



# PPS-Exempt Cancer Hospital Quality Reporting Program

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## Support Contractor

### PCHQR Program Updates and Lessons Learned

#### Presentation Transcript

##### **Moderator:**

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##### **Speaker:**

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**February 25, 2016**

**2 p.m. ET**

**Matt McDonough:** Hello, and thank you for joining us for today's webinar. My name is Matt McDonough, and I'm going to be your virtual host for today's event. Before we get started and turn things over to our speakers, I'd like to cover some event housekeeping items with you, so that you understand how today's event is going to work, and also how you can interact with our speakers on today's call. As you can see on this slide, we are streaming our audio for today's call over ReadyTalk®'s Internet Streaming Service. If you're hearing my voice coming out of your speakers or headphones right now, then you're connected. This service means that no telephone line is required to listen to today's event, but you do need to have those speakers or headphones plugged in and turned up to hear the streaming audio feed. If, for some reason, you're not able to stream audio today, or you encounter issues with the streaming audio feed, we do have a limited number of dial-in lines available. Please just send us a Chat message, if you need to dial in, and we'll get that number out to you as soon as possible. Also, as always, we are recording today's event so that it could be archived and played back at a later date.



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If you aren't streaming audio today, you may encounter some audio issues that affect the quality of your audio feed. For example, you may hear choppy audio at times, or your audio feed may stop completely. Fortunately, there are a few things you can do to try and correct this, without dialing in on the telephone. One, you can click the F5 key located in the top row of your keyboard. Two, you could click the "Refresh" button on your browser. The image here on this slide is what that button looks like in Internet Explorer. Either of these two actions will do the same thing: refresh your browser, reconnect you to the event, and restart your audio feed. This should clear up any audio issues you may be experiencing. Also, if you note that the audio feed is lagging behind the slides, you can perform either of these two actions to refresh your event and catch up in the presentation. If neither of these two options resolves your audio issue, remember, we do have those dial-in lines available. Simply reach out to us in the Chat window for a dial-in number, and you can listen to the audio feed that way.

If you're streaming audio today and hear a bad echo on the call, does it sound like you could hear my voice multiple times? Then, you may be connected in our event today in more than one browser window or tab. More than one connection in your browser equals more than one audio stream from your computer. Fortunately, this is something that you can easily fix. Simply close all but one of the browsers or tabs connected to our event today. The graphic here shows what that might look like on your screen. Once you are down to only one connection, you should only be hearing one audio stream, and the echoing issue should clear up. Again, we do have dial-in lines available, if you prefer to hear the audio feed over your telephone.

All of our attendees are in a listen-only mode today. But, that doesn't mean that you can't interact with our speakers today. We encourage you to submit any questions or comments you may have to our speakers, at any time today, using the "Chat with the Presenter" feature located in the



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bottom-left corner of your screen. Simply type your question or comment into the “Chat with the Presenter” box, and click the “Send” button. Your feedback will be visible to all of our presenters on today’s call. As time, resources, and the availability of answers allows, we will address as many questions as possible, either verbally or in the chat window. Please do note, however, that if we don’t get to your question today, all questions submitted during today’s event are being archived to be addressed in a future Q&A document. That’s going to do it for my introduction. So, at this point, I’d like to hand things over to our first speaker. Thanks for your time and enjoy today’s event.

**Henrietta Hight:** Thank you. Welcome to today’s webinar. My name is Henrietta Hight. I’m a project coordinator on the PPS-Exempt Cancer Hospital Quality Reporting Team with the Inpatient Value, Incentives and Quality Reporting, VIQR, Outreach and Education Support Contractor. We would like to welcome everyone to today’s webinar entitled, *PCHQR Program Updates and Lessons Learned*. This webinar is part of the educational series focused on the hospitals participating in the CMS PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program. Speaking today will be Tom Ross, the PCHQR Program Lead here at the Inpatient Value, Incentives and Quality Reporting Outreach and Education Support Contractor. Today’s webinar slides, transcripts and questions and answers will be posted to the *QualityNet* website in the near future and also to the Quality Reporting Center website. One reminder before we get started. Looking at the list of participants today, we see that a number of you are participating in other CMS quality reporting programs, and are not associated with one of the PPS-exempt cancer hospitals. We appreciate your interest in today’s webinar; however, as a reminder, the information presented today focuses on the PCHQR Program. Therefore, this webinar’s content only addresses aspects of the PCHQR Program and no other CMS quality reporting projects or health care settings. If you are associated with any of the other CMS programs, you will probably find



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that your time is better spent on other activities. And, now, I would like to introduce our presenter today, Tom Ross.

**Tom Ross:**

Thank you, Henrietta. Today, we'll be covering a lot of ground. To optimize the visual appearance of today's slides, we have prepared this acronyms and abbreviation slide for reference. A few new ones that I want to include are: Fxns, fractions used in radiation treatment therapy; Gy, or gray, a unit of ionizing radiation; SBRT, which stands for stereotactic body radiation therapy; and SRS, stereotactic radiosurgery. On the next slide, we will review the purpose of today's event.

As stated on the slide, the purpose of today's webinar is to, first of all, inform regarding NQF 1822 updates. Secondly, provide a review of new and updated resources on *QualityNet*. Third, to impart lessons learned in cancer-specific treatment data submission; and lastly, to highlight upcoming submission periods and dates.

We will review the objectives for today's webinar. Upon completion of this presentation, participants will be able to: apply the updated information for NQF 1822 to make the abstraction more efficient and consistent; locate and access key reference documents from the *QualityNet* website; apply the lessons learned in data submission, especially the recent February 15 submission of the CST measures for future submissions; identify key upcoming events; and, milestones to the PCHQR Program. And, as we go through today's webinar, I want to remind you, if you have questions, please submit them through the Chat function. So, let's start in with the heart of the presentation with the first topic, updates to NQF 1822 or EBRT.

So, why is this topic being revisited? Effective for January 1, 2016, this measure, which has been a PCHQR measure since January 2015, was added to the Hospital Outpatient Quality Reporting Program. And, as participants began looking at their data for eligible patients, many hospitals were having trouble finding any patients qualifying for the



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denominator for NQF 1822. The reason for this is that the denominator inclusion criteria was based, as you're aware, on CPT codes for radiation therapy treatment planning, CPT code 77261, 77262, and 77263. Some hospitals do not have access to these codes, as these are commonly found in physician, not hospital, billing data. We know that this has been a challenge for some of the PCH's as well. We, as a support contractor, reached out to the measure steward, the American Society for Therapeutic Radiology and Oncology, for guidance on this issue. They were excellent to work with. During these discussions, they related that they are in the process of revising the guideline and are preparing to resubmit the measure for NQF for updating. CMS wanted to keep the metric consistent between the PCHQR and the Hospital OQR, so the guidance that were shared with the OQR participants via ListServe is being shared today with PCH's. So, having explained the rationale for the updates, let's take a look at the material changes.

It continues to be all patients regardless of age, and these patients must have a diagnosis of a bone metastasis, as indicated by ICD-10 codes C79.51 or C79.52. This is unchanged. It should be noted that, while the description of the measure states, quote, "a diagnosis of painful bone metastasis," end quote. However, while the word "painful" is in the description, there is no code or documentation of pain necessary for inclusion in the measure. If the ICD-10 codes are present, they are still in the pool for eligibility for the denominator population. And, unchanged from before, they must have no history of radiation therapy to the same anatomic site. And, they must have received external beam therapy. This is the significant change. The measure now uses the CPT codes for external beam radiation therapy delivery codes. These codes are 77402, 77407 or 77412. Once again, the rationale for this change is that more hospitals will have access to the radiation therapy codes that are used for delivery than for the treatment planning. The delivery codes should capture the same basic population as the planning codes. It is just more accessible to more hospitals.



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Let's look at the denominator exclusion criteria. This is quite extensive. The first denominator exclusion criteria is a new one, patients treated with external beam radiotherapy that is delivered via stereotactic body radiation therapy (SBRT) or stereotactic radiosurgery (SRS). We have heard from a few PCH's that these patients are sometimes outliers, which is understandable given the delivery technology. The measure steward does not yet feel the evidence or schema for use of SBRT or SRS in treating bone mets is mature, so they are excluding these patients from the denominator. The second exclusion, which is also new, is patients who are part of a prospective clinical trial or registry study that involves the use of radiation oncology. The third denominator exclusion is not new. This is exclusion of patients with femoral axis cortical involvement greater than 3 centimeters long. The rationale for this is that these patients are at a greater risk for pathological fracture. The next exclusions are also not new. Patients who have undergone a surgical stabilization procedure at the site of the radiation, and patients who have spinal cord or cauda equina compression and patients with radicular pain. What is new is that you are now being provided ICD-10 codes for spinal cord compression or cauda equina compression and for radicular pain. This should help decrease the clinical abstraction burden. The last exclusion is documentation of patient's reasons. What is new is that this is limited to two reasons, first of all, patients who decline treatment; and secondly, economic, social or religious reasons. With our denominator being defined, let's take a look at the numerator inclusion criteria.

The recommended dosing schema have not yet changed. They continue to be 30 gray over 10 fractions, 24 gray over 6 fractions, 20 gray over 5 fractions, or 8 gray over 1 fraction. There is some clarity provided in this slide. The measure steward has clarified that patients must have received at least one fraction of external beam radiation therapy. This will be captured by the use of radiation treatment delivery CPT codes. The clarity, from my perspective, is that the concordance of the measure is determined on what dose and fractionation scheme was ordered.



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Therefore, you do not have the data burden of checking what total course of therapy was administered. And, as many of you know, this information is often on a separate radiation therapy treatment system. So, that is a lot of information in three slides. Let's recap the changes.

The first change is the transition from radiation therapy treatment planning codes to external beam radiation therapy delivery codes. This change was done to help ensure more hospitals have access to the data to identify denominator-eligible patients. The presence of a delivery code also ensures that the patient did receive radiotherapy as indicated by the measure description. A second change is that the denominator exclusions are added for patients who receive their external beam radiotherapy via SBRT or SRS, as well as excluding patients who are on a clinical protocol or study that involves the use of radiation therapy. Well, while not a change per se, ICD-10 codes are now provided for spinal cord compression, cauda equina compression and radicular pain. This should decrease burden of abstraction. Lastly, a patient's specific exclusions are more clearly defined and limited to patient declination of treatment or economic, social or religious reasons. I'm guessing that some of today's participants are happy with the changes and others are thinking, "I have been doing this for three or four quarters with the prior specifications and now it's changing." Let's take a look at slide number 14 for some guidance on how to incorporate these changes into your process.

Our recommendation is to select the date to begin using the refined criteria, preferably, the first date of a quarter. To choose this date, you obviously need to see where you are in abstracting your previous cases. Also, how long will it take for you to set up your queries to use the new CPT codes and ICD-10 codes? One logical place to begin will be October 1, 2015, cases to capture the conversion from ICD-9 to ICD-10. Another will be January 1, 2016, as you will be submitting all the 2015 cases this upcoming August. If you have not yet been collecting data for this measure, as the date of submission is not due until August, you can





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certainly use the new criteria for January 1, 2015. The good news is that the CPT code changes should not really impact the patients selected, just make the information more readily available to more hospitals. A second issue to consider, if you want to incorporate these changes in any data you have previously collected, this is your decision. There are two key factors that you should consider evaluating, if you choose to re-examine data previously collected. The first is to eliminate any patients who received SBRT or SRS as their external beam radiotherapy, as well as those patients who are in clinical trial involving radiation therapy from both the numerator and denominator. The second would be to look at any patient-specific exclusions you consider. These should be limited to these two cases outlined in the slide. Adjust the numerator and denominator as appropriate. On our next slide, slide 15, we will revisit the sampling strategy specific for the EBRT measure.

Both EBRT and the oncology care measures are “all- patient” data. Collection and reporting of this data helps to ensure the delivery of high quality care to patients in a PCH setting and provides the data CMS can use for public reporting. For each quarterly EBRT report, locate your average initial patient population size. This will dictate the minimum sample required for reporting on each quarter. If there are less than 10 patients, there is no sampling and all cases are evaluated. If there are 10 to 50 patients, the minimum sample is 10. From 51 to 125 patients of the initial population, your sample must be at least 20 percent of the initial population. And once you reach 125 patients, the minimum required sample size maxes out at 25. Remember, these are minimum sample sizes. If you sample, it must be random. The sampling strategy was developed to lessen the data burden to the PCH’s. Well, that wraps it up for EBRT. We will now begin, with slide number 16, to look at the updated information on the PPS-Exempt Cancer Hospitals tab on *QualityNet*.





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As you are aware, a key source of information for the PCHQR Program is the *QualityNet* and the PPS-Exempt Cancer Hospitals tab. There are four pages that have been updated, and four key resource documents that have also been created or updated. The first is the PCHQR Overview page. There were two significant changes made here. The first is that we re-ordered the Final Rules from newest to oldest. Secondly, we expanded the content in each year's description to be more inclusive. There is a link to each Final Rule to provide you with easy access. Let's see what the page actually looks like.

Here, you see a modified screenshot of the overview page. We cropped the images to make them more readable, if that's a word. You can see the hyperlinks to each year's rule and a brief synopsis of the significant changes in each year's rule. For example, Fiscal Year 2016, there were three new measures added and the SCIP measures were slated to be sunsetted as of October 1, 2016. [This is actually October 1, 2015.]

*QualityNet* updates Measures page. As you will see when you go to the Measures page on *QualityNet*, there are six tables, one for each of the categories or metrics currently used in the PCHQR Program. For each measure, we have now added the PCH number, which should be a nice reference for use and reporting via external files. Also, we have ensured that each measure title is identical to the measure title on *QualityNet*. We also added the new measures for the program year from the 2016 rule, which, of course, were MRSA, CDI and the Health Care Personnel Influenza Vaccination, as well as denoted, the removal of the SCIP measures effective October 1, 2015, for data collection, which would apply in Program Year 2018. Slide 16 is a screenshot of the measure tables that's for Healthcare-Associated Infections, or HAI, measures.

Here you can see the NQF number, PCH number, NQF title, and the Program Year to which the measure applies. For example, NQF 0138 is PCH-5. The measure title is CDC NHSN Catheter-Associated Urinary



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Tract Infections (CAUTI) Outcome Measure. And, the measure applies to fiscal or program years 2014 through 2018. Let's move on to...

The data collection page is really a nice tool. Once again, it consists of six tables, one for each category of measures in the PCHQR Program. As before, we have added the PCH numbers to each measure. For the HAIs, we, once again, added the new measures, as well as new links to better resources for the measure specification and data collection tools on the NHSN website. There was some rewording of the SCIP measures, and we found a document that needs to be updated, which we are currently in the process of doing on the OCM table. Remember how last month I said as soon as you put something in writing or post it, it changes? LOL, Henrietta and I will be further updating the embedded reference documents in this table over the next couple of months. As things are updated, we will keep you informed. Lastly, in the past year, we've seen a lot of changes in the accepted methods of data transmission. Let's look at an example on this slide.

This is the top of the Data Collection page. I want to highlight some of the functions available on this page. First of all, there is a hyperlink to the data submission deadlines, a very useful reference we're going to look at in detail in a little bit. For all of the measures on this slide, NQF 0139, CLABSI, there's a hyperlink to the NQF Quality Position's page for this measure. All the measures are linked to the NQF page. In the Measure Specifications and Measure Information Forms column, there is a link to the NHSN CLABSI Resources page. Then, in the Data Collection Tool column, there is a link to the CLABSI data collection tool on the actual NHSN website. And, lastly, in the Acceptable Method of Transmission, there is a link to the NHSN enrollment page because, of course, NHSN submits your HAI data to CMS for participation in the PCHQR.

Here are two more screenshots from the Data Collection page. The Cancer-Specific Treatment measures has the information that you obtain



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the data through your cancer registry via RQRS and then submit that data, as you just did, by a secure file transfer via the *QualityNet Secure Portal*. For the EBRT measure, you see similar information. I placed the screenshot to show that, currently, data submission is only via secure file transfer as is done with SCIP, OCM and now CST data. We're hoping to have the web-based data collection tool built and operational during the upcoming year. We will now look at the Data Submission page.

In most hospital quality programs, the measures are based upon event or discharge date. However, in the PCHQR, we have a variety of reference periods that this page outlines concisely. HAIs, of course, refer to the event date. We have added MRSA and CDI to this list. The CSTs are based upon diagnosis date. The OCMs and EBRT refer to a treatment or clinic visit date and the HCP measure is based upon the influenza season as defined by the CDC. And all other measures, in our case, the SCIP measures and HCAHPS are based upon discharge date. There is also information on this page about the Measure Exception Form and the Extraordinary Circumstances Extension/Exemptions Request Form.

Slide 24 is a screenshot of the top part of this page. As previously described, you can see that we have this PCHQR Program Submission Deadlines by Due Date document referenced. And then, the reference periods are discussed on the previous slide. So, HAIs upon event date, diagnosis date for the CSTs, patient treatment, or visit date for the OCMs and EBRT, the annual flu season as defined by the CDC, and all other measures which, in our case, once again, are SCIP and HCAHPS are based upon discharge date.

Let's move on to slide 25, the Resources page. Here you can see that a lot of the updates were made to the information on the Resources page. Web resources, all hyperlinks were updated. We added two new references, the Program Manual that we reviewed last month, and a new tool that I am very excited to share with you, the Relationship Matrix. A couple of tools



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were removed and others were updated including the Measure Crosswalk and the Data Submission Deadlines.

On our next slide, slide 26, we'll look at a modified screenshot of the Resources page. On the upper left hand, we see the web resources, which (as I stated) are all hyperlinks to take you to those resources. You'll note that the Cancer Hospital Workgroup, which no longer exists, was removed and we replaced that with a link to the American College of Surgeons Quality Cancer page. On the lower right-hand side, we see the program-specific resources, which include the Program Manual, the Data Submission Deadlines, the Measure Crosswalk and the PCHR measures to public reporting period relationship matrix. Additionally, there are two forms, which appear on other places on the website, the Extraordinary Circumstances Extension/ Exemptions Request Form and the Measure Exception Form. Let's take a closer look at two of these resources beginning with the measure submission deadline.

Over the years, I have been involved with the program, the Measure Submission Deadlines by Due Date has been my one go-to reference for the program. This shows all of the data submission deadlines and the data, including the appropriate timeframe, for each measure that is due on this date. This is an indispensable resource. Also, the footnotes denote in summary data, the data submission method. I encourage you to print this document out, tape it, paste it, glue it, whatever you're allowed to do, in a place where you can reference it often. It is a very useful tool. However, my new favorite resource is shown on our next slide.

This is page one of a six page document called, *The PCHQR Relationship Matrix: A Program Measures by Years and Quarters*. Not a great title, but a great tool. I also think of it as the Tracy tool, as two of our participants named Tracy, one in Seattle and one in Texas, have requested this kind of document. By measure category, this document outlines the following reading left to right. The first column is the measure category



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and the included measures with the NQF and PCH numbers. So, you'll see that there is a Cancer-Specific Treatment, an HAI category, OCMs, EBRT, HCAHPS and so forth. The next column shows the Program or Fiscal Year to which the measures apply. The next column, the Reporting Periods shows what data applies to each Program Year. And then, the fourth column is the Data Submission Deadline for each data period. Those periods which have already passed, have been grayed out in the document. Then, the newest element is the period of Hospital Compare Release in which the data will appear as part of public reporting. So, let's look at quarter two 2015 for the colon and breast chemo measures. This data applies and appears on your PPS-Exempt Cancer Hospital Report for Program Year 2016. Data submission was due on February 15, 2016. Then, reading across up to the right, you will see that the quarter two 2015 chemo measures will appear for the first time in the October 2016 release of *Hospital Compare*. It will then be part of the next three quarters of aggregate data being reported until it rolls off. So, this is really an attempt to show you the metrics, the program years to which they apply, the reporting periods, and what program year they apply to, when the data is due, and then when the data will appear for public reporting. I encourage you to spend some time with this tool. I think you will find it very useful. As far as the overall updates to the *QualityNet* website, we just took a close look at them here. But, I urge you to spend some time exploring the site. All the links are up and clean. The documents are updated. More source documents will be updated in the near future, as I said, and I think this will be a very – continue to be a very useful tool for you. So, looking at the clock, we're starting to get a bit tight on time, so let's move forward into the third component of today's event, lessons learned from the February 15 date of submission of the CST via external file.

As we review these learning points, I want you to know that these are offered in the spirit of improvement, so that we can learn and share from problems we had seen over the course of the first three data submissions using external files transmitted via secure file transfer on the *QualityNet*



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website. One issue or trap that we denoted was forgetting to replace the placeholder, quote, “CCN” that is provided in the provider column in the templates. This needs to be replaced with the PCH’s own actual CCN. This must be done for each row that contains data. Also, for those of you who have a CCN that starts with 0, such as our colleagues in California, do not forget to add leading zero back in when using the notepad view. We haven’t seen this error yet, but I want to bring it up as a reminder. So, let’s move on to slide number 30 for our next trap.

Leading zeros on the start and end dates. This is one of the most – two most common errors found during file submission, the same leading zeros in the reporting period start date and reporting period end date columns. Now, this was not a problem for the hormone file in this past submission period, as it was quarter four and December and October do not start with zeroes being the 12th and 10th month, respectively. If you enter your data in the templates using Excel, remember that the leading zeroes will be lost. You open the file with Notepad, and insert the leading zeroes, and save using Notepad. You can see on the slide that our next data submission, on May 15, should have the first quarter for hormone and third quarter for chemo. The leading zeroes will have to be inserted there. So, you can see that Enter 01012015 and 03312015 values in the hormone file and for the chemo file Enter 07012015 and 09302015 values in the chemo measure file. Remember, if you save it in Excel, the leading zeroes will, once again, disappear. And speaking of traps involving dates, our next slide shows our other most-commonly seen trap, incorrect filenames.

So, the trap is leading zeroes not appearing in the file name. An incorrect example would have pch\_acos\_chemo\_HQR\_2015Q2\_2\_8\_2016.csv.

The correct example would be

pch\_acos\_chemo\_HQR\_2015Q2\_02\_08\_2016.csv. The names of the files are extremely important. They consist, in the case of the CST files, of the following elements: the program, in our case PCH; the designation, ACOS, which is an artifact from when the American College of Surgeons



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submitted these measures on behalf of the PCH's; the content of the file, in this case, being either chemo or hormone; the program, in our case, HQR for hospital quality reporting; the period of the data period reported for the submission, in this example, cases diagnosed in 2015 and in quarter two, hence, 2015 Q2; the date the file was submitted on, and this is the trap, it must be in a month, month, underscore, day, day, underscore, then four digit year. Some folks forgot the leading zeroes for the month and date. Also, if you have to resubmit a file, please remember to change the date in the filename so that we can identify the most recent file for uploading. One check you can perform in the filename is that the data period reported for the chemo measures should always be two quarters ahead of the file being submitted for the hormone file. Slide 32 shows the last trap we will explore, which is a calculation of the rate.

Calculation of the rate: the trap is rounding incorrectly to the tenth place. The trick is to use the 100th place to round the tenth place. So, the CST's concordance data is to be reported to the tenth decimal place. The trick in rounding is to use the next digit, in this case, the hundredth place to determine if you should round up or leave it alone. If the value in that hundredth place is zero to four, leave the 10th decimal place alone. If the value in the hundredth place is five or above, round up to the 10th decimal place by one digit. So looking at our examples, 97.76. The six in the hundredth place dictates that we increase the seven to eight, making the result 97.80. In the next instance, 84.12, the two in the hundredth place indicates leaving the one in the one in the 10th place alone. The last example is what I call a double bump up, 91.95. The five in the hundredth place bumps the 9 to 10, which, of course, bumps the 91 to 92, making the final result 92.0. With that, we will round up with our last content slide, slide 33, to look at important upcoming dates and milestones.

Important upcoming dates and milestones. There is no scheduled data submission for March. You can see that HCAHPS is due on April 6. There is a planned Hospital Compare release in April, for which you will





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receive a ListServe notification; a public reporting period in April, extending into May; and then, the May 15 CST measure submission period. Please note that all dates, especially with public reporting are subject to change. You also see a list of our upcoming webinars. Our CMS Program Lead Caitlin Cromer and others will be joining me for the March webinar entitled, *Development and Selection of Quality Metrics*. April's event will be a next-steps event for *Clostridium difficile* and MRSA reporting. May will be a review of the proposed 2017 rule. And then, June will be an important session prepping us for the July 1st through August 15th data submission period. Please note that there's a plan to begin reporting population and sampling for the OCM and EBRT measures. We will supply much more information regarding that. Lastly, be looking for notification of posting of the proposed 2017 rule sometime in April. As always, these dates are subject to change and we'll communicate them clearly to you. And with that, I will turn the presentation over to Deb Price to discuss our CE process. Deb?

#### **Deb Price:**

Well, thank you very much. Today's webinar has been approved for one Continuing Education credit by the boards listed on this slide. We are now a nationally accredited nursing provider. And, as such, all nurses report their own credits to their board using the national provider number 16578. It is your responsibility to submit this number to your own accrediting body for your credits.

We now have an online CE certificate process. You can receive your CE certificate two ways. The first way is if you register for the webinar through ReadyTalk<sup>®</sup>, a survey will automatically pop up when the webinar closes. The survey will allow you to get your certificate. We will also be sending out the survey link in an email to all participants within the next 48 hours. If there are others listening to the event that are not registered in ReadyTalk<sup>®</sup>, please pass the survey to them. After completion of the survey, you notice at the bottom right-hand corner a little gray box that says "Done." You will click the "Done" box, and then another page opens



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up. That separate page will allow you to register on our Learning Management Center. This is a completely separate registration from the one that you did in ReadyTalk<sup>®</sup>. Please use your personal email for this separate registration, so you can receive your certification. Health care facilities have firewalls that seem to be blocking our certificates from entering your computer.

If you do not immediately receive a response to the email that you signed up with the Learning Management Center, that means you have a firewall up that's blocking the link into your computer. Please go back to the new user link and register a personal email account. Personal emails do not have firewalls up. If you can't get back to your new user link, just wait 48 hours because, remember, you're going to be getting another link and another survey sent to you within 48 hours.

OK. This is what the survey will look like. It will pop up at the end of the event, and will be sent to all attendees within 48 hours. Click "Done" at the bottom of the page when you are finished.

This is what pops up after you click "Done" on the survey. If you have already attended our webinar and received CEs, click "Existing User." However, if this is your first webinar for credit, click "New User."

This is what the new user screen looks like. Please register a personal email like Yahoo! or Gmail or ATT, since these accounts are typically not blocked by hospital firewalls. Remember your password, however, since you will be using it for all of our events. You notice you have a first name, a last name and the personal email, and we're asking for a phone number in case we have some kind of backside issues that we need to get in contact with you.

This is what the existing user slide looks like. Use your complete email address as your user ID and, of course, the password you registered with.



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Again, the user ID is the complete email address, including what is after the @ sign.

OK. Now, I'm going to pass the ball back to your team lead to end the webinar and to go over any questions that came in. Thank you for taking the time spent with me.

**Tom Ross:**

Thanks, Deb. At this time, we're going to take the opportunity to review a few polling questions to reinforce some key learning points from today's presentation. So, Jamie, if we can move to slide 41?

And what we want to do is ask the question, what is the main reason for the new CPT codes for NQF 1822 or EBRT? The options are: the hospital can't get doctor billing data in some instances, the change from the ICD-9 to ICD-10 codes, clinical trials involving SBRT, or improved CT simulation. Please make a selection of what you think is the appropriate choice on the screen and then click "Submit." So, what is the main reason for the new CPT codes for NQF 1822? So, it looks like we've got some responses coming in. We'll give it about – well, maybe another minute or two, not that long. So, with 18 responses in, Jamie, let's close the poll and skip to the results. And, we can see that 55.6 percent, or 10 of the responses were correct. The main reason to switch to the new CPT codes for NQF 1822 is previously was radiation treatment planning data, and frequently listed in physician billing, which some hospitals don't have access to or access is difficult. There certainly was a change in the ICD-9 codes to the ICD-10 code, but that was not really associated with the CPT code changes. Clinical trials involving SBRT or SRS that use radiation therapy, that is a new exclusion, but did not drive the CPT codes. So, we got that one pretty much on the right side. So, and I apologize. I see somebody in Chat just said that it advanced before they could vote, so I'll give a little bit more time in the next one. So, Jamie, if we can have our next polling questions?



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So, this one is a true-false question. For inclusion in the denominator of the NQF 1822, the patient must have documentation of pain. So, is that true or is that false? For NQF 1822, which is radiation therapy for painful bony metastasis, the patient must have documentation of pain. True or false? OK. It looks like responses are slowing down. I'll give it 10 more seconds here. OK. Jamie, let's see the results. And 58.8 percent said false and 41.2 percent said true. So, once again, the majority got it correct. The answer is false. While the title of the measure says it's "Radiation Therapy or Radiotherapy for Painful Bony Metastatic Disease," it's dependent on the ICD-10 code for bone metastasis and there is no requirement of documentation for pain. So, this actually should help out and it's one less thing to have to query for or to do clinical review for. So, you do not have to have documentation of pain. So, let's go to our next polling question.

In evaluating the dose and fractionation schema for NQF 1822, or EBRT, what should be evaluated? Should you evaluate – this is in the numerator – should you evaluate the dose/fractionation schema ordered, the dose/fractionation schema delivered, the dose limits to normal tissue, or there is proper CT simulation? So, the fractionation ordered, the fractionation delivered, the dose limits to normal tissue or proper CT simulation? Our responses are coming in. It's kind of like watching a horse race. It's like, one's winning by a nose, no, the other one is catching up. So, we'll give it about 10 more seconds here. OK. Let's take a look at the results, Jamie. So, this one we had dose and fractionation schema delivered was the highest response with 11 people at 55 percent. The actual answer is the dose and fractionation schema ordered. And so, the reason for this is that the CPT codes are now taking a look at if the patient received radiation therapy, so we need that component of the measure description. And then, it's on what was ordered. Something could happen during the course of therapy, a patient could refuse to finish therapy. There could be a dose adjustment based upon patient response, a number of things. So what we're really looking for in this – in NQF 1822 – is:



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was the appropriate dose schema ordered? So, focus upon that; and, once again, that's to save you some time and data abstraction because you don't have to look at everything that was delivered. So, that was a hard question, and I think an important part of clarification, so I'm glad that we had this question in the deck to enforce the point. So, we have two more polling questions, so Jamie, the next one?

Which PCHQR measures use diagnosis date as the reference period for data submission? So, is it for HAI measures, Cancer-Specific Treatment measures, Oncology Care measures, HCAHPS or SCIP measures? Which measures use the diagnosis date as the reference period? And, once again, our answers are coming in. And, this is something that differentiates the PCHQR from many other programs, and normally it's based upon discharge date or event date for most measures in other programs. But, we have some unique characteristics. Now, we have outpatient measures and inpatient measures and cancer-specific measures. I think I'm giving away an answer there. So let's give it about five more seconds, Jamie. OK. We can close the poll. And, the vast majority of people were correct in answering Cancer-Specific Treatment measures. This is where we have the measures of PCH-1, -2 and -3 for colon chemotherapy, breast chemotherapy, and adjuvant hormonal therapy. For breast cancer, it's based upon the date the patient is diagnosed, and then we look at was the adjuvant therapy or the hormonal therapy administered within 120 days for chemo and within 365 days for the hormonal measure. The HAI measures are based upon the event date that it occurred on. The OCMs are based upon the treatment date or the clinic date. HCAHPS is based upon discharge date. And, the SCIP measures, those are based upon discharge date. So, I think we got that one pretty much nailed down at 78.9 percent. So, one more question, Jamie.

Which PCHQR resource contains information that includes all of the following: Program Year, reporting period, submission deadlines and public – excuse me – Public Reporting dates? Is it the PCHQR measures



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page, the Measure Submissions Deadline, the Relationship Matrix, or the Data Collection Page? So, which contains information on Program Year, reporting period, submission deadlines and Public Reporting dates?

Answers are still coming in on this one. Still coming in, so we'll give 10 more seconds here. OK. Let's close up the poll and see what our results look like. And, the winner of the PCHQR primary here is Relationship Matrix at 61.1 percent. So, that's the correct answer. The measures page lists the measures themselves, like it sounds like, but it doesn't really list anything about public reporting. The Measure Submissions Deadline has everything, once again, except for the public reporting deadline. The Data Collection Page is the one with probably the most utilized, as far as specific references and has the links to the NQF language. But, the Relationship Matrix is the tool that we're using to try to visually lay up the relationship between all those factors. So, excellent job on the polling questions. And, Jamie, let's go to our concluding slide here in slide 46.

I think we answered the questions that came up during the Chat function today. If you have any additional questions, please submit at this time, and we'll certainly follow up on those. I want to thank you all for your participation in today's event. I hope that you find the content of today's event to be of assistance in your participation in the PPS-Exempt Cancer Hospital Quality Reporting Program. As a reminder, all questions and answers submitted during the Chat via the Chat function will be researched and answered. This document, as well as a recording of the event and a full transcript, will be posted at [qualityreportingcenter.com](http://qualityreportingcenter.com) within 10 business days since today's event. Also, as a reminder, since we talked about the *QualityNet* page, you will also find the transcript and the presentation and the slides available on [qualitynet.com](http://qualitynet.com) as well – excuse me – [qualitynet.org](http://qualitynet.org). I thank you for your time and, most importantly, the care you provide to our patients. And, I hope that you all have a great rest of the day and the week. Thank you for attending.

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