PPS-Exempt Cancer Hospitals Quality Reporting (PCHQR) Program

Support Contractor

PCHQR Program:
2017 Update to Measures

Presentation Transcript

Moderator/Speaker:
Lisa Vinson, BS, BSN, RN
Project Manager, PCHQR Program
Hospital Inpatient Value, Incentives, and Quality Reporting (VIQR)
Outreach and Education Support Contractor (SC)

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Lisa Vinson: Good afternoon. We would like to welcome everyone to today's webinar entitled, PCHQR Program 2017 Update to Measures. Today's presentation was developed by Tom Ross, PPS-Exempt Cancer Hospital Quality Reporting, or PCHQR, Program Lead, Hospital Inpatient Value, Incentives, and Quality Reporting, Outreach and Education Support Contractor; and myself, Lisa Vinson, Project Manager for the Hospital Inpatient VIQR Outreach and Education Support Contractor. Today, I will be presenting this Outreach and Education event to you. This webinar is part of the series for the PPS-Exempt Cancer Hospitals, or PCHs, participating in the PCHQR Program. As the title indicates, today, we'll be reviewing updates to the PCHQR Quality Reporting Program effective for calendar year 2017. Please note that during this presentation, we will only be discussing topics pertaining to the PCHQR Program. So, while you are welcome to participate, if you are associated with any other CMS Program, you will probably find that your time is better spent on other activities. Additionally, if you are not a participant in the PPS-Exempt Cancer Hospital Quality Reporting Program, and you have some of the same or similar measures in the quality Program in which you participate, it is extremely important that you refer to a material specific to your Program. If you have questions regarding the measures in your Program, please reach out to your Program-specific Support Contractor. For those participants in the PCHQR Program, if you have questions about the content of today's presentation, please submit them using the chat function. As time allows, our presenters will address these during today's event. If time did not allow all questions to be answered during today's event, remember that the slides, recording, transcript. and questions and answers will be posted following today's event on *Quality Reporting Center* and *QualityNet*. Also, if you're registered for this event in advance, you should have received ListServe communications previously. The second of these, received yesterday, had a link to QualityReportingCenter.com. On this website, the slides that we will be reviewing during today's presentation are available should you wish to print a hard copy for these during today's event or to retain for future reference. On slide six, let's take a look at some of the acronyms and abbreviations that will be used in today's event.

As always, we supply this list of acronyms and abbreviations to help today's slides to be more readable, and also to serve as a reference for those of you who may be new to the PCHQR Program. Some of the key abbreviations that we will use today include AJCC, the American Joint Commission on Cancer - the main group that publishes cancer staging guidelines; ACS for the American College of Surgeons; EBRT, or eeh-bert, for External Beam Radiotherapy for Bone Metastases, also referred by its NQF standard #1822; Fxns and Gy, for fractions and gray, terms used in dosing EBRT; OCM, Oncology Care Measures – the six [error – actually five] clinical process measures related to cancer care. We will spend significant time today looking at these five measures. PSA, Prostate Specific Antigen, a lab result used in staging cancer for two of the Oncology Care Measures, NQF #389 and #390; and SBRT and SRS, Stereotactic Body Radiation Therapy and Stereotactic Radiosurgery, targeted forms of EBRT. On slide number seven, we will review the purpose or overreaching goal of this Outreach and Education event.

As we related last month, on an annual basis, CMS publishes a new Final Rule for the Inpatient Prospective Payment System/Long-Term Care Hospital Rule. The rules impacting the PCHQR Program are embedded in this document, which was last published in August 2016 for Fiscal Year 2017. During today's event, we will provide an overview of the changes in the measure specifications impacting the PCHQR Program that are effective for Calendar Year 2017. This is information that you, as participants, need to know in order to accurately abstract the measures that you are required to report for this Program. As you will see, the majority of these changes impact two sets of measures, both sets of process quality indicators. The first are updates to the five Oncology Care Measures or OCMs. The second are updates to the Clinical Effective Measure, EBRT, or NQF #1822. Slide number eight, our next slide, contains the specific objectives to today's presentation.

There are three main objectives to today's program. Our goal is that upon listening and participating in today's event that participants in the PCHQR Program will be able to locate the source documentation for the significant specification changes. This is especially important given the new location of the measure specifications upon which these measures are based. Explain the

rationale for the new measure specifications – why have they been updated? – and apply the updated specifications to accurately abstract the impacted measures. As with any educational program, our goal is not merely to educate but to change behavior; in this case, helping you to more accurately and efficiently determine your performance data. On our next three slides, slide nine through 11, we will briefly review measures that are in place for the PCHQR Program for program year 2019. As a hint, we will be discussing the relationship between Calendar and Program year in more detail in a few slides.

Here, we see the six metrics in the Safety and Healthcare-Associated Infection domain, CLABSI, CAUTI, SSI for colon and abdominal hysterectomy surgeries, CDI, MRSA, and the influenza vaccination for healthcare personnel. All of the participants in the Program have been actively reporting the first five of these measures. The CLABSI and CAUTI data were part of the initial set of five measures for the Program. Then, the Surgical Site Infections for both colon surgery and abdominal hysterectomies were added. Then, beginning in August of this past year, the PPS-Exempt Cancer Hospitals began reporting the CDI and MRSA measures starting with events of January 1, 2016. Lastly, this May, the PCHs will be reporting on the current influenza season, October 1, 2016, through March 31, 2017. The measure specifications and data entry system for these measures are developed and maintained by the CDC and their National Healthcare Safety Network or NHSN. NHSN submits the data you enter into their system to CMS. Next slide, slide 10, please.

This slide is a continuation of the previous slide. Here, we see listed the three Cancer-Specific Treatment, or CST, measures and the five Oncology Care Measures or OCMs. The three CSTs, like CLABSI and CAUTI, were part of the original measure set mandated for the PCHQR Program. There are no substantive changes to these measures. There was, in the Final Rule, some clarification regarding NQF #559, Combination Chemotherapy is Considered or Administered Within 4 Months or 120 days of Diagnosis for Women Under 70 with AJCC T1cN0M0, or Stage 1B-III Hormone Receptor Negative Breast Cancer. As we report when reviewing this Final Rule last August, this update

in the AJCC staging to include patients with AJCC T1cN0M0 or stage 1B-III Hormone Receptor Negative Breast Cancer does not reflect the change in the measure inclusion criteria, but rather is reflective of an update in the AJCC staging. There are a number of updates to the five Oncology Care Measures, most significantly the expansion of a diagnosis cohort for NQF #382, Radiation Dose Limits to Normal Tissues. This expansion of the diagnosis cohort was detailed extensively in the Fiscal Year 2017 Final Rule and is due to high prevalence of breast and rectal cancers in our country. We will spend much more time on these changes later in today's event, so please hold any specific questions you have on these measures until we've had a chance to cover this material, as I think you will find, hopefully, that Tom and I address many of the questions that you may have. Next slide, please, slide 11.

Here, we see the HCAHPS measure, EBRT, and the new Claims-Based Measure, Admissions and Emergency Department (ED) Visits for Patients Receiving Outpatient Chemotherapy. For any granular questions related to HCAHPS, we do ask you refer to the HCAHPS Support Contractor. Many of the PCHs have been asked for additional information regarding the new outpatient chemotherapy. We will be working with the measure developer who will be conducting a National Provider Call, to get more specifics to you pertaining to this measure. And, this leaves us with NQF #1822, or EBRT. While there are no "measure specification changes" to this measure, there are a number of clarifications and guidance tips in abstracting this measure that we wish to communicate to you today. These clarifications are the result of extensive collaborative work between CMS, the Support Contractor for the Hospital Outpatient Quality Reporting Program Support Contractor, the measure steward, ASTRO, and our Program. The goal of these efforts is to help ensure that NQF #1822 is abstracted consistently across both Programs. Next slide, slide 12, please.

Recently, we received a very good question. “I saw in the Final Rule for Fiscal Year 2017 that starting with Program Year 2019 the diagnosis cohort for NQF #382 has been expanded to include patients with rectal and breast cancer. So, since Fiscal Year 2019 starts on October 1, 2018, we should start with patients being treated as of October 1, 2018, correct?” An excellent

question, but the answer this questioner arrived at is incorrect. The inclusion of these new diagnosis cohorts will actually start on January 1, 2017. So, how can that be? To understand this, you have to understand the relationship between the Fiscal, or Program Year, and the Calendar Year. To begin with, think of Fiscal and Program Year as the same. And, the CMS Fiscal Year does start on October 1 of the previous year. So indeed, Fiscal or Program Year 2019 starts on October 1, 2018. However, to understand the relationship between the Calendar Year and Program Year, you have to think about how all of this data performance in payment tied together for those programs with a link between pay for reporting via their Annual Payment Update in Value-Based Purchasing. Even though the PCHQR Program does not have a link between the payment and reporting, the same concepts of timing apply. Think of a new measure in a Program added for Fiscal or Program Year 2019. That is the Fiscal Year that they are being reimbursed during. In order for them to gather the data, report it, and all of the necessary calculations to occur that will apply in Fiscal Year 2019, the data has to come from the earlier timeframe. Most of the time, there is a two-year difference between the actual performance and the data, which is reported and the application to the Program or Fiscal Year. So, to go back to our question that was received, the expansion of the diagnosis cohort of NQF #382 does indeed apply to Program Year 2019. However, upon reading the Final Rule in detail, we find that the performance period starts for this measure with patients being treated January 1, 2017. Specific to the PCH Program and the Oncology Care Measures, the data is reported once per year, in the following August. So, the care provided in Calendar Year 2017 is reported in August 2018 and applies to the Program Year 2019. This can, as our friend Henrietta always said, get you talking in circles. So to help, we offer two ideas. First of all, for the current measures in the PCHQR Program, the three Cancer-Specific treatment measures, CLABSIs and CAUTI, the original five measures for the program, apply to one Program Year later. For the CSTs, this means that patients diagnosed in 2016 will be applied to Program Year 2017. Those diagnosed in 2017 will be applied to Program Year 2018. In the same way, CLABSIs and CAUTI events in Calendar Year 2016 will apply to Program Year 2017. You can see this illustrated in the data table on the bottom left end of slide. For all of the other current measures in the PCHQR Program, there is a two-year difference

between performance and Program Year. As you can see on the slide, on the lower right side, the OCM performance for 2016, reported in 2017, applies to Program Year 2018. And, performance during Calendar Year 2017 is reported in 2018, and applies to Program Year 2019. The best way to visualize this is to refer to the Relationship Matrix from which the above screenshots were taken, and is available on *QualityNet* and *Quality Reporting Center*. You will need this information, what Calendar Year performance appears in which Program Year, in order to know where to find your hospital's performance on the PPS-Exempt Cancer Hospital Quality Reports. So, with this important point behind, let's move on to how to find the new PQRS measure specifications, upon which the tool for abstracting the Oncology Care Measures are based, starting on slide 13.

As you may know, the Oncology Care Measures in the PCHQR Program are derived from measures that have been part of the Physician Quality Reporting System or PQRS. So, each year, we would assess the CMS webpage for the PQRS measures, look for the new PQRS standards that were used in the PCHQR Program and update our tools. However, this year, Tom and I were looking and looking for these updates and could not find them on the PQRS page. The reason for this is that as a result of the MACRA, or Medicare Access and CHIP Reauthorization Act of 2015, the PQRS measures have migrated to a new location shown on this slide, qpp.cms.gov. A full discussion and review of the Quality Payment Program is beyond the scope of this presentation, but you may be interested in visiting this site and learning more. At its core, the goals of the Quality Payment Program are to improve Medicare by helping you providers focus on care quality and the one thing that matters most, making patients healthier. The Medicare Access and CHIP Reauthorization Act of 2015, MACRA, ended the Sustainable Growth Rate formula. Providers may choose how you want to participate in this Program based on their practice size, specialty, location, or patient population. There are two tracks that they can choose from, Advanced Alternative Payment Models, APMs, or the Merit-Based Incentive Payment System, MIPS. In the MIPS program, one of the dimensions assessed to determine payment adjustment is quality. This quality component of the MIPS program replaces the previous PQRS Program, and this is where you will now find the measure

specifications for the OCMs. To find the specifications, go to the URL listed on the slide, (https://qpp.cms.gov/). Then, circled in red on the slide, click on "Education and Tools". This will take you to the screen shown in our next slide, slide 14.

This webpage contains a lot of excellent information about the Quality Payment Program, including the official rule, the MACRA legislation, and the number of documents – such as overview, fact sheets, and other aids to help those participating in the Quality Payment Program. Specific to OCMs, you will want to scroll down on this page, as indicated by the red arrow on this slide, to get to the section displayed on our next slide, slide 15.

Here, you see, contained within the red box, the Quality Measure Specifications. This is a large, almost 250-megabyte ZIP file, that you can download and open. Doing this will result in the view that you'd see on our next slide, slide number 16.

There will be two ZIP files that you will see. To access the PQRS measure standards, you will want to open the first one, "Claims-Registry-Measures.zip". This is shown in the top figure on this slide. When you open the ZIP file, as indicated by the red arrow on the screen, you will see 318 files in PDF format. These are all the measure specifications for the previous PQRS, now Quality Payment Program Quality Measures. There are options for those registry and claims reporting, which are two of the options available for participants in the Quality Payment Program. The measure specifications are essentially the same, just varying in terminology used on where the data is obtained. And for the purpose of obtaining the information for the PCHQR Program Oncology Care Measures, we will refer to the claims option. Now, 318 files are a lot to wade through. There are a couple ways to find the specifications for the five OCMs used in the PCHQR Program. However, as your Support Contractor, we have prepared a cross reference table shown on our next slide, slide number 17, to help you rapidly find the measure specs pertaining to the PCHQR Program.

William Shakespeare wrote in Romeo and Juliet that, "A rose by any other name would smell as sweet." By this, of course, he meant that what matters is

what something is, not what it is called. In the same way, you will see multiple numbers associated with the measures in the PCHQR Program. For example, let's think about one of the measures that the PCHQR Program refers to as the Cancer-Specific Treatment measures. The official name of one of the measures is, "Adjuvant Chemotherapy is Considered or Administered Within Four Months or 120 Days of Diagnosis to Patients Under the Age of 80 with AJCC III Lymph Node Positive Colon Cancer." Note, that even within this full descriptive name, there is a sort of code, the use of the term AJCC III, which is shorthand for a group of diagnoses dependent upon the T, N, and M status. Within the Program, we oftentimes refer to this measure, particularly when reporting data via external files as the "chemo colon measure." Also within the PCHQR Program, each measure has a PCH number. In the case of the colon chemo measure, it is PCH-1. And, as the measure was endorsed by the National Quality Forum, it also has an NQF number, NQF #223. And lastly, our colleagues in the registry refer to this measure as A-C-T, or ACT. So, to help you find the measure specs for the OCMs on the QPP website, we have provided the table on this slide. By referring to the PQRS measure numbers, you should be able to easily find the PDF documents containing the specifications for the OCMs. Now that you know where to find the measure specifications, should you so wish, we will advance to our next slide, slide number 18.

As promised, the majority of today's event will focus on the significant changes to the PCHQR measures impacting your data abstraction in Calendar Year 2017. Today, we will review these changes to the Oncology Care Measures and also provide clarification on abstracting the EBRT measure. As previously discussed, at this time, there are no real substantive changes to the HAI, CST, and HCAHPS measures that will impact your data abstraction this year. During the next couple of weeks, we will be updating the measure information forms and algorithms for these tools. And, this will be the majority of our content for the next month's Outreach and Education event. With that as a background, let's move on to slide 19 and look at some general rules to keep in mind as you begin your data collection for the care provided to your patients in Calendar Year 2017.

One of the unique characteristics of the measures in the PCHQR Program is that there are different ways to identify which dates to use when identifying which patients to include in which quarter's data. For example, the CST measures are based upon the day of diagnosis. For the OCM and EBRT measures, you will select patients for inclusion in your patient population for the data collection period based upon the day that the treatment is delivered or the date of the patient encounter. Note that for the pain measures, NQF #383 and #384, patients may have multiple encounters within one data collection period, and all of the encounters are eligible for inclusion in the population. For other measures, NQF #382, #389, #390, and #1822, patients should only be included once per quarter. Also, for those measures, where there may be multiple dates associated with one episode of treatment, such as multiple administrations of radiation therapy for NQF #382, Radiation Dose Limits and NQF 1822, #EBRT, you should use the first date of treatment during this course of therapy. If you have a patient who begins treatment in one quarter, say, on March 29, and it continues into the next quarter, say it concludes April 20, you should include the case only once in the quarter during which the first date of treatment occurred. A second point to emphasize with all of these measures is that you should be sure to use the tool specific to the Calendar Year that you are abstracting. We have removed the 2015 tools from the *QualityNet* website as this data has already been reported for the OCMs and EBRT. For the treatments delivered during Calendar Year 2016, you should use the tools currently on *QualityNet* and labelled "2016". And, as promised earlier, in the next month or so, we will have the tools for Calendar Year 2017 soon developed and posted for your use for the care delivered to patients in Calendar Year 2017. With these overall concepts in mind, we will look at each of the measures starting with slide number 20. Next slide, please.

NQF #382, Radiation Dose Limits to Normal Tissues. This measure has been in place since January 1, 2015, for the Program. In its original form the measure addressed patients with a diagnosis of pancreatic or lung cancer. This is true through the care provided through December 31, 2016. Also, note that the measure description contains the phrase, receiving 3D conformal radiation therapy. We recently had an excellent question pertaining to this measure. Should this include patients who receive their radiation therapy via

SBRT or SRS? And, the answer is no. Only those patients receiving 3D conformal radiation therapy should be included. We have clarified this with the measure steward, ASTRO, and they have supplied the CPT codes for 3D conformal therapy. Yes, they should look familiar as they are the same codes used for EBRT. And, we will include this in our update to the materials. And lastly, the measure continues to exclude those unfortunate patients with a diagnosis of metastatic cancer. What is new for Calendar Year 2017 is that per the Fiscal Year 2019 Final Rule, the diagnosis cohort is expanded to include patients with breast and rectal cancer. As previously related, this expansion in the eligible diagnoses begins with patients receiving treatment starting January 1, 2017. Next slide, please.

Here, you see the expanded ICD-10 codes to be used in identifying the eligible patients for NQF #382. These are select diagnosis codes for rectal and breast cancer. Please note, that in conversations with a couple of PCHs, you may see a large jump in the eligible patient population for NQF #382 as a result of these new codes, especially within the breast cancer population. However, remember to apply the sampling guidelines, so this increase in potential data burden should be limited. On our next slide, slide 22, we will briefly look at the updates to the pain measures currently in place for the PCHQR Program.

The reason that this is a brief look is that there are no updates to the measures or codes required for abstraction for Calendar Year 2017 encounters. However, remember that a patient may have more than one eligible encounter in a quarter. For example, a patient receiving chemotherapy may have several office visits with their medical oncology team, and each of these is eligible to be included in the population. In the same way, a patient receiving radiation therapy for 30 fractions may be seen at least six times for a radiation treatment management encounter. And, some patients may be receiving chemotherapy and radiation therapy in the same time frame. At each of these face-to-face non-treatment episodes, pain intensity should be assessed, and if pain is present, a plan to address it documented. However, once again, while this population may be extremely large for many of you, remember that sampling is allowed. If you have specific questions regarding the sampling and possible

oversampling, please refer to the prior Outreach and Education events for the Program that have addressed these topics and are archived on *QualityReportingCenter* and *QualityNet*. On our next slide, slide 23, we will begin to look at the OCM in prostate measures.

The first OCM prostate measure we will a visit is NQF #389, or Avoidance of Overuse of Bone Scan for Staging Low-Risk prostate cancer patients. What remains the same? First of all, it continues to include patients with a low risk of recurrence of prostate cancer. Additionally, it includes those patients who receive therapy to the prostate via brachytherapy, EBRT, via prostatectomy, or cryotherapy. Remember, these are "or" statements. The patient only had to receive one of these therapies to be eligible. What is new? The eligible population for this measure now includes patients not only at low risk of recurrence, but additionally those at a very low risk of recurrence. The standards now contain new parameters, or definitions, of low risk of recurrence in addition to now adding the criteria for very low risk of recurrence. On slide 24, we will take a look at these new parameters.

Low risk of recurrence is now defined as a PSA less than 10 nanograms per milliliter. This used to be, prior to 2017, less than or equal to 10 nanograms per milliliter. And the Gleason score, six or less, remains the same. And, the clinical stage has been expanded to include stage T1 to T2a while previously it was limited to T1c and T2a. Next, let's look at the parameters for very low risk of recurrence. The PSA and Gleason score criteria are the same as low risk. However, only those patients with a stage of T1c who also have presence of disease in fewer than three biopsy cores, and less than or equal to 50 percent prostate cancer involvement in any core, and have a PSA density of less than or equal to 0.15 nanograms per milliliter per centimeters cubed are included in the category of very low risk of recurrence. If we step back and look at this, the very low risk is a subset of those at low risk. And, as a diagnosis via needle biopsy that was conducted because of an increased PSA is what determines the staging as T1c, this is even a further subset of those patients who were previously designated as low risk. And, if you think about it even more, the criteria to meet the definition of very low risk, all dependent upon biopsy results, limit this population to stage T1c, those patients who've

had a needle biopsy of the prostate. So, the real changes are the expansion of low risk to include stage T1 to T2a instead of just T1c to T2a, the change for the PSA to now be less than 10, and the definition of a subset population, those at very low risk. Keep in mind that while patients at low and very low risk of recurrence are now initially included in the patient population, there are still additional criteria; therapy to the prostate via brachytherapy, EBRT, via prostatectomy, or cryotherapy to be eligible for this measure. We will now move to slide 25 to look at the other OCM prostate measure.

NQF #390 is the prostate measure addressing Adjuvant Hormonal Therapy for High Risk prostate cancer patients. The clinical intent of the standard, that patients at high or very high risk of recurrence who receive external beam radiotherapy to the prostate should receive adjuvant hormonal therapy, or androgen deprivation therapy, ADT, remains unchanged. The measure codes also remain unchanged. Note, while this is not new, that patients who meet the criteria for intermediate or high risk of recurrence maybe shifted to the next highest category of risk if they have multiple adverse factors. As with NQF #389, these measure specs contain the new definitions of low and very low risk of recurrence, which we just reviewed. These changes do not impact the patient population for NQF #390 as it addresses patients only at a high or very high risk of recurrence. Lastly, there is some expansion to a rationale and clinical recommendation statement that we will touch on in our next slide.

As related on the previous slide, the basic intent of this measure remains the same. Patients at high or very high risk of recurrence who receive external beam radiotherapy to the prostate should receive adjuvant hormonal therapy. However, the new measure specifications include more robust language supporting this guideline. The first is that several large studies have demonstrated that men who receive adjuvant hormonal therapy following the external beam radiation therapy can live longer and have a lower risk of recurrence than men who receive radiation therapy alone. Furthermore, a cost analysis conducted found that the use of adjuvant hormonal therapy and external beam radiation therapy is cost effective and adds quality-adjusted life years for patients. Lastly, while the utilization of adjuvant hormonal therapy and external beam radiation therapy for high risk patients has increased to 80

percent throughout the past two decades, utilization rates have plateaued since 2000. These facts have led to a rising concern about under-treatment of high risk prostate cancer patients, and this suggests greater outreach and education are needed to improve outcomes in care. In the section on clinical rationale statements, the following changes are noted. The first is that the androgen deprivation therapy, or ADT, may be neoadjuvant (given before), concurrent (given with), or adjuvant (given after) the EBRT to the prostate. It is our understanding that the PCHs have been abstracting this way since the inception of the measure. Secondly, these standards now note that a subset of this population may benefit from the administration of chemotherapy, with docetaxel being specifically mentioned. That concludes our discussion on the OCMs. So, let's move to our old friend EBRT, or NQF #1822, on slide 27.

The great news is that nothing substantive has changed with EBRT since the September 22, 2016, event that we presented to you. However, as you may be aware, NQF #1822 is also used in the Hospital Outpatient Quality Reporting Program. Many of the providers in this Program use vendors to help identify their patient population, and even those who don't are in general less familiar with the delivery of cancer cares than the PCHs are. Therefore, a number of clarifications have been developed and provided in their measure information forms that are consistent with the information that we communicated to you in the September event. As CMS desires to have the measure extracted consistently across the Programs, we will take a few moments to review and reinforce these lessons here, and we'll update the MIF and algorithms to reflect these clarifications as well. Slide 28, please.

NQF #1822 or EBRT should only be applied to those cases when EBRT is used to treat a metastatic bone lesion, or lesions. As you are aware, a patient with an active diagnosis of bone metastases who receives EBRT, no matter the treatment site of the EBRT, will be captured via review of the codes. Non-bone lesions treated with EBRT, say, a liver lesion or brain met, should not be included in the population for this measure; and therefore, we are adding a specific exclusion step for these instances. The exclusions for femoral axis cortical involvement, previous surgical stabilization, and spinal cord or cauda equina compression are still true. What is changing is simply

the wording that these exclusions only apply if the EBRT is to the affected site. For example, a patient with EBRT to the clavicle for a bone met is not excluded if they have femoral axis cortical involvement. Similarly, if a patient had a knee replacement and the EBRT is to a bone lesion on the ulna, this is not an exclusion. All encounters from a single treatment plan should be considered as one case. If the patient received 30 gray over 10 fractions to a bone met, this is one case, even if multiple episodes from this ten dose therapy are captured from the coding data. Remember, you are evaluating the treatment plan, not the delivery. Also, if the patient received EBRT to more than one metastatic bone lesion, each should be considered a separate case. If the EBRT is initiated but not completed, you should still include the case. You are evaluating what was prescribed. As the patients are identified using the codes for the administration of EBRT, the exclusions for patient reasons, or refusal, have been eliminated. And lastly, do not use any code for identifying patients for exclusion from this measure. This may inappropriately remove patients. For example, those who have been in EBRT to a lesion on a rib, who also have received SRS to a brain met, or have cord compression, that does not involve the lesion being treated by EBRT. Only use the ICD-10 codes for bone metastases and the CPT codes for the administration of EBRT when identifying patients for inclusion for this measure. The exclusions can only be appropriately identified via chart abstraction. Next slide, please, slide 29.

That concludes our review of the measure updates for 2017. We will now spend a couple of minutes looking at upcoming events and key dates for the PCHQR Program. Slide 30, please.

Here, you can see our upcoming webinars for the PCHQR Program. As mentioned previously, the February event will be a review of the measure information forms and algorithms developed from the concepts introduced to you today. These should be a great help to you in abstracting the data for 2017. In March, we will have a very important webinar on how to use the Web-Based Data Collection Tool. This will allow you to enter your data for the CSTs, OCMs, and EBRT directly into *QualityNet*, and you will no longer have to use the external file submission process. April will be a presentation

on the Proposed Rule impacting the Program, while August is currently slated to review the Final Rule. Lastly, we will be reaching out to you, the PCHs, to identify best practices to share with the others, particularly those which may impact the outcomes associated with the new Claims-Based Measure. Slide 31, please.

Here, we see the upcoming data submissions associated with the submission of data to the Hospital Quality Reporting Program. You have all received ListServes and targeted emails concerning the upcoming February 15, 2017, data submission deadline. We will be submitting our CST data via external file. The CDC will be submitting the HAI data you have entered into the NHSN system. A couple PCHs have already submitted their CST data files. Thank you. In April, your vendors will be submitting your quarter four 2016 HCAHPS data. Then in May, we will have another submission of the HAI and CST data. Note that the CSTs will be submitted for the first time using the Web-Based Data Collection Tool at this time, so do not miss the March webinar on how to use this tool. Also, note that this will be the first time of reporting the HCP influenza vaccination data, so be sure that this data is entered into the NHSN system.

Here, we see the upcoming dates associated with Public Reporting and the display of the PCH data on *Hospital Compare*. The April Preview Period is currently open and closes on February 7. If you have not yet run your Preview Reports, please be sure to do so. It is anticipated that this data would be refreshed on April 12. As for the July 2017 Refresh of *Hospital Compare*, we, as the Support Contractor, will be submitting the data test and production files during February. The Preview Period for this Refresh is scheduled for April 6 through May 12 and the Refresh date is tentatively scheduled for July 12. Remember that these dates are always subject to change. As they become firm, we will always communicate the Preview Periods and Refresh dates via ListServe. Well, that concludes this portion of my presentation. At this time, I will turn the presentation over to Deb Price to review the CE information. Deb?

Deb Price: Well, thank you very much. Today's webinar has been approved for one continuing education 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 register through 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 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 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 events and will be sent to all attendees within 48 hours. Click Done at the bottom of the page when you're 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'll 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 slide 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: Thanks, Deb. We would like to thank you for your time and participation in today's program, 2017 Update to Measures. We hope that you find this information beneficial as a participant in the PCHQR Program. Again, thank you and have a nice day.

END