



PPS-Exempt Cancer Hospitals Quality Reporting Program

Support Contractor

Getting Ready for the August 15, 2016 Data Submission

Presentation Transcript

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Lisa Vinson: Good afternoon, and welcome to today's webinar entitled *Getting Ready for August 15, 2016 Data Submission*. My name is Lisa Vinson, and I am the Project Manager for the PPS-Exempt Cancer Hospital Quality Reporting team with the Hospital Inpatient Value, Incentive, and Quality Reporting, or VIQR, Outreach and Education Support Contractor. This webinar is part of the educational series focused on the hospitals participating in the CMS PPS-Exempt Cancer Hospital Quality Reporting, or PCHQR, Program. Please note that the content of today's event is specific to the PPS-Exempt Cancer Hospital Quality Reporting Program. While there may be content and concepts that apply to quality reporting in general, remember that this information is specific to the PCHQR program. This is especially true with today's event, which will be focusing on the August 15, 2016 data submission requirements for the Program with great detail about the creation of the data files that the PCHs use in their submission process. So, while you are welcome to participate, unless

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you are directly involved in the PCHQR program, your time may be better spent elsewhere in all candor. Our presenters today will be Tom Ross, the PCHQR Program Lead here at the Hospital Inpatient VIQR Outreach and Education Support Contractor; and Henrietta Hight, Project Coordinator, also here at the Hospital Inpatient VIQR Outreach and Education Support Contractor. As the title indicates, we are gearing up for the upcoming August 15, 2016 data submission deadline. The slides, transcript, and questions and answers from today's webinar will be posted to the *QualityNet* website, as well as the *Quality Reporting Center* website. Now, we will take a look at the next slide, which many of you may be familiar with.

There will be a wealth of information covered in today's presentation. Please keep this acronym and abbreviation slide handy as a quick reference. We will now review the purpose of today's presentation in the next slide.

Slide number seven, please.

The purpose of today's presentation is to provide a detailed review of the August 15, 2016 data submission of the Cancer-Specific Treatment, or CST; Surgical Care Improvement Project, or SCIP; Oncology Care Measures, or OCMs; and External Beam Radiotherapy, or EBRT measures. Submission of this data via *QualityNet* Secure File Transfer in a comma-separated values, or CSV, format will be re-examined. Submission of the Healthcare-Associated Infection, or HAI, measures via the National Healthcare Safety Network, or NHSN, will also be addressed. We will now take a look at the objectives for today's webinar.

Next slide, please.

At the culmination of today's webinar, program participants will be able to summarize the similarities and differences pertaining to data entry for CST, SCIP, OCM, EBRT, and HAI measures and use the provided template and tools to enter and transmit CST, SCIP, OCM, and EBRT measure data in order to meet the data entry and submission requirements for their respective CSV files. I would now like to turn the presentation over to Tom, who will be discussing in depth the upcoming data submission requirements. Tom?

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Tom Ross: Thank you, Lisa. We had the privilege of Lisa joining our team at the Hospital Inpatient VIQR Support Contractor a couple of months ago. In addition to her work manning the phone and Q&A tool for all of the programs we provide support to, Lisa will be specializing in the PPS-Exempt Cancer Hospital Quality Reporting Program with Henrietta and myself. The topic of today's webinar is, as Lisa reminded us, the data submission period ending August 15, 2016. Over the past year, you have all been submitting Cancer-Specific Treatment Measures on a quarterly basis. This will continue in this upcoming data submission period with the submission of the Quarter 4, 2015 Diagnosis Cohort for PCH-1 and PCH-2, more familiarly known as the Chemotherapy Measures for Colon and Breast. And, remembering that the diagnosis cohort for the CST measure for Hormone Therapy always lags this by two quarters, the next submission of the Hormone file will be for the Quarter 2, 2015 Discharge Diagnosis Cohort. You will see this data appear on your fiscal – program year 2016 PPS-Exempt Cancer Hospital Report. Last summer, we had the first submission of the SCIP and OCM data, which is Quarter 1, 2015 data. This August, we will see the submission of Quarter 2 and 3, 2015 SCIP cases for the six SCIP measures. This ends with Quarter 3, 2015 as last year's Final Rule sun-setted the SCIP measures in the PCHQR program after this date. For the five Oncology Care Measures, the PCHs will submit Quarter 2 through Quarter 4, 2015 data. This summer, we will see the first submission of EBRT or NQF 1822. This will be the cases for all of calendar year 2015, all four quarters. The data for SCIP, OCM, and EBRT Measures will all appear on the newly created Fiscal Year 2017 PPS-Exempt Cancer Hospital Report. Lastly, the data for Quarter 1, 2016 cases for the Healthcare-Associated Infection Measures, CLABSI, CAUTI, SSI, both Colon and Abdominal Hysterectomy, and two of the new HAI measures, *Clostridium difficile* infection and MRSA bacteremia, will be reported on your behalf based upon the data you have entered into the National Healthcare Safety Network, or NHSN. The data for CLABSI and CAUTI will appear on the Fiscal Year 2017 Cancer Hospital Report, while the data for the SSI, CDI, and MRSA Measures will appear on the Fiscal Year 2018 report. The relationship between reporting periods and when the data appears in the PPS-Exempt Cancer Hospital Reports can be hard to keep track of. Participants are urged to reference the Relationship Matrix available on *QualityNet* and *Quality Reporting Center*. Please, let us look at the next slide,

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Number 10. There are at least three or four names for each of the measures used in the PCHQR program. We have developed the tables on this slide and the next for you to utilize as a helpful reference. To illustrate how to use this reference, let's look at the line for PCH-1. This line tells us four things: first, the measure is part of the Cancer-Specific Treatment Measures; secondly, the PCH number is PCH-1; this is needed as the PCH numbers are used in the external file layout; three, the other name for the metric, most commonly used by the American College of Surgeons and Cancer Registry folks, is ACT; and, lastly, the common measure description is Adjuvant Chemotherapy for Stage Three Colon Cancer. Please keep this table and the table on slide 11 to use as a reference in constructing your external files for the upcoming data submission period. This will help ensure that you enter the correct numerator, denominator, and compliance percentage on the correct row for each measure. On the bottom of this slide, you see the six SCIP measures with their PCH numbers. Next slide,

Slide number 11, please. The first set of measures on this slide are the Oncology Care Measures. Please note that PCH-17 is NQF 390, the Adjuvant Hormonal Therapy for Prostate Cancer Patients at High Risk of recurrence and that PCH-18 is NQF 389, the Prostate Measure for the Avoidance of Overuse of Bone Scan in Low-Risk Cancer – Prostate Cancer Patients. Also, on a lighter note, we don't have any catchy other names for the OCMs. So, if you have any ideas, I'm sure Henrietta will be interested. Next, we see the Clinical Effectiveness Measure, EBRT, which is PCH-25 and NQF 1822. And, lastly, you see the PCH numbers for the HAI Measures. You may be wondering where the logic in the PCH numbers comes from. They are numbered in the order that they were implemented into the PCHQR program. On our next slide,

Slide number 12, we will discuss the overall general process for creating the comma-separated value, or CSV, file to submit these measures. To describe the general process to create a CSV file, we have chosen to use the creation of the CSV file for the Hormone Measure, PCH-3. As you are aware from previous data submissions, we, the Support Contractor, will prepare template files for you to use. While you are free to create your own, we strongly urge you to use the templates for the specific data submission period that are provided. Once you have your data collected and abstracted, the first step is to open the template file in Excel[®]. We recommend this

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as (inaudible) in Excel® and aligns columns, and thus greatly facilitates data entry in the correct column. On the slide, you see that the columns for Provider ID, NUMERATOR, DENOMINATOR, and PERCENT fields have been highlighted. This is where you enter your facility-specific information. Note that for the hormone and all of the CST measures, the percent concordance is calculated to precision of one decimal place. In the templates, we try to remind you of this by using the placeholder of per.cent. In this example, we have replaced the CCN placeholder with a CCN number of 123456; replaced the placeholder NUM with the denominator 63 – excuse me – a numerator 63; replaced the DEN placeholder with a denominator 67; and entered the percent concordance of 94.0. Since Excel® does not keep leading or trailing zeroes after decimal points, this will save as 94. This lack of trailing zeros after the decimal point is not a problem. We now save the file with the same name as in the template; in this case, pch_acos_hormone_HQR_2015Q2_ and then the date of the file submission. In file name, the PCH obviously stands for the PCH program. The ACOS is an artifact from when ACOS submitted the files. Hormone is the short name for the data file. HQR means that this file is for Hospital Quality Reporting. And 2015Q2 means that this is the timeframe of the data reporting. When multiple quarters are reported in one file, such as with EBRT, SCIP, or OCMs, this will be the last quarter of data in the file. The date of the file submission is entered in a month underscore day underscore year year format. In our example, we are submitting the file on July 25, 2016, so the date component of the file name is 07 underscore 25 underscore 2016. When you save the file in a CSV format, the system will add the suffix of .csv to the file name. Slide 13, please.

This will show us what the file will look like in Notepad® and what we still have to do to make it ready for submission. On the top of the slide, we see the file we saved. We open the file using Notepad®. Then we add leading zeroes as needed. If you are a California PCH, please remember to add the leading zero to your CCN in the Provider ID column. In the Reporting Period Start Date and Reporting Period End Date columns, we will have to add the leading zeroes. This is because we are reporting Quarter 2, 2015 data. So, in this instance, we would have to place a leading zero in front of 4012015 for the State Date column and in front of the 6302015 in the End Date column. Once this is complete, the file should look like the

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lower image on the slide. The dates now appear as 04012015 and 06302015. Remember that the trailing zero in the Percent column disappeared, and this is okay. We now save the file in Notepad®, ensuring that it is in a CSV format. The file is ready to send. I wish to clarify one question that is sometimes asked. “Why is the Footnote column always left blank?” The Footnote field is only used in public reporting files, and the PCHs do not submit any of these for the submission. So, you will never have to answer any data in this column. Your file is now ready to send. Remember, if you open and save the file after this point in Excel®, you will lose your trailing and leading zeroes.

On slide 14, we will recap the general steps for a CSV file to contain your data and make it ready for submission, and then we will look at each of the various files you will be submitting in the upcoming data submission period. First and foremost, always use the templates provided. Open the template in Excel®. This will facilitate accurate data entry. You should never change the data in the following columns in the template: “Measure_ID,” “Measure_Description,” “Footnote,” or “Time_Period.” On slide 15, we will continue to review ...

... the general steps in preparing your CSV files for submission. Be sure to enter your data in all required rows. This will consist of in each file: “Provider_ID,” “NUMERATOR,” “DENOMINATOR,” and “PERCENT.” For the OCM and EBRT files, for the first time you will be entering your sampling frequency, your total patient population, and your sampling size. We will review this in detail when we get to these slides individually. One question I received last August was, “What do I do if I do not have any patients eligible for a measure in a given timeframe?” For example, if you do not provide radiation therapy for prostate in your hospital, you will not have any patients eligible for NQF 390, as one of the inclusion criteria is EBRT to the prostate. You should still enter a numerator of zero and a denominator of zero. And don’t worry, remember that for public reporting, in those cases with a denominator of 11 or less, the data will not appear on *Hospital Compare*. Once your data is entered in all rows, save the file as a CSV file with the date that you will submit the data. If, for some reason, you have to resubmit the data, say, there was an error in your file or you are provided with updated data, as an example, be sure to change the date in the file name to the new date of submission. This allows us and the IT contractors to know which file is the most recent for the

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purposes of uploading. Next, open the file in Notepad®, add leading zeroes, as needed, to the CCN if you are in California, and to the reporting period start and end dates, as needed, and save in Notepad®. The file is now ready to be sent via Secure File Transfer in *QualityNet*. With the overall process outlined, with the next slide,

Slide number 16, we will now take a look at the other four files that you will be creating. This is the view of the template for Quarter 4, 2015 Diagnosis Cohort for the CST Chemo file. You will note that there are two rows to enter dates on, one for PCH-1 and one for PCH-2. Once again, the highlighted fields to enter data are for the “Provider_ID,” the “NUMERATOR,” the “DENOMINATOR,” and the concordance “PERCENTAGE.” Remember the per.cent placeholder is your reminder that CST percentage is to be entered with specificity to one decimal place. Also, in the red rectangles in the top screenshot, you can see that we avoid some work with this file as it is for quarter four. The “START DATE” is 10012015 and the “END DATE” is 12312015, so no leading zeroes are needed to be inserted in the next step. The bottom screenshot in this slide is the view of Notepad® after the data has been entered. In our example files, we have entered, on both rows, our CCN of 123456, our “NUMERATORS,” “DENOMINATORS” and concordance “PERCENTAGES,” in this case, 83.3 and 76.7. And, once again, there is no need to add the leading zeroes in the date fields, as the quarter starts in the 10th month and concludes in the 12th month. You are familiar with these files from having submitted them previously, so let’s move on. On our next slide,

Slide 17, for our next file, the file for SCIP. This is a view of the SCIP file template in Excel®. You can see that there are many more rows of data for this file, a total of 12. This is because there are six measures with each measure being reported for two quarters, Quarter 2 and 3 of 2015. The reason for multiple rows – quarters for each measure – is that SCIP data is only submitted once a year. On row two, you see PCH-19 Quarter 2, and on row three, you see PCH-19 Quarter 3, and so forth, for the other five measures. Once again, the highlighted fields show you are being asked to enter your PCH-specific data, the “CCN,” “NUMERATOR,” “DENOMINATOR” and “PERCENTAGE,” with specificity to one decimal point. On our next slide,

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Slide 18, we will show what this file looks like with the data entered still in the Excel® view. And, as promised, here is a view of the SCIP file in Excel® with the data entered. In the “Provider_ID” there is the same CCN for all rows. The only time this would be different would be in the case of a vendor sending in the SCIP data for more than one organization. In the “NUMERATOR” and “DENOMINATOR” columns, we see the whole numbers entered. Then, in the “PERCENT” column, we see the percentages with specificity to one decimal place. As we saw earlier, on the percentage to the whole number, such as 75.0 percent in row two, Excel® drops the trailing zero after the decimal point. This is fine. Looking at the reporting period START and END DATE columns, we see we have some work to do. As the SCIP date is for Quarters 2 and 3 of 2015, we will have to enter the leading zeroes for all of these START and END dates. And we will see this more clearly on the next slide,

Slide number 19, when we open the newly renamed and saved file in Notepad®. Here is the view in Notepad®. First of all, notice the file name, pch underscore scip underscore HQR underscore 2015Q3 underscore 07 underscore 25 underscore 2016. The 2015Q3 portion is due to the fact that the last quarter of data being entered is Quarter 3. The date is the date the file will be transmitted, July 25, 2016, in this case. Secondly, note, as previously discussed, the trailing zeroes after the decimal point, for example, the highlighted 90 above, do not have a trailing zero. This is not an issue, and you can leave it as it is. Last, you can see that all the reporting period START and END dates are missing leading zeroes. These will have to be inserted. We will do that and show the results in our next slide,

Slide number 20. And here is the final finished product. You can see that the leading zeroes for the reporting period START and END dates, for example, 04 and 06, and 07 and 09, are all present. On slide 21,

Our next slide, we will summarize what is unique or different with the SCIP file compared to the others. Once again, we see the unique file name. Of course, containing the SCIP data, the name of the file contains scip in lowercase letters. The reporting period in the file name is the last quarter of data contained in the file, in this case, 2015 Quarter 3. The SCIP file is unique in that it has no MEASURE_DESCRIPTION column. You will have to reference the PCH number

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tables to ensure that you get your data on the correct lines. As with the CST measures, SCIP data is precise to one decimal point. And, lastly, in the SCIP file, the FOOTNOTE column is in a different order than the other files. But, remember, this is never used for Hospital Quality Reporting to CMS by the PCHs. Slide 22, please.

So, we have three files down, two more to go, OCMs and EBRT. As mentioned earlier, the reporting of Population and Sampling now applies to all OCM and EBRT submissions effective now. Remember when we reviewed the new tools for the OCM and EBRT during the April PCHQR webinar? We showed that there is a Measure Information Form, a Clean Algorithm and a Population and Sampling version for each of these. These algorithms provide the examples on how Population and Sampling numbers are obtained. The population is all the patients who are eligible for the denominator in each reporting quarter. These will be the patients identified as being eligible for the denominator because of the ICD-9 or -10 codes and the CPT codes for that measure and who did not meet any of the denominator exclusion criteria. The entire population eligible for the time period, which for the PCH program is in quarter, is what is reported. The sample is exactly that, the sample size. This sampling was done to the population for that quarter. This information will be entered in your external files by responding to three questions: Q1, question one, not quarter one, uses the placeholder of SF for sampling frequency, and here is the question, “What was your hospital sampling frequency?” If you sampled for the quarter, you enter the number “1” for “quarterly sampling.” If you did not sample, you enter a “2” for “not sampled” in place of the SF placeholder. If you have no eligible patients for the quarter, select “2,” “not sampled.” Q2, question two – this asks for your hospital initial patient population for the quarter, all those patients who meet the inclusion criteria for the quarter and were not excluded. Q3, question three – this is your hospital’s quarterly sample size. You will want to print this slide and keep it nearby for when you create your files. For NQF 382, 383, 384, and 1822, your sample size, the response to question three above, must equal your reported denominator for that measure. If it does not, the file will fail. The reason for this is that these measures do not have post-denominator exclusions. On slide 23,

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We will take a look at the numerator portion of the algorithm 389 to demonstrate this. In this example, we have opted to randomly sample 10 randomly selected patients from our population of 20. Remember that the standard is to avoid the use of a bone scan. Seven patients did not have a bone scan performed and, therefore, included in the numerator. So, our numerator is seven. However, this measure has two post-denominator or numerator exclusions. We can see that one patient had a bone scan due to a medical reason. Maybe they are having hip pain and there is concern there was metastatic disease. Since this patient meets the exclusion criteria, they are not included in either the numerator or denominator. Therefore, the numerator stays at seven, but this patient must be removed from the denominator, reducing that number to nine. The next exclusion is a bone scan performed due to a system reason. This is most often a scan done at another institution or office. In our example, this exclusion applies to one patient. Therefore, once again, they are not included in either the numerator or denominator. Therefore, our numerator stays at seven, but removing this patient from the denominator reduces the denominator to eight. We end the algorithm with one patient not included in the numerator. Therefore, our final concordance is the seven patients who did not receive a bone scan divided by the eight patients in the denominator. Remember, there were 10 in the initial sample, with the two patients removed from the post-sampling exclusions, now leaving us with the denominator of eight. So, for NQF 389, shown here and NQF 390, which also has post-denominator exclusions, the denominator maybe less than your sample size for a particular quarter. With the definition of the three Population and Sampling questions removed, let's move on to slide 24

... to view the OCM external file template from Excel[®]. By now, this view should be familiar. As there are five OCMs and you are supplying data for three quarters in this data submission, there are 15 rows for which you will need to enter data. You will be entering in the highlighted areas, once again, your CCN and, now, the answers to questions one, two, and three for Sampling Frequency, Population and Sampling, and then, of course, your NUMERATOR, your DENOMINATOR and PERCENT concordance. Note that for the OCMs, the placeholder for the PERCENT column is one word, "PERCENT," with no period. This is your reminder that the OCM data is rounded to the nearest whole number. On the next slide, slide 25,

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We will look at the same template with the data entered. Let's look at line two. This is PCH-14, Radiation Dose Limits to Normal Tissue. In column OCM underscore Q1, we see an entry of "1," which should mean that it was sampled for this quarter. The initial patient population entered on OCM underscore Q2 column was 45. In the column OCM underscore Q3, we see that the sample size was 10. Remembering our sampling guidelines for a quarterly patient population of 10 to 50, the minimum sample size is 10. In the NUMERATOR column, we see 8. In the DENOMINATOR column, we see 10. This is good because we need the DENOMINATOR column to equal the sample size for this measure as well as the other three discussed. You will see the denominators and sample size in this table are the same for all of the rows for PCH-14, -15 and -16, which are NQF 382, 383, and 384. In rows 11 through 16, you see the response to Q1, Sampling Frequency, is "2," which means "Not Sampled." This was the case because for each quarter, the Initial Patient Population in column Q2 was less than 10, and the sampling guidelines do not allow sampling in a population of 10 or less. The last thing I want to illustrate on this slide are the highlighted cells through row 12 and row 15. On row 12, we have an Initial Patient Population of four. Therefore, no sampling is allowed, and the sample size is also four. However, the denominator is three. In this case, for PCH-17, or NQF 390, there is the possibility of a post-denominator exclusion, which is what occurred. The same is true on line 15 for PCH-18, or NQF 389, where the population was seven. The sample size, therefore, is seven, but the denominator is six. On slide 26,

We will review our Population and Sampling tips. So, if you think about it, for the OCMs, if you entered "Not sampled" for your Sampling Frequency, then your population must equal your sample size. And for PCH-14, -15, and -16, as well as EBRT, as there are no post denominator exclusions, your denominator will also be the same. This does not necessarily apply to PCH-17 or -18 as the possibility of post-denominator or a numerator exclusion may apply. And, then, on this slide, we see our familiar sampling grid. Remember, if your Initial Patient Population is less than or equal to 10, sampling is not allowed. The grid displays less than 10, "No Sampling," but for a sample population, for a population of 10 to 50, the minimum sample size is 10. So, there is really no sampling for 10 or less. Slide 27 ...

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... will show us what the OCM file looks after it has data entered, saved as a CSV, and opened in Notepad[®]. Here, as with the SCIP file previously, you will see that you will have to enter the leading zeroes for the Quarter 2 and Quarter 3, for both the reporting period START and END dates for all rows. The dates for Quarter 4 do not require any modification. And, as always, if you are in California, don't forget to insert the leading on your CCN for each row. Our next slide,

Slide 28, shows the completed CSV file for the OCMs. And here it is. On each row, a six-digit CCN, Sampled or Not Sampled, Initial Population, Sample, NUMERATOR, DENOMINATOR, PERCENT, rounded to the nearest whole number, and reporting period START and END dates with leading zeroes, as appropriate. Slide 29 ...

... discusses the unique attributes of the OCM file. The file name – note that the file name – in the file name, OCM is capitalized. The data is through Quarter 4 of 2015. So, the date in the file name is 2015Q4. Percentages for the OCMs are rounded to the nearest whole number. And, lastly, we now have the inclusion of the Population and Sampling elements. Whether the data was sampled or not is the response to OCM_Q1; the Initial Quarterly Patient Population is reported in OCM underscore Q2; and the quarterly sample size is reported in OCM underscore Q3. Slide 30, please.

Four files down and one to go. Here is the Excel[®] view of the EBRT file. As there is one measure in this file being reported for all four quarters of 2015, there are four rows of data for you to enter. The data to be entered is exactly the same data elements that were entered for SCIP [Error – same data elements that were entered for the OCMs]. So, we do not have to go into detail. It is the CCN, Sampled or Not Sampled, Initial Patient Population, Sample Size, NUMERATOR, DENOMINATOR, and PERCENT. The percent is rounded to the nearest whole number for EBRT, as indicated by the use of the whole word “PERCENT” with no period. Slide 31 provides the same view, only with data entered.

We can see in this case, on row number two, the row for Quarter 1, 2015, in the EBRT underscore Question 1 column, we see a “2.” This means the data was Not Sampled. Therefore, the Initial Population of 27 in the EBRT underscore Q2

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column is 27. And as there are no post denominator exclusions for EBRT, the DENOMINATOR is also 27. The NUMERATOR was 25 for a concordance of 92.6, which rounds up to the nearest whole number of 93. On row three, the Initial Patient Population was 34. Sampling was performed, and, per the guidelines, the minimum sampling size of 10 was selected. On rows four and five, the initial population was between 51 and 125. Therefore, they chose to sample 20 percent of the population. Note, as there are no post-denominator exclusions in EBRT in each reporting time period, the sample size in the EBRT underscore Q3 column equals the denominator. As always, we save this file as a CSV file. Now, if you are looking closely at the slide, here is something new in the EBRT template file name. Your organization's CCN is in the file name. Let's see what that looks like on slide 32.

Here is the view of the same file in Notepad®. In the red box on the top left, you will see that for an imaginary PCH with a CCN of 123456, we have replaced the placeholder in the file name with the actual CCN. So, the file to be uploaded on July 25, 2016, has been named pch underscore 123456 underscore ebrt underscore HQR underscore 2015Q4 underscore 07 underscore 25 underscore 2016. As you are reporting Quarters 1, 2, 3, and 4, you have to enter the leading zeroes for the reporting period START and END dates, where indicated in the red boxes. Slide 33 shows us how the final EBRT file will look in the Notepad® view.

And here it is, the file – CSV file, for an imaginary PCH 123456 prepared for submission on July 25, 2016. Slide 34 will cover the unique attributes of the EBRT file. We already discussed that the CCN placeholder needs to be replaced with your actual CCN in the file name. As always, the reporting period is the last quarter of the file, in this case, 2015Q4. And the date the file will be uploaded is contained in the file name. PERCENTAGE, as with the OCMs, is to the nearest whole number. The Sampling Population and Sample Size are included. And, as a check, the same size for each quarter must match the denominator for that quarter for EBRT. Let's take a high-level look at the data that will be sent in the period closing on August 15, 2016 ...

... on slide number 35. So, due by August 15, 2016, we have two files for the CST measures; one file for the SCIP measures; one file for the OCMs; one for the EBRT. And then, of course, the NHSN will be submitting on your behalf, the HAI measures

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for Quarter 1 2016. So, now that you have abstracted all this data and prepared your CSV files, you will probably want to send them. Let us take a high-level look at this beginning on slide 36.

The CSV files we send securely to CMS via *QualityNet* utilizing the Secure File Transfer function. You have almost all previously submitted data using this function. So, I am not going to go into great detail but, rather, highlight a few of the changes. For a thorough review of this process, please refer to the July 2015 PCHQR webinar that we have provided a link to on this page. Slide 37 will show us the recipients for these files.

In the email function of your file transfer, please send the files to Marcus Wadsworth, Andrea Carver, Jennifer Miller, and Benton Tedder. On the CC line, please include Kim Taylor, Steven Ehlers, Robert Mitchell, and Anna Yap. Also, to be – this is very important – that you include this on the CC line as two of our analysts, Steven and Robert, will be performing the review of your files prior to them being uploaded. If there are any issues with the file, we will contact you soon after you have sent the Secure File Transfer with correction instructions. As we will be reviewing 55 external files, I firmly urge you to submit your data as soon as possible in this process. On slide 38 ...

... we will talk about attaching the CSV files to your message. In the past, we have told you to send only one file per message. Well, we are now changing this and asking you, if possible, to send all your files, five attachments, via one message. This will save you effort and also effort on behalf of those reviewing and uploading the data. Once again, it is permissible and desirable to send all files attached to one Secure File Transfer message. Now, I know this has been a lot of information and a large amount of data to prepare and submit. For this reason, we have [on] slide 39

...

... devoted to a number of support tools to assist you. Obviously, today's event is meant to be a cornerstone for the education and outreach for the upcoming data submission. Henrietta and Lisa will be distributing the templates and instructions to all the PCHs prior to July 1. You will be familiar with these, but, they are laid out in a more instruction manual, step-wise format that I think you will find useful. We are also in the process of developing a short video tutorial for each of the files that we

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hope to have available on *Quality Reporting Center* by the end of the month. And, certainly, your team here at the VIQR Education and Support Contractor is available if needed. While the official deadline for the submission of all these files is August 15, 2016 at 11:59 p.m. Pacific Time, we are urging submission by August 1. This is for two reasons: the first is that we want the time to review and, as needed, have you correct your files. As stated before, we will be going through 55 files, and this is a big task. And, secondly, as you may recall, the OCMs will be publicly reported starting December 15. We, as a Support Contractor, are submitting this data on your behalf. If we can get the OCMs' files as early as possible, that would be great and very beneficial. The window to submit data will open in mid-July, as system upgrades occur. We will provide you with more specifics as we get close to the date. So, with all that being said, I am going to turn the presentation over to Henrietta, starting on slide 40. Henrietta?

Henrietta Hight: Thank you, Tom. We are now on slide number 40, *CDI and MRSA NHSN Pointers*. Now, this slide indicates NHSN steps for CDI and MRSA reporting are more complex than those for CLABSI, CAUTI, and SSI reporting. M-R-S-A or, as we often say, "MRSA," stands for methicillin-resistant *Staphylococcus aureus*. In NHSN, the term "M-D-R-O," multidrug-resistant organism, is often used or is also used when referring to MRSA. CDI stands for *Clostridium difficile* infection. Today, we will only point out certain highlights regarding NHSN CDI and MRSA, reporting that started for the PCHQR program January 1, 2016 for first quarter 2016 events with a due date for entry into NHSN by August 15, 2016. In preparation for NHSN CDI and MRSA reporting, we strongly recommend reviewing the November 18, 2015 webinar entitled, *PCHQR – Using NHSN for the MRSA and C. difficile LabID Event Reporting* available on the *Quality Reporting Center* at the link shown on this slide. Once you click on this link, scroll down to about the bottom – the middle of the page, and you will find the November 2015 webinar. Denise Leaptrot from the CDC did a fantastic job of explaining what you need to consider when reporting CDI and MRSA events. Next slide, please.

CDI and MRSA NHSN Pointers continued. Unlike CLABSI, CAUTI, and SSI reporting, CDI and MRSA data reporting is based on laboratory-identified events, referred to as LabID events. The advantage of LabID event reporting is that it is an

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objective laboratory-based metric that allows for identifying events without extensive chart review. As the slide indicates, you will be reporting CDI and MRSA LabID events identified in your Emergency Departments, 24-Hour Observation Units, and all Inpatient Care locations. The link on this slide takes you to the *Complete Guide to CDI and MRSA Data Collection and Reporting*. This is another valuable resource. On the next slide, we will look at some new terms.

Slide 42 includes CDI and MRSA NHSN terms that you need to know. Here are some important terms that you did not use when reporting CLABSI, CAUTI, and SSI events. First, community-onset, or abbreviated, CO. These are LabID event specimens collected in an outpatient location or an inpatient location equal to or less than three days after admission to the facility., in other words, days one, two or three of an inpatient admission. Community-onset applies to both CDI and MRSA events. Then you have healthcare facility-onset, abbreviated as HO. These are LabID event specimens collected more than three days after admission to the hospital, in other words, on or after day four. This term applies to CDI or MRSA events. And, then, you have a term that applies only to CDI. And this is called community-onset healthcare facility-associated events, abbreviated as CO dash HCFA. These are LabID events that are community-onset collected from a patient who was discharged from the facility equal to or less than four weeks prior to the current date of stool specimen collection. And, again, this applies only to CDI events. Although the metric reported to CMS will be a hospital-onset, or HO, incident rate, in NHSN, you will be reporting both HO and CO LabID events. These must be reported into NHSN. Note that categorization is based on the date admitted to the facility or the date of the encounter and the date the specimen was collected. Based on the data provided, each event will be categorized by NHSN as either CO, HO, or CO-HCFA. On the next slide, let us look at some more information.

CDI and MRSA NHSN SIRs, this is a term that you encountered when reporting on the SSIs. Remember, SIR stands for standardized infection ratio. As the first bullet on the slide indicates, the SIR is calculated by dividing the number of observed events by the number of predicted or expected events. Remember that in NHSN, predicted is referred to as expected. Also, the CDI and MRSA SIR is calculated only at the quarter level. The second bullet is something very important in regard to

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CDI reporting. In addition, as the slide indicates, for CDI, for the last month of each quarter, users must report the primary type of test that was used to identify CDI in the hospital for that quarter. That test type is important because it is then used in the calculation of the CDI SIR for that quarter. On the next slide, we'll see ...

... some additional tools. So, we are now on slide number 44, MDRO. Remember, MDRO in NHSN, for our purposes, is referring to MRSA and CDI LabID Event Calculator. Due to the complexity of the terms used in CDI and MRSA reporting, the Event Calculator is a great tool. And the link is provided on the slide that will take you to the MRSA or the MDRO and CDI LabID Event Calculator, with additional information regarding using the calculator. In addition to the terms we looked at today, like CO, HO, there are other LabID event terms or categories, such as Duplicate Event used in NHSN that the CDI and MRSA LabID Event Calculator will help with. So, use this tool. In addition, use all the tools available that were included in these slides regarding the CDI and MRSA event reporting. As always, the NHSN help desk is available for questions. Their email address is shown on this slide. It's nhsn@cdc.gov. On the next slide, we will look at important upcoming dates and milestones.

Tom Ross: Here on slide 45, you can see the next three webinars that are scheduled for the PCHQR program. Two will be presented by the NHSN with the August event being a presentation of the Fiscal Year 2017 Final Rule. As far as data submission, HCAHPS for quarter one 2015 will be reported by your vendor by July 6. We have certainly covered the data period ending August 15 today, and by August 31, 2016, all of the PCHs will have to complete and fax in their 2017 DACA. This will be a manual signature and fax process this year. You will be receiving more information via ListServe about this. At this time, I will turn the event over to Deb Price to review the CE process. Deb?

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

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

Okay, this is what the – what the survey will look like. It will pop-up at the end of the event and will be sent to all attendees within 48 hours. Click [Done] at the bottom of the page when you are finished.

This is what pops up after you click [Done] on the survey. If you have already attended our 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 will notice you have a first name, a last name and the personal email, and we are asking for a phone number in case we have some kind of back-side issues that we need to get in contact with you.

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

Tom Ross:

I thank all of you for your time and attention today. Be on the lookout for the templates, instructions, and notice that the video resources are available. Please submit your data as early as possible once the data submission window opens in mid-July. And, as always, thanks for the care you provide to our patients. Have a great afternoon.

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