PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program

Support Contractor

PCHQR Program: A Year in Review and a Look Ahead

Presentation Transcript

Moderator/Speaker

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Lisa Vinson: Good afternoon. Welcome and thank you for joining today's webinar, entitled *PCHQR Program: A Year in Review and a Look Ahead*. My name is Lisa Vinson, and I serve as the Program Lead for the PPS-Exempt Cancer Hospital Quality Reporting, or PCHQR, Program with the Hospital Inpatient Value, Incentives, and Quality Reporting, or VIQR, Support Contractor. I will be your speaker for today's event. As the title suggests, I will be reviewing PCHQR Program events, updates, and changes that have occurred this year. And then, we will take a look ahead to what's to come for Calendar Year 2018.

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If you have questions about the content of today's presentation, please submit them using the chat function. As time allows, I will address these during today's event. If time does 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 presentation on *Quality Reporting Center* and *QualityNet*. Also, if you 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 use during today's event, or to retain for future reference. On slide 6, let's take a look at some of the acronyms and abbreviations you may hear during today's event.

Acronyms and abbreviations you will hear today include CST for Cancer-Specific Treatment, CY for Calendar Year, EOL for end of life, FY for Fiscal Year, and NQF for National Quality Forum. Please keep this slide available, as it can be used as a great reference tool throughout this presentation. Slide 7, please.

The purpose of today's event is to provide a recap of the PCHQR Program's key events and changes that occurred this year, and will prepare the PCHQR participants for next year, 2018. Slide 8, please.

After today's presentation, you will be able to recall significant program events and changes that occurred this year, and apply the information provided, which is effective for Calendar Year 2018. So now, we will begin our discussion with our recap of 2017, starting with key events. Slide 9, please.

There were three key events that took place this year: one, the implementation of the Web-Based Data Collection Tool, or WBCT; two, the publication of the final rule, which is customary but very important; and three, the activities related to the Admissions and ED Visits for Patients Receiving Outpatient Chemotherapy claims-based measure,

which were the national provider call and dry run. We will begin with the implementation of the Web-Based Data Collection Tool, on slide 10.

Earlier this year, specifically, during our March and June events, we announced the deployment of the newly developed Web-Based Data Collection Tool and instructions on its use. The implementation of this tool significantly impacted the method of submission for the CST, OCM, and EBRT data. As you know, the PCHQR Program measures are reported in different ways. There are the six healthcare-associated infection measures, or HAIs, which are reported to CMS on behalf of the PCHs, based upon the data that are entered into the National Healthcare Safety Network, or NHSN, system. The Hospital Consumer Assessment of Healthcare Providers and Systems, or HCAHPS, Survey data are reported to CMS by an authorized vendor with which the PCH has contracted. Then, there are the Cancer-Specific Treatment, or CST; Oncology Care Measures, or OCMs; and External Beam Radiotherapy, or EBRT, measures that, since the fall of 2015, had been submitted by you, PCH[QR] Program participants. These data were submitted to CMS via completion of CSV, or comma-separated value, files that were submitted with the Secure File Transfer function within *QualityNet*. This process required participants to extensively rework files, the Support Contractor performed careful quality control, and involved the uploading of files to the *QualityNet* data warehouse. The Web-Based Data Collection Tool was open and fully functional for the data submission period that closed May 15, 2017. Participants no longer had to submit their quarterly CST data and annual OCM and EBRT data via the external file process, but rather, directly entered these data into *QualityNet* via the use of the Web-Based Data Collection Tool. As the CST data entry was pretty straightforward, which included only numerator and denominator values, we provided an additional educational event that provided further instruction on the use of the Web-Based Data Collection Tool for the data-entry process for the OCMs and EBRT. This was done, as the OCM and EBRT data submission was a bit more involved due to the reporting requirements of the

population and sampling data. Overall, we received great feedback on the functionality and user-friendly nature of this tool. Slide 11, please.

The second event in 2017 was the publication of the Fiscal Year 2018 IPPS/LTCH PPS Final Rule in August. The final rule display copy was issued August 2, 2017, and then the final rule was published in the *Federal Register* on August 14, 2017. In April of each year, when the proposed rule is published, we encourage participants to submit comments for those topics that CMS is seeking the public's input, which they highly value. In the Fiscal Year 2018 proposed rule, there were six specific areas or topics highlighted that were open for comment: removal of the CST measures, beginning with the Fiscal Year 2020 Program Year; inclusion of four new measures for the Fiscal Year 2020 Program Year and subsequent years; input addressing accounting for social risk factors; six measures for potential inclusion in the future; data collection period for the four new end-of-life, or EOL, measures; and modifications to the Extraordinary Circumstances Exceptions, or ECE, policy. As listed on this slide, these topics were finalized changes to the program. As we emphasize each year, the final rule is the foundation of the PCHQR Program, and it affects every aspect of the program in some way, shape, or form. On the next series of slides, we will discuss these finalized program changes in more depth. Slide 12, please.

The first finalized change we will discuss is the removal of the measures from the PCHQR Program, beginning with the Fiscal Year 2020 Program Year, in which CMS finalized the removal of the three Cancer-Specific Treatment measures, which are Adjuvant Chemotherapy for Stage III Colon Cancer, or NQF number 0223; Combination Chemotherapy Hormone Receptor Negative Breast Cancer, or NQF number 0559; and Adjuvant Hormonal Therapy, or NQF number 0220. It was determined through statistical analysis that PCH performance for all three measures was found to be "topped out." It was also determined that collecting PCH data on these measures does not further program goals, as the performance is high and unvarying. The removal of these measures is effective for diagnoses occurring as of January 1, 2018. We will discuss later in this

presentation how this will affect reporting requirements in Calendar Year 2018. Slide 13, please.

Secondly, CMS finalized the addition of four new end-of-life measures: NQF number 0210, which is Proportion of Patients Who Died from Cancer Receiving Chemotherapy in the Last 14 Days of Life; NQF number 0213, which is Proportion of Patients Who Died from Cancer Admitted to the Intensive Care Unit, or ICU, in the Last 30 Days of Life; NQF number 0215, which is Proportion of Patients Who Died from Cancer Not Admitted to Hospice; and NQF number 0216, which is the Proportion of Patients Who Died from Cancer Admitted to Hospice for Less Than Three Days. The final rule pointed out that the quality of end-of-life care was identified by the National Quality Forum, or NQF, as an area of care that continues to need improvement. The intent of adding these measures was to assess the quality of end-of-life care provided to patients in the PCH setting. This is the first step in assessing what occurs in a PCH setting at the end of life, and will provide a baseline for the existing end-of-life care practices at these hospitals. As these are all claim-based measures, CMS will calculate the measure results from the claims data you submit. Therefore, there is no data submission necessary. Starting on slide 14, we will look at how the EOL measures are categorized, and also review previously finalized measures for the Fiscal Year 2020 Program Year and subsequent years.

So here, the list starts with the five Oncology Care Measures that have been a part of the program: NQF numbers 0382, 0383, 0384, 0389, and 0390. As mentioned previously, this slide highlights the addition of the four newly finalized EOL measures and their categorization, as denoted by the red boxes. NQF number 0210 and NQF number 0215 are Clinical Process measures. And, there is a new category, Intermediate Clinical Outcome measures, which includes NQF number 0213 and NQF number 0216. It is important to note that on this slide, and the next two slides, summarizing the Fiscal Year 2020 finalized measures for the program, the three Cancer-Specific Treatment measures have been removed. Slide 15, please.

Next are the six Safety and Healthcare-Associated [Infection] measures that are currently a part of the PCH Quality Reporting Program. They include CLABSI, CAUTI, SSI for both colon and abdominal hysterectomy, CDI, MRSA, and the Influenza Vaccination Coverage Among Healthcare Personnel. Slide 16, please.

And finally, listed here are the last three measures: HCAHPS Survey data; EBRT; and the claims-based outcome measure, Admissions and Emergency Department Visits for Patients Receiving Outpatient Chemotherapy. These measures are all currently a part of the program and have been retained. Slide 17, please.

In previous final rule publications, Fiscal Years 2015 through 2017, there was discussion on future measure topics in quality domain areas. These discussions specifically covered topics and measures in support of the CMS Quality Strategy domain of making care affordable, communication and care coordination, and working with communities to promote best practices of healthy living. CMS sought public comment on six potential new quality measures for inclusion for future years, which included five localized prostate cancer measures, which focused on vitality; urinary incontinence; urinary frequency, obstruction, and/or irritation; sexual function; and bowel function; and one 30-Day Unplanned Readmissions for Cancer Patients measure. If you recall, as stated in the final rule, the five prostate measures are related, patient-reported outcome measures obtained from administering the Expanded Prostate Inventory Composite, or EPIC, survey. The goal is to identify issues of variation, suboptimal performance, and disparities in care. The 30-Day Unplanned Readmissions for Cancer Patients measures the number of specific 30-day unscheduled and potentially avoidable readmissions following hospitalizations among diagnosed malignant cancer patients. It would assess the total number of unscheduled readmissions within 30 days of the index admission. It was noted that CMS will consider all commenter's views as these measures are further developed for use in the PCHQR Program. Slide 18, please.

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Public reporting has been a recent topic covered during the last two events. It is a requirement that PCHs are allowed the opportunity to review the data prior to such data being made available to the public. CMS strives to make the data available to the public as soon as possible, or feasible, and will continue to propose in rulemaking the first year for which they intend to publish data for each measure. As this slide outlines the public display requirements for the program, note that CMS will continue to defer the public display of the CLABSI and CAUTI data for the PCHs. This was actually finalized in the Fiscal Year 2017 Final Rule. This deferment will continue until collaboration with the Centers for Disease Control and Prevention, or CDC, allows identification of an appropriate time, and analytic method, to be used in the public reporting of these data.

The five original Oncology Care Measures, or OCMs, and HCAHPS Survey data will continue to be publicly reported. Of note, for NQF number 0382 beginning Fiscal Year 2019 for care delivered in 2017, the data reflected the expanded diagnosis cohort, which included breast and rectal cancers, in addition to the initial lung and pancreatic cancers. Lastly, EBRT was publicly reported for the first time this past July, with the *Hospital Compare* refresh. This measure will now be reported on an annual basis, which aligns it with the display of the five Oncology Care Measures. Slide 19, please.

In the Fiscal Year 2018 Final Rule, there were no changes to the data submission requirements for the program. However, the final rule did address the finalized data reporting schedule and data collection period for the four new end-of-life measures, as displayed on this slide. Keeping in mind that these are all claims-based measures, there is no data submission requirement for the PCHs, as the data will be obtained from Medicare claims data. It was finalized that reporting of the end-of-life measures will be done on an annual basis with a data collection period from July 1, from the year three years prior to the Program Year, to June 30 from the two years prior to the Program Year. For example, for the Fiscal Year 2020 Program Year, data will be collected from July 1, 2017, through June 30, 2018. As a reminder, the current data submission requirements for the

program are displayed on the Resources page on *QualityNet*. On the next slide, slide 20, we will review the changes to the Extraordinary Circumstances Exceptions, or ECE, policy, for the program.

To better align the ECE process for the PCHQR Program with other CMS quality programs, CMS finalized modifications to the ECE policy, the first being that CMS will strive to provide a formal response of its response to an ECE request within 90 days of receipt. Second, the deadline to request an exception or extension was extended from 30 to 90 days. And, third, CMS is allowed to grant an exception or extension due to CMS data system issues that affect data submission. As a point of clarity, it was stated that if CMS does not proactively notify PCHs that it plans to provide an exception or extension to the policy after a data system issue, a PCH may still submit a request for an exemption for CMS to consider. Now, we will look at our last key event in 2017 on slide 21.

There were two key events that surrounded the Admissions and Emergency Department, or ED, Visits for Patients Receiving Outpatient Chemotherapy measure. These were the national confidential reporting period, also known as the dry run, and the national provider call. As a brief overview, this measure was finalized for inclusion in the PCHQR Program in the Fiscal Year 2017 IPPS/LTCH PPS Final Rule. This is an outcome measure with the overall goal of reducing the number of hospital admissions and ED visits, following the patient receiving chemotherapy at a PCH in the outpatient setting. The aim of this measure is to assess the care provided to cancer patients, and encourage quality improvement efforts that will ultimately decrease admissions and ED visits. Therefore, the purpose of the dry run, which was conducted by the measure developer, was to familiarize the PCHs with this measure, in advance of the calculation of their actual performance data, and in anticipation of the future public reporting of the measure results. This was also a very important time to ensure that all of the PCHs understood the measure in detail, the calculations that were performed with the administrative data, and provided PCH providers an opportunity to ask questions of the measure development team. The dry run information was calculated based

upon claims data that were submitted for patients who had received outpatient chemotherapy at a PCH between October 1, 2015, through September 30, 2016. Once the measure is fully implemented, the first actual performance data for the PCHs will be analyzed for those patients receiving chemotherapy between July 1, 2016, and June 30, 2017. This will then occur annually. Shortly after the dry run began, CMS hosted a national provider call on August 23. The purpose of this call was to present an overview of the measure, provide guidance on interpretation of measure data and results, and provide an opportunity for facilities to ask questions. There was a wealth of information provided in a very informative question-and-answer session. I have provided information on this slide that will direct you to all of the available materials for this measure, which include mock facility-specific reports, or FSRs, and user guide; the national provider call materials, slides, transcripts, and audio recording; a fact sheet; and a frequently asked questions document. Moving onto our next topic, which will be key updates in 2017, we will begin with slide 22.

We will now turn our attention to some of the key updates that took place this year, to include PCHQR measures, resources and tools, and the PCH facility reports. Slide 23, please.

For 2017, there were no updates for two of the five Oncology Care Measures, or OCMs: Plan of Care for Pain, or NQF number 0383; and Pain Intensity Quantified, or NQF number 0384. However, there were a few updates to the remaining three OCMs. For Radiation Dose Limits to Normal Tissues, or NQF number 0382, there was one major update, which was that the diagnosis cohort was expanded to include patients with breast and rectal cancers. This was effective for care delivered in 2017. The ICD-10 codes list was updated to include these patients. For Avoidance of Overuse of Bone Scan for Staging Low-Risk Prostate Cancer Patients, or NQF number 0389, the eligible population for this measure was updated to include patients not only at low risk of recurrence, but additionally, those at a very low risk of recurrence. The standards were updated to contain the new parameters, or definitions, of low risk of recurrence, in addition to

adding the criteria for very low risk of recurrence. There were two modifications to the definition of low risk of recurrence. First, the PSA requirement was changed to a PSA of less than 10 nanograms per milliliter instead of less than or equal to 10 nanograms per milliliter. Second, the clinical stage was expanded to include patients with T1 to T2A cancer, while previously it had been T1C or T2A. With the inclusion of low patients at very low risk of recurrence, patients with clinical stage of T1C were included and must meet three additional criteria: presence of disease in fewer than three biopsy cores, and less than or equal to 50 percent prostate cancer involvement in any core, and a PSA density of less than or equal to 0.15 nanograms per milliliters per centimeters cubed. For the Prostate Cancer: Adjuvant Hormonal Therapy for High Risk Prostate Cancer Patients, or NQF number 0390, there was a point of clarification made regarding the definition of "prescribed." It was noted that while other therapies are used, such as chemotherapy, as it may be considered a treatment option for some of the high- and very high-risk patients, the requirement and intent of this measure is unchanged, which is that if the primary therapy is EBRT to the prostate, the patient should receive ADT, or androgen deprivation therapy. This was specifically related to the use of docetaxel, which is mentioned, for high-risk patients after the EBRT and while continuing the ADT, and also, as an additional therapy to the EBRT and ADT, in the very high-risk population. Clarifying information was included in the measure information forms [MIFs] to reflect this. Changes to the clinical rationale statements included that the ADT may be neoadjuvant, or given before; concurrent, or given with; or adjuvant, given after, the EBRT to the prostate. The last update that pertains to the OCMs, and an important one to make, is that the OCM specifications are now located on the Quality Payment Program, or QPP, page. They were formerly found under the Physician Quality Reporting System page. The web address listed on this slide is the QPP home page, and the OCM measure specifications are under the Merit-based Incentive Payment System, or MIPS, page. Slide 24, please.

Updates for the EBRT measure, or NQF number 1822, were to provide clarity and maintain consistency when abstracting across programs, specifically with the Hospital Outpatient Quality Reporting, or Hospital OQR, Program, which has a similar measure. The first change was to the measure description in which the word “painful” was removed. So it now reads, “with a diagnosis of bone metastases” instead of, “painful bone metastases.” The reason for this is that the ICD-10 codes only identified bone metastases. There was no requirement that the metastases be painful; therefore, the word “painful” was removed. The second change was an addition to the denominator statement to the MIF for NQF number 1822 this year, to be consistent with the MIFs for the OCMs and the Hospital OQR Program. The statement is, “All patients with bone metastases and no previous radiation to the same anatomic site who receive EBRT or the treatment of bone metastases.” An emphasis is on patients receiving the EBRT for bone metastases. There are many patients who have bone metastases present, and may be receiving the EBRT for a lesion other than the bone metastases. The EBRT measure is only assessing the appropriateness of the dosing schema for the treatment of bone metastases. There was also a specific exclusion criterion added, which was, “when the EBRT is used to treat non-bone metastases.” As this has always been the intent of the measure, the use of the codes alone will not exclude these patients. So this was explicitly added as a step in the exclusions. Slide 25, please.

Going back to the Fiscal Year 2018 Final Rule, the HCAHPS Survey underwent refinements to the pain management questions. The new pain items now titled, “Communication About Pain,” are required to begin with quarter one 2018 discharges or discharges, beginning January 1, 2018, and forward. These new questions now address how providers communicate with patients about pain, while removing ambiguities in the wording or intent of the questions. Also, PCH providers were required to report the Influenza Vaccination Coverage Among Healthcare Personnel, or HCP, measure via NHSN for the first time in May of this year. This measure was finalized in the Fiscal Year 2016 Final Rule, and was selected for

inclusion to increase patient protection and safety and to prevent adverse outcomes for high-risk cancer patients, including premature death due to influenza acquired in the PCH setting. As you know, the HCP data is reported once a year in May. Slide 26, please.

As your Support Contractor, we always want to ensure that the resources and tools made available to you on both *QualityNet* and *Quality Reporting Center* are always kept up to date. Starting with the Program Manual, updates made this year were made to align with the Fiscal Year 2018 Final Rule, such as the removal of the CST measures; addition of the four new end-of-life measures; and to reflect some of the updated resources and tools, which are also listed on this slide. The Measure Submission Deadlines by Due Date was updated also. These updates included:

- Due dates through January 3, 2019
- Going back to the CST removal, remembering that the removal is effective with the January 1, 2018 diagnosis cohort and the last reporting period being quarter four 2017, for both colon and breast cancer measures, the last data submission due date is August 15, 2018. Being that the last data submission deadline for the hormone measure will be February 15 of 2019, this table will be updated to reflect this. Eventually, both measure columns will disappear altogether.

The Web-Based Data Collection Tool, or WBDCT, Guideline by Due Date resource was first published earlier this year, when the WBDCT was released. This tool has definitely simplified using the Web-Based Data Collection Tool, as it makes it very easy to determine which fiscal year applies for the data on which you are reporting. These chart updates included submission deadline dates through [the] August 15, 2019 data submission deadline. Then, there is the PCHQR Program Relationship Matrix of (the) Program Measures by Years and Quarters. The updates to this tool included:

- The measure name column was updated to include the four new end-of-life measures, NQF numbers 0210, 0213, 0215, and 0216.
- The fiscal years were extended through Program Year 2020.
- And, while extending the Program Year through 2020, naturally, this required the remaining columns to be updated as well, such as the past reporting period and *Hospital Compare* release column being grayed out and past quarterly data submission deadlines marked "Prior."

Lastly, the applicable MIFs and algorithms were updated with the current information for 2017. Slide 27, please.

The PCHQR pages found on *QualityNet* under the PPS-Exempt Cancer Hospitals tab, are listed here. The following updates for these pages were a link to the Fiscal Year 2018 Final Rule on the Overview page; the Measures page and Data Collection page saw the addition of the four new end-of-life measures; and the Data Submission page was updated to allow the link, when clicked, to take you directly to the Measure Submission Deadlines by Due Date document, discussed on the previous slide. Then there is the Resources page. This page offers links to web resources and links to program-specific resources, specifically the bulleted items listed on the previous slide, as well. Here is where you can also find important forms, such as the Hospital Contact Change Form and the extraordinary circumstances exceptions, or ECE, request form. Slide 28, please.

During our September presentation, you were made aware of several updates to the PCH reports that you are able to generate within the *QualityNet Secure Portal*. These updates included a change in the appearance of the (N/A[1]) and (N/A[2]), as they now appear as superscripts, the data tables only displaying in the Program Years to which they apply. The best example to illustrate this point currently would be with the removal of the CST measures. Once the last quarter of data is reported for these measures, they will no longer appear on the Fiscal Year 2019 report and subsequent years. Abbreviations are no longer used in the measure

titles, and are now consistent with how the titles appear in the final rule. The QINs are now able to access the PCH reports to aid them in their work with PCHs on quality improvement efforts. Slide 29, please.

Since the CSTs are based upon the date of diagnosis, "Discharge Quarter" was replaced with "Diagnosis Cohort." Patient days will appear in the denominator column for the CDI and MRSA data, rather than (N/A[1]) since prior to the update, the system looked for a predicted number of events. Effective for Fiscal Year 2018 reports, the OCMs and EBRT data tables are identical in that [the] report now shows the population and sampling data elements for sampling frequency, the initial patient population, and sample size for the OCMs. And, the "Last NHSN Update" date now only updates for the most recent quarter. So the "Last NHSN Update" dates for the previous quarters no longer change. Well, that wraps up the recap for this year. We will now look ahead to 2018. Slide 30, please.

As with each year, program changes and/or updates are to be expected. With 2018 quickly approaching, we will discuss this a bit further. Slide 31, please.

Starting with the PCHQR measures, as we have been discussing, the CSTs were finalized for removal from the PCHQR Program, effective for Fiscal Year 2020 Program Year. You will not be required to collect data for diagnoses, starting January 1, 2018. So how does this relate to the data reporting requirements for these measures? As indicated on this slide, you will report quarter four 2017 data for the colon and breast CST measures on August 15, 2018. And then, you will report the last quarter of CST hormone data in February of the following year, which will be in 2019. Regarding the four new end-of-life measures, if you haven't noticed, the data collection table on the PCHQR *QualityNet* page indicates that the specifications for these particular measures are under development. As this is indeed the case, once the EOL measure specifications have been finalized, the PCHs will be notified when this information will be available. It is also very likely that there will be an Outreach and Education event pertaining to these measures in the very near future.

Again, as mentioned earlier, the new HCAHPS Survey Communication about Pain questions are required for all discharges, beginning January 1, 2018, and forward. And, for the Admissions and ED Visits for Patients Receiving Outpatient Chemotherapy, or the outpatient chemo, measure, you should expect to receive your official facility-specific report, or FSR, in the summer of 2018. This report will include claims data from July 1, 2016, through June 30, 2017. As the specific dates and more information become available, you will be notified via ListServe communication and in future educational events. As always, the program resources and tools will be updated accordingly to reflect any newly updated additions, changes, and/or additional information. Slide 32, please.

This table provides an overview of the 2018 *Hospital Compare* refresh timeline. This table lists the month of the *Hospital Compare* release, PCH measures, and the quarters of measure data that will be displayed. Exact dates regarding the preview period and refreshes will be communicated to you via ListServe communication, and we typically provide these pertinent details during our educational events. An important note to make here is that the public display requirements for the Admissions and ED Visits for Patients Receiving Outpatient Chemotherapy and the four end-of-life measures, have not yet been determined. Again, once these dates are specified, this information will be communicated to you. Slide 33, please.

There have already been quite a few PCH report updates, and fortunately, there are more to come. These future updates include, but are not limited to, “Last Update” date will be added to the OCM and EBRT tables; effective for Fiscal Year 2019 and forward, OCM and EBRT rates will display with precision to one decimal place; and the CDI and MRSA data table will appear how the CLABSI and CAUTI data table appear now; there will no longer be a SIR column. And, the last upcoming highlight for 2018 is that the submission of the Fiscal Year 2019 DACA will move to an electronic submission process. Once implemented, you will be able to complete this program requirement by electronically signing and submitting your Fiscal Year 2019 DACA via the *QualityNet Secure*

Portal. There will definitely be more outreach and education provided regarding this new process in the very near future. Slide 34, please.

We will conclude today's event, as always, by reviewing important upcoming dates for the PCHQR Program, beginning on slide 35.

Our next data submission deadline is January 3, 2018, which includes quarter three 2017 HCAHPS Survey data. Our preliminary analytics reports show that all PCHs have submitted these required data. So thank you for that. Then, there will be the quarterly submission of your CST and HAI data. This will include quarter two 2017 CST chemo data for breast and colon; quarter four 2016 CST hormone data; and quarter three 2017 HAI data. And, as a reminder, both data submission periods listed here do fall under the CMS-granted, hurricane-related exception for those PCHs impacted by Hurricanes Harvey and Irma, which takes us to our next slide that further highlights this exception. Slide 36, please.

Here is a list of the applicable submission deadlines and discharge periods for those PCHs in impacted areas. Please remember that CMS continues to closely monitor this situation, and if any adjustments are necessary, CMS will communicate them accordingly. So be sure to monitor your Inbox for future communications. Slide 37, please.

For December 2017, the anticipated refresh is scheduled for December 20. You also see tentative dates that pertain to the April 2018 refresh. The preview period is tentatively scheduled for February 1 through March 2 of 2018. And, the refresh is tentatively scheduled for April 25, 2018. And, as always, please remember that all dates for public reporting are subject to change. As we get closer to the preview periods and refresh dates, we will always notify you of the exact dates via ListServe. At this time, I would like to turn the presentation over to Deb Price to review the continuing education process. 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 credits.

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 who 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 in 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 webinars 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 with which you registered. 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: In closing, thank you for your time and attention during today's event. I would also like to thank all of our PCHQR Program participants for their hard work and diligence that allowed for another successful Program Year. Again, thank you, and enjoy the remainder of your day.