

Hospice

Quality Reporting Program Provider Training



Hospice Item Set (HIS)-Based Quality Measures and Associated HIS Items

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Objectives

- Explain the new items added to the HIS-Admission V2.00.0: A0550, A1400, J0905.
- Describe the two HIS-based quality measures (QMs) that will take effect during fiscal year (FY) 2017.
 - Summarize the HIS items used in the Palliative Care Composite Process measure.
 - Define the numerator and denominator for both new HIS-based QMs.
- Explain the four additional items that will be collected on the HIS-Discharge V2.00.0.

Three New HIS-Admission Items for Data Collection Only

- These new HIS V2.00.0 items are:
 - A0550. Patient ZIP Code
 - A1400. Payor Information
 - J0905. Pain Active Problem
- This data will be used for future measure refinement and patient record matching.

Section A:

A0550. Patient ZIP Code

A0550. Patient ZIP Code.

A0550. Patient ZIP Code. Enter code in boxes provided.

Patient ZIP Code:

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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A0550. Patient ZIP Code

- Enter the ZIP Code for the address at which the patient is **residing while receiving hospice** services, even if it is not the patient's usual/legal residence.
- Enter the five-digit ZIP Code (at minimum).
- If available, enter the “extended” ZIP Code (ZIP Code + 4), starting at the far left.

A0550. Patient ZIP Code – Tips

- The ZIP Code should reflect **where the patient will reside while receiving hospice services.**
- For example, if the hospice patient:
 - Permanently lives in city A but is receiving hospice services in city B:
 - Use ZIP Code for city B.
 - Resides and is receiving hospice services in a facility (e.g., nursing facility, assisted living facility, inpatient hospice facility):
 - Use ZIP Code for facility where patient receives services.
 - Initially receives hospice services in a hospice general inpatient facility, but plans to move home at a future date:
 - Use the ZIP Code of the general inpatient facility.
 - Hospice is introduced while the patient is hospitalized, but the patient will receive hospice services at home; or the patient has first encounter with hospice in the hospital, but the patient will be discharged and receive hospice at home:
 - Use the ZIP Code of the home address.

Section A: A1400. Payor Information

A1400. Payor Information

A1400. Payor Information	
↓ Check all that apply	
<input type="checkbox"/>	A. Medicare (traditional fee-for-service)
<input type="checkbox"/>	B. Medicare (managed care/Part C/Medicare Advantage)
<input type="checkbox"/>	C. Medicaid (traditional fee-for-service)
<input type="checkbox"/>	D. Medicaid (managed care)
<input type="checkbox"/>	G. Other government (e.g., TRICARE, VA, etc.)
<input type="checkbox"/>	H. Private Insurance/Medigap
<input type="checkbox"/>	I. Private managed care
<input type="checkbox"/>	J. Self-pay
<input type="checkbox"/>	K. No payor source
<input type="checkbox"/>	X. Unknown
<input type="checkbox"/>	Y. Other

A1400. Payor Information

- Check **all** boxes that best correspond to the patient's current existing payment sources.
- Identify **all payors** that the patient has, regardless of whether that payor is expected/likely to provide reimbursement.
- Do not report sources that have been applied for but have not yet been received (i.e., pending sources).

A1400. Payor Information – Tips

- Providers should validate existing pay sources (*ask to see the card*), but the response may be based on patient/caregiver report.
- Below are definitions to help providers distinguish between response options J, K, X, and Y:
 - **J, Self-pay:**
 - Any amount of personal funds available to contribute to health care expenses (e.g., services, supplies, medications) during the hospice episode of care.
 - **K, No payor source:**
 - No payor sources in response options A–I, nor any personal funds.
 - **X, Unknown:**
 - Not confirmed to have any of the above.
 - **Y, Other:**
 - One or more payor sources not listed in response options A–K.

Section J: J0905.

Pain Active Problem

J0905. Pain Active Problem

J0905. Pain Active Problem

Enter Code

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Is pain an active problem for the patient?

- 0. No → Skip to J2030, Screening for Shortness of Breath
- 1. Yes

J0905. Pain Active Problem

- This item was added based on provider input received over the past two years. It better aligns Section J with clinical practice.
 - Determines whether pain is an active problem at the time of the screening.
 - Considers factors beyond pain severity, such as historical report of pain or report of recent symptoms.
- This item is planned for future measure refinement of existing QMs.

J0905. Pain Active Problem – Tips

- The determination may be made by the assessing clinician, based on patient-specific findings.
- It is possible that the clinician will determine pain is active, even if pain is not present at that time.
- Documentation that the patient is currently taking pain medication is sufficient evidence of active pain.

Polling Scenario

- The hospice nurse asked the patient to report his pain using a numeric scale of 0–10.
- The patient denied any pain and stated that this was not an issue for him at all.
- In reviewing his medications, however, she confirmed with his wife that he is taking his long-acting oxycodone as ordered, twice per day.

Two New HIS-Based QMs in FY 2017

- CMS finalized two new QMs in the FY 2017 Final Rule.
 - Hospice and Palliative Care Composite Process Measure – Comprehensive Assessment at Admission.
 - A measure that will assess the percentage of hospice patients who received care processes consistent with guidelines.
 - Hospice Visits When Death is Imminent.
 - A measure that will assess hospice staff visits to patients and caregivers in the last 3 and 7 days of life.



Hospice and Palliative Care Composite Process Measure – Comprehensive Assessment at Admission

Hospice and Palliative Care Composite Process Measure – Comprehensive Assessment at Admission

- This QM reports the percentage of hospice patients who received all seven HIS care processes for which they are eligible at admission to a hospice.
- The measure is calculated using data from existing HIS-Admission items.
- Patient admissions occurring on or after April 1, 2017, will be included in the measure calculation.
- No new data collection will be required for this measure.

Care Processes Captured by the Composite Measure

Section of the HIS	Corresponding QMs
F: Preferences	<ul style="list-style-type: none">• Treatment Preferences (NQF #1641).• Beliefs/Values Addressed (if desired by patient) (NQF #1647).
J: Health Conditions	<ul style="list-style-type: none">• Pain Screening (NQF #1634).• Pain Assessment (NQF #1637).• Dyspnea Screening (NQF #1639).• Dyspnea Treatment (NQF #1638).
N: Medications	<ul style="list-style-type: none">• Patients Treated with an Opioid Who Are Given a Bowel Regimen (NQF #1617).

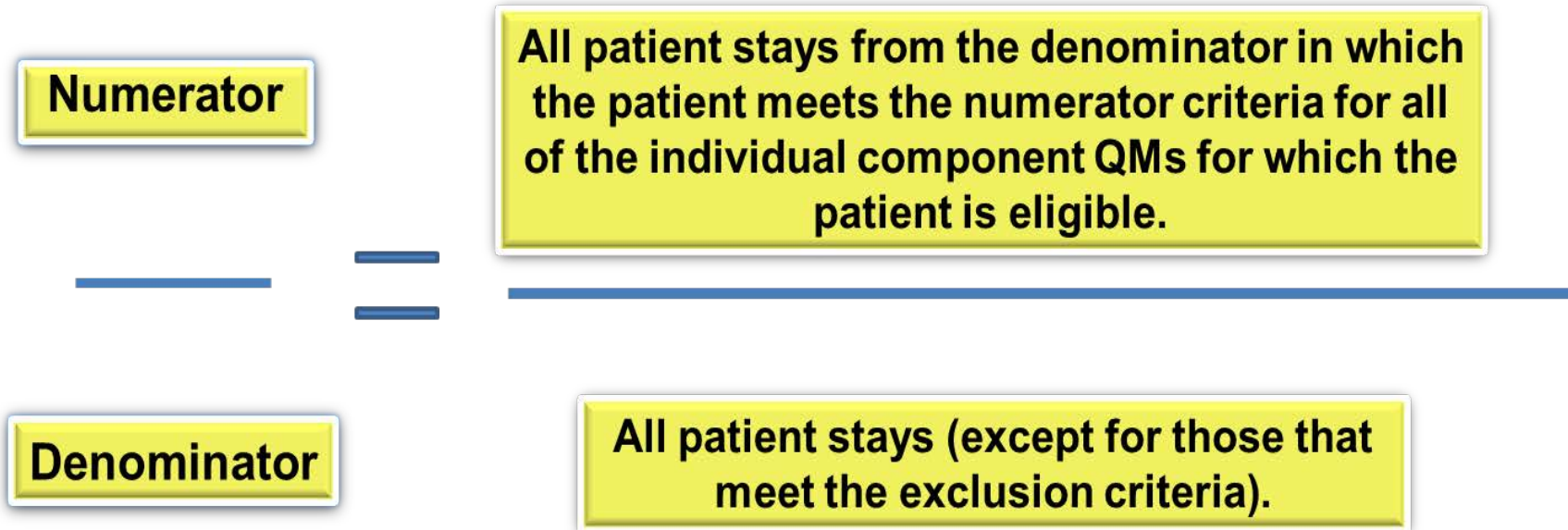
National Quality Forum (NQF) Endorsement Status

- The composite measure uses the seven NQF endorsed measures as its component measures. These seven measures are used to calculate the composite measure.
- All seven NQF component measures received their maintenance endorsement in October 2016.
- A major change to the measure specifications as part of the NQF endorsement was removal of the length of stay (LOS) criterion; all seven measures now have no LOS exclusion.

Hospice and Palliative Care Composite Process Measure – Comprehensive Assessment at Admission

- This measure will provide consumers and providers with:
 - A single measure regarding the overall quality and completeness of assessment of patient needs at hospice admission.
 - A measure that can be used to meaningfully and easily compare quality across hospice providers.
 - A measure that sets a higher standard of care for hospices.

Hospice and Palliative Care Composite Process Measure – Comprehensive Assessment at Admission



Hospice and Palliative Care Composite Process Measure – Comprehensive Assessment at Admission

- Denominator Exclusions:
 1. Discharged stays missing the admission record and active stays.
 2. Under 18 years of age as indicated by the birth date (A0900) and admission date (A0220).
- Risk Adjustment:
 - This measure is not risk-adjusted or stratified.

Hospice and Palliative Care Composite Process Measure – Comprehensive Assessment at Admission

Conditional Measures:

- Some patients may not qualify for the conditional measures NQF #1637 Pain Assessment, NQF #1638 Dyspnea Treatment, and NQF #1617 Bowel Regimen.
 - For example: If screening indicates no dyspnea (J2030), the patient is ineligible for a dyspnea treatment (J2040).
- These patients will be eligible for the numerator as if hospices completed the care processes of the conditional measures.
 - That is, the hospice would be given “credit” for completing the comprehensive respiratory assessment.

Meet Mr. Joseph

- We will use Mr. Joseph's case study throughout this presentation.
- Please review Case Study Part One at this point.
- Make special note of the following areas:
 - Preferences,
 - Respiratory status,
 - Pain, and
 - Medications.



Section F: Preferences

Section F: Preferences

- F2000. CPR Preference
- F2100. Other Life-Sustaining Treatment Preferences
- F2200. Hospitalization Preference
- F3000. Spiritual/Existential Concerns
- These items contribute to the following measures: NQF #1641 and NQF #1647.

Section F: Preferences

- These items pertain to the hospice patient's preferences regarding life-sustaining treatments and spiritual care.
- The intent is to capture:
 - The care process of eliciting patient preferences.
 - Evidence of discussion and/or communication about patient preferences.

Section F: Preferences – Tips

- These items are intended to document whether a discussion with the family/responsible party:
 - Occurred.
 - Did not occur.
 - Was offered and declined.

Section F: Preferences – Tips

- Complete these items **based on the first dated discussion about preferences** in the clinical record.
- It is permissible to consider discussions documented in the clinical record that took place during preadmission or educational visits.

Section F: Preferences – Tips

- Discussions may be included if they occur:
 - No more than 7 days prior to or within 5 days of the admission date.
 - Are based on direct report from the patient, the caregiver, or the responsible party if the patient cannot self-report.
- Discussions can be initiated by any member of the hospice staff or interdisciplinary group.

F2000. CPR Preference

F2000. CPR Preference

F2000. CPR Preference

Enter Code

A. Was the patient/responsible party asked about preference regarding the use of cardiopulmonary resuscitation (CPR)? - Select the most accurate response

0. No → Skip to F2100, Other Life-Sustaining Treatment Preferences

1. Yes, and discussion occurred

2. Yes, but the patient/responsible party refused to discuss

B. Date the patient/responsible party was first asked about preference regarding the use of CPR:

Month

Day

Year

F2000. CPR Preference – Tips

- Orders alone or short statements in the clinical record, such as “DNR/DNI” or “full code” without evidence of discussion are not sufficient.
- If a patient is admitted to hospice with a preexisting do-not-resuscitate (DNR) order or Physician Orders for Life-Sustaining Treatment that was signed in a prior care setting, the hospice should reaffirm the patient’s preferences and document in the clinical record.

F2100. Other Life-Sustaining Treatment Preferences

F2100. Other Life-Sustaining Treatment Preferences

F2100. Other Life-Sustaining Treatment Preferences

Enter Code

A. Was the patient/responsible party asked about preferences regarding life-sustaining treatments other than CPR? - Select the most accurate response

0. No → Skip to F2200, Hospitalization Preference

1. Yes, and discussion occurred

2. Yes, but the patient/responsible party refused to discuss

B. Date the patient/responsible party was first asked about preferences regarding life-sustaining treatments other than CPR:

Month

Day

Year

F2100. Other Life-Sustaining Treatment Preferences – Tips

- This applies to situations where there is documentation that the hospice brought up the topic of life-sustaining treatment other than CPR.
- The conversation does not have to result in the patient stating a preference for or against the use of life-sustaining treatments other than CPR.

F2100. Other Life-Sustaining Treatment Preferences – Tips

- There is no comprehensive list of life-sustaining treatments.
- Documentation in the clinical record indicating an attempt to discuss preference for any life-sustaining treatment other than CPR (for example, ventilator support, tube feeding, dialysis, blood transfusion, antibiotics, intravenous fluids) is sufficient to select either:
 - **1**, Yes, and discussion occurred.
 - **2**, Yes, but patient/responsible party refused to discuss.

F2200. Hospitalization Preference

F2200. Hospitalization Preference

F2200. Hospitalization Preference

Enter Code

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A. Was the patient/responsible party asked about preference regarding hospitalization? - Select the most accurate response

0. No → Skip to F3000, Spiritual/Existential Concerns

1. Yes, and discussion occurred

2. Yes, but the patient/responsible party refused to discuss

B. Date the patient/responsible party was first asked about preference regarding hospitalization:

Month

Day

Year

F2200. Hospitalization Preference – Tips

- Applies to situations in which there is documentation that the hospice brought up the topic of hospitalization and had a conversation with the patient and/or responsible party.
- “Hospitalization” does not refer to the patient's choice of a particular facility, but rather if the hospice opened the door for a conversation about preference regarding hospitalization as a care option to consider.
- The conversation does not have to result in the patient stating a preference for or against hospitalization.

F2200. Hospitalization Preference – Tips

Examples of discussions about hospitalization may include, but are not limited to:

1. Expressing a desire to keep the patient at home instead of being transferred/admitted to a hospital.
2. Discussing specific situations in which the patient/responsible party feels hospitalization would be the preferred location for care.
3. Stating that, at this time, they are unsure if being transferred/admitted to a hospital for care is something they would consider.

Polling Scenario

- In the medical record, the quality performance staff finds documentation that the admission nurse clearly addressed the issue of CPR with the patient upon admission.
- Both the nurse and social worker noted that they tried to bring up the issue of hospitalization, but the patient made statements such as:
 - “I’m glad to be home and just want to focus on being with my family now.” (admission nurse note).
 - “I’m taking it one day at a time right now!” (social worker note).

F3000. Spiritual/Existential Concerns

F3000. Spiritual/Existential Concerns

F3000. Spiritual/Existential Concerns

Enter Code

☐

A. Was the patient and/or caregiver asked about spiritual/existential concerns? - Select the most accurate response

0. No → Skip to I0010, Principal Diagnosis

1. Yes, and discussion occurred

2. Yes, but the patient and/or caregiver refused to discuss

B. Date the patient and/or caregiver was first asked about spiritual/existential concerns:

Month

Day

Year

F3000. Spiritual/Existential Concerns – Tips

- This item asks if the patient and/or caregiver was asked about spiritual/existential concerns.
 - The “caregiver” does not have to be the legally authorized representative.
 - The item captures evidence of a discussion (or attempted discussion) with the patient and/or caregiver(s).
 - It does not capture whether interventions to address concerns were initiated.

F3000. Spiritual/Existential Concerns – Tips

- There is no comprehensive list of spiritual/existential concerns.
- Examples of a discussion might include:
 - Asking about need for spiritual or religious support.
 - Questions about the cause or meaning of illness or death.
 - A discussion about a higher power related to illness.
 - Offering a spiritual resource (such as a chaplain).

F3000. Spiritual/Existential Concerns – Tips

- Completion should be based on what is included in the clinical record.
- Do not use sources external to the clinical record for this item.
- Documentation showing only the patient's religious affiliation is not sufficient.

Case Scenario:

Section F – Preferences

- Work with others at your table to complete Section F on the HIS-Admission for Mr. Joseph.
- Refer to the HIS Manual on your table, if needed.
- We will reconvene in 5-10 minutes to debrief.



Case Scenario: Section F Debrief

- F2000A. Was the patient/responsible party asked about preference regarding the use of CPR? =
- F2000B. Date the patient/responsible party was first asked about preference regarding the use of CPR: =

Case Scenario: Section F Debrief

- F2100A. Was the patient/responsible party asked about preferences regarding life-sustaining treatments other than CPR? =
- F2100B. Date the patient/responsible party was first asked about preferences regarding life-sustaining treatments other than CPR: =

Case Scenario: Section F Debrief

- F2200A. Was the patient/responsible party asked about preference regarding hospitalization? =
- F2200B. Date the patient/responsible party was first asked about preference regarding hospitalization: =

Case Scenario: Section F Debrief

- F3000A. Was the patient and/or caregiver asked about spiritual/existential concerns?
=
- F3000B. Date the patient and/or caregiver was first asked about spiritual/existential concerns: =

Section J: Health Conditions

Pain

Section J: Health Conditions

- J0900. Pain Screening
- J0910. Comprehensive Pain Assessment
 - These items contribute to the conditional measure, NQF #1637.

J0900. Pain Screening

J0900. Pain Screening

J0900. Pain Screening													
Enter Code <input type="checkbox"/>	A. Was the patient screened for pain? 0. No → Skip to J0905, Pain Active Problem 1. Yes												
	B. Date of first screening for pain: <table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td colspan="2">Month</td><td colspan="2">Day</td><td colspan="2">Year</td></tr></table>							Month		Day		Year	
Month		Day		Year									
Enter Code <input type="checkbox"/>	C. The patient's pain severity was: 0. None 1. Mild 2. Moderate 3. Severe 9. Pain not rated												
Enter Code <input type="checkbox"/>	D. Type of standardized pain tool used: 1. Numeric 2. Verbal descriptor 3. Patient visual 4. Staff observation 9. No standardized tool used												

J0900. Pain Screening

- This item asks if the patient was screened for pain during the initial nursing assessment, 2 days of the admission date.
- This item captures the patient's pain severity (none, mild, mod, severe) and whether a standardized tool was used to conduct the screen.

J0900. Pain Screening – Tips

- Consider the results of:
 - The standardized pain screening tool.
 - Any other screening approaches the clinician used that might include asking the patient about their pain comfort.
- Select the code based on the **highest level of pain** experienced during the visit during which the screening was performed.

J0905. Pain Active Problem

J0905. Pain Active Problem

J0905. Pain Active Problem

Enter Code

☐

Is pain an active problem for the patient?

0. No → Skip to J2030, Screening for Shortness of Breath

1. Yes

J0910. Pain Assessment

J0910. Comprehensive Pain Assessment

J0910. Comprehensive Pain Assessment	
Enter Code <input type="checkbox"/>	A. Was a comprehensive pain assessment done? 0. No → Skip to J2030, Screening for Shortness of Breath 1. Yes B. Date of comprehensive pain assessment: <div> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> </div> <div> Month Day Year </div> C. Comprehensive pain assessment included:
↓ Check all that apply	
<input type="checkbox"/>	1. Location
<input type="checkbox"/>	2. Severity
<input type="checkbox"/>	3. Character
<input type="checkbox"/>	4. Duration
<input type="checkbox"/>	5. Frequency
<input type="checkbox"/>	6. What relieves/worsens pain
<input type="checkbox"/>	7. Effect on function or quality of life
<input type="checkbox"/>	9. None of the above

J0910. Pain Assessment

- This item asks if hospice patients who screened positive for pain received a comprehensive pain assessment.

J0910. Pain Assessment – Tips

- A comprehensive pain assessment should address multiple aspects of pain beyond the presence of pain and its severity.
- Seven pain characteristics are listed.
- Select response options (check all that apply) based on whether the clinician ***made an attempt*** to gather the information from the patient or caregiver.
- A caregiver report is acceptable.

J0910. Pain Assessment – Tips

- For inclusion in the numerator of the Pain Assessment QM and the new composite measure:
 - If applicable, a comprehensive pain assessment must occur within 1 day of the positive pain screen, and
 - Include ***at least five of the seven pain characteristics.***

Case Scenario: Section J Pain

- Work with others at your table to complete the pain items in Section J on the HIS-Admission for Mr. Joseph.
- Refer to the HIS Manual on your table, if needed.
- We will reconvene in 5-10 minutes to debrief.



Case Scenario:

Section J Pain Debrief

- J0900A. Was the patient screened for pain? =
- J0900B. Date of first screening for pain: =
- J0900C. The patient's pain severity was: =
- J0900D. Type of standardized pain tool used: =

Case Scenario:

Section J Pain Debrief

- J0905. Pain Active Problem =
- J0910A. Was a comprehensive pain assessment done? =
- J0910B. Date of comprehensive pain assessment: =

Case Scenario:

Section J Pain Debrief

- J0910C. Comprehensive pain assessment included:
 - 1. Location =
 - 2. Severity =
 - 3. Character =
 - 4. Duration =
 - 5. Frequency =
 - 6. What relieves/worsens pain =
 - 7. Effect on function or quality of life =
 - 9. None of the above =

Section J: Health Conditions

Respiratory Status

Section J: Health Conditions

- J2030. Screening for Shortness of Breath
- J2040. Treatment for Shortness of Breath
 - These items contribute to the conditional measure, NQF #1638.

J2030. Screening for Shortness of Breath

J2030. Screening for Shortness of Breath

J2030. Screening for Shortness of Breath													
Enter Code <input type="checkbox"/>	<p>A. Was the patient screened for shortness of breath? 0. No → Skip to N0500, Scheduled Opioid 1. Yes</p> <p>B. Date of first screening for shortness of breath:</p> <table border="1"><tr><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td></tr><tr><td colspan="2">Month</td><td colspan="2">Day</td><td colspan="2">Year</td></tr></table>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Month		Day		Year	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>								
Month		Day		Year									
Enter Code <input type="checkbox"/>	<p>C. Did the screening indicate the patient had shortness of breath? 0. No → Skip to N0500, Scheduled Opioid 1. Yes</p>												

J2030. Screening for Shortness of Breath

- This item asks if the patient was screened for shortness of breath and if the screening indicated that shortness of breath was an active problem.

J2030. Screening for Shortness of Breath – Tips

- This is based on the first shortness of breath screening that appears in the clinical record.
 - **Evaluate the patient for presence/absence** of shortness of breath.
 - If present, **rate its severity**.
- There must be evidence that the **severity was rated in any manner clinically appropriate** for the patient.
 - This may/may not include use of a standardized tool.

J2040. Treatment for Shortness of Breath

J2040. Treatment for Shortness of Breath

J2040. Treatment for Shortness of Breath

Enter Code <input type="checkbox"/>	A. Was treatment for shortness of breath initiated? - Select the most accurate response 0. No → Skip to N0500, Scheduled Opioid 1. No, patient declined treatment → Skip to N0500, Scheduled Opioid 2. Yes B. Date treatment for shortness of breath initiated: <div style="display: flex; justify-content: space-around; align-items: flex-end;"> <div style="text-align: center;"> <input type="text"/><input type="text"/> Month </div> <div style="text-align: center;"> <input type="text"/><input type="text"/> Day </div> <div style="text-align: center;"> <input type="text"/><input type="text"/><input type="text"/><input type="text"/> Year </div> </div> C. Type(s) of treatment for shortness of breath initiated:
↓ Check all that apply	
<input type="checkbox"/>	1. Opioids
<input type="checkbox"/>	2. Other medication
<input type="checkbox"/>	3. Oxygen
<input type="checkbox"/>	4. Non-medication

J2040. Treatment for Shortness of Breath

- This item asks if treatment for shortness of breath was initiated, when it was initiated, and the types of treatments that were initiated, including:
 - Opioids
 - Other medications
 - Oxygen
 - Non-medication

J2040. Treatment for Shortness of Breath – Tips

- For treatments with multiple uses, orders must indicate that the treatment was initiated for shortness of breath.
- Use the date that the hospice received the order.
- If the patient received **multiple types of treatment** for shortness of breath (i.e., oxygen, education about positioning), enter the date that **the first treatment was initiated**.

J2040. Treatment for Shortness of Breath – Tips

- Comfort kits or preprinted admission orders alone are insufficient for questions regarding the initiation of treatment.
 - Treatment is **not considered initiated until the Hospice has received the order, and**
 - **There is documentation** that the patient/caregiver was instructed **to begin use** of the medication or treatment.
- Proactive education on medications in a comfort kit in anticipation of symptoms alone is insufficient.

Case Scenario: Section J

Respiratory Status

- Work with others at your table to complete respiratory status items in Section J on the HIS-Admission for Mr. Joseph.
- Refer to the HIS Manual on your table, if needed.
- We will reconvene in approximately 5 minutes to debrief.



Case Scenario: Section J

Respiratory Status Debrief

- J2030A. Was the patient screened for shortness of breath? =
- J2030B. Date of first screening for shortness of breath: =
- J2030C. Did the screening indicate the patient had shortness of breath? =

Case Scenario: Section J

Respiratory Status Debrief

- J2040A. Was treatment for shortness of breath initiated? =
- J2040B. Date treatment for shortness of breath initiated: =
- J2040C. Type(s) of treatment for shortness of breath initiated: =
 - 1. Opioids
 - 2. Other medication
 - 3. Oxygen
 - 4. Non-medication

Section N: Medications

Section N: Medications

- N0500. Scheduled Opioid
 - N0510. PRN Opioid
 - N0520. Bowel Regimen
- Items N0500 and N0520 contribute to the conditional measure, NQF #1617.

Section N: Medications

- These next three items ask if a scheduled or as needed (PRN) opioid was initiated or continued, and if a bowel regimen was initiated or continued for the patient.

Section N: Medications

- As with the dyspnea item in Section J, comfort kits or preprinted admission orders alone are insufficient for questions regarding the initiation of treatment.
 - Treatment is **not considered initiated until the hospice has received the order.**
 - **There is documentation** that the patient/caregiver was instructed **to begin use** of the medication or treatment.
- Proactive education on medications in a comfort kit in anticipation of symptoms alone is insufficient.

N0500. Scheduled Opioid

N0500. Scheduled Opioid

N0500. Scheduled Opioid													
<p>Enter Code</p> <input type="checkbox"/>	<p>A. Was a scheduled opioid initiated or continued? 0. No → Skip to N0510, PRN Opioid 1. Yes</p> <p>B. Date scheduled opioid initiated or continued:</p> <table><tr><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td></tr><tr><td colspan="2">Month</td><td colspan="2">Day</td><td colspan="2">Year</td></tr></table>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Month		Day		Year	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>								
Month		Day		Year									

N0500. Scheduled Opioid – Tips

- For orders continued from previous care settings, N0500 should be completed based on scheduled opioids for which the hospice has received orders.
- Do not include a continued treatment unless the hospice received a new order to continue the treatment.

N0510. PRN Opioid

N0510. PRN Opioid

N0510. PRN Opioid

Enter Code

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A. Was a PRN opioid initiated or continued?

0. No → Skip to N0520, Bowel Regimen

1. Yes

B. Date PRN opioid initiated or continued:

Month

Day

Year

N0510. PRN Opioid – Tips

- Use the date that the hospice initiated or continued PRN opioids.
- Treatment initiation or continuation is defined as the date that an order was received.

N0500. Scheduled Opioid and N0510. PRN Opioid – Tips

- Select response **1, Yes** if the clinical record indicates that the scheduled or PRN opioid was initiated for any reason, regardless of symptom.

N0500. Scheduled Opioid and N0510. PRN Opioid – Tips

- For different types of regularly scheduled opioids or PRN opioids in sequence over time, **enter the date that the first type of opioid treatment was initiated.**

N0520. Bowel Regimen

N0520. Bowel Regimen

N0520. Bowel Regimen

Complete only if N0500A or N0510A = 1

Enter Code

☐

A. Was a bowel regimen initiated or continued? - Select the most accurate response

0. **No** → Skip to Z0400, Signature(s) of Person(s) Completing the Record

1. **No, but there is documentation of why a bowel regimen was not initiated or continued** → Skip to Z0400, Signature(s) of Person(s) Completing the Record

2. **Yes**

B. Date bowel regimen initiated or continued:

Month

Day

Year

N0520. Bowel Regimen – Tips

- A bowel regimen may include, but is not limited to, the following:
 - Laxatives or stool softeners.
 - High-fiber supplements.
 - Enemas.
 - Suppositories.
 - Dietary interventions, such as prune juice or high-fiber diet.

N0520. Bowel Regimen – Tips

- For non-pharmacologic bowel regimens, such as prune juice or high-fiber diet, there may not be any orders.
- In this case, use the date the hospice nurse or clinician instructed the patient/family about non-pharmacologic intervention(s).

N0520. Bowel Regimen – Tips

- Documentation why a bowel regimen was not initiated could include clinical contraindications to a bowel regimen or patient was offered a bowel regimen but refused treatment.

Case Scenario: Section N Medications

- Work with others at your table to complete Section N on the HIS-Admission for Mr. Joseph.
- Refer to the HIS Manual on your table, if needed.
- We will reconvene in 5-10 minutes to debrief.



Case Scenario: Section N Debrief

- N0500A. Was a scheduled opioid initiated or continued? =
- N0500B. Date scheduled opioid initiated or continued: =

Case Scenario: Section N Debrief

- N0510A. Was a PRN opioid initiated or continued? =
- N0510B. Date PRN opioid initiated or continued: =

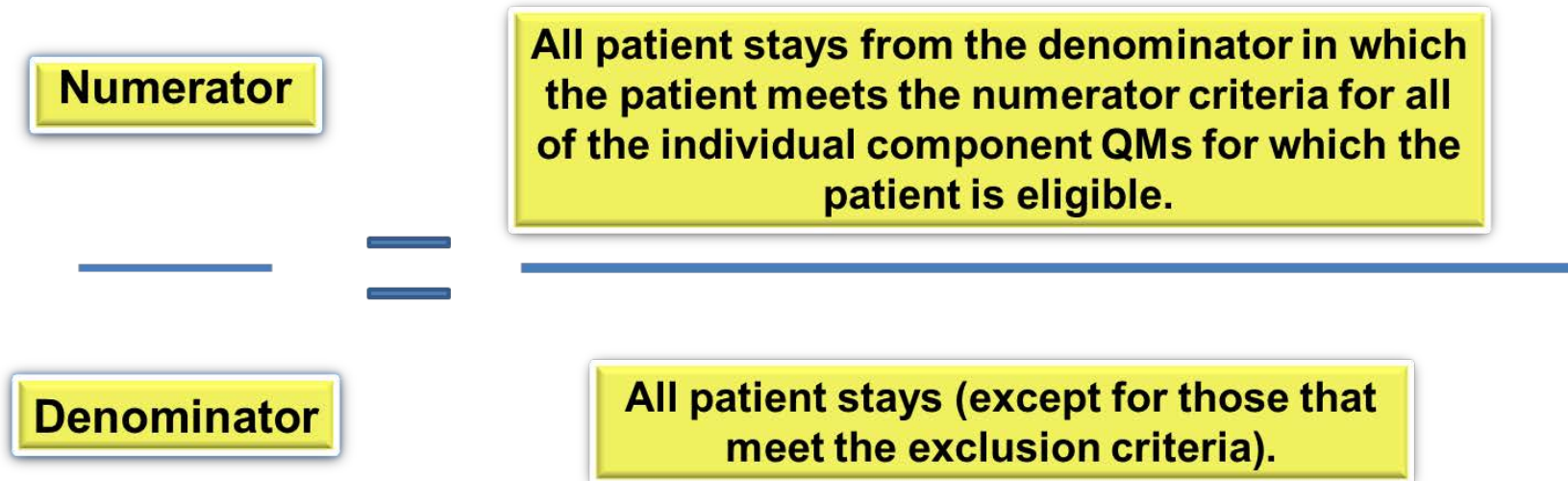
Case Scenario: Section N Debrief

- N0520A. Was a bowel regimen initiated or continued? =
- N0520B. Date bowel regimen initiated or continued: =

Hospice and Palliative Care Composite Process Measure – Comprehensive Assessment at Admission

Let's look again at how this new quality measure will actually be calculated!

Hospice and Palliative Care Composite Process Measure – Comprehensive Assessment at Admission



Calculation of the Composite Process Measure

- The calculation includes patient stays that meet the numerator criteria for ***all of the individual component quality measures for which they are eligible:***
 1. The patient/responsible party was ***asked about treatment preferences.***
 2. The patient and/or caregiver was ***asked about spiritual/existential concerns.***

Calculation of the Composite Process Measure

3. The patient was ***screened for pain*** within 2 days of the admission date and the patient reported they had no pain, or pain severity was rated and ***a standardized pain tool was used.***

Calculation of the Composite Process Measure

4. A ***comprehensive pain assessment*** was completed within 1 day of the initial nursing assessment during which the patient screened positive for pain and ***included at least five of the following characteristics:*** location, severity, character, duration, frequency, what relieves or worsens the pain, and the effect on function or quality of life (if applicable).

Calculation of the Composite Process Measure

5. The patient was ***screened for shortness*** of breath within 2 days of the admission date.
6. The patient ***declined treatment for shortness of breath or treatment for shortness of breath was initiated*** prior to the initial nursing assessment within 1 day of the initial nursing assessment during which the patient screened positive for shortness of breath (if applicable).

Calculation of the Composite Process Measure

7. There is ***documentation that a bowel regimen was initiated or continued, or why a bowel regimen was not initiated*** within 1 day of a scheduled opioid being initiated or continued (if applicable).

Hospice and Palliative Care Composite Process Measure – Comprehensive Assessment at Admission

Remember!

- The numerator for this measure includes patients who meet the numerator criteria for ***all of the individual components measures for which they are eligible.***
- Completion should be based on what is documented in the hospice clinical record.

Hospice Visits When Death is Imminent Measure Pair

Hospice Visits When Death is Imminent Measure Pair

- This measure pair assesses hospice staff visits to patients and caregivers at the end of life.
- This is specified as a set of two measures.
- Items used to calculate this measure pair are included in HIS-Discharge, V2.00.0.
- Hospice providers will begin data collection for this measure pair for patient discharges occurring on or after April 1, 2017.

Hospice Visits When Death is Imminent Measure Pair

- Captures whether ***the needs of a hospice patient and family were addressed by the hospice staff during the last days of life***, when patients and caregivers typically experience higher symptom and caregiving burdens and therefore an increased need for care.

Hospice Visits When Death is Imminent Measure Pair

- By grouping the visits from various disciplines into the same measure, the measure provides hospices with the flexibility to determine the most appropriate type of visits to meet patients and families' needs.

Section O: Service Utilization

- To collect this information, four new items have been added to the HIS-Discharge, V2.00.0:
 - Two level of care items.
 - Two visit items to capture discipline-specific information.
 - The level of care and visit items ask for the same type of information to be collected during different timeframes.

Section O: Service Utilization

Items	Additions to the HIS-Discharge V2.00.0	Purpose
Two level of care items	O5000. Level of care in the final 3 days O5020. Level of care in the final 7 days	Determine exclusions
Two visit items to capture discipline-specific information	O5010. Number of hospice visits in the final 3 days O5030. Number of hospice visits in the 3 to 6 days prior to death	Collect visit information

Section O: Service Utilization

- Complete only for patients who are discharged due to death.
 - A2115 = **01**, Expired.
- Do not complete if the reason for discharge is anything other than expired.

Patients Receiving at Least One Visit in the Last 3 Days of Life

Numerator

All patients in the denominator who receive at least one visit from registered nurses, physicians, nurse practitioners, or physician assistants in the last 3 days of life.

Denominator

All patient stays (except for those that meet any exclusion criteria).

Measure 1 Exclusion Criteria

- Discharged stays missing the admission record, and active stays.
- Patient did not expire in hospice care as indicated by reason for discharge.
- Patient received any Continuous Home Care, General Inpatient Care, or Respite Care in the last 3 days of life.

Patients Receiving at Least One Visit in the Last 3 Days of Life

- Assesses the percentage of patients receiving at least one visit from registered nurses, physicians, nurse practitioners, or physician assistants in the last 3 days of life.
- This measure addresses case management and clinical care.

O5000. Level of Care in Final 3 Days

O5000. Level of care in final 3 days

O5000. Level of care in final 3 days

Complete only if A2115, Reason for Discharge = 01 Expired

Enter Code

☐

Did the patient receive Continuous Home Care, General Inpatient Care, or Respite Care during any of the final 3 days of life?

0. **No**

1. **Yes** → Skip to Z0400, Signature(s) of Person(s) Completing the Record

O5000. Level of Care in Final 3 Days – Tips

- This item captures whether the patient received Continuous Home Care, General Inpatient Care, or Respite Care during any of the final 3 days of life.
- If the patient was on hospice for fewer than 3 days prior to death, select a response based on the days the patient was enrolled in hospice.

O5000. Level of Care in Final 3 Days – Tips

- To complete this item for non-Medicare/Medicaid patients, hospices may apply the Medicare Hospice Conditions of Participation (CoPs) definitions of the four levels of care.

O5010. Number of Hospice Visits in Final 3 Days

O5010. Number of hospice visits in final 3 days

O5010. Number of hospice visits in final 3 days

Enter the number of visits provided by hospice staff from the indicated discipline, on each of the dates indicated.

	Visits on day of death (A0270)	Visits one day prior to death (A0270 minus 1)	Visits two days prior to death (A0270 minus 2)
A. Registered Nurse	<input type="text"/>	<input type="text"/>	<input type="text"/>
B. Physician (or Nurse Practitioner or Physician Assistant)	<input type="text"/>	<input type="text"/>	<input type="text"/>
C. Medical Social Worker	<input type="text"/>	<input type="text"/>	<input type="text"/>
D. Chaplain or Spiritual Counselor	<input type="text"/>	<input type="text"/>	<input type="text"/>
E. Licensed Practical Nurse	<input type="text"/>	<input type="text"/>	<input type="text"/>
F. Aide	<input type="text"/>	<input type="text"/>	<input type="text"/>

O5010. Number of Hospice Visits in Final 3 Days

- This item records the number of visits provided by each discipline in the final 3 days.
- For each row (A–F), enter the number of visits provided by the indicated discipline on the 3 days indicated:
 - The day of death.
 - The day prior to death.
 - 2 days prior to death.

O5010. Number of Hospice Visits in Final 3 Days

- For each cell:
 - Use one character, **0** through **9**.
 - Indicate the number of visits provided by each discipline on the given day.
- Do not leave cells blank unless directed by the skip patterns.

O5010. Number of Hospice Visits in Final 3 Days

- The day of death = discharge date (the date provided in A0270).
 - 1 day prior to death = A0270 minus 1.
 - 2 days prior to death = A0270 minus 2.

O5010. Number of Hospice Visits in Final 3 Days

- If the patient did not receive a visit from a given discipline on a given day, enter 0 in the appropriate cell.
- If more than 9 visits from a given discipline, enter a 9 in the appropriate cell.

O5010. Number of Hospice Visits in Final 3 Days

- Zeros may represent one of two situations:
 - **Not enrolled in hospice:** A 0 entered in cells corresponding to days prior to enrollment indicates that the patient was not enrolled in hospice on that date.
 - **No services:** A 0 entered in cells corresponding to days on which the patient was enrolled in hospice indicates no services.

O5010. Number of Hospice Visits in Final 3 Days – Tips

- Individuals whose visits count include:
 - Hospice staff members in each of the listed disciplines who are either employees, contractors and affiliates, or who provide unpaid services.
- Visits provided to the patient's family may be counted.
- Phone calls are **not** counted.
- Postmortem visits on the day of death are **not** counted.

Patients Receiving at Least Two Visits in the Last 7 Days of Life

Numerator

All patients in the denominator who receive at least two visits from medical social workers, chaplains or spiritual counselors, licensed practical nurses, or hospice aides in the last 7 days of life.

Denominator

All patient stays (except for those that meet any exclusion criteria).

Measure 2 Exclusion Criteria

- Discharged stays missing the admission record, and active stays.
- Patient did not expire in hospice care as indicated by reason for discharge.
- Patient received any Continuous Home Care, General Inpatient Care, or Respite Care in the last 7 days of life.
- Patient had a LOS of 1 day as indicated by admission date and discharge date.

Patients Receiving at Least Two Visits in the Last 7 Days of Life

- Assesses the percentage of patients receiving at least two visits from medical social workers, chaplains or spiritual counselors, licensed practical nurses, or hospice aides.
- This measure gives providers the flexibility to:
 - Provide **individualized care that is in line with the patient and family's preferences and goals of care.**
 - Contribute to the overall well-being of the patient and family.

O5020. Level of Care in Final 7 Days

O5020. Level of care in final 7 days

O5020. Level of care in final 7 days

Complete only if A2115, Reason for Discharge = 01 Expired

Enter Code

☐

Did the patient receive Continuous Home Care, General Inpatient Care, or Respite Care during any of the final 7 days of life?

0. **No**

1. **Yes** → Skip to Z0400, Signature(s) of Person(s) Completing the Record

O5020. Level of Care in Final 7 Days

- This item captures whether the patient received Continuous Home Care, General Inpatient Care, or Respite Care during any of the final 7 days of life.

O5020. Level of Care in Final 7 Days – Tips

- If the patient was on hospice for fewer than 7 days prior to death, select a response based on the days the patient was enrolled in hospice.
- As with completing O5000, hospices may apply the Medicare CoP definitions of the four levels of care to the non-Medicare/Medicaid patients.

O5030. Number of Hospice Visits in 3 to 6 Days Prior to Death

O5030. Number of hospice visits in 3 to 6 days prior to death

O5030. Number of hospice visits in 3 to 6 days prior to death

Enter the number of visits provided by hospice staff from the indicated discipline, on each of the dates indicated.

	Visits three days prior to death (A0270 minus 3)	Visits four days prior to death (A0270 minus 4)	Visits five days prior to death (A0270 minus 5)	Visits six days prior to death (A0270 minus 6)
A. Registered Nurse	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
B. Physician (or Nurse Practitioner or Physician Assistant)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
C. Medical Social Worker	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
D. Chaplain or Spiritual Counselor	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
E. Licensed Practical Nurse	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
F. Aide	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

O5030. Number of Hospice Visits in 3 to 6 Days Prior to Death

- This item records the number of visits provided by certain disciplines in the 3 to 6 days prior to death.
- For each row (A–F), enter the number of visits provided by the indicated discipline on:
 - 3 days prior to death.
 - 4 days prior to death.
 - 5 days prior to death.
 - 6 days prior to death.

O5030. Number of Hospice Visits in 3 to 6 Days Prior to Death – Tips

- The day of death = discharge date (the date provided in A0270)
 - 3 days prior to death = A0270 minus 3
 - 4 days prior to death = A0270 minus 4
 - 5 days prior to death = A0270 minus 5
 - 6 days prior to death = A0270 minus 6

O5030. Number of Hospice Visits in 3 to 6 Days Prior to Death – Tips

- As with item O5010, for each cell:
 - Use one character, **0** through **9**.
 - Indicate the number of visits provided by each discipline on the given day.
- Do not leave cells blank unless directed by the skip patterns.
- If more than 9 visits from a given discipline, enter a 9.

O5030. Number of Hospice Visits in 3 to 6 Days Prior to Death – Tips

- As with item O5010, if there is no visit from a given discipline, enter 0.
- Zeros may represent one of two situations:
 - **Not enrolled in hospice:** A 0 entered in cells corresponding to days prior to enrollment indicates that the patient was not enrolled in hospice on that date.
 - **No services:** A 0 entered in cells corresponding to days on which the patient was enrolled in hospice indicates no services.

O5030. Number of Hospice Visits in 3 to 6 Days Prior to Death – Tips

- As with item O5010, individuals whose visits can be counted for the purpose of this item include:
 - Hospice staff members in each of the listed disciplines who are either employees, contractors and affiliates, or who provide unpaid services.
- Visits provided to the patient's family may be counted in this item.
- Phone calls are **not** counted in this item.

Case Scenario: Hospice Visits When Death is Imminent

- Please review Part Two of Mr. Joseph's case.
- Work in groups to complete Section O in the HIS-Discharge for Mr. Joseph.
- We will reconvene in approximately 10 minutes to debrief.



Case Scenario Debrief: O5010. Number of Hospice Visits in Final 3 Days

	Visits on day of death	Visits 1 day prior to death	Visits 2 days prior to death
A. Registered Nurse			
B. Physician			
C. Medical Social Worker			
D. Chaplain or Spiritual Counselor			
E. Licensed Practical Nurse			
F. Aide			

Case Scenario Debrief: O5030. Number of Hospice Visits in 3 to 6 Days Prior to Death

	Visits 3 days prior to death	Visits 4 days prior to death	Visits 5 days prior to death	Visits 6 days prior to death
A. Registered Nurse				
B. Physician				
C. Medical Social Worker				
D. Chaplain or Spiritual Counselor				
E. Licensed Practical Nurse				
F. Aide				

Questions and Answers



Resources

- FY 2017 Hospice Final Rule:
 - <https://www.federalregister.gov/documents/2016/08/05/2016-18221/medicare-program-fy-2017-hospice-wage-index-and-payment-rate-update-and-hospice-quality-reporting>.
- The Hospice Item Set Manual:
 - <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Hospice-Item-Set-HIS.html>.

Resources

- Hospice Quality Reporting:
 - <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/index.html>.
- Quality Help Desk:
 - HospiceQualityQuestions@cms.hhs.gov.
- Technical Help Desk:
 - Help@qtso.com or (877) 201-4721.



Resources

- Federal Regulations - the Four Levels of Care; Section 418.302 of the Medicare Hospice CoPs:
 - <http://www.ecfr.gov/cgi-bin/text-idx?rgn=div5;node=42%3A3.0.1.1.5>.
- Hospice Quality Reporting Program: Specifications for the Hospice Item Set-Based Quality Measures:
 - <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/Downloads/HQRP-Specifications-for-HIS-based-Quality-Measures.pdf>.