PPS-Exempt Cancer Hospitals Quality Reporting (PCHQR) Program

Support Contractor

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

Presentation Transcript

Moderator/Speaker:

Thomas Ross, MS
Program Lead, PCHQR Program
Hospital Inpatient Value, Incentives, and Quality Reporting (VIQR)
Outreach and Education Support Contractor (SC)

February 23, 2017
2 p.m. ET

Tom Ross: Good afternoon and welcome to today's Outreach and Education program for the PPS-Exempt Cancer Hospital Quality Reporting, or PCHQR, Program entitled, *PCHQR Program: Updates to the Program Manual, Measure Information Forms and Algorithms*. This presentation is prepared and conducted by the Hospital Inpatient Value, Incentives, and Quality Reporting, or VIQR, Outreach and Education Support Contractor. My name is Tom Ross and I'm the Program Lead for the PCHQR Program. I'm ably assisted by Lisa Vinson, Project Manager, whom many of you have already interacted with. Today's event will build upon the lessons of last month's event, the *2017 Update to Measures*. Today I will be narrating our webinar. As always, you can submit questions, as Matt said, using the Chat function that was discussed on slide four. As time allows, we will respond to your inquiries during today's event, sharing your responses, as appropriate, with all participants. However, time and requirements for additional research before responding to a question may preclude us from being able to respond to all questions during today's event. Please remember that all questions and answers, as well as the recording and transcript for today's event will be posted on both Quality Reporting Center as well as on Quality Net, under the PCHQR tab. And lastly, as I conclude my introductory remarks, I want to emphasize that today's event is specific to the 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 your program's Support Contractor. So now Jamie, let's move on to our next slide, slide number six.

Here you see our standard acronyms and abbreviation 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, up front, we're able to simplify the appearance of the slides for our programs. This month I'm going to highlight a few of these for

you. ADT stands for Androgen Deprivation Therapy. This is a term used in NQF #0390 Prostate Cancer: Adjuvant Hormonal Therapy for High Risk Patients. Specifically, the terms ADT refers to the use of a gonadotropin-releasing hormone antagonist or agonist in prostate cancer patients at a high or very high risk for recurrence who received External Bean Radiotherapy, or EBRT, for treatment of their disease. And there you are, I just mentioned another acronym, EBRT, which stands for External Beam Radiotherapy. This term is used in three of our Program's measures; NQF #0390 as we just mentioned, #0389 and #1822, or External Beam Radiotherapy for Bone Metastases. And speaking of #1822, this measure also frequently uses the abbreviations of Fxns for fractions, referring to the number of times of administration that a course radiation therapy is delivered; and Gy, for gray, which is a term used in expressing the dosing of radiation therapy. ICD is an abbreviation for the term International Classification of Diseases. The codes that compromise the ICD system, now in version 10, are used to identify patients for inclusion in many of our Program's denominator populations. And lastly, I will mention the term OCM frequently today, which as you know is the abbreviation for Oncology Care Measures. This is one of six categories, or buckets, that the 17 measures that are currently reported by the PPS-Exempt Cancer Hospitals, fall into. The category of measures other than the OCMs are: the six Safety and Healthcare-Associated Infection measures or, HAIs; the three Cancer-Specific Treatment measures, or CSTs; Patient Engagement or Experience of Care, which is measured by the HCAHPS survey; the Clinical Effectiveness Measure, EBRT; and the Claims-Based measure, Admissions and Emergency Department Visits for Patients Receiving Outpatient Chemotherapy. Slide number seven, please.

The purpose, or overreaching objective, of today's event, as I alluded to earlier, is to build off last month's webinar. Specifically, participants of today's program will be given a high level overview of the highlights of the 2017 Program Manual. Then, on a much more granular level, we will explore the updates to the measure information forms, or MIFs, and the algorithms for the OCMs and the Clinical Effectiveness Measures. The specific objectives are on our next slide, slide number eight.

These are pretty straight forward. First of all, we want participants to be able to describe what sections of the Program Manual have been updated for 2017. This will enable you, as a participant, to quickly access the information pertaining to the Program that you require. Secondly, we will look at all the changes to the measure information forms associated with the OCMs and EBRT. This is very specific 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 concordance, or non-compliance and non-concordance, with the numerator. And lastly, we will take a high level look at the algorithms that have changed for these measures. Algorithms are visual tools and those associated with our Program can be quite complex, so they do not always readily lend themselves to a presentation in a Power Point format. However, I will be sure to take a close enough look at the modifications to these tools so they are helpful to you in abstracting your measures for reporting. So, with all that being said, let's move into our first brief section, the updates of the 2017 Program Manual, beginning on slide number nine.

The 2017 Program Manual, this document can be accessed on both Quality Reporting Center as well as on Quality Net. We are in the process of updating this expansive document and participate, excuse me, anticipate having the 2017 version posted by the end of March. 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 and spring update, where we are now, contains the information that has emerged since the publication of the Final Rule and has any clarification and updates to assist you in understanding the Final Rule, and the measures and reporting process for the current Calendar Year's patient care. Before we look at these updates in more specificity, I want to give you a few pointers on the use of the Manual. First of all, note the name Program Manual. 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 Quality Net for the PCHQR

Program, on the Data Collection tab. Secondly, the Manual provides a comprehensive view of all aspect of the Program. As you will see, this spans from the Rules establishing and governing the Program, to the specific measures and how to report them, to participation and use of the *QualityNet* system, on 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 Manual that you're seeking information on. So, with that as 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 establishments of the Program, as well as an overview of the significant updates that have occurred annually, from Fiscal Year 2013 to 2017. There's also a link here to the PDF text of each year's Final Rule. Section two addresses the actual measures in use for the Program. This begins with a list of the six buckets of measures I referred to earlier, 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 rational for its inclusion in the Program. There's also a description of a numerator and denominator for each measure. But remember, this is descriptive only, you won't find CPT and ICD nine codes [speaker error – Program now uses ICD-10 codes] here. It does not contain the specificity needed to abstract the measures. This information is once again found on the data collection tab, in the measure information forms and algorithms, on *QualityNet*. Specific to the 2017 Manual, you'll find discussions of the updates to the OCMs and EBRT we covered today in this section. Section three is devoted to data reporting. This shows the approved methods of reporting of data for each of the measure set, which ranges from data reported by the CDC on your behalf, such as the HAI measures, to the use of a vendor measures, such as the HCAHPS data to Claims-Based measures. Significantly in this section, 2017 will introduce the use of the Web-Based Data Collection tool for the reporting of the Cancer-Specific Treatment measures in May and afterwards, and then OCM and EBRT for the August 2017 data submission. The Web-Based Data Collection Tool, or WBDCT, will

replace the current use of external files. Yay! As a reminder our next PCHQR webinar will be devoted to this topic, the Web-Based Data Collection Tool. Sections four and five are, at this point, mostly reference for the PCHQR Program participants as they address registration in *QualityNet* and authorization of a vendor. All of the PCHs currently have an active Security Administrator in *QualityNet* and all have successfully authorized their HCAHPS vendor. Slide number 11 please, Jamie.

Section six is the Notice of Participation, or NOP, and once again, this is provided as reference as the PCHs have all successfully filed Notices of Participation for the Program. We occasionally receive inquiries as to how often the NOP needs to be completed or updated. The answer is, only once. It automatically renews. The only time you would need to update – update or address your NOP is if you decided to stop participating in the Program and if you later decide to resume participation. Section seven addresses the DACA, or the Data Accuracy Completion Acknowledgement, which must be completed annually by each PCH. The due date for this is August 31. Section eight is a section that many people refer to. This tells you how to access the Facility Reports, showing your performance by Program Year for the CSTs, HAIs, OCMs and EBRT, as well as the separate HCAHPS Reports. Section nine addresses Public Reporting and section 10 is a compilation of resources. Here, when published, you will find the updated Program Measures Submission Deadline document and the PCHQR Program Relationship Matrix. So, this concludes our review of the updates to the Program Manual. Once again, we expect to publish this in March and it will be posted on both Quality Reporting Center and Quality Net. We will now move on to slide number 12 and begin our review of the granular updates to the OCMs and EBRT for patient care delivered in Calendar Year 2017.

As we shared during last month's webinar, there are no significant standard changes impacting the Cancer-Specific Treatment measures, the Safety and Healthcare-Associated measures and the HCAHPS survey process impacting the PCHQR Program for patient care delivered during Calendar Year 2017. 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, NQF #1822, or EBRT. Before we dive into the details, we want to use the next two slides to share with you some important overreaching concepts or frameworks, involving these measures and their specifications. Slide number 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 Year 2016. For each of the six measures - NQF #0382, #0383, #0384, #0389, #0390 and #1822, you will find four tools. First, a measure information form, or MIF. This document contains information we will discuss on the next slide. Secondly, there will be a clean algorithm, which is a visual tool, that shows how the denominator and the numerator for the measures are determined. The third tool you will find is a population and sampling algorithm that shows the same information, but with examples of patient numbers for population, sampling (if you so desire) denominator, and numerator – and lastly, a paper abstraction tool, which takes you through the MIF and algorithm in a step-by-step question and answer format. As stated earlier, we're in the process of updating these tools for the care provided in Calendar Year 2017 and hope to have this information posted in March of this year. The 2016 information, that is currently on *QualityNet*, should be used for care delivered in 2016, and you will report this data by August 15, 2017. The soon to be posted 2017 information will be used for care delivered in 2017 and will be reported by the August 15, 2018, submission deadline. So, we're really ahead of the curve, time-wise. Slide 14 please.

So, the measure information form is probably the most technically complete document and it's 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, the Quality Payment Program (formerly known as PQRS) for the OCMs, the 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, the NQF and PCH numbers, the National Quality Strategy Domain, what type of measure it is (outcome, process, or structure), how improvement is noted, and the measure steward. Secondly, you will find a description of the measure and any special instructions, and you'll see that's very important when we get to NQF #1822. A third item you'll find is a definition of both the denominator and numerator. And, this is where we get very specific with the ICD and CPT codes. And lastly, when available, we provide the clinical rationale and recommendation statements for the measure. Slide 15 please.

This slide is a repeat from last month, but we felt that the content was significant enough to reemphasize, especially as we continue to receive questions pertaining to information on this slide. First of all, when deciding what set of measure specifications to use, you have to know how the data collection period is designated for that measure. For example, for the HAIs, it is based upon the event date for the Healthcare-Associated Infection and the flu season for the influenza vaccination measure. The Cancer-Specific Treatment measures depend upon when the patient is diagnosed. For example, a patient eligible for PCH 3, Adjuvant Hormonal Therapy for ER/PR positive breast cancer could be diagnosed, say, on March 15, 2017. They would have until 365 days later to have the hormone therapy initiated, which would be March 14, 2018. Then, this data is not reported until May of 2018. However, the case for the Cancer-Specific Treatment measures, is attributed to the quarter in which it was diagnosed, in this case quarter one, 2017. For the OCMs and EBRT, the reporting collection period is based upon the date of treatment or visit. There are a few more subtle, albeit it important things, about the treatment and visit date in relation to the OCM and EBRT I want to share. First of all, for the pain measures NQF #0384 and #0383, patients are eligible for inclusion at each eligible encounter that they have during the measurement period. And, we're going to talk a little bit more about that. Secondly, for NQF #0382, #0389, #0390, and #1822 the measure should be reported only once per quarter. And, if a treatment course spans more than one

quarter, for example, a patient starts radiation therapy (for say, pancreatic cancer) in March but concludes that course (of say, 30 fractions in April), it should be attributed only once to the quarter in which it originated. The second portion of the slide was already addressed previously, so we'll move on to our first update; that's to NQF #0382, beginning on slide number 16.

And, that pause is me taking a drink of water. This slide is a screen shot of the introductory materials for the new MIF for NQF #0382. You can see the official name, Radiation Dose Limits to Normal Tissues, then the measure ID numbers NQF number 0382 and PCH 14. Next, you see that is in the NQF portfolios of Oncology Metrics and Radiation Oncology. And, it is located in the National Quality Strategy Domain of Patient Safety. This is a process measure for which improvement is indicated by a higher score. And lastly, the measure steward is the American Society for Radiation Oncology, or ASTRO. And, you have to keep up on that. They've changed their full name a couple times over the past couple of years, but have kept the acronym "ASTRO." Next, we see the full measure description. The essential gist of the measure is that when 3D conformal radiation therapy is utilized, that there are dose limits to normal tissues established for a minimum of two normal tissues. The key change, as you are aware, is the expansion of a diagnosis cohort for patients treated in 2017 to include breast and rectal cancers, in addition to the previously included pancreatic and lung cancers. This expansion in the diagnosis cohort is further defined in the specifications of the measure information form shown on slide 17.

The denominator definition is all patients regardless of age, with a diagnosis of breast, rectal, pancreatic, or lung cancer receiving 3D conformal radiation therapy. We next see the list of the ICD-10 diagnosis codes for breast, rectal, pancreatic, and lung cancer. I reordered them in this title, under the denominator criteria, so that they display in the order that the codes are displayed, which is numerically. So, your rectal codes are contained in the specific codes of a range of C19 through C21.8. The pancreatic codes are in the C25.0 to 25.9 codes. Lung cancer is denoted

by the C34 codes, and then you will see the large number of ICD-10 codes for breast cancer, those ranging from C50.011 through C50.929. Next, we see a big bold, underscored "AND" statement meaning it is patients with one of the aforementioned diagnoses and received 3D conformal radiation therapy. This was shown in the past by a CPT code of 77295 for radiation treatment planning. However, the measure steward has now supplied us with a radiation treatment delivery codes for those of you who have trouble identifying, or even obtaining access to the administration codes. These are CPT 77402, 77407, or 77412. As Lisa mentioned last month, these should look familiar. These are the same codes for EBRT that are used in NQF #1822. Note that you can use either set of codes to identify the patients receiving 3D conformal radiation therapy. Also, as Lisa shared last month, this measure should not be – should not include those patients who receive their radiation therapy via SBRT or SRS. Only those patients receiving 3D conformal radiation therapy should be included. And lastly, you see an "AND NOT" statement. As before, this measure excludes those patients with a diagnosis of metastatic cancer as indicated by the CPT – I'm sorry – by the ICD-10 codes listed on the slide, which are C77.0 through C79.9. We will now look at the numerator criteria on our next slide, slide 18.

The numerator statement is the same as before, patients who have documentation in the medical record that radiation dose limits to normal tissue were established prior to the initiation of a course of 3D conformal radiation for a minimum of two tissues. As before, this information could be obtained through examining the CPT II Codes, CPT 0520F indicating concordance (dose limits were established) and C520F with 8P modifier, indicating that radiation dose limits to normal tissues were not established prior to the initiation of therapy. However, we know from experience that not many, if any, of the PCHs are routinely using CPT II codes. Therefore, the measure information form also allows for clinical abstraction for assessment of the numerator. And also from experience, we know that for many of the PCHs, that this information (the establishment of dose limits) is not in the routine medical record but actually requires accessing the radiation therapy treatment planning

software for the documentation. Slide 19, our next slide, shows the algorithm for the denominator.

You can see that the diagnosis codes are expanded, as in the MIF, to include breast and rectal diagnoses. Also, we have added the CPT codes for radiation therapy administration to be used as an alternative if you're not able to use the radiation therapy treatment planning code to identify your patients. Furthermore, we have flipped the order of the algorithm from last year's. Last year, it started with, start to diagnosis to exclusion due to metastatic disease to patients receiving 3D conformal radiation therapy. This year, it flows from start to diagnosis to receiving 3D conformal radiation therapy and then to the exclusion for metastatic disease. It really does follow the same logic. It just better aligns the algorithm with the denominator definition, which reads "all patients, regardless of age, with a diagnosis who receive 3D conformal radiation therapy." You can see that that exclusion of metastasis disease is never really stated in there. So therefore, the realignment does not change the logic or inclusion criteria, nor should it change your patient population, besides the obvious expansion of a diagnosis cohort. So, in the end, the only thing that changes in this measure is expansion of the diagnosis cohort and the fact that we are now supplying the codes for radiation therapy administration as an alternative to the radiation therapy treatment planning code. Slide 20 shows the numerator portion of the algorithm.

This is unchanged from last year. You see, that from the eligible patient population, or the representative sample, should you choose to sample, that the numerator evaluates of radiation dose limits to normal tissues were established prior to the initiation of 3D conformal radiation for a minimum of two organs/tissues. Concordance, indicated here by the "Yes" arrow from either the presence of CPT II code or via chart extraction results, is being included in the numerator. Non-concordance, indicated by the "No" arrow from, once again, either the CPT II code or chart abstraction results, is not being included in the numerator. So, that ends our review of the changes to NQF #0382. Let's move on two

measures that did not change for patients receiving care in 2017. The pain measures, NQF #0383 and #0384, starting on slide 21.

So, many of you are probably saying, "Well Tom, if they didn't change, why are you taking the time to revisit these?" Well, there are a couple of things I want to emphasize today, based upon data we saw submitted last year and the questions that we continue to receive. As in the past, we will discuss these in reverse numerical order, #0384 before #0383. The reason for this is that #0384 assesses if pain intensity was assessed and quantified. This measure has been paired with NQF #0383 which requires that, if patients report pain and it is quantified, that a documented plan of care to address the pain exists. Here we see the algorithm for the denominator of NQF #0384. Notice the use of the term visit or encounter in the largest diamonds, or decision boxes. This means that each visit or encounter, as I mentioned earlier, that qualifies for the measure should be included in the population. Next we see, regardless of age, as a reminder, this includes pediatrics. We also see, "with a diagnosis of cancer, currently receiving chemotherapy" or, remember that word, or "radiation therapy" in which pain intensity is quantified. So, in the flow chart our first decision box is a diagnosis of cancer. As you know, this is a very long list of ICD-10 codes spelled out in the MIF, unchanged in 2017, for cancer diagnosis. It simply is too expansive to fit on the algorithm. The next step is split, patients receiving chemotherapy OR radiation therapy. Notice this is an "or" statement and not an "and" statement. It is not limited to patients receiving both chemotherapy and radiation therapy. If a patient receives chemotherapy or radiation therapy or even both, they are eligible for inclusion. On the chemotherapy side, patients may have multiple visits for administration. However, the encounter or visit to be assessed is the visit with the practitioner in the clinic to assess them during the chemotherapy. With chemotherapy being defined as, chemotherapy administered less than or equal to 30 days prior to and within 30 days after the encounter. In a similar way, on the radiation therapy side it is not the radiation therapy administration encounter that is reviewed for the assessment of pain but rather the "on treatment visit", where the physician

and or nurse assess the patient who is receiving radiation therapy. On slide 22, we'll move on to the denominator, denominator flow chart.

As with the denominator, the algorithm for #0384 remains unchanged in the numerator. There are two points that I want to emphasize here. First, the assessment of compliance with the numerator in the PCHQR Program can be a two-step process, depending on how your PCH documents pain assessment. The first case is, if you ask an initial screen question similar to, “Are you currently experiencing pain?” and the answer is documented that they are not experiencing pain, then pain was assessed and they are included in the numerator. If they answer, “Yes. I am experiencing pain,” then you must quantify the pain using a standardized instrument. If this is done, they are included in the numerator. So, for those PCHs that ask the screening question, “do you have pain?”, and then use a standardized scale to rate the pain, you would include in the numerator both patients who respond “No” to the screening question and then those with a documented pain of one to ten with a standardized scale in the numerator. Other PCHs use a zero to ten scale for all patients where zero is no pain. In this case the documentation of no pain is indicated by a score of zero and pain, if present, on a scale from one to ten. And this documentation, when present, allows inclusion in the numerator. Therefore, for a PCH who uses a zero to ten scale, all patients who have their pain intensity documented using the standardized scale, a score from zero to ten, are included in the numerator. The second point I want to emphasis here is that only those patients who have pain present AND it is quantified using a standardized instrument, form the patient denominator population for NQF #0383. This is indicated by the blue parallelogram in the algorithm. On our next slide, 23, we'll take a look at the numerator portion of the algorithm for the paired measure NQF #0383.

Once again, the patient denominator population for NQF #0383 are those patients from NQF #0384 who have pain AND the pain intensity is quantified using a standardized instrument. For these patients, you assess if there's a plan of care to address the pain documented during the visit that care is assessed. If a plan is present they are included in the

numerator. If not do not include them in the numerator. So, to recap, NQF #0384 and #0383 remain unchanged for patients receiving care in 2017. However, there were changes to the next measure we're going to look at, #0389, which we'll discuss beginning on slide 24.

Here's the overview of the MIF for NQF #0389, Prostate Cancer: Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients. You can see that this measure is included in a number of different NQF portfolios, including Oncology Care metrics. This is an overuse measure, so it falls into the Domain of Affordable Care. It, like the other OCMs, is a process measure. And, the measure focuses on not conducting a bone scan in low risk cancer patients. This measure is written in an inverse fashion – avoidance of overuse – so that a high score indicates better quality. And lastly, we see that the PCPI, the Physician Consortium of Performance Improvement, is the measure steward. Slide 25 please.

This slide is a screen shot of the description and denominator for NQF #0389. The overall intent of a measure remains the same, that a bone scan to assess metastatic disease is not indicated in patients at low risk of recurrence for prostate cancer. However, for 2017, there are a few changes I want to highlight for you. The first, it's interesting that the measure title remains the same – staging low risk prostate cancer patients. However, we see that the description is now expanded to include patients at low or very risk of recurrence. So, we're going to dive into that distinction a bit on the next, more, a bit more on our next slide. A second change that you need to be aware of is that, while the measure does not change but it still includes patients receiving therapy to the prostate via brachytherapy or EBRT or prostatectomy or cryotherapy – the CPT codes are slightly different for 2017. There are two new brachytherapy CPT codes, 77772 and 77799, that have been added to the list. So on slide 26, let's take a closer look at the definitions.

The external beam radiotherapy definitions from the bottom stay the same. However, as Lisa reviewed last month, there have been two modifications for the definition of low-risk of reoccurrence. The first is that the PSA requirement is now a PSA of less than ten nanograms/ml instead of less

than or equal to ten nanograms/ml. The second is that the clinical stage is expanded to now include patients with T1 to T2a cancer, while it was T1c or T2a last year. Therefore, this measure now includes those patients who meet the PSA and Gleason criteria and have a clinical stage of T1a, T1b, T1c, and T2a. Therefore, it is expanded in that low risk now includes T1a and T1b, compared to 2016. The biggest change you see to this measure is the inclusion of patients at very low risk of recurrence. You can see that the first two criteria of PSA less than ten and a Gleason score of six or less are the same as that for low risk. The difference is that the very low risk only includes patients with a clinical stage of T1c. And furthermore, there's three more criteria listed: presence of disease in fewer than three biopsy cores, less than or equal to 50% prostate cancer involvement in any core, and a density of less than or equal to 0.15 ng/ml/cm^3. Therefore, the very low-risk patients are a subset of those included in the low-risk, and in fact only those with stage T1c who meet these three additional criteria. The reason for this is that stage T1c cancer is followed by needle biopsy that was done because of an increase risk. And, the needle biopsy results are needed to answer these three additional criteria. Now, it may seem that this expansion is going to greatly increase your patient population, but remember they also have to be on active treatment such as brachytherapy, prostatectomy, cryotherapy or EBRT. So therefore, all the patients who are in watchful waiting and another non-active treatment statuses are not included in NQF #0389. Slide 27 please.

Here are the numerator criteria for #0389. These remain unchanged from last year. So if the measure is met when a bone scan is not performed - they're in the numerator. If a bone scan was performed they're not in the numerator. However, note that there are two numerator exclusions. One is documentation of a medical reason to perform the scan, say pain, suspicion of a metastatic disease or another medical reason. Or there's a system reason for the scan, most typically the scan was performed in another institution, that the PCH could not control. Now, if you remember back to submitting your population and sampling data for the OCMs last summer, the measures (#0389, and #0390), are unique in that these are the only two with numerator exclusions. For this reason, these two measures

only, #0389 and #0390, may have a population and or sample size that is different from your denominator. By this I mean to say, 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 the denominator that you report. That is why for these measures only your population and or sample size may be different from the denominator that you report. On slide 28, we'll take a look at our last OCM, NQF #0390.

NQF #0390 is Adjuvant Hormonal Therapy for High or Very High Risk prostate cancer patients. The overall intent of the measure, that patients in these risk categories and are treated with EBRT, should receive androgen deprivation therapy, or ADT, remains unchanged. There are a few minor modifications to the overview to share with you. The first is that the NQF portfolio is now only Oncology Metrics. It used to be included in Disparity Sensitive Measures, as well. However, you should note that the target population is still the elderly. And secondly, the measure steward has now changed from the PCPI to the American Urological Association's Education and Research arm or AUAER. Slide 29 please.

This slide shows the description and denominator. The description remains the same, patients – percentage of patients, regardless of age with a diagnosis of prostate cancer at high or very high risk of recurrence receiving EBRT to the prostate who were prescribed adjuvant hormonal therapy, which is a gonadotropin-releasing hormone agonist or antagonist. The denominator statement also remains the same: all patients regardless of age, with a diagnosis of prostate cancer at high or very high risk of recurrence receive EBRT to the prostate as primary therapy; as well as the ICD-10 and CPT codes to define these patients. Slide 30 please.

Slide 30 contains the definitions, which also remain unchanged for NQF #0390. The changes that we reviewed previously to low and very low risk patients don't impact this measure as it only applies to high and very high risk of recurrence. I do want to emphasize in the definition of "prescribed" that it states the following, "patients who are currently receiving medications that follow the treatment plan recommended at an

encounter during the reporting period, even if the prescription for that medication was ordered prior to encounter." The measure clinical recommendation is that this includes neoadjuvant, concurrent, and adjuvant ADT. Therefore, in the MIF, we have included this clarifying information in the definition of prescribed. Also, at this point, I want to share with you a question that was received from a few PCHs after the last webinar regarding the use of chemotherapy, particularly docetaxel, on this patient population. When we review the clinical recommendation statements contained in the MIF, you will see the use of other therapies, including the use of chemotherapy in this patient population. It's important to note that while chemotherapy may be considered a treatment option for some of these high and very high risk patients, it does not change the requirement and intent of this measure; which is that if the primary therapy is external beam radiotherapy to the prostate, the patient should receive androgen deprivation therapy, or ADT. Specifically, related to the use of docetaxel, it is mentioned for high risk patients after the EBRT and while continuing the ADT. And, for the very high risk population, it is mentioned as a potential additional therapy to the EBRT and ADT. Slide 31, shows the numerator portion of the MIF.

This also remains unchanged from 2017. So, performance is met when the ADT is prescribed or administered. Remember, it's included if it was prescribed in the PCH and then administered elsewhere, as long as you have documentation of that. And, with all the OCMs, it can be ascertained by either CPT code or chart abstraction. As with NQF #0389 there are numerator exclusion for this measure as well. The first is a medical performance exclusion, which is applied when there's a medical reason for not prescribing or administering the ADT. This could be a medical contraindication, or when EBRT is used for salvage therapy. The salvage therapy exclusion is interesting, as it also is captured in the denominator statement of all patients regardless of age with a diagnosis of prostate cancer, at high or very high risk of occurrence receiving external beam radiotherapy to the prostate as primary therapy. So really, you can exclude the patient either in the initial patient population selection (as it is not primary therapy) or you can exclude them at this point in a numerator

exclusion (when it's used for salvage therapy). In the end, it doesn't matter, as the impact on the denominator and numerator is the same. The second exclusion is when there is a patient reason, typically refusal of the therapy. So, that concludes our discussion of granular updates to the OCMs. We're going to wrap up this section of the event by looking at NQF #1822 beginning on slide 32.

So ,this screen shot displays the overview portion of MIF for NQF #1822 or PCH 25, External Beam Radiotherapy or EBRT, for bone metastases. The information remains unchanged from 2016. However, there has been much discussion and clarification regarding the interpretation and abstraction of this measure, mostly to ensure alignment between the Outpatient Hospital Quality Reporting Program. And, we will examine this on our next slide 33, and we'll move through and wrap-up on slide 36.

So, on slide 33, we see the description, instructions and denominator statement and criteria for #1822. The most significant change is that while the intent of the measure changes in no way, there are two key changes to the wording to provide clarity and direction. The first is in the measure description, the word painful has been removed. It now reads, "with a diagnosis of bone metastases." The reason for this is that the ICD-10 codes only document bone mets. There's no requirement that the mets be painful, although most are, and therefore the word painful has been removed. The second change is that we have added a denominator statement to the MIF for NQF #1822 to be consistent with the MIFs for the Oncology Care Measures and that for the Outpatient Hospital Quality Reporting Program. This statement is, "All patients with bone mets and no previous radiation to the same anatomic site who receive EBRT for the treatment of bone metastases." There it is again. This is an emphasis on patients receiving the EBRT for bone metastases. We know that many patients who have bone mets present, may be receiving EBRT for reasons other than the bone mets. NQF #1822 is only assessing the appropriateness of the dosing schema for the treatment of bone mets. Furthermore, we provide some further granularity in the instructions. These are messages you've heard before. First of all, all encounters that

result from a single treatment plan should be considered as one case; so, 30 fractions to a lesion on the ulna is one case. On the other side, EBRT administered to bone mets at different anatomic sites, say the clavicle and a femur, should be considered different cases. And, if the EBRT was initiated but not completed, the case should still be included, as you're assessing what was prescribed. The exclusion of non-bone met treatment is further emphasized on the following slide, slide 34.

Here you can see that we've added a specific exclusion criterion, when the EBRT is used to treat anything other than bone mets. That's always been the intent of the measure, we've just now provided the specific exclusion step. Patients who receive previous radiation to the same anatomic site continue to be excluded, as well as those who have the EBRT delivered by SRS or SBRT, and those who are currently enrolled in a clinical trial involving the use of radiation therapy. The next three exclusions are the same as before, but we've added clarification. So, for the exclusion due to femoral access cortical involvement, previous surgical stabilization and spinal cord comprehension, cauda equina compression, or radicular pain the exclusion only applies when the EBRT being assessed is being delivered to a site involving this exclusion. For example, if a patient had a previous knee replacement, this has no bearing upon the EBRT, they may receive to a bone mets on their arm. Slide 35 please.

This is the numerator and the acceptable dosing fractionation schemes remain the same. We note there has been discussion about a general trend toward using fewer fractions and the use of hypofractionation schemes, but at this time the NQF endorsed metric, as well as position of the measure steward, ASTRO, are that only these four schema are the approved ones for concordance with the measure. Providers and PCHs are welcome to have provide input on other acceptable fractionation schemes to the measure steward, their professional societies and throughout the CMS rule making process. Slide 36, shows the newly updated algorithm.

Now, I know this is really small and hard to read, but we've covered all this in the previous slides. The changes are first of all the algorithm reads from left to right. And then, it starts out with the CPT and ICD-10 codes,

works through the exclusion steps we talked about and then at the bottom you include in the denominator. For those patients who did not have an exclusion criterion apply the sampling criteria, as you wish, if you wish, and then assess was the fractionation schemes appropriate. The big change here is I want to emphasize is in the upper right hand side. The Abstraction Table only has the ICD-10 codes for the bone mets and for the radiation therapy delivery. Please do not use any other codes, such as those for spinal cord compression, surgical stabilization, cauda equina compression, etcetera, because you'll inadvertently exclude patients from the measure that should not be excluded. So, that wraps up our presentation on EBRT. Let's move onto slide 37.

And, we're going to conclude today's event as always by reviewing important upcoming dates for the PCHQR Program beginning on slide 38.

So, our upcoming events and webinars: we've talked about the March 23 being the Web-Based Data Collection Tool. Then in April, you'll see the Proposed Rule book-ended in August by the Final Rule. So, be sure you participate in the rule making process as we discussed many times. During May, June, and July, we will have best practice presentations. Next slide please.

As far as important upcoming dates February 24 and March 15 are the submission deadlines, which were extended for the CST and HAI data. I'm happy to tell you that, as of yesterday afternoon, I have reassurance from analytics that all PCHs have reported all their data, so great job there. On April 5, we have Quarter four 2016 HCAHPS data and in May we have the CST and HAI data that's listed on the slide. Remember that this is the first time that you'll be reporting the HCP influenza vaccination data. And this will be your first use of the Web-Based Data Collection tool. Slide 40, please Jamie.

And, here we see our upcoming dates for Public Reporting. The April 2017 Refresh is now slated for April 26. As always, we'll send out a ListServe for that. For the July Refresh, we've submitted your data for the Cancer-Specific Treatment measures; and actually, it didn't say on the

slide, but for the EBRT measure as well. And then, you can see that the Preview Period is slated for April 6 through the 12. And, anticipated refreshing on July 26. And once again, these are always subject to change, and we'll be sure to send ListServes, as we get closer to having these firmed up. So, I've gone a little bit long on my time today, so Deb I'm going to turn it over to you for a brief look at the CEs, and then I'll wrap up with a few closing comments. Deb?

Deb Price: Hi. Thank you very much Tom and now I'm just going to talk for just a brief couple minutes here. Today's webinar has been approved for one continuing education credit by the boards listed on this slide.

We are now an online CE certificate, we now have an online CE certificate process where you can receive your certificate either by staying on the line now and finishing your survey or within the next 48 hours we will be sending around an additional survey.

And, if you do not immediately receive a response to the email that you will be seeing at the end, at the end of these slides, that means that there's something wrong with your computer or the link is wrong. We ask that you go back to the new user link that you will be sent tomorrow or within 48 hours and re-register.

This is what the survey will look like and then the bottom right hand corner, you see the done button. So, when you have finished, please click done button and then…

…this page opens. This page will have two links on it. The first one is the new user link; and, if you've had any issues with getting your credit, please click the new user link. If you have not had any problems, click the existing user link.

This is where you will go with the new user link. You have the first, last name, and we ask that you put your personal email, and a personal phone number here.

And, this is what the existing user page takes you to. Your user name is your complete email address, including what is following the @ sign and, if your forgot your password, please just click into the password box and that will take you to set up a new password. And now, I'd like to turn the webinar back to Tom to finish the event. Tom?

Tom Ross: Thanks, Deb. Once again, I'd like to thank everyone for your participation today. Please be sure you look for the Web-Based Data Collection Tool webinar during March. There is going to be a lot of technical steps in there. We'll get a little bit more clinical when we get into the Proposed Rule and then the best practices, so I know you'll all enjoy that. As always, I'd like to thank you for the exemplary care that you provide to your patients and the friendships that we have and professional interactions. And lastly, I'd like to let you know that you're going to be meeting a new person in the next couple of weeks, named Sharon McNaull, who'll be coming alongside Lisa and I, and helping out with the PCHQR Program. So, thanks for all that you do and have a great day. Bye, bye.

END