PPS-Exempt Cancer Hospital Quality Reporting Program

Public Reporting Preview Help Guide

The target audience for this publication is hospitals participating in the PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program. The document scope is limited to instructions for hospitals on how to access and interpret the data provided on the public reporting user interface prior to the publication of data on *Hospital Compare.*

May 2020 Public Reporting Preview/
July 2020 *Hospital Compare* Release

Table of Contents

Overview

Hospital Compare provides information about the quality of care at more than 4,000 hospitals and facilities across the country. The website uses information from providers that receive Medicare and Medicaid payments and participate in one or more of the various quality reporting programs. Along with some contextual information about *Hospital Compare* and *QualityNet*, this help guide focuses on accessing the public reporting (PR) user interface (UI) for the PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program.

HOSPITAL COMPARE

The Centers for Medicare & Medicaid Services (CMS) and the nation's hospitals work collaboratively to publicly report hospital quality performance information on the *Hospital Compare* website located at *www.Medicare.gov/HospitalCompare** and *Data.Medicare.gov**.

**Hospital Compare* will be replaced with a new website.
However, we will use *Hospital Compare* in this help guide.
Please interpret it to mean *Hospital Compare* or its successor website.

Hospital Compare displays hospital performance data in a consistent, unified manner to ensure the availability of credible information about the care delivered in the nation's hospitals. Most of the participants are short-term acute care hospitals. These hospitals may receive a reduction to their annual payment update (APU) rate if they do not participate by submitting data. This requirement was initially established by Section 501(b) of the Medicare Modernization Act, which was extended and expanded by Section 5001(a) of the Deficit Reduction Act. PPS-exempt cancer hospitals (PCHs) are exempt and therefore do not receive reductions in APU; however, as participants in the quality reporting program, their data are subject to the same deadlines and procedures for any new releases of *Hospital Compare*.

PCHQR PROGRAM

The Social Security Amendments of 1983 exempted certain classified cancer hospitals from the Medicare inpatient prospective payment system (IPPS). These PCHs were also exempted from reporting on hospital inpatient quality measures. In 2010, the Affordable Care Act required CMS to establish a specialized quality reporting program for the PCHs. The resulting PCHQR Program measures allow consumers to compare the quality of care given at the 11 PCHs currently participating in the program.

Section 3005 of the Affordable Care Act added sections 1866(a)(1)(W) and (k) to the Act. Section 1866(k) of the Act established a quality reporting program for hospitals described in section 1886(d)(1)(B)(v) of the Act (referred to as "PPS-Exempt Cancer Hospitals" or "PCHs") that specifically applies to PCHs that meet the requirements under 42 CFR 412.23(f). Section 1866(k)(1) of the Act states that, for fiscal year (FY) 2014 and each subsequent fiscal year, a PCH must submit data to the Secretary in accordance with section 1866(k)(2) of the Act with respect to such fiscal year.

For additional background information, including previously finalized measures and other policies for the PCHQR Program, please refer to the following final rules: FY 2013 IPPS/Long-Term Care Hospital Prospective Payment System (IPPS/LTCH PPS) Final Rule (77 Federal Register [FR] 53555–53567); FY 2014 IPPS/LTCH PPS Final Rule (78 FR 50837–50853); FY 2015 IPPS/LTCH PPS Final Rule (79 FR 50277–50286); FY 2016 IPPS/LTCH PPS Final Rule (80 FR 49713–49723); FY 2017 IPPS/LTCH PPS Final Rule (81 FR 57182–57193); FY 2018 IPPS/LTCH (82 FR 38411–38425) Final Rule; and FY 2019 IPPS/LTCH PPS Final Rule (83 FR 41609–41624).

PREVIEW PERIOD

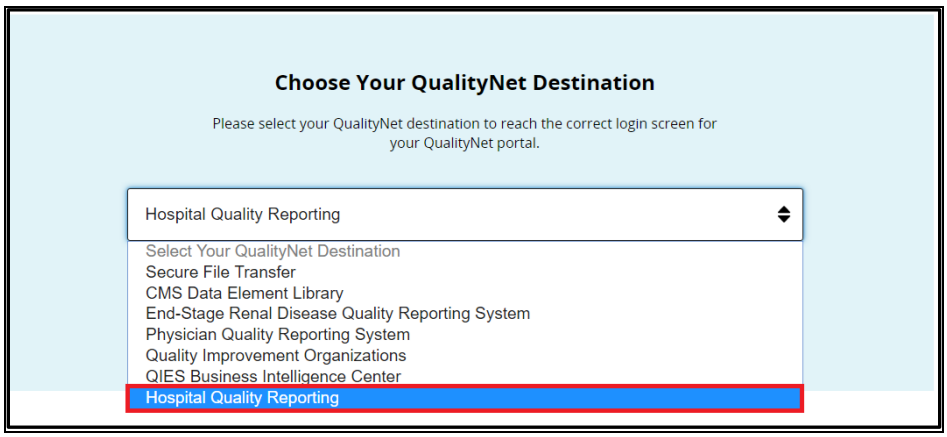
Prior to publicly reporting data on *Hospital Compare*, hospitals are given the opportunity to review data during a 30-day preview period. The data anticipated for the release can be accessed via the *QualityNet Secure Portal*, the only CMS-approved website for secure healthcare quality data exchange, located at https://www.qualitynet.org.

Public Reporting Preview User Interface (UI)

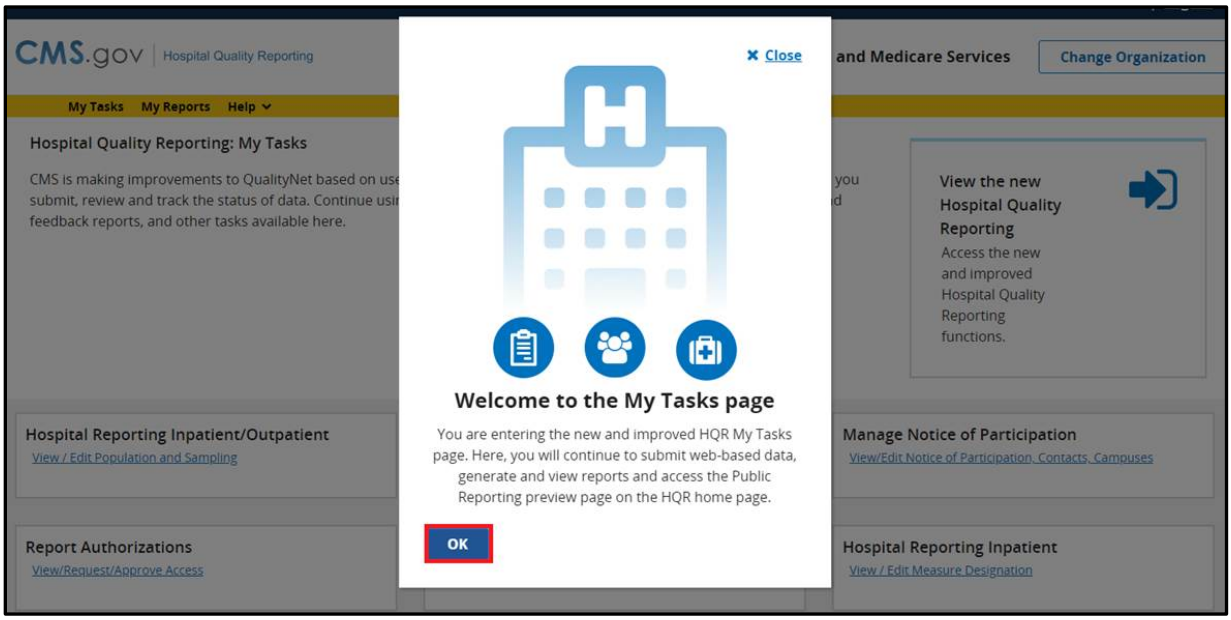
The Preview UI was developed to allow providers increased flexibility in reviewing their data. The format of the site was designed to be similar to *Hospital Compare*.

Users must be enrolled and proofed in the *QualityNet Secure Portal* in order to access the user interface. Follow the instructions below to access the UI:

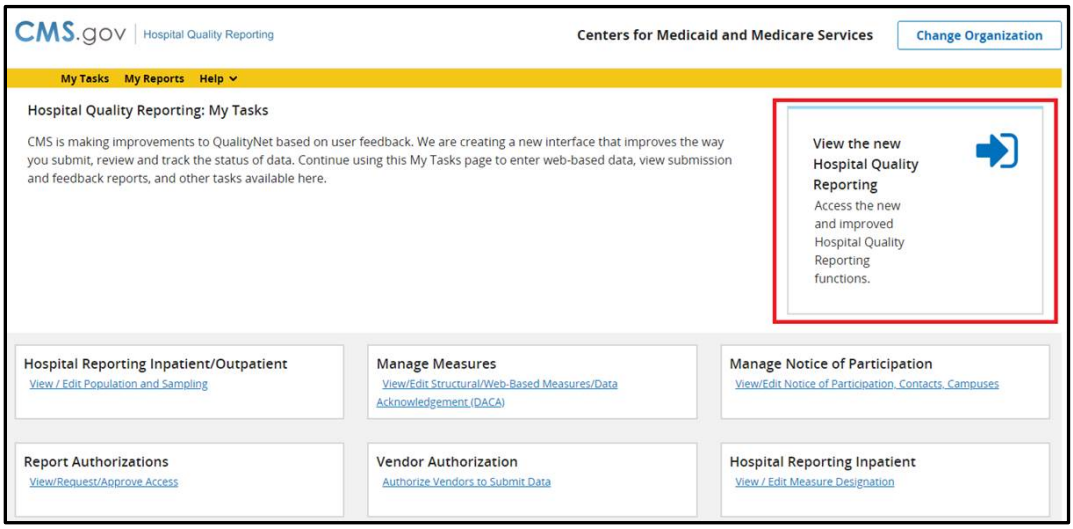
1. Access the public website for *QualityNet* at https://www.qualitynet.org.
2. Select **Login** under the *Log in to QualityNet Secure Portal* header.
3. From the **Choose Your QualityNet Destination** dashboard, select **HQR Next Generation Hospital Quality Reporting.**



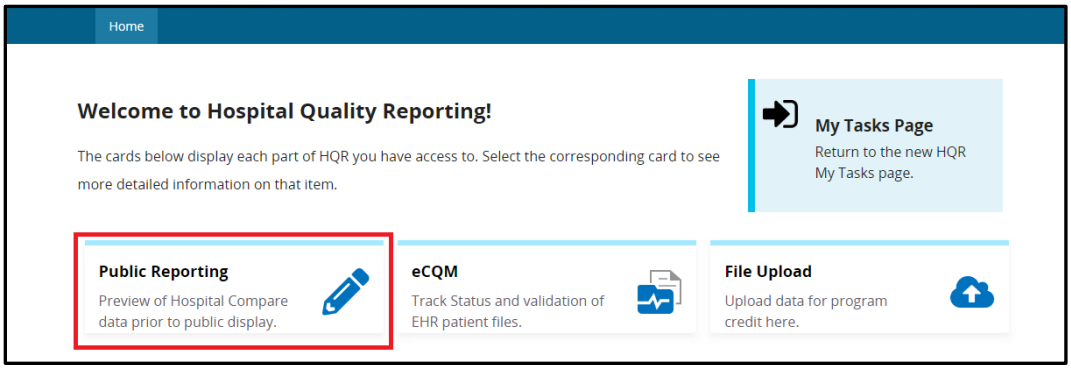
4. Enter your *QualityNet* User ID, Password, and Security Code. Then, select **Submit**.
5. Read the Terms and Conditions statement and select **I Accept** to proceed.
   Note: If **I Decline** is selected, the program closes.
6. You will be directed to the **My Tasks** page. Click **OK** on the pop up statement.



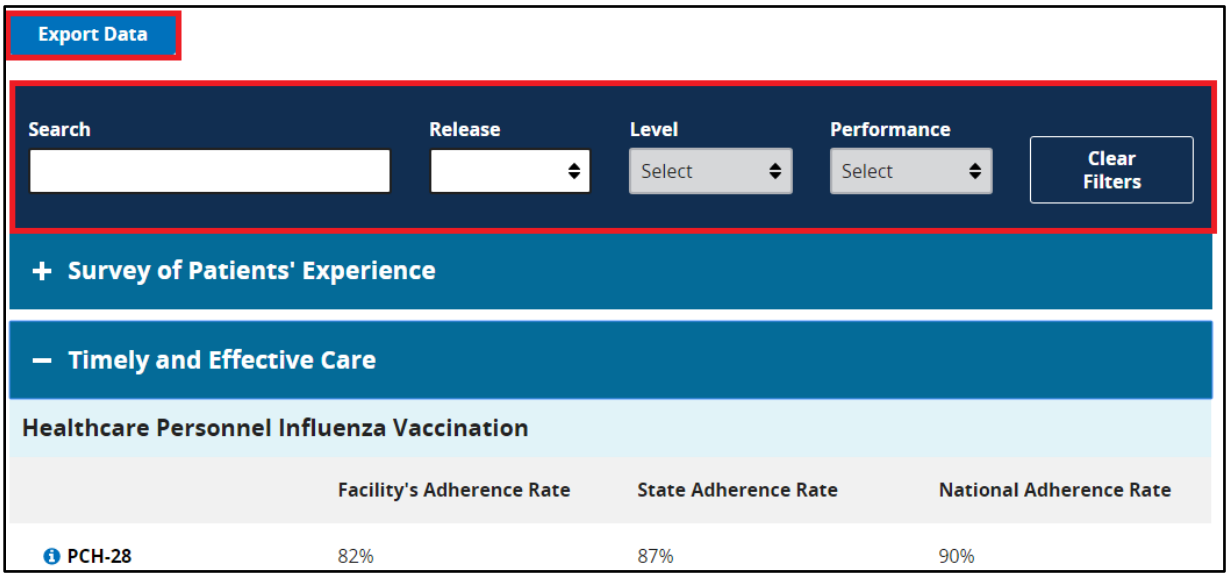
7. On the **My Tasks** page, select **View the New Hospital Quality Reporting** card in the top-right corner of the page.



8. Select **Public Reporting.**



9. Your provider name and CMS Certification Number (CCN) will appear at the top of the Preview UI. The **Change Organization Button** is available to users with roles associated with multiple facilities to see a different provider's data.
10. There are two tabs: Measure Data and Star Rating.
11. Within the Preview UI, users will be able to easily view their data. This page is an interactive analogue to the traditional PDFs. On this page, users can view measures associated by Measure Group, search the entire page for individual measures, dynamically filter through data, and export measure data. The exported measure data will be in PDF format for a user-friendly printed report. Data will be retained following the 30-day preview for future reference.



Export Data - Users will be able to export measure data into a PDF format for a user-friendly printed report.

Search - Enter specific measures into this field and the table will dynamically filter for the appropriate content.

Filtering - Users will be able to filter their benchmark data in the following ways:

- Release - Select the release data to be viewed.
- Level - Filter whether your facility's data will be compared to the "State" or "National" average during filtering. This functionality is disabled currently and will be activated in a future release.
- Performance - Filter your facility's data for being "Above," "Below," or the "Same" as previous Level selections. This functionality is disabled currently and will be activated in a future release.

PR Data Details

Hospital Characteristics

The Preview UI displays your hospital CCN and name above the hospital characteristics. Hospital characteristics include your hospital's address, city, state, ZIP Code, phone number, county, type of facility, type of ownership, and emergency service provided status.

Type of ownership is not publicly reported; however, this is publicly available in the downloadable database on *Hospital Compare*.

If the displayed hospital characteristics are incorrect, your hospital should contact your state Certification and Survey Provider Enhanced Reports (CASPER) agency coordinator to correct the information. The state CASPER contact list is available from the *Hospital Compare* home page by selecting the **Resources** button, located between the **About the Data** and **Help** buttons, directly above the *Find a Hospital* selection area. Select the **Information for hospitals,** once the screen refreshes, select the **CASPER/ASPEN** (Automated Survey Processing Environment) contacts link from the left-side navigation pane: http://www.medicare.gov/HospitalCompare/Resources/CASPER.aspx. If your hospital's state CASPER agency is unable to make the needed change, your hospital should contact its CMS regional office.

The measure IDs (e.g., PCH-1), which are displayed on *Hospital Compare,* have been provided to assist in measure identification. The measure descriptions are modified for reporting purposes.

Rounding Rules

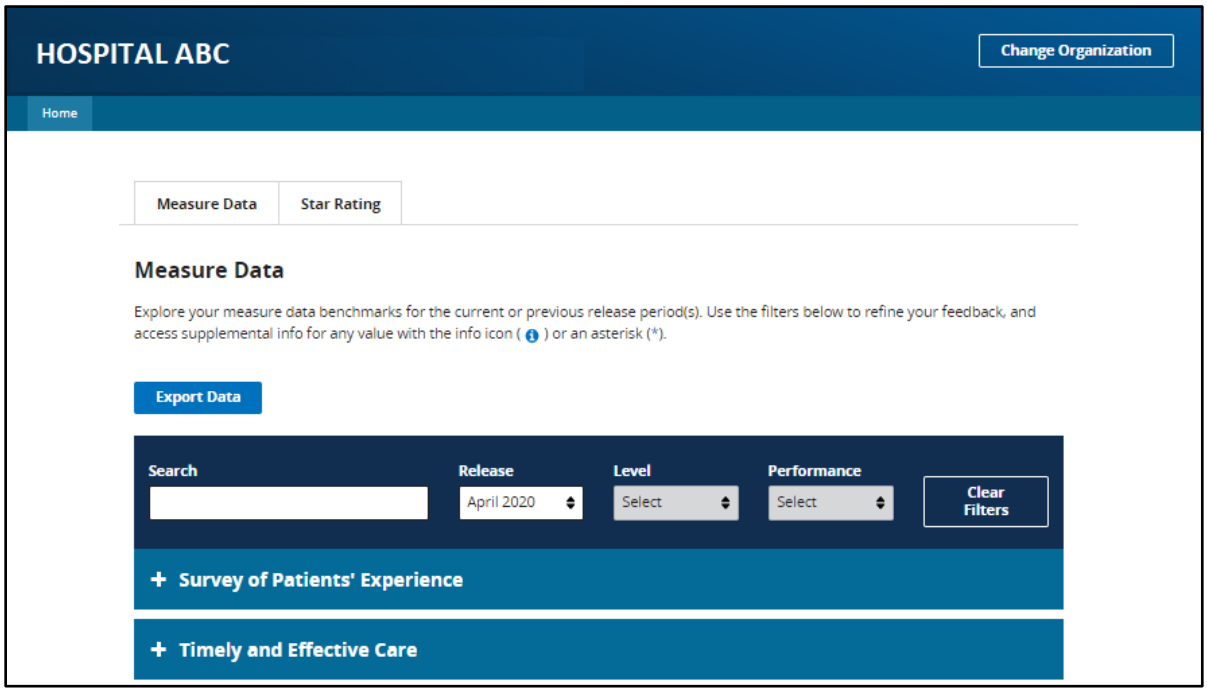
All percentage and median time calculations (provider, state, and national) are rounded to the nearest whole number using the following rounding logic, unless otherwise stated:

- Above [x.5], round up to the nearest whole number
- Below [x.5], round down to the nearest whole number
- Exactly [x.5] and "x" is an even number, round down to the nearest whole, even number (Rounding to the even number is a statistically accepted methodology.)
- Exactly [x.5] and "x" is an odd number, round up to the nearest whole, even number (Rounding to the even number is a statistically accepted methodology.)

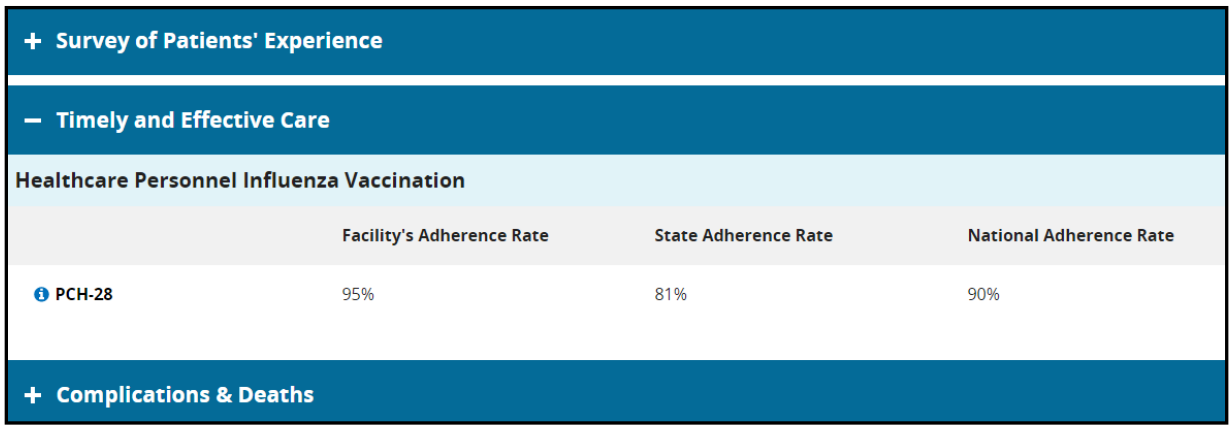
PCH Preview Details

Measure Data Tab

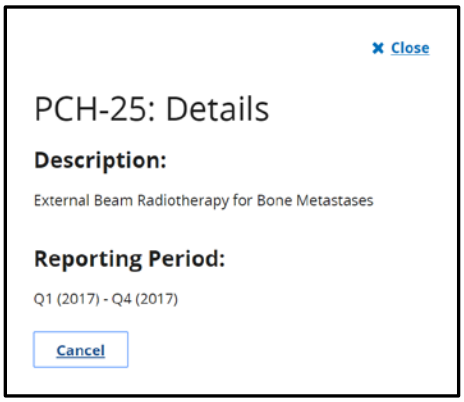
The **Measure Data** tab will display accordions and measures based on the *QualityNet Secure Portal* access that the user has.



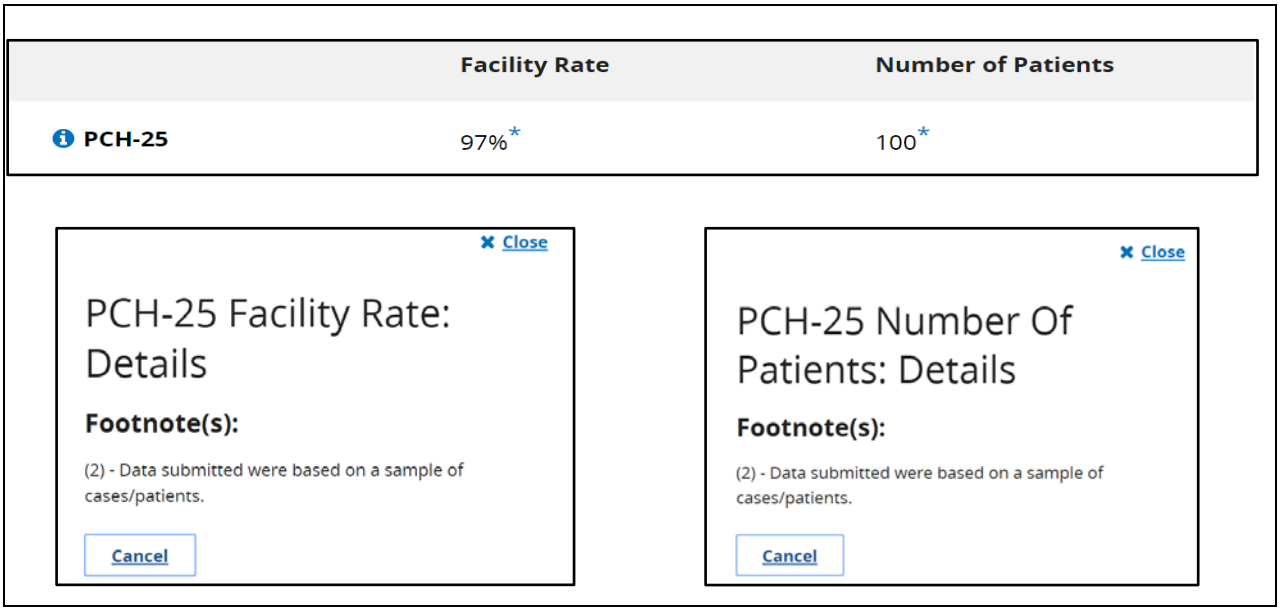
The accordions are labeled similar to the tabs on *Hospital Compare* and can be expanded by selecting the (+) to the left of the title. Selecting the (-) will collapse the table. Once the accordion is expanded, the measures and data will display.



Select the info icon ( ) to the left of the measure ID to display the full measure description in a modal.



Data will display with an asterisk (*). Selecting the data value by the asterisk will pop up a modal with additional details about the data, such as a footnote.



Accordions

+Survey of Patient's Experience

Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)

Patient Experience Data (HCAHPS)

All IPPS hospitals must continuously collect and submit HCAHPS data in order to qualify for the full APU. All participating hospitals receive a preview, and non-IPPS hospitals have the option of withholding HCAHPS results from being publicly reported on *Hospital Compare*. The HCAHPS measure data are updated quarterly.

Hospitals participating in the Hospital Inpatient Quality Reporting Program may not withhold HCAHPS results.

The HCAHPS Survey data contain survey results from four quarters of data, which display as aggregate results. Each hospital's aggregate results are compared to state and national averages. Also, the preview data contain each hospital's number of completed surveys and survey response rate for the reporting period.

HCAHPS Star Ratings

HCAHPS Star Ratings are based on the quarters of survey data in the preview. Hospitals will receive an HCAHPS Star Rating (1, 2, 3, 4, or 5 stars) for each of the 10 HCAHPS measures plus the HCAHPS Summary Star Rating, which is a single summary of all the HCAHPS Star Ratings. The preview data also contain the linear mean scores that are used in the calculation of the HCAHPS Star Ratings. For additional information on HCAHPS Star Ratings and linear mean scores, please see the HCAHPS Star Ratings section on the official HCAHPS website, http://www.hcahpsonline.org.

Note: Beginning with October 2019 public reporting, the new Composite 4 (Pain Communication) and the two associated individual questions will be displayed only in the *Hospital Compare* Preview UI. However, Composite 4 (Pain Communication) and the two associated individual questions will not be displayed on *Hospital Compare* or included in the downloadable database.

HCAHPS Composites, Individual Items, Global Items, and individual questions in the accordion include:

- HCAHPS Composites
  - Composite 1 – Communication with Nurses (Question Q1, Q2, Q3)
    - Q1 – Nurse Courtesy & Respect
    - Q2 – Nurse Listen
    - Q3 – Nurse Explain
  - Composite 2 – Communication with Doctors (Q5, Q6, Q7)
    - Q5 – Doctor Courtesy & Respect
    - Q6 – Doctor Listen
    - Q7 – Doctor Explain
  - Composite 3 – Responsiveness of Hospital Staff (Q4, Q11)
    - Q4 – Call Button
    - Q11 – Bathroom Help

  - Composite 4- Pain Communication (Q13, Q14)
    - Q13 – Pain Talk
    - Q14 – Pain Treat
  - Composite 5 – Communication about Medicines (Q16, Q17)
    - Q16 – Medicine Explain
    - Q17 – Side Effects
- Hospital Environment Items
  - Cleanliness of Hospital Environment (Q8)
  - Quietness of Hospital Environment (Q9)
- Discharge Information Composite
  - Composite 6 – Discharge Information (Q19, Q20)
    - Q19 – Help After Discharge
    - Q20 – Symptoms
- Care Transition Composite
  - Composite 7 – Care Transition (Q23, Q24, Q25)
    - Q23 – Preferences
    - Q24 – Understanding
    - Q25 – Medicine Purpose

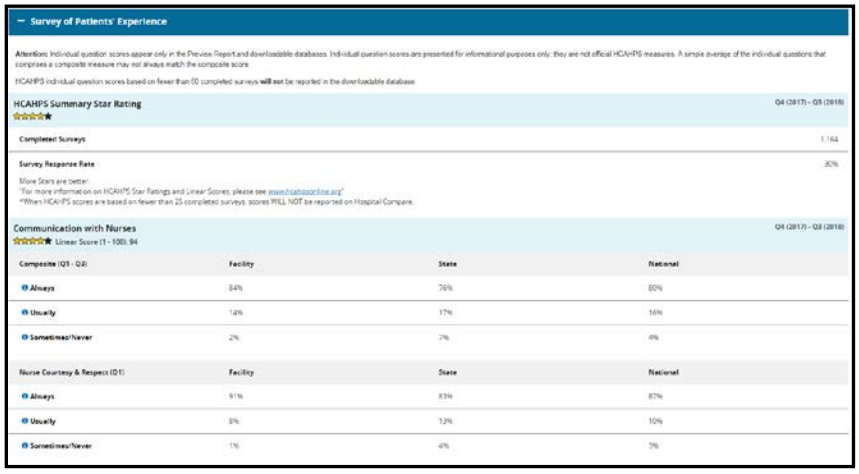
The HCAHPS Global Items include:

- Hospital Rating (Q21)
- Recommend this Hospital (Q22)

Hospitals must have at least 100 completed surveys in order to receive HCAHPS Star Ratings.

- HCAHPS Star Ratings are provided for each of the six composite measures, two environment items, and two global items.
- Whole stars (1, 2, 3, 4, or 5) are assigned to each of the 10 HCAHPS measures, plus the HCAHPS Summary Star Rating.

Linear Mean Scores: HCAHPS linear mean scores are provided for each of the six composite measures, two environment items, and two global items. The scores are available in the downloadable database on *Hospital Compare*.



State and National Average Rates

State and national un-weighted average rates for each HCAHPS measure are calculated based on all data available in the HCAHPS Data Warehouse. State and national averages are not reported for the HCAHPS Star Ratings. The state and national averages include data from Department of Defense (DoD) hospitals and Veterans Health Administration (VHA) hospitals.

HCAHPS Individual Question Scores

Scores for the 17 individual questions on the HCAHPS Survey that are used to form the seven HCAHPS composite measures will be included in the *Hospital Compare* Preview UI.

- Hospitals must have at least 50 completed surveys for individual question scores to be shown in the downloadable database.
- HCAHPS individual question scores will NOT be reported on *Hospital Compare*.

The following individual question scores are included in the Preview UI and downloadable database:

- Q1 – Nurse Courtesy & Respect
- Q2 – Nurse Listen
- Q3 – Nurse Explain
- Q4 – Call Button
- Q5 – Doctor Courtesy & Respect
- Q6 – Doctor Listen
- Q7 – Doctor Explain
- Q11 – Bathroom Help
- Q16 – Medicine Explain
- Q17 – Side Effects
- Q19 – Help After Discharge
- Q20 – Symptoms
- Q23 – Preferences
- Q24 – Understanding
- Q25 – Medicine Purpose

The following individual question scores are included in the Preview UI but will not be in the downloadable database:

- Q13 – Pain Talk
- Q14 – Pain Treat

Note: HCAHPS individual question scores are presented for informational purposes only. They are not official HCAHPS measures. A simple average of the individual questions that comprise a composite measure may not match the composite score due to rounding, item weighting, and patient-mix adjustment.

+Timely and Effective Care

Healthcare Personnel Influenza Vaccination (PCH-28)

Healthcare Personnel Influenza Vaccination

HCP Influenza Vaccination (PCH-28) includes the number of healthcare workers contributing towards successful influenza vaccination adherence within the displayed time frame, regardless of clinical responsibility or patient contact.

The Influenza Vaccination Adherence Percentage is calculated as the total number of healthcare workers contributing to successful vaccination adherence divided by the total number of healthcare workers eligible to receive the influenza vaccine per the protocol of the National Healthcare Safety Network (NHSN) at the Centers for Disease Control and Prevention (CDC).

PCH-28 displays the following data:

- Facility's Adherence Rate
- State Adherence Rate
- National Adherence Rate

Healthcare Personnel Influenza Vaccination

	Facility's Adherence Rate	State Adherence Rate	National Adherence Rate
PCH-28	95%	81%	90%

Facility's Adherence Rate

Facility's Adherence Rate is calculated as the total number of healthcare workers in your hospital contributing to successful vaccination adherence divided by the total number of healthcare workers in your hospital eligible to receive the influenza vaccine per NHSN protocol.

State Adherence Rate

State Adherence Rate is calculated as the total number of healthcare workers in the state contributing to successful vaccination adherence divided by the total number of healthcare workers in the state eligible to receive the influenza vaccine per NHSN protocol.

National Adherence Rate

National Adherence Rate is calculated as the total number of healthcare workers in the nation contributing to successful vaccination adherence divided by the total number of healthcare workers in the nation eligible to receive the Influenza vaccine per NHSN protocol.

+COMPLICATIONS & DEATHS
Infections (PCH-6, PCH-7, PCH-26, PCH-27)

INFECTIONS MEASURES

Healthcare-Associated Infections (HAIs)

Hospitals submit HAI data to the CDC's NHSN system. The CDC provides the HAI data to CMS for display on *Hospital Compare*.

The Infections Measures section of the Preview UI includes the following measures:

- PCH-06 Surgical Site Infection: Colon
- PCH-07 Surgical Site Infection: Abdominal Hysterectomy
- PCH-26 Clostridium difficile Infection (CDI)
- PCH-27 Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia

Measure Definitions

PCH-6 — Surgical Site Infections (SSI) for Colon Surgery

The SSI-Colon Surgery measure includes the number of SSIs identified among adults that occur within 30 days following criteria-specific colon surgeries performed for events identified within the displayed time frame. SSIs that were present at time of surgery (PATOS) are excluded.

PCH-7 — Surgical Site Infections for Abdominal Hysterectomy Surgery

The SSI-Abdominal Hysterectomy measure includes the number of SSIs identified among adults that occur within 30 days following criteria-specific abdominal hysterectomy surgeries performed for events identified within the displayed time frame. SSIs that were PATOS are excluded.

PCH-26 — Clostridium difficile (C. difficile) Infections

The *C. difficile* measure includes the number of hospital-onset *C. difficile* LabID events that occur in all inpatient locations, facility-wide **minus** neonatal ICUs, well-baby nurseries, or well-baby clinics within the displayed time frame.

PCH-27 — Methicillin-resistant Staphylococcus aureus (MRSA) bacteremia Blood Infections

The MRSA bacteremia measure includes the number of hospital-onset MRSA bacteremia LabID events that occur in all inpatient locations facility-wide within the displayed time frame.

HAI MEASURE DISPLAY

As noted in the image below, HAI measure information is displayed in the following columns:

- Predicted
- Reported
- Days/Procedure
- Facility Ratio
- National Ratio
- National Compare

Infections							
	Predicted	Reported	Days / Procedure	Facility Ratio	State Ratio	National Ratio	National Compare
PCH-6	14.665	11	355	0.750*	0.797*	0.894	SAME
PCH-7	2.264	4	179	1.767*	0.745*	0.899	SAME
PCH-26	112.997	86	61,628	0.761*	0.593*	0.711	BETTER
PCH-27	9.049	16	61,628	1.768*	1.038*	0.848	WORSE

PREDICTED

Your hospital's predicted number of infections is the predicted number of infections in scope for quality reporting. The predicted number of infections is calculated using national aggregate NHSN data from 2015 (resulting in the updated Standardized Infection Ratio [SIR] baseline described above) and is risk adjusted for your hospital based on several factors. The predicted number of infections is used by NHSN as the denominator to calculate your hospital's SIR.

REPORTED

Your hospital's reported number of infections is the observed number of infections reported by your hospital in scope for quality reporting. The observed number of infections is used as the numerator by NHSN to calculate your hospital's SIR.

Any data submitted to NHSN after the CMS submission deadline will **not** be included in the data reported for the Preview or on *Hospital Compare*.

Days/Procedure

PCH-6 (SSI-Colon): The procedure count field on this preview and on *Hospital Compare* displays the total number of in-plan, inpatient colon procedures performed in the facility on adults 18 years and older with no considerations to the exclusion and inclusion criteria applied to NHSN's Complex 30-day SSI SIR model. A subset of the procedure count field is used in the calculation of the number of predicted infections. This procedure count may not match the procedure count shown on NHSN's SIR Report, as NHSN's SIR Report shows the number of procedures included in the SIR calculation. More information on the procedures included in the calculation of the SIR can be found at this direct link: https://www.cdc.gov/nhsn/pdfs/ps-analysis-resources/nhsn-sir-guide.pdf.

PCH-7 (SSI-Abdominal Hysterectomy): The procedure count field on this preview and on *Hospital Compare* displays the total number of in-plan, inpatient abdominal hysterectomy procedures performed in the facility on adults 18 years and older with no considerations to the exclusion and inclusion criteria applied to NHSN's Complex 30-day SSI SIR model. A subset of the procedure count field is used in the calculation of the number of predicted infections. This procedure count may not match the procedure count shown on NHSN's SIR Report, as NHSN's SIR Report shows the number of procedures included in the SIR calculation. More information on the procedures included in the calculation of the SIR can be found at this direct link: https://www.cdc.gov/nhsn/pdfs/ps-analysis-resources/nhsn-sir-guide.pdf.

PCH-26 (*C. difficile*): The total number of patient days in hospital facility-wide inpatient locations, minus neonatal ICUs, well-baby nurseries, or well-baby clinics in scope for quality reporting.

PCH-27 (MRSA): The total number of patient days in hospital facility-wide inpatient locations in scope for quality reporting.

Facility Ratio (SIR)

The SIR is a summary measure used to track HAIs at a facility or national level over time. The SIR is calculated as observed number of infections (numerator) divided by the predicted number of infections (denominator). The number of predicted infections is adjusted based on several factors specific to your hospital. The following link provides more information regarding SIR calculations: https://www.cdc.gov/nhsn/pdfs/ps-analysis-resources/nhsn-sir-guide.pdf

When a hospital's SIR cannot be calculated for a HAI measure because there is less than one predicted infection, or because the hospital's *C. difficile* prevalence rate is above the allowed threshold, the SIR displays "N/A (with Footnote 13)" to indicate the results could not be calculated.

The upper and lower confidence intervals for the facility ratio are provided in the associated modal by selecting the data next to the Facility Ratio. The modal lists your hospital's lower-bound limit and upper-bound limit around the hospital's SIR. The lower- and upper-bound limits of the confidence interval (95%) for your hospital's SIR are an indication of precision and allow interpretation in terms of statistical significance.

When the lower limit of the confidence interval cannot be calculated due to the number of observed infections equaling zero, Footnote 8 is applied.

State Ratio

The State Ratio SIR is calculated by dividing the state numerator in scope for quality reporting by the state denominator in scope for quality reporting, for a specific infection type.

The State Ratio will be provided on the Preview UI but will not be publicly displayed on *Hospital Compar*e.

National Ratio

The National Ratio SIR is based on current aggregated data in scope for quality reporting from acute care facilities to meet the CMS rule from the same time period as the facility's data. It is shown to demonstrate where the most recent overall national SIR stands. This ratio is not shown on *Hospital Compare* to avoid confusion with the National SIR Benchmark used to compare hospital performance.

National Comparison

Your hospital's performance phrase is determined by comparing your facility's SIR to a national benchmark of 1. A confidence interval with a lower and upper limit is displayed around each SIR to indicate a high degree of confidence (95%) that the true value of the SIR lies within that interval.

Performance phrases displayed are:

- **Better** (Better than the National Benchmark): Displays if your hospital's SIR has an upper limit that is less than the National Benchmark of one
- **Same** (No Different than National Benchmark): Displays if your hospital's SIR has a confidence interval (lower to upper limit) that includes the National Benchmark of one
- **Worse** (Worse than the National Benchmark): Displays if your hospital's SIR has a lower limit that is greater than the National Benchmark of one.

+UNPLANNED HOSPITAL VISITS

Procedure Specific Outcomes (PCH-30, PCH-31)

PROCEDURE SPECIFIC OUTCOMES MEASURES

The Procedure Specific Measures section of the Preview UI includes the following measures:

PCH-30 Admission Visits for Patients Receiving Outpatient Chemotherapy - Risk Standardized Admission Rate

PCH-31 Emergency Department Visits for Patients Receiving Outpatient Chemotherapy - Risk Standardized Emergency Department Visits Rate

Note: PCH-30 and PCH-31 data were not displayed on *Hospital Compare* for January 2020. All hospitals displayed "Not Available" with footnote "4," "Data suppressed by CMS for one or more quarters," on *Hospital Compare* for these measures.

– Unplanned Hospital Visits

Admissions and ED Visits

	Eligible Discharges	Facility Rate	National Rate	National Compare
PCH-30	7,121	13%*	14.3%*	SAME
PCH-31	7,121	7.4%*	6.5%*	SAME

PROCEDURE SPECIFIC OUTCOMES DETAILS

The Preview UI displays four quarters of data. The data are updated annually in July. Each measure displays:

- Eligible Cases
- Facility Rate/ Ratio
- National Rate/ Ratio
- National Compare

+PROCESS MEASURES

Oncology Care (PCH-14, PCH-15, PCH-16, PCH-17, PCH-18)

External Beam Radiotherapy (PCH-25)

ONCOLOGY CARE MEASURES

The Oncology Care Measures (OCMs) section of the Preview UI includes the following measures:

- PCH-14 Oncology: Radiation Dose Limits to Normal Tissues
- PCH-15 Oncology: Plan of Care for Pain–Medical Oncology and Radiation Oncology
- PCH-16 Oncology: Medical and Radiation–Pain Intensity Quantified
- PCH-17 Prostate Cancer: Combination Androgen Deprivation Therapy for High or Very High Risk Prostate Cancer Patients
- PCH-18 Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients

Oncology Care		
	Facility Rate	Number of Patients
PCH-14	100%*	200*
PCH-15	100%*	77*
PCH-16	90%*	489*
PCH-17	100%*	58*
PCH-18	100%*	76*

ONCOLOGY CARE MEASURES DETAILS

The Preview UI displays an aggregate of four quarters of data. The OCM data are updated annually. Each measure displays:

- Facility Rate
- Number of Patients

EXTERNAL BEAM RADIOTHERAPY (EBRT) MEASURE

The EBRT measure section of the Preview UI contains the following:

- PCH-25 External Beam Radiotherapy for Bone Metastases
- Data display as a percent of patients (denominator)

External Beam Radiotherapy		
	Facility Rate	Number of Patients Encounters
PCH-25	95.0%*	40*

EBRT MEASURE DETAILS

The Preview UI displays an aggregate of four quarters of data. The EBRT measure data are updated annually. The measure displays:

- Facility Rate
- Number of Patients Encounters

Measure IDs Included in Measure Accordions

Measure Accordion	Measure IDs Included
Survey of Patient's Experience	Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) HCAHPS Summary Star Ratings Communication with Nurses Communication with Doctors Responsiveness of Hospital Staff Pain Communication Communication About Medicines Cleanliness of Hospital Environment Quietness of Hospital Environment Discharge Information Care Transition Hospital Rating Recommend this Hospital
Timely and Effective Care	Sepsis (SEP-1 SEV-SEP-3HR, SEV-SEP-6HR, SEP-SH-3HR, SEP-SH-6HR) Emergency Department (ED-2b, OP-18b, OP-18c, OP-22, OP-23) Immunization (IPFQR-IMM-2) Healthcare Personnel Influenza Vaccination (IMM-3, PCH-28) Perinatal Care (PC-01) Cardiac Care (OP-2, OP-3b,) Cancer Care (OP-33) Cataract (OP-31) Colonoscopy (OP-29, OP-30)
Structural Measures	Structural Measures (OP-12, OP-17)
Complications & Deaths	30-Day Death Rates (MORT-30-AMI, MORT-30-HF, MORT-30-PN, MORT-30-STK, MORT-30-COPD, MORT-30-CABG) CMS Patient Safety Indicators (PSI-3, PSI-4, PSI-6, PSI-8, PSI-9, PSI-10, PSI-11, PSI-12, PSI-13, PSI-14, PSI-15, PSI-90) Infections (HAI-1, HAI-2, HAI-3, HAI-4, HAI-5, HAI-6, PCH-6, PCH-7, PCH-26, PCH-27) Surgical Complications (Comp-HIP-KNEE)

Measure Accordion	Measure IDs Included
Unplanned Hospital Visits	Condition Specific Readmission (READM-30-AMI, READM-30-HF, READM-30-PN, READM-30-COPD) Procedure Specific Readmission (READM-30-CABG, READM-30-HIP-KNEE) Hospital Wide Readmission (READM-30-HOSPWIDE) Inpatient Psychiatric Facility Readmission (READM-30-IPF) Procedure Specific Outcomes (PCH-30, PCH-31, OP-32, OP-35 ADM, OP-35 ED, OP-36) Excess Days in Acute Care (EDAC-30-AMI, EDAC-30-HF, EDAC-30-PN)
Payment & Value of Care	Payment (PAYM-30-AMI, PAYM-30-HF, PAYM-30-PN, PAYM-90-HIP-KNEE) Medicare Spending per Beneficiary (MSPB-1)
Continuity of Care	Transition Record (TR1, TR2) Hospital-Based Inpatient Psychiatric Services (HBIPS-5) Follow-Up After Hospitalization for Mental Illness (FUH-7, FUH-30)
Substance Use Treatment	Substance Use (SUB-2, SUB-2a, SUB-3, SUB-3a) Tobacco Use (TOB-2, TOB-2a, TOB-3, TOB-3a)
Patient Experience	Hospital-Based Inpatient Psychiatric Services (HBIPS-2, HBIPS-3)
Preventative Care and Screening	Screening (SMD)
Use of Medical Imaging	Imaging Efficiency (OP-8, OP-10, OP-13,)
Process Measures	Oncology Care (PCH-14, PCH-15, PCH-16, PCH-17, PCH-18) External Beam Radiotherapy (PCH-25)

Footnote Table

Number	Description	Application
1	The number of cases/patients is too few to report.	Applied to any measure rate where the denominators are greater than zero and less than eleven. Data will not display on *Hospital Compare.* For HCAHPS: • This is applied when a hospital has zero cases, or five or fewer eligible HCAHPS patient discharges. • HCAHPS scores based on fewer than 25 completed surveys will display on the Preview UI. • Data will not display on *Hospital Compare.* • Measures based on claims data: Applied to any hospital where the number of cases reported is too small (less than 25 and greater than zero) to reliably tell how well a hospital is performing.
3	Results are based on a shorter time period than required.	Applied when CMS has opted to display HCAHPS Survey results on fewer than the required months of survey data.
4	Data suppressed by CMS for one or more quarters.	Reserved for CMS use.
5	Results are not available for this reporting period.	Applied when a hospital either elected not to submit data or the hospital had no data to submit for a particular measure or when a hospital elected to suppress a measure. For HCAHPS: • When a hospital did not participate in HCAHPS reporting during the period covered by the applicable Preview UI • When a hospital only participated in HCAHPS reporting for a portion of the period covered by the applicable Preview UI • When a hospital chooses to suppress HCAHPS results (A hospital will see HCAHPS results on its Preview UI, but not on *Hospital Compare.)*

Number	Description	Application
6	Fewer than 100 patients completed the HCAHPS Survey. (Use these scores with caution, as the number of surveys may be too low to reliably assess hospital performance.)	Applied when the number of completed HCAHPS Surveys is 50–99.
7	No cases met the criteria for this measure	Applied when a hospital treated patients for a particular topic, but no patients met the criteria for inclusion in the measure calculation.
10	Very few patients were eligible for the HCAHPS Survey. The scores shown reflect fewer than 50 completed surveys. (Use these scores with caution, as the number of surveys may be too low to reliably assess hospital performance.)	Applied when the number of completed HCAHPS Surveys is fewer than 50.
11	There were discrepancies in the data collection process.	Applied when there have been deviations from HCAHPS data collection protocols.
15	The number of cases/patients is too few to report an HCAHPS Star Rating.	Applied when CMS has determined there are too few cases or patients to report a star rating.

Resources

Note: Questions should be directed to the subject matter experts listed below. Secure File Transfer is not intended for question submission.

Timely and Effective Care Measure, Complications and Death Measures, Procedure-Specific Outcome Measures

Please direct questions to the *QualityNet* Question and Answer Tool.

OCMs and EBRT Measure

Contact the Inpatient Value, Incentives, and Quality Reporting Outreach and Education Support Contract Team via the *QualityNet* Question and Answer Tool, or call, toll-free, (844) 472-4477 or (866) 800-8765 weekdays from 8 a.m. to 8 p.m. ET.

HCAHPS Measures

Contact the HCAHPS Project Team by email at hcahps@hsag.com