WEBINAR

The Hospice Quality Reporting Program

New Policies,New Opportunities

with
Beth Noyce
RN, BSJMC, HCS-D, COS-C, HCS-H
Noyce Consulting

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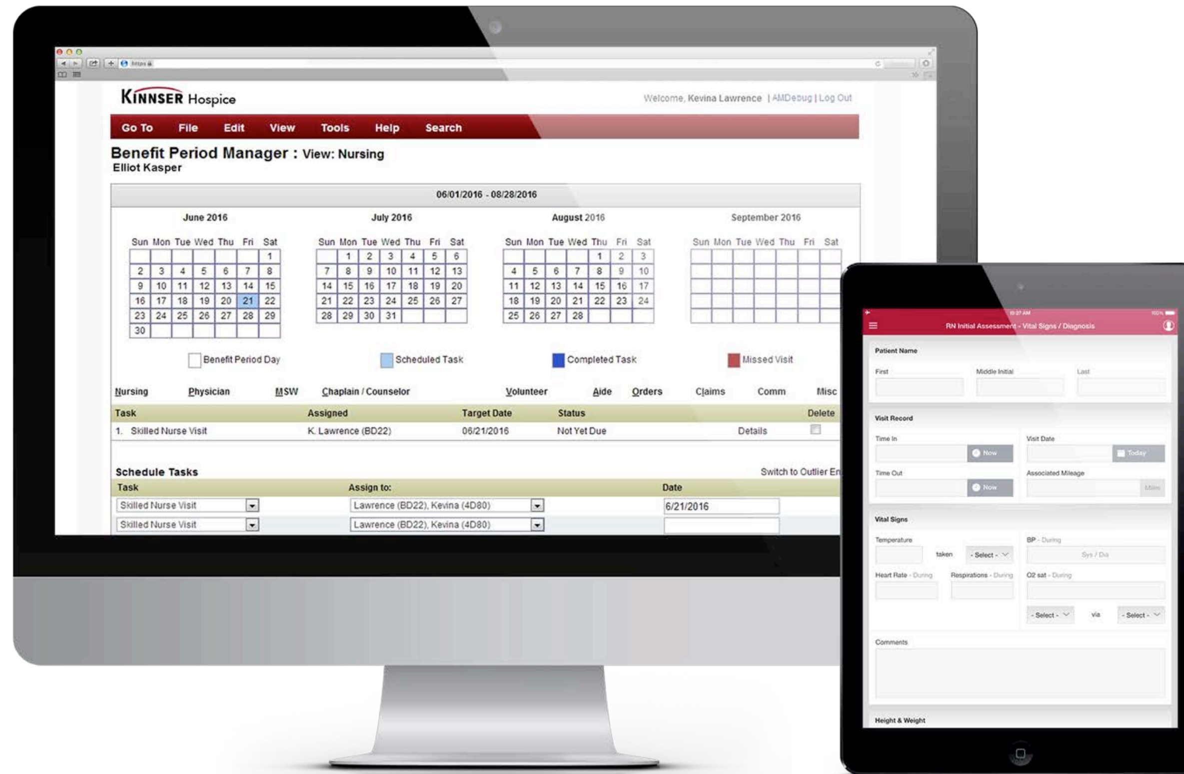

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About the presenter

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What is the HIS?

- A tool to capture process measures at admit and discharge to inform:
  - Certification and Survey Provider Enhanced Reports (CASPER)
  - Hospice Compare online
    - Consumer website
    - Later in 2017
    - New items capture begins April 1, 2017

What is the HIS?

- A “pay-for-reporting” requirement:
  - Non-compliance loses 2% of APU
- Required by law for all:
  - Medicare-certified hospices
  - Hospice-patient admissions

What is the HIS?

- Does **NOT**:
  - Replace thorough, ongoing patient assessment and standard clinical practice & judgment

Table 1: Quality Measures Calculated Using the HIS

NQF Number	Measure Name	Payment Determination (APU) Year for which the quality measure was first adopted
NQF #1641	Treatment Preferences	FY 2016
NQF #1647	Beliefs/Values Addressed (if desired by the patient)	FY 2016
NQF #1634	Pain Screening	FY 2016
NQF #1637	Pain Assessment	FY 2016
NQF #1639	Dyspnea Screening	
NQF #1638	Dyspnea Treatment	FY 2016
NQF #1617	Patients Treated with an Opioid Who Are Given a Bowel Regimen	FY 2016
N/A	Hospice and Palliative Care Composite Process Measure – Comprehensive Assessment at Admission	
N/A	Hospice Visits When Death is Imminent Measure Pair	FY 2019

Current CASPER data

Composite measure for Hospice Compare

2-Item Measure for Hospice Compare

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Rules for completing the Hospice Item Set correctly

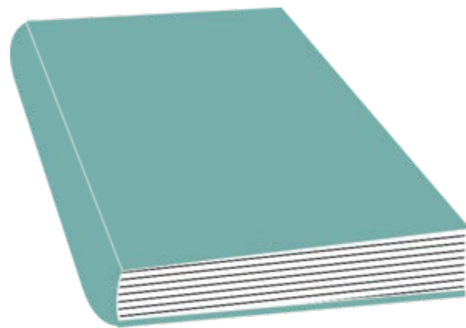
HIS CONVENTIONS

HIS Conventions

- Fully & accurately complete Admission & Discharge HIS for all admits.
- Any hospice staff member may complete any portion of the HIS.
  - All contributing to the HIS record must sign in Section Z according to Chapter 2 instructions.
  - Watch for future changes as the HIS evolves into a clinical assessment tool.

HIS Conventions

- Complete each item using only data in the patient record by HIS completion date.
  - Follow item-specific instructions & conventions.
  - Any process not documented in the clinical record is considered not done.



HIS Conventions

- Submit a HIS-Admission and HIS-Discharge even if the patient revokes or is discharged before related care processes are complete.
  - Answer "No" to questions about incomplete processes, then follow skip patterns.

"NO"

HIS Conventions

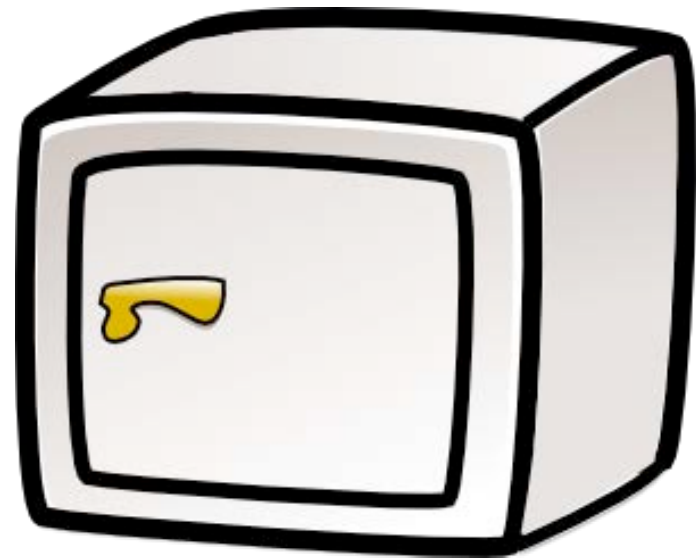
- Clinical record data extraction process at agency may…
  - Allow office personnel to identify and extract the HIS information needed from clinical assessment items.
  - Add verbatim HIS items to the clinical record/ patient assessments for 1:1 extraction.
    - The most common method for electronic medical record HIS-data aggregation for submission.

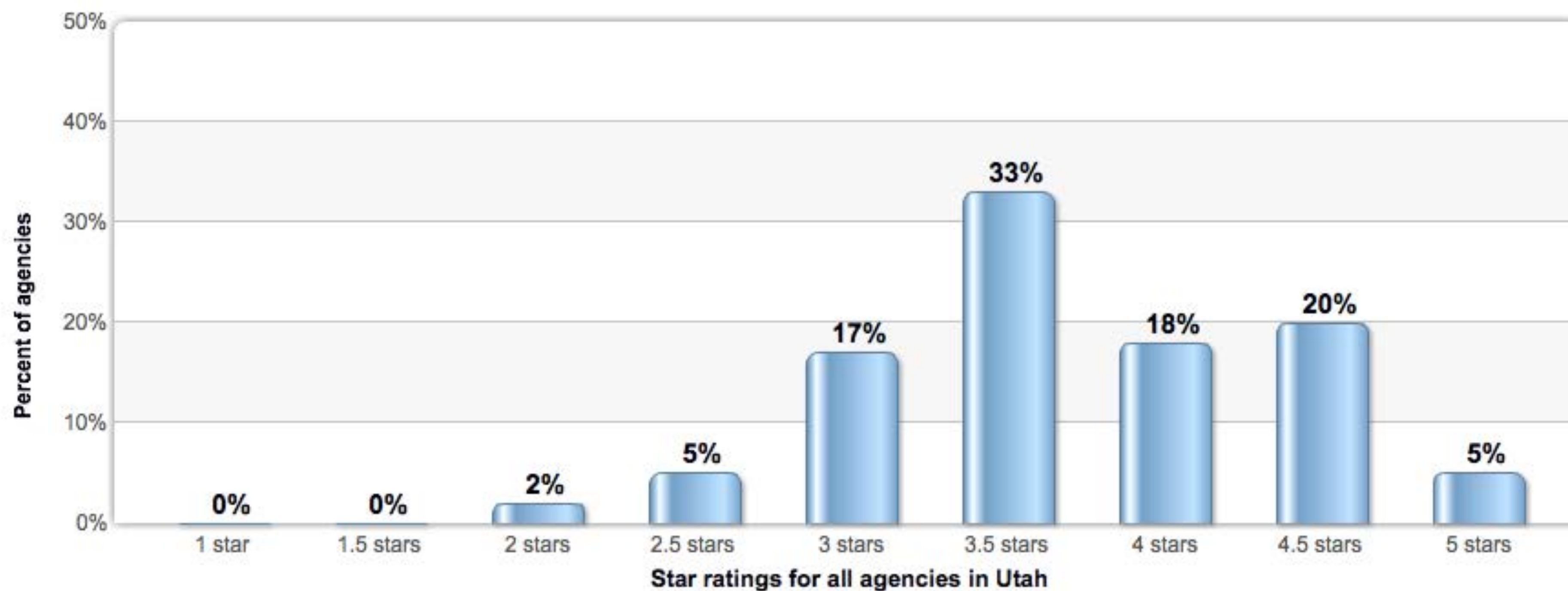
HIS Conventions

- Submit all complete HIS records electronically via QIES ASAP system.
  - In correct sequence.
    - Admission before discharge.
- Correct any HIS errors discovered after submission.
  - See HIS Guidance Manual Chapter 3.
- Consult external sources only as necessary for non-process information, as directed in Chapter 2.

HIS Record Maintenance

- Retain HIS documents.
  - Include any corrected versions.
  - Signature page.
    - Don't transmit, but retain for any future validation.
  - Ensure HIS privacy and integrity.





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Hospice Quality Reporting Program meets Hospice Compare

HQRP UPDATES

FY 2017 HQRP Updates

- HIS and CAHPS® will inform Hospice Compare beginning later in 2017.
  - Hospice CAHPS® survey = Patient-survey star ratings
  - HIS data = Patient-care-quality star ratings:
    - Currently captures process measures.
    - To become part of a more comprehensive, standardized, patient-assessment tool.
    - Future (potential) patient outcomes.

FY 2017 HQRP Updates

- Hospice Information Set (HIS):
  - Submission rates to HIS QIES ASAP and 30-day-from-event submission deadline to avoid 2% market basket update reduction two fiscal years later.
    - CY 2016: at least 70% for FY 2018
    - CY 2017: at least 80% for FY 2019
    - CY 2018: at least 90% for FY 2020

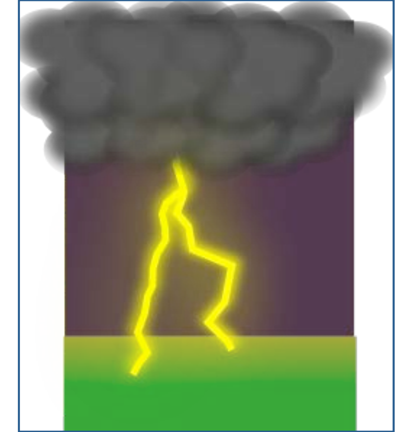
2% penalty

FY 2017 HQRP Updates

- Agencies may request extension/exemption for reporting HIS data without payment reduction penalty:
  - Within 30 days of **extraordinary circumstances** beyond the provider's control.
  - By email only to HospiceQRPReconsiderations@cms.hhs.gov .

FY 2017 HQRP Updates

- Extensions for and exemptions from submitting HIS data allowed only:
  – In extraordinary circumstances:
    - Natural or man-made disasters preventing timely submission of quality data
      – Widespread or affecting multiple structures
      – Isolated and affecting a single site only
  – Extension/exemption requests must:
    - Be for a specified time period
    - Comply with all criteria listed at CMS' HQRP Extensions and Exemptions Request web page.



FY 2017 HQRP Updates

- HIS data will be accessible to hospices via CASPER prior to public reporting for:
    1. Hospice and Palliative Care Composite Process Measure – Comprehensive Assessment at Admission
    2. Hospice Visits When Death is Imminent
- CAHPS®:
    - Includes standard survey administration protocols that allow for fair comparisons across hospices
    - Current survey to continue

Medicare.gov | Hospice compare

The Official U.S. Government Site for Medicare

FY 2017 HQRP Updates

- Hospices with **< 50** survey-eligible decedents/ caregivers may apply annually for exemption from CAHPS® Hospice Survey data collection & reporting requirements to avoid payment penalties.
- Hospices that receive CNN after 1/1/17 are exempt from FY 2019 APU Hospice CAHPS® requirement.
- Consider that **CAHPS® information can inform QAPI** in valuable ways.

< 50 DECEDENTS/CAREGIVERS

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From HIS Manual Section A

ADMINISTRATIVE INFORMATION

Section A: Administrative Information

A0050: Type of Record

Enter Code

1. Add new record
2. Modify existing record
3. Inactivate existing record

A0100: Facility Provider Numbers. Enter code in boxes provided.

A. National Provider Identifier (NPI):

B. CMS Certification Number (CCN):

A0205. Site of Service at Admission

Enter Code

01. Hospice in patient's home/residence
02. Hospice in Assisted Living facility
03. Hospice provided in Nursing Long Term Care (LTC) or Non-Skilled Nursing Facility (NF)
04. Hospice provided in a Skilled Nursing Facility (SNF)
05. Hospice provided in Inpatient Hospital
06. Hospice provided in Inpatient Hospice Facility
07. Hospice provided in Long Term Care Hospital (LTCH)
08. Hospice in Inpatient Psychiatric Facility
09. Hospice provided in a place not otherwise specified (NOS)
10. Hospice home care provided in a hospice facility

A0220. Admission Date

Month Day Year

- No change in data collection for most administrative information items.
  - Enter correct number to code response.
  - Numbers and dates begin at left, leaving no blank boxes unless otherwise specified.

Section A: Administrative Information

- A0245:

A0245. Date Initial Nursing Assessment Initiated			
	Month	Day	Year

  - Date the RN began the initial assessment.
    - If not initiated before patient DC = a dash (-) in each box.

A0250. Reason for Record	
Enter Code	01. Admission 09. Discharge

A0270. Discharge Date			
	Month	Day	Year

- If A0250 = 09, HIS-Discharge:
  - Enter date patient was discharged from hospice.
  - If patient died, death date is discharge date.
  - If live discharge, indicate, as applicable:
    - The date patient revoked hospice benefit.
    - The date hospice discharged the patient.

Section A: Administrative Information

A0500. Legal Name of Patient

A. First name:

B. Middle initial:

C. Last name:

D. Suffix:

- Enter the patient's name as it appears on the Medicare card or other government document.
  - Check spelling to avoid creating a new record for a patient.

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

Patient ZIP Code:

-

- New **in HIS version 2.00.**
  - ZIP code + 4 of patient's residence while receiving hospice services.
  - Enter at least 5 numbers, beginning at left.
  - Leave final 4 boxes blank if numbers are unknown.

Section A: Administrative Information

A0600. Social Security and Medicare Numbers

A. Social Security Number:

B. Medicare number (or comparable railroad insurance number):

- A0600 A. Social Security Number:
  - Leave blank if patient has no SSN.
- A0600 B. Medicare or RRB Number:
  - Enter exactly as on ID card.
  - Also called HIC #.
  - Name on ID card & HIS record must match.

A0700. Medicaid Number. Enter "+" if pending, "N" if not a Medicaid Recipient.

- A0700 Medicaid Number:
  - Enter Medicaid number, if applicable, even if patient has other payer.
  - Enter “+” in first box if Medicaid is pending.
  - Enter “N” in first box if patient has no Medicaid.
  - Confirm legal name matches that on Medicaid card.
  - Leave blank if unknown, or patient refuses to provide.

Section A: Administrative Information

A0800. Gender

Enter Code

1. Male
2. Female

Item-Specific Instructions

A0800. Gender

- **Code 1, Male:** Select code 1 if patient is male.
- **Code 2, Female:** Select code 2 if patient is female.

A0900. Birth Date

Month Day Year

A1000. Race/Ethnicity

↓ **Check all that apply**

- A. American Indian or Alaska Native
- B. Asian
- C. Black or African American
- D. Hispanic or Latino
- E. Native Hawaiian or Other Pacific Islander
- F. White

A1802. Admitted From. Immediately preceding this admission, where was the patient?

Enter Code

01. Community residential setting (e.g., private home/apt., board/care, assisted living, group home, adult foster care)
02. Long-term care facility
03. Skilled Nursing Facility (SNF)
04. Hospital emergency department
05. Short-stay acute hospital
06. Long-term care hospital (LTCH)
07. Inpatient rehabilitation facility or unit (IRF)
08. Psychiatric hospital or unit
09. ID/DD Facility
10. Hospice
99. None of the above

A2115. Reason for Discharge

Enter Code

01. Expired
02. Revoked
03. No longer terminally ill
04. Moved out of hospice service area
05. Transferred to another hospice
06. Discharged for cause

- A0800 Gender
- A0900 Birth Date

- A1000 Race/Ethnicity:
  - Mark all that apply.

- Enter two-digit code that best describes the patient's environment immediately before admission to hospice services.

- Complete only if A0250 = 09, Discharge.

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From HIS Manual Section Z

RECORD ADMINISTRATION

Section Z: Record Administration

- Section Z records signatures of staff members who complete the HIS, and who verify its accuracy.
- Providers must complete and retain Section Z for future reference:
  - According to hospice's policies and procedures
  - For future reference
- Not submitted as part of HIS

Section Z: Record Administration

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

I certify that the accompanying information accurately reflects patient assessment information for this patient and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that reporting this information is used as a basis for payment from federal funds. I further understand that failure to report such information may lead to a 2 percentage point reduction in the Fiscal Year payment determination. I also certify that I am authorized to submit this information by this provider on its behalf.

Signature	Title	Sections	Date Section Completed
A.			
B.			
C.			
D.			

- Item Z0400:
  - Tracking log for information in the HIS
  - Signatures attest that the signer:
    - Was authorized to collect/ document HIS information
    - Completed specified items/sections of HIS
    - Provided information that accurately reflects clinical record documentation

Section Z: Record Administration

Z0500. Signature of Person Verifying Record Completion	
A. Signature:	B. Date: Month / Day / Year

- Item Z0500:
  - Documents that Z0400 indicates that every HIS section is complete
    - Not that each section of the HIS is accurate
  - Sign at Z0500A
  - Enter signature date at Z0500B

SECTION I:
ACTIVE DIAGNOSES

Section I: Active Diagnoses

I0010. Principal Diagnosis	
Enter Code	01. Cancer 02. Dementia/Alzheimer's 99. None of the above

- Addresses most common terminal diagnoses
  - Enter code for only the **principal diagnoses**
    - Most contributory to 6-month life expectancy
    - Chiefly responsible for hospice admission
  - Must match clinical record **at hospice admission**
    - Certificate of Terminal Illness (CTI)
    - Notice of Election (NOE)
    - Plan of care (POC)

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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	• Treatment Preferences (NQF #1641). • Beliefs/Values Addressed (if desired by patient) (NQF #1647).
J: Health Conditions	• Pain Screening (NQF #1634). • Pain Assessment (NQF #1637). • Dyspnea Screening (NQF #1639). • Dyspnea Treatment (NQF #1638).
N: Medications	• Patients Treated with an Opioid Who Are Given a Bowel Regimen (NQF #1617).

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

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.

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

Numerator = All patient stays from the denominator in which the patient meets the numerator criteria for all of the individual component QMs for which the patient is eligible.

Denominator = All patient stays (except for those that meet the exclusion criteria).

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.

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***.

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SECTION F: PREFERENCES

Section F: Preferences (F2000 CPR)

- Asks whether hospice discussed CPR use preference with the patient/responsible party.
  - Expressing life-sustaining treatment preferences improves patient and family satisfaction with care.
  - A hospice patient's preference may change as does the patient's condition.
    - If prior DNR or POLST exists, must re-affirm patient's preference.

Section F: Preferences (F2000 CPR & F2100 Other LST)

F2000. CPR Preference

Enter Code

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

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

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

- OK to include discussion at pre-admission as well as during admission, based on clinical record.
- If multiple discussions appear in documentation, enter the date of the earliest discussion.
- Examples of other LST include ventilator support, tube feeding, dialysis, blood transfusion, antibiotics, and IV fluids

Section F: Preferences (F2200 Hospitalization & F3000 Spiritual/Existential Concerns)

F2200. Hospitalization Preference

Enter Code

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

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

- Choose correct response as with prior items in Section F.
- F2200 excludes GIP and Respite levels of hospice care.
- F3000A religious affiliation inadequate to code “Yes.”
- Caregiver need not be legally authorized representative.

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SECTION J: HEALTH CONDITIONS PAIN & RESPIRATORY STATUS

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***.

J0900. Pain Screening

J0900. Pain Screening

Enter Code [ ] **A. Was the patient screened for pain?**
0. No → Skip to J0905, Pain Active Problem
1. Yes

B. Date of first screening for pain:
Month / Day / Year

Enter Code [ ] **C. The patient's pain severity was:**
0. None
1. Mild
2. Moderate
3. Severe
9. Pain not rated

Enter Code [ ] **D. Type of standardized pain tool used:**
1. Numeric
2. Verbal descriptor
3. Patient visual
4. Staff observation
9. No standardized tool used

Section J: Pain

- **J0900**: **Did the RN screen the patient for pain?**
  A. During the initial nursing assessment?
  B. Within 2 days of the admission date?
  C. Rank the pain's severity at patient's **highest pain level** during screening visit.

J0900. Pain Screening

J0900. Pain Screening

Enter Code [ ]

A. Was the patient screened for pain?
0. **No** → Skip to J0905, Pain Active Problem
1. **Yes**

B. Date of first screening for pain:

[ ][ ] Month [ ][ ] Day [ ][ ][ ][ ] Year

Enter Code [ ]

C. The patient's pain severity was:
0. None
1. Mild
2. Moderate
3. Severe
9. Pain not rated

Enter Code [ ]

D. Type of standardized pain tool used:
1. Numeric
2. Verbal descriptor
3. Patient visual
4. Staff observation
9. No standardized tool used

Section J: Pain

- **J0900**: **Did the RN screen the patient for pain?**

  D. Using a standardized tool?

  – Enter code for type of standardized pain tool used.

  4. Staff observational scales:

     - Critical Care Pain Observation Tool (CPOT)
     - Checklist of Nonverbal Pain Indicators (CNPI)
     - Pain Assessment Checklist for Seniors with Limited Ability to Communicate (PACSLAC)
     - Pain Assessment in Advanced Dementia (PAIN-AD).

J0900. Pain Screening

J0900. Pain Screening

Enter Code

A. Was the patient screened for pain?
0. **No** → Skip to J0905, Pain Active Problem
1. **Yes**

B. Date of first screening for pain:

Month Day Year

Enter Code

C. The patient's pain severity was:
0. None
1. Mild
2. Moderate
3. Severe
9. Pain not rated

Enter Code

D. Type of standardized pain tool used:
1. Numeric
2. Verbal descriptor
3. Patient visual
4. Staff observation
9. No standardized tool used

Section J: Pain

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

- **J0905: Is pain an active problem?**
  - **New in HIS version 2.00**
  - Planned for future measure refinement of existing quality measures
  - Added to better align with clinical practice
    - Does screening show that pain needs intervention?
    - Providers gave input in the past 2 years requesting this item that applies screening results to patient care.

Section J: Pain

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

- **J0905: Is pain an active problem?**
  - Documentation that the patient is taking pain medication is sufficient evidence of active pain
  - The RN may determine pain is active:
    - Based on patient-specific assessment findings
    - Even if not present at the time of assessment

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).

Section J: Pain

- **J0910: Comprehensive Pain Assessment**
  - If pain screen is positive, did the clinician perform a comprehensive pain assessment?
  - Select all that apply from the options listed.
    - Mark each one for which the clinician documented ***an attempt*** to gather the information
      - **At least 5 of the 7 pain characteristics** listed
    - Report can be from the patient or **patient or caregiver**

J0910. Comprehensive Pain Assessment

Enter Code	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: Month / Day / Year
	C. Comprehensive pain assessment included:
↓ Check all that apply	
☐	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

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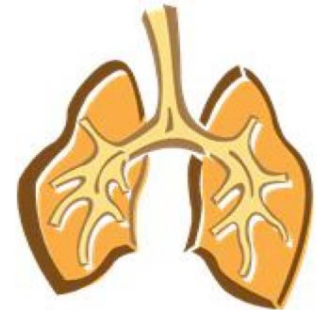
Calculation of the Composite Process Measure

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).

Section J: Respiratory Status

- Shortness of breath, or dyspnea:
  - Prevalent and undertreated in dying patients
  - Limit functional ability and cause distress
  - Screening captures presence & severity, facilitates treatment:
    - Pharmacologic or non-pharmacologic
    - Varies with:
      - Severity
      - Etiology
      - Patient/caregiver preferences



Section J: Respiratory Status

- **Key descriptors**: Shortness of breath, SOB, dyspnea, heavy breathing, tripod positioning, pursed lips, puffing, panting, pause to catch breath, unable to speak while exerting, etc.
- Evidence for extracting correct responses to **J2030** should consider any documented:
  - Historical report of the patient's dyspnea, even if not present during the assessment visit
  - Patient report of distress/trouble breathing
  - Clinical signs of dyspnea during screening visit
  - Dyspnea/SOB/shortness of breath limiting activity

J2030. Screening for Shortness of Breath

Enter Code ☐	**A. Was the patient screened for shortness of breath?** 0. **No** → Skip to N0500, Scheduled Opioid 1. **Yes**
	B. Date of first screening for shortness of breath: Month / Day / Year
Enter Code ☐	**C. Did the screening indicate the patient had shortness of breath?** 0. **No** → Skip to N0500, Scheduled Opioid 1. **Yes**

Section J: Respiratory Status

J2030. Screening for Shortness of Breath	
Enter Code ☐	**A. Was the patient screened for shortness of breath?** 0. **No** → Skip to N0500, Scheduled Opioid 1. **Yes**

- **J2030A:** “1. Yes” = documentation must show:
  - Evaluation for **presence or absence of dyspnea**, in any way clinically appropriate for the patient.
  - If the screening for shortness of breath found dyspnea (**J2030C**= “1. Yes”), and documentation specifies its severity, such as its effect on the patient’s quality of life, enter “1. Yes” at J2030A.
  - If screening found dyspnea/shortness of breath, but the documentation lacks its severity, enter “0. No”, and skip to N0500.

Section J: Respiratory Status

- **J2040B:** Dyspnea treatment initiation:
  - Date of **first** order received to begin or continue scheduled or PRN treatment for dyspnea, unless patient/caregiver instructed to begin treatment at a later date.
    - Written, or documented verbal order
    - Standing order OK only if performed
    - OK if medication ordered to also treat other symptoms

  OR

  - Date that the **first** non-medication intervention to treat dyspnea was performed
    - Such as fans, positioning, patient education, etc.

J2040. Treatment for Shortness of Breath

Enter Code [ ]

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:

Month [ ][ ] Day [ ][ ] Year [ ][ ][ ][ ]

C. Type(s) of treatment for shortness of breath initiated:

↓ **Check all that apply**

[ ]	1. Opioids
[ ]	2. Other medication
[ ]	3. Oxygen
[ ]	4. Non-medication

Section J: Respiratory Status

J2040. Treatment for Shortn
Enter Code
A. Was treatment
accurate respo
0. No → Skip
1. No, patien
Opioid
2. Yes
B. Date treatment
Month Da
C. Type(s) of trea
↓ Check all that apply
1. Opioids
2. Other medica
3. Oxygen
4. Non-medication

C. Type(s) of treatment for shortness of breath initiated:

↓ Check all that apply

- ☐ 1. Opioids
- ☐ 2. Other medication
- ☐ 3. Oxygen
- ☐ 4. Non-medication

- **J2040C: Treatment type(s) for SOB initiated**
  - Mark **all** treatments the record shows were **initiated on the date specified in J2040B** to treat dyspnea.
  - Only include treatments with intended purpose to treat SOB, even if also implemented to treat other symptoms.

Section J: Respiratory Status

J2040. Treatment for Shortn

Enter Code

A. Was treatment accurate respo

0. No → Skip
1. No, patien Opioid
2. Yes

B. Date treatment

Month Da

C. Type(s) of trea

↓ Check all that apply

1. Opioids
2. Other medica
3. Oxygen
4. Non-medication

C. Type(s) of treatment for shortness of breath initiated:
↓ Check all that apply
☐ 1. Opioids
☐ 2. Other medication
☐ 3. Oxygen
☐ 4. Non-medication

- **J2040C: Treatment type(s) for SOB initiated**
  1. Opioids
     - If the patient received opioids documented as treatment for shortness of breath, even when also prescribed for other reason(s), such as pain control.
     - Requires order received by hospice

Section J: Respiratory Status

J2040. Treatment for Shortn

Enter Code

A. Was treatment accurate respo

0. No → Skip
1. No, patien Opioid
2. Yes

B. Date treatment

Month Da

C. Type(s) of trea

↓ Check all that apply

☐	1. Opioids
☐	2. Other medica
☐	3. Oxygen
☐	4. Non-medication

C. Type(s) of treatment for shortness of breath initiated:

↓ Check all that apply

☐	1. Opioids
☐	2. Other medication
☐	3. Oxygen
☐	4. Non-medication

- **J2040C: Treatment type(s) for SOB initiated**

  2. Other Medications

  – Clinical record must specify purpose(s) of all meds.

  – Common meds to treat dyspnea include bronchodilators, inhaled corticosteroids, oral steroids, diuretics, benzodiazepines.

    - Sometimes prescribed for other symptoms as well
    - Record must state that an intention of the medication is to treat SOB

Section J: Respiratory Status

	C. Type(s) of treatment for shortness of breath initiated:
↓ Check all that apply	
☐	1. Opioids
☐	2. Other medication
☐	3. Oxygen
☐	4. Non-medication

- **J2040C: Treatment type(s) for SOB initiated**

  3. Oxygen

     - If oxygen was initiated on the date specified in J2040B

  4. Non-medication implemented, at least in part, to treat dyspnea

     - For example, fans, positioning, relaxation techniques, and education about energy conservation

SECTION N: MEDICATIONS

Noyce Consulting

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).

Section N: Medications

N0500. Scheduled Opioid

Enter Code	
☐	**A. Was a scheduled opioid initiated or continued?** 0. **No** → Skip to N0510, PRN Opioid 1. **Yes** **B. Date scheduled opioid initiated or continued:** Month Day Year

N0510. PRN Opioid

Enter Code	
☐	**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

- Code "1. Yes" for an opioid:
  - At **N0500A** if an order exists for a **scheduled opioid**;
  - At **N0510A** if an order exists for a **PRN opioid**.
- Enter the verbal (when permitted) or written order date at N0500B and N0510B.
  - Not the first-dose date.
- Code "0. No" if no such order is found.
  - Follow the skip pattern.

Section N: Medications

- **Skip N0520 if the patient is not receiving opioid therapy.**

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

- Bowel regimen or its clinical contraindication…
  - Can appear as any reference to avoiding constipation
  - Found in various parts of patient record
  - May require thorough chart review to determine accurate responses for N0520
  - Consult with clinician if unsure of correct response

Section N: Medications

- Bowel regimen element examples, which if mentioned as part of bowel program, either scheduled or PRN, qualify to code “2. Yes” at **N0520A**:
  - Laxatives or stool softeners
  - High fiber supplements
  - Enemas
  - Suppositories
  - Dietary & hydration intervention
  - Exercise

Section N: Medications

- Bowel regimen contraindication examples qualify to code "1. No but there is documentation of why bowel regimen was not initiated or continued" at **N0520A**:
  - Bowel obstruction/ileus
  - Diarrhea
  - No bowel function
  - Colostomy/ileostomy
  - Nausea/vomiting
  - Recent abdominal surgery
  - NPO/taking nothing by mouth
  - Patient offered bowel regimen, but refused treatment

Noyce Consulting

Hospice Visits When Death is Imminent

SECTION O:
SERVICE UTILIZATION

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

- CMS:
  - "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 and increased need for care."
    - Conference on Hospice: HIS-Based Quality Measures, January 2017

Section O: Service Utilization

- Complete Section O only if patient was discharged due to death.
  - A2115 = 01, Expired.
- Includes two measures of hospice visits when death is imminent.
  - **Measure 1** addresses case management and clinical care.
  - **Measure 2** gives providers the flexibility to provide individualized care that is in line with the patient, family, and caregiver's preferences and goals for care and contributing to the overall well-being of the individual and others important in their life.

Section O: Service Utilization

- If patient was not receiving hospice services on any day during the timeframe identified, enter a zero on the row for each discipline for that day.

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	☐	☐	☐
B. Physician (or Nurse Practitioner or Physician Assistant)	☐	☐	☐
C. Medical Social Worker	☐	☐	☐
D. Chaplain or Spiritual Counselor	☐	☐	☐
E. Licensed Practical Nurse	☐	☐	☐
F. Aide	☐	☐	☐

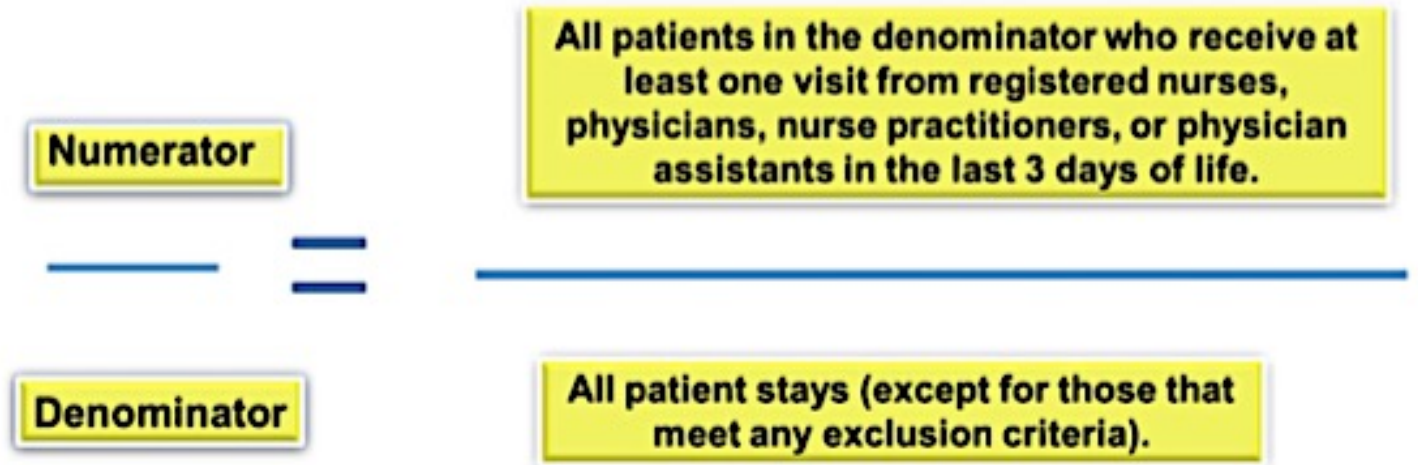
O5030. Number of hospice visits in 3 to 6 days prior to death

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	☐	☐	☐	☐
B. Physician (or Nurse Practitioner or Physician Assistant)	☐	☐	☐	☐
C. Medical Social Worker	☐	☐	☐	☐
D. Chaplain or Spiritual Counselor	☐	☐	☐	☐
E. Licensed Practical Nurse	☐	☐	☐	☐
F. Aide	☐	☐	☐	☐

Section O: Service Utilization

- Measure 1 included in Hospice Compare calculation of Hospice Visits When Death is Imminent if:
  - Patient discharged dead
  - Patient received only routine home care hospice services during the final 3 days of life



Section O: Service Utilization

- Final 3 days of life: Any CHC, GIP, or Respite?

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

  – If hospice care < 3 days before death, base response on hospice-enrolled days.
  – If yes, skip to Z0400.
  – If no, go to O5010.

Section O: Service Utilization

- Enter the number (0 – 9) of visits from each discipline provided on each of the final three days.
  - Day of death (A0270) and two days prior
  - In-person visits to patient & to family while patient lives
  - Provided by a hospice-affiliated person, paid or unpaid

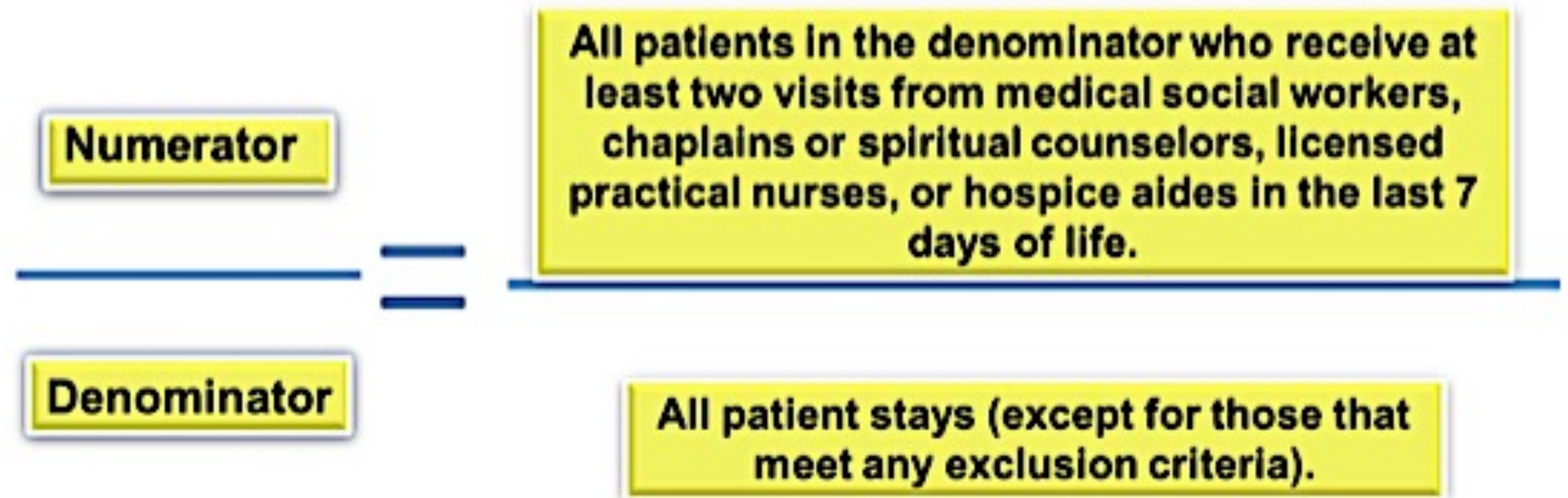
O5010. Number of hospice visits in final 3 days

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	☐	☐	☐
B. Physician (or Nurse Practitioner or Physician Assistant)	☐	☐	☐
C. Medical Social Worker	☐	☐	☐
D. Chaplain or Spiritual Counselor	☐	☐	☐
E. Licensed Practical Nurse	☐	☐	☐
F. Aide	☐	☐	☐

Section O: Service Utilization

- Measure 2 included in Hospice Compare calculation of Hospice Visits When Death is Imminent if:
  - Patient is discharged dead
  - Patient received only routine home care hospice services during the final 7 days of life
  - LOS was > 1 day



Section O: Service Utilization

- Final 7 days of life: Any CHC, GIP, or Respite?

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

  - If hospice care < 7 days before death, base response on hospice-enrolled days.
  - If yes, skip to Z0400.
  - If no, go to O5030.

Section O: Service Utilization

- Enter the number (0 – 9) of visits from each discipline provided on each final day # 4-7.
  - Day of death (A0270) is day 1
  - In-person visits to patient & to family while patient lives
  - Provided by a hospice-affiliated person, paid or unpaid

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	☐	☐	☐	☐
B. Physician (or Nurse Practitioner or Physician Assistant)	☐	☐	☐	☐
C. Medical Social Worker	☐	☐	☐	☐
D. Chaplain or Spiritual Counselor	☐	☐	☐	☐
E. Licensed Practical Nurse	☐	☐	☐	☐
F. Aide	☐	☐	☐	☐

Hospice Quality Updates

- CMS uses HQRP data to:
  - Inform further hospice payment reform
  - Identify whether beneficiaries and their families receive hospice care as intended
  - Identify hospice providers not using the hospice benefit correctly
    - For example, as a long-term care solution for seniors ineligible for home health

References

- FY 2017 Hospice Proposed & Final Rules
- FY 2015 & 2016 Hospice Final Rules
- R3378CP
- https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Extensions-and-Exemption-Requests.html
- NAHC.org
- MBPM Chapter 9
- Hospice Item Set CMS Web page
- HIS Manual by CMS
- HIS Fact Sheet
- Hospice Quality Reporting Web Page

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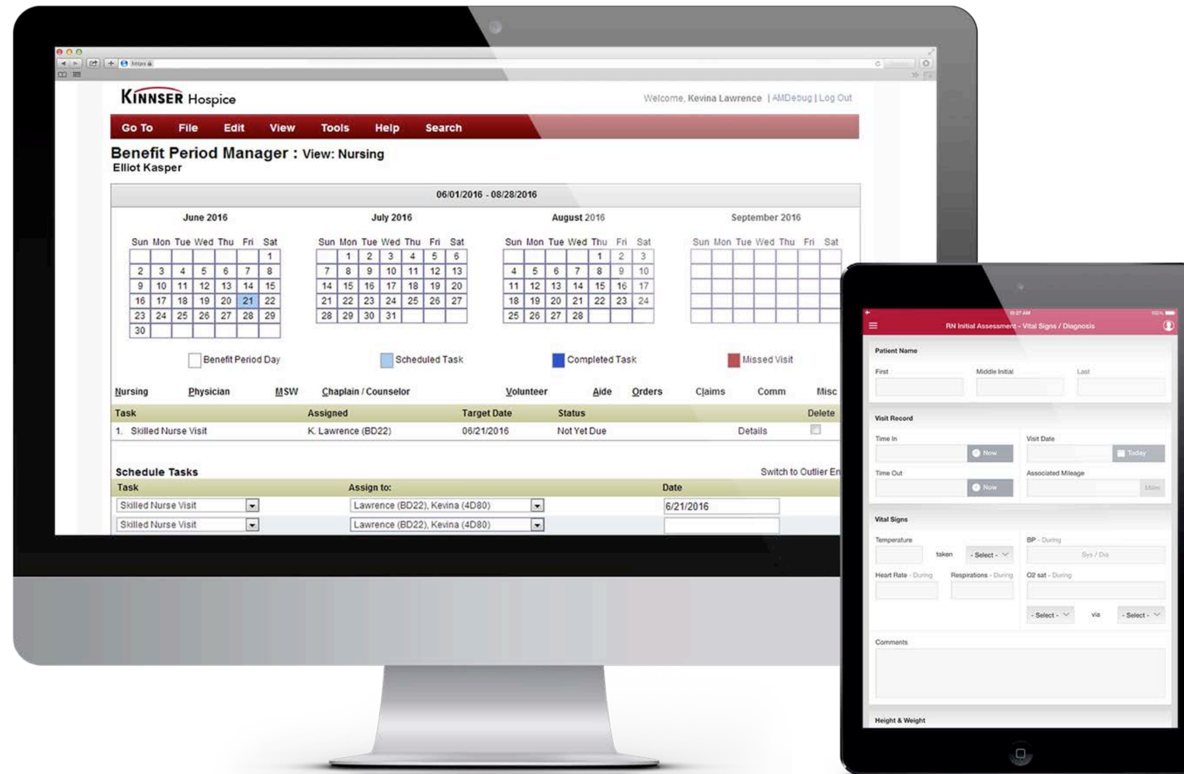

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