Course 1: Didactic Recorded Training Series

Part 5: Section M: Skin Conditions, Section N: Medications, and Section Z: Record Administration

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Introduction

Hello, and welcome to Course 1, Part 5, of 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 the national implementation of HOPE. If you followed the course offering sequentially, you've had an introduction to HOPE; reviewed Section A, Administrative Information; Section F, Preferences; Section I, Active Diagnoses; and Section J, Health Conditions. In this presentation, you'll learn about the new Section M, Skin Conditions; Section N, Medications; and Section Z, Record Administration, which includes a new item.

CMS Disclaimer

Before we get to the content of this presentation, let's review the 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 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

Now let's look at the objectives for this presentation. By the end of Part 5, you should be able to identify new Section M and its data elements and the new data element in Section Z, summarize the intent and rationale for the new Section M, name at least three of the types of skin conditions in item M1195, and describe the new timepoints for data collection in Section N, Medications.

Speaker

My name is Teresa Mota. I'm 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, subacute 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 in standardized patient, resident, assessment data element, development and maintenance across post-acute care setting, assisting with the implementation of the Improving Medicare Post-Acute Care Transformation, or IMPACT, Act 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 disorder, and 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 now 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 M: Items

Let's start with the new Section M. The items in this section include M1190, Skin Conditions; M1195, Types of Skin Conditions; and M1200, Skin and Ulcer/Injury Treatments.

Section M: Skin Conditions Intent and Rationale

The intent of this section is to record the presence, type, and treatment of common skin conditions in hospice patients. It's important that each patient be assessed for existing or potential skin injuries. The rationale for collecting these data is that skin issues may cause pain, limit mobility, and reduce quality of life, and to identify those at risk for further complications or skin injury.

M1190. Skin Conditions

Here's the first data element, M1190, Skin Conditions. This data element is collected on admission and the HOPE update visit timepoints or HUV1 and HUV2. The question in this item asks if the patient has one or more skin conditions. If the patient doesn't have any skin conditions, you would answer 0, No, and skip over the entire section and move on to the scheduled opioid item N0500. If the patient does have one or more skin conditions, you'd answer 1, Yes, and move on to the next item.

M1190: Item-Specific Instructions

To obtain the information necessary to complete this item, you should review the medical record to see if there is mention of any skin conditions. Ask the patient and/or their caregiver about any skin conditions. And if there are skin conditions identified such as ulcers, wounds, or other skin problems, they should be assessed.

M1195. Types of Skin Conditions

Here's the second item in Section M, M1195, Types of Skin Conditions. This, too, is completed on admission and the HUV timepoints. If the patient has skin conditions identified, you assess the patient and make note of any of the skin conditions listed here and check off all that apply. If the skin condition identified is not in this list, you would check Z, None of the above were present.

M1195: Item-Specific Instructions

To complete this item, review the medical record for information on any type of skin condition present; assess the skin conditions present such as ulcers, wounds, rashes, skin tears, and lesions; and check those that apply at the time of the assessment.

M1200. Skin and Ulcer/Injury Treatments

And finally, the last item in this new section is M1200, Skin and Ulcer/Injury Treatments. For those skin conditions identified in the prior item, you're going to check off here all types of skin and ulcer/injury treatments and interventions that apply and are being used to help address the skin issues identified. As you can see in this item, there are many types of interventions and treatments listed, such as pressure-relieving devices for beds and chairs; turning repositioning program; nutrition or hydration interventions; care to pressure ulcers, injuries, and surgical wounds; application of dressings with or without topical medications to the feet or other than to the feet; and incontinence management. If none of the interventions or treatments in this list were used, you would check Z, None of the above were present.

M1200: Item-Specific Instructions

Some specifics about completing this item include reviewing the medical record, including treatment records, health care provider orders, and documented skin treatments and interventions, as well as asking the patient and/or caregiver about any wound, skin treatments, or interventions.

M1200: Item-Specific Instructions (cont.)

If you are working with patients who are living in a facility, be sure to speak to direct care staff and the treatment nurse to confirm any conclusions drawn during your review of the medical record. Note that some skin treatments can be simply observed, for example, seeing a pressure-reducing device on the patient's bed or wheelchair.

Section N: Medications

Now let's look at Section N, Medications.

Section N: Items

While the items in this section have not changed, they're being collected at additional timepoints, which I'll discuss in a moment. First, let's look at the current list of items in this section. They include N0500, Scheduled Opioid; N0510, PRN Opioid; and N0520, Bowel Regimen.

Section N: Medications Intent

The intent of collecting the items in Section N is to gather information about opioids and bowel regimens.

Section N: Medications Rationale

The rationale for collecting this information is that opioids are commonly used to manage pain and other symptoms. Constipation is one of the most common adverse side effects related to opioid use. Most patients will develop some degree of constipation when they start opioids and when opioid dosages increase. If hospices can work to reduce opioid-induced constipation, it has the potential to reduce patient discomfort and improve their quality of life. Note that patients do not develop a tolerance to opioid-induced constipation, and clinical guidelines recommend prophylactic bowel regimens.

Section N: Item-Specific Instructions

To complete these items, you should base your responses on what is determined during the assessment visit and/or what is included within documentation found in the clinical record. Do not use sources external to the clinical record to complete these items. Review the patient's clinical record for information related to medications and prescriptions. And be sure to review all response options prior to making a selection.

N0500. Scheduled Opioid

The first item in Section N is N0500, Scheduled Opioid. This item documents whether a scheduled opioid was initiated or continued and the date of the initiation or continuation. This item is unchanged and was previously only collected on admission but is now also collected on the new HUV timepoints.

N0510. PRN Opioid

The next item, N0510, is similar to N0500, but it's to document PRN opioids that are initiated or continued, as well as the date of initiation or continuation. This item is also unchanged and collected on admission in the new HUV timepoints.

N0500 and N0510: Item-Specific Instructions

For both of these opioid items, you'll determine whether or not a scheduled or PRN opioid was initiated or continued. If there was a scheduled or PRN opioid initiated or continued, you'll enter the date that the order for either a scheduled or PRN opioid was received regardless of when the first dose of the medication was given. Note that treatment is considered initiated when the hospice has received the order and there is documentation that the patient and/or caregiver was instructed to begin use of the medication or treatment.

N0520. Bowel Regimen

The final item in this section is N0520, Bowel Regimen. This item remains unchanged and, again, is collected on admission and the new HUV timepoints.

N0520: Item-Specific Instructions

If a bowel regimen is initiated or continued, you'll select the most accurate response listed. If no bowel regimen was initiated or continued, you'd select Code 0 and move on to Section Z. If there was not a bowel regimen initiated or continued but there is documentation of why it wasn't, you'd select Code 1 and move on to complete Section Z. If there was a bowel regimen initiated or continued, you'd Code 2, Yes, and enter the date that the bowel regimen was initiated or continued. Again, note that treatment is considered initiated when the hospice has received the order and there is documentation that the patient and/or caregiver was instructed to begin use of the medication or treatment.

Section N and Comfort Kit Orders

Regarding comfort kit orders and pre-printed admission orders, note that proactive education on medications in a comfort kit in anticipation of symptoms is not considered initiation.

Section Z: Record Administration

The last section we'll review today is Section Z, Record Administration.

Section Z: Items

There is a new item in this section, Z0350, Date Assessment was Completed, and two unchanged items, Z0400, Signatures of Persons Completing the Record, and Z0500, Signature of Person Verifying Record Completion.

Section Z: Record Administration Intent and Rationale

The intent of this section is for individuals completing HOPE to sign and document the items completed on the HOPE record and the signature of the individual verifying HOPE record completion. The rationale is that it's the responsibility of the hospice to ensure that HOPE is fully completed.

Z0350. Date Assessment was Completed

So here's the new item, Z0350, Date Assessment was Completed. This item is collected only on the HUV timepoints.

Z0350: Item-Specific Instructions

To complete this item on HUV1 and HUV2, enter the date that the assessing clinician gathered the information responses, including any follow-up visit data that was added for a symptom follow-up visit, or SFV, as applicable. The date entered in Z0350 is the date that the entire HUV item set is complete, including SFVs, if any were conducted.

Z0350: Item-Specific Instructions (cont.)

The submission of HUV timepoints is based on this date. It's important to note that in situations where an SFV is conducted, this date may extend beyond the HUV assessment time frames.

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

Here's Z0400, Signatures of Persons Completing the Record. This item was originally only collected on admission and discharge but is also now collected on the HUV timepoints. The signatures here should reflect those hospice staff members who completed HOPE, which may or may not be the clinician who completed care processes documented in the clinical record. Signatures entered here may be electronic. All staff who can complete any part of the HOPE record

should enter this signature, title, section, or portions of a section they complete, as well as the date completed.

Z0400: Item-Specific Instructions

This item provides a tracking log for the information that was gathered or abstracted in HOPE. The signatories certify that the information they provided on the HOPE tool is accurate and that the person signing is authorized to collect and document this information.

Z0500. Signature of Person Verifying Record Completion

The final item in Section Z is Z0500, Signature of the Person Verifying Record Completion. This item is unchanged and is still collected on admission and discharge but is also now collected on the HUV timepoints.

Z0500: Item-Specific Instructions

Z0500 is used to document the person responsible for ensuring that HOPE was completed in a timely manner. The signature in Z0500 certifies only that all sections are complete and are not certifying the accuracy of portions of the HOPE record that were completed by other hospice staff members. The date entered in Z0500B is the date that the person signing in Z0500A verified that all items on the record are complete and signatures are present in Z0400 for those who completed HOPE.

Key Takeaways

So here are the key takeaways from this presentation. HOPE has a new section, Section M, Skin Conditions, which collects data about skin conditions, such as rashes, lesions, surgical wounds, and more. The items in Section N, Medications, have not changed but are now collected on the new HUV timepoints. There is a new item in Section Z, Z0350, Date Assessment was Completed, which captures the date that the HUV item set was completed, including any applicable SFVs. The other items in Section Z are unchanged but collected now on the HUV timepoints. For additional information and coding details related to the items in this presentation, please refer to the HOPE Guidance Manual, Version 1.01.

Resources

And here is a list of resources with links to all of the information related to the Hospice Quality Reporting Program and the HOPE tool, as well as helpful links to sign up to receive updates via email, links to the iQIES website, and the fiscal year 2025 rule.

Thank You!

Thank you for your attentiveness and participation in reviewing this presentation. You've completed Part 5 of the five-part training for HOPE. Feel free to revisit any of the other parts in this training if you'd like to review any of the information that was presented.

HOPE Coding Workshop

As you've heard throughout the presentations in this course, a HOPE Coding Workshop is coming soon. If you'd like to submit any questions you've had as you've gone through all five parts of this course, send them to the CMSPostAcuteCareTraining@RainmakersSolutions.com email address listed on this slide. Select questions that are received will be answered during the Coding Workshop.