

**HOSPICE QUALITY REPORTING PROGRAM (HQRP)  
PROVIDER TRAINING**

**PARTICIPANT QUESTIONS FROM IN-PERSON TRAINING  
ON JANUARY 18, 2017**

**Current as of May 2017**



**CMS: HQRP Provider Training – Participant Questions From In-Person Training on January 18, 2017**

#	Question Category	Question	Answer
1	CAHPS	If a family member says they do not want to receive ANY mailings from the hospice following a patient's death, can we mark this as no publicity?	In order for the patient to be considered "no publicity," the patient or caregiver must <i>initiate</i> the request for no contact. If he/she does initiate the request, you may mark the patient as no publicity.
2	CAHPS	Is there a form from CMS on nonpublication, or do we make our own and keep for 3 years?	Hospices should document the request. If the request comes in a letter or email, we suggest you print and preserve it. If not, we suggest you create your own form. We do not have a form.
3	CAHPS	The use of the word "training" when asking if the caregiver received training from the hospice about the different areas (e.g., such as side effects of pain medications, when/if to give more medication) can affect the answer. In our area of the country, "training" would imply that the caregiver went to special classes to receive training rather than being taught about these things in the home. Can the wording of the survey be changed so it is non-prejudicial?	CMS is always interested in how questions are interpreted and will keep this in mind for future revisions.
4	CAHPS	Will CAHPS ever account for care provided in different settings over the course of care for one patient? Patients can and do change locations throughout their episodes of care, and the responses by the caregivers may be influenced based on which location they are remembering when answering the questions.	The survey is intended to focus on the final setting of care.

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5	CAHPS	Is an agency allowed to begin submitting CAHPS data even if they are exempted by size? Is sending the information without need recommended?	<p>If a hospice is eligible for an exemption (for size or newness), it may choose one of three options:</p> <p><b>Option 1: Not participate in the CAHPS Hospice Survey.</b> If a hospice is eligible for an exemption (for size or newness), it is not required to administer the CAHPS Hospice Survey, either officially or unofficially. Please be aware that if a hospice is eligible for Participation Exemption for Size from CAHPS Hospice Survey data collection and reporting requirements, a Participation Exemption for Size Form must be submitted in order to be considered for the exemption. The Participation Exemption for Size Form is available to complete and submit online. For more information on the Participation Exemption for Size process or to view the Participation Exemption for Size Form, visit the CAHPS Hospice Survey website (<a href="http://www.hospicecahpsurvey.org">www.hospicecahpsurvey.org</a>) on the Participation Exemption for Size page.</p> <p><b>Option 2: Officially participate in the CAHPS Hospice Survey.</b> If a hospice is eligible for an exemption (for size or newness) and chooses to officially participate in CAHPS Hospice Survey data collection and reporting requirements, the protocols listed in the CAHPS Hospice Survey Quality Assurance Guidelines must be complied with, including submission of all data to the CAHPS Hospice Survey Data Warehouse. CMS will publicly report CAHPS Hospice Survey measure scores for hospices that submit their data to the CAHPS Hospice Survey Data Warehouse. As noted above, if a hospice is eligible for Participation Exemption for Size from CAHPS Hospice Survey data collection and reporting requirements, a Participation Exemption for Size Form must be submitted in order to be considered for the exemption.</p> <p><b>Option 3: Unofficially participate in the CAHPS Hospice Survey.</b> It is permissible to administer the CAHPS Hospice Survey questions for quality improvement purposes, as the survey instrument is in the public domain. However, in this instance, references to CMS must not be included on any materials. In addition, in this instance, the data collected cannot be submitted to the CAHPS Hospice Survey Data Warehouse. As noted above, if a hospice is eligible for Participation Exemption for Size from CAHPS Hospice Survey data collection and reporting requirements, a Participation Exemption for Size Form must be submitted in order to be considered for the exemption; unofficial participation in the CAHPS Hospice Survey does not fulfill CAHPS Hospice Survey data collection and reporting requirements.</p>

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6	CAHPS	Our agency is about a mile from the Canadian border. Family members do come down from Canada to take care of our hospice patients and are the primary care provider for them. They don't have American addresses. Are you going to change so agencies on the borders can list Canadian or Mexican addresses?	The caregiver must have a U.S. address to receive a CAHPS survey.
7	CAHPS	Who should be identified as the CAHPS survey recipient?	The primary caregiver as determined by the hospice.
8	CAHPS	Please define primary caregiver. Should this be a person who is providing care or the patient's legal decision-maker?	The primary caregiver is the individual who the hospice has defined as the primary caregiver in the record and does not need to be the patient's legal decision maker.
9	CAHPS	We serve several patients living in assisted living homes. Are surveys sent to the primary caregiver who signed the caregiver consent form (in the assisted living) or to the family?	The primary caregiver is the individual who the hospice has defined as the primary caregiver in the record and does not need to be the patient's legal decision maker.
10	CAHPS	This question is about the primary caregiver. What if the patient is in a facility such as a nursing home and there is no significant caregiver? The patient signed Election of Benefit, and no family members are involved. In this case, if you would, the facility is actually the caregiver. Would this be an excluded patient?	Yes
11	CAHPS	We are a small hospice. Fewer than 20 returned surveys for calendar year 2016. Is there a threshold for public reporting? I recall reading or hearing that a low survey return rate would not allow enough data for public reporting.	If there are fewer than 20 patient stays based on 12 rolling months of data, the Hospice Item Set (HIS)-based Quality Measures will not be publicly reported. CMS is making final determinations regarding a minimum threshold for Hospice CAHPS surveys and will alert providers when this is finalized.
12	CAHPS	When will the calculation of CAHPS Hospice Survey quality measures be added to the Quality Assurance Guidelines (QAGs) or other document on the Hospice CAHPS website?	Yes. We can put information on how the CAHPS measures are calculated on the survey website and in the next version of the QAG.

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#	Question Category	Question	Answer
13	CAHPS	Is there a threshold for the number of surveys that must be returned for public reporting? For CY 2016, so far we have approximately 20 returned surveys. I recall reading/hearing that small returns would not be considered for public reporting due to small sample size.	We will have a threshold for the number of returned surveys in order to be included in public reporting. We have not yet made a final decision on how many surveys that will be.
14	CAHPS	When will Hospice CAHPS results be publicly available?	CMS has not yet determined when the CAHPS results will be publicly available.
15	CAHPS	With the first public release of Hospice CAHPS scores, do you anticipate releasing scores as top box, linear mean, both, other?	The final decision has not yet been made. However, most other CAHPS sites do use top box scores, and we expect our reporting to be similar.
16	CAHPS	Which questions or domains will be included in the publicly reported data?	<p>There will be a total of six multi-item measures:</p> <ul style="list-style-type: none"> <li>• Hospice Team Communication</li> <li>• Getting Timely Care</li> <li>• Treating Family Member with Respect</li> <li>• Getting Emotional and Religious Support</li> <li>• Getting Help for Symptoms</li> <li>• Getting Hospice Care Training</li> </ul> <p>In addition, there are two other measures, also called “global ratings”:</p> <ul style="list-style-type: none"> <li>• Rating of Hospice</li> <li>• Willingness to Recommend</li> </ul>
17	CAHPS	If a new hospice gets its CMS Certification Number (CCN), when can you get into the CAHPS data submission? Are there only certain times of the year that you can enter CAHPS? Thank you.	To qualify for the Annual Payment Update, the hospice must participate January through December of the relevant year. A new hospice will be exempted from participating in CAHPS if it receives its CCN during the performance period. Thus, if the hospice receives its CCN on or after January 1, 2017, it is exempt from participating for the entire year 2017, but it should plan to start participating on January 1, 2018.
18	CAHPS	Regarding the National Benchmarks CAHPS for public reporting, are any of the eight categories combined scores (e.g., HS Team Communication—does this also include Information Continuity)?	Yes; as noted above, six of the measures involve multi-item scores.

#	Question Category	Question	Answer
19	CAHPS	The items listed on the slide of measures eligible for reporting did not include Hospice CAHPS. Will the CAHPS results also be publicly displayed?	We plan to display the six multi-item measures and the two ratings measures: <ul style="list-style-type: none"> <li>• Hospice Team Communication</li> <li>• Getting Timely Care</li> <li>• Treating Family Member with Respect</li> <li>• Getting Emotional and Religious Support</li> <li>• Getting Help for Symptoms</li> <li>• Getting Hospice Care Training</li> <li>• Rating of Hospice</li> <li>• Willingness to Recommend</li> </ul>
20	CAHPS	What are the CAHPS data that will be included on Hospice Compare? What is the number of surveys that must be completed in order for data to be reported on the website?	We have not yet determine how many surveys must be returned before a hospice can appear on the website. We are balancing the need for reliable data with the preference for many hospices to be included, even if their sample size is small.
21	CAHPS	What hospice CAHPS questions/answers will be publically reported?	We plan to display the six multi-item measures and the two ratings measures: <ul style="list-style-type: none"> <li>• Hospice Team Communication</li> <li>• Getting Timely Care</li> <li>• Treating Family Member with Respect</li> <li>• Getting Emotional and Religious Support</li> <li>• Getting Help for Symptoms</li> <li>• Getting Hospice Care Training</li> <li>• Rating of Hospice</li> <li>• Willingness to Recommend</li> </ul>
22	CAHPS	Regarding “no publicity,” if a caregiver contacts the vendor and asks to be placed on a “No Publicity”/”Do Not Survey” list/requests to stop receiving surveys, may the vendor provide that information to the Hospice (for the small chance that caregiver may be identified within the 3-year retain period)?	No. The vendor may not tell the hospice.
23	CAHPS	If the primary caregiver for a descendant is a conservator only and therefore would not be involved in patient care, how do you handle the CAHPS survey that would go out?	This type of caregiver is not eligible to participate in the CAHPS Hospice survey and should not receive any questionnaire.

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24	CAHPS	Can you please repeat the correct web address for the CAHPS Hospice Survey Data Warehouse?	The CAHPS Hospice Survey Data Warehouse is located at <a href="https://kiteworks.rand.org">https://kiteworks.rand.org</a> .
25	CAHPS	CMS has provided the specifications for HIS-Based Quality Measures. When will similar details for the hospice CAHPS-based composites and individual measures be available?	We will provide the specifications for the Hospice CAHPS measures when they are publicly reported.
26	CAHPS	Regarding applying for survey exemptions due to size, what if the size fluctuates throughout the year, but the majority of the time the census is less than 50?	The size exemption applies to hospices that care for fewer than 50 patients over the course of a calendar year, not the census at any given time.
27	Case Study	This question may be answered as the presentation continues, but I want to be sure it is addressed. In Case Scenario #1, the nurse was unable to complete the comprehensive pain assessment because the patient changed the subject and diverted his attention to the grandchildren. The nurse was not able to complete the pain assessment until 3 days later. With the elimination of the 7-day exclusion, had the patient died in 2 days the lack of a complete assessment would have counted against the hospice. If a hospice thinks a patient may die soon, are they then expected to push the patient to allow them to complete the assessment? Is consideration being given to allow a response of “patient refused to complete assessment” or similar? Patients have a right to refuse an in-depth assessment. Thank you.	We agree that sometimes not completing a full assessment is the correct clinical course of action, as you describe. Hospices should never coerce or push patients to allow a comprehensive assessment if the patient’s status could be compromised. As a result, the HIS does not dictate clinical practice. Clinicians should always use their best clinical judgement when completing assessments for patients, and patient preference or refusal is important to take into account. CMS acknowledges that scenarios like the one you described may occur. Therefore, the expectation for measure performance is never 100 percent. CMS will take the suggestion regarding an additional response update into advisement for future item and measure updates.

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28	Case Study	Regarding HIS Case Study #1, when the patient stated preference was not to return to the hospital but would consider returning to the hospital for symptom management or caregiver relief, it was said that he refused to discuss his preference. It appears to me that he did discuss his preference, in light of earlier instruction that could be discussed even if undecided at the time of discussion. Am I looking at this incorrectly?	The polling question provided an example of a patient who refused to discuss his preferences. In the case study, the patient discussed his preferences.
29	Case Study	In the case study, the nurse called the next day and the visit was declined. Could that nurse have asked the comprehensive pain assessment questions over the phone related to duration, frequency, and effect on quality of life to Mr. J or his primary caregiver?	While patient interview regarding the presence and severity of pain CAN occur over the phone, only assessment data collected as part of an in-person visit should be considered for inclusion in pain items in Section J, including item J0910. Patient or caregiver interview by phone should not be considered the first pain assessment for the purpose of HIS data collection.
30	Case Study	Can you please repeat the answer for the patient's pain severity and the date? I found pain severity of 6, dated November 15, 2016.	We assume you are asking about the patient's pain severity score and the date of the pain screening presented in Case Study 1. These questions pertain to Item J0900. Pain Screening. The rationale for completion of the Pain Screening item is as follows: The reason for these responses, as you see in Case Study One, is based on the clinical record documentation from November 15, 2016, which clearly shows Mr. J. was screened for pain since severity was assessed using a standardized tool. Looking at parts C and D specifically (severity and type of tool), Mr. J stated his pain was 6 on a numeric scale of 0 to 10. As stated in the HIS manual, a score of 6 on a numeric scale correlates to "moderate," so we select moderate for J0900C. Since a 0–10 numeric scale was used, we select "numeric" for J0900D.
31	Data Submission and Reporting	We are a new hospice that received our CCN February 2016. The submission rate to date is 67 percent, below the 70-percent expectation. Since we are a new hospice this year, will we be exempt?	The HIS reporting exemption for newness applies only to hospices that receive their CCN on or after November 1 of the reporting year (e.g., November 1, 2016, to impact the Annual Payment Update (APU) for 2018). If you feel there are extenuating circumstances that apply to your situation, you may file a reconsideration request.
32	Data Submission and Reporting	If the location changes between Admission and Discharge, moving from care under one CCN to another, would the first location need to discharge the patient and the second location submit a new admission?	Yes.

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33	Data Submission and Reporting	Will the Quality Improvement and Evaluation System (QIES) system continue to return a - 909 Inconsistent Record Sequence warning when a Discharge is submitted prior to an Admission, or will the record reject?	The email helpdesk you have contacted is made available specifically to support the educational needs of hospice providers and stakeholders related to Hospice Quality Measures, HIS completion, and policy issues related to the Hospice Quality Reporting Program. In order to ensure that this focused need can be maintained, questions outside of the described scope cannot be addressed through this helpdesk. You may find the following resources helpful: For technical questions (registration for User IDs, technical training for data transmission, etc.), consider contacting the Technical Helpdesk. Email: help@qtso.com. Phone: 1-877-201-4721. Hours: Monday–Friday, 7 a.m.–7 p.m. CT.
34	Data Submission and Reporting	We frequently get on HIS submission a warning that the facility ID A0700–patient information mismatch. The file says it is accepted always, but this warning message is frequently received. Could you clarify?	The email helpdesk you have contacted is made available specifically to support the educational needs of hospice providers and stakeholders related to Hospice Quality Measures, HIS completion, and policy issues related to the Hospice Quality Reporting Program. In order to ensure that this focused need can be maintained, questions outside of the described scope cannot be addressed through this help desk. You may find the following resources helpful: For technical questions (registration for User IDs, technical training for data transmission, etc.), consider contacting the Technical Helpdesk. Email: help@qtso.com. Phone: 1-877-201-4721. Hours: Monday–Friday, 7 a.m.–7 p.m. CT.
35	Data Submission and Reporting	I have tried to enter a date that is prior to admit, as I have had discussion, but the HIS data will then not validate and it is because of the dates not matching to the admit date.	The email helpdesk you have contacted is made available specifically to support the educational needs of hospice providers and stakeholders related to Hospice Quality Measures, HIS completion, and policy issues related to the Hospice Quality Reporting Program. In order to ensure that this focused need can be maintained, questions outside of the described scope cannot be addressed through this helpdesk. You may find the following resources helpful: For technical questions (registration for User IDs, technical training for data transmission, etc.), consider contacting the Technical Helpdesk. Email: help@qtso.com. Phone: 1-877-201-4721. Hours: Monday–Friday, 7 a.m.–7 p.m. CT.

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36	Data Submission and Reporting	What happens if the discharge HIS is submitted before the admission HIS? It is stated in the presentation that Admission HIS must be submitted before Discharge HIS; however, in the Q&A from January 2015, it says an error message would be received Warning edit- 909 "Inconsistent Record Sequence" but the record can still be accepted by the QIES ASAP system. So although the HIS submission requirements state that the admission HIS must be submitted before the discharge HIS, the QIES ASAP system will still accept it? Even though it is accepted, are hospices penalized in some way?	The email helpdesk you have contacted is made available specifically to support the educational needs of hospice providers and stakeholders related to Hospice Quality Measures, HIS completion, and policy issues related to the Hospice Quality Reporting Program. In order to ensure that this focused need can be maintained, questions outside of the described scope cannot be addressed through this helpdesk. You may find the following resources helpful: For technical questions (registration for User IDs, technical training for data transmission, etc.), consider contacting the Technical Helpdesk. Email: help@qtso.com. Phone: 1-877-201-4721. Hours: Monday–Friday, 7 a.m.–7 p.m. CT.
37	Data Submission and Reporting	Why does the QIES system record the warning of a new facility ID as an error? Is this going to be fixed before public reporting begins?	The email helpdesk you have contacted is made available specifically to support the educational needs of hospice providers and stakeholders related to Hospice Quality Measures, HIS completion, and policy issues related to the Hospice Quality Reporting Program. In order to ensure that this focused need can be maintained, questions outside of the described scope cannot be addressed through this helpdesk. You may find the following resources helpful: For technical questions (registration for User IDs, technical training for data transmission, etc.), consider contacting the Technical Helpdesk. Email: help@qtso.com. Phone: 1-877-201-4721. Hours: Monday–Friday, 7 a.m.–7 p.m. CT.
38	Data Submission and Reporting	What percentage of HIS-Discharge submission (April 1, 2017) is required to avoid APU reduction?	The threshold for HIS records in calendar year 2017 is 80 percent. This single threshold applies to all HIS records; there are no separate thresholds for admission and discharge records.
39	Data Submission and Reporting	If I need to inactivate a HIS and resubmit and it is past the 30 days, do we incur a penalty?	As noted in the HIS Completion Threshold Fact Sheet, only new records (A0050=1) are included in the denominator for the Timeliness Compliance Threshold, so that modifications/inactivations do not "count against" providers. You can view the Timeliness Compliance Threshold Fact Sheet here: <a href="https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Hospice-Item-Set-HIS.html">https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Hospice-Item-Set-HIS.html</a> .

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40	Data Submission and Reporting	Good Morning. The presenter mentioned that the threshold for the HIS is for timely submission. Does this mean that if the Admission or Discharge HIS is verified after the 14- or 7-day requirement, that is not a determining factor in the submission threshold requirement for the FY considerations?	The timeliness threshold criterion applied to submission deadlines only, not completion timeframes.
41	Data Submission and Reporting	I thought I heard the speaker say that the 14-day requirement to have the admission completed was a guideline. Everything I have always read was that it was a requirement. Did I mishear the speaker? Thanks	As stated in the HIS Manual on Page 1-8: The completion deadlines above are outlined as CMS guidance only. Compliance with completion deadlines is not considered in APU determinations. Although it is at the discretion of the hospice to develop internal policies for completing HIS records, CMS continues to recommend that providers complete and attempt to submit HIS records early, prior to the submission deadline of 30 days, allowing ample time to address any technical issues encountered in the QIES ASAP submission process, such as correcting fatal error messages. You can view the most recent HIS Manual here: <a href="https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Hospice-Item-Set-HIS.html">https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Hospice-Item-Set-HIS.html</a> .
42	Data Submission and Reporting	For Discharge HIS, is the required time for signing as completed only 7 days and not 14 days like an admission HIS? The required visit data are A LOT to gather for a limited timeframe.	Correct. The completion deadline for HIS records is 7 days. However, as stated in the HIS Manual on Page 1-8: The completion deadlines above are outlined as CMS guidance only. Compliance with completion deadlines is not considered in APU determinations. Although it is at the discretion of the hospice to develop internal policies for completing HIS records, CMS continues to recommend that providers complete and attempt to submit HIS records early, prior to the submission deadline of 30 days, allowing ample time to address any technical issues encountered in the QIES ASAP submission process, such as correcting fatal error messages. You can view the most recent HIS Manual here: <a href="https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Hospice-Item-Set-HIS.html">https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Hospice-Item-Set-HIS.html</a> .
43	Data Submission and Reporting	Do you have to submit an HIS Record if the patient is under the age of 18?	Yes. As stated in the HIS Manual, HIS records must be submitted for all patients, regardless of age, payer source, length of stay, or where the patient receives hospice services.

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44	Data Submission and Reporting	If you submit the HIS Discharge and find out later that there was a visit that was not entered into the discharge HIS, do you have to modify the discharge HIS?	<p>As noted in Section 3.6 in the HIS Manual, Hospices should correct any errors necessary to ensure that the information in the QIES ASAP system accurately reflects the patient's hospice record. Inaccurate information in the QIES ASAP system may affect hospice quality reporting results. A HIS record may be corrected even if subsequent records have been accepted for the patient.</p> <p>An error identified in a QIES ASAP system HIS record must be corrected. Inaccuracies can occur for a variety of reasons, such as transcription errors, data entry errors, software product errors, item response selection errors, or other errors. The following two processes exist for correcting HIS records that have been accepted into the QIES ASAP system:</p> <ul style="list-style-type: none"> <li>• Modification Request</li> <li>• Inactivation Request</li> </ul>
45	Data Submission and Reporting	If we have a mistake with the birthday, is that something that requires a modification?	<p>Yes. As noted in Section 3.6 in the HIS Manual, Hospices should correct any errors necessary to ensure that the information in the QIES ASAP system accurately reflects the patient's hospice record. Inaccurate information in the QIES ASAP system may affect hospice quality reporting results. A HIS record may be corrected even if subsequent records have been accepted for the patient.</p> <p>An error identified in a QIES ASAP system HIS record must be corrected. Inaccuracies can occur for a variety of reasons, such as transcription errors, data entry errors, software product errors, item response selection errors, or other errors. The following two processes exist for correcting HIS records that have been accepted into the QIES ASAP system:</p> <ul style="list-style-type: none"> <li>• Modification Request</li> <li>• Inactivation Request</li> </ul>
46	Data Submission and Reporting	What is the timeframe allowed to submit a modification to a previously submitted and accepted HIS report?	<p>You can submit modifications and inactivations for up to 3 years. If more than 36 months have passed since the target date of the record (admission or discharge date), the record will be rejected by the QIES ASAP system. Note that if the records containing erroneous data have already been used in the calculation quality measures on Hospice Compare, the measures will not be updated to accommodate the modifications and inactivations. However, providers will be given an opportunity to preview their quality measure data prior to publicly reporting information as well as an opportunity to request review of their data by CMS during the preview period if they believe that errors in data submitted to CMS may have resulted in incorrect measure scores and can submit proof along with a plan describing how the errors will be corrected.</p>

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47	Data Submission and Reporting	There is a HIS Q&A that states if a patient is being discharged due to a missed FTF and there is no break/gap in care with Start of Care (SOC) being the next day, then the Discharge HIS and new SOC HIS are not required. Will it have a negative impact of any sort if those two HIS records do get submitted? The Q&A only references missed FTF, but would this apply for any of “technical” D/Cs/new SOC as well?	You should submit records in accordance with submission sequence policies. As long as there is no interruption in care, submission of an HIS-Discharge and subsequent HIS-Admission is not required (e.g., change in payor sources). If you determine that an HIS-Discharge and HIS-Admission should be submitted, from the quality measure perspective, the HIS-Discharge concludes the previous stay and the HIS-Admission starts a new stay. Each stay, if it meets a quality measure’s denominator criteria, would also need to meet the numerator criteria in order for your hospice to get credit for the quality measure.
48	Data Submission and Reporting	Why does the end user not have the option to enter a date range when requesting the Timeliness Report out of CASPER? Is this report data/calculations from 7/1/14 or from 1/1 of the current year, etc.?	The Hospice Timeliness Compliance Threshold Report summarizes the number and percentage of HIS records submitted within the 30-day submission deadline for the APU determination. The selection options for this report allow for the report to be calculated for the reporting period of fiscal year (FY) only. For FY 2018, the report will include all new HIS records (A0050=1) that have been submitted and accepted by the QIES ASAP system with a target date during the reporting period. For the FY 2018 APU year, the reporting period is January 1, 2016, through December 31, 2016. Note that for each reporting period (FY), the report will include data from the beginning of that FY (January 1) through the date on which the provider runs the report, but will include submissions that occur no later than December 31 of that year. Information on the details of the Hospice Timeliness Compliance Threshold Report can be found in the CASPER Reporting Provider User’s Guide, Chapter 3 – Hospice Provider Reports at <a href="https://www.qtso.com/download/Guides/hospice/cspr_sec3_hospc_prvdr.pdf">https://www.qtso.com/download/Guides/hospice/cspr_sec3_hospc_prvdr.pdf</a> and in the Information on the Timeliness Compliance Threshold for HIS Submissions: Fact Sheet Updated: August 2016 at <a href="https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Downloads/Timeliness-Compliance-Threshold-Fact-Sheet_Update_August-2016_FINAL.pdf">https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Downloads/Timeliness-Compliance-Threshold-Fact-Sheet_Update_August-2016_FINAL.pdf</a> .
49	Data Submission and Reporting	Which specialty services will be listed and/or available for consumers to search on the Hospice Compare website?	CMS is currently working with its contractors on the design of Hospice Compare website. CMS will consider the feasibility of including this type of information on the Hospice Compare website.
50	Data Submission and Reporting	Will State rates be publicly reported on the Hospice Compare website?	At this time, State rates will not be publicly reported on the Hospice Compare website.

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51	Data Submission and Reporting	Please explain the HIS submission guideline for a provider obtaining a CCN before November 1. Should a licensed hospice collect HIS data for all patients served prior to obtaining the CCN and submit those data after the CCN is awarded?	Hospice providers are responsible to submit HIS data for patient admissions occurring on or after the date that is noted on the letterhead of the CCN notification letter.
52	Data Submission and Reporting	The team stated that HIS will be available to the public sometime this summer. But how far back will the data start being collected? In other words, what date will the data begin to be collected from?	The HIS data to be publically reported this summer will include HIS-admission and discharge records for patient stays discharged from Quarter 4 of 2015 through Quarter 3 of 2016.
53	Data Submission and Reporting	What is the data selection period that will be used when public reporting is made available this summer? Since the measure reporting was only recently made available to us, we would like the opportunity to correct any deficiencies in our processes used in completing the HIS forms prior to public reporting of the data.	The HIS data selection period to be publicly reported this summer will include data for patient stays discharged from Quarter 4 of 2015 through Quarter 3 of 2016. A preview report will be made available in the CASPER system prior to public reporting and will offer providers the opportunity to review their quality measure data prior to public reporting.
54	Data Submission and Reporting	What will be the initial data selection period that is publicly reported? Will the initial public reporting contain data prior to the recent 2016 release of the CASPER Hospice-Level Quality Measure Report?	<p>The HIS data selection period to be publicly reported this summer will include data for patient stays discharged from Quarter 4 of 2015 through Quarter 3 of 2016. The recently released CASPER Hospice-Level Quality Measure Report is run on demand and thus enables hospice providers to view and compare their performance to a national comparison group at any time and for a reporting period of their choice. As noted, the provider selects the reporting period displayed on the CASPER QM Reports. HIS data from as far back as July 1, 2014, can be reviewed by running the CASPER QM Reports.</p> <p>Please refer to the <i>Getting Started with Hospice CASPER Quality Measure Reports: December 2016</i> fact sheet, which can be found in the Downloads section of the HQRP Requirements and Best Practices page: <a href="https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/HQRP-Requirements-and-Best-Practices.html">https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/HQRP-Requirements-and-Best-Practices.html</a>. Note that there is a 6-week lag in the data that the QM reports can be run on. For example, if you are interested in the scores based on data up to HIS records with a target date of today, you will have to wait until 6 weeks from today to run the reports. The purpose of this lag is to ensure that the quality measure scores in the report consider complete HIS data.</p>

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#	Question Category	Question	Answer
55	Data Submission and Reporting	What date range will the initial reporting period cover for publically reported data?	The HIS data selection period to be publicly reported this summer will include data for patient stays discharged from Quarter 4 of 2015 through Quarter 3 of 2016.
56	Data Submission and Reporting	What will the data selection period and the target periods be for the HIS 7 Measure Public Reporting that we can expect to begin late summer 2017?	The HIS data selection period to be publicly reported this summer will include data for patient stays discharged from Quarter 4 of 2015 through Quarter 3 of 2016.
57	Data Submission and Reporting	What are the timeframes for HIS and CAHPS data that have been collected and that will be publicly reported this summer? (e.g., April 1, 2015, through March 31, 2016)	Hospice Compare is expected to launch in summer 2017. The HIS data selection period to be publicly reported this summer will include data for patient stays discharged from Quarter 4 of 2015 through Quarter 3 of 2016. CAHPS Hospice Survey scores will be reported for patients who died while receiving hospice care from Quarter 2 of 2015 through Quarter 3 of 2016 (April 2015 through September 2016). Please continue to check the “Hospice Quality Reporting Spotlight & Announcements” web page ( <a href="https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Spotlight.html">https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Spotlight.html</a> ) and “Hospice Quality Public Reporting” web page ( <a href="https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Hospice-Quality-Public-Reporting.html">https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Hospice-Quality-Public-Reporting.html</a> ) for future updates, including specific dates related to the launch of the Hospice Compare website. The “Hospice Quality Public Reporting” web page noted above is not expected to be live until the summer 2017.
58	General	My understanding of the CAHPS and Conditions of Participation regulations is that an RN may perform dietary assessment and education. If the education is outside the scope of what the RN can provide, then the Agency needs to have a registered dietician (RD) provide the assessment/teaching. The Agency does not have to have a RD employed or contracted. Is this correct?	The email helpdesk you have contacted is made available specifically to support the educational needs of hospice providers and stakeholders related to Hospice Quality Measures, HIS completion, and policy issues related to the Hospice Quality Reporting Program. In order to ensure that this focused need can be maintained, questions outside of the described scope cannot be addressed through this helpdesk. Please contact your MAC to determine assistance with compliance and billing: <a href="http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/">http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/</a> . Another helpful resource might be: the Internet Only Manuals, which provide clear direction on Medicare Benefits (Manual 100-02) and Claims Processing (100-04): <a href="http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html">http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html</a> .

#	Question Category	Question	Answer
59	General	Hospice Agency – Data.Medicare.gov. Who do I contact if one of our providers is not listed?	If the information on the Hospice Data Directory is incorrect, contact the Regional Office (RO) or State coordinator listed for your area. The RO and State coordinator list can be found at <a href="https://data.medicare.gov/Hospice-Data-Directory/Hospice-CASPER-ASPEN-Contacts/qx7x-wipa">https://data.medicare.gov/Hospice-Data-Directory/Hospice-CASPER-ASPEN-Contacts/qx7x-wipa</a> . Note that the Hospice Agency data file is updated quarterly, so your update may not appear on data.medicare.gov until the next scheduled refresh.
60	General	One of the speakers stated, “so we had to revoke her.” I thought revocation was patient/family choice and not an action taken by the hospice.	The email helpdesk you have contacted is made available specifically to support the educational needs of hospice providers and stakeholders related to Hospice Quality Measures, HIS completion, and policy issues related to the Hospice Quality Reporting Program. In order to ensure that this focused need can be maintained, questions outside of the described scope cannot be addressed through this help desk. Please contact your MAC to determine assistance with compliance and billing. <a href="http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/">http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/</a> . Another helpful resource might be the Internet Only Manuals, which provide clear direction on Medicare Benefits (Manual 100-02) and Claims Processing (100-04): <a href="http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html">http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html</a> .
61	General	What is the appropriate response if we have a non-funded patient who is admitted under the hospice charity program?	Response K – No Payor Source should be selected if the patient does not have any of the payor sources in A1400 responses A-I available nor do they have any personal funds available (response J, Self Pay) to contribute to healthcare expenses during the hospice episode of care, and the hospice does not anticipate receiving funding from any source for the care provided. This would include a charity patient for whom the hospice will not receive any charity funds.  Response Y – Other should be selected if the patient has available one or more payor sources (including a funded charity program) that are not listed in response options A1400 A-K to contribute to healthcare expenses during the hospice episode of care.
62	General	Just a clarification...On slide 8, you talked about marking all current pay sources. You stated if the patient had a Medicare Advantage plan, that you would mark that. Would you also mark straight Medicare in that instance since the Medicare Advantage plan would be waived and straight Medicare pays?	The item asks that you check all that apply. In the scenario provided, Medicare and Medicare Advantage would be checked.

#	Question Category	Question	Answer
63	General	To clarify, even if the patient has insurance coverage and there is no need for them to use any personal funds for services, we still need to ask them if they do have personal funds so that we can submit this info on the HIS? This seems like it would be a strange question to ask patients/families if there is no need for them to use these personal funds and we are purely asking for informational purposes.	A1400 Payor Information is intended to identify all pay sources that the patient has, regardless of whether or not the pay source is likely to provide reimbursement for any services, supplies, medications, etc., that the patient may receive during the hospice episode of care. The existence of a pay source can be based on patient/caregiver report. For additional guidance, see the HIS Manual V2.00 page 2A-14.
64	General	If the patient has a Medicare Advantage Plan and when they chose hospice benefit it reverts back to original Medicare, would you choose box A Medicare (traditional fee-for-service) only, or would you choose Box A Medicare (traditional fee-for-service) and B Medicare (managed care/Part C/Medicare Advantage)?	Both would be selected.
65	General	When a patient elects the Medicare Hospice Benefit that had a Medicare Advantage Plan prior to election, my understanding is that the patient converts to traditional Medicare. Why should we in that case select as payer sources both traditional Medicare and Medicare Advantage Plan?	A1400 is collecting all payor sources, regardless of whether or not they are paying for the patient's hospice care.
66	General	Will we be receiving the slides for references? I am attending via webcast.	They are currently available on the CMS Hospice QRP Training page without answers. The presentations with answers and the video recordings of the presentations will be posted following the training.
67	General	Please consider changing the format of the FAQs, as it makes it difficult to search; for example, Joint Commission sorts the information based on standard chapter, so I could see a similar set up for sections of the HIS: Administrative, Pain, etc.	Thank you for your feedback. We will take this into consideration.
68	General	When will the new Discharge Set results be publicized?	There is no date set for reporting the Hospice Visits when Death is Imminent measure pair.

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#	Question Category	Question	Answer
69	General	When is the anticipated date that CMS will implement a complete patient assessment document for the HIS similar to the Home Care OASIS assessment?	CMS has discussed the development of a patient assessment tool for hospice in the FY 2017 final rule (Section 7f. New Data Collection Mechanisms Under Consideration). As noted in the FY 2017 rule, CMS has not yet proposed such a tool, and thus there is no implementation date. CMS will provide updates about the development of a patient assessment tool in future rulemaking cycles.
70	General	Where do you find the Case Study for downloading?	Training materials without answers, including the case study, are currently available on the CMS Hospice QRP Training page at the following URL: <a href="https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Hospice-Quality-Reporting-Training.html">https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Hospice-Quality-Reporting-Training.html</a> . The presentations with answers and the video recordings of the presentations will be posted following the training.
71	General	Cannot find the case study. Watching online.	Training materials without answers, including the case study, are currently available on the CMS Hospice QRP Training page at the following URL: <a href="https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Hospice-Quality-Reporting-Training.html">https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Hospice-Quality-Reporting-Training.html</a> . The presentations with answers and the video recordings of the presentations will be posted following the training.
72	General	Will the slides with the answers to the case scenarios be added to the online training material ZIP files? This can be very helpful for hospices to use to educate staff.	Training materials without answers, including the case study, are currently available on the CMS Hospice QRP Training page at the following URL: <a href="https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Hospice-Quality-Reporting-Training.html">https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Hospice-Quality-Reporting-Training.html</a> . The presentations with answers and the video recordings of the presentations will be posted following the training.
73	General	Will the presentation be sent out to viewers? I would like a copy.	They are currently available on the CMS Hospice QRP Training page without answers. The presentations with answers and the video recordings of the presentations will be posted following the training.
74	General	Do you have training for clinicians in the field vs. reviewers? If not, can you recommend a good source?	The training materials without answers from this training are currently posted on the CMS website. Recordings of the training and presentations with answers will be posted following the training.
75	General	Where is the document for the current presentation on the new HIS measures in the HIS discharge? I can't find it in the list of 10+ PDFs that are linked here?	Training materials without answers, including the case study, are currently available on the CMS Hospice QRP Training page at the following URL: <a href="https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Hospice-Quality-Reporting-Training.html">https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Hospice-Quality-Reporting-Training.html</a> . The presentations with answers and the video recordings of the presentations will be posted following the training.

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#	Question Category	Question	Answer
76	General	When will the final threshold report for 2016 be available?	CMS will make the final Hospice Timeliness Compliance determination that will be used for the APU determination for FY 2018 based on HIS records with a target date from January 1, 2016, through December 31, 2016. The timeline of the final determination is still being decided. Updates will be communicated to providers via the usual HQRP communication channels, including Open Door Forums, webinars, listening sessions, memos, email notifications, and web postings.
77	General	How does CMS ensure standardization of data across hospices?	As noted in the FY 2017 Final Rule, CMS acknowledges that validity of self-reported HIS measures is of the utmost importance. Publicly reported quality measure data rely on the submission of valid and reliable data at the patient level. Our measure development contractor conducts ongoing testing and validation of the quality measure data to identify data irregularities and trends. We will consider additional validation processes for future rulemaking cycles.
78	QM	Can you give more details on how the “conditional measures” of pain assessment and bowel regimen are used in the composite measure?	Three of the seven component measures are “conditional measures” (NQF #1617, NQF #1637, NQF #1638). A conditional measure is one where only a subset of patients are included in the measure denominator, so the measure is “conditional” or dependent on some other factor. The conditional measures get special treatment in the composite measure. In the individual measure, patients are left out of the measure entirely (excluded from the denominator) if they do not meet the “condition.” In the composite measure, patients who are not eligible for one of the conditional measures are treated as if they were, and the hospice “gets credit” for completing that care process any way.
79	QM	Who is responsible for calculating the percentages for the new quality measures?	Once hospices start to submit HIS data for the Hospice and Palliative Care Composite Process Measure – Comprehensive Assessment at Admission measure and Hospice Visits When Death is Imminent Measure Pair, CMS will work with its contractors to start data analysis to establish the reliability and validity of the measures. This analysis will determine the timeline to add these measures into the CASPER Quality Measures (QM) report and the future Hospice Compare website. Once the timeline is determined, CMS will work with its contractors to create these reports.
80	QM	What is the timeframe for the composite measure: monthly, quarterly, calendar year?	The composite measure will be added to public reporting in the future. CMS will provide details via the hospice quality reporting website in the future.
81	QM	Will the composite score affect reimbursement or an overall rating at some point?	The HQRP is currently based on meeting reporting requirements rather than performance on quality measures.

#	Question Category	Question	Answer
82	QM	Slide 17, Bullet 3 says Admissions occurring on or after April 1 will be included in measure calculation? If this measure is effective April 1, how can it be included in public reporting this summer?	<p>The quality measures to be included in public reporting in summer 2017 are as listed below:</p> <ul style="list-style-type: none"> <li>• Patient Treated with an Opioid who are Given a Bowel Regimen (NQF #1617)</li> <li>• Pain Screening (NQF #1634)</li> <li>• Pain Assessment (NQF #1637)</li> <li>• Dyspnea Treatment (NQF #1638)</li> <li>• Dyspnea Screening (NQF #1639)</li> <li>• Treatment Preferences (NQF #1641)</li> <li>• Beliefs/Values Addressed (If Desired by the Patient) (NQF #1647)</li> </ul> <p>The timeline for public reporting of the two new measures (Hospice and Palliative Care Composite Process Measure – Comprehensive Assessment at Admission measure and Hospice Visits When Death is Imminent Measure Pair) is TBD. Future updates to the Compare website will be announced via the HQRP Spotlight and Announcements page, MLN Listserv announcements, Open Door Forums, etc.</p>
83	QM	Scores will be reported as with an example being 8 out of 10 patients met composite scoring: Score is 8 out of 10. Score is 80 percent compliant. Score is 20 percent non-compliant.	<p>Measure specifications for the composite measure are still draft; CMS will finalize the specifications and communicate the final specifications on the CMS HQRP website. You can view current draft specifications for the measure here: <a href="https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Current-Measures.html">https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Current-Measures.html</a> (see HQRP Specifications for HIS-based measures download). In general, your example is correct. If 10 patients were eligible for the denominator and 8 met the numerator criteria, then your score would be 80 percent.</p>
84	QM	When calculating the quality measure for Patients treated with an Opioid who are Given a Bowel Regimen (NQF #1617), is the measure only looking at scheduled opioids or both scheduled and prn opioids and initiation/continuation of bowel regimen unless contraindicated? Slide #112 only references scheduled opioids being initiated or continued. So while we collect data on both scheduled and PRN opioids, only patients on scheduled opioids are counted in the measure, correct?	<p>That is correct. NQF #1617 includes only patients on scheduled opioids.</p>

#	Question Category	Question	Answer
85	QM	Please clarify the 1-day length-of-stay exclusion for Measure 2 of the Hospice Visits when Death is Imminent Measure Pain.	The 1-day length-of-stay exclusion for Measure 2 of the Hospice Visits when Death is Imminent Measure Pair is based on the number of days within a stay, that is, from a patient's stay start date through stay end date. When counting the number of days, include the stay start date but not the stay end date, unless the start and end of the stay occurred on the same day; in that case, the number of days in the stay is equal to 1. In other words, a patient with date of death the same day as admission would have a length of stay equal to 1, and a patient with a date of death the day after admission would also be considered to have a length of stay equal to 1 under this definition. You can view the draft specifications for the Hospice Visits when Death is Imminent Measure Pair on the CMS HQRP website here: <a href="https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Current-Measures.html">https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Current-Measures.html</a> .
86	QM	Are patients under 18 years of age excluded from the denominator in the Hospice Visits when Death is Imminent Measure Pair?	No, patients under 18 years of age are not excluded from the denominator in the Hospice Visits when Death is Imminent Measure Pair. There is no age-based exclusion for the Hospice Visits when Death is Imminent Measure Pair.
87	QM	"When death is imminent" deaths on hospice do sometimes happen "unexpectedly" or sooner than we thought; how is that going to be mentioned?	We recognize that rapid and unanticipated patient declines do occur; thus, a score of 100 percent is not the expectation for this measure pair. We do expect that hospices delivering high-quality care will be responsive to the patient and caregiver needs that arise during the last days of a patient's life.
88	Section A	If the patient starts hospice services in one ZIP Code but moves to another during hospice services, does this need to be captured here (e.g., the patient is moved from home to nursing home in another town several weeks or more after admission)?	The ZIP Code is collected on the HIS Admission assessment. If a patient's site of care changes, the hospice may update its internal demographic information to facilitate ongoing care, but there is no need to update or correct the ZIP Code reported on the HIS.

#	Question Category	Question	Answer
89	Section A	The admission date is considered when the patient elects. Please clarify when a patient is considered admitted to the hospice for purposes of completing the HIS.	<p>For the purposes of completing the HIS, a patient is considered admitted to a hospice if the following conditions are met:</p> <ol style="list-style-type: none"> <li>1. There is a signed election statement (or other agreement for care for non-Medicare patients).</li> <li>2. The patient did not expire before the effective day of the election or agreement for care.</li> <li>3. The hospice made a visit in the setting where hospice services are to be initiated.</li> </ol> <p>All three criteria listed above must be met for the patient to be considered admitted to a hospice for the purposes of HIS reporting. In the above question, if no visit to provide hospice services was made, then all three criteria were not met, and an HIS-Admission record would not be completed or submitted. The hospice visit described in criteria #3 may be made by any hospice staff member who provides a clinical service.</p>
90	Section A	Is a patient admitted if he/she dies during the first visit made by the RN?	The patient is considered admitted if the hospice makes a visit in the location where services are to be provided, even if the entire visit or assessment is not completed.
91	Section A	Since there is not a response in A2115 for discharging a patient when a face-to-face is not timely met and that is our current process, and our software vendor requires us to discharge and re-admit, what response should be select in A2115?	A hospice is expected to continue to provide services to a patient in situations where a hospice fails to meet the face-to-face requirement timely. While the hospice must administratively discharge the patient, no HIS assessment would be conducted. As long as the patient remains under the care of the hospice with no interruption in hospice services, completion of a Discharge HIS assessment would not be required, and therefore A2115 would not be completed until the patient was discharged for one of the six reasons listed in the A2115 item responses.
92	Section A	ZIP Code—You mentioned starting GIP (general inpatient care) and then going home and using the home address. A patient is supposed to elect their benefit in the setting in which they are to receive care. Therefore, if they received GIP level of care and elected their benefit in a hospital setting, for example, and then went home, I am struggling with when you expect a hospice to change to the home ZIP Code—is there a day limit? I think you will need to be more specific.	The assessment needs to take place in the location where hospice services are being delivered. In a situation where a patient is residing and initially receiving hospice services in a facility other than their home, enter the ZIP Code of the address where the first hospice service is being provided, even if there are plans for the patient to receive hospice services at home at a future point (HIS V2.00 page 2A-7). An initial encounter (an informational visit) provided prior to the effective date would not be considered a hospice service visit for the purpose of this discussion.
93	Section F	If the patient is currently hospitalized, what is the correct response for the hospitalization section?	The fact that the patient is in the hospital does not indicate his/her preferences regarding hospitalization. Patient preferences regarding hospitalization should be discussed regardless regarding of the patient's location.

#	Question Category	Question	Answer
94	Section F	What was the inter-rator reliability in testing for Section F?	You can find results of HIS analyses on the CMS HQRP web page here: <a href="https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Current-Measures.html">https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Current-Measures.html</a> . All NQF-endorsed measures are tested in accordance with NQF standards, which include reliability analyses. For more information on NQF requirements for measure testing, see <a href="https://www.qualityforum.org/Measuring_Performance/Submitting_Standards.aspx">https://www.qualityforum.org/Measuring_Performance/Submitting_Standards.aspx</a> . NQF accepts several types of reliability testing. All HIS V1.00.0 items have been analyzed for stability analysis, split-half analysis, and signal-to-noise ratio analysis (all of which are reliability analyses), but items (including those in Section F) have not been analyzed for inter-rater reliability.
95	Section F	If a liaison saw a patient and asked them questions regarding their preferences for CPR or hospitalization in Section F, and 3 days later the admission nurse asked those same questions, can we use the date of the admission nurse since she is filling out the HIS on admission and opening the discussion also?	The first date of discussion that appears in the clinical record should be reflected on the HIS.
96	Section F	As I understand it, HIS components addressing treatment initiation includes both an initiation of a treatment and education to the patient/caregiver in order to be considered compliant with the measure. For patients who are residents of nursing facilities, who is included as the caregiver (family vs. nursing home staff) for education and thus compliance with the measure?	Initiation of treatment is considered to have occurred when an order was received to initiate or continue a treatment, with the following exceptions: comfort kits, preprinted admission orders, or for non-medication interventions. In the case of comfort kits, preprinted admission orders, initiation of treatment is considered to have occurred when the hospice has received an order AND there is documentation that the patient/caregiver was instructed to begin use of the medication or treatment for the relevant symptom. In the case of non-medication interventions (e.g., fans, positioning), initiation of treatment is considered to have occurred on the date the hospice first discussed the intervention with the patient/caregiver (HIS V2.00 page 2J-16).  For hospice patients who are residing in nursing facilities, “caregiver” may be defined as anyone (nursing home staff and/or family) who is able to facilitate in getting the treatment started. For instance, the hospice may request that the facility provide a fan for the patient’s use. This first discussion is considered the date of treatment initiation. The hospice may instruct the patient or a family member on positioning to minimize pain. This first discussion would be considered the date of treatment initiation.

#	Question Category	Question	Answer
97	Section F	I understand that if a patient dies before assessment of the Beliefs/Values HIS question that the “0” answer must be chosen. Is there any thought that an additional answer selection of “Death Before Assessment” might be added? I’m asking because most of our nurses defer that question to our chaplains who of course have 5 days to do their assessment. Thank you.	Thank you for the suggestion. We would like to clarify that CMS does not require a chaplain to begin the discussion regarding beliefs and values, and the HIS item should reflect any team member who initiates that discussion.
98	Section F	Regarding spiritual/existential concerns for long-term care residents, when family/friends are not available for discussion at the time of the assessment, is it acceptable to ask facility staff if they know of any spiritual/existential concerns for residents who are unable to express their concerns themselves?	The intent of F3000 and the corresponding NQF #1647 measure is to open the door for a conversation about spiritual and/or existential concerns. As stated on Page 2F-14 of the HIS Manual, for Item F3000, “caregiver” does not have to be the legally authorized representative. In instances where the patient is unable to self-report, you should speak with the party most knowledgeable about the patient’s potential spiritual/existential concerns. While it is recommended that the hospice attempt to reach out to the patient’s family caregiver, in instances where the patient lives in a nursing facility, you may consider facility staff as caregivers for Item F3000. You can view the most recent version of the HIS Manual on the CMS HQRP website here: <a href="https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Hospice-Item-Set-HIS.html">https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Hospice-Item-Set-HIS.html</a> .
99	Section F	Did I understand correctly that asking if the patient wishes a visit from a spiritual care person is sufficient to answer yes, it was discussed?	As stated on Page 2F-14 of the HIS Manual, there is no comprehensive list of spiritual or existential concerns. Discussion of spiritual or existential concerns may include asking the patient/caregiver about need for spiritual or religious support, or offering a spiritual resource. You can view the most recent version of the HIS Manual on the CMS HQRP website here: <a href="https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Hospice-Item-Set-HIS.html">https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Hospice-Item-Set-HIS.html</a> .
100	Section F	Patients often arrive to the In-Patient Unit (IPU) unresponsive and without a Durable Power of Attorney (DPOA) or other representative, so the admission RN is unable to ask the preferences questions. Then the patient dies before anyone comes to the IPU to answer the questions. Is this counted against us for not asking?	The length of stay exclusion has been removed from the “original” seven HIS measures that were implemented for FY 2016 APU and beyond. Thus, patients who die prior to delivery of care processes are included in the denominator for all of the quality measures; if you respond “no” for the numerator questions, you would not receive credit for the measure.

#	Question Category	Question	Answer
101	Section J	On the breathing screen, if the answer to dyspnea is zero, but patient is on 2 liters of oxygen continuously, we know that they are not short of breath because they are currently at time of visit on oxygen. Do we answer yes, they are short of breath, because they are needing continuous oxygen, or no, because the oxygen is keeping them from exhibiting shortness of breath? Not sure how to answer it.	The scenario describes a patient who has an active problem of shortness of breath that, based on the description, is well managed. This scenario represents an example of a patient receiving treatment for an active problem of shortness of breath.
102	Section J	Can you go into more detail regarding rating the severity of shortness of breath, what type of tools must be used, what type of rating, etc.? The example given in the first case study was not helpful because in that case the patient screened negative for shortness of breath.	<p>As noted on Page 2J-12 of the HIS Manual, 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.</p> <ul style="list-style-type: none"> <li>• 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).</li> <li>• If documentation indicates the patient had shortness of breath, but severity was not evaluated in any manner, answer “no” to J2030A.</li> </ul> <p>You can view the most recent version of the HIS Manual on the CMS HQRP web page here: <a href="https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Hospice-Item-Set-HIS.html">https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Hospice-Item-Set-HIS.html</a>.</p>

#	Question Category	Question	Answer
103	Section J	In answering J2030C, screening for shortness of breath, we are to consider whether shortness of breath is an active problem, and the severity must be rated in any manner clinically appropriate. If a patient is admitted who is unresponsive and has active respiratory treatment secondary to a respiratory disease process and, during admission assessment does not have shortness of breath and the severity of past shortness of breath cannot be determined by caregiver or medical record content, do we answer no, even though it is evident that shortness of breath is an active problem by the HIS manual definition?	The scenario describes a patient who has an active problem of shortness of breath that, based on the description, is well managed. This scenario represents an example of a patient receiving treatment for an active problem of shortness of breath.
104	Section J	When answering if a patient screened positive for shortness of breath, is it still based on whether it is determined that a patient has shortness of breath as an active problem (i.e., not shortness of breath during visit but experiences it with going up the stairs) vs. screening positive only if experiencing shortness of breath during the assessment?	As noted on page 2J-12 of the HIS Manual, you should make the determination about whether the patient screened positive for shortness of breath based on whether shortness of breath is an active problem for the patient. Thus, it is possible for the clinician to determine shortness of breath is an active problem even if the patient does not experience shortness of breath during the assessment visit. You can view the most recent version of the HIS Manual on the CMS HQRP web page here: <a href="https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Hospice-Item-Set-HIS.html">https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Hospice-Item-Set-HIS.html</a> .
105	Section J	Should dyspnea be treated the same as pain in that if there is active dyspnea treatment in place, should we answer yes to dyspnea as a current problem? If dyspnea treatment is only pro re nata (PRN), should we answer yes to dyspnea as an active problem?	In general, documentation that the patient is currently on treatment for shortness of breath is sufficient evidence that shortness of breath is an active problem for the patient. Note however, that for treatments that have multiple uses (e.g., opioids can be used for pain or shortness of breath), you should see evidence that the intended purpose of the treatment is specifically for shortness of breath to consider it a treatment for shortness of breath and thus to consider shortness of breath to be an active problem.
106	Section J	Section J: How is dementia managed or adjusted for IF J0910 got answered by a responsible caregiver. Is there a risk adjusting methodology? If yes, when will it be published? Thank you.	Currently, the quality measure is not risk adjusted.

#	Question Category	Question	Answer
107	Section J	What are the criteria for excluding a record from the numerators for Pain Severity and Pain Assessment?	You can view the inclusion criteria for the numerator for both of the pain measures in the QM User's Manual: <a href="https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Current-Measures.html">https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Current-Measures.html</a> . In general, to meet the numerator criteria for the pain screening measure, the patient must be screened for pain within 2 days of the admission date and report that they had no pain OR the patient must be screened for pain within 2 days of the admission date; the patient's pain severity must be rated mild, moderate, or severe; and a standardized pain tool must be used to rate severity. For the pain assessment measure, a comprehensive pain assessment measure must be completed within 1 day of the positive pain screening, and the pain assessment must include at least five of the following characteristics: location, severity, character, duration, frequency, what relieves or worsens the pain, and the effect on function or quality of life.
108	Section J	With a patient who is unresponsive and is showing a mild form of pain (grimacing, furrow brow) but becomes comfortable in appearance with body repositioning and comfort medications (morphine for dyspnea/pain), would you answer YES to active problem? Thank you!	Yes.
109	Section J	For clarification, if a clinician answers "Yes" to the new J0905, is the expectation that they will then complete the Comprehensive Pain Assessment? If they answer "No," they will not be expected to complete the Comprehensive Pain Assessment? And does this eliminate the previous Pain Severity Screening "Skip Pattern"?	If the clinician answers 1, Yes to J0905, they will then answer J0910, Comprehensive Pain Assessment. If they answer 0, No to J0905, for the purposes of completing the HIS, they will skip J0910. The pain active problem skip pattern replaces the prior pain screening skip pattern.

#	Question Category	Question	Answer
110	Section J	To clarify, if a patient denies pain at the time of the visit but further assessment shows that the patient is on an opioid for pain and has had pain in the last 2 days, we would be expected to complete a comprehensive pain assessment for that patient. So when answering the HIS, J0900 would be None for severity, but J0905 would be Yes, therefore requiring a comprehensive pain assessment to be completed. Since J0905 is not used in the measure calculations, will a patient who does not have pain at time of assessment but has pain as an active problem requiring a comprehensive pain assessment, will they be counted in the NQF #1637 pain assessment?	Currently, patients who do not have pain at the time of the screening (J0900C=0, none) but for whom pain is an active problem are not included in the NQF #1637 measure. CMS will analyze HIS V2.00.0 data and will use analyses to make updates to measure specifications in the future.
111	Section J	Can you review how a Pain Assessment in Advanced Dementia (PAINAD) tool would be answered here?	J0910 should be answered based on the signs and symptoms observed by the clinician or reported by the patient/caregiver.
112	Section J	Consider the following scenario. The patient is unresponsive, we use a PAINAD scale to answer the pain screening, and the patient does not have pain during the assessment. The PAINAD scale requires observing and moving the patient to determine pain. They do not demonstrate pain currently, but the answer to J0905 is yes, pain is an active problem. How then do we complete the comprehensive assessment when it is based on observation and we do not observe any indications of pain during the first screening?	It is possible that the assessing clinician may determine that pain is an active problem for the patient, even if pain is not present during the clinical encounter. This would be based on patient-specific findings beyond pain severity at the time of the clinical encounter, such as historical report of pain, reports of recent symptoms, and current treatment for pain (pharmacologic and/or non-pharmacologic) (HIS Manual V2.00 page 2J-6).  In such situations, a comprehensive pain assessment could still be completed by the clinician by interviewing the patient or caregiver regarding characteristics of recent pain episodes, including the pain location, character, duration, frequency, what relieved/worsened, and effect on function or quality of life. The comprehensive pain assessment may be conducted using clinician observation, but may also be completed using patient or caregiver report.
113	Section J	Duration-related to med half-life/breakthrough pain.	Assessment of pain duration is not equivalent to duration of pain medication effect.
114	Section J	In the case study, pain assessment items were less than five out of seven; does this mean a fallout for comprehensive pain assessment?	If fewer than five of the seven characteristics of pain are assessed, the patient does not meet the numerator criteria for the pain measure.

#	Question Category	Question	Answer
115	Section J	If you check the box to indicate “pain is an active problem,” but the pain level is currently “0,” do you then need to choose an assessment type and fill out what was included in the comprehensive pain assessment?	If you mark pain as an active problem when answering the HIS, you move on to the comprehensive pain assessment item.
116	Section J	Regarding the pain assessment, does a reference to how long the patient has been experiencing that pain (days, weeks, months), instead of how long does the pain episode last (minutes, hours), qualify to report that duration was assessed? For example, as a reviewer, can I report that duration was assessed if there is a statement like “patient has been experiencing this type of pain on and off for weeks”?	Duration captures how long a patient has experienced pain. This could include the timeframe that the patient has experienced a particular episode of pain (e.g., lasting hours or minutes) or pain they have experienced over a longer period of time (e.g., beginning with a specific event such as a surgical procedure).
117	Section J	If J0905 is not included in the quality measures, will J0910 be included if it is only triggered by J0905?	The current denominator inclusion criteria for NQF 1637 is tied to responses to J0900C, pain severity. Responses to J0905, Pain active problem do not impact the denominator at this time.
118	Section J	If you answer yes to J0900A, enter date for J0900B, and enter 0, None for J0900C, do you need to enter anything in J0900D?	As noted on the HIS, there is no skip pattern for J0900D based on how you respond to J0900C, so if you respond none to J0900C, you still need to complete J0900D.
119	Section J	On a pain assessment on a verbal or nonverbal patient, can you measure duration of pain as you medicate a patient for pain and 1 hour later the patient has no signs or symptoms of pain or says his pain is 0? Can you measure frequency of pain on a nonverbal patient by how often the patient had pain symptoms in that first 24-hour period from the pain screen?	With regard to completing J0910 Comprehensive Pain Assessment, “duration” refers to how long a patient has experienced pain, or how long a nonverbal patient exhibited any nonverbal cues of pain. Duration could include the timeframe that the patient has experienced a particular episode of pain (e.g., lasting hours or minutes) or duration could represent the complete timeframe that a particular pain has existed (e.g., hip pain has been present since a fall, or radiating leg pain began after a surgical procedure).  “Frequency” refers to how often a patient experienced pain or how often a nonverbal patient exhibited any nonverbal cues of pain. Pain frequency could be described in terms such as pain being present “most of the time,” “only at night,” or “intermittently.”

#	Question Category	Question	Answer
120	Section J	In the case scenario for Section J Pain, I am still confused as to how this was answered. J0910A the answer was “yes” a comprehensive assessment was done but only four qualifiers were answered, so should the answer be “no” to a comprehensive assessment?	You respond to J0910A irrespective of whether or not five of the seven elements in J0910C were completed. If you checked off at least one element in J0910C, you should respond “yes” to J0910A. Note that for the purposes of the quality measure, you must complete 5/7 of the elements in J0910C to receive credit for the measure.
121	Section J	In order to receive a complete “patient was assessed for pain” in the composite score area, did I see a slide that said there must also be a pain tool used? I know this sounds silly, but sometimes an RN in the past said “no tool used” d/t patient unresponsiveness... we have done teaching regarding this answer but I was just curious for this composite measure. Thank you.	The requirement for use of a standardized tool applied to the pain screening quality measure and rating the patient’s pain severity. The clinician may use a standardized tool to assist in the comprehensive pain assessment, but it is not a requirement for the measure.
122	Section J	If the patient is not ordered scheduled pain medication at time of admission but PRN pain med is ordered, do we answer “yes” to pain as an active problem.	The determination of whether or not pain is an active problem may be made by the assessing clinician based on patient-specific findings. The clinician may consider factors such as pain severity, historical report of pain, reports of recent symptoms, current treatment (including non-pharmacologic), etc. Based on the patient-specific assessment, the clinician would determine if pain is an active problem. The presence of an order for a PRN opioid alone should not be the sole determinant of whether or not pain is an active problem.

#	Question Category	Question	Answer
123	Section J	<p>I was recently put in charge of my hospice's HIS submissions, and I have done extensive research. However, if there's an article or CMS link that answers my question, please feel free to direct me and disregard addressing my question at the webinar. My question extends from a question asked at the April 2015 Quarterly Update. The question has been revised.</p> <p>Section J: Pain (Items J0900 and J0910):                      Question 1: the HIS skip pattern for a patient with no pain doesn't allow capturing comprehensive pain assessment data. How do we get credit for the comprehensive pain assessment?                      Answer 1: If J0900C is "0, none," the skip pattern would skip over Item J0910 Comprehensive Pain Assessment. This does not mean that the clinician did not or should not complete a comprehensive assessment.</p> <p>We have instructed our hospice nurses to do a comprehensive pain assessment regardless of whether the patient has pain or has no pain during the admission assessment. My concern is that if we happen to have a high number of patients without pain at admission, how will CMS know that we are doing our due diligence to assess our patients' chronic pain, as pain issues are of extreme importance to both CMS and to us? Also, given that our HIS data are used to assess our quality of care and are revealed indirectly to the public, how will this reflect to the public if we are unable to show that we perform a comprehensive pain assessment regardless if one's pain is resolved at admission or not?</p>	<p>We are aware that the skip pattern between J0900C and J0910 does not align with current clinical practice (clinicians will complete a comprehensive pain assessment even if patient does not report current pain at the time of the screening). Based on this, we have updated the HIS on V2.00.0 to include the pain active problem item (J0905). Now, you respond to J0910 based on whether or not pain is an active problem, not whether the patient has current pain at the time of the screening (J0900C). So now, even if the patient is NOT in pain at the time of the screening, but pain is an active problem for the patient, you will complete J0910A. Note that the HIS does not dictate clinical practice; thus, you should still complete care processes you deem clinically appropriate for the patient, even if the HIS skip patterns direct you to skip over an item. Currently, J0905 is not used in the calculation of the HIS pain quality measures; CMS will analyze HIS V2.00.0 data and use analysis to inform updates to the measure specifications. Finally, note that if the HIS directs you to skip the comprehensive pain assessment item, does not "count against you" in the quality measure. We recommend you view the new version of the HIS Manual available on the CMS HQRP website here: <a href="https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Hospice-Item-Set-HIS.html">https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Hospice-Item-Set-HIS.html</a>.</p>

#	Question Category	Question	Answer
124	Section J	I want to confirm that for the comprehensive pain assessment, if the clinician ATTEMPTS to gather pain assessment information on the seven indicators, then we can mark yes and take credit for the attempt, even if the patient or family is unable to answer all the questions because they do not know but the clinician asks them and attempts.	Correct. As stated in the HIS Manual on Page 2J-9, select response options for J0910C 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. You can view the latest version of the HIS Manual here: <a href="https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Hospice-Item-Set-HIS.html">https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Hospice-Item-Set-HIS.html</a> .
125	Section J	If pain screen was done at admission with no pain reported, but pain was considered an active problem, could a comprehensive pain assessment interview via phone be reported in J0910?	While patient interview regarding the presence and severity of pain CAN occur over the phone, only assessment data collected as part of an in-person visit should be considered for inclusion in pain items in Section J, including item J0910. Patient or caregiver interview by phone should not be considered the first pain assessment for the purpose of HIS data collection.
126	Section J	Regarding duration of pain, orders state physicians changed the breakthrough med to every 4–6 hours, which indicates duration of pain is every 4–6 hours.	With regard to completing J0910 Comprehensive Pain Assessment, “duration” refers to how long a patient has experienced pain or how long a nonverbal patient exhibited any nonverbal cues of pain. Duration of medication effectiveness or the prescribed dosing schedule should not be considered equivalent to assessing pain duration.
127	Section J	If we have a comfort pack ordered with each admission that includes morphine, does that mean that even if a patient denies pain (no history or previous complaints), we are to complete a comprehensive pain assessment in HIS due to having morphine available?	Having morphine available in the comfort kit alone does not indicate pain is an active problem.
128	Section J	On the example, if the comprehensive assessment had been conducted on November 18 (with screening completed on November 15), would the hospice not get credit for the comprehensive assessment?	To be included in the numerator, the comprehensive pain assessment must be completed within 1 day of a positive pain screen.
129	Section J	Do you need five of seven characteristics of pain to make it to the numerator or all 7?	Correct. You must complete 5/7 elements to receive credit for the NQF #1637 quality measure.

#	Question Category	Question	Answer
130	Section N	Is the quality measure related to N0520 reflecting that a bowel regimen was started or had documentation of why it was not started applicable for both scheduled and PRN opioids? I recently submitted a question to the CMS HQRP helpdesk, and their answer indicated that it was only related to scheduled opioids. Is this a change from HIS version 1 to HIS version 2?	Although items in Section N collect data on both PRN and scheduled opioids, the quality measure NQF #1617 includes only patients on scheduled opioids.
131	Section N	Can you please repeat, regarding N0500, N0510, if these answers are no, is that marked against the hospice that no opioids started/not get credit? Say we answer pain was present but no routine or PRN started because the patient did not want it.?	The NQF #1617 measure captures whether patients who are on opioids are given a bowel regimen. The intent of the measure is about preventing opioid-induced constipation, not about whether opioids were initiated to treat symptoms. Thus, responses to N0500 and N0510 do not impact performance on numerator criteria for the NQF #1617 measure.
132	Section N	If the patient is having regular bowel movements and they are not started on a bowel regimen, would that be a reason to answer #1?	N0520 reports if a bowel regimen was initiated or continued for the patient on a scheduled and/or PRN opioid. If documentation exists explaining why a bowel regimen was not initiated or continued, report Response 1. If a patient taking an opioid is currently having regular bowel movements, it would represent best practice to offer the patient instruction in bowel management strategies to implement as needed, should opioid-induced constipation occur at a future time. If the patient refuses the bowel treatment at the time of instruction because they are not currently experiencing constipation, Response 1 would still be the appropriate response.
133	Section N	When patients are directly admitted to our hospice care center, they are placed with a standing order for a bowel protocol. In this case, our nurses document alongside their bowel assessment that there is a standing order if needed. Would you answer 0; NO or 2; No, but there is documentation for "Was a Bowel regimen initiated or continued"? Thank you!	As stated on page 2N-6 of the HIS Manual, for comfort kits or preprinted 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. In situations where a hospice patient is admitted with preprinted admission orders (or standing orders) for a bowel protocol, select Response 0 – No if the clinical record does not indicate that the patient/caregiver was instructed to begin the bowel regimen, and no documentation is present indicating why the bowel regimen was not initiated. Select Response 1 – No, if the clinical record indicates that the patient/caregiver was not instructed to begin the bowel regimen, and documentation is present indicating why the bowel regimen was not initiated. Select Response 2 – Yes, for N0520B if the patient/caregiver was instructed to begin the bowel regimen. You can view the latest version of the HIS Manual here: <a href="https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Hospice-Item-Set-HIS.html">https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Hospice-Item-Set-HIS.html</a> .

#	Question Category	Question	Answer
134	Section O	Will non-hospice clerical visits from the community clergy count if they are documented in the chart? In many smaller counties, community clergy are very involved with families and they do not need the hospice clergy.	O5010 and O5030 are intended to capture visits provided by the hospice. Unpaid visits conducted by hospice staff can be counted in O5010 and O5030; however, visits by a community clergy member (e.g., a patient's person pastor) cannot be counted.
135	Section O	For clarification, if a volunteer who is a nurse provides nursing services in the last 3 days of life, would that be included in the nursing visits when death is imminent measure?	Hospice visits from registered nurses or licensed practical nurses are reported in items O5010 and O5030, even if those staff members provide unpaid services to patients.
136	Section O	Can you count on O5010 if you go to the home to pronounce a person	No. Post-mortem visits, including visits for the purpose of pronouncement, should not be recorded as visits in item O5010. These measures are intended to capture visits prior to death that may address the increased symptom burden many patients experience when death is imminent, and provide an opportunity for proactive assessment and communication. For this reason, visits for the purpose of pronouncement are not included.
137	Section O	For visits on the day of death, how would you mark it for a visit in which with patient was alive at the start of the visit but then died prior to the end of the visit, for an RN?	Visits on the day of death that began prior to the patient's death may be counted in item O5010.
138	Section O	If A2115="01," is a value of "0" or "1" required in O5020 (Level of care in final 7 days), and if blank will the record reject in the QIES system? The submission specifications only require a value in O5000. However, Page 20-13 of the HIS Manual indicates that O5020 should have a value of "0" when the patient was not enrolled in the 3 to 6 days prior to death. The related submission edits do not reference O5020: 'If A2115=[01], then O5000 must not be equal to [^]' and 'If O5000=[0], then all active items from O5010A1 through O5010F3 must not be equal to [^]'.	O5020 should not be left blank unless directed to do so by the skip pattern. If A2115=01 and O5000=0, then O5020 should be answered, either 0. no, or 1. yes. CMS has issued an errata to address this issue. If O5000=[0], then all active items from O5010A1 through O5020 must not be equal to [^]. Please refer to the Errata v2.00.1 for v2.00.0 of the HIS data submission specifications, available in the download section of the HIS Technical Information page of the CMS Hospice Quality Reporting website: <a href="https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/HIS-Technical-Information.html">https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/HIS-Technical-Information.html</a> .

#	Question Category	Question	Answer
139	Section O	For States where official time of death is not until RN pronouncement has occurred, there will likely always be a portion of the pronouncement visit that occurs prior to official time of death. Many EMRs split this final visit into one short visit without PM modifier and then the remainder of the visit as a separate visit with PM modifier. For purposes of the quality measure, does this first part of the visit count as a visit in final days of life?	No. Post-mortem visits, including visits for the purpose of pronouncement, should not be recorded as visits in item O5010. These measures are intended to capture visits prior to death that may address the increased symptom burden many patients experience when death is imminent, and provide an opportunity for proactive assessment and communication. For this reason, visits for the purpose of pronouncement are not included.
140	Section O	In regard to post-mortem visits, on the Medicare claim, we have to report a visit in which certain disciplines arrive before time of death (patient still alive on arrival) separately from the time starting at time of death if the patient dies during the visit. In other words, those are two different line items on the claim: one without a PM modifier and one with. How is this treated with this new visit measure? I'm assuming if the RN arrives before time of death and provides medical care and the patient dies during the visit, this would count as one RN visit on DOD. Is this correct?	That is correct. Visits that begin prior to death are counted in O5010, even if the patient dies during the visit. However, please note that visits for the purpose of pronouncement should not be recorded as visits in item O5010. This includes visits that start prior to the official time of death in States where official time of death is not until RN pronouncement has occurred. These measures are intended to capture visits prior to death that may address the increased symptom burden many patients experience when death is imminent and provide an opportunity for proactive assessment and communication. For this reason, visits for the purpose of pronouncement are not included.
141	Section O	Specific to hospice visits prior to death, what would the reporting process be for those families who are prepared for the death and choose not to have a daily visit made?	We recognize that some patients and families may choose to decline certain visits; thus, scores of 100 percent is not the expectation for this measure pair. If no visit was provided from a given discipline on a given day, simply mark a "0" (zero) in the appropriate cell of O5010 or O5030.

#	Question Category	Question	Answer
142	Section O	For patients in routine hospice care (RHC) but in a hospice residence, please clarify whether these patients are included in section O. If they are, how would you count the number of visits that the patient receives on any given day (last 3 days of life as well as last 6 days)?	<p>Yes, these patients would be included in Section O if the stay ended in death. You would answer item O5000 and O5020 with “0. No” because the patient did not receive continuous home care (CHC), GIP, or respite care during the timeframe. You would complete items O5010 and O5030 with the number of visits from each discipline on each day. For clinical encounters with RHC patients in an inpatient hospice setting, please count any visit that requires documentation in the patient’s medical record.</p> <p>If more than nine visits were provided from a given discipline on a given day, enter a 9. Please note that once the conditions for inclusion in the numerator of 1 of the Visits when Death is Imminent Measures is met (e.g., at least 1 clinical visit in the final 3 days), then a greater number of visits (like 10 compared with 9) will not change the hospice’s performance on the measure.</p>
143	Section O	Does the RN admission visit “count” when the length of stay is less than 3 or 7 days? If the patient lives 4 days and multiple visits were made in the last 3 days, how is the second measure calculated?	<p>Yes, an RN admission visit may be recorded as a visit under item O5010 or O5030, as long as it falls into the appropriate time window. Related to your second question, Measure 2 of this measure pair is calculated based on whether the patient received at least two visits from select disciplines during the final 7 days of life, inclusive of the final 3 days of life. Thus, if the patient received two such visits during the final 3 days, that stay would be counted in the numerator of Hospice Visits when Death is Imminent Measure 2.</p>
144	Section O	I understand that post-mortem visits are not included when counting visits for Section O. If a patient is alive when the RN arrives, but then expires during the visit (even if it is only a few minutes after arrival), does that visit then get included in the count?	<p>Visits on the day of death that began prior to the patient’s death may be counted in item O5010.</p>
145	Section O	In reporting the number of hospice visits in 3–6 days prior to death a physical therapist makes a visit to teach family safe transfer of patient are we able to count that visit?	<p>Visits from physical therapists are not reported in items O5010 and O5030. As described in the HIS Manual V2.00, page 2O-1, only visits from registered nurses; physicians, nurse practitioners, or physician assistants; medical social workers; chaplains or spiritual counselors; licensed practical nurses; or aides are reported in these items.</p>

#	Question Category	Question	Answer
146	Section O	If a patient is admitted to the Inpatient Hospice Unit during the last 1–2 or 3–6 days of life at Routine Level of Care, how are visits counted (3 shifts = 3 RN visits and 3 CNA visits?), or is any admission (again not GIP) considered an exclusion? Thanks!	<p>This patient would be included in Section O if the stay ended in death. You would answer item O5000 and O5020 with “0. No” because the patient did not receive CHC, GIP, or respite care during the timeframe. You would complete items O5010 and O5030 with the number of visits from each discipline on each day. For clinical encounters with RHC patients in an inpatient hospice setting, please count any visit that requires documentation in the patient’s medical record.</p> <p>If more than nine visits were provided from a given discipline on a given day, enter a 9. Please note that once the conditions for inclusion in the numerator of 1 of the Visits when Death is Imminent Measures is met (e.g., at least 1 clinical visit in the final 3 days), then a greater number of visits (like 10 compared with 9) will not change the hospice’s performance on the measure.</p>
147	Section O	How to complete HIS-Discharge Set when the patient died on the day, within 1 day, 2 days, and 3 days of admission to hospice?	Section O of the HIS-Discharge is completed for all patients discharged due to death, regardless of the length of stay. Further instructions are provided in the HIS Manual V2.00, pages 2O-2 through 2O-7. Items O5000 and O5020 should be completed based on the days when the patient was enrolled in hospice, even if that is fewer days than specified in the item. Items O5010 and O5030 should be completed for all days indicated in each item. If the patient was not enrolled in hospice on some of the days indicated in the item, enter zeros in the cells of that column.
148	Section O	Do post-mortem day visits on the last day count as a visit for Section O?	Post-mortem visits provided on the last day of life should not be recorded as visits in item O5010.
149	Section O	Level of Care (LOC) Final 7 day question: At present looking at total visits over last 7 days of life. What are researchers looking at 1 day prior, 2 days prior, 3 days prior, 4 days prior, etc. versus just a total of visits over last 7 days prior to death?	Data are collected separately for each date in order to provide enough detail to calculate each of the Visits When Death is Imminent Measures: Measure 1 is calculated using 3 days, while Measure 2 is calculated using 7 days. In addition, this level of detail allows for improved testing of the reliability and validity of this measure pair.
150	Section O	A patient in our inpatient unit is on RHC at the time of death. How do we count “visits” when there are three RNs and three aides in 24 hours?	<p>You would complete items O5010 and O5030 with the number of visits from each discipline on each day. For clinical encounters with RHC patients in an inpatient hospice setting, please count any visit that requires documentation in the patient’s medical record.</p> <p>If more than nine visits were provided from a given discipline on a given day, enter a 9. Please note that once the conditions for inclusion in the numerator of 1 of the Visits when Death is Imminent Measures is met (e.g., at least 1 clinical visit in the final 3 days), then a greater number of visits (like 10 compared with 9) will not change the hospice’s performance on the measure.</p>

#	Question Category	Question	Answer
151	Section O	According to Page 2O-13 (Slide 57) of HIS Manual, a value of “0” should be selected for O5020, along with “0” in all O5030A1-F4 items, when the patient was not enrolled in hospice 3 to 6 days prior to death. However, the V2.00.0 specifications do not identify a matching edit. The specifications only indicate if “A2115=[01], then O5000 must not be equal to [^],” but does not indicate that O5020 cannot be blank. Is a non-blank value required for both O5000 and O5020 when A2115 is equal to “01” (Expired), and will records reject in the QIES system if O5020 is blank?	O5020 should not be left blank unless directed to do so by the skip pattern. If A2115=01 and O5000=0, then O5020 should be answered, either 0. no, or 1. yes. CMS has issued an errata to address this issue. If O5000=[0], then all active items from O5010A1 through O5020 must not be equal to [^]. Please refer to the Errata v2.00.1 for v2.00.0 of the HIS data submission specifications, available in the download section of the HIS Technical Information page of the CMS Hospice Quality Reporting website: <a href="https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/HIS-Technical-Information.html">https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/HIS-Technical-Information.html</a> .
152	Section O	If a patient is a resident in our hospice inpatient facility, their level of care is routine, and they are in the last 7 days of life, and there are no symptom management issues justifying general inpatient care, how do they fit in the level of care question and the subsequent counting of visits? They are cared for by RN and aide staff 24 hours a day.	The levels of care are defined in the Hospice Conditions of Participation. From your description, this patient received Routine Home Care. You would answer item O5000 and O5020 with “0. No” because the patient did not receive CHC, GIP, or respite care during the timeframe. You would complete items O5010 and O5030 with the number of visits from each discipline on each day. For clinical encounters with RHC patients in an inpatient hospice setting, please count any visit that requires documentation in the patient’s medical record.  If more than nine visits were provided from a given discipline on a given day, enter a 9. Please note that once the conditions for inclusion in the numerator of 1 of the Visits when Death is Imminent Measures is met (e.g., at least 1 clinical visit in the final 3 days), then a greater number of visits (like 10 compared with 9) will not change the hospice’s performance on the measure.
153	Section O	We utilize music therapists for our patients. Can we count a visit made by the music therapist for the number of hospice visits in the final 3 days? If so, what discipline would we list this under?	Visits from music therapists are not reported in items O5010 and O5030. As described in the HIS Manual V2.00, page 2O-1, only visits from registered nurses; physicians, nurse practitioners, or physician assistants; medical social workers; chaplains or spiritual counselors; licensed practical nurses; or aides are reported in these items.

#	Question Category	Question	Answer
154	Section O	Is there an expectation that a record be deactivated and reactivated if a level of care in that last 7 days of life is changed based on information that is received after the Discharge HIS is received? The 7 days to abstract is a guideline I understand. but we have used this as our standard and I can see that changes in LOC may occur after we have completed HIS for continuous care and respite in particular.	As noted in Section 3.6 in the HIS Manual, hospices should correct any errors necessary to ensure that the information in the QIES ASAP system accurately reflects the patient's hospice record. Inaccurate information in the QIES ASAP system may affect hospice quality reporting results. A HIS record may be corrected even if subsequent records have been accepted for the patient. An error identified in a QIES ASAP system HIS record must be corrected. Inaccuracies can occur for a variety of reasons, such as transcription errors, data entry errors, software product errors, item response selection errors, or other errors. The following two processes exist for correcting HIS records that have been accepted into the QIES ASAP system: <ul style="list-style-type: none"> <li>• Modification Request</li> <li>• Inactivation Request</li> </ul>
155	Section O	Will HIS O5000-O5030 be included on the hospice time of death visit to be completed by the nurse or will the person submitting the data be completing these questions?	The process for completing HIS items is left up to hospice discretion. Completing the items using a data abstraction process by the person submitting the data may work better for Section O. Completing this section depends on a look back scan of visits received by patients and family and correctly identifying final 7 days of life.
156	Section O	On the discharge summary it only mentions licensed practical nurse (LPN), but are licensed vocational nurses (LVNs) considered the same as LPN on this document?	Yes, visits from an LVN may be recorded as LPN visits.
157	Section O	Regarding HIS Section O, how do you count visits for patients on Routine level of care in a Hospice facility (particularly RN/LPN or Aide)?	You would complete items O5010 and O5030 with the number of visits from each discipline on each day. For clinical encounters with RHC patients in an inpatient hospice setting, please count any visit that requires documentation in the patient's medical record.  If more than nine visits were provided from a given discipline on a given day, enter a 9. Please note that once the conditions for inclusion in the numerator of 1 of the Visits when Death is Imminent Measures is met (e.g., at least 1 clinical visit in the final 3 days), then a greater number of visits (like 10 compared with 9) will not change the hospice's performance on the measure.
158	Section O	Is RN not included? They are not listed on the slide.	Slide 138 describes Measure 2 in the Hospice Visits When Death is Imminent Measure Pair. RN visits are not included in Measure 2. Those visits are included in Measure 1 only. Each of the two measures focuses on a different set of disciplines.

#	Question Category	Question	Answer
159	Section O	Would you consider an unpaid visit of a supply drop by a CNA as visit for this measure? thanks	These measures are intended to capture visits prior to death that may address the increased symptom burden many patients experience when death is imminent and provide an opportunity for proactive assessment and communication. A supply drop by a CNA that includes a visit with the patient or family, for example to provide training or treatment, would be counted as a visit in items O5010 or O5030.
160	Section O	If the response to O5000 was “Yes,” will the O5020 question even be answered given that an answer of “Yes” to O5000 guides the skip pattern and refers to go straight to the Z signature? If the O5020 question must be answered in this scenario, wouldn’t the answer have to be “Yes” if the answer to O5000 was “Yes”?	If the answer to O5000 is 1. yes, then the skip pattern instructs the user to skip to Z0400. O5010, O5020, and O5030 will all be left blank in that situation.
161	Section O	Why is CMS not collecting # of visits by discipline for patients that expire from the agency’s final claim that is submitted with the line item visit details? Why place the task (burden) on the Hospice to “count” information/data that is submitted to CMS/Fiscal Intermediary?	This HIS-based measure pair will expand upon information that would be available in Medicare hospice claims. The HIS includes data for all hospice patients, regardless of payment source, while claims data capture only Medicare fee-for-service beneficiaries. In addition, the HIS items will capture hospice visits by members of disciplines that are not included in the Medicare hospice claims, including chaplains. Finally, visit information on the HIS can be assessed and reported in a timelier manner than Medicare claims, providing hospices with opportunities to review and improve care.
162	Section O	On Page 122, it shows that the numerator only includes visits by RN, Physician, NP, or physician assistant. However, on page 134, the speaker gave an example of a volunteer chaplain being counted. Please clarify which disciplines are counted for the last 3 days versus last 7 days.	The numerator of Measure 1 of the Hospice Visits when Death is Imminent Measure Pair includes patients in the denominator who received at least one visit from a registered nurse, physician, nurse practitioner, or physician assistant. Chaplain visits are not a part of Measure 1. However, chaplain visits were addressed on slide 134 of this presentation because chaplain visits are collected in item O5010. Those data are used to calculate Measure 2 of the measure pair.

#	Question Category	Question	Answer
163	Section O	We are really small and only employ RNs who do total patient care. When reporting number of hospice visits on the discharge HIS, it would appear that we don't have Aide or LPN visits or services. Do we need to start documenting this single visit as multiple visits by different disciplines when we perform different duties?	A single visit from a single person should be documented as one visit. Please accurately report the discipline of each visit you provide. Each measure in the pair groups multiple disciplines together. In order for a patient to be counted in the numerator of Measure 2, the patient must have received at least two visits total from any of the included disciplines: medical social workers, chaplains or spiritual counselors, licensed practical nurses, or hospice aides. It is not required to provide a visit from any specific discipline. If your hospice does not employ LPNs or Aides, visits from social workers and chaplains will still be considered in this measure. Finally, a score of 100 percent is not the expectation for this measure pair. If no visit was provided from a given discipline on a given day, simply mark a "0" (zero) in the appropriate cell of O5010 or O5030.
164	Section O	Do visits from the patient's/family's own pastor count (if they are not formally associated with the hospice)?	No, O5010 and O5030 are intended to capture visits provided by the hospice. Unpaid visits conducted by hospice staff can be counted in O5010 and O5030; however, visits by a community clergy member (e.g., a patient's personal pastor) cannot be counted.
165	Section O	Would a bereavement counselor who is not an MSW or a chaplain count?	A visit from a bereavement counselor who is not one of the disciplines listed would not be reported in items O5010 and O5030. These measures focus specifically on visits that may address the increased symptom burden many patients experience when death is imminent, and provide an opportunity for proactive assessment and coordination.
166	Section O	On O5030, regarding Individuals who provide unpaid services (these would be volunteers), we have volunteers who are retired chaplains or active chaplains in the community, but volunteer here as Spiritual Volunteers. They record and document their services. They may spend time at the bedside during a patient's last 3 to 7 days. Do we count their time? We also have several members of the community who go through our volunteer training and then additional training to become Certified No One Dies Alone (NODA) volunteers. They provide services and spend 4 to 8 hours at the bedside in SNFs at the last 72 hours of someone who may be imminently dying. Do we count their hours?	We agree that volunteers play an important role in hospice care and that their visits are important to patients and families. However, volunteer visits that are outside of the disciplines listed in items O5010 and O5030 are not counted in those items. Individuals whose visits can be counted in these items are limited to hospice staff members in each of the listed disciplines who are either employees, contractors and affiliates, or those who provide unpaid services. A visit from an unpaid chaplain may be counted, provided the chaplain is acting in the role of that discipline.

#	Question Category	Question	Answer
167	Section O	In the hospice visits when death is imminent section, slide 124 lists which clinicians are counted 3 days prior to death, yet slide 128 lists more clinicians?	The list on slide 124 shows the disciplines included in Measure 1 of the Hospice Visits When Death is Imminent Measure Pair. Slide 128 shows item O5010. In items O5010 and O5030, the list of disciplines include those used for Measure 1 as well as Measure 2 of the measure pair. The additional disciplines you see (rows C through F) are used for calculation of Measure 2.
168	Section O	Our discharge HIS review doesn't go into depth with section O. When does this take effect??	Data will be collected for Section O beginning April 1, 2017, when the HIS V2.00.0 is implemented. Hospices are required to submit Section O items on HIS V2.00.0 discharge record for patients discharged on or after April 1, 2017.
169	Section O	In Puerto Rico, LPNs are the ones that function as home health aides, so in which staff indicator should we mark those visits?	If an individual providing a visit is qualified to provide the services of more than one of the disciplines listed in items O5010 and O5030, please record the visit based on the main type of service provided during that visit.