consider whether they attempted to gather the information from the patient, family, or caregiver.

J0915. Neuropathic Pain

The final pain item is new for HOPE, J0915, Neuropathic Pain. Like the other pain items, it is collected on admission.

J0915. Neuropathic Pain - Definition

Here is the definition for neuropathic pain: Neuropathic pain is caused by a lesion or disease of a somatosensory nervous system.

J0915: Item-Specific Instructions

In addition to clinical assessment, the clinician can use patient, caregiver, or responsible party interview, observation, and clinical judgment to inform a response to this item. The clinician should assess the patient for signs and symptoms of neuropathic pain. The clinician should ask themselves, does the patient describe their pain in a manner consistent with the definition of neuropathic pain? Pain should accompany the symptoms. Symptoms without pain should be coded 0, No. Now I will move to the data elements for shortness of breath.

J2030. Screening for Shortness of Breath

There are two shortness of breath items. The first is J2030, Screening for Shortness of Breath. This item was carried over from the HIS and is unchanged. It continues to be collected on admission. This item asks the clinician if the patient was screened for shortness of breath. The next question asks for the date of the first screening for shortness of breath. Reminder: Complete HIS shortness of breath screening items based on the first shortness of breath screening that appears in the clinical record.

To answer “Yes” to J2030A, clinical record documentation must show that the patient was screened for the presence or absence of shortness of breath. And if the patient was found to be short of breath, there must also be evidence that severity was rated in any manner clinically appropriate for the patient. On the basis of reports of recent symptoms, current treatment, and patient and family history, 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.

J2040. Treatment for Shortness of Breath

The second item is J2040. This item was also carried over from the HIS, continues to be collected on admission, but was revised with the removal of Part C, which was type or types of treatment for shortness of breath initiated.

J2030 and J2040: Item-Specific Instructions

For J2030, Screening for Shortness of Breath, and J2040, Treatment for Shortness of Breath, the clinician should assess the patient for the presence or absence of shortness of breath. Then in the presence of shortness of breath, the clinician should rate the severity.

J2030 and J2040: Item-Specific Instructions (cont.)

Responses to items J2030 and J2040 should be based on findings during the assessment visit or in the clinical record. Now I will review the new symptom impact items for Section J.

J2050. Symptom Impact Screening

The first data element for symptoms is J2050, Symptom Impact Screening. As mentioned, this is a new item for Section J. J2050, Symptom Impact Screening, is collected on admission at HUV1 and HUV2. This item asks the clinician if the patient was screened for the impact of symptoms. If the screening was done, the clinician would add the date.

J2050. Symptom Impact - Definition

Symptom impact is defined as, the effect of symptoms on the patient. Symptoms may impact a patient in multiple ways, for example, sleep, concentration, or day-to-day activities.

J2050: Item-Specific Instructions

Responses to this item should be made based on the clinical assessment at the time of the assessment visit and/or from information in the clinical record.

J2051. Symptom Impact

If the clinician determines the patient has been impacted by symptoms, the next new item is J2051, Symptom Impact. This item is also collected on admission at HUV1 and HUV2. It asks the clinician, “Over the past 2 days, how has the patient been affected by each of the listed symptoms?” You should base your response on your clinical assessment or interview of the patient or caregiver, and it reminds the clinician that symptoms may impact multiple patient activities including, but not limited to, sleep, concentration, day-to-day activities, or the ability to interact with others. The symptoms of focus are pain, shortness of breath, anxiety, nausea, vomiting, diarrhea, constipation, and agitation.

J2051: Item-Specific Instructions

For J2051, Symptom Impact, the clinician assesses the patient for the impact of eight symptoms, the ones we just discussed. The key takeaway here is this is not an assessment of characteristics like severity or intensity or frequency but an assessment of the impact of the symptoms on the patient.

J2051: Item-Specific Instructions (cont.)

The clinician should rate each symptom based on the impact to the patient over the past two days. To code this item, the clinician can use patient or caregiver interviews, observation, and clinical assessment and judgment.

J2052. Symptom Follow-up Visit (SFV)

The next new item is J2052, Symptom Follow-up Visit, also known as SFV. Like other symptom data elements, this one is also collected on admission at HUV1 and HUV2 only if the clinician identifies any symptom in the prior data element, J2051, Symptom Impact, as having a moderate or severe impact on the patient. It reads, “An in-person Symptom Follow-up Visit (SFV) should occur within 2 calendar days as a follow-up for any moderate or severe pain or non-pain symptom identified during Symptom Impact assessment at Admission or HOPE Update Visit.” The first question asks, “Was an in-person SFV completed?” Then it asks the date of the in-person SFV.

And then C, there may be times when SFV is not completed, so J2052C lists several possible reasons. The first, “Patient or caregiver declined an in-person

visit," or two, "Patient unavailable." Some examples are given for this response, for example, traveling outside the service area or the patient expired. "Attempts to contact the patient and/or caregiver were unsuccessful." That's option three. And four is "None of the above."

J2052: Item-Specific Instructions

J2052 should be completed within two calendar days to follow up on any moderate or severe symptom or symptoms identified in J2051, Symptom Impact, on admission during HUV1 or HUV2. There are a couple of important points to mention here. It is possible that the follow-up visit could extend beyond the admission or HUV timeframes, because if there is a moderate or severe impact, the nurse still has two more days to do a follow-up visit. The follow-up visit can occur on the same day but must be a separate visit. And finally, unlike J2051, Symptom Impact, which must be completed by the RN, the follow-up visit may be conducted by the LPN or LVN.

J2053. SFV Symptom Impact

J2053, SFV Symptom Impact, is the last new item in Section J. Like the previous items, this is collected on admission at HUV1 and HUV2. This one includes the same symptoms. Only, this time, the clinician will ask whether the impact has changed since the last assessment visit.

J2053, Symptom Impact, is only completed if a SFV is required to follow up on any moderate or severe symptom or symptoms identified in J2051. If there is no symptom impact of moderate or severe symptoms, this would be skipped.

J2053: Item-Specific Instructions

J2053 is used during the symptom follow-up visit to rate symptoms identified in J2051, Symptom Impact, on an admission or HUV.

J2053: Item-Specific Instructions (cont.)

Once again, just like in J2051 or J2053, SFV Symptom Impact, the clinician will rate the impact of each symptom listed in the item. The clinician can use patient or caregiver interview, observation, and clinical judgment. It is possible the clinician will identify new impactful symptoms or the persistence of prior identified symptoms. In these cases, there is no need to complete another SFV

for this timepoint for the purpose of HOPE submission. However, the clinician should follow clinical practice guidelines to manage the symptoms.

Key Takeaways

Well, we covered a lot of important information about Section J. Here are some of the key takeaways. Section J, Health Conditions, now contains new data elements to assess the signs of imminent death, the presence of neuropathic pain, when pain is an active problem, and items that evaluate the impact of a variety of symptoms. The Symptom Impact item is an overall rating of how a variety of symptoms are impacting the patient. The SFV is a follow-up visit that is required within two calendar days if triggered by the presence of moderate or severe symptom impact during a HOPE admission or HUV. We do suggest you review the full HOPE Guidance Manual for much more detail about these items.

Submitting Questions

If you would like to submit any questions based on this presentation, please use the link on this slide: CMSPostAcuteCareTraining@RainmakersSolutions.com. During the Coding Workshop, select questions will be answered.

Thank You!

Thank you for your attention to Part 4 of this training. Please proceed to Part 5 to learn more about the HOPE data elements for Sections M, Skin Conditions; Section N, Medications; and Section Z, Record Administration.