Centers for Medicare & Medicaid Services
Skilled Nursing Facility Quality Reporting Program: Assessment-Based Measure Confidential Feedback Report Webinar
December 6, 2017

Moderator: Hello. Welcome, everyone, and thank you for joining today's webinar on "Skilled Nursing Facility Quality Reporting Program Assessment Base Measures Confidential Feedback Report." Experts from the Centers for Medicare and Medicaid Services (CMS) will provide information on the confidential feedback reports for the assessment-based measures adopted for a Skilled Nursing Facility Quality Reporting Program. CMS will present information on the assessment-based IMPACT Act measures included in the reports and direct participants to measure specifications. The slides from today's presentation are posted on the SNF Quality Reporting Program Training website for viewing purposes. Now I will turn the call over to Amanda Barnes from the Division of Chronic and Post-Acute Care at CMS. Please go ahead.

Announcements and Introduction

Amanda Barnes: Thank you so much. My name is Amanda Barnes from the Division of Chronic and Post-Acute Care in the Center for Clinical Standards and Quality here at CMS, and I'd like to welcome you to this webinar on this Skilled Nursing Facility Quality Reporting Program Measures, also known as the confidential feedback reports for the assessment-based Measures. The report is not currently live, but we anticipate it coming out in the next couple of days, and this call will be going over, as the moderator said, that report, as well as the measures contained within that report, as well as additional resources, and we will have a question-and-answer session. The slides will be posted to, or are posted, excuse me, to the Skilled Nursing Facilities Training web page in the download section, and now I'm going to turn the call over to Michael Lepore. Michael?

Michael Lepore: Thank you, Amanda, and good afternoon, everyone. My name is Michael Lepore, and I'm from RTI International. RTI is an independent nonprofit institute and contractor for CMS, helping to support this work, and I'm presenting today's webinar, along with Roberta Constantine and several other colleagues from RTI, as well as the Division of Chronic and Post-Acute Care from CMS, and if we could just go back one slide, please? Thank you.

Presentation Purpose

And so here, on Slide 1, you'll see the purpose of today's webinar Amanda's already reviewed, and our goal is to provide information on the QM Reports, and these are also referred to as confidential feedback reports, and specifically on the assessment-based measures that were adopted by CMS for the Skilled Nursing Facility Quality Reporting Program, or the SNF QRP. Next slide, please.

SNF QRP QM Report Training – 9/28/17

So, we're currently coming on to Slide 2, and on September 28, 2017, CMS provided a webinar that covered the background for the Skilled Nursing Facility Quality Reporting Program, the IMPACT Act of 2014, and the QM Reports for the claims-based measures. The assessment-based measures that we are discussing today were required by the IMPACT Act, or the Improving Medicare Post-Acute Care Transformation Act of 2014. The IMPACT Act requires that CMS develop and implement quality measures from five quality-measure domains using standardized assessment data. The IMPACT Act also requires the development and reporting of resource use and other measures, in addition to the assessment-based measures that are included in the QM Reports, which we will review today, SNF QRP QM Reports include claims-based measures, as well, and those recovered in the September training. The slides, the audio recording, and the transcript from the training are available on the CMS website at the links provided on Slide 2. Go on to the next slide, please.

Agenda

And on Slide 3, you'll see the agenda for today's webinar. First, we'll provide a brief overview of the Skilled Nursing Facility Quality Reporting Program Quality Measure, or QM Reports. We will give a high-level overview of the MDS assessment-based measures in the QM Reports, and we will present the layout of those confidential feedback reports and provide additional resources and highlight key next steps. At the end of the call, we will have a question-and-answer period during which we will respond to questions about the confidential feedback reports, public reporting, and future reports. And the next slide, please.

SNF QRP QM Reports

On Slide 4, you see that the IMPACT Act requires the confidential feedback reports, which also are referred to as quality measure, or QM Reports, prior to the public reporting of the required SNF QRP measures. There are facility-level and resident-level QM Reports for the assessment-based measures, and, in contrast, for claims-based measures, there are only the facility-level QM Reports, which were reviewed in the September training mentioned earlier. When accessing the QM reports, providers are able to specify the reporting period and obtain aggregate performance for that current quarter, and that may be partial data, as well as the past three quarters, and the QM Reports are available on demand, and they are refreshed with new data monthly. Next slide, please.

Confidential Feedback Reports (i.e., QM Reports)

And as we get to Slide 5, you'll see that the facility and resident-level QM Reports are intended to help providers understand the measures and their performance for quality-improvement purposes. CMS released SNF's confidential feedback reports, or QM Reports, in two phases. First, in early October of 2017 of this year, the facility-level QM Reports, including the three claims-based measures, were made available, and then in early December, as Amanda mentioned, the facility level QM Reports, including all of the SNF QRP measures, both the claims-based and the assessment-based measures, and the resident-level QM Reports, including the three assessment-based measures, will all be made available in the next approximate week or so. Next slide, please.

Risk Adjustment in Confidential Feedback Reports (i.e., QM Reports)

We will next be on Slide 6, and some of the measures in the Skilled Nursing Facility Quality Reporting Program are risk-adjusted, including one of the assessment-based measures that we will review today. That's NQF Number 0678 with a focus on pressure ulcers, and for these risk-adjusted quality measures, facility-level QM Reports include both observed scores and risk-adjusted scores, and those scores may differ, and in contrast, the review in correct reports, which come out quarterly, those include only observed scores, not the risk-adjusted scores, so we wanted to highlight that difference between the reports. Next slide, please.

SNF QRP MDS 3.0 Assessment-based IMPACT Act Measures

We'll next be on Slide 7, and there are currently three MDS assessment-based IMPACT Act measures in the SNF QRP QM Reports. That's the percent of residents or patients with pressure ulcers that are new or worsened. It's a short-stay measure. That's NQF Number 0678. The application of the percent of long-term-care hospital patient with an admission and discharge functional assessment and a care plan that addresses function. That's NQF Number 2631. And then the application of the percentage of residents experiencing one or more falls with major injury, that's a long-stay measure, and that's NQF

Number 0674. And the word "application" in the title of these last two measures, that indicates that the measure is being applied in the Skilled Nursing Facility Quality Reporting Program, but also in another program, like the Long-Term Care Hospital Quality Reporting Program. And we will briefly review each of these three measures in the next three slides. Next slide, please.

Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678)

And on Slide 8, you see the percent of residents or patients with pressure ulcers that are new or worsened, that's short-stay measure NQF Number 0678, and that measure assesses the risk-adjusted percent of resident stays during which SNF residents developed pressure ulcers or the pressure ulcers worsened. The next slide.

Application of Percent of Long-Term Care Hospital (LTCH) Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function (NQF #2631)

On Slide 9, briefly review the application of the percent of long-term-care hospital patients with an admission and discharge functional assessment and a care plan that addresses function. That's NQF Number 2631. And this measure assesses the percent of resident stays during which an admission and discharge functional assessment were completed, and a care plan was developed that addresses function. And we'll go to the next slide, please.

Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674)

On Slide 10, just briefly review the application of the percent of residents experiencing one or more falls with major injury. That's long-stay measure NQF 0674. And this measure assesses the percent of resident stays during which residents experienced one or more falls with major injury. We can move on to the next slide, please.

Measure Adoption and Specifications

We're currently on Slide 11. All three of these assessment-based measures, which we just briefly reviewed, were adopted by CMS in the Fiscal Year 2016 SNF PPS Final Rule and measure specifications, which detail how each of these measures are calculated, are available at a link on the slides in the downloads section of CMS' SNF QRP web page. Go to the next slide, please.

Overview of Implementation Dates for Assessment-based Measures

We'll next be on Slide 12. All three of these assessment-based measures first appear in the December 2017 release of the SNF QRP QM Reports, those which are forthcoming in about the next week, and in these reports, the assessment-based measures are calculated based on assessment data from October 1, 2016 to September 30, 2017, and the SNF QRP assessment-based measures will first be publicly reported on the CMS website starting October 2018, so just under a year from now. Move on to the next slide, please.

FACILITY-LEVEL QM REPORTS

And on Slide 13, we're just going to shift into reviewing the facility-level QM Reports. So, these reports include the three assessment-based quality measures, which we just briefly reviewed, as well as the claims-based quality measures, which were reviewed in the training that was provided in September.

And the links to that presentation are included on this slide (webinar audio and transcript // webinar presentation). We can shift on to the next slides. Slide 14, please.

Facility-Level QM Report Header

And, on Slide 14, we provide an overview of what is included on the facility-level QM report header -- so the header page of these reports. The facility-level QM reports have a common header that includes the facility I.D., the CMS Certification Number, or CCN, the facility name, city, state of the facility, the report period, the date that the data was calculated on, the comparison group period, the report run date, and the report version number. We could go on to the next slide. The next slide will actually show an image of what this report header will look like.

So, we're currently on Slide 15, and this is a sample of what the header of the facility-level QM reports look like. Down the left side of the header are the facility I.D., the CMS Certification Number, or CCN, the facility name, and the city and state where the facility is located, with just sample information added for these images, and then down on the right side of the header are listed the report period, again, that's October 1, 2016 through September 30, 2017 is what will be visible on the first release of these reports, the date that the data was calculated on, the comparison-group period, the report run date, beneath that, and that would be when you access your report, and, finally, the report version number. We could go on to the next slide, please.

Facility-Level QM Report – page 1

And on Slide 16, we will review the information included, the sort of the content of the report. So, the first page of the facility-level QM report includes information on just one measure. That's the percent of residents or patients with pressure ulcers that are new or worsened. That's short-stay measure NQF 0678, and this page includes a table legend, the data source, which is the Minimum Data Set Version 3.0, the measure name, the CMS Measure I.D., the numerator for the measure, the denominator for the measure, the facility-observed percent, that is the observed percentage of residents who had a new or worsened pressure ulcer, and the comparison-group national average, and, finally, a disclaimer at the bottom, and on the next slide -- We could shift to the next slide. This next slide will show an image of what that page of the report looks like.

So, we'll be on Slide 17, which shows this example of what Page 1 of the facility-level QM Reports look like. It includes facility-level data on the percent of residents or patients with pressure ulcers that are new or worsened, and at the top left of the page is the table legend. The table legend defines "N.A." as "Not Available," and provides a note that dashes represent a value that cannot be computed. The data source, the Minimum Data Set Version 3.0, is listed on the next line, and then the table presents, from left to right, the measure name, the CMS Measure I.D., the numerator for the measure, the denominator for the measure, the facility-observed percent, the facility risk-adjusted percent, and the comparison-group national average. The facility-observed percent is calculated by dividing the numerator by the denominator and multiplying by 100, and the facility risk-adjusted percent is computed using a mathematical model that accounts for resident characteristics and the national rate. So, comparison-group national average shows the nationwide average of the measure within the comparison-group period for comparison purposes. Then, at the bottom of all report pages is the disclaimer, "This report may contain privacy-protected data and should not be released to the public, and any alteration to this report is strictly prohibited." Next slide, please.

Facility-Level QM Report – page 2

The next slide, Slide 18, will show what is included on the second page of the facility-level QM report, and the second page of the report includes information on two measures -- application and percent of long-term-care hospital patients with an admission and discharge functional assessment and a care plan that addresses function, NQF 2631, and then the falls measure, application of percent of residents experiencing one or more falls with major injury, NQF 0674. So, this page of the report includes a table legend, the data source, which is the Minimum Data Set Version 3.0, the measure name, the CMS Measure I.D., the numerator for the measure, the denominator for the measure, the facility percent, the comparison-group national average, and the disclaimer. We can go on to the next slide, please.

That's Slide 19, and this provides an image of what that second page of the facility-level QM report will look like. So, here's the example of what Page 2 of a facility-level QM report looks like. It includes the facility-level data on those two measures, the measure-application percent of long-term-care hospital patients who've had an admission and discharge functional assessment and a care plan that addresses function, and then the falls measure, as well, the application of percent of residents experiencing one or more falls with major injury. At the top left of the page is the table legend, which, like on page one, defines "N.A." as "Not Available," and provides a note regarding the use of dashes -- for example, a dash may display a facility percent in the denominator column were to equal zero -- the data source, the Minimum Data Set Version 3.0 is listed on the next slide, and then the table presents, from left to right, the measure name, the CMS Measure I.D., the numerator for the measure, the denominator for the measure, the facility percent, and then the comparison-group national average. The first row of the table presents this information for the measure NQF 2631, the function measure, and then the second row in the table presents this information for the falls measure, NQF 0674, then, at the bottom of the page, that same disclaimer. If we could go on to the next page, please, the next slide.

RESIDENT-LEVEL QM REPORTS

And this next slide, then, we will shift to the resident-level QM reports. As mentioned earlier, there will be both facility-level QM reports, which we just reviewed, and then the resident-level QM reports, which we will take a look at now. So, the resident-level QM reports include only the assessment-based quality measures, not claims-based quality measures. And the assessment-based measures that are included in the resident-level reports are the same three as those included in the facility-level QM reports -- briefly, the pressure ulcers, functions, and falls measures -- and we would like to note that the resident-level reports can be very long, because they include information on all of the residents in the selected report period, and we'd encourage that to be taken into account before printing these reports. We could shift on to the next slide, please.

Resident-level QM Report Header

And on Slide 21, we list what is included in the resident-level QM reports in the header of these reports. So, these all include a common header, and it includes the facility I.D., the CCN, the facility name and city and state, the report period and report run date, the report version number, as well. And we go on to the next slide, where you'll see an image of what the header of the resident-level QM report looks like, and that will be Slide 22.

So, on Slide 22, this is a sample of what the header of the resident-level QM Rreport looks like. Down the left side of the header are listed the facility I.D., the CMS Certification Number, or CCN, the facility

name and the city, state where the facility is located, and then down the right side of the header are listed the report period, the report run date, and the report version number. Between the resident-level QM report and the facility-level QM report headers, they're very similar, but there are some differences, so we wanted to be sure to walk through both of them with you. For the SNF QRP QM reports being released this month, or about the next week, only one report period, we expect, will be available, and it's October 1, 2016 through September 30, 2017. That's shown on the slide. And for the assessment-based measures, as each quarter advances, the assessment data from the most recent quarter will be added to the QM reports, and then in contrast to those assessment-based data, which are updated quarterly, the claims-based measures are updated annually, not quarterly. So, those would not change from quarter to quarter. We could shift on to the next slide, and that will be Slide 23, and we will review the content of the resident-level QM reports.

Resident-level QM Report Content

So, on Slide 23, you could see the resident-level QM reports include a status legend, and this legend includes an "X" for "Triggered," meaning that the individual resident is counted in the numerator of the measure, "N.T." for "Not Triggered," meaning that the individual resident is not counted in the numerator, "E" for "Excluded from Analysis Based on Exclusion Criteria in the Measure Specifications," and "N.A." for "Not Available." Next is a description of the measures included on the report page, so, which is either, desirable outcomes or processes performed, or undesirable outcomes and processes not performed. So, there will be two different pages, one for each of those measures, and then the data source is listed, which is the MDS for all of the quality measures in the resident-level Quality Measure Reports, and then there's a table with the resident name, the resident I.D., the admission date, the discharge date, and then the status for the selected report period, and those statuses align with the items in the status legend, which is shown above. We go on to the next slide, please. That will be Slide 24, which shows an example of one of the pages of the resident-level QM report.

Resident-level QM Report - Desirable Outcomes/Processes Performed

So, here on Slide 24, this is an example of what a desirable outcomes processes performed page of the resident-level QM report looks like. It includes resident-level data on the application of the percent long-term-care hospital patients with an admission and discharge functional assessment and a care plan that addresses function, NQF 2631, the function measure. At the top left of the page, is the status legend, which includes the "X" for "Triggered," the "N.T." for "Not Triggered," and that is bolded for this page, the "E" as "Excluded from Analysis Based on Quality-Measure Exclusion Criteria," and then "N.A." is "Not Available," and we'll explain the reason for the bolding of the "Not Triggered" shortly. The type of quality measure, desirable outcomes, processes performed is listed next, and you can see that centered and underlined, and then the data source, the Minimum Data Set Version 3.0, is centered on the next line and in italics. Then the table presents, from left to right, the resident name, the resident I.D., admission date and discharge date for that resident, and then the status for the measure. For this measure, the function measure, "Triggered" is the Desirable status. "N.T.," "Not Triggered," is bolded in the table to facilitate easy identification by providers of the residents who are not included in the numerator for this Desirable process measure. Then at the bottom of the page is that same disclaimer. We go on to the next slide, please. That's Slide 25, and we'll review the next set of pages of the resident-level QM report would look like.

Resident-level QM Report - Desirable Outcomes/Processes Not Performed

So, here on Slide 25 shows an example of what an undesirable outcomes or processes not performed page of the resident-level QM reports look like. So, it includes resident-level data on two measures. That is the pressure ulcer measure and the falls measure, both undesirable outcomes. At the top left of the page is the status legend, and this legend defines "X" as "Triggered," and on these pages, the "X" is bolded, whereas "N.T.," still meaning "Not Triggered," is not bolded on the undesirable pages. "E" is "Excluded from Analysis," again, based on the quality-measure exclusion criteria and the measure specifications, and "N.A.," as "Not Available," as with the prior pages. The type of quality measure, undesirable outcomes, processes not performed is listed next -- again, centered and underlined, and then the data source, the Minimum Data Set Version 3.0, is centered on the next line in italics. Then, below that, the table presents from left to right the resident name, resident I.D., admission date, discharge date, and status for each of these measures, and for each of these measures, "Not Triggered" is desirable, "X" for "Triggered," is bolded in the table to facilitate easy identification by providers of the residents who are included in the numerator of these undesirable outcome measures. In other words, those who have had either a fall with major injury or a pressure ulcer that is new or worsened, and as with the other pages, at the bottom of this page is the disclaimer. We can go on to the next slide, please.

Accessing QM reports

Starting on Slide 26, we will review how to access the QM reports -- again, these confidential feedback reports. The QM reports are accessible to providers on-demand. Providers are able to specify the reporting period and obtain aggregate performance for the current quarter, though the current quarter data may be partial if the quarter has not been completed yet, and then for the past three quarters, as well, and the reports are refreshed monthly. And starting on the next slide, we'll show how to access the reports. Go on to the next slide, please.

And on Slide 27, you can access the QM reports. Providers must enter the key system and select "CASPER Reporting," and then the CASPER Reporting appears toward the bottom left of the screen and is demarcated with a red box on this slide, and we could shift on to the next slide, please.

After selecting the "CASPER Reporting," on Slide 28, you'll see the next page that you would reach. So, after selecting "CASPER Reporting," the QIES login page opens. So, to access the reports, you would enter your user I.D. and password, and then press the login button, and we'll go to the next slide, please, and show what appears at that point in the system.

So there, next on Slide 29, the slide shows the screen that appears after logging in, and at the top of the page, there are several buttons, including one for reports. So, to access the QM reports, you'd select the "Reports" button, and we could go to the next slide, which shows what will show after selecting that "Reports" button, and that will be on Slide 30.

And, so, on Slide 30, this shows the screen that appears after selecting "Reports." At the left side of the screen is a list of different report categories. To access the Skilled Nursing Facility Quality Reporting Program Reports, select "SNF Quality Reporting Program." After selecting "SNF Quality Reporting Program," the available SNF QRP reports are listed on the right side of the screen, as shown on this slide. And what shows on the slide are the types of reports that are available to SNFs. This includes the

SNF Facility-Level Quality Measure Report, and the SNF Resident-Level Quality Measure Report -- we just reviewed those two -- as well as the SNF Review and Correct Report, which have been reviewed in previous training, and those also are quarterly reports. You would select the report that you would like to review on this page, and would you go to the next slide, please? And on Slide 31, you'll see what shows after selecting one of these reports.

So here on Slide 31, this shows the page that appears after selecting, the top image shows what appears after selecting the SNF Facility-Level Quality Measure Report on the top, and then on the bottom, it shows what appears after selecting the SNF Resident-Level Quality Measure Report. For either of these reports, providers can choose the begin date and end date, and then the examples on the slide, the selected begin date is January 1, 2017, and the selected end date is December 31, 2017. These are just examples. And, then at the bottom of the page, you would select the template folder and template name for the report, and then select one of the buttons on the bottom right of the screen -- submit, save and submit, back, or save. And we can go to the next slide, please.

The next slide will be Slide 32, and on Slide 32, you'll see we're showing an example of the provider's inbox with the resident and facility-level QM reports demarcated in the red box, and this page shows all of the reports that are available for the provider to view, and it lists the date and time that each report was requested. The number of pages of the available report is listed at the center bottom of the page, so there may be multiple pages of reports available, and then command buttons at the bottom right of the page include select all -- selecting all of the reports -- printing, and, again, just take caution with printing the resident-level reports, as they may be very long -- to zip the files, to merge PDFs, to move and delete. So, those are the various buttons there at the bottom right, and that would be how to access the QM reports. And we could shift on to the next slide, please.

Additional Resources

We'll just take a look at some additional resources that are available, and this will be on Slide 33. So, if you have any questions about your QM report, there is a help desk available. You'd be encouraged to please submit your questions to the help desk e-mail, which is snfqualityquestions@cms.hhs.gov, and this help desk assists with various SNF questions, including the SNF QRP quality measures, SNF QRP requirements, and general QRP and reporting deadlines. You can go on to the next slide, please.

And on Slide 34, some additional resources are listed. On Slide 34, these additional resources include the SNF QRP technical specifications for reporting assessment-based measures for FY 2018, Fiscal Year 2018. This includes item values that may count against the A.P.U., or the Annual Payment Update, and there is a link available there, and also another valuable resource is the SNF QRP User's Manual, which provides detailed information on how each of the SNF QRP measures are calculated. And links to both of these items are available. You can go on to the next slide. And we are just going to briefly review some next steps before we transition over to a Q&A period.

Next Steps

And, so, on Slide 35, we just briefly review some next steps in which SNFs, for one, can access their confidential feedback reports, including the facility and resident-level QM reports, and those full reports are expected to be made available in approximately the, within the next week. Providers are encouraged to review the measure specifications to better understand the measure calculations.

You're encouraged to e-mail the help desk with any important questions that need to be addressed, and, of course, always provide CMS with any feedback you have, and as a reminder, these measures will ultimately be publicly reported starting in October 2018, so just under a year away. We could shift on to the next slide, please. And I'd like to thank you all for your attention, and we could open it up for some questions.

Question and Answer

Moderator: We are now going to the Q&A portion of the webinar. You can ask questions via chat or phone. To ask a question via phone, please dial 1-866-452-7887. Again, that's 1-866-452-7887. If prompted, please give Conference I.D. 4096598, then press Star 1 to ask your question.

Moderator 2: Great. Thanks. While we wait for folks to dial in, we have had some chat questions come through, so we will read some of those aloud for the subject-matter experts to answer.

Moderator 3: Our first question is, "What is the patient with the admission and discharge functional assessment and care plan that addresses function -- Section GG?"

Roberta Constantine: Thank you. My name is Roberta Constantine, and I'm a Senior Policy Analyst with RTI, and I work with Michael on the SNF public reporting side. So, in regards to that question, the answer is, you are correct, it is Section GG, which is the functional abilities and goals section.

Moderator 3: Great. Our next question is, "Is QRP only for SNF Medicare residents, or to any payer?"

Roberta Constantine: Thank you again. That's a great question, and the answer is, it applies to Medicare Part A patients only.

Moderator 3: Our next question is, "Is there dissemination between the type of facilities and the groups they are compared to on the national average? For example, those that handle orthopedic cases will have a different average outcome than those who take more complex cases."

Roberta Constantine: Oh. Thank you. That's a great question. In regards to the calculation of the national average, that is calculated including all the skilled nursing facilities in the Quality Reporting Program that submit the data. So, again, it's the national average, so it's not specific to any type of facility -- like, for example, one that would handle orthopedic cases or one that's more tailored to complex medical cases. Thank you. That's a great question.

Moderator 3: Our next question is, "On Slide 25, for the falls and pressure ulcer measure, does 'Not Triggered' mean the patient doesn't have any data or that they did not fall and did not have a pressure ulcer? In other CMS reports, 'N.T.,' or 'Not Triggered,' typically means that the patient is not in the numerator. For falls and pressure ulcers, this would be desirable instead of undesirable. Can you please clarify Slide 25?"

Roberta Constantine: Certainly. Is it possible to go back to Slide 25 so we could view it?

Moderator 2: Deirdre, are you there?

Moderator: Yes, I just pushed it up there.

Roberta Constantine: Okay. Let me just give it a minute to appear. And I'm sorry. I cannot see it at the moment.

Moderator 3: Deirdre, could you please go back to Slide 25?

Moderator: Yes, going back there right now.

There you go. Sorry about the delay.

Roberta Constantine: Okay.

Moderator 3: Deirdre, I'm sorry. I think we're on Slide 23 right now. If you could go to 25, please?

Roberta Constantine: Thank you. Okay. And, actually, it might be easier, actually, to back up a little bit. So, maybe, actually, Slide 20?... Yep, back to that. Yep, that's great. So, thank you.

In regards to whether the measure is triggered or not triggered, so, if you take a look at, first what we see is the falls with major injury measure. So, if you go down, and on the first row, you see the resident's name, I.D., the admission and discharge date, and then -- Sorry, could you go?... Go back one to the falls measure and the pressure-ulcer measure? I believe it's one more slide back. Slide 20... 24. Yeah. That's 24? Nope. It's the one that shows -- I have it down here listed as... the undesirable outcomes or processes before performed...

Michael Lepore: The next slide, please.

Roberta Constantine: Yeah.

Okay. All right.

Moderator 2: Why don't you go ahead and --

Roberta Constantine: Oh, hi. So, I think we've got the slide up now. So, thank you very much and thank you for your patience. So, if you take a look at the slide, on your resident's name, you see the resident I.D., the admission and the discharge, and then for the application of percent of residents with falls with major injury, you see "Not Triggered." So, by that, that means that the patient's stay was included in the denominator for this quality measure, but, the patient did not have any falls with major injury, so that particular patient's stay did not trigger the quality measure. So, hopefully that answered the question. So, it's not included in the numerator, and it is a desirable outcome in that the patient's stay did not trigger the measure.

Okay. Next question?

Moderator 3: Great. Stephanie, do we have any questions on the phone?

Moderator 2: No audio questions at this time.

Moderator 3: Okay, we can go back to the chat questions. So, our next question is, "What does it mean if SNF observed rate is 0% on pressure ulcer?"

Roberta Constantine: So, I'm sorry. Could you repeat that again?

Moderator 3: Sure. The question is, "What does it mean if SNF observed rate is 0% on pressure ulcer?"

Roberta Constantine: Okay. If the observed rate is 0%, that means for the facility, there's been zero new or worsened pressure ulcers that are reported for the measure.

Moderator 3: Our next question is, "On risk-adjusted reports, is the national average the national observed average or the national risk-adjusted average?"

Roberta Constantine: Mm-hmm. Okay, thank you. Another great question. The national average is the risk-adjusted average, and that allows for comparison facility to the national average rate.

Moderator 3: Great. Thank you, Roberta. And as a reminder, to ask your question over the phone, please dial 1-866-452-7887. Again, that number is 1-866-452-7887.

Moderator 2: There are still no audio questions.

Moderator 3: Our next question is, "What is the look-back period for these indicators?"

Roberta Constantine: When you say -- So, thank you. In regards to the look-back period, you're probably referring to on the patient's stay level.

Moderator 2: That was the extent of the chat questions, so if that's not clear, we can try another one, and the person who submitted that chat question, if you want to try again, we will clarify. So, next question, "Can you briefly differentiate the observed rate versus the risk-adjusted rate?"

Roberta Constantine: Certainly. So, with the observed rate, that is the rate that -- It does not include the risk adjustment in regards to the observed rate. So, for example, with the Review and Correct Report, you have an observed rate.

Moderator 2: Okay, next question, "How is the fall data collected? Is it per 1,000 resident days?"

Roberta Constantine: Hi. Could you repeat that question?

Moderator 2: Sure. "How is the fall data collected? Is it per 1,000 resident days?"

Roberta Constantine: No. It's collected from the data-assessment data that's entered the QIES system, and it's not reported per 1,000 days or 1,000 stays. What you want to look at is the denominator. So, that is the number of patient stays that is included in the calculation of the measure, and one important note -- again, these are user on-demand reports, so if you're looking at the most recent quarter, it could be a partial data for that quarter. So, it's important to know that when you're accessing the data, it's refreshed monthly, and so that denominator could change, but, the calculation is based on the assessments that are submitted.

Moderator 2: Great. Do we have any phone questions at this time?

Moderator: No phone questions at this time.

Moderator 2: Okay. We can ask another chat question. "Can you clarify the timing between receiving the QM report and the period being reported? How much of a lag is there?"

Roberta Constantine: Thank you. That's a good question. It really depends on -- in regards to the lag period -- really depends on the time period that's selected. For example, when you receive the reports, and you see them for the first time, depending on when you select a period, and, again, the monthly update, really, so it can differ in regards to the lag period. And, additionally, one additional comment that I would make is, it also depends on the particular quality measure. For example, for the claims measures, those are updated only on an annual basis, and, obviously, there's a considerable lag period in regards to that, versus what are the assessment-based measures.

Moderator 2: Great. "What time of the month is the data refreshed?"

Roberta Constantine: Thank you for that question. I would defer if there is somebody from Telligen that might be able to specify when the monthly refresh occurs. If not, we can get back to you with that information.

Julie Ellingson: Hi, Roberta, this is Julie Ellingson from Telligen. Right now, the data will be recalculated monthly on the first day of the month.

Roberta Constantine: The first day of the month.

Julie Ellingson: Mm-hmm.

Roberta Constantine: Thank you very much, Julie.

Julie Ellingson: Sure.

Moderator 2: Okay, we just have five minutes left. Are there still no phone questions?

Moderator: No phone questions at this time.

Moderator 2: Okay, next question. "How do you determine the denominator?"

Roberta Constantine: Thank you. The denominator is determined by the number of assessments that are submitted into the QIES system at the time that the reports are calculated. So, for example, before the report is produced, if 50 assessments for that particular period are submitted in QIES, for that particular reporting period, during the selection process, that is what is included. So, that's why we would encourage providers to submit their reporting data as timely as possible, so they're able to see their results when they utilize this report.

Moderator 2: Great. I think we just have time for one more question. "What was the date that this information will go public again?"

Roberta Constantine: Okay. So, in regards to public reporting, in the future, next summer, there will be a provider preview report, and we'll give instruction, and also a presentation on that report, as well, and providers will be able to have a last look in regards to their results for the quality measures, and then in fall of 2018, the reports will be posted on the computer website.

Conclusion

Moderator 2: Okay, great. Thank you. I think we are about out of time, so thank you all for joining.

Moderator: Thank you. This concludes today's conference. You may now disconnect. Speakers, please hold the line.