PPS-Exempt Cancer Hospital Quality Reporting Program

Support Contractor

PCHQR Program: An Overview of Best Practices to Mitigate Chemotherapy-Related Adverse Events

Presentation Transcript

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Tom Ross: Good afternoon, my name is Tom Ross, and I am the Program Lead for the PPS-Exempt Cancer Hospital Quality Reporting, or PCHQR, Program. I work for the Hospital Inpatient Values, Incentives, and Quality Reporting, or VIQR, Outreach and Education Support Contractor. Today's event is entitled "PCHQR Program: An Overview of Best Practices to Mitigate Chemotherapy-Related Adverse Events." Let's take a closer look, which should be quite instructive in framing today's presentation, before we dive into the presentation materials themselves. The first thing I want to stress is the term "PCHQR Program" in the title. Today's educational presentation is offered by the Support Contractor supporting the PCHQR Quality Reporting Program on behalf of CMS. Therefore, the content of today's event, and any questions submitted and answered, should only be applied to those hospitals deemed as PPS-Exempt Cancer Hospitals, or PCHs. This is very important, as this measure has also been added to the Hospital Outpatient Quality Reporting Program or Hospital OQR Program. Participants in the Hospital OQR Program must refer to education materials provided by that Program's support contractor. Today's presentation will be looking primarily at the tools available to hospitals to mitigate adverse events related to the administration of chemotherapy, particularly in the outpatient setting. Therefore, the clinical content and resources may certainly be of interest to participants in other Quality Reporting Programs who administer outpatient chemotherapy; however, remember that the content, questions and answers associated with today's event are limited to those participating in the PPS-Exempt Cancer Hospital Quality Reporting Program. The second part of the title emphasizes the focus of today's webinar, "An Overview of Best Practices to Mitigate Chemotherapy-Related Adverse Events." This measure, which is derived from Medicare claims data, there is no additional data abstraction or submission work required on behalf of the PCHQR Program participants, was added to the Program in the Fiscal Year 2017 Inpatient Prospective Payment System/LTCH Final Rule and applies to Program Year or Fiscal Year 2019. On the next slide, slide number seven, we will take a look at the abbreviations and acronyms used in today's presentation.

This slide should look very familiar to the regular attendees of our events. We supply this tool to you to save real estate on our slides, to make them more readable, and to serve as a resource to you while conducting the business of the Program. You'll see a number of these are bolded. These are the abbreviations and acronyms being used today. I'm going to call out a few of these to allow the presentation to make more sense. The first one is A-S-C-O, or ASCO, which is the American Society of Clinical Oncology. Right below that, we see A-S-H, or ASH, the American Society of Hematology. Moving down the list a little bit, we see D-A-C-A, or DACA, for the Data Accuracy and Completeness Acknowledgement form that must be completed annually. We also see ED, for Emergency Department; IDSA, the Infectious Diseases Society of America; NQS, which is the CMS National Quality Strategy; ONS, the Oncology Nursing Society, who developed another abbreviation, the PEP, or Putting Evidence into Practice. And the last two abbreviations, on the lower right-hand side, RSAR and RSEDR are the abbreviations used for the measures we are focusing on today, RSAR, for Risk-Standardized Admission Rate, and RSEDR, for Risk-Standardized Emergency Department Visit Rate. The next slide shows the purpose of today's presentation.

The overall intent of the measure is to encourage hospitals who administer outpatient chemotherapy to attempt to decrease the occurrence and severity of adverse events associated with these treatments, and thereby decrease hospital admissions and emergency department visits in this patient population. The purpose of today's event is to briefly review the measure, including the adverse events most commonly associated with the admissions and ED visits. I will then share with you a review of some of the resources available to you in learning best practices and to potentially mitigate these events. The specific objectives, on slide 8, are as follows.

The first is to summarize the rationale for the inclusion of the Admissions and Emergency Department, or ED, visits for Patients Receiving Outpatient Chemotherapy measure in the PCHQR Program. This will look at the measure structure and evaluation process, then the adverse events associated with outpatient chemotherapy. After participating today,

you should also be able to list the top ten reasons associated with hospital admissions and ED visits for patients receiving outpatient chemotherapy. And lastly, you should be able to discuss, on a fairly high level, the risk mitigation strategies you can employ to lessen the occurrence of these events. Over the rest of this year, we will have more in-depth focused presentations on strategies to manage these events, and we will be asking you, the experts in cancer care, to help in developing and conducting these presentations using these webinars as a forum to share best practices. So, with our purpose and the objectives established, let's begin our overview of the measure, starting on our next slide, slide number nine.

As I stated earlier, this measure, "Admissions and ED Visits for Patients Receiving Outpatient Chemotherapy," was added to the PCHQR Program in last year's Final IPPS/LTCH Rule. This measure is for the Fiscal Year 2019 Program and subsequent years. The data for Fiscal Year 2019 will be obtained from Medicare claims data for those patients who received outpatient chemotherapy between the dates of July 1, 2016, through June 30, 2017, and then it will be derived from data from July 1 through June 30 for subsequent years. This is an outcome measure, with the overall goal of reducing the number of emergency department visits and hospital admissions following the patient receiving outpatient chemotherapy, and this is key, at a PCH. One of the reasons for the measure's inclusion in the PCHQR Program is that the use of outpatient-based chemotherapy has increased from 18% to 29% from 2008 to 2012, and is likely to continue. The aim of this measure is to assess the care provided to cancer patients and encourage quality improvement efforts that will ultimately decrease admissions and ED visits. In including this measure in the Program, two of the National Quality Strategy goals, one, Promoting Effective Communication and Coordination of Care; and, two, Promoting the Most Effective Prevention and Treatment Practices for the Leading Causes of Mortality, are being addressed. If you remember from last year's discussion, the final rule stated that each year about 22% of patients with cancer receive chemotherapy, and in 2011 chemotherapy treatments totaled $34.4 billion, or almost 10% of Medicare Fee for Service expenditures. Furthermore, a review of the literature shows that for these

patients receiving outpatient chemotherapy, there are several gaps in care, including a delayed onset of adverse events that the patient must manage at home; secondly, patients lack education and therefore assume nothing can be done and not seek appropriate assistance in that setting; and, lastly, limited access and communication with providers who may be able to assist them in managing their care. These unmet patient needs and associated resultant admissions and ED visits have a number of consequences, including the negative impact on patient's quality of life in terms of physical and emotional well-being, disruption of schedules in employment, lack of engagement in the activities of daily living, and negative sequelae to their families. There are also financial burdens. In fact, the average admission resulting from outpatient chemotherapy, on a cost basis, costs $22,000, and the average cost of an emergency department visit was $800. So, obviously, this measure has the potential to impact quality in many different ways. Let's take a look at slide 10 to review the basics of this new measure.

There are a few points from this slide that I want to emphasize. First, this is a risk-adjusted outcome measure for patients 18 years or older who receive outpatient chemotherapy at a PPS-Exempt Cancer Hospital. All types of cancer, except for leukemia, are included. Secondly, this is a claims-based measure. As I said before, the PCHs don't have to do any special submissions or analysis to report this, it will be reported on their behalf based upon the claims they file. The information is obtained from Medicare Fee for Service Part A, or hospital, and B, or physician billing, administrative claims data. There will be no additional data submission by the PCHs. Thirdly, one of the qualifying diagnoses or diagnosis, I always say that wrong, on the admission or ED visit claim must be the primary diagnosis. In other words, the primary diagnosis has to be an adverse event such as emesis, diarrhea, neutropenic fever, as a primary diagnosis, or a secondary diagnosis accompanied by a primary diagnosis of cancer. So, you could have a primary of, say, prostate cancer with a secondary of diarrhea, and qualify for this measure. Next slide, slide number 11, please.

Furthermore, the admission or ED visit must be within 30 days after the PCH outpatient chemotherapy treatment encounter. And, lastly, the outcomes for inpatient admission and emergency department visits are identified separately. Note, that if a patient has received outpatient chemotherapy experiences, both a hospital admission and an emergency department visit within the 30 days following the administration of the outpatient chemotherapy that, due to costs and clinical significance, the admission trumps the ED visit and only the admission counts in the calculation of the rates. So, in summary, the measure is looking at coding data to identify patients who receive chemotherapy at a PCH based upon ICD and CPT codes. Then, Medicare claims data is reviewed for these patients to see if they had an admission or ED visit within 30 days of the outpatient chemotherapy. Now remember, because this is based upon Medicare claims data, this includes admissions and ED visits to other hospitals and institutions, not just the PCH where the outpatient chemotherapy was administered. Then, for each admission or ED visit, the claim is analyzed to see if the qualifying diagnosis for the claim and adverse event associated with chemotherapy was the primary diagnosis, or was a secondary diagnosis accompanied by a primary diagnosis of cancer. There are some specific groups that were excluded from this measure, and we're going to look at these on slide number 12.

First of all, note that the measure does not include patients receiving only oral chemotherapy. The reason for this is that it's challenging to identify patients receiving oral chemotherapy without using pharmacy claims data, or Part D data. And, according to the CMS Technical Expert Panel for this measure, most oral chemotherapies have fewer adverse reactions that result in admissions. So, while it's not an exclusion criteria, it's not an inclusion criteria to receive outpatient oral chemotherapy. So, speaking of exclusion criteria, there are three specific exclusions. The first is a diagnosis of leukemia at any time during the measurement period. This is because of the high toxicity profile of many of the regimens used in treating leukemia, and due to the fact that many admissions or ED visits for leukemic patients may be indicative of a relapse or disease progression rather than poorly managed outpatient care. The second exclusion is those

patients who are not enrolled in Medicare Fee for Service Parts A and B in the year prior to the first outpatient chemotherapy encounter. This is because the data from the Medicare Part A and B is used in the risk adjustment when we do the predicted rates, which we'll talk about later. So, simply stated, the claims data will not be necessary – contain the necessary information for risk adjustment. And the third exclusion is for those patients who do not have at least one outpatient chemotherapy treatment encounter followed by 30 days of continuous enrolment in Medicare Fee for Service Parts A and B after the encounter. So, they're looking for the adverse event within 30 days of the administration of chemotherapy. If they're not enrolled in Medicare Part A or B, then you don't know if they had an admission or ED visit. So, once again, the data simply does not exist. Also note that patients enrolled in clinical trials are not excluded because there are many challenges associated with systematically identifying these patients and collecting information on applicable clinical trials. CMS and the contractor cannot identify these patients using claims data and many patients participate in clinical trials. Lastly, note that the measure does not exclude patients receiving palliative care, because published literature shows that all patients receiving outpatient chemotherapy regardless of the reason for chemotherapy, be it palliative or curative, may experience a gap in care that leads to acute, potentially preventable hospitalization. Improving patient's quality of life by keeping patients out of the hospital is a main goal of cancer care, especially at the end of life. On slide number 13 we will look at how these results will be measured and presented.

Our technical writer was laughing at me because I was so proud of the parens that I made on this slide. So just note, that it's a beautiful slide. The numerator, the predicted number of outcomes, is the risk adjusted actual patients with the measured adverse outcome, an admission, or ED visit. The denominator is the number of patients with the measured adverse outcome the PCHs expect that they have based upon the national performance with that particular case mix. So we're looking much like a standardized infection ratio measure with the HAIs. If the predicted is greater than the expected, the ratio will be greater than one, and the risk

standardized rate will be higher than the national observed rate. If the predicted is less than the expected, this ratio will be less than one, and the risk standardized rate will be lower than the national observed rate. The national observed rate for the PCHQR Program is that obtained from combining the data from all of the PCHs over the measurement period. So this is a PCH-specific national observed rate. Each PCH, as I mentioned earlier, will have two rates reported: a Risk Standardized Admission Rate, or RSAR, and a Risk Standardized ED Rate, or RSEDR. Remember, if a patient experiences both an admission and an ED visit after outpatient chemotherapy, the result will be attributed to the admission or RSAR rate. Slide number 14, please.

CMS is planning to publicly report the RSAR and RSEDR for this measure for all participating PCHs who have 25 or more eligible patients per measurement period, or year. So you would think that all PCHs would have at least 25 patients who received outpatient chemotherapy within a year period. The starting date for the public reporting of this data has not yet been specified in Rule by CMS, and CMS states in the Final Rule that they will notify participants when public reporting will first occur. To prepare the PCHs for understanding this measure, and to prepare them for the future public reporting, a dry run of confidential national reporting of the measure's results will be conducted prior to public reporting. We will discuss the initial plans for this dry run on the next slide, but first let's review the purpose of the dry run. The first purpose is to educate PCHs and other stakeholders about the measure. The second is to allow PCHs to review their individual results and data prior to public reporting. To this end, as occurs with claim-based measures in other CMS programs, each PCH will receive a confidential report, probably called a Facility or Hospital-Specific Report, so you may hear the term FSR or HSR, containing their data. This not only will contain the measure calculations and results, but will also contain patient-level data that will allow the PCHs to analyze their data. Due to the report containing this patient-level data, it is distributed via the secure file transfer functionality of *QualityNet*. At this time, it is anticipated that this report will be received by the Security Administrators of the PCHs. Therefore, it is vital that you

keep this role current. The dry run will also allow the PCHs, upon seeing their reports, to ask questions of the measure developer, and have questions about the measure, measure specifications and methodology addressed. And, lastly, based upon the analysis performed by the measure developer and the feedback received from the PCHs, there may be technical changes to the measure identified during the process. I cannot emphasize strongly enough the need for you to closely monitor the upcoming information and the results of the dry run over the next few months. So, speaking of measure specifications, let's take a look at slide 15 next.

The measure developers for CMS for this project are Mathematica Policy Research under subcontract to Yale New Haven Health Services Corporation/Center for Outcomes Research and Evaluation. The Measure Technical Report, "Admissions and Emergency Department Visits for Patients Receiving Outpatient Chemotherapy, Measure Technical Report" is available on the link provided on this slide. The link takes you to the CMS.gov Measure Methodology page. There you will find the link for this measure. Clicking on the link will open a zip file. In the zip file, you will find the PDF document I just mentioned, as well as an Excel spreadsheet. The Excel spreadsheet, for those who wish to get into the specifics of the measure, contains in the neighborhood of 25 tabs of data, including, first of all, numerator details, ICD codes for the ten numerator criteria, which are the adverse events associated with admissions and ED visits. Secondly, denominator detail for inclusion, which are the cancer diagnosis and chemotherapy codes, and the exclusion codes for leukemia. And then the risk model specifications and variable definitions for the various disease states or cancer types. Our next slide, slide 16, will provide a lot of upcoming information that I know many of the PCHs have been thinking and asking about, information about upcoming events related to the dry run that we discussed.

So here you see a general outline of the events that will be taking place later this summer and early fall. As specific dates and timeframes are finalized, we will be communicating this data via our webinars and

ListServes. The dry run we spoke of earlier will be conducted in the late summer to early fall of 2017. The plan is to do this on chemotherapy administered from October 1, 2015, to September 30, 2016. This will allow the dry run to evaluate the measure entirely on ICD-10 data. After the data has run, the reports, the FSRs or HSRs, containing each PCH's performance rates and patient-level data, will be distributed via *QualityNet's* secure portal. During this same timeframe the measure development team will also be hosting a national provider call. This is a chance for you to ask specifics pertaining to the measure, data collection, calculations, risk adjustment, and any other specifics you do have. Then once the reports are distributed, there will be an opportunity for you to submit questions regarding your measure mix and data. Lastly, I want to emphasize that, at this time, the timeframe for both the performance period and the posting of information for public reporting has not yet been determined. So with this information in mind, and as we prepare to look at some of the resources available to the PCHs to potentially mitigate these events, let's take a look at the anticipated outcome of this impact of this measure, why is it included in the PCHQR Program.

Here, on slide 17, I want to begin by restating what CMS put in the final rule, quote, "While the goal is not to reach zero admissions and ED visits, the promise is that reporting this information will promote an improvement in patient care over time for two reasons. First, transparency in public reporting this measure will raise hospital and patient awareness of unplanned hospital visits following chemotherapy. Second, this reporting will incentivize hospital outpatient departments to incorporate quality improving activities into their chemotherapy care planning in order to improve care coordination and reduce the number of events." Specifically, in terms of quality of life, it is anticipated this measure will foster physical and emotional well-being, ease disruption of schedules, allow more engagement of work and social activities, and decrease the burden placed upon the family and caregivers of those patients receiving outpatient chemotherapy. The second set of bulleted items illustrates the fact that the use of outpatient chemotherapy is very prevalent and its use is increasing. Furthermore, there are significant fiscal implications, noting

that Medicare payments for cancer care was almost 10% of Fee for Service in 2010 or $34.4 billion. And, lastly, as mentioned before, the average cost of a chemotherapy-related admission is $22,000, while that for an emergency room visit is $800. So with a review of the basics of this measure and the anticipated impact being established, let's begin to look at the potentially preventable adverse events associated with outpatient chemotherapy that can lead to admissions and ED visits. As an introduction, I want to share a story from my pharmacy performance improvement days. There was an investigational drug, at the time it was investigational, it certainly dates me, called CPT-11 or camptothecin 11, you know it now as irinotecan, that was just approved for FDA use. It had two types of diarrhea associated with it. There was an acute phase during administration, which we could control in the infusion center, and a delayed onset. And, early in its use through our adverse drug events reporting program, we found that we were having a lot of admissions due to diarrhea, late phase, with irinotecan. However, we found that aggressive use of over-the-counter anti-diarrheals could prevent the diarrhea associated with admissions with this drug. By implementing an inexpensive intervention, an OTC medication, and educating patients, we were able to decrease preventable admissions. This is good for the patients and hospitals. This is the type of improvement this measure is striving to drive. So here we see the ten adverse events associated with admissions or emergency department visits within 30 days after the administration of chemotherapy that qualify a patient for inclusion in the numerator of this measure. They are: anemia, dehydration, diarrhea, emesis, fever, nausea, neutropenia, pain, pneumonia and sepsis. These were cited in the Fiscal Year 2017 Final Rule as the adverse events most commonly associated with admissions and emergency departments after outpatient chemotherapy. Keep in mind that the goal of this measure is not to reach zero admissions or ED visits, but rather to increase awareness and to drive quality improvement efforts to reduce the occurrence of these events. The Fiscal Year 2017 Final Rule cites that treatment plans and guidelines exist to support the management of these conditions, and they cite the resources listed on our next slide, slide number 19.

So here we really move into the second big part of the presentation, what evidence-based interventions are available. And we're going to take a look at (in-depth) the four that are listed here on this slide, those from ASCO, NCCN, ONS and the Infectious Diseases Society of America. And then we'll take a look at a few other sources that you might want to look at. So, slide number 20, please.

The American Society of Clinical Oncology, or more commonly known as ASCO. The link at the top of this page will take you to a guidelines tools and resources page of ASCO. Their website states, "ASCO develops and publishes clinical practice guidelines, provisional clinical opinions, or PCOs, and clinical [guideline] endorsements, providing evidenced-based recommendations to serve as a guide for doctors and outline appropriate methods of treatment and care. The guidelines can also address clinical situations, disease-oriented, or use of approved medical products, procedures or tests, modality-oriented. Multi-disciplinary panels of experts, including patient advocates, develop ASCO's clinical practice guidelines." On this page you will find multiple sources of information, including the guidelines by clinical area. Within this section there are multiple links, including those pertaining to assays and predictive markers, disease specific guidelines for individual cancers such as GU or GYN cancer, and guidelines for patient and survivor care. For the purpose of today's event, the most informative link is that to "Support Care and Treatment Related Issues." Clicking on this link will take you to a page contained in the guidelines displayed on slide number 21.

When we take a look at these guidelines, you will see that many of the adverse events associated with this measure are included: emesis, neutropenia, infectious processes and anemia, to guidelines such as the ASCO-ASH Update on the Use of Epoetin and Darbepoetin. Clicking on any of these links will unearth a treasure trove of tools. There are references, full-text and PDF versions of the guidelines, slide decks, algorithms, and other tools such as flow sheets, different tools and even patient information. This is a very valuable set of resources that

encourage you and your quality improvement teams to spend some time accessing. Slide 22, please.

This is for the National Comprehensive Cancer Network, or, more familiarly, known as NCCN. The link on the top of this slide will take you to a page that many of you are familiar with. In fact, many of the PCHs are members, and even founding members, of the National Comprehensive Cancer Network. As the slide states, the NCCN is a not-for-profit alliance of 27 leading cancer centers devoted to patient care, research and education. Their site contains many links, those most pertinent to today's presentation being on the tab called "NCCN Guidelines." You will find guidelines for treatment by disease type, prevention and screening, guidelines for patients, and guidelines for providers among others. As we are on the top, mitigating adverse events, the most utile link will be to the "NCCN Guidelines for Supportive Care," for which a hyperlink is provided on this slide. Clicking on this link will take you to the NCCN Guidelines page. Scrolling down a bit will take you to the section on Supportive Care. The available topics are listed on slide 23.

Here you will find guidelines in a PDF format on many topics related to adverse events associated with this measure, including pain, emesis, anemia, prevention of infection, and the use of growth factors to mitigate neutropenia. When you click on the link to the PDF document, you will find that you must create an account with the NCCN to access the document. Once you do so, and log in, you will see the guideline. It starts here with the panel members, and you will see great representation from the PCH is here. Next, you will see a table of contents where you can hyperlink to a specific portion of the guideline. If you proceed page-wise through the guideline, you will see that it is laid out in a stepwise progression. There will be further diagnostics, treatments, monitoring, and links to further guidelines. This is really a great resource to spend time in to understand the clinical decision-making process that one should follow to optimize the care of patients who is or may undergo one of these

adverse events. The next resource we will look at, on slide 24, are the tools available from the Oncology Nursing Society, or ONS.

As with the prior slides, the top link here will take you to the homepage for the Oncology Nursing Society. The ONS is a professional association of more than 39,000 members committed to excellence in oncology nursing. Their website has many resources available. Those most applicable to today's presentation are under the "Practice Resources" tab on the homepage, and are found on the "Putting Evidence into Practice," or PEP, section, which is hyperlinked on the slide. Slide 25, please.

Their website states that "ONS PEP resources are designed to promote evidence-based interventions for patient care and teaching. PEP topic teams of nurse scientists, advanced practice nurses and staff nurses summarize and synthesize the available evidence in PEP topic areas. These resources can be used to plan individual care, patient education, nursing education, quality improvement and research." There is a wide variety of topics covered. Pertinent to the outpatient chemotherapy measure, topics addressed include: chemotherapy-induced nausea and vomiting for both adult and pediatric populations; diarrhea, both chemotherapy and immunotherapy induced; mucositis, and while this is not specifically one of the ten adverse events evaluated in this measure, it's often a significant source of pain, so I thought it was worth mentioning. And speaking of pain, there are sections on acute pain, breakthrough pain, chronic pain, and refractory or intractable pain. And, lastly, prevention of infection, both general and specific, for the transplant population. On our next slide, slide number 26, we will look at the last organization specifically cited in the Final Rule, the Infectious Diseases Society of America.

On the top of this slide you see the purpose statement of the IDSA. Note that unlike the first three organizations we addressed, the IDSA is not specific to oncology, but infectious diseases in general. That being said, there are a number of IDSA practice guidelines that will be beneficial to those providing care to cancer patients. To access these, you go to the "Guidelines/Patient Care" tab on the homepage, and click on the IDSA

Practice Guidelines link. Keep in mind that the IDSA is not oncology specific. You will see more general headings here, such as antimicrobial agent use, infections by organ, infections by organism, and other guidelines. However, within these there are some very applicable guidelines to the outpatient chemotherapy measure. Under the Antimicrobial Agent Use tab, you will find an excellent guideline for neutropenic patients with cancer and outpatient parenteral anti-infective therapy. Most of the cancer-specific resources are found under the "Other Guidelines" tab. Here you will find the guidelines on catheter-related infections, opportunistic infections in stem cell transplant recipients, and vaccination of the immunocompromised host. And, lastly, while not specific to this measure, I thought that I would mention that under Infections by Organism, you will find guidelines impacting other PCHQR Program measures, including *C. difficle* and MRSA. And, of course, *Clostridium difficle* certainly can cause admissions and ED visits due to diarrhea. This concludes a review of the four organizations and the resources specifically called out in the Final Rule. But, certainly, there are other sources of information for your access in learning about these potentially preventable adverse events and in developing improvement strategies to mitigate their impact. We will briefly look at a few of these on slide 27.

At the top, is a website most of you are very familiar with, the CDC or Centers for Disease Control and Prevention. They have resources available on preventing infections in cancer patients, and scholarly articles related to infections in cancer patients. Many other organizations such as the American Pain Society and ASH, or the American Society of Hematology, also have pertinent information, as do other professional organizations, such as the Alliance of Dedicated Cancer Centers, and the Consortium of Comprehensive Cancer Centers for Quality Improvement. As you are looking at future meeting ideas, I know that often times this is the forum for sharing best practices, so you may want to consider these adverse events associated with outpatient chemotherapy as potential topics. And, of course, there are always primary literature searches and literature reviews that can be conducted. So, obviously, from looking at

the materials we've briefly covered today, there is much more substance and granularity that can be found on any and all of these topics. Slide number 27, please.

To that end, we are planning education on using a number of our upcoming PCHQR Program Outreach and Education events, our webinars, to delve more deeply into these topics. We are asking you, the experts in cancer care, to help us with this. As you look into these adverse events and find experts and best practices within your organizations, please reach out to us at the VIQR Support Contractor to nominate colleagues for future presentations. We would like to start this series of best practices starting with the July event. Slide number 29, please.

Well, we're at 44 minutes into the presentation, and that concludes my didactic portion of today's event. We'll continue today's presentation, as always, by reviewing important upcoming dates for the PCHQR Program, beginning on slide number 30.

So here are our important upcoming events which are upcoming webinars. On June 22nd, Lisa will be presenting on the Web-Based Data Collection Tool Version 2, the sequel. The use of our Web-Based Data Collection Tool Number 1 worked great. You all did fabulous, submitted all your data for the Cancer-Specific Treatment measures. This will build upon that webinar, and we're going to talk more about population and sampling and how that's documented and how you should be using it to use the tool to enter that data for the OCM, and our favorite EBRT, for the August 15th data submission. Then, on July 27th, as I mentioned, we're going to start a series of best practices, and so I'm looking for a volunteer to present on one of our adverse events we discussed today. On August 24th, we're going to be discussing the Fiscal Year 2018 Inpatient Prospective Payment System/Long-Term Care Hospital Final Rule, so Caitlin will join us for that presentation. Then, in September, we'll have a second best practice regarding today's event. And we'll probably have one or two more of those during October to December. But, as you know, there's always a couple of other topics that pop up in the meantime. So, that's the upcoming webinars, and, once again, they're all scheduled for the fourth

Thursday of the month until we get into the holiday season, where we move to the third Thursday in November and December. Next slide please, Deb.

The first Hospital Quarter Reporting Data Submissions, you can see that on July 5, 2017, your quarter one 2017 HCAHPS data is due. I know that all the PCHs use a vendor for submission of this data. And, according to our analytics, all have submitted at least some data. So your data submission requirements are met. But be sure you work with your vendor to be sure that you've completed all your quarter one data collection and submission for that, but everything is looking good for that. On August 15th, we have the close of our data submission period, which opens on July 1, 2017, of our biggest submission of the year. You'll have quarter four 2016 CST measures for the colon and breast measures; quarter two 2016 for the CST for hormone; and then you'll have your 2016, all four quarters for the five Oncology Care Measures and EBRT; and quarter one 2017 for the HAI Measures, of course, other than influenza, which was just submitted. And, speaking of HAIs, once again, congratulations. All of the PCHs submitted all of their HAI data that was due on the May 15th, including the first time on the healthcare provider influenza vaccinations, so great work on that. August 31st brings us to the annual submission of the DACA. This is the attestation that you've submitted your data completely and as accurately as you can. It will be for Fiscal Year 2018. That document will be available on www.qualityreportingcenter.com and on www.QualityNet.org underneath the PCHQR tab. We will be sending a ListServe on June 1st about that, so be looking for that. And, once again, that's due by August 31st. Then on October 4th, you can see we have quarter two of the HCAHPS data. So, our next slide, 32, Deb.

Here we see important upcoming dates for Hospital Compare Public Reporting. The July refresh is coming up. The anticipated refresh for that is expected to be on July 26th. And you can see the data there. As always, there will be four quarters of CST data. We always roll the oldest quarter off and add the current quarter. That will be the first time that your EBRT data is publicly reported. And, once again, you see there will

be four quarters of HCAHPS on there. And one thing that Lisa and I noticed from looking at this, it's interesting to kind of keep this straight in your mind. The CST data, the hormone data always lags the chemo data by two quarters because of the 365-day lag versus the 120. And then the HCAHPS, being that's a patient satisfaction and you aren't waiting, actually is one year more current than the hormone data. So that's just the way that we tend to keep that straight in our mind. And, so, once again, the July refresh is anticipated for July 26th. You'll soon be getting information regarding the October refresh. The Preview Period actually starts before the July refresh. But, the October Preview Period will be July 14th to August 13th. So right about the 14th, you'll be getting a ListServe to notify you of that, and there will be information on *QualityNet*. And the anticipated refresh of this data is October 18th. So, Deb, that takes us to 50 minutes into the hour. So I'll turn it over to you for a review of the continuing education material and then you can pass it back to me.

Debra Price: Okay, great, Tom. Thank you very much for your time. Today's webinar has been approved for 1.0 continuing education credit by the Boards listed on this slide. Since we are now a nationally accredited nursing provider, all nurses report their own credits to their Boards using the Provider Number you see there on the last bullet (Provider #16578).

We now have an online CE certificate process, so you can receive your certificate two different times. Either today, right after we click the last slide, a survey will pop up and that will take you to our Learning Management Center and you will be able to get your certificate that way. But if you don't have time at the end of the webinar, within 48 hours you will be receiving another survey. So then take that survey and it will be the exact same survey. Don't take it twice, and that way you will be able to get your CE. After the completion of the survey, make sure you click the "Done" button, because that "Done" button is linked to another page at the Learning Management Center. It's an entirely separate registration from the registration you use for this event. Please use your personal email so you can receive the certificates, because most of the healthcare

facilities tend to block our automatic links. So, again, please register your personal email.

If you do not immediately receive a response when you register into the Learning Management Center, that means that the link is not working or your computer is not letting our link through. So, if that's the case, please go back and register as a new user using your personal email or wait 48 hours, because in 48 hours you're going to get the new survey and then you'll have the chance to register your personal email.

This is what the survey is going to look like in another couple of minutes. At the bottom right-hand side, you see the little button that says "Done." That "Done" button is linked to the Learning Management Center.

And this is the page that comes up after you hit the "Done" button. If you are an existing user and you have not had any problems getting your certificate, click on that. That second green link, the one that's the "Existing User" link, will take you to your certificate. However, if you have had any problems getting a certificate please click on the "New User" link, register your personal email, like Yahoo or AT&T or whatever your personal email is. Use the "New User" link, use the personal email, and a personal phone number and you won't have any problems.

This is what the "New User" link looks like; it takes you here. You put your first name, your last name, your entire email, your personal email, and a personal phone number.

This is the page that the "Existing User" takes you to. Your username is your entire email, including what's after the "@" sign, and, of course, your password. If you forgot your password, just click in the box, and you'll be able to register a new password. And now I'd like to pass the ball back to Tom Ross to finish out the webinar. Thank you, Tom, for giving me these few minutes.

Tom Ross: Thanks, Deb. So I'd like to thank everyone for their time and attention today. We did receive one question, which is a great question, which, unfortunately, I don't have an answer to. The question is, "In addition to

acute care inpatient admissions (ED) visits, does the measure capture observation admissions within 30 days?" So, what I'll do on that, to the person who asked the question, and for the rest of you, is I will turn to the measure development people and ask for an answer on that. So the Q&A, the transcripts and the recording will be posted on www.qualityreportingcenter.com within ten business days. And typically you'll see a lot of the new information gets up quicker, but within ten business days it will be up on there. As far as mentioning the measure developer, we will continue to work with them, and we'll communicate with you as we know more specifics about the actual dates of conducting the dry run on the National Provider Call, and that series of events. We've had good conversations with them, so we'll continue to get that information to you. And the last thing I just want to remind you to, as we're getting into, it always amazes me how fast time flies. that we are at May 25th, that for the care delivered in 2017, we do have the new tools posted for the Oncology Care Measures and NQF 1822, or EBRT, posted on *QualityNet* under the Data Collection tab. So, as you move into abstracting your cases for 2017, be sure that you use the 2017 tools. So, as always, I appreciate each and every one of you, all the care that you offer for your patients and I hope that this information has been helpful to you. And have a great rest of your day. Thanks so much, bye bye.