QAPI
Quality Assessment
Performance Improvement

HIS (Hospice Item Set)

Home Health VNA
Merrimack Valley Hospice
HomeCare, Inc.

The Leaders in Home Health and Hospice Care

Objectives

- The participant will be able to discuss the Hospice QAPI Program and Hospice Item Set (HIS)

418.58 QAPI

Quality Assessment/Performance Improvement

Program must be:

- Effective, ongoing, data driven
- Involving of all hospice services
- Focused on improved outcomes for patients and families
- Focused on improvements in hospice performance

QAPI – Quality Indicators – MVH

- **Patient care related**
  HIS
- **Safety related**
  Incidents
  Infections
- **Satisfaction related**
  CAHPS
  Complaints
- **Chart review /documentation indicators**
  (Examples _

Performance Improvement Projects

Performance Improvement Projects (PIPs)

1. Hospice Item Set
2. Hospice Education Project
3. Qualiance

What is HIS?

- HIS is an "**Hospice Item Set**" which is a standardized mechanism for abstracting data from the medical record.
- It is a review of content in the medical record to make sure that best practices identified by the National Quality Forum are taking place in every Hospice organization.
- Implementing HIS involves "**mapping**" of items currently in the medical record to meet the 7 quality measures being required by the Center for Medicare Services (CMS)
- For each patient admitted on or after July 1, 2014, completion of the HIS will be required on **Admission** and on **Discharge.**

What is HIS?

A “HIS” is submitted for all patients admitted to a Medicare-certified Hospice program regardless of:

- Payor Source
- Patient Age
- Where the patient receives Hospice services
- Whether the patient is a transfer from another Hospice
- Whether the patient previously revoked the Hospice benefit or was discharged

What does this mean for me?

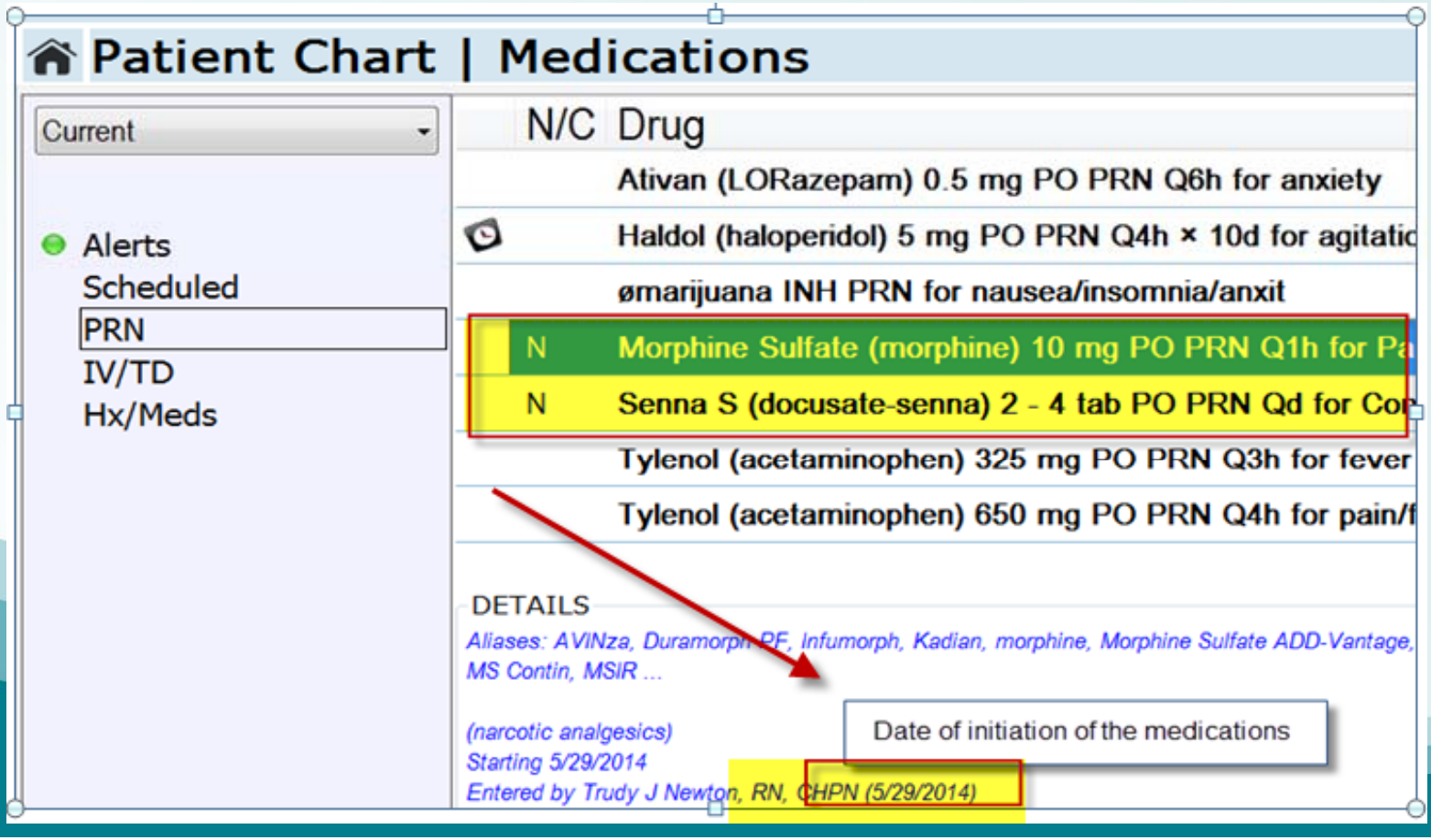
- Practices and processes for patient assessment and documentation will capture the elements required to populate the HIS form.
- Hospices will have 14 days from admission to complete HIS-Admission records and 7 days from discharge to complete HIS-Discharge records. These HIS records will be sent to CMS electronically; Hospices will have 30 days from the patient admission or discharge to submit the record for the patient.
- QA will be reviewing the visit notes to assure that items are being “mapped” correctly for submission.
- If there are errors you will be contacted to clarify and may be asked to add an addendum if indicated.

HIS Items captured in Visit

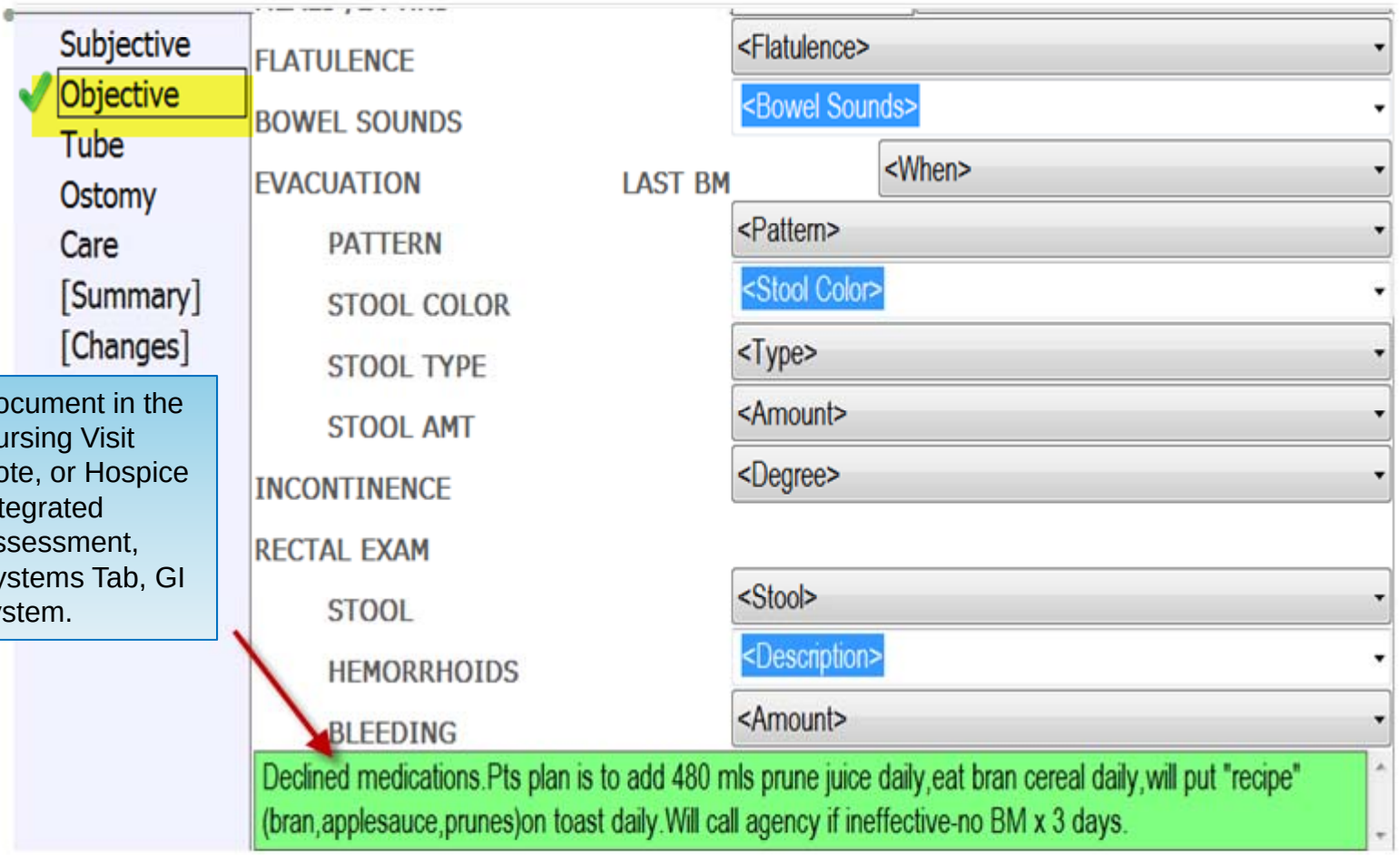
- Patients Treated with an opioid who are given a bowel regime.
- Pain Screening
- Pain Assessment
- Dyspnea Treatment
- Dyspnea Screening
- Treatment Preferences- Hospitalization & CPR
- Beliefs/Values Addressed(if desired by patient)

Patients treated with an Opioid who are given a bowel regime- Med Intervention Prescribed (NQF#1617)

- Care Process: Patients treated with an opioid that are offered/prescribed a bowel regime or documentation of why this was not needed.

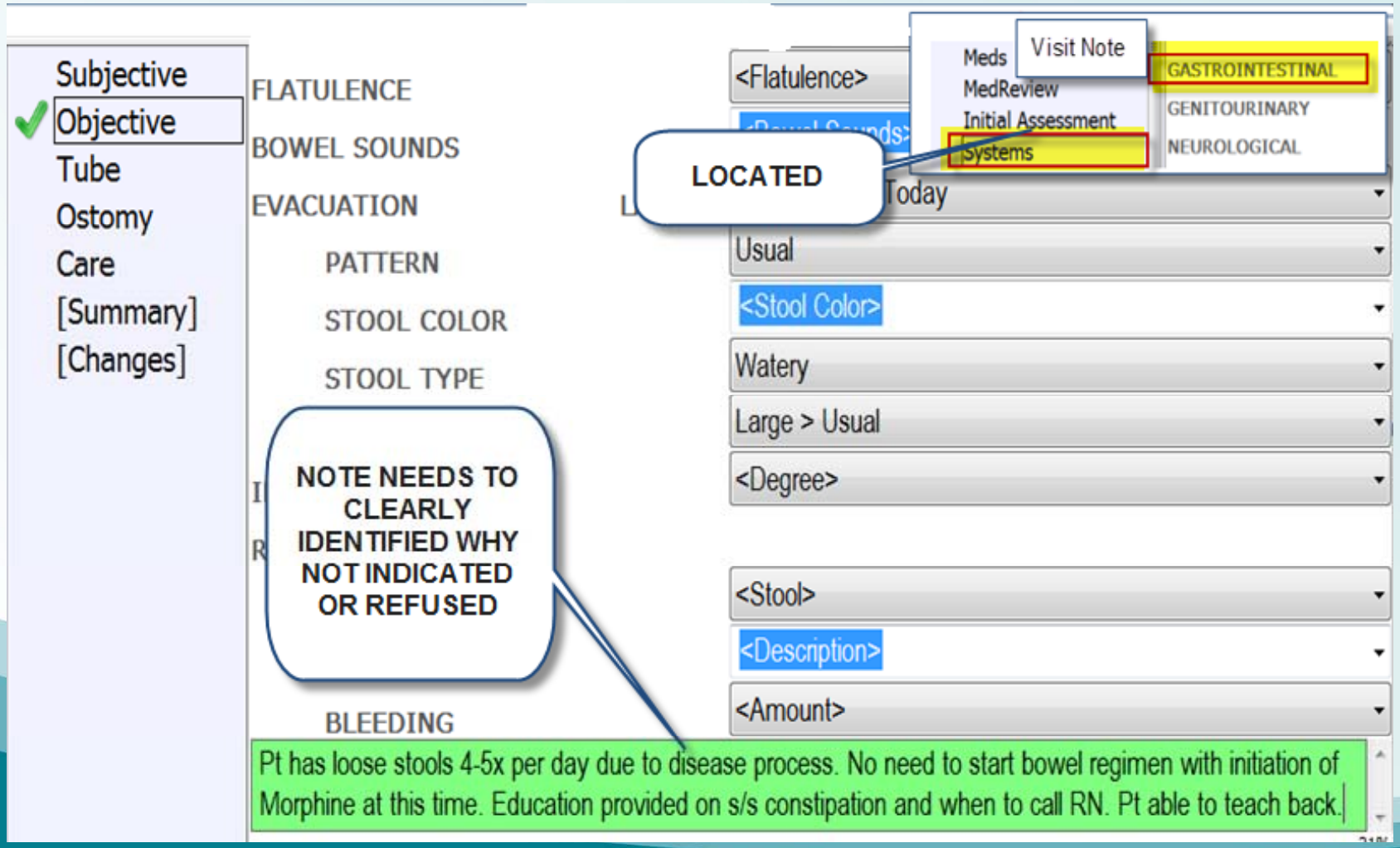


Patients treated with an Opioid who are given a bowel regime– NON–Med Intervention Prescribed (NQF#1617)



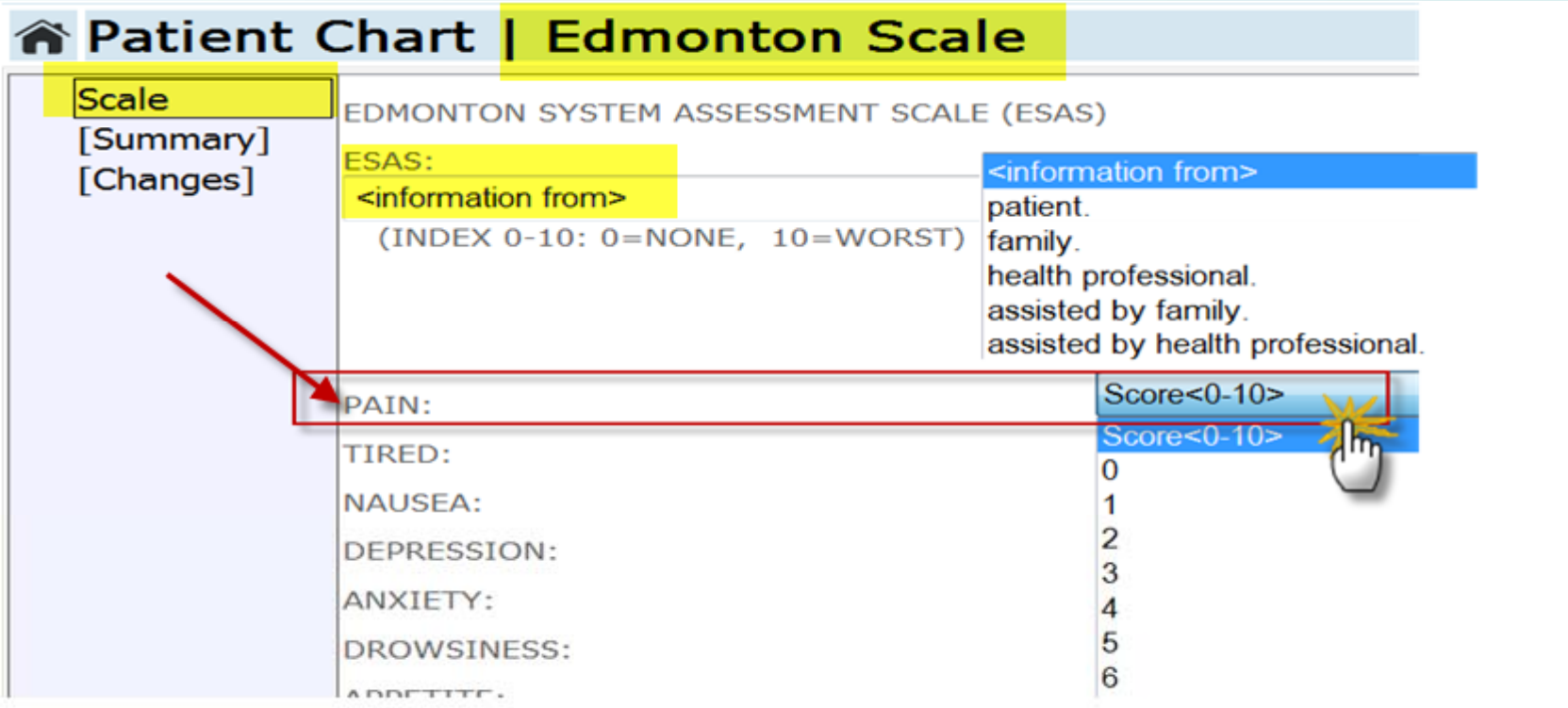
Document in the Nursing Visit Note, or Hospice Integrated Assessment, Systems Tab, GI system.

Documentation of meds refused or not needed



Pain Screening (NQF#1634)

- Care Process: The patient was screened for the presence of pain during the initial nursing assessment. Pain screening includes evaluating the patient for presence of pain, and if pain is present, rating of its severity using a standardized tool.
- Edmonton Scale completed at SOC



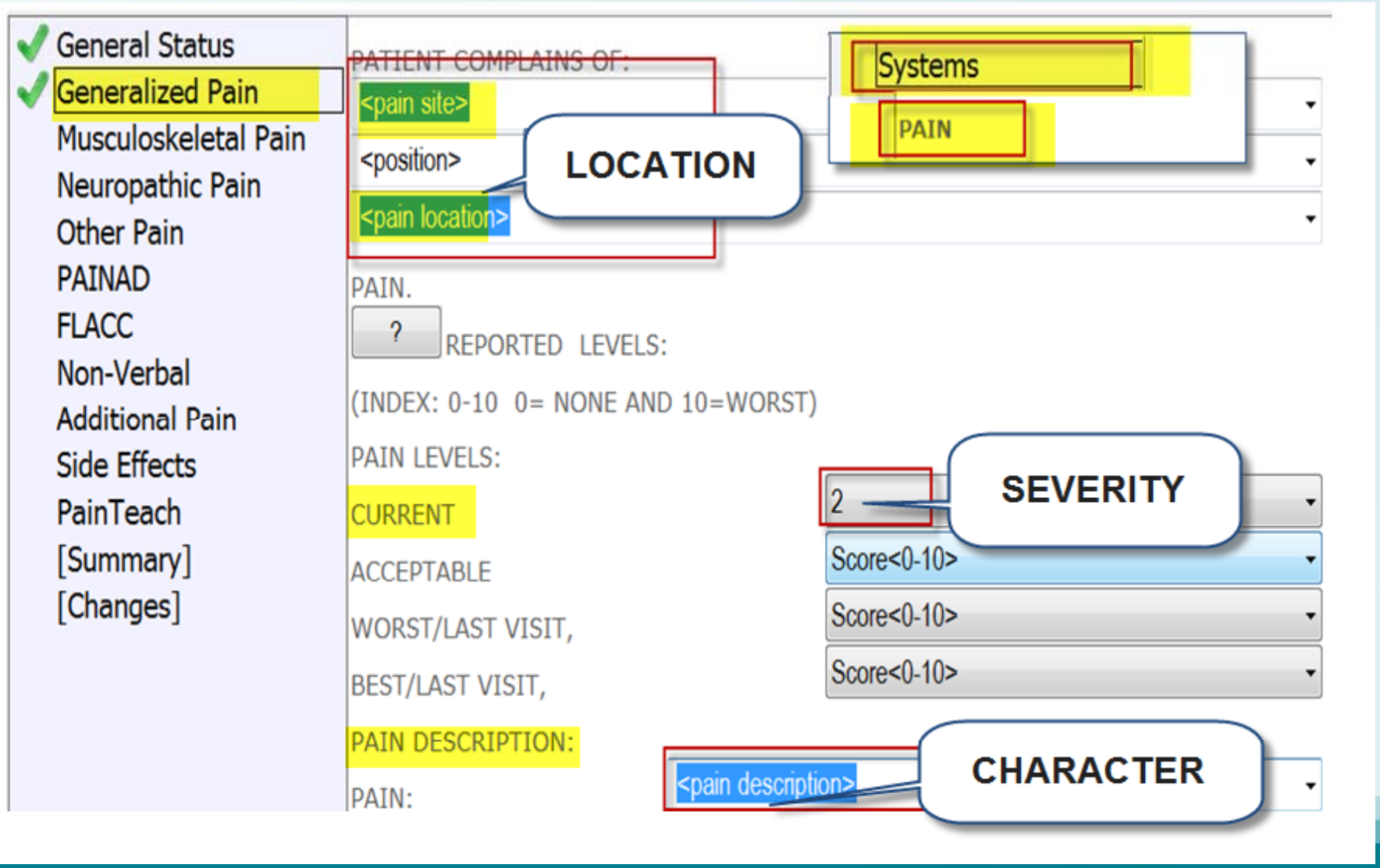
Pain Assessment (NQF#1637)

- Care Process: If the patient screened **POSITIVE** for pain then need a pain assessment documented at **THAT TIME.**

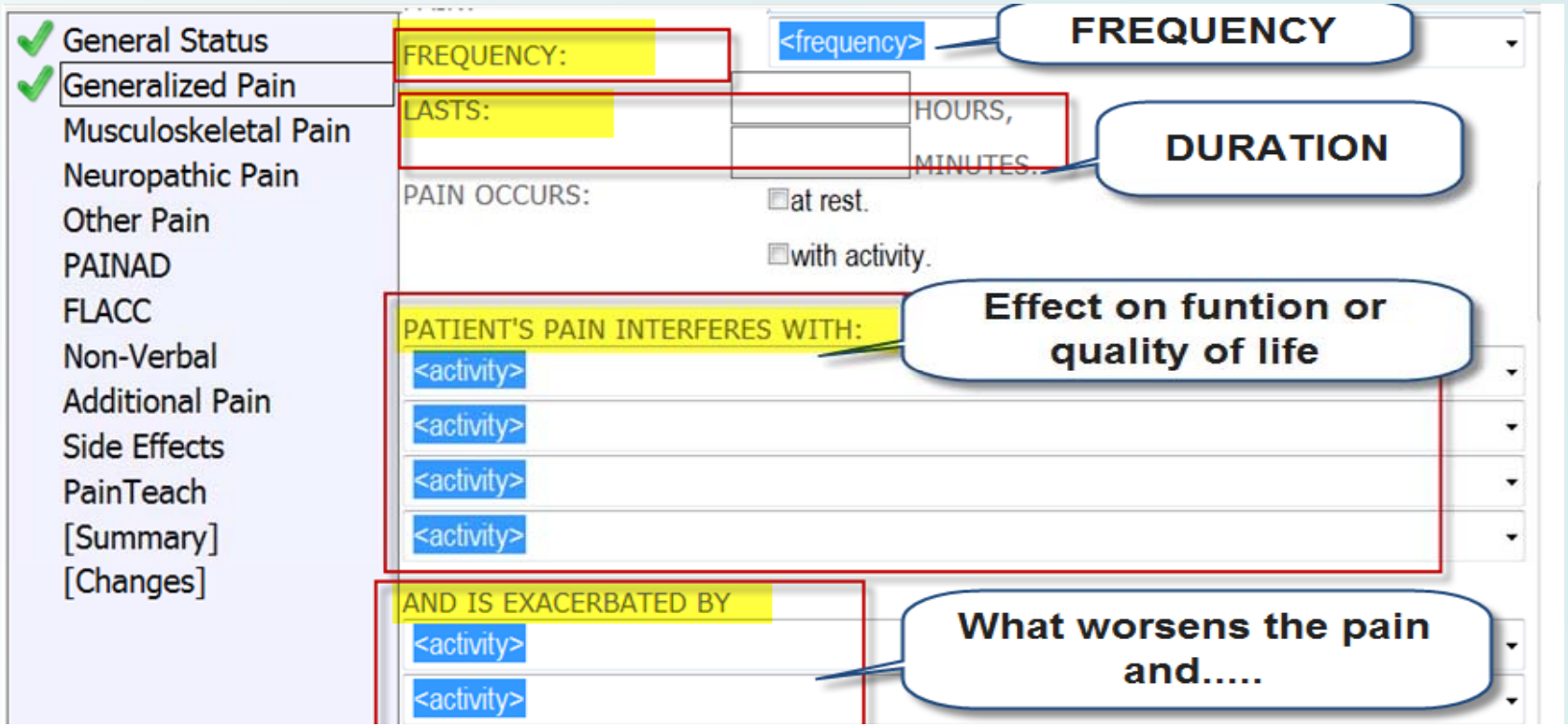
- Pain Assessment documentation must include at least 5 of the following 7 :
  - Location
  - Severity
  - Duration
  - Frequency
  - Character
  - What relieves or worsens the pain
  - Effect on function or quality of life

***Non-verbal patients- Caregiver or responsible party report on at LEAST ONE of these characteristics is acceptable, and or a clinician's notes of his/her observations of at LEAST ONE of these characteristics is also acceptable.

Current Pain Assessment Documented in MW

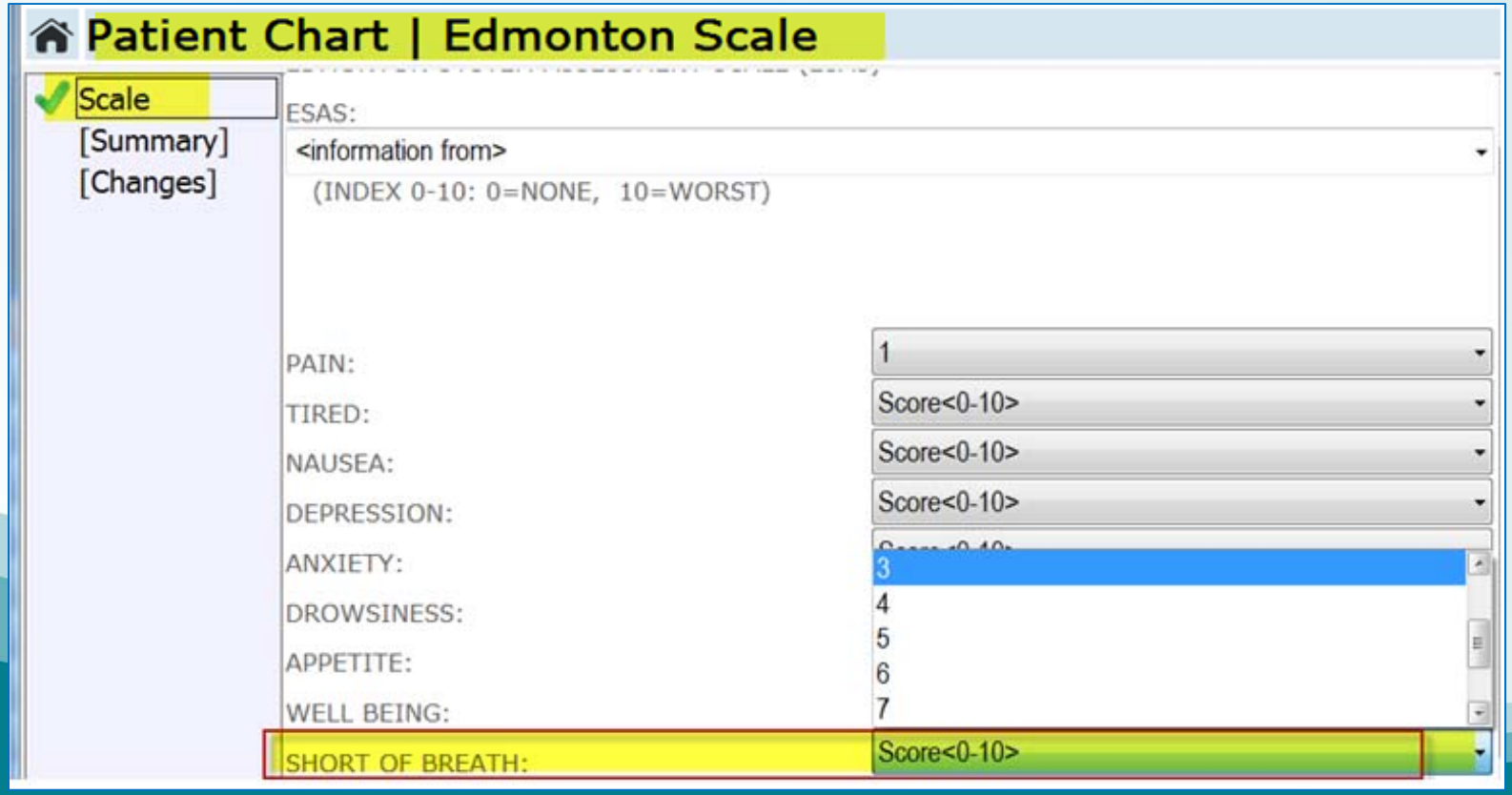


Pain Documentation: Cont.



Dyspnea Screening (NQF 1639)

- Care Process: The patient screened for dyspnea during the initial nursing assessment
- Standard: Edmonton scale is completed on SOC for admits.

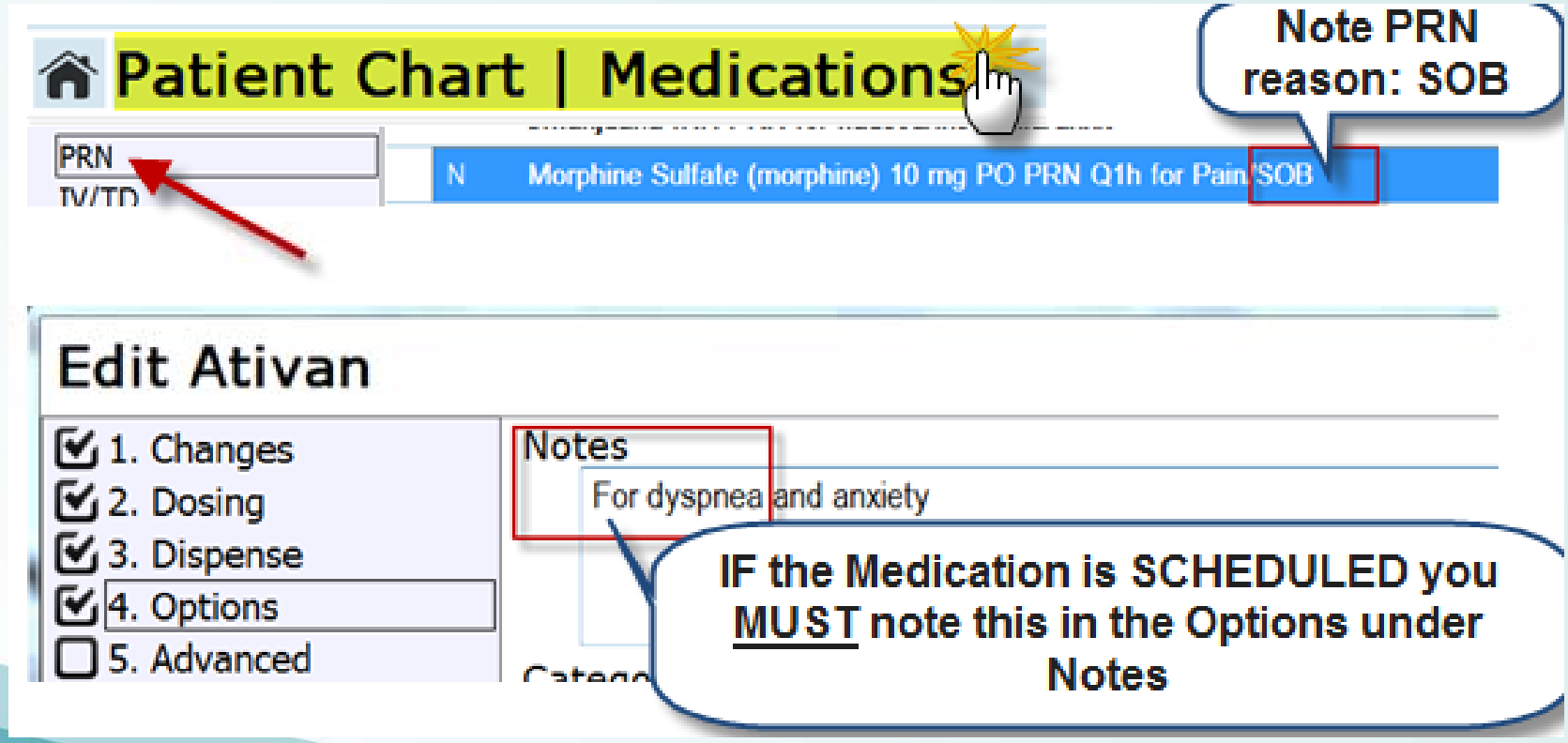


Dyspnea Treatment (NQF#1638)

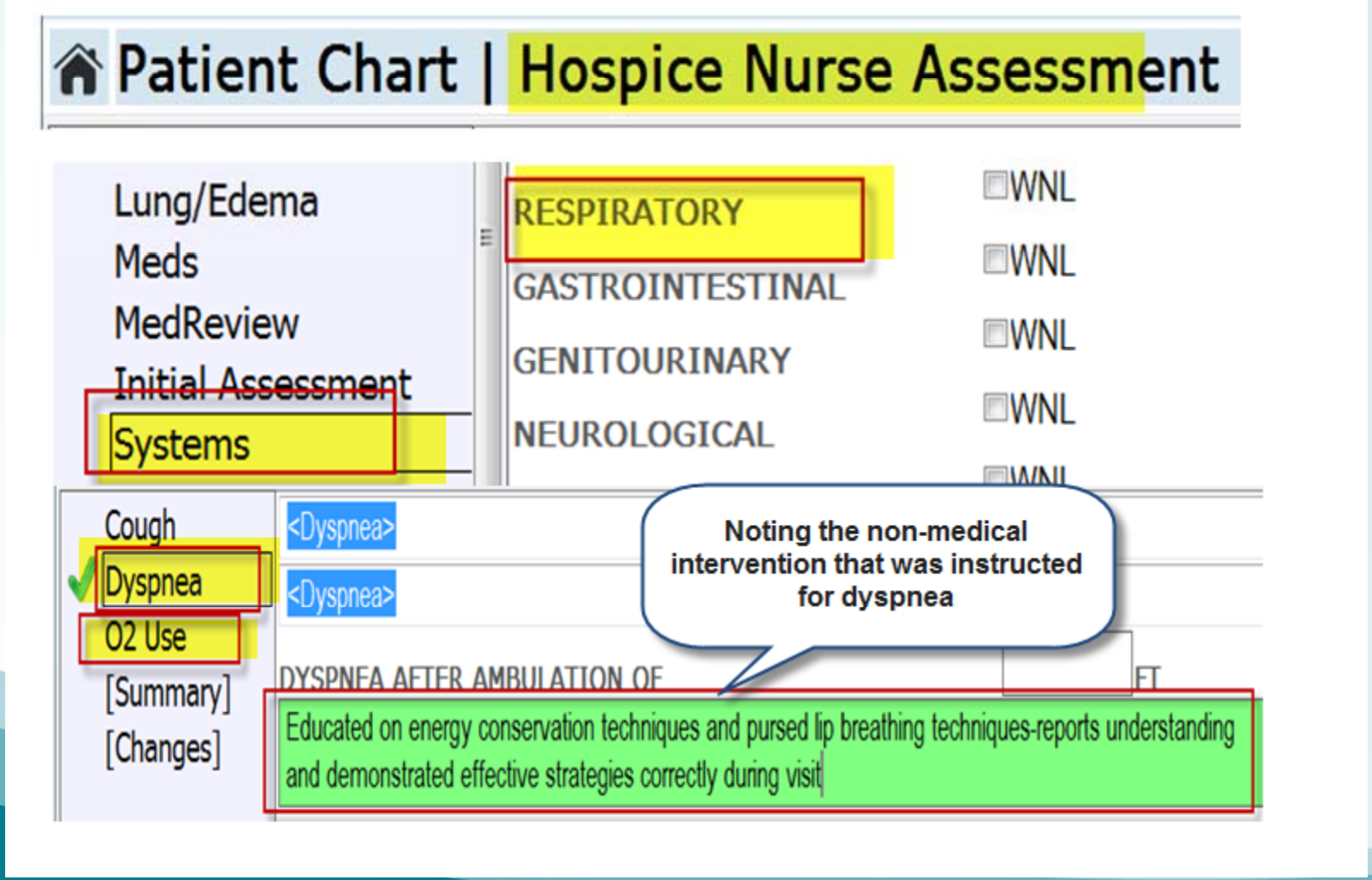
- Care Process: Hospice patients who screened positive for dyspnea received treatment within 1 day of the screening. Treatment may include inhaled meds, steroids, diuretics, oxygen, benzos or opioids (if clearly prescribed for dyspnea), or non-medication strategies such as fans, positioning, patient education efforts.

- Standard: Patients that screen **POSITIVE** for dyspnea will have interventions to alleviate that dyspnea **at time of screening positive.**

Dyspnea Treatment: Medication Example

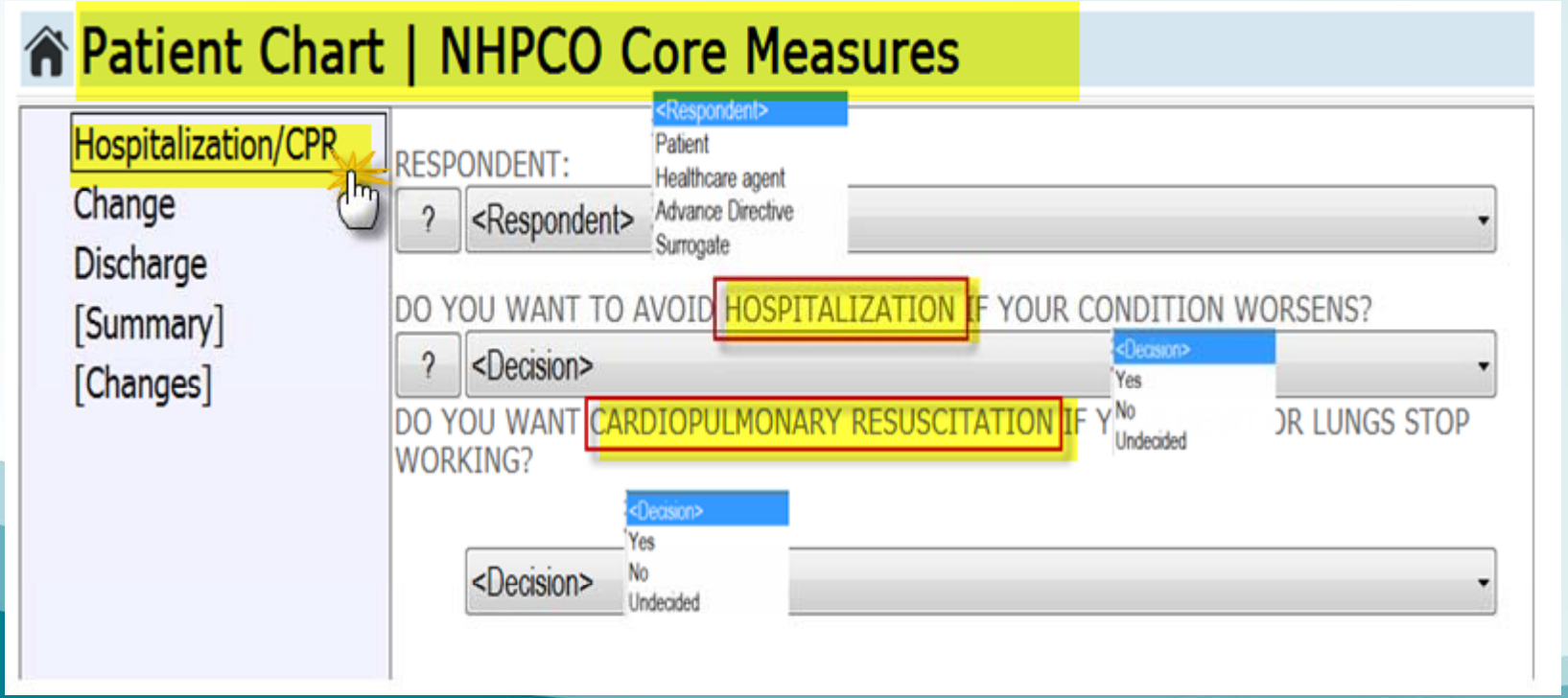


Dyspnea Treatment: Non-Medication example



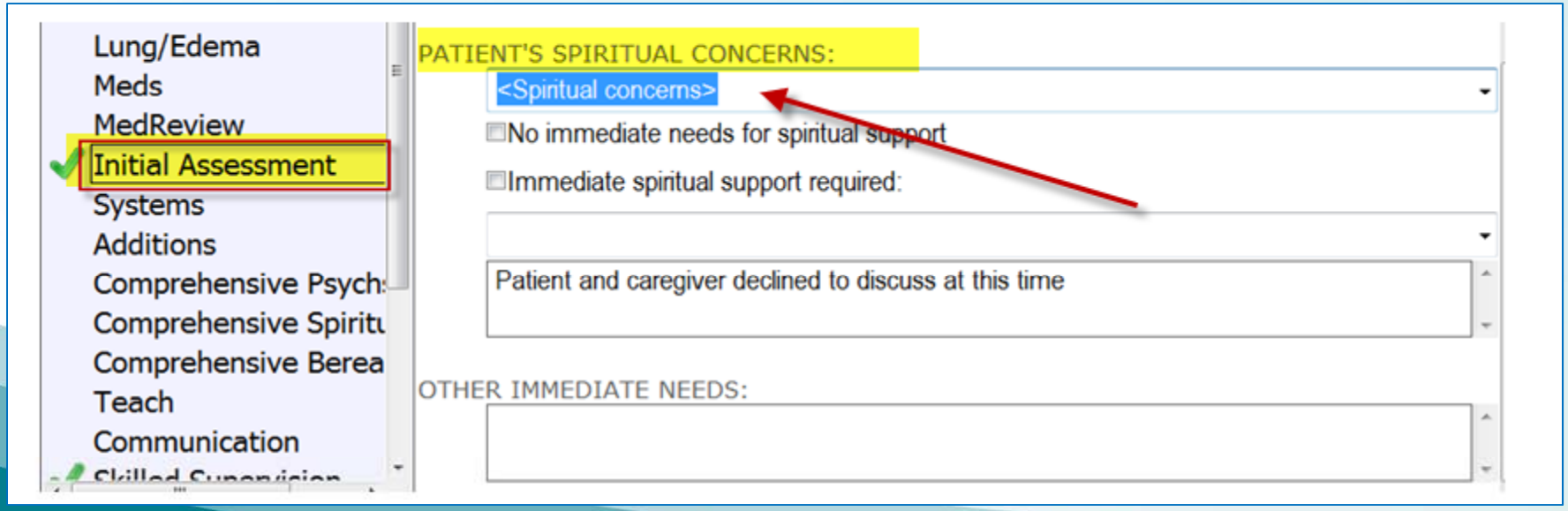
Treatment Preferences (NQF#1641)

- Care Process: The patient or responsible party are asked about preferences related to CPR and hospitalization.
- NHPCO Core Measures must added at SOC visit until the item is mapped to the Integrated Assessment.



Beliefs/Values Addressed (if desired by patient) (NQF#1647)

- Care Process: Discussion or **Attempted** discussion of spiritual/existential concerns or documentation that the patient and/or caregiver did not want to discuss.
- **Initial Spiritual Assessment form is completed at SOC. Comprehensive Spiritual Assessment form completed by day 5.**



Beliefs/Values- Example: Comprehensive Assessment- Should be completed by MSW or Clergy, defaults to SN as needed to complete by day five.