PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program

Support Contractor

PCHQR Program:
Updates to PCHQR Program Manual, Measure Information Forms, and Algorithms

Presentation Transcript

Speaker/Moderator

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June 28, 2018
2 p.m. ET

Lisa Vinson: Good afternoon and welcome to today's Outreach and Education program for the PPS-Exempt Cancer Hospital Quality Reporting, or PCHQR, Program, entitled *Updates to Program Manual, Measure Information Forms, and Algorithms*. My name is Lisa Vinson and I am the Program Lead for the PCHQR Program. As the title suggests, today's presentation will focus on the 2018 updates to the data collection tools and a brief highlight regarding the updates to the 2018 Program Manual. As always, you can submit questions using the chat function that was discussed previously on slide number four of today's webinar, and as time allows, we will respond to your inquiries during today's event. However, time and the requirement for additional research before responding to a question may prevent us from being able to respond to all questions received. Please remember that all questions and answers, as well as the recording and transcript for today's event, will be posted on both *QualityReportingCenter.com* and *QualityNet.org* under the PCHQR Program tab. Lastly, I would like to emphasize that today's event is specific to participants in the PPS-Exempt Cancer Hospital Quality Reporting Program only. Others interested in the topics covered during today's webinar are certainly welcome to attend; however, the information presented today only pertains to those participating in the PCHQR Program. If you are not a participant in the PCHQR Program and have similar metrics in your CMS quality reporting program, please refer to the materials supplied by that program support contractor. Let's now move to our next slide, slide number six.

This slide is our standard acronyms and abbreviations slide. We provide this during each event to serve as a reference for you to use as we discuss our program. And also, by listing the abbreviations and their corresponding full name here at the beginning, we are able to simplify the appearance of the slides in our programs. At this time, I would like to highlight a few of the acronyms and abbreviations you may hear today: ADT for androgen deprivation therapy, CPT® for Current Procedural Terminology, EBRT or "EBERT," for external beam radiotherapy, ICD for International Classification of Diseases, MIF for Measure Information Form, and PSA for prostate-specific antigen. Slide seven, please.

The purpose of today's event is to provide program participants with a high-level overview of the highlights of the 2018 Program Manual. Then we will explore the updates to the Measure Information Forms, or MIFs, and algorithms for the Oncology Care Measures and Clinical Effectiveness measure, also known as EBRT. The specific objectives for today's event are outlined on our next slide, slide 8.

Today's objectives are rather straightforward. First, we want participants to be able to describe and locate the sections of the Program Manual that have been updated for 2018. This will enable you to quickly access the information pertaining to the program that you require. Second, we will look at the changes to the Measure Information Forms associated with the OCMs and EBRT. This is very important information that you, as participants in the PCHQR Program, need in order to accurately identify the patient population for these measures and correctly abstract the information to identify compliance or noncompliance with the numerator. And lastly, we will take a high-level look at the updated algorithms for these measures. These algorithms are visual tools and are helpful to you in abstracting your measures for reporting. Therefore, let's move into our first brief section, the updates to the 2018 Program Manual. Slide 9, please.

The 2018 Program Manual is accessible on both *QualityReportingCenter.com*, as well as *QualityNet.org*. The manual is usually updated twice a year with the most significant update occurring during the early fall, after the final rule is published in August. The winter/spring updates, which is the current version posted, typically contains the information that has emerged since the publication of the final rule and has any clarifications and updates to assist you in understanding the measures and reporting process for the current calendar year's patient care. Before I share the updates, I would like to go over a few reminders on the use of this manual. First, this document is an overview of the program. It is not a measure specification manual. For the measure specifications needed to abstract the measures, you have to refer to the materials presented during these educational events and also available on *QualityNet* for the PCHQR Program; specifically on the Data Collection

tab. Secondly, the manual provides a comprehensive view of all aspects of the program. As you will see, this spans from the rules establishing and governing the program, to specific measures and to how to report them, to participation and use of the *QualityNet* system, to public reporting. And thirdly, the manual has electronic links. This allows you—from the table of contents—to jump to the specific portion of the program that you are seeking information on. With that as a background, let's look at the updates to this document on our next two slides, starting with slide number 10.

Section one of the manual provides an overview of the program, including the statutory establishment of the program, as well as an overview of the significant updates that have occurred annually from Fiscal Year 2013 through 2018. There's also a link to the PDF text of each year's final rule. Section two addresses the actual measures and use for the program. This begins with a list of the six categories of measures, as well as each measure with its NQF and PCH number, as appropriate. Each category of measures then includes an overview of each individual measure, including the clinical rationale for its inclusion in the program. There's also a description of the numerator and denominator for each measure. But remember, this is descriptive only. It does not contain the specifics needed to abstract the measures. This information is found on the Measure Information Forms and algorithms on *QualityNet*. Specific to the 2018 manual, you will find discussions on the updates of the OCMs and EBRT measure in this section. Section three is devoted to data reporting. This shows the allowed methods of reporting of data for each of the measure sets, which ranges from data reported by the CDC on your behalf to the use of a vendor to claims-based measures. When the Program Manual was updated, […] the implementation of the Web-Based Data Collection Tool and its use was introduced for the reporting of the cancer-specific treatment measures, beginning with the May 2017 submission deadline and forward, and then the OCMs and EBRT for the August 2017 data submission. Sections four and five are mostly reference for the PCHQR Program participants as they address registration in *QualityNet* and authorization of a vendor. All of the PCHs currently have active Security

Administrators in *QualityNet*, and all have successfully authorized their HCAHPS vendor. Slide 11, please.

Section six, the Notice of Participation, or NOP, is once again provided for reference as the PCHs have all successfully filed their Notice of Participation for the program. In the past, we have received inquiries as to how often the NOP needs to be completed. The answer is, only once, since it automatically renews. The only time you would need to address your NOP is if you decide to stop participating in the program and if you later decide to resume participation. Section seven addresses the Data Accuracy and Completeness Acknowledgement, which must be completed annually by each PCH. This annual requirement is due August 31. For Fiscal Year 2019 and forward, the submission process will be electronic. The screen captures in the Program Manual have been updated to reflect this appropriately. Section eight, I'm sure is frequented by many users. It tells you how to access both your facility reports showing your performance by program year for the CSTs, HAIs, OCMs, and EBRT, and the HCAHPS reports. Section nine addresses public reporting and section 10 is a compilation of resources. Here is where you will find the updated program measure submission deadlines and the relationship matrix. On our next slide, slide 12, we will begin our review of the updates to the OCMs and EBRT.

There are no significant standard changes impacting the cancer-specific treatment measures, the Safety and Healthcare-Associated [Infection] measures and the HCAHPS survey process impacting the PCHQR Program for patient care delivered during calendar year 2018. Therefore, we will devote the majority of the updates during the rest of today's events to the changes to the five Oncology Care Measures and the Clinical Effectiveness measure, or EBRT. However, before we begin our review, we will discuss some important overreaching concepts or frameworks involving these measures and their specifications on the next two slides that you are very familiar with. Slide 13, please.

Currently on *QualityNet*, under the PCHQR Program, and on the Data Collection tab, you will find the measure specifications for the care

provided for the OCMs and EBRT for calendar years 2017 and 2018. For each of the six measures, NQF numbers 0382, 0383, 0384, 0389, 0390 and PCH number 25, or EBRT, you will find four tools: the Measure Information Form, or MIF; the clean algorithm, which is a visual tool that shows how the denominator and numerator for the measure are determined; a population and sampling algorithm that shows the same information, but with examples of patient numbers for population sampling, denominator, and numerator; and a paper abstraction tool, which takes you through the MIF and algorithms in a step-by-step question-and-answer format. The 2017 information that is currently on *QualityNet* should be used for care delivered in 2017 and will be reported for the August 15, 2018 data submission deadline. The 2018 information will be used for the care delivered in 2018 and will be reported by August 15 of 2019. Slide 14, please.

The Measure Information Form is a consolidation of information developed by the support contractor for your use. The information for the MIF is derived from a number of sources, including the National Quality Forum, or NQF; the Quality Payment Program, or QPP (formerly PQRS) for the OCMs; CMS final rules; and other sources, including clarification and guidance from the measure steward or stewards. The Measure Information Form consists of the following components: an overview with official measure name, NQF and PCH numbers, National Quality Strategy domain, type of measure, how improvement is noted, and the measure steward; a description of the measure and any special instructions; a definition of the denominator and numerator with ICD and CPT codes; and clinical rationale and recommendation statements, as applicable. Slide 15, please.

This slide should look familiar since it was presented in a past webinar. These universal applications for OCM and EBRT are still valid for 2018. I felt that the content was significant enough to revisit and reemphasize. First, when deciding which set of measure specifications to use, you have to know how the data collection period is designated for the measure. For the HAIs, it is based upon event date for the healthcare-associated

infections and flu season for the influenza vaccination measure, or HCP. The cancer-specific treatment measures depend upon when the patient is diagnosed. For example, a patient eligible for PCH-3, or Adjuvant Hormonal Therapy, could be diagnosed in March; let's say, the fifteenth, in 2018. They would have until 365 days later to have the hormone therapy initiated, which would be March 14 of 2019. Then, this data is not reported until May of 2019. However, the case for the CSTs is attributed to the quarter it was diagnosed, which is quarter one 2018. For the OCMs and EBRT, it is based upon patient treatment or visit date. There are a couple of more subtle, albeit important, things about the treatment or visit date in relation to the OCMs and EBRT. First, for the pain measures, which are NQF numbers 0384 and 0383, patients are eligible for inclusion at each eligible encounter that they have during the measurement period, which is each quarter, in the case of the OCMs. Secondly, for NQF numbers 0382, 0389, 0390, and PCH-25, the measure should be reported only once per quarter. And, if a treatment course spans more than one quarter, for example, starting in March but concluding in April, it should be attributed only once to the quarter in which it originated. The second portion of this slide was already addressed previously, so we will take a look at NQF numbers 0382 and 0383 on Slide 16.

Beginning with NQF number 0382, Radiation Dose Limits to Normal Tissues, there were no updates to the Measure Information Forms, or MIFs, and algorithms for this measure. Moving to NQF number 0383, Plan of Care for Pain, there were updates to the denominator, which we will look at more closely on the MIF on the next two slides. Please note that there were no updates to the algorithm for this measure. Slide 17, please.

Here is the overview portion, which has not changed for NQF number 0383 of the MIF, which includes the measure name, both the NQF and PCH numbers for the measure ID, applicable NQF portfolios, the National Quality Strategy priority, type of measure, improvement noted as, and the measure steward. Next, we will take a look at the denominator portion of the MIF, which included the updates mentioned earlier. Slide 18, please.

Here is the denominator and criteria for NQF number 0383 as listed on the MIF. Updates to the denominator, as mentioned on Slide 16, include 17 ICD-10 codes added and two ICD-10 codes removed related to malignant neoplasms. These 17 new codes were added and two codes removed from the extensive list of codes under the diagnosis for cancer. Please note that due to this list being so extensive, the entire list of codes is not captured here on this slide. Second, CPT code 77470 was removed from the patient encounter for radiation therapy during the reporting period list. This code is typically used to report the addition of time and effort required when a medical physician and radiation oncologist must plan for, and deliver treatment under, unusual clinical circumstances. This code should not be billed routinely in connection with usual and customary services. Last, the telehealth modifiers 95 and POS, or Place of Service, 02, were added to the other two telehealth modifiers originally included in the 2017 measure specifications, which were GQ and GT. Slide 19, please.

Moving to NQF number 0384, Pain Intensity Quantified, which is paired with the previous measure discussed, NQF number 0383; this slide lists out the 2018 MIF updates. Again, there were no updates to the algorithm for this measure. We will go into detail for each of these updates on the next series of slides. Slide 20, please.

Again, here's the measure overview found at the beginning of the MIF. The description of NQF number 0384 has been included, as well. All of this information remains the same. Slide 21, please.

As this measure is paired with NQF number 0383, the denominator updates are the same. There were 17 ICD-10 codes added. There were two ICD-10 codes removed. Again, this is not the complete list of the diagnosis of cancer ICD-10 codes listed on this slide. One CPT code was removed from the patient encounter for radiation therapy during the reporting period list. And, there were the two additional telehealth modifiers added, 95 and POS 02. Slide 22, please.

Here are the numerator details for NQF number 0384. There were no significant updates to this portion of the measure other than examples

added to the numerator instructions. For clarity, examples of standardized instruments were provided in the 2018 QPP measure specifications, which are now also included on the MIF. These examples, the Faces Pain Rating Scale and the Brief Pain Inventory, or BPI, are appropriate or acceptable tools that can be used to quantify a patient's pain level. Slide 23, please.

The rationale was updated with more specific information about pain assessments. Additional information has been included to explain the value or importance of initial and ongoing pain assessments, which is essential to ensure proper pain management among the cancer patient population. This updated rationale also provides insight into the impact of inadequate pain assessments in this population, as well. These details were provided by the National Comprehensive Cancer Network, or NCCN, cited in 2016. Slide 24, please.

In addition to the rationale for NQF number 0384 being updated, the clinical recommendation statements were updated, as well. Per the 2016 NCCN guidelines, there was an additional recommendation statement added that includes other aspects that need to be considered, in addition to using rating scales when pain assessments are conducted, which include patient reporting of quality of pain, breakthrough pain, treatments used and their impact on pain, patient reporting of adequate comfort, satisfaction with pain relief, provider assessment of adequacy of function, and any special issues for the patient relevant to pain treatment. The original statement regarding obtaining additional information for family or caregiver and impact of function remains. Lastly, there has been a new statement added that states, "Evaluate the patient for risk factors of opioid misuse." Slide 25, please.

Our next to last OCM we will be reviewing, NQF number 0389, Avoidance of Overuse of Bone Scan for Staging Low-Risk Prostate Cancer Patients, saw a few updates, as well. We will look at the MIF, specifically the denominator definitions and rationale. And, there is an update to the algorithm. Slide 26, please.

Here is the overview portion of the MIF for NQF number 0389 entitled, Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low-Risk Prostate Cancer Patients. In the PCHQR Program, this measure is number 18. Of note, this information has not changed. As you can see, this measure is included in a number of different NQF Portfolios, notably Oncology Metrics for the PCHQR Program. As a reminder, this is an overuse measure, so it falls in the domain of Affordable Care. It, like the other OCMs, is a process measure. While the measure focuses on not conducting a bone scan in low-risk prostate cancer patients, this measure is written in an inverse fashion—avoidance of overuse—therefore, a higher score indicates better quality. And lastly, the measure steward is the AMA-convened Physician Consortium for Performance Improvement, or PCPI. Next slide, please.

This slide is a screenshot of the denominator and definitions for NQF number 0389. The overall intent of the measure remains the same, that a bone scan to assess for metastatic disease is not indicated in patients at low risk of reoccurrence of prostate cancer. The most significant change in this measure occurred last year, which was the inclusion of low patients at very low risk of reoccurrence. The first criteria, a PSA less than 10 nanograms per milliliter is the same. A Gleason score of six or less applies to the very low-risk patients. And the very low-risk patients still include those with a clinical stage of T1c. And, these patients must still have presence of disease and fewer than three biopsy cores and less than or equal to 50 percent prostate cancer involvement in any core. And now, the PSA density has been updated from less than or equal to 0.15 nanograms per milliliter per centimeter cubed to less than [0.15] nanograms per milliliter per gram. The very low-risk patients are still a subset of those included in the low risk and only those with T1c who meet these three additional criteria. As we identified during last year's update, the reason for this is that stage T1c cancer is found by needle biopsy, which was done because of an increased PSA. The needle biopsy results are needed to answer the three additional criteria. The denominator definitions are continued on our next slide, number 28.

As mentioned on the previous slide, the PSA level is the same for both low and very low risk of reoccurrence groups. However, the Gleason score has been updated from six or less to six for the low-risk group. Also, last year's update included the clinical stage being expanded to include patients with T1 to T2a cancer, which includes those patients who meet the PSA and Gleason criteria and had a clinical stage of T1a, T1b, T1c, and T2a. This remains unchanged as indicated on this slide. Remember that this measure requires that the patient be low- or very low-risk prostate cancer patients who also receive therapy with brachytherapy, EBRT, prostatectomy, or cryotherapy to the prostate. Of note, the definitions of external beam radiotherapy shown here also remain unchanged. Slide 29, please.

Lastly, as it pertains to the MIF, the rationale has been updated to provide more details regarding this measure, noting that multiple studies have indicated that a bone scan is not clinically necessary for staging prostate cancer in men at low or very low risk of reoccurrence and receiving primary therapy. As those categorized as low-risk, bone scans are unlikely to identify their disease. Furthermore, less than one percent of low-risk patients are at risk of metastatic disease. Now, we will look at the algorithm on slide 30.

Here, on this slide, is the top portion of the algorithm for NQF number 0389, which has been captured since it is the only portion that has been updated, specifically, the Data Abstraction Table on the left-hand side. The definitions for very low and low risk were updated to include the changes previously mentioned, which were the PSA density and Gleason score. The other sections of the algorithm—denominator, numerator, and quarterly sample size instructions—remain the same. Regarding the numerator, although not shown here, the numerator criteria remain unchanged from last year. However, I would like to add a few reminders regarding this measure along with NQF number 0390, which we will be discussing next. First, the measure is met if, for an eligible patient, a bone scan is not performed. This can be determined by CPT-2 code or via chart abstraction. Two, the measure is not met if a bone scan for an eligible

patient was performed. Once again, this can be determined by CPT-2 code or via chart abstraction. Three, remember, there are two numerator exclusions: when there is documentation of a medical reason to perform the scan (pain or other medical reason) or there is a system reason for the scan; also, most typically, the bone scan was performed in another institution than a reporting PCH. And, this is, therefore, inevitable. Fourth, for population and sampling data for the OCMs data submission, which is coming up in August, this measure, NQF number 0389 and NQF number 0390, are unique in that they have these numerator exclusions. For this reason, which applies to these two measures only, your population and/or sample size may be different from your denominator, which means a patient may qualify initially for the denominator population when you work through the algorithm. But, if a numerator exclusion is present, you remove the patient from both the numerator and denominator that you report. This is why for NQF number 0389 and 0390, your population and/or sample size, if you sample, may be different from the denominator you report. Beginning on slide 31, we will take a look at our last OCM NQF number 0390.

The most immediate and notable update you will see to NQF number 0390 is the measure title, description, and language throughout. Both the numerator and denominator have been updated along with the rationale and clinical recommendation statements. The algorithm has been updated, as well, to reflect these changes. In the next series of slides, we will take a closer look at these details. Slide 32, please.

This is the overview and description of NQF number 0390. The former measure name, Adjuvant Hormonal Therapy for High- or Very High-Risk Prostate Cancer Patients, as you can see, has been updated to Combination Androgen Deprivation Therapy for High- or Very High-Risk Prostate Cancer Patients. As with the other MIFs we have discussed, the overview portion includes the measure ID number, NQF portfolio, National Quality Strategy priority, type of measure with improvement noted as, and the measure steward are listed, which all remain unchanged. In the measure description, those who were prescribed adjuvant hormonal therapy was

replaced with androgen deprivation therapy in combination with EBRT to the prostate. Slide 33, please.

This slide contains the denominator statement, which is unchanged, and the updated definitions for NQF number 0390. All of the risk strata, which are very low, low, intermediate, high, and very high, now include Gleason Grade Groups, ranging from one to five, which further describe the Gleason scores. Per the NCCN guidelines, the Gleason Grade Groups are described as follows. Gleason Grade Group one is defined as a Gleason score of six or less and describes only individual discreet well-formed glands. These glands are small and close together. This group includes the very low- and low-risk strata. Gleason Grade Group two is defined as a Gleason score of three plus four totaling seven and describes glands that are poorly formed, larger, and have more space in between them. Gleason Grade Group three is defined as a Gleason score of four plus three totaling seven and describes predominantly poorly formed with lesser component of well-formed glands and are even further apart, darker in color, and have different shapes. Gleason Groups two and three include the intermediate-risk strata. Gleason Grade Group four is defined as a Gleason score of four plus four or three plus five and five plus three, all totaling eight and describes only poorly formed glands, which are hardly there, and cancer cells have lost their ability to form glands. Gleason Grade Group five is defined as a Gleason score from nine to 10 and describes a lack of gland formation, or with necrosis. Often, there are no glands, and sheets of cancer cells are present throughout the tissue. Both Gleason Groups four and five include the high- and very high-risk strata. Slide 34 displays the numerator portion of the MIF. Next slide, please.

The numerator statement has been updated to include prescribed androgen deprivation therapy in combination with external beam radiotherapy to the prostate, with the adjuvant hormonal therapy verbiage being removed. The definition of prescribe remains unchanged as it still includes the clarifying information included last year, based on the clinical recommendation statement, including neoadjuvant concurrent and adjuvant ADT. All performance criteria were updated to include androgen deprivation therapy

prescribed or administered or not prescribed or administered in combination with external beam radiotherapy to the prostate, removing all instances of adjuvant hormonal therapy. Slide 35, please.

The content of the measure rationale remains the same, except for adjuvant hormonal therapy has been replaced with androgen deprivation therapy and/or in combination with external beam radiotherapy. As stated earlier on the measure update summary slide for NQF number 0390, the clinical recommendation statements were updated, as well. Gleason Grade Groups were added to the Gleason score criteria, as cited from the 2017 NCCN guidelines. And, additional treatment options for the patients at very high risk were included, which are radical prostatectomy plus PLND in younger, healthier patients with no tumor fixation to the pelvic side wall and ADT or observation for patient not candidates for definitive therapy. EBRT and long-term ADT and EBRT plus brachytherapy with or without long-term ADT remains unchanged. Slide 36, please.

The algorithm for NQF number 0390 has been updated to include the new measure name. The measure description, numerator, and denominator statements have been updated, as well. The Data Abstraction Table now includes the Gleason Grade Groups for the definitions for high and very high risk of reoccurrence, which we will also see in the lower portion of the denominator of the algorithm on slide 37.

This slide simply illustrates the updates to the denominator portion of the algorithm, which includes the updated Gleason Grade Groups. So, that wraps up the updates to the five OCMs. Now, we will move to EBRT on slide 38.

In March of this year, the NQF endorsement for EBRT, formerly known as NQF number 1822, was removed at the discretion of the measure steward, ASTRO. Per guidance received from CMS, there were no content changes to the MIFs and algorithms for this measure. The only update you will notice is that the measure will now be referred to by its PCH number, which is 25. Therefore, all NQF verbiage has been removed and replaced with PCH-25. At this time, CMS, the Hospital OQR, ASTRO, and the

VIQR Support Contractor will continue to collaborate to maintain alignment across programs. Slide 39, please.

This screenshot displays the overview portion of the Measure Information Form for PCH-25, or EBRT. Again, the content will not change from 2017 and the measure will be referred to as PCH-25, moving forward. Slide 40, please.

For your convenience, I have included the *QualityNet* and *Quality Reporting Center* PCHQR Program page links, which will take you directly to the tools we have discussed today. Slide 41, please.

We will conclude today's event as always by reviewing key reminders for the PCHQR Program, beginning on slide 42.

As for upcoming webinars, you will notice that our next event is earlier than normal, scheduled for July 12. This is due to the topic that will be covered, which will be the August 15 and August 31 submission of the required data and the Fiscal Year 2019 DACA, respectively, which is also outlined below on this slide. Customarily, our August event is focused on the publication of the final rule. So that will be the topic of discussion at that time. You should have received a communication from the Centers for Disease Control and Prevention, or CDC, announcing that the deadline for completing the online NHSN Agreement to Participate and Consent Form has been extended to Monday, July 9. This applies to all facilities currently enrolled in NHSN, regardless of their CMS participation. The reconsent is accessible to only the NHSN Facility Administrator or primary contact users. The new deadline provides additional time for each facility's NHSN Facility Administrator or primary contact to complete the online consent and avoid any interruptions in accessing the NHSN application, including access for purposes of submitting data to meet local, state, or federal reporting requirements. Please be informed that if this consent is not completed by the new deadline date, access to NHSN will temporarily be suspended. Additionally, users will receive an error message when they attempt to log in to NHSN, redirecting them to the Facility Administrator or primary contact. You may click the link

provided on this slide for additional information and also please direct questions to nhsn@cdc.gov. Again, the upcoming data submission deadline requirements have been provided here, as well. It is important to note that the August 15 data deadline will be the last submission of the cancer-specific treatment colon and breast chemo data as these measures were finalized for removal from the program with the last required reporting period being quarter four of 2017. However, there are still two quarters of data reporting required for the CST hormone data. Also, for those PCH facilities who wish to file a Measure Exception Form for calendar year 2018, please keep in mind that this form must be submitted by the August 15 deadline. Slide 43, please.

And, here are the updates for public reporting of the PCHQR Program data. The anticipated July refresh is scheduled for July 25. And, for the October 2018 refresh the preview period is tentatively slated to open July 27 and will close August 25 with public posting anticipated for October 31. As with all public reporting dates, these are subject to change, and we will inform you of specific dates via ListServe as they become available. Slide 44, please.

Finally, here's how to access the PCHQR Questions and Answers tool via the *QualityNet* Home page. You can access this tool by clicking the PPS-Exempt Cancer Hospitals link, as indicated by the red box on this slide, to begin this process. Please keep in mind that there is a first-time registration required if you are accessing this tool for the first time. With that, I am going to turn the event over to Deb Price to review the CE information for today's event, and then I will have a few closing remarks. Deb?

Deb Price: Well, thank you very much. Today's webinar has been approved for one continuing educating credit by the boards listed on this slide. We are now a nationally accredited nursing provider. And as such, all nurses report their own credits to their boards using the National Provider Number 16578. It is your responsibility to submit this number to your own accrediting body for your credit.

We now have an online CE certificate process. You can receive your CE certificate two ways. First way is, if you registered for the webinar through ReadyTalk®, a survey will automatically pop up when the webinar closes. The survey will allow you to get your certificate. We will also be sending out the survey link in an email to all participants within the next 48 hours. If there are others listening to the event that are not registered in ReadyTalk, please pass the survey to them. After completion of the survey, you'll notice at the bottom right-hand corner a little gray box that says, "Done." You will click the Done box, and then another page opens up. That separate page will allow you to register on our Learning Management Center. This is a completely separate registration from the one that you did in ReadyTalk. Please use your personal email for this separate registration so you can receive your certificate. Healthcare facilities have firewalls that seem to be blocking our certificates from entering your computer.

If you do not immediately receive a response to the email that you signed up with in the Learning Management Center, that means you have a firewall up that's blocking the link into your computer. Please go back to the New User link and register a personal email account. Personal emails do not have firewalls up. If you can't get back to your New User link, just wait 48 hours because, remember, you're going to be getting another link and another survey sent to you within 48 hours.

Okay, this is what the survey will look like. It will pop up at the end of the event and will be sent to all attendees within 48 hours. Click Done at the bottom of the page when you are finished.

This is what pops up after you click Done on the survey. If you have already attended our webinar and received CEs, click Existing User. However, if this is your first webinar for credit, click New User.

This is what the New User screen looks like. Please register a personal email like Yahoo!, or Gmail, or ATT since these accounts are typically not blocked by hospital firewalls. Remember your password, however, since you will be using it for all of our events. You notice, you have a first

name, a last name, and the personal email. And, we're asking for a phone number in case we have some kind of backside issues that we need to get in contact with you.

This is what the Existing User [screen] looks like. Use your complete email address as your User ID and, of course, the password you registered with. Again, the User ID is the complete email address, including what is after the @ sign. Okay, now, I'm going to pass the ball back to your team lead to end the webinar and to go over any questions that came in. Thank you for taking the time spent with me.

Lisa Vinson: As always we do thank you for your time and attention during today's event. Thank you so much and we will see you next month. Thank you and enjoy the rest of your afternoon.