Tool: Hospice Item Set measures at a glance

Use this table as a quick reference for the details of each of the seven National Quality Forum (NQF)-endorsed measures CMS has proposed for use in the Hospice Item Set (HIS). Hospices will submit an HIS-Admission and an HIS-Discharge for ALL patients but data on measures are only completed for patients 18 years of age and older. The table was created and updated by Katie Wehri, a hospice operations expert at the National Association for Home Care & Hospice.

Measure	Description	Numerator	Denominator	Population	Measure details
NQF #1617: Patients treated with an opioid who are given a bowel regimen	Percentage of vulnerable adults treated with an opioid that are offered/prescribed a bowel regimen or documentation of why this was not needed	Patients from the denominator given a bowel regimen; or documentation exists indicating why this was not needed Timeframe: Within one day of the patient being prescribed a scheduled opioid	Vulnerable adults who are given a new prescription for an opioid	Not already taking an opioid	New prescription: any new prescription — means the patient was not already taking an opioid Bowel regimen: offer/prescription of a laxative, stool softener or high fiber supplement/diet OR documentation of why one of these not needed
NQF #1634: Pain screening	Percentage of patients who were screened for pain during the hospice admission evaluation	Patients who are screened for presence or absence of pain within two days of the admission date (if present, rating of its severity) using a standardized, quantitative tool during the admission evaluation	Patients enrolled in hospice for seven or more days	Length of stay (LOS) > seven days	Paired with NQF #1637 Screening may be completed using verbal, numeric, visual analog or rating scales designed for use in non-verbal patients or other standardized tools.
NQF #1637: Pain assessment	Percentage of patients who screened positive for pain and who received a clinical assessment of pain within 24 hours of screening	Patients who received a comprehensive clinical assessment to determine the severity, etiology and impact of their pain within one day of the initial nursing assessment during which the patient screened positive for pain	Patients in hospice who report pain when pain screening is done on the admission evaluation/initial encounter	LOS > seven days Exclude patients not screened for pain, patients who screened negative for pain	Positive screen: ▸ Any response other than none on verbal scale ▸ Any number > zero on numerical scale ▸ Any observation ▸ Any self-report of pain Clinical assessment of pain must include at least five of the following characteristics of pain: ▸ Location/Frequency ▸ Severity/Character ▸ Duration ▸ What relieves or worsens the pain ▸ Effect on function or quality of life

Measure	Description	Numerator	Denominator	Population	Measure details
NQF #1638: Dyspnea treatment	Percentage of patients who screened positive for dyspnea who received treatment within 24 hours of screening	Patients who screened positive for dyspnea who received treatment within one day of the initial nursing assessment during which the patient screened positive for shortness of breath	Patients enrolled in hospice for seven or more days who report dyspnea when screened during the initial nursing assessment	LOS > seven days	This includes dyspnea screening at the admission evaluation/initial assessment only. Positive screen: ▸ Any response other than none on verbal screen ▸ Any number > 0 on numerical scale ▸ Any observation ▸ Any self-report of dyspnea Treatment — Within one day of the initial nursing assessment during which the patient screened positive for shortness of breath– medical treatment plan, orders or pharmacy records show: ▸ Inhaled medications ▸ Steroids ▸ Diuretics ▸ Non-medication strategies (02, energy conservation) ▸ Benzodiazepine or opioid (IF clearly prescribed for dyspnea)
NQF #1639: Dyspnea screening	Percentage of patients who were screened for dyspnea during the admission evaluation	Patients who are screened for the presence or absence of dyspnea and its severity within two calendar days of the admission date	Patients enrolled in hospice for seven or more days	LOS > seven days	Paired with NQF #1638 Screening may be completed using verbal, numeric, visual analog or rating scales designed for use with non-verbal patients.
NQF #1641: Patient preference	Percentage of patients with chart documentation of preferences for life-sustaining treatments	Patients whose medical record includes documentation of life-sustaining preferences	Seriously ill patients enrolled in hospice	LOS > seven days	Documentation of life-sustaining treatment preferences should reflect patient self-report; if not available, discussion with surrogate decision-maker and/or review of advance directive documents are acceptable. Timeframe: Prior to admission date or within five calendar days of admission date. Must be evidence of discussion/communication. Documentation of short statements such as “Full Code” or “DNR/DNI” do not count in the numerator. Documentation using the POLST paradigm with evidence of patient or surrogate involvement, such as co-signature or description of discussion, is adequate evidence and can be counted in this numerator.
NQF #1647: Beliefs/values addressed (if the patient desires)	Percentage of hospice patients with documentation of a discussion of spiritual/religious concerns or documentation that the family/caregiver did not want to discuss	Patients with clinical record documentation of spiritual/religious concerns or documentation that the patient/family did not want to discuss	Total number of patients discharged from hospice care during the designated reporting period	All patients discharged from hospice care during the designated reporting period	Cases are eligible for inclusion upon admission to a hospice program. Discussion of spiritual/religious concerns can occur with any member of the IDT within five calendar days of the admission date. Documentation of only patient’s religious or spiritual affiliation does not count for inclusion in numerator. Data are collected via chart review. Criteria are: 1) evidence of a discussion about spiritual/religious concerns, or 2) evidence that the patient and/or family declined to engage in a conversation on this topic. Evidence may be found in the initial screening/assessment, comprehensive assessment, updated assessments, visit notes documented by any member of the team and/or the spiritual care assessment. Note that these are examples and not a complete list.