Ladies and gentlemen, this is the operator. Today's conference is scheduled to begin momentarily. Until that time, your lines will again be placed on music hold. We thank you for your patience and ask that you please remain connected.

Hello, and welcome to today's Hospice Quality Reporting Program "From Data to Measure" webinar. Today, representatives from the Center for Medicare and Medicaid Services will provide detailed information regarding how CMS takes raw Hospice Item Set data and calculates hospice's performance on the Hospice Item Set Quality Measures. During this webinar, providers will learn how to interpret the Quality Measure specifications, as well as how to interpret the two Quality Measure reports available in CASPER. You can listen to the presentation through your computer speakers. If you cannot hear audio through your speaks, please contact CMS Quality Team at ketchum.com. Questions will be taken via the phone line and question box at the end of the presentation. I would now like to introduce Cindy Massuda, Health Insurance Specialist at CMS. Ms. Massuda, you may now begin.

Thank you very much, Devin. Good afternoon, everybody. I'm Cindy Massuda, the CMS Hospice Quality Reporting Program Coordinator, and on behalf of the Centers for Medicare and Medicaid Services, I want to welcome you to today's training. CMS provides this training webinar as part of its outreach in education for the Hospice Quality Reporting Program. We have been providing trainings on about a quarterly basis. All Hospice Quality Performing trainings for outreach and education are available on the Hospice Quality Reporting web page under the Training Library tab. Here you will find a variety of trainings available 24/7, 365 days a year for users of all levels and experience to access and learn. We purposely provide a variety of trainings to meet the diversity of learning styles, and with that, I'm going to turn this call over to Alexis Kirk for today's insightful and exciting training.

Great. Thank you, Cindy. So, if we want to turn over to Slide 2, we'll start out by looking through the list of acronyms that will be used throughout this presentation.

Looking at Slide 3 now, let's begin with a brief background of the HQRP and the HIS. Remember, although the HQRP equals 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. HIS data are then submitted to CMS via the QIES ASAP system. After data are submitted to CMS, CMS then uses that data to calculate hospices' performance on nine Quality Measures, which you can see listed here on Slide 3. The nine Quality Measures include what we refer to as the "Original 7 HIS Measures," which were implemented in 2014, as well as two other measures that which were 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 the scores are then displayed on Hospice Compare. Next slide.

Currently, hospices' performance on seven of those nine measures are displayed on Hospice Compare. The seven measures that are currently displayed on Compare are highlighted in bold font on this slide. Display of the Hospice Comprehensive Assessment Measure will begin in Fall of 2018, and

display of the Visits Measure is still under determination by CMS. Before any measure data are displayed on Compare, hospices can review their QM performance through various reports in CASPER, including QM reports and preview reports. We'll be focusing on QM reports today and how data flows from your submitted data in the QIES System into the CASPER system and into your QM reports. Next slide.

As mentioned earlier, provider submit HIS data to CMS, and the goal of this data submission is to eventually report QM scores on Hospice Compare so that the public can use performance data to inform their decision-making when choosing a hospice. Since Compare launched, we've seen some knowledge gaps in our Help Desk. Providers are sometimes surprised at the QM scores that they're seeing, and we find that this surprise really comes from one of two things -- first is a lack of understanding about how CMS gets from the raw HIS data to the QM scores that are publicly reported. So providers will often write in with questions like, "I answered 'Yes' to the pain assessment question but didn't end up getting credit for the Pain Assessment Quality Measure. Why is that?" And the answer to that question is that there are some important transformation steps that happen when you get from data to measure and knowing those transformation steps are really important since that's ultimately how the score that gets publicly reported is determined. Another reason why providers are often surprised is that we find that they're sometimes not checking other reports available to them in CASPER on a regular basis, specifically the QM reports. QM reports are available at any time and, ideally, providers should be checking these reports regularly to see how they're performing on QMs. Providers shouldn't wait until preview reports are released to review their QM scores. So often, we'll see providers writing into the Help Desk having looked at their preview reports, and they may be surprised at a relatively low score that they see, or they may find out that there is an error in their data, which they uncovered only after looking at the preview reports. To avoid these types of surprises, CMS recommends looking at your QM reports regularly and understanding how to interpret them. So that's going to be the second focus for our presentation today. Next slide.

So, the types of questions that I just went over and the knowledge gaps that stem from those questions motivated today's presentation and the learning objectives for today, which you can see listed here on Slide 6. Next slide.

As mentioned earlier, today we're going to cover two main topics -- how your QM scores are calculated -- or how we get from data to measure -- and how to use and interpret QM reports to understand your hospice's performance and avoid those surprises that may come around during preview period time. 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. Next slide.

In trying to think of a relatable analogy to explain those transformation steps that happen when you go from data to measure, we came up with the analogy of baking a cake. When you bake a cake, you have three main things that you're dealing with -- the ingredients, a recipe, and the final product, or the cake itself. And it's the same with how we get from HIS data to our final product. So, first, we start out with our ingredients. For us, the HIS data that you collect and submit are your raw ingredients. It's the basics of what you need to make your cake. The second thing we need is our recipe, and our recipe is how we take our ingredients and transform them to get our cake. In our cake, the HIS QM specifications are the recipe. And if you're not familiar with the QM specifications, that's okay. I'm going to go

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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 to those ingredients to bake your cake. So once you've gathered your ingredients and followed your 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. Next slide.

Let's go over the ingredients first. Next slide.

As I mentioned on the previous slide, HIS data are like your ingredients. They're the raw materials used to make the final product. And just like making a cake, the ingredients are the foundation of your cake, so they're really important. This means that you want to make sure that your pantry is fully stocked and your ingredients are high quality. So, what does that mean in the case of the HIS? What steps can you as a hospice take? First, you should make sure that you're submitting HIS data for all patients. This makes sure that your pantry is fully stocked. It's important to submit all required data for a couple of reasons. First, it's a CMS requirement to submit data for all patients. Second, missing data can impact your performance on QMs. Just like an leaving out an ingredient can cause problems when you're making your cake, not submitting data for all patients can negatively impact your QM score, especially if you forget to submit data for a patient who actually should have gotten credit for any given measure. Second, you want to ensure high-quality ingredients -- so high-quality 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 high-quality ingredients in timeliness. Submitting your HIS data on time is how your compliance is determined, which means -- in addition to unpacking your QM scores, untimely data can also impact your compliance. Next slide.

Here on Slide 11, you'll see that we've listed some recommendations to ensure a fully stocked and high-quality pantry. Included on this slide 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 would include having a back-up person who knows how to complete and submit HIS records in case your primary designated staff member is sick or out of the office. Another thing you can do is track regularly scheduled QIES ASAP downtime to ensure all records can be submitted timely even during these system downtimes. You should also be regularly checking your Final Validation Reports in CASPER to ensure that the data you submit is actually accepted by QIES ASAP. And checking the Final Validation Report is the only way to ensure this. Finally, you should make sure that both you and your vendor are working with the most up-to-date version of the HIS and the technical specifications for the HIS item. This ensures that you're collecting and submitting HIS data in full. And you'll notice that this slide contains several embedded hyperlinks. That can help you put some of these processes in place by providing some more resources. Next slide.

Now that we better understand the importance of ingredients, let's talk about the next step in baking our cake, which is the recipe, or, for us, the QM Specifications. Next slide.

The QM specifications tell you what HIS data, or what 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. I really like to think of the QM User's Manual as a cookbook, where each individual HIS measure has its own specification, or recipe. Next slide.

Just like cake recipes tend to follow a basic pattern -- letting you know the ingredients you need, letting you know what order to combine them in, what temperature your oven should be at, and how long you should bake it, QM specifications also follow some basic steps for calculating each QM. Those steps are to define the denominator, denominator exclusions, and the numerator for each measure. Next slide.

Let's look at the denominator first. The denominator is important because not all measures apply to all of your patients. So, the denominator tells you which patient any given 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 that I treat, however, when I think about a Quality Measure for foot exams, I wouldn't want the measure to apply to all of my patients, right? That's because, clinically, I don't need to provide a foot exam for every single patient I see, just those with Diabetes. And this is what the denominator tells you -- which patients a measure applies to. In other words, the denominator definition will tell you which patient you should be held accountable for providing a certain care process for or achieving a certain outcome for. I like to think the denominator as the end group, or the rule of thumb, for any given Quality Measure. In this foot exam example, we would only want to be held accountable for providing foot exams to those patients with Diabetes, not those who come into our office for other reasons, like the flu, but don't have Diabetes. So our end group is patients with Diabetes. Next slide.

Next, our denominator exclusions. So, if a denominator is our rule for which patients the measure applies to, I think of denominator exclusions as the exceptions to the rule. In this sense, denominator exclusions further limit who's ultimately in the denominator. So if a patient meets the denominator definition but they also meet an exclusion criterion, they are ultimately excluded from the measure. Going back to our foot exam example from the prior slide, in the prior slide, you'll remember we decided that denominator would include diabetic patients. That's our rule. However, as clinicians, we can probably think of some exceptions to that rule -- in other words, diabetics patients that it wouldn't be fair to be held accountable for providing a foot exam for. One exception to this rule 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 diabetic patients who have had a double-foot amputation. Quality Measures can have multiple denominator exclusions. Another common denominator exclusion for a lot of the CMS Quality Measures is patient age, and many of our measures exclude patients under 18. This exclusion is often not made for clinical reasons the way amputees are excluded from foot exams, because they're not clinically

necessary, but rather, the exclusion for age is in place due to limited research in pediatric populations. Next slide.

Now that we've talked about what the 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 who sees about 20 patients this year. That's what's here on Slide 17. Think of these 20 patients as my total patient population. Next slide.

So when calculating our Quality Measure, the first thing I need to do is figure out the denominator. And, remember -- that's the patients this measure applies to because not all patients will be included in a measure. In this example, it would be the patient I'm going to be held responsible for providing a foot exam for. From our prior discussion, we'll remember that our denominator definition was limited to patients who had diabetes. So among my patient population of 20, let's say there were a total of eight patients with Diabetes, as you can see in the dotted oval on this slide. This oval outlines the initial subgroup of patients I'm responsible for providing a foot exam for prior to considering any exclusions. Next slide.

So, our denominator told us we had eight diabetic patients out of the total of 20 patients that we saw that year. However, eight is not our final denominator, as we haven't yet considered exclusions. From our prior discussion, remember -- diabetic patients are excluded if they are either a bilateral foot amputee or under 18 years of age. In this example, let's say we had two bilateral foot amputees and one patient under 18. This means we have three patients excluded from the denominator, taking our final denominator count down to five from eight. Next slide.

Now that we have the denominator and denominator exclusions under our belt, let's turn to Step 3 in our recipe -- figuring out the numerator. Remember, the final 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 tells us exactly what a foot exam must include for it to be considered successful for the purpose of the Quality Measure. Let's go over a few notes about the numerator. First, 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 your exam must include visual, sensory, and pulse components. That would be the "what" of the numerator definition, as it tells you exactly what you have to do to get credit for the measure. The numerator may also specify a time component. In this example, let's say that you must provide the foot exam at least one time per calendar year. This would be a "when" component. But if the numerator has multiple components -- so both a "what" and a "when," you must meet all components to get credit for that measure. So if you only provided, say, a visual and pulse component to your foot exam, this wouldn't get you credit because you didn't meet the "what" portion. If you provided a full foot exam but forgot to do it within that calendar year, then you also wouldn't get credit for the measure because you didn't meet the "when" component. Next slide.

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 that we saw that year, after we applied the denominator definition

and the denominator exclusions, we ended up with five patients in the final denominator. So this means that, per the requirements of the measure, we're responsible for giving a foot exam to those five patients. So when I think about the numerator, I only need to figure out the numerator for those five patients, not all 20 I saw in my practice last year, and not even all eight who had Diabetes. And the numerator will tell us exactly what our foot exam must include for those five patients in order to get credit for the measure. Next slide.

For the numerator for this measure, we had to do two things 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. So let's say that out of my five patients, I met the numerator definition for three of them. Thus, we only get credit for three out of five patients, and you can see that by looking at the green checkmarks over each patient's head. The other two patients that didn't meet the numerator definition could have fallen out of the measure for any combination of reasons -- either we did a foot exam in the past year but it was missing one of those three sensory, pulse, or visual components, or we completed a full foot exam but it happened greater than one year ago. Next slide.

So with both our numerator and denominator known, calculating the score for this measure would be relatively straightforward since it's just a percentage. So to calculate your score, you would create a fraction where the numerator is divided by the denominator. Here, our final denominator was 5 and the numerator was 3. So our fraction is 3 over 5, which comes out to .6, or 60%. Next slide.

So let's review what we've just learned about the three steps that are in our basic recipes for all of our QM specifications, which is to figure out the denominator, the denominator exclusions, and numerator. Remember, the denominator is your general rule of thumb for what patients the measure applies to. Denominator exclusions are your exceptions to the rule, so patients you won't be held accountable for for purposes of the measure. And remember -- your denominator isn't final until you've taken these 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 it can have multiple parts that you must comply with to get credit for the measure. Next slide.

Before we move on, I'd like to point out one more detail about Quality Measure calculation versus clinical practice, as this is often an area of confusion that we see in our Help Desk. So, 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, however, 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 of the measure, even though you provided a foot exam for them, and the reason for this is because the measure excludes patients under 18. Next slide.

To illustrate this point in numbers and pictures, let's return to our example. So, here on Slide 26, we're back to our patient population that we had earlier. Remember, we had 20 patients that we saw that year. Our initial denominator was eight, but we excluded three patients based on age and/or

the fact that they were bilateral foot amputees. Those excluded patients are the patients in red at the top-right of the graphic on Slide 26. Thinking about our numerator, our numerator was represented by patients who have a checkmark above their head, and 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. So this means that our final numerator count is still three, not four. And the fact that this pediatric patient doesn't get counted in our numerator neither hurts nor helps our overall score, and the reason for this is because a patient can only help or hurt your overall QM score if they end up in the final denominator. Next slide.

And this may sound simple, but we find that it often trips people up with the HIS measures, as clinicians will often say, for example, "I provided a comprehensive pain assessment meeting all components of the numerator definition for Mrs. Jones, but Mrs. Jones isn't appear in the numerator count for my measure. Why is that?" And assuming that Mrs. Jones' pain assessment really did meet the numerator definition -- all components of it -- then the answer to that question would be "Because Mrs. Jones is excluded from the denominator." So to make sure I don't trip myself up on this point, I like to tell people -- Never start calculating your measure by counting up the numerator first. Always start with the denominator and then count the numerator only for those patients who end up in the final denominator after accounting for exclusions. So I would recommend taking a report of all patients that you saw in a given time period and start counting whether you met the numerator for all of those patients. Figure out your final denominator first, then figure out the numerator only for that subset of patients. And, remember, going back to our recipe analogy, just like it's important to follow steps in a recipe in order when baking a cake, it's important to follow the order of the QM specifications when calculating your measure, which means starting with the denominator first. Next slide. With those basics under our belt, I'll now walk through an example of how get from data to measure, or ingredient through recipe, using an example from the HIS QM specifications. This Quality Measure we'll be calculating in this example will be the Comprehensive Pain Assessment Quality Measure, also known as NQF1637. The HIS item, or ingredient, that will be used in the calculation of this Quality Measure is the Comprehensive Pain Assessment Item from the HIS submission, which is item J0910. This item, as you can see in the picture here, captures whether pain assessment was completed, the date of the assessment, and what the assessment included, so whether it included aspects like location, severity, character, duration. On this item alone, as an ingredient, it tells you little about how the measure is constructed. In other words, the item won't tell you the numerator, denominator, or what the denominator exclusions are and how to put it all together, much as the same way that looking at an egg or a stick of butter won't tell you much about how to bake a cake. To know this information, I need to figure out the measure specifications for NQF1637, or the recipe. Additionally, just like you can't make a cake with one ingredient, I cannot calculate a 1637 measure using just this single item alone. The QM specification, or recipe, will tell me what other HIS items, or ingredients, I need to gather to calculate this measure. Next slide.

Slide 29 is an excerpt from the QM User's Manual and shows the QM specification, or recipe, for the 1637 Pain Assessment QM. As you can see, this recipe includes the three 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 specifications tell us which other ingredients we need to gather, or which other items are used in the calculation of this Quality Measure. In addition to item J0910, we see item A0220, A0900, and J0900 are also used in the calculation of this measure. We'll now go through each calculation step for this measure in greater detail. Next slide.

Step 1 is to figure out our denominator, so who from our total patient population this measure applies to. And the first part of the denominator is clinically driven, as the denominator is limited to only those patients who screened positive for pain. We also see that our denominator definition has a second component. The second component is not clinically driven but applies to whether a patient is still in service. As we can see from the QM specification, the measure applies to only Type 1 stays, and a Type 1 stay is defined as a patient who's been discharged and has an HIS Discharge record in the QIES System along with their admission record. This means that the NQF1637 measure is only calculated for patients who have been discharged. And people often ask why the HIS measures are limited to Type 1 stays. In other words, why do we have to wait until a patient is discharged to include in a measure? And the answer to this is that including only Type 1 stays, avoid double-counting patients, and Hospice Compare refreshes. Next slide.

Step 2 tells us who is excluded from the denominator. Here, we see that patients under 18 are excluded, and we also see that 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 are also excluded. And I want to pause here to 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 HIS data for all patients, not all patients end up in a QM. So, for example, even though you submit data for patients under 18, those patients are never included in your publicly reported score because the recipe tells you to exclude them. Second, note that in addition to telling these things in words, the QM specification also tells you things in technical language. So in addition to telling you that patients under 18 are excluded, it tells you exactly how that's calculated. So, birth date minus admission date using items A0900 and A0220. Next slide.

Now, let's focus on the numerator, which is Step 3 in our recipe. The first thing you'll notice is that the QM specifications remind us that the numerator applies only to patients included in the denominator, and we can see that by the language that reads "Calculate the total number of stays from the denominator where a Comprehensive Pain Assessment was completed." This takes us back to our point about clinical practice versus QM specifications. So, for example, many people will tell us on the Help Desk that even if a 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. And the question that we get on the Help Desk about this scenario is "My hospice did a pain assessment for those patients, but they're not showing up in the numerator for the pain assessment measure. Is this hurting our score? I want to make sure I'm getting credit for these pain assessments for these patients. And before we dive in to how to answer that question, I want to emphasize the role between Quality Measures to HIS and clinical judgment. The HIS and its associated QMs are not intended to replace clinical judgment and to not supersede clinical judgment. So you should always do what is clinically appropriate

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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 QM score is no. They do not hurt your QM score by not being counted in the numerator. In this situation, having completed a pain assessment for these patients may be good clinical practice, so you should keep doing it if it's appropriate. But the fact that they don't end up in the numerator doesn't hurt your score, and the reason why is because those patients were not in the final denominator. So in addition to not counting against you, you're also not losing any extra credit for these patients. That's because in the HQRP measures, there is no such thing as extra credit. If a patient is not in the final denominator, it won't boost your score to have done that extra care process for them. So, back to the numerator definition. We can see here that to get credit for this measure, we must complete a comprehensive assessment that includes at five of the seven characteristics and it must be done within one day of screening positive for pain. So this numerator has both a "what" and a "when" component. Next slide.

The last thing I want to point out here is an ingredients-versus-recipe distinction. Remember, we started with our main ingredient, item J0910, but having now looked at the QM specifications, or our recipe, we can really see how looking at that HIS item alone tells you little about how the measure itself is calculated. For example, many people incorrectly assume that all they need to do is answer "Yes" to J0910A, which is a question that says "Was a Comprehensive Pain Assessment done?" Many people incorrectly think that simply by answering "Yes" to this question, you get credit for the measure. Having reviewed the QM specification numerator definition, however, we see that that's not the case. In fact, J0910A isn't even included in the numerator definition. To meet the numerator definition, you must have done five of seven components of a pain assessment, as indicated by J0910C, and it must have been done within one day of screening positive for pain. So, remember, look at the QM specifications, or the recipes, to understand how measures are calculated, not just HIS items alone. Next slide.

So, we've just gone through the QM specifications for one measure, NQF1637, 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. For example, the HIS is submitted for all patients regardless of their age, but only those 18 and over end up in the measure denominator. Similarly, only Type 1 stays are included in the denominator. So patients who have been discharged and have both of the HIS records in the QIES ASAP system. Type 2 and Type 3 stays are excluded. 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, and that may be good clinical practice, but that patient won't end up in your numerator. And this is okay. All these patients will neither count for nor against you in your final score. Next slide.

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. That's because, remember, many of our measures have both a "what" and a "when" component for the numerator. The only way to know what gets you credit is to look at the QM specifications. Finally, I'm going to mention it one more time because it's going to come up

again later on in the presentation. Remember -- all HIS measures are calculated for Type 1 stays only. This means only patients who have been discharged and have both an admission and discharge record in QIES will be included in final measure calculation. Next slide.

This takes us through our ingredients and our recipe. Now we can move on to the publicly report score, or the cake. The publicly reported score is our final product because that's what is ultimately reported on Hospice Compare. Next slide.

So, once you follow the recipes, we're ready for the last step -- finishing our cake, or getting to our publicly reported score. And just like baking a cake, you're not completely done after you follow the recipe. With most any cake, there is some final assembly steps required. You have to remove the cake from the pan, and usually you ice it or decorate it. And it's the same with the HIS QMs. After we go through our recipes, or QM specifications, there are still some final assembly checks we must go through to get from that 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. Next slide.

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 of the 8 HIS Quality Measures to be reported in 2018, which included the seven original HIS measures and the Hospice Comprehensive Assessment Composite Measure, these two things happen to be the same. The data selection period for these QMs is a rolling four quarters, and the minimum denominator size is 20 patient stays. Next slide.

So, what does the data selection period and the minimum denominator size tell us, and why do we have it? For a lot of you, you've probably been collecting and submitting HIS data since July 2014, or for just over 4 years now. But CMS doesn't report all 4 years 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 four calendar-year quarters, worth of data at a time. For the August 2018 refresh, the data selection period for all HIS measures is Quarter 4 2016 through Quarter 3 2017. With each Hospice Compare refresh, the oldest quarter's worth of data is dropped and the newest quarter is added. So, for the refresh that will come after August, which is the November 2018 refresh, the data selection period will change. It will still be four quarters long, but it will be a different four quarters. The November refresh will be Quarter 1 2017 through Quarter 4 2017. And a complete refresh schedule can be found at the hyperlink here on Slide 39. Next slide.

So 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 publicly reported. Instead, a footnote will be displayed. Next slide.

Let's walk through the data selection period and minimum denominator size using an example. Let's use the pain assessment measure again, or NQF1637. Recall that the minimum denominator size for all of the HIS QMs, including 1637, is 20 eligible patient stays each data selection period. This means you must have 20 eligible patient stays for the four quarters of data being displayed for your score to appear on Hospice Compare for this measure. For the August 2018 refresh, this means you must have 20 patients in the final denominator for 1637 from Quarter 4 2016 to Quarter 3 2017 in order for your score for this quality measure to be displayed on Compare. If you don't have 20 eligible patient stays for this time period, your score will not be displayed, and instead a footnote will appear that states that your hospice had too few patients for this measure. Also, remember from our discussion of the QM specs that the measure denominators limited to Type 1 stays are 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 in that data selection period that were over 18 and screened positive for pain. And a lot of people ask why we have the minimum denominator size and the data selection period to begin with, and the answer to that question is that we need the measures that are displayed on Compare to be stable, and measures are unstable when the denominator is too small. Let's think back to school when we used to have tests to put this into context. So, if you were in school, would you rather have a test with two questions or a test with 100 questions? I bet your answers is 100-question test. With a two-question test, if you miss just one single question, your score on that test is a 50%. That's a big hit to your final score for missing just one question. With the 100-question test, however, the impact of a single question is much smaller. It means the difference between a 99% or 100% or a 98% or a 99%. And it's the same with QM scores. If your denominator is smaller than 20, not meeting the numerator for one patient is really going to have a big impact on your score, leading to a measure that's not stable. So we have the minimum denominator size to make sure your agency score is stable. And the data selection period is related. A lot of hospices are small, so if the data selection period were shorter, like, say, 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 four-month period. Next slide.

Slide 42 presents some takeaways, or key summary points for the content that we just went over on minimum denominator size and data selection period. Some things to keep in mind is that your hospice's QM score is based on a rolling four quarters' worth of data, and that for each refresh, the minimum denominator size is 20 eligible patient stays in order for your score to be displayed for that measure. This slide may be a useful quick reference if you're thinking about these issues in the future. At this point, I'd like to turn the call over to Dorothy Wu who will lead the next portion of our presentation today.

Thank you, Alexis. Next slide, please.

So, for the second portion of our presentation, we'll be focusing on how to interpret your QM scores in CASPER. Next slide.

So, now that we know how QMs are calculated, let's talk about where you can go to view hospice's performance on individual QMs. Now, there are two names to know here -- QIES ASAP and CASPER. QIES ASAP is the system to submit HIS data to CMS. Within QIES is a CASPER reporting application. The CASPER reporting application is where you go to view various CASPER reports, which can tell you details on your hospice's submitted HIS data, including your hospice's performance on the HIS QMs. This presentation won't go into the nuts and bolts of how to access and log in to QIES and CASPER. If you are looking for more information on that, please check out CMS's Hospice Data Submission and Reporting webinar available at the link provided on this slide. Next slide.

Slide 45 outlines the main types of CASPER reports available. Again, CASPER reports are reports that are available to all hospice providers and can provide useful information before a hospice's data is displayed on Compare. There are a total of 15 different reports available in CASPER for hospice providers. Today, we will be focusing on two of them. As a useful mental schema and to better understand the purpose of these two reports, let's take a look at the graphic presented here on this slide. The 15 reports available in CASPER can first be divided into two main boxes. Those useful for quality purposes in the light pink box above and those useful for compliance purposes in the yellow box below. In this presentation, we are focusing on reports useful for quality purposes. Specifically, we're going to focus on the QM reports, which is in left-most arrow in the pink box of which there are two types. Before I go on, you may notice that provider preview reports are also in this pink box as they are another type of quality report available for hospice providers. We won't be focusing on these today, but it may be helpful to briefly note the main differences between QM reports and preview reports. Preview reports serves one very specific purpose. They show you exactly how your hospice's HIS data will be displayed on Hospice Compare for a given refresh. These are parts of the release about two months before a given refresh and are provided last-chance to ensure that the scores 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 measured scores. On the other hand, QM scores are different from preview reports in that, provided themselves, they can generate QM reports at anytime and for any data selection period. This way, providers can see how they are performing on any of the HIS measures and at any point in time. We often find that provider under-utilize QM reports and wait until the preview report is released to check their QM scores. At that point, it's too late for the provider to take action to improve their score. The scores are set to be displayed on Compare, or, in other words, the cake is iced, sliced, and ready to serve, regardless of whether you forgot any ingredients or followed the recipe incorrectly. So, this is where QM reports can come in handy. If you're monitoring the QM reports regularly, you can identify any quality problem areas at your hospice as they are happening and then act on them to improve your performance. This way, by the time preview reports roll around, you are not taken by surprise by any of your hospice's QM scores. Monitoring QM reports regularly is also a good way for you to ensure that you do not have any missing or inaccurate HIS data. In other words, a fully stocked and high-quality pantry. If you review a QM report and identify any missing or incorrect data, you can correct the missing or incorrect data prior to when the preview reports are released, by which point your data will be frozen for the preview report. Once the data has been frozen for the preview report, it would be 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 that you can run to tell you how your hospice is performing. And to expand this analogy further, preview reports are your final report card. In school, you would never want to wait until the final report card to figure out your grade and how to improve it. That's because, at that point, it would be too late to take any action, to turn in any assignments you've found were missing or incomplete. So we strongly encourage providers to use QM reports early and often which is why we're focusing on them today instead of preview reports. Next slide.

So, going back to our baking a cake analogy, QM reports are like your private chef. They take your ingredients, the HIS data, and follow the recipe, the QM specifications, to bake the cake, which is your hospice QM score. Now, however, although the QM reports bake the cake for you, remember that they do not automatically perform the final cake assembly steps, which is applying the minimum denominator size and the relevant data selection period. This means that the QM score displayed on QM report are not necessarily the QM scores that will be displayed on Hospice Compare. In order for your to see an approximation of what your scores will look like on Hospice Care before your preview reports are released, you can select to generate the QM report for the same time period that the Hospice Compare refresh will reflect. Keep in mind that any denominators of less than 20 patient stays, which will show up on your QM report will not be publicly displayed on Hospice Compare as it does not meet the minimum denominator size. Next slide.

So, there are two types of QM reports available to you, which we are focusing on for this training. There is the hospice-level QM reports and the patient stay-level QM reports. Now, both of these reports will tell you how your hospice is performing on the HIS QMs but from different perspectives. The hospice-level QM report will tell your hospice's score for each QM. Because your hospice's QM score 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 admission and HIS discharge record submitted and accepted in QIES ASAP. In addition to telling you your hospice's QM scores, this report will also share with you how your score compares to the national average and percentile. As this report is generated at the measure level and provides you with comparative quality information, it is useful for identifying your hospice's areas for improvement. Now, the patient stay-level QM report doesn't tell you your overall hospice's score on the QMs. Instead, it provides you with a roster of all your hospice's patients and tells you whether each patient's stay was eligible for the denominator of each of the HIS measures. And if they were, the report tells you whether or not that patient's stay met the numerator for that measure. As such, once you've identified a measure that you want to improve on, the patient stay-level report can be useful for drilling down to see which patients you met the measured numerator for and which you did not. In this sense, these reports can help you figure out where you went wrong and why. As this report looks at quality performance patient by patient, it includes all patients of all stays so that you may view if and how the care provided to each individual patient affected your hospice's overall QM scores. If we go back to the report card example, the hospice-level QM report is like a teacher's average score across all their students for each subject they teach. So it would indicate the average math grade for the class, the average biology grade for the class, and so forth. On the other hand, the patient's stay-level report would be like a student roster that informs the teacher of each individual student's grade in each of these subjects. So if a hospice-level QM report indicated that the overall average in the math

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class is a B, the patient's stay-level report would help the teacher understand why. The patient's stay-level report would provide information on whether the class average was a B because most students were receiving B's or whether this was because most students were receiving A's, but one or two students with F's brought down the overall class average. Next slide.

Both of the QM reports are on-demand and customizable. This means that you can run the reports at any time so you don't have to wait for them to be generated for you, and you can run the report to reflect any time period of your choice, whether it be 1 more, 4 months, 12 months, et cetera. So this is another reason why the QM score displayed in your QM reports may not match your publicly reported QM score. They may be reflecting a time period different to the time period of the data being publicly displayed on Hospice Compare. CMS believes that it is important for providers to have ample time to view and become familiar with their QM scores using the CASPER reports before any of the measures are reported on a preview report and on Hospice Compare. Getting back to our point about report cards, CMS believes that it is important for providers to have progress reports prior to having their final grade reported on their report card. Therefore, there may be measures available for you to view on your reports that are not yet available for consumers to view on Hospice Compare. For example, the Hospice Comprehensive Assessment measure scores were made available on your CASPER QM reports beginning in February 2018. However, this measure will not be reported on preview reports or on Hospice Compare until later this fall. Having the Hospice Comprehensive Assessment Measure on your QM reports now will give you the time and opportunity to view your performance on this measure before you final grade, or you final measure score, is publicly reported on Hospice Compare in the fall. Next slide, please.

Now that we have a general understanding of what QM reports are, let's walk through each report individually and how you may interpret them. The hospice-level QM report shows you your hospice's average score on each measure. It will display your hospice's overall numerator and denominator for each measure, accounting for any denominator exclusions, as well as your hospice's percentage QM score. This report also provides some comparative information to let you know how your hospice is performing on each QM compared to the national averages and percentiles. Next slide.

Here on Slide 50, we have an example hospice-level QM report. You can see in this snapshot how this report is formatted. There's a row for each of the HIS quality measures, and there are columns that display your data and your scores. Remember, this report will only include Type 1 stays, which are patients that have been discharged and both their HIS admission and HIS discharge reports have been submitted and accepted by QIES ASAP. Therefore, the numbers presented in this report for numerators, denominators, and observed percentages are based only off of the Type 1 phase that was discharged within the time period selected to generate this report. You can select the time period for which you want the report to reflect in QIES ASAP when you're pulling the report. You can see in this example in the upper-right corner this report was selected to be generated for patient stays with discharge dates between January 2018 and June 2018. So if you pull the QM report right now, you'd see a line for each of the seven original HIS measures, as well as the Hospice Comprehensive Assessment Measure. To save space in this presentation, we've included rows for three measures in this example, but an actual QM report would display information for all the eight measures I just mentioned. Now, let's walk through what each of the columns mean. The first and second columns tell you the name and ID of the measures.

The first column displays NQF ID and the second column tells you the CMS Measure ID. As a provider, you're likely to be more familiar with the measure's NQF ID, so the first column may be more helpful to you. Next slide.

Now, let's look at numerator and denominator columns. The numerator, as you may remember, is a number of stays from the denominator that met the numerator definition according to and measures QM specifications. Remember that because the numerator is only calculated for patients in the final denominator, the numerator will always be less than or equal to the denominator. Now, the denominator, as you may remember, is the number of stays during the time period selected that met the denominator definition, accounting for any exclusions. The denominator column will show you your final denominator count for that measure. So any excluded patients have already been removed and are not counted in this tally. Next slide.

Next, let's go over the Hospice Observed Percent column. Now, this is your hospice score on a given QM over the time period selected for this report. To calculate this number, you would simply divide the numerator by the denominator and multiply it by 100 to find the percentage. So, for the first row here, NQF 1641, we see that the Hospice Observed Percent is 50%. We calculated that by dividing 10 by 20 to get 0.5 and multiplied that by 100 to get our measure score of 50%. But what does this 50% mean to you? 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, but 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 the measure across all hospice agencies in the U.S. In this example, the national average for NQF1641 is 75.2%. This hospice's score was 50%. This tells us that this hospice is performing worse than the national average. Now, the Comparison Group National Percentile column is another piece of relative information. I'd like to think of percentiles as rank, so the 23 appearing in this column for NQF1641 tells us that 23% of providers had a QM score for NQF1641 that was worse than yours. Or stated another way, you did better than 23% of providers. For this column, higher ranks, or higher numbers, indicate better performance. Next slide.

Slide 53 presents some key takeaways for the hospice-level QM reports. This slide may be a useful reference for you to keep handy as you're pulling and review hospice-level QM reports. Our walk-through of the hospice-level QM report formatting, which we just went over, is also available in the From Data to Measure Worksheet designed to accompany this training. So we recommend that you keep a copy of this worksheet for when you're reviewing the hospice-level QM reports on your own. Next slide.

The second QM report available to you that we're also focusing on in this training 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 patient 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 to 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 the individuals that received good or bad grades to gain further understanding of your hospice's overall performance. Another important difference between the hospice-level and the patient stay-

level QM report is which stays are included. While the hospice-level report included only Type 1 stays, the patient stay-level report includes all types of stays -- Type 1, 2, and 3. In other words, the patient stay-level report includes all patient admissions that your hospice has submitted any HIS data for during the time frame specified for this report. By including all stays, the patient stay-level report gives you information on your performance closer to real-time because you won't have to wait for a patient to be discharged for them to appear on this report. You can imagine how this might come in hand for long-stay patients, as you wouldn't want to wait until the patient was discharged to see whether or not you met the numerator on each of the measures for that patient. CMS's intention of having the hospice-level QM report only include Type 1 stays was so that providers can view an ongoing score of what would be publicly reported or close to publicly reported for any given measure. Remember -- as so happens for all the HIS measures that are currently publicly reported, these measures only include Type 1 stays, or patients that have been discharged and have both an HIS admission and discharge record submitted QIES ASAP. For your real-time performance, your patient stay-level report includes all your patients for the specified timeframe. So it should tell you whether or not they were included in the measure in the first place and whether you received credit for them. Next slide.

So, here on Slide 55, we have an example of a patient stay-level QM report. Right off the bat, you notice that the rows and columns are different from those from the hospice-level report, and there are no percentages or scores displayed here. Instead, the patient stay-level report shows you for each patient stay whether you received credit or not for the HIS QMs. So each of the rows in the report are individual patient stays and not measures. As discussed on the previous slide, the patient stay-level 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 that the report is generated for. Remember that this is a major difference between the patient stay-level report and the hospice-level report, as the hospice-level report only displays Type 1 stays. As you can see in this example, the patient stay-level report is generated to reflect the stays of--all the stays -- Type 1, 2, and 3 -- between June 2014 and June 2015. The columns in this report are as follows. The first and second column tells you the patient's name and their QIES ID. The third and forth column are their admission and discharge dates, and then the eight columns following, you have the eight HIS measures to be publicly reported in 2018. You may notice that the measures are indicated here by their descriptive titles rather than their NQF ID. Finally, the last column is a quality measure count for that patient stay. As you can see, this report is a lot more complicated than the hospice-level report and displays many more values, such as X's, B's, and E's that aren't necessarily intuitive. Let's break down how to read this report and the useful information that it can provide to you. Next slide.

So, in order to interpret this report, here are three helpful guiding questions. The questions and the way they are laid out will help you determine whether you have any missing data for the patients, as well as interpret your hospice's measure performance for each patient stay. The first question helps determine missing data by asking "Does a 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 understand measure performance for each patient. The second question asks whether the patient was included in the measure denominator, and the third question asks if included in the

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denominator, did your hospice meet the numerator criteria for this measure for this patient? Note that the order of the questions matter. If you respond "No" to Question 1 or to Question 2, you do not move on to the next question for that patient or that measure. Now, let's apply the three questions to our example patient stay-level report to understand how to get the most information out of it. Next slide.

Here on Slide 57, we see a sample patient's stay-level report that includes three patients -- Carol, Leslie, and Ruth Doe. The first thing we want to do when interpreting the patient stay-level report is to ask our first question. Do these patients have an HIS Admission record, and, if they've been 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 at the Admission and Discharge Date columns. Let's look first at Carol, though. For Carol, we see dates in the Admission and Discharge Date columns with no additional letters. This means that Carol was admitted and discharged and we have submitted both and HIS submission and HIS discharge record for her, and they've been accepted by QIES ASAP. This not only means that Carol's a Type 1 stay, but it also means that there are no missing record concerns for Carol, and we can move on to the next questions for her to understand the quality of care that our hospice provided. Now, for Leslie, we see that there's a letter C in the Admission Date column, which we have circled here in red. The letter C means that the HIS admission record for Leslie is missing. As there's a date in the HIS Discharge column with no additional letters, we know that the HIS discharge record for Leslie was submitted and accepted. The missing HIS admission record for Leslie is a problem. Not only does your hospice have missing HIS data, but it means that Leslie is a Type 2 stay, which means her stay will not be included in any of the hospice's QM calculations. If you see the letter C in the Admission Date column, it means that you should find and submit the missing HIS submission record so that the patient's data can be included in your hospice QM calculations. Checking for these C's is one way to make sure that our pantry is fully stocked. A patient's stay-level report with lots of C's would indicate that you are missing many HIS admission records, which could have a negative impact on your QM score and your compliance. Last, let's look at Ruth Doe. For Ruth, the admission date looks fine. There are no letter C's. However, there is an N/A in the Discharge Date column. This could mean two things. 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's the former and Ruth has yet to be discharged, there's no further action needed by your hospice at this time, but if it's the latter and your HIS discharge record is missing, then, again, this is indicative of a missing data issue and you should find the missing HIS discharge record for Ruth and submit it as soon as possible. Either way, patients with an "N/A" in the Discharge column for either of these reasons are considered Type 3 stays and are also not included in your hospice's QM calculations. As Type 2 and 3 stays are not included in hospice QM calculations, this is why you see a letter E for every measure in Leslie's and Ruth's row. In the next few slides, we will explain further what the letter E means. As for a next step for both Ruth and Leslie, we need to take action to either submit the missing HIS record or verify that no HIS record is missing. As they won't be included in any of the HIS measures as Type 2 and 3 stays, we do not need to proceed with the next questions for Ruth or Leslie. We will only proceed with questions 2 and 3 for Carol, which we will go over in the next slide. Next slide, please.

So, Slide 58 and 59 summarize what we just went over in flow chart form. This may be a helpful reference to keep at your hospice. The flow chart section here, as well as those that will be presented later in this training, are also available in the "From Data to Measure" worksheet that accompanies this training. Again, we recommend that you keep a copy of this worksheet for your own reference to guide you as you review the patient's stay-level QM report on your own. Next slide. Next slide.

So, for patients that we have determined have both their HIS admission and discharge records submitted to QIES ASAP -- in other words, Type 1 stays -- we can now figure out how we perform on each of the QMs for these patients. Question 2 and 3 will help us in identifying this information in the patient stay-level report. Question 2, for starters, will help us to determine whether or not the patient is included in the measure denominator. Remember that we always begin with determining our denominator in order to assess whether the patient is included in the measure or not in the first place. To answer Question 2, we would look to the eight columns that each correspond to an HIS QM, and we would look for the letters E and D. E's and D's would both tell us that the patient was not included in the measure denominator, although each letter is for a different reason. The letter E means that the patient was not included in the final denominator, either because they did not meet the denominator definition or they met one of the denominator exclusions. As you can see in Carol's row, she has an E for the patient assessment QM, indicating that she was not included in this measure's denominator. This could either 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 being a Type 2 or 3 stay. The letter D may be new to many of you, as it was recently added to the patient stay-level QM report. At the current time, the letter D applies largely to the Hospice Comprehensive Assessment Measure. The letter D means that the patient's admission or discharge date occurred before the measure was implemented. So, for example, the Hospice Comprehensive Assessment Measure was implemented on April 1st of 2017. So patients who have admission dates before April 1st of 2017 including Carol, who was a patient at this hospice in 2014, were before the implementation of this measure and, thus, not included. Having a letter E or D means that this patient was not included in the final denominator of that measure. These patients are unusual with respect to your hospice's score on that QM. They were not included in the QM denominator count and therefore not included in the measure's calculation. If the patient has a letter E or D, you do not need to move on to the next question, Question 3, for that measure to figure out whether or not they met the numerator criteria. Remember -- only patients that are included in the final denominator of the measure are up for consideration for the numerator. So to determine whether or not Carol's stay met the numerator for all the other measures that did not indicate letters E or D, let's proceed with Question 3. Next slide.

Slide 61 and 62 outline what we just went over. Again, this flow chart section is also available in the worksheet for your reference. Next slide. Next slide again, please.

Our final question, Question 3, helps us determine measure performance. It helps us figure out whether patients in the final denominator then met the numerator criteria. To answer Question 3, we look for the letters B and X. Some fast and easy ways to think about these letters are to think of the letter B as for "bad." B's indicate that the patient was included in the final denominator but they did not meet the numerator criteria. You did not

receive credit for this measure for this patient. As you can see in this example, Carol is in the final denominator for Beliefs and Values Measure, the Dyspnea Screening Measure, and the Dyspnea Treatment Measure, but the hospice did meet the numerator criteria and receive credit for these measures. B's would represent areas for improvement. If you see any B's in your patient stay-level report, you might want to dig further and find out why the numerator was not met for this measure, for this patient. The letter X, however, is good. I'd like to think of this as "X marks the spot." This is what we're looking to find and looking to attain. X's indicate that the patient was included in the denominator and your hospice met the numerator criteria for that measure. Therefore, your hospice received this measure for this patient. In this sense, X's indicate good performance. Next slide.

Slide 64 presents a flow chart section for Question 3, which we just went over. Again, this is also available in the company "From Data to Measure" worksheet. Next slide, please.

Slide 65 presents some overall takeaways for the patient stay-level report as a whole. Remember, when interpreting these reports, we first want to determine whether we have any missing data problems, which is addressed by Question 1. For patients that are Type 1 stays with no missing data problems, we can then proceed to figure out whether the patient was included in the denominator for each measure, as asked by Question 2. If they were included in the final denominator, we can proceed to determine whether or not our hospice met the numerator criteria for that measure for that patient, as asked by Question 3. Next slide.

Remember, we're discussing the QM reports today because they are valuable tools for regularly assessing your hospice's performance before your quality scores are frozen in the preview reports. At that point, the cake would already be fully assembled for public reporting on Hospice Compare. Therefore, CMS encourages you to check your QM reports at the hospice level and the patient stay level early and often. They are the "canary in the mine," so to speak, providing critical information about the quality of your pantry and your QM performance before your quality scores are publicly reported. Checking your QM reports early and often ensures that you identify any areas for improvement well before the freeze dates for Hospice Compare and also enables you to begin improving in these areas as early as possible. Once CMS freezes HIS data to generate the preview reports, it would be too late to improve your performance for that data selection period. So remember to treat QM reports as critical progress reports and monitor them before you final HIS grade on your report is cemented. Now, I'll turn it back over the Alexis for the conclusion of our presentation. Thanks.

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

Slide 68 presents some of the key resources that we've mentioned throughout the presentation today, including the QM User's Manual, as well as some additional resources that you may find useful. Hyperlinks to all of these resources are embedded on this slide. Next slide.

Although we didn't focus on preview reports today, Slide 69 is here as a reminder that they are also important CASPER reports that 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 and access your

preview reports, see the training links here on Slide 69. Remember, preview reports are like your final report card. They're the final check to make sure the QM scores to be publicly displayed on Compare for the next refresh are accurate. If you find any errors in your preview report, you can submit a request for CMS review of HIS data. If this request is approved, your data will not be displayed on Compare for that particular refresh. Next slide.

This concludes today's presentation. We will now turn it over to have a Q&A session.

At this time, we would like to take any questions you may have for us today. To ask a question via the web, click the Q&A button in the lower-left-hand corner of your screen, type your question in the open area, and click "Submit." If you'd like to ask a question over the phone, simply press "star" then the number 1 on your telephone keypad. If you'd like to withdraw your question, press the "pound" key.

All right, at this time, we will begin by taking questions from the Chat Box. The first question is "No exclusion if patient is under 48 hours or less?"

Hi, this is Tracy. I'll be taking this question. So, the answer to this question is that every Quality Measure has its own measure exclusion criteria. For the measure that we presented today, which is NQF 1637, which is Comprehensive Pain Assessment Measure, the answer to that question is affirmative -- no exclusions based on length of stay. And we encourage the users to refer to the QM User's Manual to look at the exclusion criteria, which is part of the measure's expectations for all the measures implemented in the HQRP program. You can find the manual on the CMS HQRP website under the "Current Measures" page under the "Download" section.

Thank you.

Thank you. Next question. "I had a patient that denied pain but had pretty significant Dyspnea that I started morphine for. When submitting this info in HIS, I was given an error warning because I said no to pain but had started a prescription opioid.

Yep, so this is Alexis from RCI, and I'm happy to answer that question. So, essentially, the warning edit that this provider is referring to is Warning Edit 3077 in QIES, and essentially what causes this warning edit to fire is if you indicate no for the pain active problem item but indicate that the patient was on an opioid. I'll take a moment here just to clarify the difference between Warning Edits and Fatal Edits. So, a warning edit is essentially just asking you "Are you sure this is how you want to respond to this question?" So it's a signal for you to go back and double-check what you've entered in the HIS, and if you confirm that what you've entered into the HIS is correct, you can go ahead and submit that record with that warning edit still there. It won't cause that record to be rejected by the system. And that's in contrast to what we refer to as "Fatal Errors" or "Fatal Edits." So a fatal edit, it will prevent you from submitting that record successfully into the QIES system until you resolve whatever the issue is that was causing the fatal error. So 3077 is a warning edit, and essentially, what this warning is prompting you to do is to double-check, really, the reason why you started that opioid. So in the case that the questioner pointed out, where the opioid was only for shortness of breath, if the opioid was only for shortness of breath and there's no other

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indication that that pain is an active problem for the patient, then what you can do is just go ahead and ignore that warning edit and submit the record. You don't need to change your answer to J0905 to an active problem in that instance. However, if you go back and double-check the reason why that opioid was initiated and you see that it was initiated, say, for multiple reasons, such as to treat shortness of breath and pain, or you look elsewhere in their record and see evidence that pain is an active problem, then you should go back and answer "Yes" to "Pain Active Problem."

Thank you. Next question. "For NQF1637, do discharge patients include death in discharge or just live discharges?"

The denominator for this measure, which is, again, Comprehensive Pain Assessment, includes all Type 1 stays, which is complete stays with an admission and discharge record. So as long as a patient stay indicates the patient is older than 18 years old, the stay will be included in the denominator. In other words, regardless of whether it's a discharge because of death or a live discharge, the stay will be included as a denominator for this measure.

Thank you. Next question. "What question makes you positive for screening for pain -- for example, the severity level?"

This is Alexis again. The answer to that question for the purposes of the Quality Measures, so looking really just at the QM specifications that are in the QM User's Manual, what counts you as screening positive for pain -- so, in other words, what gets you into the denominator for the pain assessment measure -- is J0900C, which is that pain severity level item. So to be included for the denominator for the Comprehensive Pain Assessment Measure, you have to have mild, moderate, or severe pain as indicated by J0900C.

Thank you. Next question. "Is the information or data for patients who have not yet died or just discharged held until they are discharged and included in the denominator at that time?"

So, I think the answer to that question is that, yes, similar to the previous question, the denominator for the measure that we were presenting today, Comprehensive Pain Assessment, includes Type 1 stay -- again, this is a stay with both an admission and a discharge record. So a patient would not be included in the measure until the patient is discharged and the discharge record had been submitted.

Thank you. The next question is -- "When is the next Hospice Compare refresh? I thought it was supposed to be yesterday."

Yep, so Hospice Compare was actually refreshed this morning. The providers can go in and see their data for HIS data for patient stays discharged between Quarter 4 2016 and Quarter 3 2017. CAHPS data was also refreshed and includes data from Quarter 4 2015 to Quarter 3 2017.

Thank you. Next question. "Do you use the calendar year for determining quarters or CMS year, which starts in October?"

It is calendar years for determining quarters. So Quarter 1, an example would be January through March, Quarter 2 would be April through June,

Quarter 3 would be July through September, and Quarter 4 is October through December.

Thank you. Next question. "How often are these reports updated on CASPER?"

So, the reports are available on demand to providers. Providers can access them for whichever reporting period they would like at any time by going into the CASPER system. That being said, the data that's included in the reports is updated monthly, generally around the 15th of the month.

Thank you. Next question. "Please repeat what the Comparison Group National Percentile means."

The Comparison Group National Percentile is a way to see how you're doing relative to other providers on your hospice-level QM reports. For example, if a hospice provider's national percentile, like we went through in the slides is a 23, that means that 23% of hospice providers in the national had a Quality Measure score that was less than or equal to the hospice provider's score.

Thank you. Next question. "Can you define Type 1, 2, and 3 stays?"

Type 1 is a stay with both the admission and the discharge records. So this typically indicates a stay where the patient has already been discharged. Type 2 stay is a stay where we see, in the system, there is a discharge record but there isn't any admission record. So this typically indicates a patient that has been discharged, but the admission record is missing in the data system. Type 3 stay is a stay where there is an admission record, but there is no discharge record. So this typically indicates that the patient is still an active patient -- or, in other words, the patient has not been discharged. So, as we discussed during the presentation today, right now the Current Measures, the starting point for the denominator is Type 1 stay. We consider that as a complete stay. The patient has been discharged, and the stay is defined by both an admission and discharge record. Type 2 and Type 3 stays are typically excluded from measure denominator.

Thank you. The next question is -- "Are hospice-level QM reports the only reports published on Hospice Compare versus hospice-level stay reports?"

Thank you. So, to clarify, on Hospice Compare, all the data is on the hospice level. There is no patient stay-level data reported on Hospice Compare. So, that being said, the closest approximation before your preview reports that you can get of the data that will be posted on Hospice Compare is through your hospice-level QM reports, provided you do run them for the correct time period so the data selection period matches the Hospice Compare refresh, and keep in mind the minimum denominator size, as well.

Thank you. Next question. "Which item on the HIS determines if a patient screens positive for pain?"

So, I'm going to answer that again from the perspective of the Quality Measure. So, from the perspective of the Quality Measure, the item that determines whether or not a patient screens positive for pain, and thus whether a patient goes into the denominator of 1637 is J0900C, that pain severity score.

Thank you. Next question. "When will the visits at the end of life be displayed in Hospice Compare?"

The Hospice Visits When Death is Imminent Measure pair will be displayed on Hospice Compare sometime in Fiscal Year 2019. The exact timeline is still under determination, but we will be sure to alert providers before any public reporting begins through regular communication channels.

Thank you. The next question is -- "I thought the QIES ASAP system requires the HIS data to be submitted sequentially. How does the discharge HIS get accepted without the admission HIS being accepted first regarding Error C, denoting missing admission data?"

Mm-hmm. So that's a great question. So, typically, a hospice would submit an HIS admission record first, just because admission happens before discharge, but there are instances where you may submit a discharge record first, and we often see hospices doing that for patients that have really short length-of-stay. The answer to the questions about QIES ASAP specifically an that's allowed to happen in the system is what I referred to earlier about the difference between a warning error and a fatal error. So, submitted records out of order, submitting a discharge before an admission would be an example of warning error. So an error message will pop up and say, "Hey, these records are out of order. Are you sure you want to do this?" But because it's just a warning edit, you can submit them out of order. However, we would recommend that if do submit the discharge first, you go and try to submit the admission record very soon thereafter, just to avoid any potential instances of where you end up with those C's on your report, for example, and it appears that you have missing data.

Thank you. At this point, we do have additional questions that we would be happy to read through the chat box, but is there anybody on the line who would like to ask any other questions first?

We do have a question from Jamie O'Brien. Jamie?

Hi! I'm just going through the pain question again, and I understand that when you do your initial pain screening, if on the day that the clinician assesses the patient and the patient says "Right now, I do not have any pain," the question would be "No" and then they would not go forward and do a Comprehensive Pain Assessment. So that patient would not be in the denominator, correct?

That's correct. So if you asked the patient on the day of admission if they're having any pain currently during the time of what we would call the pain screening visit and they say no, then that patient would not into the denominator because you would have selected "None" for J0900C.

Okay. So even if they're not having pain because they're on an opioid -- So "Are you having pain?" They say no. But we know that they're not having pain because they're on morphine, do you still answer no and they do not go in the denominator?

So, they do not go in the denominator, that is true, because what you put down for J0900C was "None." However, I think kind of what you're getting at is how does the Pain Active Problem item fit into this? And so we've gotten a couple of other questions about this on the Chat Box, so I can go ahead and address that.

Okay.

So, this is one instance, and remember, when we went over the presentation, we talked about how sometimes there are differences between how a QM is specified in clinical practice. And what happens a lot of times is exactly what you point out. A patient comes into hospice, they've had pain as a problem for months or however long. They're already on a treatment regimen.

Right.

So their pain is well-managed using that treatment regimen. So in those instances, the patient may not have pain during that pain screening initial visit when you ask them. They may say "Nope, my pain is fine now. It's none but that's because I'm good with my pain treatment regimen." So, for the purposes of the QM, then it's as we stated. That patient is a "None" for J0900C. They don't do into the denominator. However, that's one issue, which is the QM specifications. The second issue to think about is how you then fill out the rest of the HIS. So you've already filled out item J0900. You've gone through Parts A through D of that item. You then move on to the next item, which J0905, Pain Active Problem. So that item, the instructions are a little bit different. So, for that item, you're not only considering what the patient is telling you right then and there. You're also considering any history of pain, other factors like whether the patient is on any sort of pain regimen, whether it be opioids, medication, non-medication therapies. If the patient has a history of pain or is currently on a pain regimen, then you would answer "Yes" to Pain Active Problem, and then you would move on and complete item J0910, which is the Comprehensive Pain Assessment item. So although you're moving on to complete item J0910, just remember that that patient, the fact that you went ahead and did a Comprehensive Pain Assessment, which was good practice, that patient still isn't going to end up in the measure because the denominator for the measure is driven only by J0900C. Does that make sense? Okay. I'll take the silence as a yes for now.

Thank you. Are there any other questions on the speaker line? All right. If not, I'll continue to read from the Chat Box. The next question is -- "On the potential missing data question, if the admission HIS is missing and there is not a discharge, would the QM report know that we are missing the admission?"

The answer to that is no. The only way it knows that the admission record is missing in that situation is once you submit the discharge, and then, in that case, you will have submitted a discharge record, but there will be no admission, so you will get that C that Dorothy was talking about.

Thank you. The next question is -- "When is there a PRN opioid HIS admission question appropriate to answer "Yes?" We often put PRN opioids in place on "Admit To Hospice" and patients/families are educated on the use of these medications, but the patient may or may not use the medication for quite some time. I'm never quite sure whether to mark "Yes" to the PRN opioid HIS question.

Mm-hmm. So, we have guidance about this in the HIS Manual, and we explain it in the context of comfort kits, or pre-printed admission orders. So those would be things that your hospice puts in place pretty routinely, and in the situation of a comfort kit, there are things available at the home so that

the patient can easily access it once they're instructed to do so by a provider, and it's there to kind of save time. And for these instances, treatment is considered initiated when the hospice has received the order for the medication and there is documentation that the patient or caregiver was instructed to begin use of the medication or treatment. So if you have a comfort kit in the home, and sometime around the time of admission, the nurse explains to the patient where the comfort kit is, what's in the comfort kit, education about "If you call me and your dad's symptoms are getting worse, I may instruct you to pull X, Y, or Z out of the comfort kit and begin using it." That education alone is not enough to say that any treatment in the comfort kit has been initiated. So, for comfort kits, or pre-printed admission orders, what would need to happen is something beyond that education. So the nurse saying, "Okay, you've now called me and told me that your dad's pain is getting worse. I want you to go into the comfort kit, get X, Y, Z out, and let's start using that." So that would be kind of the trigger for answering "Yes" for PRN opioids that are part of comfort kits or pre-printed admission orders.

Thank you. There's a question from speaker line that we'll be taking next.

And our next question is from Sheryl Jason.

Hey. And our next question is from Sheryl Jason.

I was just wondering -- I am sorry, I didn't know how to respond quick enough. Can you review again the question you just talked about, when pain is active problem and you're answering "Yes" because of a history of pain and the patient is on a pain regime that's controlling his pain. What did you say about the denominator?

Mm-hmm.

Thank you.

So, when you answer "None" to J0900C -- the patient says, "No, I'm not having any pain right now at this moment, but that's because I'm on this pain regimen. My pain is well-controlled. You answer "None" to J0900C, just remember, it's J0900C that drives the denominator. So that patient will not end up in the denominator. However, although you answered "None" to J0900C, the HIS still instructs you to move on to the next items from the pain series, which are J0905 and J0910. So in the situation that you're talking about for J0905, you'd answer "Yes" because pain is an active problem, the patient is on a pain regimen, indicating that pain is active problem, and then the HIS itself instructs you to go ahead and complete the Comprehensive Pain Assessment anyway, which your clinicians would do. However, although in practice you have completed the comprehensive pain assessment, that pain assessment that you did for that patient won't go into any measure. So it won't get counted in the numerator, and that's because that patient was excluded from the denominator. So just remember kind of like what we were talking about when we had the pictures with the patients and the circles. Think about your denominator as kind of the boundary line. So only patients who end up within that final boundary line, who aren't excluded do you need to determine the numerator for. So although you've provided a Comprehensive Pain Assessment for that patient, it won't go into the numerator because that patient was excluded from the denominator.

Okay, thank you so much.

Mm-hmm.

Thank you. I'll read one more question from the Chat Box at this time. This will probably be our last one. "What are the resources we need to learn how to re-submit if the HIS is incorrect?"

Yep. So, if you identify an error in your HIS record -- So, say you've selected the wrong response to a particular question by accident or you left something blank. If that record has been already submitted and accepted to the QIES ASAP system, then you'll need to do what is called either a modification or an Inactivation Request. And if you look at the HIS manual, which I believe is linked on the "Resources" slide. If you go into the HIS Manual and to Chapter 3 of the manual, if you go to Section 3.6, it will walk you through step by step how to do either the modification request or the inactivation request. And whether you complete a modification or inactivation request depends on which item was incorrect. So if you have a key identifier that's wrong -- so, something like the patient's name, their Social Security Number, gender, birth date -- if any key patient or record identifiers are incorrect, you have to use the Inactivation Request, but for any other item -- so all of the clinical items, the pain items, the shortness-of-breath items -- you can correct those using the modification request, and the instructions for how to do that, again, are in Chapter 3, Section 3.6 in the HIS Manual. And if you need any assistance kind of figuring out how to do that from a technical perspective, you can reach out to the Help Desk, and they can assist you with that.

Thank you so much. At this time, we would like to turn it over to CMS to close the call.

Hello. This is Carol Schwartz. I hope that you all found this presentation to be very helpful. I think it went into a lot of detail, and we also answered a lot of questions. I would encourage you to refer to our CMS website, to our Hospice Quality Reporting Page and specifically the Hospice Quality Reporting Training and Education Library. And I just wanted to thank you all for attending and for asking very thoughtful questions and for doing your best to improve your reporting. Thank you very much.

Well thank you to all of our participants for joining us today. We hope you found this webcast and presentation informative. This concludes our webcast. You may now disconnect. Have a great day.