Item-Specific Coding in the Hospice Item Set (HIS)

May 1, 2019

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SESSION SUMMARY

- HIS is one of the main data sources for quality measures that are reported on Hospice Compare. This session offers tips to help with HIS item specific coding, quality measure specification calculation using HIS item coding and ways to integrate Hospice Quality Reporting Program (HQR) resources into your hospice practice for Hospice Compare success

LEARNING OBJECTIVES

- Accurately complete select HIS items from CMS FAQs
- Define HIS completion deadline vs Quality Measure Credit
- Describe quality measure specifications and their impact on Hospice Compare scores
- Identify strategies for success and improvement of HIS data collection and HQRP resources that will help to improve patient assessment and quality reporting

ACRONYMS

APU: Annual Payment Update

CASPER: Certification and Survey Provider Enhanced Reports

FVR: Final Validation Report

HIS: Hospice Item Set

HQRP: Hospice Quality Reporting Program

LOS: Length of Stay

NQF: National Quality Forum

QIES ASAP: Quality Improvement and Evaluation System Assessment Submission and Processing

QM: Quality Measure

HOSPICE ITEM SET (HIS) GENERAL INFORMATION

- All Medicare-certified hospices are required to submit HIS data
- HIS-Admission and HIS-Discharge records submitted for all patients regardless of payer, age, where patient receives hospice services, and length of stay (LOS)
- The HIS can be completed by any hospice staff member
- **HIS data** are submitted to CMS via the QIES ASAP system
- After data are submitted to CMS, the HIS data are then used to calculate hospices' performance on 9 **QMs**
- Once CMS has calculated the QM scores, some of those scores are then displayed on **Hospice Compare**

NINE QUALITY MEASURES FROM HIS

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 Assessment**
NQF #1617	**Patient Treated with an Opioid who are Given a Bowel Regimen**
NQF #3235	**Hospice and Palliative Care Composite Process Measure-Comprehensive Assessment at Admission**
N/A	Hospice Visits When Death is Imminent Measure Pair

HIS COMPLETION TIMING (RECOMMENDED)

- Completion deadlines are recommended
- Recommended completion for HIS-Admission is Admission Date + 14 calendar days
- Recommended completion for HIS-Discharge is Discharge Date + 7 calendar days
- Recommendation is to complete and submit HIS records early, which:
    - Allows for time to correct fatal error messages and warnings
    - Allows time to address any technical issues

HIS SUBMISSION TIMING

- Submission deadline: latest possible date HIS records should be ***submitted*** and ***accepted*** by the Quality Improvement and Evaluation System Assessment Submission and Processing (QIES ASAP) system.
- Submission timing is important:
- Affects compliance with HIS requirements and APU
- Providers must submit a minimum % of their records on time to be compliant.
- Submission deadline for HIS records is the target date + 30 calendar days
- To ensure records are **submitted and accepted**, view Final Validation Report (FVR)

HIS RECOMMENDED COMPLETION DEADLINE VERSUS QUALITY MEASURE CREDIT

HIS Data	Quality Measure
Pain screening can be abstracted anytime between the admission + 14 days. The first screen date will be reported	States the first pain screen must occur within 2 days of admission to get credit
Dyspnea screening can be abstracted anytime between admission + 14 days. The first screen date will be reported	States the first pain screen must occur within 2 days of admission to get credit
Treatment Preferences	States patient/caregiver was asked about treatment preferences no more than 7 days prior to admission or within 5 days of the admission date
Beliefs/Values Addressed (if desired by the patient)	States patient/caregiver was asked about treatment preferences no more than 7 days prior to admission or within 5 days of the admission date

SECTION A- ADMINISTRATIVE INFORMATION

Items in Section A capture key demographic information about the patient, including unique identifiers (name, date), key days (admission and discharge date), type of record, and reason for the record

A0500. Zip Code

- The patient's ZIP Code for the address at which the patient is **residing while receiving hospice** services

A1400. Payor Information

- Check **all** the 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

SECTION I- ACTIVE DIAGNOSIS

- Section I reports the diagnosis chiefly responsible for the patient's admission to hospice, and most contributory to the patient having a life expectancy of six months or less
- Not included in quality measure calculation
- These diagnoses were chosen because they are the most common principal diagnoses for hospice patients

SECTION Z:
RECORD ADMINISTRATION

Items in this section contain signatures of individuals completing the HIS and the signature of the individual verifying the HIS record completion

Z0400. SIGNATURE(S) OF PERSON(S) COMPLETING THE RECORD

Signatures should reflect the hospice staff who *completed* the HIS

- This may/may not be the person who completed the care process that is documented in the record
- Provides a tracking log for the abstracted information contained in the HIS

Z0400 is not submitted as part of the HIS record in the QIES ASAP system

- CMS suggests retaining signature record at the hospice
- Signatures may be electronic

Z0500. SIGNATURE OF PERSON VERIFYING RECORD COMPLETION

- Z0500 verifies that the HIS is complete and Z0400 has been signed
- Not submitted as part of the record in QIES/ASAP system
- The signature in Z0500A certifies that all sections are complete
- In the case of a modification or inactivation request, Z0500B should contain the original date on which the record was completed
    - Do not change the original Z0500B response unless the date in Z0500B in the original record was incorrect and the modification request is to correct the date in Z0500B

SECTION F- PREFERENCES

The items in this section correspond to Quality Measures:

- NQF #1641 Treatment Preferences
- NQF #1647 Beliefs/Values Addressed (if desired by the patient)
- NQF #3235 Hospice and Palliative Care Composite Process Measure – Comprehensive Assessment at Admission

SECTION F- PREFERENCES

- Section F items capture whether the hospice *opened the door* for a conversation about various patient preferences
- Discussions can be initiated by any hospice staff member
- It is permissible to consider care processes conducted during pre-admission or educational/informational visits
- Preferences are best discussed with the patient, though discussion with responsible party or caregiver is permissible

F2000. CPR PREFERENCES

- Without evidence of further discussion, orders alone, completed DNR/POLST, and short answers such as “DNR/DNI” or “Full Code” are not sufficient to answer “Yes” to F2000A

- Complete F2000 based on the ***FIRST*** dated discussion or attempted discussion about CPR preferences

- To answer “yes” to F2000A, the discussion does not need to result in a decision

F2100. OTHER LIFE-SUSTAINING TREATMENT PREFERENCES

- There is no comprehensive list of life-sustaining treatments
- Examples of other life-sustaining treatments may include but are not limited to: antibiotics, intravenous (IV) fluids, tube feeding, dialysis, ventilator support, blood transfusions

F2200. HOSPITALIZATION PREFERENCE

- The fact that the patient is in the hospital does *not* indicate their preferences regarding hospitalization
- Discussions about more intensive levels of hospice care (e.g., respite, general inpatient) do *not* count as a discussion re: hospitalization
- Hospitalization preference does not refer to the patient's choice of a particular hospital, but rather if patient has a preference of hospitalization as a care option

F3000. SPIRITUAL/EXISTENTIAL CONCERNS

- For Item F3000, "caregiver" does not have to be the legally authorized representative
- In instances where the patient is unable to self-report, you should speak with the party most knowledgeable of the patient's potential spiritual/existential concerns
- Indicating an initial assessment was set up with the chaplain or spiritual counselor, would not be sufficient documentation to show that the door was opened for a conversation or that one occurred

NQF #1641 TREATMENT PREFERENCES

- Percentage of patient stays with chart documentation that the hospice discussed (or attempted to discuss) preferences for life-sustaining treatments

- To meet the numerator criteria for NQF #1641:
    - The patient/responsible party should be asked about preference regarding use of cardiopulmonary resuscitation, hospitalization, or other life-sustaining treatments no more than 7 days prior to admission or within 5 days of the admission date

NQF #1647 BELIEFS/VALUES ADDRESSED (IF DESIRED BY PATIENT)

- Percentage of patient stays with documentation of a discussion of spiritual/religious concerns or documentation that the patient/caregiver did not want to discuss spiritual/religious concerns

- To meet the numerator criteria for NQF #1647:
    - The patient/responsible party should be asked about spiritual/existential concerns no more than 7 days prior to admission or within 5 days of the admission date.

SECTION J: PAIN

The items in this section correspond to Quality Measures:

- NQF #1634 Pain Screening
- NQF #1637 Pain Assessment
- NQF #3235 Hospice and Palliative Care Composite Process Measure – Comprehensive Assessment at Admission

SECTION J: PAIN

- Items in this section capture 2 processes of care that should be delivered around the time of admission to hospice:
  - The first pain screening, including the result of the screening, and, if the patient was in pain, pain severity and type of screening tool used
  - If the patient had pain, whether a comprehensive pain assessment was conducted

J0900. PAIN SCREENING

- Reports details about the pain screening date, result of screening, and type of screening tool used
- J0900 captures the FIRST documented screening
- Rate severity using a standardized tool
- Select the best response for pain severity **at the time of the visit** during which the screening was performed

NQF #1634 – PAIN SCREENING

Percentage of patient stays during which the patient was screened for pain during the initial nursing assessment

To meet the numerator criteria for NQF #1634, you must:

- Conduct the screening within 2 days of the admission date
  AND
- If the patient had pain, you must have rated their pain severity using a standardized tool

Responding “yes” to J0900A is not sufficient to receive credit for the pain screening QM (NQF #1634)

J0905. PAIN ACTIVE PROBLEM

- Reports whether pain is an active problem for the patient
- Consider facts beyond severity at the time of the screening clinical encounter such as historical report of pain or recent symptom
- Generally, clinical documentation that the patient is currently taking pain medication is evidence that pain is an active problem
- Comfort kits or pre-printed admission orders alone is insufficient evidence to determine pain is an active problem
- Item J0905 is not used in the calculation of a quality measure.

J0910. COMPREHENSIVE PAIN ASSESSMENT

- Reports if clinical documentation supports that the patient received a comprehensive pain assessment, and if so, the date and pain characteristics included in the FIRST documented comprehensive pain assessment

- Pain characteristics include location, severity, character, duration, frequency, what relieves or worsens pain, and its effect on quality of life

COMPREHENSIVE PAIN ASSESSMENT FOR NON-VERBAL/NON-RESPONSIVE PATIENTS

May use caregiver report for comprehensive pain assessment

May use clinical notes about assessment of non-verbal indicators of pain including:

- Crying, whining, groaning, grimacing, clenching jaw, guarding, rubbing, bracing, clutching

Coding can be based on documentation that supports that the clinician **attempted** to gather information from a patient/caregiver

- For example: The clinician asks the caregiver of a non-verbal/non-responsive patient about location of pain. The caregiver answers “I don’t know; I’m not sure.”
- This is considered an attempt to gather information, so location should be checked J0910C, as the clinician attempted to gather information

NQF #1637 – PAIN ASSESSMENT

Percentage of patient stays during which the patient screened positive for pain and received a comprehensive assessment of pain within 1 day of the screening

To meet the numerator criteria for NQF #1637:

- A comprehensive pain assessment must be completed within 1 day of the positive pain screening
  AND
- The assessment must include at least 5 of the following characteristics:
  - -Location
  - -Severity
  - -Character
  - -Duration
  - -Frequency
  - -What relieves or worsens the pain
  - -Effect on function or quality of life

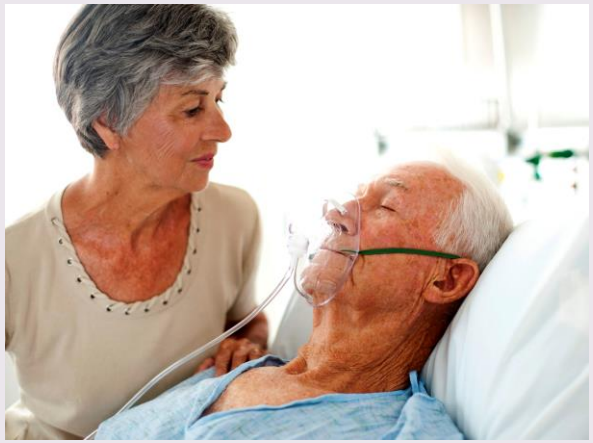
SECTION J: RESPIRATORY STATUS

The items in this section correspond to Quality Measures:

- NQF #1639 Dyspnea Screening
- NQF #1638 Dyspnea Treatment
- NQF #3235 Hospice and Palliative Care Composite Process Measure – Comprehensive Assessment at Admission

SECTION J: RESPIRATORY STATUS

- Items in this section capture 2 processes of care that should be delivered around the time of admission to hospice:
    - Whether the patient was screened for shortness of breath
    - If the patient had shortness of breath, whether treatment was initiated



J2030. SCREENING FOR SHORTNESS OF BREATH

- Reports whether the patient was screened for shortness of breath, and if so, the date and result of screening
- J2030 captures the FIRST documented screening
- Severity Rating
    - Structured clinical evaluation for shortness of breath is not well defined; therefore, use of a standardized tool for rating severity is not required
- Select the best response for shortness of breath severity **at the time of the visit** during which the screening was performed

NQF #1639- DYSPNEA SCREENING

- Percentage of patient stays during which the patient was screened for dyspnea during the initial nursing assessment (visit in which the patient was screened)

- To meet the numerator criteria for #1639 for Dyspnea Screening you must:
    - Complete the screening for shortness of breath *within 2 days of the admission date*

J2040. TREATMENT FOR SHORTNESS OF BREATH

- Reports if clinical documentation supports that the patient was treated for shortness of breath, and if so, the date and type of treatment(s)

- **Conditional item**
  - Only complete this item if the patient screened positive for shortness of breath as noted in J2030C
  - As directed in HIS, skip J2040 if you answered “no” to J2030C
  - If it is documented in the clinical record that a patient screened positive for dyspnea but does not want or denies dyspnea treatment, this is **not** held against your organization

NQF #1638- DYSPNEA TREATMENT

- Percentage of patient stays during which the patient screened positive for dyspnea and received treatment within 1 day of the screening

- To meet the numerator criteria for NQF #1638:
    - Treatment for shortness of breath must be received within 1 day of screening positive for dyspnea

SECTION N: MEDICATIONS

The items in this section correspond to Quality Measures:

- NQF #1617 Patients Treated with an Opioid who are Given a Bowel Regimen
- NQF #3235 Hospice and Palliative Care Composite Process Measure – Comprehensive Assessment at Admission

SECTION N: MEDICATIONS

Items in this section of the HIS gather information on opioids and bowel regimens

The intent of the measure is about preventing ***opioid-induced*** constipation

It is **not** about:

- Whether opioids were initiated to treat symptoms
- Or whether a bowel regimen was initiated to prevent *non* opioid-induced constipation

N0500. SCHEDULED OPIOID

- Reports if clinical documentation supports that a scheduled opioid was either initiated of continued, and if so, the date the order was received
- Scheduled opioids can be initiated/continued for any reason, regardless of symptom
- For standing orders and comfort kits: initiation is defined as the date the order was received by the hospice **AND** there was documentation of instruction to begin using medication/treatment
- For orders continued from previous care settings:
    - N0500 should be completed based on scheduled opioids for which the hospice **has** received orders

N0510. PRN OPIOID

- Reports whether a PRN opioid was either initiated of continued, and if so, the date the order was received
- PRN opioids can be initiated for any reason, regardless of symptom
- For standing orders and comfort kits: initiation is defined as the date the order was received by the hospice **AND** there was documentation of instruction to begin using medication/treatment
- For orders continued from previous care settings:
    - N0510 should be completed based on PRN opioids for which the hospice **has** received orders

N0520. BOWEL REGIMEN

- Reports whether a bowel regimen was initiated or continued, and the date of initiation/continuation
- For non-pharmacologic regimens (for example prune juice), report the date the hospice nurse or clinician discussed the intervention with patient/caregiver
- For standing orders and comfort kits: initiation is defined as the date the order was received by the hospice **AND** there was documentation of instruction to begin using medication/treatment

- **Conditional Item**
  - Complete **ONLY** if patient is taking an opioid (scheduled and/or PRN)
  - Per HIS instruction, if the patient is NOT on an opioid, skip this item *even if the patient is on a bowel regimen for non opioid-induced constipation*

NQF #1617- PATIENTS TREATED WITH AN OPIOID WHO ARE GIVEN A BOWEL REGIMEN

- NQF#1617 is the percentage of patient stays treated with opioids that are offered/prescribed a bowel regimen or there is documentation of why this was not needed

- Conditional Measure: includes only patients on scheduled opioids

- To meet the criteria for the numerator, patient's that are taking a scheduled opioid:
    - Must be offered/prescribed a bowel regimen within 1 day of a scheduled opioid being initiated or continued
      OR
    - Must be documentation as to why a bowel regimen was not needed

SECTION O: SERVICE UTILIZATION

The items in this section correspond to:

Hospice Visits When Death is Imminent Measure Pair

- Section O contains key information about service utilization and includes two types of items: level of care items and visit items.
- Items in this section are intended to capture information about level of care and the number of hospice staff visits provided to the patient in their final 3 days of life and final 3-6 days of life
- Visits are completed for patients on Routine Home Care **ONLY**
- Complete Section O items only for discharges ending in death (A2115, Reason for Discharge = 01 Expired)

SECTION O: SERVICE UTILIZATION
LEVEL OF CARE ITEMS

- When completing items O5000 and O5020, consider the level of care, not the setting of care

- The levels of care are defined in the Hospice Conditions of Participation

SECTION O: SERVICE UTILIZATION
VISITS ITEMS

***What** counts as a visit?*

- Visits that begin when the patient is alive, but dies during the visit may be counted
- Visits to family may be counted
- Phone calls, post-mortem, and pronouncement visits are **NOT** counted

SECTION O: SERVICE UTILIZATION *VISITS ITEMS*

***Whose** visits can be counted?*

- Hospice staff members in each of the listed disciplines who are either employees, contractors and affiliates, or who provide unpaid services
  - -Example: staff from the quality division of the health system to which a hospice belongs counts
  - -Example: a chaplain or spiritual counselor who is an unpaid staff member at the hospice counts
- Volunteer visits may **NOT** be counted

O5000. LEVEL OF CARE IN FINAL 3 DAYS

- O5000 asks “Did the patient receive Continuous Home Care, General Inpatient Care, or Respite Care during any of the final 3 days of life?”
- If O5000 is “YES” then skip all remaining Section O items and go to Z0400
- Item O5000 addresses level of care, and is a "gateway" question to the remaining items in Section O

O5010. NUMBER OF HOSPICE VISITS IN FINAL 3 DAYS

- Reports the number of visits provided by the hospice staff from each indicated discipline in the final 3 days of life.

- For this item, report the number of visits received during a 3 day time window. This 3-day time window is defined as:
    - Final day of life is defined as the Discharge Date (A0270)
    - One day prior to death is calculated as A0270 minus 1
    - Two days prior to death is calculated as A0270 minus 2

- Included disciplines:
    - Registered Nurse, Physician (including Nurse Practitioner or Physician Assistant), Medical Social Worker, Chaplain or Spiritual Counselor, Licensed Practical Nurse, Aide

O5020. LEVEL OF CARE IN FINAL 7 DAYS

- O5020 asks “Did the patient receive Continuous Home Care, General Inpatient Care, or Respite Care in the final 7 days of life?”
- If O5020 is “YES” then skip to Z0400
- Item O5020 addresses level of care, and is a "gateway" question to Item O5030

O5030. NUMBER OF HOSPICE VISITS IN FINAL 3-6 DAYS PRIOR TO DEATH

- Reports the number of visits received by the patient from each discipline for a 4-day time window (3-6 days prior to death)

- This time window is ***different*** from the prior visits item. The time window for O5030 is calculated as follows:
    - Three days prior to death is calculated as A0270 (Discharge Date) minus 3
    - Four days prior to death is calculated as A0270 (Discharge Date) minus 4
    - Five days prior to death is calculated as A0270 (Discharge Date) minus 5
    - Six days prior to death is calculated as A0270 (Discharge Date) minus 6

HOSPICE VISITS WHEN DEATH IS IMMINENT MEASURE PAIR

- Measure 1: Percentage of patients receiving at least *one* visit from registered nurses, physicians, nurse practitioners, or physician assistants in the last **3** days of life

- To meet the numerator criteria, a patient must have received at least *1* visit from a registered nurse, physician, nurse practitioner or physician assistant in the last **3** days of life

- The measure requires 1 visit total, not 1 visit from each listed discipline

HOSPICE VISITS WHEN DEATH IS IMMINENT MEASURE PAIR

- Measure 2: Percentage of patients receiving at least *two* visits from medical social workers, chaplains or spiritual counselors, licensed practical nurses or hospice aides in the last **7** days of life

- To meet the numerator criteria a patient must have received at least *2* visits from MSWs, Chaplains or spiritual counselors, licensed practical nurses or hospice aides in the last **7** days of life
    - The measure requires 2 visits total, not two visits from each listed discipline

HIS RECORD CORRECTION

- **Modification Request**
  - One- step process
  - Used when a HIS record has been accepted into the QIES ASAP system but contains clinical on non-key demographic error

- **Inactivation Request**
  - Two-step process
  - Use an inactivation request for record identifiers and/or patient identifiers

Record identifiers: Admission date, Discharge date, Reason for Record
Patient identifiers: First and Last name, Social Security Number, Gender, and Birth Date

STRATEGIES FOR SUCCESS IN IMPROVING HIS SCORES

- Be sure clinicians are familiar and comfortable with the HIS
- Provide regular updates to clinicians and staff
- Review clinical processes
- What else can we do to support these measures?
- QAPI projects
- Ensure adequate “tools in the tool box”
- For example, have standardized pain assessments readily available
- Know your resources
  - -CMS HIS Manual
  - -HIS Trainings
  - -HIS Fact Sheets
  - -Quarterly Update Documents

STRATEGIES FOR SUCCESS IN QUALITY REPORTING

- Assign a staff member to review all completed HIS records for completeness and accuracy before submitting them to the QIES ASAP system
- Have a back-up person who knows how to complete and submit HIS records
- Check Final Validation reports in CASPER to ensure that data was submitted **and** accepted by QIES ASAP
- Track scheduled QIES ASAP downtime to ensure all records can be submitted timely
- Don’t wait until the last minute
- Early submission allows a buffer for correction and re-submission
- Be sure that both you and your vendor are both working with the most current version of the HIS and item specifications

RESOURCES

Information regarding the Hospice Quality Reporting Program (HQRP) can be found at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/index.html

Specifics on the HIS Hospice Quality Measures may be found on Hospice Quality Reporting Program (HQRP) website: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Current-Measures.html

The QM User's Manual describes the calculation and the numerator and denominator for each of the quality measures and can be accessed here: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Downloads/HQRP-QM-Users-Manual-v101_FINAL.pdf

The HIS Manual v2.01 with the change table can be accessed here: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Hospice-Item-Set-HIS.html in the Download section at the bottom of the page

HOSPICE QUALITY HELP DESK

For general questions about the Hospice Quality Reporting Program (HQRP), providers can email the Hospice Quality Help Desk at HospiceQualityQuestions@cms.hhs.gov

QUESTIONS

THANK YOU