Hospice Quality Reporting: Preparing for HIS

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Objective

- Explain the Hospice Information Set (HIS)
- Explain the regulatory authority and requirements for HIS reporting
- Describe the HIS quality reporting measures
- Identify where to capture HIS data in the Patient record
- Develop processes to extract HIS data and record in the HIS report

What is Hospice Information Set Reporting

- Hospice Quality Reporting Program is mandated by the 2010 Affordable Care Act
- Currently a "pay-for-reporting" system, not a "pay-for-performance" system
- Performance level is not a factor in determining reimbursement
- HIS is a snapshot in time. It does not reflect the Pt's status throughout their hospice admission.

HIS 2014 Data Submission

- 2014 HIS submission begins July 1, 2014
- Two HIS reports for each patient: admission report and discharge report
- HIS data collection training sessions were held on February 4 & 5, and are available on CMS website (see Resources at end of slides)
- HIS technical training (with additional instruction) begins in May 2014
- Data collection and report for CY 2014 effects reimbursement for FY 2016

Penalty for Non-Report

- All Medicare hospice providers with active CNN number (provider number) must report
- Hospices awaiting certification will be expected to have HIS processes in place at the time of their initial survey for deemed status
- 2% reduction in market basket for FY 2016 if non-report
- Must submit both reports (admit and discharge) for all admissions

Hospice Information Set

- Previous HQR Structural Measure and NQF 0209 have been eliminated
- 2014 will begin collection of new data
- Need a new account for HIS; HQR account is no longer operational
- Data will be used in determining future reimbursement models
Hospice Information Set…cont.

› HIS (Hospice Information Set) is:
  › Set of data elements endorsed by National Quality Forum
  › Used to calculate 7 quality measures
  › A standardized mechanism for abstracting data from the medical record

› HIS is not:
  › A Pt assessment tool
  › Will not be administered to Pt/family/PCG

Hospice Information set…cont.

› Hospice Information set (HIS) will collect data on seven new measures
  › NQF 1617 Patients Treated with an Opioid who are Given a Bowel Regimen
  › NQF 1634 Pain Screening
  › NQF 1637 Pain Assessment
  › NQF 1638 Dyspnea Treatment
  › NQF 1639 Dyspnea Screening
  › NQF 1641 Treatment Preferences
  › NQF 1647 Beliefs/Values Addressed (if desired by Pt)

HIS…cont.

› Submit admission and discharge data for ALL Pts regardless of:
  › Payor source (Mcr, MK, private payor)
  › Pt age
  › Location where Pt receives services: home, NF, ALF, in–Pt
  › If Pt is a transfer
  › Previous revocation or discharge

HIS…cont.

› Required to submit two HIS records for each admission:
  › HIS–Admission record (45 data elements)
    › Contains administrative data about Pt
    › Contains clinical items to calculate the 7 quality measures
  › HIS–Discharge record (15 data elements)
    › Contains limited set of administrative items for Pt identification
    › Contains discharge information used to determine exclusions for quality measures (i.e. LOS)

HIS…cont.

› Submitted electronically (no paper transmission)
› Admit and discharge date may be the same
› Submitted on an ongoing basis
  › Have 14 calendar days from admit to complete HIS–Admit records
  › Have 7 calendar days from discharge to complete HIS–Discharge records
  › Have 30 calendar days from Admit or Discharge to submit HIS records to CMS

Administrative Information

› Admission date is date of EOB to your hospice, for this benefit period
› Discharge date is date Pt leaves your hospice
› Admit and discharge can be the same day
› Leave unknown Pt information blank
› Pt setting prior to admission may not change with hospice admission i.e. LTCF, home
CPR Preference

- HIS: Was the Pt/responsible party asked about preference regarding use of CPR?
- HIS: Date the Pt was first asked...
- Must ask Pt preferences even if they are recorded on referral documentation – Pt may make new decision w/ hospice admit.
- Orders for "DNR" do not meet the criteria for discussion of Pt preferences.
- HIS documents discussion w/ Pt, not the Pt’s decision. Date of conversation is not effected by Pt changing her/his mind during subsequent conversations. (Snapshot in time.)

CPR Preference...cont.

- Pt admitted 08/01/2014 Clinical record documents DNR is in effect, dated 07/15/2013.
- Does this meet the burden for HIS discussion?
- What would need to be done to meet the burden? (Conversation to verify DNR status.)

Other Life–Sustaining Preferences

- SCENARIO: Pt admitted 06/23/2014. Clinical record documents "Discussed Pt’s views re: antibiotics. Pt does not know what she wants, wants to think about it."
- Clinical note 06/30/2014 "Pt states she wishes to have antibiotics if needed."
- What is the date Pt was first asked about antibiotics?
  - 06/23/2014
  - Pt’s subsequent decision does not impact HIS.

Hospitalization

- HIS: Was the Pt/responsible party asked about preference regarding hospitalization?
- HIS: Date Pt was first asked...
- Must ask Pt preferences even if they are recorded on referral documentation.
- Conversation may be initiated by any hospice staff.
- Who will ask, what will they ask, where will it be documented?
Spiritual/Existential Concerns

› HIS: Was the Pt/responsible party asked about spiritual/existential concerns?
  HIS: Date Pt was first asked...
› Documentation of evidence of a discussion. Clinical documentation of Pt’s religious preference does not meet the standard.
› Pt/responsible party may refuse to discuss.
› There is no comprehensive list of existential questions/concerns. How will you define/document this?

Active Diagnosis

› Record the Pt’s principle diagnosis, the diagnosis that most contributes to the Pt’s terminal condition.
› Determined by the Medical Director in collaboration with the IDT.
› Diagnosis code must match ICD–9/10
› Three choices:
  ◦ Cancer
  ◦ Dementia/Alzheimer’s
  ◦ None of the above

Pain Screen

› HIS: Was the Pt screened for pain?
› HIS: Date for screening
› HIS: Pain severity – for HIS reporting, score is converted to none, mild, moderate, severe, or not rated
› HIS: Type of standardized pain screening tool
› Must use a standardized test for screening. Reported on HIS as numeric, verbal, visual, staff observation, or none used.

Pain Screen…cont.

› Report score at the time of the assessment.
› If a range is given during the screen, document the highest level of pain.
› Clinical judgment can be used to document severity of pain if screening tool does not provide.
› Screen tool may not be required if Pt reports she/he is not in pain and appears to be comfortable.

SCENARIO: Clinical note states “Pt drowsy, appears comfortable.”

› Is this a pain screen? Yes.
  ◦ Although there is no standardized tool, it is clear the clinician did an assessment.

SCENARIO: Clinical record states “Pt pain free now, reports abdominal pain rated 4–5 through the night.”

› What is the pain screen for this screen?
  ◦ 4–5 (reported in HIS as “moderate”)
  ◦ HIS records the greater pain when a range is reported
Comprehensive Pain Assessment

- HIS: Was a comprehensive pain assessment done?
- HIS: Date of pain assessment.
- Documentation of the following is acceptable evidence of pain assessment:
  - Caregiver report of pain
  - Non-verbal indicators of pain
  - Documentation of the clinician’s attempt to gather information about pain

A comprehensive pain assessment consists of seven elements. At least one must be documented in the record as evidence that a pain assessment was completed:
- Location
- Severity
- Character
- Duration
- Frequency
- What relieves/worsens pain
- Effect on function or quality of life

SOB Screen

- HIS: Was the Pt screened for shortness of breath?
- HIS: Date of screen.
- No standardized assessment tool is required for assessment of SOB
- Documentation of a positive screen may include Pt’s verbal statements, caregiver reports, clinician’s observations
- Changes in Pt status over time do not impact the HIS. (Snapshot in time.)

Treatment for SOB

- HIS: Was treatment of shortness of breath initiated?
- HIS: Date treatment was initiated.
- HIS: Types of treatment initiated:
  - Opioids
  - Other medication
  - Oxygen
  - Non-medication
- Consider both scheduled and PRN meds
- Include standing orders only if they are initiated
- For this question, include only those treatments specifically ordered in response to this positive SOB screen

Treatment for SOB...cont.

- Non-medication interventions (other than O2) may include:
  - Repositioning
  - Fans
  - HOB elevated
  - Relaxation techniques
  - Breathing exercises
  - Pt education about energy conservation

SCENARIO: 08/17/2014  Clinical note states “Pt reports SOB at rest.” Clinical assessment of dyspnea, rapid and shallow resp. Instructed PCG in use of fan and elevated HOB. 08/15/2014 order for PRN morphine. What is date treatment was initiated? What treatment?
- Treatment date 08/17 (fan and HOB) since MS order does not state intended use for SOB.
- Treatments: fan, HOB, O2
Treatment for SOB...cont.

- SCENARIO: 08/19/2014 Clinical assessment of SOB, discussion with PCG on use of fan and elevated HOB. 08/20/2014 O2 ordered. What is date of initiation of treatment?
  - Treatment date 08/19/2014 for Pt instruction.
  - Treatments: instruction and O2.

NOTE: Next section on medications is not specific to treatment for dyspnea!

Medications – Scheduled Opioid

- HIS: Was a scheduled opioid initiated or continued?
- HIS: Date opioid initiated or continued.
- If Pt received several different opioids in sequence over time, record the date the first opioid was initiated
  - Date is defined as the date the order was received.
- Order may be written or verbal
- Answer "yes" if regularly scheduled opioid is initiated, regardless of reason.

Medications – PRN Opioid

- HIS: Was a PRN opioid initiated or continued?
- HIS: Date opioid initiated or continued.
- If Pt received several different PRN opioids in sequence over time, record the date the first PRN opioid was initiated
  - Date is defined as the date the order was received.
- Order may be written or verbal
- Answer "yes" if PRN opioid is initiated, regardless of reason.

Bowel Regimen

- HIS: Was a bowel regimen initiated or continued?  N  No, but...  Y
- HIS: Date bowel regimen was initiated or continued.
- Orders may include regularly scheduled treatments/med or PRN.
- Bowel regimen may include:
  - Laxatives or stool softeners
  - High fiber supplements
  - Enemas
  - Suppositories

Bowel Regimen...cont.

- Documentation of why a bowel regimen was not initiated (No, but...), may include:
  - Bowel obstruction, ileus
  - Diarrhea
  - No bowel function
  - Colostomy/ileostomy
  - Nausea/vomiting
  - Recent abdominal surgery
  - NPO
  - Bowel regimen offered and refused by Pt
Bowel Regimen...cont.

› HIS record of bowel regimen is linked to relief of constipation from any cause and not exclusively linked to opioid prescription.
› It may be necessary to review other parts of the clinical record to find documented evidence of bowel regimen or contraindications. i.e.
  ◦ In the GI assessment
  ◦ In nutritional assessment

Record Administration – Section Z

› Any staff may complete the HIS report.
› Clinician who does screens and assessments may not be the person completing the HIS.
› Multiple staff may make entries in the HIS.
› Administrative signatures must include everyone who recorded data in the HIS report.
› Each person signs the report and records which sections of the report they completed.

Record Administration – Section Z...cont.

› Signature on the HIS record does not attest to the accuracy of the assessments in the clinical record.
› Signature on the HIS record certifies only that the HIS record itself is complete.
› If EMR extracts data for HIS, signature page must still be signed.

Capturing the HQR Data

› Analyze your existing forms for presence/absence of each of the HIS measures (mapping)
› Review clinical forms
  ◦ Comprehensive Assessment, including Initial Nursing Assessment, SW Assessment, and Spiritual Assessment
  ◦ Nursing Visit Note
  ◦ QAPI Chart Audit Tool – for ongoing monitoring of HIS process

Capturing Data...cont.

› Data elements to find in current forms:
  ◦ CPR preferences
  ◦ Other life-sustaining treatment preferences
  ◦ Hospitalization preferences
  ◦ Spiritual/existential concerns
  ◦ Pain screening on admit
  ◦ Comprehensive pain assessment
  ◦ SOB assessment
  ◦ SOB treatment
  ◦ Scheduled and PRN opioids
  ◦ Bowel regimen

Capturing Data...cont.

› Can you find all of the HIS measures in your assessments and audit tools?
› Identify presence or absence of specific measures; revise forms accordingly
› Educate staff to observe and record data in a systematic way
Capturing Data…cont.

- Create a HIS process to:
  - Screen and assess
  - Document in the clinical record
  - Locate appropriate data in the clinical record
  - Process for extracting data from the clinical record

Reporting Data

- Only data available in the Pt’s clinical record may be used for HIS.
- Evidence found in referral documentation does not apply.
- Retain a copy of the HIS and signature page.

Appendix C of HIS manual gives guidance on how to use the HIS data to calculate the NQF (National Quality Forum) measures. This is not a requirement, but may be used in your QAPI process.

Time/Cost Burdens*

- Time Estimate:
  - Average admissions per hospice/mo = 24
  - Estimated # of HIS records/mo = 49
- Cost Estimate
  - $3,818.26 annual cost per hospice
    - Includes clinical and admin/clerical time to abstract and upload assessment data for admission reports, and abstract and upload data for discharge reports
    - Cost to provider per Pt = $13.11

*Based on 2011 statistics from NQF and US Bureau of Labor Statistics

Resources

- Technical User manual draft is currently available
- HIS User Manual available February 2014 at CMS HQR website
- HIS technical data requirements can be found at:

Resources…cont.

- Bookmark CMS HQR web page
  - Hospice Item Set (HIS)
  - HIS Technical Information
  - Help Desk
- CMS WebEx training
- HIS Fact Sheet from CMS website
- Listserv for: CMS Home Health, Hospice, and DME Open Door Forums
- MLN e-news
- National and state hospice provider associations
Resources...cont.


Resources...cont.