

# From Data to Measure

Understanding calculation of Hospice Item Set (HIS) quality measures and interpreting Certification And Survey Provider Enhanced Reports (CASPER) Quality Measure (QM) reports

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## Acronyms used in this presentation

- CAHPS®: Consumer Assessment of Healthcare Providers and Systems
- CASPER: Certification And Survey Provider Enhanced Reports
- CMS: Centers for Medicare & Medicaid Services
- FAQ: Frequently Asked Questions
- HIS: Hospice Item Set
- HQRP: Hospice Quality Reporting Program
- QAPI: Quality Assessment and Performance Improvement Program
- QIES ASAP: Quality Improvement and Evaluation System Assessment Submission and Processing
- QMs: Quality measures
- QTSO: QIES Technical Support Office

## Background: Hospice Item Set (HIS)

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

### QMs calculated using the HIS

NQF#1617 Patients Treated with an Opioid who are Given a Bowel Regimen

NQF #1634 Pain Screening

NQF #1637 Pain Assessment

NQF #1639 Dyspnea Screening

NQF #1638 Dyspnea Treatment

NQF #1641 Treatment Preferences

NQF #1647 Beliefs/Values Addressed (if desired by the patient)

Hospice Visits when Death is Imminent

NQF #3235 Hospice and Palliative Care Composite Process Measure – Comprehensive Assessment at Admission

## Background: Hospice Item Set (HIS)

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

### QMs calculated using the HIS

**NQF#1617 Patients Treated with an Opioid who are Given a Bowel Regimen**

**NQF #1634 Pain Screening**

**NQF #1637 Pain Assessment**

**NQF #1639 Dyspnea Screening**

**NQF #1638 Dyspnea Treatment**

**NQF #1641 Treatment Preferences**

**NQF #1647 Beliefs/Values Addressed (if desired by the patient)**

Hospice Visits when Death is Imminent

NQF #3235 Hospice and Palliative Care Composite Process Measure – Comprehensive Assessment at Admission

## Motivations for this training

Providers often have questions about how their QM scores are calculated:

- Why they did not “receive credit” for certain QMs based on submitted HIS data
- How to interpret CASPER QM reports

## Learning Objectives

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

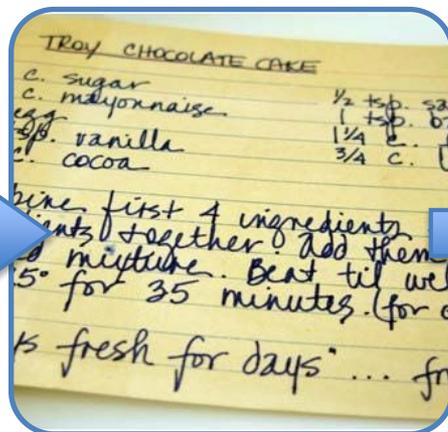
# **Part I: Using HIS data to calculate publicly reported QM scores**

# From HIS data to publicly reported QM scores: “It’s just like baking a cake”



## Ingredients

The HIS data are your raw ingredients – what you need to bake the cake.



## Recipe

The QM specifications are the recipe – tells you which ingredients you need, and how to combine them to bake your cake.



## Cake

The publicly reported score is the cake -- final product resulting from cake assembly steps.



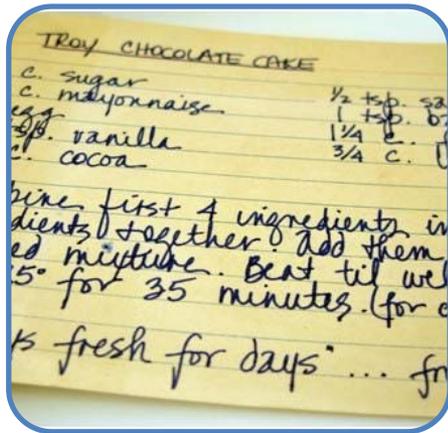
# Ingredients: HIS data

## Ingredients: HIS data

- To ensure a successful final product, make sure your pantry is fully stocked and your ingredients are high quality
  - Fully stocked: ensure you submit HIS data for all patients
  - High quality: ensure HIS data are accurate, complete, and timely
- Just as missing or poor ingredients impact the quality of your cake, missing, incomplete, inaccurate, and/or untimely data can all have negative consequences on your publicly reported QM score and/or compliance

## Ingredients takeaways

- To ensure that your QM score is accurate, make sure that your hospice has quality assurance and monitoring processes in place to ensure data are submitted for all patients, and that data are complete, accurate, and timely. For example:
  - Staff review of completed HIS records to ensure completeness and accuracy prior to submitting to CMS (including back-up staff)
  - Tracking QIES ASAP downtime to ensure all records can be submitted timely (downtime schedule available on the “[Providers](#)” page of the QIES Technical Support Office (QTSO) website)
  - Check Final Validation Reports in CASPER to ensure successful submission of data
  - Ensure that you and your vendor are working with the most up-to-date version of the HIS and HIS item specifications which can be found [here](#)



# Recipe: QM Specifications

## Recipe: QM specifications

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



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

User’s Manual Version 2.00

Current as of January, 2018

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

## Recipe: QM specifications

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



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

User’s Manual Version 2.00

Current as of January, 2018

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

# Recipe: Step 1

## *Understanding the Denominator*

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

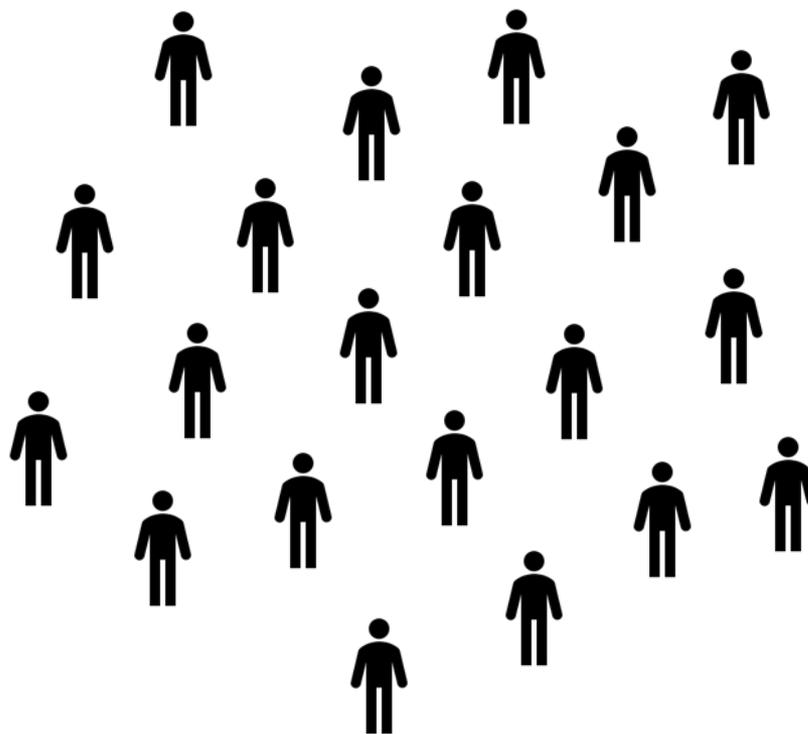
## Recipe: Step 2

### *Understanding Denominator Exclusions*

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

## Example: Foot Exam for Diabetes patients

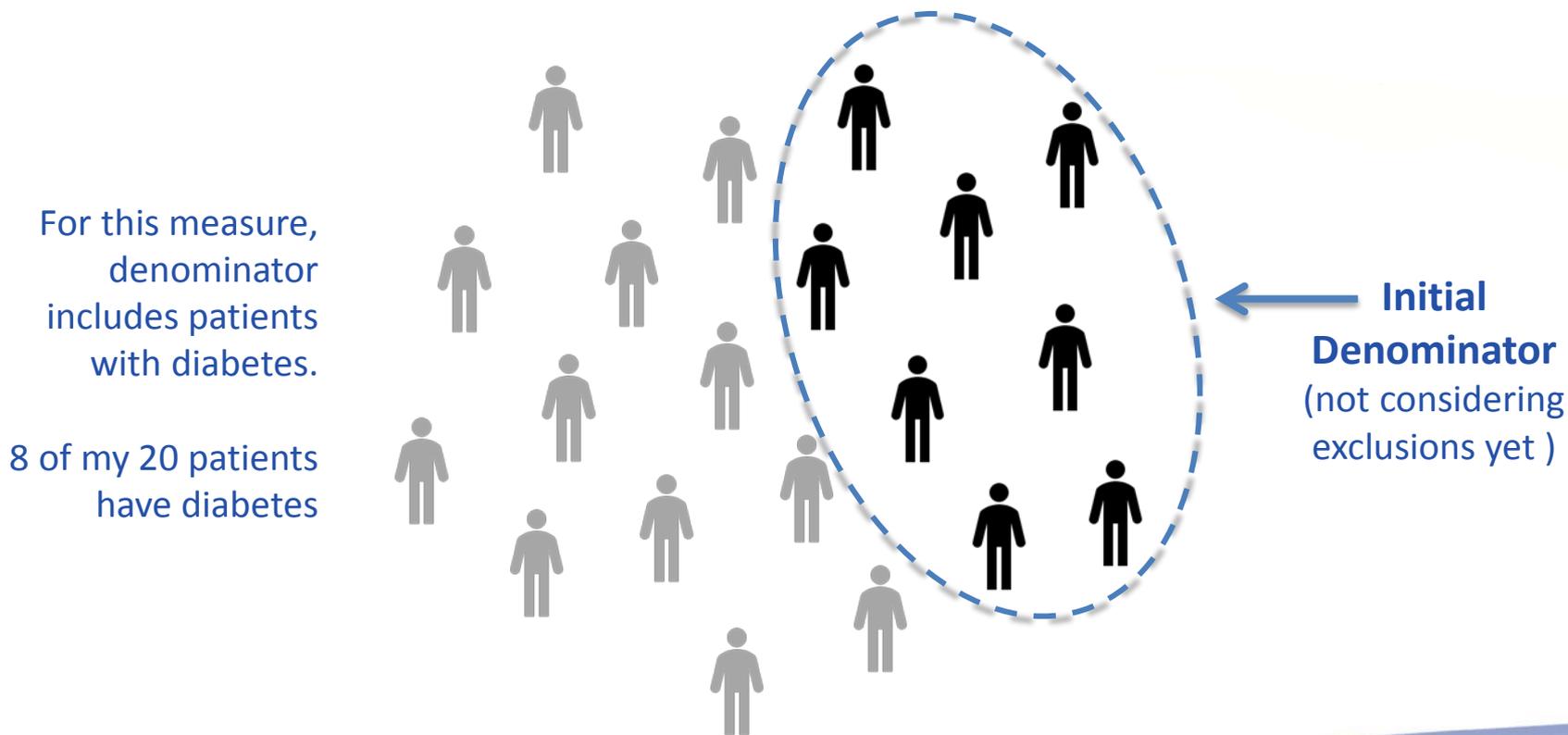
As a primary  
care provider,  
these are my  
20 patients.



Total Patient  
Population

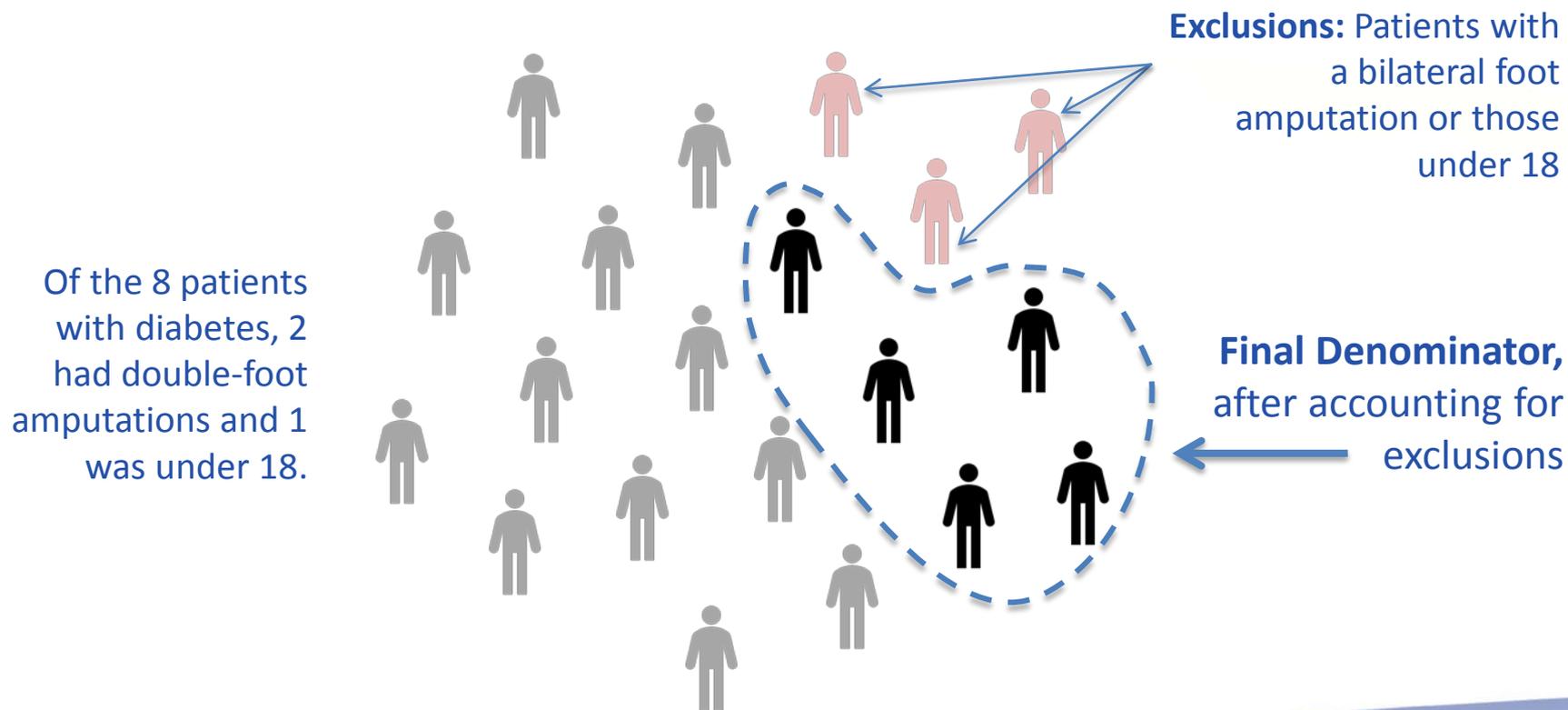
## Example: Foot Exam for Diabetes patients

Denominator: Which patients does this measure apply to?



## Example: Foot Exam for Diabetes patients

Denominator exclusions: Are there any exceptions?



## Recipe: Step 3

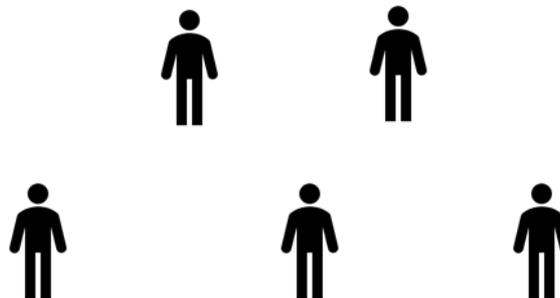
### *Understanding the Numerator*

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

## Example: Foot Exam for Diabetes Patients

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

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

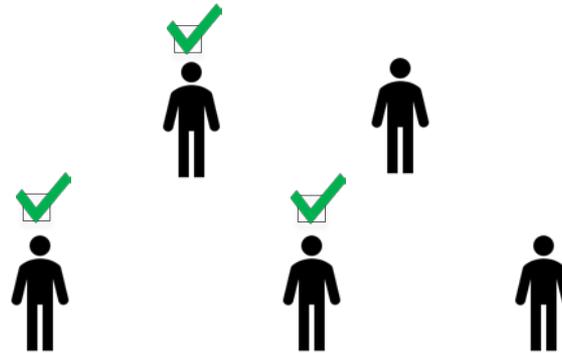


## Example: Foot Exam for Diabetes Patients

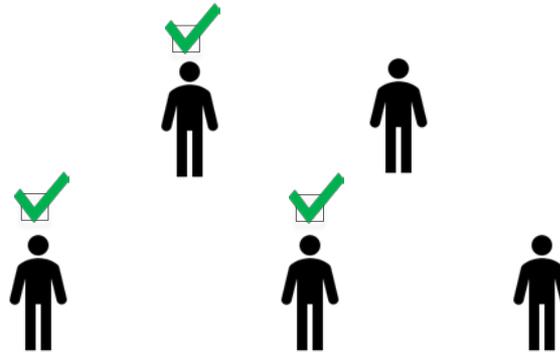
Numerator: What needs to happen to receive credit for the measure?

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

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



## Example: Foot Exam for Diabetes Patients



$$\frac{\text{numerator}}{\text{denominator}} = \frac{3}{5} = .6 \text{ or } 60\%$$

# QM specifications

## *Putting it all together*

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

# QM specifications

## *Putting it all together*

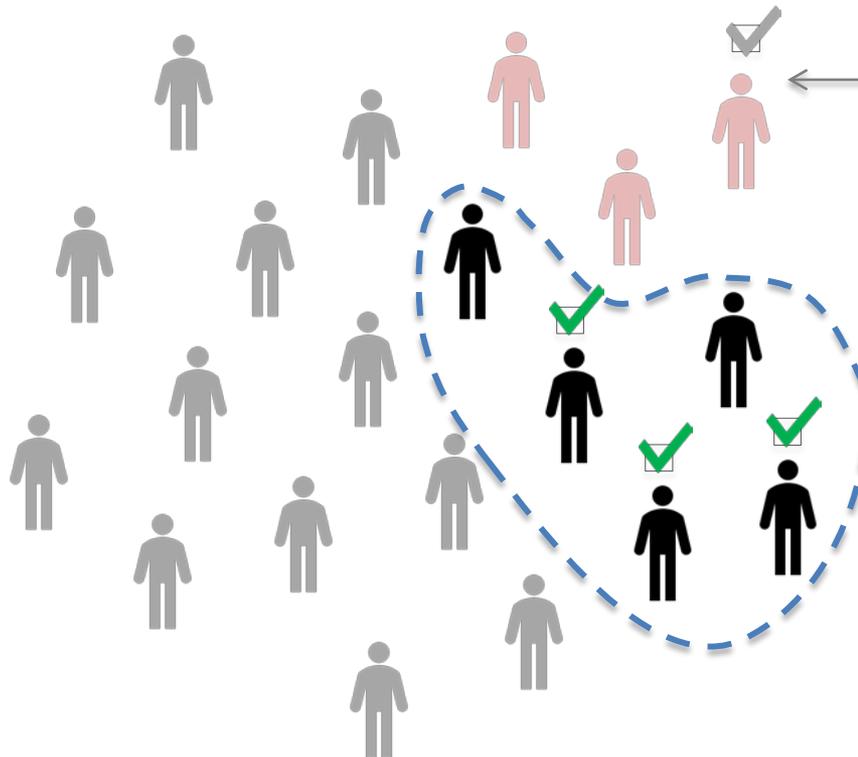
Clinical practice vs QM specifications – an example:

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

# QM specifications

## *Putting it all together*

### Clinical practice vs QM specifications



This patient is under 18 and not included in the final denominator

So even if this patient has received a foot exam, he/she does not go into the numerator calculation. These patients neither help nor hurt you.

Only the patients included in the **final denominator** are included in the QM numerator calculation. These are the only patients that can help/hurt your score

# QM specifications

## *Putting it all together*

### Clinical practice vs QM specifications

- In these instances, your measure calculations will be not be correct if they are done out of order (i.e., numerator calculated first)
- Always build your denominator first (accounting for exclusions), then determine your numerator count **ONLY** based on patients included in the final denominator

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

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

To calculate NQF#1637 QM:

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

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

### QM Specifications

#### ***NQF #1637: Hospice and Palliative Care—Pain Assessment***

The following steps are used to calculate the measure:

Step 1. Calculate the denominator count:

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

Step 2. Identify excluded stays:

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

Step 3. Calculate the numerator count:

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

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

### QM Specifications

#### ***NQF #1637: Hospice and Palliative Care—Pain Assessment***

Step 1. Calculate the denominator count:

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

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

We see from the QM specification this measure applies to:

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

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

### QM Specifications

#### ***NQF #1637: Hospice and Palliative Care—Pain Assessment***

Step 2. Identify excluded stays:

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

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

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

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

### QM Specifications

#### ***NQF #1637: Hospice and Palliative Care—Pain Assessment***

Step 3. Calculate the numerator count:

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

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

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

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

# Ingredient vs Recipe

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

## NQF #1637: Hospice and Palliative Care—Pain Assessment

Step 1. Calculate the denominator count:

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

Step 2. Identify excluded stays:

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

Step 3. Calculate the numerator count:

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

## Important QM specification takeaways for all HIS QMs

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

## Important QM specification takeaways for all HIS QMs

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

# Cake: The Publicly Reported QM Score



## Cake: The Publicly Reported QM Score

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

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

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

# Data Selection Periods

## An example with NQF #1637 for the August 2018 refresh

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

# Minimum Denominator Size

## An example with NQF #1637 for the August 2018 refresh

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

## Minimum Denominator Size

### An example with NQF #1637 for the August 2018 refresh

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

## Important Publicly Reported QM Score Takeaways

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



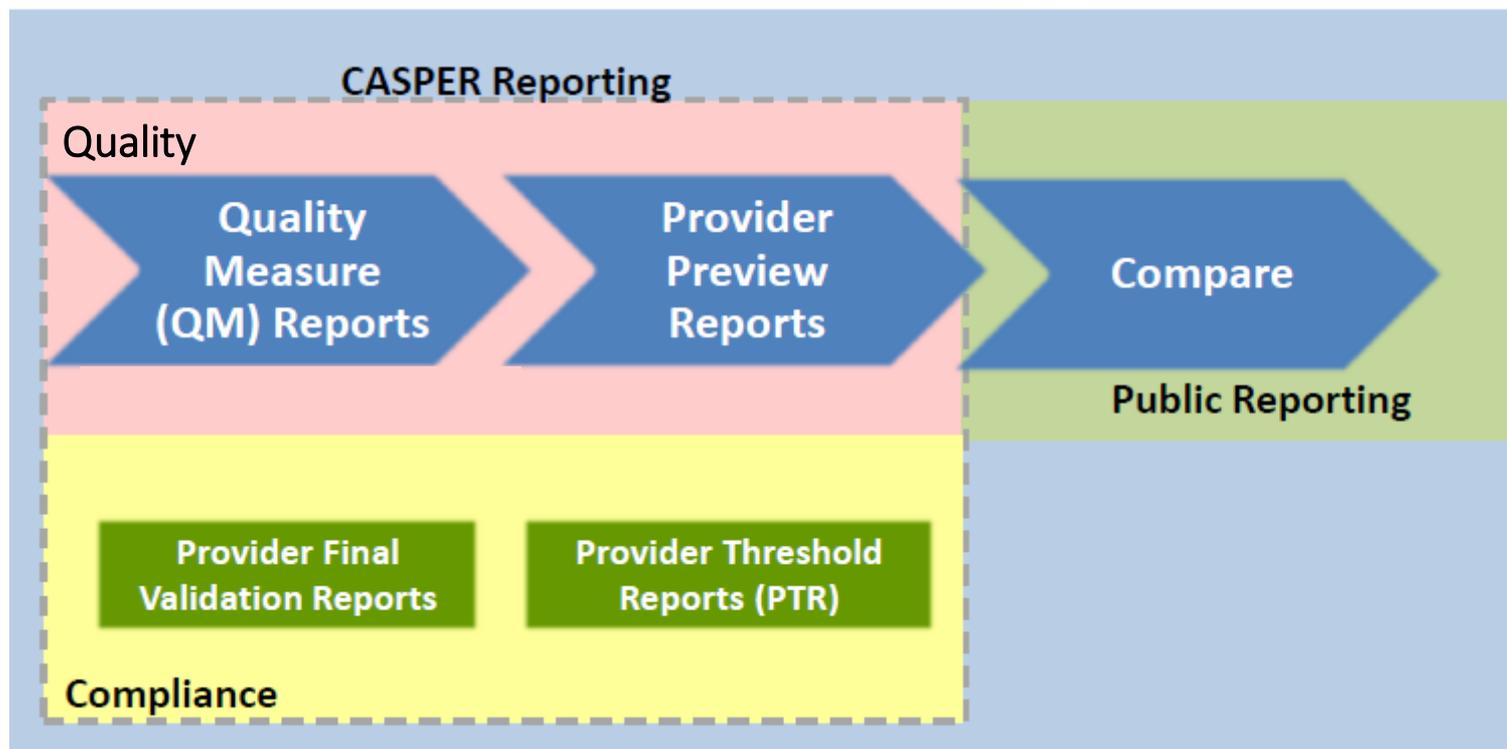
# **Part II: Interpreting QM Reports in CASPER**

## CASPER Reports

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

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

# Main Types of CASPER Reports



## QM Reports

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

## Types of QM Reports

- Hospice-level Quality Measure Report
  - Displays your hospice's score for each QM
  - Also provides comparative information ( national average QM scores and percentiles)
  - Helpful for identifying areas for improvement
  - Includes only Type 1 patient stays
  
- Patient stay-level Quality Measure Report
  - Provides information at the patient level:
    - Whether a patient was included in the final denominator
    - If so, whether that patient met numerator criteria for that measure
  - Includes ALL patient stays (Type 1, 2, and 3)

## QM Reports

- Both QM reports are “on-demand” and customizable
  - This means that you can run the reports at any given time (don’t have to “wait” for it to be generated for you)
  - And you can run the report for any time period of your choice (e.g., 1 month, 4 months, 12 months, etc.)
  - This is one reason why the QM score displayed in your QM Report may not match the QM score displayed on your Preview Report
- Both QM reports currently show information for 8/9 HIS measures
  - The Visits measure is currently not included; this measure is anticipated to be added sometime in FY 2019

## Hospice-level QM Reports

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

# Hospice-level QM Reports

REPORT TIMEFRAME: 01/01/18 – 06/30/18

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

Note: Hospice-level report includes only Type 1 stays

# Hospice-level QM Reports

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



REPORT TIMEFRAME: 01/01/18 – 06/30/18

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



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

# Hospice-level QM Reports

Average score of all hospice agencies in the US

REPORT TIMEFRAME: 01/01/18 – 06/30/18

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

Your hospice's QM score

$$\frac{\text{numerator}}{\text{denominator}} \times 100\%$$

Your national rank (i.e., this hospice scored higher than 23% of hospice providers)

## Hospice-level QM Report: Key Takeaways

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

## Patient Stay-level QM Report

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

# Patient Stay-level QM Report

REPORT TIMEFRAME: 06/01/14 – 06/30/15

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

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

## Interpreting the Patient Stay-level QM Report

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

# Patient Stay-level QM Report

REPORT TIMEFRAME: 01/01/18 – 06/30/18

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

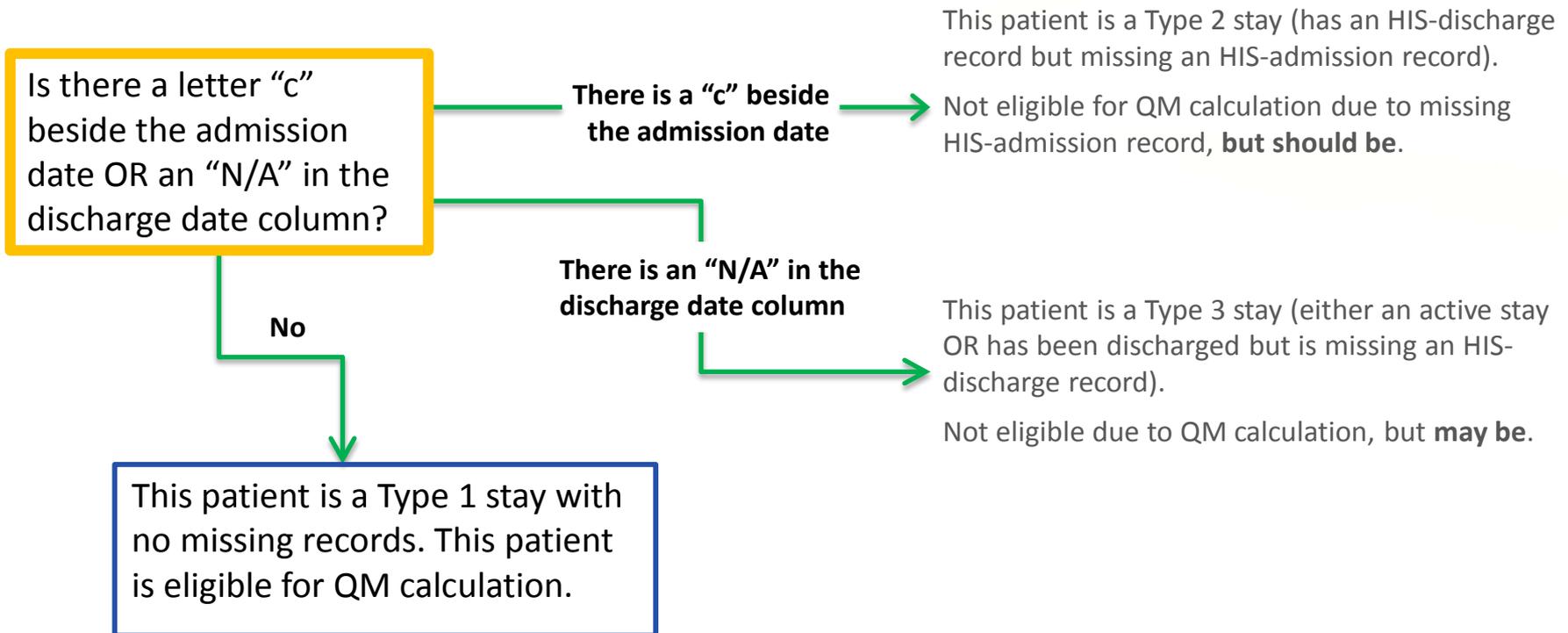
## Question 1) – Potential missing data: Does the patient have both an HIS-Admission and HIS-Discharge record submitted to QIES ASAP?

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

\*These patients are “neutral” from a performance perspective

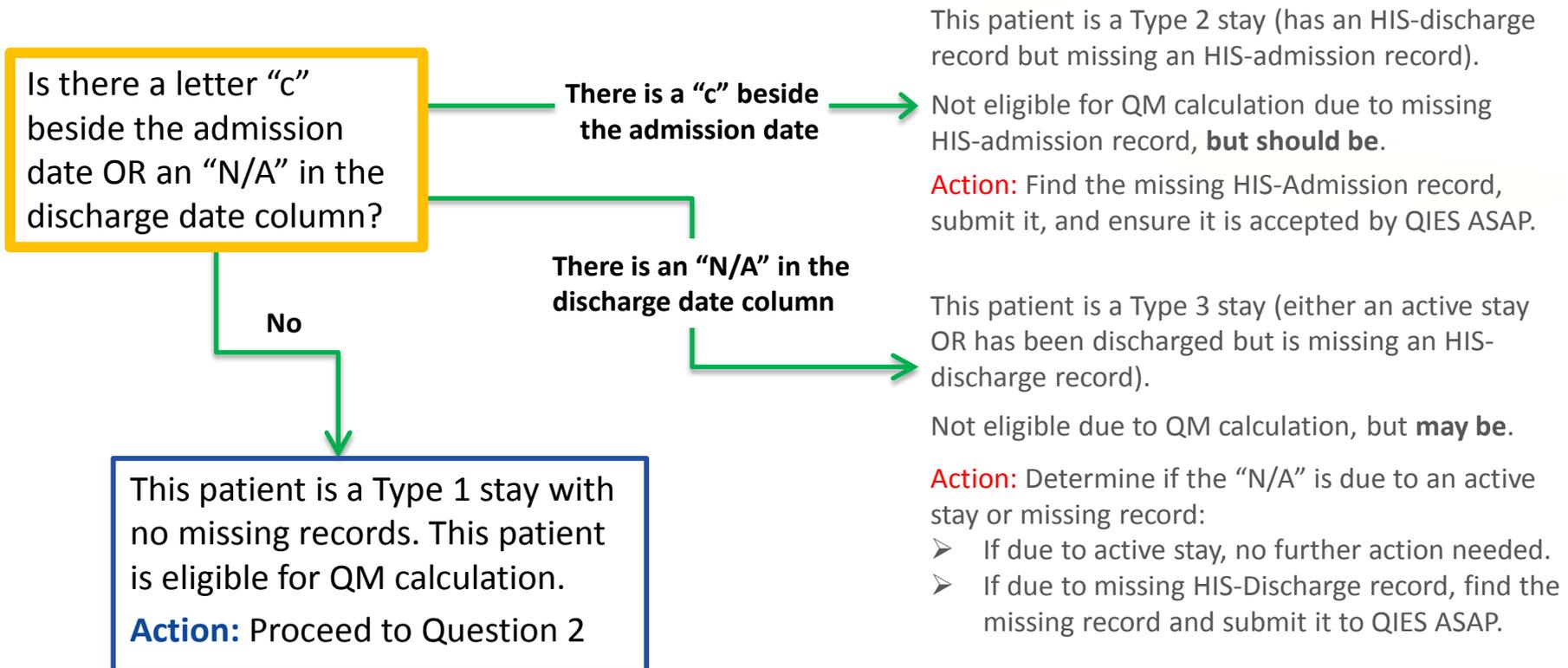
# Patient Stay-level QM Report

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



# Patient Stay-level QM Report

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



# Patient Stay-level QM Report

REPORT TIMEFRAME: 01/01/18 – 06/30/18

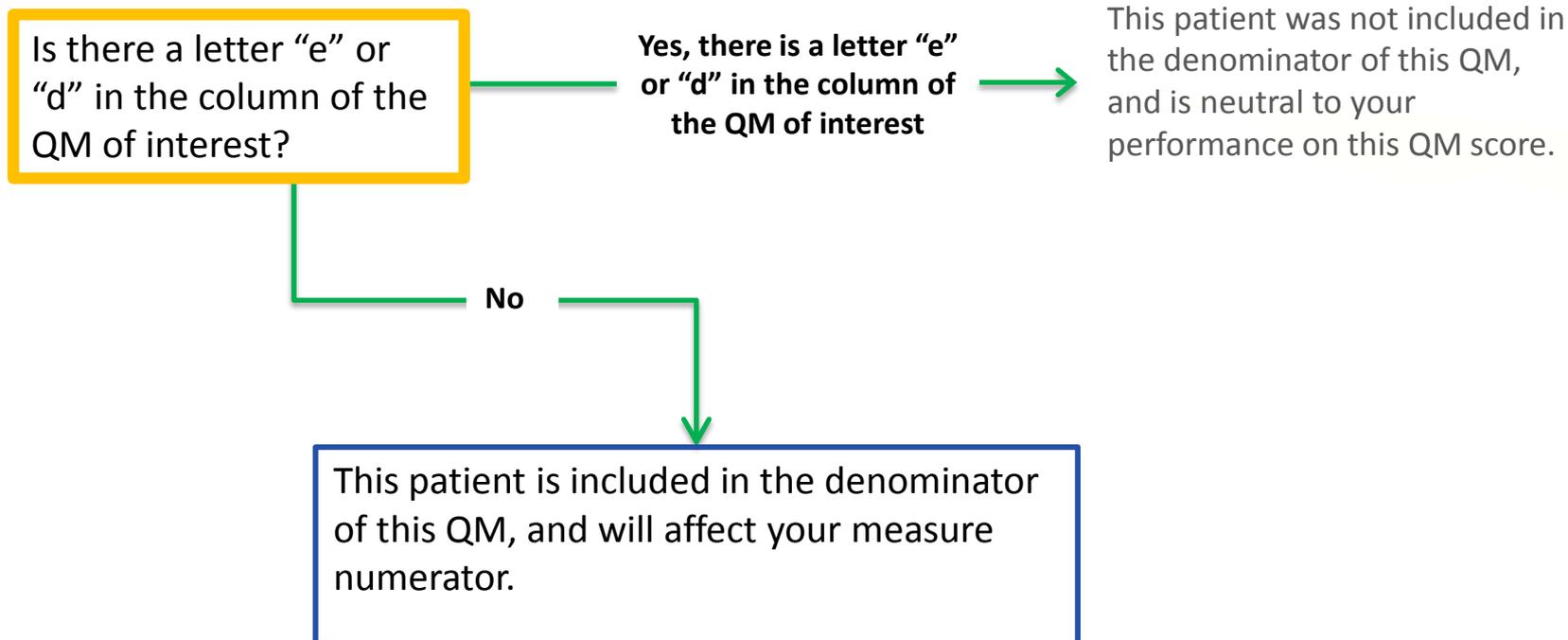
Patient Name	Patient ID	Admission Date	Discharge Date	Treatment Preferences	Beliefs/Values	Pain Screening	Pain Assessment	Dyspnea Screening	Dyspnea Treatment	Bowel Regimen	Hospice Comprehensive Assessment	Quality Measure Count
Doe, Carol	234567	10/25/2014	11/04/2014	X	b	X	e	b	b	X	d	3

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

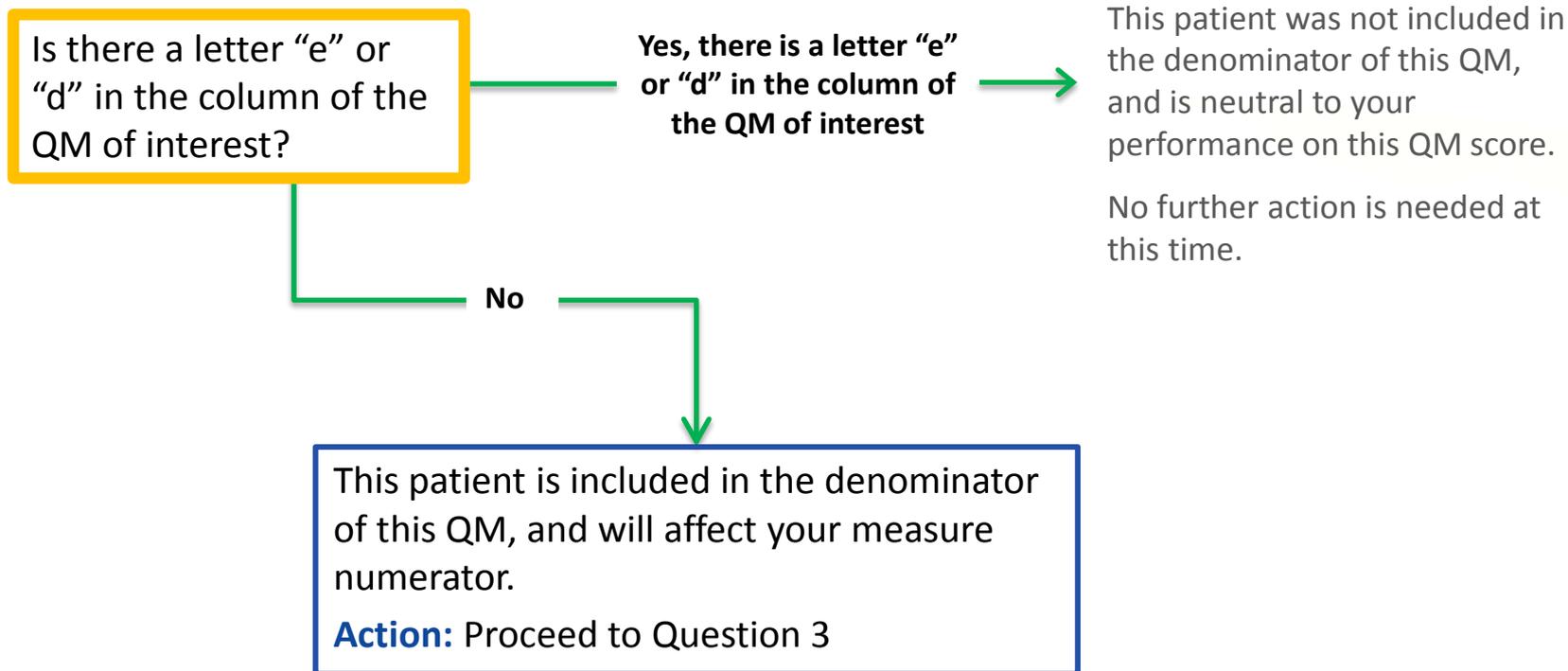
- “e” OR “d” = patient not included in the measure denominator
- e = excluded from the QM denominator
  - Did not meet denominator definition (e.g., did not screen positive for pain) or
  - Met denominator exclusion criteria (e.g., under 18)
- d = measure not implemented based on patient’s admission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

\*These patients are “neutral” from a performance perspective

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



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



# Patient Stay-level QM Report

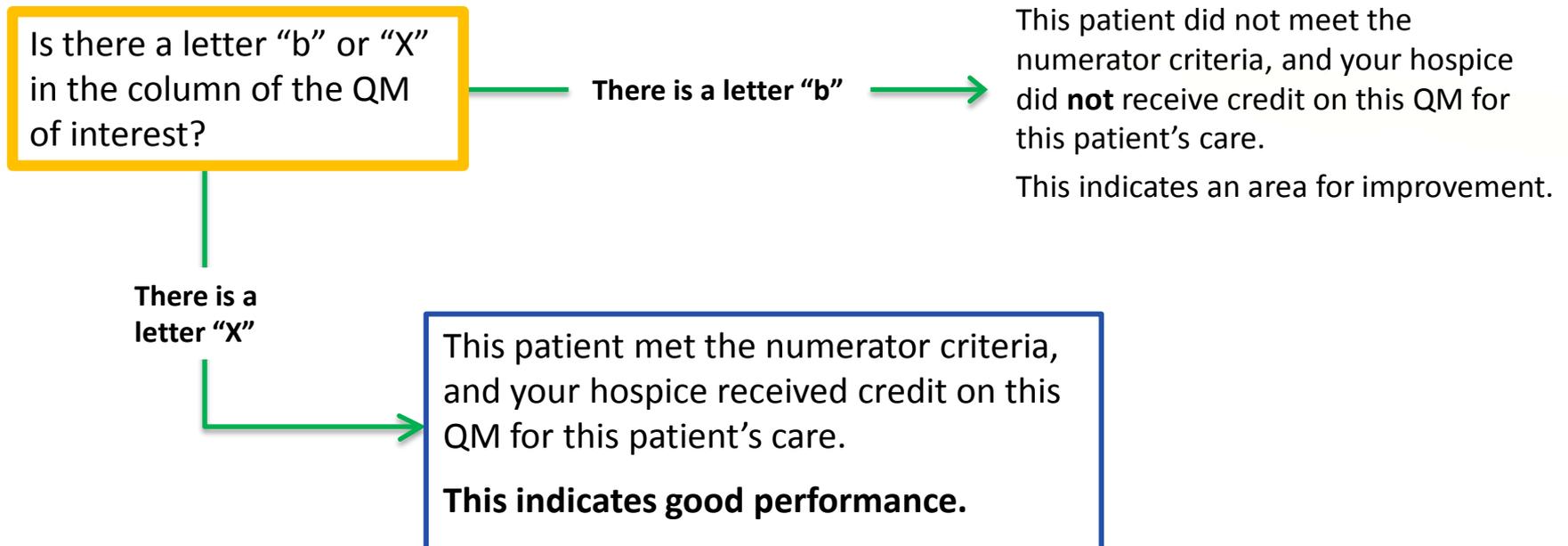
REPORT TIMEFRAME: 01/01/18 – 06/30/18

Patient Name	Patient ID	Admission Date	Discharge Date	Treatment Preferences	Beliefs/Values	Pain Screening	Pain Assessment	Dyspnea Screening	Dyspnea Treatment	Bowel Regimen	Hospice Comprehensive Assessment	Quality Measure Count
Doe, Carol	234567	10/25/2014	11/04/2014	X	b	X	e	b	b	X	d	3

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

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

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



## Patient Stay-Level Report Overall Takeaways

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

## Check your QM Reports early and often

- Both QM reports can serve as a “canary in the mine”
- Hospice-level QM reports can identify areas for improvement early, prior to when data are frozen for the Preview Reports and reporting on Compare
- Patient stay-level reports can help identify missing HIS records and help you drill down to see why your facility-level score is the way it is (which patients you “missed” the numerator for)

# **Additional resources**

## Resources

CMS HQRP [Current Measures](#) webpage

Contains the most up-to-date HQRP QM User's Manual (in the "Downloads" section), as well as information on each of HQRP (including HIS) quality measures

CMS HQRP [Hospice Item Set \(HIS\)](#) webpage

Provides updates, announcements, and resources specific to the HIS, including the most up-to-date HIS Manual V2.00

QTSO.com [Hospice User Guides & Training](#)

Contains CASPER System User's Guide

[QM Reports Fact Sheet](#)

Provides information on the Hospice-level QM Report and the Patient stay-level QM Report, as well as sample processes for using the QM reports for quality improvement

CMS HQRP [Training and Education Library](#) webpage

Contains all materials and recordings of previous CMS HQRP trainings (including those referenced in this training), such as on:

- Hospice Item Set V2.00.0
- Data Submission and CASPER Reports
- Preview Reports

Training on HIS-based QMs and Associated HIS Items ([Youtube](#))

This training explains the new Hospice Comprehensive Assessment measure and the Visits measure, as well as related items added to the HIS-Admission and Discharge V2.00.0.

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

## Reminder: Preview Reports

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

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



# Question and Answer Session

## Additional Questions?

### General HQRP or HIS-specific Inquiries

Hospice Quality Help Desk: [HospiceQualityQuestions@cms.hhs.gov](mailto:HospiceQualityQuestions@cms.hhs.gov)

### CAHPS®-specific Inquiries

Email: [hospicecahpssurvey@HCQIS.org](mailto:hospicecahpssurvey@HCQIS.org)

Telephone: 1-844-472-4621

### For Technical Assistance (QTSO, QIES, HART, or CASPER)

QTSO Help Desk:

Email: [help@qtso.com](mailto:help@qtso.com)

Phone: 1-877-201-4721 (M-F, 7AM-7PM CT)