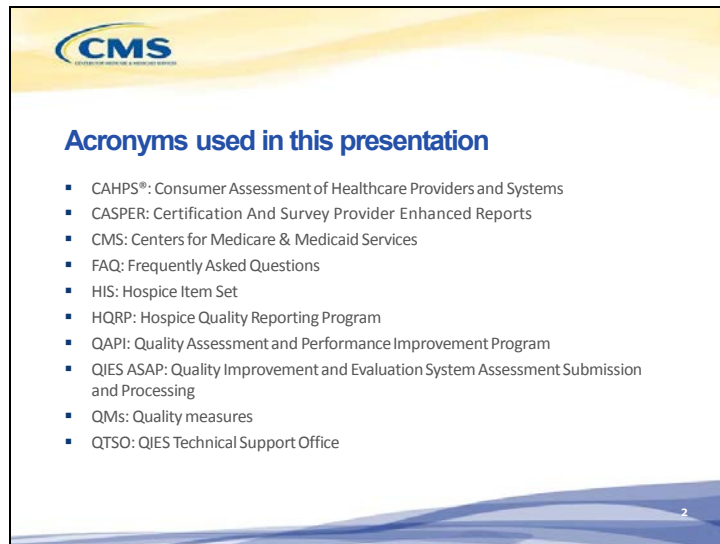



Good afternoon. My name is Cindy Massuda and I'd like to welcome you to the Centers for Medicare and Medicaid Services presentation, "From Data to Measure". This presentation is part of CMS's quarterly Hospice Quality Reporting Program, or HQRP, educational series. Last year, CMS started hosting quarterly trainings and educational events to increase provider knowledge on various aspects of the HQRP. We kicked off the series last fall with a back-to-basics presentation on HQRP compliance; the motivation behind these quarterly events is to provide additional outreach and education on specific topic areas of varying complexity. This presentation is intended for advanced Hospice Item Set, or HIS, users and will go over in detail how HIS data are used to calculate the various HIS quality measures. In today's presentation, we'll cover how to interpret quality measure specifications for the HIS measures, how publicly reported scores are calculated, and how to interpret the quality measure, or QM, reports in CASPER. Following the presentation, we will host a question and answer session.



Our presenters today will be Alexis Kirk and Dorothy Wu from RTI International. At this point, I'll turn it over to Alexis who will lead the first portion of today's presentation.



Thank you, Cindy for that introduction. Slide 2 contains a list of acronyms that will be used in this presentation.




Background: HIS

- All Medicare-certified hospices must submit HIS data to CMS for all patient admissions
- HIS data are submitted to CMS via the QIES ASAP system
- HIS data is then used to calculate 9 QMs

QMs calculated using the HIS
NQF#1617 Patients Treated with an Opioid who are Given a Bowel Regimen
NQF #1634 Pain Screening
NQF #1637 Pain Assessment
NQF #1639 Dyspnea Screening
NQF #1638 Dyspnea Treatment
NQF #1641 Treatment Preferences
NQF #1647 Beliefs/Values Addressed (if desired by the patient)
Hospice Visits when Death is Imminent
NQF #3235 Hospice and Palliative Care Composite Process Measure – Comprehensive Assessment at Admission

Let’s start out with a brief background of the HQRP and the HIS. Remember, although the HQRP = HIS and CAHPS, today’s presentation will focus on the HIS only --- specifically, how HIS data are used to calculate quality measures. All Medicare-certified hospices must submit HIS data for all patient admissions to their hospice. Data are submitted to CMS via the QIES ASAP system. After data are submitted to CMS, the HIS data are then used to calculate hospices’ performance on 9 QMs, which you can see listed here on slide 3. The 9 quality measures include what we refer to as the “original 7” HIS measures, which were implemented in 2014, as well as two other measures, implemented in 2017. The other two measures are the Hospice and Palliative Care Composite Process Measure – Comprehensive Assessment at Admission (or “the Hospice Comprehensive Assessment measure” for short) and the Hospice Visits when Death is Imminent Measure Pair (or “Visits measure” for short). Once CMS has calculated the QM scores, some of those scores are then displayed on Hospice Compare.



Background: Hospice Item Set (HIS)

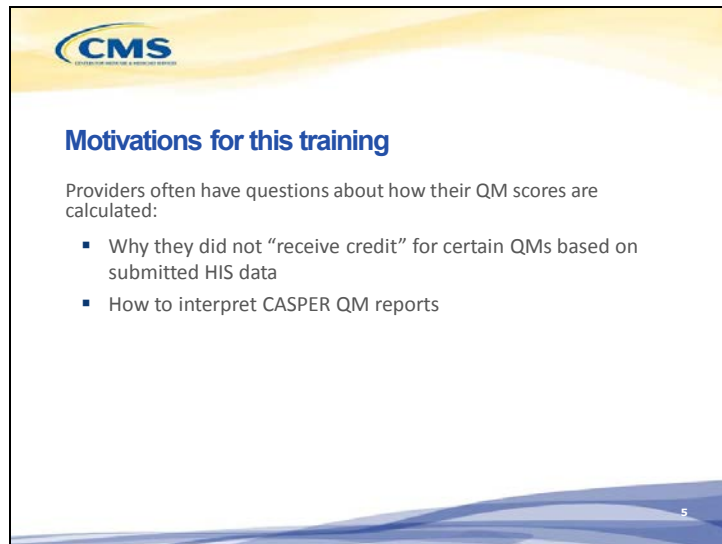
- Information on QM performance available in the Certification And Survey Provider Enhanced Reports (CASPER) system prior to display on Hospice Compare
- HIS QMs displayed on Hospice Compare:
 - Original 7 HIS measures displayed beginning August 2017
 - Hospice Comprehensive Assessment Measure will be displayed beginning Fall 2018
 - Hospice Visits measure timeline for display on Compare TBD

QMs calculated using the HIS
NQF#1617 Patients Treated with an Opioid who are Given a Bowel Regimen
NQF #1634 Pain Screening
NQF #1637 Pain Assessment
NQF #1639 Dyspnea Screening
NQF #1638 Dyspnea Treatment
NQF #1641 Treatment Preferences
NQF #1647 Beliefs/Values Addressed (if desired by the patient)
Hospice Visits when Death is Imminent
NQF #3235 Hospice and Palliative Care Composite Process Measure – Comprehensive Assessment at Admission

Currently, hospices' performance on 7 of those 9 measures are displayed on Hospice Compare. These 7 measures are highlighted in bold font on this slide. Display of the Hospice Comprehensive Assessment measure will begin in Fall 2018 and display of the Visits measure is still under determination by CMS.

Before any measure data is displayed on Compare, hospices can review their QM performance and score through various reports in CASPER, including QM reports.

Before we move on, as Cindy mentioned earlier, today's presentation is intended for advanced HIS users. If you need a refresher on general HQRP requirements or an introduction to the HIS, we recommend reviewing some of the resources listed on slide 69 at the end of this presentation.




When Hospice Compare launched last year, we started seeing an increasing number of questions from hospice providers wanting to know exactly how their Compare scores were calculated. Specifically, we started seeing a couple types of questions about QM scores and performance.

The first bucket of questions was about why providers weren't getting credit for measures. We'd often get questions from providers like "I answered 'yes' to the pain assessment question, but did not get credit for the measure – why is that?" or "I thought my performance on a measure was high but I looked at my CASPER Report and saw it was 60%, which was much lower than expected -- why is that?"

The second bucket of questions was about how to interpret the CASPER reports, specifically the QM reports. We'd get questions like "I looked at my QM report and am not sure why this patient received a "b", what does that mean and what action do I take?"

These types of questions motivated today's presentation and the learning objectives.

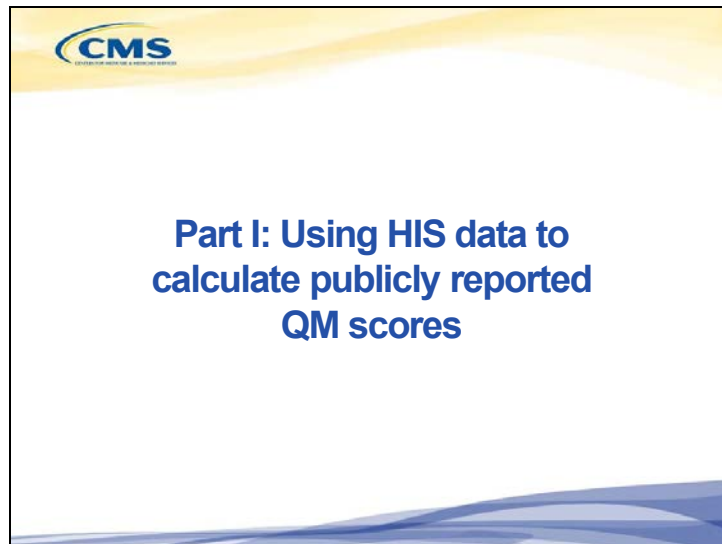


Learning Objectives

- Learn what role HIS data and QM specifications play in calculation of QM scores
- Learn what the QM reports in CASPER are and how they are different from other CASPER reports
- Learn how to interpret hospice-level and patient stay-level CASPER QM reports, including footnotes
- Learn about new footnotes and data added to CASPER reports for the HIS QMs, including the Hospice Comprehensive Assessment measure

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The learning objectives for today are listed on slide 6.

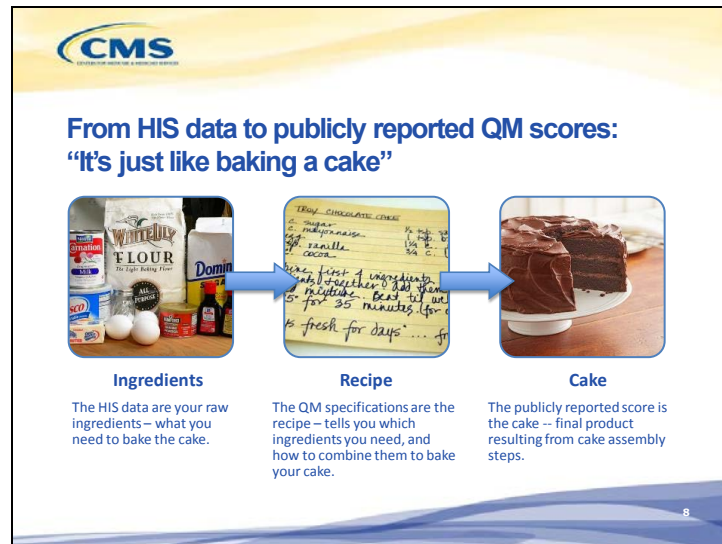


As mentioned earlier, providers submit HIS data to CMS and the goal of this data submission is to eventually report QM scores on Hospice Compare so the public can use performance data to inform their decision-making when choosing a hospice. Since Compare launched, we've seen some knowledge gaps on our Help Desk. Providers are sometimes surprised at the QM scores they're seeing, and this surprise comes from 2 things.

First, is a lack of understanding about how CMS gets from the raw HIS data to QM scores to publicly reported scores. There are some transformation steps that happen, and they are important to know since they're ultimately how your publicly reported score is determined.

Another reason why providers are surprised is that sometimes they're not checking other reports available to them in CASPER on regular basis – specifically, the QM reports. QM reports are available at any time and ideally providers should be checking them regularly, to see how they are performing on QMs, and not waiting until Preview Reports are released to view their QM scores.

We're going to cover both of these topics today, starting with the transformation steps of how we get from HIS data to publicly reported score.

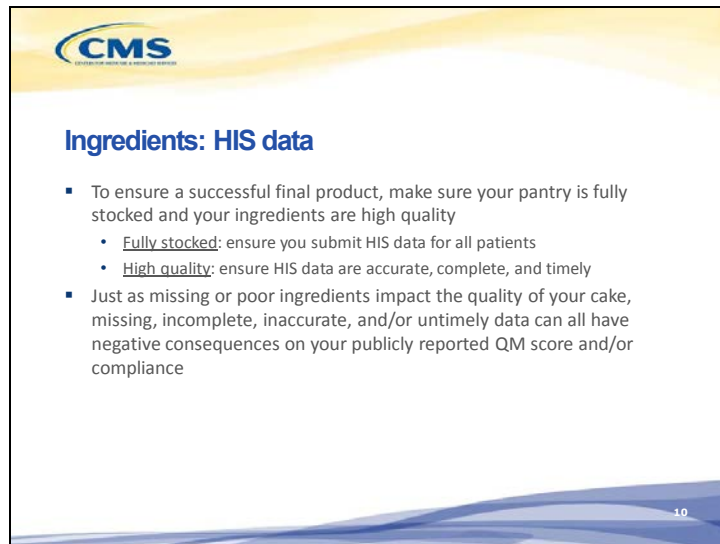


In trying to think of a relatable analogy to explain those transformation steps, we came up with the analogy of baking a cake. When you bake a cake, you have 3 main things you’re dealing with: ingredients, a recipe, and the final product – or the cake itself. It’s the same with how we get from the HIS data to our final product – the publicly reported QM score.

- So first, we start out with our ingredients. For us, the HIS data you collect and submit are your raw ingredients. It’s the basics of what you need to bake your cake.
- The second thing we need is our recipe – how we take our ingredients and transform them into a cake. In our case, the QM specifications are the recipe. If you’re not familiar with the QM specifications are, that’s OK. I’m going to go over them in detail in another slide, but for now, just think of them as the recipe that tells you which ingredients you need and what to do with those ingredients to bake your cake.
- Once you’ve gathered your ingredients and followed the recipe, you ultimately want to end up with a finished cake. For us, the finished cake – or final product -- is the publicly reported QM score.



Let's go over ingredients first.

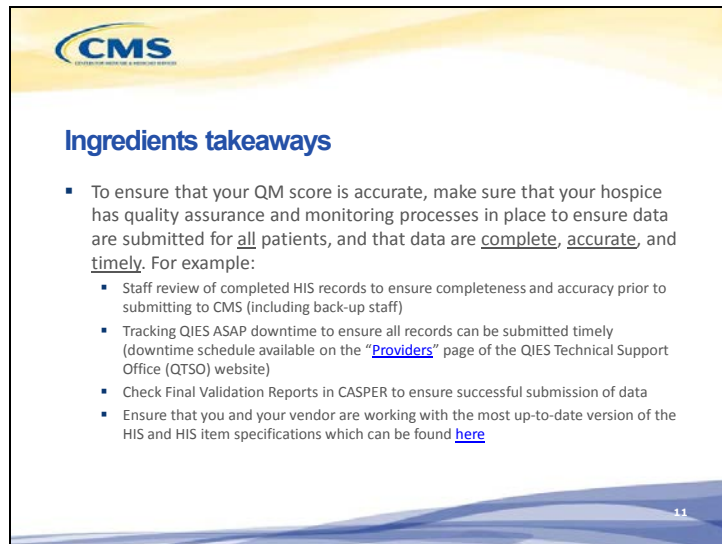


As I mentioned on the previous slide, HIS data are like your ingredients – they are the raw materials used to make the final product (publicly reported score).

And just like making a cake, the ingredients are the foundation of your cake, so they are important! This means you want to make sure your pantry is fully stocked and your ingredients are high quality – so what does that mean for HIS? What can you do?

First, make sure you're submitting HIS data for all patients – that makes sure your pantry is "fully stocked". It's important to submit all required data for a couple of reasons. First, it's a requirement to submit data for all patients. Second, missing data can impact your performance on QMs. Just like leaving out an ingredient can cause problems with your cake, not submitting data for all patients can negatively impact your QM score – especially if you forgot to submit data for patients who "got credit" for the measure.

Second, you want to ensure high quality ingredients (or HIS data) by making certain the data you submit is accurate, complete, and timely. We often hear instances where providers weren't answering an HIS question correctly or were inadvertently skipping an HIS item. This would be a case of inaccurate or incomplete HIS data, and just like using too much of an ingredient or the wrong ingredient can negatively impact your cake, inaccurate or incomplete data can negatively impact your QM performance. The last aspect of quality is timeliness. Submitting your HIS data on time is how your compliance is determined, which means in addition to impacting your QM scores, untimely data can also impact your compliance.

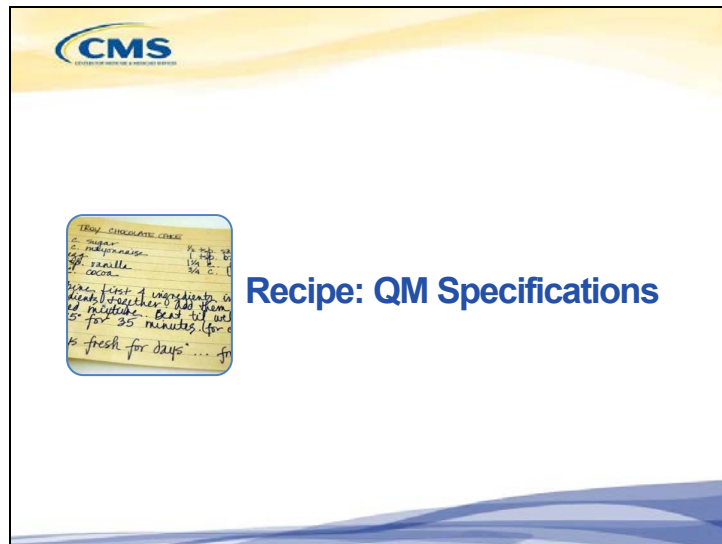


We have listed here some recommendations to ensure a fully stocked and high quality pantry.

Listed here on slide 11 are some quality assurance and monitoring processes that can act as fail-safes to ensure complete, accurate, and timely data submissions. Some examples may include:

- Assigning a staff member to review all completed HIS records for completeness and accuracy before submitting them to the QIES ASAP system. This includes having a back-up person who knows how to complete and submit HIS records in case your primary designated HIS staff member is sick or out of the office
- Tracking scheduled QIES ASAP downtime to ensure all records can be submitted timely, even during the system downtimes
- Checking Final Validation reports in CASPER to ensure that data you were submitting were being accepted by QIES ASAP
- And finally, making sure that both you and your vendor are both working with the most up-to-date version of the HIS and item specifications, so that you are collecting and submitting HIS data in full.

This slide contains several embedded hyperlinks to assist you in building in some of these quality assurance and monitoring processes.



Now that we better understand the importance of ingredients, let's talk about the next step in baking our cake – the recipe or QM specifications.



Recipe: QM specifications

- QM specifications are “the recipe” – they state which HIS data elements (ingredients) to use and how to transform them to create your final product
- Each individual HIS quality measure has its own specification or “recipe”
- QM specifications are found in the QM User’s Manual, which you can think of as your “cookbook”



Hospice Item Set–Based Quality Measures for the Hospice Quality Reporting Program

User’s Manual Version 2.00


Current as of January, 2018

Link to the HIS QM User’s Manual Version 2.00 [here](#)

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The QM specifications tell you what HIS data (ingredients) to use and how to use them to create your final product. QM specifications for all HIS measures can be found in the QM User’s Manual, which is hyperlinked here on Slide 13 and can be found in the Downloads section of the Current Measures webpage on the CMS HQRP website.

Think of the QM Manual as your cookbook where each individual HIS measure has its own specification, or recipe.



Recipe: QM specifications

- Each QM specification, or recipe, comprises the same basic steps, which include defining the following for each measure:
 - Denominator definition
 - Denominator exclusions
 - Numerator definition



Hospice Item Set–Based Quality Measures for the Hospice Quality Reporting Program


User's Manual Version 2.00

Current as of January, 2018

Link to the HIS QM User's Manual Version 2.00 [here](#)

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Just like cake recipes tend to follow a basic pattern – gathering ingredients, what order to combine the ingredients in to mix up the batter, baking time and oven temperature -- QM specifications follow some basic steps for calculating each QM. Those steps are to define the: denominator, denominator exclusions, and numerator for each measure.



Recipe: Step 1
Understanding the Denominator


- Denominator: Which patients does this measure apply to?
 - Denotes the patient group that is included in the measure
 - Defines the subgroup of patients you should be held accountable for providing a certain care process or achieving a certain outcome for
 - Can include an entire population or just a subgroup of patients, as care processes or outcomes are not always appropriate for, or applicable to, all patients
- Example: Foot Exams for Diabetes Patients
 - Foot exams are important for a specific subgroup of patients – those with diabetes
 - Thus, the denominator for this measure would include only patients who had diabetes as it wouldn't be clinically appropriate to hold a doctor accountable for providing a foot exam for ALL patients he/she sees (such as those who come in with the flu, but don't have diabetes)

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Let's look at the denominator first – the denominator is important because not all measures apply to all patients. So the denominator tells you which patients the measure applies to.

Let's think about an example from a totally different care setting. Let's say we were a primary care practice and one of our QMs was about providing foot care for diabetic patients. If I'm a primary care provider, I know that providing an annual foot exam is important for the diabetic patients I treat. However, when I think about a QM for foot exams, I wouldn't want the measure to apply to all my patients, right? That's because clinically, I don't need to provide a foot exam to all the patients I see, just those with diabetes. That's what the denominator tells you – which patients a measure applies to.

In other words, the denominator definition tells you which patients you should be held accountable for providing a certain care process for, or achieving a certain outcome for. I like to think of the denominator as the "in-group" or the "rule" for any given QM. In this foot exam measure, we would only want to be held accountable for providing foot exams to patients with diabetes, not those who come into our office for other reasons – like the flu – but don't have diabetes. So our "in-group" or "rule of thumb" for this measure is patients with diabetes.



Recipe: Step 2

Understanding Denominator Exclusions

- Denominator exclusions: Are there any exceptions?
 - Think of exclusions as “exceptions to the rule”
 - A QM may have multiple denominator exclusions
 - Even if a patient meets the denominator, if they also meet exclusion criterion, they are excluded from the measure
- Example: Foot exams for Diabetes Patients
 - Even among patients with diabetes, it may not be appropriate to hold the provider accountable for providing a foot exam to ALL diabetic patients
 - For example, patients who are bilateral foot amputees would not need a foot exam and would be excluded from the denominator
 - Age is another common denominator exclusion, and patients under 18 are excluded from this measure

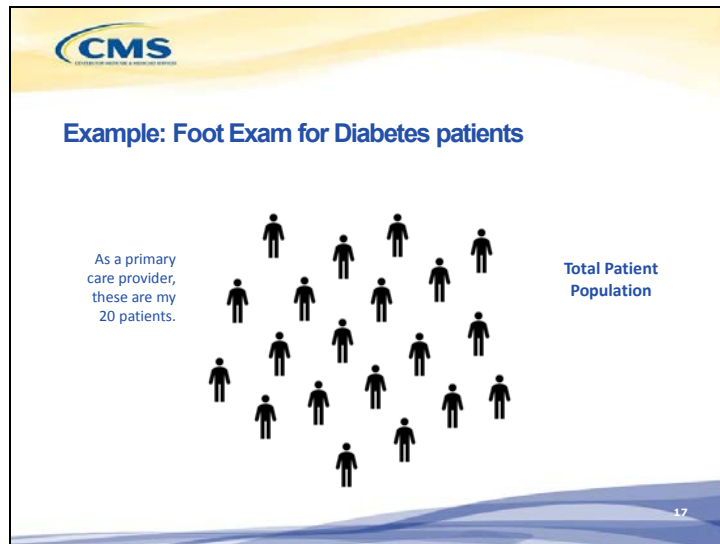
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Next are denominator exclusions. If the denominator is the “rule” for which patients the measure applies to, then denominator exclusions are the “exceptions to the rule”. In this sense, denominator exclusions further limits who is included in the denominator.

If a patient meets the denominator definition, but they also meet an exclusion criterion, they are EXCLUDED from the measure.

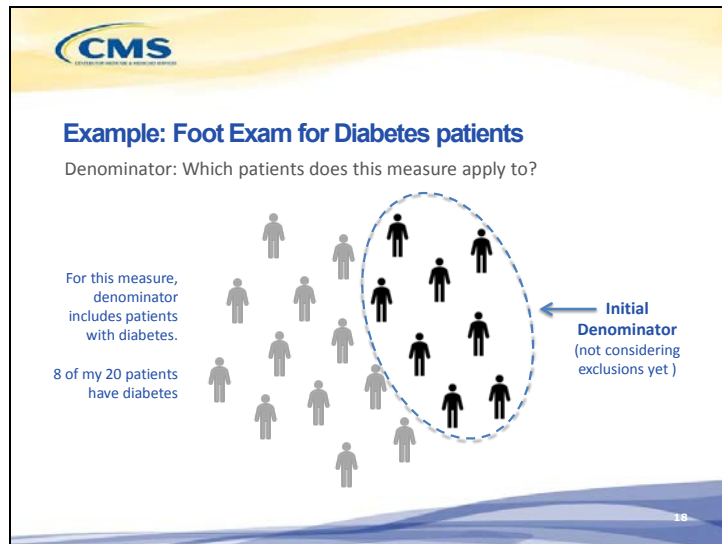
Going back to our foot exam example from the prior slide, in the prior slide, we decided the denominator would include diabetic patients. That’s our rule – so that’s the group of patients a provider is going to be held accountable for providing a foot exam for. However, as clinicians, we can probably think of some exceptions to this rule – diabetic patients that it wouldn’t be fair to be held accountable for providing a foot exam for. One exception could be patients who are bilateral foot amputees. For these patients, the foot exam is not necessary. Thus, one exclusion to this measure would be patients who have had a double-foot amputation.

QMs can have multiple denominator exclusions. Another common denominator exclusion is patient age, and many CMS quality measures exclude patients under 18. This exclusion is often not made for a clinical reason, the way amputees are excluded because a foot exam is not clinically necessary. But rather, the exclusion for age is in place due to limited research in pediatric populations to support the appropriateness of certain care processes for pediatric patients.



Now that we've talked about what denominator and denominator exclusions are in words, let's look at an example with pictures and numbers.

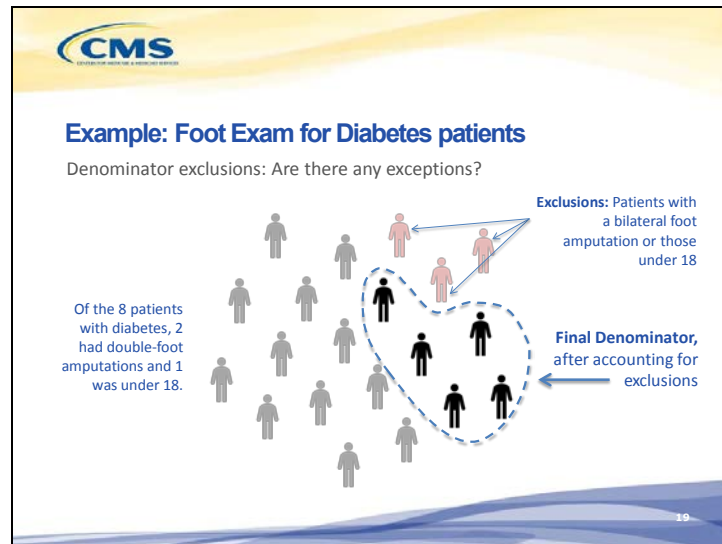
Going back to our foot exam example, let's say I'm a primary care provider, or PCP, who sees 20 patients in a year. That's what's here on slide 15. These 20 patients are my TOTAL patient population.



When calculating our measure, the first thing we need to do is figure out the denominator. Remember, that's the patients this measure applies to – in this example, it would be the patients I'm going to be held responsible for providing a foot exam for. From our prior discussion on this measure, remember that our denominator was limited to patients who had diabetes.

Among my patient population of 20, there are a total of 8 patients with diabetes, as you can see in the dotted oval on the slide.


The oval outlines the initial subgroup of patients I'm responsible for providing a foot exam for --- prior to considering any denominator exclusions.



So our denominator told us we had 8 diabetic patients out of 20 total patients. However, that's not our final denominator, as we haven't yet considered exclusions.

From our prior discussion remember, diabetic patients are excluded if they are a bilateral foot amputee or are under 18.

In this example, let's say we have 2 bilateral amputees and one patient under 18. This means we have 3 patients excluded from the denominator, taking our final denominator count down to 5.



Recipe: Step 3

Understanding the Numerator

- Numerator: What needs to happen to receive credit for the measure?
 - Can have multiple components (e.g., “what” and “when” components)
 - Must meet all components to get credit for the measure
- Example: Foot Exam for Diabetes Patients
 - “What” component: exam must include visual, sensory, and pulse components
 - “When” component: exam must be conducted 1x per calendar year
 - Must meet both the “what” and “when” components to get credit for the measure


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Now that we have the denominator and denominator exclusions under our belt, let's turn to step 3 – the numerator.

Remember, the final denominator (denominator after accounting for any excluded patients) tells you which patients you're responsible for completing a certain care process for or achieving a certain outcome for. The numerator definition tells you what needs to happen to “get credit” for the measure. In this sense, the numerator sets a clear definition for “success”. In the foot exam example, the numerator would tell exactly what a foot exam must include for it to be considered “successful”.

A few notes about the numerator:


- The numerator definition can have multiple components, such as both a “what” and a “when” component. For example, thinking about what ‘counts’ as a successful foot exam, the numerator may specify that to count as a foot exam, your exam must include visual, sensory, and pulse components. This would be the “what” of the numerator definition as it tells you exactly WHAT you had to do.
- The numerator may also specify a time component – in this example, you must provide the foot exam at least 1x per calendar year. This would be a “when” component.
- If a numerator has multiple components (so a what and when component) you must meet ALL components to get credit for the measure. So if you only provided a visual and pulse component to your foot exam that year, this would not get you credit for the measure because although you met the “when” portion, you did not fully meet the “what” portion.



Example: Foot Exam for Diabetes Patients

Numerator: What needs to happen to receive credit for the measure?


Factoring in my denominator definition and exclusions, I was responsible for completing a foot exam on 5 patients.



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Now that we understand in words what the numerator definition tells you, let's go back to our example. Remember, for our practice that had 20 patients, after we applied the denominator definition and denominator exclusions, we ended up with 5 patients in the final denominator. So, per the measure, we're responsible for giving a foot exam to those 5 patients. So I only need to figure out the numerator for these 5 patients, not all 20 I saw in my practice last year, and not all 8 who had diabetes.

The numerator will tell us exactly what our foot exam must include for those 5 patients to get credit for the measure.




Example: Foot Exam for Diabetes Patients

Numerator: What needs to happen to receive credit for the measure?

- What: Exam must have visual, sensory, and pulse component
- When: Must have 1 exam within the past calendar year

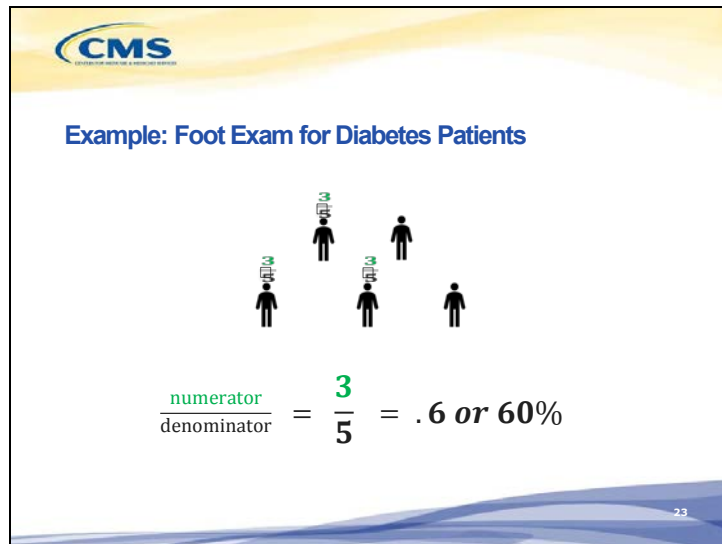
Of those 5 patients, I met the numerator (had a foot exam with all three components AND it was within the last year) for 3 patients.



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For the numerator for this measure, we had to do 2 things we had to do to get credit for the measure. Based on our “what” component, our exam had to include a visual, sensory, and pulse component. Based on our “when” component, we had to provide a foot exam within the past calendar year.

Out of my 5 patients, let’s say only 3 of them met the numerator definition. Thus we only get credit for 3 out of our 5 patients. The other two patients that didn’t meet the numerator definition could have fallen out for any combination of reasons – either we did a foot exam in the past year but it was missing one of the sensory/pulse/visual components OR we completed a full visual/sensory/pulse exam, but it happened greater than 1 year ago.



With both our numerator and denominator known, calculating the foot care measure score is straightforward. Because this measure is a percentage, to calculate your score, you just create a fraction where the numerator is divided by the denominator.

Here, our final denominator was 5 and the numerator is 3. So our fraction is 3 over 5 or 3 divided by 5 which comes out to .6 or 60%.




QM specifications
Putting it all together

QM component	Definition	Notes
Initial Denominator	Patients included in the measure	<ul style="list-style-type: none"> ▪ “The rule” for which patients the measure applies to
Denominator Exclusions	Patients excluded from the measure	<ul style="list-style-type: none"> ▪ “Exceptions to the rule”
Numerator	What you must do to get credit for the measure	<ul style="list-style-type: none"> ▪ Only applies to patients included in the final denominator ▪ Can have multiple components (e.g., what and when) ▪ All components must be met to get credit

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Let’s review what we’ve just learned about the 3 steps in most QM specification “recipes” – the denominator, denominator exclusions, and numerator. Remember, the initial denominator is your general rule of thumb for what patients the measure applies to. The denominator exclusions are your exceptions to the rule – patients you won’t be held accountable for purposes of the measure. Remember, your denominator isn’t final until you’ve taken the exclusions into account.

The numerator tells you what you must do to get credit for the measure. Remember, the numerator applies only to patients in the final denominator and can have multiple parts and you must comply with to get credit for the measure



QM specifications

Putting it all together

Clinical practice vs QM specifications – an example:

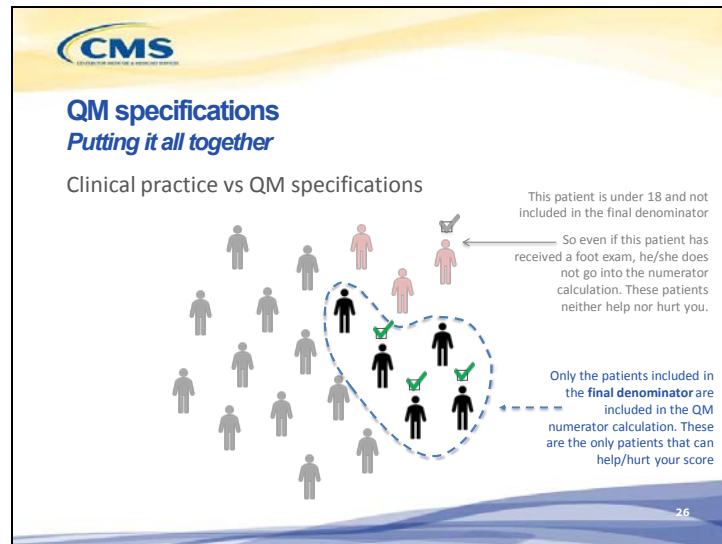
- In foot exam QM, one of our denominator exclusions was for patients under the age of 18
- Although the measure applies to patients 18+ only, a physician may perform a foot exam on pediatric diabetic patients and CMS may require you to submit data on patients of any age, even though patients under 18 are excluded from the measure
- In these instances, although providing a foot exam to pediatric patients is good clinical practice, these patients will NOT be counted in the numerator

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Before we move on, I want to point out one more detail about quality measure calculation vs clinical practice, as this is often an area of confusion our Help Desk.

Thinking back to our foot exam example, one of our denominator exclusions was based on age, where patients under 18 were excluded.

In clinical practice, a physician may perform a foot exam on diabetic patients under 18 years of age, and that would be good clinical care for those patients. However, although it is clinically appropriate, those patients would not be counted in the numerator, even though you provided a foot exam for them. That is because the measure excludes patients under 18.



To illustrate this point in numbers and pictures, let's return to our example. We had 20 patients we saw that year. We started with 8 in the denominator, but excluded 3 based on age and/or the fact that they were bilateral-amputees. Those excluded patients are the patients in red in the top right of the graphic. Thinking about our numerator, our numerator is represented by patients who have a check-mark above their head. We see that for one of our excluded patients, the patient under 18, we did provide a foot exam for that patient, as denoted by the checkmark. However, although we provided a foot exam and that was good clinical care, that patient doesn't go into our numerator count BECAUSE THEY WERE EXCLUDED FROM THE DENOMINATOR. This means our final numerator count is still 3, not 4.

The fact that the pediatric patient doesn't get counted in our numerator does not hurt our overall score. The reason for this is because a patient can only "help" or "hurt" your score if they are in the denominator.



This may sound simple now, but it often trips people up with the HIS measures as clinicians will often say “I provided a comprehensive pain assessment meeting all components of the numerator definition for Ms. Jones but Ms. Jones isn’t appearing in the numerator count for my measure – why is that?”

Assuming Ms. Jones’s pain assessment really did meet the numerator definition – all components of it – then the answer to that is bc Ms. Jones was excluded from the denominator.

To make sure I don’t trip myself up, I like to tell people – never start calculating your measure by counting the numerator first. Always start with the denominator, and then count the numerator **ONLY FOR THOSE PATIENTS WHO END UP IN THE FINAL DENOMINATOR**. So never take a report of all patients you saw in a given time period and start counting whether you met the numerator for all patients. Figure out your final denominator first, then figure out the numerator only for that subset of patients.

Remember, just like it’s important to follow the steps in a recipe in order when baking a cake, its important to follow the order of the QM specifications when calculating your measure.

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An example with the Comprehensive Pain Assessment QM (NQF#1637)

J0910. Comprehensive Pain Assessment	
Enter Code	A. Was a comprehensive pain assessment done?
<input type="checkbox"/>	0. No → Skip to J2030, Screening for Shortness of Breath
	1. Yes
	B. Date of comprehensive pain assessment:
	Month Day Year
	C. Comprehensive pain assessment included:
↓ Check all that apply	
<input type="checkbox"/>	1. Location
<input type="checkbox"/>	2. Severity
<input type="checkbox"/>	3. Character
<input type="checkbox"/>	4. Duration
<input type="checkbox"/>	5. Frequency
<input type="checkbox"/>	6. What relieves/worsens pain
<input type="checkbox"/>	7. Effect on function or quality of life
<input type="checkbox"/>	9. None of the Above

To calculate NQF#1637 QM:


- First, gather the ingredients (HIS items). Main ingredient for this measure is HIS item J0910.
- Then, follow the recipe. The recipe is the QM specification for NQF#1637.

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With those basics under our belt, I'll now walk through an example of how we get from data to measure (or ingredient through recipe) using an example from the HIS QM specs. The quality measure we will be calculating in this example will be the Comprehensive Pain Assessment Quality Measure, also known as NQF#1637.

The HIS item – or the ingredient – that will be used to calculate the NQF#1637 is the comprehensive pain assessment item, item J0910. This item, as you can see in the picture here, captures whether a pain assessment was completed, the date of the assessment, and what the assessment included (location, severity, etc.). The item alone, as an ingredient, tells you little about how the measure is constructed – what the numerator, denominator, or exclusions are, and how to put it all together. Much of the same way that looking at an egg or a stick of butter alone wouldn't tell you how to bake a cake.

To know this information, I need to find the measure specifications for NQF#1637 – or the recipe. Additionally, just like you can't make a cake with 1 ingredient, I cannot calculate the 1637 measure using this 1 item alone. The QM specifications (or recipe) will tell me what other items (ingredients) I need to gather to calculate this measure.



An example with the Comprehensive Pain Assessment QM (NQF#1637)

QM Specifications

NQF #1637: Hospice and Palliative Care—Pain Assessment
 The following steps are used to calculate the measure:

Step 1. Calculate the denominator count:

- Calculate the total number of **Type 1** stays in the denominator where the patient's pain severity was rated mild, moderate, or severe (**J0900C = {1,2,3}**) that do not meet the exclusion criteria.

Step 2. Identify excluded stays:

- Patient stay is excluded if patient is under 18 years of age as indicated by the birth date (**A0900**) and admission date (**A0220**); **OR**
- It is a **Type 2 or 3** patient stay.


Step 3. Calculate the numerator count:

- Calculate the total number of stays from the denominator where a comprehensive pain assessment was completed within 1 day of the pain screening during which the patient was screened positive for pain (**J0910B – J0900B ≤ 1 and J0910B and J0900B ≠ [-,^]**) **AND** included at least 5 of the 7 characteristics (**5 or more items in J0910C1 – J0910C7 checked and not all J0910C boxes = [-,^]**).

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Slide 29 is an excerpt from the QM User's Manual and shows the QM specification (or recipe) for the NQF #1637 Pain Assessment QM. As you can see, this recipe includes 3 main steps that we just went over – which is to figure out the denominator, account for any denominator exclusions, and then figure out the numerator. As you can also see, besides our main ingredient (Item J0910) the specification tells you which other ingredients you need to gather – or which other items are used in the calculation of the QM. In addition to J0910, we see Item A0220, A0900, and J0900 are also used in the calculation of this measure.

We'll now go through each step for this measure in greater detail.



An example with the Comprehensive Pain Assessment QM (NQF#1637)

QM Specifications

NQF #1637: Hospice and Palliative Care—Pain Assessment

Step 1. Calculate the denominator count:

- Calculate the total number of **Type 1** stays in the denominator where the patient's pain severity was rated mild, moderate, or severe (**J0900C = {1,2,3}**) that do not meet the exclusion criteria.

Step 1 is to figure out our denominator, or who the measure applies to.


We see from the QM specification this measure applies to:

- Patients who have screened positive for pain, **and**
- Patients with a Type 1 stay (patient has been discharged and has an HIS Discharge record in Quality Improvement and Evaluation System Assessment Submission and Processing (QIES ASAP) System

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Step 1 is to figure out our denominator or who from our total patient population this measure applies to. The first part of the denominator is clinically driven – as the denominator is limited to only those patients who screen positive for pain.

We also see that our denominator definition has a second component – this second component is not clinically driven, but applies to whether a patient is still on service. We can see from the second bullet that this measure applies only to Type 1 stays. A Type 1 stay is defined as a patient who has been discharged and has an HIS-DC record in the QIES System. This means the measure score is only calculated for patients who have been discharged. CMS includes only Type 1 in measure calculation because this avoids double-counting patients in Hospice Compare refreshes.



An example with the Comprehensive Pain Assessment QM (NQF#1637)

QM Specifications

NQF #1637: Hospice and Palliative Care—Pain Assessment

Step 2. Identify excluded stays:

- 1.1 Patient stay is excluded if patient is under 18 years of age as indicated by the birth date (A0900) and admission date (A0220); OR
- 1.2 Type 2 and 3 patient stays.

Step 2 tells us our denominator exclusions, or “the exceptions to the rule”:


- Patients under the age of 18
- Patients who have been discharged but are missing an admission record (Type 2 stay), and patients who are still on service and not yet discharged (Type 3 stay)

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Step 2 tells us who is excluded from the denominator. Here, we see that patients under 18 are excluded, as well as Type 2 and Type 3 stays, which are patients who have not yet been discharged or patients who have a Discharge record but are missing an admission record.

I want to pause here and point out a few things.

- First, just like you don't use all of the ingredients in your pantry to make a cake, even though you submit data for all patients, not all patients end up in your score. SO even though you submit data for patients under 18, these are never included in your publicly reported score because the “recipe” tells you to exclude them.
- Second, note that in addition to telling you things “in English” the QM specification also tells you things in “technical” language. So in addition to telling you patients under 18 are excluded, it tells you exactly how that is calculated – birth date minus admit date using Items A0900 and A0220.



An example with the Comprehensive Pain Assessment QM (NQF#1637)

QM Specifications

NQF #1637: Hospice and Palliative Care—Pain Assessment

Step 3. Calculate the numerator count:

- Calculate the total number of stays from the denominator where a comprehensive pain assessment was completed within 1 day of the pain screening during which the patient was screened positive for pain ($J0910B - J0900B \leq 1$ and $J0910B$ and $J0900B \neq [-,A]$) AND included at least 5 of the 7 characteristics (5 or more items in $J0910C1 - J0910C7$ checked and not all $J0910C$ boxes = $[-,A]$).

Next, we need to calculate our numerator. This will only apply to the patients in our final denominator.

Step 3 tells you the numerator criteria, or what you must do to get credit for the measure:

- Complete a comprehensive pain assessment that includes at least 5 of the 7 characteristics AND
- Complete this assessment within 1 day of the patient screening positive for pain

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Now, let's focus on the numerator, which is Step 3 of our recipe.

First, the QM specifications remind us that the numerator only applies to patients included in the denominator as noted by the language that reads "calculate the total number of stays **from the denominator** where a comprehensive pain assessment was completed". This gets us back to our point about clinical practice vs QM specifications. For example, many people tell us on the Help Desk that even if the patient doesn't have pain during the screening visit, the hospice will complete a comprehensive assessment anyway for those patients because they have an active history of pain. The question we get on the Help Desk in this situation is "we did a pain assessment for those patients, but they're not showing up in our numerator – is this hurting our score? I want to make sure I'm getting credit for these patients"

Before we dive into that question, I want to emphasize the role between QMs, the HIS, and clinical judgement. The HIS and associated QMs are not intended to replace clinical judgement and should not supersede clinical judgement. So you should always do what is clinically appropriate for a patient, independent of the HIS or any QM specifications.

With that said, the answer to how patients who don't screen positive for pain but you provide a pain assessment for anyway – the answer to whether those patients hurt your score is no – having completed a pain assessment for these patients may be good clinical practice, so you may want to keep doing it, but the fact that they don't end up in your numerator doesn't hurt your score. And the reason why is because they don't go into the denominator. In addition to not counting against you, you're also not losing any "extra credit" for these patients. That's because for the HQR measures, there is not extra credit. If a patient is not in the denominator, it won't boost your score to have done the "extra" care process for them.

Now, back to the numerator definition. We can see here that to get credit for this measure, we must complete a comprehensive pain assessment that includes at least 5/7 characteristics AND it must be done w/in 1 day of screening positive for pain. So this numerator has a what and a when component.



Ingredient vs Recipe

J0910. Comprehensive Pain Assessment

Enter Code

A. Was a comprehensive pain assessment done?

0. No → Skip to J2030, Screening for Shortness of Breath

1. Yes

B. Date of comprehensive pain assessment:

Month Day Year

C. Comprehensive pain assessment included:

☐ Check all that apply

<input type="checkbox"/> 1. Location
<input type="checkbox"/> 2. Severity
<input type="checkbox"/> 3. Character
<input type="checkbox"/> 4. Duration
<input type="checkbox"/> 5. Frequency
<input type="checkbox"/> 6. What relieves/worsens pain
<input type="checkbox"/> 7. Effect on function or quality of life
<input type="checkbox"/> 8. None of the Above

NQF #1637: Hospice and Palliative Care—Pain Assessment

Step 1. Calculate the denominator count:

- Calculate the total number of **Type 1** stays in the denominator where the patient's pain severity was rated mild, moderate, or severe (**J0900C = [1,2,3]**) that do not meet the exclusion criteria.

Step 2. Identify excluded stays:

- Patient stay is excluded if patient is under 18 years of age as indicated by the birth date (**A0900**) and admission date (**A0220**);
- OR**
- It is a **Type 2 or 3** patient stay.

Step 3. Calculate the numerator count:


- Calculate the total number of stays from the denominator where...

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The last thing I want to point out here is an ingredients vs recipe distinction. Remember, we started out with our “main” ingredient – Item J0910, but having now looked at the QM specification, we can really see how looking at that HIS item alone tells you little about how the measure is calculated. For example:

- Many people incorrectly assume that all they need to do is answer “yes” to J0910A to get credit for the measure. Having reviewed the QM specification numerator definition, however, we see that’s not the case! In fact, J0910A isn’t included in the numerator definition at all. To meet the numerator definition, you must have done 5/7 elements of a pain assessment (J0910C) and it must have been done w/in 1 day of screening positive for pain (J0910B minus J0900B <= 1).

So remember, look at the QM specification to understand how measures are calculated, not just HIS items alone.




Important QM specification takeaways for all HIS QMs

- Even though you will submit data for all your patients, not all patients are included in each measure
 - Ex: HIS records are submitted for all patients; measure applies only to those over 18 and those that have been discharged (Type 1 stay) and have all their HIS records in QIES ASAP
- For measure purposes, completing a care process only affects your measure score if the patient is in the measure denominator
 - Ex: Completing a pain assessment for a patient that's NOT in the denominator → this patient is neutral to your measure score because they are not in the denominator
 - Although you completed the pain assessment, this patient doesn't count for or against you in your measure score.

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So we've just gone through the QM specifications for one measure, NQF #1637, but there are some important key takeaways from that example that can be applied to all HIS QMs and their specifications.

- First, remember that even though you submit data for all patients, not all patients end up in a measure – ex: HIS is submitted for all patients, regardless of age, but only those 18 and over, as well as those that did not have a double-foot amputation end up in the measure denominator
- Second – for the purposes of QM reporting -- completing a care process only matters if the patient is in the denominator. If the patient ends up being excluded from the denominator, you can still complete that care process, but they won't end up in your numerator. This is OK as these patients will neither count for nor against you in your final score.



Important QM specification takeaways for all HIS QMs

- Don't rely on HIS items alone; look at the QM specifications to know what will actually get you credit for a measure
 - Ex: Answering "yes" to J0910A does NOT get you credit for the NQF #1637 measure
- All HIS measures are calculated for Type 1 stays only (patients who have been discharged and have both an HIS-A and HIS-D record in QIES ASAP)
 - Type 2 (patients who have been discharged but are missing an admission record) and Type 3 (patients who are still on service and not yet discharged) stays are excluded

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- Third, never rely on an HIS item alone as an indication of what will get you credit for a measure. Simply answering "yes" to an item in and of itself is unlikely to get you credit for a QM. The only way to know what gets you credit is to look at the QM specifications.
- Finally, back to Type 1 stays again because it's going to come up several more times in this presentation. Remember, **all** HIS measures are calculated for Type 1 stays only. This means only patients who have been discharged and have both an HIS-A and HIS-D record in QIES will be included in any measure calculation



Cake: The Publicly Reported QM Score



That takes us through our ingredients and our recipe. Now, we can move on to the publicly reported score or the cake. The publicly reported score is our “final product” because that’s what is ultimately reported on Hospice Compare.



Cake: The Publicly Reported QM Score

- Once you have applied the recipe (QM specifications) to transform your ingredients (HIS data), the final step in our process is to assemble the cake itself – the publicly reported QM score on Hospice Compare
- Hospice Compare reports HIS and Hospice Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey data for hospice providers
 - Reporting is at the CCN-level
 - Data are refreshed quarterly (typically in February, May, August, and November)
 - Refreshing the data quarterly ensures that the QMs scores reported for your hospice are current

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Once you've followed the recipe, we're ready for the last step – finishing the cake or getting our publicly reported score.

Just like baking a cake – you're not completely done after you follow the recipe. With most any cake, there are some final steps required. You have to remove the cake from the pan, and ice it or decorate it. Same with the HIS QMs. Remember, our final end product is the publicly reported score, and after we follow the QM specs (recipe) there are some final "assembly" steps we must go through to get from QM score to the publicly reported score that will display on Compare.

Before we delve into what those final assembly steps are, I'd like to present a bit of background on Hospice Compare.

Hospice Compare launched in August 2017 and now reports both HIS and Hospice CAHPS data.

Reporting is at the CCN-level and data on Compare are refreshed quarterly. These quarterly refreshes help ensure that the QM scores reported for your hospice are up-to-date and current.




**Final Cake Assembly:
Data Selection Period and Minimum Denominator Size**

- Data selection period and minimum denominator size are determined on a measure-by-measure basis
- For the 8 HIS QMs that will be publicly reported in 2018:
 - Data selection period is rolling 4 quarters
 - Minimum denominator size is 20 patient stays

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With that background, back to the final cake assembly steps, which are the data selection period and minimum denominator size. The data selection period and minimum denominator size are determined individually for each measure. For all the 8 HIS quality measures to be reported in 2018 (7 “original” HIS measures and the Hospice Comprehensive Assessment measure), they happen to be the same. The data selection period for these QMs is a rolling 4 quarters, and the minimum denominator size is 20 patient stays.



Data Selection Periods

An example with NQF #1637 for the August 2018 refresh


- The publicly reported QM score is based on a rolling 4 quarters worth of data
- So at any given time, your score on Compare was calculated using 4 quarters worth of data, but **which** 4 quarters are reported changes with each refresh
- For August 2018, the 4-quarter data selection period for NQF # 1637 (and all other HIS QMs) will be Quarter 4 2016 – Quarter 3 2017
 - With each refresh, the oldest quarter's worth of data is dropped, and the newest quarter is added
 - So for the next refresh (November 2018), the data to be reported would be Quarter 1 2017 – Quarter 4 2017
- The Hospice Compare refresh schedule can be found on the "[Key Dates for Providers](#)" page of the CMS HQR website

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So what does the data selection period and minimum denominator size tell us and why do we have it?

For most of you, you've been collecting and submitting HIS data since July 2014 – or for just over 4 years. But CMS doesn't report all 4 years worth of data on Compare. That's where the data selection period comes in. For the HIS measures currently reported on Hospice Compare, CMS reports 12 months (or 4 calendar year quarters) worth of data at a time. For the August 2018 refresh, the data selection period for all HIS measures will be Q4 2016 – Q3 2017.

With each refresh, the oldest quarter's worth of data is dropped and the newest quarter is added. So for the refresh following August 2018 – which would be November 2018 refresh, the data selection period would become Q1 2017 – Q4 2017. The complete refresh schedule can be found at the hyperlink on this slide.




Minimum Denominator Size

An example with NQF #1637 for the August 2018 refresh

- The minimum denominator size is the minimum number of patient stays you must have in the final denominator of a measure **for that data selection period** for your score to be displayed on Compare for that refresh
 - Remember to take into account denominator exclusions
- If you don't meet the minimum denominator size for a given data, the QM score is at risk of being unstable and will **not** be publicly reported

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The second and final cake assembly step is applying the minimum denominator threshold. The minimum denominator size is the **MINIMUM** number of patient stays you must have in your final denominator of a measure, for that data selection period, in order for your score to be displayed on Hospice Compare for that refresh. If the denominator for that data selection period is too low and does not meet the minimum, the QM score is at risk of being unstable and will not be publicly reported. Instead, a footnote will be displayed.



Minimum Denominator Size

An example with NQF #1637 for the August 2018 refresh

- Data selection period for August 2018 refresh is Q4 2016 – Q3 2017; minimum denominator size is 20
 - For the August 2018 refresh, your final denominator for NQF #1637 must be at least 20 based on patient stays from the relevant data selection period
 - Remember, only Type 1 stays meeting all other denominator requirements (≥ 18 and screened positive for pain) count towards your 20 patient stays
- If you don't have 20 patient stays for this data selection period, your score will not be displayed


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Let's walk through the data selection period and minimum denominator size using an example – NQF #1637. Recall that the minimum denominator size for all the HIS QMs, including NQF#1637, is 20 ELIGIBLE patient stays each data selection period. This means you must have 20 eligible patient stays for the 4 quarters of data being displayed for your score to be displayed on Compare.

For the August 2018 refresh, this means you must have 20 patients in the denominator for NQF #1637 from Q4 2016 to Q3 2017 for your score for NQF #1637 to be displayed on Compare. If you don't have 20 eligible patient stays for that time period, your score will not be displayed and instead a footnote will appear that states your hospice had too few patients for this measure. Also remember from our discussion of the NQF #1637 QM specs that the measure denominator is limited to Type 1 stays – or patients that have been discharged. This means to meet the minimum denominator size, you must have 20 DISCHARGED patient stays during the data selection period. For example, for the August 2018 refresh, you'd need 20 Type 1 stays between Q4 2016 – Q3 2017 that were over 18 and screened positive for pain to have your score for NQF #1637 displayed on Compare for the August 2018 refresh.

A lot of people ask why we have the minimum denominator size and the data selection period. And the answer is that we need the measures to be stable and measures are unstable when the denominator is too small. Think back to school when you used to have tests – would you rather have a test with 2 questions or 100 questions? I'd bet the 100 question test. With the 2 question test, if you miss one question your grade is a 50% – that's a big hit to your final grade for missing just 1 question. With a 100 question test, 1 question is the difference between a 99 or 100 or a 98 or 99 – so the impact of 1 question is a lot smaller. It's the same with the QM scores – if your denominator is smaller than 20, not meeting the numerator for 1 patient is really going to change your score drastically, leading to a measure that's not stable. So, we have the minimum denominator size to make sure your agency score is stable.

The data selection period is related – a lot of hospices are small, so if the data selection period were shorter – like 4 months instead of 12, there'd be a lot of smaller hospices that wouldn't meet the minimum denominator size since they likely wouldn't have 20 patient stays in a 4 month period.



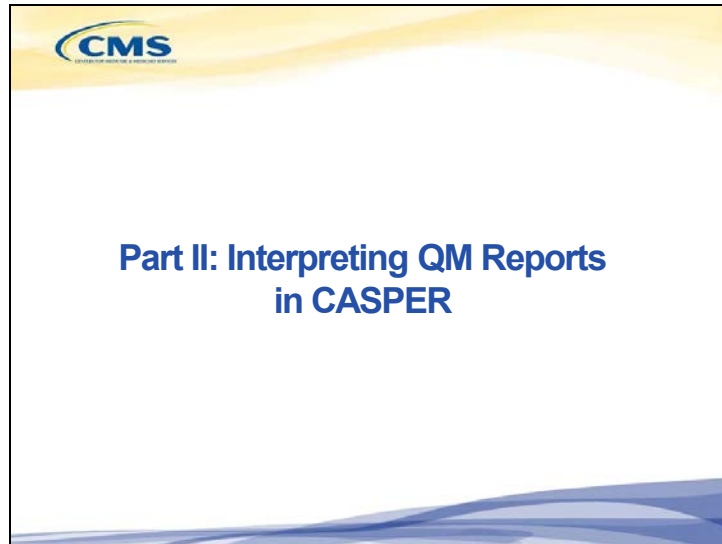
Important Publicly Reported QM Score Takeaways

- On Hospice Compare, your hospice's QM score is based on a rolling 4 quarters of data
- For each refresh, the minimum denominator size is 20 eligible patient stays for QM scores to be stable enough for display
 - Number of patient stays based on discharge records during the data selection period (not admission records)
 - Remember to factor in denominator exclusions
 - 20 stay cut-off determined on a measure-by-measure basis (i.e., if you have 22 stays for the NQF #1637 measure but only 10 for the NQF #1641 measure, only the NQF #1641 score is **not** displayed)


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Slide 42 presents some takeaways – or key summary points – for the content we just went over on minimum denominator size and data selection period. This slide may be a useful quick reference as you're thinking about these issues in the future.

At this point, I'll turn it over to Dorothy who will lead Part II of this call.



Thanks, Alexis. Part II will focus on how to interpret your QM reports from CASPER.



CASPER Reports

- QIES ASAP is the system used to both:
 - Submit HIS data to CMS
 - Access CASPER reports
- CASPER reports are the best way to get to know your data

Check out the CMS training on Hospice Data Submission and Reporting Webinar (released May 2018), which provides further guidance on how to navigate the CASPER System

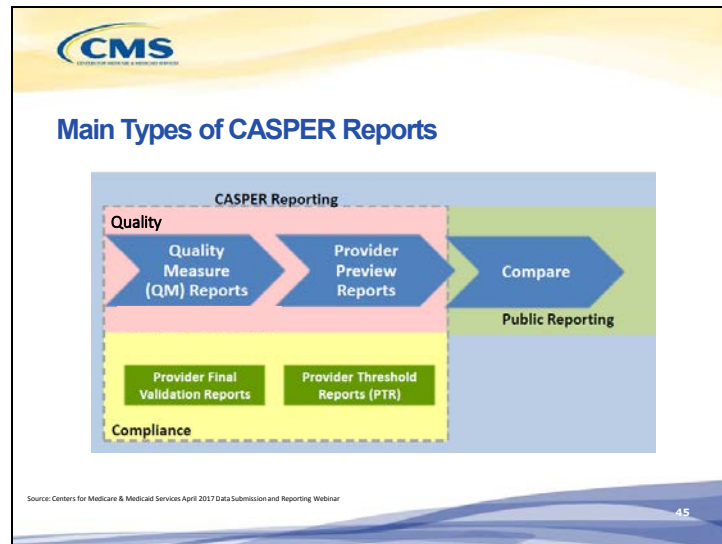
44

Now that we know how QMs are calculated, let's talk about where you can go to view your hospice's performance on individual QMs.

There are 2 names to know here – first is QIES ASAP, second is CASPER.

QIES ASAP is the system used to submit HIS data to CMS. Within QIES is the CASPER Reporting application, which is where you go to view various "CASPER Reports" that can tell you details on your hospice's submitted HIS data, including your hospice's performance on HIS QMs.

This presentation won't go into the nuts and bolts of how to access and login to QIES and CASPER, if you need help with that, check out the training available at the link provided on this slide.



This slide outlines the main types of CASPER reports available. Again, CASPER Reports are reports available to all hospice providers that can provide useful information before a hospice's data is displayed on Compare.


All in all, there are 15 different reports available in CASPER for hospice providers; today, we will be focusing on 2 of them.

As a useful mental schema, I like the graphic presented here on slide 45. The 15 reports available in CASPER can be divided into two main types of reports – those useful for quality purposes (in the light pink box), and those useful for compliance purposes (in the yellow box).

We'll focus today on some of the quality reports; specifically, we're going to focus on the QM reports – there are two of those. As you can see, Provider Preview Reports are another type of quality of report available, but we won't be focusing on those today. Although we won't be focusing on Preview reports today, it is helpful to know the main differences between QM reports and Preview reports. Preview reports serve one very specific purpose. They show you EXACTLY how your HIS data will display on Hospice Compare for a given refresh. They are released about 2 months before a given refresh and are providers' LAST CHANCE to ensure the scores that are to be reported are accurate. Preview reports are automatically generated for you and are not customizable. So going back to our cake analogy, your preview report will show you your final, assembled cake for your agency's measure scores.

QM reports are different from preview reports in that providers can generate a QM report at any time, for any data selection period, to see how they are performing on HIS measures. We often find providers underutilize QM reports and will wait until a Preview report is released to check-in and see what their QM scores are. At that point, it's too late to take action to improve your score. Your scores are set – the cake is iced, sliced, and ready to serve, regardless of whether you've forgotten any ingredients or followed the recipe incorrectly. This is where QM reports can come in handy; if you are monitoring QM reports regularly, you can identify trouble areas at your hospice and act on them to improve your performance so that by the time preview reports roll around, you're not 'surprised' by any QM scores. Monitoring QM reports regularly is also a good way for you to ensure you don't have any missing or inaccurate HIS data (i.e., a fully stocked and high-quality pantry). If you review a QM report early and identify missing or incorrect data, you can correct the missing/incorrect data prior to the Preview reports, when data are "frozen". Once the data are frozen for preview reports, it's too late to submit any missing or corrected HIS records for that particular Compare refresh.

In this sense, I like to think of the QM reports as progress reports – interim reports you can run to tell you how you're doing. And the preview report is the final report card. In school, you'd never want to wait till the final report card to figure out your grade, because at that point, it's too late to take any action to try and improve your grade, or turn in any assignments you found out were missing or incomplete. So we encourage providers to use QM reports early and often, which is why we're focusing on them today instead of Preview reports.



QM Reports

- QM Reports are like your private chef: they take your ingredients (HIS data) and follow the recipe (QM specifications) to bake the cake (your hospice's QM score)
- However, although the QM Reports “bake the cake” for you, they do not automatically perform the final “cake assembly” steps (apply the correct data selection period and minimum denominator size)
- This means that the QM scores displayed on your QM Report are not necessarily the QM scores that will be displayed on Hospice Compare

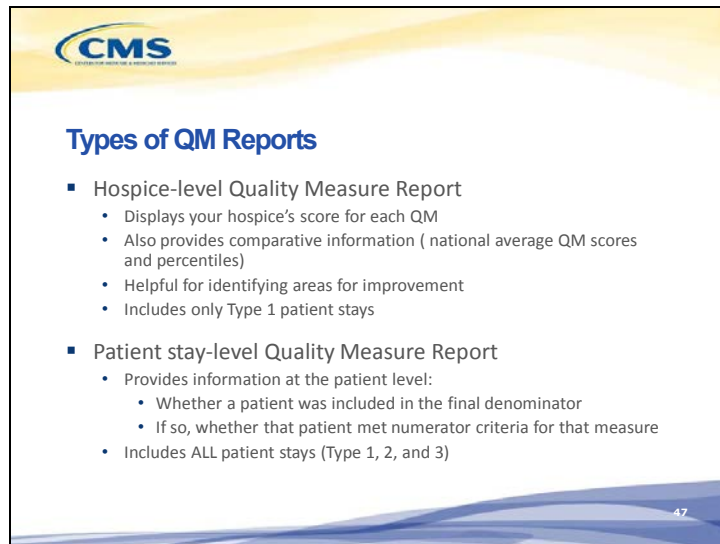
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Going back to our baking a cake analogy, QM Reports are like your private chef: they take your ingredients (HIS data) and follow the recipe (QM specifications) to bake the cake (your hospice's QM score)

However, although the QM Reports “bake the cake” for you, they do not automatically perform the final “cake assembly” steps (apply the minimum denominator size and relevant data selection period automatically).

This means that the QM scores displayed on your QM Report are not necessarily the QM scores that will be displayed on Hospice Compare. In

In order for you to see an approximation what your scores will look like on Hospice Compare before the preview reports are released, you'd want make sure you are running the report for the right data selection period, and keep in mind that if you see denominators <20, those scores will not be displayed on Compare.

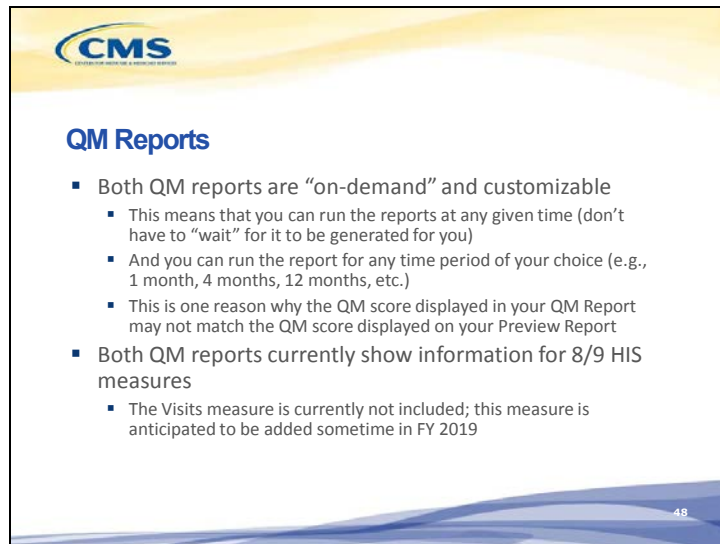


There are 2 QM reports available to you, the hospice-level QM report and the patient stay-level QM report.

Both of these reports tell you how your hospice is performing on HIS QMS, but from different perspectives. The hospice-level report tells you your hospice's score for each QM. Because the QM is calculated at the overall hospice-level, this report only takes into account Type 1 patient stays – so patients that have been discharged and have both an HIS-A and HIS-D record in QIES – in order to calculate your overall hospice QM score. In addition to telling you YOUR hospice's score, this report also tells you how your score compares to the national average and percentile. Because this report is at the measure level and provides the comparative information, it is useful for identifying areas for improvement.

The patient stay-level report doesn't tell you your hospice's score on the QMs. Instead, it provides a roster of all patients and tells you whether that patient was eligible for the denominator of each measure and, if so, whether they met the numerator for that measure. As such, once you've identified a measure you want to improve on, the patient-stay level report can be useful for drilling down to see which patients you met the measure numerator for and which you did not. In this sense, these reports can help you figure out where you went wrong and WHY your score is the way it is. Because this report looks at quality performance patient by patient, the report includes all patients of all stays so that you may view if and how the care provided to each individual patient affected a QM measure.


If we go back to the report card example, the Hospice-level QM report is like a teacher's average score among all her students, for each subject she teaches. So it would tell the average math grade for her class and the average grade in science for her class. The Patient Stay-level report, on the other hand, would be like a student roster that would tell her each individual student's grade in each subject. So if the overall average in her math class was a B, the patient-stay level report would help her figure out why. The patient-stay level report would show her whether her class average was a B because most students were receiving B's or if there was a different situation --- like most of her students were receiving A's but there were one or two students with F's that brought down her overall average.



Both QM reports are “on-demand” and customizable

- This means that you can run the reports at any given time (don’t have to “wait” for it to be generated for you)
- And you can run the report for any time period of your choice (e.g., 1 month, 4 months, 12 months, etc.)
- This is one reason why the QM score displayed in your QM Report may not match the publicly reported QM score

CMS believes it is important for providers to have time to view and become familiar with their QM scores using the CASPER reports, before measures are reported on the Preview reports and Hospice Compare. Getting back to our point about report cards, CMS thinks it is important for providers to have progress reports prior to their final grade reported on their report card. Therefore, there may be more measures available for you to view on your reports than are available for consumers to see on Hospice Compare. For example, the Hospice Comprehensive Assessment measure scores were made available on your CASPER QM reports in February 2018, though this measure will not be reported on the preview reports and Hospice compare later this fall. Having the Comprehensive Assessment measure on the QM reports now gives providers an opportunity to do a progress report check-in before their “final grade” is reported on Hospice Compare in the fall.




Hospice-level QM Reports

- Displays the numerator and denominator (accounting for exclusions) for each measure, as well as the calculated percentage QM score
- Also provides relative information for each measure:
 - National average comparison group
 - National percentile comparison group

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Now that we have a general understanding of what QM reports are, let's talk about each one individually. The hospice level QM report shows you your hospice's average score on each measure. The report will display the numerator, denominator (accounting for any exclusions) for each measure, as well as the percentage QM score.

This report also provides some comparative information to let you know how your hospice is performing on each QM, compared to national averages and percentiles.



Hospice-level QM Reports

REPORT TIMEFRAME: 01/01/18 – 06/30/18

Measure Name (NQF ID)	CMS Measure ID	Numerator	Denominator	Hospice Observed Percent	Comparison Group National Average	Comparison Group National Percentile
NQF #1641	H001 01	10	20	50%	75.2%	23
NQF #1647	H002 01	5	20	25%	50.2%	5
NQF #1634	H003 01	0	0	-	50.2%	-
Etc.						

Note: Hospice-level report includes only Type 1 stays


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Let’s look now at an example Hospice-Level QM report. Displayed on slide 49 is a snapshot of how the QM report is formatted – you see there is a row for each measure and the columns are your data and scores.

Note that this report will only include Type 1 stays– or patients that have been discharged and have both of their required HIS records submitted in QIES (HIS-A and HIS-D). So the numbers presented in this report for numerator, denominator, observed percent are based only off of Type 1 stays that were discharged within the time period you specified for this report to be on QIES ASAP. This report was selected to be generated for patient stays with discharge dates between January 2018 to June 2018.

So if you pulled a QM report today, you’d see a line for the original 7 HIS measures as well as the Hospice Comprehensive Assessment measure. To save space, we’ve only included rows for 3 measures in this presentation, but an actual QM report would display information for all 8 measures I just mentioned.

Let’s now walk through what each of the columns mean. The first and second columns just tell you the name of the measure. The first column tells you the NQF ID and the second column tells you the CMS Measure ID. As a provider, you’re more likely to know the measure and refer to it by its NQF ID, so column 2 may not be that important to you.



Hospice-level QM Reports

Number of stays from the denominator that met numerator criteria, per the QM specifications

REPORT TIMEFRAME: 01/01/18 – 06/30/18

Measure Name (NQF ID)	CMS Measure ID	Numerator	Denominator	Hospice Observed Percent	Comparison Group National Average	Comparison Group National Percentile
NQF #1641	H001 01	10	20	50%	75.2%	23
NQF #1647	H002 01	5	20	25%	50.2%	5
NQF #1634	H003 01	0	0	-	50.2%	-
Etc.						

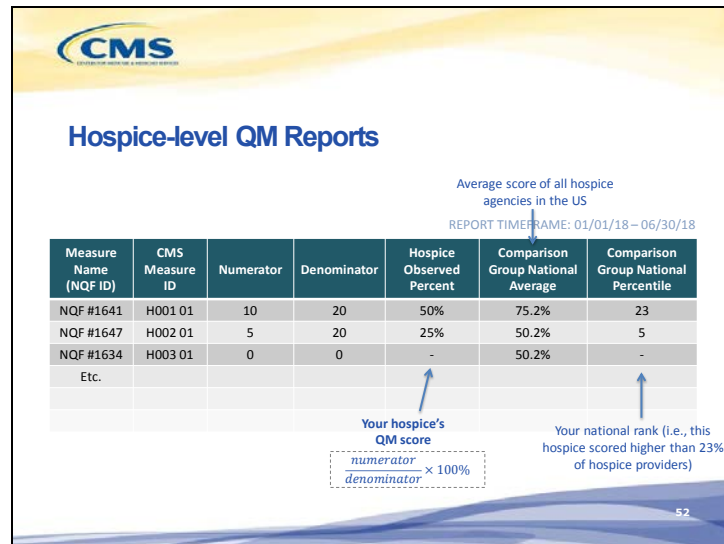
Number of stays during time period selected that met denominator definition, accounting for exclusions

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Let's look now at the numerator and denominator columns.

The numerator, as you may remember, is the number of stays from the denominator that met numerator definition, according to the QM specifications. Remember that because the numerator is only calculated for patients in the final denominator, the numerator will always be either less than or equal to the denominator.

Next, we have the denominator, which is the Number of stays during time period selected that met denominator definition, accounting for exclusions. The denominator column will show you your FINAL denominator count. So any excluded patients have been removed and won't be counted in this tally.




Next, let's go over the hospice observed percent column. This is your hospice's score on a given QM, over the time period you selected. To calculate this number, you simply do numerator divided by denominator and multiply it by 100. So for the NQF #1641 measure row here, we see the hospice observed percent is 50%. We calculated that by dividing 10 by 20 and (.5) and multiplying that by 100 (50%).

The last two columns of interest are the comparison group national average and the comparison group national percentile. These aren't specific to your hospice. They are comparative information that is intended to give you an idea of how you are performing on a given QM relative to your peers.

The comparison group national average is just the average score for that measure across all hospice agencies in the US. Your score was 50%, which is lower than the national average of 75.2%. This tells us that this hospice is performing *worse* than the national average.

The comparison group national percentile column is another piece of relative information. I like to think of percentiles as a rank. The 23 appearing in this column for NQF #1641 tells us that 23% of providers had a QM score for NQF #1641 that was worse than yours. Or stated another way, you did better than 23% of providers. For this column, higher ranks or numbers indicate better performance.




Hospice-level QM Report: Key Takeaways

- Hospice-level report can be run for any timeframe that you specify
- The report will include only Type 1 stays (patients that have been discharged and have both of their HIS records in QIES ASAP)
- The numerator and denominator columns are automatically calculated according to the QM specifications found in the QM User's Manual
- Your hospice observed percent is your QM score
- The national average and percentile columns are relative or comparative data to help you interpret your hospice's QM score
 - This may help you identify what your hospice is doing well in, as well as areas for improvement

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Slide 53 presents some key takeaways for the Hospice-level QM report. This slide may be a useful reference for you to keep handy as you're pulling and reviewing Hospice-level QM reports.



Patient Stay-level QM Report

- Where the hospice-level QM Report is organized by measure, the patient stay-level QM Report is organized by patient
- This report is useful for getting into the specifics of which patients you **did** and **did not** receive credit for on each of the measures
- This report includes **all** patient admissions (Type 1, 2, and 3 stays) that your hospice has submitted any HIS data for during the timeframe specified for the report
 - Thus, this report provides information on performance in closer to “real-time”
 - Useful for long-stay patients so you don’t have to wait until they are discharged to assess your performance


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The second QM report available to you is the patient stay-level QM report. Where the hospice-level QM Report is organized by measure, the patient stay-level QM Report is organized by patient. This report is useful for getting into the specifics of which patients you **did** and **did not** receive credit for on each of the measures.

This report is more complex than the Hospice-level report; getting back our school analogy, if you were a teacher, this report would show you each student you teach and their grades in each subject. As such, this report is useful for identifying individual people that got good/bad grades to shed light on your performance overall/on average.

Another important difference between the Hospice-level report and the patient stay-level report is which stays are included. Unlike the hospice-level QM report that includes ONLY Type 1 stays (which are patients that have been discharged and have both of their HIS records in QIES), the patient-level report includes ALL types of stays: Types 1, 2, and 3. In other words, it includes all patient admissions that your hospice has submitted any HIS data for during the timeframe specified for the report. By including all stays, the patient-stay level report gives you performance information in closer to “real-time” because you don’t have to wait for a patient to be discharged for them to appear on this record. You can imagine how this might come in handy for long-stay patients as you wouldn’t want to wait until they were discharged to see whether you met the numerator for each measure for them.

CMS decided to have the Hospice-level QM report include only Type 1 stays so that you could see a score closer to what would be publicly reported for any given measure, as only stays that have been discharged are included in measure calculation for public reporting.



Patient Stay-level QM Report

REPORT TIMEFRAME: 06/01/14 – 06/30/15

Patient Name	Patient ID	Admission Date	Discharge Date	Treatment Preferences	Beliefs/Values	Pain Screening	Pain Assessment	Dyspnea Screening	Dyspnea Treatment	Bowel Regimen	Hospice Comprehensive Assessment	Quality Measure Count
Doe, Ann	123456	10/01/2014	10/15/2014	b	b	b	b	b	b	b	d	0
Doe, Carol	234567	10/25/2014	11/04/2014	x	b	x	e	b	b	x	d	3
Doe, Leslie	345678	01/06/2015 c	02/01/2015	e	e	e	e	e	e	e	d	e
Doe, Ruth	456789	11/17/2014	N/A	e	e	e	e	e	e	e	d	0
Etc.												

Note: Patient-level report includes Type 1, 2, and 3 stays

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Here's what a patient stay-level QM report looks like. Right off the bat, you notice that the rows and columns are not the same, and that there are no %s or scores reported on this report. Whereas the hospice-level QM report shows you your hospice-level score for a measure (e.g., score of 50% for the NQF #1641 or preferences measure), the patient-level report shows you where you received credit for a measure, and where you did not, for each patient stay. So in this report, the rows are patients, not measures.

As discussed on the prior slide, the patients listed in the patient stay-level QM report includes Type 1, 2 and 3 stays, which means that this report includes patients that have been discharged, or may still be active stays, within the time period the report is generated for. This is another major difference between the patient stay-level QM report and the hospice-stay level report. Remember, the hospice-stay level report only displayed Type 1 stays that are DISCHARGED within the specified time period. On the other hand, the patient stay-level report includes all types of stays – 1, 2, and 3 –, which may include both patients discharged and patients that are still active, within the time period specified. As you can see in this example report, this report is generated to reflect those stays between June 2014 to June 2015.

which is another major difference between this report and the hospice-stay level report. The patient stay-level QM report is also generated for a specific time period, as you can see indicated at the upper right corner of the report. As the patient-stay level report includes all types of stays, all patient stays that occurred within this specified time period (whether they are still active or have already been discharged) are displayed in this report. This is also different than the hospice-stay level report, that only displays Type 1 stays that are discharged within the specified time period.

The columns in this report are as follows. The first and second column tells you the patient's name and QIES ID number, the third and fourth column are their admission and discharge date. In the 8 columns following, you have the 8 HIS measures to be publicly reported in 2018, here, though, they're named in words/descriptive titles, not by their NQF ID number. The final column is a quality measure count.

As you can see, this report is much more complex than the Hospice-level report with many more values (e.g., x's, b's, e's) that aren't necessarily intuitive. Let's break down how to read this report, and the useful information it can provide to you.



Interpreting the Patient Stay-level QM Report

- Ask the following questions:
 - 1) **Potential Missing Data:** Does the patient have an HIS-Admission record and, if discharged, an HIS-Discharge record, submitted and accepted to QIES ASAP?
 - 2) **Measure performance:** Is the patient included in the measure denominator?
 - 3) **Measure performance:** Did my hospice get credit on this measure for this patient (i.e., did I meet the numerator)?
- If the answer to 1) or 2) is “no”, you do not move on to the next question (they do not apply)

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In order to interpret these report, here are 3 helpful guiding questions. These questions will help you determine whether you have any missing data for any patients and also details about measure performance for each patient.

The first question helps determine missing data by asking: does the patient have an HIS-Admission record and, if they have already been discharged, an HIS-Discharge record, submitted and accepted to the QIES ASAP system?

The second and third questions help you determine measure performance for each patient. The second question asks whether that patient was included in the measure denominator, and the third asks, if included in the denominator, did the patient meet the numerator definition (i.e., did I get credit for the measure for this patient)?

Note that if you respond “no” to either question 1) or 2), you do not move on to the next questions for that patient or that measure.

Let’s go through each of these 3 questions now, using our sample patient stay-level report.

 Patient Stay-level QM Report <small>REPORT TIMEFRAME: 01/01/18 – 06/30/18</small>													
Patient Name	Patient ID	Admission Date	Discharge Date	Treatment Preferences	Beliefs/Values	Pain Screening	Pain Assessment	Dyspnea Screening	Dyspnea Treatment	Bowel Regimen	Hospice Comprehensive Assessment	Quality Measure	Count
Doe, Carol	234567	10/25/2014	11/04/2014	X	b	X	e	b	b	X	d		3
Doe, Leslie	345678	01/06/2015 c	02/01/2015	e	e	e	e	e	e	e	d	e	
Doe, Ruth	456789	11/17/2014	N/A	e	e	e	e	e	e	e	d		0

Question 1) – Potential missing data: Does the patient have both an HIS-Admission and HIS-Discharge record submitted to QIES ASAP?

- c = HIS-Admission record missing; date extracted from the HIS-Discharge record
- N/A = Not available; the patient stay is either active or the HIS-Discharge record is missing

*These patients are “neutral” from a performance perspective

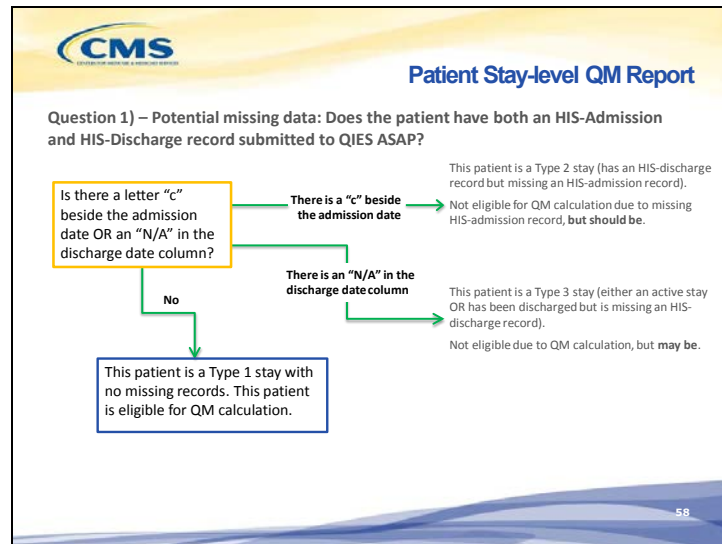
On slide 57 we see a sample patient stay-level report that includes 3 patients -- Carol, Leslie, and Ruth Doe. The first thing we want to do when interpreting the patient stay-level report is ask our first question: Do these patients have an HIS-Admission record and, if discharged, an HIS-Discharge record, submitted and accepted to QIES ASAP? Answering this question will help us determine if we have any missing data problems. We answer this question by looking in the “admission and discharge date” columns.

Let’s look at Carol Doe first – for Carol, we see a dates in the Admission and Discharge date columns, with no additional letters. This means Carol was admitted and discharged, and we’ve submitted the HIS-A and HIS-D for her and they were both accepted by QIES ASAP. This means there are no missing record concerns for Carol and we can move on to question 2 and 3 for Carol to get the most out of this report.

For Leslie, we see there is a letter “c” (in the red circle) in the admission date column. This means that the HIS-Admission record for Leslie was missing. Meaning, an HIS-Discharge was submitted and accepted for Leslie, but there is no HIS-Admission record that has been submitted and accepted for Leslie. This is a problem. The missing HIS-Admission record means missing HIS data and makes Leslie a Type 2 stay, and thus Leslie’s stay is not included in any of the QM calculations. If you see this ‘c’ it means you should submit the missing record so that the patient’s data can be included in QM calculation. Checking for these c’s is one way to make sure our pantry is fully stocked. A patient-stay level report with lots of c’s would indicate that you are missing HIS records, which could have a negative impact on your QM scores and/or your compliance.

Last, let’s look at Ruth. For Ruth, the admission date looks fine (no c), but there is an N/A in the Discharge date column. This means that either Ruth is still an active patient and has yet to be discharged, or she has been discharged but her HIS-Discharge record is missing. If it is the former, no further action is needed. If it is the latter, again, this is indicative of a missing data problem and you should find the missing HIS-D for Ruth and submit it. Either way, patients with an N/A in the discharge date column – for any reason – are considered Type 3 stays and will NOT be included in any QM calculation. That is why you see an “e” for every measure in her report”, and in the next few slides, we will further explain what this “e” means.

To re-cap, for Ruth and Leslie, we need to take action to either submit the missing HIS record and/or verify no HIS record is missing. But, we don’t need to proceed with questions 2 or 3. We only need to proceed with questions 2 and 3 for Carol, which is what we’ll go over next.



Slides 58 and 59 summarizes what we just went over. This may be a helpful reference to keep at your hospice.



Patient Stay-level QM Report

Question 1) – Potential missing data: Does the patient have both an HIS-Admission and HIS-Discharge record submitted to QIES ASAP?

Is there a letter “c” beside the admission date OR an “N/A” in the discharge date column?

There is a “c” beside the admission date

This patient is a Type 2 stay (has an HIS-discharge record but missing an HIS-admission record).

Not eligible for QM calculation due to missing HIS-admission record, **but should be.**

Action: Find the missing HIS-Admission record, submit it, and ensure it is accepted by QIES ASAP.

There is an “N/A” in the discharge date column

This patient is a Type 3 stay (either an active stay OR has been discharged but is missing an HIS-discharge record).

Not eligible due to QM calculation, but **may be.**


Action: Determine if the “N/A” is due to an active stay or missing record:

- If due to active stay, no further action needed.
- If due to missing HIS-Discharge record, find the missing record and submit it to QIES ASAP.

No

This patient is a Type 1 stay with no missing records. This patient is eligible for QM calculation.

Action: Proceed to Question 2

 Patient Stay-level QM Report <small>REPORT TIMEFRAME: 01/01/18 – 06/30/18</small>												
Patient Name	Patient ID	Admission Date	Discharge Date	Treatment Preferences	Beliefs/Values	Pain Screening	Pain Assessment	Dyspnea Screening	Dyspnea Treatment	Bowel Regimen	Hospice Comprehensive Assessment	Quality Measure Count
Doe, Carol	234567	10/25/2014	11/04/2014	X	b	X	e	b	b	X	d	3

Question 2) Is the patient included in the measure denominator?

- “e” OR “d” = patient not included in the measure denominator
- e = excluded from the QM denominator
 - Did not meet denominator definition (e.g., did not screen positive for pain) or
 - Met denominator exclusion criteria (e.g., under 18)
- d = measure not implemented based on patient’s admission and/or discharge date(s); currently, this applies to the Hospice Comprehensive Assessment measure only
 - A “d” means the patient’s admission date was prior to implementation of the measure (prior to 4/1/17)

*These patients are “neutral” from a performance perspective

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So for patients that have both their HIS admission and discharge records submitted and accepted (i.e., Type 1 stays), we then need to figure out how we performed on each QM for these patients. Question 2 and 3 will help us with this. Question 2 helps us determine whether or not the patient is included in the measure denominator. Remember, we start with Question 2 because we always start by figuring out the denominator first.

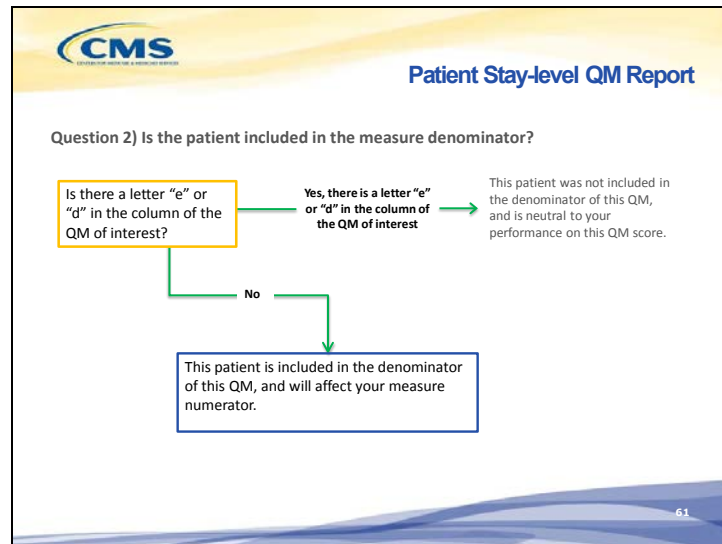
To answer question 2, you would look at the 8 columns corresponding to the HIS QMs. To answer question 2, we’re looking for “e’s” and “d’s”. “E” and “d” mean that the patient was NOT included in the measure denominator, but for different reasons.

The letter “e” means that the patient was not included in the final denominator, either because they did not meet the denominator definition, or met one of the denominator exclusions. As you can see in Carol’s row, she has an “e” for the Pain Assessment QM, indicating that she was not included in this measure. This could be because she did not meet the denominator inclusion criteria because she screened negative for pain, or she met the exclusion criteria by either being under the age of 18, or was a type 2 or 3 stay.

Next is the letter “d”, which may be new to some of you as it was recently added to the patient-stay level QM report for the Hospice Comprehensive Assessment measure. The letter “d” means that the measure was not implemented for this patient due to their admission or discharge date. An example of this is the Hospice Comprehensive Assessment measure, which was implemented on April 1st of 2017. So patients who have admission dates before April 1st of 2017 were before the implementation of this measure, and thus not included.

Having an “E” or “D” means the patient was not included in the final denominator for the measure, so when we think about how these patients impacted your hospice’s overall QM scores, these patients are neutral. A patient with an “e” or “d” is not included in the denominator count and not included in measure calculations, so they do not affect your QM performance.

If the patient has an E or D, you don’t need to move on to question 3 (figuring out if they met the numerator criteria). Remember, that’s because the numerator only matters for patients included in the final denominator.



Slides 61-62 present some take-aways for what we just went over. This may be a helpful reference to your hospice as you're interpreting patient stay-level reports.



Patient Stay-level QM Report

Question 2) Is the patient included in the measure denominator?

Is there a letter "e" or
"d" in the column of the
QM of interest?

Yes, there is a letter "e"
or "d" in the column of
the QM of interest


This patient was not included in
the denominator of this QM,
and is neutral to your
performance on this QM score.

No further action is needed at
this time.

No

This patient is included in the denominator
of this QM, and will affect your measure
numerator.

Action: Proceed to Question 3

 Patient Stay-level QM Report												
REPORT TIMEFRAME: 01/01/18 – 06/30/18												
Patient Name	Patient ID	Admission Date	Discharge Date	Treatment Preferences	Beliefs/Values	Pain Screening	Pain Assessment	Dyspnea Screening	Dyspnea Treatment	Bowel Regimen	Hospice Comprehensive Assessment	Quality Measure Count
Doe, Carol	234567	10/25/2014	11/04/2014	X	b	X	e	b	b	X	d	3

Question 3) Did my hospice receive credit on this measure for this patient's care?

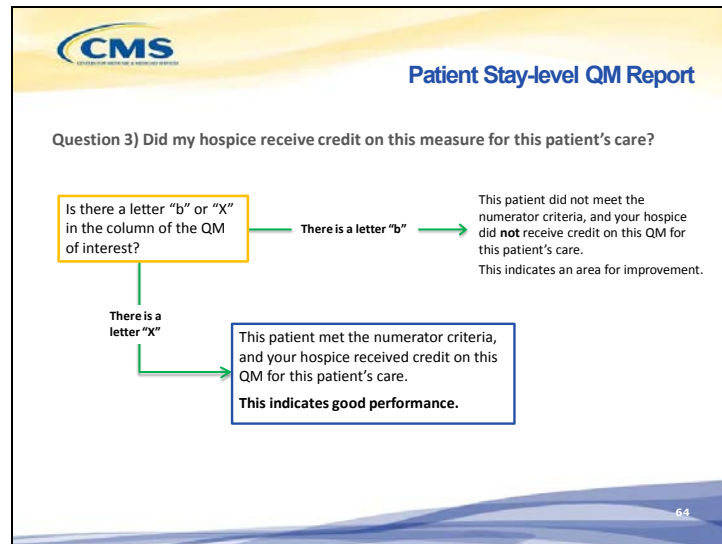
- b = patient included in the denominator but did not receive credit for the measure
 - "Not triggered"; did not meet numerator criteria
 - Represent areas for improvement
- X = patient included in the measure and **received credit** ("triggered")
 - "Triggered"; met numerator criteria
 - Indicates good performance

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Our final question – question 3 – helps us determine measure performance by helping us figure out whether patients who were included in the denominator received credit for the numerator. To see whether a patient counted towards the numerator or denominator, look for b's and x's.

I like to think of "b's" as "bad" – b's indicate that the patient was included in the denominator, but did not meet the numerator criteria. These are patients you didn't receive credit for. B's would represent areas for improvement. If you see a b, you may want to dig further and find out WHY the numerator was not met for that patient.

The other thing we're looking for to answer question 3 is x's. I think of x's as good – I remember this by thinking "x marks the spot, which means there's some good treasure there". X's indicate the patient was included in the denominator AND your hospice met the numerator definition for this patient for this measure. In this sense, X's indicate good performance.



This slide presents some take-aways as for what we just went over. This may be a helpful reference to your hospice as you're interpreting patient stay-level reports.

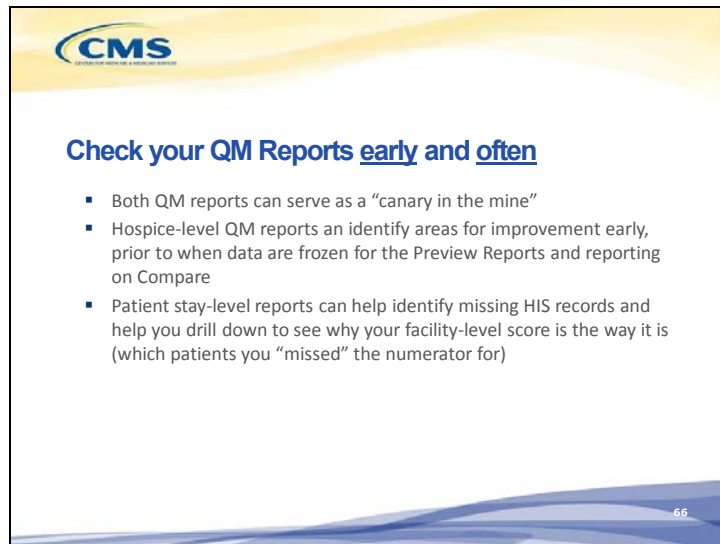


Patient Stay-Level Report Overall Takeaways

- First, look at the Admission and Discharge Date columns to discern Type 1, 2, and 3 stays, and whether your hospice has any missing data issues
- For Type 1 stays, then look at each QM column to assess:
 - Which patients met the final denominator for any given measure?
 - “d” or “e” means patient not included in the denominator for that measure
 - Which patients met the numerator for any given measure?
 - “b”’s are bad and indicate areas for improvement; “x”’s are good and indicate good performance

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Slide 65 presents some overall takeaways for patient stay-level reports as a whole. Remember, we want to first determine whether we have any missing data problems by answering question 1. For our type 1 stays, we then want to figure out which patients met the denominator for which measures and then determine whether patients included in the denominator met numerator criteria.

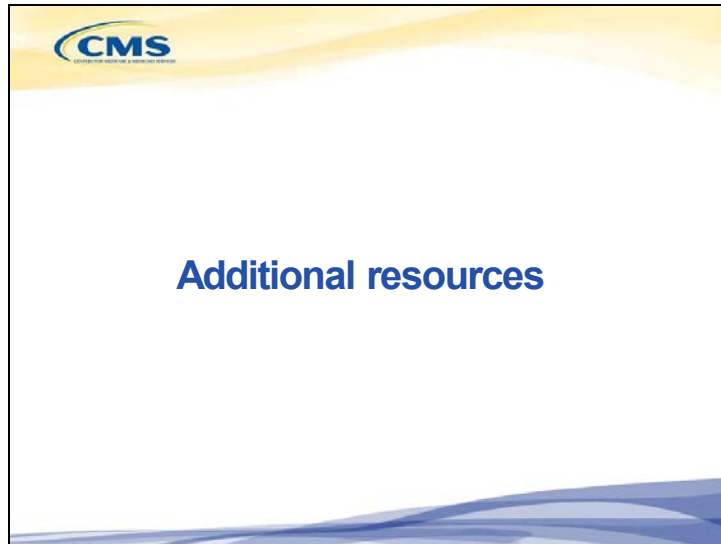


Remember, we’re discussing the QM reports today because we want you to use them as a tool for assessing your performance and quality of your HIS data BEFORE your performance is “frozen” on the Preview reports and your cake is fully assembled for reporting on compare.


Because of that, CMS encourages you to check your QM reports – both the hospice-level and the patient stay-level -- early and often. They are the “canary in the mine” providing critical information about the quality of your pantry and your QM performance.

Again, it’s important to check them early so that you can identify areas for improvement (and start improving!) prior to the freeze dates for Compare. And this is where the preview reports come back in. Once CMS freezes data and generates preview reports, it’s too late to improve your performance for that data selection period, so treat QM reports as critical progress reports and monitor them before your final grade on your report card is cemented.

Now, I’ll turn it back over to Alexis for the conclusion of our presentation.



Thanks, Dorothy. We've covered a lot of material in today's presentation and want to conclude by sharing some additional resources that may be of help to you.




Resources

CMS HQRP Current Measures webpage	Contains the most up-to-date HQRP QM User's Manual (in the "Downloads" section), as well as information on each of HQRP (including HIS) quality measures
CMS HQRP Hospice Item Set (HIS) webpage	Provides updates, announcements, and resources specific to the HIS, including the most up-to-date HIS Manual V2.00
QTSO.com Hospice User Guides & Training	Contains CASPER System User's Guide
QM Reports Fact Sheet	Provides information on the Hospice-level QM Report and the Patient stay-level QM Report, as well as sample processes for using the QM reports for quality improvement
CMS HQRP Training and Education Library webpage	Contains all materials and recordings of previous CMS HQRP trainings (including those referenced in this training), such as on: <ul style="list-style-type: none"> • Hospice Item Set V2.00.0 • Data Submission and CASPER Reports • Preview Reports
Training on HIS-based QMs and Associated HIS Items (Youtube)	This training explains the new Hospice Comprehensive Assessment measure and the Visits measure, as well as related items added to the HIS-Admission and Discharge V2.00.0.

Sign up for the CMS listserv [here](#)

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Slide 68 presents some of the key resources we've mentioned today, including the QM User's manual, as well as some additional resources you may find useful. Links to each of the resources are embedded in the referencing text.



Reminder: Preview Reports

- Preview Reports are released prior to each Hospice Compare refresh
 - The Preview Report release schedule for past and upcoming refreshes is available on the [Public Reporting: Key Dates for Providers](#) webpage of the CMS HQR website
- Review your Preview Reports on CASPER
- If you identify an error, submit a request for CMS to review your data as soon as possible, but no later than the end of the 30-day Preview Period
 - For requirements and instructions to submit requests for CMS review, please refer to the [Public Reporting: HIS Preview Reports and Requests for CMS Review of HIS Data](#) webpage of the CMS HQR website

Check out the CMS training on Preview Reports (released April 2017) at the link [here](#)

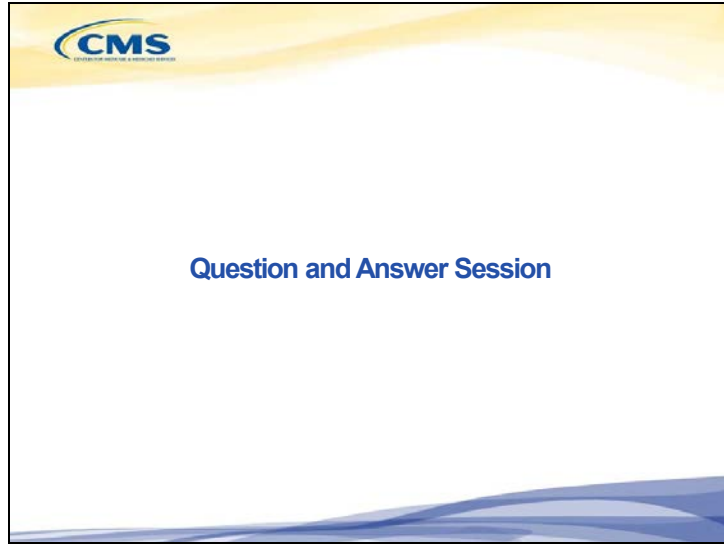
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Although we didn't focus on preview reports today, slide 69 is here as a reminder that they are also important CASPER Reports you should be viewing.


It's mid-August now, and the next Preview Reports will be released in September. If you need help figuring out how to review your Preview Report, see the training linked here.

Remember, preview reports are like your final report card. They are the final check to make sure the QM scores to be publicly displayed are Compare in the next refresh are accurate.

If you submit a request for CMS review of HIS data and it is approved, your data will not be displayed on Compare for that particular refresh; you cannot submit any corrections for data for that particular refresh.



We'll now have a Q&A session with our CMS experts.



Additional Questions?

General HQR or HIS-specific Inquiries
Hospice Quality Help Desk: HospiceQualityQuestions@cms.hhs.gov

CAHPS®-specific Inquiries
Email: hospicecahpsurvey@HCQIS.org
Telephone: 1-844-472-4621

For Technical Assistance (QTSO, QIES, HART, or CASPER)
QTSO Help Desk:
Email: help@qtso.com
Phone: 1-877-201-4721 (M-F, 7AM-7PM CT)

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If you have a question that was not answered during the Q&A session, you can submit it to the appropriate Help Desk using the contact info here.