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Overview

The PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) program was established by Section 3005 of the Affordable Care Act, which added subsections (a)(1)(W) and (k) to section 1866 of the Social Security Act. Section 1866(k) of the Act establishes a quality reporting program for hospitals described in section 1886(d)(1)(B)(v) of the Act. These hospitals are excluded from payment under the Inpatient Prospective Payment System (IPPS).

The PCHQR program is intended to equip consumers with quality-of-care information to make informed decisions about healthcare options. It is also intended to encourage hospitals and clinicians to improve the quality of inpatient care provided to Medicare beneficiaries by ensuring that providers are aware of and reporting on best practices for their respective facilities and type of care.

NOTE: This document is intended for use as a reference guide and does not contain specifications for individual measures. Each section provides detailed instructions for successful implementation of the PCHQR Program.

Program Eligibility

Eligible hospitals are described in section 1886(d)(1)(B)(v) and referred as PPS-Exempt Cancer Hospitals (PCHs). These hospitals are excluded from payment under the IPPS. Eleven hospitals have been granted the PPS-Exempt Cancer Hospital designation by the Centers for Medicare & Medicaid Services (CMS).

A list of hospitals with the PCH designation is available at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/PPS_Exc_Cancer_Hospasp.html.

Hospital Inpatient Prospective Payment Systems (IPPS) Final Rule

CMS publishes proposed program and policy changes to the PCHQR Program in April. The proposed changes are published to the Federal Register and are open to the public for review and comment for 60 days. CMS also provides notices through the QualityNet website to ensure broad awareness. Following the comment period, CMS summarizes the comments and responds to them in the Final Rule. The Final Rule is then published in August. Information regarding the PCHQR Program can be found in the following Final Rule publications:

- In the Fiscal Year (FY) 2013 Inpatient Prospective Payment System and Long Term Care Hospitals Prospective Payment System (IPPS/LTCH PPS) Final Rule, CMS finalized five quality measures for the FY 2014 program and subsequent years. Two hospital-acquired infection (HAI) and three cancer-specific treatment measures comprise the five measures added. Information for the PCHQR Program is contained on pages 53555 through 53567 in the Federal Register/Volume 77; Number 170 published August 31, 2012. The direct download (12.8 MB) can be accessed here: http://www.gpo.gov/fdsys/pkg/FR-2012-08-31/pdf/2012-19079.pdf.
In the FY 2014 IPPS/LTCH PPS Final Rule, CMS finalized one additional new HAI quality measure for the FY 2015 program and subsequent years, the Surgical Site Infection (SSI) measure. In addition, CMS finalized 12 new quality measures, including five clinical process oncology care measures for the FY 2016 program and subsequent years. CMS did not remove or replace any of the previously finalized measures from the PCHQR Program for FY 2015 and FY 2016. Information for the PCHQR Program is contained on pages 50837 through 50853 in the Federal Register/Volume 78; Number 160 published August 19, 2013. The direct download (12.5 MB) can be accessed here: http://www.gpo.gov/fdsys/pkg/FR-2013-08-19/pdf/2013-18956.pdf.

In the FY 2015 IPPS/LTCH PPS Final Rule, CMS finalized one new clinical effectiveness measure for the FY 2017 program and subsequent years, the External Beam Radiotherapy (EBRT) measure. CMS did not remove or replace any of the previously finalized measures from the PCHQR Program for the FY 2017 program and subsequent years. Information for the PCHQR Program is contained on pages 50277 through 50286 in the Federal Register/Volume 79; Number 163 published August 22, 2014. The direct download (5.78 MB) can be accessed here: http://www.gpo.gov/fdsys/pkg/FR-2014-08-22/pdf/2014-18545.pdf.

In the FY 2016 IPPS/LTCH PPS Final Rule, CMS adopted three new Safety and Healthcare-Associated Infection (HAI) measures collected via the Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN) and removed six Surgical Care Improvement Project (SCIP) measures from the PCHQR program for the FY 2018 program and subsequent years. Information for the PCHQR Program is contained on pages 49713 through 49723 in the Federal Register/Volume 80; Number 158 published August 17, 2015. The direct download (3.25 MB) can be accessed here: https://www.gpo.gov/fdsys/pkg/FR-2015-08-17/pdf/2015-19049.pdf.
Section 2: Measures

The PCHQR program has multiple types of measures that are collected and reported starting with Program Year (PY) 2013 and subsequent years. The PCHQR Program measures are collected by participating PCHs using a variety of data collection methods. Refer to the tables in Section 3 for reporting methods, measure information, and sampling requirements.

Hospitals participating in the PCHQR Program will be required to report the measures listed below. Measures were adopted for PY 2013, with subsequent measures added for PYs 2014, 2015, 2016, 2017, and 2018. Refer to Appendix A for data submission dates.

Safety and Healthcare-Associated Infection (HAI)
- Central Line-Associated Bloodstream Infection (CLABSI) (NQF # 0139) (PCH-4)
- Catheter-Associated Urinary Tract Infection (CAUTI) (NQF #0138) (PCH-5)
- Harmonized Procedure Specific Surgical Site Infection (SSI) (NQF #0753) (PCH-6 (colon) and PCH-7 (hysterectomy))
- Facility-wide Inpatient Hospital-onset *Clostridium difficile* Infection (CDI) Outcome Measure (NQF #1717) (PCH-26)
- Facility-wide Inpatient Hospital-onset Methicillin-resistant *Staphylococcus aureus* (MRSA) Bacteremia Outcome Measure (NQF #1716) (PCH-27)
- Influenza Vaccination Coverage Among Healthcare Personnel (HCP) Measure (NQF #0431) (PCH-28)

Clinical Process/Cancer-Specific Treatment (CST)
- Adjuvant Chemotherapy is Considered or Administered Within four Months (120 days) of Diagnosis to Patients Under the Age of 80 with AJCC III (lymph node positive) Colon Cancer (NQF #0223) (PCH-1)
- Combination Chemotherapy is Considered or Administered Within four Months (120 days) of Diagnosis for Women Under 70 with AJCC T1cN0M0, or Stage IB – III Hormone Receptor Negative Breast Cancer (NQF #0559) (PCH-2)
- Adjuvant Hormonal Therapy (NQF #0220) (PCH-3)

Surgical Care Improvement Project (SCIP)
- SCIP-Inf-1: Prophylactic Antibiotic Received Within one Hour Prior to Surgical Incision (NQF #0527) (PCH-21)
- SCIP-Inf-2: Prophylactic Antibiotic Selection for Surgical Patients (NQF #0528) (PCH-22)
- SCIP-Inf-3: Prophylactic Antibiotics Discontinued Within 24 Hours After Surgery End Time (NQF # 0529) (PCH-23)
- SCIP-Inf-9: Urinary Catheter Removed on Post-Operative Day 1 or Post-Operative Day 2 with Day of Surgery Being Day Zero (NQF #0453) (PCH-20)
- SCIP-Card-2: Surgery Patients on Beta Blocker Therapy Prior to Admission who Received a Beta Blocker During the Perioperative Period (NQF #0284) (PCH-24)
- SCIP-VTE-2: Surgery Patients who Received Appropriate Venous Thromboembolism Prophylaxis within 24 Hours Prior to Surgery to 24 Hours After Surgery End Time (NQF #0218) (PCH-19)

Clinical Process/Oncology Care Measures (OCM)
- Oncology: Radiation Dose Limits to Normal Tissues (NQF #0382) (PCH-14)
- Oncology: Plan of Care for Pain (NQF #0383) (PCH-15)
- Oncology: Pain Intensity Quantified (NQF #0384) (PCH-16)
• Prostate Cancer: Adjuvant Hormonal Therapy for High-Risk Patients (NQF #0390) (PCH-17)
• Prostate Cancer: Avoidance of Overuse Measure-Bone Scan for Staging Low-Risk Patients (NQF #0389) (PCH-18)

Clinical Effectiveness Measure
• External Beam Radiotherapy (EBRT) for Bone Metastases (NQF #1822) (PCH-25)

Patient Engagement/Experience of Care
• Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey (NQF #0166) (PCH-NA)
Measure Information

The sections below provide a summary of each measure set and where to obtain additional measure information. On electronic versions of this document, the blue measure numbers in the headings provide a direct link to the National Quality Forum (NQF) website page for the specified measure. The NQF measure descriptions can be found at http://www.qualityforum.org/QPS.

Healthcare-Associated Infection (HAI)

For PY 2014, CMS initially adopted two HAI measures, CLABSI and CAUTI, from the CDC. The measure data are reported on a quarterly basis through the NHSN.

Beginning with PY 2015, CMS adopted the SSI measure for the PCHQR program. This measure assesses the incidence of SSIs following colon surgeries and abdominal hysterectomies performed by PCHs. Users reporting CAUTI, CLABSI, and SSI data must adhere to the definitions and reporting requirements as specified in the NHSN Patient Safety Component Protocol.


The 2016 NHSN Patient Safety Component (PSC) Manual is posted on the NHSN website. The surveillance protocols and definitions contained within the 2016 Manual should be used for surveillance and data collection beginning on January 1, 2016. Previous versions are available on the NHSN website in the Data Validation section of the website.

0138: Catheter-associated urinary tract infection (CAUTI) (PCH-5)

The NHSN Analysis Output Option, “Rate Table - CAUTI Data for CMS PPS-Exempt Cancer Hospitals,” was created to allow facilities to review those CAUTI data that will be submitted to CMS on their behalf. This report only includes in-plan CAUTI data for each oncology intensive care unit (ICU), ward, and step-down unit.

The numerator is defined as the total number of observed healthcare-associated CAUTI among patients in bedded inpatient care locations. The denominator is the total number of indwelling urinary catheter days for each location under surveillance for CAUTI during the data period.
0139: Central line-associated bloodstream infection (CLABSI) (PCH-4)

The NHSN Analysis Output Option, “Rate Table - CLABSI Data for CMS PPS-Exempt Cancer Hospitals,” was created to allow facilities to review those data that will be submitted to CMS on their behalf. This report includes only in-plan CLABSI data for each oncology intensive care unit (ICU), ward, and step-down unit beginning with 2013 data.

The numerator is the total number of observed healthcare-associated CLABSI among patients in bedded inpatient care locations. The denominator is the total number of central line days for each location under surveillance for CLABSI during the data period.

0753: Harmonized procedure specific surgical site infection (SSI) (PCH-6 (colon) and PCH-7 (hysterectomy))

The Standardized Infection Ratio (SIR) of an SSI is calculated by dividing the number of observed infections by the number of expected infections for an operative procedure category. The number of expected infections, in the context of statistical prediction, is derived from a logistic regression model using a baseline time period.

The numerator is the deep incisional primary (DIP) and organ space SSIs during the 30-day postoperative period among patients at least 18 years of age, who undergo inpatient colon surgeries or abdominal hysterectomies. SSIs will be identified before discharge from the hospital, upon readmission to the same hospital, or during outpatient care or admission to another hospital (post-discharge surveillance). The denominator is the expected number of SSIs obtained using multivariable logistic regression models for colon surgeries and abdominal hysterectomies. These expected numbers are summed by facility and surgical procedure and used as the denominator of this measure.

1717: Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) (PCH-26)

CMS published Final Rules in the Federal Register on August 17, 2015 for the PCHQR program that include a requirement for PCHs to report CDI laboratory-identified (LabID) events that occur in their emergency departments, 24-hour observation units, and all inpatient care locations to the CDC’s NHSN. The reporting requirement is for events that occur on or after January 1, 2016.

The SIR of hospital-onset CDI LabID events will be calculated among all inpatients in the facility. The numerator is the total number of observed hospital-onset CDI LabID events among all inpatients in the facility. The denominator is the expected number of hospital-onset CDI LabID events, calculated using the facility’s number of inpatient days, bed size, affiliation with medical school, microbiological test used to identify C. difficile, and community-onset CDI admission prevalence rate.

NHSN users reporting FacWideIN CDI LabID event data to the system must adhere to the definitions and reporting requirements for those events as specified in the NHSN Multidrug-Resistant Organism (MDRO) and Clostridium difficile Infection (CDI) Module protocol http://www.cdc.gov/nhsn/PDFs/pscManual/12pscMDRO_CDADeurrent.pdf. This includes individually mapping all inpatient locations from the entire cancer hospital in NHSN. Facilities must also map and report from emergency departments (EDs) (i.e., adult and pediatric) and 24-hour observation locations. Facilities will report a single monthly Facility-wide Inpatient (FacWideIN)
denominator summed for all inpatient locations (total facility patient days and total facility admissions), as well as separate denominators, to capture ED and 24-hour observation location(s) encounters for each mapped location.

**1716: Facility-wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia (PCH-27)**

CMS published Final Rules in the *Federal Register* on August 17, 2015 for the PCHQR Program that include a requirement for PCHs to report MRSA blood specimen (bacteremia) LabID events that occur in their EDs, 24-hours observation units, and all inpatient care locations to the CDC’s NHSN. The reporting requirement is for events that occur on or after January 1, 2016.

The SIR of hospital-onset unique blood source MRSA LabID events will be calculated among all inpatients in the facility. The numerator is the total number of observed hospital-onset unique blood source MRSA LabID events among all inpatients in the facility. The denominator is the expected number of hospital-onset unique blood source MRSA LabID events, calculated using the facility’s number of inpatient days, bed size, affiliation with medical school, and community-onset MRSA bloodstream infection admission prevalence rate.

NHSN users reporting FacWideIN MRSA bacteremia LabID event data to the system must adhere to the definitions and reporting requirements for those events as specified in the NHSN Multidrug-Resistant Organism (MDRO) and CDI Module protocol, [http://www.cdc.gov/nhsn/PDFs/pscManual/12pscMDRO_CDADcurrent.pdf](http://www.cdc.gov/nhsn/PDFs/pscManual/12pscMDRO_CDADcurrent.pdf). This includes individually mapping all inpatient locations from the entire cancer hospital in NHSN. Hospitals must also map and report from EDs (i.e., adult and pediatric) and 24-hour observation locations. Facilities will report a single monthly FacWideIN denominator summed for all inpatient locations (total facility patient days and total facility admissions), as well as separate denominators to capture ED and 24-hour observation location(s) encounters for each mapped location.

**0431: Influenza Vaccination Coverage Among Healthcare Personnel (HCP) (PCH-28)**

The HCP measure assesses the percentage of HCP who receive the influenza vaccination. The measure is designed to ensure that reported HCP influenza vaccination percentages are consistent over time within a single healthcare facility, as well as comparable across facilities.

The denominator includes the number of HCP working in the healthcare facility for at least one working day between October 1 and March 31 of the subsequent year, regardless of clinical responsibility or patient contact, and is calculated separately for employees, licensed independent practitioners, and adult students/trainees and volunteers. The measure has no exclusions.

The numerator includes the HCP from the denominator population who met the following criteria between October 1 (or when the vaccine became available) and March 31 of the subsequent year:

- Received an influenza vaccination administered at the healthcare facility, reported in writing (paper or electronic), or provided documentation that influenza vaccination was received elsewhere;
- Had a medical contraindication/condition of severe allergic reaction to eggs or to other component(s) of the vaccine, or has a history of Guillain-Barre Syndrome within six weeks after a previous influenza vaccination;
- Declined influenza vaccination; or
- Had an unknown vaccination status or did not otherwise fall under any of the abovementioned
numerator categories.

**Sampling**

There is no sampling for the NHSN measures.

**HAI Measures Reporting Period and Submission Deadlines**

Hospitals are encouraged to submit their data monthly (within 30 days of the end of the month in which it is collected) in order to have the greatest impact on infection prevention activities. It is important to review the data that is entered to ensure it is complete and accurate. Data must be reported to NHSN by means of manual data entry into the web-based application or via file imports.

For data to be shared with CMS, each quarter’s data must be entered into the NHSN no later than four and a half months after the end of the quarter. For example, Quarter (Q)1 (January 1–March 31) data are entered into NHSN by midnight August 15.

For HAI measures’ reporting periods and submission deadlines, refer to Appendix A.

**Additional Resources**

For questions specific to the HAI measures, refer to the CDC website at: [http://www.cdc.gov/nhsn/index.html](http://www.cdc.gov/nhsn/index.html).
**Cancer-Specific Treatment (CST)**

Listed below are three Cancer-Specific Treatment measures, initially adopted by CMS from the American College of Surgeons Commission on Cancer (ACoS CoC) for PY 2014. The patient data is entered into the Rapid Quality Reporting System (RQRS) of the ACoS by the cancer hospitals. The cancer hospitals access the RQRS system and generate reports on a quarterly basis. The data is then used to report performance on the CSTs to CMS on a quarterly basis.

**0223: Adjuvant chemotherapy is considered or administered within four months (120 days) of diagnosis to patients under the age of 80 with AJCC III (lymph node positive) colon cancer (PCH-1)**

There are substantial data indicating that there is underuse and wide variation in the use of chemotherapy with Stage III colon cancer.

The numerator is defined as the number of patients with chemotherapy administered within four months (120 days) of diagnosis or it is considered. The denominator is the population of patients who meet the following characteristics:

- The patient must be age 18–79 at time of diagnosis.
- The diagnosis is known or assumed to be first or only cancer diagnosis.
- The diagnosis involves primary tumors of the colon.
- It must be an epithelial malignancy only.
- There must be at least one pathologically-examined regional lymph node positive for cancer (AJCC Stage III).
- All or part of first course of treatment performed at the reporting facility.
- The patient must be known to be alive within four months (120 days) of diagnosis.

**0559: Combination chemotherapy is considered or administered within four months (120 days) of diagnosis for women under 70 with AJCC T1cN0M0, or Stage IB - III hormone receptor negative breast cancer (PCH-2)**

There is extensive documentation of the benefit of multi-agent chemotherapy (combination chemotherapy or single agent chemotherapy with a biologic response modifier) in women with hormone receptor negative breast cancer. Chemotherapy reduces by about one-third the risk of distant disease recurrence and death. The restriction to women under age 70 is because this measure is for the purpose of provider accountability. There are limited data in women over age 70 to guide recommendations, and a higher fraction of these women have reasons to omit chemotherapy, including co-morbidity. Malignant phyllodes tumors are excluded from this measure.

The numerator is defined as patients with combination chemotherapy administered within four months (120 days) of the date of diagnosis or it is considered. The denominator is the number of women who meet the following characteristics:

- The patient is age 18-69 at time of diagnosis.
- The diagnosis is known or assumed first or only cancer diagnosis.
- The diagnosis involves primary tumors of the breast.
- It must be an epithelial invasive malignancy only.
- The malignancy must be AJCC T1cN0M0, or Stage IB to III.
- The primary tumor must be estrogen receptor negative and progesterone receptor negative.
• All or part of first course of treatment performed at the reporting facility.
• The patient be known to be alive within four months (120 days) of diagnosis.

0220: Adjuvant hormonal therapy (PCH-3)

There is extensive evidence that hormone (endocrine) therapy with hormone receptor positive breast cancer reduces the risk of local recurrence, contralateral breast cancer, distant recurrence, and death. The measure specifies use of tamoxifen or third-generation aromatase inhibitor rather than specifying tamoxifen for premenopausal and aromatase inhibitor for postmenopausal women. There are two reasons for this: one is the difficulty in clearly identifying from records or administrative data the menopause status; the other is the variation in appropriate use of tamoxifen in postmenopausal women and some reasonable use of aromatase inhibitors in premenopausal women with the use of ovarian suppression.

The numerator is the number of patients with hormone therapy administered within one year (365 days) of the date of diagnosis or the therapy being considered.

The denominator is the number of women who meet the following characteristics:
• The patient must be age ≥18 at time of diagnosis.
• The diagnosis is known or assumed to be first or only cancer diagnosis.
• It must be an epithelial malignancy only.
• The diagnosis involves primary tumors of the breast.
• The malignancy is AJCC T1cN0M0 or Stage IB – III.
• The Primary tumor must be estrogen receptor positive or progesterone receptor positive.
• All or part of first course of treatment performed at the reporting facility.
• Known to be alive within one year (365 days) of date of diagnosis.

Sampling

There is no sampling for the CST measures.

CST Measures Reporting Period and Submission Deadlines

For CST measures reporting period and submission deadlines, refer to Appendix A.

Additional Resources

For additional information regarding the CST measures and the RQRS, refer to the following documents from the American College of Surgeons.

• For NQF #0223 please refer to: Colon Measure Specifications
• For NQF #0559 and #0220 please refer to: Breast Measure Specifications
**Surgical Care Improvement Project (SCIP)**

SCIP measures assess effective care for patients undergoing surgery, including the use of antimicrobial prophylaxis, continuity of beta blocker therapy during the perioperative period, removal of urinary catheter (when appropriate) on post-operative Day 1 or 2, and the prevention of venous thromboembolism. Detailed specifications can be found within the Specifications Manual for National Hospital Inpatient Quality Measures on the QualityNet website.

Facilities must use version 4.4a of the Specifications Manual for National Hospital Inpatient Quality Measures on the QualityNet website, as subsequent versions will not contain the SCIP specifications.

https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1141662756099

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**0527: SCIP-Inf-1 Prophylactic Antibiotic Received Within One Hour Prior to Surgical Incision (PCH-21)**

A goal of prophylaxis with antibiotics is to establish bactericidal tissue and serum levels at the time of skin incision. Studies performed in the 1960s and the 1970s demonstrated that a common reason for failure of prophylaxis was delay of antibiotic administration until after the operation. In a study of 2,847 surgery patients at LDS Hospital in Salt Lake City, it was found that the lowest incidence of postoperative infection was associated with antibiotic administration during the one hour prior to surgery. The risk of infection increased progressively with greater time intervals between administration and skin incision. This relationship was observed whether antibiotics preceded or followed skin incision (Classen, 1993).

Opportunities to improve care have been demonstrated, and timely administration has been recommended. For example, at LDS Hospital, administration of the first antibiotic dose “on call” to the operating room was frequently associated with timing errors. Altering the system there resulted in an increase in appropriate timing from 40% of cases in 1985 to 99% of cases in 1998.

The numerator is defined as the number of surgical patients with prophylactic antibiotics initiated within one hour prior to surgical incision (two hours if receiving vancomycin or a fluoroquinolone). The denominator is defined as selected surgical patients with no evidence of prior infection. The exclusions are listed in the Measure Information Form.

---

**0528: SCIP-Inf-2 Prophylactic Antibiotic Selection for Surgical Patients (PCH-22)**

A goal of prophylaxis with antibiotics is to use an agent that is safe, cost-effective, and has a spectrum of action that covers most of the probable intraoperative contaminants for the operation. First or second-generation cephalosporins satisfy these criteria for most operations, although anaerobic coverage is needed for colon surgery. Vancomycin is not recommended for routine use because of the potential for development of antibiotic resistance, but is acceptable if a patient is allergic to beta-lactams, as are fluoroquinolones and clindamycin, in selected situations.

The numerator is defined as the number of surgical patients who received prophylactic antibiotics recommended for their specific surgical procedure. The denominator is defined as selected surgical patients with no evidence of prior infection. The exclusions are listed in the Measure Information Form.
**0529: SCIP-Inf-3 Prophylactic Antibiotic Discontinued Within 24 Hours After Surgery End Time (PCH-23)**

A goal of prophylaxis with antibiotics is to provide benefit to the patient with as little risk as possible. It is important to maintain therapeutic serum and tissue levels throughout the operation. Intraoperative re-dosing may be needed for long operations. However, administration of antibiotics for more than a few hours after the incision is closed offers no additional benefit to the surgical patient. Prolonged administration does increase the risk of CDI and the development of antimicrobial resistant pathogens.

The numerator is defined as the number of surgical patients whose prophylactic antibiotics were discontinued within 24 hours after Anesthesia End Time, 48 hours for Coronary Artery Bypass Graft (CABG) or other cardiac surgery. The denominator is defined as selected surgical patients with no evidence of prior infection. The exclusions are listed in the Measure Information Form.

**0453: SCIP-Inf-9 Urinary Catheter Removed on Post-Operative Day One (POD1) or Post-Operative Day Two (POD2) with Day of Surgery Being Day Zero (PCH-20)**

It is well-established that the risk of catheter-associated UTI increases as indwelling urinary catheterization is prolonged. In 2000, Sanjay Saint, MD, MPH, Division of General Medicine, University of Michigan Health System, reported the results of a pooled analysis of ten prospective trials dating from 1983 to 1995 which estimated that bacteriuria will develop in 26% of patients after two to ten days of catheterization (95% CI 23-25%). Additional pooled analyses demonstrated that 24% (95% CI = 16% to 32%) of those patients will develop symptomatic UTI, and bacteremia will develop in 3.6%. Among surgical patients, two studies of postoperative patients discharged to subacute care with urinary catheters were more likely to be readmitted to the hospital with a UTI compared with those who had catheters removed prior to hospital discharges (Heidi Wald, MD, MPH, University of Colorado school of Medicine, 2005 and Wald, 2008). Among selected major surgical patients in the Surgical Infection Project (SIP) cohort, Wald demonstrated that 85% had perioperative indwelling catheters placed and half of those patients had catheters for greater than two days postoperatively. These patients were twice as likely to develop UTIs prior to hospital discharge. On multivariate analysis, those who had indwelling bladder catheters for more than two days postoperatively were 21% more likely to develop UTI, significantly less likely to be discharged to home, and had a significant increase in mortality at 30 days. Additional analyses suggest that there is sizeable variation in the duration of postoperative catheterization among hospitals and that hospital factors may account for this variation. In 2006, Francois Stephan, MD, PhD, reported the results of a multifaceted intervention study in orthopedic surgery patients in which protocols limiting the use and duration of postoperative catheterization played a large role. They reported a resultant 60% reduction in UTI incidence-density.

The numerator is defined as the number of surgical patients whose urinary catheter is removed on POD 1 or POD 2 with day of surgery being day zero. The denominator is defined as selected surgical patients with a catheter in place postoperatively. The exclusions are listed in the Measure Information Form.
0284: SCIP-Card-2 Surgery Patients on Beta-Blocker Therapy Prior to Admission Who Received a Beta-Blocker During the Perioperative Period (PCH-24)

Concerns regarding the discontinuation of beta-blocker therapy in the perioperative period have existed for several decades. Shammash and colleagues studied a total of 140 patients who received beta-blockers preoperatively. Mortality in the eight patients who had beta-blockers discontinued postoperatively (50%) was significantly greater than in the 132 patients in whom beta-blockers were continued. Hoeks and colleagues studied 711 consecutive peripheral vascular surgery patients. After adjustment for potential confounders and the propensity of its use, continuous beta-blocker use remained significantly associated with a lower one-year mortality than among non-users. In contrast, beta-blocker withdrawal was associated with an increased risk of 1-year mortality compared with nonusers. The American College of Cardiology/American Heart Association cite continuation of beta-blocker therapy in the perioperative period as a class I indication, and accumulating evidence suggests that titration to maintain tight heart rate control should be the goal.

The numerator is defined as the number of surgery patients on beta-blocker therapy prior to arrival who received a beta-blocker during the perioperative period. The denominator is defined as all surgery patients on beta-blocker therapy prior to arrival. The exclusions are listed in the Measure Information Form.

0218: SCIP-VTE-2 Surgery Patients Who Received Appropriate Venous Thromboembolism Prophylaxis within 24 Hours Prior to Surgery to 24 Hours After Surgery (PCH-19)

There are over 30 million surgeries performed in the United States each year. Despite the evidence that venous thromboembolism (VTE) is one of the most common postoperative complications, and prophylaxis is the most effective strategy to reduce morbidity and mortality, it is often underused. The frequency of VTE, that includes deep vein thrombosis and pulmonary embolism, is related to the type and duration of surgery, patient risk factors, duration and extent of postoperative immobilization, and use or nonuse of prophylaxis. According to Heit et al, 2000, surgery was associated with over a twenty-fold increase in the odds of being diagnosed with VTE. Studies have shown that appropriately used thromboprophylaxis has a positive risk/benefit ratio and is cost effective. Prophylaxis recommendations for this measure are based on selected surgical procedures from the 2008 American College of Chest Physicians guidelines.

Timing of prophylaxis is based on the type of procedure, prophylaxis selection, and clinical judgment regarding the impact of patient risk factors. The optimal start of pharmacologic prophylaxis in surgical patients varies and must be balanced with the efficacy-versus-bleeding potential. Due to the inherent variability related to the initiation of prophylaxis for surgical procedures, 24 hours prior to surgery to 24 hours post-surgery was recommended by consensus of the SCIP Technical Expert Panel in order to establish a timeframe that would encompass most procedures.

The numerator is defined as surgery patients who received appropriate VTE prophylaxis within 24 hours prior to Anesthesia Start Time to 24 hours after Anesthesia End Time. The denominator includes all selected surgery patients. The exclusions are listed in the Measure Information Form.
Sampling

Sampling guidance is included in the technical specification, if available, from the measure steward. Sampling should be systematic to ensure that all eligible individuals have an equal chance of inclusion. CMS has adopted the existing sampling tables as specified in Section 2-Measurement Information of the Specifications Manual for National Hospital Inpatient Quality Measures: (http://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1141662756099).

SCIP Measures Reporting Period and Submission Deadlines

For the SCIP measures reporting period and submission deadlines, refer to Appendix A.

Additional Resources

For questions specific to the SCIP measures, access the CMS Question and Answer Tool at: https://cms-ip.custhelp.com/app/homepch/p/830

Oncology Care Measures (OCM)

The OCMs, endorsed by the NQF, were derived from the Physician Quality Reporting System (PQRS). They assess the quality of medical assessment, treatment and diagnostics of cancer by PCHs. The PCHs will collect and report aggregated numerators and denominators by quarter, with an annual submission period of July 1 through August 15.

0382 - Oncology: Radiation Dose Limits to Normal Tissues (PCH-14)

Identifying radiation dose limits to normal tissues is an important step in the process of care for patients receiving radiation therapy treatments. Although no specific data is available, in its practice accreditation reviews, the American College of Radiation Oncology has found that radiation dose limits to normal tissues are included in the patient chart less frequently than reviewers expected. While dose constraint specification is an integral part of Intensity Modulated Radiation therapy (IMRT), it is not required for 3D conformal radiation therapy. Patients treated with 3D conformal radiation therapy are often subjected to dose levels that exceed normal tissue tolerance. Precise specifications of maximum doses to be received by normal tissues represent both an intellectual process for the physician during radiation treatment planning and a fail-safe point for the treating therapists. In most circumstances where facilities require specification of radiation dose limits to normal tissues prior to initiation of therapy, policies and procedures exist that prohibit exceeding those limits in the absence of written physician approval.

The numerator is defined as patients who had documentation in the medical record that radiation dose limits to normal tissues were established prior to the initiation of a course of 3D conformal radiation for a minimum of two tissues/organs. The denominator includes all patients, regardless of age, with a diagnosis of pancreatic or lung cancer receiving 3D conformal radiation therapy. There are no exclusions.
0384 - Oncology: Pain Intensity Quantified (PCH-16)

Pain, both acute and chronic, is one of the most frequently documented symptoms in the cancer patient population. Estimates on the prevalence of pain in this patient population vary depending upon a number of factors such as type of assessment, treatment, extent of disease, type of cancer and patient setting. Beuken-van Everdingen and colleagues reported in a meta-analysis reported pain prevalence rates ranging from 33% in patients after curative treatment to 64% in patients characterized as having advanced/metastatic/terminal disease. Not only is pain a problem in its own right, but pain in the cancer patient has also been linked to decreased quality of life, depression, anxiety, and even decreased survival. The National Institute of Health’s (NIH’s) Pain – for health professionals (PDQ®) states, “Failure to properly assess pain is a critical factor leading to undertreatment.”

Inadequate cancer pain management is widely prevalent, harmful to the patient, and costly. All patients with cancer should be screened for pain during therapy/treatment. If pain is present on a screening evaluation, the pain intensity should be quantified using a standardized instrument. The identification and quantification of pain is the first step toward improving quality of care by monitoring, managing, and controlling pain.

The numerator is defined as the number of patient visits in which pain intensity is quantified. The denominator includes all visits for patients, regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy. There are no exclusions.

0383 - Oncology: Plan of Care for Pain – Medical Oncology and Radiation Oncology (PCH-15)

Once pain in a cancer patient is identified, it is imperative that, due to the physical, emotional, and quality of life implications, a plan of care for the pain is undertaken. It has been reported by the NIH that up to 90% of cancer pain can be managed through relatively simple means. Others have cited research that proposes that 70–90% of cancer patients should be able to be effectively treated for their pain. Clinicians must respond to reported pain in a manner appropriate to the type of pain and setting. The National Comprehensive Cancer Network (NCCN) and others provide guidelines for opioids, non-opioid analgesics, and adjuvant analgesics. It should be noted that appropriate responses may not always include more opioids but rather more detailed assessments, use of non-opioid analgesics or techniques, or non-pharmacologic interventions (e.g., education, relaxation, and use of heat or cold).

The numerator is defined as the number of patient visits that included a documented plan of care to address pain. The denominator includes all visits for patients, regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy who report having pain and the pain is quantified. There are no exclusions.

0389 - Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients (PCH-18)

A bone scan is generally not required for staging prostate cancer in men with a low risk of recurrence and receiving primary therapy. Low risk prostate cancer is defined as having all of the following: a PSA of $\leq 10$ng/ml AND a Gleason score of $\leq 6$ AND most recent clinical stage T1c or T2a.
The numerator is defined as the number of patients who did not have a bone scan performed at any time since diagnosis of prostate cancer at the PCH. The denominator includes all patients, regardless of age, with a diagnosis of prostate cancer at low risk of recurrence, receiving one of the following: interstitial prostate brachytherapy OR external beam radiotherapy to the prostate OR radical prostatectomy OR cryotherapy. Exclusions include medical and system reasons for having a bone scan performed.

**0390 - Prostate Cancer: Adjuvant Hormonal Therapy for High Risk Prostate Cancer Patients (PCH-17)**

If receiving EBRT as primary therapy, prostate cancer patients with a high or very high risk of recurrence should also be prescribed hormonal therapy, which has been shown to increase the effectiveness of the radiotherapy and may also prolong survival. High risk prostate cancer is defined as having one of the following: a PSA $\geq 20$ ng/ml; OR a Gleason score of eight to ten; OR Clinical Stage T3a. Note that patients with multiple adverse factors may be shifted into the high risk category. Very high risk of recurrence is defined as clinical stage T3b to T4; OR primary Gleason pattern 5; OR more than 4 cores with Gleason score 8 to 10.

The numerator is defined as the number of patients who were prescribed adjuvant hormonal therapy (gonadotropin-releasing hormone [GnRH] agonist or antagonist). The denominator includes all patients, regardless of age, with a diagnosis of prostate cancer at high or very high risk of recurrence receiving EBRT as primary therapy to the prostate. Patients who receive EBRT after prostatectomy (adjuvant radiation therapy) are not included in the measure. Exclusions include medical and patient reasons for not prescribing or administering adjuvant hormonal therapy.

**OCM Reporting Period and Submission Deadlines**

For the OCMs reporting period and submission deadlines, refer to Appendix A.

**Additional Resources**

For detailed information regarding the PQRS measures, refer to the 2016 PQRS Measures List located at: [http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/MeasuresCodes.html](http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/MeasuresCodes.html).

**Clinical Effectiveness**

The PCHQR Program supports the National Quality Strategy (NQS) national priorities, the Department of Health and Human Services Strategic Plans and Initiatives, the CMS Quality Strategy, and strives to reduce the burden on participating PCHs whenever possible. In alignment with this mission, the following measure was added in FY 2015 to reduce the rate of EBRT services, decrease overuse, promote patient safety, and support the priority of palliative care for cancer patients.

**1822: External Beam Radiotherapy for Bone Metastases (EBRT) (PCH-25)**

The EBRT measure, endorsed by the NQF, was developed to assess radiation therapy in the management of painful bone metastases. Bone metastasis is a common manifestation of malignancy and the evidence review shows variation in treatment with EBRT.

The role of radiation therapy in palliation of bone metastases has been well established; however, literature shows widespread variation in the practice patterns for using radiation therapy for
palliation. The measure reports the percentage of patients, regardless of age, with a diagnosis of painful bone metastases and no history of previous radiation who received EBRT with an acceptable fractionation scheme, as defined by the guideline.

The numerator is defined as the number of patients who receive EBRT with any of the following recommended fractionation schemes: 30Gy/10fxns, 24Gy/6fxns, 20Gy/5fxns, 8Gy/1fxn. The denominator includes all patients with a diagnosis of bone metastases who have an order for EBRT. Exclusions from the denominator include previous radiation to the same anatomic site, treatment with stereotactic body radiation therapy (SBRT) or stereotactic radiosurgery (SRS), enrollment in a clinical trial or registry study involving the use of radiation therapy, femoral axis cortical involvement >3 cm in length, previous surgical stabilization of the site, spinal cord or cauda equina compression or radicular pain, and patient specific exclusions. The patient-specific exclusions are limited to patient declination of therapy or economic, social, or religious reasons.

**EBRT Measure Reporting Period and Submission Deadlines**

For the EBRT measure reporting period and submission deadlines, refer to Appendix A.

**Additional Resources**

For detailed information regarding this measure, refer to the EBRT Specifications.

**Sampling (OCM, EBRT)**

The sampling methodology allows for different numbers of cases to be reported based on each PCH’s cancer patient population size. Sampling should be systematic to ensure that all eligible cases have an equal chance of inclusion. PCHs must submit aggregate data for the required quarters during the data submission period.

<table>
<thead>
<tr>
<th>Average Quarterly Initial Population Size “N”</th>
<th>Minimum Required Sample Size “N”</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt;125</td>
<td>25 cases</td>
</tr>
<tr>
<td>51–125</td>
<td>20 percent of the Initial Patient Population</td>
</tr>
<tr>
<td>10–50</td>
<td>10 cases</td>
</tr>
<tr>
<td>&lt;10</td>
<td>No sampling; 100 percent of the Initial Patient Population</td>
</tr>
</tbody>
</table>

There has been extensive discussion between the PCHQR participants, the measure stewards, CMS, and the Support Contractor about the sampling for the OCM measures NQF 0383 and 0384. The numerator patients identified in NQF 0384 (those who have pain and the pain intensity is quantified) are the denominator patients for NQF 0383. To obtain a larger, more representative sample size for NQF 0383, many participants choose to “over sample” for NQF 0384. Remember that the sample sizes in the above table are a minimum sample size. Participants are asked to refer to the PCHQR webinar of September 24, 2015, for an in-depth review of this topic: NQF #0384 and #0383 Sampling, Assessment, and Lessons Learned.
Patient Engagement/Experience of Care

The intent of the HCAHPS initiative is to provide a standardized survey instrument and data collection methodology for measuring patients' perspectives on hospital care. The HCAHPS survey is a core set of questions that can be combined with a broader, customized set of hospital-specific items. HCAHPS survey items complement the data that hospitals currently collect to support improvements in internal customer services and quality related activities. For detailed information, refer to: http://www.hcahpsonline.org/home.aspx.

0166: Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) (PCH-NA)

The HCAHPS survey produces eleven reported measures. Seven measures are multi-item measures, including: communication with doctors, communication with nurses, responsiveness of hospital staff, pain control, communication about medicines, discharge information and how well patients understood the care they would need after leaving the hospital. Four measures are single-item measures, including: cleanliness of the hospital environment, quietness of the hospital environment, overall rating of the hospital, and recommendation of the hospital.

Sampling

The HCAHPS specifications describe a precise method for sampling, with patients surveyed throughout each month of the year. PCH hospitals must achieve at least 300 completed surveys over four calendar quarters. The sampling specifications can be accessed at: http://www.hcahpsonline.org/techspecs.aspx.

HCAHPS Measure Reporting Period and Submission Deadlines

For the HCAHPS measure reporting period and submission deadlines, refer to Appendix A.

Additional Resources

For detailed information regarding the HCAHPS measures, refer to the specifications located at: http://www.hcahpsonline.org/techspecs.aspx.
Section 3: Data Reporting

To meet program requirements, PCHs are required to submit specific quality measures to CMS, beginning with the FY 2013 payment determination year. Participating facilities must comply with the program requirements, including public reporting of the measure rates on *Hospital Compare*.

The PCHQR Program measures are collected by participating PCHs using a variety of data collection methods. PCHs participating in the PCHQR Program must submit the required data via the acceptable methods of transmission no later than 11:59 p.m. PT on the submission deadline date as established by the CMS. Only data submitted according to the established deadlines of CMS qualify for inclusion in the PCHQR Program.

Appendix A provides specific data submission deadlines for the required PCHQR Program measures by data collection period due date. The reference periods noted for CLABSI, CAUTI, SSI, CDI, and MRSA refer to event dates; the reference periods for the other measures denote designated measure periods (patient visit, inpatient discharge dates, etc.).

The document displaying the program requirements by fiscal year is located at: [PCHQR Measure Crosswalk](#)

**Reporting Methods**

The PCHQR Program measures are collected by participating PCHs using a variety of data collection methods. The table below provides an overview of the measure types and reporting methods.

<table>
<thead>
<tr>
<th>Measure Topic/Names</th>
<th>Method of Reporting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safety/HAI</td>
<td></td>
</tr>
<tr>
<td>• CLABSI</td>
<td>Via the CDC NHSN</td>
</tr>
<tr>
<td>• CAUTI</td>
<td></td>
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<tr>
<td>• Harmonized Procedure Specific SSI</td>
<td></td>
</tr>
<tr>
<td>• CDI</td>
<td></td>
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<tr>
<td>• MRSA</td>
<td></td>
</tr>
<tr>
<td>• HCP Influenza Vaccination</td>
<td></td>
</tr>
<tr>
<td>Clinical Process/CST</td>
<td></td>
</tr>
<tr>
<td>• Adjuvant Chemotherapy is Considered or Administered Within Four Months (120 days) of Diagnosis to Patients Under the Age of 80 with AJCC III (lymph node positive) Colon Cancer</td>
<td>Data obtained from the RQRS of the ACoS. Aggregate data then sent via secure file transfer within the <em>QualityNet Secure Portal</em>.</td>
</tr>
<tr>
<td>• Combination Chemotherapy is Considered or Administered Within Four Months (120 days) of Diagnosis for Women Under 70 with AJCC T1c, or Stage II or III Hormone Receptor Negative Breast Cancer</td>
<td></td>
</tr>
<tr>
<td>• Adjuvant Hormonal Therapy</td>
<td></td>
</tr>
<tr>
<td>Measure Topic/Names</td>
<td>Method of Reporting</td>
</tr>
<tr>
<td>--------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td><strong>Clinical Process/ SCIP</strong></td>
<td>Secure file transfer via QualityNet Secure Portal</td>
</tr>
<tr>
<td>- SCIP-Inf-1: Prophylactic Antibiotic Received Within One Hour Prior to Surgical Incision</td>
<td></td>
</tr>
<tr>
<td>- SCIP-Inf-2: Prophylactic Antibiotic Selection for Surgical Patients</td>
<td></td>
</tr>
<tr>
<td>- SCIP-Inf-3: Prophylactic Antibiotics Discontinued Within 24 Hours After Surgery End Time</td>
<td></td>
</tr>
<tr>
<td>- SCIP-Inf-9: Urinary Catheter Removed on Post-Operative Day 1 or Post-Operative Day 2 with Day of Surgery Being Day Zero</td>
<td></td>
</tr>
<tr>
<td>- SCIP-Card-2: Surgery Patients on Beta Blocker Therapy Prior to Admission who Received a Beta Blocker During the Perioperative Period</td>
<td></td>
</tr>
<tr>
<td>- SCIP-VTE-2: Surgery Patients who Received Appropriate Venous Thromboembolism Prophylaxis within 24 Hours Prior to Surgery to 24 Hours After Surgery End Time</td>
<td></td>
</tr>
<tr>
<td><strong>Clinical Process/Oncology Care</strong></td>
<td>Secure file transfer via QualityNet Secure Portal</td>
</tr>
<tr>
<td>- Oncology: Radiation Dose Limits to Normal Tissues</td>
<td></td>
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<tr>
<td>- Oncology: Plan of Care for Pain</td>
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<tr>
<td>- Oncology: Pain Intensity Quantified</td>
<td></td>
</tr>
<tr>
<td>- Prostate Cancer: Adjuvant Hormonal Therapy for High-Risk Patients</td>
<td></td>
</tr>
<tr>
<td>- Prostate Cancer: Avoidance of Overuse Measure-Bone Scan for Staging Low-Risk Patients</td>
<td></td>
</tr>
<tr>
<td><strong>Clinical Effectiveness</strong></td>
<td>Secure file transfer via QualityNet Secure Portal</td>
</tr>
<tr>
<td>- EBRT for Bone Metastases</td>
<td></td>
</tr>
<tr>
<td><strong>Patient Engagement/Experience of Care</strong></td>
<td>Submitted via vendor or upload via the QualityNet Secure Portal using the online data entry tool or in XML format</td>
</tr>
<tr>
<td>- HCAHPS</td>
<td></td>
</tr>
</tbody>
</table>

**Extraordinary Circumstances**

A facility can request an extension or waiver of various Quality Reporting Program requirements due to extraordinary circumstances beyond the control of the facility. To request an extension or exemption, complete and submit the Extraordinary Circumstances Extensions/Exemptions Request Form within 30 days of the disaster or extraordinary circumstance.

**Measure Exception Form**

For the CDC NHSN measures, some hospitals may not have locations that meet the NHSN criteria for CLABSI or CAUTI reporting. Other hospitals may perform so few procedures requiring surveillance under the SSI measure that the data may not be meaningful for Hospital Compare or sufficiently reliable to be utilized for quality reporting purposes in a program year. Reporting will not be required for the NHSN SSI measures if the PCH performed a combined total of nine or fewer colon and abdominal hysterectomy procedures in the calendar year prior to the reporting year. To indicate that the NHSN SSI data is not being reported, the Measure Exception Form should be completed using the top portion of the form.
PCHQR participating hospitals will be submitting SCIP data for the second and third quarters of 2015. If your facility had 10 or fewer eligible SCIP discharges in the second and third quarters of 2015 combined, complete the bottom portion of the Measure Exception Form, under the section entitled “Other.” (See instructions and example below.) The submission deadline for data receipt is August 15, 2016.

1. Select the “Other” check box.
2. Detail the exception request in the text box, indicating the number of eligible SCIP discharges.
3. **Do not complete** the “Calendar Year Prior to Reporting Year,” “Number of Procedures Performed,” or “Exclusion Requested for Calendar Year” fields below the text box as they do not apply.
4. Complete page 2 of 2 in its entirety, and submit the form by email prior to the August 15, 2016 submission deadline.

The Measure Exception Form is located on QualityNet at: PCHQR Data Submission Page.
Section 4: QualityNet Registration Process

To participate and submit data for reporting in the PCHQR Program, facilities must obtain a QualityNet user account and register for access to the QualityNet Secure Portal.

All users requesting access to the QualityNet Secure Portal must be individually approved and verified at the facility level and submitted to QualityNet. This mandatory registration process is used to maintain the confidentiality and security of healthcare information and data transmitted via the QualityNet Secure Portal. These are CMS-approved sites for secure healthcare quality data exchange to enable facility reporting.

PCHQR Program Requirements

The PCHQR program requirements are listed below. Click on the hyperlink imbedded within the text to be directed to detailed instructions for each step, as necessary.

1. Register with QualityNet and enroll in the QualityNet Secure Portal.
3. Have a Notice of Participation.
4. Submit data based on the data collection & submission timelines.
5. Complete the Data Accuracy and Completeness Acknowledgement (DACA) by the submission deadline.

Security Administrator/Non-Administrative User Registration Process

1. Access the Internet, and then navigate to the QualityNet website located at http://www.qualitynet.org.
2. On the Home page, on the left-hand side of the screen, under the section labeled QualityNet Registration, select the [Cancer Hospitals] hyperlink as shown below.
3. Select the [Security Administrator] or [Basic User] link on the QualityNet Registration PPS-Exempt Cancer Hospitals page as shown below.

Before completing the registration, users should review the [System Requirements] link on the left-hand side of the screen under Getting Started with QualityNet, to test their system to ensure compatibility.

4. From the QualityNet Security Administrator Registration PPS-Exempt Cancer Hospitals page begin registration by selecting the [QualityNet Security Administrator Registration Packet] link located in the first sentence of the first step (shown in screenshot below).

After downloading the packet, follow the instructions for completing and submitting the registration and authorization forms.
QualityNet Security Administrator

The PCHQR Program requires every facility to have at least one active QualityNet Security Administrator (SA). It is recommended that facilities designate a minimum of two QualityNet SAs; one to serve as the primary QualityNet SA and the other to serve as the alternate SA. To keep your facility’s account active, your SA should sign-in to the Secure Portal at least every 60 days and change the password at least every 60 days. More frequent access and updating are encouraged to keep your account active. If it becomes necessary to reactivate your account, call the QualityNet Help Desk at 866.288.8912.

Security Administrator Responsibilities

The PCH SA has the following responsibilities:

- Creating, approving, editing, and terminating QualityNet user accounts for their PCH
- Assigning user roles for basic users within their PCH in order to ensure users’ access to the secure web-based applications
- Monitoring QualityNet usage at the PCH to ensure security and confidentiality is maintained
- Serving as a point of contact for information regarding QualityNet

Non-Administrative User

Any user not designated as a QualityNet SA or a QualityNet Security Designate is considered a Non-administrative User, or Basic User. Various roles to fit job needs can be assigned to the Non-administrative User.

If assigned the appropriate roles, the user may perform one or more of the following tasks:

- Access reports
- Authorize vendors to submit data
- Manage measures
- Manage security
- Manage Notice of Participation
- View/edit online forms

Completing the QualityNet Registration Form

When completing the QualityNet Registration Form, print the information legibly and completely in each of the applicable fields. Then, follow the steps below:

1. Select the [PPS-Exempt Cancer Hospital] box, in the Specify Setting section.
2. Sign and date the QualityNet Security Administrator Form in the presence of a Notary Public, obtaining the Notary’s stamp and seal on the form.

Although not all states require the notary stamp or seal, it is a requirement for QualityNet.

3. Have the highest-level executive at your location complete and sign the QualityNet Security Administrator Authorization Form.

Depending on the facility, this may be the Chief Executive Officer, Administrator, Medical Director, or other similar position.

4. Mail the forms as instructed in the packet. This will initiate a process whereby the applicant will receive a user ID and temporary password via a confirmation email.

Refer to the information below for mailing instructions of the original, completed QualityNet Security Administrator Registration Form and the QualityNet Security Administrator Authorization Form.

NOTE: Photocopies or faxes of the forms will not be accepted. The facility should retain a copy of all forms for their records.

Mail the original completed form (not a copy) to the QualityNet Help Desk at the following address:

QualityNet Help Desk
12000 Ridgemont Drive
Urbandale, IA 50323-2317

For questions regarding the QualityNet Registration Form, contact:

QualityNet Help Desk
Monday through Friday
7 a.m.–7 p.m. CT
E-mail: www.qnetsupport@hcqis.org
Phone: 866.288.8912
TTY: 877.715.6222
FAX: 888.329.7377
Activating Security Administrator Account When Email Notification Received

Once the QualityNet Registration Forms are processed by QualityNet, the approved SA(s) will receive an email notification with the individual assigned username and a temporary password.

To begin account activation:

1. Go to the QualityNet.org website.
2. Select the [Log In] button or [Login] link.
3. Enter the assigned username and a temporary password provided via the email notification.
4. Follow the instructions to establish a new password.

After the password is established, the user must complete the enrollment to obtain access to the QualityNet Secure Portal. This establishes access to the web-based Notice of Participation (NOP), Web-Based Measures, Data Accuracy and Completeness Acknowledgement (DACA) applications, and PCHQR Program reports.

QualityNet Secure Portal Access

Before logging in to the QualityNet Secure Portal for the first time, a user must complete the New User Enrollment Process. The prerequisites for this process are:

- A completed QualityNet Registration
- Receipt of the applicable user roles assigned by your facility’s SA
- A completed Symantec VIP multifactor credential application in order to obtain VeriSign, an authentication service that enables secure access to networks and applications.

To download the multifactor authentication application to a PC or tablet:

1. Go to the QualityNet.org website. Select the [Download Symantec ID] link.
2. The VeriSign ID Protection Center* page will appear.
3. Select the download option that is appropriate to the device being used, either for Windows® or Mac®.

   NOTE: It may be necessary to consult with your IT department before downloading the VeriSign ID to the PC due to system firewalls or other restrictions.

Once the Symantec multifactor authentication application download is on the computer, users are ready to access the QualityNet Secure Portal.

4. Access the QualityNet Secure Portal from the QualityNet.org website and then select the [Log In] button or [Login] link.

   The Log In to QualityNet window appears.
Each PCHQR user must complete the authenticating (proofing), required by the Federal Information Security Management Act (FISMA), for accessing government systems.

5. Select the [Start/Complete New User Enrollment] link on the login page to begin the enrollment process.

The QualityNet Starting and Completing New User Enrollment page appears.

6. Enter your [User ID] and [Password] and select [Submit].

7. Follow the instructions for the enrollment process described in the following sections.
Verifying Identity

To verify a user’s identity:

1. Access the QualityNet Starting and Completing New User Enrollment page and log in.
   The Verify Identity page appears.

2. Enter the required information within each field on the screen.

   A Social Security number is required for users residing within the United States. A Social
   Security number is considered the most available source of identification that can be
   verified, as not all users have a driver’s license or passport. When a user enters a Social
   Security number, the screen displays hash marks instead of numbers to protect privacy.

   NOTE: you must enter your personal street address, NOT your associated facility’s address.

   CMS is aware of the privacy concerns regarding disclosure of personal data, including social
   security numbers. CMS is collecting the Personally Identifiable Information (PII) on this
   screen and on the identity question screen to verify identity only. Verifying a user’s identity
   meets the National Institute of Standards and Technology (NIST) and the Federal
   Information Security Management Act (FISMA) requirements.

   FISMA was passed as Title III of the E-Government Act (Public Law 107-347) in December
   2002. FISMA requires each federal agency to develop, document, and implement an
   agency-wide program to provide information security for the information and information
   systems that support the operations and assets of the agency, including those provided or
   managed by another agency, contractor, or other source. This Act assigned NIST the
   responsibility to develop standards to be used by Federal agencies to categorize information
   and information systems based on the objectives of providing appropriate levels of
   information security according to a range of risk levels.

   CMS is complying with the NIST standards by verifying a user’s identity using Experian’s
   Precise ID platform (an external authentication service provider). To maintain the privacy
   of users, Social Security numbers will be masked and encrypted during this transaction to
   ensure they are secure. Other than a name, none of the PII data collected in this process is
   retained by CMS.
3. Once the required fields have been entered, check the privacy statement, and click [Submit].

The screen will display a message stating that the information has been sent to Experian and will instruct the user to wait as the information is being processed.

A set of questions will be generated that will need to be answered.

Example questions may be downloaded from the User Guide located on QualityNet. Typical types of identity proofing questions include:

- Verification of where you live or have lived (street address, city, and state)
- Verification of the type of car you own or have leased (color, make, license plate number)
- Verification of banking institutions that you may or may have used for banking or various types of loans
- Verification of phone numbers (home and cell)
- Verification of education completed
- Verification of where you have been employed
- Verification of dates associated with any of the above activities
4. Answer the identity proofing questions, and then select [Submit].

Once a user has completed the identity proofing questions correctly, the verification will display on the computer screen indicating successful completion of the CMS identity proofing.

![CMS.gov | QualityNet](image)

If the questions are not answered accurately or if there is an alert on the credit report due to identity theft, the user will be prompted to call Experian to complete telephone verification.

A phone number will appear on the screen. If unsuccessful during the telephone verification, the user will be referred to the facility’s SA to complete a face-to-face verification.

**NOTE:** An individual user must have attempted both the online and telephone verification before a face-to-face verification can be done.

---

**Enrolling the Credentials**

To enroll credentials, access the [QualityNet Starting and Completing New User Enrollment](https://example.com) page. After, entering identity questions, the next step is to [Enroll Credential].

Steps for enrolling the two-factor credential are as follows:

1. Access the previously downloaded Symantec VIP Application from your desktop.
   
The Symantec VIP window appears.

![Symantec VIP](image)

2. Enter the Credential ID number in the first field.

3. Enter the Security Code within the 30-second freshness period.
   
   **NOTE:** A counter will display a countdown of the seconds from 30 until the next code displays. The security code may be typed in the field or copied and pasted into the Security Code field.

4. Select [Submit].

The link is found under Resources in the QualityNet website.

The New User Enrollment Process information is contained in Section 4 of the guide.
Logging In to the QualityNet Secure Portal

After completing all necessary paperwork and the New User Enrollment, a user will have access to the QualityNet Secure Portal.

To access the QualityNet Secure Portal:

1. Go to the QualityNet.org website and select the [Log In] button or [Login] link.

2. The Choose Your QualityNet Destination screen appears. Select [PPS-Exempt Cancer Hospital Quality Reporting Program].

3. The Log In to QualityNet screen appears. Enter the [User ID], [Password], and [Security Code], then select [Submit].

For additional information on the login process, refer to the QualityNet Secure Portal User Guide.
4. The security screen will be displayed, indicating the user has accessed a U.S. Government Information system.

5. Accept the terms to be granted access to the QualityNet Secure Portal.

6. The Quality Reporting Secure Portal page appears. To access the PCHQR Program, click on the drop-down arrow next to Quality Program; then select [Hospital Quality Reporting: IQR, OQR, ASCQR, IPFQR, PCHQR].

After selecting the Quality Program, the My Tasks page is displayed on the next screen.
The content of the My Tasks page is dependent upon the user roles assigned to the individual. If assigned the appropriate roles, the user may perform one or more of the following tasks:

- Access reports
- Authorize vendors to submit data
- Manage measures
- Manage security
- Manage Notice of Participation
- View/edit online forms

**User Roles**

For the PCHQR Program, there are only two types of user designations which can be assigned for any of the authorized roles listed below, **Update** and **Read Only**. The **Update** designation permits a user to edit information within the application while the **Read Only** designation just permits the user to browse information.

Below is a list of roles that may be assigned to a user participating in the PCHQR Program:

**Notice of Participation**

- PCHQR Notice of Participation Read
- PCHQR Notice of Participation Update

**Web-Based Measure/DACA Application**

- PCHQR Web-Based MSR DACA Read
- PCHQR Web-Based MSR DACA Update

**Reports**

- PCHQR Reports Read
- PCHQR Reports Update
- PCHQR Feedback Reports
- PCHQR Preview Reports
- HCAHPS Warehouse Feedback Reports (accessed under IQR)

**Vendor Authorization**

- PCH Vendor Authorization

**File Exchange**

- File Search and Exchange

**Online Access Request System (OARS)**

- OARS Approve Users
- OARS Create/Edit Users
- OARS Final Approval
Manage Security Settings

After gaining access to the QualityNet Secure Portal, users can manage their account information on the My Tasks page. Refer to the instructions below to update/change the settings for the following topics:

- Update account information
- Reset or change passwords
- Update security questions

**Update Account Information**

To update your account information:


2. The My Account window will open. Scroll down to review current entries. The fields will be pre-populated with the information that you provided in the initial account setup. Update the contact information as needed and then select the [Submit] button to save your changes.
Password Reset/Change

The QualityNet Secure Portal requires a password reset/change every 60 days. To change your password, complete the following steps:


   ![Manage Security](image1.png)

2. The My Account screen will appear. Select the [Change your password] link to reset/change the password.

   ![My Account](image2.png)

3. The Account Security window will open. Complete all fields and then select the [Submit] button to change the password.

   ![Account Security](image3.png)

   **NOTE:** Review password rules before changing your password. Rules are located on the Account Security page as shown below.
Update Security Questions

To update your security questions:


2. The My Account screen will appear. Select [Update your security questions.]

3. The Account Security window will open. The security question fields will be pre-populated with the information that was provided in the initial account setup.

   Review and/or update the answers to the questions. Answer at least six questions. You are not required to answer all 10 questions.

4. Select the [Submit] button to save your changes.
Section 5: Vendor Authorization

Facilities may elect to use a vendor to collect and submit data on their behalf. A vendor must have an assigned vendor ID and be authorized to submit data prior to the PCH authorizing them to submit data or to have access to their facility’s data and/or reports.

To receive the vendor registration instructions and forms, the vendor may submit an email request to one of the following email addresses: vendorreg@hcqis.org or qnetsupport@hcqis.org.

NOTE: The PCH may authorize a vendor to submit data on behalf of the facility. However, CMS holds a PCH responsible for ALL data submission, even when contracting with a vendor.

Currently, vendor authorization is required only for submission of the quarterly HCAHPS data for the PCHQR Program.

Vendors must be authorized to submit data on behalf of providers. The [Authorize Vendors to Submit Data] option enables providers to authorize vendors to submit web-based measure information. It also enables providers to update existing authorizations.

PCHs must have the PCH Vendor Authorization role to access the [Vendor Authorization] link.

1. From the Quality Programs tab on the QualityNet Secure Portal Landing page, select the [Quality Programs: Hospital Quality Reporting: IQR, OQR, ASCQR, IPFQR, PCHQR] link.

   The Quality Reporting System: My Tasks page appears:

   ![Quality Reporting System: My Tasks](image)

2. Choose the [Vendor Authorization] link.

The Vendor Authorization screen appears.
3. Select the PCH Vendor Authorization role from the drop-down box and click [Submit].

The Authorize Vendor to Submit screen appears.

![Authorize Vendor to Submit](image)


All vendors that have been allowed to submit clinical data on the institution’s behalf are automatically authorized to submit web-based measures for the data submission period beginning July 1, 2014.

The Authorized Vendors to Submit Data page appears.

5. Select a vendor from the list and verify the correct vendor is displayed.

**NOTE:** Use the [Cancel] button to return to the previous page to make a vendor change, if necessary.

6. Scroll to the measure.

7. Select the [Calendar] icon to choose a **Discharge/Encounter Date>Start** and **Data Transmission Date>Start** for the measures.

Both start dates are required but end dates are not. **Discharge/Encounter Date>Start Date** must be the first day of a quarter. The **Data Transmission Date>Start Date** must be equal to or greater than the current date.

**Recommendations**

Do not enter end dates unless it is known that a specific vendor will not submit data after the specified end dates or if you are converting from one CCN to a new CCN. The **Discharge/Encounter Date>End Date** must be the last day of a quarter.

If you are terminating a vendor relationship at the end of a submission period, it is recommended that you do not enter the submission deadline date as the **Data Transmission Date>End Date**, due to the possibility of a submission date extension. It is recommended that you enter the **Data Transmission Date>End Date** when all data have been transmitted.

If more than one vendor is authorized for the same topic and timeframe, a message indicating there is more than one vendor authorized to submit data for the same measure set and time period will display. You will be able to proceed but will need to verify that the dates entered are correct.
8. Decide if the vendor selections are as desired.
   - Select [Cancel] to return to the vendor’s currently authorized page without saving.
   - Select [Continue] to proceed.

   The Approve New or Changed Vendor Authorization page appears.

9. Verify that the vendor information and authorized dates are correct.
   - Select [Submit] if the information is as desired
   - Select [Edit] to return to the previous page to make any date changes.

   NOTE: Once an authorization has been submitted, the only dates that can be modified are future dates. If incorrect dates were entered and need to be modified, please send an email to qnetsupport@hcqis.org or call 866.288.8912.

   The Vendor Authorization Complete page will display and summarize the submitted Vendor Authorization.

10. Select [Print] for a printer-friendly copy of the authorization.
Section 6: Notice of Participation (NOP)

The PCHs electing to participate in the PCHQR program must complete a Notice of Participation (NOP), via the QualityNet Secure Portal. Submission of the NOP is an indication that the PCH agrees to participate and publicly report their measure rates. A direct link to manage the NOP is found on the Quality Reporting System: My Tasks page.

NOTE: Hospitals with a PCHQR NOP will remain active program participants until a withdrawal is submitted via the QualityNet Secure Portal.

Accessing the Online Notice of Participation Application

To access the NOP application:

1. Ensure the PCHQR NOP Read or PCHQR NOP Update (to add or edit) role has been assigned by the SA.

   Users that are affiliated with only one facility will see their facility’s six digit CMS Certification Number (CCN) after selecting the [Manage Notice of Participation] link under the My Tasks screen.

   Users that are affiliated with more than one facility will be prompted to enter the six digit CCN as shown below.

3. Select the action to be completed: [View], [Add], or [Update] the Notice of Participation, Facility Contacts, or Additional Campus information.
Additional campus information may not apply to all PCHs. It is applicable for facilities that have more than one physical location but are licensed and reimbursed under the same CCN.

Quality data is reported and published under the same CCN regardless of the number of physical locations associated with a CCN.

4. Enter the contact information if this is the first time the NOP is being added.

5. Select [Contacts] from the list.

   Enter at least two facility contacts within the contact screen. The contact information is used for sending email alert notifications if edits are made within the NOP application.

6. If the facility completed a paper NOP, then there will not be any contact information entered in the application. It is recommended that the facility log in and update the contact information.
7. Select the desired pledge option and the acknowledgement check box.

Upon initial completion of the NOP, two pledge options are available: [Participate] or [Do not agree to participate].
8. Following the pledge selection select the [Save] button.

A confirmation screen appears asking the user to confirm the selection in order to save the document.

Once a facility has agreed to participate, they remain a program participant until they log in and select the [Request to be withdrawn from participation] option. Above is an example of a withdrawal submission.

Detailed information about the NOP application is accessible on the QualityNet Home page by logging in through the QualityNet Secure Portal at: http://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetHomepage&cid=1120143435363.
Section 7: Data Accuracy and Completeness Acknowledgement

Beginning with Program Year 2015, PCHs should complete an online Data Accuracy and Completeness Acknowledgement (DACA) to attest to the accuracy and completeness of the entered data.

NOTE: By August 31, 2016 all PCHQR participating organizations must complete the DACA for Fiscal/Program Year 2017. Due to a QualityNet system constraint for this year, completion and submission of the DACA will be a manual process. A ListServe with instructions will be sent to the PCHQR participants on or about July 1, 2016. At this time it is expected that this will only be in effect for the DACA for Fiscal/Program Year 2017 and that resuming next year, the process outlined below will once again be in effect.

The DACA must be completed annually by the August 31 submission deadline, prior to the respective PCHQR Program year; e.g., for Program Year 2017, the DACA should be completed by August 31, 2016. The DACA web application is accessible annually between July 1 and August 31, as shown in the example below:

1. On the next screen select [PPS Exempt Cancer Hospitals DACA].
2. Choose Fiscal Year [2016] from the drop-down list and select [Continue].

The Summary screen will display the status of the DACA submission as Incomplete or Completed.

3. Select the blue [DACA] hyperlink to begin the DACA submission process, if the DACA status is Incomplete.

4. Select the [Yes, I Acknowledge] checkbox and complete the Position field.

5. Click the [Submit] button to complete the DACA submission.

   NOTE: The [Submit] button opens up an editable DACA screen.

6. Select the [Print] button to print the completed DACA.

7. Select the [Return to Summary] button to return to the previous screen.
Once the DACA is submitted, the Summary screen displays a **Completed** status.

8. To view the completed DACA, select the blue **[DACA]** hyperlink.
Section 8: Accessing and Reviewing Reports

The reports described in this section are helpful in monitoring PCH status as it relates to the PCHQR program. The reports should be used as reference tools only.

Types of Reports

PCHQR Facility Report

The facility report is specific to the facility accessing the report.

To run a PCHQR Facility Report:

1. Select [Run Reports] from the My Reports drop-down menu in the yellow tool bar near the top of the summary screen.
2. Select the [Run Report(s)] tab.
4. Select the [PPS-Exempt Cancer Hospital Report].
5. Enter your desired report parameters, and select the [Fiscal Year] from the drop-down list, e.g., 2016.
7. Select the [Search Reports] tab.
8. Select the new report and open it.

The PCHQR Facility Report for FY 2016 identifies data for the following PCHQR measure categories: CLABSI, CAUTI, and SSI (Colon, SSI–Abdominal Hysterectomy, and CST) Measures.

For FY 2016, the report also includes the PCHQR measure categories of OCMs and SCIP Measures.
PCHQR HCAHPS Report

The QualityNet Secure Portal also displays HCAHPS data for the PCHQR Program participants starting with the first PCHQR HCAHPS data submission in October 2014.

The PCHQR HCAHPS reports are accessed through the IQR Program selection.

To run a PCH HCAHPS Report:

1. Select [Run Reports] from the [My Reports] drop-down menu in the yellow tool bar near the top of the summary screen.
2. Select the [Run Report(s)] tab.
4. Select the [HCAHPS Data Review and Correction Report].
5. Enter your desired report parameters. Select the [Fiscal Year] from the drop-down list, e.g., 2015.
7. Select the [Search Reports] tab.
8. Select the new report and open it.
Section 9: Public Reporting

Background

Section 1886(s)(4)(E) of the Social Security Act requires the Secretary of Health and Human Services to establish procedures for making the data submitted under the PCHQR program available to the public.

The Department of Health & Human Services (HHS) hosts the Hospital Compare website, http://www.hospitalcompare.hhs.gov/, which publicly reports hospital performance on numerous measures. Hospital Compare is designed to make meaningful, relevant, and easily understood information about hospital performance accessible to the public and to inform and encourage hospitals’ efforts to improve care quality. Accessibility and use of performance information spurs positive changes in healthcare delivery.

Public Display Timeline

The PCHQR program has quality of care data publicly displayed on a rolling quarter basis. The data are published four times each year beginning in December 2014 and subsequent Program years. For the Hospital Compare 2016 releases, the three CST, HCAHPS, and OCM Measures will be displayed as outlined on the table below.

PCHQR measures are often identified by a PCH numbering system:

- **PCH-1** Adjuvant chemotherapy is considered or administered with positive lymph node colon cancer
- **PCH-2** Combination chemotherapy is considered or administered with Stage II or Stage III hormone receptor negative breast cancer
- **PCH-3** Adjuvant hormonal therapy
- **PCH-14** Radiation dose limits to normal tissues
- **PCH-15** Plan of care for pain
- **PCH-16** Pain intensity quantified
- **PCH-17** Adjuvant hormonal therapy for high-risk prostate cancer patients
- **PCH-18** Avoidance of overuse of bone scan for staging low-risk prostate cancer patients

<table>
<thead>
<tr>
<th>Hospital Compare Release</th>
<th>Measures</th>
<th>Quarters Displayed</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 2016</td>
<td>PCH-1, PCH-2 PCH-3</td>
<td>Q1, Q2, Q3, Q4 2014 Q3, Q4 2013 and Q1, Q2 2014</td>
</tr>
<tr>
<td>July 2016</td>
<td>PCH-1, PCH-2 PCH-3</td>
<td>Q2, Q3, Q4 2014 and Q1 2015 Q4 2013 and Q1, Q2, Q3 2014</td>
</tr>
<tr>
<td>October 2016</td>
<td>PCH-1, PCH-2 PCH-3</td>
<td>Q3, Q4 2014 and Q1, Q2 2015 Q1, Q2, Q3, Q4 2014</td>
</tr>
<tr>
<td>December 2016</td>
<td>PCH-1, PCH-2 PCH-3 HCAHPS Oncology Care Measures (PCH-14, PCH-15, PCH-16, PCH-17, PCH-18)</td>
<td>Q4, 2014 and Q1, Q2, Q3 2015 Q2, Q3, Q4 2014 and Q1 2015 Q2, Q3, Q4 2015 and Q1 2016 Q1, Q2, Q3, Q4 2015</td>
</tr>
</tbody>
</table>
Based on the FY 2016 Final Rule, the following timeline has been established for future public reporting and Hospital Compare releases:

<table>
<thead>
<tr>
<th>Measures</th>
<th>Public Reporting Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Adjuvant Chemotherapy is Considered or Administered Within four Months (120 days) of Diagnosis to Patients Under the Age of 80 with AJCC III (lymph node positive) Colon Cancer (NQF #0223)</td>
<td>2014 and subsequent years</td>
</tr>
<tr>
<td>• Combination Chemotherapy is Considered or Administered Within four Months (120 days) of Diagnosis for Women Under 70 with AJCC T1c, or Stage II or III Hormone Receptor Negative Breast Cancer (NQF #0559)</td>
<td>2015 and subsequent years</td>
</tr>
<tr>
<td>• Adjuvant Hormonal Therapy (NQF #0220)</td>
<td>2015 and subsequent years</td>
</tr>
<tr>
<td>• Oncology: Radiation Dose Limits to Normal Tissues (NQF #0382)</td>
<td>2016 and subsequent years</td>
</tr>
<tr>
<td>• Oncology: Plan of Care for Pain (NQF #0383)</td>
<td>2016 and subsequent years</td>
</tr>
<tr>
<td>• Oncology: Pain Intensity Quantified (NQF #0384)</td>
<td>2016 and subsequent years</td>
</tr>
<tr>
<td>• Prostate Cancer: Adjuvant Hormonal Therapy for High Risk Patients (NQF #0390)</td>
<td>2016 and subsequent years</td>
</tr>
<tr>
<td>• Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Patients (NQF #0389)</td>
<td>2016 and subsequent years</td>
</tr>
<tr>
<td>• HCAHPS (NQF #0166)</td>
<td>2016 and subsequent years</td>
</tr>
<tr>
<td>• CDC NHSN Central Line-Associated Bloodstream Infection (CLABSI) Outcome Measure (NQF #0139)</td>
<td>2017 and subsequent years</td>
</tr>
<tr>
<td>• CDC NHSN Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure (NQF #0138)</td>
<td>2017 and subsequent years</td>
</tr>
</tbody>
</table>

**Preview Period**

Prior to the public release of data on CMS’ Hospital Compare website, facilities are given the opportunity to preview data for 30 days. Preview reports will be accessible for download by the facility from the QualityNet Secure Portal. Providers will be notified via ListServe when the reports are available.

**Accessing and Reviewing Public Reporting Preview Reports**

To run the PCHQR Public Reporting Preview Report:

1. Select [Run Reports] from the My Reports drop-down menu in the yellow tool bar near the top of the summary screen.
2. Select the [Run Report(s)] tab.
4. Select the [VIEW REPORTS] button.
**Preview Report Content**

The report contains facility level data in an aggregate format, displaying four quarters of data. The reporting quarters and measures included on the report are the same as those submitted for the specific program year.

**Footnotes**

There are instances where footnotes are necessary to clarify data displayed in the Preview Report. Three footnotes may be applicable for PCHQR:

**Footnote 1**  The number of cases/patients is too few to report. This is applied to any measure rate where the denominators are greater than 0 and less than 11. Data will display on the Preview Report but will not display on Hospital Compare.

**Footnote 4**  Data suppressed by CMS for one or more quarters.

**Footnote 5**  Results are not available for this reporting period.

A description of how to read/use a PCHQR Program Preview Report is provided below:

- Starting at the top of the report, the Report Header lists the program and the reporting period. Note: there is also a Report Run date and Page number in the top section.
- The Facility CMS Certification Number is followed by the Facility Name. Note that there are a few instances where your facility name may have changed; however, if the information has not been updated by the state survey and certification department, then it may still display as the previous name.
- Just below the facility name, there is a section containing facility demographic information such as the City, State, Zip, Phone Number, and County where the facility is located, the type of facility, the type of ownership, and whether your facility provides emergency services.
- The data are displayed in measure order. There are columns for the numerator, the denominator, the rate. There is also a new column for Reporting Period.

Example of page 1 of the Preview Report is displayed below: The Preview Report displayed is for the December 2015 Hospital Compare Release anticipated for December 10, 2015. The anticipated Preview Dates are September 15, 2015, through October 14, 2015.
Note that at the bottom of the report, there is a footnote (FN) legend that lists the footnotes that currently apply to the PCHQR Program:

**FN 1** The number of cases/patients is too few to report  
**FN 4** Data suppressed by CMS for one or more quarters  
**FN 5** Results are not available for this reporting period

Footnote 1 is applied to any measure rate where the denominators are greater than 0 and less than 11. Data will display on the Preview Report but will **not** display on Hospital Compare.

Currently the PCHQR Preview Report has only one page due to the small number of measures being publicly reported.

**Medicare.gov Website**

Direct Link: [http://medicare.gov/hospitalcompare/search.html](http://medicare.gov/hospitalcompare/search.html)

**Medicare.gov Home Page – Hospital Compare**

1. Scroll down to the **Spotlight** section.
2. Select the **[Get PPS-exempt cancer hospital data]** link.
The PCHQR Program page includes a brief description of the Program and the measures. The data is in an aggregate annualized format of the quarters for the reporting period.

3. Scroll down the page to see the next section, **Data by Facility**.
   The upper left corner of the data table is labeled as [Data.Medicare.gov](http://data.medicare.gov).

4. Open the drop-down menu in the top right corner.
   The drop-down contains options to sort and filter data.

5. After selecting from the menu list, access the **[Download]** option.

   Once the download is complete, filtering and other types of data manipulation are available depending on the file format selected. An alternate method to access the data is to access the Data.Medicare.gov website at: [http://data.medicare.gov](http://data.medicare.gov)
The data displayed on _Hospital Compare_ is public. You, other PCHQR participants, patients, and providers can see your data and the data from other PCHs.

6. Scroll across the page to see the measures and associated data results.

For PCHs, one of these two footnotes might display:

- **Footnote #1** – The number of cases/patients is too few to report
  - Applied to any measure rate where the denominators are greater than 0 and less than 11
  - Data will not display on _Hospital Compare_
- **Footnote #5** – Results are not available for this reporting period
  - Applied when a hospital either elected not to submit data, the hospital had no data to submit for a particular measure, or when a hospital elected to suppress a measure
Section 10: Resources

The following information contains additional resources available for PCHs participating in the CMS PCHQR Program.

For resources and tools from the PCHQR SC, users can access the website http://www.QualityReportingCenter.com. Data collection tools, timelines, and calendars, as well as other valuable resources, can be located on this website. In the dropdown menu for the Inpatient tab, select the [PCHQR Program].

National Provider Webinars are provided by CMS and by the PCHQR SC on a routine basis. The slides from each of the education sessions are published to the QualityNet website and are available for review under the PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) tab by selecting the [Webinars/Calls] link from the drop-down menu.

PCHQR ListServe

To receive important PCHQR program updates and notifications, please subscribe to the ListServe on the QualityNet website. On the left side of the page, navigate to the Join ListServes box and select the [Notifications and Discussions] link. Enter your User Information; check the box next to PPS-Exempt Cancer Hospitals Quality Reporting Program; select any other notifications desired; and click [Submit].

Questions and Answers

The CMS Q&A Tool is also a good resource for program information. The tool is intended to help users quickly find program answers when they are needed. The Q&A Tool can be accessed from QualityNet from the Questions & Answers section on the right side of the page and then selecting the [PPS-Exempt Cancer Hospitals] link. The direct link is https://cms-jp.custhelp.com/app/homepch/p/830.

If needed information is not found in the Q&A Tool, select the [Ask a Question] link to submit a question to the PCHQR SC or call, toll-Free, 844.472.4477 or 866.800.8765, between the hours of 8 a.m. and 8 p.m. ET (5 a.m. to 5 p.m. PT).

Help Desk - QualityNet

For technical issues contact the QualityNet Help Desk at:
Toll-Free Telephone: 866.288.8912
Email: qnetsupport@hcqis.org
Hours of Operation: 7 a.m. to 7 p.m. CT
**QualityNet Website**

Established by CMS, *QualityNet* provides healthcare quality improvement news, resources, and data reporting tools and applications used by healthcare providers and others. *QualityNet* is the only CMS-approved website for secure communications and healthcare quality data exchange between quality improvement organizations, hospitals, physician offices, nursing homes, end-stage renal disease networks and facilities, and data vendors.

The PCHQR program uses *QualityNet* to publish information, including requirements, announcements about educational offerings, and news stories. The PCHQR Program home page is located at (direct link):


The *QualityNet* home page (direct link [www.qualitynet.org](http://www.qualitynet.org)) offers a User Guide for the *Secure Portal* and User Guide for the *Secure Portal Reports*. Links are located on the right side of the webpage just below *Log in to QualityNet Secure Portal* at (direct link):


**Paper Abstraction Tools**

Paper Abstraction Tools have been developed for PCHs to use as an optional mechanism to aid in the collection of the measure data for the CMS PCHQR Program. The data collection tools are located under the *PPS-Exempt Cancer Hospitals Measure Data Collection* section at (direct link):


**Other Resources**

Additional resources are located on *QualityNet* (direct link):

Data must be submitted no later than 11:59 p.m. PT on the submission deadline. Only data submitted according to the established deadlines of the Centers for Medicare & Medicaid Services (CMS) qualify for inclusion in the PCHQR Program. The reference periods noted for Central Line-Associated Bloodstream Infection (CLABSI), Catheter-Associated Urinary Tract Infection (CAUTI), Surgical Site Infections (SSI), Methicillin-Resistant Staphylococcus aureus (MRSA), and Clostridium difficile Infection (CDI) refer to event dates; the reference periods for the other measures denote designated measure periods (patient visit, discharge date, etc.). For complete measure titles and National Quality Forum designations, please visit the QualityNet PCHQR Measures page.

<table>
<thead>
<tr>
<th>Due Date</th>
<th>Colon Cancer/Breast Cancer*</th>
<th>Adjuvant Hormonal Therapy*</th>
<th>CLABSI/CAUTI/SSI**</th>
<th>MRSA/CDI**</th>
<th>HCP Flu Vacc**</th>
<th>SCIP†‡</th>
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*Data entered into American College of Surgeons Rapid Quality Reporting System, extracted and then submitted to CMS via the QualityNet Secure Portal at [www.qualitynet.org](http://www.qualitynet.org)

**Submitted to the Centers for Disease Control and Prevention via the National Healthcare Safety Network

†Submitted to CMS via the QualityNet Secure Portal located at [www.qualitynet.org](http://www.qualitynet.org)

‡Annual submission, stratified by quarter
This reference document for PCHQR Program participants shows how each of the measures in the Program relates to the following:

- Specific measures with their NQF and PCH number
- Program (Fiscal) Year to which the measure applies
- Reporting Periods that apply to each respective Program Year
- Quarterly Data Submission Deadlines for each Reporting Period
- Timeframes displayed when each metric will be displayed for Public Reporting on the *Hospital Compare* website

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### Oncology Care Measures

| NQF #0382 (PCH-14) | Program (Fiscal Years) | Reporting Periods - Calendar Year Quarters | Quarterly Data Submission Deadlines | Hospital Compare Release April 2015 | Hospital Compare Release July 2015 | Hospital Compare Release October 2015 | Hospital Compare Release December 2015 | Hospital Compare Release April 2016 | Hospital Compare Release July 2016 | Hospital Compare Release October 2016 | Hospital Compare Release December 2016 | Hospital Compare Release April 2017 | Hospital Compare Release July 2017 | Hospital Compare Release October 2017 | Hospital Compare Release December 2017 |
|---------------------|------------------------|-------------------------------------------|-----------------------------------|-------------------------------------|-----------------------------------|----------------------------------------|----------------------------------------|-------------------------------------|-----------------------------------|----------------------------------------|----------------------------------------|----------------------------------------|----------------------------------------|----------------------------------------|
| 2016                | 1Q 2015                | PRIOR                                     |                                   |                                     |                                   |                                        |                                        |                                     |                                   |                                        |                                        |                                        |                                        |                                        |
| 2018                | 1Q 2016                | 2Q 2016                                   | 3Q 2016                           | 4Q 2016                             | 8/15/2017                         |                                        |                                        |                                     |                                   |                                        |                                        |                                        |                                        |                                        |

### SCIP Measures

| NQF #0218 (PCH-19) | Program (Fiscal Years) | Reporting Periods - Calendar Year Quarters | Quarterly Data Submission Deadlines | Hospital Compare Release April 2015 | Hospital Compare Release July 2015 | Hospital Compare Release October 2015 | Hospital Compare Release December 2015 | Hospital Compare Release April 2016 | Hospital Compare Release July 2016 | Hospital Compare Release October 2016 | Hospital Compare Release December 2016 | Hospital Compare Release April 2017 | Hospital Compare Release July 2017 | Hospital Compare Release October 2017 | Hospital Compare Release December 2017 |
|---------------------|------------------------|-------------------------------------------|-----------------------------------|-------------------------------------|-----------------------------------|----------------------------------------|----------------------------------------|-------------------------------------|-----------------------------------|----------------------------------------|----------------------------------------|----------------------------------------|----------------------------------------|----------------------------------------|
| 2016                | 1Q 2015                | PRIOR                                     |                                   |                                     |                                   |                                        |                                        |                                     |                                   |                                        |                                        |                                        |                                        |                                        |
| 2017                | 2Q 2015                | 3Q 2015                                   | 8/15/2016                         |                                     |                                   |                                        |                                        |                                     |                                   |                                        |                                        |                                        |                                        |                                        |
| SCIP measures discontinued after 3Q 2015 |

Public Reporting scheduled to begin in 2016. Specific dates not yet known.

Public Reporting not addressed in Final Rule.
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Appendix C: Glossary of Terms

**Aggregate (data):** Aggregate data are elements derived for a specific hospital from the results of each measures algorithm over a given period of time period (e.g. quarterly).

**Algorithm:** An algorithm is an ordered sequence for data element retrieval and aggregation through which numerators and denominators are identified.

**Calendar Year:** A calendar year is the time period between January 1 and December 31 of a given year.

**Data Accuracy and Completeness Acknowledgement (DACA):** The DACA is a requirement for facilities participating in the PCHQR Program. The DACA is an electronic acknowledgement, which indicates that the data provided to meet the APU data submission requirements are accurate and complete to the best of the facility's knowledge at the time of data submission.

**Data Collection:** Data collection is the act or process of capturing raw or primary data from a single or number of sources; also called “data gathering.”

**Denominator:** The denominator is the lower part of a fraction used to calculate a rate, proportion, or ratio.

**Excluded Populations:** Excluded Populations are based on detailed information describing the populations that should not be included in the indicator. For example, specific age groups, ICD procedure or diagnostic codes, or certain time periods could be excluded from the general population drawn upon by the indicator.

**Initial Patient Populations:** Initial Patient Populations are based on detailed information describing the population(s) that the indicator intends to measure. Details could include such information as specific age groups, diagnoses, ICD diagnostic and procedure codes, CPT codes, revenue codes, enrollment periods, insurance and health plan groups, etc.

**Format:** Format specifies the character length of a specific data element, the type of information the data element contains (i.e., numeric, decimal, number, date, time, character, or alphanumeric), and the frequency with which the data element occurs.

**Measure Information Form:** This tool provides specific clinical and technical information on a measure. The information contained includes: measure set, performance measure name, description, rationale, type of measure, improvement noted as, numerator/denominator/continuous variable statements, included populations, excluded populations, data elements, risk adjustment, data collection approach, data accuracy, measure analysis suggestions, sampling, data reported as, and selected references.

**Medical Record (Data Source):** A medical record is the source of data obtained from the documentation maintained on a patient in any healthcare setting (e.g., hospital, home care, long-term care, practitioner’s office), including automated and paper medical record systems.

**Notice of Participation (NOP):** A requirement for PCHQR Program participating facilities, the NOP indicates a facility’s agreement to participate in the program and to allow public reporting of its measure rates. The NOP has three options: agree to participate, do not agree to participate, and request to be withdrawn from participation.
**Numerator:** The upper portion of a fraction used to calculate a rate, proportion, or ratio.

**Patient Level Data:** The phrase “patient level data” refers specifically to the collection of data elements that depict the healthcare services provided to an individual patient. Patient level data are aggregated to generate data at the setting level (e.g., hospital) and/or comparison group data.

**Process:** Here the term “process” refers to an interrelated series of events, activities, actions, mechanisms, or steps that transform inputs into outputs.

**Reporting Period:** The reporting period is the defined time frame during which medical records are to be reviewed.

**Sampling Method:** The sampling method is essentially the process used to select a sample. Sampling approaches for the PCHQR Program are simple random sampling and systematic random sampling. Refer to the Sampling Approaches discussion in the Population and Sampling Specifications section of the respective manuals, such as the Specifications Manual for National Hospital Inpatient Quality Measures for further information.

**Sampling Size:** The sampling size refers to the number of individuals or particular patients included.

**Simple Random Sample:** A “Simple Random Sample” is a selection of patients from the total population that is processed in a way that every case has a similar chance of being selected.

**Specifications Manual for National Hospital Inpatient Quality Measures:** This is a manual that presents detailed information for the Hospital Inpatient Quality Reporting (IQR) Program measures, including a data dictionary and Measurement Information Forms.

**Strata:** See “Stratified Measure” below.

**Stratified Measure:** A stratified measure is used to assist in analysis and interpretation that is classified into a number of categories. The overall or un-stratified measure evaluates all of the strata together. A stratified measure, or each stratum, consists of a subset of the overall measure. For example, the OCMs are stratified by quarter.

**Systematic Random Sampling:** Systematic random sampling is a process in which the starting case is selected randomly and the next cases are selected according to a fixed interval based upon the number of cases in the population. Refer to the Sampling Approaches discussion in the Population and Sampling Specifications section of the respective manuals, such as the Specifications Manual for National Hospital Inpatient Quality Measures for further information.