



## PPS-Exempt Cancer Hospital Quality Reporting Program

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### Support Contractor

## PCHQR Reporting: Focus on Cancer- Specific Treatment Measures

### Presentation Transcript

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**October 22, 2015**

**2 p.m. ET**

**Matt McDonough:** Good afternoon everybody, and thank you for joining us for this afternoon's webinar. My name is Matt McDonough and I am going to be your virtual training host for today's event.

And as always, before we get started, we'd like to cover some housekeeping items with you so you know how today's event is going to operate and how you can interact with our panelists today at any time during today's event.

So, first off, as you can see on this slide, we are streaming our audio feed for this event over internet. It means that no telephone line is required to listen in.

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As long as you've got those computer speakers or headphones connected, you'll be able to hear our streaming.

However, if at any time you do encounter some difficulty that you're not able to fix with that streaming audio feed, we do have a limited number of dial-in lines available. Just send us a chat message if you need one of those and one of our assistants – our hosts on the call – will be able to send that you immediately

Also, as a matter of standard practice, this event is being recorded and will be archived and published at a later date.

All right. So, if you are streaming audio over the computer, you may encounter some issues from time to time such as your computer audio breaking up, getting choppy or it may suddenly stop all together. If that does happen, there are a couple of things that you can do to try and resolve that. Number one is you can click the refresh icon. And in the bottom graphic here, this is an example of the top of the Internet Explorer window. And you can see the refresh icon is highlighted there in that red box. That will refresh your browser window. It may take a moment but it will reconnect you to the event and your audio feed should resume.

Also, a shortcut for doing that is simply clicking the F5 key on your keyboard as shown here and that will also refresh your entire browser and reconnect you to the event and restart your audio feed. Now, if that doesn't work for you, of course, we do have those dial-in lines available if needed.

Now, if you're connected today and you have a very bad echo, my voice sounds like it's coming through multiple times. Well, that's probably because you're connected multiple times to the event and you're hearing more than one audio feed. That's really easy to fix this problem, simply close any extra instances and leave one browser open. You can see here we've got an example of what two connections look like – just close one of those. Close everything so that you've only got one window open and you'll only hear one audio feed and that will clear up the echo problem that you may be experiencing.

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Now, although as attendees, we are in Listen-Only Mode today, that doesn't mean that you can't submit your questions today. Anytime during the event you can submit a question to our panelists. Simply type your questions into the bottom left corner of your screen. It is highlighted with the yellow arrow that you're seeing there on your screen now. Type your question in and click Send. As time and as resources allow and as the availability of answers allows us as well, we'll get to as many questions as we can during today's event. However, keep in mind that all of your questions are being archived to be addressed in a future Q&A document.

Well, that's going to do it for my introduction. So, without any further ado, I'm going to hand things over to our first speaker of the day.

**Henrietta Hight:** Thank you, Matt. My name is Henrietta Hight. I'm a project coordinator on the PPS-Exempt Cancer Hospital Quality Reporting Team. We'd like to invite everyone to today's webinar entitled, *PCHQR Reporting: Focus on Cancer-Specific Treatment Measures*". This webinar is part of the educational series provided to hospitals participating in the CMS PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program.

Our presenters today are Tom Ross, PCHQR Program Lead at the Inpatient Value, Incentives, and Quality Reporting;, we refer to it as VIQR, Outreach and Education Support Contractor.

Our guest presenter is well-known to the PCHQR participants, Leah Kiesow. Leah is currently the director of the Cancer Registry at the Temple University Health System in Philadelphia, Pennsylvania. Leah has been with Temple University Health System for over 3 years and some of her most noted activities include a Coordinator for all activities of the Cancer Committee, implementing new follow-up methods that led to an increase from 90 percent to 94 percent in the 5 year rate, and improving case finding and abstracting processes that resulted in a productivity increase from 24 percent to 96 percent during a 6 month timeframe.

Leah's past positions related to today's webinar include Manager of Cancer Data Services for the Comprehensive Cancer Program in Asheville, North

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Carolina and Manager of Cancer Data Management for the integrated Network Cancer Program in Portland, Oregon. Leah received her MBA in Health Administration from the University of Phoenix in Portland, Oregon and her Bachelor of Science in Corvallis, Oregon.

One last reminder before we get started. Looking at the list of participants today of the people who have registered for the webinar, we see that a number of you are perhaps involved in other CMS Quality Reporting Programs and are not associated as one of the PPS-Exempt Cancer Hospitals. We appreciate your interest in today's webinar; however, unlike many of our previous webinars, today's webinar focuses on PCHQR measure reporting and submission as well as PCHQR public reporting. The information provided does not apply to any of the other CMS Cancer Quality Reporting Programs. Therefore, if you are participating in or associated with one of the other CMS programs, you will probably find your time better spent on other activities today. So now, let's go to slide number 6 to review the purpose of today's webinar.

As slide number 6 indicates, the purpose of this presentation is to review the measures and reporting periods for the PCHQR Program. The timeframes reviewed pertain to Quality Reporting – Hospital Quality Reporting, referred to as HQR and Public Reporting referred to as PR. There will be a specific focus on obtaining and reporting the three Cancer-Specific Treatment Measures.

And now, we'll look at the objectives for today's webinar on the next slide. So, as the slide indicates, the learning objectives for today's webinar are the following so that you as a participant will be able to, first, list the required reporting periods and data submission dates for all PCHQR measures for both Hospital Quality Reporting and Public Reporting. Second, state the systems by which individual measure groups may be submitted. Third, explain the relationship between PCHQR measures and specific Program Years. And last, use the information to obtain Cancer-Specific Treatment Measures for their hospital and report them to maintain compliance with the requirements of the PCHQR Program.

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And then on the next slide, you'll see a list that you've seen before, acronyms. I guess we can't live without them. And it's interesting that at the beginning of using an acronym, we have to stop and think about how to spell it or say it. And then after a while, we have to stop and think or remember what the acronym stands for. But anyway, this list is here for you to refer to.

And then just very quickly before we continue with the webinar, again, for those who may have joined the webinar a couple of minutes late, I just want to repeat that this webinar really is only focused on the reporting needs of the PCHQR Program. So, again, if you're participating in or if you're associated with one of the other CMS Reporting Programs, again, this is not going to really provide information that's related to your specific program.

So meanwhile, I'd like to welcome all the PCHQR Program participants or those associated with the programs to today's webinar. And I would like to ask Tom to continue with the next slide, slide number 9.

**Tom Ross:**

Thanks, Henrietta. On slide number 9 and 10, we see the list of the summary of finalized PCHQR Measures which are familiar with most of the people. They can be grouped into 6 broad categories first the Healthcare-Associated Infections, or HAIs. This includes the previously existing CLABSI, CAUTI and SSI Measures-of which CLABSI and CAUTI were "original PCHQR metrics." And the 3 measures added in the most recent Rule-Hospital-onset *Clostridium difficile*, Hospital-onset MRSA, as well as the Influenza Vaccination Coverage among Healthcare Personnel.

A second category is the Clinical Process/Cancer Specific Treatment metrics and we referred to these as CSTs. These are 3 original metrics of adjuvant chemotherapies within 120 days of diagnosis for Stage III colon cancer, combination chemotherapy within 120 days of diagnosis for women with hormone receptor negative breast cancer, and adjuvant hormonal therapy within 365 days of diagnosis for women with hormone receptor positive breast cancer. In the cancer registry world, these are often referred to as ACT, MAC, and HT, respectively. These are the special twists in today's presentation, as there are metrics with challenges in aligning reporting periods

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of performance due to the 120 and 360 day windows in which therapy should be considered or administered. Next slide please, Deb.

A third category is that of the Clinical Process/Oncology Care Measures, which we refer to as OCMs. This contains five metrics familiar to the group as radiation dose limits to normal tissues, plan of care for pain and pain intensity quantified, and the 2 prostate cancer measures - adjuvant hormonal therapy for high risk patients and avoidance of overuse bone scans in low-risk patients.

A fourth category is Patient Engagement/Experience of Care, which consists of the HCAHPS data.

A fifth category introduced last year was Clinical Effectiveness Measure, which is NQF 1822, external beam radiotherapy for bone metastases. As Henrietta said we tend to decide how to pronounce this and familiarly we now call this "EBRT". EBRT. And lastly, the sixth category of the 6 Surgical Care Improvement Metrics, which will be sunseting at the end of quarter three 2015.

Next slide please. A couple of weeks ago, as I was working on the initial draft of the slide deck for today, I received an email from one of the PCHs. The question was, "Can you please tell me about the CMS Fiscal Year and how the metrics relate to that?" I spoke to a number of people who answered it from across the programs that we support it as the Support Contractor and they agreed that this is a frequent, and sometimes challenging question to answer. Remembering that the purpose of today's webinar is to review the measures and reporting periods for the PCHQR Program, we must first understand the relationship between Calendar Years, the CMS Fiscal Years and Program Years.

Calendar Years are obviously January 1 through December 31 of a given year. The CMS Fiscal Year straddles two Calendar Years, starting on October 1 of the previous year and ending on September 30 of the named Fiscal Year. For example, Fiscal Year 2016 starts on October 1, 2015 and ends on September 30, 2016. A Program Year is equivalent to a given Fiscal Year and, in fact,

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you will see “Program Year” followed by (FY) in the tables in the Final Rule addressing reporting periods and submission timeframes. So on the next slide, number 12, we will look at an actual measure, *Clostridium difficile* (CDI), to illustrate the relationship between Calendar Years and Fiscal Years.

So, Hospital-onset *C. difficile* infections, NQF 1717, was added to the PCHQR Program in the Fiscal Year 2016 Final Rule that was published on August 17, 2015 in the Federal Register. And it was noted that the measure would begin with Program Year or Fiscal Year 2018.

In the Final Rule, there is a table on page 49722 that provides clarity and specificity. For Program Year 2018, the Reporting Periods for the CDI metric are Calendar Year Q1 - Q4 events for 2016. However, the data is not already collected and ready for submission on the last day of Reporting Period as all of our infection control prevention experts, cancer registrars, and quality professionals can attest to. CMS recognizes this and allows time for the data to be collected and put into the relevant systems - in the case of CDI, into the NHSN system. For these events, there are – for these dates, there is a 4 and 1/2 month allowance for this to occur. Therefore, the data for quarter one events - January to March - is due for submission on August 15. For the last event on the Calendar Year, theoretically on December 31, 2016, the data is not due for submission until May 15 of 2017.

The rationale for this “lag time” between the event Reporting Period and the Program Year, to which it is attributed, is for CMS to obtain all the data in order to determine the Annual Payment Updates and other incentives, such as Value-Based Purchasing for the 2018 Fiscal Year. Of course, the PCHQR does not include payments adjustments at this time, so we more commonly referred to the Program Year, as is used in the Final Rule.

So why is the question of “What is the Fiscal Year?” not really easy to answer? You have to look at each year’s Rule, understand the relationship between the Calendar Year and the Program Year, and then understand the impact of the time for treatment to occur (if appropriate), events to be reviewed and analyzed, and the data to be entered into the appropriate system. So, with that theoretical discussion behind us, we’ll just practically look at

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how these relationships impact each of our measures or measure sets. Next slide please.

On slide 13, we see the Program Year, reporting periods and data submission deadlines for the HAI measures, CLABSI and CAUTI. As you may be aware, these are the two of the original 5 metrics applied to the PCHQR. They were published in the 2013 Final Rule effective for events starting January 1, 2013, and they were applied to the next year, which was Fiscal Year 2014.

Therefore, there's a 1 year lag from event reporting period to the Program Year to which they apply. Data submission for this is quarterly from the CDC NSHN and this data is 4 and ½ months following the last quarterly event date. So you can see that on November 15, 2015, data from quarter two 2015 – quarter two 2015 events, which is April 1 through June 30, 2015, are to be submitted. The 4 quarters of data from 2015 events will apply to the 2016 Program Year. And this is also where these events appear on your Facility Report [2016]. On the next slide, slide 14, we will look at the other measures.

SSI events were added to the PCHQR in the 2014 Final Rule for event dates starting January 1, 2014. These are events that were then phased in over the next 2 Program Years, 2015 and 2016. The quarter one 2014 events were reported on August 15, 2014 and applied to the 2015 Program Year. The quarter two through four events of 2014 were reported on the dates in the table including quarter four on May 15, 2015. These three quarters are applied to the Program Year 2016.

Then we can see that starting in 2017, we look at 2015 events applying two years later to the Program Year. For the newly adopted CDI and MRSA measures finalized in the Final Rule of 2016, the same 2year lag - in other words - 2016 events will apply to Program Year 2018. Next slide please.

The HCP Measure that was adopted for the Fiscal Year 2016 Final Rule was a bit of a different animal by definition because the events - vaccination of healthcare personnel - are set to the flu season which spans 2 Calendar Years. The flu season, for the intent of the measure, runs from October 1 of one year and extends through March 31 of the following Calendar Year. So, essentially you have quarter four of one Calendar Year and quarter one of the next



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Calendar Year. The data is submitted by the CDC NHSN system on May 15 following the flu season.

So as we see on the table, the measure is added for PCHQR for the 2018 Program Year. The events for the reporting period occur between quarter four of 2016 (or 2 years before and quarter one of 2017 or 1 year before the Program Year. This is an annual submission occurring on May 15 of the year, 1 year before the Program Year. Next slide please.

The Cancer-Specific Measures add a new element, that of the 120 day or 360 day window for the treatment to be considered and/or administered. Once again, these were the three of the original 5 metrics applied to the PCHQR starting effective with diagnosis of January 1, 2013. These measures apply to the Program Year one year after the diagnosis year. We can look at NQF 0223 and NQF 0559 together, as they both have the same 120 day treatment window. Note also that the reporting periods for these metrics are based upon date of diagnosis, which is different than the event date for the HAI metrics.

Let's look at Program Year 2016. The cases included in this program year are those diagnosed in 2015. So quarter one includes patients diagnosed between January 1 and March 31, 2015. Therefore, the last eligible diagnosis date for this cohort would be March 31. However, there's a 120 day treatment window for these 2 metrics. Therefore, in round numbers, that last eligible diagnosis date can be treated as late as the end of July.

There is then an additional period of time to allow for case finding and entering transmission into the RQRS system, or Rapid Quality Reporting System. Therefore, an additional 3 and ½ months are added before the data submission deadline - which for quarter one, is November 15. So in total, there's a 7 and ½ month lag to these data submission deadlines. The good news is this results in the data submission deadlines lining up for the HAI metrics, although the reporting periods are 1 month earlier than those for the HAIs. When quarter two events for HAI are due for submission, quarter one events for the colon and breast chemotherapy measures are due.

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On slide 17, the next slide, we will look at the remaining CST measure, adjuvant hormonal therapy. NQF 0220, adjuvant hormonal therapy, allows - due to the various treatments these patients require such as chemotherapy and/or surgery and/or radiation therapy - up to 365 days from the date of diagnosis to administration or consideration of tamoxifen or third generation aromatase inhibitor. As with the other 2 CSTs, there is a 1 year lag between diagnosis cohort in applicable Program Year. As you can see in the table, those eligible patients diagnosed in 2015 apply to Program Year 2016. Where this measure differs is that to allow for the 365 day treatment window to initiate therapy, this data is due 13 and 1/2 months after the last diagnosis date.

So let's take a look at a patient who is diagnosed in the last date of quarter one 2015 which will, of course, again be March 31, 2015. This patient would have until March 31, 2016 to comply or not with the measure. This data is then due for submission 1 and 1/2 months after the 1 year treatment window closes, or on May 15, 2016. Once again, this is good in that the data submission deadlines - once again quarterly - align with those of the other CSTs and HAIs. Although, of course, the diagnosis cohort in this case is 2 quarters earlier than that for the breast and colon chemo measures. Thus, when you're reporting quarter three breast and colon chemo cases for a given year, you will report in quarter one cases for the same reporting period year for the adjuvant chemotherapy measures. Next slide please.

On this slide, slide 18, we see the relationship of the Program Year, reporting periods and data submission deadlines for the 5 Oncology Care Measures for the Hospital Quality Reporting function. This slide classically illustrates how a metric can be "phased into" a program in a step wise manner. The OCMs were added in the 2014 Final Rule to start with treatments/clinics visits effective January 1, 2015. The Rule further stated that this is to be aggregate data, not patient level, segregated by quarter and submitted once annually. This was done to decrease the data reporting burden to the cancer centers.

Therefore, quarter one 2015 treatment data were to be submitted in the July 1 to August 15, 2015 submission period and applied to Program Year 2016.

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This was done as only 1 quarter of data would be available for this data submission period.

In a similar manner, quarter two through quarter four of 2015 treatments are to be reported during the annual data submission period in 2016. This data will then apply to the 2017 Program Year. Then, starting 2016 – for 2016 treatments, the reporting period 2 years before the Program Year of 2018, all 4 quarters of data will reported once annually during the annual data submission period, the year before the Program Year. Next slide please.

Slide 19 displays the HQR dates for the SCIP Measures. This is directly parallel to the OCM reporting schedule. Of course, reporting is going to end after quarter three 2015 discharges per the 2016 Final Rule. So we'll just move to the next slide.

EBRT. This measure was added to the PCHQR in the 2015 Final Rule. It has the 2 year lag from reporting period treatment to application to the Program Year. But unlike SCIP, OCM and SSI measures, this was not “phased in.” It started effective for patients January 1, 2015. All of the 2015 eligible patients, sampled as appropriate, are to be submitted in aggregate -segregated by quarters - during the July to August 15, 2016 data submission period. This data will then apply to the 2017 program year. So for EBRT, the reporting period is always 2 years prior to the Program Year, and the date of submission period is always the annual submission period 1 year prior to the Program Year. Next slide please.

HCAHPS. HCAHPS reporting is straight forward for the PCHs as (according to our most recent information) all are using a vendor for the submission of their HCAHPS data. As with the EBRT measure, there's a 2 year difference between the reporting period and the Program Year. So, 2014 data applies to 2016, 2015 to 2017 and so forth. (Inaudible) so let me try to summarize this information on the next slide.

The rules for applying the measures to a particular Program Year are specified in each Final Rule, but in general, apply the following thought process: The original 5 metrics, the 3 Cancer-Specific Treatment Measures, CLABSI and

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CAUTI - have a 1 year lag to the Program Year. The other measures - CDI, MRSA, SSI, EBRT, the OCMs, SCIP, and HCAHPS have a 2 year difference between the calendar event date and their Program Year to which they apply. For example, 2016 events apply to Program Year 2018. And remember, that some of the older measures that were added such as SSI, SCIP and the OCMs are being phased in. But by 2018 Program Year, all of these will be based upon 2016 data.

There will not to be a test on this. Rather, we thought it was important to explain the relationship between Calendar Year event dates, the date of submission timeframes and the application to the Program Year. In the meantime, the slides from today's webinar should provide a link between this and we will continue to supply tools with report dates and submission deadlines in the applicable program year on our educational sites. Next slide please.

The second part to look at is the other type of reporting associated with the PCHQR, the Public Reporting of data. As with the Hospital Quality Reporting, the timeframes for Public Reporting of the metrics are defined in the Final Rule. The first 2 measures to appear for Public Reporting were NQF 0223 and 0559, the colon and breast chemo measures. Public Reporting started in 2014 after 3 quarters of data were available for these measures. The next Public Reporting period added a fourth quarter. Since that time, Public Reporting consists of rolling 4 quarters of data. As the new quarter of data is added, the oldest quarter rolls off.

The next metric to appear (which just happened last quarter) was NQF 0220, the adjuvant hormonal therapy. The lag time between this metric being added in the first 2 measures was due to the 365 days to wait after diagnosis to ascertain concordance. So, just as of Hospital Reporting, the timeframes for this metric are always 6 months earlier than that for other Cancer-Specific Measures. Interestingly, the 2 other original PCHQR metrics, CLABSI and CAUTI, have not yet been publicly reported. This has been the result of comments received from the Proposed Rule, extensive conversation between CMS and the PCHs, changes in definition and attribution, and waiting for baseline and anticipated rates to be calculated. These measures are currently

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planned for Public Reporting in 2017 and subsequent years. In Calendar Year 2016 and subsequent years, the Final Rule has the OCMs and HCAHPS slated for Public Reporting. Next slide please.

So, just as with Hospital Quality Reporting, Public Reporting also has data submission due dates with specific data periods, which are reflected in the chart. As I stated before, Public Reporting is updated on a quarterly basis. What is different, as you can see on this table, is that each data submission timeframe has 2 files required, a Test File and a Production File. The purpose of the Test File is just as it sounds - to have the files checked for structure and integrity, but not necessarily data accuracy. The Production Files contain the data that will be available on the Preview Report for 30 days prior to the posting for Public Reporting. Then approximately 2 months after the end of the 30 day Preview Period, the data on Hospital Compare is refreshed.

As most of you are aware, in the past, this data submission was done by the American College of Surgeons (ACoS). The contract between CMS and the college was not renewed and expired in September of this year. Therefore, in the last couple of weeks an alternative methodology for the submission of data needed to be developed and in a few minutes, Leah Kiesow is going to share this with you. The good news is that we have validated the content of the Test Files submitted by the College for the April Public Reporting period which is due on November 16. We found 100 percent concordance with what is in the Facility Reports - which were submitted for Hospital Quality Reporting by the College. So, CMS is going to allow the use of the Test File as the Production File for the November 16, 2015 submission. Therefore, no submission from the PCHs or UHC will be required for this period for Public Reporting. On the next slide, we will briefly look at the various ways that data is submitted for the PCHQR Program.

The HAI and HCP measures are submitted for both HQR and PR by the NHSN on a quarterly basis. You get the information into the System, comply with the requirements, and the data is submitted. For the Cancer-Specific Treatment Measures, we will now ,(as we will discuss. have to use either an aggregate data submission external file uploaded by Secure File Exchange to the CMS Clinical Warehouse which can be done by the individual PCH or the

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University Healthsystem Consortium, which recently changed their name from University Hospital Consortium.

It's interesting to note that we are on track for next summer to have direct entry of the data by the *QualityNet* Secure Portal under the web-based measures area. That is not active at this time but plans are to have that for July of 2016. The SCIP and the OCM Measures and EBRT will all continue to be reported by a Secure File Exchange as what's done in the past and will in the future for the EBRT measure by the *QualityNet* Secure Portal. And once again, we hope to have the direct entry of data via the *QualityNet* Web-based Measures Tool in the future. And (inaudible), of course, HCAHPS is done by the vendor. Next slide please.

So as you are aware, the contract between CMS and ACoS expired on September 27, 2015. This impacts the PCHs in two ways. Reports of quarterly performance are no longer available on the PCHQR tab, as it is grayed out. And also, ACoS will no longer send the files to CMS for performance on the CSTs for either Hospital Quality Reporting or Public Reporting.

I am now going to turn the presentation over to Leah Kiesow, who many of you know, to lead an educational session on how to obtain the data from the RQRS system. Leah?

**Leah Kiesow** Thank you, Tom. So even without the PCHQR report that the COC has been supplying us for a couple of years now, the data can still be pulled from the Rapid Quality Reporting System (RQRS) and we'll still be able to calculate our percentages for the respective measures. So anyone who has access to RQRS will be able to do what I'm about to show you - or the steps that I'm going to cover with you. So for the next few slides, I'll provide some step by step instructions with some screenshot examples from RQRS.

So jumping ahead kind of switching gears here to RQRS, so once you're in the RQRS system, you would want to select the Case List. So this is the tab kind of towards the top of the screen. And you would want to expand the folder for the appropriate year. And then from there, you want to expand the

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folder for the tumor site, whether it would be breast or colon. And then you want to expand the folder for the measure being queried. And then once you have done, you'll see on the lower left hand corner, there's an icon and it says "click to download to Excel." And so you can click on that, open or save the Excel sheet.

So, on this slide here, this is an example of the main page with the Case List screen. The hormone therapy folder is highlighted there in blue. And then at the bottom left, you can see the Excel icon and that's what you would want to click on.

So once that has been – once that page has been brought up and you have downloaded or saved your Excel sheet, you want to identify your patients for the diagnosis cohort. So Tom already mentioned that these measures are, you know, based on the quarter for diagnosis date. So, at this point, you'd want to sort your spreadsheet by the date of diagnosis and the column header is DX\_DATE. And then you'd want to delete all the dates not in the timeframe being queried. So, this will give you the applicable cases that you want to look at and then determine your concordance rates from there.

So, again, this is kind of just a screenshot example of the diagnosis date so you see the diagnosis date there column G. Now, when I was doing the screenshots for Tom, you know, this is just a sample. I think I was working on July through September cases for the hormone therapy measures. So, you know, seeing all of – all of my cases here are just a sample shot.

So then the next step would be to remove the not eligible patients. So you would do this by filtering the spreadsheet by the column labeled MEASURE\_STATUS. And then within that column, you're going to see patients identified as either "I" for incomplete or "NE" for not eligible. These patients we want to delete from the spreadsheet so we can, again, filter and narrow our results down to the patients that we really need to look at.

And this slide is not fully filtered or sorted. I just highlighted some rows where the patients are identified as "NE" or "I", just as examples of what you

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would see. Of course, these would be the cases that we would want to delete from the spreadsheet.

And then last, but not least, determining the measure status and concordance. So, again, you want to sort your spreadsheet by MEASURE\_STATUS. And in this list, we're going to have cases that are noted as Comp and Consider. These are concordant cases. Comp stands for complete and Consider is considered. The rRx cases equal non-concordant. And I have a little note included in here that even, you know, though we don't have the PCHQR tab, you know, those nice reports that just showed as everything that we needed to see, you know, these Excel sheets with filtered data still serve the same purpose. We can check on nonconcordant because, I think, probably hopefully most of us are monitoring these cases on an ongoing basis, but again, it's just another tool to use in absence of those other reports so cases can be checked and researched and, you know, hopefully maybe finalized for updates prior to our submissions.

So for calculating the actual numerator, denominator and concordance, your numerator is going to be equal to your Comp and Considered cases. Your denominator is going to be your Comp, Considered, and rRx - or a total of all of those cases. And then the % Concordance will be our numerator divided by our denominator multiplied by 100. And then the concordance will be reported to one decimal place. So, in this example, you know, 90.2.

And so this last slide, just kind of a final example, once you've done all of your sorting and filtering and get ready to determine your final concordance rate, you'll see here the Comp labeled E is MEASURE\_STATUS. You have your applicable cases so you're complete, you're considered and your rRx. So, that's kind of the total population for whatever diagnosis cohort we are looking at.

So with that, I'm going to go ahead and turn the presentation back to Tom.

**Tom Ross:** OK. Thank you, Leah. Next slide...

**Leah:** Sure.



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**Tom Ross:** Please, Deb. I wish to thank Leah for this excellent information as well as her work with me in developing this portion of this presentation. I would also be remiss if I do not thank all the PCHs for their cooperation and collegiality in working together under the able leadership of Steve Flaherty in addressing this issue.

The next reporting date for Hospital Quality Reporting for the Cancer-Specific Treatment Measure is November 15, 2015. As you can see on this slide, this will be quarter one 2015 data for NQF 0223 and 0559 and quarter three 2014 data for adjuvant hormonal therapy. Next slide please.

For Public Reporting, the next due date is November 16, not November 17, as indicated on this slide. Excuse me. However, the PCHs do not have to submit data for this period, as related earlier, CMS will be using the file sent by the ACoS while the contract was still in effect.

We have validated the contents of the file and it is identical - as it should be - with the data that was previously sent in for Hospital Quality Reporting. This is an important educational point worth emphasizing. For the Cancer-Specific Treatment Measures, the values that are submitted for Hospital Quality Reporting are the same values that were submitted for Public Reporting. In other words, once the data submission deadline for a particular reporting period passes for Hospital Quality Reporting, the data has been submitted and no further updates are allowed in the data reported to Hospital Quality or Public Reporting.

The same is true for HAI data sent on your behalf by the NHSN. Once the data submission deadline passes for Hospital Quality Reporting, the data for that quarter is “frozen” for that time period for both Hospital Quality and Public Reporting. You can, and should, enter changes in the system if new events are found or new information is found so that your data is reflective of your performance for internal analysis and performance improvement. But in terms of Hospital Quality and Public Reporting, the data does not change after the submission deadline for that measure period has closed.

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Therefore, when reporting Public Reporting data starting by the Test File date by December 18, you'll have 2 options. You'll have the values and the appropriate quarters for your Facility Report maintained in *QualityNet* and/or you can use any historical reports that you saved for internal purposes or the date and the files that you sent in previously for Hospital Quality Reporting. The good news is that for Public Reporting for the Cancer-Specific Treatment Measures, you do not have to, and in fact SHOULD NOT, go back into RQRS and run new reports as Leah described.

The values submitted for Public Reporting should be the same as those that were submitted for Hospital Quality Reporting. So now that you have your data, how do you submit it? Next slide please.

The process is identical to what was done last summer for the OCM and SCIP measures, so that should be comforting. As you are aware, there are a number of PCHs that have an agreement with UHC and I know that Raj Iyer is on the call today and some of his team members have registered for the event. And you can have UHC submit the data that you provide to them. Alternatively, a PCH may submit their data independently. Do NOT submit the same data via both UHC and independently. Make a choice and stick with it. And we may actually ask you beforehand which you're going to use so that we know how to audit.

There will have to be 2 separate CSV files created for both Hospital Quality and Public Reporting each time, as there are 2 separate timeframes. One of the files will contain the data for NQF 0223 and 0559 (as they have the same timeframe) and one file will contain the data for NQF 0220. For Hospital Quality Reporting, each file will contain one quarter of data for each metric. For Public Reporting, each file will contain four quarters of data for each metric.

As we did for the OCM and SCIP data submissions, we will create file templates for your use, if you wish. Also, we will develop detailed instructions sheets as before. Pay particular attention to the file nomenclature. This must be accurate. Also, I know there were some frustrations last summer and settled differences about capitalization and the differences between the

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OCM and the SCIP and things like that. We are working to, by next summer, have the same file format consistently across the different measure groups.

We strongly urge you to submit your data in advance of the deadline, preferable a week or so before. This will allow us to see if there are problems in the file structure or file names.

Lastly, the files will be sent via *QualityNet* Secure File Transfer. Submitters are asked to reference the July 30, 2015 Webinar for detailed instruction on building a CSV file and using the Secure File Functionality. A link to this presentation is contained on this slide.

Due to the rapid recent evolution of this issue, we were not able to build and validate the templates for the files, nor the instruction sheets, for inclusion in this webinar. However, we will have these in the next few days for your use.

So at this time, Matt, if you could help us out here, we'd like to open up a couple polling questions.

**Matt McDonough:** You got it, Tom. And so the way this is going to work with our polling questions is on the next slide, we're going to have a few questions that appear and it will be a multiple choice question. You'll simply make a selection what you think the correct answer is and then click the 'Submit' button. Once we've received all the responses, we'll close it down and Tom you can (inaudible) any feedback from our users.

So let's get right to it. Question number one is on your screen now. The data values for each particular quarter of Public Reporting should be identical to those submitted previously for Hospital Quality Reporting. Is that a true statement or is that a false statement? You'll just select either true or false. And once you make your choice, click that 'Submit' button. And I know we've – we got – it looks like we got about 70 folks on the line right now so it should not take too long (inaudible) from everybody but we'll leave this open until we feel like it's slow down a bit. It looks like it's still coming in.

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Again, the statement there on your screen, is that a true statement? You'd click true and then click 'Submit.' Or if you think that is a false statement, click false and then click 'Submit.'

And, Tom, it looks like it's slowed down quite a bit. So let's do a last call for answers. About 5 more seconds to get your answer in and then we'll close this poll and we'll share the responses with everybody.

All right, let's do it. We'll close this poll now. And, Tom, you know, it's about a 75/25 split true to false.

**Tom Ross:** Well, the correct answer is true. And the reason I asked this, Matt, is a lot of the times we've used the Cancer-Specific Treatment Measures. So if data submitted in May 15 for quarter which used the hormone-specific – or the hormone – the adjuvant hormone metric, if the data submitted on May 15 of 2015, you're looking at the cases from the prior year in 2014. And the data submitted at that point in time, the Hospital Quality Reporting. A lot of times future case finding or identification of patients or internal communication from people who are being treated outside of the PCH will be received and may change the concordance of that patient. Our new cases could be identified that were not initially in the cohort.

So, therefore, CMS - as with the HAI data - "freezes" the data that's used in Hospital Quality Reporting so that it's identical to what's used in Public Reporting. The good news is that the centers do not have to go back in and require RQRS if there were any changes. So Hospital Quality data should always equal the Public Reporting data

So I think we have time for one or two more questions, Matt. Let's try the next one.

**Matt McDonough:** All right, let's go right to it. Question number two is going to be on your screen right now and this is a multiple choice question as well. What is the time lag or the difference between the PCHQR Reporting Period and the Program Year to which the measure applies? Option one is they are the same, there is no difference, one year, two years, or it varies by measure. Those are your four choices

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So, again, just like the last time, make one of your – make a selection from one of these four choices and then click that submit button. What is the time lag or the time difference between the PCHQR Reporting Period and the Program Year to which the measure applies?

All right, it looks like we've hit the same number of responses on our last question. That's good. It looks like we're exceeding that now. So we'll go ahead – we'll go ahead and we'll do a last call for answers here. We'll do about five more seconds if you have not responded to this particular question. Again, make your selection and click 'Submit' because we've got to close this one down right now. And we're going to go ahead and do that here.

So, Tom, if you will just give me a second, we'll close this down. And you'll see the breakdown here, 82 percent said it varies by measure and then it's broken up amongst the other options, one year and two year.

**Tom Ross:** Well, I think people did a great job of number one, staying awake going through all those data tables, but number two, the correct answer was it varies by measure. Remember the original five measures, CLABSI, CAUTI and the Cancer-Specific Treatment Measures have a one year time lag. So 2014 applies in '15, '15 in '16. Then all the other measures except for the healthcare personnel have a two-year lag from – so 2014 applies to '16 with some of those being phased in. But by 2018 Program Year, they'll all be phased in. And the odd ball out, of course, is the influenza vaccination of healthcare personnel because it actually expands both two and one-year prior to the Program Year. So the data from quarter four of 2016 and quarter one of 2017 will apply to 2018.

And I did include that one, Matt, because the characters would not fit on the question screen. So I think we have time for one more.

**Matt McDonough:** Yes, all right, let's go right to it because we're getting close to our end time here. Our third and final question today is this, how many files will be required to be submitted at each submission for the CSTs, for Hospital Quality and Public Reporting? Your four choices are one, two, four, or one for each patient. So please make your selection from those choices. By now, you are experts at this polling thing so I will not bore you with the instructions.

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**Tom Ross:** And I want...

**Matt McDonough:** What's that, Tom?

**Tom Ross:** I want to remind people CST is the Cancer-Specific Treatment Measures that were previously submitted by the American College of Surgeons (ACoS). A little bit of a lifeline there.

**Matt McDonough:** Thank you. All right, we still got some responses rolling in here. Again, make your selection from these four choices and then click 'Submit.' Don't forget to click that 'Submit' button; it's the most important part of this polling process.

All right, we're going to start to wind this one down too. This is your five-second warning here. If you have not made a selection yet, please do so because we've got to close this one down right now. So, Tom, just give me a second here.

**Tom Ross:** All right.

**Matt McDonough:** And you can see the breakdown there, 65.6 percent said two. That was our most popular choice.

**Tom Ross:** And the – excuse me – the popular choice was the correct choice. Each time the Cancer-Specific Treatment Measures are submitted for Hospital Quality Reporting, Public Reporting - whether it would be the Test or the Production File - it requires two files because remember the two 120-day metrics, colon chemo and breast chemo can be in one file because they have the same timeframe but the adjuvant hormonal therapy has the 365-day timeframe and therefore lags by two quarters and requires a separate file. So each time there will need to be two files submitted.

So we did great on the educational questions on this time. So, I think – hopefully we got some good information over you – over to you. And at this time, I'm going to give you information on how to obtain your continuing education credits by turning today's webinar over to the author of Chapters 42

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- Carbon Dioxide and Chapter 44 - Carbon Disulfide in the Sixth Edition of Hamilton and Hardy's Industrial Toxicology, Dr. Debra J. Price. Dr. Price?

**Debra J. Price:** Gee, thanks, Tom, for that glowing introduction. And now I'd like to spend a few minutes talking about certificates. OK, today's program is approved for one continuing education credit for the following boards. 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 shown on this screen.

OK. We now have an online CE certificate process. You can receive your certificate two separate ways. If you registered for the webinar through ReadyTalk, a survey will automatically pop-up when the webinar closes. This survey will allow you to get your certificate. We will also be sending out another survey link within 48 hours. If you are listening with someone else in the room, please forward that link to the other person in the room. After completion of the survey, you just click the 'Done' button at the bottom of the screen and another page will open up. And that page is the one that you will register to get your certificate.

Please keep in mind that this is a separate registration from the one that you had when you registered for the webinar. This registration takes you directly to HSAG, that's Health Services Groups Learning Management Center. We are asking that you use your personal e-mail account to register for this certificate. And that's because the hospital firewalls seemed to be keeping our links from getting through to your computers.

And this screen basically says the same thing that I just intimated. It's if you have been having problems with your certificate and you do not immediately receive a response, then go back and use a new user link and register your personal e-mail.

OK, this is what your survey will look like, the bottom of the survey that will pop-up within like one minute. You see on the bottom there the little 'Done' button. Click the 'Done' button as soon as you are complete. And then this

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page is the one that will take you to our HSAG's Learning Management Center. If you're a new user, click on the top link called the new user link and please register your personal e-mail account like Yahoo or Gmail or AT&T.

If you've been receiving certificates from us, then you can click on the existing user link. This is what the new user page will look like. You noticed you have to put your first name, your last name and then, of course, your personal e-mail account and your phone number to register.

This is what the existing user link takes you to. And your username is your complete e-mail address including the @ button and then whatever follows the @ button.

And finally, I'd like to pass the webinar back to our PCHQR lead, Tom Ross.  
Tom

**Tom Ross:** Thank you, Deb. I see that we're at 2:58 on the clock. So to respect people's time, we're going to conclude today's webinar. I would like to thank everyone for the time, attention and care that you provide to the patients that we all are here to serve.

And if you have questions, feel free to reach out to us. The questions that were submitted, a number were answered during the webinar. All the questions will be recorded in the transcript document, a Q&A document and will be research and posted within 10 business days on [qualityreportingcenter.com](http://qualityreportingcenter.com) as well as this presentation, as well as the transcript of the presentation.

So, once again, thank you for your time on today's call. Thank you very much.