



## **PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program**

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### **Support Contractor**

### **PCHQR Program: Why Your Participation Matters**

#### **Presentation Transcript**

#### **Moderator/Speaker**

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**October 26, 2017  
2 p.m. ET**

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**Lisa Vinson:**

Good afternoon. My name is Lisa Vinson, and I serve as the PCHQR Program Lead for the Hospital Inpatient Value, Incentives, and Quality Reporting, or VIQR, Support Contractor. I would like to welcome you to today's event entitled "PCHQR Program: Why Your Participation Matters." I will be the moderator and speaker for this event. Today I will be discussing familiar topics, such as the purpose and foundational principles of the PCHQR Program and, most importantly, we will take a look at how your participation in the program helps to accomplish the program goals. You will also see how we, as a support contractor, play a part in this as well. As we move forward, you may find information about new resources that are available and may be of great benefit to you as a provider, particularly with quality improvement efforts. As always, you can submit questions using the chat function and, as time allows, your inquiries will be addressed during today's event. However, if time does not allow questions to be answered during the presentation, please remember that all questions and answers, as well as the recording and transcript for today, will be posted on both [QualityReportingCenter.com](http://QualityReportingCenter.com) as well as [QualityNet.org](http://QualityNet.org). I want to emphasize that today's event is specific for the participants in the PPS-Exempt Cancer Hospital Quality Reporting Program. Others interested in the topics covered during today's webinar are certainly welcome to attend. If you are not a participant in the PCHQR Program, please refer to the materials supplied by your program support contractor. Now we will take a look at some of the acronyms and abbreviations that you will see and hear during our discussion. Slide 6, please.

Acronyms and abbreviations, you will hear today include: CMS, for Centers for Medicare and Medicaid Services; HQR, for Hospital Quality Reporting; MAP, for Measure Applications Partnership; MUC, for Measures Under Considerations; and QIN for Quality Innovation Network. Please keep this slide available as it can be used as a great reference tool throughout this presentation. Next slide, please.

The purpose of today's event is to review the formative intent of the PCHQR Program, which you all may be familiar with. However, in

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addition to reviewing the program's purpose, I will also relate how your participation helps to reach the PCHQR Program goals. The specific objectives are on the next slide, slide 8.

After today's presentation, you, as a PCHQR participant, will be able to do the following: synthesize the requirements, as stated in the rules governing the program into practice through the development and implementation of program measures and the publication of the final rule; become cognizant of best practices, and achieve measurable quality improvement within your facility for the patients you serve through data reporting, quality improvement resources, along with the assistance from the support contractor; and publicly report quality of care information to help patients and caregivers make informed decisions, which is accomplished through *Hospital Compare* and Public Reporting resources. Next slide, please.

The information found in the PCHQR Program overview page should be very familiar to you. This overview provides the origin of the program, which was developed as mandated by Section 3005 of the Affordable Care Act, and the requirements for participation in the program, wherein the PCHs are required to submit specific quality measures related to the PCHQR Program to the Centers for Medicare and Medicaid Services, or CMS, in addition to public reporting of the measure rates on *Hospital Compare*. There are three main goals of the program, which are clearly identified here as well. One, to equip consumers with quality of care information to make informed decisions about healthcare options. Two, to encourage hospitals and clinicians to improve the quality of inpatient care that is provided to Medicare beneficiaries. And three, to ensure that providers are aware of and reporting on best practices for their respective facilities and type of care. All in all, the purpose of the program is to put patients first by allowing them to make data decisions along with their providers using information from data-driven insights. In combination with other quality reporting programs, the PCHQR Program helps to incentivize hospitals to improve healthcare quality and value. Through your participation, as it relates to understanding the program measures,

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data reporting, which in turn is publicly reported, and quality improvement tools and resources, the goals of the program are successfully met. But where does it all begin? We will answer this question on the next few slides as we revisit the foundational principles of the program, starting with the proposed and final rules. Slide 10, please.

The most important foundational principles of the PCHQR Program are the proposed and final rules. Every aspect of the PCHQR Program is in some way, shape, or form directed by final rule. On the next six slides, we will briefly review the proposed and final rules and your impact as a program participant on the PCHQR Program measures from measure development and implementation. Slide 11, please.

The final rules have been published from Fiscal Year 2013 through 2018 to guide the program. As depicted on this slide, here is a list of each final rule with the key changes to the program. A hyperlink to the PDF version of the final rule is available as well. This particular list can be found on *QualityNet* on the PCHQR Program overview page, and please note that the link for this particular page is at the top of the slide. This information can also be found on *Quality Reporting Center* on the PCHQR tab and in the program manual, which is posted on both *Quality Reporting Center* and *QualityNet*. The PCHQR portion of the final rule is organized by sections. These sections vary slightly according to the content of the publication. Sections that have been included across the final rule publications include Background or Statutory Authority. For the program measures, there have been various topics included such as Criteria for Removal and Retention of PCHQR Program Measures, Retention and Removal of Previously Finalized Quality Measures for PCHs Beginning With the Respective Fiscal Year, Accounting for Social Risk Factors for the PCHQR Program, New Quality Measures, and Possible New Quality Measure Topics for Future Years. There are also the Maintenance of Technical Specifications for Quality Measures, Public Display Requirements, Form, Manner and Timing of Data Submission, and Extraordinary Circumstances Exceptions, or ECE Policy, under the PCHQR Program sections. All of these sections that make up the final rule

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provide valuable information and guidance for participants and programs and those sections pertaining to program measures are key. At the helm of meeting program requirements is submitting specific quality measures related to the PCHQR Program to CMS. On our next slide, we will revisit the measure lifecycle and the measure implementation process. Next slide please.

This slide should look familiar as it was a part of a presentation held back in March of 2016. This webinar was entitled “Development and Selection of Quality Metrics for the PCHQR Program.” Valuable information was provided on the measure development, selection, and implementation process. For the purposes of this presentation, we will start with this diagram that depicts the flow of the measure lifecycle, and as you can see, it is ongoing. We will not spend time discussing each stage of the life cycle in depth, but let’s focus on opportunities where you can make an impact during this entire process. Looking at each red rectangle on this slide, these are points in the life cycle of measure development in which you as a provider can be involved. How? By providing input to CMS and the National Quality Forum, or NQF, during this process. As you can see, this opportunity exists during each step in this cycle, from the beginning with measure conceptualization to the end during the Measure Use, Continuing Education, and Maintenance stage. So, the Technical Expert Panels are formally convened during the first three phases of the measure lifecycle. This is a great opportunity for you, as a PCH provider, to share your 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 lifecycle. During these stages, you are able to provide comments, as your input is valued. As it has been said numerous times before, CMS actively seeks and listens to your input. The second to last stage of this measure lifecycle is measure implementation. Within this phase is the publication of the Measures Under Consideration, or MUC List, for public review. Let’s discuss this some more on the next slide, slide 13.

The measure implementation phase is where CMS considers whether there is a consensus to adopt measures. As illustrated on the previous slide, this

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part of the measure lifecycle includes the publication of the Measures Under Consideration, or MUC List, for public review. As I mentioned before, this is a stage in the process where you can make an impact regarding the measures being considered. Specific to PCHQR measures on the MUC List, the Measures Applications Partnership, or MAP, meetings, are held in December. CMS considers gap areas in the program, program need, and the future direction of the program on choosing measures for the MUC List. The MUC List measures are taken to the hospital workgroup for MAP and the MAP then provides recommendations. They either support, do not support, or offer conditional support for these measures. After these meetings, the public has the opportunity to comment on these recommendations. The MAP recommendations are then finalized in January when the MAP coordinating committee meets. After considering recommendations of the MAP, CMS might choose to include a measure in one of its quality reporting programs, which is defined through a pre-rule-making process as outlined on this slide. Please be sure to bookmark the web link at the top of this page, as it provides information about the MUC List and its availability, once published. There are also educational webinars and additional resources housed here as well. Next slide, please.

Here are three annual key milestones based on what we have discussed thus far. The MUC List is officially open between May 2nd through July 15th. By law, the MUC List is made publicly available no later than December 1st. Then, there is the annual publication of the proposed and final rules, which happen in April and August, respectively. The foundation of the program lies in the rules. So, how are the proposed and final rules prepared? We will begin with a brief overview of preparing the proposed rule, followed by the final rule on the next two slides. Slide 15, please.

This is a brief summary of how the proposed rule is prepared. CMS begins this process in January each year. The MAP recommendations are used by CMS to determine whether or not the measures will be used in CMS programs. As you know, the PCHQR Program is included in the IPPS/LTCH PPS Proposed Rule which is published in early April

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annually, and the public comment period lasts three months. Again, this is another opportunity for you to provide your expertise as a program participant. Next slide, please.

So now, moving from the proposed rule to the final rule, once the public comment period ends, CMS analyzes these comments on the proposals and the decision has to be made whether to finalize, modify, or not finalize the proposal. This is all based on the public comments received. On this slide is a list of some of the factors CMS evaluates during their decision-making process, which includes, but are not limited to, information regarding the burden of proposed measures, proposals for other measures on the same or similar topics, and potential unintended consequences of implementing the proposed measure. From this, the final rule is published in August each year. Of note, updates to the program occur during the annual publication of the final rule, and there is a sub-regulatory process to allow non-substantive updates to the measures and the program. So, that sums up the review of the foundational principles of the PCHQR Program. We will now turn our attention to the topics of best practices and quality improvement. Slide 17, please.

Another important aspect of the PCHQR Program is ensuring that participants are aware of best practices for the patients served and are in support of improvement. Being aware of best practices and striving to improve the quality of care you provide to your patients helps to meet the goals of the program. Next slide, please.

Best practices are methods or techniques used in which a desired result is achieved and can evolve to become better as improvements are discovered. Within the PCHQR Program, there are ways in which you are made aware of best practices. This includes helping you as a participant understand program measures, making you aware of data submission requirements set forth by CMS, and understanding our role as a support contractor through providing outreach and education, along with information about resources available for quality improvement. Let's take a few moments to look at each of these individually. Next slide, please.



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Earlier, we briefly discussed the measure lifecycle and the impact you can make during that process. Once the program measures are finalized for inclusion in the program, where are the details found needed to accurately abstract and report these measures? As the support contractor, we review the materials underlying the measures which contain these details which are necessary to understand the measure and accurately abstract it. There are many sources for this kind of data. Examples include, the quality payment system, or QPP, measure specifications, which are useful in extracting the oncology care measures, the Centers For Disease Prevention and Control, or CDC, pages, and those for the National Healthcare Safety Network, or NHSN, which all provide the clinical rationale, slide decks, data collection forms, and other tools useful for handling the HAI and safety measures, and materials published by the actual measure developer are useful as well. This will be in the case of the external beam radiotherapy, or EBRT measure, with the American Society of Therapeutic Radiation Oncology, the American Neurological Association for the OCM prostate measures, and the materials available from the American College of Surgeons Commission on Cancers for the CST measures. An additional source that may provide clarity as well are the National Comprehensive Care Network, or NCCN, guidelines. I know this seems like a wealth of materials for use; however, the good news is that we, the support contractor, provide links to these alternative data sources on the program's *QualityNet* page under the data collection and resources tabs which we discussed last month. As of right now, all tools have been updated and are available on *QualityNet*. Also, for those measures, which the PCHs have to abstract on their own, such as EBRT and the OCMs, the support contractor has developed measure information forms, algorithms, examples of population and sampling, and paper data abstraction tools, also 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 measure data, but also how to accurately report it and also to verify the accuracy of data in both Hospital Quality Reporting and in Public Reporting. So, for any given measure included in the PCHQR Program, there are always updated tools and resources that have been developed to aid you, a participant, in understanding the



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measures and how to report data, so that it is accurate and reflective of your patient population. On our next slide, slide number 20, we will discuss aspects of Hospital Quality Reporting.

The Affordable Care Act required CMS to establish a quality reporting program for the PPS-Exempt Cancer Hospitals for Fiscal Year 2014 and subsequent years. At this time, the 11 PPS-Exempt Cancer Hospitals must report quality data according to CMS's requirements, with no Medicare payment penalty or incentive. As it has always been, CMS proposes measures and reporting requirements through the rule-making process we discussed earlier. Hospital-level measure rates are required to be publicly reported for participating PCHs. So, from the final rule, you know which measures are required. Then, you have used the available tools and resources provided to properly abstract your data. Now, what do you do with your data and what steps are taken to ensure that you are successful in meeting this program requirement? Currently, data is submitted on a quarterly and annual basis. Quarterly submissions have included data for HCAHPS, CSTs and HAIs, and the annual submissions include the OCMs, EBRT and HCP data. The HCAHPS Survey data, which is submitted to CMS for you via your HCAHPS vendor, occurs four times a year. Then, next is the submission of the CST measures and the HAIs. You submit the CST measures while the NHSN submits your HAI data that you entered in their system. We send multiple ListServes preparing and reminding you of these submission dates, as well as targeted outreach as data deadlines approach and data has not yet been received. As a matter of fact, you should have recently received a ListServe communication regarding the November 15th data submission deadline, which includes the CST and HAI measures. Another important step and function of the PCHQR Program participants is the review of the data that you have submitted to CMS. By accessing the *QualityNet Secure Portal*, you are able to generate your hospital reports, which have recently been updated as discussed last month, as well, which contain your CST, OCM, EBRT and HAI data and also the HCAHPS reports. Regarding the HCAHPS reports, you probably received this data already from your HCAHPS vendor, but it is still important to validate. As the support contractor, we

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have multiple activities that support you in the submission of your data. This includes instructions and reminders of submission deadlines. Less obvious to you, is the work that we do to ensure that the PCHQR data is recorded 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. We will discuss this more very soon during today's event. On our next slide, we will take a look at the education and outreach efforts put forth to ensure your success in meeting this requirement and fulfilling the goals of the program. Slide 21, please.

There are many activities that we as the support contractor do to support your participation in the program. Program participants can expect to receive the following monthly communications pertaining to our educational events. These include flyers and ListServes, that are sent two weeks prior to the scheduled event; a reminder informing that the slides are available, which is sent one day prior to the event. Minutes are distributed within two business days after the event, and, as we mention at the beginning of each presentation, the questions and answers, presentation transcript, and recording are all posted within ten days of the event. This information is available on both *QualityNet* and *Quality Reporting Center*. Slide 22, please.

As stated earlier, we will send ListServes prior to data submission deadlines. We will send these ListServes out 30 and 15 days prior to these deadlines. Then, seven days prior to the data submission deadline, we will send a targeted email 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 still not submitted their data. As you can tell, data submission is a priority. Also, as needed, you will receive ListServes stating known issues with the *QualityNet* system that impact the PCHQR Program. This information is also posted on *QualityNet*. The information will state the issue, its known impact, any available workarounds, and when resolution of the issue is expected. In relation to Public Reporting,

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we also prepare and distribute educational materials and reminders that are sent out to you and posted on *QualityNet* about the availability of Public Reporting preview periods, as well as when data on *Hospital Compare* is refreshed. Lastly, we will send ListServes as needed when important information about the program needs to be communicated. Examples of these include completion of the measure exception forms, new updates to *QualityNet* and, mostly recently, the communications you received regarding the outpatient chemotherapy measure national dry run and the CMS-granted hurricane exceptions. Next, I would like to highlight a *QualityNet* tool you may or may not be familiar with. Slide 23 please.

As your support contractor, we are available to answer any questions you may have. As illustrated on this slide by the red box and arrow on the right-hand side, the *QualityNet* questions-and-answers tool can be accessed from the *QualityNet* homepage. I would like to point out that, since I have mentioned ListServe communications quite a bit so far during our discussion today, for those who may be fairly new to the program and/or have not registered to receive these notifications for the program, you can do this by clicking the link that is shown on this slide in the circle on the left-hand side. As we move along, the next few slides will provide visuals as we walk through the process of logging in as an existing user or completing a one-time registration for new users, in order to submit a question using this tool. Slide 24, please.

Depicted here are two options depending on the user type: existing or new. If you are an existing user, meaning you have used this tool before, you will need to click “Log In” as shown by the red box in the upper right-hand corner of this slide. If you are a new user, you will click “Sign Up”. Each user process is different, so let’s look at both. Next slide, please.

For the existing user, once you click the “Log In” link, this is the screen you will see. You will be prompted to enter your user name and password that you established when you completed the registration process. Please note that these log-in credentials are separate from the credentials used to access the *QualityNet Secure Portal*. Once you have entered this information, you will then click “Log In.” Next slide, please.

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This is what the new user will see when you click “Sign Up.” There is a required one-time registration process that must be completed in order to access the tool. Be sure to create a user name and password that are unique and easy for you to remember. So, once you have selected “Create a New Account,” as shown in the circle on the left-hand side of the screen, you will be taken to the “Create an Account” page, as shown on the right-hand side of this slide. At this point, you will need to complete all required fields as indicated by an asterisk and then, select “Create Account.” Slide 27, please.

Once you are logged in, you are now ready to ask your question. Although not shown here, you will have the option to select a Hospital Inpatient Quality Reporting Program, which in this case, is PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program. After the PCHQR selection is made, you can ask a question by clicking on the tab “Ask a Question”, as indicated by the red arrow on the slide. Please note that you are also able to search the database to see if your question may have been addressed previously. You can do this by typing a word or phrase in the search box, or by selecting a specific answer category listed as shown, such as “Cancer Measures,” “PCHQR Program Requirements,” or “Extraordinary Circumstance Exceptions.” Next slide, please.

Here is where you can submit your question. Again, there are required fields, as indicated by an asterisk. Your six-digit CMS Certification Number, or CCN, is required. Next slide, please.

Once all fields are completed and your question is drafted, you are ready to select the “Continue” button. Of note, as illustrated on this slide, if you are inquiring about “PCHQR Program requirements”, you will be required to select from a subgroup of options in order to proceed. As shown, you will need to choose either “*QualityNet* System Requirements” or “Notice of Participation”. At that point, after selecting “Continue”, you will receive a confirmation that your question has been submitted and a reference or incident number will be provided to you for follow-up purposes. Your question will be answered by a subject matter expert within two business days. Again, your question is trackable, as the system

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will provide you with an incident or reference number that you should retain for your records. This method is advantageous, as it allows for you to receive a timely response, and the response will be provided in writing. Next slide, please.

So, how do you know how well you, as a provider, are performing, and in what ways you can improve? Here we will discuss three resources that are available to you: the Quality Innovation Networks, or QINs; the CMS Impact Assessment; and the CMS Measures Inventory, which are both located on the CMS.gov website. We will begin our discussion with the Quality Innovation Networks. Slide 31, please.

As stated on the QIN-QIO website, the Quality Improvement Organizations, or QIO, Programs 14 QIN-QIOs bring Medicare beneficiaries, providers, and communities together in data-driven initiatives that increase patient safety, make communities healthier, better coordinate post-hospital care, and improve clinical quality. The QIN-QIOs are skilled in creating opportunities to providers to learn from each other, applying advanced improvement and analytical methods, engaging patients and families, and structuring processes to sustain positive change. Ultimately, the QINs are responsible for working with providers and the community on multiple data-driven quality initiatives to improve patient safety, reduce harm, engage patient and families, and improve clinical care at their local and regional levels. So, you may be wondering, how do you find your state's QIN? I will tell you on the next slide. Next slide, please.

By serving regions of two to six states each, QIN-QIOs are able to help best practices for better care spread more quickly while still accommodating local conditions and cultural factors. As the QINs are organized by state, there are a total of six QINs that cover the 11 PCHs, with two of these QINs covering more than one state. After this presentation was finalized, the steps to identify your state's QIN had been simplified. Therefore, the map seen here is no longer available and you are now simply able to select your state from a dropdown menu and the QIN's name, phone number, and website address are provided. To locate your QIN, you can visit [www.qioprogram.org/locate-your-qio](http://www.qioprogram.org/locate-your-qio). Slide 33, please.

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The first CMS impact report was published in 2012 and the most recent report came out in 2015, with the next one due in 2018. The CMS Impact Assessment occurs every three years. It is a publicly available assessment of the quality and efficiency impact of the use of endorsed measures described in Section 1870(b), 7(B) of the Social Security Act. These reports provide a quality check to determine if CMS is making progress on the healthcare delivery system to achieve the three aims of better care, smarter spending, and healthier people. The 2015 impact report encompasses 25 CMS programs and nearly 700 quality measures from 2016 (2006) to 2013. The great news is that the key findings of the 2015 report indicate that CMS is making a difference for the patients we serve. As participants in the PCHQR Program, which is included in this assessment, this is a reflection of your value as a program participant. Next slide, please.

Lastly, CMS publishes an updated measures inventory bi-annually every February and July. This is a compilation of measures used by CMS in various quality reporting and payment programs. This inventory lists each measure by program, reporting measure specifications including, but not limited to numerator, denominator, exclusion criteria, National Quality Strategy, or NQS domain, measure type, and National Quality Forum, or NQF, endorsement status. It is important to note that any changes to measures such as data, use and status, etc. are validated in federal rules and/or CMS Program or Measure Leads.. Any updates that occur after the CMS Quality Measures Inventory has been publicly posted will not be captured until the next posting. CMS provides this list of planned measures for the purposes of promoting transparency, measure coordination and harmonization, alignment of quality improvement efforts, and public participation. Now, we will take a look at the ways the program equips consumers with quality of care information through Public Reporting. Slide 35, please.

The process of Public Reporting uses the data you submit via Hospital Quality Reporting. It goes through processing before being publicly viewable, which includes a review by you as a program participant.

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Essentially, data that you submit is made available to the public, which allows consumers to make more informed decisions about their healthcare options. To fulfill program requirements, public reporting of measure rate via *Hospital Compare* is required. We will look at *Hospital Compare* on our next slide, slide 36.

Here you see the main entry page for *Hospital Compare* that I am sure most of you are familiar with. The *Hospital Compare* site has information about the quality of care at over 4,000 hospitals and facilities across the country. On this website, you will find hospital performance data in a consistent, unified manner to ensure the availability of credible information about the care delivered in the nation's hospitals. Providers that receive Medicare and Medicaid payments and participate in one or more of the various quality reporting programs provide information for this database. The Centers for Medicare and Medicaid Services, or CMS, and the nation's hospitals work together closely to create and publicly report hospital quality performance information on the *Hospital Compare* website. This information helps the consumer to make decisions about where to get their healthcare and encourages hospitals to improve the quality of care they provide.

So here on this slide, you are directed to where you can find PCH data. The publicly reported data for the PCHQR measures is found by clicking on the link in the red rectangle on this slide. Selecting this link takes you to what we refer to as the landing page for the PCHQR Program, which contains a brief overview of the program and a list of the measures currently reported on, and also on the same webpage, directly under the list of measures, there is a Socrata table that contains the actual data available at the last refresh of *Hospital Compare*. So, where does the data on *Hospital Compare* come from? It is important to note that Hospital Quality Reporting and Public Reporting are two distinct separate programs with varying data sources. For the Hospital Quality Reporting program, HAI data is received from the CDC, HCAHPS data is received from the designated vendor, and the CST, OCM and EBRT data is received from you, the PCH Program participants. For Public Reporting, HAI data is



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received from the CDC, HCAHPS data is received from the HCAHPS Support Contractor, and the CST, OCM and EBRT data is received from us, the Hospital Inpatient VIQR Support Contractor. Slide 37, please.

There was a recent update to the “PPS-Exempt Cancer Hospitals” tab selection list, which was the addition of the Public Reporting page. This page can be accessed by selecting the “Public Reporting” link, illustrated by the red circle on this slide. Slide 38, please.

As shown here on this slide, this is what the Public Reporting page looks like. This page addresses Public Reporting as it pertains to the PCHQR Program, and includes the purpose of *Hospital Compare*, which we just discussed, applicable PCHQR Program measures and their update frequency (for example, the CST measures are updated on a quarterly basis), and links to the *Hospital Compare* preview report resource documents. Next slide, please.

In addition to the information available on *QualityNet*, the Public Reporting preview document resources are also available on the Resources and Tools page on *Quality Reporting Center*. As shown in the red box on this slide, you are able to review the PCHQR *Hospital Compare* Preview Quick Reference Guide and the PCHQR *Hospital Compare* Preview Guide for December 2017. These *Hospital Compare* preview document resources are updated to coincide with the preview period for each annual refresh that occurs in April, July, October and December. Next slide, please.

Well, that concludes the didactic portion of today’s presentation. I will now review some important upcoming information and dates for the PCHQR Program. Slide 41, please.

In regards to the outpatient chemotherapy measure, this is a reminder that the updated FSRs are still available through approximately November 3, 2017. Please continue to submit your questions to CMSChemotherapyMeasure@yale.edu. Information about the national dry

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run and measure resources are available on the *QualityNet* website at the pathway listed on this slide. Slide 42, please.

Please note that our remaining two educational events for this year are scheduled to take place a week earlier than normal due to the upcoming holidays. Of note, there will be an alternative topic presented for next month as the new end-of-life measures presentation with the American Society of Clinical Oncology, or ASCO, will be rescheduled for a future date. Please stay tuned for more information regarding the November event, which will be available in the flyer and ListServes you will be receiving soon. Then, on December 14th, we will recap what has happened with the program this year and what is to come in 2018. Next slide, please.

Our next data submission deadline is November 15, 2017. This will include your data for quarter one 2017 CST chemotherapy breast and colon; quarter three 2016 CST hormone data; and quarter two 2017 HAI data. And, as a reminder, this data submission period does fall under the CMS-granted hurricane-related exception for those PCHs impacted by hurricanes Harvey and Irma. Next slide, please.

This slide is a continuation and provides further elaboration on the applicable submission deadlines and discharge periods for those PCHs in impacted areas. Please remember that CMS continues to closely monitor this situation and, if any adjustments are necessary, CMS will communicate them accordingly. So, be sure to monitor future communications. Next slide, please.

For Public Reporting, the October data was refreshed on October 25th. For December 2017, the preview period, which is currently underway, will end October 31st, and the anticipated refresh is scheduled for December 20th. As always, please remember that all dates for Public Reporting are subject to change. As we get closer to the preview periods and refresh dates, we will always notify you of the exact dates via ListServe. At this time, I would like to turn the presentation over to Deb Price to review the continuing education process. Deb?

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### **Deb Price:**

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

We now have an online CE certificate process. You can receive your CE certificate two ways. First way is if you register through 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 at the bottom right-hand corner a little grey box that says "Done." You will 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 this separate registration, so you can receive your certificate. Healthcare facilities have firewalls that seem to be blocking our certificates from entering your computer.

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

# PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program

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

This is what the “New User” screen looks like. Please register a personal email like Yahoo!, or Gmail, or ATT, since these accounts are typically not blocked by hospital firewalls. Remember your password, however, since you will be using it for all of our events. You’ll 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 and we need to get in contact with you.

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

**Lisa Vinson:**

Thank you, Deb. I would like to thank each of you for your time and attention during today’s presentation. I hope that the information shared today allowed you to see how your participation is valuable, as it helps to fulfil the goals of the PCHQR Program. Thank you for all that you do within your facilities, and for the patients you serve. Have a great day.