

HIS Manual

Guidance Manual for Completion of the Hospice Item Set (HIS)

Centers for Medicare and Medicaid Services
Hospice Quality Reporting Program

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According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1153**. The time required to complete this information collection is estimated to average **19 minutes** per response for the HIS-Admission and **10 minutes** per response for the HIS-Discharge, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

OMB Control # 0938-1153



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CHAPTER 1: BACKGROUND AND OVERVIEW OF THE HOSPICE ITEM SET MANUAL

1.1 Background and Statutory Authority

Section 3004 of the Patient Protection and Affordable Care Act (ACA) authorizes the Health and Human Services Secretary to establish a quality reporting program for hospices. The ACA specifies that, for fiscal year (FY) 2014 and each subsequent FY, hospice programs shall submit to the Secretary data on quality measures; the ACA also describes measure endorsement requirements for any measures specified by the Secretary. A hospice is not required to obtain patient consent to collect data for quality measures for the Hospice Quality Reporting Program (HQRP) because the Centers for Medicare & Medicaid Services (CMS) has the statutory authority to collect quality data for hospices under Section 3004(c) of the ACA. CMS established the HQRP in the FY 2012 Hospice Wage Index final rule (76 FR 47318-47324). CMS finalized the requirement for the Hospice Item Set (HIS) as part of the HQRP in the FY 2014 Hospice Wage Index final rule (78 FR 48255-48262). Medicare-certified hospices (hospices) will submit a HIS-Admission record and a HIS-Discharge record for each patient admission on or after July 1, 2014. Hospices will continue to collect and submit HIS data on all patient admissions; HIS data will be submitted to CMS on a regular and ongoing basis from July 1, 2014, onward.

The HIS is a standardized set of items intended to capture patient-level data on each hospice patient admission. Current HIS items can be used to calculate six National Quality Forum (NQF)-endorsed measures and a modification of one NQF-endorsed measure (**Table 1**). Please note that the HIS is not an assessment instrument and does not replace a thorough and ongoing assessment of each patient as required by the Medicare Hospice Conditions of Participation, nor does it replace standard clinical practice and judgment.

Table 1: Quality Measures Calculated Using the HIS

NQF Number	Measure Name
NQF #1641	Treatment Preferences
Modified 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

1.2 Manual Overview

The purpose of the HIS Manual is to offer hospices guidance on the collection and submission of HIS data to CMS. The manual is divided into three chapters and appendices:

Chapter 1 – Provides an introduction of contextual information, timing and sequence policies, and general guidance.

Chapter 2 – Contains item-specific guidance for completing each item in the HIS.

Chapter 3 – Includes information on HIS record submission and correction processes.

Appendices – Include the HIS-Admission and HIS-Discharge, quality measure specifications, glossary, and resources.

1.3 HIS Requirements and Reporting Years

Hospices shall submit two HIS records (a HIS-Admission record and a HIS-Discharge record) for each patient admission occurring on or after July 1, 2014. HIS reporting consists of three primary activities: HIS data collection, HIS record conversion, and HIS record submission. See **Figure 1**.

Figure 1: Three primary phases of HIS reporting



HIS data collection consists of selecting responses to HIS items in conjunction with patient assessment activities or via abstraction from the patient's clinical record. HIS data may be collected on paper forms or using an electronic health record, but prior to submission, HIS data must be converted into the proper electronic file format (XML), which is necessary for successful submission. To convert HIS records into the proper XML file format, providers can use either the Hospice Abstraction Reporting Tool (HART) software, which is free to download and use, or a vendor-designed software. Once HIS records are converted, files are submitted to CMS via the Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing (ASAP) system. Records should be completed and submitted according to the time frames outlined in **Section 1.7, Timing and Sequence Policies**. Although this manual contains general HIS record completion and submission policies, it does not contain

detailed information about conversion and submission software and procedures. Please see **Chapter 3** for links to additional resources on HIS record conversion and submission.

Any hospice that does not comply with the data submission requirements for any given reporting year shall have its market basket update, also known as the Annual Payment Update (APU), reduced by 2 percentage points for the relevant FY.

HIS reporting activities currently operate on a cycle of HIS data collection and submission, compliance determinations, and payment impact that spans 3 years. HQRP reporting years are referenced by the relevant FY APU affected. For example, the FY 2017 Reporting Year consists of data collection and submission in calendar year (CY) 2015, compliance determinations in 2016, and payment impact for the FY 2017 APU. See **Figure 2**, below.

Figure 2: FY 2017 Reporting Year Activities

CY 2015	CY 2016	CY 2017
<p>Data Collection and Submission: Collect and submit HIS data for all patient admissions occurring during CY 2015 (January 1, 2015 – December 31, 2015).</p>	<p>Compliance Determinations: In 2016, CMS makes compliance determinations based on HIS submissions for patient admissions occurring in 2015.</p>	<p>Payment Impact: Determinations of noncompliance made in 2016 will go into effect in FY 2017 (10/1/2016), reducing the FY 2017 APU by 2 percentage points.</p>

For more information on criteria for compliance determinations, see **Section 1.9, Compliance with HQRP Requirements and APU Determinations.**

1.4 Applicable Facilities and Requirements for New Facilities

All Medicare-certified hospice providers are required to submit HIS data on all patient admissions on or after July 1, 2014, onward.

Reporting eligibility and requirements for new hospice providers is addressed by CMS through rulemaking. In the FY 2015 Hospice Wage Index and Payment Rate Update final rule (79, FR 50487), CMS finalized that any hospice that receives its CMS Certification Number (CCN) notification letter on or after November 1 of the preceding year involved is excluded from any payment penalty for quality reporting purposes for the APU determinations for that particular FY. For example, a new hospice that received its CCN notification letter on November 2, 2015, would not be required to submit quality data on patient admissions occurring during CY 2015 (which would affect the FY 2017 APU). In this example, the hospice would begin HIS data collection and submission on patient admissions occurring on or after January 1, 2016, at the latest, and collect and

submit data for all subsequent years. HIS data submitted on patient admissions for CY 2016 would affect the FY 2018 APU.

For more details on requirements for new facilities, see proposed and final rules published by CMS in the Federal Register: <https://www.federalregister.gov/>.

1.5 Applicable Patients

A HIS-Admission and a HIS-Discharge record are submitted for all patient admissions to a Medicare-certified hospice program on or after July 1, 2014, regardless of the following:

- Payer source (Medicare, Medicaid, or private payer).
- Patient age.
- Where the patient receives hospice services (home, nursing home, assisted living facility, freestanding hospice).

1.6 Record Types and Definitions

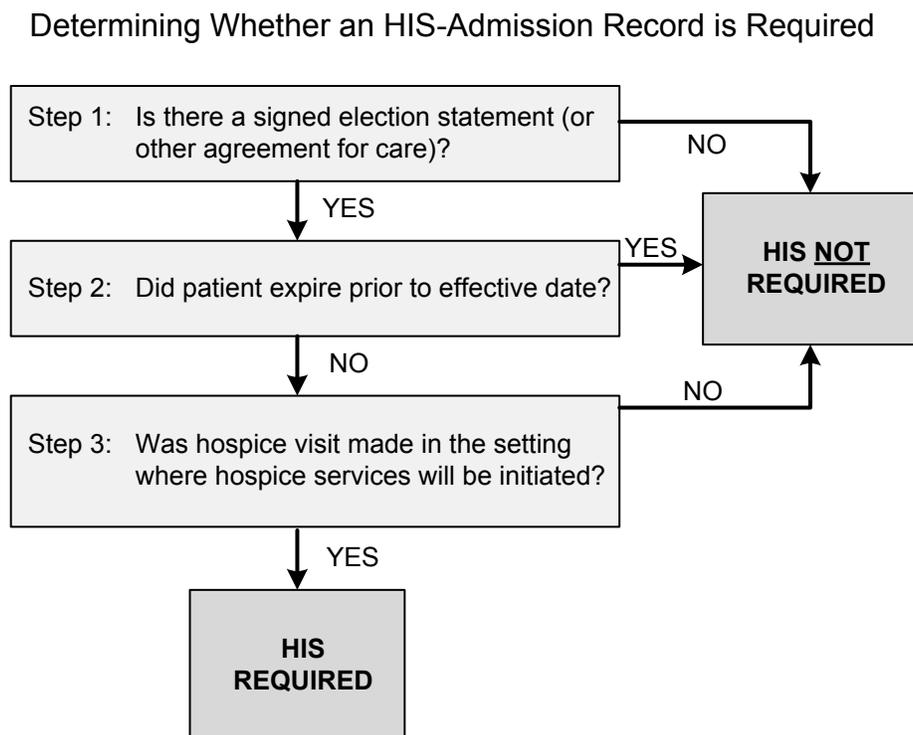
Hospices are required to submit two HIS records for each patient admission to their organization: a HIS-Admission record and a HIS-Discharge record. HIS-Admission and HIS-Discharge completion is generally triggered by the patient's admission to or discharge from a Medicare-certified hospice.

Admission: For the purposes of completing the HIS, a patient is considered admitted to a hospice if the following conditions are met:

1. There is a signed election statement (or other agreement for care for non-Medicare patients).
2. The patient did not expire before the effective date of the election or agreement for care.
3. The hospice made a visit in the setting where hospice services are to be initiated.

All three criteria listed above must be met for the patient to be considered admitted for the purposes of HIS reporting (see **Figure 3**, below).

Figure 3: Flowchart for Patient Admission



Admission date: The date on which the hospice becomes responsible for the care of the patient. For Medicare patients, this is the effective date of the election or re-election, which may be the first day of hospice care or a later date, but may be no earlier than the date of the election statement.

Discharge: For the purposes of completing the HIS, a patient is considered discharged when the patient is no longer receiving services from the hospice or there is an interruption in care/services related to one of the reasons listed in Item A2115 (expired, revoked, no longer terminally ill, moved out of hospice service area, transferred to another hospice, discharged for cause).

Discharge date: The date the hospice discharged the patient. If the patient expired, the date of death is the discharge date. For live discharges, the date the patient revoked the benefit or the date the hospice discharged the patient is the discharge date.

Special Circumstances

Certain circumstances may not be considered an admission or discharge for the purposes of HIS completion. Special circumstances and the appropriate HIS record action are presented below.

Patient transfers from a provider with one CCN to a provider with different CCN: HIS reporting is at the CCN level. If a hospice patient’s care transfers or changes from one hospice to another, and the two hospices have different CCNs, each hospice

should complete a HIS-Admission and a HIS-Discharge record for the care provided to the patient by their organization. When the transferring hospice completes its HIS-Discharge, response 05, “transferred to another hospice,” should be selected for Item A2115—Reason for Discharge.

Change in patient payer source or other administrative discharges with no interruption in care: In some circumstances, a hospice’s policy may be to administratively discharge a patient and re-admit them. Such circumstances might include the following:

- Change in patient’s payer source: a private pay patient becomes eligible for Medicare during the course of hospice stay; hospice completes an “administrative” discharge and re-admission for the patient for billing purposes.
- Hospice fails to meet the face-to-face requirement: if a hospice fails to meet the face-to-face requirement, the hospice must administratively discharge the patient, but the patient remains on service.
- In general, as long as the patient remains under a hospice’s care with no interruption in hospice service, completion of a HIS-Discharge is not required. In both of the situations listed above, because the patient remained under the hospice’s care with no interruption in service, the hospice would not be required to submit a HIS-Discharge. Hospices should submit a HIS-Discharge once the patient is no longer receiving hospice service or there is an interruption in care related to one of the reasons for discharge listed in Item A2115.

Traveling patients: Hospice patients may on occasion travel outside of their “home hospice’s” service area. In these circumstances, during the time the patient is outside of the home hospice’s service area, the patient may receive services from a “host hospice.” Per CMS regulations at 418.26, a hospice may discharge a patient if the patient moves out of the service area or transfers to another hospice. However, per the hospice regulations, a hospice may also enter into a written arrangement with another Medicare-certified hospice program for the provision of core services to supplement hospice employees/staff to meet the needs of patients. Circumstances under which a hospice may enter into a written arrangement for the provision of core services include a patient temporarily traveling outside of the hospice’s service area. In the case of a traveling patient, whether or not a hospice should submit a HIS-Discharge and new HIS-Admission depends on whether the home hospice discharged the patient and if the host hospice admitted the patient to hospice care and filed a notice of election (NOE) within the claims processing system. If there is no discharge by the home hospice, then the home hospice is not required to submit a HIS-Discharge when the patient travels out of the home hospice’s service area. Relatedly, the host hospice would not need to submit a HIS-Admission or HIS-Discharge for a traveling patient whom they are providing services to under a written agreement with the home hospice.

1.7 Timing and Sequence Policies

Hospices will submit two HIS records—a HIS-Admission record and a HIS-Discharge record—for each **patient admission**. Hospices should complete and submit each record in accordance with the policies listed in **Table 2**. Timing is not the same for all HIS records, as timing is based on the Admission Date or Discharge Date.

Table 2: Timing Definitions

Admission Date (Item A0220)	The date on which the hospice becomes responsible for the care of the patient. For Medicare patients, it is the same as the effective date of the hospice benefit election (or re-election), which may be the first day of hospice care or a later date, but may be no earlier than the date of the election statement. ¹
Discharge Date (Item A0270)	The date a patient leaves the hospice. If the patient has expired, it is the date of death. For live discharges, it is the date the patient revoked the hospice benefit or the date the hospice discharged the patient. ²
Completion Date (Item Z0500B)	The actual date on which the hospice completes the record. Defined as the date all required information has been collected and recorded and staff have signed and dated that the record is complete. This date should represent the completion date for the HIS record that has been verified by the individual authorized to do so. This individual signs and dates Item Z0500. The completion date should be no later than the completion deadline.
Completion Deadline	The latest possible date on which a provider should complete a HIS record. The completion deadline for the HIS-Admission record is defined as the Admission Date + 14 calendar days. The completion deadline for the HIS-Discharge record is defined as the Discharge Date + 7 calendar days.
Submission Date	The actual date on which the hospice submits the completed record. Defined as the date on which the completed record is submitted and accepted to the QIES ASAP system. The submission date should be no later than the submission deadline.
Submission Deadline	Defined as the latest possible date on which a provider should submit a HIS record. The submission deadline for the HIS-Admission record is defined as the Admission date + 30 calendar days. The submission deadline for the HIS-Discharge record is no later than the Discharge Date + 30 calendar days.

¹ "Hospice Care." 42 CFR 418.24 (2011).

² Centers for Medicare & Medicaid Services. *Medicare Claims Processing Manual*.

Completion Timing

For HIS-Admission records, the Completion Deadline is defined as the Admission Date + 14 calendar days. This means the Completion Date (Z0500B, the actual date on which the record was completed) should be no later than the Admission Date + 14 calendar days. The Completion Date can be equal to the Admission Date or Completion Deadline. The QIES ASAP system will issue a warning on the Final Validation Report if the Completion Date is more than 14 days after the Admission Date. For more information on Validation Reports, see **Chapter 3**.

For HIS-Discharge records, the Completion Deadline is defined as the Discharge Date + 7 calendar days. This means the Completion Date (Z0500B, the actual date on which the record was completed) should be no later than the Discharge Date + 7 calendar days. The Completion Date can be equal to the Discharge Date or Completion Deadline. The QIES ASAP system will issue a warning on the Final Validation Report if the Completion Date is more than 7 days after the Discharge Date.

The completion deadlines above define only the latest possible date on which a hospice should complete each HIS record. To better align HIS completion processes with clinical workflow processes, hospices may develop internal policies to complete HIS records early (prior to the Completion Deadline). If a hospice chooses to complete a HIS-Admission record prior to the Completion Deadline, the hospice should consider care processes that were documented in the clinical record up to the Completion Date. If the patient's status with respect to care process items changes between the Completion Date and the Completion Deadline, hospices *should not* update the HIS-Admission record.

Completion timing policies above do not outline timing of care processes that are captured by HIS items for quality measure calculation purposes. For additional information on timeliness criteria, see **Chapter 3**. For more information on timing for quality measure calculation purposes, please see **Appendix C**.

Submission Timing

For HIS-Admission records, the submission deadline is defined as the Admission Date + 30 calendar days. This means the Submission Date should be no later than the Admission Date + 30 calendar days. The Submission Date can be equal to the Admission Date, but no greater than 30 days later. The QIES ASAP system will issue a warning on the Final Validation Report if the Submission Date is more than 30 days after the Admission Date.

For HIS-Discharge records, the submission deadline is defined as the Discharge Date + 30 calendar days. This means the Submission Date should be no later than the Discharge Date + 30 calendar days. The Submission Date can be equal to the Discharge Date, but no greater than 30 days later. The QIES ASAP system will issue a warning on the Final Validation Report if the Submission Date is more than 30 days after the Discharge Date.

The submission deadlines timing policies outlined above only define the latest possible date a hospice should submit each HIS record. For additional information on timeliness criteria, see **Chapter 3**.

Completion and submission timing is further illustrated in the tables below. The first example in **Tables 3** and **4** shows a HIS record that is completed and submitted on the latest possible date. The second example in each table shows a HIS record that is completed and submitted early.

Table 3: Timing for HIS-Admission

Examples	Admission Date (A0220)	Completion Date (Z0500B)	Submission Date
Completed and submitted by latest dates	11/11/2015	11/25/2015 (Admission Date+14)	12/11/2015 (Admission Date+30)
Completed and submitted early	11/11/2015	11/17/2015	11/20/2015

Table 4: Timing for HIS-Discharge

Examples	Discharge Date (A0270)	Completion Date (Z0500B)	Submission Date
Completed and submitted by latest dates	12/22/2015	12/29/2015 (Discharge Date+7)	1/21/2016 (Discharge Date+30)
Completed and submitted early	12/22/2015	12/25/2015	1/3/2016

Hospices should have a system in place to ensure all required item sets are submitted appropriately. If a hospice finds it has not submitted a required item set, the hospice should submit the missing item set as soon as the error is identified.

If a hospice realizes that it will not meet the timeliness criteria for any given record, it should still complete and submit that record, even if that means the record would be late. Late completion and submission of HIS records will result in a nonfatal (warning) error. Records containing nonfatal errors can still be accepted by the QIES ASAP system.

Correction policies are further outlined in **Chapter 3** of this manual.

Submission Sequence

The QIES ASAP system will issue a warning on the Final Validation Report when a record is submitted out of sequence. Examples include the following:

- A HIS-Admission record submitted after a HIS-Discharge record.
- Submission of a HIS-Admission record where the prior record submitted was also a HIS-Admission record.
- Any record submitted on a patient after the submission of a HIS-Discharge record indicating that the patient has expired (A2115 = 01).

HIS-Admission and HIS-Discharge records may be completed and submitted on the same day when situations arise that warrant this; for example, when a patient is admitted and discharged on the same day.

1.8 Maintenance of HIS Records

We recommend that hospices retain a copy of HIS records, along with any corrected versions. Note that although the signature page is not transmitted to the QIES ASAP system, we recommend that it be retained by the hospice for potential future validation purposes. Copies of HIS records can be maintained in electronic format.

Hospices must ensure that proper security measures are implemented via facility policy to ensure the privacy and integrity of the HIS, regardless of whether the record is in electronic or other form.

1.9 Compliance with HQRP Requirements and APU Determinations

The HQRP is currently a “pay-for-reporting” program, meaning that the act of submitting required HIS records determines compliance with program requirements. The performance rate on a specific quality measure is not a factor in determining compliance with HQRP requirements at this time. Providers who do not comply with reporting requirements for any given reporting period will have their APU reduced by 2 percentage points for the corresponding FY’s APU (see **Section 1.3**, HIS Requirements and Reporting Years).

Specific criteria for determining compliance with HQRP requirements is proposed and finalized through the federal rulemaking cycle. Providers can view proposed and final rules in the Federal Register: <http://www.federalregister.gov>.

Beginning with the FY 2017 reporting year, hospices will also have to meet requirements for the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Hospice Survey as part of general HQRP requirements. This means that, beginning with the FY 2017 reporting year, hospices will have to meet HIS and CAHPS requirements in order to avoid the 2 percentage-point reduction in their APU. For more information on CAHPS Hospice Survey requirements, please visit <http://www.hospicecahpsurvey.org>.

CHAPTER 2: ITEM-SPECIFIC INSTRUCTIONS

2.1 Overview

This chapter presents each item in the Hospice Item Set (HIS), along with instructions for completing each item. **Chapter 2** is organized to correspond with each section of the HIS:

- **Section A:** Administrative Information
- **Section F:** Preferences
- **Section I:** Active Diagnoses
- **Section J:** Health Conditions (Pain and Dyspnea)
- **Section N:** Medications
- **Section Z:** Record Administration

The beginning of each section contains an overview of all HIS items in the section, as well as a section rationale, which explains the purpose of items in each section.

For each HIS item, the general order of information presented in **Chapter 2** is as follows:

- **Item Display:** Provides a screenshot of each item as it appears on the HIS.
- **Item-Specific Instructions:** Outlines the proper method for completing each HIS item, including explanations of all response options for each item.
- **Item-Specific Tips:**¹ States clarifications, issues of note, and conditions to be considered when completing HIS items.
- **Examples:**¹ Illustrates examples of appropriate HIS item completion based on sample clinical record documentation. This manual provides examples to assist hospices in understanding the rationale for how to select the most accurate responses when completing the HIS. These examples are **not** intended to dictate or endorse language hospices may use in clinical record documentation. Direct quotes that appear in examples are for illustration purposes only and do not represent Centers for Medicare & Medicaid Services (CMS) endorsement of specific documentation language or products.

¹ Not all HIS items in Chapter 2 include item-specific tips and examples. Item display and item-specific instructions are included for all HIS items.

2.2 HIS Item Completion Conventions

General Conventions for Completing the HIS

1. A HIS (HIS-Admission and HIS-Discharge) should be fully and accurately completed on all patient admissions on or after July 1, 2014.
2. To complete each HIS accurately and fully, hospice staff should understand what information and data each item requires, and complete the item based only on what is being requested. Responses to items on the HIS can be selected by the assessing clinician as part of the patient visit/assessment, or could be based on information documented in the clinical record and abstracted on or before the Completion Date (Item Z0500B).
3. All completed HIS records must be electronically submitted to the Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing (ASAP) system.
4. HIS record submission should follow the sequence outlined in **Section 1.7, Timing and Sequence Policies**.
5. Policies outlined in **Chapter 3** describe how to correct errors in a HIS record that has already been accepted by the QIES ASAP system.
6. A HIS-Admission and HIS-Discharge should be submitted even if the patient revokes the hospice benefit or is discharged from hospice before all HIS-related care processes are complete. Follow the gateway questions and skip patterns for item completion.

Who May Complete the HIS

The HIS may be completed by any hospice staff member, including volunteers, contractors, and affiliates (for example, staff from the quality division of the health system to which a hospice belongs). The hospice is responsible for the accuracy and completeness of information in the HIS. It is at the discretion of the hospice to determine who can accurately complete the HIS. Each person completing any portion of a HIS record should provide a signature in Section Z, Record Administration, in accordance with the instructions provided in **Section Z** of this chapter.

Acceptable Sources of Documentation

The primary sources of information for completing the HIS include the following:

- Data collected through clinical care processes as they are completed.
- Documentation in the hospice clinical record from which the HIS responses can be abstracted.

This means that, in general, sources external to the clinical record should not be used when completing the HIS.

- In some instances, a provider may consult sources other than the hospice clinical record to complete HIS items. For example, completion of Section A (Administrative Information) items may require review of claims or billing records; Section F (Preferences) items may require review of POLST (Physician Order for Life-Sustaining Treatment) forms or other equivalent forms.
- If a particular HIS care process is not documented in the hospice clinical record, the care process is considered not to have occurred. Complete the HIS items accordingly, following skip patterns outlined in the HIS.

Relationship Between Care Processes and the HIS

Most of the items in the HIS-Admission relate to care processes that align with the initial assessment or the comprehensive assessment period, as required by the Medicare Hospice Conditions of Participation. Thus, completing the HIS-Admission record after the comprehensive assessment period ends and before the completion deadline (defined as the Admission Date + 14 calendar days) meets the intent of the HIS. Completion timelines outlined above may not necessarily align with timing requirements for quality measure calculation purposes. See **Appendix C** for additional information on how timing of items in the HIS relates to quality measure calculation. See **Section 1.7** for additional information on timing and sequence policies.

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SECTION A: ADMINISTRATIVE INFORMATION

Items in this section of the Hospice Item Set (HIS) pertain to administrative information.

RATIONALE

This section obtains key information that uniquely identifies each patient, the hospice from which he or she receives services, and the reason for record.

A0050: Type of Record

Enter Code	1. Add new record
<input type="checkbox"/>	2. Modify existing record
	3. Inactivate existing record

Item-Specific Instructions

Indicate whether a HIS record is a new record to be added to the Quality Improvement Evaluation System (QIES) Assessment Submission and Processing (ASAP) system or if a HIS record that was previously submitted and accepted in the QIES ASAP system requires modification or inactivation.

- **Response 1, Add new record:** Select response 1 if this is a *new* HIS record that has not been previously submitted and accepted in the QIES ASAP system.
 - If there is an existing record for the same patient in the same hospice with the same reason for record and with the same event date(s) (for example, admission date or discharge date), then the current record would be a duplicate and not a new record. In this case, when submitted, the record will be rejected by the QIES ASAP system and a fatal error will be reported to the provider on the Final Validation Report. Further details on the Final Validation Report can be found in **Chapter 3**.
- **Response 2, Modify existing record:** Select response 2 if this is a *request to modify data* for a record that already has been submitted and accepted in the QIES ASAP system. Selecting response 2 creates a **Modification Request**, which is used when a HIS record has been previously submitted and accepted in the QIES ASAP system, but the record contains clinical or non-key demographic errors.
 - Errors in most items on a HIS record can be corrected with a Modification Request, with some exceptions. For more details on Modification Requests, see **Chapter 3** of this manual.
- **Response 3, Inactivate existing record:** Select response 3 if this is a *request to inactivate* a HIS record that has already been submitted and accepted in the QIES ASAP system. Selecting response 3 creates an **Inactivation Request**, which is used when a HIS record has been previously submitted and accepted in the QIES ASAP system but one of the following occurs:
 - Particular item values (for example, recent event identifiers or key patient identifiers) are inaccurate.
 - The corresponding event did not occur (for example, a HIS discharge record was submitted, but the patient was not discharged).

For more details on Inactivation Requests, see **Chapter 3** of this manual.

Item-Specific Tips													
<p>Corrections should be made to any HIS record(s) that have errors to ensure that the information in the QIES ASAP system accurately reflects any of the following: the patient's identification, location, and reason for the record.</p>													
<p>A0100: Facility Provider Numbers. Enter code in boxes provided.</p>													
<p>A. National Provider Identifier (NPI):</p> <table border="1" style="width: 100%; height: 20px;"> <tr> <td style="width: 25px;"></td> </tr> </table>													
<p>B. CMS Certification Number (CCN):</p> <table border="1" style="width: 100%; height: 20px;"> <tr> <td style="width: 25px;"></td> <td style="width: 25px; background-color: #cccccc;"></td> </tr> </table>													
Item-Specific Instructions													
<p>A0100: Facility Provider Numbers</p> <p>A. National Provider Identifier (NPI):</p> <ul style="list-style-type: none"> • Enter the NPI. The NPI is a unique federal number that identifies providers of health care services. <p>B. CMS Certification Number (CCN):</p> <ul style="list-style-type: none"> • Enter the hospice's CCN. The CCN is also known as the Medicare provider number. It is a six-digit number, usually in the format xx-xxxx. 													
A0205. Site of Service at Admission													
<p>Enter Code</p> <table border="1" style="width: 100%; height: 20px;"> <tr> <td style="width: 25px;"></td> <td style="width: 25px;"></td> </tr> </table>			<ol style="list-style-type: none"> 01. Hospice in patient's home/residence 02. Hospice in Assisted Living facility 03. Hospice provided in Nursing Long Term Care (LTC) or Non-Skilled Nursing Facility (NF) 04. Hospice provided in a Skilled Nursing Facility (SNF) 05. Hospice provided in Inpatient Hospital 06. Hospice provided in Inpatient Hospice Facility 07. Hospice provided in Long Term Care Hospital (LTCH) 08. Hospice in Inpatient Psychiatric Facility 09. Hospice provided in a place not otherwise specified (NOS) 10. Hospice home care provided in a hospice facility 										

Item-Specific Instructions

A0205. Site of Service at Admission

- **Response 01, Hospice in patient's home/residence:** Select response 01 if the patient received hospice care in their home/residence at the time of admission.
 - This would include a patient receiving hospice care in the private home/residence of a family member or caregiver.
- **Response 02, Hospice in Assisted Living facility:** Select response 02 if the patient received hospice care in an Assisted Living facility at the time of admission.
- **Response 03, Hospice provided in Nursing Long-Term Care (LTC) or Non-Skilled Nursing Facility (NF):** Select response 03 if the patient received hospice care in a Nursing Long Term Care (LTC) or Non-Skilled Nursing Facility (NF) at the time of admission.
- **Response 04, Hospice provided in a Skilled Nursing Facility (SNF):** Select response 04 if the patient received hospice care in a Skilled Nursing Facility (SNF) at the time of admission.
- **Response 05, Hospice provided in Inpatient Hospital:** Select response 05 if the patient received hospice care in an Inpatient Hospital at the time of admission.
- **Response 06, Hospice provided in Inpatient Hospice Facility:** Select response 06 if the patient received hospice care in an Inpatient Hospice Facility at the time of admission.
- **Response 07, Hospice provided in Long Term Care Hospital (LTCH):** Select response 07 if the patient received hospice care in a Long Term Care Hospital (LTCH) at the time of admission.
- **Response 08, Hospice in Inpatient Psychiatric Facility:** Select response 08 if the patient received hospice care in an Inpatient Psychiatric Facility at the time of admission.
- **Response 09, Hospice provided in a place not otherwise specified (NOS):** Select response 09 if the patient received hospice care in a place not otherwise specified (NOS) at the time of admission.
- **Response 10, Hospice home care provided in a hospice facility:** Select response 10 if the patient received hospice care provided in a hospice residence or facility at the time of admission.

Item-Specific Tips

- Response options for Item A0205 are structured to match sites of service found on Medicare claims. Because the site of service must be identified on Medicare claims for the initial level of care billed, identifying site of service the same way when completing this HIS item can reduce administrative burden for the hospice.
- For purposes of completing Item A0205, SNF is not synonymous with nursing facility. The response option for SNF is to be used for patients in a SNF or patients in the SNF portion of a dually-certified nursing facility. If a beneficiary is in a nursing facility but doesn't meet the criteria above, do not use the response option for SNF; instead, use the response option for long-term care facility (also known as NF or nursing facility).

A0220. Admission Date		
<input type="text"/>	<input type="text"/>	<input type="text"/>
Month	Day	Year
Item-Specific Instructions		
<p>A0220. Admission Date</p> <ul style="list-style-type: none"> • Enter the date of admission to this hospice. Use the format Month-Day-Year: MM-DD-YYYY. Do not leave any spaces blank. If the month and/or day contain only a single digit, enter “0” in the first box of the month and/or day. For example, November 1, 2015, would be entered as 11-01-2015. A day begins at 12:00 a.m. and ends at 11:59 p.m. • The admission date specifies the date on which the hospice becomes responsible for the care of the patient. <ul style="list-style-type: none"> – For Medicare patients, this is the effective date of election or of re-election. – For patient transfers (regardless of payer source), this is the date the patient was transferred to your hospice from another hospice organization; specifically, the date your hospice became responsible for the patient’s hospice care. 		
A0245. Date Initial Nursing Assessment Initiated		
<input type="text"/>	<input type="text"/>	<input type="text"/>
Month	Day	Year
Item-Specific Instructions		
<p>For more information on what constitutes a patient admission for the purposes of HIS reporting, see Section 1.6, Record Types and Definitions.</p> <p>A0245. Date Initial Nursing Assessment Initiated</p> <ul style="list-style-type: none"> • Enter the date the hospice clinician began the initial nursing assessment. Use the format Month-Day-Year: MM-DD-YYYY. Do not leave any spaces blank. If the month and/or day contain only a single digit, enter “0” in the first box of the month and/or day. For example, November 1, 2015, would be entered as 11-01-2015. • Item A0245 refers to the initial assessment the registered nurse must complete, as defined in the Medicare Hospice Conditions of Participation. • Item A0245 is intended to reflect the date on which the initial nursing assessment (as defined in the Medicare Hospice Conditions of Participation) was initiated. For patients that are discharged for any reason before the initial assessment is completed, enter the date on which the initial assessment was initiated, even if the entire initial assessment was not completed or was initiated in another care setting. If no initial assessment was initiated, enter a dash (-) for Item A0245. 		

A0250. Reason for Record	
Enter Code <input type="text"/> <input type="text"/>	01. Admission 09. Discharge
Item-Specific Instructions	
<p>A0250. Reason for Record</p> <ul style="list-style-type: none"> • Response 01, Admission: Select response 01 for a HIS-Admission record. • Response 09, Discharge: Select response 09 for a HIS-Discharge record. 	
Item-Specific Tips	
<p>A HIS-Admission and a HIS-Discharge record must be completed for each patient admission. For detailed information on the requirements for sequencing the completion and submission of the two record types, see Chapter 1 of this manual.</p>	
A0270. Discharge Date	
<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
Month	Day
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Year
Item-Specific Instructions	
<p><i>Complete only if A0250 = 09, Discharge.</i> For more information on what constitutes a patient discharge for the purposes of HIS reporting, see Section 1.6, Record Types and Definitions.</p> <ul style="list-style-type: none"> • Enter the date the patient was discharged from hospice (whether or not return is anticipated). Use the format Month-Day-Year: MM-DD-YYYY. Do not leave any spaces blank. If the month and/or day contain only a single digit, enter "0" in the first box of the month and/or day. For example, November 1, 2015, would be entered as 11-01-2015. • If the patient expired, the date of death is the discharge date. • For live discharges, the date the patient revoked the hospice benefit or the date the hospice discharged the patient is the discharge date. 	

A0600. Social Security and Medicare Numbers																																
<p>A. Social Security Number:</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> <td style="width: 10px; text-align: center;">-</td> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> <td style="width: 10px; text-align: center;">-</td> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> </tr> </table> <p>B. Medicare number (or comparable railroad insurance number):</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> </tr> </table>				-			-																									
			-			-																										

Item-Specific Instructions

<p>A0600. Social Security and Medicare Numbers</p> <p>A. Social Security Number</p> <ul style="list-style-type: none"> • Enter the Social Security Number (SSN), one number per space, starting with the left-most space. If the patient does not have an SSN or the SSN is unavailable, the item may be left blank. <ul style="list-style-type: none"> – An SSN is a tracking number assigned to an individual by the U.S. federal government for taxation, benefits, and identification purposes. <p>B. Medicare Number (or comparable railroad insurance number)</p> <ul style="list-style-type: none"> • Enter the Medicare number exactly as it appears on the patient’s Medicare card. If the patient does not have a Medicare number, a Railroad Retirement Board (RRB) number may be substituted. RRB numbers contain both letters and numbers; to enter the RRB number, enter the first letter of the code in the left-most space followed by one letter/digit per space. If the person has neither a Medicare number nor an RRB number, the item may be left blank. <ul style="list-style-type: none"> – A Medicare number is an identifier assigned to an individual for participation in national health insurance program(s). The Medicare number may also be referred to as a Health Insurance Claim (HIC) number. The Medicare Health Insurance Claim (HIC) number may differ from the patient’s SSN. For example, many patients receive Medicare benefits based on a spouse’s Medicare eligibility. The HIC number may contain both letters and numbers. – Confirm that the patient’s name on the HIS record matches the patient’s name on the Medicare or RRB card.
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Item-Specific Tips

To avoid inaccuracies in patient record matching, Item A0600 should only be left blank if the patient does not have a SSN or in rare instances where the SSN is unavailable.

- Item A0600B can only be a Medicare (HIC) number or an RRB number.
- *The Medicare Number or RRB number entered in A0600B is not intended to reflect the patient's payer source.* For the purposes of HIS item completion, the Medicare Number or RRB number is used for patient identification purposes only. *If the patient has a Medicare Number or RRB number, enter it in A0600B, even if Medicare is not a payer or is a secondary payer.*
- If the hospice is notified after the record has been submitted that the patient does have a Medicare number, include it on the next record. For instance, if the Medicare number is received after submission of the HIS-Admission record, include the patient's Medicare number on the HIS-Discharge record. Including the Medicare number on the HIS-Discharge record at a later date does not require a Modification Request to the original HIS-Admission Record.

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

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Item-Specific Instructions

A0700. Medicaid Number

- **Enter the Medicaid number** if the patient is a Medicaid recipient. Enter one number per box, beginning in the left-most box.
 - Enter a "+" in the left-most box if the Medicaid number is pending.
 - If the patient is not a Medicaid recipient, enter "N" in the left-most box.
 - Confirm that the patient's legal name on the HIS record matches the patient's legal name on the Medicaid card.
 - If the patient refuses to supply his or her Medicaid number or the Medicaid number is unknown, leave A0700 blank.

Item-Specific Tips

- To obtain the Medicaid number, check the patient's Medicaid card, admission or transfer records, or hospice clinical record.
- The Medicaid Number entered in A0700 is not intended to reflect the patient's payer source. For the purposes of HIS item completion, the Medicaid Number is used for patient identification purposes only. If the patient has a Medicaid Number, enter it in A0700, even if Medicaid is not a payer or is a secondary payer.
- If the hospice is notified after the record has been submitted that the patient does have a Medicaid number, include it on the next record. For instance, if the Medicaid number is received after submission of the HIS-Admission record, include the patient's Medicaid number on the HIS-Discharge record. Including the Medicaid number on the HIS-Discharge record at a later date does not require a Modification Request to the original HIS-Admission Record.

A0800. Gender

Enter Code

1. Male
2. Female

Item-Specific Instructions

A0800. Gender

- **Response 1, Male:** Select response 1 if patient is male.
- **Response 2, Female:** Select response 2 if patient is female.

A0900. Birth Date

Month	Day	Year					

Item-Specific Instructions	
<p>A0900. Birth Date</p> <ul style="list-style-type: none"> • Enter the birth date of the patient. Use the format Month-Day-Year: MM-DD-YYYY. Do not leave any spaces blank. If the month and/or day contain only a single digit, enter “0” in the first box of the month and/or day. For example, November 1, 2015, would be entered as 11-01-2015. • If only the birth year or the birth year and birth month of the patient are known, handle each situation as follows: <ul style="list-style-type: none"> – If only the birth year is known, enter the year in the “year” boxes of A0900 and leave the “month” and “day” boxes blank. – If the birth year and birth month are known, but not the birth day, enter the year in the “year” boxes of A0900, enter the month in the “month” boxes, and leave the “day” boxes blank. 	
A1000. Race/Ethnicity	
<p>↓ Check all that apply</p>	
<input type="checkbox"/>	A. American Indian or Alaska Native
<input type="checkbox"/>	B. Asian
<input type="checkbox"/>	C. Black or African American
<input type="checkbox"/>	D. Hispanic or Latino
<input type="checkbox"/>	E. Native Hawaiian or Other Pacific Islander
<input type="checkbox"/>	F. White
Item-Specific Instructions	
<p>A1000. Race/Ethnicity</p> <ul style="list-style-type: none"> • Check the box(es) that correspond(s) to the race or ethnic category/categories the patient uses to identify him or herself, or check the box(es) the patient’s family, significant other, guardian, or legally authorized representative uses to identify the patient. Observer identification can be used to complete this item if the patient is unable to respond and/or no family member, significant other, guardian, or legally authorized representative is available. <p>Check all that apply.</p> <ul style="list-style-type: none"> • Check A, American Indian or Alaska Native, if the patient is American Indian or Alaska Native. <ul style="list-style-type: none"> – A person having origins in any of the original peoples of North and South America (including Central America) and who maintains tribal affiliation or community attachment. 	

Item-Specific Instructions (continued)

- **Check B, Asian**, if the patient is Asian.
 - A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
- **Check C, Black or African American**, if the patient is Black or African American.
 - A person having origins in any of the black racial groups of Africa. Terms such as "Haitian" or "Negro" can be used in addition to "Black or African American."
- **Check D, Hispanic or Latino**, if the patient is Hispanic or Latino.
 - A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. The term "Spanish origin" can be used in addition to "Hispanic or Latino."
- **Check E, Native Hawaiian or Other Pacific Islander**, if the patient is Native Hawaiian or other Pacific Islander.
 - A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
- **Check F, White**, if the patient is white.
 - A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

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

Enter Code <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>	01. Community residential setting (e.g., private home/apt., board/care, assisted living, group home, adult foster care) 02. Long-term care facility 03. Skilled Nursing Facility (SNF) 04. Hospital emergency department 05. Short-stay acute hospital 06. Long-term care hospital (LTCH) 07. Inpatient rehabilitation facility or unit (IRF) 08. Psychiatric hospital or unit 09. ID/DD Facility 10. Hospice 99. None of the above
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Item-Specific Instructions

Enter the two-digit response that best describes the setting in which the patient was staying immediately preceding this admission.

- **Response 01, Community residential setting:** Select response 01 if the patient was admitted from a private home, apartment, board and care, assisted living facility, group home, or adult foster care. A community residential setting is defined as any house, condominium, or apartment in the community, whether owned by the patient or another person, retirement communities, or independent housing for the elderly.

Item-Specific Instructions (continued)

- **Response 02, Long-term care facility (also known as a Non-Skilled Nursing Facility or NF):** Select response 02 if the patient was admitted from an institution that is primarily engaged in providing medical and non-medical care to people who have a chronic illness or disability. These facilities provide care to people who cannot be cared for at home or in the community. Long-term care facilities provide a wide range of personal care and health services for individuals who cannot take care of themselves due to physical, emotional, or mental health issues.
- **Response 03, Skilled Nursing Facility (SNF):** Select response 03 if the patient was admitted from a nursing facility with the staff and equipment for the provision of skilled nursing services, skilled rehabilitative services, and/or other related health services. This category includes swing bed hospitals, which are generally small, rural hospitals or critical access hospitals (CAH) participating in Medicare that have CMS approval to provide post-hospital SNF care and meet certain requirements.
- **Response 04, Hospital emergency department:** Select response 04 if the patient was admitted from an organized hospital-based facility for the provision of unscheduled or episodic services to patients who present for immediate medical attention.
- **Response 05, Short-stay acute hospital:** Select response 05 if the patient was admitted from a hospital that is contracted with Medicare to provide acute inpatient care and accept a predetermined rate as payment in full.
- **Response 06, Long-term care hospital (LTCH):** Select response 06 if the patient was admitted from an acute-care hospital that provides treatment for patients who stay, on average, more than 25 days. Most patients are transferred from an intensive or critical care unit. Services provided include comprehensive rehabilitation, respiratory therapy, head trauma treatment, and pain management.
- **Response 07, Inpatient rehabilitation facility or unit (IRF):** Select response 07 if the patient was admitted from a hospital, or a distinct unit of a hospital, that provides an intensive rehabilitation program to inpatients.
- **Response 08, Psychiatric hospital or unit:** Select response 08 if the patient was admitted from an institution that provides, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill patients.
- **Response 09, ID/DD Facility:** Select response 09 if the patient was admitted from an institution that is engaged in providing, under the supervision of a physician, any health and rehabilitative services for individuals who are intellectually disabled (ID) or who have developmental disabilities (DD).
- **Response 10, Hospice:** Select response 10 if the patient was admitted from another hospice.
- **Response 99, None of the above:** Select response 99 if the patient was admitted from none of the above.

Item-Specific Tips

- If the patient was in multiple settings prior to hospice admission, enter the response that reflects where the patient was at the time of referral to hospice.
 - For example, if a patient was referred to hospice in the hospital in the week prior to admission to hospice and was discharged from the hospital to the home 2 days prior to the start of hospice services, select response “5, Short-stay acute hospital,” because the patient was in the hospital at the time of referral.
- If the patient was enrolled in a hospice program and resided in the community, select response “10, Hospice,” rather than response “01, Community residential setting.”
- The term “Admitted from” does not necessarily mean that the patient left the facility to be admitted to hospice. The location immediately before admission may be the same as immediately after (for example, a patient may be residing in a long-term care facility and remain there during and after hospice admission), or the two may be different (for example, a patient may elect hospice while in an acute care hospital and begin receiving hospice services upon returning to their home).
- For purposes of completing Item A1802, SNF is not synonymous with nursing facility. The response option for SNF is to be used for patients in a SNF or patients in the SNF portion of a dually-certified nursing facility. If a beneficiary is in a nursing facility but doesn't meet the criteria above, do not use the response option for SNF; instead, use the response option for long-term care facility (also known as NF or nursing facility).

A2115. Reason for Discharge	
Enter Code <input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/>	01. Expired 02. Revoked 03. No longer terminally ill 04. Moved out of hospice service area 05. Transferred to another hospice 06. Discharged for cause
Item-Specific Instructions	
<p><i>Complete only if A0250 = 09, Discharge</i></p> <p>Review the clinical record, including the discharge plan and discharge order, for documentation of discharge reason. Select the response that corresponds to the patient's reason for discharge.</p> <ul style="list-style-type: none"> • Response 01, Expired: Select response 01 if the patient has died. • Response 02, Revoked: Select response 02 if the beneficiary has chosen to revoke their hospice election. • Response 03, No longer terminally ill: Select response 03 in the case of a discharge when the hospice determines the beneficiary is no longer terminally ill. • Response 04, Moved out of hospice service area: Select response 04 in the case of a discharge when the beneficiary moves out of the hospice's service area. • Response 05, Transferred to another hospice: Select response 05 in the case of a discharge when the beneficiary transfers to another hospice. • Response 06, Discharged for cause: Select response 06 in the case of a discharge for cause. <ul style="list-style-type: none"> – CMS defines discharge for cause as a discharge made because the patient's (or other persons in the patient's home) behavior is disruptive, abusive, or uncooperative to the extent that delivery of care to the patient or the ability of the hospice to operate effectively is seriously impaired. 	

SECTION F: PREFERENCES									
<p>Items in this section of the Hospice Item Set (HIS) pertain to the hospice patient's preferences regarding life-sustaining treatments and spiritual care. Preferences are best obtained directly from the patient, or the caregiver or responsible party if the patient cannot self-report. The items in this section do not represent an exhaustive list of patient preferences that hospices should consider, and completion of this section does not replace a thorough and ongoing discussion of patient preferences throughout an episode of care.</p>									
RATIONALE									
<p>Seriously ill and dying patients who are given the opportunity to express their preferences regarding life-sustaining treatment are more likely to receive care consistent with their values, improving patient and family outcomes, including greater satisfaction with care.</p> <ul style="list-style-type: none"> • Patients may come into hospice with documentation of preferences for life-sustaining treatment. However, pre-existing documentation may not reflect their current preferences because patient preferences may change, particularly as their condition changes. <p>Care for spiritual needs is a critical element of quality of life at the end of life. Patients and/or caregivers should be given the opportunity to express their needs for spiritual care to help ensure their needs are met.</p> <ul style="list-style-type: none"> • One of the unique aspects of hospice care is an interdisciplinary approach toward providing care for the physical, psychosocial, and spiritual needs of the patient and caregiver(s). Discussion of spiritual concerns is the core of a rigorous assessment of spiritual care needs and is essential to assuring that these needs are met. <p>Items in this section are intended to capture the <i>process</i> of eliciting patient preferences; they are intended to <i>capture evidence of discussion and/or communication about patient preferences</i>.</p>									
F2000. CPR Preference									
<p>Enter Code</p> <div style="border: 1px solid black; width: 30px; height: 30px; margin: 5px auto;"></div>	<p>A. Was the patient/responsible party asked about preference regarding the use of cardiopulmonary resuscitation (CPR)? Select the most accurate response.</p> <ol style="list-style-type: none"> 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 <p>B. Date the patient/responsible party was first asked about preference regarding the use of CPR:</p> <table style="width: 100%; text-align: center; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 30px; height: 25px;"></td> <td style="border: 1px solid black; width: 30px; height: 25px;"></td> <td style="border: 1px solid black; width: 30px; height: 25px;"></td> <td style="border: 1px solid black; width: 30px; height: 25px;"></td> </tr> <tr> <td>Month</td> <td>Day</td> <td colspan="2">Year</td> </tr> </table>					Month	Day	Year	
Month	Day	Year							

Item-Specific Instructions

Review the clinical record for information regarding discussion of patient preference for cardiopulmonary resuscitation (CPR). For this item, it is also permissible to consider care processes documented in the clinical record that took place during pre-admission or educational visits. Item completion should be based on what is included in the clinical record. Review all response choices before making a selection.

F2000A: Was the patient/responsible party asked about preference regarding the use of cardiopulmonary resuscitation (CPR)?

- **Response 0, No:** Select response 0 if there is no documentation that the hospice discussed (or attempted to discuss) preference regarding the use of CPR with the patient or responsible party. Skip to Item F2100, Other Life-Sustaining Treatment Preferences.
 - Response 0 applies to situations where there is no documentation that a discussion occurred or was attempted with the patient or responsible party. This could happen if the patient was unable to discuss and/or the responsible party was unavailable.
- **Response 1, Yes, and discussion occurred:** Select response 1 if there is documentation that the hospice discussed preference regarding the use of CPR with the patient or responsible party.
 - Response 1 applies to situations where there is documentation that the hospice brought up the topic of CPR use and had a conversation with the patient, the responsible party, or both. The conversation does not have to result in the patient stating a preference for or against the use of CPR to select response 1 for F2000A. For the purposes of Item F2000, select response 1 if the hospice opened the door for a conversation and there is documentation that the patient or responsible party engaged with the hospice in a discussion regarding CPR.
- **Response 2, Yes, but the patient/responsible party refused to discuss:** Select response 2 if there is documentation that the hospice asked about preference regarding the use of CPR, but the patient or responsible party refused to discuss or was unable to discuss.
 - Response 2 applies to situations where there is documentation that the hospice attempted to have a conversation with the patient and responsible party, but both the patient and responsible party *explicitly refused* to discuss the topic with the hospice. This would include statements such as “I don’t want to talk about this” or “I’m only going to talk to my priest about this.” In these instances, the hospice was not successful in engaging the patient and/or responsible party in a discussion.
 - Response 2 also applies to situations in which the hospice attempted to discuss the topic, but the patient was unable to discuss because of their clinical status *and* the responsible party *explicitly refused* to discuss.

Item-Specific Instructions (continued)**F2000B: Date the patient/responsible party was first asked about preference regarding the use of CPR**

- **Enter the date** the hospice first discussed (or attempted to discuss) patient preference regarding the use of CPR. Use the format Month-Day-Year: MM-DD-YYYY. If the month and/or day contain only a single digit, enter "0" in the first box of the month and/or day. For example, November 1, 2015, would be entered as 11-01-2015.
- It is possible that at the time of HIS completion, multiple discussions regarding the use of CPR will be documented in the clinical record. Complete HIS items based on the *first* dated discussion about preference regarding the use of CPR that appears in the clinical record.
- For this item, it is permissible to consider care processes documented in the clinical record at pre-admission or educational visits (before the Admission Date). In these instances, use the date on which the discussion occurred for F2000B.

Item-Specific Tips

F2000 asks whether or not the patient or *responsible party* was asked about preference regarding the use of CPR. "Responsible party" refers to the legally responsible or authorized individual, such as the Health Care Power of Attorney or legal guardian. In cases where there is no legal guardian or power of attorney identified, the hospice should use state law guidance to identify the appropriate surrogate decision-maker.

- In order to report "Yes" to F2000A, if a party other than the patient was asked about preference regarding the use of CPR, there must be evidence in the clinical record that the responsible party *as defined above* was asked about preferences.

F2000 is intended to capture evidence of a *discussion* (or attempted discussion) about patient preference regarding the use of CPR.

- A discussion about CPR preference can be initiated by any member of the hospice staff or interdisciplinary group (IDG).
- Orders alone or short statements in the clinical record, such as "DNR/DNI" or "full code," without evidence of discussion or involvement from patient/responsible party, are *not* sufficient to report "Yes" for F2000A.

Evidence of a discussion could be documented in the clinical record or via a Do Not Resuscitate (DNR) order, Physician Orders for Life-Sustaining Treatment (POLST) order, or equivalent.

- A newly completed DNR order or POLST form that is signed by the hospice clinician after the admission to hospice or during a preadmission visit is sufficient to select response "1, Yes" for F2000A, *provided there is evidence of involvement from the patient/responsible party*, such as signature of the patient or responsible party on POLST forms, or clinical documentation, such as "DNR preference confirmed with responsible party."

Item-Specific Tips (continued)

- If a patient is admitted to hospice with a pre-existing DNR order or POLST that was signed in a prior care setting, the hospice should re-affirm the patient's preferences that appear in the pre-existing DNR order or POLST. This reaffirmation should be documented in the clinical record. Clinical record documentation, such as "discussed CPR preference during the admission visit with patient," is sufficient to select response "1, Yes."
 - If the clinical record is ambiguous as to whether the hospice attempted to re-affirm patient preferences documented in a pre-existing DNR order/POLST, select response "0, No" for F2000A and skip to Item F2100.

Examples**Situation A - Patient's clinical record contains the following information:**

Patient admitted on 08-01-2015. Clinical note dated 08-01-2015 shows, "talked with patient about preference for CPR; patient states they are not sure. Requests time to think and wants to discuss later." Clinical note dated 08-05-2015 shows, "discussed patient's preference for CPR; patient stated preference for DNR. DNR order signed and in clinical record."

- **HIS Response Selection:**
F2000A: Was the patient/responsible party asked about preference regarding the use of cardiopulmonary resuscitation (CPR)? Select response "1, Yes, and discussion occurred."
F2000B: Date the patient/responsible party was first asked about preference regarding the use of CPR: Enter "08-01-2015."
- **Explanation:** Although the patient later stated a preference regarding DNR on 08-05-2015, F2000 should be completed based on the *first* dated discussion in the clinical record. The most appropriate response option for F2000A is "1" because although at the first dated discussion the patient did not express a clear preference regarding the use of CPR, a *discussion did occur*. Enter "08-01-2015" for F2000B because it is the first dated discussion that appears in the clinical record.

Situation B - Patient's clinical record contains the following information:

Patient admitted 08-01-2015. Clinical record for the patient includes a DNR order, signed in the prior care setting, which is dated 07-15-2015.

- **HIS Response Selection:**
F2000A: Was the patient/responsible party asked about preference regarding the use of cardiopulmonary resuscitation (CPR)? Select response "0, No." Skip to Item F2100, Other Life-Sustaining Treatment Preferences.
- **Explanation:** Although the patient has a recently dated DNR order, it was signed in a prior care setting. There is no documentation in the clinical record to indicate that the hospice re-confirmed the patient's preferences. If a statement such as "DNR order confirmed with responsible party, patient's daughter" was included, that would be sufficient to select response "1, Yes, and discussion occurred."

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			

Item-Specific Instructions

Review the clinical record for information regarding patient preference for life-sustaining treatment other than CPR. For this item, it is permissible to consider care processes documented in the clinical record that took place during pre-admission or educational visits. Item completion should be based on what is included in the clinical record. Review all response choices before making a selection.

F2100A: Was the patient/responsible party asked about preferences regarding life-sustaining treatment other than CPR?

- **Response 0, No:** Select response 0 if there is no documentation that the hospice discussed (or attempted to discuss) preferences regarding life-sustaining treatment other than CPR with the patient or responsible party. Skip to Item F2200, Hospitalization Preference.
 - Response 0 applies to situations where there is no documentation that a discussion occurred or was attempted with the patient or responsible party. This could happen if the patient was unable to discuss and/or the responsible party was unavailable.
- **Response 1, Yes, and discussion occurred:** Select response 1 if there is documentation that the hospice discussed preferences regarding life-sustaining treatment other than CPR with the patient or responsible party.
 - Response 1 applies to situations where there is documentation that the hospice brought up the topic of life-sustaining treatment other than CPR and there was a conversation with the patient and/or responsible party. The conversation does not have to result in the patient stating a preference for or against the use of life-sustaining treatments other than CPR to select response 1 for F2100A. For the purposes of Item F2100, select response 1 if the hospice opened the door for a conversation and there is documentation that the patient or responsible party engaged with the hospice in a discussion regarding life-sustaining treatment preferences other than CPR.

Item-Specific Instructions (continued)

- **Response 2, Yes, but the patient/responsible party refused to discuss:**
Select response 2 if there is documentation that the hospice asked about preferences regarding life-sustaining treatment other than CPR, but the patient or responsible party refused to discuss or was unable to discuss.
 - Response 2 applies to situations where there is documentation that the hospice attempted to have a conversation with the patient and responsible party, but both the patient *and* responsible party *explicitly refused* to discuss the topic with the hospice. This would include statements such as “I don’t want to talk about this” or “I’m only going to talk to my priest about this.” In these instances, the hospice was not successful in engaging the patient and/or responsible party in a discussion.
 - Response 2 also applies to situations in which the hospice attempted to discuss the topic, but the patient was unable to discuss because of their clinical status *and* the responsible party *explicitly refused* to discuss.

F2100B: Date the patient/responsible party was first asked about preferences regarding life-sustaining treatments other than CPR

- *Enter the date* the hospice first discussed (or attempted to discuss) patient preferences regarding life-sustaining treatment other than CPR. Use the format Month-Day-Year: MM-DD-YYYY. If the month and/or day contain only a single digit, enter “0” in the first box of the month and/or day. For example, November 1, 2015, would be entered as 11-01-2015.
- It is possible that at the time of HIS completion, multiple discussions regarding the use of life-sustaining treatments other than CPR will be documented in the clinical record. Complete HIS items based on the *first* dated discussion about preference regarding life-sustaining treatment other than CPR that appears in the clinical record.
- For this item, it is permissible to consider care processes documented in the clinical record at pre-admission or educational visits (before the Admission Date). In these instances, use the date on which the discussion occurred for F2100B.

Item-Specific Tips

F2100 asks whether or not the patient or *responsible party* was asked about preferences regarding life-sustaining treatments other than CPR. “Responsible party” refers to the legally responsible or authorized individual, such as the Health Care Power of Attorney or legal guardian. In cases where there is no legal guardian or power of attorney identified, the hospice should use state law guidance to identify the appropriate surrogate decision-maker.

- In order to report “Yes” to F2100A, if a party other than the patient was asked about preferences regarding life-sustaining treatments other than CPR, there must be evidence in the clinical record that the responsible party *as defined above* was asked about preferences.

Item-Specific Tips (continued)

F2100 is intended to capture evidence of a *discussion* (or attempted discussion) about patient preference regarding life-sustaining treatment other than CPR. Evidence of a discussion could be documented in the clinical record or via a POLST order or equivalent.

- A discussion about preference for life-sustaining treatment other than CPR can be initiated by any member of the hospice staff or IDG.
- Orders alone, without evidence of discussion or involvement from patient/responsible party, are *not* sufficient to report “Yes” for F2100A.
- There is no comprehensive list of life-sustaining treatments. Documentation in the clinical record indicating that a member of the hospice staff or IDG attempted to discuss preference for *any* life-sustaining treatment other than CPR (for example, ventilator support, tube feeding, dialysis, blood transfusion, antibiotics, intravenous [IV] fluids) is sufficient to select either of the following for F2100A:
 - “1, Yes, and discussion occurred”
 - “2, Yes, but patient/responsible party refused to discuss”

Evidence of a discussion could be documented in the clinical record or via a POLST order or equivalent:

- A newly completed POLST form that is signed by the hospice clinician after the admission to hospice or during a preadmission visit is sufficient to select “1, Yes” for F2100A, *provided there is evidence of involvement from the patient/responsible party*, such as signature of the patient or responsible party on POLST forms, or clinical documentation such as “treatment preference confirmed with responsible party.”
- If a patient is admitted to hospice with a pre-existing POLST that was signed in a prior care setting, the hospice should re-affirm the patient’s preferences that appear in the pre-existing POLST. This re-affirmation of preferences should be documented in the clinical record. Clinical record documentation, such as “discussed life-sustaining treatment preferences during the admission visit with patient,” is sufficient to select response “1, Yes”.
 - If the clinical record is ambiguous as to whether the hospice attempted to re-affirm patient preferences in a pre-existing POLST, select response “0, No” for F2100A and skip to Item F2200, Hospitalization Preference.

Examples**Situation A - Patient’s clinical record contains the following information:**

Patient admitted on 08-01-2015. Clinical note dated 08-01-2015 shows, “Had discussion with patient about preference for use of prolonged IV fluids; patient was hesitant and stated they weren’t sure and wanted to discuss later. Told patient we could discuss at later date.”

Examples (continued)													
<ul style="list-style-type: none"> • HIS Response Selection: F2100A: Was the patient/responsible party asked about preference regarding the use of any life-sustaining treatment other than CPR? Select response “1, Yes, and discussion occurred.” F2100B: Date the patient/responsible party was first asked about preference regarding the use of CPR: Enter “08-01-2015.” • Explanation: The most appropriate response option for F2100A is “1” because although the patient did not express a clear preference regarding use of prolonged IV fluids, a discussion did occur. <p><u>Situation B - Patient’s clinical record contains the following information:</u></p> <p>Patient admitted 08-01-2015. Clinical record for the patient includes an order from the prior care setting, “no life-sustaining treatments desired,” which is dated 07-15-2015.</p> <ul style="list-style-type: none"> • HIS Response Selection: F2100A: Was the patient/responsible party asked about preference regarding life-sustaining treatments other than CPR? Select response “0, No.” Skip to Item F2200, Hospitalization Preference. • Explanation: Although the patient has a recently dated order regarding life-sustaining treatment preferences, it was signed in a prior care setting. There is no documentation in the hospice clinical record to indicate that the hospice re-confirmed the patient’s preferences. If a statement such as “desire to avoid all forms of life-sustaining treatments confirmed with responsible party, patient’s daughter” was included, that would be sufficient to select response “1, Yes, and discussion occurred.” 													
F2200. Hospitalization Preference													
Enter Code <input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/>	<p>A. Was the patient/responsible party asked about preference regarding hospitalization? Select the most accurate response.</p> <ol style="list-style-type: none"> 0. No → Skip to F3000, Spiritual/Existential Concerns 1. Yes, and discussion occurred 2. Yes, but the patient/responsible party refused to discuss <p>B. Date the patient/responsible party was first asked about preference regarding hospitalization:</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 25px; height: 25px; text-align: center;"> </td> <td style="border: 1px solid black; width: 25px; height: 25px; text-align: center;"> </td> <td style="border: 1px solid black; width: 25px; height: 25px; text-align: center;"> </td> <td style="border: 1px solid black; width: 25px; height: 25px; text-align: center;"> </td> <td style="border: 1px solid black; width: 25px; height: 25px; text-align: center;"> </td> <td style="border: 1px solid black; width: 25px; height: 25px; text-align: center;"> </td> </tr> <tr> <td style="text-align: center;">Month</td> <td style="text-align: center;">Day</td> <td colspan="4" style="text-align: center;">Year</td> </tr> </table>							Month	Day	Year			
Month	Day	Year											

Item-Specific Instructions

Review the clinical record for information regarding patient preference for hospitalization. For this item, it is permissible to consider care processes (discussions) documented in the clinical record that took place during pre-admission or educational visits. Item completion should be based on what is included in the clinical record. Review all response choices before making a selection. For the purposes of this item, “hospitalization” does not include hospice care (such as general inpatient or respite level of care) provided in contracted acute care settings or hospital-based inpatient hospice units.

F2200A: Was the patient/responsible party asked about preference regarding hospitalization?

- **Response 0, No:** Select response 0 if there is no documentation that the hospice discussed (or attempted to discuss) preference regarding hospitalization with the patient or responsible party. Skip to Item F3000, Spiritual/Existential Concerns.
 - Response 0 applies to situations where there is no documentation that a discussion occurred or was attempted with the patient or responsible party. This could happen if the patient was unable to discuss and/or the responsible party was unavailable.
- **Response 1, Yes, and discussion occurred:** Select response 1 if there is documentation that the hospice discussed preference regarding hospitalization with the patient or responsible party.
 - Response 1 applies to situations where there is documentation that the hospice brought up the topic of hospitalization and had a conversation with the patient and/or responsible party. The conversation does not have to result in the patient stating a preference for or against hospitalization to select response 1 for F2200A. For the purposes of Item F2200, select response 1 if the hospice opened the door for a conversation and there is documentation that the patient or responsible party engaged with the hospice in a discussion regarding hospitalization.
- **Response 2, Yes, but the patient/responsible party refused to discuss:** Select response 2 if there is documentation that the hospice asked about preference regarding hospitalization, but the patient or responsible party refused to discuss or was unable to discuss.
 - Response 2 applies to situations where there is documentation that the hospice attempted to have a conversation with the patient and responsible party, but both the patient *and* responsible party *explicitly refused* to discuss the topic with the hospice. This would include statements such as “I don’t want to talk about this” or “I’m only going to talk to my priest about this.” In these instances, the hospice was not successful in engaging the patient and/or responsible party in a discussion.
 - Response 2 also applies to situations in which the hospice attempted to discuss the topic, but the patient was unable to discuss because of their clinical status *and* the responsible party *explicitly refused* to discuss.

Item-Specific Instructions (continued)**F2200B: Date the patient/responsible party was first asked about preference regarding hospitalization**

- **Enter the date** the hospice first discussed (or attempted to discuss) patient preference regarding hospitalization. Use the format Month-Day-Year: MM-DD-YYYY. If the month and/or day contain only a single digit, enter "0" in the first box of the month and/or day. For example, November 1, 2015, would be entered as 11-01-2015.
- It is possible that at the time of HIS completion, multiple discussions regarding hospitalization preferences will be documented in the clinical record. Complete HIS items based on the *first* dated discussion about preference regarding hospitalization that appears in the clinical record.
- For this item, it is permissible to consider care processes documented in the clinical record at pre-admission or educational visits (before the Admission Date). In these instances, use the date on which the discussion occurred for F2200B.

Item-Specific Tips

F2200 asks whether or not the patient or *responsible party* was asked about preferences regarding hospitalization. "Responsible party" refers to the legally responsible or authorized individual, such as the Health Care Power of Attorney or legal guardian. In cases where there is no legal guardian or power of attorney identified, the hospice should use state law guidance to identify the appropriate surrogate decision-maker.

- In order to report "Yes" to F2200A, if a party other than the patient was asked about preference regarding hospitalization, there must be evidence in the clinical record that the responsible party *as defined above* was asked about preferences.

F2200 is intended to capture evidence of a *discussion* (or attempted discussion) about patient preference regarding hospitalization.

- A discussion about hospitalization preference can be initiated by any member of the hospice staff or IDG.

Evidence of a discussion could be documented in the clinical record or via a POLST form:

- A newly completed POLST form that is signed by the hospice clinician after the admission to hospice or during a preadmission visit is sufficient to report "1, Yes" for F2200A, *provided there is evidence of involvement from the patient/responsible party*, such as the signature of the patient or responsible party on POLST forms, or clinical documentation, such as "hospitalization preference confirmed with responsible party."

Item-Specific Tips (continued)

- If a patient is admitted to hospice with a pre-existing POLST that was signed in a prior care setting, the hospice should re-affirm the patient's preferences that appear in the pre-existing POLST. This re-affirmation of preferences should be documented in the clinical record. Clinical record documentation, such as "discussed preference regarding hospitalization during the admission visit with patient," is sufficient to select response "1, Yes."
 - If the clinical record is ambiguous as to whether the hospice attempted to re-affirm patient preferences present in a pre-existing POLST, select response "0, No" for F2200A and skip to Item F3000, Spiritual/Existential Concerns.

Examples**Situation A - Patient's clinical record contains the following information:**

Patient admitted on 08-01-2015. Clinical note dated 08-01-2015 shows, "Talked with patient about preference for readmission to hospital; patient was hesitant and stated they weren't sure. Told patient we could discuss at later date."

- **HIS Response Selection:**
 - F2200A: Was the patient/responsible party asked about preference regarding hospitalization?** Select response "1, Yes, and discussion occurred."
 - F2200B: Date the patient/responsible party was first asked about preference regarding hospitalization:** Enter "08-01-2015."
- **Explanation:** The most appropriate response option for F2200A is "1" because although the patient did not express a clear preference regarding hospitalization, a discussion occurred.

Situation B - Patient's clinical record contains the following information:

Patient admitted 08-01-2015. Clinical record for the patient includes a POLST form completed in the prior care setting indicating selection of comfort-oriented care, including desire to avoid hospitalization, which is dated 07-15-2015.

- **HIS Response Selection:**
 - F2200A: Was the patient/responsible party asked about preference regarding hospitalization?** Select response "0, No." Skip to Item F3000, Spiritual/Existential Concerns.
- **Explanation:** Although the patient has a recently dated POLST, it was signed in a prior care setting. There is no documentation in the clinical record to indicate that the hospice re-confirmed the patient's preferences for comfort-oriented care and avoidance of hospitalization. If a statement such as "All POLST treatment preferences confirmed with responsible party, patient's daughter" was included, that would be sufficient to select response "1, Yes."

F3000. Spiritual/Existential Concerns									
Enter Code <input type="checkbox"/>	<p>A. Was the patient and/or caregiver asked about spiritual/existential concerns? Select the most accurate response.</p> <ol style="list-style-type: none"> 0. No → Skip to I0010, Principal Diagnosis 1. Yes, and discussion occurred 2. Yes, but the patient and/or caregiver refused to discuss <p>B. Date the patient and/or caregiver was first asked about spiritual/existential concerns:</p> <table style="width: 100%; border: none;"> <tr> <td style="border: 1px solid black; width: 30px; height: 20px;"></td> <td style="border: 1px solid black; width: 30px; height: 20px;"></td> <td style="border: 1px solid black; width: 30px; height: 20px;"></td> <td style="border: 1px solid black; width: 30px; height: 20px;"></td> </tr> <tr> <td style="text-align: center;">Month</td> <td style="text-align: center;">Day</td> <td colspan="2" style="text-align: center;">Year</td> </tr> </table>					Month	Day	Year	
Month	Day	Year							
Item-Specific Instructions									
<p>Review the clinical record for information regarding spiritual/existential concerns. For this item, it is permissible to consider care processes documented in the clinical record that took place during pre-admission or educational visits. Item completion should be based on what is included in the clinical record. Do not use sources external to the clinical record. Review all response choices before making a selection.</p> <p>F3000A: Was the patient and/or caregiver asked about spiritual/existential concerns?</p> <ul style="list-style-type: none"> • Response 0, No: Select response 0 if there is no documentation that the hospice discussed (or attempted to discuss) spiritual/existential concerns with the patient and/or caregiver(s). Skip to Item I0010, Principal Diagnosis. <ul style="list-style-type: none"> – Response 0 applies to situations where there is no documentation that a discussion occurred or was attempted with the patient and/or caregiver. This could happen if the patient was unable to discuss and/or the caregiver was unavailable. • Response 1, Yes, and discussion occurred: Select response 1 if there is documentation that the hospice discussed spiritual/existential concerns with the patient and/or caregiver(s). <ul style="list-style-type: none"> – Response 1 applies to situations where there is documentation that the hospice brought up the topic of spiritual/existential concerns and there was a conversation with the patient and/or caregiver. The conversation does not have to result in initiation of intervention(s) to address spiritual/existential concerns to select response 1 for F3000A. For the purposes of Item F3000, select response 1 if the hospice opened the door for a conversation and there is documentation that the patient and/or caregiver engaged with the hospice in a discussion regarding spiritual/existential concerns. • Response 2, Yes, but patient and/or caregiver refused to discuss: Select response 2 if there is documentation that the hospice asked about spiritual/existential concerns, but the patient and/or caregiver(s) refused to discuss or were unable to discuss. 									

Item-Specific Instructions (continued)

- Response 2 applies to situations where there is documentation that the hospice attempted to have a conversation with the patient and caregiver, but both the patient *and* caregiver *explicitly refused* to discuss the topic with the hospice. This would include statements such as “I don’t want to talk about this” or “I’m only going to talk to my priest about this.” In these instances, the hospice was not successful in engaging the patient and/or caregiver in a discussion.
- Response 2 also applies to situations in which the hospice attempted to discuss the topic, but the patient was unable to discuss because of their clinical status *and* the caregiver *explicitly refused* to discuss.

F3000B: Date the patient and/or caregiver was first asked about spiritual/existential concerns

- **Enter the date** the hospice discussed (or attempted to discuss) spiritual/existential concerns. Use the format Month-Day-Year: MM-DD-YYYY. If the month and/or day contain only a single digit, enter “0” in the first box of the month and/or day. For example, November 1, 2015, would be entered as 11-01-2015.
- It is possible that at the time of HIS completion, multiple discussions regarding spiritual/existential concerns will be documented in the clinical record. Complete HIS items based on the *first* dated discussion about spiritual/existential concerns that appears in the clinical record.

Item-Specific Tips

F3000 asks whether the patient and/or *caregiver* was asked about spiritual/existential concerns. For the purposes of completing Item F3000, “caregiver” does not have to be the legally authorized representative.

F3000 is intended to capture evidence of a *discussion* (or attempted discussion) of spiritual/existential concerns with the patient and/or caregiver(s). This item does not capture whether interventions to address concerns were initiated.

- There is no comprehensive list of spiritual/existential concerns. Examples of a discussion regarding spiritual/existential concerns might include, but are not limited to, asking the patient/caregiver about need for spiritual or religious support, asking questions about the cause or meaning of illness or death, having a discussion about a higher power related to illness, or offering a spiritual resource (such as a chaplain). Documentation in the clinical record indicating that a member of the hospice staff or IDG attempted to discuss spiritual/existential concerns is sufficient to select either of the following for F3000A:
 - “1, Yes, and discussion occurred”
 - “2, Yes, but the patient and/or caregiver refused to discuss”
- Brief statements or data in the clinical record denoting a patient’s religious affiliation is not sufficient to select “Yes” for F3000A.

Item-Specific Tips (continued)

- If clinical record documentation is ambiguous as to whether discussion about spiritual/existential concerns was attempted, select response “0, No” for F3000A and skip to Item I0010, Principal Diagnosis.

A discussion with the patient and/or caregiver(s) about spiritual/existential concerns can be initiated by any member of the hospice staff or IDG.

Examples**Situation A - Patient’s clinical record contains the following information:**

Social worker questionnaire dated 08-01-2015 shows, “Patient’s spouse in great deal of spiritual distress and would like to speak with chaplain. Referral made.”

- **HIS Response Selection:**

F3000A: Was the patient and/or caregiver asked about spiritual/existential concerns? Select response “1, Yes, and discussion occurred.”

F3000B: Date the patient and/or caregiver was first asked about spiritual/existential concerns. Enter “08-01-2015.”

- **Explanation:** The completed questionnaire is strong evidence that the hospice engaged the patient and/or caregiver in a discussion regarding spiritual/existential concerns. Even though the clinical record does not contain documentation of a visit by the chaplain, select response “1, Yes, and discussion occurred” for F3000A because the intent of F3000 is to capture initiation of a *discussion* about spiritual/existential concerns.

Situation B - Patient’s clinical record contains the following information:

Patient’s initial assessment shows, “patient identifies their religious affiliation as Baptist.”

- **HIS Response Selection:**

F3000A: Was the patient and/or caregiver asked about spiritual/existential concerns? Select response “0, No” and skip to Item I0010, Principal Diagnosis.

- **Explanation:** The intent of F3000 is to capture initiation of a discussion (or attempted discussion) about spiritual/existential concerns. Clinical record documentation showing only the patient’s religious affiliation is not sufficient evidence that the hospice had (or attempted to have) a *discussion* regarding spiritual/existential concerns with the patient and/or caregiver.

SECTION I: ACTIVE DIAGNOSES			
<p>Items in this section of the Hospice Item Set (HIS) pertain to principal diagnosis of the patient. This section has only one item, I0010, Principal Diagnosis.</p> <p>Disclaimer: The HIS is intended for use in quality reporting; it does not imply acceptability for payment purposes.</p>			
RATIONALE			
<p>Disease processes and conditions can impact service delivery. This section includes the most common principal diagnoses among hospice patients.</p>			
I0010. Principal Diagnosis			
<p>Enter Code</p> <table border="1"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table>			<p>01. Cancer</p> <p>02. Dementia/Alzheimer's</p> <p>99. None of the above</p>
Item-Specific Instructions			
<p>Review the clinical record for information regarding principal diagnosis. Item completion must be based on what is indicated in the clinical record. Do not use sources external to the clinical record. Review all response choices before making a selection. This item should be completed based on the patient's principal diagnosis at the time of admission to hospice.</p> <p>I0010: Principal Diagnosis</p> <ul style="list-style-type: none"> • Response 01, Cancer: Select response 01 if the patient's principal diagnosis is cancer (including leukemia). • Response 02, Dementia/Alzheimer's: Select response 02 if the patient's principal diagnosis is dementia (Alzheimer's Disease; frontotemporal dementia; Pick's disease; other frontotemporal dementia; senile degeneration of brain; dementia with Lewy bodies). Note that some dementia codes have ICD-9-CM and ICD-10-CM manifestation/etiology or sequencing conventions; ensure that coding guidelines have been met for reporting principal diagnosis. • Response 99, None of the above: Select response 99 if the patient's principal diagnosis is a disease or condition other than cancer or dementia/Alzheimer's. 			
Item-Specific Tips			
<p>The principal diagnosis is defined as the condition established after study to be chiefly responsible for the patient's admission. For hospice patients, this is the diagnosis most contributory to the patient having a life expectancy of 6 months or less if the illness runs its normal course.</p>			

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SECTION J: HEALTH CONDITIONS

Items in this section of the Hospice Item Set (HIS) pertain to physical symptom management for hospice patients. Physical symptoms included in this section are pain and shortness of breath.

SECTION J, PAIN: RATIONALE

Pain is prevalent and undertreated for many populations of seriously ill patients, including those patients nearing the end of life. Patients and family caregivers rate pain management as a high priority when living with serious and life-limiting illnesses. The consequences of inadequate screening, assessment, and treatment for pain include physical suffering, functional limitation, and development of apathy and depression.

- Inclusion of pain screening items will improve awareness of the presence of pain, which is the first essential step for quality pain management and treatment.
- Inclusion of pain assessment items will improve awareness of assessment of pain severity, etiology, and effect on function, which is the second step for quality pain management and treatment.

J0900. Pain Screening

Enter Code <input style="width: 30px; height: 20px;" type="checkbox"/>	<p>A. Was the patient screened for pain?</p> <p>0. No → Skip to J2030, Screening for Shortness of Breath</p> <p>1. Yes</p>
Enter Code <input style="width: 30px; height: 20px;" type="checkbox"/>	<p>B. Date of first screening for pain:</p> <p style="text-align: center;"> <input style="width: 30px; height: 20px;" type="text"/> </p> <p style="text-align: center;"> Month Day Year </p>
Enter Code <input style="width: 30px; height: 20px;" type="checkbox"/>	<p>C. The patient's pain severity was:</p> <p>0. None → Skip to J2030, Screening for Shortness of Breath</p> <p>1. Mild</p> <p>2. Moderate</p> <p>3. Severe</p> <p>9. Pain not rated</p>
Enter Code <input style="width: 30px; height: 20px;" type="checkbox"/>	<p>D. Type of standardized pain tool used:</p> <p>1. Numeric</p> <p>2. Verbal descriptor</p> <p>3. Patient visual</p> <p>4. Staff observation</p> <p>9. No standardized tool used</p>

Item-Specific Instructions

Review the clinical record for information regarding pain screening. Item completion should be based on what is included in the clinical record. Do not use sources external to the clinical record. Review all response choices before making a selection. Consider results of the standardized pain screening tool and any other screening approaches the clinician used that might include asking the patient about their pain comfort.

J0900A: Was the patient screened for pain?

- **Response 0, No:** Select response 0 if there is no documentation that the patient was screened for pain. Skip to Item J2030, Screening for Shortness of Breath (Dyspnea).
- **Response 1, Yes:** Select response 1 if there is documentation that the patient was screened for pain.

J0900B: Date of first screening for pain

- **Enter the date of the first screening for pain.** Use the format Month-Day-Year: MM-DD-YYYY. If the month and/or day contain only a single digit, enter a "0" in the first box of the month and/or day. For example, November 1, 2015, would be entered as 11-01-2015.
- It is possible that at the time of HIS completion, multiple pain screenings will be documented in the clinical record. Complete HIS pain screening items based on the *first* pain screening documented in the clinical record.

J0900C: The patient's pain severity was

- **Response 0, None:** Select response 0 if the patient's pain severity score was none. This would include a score of 0 on a 10-point numeric scale *or* equivalent on verbal, visual, other numeric, or staff observation scale. Skip to Item J2030, Screening for Shortness of Breath (Dyspnea).
- **Response 1, Mild:** Select response 1 if the patient's pain severity score was mild. This would include a score of 1–3 on a 10-point numeric scale *or* equivalent on verbal, visual, other numeric, or staff observation scale.
- **Response 2, Moderate:** Select response 2 if the patient's pain severity score was moderate. This would include a score of 4–6 on a 10-point numeric scale *or* equivalent on verbal, visual, other numeric, or staff observation scale.
- **Response 3, Severe:** Select response 3 if the patient's pain severity score was severe. This would include a score of 7–10 on a 10-point numeric scale *or* equivalent on verbal, visual, other numeric, or staff observation scale.
- **Response 9, Pain not rated:** Select response 9 if the patient had pain, but the patient's pain severity was not assessed or recorded.

Item-Specific Instructions (continued)**J0900D: Type of standardized pain tool used**

- **Response 1, Numeric:** Select response 1 if a numeric scale was used to conduct pain screening.
 - Examples of standardized numeric scales include but are not limited to, 10-point scale, the Symptom Distress Scale (McCorkle), the Memorial Symptom Assessment Scale (MSAS), and the Edmonton Symptom Assessment System (ESAS).
- **Response 2, Verbal descriptor:** Select response 2 if a verbal descriptor scale was used to conduct pain screening.
 - Examples of standardized verbal descriptor scales include, but are not limited to, the Brief Pain Inventory, the McGill pain questionnaire, and the 6-Point Verbal Pain Scale.
- **Response 3, Patient visual:** Select response 3 if a patient visual scale was used to conduct pain screening.
 - Examples of standardized patient visual scales include, but are not limited to, the Wong-Baker FACES Pain Scale, a visual analog scale, and a distress thermometer.
- **Response 4, Staff observation:** Select response 4 if a staff observational scale was used to conduct pain screening. Select response 4 only if a standardized staff observational scale was used.
 - Examples of standardized staff observation scales include, but are not limited to, the Critical Care Pain Observation Tool (CPOT), the Checklist of Nonverbal Pain Indicators (CNPI), the Pain Assessment Checklist for Seniors with Limited Ability to Communicate (PACSLAC), and Pain Assessment in Advanced Dementia (PAIN-AD).
- **Response 9, No standardized tool used:** Select response 9 if no standardized scale was used to screen for the presence and severity of pain.

Item-Specific Tips

Pain screening includes evaluating the patient for presence of pain, and if pain is present, rating its severity using a standardized tool. A standardized tool is one that (1) has been scientifically tested on a population with characteristics similar to that of the patient being assessed (for example, community-dwelling elderly, non-institutionalized adults with disabilities), and (2) includes a standard response scale (for example, a scale where patients rate pain from 0–10). The standardized tool must be appropriately administered as indicated in the instructions and must be relevant for the patient's ability to respond.

- Select the best response for pain severity based on the pain level at the time of the visit during which the screening was performed. If a range is provided, such as mild to moderate, report the highest level of severity experienced during the visit.

Item-Specific Tips (continued)

- If a non-numeric scale was used to screen the patient for pain, select the pain severity item based on the standard established for that scale. If no standard has been established for that scale, use clinician judgment to categorize severity.

If the screening indicated the patient was not in pain, the clinician may not have used a standardized pain tool to determine presence and severity of pain.

- If documentation in the patient's clinical record indicates the patient was assessed clinically and was found to have no pain, but no standardized pain tool was used to screen the patient, the best course of action is to select response "1, Yes" for J0900A, enter the date for J0900B, select response "0, None" for J0900C pain severity, and skip to Item J2030, Screening for Shortness of Breath (Dyspnea).

If documentation in the patient's clinical record indicates the patient has been clinically evaluated for pain and was found to be in pain, but it is ambiguous as to whether a screening was conducted using a *standardized* pain tool (with which severity of pain was also noted), the best course of action is to select response "1, Yes" for J0900A, enter the date for J0900B, and select response "9" for J0900C and J0900D.

Examples**Situations A and B - Patient's clinical record contains the following information:**

Situation A: Clinical note dated 08-12-2015 shows, "patient very drowsy; appears to be comfortable during visit. No nonverbal signs of pain observed during the visit."

Situation B: Clinical note dated 08-12-2015 shows, "patient stated he was not in pain today; no complaints from patient or family"

- **HIS Response Selection for Situations A and B:**

J0900A: Was the patient screened for pain? Select response "1, Yes."

J0900B: Date of first screening for pain: Enter "08-12-2015."

J0900C: The patient's pain severity was: Select response "0, None" and skip to Item J2030, Screening for Shortness of Breath (Dyspnea).

- **Explanation for Situations A and B:** Although there was no standardized pain tool used to screen the patient, it is evident the clinician evaluated the patient and determined the patient was not in any pain. The correct course of action is to complete J0900A-C, skipping J0900D because the clinician determined the patient was not in any pain and thus did not use a standardized pain tool in their evaluation of the patient.

Situation C - Patient's clinical record contains the following information:

Clinical note dated 08-12-2015 shows, "patient reports 3/10 abdominal pain now; was 6/10 during past 24 hours."

- **HIS Response Selection:**

J0900A: Was the patient screened for pain? Select response "1, Yes."

J0900B: Date of first screening for pain: Enter "08-12-2015."

Examples (continued)

J0900C: The patient's pain severity was: Select response "1, Mild."

J0900D: Type of standardized pain tool used: Select response "1, Numeric."

- **Explanation:** It is evident that the patient was in pain, and that the clinician evaluated the patient's pain using a standardized pain tool, noting pain severity. For J0900C, the correct course of action is to select response "1, Mild" based on the patient's pain severity rating *at the time of the visit*.

Situation D - Patient's clinical record contains the following information:

Clinical note dated 08-12-2015 shows, "patient unable to speak; observed during 20 minute evaluation; pain severity on nonverbal scale moderate to severe."

- **HIS Response Selection:**

J0900A: Was the patient screened for pain? Select response "1, Yes."

J0900B: Date of first screening for pain: Enter "08-12-2015."

J0900C: The patient's pain severity was: Select response "3, Severe."

J0900D: Type of standardized pain tool used: Select response "4, Staff observation."

- **Explanation:** It is evident that the patient was in pain, and that the clinician evaluated the patient's pain and noted pain severity. Although the clinical tool is not named, it is still evident that the clinician used a standardized approach or clinical protocol to screen the patient. For J0900C, the correct course of action is to select response "3, Severe," based on *the highest severity of pain at the time of the visit*.

Situation E – Patient's clinical record contains the following information:

Initial assessment form dated 08-14-2015 shows, "patient reports he has recently taken a dose of his pain medication, and throughout the visit his pain is reported as 0/10. Patient states he has a history of pain, at its worst pain is 6/10 and is a dull, aching pain in lower abdomen. Historically, pain is worse when patient walks and pain is better when lying down."

- **HIS Response Selection:**

J0900A: Was the patient screened for pain? Select response "1, Yes."

J0900B: Date of first screening for pain: Enter "08-14-2015."

J0900C: The patient's pain severity was: Select response "0, None" and skip to Item J2030, Screening for Shortness of Breath (Dyspnea).

- **Explanation:** Selecting a response for Item J0900 should be based on the patient's pain status *at the time of the screening*. This means that although the patient reported a history of pain, because the patient rated his pain as a 0/10 throughout the visit, Item J0900 should be completed based on the patient's report that he was not in any pain. Although there is clinical record documentation that the nurse further assessed the patient's pain (historical rating, location, character, what makes pain better/worse), because the patient's pain rating at the time of the screening was "0, None," providers should follow skip patterns as indicated on the HIS, skipping J0900D and J0910. In this situation, because the patient has a history of pain, it is clinically appropriate for the clinician to have further assessed the patient's pain; this information is not reported on the HIS, however.

J0910. Comprehensive Pain Assessment	
Enter Code <input type="checkbox"/>	<p>A. Was a comprehensive pain assessment done?</p> <p>0. No → Skip to J2030, Screening for Shortness of Breath</p> <p>1. Yes</p> <p>B. Date of comprehensive pain assessment:</p> <p> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> </p> <p style="text-align: center;"> Month Day Year </p> <p>C. Comprehensive pain assessment included:</p>
↓ Check all that apply	
<input type="checkbox"/>	1. Location
<input type="checkbox"/>	2. Severity
<input type="checkbox"/>	3. Character
<input type="checkbox"/>	4. Duration
<input type="checkbox"/>	5. Frequency
<input type="checkbox"/>	6. What relieves/worsens pain
<input type="checkbox"/>	7. Effect on function or quality of life
<input type="checkbox"/>	9. None of the Above

Item-Specific Instructions

Review the clinical record for documentation of a comprehensive pain assessment. Pain assessment documentation includes a clinician's record of information about the location, severity, character, and other characteristics of a patient's pain. Pain assessment can be completed for verbal and nonverbal patients. Item completion should be based on what is included in the clinical record. Do not use sources external to the clinical record. Review all response choices before making a selection.

J0910A: Was a comprehensive pain assessment done?

- **Response 0, No:** Select response 0 if there is no documentation that a comprehensive pain assessment was done. Skip to Item J2030, Screening for Shortness of Breath (Dyspnea).
- **Response 1, Yes:** Select response 1 if there is documentation that a comprehensive pain assessment was done.

J0910B: Date of comprehensive pain assessment

- **Enter the date the hospice conducted the comprehensive pain assessment.** Use the format Month-Day-Year: MM-DD-YYYY. If the month and/or day contain only a single digit, enter "0" in the first box of the month and/or day. For example, November 1, 2015, would be entered as 11-01-2015.
- It is possible that at the time of HIS completion, multiple comprehensive pain assessments will be documented in the clinical record. Complete HIS pain assessment items based on the *first* dated comprehensive pain assessment that appears in the clinical record.

J0910C: Comprehensive pain assessment included:**Check all that apply:**

- **Check 1, Location,** if the *location* of the patient's pain was assessed.
- **Check 2, Severity,** if the *severity* of the patient's pain was assessed.
- **Check 3, Character,** if the *character* of the patient's pain was assessed.
- **Check 4, Duration,** if the *duration* of the patient's pain was assessed.
- **Check 5, Frequency,** if the *frequency* of the patient's pain was assessed.
- **Check 6, What relieves/worsens pain,** if *what relieves/worsens* the patient's pain was assessed.
- **Check 7, Effect on function or quality of life,** if the *pain's effect on the patient's function or quality of life* was assessed.
- **Check 9, None of the Above,** if there is no documentation that any of the above characteristics (1–7) were included in the pain assessment.

Item-Specific Tips

A comprehensive pain assessment should address multiple aspects of pain, beyond a determination of the presence of pain and its severity.

It is possible to include elements of the pain assessment listed in J0910C for nonverbal patients.

- A caregiver report about any of the above characteristics is acceptable. Clinical notes about assessment of nonverbal indicators of pain for any of the above characteristics are also acceptable.
- Nonverbal indicators of pain include nonverbal sounds such as crying, whining, and groaning; facial expressions, such as grimacing and clenching jaws; and protective body movements or postures such as bracing, guarding, rubbing, or clutching a body part. For example:
 - An assessment that included pain *location* for a nonverbal patient may include documentation, such as “patient grimaced and shouted when clinician touched their right leg” or other documentation denoting patient exhibiting nonverbal cues of pain *for a specific location on the body*.
 - An assessment that included pain *severity* for a nonverbal patient may include documentation about *intensity* of nonverbal expressions of pain (grimaces, wincing, and clenched teeth/jaw) or protective body movements (bracing, guarding, rubbing, clutching, or holding of a certain body part/area). It could also include documentation of severity using a nonverbal standardized rating scale.
 - An assessment that included pain *duration* for a nonverbal patient may include documentation about *how long* a patient exhibits any nonverbal cues of pain, such as “patient cradled right arm throughout entire visit.”
 - An assessment that included pain *frequency* for a nonverbal patient may include documentation about *how often* a patient exhibits any nonverbal cues of pain, such as most of the time, only at night, intermittently.
 - An assessment that included *what relieves/worsens pain* for a nonverbal patient may include documentation about *actions, activities, or positions that relieve/worsen pain*, such as “patient exhibits fewer nonverbal signs of pain when sitting up versus lying down.”
 - An assessment that included pain’s *effect on function or quality of life* for a nonverbal patient may include documentation about *change in patient activity*, such as “family caregiver reports that patient is no longer able to sit up in bed without moaning.”

For any of the seven characteristics included in the pain assessment, select response options based on whether the clinician *made an attempt* to gather the information from the patient/caregiver.

- For example, if, for a nonverbal patient, the clinician asked the family/caregiver about pain location and the family/caregiver responded “I’m not sure” or “I don’t know,” “1, Location” should be checked for J0910C because the clinician *attempted* to gather the information.

Examples**Situation A - Patient's clinical record contains the following information:**

Clinical note dated 08-12-2015 shows, "patient unable to speak; noticed some loud moaning/grimacing during visit. Asked patient's family about how long patient had been in distress—family stated patient had been moaning all morning, and rarely looked comfortable. Family stated patient often clutches lower abdomen when touched. Unable to move patient because of signs of distress when turning or attempting to get up from bed. Family uncertain what makes pain worse or better."

- **HIS Response Selection:**

J0910A: Was a comprehensive pain assessment done? Select response "1, Yes."

J0910B: Date of comprehensive pain assessment: Enter "08-12-2015."

J0910C: Comprehensive pain assessment included: Check "1, Location" (clutching lower abdomen); check "2, Severity" (loudly moaning/grimacing); check "4, Duration" (patient had been moaning all morning); check "5, Frequency" (rarely looked comfortable); check "6, What relieves/worsens pain" (family uncertain); and check "7, Effect on function or quality of life" (unable to move because of distress).

- **Explanation:** Because at least one of the seven characteristics of a comprehensive pain assessment were clearly documented in the patient's clinical record, select response "1, Yes" for J0910A and continue to J0910B-J0910C, selecting responses based on documentation in the clinical record. Even though the family stated they were not sure what made the pain better or worse, "6, What relieves/worsens pain" can still be checked because there was documentation that the clinician asked about what relieves or worsens pain.

Situation B - Patient's clinical record contains the following information:

Clinical documentation dated 08-12-2015 shows, "Current pain intensity: moderate; Rated by: patient; Frequency: intermittent; Type of pain: throbbing; What makes pain worse: movement; Pain affects patient's: appetite, emotions; Relief measures that work: heat, distraction, massage."

- **HIS Response Selection:**

J0910A: Was a comprehensive pain assessment done? Select response "1, Yes."

J0910B: Date of comprehensive pain assessment: Enter "08-12-2015."

J0910C: Comprehensive pain assessment included: Check "2, Severity" (moderate); Check "3, Character" (throbbing); Check "5, Frequency" (intermittent); Check "6, What relieves/worsens pain" (heat, distraction, massage, movement); Check "7, Effect on function or quality of life" (appetite, emotions).

- **Explanation:** Because at least one of the seven characteristics of a comprehensive pain assessment were clearly documented, select response "1, Yes" for J0910A and continue to J0910B-J0910C, selecting responses based on documentation found in the clinical record.

SECTION J, RESPIRATORY STATUS: RATIONALE

Shortness of breath (dyspnea) is prevalent and often under-treated among patients nearing the end of life.

- Screening for shortness of breath is necessary to determine its presence and severity, and screening forms the basis for treatment decision making.

Shortness of breath can be functionally limiting and distressing to patients and their families/caregivers.

- Effective treatment is available to alleviate symptom distress.
- Treatment can include pharmacologic and non-pharmacologic interventions.
- Treatment for shortness of breath will vary in severity and etiology, and with patient and caregiver preferences.

J2030. Screening for Shortness of Breath

Enter Code <input type="checkbox"/>	<p>A. Was the patient screened for shortness of breath?</p> <p>0. No → Skip to N0500, Scheduled Opioid</p> <p>1. Yes</p> <p>B. Date of first screening for shortness of breath:</p> <p> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> </p> <p style="text-align: center;"> Month Day Year </p>
Enter Code <input type="checkbox"/>	<p>C. Did the screening indicate the patient had shortness of breath?</p> <p>0. No → Skip to N0500, Scheduled Opioid</p> <p>1. Yes</p>

Item-Specific Instructions

Review the clinical record for documentation of screening for shortness of breath. Item completion should be based on what is included in the clinical record. Do not use sources external to the clinical record. Review all response choices before making a selection.

J2030A: Was the patient screened for shortness of breath?

- **Response 0, No:** Select response 0 if there is no documentation that the patient was screened for shortness of breath. Skip to Item N0500, Scheduled Opioid.
- **Response 1, Yes:** Select response 1 if there is documentation that the patient was screened for shortness of breath.

J2030B: Date of first screening for shortness of breath

- **Enter the date the hospice first screened the patient for shortness of breath.** Use the format Month-Day-Year: MM-DD-YYYY. If the month and/or day contain only a single digit, enter a “0” in the first box of the month and/or day. For example, November 1, 2015, would be entered as 11-01-2015.

Item-Specific Instructions (continued)

- It is possible that at the time of HIS completion, multiple screenings for shortness of breath will be documented in the clinical record. Complete HIS shortness of breath screening items based on the first shortness of breath screening that appears in the clinical record.

J2030C: Did the screening indicate the patient had shortness of breath?

- **Response 0, No:** Select response 0 if the screening indicated that the patient did not have shortness of breath. Skip to Item N0500, Scheduled Opioid.
- **Response 1, Yes:** Select response 1 if the screening indicated that the patient had shortness of breath.

Item-Specific Tips

A screening for shortness of breath must include evaluating the patient for presence/absence of shortness of breath and, if shortness of breath is present, rating its severity. Structured clinical evaluation for shortness of breath is not well defined; therefore, documentation found in the clinical record for screening of shortness of breath may vary and may not include use of a standardized tool for rating severity.

- To answer “yes” to J2030A, clinical record documentation must show that the patient was screened for presence/absence of shortness of breath, *and*, if the patient was found to be short of breath, there must also be evidence that severity was rated in any manner clinically appropriate for the patient (which may/may not have included the use of a standardized tool to rate severity).
- If documentation indicates the patient had shortness of breath, but severity was not evaluated in any manner, answer “no” to J2030A.

Evidence of a “positive” screen for shortness of breath should consider whether shortness of breath was an active problem for the patient at the time of the screening clinical encounter. In determining whether shortness of breath was an active problem for the patient, providers may need to consider historical report of patient’s shortness of breath, documentation of patient’s self-report of distress, and observed clinical signs of shortness of breath at the time of the visit in which the screening was conducted. On the basis of reports of recent symptoms, current treatment, and so on, the assessing clinician may determine that shortness of breath is an active problem, even if shortness of breath does not occur during the assessment visit. The clinical record could include patient’s self-report of distress or “trouble breathing” from shortness of breath or dyspnea; documentation of shortness of breath or dyspnea at rest, upon exertion, or at other times; patient/caregiver report of shortness of breath; observed clinical signs of distress from shortness of breath; and/or documentation that the symptom is distressing or limits patient function or quality of life.

Examples**Situation A - Patient's clinical record contains the following information:**

Clinical note dated 08-12-2015 shows, "patient very drowsy; appears to be comfortable during visit."

- **HIS Response Selection:**
J2030A: Was the patient screened for shortness of breath? Select response "0, No" and skip to Item N0500, Scheduled Opioid.
- **Explanation:** The documentation in Situation A provides no evidence that the patient was screened for shortness of breath. Thus, select response "0, No" for J2030A and skip to Item N0500.

Situation B - Patient's clinical record contains the following information:

Clinical note dated 08-12-2015 shows, "patient reports no discomfort and is breathing shallowly but without signs of distress; no concerns about breathing from patient or family."

- **HIS Response Selection:**
J2030A: Was the patient screened for shortness of breath? Select response "1, Yes."
J2030B: Date of first screening for shortness of breath: Enter "08-12-2015."
J2030C: Did the screening indicate the patient had shortness of breath? Select response "0, No" and skip to N0500, Scheduled Opioid.
- **Explanation:** The documentation in Situation B gives evidence that breathing was screened or assessed. J2030C is reported as "0, No" because the screening indicated that although the patient was breathing shallowly, there were no signs of distress or concerns from patient/family.

Examples (continued)**Situations C and D - Patient's clinical record contains the following information:**

Situation C: Clinical note dated 08-12-2015 shows, "patient reports great difficulty with breathing when walking to the bathroom; breathing is eased after resting and better if using oxygen when active."

Situation D: Clinical note dated 08-12-2015 shows, "patient unable to speak; observed during 20-minute evaluation; respiratory rate 28 with intermittent use of abdominal breathing; some wheezing on exam but good air movement."

- **HIS Response Selection for Situations C and D:**

J2030A: Was the patient screened for shortness of breath? Select response "1, Yes."

J2030B: Date of first screening for shortness of breath: Enter "08-12-2015."

J2030C: Did the screening indicate the patient had shortness of breath? Select response "1, Yes."

- **Explanation for Situations C and D:** In both Situations C and D it is evident that the clinician used careful questioning and observation to establish the presence and severity of shortness of breath. Thus, select response "1, Yes" for J2030A, and continue to J2030B-J2030C, using evidence in the clinical record to report date and presence or absence of shortness of breath.

Situation E - Patient's clinical record contains the following information:

Clinical note dated 08-15-2015 reads, "patient reports he is currently not experiencing any shortness of breath. Patient reports that he does become short of breath when walking from the bed to the bathroom. Patient reports that when he is short of breath, shortness of breath is mild to moderate, depending on activity level."

- **HIS Response Selection:**

J2030A: Was the patient screened for shortness of breath? Select response "1, Yes."

J2030B: Date of first screening for shortness of breath: Enter "08-15-2015."

J2030C: Did the screening indicate the patient had shortness of breath? Select response "1, Yes."

- **Explanation:** In Situation E, it is evident the clinician evaluated the patient for presence and severity of shortness of breath. Thus, select response "1, Yes" for J2030A and continue to J2030B, entering the date of the screening. J2030C should be completed based on whether documentation in the clinical record demonstrates that shortness of breath was an active problem for the patient. Although the patient was not experiencing shortness of breath at the time of the screening, clinical record documentation shows that shortness of breath is a current, active problem for the patient when engaging in certain activities. Thus, select response "1, Yes" for J2030C.

J2040. Treatment for Shortness of Breath	
Enter Code <input type="checkbox"/>	<p>A. Was treatment for shortness of breath initiated? Select the most accurate response</p> <p>0. No → Skip to N0500, Scheduled Opioid</p> <p>1. No, patient declined treatment → Skip to N0500, Scheduled Opioid</p> <p>2. Yes</p> <p>B. Date treatment for shortness of breath initiated:</p> <p> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> </p> <p style="text-align: center;"> Month Day Year </p> <p>C. Type(s) of treatment for shortness of breath initiated:</p>
↓ Check all that apply	
<input type="checkbox"/>	1. Opioids
<input type="checkbox"/>	2. Other medication
<input type="checkbox"/>	3. Oxygen
<input type="checkbox"/>	4. Non-medication
Item-Specific Instructions	
<p>Review the clinical record for information regarding treatment for shortness of breath. Item completion should be based on what is included in the clinical record. Do not use sources external to the clinical record. Review all response choices before making a selection.</p> <p>J2040A: Was treatment for shortness of breath initiated?</p> <ul style="list-style-type: none"> • Response 0, No: Select response 0 if there is no documentation that treatment for shortness of breath was initiated or offered. Skip to Item N0500, Scheduled Opioid. • Response 1, No, patient declined treatment: Select response 1 if there is documentation that the hospice offered treatment for shortness of breath but the patient or responsible party declined. Skip to Item N0500, Scheduled Opioid. • Response 2, Yes: Select response 2 if there is documentation that treatment for shortness of breath was initiated. <p>J2040B: Date treatment for shortness of breath initiated</p> <ul style="list-style-type: none"> • Enter the date the hospice initiated treatment for shortness of breath. Use the format Month-Day-Year: MM-DD-YYYY. If the month and/or day contain only a single digit, enter "0" in the first box of the month and/or day. For example, November 1, 2015, would be entered as 11-01-2015. 	

Item-Specific Instructions (continued)

- For *pharmacologic interventions*, treatment initiation is defined as the date that an order was received to initiate or continue a treatment. An order may be verbal (when permitted) or written; responses for this item should be based on whichever was used to determine the start of treatment. Enter the date of the order, irrespective of if/when the first dose was given.
 - For *orders continued from previous care settings*, J2040 should be completed based on treatments for which the *hospice* has received orders. Do not include a “continued” treatment unless the hospice received a new order to continue the treatment. Once an order is received by the hospice to continue a treatment, use the date the hospice received the order in J2040B.
 - For *comfort kits or pre-printed admission orders*, treatment is considered initiated when the hospice has received the order *and* there is documentation that the patient/caregiver was instructed to begin use of the medication or treatment for the relevant symptom. If the date the hospice received the order is different than the date the hospice instructed the patient/caregiver to begin using the treatment/medication, “date treatment initiated” would be the later date, when both conditions were met (hospice received order and instructed patient/caregiver to begin use). Proactive education on medications in a comfort kit in anticipation of symptoms is not considered “initiation.”
- For *non-medication interventions* (for example, fans, positioning, patient education efforts) there will not be any orders; in this case, use the date on which the hospice first discussed the intervention with the patient/caregiver.
- If the patient received multiple types of treatment for shortness of breath (for example, oxygen and education about positioning), enter the date that the first treatment was initiated.

J2040C: Type(s) of treatment for shortness of breath initiated

Check all that apply:

- **Check 1, Opioids**, if the patient received opioids and there is documentation that opioids were initiated *for shortness of breath*.
- **Check 2, Other medication**, if a non-opioid medication was initiated for shortness of breath.
 - Common examples of non-opioid medications that are frequently used for dyspnea include inhaled bronchodilators, steroids, diuretics, and benzodiazepines. Orders must indicate that the medication was initiated *for shortness of breath*.
- **Check 3, Oxygen**, if the patient received oxygen.
- **Check 4, Non-medication**, if the patient received a non-medication intervention for shortness of breath other than oxygen. This could include (but is not limited to) fans, positioning, and education about energy conservation techniques.

Item-Specific Tips

When reviewing the clinical record for treatments initiated for shortness of breath:

- Include both scheduled and PRN treatments for shortness of breath.
- Include comfort kits or pre-printed admission orders only if the hospice has received the order *and* the patient/caregiver has been instructed to begin use of the medication or treatment for the relevant symptom.

Some treatments have multiple uses (for example, opioids can be used to treat pain or shortness of breath; relaxation techniques can be used to help with shortness of breath or anxiety).

- Only include such treatments in J2040 if the clinical record indicates that the intended purpose of the treatment is to address the patient's shortness of breath.
- Orders that contain multiple purposes for the medication are acceptable as long as one of the stated purposes is to address shortness of breath.

For J2040C, only include treatments that were initiated on the date listed in J2040B. If additional treatments for shortness of breath are initiated at a later date, the hospice should not update J2040C to reflect these additional treatments.

Examples**Situation A - Patient's clinical record contains the following information:**

Clinical documentation dated 08-12-2015 shows, "dyspnea/shortness of breath at rest, clinical signs indicate patient is short of breath. Patient/family instructed on energy conservation techniques to alleviate shortness of breath." Order dated 08-12-2015 shows, "morphine 2-15 mg IV every 4 hours as needed."

- **HIS Response Selection:**

J2040A: Was treatment for shortness of breath initiated? Select response "2, Yes."

J2040B: Date treatment for shortness of breath initiated: Enter "08-12-2015."

J2040C: Type(s) of treatment for shortness of breath initiated: Check "4, Non-medication" (energy conservation techniques).

- **Explanation:** Documentation in the clinical record clearly indicates that the patient was short of breath and that treatment was initiated for shortness of breath (energy conservation techniques). The morphine treatment listed in the order list *cannot* be deemed treatment for shortness of breath because there is no indication listed in the clinical record that the morphine was prescribed to treat shortness of breath. To be considered a treatment for shortness of breath, the order list would need to read "morphine 2-15 mg IV every 4 hours as needed *for shortness of breath*" or "*as needed for shortness of breath and pain.*"

Situation B - Patient's clinical record contains the following information:

Clinical documentation dated 09-15-2015 shows, "dyspnea/shortness of breath at rest. Instructed family to keep patient's head elevated on pillows while patient is in bed." Order dated 09-16-2015 shows, "oxygen ordered and scopolamine to dry respiratory secretions."

- **HIS Response Selection:**

J2040A: Was treatment for shortness of breath initiated? Select response "2, Yes."

J2040B: Date treatment for shortness of breath initiated: Enter "09-15-2015."

J2040C: Type(s) of treatment for shortness of breath initiated: Check "4, Non-medication" (positioning with pillows).

- **Explanation:** Documentation in the clinical record clearly indicates that the patient was short of breath and that more than one treatment was initiated for shortness of breath. The date that the *first* treatment for shortness of breath is initiated (09-15-2015, education about positioning) is the proper date to list in Item J2040B. For J2040C, only list treatments that were initiated on the date listed in J2040B.

Situation C - Patient's clinical record contains the following information:

Clinical documentation dated 09-15-2015 shows, "patient reports shortness of breath and is currently using oxygen and nebulizer ordered in previous care setting." No orders for oxygen or nebulizer found in the hospice record.

Examples (continued)

- **HIS Response Selection:**

J2040A: Was treatment for shortness of breath initiated? Select response “0, No.” Skip to Item N0500, Scheduled Opioid.

J2040B: Date treatment for shortness of breath initiated: Do not complete.

J2040C: Type(s) of treatment for shortness of breath initiated: Do not complete.

- **Explanation:** Item J2040 should be completed based on treatments for which the *hospice* has received orders after assuming responsibility for the care of the patient. “Initiation” (or continuation) of a treatment from a previous care setting is defined as the date the hospice received new orders to continue the treatment. In Situation C, the nebulizer and oxygen cannot be listed as treatments for shortness of breath in J2040 because there was no evidence in the clinical record that the *hospice* received orders to continue these treatments under hospice care. If new orders for the oxygen and nebulizer were listed in the hospice clinical record/order list, the treatments could be considered when completing J2040; in that situation, the hospice would enter the date that the hospice received the order in J2040B.

Situation D - Patient’s clinical record contains the following information:

Clinical documentation dated 09-15-2015 shows, “comfort pack in patient’s home and on stand-by.” Documentation states, “patient and family were educated on what medications were in the comfort pack, what symptoms the medications might be used for (including shortness of breath), and where to store the pack until needed. Patient and family instructed not to use the medications in the comfort kit until specifically advised to do so.”

- **HIS Response Selection:**

J2040A: Was treatment for shortness of breath initiated? Select response “0, No.” Skip to Item N0500, Scheduled Opioid.

J2040B: Date treatment for shortness of breath initiated: Do not complete.

J2040C: Type(s) of treatment for shortness of breath initiated: Do not complete.

- **Explanation:** Documentation in the clinical record indicates that the comfort pack included treatments that could be used for shortness of breath, and that the nurse provided proactive education to the patient/family about the availability of such treatments. However, documentation in the clinical record does not indicate that the nurse instructed the patient/family to begin using any of the treatments for shortness of breath. Thus, for the purposes of completing Item J2040, treatment for shortness of breath was *not* initiated; in this situation, the hospice would enter “0, No” for J2040A and skip J2040B-C. Had the clinical record included an additional note stating “instructed patient/family to begin using morphine 2mg PO/SL PRN for shortness of breath,” this would be sufficient evidence that treatment was initiated, and the hospice would enter “1, Yes” for J2040A. Date treatment initiated in this situation would be the date on which the nurse instructed the patient/family to begin using the treatments.

SECTION N: MEDICATIONS									
Items in this section of the Hospice Item Set (HIS) gather information on opioids and bowel regimens.									
SECTION N: RATIONALE									
Opioids are commonly used in the management of pain and other symptoms. Constipation is one of the most common opioid-related adverse effects. Most patients develop some degree of constipation after opioid initiation or dose increases, and reducing opioid-induced constipation has the potential to reduce patient discomfort and improve quality of life. Patients do not develop a tolerance to opioid-induced constipation; clinical guidelines recommend prophylactic bowel regimens.									
N0500. Scheduled Opioid									
Enter Code <input style="width: 30px; height: 20px; border: 1px solid black;" type="checkbox"/>	<p>A. Was a scheduled opioid initiated or continued?</p> <p>0. No → Skip to N0510, PRN Opioid 1. Yes</p> <p>B. Date scheduled opioid initiated or continued:</p> <table style="width: 100%; border: none;"> <tr> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> </tr> <tr> <td style="text-align: center;">Month</td> <td style="text-align: center;">Day</td> <td colspan="2" style="text-align: center;">Year</td> </tr> </table>					Month	Day	Year	
Month	Day	Year							
Item-Specific Instructions									
Review the clinical record for information regarding medications and prescriptions. Item completion should be based on what is included in the clinical record. Do not use sources external to the clinical record. Review all response choices before making a selection.									
<p>N0500A: Was a scheduled opioid initiated or continued?</p> <ul style="list-style-type: none"> • Response 0, No: Select response 0 if the clinical record indicates that a regularly scheduled opioid was neither initiated nor continued by the hospice and skip to Item N0510, PRN Opioid. • Response 1, Yes: Select response 1 if the clinical record indicates that a regularly scheduled opioid was initiated or continued from the previous care setting. <p>N0500B: Date scheduled opioid initiated or continued</p> <ul style="list-style-type: none"> • Enter date scheduled opioid was initiated or continued. Use the format Month-Day-Year: MM-DD-YYYY. If the month and/or day contain only a single digit, enter "0" in the first box of the month and/or day. For example, November 1, 2015, would be entered as 11-01-2015. 									

Item-Specific Instructions (continued)

- This is the date that the hospice initiated or continued regularly scheduled opioids. Treatment initiation or continuation is defined as the date that an order was received. An order may be verbal (when permitted) or written; responses for this item should be based on whichever was used to determine the start of treatment. Enter the date of the order, irrespective of if/when the first dose was given.
 - For orders continued from previous care settings, N0500 should be completed based on scheduled opioids for which the *hospice* has received orders. Do not include a continued treatment unless the hospice received a new order to continue the treatment. Once an order is received by the hospice to continue a treatment, use the date the hospice received the order in N0500B.
 - For *comfort kits or pre-printed admission orders*, treatment is considered initiated when the hospice has received the order *and* there is documentation that the patient/caregiver was instructed to begin use of the medication or treatment. If the date the hospice received the order is different than the date the hospice instructed the patient/caregiver to begin using the treatment/medication, “date treatment initiated” would be the later date, when both conditions were met (hospice received order and instructed patient/caregiver to begin use). Proactive education on medications in a comfort kit in anticipation of symptoms is not considered initiation.
- If the patient received different types of regularly scheduled opioids in sequence over time, enter the date that the first type of opioid treatment was initiated.

Item-Specific Tips

- Select response “1, Yes” if the clinical record indicates that a regularly scheduled opioid was initiated for any reason, regardless of symptom.
- For the purposes of completing Item N0500, an “opioid” includes Schedule II–Schedule IV opioids, including hydrocodone and tramadol, because of the side effect profile, which includes constipation.

N0510. PRN Opioid													
Enter Code <input style="width: 30px; height: 20px; margin-top: 5px;" type="checkbox"/>	<p>A. Was a PRN opioid initiated or continued?</p> <p>0. No → Skip to N0520, Bowel Regimen 1. Yes</p> <p>B. Date PRN opioid initiated or continued:</p> <table style="width: 100%; border: none;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;"> </td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;"> </td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;"> </td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;"> </td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;"> </td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;"> </td> </tr> <tr> <td style="text-align: center;">Month</td> <td style="text-align: center;">Day</td> <td colspan="4" style="text-align: center;">Year</td> </tr> </table>							Month	Day	Year			
Month	Day	Year											
Item-Specific Instructions													
<p>Review the clinical record for information regarding medications and prescriptions. Item completion should be based on what is included in the clinical record. Do not use sources external to the clinical record. Review all response choices before making a selection.</p> <p>N0510A: Was a PRN opioid initiated or continued?</p> <ul style="list-style-type: none"> • Response 0, No: Select response 0 if the clinical record indicates that a PRN opioid was neither initiated nor continued from the previous care setting. • Response 1, Yes: Select response 1 if the clinical record indicates that a PRN opioid was initiated or continued from the previous care setting. <p>N0510B: Date PRN opioid initiated or continued</p> <ul style="list-style-type: none"> • Enter the date PRN opioid was initiated or continued. Use the format Month-Day-Year: MM-DD-YYYY. If the month and/or day contain only a single digit, enter “0” in the first box of the month and/or day. For example, November 1, 2015, would be entered as 11-01-2015. • This is the date that the hospice initiated or continued PRN opioids. Treatment initiation or continuation is defined as the date that an order was received. An order may be verbal (when permitted) or written; responses should be based on whichever was used to determine the start of treatment. Enter the date of the order, irrespective of if/when the first dose was given. <ul style="list-style-type: none"> – For orders continued from previous care settings, N0510 should be completed based on PRN opioids for which the <i>hospice</i> has received orders. Do not include a continued treatment unless the hospice received a new order to continue the treatment. Once an order is received by the hospice to continue a treatment, use the date the hospice received the order in N0510B. 													

Item-Specific Instructions (continued)

- For *comfort kits or pre-printed admission orders*, treatment is considered initiated when the hospice has received the order *and* there is documentation that the patient/caregiver was instructed to begin use of the medication or treatment. If the date the hospice received the order is different than the date the hospice instructed the patient/caregiver to begin using the treatment/medication, “date treatment initiated” would be the later date, when both conditions were met (hospice received order and instructed patient/caregiver to begin use). Proactive education on medications in a comfort kit in anticipation of symptoms is not considered initiation.
- If the patient received different types of PRN opioids in sequence over time, enter the date that the first type of opioid treatment was initiated.

Item-Specific Tips

- Select response “1, Yes” if the clinical record indicates that a PRN opioid was initiated for any reason, regardless of symptom.
- For the purposes of completing Item N0510, an “opioid” includes Schedule II–Schedule IV opioids, including hydrocodone and tramadol, because of the side effect profile, which includes constipation.

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

Item-Specific Instructions

Review the clinical record for information regarding medications and prescriptions. Item completion should be based on what is included in the clinical record. Do not use sources external to the clinical record. Review all response choices before making a selection.

N0520A: Was a bowel regimen initiated or continued?

Only complete N0520A if N0500A or N0510A = 1. Skip N0520A if the patient is not on any type of opioid.

- **Response 0, No:** Select response 0 if the clinical record does not include documentation that a bowel regimen was initiated or continued from the previous care setting. Skip to Item Z0400: Signature(s) of Person(s) Completing the Record.
- **Response 1, No, but there is documentation of why a bowel regimen was not initiated or continued:** Select response 1 if the clinical record indicates that a bowel regimen was not initiated or continued, and includes a reason why it was not initiated or continued. Skip to Item Z0400: Signature(s) of Person(s) Completing the Record.
 - Documentation why a bowel regimen was not initiated could include clinical contraindications to a bowel regimen or patient was offered a bowel regimen but refused treatment.
- **Response 2, Yes:** Select response 2 if the clinical record includes documentation that a bowel regimen was initiated or continued from the previous care setting.

Item-Specific Instructions (continued)**N0520B: Date bowel regimen initiated or continued**

- **Enter date bowel regimen was initiated or continued.** Use the format Month-Day-Year: MM-DD-YYYY. If the month and/or day contain only a single digit, enter “0” in the first box of the month and/or day. For example, November 1, 2015, would be entered as 11-01-2015.
- This is the date that the hospice initiated or continued a bowel regimen. Treatment initiation or continuation is defined as the date that an order was received. An order may be verbal or written; HIS response selection should be based on whichever was used to determine the start of treatment. Enter the date of the order, irrespective of if/when the first dose was given.
 - For orders continued from previous care settings, N0520 should be completed based on bowel regimens for which the *hospice* has received orders. Do not include a continued bowel regimen unless the hospice received a new order to continue the bowel regimen. Once an order is received by the hospice to continue a bowel regimen, use the date the hospice received the order in N0520B.
 - For *comfort kits or pre-printed admission orders*, treatment is considered initiated when the hospice has received the order *and* there is documentation that the patient/caregiver was instructed to begin use of the medication or treatment for the relevant symptom. If the date the hospice received the order is different than the date the hospice instructed the patient/caregiver to begin using the treatment/medication, “date treatment initiated” would be the later date, when both conditions were met (hospice received order and instructed patient/caregiver to begin use). Proactive education on medications in a comfort kit in anticipation of symptoms is not considered initiation.
- For non-pharmacologic bowel regimens, such as prune juice or high-fiber diet, there may not be any orders; in this case, use the date the hospice nurse or clinician instructed the patient/family about non-pharmacologic intervention(s).
- If multiple bowel regimens were ordered, enter the date that the first treatment was initiated.
- In certain instances, the date the bowel regimen was initiated or continued (listed in N0520B) may precede the date an opioid (scheduled or PRN) was initiated (listed in N0500B and/or N0510B). This is permissible.
- The bowel regimen order need not explicitly state it is for the management of opioid-induced constipation.

Item-Specific Tips

A bowel regimen may include, but is not limited to the following:

- Laxatives or stool softeners
- High fiber supplements
- Enemas
- Suppositories
- Dietary interventions, such as prune juice or high fiber diet

Clinical record documentation indicating that any of the above bowel regimens were initiated is sufficient to select response “2, Yes” for N0520A. *Orders may be for regularly scheduled use or for PRN use.*

Documentation for why a bowel regimen was not initiated could include clinical contraindication, including but not limited to the following:

- Bowel obstruction/ileus
- Diarrhea
- No bowel function
- Colostomy/ileostomy
- Nausea/vomiting
- Recent abdominal surgery
- NPO/taking nothing by mouth

Clinical record documentation indicating that any of the above clinical contraindications (or any other appropriate clinical contraindication) were present is sufficient to select response “1, No, but there is documentation of why a bowel regimen was not initiated or continued” for N0520A.

A bowel regimen—or any clinical contraindication to a bowel regimen—may appear in the patient clinical record as any reference to avoiding constipation, which may not be linked to opioid prescription.

- In practical terms, this means completing Item N0520 may require review of other portions of the clinical record (for example, gastrointestinal assessment, elimination status, bowel function) to find evidence about bowel regimen or clinical contraindications to bowel regimen.

Examples**Situation A - Patient's clinical record contains the following information:**

Order dated 08-13-2015 shows, "Oxycodone 10 mg PO every 4 hours, PRN for pain." Clinical documentation dated 08-13-2015 shows, "Patient has diarrhea."

- **HIS Response Selection:**

N0500A: Was a scheduled opioid initiated or continued? Select response "0, No." Skip to N0510, PRN Opioid.

N0510A: Was a PRN opioid initiated or continued? Select response "1, Yes."

N0510B: Date PRN opioid initiated or continued: Enter "08-13-2015."

N0520A: Was a bowel regimen initiated or continued? Select response "1, No, but there is documentation of why a bowel regimen was not initiated or continued." Skip to Item Z0400, Signature(s) of Person(s) Completing the Record.

- **Explanation:** Even though the patient is on a PRN opioid, the clinical record clearly indicates that the patient also has a clinical contraindication (diarrhea). Thus, select response 1 for N0520A and skip to Item Z0400.

Situation B - Patient's clinical record contains the following information:

Order dated 07-23-2015 shows, "Morphine 4 mg per hour IV continuous with 2 mg IV PCA every 15 minutes PRN breakthrough pain." Clinical documentation dated 07-23-2015 shows, "Last bowel movement 5 days ago. Patient complaining of abdominal discomfort." Order dated 07-24-2015 shows, "Polyethylene glycol 17 g PO with full glass of water once daily."

- **HIS Response Selection:**

N0500A: Was a scheduled opioid initiated or continued? Select response "1, Yes."

N0500B: Date scheduled opioid initiated or continued: Enter "07-23-2015."

N0510A: Was PRN opioid initiated or continued? Select response "1, Yes."

N0510B: Date PRN opioid initiated or continued: Enter "07-23-2015."

N0520A: Was a bowel regimen initiated or continued? Select response "2, Yes."

N0520B: Date bowel regimen initiated or continued: Enter "07-24-2015."

- **Explanation:** Clinical record documentation clearly indicates the patient was on an opioid (Morphine) and that a bowel regimen was initiated (Polyethylene glycol).

Examples (continued)**Situation C - Patient's clinical record contains the following information:**

Clinical documentation dated 08-13-2015 shows, "Last bowel movement 5 days ago. Patient complaining of abdominal discomfort." Order dated 08-13-2015 shows, "Polyethylene glycol 17 g PO with full glass of water once daily."

- **HIS Response Selection:**

N0500A: Was a scheduled opioid initiated or continued? Select response "0, No." Skip to N0510, PRN Opioid.

N0510A: Was PRN opioid initiated or continued? Select response "0, No." Skip to N0520, Bowel Regimen.

N0520A: Was a bowel regimen initiated or continued? Do not complete. Skip to Item Z0400, Signature(s) of Person(s) Completing the Record.

- **Explanation:** Even though the patient's clinical record shows that a bowel regimen was initiated, because the patient is not on an opioid, do not complete Item N0520. Skip to Item Z0400, Signature(s) of Person(s) Completing the Record.

Situation D – Patient's clinical record contains the following information:

Clinical documentation of initial assessment dated 07-23-2015 shows, "comfort pack in patient's home and on stand-by. Instructed patient and family on what medications are in the comfort pack, including pain medication." Order dated 07-23-2015 shows, "Polyethylene glycol 17 g PO with full glass of water once daily." Clinical note dated 07-25-2015 reads, "caregiver called and reported patient was in moderate pain. Instructed caregiver to open comfort pack and begin giving patient oxycodone 10 mg every 4 hours as needed for pain."

- **HIS Response Selection:**

N0500A: Was a scheduled opioid initiated or continued? Select response "0, No." Skip to N0510, PRN opioid.

N0500B: Date scheduled opioid initiated or continued: Do not complete.

N0510A: Was PRN opioid initiated or continued? Select response "1, Yes."

N0510B: Date PRN opioid initiated or continued: Enter "07-25-2015."

N0520A: Was a bowel regimen initiated or continued? Select response "2, Yes."

N0520B: Date bowel regimen initiated or continued: Enter "07-23-2015."

- **Explanation:** For Item N0500A, because there is no scheduled opioid, the response "0, No" should be selected. For N0510A, the hospice would select response "1, yes" because clinical record documentation shows there was a comfort kit including a PRN opioid (oxycodone) for pain and there is documentation that the nurse instructed the patient/caregiver to begin using the treatment. For N0510B, use the date on which the nurse instructed the patient/family to begin using the treatment, which was 07-25-2015. For N0520A, select "1, Yes." For N0520B, enter the date of the order for polyethylene glycol.

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SECTION Z: RECORD ADMINISTRATION

Items in this section contain signatures of individuals completing the Hospice Item Set (HIS) and the signature of the individual verifying HIS record completion.

SECTION Z: RATIONALE

It is the responsibility of the hospice to ensure the completeness of the HIS.

- Section Z is to be used by the provider and should be retained and archived by the provider in accordance with provider policies and procedures related to patient information.
- Item Z0400 provides a tracking log for the abstracted information contained in the HIS. The signatures in Z0400 are used to certify that the information the individual(s) provided is accurate and that the signer was authorized to collect the information documented on the HIS.
- Item Z0500 is used to document the individual responsible for ensuring the HIS is completed in a timely manner.

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

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

Signature	Title	Sections	Date Section Completed
A.			
B.			
C.			
D.			
E.			
F.			
G.			
H.			
I.			
J.			
K.			
L.			

Item-Specific Instructions

Signatures in Z0400 should reflect those hospice staff members who completed the HIS, which may or may not be the clinician who completed care processes documented in the clinical record. Signatures may be electronic.

All staff who complete any part of the HIS record shall enter their signature, title, section, or portion(s) of a section(s) they completed, as well as the date completed.

- If an individual completes multiple sections of the HIS, that individual can sign once in Z0400 and indicate which sections they completed in the “Sections” portion of Z0400.
- One or more staff members can complete items within the same section of the HIS record. When filling in the information for Z0400, any staff member who has completed a portion of a section should identify which item(s) he or she completed within that section.
- If a staff member cannot sign and date Z0400 on the same day that he or she completed a section or portion of a section of the HIS record, that staff member should enter the original date of HIS record completion when signing Z0400.
- The hospice is responsible for the accuracy of all items on the HIS, irrespective of how they are completed or auto-populated in the HIS record.

Read the Attestation Statement carefully. Persons signing Z0400 are certifying that the information in the HIS record, to the best of their knowledge, most accurately reflects documentation in the patient’s clinical record.

Item-Specific Tips

- Z0400 is not submitted as part of the HIS record in the QIES ASAP system; developing internal policies and procedures for completing and archiving Z0400 is up to the discretion of the hospice.
- This signature-block section (Z0400) is provided for use by the hospice, and it is suggested that it be retained at the hospice in accordance with policies and procedures related to patient information.

Z0500. Signature of Person Verifying Record Completion

<p>A. Signature:</p> <p>_____</p>	<p>B. Date:</p> <table style="width: 100%; text-align: center;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td colspan="2">Month</td> <td colspan="2">Day</td> <td colspan="4">Year</td> </tr> </table>									Month		Day		Year			
Month		Day		Year													

Item-Specific Instructions

Sign and date Z0500 after verifying that all items on the record are complete and that Item Z0400, Signature(s) of Person(s) Completing the Record, contains attestation for all HIS sections.

- If for some reason the person verifying record completion is unable to sign Z0500A on the date the HIS is completed, the staff member should enter in Z0500B the date when he or she signs Z0500A.

Item-Specific Tips

- The signature in Z0500A certifies only that all sections are complete. Persons completing Z0500 are not certifying the accuracy of portions of the HIS record that were completed by other hospice staff members.
- Z0500A is not submitted as part of the HIS record in the Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing (ASAP) system; it is at the discretion of the hospice to develop internal policies and procedures for completing and archiving Z0500A.
- In the case of a Modification or Inactivation Request, Z0500B should contain the original date on which the record was completed. Do not change Z0500B unless the date in Z0500B in the original record was incorrect and the modification request is to correct the date in Z0500B.

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CHAPTER 3: SUBMISSION AND CORRECTION OF HOSPICE ITEM SET RECORDS

This chapter details the submission and correction process for Hospice Item Set (HIS) records and requirements for data submission by hospices for the Hospice Quality Reporting Program (HQRP) starting July 1, 2014.

3.1 Submitting HIS Records

Hospices must complete and submit required HIS records to the Centers for Medicare & Medicaid Services' (CMS's) Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing (ASAP) system. Each provider must create electronic HIS records and submission files using software that creates files that meet the requirements detailed in the current HIS Data Submission Specifications, available on the CMS HQRP website at <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/HIS-Technical-Information.html>.

Providers must establish communication with the QIES ASAP system to submit a file. This is accomplished by using specialized communications software installed on their computer to access the CMS secure wide area network (WAN). Details about how to obtain WAN software and access are available on the QIES Technical Support Office (QTSO) website at <https://www.qtso.com>.

Once communication is established with the QIES ASAP system via the CMS WAN, the provider can access the hospice welcome page in the QIES ASAP system. This site allows providers to register for QIES user IDs to submit HIS records and access reports. Other information, such as user's guides and bulletins, may also be found on the hospice welcome page. The technical user guide for HIS submission, the *Hospice Item Set (HIS) Submission User's Guide*, is located on the hospice welcome page and provides more detailed information about the QIES ASAP system. The technical user guide is also available on the QTSO website at <https://www.qtso.com/hospicetrain.html>.

When the submission file is received by the QIES ASAP system, the system performs a series of validation checks to evaluate whether the data submitted meet the required data specifications. HIS records are edited to verify that clinical responses are within valid ranges and are consistent with other items in the record, dates are reasonable, and the submitted record is in the proper order with regard to the records that were previously accepted by the QIES ASAP system for the same patient. The provider is notified of the results of this evaluation by error and warning messages on a Final Validation Report. All error and warning messages are detailed and explained in Section 5 of the *Hospice Item Set (HIS) Submission User's Guide*.

3.2 Timeliness Criteria

HIS completion and submission timing requirements have been defined by CMS. The timing requirements in place encourage appropriate record completion and file

submission for timely quality reporting. Providers are notified when the timing criteria have not been met by warnings that appear on the Final Validation Reports.

- Completion timing for HIS records:
 - For HIS-Admission records (A0250 = 1), the Completion Date (Z0500B) may be no later than *14 days* from the Admission Date (A0220). Therefore, Z0500B (Completion Date) minus A0220 (Admission Date) should be less than or equal to 14 days.
 - For HIS-Discharge records (A0250 = 2), the Completion Date (Z0500B) may be no later than *7 days* from the Discharge Date (A0270). Therefore, Z0500B (Completion Date) minus A0270 (Discharge Date) should be less than or equal to 7 days.
- Submission timing for HIS records: All HIS records should be submitted electronically to the QIES ASAP system within 30 days of the Event Date. The Event Date for a HIS-Admission record is the Admission Date (A0220), and the Event Date for a HIS-Discharge record is the Discharge Date (A0270).
 - For HIS-Admission records (A0250 = 1), the Submission Date may be no later than 30 days from the Admission Date (A0220). Therefore, the Submission Date minus the Admission Date (A0220) should be less than or equal to 30 days.
 - For HIS-Discharge records (A0250 = 2), the Submission Date may be no later than 30 days from the Discharge Date (A0270). Therefore, the Submission Date minus the Discharge Date (A0270) should be less than or equal to 30 days.

3.3 Validation of Records and Files

The QIES ASAP system validation edits are designed to monitor the timeliness and ensure that the submitted records conform to the HIS Data Submission Specifications. If submitted HIS records do not meet the edit requirements, the system will provide fatal error and/or warning messages on the Final Validation Report. The following describes the validation, storage, and reporting of records in a submission file.

1. **Initial Submission Confirmation.** For each file submitted, the submitter will receive an online confirmation that the file was received for processing and editing by the QIES ASAP system. This confirmation information includes the file submission number, as well as the date and time the file was received for processing. Providers should print and maintain a copy of this confirmation.
2. **Validation and Editing.** Each time a user submits a HIS file to the QIES ASAP system, three types of validation are performed:
 - **Fatal File Errors.** The file structure is validated to ensure it follows the requirements outlined in the HIS Data Submission Specifications provided by CMS. The file is rejected by the QIES ASAP system if the file structure does

not meet these requirements. Examples of fatal file errors include the following:

- The file is not a ZIP file.
 - The records in the ZIP file cannot be extracted.
 - The file cannot be read.
- The Submitter Final Validation Report will list any fatal file error(s). Files that are rejected must be corrected and resubmitted.
 - **Fatal Record Errors.** If the file structure is acceptable, then each HIS record in the file is validated individually for fatal record errors. These errors include, but are not limited to, the following:
 - Out-of-range responses (for example, the valid responses for the item are 1, 2, and 3, and the submitted value is 6).
 - Inconsistent relationships between items. For example, an inconsistent date pattern, such as the Patient's Birth Date (Item A0900) is later than the Admission Date (Item A0220).
 - Fatal record errors result in rejection of individual records by the QIES ASAP system. The provider is informed of fatal record error(s) on the Final Validation Report. Rejected records must be corrected and resubmitted.
 - **Warnings (Non-fatal Errors).** The record is also validated for warnings (non-fatal errors). Warnings include, but are not limited to, missing or questionable data of a non-critical nature or item consistency errors of a non-critical nature.
 - Examples of warnings include the following:
 - Timing errors
 - Submission date is more than 30 days after the Admission Date (A0220) when A0250 = 01.
 - Completion Date (Z0500B) is more than 14 days after the Admission Date (A0220) when A0250 = 01.
 - Record sequencing errors
 - A HIS-Admission record is submitted after a previous HIS-Admission record and there was no HIS-Discharge record submitted in between.
 - A record is submitted for a patient after a HIS-Discharge record with a Reason for Discharge (A2115) equal to Expired (01) has been submitted.

All warnings (nonfatal errors) are reported to the provider in the Final Validation Report. The provider must evaluate each warning to identify necessary corrective actions.

- 3. Storage to the QIES ASAP System.** If there are any fatal record errors, the record will be rejected and not stored in the QIES ASAP system. If there are no fatal record errors, the record is stored in the QIES ASAP system, even if the record has warnings (non-fatal errors).

Detailed information on the validation error and warning messages is available in the *Hospice Item Set (HIS) Submission User's Guide*, which is available on the hospice welcome page and on the QTSO website at <https://www.qtso.com/hospicetrain.html>.

3.4 HIS Record Correction Policy

The HIS record should be accurate when submitted and accepted into the QIES ASAP system. When a provider determines that one or more data elements in an accepted record are inaccurate, the provider must take the necessary steps to correct the erroneous record (see **Section 3.6**).

Changes made to the provider's copy of the HIS record *after* the record is accepted into the QIES ASAP system will not be recognized. It is the provider's responsibility to correct any errors that exist in a submitted HIS record according to the HIS Record Correction Policy. This ensures that the information in the QIES ASAP system accurately reflects the patient's hospice record. A correction can be submitted for any accepted record, even if there has been a submission and acceptance of subsequent records for the patient. Furthermore, it is the provider's responsibility to ensure the record is complete and accurate prior to submission to the QIES ASAP system.

Several processes have been put in place to ensure that HIS records are accurate both at the provider level and in the QIES ASAP system:

- Software used by the provider to create electronic HIS record files must run all standard edits as defined in the HIS Data Submission Specifications released by CMS.
- Record rejection standards have been implemented in the QIES ASAP system whereby if a HIS record contains responses that are out of range (for example, a 4 is entered when only 0–3 are allowable responses for an item), or item responses are inconsistent (for example, a skip pattern is not observed), the record is rejected. Rejected records are not stored in the QIES ASAP database.
- If an error is discovered in a record that has been accepted by the QIES ASAP system, modification or inactivation procedures must be implemented by the provider to ensure that the QIES ASAP system information is corrected.

The remaining sections of this chapter present the decision processes necessary to identify the proper correction steps.

3.5 Correcting Errors in HIS Records That Have Not Yet Been Accepted into the QIES ASAP System

If a HIS record is found to have errors that incorrectly reflect the patient's information within the respective record period as established by CMS, then that record must be corrected. The correction process will depend on the type of error. HIS records that have not yet been accepted in the QIES ASAP system include records that have been submitted and rejected, or records that have not been submitted at all. Records that have been submitted and rejected can usually be corrected and resubmitted without any special correction procedures because they were never accepted by the QIES ASAP system. Hospices are responsible for correcting any errors to the record prior to submission or re-submission of the record to the QIES ASAP system.

3.6 Correcting Errors in HIS Records That Have Been Accepted into the QIES ASAP System

Hospices should correct any errors necessary to ensure that the information in the QIES ASAP system accurately reflects the patient's hospice record. Inaccurate information in the QIES ASAP system may affect hospice quality reporting results. A HIS record may be corrected even if subsequent records have been accepted for the patient.

An error identified in a QIES ASAP system HIS record must be corrected. Inaccuracies can occur for a variety of reasons, such as transcription errors, data entry errors, software product errors, item response selection errors, or other errors. The following two processes exist for correcting HIS records that have been accepted into the QIES ASAP system:

- Modification Request
- Inactivation Request

Completion of a *Modification Request* record will archive the inaccurate HIS record within the QIES ASAP system and replace the record with the new, corrected record. Completion of an *Inactivation Request* will also archive an inaccurate HIS record within the QIES ASAP system, but will not replace the record with the new record.

We recommend that hospices retain a copy of the HIS, along with any corrected versions, to track what was modified. In addition, it is suggested that the hospice keep a copy of inactivated records. Copies of HIS records can be maintained in electronic format. For more details on maintenance of HIS records, see **Chapter 1**.

Modification Requests

A Modification Request record (A0050 = 2) is used when a HIS record is accepted into the QIES ASAP system, but the information in the record contains clinical or non-key demographic errors.

The Modification Request record (A0050 = 2) is used to correct HIS record items that are erroneous. However, there are items that cannot be corrected with a Modification Request; rather, the invalid record must be inactivated with an Inactivation Request record or manually deleted and a new record submitted to the QIES ASAP system.

Items that *cannot be corrected* with a Modification Request are:

Record Event Identifiers:

- A0220: Admission Date (on a HIS-Admission record A0250 = 01)
- A0250: Reason for Record
- A0270: Discharge Date (on a HIS-Discharge record A0250 = 09)

Patient Identifier:

- A0500A: First Name
- A0500C: Last Name
- A0600: Social Security Number (SSN)
- A0800: Gender
- A0900: Birth Date

Note: To make record event identifier and/or patient identifier corrections, you must complete an **Inactivation Request record** for the incorrect record and create a new record with the correct information. Refer to Inactivation Requests below.

When an error is discovered (except for those items listed in the preceding bullets) in a HIS record, the provider must submit a Modification Request record (A0050 = 2) to the QIES ASAP system. When completing a Modification Request record, the Modification Request record must contain correct values for *all* items. This means if A0050 = 2, the provider should proceed to A0100, Facility Provider Numbers, and complete all items in all other HIS record sections.

Note: In the case of a Modification or Inactivation Request, Z0500B should contain the original date on which the record was completed. Do not change Z0500B unless the date in Z0500B in the original record was incorrect and the modification request is to correct the date in Z0500B.

Note: File creation software varies on how Modification Request records are created. Please contact your software vendor for specific instructions.

When a Modification Request record (A0050 = 2) is submitted, the QIES ASAP system will process the record as follows:

1. The system will attempt to locate the existing record in the QIES ASAP database for the hospice using specific identifiers:
 - Last name
 - First name
 - SSN
 - Birth date
 - Gender
 - Facility identifier (facility and state code)
 - Event identifiers (for example, the reason for record and admission or discharge date)
2. If the existing record is not found, the submitted Modification Request record will be rejected and not accepted in the QIES ASAP system. A fatal error will be reported to the hospice on the Final Validation Report.
3. If the existing record is found, then the system performs a series of validation edits to evaluate whether the data submitted meets the required data specifications. HIS records are edited to verify that clinical responses are within valid ranges and are consistent with other items in the record, dates are reasonable, and the submitted record is in the proper order with regard to the records that were previously accepted by the QIES ASAP system for the same patient. If there are any fatal errors, the Modification Request record will be rejected and not accepted in the QIES ASAP system. The fatal error(s) will be reported to the hospice on the Final Validation Report.
4. If the Modification Request record passes all the edits, it will replace the prior erroneous record in the QIES ASAP database. The prior erroneous record will be stored in an archive file within the QIES ASAP database.

Inactivation Requests

An Inactivation Request record (A0050 = 3) must be used when a record has been accepted into the QIES ASAP system but the corresponding event did not occur, (for example, a HIS-Discharge record was submitted for a patient, but there was no actual discharge) and when one or more of the event identifiers or patient identifiers is found to be in error.

An Inactivation Request (A0050 = 3) *must* be completed when any of the following items are inaccurate:

Record Event Identifiers:

- A0220: Admission Date (on a HIS-Admission record A0250 = 01)
- A0250: Reason for Record

- A0270: Discharge Date (on a HIS-Discharge record A0250 = 09)

Patient Identifier:

- A0500A: First Name
- A0500C: Last Name
- A0600: Social Security Number (SSN)
- A0800: Gender
- A0900: Birth Date

Note: Any item in the previous list that was submitted as part of the original record must also be submitted as part of the Inactivation Request, and values for each item must match in the erroneous record and the inactivation record. For example, if A0600A, Social Security Number, was left blank on the original record, it should be left blank on the inactivation record.

If an Admission Date (A0220), Reason for Record (A0250), or Discharge Date (A0270) is incorrect, or if one or more patient identifiers are found to be in error, the provider must inactivate the record in the QIES ASAP system, and then complete and submit a new HIS record with the correct event and/or patient identifiers and ensure that the clinical information is accurate.

Note: For an inactivation of a HIS-Admission record, the Discharge Date (A0270) will be blank.

When an Inactivation Request record (A0050 = 3) is submitted, the QIES ASAP system will process the record as follows:

1. The system will attempt to locate the existing record in the QIES ASAP database for this hospice using specific identifiers:
 - Last name
 - First name
 - SSN
 - Birth date
 - Gender
 - Facility identifier (facility and state code)
 - Event identifiers (for example, the reason for record and admission or discharge date)
2. If the existing record is not found in the QIES ASAP database, the submitted Inactivation Request record will be rejected, and a fatal error will be reported to the hospice on the Final Validation Report.

3. If the existing record is found, the erroneous record will be removed from the active records in the QIES ASAP database and stored in an archive file within the QIES ASAP database.

3.7 Special Manual Record Deletion Request

A special Manual Record Deletion Request is only necessary when there has been an error in a record that has been accepted into the QIES ASAP system that cannot be corrected with a Modification or Inactivation Request record. There are only two items to which this applies. A Manual Record Deletion Request must be performed when the record has the wrong state code (STATE_CD) and/or facility ID (FAC_ID) in the control items. Control items are items created by the HIS software. These errors most likely occurred at the time of software installation when initializing the software, and not during the routine entry of the patient's administrative or clinical data.

If a QIES ASAP system record has the wrong state code and/or facility ID (control items STATE_CD and FAC_ID), then the record must be removed without leaving any trace in the QIES ASAP system. The record must be resubmitted with the correct STATE_CD and FAC_ID value, when indicated. All data items must be complete and correct on the newly submitted record.

In the event that this error has occurred, the provider must contact the QTSO Help Desk at help@qtso.com or 1-877-201-4721 to obtain the Manual Hospice Item Set Record Correction form. The provider is responsible for completing the form. The provider must submit the completed form to the QTSO Help Desk at the address on the form via Certified Mail through the United States Postal Service (USPS). The QTSO Help Desk will contact CMS for approval upon receipt of such a request. Upon CMS approval of the manual deletion request, the QTSO Help Desk will work through the request with the provider.

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APPENDIX A: ACRONYMS AND GLOSSARY

Acronyms

ACA—Patient Protection and Affordable Care Act
CAH—Critical Access Hospital
CCN—CMS Certification Number (also known as Medicare Provider Number)
CMS—Centers for Medicare & Medicaid Services
CNPI—Checklist of Nonverbal Pain Indicators
CPOT—Critical Care Pain Observation Tool
CPR—Cardiopulmonary resuscitation
DD—Developmental Disability
DNI—Do Not Intubate
DNR—Do Not Resuscitate
ESAS—Edmonton Symptom Assessment System
FR—Final Rule
FY—Fiscal Year
HART—Hospice Abstraction Reporting Tool
HIC—Health Insurance Claim
HIS—Hospice Item Set
HQRP—Hospice Quality Reporting Program
ID—Intellectual Disability
IDG—Interdisciplinary Group (also known as Interdisciplinary Team, or IDT)
IRF—Inpatient Rehabilitation Facility or Unit
IV—Intravenous
LTC—Long-Term Care
LTCH—Long-Term Care Hospital
MSAS—Memorial Symptom Assessment Scale
NF—Non-Skilled Nursing Facility
NOS—Not Otherwise Specified
NPI—National Provider Identifier
NPO—Nothing by mouth, “Nil per os”
NQF—National Quality Forum
PACSLAC—Pain Assessment Checklist for Seniors with Limited Ability to Communicate
PAIN-AD—Pain Assessment in Advanced Dementia
PCA—Patient-Controlled Analgesia
PO—By mouth, “Per os”
POLST form—Physician Orders for Life-Sustaining Treatment form
PRN—As needed, “Pro re nata”
QIES ASAP system—Quality Improvement and Evaluation System (QIES) Assessment and Submission Processing (ASAP) system

QTSO—QIES Technical Support Office
RRB—Railroad Retirement Board
SNF—Skilled Nursing Facility
SSN—Social Security Number
USPS—United States Postal Service
WAN—Wide Area Network

Definitions

Hospice Item Set (HIS): A standardized set of items intended to capture patient-level data on each hospice patient admission. HIS items can be used to calculate six National Quality Forum (NQF)—endorsed measures and one modified NQF measure. Hospices will submit a HIS-Admission and a HIS-Discharge for each patient admission on or after July 1, 2014.

Admission Date: The date on which the hospice becomes responsible for the care of the patient. For Medicare patients, it is the same as the effective date of the hospice benefit election (or re-election), which may be the first day of hospice care or a later date, but may be no earlier than the date of the election statement.

Bowel Regimen: If a patient does not have regular bowel movements or has constipation, a bowel regimen may be used to induce and control bowel movements. A bowel regimen may include such components as a diet, laxatives, stool softeners, and Milk of Magnesia. A bowel regimen is specific for the patient.

Care Process Item: Care process items appear in Sections F, J, and N of the HIS-Admission. In general, HIS care process items direct providers to abstract data from the hospice clinical record, capturing information about care processes that took place during the initial or comprehensive assessment periods. Specifically, HIS care process items capture data about (1) whether or not a care process took place; (2) when the care process took place; and (3) in some instances, what the results of that care process were.

Comfort Kit (or pre-printed admission order): A set of medications or treatments reviewed and approved by medical staff and consistent with nationally recognized and evidence-based standards, routinely ordered for all patients upon admission to the hospice (also known as, comfort kits, comfort packs, emergency kits, E kits).

Completion Date: The date all required information has been collected and recorded and staff have signed and dated that the record is complete. This date should represent the date the completion of the item set record has been verified by the individual authorized to do so. This individual signs and dates Item Z0500.

Conditions of Participation: The Centers for Medicare & Medicaid Services (CMS) develops Conditions of Participation (CoPs) that health care organizations must meet in order to begin and continue participating in the Medicare and Medicaid programs. These health and safety standards are the foundation for improving quality and

protecting the health and safety of beneficiaries. Hospice Conditions of Participation can be found on the cms.gov website.

Discharge Date: The date a patient leaves the hospice. If the patient has expired, it is the date of death. For live discharges, it is the date the patient revoked the hospice benefit or the date the hospice discharged the patient for one of the following reasons:

- Determined to be no longer terminally ill
- Moved out of the hospice service area
- Transferred to another hospice
- For cause

Inactivation Request: Used when a record has been accepted into the Quality Improvement and Evaluation System (QIES) Assessment and Submission Processing (ASAP) system but the corresponding event did not occur and when one or more of the event identifiers and/or patient identifiers is found to be in error.

Manual Deletion Request: Used when a HIS record has been previously submitted and accepted in the QIES ASAP system but the record was submitted for the wrong facility. This request will permanently delete all traces of a record from the QIES ASAP database.

Modification Request: Used when a HIS record has been previously submitted and accepted in the QIES ASAP system, but the information in the record contains clinical or non-key demographic errors.

PRN Order: An order prescribed on a patient-by-patient basis for medication or treatment that is to be used on an “as needed” basis for specific signs and symptoms a patient is having or may have based on patient-specific conditions or assessment findings.

Scheduled Order: An order prescribed on a patient-by-patient basis for medication or treatment that is to be used on a scheduled basis because of patient-specific conditions or assessment findings. Includes orders to start and to continue scheduled administration or treatment use.

Submission Date: The date on which the completed record is submitted to the QIES ASAP system.

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APPENDIX B: CMS HOSPICE QUALITY REPORTING PROGRAM RESOURCES

Websites:

The following links provide more information about the Hospice Quality Reporting Program (HQRP), and the Hospice Item Set (HIS). The Centers for Medicare & Medicaid Services (CMS) HQRP website is the official source of information about HQRP requirements. Providers should bookmark this website and visit it on a regular basis to make sure they have the most current information pertinent to the HQRP.

1. CMS HQRP Main Page: <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/>.
 - This website contains additional information about data collection and submission, HIS Quality Measures, and HIS technical requirements.
2. QIES Technical Support Office (QTSO): Vendors and software developers should familiarize themselves with this website and review it regularly for important technical information and updates: <https://www.qtso.com/>.
 - The HIS Submission User Guide provides more detailed information about the QIES Assessment Submission and Processing (ASAP) system and is available at <https://www.qtso.com/hospicetrain.html>.
 - Vendors should register at <https://www.qtso.com/vendor.html> to receive important announcements.
3. National Quality Forum (NQF): To read more about the six NQF-endorsed measures and the one modified NQF-endorsed measure, visit the NQF website: <http://www.qualityforum.org/Home.aspx>.

Help Desks:

1. Quality Help Desk: For assistance with questions related to reporting requirements, quality measures, and reporting deadlines.
 - E-mail: HospiceQualityQuestions@cms.hhs.gov
2. General QTSO Help Desk: For assistance regarding technical questions.
 - Phone: 1-877-201-4721
 - E-mail: help@qtso.com

Listservs:

1. Open Door Forum (ODF) listserv: CMS regularly holds Open Door Forums in which it makes announcements pertinent to various programs/care settings. Open Door Forums are also an opportunity for live dialogue between CMS and the provider community. The specific Open Door Forum pertinent to the HQRP is the "Home Health, Hospice, and Durable Medical Equipment Open Door Forum." Use the link to sign up:
https://public.govdelivery.com/accounts/USCMS/subscriber/new?topic_id=USCMS_502
2. MLN Connects® Provider eNews Listserv: CMS sends out a weekly e-Newsletter, which contains information pertinent to various Medicare programs and care settings. Use the link to sign up: <http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive.html>

APPENDIX C: QUALITY MEASURE LOGICAL SPECIFICATIONS

The Centers for Medicare & Medicaid Services (CMS) implemented the Hospice Item Set (HIS) as part of the Hospice Quality Reporting Program in the fiscal year (FY) 2014 Hospice Wage Index final rule (78 FR 48234-48281). The HIS is a standardized set of items intended to capture patient-level data on each hospice patient admission. Current HIS items can be used to calculate six National Quality Forum (NQF)-endorsed measures and a modification of one NQF-endorsed measure. This appendix provides basic information on how HIS items can be used to calculate these measures. For more information on the quality measures, please refer to the NQF website: <http://www.qualityforum.org/Home.aspx>.

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Treatment Preferences (NQF #1641)¹

MEASURE DESCRIPTION	MEASURE SPECIFICATIONS
<p>The percentage of hospice patients with chart documentation of preferences for life sustaining treatments.</p>	<p>Numerator Patients are included in the numerator if they meet the following criteria during the numerator time window:</p> <ol style="list-style-type: none"> 1. The patient/responsible party was asked about preference regarding the use of cardiopulmonary resuscitation (CPR) (F2000A = 1 or 2), and/or 2. The patient/responsible party was asked about preferences regarding life-sustaining treatments other than CPR (F2100A = 1 or 2), and/or 3. The patient/responsible party was asked about preference regarding hospitalization (F2200A = 1 or 2). <p>Numerator Time Window Prior to admission or within 5 days of the admission date ([F2000B - A0220 ≤ 5] and/or [F2100B - A0220 ≤ 5] and/or [F2200 - A0220 ≤ 5])</p> <p>Denominator Patients 18 years of age and older enrolled in hospice for 7 or more days.</p> <p>Denominator Exclusions Patients are excluded from the denominator if they are under 18 years of age and/or have a stay of less than 7 days in hospice.</p>

¹ This measure is NQF-endorsed for use in the hospice and/or palliative care setting.

Beliefs/Values Addressed (if desired by the patient) (modified NQF #1647)¹

MEASURE DESCRIPTION	MEASURE SPECIFICATIONS
<p>The percentage of hospice patients with documentation of a discussion of spiritual/existential concerns or documentation that the patient and/or caregiver did not want to discuss.</p>	<p>Numerator Patients are included in the numerator if they meet the following criterion during the numerator time window:</p> <ol style="list-style-type: none"> 1. Patient and/or caregiver was asked about spiritual/existential concerns (F3000A = 1 or 2). <p>Numerator Time Window Prior to admission or within 5 days of the admission date (F3000B - A0220 ≤ 5).</p> <p>Denominator Patients 18 years of age and older enrolled in hospice for 7 or more days.</p> <p>Denominator Exclusions Patients are excluded from the denominator if they are under 18 years of age and/or have a stay of less than 7 days in hospice.</p>

¹ This is a modified version of a NQF-endorsed measure for use in the hospice and/or palliative care setting. The measure is considered modified because the NQF measure specifications indicate that the numerator condition can be met at any time during the patient's hospice episode of care. Instead, we have opted to include the relevant items for this measure on the HIS-Admission even though the NQF measure specifications permit the numerator condition to be met at any time during the hospice episode of care.

Pain Screening (NQF #1634)¹

MEASURE DESCRIPTION	MEASURE SPECIFICATIONS
<p>The percentage of hospice patients who were screened for pain during the initial nursing assessment.</p>	<p>Numerator Patients are included in the numerator if they meet the following criteria during the numerator time window:</p> <ol style="list-style-type: none"> 1. Patient was screened for pain (J0900A = 1), and 2. Patient reported that they had no pain (J0900C = 0) <p style="text-align: center;">OR</p> <ol style="list-style-type: none"> 3. Patient was screened for pain (J0900A = 1), and 4. Patient’s pain severity was rated mild, moderate, or severe (J0900C = 1, 2, or 3), and 5. A standardized pain tool was used (J0900D = 1, 2, 3, or 4). <p>Numerator Time Window Within 2 days of the admission date (J0900B - A0220 ≤ 2).</p> <p>Denominator Patients 18 years of age and older enrolled in hospice for 7 or more days.</p> <p>Denominator Exclusions Patients are excluded from the denominator if they are under 18 years of age and/or have a stay of less than 7 days in hospice.</p>

¹ This measure is NQF-endorsed for use in the hospice and/or palliative care setting.

Pain Assessment (NQF #1637)¹

MEASURE DESCRIPTION	MEASURE SPECIFICATIONS
<p>The percentage of hospice patients who screened positive for pain and who received a comprehensive assessment of pain within 1 day of screening.²</p>	<p>Numerator Patients are included in the numerator if they meet the following criteria during the numerator time window:</p> <ol style="list-style-type: none"> 1. A comprehensive pain assessment was completed (J0910 = 1), and 2. The comprehensive pain assessment included <i>at least five of the following characteristics</i>: location, severity, character, duration, frequency, what relieves or worsens the pain, and the effect on function or quality of life (five or more of J0910C boxes checked). <p>Numerator Time Window Within 1 day of the initial nursing assessment during which the patient screened positive for pain (J0910B - J0900B ≤ 1 day).</p> <p>Denominator Patients 18 years of age and older enrolled in hospice for 7 or more days and screened positive for pain during the initial nursing assessment (J0900C = 1, 2, or 3).</p> <p>Denominator Exclusions Patients are excluded from the denominator if they are under 18 years of age, have a stay of less than 7 days in hospice, and/or report that they have no pain during the initial nursing assessment (J0900C = 0).</p>

¹ This measure is NQF-endorsed for use in the hospice and/or palliative care setting.

² The pain screening took place during the initial nursing assessment.

Dyspnea Screening (NQF #1639)¹

MEASURE DESCRIPTION	MEASURE SPECIFICATIONS
<p>The percentage of hospice patients who were screened for dyspnea during the initial nursing assessment.</p>	<p>Numerator Patients are included in the numerator if they meet the following criterion during the numerator time window:</p> <ol style="list-style-type: none"> 1. Patient was screened for shortness of breath (J2030A = 1). <p>Numerator Time Window Within 2 days of the admission date (J2030B - A0220 ≤ 2).</p> <p>Denominator Patients 18 years of age and older enrolled in hospice for 7 or more days.</p> <p>Denominator Exclusions Patients are excluded from the denominator if they are under 18 years of age and/or have a stay of less than 7 days in hospice.</p>

¹ This measure is NQF-endorsed for use in the hospice and/or palliative care setting.

Dyspnea Treatment (NQF #1638)¹

MEASURE DESCRIPTION	MEASURE SPECIFICATIONS
<p>The percentage of hospice patients who screened positive for dyspnea who received treatment within 1 day of the screening.²</p>	<p>Numerator Patients are included in the numerator if they meet the following criteria during the numerator time window:</p> <ol style="list-style-type: none"> 1. Treatment for shortness of breath was initiated (J2040A = 2), or 2. The patient declined treatment (J2040A = 1). <p>Numerator Time Window Within 1 day of the initial nursing assessment during which the patient screened positive for shortness of breath (J2040B - J2030B ≤ 1).</p> <p>Denominator Patients 18 years of age and older enrolled in hospice for 7 or more days and screened positive for shortness of breath during the initial nursing assessment (J2030C = 1).</p> <p>Denominator Exclusions Patients are excluded from the denominator if they are under 18 years of age, have a stay of less than 7 days in hospice, and/or screen negative for shortness of breath during the initial nursing assessment (J2030C = 0).</p>

¹ This measure is NQF-endorsed for use in the hospice and/or palliative care setting.

² The dyspnea screening took place during the initial nursing assessment.

Patients Treated with an Opioid Who Are Given a Bowel Regimen (NQF #1617)¹

MEASURE DESCRIPTION	MEASURE SPECIFICATIONS
<p>The percentage of vulnerable adults treated with an opioid that are offered/ prescribed a bowel regimen or documentation of why this was not needed.</p>	<p>Numerator Patients are included in the numerator if they meet the following criteria during the numerator time window:</p> <ol style="list-style-type: none"> 1. A bowel regimen was initiated or continued (N0520A = 2), or 2. There is documentation of why a bowel regimen was not initiated or continued (N0520A = 1). <p>Numerator Time Window Within 1 day of the patient being prescribed a scheduled opioid (N0520B - N0500B ≤ 1).</p> <p>Denominator Patients 18 years of age and older who are given a prescription for a scheduled opioid (N0500A = 1).</p> <p>Denominator Exclusions Patients under 18 years of age.</p>

¹ This measure is NQF-endorsed for use in the hospice and/or palliative care setting.

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APPENDIX D: HOSPICE ITEM SET—ADMISSION

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Section A**Administrative Information****A0050. Type of Record**

Enter Code

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

A0100. Facility Provider Numbers. Enter code in boxes provided.**A. National Provider Identifier (NPI):**

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B. CMS Certification Number (CCN):

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

A0205. Site of Service at Admission

Enter Code

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

A0220. Admission Date

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Month

--	--

Day

--	--	--	--

Year

A0245. Date Initial Nursing Assessment Initiated

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Month

--	--

Day

--	--	--	--

Year

A0250. Reason for Record

Enter Code

01. Admission
09. Discharge

Section A**Administrative Information****A1802. Admitted From. Immediately preceding this admission, where was the patient?**

Enter Code

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

Section F**Preferences****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

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

F2200. Hospitalization Preference

Enter Code

A. Was the patient/responsible party asked about preference regarding hospitalization? - Select the most accurate response

0. No → Skip to F3000, Spiritual/Existential Concerns

1. Yes, and discussion occurred

2. Yes, but the patient/responsible party refused to discuss

B. Date the patient/responsible party was first asked about preference regarding hospitalization:

Month

Day

Year

F3000. Spiritual/Existential Concerns

Enter Code

A. Was the patient and/or caregiver asked about spiritual/existential concerns? - Select the most accurate response

0. No → Skip to I0010, Principal Diagnosis

1. Yes, and discussion occurred

2. Yes, but the patient and/or caregiver refused to discuss

B. Date the patient and/or caregiver was first asked about spiritual/existential concerns:

Month

Day

Year

Section I**Active Diagnoses****I0010. Principal Diagnosis**

Enter Code

- 01. Cancer
- 02. Dementia/Alzheimer's
- 99. None of the above

Section J

Health Conditions

Pain

J0900. Pain Screening

Enter Code

A. Was the patient screened for pain?

- 0. No → Skip to J2030, Screening for Shortness of Breath
- 1. Yes

B. Date of first screening for pain:

Month

Day

Year

Enter Code

C. The patient's pain severity was:

- 0. None → Skip to J2030, Screening for Shortness of Breath
- 1. Mild
- 2. Moderate
- 3. Severe
- 9. Pain not rated

Enter Code

D. Type of standardized pain tool used:

- 1. Numeric
- 2. Verbal descriptor
- 3. Patient visual
- 4. Staff observation
- 9. No standardized tool used

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**Health Conditions****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

Section N**Medications****N0500. Scheduled Opioid**

Enter Code

A. Was a scheduled opioid initiated or continued?

0. No → Skip to N0510, PRN Opioid
1. Yes

B. Date scheduled opioid initiated or continued:

Month

Day

Year

N0510. PRN Opioid

Enter Code

A. Was a PRN opioid initiated or continued?

0. No → Skip to N0520, Bowel Regimen
1. Yes

B. Date PRN opioid initiated or continued:

Month

Day

Year

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

Section Z**Record Administration****Z0400. Signature(s) of Person(s) Completing the Record**

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

Signature	Title	Sections	Date Section Completed
A.			
B.			
C.			
D.			
E.			
F.			
G.			
H.			
I.			
J.			
K.			
L.			

Z0500. Signature of Person Verifying Record Completion**A. Signature:**

B. Date:

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Month

--	--

Day

--	--	--	--

Year

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APPENDIX D: HOSPICE ITEM SET—DISCHARGE

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Section A**Administrative Information****A0600. Social Security and Medicare Numbers****A. Social Security Number:**

<input type="text"/>	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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B. Medicare number (or comparable railroad insurance number):

<input type="text"/>														
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A0700. Medicaid Number - Enter "+" if pending, "N" if not a Medicaid Recipient

<input type="text"/>																			
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A0800. Gender

Enter Code

<input type="text"/>

1. Male
2. Female

A0900. Birth Date

<input type="text"/>									
Month		Day		Year					

A2115. Reason for Discharge

Enter Code

<input type="text"/>	<input type="text"/>
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01. Expired
02. Revoked
03. No longer terminally ill
04. Moved out of hospice service area
05. Transferred to another hospice
06. Discharged for cause

Section Z**Record Administration****Z0400. Signature(s) of Person(s) Completing the Record**

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

Signature	Title	Sections	Date Section Completed
A.			
B.			
C.			
D.			
E.			
F.			
G.			
H.			
I.			
J.			
K.			
L.			

Z0500. Signature of Person Verifying Record Completion**A. Signature:**

B. Date:

--	--

Month

--	--

Day

--	--	--	--

Year

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