



PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program
Inpatient, Value, Incentives, and Quality Reporting (VIQR)
Outreach and Education Support Contractor

**PCHQR Program: 30-Day Unplanned Readmissions for
Cancer Patients Measure (PCH-36)**

Presentation Transcript

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Lisa Vinson:

Good afternoon and thank you for joining today's PPS-Exempt Cancer Hospital Quality Reporting, or PCHQR, Program educational event entitled *30-Day Unplanned Readmissions for Cancer Patients Measure (PCH-36)*. My name is Lisa Vinson and I am the Program Lead for the PCHQR Program with the Inpatient, Value, Incentives, and Quality Reporting, or VIQR, Outreach and Education Support Contractor. I will be the moderator for today's event. As the title suggests, our discussion today will focus on one of the PCHQR Program's claims-based outcome measure, 30-Day Unplanned Readmissions for Cancer Patients, also known as PCH-36, or NQF number 3188. This measure was finalized for inclusion in the PCHQR Program in the Fiscal Year 2019 Inpatient Prospective Payment System (IPPS)/Long-Term Care Hospital Prospective Payment System (LTCH PPS) Final Rule, published in August 2018. Also, PCHQR Program participants received their confidential Facility-Specific-Reports, or FSRs, on July 29. I would like to emphasize that the specific content for today's webinar is only applicable to the participants in the PPS-Exempt Cancer Hospital Quality Reporting Program as it relates to participation and reporting in CMS Quality Reporting Programs. As a reminder, the slides for today's event were posted on QualityReportingCenter.com prior to the event. The questions, answers, transcript, and recording of today's event will be posted on the same website and QualityNet in the near future. Lastly, as discussed on the previous slide, 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 question-and-answer session. For the speakers to best answer your question, we ask that at the beginning of your question to please reference the slide number, along with your question, in the chat window. Questions that are not addressed during this questions and answer session will be posted to Quality Reporting Center and QualityNet at a later date.

Today, we are joined by Tamara Mohammed, who is a Senior Health Outcomes Researcher with the Yale Center for Outcomes Research and Evaluation organization. Tamara, her team, and I collaborated on the information we will be sharing today.

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We hope that you find it beneficial in understanding the PCH-36 measure as it relates to the content of your confidential facility-specific reports.

As stated earlier, there will be a question-and-answer segment at the end of the didactic portion of this presentation. We request that you submit your questions, pertinent to the webinar topic, via the Chat tool as we go through the event. As time allows, questions will be addressed in the order received. Questions unable to be addressed will be included in a question-and-answer summary document. This document will be posted and available to view on the PCHQR Program pages on the Quality Reporting Center and QualityNet websites. As indicated on this slide, and I will further review at the end the presentation, the [QualityNet Question and Answer Tool](#) is always at your disposal. You can submit any additional questions after this webinar via the QualityNet Question and Answer tool. If you have an unrelated question to the current webinar topic, please utilized the search function within the question-and-answer tool to see if your questions may have already been answered. If not, feel free to submit a question, and a response will be proved as soon as possible.

Here is our standard abbreviations and acronyms slide. Abbreviations and acronyms you may hear today include C-Y, for calendar year; F-S-R, for Facility-Specific Report; H-A-R-P, for HCQIS Access Roles and Profile; H-Q-R, for Hospital Quality Reporting; I-P-P-S, for inpatient prospective payment system; M-F-T, for Managed File Transfer; and R-S-R-R, for Risk-Standardized Readmission Rate.

The purpose of today's presentation is to provide an overview of the PCHQR Program's 30-Day Unplanned Readmissions for Cancer Patients measure, which we will refer to as PCH-36, and the confidential Facility-Specific Reports, or FSRs, which were recently distributed to the PCHs.

At the culmination of this event, we hope that participants are able to understand how the PCHQR Program specifies and calculates PCH-36, interpret fiscal year 2022 PCH-36 measure results in their confidential FSRs, and ask questions regarding the calculation and confidential reporting of PCH-36.

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At this time, I would like to turn the presentation over to Tamara. Tamara, the floor is yours.

Tamara

Mohammed:

Thanks, Lisa. Hello, everyone. My name is Tamara Mohammed. Today, I will be providing you with an overview of the 30-Day Unplanned Readmissions for Cancer Patients measure. Since the name of the measure is a mouthful to say, for the rest of the presentation, I'll be referring to this measure as the PCH-36 measure, or the cancer readmissions measure, which is more abbreviated form of the measure name by CMS. During our conversation today, we'll discuss how the measure works. Then, we'll discuss the reports that CMS sent to hospitals for this measure. Then, finally, we will wrap up by talking about where you can go to access information on this measure.

To begin, the PCH-36 cancer readmissions measure is a measure that looks at the rate of unplanned readmissions for cancer patients within 30 days of the initial hospitalization. We'll go into a bit more detail with how the measure works. The measure itself evolved from the Comprehensive Cancer Centers of NCI, the Alliance of Dedicated Cancer Centers, or ADCC. The measure was endorsed by NQF, or National Quality Forum, in 2017 before being finalized for use in the PCHQR Program in the Fiscal Year 2019 IPPS, or Inpatient Prospective Payment System, Final Rule.

As the measure was finalized for use in PCHQR Program, CMS recently, on July 29, provided hospitals with reports for PCH-36, the cancer readmissions measure. These reports which are named Facility-Specific Reports, or FSRs, are confidential reports, and they provide detailed information to hospitals on the performance of the PCH-36 measure. For the fiscal year 2022 program year, which is the program year relevant to the FSRs release in July 2021, these reports are confidential only and the results in these reports are not intended for use and public reporting at this time.

Let's talk a bit about the PCH-36 cancer readmissions measure and works. This is a claims-based measure.

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CMS gets results for the measure by using information from claims that were already submitted to CMS. Hospitals for this measure don't need to submit any additional information to CMS. More specifically, the PCH-36 cancer readmissions measure is calculated using Medicare Part A administrative claims data. For the fiscal year 2022 program year, the FSRs distributed in July 2021 contain results based on inpatient cancer admissions between October 1, 2019, and December 1, 2019, and then again on July 1, 2020, to September 30, 2020. You'll notice that the data collection period for the 2022 program year is a bit disjointed. This is because the performance period for the measure was shortened to exclude data from January to June 2020 in accordance with the COVID-19 data waiver that CMS issued in March 2020. We expect CMS to send the next FSR for this measure in July 2022 for 2023 program year. In that report they expect that the measure will be calculated using data from admissions that occurred between October 1, 2020, and September 30, 2021.

On the previous slide, CMS calibrated the PCH-36 measure based on data from cancer admissions that occurred during a specific time frame. With regard to exactly which admissions are included in those time frames, the PCH-36 measure includes hospitalization from Medicare Fee-For-Service patients age 18 or older who are discharged from PPS-Exempt Cancer Hospital during the reporting period with a principal or secondary diagnosis of malignant cancer. If, however, the patient was less than 18 years of age, died during index admission, discharged against medical advice, transferred to another acute care hospital during the index admission, discharged with planned readmission, has missing or incomplete data, or was admitted to an inpatient bed, then that patient was excluded from the measure excluded from the measure calculation.

Now for each case that meets the measure inclusion criteria, the measure looks for whether or not the unplanned readmission occurred within 30 days of discharge from that index admission. Then, it calculates the Risk-Standardized Readmission Rate, or RSRR. To be clear, if an unplanned readmission did occur within 30 days then the admission was considered to have an outcome.

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For the PCH-36 cancer readmissions measure, an unplanned readmission is considered to be an admission to a short-term acute care hospital with a primary claim diagnosis code type of emergency (1) or urgent (2). However, if the readmission occurs within the primary clean diagnosis of metastatic cancer or chemotherapy/radiation encounter then this readmission is considered planned and therefore would not count as outcome for the PCH-36 measure.

Like many CMS's other claims-based outcome measures, this cancer readmission measure is a risk-adjusted measure and is specifically risk adjusted for ten variables. It is risk adjusted for whether the patient had an ICU stay during the index admission, risk adjusts for the patient's gender, whether the patient was dual eligible patient, whether the surgery occurred during the index admission, whether the patient had multiple comorbidities, and whether the length of the stay was greater than three days. It also risk adjusts for age and is broken in six categories and you can see that they are listed here on the screen under the table. The measure also risk adjusts for whether the patient was hospitalized in the prior 60 days or discharged from home or whether the patient discharged to hospice.

So, now we know what kind of hospitalizations are attached to the measure, what the outcome of the measure is and what we are measuring, and what risk variables are used by the measure. These pieces are all used to calculate RSRR, or risk-standardized readmission rate, for the measure. Broadly, the formula used to calculate the RSRR is the one that you see here on the screen. It is calculated as the observed rate divided by the expected rate and multiplied by the national readmission rate. Here, these are calculated by the sum of observed unplanned readmissions for each hospital. The expected rate is calculated based on the sum of the probability of unplanned readmission for all index admissions at each hospital. By using this formula, the RSRR is calculated for every hospital. The lower RSRR are interpreted as indicating better quality care, while higher RSRR is indicative of poorer quality.

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Now, since we spent time discussing how the measure was calculated, let's spend some time talking about the report CMS recently issued for hospitals for the PCH-36 measure.

Before we dive into the details of each report, I want to explain how CMS categorizes hospital performance on the measure since the information on performance is contained within each PCH-36 FSR. In addition to calculating the RSRR for the PCH-36 measure, CMS also categorizes hospital performance on the measure in order to help stakeholders interpret their results and understand how they are performing on the measure. They are first categorizing hospital performance on the PCH-36 measure. CMS categorizes the measures. Specifically, the PCH-36 cancer readmission measure categorizes hospital performance by comparing the hospital's 95 percent confidence interval against the national rate for the measure. So, when CMS calculates hospitals RSRRs, it also calculates a 95 percent confidence interval in the RSRR, which can be interpreted as the range CMS is 95 percent sure the true RSRRs lie. To categorize hospitals performance, CMS compares the range against the national rate. If you look at the image here. We're going to start at the right-hand corner. You can see hospital in red, Hospital C, has a confidence interval that ranges from 18.3 to 26.2. Since the range of 18.3 to 26.2 on this image is to the right of national readmission rate for PCH-36 measure, which in this example is 14.8, you can see on the map of the United States at the top and you see depicted by the grey dotted line that runs through the image. You can see that the range of 18.3 to 26.2 lies to the right of those dotted lines. That means that Hospital C is categorized as performing within the national rate. If we look at Hospital B, which is the yellow hospital in the middle, and the 95 percent confidence interval estimated here is 18.0 to 16.0. Since the national rate of 14.8 falls within this range, then the Hospital B is classified as performing no different than the national rate. Finally, Hospital A is green at the bottom and the interval rate ranges from 5.3 to 10.8. Since this is on the left-hand of the national rate of 14.8, then this means that this hospital classified better than the national rate. Now only those hospitals that have a minimum of hospital admissions are included in the measure.

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Only hospitals that have a minimum of 50 patient admissions included in the measure receive one of these two performance categories. To receive a category of better, you have to have at least 50 cases in the measure.

If a hospital has less than 50 patient admissions in the measure, then CMS classified the performance as number of cases too small. So, the number of cases in the measure is too small to rely on the estimate of the hospital performance.

Now, with regard to whether or not you have 50 cases, only hospitals who are nonfederal PCHs and have at least one eligible cancer admission during the reporting period -can receive a PCH-36 file from CMS. As I mentioned earlier, FSRs were delivered a few weeks ago on July 29 and sent to hospitals by MFT and large file transfer which we will talk about later. Each FSR is available with a FSR User Guide which is a PDF document which is meant to be used alongside the FSR. The FSR User Guide was created to help hospitals understand the information contained within the FSR. It is a very useful document for you to have. If you are familiar with the FSR for the PCH-30/11 chemotherapy measure, then it might be helpful for you to know the PCH-36 FSR is structured in same way and contains same type of information and same order to help you orient yourself to this document and enhance the FSR's usability to you.

To quickly review the actual information contained in the FSR, if you take a look at the screen, what you find is an example of the kind of information included in FSR for PCH-36 cancer readmission measure. The first table contains information on your hospital's performance. It tells you what your hospital's RSRR is. It tells you what your hospital's performance category is and how CMS defines categories using the confidence intervals. The RSRR table also tells you what your hospital's confidence interval is. On this table, you also find information used in the calculation of the measure at your hospital and how many patients had a readmission outcome. You can also find on this table what the national PCH-36 rate is and how many cases were included in the measure in the nation and also how many cases had an outcome.

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The second table in your FSR provides information on how the nation performed on the measure, so you can get a sense of where you stand compared to others. It tells you how many hospitals in the nation are classified as better, no different, or worse than the national rate. It also shows how cases met the classification.

The third table in the FSR contains patient-level information, the number that met the inclusion criteria. It tells you when the admission occurred, why it occurred, whether it was included in the measure calculation and, if yes, if an outcome occurred. If an unplanned readmission outcome did occur, it tells you when, where, and why this occurred. This information is provided to help hospitals understand the patient-level data included in the calculations. They can examine the cases and engage in quality treatment activities as deemed appropriate.

The fourth and last table in FSR provides you information on the risk distribution. It tells you what risk factors in patients in the measure and tells you so you can compare prevalence of those factors amongst all the patients in the nation for the measure.

After all the information is provided to you in the FSRs, in addition to your performance on the measure, and the FSR User Guide, CMS also provides you with the number of resources on the PCH-36 cancer readmission measure. If you go to the QualityNet website, and the hyperlink for the website is at the top of the page:

<https://qualitynet.cms.gov>. You follow the path, then you can find a FAQ document that provides you information on the measure, how it is calculated and implementation in the PCHQR Program. You can also find the cancer readmission measure in the dictionary, which is an XML file that lists all the codes in the PCH-36 cancer readmission measure. You can find a mock FSR. A sample FSR contains real national information and simulated hospital information is provided primarily for those who received an FSR to understand the kinds of information CMS included. A copy of the FSR User Guide is also located on the QualityNet website.

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Lastly, if you have a question about the PCH-36 measure, CMS has made a Q&A avenue available to you. You can submit a question to the QualityNet question-and-answer site using the link there on the screen. From that link, you can select PCH for the program. Under the topic, you would select the PCH-36 measure. If you want to submit a question about the PCH-36 measure, use this Q&A tool. You will receive a direct answer to the specific question that you asked. Okay, now, I'm going to hand it back to Lisa for the next segment of today's presentation.

Lisa Vinson:

Thanks, Tamara! I would now like to take a few moments to review the steps on accessing the Facility-Specific Report, or FSR. As mentioned previously, the FSRs were distributed on July 29; however, in the event that you have not had the opportunity to retrieve your FSR and/or may not know how to do so, the next series of slides will provide detailed steps on how to accomplish this.

You may recall that in the past, the Facility-Specific Reports were retrieved via functionality within the *QualityNet Secure Portal* via Secure File Transfer. With the recent and ongoing system enhancements, the FSRs are now delivered via the Managed File Transfer, or MFT, functionality within the Hospital Quality Reporting, or HQR, System. The FSRs are provided to hospital-associated users who have the appropriate, approved permissions, which are Auto-Route and Managed File Transfer. These permissions are found within their HQR profile. On March 18, instructions were provided via Listserve communication to request these permissions or to confirm that these permissions are in an active status on our profile. A hyperlink to this communication is provided on this slide for convenience. If you are not a Security Administrator/Official for your hospital or you have not recently taken action to request these permissions in the previous few months on your account, you will not have the permissions on your profile required to receive an FSR. If you have not already done so, please take some time to review the Listserve communication so that you are able to receive your FSR in the future.

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Once you've confirmed that you have the appropriate permissions and are set to receive the FSRs, when the actual FSR is delivered to your MFT inbox, you will receive an AutoRoute file delivery notification to your email inbox. Of note, we customarily send a Listserve communication to all registered recipients on the PCHQR Notify: PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program Notifications Listserve group. On July 29, this communication announced that the FSRs were delivered. Shortly thereafter, the AutoRoute file delivery notification should have arrived in your email inbox. In that notification, there is a hyperlink to direct you to the MFT, or Managed File Transfer, sign-in page, which we will further discuss on the next slide.

When your hospital's FSR is delivered to your MFT mailbox, a notification is sent to the email address associated with your HARP account. Upon receipt of this notification, you will need to follow the steps outlined on this slide to access your FSR in your MFT inbox. These steps include navigating to the CMS MFT login page. The hyperlink is provided on the slide for your convenience. Enter your HARP credentials, and agree to the Terms and Conditions. You will then authenticate your account via entering the code sent to your device or email inbox. Once logged in, you will go to your inbox under the header of Mail. You will then select the line that contains the FSR to open your message. Lastly, you will download the FSR by selecting the file in the section labeled Attachments. From there, you are able to view your FSR. It is important to note that the FSRs will only be available in your MFT mailbox for a 30-day period after the delivery date, which in this case was July 29.

If for some reason you did not receive an email notifying you of the FSR delivery and you confirmed you have the appropriate permission of Autoroute and Managed File Transfer, follow the steps outlined on the previous slide for accessing your FSR to check if the report was delivered despite not receiving an official notification. If the report was not delivered, confirm that your profile has the permissions required to receive the report and note the following:

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If your profile did not have active Auto-Route and MFT permissions prior to July 29, you may request these permissions now using the instructions by accessing the notification link on the slide. If your profile did have active Auto-Route and MFT permissions prior to July 29, and you did not receive your report, please contact the QualityNet Help Desk for further assistance at qnetsupport@hcqis.org. Your hospital's Security Administrator/Official will review your requested permissions. Once you have been granted the proper permissions, you will have access to any future report deliveries via MFT; however, this report will not be available unless a request to resend the report is submitted.

We will now move into our question-and-answer portion of today's event. Tamara, her team and I will be addressing questions submitted as time allows. Please remember to include your slide with your question for the speaker to best answer your question. Lastly, if we do not answer your question today, all questions and answers will be posted to both Quality Reporting Center and QualityNet in the near future. Let's begin with our first question: Where can we get these reports from?

Specifically, the Facility-Specific Reports, just to note that these confidential FSRs were delivered to PCH users to their Managed File Transfer inbox on July 29 to those individuals with the appropriate permissions. Just to add to that, if we can go to slide 31, for those who are at a PCH and may be looking for their report, in the event that you did not receive it, please keep in mind that the first step is to confirm that you have the appropriate permissions, which are the AutoRoute and MFT. These permissions are required to ensure that the reports are distributed to the appropriate users within your PCH. If you did not receive your report, make sure to confirm that the permissions are appropriately assigned. Then, you may connect with QualityNet Help Desk for further assistance. The email address has been provided for you on this slide for your convenience. Another way to get your report is to reach out to your Security Administrator or Official to obtain the report.

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However, these reports will need to be handled securely since they do contain Personal Identifiable Information and/or Protected Health Information, also known as PII or PHI, respectively. I would like to emphasize that these confidential reports were only distributed to the 11 PCHs to those with the appropriate permissions as discussed.

Next question: If a patient was admitted to our PCH hospital and then visited the emergency department, or ED, of another hospital, is the ED visit to the other hospital an outcome?

Tamara

Mohammed:

So, this is Tamara. So, the outcomes of the PCH-36 measure is unplanned inpatient readmission within 30 days. As a result, if the patient in the scenario you described visited the ED only and was not admitted to hospital as an inpatient, then this is not considered to be an outcome of the measure. If, however, rather than an ED visit, the patient has an inpatient admission at another hospital, as long as that inpatient admission occurred within 30 days of that index admission, occurred at a short-term hospital, and was considered to be unplanned, then this would be considered to be a readmission outcome for the measure.

Lisa Vinson:

Thank you. Next question: How was the measure affected by COVID-19?

Tamara

Mohammed:

This is Tamara again. Like many of CMS's other measures, the PCH-36 cancer readmission measure is subject to the COVID-19 data waiver that CMS issued in March of 2020. So, this means that the data from January to June 2020 is not included in any of the measure calculations for this PCH-36 measure.

Lisa Vinson:

Thank you. For the next question, I can address this one. The question states, "Will CMS publicly report this measure in the future?" For the PCHQR Program, unlike other CMS quality reporting programs, public reporting must be specified in a final rule publication.

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At this time CMS has not confirmed plans for public reporting. However, these plans will be communicated to all stakeholders again via a final rule publication as this is how it is customarily handled for the PCHQR Program.

Next question: If a cancer hospitalization occurs at our hospital, and then the patient has another cancer hospitalization within the 30-day period, is this considered to be another indexed hospitalization?

Tamara

Mohammed:

Tamara, again. So, if a patient had a qualifying cancer admission at a PCH and was admitted again to hospital within 30 days, then if that second admission was also a qualifying cancer admission, it would meet the measure inclusion/exclusion criteria I described earlier, then both of the admissions can count as index admissions for the measure. However, it is also important to note that the cancer second admission can also count as an outcome to first cancer admission as long as it met that criteria I described earlier, where it was considered to be unplanned. For example, if patient was admitted to a PCH on March 1 with a qualifying cancer admission and then was admitted again on March 15 with another qualifying cancer admission, then as long as the second admission on March 15 was considered to be unplanned readmission, then it can be both an index admission as well as outcome admission for the March 1 admission.

Lisa Vinson:

Thank you. Next question: What happens if the second hospitalization within 30 days is not at my hospital? Does this matter?

Tamara

Mohammed:

That's a good question. If within the 30 days after that first index cancer admission, a patient has an unplanned readmission at any short-term acute care center, regardless of whether or not this short-term acute care center was a PCH, even if it was not your PCH, it could be another PCH, then this would be an outcome for the measure.

Lisa Vinson:

Great. Thank you. If we can go to slide number 15, this question relates to that particular slide.

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It states on slide 15 that one of the exclusion criteria is “discharged with a planned readmission.” How is this defined in the measure?

Tamara

Mohammed: So, in order to identify whether or not a patient was discharged from index admission with a planned readmission or what could be an index admission with a planned readmission, the measure looks at the patient discharge status code. If the patient discharge status code on the claim for that admission has a value between 81 and 95, then this indicates that the patient was discharged with a plan for readmission and therefore excluded from the measure cohort.

Lisa Vinson: Okay. Thank you. Next question: What is the national rate for this measure?

Tamara

Mohammed: So, for the FSR released for fiscal year 2022, under the PCHQR Program, the national rate for the PCH-36 measure is 22.2.

Lisa Vinson: Okay. Next question: What information does my hospital need to report for this measure?

Tamara

Mohammed: For PCH-36, hospitals don't really need to report any additional information to CMS. The PCH-36 measure is a claims-based measure, so all the data that CMS uses to calculate the measure are derived from the administrative claims data the hospital already originally submitted to CMS. So, the claims data that they have are already sufficient for this measure.

Lisa Vinson: Okay. Next question: Is there something I need to do with this report, the confidential FSR. Is there some action I need to take?

Tamara

Mohammed: So, for the FSR, CMS provides FSRs to the hospital so they can take a look at the report and understand how they're performing on the measure.

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The report provides information, detailed, patient-level information for hospitals to take a look at that and understands each of the cases that CMS included in the calculation of the PCH-36 measure. There's no real specific action hospitals can take. CMS hopes that hospitals will download the FSR report, review performance from the measure, and then take a look at the data in the report to help them to find appropriate opportunities to improve the quality of care provided to patients.

Lisa Vinson:

Okay. I just want to reiterate once more. We did receive another question regarding obtaining the reports. I would just like to remind everyone that these reports were only delivered to the PCHs for confidential reporting. Slide 31 details the information as the required permissions in order to obtain those reports. So, if you need assistance with confirming your permissions, you will need to log into your HARP profile to confirm these permissions. Also, your Security Administrator or Official can assist you with identifying the permissions, helping you get the right permissions. Also, they can provide you with the reports securely.

So, it looks like our time has been met for our question-and-answer session. We are going to close this portion of the event out. Please keep in mind that if your question was not addressed during this time, we will include all of the questions that we've responded to, in addition to the ones that we were not able to respond to, in a question-and-answer summary document, which will be made available on the Quality Reporting Center and QualityNet websites. Next slide, please.

So, again, before we close out today's event, I would like to briefly review the steps to submit questions via the QualityNet Question and Answer Tool. Next slide, please.

Displayed on this slide is how you can access the PCHQR Program question-and-answer tool. This is via the QualityNet home page. You will access the tool by selecting the Help drop-down link as indicated by the red box and selecting the PPS-Exempt Cancer Hospitals link to start the process. Next slide, please.

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Now, you are at the QualityNet Question and Answer Tool landing page. After you select the Ask A Question link as shown by the red box on this slide, you will be taken to a page where you will need to complete your personal information. Then, you will be asked to enter details regarding the inquiry you are submitting. On this page, displayed on this slide, you are also able to browse program articles and search to see if your questions may have been previously addressed and posted for viewing. Next slide, please.

I would like to highlight a point made on slide 26, specifically bullet item number two. It references submitting questions using the question-and-answer tool specifically related to the PCH-36 measure. As displayed on this slide, please be sure to select the correct topic, which is PCH-36, 30-Day Unplanned Readmissions for Cancer Patients. This is to ensure that your questions or your question is routed appropriately to be addressed. Next slide, please.

Today's event is approved for one continuing education credit. The approved boards are listed on this slide for your convenience. You can also access the CE credit link for more information as it relates to successfully obtaining credit for attending today's event. Next slide, please.

In closing, as always, we would like to say thank you for your time and attention during this presentation. I would also like to thank Tamara and her team for providing their expertise on this measure. We hope that you have found this information valuable. Thank you again and enjoy the remainder of your day.