WEBINAR
HOSPICE

Optimizing Your Success with the New

HIS Measures

with

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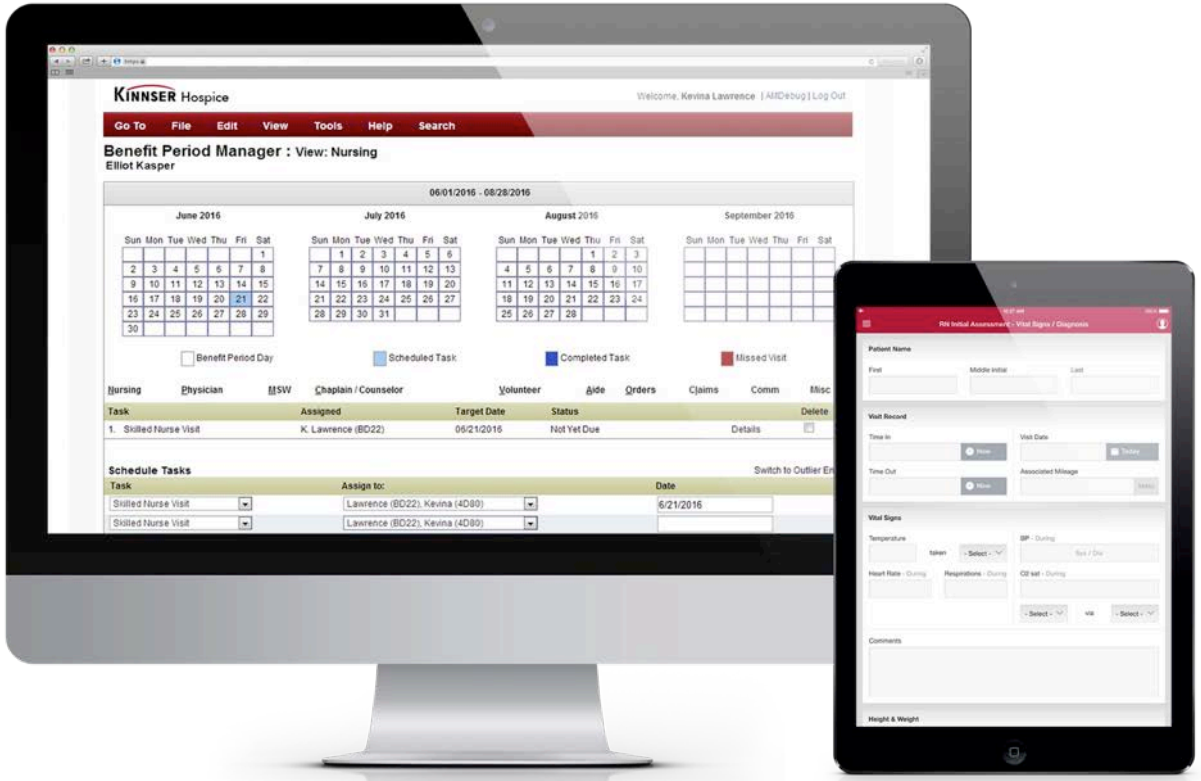

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About the presenter

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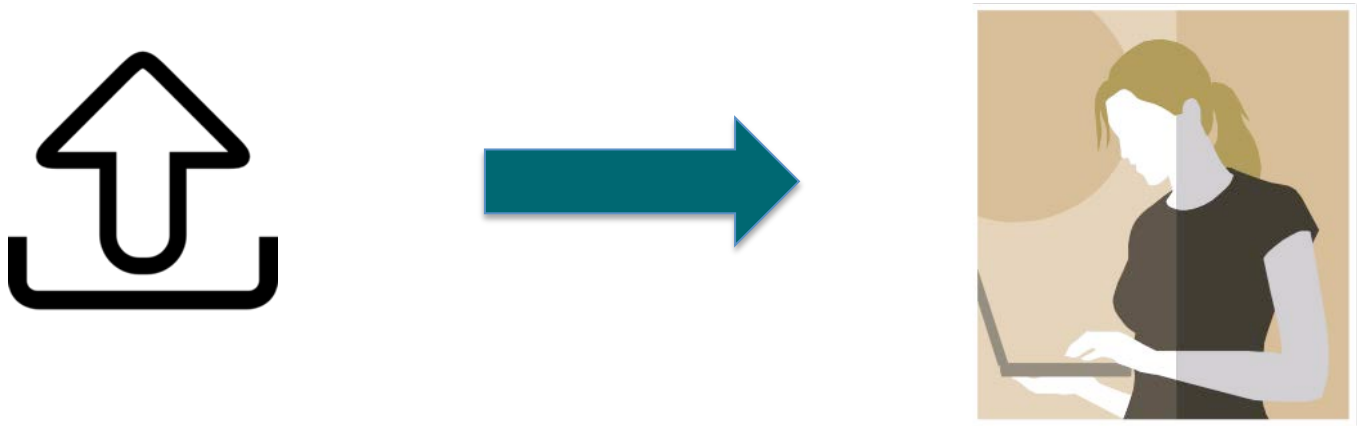
What is HIS V2.00?

- CMS's current data-capture tool for process measures at admit and discharge, as of April 1, 2017, for all admits and discharges
  - Will inform hospice Certification And Survey Provider Enhanced Reports (CASPER)



What is HIS V2.00?

- HIS V2.00 will provide data for public reporting.
  - Hospice Compare online
    - Consumer website
    - Late summer 2017

What is the HIS?

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

What is the HIS?

- A measure of hospice agency adherence to best practice processes
- A source of information for regulatory bodies scrutinizing hospices to find and prevent Medicare fraud and abuse

What is the HIS?

Table 1: Quality Measures Calculated Using the HIS

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

- Currently, data extracted from patient record by any hospice staff member:
  - 7 national quality forum-endorsed measures
  - 2 utilization measures
- Future:
  - 7 NQF items will combine for “Comprehensive Assessment at Admission” score on Hospice Compare site
  - 2 utilization measures will combine for “Hospice Visits When Death is Imminent” score
  - Along with HCAHPS© will contribute to 5-star rating
  - Part of a clinical assessment tool

Apply to all current HIS – new and old

HIS CONVENTIONS

HIS Conventions

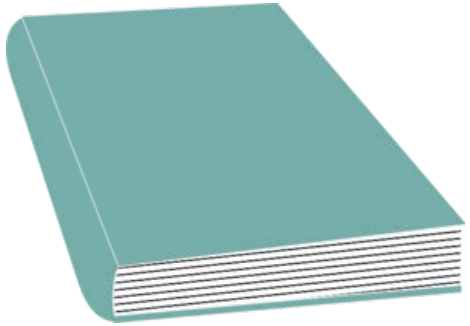
- For now, the same rules apply to both familiar and new items.
  - Watch for changes as the HIS evolves into a clinical assessment tool.
  - CMS will announce changes through future rule-making processes.
- Quick review of conventions . . .

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

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 an 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.
    - A “No” response will prompt the contributor to follow a defined skip pattern.

HIS Conventions

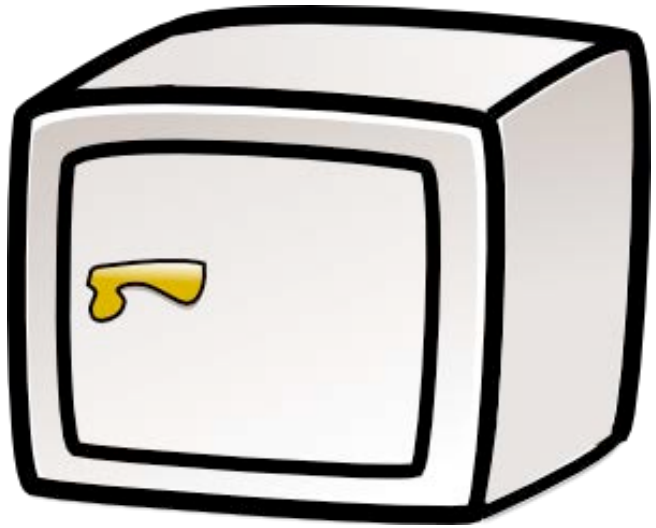
- Clinical record data extraction process at agency may…
  - Allow office personnel identify and extract from clinical assessment items the HIS information needed
  - Add verbatim HIS items to the clinical record/ patient assessments to allow for 1:1 extraction
    - Most common method for electronic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

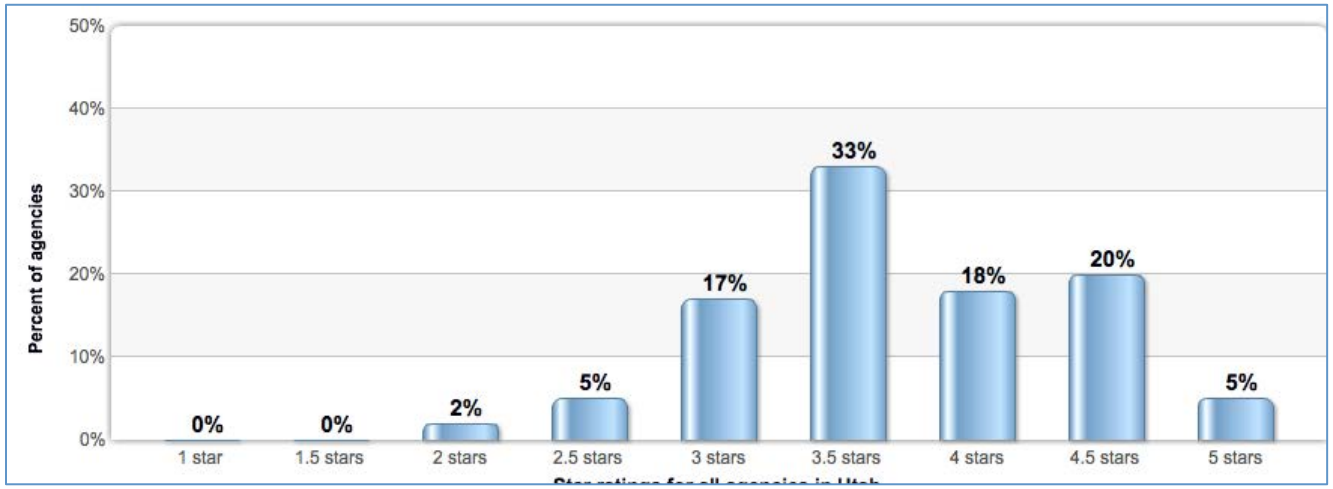
HIS Conventions

- Submit all complete HIS records electronically via QIES ASAP system
  - Within 30 days of the event
  - 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



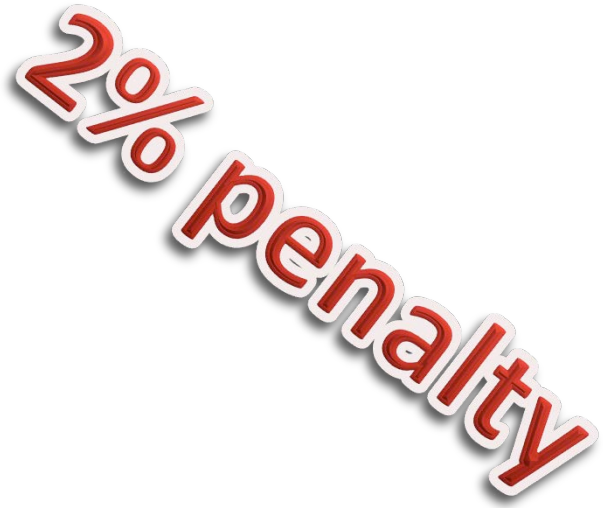


Financial penalties aren't the only reason

WHY REPORT NEW HIS?

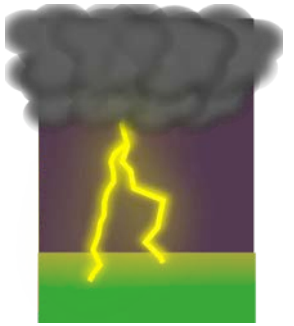
Why Report New HIS?

- Hospice Information Set (HIS):
  - Submission rates to HIS QIES ASAP and 30-day-from-event submission deadline must include new items to avoid 2% market basket update reduction two fiscal years later:
    - CY 2016: at least 70% for FY 2018
      - It's too late to avoid FY 2018 penalty.
    - CY 2017: at least 80% for FY 2019
      - There's still time for hospices who start now!
    - CY 2018: at least 90% for FY 2020
      - 90% is virtually ALL. Don't wait until 2018.



Why Report HIS?

- HIS reporting extension/exemption without payment reduction is allowed only…
  - When requested within 30 days of **extraordinary circumstances** beyond the hospice's control that prevent timely quality data submission, such as…
    - Natural disasters
    - Man-made disasters
  - For a specified time period, according to criteria listed at CMS' HQRP Extensions and Exemptions Request web page.



Why Report HIS?

- Studying HIS V.2.00 data submitted on and beyond 4.1.2017 will…
  - Give more feedback via CASPERs to hospice providers for QAPI programs
  - Allow CMS contractors to refine HIS in preparation for public reporting and for its future change to a clinical assessment tool
  - Continue giving the Office of Inspector General (OIG) information for its promised ongoing hospice scrutiny

Why Report HIS?

- Agency-specific CASPER reports will add more information for hospice QAPI activities to…
  - Improve patient care
  - Help hospices align goals with CMS- & OIG-stated goals to…
    - Ensure hospices are administering hospice benefit as intended
    - Reduce fraud and abuse of the Medicare hospice benefit
  - Allow agencies to dispute any scoring errors before **Hospice Compare** goes live

Medicare.gov | Hospice compare
The Official U.S. Government Site for Medicare

Why Report HIS?

- Eventually, Hospice Compare will (if all goes as planned) group the HIS into two categories with star ratings for Quality of Patient Care
  1. Hospice and Palliative Care Composite Process Measure – Comprehensive Assessment at Admission
  2. Hospice Visits When Death is Imminent

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Why Report HIS?

- Data of the first seven HIS measures for period of 10.1.2014 – 9.30.2015 were studied…
  - To establish scientific soundness in reliability and validity before proceeding with Hospice CASPERs and Hospice Compare
  - To provide actionable data for CASPERs to help hospices improve patient care
  - As basis for continued CMS contractor testing of reliability and validity using data that hospices continue to submit

12 MONTHS OF DATA

Why Report HIS?

- Now, CASPERs allow hospices to:
  - Compare agency processes to other hospices in the same state and in the nation
  - Enrich QAPI and compliance programs to improve patient care
  - Spot any miscalculated scores and contest before they affect scores published when **Hospice Compare** goes live

Why is this Important?

- The HQRP promotes the delivery of person-centered, high quality, and safe care by hospices.
- CMS has sought to adopt measures recommended by multi-stakeholder organizations and developed with the input of providers, purchasers and/or payers, and other stakeholders.

HIS V2.00 – effective April 1, 2017
as presented January 18, 2017 by CMS

NEW ITEMS IN HIS – ADMISSION

(OVERVIEW)

Hospice

Quality Reporting Program Provider Training

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

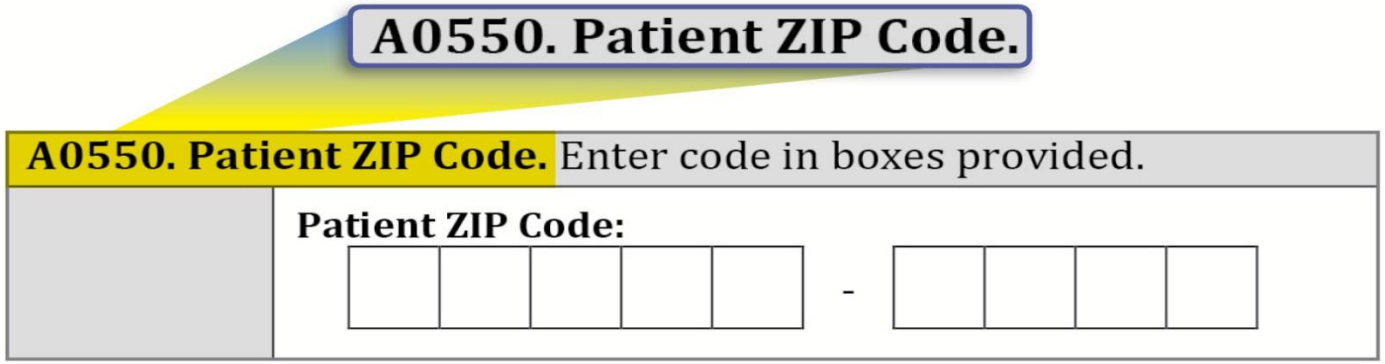
Presenters: Alexis Kirk, M.S.P.H., Jennifer Frank, M.P.H., and Franziska Rokoske, P.T., M.S.

Date: January 18, 2017

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



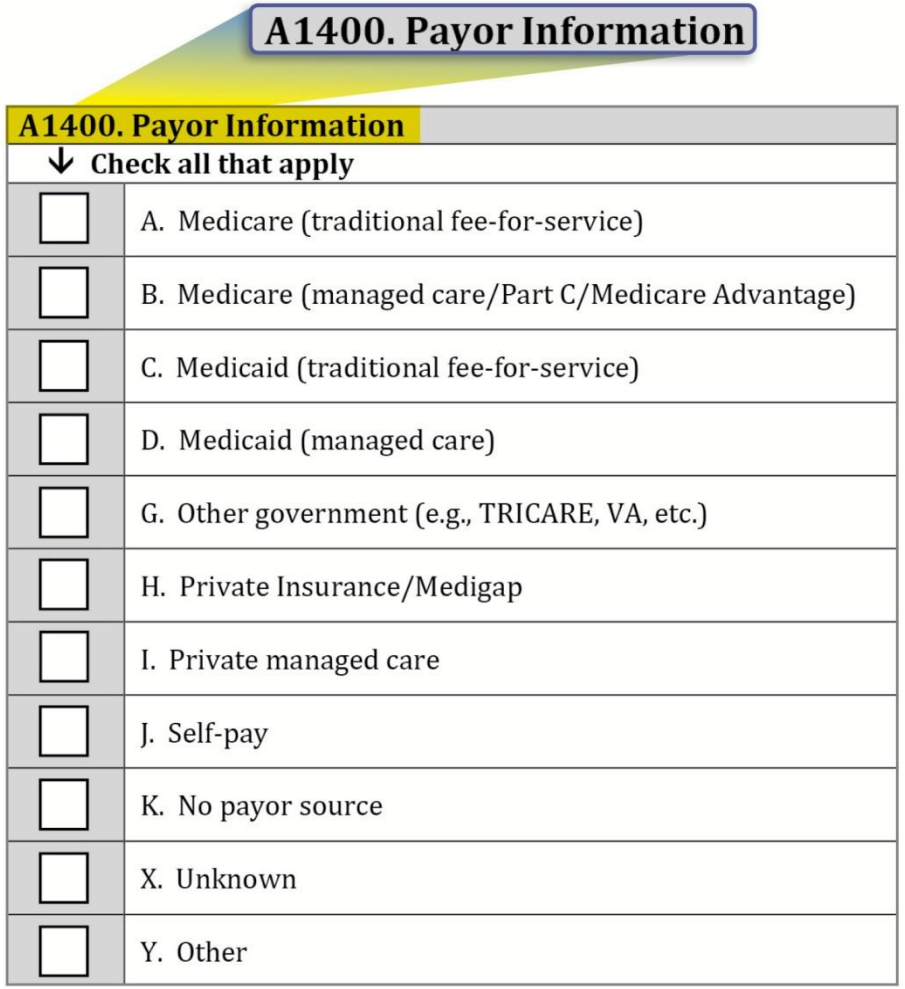
A0550. Patient ZIP Code

- 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



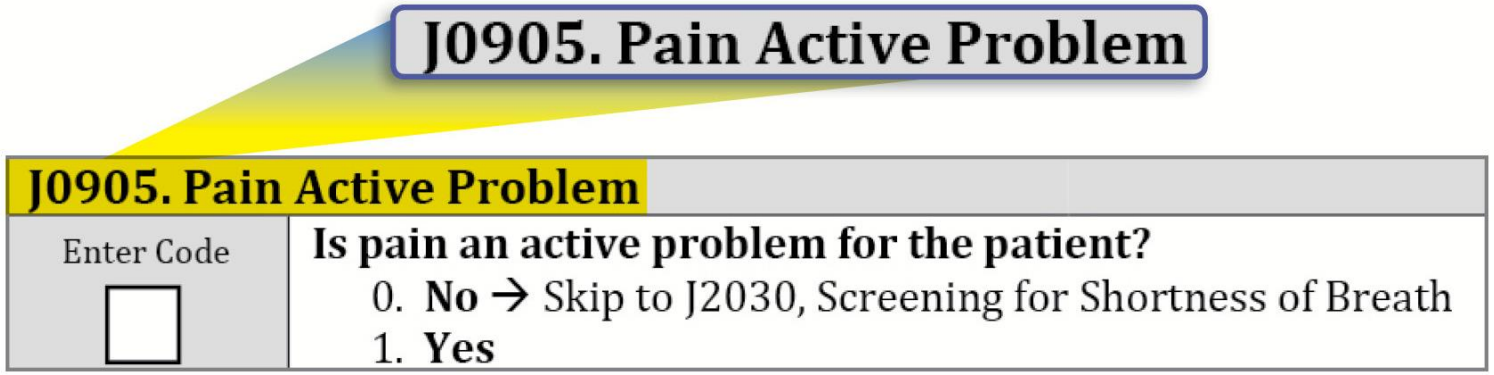
A1400. Payor Information

- 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

- 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.

Hospice and Palliative Care Composite Process Measure

COMPREHENSIVE ASSESSMENT AT ADMISSION

Same HIS measures, new application

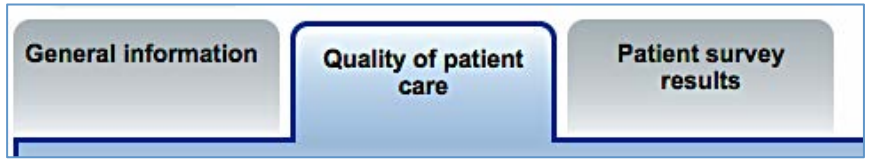
- Data collection for Preferences (F), Health Conditions (J), and (N) will have dual purposes:
  - Continue enriching CASPER data
  - Build database for Hospice Compare
- Initially scores for each measure will show how often the hospice followed each specific best-practice process
- Later, scores will combine to calculate a "Composite Measure" score
- Let's explore how that will likely work. . .

Same HIS measures, new application

- When Hospice Compare launches late this summer, if this timeline goal holds:
  - Most likely time period data scores to appear first are:
    - From the 7 NQF-endorsed, familiar HIS measures
    - Data collected throughout 2016
  - Quality of Patient Care

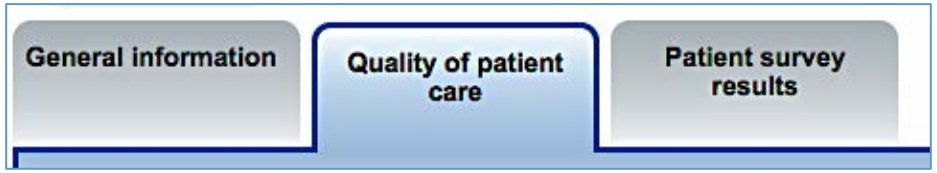
    Tab will display individual item scores
  - Patient Survey Results

    Tab will display Hospice CAHPS© results
  - No 5-star ratings for now



Same HIS measures, new application

- When Hospice Compare launches, **Quality of Patient Care** scores will be based on already-submitted data from hospices.
  - Remember, Hospice Compare will calculate data for an 12-month rolling period, updated quarterly
  - CASPERs available to agencies, with the data for 12 months, ending one quarter before CASPERs are available to hospices
  - CMS allows, before Hospice Compare updates…
    - 30 days for hospices to request recalculations
    - 60 days for any recalculations



Same HIS measures, new application

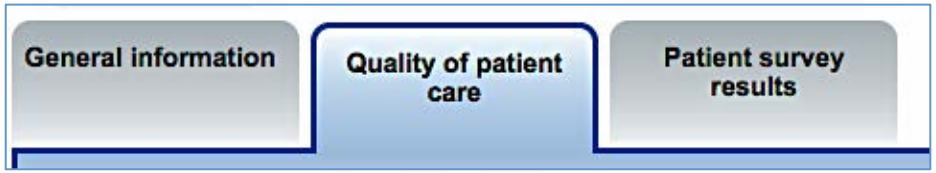
- Documentation now on each admit and discharge will affect the following:
  - CASPER scores 15 months into the future
  - Hospice Compare scores 18 months into the future
- Be sure the documentation, extraction and submission are accurate now.

Same HIS measures, new application

- Data collection processes for Preferences (F), Health Conditions (J), and (N) Medications need not change, but will soon be reported publicly.
  - Continue extracting data for the F, J, and N items
    - Data from a 12-month period ending at least 6 months before will post when Hospice Compare goes live, if CMS' "late summer" launch timeline holds
    - Will display individual item scores at first

Same HIS measures, new application

- At a future, undisclosed date, on Hospice Compare:



  - Quality of Patient Care Tab will display two values:
    - Hospice and Palliative Care Composite Process Measure – Comprehensive Assessment at Admission
    - Hospice Visits When Death is Imminent
      - » Potentially when 12 months of data are available – as soon as April 2018

  - The Patient Survey Results Tab will still display Hospice CAHPS® results
  - 5-star ratings will post for each

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).**

- Don’t worry. We’ll discuss this more in a little while.

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***.

Unconditional process measures: all admits count

SECTION F: PREFERENCES

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.

Section F: Preferences

- **Absence of a discussion of any one preference in** patient record documentation **decreases the agency's score** for how often the hospice…
  - Discusses the specific preference
    - When Hospice Compare initially goes live
  - Performs a comprehensive assessment at admission
    - Once the composite measure and star-ratings are implemented on Hospice Compare

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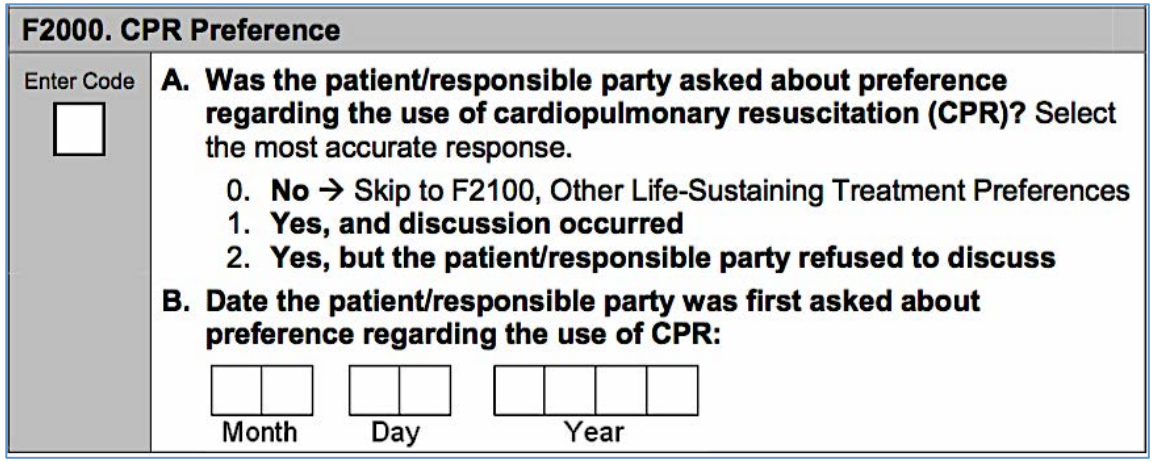
Section F: Preferences (F2000 CPR)

- Asks whether the hospice discussed with the patient/ responsible party whether the patient prefers CPR.
  - Giving patients/families a chance to express life-sustaining treatment preferences improves patient and family satisfaction with care



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

Section F: Preferences (F2100 Other LST)

- Include any discussion at pre-admission as well as during admission, based on the clinical record
  - Within allowed window **– 7 days prior to 5 days after admit**
- If multiple discussions appear in documentation**, enter the date of the earliest discussion** within the timeframe window.
- Examples of other LST include ventilator support, tube feeding, dialysis, blood transfusion, antibiotics, and IV fluids.

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.

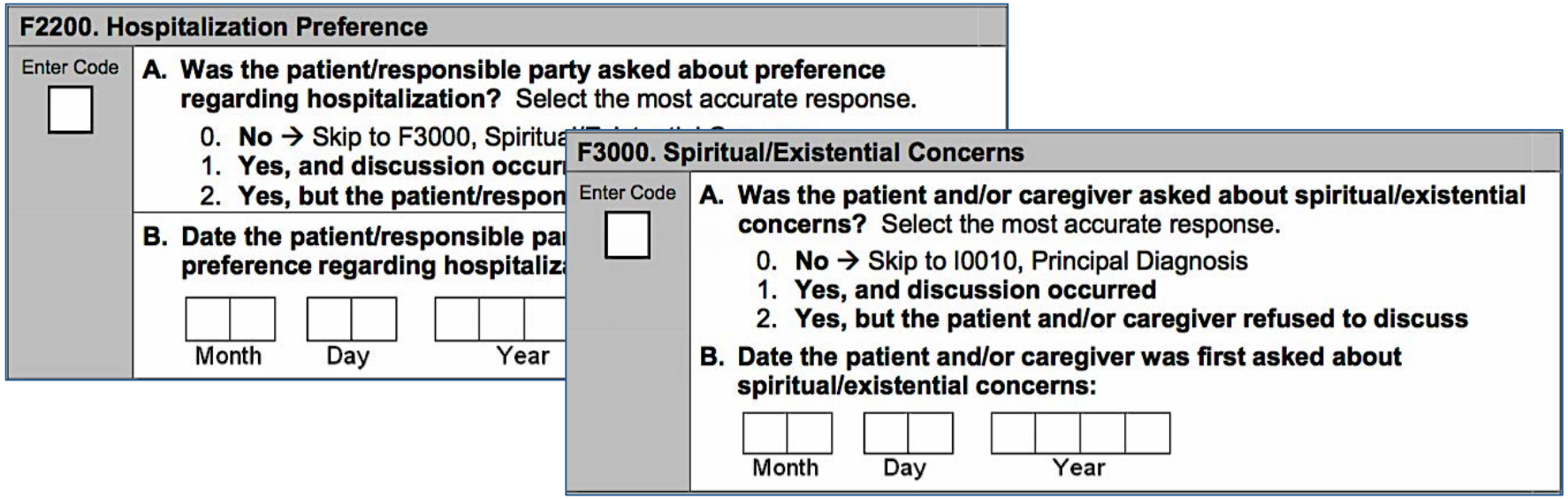
0. **No** → Skip to F2200, Hospitalization Preference
1. **Yes, and discussion occurred**
2. **Yes, but the patient/responsible party refused to discuss**

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

☐☐ Month ☐☐ Day ☐☐☐☐ Year

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, Spiritua
1. **Yes, and discussion occur**
2. **Yes, but the patient/respon**

B. Date the patient/responsible pa preference regarding hospitaliz

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 (hospitalization) **excludes GIP and Respite** levels of hospice care
- F3000A religious affiliation inadequate to code “Yes”
- Caregiver needn’t be legally authorized representative

Conditional process measures –
credit awarded if patient doesn't qualify

SECTION J: HEALTH CONDITIONS
PAIN & RESPIRATORY STATUS

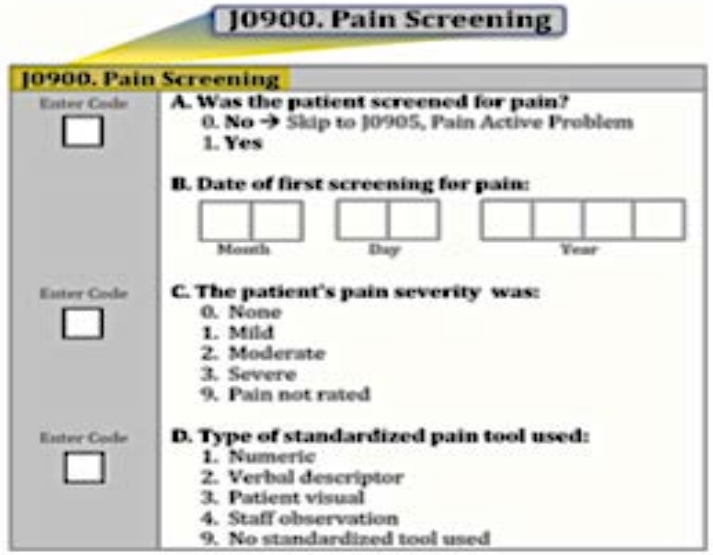
Section J: Pain

- Pain is prevalent and undertreated in dying patients.
- Patients and family caregivers rate pain management as a high priority when living with life-limiting illness.
  - Meaningful, relevant consumer information for Hospice Compare

- At Hospice Compare's launch, will appear as separate score.
- Its inclusion in "composite measure" calculation later is multi-factorial.

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***.



Section J: Pain

- Both elements must be present to include pain assessment in composite measure calculation:
  - Pain screening

  AND

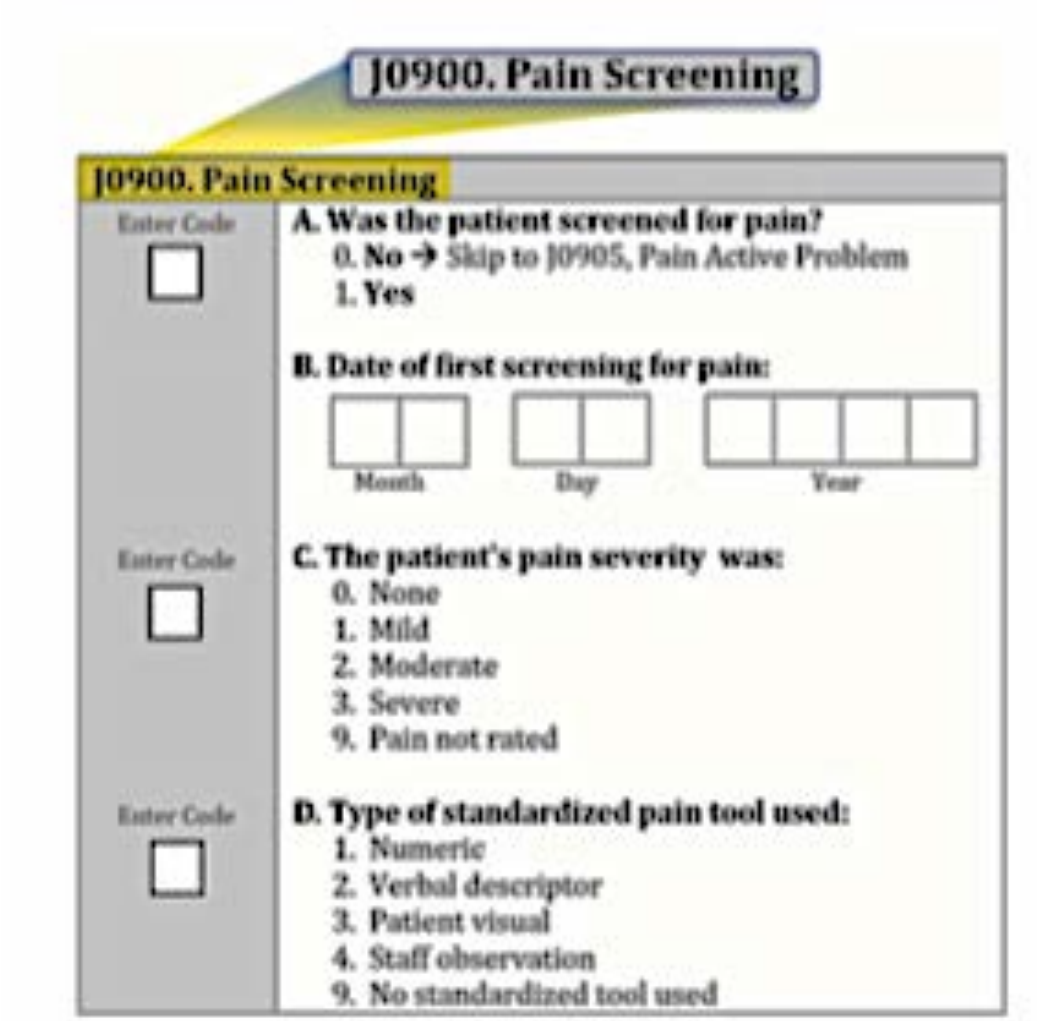
  - Either
    - Absence of pain

    OR

    - Comprehensive pain assessment

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.



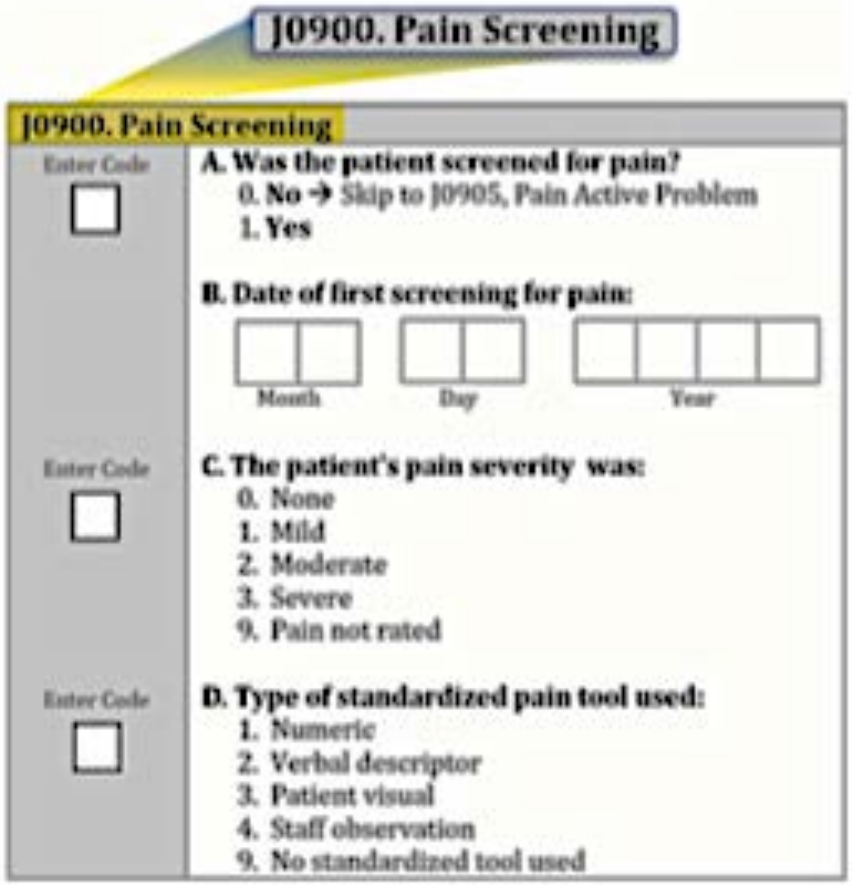
Section J: Pain

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

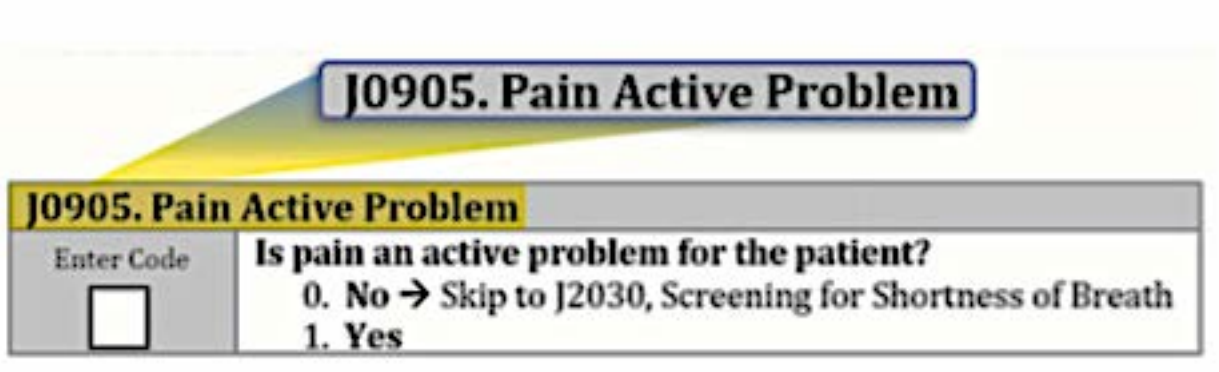
D. Using a standardized tool?

– Enter code 4 for any Staff observational scale used:

- 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)

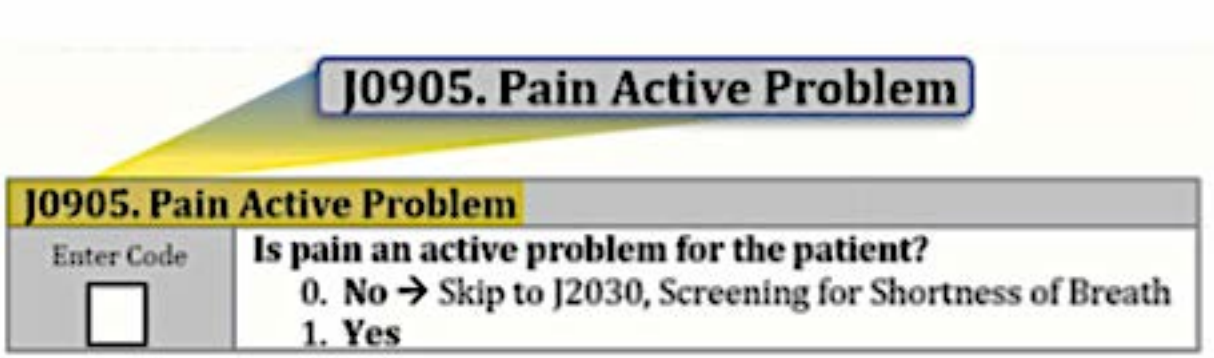


Section J: Pain



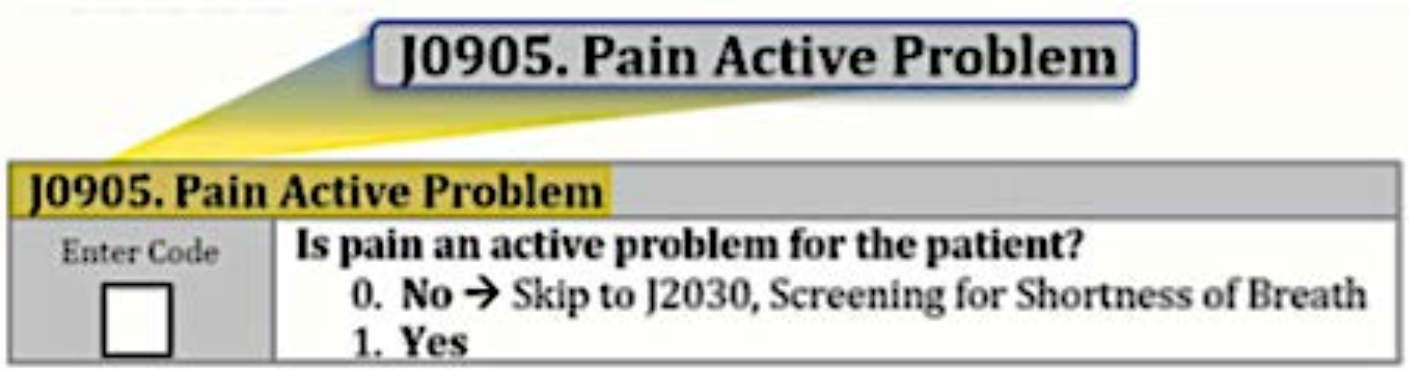
- **J0905: Is pain an active problem?**
  - **New in HIS version 2.00**
  - Planned for future measure refinement of existing quality measures

Section J: Pain



- **J0905: Is pain an active problem?**
  - 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



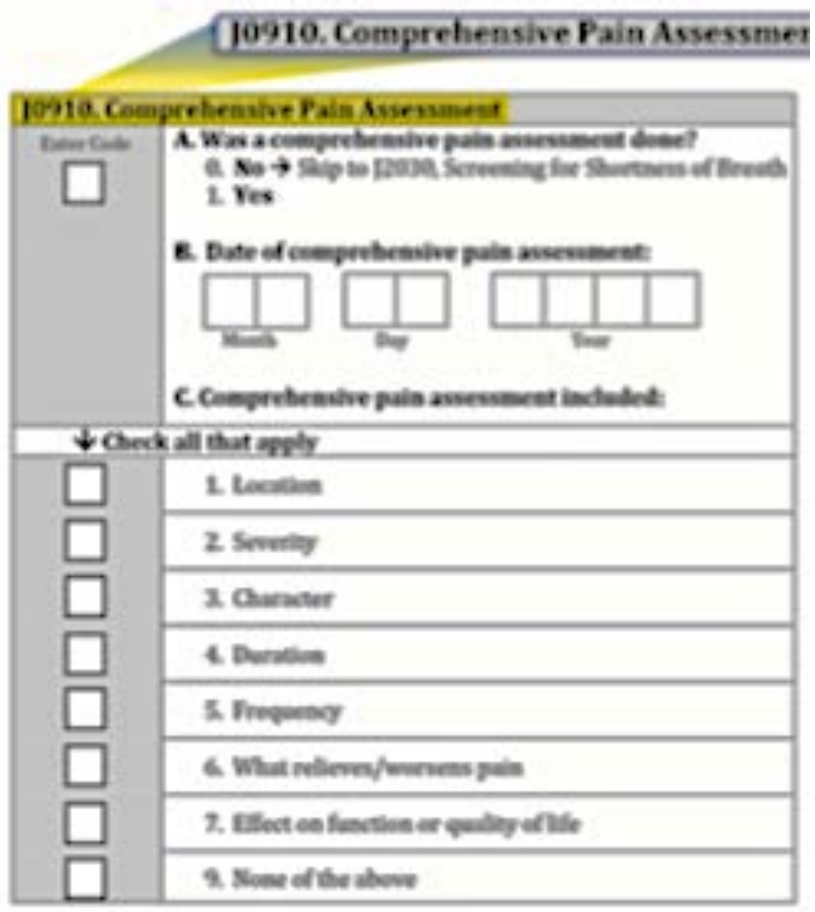
- **J0905: Is pain an active problem?**
  - Documentation that the patient is taking pain medication is sufficient evidence of active pain
  - The RN may determine pain is active:
    - Based on patient-specific assessment findings
    - Even if not present at the time of assessment

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 clinician perform a comprehensive pain assessment?
  - Pain assessment items aim to improve awareness of pain severity, etiology, and effect on function, which is the second step for quality pain management and treatment.


J0910. Comprehensive Pain Assessment

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

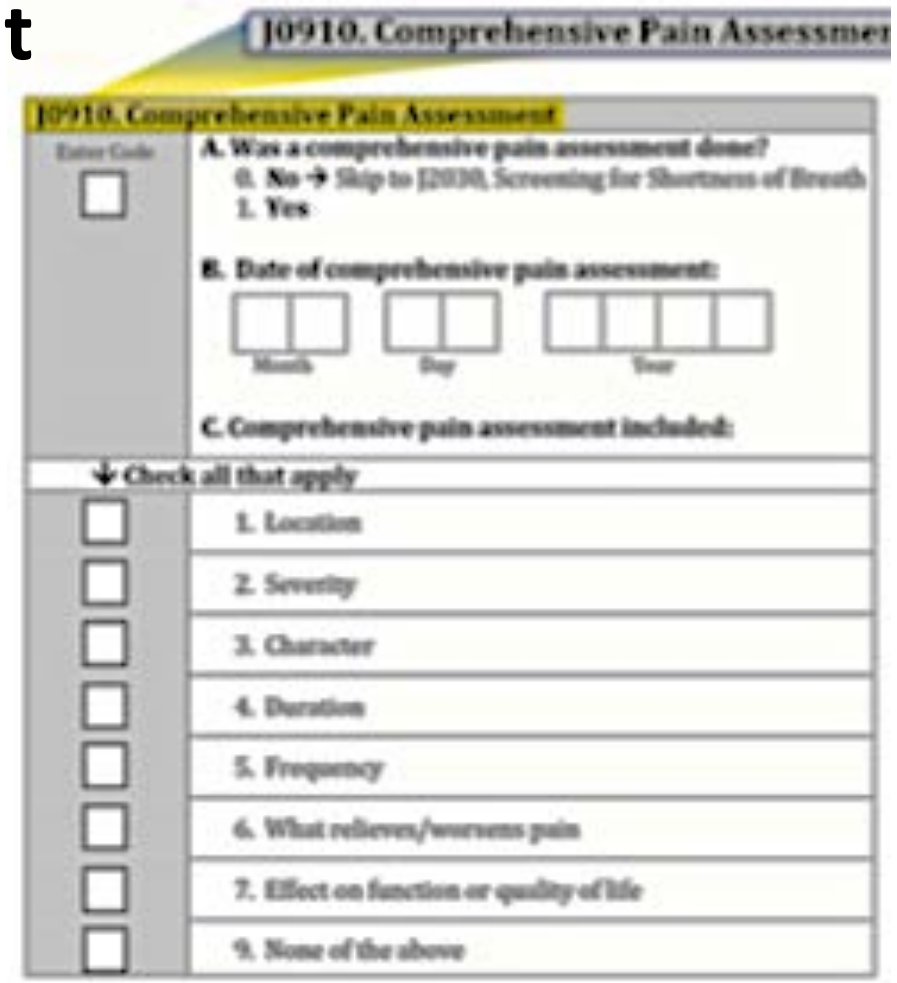
B. Date of comprehensive pain assessment:
Month Day Year

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

Section J: Pain

- **J0910: 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 caregiver**


J0910. Comprehensive Pain Assessment

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

Section J: Pain

- Quarterly Q&As give ongoing direction
  - For example, the example below was in the January 2017 Q&A

Section J. Pain:

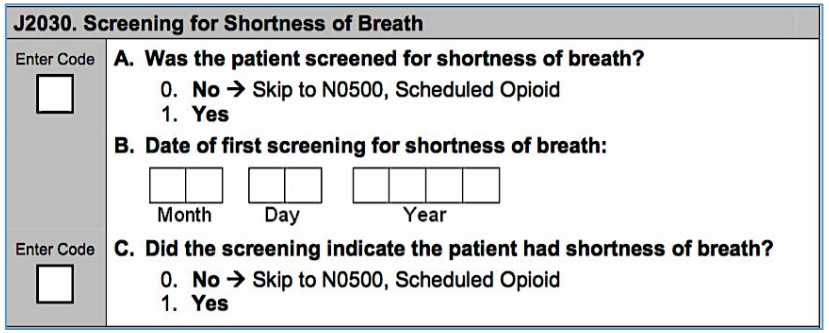
Question 5. **If a patient cannot respond to questions about pain, how can we complete the comprehensive pain assessment and receive credit for the NQF #1637 measure?**

Answer 5. As noted in the HIS Manual, it is possible to complete 5/7 of the comprehensive pain assessment characteristics for patients who are non-responsive or are otherwise unable to answer questions about pain. Page 2J-8 and 2J-9 of the HIS Manual include details on comprehensive pain assessments for nonverbal patients. In general, behavioral indicators of pain or caregiver report about pain characteristics can be used to assess pain for nonverbal patients.

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



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**

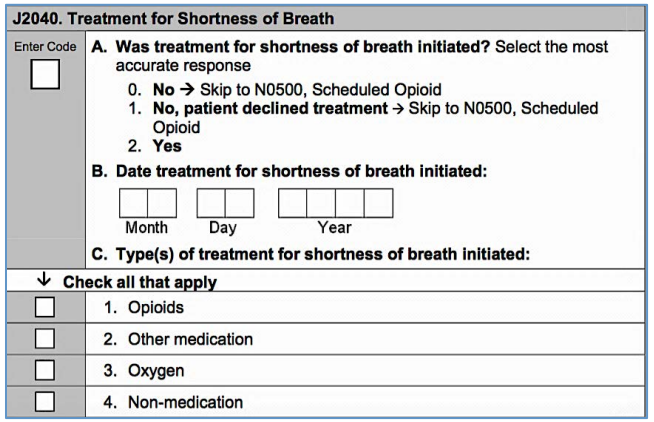
B. Date of first screening for shortness of breath:

☐☐ 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**



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

- Credit for respiratory screening and treatment is granted for Composite Measure Calculation when:
  - J2030A and J2030C both = 1. Yes

AND

  - The date at J2030 B is within 2 days of admit

AND

  - J2040 is either 1. No (patient declined) or 2. Yes

AND

  - The date at J2040B = within one day of initial nursing assessment date

Conditional best-practice process measure

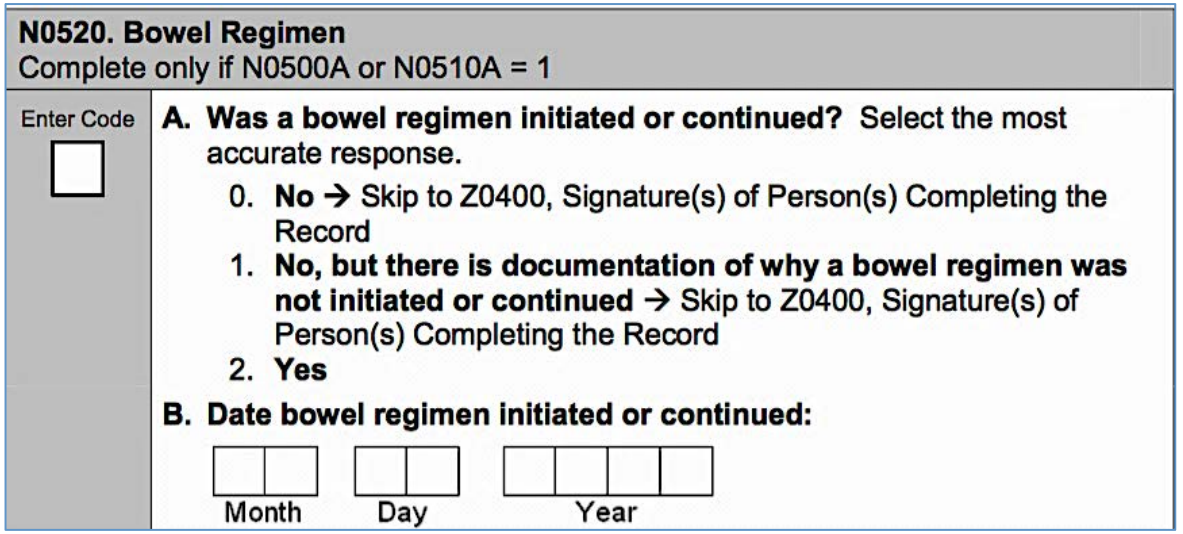
SECTION N: MEDICATIONS

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

- The hospice receives "credit" in the composite measure calculation for bowel regimen implementation when any of these is true:
  - N0520 is skipped because the patient is not receiving opioid therapy.
    - Patient doesn't "qualify for" a bowel program.
  - N0520A = 1. No.
    - Meaning documentation explains why no bowel regiment was implemented or continued.
  - N0520A = 2. Yes and N0520B = a date within 1 day of opioid continuation or initiation.



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

Guidance Manual Section O: Service Utilization

HOSPICE VISITS WHEN DEATH IS IMMINENT

Hospice Visits When Death is Imminent

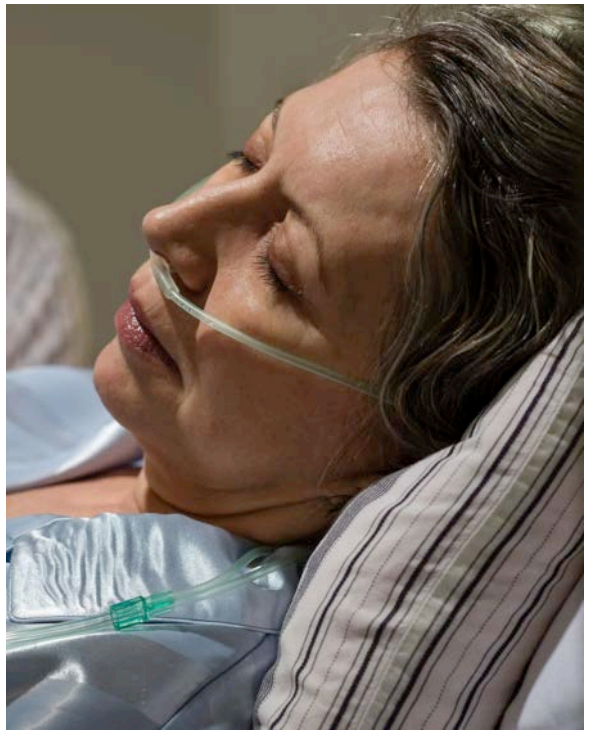
- The other process measure that will eventually hold real estate in the “Quality of Patient Care” tab is “Hospice Visits When Death is Imminent.”
  - Based on 4 new items collected after discharge due to patient death

Hospice Visits When Death is Imminent

- CMS describes these discharge items, as capturing “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

- CMS: FY 2014 claims data show that on any one of the last 7 days of a hospice patient's life:
  - Almost 49% received no SN visit
  - 91% received no social worker visit
- The Journal of the American Medical Association (JAMA): 2014 claims data showed **no professional staff** visited 81,478 (12.3 %) of hospice decedents in their last 2 days of life
- Abt (Medicare Research Contractor) Report: 28.9% of Routine Home Care hospice decedents in 2014 received **no visit** from a nurse, social worker, or therapist the day they died



Hospice Visits When Death is Imminent

- CMS and the Office of Inspector General (OIG) continue to monitor claims and HIS data for “concerning” behavior of some hospice agencies.
  - Includes new items focusing on the problem of too few hospice visits during some hospice patients’ last days

Hospice Visits When Death is Imminent

- Still feeling like a deer in the headlights with all this scrutiny?
- Hospice's own claims data prompted CMS to add discharge measure items that count end-of-life visits.
- Documentation NOW determines Hospice Compare scores in 2018.
- Implement QAPI process to ensure that:
  - **DC HIS data matches claims data**
  - **Hospice visits match patient/family needs**
  - **When end-of-life visits are scarce, documentation clearly describes why**

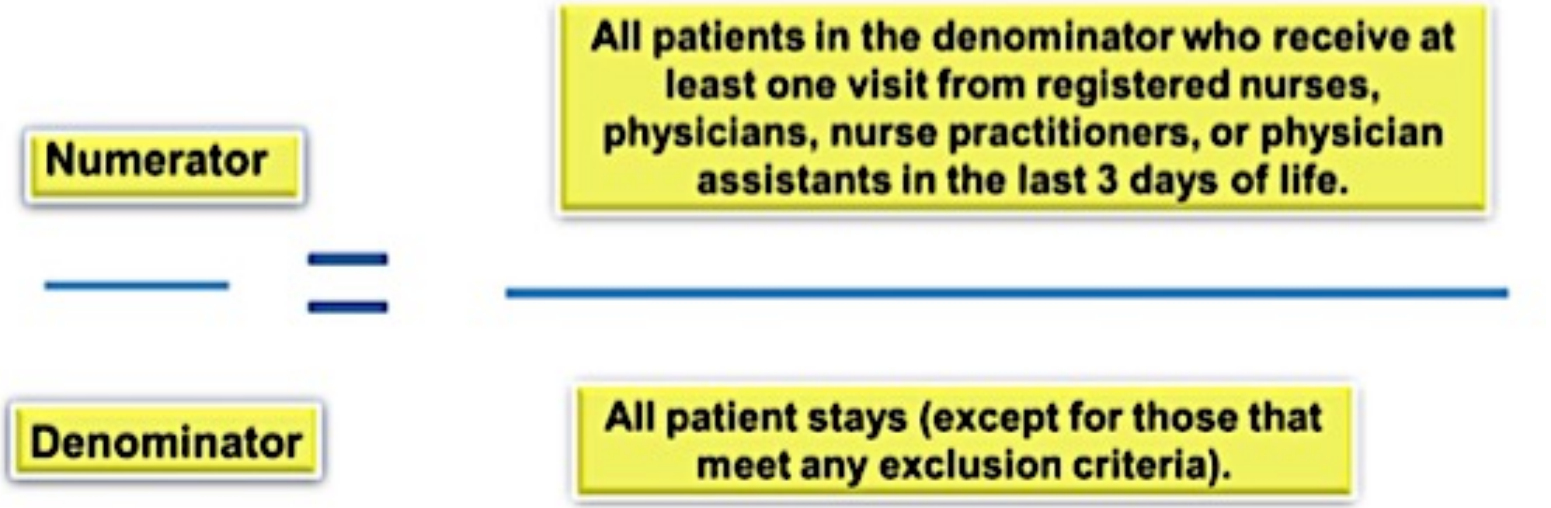
Section O: Service Utilization

Complete if patient died.

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 **Excluded if patient received any level of care other than routine home care (RHC) on days cited.**
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

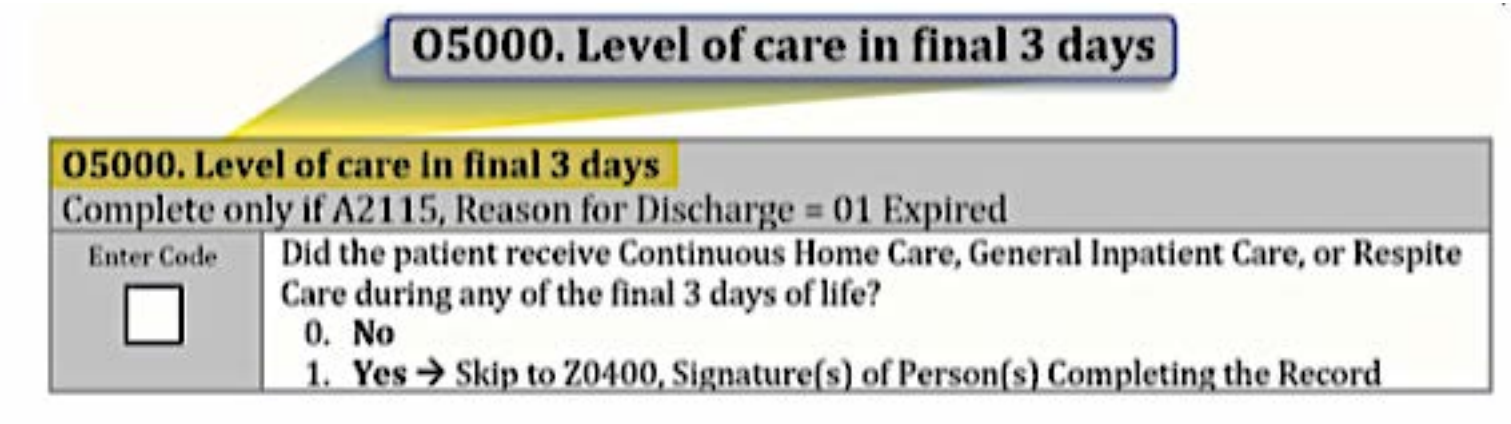
Hospice Visits When Death is Imminent

- Measure 1 included in Hospice Compare calculation if the patient received only routine home care (RHC) hospice services during **the final 3 days of life**.
  - Other care levels, by definition provide in-person services daily
    - Caution: OIG states about 1/3 of audited GIP stays did not support medical necessity for level of care
    - Scrutinizing current claims for level-of-care medical necessity



Hospice Visits When Death is Imminent

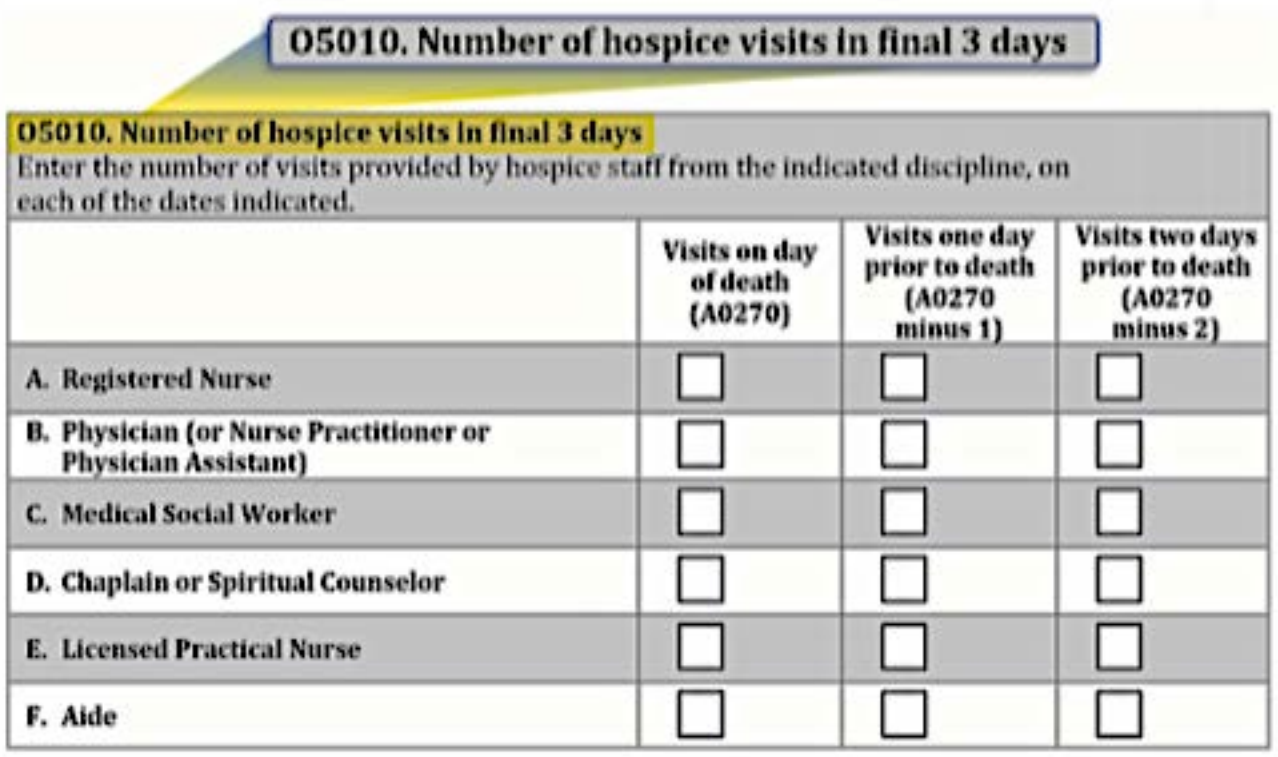
- Final 3 days of life: Any CHC, GIP, or Respite?



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

Hospice Visits When Death is Imminent

- Enter the number (0 – 9) of visits from each discipline provided on each of the final 3 days
  - Day of death (A0270) and 2 days prior
  - In-person visits to patient & to family while patient lives
  - Provided by a hospice-affiliated person, paid or unpaid



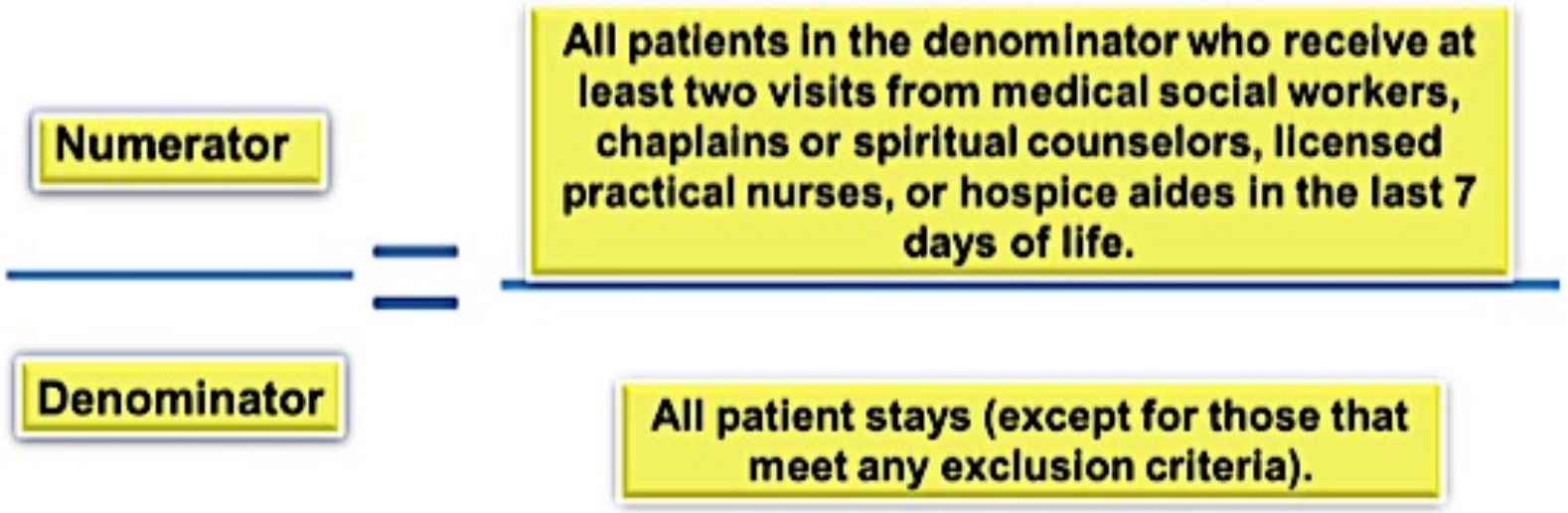
O5010. Number of hospice visits in final 3 days

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	☐	☐	☐

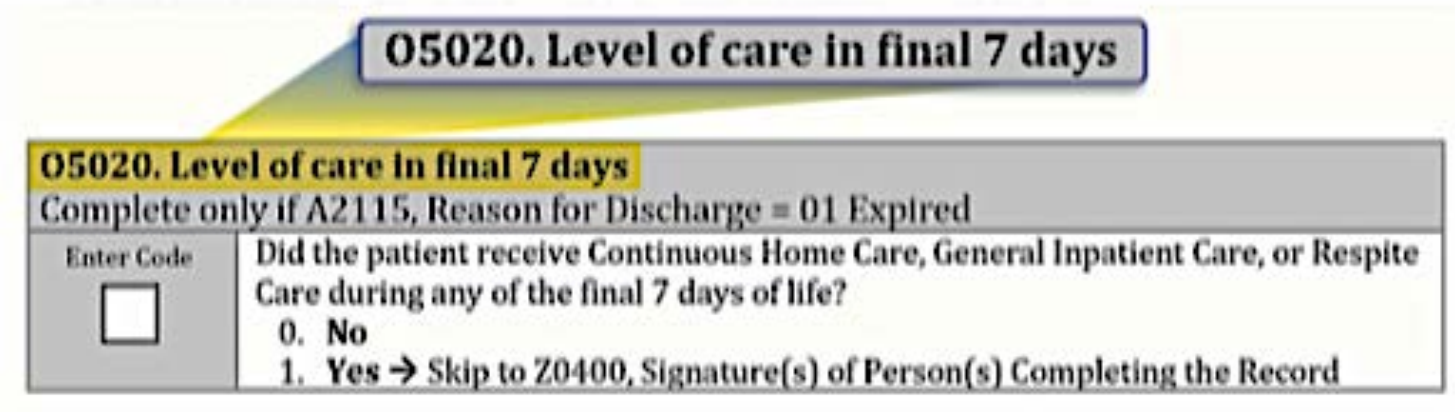
Hospice Visits When Death is Imminent

- Measure 2 included in Hospice Compare calculation if the patient received:
  - RHC hospice services exclusively during **the final 7 days of life**
  - More than 1 day of hospice services



Hospice Visits When Death is Imminent

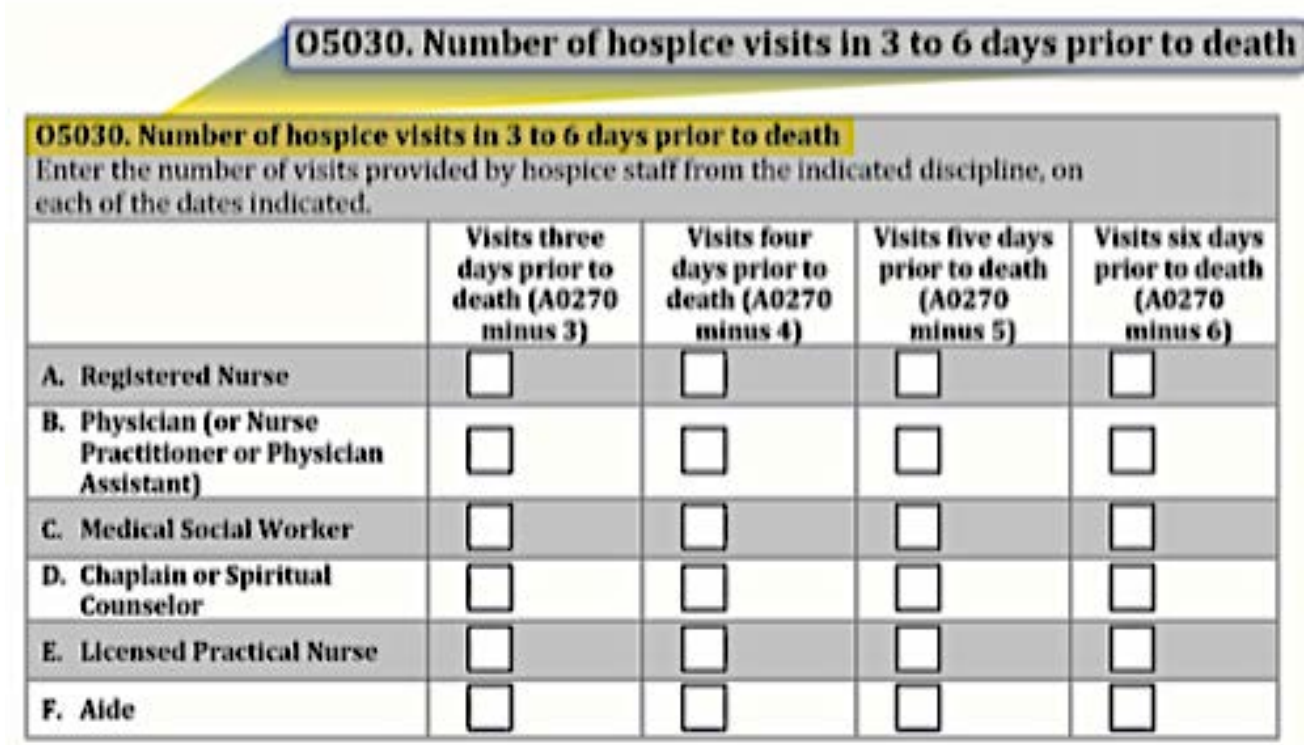
- Final 7 days of life: Any CHC, GIP, or Respite?



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

Hospice Visits When Death is Imminent

- 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	☐	☐	☐	☐

Survive the Scrutiny Storm!

- CMS and OIG scrutiny continues.
- Hospices that comply with coverage and Conditions of Participation rules will flourish.
- Absence of attention in the past **does NOT** indicate that an agency is escaping scrutiny.
- Thank you for helping build a compliant hospice industry!

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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