PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program

Inpatient Value, Incentives, and Quality Reporting (VIQR) Outreach and Education Support Contractor

PCHQR Program: Overview of the End-of-Life Measures

Presentation Transcript

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Lisa Vinson: Good afternoon and thank you for joining today's PPS-Exempt Cancer Hospital Quality Reporting Program educational event entitled *Overview of the End-of-Life Measures*. My name is Lisa Vinson, and I am the PCHQR Program Lead for the PPS-Exempt Cancer Hospital Quality Reporting, or PCHQR, Program with the Inpatient Value, Incentives, and Quality Reporting, or VIQR, Outreach and Education Support Contractor. I will be one of the speaker today's event.

As the title indicates, today's presentation will focus on the four End-of-Life, or EOL, measures that were finalized for inclusion in the PCHQR Program effective for the fiscal year 2020 program year. These measures are claims-based which, as you know, require no additional or separate data submission requirement for program participants as CMS utilizes Medicare administrative claims data. Furthermore, this topic and information provided today will be beneficial to PCHQR Program participants as they gear up to receive their fiscal year 2022 confidential national reports. Additionally, I would like to emphasize that the specific content for today's webinar is only applicable to the participants in the PCHQR Program related to participation and reporting in CMS Quality Reporting Programs. If you have a question as we go along through today's presentation, please type your question in the chat window. At the end of this event, we will have a moderated question-and-answer session. For our speakers to best answer your question, we ask that, at the beginning of your question, please reference the slide number along with your question in the chat window. Questions that are not addressed during this question-and-answer session will be posted on QualityNet and Quality Reporting Center websites at a later date. We look forward to addressing as many of your questions related to this webinar topic as time allows. Any questions received that are not related to the topic of the webinar will not be answered in the chat tool, during the question-and-answer session, nor in the question-and-answer summary document for the webinar. To obtain answers to questions that are not specific to the content of this webinar, we recommend that you go to the QualityNet Q&A Tool. You can access the question-and-answer tool from the QualityNet homepage.

There, you can search for questions unrelated to the current webinar topic. If you do not find your question there, then you can submit your question to us via the question-and-answer tool. Later in today's presentation, I will review how to submit inquiries via this tool. Lastly, the slides for today's event were posted on QualityReportingCenter.com prior to the event. The transcript and recording of today's event will be posted on the same website and QualityNet in the near future as well.

Today's materials were created in collaboration with two consultants to the Alliance of Dedicated Cancer Centers, or ADCC, Tom Ross and Kris McNiff Landrum. Tom is the President of Ross Oncology Consulting, and Kris is the President of KM Healthcare Consulting. We are happy they joined us today to lend their expertise on this topic.

The purpose of today's event is to provide an overview of the End-of-Life, or EOL, measures specifically for the PCHQR Program. This overview will include details surrounding the measure specifications and upcoming confidential reporting period for fiscal year 2022.

At the culmination of today's event, we hope that you, as a PCHQR Program participant, will be able to understand how the PCHQR Program EOL measures were developed based on measure specifications; locate and access the confidential fiscal year 2022 EOL reports in the Hospital Quality Reporting, or HQR System; understand the contents of the confidential fiscal year 2022 EOL reports; and understand the steps to provide your feedback.

Here is a list of acronyms and abbreviations you may hear during today's presentation. These are quite familiar to program participants and regular attendees of our events. Acronyms and abbreviations you may hear and see include ADCC, for Alliance of Dedicated Cancer Centers; ASCO, for American Society of Clinical Oncology; DOB, for date of birth; DOD, for date of death; EOL, for End-of-Life; HQR, for Hospital Quality Reporting; NQF, for National Quality Forum; and MBI, for Medicare Beneficiary Identifier.

Before we delve into today's topic, I would first like to provide background information as it relates to the EOL measures and the PCHQR Program.

First, it is important that you are able to identify the four EOL measures in the PCHQR Program, which are Proportion of Patients Who Died from Cancer Receiving Chemotherapy in the Last 14 Days of Life; Proportion of Patients Who Died from Cancer Admitted to the Intensive Care Unit, or ICU, in the Last 30 Days of Life; Proportion of Patients Who Died from Cancer Not Admitted to Hospice; and Proportion of Patients Who Died from Cancer Admitted to Hospice for Less Than 3 Days. Also provided on this slide are the National Quality Forum, or NQF, numbers; the PCH numbers; and the measure short name or abbreviated measure name. Please feel free to use this slide as a reference as we discuss each measure during today's event.

As I mentioned earlier, the four End-of-Life measures were finalized for inclusion in the PCHQR Program in the Fiscal Year 2018 Inpatient Prospective Payment System/Long-Term Care Hospital Prospective Payment System Final Rule effective for the fiscal year 2020 program year. The *Federal Register* page citation is included on this slide as well for your convenience. In the fiscal year 2018 rule, the data collection period was established as July 1, 2017, through June 30, 2018. Please note that this data collection period correlates with fiscal year 2020.

The National Quality Forum, or NQF, has identified quality of end-of-life care as an area of care that needs continued improvement. It is important to note the difference between end-of-life care and palliative care. End-of-life care can be defined as comprehensive care that address medical, emotional, spiritual, and social needs during the last stages of a person's terminal illness; whereas, palliative care is generally defined as multi-faceted, holistic care that anticipates, prevents, and alleviates suffering. Research has shown that the use of palliative care, including end-of-life care, results in various positive outcomes and, when death is imminent, providing less aggressive care can certainly improve quality of life for patients.

Although end-of-life and palliative care services remain underutilized, there are benefits. One of importance is to better one's chances of maintaining a high quality of life when dying.

Now, we will review the NQF-endorsed EOL measures on the next series of slides. The numerator and denominator statements are provided along with additional details regarding the intent of the measure. Beginning with Proportion of Patients Who Died from Cancer Receiving Chemotherapy in the Last 14 Days of Life, or PCH-32, this measure is in the Clinical Process category and evaluates the proportion of patients who died from cancer who received chemotherapy in the last 14 days of life. PCH-32 seeks to assess the use of chemotherapy at the end of life with the intent to alleviate disease symptoms, in addition to evaluating how often chemotherapy is administered near the end of life in PCHs.

PCH-33, or Proportion of Patients Who Died from Cancer Admitted to the Intensive Care Unit, or ICU, in the Last 30 Days of Life is included in the Intermediate Clinical Outcome measure category. This measure assess whether cancer patients were admitted to the ICU in the last 30 days of life, specifically the frequency of end-of-life admissions to the ICU in this setting.

Proportion of Patients Who Died from Cancer Not Admitted to Hospice, or PCH-34, assesses the proportion of patients who died from cancer who were not admitted to hospice and seeks to evaluate whether patients were admitted to hospice or not. This is a clinical process measure.

Finally, PCH-35, Proportion of Patients Who Died from Cancer Admitted to Hospice for Less Than 3 Days is an Intermediate Clinical Outcome measure, which is related to PCH-34. It assesses whether, if patients were admitted to hospice, they were admitted prior to or when death was immediately imminent. I would now like to turn the floor over to Tom, who will discuss the EOL measure specifications for the PCHQR Program in detail. Tom, the floor is yours.

Tom Ross: Good afternoon. Lisa, thank you for providing the history of the four End-of-Life, or EOL, measures in the PCHQR Program.

Developed by the American Society of Clinical Oncology, or ASCO, in 2007–2009, these NQF-endorsed measures have been used in various quality reporting programs, including ASCO's Quality Practice Initiative, or QOPI; the CMS Merit-Based Incentive Payment System, or MIPS; and in the CMS Oncology Care Model, or OCM. During 2015 to 2016, the Alliance of Dedicated Cancer Centers, or ADCCs, was working to identify meaningful quality measures for assessing quality of care in oncology. The End-of-Life measures were of interest, but a key challenge identified was that these measures, if claims data were used, required the use of codes such as G-codes that are not routinely used in hospital billing. Therefore, the ADCC began a project to see if these data could be generated using routinely submitted administrative claims data as the sole source. If successful, the resultant measures could be generated without any reporting burden and would provide hospitals with access to complete chemotherapy, ICU, and hospice utilization for Medicare Fee For Service patients near the end of life. The use of the full Medicare FFS dataset, beyond just the hospitals' own internal administrative data, was important in that the measures would then also include utilization outside of the facility to which the patient is attributed.

Once the codes and measure logic were developed, the ADCC ran the data based upon Medicare Fee For Service claims from 2011–2014. Analysis of this data run, which was supplied via the JIRA system in the Measures Under Consideration Process showed that the hospital performance data resulting from the ADCC's claims cohort identification and attribution were consistent with the data supporting NQF endorsement and with more recent analyses under OCM. Once the measures were added to the program in the fiscal year 2018 final rule, the ADCC has continued to work with both CMS and Health Services Advisory Group to operationalize these measures in the PCHQR Program, culminating in this educational event and the anticipated release of the confidential Facility-Specific Reports.

This slide provides a high-level overview of the specifications. I wanted to highlight these specifications are claims-based. No manual abstraction is required. They are intended to be used at the hospital, or facility-level. Lastly, due to feedback from the clinical staff, including members of the ADCC's Physician Advisory Workgroup, we have developed a stratification method to provide facilities with their data stratified into one of three groups: acute hematology, non-acute hematology, and solid tumors. While this stratification is not part of the NQF-endorsed measures, nor will it be used in public display, we feel having the EOL measure data stratified into these three groups will provide the PCHs with more actionable data for quality improvement. I will now provide a high-level overview of the methods logic on slides 21 and 22, followed by a more granular breakdown of each step. Next slide, please.

As stated before, the measures overall population or cohort for a given performance period is identified from the Medicare claims files. As cancer patients oftentimes receive care at different facilities, there is an attribution method to assign patients to hospitals. Then patients attributed to each hospital are evaluated for inclusion in the denominator. As you will see, the denominators for NQF #210, #213, and #215 are identical. The denominator for NQF #216 (Proportion of Patients Who Died from Cancer Admitted to Hospice for Less Than 3 Days) requires an addition step as it is a subset of those patients who were admitted to hospice. So, once again, we are going to identify the overall population, then attributed to the hospital, then the denominator. Slide 22, please.

Once attribution and the denominators have been determined, the numerator is determined for each of these four measures. The performance rate is then simply determined by dividing the numerator by the denominator. It is important to note that BETTER QUALITY for all four of these measures is indicated by a LOWER number. I have to interject here that the ultimate goal is NOT a performance rate of 0. In all patient care, the patients' and families' desires must be paramount in importance in planning their care. Goal-concordant care, care that aligns with the patients' and families' desires, is the desired outcome.

Lastly, as I mentioned earlier, the results for each hospital with then be stratified into one of three groups, as outlined on the slide. On the next slide, 23, we will begin to break down each of these steps.

Step 1. The identification of patient population is defined on this slide and the next. These steps must be done in the order in which they are presented. The first step is to identify those patients who died in the data collection period. If you will recall, each of the four measures begins with the phrase, Proportion of Patients Who Died. Next, this measure is limited to those patients aged 65 or greater as of their date of death. Next, patients must have been continuously enrolled in Medicare Parts A and B during the last 12 months before death. If they were enrolled in an HMO at any time during this timeframe, they are excluded. Slide 24, please.

The next step addresses the part of the measure that says the patient DIED FROM CANCER. To assign a patient to the population of having died from cancer the following logic is used: "Patients with at least 2 cancer-related inpatient, outpatient or hospice visits during the 6 months before death. A cancer-related visit has a cancer diagnosis code listed within the top 3 diagnoses." When evaluating this you have to consider inpatient stays and outpatient visits in a different way. For inpatient visits, EACH ADMISSION with a cancer diagnosis within the top three diagnoses counts as one visit, regardless of the length of stay. An inpatient admission counts as one of the two visits. For outpatient visits, once again, only those claims with a cancer diagnosis within the top three diagnoses count. However, if there are multiple outpatient claims on the same calendar day, the day with one or multiple claims counts as only one day. You'll hear me refer to this as a "claims day." The reason for this is that many cancer patients may have multiple visits billed on one day, say with a med onc, rad onc, and possibly the infusion center, on any given day. Therefore, no matter how many claims on one given day, the day only counts once towards the two visits required. Our next slide is simply a graphical representation of the logic we covered on slides 23 and 24. Slide 25, please.

Here you see the flow of the elements to determine which patients are eligible for inclusion for the measure. Patients who died, patients aged 65 or greater at time of death, patients continually enrolled in Medicare Part A and B during the 12 months prior to death, then, to identify them as having died of carcer, they must have had at least two cancer-related inpatient, outpatient, or hospice visits during the six months prior to death. The cancer diagnosis must be within the top three diagnoses. Each admission counts as one cancer-related visit, and each day with an outpatient claims – despite the number of claims on that day – counts as one cancer-related visit. Now that we have identified the patients who died of cancer, we have to attribute their care to a hospital or facility. This is discussed on slides 26 through 28.

The overall rule is that a patient is attributed, or counts, toward an individual hospital, or PCH in this case, where they received the majority of their care. A majority is defined as greater than 50 percent of all claims, both inpatient and outpatient. As an extra logic check, to begin this, you remove all patients without any outpatient visits or inpatient stays in the last six months before death. Next, those patients who had no individual hospital with more than one clam in the last six months before death are removed. We now have to address those situations where a patient does not have a majority of all claims – inpatient plus outpatient – of greater than 50 percent at a single hospital. The first step when you have this scenario is to attribute to the hospital with the highest total of outpatient claim days. If the number of outpatient claims days is tied, you then attribute to the hospital with the highest number of inpatient claims. If you still have a tie, you then attribute to the hospital with the last INPATIENT claim before death. This is a bit confusing, so I am going to lay this out graphically on slides 27 and 28. Next slide, please.

To reinforce, you remove those patients from the initial cohort identified from claims data who did not have any outpatient claims days or inpatient stays in the last six months prior to death. You also remove those patients who have no individual hospital with more than one claim in last six months before death.

After these patient are removed, you evaluate if there is any one hospital with a majority – defined as greater than 50 percent of inpatient and outpatient claims – for each patient. For those who meet criteria, you attribute them to that hospital. You then get into what I call the "tie breakers." If there is no one hospital with more than 50 percent of the claims days, you attribute to the hospital with the highest number of outpatient claims days. If this is tied, you then attribute the patients to the highest number of inpatient stays. If still tied, then the hospital with the last inpatient claim before death, the patient is attributed to that hospital. Now that we have the patient population – those who died of cancer – has been defined and the patients have been attributed to hospitals, for each patient you now determine the denominator for each hospital for the four EOL measures. Slide 29, please.

For the Chemo, ICU, and Not Admitted to Hospice measures, the denominator is the number of patients attributed to the hospital in the performance period. As I hinted at earlier, there is a unique denominator for NQF #216: patients admitted to hospice for less than three days. To be eligible for this evaluation, they would of have to have been admitted to hospice. The denominator for this measure is therefore the number of patients attributed to the hospital in the performance period AND who were admitted to hospice in the last six months of life. Now, we will move to the fourth overall step, the numerator calculation, beginning on slide 30.

For NQF #210, Chemotherapy in the Last 14 days of Life, it may seem obvious that you start with all of the patients attributed to the hospital in the data period. Then, evaluating claims data, you look for the presence of a chemotherapy administration HCPCS code, as defined on the slide and in the data dictionary, indicating the administration of chemotherapy and the date of death. The date of death minus the last date of chemotherapy administration is less than or equal to 14 days. This then tells you that the patient received chemotherapy in the last 14 days of life. This measure, as the code is written, does not currently include outpatient chemotherapy as this data are most often included in Part D data, which is not in the Medicare Fee for Service data set used for this measure.

Slide 31 shows the numerator for our next measure, NQF #213.

To determine the numerator for this measure, ICU utilization in the last 30 days of life, you look for the revenue codes for ICU, 200–219. The patient counts toward the numerator (having an ICU stay in the last 30 days of life) if that revenue code occurs in the 30 days prior to death. On slide 32, we will look at the Patient Not Admitted to Hospice in the last 30 days of life. Next slide, please.

It is important to remember that, for all four of these measures, a lower score, indicates quality. Therefore, NQF #215, Proportion of Patients Who Died from Cancer Not Admitted to Hospice, is worded using the word NOT. This is a bit tricky to understand at first. You want your patients, in general, to be admitted to hospice. Therefore, having a lower percentage of patients NOT admitted to hospice is desirable. The patient is attributed to the numerator of not being admitted to hospice in the last six months of life if there are NO hospice claims during the last six months of life. On slide 33, we will look at the numerator for the last of EOL measures in the PCHQR Program, NQF #216. Slide 33, please.

Remember, you are using a different denominator for this measure only. It is those patients attributed to the hospital AND who were admitted to hospice in the last six months of life. For this set of patients, the patient counts towards the numerator if the DATE of DEATH minus the Hospice Enrollment Date is less than or equal to three days. As the footnote explains, while the official name of the measure is Proportion of Patients Who Died from Cancer Admitted to Hospice for Less Than 3 Days, when examining the NQF specifications, it clearly states that the calculation to be used is less than or equal to three days. Slide 34, please.

The calculation of the performance rate is straightforward. For each measure you simply divide the numerator by the denominator, remembering that for the hospice less than three days, you are using a different denominator.

These measures are written so that a lower score indicates better quality: less chemo within last 14 days of life; less intensive care utilization in last 30 days of life; MORE hospice care is desired in last six months of life, so the measure is written to the reflect this; proportion of patients who died from cancer not admitted to hospice,

we want fewer patients not admitted to hospice; and lastly, EARLIER enrollment in hospice is better, so measure is written, "Proportion of patients who died from cancer admitted to hospice for less than 3 days." Once again, the goal is not 0 percent. In all patient care, patients' and families' desires must be paramount in importance when planning their care. Goal-concordant care, care that aligns with the patients' and families' desires, is the true desired outcome. Slides 35 and 36 we will look at the stratification of these measures.

Many of the clinicians in the ADCC felt that stratified data would be useful to the PCHs due to different standards of care in their patient populations, especially in evaluating these measures in the hematologic oncology versus non-hematologic cancer patient populations. Therefore, working with a sub-group of the ADCC's Physician Advisory Workgroup, we have developed a stratification method to provide facilities with their data stratified into one of three buckets: acute hematology, non-acute hematology, and the rest are lumped into solid tumors. While this stratification is not part of the NQF-endorsed measures, nor will it be used in public display, we feel having the End-of-Life measure data stratified into these three groups will provide the PCHs with more actionable data for quality improvement. The specific diseases are spelled out on this slide, while our next slide shows the specific codes to be used in stratifying the data.

At this point, I will turn the presentation back over to Lisa, who will guide you through the upcoming release of the confidential national data reporting period. We wanted you to understand the logic behind this measure, but remember that the CMS support contractor will be actually calculating these results for you. I thank you for your time and attention and hope this walkthrough of the measure specifications was helpful. Lisa.

Lisa Vinson: Thanks, Tom. I would now like to turn our attention to confidential national reporting.

Confidential national reporting of the four EOL measure was finalized in the Fiscal Year 2020 IPPS/LTCH PPS Final Rule.

The data collection period that correlates with fiscal year 2022 is July 1, 2019, through June 30, 2020. It is important to note that the collection period has been adjusted due to the COVID-19 Public Health Emergency, which excluded Q1 2020 and Q2 2020 claims data.

Here is a quick reminder about the goals of confidential national reporting, which you may be familiar with as other claims-based measures have undergone this type of reporting. The goals include educating PCHs and other stakeholders about the measure, allowing PCHs to review their measure results and data prior to public reporting, answering questions from PCHs and other stakeholders, testing the production and reporting process, and lastly identifying potential additional technical changes to the measure specifications that might be warranted.

Now we will review the steps you will need to take to access your confidential national report via the Hospital Quality Reporting, or HQR, system. I would like to highlight that the EOL confidential reports are still under development and a Listserve communication will be distributed as soon as the reports are available. With that being said, although the reports are not immediately available, our team was able to develop images of what we anticipate the reports will look like, so please be advised that once the reports are deployed or made available, there may be some slight modifications to what you see during today's presentation.

The steps to access the HQR System remain the same as these are the same steps you take to complete such tasks as entering measure data or accessing your facility's public reporting preview reports. Therefore, to get started, and as displayed on this slide, you will need to first navigate to the HQR sign-in page. Then, you will enter your HARP user ID and password, and select the Login button.

As displayed on this slide, you will need to authenticate your account. Depending on how you set up your method to authenticate, you will need to make a selection how you would like to receive the authentication code, whether by SMS text, phone call, or email. Once you select the method of delivery, you will select the Next button.

Here is where you will enter the 6-digit verification code you received. Once you enter the code, you will then select the Continue button.

Before you are directed to the HQR home page, you will need to review and accept the Terms and Conditions. You will need to use the scroll bar to scroll down as denoted by the red arrow on this slide. Once you reach the end of the text box, the Accept button will illuminate and you will be able select it. By doing so you, will be taken the HQR home page as shown on the next slide.

This is the HQR home page. As this system is continually undergoing enhancements, this page may appear slightly different when you log in.

On the home page and within the navigational pane on the left-hand side, you will select Performance Reports, which is found under the Program Reporting header.

Under Performance Reports, you will need to select PCHQR under Program, which populates the available reports to include the confidential EOL reports, which are the Patient Summary Report and the Measure Performance Report. You will also need to select the appropriate fiscal year, which is 2022. Then, you will select the Export CSV button. At this point, the Excel comma-separated values, or CSV, report file will download and open in a separate window. We will begin our review with the EOL Measures Patient Summary Report.

Again, the patient summary report is in a CSV file format. Please note that due to the file format, we will be reviewing examples of each report in segments since the entire report cannot fit on one slide. The Patient Summary Reports provide details about the End of Life claims at the beneficiary level.

The fiscal year and data collection or performance period, again which is adjusted to exclude Q1 and Q2 2020 claims data, are listed in the first two columns. The ID number and six-digit provider number are provided in columns 3 and 4. The 11-digit MBI, or Medicare Beneficiary Identifier, is listed in column 5. Column 6 lists the unique medical record number

Column 7 and 8 note the patient's date of birth and date of death, respectively. Column 9 lists the patient's age, which includes those beneficiaries who are 65 years or older at the date of death.

This segment of the report displays cancer diagnosis codes which include specific ranges in code categories C, D, J and R. Also, you will see the three different stratification categories Tom discussed during his explanation of the measure specifications, which include solid tumor or acute hematology or non-acute hematology. The report further identifies chemotherapy treatment codes, which include the Q category; the date of chemotherapy treatment, if received in the last 14 days of life; and ICU-related data, such as the provider ID, encounter code (ICU revenue codes ranging 200–219), and the date of service (which was evaluated to determine if the admission date was within or beyond 30 days of death).

The last segment of the Patient Summary Report is related to hospice, which includes the hospice provider ID number, hospice care codes, date of admission to hospice and, if applicable, the number of hospice days.

Ultimately, based on what measure criteria were met or not met, a Yes or No for the numerator and denominator for each EOL measure will be displayed here. Yes means the patient qualified for inclusion in the numerator and/or denominator. No means the patient did not qualify for inclusion in the numerator and/or denominator.

The other available confidential reports selection is the EOL Measures Performance for fiscal year 2022. The purpose of this report is to display End-of-Life measure results at the facility level. Again, you will need to select EOL Measures Performance under Report and Export CSV to review this report.

Again, this report highlights each EOL measure performance at the facility level. The first segment of this report displays the provider ID, which is your facility CMS Certification Number, or CCN; the fiscal year, which is 2022. There will be individual rows for each EOL measure. So, there will be row for PCH-32, PCH-33, PCH-34, and PCH-35.

There will also be individual rows with numerical values for the three stratification categories for each EOL measure. In addition, there will be a row labeled Overall which provides a sum of the stratified cases for each measure.

This segment of the EOL measures report displays the numerator; the denominator; the measure rate, which is the numerator divided by the denominator; a footnote description, if applicable, which may display Footnote 5, which means that results are not available for this reporting period wherein a value of "0" is recorded for numerator and denominator values. A footnote of 7 denotes that no cases met the criteria for this measure which is applied when the measure rate equals 0 (in the case where the numerator equals 0). Lastly, the adjusted performance period is displayed, which is July 1, 2019, through December 31, 2019.

I hope this overview of the patient- and facility-level confidential EOL reports was beneficial and provides insight into what you can expect to see and aid in your understanding of the contents of the fiscal year 2022 reports.

As with all program inquiries, we encourage participants to utilize the QualityNet Question and Answer Tool. For your convenience, you can access this page directly via the hyperlink on this page. The image of this page is also displayed on this slide. Although this tool can be used to inquire about various PCHQR Program topics, for the purpose of this presentation, we will focus on how to submit questions specifically for the EOL measures and reports. You will start by selecting the option that says Ask a Question as denoted by the red box on this slide.

If you noticed, as I was going through the measures early in the presentation, I mentioned the measure category. This is important as it relates to selecting the appropriate topic.

As illustrated here, PCH-32 and PCH-34 fall under the Clinical Process category, and the remaining two EOL measures, PCH-33 and PCH-35, are categorized under Intermediate Clinical Outcome measures category. You will select the appropriate topic, fill in the required fields, draft your inquiry, and then submit.

As you may be aware, this is the time of year when the program-specific QualityNet resources and tools pages undergo updates. These updates are currently in process. As we just discussed, the QualityNet Question and Answer Tool should be used to submit questions regarding the EOL measures and reports. There will also be updates to the PCHQR Program QualityNet site, specifically the Measures page, by adding the EOL measures information to the list of the other claims-based measures and also updating the Data Collection page, so that the EOL measure information is easily accessible. Please stay tuned for these updates, along with the communication regarding the availability of the EOL reports.

Now, we would like to address questions received in the chat box. As I mentioned at the start of our event, we will address as many questions as time allows. If we are not able to address your question during this session, the question-and-answer summary document will be posted at a later date on both QualityNet and Quality Reporting Center websites. So, now to start, Tom, I'm just going to open up the floor to you quickly for a clarification that you wanted to provide for slide 30.

Tom Ross: If you can please go to slide 30, during the event you see here that it says you look for the chemotherapy administration, HCPCS codes, and I misspoke and said this does not include outpatient chemotherapy. It does include outpatient chemotherapy. It does not include oral chemotherapy. Oral chemotherapy is the part that is billed in Part D, and that is not part of the claims file used in this measure. So, just to be clear, it includes outpatient chemotherapy, but it does not include oral chemotherapy. We can put a note in the transcript to clarify that and people on the call have heard it as well. I apologize for the miscommunication.

Lisa Vinson: Okay, thank you, Tom.

Tom Ross: You're welcome.

Lisa Vinson: If you can go to slide 53, please. There was a question regarding the red box on this slide for the stratification. Slide 53 shows all 32 in the bottom red box, should it be 32 through 35?

So, essentially how the report is going to show it is there will actually be these four rows for each measure. I just pulled out one of the measures. So, you will see the acute hematology, non-acute hematology, solid tumor, and overall for measure PCH-32. You'll see the same four rows for measure 33 and so forth and so on. I hope that makes that a little bit clearer for you.

One other question, when will the confidential reports be available? As I stated earlier during the presentation, the EOL reports are still under development; however, at this current time, we do anticipate that the report may be available sometime in January of 2022. We encourage all program participants to ensure that they are signed up to receive PCHQR Program notifications as this will be the source of communication. A Listserve communication will be the official communication regarding the delivery of these reports. If you are not signed up to receive these notifications, you can do so by visiting the QualityNet.org website, and there's a box on the home page that says Subscribe to E-mail Updates. Once you click that button, you will just simply follow the steps in order to get your e-mail address registered to receive those communications.

Another question. When will the EOL measures be publicly reported? At this time, CMS has not confirmed plans for public reporting of these measures. Specifically, for the PCHQR Program, the final rule must specify any plans as it relates to public reporting. So, CMS will communicate these plans regarding the EOL measure public display to all stakeholders via a final rule publication.

As I don't see any more questions during our event right now, we will go ahead and conclude the question-and-answer session. We thank those who did submit inquiries and thank you, Tom, for providing a clarification regarding that slide.

Moving onto continuing education as indicated on this slide, today's event has been approved for continuing education credit by the boards listed. If you need additional information or assistance obtaining these credits, please utilize the CE credit listed on this slide. Next slide, please.

In closing, thank you for your time and attention during today's presentation. Also, a special thank you to Tom and Kris for their expertise and participation. We hope that the information provided today was beneficial to you as a PCHQR Program participant.

Thank you and enjoy the remainder of your day.