



Inpatient Quality Reporting Program

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Identifying Initial Populations and Sampling for OCM & EBRT Measures

Moderator:

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Speaker:

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2 p.m.

Matt McDonough: Good afternoon, everybody, 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. We, again, thank you for joining us. And before we start with today's presentation, we would like to cover some housekeeping items so that you know how, that you can interact with our presenters throughout today's presentation.

As you can see on your screen, and hopefully you can hear me, the audio for this event is being provided via Internet streaming. No telephone line is required to listen to the audio today. But of course, computer speakers or headphones are necessary to listen to the, our audio portion of our presentation today.

However, that doesn't mean that you're not able to interact with our presenters today. You are able to submit questions to our team of presenters today using the chat panel, which is located on the left side of your screen. As you can see on the left panel, there is a chat box. Type your question in the chat window and then click the send button



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which is highlighted by the yellow arrow that you're seeing on your screen.

When you click send, your question will be sent to all of our presenters, and certain questions may be answered live on the call today, and other questions may need some additional follow-up, but your questions will be received by our presentation team today.

So that's how you can interact with our team. Submit your questions related to today's content. That's going to do it for the call, for my portion of the call today.

So let me hand [you] over to Henrietta Hight, who will be our first presenter today.

Henrietta Hight: Actually, this is Henrietta Hight, Deb Price, our corporate educator, has a few words to say.

Debra Price: Thank you, Henrietta. Hello and welcome to our webinar. I will be your host for today's event. Before we begin, I'd like to make a few announcements.

This program is being recorded. A transcript of the presentation, along with the Q&As will be posted to our new Inpatient website, www.qualityreportingcenter.com within two days. And, it will also be posted to the QualityNet.org at a later date.

If you registered for this event, a reminder email, as well as slides, was sent out to your email one hour ago. If you didn't receive that email,



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you can download the slides at the new Inpatient website. Again, that address is www.qualityreportingcenter.com.

And now I'd like to introduce Henrietta Hight. Henrietta is a registered nurse with over 34 years of experience, planning and conducting nursing quality improvement and computer software programming with nursing and non-nursing personnel in classrooms, clinical, healthcare, and insurance settings, utilizing onsite and online format.

Previous positions held at HSAG were the IQC – CQI Coordinator. Now it's Management Trainer Specialist and Corporate Educator, Patient Safety Project Coordinator for the SCIP Project and Quality Specialist working with Florida and California hospitals on Inpatient and Outpatient clinical measures and healthcare associated infections for recording and quality improvement activity.

Wow, that's impressive. And now Henrietta, take it away.

Henrietta Hight: Deb, thank you very much. Yes, this is Henrietta Hight. We would like to welcome everyone to today's webinar on identifying the initial population and the sampling process for the five oncology care measures and the external beam radiotherapy measure. During the webinar we will probably refer to these measures as OCM and EBRT.

The topics we are covering today are the following: first, concepts and purpose of the initial population identification; the concept and purpose of sampling; and then [the] application of population sampling to the oncology care measures and the external beam radiotherapy measure.



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We'll also be covering some, at the end, some important reminders in providing you with information regarding resources and updates. Again, as we go through the webinar, please use the Q&A features to post any questions that you have. All questions and answers will be compiled into a transcript and posted so that all can benefit from the information.

Also, we recommend that all participants refer to the ADCC document to see if their questions have been discussed. As a reminder, one hour [of] continuing education credit is available for this presentation, and Deb will be providing more information regarding the process for obtaining your continuing education credit at the end of the webinar.

Now, before we actually get into today's topics, we would like to welcome a new member to the PCHQR team. Some of you may know him, Lynn Jones. Lynn, would you like to say a few words?

Lynn Jones: I'll be very brief because we have so much to cover today. But it is truly exciting to be part of this opportunity with working on oncology. The 11 exempt hospitals that are represented and others that will be taking part in this really have a wonderful mission, and it's great to be able to contribute to that mission.

Just to give you a little brief background about myself: I was originally from Louisiana, went to LSU, and then went into the Air Force for approximately 25 years. During this time I was in healthcare. And then, after matriculating from the Air Force, I had the opportunity to work at a very unique cancer center by the name of H. Lee Moffitt Cancer Center



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and really had a wonderful opportunity to get immersed in the oncology field.

Following that, I went into consulting for about four years. And then, I also had the opportunity to be a Director at a number of Cancer Centers. My last position was at MITRE where I had the opportunity to work on the launch of the Hospital Value-Based Purchasing program, as well as the Measures and Evaluation (M&E) program. And I also had the opportunity to work with the Veteran's Administration (VA) on some of the challenges that they are facing.

Again, it is truly a wonderful experience to be here, and I hope I can help you all in some way make things better for our patients. Thank you.

Henrietta Hight: Thank you, Lynn. And we're very, very excited to have Lynn with us. And just a little update regarding myself ... Back in November, we announced that I was retiring. I'm not quite ready for a full retirement, so I will be continuing to work part time, assisting Lynn. But Lynn will be your primary contact for the PCHQR program.

So again, these are the learning objectives, the items that we will be covering. If you're wondering, just to sort of orient you, right now we're on slide four.

Next slide, please.



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We're going to start off – we're going to start off looking at the use of the Initial Patient Population, and then we'll proceed to looking at the sampling concept and process.

What do we mean when we use the term, Initial Patient Population? Really, Initial Patient Population, when we're talking about Initial Patient Population, we're referring to all patients. That includes Medicare and non-Medicare patients.

Generally, when we're talking about Initial Patient Population, we're looking at a group of patients, who share a common set of specified administratively derived data elements.

The data on this may include ICD-9 diagnosis codes or other population characteristics such as age. For example, the data element for the EBRT measure population includes all patients with the ICD-9-CM diagnosis code of bone metastasis and a prescription of EBRT. And we'll be looking at this in greater detail.

Sometimes the Initial Patient Population also applies to patients with a length of stay less than or equal to 120 days, and that would be your admission date minus your discharge date in cases identified as being in the Initial Patient Population of the measure or measures set [that are eligible to be sampled.

Next slide.

So what do we mean when we talk about sampling? OK. Sampling is the process of selecting a representative part of the population. The



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reason for doing this we're estimating the hospital's performance without collecting data for its entire population. And it's a useful technique that you can use to measure your performance, how well you were doing. And, you're most likely going to be gathering this data from reviewing the medical records for your patient.

So, why do sampling? Well, actually, by using – by doing sampling and using a statistically valid sample, you, as a hospital, can measure your performance in an effective and efficient manner, an important point to remember.

Okay, if a hospital has a very large number of cases in the Initial Patient Population, a fairly large number of sample cases are needed. So, if you have a small population, you're going to probably – and we're going to look at the grid for population sampling, which you're going to find yourself, either sampling, not really actually doing sampling, but looking at all your cases or a portion of your cases.

Next slide.

So, what do we mean by statistically valid data?

Okay, sample data. An important item to remember is that this, these data or these cases are randomly selected. They're randomly selected in a way that the, each individual case in the population has an equal chance of being selected. The sample that you obtain, you want to represent the whole population so that you have meaningful and useful performance measure data.



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The statistically valid sample also is going to provide you with an unbiased picture of your performance. So it really is, prevents cherry-picking, or picking and choosing, let's say, only those cases that will quote "pass the measure."

Another thing to remember is, even if we're going to look at the, when we look at the population in sampling grid, we talk about the minimum sample size. As [a] hospital, you're not required to sample your data. But say, if you only have 80 cases in your Initial Patient Population and the sample size, minimum sample size is 76 cases. If you want, you can go ahead and choose all your cases. You don't have to sample.

Next slide, please.

So, let's look at how you do statistically valid sample data. Because remember, we want our data to be random, and we want each case or each record to have an equal opportunity to be selected or included in the sample. There are two general kinds of sampling: there's the simple random sampling, and then [there is] the systematic random sampling.

[With] simple random sampling, you're going to have a population size of a certain number of objects, or, in our case, records, and then you're going to come up with your actual sample size. Think of this simple random sample: sampling like when you go to a party or to an event and you're given like, an entrance ticket that has a number on it and they take or they keep half of that ticket. And then, at one point in the party, they take all those portions of the ticket, of your ticket, and everybody else's ticket, put them in a bowl or a basket, and then



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someone draws out a number. And then they shake it up again, and they draw out another number, and they keep doing that 'til they reach the number that they want to achieve in their sample.

The systematic random sampling ... the best way to explain it is, where at one point, some people, what they will do is, they'll have a set of dice, a pair of dice. And what they want to do is, they want to start off with what they call the starting number. And then they want an interval number. So, it's like a progression of arithmetic.

So what they'll do is, they'll roll the dice. They'll come up with a number, for instance, five. Five will be their starting point. And then they'll roll the dice again, and they'll come up, let's say, with eight, and that's going to be their interval.

So they start off their first case, they will have five, and then they'll take the next case that's eight down the road, and they'll – It will be 13. And then they'll take 13, and they'll take the next case in their – waiting to be selected, and that would be case 21. And then they'll just continue down there until they have a number of cases that they want to include in their sample.

Next file, I mean next case. Oh, excuse me, next slide. I got carried away in the cases and the record.

Okay, so again, from the point of view of the PCH Cancer Hospitals, in this population sampling allow for different numbers of cases reported, based on each of your cancer patient population size. Because of having worked with you all, I know that you have varying numbers of



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population, Okay? So it will accommodate all the PCH bed sizes from 20 to more than 250 beds.

So, next slide. We're going to look at the OCM measures. I know you all have – are very familiar with the OCM measures. If you're, looking at the ADCC document, you've already started sharing questions and answers. And we [have] found those questions and answers very valuable and very helpful.

So, we're going to be looking at the initial population and associated sampling requirements. And then we will look at each of the measures, discuss the denominator and numerator descriptions, and discuss the algorithms or specifics of the algorithms for each of these measures.

Note, as we review the following Measure Information Form and as you use the measure information which are referred to as "MIF," we're also – we're going to also be talking about the data collection tools and algorithms.

You use these tools as roadmaps. So when you're using your algorithm for one of the measures, refer to the "MIF." Refer to the data collections tool. There's also the data definition. These will help you work through the process of identifying your initial population, determining your denominator, and then moving on to your numerator, based on your sampling.

Okay, just a reminder, for all the oncology care measures and also for the EBRT measure, data's going to be submitted, stratified by quarter,



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and submitted once a year. And we're going to be looking at the grid for the reporting period and the data submission deadline.

But just to keep in mind, a lot of hospitals do what we call concurrent review rather than retrospective chart review, and this is strongly encouraged. Concurrent review provides for timely identification of opportunities for improvement and for staff education.

So, the OCM and EBRT are what we call process measures. So again, looking at your work as you go through the quarter represents an opportunity for you to look at what you're doing, how – what the processes are, and [to] find room for – for improvement. And we can always improve on what we do.

Next slide, please.

Okay, this is the OCM population and sampling grid showing what your quarterly population would be and what the minimum required sample size would be, corresponding to what your initial population is. When we get to the EBRT section of this presentation, you will find that it's the exact same population and sampling grid. So, it kind of saves you on having to remember two sets of grids.

So, just look at this. If you have fewer than 10 records or 10 patients during the quarter, there is no sampling. You've got to look at 100 percent of the records that constitute your initial patient population. If you, in the quarter have 10 to 50 records, then you're going to – your minimum sample size is 10 cases. But again, remember, you can



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submit more than 10. Okay? Or, you can include in your sample size more than 10.

If your quarterly initial population is 51 to 125, then your minimum sample size is 20 percent of the initial patient population. If you have more in the quarter, if you have more than 125 cases, then your minimum sample size will be 25 cases.

Now, I don't want to put any one on the spot, but as a question, saying to yourself, if during the quarter, in the quarter for particular measure, if you have had 100 cases in your initial population, a hundred cases is in your initial population, what would be the minimum sample size?

Lynn, you know?

Lynn Jones: Yes.

Henrietta Hight: Twenty percent ...

Lynn Jones: Twenty percent of that.

Henrietta Hight: Twenty percent of a hundred.

Lynn Jones: Yes.

Henrietta Hight: What, what, what?



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Lynn Jones: Twenty.

Deb Price: Twenty.

Henrietta Hight: Twenty. Correct. Twenty.

Lynn Jones: Besides (health).

Henrietta Hight: Yes. So, just think of that, okay?

So, next slide. Let's look at again – let's look at some of the information associated with each of the OCM, OK? And again, I'm not going to spend a lot of time going in to the clinical aspects of it because I know you all, you know your measures very well.

Okay, so, NQF 0382 is for radiation. Dose limits to normal tissues is focusing on patients, regardless of age, with a diagnosis of pancreatic or lung cancer who receive 3D conformal radiation therapy with documentation in the medical records that radiation dose limits to normal tissue are established prior to the initiation of the radiation for a minimum of two tissues. Okay?

Remember, these measures are to be reported once per reporting period, for patients with a diagnosis of either pancreatic or lung cancer receiving 3D conformal radiation therapy. And the rationale that's provided in the "MIF" for the Measure Information Form is the feeling that identifying radiation dose limits to normal tissue is an important



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step in the process of care for patients receiving radiation therapy treatment.

The “MIF” also indicates that the American College of Radiation Oncology found that radiation dose limits to normal tissue are included in the patient chart less frequently than the reviewers expected. So, they found room for improvement. Next slide, please. And in case you’re wondering, we are on slide 13.

A little bit more on the NQF 0382 radiation dose limits to normal tissue. We’re going to sort of concentrate on how you would work through the algorithm, and we are posting the algorithms to the *QualityNet* website. When you go to the *QualityNet* website you’re going to see, for each of these measures, two versions of the algorithm. There will be what we’re calling the *clean* version of the algorithm, which is just the algorithm presented “as is,” and then we’re going to have what we call a *sample* version of the – of each algorithm. And that’s going to include some numbers to show you that, as you go through the algorithm, as you go through the review of your records, based on like the denominator, most of the denominators have exclusions of one sort or another that you’re going to exclude certain records from your final denominator count.

So again, sometimes some people do better with algorithms than others. So again, we encourage you to not only look at the algorithms but also look – use the data collection paper tools and the data abstraction definition tools that are also being posted to the *QualityNet* website. Okay?



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So, again, the algorithm for the NQF 0382 radiation dose limits to normal tissue data permits you, as the user, to figure out which patients from your population meet denominator criteria for this measure and which patients are excluded. For this measure, this should [be] accomplished by confirming the number of total diagnoses of pancreatic cancer or lung cancer from within the population and determining whether or not the identified sub-population of patients received 3D conformal radiation during the measurement period. And then it's determining whether or not there's documentation that radiation dose limits to normal tissue were established prior to the initiation of the radiation therapy.

So, essentially, when you look at an algorithm, it's going to take you through a series of steps where you have to answer "yes" or "no" and, depending on how you answer, "yes" or "no" to a particular step in the algorithm that would determine whether or not that particular case will be included in your denominator. And then also, [a] "yes" or "no," answer will also determine whether or not that case is included in your numerator and whether or not that case (what we often refer to) "passes" the measure.

Essentially, when you're working with your cases, with your algorithm, you want to find opportunity for quality improvement. And so, you want, working with your cases, using the information to gather from your data collection, you want to improve on your performance and hopefully, if possible, reach 100 percent.

So again, the concepts of Initial Population Sampling and the use of the algorithms, the data collection tools, [and] the data definition tools



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[are] applied to not just the NQF 0382 measure, but also to the other oncology care measures and the EBRT measure.

Since we only have an hour today, we're not – we will not cover in-depth the use of the algorithm for each of the other oncology care measures and the EBRT measures, but we are here to help and answer any questions that you may have. Next slide.

Okay. NQF 0384 oncology pain intensity quantified: Now, what I have done, this is a, these are, this measure is paired with another measure, and that other measure is the 0383, where there is a pain – a plan of care for pain.

So essentially, what you're doing with these two measures, first you are identifying whether or not the patient is experiencing pain and whether you have or not, you have measured that level of pain, and then, if the patient indicates that they have, they are experiencing pain, then the next step would be NQF 0383, to develop a plan of care for pain.

So again, for the webinar, we're discussing NQF 0384, oncology pain intensity quantified, before we discuss NQF 0383, the plan of care because the plan of care measure only applies if the patient, if pain is present. And, according to the "MIF" or the Measure Information Form, the rationale for this measure is that inadequate cancer pain management is widely prevalent, harmful to the patient, and costly.

Next slide, please.



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Okay, continuing a little bit on this 0384, oncology pain intensity quantified. Again, like all of the – like all of the other measures, they've written them so [a] higher score indicates better care. And this is based on the numerator statement of patient visits in which pain intensity is quantified.

Now, there are different ways that you can measure the pain, such as a zero to 10 numerical rating score or use of a pictorial scale. The pictorial scale is often recommended, let's say for – let's say it's a younger person or child, or if say, let's say there are some language communication challenges. And it's important that you use it consistently, and that you remember to document the pain intensity in the patient's medical record. The feeling is that, when you look at the algorithm, it begins with the understanding or the premise that all patients with cancer should be screened for pain during therapy or treatment.

And just a reminder about algorithms ... sometimes, algorithms can become a little bit confusing. Some of them are simpler than others. Some of them are complicated and so, in going through this and other algorithms, I mean it can be helpful to read the algorithm out loud or write down example dates. And sometimes even here in the office, we find ourselves sort of looking together at [an] algorithm and conferring with each other, you know, [about] how the algorithm is flowing.

Okay, next slide.

Okay, paired with the previous measure, OCM measure NQF 0383 is your plan of care for pain. And again, this is a two-part measure. You



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won't do NQF 0383 plan of care for patient if the patient does not complain of pain; there's no reporting of pain; and there's nothing chartered in the medical record. And again, this is for people, patients who are receiving chemotherapy or radiation therapy. And then the plan of care for pain based on the quantification of pain should be reported in each visit during the reporting period for patients with the diagnosis of cancer and in which the pain is present, and [who] were seen during the reporting period.

Next slide, please.

Okay, the next slide – next slide. I'm jumping ahead of myself.

Okay, a little bit more about the plan of care for pain, okay? Again, if the pain ratings scale score is above zero, a comprehensive pain assessment is initiated. And if you look at the Measure Information Form, the Measure Information Form provides a description or distinguishes three levels of pain intensity based on the zero to 10 numerical value, with the three levels of pain: mild pain being described as one to three; moderate pain, four to six; and severe pain, 7 to 10.

Next slide, please.

Okay, the next OCM that we're going to be looking at is specific to prostate cancer so that when you start your algorithm, one of the first questions, I think it's actually the first question that's asked is, "Is the patient male?" If your answer is no to that question, then it's implying



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that the patient is female and that patient or that record is automatically excluded from the measure. You don't need to go any further.

Okay, and then the next question is, "Does the patient have a diagnosis of prostate cancer?" Again, it's going to be a "yes/no" question, and if you say, "No, they don't have a diagnosis of prostate cancer or low risk prostate cancer," then that case or that record will be excluded from your Initial Patient Population and will not be included in your denominator.

Note that this measure is expressed, kind of in a negative approach of using the term avoidance. So, the, you're trying to avoid the use of bone scans in patients that have a low risk. So again, higher is better. Your performance goal is hopefully 100 percent.

And the rationale, if you look at the MIF, the rationale for this measure is that a bone scan is generally not required for staging prostate cancer in men with low risk of recurrence and receiving primary therapy.

Next slide, please.

Again, looking at, you know, looking at the measure, the numerator, and the denominators, okay? And as you look at your algorithms, look also at the Measure Information Form or the MIF because it does provide a very clear definition or detail regarding what is considered low, intermediate, and high risk for prostate cancer. Also, this measure does also have denominator exclusions based on medical or system reasons.



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Next slide, please.

The next – next to [the] OCM measure is your NQF – 0390, Prostate cancer Adjuvant hormonal therapy for high risk prostate cancer patients. So again, this is focusing on— this measure is focusing on patients with prostate cancer. So again, as you start looking at your algorithm, one of the first, the first question's going to be whether or not the patient is male or female. If the patient is female, they're not going to be included in this measure.

Also, if you look at your Measure Information Form, for this measure for the Adjuvant hormonal therapy for high risk prostate cancer patients, if you look at the MIF or the Measure Information Form, there is a definition. They include the definition for what is considered low, and immediate, and high risk. And just as a little aside, I know there has been some discussion regarding the use of the term, of the word "Adjuvant." That is being looked into by the measures steward.

Continuing a little bit on NQF – 0390... Again, as I said just a few minutes ago, there is identification of the, in the, when you're identifying your denominator, there are exclusions for medical or patient reasons, not system reasons, but medical or patient reasons. And of course, as it notes on the slide, only your patients with prostate cancer with a high risk of recurrence will be counted in the denominator of this measure.

Next slide, please.



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So, just to summarize a little bit, the tools that you will be able to find on the *QualityNet* website are the Paper Tools for the OCM population sampling measures. You'll be able to find the Abstraction Tools, both what we're calling the, you know, the abstraction fields under your data collection tools, the definition and the algorithms where we have two versions that we're calling the *clean* version of each algorithm and then the *sample* version of the algorithm.

Remember, when you look at the sample version, so, the numbers will not probably meet what your numbers are. The numbers are included just as illustrations to show you as you go through the algorithm, some records may be eliminated or excluded from your population.

A note of – a little bit of a note in regard to the *QualityNet* website ... it has gone under some pretty major redesign for the PCH section tab, and we are looking at [holding] a webinar in February to help you navigate that website and help you find what you're looking for.

Next slide, please.

This is probably something that you have seen before. This is the grid that comes from the Final 2015 rule, showing you again for the OCM data submission, what the recording periods are[and] then what the associated data submission deadlines are. So, the initial data submission period starts with first quarter 2015 and that's so – that started with January 1st and goes through March 31st. When you get ready to submit your data, your data, it's going to be stratified or divided up by quarter.



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So, again, we really encourage you [to periodically report], even just for calendar year 2015, which is your first submission period. Your data submission deadlines are not until July 1, 2015 through August 15, 2015. We really encourage you to collect your data as you go through your discharges. Don't wait for the last minute.

So again, concurrent review or if not, concurrent review, going through your records and doing your population and sampling, let's say like – within 30 days after the end of a quarter is a generally strongly recommended process. Again, looking at your records as you go through the quarter or right after a quarter ends will give you an opportunity to identify ways that you can improve your processes and therefore improve patient safety and provide staff education.

So, plan ahead. Again, plan ahead. Even though you have a period of submitting data from July 1 through August 15, 2016, plan ahead. Don't wait for the last minute or the day before. Also, if you're using a vendor, work with your vendor ahead of time to confirm the accuracy and completeness of the data. And here is a slide, again, just to give you some key points to kind of, as a reminder of what you need to do when you're working with your OCM measure.

Okay, next slide.

Okay, the next slide. We did have, back in November, an hour webinar on the external beam radiotherapy measure, EBRT. So I'm not going to spend a lot of time on this. That webinar is available on the *QualityNet* website. If you have any trouble finding it, let us know. We can direct you to where it is. So again, the EBRT measure is reporting



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the percentage of the patients, again, regardless of age, with the diagnosis of painful bone metastasis and then no history of previous radiation who receive EBRT with an exceptional – acceptable fractionation scheme as defined by the guideline.

Next slide, please.

And just to bring everyone on to the same page, in case you got distracted or we went too fast with changing our slide, we are currently on slide 26.

Okay, the EBRT population and sampling, that should look familiar to you because it's the exact same grid or population and sampling approach that would be used, that we saw a few minutes ago, for the OCM population and sampling. I won't put anyone on the spot but ...

Lynn Jones: But I'm prepared this time.

Henrietta Hight: But Lynn is prepared. So, I can think of one right off the top of my head ...

Lynn Jones: Good, good.

Henrietta Hight: But let's say if your initial population size is nine for the quarter, nine cases, what's your minimum sample size?

Lynn Jones: Are you asking me a question? You said you weren't going to ask me a question.



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Henrietta Hight: I'm asking you. If you're not ...

Deb Price: You changed your mind.

Henrietta Hight: Hey, I'm the teacher. I have the right to change my mind. Your initial population size is nine.

Lynn Jones: Nine.

Henrietta Hight: What is your minimum required sample size?

Lynn Jones: That's 10 isn't it? I need help here.

Deb Price: Nine.

Henrietta Hight: Nine.

Lynn Jones: Nine, okay.

Henrietta Hight: We're going to have to bring Lynn up to speed over this. Okay, now this is your numerator statement and your denominator statement.

Lynn Jones: Let me – let me ask you a question. If it's nine, but you have a much larger number, and you get a decimal point in the number, you round it up or you round down?



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Henrietta Hight: I would have to refresh my memory on the rounding process.

Lynn Jones: Okay.

Henrietta Hight: Good question. See? He's got me wondering.

Okay, we won't spend a lot of time on this but just as a reminder, you may remember what our – excuse me – our webinar with (Dr. Lutz) back in November [when] he clarified that the term G – capital G, small y – refers to Gray, and Gray was a gentlemen, the name of the person who developed the dosing measure. So, it was one of my questions. You all probably already knew that. Okay.

Okay, next. When you're going through the EBRT measure and you're going through your algorithm, it can get kind of confusing because there are medical reasons for the denominator exclusion, and then there are patient reasons for [a] denominator exclusion. And the way the exclusion questions kind of, are verbalized, it can be a little bit of a mind and brain teaser because it will say, "No history of radiation to the same anatomic site." They'll have [to] say, "No history."

And then you've got to answer either "no" or "yes." If you answer "yes," then that record continues on through the algorithm. If you answer "no," it's like a double negative. So you're saying, no history of radiation therapy. You're saying "no" to "no," that means they have a history of radiation therapy. So that's just a little bit of a thing to keep in mind.



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Okay, we know that there are probably questions about the population sampling methodology. Again, please submit your questions using the Q&A function while we're still online. Here are again the tools that are, we're posting or will be posting. Some of them we have already posted to the *QualityNet* website under the PCH tab.

And again, we're looking at planning a webinar, probably in February, to give you some ideas on how to navigate the [QualityNet] website and help you find what you are looking for.

And again, these are the EBRT data submission tools. Again, it's the – they use – they're using the same data submission reporting period [and] data submission deadline as the OCM measure. You're only submitting the data, stratified by quarter, once a year. The reason for this is to lessen the burden of, for your pre-collected data and reported data.

And again, a few recommendations: Even though you're collecting your data by quarters, you're only reporting it once. Again, we strongly encourage everybody not to wait until the last minute to submit your data. There have been situations, not with the PCHQR, but last year when I was working with the Inpatient Quality Reporting program for the acute care hospitals. We had some situations where the person who was responsible for reporting the data had to be out of the office unexpectedly. And it was right at the end, coming right up onto the data submission deadline. And there were some sleepless nights for a couple of hospitals. Again, plan ahead because you'll never know if there's going to be something happening with you all internally, coming up on a deadline. Or there have been times when there were some issues with *QualityNet*.



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Okay, I'm going to turn the next slide over to Deb. So Deb is going – I'm going to turn the next slide over to Debbie because she's going to go over with you the continuing education approval process.

Debra Price: Thank you very much, Henrietta. Before we begin by asking our subject matter experts to read off questions that were sent in, I want to remind you that our program has been approved for one continuing education credit by the boards listed on that screen.

We now have an online CE certificate process. If you registered for this webinar through Ready Talk, a survey will automatically pop up when the webinar closes. And, after you complete the survey, a page will display that registers – for you to register as either a new user if you have not attended any of our webinars, or if you have, you're an existing user. A one-time registration is required. If you do not receive the survey, don't worry because we'll be sending out the same survey link in 48 hours.

And now we've opened the phone line to our subject matter experts, Lynn and Henrietta, to begin the Q&A session. Henrietta?

Henrietta Hight: Okay, just a point of clarification [for some of the measures. Back on the slide that are – where it was listing information about the initial patient population and I had included a bullet of patients with a length of stay less than or equal to 120 days, that's going to imply that is not necessarily applicable to what you PCHs are doing. Your OCM and EBRT [measures] are really measures that are more for your



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Outpatient population and probably, I probably should not have included that bullet on that slide. So, I apologize for that.

Debra Price: Okay, Lynn, do you want to read off some questions now? You and Henrietta go through some of them.

Lynn Jones: And these will be posted where?

Debra Price: They will be posted on the site that you see right on the slide in front of you, www.qualityreportingcenter.com, as well as the *QualityNet* website at a later date.

Lynn Jones: And I'd also like to refresh everybody's memory on this, the *QualityNet* website question area is an excellent tool to help others with your questions because we post that and everybody gets the benefit of the insight of your question. So again, we strongly recommend that you use that method. Ask any questions as you get ready for all this reporting that you have to do as new tools come out.

Ask those questions because your questions will actually help others. Hey, the first question that we got, and by the way these are excellent questions, "The slides indicate that the Initial Patient Population applies to patients with the length of stay of less than or equal to 120 days. That's the admission date minus discharge date less than or equal to 120 days, but many of the OCM measures are out-patient measures. And so, how does this pertain to these measures?"

My, that's an excellent question, and we will get those answers.



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Henrietta Hight: And again, I probably should not have included that bullet in the slide. We can, and you'll notice that on the reporting period data submission grid, that are, that come from the Final Rule, they use the term discharges. And throughout the measures, they're talking about patient visits [vs.] episodes of care.

So again, we understand that the OCM measures, the EBRT measure in many cases, is a care that's provided in an out-patient setting, not Inpatient.

Lynn Jones: Alright, Henrietta. Going on, we have approximately five questions that we'll be reading to you. "Based on this information, it seems that each cancer center is therefore responsible for our own sampling. Is this correct? I ask this as the past vendors for the core measures, for instance, provided the random sample for abstract." Great question. We'll get you the answer.

"Henrietta and Lynn, for sampling NQF 383 and 384, we would certainly have a population that requires a sample of at least 25 patients for 384 pain adjustment quantified. My question is, can we use the same sample population for measuring 383 plan for pain? This would require oversampling, as not every patient has pain in 384. But if we can use the same patient, it will save a lot of resources as 383 will require chart review." Thank you, that's another great question.

Henrietta Hight: That's a good one ...

Lynn Jones: I won't ...



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Henrietta Hight: That's excellent.

Lynn Jones: I won't mention the names individual or name of the individual, but great questions. Our fourth question, "Do we not have to submit quarter one, 2015 data until July through August of 2016? I thought we needed to report the Q1 2015 data in July through August 2015, and not 2016. My apologies if I'm confusing the date, thank you." I will respond that we will be sending out periodic reminders of your actual reporting date.

As a matter of fact, we were drafting some of those just now for the February 15th status submission period. But we'll clarify.

"On previous CHW polls and other CMS documents, the first quarter submission deadline for the OCM and EBRT measures was July through August 2015. I just want to confirm that this is now, in fact, changed to 2016." Again, we will post these with the correct information. We will also be sending out periodic reminders so that you will know in advance that, usually within 30 days of the reporting, so that you will have a chance to make sure that you're getting the right data.

Are there any questions that [have been] submitted?

Marie Hall: Hi, Lynn, this is Marie Hall. Can you hear me OK?

Lynn Jones: Yes, we can.



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Marie Hall: Okay, one of the things that I wanted to clarify, perhaps on behalf of the questions that were submitted regarding the submission of the OCM measure data for first quarter 2015, I think we need to look at that because I'm looking at the data submission deadline by due date document that's posted on *QualityNet* and it is telling me that first quarter 2015 data for the OCM measures would be due August 15th of this year and that second quarter to fourth quarter 2015 would be due August 15, 2016.

So, I think that's the question that's being asked and we need to clarify that. Because ...

Henrietta Hight: I know that [the posted data submission] calendar or timelines does hold true for what they're anticipating let's say, for the SCIP measure, where there's going to be area – kind of like that. What I'm looking at is what is in the fiscal year 2015 Final Rule. But we will, for everybody's sake, confirm that, because there are different measures for the cancer hospitals, for the PCHs, different measure steps that have [a] different data submission quarter and deadline.

So, yes, we will make sure we confirm all that so nobody gets the wrong information.

Marie Hall: Thank you.

Henrietta Hight: Are there any other questions, Lynn?

Lynn Jones: No, not that I can see.



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Henrietta Hight: Okay, so, just a few reminders... Okay, as we were indicating, Lynn will be your primary point of contact. I will be assisting him on a part-time basis. So again, if you have any questions, please direct your questions to Lynn. We definitely thank everyone for participating in today's webinar. We always welcome your ideas for additional training sessions, and also, a recording [of] today's webinar and minutes will be available by Monday, January 26th, and the answers to the submitted questions will be available within 10 days of this webinar.

So again, thank you, everybody. Please enjoy the rest of your day.

Operator: Thank you, ladies and gentlemen. This does conclude today's webinar. You may now disconnect your lines. Presenters, please remain online.

END