

QAPI

Quality Assessment Performance Improvement

HIS (Hospice Item Set)

Home Health VNA
Merrimack Valley Hospice
HomeCare, Inc.



The Leaders in Home Health and Hospice Care

Objectives

- ▶ The participant will be able to discuss the Hospice QAPI Program and Hospice Item Set (HIS)

418.58 QAPI

Quality Assessment/Performance Improvement

Program must be:

- ▶ Effective, ongoing, data driven
- ▶ Involving of all hospice services
- ▶ Focused on improved outcomes for patients and families
- ▶ Focused on improvements in hospice performance

QAPI – Quality Indicators – MVH

- **Patient care related**
HIS
- **Safety related**
Incidents
Infections
- **Satisfaction related**
CAHPS
Complaints
- **Chart review /documentation indicators**
(Examples _

Performance Improvement Projects

Performance Improvement Projects (PIPs)

1. Hospice Item Set
2. Hospice Education Project
3. Qualiance

What is HIS?


- ▶ HIS is an “Hospice Item Set” which is a standardized mechanism for abstracting data from the medical record.
- ▶ It is a review of content in the medical record to make sure that best practices identified by the National Quality Forum are taking place in every Hospice organization.
- ▶ Implementing HIS involves “mapping” of items currently in the medical record to meet the 7 quality measures being required by the Center for Medicare Services (CMS)
- ▶ For each patient admitted on or after July 1, 2014, completion of the HIS will be required on Admission and on Discharge.

What is HIS?

A “HIS” is submitted for all patients admitted to a Medicare–certified Hospice program regardless of:

- ▶ Payor Source
- ▶ Patient Age
- ▶ Where the patient receives Hospice services
- ▶ Whether the patient is a transfer from another Hospice
- ▶ Whether the patient previously revoked the Hospice benefit or was discharged

What does this mean for me?

- ▶ Practices and processes for patient assessment and documentation will capture the elements required to populate the HIS form.
 - ▶ Hospices will have 14 days from admission to complete HIS–Admission records and 7 days from discharge to complete HIS–Discharge records. These HIS records will be sent to CMS electronically; Hospices will have 30 days from the patient admission or discharge to submit the record for the patient.
 - ▶ QA will be reviewing the visit notes to assure that items are being “mapped” correctly for submission.
 - ▶ If there are errors you will be contacted to clarify and may be asked to add an addendum if indicated.
- 

HIS Items captured in Visit

- ▶ Patients Treated with an opioid who are given a bowel regime.
- ▶ Pain Screening
- ▶ Pain Assessment
- ▶ Dyspnea Treatment
- ▶ Dyspnea Screening
- ▶ Treatment Preferences– Hospitalization & CPR
- ▶ Beliefs/Values Addressed(if desired by patient)

Patients treated with an Opioid who are given a bowel regime– Med Intervention Prescribed (NQF#1617)

- ▶ Care Process: Patients treated with an opioid that are offered/prescribed a bowel regime or documentation of why this was not needed.

Patient Chart | Medications

Current

- Alerts
- Scheduled
- PRN
- IV/TD
- Hx/Meds

| N/C | Drug |
|-----|---|
| | Ativan (LORazepam) 0.5 mg PO PRN Q6h for anxiety |
| | Haldol (haloperidol) 5 mg PO PRN Q4h × 10d for agitated |
| | Ømarijuana INH PRN for nausea/insomnia/anxiet |
| N | Morphine Sulfate (morphine) 10 mg PO PRN Q1h for Pa |
| N | Senna S (docusate-senna) 2 - 4 tab PO PRN Qd for Con |
| | Tylenol (acetaminophen) 325 mg PO PRN Q3h for fever |
| | Tylenol (acetaminophen) 650 mg PO PRN Q4h for pain/f |

DETAILS

Aliases: AVINza, Duramorph PF, Infumorph, Kadian, morphine, Morphine Sulfate ADD-Vantage, MS Contin, MSIR ...

(narcotic analgesics)

Starting 5/29/2014

Entered by Trudy J Newton, RN, CHPN (5/29/2014)

Date of initiation of the medications

Patients treated with an Opioid who are given a bowel regime– NON-Med Intervention Prescribed (NQF#1617)

▶

| | | |
|-------------|--------------|----------------|
| Subjective | FLATULENCE | <Flatulence> |
| ✓ Objective | BOWEL SOUNDS | <Bowel Sounds> |
| Tube | EVACUATION | LAST BM <When> |
| Ostomy | PATTERN | <Pattern> |
| Care | STOOL COLOR | <Stool Color> |
| [Summary] | STOOL TYPE | <Type> |
| [Changes] | STOOL AMT | <Amount> |
| | INCONTINENCE | <Degree> |
| | RECTAL EXAM | |
| | STOOL | <Stool> |
| | HEMORRHOIDS | <Description> |
| | BLEEDING | <Amount> |

Document in the Nursing Visit Note, or Hospice Integrated Assessment, Systems Tab, GI system.

Declined medications. Pts plan is to add 480 mls prune juice daily, eat bran cereal daily, will put "recipe" (bran, applesauce, prunes) on toast daily. Will call agency if ineffective-no BM x 3 days.

Documentation of meds refused or not needed

Subjective
☒ **Objective**
Tube
Ostomy
Care
[Summary]
[Changes]

FLATULENCE
BOWEL SOUNDS
EVACUATION
PATTERN
STOOL COLOR
STOOL TYPE
BLEEDING

NOTE NEEDS TO CLEARLY IDENTIFIED WHY NOT INDICATED OR REFUSED

LOCATED

<Flatulence>
<Bowel Sounds>
Today
Usual
<Stool Color>
Watery
Large > Usual
<Degree>
<Stool>
<Description>
<Amount>


Meds
MedReview
Initial Assessment
Systems

Visit Note
GASTROINTESTINAL
GENITOURINARY
NEUROLOGICAL

Pt has loose stools 4-5x per day due to disease process. No need to start bowel regimen with initiation of Morphine at this time. Education provided on s/s constipation and when to call RN. Pt able to teach back.

Pain Screening (NQF#1634)

- ▶ Care Process: The patient was screened for the presence of pain during the initial nursing assessment. Pain screening includes evaluating the patient for presence of pain, and if pain is present, rating of its severity using a standardized tool.
- ▶ Edmonton Scale completed at SOC

 **Patient Chart | Edmonton Scale**



Scale
[Summary]
[Changes]

EDMONTON SYSTEM ASSESSMENT SCALE (ESAS)
ESAS:
<information from>
(INDEX 0-10: 0=NONE, 10=WORST)

PAIN:
TIRED:
NAUSEA:
DEPRESSION:
ANXIETY:
DROWSINESS:
APPETITE:

<information from>
patient.
family.
health professional.
assisted by family.
assisted by health professional.

Score<0-10>
Score<0-10>
0
1
2
3
4
5
6



Pain Assessment (NQF#1637)

- ▶ Care Process: If the patient screened **POSITIVE** for pain then need a pain assessment documented at **THAT TIME.**
- ▶ Pain Assessment documentation must include at least 5 of the following 7 :
 - Location
 - Severity
 - Duration
 - Frequency
 - Character
 - What relieves or worsens the pain
 - Effect on function or quality of life

*****Non-verbal patients– Caregiver or responsible party report on at LEAST ONE of these characteristics is acceptable, and or a clinician's notes of his/her observations of at LEAST ONE of these characteristics is also acceptable.**

Current Pain Assessment Documented in MW

The screenshot shows a pain assessment form with a sidebar on the left and a main content area on the right. The sidebar contains a list of assessment categories, with 'General Status' and 'Generalized Pain' checked. The main content area is divided into sections for 'PATIENT COMPLAINS OF:', 'PAIN.', 'REPORTED LEVELS:', 'PAIN LEVELS:', 'PAIN DESCRIPTION:', and 'PAIN:'. Annotations with callout boxes highlight specific fields: 'LOCATION' points to the '<pain site>', '<position>', and '<pain location>' fields; 'SEVERITY' points to the '2' in the 'CURRENT' level; 'CHARACTER' points to the '<pain description>' field.

General Status
Generalized Pain
Musculoskeletal Pain
Neuropathic Pain
Other Pain
PAINAD
FLACC
Non-Verbal
Additional Pain
Side Effects
PainTeach
[Summary]
[Changes]

PATIENT COMPLAINS OF:

LOCATION

SEVERITY

CHARACTER

PAIN.
? REPORTED LEVELS:
(INDEX: 0-10 0= NONE AND 10=WORST)

PAIN LEVELS:
CURRENT
ACCEPTABLE
WORST/LAST VISIT,
BEST/LAST VISIT,

PAIN DESCRIPTION:
PAIN:

Pain Documentation: Cont.

| | | | |
|----------------------|--|--------------------|-----------|
| ✓ General Status | FREQUENCY: | <frequency> | FREQUENCY |
| ✓ Generalized Pain | LASTS: | HOURS, MINUTES. | DURATION |
| Musculoskeletal Pain | PAIN OCCURS: <input type="checkbox"/> at rest. <input type="checkbox"/> with activity. | | |
| Neuropathic Pain | PATIENT'S PAIN INTERFERES WITH: | | |
| Other Pain | <activity> | | |
| PAINAD | <activity> | | |
| FLACC | <activity> | | |
| Non-Verbal | <activity> | | |
| Additional Pain | Effect on function or quality of life | | |
| Side Effects | <activity> | | |
| PainTeach | <activity> | | |
| [Summary] | AND IS EXACERBATED BY | | |
| [Changes] | <activity> | | |
| | <activity> | | |
| | What worsens the pain and..... | | |
| FLACC | ADDITIONAL PAIN RELIEF MEASURES: | | |
| Non-Verbal | <measures> | | |
| Additional Pain | <measures> | | |
| Side Effects | <measures> | | |
| PainTeach | <measures> | | |
| [Summary] | ...What relieves the pain | | |
| [Changes] | WITH <level> RELIEF | | |

Dyspnea Screening (NQF 1639)

- ▶ Care Process: The patient screened for dyspnea during the initial nursing assessment
- ▶ Standard: Edmonton scale is completed on SOC for admits.

Patient Chart | Edmonton Scale

☒ **Scale**
[Summary]
[Changes]

ESAS:
<information from>
(INDEX 0-10: 0=NONE, 10=WORST)

PAIN: 1
TIRED: Score<0-10>
NAUSEA: Score<0-10>
DEPRESSION: Score<0-10>
ANXIETY: 3
DROWSINESS: 4
APPETITE: 5
WELL BEING: 6
SHORT OF BREATH: Score<0-10>

Dyspnea Treatment (NQF#1638)

- ▶ Care Process: Hospice patients who screened positive for dyspnea received treatment within 1 day of the screening. Treatment may include inhaled meds, steroids, diuretics, oxygen, benzos or opioids (if clearly prescribed for dyspnea), or non-medication strategies such as fans, positioning, patient education efforts.
- ▶ Standard: Patients that screen **POSITIVE** for dyspnea will have interventions to alleviate that dyspnea at time of screening positive.

Dyspnea Treatment: Medication Example

Patient Chart | Medications

PRN TV/TD ☐ N Morphine Sulfate (morphine) 10 mg PO PRN Q1h for Pain SOB

Edit Ativan

- ☒ 1. Changes
- ☒ 2. Dosing
- ☒ 3. Dispense
- ☒ 4. Options
- ☐ 5. Advanced

Notes
For dyspnea and anxiety

IF the Medication is SCHEDULED you MUST note this in the Options under Notes

Dyspnea Treatment: Non-Medication example

Patient Chart | Hospice Nurse Assessment

| | | |
|--------------------|--------------------|------------------------------|
| Lung/Edema | RESPIRATORY | <input type="checkbox"/> WNL |
| Meds | GASTROINTESTINAL | <input type="checkbox"/> WNL |
| MedReview | GENITOURINARY | <input type="checkbox"/> WNL |
| Initial Assessment | NEUROLOGICAL | <input type="checkbox"/> WNL |
| Systems | | <input type="checkbox"/> WNL |

| | |
|--|---|
| Cough | <Dyspnea> |
| <input checked="" type="checkbox"/> Dyspnea | <Dyspnea> |
| <input type="checkbox"/> O2 Use | |
| [Summary] | DYSPNEA AFTER AMBULATION OF |
| [Changes] | Educated on energy conservation techniques and pursed lip breathing techniques-reports understanding and demonstrated effective strategies correctly during visit |

Noting the non-medical intervention that was instructed for dyspnea

Treatment Preferences (NQF#1641)

- ▶ Care Process: The patient or responsible party are asked about preferences related to CPR and hospitalization.
- ▶ NHPCO Core Measures must added at SOC visit until the item is mapped to the Integrated Assessment.

The screenshot displays a web-based interface for managing patient treatment preferences. The main header is "Patient Chart | NHPCO Core Measures". On the left, a sidebar menu includes "Hospitalization/CPR" (highlighted with a yellow box and a hand cursor), "Change", "Discharge", "[Summary]", and "[Changes]". The main content area is titled "RESPONDENT:" and features a dropdown menu with options: "<Respondent>", "Patient", "Healthcare agent", "Advance Directive", and "Surrogate". Below this, a question is posed: "DO YOU WANT TO AVOID HOSPITALIZATION IF YOUR CONDITION WORSENS?". The word "HOSPITALIZATION" is highlighted with a yellow box. To the left of the question is a dropdown menu with "<Decision>" and a question mark. To the right is another dropdown menu with "<Decision>", "Yes", "No", and "Undecided". Below this, another question is partially visible: "DO YOU WANT CARDIOPULMONARY RESUSCITATION IF YOUR HEART OR LUNGS STOP WORKING?". The word "CARDIOPULMONARY RESUSCITATION" is highlighted with a yellow box. To the left of this question is a dropdown menu with "<Decision>" and a question mark. To the right is another dropdown menu with "<Decision>", "Yes", "No", and "Undecided".

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

- ▶ Care Process: Discussion or Attempted discussion of spiritual/existential concerns or documentation that the patient and/or caregiver did not want to discuss.
- ▶ Initial Spiritual Assessment form is completed at SOC. Comprehensive Spiritual Assessment form completed by day 5.

The screenshot displays a medical software interface. On the left is a vertical sidebar menu with the following items: Lung/Edema, Meds, MedReview, Initial Assessment (highlighted with a yellow box and a green checkmark), Systems, Additions, Comprehensive Psych, Comprehensive Spiritu, Comprehensive Berea, Teach, Communication, and Skilled Supervision. The main content area on the right is titled 'PATIENT'S SPIRITUAL CONCERNS:' in a yellow header. Below this is a dropdown menu currently showing '<Spiritual concerns>'. A red arrow points from the text 'Immediate spiritual support required:' to the dropdown menu. Below the dropdown are two checkboxes: 'No immediate needs for spiritual support' and 'Immediate spiritual support required:'. The 'Immediate spiritual support required:' checkbox is selected. Below these checkboxes is a text input field containing the text 'Patient and caregiver declined to discuss at this time'. At the bottom of the form is another section titled 'OTHER IMMEDIATE NEEDS:' followed by an empty text input field.

Beliefs/Values– Example: Comprehensive Assessment– Should be completed by MSW or Clergy, defaults to SN as needed to complete by day five.

Source of Info
Subjective
Patient Rights
Vitals
HT/WT.
Lung/Edema
Meds
MedReview
Initial Assessment
Systems
Additions
Comprehensive Psychsoc
Comprehensive Spiritual
Comprehensive Bereaver
Teach
Communication
Initial Assessment
Systems
Additions
Comprehensive Psychsoc
Comprehensive Spiritual
Comprehensive Bereaver
Teach
Communication
Skilled Supervision

PATIENT VERBALIZES CONCERNS ABOUT:

<Spiritual concerns>
<Spiritual concerns>
<Spiritual concerns>
<Spiritual concerns>

COMMENTS:

FAMILY/CAREGIVER VERBALIZES CONCERNS ABOUT:

<Spiritual concerns>
<Spiritual concerns>
<Spiritual concerns>
<Spiritual concerns>

SOURCES OF SUPPORT:

<sources of support>
<sources of support>
<sources of support>
<sources of support>

COMMENTS:

Clearly notes discussion and identified sources of support for both patient and caregiver.