PPS-Exempt Cancer Hospitals Quality Reporting Program

Updates to the Oncology Care Measures (OCMs) and NQF #1822

Presentation Transcript

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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 the 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 yours 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 can be archived and played back at a later date.

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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 Presenter] feature located in the bottom left corner of your screen. Simply type your question or comment into the [Chat with 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 from my introduction. So, at this point, I'd to hand things over to our first speaker. Thanks for your time, and enjoy today's event.

Henrietta Hight: Good afternoon, everybody. 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 *Updates to the Oncology Care Measures (OCMs) and NQF Number 1822*, which is External Beam Radiotherapy Treatment, also fondly referred to as EBRT. 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 Outreach and Education Support Contractor, as well as, myself, Henrietta Hight. The slides, transcript, and questions and answers from today's

webinar will be posted to the *QualityNet* website, as well as the *Quality Reporting Center* website, which is available at www.qualityreportingcenter.com. 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 PSS-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 content only addresses aspects of the PCHQR Program and no other quality reporting projects or healthcare settings. If you are associated with any of the other CMS programs, you will probably find that your time is better spent on other activities. And now I will turn the program over to Tom, who will start with slide number six. Tom.

Tom Ross: Thank you, Henrietta. To optimize the visual appearance of today's slides, we have prepared this acronyms and abbreviations slide for reference. I'm sure many of you are familiar with most of these, but it is always good to have it available as a handy reference. We will review the purpose of today's presentation on the next slide, slide number seven.

In some ways, the documentation for a program such as the PCHQR is like an onion; the information to support participation comes in multiple layers. In January we rolled out the overarching summary document, the 2015 PCHQR Program Manual. This is a global resource containing the overall purpose of the program, the measures in the program with the clinical rationale for their inclusion, and then a lot of specifics about participation, such as the *QualityNet Secure Portal* and running and reviewing reports. However, you may recall and we emphasize that this is not a specifications manual. The actual measure specifications are on the PCHQR tab of *QualityNet*. Peeling off the outer layer of the onion, we get to the next layer, the PCHQR tab on *QualityNet*. In February's webinar,

we shared with you the extensive updating of the PCHQR materials on *QualityNet*. The following pages were updated: the Overview of the PCHQR Program; the Measures page; Data Collection page, Data Submission page and the Resource page with the updates to the tools, especially the *Data Submission Deadlines* document. All of this brings us to the most granular detail, the actual measure specifications. The needs to update measure specifications can be many. Certainly, the most prominent reason is when the IPPS/LTCH Final Rule containing the regulations for the program is updated. Also, as we discussed in the February webinar, CMS can utilize a sub-regulatory process to make non-substantive changes and updates to measures, as was communicated during the meeting discussing NQF 1822 or EBRT. Other reasons for updates to the measure specification can be changes in tumor staging, source documents, such as PQRS, and changes to NQF-endorsed measures, which can or cannot be substantive or non-substantive. We have updated the measure specification tools for the Oncology Care Measures or OCMs and the Clinical Effectiveness Measure NQF 1822 or EBRT. Today's presentation will provide you with a detailed review of how the measure specifications, algorithms, and data collection tools are updated. The next slide, slide number eight, contains the objectives of today's event.

There are three objectives for today's event. The first is for you to be able to summarize the updates to the materials discussed. Why were these measures updated? The second is for you to be able to locate these tools and apply them to the correct patient populations. The third objective and the overall goal of ours as your Support Contractor, is for you to be able to use these tools to accurately and efficiently abstract and report the data for all five of the OCMs and EBRT. For each of these measures, there are

now four new or updated documents posted on *QualityNet*. We will look at what these documents are on slide number nine.

There are six measures that have been updated: the five OCMs, which are NQF 382, 383, 384, 389, and 390, as well as the clinical effectiveness measure, External Beam Radiotherapy for Bone Metastasis (EBRT) or NQF 1822. For each of these measures, on the PCHQR Data Collection page in *QualityNet*, you will find four items: a Measure Information Form or MIF, a clean algorithm, a Population and Sampling algorithm, and a Paper Data Abstraction Tool. It's important to note that these are for use in 2016. This is for patients treated or have the specific encounter that qualifies them to the measure during Calendar Year 2016. For both the OCMs and EBRT, these patients in Calendar Year 2016, will be submitted during the summer of 2017 and be applied to Program Year 2018. Next slide please.

The Measure Information Form or MIF. The content of the MIF is obtained from a number of various sources, including the National Quality Forum, the 2016 PQRS measure specification, CMS themselves, and in the case of NQF 1822, collaboration with the measure steward, in this case, the American Society of Therapeutic Radiology and Oncology or ASTRO. Each MIF has the same basic structure with some variation depending upon the measure and its unique characteristics. There is some introductory information where the measure name, NQF and PCH numbers, National Quality Strategy Domain, type of measure, structure process or outcome, how improvement is noted, and the measure steward. The next section contains the heart of these measure abstraction and tools, the definitions of the denominator and numerator. This will be mixture, depending upon the measure of the electronic ICD-10 and CPT codes and clinical data abstraction elements. Of course, since the PCHs are very aware, there are great differences between various electronic health

records and the maturity of their implementation, for the electronic in one system may still require a chart abstraction in another. Furthermore, the analytic components and abilities of EHRs being used vary greatly, as well. The required data element may be available electronically and even discretely, but they may not be in a location that the analytic program can find it. Lastly, most PCHs have a mixture of EHRs, data warehouses, and external databases to which they report. This is certainly a challenging topic to address. Most of the most MIFs then conclude with abstraction and a rationale for having the measure and then clinical recommendation statements. The overall momentum for the PCHQR and the other quality programs is to move toward electronic measures. This is difficult due to the many of the factors I've just discussed. Another point that I wanted to bring here was the use or lack of use of CPT II codes. As you may be aware, all the PCHQR measures that are used in the Physician Quality Reporting System, or PQRS, use CPT II codes for the numerator determination. However, as far as we are aware, these codes are not widely utilized; therefore, in these cases, our measure information sheets note that clinical abstraction may be used to determine compliance with the numerator criteria. To show these individual components of a MIF, we're going to use NQF 382, Radiation Dose Limits to Normal Tissues, as our example today. We covered NQF numbers 384 and 383, the Pain Measures in detail during last September's event, and EBRT, NQF 1822, during the February event. NQF 389 and 390 are very complex algorithms so for the purpose of today's event we chose to focus on NQF 382. Next slide, slide number eleven, please.

Here, we see the introductory information for the MIF for NQF 382. We see the title and measure I.D. We included the NQF portfolios that the measure is included in, in this case, Oncology Metrics and Radiation Oncology. You can next see the National Quality Strategy Domain, which

in the case of establishing Radiation Dose Limits is Patient Safety. This is a process measure in which improvement is noted as a higher score correlating to better quality. The measure steward that checked this measure with NQF and maintained it is ASTRO. Lastly, you see the description, "The percentage of patients, regardless of age, with a diagnosis of pancreatic or lung cancer receiving three dimensional or 3D conformal radiation therapy who had documentation in the medical record that radiation dose limits to normal tissues were established prior to the initiation of a course of 3D conformal radiation for a minimum of two tissues." I want to interject a couple more specific learning points to NQF 382 at this point. You will note that the diagnoses for this measure are pancreatic and lung cancer for 2016. As many of you are aware, ASTRO recommended that the cohort be expanded to include breast and rectal diagnosis to the NQF and this was endorsed. However, CMS views this as a substantive change that will have the potential to significantly change the denominator population. Therefore, being substantive, this change must go through the rule-making process which was discussed during last month's webinar. Therefore, this change is in the Fiscal Year 2017 Proposed Rule that that was released April 19th. We'll begin discussing this in-depth with our Program Lead, Caitlin Cromer, next month. Our next slide, slide number 12,

…shows an example of the denominator section of the MIF. Here we see the denominator definition for NQF 382. The eligible cases are defined as those ICD-10 codes, remember, these patients are for 2016, so we're past the conversion date of ICD-9 to ICD-10, for pancreatic and lung cancer. The next set of code addresses an exclusion criterion, those patients with metastatic cancer. Therefore, we use the terminology "AND NOT." I try to always use bold-capital on this decision points because they are so vital on identifying the correct eligible patient population. The third step in

defining the denominator addresses the issue of receiving 3D conformal radiation therapy. This is a CPT code, 77295, which is the code for 3D Dimensional Radiotherapy Planning. Now, our denominator is defined and it's time to assess performance by evaluating the numerator on slide number 13.

The numerator is defined as "patients who had documentation in the medical record that radiation dose limits to normal tissues were established prior to initiation of a course of 3D conformal radiation for a minimum of two tissues." Then we see that qualifying CPT II codes for performance met or inclusion in the numerator. This is called CPT II 0520F. Performance not met with use of CPT II code 0520F with 8P, which means that radiation dose limits to normal tissues were not established for minimum of two organs or tissues, and the reason for this is not otherwise specified. As stated earlier, many of the PCHs do not use CPT II codes, so this requires chart abstraction. This chart abstraction may be in your own primary electronic health record or may require using your radiation therapy software record to determine compliance or non-compliance. While the MIFs are quite informative, sometimes a picture tells a better story. In the world of quality, that is often the time when we evoke a flowchart, which I'd love to do, because I love using Visio.

On slide 14 we'll take a high level view of NQF 382 Algorithms. Here it is. Of course its too small to be legible on one slide, so we're going to break it down to the three individual screenshots on slides 15 through 17. Slide 15 please.

The Clean Algorithm for NQF 382 … here, we are looking at the description, numerator, and denominator statements. It starts with a title, then the overall measure description is listed. We then have the text for both the numerator statement, "percentage of patients who had

documentation in medical record that radiation dose limits to normal tissues were established prior to the initiation of a course of 3D conformal radiation for a minimum of two tissues," and the denominator statement, "all patients regardless of age, with a diagnosis of pancreatic or lung cancer who received 3D conformal radiation therapy." With the oval, "Start/End" shape, we start the abstraction process, first moving through the identification for those patients eligible to be included in the denominator, which is displayed on slide 16.

The first step is a decision box or diamond, "Does the patient have a diagnosis of pancreatic or lung cancer during the measurement period?" which is the particular quarter of the Calendar Year you're analyzing. If the answer is "No," you exclude the patient – do not include them in your denominator. If the answer is, "Yes," they are still eligible. The notable improvement we believe is that the new flowcharts for 2016 have included the codes for use in the abstraction process, if space allows. As you are aware, there are literally hundreds of codes for a measure such as NQF 384 where a diagnosis of cancer is an inclusion criteria and space just does not allow this to be done. However, for NQF 382, 389, 390, and 1822, we have been able to include the codes on the flowcharts for you. The second decision box is asking the question, "Does the patient have metastatic disease?" In this case, the question is an exclusion criteria. So if answer is, "Yes," the patient is not included in denominator, but if the answer is, "No," they're still eligible and move on to the third question. The third question is, "Is the patient receiving 3D conformal radiation during the measurement period?" This is denoted by the presence of CPT code 77295. If the answer is "No," they're excluded from the denominator and if the answer is "Yes," they're included. At this point, we have defined the denominator, all of the patients eligible for the population for the measurement period. As you are aware, CMS allows sampling of the

OCM and SCIP measures in a familiar minimum random sample box I've included. The patients that you randomly select from the population or the entire population of the sample if the entire population is less than 10, or if you chose not the sample, becomes your sample size. So, we move on to determine the numerator on slide number 17.

This is a very simple step for NQF 382. There is one question to ask, "Are the dose limits to a minimum of two tissues or organs established prior to treatment?" There are no post-denominator exclusions in this measure. There are for NQF 389 and 390, and we'll review those later because it can be a bit confusing. If the answer is "Yes," whether by CPT II code or via chart abstraction, the patient is included in the numerator. This is the box on the right. If the answer is "No," once again, by either – via CPT II code or via chart abstraction, the patient is not included in the numerator, which is the box on the left. So that ends our tour of the Clean Algorithm. On slide 18, we will share the same algorithm…

…tool supplied with actual numbers to illustrate how to arrive at the population, sampling, and calculation of the final rate. This is the denominator section of the NQF 382 Population and Sampling algorithm. In this example, we start with the patient population of 1500 encounters in the measurement period or quarter. Of these 1500 patients, 100 stay eligible for the denominator in the first decision box as they have the appropriate diagnosis. 1400 patients are excluded. Unfortunately, in the next decision point, "Does the patient have metastatic disease?" Twenty-five patients do have metastatic disease and are therefore excluded, leaving 75 patients in the denominator. The third decision point, "Does the patient receive 3D conformal radiation during the measurement period?" Of the 75 patients remaining eligible for the denominator, 50 did receive 3D conformal radiation. Therefore, our population for this timeframe is 50. The 25 who did not are excluded. We now enter the

Sample Size box. As the population is 50, you can elect to randomly sample ten patients. However, remember that if you wish, you can randomly select more than ten. Ten is the minimum for a population of 10 to 50 cases, or you can elect not to sample and audit all 50 cases. In our example algorithm, we elect to sample 10 patients. On the next slide, slide number 19,

…we will look at the numerator. Here we see that of ten randomly selected patients, nine did have dose limits to a minimum of two tissues/organs established prior to the initiation of therapy. These nine are included in the numerator. One patient did not and is therefore not included in the numerator. We now calculate our concordance, nine divided by ten, or 90 percent. Noting that the OCM measures, of which NQF 382 is one, are rounded to a nearest whole number, the concordance will be reported as 90 percent. We'll now move on to slide number 20 to look at the fourth tool supplied…

…for each OCM and EBRT, the Paper Abstraction Tool. I don't know that many PCHs will elect to use this tool for each and every case, but it is very illustrative of the abstraction process we just talked about and walked through in the algorithms. As you can see, the tool is reflective of the time period to which these specifications apply. For patients treated during calendar year 2016, data will be reported by quarters and all four quarters are to be submitted once annually during the data submission period closing August 15th. There's a place at the top of the form for you to identify the patient, probably by a medical record number, the treatment date you're evaluating, and the reporting period, which will be the quarter. On slide 21, we'll move into the details of the tool.

Just as in the algorithm, each decision box is displayed as a question. In the case of NQF 382, the first questions is "Is there a diagnosis of

pancreatic or lung cancer during the measurement period?" If "Yes," you proceed to the metastatic cancer question, if "No," the case is excluded – stop abstracting. The case will not be included in the numerator or denominator count. These endpoints where you stop abstracting, are in red text on the tool. You can see that the paper tool is really a narrative of the logic displayed in the algorithm. Questions number two is, "Was the patient diagnosed with metastatic cancer?" In this case, if your answer is "Yes," the case will be excluded and you should stop abstracting. This is a stop, so once again, it is in red. Question three addresses the patient receiving 3D conformal radiation therapy during the measurement period. If "No," stop; if "Yes," proceed to the next step. So this concludes our tour of the tools that are provided for each OCM and EBRT. So, let's move into what is new for these measures. Slide 22 please.

As a reminder, the five OCMs include 382, Radiation Dose Limits to Normal Tissues; 383, Plan of Care for Pain; 384, Pain Intensity Quantified; 389, Prostrate Cancer: Avoidance of Overuse of Bone Scan for Staging Low-Risk Patients; and 390, Prostate Cancer, Adjuvant Hormonal Therapy for High Risk Patients. Slide number 23, please.

So what is new? For NQF 382, the measure remains unchanged from 2015. Note, that as related earlier from the NQF and PQRS version of this metric contained breast and rectal diagnoses for Calendar Year 2016, this is not the case for the PCHQR Program at this time. The addition of these two diagnoses for the cohort is in the Proposed Rule that was recently released. If these diagnoses are added to the PCHQR Program, we will update the measures. The Proposed Rule includes these diagnoses for Fiscal Year 2019, which would mean, if adopted, these patients would be included in Calendar Year 2017. For the Pain Measures, NQF 384 and 383, there are no changes. Participants are asked to refer to the September 2015 PCHQR event on either *QualityNet* or *Quality Reporting Center* for

in-depth review and discussion of these two measures. For NQF 389, Avoidance of Overuse of Bone Scan for Staging of Low-Risk Prostate Cancer Patients, and 390, the Adjuvant Hormonal Therapies for High Risk Prostate Cancer Patients, we have updated the algorithms to provide clarity in the post-sampling exclusion and calculation of the numerator and denominator, which we'll review on the next couple of slides. Also, there have been some other changes for 390. First of all, we've clarified, to be consistent with the NCCN Guidelines, that this measure is specific for External Beam Radiotherapy to the prostate as primary therapy. Adjuvant or EBRT after a radical prostatectomy does not require adjuvant hormonal therapy and therefore is not an inclusion criteria. Although the measure name remains the same, adjuvant hormonal therapy for high risk prostate cancer patients, the PQRS standard has split the definition of high risk of recurrence in the two populations, high risk and very high risk, and we'll look at this in a bit more detail. And lastly, the measure used to state that adjuvant hormonal therapy is needed to be "prescribed/administered." Now, it simply states "prescribed." Let's move on to the next slide, slide…

…number 24 to look at the numerator portion of the new 389 algorithm. In this example we have opted to sample ten randomly-selected patients from our population. Remembering that the standard is to avoid the use of a bone scan, seven patients do not have a bone scan performed and are therefore included in the numerator. So our numerator is seven. However, this measure gets two post-sampling inclusions. You can see that one patient had a bone scan due to a medical reason. Maybe they're having hip pain and there was a concern that there was metastatic disease. Since this patient meets the exclusion criteria, they are not included in either the numerator or denominator. Therefore our numerator stays at seven, but this patient must be removed from the denominator, reducing

our number to nine. The next exclusion, the bone scan performed due to a system reason. This is most often scanned at another institution or office. In our example, this exclusion applies to one patient. Therefore, once again, they are not included into the numerator or denominator. Therefore, the numerator stays at seven, but removing this patient from the denominator, reducing the denominator to an eight. We end the algorithm with one patient not included in the numerator; therefore a final concordance is the seven patients who did not receive a bone scan divided by the eight patients in the final denominator. Our concordance, therefore, is seven divided eight, or 87.5 percent. As the OCMs are rounded up to the nearest whole number, this rate will be reported as 88 percent. Our next slide, slide 25, will reinforce…

…this post sample exclusion concept. This is the bottom half for the new algorithm NQF 390, Adjuvant Hormonal Therapy. In the part of the algorithm highlighted by the red number one, you see the decision box "Have received EBRT to prostrate during reporting of period as primary therapy." Remember, this measure applies to EBRT as primary therapy not adjuvant therapy. The next area, highlighted by the blue number two, accounts for inclusion of patients having high and now very high-risk of recurrence. Remember that these are OR statements, meaning that only one of these criteria, the criteria for the definitions of how high or very high risk of recurrence must be met. So the patient has any one of: a PSA greater than or equal to 20; a Gleason score of eight to ten; a primary Gleason pattern of five; more than four cores with a Gleason of eight to one; or a clinical stage of T3A, T3B, or T4 they are eligible for inclusion, as long as the inclusion criteria prior is to this, of course. In the third section, highlighted with the green number three, there are two points I wish to make. The first is that now the patient must only be prescribed adjuvant hormonal therapy, androgen deprivation therapy (or ADT) to be

included in the numerator. The second is the exclusion steps in the numerator portion of the metric, as was done for NQF 389. In this case, we elected not the samples of a population of 35 equals a sample of 35. Of these 35 patients, 27 were prescribed hormonal therapy and the numerator is 27. At the second diamond in the bottom line, you see that three patients were excluded due to a medical reason. This reduces our denominator from 35 to 32. At the third decision point, we see that two patients refuse therapy, reducing your denominator from 32 to 30. Our final concordance is calculated as the numerator of 27 divided by our adjusted denominator of 30, which yields a concordance of 90 percent. And once again, in an OCM, we report concordance to the nearest whole number, which is 90 percent. On the next couple of slides, 26 and 27, we'll review the updates to 1822 or EBRT, reviewed in detail during the February PCHQR Webinar.

To recap, many hospitals have difficulty obtaining access to physician billing data, so the measure steward has applied radiation therapy delivery codes to ease the restriction. Also, NQF 1822 was added to the Hospital Outpatient Quality Reporting Program effective January 1, 2016, and alignment between the two programs is desirable. Also, the measure steward was in process of updating these, so we had a really efficient and collaborative effort. And lastly, these changes were more technical in manner, so they were able to be implemented by the sub-regulatory process for non-substantive changes. For more details, participants are asked to refer to the February 2016 PCHQR event for which a link is supplied. Slide 27, recaps the specific changes.

I'm not going to take the time to go through these. They're certainly included in the tools that are posted on *QualityNet*, as I said, we've covered them in-depth during the February webinar. So, I really urge you to take the time to go to *QualityNet* and look at the various tools. There's

a lot of work and effort that went into updating and optimizing these materials. On our next slide, slide 28,

I'd like to show you what *QualityNet* looks like for this section. This is a mockup of the updates being done on the *QualityNet* site while we prepared the presentation. To find all of the updated tools for the OCMs and EBRT, please go to qualitynet.org and look under the PPS-Exempt Cancer Hospital tab under Data Collection. You can see here how we split the older specifications down in the columns and above, we have 2016 MIFs, Clean Algorithms, Pop and Samp algorithms, and the data abstraction tools. The 2016 MIFs and algorithms are to be used for patients treated in 2016. These cases in this data will be reported in the summer of 2017 and applied to the 2018 Program Year. Please be sure to use the 2014 to '15 tools for the patients from 2015 that will be reported this summer by the August 15th data collection date. At this point, I am going to sit back and turn this one over to my colleague, Henrietta, to talk to these important points regarding population and sampling. Next slide and Henrietta.

Henrietta Hight: Slide 29, OCM and EBRT Sampling Strategy. For those participating in the PCHQR program, as the slide indicates, we are also including data that is "all-patient" for our population and sampling, but we do not have to show CMS the breakdown between Medicare and non-Medicare patients. This grid that you see, with the big X over it, is for the Hospital Inpatient Quality Reporting Program. So on the next slide, slide 30,

…we're going to look at the grid that participants in the PCHQR Program will be using. I'm not going to spend a lot of time looking at this because Tom, in looking at the algorithms, has laid this out. But just quickly, if you have an initial patient population of over 125, your minimum required sample size will be 25. If you have 51 to 125 in your initial population,

you have to have a minimum sample size of 20 percent of initial population. So, for example, if you have 100 cases in your initial population, you have to have a minimum of 20 in your sample. If you have 10 to 50 in the initial population, you have to have a minimum of 10 cases in your sample. Now, on the next slide, a few additional slides, let's look at the concept of identifying your population in finding your samples.

In looking at your population, the first step for estimating a hospital's performance is identifying the population. A population is generally defined as a collection of patients sharing a common set of universally measured characteristics, such as an ICD-9 principal code or procedure code. As indicated, oftentimes that common characteristic will be the primary diagnosis. For example, as we saw when Tom discussed the algorithm for the case of OCM 0382, radiation limits to normal tissue, we use the diagnosis of pancreatic or lung cancer to identify the cases that would be included in the initial population. But then, the diagnosis of metastatic cancer, if that's in the case, that case is included or which is not included, is excluded. Now it's not included in the initial population. As the slide indicates, cases identified as being in the initial patient population will become part of a group from which you will be sampling. Let's talk about sampling on the next slide.

Here are some points. Sampling is a process of selecting a representative part of a population in order to estimate the hospital's performance without collecting data for the entire population. Remember, fairly large number of sample sizes are needed to achieve a representative sample of the population. Even among the 11 PCHs, your population varies, so you want to be sure you have a sample that represents your patient population. On Slide 33,

…let's look some more at the idea of population and sampling. Here are some of the important points. The first bullet on the slide makes some very important points. Your sample needs to be random. You don't want to have a biased selective group of cases. Every case in the initial population needs to have an equal chance of being selected. Think of sampling as an equal opportunity situation. Now, as Tom mentioned, hospitals are not required to sample their data. You may choose to use a larger sample size than the required minimum or you may decide to sample all of your cases. On Slide 34, let's look at some more ideas about…

…population and sampling. On Slide 34, let's look at a couple approaches – start looking at a couple of approaches towards sampling of your initial population. The first approach you can use is what's known as "simple random sampling" or selecting a size of population, sample, from an initial population in such a way that every case has the same chance of being selected. The example given on the slide says that you have a group of 25 employees chosen out of hat from a company of 250 employees. The population is all 250 employees. The sample of 25 is random because each employee has an equal chance of being chosen. Just think about the last time your company had an employee luncheon or you went to a professional organization's meeting and they had a – there was a set number of door prizes, such as gift certificates or maybe a trip to Paris. Each attendee was given a ticket, and the corresponding ticket was placed in a basket for drawing. Everyone held their breath and looked at the number on their ticket as the tickets were called out. That was random because everyone had the equal chance of getting one of the door prizes. So now, on the next slide,

…slide 35, let's look at another sampling approach that's a little bit, maybe let's say, more systematic. This is an example of an approach

called "systematic random sampling," where you take – you can select "K," which is a starting point, and then you select an interval, like every fourth record, every fifth record, from a population of size, your starting off initial population. The first sample records, the starting point must be randomly selected before taking every interval record. This requires selecting samples based on a system of intervals in a numbered population. Now, this sounds kind of complicated. It's a two-step process. You identify your starting point and then you identify your interval, and you then select your sample based on the intervals. Let's look at an example because this sounds complicated. So in Slide 37, let's look at – I mean, slide 36,

…let's look at this example. Population and sampling, here are some points. Here's an example of "systematic random sampling." The example says, "Lucas is a new manager at the local movie theater. He's tasked by the owner to find out how the customers feel about the renovations done at the theater. Lucas can't ask every customer that comes in how they feel." This is where population sampling techniques can come in. In this case, Lucas and his manager or the owner, they throw a dice, and they get the sample or the number "four" for the starting point in the sampling interval. So, they decide to sample 100 customers on Friday night starting with the fourth customer. So, what Lucas does, he gives a survey to every fourth customer that comes into the movie theater. The sample system is a systematic system given that Lucas is giving the survey to every fourth customer. And this is a random sample because Lucas can't control what type of customer comes through the movie theater. So, that breaks it down and makes, you know, systematic random sampling really very, very easy. So, now, I'm going to turn Slide 37 over to Tom.

Tom Ross:	Thanks, Henrietta. Here, we see a compressed version of the algorithm for NQF 1822. Actually, so we can read it on one slide as we combined the six exclusion criteria into the fourth decision box on down the slide. But we've gone through this, but just to reinforce, we've started out with 23,000 patient s in the reporting period. There's only 3000 patients who are eligible by having the diagnosis of metastatic bone disease. Then out of those we ask, "Do they have a prescription for external beam radiotherapy?" There are 100 patients eligible and out of that, we have asked the question "Is there a history of radiation therapy to a same anatomic site, which is the case for 25 of the patients, which leads us with 75 eligible cases. Out of those 75 eligible cases, 28 met other exclusion criteria in the fourth diamond, therefore, this leaves us with 47 eligible patients. This is our population. With a population of 47, they're eligible to sample 10 patients at a minimum. In this case, we chose to do the minimum sample of 10, so our sample will be recorded as 10. We'll then evaluate against the fractionation schema that was prescribed. Eight met the acceptable schema while two were prescribed a non-recommended schema. Therefore, our final concordance is eight divided by ten, or 80 percent. So, we would report this and you'll soon hear more about this during the June webinar, as a population of 47, sample of ten, numerator eight, denominator ten, and a percentage of 80. On the next slide, we'll take a look at the OCMs and EBRT data submission.
	As we've mentioned, the next data submission period for the OCMs and EBRT will be on – concluding on August 15, 2016, although, you can certainly do it early. You will be reporting Quarters 2 through Quarters 4 of Calendar Year 2015 for the OCM and all four quarters of Calendar Year 2015 for EBRT. It will include population and sampling data, and will apply to the Program Year 2017. As usual, we'll supply CSV file

templates and also instructions on how to complete these, as well as a review during the June webinar. Next slide please.

A couple of data submission reminders. You'll have to enter the actual CCN for the Provider, and remember, if you're in California, you must also ensure that the leading zero was present. And be sure that you look for the leading zeroes for the reporting period start date and reporting period end date columns, as necessary. So, once again, we're going to cover this in great depth in the June webinar, here we just want to give you some gentle reminders. Next slide please.

Some of the most common things to look for while you're doing your files are the final naming conventions are extremely important. Please stick with what give you. And then on the leading zeroes, and we've been familiar with that, about putting them in the CSV files. Leading zeroes will not save in Excel. And then your final name will be modified to include the actual data submission. If for some reason, you have to resubmit your data due to a file naming error, or calculation, or other reason, resubmit your file with a new date submittal so you know that is is a different file So, next slide please.

Reminder about data submission reminders and the calculation of rates for the OCMs and EBRT, we round to the nearest whole number, So, for example, 93.76, the six in the hundredth place, will tell us to round up to 93.8. But remembering this is for OCM or EBRT, always round up to the whole number. So 93.76 would round up to 94; 84.12 would round down to 84; and 91.95 would round up to 92. So that concludes our presentation on the new material. Next slide please.

So, Henrietta, I'm back to the outer layer of my onion analogy I started out with. The Program Manual, we're pleased to share that with the PCHs – that the 2016 Manual is now finalized and posted on *Quality Reporting*

Center, and hopefully by the time this event is broadcast, on *QualityNet*. We've got the links here to the 2016 Manual on each site available, and we'll look at 43 slide to any particular changes in the manual. So slide 43, please.

The biggest addition for adding the 2016 IPPS Final Rule as a link. We certainly added information on the three new HAI metrics: MRSA, CDI, and HCP Influenza Vaccination. We've altered the CST measure file information to reflect that you submit these via external files. And we updated the OCM and EBRT text to reflect the changes discussed today. You'll note that we're be doing a, um, faxed-in DACA submission this year. We'll have more information for you on that. We updated the information on Public Reporting dates and measures, including more specificity on using the Public Reporting Preview Reports; and, as always, updated Measure Submission Deadlines and the inclusion of the new PCHQR Relationship Matrix. So let's take a look at slide 44 and then

…45 to look at upcoming important dates. As always, in the role of the Outreach and Education Support Contractor, I want to conclude today's event to look at some important coming dates and milestones. On the slide you can see in the July Public Reporting Preview Period. This has actually been moved back a couple weeks. It will begin on May 6. You will have 30 days to do your data, as always, and we will send a ListServe to notify you when they are available. Always remember when we talk about future dates they are tentative. And then secondly, you've already received the ListServe about May 15th, at the latest, your data is due for the third quarter for the Chemo Measures, first quarter for the Hormone Measures, and fourth quarter for the CLABSI, CAUTI, and SSI Measures. And those, of course, will be transmitted by the NHSN, as well – as long you have your data there, updated in there. We have already sent you instructions and CSV files for submitting the Chemo and Hormone

Measures. So, I'm going to wrap for our sectional webinar on our last slide for me to speak to, slide 45.

Here you see the tentative list of upcoming PCHQR Webinars. In May, Caitlin, Henrietta, and I will be discussing the Proposed Fiscal Year 2017 PCHQR Rule. It was released on April 18th, and there's a ListServe informing you of this. And the content is found on pages 1066 to 1094. In June, as Henrietta mentioned, there's a very important webinar to prepare you for the perfect storm of August 15th data submission. This will be a period that includes SCIP, OCM, EBRT, and the Cancer-Specific Treatment Measures, as well as HAI data from NHSN. July and September we'll have presentations from the CDC NHSN on the Healthcare Personal Influenza Vaccination Measures and a follow-up to the *C-Difficile* and MRSA Measures. This will be wrapped around the August event during which we'll discuss the Fiscal Year 2017 PCHQR Final Rule. And with that, I thank you for your time and attention today. I'm now going to turn the deck over to Debra Price, who will review about the Continuing Education process. And I hope that you'll have a great rest of your day.

Debra 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 boards using the National Provider Number 16578. It is your responsibility to submit this number to your own accrediting body for your credit.

We have now an online C.E. Certificate process. You can receive your C.E. Certificate two ways. First way is if you registered for the webinar through ReadyTalk®, 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®, please pass the survey to them. After completion of the survey, you'll notice that the bottom right hand corner a little gray box that says "Done." You'll click the "Done" box and then another page opens 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®. Please use your personal email for the separate registration so you can receive you certificate. Healthcare facilities have firewalls that seem to be blocking our certificate from entering your computer.

If you do not immediately receive a response to the email that you signed up with the Learn 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.

Okay, 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 e-mail at Yahoo, or G-mail, or ATT, since these accounts are typically not blocked by hospital firewalls. Remember your password, however, since

you'll 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 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. Again, the "User ID" is the complete email address, including what is after the "@" sign.

Okay, 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. I wish to thank everyone for their attention during today's event. I hope that these tools and other information provided today are of value to you as you participate in the PPS-Exempt Cancer Hospital Quality Reporting Program. As always, thanks for all that you do for our patients. Enjoy the rest of your day. Goodbye now.

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