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# Supporting Analyses for Updates to the HIS V2.00.0: Findings from a Pilot Study and Technical Expert Panel

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SUPPORTING ANALYSES FOR UPDATES TO THE HIS V2.00.0: FINDINGS FROM A  
PILOT STUDY AND TECHNICAL EXPERT PANEL

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## SECTION 1 INTRODUCTION AND OVERVIEW

### 1.1 Introduction

This document provides supporting analyses for changes made by the Centers for Medicare & Medicaid Services (CMS) to the HIS V2.00.0, which will be implemented on April 1, 2017. The analyses presented here support the following additions that were made to the HIS V2.00.0:

- New section and items added in the HIS-Discharge record – Section O: Service Utilization (Items O5000, O5010, O5020, and O5030) – to collect data for the Hospice Visits when Death is Imminent Measure Pair
- New item added to Section J: Pain in the HIS-Admission record (Item J0905).<sup>1</sup>

This report presents analyses and findings from the HIS V2.00.0 Pilot and a telephone-based Hospice Technical Expert Panel (TEP) related to those updates. For more information on Pilot and TEP, see *Appendix A*.

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<sup>1</sup> Note that two other items were also added to the HIS V2.00.0: a patient zip code item and a payor item. These administrative items were added to Section A: Administrative Information for the purposes of patient record matching and future public reporting of hospice quality data. Supporting analyses for the addition of these items are not included in this report.

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## **SECTION 2**

### **ANALYSES TO SUPPORT THE ADDITION OF ITEMS TO COLLECT DATA FOR HOSPICE VISITS WHEN DEATH IS IMMINENT QUALITY MEASURE PAIR**

#### **2.1 Measure Description**

“Hospice Visits when Death Is Imminent” will assess hospice staff visits to patients and caregivers at the end of life.

The data source for this measure will be the HIS. Visits will be measured as whether the patient and caregiver received a certain number of visits from select disciplines in the final 3 or final 7 days of life. Hospices will review their patients’ medical records and submit this information on V2.00.0 of HIS-Discharge records.

This HIS-based measure will expand upon information that can be found in Medicare hospice claims. The HIS includes data for all hospice patients, regardless of payment source, while claims data capture only Medicare beneficiaries. Medicare claims capture visits from skilled nursing, medical social services, aides, physical therapy, occupational therapy, and speech therapy – language pathology. HIS items can capture hospice visits by members of additional disciplines that are not included in Medicare hospice claims (e.g., chaplains). Finally, visit information on the HIS can be assessed and reported in a timelier manner, providing hospices with opportunities to review and improve care.

#### **2.2 Summary of TEP Discussion**

The TEP discussion on this measure focused on five major topics: (1) types of visits to include and report, (2) single measure versus two paired measures, (3) logical specifications, (4) time frame, and (5) exclusion and risk adjustment. TEP discussion was informed by earlier TEP input and results from the HIS 2.00.0 Pilot. In the following subsections, we summarize the options and consensuses derived from the TEP discussion.

##### **2.2.1 Types of Visits to Include**

Many TEP members provided comments about this topic before the TEP meeting. We also solicited feedback on this topic from the caregiver workgroup. We began the TEP discussion by presenting a summary of pre-TEP feedback from both TEP members and caregivers regarding what visits are important for quality of hospice care when death is imminent. The discussion revealed two important points. First, visits from registered nurses (RNs), licensed practical nurses (LPNs), aides, chaplains, and social workers are the most important and thus should be included to measure quality. Second, TEP members did not support including visits from physicians<sup>2</sup>, therapists, volunteers, or complementary and alternative therapists in this measure. The TEP suggested that visits from these disciplines are not consistently provided across hospices, and may be more reflective of how hospices are able

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<sup>2</sup> The inclusion of physicians was discussed further during the post-TEP activities, described in section 2.4.

to structure service delivery than of quality of care. We then focused the discussion on whether the measure should focus on visits from RNs, LPNs, social workers, aides, and chaplains.

One TEP member pointed out that the Service Intensity Add-On (SIA) payment, beginning January 2016, will provide hospices with additional financial incentive to provide RN and social worker visits during the last week of life. TEP members expressed that while it is good for payment and quality to align, this measure must remain a measure of quality, not of practice driven by the reimbursement structure. In addition, for hospice patients with short length of stay whose last days of life overlap with their initial assessment period after hospice admission, the measure should not just reflect compliance with the requirement of a comprehensive assessment visit in the first 5 days of care.

Overall, the TEP members agreed that the measure should focus on visits from RNs, LPNs, social workers, aides, and chaplains. This set covers more disciplines than those targeted by the SIA and thus captures quality information beyond practices driven by the reimbursement structure.

### **2.2.2 Number of Measures for this Concept**

During the May 2015 TEP discussion, members suggested developing two paired measures to look at visits when death is imminent (for example, one measure addressing RN visits and one measure addressing visits from other select disciplines), rather than one measure that included all selected disciplines. We asked the TEP whether a single measure or two paired measures would present better measurement of the quality of hospice care.

Many TEP members preferred the use of paired measures. One main reason for using two measures is to report RN and LPN visits in separate measures, so that the roles of RNs and LPNs in hospice care planning and delivery remain distinct. Some TEP members described RN visits as being particularly important because as the case manager, RNs can work to identify what other disciplines' visits are needed, while LPNs must practice under the supervision of an RN. Therefore, it is important to distinguish between RNs and LPNs. Because RNs and LPNs both play important roles, but have different scopes of practice, it is important that the visits from the two disciplines not be viewed as interchangeable. TEP members suggested collecting data on and assessing RN and LPN visits separately to address the distinction between their roles.

The TEP then discussed the appropriate combinations of disciplines in each measure. In particular, one TEP member questioned whether it would be appropriate to group social workers, aides, and chaplains together, as they provide different services. Some members suggested that rather than grouping together dissimilar disciplines, each discipline could be reported in a separate measure, and a composite measure could be created from these. Reporting visits from each discipline separately would allow consumers to focus on disciplines that are important to them and discount those that they do not expect to use. Two concerns were raised about developing separate measures for each discipline's visits. First, it could potentially incentivize unnecessary or unwanted visits if hospices wish to perform well on every measure. Second, a small sample may be a concern if each measure focuses on the patients and families who need and want a visit from a particular discipline. For example, if many patients and families decline chaplain visits, then the small denominator size for the measure for chaplain visits would

threaten the measure performance. To avoid the problem of small denominator size, one member proposed the use of three measures by grouping some disciplines: RN, LPN and aide, and social worker and chaplain. However, the potential unintended consequence of unnecessary or unwanted visits remains.

One TEP member said that the measures should reflect the receipt of visits from all disciplines within the group (e.g., LPN *and* aide) rather than a visit from any of the disciplines (e.g., LPN *or* aide). The following discussion indicated that the latter approach reflects tailored care and the former approach may incentivize unnecessary or unwanted visits (e.g., hospices may want to provide both LPN and aide visits for a good quality measure score regardless of the patient and family's needs). TEP members said that ideally, there would be data to determine level of need, and these data could be matched to receipt of a visit from a needed discipline. This would capture unmet needs while also avoiding the unintended consequence of incentivizing unnecessary visits. Unfortunately, it would be very difficult to obtain these data and ensure their accuracy.

### **2.2.3 Logical Specifications**

We presented to the TEP three possible approaches to the logical specifications of the measure “visits when death is imminent.” Approach 1 measures the percentage of patients receiving a visit on at least 1 day in the last 7 days of life. Approach 2 measures the average percentage of days with a visit in the last 7 days of life. Approach 3 measures the average number of visits per day in the last 7 days of life. We asked TEP members which of the three approaches is the most appropriate measure of quality of hospice care.

Some TEP members stated that Approach 1, receipt of at least one visit in the last 7 days of life, would be more appropriate for chaplain or social worker visits, but less appropriate for RN visits because of an expected ceiling effect (i.e., a high percentage of patients received a RN visit on at least 1 day in the last 7 days of life). However, later discussions on measure time frame (summarized in Section 2.2.4) indicated that the ceiling effect may be alleviated by a shorter measure time frame. Between Approaches 2 and 3, TEP members favored Approach 2, percentage of days with visit, over Approach 3, average number of visits per day. Some TEP members stated that Approach 2 would have an advantage over Approach 3 by incentivizing staggered or spread out visits throughout the last 7 days of life. A high number of visits on one day may occur because of the increased need related to a crisis, resulting in a high score using Approach 3. However, this may not sufficiently and comprehensively reflect quality of care spanning the last 7 days of life. TEP members supported collecting data of sufficient detail that all three approaches could be tested.

Some TEP members expressed concerns about the actionability of Approaches 2 and 3 because there is no target number of visits or target days of visits for providers to work toward. Others expressed the reverse concern about Approach 1, receipt of at least one visit, because setting a standard may incentivize providers to meet only the minimum requirement of that standard (i.e., provide only one visit). TEP members agreed that it would not be feasible to determine a standardized target level of service intensity because needs vary greatly by patient and family. Without a means to measure patient need, there is no way to determine target service intensity. One TEP member pointed out that the goal should not be to anchor quality

care to a target, but rather to compare service intensity across hospices. During the actively dying phase, when symptom burden and caregiver stress are at a higher level, higher service intensity generally affords more opportunities to manage patients' symptoms and relieve caregivers' stress.

A few alternative ideas suggested by TEP members did not gain traction with the group. Because patients' needs are expected to increase at the end of life, one TEP member suggested comparing the rate of visits at end of life to the rate of prior visits. One member suggested the possibility of reporting the median number of days of care, rather than the mean, to more accurately reflect the quality of smaller hospices that may have more outliers.

Some TEP members supported mixed approaches to the logical specifications, with Approach 2 (percentage of days with visit) for RNs and Approach 1 (receipt of at least one visit) for other disciplines. Others preferred that one approach be selected and used consistently in all measures created for this concept in order to reduce confusion for consumers and providers.

#### **2.2.4 Time Frame**

Results from RTI's pilot test and internal analysis of Medicare claims indicated that most hospices provide at least one visit to most patients during the last 7 days of life. Because of this, there may be a ceiling effect for the quality measures using the 7-day time frame. We presented the option of using a shorter 3-day time frame for the measures and asked which time frame would more appropriately reflect imminent death or active dying for most patients.

TEP members stated that the 3-day time frame would be more reflective of the active dying phase, but the last 3 days of life may be challenging for hospices to accurately identify prospectively because of unpredictability of the timing of death. On the other hand, the 7-day time frame covers both the active dying phase and the transition period before and thus could also capture important visits related to preparation for active dying. Some TEP members supported using a 3-day time frame to focus specifically on visits driven by needs during active dying and to reduce the expected ceiling effect of the measure, particularly the measure of RN visits. However, one concern is that a shorter time frame may encourage providers to compress visits into a shorter time period (which can be potentially burdensome for patients and caregivers) rather than spreading them out appropriately.

A consensus achieved from the discussion was to apply different time frames in measures for visits from different disciplines. TEP members agreed on using the 3-day time frame for visits from RNs and the 7-day time frame for other disciplines. This would capture RN visits to address increased symptom burden during active dying, reduce the ceiling effect that may occur for RN visits, and capture visits from other disciplines made to prepare for active dying.

#### **2.2.5 Exclusions and Risk Adjustment**

We requested TEP feedback on multiple possible exclusion criteria or risk adjusters.

**Exclusion—visit refusal:** We presented to the TEP the results of the pilot test, which found a small percentage of patients who declined visits from only a few disciplines (i.e., aide, chaplain, and volunteer) in the last week of life. We also shared our qualitative finding that pilot

sites indicated that visit refusal information is available, but burdensome to report because it is often recorded in unstructured notes. We asked whether the TEP would recommend additional data collection to capture visit refusals as an exclusion. TEP members expressed initial support for collecting these data and excluding patients or caregivers who decline a visit. After a discussion of the burden on providers of reporting these data, the TEP members agreed that the burden of data collection would outweigh the benefit of excluding patients who refuse visits. Then TEP members suggested voluntary reporting of visit refusal. Some TEP members expressed concern that voluntary reporting of an exclusion criteria would make the data inconsistent. In addition, there was concern that data may be misreported and there would be no way to confirm the accuracy of data. One TEP member pointed out that if visits are refused at equal rates across hospices, then this would not be an important exclusion criterion.

**Exclusion or risk stratification—intensive service levels:** We asked whether the TEP would recommend excluding or stratifying for patients in more-intensive service levels (general inpatient care, continuous home care). TEP members agreed that it would be difficult to clearly define and measure visits provided in general inpatient care and continuous home care. In addition, there was concern that the measures may be topped out among patients receiving these levels of care, and may not provide meaningful quality information. TEP members agreed that it is important to measure quality of care in these levels of care, but that different measures may be needed. Overall, TEP members suggested that the measures be focused on patients receiving only routine home care in the last days of life, including patients residing in long-term care settings, and thus exclude patients in more-intensive service levels.

**Risk adjustment—diagnosis:** We asked whether the TEP recommended risk adjustment of the measures by primary hospice diagnosis and/or secondary diagnosis. TEP members stated that the primary diagnosis may not reliably predict symptom burden at the end of life. In addition, hospices are changing their practices in terms of how to code primary diagnosis (e.g., hospices can no longer code failure to thrive as the primary diagnosis), so it would be difficult to determine appropriate risk adjustment on this variable. The TEP members agreed that secondary diagnoses may be unreliably reported and may not reliably predict symptom burden at the end of life.

**Risk adjustment—length of stay:** The issue of many hospice patients having short length of stay was discussed under the topic of risk adjustment. TEP members agreed that it would be important that the measures take into account length of stay, either through risk adjustment or different measure specifications for patients with short length of stay.

## **2.2.6 Other Topics Relevant to Measure Development**

TEP members revisited the topic of whether phone calls from hospice staff to patients and family should be counted as visits, as sometimes hospices, especially rural hospices and small hospices, rely on phone calls to check on their patients. This was brought up in the previous TEP meeting in May 2015, and the TEP suggested that phone calls should not be considered as a substitute for visits, especially during the actively dying phase. Discussion during this TEP confirmed the decision.

## 2.3 Main Takeaways

Types of Visits to Include: TEP members agreed that visits from RNs, LPNs, aides, social workers, and chaplains at the end of life should be used to assess quality of care.

Number of Measures for this Concept: TEP members supported developing more than one measure. There was not consensus during the TEP meeting regarding whether to use two measures, three measures, or separate measures for each discipline plus a composite measure.

Logical Specifications: TEP members expressed concerns about a ceiling effect when using Approach 1, receipt of at least one visit at the end of life, as well as the actionability of Approach 2, percentage of days with a visit, and Approach 3, average number of visits per day. TEP members preferred Approach 2 over Approach 3, visits per day. Some TEP members supported use of Approach 2 for RNs and Approach 1 for all others, whereas others expressed concern about confusion caused by mixing approaches.

Time Frame: TEP members agreed that using different time frames for the two measures would make the measures more meaningful and would not be overly confusing. TEP members supported using a 3-day time frame for the RN measure and a 7-day time frame for other disciplines.

Exclusions and Risk Adjustments: Because of the burden of data collection and uncertain utility, TEP members reached a consensus against excluding patients who refuse visits. TEP members supported focusing the measures on patients receiving routine home care. TEP members decided against risk adjusting for primary or secondary diagnosis. The TEP also agreed on the importance of taking into account length of stay, either through risk adjustment or different measure specifications for patients with short length of stay.

In addition to these decisions, the TEP provided recommendations for moving forward with measure development. The TEP recommended collecting data with sufficient detail to test any of the proposed approaches to measure specification. TEP members also recommended seeking further input from the caregiver workgroup regarding measure specifications.

## 2.4 Post-TEP Activities

RTI continued to solicit feedback on this measure through a post-TEP debriefing meeting and other communication methods (e.g., group email discussion) with subcontractors and consultants. On the basis of the TEP meeting discussion and additional recommendations from subcontractors and consultants, we made several updates to the specifications of the measures.

Types of Visits to Include: Because some hospices disproportionately rely on physicians for important clinical care, visits from physicians, nurse practitioners, and physician assistants are included in the measures so that those hospices receive credit for providing appropriate care for patients.

Number of Measures for this Concept: We specified one measure that would include visits from an RN, physician, nurse practitioner, or physician assistant, and a second measure that would include visits from a social worker, chaplain, LPN, or aide. The ultimate goal of

these two measures is to ensure that hospice patients and their families' needs are met by the hospice staff during the last days of life. The first measure groups visits from an RN, physician, nurse practitioner, or physician assistant in order to address case management and clinical care. By grouping other visits, Measure 2 gives hospices the flexibility to provide tailored care that is in line with patients and their families' preferences and goals for care and contributes to the overall well-being of patients and their families.

Logical Specifications: For Measure 2, assessing visits from social workers, chaplains, LPNs, or aides, we modified logical specification Approach 1 to measure the percentage of patients who receive at least two visits (rather than one). This may reduce the expected ceiling effect that may result from grouping multiple disciplines together in Measure 2. In addition, using two visits instead of one would allow the measure to capture the visit(s) to address the imminently dying phase in addition to the initial assessment visit upon admission to meet the compliance requirement for patients with a short length of stay (whose last days of life overlap with their initial assessment period after hospice admission). This modification is not necessary for Measure 1, RNs and physicians, because the shorter 3-day timeline should serve to reduce the expected ceiling effect, and because it may not be necessary or feasible (particularly for rural hospices) to provide two such visits in 3 days. Approach 1, with this modification for Measure 2, is expected to be more easily understood by consumers and providers than Approaches 2 or 3. This is because Approach 1 will be reported as the percentage of patients receiving certain services, which is in line with existing hospice QMs. Approaches 2 and 3 would report the percentage of days a visit was received, or the average number of visits per day, which may be difficult to interpret without a set quality benchmark; it may not be easy to establish a quality benchmark as the appropriate amount of visits depends on each patient and family's needs and preferences.

Exclusion Criteria: To account for the fact that many patients with a length of stay of 1 day (i.e., admitted and discharged on the same day) may not receive two visits, we excluded patients with a 1-day length of stay from Measure 2.

On the basis of all feedback received prior, during and after the TEP meeting from the TEP, our subcontractors and consultants; and caregiver workgroup, we updated the specifications to the measures as the following:

- Measure 1: Percentage of patients receiving at least one visit from a registered nurse (RN), physician, nurse practitioner, or physician assistant in the final 3 days.
- Measure 2: Percentage of patients receiving at least two visits from a medical social worker, chaplain or spiritual counselor, licensed practical nurse, hospice aide, or any combination of these disciplines in the final 7 days.

A few notes regarding these specifications need to be mentioned. Overall, the feedback supported measuring visits from RNs, physicians, nurse practitioners, or physician assistants separately from other disciplines. There were some concerns for the second measure about grouping social worker, chaplain, LPN, and aide visits in the same measure, which considers visits from these disciplines equally contributing to quality of care. Some TEP members suggested that because these disciplines offer very different types of services, they should not be

grouped into one measure. However, by grouping the visits from various disciplines into the same measure, the second measure allows hospices to determine the most appropriate type of visits to meet patients and families' needs and still achieve good performance on the measure, promoting the holistic care approach. TEP members and caregivers supported using the 1-day length of stay exclusion criterion for Measure 2, receipt of two visits from social workers, chaplains, LPNs, or aides.

## SECTION 3 ANALYSES TO SUPPORT THE HOSPICE ITEM SET REVISION: SECTION J

### 3.1 Background and Proposed Revisions

V1.00.0 of the HIS-Admission record includes two pain items: Item J0900, Pain Screening, and Item J0910, Comprehensive Pain Assessment. These items correspond to the NQF #1634 Pain Screening quality measure and the NQF #1637 Pain Assessment quality measure. NQF #1634 calculates the percentage of patients that were screened for pain within 2 days of admission. Patients who screen positive for pain are included in the denominator for NQF #1637, which measures the percentage of patients who screened positive for pain that received a comprehensive pain assessment within 1 day.

Under current specifications for NQF #1637, if a given patient is *not* in pain at the time of the first screening (from Item J0900), that patient is not included in the denominator for NQF #1637, even if pain is an active problem for the patient. As such, if a patient is not in current pain at the time of the first pain screening, HIS skip patterns direct providers to skip Item J0910, the comprehensive pain assessment item. RTI received feedback from the provider community that the measure specifications and the associated skip pattern between J0900 and J0910 do not align with clinical practice. Rather, clinicians often complete a comprehensive pain assessment for patients where pain is an active problem but the patient is not in pain at the time of the screening.

As a result, RTI requested feedback on possible revisions to the items J0900 and J0910 to better reflect clinical practice and capture patients for whom pain is an active problem. The goal of these revisions was to better align the items and associated skip patterns in this section with clinical practice so that skip patterns and item logic direct providers to complete the comprehensive pain assessment item on all patients for whom pain is an active problem. Analysis of HIS V2.00.0 data will inform any future revisions to the NQF #1637 quality measure specifications. Revisions made to Section J: Pain also make this section consistent with the current structure of Section J: Respiratory Status Items; skip patterns in Section J: Respiratory Status are completed based on whether or not dyspnea is an active problem for the patient (i.e., whether the patient screened positive for dyspnea).

### 3.2 Summary of TEP Discussion

TEP discussions for Section J: Pain revisions were informed by results from the HIS V2.00.0 Pilot test. RTI piloted two primary revisions to Section J: Pain. The primary revision piloted was a new item, J0905, Pain Active Problem. In addition to piloting J0905, Pain Active Problem, RTI also piloted a revision to the current pain screening item (J0900), which captured whether the patient had moderate to severe pain in the past 3 days.

Regarding the moderate to severe pain in the past 3 days item, pilot sites found this information difficult to locate and unreliable. Most hospices reported difficulty finding the data to complete this item because data were often unavailable or required review of multiple, unstructured data sources, including nurses' notes or documentation from the referring provider. Difficulty in finding data to complete the item stemmed from the fact that the first pain screening occurred on the date of admission; thus, the "past 3 days" was before the patient's admission to

hospice. This increased the difficulty of finding appropriate documentation. Hospices noted that documentation about pain in the past 3 days was more likely to be present if pain was a problem for the patient. Based on pilot results, RTI did not present the moderate to severe pain in the past 3 days subcomponent to the TEP. Instead, TEP discussions focused on structure and revisions to the J0905, Pain Active Problem item.

Overall, TEP members agreed with the logic that patients for whom pain is an active problem should have a comprehensive pain assessment and that RTI should conduct analysis to consider potential revisions to the NQF #1637 measure to reflect this care pattern.

RTI solicited TEP input on whether the revised J0905 should be a simple “yes/no” response or a “check all that apply” response option. RTI posited that the checklist may help provide data validation and make the logic for the item more clear; however, hospices may just fill in the first response option that applies, which limits the value of the data. The “yes/no” response option would align more closely with the dyspnea item structure on the current HIS-admission record and would limit hospice burden in completing the item.

The TEP suggested that the “yes/no” response option was preferable for multiple reasons. One TEP member appreciated that this gives the provider more clinical license to determine why pain might be an active problem. The TEP also suggested that this will give the necessary information without undue burden on hospices.

### **3.3 Main Takeaways**

The TEP suggested that the comprehensive pain assessment should be administered to all patients for whom pain is an active problem, even if their pain is well-controlled at the time of the pain screening. Given the TEP’s suggestion, RTI pursued modifications to Section J of the HIS-Admission. RTI will conduct analyses of HIS V2.00.0 data to inform potential future revisions to the NQF #1637 measure.

## **APPENDIX A TEP AND PILOT TEST**

The telephone-based Hospice Technical Expert Panel (TEP), consisting of 15 members, convened on October 19 and October 21, 2015. The TEP was held to present the results of the pilot test and other measure and item development activities that had occurred since May 2015 to the same panel of experts, and to solicit TEP input on measure development and HIS item revision. Specific to the HIS V2.00.0 revisions, RTI sought input on the following topics: (1) the Hospice Visits when Death Is Imminent quality measure, (2) potential revisions to current pain screening items in Section J of the HIS.

The pilot test was conducted with hospices from June - August 2015. The Hospice Visits when Death Is Imminent measure was tested at the item level to determine the feasibility and burden of patient-level data item reporting by hospices. Revisions to Section J: Pain of the current HIS V1.00.0 was also tested. Revisions to these items were developed on the basis of input from the provider community and other stakeholders.