

# Hospice Item Set (HIS)

July 2023



#### What is the Hospice Item Set (HIS)?

- HIS is a set of data elements that can be used to calculate 7 quality measures.
   A pay-for-reporting requirement, which effects the rate of reimbursement we receive from Medicare.
- HIS is required by law as part of the Affordable Care Act for all Medicarecertified Hospice agencies and for All Hospice Admissions.
- It measures a hospice agency's adherence to best practice processes.
- A source of information for regulatory bodies scrutinizing hospices to fine and prevent Medicare fraud and abuse.
- Hospices have been using HIS for all patients since July 1, 2014.



#### What is the Hospice Item Set (HIS)?

- Two HIS records for each patient must be submitted, one for admission and one for discharge.
- The HIS are reviewed, processed and submitted to CMS, Centers of Medicare & Medicaid Services consistently.
- HIS quality measures as well as CAHPS Hospice Survey results are publicly reported. This influences Hospice star ratings as compared with other hospice providers.
- Star ratings have a direct correlation with the reimbursement percentage rate to hospices from CMS.
- Start ratings and survey results for Hospice agencies are listed on the CMS Hospice Compare website.

## Hospice Item Set (HIS)

HIS Measures	Explanation	
Treatment Preferences	CPR Preference Other Life-sustaining Treatment Preferences Hospitalization Preference	
Belief Value	Spiritual/Existential Concerns	
Pain Screening	Was the patient screened for pain? The patient's pain severity  Type of standardized pain tool used	
Pain Assessment	Was a comprehensive pain assessment done? Comprehensive pain assessment includes at least 5 of 7 pain assessment elements (location, severity, character, duration, frequency, what relieves/worsens pain, effect on function or quality of life)	
Dyspnea Screen	Was the patient screened for shortness of breath?	
Dyspnea Treatment	Was the treatment for shortness of breath initiated?  Types of treatment (just check at least one treatment – opioids, other medication, oxygen or non-medication)	
Opioid Bowel Regimen	Was a scheduled opioid initiated or continued?  If answer to above no, then was a PRN opioid initiated or continued? Was a bowel regimen initiated or continued?	



# Hospice Item Set (HIS) Pain Assessment Requirements

One of the 7 HIS measures is "Pain Assessment."

The pain assessment must include at least 5 of the 7 pain assessment elements. The 7 pain

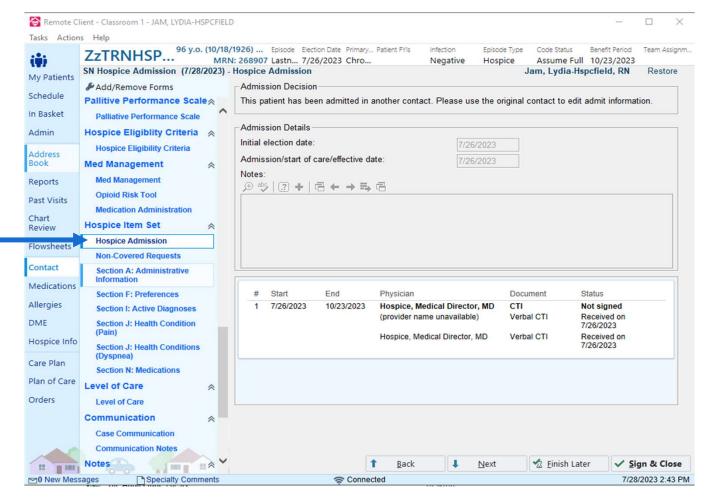
assessment elements are:

- 1. Location
- 2. Severity
- 3. Character
- 4. Duration
- 5. Frequency
- 6. What relieves/worsens pain
- 7. Effect on function or quality of life

The following slides shows you the fields in the electronic medical record where you **must** enter the pain assessment in the SOC visit in order to meet the HIS measures required by CMS.



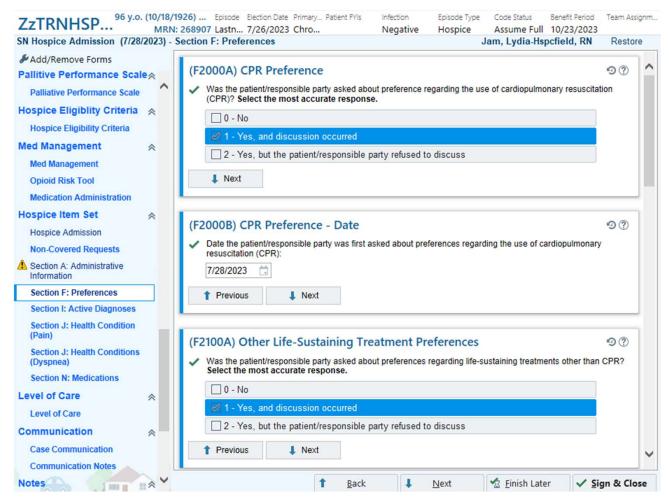
### Complete the HIS within the Admission Visit







#### HIS Section F: Preferences



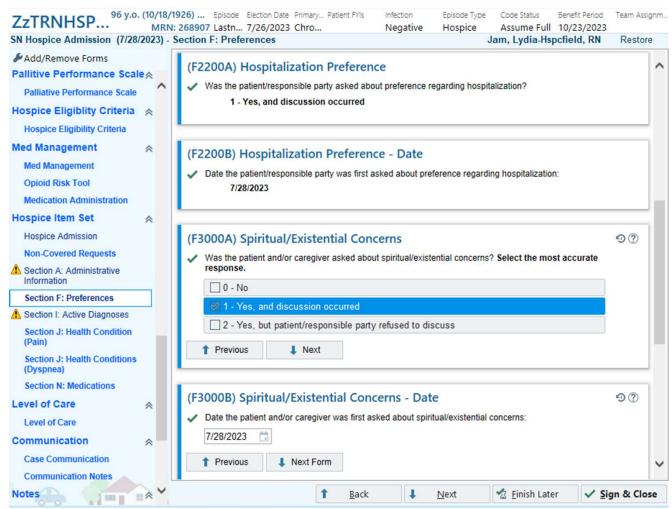
CHO These questions should be part of admission assessment and are a Medicare Requirement. Date should not be prior to the admission date.

Answer yes if reviewed with patient, if they are asked and state the no to wanting you will still answer yes as this discussion did occur.

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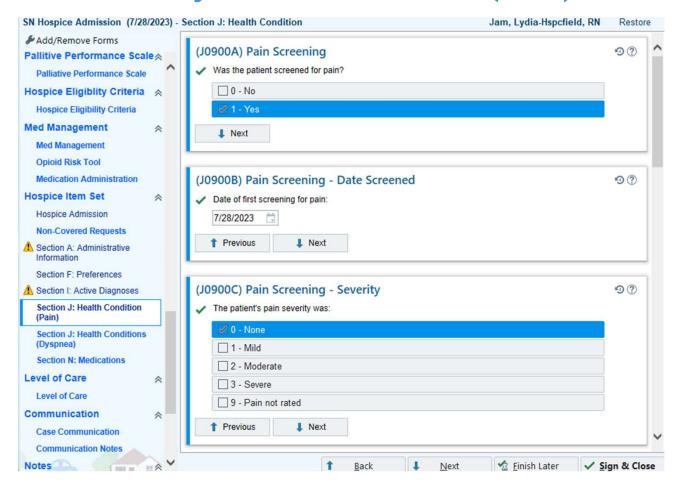


#### HIS Section F: Preferences





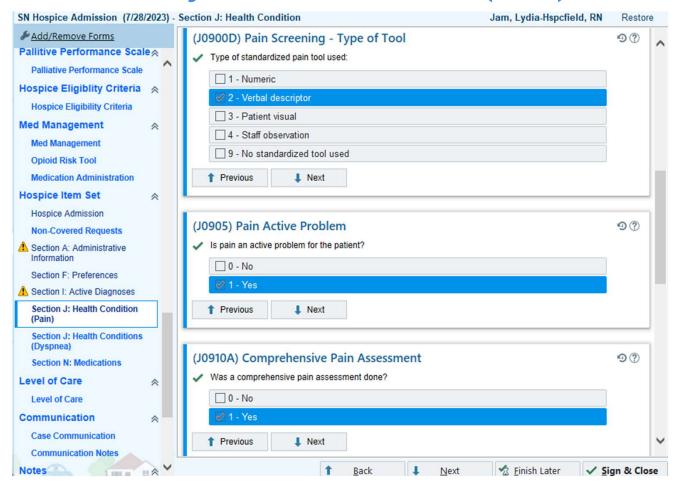
#### HIS Section J: Health Condition (Pain)







#### HIS Section J: Health Condition (Pain)



**CHO** Pain screening is a regulatory requirement and must be completed.

Please note this is not the pain assessment but a reporting tool.

The answers here must match and be supported by your documentation under the pain assessment section of the head-to-toe assessment.

If patient has no pain, an assessment is still required.

Answer yes completed, and no to presence of pain, followed by the type of tool.

Please DO NOT select option 9-No standardized tool.

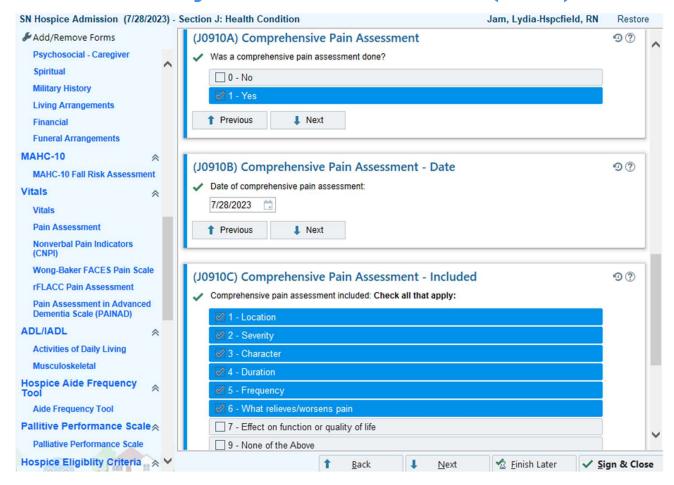
If asked patient: select verbal, if asking "on a scale of 1-10..." select numeric. Staff observation is used for non-verbal patients and when used CNPI, FLACC, or PAINAD pain scales under pain assessment section of the Head-to-toe assessment. Patient visual is when patient uses the Faces scale or similar - it is their visual of a pain scale and not the assessing clinician viewing the patient (that would be staff observation).

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#### HIS Section J: Health Condition (Pain)



CHO Comprehensive pain assessment is required if: patient has pain, or if no pain at moment and is an active problem.

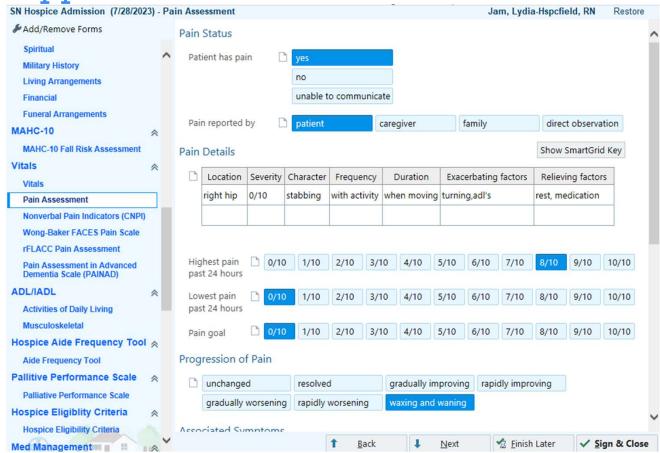
This is where the characteristics and pain attributes from the pain assessment are listed and at least 5 of 7 are required in order to be considered a "COMPLETE" pain assessment under CMS guidelines for Public reporting as discussed in earlier slides.

If you have less or answer 9 - None of the above it is considered the same as not doing a pain assessment and reflects negatively on the hospice agency in public reporting.

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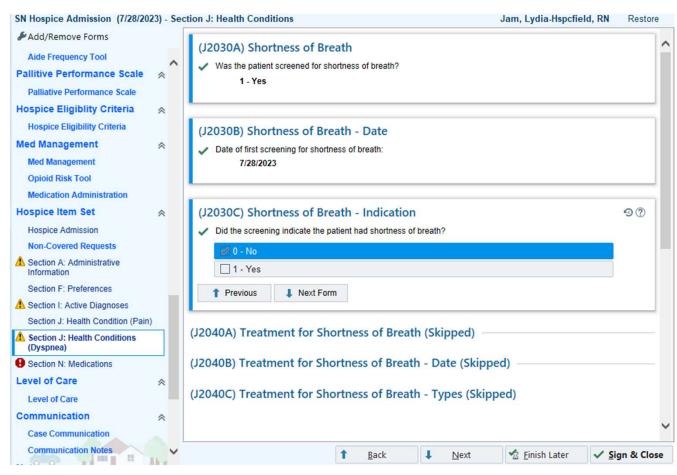
Pain Assessment in Vitals section supports the HIS Pain answers







#### HIS Section J: Health Condition (Dyspnea)



**CHO** Dyspnea Screening is another HIS/Medicare regulatory requirement.

Answer yes to screening as this is part of assessing the patient with the Head to toe assessment.

If Pt has No Shortness of Breath/Dyspnea, then you answer yes screened and no to patient having.

As a reminder this is the date you are assessing (you may enter "T" for today and enter in the date field for "today's date."

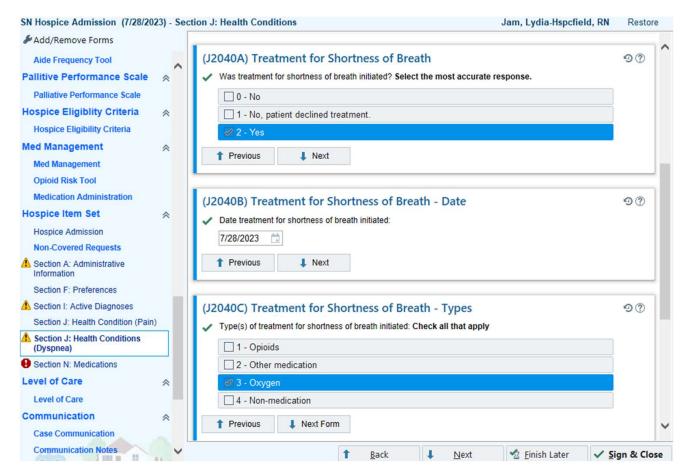
If no to dyspnea, a skip pattern will display as shown here, as these questions only need to be answered in the presence of dyspnea.

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#### HIS Section J: Health Condition (Dyspnea)



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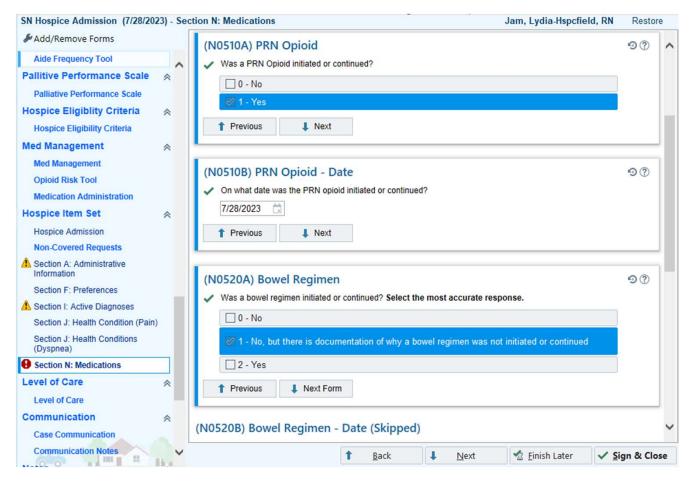
When you answer Yes, patient has Shortness of breath, then these questions appear. Please be sure date treatment initiated is date of assessment even if prior to admission as the system does not recognize this date. This is due to patient being new admission and care began at time you are admitting the patient.

In this slide you will see the various treatment options available, you may select one or all as applicable. Clarke, Heather, 2023-07-28T19:34:35.344





#### **HIS Section N: Medications**



**CHO** Please note here that this is what patient is currently taking.

If patient is going to be starting on an opioid but is not currently taking then you would answer NO.

Comfort kits are often ordered at admission, teaching is done at subsequent visit but does not always indicate a patient will use upon arrival. Therefore this should be answered NO as in currently taking, rather than what is anticipated in the future.

If patient is on an Opioid they must be on a bowel regiment, even if prn is ordered.

If the answer is 0 or 1, No- then it should be in the narrative note that the Physician was notified and the reasoning patient is not on to support answer 1. (0-would be negatively reflected in public reporting and you could be asked to clarify later on the why as constipation is side-effect of opioids and why this question is in place as a quality measure.

Clarke, Heather, 2023-07-28T19:43:42.021



## Summary of Hospice Item Set (HIS)

HIS Measures Answer to Meet HIS Measure

III Micasures	Allswei to Meet III3 Measure	
1. Treatment Preferences		
CPR Preference	Yes, patient was asked about CPR preference	
Other Life-Sustaining Treatment Preferences	Yes, patient was asked about life-sustaining treatment preference	
Hospitalization Preference	Yes, patient was asked about hospitalization preference	
. Belief Value		
Spiritual/Existential Concerns	Yes, the patient was asked about spiritual/existential concerns	
. Pain Screening		
Was the patient screened for pain?	Yes	
The patient's pain severity	None, Mild, Moderate or Severe	
Type of standardized pain tool used	Numeric, Verbal, Visual, or Staff observation	
. Pain Assessment		
Was a comprehensive pain assessment done?	Yes	
Comprehensive assessment included (must have at least 5 of 7	•	
pain assessment elements)	Location	
•	Severity	
	Character	
	Duration	
	Frequency	
	What relieves/worsens pain	
	Effect on function or quality of life	
. Dyspnea Screen	The second secon	
Was the patient screened for shortness of breath?	Yes	
. Dyspnea Treatment		
Was treatment for shortness of breath initiated?	Imitated or declined	
Types of treatment (must check at least one treatment)	Opioids	
,	Other medication	
	Oxygen	
	Non-medication	
. Opioid Bowel Regimen		
Was a scheduled opioid initiated or continued?	Yes or no	
If answer to above no, then was a PRN opioid initiated or continued?	Yes or no	
Was a bowel regimen initiated or continued?	If yes to either of above questions, then the answer should be yes or no, but there is documentation of why a bowel regimen was not initiated or continued	

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## Thank You

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