

Appendices

PCHQR Notice of Participation Text

Last Updated 03072012

Review the Notice of Participation below, choose an option and enter your Password to confirm.

PPS-exempt Cancer Hospital Quality Reporting Program Notice of Participation (Pledge Form) - Agreement

The hospital agrees to follow procedures for participating in the PPS-exempt Cancer Hospital Quality Reporting (PCHQR) Program as outlined in the federal regulations found in the Federal Register, or is indicating its decision to decline participation.

Each hospital must complete this "PPS-exempt Cancer Hospital QR Notice of Participation" as outlined in the PCHQR Reference Checklist on QualityNet and in the federal regulations found in the Federal Register. In an effort to alleviate the burden associated with submitting this form annually, effective with the PCHQR Notice submitted for participation in FY 2014 or later, a hospital that indicated its intent to participate will be considered an active PCHQR participant until CMS determines a need to pledge again, or the hospital submits a withdrawal to CMS.

This information is in compliance with the CMS guidelines for hospitals submitting their quality performance data in accordance with Section 5001(b) of the Deficit Reduction Act of 2005. Hospitals must also continue to display quality information for public viewing as required by section 1866(k)(4) of the Social Security Act. Before this information is displayed, hospitals will be permitted to review their information as it is recorded. Eligible hospitals must follow the regulations as outlined in the federal regulations and as summarized in the PCHQR Reference Checklist on QualityNet.

CMS must publish on Hospital Compare the hospital's submitted data for the required measures. Data aggregated at the hospital level will be provided to the Secretary.

We entities operating under the submitted Provider ID...

Agree to participate.

Do not agree to participate.

Request to be withdrawn from participation.

This acknowledgement (to participate or not to participate or to withdraw) remains in effect until an electronically signed acknowledgement applying changes has been entered.

By entering my password, I hereby issue this Hospital IQR Notice of Participation with the specified direction contained within:

NOTE: CMS allows hospitals to submit optional quality measures that can be publicly reported and are not required for the PCHQR Program. In order to have the opportunity to submit, preview and publish the optional measures, the following Inpatient Public Reporting Notice of Participation is necessary in addition to PPS-exempt Cancer Hospital Quality Reporting Program Notice of Participation Agreement shown above.

By entering this pledge, I agree to:

- (1) Transmit or have data transmitted to CMS and/or the QIO Clinical Warehouse; and
- (2) Permit my hospital's performance information to be publicly reported beginning with discharges for the quarter indicated below:

QUARTER: First Second Third Fourth **YEAR:** 20_____

I understand that:

- The hospital will have at least 30 days to preview performance information before the data are made public.
- The hospital may be able to suppress a measure or measures prior to their posting.
- The hospital may withdraw from this effort at any time.
- This pledge will remain in force and cover current and future measures or measurement sets.

We entities operating under the submitted Provider ID...

Agree to participate.

Request to be withdrawn from participation.

This acknowledgement (to participate or to withdraw) remains in effect until an electronically signed acknowledgement applying changes has been entered.

By entering my password, I hereby issue this Inpatient Public Reporting Notice of Participation with the specified direction contained within:

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-XXXX . The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

PPS-exempt Cancer Hospital Quality Reporting (PCHQR) Program

Decline to Participate

Agreement

The facility named below agrees to follow procedures for participating in the PPS-exempt Cancer Hospital Quality Reporting (PCHQR) Program as outlined in the **federal regulations** found in the Federal Register and is **indicating its decision to decline participation**.

Each facility must complete the online electronic “Notice of Participation” or the “Decline to Participate” paper form as outlined in the federal regulations found in the Federal Register. In an effort to alleviate the burden associated with completing this annually, effective with the Notice of Participation submitted for participation in the FY 2014 or later PCHQR Program, a facility that has previously indicated its intent to participate will be considered an active PPS-exempt Cancer Hospital Quality Reporting Program participant until such time as the facility submits a withdrawal to CMS.

This information is in compliance with the CMS guidelines for facilities submitting their quality performance data, facilities must also continue to display quality information for public viewing as required by section 1866(k)(4) of the Social Security Act. Before this information is displayed, facilities will be permitted to review their information as it is recorded. Eligible facilities must follow the regulations as outlined in the federal regulations and as summarized on the *QualityNet* Web site.

CMS must publish on CMS.gov the facility’s submitted data for the required measures. Data at the hospital level will be provided to the Secretary.

To participate, a hospital must access the online QualityNet Notice of Participation tool.

To *DECLINE* to participate, the below signature states the signer has read and agrees to the foregoing provisions and the participation decision, and acknowledges same by signing here.

Facility’s Name _____

CMS Certification Number (CCN) _____

Signature of CEO (or Designee) _____

Signer’s Name, Printed or Typed _____

Signer’s Title _____

Date Signed _____

If declining to participate, submit this completed and signed “Decline to Participate” form directly to your IPF Support Contractor.

PRA Disclosure Statement

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Data Accuracy and Completeness Acknowledgement

I acknowledge that, to the best of my ability, all of the information reported for this hospital for the PPS-exempt Cancer Hospital Quality Reporting (PCHQR) Program, as required for the annual Fiscal Year 2014 PCHQR Program requirements, is accurate and complete. This information includes the following:

- Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey;
- Healthcare Associated Infection measure(s) reported using the National Healthcare Safety Network (NHSN);
- Cancer-Specific measures and
- Current Notice of Participation and QualityNet Security Administrator.

I understand this acknowledgement covers all PCHQR information reported by this hospital (and any data or survey vendor(s) acting as agents on behalf of this hospital) to the Centers for Medicare & Medicaid Services (CMS) and its contractors for the FY 2014.

To the best of my knowledge, this information was collected in accordance with all applicable requirements. I understand that this information is used as the basis for the public reporting of quality of care and patient assessment of care.

I understand that this acknowledgement is required for purposes of meeting any Fiscal Year 2014 PCHQR Program requirements.

Yes, I Acknowledge

Name _____

Position _____

Date _____

PRA Disclosure Statement

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**Centers for Medicare & Medicaid Services (CMS) Hospital Inpatient Quality Reporting (IQR) Program
Healthcare Associated Infection (HAI) Exception Form**

This exception must be renewed at least annually

Specify the calendar year and applicable quarter(s) for the specific National Healthcare Safety Network (NHSN) HAI Measure exception request(s).

* Indicates required fields

***HAI Measure Exception Information** (The exception(s) you are requesting must be selected)

Select all that apply

<ul style="list-style-type: none">• Catheter-Associated Urinary Tract Infection (CAUTI) Hospital has no Adult or Pediatric Intensive Care Unit (ICU) locations Calendar Year (YYYY) _____<ul style="list-style-type: none">• January 1 through March 31• July 1 through September 30• April 1 through June 30• Oct 1 through Dec 31
<ul style="list-style-type: none">• Central Line-Associated Bloodstream Infection (CLABSI) Hospital has no Adult, Pediatric or Neonatal Intensive Care Unit (NICU) locations Calendar Year (YYYY) _____<ul style="list-style-type: none">• January 1 through March 31• July 1 through September 30• April 1 through June 30• Oct 1 through Dec 31
<ul style="list-style-type: none">• Surgical Site Infection (SSI) Hospital performed a combined total of 9 or fewer colon surgeries and abdominal hysterectomies in the calendar year prior to the reporting year. Calendar Year prior to reporting year (YYYY) _____ Number procedures performed _____ Exclusion requested for Calendar Year (YYYY) _____

***I have reviewed NHSN definitions for (select all that apply):**

- ICU locations
- NICU locations
- Specified colon surgery and abdominal hysterectomies

An intensive care unit (ICU) is defined as:

The Centers for Disease Control and Prevention (CDC)-defined designation given to a patient care area housing patients who have similar disease conditions or who are receiving care for similar medical or surgical specialties. Each facility location that is monitored is "mapped" to one CDC Location. The specific CDC Location code is determined by the type of patients cared for in that area according to the 80% Rule. That is, if **80%** or more of the area's patients are of a

certain type (e.g., intensive care unit patients) then the area is designated as that type of location (in this case, an intensive care unit).

Conversely, if fewer than 80% of the patients in any hospital unit do not receive intensive observation, diagnosis, and therapeutic procedures for critical illness, i.e., are not ICU patients, then the hospital by definition has no ICU and is eligible to complete the "Healthcare Associated Infection (HAI) Exception" form consistent with CDC's "80% rule" and CMS Hospital IQR policy guidance.

Specified colon and abdominal hysterectomy surgical procedures:

Only hospitals that performed 9 or fewer of any of the specified colon **and** abdominal hysterectomy combined in the calendar year prior to the reporting year. The **NHSN Operative Procedure Category Mappings to International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) Codes** (Table 1 extract) is located on the *NHSN* website.

Facility Contact Information

*CMS Certification Number (CCN): _____

*Facility Name: _____

*CEO/Designee Last Name: _____

*CEO/Designee First Name: _____

*Title _____

*CEO/Designee E-Mail Address: _____

*CEO/Designee Telephone Number: ___ - ___ - ____ ext. _____

Additional Comments:

I hereby certify that the facility meets the exception criteria and therefore has no data to submit related to the specified HAI measure(s)

Name _____

Position _____

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