Hospice
Quality Reporting Program
PROVIDER TRAINING

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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Hospice Item Set (HIS)

Section F, Section J, Section N and Section O

HOSPICE
QUALITY REPORTING PROGRAM

SECTION F: PREFERENCES

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.

RATIONALE

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.

- 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.

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.

- 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.

Items in this section are intended to capture the *process* of eliciting patient preferences; they are intended to *capture evidence of discussion and/or communication about patient 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

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, 2017 would be entered as 11-01-2017.
- 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 08-01-2017. Clinical note dated 08-01-2017 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 08-05-2017 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 "08-01-2017."
- **Explanation:** Although the patient later stated a preference regarding DNR on 08-05-2017, 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 "08-01-2017" 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 08-01-2017. Clinical record for the patient includes a DNR order, signed in the prior care setting, which is dated 07-15-2017.

- **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, 2017 would be entered as 11-01-2017.
- 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

<u>Situation A - Patient's clinical record contains the following information:</u>

Patient admitted on 08-01-2017. Clinical note dated 08-01-2017 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)

- **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 "08-01-2017."
- **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.

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

Patient admitted 08-01-2017. Clinical record for the patient includes an order from the prior care setting, "no life-sustaining treatments desired," which is dated 07-15-2017.

- **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 ☐

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

Item-Specific Instructions

Review the clinical record for information regarding patient preference for hospitalization. This is not referring to the patient's choice of a particular facility, but rather if the patient/caregiver has a preference regarding hospitalization as a care option to consider. Examples of discussions with the patient or family that could be considered for this item include, but are not limited to:

1.) The patient and/or caregiver expressed the desire to keep the patient at home and not to be transferred/admitted to a hospital again
2.) The patient and/or caregiver discussed specific situations in which they feel hospitalization would be the preferred location for their care
3.) The patient or caregiver state that, at this time, they are unsure if being transferred/admitted to a hospital for care is something they would consider.

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 a contracted acute care settings or hospital-based inpatient hospice units.

Item-Specific Instructions (continued)

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, 2017 would be entered as 11-01-2017.
- 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 08-01-2017. Clinical note dated 08-01-2017 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 "08-01-2017."

- **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 08-01-2017. 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 07-15-2017.

- **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 ☐

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

Item-Specific Instructions

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.

F3000A: Was the patient and/or caregiver asked about spiritual/existential concerns?

- **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.
  - 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).
  - 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, 2017 would be entered as 11-01-2017.
- 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.

While these conversations are best held face-to-face, phone conversations with patients/families about spiritual/existential issues can be used to answer yes to F3000 as long as the clinical documentation supports that a discussion was had with the patient and/or caregiver.

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 08-01-2017 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 "08-01-2017."

- **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 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 ☐

A. Was the patient screened for pain?

0. **No** → Skip to J0905, Pain Active Problem
1. **Yes**

B. Date of first screening for pain:

☐☐ Month ☐☐ Day ☐☐☐☐ Year

Enter Code ☐

C. The patient's pain severity was:

0. **None**
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**

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 J0905, Pain Active Problem.
- **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, 2017 would be entered as 11-01-2017.
- 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.
- **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 select response 9, No standardized tool used for J0900D.

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 08-12-2017 shows, "patient very drowsy; appears to be comfortable during visit. No nonverbal signs of pain observed during the visit."

Situation B: Clinical note dated 08-12-2017 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 "08-12-2017."
  J0900C: The patient's pain severity was: Select response "0, None"
  J0900D: Type of Standardized pain tool used: Select response "9, No standardized tool used".
  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-D.

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

Clinical note dated 08-12-2017 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 "08-12-2017."

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 08-12-2017 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 "08-12-2017."
  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*.

J0905. Pain Active Problem

Enter Code	
☐	**Is pain an active problem for the patient?** 0. **No** → Skip to J2030, Screening for Shortness of Breath 1. **Yes**

Item-Specific Instructions

J0905. Pain Active Problem

- **Response 0, No:** Select response 0 if pain is not an active problem for the patient.
- **Response 1, Yes:** Select response 1 if pain is an active problem for the patient.

Item-Specific Tips

- The determination of whether or not pain is an active problem may be made by the assessing clinician, based on patient-specific findings. In determining whether pain is an active problem for the patient, clinicians may need to consider factors beyond pain severity at the time of the clinical encounter, such as historical report of pain, reports of recent symptoms, current treatment for pain (pharmacologic and/or non-pharmacologic), etc. **It is possible that the clinician may determine pain is an active problem for the patient, even if pain is not present during the clinical encounter.**
- Generally, clinical documentation that the patient is currently taking pain medication is evidence that pain is an active problem for the patient.
- Comfort kits or pre-printed admission orders alone is insufficient evidence to determine pain is an active problem. For comfort kits and pre-printed admission orders, treatment is not considered initiated until the hospice has received the order *and* there is documentation that the patient/caregiver was instructed to begin use of the medication or treatment; thus, proactive education on medications in a comfort kit in anticipation of symptoms alone is insufficient evidence to determine pain is an active problem.

Examples

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

Clinical documentation dated 08-14-2017 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 "08-14-2017."
  J0900C: The patient's pain severity was: Select response "0, None"
  J0900D: Type of standardized pain tool used: Select response "1, Numeric".
  J0905: Pain Active Problem Select response "1, Yes".

- **Explanation:** Item J0900. Pain Screening should be completed based on the patient's pain status *at the time of the screening clinical encounter.*
  - This means that although the patient reported a history of pain, because the patient rated his pain as a 0/10 throughout the pain screening visit, item J0900 should be completed based on the patient's report that he was not in any pain *at the time of the visit*. Thus, J0900C would be completed as "0, None" indicating the patient had no pain at the time of the visit.

  Item J0905. Pain Active Problem considers factors *beyond pain severity at the time of the screening clinical encounter*, such as historical report of pain or report of recent symptoms.
  - In this situation, because the patient has a history of pain, it is clinically appropriate for the clinician to consider pain to be an active problem for the patient, and select "1, Yes" for Item J0905. Pain Active Problem.
  - Since pain is an active problem for the patient, it is also clinically appropriate for the clinician to complete a comprehensive pain assessment, assessing other aspects of the patient's pain (historical severity rating, location, character, what makes pain better/worse); these assessment characteristics would be documented in the HIS-Admission record for Item J0910. Comprehensive Pain Assessment.

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

Clinical documentation dated 08-14-2017 shows that the patient is not allowing necessary dressing changes or incontinence/skin care because he/she cannot tolerate the pain that each intervention causes. Documentation also shows that the patient reports no other pain except that caused by dressing and/or incontinence/skin care interventions.

- **HIS Response Selection:**

  J0905: Pain Active Problem Select response "1, Yes".

- **Explanation:** Although the patient reports no pain other than pain caused during dressing changes and/or incontinence/skin care, it is evident that pain is interfering with clinical care and potentially affecting the patient's quality of life. Thus, in this situation, pain is considered an active problem.

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

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.*

Item-Specific Tips (continued)

- An assessment that included pain *severity* for a nonverbal patient may include documentation about *intensity* of nonverbal expressions of pain (grimaces, winces, 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 08-12-2017 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 "08-12-2017."

  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 08-12-2017 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 "08-12-2017."

  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 ☐

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**

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, 2017 would be entered as 11-01-2017.

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. Evidence of shortness of breath being an active problem for the patient could include (but is not limited to) clinical record documentation noting any of the following: 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.

On the basis of reports of recent symptoms, current treatment, and patient/family history, 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. However, there may be situations where an order for Oxygen PRN exists, but the assessing clinician does not determine shortness of breath to be an active problem for the patient at the time of the screening. In this situation, the skip pattern is maintained for J2030C to skip J2040, and the oxygen would not be reported as a treatment for J2040.

Examples

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

Clinical note dated 08-12-2017 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 08-12-2017 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 "08-12-2017."
  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 08-12-2017 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 08-12-2017 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 "08-12-2017."
  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 08-15-2017 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 "08-15-2017."
  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 ☐

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

Item-Specific Instructions

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.

J2040A: Was treatment for shortness of breath initiated?

- **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.

J2040B: Date treatment for shortness of breath initiated

- **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, 2017 would be entered as 11-01-2017.

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 was initiated for shortness of breath. Common examples include bronchodilators, inhaled corticosteroids, oral steroids, diuretics and benzodiazepines. Orders for "other medications" that have multiple uses (e.g., oral steroids, diuretics, benzodiazepines) 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 08-12-2017 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 08-12-2017 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 "08-12-2017."
  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."

Examples (continued)

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

Clinical documentation dated 09-15-2017 shows, "dyspnea/shortness of breath at rest. Instructed family to keep patient's head elevated on pillows while patient is in bed." Order dated 09-16-2017 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 "09-15-14."
  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 (09-15-2017, 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 09-15-2017 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.
- **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.

Examples (continued)

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

Clinical documentation dated 09-15-2017 shows, "comfort kit in patient's home and on stand-by." Documentation states, "patient and family were educated on what medications were in the comfort kit, what symptoms the medications might be used for (including shortness of breath), and where to store the kit 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 kit 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 ☐

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

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.

N0500A: Was a scheduled opioid initiated or continued?

- **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.

N0500B: Date scheduled opioid initiated or continued

- **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, 2017 would be entered as 11-01-2017.

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 ☐

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

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.

N0510A: Was a PRN opioid initiated or continued?

- **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.

N0510B: Date PRN opioid initiated or continued

- **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, 2017 would be entered as 11-01-2017.
- 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.
  - For orders continued from previous care settings, N0510 should be completed based on PRN 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 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, 2017 would be entered as 11-01-2017.
- 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 08-13-2017 shows, "Oxycodone 10 mg PO every 4 hours, PRN for pain." Clinical documentation dated 08-13-2017 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 "08-13-2017."

  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 07-23-2017 shows, "Morphine 4 mg per hour IV continuous with 2 mg IV PCA every 15 minutes PRN breakthrough pain." Clinical documentation dated 07-23-2017 shows, "Last bowel movement 5 days ago. Patient complaining of abdominal discomfort." Order dated 07-24-2017 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 "07-23-2017."

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

  N0510B: Date PRN opioid initiated or continued: Enter "07-23-2017."

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

  N0520B: Date bowel regimen initiated or continued: Enter "07-24-2017."

- **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 08-13-2017 shows, "Last bowel movement 5 days ago. Patient complaining of abdominal discomfort." Order dated 08-13-2017 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 07-23-2017 shows, "comfort kit in patient's home and on stand-by. Instructed patient and family on what medications are in the comfort kit, including pain medication." Order dated 07-23-2017 shows, "Polyethylene glycol 17 g PO with full glass of water once daily." Clinical note dated 07-25-2017 reads, "caregiver called and reported patient was in moderate pain. Instructed caregiver to open comfort kit 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 "07-25-2017."

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

  N0520B: Date bowel regimen initiated or continued: Enter "07-23-2017."

- **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 07-25-2017. For N0520A, select "1, Yes." For N0520B, enter the date of the order for polyethylene glycol.

SECTION O: SERVICE UTILIZATION

Items in this section of the Hospice Item Set pertain to hospice utilization during the last days of life.

SECTION O: RATIONALE

This section contains key information about level of service utilization and the disciplines that provided visits during the last days of a patient's life. The last week of life is typically the period in the terminal illness trajectory with the highest symptom burden, and the literature supports hospice visits when death is imminent as a high priority in end-of-life care. Clinician visits to patients at the end of life have been demonstrated to be associated with improved outcomes such as decreased risk of hospitalization, emergency room visits, and hospital death; and higher satisfaction with care.

SECTION SPECIFIC TIPS

Section O contains 4 items (O5000, O5010, O5020, O5030) that capture information about level of care and the disciplines that provided visits during the final 7 days of a patient's life. **Section O is only completed for patients who are discharged due to death (A2115 = 01, Expired)**. If the reason for discharge was anything other than 01, Expired, do not complete any items in Section O.

Section O includes two types of items: level of care items and visits items.

There are two "level of care" items, which capture information about the level of care (Routine Home Care, Continuous Home Care, Inpatient Care, or Respite Care) received by the patient in the final days of life. The level of care received by the patient is important because a hospice will only complete the "visits" items if the patient received Routine Home Care only. The two level of care items are O5000, Level of care in final 3 days and O5020, Level of care in final 7 days.

- Although the two level of care items cover different timeframes, both items ask about the same levels of care (Continuous Home Care, General Inpatient, and Respite Care).

There are two "visits" items, which capture the number of visits provided to patients in the final days of life. The two visits items are O5010, Number of hospice visits in the final 3 days and O5030, Number of hospice visits in 3 to 6 days prior to death.

- Although the two visits items cover different timeframes, both items ask about the same types of visits from the same disciplines (Registered Nurse, Physician [or Nurse Practitioner or Physician Assistant], Medical Social Worker, Chaplain or Spiritual Counselor, Licensed Practical Nurse, and Aide).

O5000. Level of care in final 3 days
Complete only if A2115, Reason for Discharge = 01 Expired

Enter Code	
☐	**Did the patient receive Continuous Home Care, General Inpatient Care, or Respite Care during any of the final 3 days of life?** 0. **No** 1. **Yes** → Skip to Z0400, Signature(s) of Person(s) Completing the Record

Item-Specific Instructions

Complete only if A2115 Reason for Discharge = 01, Expired.

If the reason for discharge (A2115) is anything other than "01, Expired", skip this item (O5000) and all other items in Section O and go to Z0400, Signature(s) of Person(s) Completing the Record.

For stays ending in death, report whether or not the patient received Continuous Home Care, General Inpatient Care, or Respite Care during any of the final 3 days of life.

- **Response 0, No:** Select response 0 if patient did not receive Continuous Home Care, General Inpatient Care, or Respite Care at any time during the final 3 days of life (i.e., received only Routine Home Care).
- **Response 1, Yes**: Select response 1 if the patient received Continuous Home Care, General Inpatient Care, or Respite Care at any time during the final 3 days of life. Skip to Z0400, Signature(s) of Person(s) Completing the Record.

Item-Specific Tips

- If the patient was on hospice for fewer than 3 days prior to death, select a response based on the days the patient was enrolled in hospice.
- For definitions of the four levels of hospice care, see Section 418.302 of the Medicare Hospice Conditions of Participation (CoPs) http://www.ecfr.gov/cgi-bin/text-idx?rgn=div5;node=42%3A3.0.1.1.5
  - For the purposes of completing Item O5000, hospices may apply the Medicare CoP definitions of the four levels of care to non-Medicare/Medicaid patients.
  - A Routine Home Care patient for whom the hospice receives a Service Intensity Add-on (SIA) payment is considered to be receiving Routine Home Care for the purposes of completing Item O5000.

O5010. Number of hospice visits in final 3 days
Enter the number of visits provided by hospice staff from the indicated discipline, on each of the dates indicated.

	Visits on day of death (A0270)	Visits one day prior to death (A0270 minus 1)	Visits two days prior to death (A0270 minus 2)
A. Registered Nurse	☐	☐	☐
B. Physician (or Nurse Practitioner or Physician Assistant)	☐	☐	☐
C. Medical Social Worker	☐	☐	☐
D. Chaplain or Spiritual Counselor	☐	☐	☐
E. Licensed Practical Nurse	☐	☐	☐
F. Aide	☐	☐	☐

Item-Specific Instructions

Complete only if A2115 Reason for Discharge = 01 Expired

For each row (A-F), enter the number of visits provided by the indicated discipline, on the three days indicated: the day of death, the day prior to death, and two days prior to death.

- The day of death is the same as the date provided in A0270, Discharge Date.
- One day prior to death is calculated as A0270 minus 1.
- Two days prior to death is calculated as A0270 minus 2.

For each cell, use one character, 0 through 9, to indicate the number of visits provided by each discipline on the given day. Do not leave cells blank unless directed to do so by skip patterns.

Item-Specific Instructions (continued)

- If the patient did not receive a visit from a given discipline on a given day, enter 0 in the appropriate cell (e.g., if patient received 0 visits from the RN on the day of death, enter 0 in the cell corresponding to RN visits on the day of death).
- Note that 0's may represent one of two situations:
  - **Not enrolled in hospice:** A zero (0) entered in cells corresponding to days prior to enrollment indicates that the patient was not enrolled in hospice on that date.
  - **No services:** A zero (0) entered in cells corresponding to days on which the patient was enrolled in hospice indicates no services.
- If the patient received more than 9 visits from a given discipline on a given day, enter 9 in the appropriate cell.

Item-Specific Tips

- Individuals whose visits can be counted for the purpose of completing O5010 include hospice staff members in each of the listed disciplines who are either employees, contractors and affiliates, or who provide unpaid services.
- Visits provided to the patient's family may be counted in this item.
- Phone calls are **not** counted as a visit in this item.
- Visits that occur on the day of death but are post-mortem are **not** counted as a visit in this item.

O5020. Level of care in final 7 days
Complete only if A2115, Reason for Discharge = 01 Expired

Enter Code ☐	Did the patient receive Continuous Home Care, General Inpatient Care, or Respite Care during any of the final 7 days of life? 0. **No** 1. **Yes** → Skip to Z0400, Signature(s) of Person(s) Completing the Record

Item-Specific Instructions

Complete only if A2115 Reason for Discharge = 01 Expired

For stays ending in death, report whether or not the patient received Continuous Home Care, General Inpatient Care, or Respite Care during any of the final 7 days of life.

- **Response 0, No:** Select response 0 if patient did not receive Continuous Home Care, General Inpatient Care, or Respite Care at any time during the final 7 days of life (i.e., received only Routine Home Care).
- **Response 1, Yes**: Select response 1 if the patient received Continuous Home Care, General Inpatient Care or Respite Care at any time during the final 7 days of life. Skip to Z0400, Signature(s) of Person(s) Completing the Record.

Item Specific Tips

- If the patient was on hospice for fewer than 7 days prior to death, select a response based on the days the patient was enrolled in hospice.
- As with Item O5000, for definitions of the four levels of hospice care, see Section 418.302 of the Hospice Conditions of Participation http://www.ecfr.gov/cgi-bin/text-idx?rgn=div5;node=42%3A3.0.1.1.5
  - For the purposes of completing Item O5020, hospices may apply the Medicare CoP definitions of the four levels of care to non-Medicare/Medicaid patients.
  - As with Item O5000, a Routine Home Care patient for whom the hospice receives a Service Intensity Add-on (SIA) payment is considered to be receiving Routine Home Care for the purposes of completing Item O5020.

O5030. Number of hospice visits in 3 to 6 days prior to death
Enter the number of visits provided by hospice staff from the indicated discipline, on each of the dates indicated.

	Visits three days prior to death (A0270 minus 3)	Visits four days prior to death (A0270 minus 4)	Visits five days prior to death (A0270 minus 5)	Visits six days prior to death (A0270 minus 6)
A. Registered Nurse	☐	☐	☐	☐
B. Physician (or Nurse Practitioner or Physician Assistant)	☐	☐	☐	☐
C. Medical Social Worker	☐	☐	☐	☐
D. Chaplain or Spiritual Counselor	☐	☐	☐	☐
E. Licensed Practical Nurse	☐	☐	☐	☐
F. Aide	☐	☐	☐	☐

Item-Specific Instructions

Complete only if A2115 Reason for Discharge = 01 Expired

For each row (A-F), enter the number of visits provided by the indicated discipline, on the four days indicated: 3 days prior to death, 4 days prior to death, 5 days prior to death, and 6 days prior to death.

- Three days prior to death is calculated as A0270 (Discharge Date) minus 3.
- Four days prior to death is calculated as A0270 minus 4.
- Five days prior to death is calculated as A0270 minus 5.
- Six days prior to death is calculated as A0270 minus 6.

For each cell, use one character, 0 through 9, to indicate the number of visits provided by each discipline on the given day. Do not leave cells blank unless directed to do so by skip patterns.

- If the patient did not receive a visit from a given discipline on a given day, enter 0 in the appropriate cell (e.g., if patient received 0 (zero) visits from the RN four days prior to death, enter 0 in the cell corresponding to RN visits four days prior to death).
- Note that 0's may represent one of two situations:
  - **Not enrolled in hospice:** A zero (0) entered in cells corresponding to days prior to enrollment indicates that the patient was not enrolled in hospice on that date.
  - **No services:** A zero (0) entered in cells corresponding to days on which the patient was enrolled in hospice indicates no services.
- If the patient received more than 9 visits from a given discipline on a given day, enter 9 in the appropriate cell.

Item-Specific Tips

- Individuals whose visits can be counted for the purpose of completing O5030 include hospice staff members in each of the listed disciplines who are either employees, contractors and affiliates, or who provide unpaid services.
- Visits provided to the patient's family may be counted in this item.
- Phone calls are **not** counted in this item.

Examples

Situation A

Patient's clinical record contains the following information:

Monday, 4/17: Patient is admitted. Patient received two RN visits.

Tuesday, 4/18: Patient received one visit from an aide.

Wednesday, 4/19: No visits received.

Thursday, 4/20: Patient received one RN visit.

Friday, 4/21: Patient received one chaplain visit.

Saturday, 4/22: Patient is discharged due to death (Item A2115 = 01). The chaplain made a visit prior to patient death. The RN made a visit after being notified that the patient had died.

Level(s) of care: Patient received Routine Home Care each day 4/17-4/22.

Depiction of visit schedule based on scenario:

April 2017

Sunday 4/16	**Monday 4/17**	**Tuesday 4/18**	**Wednesday 4/19**	**Thursday 4/20**	**Friday 4/21**	**Saturday 4/22**
Six days prior to death (A0270 minus 6)	Five days prior to death (A0270 minus 5)	Four days prior to death (A0270 minus 4)	Three days prior to death (A0270 minus 3)	Two days prior to death (A0270 minus 2)	One day prior to death (A0270 minus 1)	Day of Death (A0270)
	Patient Admitted (A0220) **[RHC]** 2 RN Visits	**[RHC]** 1 Aide Visit	**[RHC]** No visits	**[RHC]** 1 RN Visit	**[RHC]** 1 Chaplain Visit	**Patient Discharged (A0270) as Expired (A2115 = 01)** **[RHC]** 1 Chaplain Visit 1 RN Visit (post-mortem)

Situation A: Section O Item Completion and Explanations

O5000. Level of care in final 3 days
Complete only if A2115, Reason for Discharge = 01 Expired

Enter Code	
0	Did the patient receive Continuous Home Care, General Inpatient Care, or Respite Care during any of the final 3 days of life? 0. **No** 1. **Yes** → Skip to Z0400, Signature(s) of Person(s) Completing the Record

Select "0, No" for O5000 since the clinical record ndicates the patient received RHC for the entire stay.

O5010. Number of hospice visits in final 3 days
Enter the number of visits provided by hospice staff from the indicated discipline, on each of the dates indicated.

	Visits on day of death (A0270)	Visits one day prior to death (A0270 minus 1)	Visits two days prior to death (A0270 minus 2)
A. Registered Nurse	0	0	1
B. Physician (or Nurse Practitioner or Physician Assistant)	0	0	0
C. Medical Social Worker	0	0	0
D. Chaplain or Spiritual Counselor	1	1	0
E. Licensed Practical Nurse	0	0	0
F. Aide	0	0	0

Item O5010 considers only visits in the final 3 days (4/22, 4/21, 4/20). Although linical record documentation shows visits on other days (e.g., 2 RN visits on 4/17), only visits on the final 3 days are counted in this item.

Row A gathers the number of visits provided by an RN in the final **3 days**. Clinical record documentation shows that an RN visit occurred on two of the final three days (4/20 and 4/22). Enter a "1" to reflect the RN visit received on 4/20 (two days prior to death). The RN visit on 4/22 (the day of death) is not counted in O5010 because it was conducted post-mortem.

Rows B and C gather the number of ospice visits provided by physicians, NPs or PAs and Medical Social Workers in the final 3 days. The patient did not eceive any visits from these disciplines in the final 3 days of life. Therefore, enter "0" in rows B and C for all of the columns.

Row D gathers the number of chaplain or spiritual counselor visits in the final 3 days of life. Clinical record documentation shows that the patient received chaplain visits on 4/22 and 4/21. Although the visit n 4/22 is on the day of death, clinical record documentation clearly indicates the visit occurred before the patient died; thus, enter "1" to reflect the 4/21 visit (one day prior to death). Enter a "1" to reflect the 4/22 visit (day of death). Enter "0" to reflect that no chaplain visits were provided on 4/20 (two days prior to death).

Rows E and F: Enter "0" for all cells in Rows E and F since the patient did not eceive any visits from LPNs or Aides in he final 3 days.

O5020. Level of care in final 7 days
Complete only if A2115, Reason for Discharge = 01 Expired

Enter Code: 0

Did the patient receive Continuous Home Care, General Inpatient Care, or Respite Care during any of the final 7 days of life?

0. **No**
1. **Yes** → Skip to Z0400, Signature(s) of Person(s) Completing the Record

Select "0, No" for O5020 since the clinical record ndicates the patient eceived RHC for the entire stay.

O5030. Number of hospice visits in 3 to 6 days prior to death
Enter the number of visits provided by hospice staff from the indicated discipline, on each of the dates indicated.

	Visits three days prior to death (A0270 minus 3)	**Visits four days prior to death (A0270 minus 4)**	**Visits five days prior to death (A0270 minus 5)**	**Visits six days prior to death (A0270 minus 6)**
A. Registered Nurse	0	0	2	0
B. Physician (or Nurse Practitioner or Physician Assistant)	0	0	0	0
C. Medical Social Worker	0	0	0	0
D. Chaplain or Spiritual Counselor	0	0	0	0
E. Licensed Practical Nurse	0	0	0	0
F. Aide	0	1	0	0

Item O5030 considers visits in the 3 to 6 days prior to death 4/16-4/19).

- Note that on 4/16 (six days prior to death), the patient had not yet been admitted to hospice. Enter 0 in all cells in the column for six days prior to death.
- Visits made three, four, and five days prior to death are reported based on clinical record documentation, which indicates the patient had 2 RN visits on 4/17 (five days prior to death) and 1 aide visit on 4/18 (four days prior to death).
- All cells in the column for three days prior to death contain zeros because the patient received no visits that day from any discipline.

Examples (continued)

Situation B

Patient's clinical record contains the following information:

Thursday, 4/20: Patient is admitted. Patient received 1 RN visit.

Friday, 4/21: Patient received 1 chaplain visit and 1 Medical Social Worker visit to wife and children.

Saturday, 4/22: Patient is discharged due to death (Item A2115 = 01). The chaplain visited once, prior to patient death. The RN visited once, after being notified that the patient had died.

Level(s) of care: Patient received Routine Home Care only 4/20-4/22.

Depiction of visit schedule based on scenario:

April 2017

Sunday 4/16 Six days prior to death (A0270 minus 6)	**Monday 4/17** Five days prior to death (A0270 minus 5)	**Tuesday 4/18** Four days prior to death (A0270 minus 4)	**Wednesday 4/19** Three days prior to death (A0270 minus 3)	**Thursday 4/20** Two days prior to death (A0270 minus 2)	**Friday 4/21** One day prior to death (A0270 minus 1)	**Saturday 4/22** Day of Death (A0270)
				Patient Admitted (A0220) **[RHC]** 1 RN Visit	**[RHC]** 1 Chaplain Visit 1 Medical Social Worker Visit to wife and children	**Patient Discharged (A0270) as Expired (A2115 = 01)** **[RHC]** 1 Chaplain Visit 1 RN Visit (post-mortem)

Situation B: Section O Item Completion and Explanations

O5000. Level of care in final 3 days
Complete only if A2115, Reason for Discharge = 01 Expired

Enter Code	
0	Did the patient receive Continuous Home Care, General Inpatient Care, or Respite Care during any of the final 3 days of life? 0. **No** 1. **Yes** → Skip to Z0400, Signature(s) of Person(s) Completing the Record

Select "0, No" for O5000 since the clinical record ndicates the patient eceived RHC for the entire stay.

O5010. Number of hospice visits in final 3 days
Enter the number of visits provided by hospice staff from the indicated discipline, on each of the dates indicated.

	Visits on day of death (A0270)	Visits one day prior to death (A0270 minus 1)	Visits two days prior to death (A0270 minus 2)
A. Registered Nurse	0	0	1
B. Physician (or Nurse Practitioner or Physician Assistant)	0	0	0
C. Medical Social Worker	0	1	0
D. Chaplain or Spiritual Counselor	1	1	0
E. Licensed Practical Nurse	0	0	0
F. Aide	0	0	0

tem O5010 considers only visits in the inal 3 days (4/22, 4/21, 4/20).

Row A: Enter a "1" to reflect the RN visit hat occurred on 4/20 (2 days prior to eath). The RN visit on 4/22 (day of death) is not counted in Item O5010 because clinical record documentation shows it occurred post mortem.

Row B: Enter "0" in all cells since the atient did not receive any Physician, NP or PA visits in the final 3 days.

Row C: Enter a "1" in the "visits one day prior to death" column to account for the Medical Social Worker visit to the wife and children on 4/21.

Row D: Enter a "1" in the "visits on day of death" and "visits one day prior to death" olumns to reflect the visits provided by the chaplain on 4/21 and 4/22.

Rows E and F: Enter "0" in all cells since the patient did not receive any LPN or aide visits in the final 3 days.

O5020. Level of care in final 7 days
Complete only if A2115, Reason for Discharge = 01 Expired

Enter Code: 0

Did the patient receive Continuous Home Care, General Inpatient Care, or Respite Care during any of the final 7 days of life?

0. **No**
1. **Yes** → Skip to Z0400, Signature(s) of Person(s) Completing the Record

Select "0, No" for O5020 since the clinical record indicates the patient received RHC for the entire stay. Since this patient was not enrolled n hospice for all 7 of these days, O5020 is completed based on the 3 days the patient was enrolled in hospice.

O5030. Number of hospice visits in 3 to 6 days prior to death
Enter the number of visits provided by hospice staff from the indicated discipline, on each of the dates indicated.

	Visits three days prior to death (A0270 minus 3)	**Visits four days prior to death (A0270 minus 4)**	**Visits five days prior to death (A0270 minus 5)**	**Visits six days prior to death (A0270 minus 6)**
A. Registered Nurse	0	0	0	0
B. Physician (or Nurse Practitioner or Physician Assistant)	0	0	0	0
C. Medical Social Worker	0	0	0	0
D. Chaplain or Spiritual Counselor	0	0	0	0
E. Licensed Practical Nurse	0	0	0	0
F. Aide	0	0	0	0

Enter 0's (zeros) in all cells in item O5030 ecause no visits were rovided from 4/16 through 4/19 (the days three to six days prior to death). Note that zeros are reported even though the reason that visits were not provided was because the patient was not yet on hospice service.

Examples (continued)

Situation C

Patient's clinical record contains the following information:

Sunday 4/16: Patient is admitted. Patient received 2 RN visits and 1 aide visit.

Monday, 4/17: Patient received 1 aide visit.

Tuesday, 4/18: Patient received 3 RN visits and 1 physician visit.

Wednesday, 4/19: Patient received 1 Medical Social Worker visit, 2 RN visits, and 2 physician visits.

Thursday, 4/20: Patient received 1 RN visit.

Friday, 4/21: Patient received 1 chaplain visit and 1 Medical Social Worker visit to family.

Saturday, 4/22: Patient is discharged due to death (Item A2115 = 01). The chaplain visited once, prior to patient death. The RN visited once, after being notified that the patient had died.

Level(s) of care: Patient received Routine Home Care 4/16 and 4/17, General Inpatient Care 4/18 and 4/19; and Routine Home Care on 4/20, 4/21, and 4/22.

Depiction of visit schedule based on scenario:

April 2017

Sunday 4/16	**Monday 4/17**	**Tuesday 4/18**	**Wednesday 4/19**	**Thursday 4/20**	**Friday 4/21**	**Saturday 4/22**
Six days prior to death (A0270 minus 6)	Five days prior to death (A0270 minus 5)	Four days prior to death (A0270 minus 4)	Three days prior to death (A0270 minus 3)	Two days prior to death (A0270 minus 2)	One day prior to death (A0270 minus 1)	Day of Death (A0270)
Patient Admitted (A0220) [RHC] 2 RN Visits 1 Aide Visit	**[RHC]** 1 Aide Visit	**[GIP]** 3 RN Visits 1 Physician Visit	**[GIP]** 1 Medical Social Worker Visit 2 RN Visits 2 Physician Visits	**[RHC]** 1 RN Visit	**[RHC]** 1 Chaplain Visit 1 Medical Social Worker Visit to family	**Patient Discharged (A0270) as Expired (A2115 = 01) [RHC]** 1 Chaplain Visit 1 RN Visit (post-mortem)

Situation C: Section O Item Completion and Explanations

O5000. Level of care in final 3 days
Complete only if A2115, Reason for Discharge = 01 Expired

Enter Code	
0	Did the patient receive Continuous Home Care, General Inpatient Care, or Respite Care during any of the final 3 days of life? 0. **No** 1. **Yes** → Skip to Z0400, Signature(s) of Person(s) Completing the Record

Select "0, No" for O5000 since the clinical record ndicates the patient eceived RHC only for the final 3 days (4/22, 4/21, 4/20).

O5010. Number of hospice visits in final 3 days
Enter the number of visits provided by hospice staff from the indicated discipline, on each of the dates indicated.

	Visits on day of death (A0270)	Visits one day prior to death (A0270 minus 1)	Visits two days prior to death (A0270 minus 2)
A. Registered Nurse	0	0	1
B. Physician (or Nurse Practitioner or Physician Assistant)	0	0	0
C. Medical Social Worker	0	1	0
D. Chaplain or Spiritual Counselor	1	1	0
E. Licensed Practical Nurse	0	0	0
F. Aide	0	0	0

tem O5010 considers only visits in the nal 3 days (4/22, 4/21, 4/20).

Row A: Enter a "1" to reflect the RN visit that occurred on 4/20 (two days prior to death). The RN visit on 4/22 (day of death) is not counted in Item O5010 because clinical record documentation shows it occurred post mortem.

Row B: Enter "0" in all cells since the atient did not receive any Physician, NP or PA visits in the final 3 days.

Row C: Enter a "1" in the "visits one day prior to death" column to account for the Medical Social Worker visit to the family on 4/21.

Row D: Enter a "1" in the "visits on day of eath" and "visits one day prior to death" olumns to reflect the chaplain visits provided on 4/21 and 4/22.

Rows E and F: Enter "0" in all cells since the patient did not receive any LPN or aide visits in the final 3 days.

O5020. Level of care in final 7 days
Complete only if A2115, Reason for Discharge = 01 Expired

Enter Code	
1	Did the patient receive Continuous Home Care, General Inpatient Care, or Respite Care during any of the final 7 days of life? 0. **No** 1. **Yes** → Skip to Z0400, Signature(s) of Person(s) Completing the Record

Although the patient received RHC on ome of the final 7 ays, the patient also received other levels of care. Specifically, the patient received GIP on 4/18 (four days prior to death) and 4/19 (three days prior to death). Thus, select "1, yes" for O5020 because the clinical record indicates the patient received GIP for at least some of the final 7 days.

O5030. Number of hospice visits in 3 to 6 days prior to death
Enter the number of visits provided by hospice staff from the indicated discipline, on each of the dates indicated.

	Visits three days prior to death (A0270 minus 3)	Visits four days prior to death (A0270 minus 4)	Visits five days prior to death (A0270 minus 5)	Visits six days prior to death (A0270 minus 6)
G. Registered Nurse	☐	☐	☐	☐
H. Physician (or Nurse Practitioner or Physician Assistant)	☐	☐	☐	☐
I. Medical Social Worker	☐	☐	☐	☐
J. Chaplain or Spiritual Counselor	☐	☐	☐	☐
K. Licensed Practical Nurse	☐	☐	☐	☐
L. Aide	☐	☐	☐	☐

O5030 is only completed for patients who do not receive CHC, GIP, or Respite Care in the final 7 days, as indicated in O5020. This patient did receive some GIP care during that time, so the answer to O5020 is "1, yes," and, as directed by skip patterns, O5030 is skipped.