PPS-Exempt Cancer Hospitals Quality Reporting (PCHQR) Program

Support Contractor

PCHQR Program:
A Year in the Life of the Program

Presentation Transcript

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Tom Ross: Good afternoon. We would like to welcome everyone to today's webinar entitled *PCHQR Program – A Year in the Life of the Program*. Our presenter today will be myself, Tom Ross, MS, PPS-Exempt Cancer Hospital Quality Reporting Program Lead for the Hospital Inpatient Values, Incentives, and Quality Reporting Outreach and Education support contractor. This presentation was also developed in conjunction with my colleague, Lisa Vinson, who is a Project Manager for the VIQR. Today's webinar is part of the series for the PPS-exempt cancer hospitals participating in the PCHQR Program. As the title indicates, today we will provide an overview of the activities relating to the participants' experiences over the course of a year in the PCHQR Program. Please note that during this presentation, we will only be discussing topics pertaining to the PCHQR Program. So, while you are welcome to participate, if you are associated with any of the other CMS programs, you will probably find that your time is better spent on other activities. If you do have questions about the content of today's presentation, please submit them using the chat function. As time allows, our presenters will address these during today's event. If time does not allow all questions to be answered during today's event – remember that the slides, recording, transcript, and questions and answers will be posted following the event on Quality Reporting Center and *QualityNet*. Also, if you registered for this

event in advance, you should have received a ListServe communication previously. The second of these, received yesterday, had a link to qualityreportingcenter.com. On this website, the slides that we will be reviewing during today's presentation are available should you wish to print a hard copy for use during today's event or to retain for future reference. On our next slide, slide number six, let us take a look at some of the acronyms and abbreviations you may hear during today's event.

By now, these should be very familiar to most of you. However, we provide this list of acronyms and abbreviations for two reasons. The first is that this page can serve as a handy reference guide of abbreviations frequently use in the PPS-Exempt Cancer Hospital Quality Reporting program. This can be especially helpful to those participants who are new to the program. Some of the abbreviations that are unique to the program relative to other CMS quality programs include ACS for the American College of Surgeons; ADCC for the Alliance of Dedicated Cancer Centers; CST for the Cancer-Specific Treatment measures; EBRT, affectionately known as ("Ebert") for External Beam Radiotherapy for bone metastasis; Fxns and Gy for Fractions and Gray, terms used in dosing EBRT; OCM, for the Oncology Care Measures; and two new terms, RSAR and RSEDR, which stand for risk-standardized admission and emergency department visit rate, respectively. These terms are used for the new claims-based measure. And, lastly, SBRT and SRS, stereotactic body radiation therapy and stereotactic radiosurgery, which are targeted forms of EBRT. Secondly, the use of these acronyms and abbreviations makes the slides much more concise and readable. We will now look at the contents of slides seven and eight, discussing the purpose of today's event and take a high-level look at the various activities that, in whole, constitute participation in the PCHQR Program.

I know that all of you working with the PCHQR Program wear many different hats. Mostly working in the field of cancer quality, you are involved in various capacities in such diverse activities as patient satisfaction, patient safety, accreditation, infection prevention and control, development of new cancer-specific quality measures, internal quality improvement efforts, generation of dashboards for various customers, and on and on. One component of this is your organization's involvement in the PPS-Exempt

Cancer Hospital Quality Reporting Program. As such, the amount of information that you receive can become overwhelming at times. We, as the CMS support contractor for the program, try to minimize the extra noise that you receive related to your participation in the program. However, at the same time, we want to be sure that you are kept up to date about all of the requirements of the program to ensure your successful participation. This was the impetus behind the development of today's outreach and education event. The intent of today's webinar is to provide participants with an overview of the PCHQR Program and how each element of the program serves to reinforce the others. Essential program elements consist of all facets of outreach and education, including but not limited to, ListServes, manuals, measure information forms, rules, Public Reporting, and webinars. Through a demonstration of how each of these elements are interconnected, attendees will gain a comprehensive understanding of the program and how to optimize their participation. Our next slide, slide number eight, will graphically illustrate the sheer volume of activities related to participation in the program in the form of a timeline.

Now, don't worry. There will not be a quiz on the content of this slide. However, we wanted to share this with you to give you a high-level view of the overall flow of the activities involved in a year in the program. At first blush, if you count quick, there are approximately 45 individual elements or activities that comprise participation in the program. This can be overwhelming. However, it begins to make more sense and become more manageable when you break it down into the main components that comprise the program. In the purple color, you will see two key events that triggered the rest of the activities in the program. These two elements are the publication of the proposed IPPS/LTCH rule in April and the publication of the final IPPS/LTCH rule in August of each year. Remember that the requirements for the program are embedded within this rule. We will be discussing this more in detail later today. But, keep in mind that all of the rest of the activities are derived from the direction posted in the Final Rule for the Program. The Rule covers a lot of ground. But, for participants in the Program, probably the most significant is the designation of the quality measures for the program, as well as their applicable timeframes, reporting

schedules, and use in Public Reporting. Related to the information contained in the Final Rule, you will see, in orange, two publications annually of the Program Manual for the Program. This is an annual release published in the first quarter of the year that will address changes and measures resulting from updates to the Physician Quality Reporting System, updates to the National Quality Forum standards, and information contained in the Final Rule that becomes effective as of January 1 of the year. There is also an update to the Manual, usually in the fall that addresses changes to the Program that results from the Final Rule published in August of each year. See how it all starts to fit together? Now, looking at the second line from the top in the blue color, you will see reporting schedules for the quality measures currently used in the program as of July 1, 2016. You will see that the HCAHPS survey data is reported quarterly, or four times per year. This reporting occurs in July, October, January, and April. There is an approximate three-month lag from the close of each reporting period to when the data is required to be submitted to CMS. Similarly, there are also submission of the other quality measures at other intervals in the year. There is a submission of a Cancer-Specific Treatment and HAI data on a quarterly basis and submission of the OCMs, EBRT data, and NHSN influenza vaccination of healthcare personnel on an annual basis. The HAI data is reported approximately four and one-half months after the close of the quarter while the CST data lags by seven and one-half months for the colon and breast chemo measures and 13and one-half months for the hormone measures. This can be confusing, and that is why we devote significant time and energy as your Support Contractor in communicating these submission deadlines and timeframes via the Measures Submission Deadlines document posted on *QualityNet*, as well as communicated extensively via ListServes. Next, the Public Reporting activities are shown on the timeline in light blue and red. The light blue activities, submission of the data for Public Reporting on *Hospital Compare*, is something that is relatively transparent to you as participants in the program. Data flows from the clinical data warehouse, or from us as your Support Contractor, to be published on *Hospital Compare*. However, the activities in red are the ones for you to be aware of. This is the availability of the Public Reporting Preview Reports for you to review, as well as the posting to the data for public consumption on *Hospital Compare*. As the data on

Hospital Compare is refreshed – is refreshed quarterly, there are four opportunities for you to review your preview reports and four times for you to review the information on *Hospital Compare*. The October 2016 event we just held reviewed this information in detail, and you are asked to refer to those materials as needed. Lastly, across the top of the timeline in green, you see the monthly scheduled webinars. In these events, we review topics related to participation in the Program, including review of measures, instruction and reporting guidelines, and occasionally, more philosophical presentations, such as today's. We are always open to your input to further topics. The specifics for each webinar are communicated via ListServes, which we will address much more in detail later in today's presentation. So, with this general and possibly overwhelming review of the Program, we will now turn back to some of the rationale behind the programs and these activities beginning on slide number nine.

The Affordable Care Act, or ACA, required the secretary of the Department of Health and Human Services, or HHS, to establish a national strategy that will improve the delivery of health care services, health outcomes, and population health. There are three aims of the CMS quality strategy which, in turn, frame the CMS Measures Management System and help prioritize measures considered for implementation. These three aims are better care, smarter spending and healthier people, healthier communities. There are six domains addressed, each of which are very familiar to you. These six domains are patient and family engagement, patient safety, care coordination, population/public health, efficient use of health care resources, and clinical process/effectiveness. So, on a practical application basis, let us consider NQF 1822 or EBRT, External Beam Radiotherapy for the Treatment of Bone Metastasis. Looking at this measures as an example, we will see how this palliative care measure addresses multiple domains of quality. As you will recall, this measure evaluates the EBRT dosing schema ordered to treat bone metastasis. Acceptable fractionation schemes include 30 gray per 10 fractions, 24 gray per 6, 20 per 5, and 10 gray per 1. As these recommendations are based upon literature-supported dosing schema, this measure addresses the domain of effectiveness. By decreasing the overall fractionations, it addresses the domain of efficiency; and, also by decreasing

patient visits, potentially the domain of patient and family engagement. Lastly, by using literature-supported recommendations, toxicities may be avoided, which support the domain of patient safety. So, you can see that one measure can address multiple domains within the National Quality Strategy. With this framework in mind, on slides 10 through 14, we will talk about the development, selection, implementation and monitoring of the quality measures in our program.

Last spring, Caitlin Cromer and Elizabeth Bainger from CMS led a program and a webinar entitled *Development and Selection of Quality Metrics for the PCHQR Program*. Internally, we like to refer to this presentation as "From the MUD to the MUC to the PCHQR," referring to the process of the measure moving from the measures under development, or MUD list, to the measures under consideration, or MUC list, to selection for, and implementation in, the PCHQR Program. This slide illustrates the overall process outlined in the blueprint for the CMS Measures Management System. As we review this, keep in mind the National Quality Strategies we just discussed. The first step is measure conceptualization. This involves an evaluation of the current literature for what standards are currently in use and what gaps in measurement might exist. This is reviewed by an expert panel and gaps in measurement are submitted to CMS for approval. In the measure specification process, public review is sought, feasibility studies are conducted and the business case is refined. The third phase involves measure testing. The results are again posted for public review and an expert panel makes recommendations to CMS. To this point, measures are considered Measures Under Development, or on the MUD list. These are measures that CMS is in the process of evaluating but are not yet fully developed. Interestingly, CMS also maintains benchmarking databases that serve as an inventory tool to identify source of quality measures. As of July 2016, this inventory included information from more than 130 databases and references to more than 540 performance measures. The next stage, the fourth phase called measure implementation, we move into the concrete action items that may impact the program. Measures considered potentially beneficial are published, once again for public review, on the MUC list. Each year, the NQF convenes a multidisciplinary stakeholder group called the Measures

Application Process, or MAP, to review standardized performance measures that the U.S. Department of Health and Human Services is considering for use in one of their 16 federal health programs, including the PCHQR. On November 22, 2016, Kate Goodrich, the director of Center for Clinical Standards and Quality at CMS, announced the 2016 MUC list. This year's MUC list contains 97 measures that are considered to have the potential to drive improvement across numerous settings of care, including the PCHs. Specific to the PCHs, there are 10 total measures on the MUC list. These include measures that are end of life measures, four of them, from the American Society of Clinical Oncology, or ASCO, and six measures related to prostate cancer stewarded by the University of Texas MD Anderson Cancer Center. The prostate measures include five outcome measures and one process measure. The last stage in the measure life cycle is that of measure use, continuing education and maintenance. This is the active use and refinement of measures. Data is reported or collected then aggregated and analyzed, assessed, and reports from the data are published. This is used by CMS to revise current measures and to make new measure recommendations. So, with a thorough understanding of the National Quality Strategy and the CMS measure life cycle under our belts, it is time to get into the nitty-gritty of today's presentation. How does all of this impact a year in the life of the program? To begin this, we will start at the one source of truth, the Final Rule, on slide number 11.

Here, we see a screenshot of the Federal Register from Monday, August 22, 2016, which should be familiar to you, as it contains the most recent IPPS/LTCH Final Rule for fiscal year 2017. Once again, within this document are the specifics for the PCHQR Program. When new employees are hired here at Health Services Advisory Group, the Support Contractor for the PCHQR Program, one of the first things that you are given are copies of the Final Rules impacting the programs that we support. During their orientation process, they meet with me. When asked what they have been doing, they all reply, "Reading Final Rules." I emphasize to them that this is extremely important. In fact, almost everything that they do will in some way, shape, or form be directed by a Final Rule. I refer to the Final Rule as the one source of truth to the program. Whenever questions arise, the documents that

I refer back to in most cases are the Final Rules for the program. Now, as important as the Final Rules are, the one source of truth, there are other sources of clarification and granularity that are required to be evaluated by us as the Support Contractor, and you as the participants, to successfully and optimally participate in the program. We will look at examples of some of these on our next, slide number 12.

So, where are the details necessary to accurately abstract and report these measures? The majority of this responsibility lies with us as the support contractor. By this, I need to communicate that we review the materials underlying the measures containing the details necessary to understand the measure and accurately abstract it. There are many sources for this kind of data. Examples include the Physician Quality Reporting System, or PQRS, measure specifications, which are very useful on abstracting the oncology care measures. The most exhaustive and complete set of information is part of the Centers for Disease Prevention and Control, or CDC, pages and those for the National Healthcare Safety Network that address the HAI and safety measures. And sometimes, we go back to the materials published by the actual measure developer. This is the case with the EBRT measure, when we go back to the American Society of Therapeutic Radiation Oncology, the American Urologic Association for the OCM prostate measures, and the materials available from the American College of Surgeons' Commission on Cancer for the CST measures. Other sources may provide clarity as well, such as NCCN guidelines and even direct contact with the PCHs themselves. I know that many of you have been personally reached out to by us for your input to harness your wisdom and insight. Now, the good news for the PCHQR Program participants is that we provide links to these alternative data sources on the program's *QualityNet* page primarily under the Data Collection and Resources tabs, which we will look at in more detail. Also, for those measures which have – which the PCHs have to abstract on their own, such as EBRT and the OCMs, we have developed measure information forms, algorithms, examples of population and sampling, and paper data abstraction tools. Once again, these are all available on *QualityNet*. Lastly, we use events such as today, as well as ListServes and targeted emails to convey, not only information about the collection of the measured data, but also how to

accurately report it and to verify the accuracy of the data in both hospital quality reporting and in Public Reporting. So, there is a lot to know. But, where to start in explaining the year in the program? As Lisa and I were discussing this presentation, we decided that the beginning is a fine place to start. But, where is the beginning? So, we decided to go back to the single source of truth, the Final Rule. Next slide, please.

So, to review, the Final Rule that is published in August of each year is effective the following Fiscal Year, which starts on August 1, the same year it is published. And, it is important to realize that these Final Rules do not just appear. The process starts back with the entire measure development process. After the MUC list is published, all the comments received are evaluated and considered before drafting the proposed rule. The proposed rule is published in April of each year. Once again, CMS asks for your input. Then, these comments are evaluated and considered before the Final Rule is published, usually in August each year. The import of this process can be seen by the fact that we devote two full outreach and education events annually to this process, one for the Proposed Rule and one for the Final Rule. And, lastly, while the Final Rule is the most important source of truth and the one that has the most impact in your day-to-day functioning within the program, I want you to realize that there are significant opportunities for the PCHs to have input and influence on the content of the Final Rule. We will look at this on our next slide, slide number 14.

On this slide, each of the red rectangles encompass or emphasize points in the life cycle of measure development in which you, as an engaged provider, can provide input to CMS and NQF during this process. You will note that this opportunity exists during each step in this process from measure conceptualization through measure use, continuing education, and maintenance. Technical Expert Panels are formally convened during the first three phases of the measure life cycle. This is, and has been, a great opportunity for the PCHs to share their expertise in the field of oncology. Secondly, there are opportunities for public review and input in all four of the latter stages of the measure life cycle. Once again, I know that the Alliance of Dedicated Cancer Centers has extensively commented in the past, during these phases. Also, some of the individual PCHs have chosen to comment on

their own behalf as well. We do want to communicate that all those who wish to comment are encouraged to do so, sharing their expertise and perception. As Director Goodrich stated in her blog concerning the recently-released MUC list, and as you have seen in prior Final Rule presentations, CMS actively seeks and listens to your input. So, now, starting with the release of the Final Rule, we will walk through the annual, quarterly, and monthly components of the PCHQR, showing that you can expect from us as the support contractor and what your responsibilities are as the participant in the program. Slide 15, please.

As the Final Rule is published on an annual basis, we decided to start our discussion about a year in the life of the program with the annual program responsibilities for both you as participants and us as the support contractor. One of the requirements of participation in the PCHQR Program is to have an active Notice of Participation, or NOP. All of the eligible PCHs have previously filed an NOP and that renews automatically there is no action that you must take on an annual basis. If your organization decides to stop participating in the PCHQR Program, you can make this election on *QualityNet*. And, if you decide to later rejoin the Program, this too would be done through *QualityNet*. However, we certainly hope that none of you make this election. Secondly, on an annual basis, you must complete the DACA, or Data Accuracy and Completeness Acknowledgement. This is required by August 31 of each year. The DACA is an attestation that, to the best of your knowledge, the data that you have submitted as a participant in the PCHQR Program is complete and accurate. In the ideal world, this document is completed electronically in *QualityNet*. However, this past year and the year coming up, you have to access this form, print it from *QualityNet*, complete it, and fax or email it to us as the Support Contractor. We will, of course, be sending more details about this to the PCHQR participants later in 2017 as this deadline approaches. The third annual task, which applies to some of you, is the filing of the Measure Exception Form, if you quality for an exemption to report in any of the measures for the PCHQR Program. In the past, there are exemptions granted for the SCIP and the Surgical Site Infection metric. As you are aware, the SCIP measures have been retired. So, anticipate that only those PCHs without a sufficient volume of qualifying

inpatient surgeries will file for an exemption. This form is located on *QualityNet* under the PCHQR Resources tab. If you are filing for this exemption, and there are three PCHs that did so in 2016, you must file prior to August 15, 2017, as this is the data submission deadline for quarter one HAI events, which include the SSI measure. Of course, you are encouraged to file earlier. And, we will be sending a ListServe reminder soon after the first of the new year. The last annual task for the PCHs is the submission of the OCMs, EBRT, and the influenza vaccination for healthcare providers. The OCMs and EBRT 2016 performance data must be submitted prior to August 15. The HCP influenza vaccination data will be submitted on your behalf by the NHSN and will be submitted on May 15, 2017. This will be the data for the 2016-2017 influenza season, which runs from October 1, 2016, to March 31, 2017. Therefore, you should already be collecting this data. In regards to the submission of the OCM and EBRT data, we plan to have a web-based data submission tool available for your use starting in the last spring of 2017. At this time, we are planning an outreach and education event for our March 23 date to instruct you in the use of this tool. As this tool will remove the necessity of submitting the external files, we are really, really, really looking forward to this as I am sure you all are as well. In support of this – in terms of the Support Contractor, our annual activities are really based upon the publication of materials that impact the education materials that we provide to you in order to abstract the measures in the PCHQR Program. Therefore, we will publish a Program Manual in the first quarter of each year following the release of the PQRS measure specifications and from other updates to the standards and then an update to the Manual in the following winter of each year following the release of the Final Rule. In a similar manner, we will update the measure information form and related algorithms for the metrics in *QualityNet* as this information becomes available and as it is needed for you to abstract the cases for a given timeframe. On our next slide, slide number 16, we will look at the quarterly program activities.

As we looked at in reviewing the timeline, all participants from the past are familiar with how you submit data to the program on a quarterly basis. This data really comes in two buckets. The first is the HCAHPS data, which is submitted to CMS for you via your HCAHPS contractor. This occurs four

times a year. The second data submission schedule is for the submission of the CST measures and the HAIs. You submit the CST measures while the NHSN submits your HAI data that you have entered into their system. We send multiple ListServes preparing and reminding you for each of these submission dates, as well as do targeted as the data deadlines approach and data has not been received. Less obvious, but still important function for the PCHQR Program participants, is to review the data that you have submitted to CMS. By accessing the *QualityNet Secure Portal*, you are able to generate your hospital reports, which contain your CST, OCM, EBRT and HAI data and also to access your HCAHPS reports. It is important that you look at those to validate your data. As your Support Contractor, on a quarterly basis, we have multiple activities to support you in the submission of your HAI, CST, OCM and EBRT data. This includes templates, instructions, and reminders of data submission. Less obvious to you is the work that we do to ensure that the PCHQR data is reported in an accurate and timely manner for the purposes of Public Reporting. To this end, we also prepare and distribute educational materials and reminders that are sent to you and posted on *QualityNet* about the availability of Public Reporting preview periods, as well as when the data on *Hospital Compare* is refreshed. Lastly, on slide 17 and 18, let us look at the month's tasks and responsibilities associated with the program.

There is nothing that the PCHQR participants are directly responsible for initiating on a monthly basis. But, there are a lot of activities that we as a Support Contractor do to support your participation in the Program. Here on slide 17, we will review all the materials that are made available to you in conjunction with the monthly outreach and education events or webinars. I shared with Lisa that, at times, as a provider, I felt overwhelmed by the sheer volume of communications received, and I didn't always understand the purpose of them. So, this slide is really to straighten me out as well as to educate you. Two weeks prior to each webinar, those of you who subscribe to the PCH Program ListServes will receive an email that contains information about that month's webinar. This will also have a flyer as an attachment. These documents contain links that allow you to register for the event. The date prior to the event, you will receive a similar ListServe. This ListServe

has three purposes. The first is to remind you of the event. The second is to allow you to register, if you have not already done so. And, the third is a note that the slides are available for the event on qualityreportingcenter.com, if you wish to print them out prior to the event. Now, after the event, participants will be sent brief minutes of the event within two business days. Then, within 10 business days, the questions and answers, transcript, and recording of the event will be posted to qualityreportingcenter.com. These will also be posted on *QualityNet* as well at a later date. On our last slide of this section, slide 18, we will look at some other routine or monthly communications that you receive from us.

As stated earlier, we will send ListServes prior to data submission deadlines. We send out ListServes 30 and 15 days prior to these deadlines. Then, seven days prior to the data submission deadline, we will send a targeted emails to those who have not yet submitted their data. Lastly, three days prior to the deadline, we will make targeted phone calls to those who have not submitted their data. As you can tell, data submission is a priority. Also, as needed, you will receive ListServes stating known issues of the *QualityNet* system that impact the program. This information is also posted on *QualityNet* and will state the issue, its known impact, any available workaround and when resolution of the issue is expected. In relation to Public Reporting, we also prepare and distribute educational materials and reminders that are sent to you and posted on *QualityNet* about the availability of Public Reporting preview periods as well as when the data on *Hospital Compare* is refreshed. And, lastly, we will send ListServes as needed, or PRN, to use my pharmacy language, when important information about the program needs to be communicated. Examples of this include completion of the Measure Exception Form, new updates to quality and other breaking news. So, that wraps it up for the discussion of a life in the year of the program. We will now share with you the numerous updates to *QualityNet* that contain updated information related to the program that will facilitate your participation starting on slide number 19.

As with the Program Manual, we tend to do major updates to *QualityNet* twice a year. We just finished a major update with the changes posting on December 2. We wish to share with you the highlights of these with you. We

encourage you to spend some time reviewing these pages in detail. Slide 20 is the newly updated Overview page.

The Overview page is exactly that, an overview of the Program. The top part of the page may be old news to you. However, I find it very helpful in orienting new people to the origin, purpose, and requirements for participation in the program. The bottom of this page is a very helpful resource. It contains links to all the PDF versions of the IPPS/LTCH Rules that have been issued since the inception of the program. And, as the Rules are the single source of truth, this is essential information. I think of the PCHQR Program Overview page as "PCHQR Program 101." The information is basic but essential to understanding the program. On slide 21, we will share an overview of the Measures page with you.

The PCHQR Measures page contains, not surprisingly, information about the measures currently in effect for the program. They are organized by group, for example, HAIs, CSTs, OCMs. And here on this screenshot, you see the EBRT, HCAHPS and the new claims-based measure. For each member, you will find the related NQF standard, the PCH number for the measure and, most significantly, the program or fiscal year that the measure was, or is, in effect for. As an example, here we see that EBRT was first in effect for Fiscal Year 2017 and remains in effect for Fiscal Years 2018 and 2019. This information is most useful when you are looking at your PPS-Exempt Cancer Hospital Reports and trying to figure out which report the data will appear on. To follow up using EBRT as our example, the 2015 EBRT data for encounters during 2015 will appear on the 2017 PCHQR Program report. On our next slide, slide number 22, we will take a look at the new version of the Data Collection page.

This is the new streamlined Data Collection page. It is streamlined as the 2015 measure information forms and supportive materials have been removed as data collection for this timeframe is in the past. On this screenshot, you see the EBRT measure and the new PCHQR Program measure. Using EBRT once again as our example, you can see the 2016 measure information form, the supportive algorithm, and the algorithm that contains the population and the sampling model, called the example version. In the next column, you see

a link to the paper abstraction tool and, in the last column, the information that currently has the acceptable method of the transmission of the data; and that is via Secure File Transfer. It is important to remember, when looking at the data collection tool, that they are for the year of the patient event, encounter or treatment. So, here, you would use the MIF and algorithm to assist you in abstracting EBRT treatments started in calendar year 2016. In the near future, we will be updating this to contain information for the 2017 cases for the measures. Once again, be sure to use this tool for the correct year that you are abstracting. At this point, we are going to advance to slide 23 and take a look at the PCHQR Resources tab.

The Resources page is pretty big, so we have chosen to break it up into three screenshots. Here, we see the top of the page, which contains the links to many of the sources of clarity that we discussed earlier. You see links for the ACoS, ASTRO, AUA, NHSN, and others. The only change in this update is that we have replaced the old American Medical Association Physician Consortium for Performance Improvement, or AMA-PCPI, link with a link to the CMS PQRS page. Next slide, slide 24, please.

This section of the Resources page contains the Program-specific resources. These are documents that many of you have told us are the most useful to you in assisting your participation in the Program. So, we are going to spend a little time delving into each one of these. The first three links are the manuals. We have left the 2015 and initial 2016 versions on this site for your reference. But, the version you should be using now is the 2016 Program Manual version 2.0. We will discuss the key updates to this on slide 25.

Now, the Program Manual is a very large document. So, it is up to you whether you want to print it out or just retain the link electronically. The advantage to the electronic version is that there are many links embedded within the manual which should serve as an excellent resource for you. There are five main updates to the manual version 2.0, none of which should be a surprise; these are: adding the Fiscal Year 2017 Final Rule, removing SCIP, adding the claims-based measure, updating the timeframe for Public Reporting and updating the resources component. On our next slide, slide 26,

we will take a look at what is, for me, the most frequently-used document in the PCHQR Program, the data submission deadlines.

All of the quarterly and annual data submissions that we reviewed as being part of the life in a year of the Program are contained on this document. It has a prominent place on the whiteboard right next to my PC and phone that I refer to all the time. Also, as each data deadline passes, I derive great joy in crossing out the recently passed data deadline. We have updated this document to cover all the data submissions from August 15, 2016, through November 15, 2017. You will see all the various measures, when the data submission is due, and the time period of care that is covered in that data submission deadline. Given the fact that the PCHQR Program has so many idiosyncrasies with quarterly reporting, annual reporting, 120-day delays, 365 delays, and so forth, I think that you will find this an invaluable resource. On slide 27, we will take a very brief look at the Measure Crosswalk.

We won't spend a lot of time on this, as the Measure Crosswalk form is really a PDF easily-printed version of the Measures page [that was reviewed] a few slides ago. It displays the measures for the Program grouped by category, their NQF and PCH numbers, and the Program Year that the measure applies to. Our next two slides, 28 and 29, will be screenshots of my favorite new tool, the PCHQR Relation Matrix.

In discussions with PCH Program participants, probably the largest knowledge gap that I found was the relationship between the measures reported by the PCHs for participation in the Program and how these measures apply to Public Reporting on *Hospital Compare*. This document addresses this issue. Looking at this screenshot for PCH one and two, the colon and breast chemo measures, you will see that they have been applied to Program Year 2014 and subsequent years. In the next column, you will see the reporting period, based upon diagnosis cohort for the cancer-specific treatment measures that apply to each Program Year. The next column shows when the quarterly data submission deadline was or is coming up for each reporting period. Those reporting periods that are in the past are grayed out in the document. And, lastly, moving to the right, you see the timeframe of data that will be displayed for Public Reporting for each refresh of *Hospital*

Compare. So, let us look at program year 2017, the first quarter 2016 diagnosis cohort. These are patients diagnosed from January 1 through March 31, 2016. Allowing the 120 days for treatment and then for data abstraction, this data was due to be reported to CMS by the November 15, 2016, data submission deadline. Then, moving to the right, we can see that the first time this data, first quarter 2016 diagnosis cohort, will be publicly reported is in the July 2017 refresh of *Hospital Compare* when the aggregate total performance for quarters two 2015 through quarter one 2016 will be displayed. Then, you can see that each quarterly refresh of *Hospital Compare*, the oldest quarter of data rolls off, and a new quarter of data is added. Slide 29 will show how the matrix displays for the OCM data.

As you know, the PCHs report the OCM data on an annual basis. You can see from the screenshot that quarter one 2015 data apply to Program Year 2016. Then, quarter two through quarter four 2015 data apply to Program Year 2017. As this measure is now phased in, this becomes more straightforward and 2016 performance of data applies to 2018 and so forth. In terms of Public Reporting, the first occurrence of this, once again, as specified in the Final Rule – it always goes back to the Final Rule – will occur this December for the December 2016 refresh of *Hospital Compare*. This will contain the data from quarter one through quarter four 2015. This performance data will remain on *Hospital Compare* until December 2017 when the 2016 performance data submitted by August 15, 2017, will replace it. On slide 30, I will wrap up our review of the Resources page.

There are three documents contained on the Resources page. But, first is the Hospital Contact Change Form. This is sent to you annually, and you are asked to update and inform the information and return it to us, so that we can update our databases. However, if there are significant changes in your leadership during the year, you are encouraged to complete this form with the updated information and send it to us. The second form here is Extraordinary Circumstances Extension Request Form. In the event of a disaster, this is the form that you would complete and submit to get an exemption or extension from reporting data. And lastly, is the Measure Exception Form, which we have already discussed, and must be completed annually, if you are claiming an exemption through reporting any data to the program. Now, at this point,

we usually have a slide that reviews the upcoming data submission deadlines and webinars. The next data submission due is quarter three HCAHPS data, which is due to be submitted by January 4, 2017. Our analytics reports show that all of the PCHs have data submitted for this reporting period. As far as upcoming webinars, we are currently formulating our 2017 schedule. We are planning the following: January – 2017 update measures – 2017 update to the measures; then, in March, how to use the new Web-based data collection tool; April, the Proposed Rule; and August, the Final Rule. We are asking for your input as to what other topics you would like us to cover during the upcoming year. You can do so now by submitting them via the chat function or there is a place for your input on the evaluation form that is sent to all attendees. And, so, with this information – and please give us your input about the upcoming webinars – I am going to turn the program over to Deb Price to review the CE information for today's event and, then, I will have some brief closing remarks for us. Deb?

Deb Price: Well, thank you, Tom. Today's webinar has been approved for one continuing education credit by the board listed on this slide. We are now a nationally-accredited nursing provider. And, as such, all nurses report their own credit to their boards using our national nursing provider number 16578. You will notice that it is in the last bullet on this slide.

We now have an online CE certificate process. And, you can receive your certificate two different times. If you are listening right now, and you have a couple of minutes after the event, please take our survey. And after the survey, you will be directed to the HSAG Learning Management Center. And that is where you will register for your certificate. If you don't have the time to take your survey today, we will be sending out an additional one within 48 hours. And at that time, you will be able to get your certificate.

If you have any problems – in other words, if you do not immediately get a response to the email that you register for the certificate, that means that either you have a firewall up that is blocking you – blocking the links that we are sending out or the links are ending up in your trash or your spam box. Please

go back and use a new user link, and that link will help you achieve your certificate.

This is what the survey will look like in about a minute, if you are going to wait for the survey. You notice at the bottom right-hand corner is the Done button. You click the Done button. And this is the page that is important. There are two separate links on this page, the New User link and the Existing User link. If you have not had any problems getting your certificate in the past, please use the Existing Users link. If, however, you have had problems or your computer has a firewall that is blocking our automatic links, use the New User link and register a personal email and a personal phone number.

This is what the New User link will take you to. It is our HSAG Learning Management Center. Put your first name, last name, and we are asking for your personal email, such as Yahoo!, Gmail, ATT, what – you know, whatever you use at home, and personal phone number, so our database does not confuse you with your work email.

This is what the Existing User page and link takes you to. Your user name is the complete email including what is after the @ symbol. And, of course, your password. If you forget what your password is, just click in that box – the password box – and there will be a popup notification that you click on to retrieve your password.

And, now, I am going to send the webinar back to your team lead, Tom Ross. Tom, take it away.

Tom Ross: Thanks, Deb. Thanks, Deb. Lisa and I want to thank you for your time and participation in today's program, *The PCHQR Program – A Year in the Life of the Program*. We hope that today's event has served as a refresher of the activities required for successful participation in the Program and, more so, has helped you to see how all these activities relate together as a whole in support of the quality mandate of the Program as set forth in the Final Rules. As always, thank you for the care you provide to your patients, and we hope that you enjoy the rest of your day and have a joyous holiday season. Thank you.

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